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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE PHYLLIS J. HAMILTON, JUDGE

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE,	
PLAINTIFFS,	
VS.	NO. C 03-4872 PJH
JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY,	MONDAY, APRIL 5, 2004
	SAN FRANCISCO, CALIFORNIA
DEFENDANT.	

REPORTER'S TRANSCRIPT OF PROCEEDINGS

APPEARANCES:

FOR PLAINTIFFS: BINGHAM MCCUTCHEON LLP
THREE EMBARCADERO CENTER
SAN FRANCISCO, CALIFORNIA 94111-4003
BY: BETH H. PARKER, ATTORNEY AT LAW
DEBORAH ADLER, ESQUIRE

PLANNED PARENTHOOD FEDERATION OF AMERCIA
434 W. 33RD STREET.
NEW YORK, NEW YORK 10001
BY: EVE C. GARTNER, ESQUIRE

(APPEARANCES CONTINUED ON NEXT PAGE)

REPORTED BY: DIANE E. SKILLMAN, CSR 4909
OFFICIAL COURT REPORTER

1 PLANNED PARENTHOOD FEDERATIONF AMERICA
1780 MASSACHUSETTS AVENUE, N.W.
2 WASHINGTON, D.C. 200036
BY: HELENE T. KRASNOFF, ESQUIRE
3

4

5

6 FOR INTERVENOR OFFICE OF THE CITY ATTORNEY
PLAINTIFFS CITY 1390 MARKET STREET, SUITE 1008
7 AND COUNTY OF SAN FRANCSICO, CALIFORNIA 94102
SAN FRANCISCO: BY: KATHLEEN SUZANNE MORRIS,
8 ALEETA MARIE VAN RUNKLE,
DEPUTY CITY ATTORNEYS
9

10 FOR DEFENDANT: U.S. DEPARTMENT OF JUSTICE
20 MASSACHUSETTS AVENUE, N.W. ROOM 7128
11 WASHINGTON, D.C. 20530
BY: MARK THOMAS QUINLIVAN
12 W. SCOTT SIMPSON,
KAIJA MARIE CLARK,
13 ASSISTANT U.S. ATTORNEYS

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1 APRIL 5, 2004 8:30 O'CLOCK A.M.
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3 P R O C E E D I N G S
4 THE COURT: ALL RIGHT. GOOD MORNING, COUNSEL.
5 MR. QUINLIVAN: GOOD MORNING.
6 THE COURT: ARE YOU READY WITH YOUR NEXT WITNESS?
7 MS. GARTNER: YES, YOUR HONOR.
8 MR. SIMPSON: YOUR HONOR, IF WE COULD RAISE ONE VERY
9 SMALL THING BEFORE WE DO THAT. WE JUST WANTED TO LET THE COURT
10 KNOW THAT THE ISSUE AS TO THE USE OF THE CHASEN STUDY HAS BEEN
11 RESOLVED.
12 WE HAVE GIVEN PLAINTIFFS' COUNSEL THIS MORNING THE
13 TWO SUPPLEMENTAL REPORTS THAT THE COURT ORDERED, AND WE WILL BE
14 FILING THOSE LATER TODAY.
15 THE COURT: OKAY, GOOD. ALL RIGHT. NEXT WITNESS?
16 MS. GARTNER: THANK YOU, YOUR HONOR. PLAINTIFFS
17 CALL DR. FREDRIK BROEKHUIZEN TO THE STAND.
18 THE CLERK: PLEASE RAISE YOUR RIGHT HAND.
19 DR. FREDRIK FRANCOIS BROEKHUIZEN
20 CALLED AS A WITNESS FOR THE PLAINTIFFS, HAVING BEEN DULY SWORN,
21 TESTIFIED AS FOLLOWS:
22 THE WITNESS: I DO.
23 THE CLERK: TAKE THE STAND.
24 PLEASE STATE YOUR NAME FOR THE COURT.
25 THE WITNESS: FREDRIK FRANCOIS BROEKHUIZEN.

1 THE CLERK: WOULD YOU PLEASE SPELL FREDRIK?
2 THE WITNESS: F-R-E-D-R-I-K.
3 THE CLERK: WOULD YOU PLEASE SPELL YOUR OTHER?
4 THE WITNESS: F-R-A-N-C-O-I-S.
5 THE CLERK: AND YOUR LAST NAME?
6 THE WITNESS: B-R-O-E-K-H-U-I-Z-E-N.
7 THE CLERK: THANK YOU.
8 DIRECT EXAMINATION
9 BY MS. GARTNER:
10 Q. GOOD MORNING, DR. BROEKHUIZEN.
11 A. GOOD MORNING.
12 MS. GARTNER: YOUR HONOR, MAY I APPROACH THE
13 WITNESS?
14 THE COURT: YES.
15 BY MS. GARTNER:
16 Q. DR. BROEKHUIZEN, I HAVE HANDED YOU WHAT IS EXHIBIT 6. IS
17 THIS A CURRENT COPY OF YOUR CURRICULUM VITAE?
18 A. IT IS MY CURRICULUM VITAE THAT IS CURRENT AS OF DECEMBER,
19 2003.
20 Q. DID YOU PREPARE THIS DOCUMENT YOURSELF?
21 A. YES, I DID.
22 Q. IS THE INFORMATION ON THIS C.V. TRUE AND CORRECT?
23 A. TRUE AND CORRECT.
24 Q. ARE THERE ANY UPDATES TO THIS C.V. AS FAR AS YOU KNOW?
25 A. NO, NO PUBLICATIONS. THERE ARE SOME TALKS THAT I MAY HAVE

1 GIVEN SINCE THAT TIME.
2 Q. OKAY.
3 MS. GARTNER: YOUR HONOR, PLAINTIFFS MOVE TO
4 INTRODUCE PLAINTIFFS' 6 INTO EVIDENCE.
5 THE COURT: ANY OBJECTION?
6 MR. SIMPSON: NO OBJECTION.
7 THE COURT: IT MAY BE ADMITTED.
8 THE CLERK: SIX INTO EVIDENCE.
9 (PLAINTIFFS' EXHIBIT 6
10 WAS RECEIVED IN EVIDENCE.)
11 BY MS. GARTNER:
12 Q. DR. BROEKHUIZEN, ARE YOU BOARD CERTIFIED IN OBSTETRICS AND
13 GYNECOLOGY?
14 A. YES, I AM.
15 Q. CAN YOU PLEASE TELL ME THE PLACES WHERE YOU ARE CURRENTLY
16 EMPLOYED?
17 A. I AM CURRENTLY EMPLOYED AT THE MEDICAL COLLEGE OF
18 WISCONSIN, WHICH IS MEDICAL SCHOOL LOCATED IN MILWAUKEE FOR
19 80 PERCENT OF MY TIME. THE OTHER 20 PERCENT OF MY TIME I DO
20 INTERNATIONAL HEALTH CONSULTING-TEACHING WORK.
21 AND IN THE TIME THAT I AM EMPLOYED AT THE MEDICAL
22 COLLEGE, 30 PERCENT OF THAT TIME THERE IS AN ARRANGEMENT
23 BETWEEN PLANNED PARENTHOOD OF WISCONSIN AND THE MEDICAL SCHOOL
24 TO HAVE ME FUNCTION AS THE PART-TIME MEDICAL DIRECTOR OF
25 PLANNED PARENTHOOD OF WISCONSIN.

1 Q. OKAY. CAN YOU DESCRIBE YOUR DUTIES AT THE MEDICAL COLLEGE
2 OF WISCONSIN, LEAVING ASIDE A MINUTE WHAT YOU DO AT PLANNED
3 PARENTHOOD OF WISCONSIN?
4 A. I AM A FACULTY MEMBER. I AM A FULL PROFESSOR IN OBSTETRICS
5 AND GYNECOLOGY. I HAVE TEACHING DUTIES TEACHING RESIDENTS AND
6 MEDICAL STUDENTS.
7 I WILL LECTURE. I PARTICIPATE IN SECOND AND
8 THIRD-YEAR COURSES OF CERTAIN SUBJECTS. I HAVE A CLINICAL
9 PRACTICE IN GENERAL OB/GYN AT THE MEDICAL COLLEGE. AND I AM
10 LOCATED FOR AT LEAST ONE THIRD OF MY TIME IN THE DIVISION OF
11 INTERNAL FETAL MEDICINE WHERE I DO MAINLY MANAGEMENT OF
12 HIGH-RISK OBSTETRICAL CARE AND ULTRASOUND AND PRENATAL
13 DIAGNOSIS.
14 Q. AND DO YOU DELIVER BABIES AS PART OF YOUR PRACTICE?
15 A. I CERTAINLY DELIVER BABIES AS PART OF MY PRACTICE.
16 Q. DO YOU HAVE SPECIFIC NICHES IN WHICH YOU HAVE PARTICULAR
17 EXPERTISE?
18 A. WELL, OVER THE YEARS I'VE KIND OF BEEN INVOLVED IN SPECIFIC
19 NICHES. I -- FOR WHEN I WAS IN MY PREVIOUS EMPLOYMENT, I WAS
20 WORKING IN A CITY HOSPITAL AND DID A LOT OF PUBLIC
21 HEALTH-RELATED ACTIVITIES, SUBSTANCE ABUSE AND PREGNANCY, ET
22 CETERA.
23 I HAVE BEEN FOR CLOSE TO 24 YEARS BEING THE MEDICAL
24 DIRECTOR OF PLANNED PARENTHOOD COLPOSCOPY CLINICS FOR PATIENTS
25 WITH ABNORMAL PAP SMEARS. AND I'VE DEVELOPED AN INTEREST IN

1 CERVICAL CANCER, DETECTION OF THE PRECURSORS OF CERVICAL CANCER
2 DETECTION.
3 AND SOME OF MY INTERNATIONAL WORK RELATES TO THE
4 DETECTION OF EARLY CERVICAL CANCER OR PRECANCER.
5 MY INTERNATIONAL INTEREST, AS WELL, INCLUDES
6 PREVENTION OF MATERNAL MORTALITY DUE TO HEMORRHAGE. AND IN THE
7 MILWAUKEE AREA OVER THE LAST 24 YEARS, ONE OF MY NICHES HAS
8 BEEN THE PROVISION OF ABORTION SERVICES IN HOSPITAL SETTINGS.
9 Q. AND IS THERE A PARTICULAR HOSPITAL AT WHICH YOU GENERALLY
10 PRACTICE MEDICINE AS A PART OF YOUR WORK WITH THE MEDICAL
11 COLLEGE OF WISCONSIN?
12 A. MOST OF MY CLINICAL PRACTICE AT THE MOMENT IS LOCATED AT
13 FROEDTERT -- IT'S A -- I THINK IT'S CALLED FROEDTERT MEMORIAL
14 LUTHERAN HOSPITAL.
15 Q. CAN YOU SPELL "FROEDTERT"?
16 A. F-R-O-E-D-T-E-R-T.
17 I AM ON THE MEDICAL STAFF OF ABOUT EIGHT HOSPITALS
18 IN THE MILWAUKEE AREA.
19 Q. AND DO YOU PERFORM ABORTIONS AT FROEDTERT HOSPITAL?
20 A. I DO.
21 Q. AND UNDER WHAT CIRCUMSTANCES DO YOU PERFORM ABORTIONS AT
22 FROEDTERT?
23 A. FROEDTERT HOSPITAL HAS ITS OWN RULES ABOUT WHAT WOULD BE
24 ALLOWED FOR PREGNANCY TERMINATIONS. THE INDICATIONS THERE
25 WOULD BE LETHAL FETAL ANOMALIES OR HEALTH CONDITIONS THAT WOULD

1 POSE A RISK TO THE LIFE OF THE MOTHER.
2 Q. CAN YOU EXPLAIN WHAT YOU MEAN BY A "LETHAL FETAL ANOMALY"?
3 A. THAT WOULD BE A FETAL ANOMALY WHERE THERE IS NO LONG TERM
4 MEANINGFUL LIFE EXPECTANCY. A DEATH WOULD BE EXPECTED WITHIN
5 HOURS TO SOMETIMES WEEKS.
6 Q. AND HOW LONG HAVE YOU BEEN ON THE FACULTY OF THE MEDICAL
7 COLLEGE OF WISCONSIN?
8 A. SINCE JANUARY OF 2001.
9 Q. AND WHERE WERE YOU BEFORE YOU JOINED THE FACULTY AT THE
10 MEDICAL COLLEGE OF WISCONSIN?
11 A. FROM THE END OF 1979 UNTIL JANUARY OF 2001, I WAS A FACULTY
12 MEMBER OF THE UNIVERSITY OF WISCONSIN MEDICAL SCHOOL, WHICH
13 MAIN CAMPUS IS IN MADISON, WISCONSIN, BUT THEY HAVE A CLINICAL
14 CAMPUS WHICH IS LOCATED IN MILWAUKEE.
15 Q. AND WERE YOU EVER THE CHAIR OF THE DEPARTMENT AT THE
16 MILWAUKEE CAMPUS AT THE UNIVERSITY OF WISCONSIN?
17 A. I WAS THE CHAIR OF THE DEPARTMENT OF OBSTETRICS AND
18 GYNECOLOGY FROM 1989 UNTIL 1998.
19 Q. AND WHERE WAS -- THE MILWAUKEE CAMPUS OF THE UNIVERSITY OF
20 WISCONSIN, WHERE WAS THAT LOCATED?
21 A. IT WAS LOCATED AT ONE OF THE HOSPITALS IN MILWAUKEE. OVER
22 THE LAST 24 YEARS, THE NAME HAS CHANGED ABOUT FOUR TIMES. IT
23 STARTED OUT TO BE SINAI HOSPITAL. THEN, IT MERGED AND BECAME
24 SINAI SAMARITAN MEDICAL CENTER. AND CURRENTLY IT CALLED AURORA
25 SINAI MEDICAL CENTER.

1 Q. AND AT AURORA SINAI, DID YOU PROVIDE ABORTIONS IN A WIDER
2 RANGE OF CIRCUMSTANCES THAN YOU CURRENTLY DO AT FROEDTERT?
3 A. YES I HAVE. AND YES, I DO. AT AURORA SINAI HOSPITAL THERE
4 ARE NO INSTITUTION-BASED RESTRICTIONS ON THE INDICATIONS FOR A
5 PREGNANCY TERMINATION.
6 Q. AND WHEN YOU SAY: "YES, I DO," DOES THAT MEAN THAT YOU
7 STILL PERFORM SOME ABORTIONS AT AURORA SINAI?
8 A. I STILL PERFORM SOME ABORTIONS AT AURORA SINAI.
9 Q. CAN YOU EXPLAIN THE CIRCUMSTANCES IN WHICH YOU WOULD DO
10 ABORTIONS CURRENTLY AT AURORA SINAI?
11 A. THE MAJORITY OF PATIENTS ARE REFERRED TO ME BY PRACTICING
12 OB/GYN PHYSICIANS IN THE COMMUNITY OR PERINATOLOGISTS IN THE
13 STATE OF WISCONSIN.
14 AND IF I SEE THE PATIENT, CONFIRM THE DIAGNOSIS AND
15 COME TO A CONSENSUS WITH THE PATIENT THAT PREGNANCY TERMINATION
16 IS THE PROPER THING TO PROCEED WITH, THE INDICATIONS, THAT'S
17 THE CONDITIONS, THERE ARE SITUATIONS WHERE I CANNOT PERFORM
18 THAT PROCEDURE AT FROEDTERT HOSPITAL FOR NONLETHAL FETAL
19 ANOMALIES, AS AN EXAMPLE. AND THOSE PATIENTS THEN I WILL
20 PROVIDE THE SERVICES AT AURORA SINAI MEDICAL CENTER.
21 Q. AND YOU TESTIFIED THAT YOU ARE THE PART-TIME MEDICAL
22 DIRECTOR OF PLANNED PARENTHOOD OF WISCONSIN; IS THAT RIGHT?
23 A. THAT'S CORRECT.
24 Q. AND CAN YOU DESCRIBE YOUR DUTIES AND MEDICAL PRACTICE AT
25 PLANNED PARENTHOOD OF WISCONSIN?

1 A. WELL, PLANNED PARENTHOOD OF WISCONSIN HAS A LITTLE OVER 30
2 CLINICS ACROSS THE STATE. AS AN EXAMPLE, THERE ARE SIX IN
3 MILWAUKEE. MOST OF THE SERVICES AT THESE PLANNED PARENTHOOD
4 CLINICS ARE FAMILY PLANNING SERVICES AND CERVICAL CANCER AND
5 BREAST CANCER SCREENING PRACTICES.
6 AND MAINLY NURSE PRACTITIONERS WHO PROVIDE THESE
7 SERVICES, I AM THEIR DIRECT PHYSICIAN SUPERVISOR AND PROVIDE A
8 LOT OF CONSULTATIONS BY E-MAIL AND BY PHONE.
9 I RUN A PROBLEM CLINIC FOR SITUATIONS THAT NURSE
10 PRACTITIONERS CANNOT HANDLE WITHIN THEIR SCOPE OF PRACTICE.
11 AND THEN, I PROVIDED THE COLPOSCOPY SERVICES.
12 I AM THE HEAD OF A COMMITTEE OF ASSOCIATE MEDICAL
13 DIRECTORS/PHYSICIANS. ALL THE CLINICS HAVE AN ASSOCIATE LOCAL
14 MEDICAL DIRECTOR. AND WE KIND OF SET PROTOCOLS, AND QUALITY OF
15 CARE STANDARDS FOR THE PROVISION OF MAINLY FAMILY PLANNING
16 SERVICES.
17 Q. AND ARE ABORTIONS PERFORMED AT PLANNED PARENTHOOD
18 WISCONSIN?
19 A. TWO OF THOSE CLINICS HAVE ABORTIONS ARE BEING PERFORMED.
20 Q. HOW LATE ARE ABORTIONS PERFORMED AT THOSE CLINICS?
21 A. UP UNTIL 16 WEEKS.
22 Q. AND DO YOU PERSONALLY PERFORM ABORTIONS AT PLANNED
23 PARENTHOOD?
24 A. NO, I DON'T.
25 Q. WHY IS THAT?

1 A. I LIST FOR YOU ALL MY INTEREST AND MY ACTIVITIES. AND IT
2 IS JUST A MATTER OF CHOOSING, YOU KNOW, WHERE I SPEND MY TIME.
3 THERE ARE OTHER PHYSICIANS WHO PROVIDE THE SERVICES, ABORTION
4 SERVICES AT THE TWO PLANNED PARENTHOOD CLINICS WHERE ABORTIONS
5 ARE BEING PROVIDED.
6 Q. HOW LONG HAVE YOU BEEN THE MEDICAL DIRECTOR OF PLANNED
7 PARENTHOOD?
8 A. SINCE SOMETIME IN 2001, SHORTLY AFTER I JOINED THE MEDICAL
9 COLLEGE.
10 Q. AND DID YOU PROVIDE MEDICAL SERVICES AT PLANNED PARENTHOOD
11 BEFORE BECOMING THE MEDICAL DIRECTOR?
12 A. SINCE 1980 I HAVE BEEN THE MEDICAL DIRECTOR FOR THEIR
13 COLPOSCOPY SERVICES. AND IN MANY WAYS I HAVE, YOU KNOW, BEEN
14 ON THEIR ADVISORY BOARDS. AND I HAVE -- I USED TO TAKE MEDICAL
15 STUDENTS TO PLANNED PARENTHOOD CLINICS TO TEACH THEM FAMILY
16 PLANNING.
17 Q. YOU SAID THAT YOU ALSO DO INTERNATIONAL HEALTH WORK. CAN
18 YOU DESCRIBE THAT WORK?
19 A. I -- MANY YEARS AGO I WORKED AS A TROPICAL PHYSICIAN IN
20 ETHIOPIA. AND -- BUT IN THE LAST FIVE, SIX YEARS I HAVE DONE
21 INTERNATIONAL CONSULTING AND TRAINING WORK FOR THE WORLD HEALTH
22 ORGANIZATION, AND MAINLY FOR AN ORGANIZATION JHPIEGO. IT'S A
23 JOHN HOPKINS AFFILIATE THAT DOES TRAINING IN REPRODUCTIVE
24 HEALTH, PROJECTS IN PRACTICE MATERNAL AND NEONATAL HEALTH AND
25 IN CERVICAL CANCER PREVENTION IN SEVERAL COUNTRIES ACROSS THE

1 WORLD.
2 Q. AND WHAT COUNTRIES HAVE YOU BEEN FOCUSING ON RECENTLY?
3 A. THE LAST THREE YEARS I HAVE WORKED IN THAILAND, GHANA AND
4 MALAWI.
5 Q. DR. BROEKHUIZEN, HAVE YOU PUBLISHED IN THE AREA OF
6 OBSTETRICS AND GYNECOLOGY?
7 A. YES, I HAVE.
8 Q. AND, GENERALLY, WHAT SUBJECT AREAS HAVE YOU PUBLISHED IN?
9 A. I HAVE BEEN -- WHEN I LOOK AT MY CURRICULUM VITAE, I
10 PROBABLY WILL IDENTIFY THE AREAS I WAS INTERESTED IN IN GENERAL
11 OBSTETRICS AND GYNECOLOGY AND HIGH-RISK OBSTETRICS AT CERTAIN
12 TIME, IN HUMAN PAPILLOMA VIRUS IN RELATIONSHIP TO PRECANCER,
13 CERVICAL CANCER DETECTION.
14 AND SO IT HAS BEEN A PRETTY WIDE RANGE AND NOT
15 ONE -- ALL IN ONE PARTICULAR AREA.
16 Q. AND ARE YOUR PUBLICATIONS ALL LISTED ON YOUR CURRICULUM
17 VITAE?
18 A. THEY ARE ALL LISTED ON MY CURRICULUM VITAE.
19 Q. DO YOU DO MEDICAL RESEARCH IN THE FIELD OF OBSTETRICS AND
20 GYNECOLOGY?
21 A. I HAVE BEEN INVOLVED IN TWO. I HAVE CONDUCTED THE
22 RANDOMIZED TRIAL WITH ONE OF MY RESIDENTS AT THE UNIVERSITY OF
23 WISCONSIN. I HAVE BEEN INVOLVED IN TWO MULTICENTER STUDIES.
24 AND, YES, I HAVE BEEN INVOLVED IN DIFFERENT RESEARCH PROJECTS.
25 Q. AND DR. BROEKHUIZEN, WHAT METHODS OF ABORTION DO YOU

1 CURRENTLY PERFORM IN YOUR PRACTICE?
2 A. I PERFORM FIRST-TRIMESTER SUCTION D&C, SECOND-TRIMESTER
3 D&E'S AND SECOND-TRIMESTER INDUCTION METHODS OF PREGNANCY
4 TERMINATION.
5 Q. AND IN YOUR PRACTICE, YOUR CURRENT PRACTICE, TO WHAT
6 GESTATIONAL AGE DO YOU PERFORM D&E ABORTIONS?
7 A. UP UNTIL 20 WEEKS.
8 Q. AND TO WHAT GESTATIONAL AGE DO YOU PERFORM INDUCTION
9 ABORTIONS?
10 A. UP TO THE LEGAL LIMIT IN WISCONSIN, WHICH IS 24 WEEKS.
11 Q. AND DO YOU EVER INDUCE A TERMINATION OF PREGNANCY AFTER 24
12 WEEKS WITH THE KNOWLEDGE THAT THE FETUS WON'T SURVIVE?
13 A. YES. WE WILL -- THERE ARE SITUATIONS WHERE WE WILL HAVE
14 LABOR INDUCTION AFTER 24 WEEKS IN CASES OF LETHAL FETAL
15 ANOMALIES.
16 UNDER THESE CIRCUMSTANCES USUALLY THERE HAS BEEN
17 CONSULTATION WITH THE NEONATOLOGIST OR THE PEDIATRIC SITE AS
18 FAR AS WHAT TYPE OF SUPPORT OF PALLIATIVE CARE WILL BE PROVIDED
19 TO THE NEWBORN IF IT IS BORN ALIVE, WHICH IS INEVITABLY GOING
20 TO DIE.
21 Q. AND YOU USED THE TERM "PALLIATIVE CARE." CAN YOU EXPLAIN
22 WHAT YOU MEAN BY THAT?
23 A. PALLIATIVE CARE IN THAT SETTING IS REALLY PROVIDING SUPPORT
24 OF CARE, TO PROVIDE ALL OF THE SUPPORT TO THE MOTHERS AND THE
25 BABY. AND BUT AS FAR AS THE BABY IS CONCERNED, TO REALLY

1 PROVIDE AN ENVIRONMENT IN WHICH THE BABY CAN PEACEFULLY DIE.
2 Q. DOES PALLIATIVE CARE INCLUDE LIFE SUPPORT?
3 A. WOULD NOT INCLUDE LIFE SUPPORT UNDER THESE CIRCUMSTANCES,
4 BUT IT MAY INCLUDE PAIN RELIEF.
5 Q. DO YOU TEACH ABORTION METHODS TO OB/GYN RESIDENTS AND
6 MEDICAL STUDENTS?
7 A. YES, I DO.
8 Q. WHAT METHODS OF ABORTION DO YOU TEACH?
9 A. ALL THE METHODS THAT I JUST DESCRIBED TO YOU IN A
10 THEORETICAL SENSE IN LECTURES AND DISCUSSIONS. WHAT STUDENTS
11 AND RESIDENTS WILL OBSERVE IN A PRACTICAL SENSE DEPENDS ON WHAT
12 CASES THAT PRESENT THEMSELVES DURING THEIR ROTATIONS.
13 Q. IS THE PERFORMANCE OF D&E ABORTIONS A REGULAR PART OF YOUR
14 PRACTICE?
15 A. YES, IT IS.
16 Q. HOW LONG HAS THAT BEEN THE CASE?
17 A. SINCE THE EARLY 1980'S.
18 Q. IS THE PERFORMANCE OF INDUCTION ABORTIONS A REGULAR PART OF
19 YOUR PRACTICE?
20 A. YES, IT IS.
21 Q. HOW LONG HAS THAT BEEN THE CASE?
22 A. SINCE THE EARLY '80'S.
23 Q. ARE PATIENTS REFERRED TO YOU SPECIFICALLY FOR ABORTIONS?
24 A. YES, THEY ARE.
25 Q. CAN YOU EXPLAIN SOME OF THE CIRCUMSTANCES IN WHICH THAT

1 OCCURS?
2 A. THE MOST COMMON CIRCUMSTANCE WOULD BE IN FETAL ANOMALY
3 DIAGNOSED BY ULTRASOUND OR AMNIOCENTESIS. THE REFERRALS WOULD
4 COME FROM MATERNAL FETAL MEDICINE SPECIALISTS OR OB/GYN
5 PHYSICIANS OR FAMILY PHYSICIANS WHO PRACTICE OBSTETRICS.
6 OCCASIONALLY, THERE ARE REFERRALS FROM SPECIALISTS
7 IN OTHER AREAS, LIKE ONCOLOGISTS OR CARDIOLOGISTS. IF, FOR
8 INSTANCE, THE DIAGNOSIS OF CANCER IN THE SECOND-TRIMESTER IS
9 MADE OR SEVERE CARDIOVASCULAR DISEASE WHERE THE PREGNANCY WOULD
10 COMPLICATE THE UNDERLYING PREEXISTING INTERNAL DISEASE. BUT
11 MOST OF THE TIME THE REFERRAL WOULD COME FROM THE PRIMARY
12 OB/GYN PHYSICIAN.
13 Q. AND WHY DID THEY MAKE THESE REFERRALS TO YOU?
14 A. CURRENTLY IN WISCONSIN, THERE ARE ONLY FOUR HOSPITALS WHERE
15 PREGNANCY TERMINATIONS WILL TAKE PLACE A IN HOSPITAL SETTING.
16 THERE ARE PROBABLY ONLY ABOUT FOUR OR FIVE PHYSICIANS WHO
17 PROVIDE HOSPITAL-BASED PREGNANCY TERMINATION SERVICES.
18 AND IN SOUTHEASTERN WISCONSIN, WHERE I AM LOCATED,
19 REALLY ONLY ONE OF MY PARTNERS AT THE MEDICAL COLLEGE AND
20 MYSELF WILL TAKE THE MAJORITY OF REFERRALS, I GUESS.
21 AT AURORA SINAI HOSPITAL WHERE I USED TO WORK THERE
22 ARE OCCASIONALLY OTHER PHYSICIANS PROVIDE PREGNANCY TERMINATION
23 SERVICES, BUT THEY ARE -- REALLY DO NOT GET MANY REFERRALS.
24 MR. SIMPSON: WE WILL HAVE TO OBJECT TO THE LACK OF
25 FOUNDATION FOR THAT LAST QUESTION AND ANSWER.

1 THE COURT: OVERRULED.
2 BY MS. GARTNER:
3 Q. DR. BROEKHUIZEN, HAVE YOU EVER TESTIFIED BEFORE IN A CASE
4 CHALLENGING THE CONSTITUTIONALITY OF A LAW THAT RESTRICTS
5 ABORTION PRACTICE?
6 A. YES, I DID. I WAS ONE OF THE PLAINTIFFS, I THINK, IN THE
7 WISCONSIN CASE WHERE THERE WAS A WISCONSIN PARTIAL-BIRTH
8 ABORTION LAW BASED.
9 Q. AND WHEN YOU SAY YOU THINK YOU WERE PLAINTIFF, DO YOU JUST
10 MEAN THAT YOU WEREN'T -- IS YOUR QUESTION --
11 A. I KNOW I WAS A PLAINTIFF, BUT I SOMETIMES GETS CONFUSED
12 WHEN I AM A PLAINTIFF VERSUS AN EXPERT.
13 Q. WERE YOU A PLAINTIFF IN THAT CASE?
14 A. YES, I WAS.
15 Q. AND WHY DID YOU CHOOSE TO GET INVOLVED IN THAT WISCONSIN
16 CASE?
17 A. ON MY READING AND INTERPRETATION OF THE LAW, I WAS VERY
18 CONCERNED THAT THAT LAW COULD BE APPLIED TO SOME OF THE
19 PREGNANCY TERMINATIONS I PERFORMED, WOULD BAN SOME OF THOSE
20 PROCEDURES AND WOULD DEPRIVE PATIENTS FROM MEDICALLY-NECESSARY
21 SERVICES.
22 MS. GARTNER: YOUR HONOR, WE WOULD MOVE TO QUALIFY
23 DR. BROEKHUIZEN AS AN EXPERT WITNESS IN THE AREA OF OBSTETRICS
24 AND GYNECOLOGY, HIGH-RISK OBSTETRICS AND GYNECOLOGY AND
25 ABORTION PRACTICE.

1 THE COURT: ANY OBJECTION?
2 MR. SIMPSON: YOUR HONOR, THEY'VE INCLUDED HIGH-RISK
3 OBSTETRICS. AND DR. BROEKHUIZEN, AS I UNDERSTAND, IS NOT BOARD
4 CERTIFIED IN HIGH-RISK OBSTETRICS.
5 THE COURT: IS IT A REQUIREMENT THAT HE BE BOARD
6 CERTIFIED TO BE AN EXPERT?
7 MR. SIMPSON: I SUPPOSE NOT, YOUR HONOR. WE WON'T
8 OBJECT TO THE DESIGNATION AS AN EXPERT, BUT WE WILL BE CROSSING
9 ON THAT.
10 THE COURT: ALL RIGHT. HE WILL BE ACCEPTED AS AN
11 EXPERT.
12 MS. GARTNER: THANK YOU.
13 BY MS. GARTNER:
14 Q. DR. BROEKHUIZEN, DID YOU COME HERE TODAY TO OFFER EXPERT
15 OPINIONS REGARDING THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003?
16 A. YES, I DID.
17 Q. IN YOUR OPINION, COULD THIS LAW BAN SOME OF THE ABORTIONS
18 THAT YOU DO IN THE SECOND-TRIMESTER OF PREGNANCY?
19 A. YES, I THINK IT WOULD.
20 Q. IN YOUR OPINION, COULD THIS LAW BAN SOME OF THE TECHNIQUES
21 THAT YOU USE TO TREAT WOMEN WHO ARE IN THE MIDST OF A
22 SECOND-TRIMESTER MISCARRIAGE?
23 A. YES, IT WOULD.
24 Q. IN YOUR OPINION, COULD THIS LAW BE UNDERSTOOD AS
25 PROHIBITING PROCEDURES THAT, IN YOUR JUDGMENT, ARE NEEDED BY

1 YOUR PATIENTS DUE TO A SPECIFIC MATERNAL HEALTH CONDITION?
2 A. YES.
3 MR. SIMPSON: OBJECTION, YOUR HONOR, LEADING.
4 THE COURT: ALL RIGHT. I ALLOW LEADING QUESTIONS ON
5 THE BACKGROUND QUESTIONS. AND THIS SEEMS TO ME TO BE STILL IN
6 THAT AREA.
7 BY MS. GARTNER:
8 Q. AND IN YOUR OPINION, DR. BROEKHUIZEN, COULD THIS LAW BE
9 UNDERSTOOD AS PROHIBITING PROCEDURES THAT, IN YOUR OPINION, ARE
10 NEEDED BY YOUR PATIENTS DUE TO A SPECIFIC FETAL CONDITION?
11 A. YES, THEY WOULD.
12 Q. AND COULD THIS LAW BE UNDERSTOOD IN YOUR OPINION AS
13 PROHIBITING PROCEDURES THAT IN YOUR JUDGMENT ARE NEEDED BY YOUR
14 PATIENTS TO OBTAIN INFORMATION NEEDED TO PLAN FOR A FUTURE
15 PREGNANCY?
16 A. YES, THEY WOULD.
17 Q. DR. BROEKHUIZEN, YOU'VE INDICATED THAT SOME OF YOUR
18 PATIENTS HAVE CHOSEN TO END THEIR PREGNANCY DUE TO A MATERNAL
19 HEALTH CONDITION; IS THAT CORRECT?
20 A. THAT'S CORRECT.
21 Q. DOES THIS SOMETIMES ARISE WITH MEDICAL CONDITIONS THAT THE
22 WOMAN HAD PRIOR TO BECOMING PREGNANT?
23 A. YES, IT WOULD.
24 Q. COULD YOU GIVE ME SOME EXAMPLES OF THOSE?
25 A. IT COULD BE SEVERE CARDIOPULMONARY DISEASE. WHAT COMES TO

1 MIND WOULD BE A CONDITION CALLED PULMONARY HYPERTENSION WHERE
2 CARRYING A PREGNANCY MAY HAVE A MORTALITY RISK AS HIGH AS 30,
3 40 PERCENT.
4 PATIENTS WITH SEVERE CORONARY HEART DISEASE.
5 PATIENT WITH END STAGE RENAL DISEASE, LIVER DISEASE.
6 Q. AND DO SOME OF YOUR PATIENTS CHOOSE TO END A PREGNANCY DUE
7 TO A MEDICAL CONDITION THAT IS UNRELATED TO THE PREGNANCY BUT
8 IS NEWLY-DIAGNOSED DURING THE PREGNANCY?
9 A. YES. EXAMPLES OF THAT WOULD BE WHEN A NEW DIAGNOSIS OF
10 CANCER IN THE SECOND-TRIMESTER.
11 Q. AND WHY WOULD A DIAGNOSIS OF CANCER LEAD SOME PATIENTS TO
12 CHOOSE TO END THEIR PREGNANCY?
13 A. THE TREATMENT FOR THE CANCER CERTAINLY WOULD INTERFERE,
14 COULD CAUSE -- OR COULD CAUSE BIRTH DEFECTS OR COULD INTERFERE
15 WITH THE NORMAL DEVELOPMENT OF THE PREGNANCY. OR THE PREGNANCY
16 ITSELF, RIGHT, WOULD MAKE THE TREATMENT MORE -- MAKE THE
17 TREATMENT MORE COMPLICATED OR INTERFERE WITH THE SUCCESS OF THE
18 TREATMENT.
19 Q. AND DOES IT SOMETIMES HAPPEN THAT A PREGNANCY TERMINATION
20 IS INDICATED DUE TO A PREGNANCY COMPLICATION?
21 A. THERE ARE SITUATIONS WHERE PREGNANCY COMPLICATION EVEN
22 PRIOR TO 24 WEEKS WOULD BE THE REASON FOR PREGNANCY
23 TERMINATION. WHAT COMES TO MIND WOULD BE A CONDITION CALLED
24 TRIPLOIDY, WHERE THERE IS A TOTAL EXTRA SET OF CHROMOSOMES THAT
25 IS IN ITSELF IS A LETHAL FETAL ANOMALY. BUT THAT IS ASSOCIATED

1 WITH A PLACENTAL CONDITION AND INCREASED RISK OF EARLY ONSET OF
2 PREECLAMPSIA, WHICH IS A PREGNANCY COMPLICATION.
3 Q. AND IN YOUR PRACTICE, IN WHAT GENERAL TIME FRAME OF
4 PREGNANCY ARE ABORTIONS FOR MATERNAL HEALTH CONDITIONS
5 PERFORMED?
6 A. UP TILL THE LEGAL LIMIT IN WISCONSIN: 24 WEEKS.
7 Q. AND WHEN DO THESE CONDITIONS TEND TO BE DIAGNOSED? IS
8 THERE A TYPICAL TIME FRAME?
9 A. THERE IS REALLY NOT A TYPICAL TIME FRAME. SOME OF THEM
10 WOULD BE FAIRLY EARLY TERMINATIONS, BECAUSE THE PATIENT IS VERY
11 WELL-AWARE OF HER SERIOUS HEALTH CONDITION. BUT, FOR INSTANCE,
12 IN FAMILY PLANNING, METHODS MAY FAIL. THOSE PATIENTS TEND TO
13 BE REFERRED RELATIVELY EARLY.
14 ON THE OTHER HAND, THERE ARE PATIENTS WHO SEEK OR
15 WHO HAVE PROBLEMS I ACCESSING PRENATAL CARE OR UNAWARE OF THEIR
16 OWN HEALTH CONDITIONS WHERE SOMETIMES THIS MAY BE RELATIVELY
17 LATE.
18 Q. DO YOUR PATIENTS EVER CHOOSE TO END THEIR PREGNANCIES DUE
19 TO A FETAL CONDITION?
20 A. I WOULD SAY THE MAJORITY OF THE TERMINATIONS I PERFORM ARE
21 FOR FETAL CONDITIONS.
22 Q. I THINK YOU HAVE DESCRIBED A FEW OF THOSE, BUT CAN YOU JUST
23 BRIEFLY DESCRIBE A FEW OTHER CONDITIONS THAT YOU TYPICALLY SEE
24 IN YOUR PRACTICE WHERE WOMEN CHOOSE TO END THEIR PREGNANCIES
25 FOR A FETAL CONDITION?

1 A. WELL, THEY WOULD RANGE FROM LETHAL FETAL ANOMALIES,
2 CHROMOSOMAL ANOMALIES AS TRISOMY 13, OR 18, OR TRIPLOIDY.
3 LETHAL ANOMALIES THAT ARE MORE STRUCTURAL IN NATURE LIKE
4 ANENCEPHALY WHERE THERE IS NO DEVELOPMENT OF THE BRAIN.
5 CONDITIONS AS RENAL AGENESIS WHERE THERE IS NO DEVELOPMENT OF
6 ANY KIDNEYS, WHICH THEN LEADS TO NONDEVELOPMENT OF THE FETAL
7 LUNGS.
8 AND THEN, THERE ARE THE CONDITIONS AS TRISOMY 21 OR
9 SPINA BIFIDA, WHICH BY ITSELF ARE NOT LETHAL, BUT ARE DIAGNOSED
10 BY ULTRASOUND AND AMNIOCENTESIS WHERE PATIENTS CHOOSE TO HAVE A
11 PREGNANCY TERMINATION.
12 Q. IN WHAT GENERAL TIME FRAME OF PREGNANCY ARE ABORTIONS FOR
13 FETAL CONDITIONS TYPICALLY PERFORMED?
14 A. MORE -- THERE HAS BEEN SOME SHIFT IN THE LAST 20 YEARS.
15 WITH THE ABILITY TO DIAGNOSE SOME FETAL ANOMALIES BY CHORIONIC
16 VILLUS SAMPLING OR DNA ANALYSIS, AT LEAST SOME OF THE DIAGNOSIS
17 WHEN THERE IS A STRONG FAMILY HISTORY OR IN HIGH RISK HAS BEEN
18 MOVED TO BE EARLIER PART OF PREGNANCY. BUT SOME OF THE
19 STRUCTURAL ANOMALIES, WHICH I DIAGNOSE BY ULTRASOUND IN
20 PATIENTS WHO DO NOT HAVE A PRIORITY RISK, TEND TO BE MORE LATER
21 IN THE PREGNANCY.
22 Q. AND IS IT THE CASE THAT ALL OF THE CHROMOSOMAL ANOMALIES
23 TEND TO BE DETECTED EARLIER IN PREGNANCY WITH CHORIONIC VILLUS
24 SAMPLING?
25 A. NO, THAT VERY MUCH DEPENDS ON WHAT IS THE PRACTICE IN A

1 GIVEN COMMUNITY AS FAR AS PRENATAL DIAGNOSIS. AND IT IS MY
2 SENSE THAT IN THE MIDWEST WHERE I LIVE AMNIOCENTESIS IS STILL
3 THE NUMBER 1 DIAGNOSTIC TOOL USED BY PATIENTS WITH ADVANCED
4 MATERNAL AGE OR AN ABNORMAL TRIPLE SCREEN, WHILE I THINK ON THE
5 WEST AND THE EAST COAST THERE MAY BE MORE CHORIONIC VILLUS
6 SAMPLING DONE.
7 BUT IN MY ENVIRONMENT MOST PATIENTS WITH FETAL
8 ANOMALIES ARE AFTER -- ARE DIAGNOSED AFTER 16 WEEKS.
9 Q. ARE THERE PARTICULAR FETAL ANOMALIES WHERE IT IS IN THE
10 WOMAN'S PHYSICAL HEALTH INTEREST TO END THE PREGNANCY WITHOUT
11 CARRYING THE PREGNANCY TO TERM?
12 A. THERE ARE DIAGNOSES AND SITUATIONS WHERE THE CONTINUATION
13 OF THE PREGNANCY WILL HAVE DIRECT -- WILL HAVE DIRECT EFFECT ON
14 THE ABILITY TO DELIVER VAGINALLY.
15 THERE ARE CONDITIONS WHERE MACROCEPHALY WILL DEVELOP
16 WHERE THE FETAL HEAD CAN BECOME SO BIG THAT IT WILL BE TOO BIG
17 TO PASS THROUGH THE BIRTH CANAL.
18 THERE ARE CONDITIONS AS NONIMMUNE HYDROPS OR FETAL
19 ASCITES. THAT MEANS FLUID GETS ACCUMULATED IN THE FETAL
20 ABDOMEN OR EDEMA IS DEVELOPING IN ALL OF THE FETAL TISSUES
21 WHERE PART OF THE FETAL BODY CAN BECOME SO BIG THAT IT WOULD BE
22 IMPOSSIBLE TO DELIVER VAGINALLY. AND I WOULD CONSIDER THOSE
23 SITUATIONS WHERE THAT IS GOING TO DEVELOP OR RUN A TEST TO
24 POTENTIAL TO DEVELOP, ESPECIALLY IN THE CONTEXT OF A LETHAL
25 ANOMALY, A MATERNAL INDICATION FOR A PREGNANCY TERMINATION OR

1 EVEN EARLIER INDUCTION AFTER 24 WEEKS TO AVOID SURGICAL
2 PROCEDURES WITH MORE MORBIDITY AND MORE COMPLICATION.
3 Q. WHEN YOU REFER TO AVOIDING A SURGICAL PROCEDURE, WHAT
4 SURGICAL PROCEDURE ARE YOU TALKING ABOUT AVOIDING?
5 A. THAT WOULD BE A CESAREAN SECTION OR A VARIANT OF CESAREAN
6 SECTION, EITHER HYSTEROTOMY OR A CESAREAN SECTION.
7 Q. DR. BROEKHUIZEN, WHEN A PATIENT IS REFERRED TO YOU FOR
8 PREGNANCY TERMINATION, WHAT IS THE FIRST THING THAT YOU DO?
9 A. BASICALLY, IN ALL PATIENTS I KIND OF COLLECT THE
10 INFORMATION THAT I HAVE OR I COLLECT MORE INFORMATION FROM
11 THEM. AND SO I CONFIRM THE DIAGNOSIS. I IDENTIFY THE REASONS
12 WHY THEY WOULD CHOOSE TO HAVE A PREGNANCY TERMINATION.
13 THERE ARE SITUATIONS WHERE I WILL ASK ONE OF MY
14 COLLEAGUES TO GIVE A SECOND OPINION ABOUT A GIVEN DIAGNOSIS.
15 THERE ARE SITUATIONS WHERE I MAY DO AN ULTRASOUND MYSELF TO
16 CONFIRM THE SITUATION.
17 SUBSEQUENTLY, I WILL GO IN DETAIL WITH THE PATIENTS
18 ABOUT WHAT THERAPEUTIC OPTIONS THERE ARE. AND ON THE MORE
19 CIRCUMSTANCES THAT WOULD MEAN A DETAILED DESCRIPTION OF WHAT A
20 DILATION AND EVACUATION PROCEDURE WOULD BE AND DETAILED
21 DESCRIPTION OF WHAT AN INDUCTION METHOD WOULD BE.
22 AND DURING THAT DETAILED DESCRIPTION I WILL DESCRIBE
23 THE COMPLICATIONS AND RISK OF THESE PROCEDURES. I WOULD
24 COMPARE THAT WITH THE RISK AND COMPLICATIONS OF NO
25 INTERVENTION. THAT MEANS CONTINUATION OF THE PREGNANCY. AND

1 AFTER THAT WOULD COME TO A CONCLUSION WITH THE PATIENTS ABOUT
2 WHAT THEY WOULD CONSIDER THE BEST OPTION UNDER THESE
3 CIRCUMSTANCES.
4 Q. DO YOU EVER -- IN THE CASE WHERE THE INDICATION FOR THE
5 TERMINATION IS A FETAL ANOMALY, DO YOU TALK WITH YOUR PATIENTS
6 ABOUT AUTOPSY OR GENETIC TESTING?
7 A. YES. THERE ARE SCENARIOS WHERE THERE IS -- WHERE IT IS
8 CLEAR FROM THE ULTRASOUND FINDINGS THAT THERE IS A LETHAL
9 ANOMALY, BUT, FOR INSTANCE, NO CYTOGENETIC TESTING, NO
10 CHROMOSOMAL ANALYSIS HAS BEEN DONE YET. THAT COULD BE DONE
11 BEFORE THE PROCEDURE OR AS PART OF THE PROCEDURE IF
12 AMNIOCENTESIS IS DONE.
13 OR IT COULD BE DONE ON PLACENTAL OR FETAL TISSUE
14 AFTER A DELIVERY. AND THERE ARE SITUATIONS WHERE THERE ARE
15 LETHAL SYNDROME THAT THERE IS A LOT OF PROBLEMS. OR IN THE
16 CASE OF A LETHAL ANOMALY, A LETHAL SYNDROME, WHERE A DETAILED
17 AUTOPSY WOULD MAYBE MAKE THE DIAGNOSIS MORE CORRECT OR MORE
18 PRECISE.
19 AND DURING THIS DISCUSSION, WE OFTEN END UP TALKING
20 ABOUT:
21 "WELL, WHAT INFORMATION DO YOU NEED FOR A
22 FUTURE PREGNANCY?" BECAUSE THE QUESTION THAT MOST
23 PATIENTS HAVE IS:
24 "WELL, IS THIS GOING TO HAPPEN AGAIN? AND WHAT
25 ARE MY CHANCES OF THAT HAPPENING?"

1 AND SO THERE ARE SITUATIONS WHERE AN AUTOPSY AND A
2 DETAILED EXAMINATION OF THE FETUS IS VERY IMPORTANT. AND THERE
3 ARE SITUATIONS WHERE THAT REALLY IS NOT THAT IMPORTANT.
4 IN DIAGNOSIS AND KNOWN CHROMOSOMAL ANOMALY, WE KNOW
5 WHAT THE QUALITIES OF THE STRUCTURAL ANOMALY. IF THERE IS
6 NORMAL CHROMOSOMES, BUT AN UNUSUAL SYNDROME, THE PRECISE NATURE
7 OF THAT SYNDROME IS IMPORTANT TO HAVE THAT INFORMATION TO
8 COUNSEL THE PATIENT FOR A FUTURE PREGNANCY.
9 Q. AND IN ADDITION TO YOURSELF, ARE OTHER PHYSICIANS INVOLVED
10 IN COUNSELING AND ADVISING THE PATIENT?
11 A. YES. AS I SAID BEFORE, SOMETIMES SPECIALISTS IN OTHER
12 AREAS, PULMONARY SPECIALISTS, CARDIOLOGISTS, CANCER SPECIALISTS
13 ALREADY ARE INVOLVED AND HAVE DISCUSSED WITH THEM, YOU KNOW,
14 THE RISK OF THEIR MEDICAL DISORDER WITH CONTINUATION OF THE
15 PREGNANCY.
16 IN THE AREA OF FETAL ANOMALIES, IT IS NOT UNCOMMON
17 FOR US -- FOR ME TO ACTUALLY HAVE THE PATIENTS TALK TO
18 PEDIATRIC NEUROSURGEONS, ANY PEDIATRIC SUBSPECIALTY RELATED TO
19 THE PARTICULAR ANOMALY TO HAVE THE PATIENT BE KNOWLEDGEABLE
20 ABOUT WHAT IS THE EXACT NEONATAL PROGNOSIS. BECAUSE IN THE
21 NONLETHAL ANOMALY AREA, IT IS OBVIOUSLY THE MORBIDITY AND HOW
22 SICK AND THE LONG-TERM PROGNOSIS OF THE NEWBORNS THAT CAN BE
23 DECIDING POINTS IN THE PATIENTS TO MAKE DECISIONS ABOUT
24 CONTINUATION OF THE PREGNANCY OR HAVING A PREGNANCY
25 TERMINATION.

1 AT THE MEDICAL COLLEGE WE HAVE A PROGRAM THAT'S
2 CALLED "FETAL CONCERNS PROGRAM," WHERE PATIENTS ARE BEING
3 REFERRED IN THE DIAGNOSIS OF THE FETAL ANOMALY. AND THE
4 NUMBER 1 PURPOSE OF THAT PROGRAM IS TO HAVE BABIES BORN IN
5 HOSPITALS WHERE NEONATAL SURGERY CAN BE DONE WITH THE HIGHEST
6 SUCCESS RATE.
7 SO THIS IS IN THE CONTEXT OF ALL ANOMALIES, RIGHT,
8 THEN ONE ENCOUNTERS A LOT OF NONCORRECTABLE FETAL ANOMALIES.
9 SO A PROGRAM LIKE THAT ACTUALLY ATTRACTS A LOT OF TRAGIC LETHAL
10 ANOMALIES, AND THOSE ARE THE PATIENTS THAT I HAVE TO DEAL WITH
11 THEN.
12 Q. IN YOUR PRACTICE, HOW IS THE DECISION MADE REGARDING WHAT
13 METHOD OF ABORTION THE WOMAN WILL HAVE?
14 A. AS I EXPLAINED BEFORE, I WILL GO IN -- WELL, I MAKE IT
15 CLEAR UPFRONT THAT I PREFER NOT -- I WILL DO D&E'S UP TILL 20
16 WEEKS, UNLESS THERE ARE THREE CLEARLY OVERRIDING REASONS THAT
17 AN INDUCTION WOULD BE CONTRAINDICATED AFTER 24 WEEKS.
18 OTHERWISE, IT DEPENDS ON -- THE PATIENTS REALLY WILL
19 MAKE THE DECISION ABOUT WHAT METHODS SHE WILL CHOOSE. WHAT --
20 THERE ARE MANY FACTORS THAT PLAY IN THESE DECISIONS. SOME OF
21 THEM ARE THE NEED FOR AN AUTOPSY OR FURTHER TESTING.
22 OTHER FACTORS ARE THE PATIENT'S PERSONAL BELIEFS,
23 PART OF THEIR RELIGIOUS BELIEF. THERE ARE PATIENTS WHO REALLY
24 HAVE PROBLEMS WITH THE DESTRUCTIVE NATURE OF A D&E PROCEDURE
25 AND PREFER AN INTACT DELIVERY. AND THERE ARE PATIENTS WHO HAVE

1 STRONG FEELINGS ABOUT THE LABOR PROCESS UNDER THESE
2 CIRCUMSTANCES, AND BASED ON THEIR PREVIOUS EXPERIENCE WITH
3 LABOR MAY BE REALLY RELUCTANT TO UNDERGO AN INDUCTION METHOD.
4 AND IN MY OPINION, THE MOST IMPORTANT PART IS TO
5 ACTUALLY ASCERTAIN THEIR FIRM -- THEIR FIRM BELIEF THAT THEY
6 ARE DOING WHAT IS BEST FOR THEM. AND I -- THE BEST I CAN DO IS
7 GIVE THEM THE RISK AND COMPLICATIONS OF THE TWO PROCEDURES SO
8 THEY CAN MAKE AN INFORMED CHOICE THAT THEY ARE COMFORTABLE
9 WITH, BECAUSE I CONSIDER BOTH OF THOSE METHODS VERY SAFE.
10 AND MY GENERAL -- EVEN WHILE I GO IN DETAIL ABOUT
11 THE COMPLICATIONS OF THESE PROCEDURES, I ALWAYS PUT A
12 SURROUNDING COMMENT THERE THAT CONTINUATION OF THE PREGNANCY
13 AND GOING THROUGH CHILDBIRTH THERE'S A POSSIBILITY OF CESAREAN
14 SECTION ALWAYS IS A HIGHER -- ENTAILS A HIGHER RISK THAN ANY OF
15 THESE PROCEDURES.
16 Q. WHAT, SPECIFICALLY, DO YOU TELL YOUR PATIENTS ABOUT THE
17 RISKS AND POTENTIAL COMPLICATIONS OF D&E AND INDUCTION?
18 A. WELL, THE THREE -- THE COMPLICATIONS THAT ARE THE MOST
19 RELEVANT TO THE PATIENTS ARE DAMAGE TO THE CERVIX OR THE
20 UTERUS, AND COMPLICATIONS AS HEMORRHAGE AND INFECTION. AND
21 THEY COULD OCCUR, RIGHT, IN BOTH METHODS.
22 Q. I AM SORRY. ALL OF THOSE COMPLICATIONS COULD --
23 A. ALL OF THOSE COMPLICATIONS COULD OCCUR WITH BOTH METHODS.
24 THE DIFFERENCE -- THE DIFFERENCE BETWEEN THE TWO METHODS IS
25 THAT THE -- THERE MAY BE SUBTLE DIFFERENCES IN THE INCIDENCE OF

1 THESE COMPLICATIONS. AND MANY -- FOR MANY PATIENTS IT IS
2 ACTUALLY NOT THE COMPLICATION ITSELF, BUT THE CONSEQUENCES OF
3 THE COMPLICATIONS THAT THEY ARE INTERESTED IN.
4 IN OTHER WORDS, EVEN WHILE THE BEST EXAMPLE IS THE
5 PERFORATION OR DAMAGE TO THE UTERUS HAS THE POTENTIAL, EVEN
6 THOUGH THAT IS VERY RARE, TO LEADING TO A HYSTERECTOMY.
7 FOR A PATIENT IN WHOM THIS IS THE FIRST PREGNANCY,
8 WHO CLEARLY DID NOT EVER INTEND TO BE THERE AT THIS POINT IN
9 TIME, SHE MAY WEIGH THAT COMPLICATION A LITTLE HIGHER IN
10 COMPARING INDUCTION VERSUS D&E PROCEDURE VERSUS THE PATIENT WHO
11 HAS ALREADY HAD SEVERAL CHILDREN, WHO IS 44 YEARS OLD, WHERE
12 THAT COMPLICATION OR THE CONSEQUENCE OF THAT COMPLICATION,
13 RIGHT, HAS LESS WEIGHT THAN IN THE FIRST PATIENT.
14 AND SO MANY PATIENTS IN MY EXPERIENCE ASK ME:
15 "WELL, WHAT WOULD HAPPEN IF THAT COMPLICATION
16 OCCURS?"
17 AND I FIND THAT MORE IMPORTANT TO ACTUALLY DISCUSS
18 THROUGH THAN GIVE THEM JUST NUMBERS AND SAY:
19 "WELL, THE COMPLICATION RATE IS .3 PERCENT FOR
20 THIS OR .2 PERCENT FOR THIS."
21 PATIENTS ARE REALLY INTERESTED IN WHAT IT MEANS TO
22 THEM AS FAR AS THEIR FUTURE FUTILITY OR CHILDBEARING.
23 SO THAT'S BASICALLY WHAT I DO DURING THIS
24 COUNSELING.
25 Q. I THINK YOU INDICATED THAT THERE ARE SOME WOMEN FOR WHOM

1 LABOR INDUCTION IS CONTRAINDICATED; IS THAT CORRECT?
2 A. WELL, THERE ARE PATIENTS WHO HAVE A PREVIOUS SCAR IN THEIR
3 UTERUS FROM A PREVIOUS C-SECTION. AND EVEN WHILE WE ARE NOT --
4 I DON'T THINK WE REALLY KNOW WHAT THE EXACT INCIDENCE IS OF
5 RUPTURE OF THAT SCAR WITH THE INDUCTION METHODS -- LET'S SAY
6 BETWEEN 20 AND 24 WEEKS -- RUPTURES CLEARLY HAVE BEEN DESCRIBED
7 AND WE KNOW AT TERM THAT THAT WOULD BE A RISK OF LABOR. AND SO
8 I THINK THAT COULD BE -- THAT CERTAINLY WOULD BE A RELATIVE
9 CONTRAINDICATION AND SOMETHING THE PATIENT NEEDS TO BE AWARE
10 OF: THAT THERE IS THAT RISK.
11 Q. OTHER THAN A WOMAN WITH A PRIOR UTERINE SCAR, ARE THERE
12 OTHER SITUATIONS IN YOUR PRACTICE WHERE YOU CONSIDER INDUCTION
13 TO BE CONTRAINDICATED OR AT HIGH RISK FOR THE WOMAN?
14 A. WHEN THERE IS A PLACENTA PREVIA.
15 Q. CAN YOU EXPLAIN WHAT THAT IS?
16 A. PLACENTA PREVIA IS WHERE THE PLACENTA IS LOCATED OVER THE
17 CERVIX. AND THAT IS A SITUATION WHERE IF LABOR WERE TO OCCUR
18 THE CERVIX WOULD OPEN, THE PLACENTA WOULD SEPARATE, AND THAT
19 WOULD LEAD TO BLEEDING.
20 AND IN THE SITUATION AFTER 24 WEEKS THAT WOULD LEAD
21 TO A CESAREAN SECTION. AFTER 22 WEEKS, BLEEDING WOULD OCCUR
22 UNDER THOSE CIRCUMSTANCES, AND THEN THERE WOULD BE MORE
23 HEMORRHAGE AND MORE BLEEDING WITH THE INDUCTION METHOD THAN
24 WITH THE D&E PROCEDURE.
25 Q. AND ARE THERE SITUATIONS OR CONDITIONS WHERE THE ACTUAL --

1 NOT WHERE IT IS NOT THE LABOR PROCESS ITSELF THAT IS
2 CONTRAINDICATED, BUT WHERE THE MEDICATION USED TO INDUCE THE
3 LABOR IS CONTRAINDICATED?
4 A. YES, THERE ARE MEDICATIONS BEING USED WOULD BE GENERALLY
5 USED FOR INDUCTION METHODS NOWADAYS WOULD BE MISOPROSTOL. AND
6 THERE USED TO BE OTHER PROSTAGLANDINS. AND THERE ARE
7 CONDITIONS WHERE PROSTAGLANDINS MAY HAVE UNDESIRABLE SIDE
8 EFFECTS IN PATIENTS WITH CERTAIN MATERNAL CONDITIONS LIKE
9 SEVERE ASTHMA.
10 Q. DR. BROEKHUIZEN, YOU TALKED ABOUT AN UTERINE SCAR BEING A
11 RELATIVE CONTRAINDICATION; IS THAT CORRECT?
12 A. I DO NOT THINK THAT THERE EVER IS AN ABSOLUTE
13 CONTRAINDICATION FOR ANY OF THE METHODS. I THINK THERE ARE
14 DIFFERENCES THAT ARE SIGNIFICANT FOR INDIVIDUALS, AND I THINK A
15 RELATIVE CONTRAINDICATION WOULD BE A SET OF PATIENTS WOULD BE
16 NEED TO BE WELL-INFORMED ABOUT WHAT COMPLICATIONS MAY ARISE
17 FROM THAT PARTICULAR PROCEDURE.
18 Q. IF THE WOMAN HAD MORE THAN ONE UTERINE SURGERY WOULD THE
19 RISKS OF LABOR INCREASE?
20 A. THE RISK OF RUPTURE WOULD INCREASE.
21 Q. IN ADDITION TO D&E AND INDUCTION, ARE THERE ANY OTHER WAYS
22 OF ENDING A PREGNANCY PREVIABILITY IN THE SECOND-TRIMESTER?
23 A. THERE WOULD BE -- THERE WOULD BE THE POSSIBILITY OF SERIAL
24 DILATATION, THAT IN ITSELF WOULD LEAD TO A DILATATION WIDE
25 ENOUGH THAT THE FETAS WOULD DELIVER COMPLETELY. OR THAT IN

1 ITSELF WOULD INITIATE A LABOR PROCESS.
2 Q. AND COULD YOU EVER USE A HYSTEROTOMY OR A CESAREAN SECTION
3 METHOD TO END THE PREGNANCY?
4 A. WELL, THAT IS CLEARLY A POSSIBILITY TO DO A HYSTEROTOMY OR
5 CESAREAN SECTION, BUT GIVEN THE CIRCUMSTANCES THAT I PREFER
6 PREGNANCY TERMINATION MOST PATIENTS WOULD NOT WANT TO UNDERGO A
7 MORE MAJOR SURGICAL PROCEDURE.
8 AND SO MY GOAL IS TO AVOID EVER HAVING TO DO THAT
9 PRIOR TO 24 WEEKS. NOW, I HAVE DONE HYSTEROTOMIES WHERE
10 INDUCTIONS HAVE FAILED, AND SO IT'S NOT THAT THAT IS NOT AN
11 OPTION, BUT IT WOULD BE THE LAST OPTION.
12 Q. IN THOSE SITUATIONS WHERE YOU USED A HYSTEROTOMY WHERE
13 INDUCTION FAILED, WHY DIDN'T YOU CONVERT TO A D&E-TYPE
14 PROCEDURE?
15 A. WELL, THE INDUCTION FAILED, BUT THEN THE CONVERSION TO A
16 D&E PROCEDURE FAILED, AS WELL. SO, IN OTHER WORDS, THAT WAS
17 THE NEXT STEP, AND THEN WHEN THAT FAILED -- THOSE WERE TWO
18 SITUATIONS, TWO PATIENTS THAT I RECALL WHERE THEY HAD
19 SIGNIFICANT CERVICAL SCARRING FROM PREVIOUS SURGICAL PROCEDURES
20 TO THEIR CERVIX. AND IT WAS JUST IMPOSSIBLE TO ACHIEVE
21 SUFFICIENT DILATATION OR ANY DILATATION AT ALL.
22 Q. AND, DR. BROEKHUIZEN, JUST TO BE CLEAR, WHEN YOU USE THE
23 TERM "DILATATION" DOES THAT MEAN THE SAME THING AS DILATION?
24 A. THAT IS THE SAME TERM.
25 Q. DR. BROEKHUIZEN, YOU SAID THAT WHEN YOU'RE IN THE PROCESS

1 OF COUNSELING YOUR PATIENTS WHEN THEY FIRST COME AND SEE YOU,
2 THAT YOU GIVE THEM A DETAILED DESCRIPTION OF THE METHODS OF
3 ABORTION THAT ARE AVAILABLE TO THEM.
4 COULD YOU TELL US WHAT -- IN DESCRIBING A D&E
5 PROCEDURE TO YOUR PATIENT, CAN YOU TELL US WHAT YOU WOULD SAY
6 TO HER?
7 A. I WOULD DESCRIBE IT IN THE FOLLOWING MANNER. I WOULD SAY:
8 "YOU ARE GOING TO" -- DEPENDING ON THE TIME
9 THAT THE PROCEDURE IS SCHEDULED IN THE OPERATING ROOM --
10 USUALLY THEY WOULD BE SCHEDULED IN THE AFTERNOON -- I WOULD
11 SAY:
12 "YOU ARE GOING TO COME IN THE MORNING AT
13 8:00 O'CLOCK, AND WE ARE GOING TO PLACE MISOPROSTOL
14 OR LAMINARIA OR A COMBINATION OF LAMINARIA AND
15 MISOPROSTOL. THEN ABOUT FOUR HOURS LATER, I WILL
16 MEET YOU IN THE OPERATING ROOM WHERE WE FINALIZE THE
17 PROCEDURE. IN THE MEANTIME, YOU GO TO THE PRE-OP
18 AREA. THE ANESTHESIOLOGIST WILL TALK TO YOU ABOUT
19 WHAT KIND OF ANALGESIA OR ANESTHESIA YOU WILL
20 RECEIVE DURING THIS PROCEDURE. THEN, THE PROCEDURE
21 ENTAILS UTILIZING SUCTION METHODS AND INSTRUMENTS TO
22 REMOVE THE FETUS IN PARTS, AND THE PLACENTA, IN
23 PART. AFTER THAT PROCEDURE AND DURING THAT
24 PROCEDURE, YOU WILL RECEIVE SOME MEDICATION TO
25 REDUCE THE AMOUNT OF BLOOD LOSS. AND AFTER THE

1 PROCEDURE YOU WILL BE IN THE HOSPITAL FOR ABOUT
2 ONE-AND-A-HALF, TWO HOURS. AND THEN, YOU CAN GO
3 HOME."
4 AND THEN, I WILL GIVE THEM THE INSTRUCTIONS ABOUT
5 WHEN I WILL SEE THEM BACK, AND KNOW WHAT KIND OF PRECAUTIONS
6 SHE HAS TO TAKE UNTIL I SEE HER BACK.
7 WE WILL DISCUSS IN THE CASES OF THE NEED FOR
8 CYTOGENETIC TESTING OR THAT SHE AGREES TO HAVE THAT DONE,
9 ANALYSIS OF SOME OF THE TISSUE.
10 THERE ARE EVEN SITUATIONS WHERE PATIENTS HAVE
11 REQUESTED EVEN WITH THE D&E PROCEDURES PRIOR TO 20 WEEKS, EVEN
12 THOUGH THERE IS NO BURIAL REQUIREMENT IN WISCONSIN OF LESS THAN
13 20 WEEKS, BUT THERE ARE SITUATIONS WHERE THE PATIENT ACTUALLY
14 ASK TO HAVE CLERGY INVOLVED AND HAVE BLESSING OF THE REMAINS.
15 AND I DISCUSS THAT TYPE OF SUPPORT WITH PATIENTS.
16 Q. LET ME ASK YOU SOME FOLLOW-UP QUESTIONS ON THAT. YOU SAID
17 THAT YOU WOULD PLACE LAMINARIA OR MISOPROSTOL OR BOTH. HOW --
18 HOW WOULD YOU MAKE THE DETERMINATION OF WHICH YOU WOULD --
19 WHICH OR WHETHER YOU WOULD PLACE BOTH?
20 A. IT HAS EVOLVED OVER THE YEARS. I USED TO PLACE LAMINARIA.
21 THEN UP UNTIL ABOUT -- UP UNTIL 18 WEEKS I WILL ONLY USE
22 MISOPROSTOL. AFTER -- FROM BETWEEN 18 -- BEYOND 18 WEEKS I
23 WILL PLACE LAMINARIA AND MISOPROSTOL, CURRENTLY.
24 Q. AND WHEN YOU USE THE LAMINARIA, HOW DO YOU DETERMINE HOW
25 MUCH LAMINARIA YOU WILL PLACE IN THE PATIENT?

1 A. I BASICALLY WILL PLACE AS MANY LAMINARIA AS I SAFELY CAN
2 PLACE IN THE CERVIX.
3 Q. AND WHEN YOU ARE USING THE MISOPROSTOL -- ARE YOU
4 ACTUALLY -- YOU'RE USING THE MISOPROSTOL WITH EVERY D&E PATIENT
5 NOW; IS THAT --
6 A. I USE ACTUALLY MISOPROSTOL WITH EVERY PREGNANCY TERMINATION
7 UP UNTIL 18 WEEKS.
8 Q. OKAY. AND THEN AFTER 18 -- IF YOU ARE DOING A D&E BETWEEN
9 18 AND 20 WEEKS?
10 A. I WILL PLACE LAMINARIA PLUS MISOPROSTOL.
11 Q. HOW DO YOU ADMINISTER THE MISOPROSTOL?
12 A. I PLACE THE MISOPROSTOL VAGINALLY.
13 Q. AND WHAT -- CAN YOU EXPLAIN WHAT MISOPROSTOL DOES TO
14 PREPARE THE CERVIX FOR THE EVACUATION?
15 A. MISOPROSTOL WILL HAVE A DIRECT LOCAL EFFECT ON THE CERVIX
16 AND SOFTENS IT AND DILATE IT, AS WELL AS HAVE AN EFFECT ON
17 UTERINE ACTIVITY. AND IT WILL START UTERINE ACTIVITY THAT IS
18 THE COMBINATION OF THAT WILL LEAD TO A SOFT, PLIANT AND OFTEN
19 DILATED CERVIX.
20 Q. CAN THE EFFECT OF MISOPROSTOL ON THE CERVIX BE PREDICTED
21 AHEAD OF TIME?
22 A. NO.
23 Q. IN YOUR PRACTICE, HAVE YOU SEEN THAT SOME WOMEN CAN DELIVER
24 THE FETUS COMPLETELY SIMPLY AS A RESULT OF THE MISOPROSTOL THAT
25 YOU PLACE PRIOR TO THE D&E?

1 A. YES, I HAVE SEEN SITUATIONS WHERE THE MISOPROSTOL LED TO A
2 RATHER RAPID LABOR PROCESS WHERE IN THE FOUR HOURS BETWEEN THE
3 PLACEMENT OF THE MISOPROSTOL AND THE PLANNED D&E DELIVERY HAS
4 COMPLETELY TAKEN PLACE. AND I HAVE ENCOUNTERED SITUATION WHERE
5 DELIVERY PARTIALLY HAS TAKEN PLACE.
6 Q. IN THE SITUATIONS WHERE THE DELIVERY HAS PARTIALLY TAKEN
7 PLACE BEFORE SHE COMES INTO THE OPERATING ROOM, COULD THE FETUS
8 BE OUTSIDE OF THE WOMAN'S BODY IN PART TO THE EXTENT WHERE THE
9 FETUS IS OUT OF THE UTERUS PAST THE FETAL NAVEL?
10 A. THAT IS POSSIBLE, DEPENDING ON THE SIZE OF THE FETUS AND
11 THE GESTATIONAL AGE.
12 Q. COULD THE FETUS BE ALIVE AT THAT POINT?
13 A. IT COULD BE ALIVE.
14 Q. AND HOW WOULD YOU COMPLETE THE PROCEDURE IN THAT
15 CIRCUMSTANCE?
16 A. BY THE SIMPLEST POSSIBLE EXTRACTION WAY. IT MAY -- THE
17 CERVIX MAY BE DILATED SUFFICIENTLY THAT THE DELIVERY PROCESS
18 CAN BE COMPLETED BY JUST TRACTION, AND THE HEAD WILL FOLLOW.
19 MORE COMMONLY, IF THE TRUNK AND THE EXTREMITIES HAVE
20 DELIVERED, THE CERVIX MAY NOT BE DILATED ENOUGH FOR THE HEAD,
21 AND THE SIMPLEST POSSIBLE COMPRESSION-DECOMPRESSION METHOD I
22 WOULD USE TO EFFECT DELIVERY OF THE AFTER-COMING.
23 Q. AND WOULD THAT COMPRESSION OR DECOMPRESSION METHOD RESULT
24 IN FETAL DEMISE?
25 A. IF THE FETUS WILL BE ALIVE AT THAT TIME IT CERTAINLY WOULD.

1 Q. DO YOU ADVISE YOUR PATIENTS WHEN YOU ARE DESCRIBING THE
2 PROCEDURE TO THEM THAT MISOPROSTOL MAY HAVE THIS EFFECT OF
3 RESULTING IN EITHER COMPLETE OR PARTIAL DELIVERY BEFORE THE
4 ACTUAL OPERATION OR SURGERY BEGINS?
5 A. YES, I EXPLAIN TO THEM THAT THERE ARE TWO -- WELL, THERE
6 ARE TWO PURPOSES OF PLACING THE MISOPROSTOL. ONE OF THEM WOULD
7 BE TO AVOID AS MUCH AS POSSIBLE MECHANICAL DILATION WITH METAL
8 DILATORS.
9 THE SECOND PURPOSE WOULD BE TO -- ADVANTAGE MAY BE
10 THAT THE CERVIX IS SUFFICIENTLY DILATED THAT IT WILL NOT
11 REQUIRE MANY INSTRUMENTAL PASSES. AND TO SOME EXTENT IF THAT
12 WERE TO HAPPEN, THAT WOULD REDUCE THE MORBIDITY OF THE
13 PROCEDURE, IN MY OPINION.
14 Q. AND WHEN YOU ARE BEGINNING THE -- WHEN THE FETUS DOESN'T
15 DELIVER AT ALL BECAUSE OF THE MISOPROSTOL SO THE FETUS IS
16 COMPLETED IN UTERO WHEN YOU GO INTO THE OPERATING ROOM WHEN YOU
17 BEGIN THE EVACUATION PART OF THE PROCEDURE CAN THE FETUS BE
18 ALIVE?
19 A. I THINK IF ALL THE MISOPROSTOL HAS DONE IS TO ACHIEVE
20 DILATATION SUFFICIENTLY FOR ME TO INTRODUCE A LARGE SUCTION
21 CANULA OR INSTRUMENT, I WOULD ASSUME UNDER MOST CIRCUMSTANCES
22 THE FETUS IS STILL ALIVE.
23 Q. AND YOU HAD MENTIONED TALKING TO THE WOMAN ABOUT HER
24 CHOICES OF ANALGESIA AND ANESTHESIA. CAN YOU EXPLAIN WHAT
25 THOSE -- WHAT HER CHOICES ARE IN THAT RESPECT?

1 A. ARE YOU ASKING ABOUT THE D&E?
2 Q. YES. IN THE D&E CONTEXT, YES.
3 A. WELL, THE CHOICES WOULD BE A SPINAL ANESTHETIC. THE OTHER
4 CHOICE WOULD BE CONSCIOUS SEDATION WHERE THE PATIENT DOESN'T
5 GET INTUBATED BUT RECEIVES COMBINATIONS OF AN ANALGETIC
6 MEDICATIONS AND OPIATE-TYPE DRUG. SOMETIMES THAT IS REFERRED
7 TO AS TWILIGHT SLEEP.
8 AND THEN, THERE WOULD BE GENERAL ANESTHESIA. NOW,
9 IN GENERAL ONE TRIES TO AVOID GENERAL ANESTHESIA BECAUSE THAT
10 HAS BEEN ASSOCIATED WITH MORE HEMORRHAGE, LESS CONTRACTION OF
11 THE UTERUS DURING THE PROCEDURE AND POTENTIALLY HIGHER RISK OF
12 PERFORATION OR WRONG PASSES.
13 BUT THERE ARE SITUATIONS WHERE VERY OBESE PATIENTS,
14 IN PATIENTS WITH SOMETIMES MORE SERIOUS MEDICAL CONDITIONS
15 WHERE ANESTHESIOLOGISTS WILL COME TO THE CONCLUSION THAT
16 GENERAL ANESTHESIA, THEY WON'T HAVE MORE HANDLE ON
17 COMPLICATIONS THAT COULD ARISE DURING THE SURGERY.
18 BUT THE MAJORITY OF PROCEDURES THAT I PERFORM I KNOW
19 ARE DONE UNDER GENERAL ANESTHESIA.
20 Q. AND DR. BROEKHUIZEN, WHEN YOU BEGIN THE EVACUATION PART OF
21 THE PROCEDURE, WHAT IS THE TYPICAL DISTANCE BETWEEN THE
22 EXTERNAL PART OF THE CERVIX AND THE VAGINAL OPENING? IF IT
23 HELPS TO REFER TO EITHER OF THESE CHARTS, FEEL FREE TO DO SO.
24 A. WELL, IT VERY MUCH DEPENDS ON THE MOBILITY. IT DEPENDS ON
25 THE INDIVIDUAL PATIENTS. HAVING GIVEN BIRTH CERTAINLY CREATES

1 MORE MOBILITY TO THE CERVIX AND TO THE BIRTH CANAL. BUT
2 BASICALLY ONE PLACES AN INSTRUMENT. AND I USE A LS CLAMP ON
3 THE ANTERIOR OR POSTERIOR LIP OF THE CERVIX. AND I PULL IT
4 DOWN AS FAR AS POSSIBLE, BECAUSE ONE WANTS TO HAVE A STRAIGHT
5 PASSAGE FOR INSTRUMENTS.
6 AND THERE ARE SITUATIONS WHERE ACTUALLY PATIENTS IN
7 DORSOLITHOTOMY POSITION, WHERE THE LEGS ARE UP. ONE PLACES THE
8 INSTRUMENT WHERE THE CERVIX ITSELF CAN COME TO THE INTROITUS.
9 THERE ARE OTHER SITUATIONS WHERE THAT WOULD ONLY HAPPEN HALFWAY
10 INTO THE VAGINA. AND THERE ARE FAIRLY RARELY SITUATIONS WHERE
11 IT ACTUALLY MAY BE ABLE TO BE PULLED OUTSIDE THE INTROITUS.
12 Q. SO THAT THE CERVIX IS ACTUALLY OUT -- ALREADY OUTSIDE OF
13 THE WOMAN'S BODY?
14 A. CORRECT.
15 Q. AND DO YOU DO D&E PROCEDURES UNDER ULTRASOUND?
16 A. AFTER 18 WEEKS I WILL ALWAYS USE ULTRASOUND NOW. PRIOR TO
17 18 WEEKS, NOT ALL THE TIME.
18 Q. WHAT DETERMINES -- PRIOR TO 18 WEEKS, WHAT DETERMINES
19 WHETHER YOU CHOOSE TO USE THE ULTRASOUND?
20 A. IT'S PROUDLY MY FINDINGS DURING THE INSERTION OF THE
21 LAMINARIA THAT WILL HELP ME DETERMINE. IF I CANNOT PLACE MANY
22 LAMINARIA, IF THERE IS SOMETHING ON THE EXAMINATION THAT MAKES
23 ME THINK I MAY HAVE MORE PROBLEMS IDENTIFYING PARTS, BUT IT IS
24 VERY SUBJECTIVE MEASURE OR A DETERMINATION ON MY PART.
25 Q. IN PERFORMING THE ACTUAL EVACUATION PART OF THE PROCEDURE,

1 DO YOU EVER CONVERT THE LIE OF THE FETUS FROM EITHER A VERTEX
2 PRESENTATION OR A TRANSVERSE PRESENTATION TO A BREECH
3 PRESENTATION OF THE FETUS?
4 A. WELL, DURING THE D&E PROCEDURE, THE FIRST PART IS I USE A
5 LARGE SUCTION CURETTE TO REMOVE FLUID, SOMETIMES EVEN PARTS OF
6 PLACENTA WILL COME AT THAT TIME. THE NEXT STEP IS TO INTRODUCE
7 AN INSTRUMENT.
8 AND REALLY THE GOAL OF THAT FIRST PLACEMENT OF THE
9 INSTRUMENT IS TO GRAB AN EXTREMITY OR ANY PART OF THE TRUNK
10 THAT I CAN PULL THROUGH THE CERVIX OR AS CLOSE AS POSSIBLE TO
11 THE CERVIX.
12 UNDER MOST CIRCUMSTANCES THE FETAL HEAD WOULD BE THE
13 LARGEST PART, AND I WOULD NOT EXPECT THAT I WOULD GRAB THAT. I
14 DO NOT PAY ATTENTION TO IF IT WAS LYING SIDEWAYS, IF THE FETAL
15 HEAD WAS FIRST OR IF THE EXTREMITIES WERE FIRST. I KNOW THAT
16 AT THAT GESTATIONAL AGE AT LEAST HALF OF THE TIME IT WILL BE IN
17 A BREECH-TYPE POSITION.
18 AND SO DURING THAT PROCESS, I AM SURE THAT I
19 INFLUENCE THE POSITION, RIGHT, OF THE FETUS, DEPENDING ON WHAT
20 I GRAB AND WHAT I PULL DOWN.
21 Q. SO IT IS POSSIBLE THAT YOU COULD BRING THE FEET DOWN FROM A
22 POSITION THAT HAD BEEN EITHER AN VERTEX OR A TRANSVERSE
23 POSITION?
24 A. THAT'S CLEARLY POSSIBLE.
25 Q. DR. BROEKHUIZEN, ARE YOU AWARE OF THE FACT THAT CONGRESS IN

1 PASSING THIS LAW MADE CERTAIN FACTUAL FINDINGS?
2 A. I AM AWARE OF THE DESCRIPTION OF FACTUAL FINDINGS. I AM
3 NOT SURE WHAT THESE FINDINGS ARE BASED ON.
4 Q. ARE YOU AWARE THAT ONE OF THE FINDINGS THAT CONGRESS MADE
5 WAS THAT CONVERTING THE FETUS TO A BREECH POSITION DURING AN
6 ABORTION PROCEDURE INCREASES THE RISK OF UTERINE RUPTURE,
7 ABRUPTION, AMNIOTIC FLUID EMBOLUS AND TRAUMA TO THE UTERUS?
8 A. I AM AWARE THAT THAT WAS STATED. I AM AT A LOSS TO EXPLAIN
9 THIS IN THE CONTEXT OF A SECOND-TRIMESTER PREGNANCY TERMINATION
10 OR AN INDUCTION METHOD UP TO 24 WEEKS.
11 I THINK THAT WHAT'S BEING REFERRED TO ARE FINDINGS
12 AND EFFECTS IN THE OBSTETRICAL LITERATURE IF ONE DID THESE
13 PROCEDURES LATER IN PREGNANCY, THAT THAT WOULD BE AN
14 ASSOCIATION WITH AMNIOTIC FLUID EMBOLISM AND ABRUPTION.
15 AND SO I THINK THAT THIS APPLYING FACTS AND
16 KNOWLEDGE ABOUT OF OBSTETRICAL PRACTICE AFTER VIABILITY TO A
17 SITUATION THAT IT REALLY SHOULD NOT, HAS NO APPLICATION FOR IT,
18 IN MY OPINION.
19 Q. SO, IN YOUR OPINION, IS THERE A RISK OF -- ARE THERE ANY
20 SPECIAL RISKS TO THE WOMAN OF CHANGING THE LIE OF THE FETUS
21 DURING A PRE-VIABILITY D&E PROCEDURE?
22 A. I AM UNAWARE OF ANYTHING IN THE LITERATURE ABOUT D&E
23 PROCEDURES THAT HAS ASSOCIATED THE PROCEDURE WITH ANY OF THE
24 COMPLICATIONS THAT YOU'VE JUST DESCRIBED.
25 Q. ISN'T --

1 A. AND SO, I THINK THE ONLY REFERENCE THAT I THINK I FOUND WAS
2 TO WILLIAMS TEXTBOOK OF OBSTETRICS. AND, SPECIFICALLY, I THINK
3 THE CHAPTER ABOUT SOME ARE IN BREECH PRESENTATION. AND THAT
4 CHAPTER IS WRITTEN ABOUT THE MANAGEMENT OF BIRTH LATER IN
5 GESTATION. AND IT IS NOT WRITTEN ON THE MANAGEMENT OF
6 PREGNANCY TERMINATION BY INDUCTION OR D&E PRIOR TO 24 WEEKS.
7 Q. DR. BROEKHUIZEN, WHEN YOU ARE EVACUATING THE UTERUS IN A
8 D&E PROCEDURE, WHAT IS YOUR OBJECTIVE?
9 A. MY OBJECTIVE IS TO EVACUATE THE CONTENT OF THE UTERUS, THE
10 FETUS AND PLACENTA, WITH THE LEAST POSSIBLE TRAUMA TO THE
11 MOTHER IN THE SHORTEST PERIOD OF TIME.
12 Q. AND WHY IS IT IMPORTANT TO DO IT IN THE SHORTEST PERIOD OF
13 TIME?
14 A. BECAUSE DURING THIS PROCEDURE, INEVITABLY BLEEDING WILL
15 OCCUR. AND THE BLEEDING WILL PROBABLY NOT CEASE UNTIL THE
16 EVACUATION IS COMPLETE.
17 Q. YOU ALSO SAID YOUR GOAL EVACUATION OR YOUR OBJECTIVE IS TO
18 DO THIS WITH THE LEAST POSSIBLE TRAUMA TO THE WOMAN. HOW DO
19 YOU ACCOMPLISH THAT?
20 A. I ACCOMPLISH THAT IN THREE WAYS. THE FIRST WAY IS TO
21 PREPARE THE CERVIX PRIOR TO THE PROCEDURE. AND THAT WOULD BE
22 THE USE OF LAMINARIA AND MISOPROSTOL.
23 THE SECOND ONE IS TO ASCERTAIN AT THE BEGINNING OF
24 THE PROCEDURE THAT I HAVE SUFFICIENT DILATATION TO DO THE
25 PROCEDURE. AND IF I DON'T, TO ACTUALLY REINSERT LAMINARIA AND

1 ALLOW MORE TIME TO GET MORE DILATATION SO I AM NOT TRYING TO
2 FORCE INSTRUMENTS THROUGH INSUFFICIENT DILATATION.
3 AND THE THIRD ONE IS TO MAKE SURE THAT I DO AS FEW
4 PASSES WITH THE INSTRUMENT AS POSSIBLE AND ACHIEVE MOST OF THE
5 EXTRACTION PART IN THE LOWER PART OF THE UTERUS. AND I ACHIEVE
6 THAT, AS WELL, BY AT SOMETIME IN THE PROCEDURE GIVING EXTRA
7 OXYTOCIC AGENTS THAT ACTUALLY CAUSE MORE CONTRACTIONS DURING
8 THE PROCEDURE, IF THAT IS APPROPRIATE.
9 BUT THE MAINSTAY IS TO ACHIEVE SUFFICIENT
10 DILATATION, RIGHT, THAT REQUIRES EASY EXTRACTION.
11 Q. AND DO YOU USE FORCEPS TO EVACUATE THE UTERUS?
12 A. WELL, IT IS NOT FORCEPS IN THE OBSTETRICAL SENSE.
13 OBSTETRICAL FORCEPS IS AN INSTRUMENT THAT ONE PLACES AROUND THE
14 FETAL HEAD TO DELIVER THE HEAD. IT IS AN INSTRUMENT THAT -- IT
15 IS REALLY MORE A GRABBING INSTRUMENT. THERE ARE DIFFERENT
16 TYPES. ONE OF THEM IS CALLED THE SOPHER FORCEPS. THEY ARE
17 KIND OF ROUND. THEY ARE KIND OF SQUARED, SERRATED SURFACES
18 THAT CAN CRUSH TISSUE AND HOLD ON TO TISSUE. AND THEY COME IN
19 DIFFERENT SIZES.
20 Q. AND IS THE PURPOSE OF USING THESE INSTRUMENTS TO
21 DISARTICULATE THE FETUS?
22 A. THE MAIN PURPOSE OF THESE INSTRUMENTS IS TO BRING FETAL
23 PARTS THROUGH THE CERVIX OR FAIRLY CLOSE TO THE CERVIX. DURING
24 THIS PROCESS OF EXTRACTION, RIGHT, DISARTICULATION MAY TAKE
25 PLACE, BUT IT IS NOT -- THAT IS NOT THE PRIMARY PURPOSE OF THE

1 INSTRUMENT. THE INSTRUMENT IS TO PROVIDE TRACTION.
2 Q. AND IS IT -- DOES IT SOMETIMES OCCUR THAT DISARTICULATION
3 DOESN'T HAPPEN IN THE EVACUATION OR EXTRACTION PROCESS?
4 A. AGAIN, THAT DEPENDS ON THE AMOUNT OF DILATATION. IF THERE
5 IS SUFFICIENT DILATATION, IT IS POSSIBLE THAT ONE WILL REMOVE
6 MOST OF THE EXTREMITIES AND TRUNK WITHOUT DISARTICULATION.
7 Q. DO YOU HAVE A PREFERENCE WHEN YOU ARE DOING THE EXTRACTION
8 WHETHER IT COMES OUT INTACT OR DISARTICULATED?
9 A. I HAVE TO ACCEPT THE SITUATION THAT I ENCOUNTER. BUT THE
10 LEAST PASSES AND THE LEAST DISARTICULATION AND LEAST CRUSHING I
11 PREFER, BECAUSE THAT WOULD ELIMINATE BONEY FRAGMENTS OR SHARP
12 EDGES THAT IN ITSELF COULD, YOU KNOW, DO DAMAGE TO THE CERVIX
13 OR UTERINE WALL OR BLEEDING.
14 Q. IF DISARTICULATION DOES OCCUR, WHERE IS THE PART THAT IS
15 ACTUALLY BEING DISARTICULATED?
16 A. THAT COULD BE IN THE UTERUS. IT COULD BE IN THE CERVIX.
17 IT COULD BE -- HAPPEN IN THE VAGINA --
18 Q. AND --
19 A. -- OUTSIDE THE CERVIX.
20 Q. AND DEPENDING ON THE DISTANCE BETWEEN THE CERVIX AND THE
21 INTROITUS, COULD IT BE OUTSIDE THE WOMAN'S BODY?
22 A. SURE. IT IS POSSIBLE THAT PART OF THE EXTREMITY IS OUTSIDE
23 THE INTROITUS WHEN DISARTICULATION TAKES PLACE.
24 Q. AND IN CIRCUMSTANCES WHERE THERE IS DISARTICULATION, DOES
25 THE DISARTICULATION OCCUR ONLY AT THE JOINTS OF THE BONES?

1 A. NOT NECESSARILY.
2 Q. AND DOES IT EVER HAPPEN IN DOING A D&E THAT YOU -- THAT YOU
3 ARE ABLE TO BRING THE FETUS OUT WITHOUT ANY DISARTICULATION TO
4 THE POINT WHERE THE CALVARIUM LODGES AT THE CERVICAL OS?
5 A. YES, THAT CAN OCCUR.
6 Q. HAS THAT HAPPENED IN YOUR PRACTICE?
7 A. THAT'S HAPPENED.
8 Q. AND COULD THE FETUS BE LIVING AT THAT TIME?
9 A. AGAIN, DEPENDING ON THE AMOUNT OF DILATATION AND THE
10 GESTATIONAL AGE, IT COULD.
11 Q. AND COULD THE FETUS AT THAT POINT BE OUTSIDE OF THE
12 INTROITUS TO THE POINT WHERE AT LEAST UP TO THE FETAL NAVEL IS
13 OUTSIDE THE INTROITUS?
14 A. AGAIN, DEPENDING ON THE CONSENSUS OF THE CERVIX THAT COULD
15 HAPPEN.
16 Q. IN YOUR PRACTICE, WHAT IS THE EARLIEST GESTATIONAL AGE
17 WHERE YOU HAVE BEEN ABLE TO EXTRACT THE FETUS INTACT UP TO THE
18 POINT WHERE THE HEAD LODGES AT THE CERVIX?
19 A. I WOULD SAY 12, 13 WEEKS. AND ALL HAVE -- AND MOST -- MORE
20 OFTEN SINCE THE INTRODUCTION OF MISOPROSTOL.
21 Q. WHEN THAT HAPPENS, WHERE YOU ARE ABLE TO EXTRACT THE FETUS
22 INTACT IN THAT WAY, DO YOU CONSIDER IT TO BE A DIFFERENT
23 PROCEDURE FROM AN ABORTION IN WHICH THE FETUS IS DISARTICULATED
24 BEFORE THAT, BEFORE THAT POINT?
25 A. I DO NOT CONSIDER IT FUNDAMENTALLY DIFFERENT.

1 Q. AND YOU MAY HAVE SAID THIS, BUT WHAT DETERMINES WHETHER YOU
2 WILL BE ABLE TO BRING THE FETUS OUT INTACT UP TO THAT POINT?
3 A. THE AMOUNT OF CERVICAL DILATATION.
4 Q. AND BEFORE BEGINNING THE D&E ASK CAN YOU PREDICT IF THIS
5 WILL OCCUR?
6 A. NOT REALLY. NOT WHEN I COUNSEL THE PATIENTS. NOT EVEN
7 WHEN I PLACE THE LAMINARIA OR THE MISOPROSTOL. I PROBABLY WILL
8 HAVE A BETTER IDEA THE MOMENT I REMOVE THE LAMINARIA AND I CAN
9 START THE EXTRACTION METHOD. AND I AM MORE CONCERNED THERE NOT
10 ABOUT HAVING TOO MUCH DILATATION THAT TOTAL DELIVERY COULD
11 OCCUR, I AM ACTUALLY MORE CONCERNED ABOUT THE OPPOSITE. AND
12 THAT IS THAT I HAVE INADEQUATE DILATATION AND WOULD HAVE TO DO
13 MULTIPLE PASSES AND LEAD TO MORE COMPLICATED PROCEDURE.
14 SO I AM MORE LOOKING AT THAT POINT FOR THE RARE
15 SITUATION WHERE I MAY HAVE TO, SAY, STOP THE PROCEDURE NOW AND
16 PLACE SOME MORE LAMINARIA AND ACHIEVE MORE DILATATION AND BRING
17 THE PATIENT BACK IN A FEW HOURS.
18 Q. IN THOSE CIRCUMSTANCES WHERE AFTER YOU REMOVE THE LAMINARIA
19 OR YOU EXAMINE THE PATIENT AND YOU SEE THAT YOU HAVE ENOUGH
20 DILATION THAT IT IS POSSIBLE THAT YOU'LL BE ABLE TO BRING THE
21 FETUS OUT INTACT, WOULD YOU EVER ATTEMPT TO DISARTICULATE THE
22 FETUS RATHER THAN ATTEMPT TO EXTRACT IT INTACT?
23 A. NO. AS I EXPLAINED BEFORE, THE LEAST PASSES AND THE
24 LEAST -- INSTRUMENT PASSES, THE EASIER THE PROCEDURE, RIGHT? I
25 WOULD VERY MUCH PREFER THAT FOR MATERNAL REASONS.

1 Q. SO IN THOSE CIRCUMSTANCES WHERE YOU ARE ABLE TO BRING THE
2 FETUS OUT INTACT OR RELATIVELY INTACT TO THE POINT WHERE THE
3 CALVARIUM LODGES AT THE CERVIX, IS IT USUALLY POSSIBLE TO
4 COMPLETE THE DELIVERY JUST WITH TRACTION?
5 A. THE FETAL HEAD IS -- I MEAN, ALL THE GESTATIONAL AGES WE
6 ARE DESCRIBING HERE IS THE LARGEST PART. AND SO IT DEPENDS ON
7 THE DILATATION. THERE ARE SITUATIONS WHERE THE DILATATION MAY
8 BE SUFFICIENT ENOUGH WHERE THE HEAD WOULD FOLLOW, BUT MOST OF
9 THE TIME THAT IS NOT THE CASE.
10 AND SO, THEN, DEPENDING ON THE GESTATIONAL AGE,
11 RIGHT, ONE HAS TO DECIDE WHAT METHODS OF COMPRESSION AND
12 DECOMPRESSION WILL ONE USE.
13 Q. AND WHEN YOU SAY "METHODS OF COMPRESSION OR DECOMPRESSION,"
14 CAN YOU EXPLAIN THAT A LITTLE MORE?
15 A. IT'S POSSIBLE TO GRASP OR TO CRUSH THE SKULL AT THAT TIME
16 THAT WOULD LEAD TO RELEASE OF BRAIN TISSUE AND COLLAPSE OF THE
17 SKULL, AND THAT IN ITSELF WOULD DO IT.
18 IT IS POSSIBLE THAT TRACTION AT THE BASE OF THE
19 SKULL WILL ACTUALLY RELEASE BRAIN FLUIDS AND BRAIN TISSUE AND
20 BRAIN FLUIDS AND MAKE THE SKULL COLLAPSE.
21 THERE ARE -- NOT IN THE D&E'S UP UNTIL 20 WEEKS, BUT
22 AFTER 20 WEEKS THERE ARE OTHER METHODS THAT I WOULD UTILIZE,
23 ESPECIALLY IN THE CASE OF FETAL ANOMALIES THAT HAD THIS
24 DISPROPORTIONALLY ENLARGED TO DECOMPRESS THE HEAD BY PLACING
25 TROCARS AT THE BASE OF THE SKULL AND REALLY DECOMPRESS THE

1 UNUSUAL CONTENT OF THE INTRACRANIAL CONTENT.
2 Q. CAN YOU DESCRIBE WHAT A TROCAR IS?
3 A. A TROCAR IS A HOLLOW INSTRUMENT WITH A SHARP EDGE THAT ONE
4 CAN KIND OF PUSH INTO HOLE. OR AT LEAST LAPAROSCOPY SURGERY,
5 WHICH MOST PEOPLE ARE AWARE OF, ONE INTRODUCES THOSE IN THE
6 ABDOMINAL CAVITY TO INTRODUCE INSTRUMENTS TO DO SURGERY ON THE
7 INTERNAL ORGANS. THAT IS THE TYPE OF INSTRUMENT. SO IT IS A
8 SHARP -- IT IS KIND OF LIKE -- WELL, IT'S A SHARP POINT. IT IS
9 KIND OF LIKE A BIG NEEDLE. THEN, THE NEEDLE IS INSIDE AND
10 WHOLE.
11 Q. AND HOW LONG DOES THE EVACUATION PART OF THE D&E TYPICALLY
12 TAKE?
13 A. THAT REALLY VARIES A LOT. IT DEPENDS. I WOULD SAY THAT ON
14 THE AVERAGE THAT THAT WOULD BE 15 TO 20 MINUTES.
15 Q. DOES -- AND DOES THE TIME IT TAKES, IS IT AFFECTED BY
16 WHETHER THE FETUS IS EXTRACTED INTACT OR WHETHER IT IS
17 DISARTICULATED?
18 A. YES. IT VERY MUCH DEPENDS ON THE AMOUNT OF DILATATION AND
19 THE INDIVIDUAL CIRCUMSTANCES. AND SO, I AM SURE I'VE BEEN
20 THERE UP TO 40 MINUTES. AND I AM SURE SOME PROCEDURES WERE
21 FINALIZED IN FIVE MINUTES AFTER SUFFICIENT DILATATION.
22 Q. HAVE YOU EVER, IN YOUR PRACTICE, LACERATED OR PERFORATED
23 THE CERVIX OR UTERUS IN THE COURSE OF DOING THE D&E?
24 A. I HAVE NEVER PERFORATED THE UTERUS OR HAD TO DO A
25 LAPAROTOMY AFTER A D&E PROCEDURE. I THINK ON TWO OCCASIONS

1 WHERE THERE WAS AN ELEMENT OF MECHANICAL DILATATION HAD TO DO
2 REPAIR THE CERVIX BECAUSE OF A CERVICAL LACERATION OR THE
3 CERVICAL LACERATION OCCURRED DURING -- AS PART OF THE
4 EXTRACTION.
5 SO I HAD TO DO SOME SUTURE REPAIR OF THE CERVIX.
6 Q. DO YOU KNOW WHETHER IN EITHER OF THOSE CASES YOU WERE ABLE
7 TO EXTRACT THE FETUS INTACT UP TO THE HEAD OR WERE THOSE MORE
8 DISARTICULATION-TYPE PROCEDURES?
9 A. I AM SURE THAT THESE WERE DIFFICULT, MORE DIFFICULT D&E'S
10 WITH MORE PASSES AND MORE DISPROPORTION BETWEEN DILATATION AND
11 THE SIZE OF THE FETUS.
12 Q. AND AFTER YOU COMPLETE THE EVACUATION WITH THE INSTRUMENTS,
13 WITH THE FORCEPS OR OTHER INSTRUMENTS, WHAT DO YOU DO NEXT IN
14 THE D&E PROCEDURE?
15 A. CAN YOU REPEAT THE QUESTION?
16 Q. I AM SORRY. AFTER YOU'VE -- AFTER YOU'VE EXTRACTED THE
17 FETUS WITH THE FORCEPS, WHAT DO YOU DO NEXT TO COMPLETE THE
18 PROCEDURE?
19 A. WELL, OBVIOUSLY, THE PLACENTA HAS TO BE REMOVED, TOO. NOW,
20 SOMETIMES THAT'S ALREADY PART OF THE PLACENTA MAY ACTUALLY HAVE
21 DELIVERED AS PART OF THE SUCTION THAT I START WITH. OR MAYBE
22 ONE OF THE FIRST THINGS I GRAB WOULD BE THE PLACENTAL TISSUE.
23 BUT, ONE HAS TO MAKE SURE THAT ALL OF THE UTERINE
24 CONTENTS HAVE BEEN REMOVED. AND THERE IS A COMBINATION OF
25 SUCTION AND FEELING THIS AND BLUNT CURETTE, I TRY TO ASCERTAIN

1 THAT THERE ARE NO FETAL OR PLACENTAL PARTS LEFT, AT LEAST NO
2 GROSS, NO SIZEABLE FETAL PARTS, BECAUSE I DO NOT THINK I CAN
3 EVER BE ASSURED THAT THERE ARE NO SMALL PIECES OF TISSUE OR
4 EVEN SMALL PLACENTAL FRAGMENTS LEFT INSIDE THE UTERUS.
5 Q. WHAT ARE THE RISKS OF LEAVING EITHER PLACENTA OR OTHER
6 TISSUE IN THE UTERUS?
7 A. WOULD BE BLEEDING AND INFECTION.
8 Q. SO DR. BROEKHUIZEN, HOW DO YOU LEAVE D&E FOR NOW, WHEN A
9 PATIENT -- WHEN YOU ARE HAVING YOUR INITIAL CONSULT WITH THE
10 PATIENT, CAN YOU DESCRIBE FOR US HOW YOU WOULD TELL HER ABOUT
11 THE INDUCTION PROCEDURE AND HOW THAT WOULD GO IF THAT IS WHAT
12 SHE CHOSE?
13 A. OKAY. IN THE INDUCTION, I WOULD EXPLAIN TO HER THAT SHE
14 WOULD BE ADMITTED IN THE HOSPITAL. THAT WE WOULD START THE IV.
15 THAT WE WOULD PLACE MEDICATION VAGINALLY EVERY FOUR TO SIX
16 HOURS, DEPENDING ON THE GESTATIONAL AGE.
17 Q. LET ME JUST ACTUALLY STOP YOU THERE. WHEN YOU SAY SHE
18 WOULD BE ADMITTED IN THE HOSPITAL, WOULD SHE BE ADMITTED AS AN
19 INPATIENT?
20 A. CORRECT.
21 Q. AND JUST TO GO BACK TO THE D&E WOULD THAT BE AN OUTPATIENT
22 PROCEDURE OR AN INPATIENT PROCEDURE?
23 A. WELL, YES, THE D&E WOULD BE AN OUTPATIENT PROCEDURE. THE
24 ADMISSION TO THE HOSPITAL -- ACTUALLY, SINCE SOME PATIENTS CAN
25 GO HOME WITHIN 23 HOURS FOR INSURANCE REASONS THEY OFTEN GET

1 ADMITTED AS A 23 HOUR STAY. THEN, IF THE PROCEDURE LASTS
2 LONGER, THEN THEY WILL BECOME AN INPATIENT.
3 Q. AND THAT IS WITH THE INDUCTION?
4 A. YES, THAT'S AN INDUCTION.
5 Q. OKAY. SO I'M SORRY TO INTERRUPT YOU.
6 A. BUT BASICALLY THE PATIENT GETS ADMITTED TO AN INPATIENT
7 WARD, WHICH IN ONE OF THE INSTITUTIONS IS ACTUALLY LABOR AND
8 DELIVERY. IN ANOTHER INSTITUTION IT IS PART OF THE POSTPARTUM
9 WARD.
10 THE PATIENT WILL HAVE MEDICATION PLACED EVERY FOUR
11 TO SIX HOURS. AND I EXPLAIN TO THEM THAT IT WILL START A
12 CRAMPING, LABORING, MISCARRYING TYPE OF PROCESS. FOR PATIENTS
13 WHO HAVE GIVEN BIRTH BEFORE, I CAN EXPLAIN IT A LITTLE EASIER
14 BECAUSE THEY HAVE EXPERIENCED LABOR AND NO WHAT LABOR PAINS
15 ARE.
16 I EXPLAIN TO THEM THAT SOME PHYSIOLOGICAL PROCESS
17 THAT WE ARE USING MEDICATIONS THAT ARE REALLY MUCH MORE POTENT
18 THAN ANY OF THE MEDICATION ONE WOULD USE WITH AN INDUCTION AT
19 TERM.
20 WE ARE KIND OF OVERRIDING NATURE BECAUSE THERE IS
21 NOT -- REALLY NOTHING. THERE ARE USUALLY SIGNALS AT THIS TIME
22 THAT SUPPRESSED UTERINE ACTIVITY THAT COMES FROM THE PLACENTA
23 OR UTERUS, SO THAT THE PAIN MAY BE STRONGER.
24 I EXPLAIN TO THEM THAT GIVEN THE CIRCUMSTANCES THAT
25 WE CAN BE VERY LIBERAL WITH PAIN RELIEF. WE DISCUSS EPIDURAL

1 ANESTHESIA AND IV DRIP WITH MORPHINE OR DILAUDID OR DEMEROL,
2 COMPLETE ULTIMATE TYPE OF USUALLY SELF-ADMINISTERED DRIP THAT
3 THE PATIENT CAN USE, SIMILARLY AS PATIENTS WHO UNDERGO MAJOR
4 SURGERY AND HAVE USED THAT FOR PAIN AFTER THEIR SURGERY.
5 AND I EXPLAIN TO THEM THAT I CANNOT PREDICT HOW LONG
6 THIS PROCEDURE WILL TAKE UNTIL DELIVERY. IT MAY BE AS SHORT AS
7 EIGHT HOURS. THAT MAY BE THE SHORTEST TIME FRAME I HAVE SEEN
8 IT. BUT I HAVE SEEN IT GO AS LONG AS 72 HOURS.
9 I EXPLAIN TO THEM THAT THERE MAY BE SITUATIONS WHERE
10 WE MAY HAVE TO CONVERT TO MECHANICAL EVACUATION METHOD OR
11 CONVERT TO THE D&E OR LAMINARIA, ESPECIALLY IF COMPLICATIONS AS
12 INFECTION WOULD OCCUR.
13 I EXPLAIN THAT AFTER DELIVERY OF THE FETUS WE
14 DISCUSS THE SCENARIO OF LIVE BORN VERSUS STILLBIRTH. IN MOST
15 CIRCUMSTANCES THIS PROCESS IS STRONG PHYSIOLOGICAL THAT IT WILL
16 LEAD TO STILLBIRTH, ESPECIALLY LESS THAN 20 WEEKS.
17 AND WE DISCUSS WHAT KIND OF TESTING, WHAT SHE WOULD
18 WANT TO DO, ACTUALLY, AS FAR AS THE FETUS IS CONCERNED, WHAT
19 SUPPORT FROM CLERGY THAT SHE WANTS. THAT DOES SHE WANT TO HOLD
20 IT?
21 AND THERE ARE MANY PATIENTS, ESPECIALLY CHOOSING
22 INDUCTION METHODS, FOR WHOM THAT IS VERY IMPORTANT BECAUSE THEY
23 ARE EXPERIENCING THIS PROCESS VERY SIMILARLY AS IF THEY WERE
24 UNAWARE OF THE SITUATION, WOULD HAVE BEEN UNAWARE OF THE
25 SITUATION, DELIVER A BABY THAT IS NOT GOING TO LIVE AND WANT TO

1 GIVE ALL THE SUPPORT NECESSARY.
2 AFTER THE -- TO GO BACK TO THE TECHNICAL ELEMENTS,
3 AFTER THE FETUS IS DELIVERED I USUALLY CHANGE THE MEDICATION IN
4 THE IV AND I GIVE HIGH DOSAGES OF OXYTOCIN, WHICH IS THE SAME
5 MEDICATION USED FOR INDUCTION AT TERM, BUT THEN AT MUCH HIGHER
6 DOSAGES.
7 AND THEN, I ALLOW A LONGER TIME THAN AT TERM FOR
8 DELIVERY OF THE PLACENTA. AS LONG AS THERE IS NO SIGNIFICANT
9 BLEEDING, I AM COMFORTABLE WAITING UP TO FOUR HOURS FOR -- TO
10 WAIT FOR SPONTANEOUS DELIVERY OF THE PLACENTA.
11 BUT I COUNSEL PATIENTS THAT DEPENDING ON HOW MUCH
12 BLEEDING THERE IS, OR HOW MUCH TIME ONE ALLOWS, THAT THERE MAY
13 BE UP TO 20 TO 30 PERCENT CHANCE THAT THE PLACENTA MAY NOT COME
14 SPONTANEOUSLY AT THIS GESTATIONAL AGE, AND WE WOULD HAVE TO
15 REMOVE THAT WITH AN INSTRUMENT AND KIND OF DO A D&C TYPE OF
16 PROCEDURE.
17 Q. WHEN YOU SAY "D&C TYPE OF PROCEDURE," WE HAVEN'T HAD MUCH
18 TESTIMONY ABOUT FIRST-TRIMESTER ABORTIONS. WHAT IS A D&C?
19 A. THAT IS ACTUALLY THE WRONG WORD TO CALL IT D&C PROCEDURE,
20 BECAUSE THOSE PATIENTS' CERVIXES AREN'T DILATED AT THAT TIME.
21 IT IS REALLY MORE AN INSTRUMENTAL REMOVAL PROCEDURE.
22 AND UNDER THESE CIRCUMSTANCES QUITE OFTEN IT IS POSSIBLE TO
23 REMOVER THE PLACENTA INTACT. IT JUST IS KIND OF TRAPPED THERE.
24 IT IS NOT ALWAYS ADHERING.
25 Q. OKAY.

1 THE COURT: MS. GARTNER, IT IS TIME FOR OUR FIRST
2 BREAK OF THE MORNING. WE WILL TAKE A BREAK NOW. FIFTEEN
3 MINUTES.
4 THE CLERK: ALL RISE.
5 (RECESS TAKEN AT 10:00 A.M.)
6 (PROCEEDINGS RESUMED AT 10:15 A.M.)
7 THE COURT: ALL RIGHT. PLEASE CONTINUE.
8 BY MS. GARTNER:
9 Q. DR. BROEKHUIZEN, I THINK YOU STATED THAT YOU DESCRIBED TO
10 THE PATIENTS THAT YOU WILL INDUCE THE LABOR WITH MEDICATIONS.
11 I AM NOT SURE YOU STATED WHAT THOSE MEDICATIONS ARE.
12 A. CURRENTLY THAT WOULD BE MISOPROSTOL.
13 Q. AND HOW WOULD YOU ADMINISTER THE MISOPROSTOL?
14 A. PLACED IT VAGINALLY.
15 Q. I THINK YOU SAID BEFORE THE BREAK THAT WHEN YOU'RE
16 DESCRIBING THE PROCEDURE TO YOUR PATIENTS THAT YOU TELL THEM
17 THAT YOU MAY HAVE TO CONVERT TO D&E TECHNIQUES; IS THAT WHAT
18 YOU SAID?
19 A. I THINK THAT I WILL COUNSEL THEM ON THE FACT THAT
20 INDUCTIONS SOMETIMES FAIL, AND THEN THE ALTERNATIVE WOULD BE
21 THE CONVERSION TO A D&E METHOD.
22 AND THERE ARE SITUATIONS WHERE I KNOW THAT
23 SPONTANEOUS DELIVERY WILL NOT OCCUR BECAUSE OF GROSS
24 DISPROPORTION. THIS WOULD BE USUALLY IN THE CASE OF FETAL
25 ANOMALIES OR AS IN HIGH PROBABILITY OF NOT OCCURRING, BECAUSE

1 THE FETAL HEAD OR A PART OF THE FETAL BODY WILL BE SO BIG, IN
2 WHICH I COUNSEL WE WILL START WITH THE INDUCTION METHOD. BUT
3 WE MAY THEN HAVE TO DO OTHER MANEUVERS TO ALLOW FOR -- TO
4 CREATE ENOUGH SPACE FOR VAGINAL DELIVERY BY DECOMPRESSING THE
5 FETAL HEAD OR DECOMPRESSING THE FETAL ABNORMAL TRAITS INVOLVED.
6 Q. OKAY. I WANT TO -- JUST FOR NOW I WANT TO LEAVE ASIDE
7 THOSE SITUATIONS OF THE GROSS DISPROPORTION DUE TO A FETAL
8 ANOMALY, AND TALK ABOUT OTHER INSTANCES WHERE IN THE INDUCTIONS
9 YOU SWITCH IT A D&E TECHNIQUE.
10 CAN YOU DESCRIBE BRIEFLY THOSE CIRCUMSTANCES?
11 A. THERE ARE CIRCUMSTANCES WHERE THE MEMBRANES WILL RUPTURE
12 RELATIVELY EASY, EARLY IN THE PROCESS, WHERE INFECTION MAY
13 OCCUR AS A RESULT OF THAT. OR INFECTION MAY OCCUR EVEN IN THE
14 PRESENCE OF INTACT MEMBRANES.
15 BUT IF THE MOTHER DEVELOPS AMNIONITIS, THEN THE TIME
16 FRAME IN WHICH THE DELIVERY NEEDS TO BE ACHIEVED, RIGHT, IS
17 CLEARLY FORESHORTENED, BECAUSE THAT WOULD REPRESENT A
18 SIGNIFICANT RISK TO THE PATIENT. AND ACHIEVING, NO MATTER WHAT
19 METHOD ONE USES, THE WHOLE GOAL OF THAT IS TO REDUCE THE
20 COMPLICATIONS FOR THE PATIENTS AND TO MAKE IT THE SAFEST
21 PROCEDURE POSSIBLE.
22 UNDER THOSE CIRCUMSTANCES, EVEN PATIENTS WHO MAY --
23 WHO MAY -- REALLY THEIR DESIRE WOULD BE TO HAVE AN INTACT
24 DELIVERY, RIGHT, I COUNSEL THEM THAT UNDER THOSE CIRCUMSTANCES,
25 EVEN WHILE THAT IS WHAT THEY WOULD WANT, YOU KNOW, FOR THEIR

1 COMFORT, THAT UNDER THOSE CIRCUMSTANCES WE MAY HAVE TO CROSS
2 THE BRIDGE TO ANOTHER METHOD IN ORDER TO REDUCE SIGNIFICANT
3 COMPLICATIONS FOR HER, AND CONVERT TO A D&E PROCEDURE.
4 BLEEDING WOULD BE ANOTHER. INFECTION AND BLEEDING
5 ARE THE TWO SCENARIOS IN WHICH THE TIMETABLE CAN BECOME
6 SHORTER. AND MY MAIN GOAL IS TO HAVE A HEALTHY PATIENT AT THE
7 END OF THIS PROCEDURE.
8 THE CIRCUMSTANCES THAT LEADS TO THE PREGNANCY
9 TERMINATIONS, IN MY CIRCUMSTANCES ARE OFTEN ALREADY TRAGIC.
10 AND TO -- NO, I DON'T WANT TO EXPOSE THE PATIENTS TO ANY EXTRA
11 RISK. AND THAT IS WHY THERE NEED TO BE FLEXIBILITY ON THEIR
12 PART IN UNDERSTANDING, RIGHT, WHAT THE GOAL IS OF THE
13 PROCEDURE, AND NOT THE PROCEDURE MAKE THE GOAL ITSELF.
14 Q. IN THOSE CIRCUMSTANCES, FOR EXAMPLE, WHERE IN THE MIDST OF
15 THE INDUCTION THE WOMAN DEVELOPS BLEEDING OR INFECTION TO THE
16 EXTENT THAT YOU FEEL THAT THE INDUCTION -- THAT YOU NEED TO END
17 THE PROCEDURE MORE RAPIDLY, COULD THE FETUS BE PARTIALLY
18 DELIVERED AT THAT POINT?
19 A. IT COULD.
20 Q. OKAY. AND COULD THE FETUS STILL BE LIVING AT THAT POINT?
21 A. IT COULD.
22 Q. WHEN YOU DO THEN CONVERT TO THE D&E TECHNIQUES, HOW WOULD
23 YOU GO ABOUT COMPLETING THE PROCEDURE IN THE CIRCUMSTANCE WHERE
24 THE FETUS HAS PARTIALLY DELIVERED BUT DUE TO INFECTION OR
25 BLEEDING YOU NEED TO END THE PROCEDURE MORE RAPIDLY?

1 A. IN THE CASE OF A PARTIALLY-DELIVERED FETUS, THE SUFFICIENT
2 DILATATION THAT I CAN DO A COMPRESSION AND DECOMPRESSION
3 METHODS TO DELIVER THE FETAL HEAD. I WOULD, DEPENDING ON THE
4 GESTATIONAL AGE, HAVE TO CHOOSE A METHOD THAT WOULD MOST SAFELY
5 ACCOMPLISH THAT FOR THE PATIENT UNDER THE PARTICULAR
6 CIRCUMSTANCES.
7 Q. IN THOSE CIRCUMSTANCES, ARE THERE OPTIONS FOR DELIVERING
8 THE HEAD WITHOUT USING A DESTRUCTIVE PROCEDURE?
9 A. WELL, ONE OPTION WOULD BE TO CONTINUE WITH THE INDUCTION
10 METHOD AND WAIT FOR MORE DILATATION, IF ONE WOULD NOT EXPECT
11 ABSOLUTE DISPROPORTION.
12 BUT IN THE CONTEXT OF BLEEDING AND INFECTION, THAT
13 WOULD NOT BE IN THE INTEREST OF THE PATIENT TO ALLOW MORE TIME
14 TO NOT EFFECTIVELY TREAT THE INFECTION.
15 WE CAN GIVE ANTIBIOTICS, BUT BEST TREATMENT OF A
16 CHORIOAMNIONITIS IS NOT ONLY GIVING ANTIBIOTICS, BUT TO THE
17 EVACUATE THE UTERUS AS EXPEDITIOUSLY AS POSSIBLE.
18 Q. HAVE YOU EVER HEARD OF A TECHNIQUE CALLED "DURHRSSEN'S
19 INCISIONS?
20 A. DURHRSSEN'S INCISIONS IS A TECHNIQUE THAT, AGAIN, GENERALLY
21 IT DESCRIBES IN OBSTETRICAL PRACTICE AFTER 24 WEEKS. THERE
22 THE -- WHERE A BABY IN BREECH POSITION IS PARTIALLY-DELIVERED,
23 BUT THE CERVIX IS INSUFFICIENTLY DILATED AND THE HEAD IS NOT
24 TOO BIG TO COME TO THE CERVIX WHERE ONE WOULD PLACE -- YOU
25 KNOW, CUT THREE INCISIONS IN THE CERVIX TO BASICALLY FORCE THE

1 CERVIX OPEN AND ALLOW THE HEAD TO DELIVERY.
2 THAT IS A PROCEDURE THAT IS GENERALLY USED NOT TO --
3 IF THAT WERE TO OCCUR. IT IS A PROCEDURE THAT WE ALL HOPE WE
4 NEVER HAVE TO USE, BECAUSE IT WOULD BE KIND OF LIKE A
5 LIFE-SAVING PROCEDURE FOR OFTEN A PREMATURE BABY IN A BREECH
6 PRESENTATION.
7 AND IN 2004, I THINK IT SELDOM WOULD BE USED BECAUSE
8 WE DO NOT DELIVERY MANY BREECH BABIES --
9 Q. WOULD YOU --
10 A. -- VAGINALLY, ESPECIALLY NOT WHEN THEY ARE PREMATURE.
11 Q. WOULD YOU EVER CONSIDER DUHRSSEN'S INCISIONS TO BE AN
12 APPROPRIATE WAY IN THE CONTEXT OF AN INDUCTION ABORTION TO
13 COMPLETE AN INDUCTION WHERE THE HEAD WAS TRAPPED BUT THE WOMAN
14 WAS INFECTED OR BLEEDING?
15 A. NO, I WOULD NEVER CONSIDER THAT UNDER THESE CIRCUMSTANCES
16 IF I WERE TO CONSIDER THE CONSEQUENCES FOR THE PATIENTS AND
17 FUTURE PREGNANCIES, BECAUSE THAT REALLY WOULD BE PURPOSELY
18 INFLICTING TRAUMA TO THE CERVIX, WHICH, INDEED, I CAN REPAIR.
19 BUT THAT CLEARLY COULD INCREASE THE RISK OF ANY CERVICAL
20 PROBLEMS IN A FUTURE PREGNANCY.
21 AND IN THE CONTEXT OF A PREGNANCY TERMINATION, ALL
22 RIGHT, ONE HAS TO BALANCE, YOU KNOW, CERTAIN RISKS TO THE
23 MOTHER. I THINK THAT WOULD BE A RISK THAT ONE WOULD NOT WANT
24 TO EXPOSE THE PATIENT TO.
25 Q. ARE THERE OTHER TECHNIQUES THAT ARE USED IN BREECH

1 DELIVERIES AT TERM WHERE THE FETAL HEAD GETS STUCK TO ENABLE
2 THE HEAD TO BE DEVELOPED -- OR TO BE DELIVERED?
3 A. THERE IS A METHOD. THERE ARE METHODS TO EVEN WITH BREECH
4 DELIVERY AT ANY GESTATIONAL AGE BEYOND 24 WEEKS, BUT ESPECIALLY
5 AT TERM, THERE ARE SITUATIONS WHERE THE HEAD IS DEFLECTED AND
6 THERE IS A PROBLEM WITH SPONTANEOUS DELIVERY OF THE HEAD.
7 AND THERE ARE TECHNIQUES WHERE ONE PLACES A FINGER
8 IN THE MOUTH OR TWO FINGERS ON THE MAXILLA TO ACTUALLY PROMOTE
9 FLEXION OF THE FETAL HEAD, AND COMBINE THAT MANEUVER -- THIS IS
10 A MANEUVER, INTERNAL MANEUVER, AND THEN HAVE SOMEONE ELSE PUSH
11 ON THE FETAL HEAD FROM JUST ABOVE THE SYNTHESIS. OR I WAS
12 ACTUALLY TAUGHT TO DO THAT MYSELF WITH MY OTHER HAND TO ACHIEVE
13 DELIVERY OF THE AFTER-COMING HEAD.
14 AND THAT, OF COURSE, IS UNDER THESE CIRCUMSTANCES, A
15 LIFE-SAVING MANEUVER, BECAUSE IF PART OF THE BODY IS DELIVERED
16 AND THE HEAD IS STILL THERE, THEN WE HAVE A -- THERE IS A
17 PROBLEM.
18 BUT THAT MANEUVER IS CALLED MAURICEAU'S MODIFIED
19 MANEUVER. BUT THAT MANEUVER IS REALLY PART OF THE OBSTETRICAL
20 AREA. IT IS NOT OF THE TECHNIQUES USED FOR PREGNANCY
21 TERMINATION LESS THAN 24 WEEKS FOR THE FAIRLY SIMPLE REASON ONE
22 WOULD NEED SUFFICIENT DILATATION FOR -- TO PLACE SOMEONE'S HAND
23 THROUGH THE CERVIX. AND THAT IS NOT WHAT WE ARE DEALING WITH
24 UNDER THESE CIRCUMSTANCES MOST OF THE TIME.
25 Q. DR. BROEKHUIZEN, YOU HAVE JUST BEEN DESCRIBING FOR US THE

1 D&E AND INDUCTION PROCEDURES AS YOU DO THEM. IN YOUR PRACTICE
2 IS THERE AN OVERLAP BETWEEN D&E AND INDUCTION ABORTIONS?
3 A. WELL, THERE IS AN OVERLAP IN THE SENSE THAT INDUCTION,
4 RIGHT, MAY LEAD TO A D&E PROCEDURE UNDER CERTAIN CIRCUMSTANCES.
5 THE REVERSE IS REALLY NOT TRUE.
6 IT IS AN OVERLAP IN MY PRACTICE THAT I COUNSEL
7 PATIENTS ON BOTH PROCEDURES. AND WHAT IS MOST IMPORTANT FOR ME
8 IS THAT PATIENTS CHOOSE THAT PROCEDURE THAT THEY ARE THE MOST
9 COMFORTABLE WITH.
10 AND SO I, UNDER RARE CIRCUMSTANCES, ALL RIGHT, WOULD
11 I EXCLUDE ONE PROCEDURE OVER THE OTHER.
12 Q. DR. BROEKHUIZEN, IN YOUR PRACTICE HAVE THERE EVER BEEN
13 SPECIAL CIRCUMSTANCES WHERE IN YOUR OPINION IT WAS SAFEST TO DO
14 THE ABORTION IN A WAY WHERE YOU KNEW YOU HAD ENOUGH DILATATION
15 THAT YOU COULD ACHIEVE AN INTACT EXTRACTION OF THE FETUS UP TO
16 THE HEAD?
17 A. YES, THERE HAVE BEEN.
18 Q. DID ANY OF THOSE SITUATIONS INVOLVE A D&E THAT WAS
19 PERFORMED FOR A SERIOUS MATERNAL HEALTH CONDITION?
20 A. YES. ONE OF THOSE THAT COMES TO MIND WAS -- AND THE ONE
21 THAT I ACTUALLY DESCRIBED IN DETAIL IN THE WISCONSIN CASE, WAS
22 FOR A SERIOUS MATERNAL CONDITION WHERE THE GOAL WAS TO DO
23 SERIAL DILATATION, AVOID MEDICATION FOR INDUCTION AND AVOID THE
24 TRADITIONAL D&E-TYPE METHOD.
25 Q. AND CAN YOU DESCRIBE THE MEDICAL CIRCUMSTANCES OF THAT

1 WOMAN AND WHY YOU CONSIDERED THAT TO BE THE BEST METHOD OF
2 ABORTION FOR HER?
3 A. THIS WAS A PATIENT WHO HAD A CONDITION OF SCLERODERMA, WHO
4 HAD SIGNIFICANT PULMONARY HYPERTENSION, HAD SIGNIFICANT OTHER
5 VASCULAR DISEASE, WHO WAS 23 WEEKS AND ONE DAY PREGNANT; WAS
6 TRANSFERRED FROM ANOTHER HOSPITAL TO THE TERTIARY CARE
7 INSTITUTION I WAS WORKING AT THAT TIME. SHE WAS IN THE
8 CRITICAL CARE UNIT. SHE WAS VERY UNSTABLE. SHE WAS ON
9 MULTIPLE MEDICATIONS. AND IT WAS CLEARLY FELT THAT THE
10 CONTINUATION OF THE PREGNANCY WOULD BE -- WOULD LEAD TO HER
11 DEATH.
12 THE INTERNAL MEDICINE SPECIALIST AND THE
13 PULMONOLOGIST AND THE CARDIOLOGIST REALLY FELT THAT
14 PROSTAGLANDINS WERE CONTRAINDICATED IN THIS PATIENT.
15 Q. LET ME JUST INTERRUPT YOU THERE. IS MISOPROSTOL A
16 PROSTAGLANDIN?
17 A. CORRECT. WERE CONTRAINDICATED IN HER SITUATION. SHE
18 THOUGHT THAT THE WHOLE LABORING PROCESS WITH FLUID SHIFTS AND
19 TIME WOULD BE MORE STRESSFUL FOR HER THAN -- IN OTHER WORDS,
20 INDUCTION WAS NOT THE BEST OPTION.
21 THE OPTION OF A D&E PROCEDURE WHERE THE PATIENT
22 WOULD NEED TO HAVE ANESTHESIA, WAS ALREADY -- ANESTHESIOLOGISTS
23 WERE VERY CONCERNED ABOUT WHAT ANESTHESIA -- WHAT ANESTHESIA
24 METHOD TO GIVE HER. AND IF THERE WAS A PROCEDURE, THAT WOULD
25 HAVE TO BE AS SHORT AS POSSIBLE WITH THE LEAST AMOUNT OF

1 ANESTHESIA. THAT WAS KIND OF THE SCENARIO WE WERE CONFRONTED
2 WITH AT THAT TIME.
3 AND I DECIDED TO PROCEED AT THAT TIME WITH SERIAL
4 DILATATION WHERE WE PLACED LAMINARIA EVERY FOUR TO SIX HOURS.
5 AND THE CONCEPT WAS THAT THAT, IN ITSELF, MAY LEAD TO
6 SUFFICIENT DILATATION THAT WE COULD TAKE THE PATIENT TO THE
7 OPERATING ROOM WITH MINIMAL MEDICATION, HAD SUFFICIENT
8 DILATATION THAT WE COULD DO AT LEAST A PARTIAL EXTRACTION OR
9 MAYBE A TOTAL EXTRACTION.
10 AND THAT IS WHAT WE SET OUT TO DO UNDER THOSE
11 CIRCUMSTANCES.
12 Q. AND WHAT ACTUALLY HAPPENED WITH THAT PATIENT?
13 A. THAT PATIENT WE PLACED THE LAMINARIA THREE TIMES. THE LAST
14 TIME WE WERE UP TO ABOUT FOUR OR FIVE CENTIMETERS DILATATION.
15 AND WHEN WE ACTUALLY TOOK HER TO THE OPERATING ROOM FOUR HOURS
16 LATER THE FETUS HAD COMPLETELY DELIVERED SO WE DIDN'T HAVE
17 TO -- AND, ACTUALLY, THE PLACENTA WAS SITTING IN THE CERVICAL
18 OS. SO BASICALLY WE HAD JUST TO GRAB THE PLACENTA, AND THE
19 PROCEDURE COMPLETED ITSELF.
20 BUT I WOULD HAVE BEEN PREPARED AT THAT TIME TO --
21 ASSUMING THAT THERE WOULD HAVE BEEN A PARTIAL DELIVERY AND THE
22 HEAD STILL THERE, TO DO COMPRESSING AND DECOMPRESSING METHODS.
23 Q. AND IN YOUR PRACTICE HAVE YOU TREATED OTHER PATIENTS IN
24 SIMILAR SITUATIONS WHERE INDUCTION WAS CLEARLY CONTRAINDICATED,
25 BUT THIS TYPE OF SERIAL DILATATION TECHNIQUE WAS IN YOUR BEST

1 JUDGMENT THE OPTIMAL FOR THE PATIENT?
2 A. IN SOME OVER 20 YEARS, CASES SOMETIMES BLUR. BUT I THINK I
3 HAVE DONE AT LEAST TWO OTHER CASES OF SIMILAR NATURE AT LESS
4 GESTATION AGE. BUT, AGAIN, SITUATIONS WHERE IT WAS FELT THAT
5 AVOIDING OF MEDICATION, SURGERY, ANESTHESIA OR MINIMIZING THAT
6 AND SERIAL DILATATION WOULD BE THE BEST METHOD.
7 Q. AND DR. BROEKHUIZEN, IN YOUR PRACTICE HAVE THERE BEEN OTHER
8 CIRCUMSTANCES WHERE YOUR PATIENT HAD COMPELLING PERSONAL
9 REASONS FOR HAVING A D&E WHERE THE FETUS WAS REMOVED INTACT AND
10 WHERE YOU ATTEMPTED TO DO THAT FOR HER?
11 A. I HAD A PATIENT THAT HAD WAS DIAGNOSED WITH A LETHAL
12 SKELETAL DYSPLASIA.
13 Q. THE FETUS WAS?
14 A. THE FETUS HAD SKELETAL DYSPLASIA FORM OF DWARFISM
15 INCOMPATIBLE WITH SURVIVAL. MOST PATIENTS UNDER THESE
16 CIRCUMSTANCES, AFTER THE COUNSELING THAT I DESCRIBED BEFORE,
17 SINCE THERE QUITE OFTEN IS A NEED FOR A MORE PRECISE DIAGNOSIS
18 AND AUTOPSY, WE OPT FOR AN INDUCTION METHOD.
19 THIS PATIENT HAD A PREVIOUS CESAREAN SECTION AND
20 VERY TRAUMATIC BIRTHING PROCESS THE FIRST TIME AND REALLY DID
21 NOT WANT TO HAVE AN INDUCTION. NOT SO MUCH BECAUSE OF THE
22 RUPTURE RISK, BUT REALLY BECAUSE OF THE EXPERIENCE OF GOING
23 THROUGH A LABORING PROCESS.
24 AND SHE, AGAIN -- AND AT THE SAME TIME SHE REALLY
25 WAS INTERESTED IN HAVING AS MUCH INFORMATION. AND SO, WE NEED

1 AT LEAST THE TRUNK AND SKELETAL PART. THAT EXAMINATION WAS
2 IMPORTANT FOR HER. AND WE DECIDED TO EMBARK ON THE SAME METHOD
3 AS I DESCRIBED IN THE PREVIOUS CASE WITH SERIAL DILATATION,
4 WHICH COULD LEAD TO LABORING PROCESS, WHICH WOULD BE MAYBE A
5 LITTLE BIT MORE OR LESS PAINFUL OR PHYSIOLOGICAL OR A
6 SIGNIFICANT DILATATION THAT WE COULD TAKE THE PATIENT AND DO A
7 PARTIAL OR TOTAL EXTRACTION.
8 Q. AND WHAT HAPPENED WITH THIS PATIENT?
9 A. THE SERIAL DILATATION IN THE SENSE WAS SO SUCCESSFUL THAT,
10 AGAIN, THIS PATIENT DELIVERED SPONTANEOUSLY. BUT IT WAS VERY
11 SHORT TIME OF LABOR PERCEIVED BY HER. SO SHE WAS -- IT ENDED
12 UP EXACTLY AS WHAT SHE HAD WANTED IT TO BE.
13 Q. AND HAVE YOU HAD OTHER PATIENTS WHO FELT STRONGLY AGAINST
14 INDUCTION, BUT WHO WANTED AN INTACT FETUS FOR AUTOPSY PURPOSES?
15 A. PROBABLY SIMILAR SCENARIO. IT IS VERY RARE, BUT ONE OR TWO
16 TIMES.
17 Q. OKAY. AND I THINK YOU'VE ALLUDED TO THIS ALREADY IN YOUR
18 TESTIMONY: HAVE YOU PERFORMED INDUCTION ABORTIONS WHERE YOU
19 KNEW AHEAD OF TIME THAT DUE TO SOME TYPE OF GROSS FETAL
20 DISPROPORTION THE HEAD OR ANOTHER BODY PART WOULD BECOME LODGED
21 AT THE CERVIX DURING THE INDUCTION AND YOU WOULD HAVE TO
22 COMPLETE THE ABORTION INSTRUMENTALLY?
23 A. THAT PROBABLY HAS HAPPENED MORE OFTEN THAN THE TWO PREVIOUS
24 SCENARIOS. THE CASE THAT I DESCRIBED IN WISCONSIN A CASE WAS A
25 SITUATION WITH A LETHAL CHROMOSOMAL ANOMALY AND SIGNIFICANT

1 MACROCEPHALY THAT CLEARLY WAS INCOMPATIBLE WITH SURVIVAL. BUT
2 THE HEAD WAS GOING TO -- HAD ALREADY REACHED PROPORTIONS THAT
3 WERE LARGER THAN THE HEAD OF A BABY AT TERM, WHERE THE
4 ALTERNATIVE WOULD HAVE BEEN TO DO A SURGICAL PROCEDURE LIKE AT
5 THAT TIME THAT REALLY WOULD HAVE BEEN A SCAR AS BIG AS A
6 CESAREAN SECTION SCAR. OR AN INDUCTION AND BEING PREPARED TO
7 DECOMPRESS THE FETAL HEAD AND TO LET THE SKULL COLLAPSE TO
8 ALLOW FOR VAGINA DELIVERY.
9 AND IN THE CONTEXT OF THE LETHAL ANOMALY THIS
10 PATIENT REALLY DIDN'T WANT TO EXPOSE HERSELF TO A SURGICAL
11 PROCEDURE EXCEPT IF TRAGIC DEVELOPMENT. AND THE PLAN WAS TO
12 INDUCE LABOR. WHEN THERE IS THAT MUCH DISPROPORTION, IT'S
13 USUALLY IN A BREECH PRESENTATION. AND TO BE PREPARED AT
14 SUFFICIENT DILATATION TO BE DECOMPRESS THE FETAL SKULL.
15 Q. AND WHAT ACTUALLY HAPPENED WITH THAT PATIENT?
16 A. THAT PATIENT ACTUALLY -- THAT WENT ACCORDING TO PLAN. SHE
17 DELIVERED THE BODY PARTIALLY. AT THAT TIME IT WAS SUFFICIENT
18 DILATATION THAT I COULD VISUALIZE THE BASE OF THE SKULL AND
19 INSERT A THIN TROCAR TO REDUCE THE FLUID. AND AT THAT POINT,
20 OF COURSE, FLUID AND BRAIN TISSUE WILL APPEAR.
21 I THINK I STILL NEEDED TO HAVE SOME -- I USED
22 ACTUALLY PREMIE-TYPE OF OBSTETRICAL FORCEPS BECAUSE I STILL
23 NEEDED TO CREATE SOME COLLAPSING OF THE SKULL. BUT I COULD USE
24 THAT TYPE OF FORCEPS AT 6 OR 7 CENTIMETERS OF DILATATION.
25 Q. DID YOU SAY THE TROCAR WHEN YOU INSERTED IT, WAS THAT UNDER

1 YOUR DIRECT VISUALIZATION?
2 A. IT WAS UNDER DIRECT VISUALIZATION.
3 Q. AND WAS THE FETUS -- IN THAT CASE, WAS THE FETUS ALIVE AT
4 THE POINT WHEN THE HEAD LODGED AT THE OS?
5 A. I KNOW IN THAT CIRCUMSTANCE THAT THE CORD WAS PULSATING AT
6 THAT TIME.
7 Q. AND HAVE YOU PERFORMED OTHER SIMILAR ABORTIONS IN YOUR
8 CAREER WHERE YOU KNEW THAT THE HEAD OR ANOTHER VERY LARGE FETAL
9 PART WOULD LODGE WITHOUT BEING ABLE TO COMPLETE THE INDUCTION
10 WITHOUT INSTRUMENTS?
11 A. YES. THIS CLEARLY HAS HAPPENED MORE OFTEN. I HAD A
12 SITUATION LIKE THIS ONLY A FEW WEEKS AGO.
13 Q. DR. BROEKHUIZEN, I WANT TO ASK YOU A FEW MORE QUESTIONS
14 ABOUT THESE PATIENTS OR THESE SCENARIOS YOU WERE JUST
15 DESCRIBING.
16 BEFORE I DO, LET ME ASK YOU: AM I RIGHT THAT YOU
17 DESCRIBED THESE THREE SCENARIOS IN YOUR DECLARATION IN THIS
18 CASE?
19 A. YES, I DID.
20 Q. AND DID YOU DISCUSS THEM IN YOUR DEPOSITION IN THIS CASE?
21 A. I DID.
22 Q. AT THE TIME OF YOUR DEPOSITION DID YOU ALSO STATE THAT
23 THERE WERE OTHER SIMILAR CASES LIKE THEM?
24 A. YES, I DID.
25 Q. AT ANY TIME IN THIS CASE HAS THE GOVERNMENT REQUESTED THAT

1 YOU PRODUCE THE MEDICAL RECORDS FOR THESE ABORTIONS OR FOR
2 SIMILAR ABORTIONS YOU PERFORMED?
3 A. NO, THEY HAVE NOT.
4 Q. DR. BROEKHUIZEN, IN YOUR OPINION WERE THESE ABORTIONS WHERE
5 YOUR GOAL WAS INTACT EXTRACTION TO THE CALVARIUM, WERE THESE
6 THE SAFEST AND BEST OPTIONS FOR THESE PATIENTS?
7 A. IN MY OPINION THEY WERE THE SAFEST FROM THE PERSPECTIVE OF
8 THE LEAST MATERNAL HEALTH RISKS OR COMPLICATIONS.
9 Q. AND --
10 A. MORE IMPORTANTLY, THESE WERE THE CHOICES THAT THE PATIENTS
11 MADE. I HAVE HAD -- I HAVE DONE SURGICAL PROCEDURES ON
12 PATIENTS WITH LETHAL ANOMALIES WHERE PATIENTS -- THAT WAS THEIR
13 CHOICE.
14 Q. WHEN YOU SAY "SURGICAL PROCEDURES"?
15 A. LIKE C-SECTION OR HYSTEROTOMY. THEY CHOSE NOT TO HAVE THIS
16 PROCEDURE DONE.
17 Q. SO IS IT THE CASE THAT SOMETIMES PATIENTS CHOOSE PROCEDURES
18 THAT YOU KNOW CARRY MORE HEALTH RISK TO THEM?
19 A. SOMETIMES PATIENTS CHOOSE FOR THEIR PERSONAL BELIEFS
20 PROCEDURES THAT IF ONE WERE TO COMPARE ONE COMPLICATION WITH
21 ANOTHER WOULD BE LITTLE HIGHER COMPLICATION THAN THE OTHER.
22 AND SO SOMETIMES PATIENTS WEIGH THE MEDICAL RISK OF
23 PROCEDURES, BUT AT THE SAME TIME BALANCE THAT WITH THEIR
24 PERSONAL BELIEFS OR THEIR PERSONAL FEELINGS ABOUT WHAT IS
25 ACCEPTABLE TO THEM.

1 I AM SURE THAT RELIGION AND RELIGIOUS BELIEFS OFTEN
2 PLAY A ROLE IN THIS, AND I HAVE NO PROBLEM IF PATIENTS MAKE
3 THESE INFORMED CHOICES TO DO A PROCEDURE THAT MAY HAVE A LITTLE
4 BIT HIGHER RISK THAN ANOTHER ONE, BECAUSE ALL OF THESE
5 PROCEDURES, RIGHT, IN ITSELF ARE SAFE COMPARED WITH MANY
6 COMPLICATIONS THAT PATIENTS EXPOSE THEMSELF IN ANY PREGNANCY
7 AND WITH CHILDBIRTH.
8 Q. IN YOUR OPINION, ARE THERE ANY SPECIAL RISKS TO EXTRACTING
9 THE FETUS INTACT IN A D&E PROCEDURE?
10 A. THERE ARE NO -- THE ONLY DIFFERENCE IS ACHIEVING LARGER
11 AMOUNT OF CERVICAL DILATATION. THAT IS THE CRITICAL
12 DIFFERENCE. THE -- IT IS POSSIBLE THAT COMPARED TO THE D&E THE
13 LEAST PASSIVE OF INSTRUMENTS WOULD ACTUALLY REDUCE THE RISK OF
14 DIRECT TRAUMA TO THE UTERUS.
15 THE ONLY FUNDAMENTAL DIFFERENCE IS IF ONE TRIES TO
16 ACHIEVE MORE DILATATION.
17 Q. JUST TO PUT THAT IN CONTEXT, IF YOU ARE ASSUMING, SAY, A
18 22-WEEK D&E, WHAT WOULD BE A TYPICAL AMOUNT OF DILATATION THAT
19 YOU WOULD GET FOR A D&E AT THAT GESTATIONAL AGE?
20 A. I THINK AT 22 WEEKS ONE WOULD TRY TO ACHIEVE 3 TO
21 4 CENTIMETERS.
22 Q. WHAT ABOUT IF YOU WERE DOING AN INDUCTION ABORTION AT 22
23 WEEKS, HOW MUCH DILATATION WOULD THERE BE?
24 A. I THINK PROBABLY MOST OF THE TIME SIX, SEVEN CENTIMETERS
25 WOULD BE SUFFICIENT FOR DELIVERY.

1 Q. AND THEN, JUST TO PUT THAT IN THE CONTEXT OF VAGINAL
2 DELIVERY AT TERM, HOW MUCH DILATATION WOULD YOU NEED IF A WOMAN
3 WERE DELIVERING A BABY AT FULL TERM?
4 A. TEN CENTIMETERS.
5 Q. AND BASED ON YOUR CLINICAL EXPERIENCE AND YOUR READING OF
6 THE MEDICAL LITERATURE, CAN YOU SUMMARIZE YOUR UNDERSTANDING OF
7 WHETHER CERVICAL DILATATION USING GRADUAL OSMOTIC DILATATION OR
8 MISOPROSTOL TO PREPARE THE CERVIX FOR A SECOND TRIMESTER D&E IS
9 ASSOCIATED WITH CERVICAL INCOMPETENCE IN FUTURE PREGNANCIES?
10 A. MY READING OF THE LITERATURE IS THIS: UP TO 20 WEEKS THERE
11 IS, I THINK, SUFFICIENT EVIDENCE TO CONCLUDE THAT WITH MODERN
12 METHODS OF CERVICAL DILATATION THERE IS NO INCREASED RISK OF
13 PREMATURE DELIVERY OR CERVICAL INCOMPETENCE IN SUBSEQUENT
14 PREGNANCY.
15 THERE MAY BE WITH MECHANICAL DILATATION. AND AFTER
16 20 TO 24 WEEKS, I DO NOT THINK THAT THERE IS SUFFICIENT
17 EVIDENCE AND SUFFICIENT LITERATURE OUT THERE TO MAKE A
18 STATEMENT FOR OR AGAINST. OR THERE IS NO POSITIVE NOR NEGATIVE
19 TO MY KNOWLEDGE AT THIS PARTICULAR POINT.
20 NOW, I NEED TO USE THAT LACK OF INFORMATION WHEN I
21 COUNSEL PATIENTS. AND I ACTUALLY COUNSEL PATIENTS UP TO 20
22 WEEKS I DO NOT THINK THAT ANY OF THE METHODS THAT WE HAVE,
23 HYGROSCOPIC DILATORS OR MISOPROSTOL WOULD POSE THAT RISK. BUT
24 AFTER 20 TO 24 WEEKS IT MAY BE THERE. AND I COUNSEL THEM THAT
25 IF IT IS, IT WOULD BE A LOW RISK.

1 BUT THERE ARE ACTUALLY CONSULTATIONS AFTER
2 SECOND-TRIMESTER TERMINATIONS AT THAT GESTATIONAL AGE THAT IN A
3 FUTURE PREGNANCY I WOULD RECOMMEND THAT THEIR CERVIX GETS
4 CHECKED SERIALLY BY ULTRASOUND; THAT THEIR OBSTETRICIANS ARE
5 AWARE OF THIS, BECAUSE IT IS POSSIBLE IF THAT WERE THE CASE TO
6 MAKE THE DIAGNOSIS MAYBE EARLY ENOUGH THAT SURGICAL CERCLAGE
7 COULD BE PLACED, AND THE NEXT PREGNANCY COULD BE SAVED, IF THAT
8 CONDITION WERE TO OCCUR.
9 Q. DR. BROEKHUIZEN, IF THERE WERE AN INCREASED RISK OF
10 CERVICAL INCOMPETENCE AFTER 20 WEEKS, DO YOU THINK THAT RISK
11 WOULD BE ENOUGH TO MAKE THE ABORTIONS AT THAT STAGE UNSAFE?
12 A. NO, I DO NOT THINK THAT THAT WOULD -- IT WOULD NOT -- IF --
13 I DOUBT THAT THAT RISK WOULD BE HIGHER THAN THE RISK ASSOCIATED
14 WITH LARGE CONIZATIONS OF THE CERVIX OR A LARGE LEEP
15 PROCEDURES, IF THERE IS AN ASSOCIATION THERE. AND THAT IS
16 CONTROVERSIAL, AS WELL, BECAUSE IT DEPENDS ON THE SIZE OF
17 TISSUE THAT IS REMOVED.
18 AND SO, I DO NOT THINK THAT WHATEVER THAT NUMBER
19 WOULD BE, THAT THAT EVER WOULD BE IN A RANGE THAT ONE WOULD
20 CONSIDER THE PROCEDURE UNSAFE IN COMPARISON WITH OF COURSE THE
21 INDICATIONS FOR THE PREGNANCY TERMINATIONS THAT THE PATIENT IS
22 FACING.
23 Q. WHAT IS A LEEP PROCEDURE? COULD YOU SPELL THAT, FIRST?
24 A. IT'S L-E-E-P PROCEDURE: LOOP ELECTROSURGICAL EXCISION
25 PROCEDURE. IT IS A PROCEDURE THAT IS USUALLY USED FOR THE

1 TREATMENT -- SOMETIMES DIAGNOSIS AND TREATMENT OF A
2 PRECANCEROUS CONDITION OF THE CERVIX WHERE PART OF THE CERVIX
3 IS REMOVED WITH AN ELECTRICAL LOOP.
4 AND SOMETIMES PRECANCER OF THE CERVIX CAN EXTEND
5 INTO THE CERVICAL CANAL, AND THAT HAS TO BE REMOVED PRETTY HIGH
6 UP THERE WHERE ONE COULD LOSE, LET'S SAY, HALF OF ITS CERVICAL
7 LENGTH.
8 AND, AGAIN, THERE IS A CONCERN: CAN THAT LEAD TO
9 WEAKNESS OF THE CERVIX IN A SUBSEQUENT PREGNANCY?
10 Q. WHEN YOU SAY THAT YOU HAVE PATIENTS THAT ARE HAVING
11 ABORTIONS AFTER 20 WEEKS AND YOU COUNSEL THEM THAT:
12 "WE DON'T KNOW ABOUT THE RISK, BUT THERE COULD
13 BE A RISK," DO YOU DO THAT FOR BOTH D&E AND
14 INDUCTION ABORTIONS?
15 A. YES, I DO.
16 Q. AND IS THIS -- IS THAT, THE UNCERTAINTY ABOUT THAT, AN
17 IMPORTANT CONSIDERATION FOR YOUR PATIENTS?
18 A. I DON'T -- I CANNOT RECALL ANY PATIENT FOR WHOM THAT EVER
19 HAS BEEN THE DECIDING REASON TO UNDERGO OR NOT UNDERGO A
20 PREGNANCY TERMINATION AT THAT GESTATION RATE, BECAUSE THE
21 REASONS FOR THE PREGNANCY TERMINATIONS ARE USUALLY VERY CLEAR
22 TO THEM AND WOULD OVERRIDE THIS CONCERN.
23 Q. OKAY. AND THEN, JUST TALKING, AGAIN, ABOUT THOSE THREE
24 SCENARIOS: THE WOMAN WITH SCLERODERMA; THE WOMAN WITH THE
25 FETUS WITH SKELETAL DYSPLASIA; AND THE VERY HIGH MACROCEPHALIC,

1 HYDROCEPHALIC FETUS, IS THERE A PARTICULAR TERM THAT YOU USE TO
2 DESCRIBE THE METHOD OF ABORTION THAT YOU HAVE USED IN THOSE
3 CASES?
4 A. I ASSUME YOU MEAN TO DESCRIBE IT TO THE PATIENT.
5 Q. YES.
6 A. NO, I TRY TO, IN THE MOST GENTLE WAY, EXPLAIN WHAT I MAY
7 HAVE TO DO. I MEAN, THESE ARE NOT EASY DISCUSSIONS THAT I HAVE
8 WITH PATIENTS. THESE ARE -- THERE IS A LOT OF TEARS SHED
9 DURING MANY OF MY COUNSELING SESSIONS.
10 AND SO I DESCRIBE IT IN A FACTUAL SENSE, BUT I DON'T
11 REALLY COIN IT WITH A PHRASE OR A TERM OR A MEDICAL TERM.
12 Q. OKAY.
13 MS. GARTNER: YOUR HONOR, MAY I APPROACH TO PUT THE
14 COPY OF THE ACT UP?
15 THANK YOU.
16 THE COURT: ARE YOU MOVING TO A NEW SECTION?
17 MS. GARTNER: I AM.
18 THE COURT: I WOULD LIKE TO ASK A FEW QUESTIONS ON
19 THIS LAST SUBJECT BEFORE I FORGET.
20 DOCTOR, YOU DESCRIBED A COUPLE OF SITUATIONS WHERE
21 YOU USED WHAT YOU CALL "SERIAL DILATION" TO ACHIEVE A GREATER
22 LEVEL OF DILATION OF THE CERVIX SO YOU COULD ATTEMPT TO REMOVE
23 THE FETUS INTACT OR AT LEAST PARTIALLY INTACT.
24 MY QUESTION IS: HAVE YOU HAD OCCASION TO DELIVER
25 THE FETUS INTACT OR PARTIALLY INTACT WHEN YOU HAVE NOT USED

1 SERIAL DILATATION? IN OTHER WORDS, WHEN YOU ARE SIMPLY
2 PREPARING FOR A REGULAR D&E, HAVE YOU EVER HAD THE OCCASION TO
3 REMOVE THE FETUS INTACT OR PARTIALLY INTACT UNINTENTIONALLY?
4 THE WITNESS: NOT WITHOUT ANY MEDICATION UNLESS THE
5 PATIENT SPONTANEOUSLY WOULD HAVE STARTED THE MISCARRYING
6 PROCESS. THAT HAS HAPPENED, TOO.
7 IN THE CONTEXT OF THE DIAGNOSIS FOR WHICH I DO
8 PREGNANCY TERMINATIONS LIKE FAIRLY SERIOUS FETAL ANOMALIES IT
9 IS POSSIBLE THAT BETWEEN THE TIME I SEE THE PATIENTS AND THE
10 PROCEDURE CEASES SPONTANEOUSLY. THEY WILL DO THAT.
11 IN THE CONTEXT OF THE D&E, IF I UNDERSTAND YOUR
12 QUESTION, I THINK COUNSEL ASKED THAT QUESTION BEFORE. WHEN YOU
13 START THE MISOPROSTOL TO PREPARE THE CERVIX IN THAT PRECEDING
14 HOURS, IT IS POSSIBLE THAT IN ITSELF WILL LEAD TO SUFFICIENT
15 DILATATION. BUT I ALREADY CALL THAT AN INTERVENTION, BECAUSE
16 THE MISOPROSTOL IS PART AND PARCEL FOR THE PROCEDURE.
17 THE COURT: THERE IS A CERTAIN AMOUNT OF MISOPROSTOL
18 THAT YOU USE AND A NUMBER OF LAMINARIA THAT YOU USE TO ACHIEVE
19 A DILATATION OF THREE TO 4 CENTIMETERS FOR A REGULAR D&E; IS
20 THAT CORRECT, SAY UNDER 22 WEEKS?
21 THE WITNESS: YES. YOU CANNOT REALLY PREDICT WHAT
22 DILATATION YOU WILL ACHIEVE, BUT IN MOST CASES YOU WILL ACHIEVE
23 2 OR 3 CENTIMETERS USING MISOPROSTOL OR --
24 THE COURT: I THINK MY QUESTION IS SIMPLY: HAS IT
25 BEEN YOUR EXPERIENCE THAT YOU ONLY ESSENTIALLY PERFORMED AN

1 INTACT D&E ONLY IN THOSE CIRCUMSTANCES IN WHICH YOU SOUGHT TO
2 PERFORM AN INTACT D&E AT THE OUTSET?
3 THE WITNESS: NO. IT HAS HAPPENED -- IT HAS
4 HAPPENED AFTER PLACEMENT OF LAMINARIA OR MISOPROSTOL AS A
5 PRELUDE TO THE SURGICAL PART, THE EVACUATION PART. IT HAS
6 HAPPENED IN THE INTERVENING TIME. SO I HAVE SEEN THAT HAPPEN.
7 THE COURT: EVEN THOUGH WHEN YOU PLACED THE
8 LAMINARIA, THAT WAS NOT YOUR INTENT?
9 THE WITNESS: CORRECT.
10 THE COURT: ALL RIGHT. MY OTHER WITH QUESTION WAS:
11 DO ALL OF THESE SECOND-TRIMESTER ABORTIONS THAT YOU PERFORM,
12 ARE THEY THE RESULT OF A MATERNAL OR A FETAL HEALTH CONDITION?
13 THE WITNESS: YES.
14 THE COURT: ALL OF THEM.
15 THE WITNESS: ALL OF THEM.
16 THE COURT: OKAY. ALL RIGHT.
17 BY MS. GARTNER:
18 Q. DR. BROEKHUIZEN, I WOULD LIKE YOU TO LOOK AT THIS CHART
19 WHICH HAS THE OPERATIVE DEFINITION OF THE LAW THAT IS AT ISSUE
20 IN THIS CASE. AND DID YOU HAVE A CHANCE TO READ IT?
21 A. I HAVE READ THIS PART.
22 Q. OKAY. ARE YOU CONCERNED ABOUT THE POTENTIAL IMPACT OF THIS
23 LAW ON YOUR MEDICAL PRACTICE?
24 A. I AM VERY CONCERNED ABOUT THE POTENTIAL IMPACT OF THE LAW
25 ON MY PRACTICE.

1 Q. COULD -- IN YOUR OPINION, COULD THIS LAW BE UNDERSTOOD AS
2 BANNING SOME OF THE D&E'S THAT YOU DO?
3 A. I AM VERY CONCERNED THAT THE LAW WOULD BAN SOME OF THE
4 PROCEDURES I JUST DESCRIBED.
5 Q. JUST TO FOLLOW UP ON JUDGE HAMILTON'S QUESTION, ARE YOU
6 CONCERNED ABOUT THIS LAW ONLY IN THOSE CASES WHERE -- THE
7 IMPACT OF THE LAW ONLY IN THOSE CASES WHERE YOU DO THE SERIAL
8 DILATATION WITH THE INTENT OF GETTING TO THE POINT WHERE YOU
9 KNOW YOU'LL HAVE ENOUGH DILATION TO BRING THE FETUS OUT INTACT,
10 OR WOULD YOU THINK IT WOULD ALSO APPLY TO THE OTHER D&E'S WHERE
11 YOU MAY OR MAY NOT HAVE ENOUGH DILATION TO BRING IT OUT INTACT?
12 A. I THINK IT'S -- MY CONCERN IN BOTH SCENARIOS. I AM
13 CONCERNED IN THE SITUATIONS THAT I DESCRIBED AS IN THE THREE
14 CASES WHERE THAT WAS -- THE GOAL WAS TO ACHIEVE PARTIAL
15 DELIVERY OR POSSIBLY INTACT DELIVERY.
16 BUT I AM AS WELL CONCERNED ABOUT THE APPLICATION OF
17 THIS LANGUAGE AND THIS PROCEDURE TO ANY D&E PROCEDURE, WHERE
18 THIS COULD HAPPEN WITHOUT THAT BEING THE PRIMARY GOAL.
19 Q. AND IN YOUR OPINION COULD THIS LAW ALSO BE UNDERSTOOD AS
20 BANNING SOME OF THE INDUCTION ABORTIONS YOU DO?
21 A. IT WOULD. I WOULD BE VERY CONCERNED THAT IT WOULD BAN SOME
22 OF THE INDUCTION METHODS IN WHICH I KNOW THAT I HAVE TO CONVERT
23 TO AN ELEMENT OF -- MAYBE NOT AN ELEMENT. WHERE IT WOULD
24 INCLUDE PART -- THE SITUATION WHERE I CAN ANTICIPATE THAT THERE
25 WILL BE PARTIAL DELIVERY, AND I KNOW THAT THERE IS GOING TO BE

1 AN INTERRUPT BODY PART. AND IT MAY NOT JUST ONLY BE THE HEAD.
2 I CAN THINK OF SITUATIONS WHERE THERE WOULD BE DISPROPORTION IN
3 THE FETAL ABDOMEN THAT WOULD PRECLUDE DELIVERY THAT I MAY HAVE
4 TO DECOMPRESS.
5 Q. ARE YOU CONCERNED ABOUT THE IMPACT OF THIS LAW IN THOSE
6 SITUATIONS WHERE YOU DESCRIBED WHERE IN AN INDUCTION THE WOMAN
7 STARTS TO BLEED OR BECOME INFECTED AND YOU NEED TO CONVERT THE
8 PROCEDURE TO A D&E?
9 A. I WOULD BE CONCERNED FOR THE SAME REASONS.
10 Q. DR. BROEKHUIZEN, THE DEFINITION OF PARTIAL-BIRTH ABORTION
11 DESCRIBES TWO, TWO SCENARIOS IN TERMS OF THE FETAL
12 PRESENTATION. IT TALKS ABOUT DELIVERING A LIVING FETUS UNTIL,
13 IN THE CASE OF A HEADFIRST PRESENTATION, THE ENTIRE FETAL HEAD
14 IS OUTSIDE THE BODY OF THE MOTHER. THAT IS THE FIRST SCENARIO.
15 AND THE SECOND SCENARIO IS IN THE CASE OF A BREECH
16 PRESENTATION, ANY PART OF THE FETAL TRUNK PAST THE NAVEL IS
17 OUTSIDE THE BODY OF THE MOTHER.
18 ARE THERE CIRCUMSTANCES IN YOUR PRACTICE WHERE
19 YOU'VE DONE AN INDUCTION WHERE THE FETUS PRESENTS IN A
20 HEADFIRST OR BREECH -- I AM SORRY -- HEADFIRST OR VERTEX
21 PRESENTATION. AND AFTER THE FETAL HEAD IS OUTSIDE THE BODY OF
22 THE MOTHER, AS STATED IN THE LAW, YOU MUST DO A DESTRUCTIVE ACT
23 TO COMPLETE THE PROCEDURE?
24 A. YES, I HAVE ENCOUNTERED THAT SITUATION. THERE ARE
25 CONDITIONS AS NONIMMUNE HYDROPS OR CONDITIONS WHERE THERE IS

1 FETAL ASCITES WHERE THERE IS SIGNIFICANT AMOUNT OF FLUID IN THE
2 FETAL ABDOMINAL CAVITY THAT WOULD LEAD TO THE ABDOMEN BEING TOO
3 LARGE. OR A CYSTIC MALFORMATION WHERE THERE'S A FLUID-FILLED
4 AREA. THESE BOTH ARE LETHAL CONDITIONS, AND I HAVE HAD TO USE
5 TROCAR OR SPINAL NEEDLE TO DECOMPRESS PART OF THE FETAL CHEST
6 AND ABDOMEN WHERE THE CONTENTS -- IN ORDER TO ACHIEVE DELIVERY
7 OF THE REMAINDER OF THE BABY.
8 Q. AND WAS THAT AFTER THE HEAD HAD FULLY DELIVERED THROUGH THE
9 CERVIX?
10 A. THAT'S, IN THESE SITUATIONS, THE ONLY WAY THAT ONE CAN
11 ACTUALLY DO THE DECOMPRESSION IF THE HEAD IS NOT ONLY DELIVERED
12 THROUGH THE CERVIX. IF THE HEAD WAS ACTUALLY DELIVERED THROUGH
13 THE INTROITUS, BECAUSE I NEED TO HAVE THE SPACE TO REACH THE
14 DISPROPORTIONATELY LARGE ABDOMEN.
15 THESE ARE FAIRLY RARE SITUATIONS, BUT THEY -- THESE
16 ARE SOME OF THE MORE SERIOUS, YOU KNOW, DISFIGURING FETAL
17 ANOMALIES THAT ONE CAN ENCOUNTER.
18 Q. AND YOU HAVE ENCOUNTERED THEM IN YOUR PRACTICE?
19 A. CORRECT.
20 Q. IN THE ABORTIONS THAT YOU HAVE DONE USING SERIAL DILATATION
21 TO ENSURE THE INTACT FETUS, KNOWING THAT YOU MIGHT HAVE TO USE
22 A DESTRUCTIVE ACT TO DELIVER THE HEAD, DID YOU DELIVER THE
23 FETUS TO THAT POINT FOR THE PURPOSE OF PERFORMING THE
24 DESTRUCTIVE ACT?
25 A. NO. MY -- NOT FOR THE PURPOSE, BECAUSE IF THERE -- IF

1 THERE WOULD HAVE BEEN THE SITUATION WHERE I DIDN'T HAVE TO DO
2 THAT, WHERE THE HEAD DELIVERED SPONTANEOUSLY, I CERTAINLY WOULD
3 HAVE PREFERRED THAT.
4 BUT IN CERTAIN SCENARIOS, IT IS IMPROBABLE, RIGHT,
5 THAT THE HEAD WILL DELIVER. SO IT IS THE DISPROPORTION --
6 LET'S SAY I DESCRIBED A CASE WHERE THE FETUS HEAD WAS REALLY
7 VERY DISPROPORTIONATE. BUT AT 21, 22 WEEKS WITH INDUCTION
8 METHOD THERE OFTEN IS ENOUGH DISPROPORTION THAT AT THE
9 DILATATION OF FIVE, SIX CENTIMETERS THE TRUNK WILL DELIVER BUT
10 THE HEAD WILL NOT.
11 SO IT IS -- WHILE IT IS NOT ABSOLUTE
12 DISPROPORTIONATELY, RIGHT, THERE IS RELATIVE DISPROPORTION.
13 BUT UNDER THOSE CIRCUMSTANCES, I HAVE SEEN, EVEN
14 WITH THE DISPROPORTION, THE SPONTANEOUS DELIVERY. BUT I HAVE
15 SEEN SITUATIONS WHERE THAT DID NOT OCCUR, AND THEN I AM FACED
16 WITH THE CHOICE OF EXPEDITING THE PROCEDURE AT THAT TIME OR
17 NOT.
18 AND THAT'S WHY I NEED TO DISCUSS THAT WITH THE
19 PATIENT, THAT OPTION MAY OR THAT SITUATION MAY ARISE.
20 Q. IN YOUR PRACTICE, DO YOU EVER BRING THE FETUS PARTLY BUT
21 NOT ENTIRELY OUT OF THE UTERUS FOR THE PURPOSE OF DOING A
22 DESTRUCTIVE ACT?
23 A. NOT FOR THE PURPOSE OF DOING A DESTRUCTIVE ACT, BUT I NEED
24 TO BE PREPARED TO HAVE TO DO A DESTRUCTIVE ACT.
25 Q. DOES YOUR PURPOSE IN EVACUATING THE UTERUS VARY BY WHETHER

1 YOU ARE DOING A D&E PROCEDURE OR AN INDUCTION PROCEDURE OR THE
2 SERIAL DILATION-TYPE PROCEDURE THAT YOU DESCRIBED?
3 A. THE PURPOSE IS TO EVACUATE THE CONTENT OF THE UTERUS IN THE
4 SAFEST POSSIBLE WAY FOR THE PATIENT WITH THE LEAST
5 COMPLICATIONS, REGARDLESS OF WHAT METHODS I WOULD CHOOSE OR
6 REGARDLESS WHAT METHOD THE PATIENTS WOULD PREFER I USE.
7 Q. OKAY. DR. BROEKHUIZEN, DO YOU EVER TREAT WOMEN WHO PRESENT
8 TO YOU IN THE MIDST OF A SPONTANEOUS SECOND-TRIMESTER
9 MISCARRIAGE?
10 A. SURE I DO.
11 Q. AND WOULD THE TREATMENT THAT YOU OFFER TO THOSE WOMEN EVER
12 BE COVERED BY THIS LAW AS YOU UNDERSTAND THE LAW?
13 A. I THINK IF PATIENTS PRESENT AS A SPONTANEOUS
14 SECOND-TRIMESTER MISCARRIAGE, IF IN THE ABSENCE OF BLEEDING OR
15 INFECTION, I WOULD PROBABLY LET THE PROCESS NATURALLY TAKE
16 PLACE.
17 BUT IN THE SCENARIO OF INFECTION OR SIGNIFICANT
18 BLEEDING, I MAY BE CONFRONTED WITH THE SITUATION THAT WOULD BE
19 FAIRLY SIMILAR AS IF I DID AN INDUCTION METHOD PREGNANCY
20 TERMINATION WHERE I HAVE TO CONVERT TO A D&E PROCEDURE FOR
21 MATERNAL HEALTH REASONS BECAUSE NOW CONTINUATION OF THE NATURAL
22 PROCESS OR CONTINUATION OF AN INDUCTION PROCESS WILL TAKE MORE
23 TIME, AND IN THE CONTEXT OF BLEEDING OR INFECTION MAY INCREASE
24 HER HEALTH RISKS AND WOULD INCREASE THE MORBIDITY.
25 SO I CAN THINK OF THE SCENARIO WHERE I WOULD BE

1 CONFRONTED WITH THE SAME DILEMMA THAT I MAY ENCOUNTER IN THE
2 PLAN'S PREGNANCY TERMINATION BY AN INDUCTION METHOD.
3 Q. IN ENDING THE PREGNANCY USING D&E TECHNIQUES, IS IT
4 POSSIBLE, THEN, THAT YOU WOULD EXTRACT THE FETUS TO THE POINT
5 WHERE THE FETUS IS OUTSIDE THE WOMAN'S BODY PAST THE FETAL
6 NAVEL?
7 A. AGAIN, IF ONE WERE TO CONVERT, ONE WOULD WANT TO EXTRACT
8 THE FETUS IN THE MOST SAFEST AND MOST EXPEDITIOUS WAY WITH THE
9 LEAST POTENTIAL RISK FOR THE MOTHER. AND THEN, SINCE IT IS THE
10 EXTRACTION PORTION THAT WOULD BE THE LEAST RISKY PART, RIGHT,
11 ONE COULD ENCOUNTER THAT SAME SITUATION.
12 MS. GARTNER: YOUR HONOR, MAY I APPROACH TO PUT UP
13 THE OTHER PART?
14 THE COURT: YES.
15 BY MS. GARTNER:
16 Q. DR. BROEKHUIZEN, THIS IS THE BEGINNING OPERATIVE SECTION OF
17 THE STATUTE. THE SECOND SENTENCE OF THIS SUBSECTION, WHICH IS
18 SECTION 1531(A), INCLUDES WHAT IS CALLED "THE LIFE EXCEPTION"
19 TO THIS LAW. IF YOU COULD READ THAT SECOND SENTENCE?
20 A. "THIS SUBSECTION DOES NOT APPLY TO A PARTIAL-BIRTH ABORTION
21 THAT IS NECESSARY TO SAVE THE LIFE OF A MOTHER WHOSE
22 LIFE IS ENDANGERED BY A PHYSICAL DISORDER, PHYSICAL
23 ILLNESS OR PHYSICAL INJURY, INCLUDING A LIFE-
24 ENDANGERING PHYSICAL CONDITION CAUSED BY OR ARISING
25 FROM THE PREGNANCY ITSELF."

1 Q. IN YOUR OPINION, WOULD THIS LIFE EXCEPTION ENABLE YOU TO
2 PERFORM THE ABORTIONS THAT YOU CURRENTLY PERFORM IN ALL
3 SITUATIONS OF SERIOUS MATERNAL HEALTH CONDITIONS?
4 A. WELL, WHAT TROUBLES ME ABOUT THIS LANGUAGE IS THAT IT IS
5 NOT CLEAR TO ME WHO DETERMINES THE NECESSITY. WHO DEFINES WHAT
6 IS NECESSARY TO SAVE THE LIFE OF THE MOTHER? WHAT IS THE
7 ACTUAL RISK, YOU KNOW? IS THAT A PERCENTAGE, RISK OF
8 MORTALITY?
9 IT CERTAINLY DOESN'T COVER HEALTH COMPLICATIONS LIKE
10 INCREASING THE RISK OF NEEDING A NEW KIDNEY TRANSPLANT IN A
11 SOONER PERIOD OF TIME. BUT AS FAR AS THE RIGHT, SO THAT
12 TROUBLES ME, TOO. BUT WHO DETERMINES THE NECESSITY, AND WHAT
13 IS REALLY "LIFE ENDANGERMENT" IS WHAT TROUBLES ME.
14 I THINK THAT I HAVE SEEN PATIENTS, SINCE I TAKE CARE
15 OF PATIENTS WHO TAKE VERY HIGH RISKS IN CONTINUATION OF
16 PREGNANCY. I HAVE SEEN PATIENT TAKE RISKS THAT ARE AS HIGH AS
17 30 PERCENT. AND I HAVE SEEN PATIENTS WHO CONSIDER THE RISK OF
18 2 PERCENT OF DEATH INSIGNIFICANT RISK COMPARED WITH THE NORMAL
19 BACKGROUND RISK OF DYING FROM BEING PREGNANT.
20 AND I THINK THAT THE PERSONAL CHOICES AND THE
21 PERSONAL CIRCUMSTANCES THAT PEOPLE HAVE, THE DETERMINATION OF
22 WHAT DEATH MAY MEAN FOR THEIR CHILDREN, FOR THEIR FAMILIES,
23 VARIES SO SIGNIFICANTLY THAT I THINK THAT THE ONLY PERSON WHO
24 REALLY CAN DETERMINE WHAT RISK FOR LIFE ONE WOULD TAKE IS THE
25 PATIENT ITSELF.

1 AND THEN, HOW ONE REDUCES THAT RISK WOULD BE UP TO
2 ME AND THE PATIENT BY WHAT METHOD TO DO IT.
3 SO IN OTHER WORDS, THAT'S -- I WOULD BE VERY
4 UNCOMFORTABLE, BECAUSE I WOULD THINK THAT ANYBODY COULD SAY:
5 "WELL, THAT WASN'T NECESSARY," WHILE IT WAS VERY
6 NECESSARY FOR THAT PATIENT WITH THOSE PARTICULAR CIRCUMSTANCES.
7 Q. DR. BROEKHUIZEN, YOU REFERRED TO OR ALLUDED TO HEALTH
8 CONDITIONS THAT MIGHT LEAD TO THE PATIENT NEEDING A KIDNEY
9 TRANSPLANT SOONER THAN OTHERWISE. WAS THAT -- WERE YOU
10 REFERRING TO A PARTICULAR TYPE OF MEDICAL SITUATION THERE?
11 A. WELL, THERE ARE SITUATIONS WHERE PEOPLE WILL HAVE
12 PREEXISTING RENAL DISEASE OR, SAY, IN THE CONTEXT OF SYSTEMIC
13 LUPUS, WHERE THE PROCESS IS AN ONGOING PROCESS, WHERE THE
14 PREGNANCY MAY SPEED IT UP OR THE PATIENT MAY BE UNWILLING TO
15 ACCEPT THAT PROCESS.
16 SO, THERE ARE SITUATIONS WHERE THE ISSUE IS NOT
17 LIFE, BUT THE ISSUE IS REALLY HEALTH. AND HOW DOES THE
18 PREGNANCY -- HOW POTENTIALLY CAN IT EFFECT THE PROGRESSION OF
19 THE DISEASE THAT THE PATIENT ALREADY HAS.
20 AND, AGAIN, PATIENTS THERE WILL MAKE INDIVIDUAL
21 CHOICES ABOUT WHAT THEY WILL ACCEPT AS A HEALTH RISK OR NOT.
22 Q. DR. BROEKHUIZEN, THINKING BACK TO THE PATIENT YOU
23 DESCRIBED, THE FIRST PATIENT YOU DESCRIBED WHERE YOU DID THE
24 SERIAL DILATATION, THE WOMAN WHO HAD -- I THINK HAD SCLERODERMA
25 AND SOME OTHER MEDICAL CONDITIONS, DO YOU BELIEVE THAT THIS

1 EXCEPTION WOULD HAVE APPLIED TO THAT PATIENT?
2 A. I CERTAINLY WOULD HOPE THAT EXCEPTION WOULD APPLY TO THAT
3 PATIENT. THERE WERE AT LEAST FIVE OR SIX PHYSICIANS INVOLVED
4 IN COMING TO THE CONCLUSION THAT THIS REALLY REPRESENTED A
5 LIFE-THREATENING -- VERY IMMEDIATE LIFE-THREATENING RISK. NOT
6 A LIFE-THREATENING RISK A FEW WEEKS DOWN THE ROAD, WHICH IS
7 MORE OFTEN THE CASE.
8 BUT I AM CONCERNED THAT SOMEONE WOULD TAKE THE
9 POSITION THAT IT HAS TO BE AT LEAST 75 PERCENT CERTAIN AND MAY
10 NOT HAVE -- MAY HAVE TAKEN THE POSITION THAT IT WASN'T
11 NECESSARY.
12 I DON'T KNOW WHO IS THE BEST JUDGE BEYOND THE
13 PATIENT AND THE PHYSICIAN THAT SHE IS MAKING A CHOICE WITH.
14 WHO CAN MAKE -- I DON'T THINK OF BETTER PEOPLE WHO CAN MAKE
15 THAT CHOICE THAN THOSE TWO.
16 Q. AND IN THE CASE OF THAT PATIENT WITH SCLERODERMA, EVEN IF
17 THE INDUCTION WAS CONTRAINDICATED FOR HER BECAUSE OF HER
18 MEDICAL CONDITIONS, WAS HYSTEROTOMY AN OPTION FOR HER?
19 A. ACTUALLY, THE ANESTHESIOLOGIST AND THE PULMONARY SPECIALIST
20 AND THE CRITICAL CARE SPECIALIST AND THE CARDIOLOGIST ALL FELT
21 THAT GIVEN THE PATIENT MINIMAL AMOUNT OF ANESTHESIA OR
22 COMPLICATIONS THAT COULD OCCUR FROM THE SURGICAL PROCEDURE
23 WOULD BE HIGHER THAN ANY RISK THAT COULD OCCUR FROM THE SERIAL
24 DILATATION.
25 MS. GARTNER: YOUR HONOR, MAY I APPROACH THE

1 WITNESS?
2 THE COURT: YES.
3 BY MS. GARTNER:
4 Q. DR. BROEKHUIZEN, I AM HANDING YOU A COPY OF THE ENTIRE ACT
5 THAT IS AT ISSUE IN THE CASE. AND I HAVE TURNED IT TO
6 PAGE S3-7, WHICH IS THE SECOND TO LAST PAGE. AND I WOULD LIKE
7 TO DIRECT YOUR ATTENTION ABOUT TWO-THIRDS OF THE WAY DOWN THE
8 PAGE TO THE PARAGRAPHS THAT ARE MARKED "D-1" AND "D-2."
9 IF YOU COULD JUST TAKE A LOOK AT THOSE BRIEFLY.
10 A. I AM READING THEM.
11 Q. OKAY. DO YOU UNDERSTAND THAT THESE SECTIONS ALLOW A
12 PHYSICIAN WHO HAS BEEN ACCUSED OF VIOLATING THIS LAW TO SEEK A
13 HEARING BEFORE THEIR STATE MEDICAL BOARD ON WHETHER THE
14 ABORTION WAS NECESSARY FOR THE WOMAN'S LIFE, AND THAT THE
15 FINDINGS OF THE STATE MEDICAL BOARD COULD BE MADE PART OF THE
16 RECORD AT THE PHYSICIAN'S CRIMINAL TRIAL?
17 A. I AM READING THAT THAT IS IN THE LAW.
18 Q. DOES THE EXISTENCE OF THIS PROCEDURE BEFORE THE STATE
19 MEDICAL BOARD GIVE YOU ANY COMFORT THAT THE ABORTIONS THAT YOU
20 DO TO PRESERVE MATERNAL HEALTH OR THAT YOU BELIEVE ARE
21 NECESSARY FOR THE WOMAN'S LIFE WOULD NOT BE FOUND TO VIOLATE
22 THIS LAW?
23 A. I AM NOT COMFORTABLE AT ALL WITH THIS LANGUAGE AS A
24 PROTECTIVE MECHANISM, BECAUSE IT SEEMS TO ME I WOULD BE
25 INDICTED FIRST, AND THEN I WOULD BE SUBJECT TO A HEARING BY A

1 STATE MEDICAL BOARD OF WHICH I REALLY DO NOT KNOW WHAT
2 EXPERIENCE, EXPERTISE THEY HAVE IN THIS PARTICULAR SITUATION.
3 AND IT IS MY UNDERSTANDING THAT -- AND SO I THINK
4 THAT IT WOULD INDICT ME FIRST, AND THEN THE MECHANISM OF -- THE
5 MECHANISM BY WHICH THE STATE MEDICAL BOARD COULD THEN DECIDE I
6 DID THE RIGHT THING ALREADY WOULD HAVE HAD SIGNIFICANT IMPACT
7 ON MY ABILITY TO PROVIDE SIMILAR SERVICES TO PATIENTS OR
8 PROBABLY COULD EFFECT MY CAREER IN A SIGNIFICANT FASHION.
9 Q. DR. BROEKHUIZEN, IS IT YOUR UNDERSTANDING THAT YOU COULD
10 AVOID THE REACH OF THIS ACT BY INDUCING FETAL DEMISE BEFORE YOU
11 BEGIN THE EVACUATION PART OF THE D&E PROCEDURE OR THE INDUCTION
12 PROCEDURE?
13 A. YES. THAT WOULD BE A WAY OF AVOIDING THE CONSEQUENCES OF
14 THIS ACT.
15 Q. DO YOU DISCUSS WITH YOUR PATIENTS THE OPTION OF INDUCING
16 FETAL DEMISE BY INJECTING DIGOXIN INTO THE FETUS BEFORE THE
17 ABORTION?
18 A. YES, I DO.
19 Q. AND DO ALL OF YOUR PATIENTS CHOOSE TO HAVE FETAL DEMISE
20 INDUCED?
21 A. NO, NOT ALL OF MY PATIENTS CHOOSE TO HAVE FETAL DEMISE
22 INDUCED.
23 Q. AND WHY --
24 A. THERE ARE ACTUALLY PATIENTS WHO DO NOT WANT FETAL DEMISE
25 INDUCED.

1 Q. WHY IS THAT?
2 A. ESPECIALLY IN THE CONTEXT OF THE PATIENTS WITH LETHAL
3 ANOMALIES, PATIENTS DO NOT FEEL THAT THEY NEED TO WITNESS A
4 LETHAL INJECTION, WHICH WOULD BE UNDER ULTRASOUND GUIDANCE, AND
5 ACTUALLY PREFER TO HAVE AN EARLIER DELIVERY OF A BABY THAT
6 CANNOT LIVE. AND SOME OF THEM ACTUALLY DO NOT MIND IF THERE
7 WAS SIGNS OF LIFE. AND SOME PATIENTS HAVE EVEN EXPRESSED THAT
8 THAT IS WHAT THEY WOULD PREFER TO LET THE BABY DIE IN THEIR
9 ARMS.
10 AND I THINK IN SOME RELIGIONS THERE IS A DIFFERENCE
11 BETWEEN BLESSING AND BAPTIZING, AND SO THERE ARE PATIENTS WHO
12 ACTUALLY WILL TRAVEL FROM ONE -- FROM MADISON, WISCONSIN TO
13 MILWAUKEE AFTER THE DIAGNOSIS OF FETAL ANENCEPHALY, BECAUSE IN
14 ONE OF THE HOSPITALS THERE THEY HAVE A RULE THAT IT NEEDS TO BE
15 DONE AFTER 20 WEEKS. AND PATIENTS ACTUALLY REALLY CHOOSE NOT
16 TO HAVE THAT DONE.
17 ON THE OTHER HAND, THERE ARE PATIENTS WHO -- FOR
18 WHOM THAT IS A VERY COMFORTING PROCEDURE TO HAVE TAKEN PLACE,
19 YOU KNOW, AS PART OF THE PRACTICE OF TERMINATION PROCEDURE.
20 BUT, AGAIN, THIS IS A VERY INDIVIDUAL CHOICE THAT
21 PATIENTS MAY MAKE ON THEIR SET OF BELIEFS AND THEIR COMFORT
22 LEVEL.
23 MR. SIMPSON: OBJECTION, YOUR HONOR, AS TO LACK OF
24 FOUNDATION AND HEARSAY AS TO THE RELIGIOUS BELIEFS AND
25 PRACTICES.

1 THE COURT: OVERRULED.
2 BY MS. GARTNER:
3 Q. DR. BROEKHUIZEN, ONE FINAL QUESTION: IF THIS LAW WERE
4 ENFORCED, WHAT IMPACT WOULD IT HAVE ON YOUR PRACTICE AND ON
5 YOUR PATIENTS?
6 A. WELL, IT WOULD -- IT CERTAINLY WOULD MAKE IT MORE
7 DIFFICULT. IT WOULD MAKE IT SIGNIFICANTLY MORE DIFFICULT TO
8 PROVIDE THE MEDICALLY NECESSARY SERVICES THAT SOME PATIENTS
9 CHOOSE UNDER THE CIRCUMSTANCES THAT I PERFORM PREGNANCY
10 TERMINATION.
11 AND SO THE ALTERNATIVE OF THE LETHAL INJECTION,
12 RIGHT, WOULD PROBABLY BECOME MORE PROMINENT. I WOULD PROBABLY
13 HAVE TO UTILIZE THAT MORE TO AVOID THE CONSEQUENCES OF THE LAW.
14 BUT AS I JUST EXPLAINED, THAT MAY NOT REALLY BE IN THE BEST
15 INTEREST OF THE PATIENTS AND WHAT THEY WOULD CHOOSE AS THE BEST
16 METHOD.
17 MS. GARTNER: THANK YOU.
18 THE COURT: ARE YOU FINISHED?
19 MS. GARTNER: YES, I AM, YOUR HONOR.
20 THE COURT: MR. SIMPSON.
21 CROSS-EXAMINATION
22 BY MR. SIMPSON:
23 Q. DR. BROEKHUIZEN, HOW ARE YOU?
24 A. I AM FINE.
25 Q. YOU'VE TESTIFIED, DOCTOR, THAT YOU'RE THE PART-TIME MEDICAL

1 DIRECTOR OF PLANNED PARENTHOOD OF WISCONSIN, CORRECT?
2 A. THAT'S CORRECT.
3 Q. YOU DON'T SUPERVISE THE PERFORMANCE OF ABORTIONS AT PLANNED
4 PARENTHOOD, DO YOU?
5 A. NO, I DON'T.
6 Q. IN YOUR CAPACITY AS PART-TIME MEDICAL DIRECTOR, YOU DON'T
7 HAVE ANY INVOLVEMENT AT ALL WITH PLANNED PARENTHOOD ABORTION
8 CLINICS?
9 A. I HAVE NO DIRECT SUPERVISORY, OR I DON'T WORK THERE. I
10 DON'T PERFORM ABORTIONS, AND I DON'T DIRECT SUPERVISORY ROLE IN
11 THOSE -- I HAVE A SUPERVISORY ROLE IN THE CLINICS, BUT NOT FOR
12 THE ABORTION PARTS.
13 THERE IS A SEPARATE MEDICAL DIRECTOR FOR ABORTION
14 SERVICES IN THOSE TWO CLINICS.
15 Q. YOU DON'T HAVE ANY INVOLVEMENT AT ALL AS TO ABORTION
16 CLINICS IN A MEDICAL DIRECTOR SENSE?
17 A. CORRECT.
18 Q. DOCTOR, YOU'VE TESTIFIED THAT YOU HAVE CERTAIN NICHES,
19 CERTAIN AREAS IN WHICH YOU HAVE PARTICULAR EXPERTISE. ARE YOU
20 FAMILIAR WITH THE SUBSPECIALTY WITHIN OBSTETRICS AND GYNECOLOGY
21 KNOWN AS MATERNAL FETAL MEDICINE?
22 A. YES, I AM FAMILIAR WITH THAT.
23 Q. MATERNAL FETAL MEDICINE DEALS WITH PREGNANCIES THAT ARE
24 HIGH RISK EITHER BECAUSE OF A MATERNAL HEALTH CONDITION OR A
25 FETAL ANOMALY?

1 A. YES. AND PRENATAL DIAGNOSIS AND PRENATAL TESTING IS
2 CERTAINLY PART OF IT.
3 Q. CAN A PHYSICIAN BECOME BOARD CERTIFIED IN MATERNAL FETAL
4 MEDICINE AS WELL AS OB/GYN?
5 A. YES, THEY CAN.
6 Q. BUT YOU ARE NOT BOARD CERTIFIED IN MATERNAL FETAL MEDICINE,
7 CORRECT?
8 A. NO, I NEVER FORMALLY FINISHED A FELLOWSHIP IN MATERNAL
9 FETAL MEDICINE. I AM IN MY DEPARTMENT. I AM NOT BOARD
10 CERTIFIED IN MY DEPARTMENT. I AM HOUSED IN THIS SECTION OF
11 MATERNAL FETAL MEDICINE, AND I PERFORM THE SAME DUTIES AS MY
12 COLLEAGUES WHO ARE BOARD CERTIFIED IN MATERNAL FETAL MEDICINE.
13 Q. YOU HAVE NEVER BEEN FORMALLY TRAINED IN MATERNAL FETAL
14 MEDICINE, CORRECT?
15 A. I ACTUALLY WAS FORMALLY TRAINED FOR ABOUT 20 MONTHS OF THE
16 24 MONTHS OF A FELLOWSHIP, BUT AT THAT TIME MY PLAN WAS TO GO
17 BACK TO THE NETHERLANDS AND PRACTICE THERE. AND THEN, I
18 RELOCATED TO MILWAUKEE. IN ORDER TO FINISH THE FELLOWSHIP I
19 WOULD HAVE HAD TO GO BACK TO MY FELLOWSHIP, AND I CHOSE NOT TO
20 DO THAT.
21 SO I CERTAINLY HAVE HAD TRAINING AND 20 YEARS OF
22 PRACTICE IN THAT FIELD.
23 Q. BUT YOU HAVE NEVER BEEN FORMALLY TRAINED IN THAT FIELD?
24 A. I ACTUALLY WAS FORMALLY TRAINED FOR ABOUT 20 MONTHS IN THAT
25 FIELD. I CHOSE NOT TO FINISH MY FELLOWSHIP, AND I CHOSE NOT TO

1 SIT FOR THE BOARDS.
2 AND I COULDN'T BECAUSE I NEVER FINISHED MY
3 FELLOWSHIP.
4 Q. DOCTOR, YOU HAVE ALSO NEVER HAD ANY LEGAL TRAINING,
5 CORRECT?
6 A. NO.
7 Q. THAT'S CORRECT?
8 A. THAT'S CORRECT.
9 Q. DOCTOR, IN PERFORMING A D&E YOU REACH FOR WHATEVER FETAL
10 PART PRESENTS AT THE INTERNAL OS, CORRECT?
11 A. THAT'S TRUE MOST OF THE TIME. I GRAB FOR THE PART THAT I
12 CAN GRAB. USUALLY THAT'S A PART THAT IS CLOSE TO THE INTERNAL
13 OS, BUT NOT ALWAYS.
14 Q. AND, IN GENERAL, YOU REACH FOR WHATEVER PART PRESENTS AT
15 THE INTERNAL OS?
16 A. I GRASP FOR WHATEVER PART I CAN GRASP, AND THAT IS ALMOST
17 NEVER THE FETAL HEAD.
18 Q. YOU GENERALLY REACH FOR WHATEVER PART PRESENTS AT THE
19 INTERNAL OS?
20 A. CORRECT.
21 Q. NOW, DOCTOR, A MID-TRIMESTER D&E NORMALLY INVOLVES REMOVING
22 THE FETUS IN PARTS, CORRECT? A MID-TRIMESTER D&E NORMALLY
23 INVOLVES REMOVING THE FETUS IN PARTS?
24 A. NO, THAT'S -- WELL, THAT IS -- IN THE MAJORITY OF CASES
25 THAT WILL TAKE PLACE. THAT WILL OCCUR.

1 Q. IN FACT, IN DESCRIBING THE D&E PROCEDURE TO A PATIENT AT 14
2 WEEKS, YOU WOULD TELL HER THAT THE FETUS WILL PROBABLY BE
3 REMOVED IN PARTS?
4 A. YES, I DO.
5 Q. IN DESCRIBING THE D&E PROCEDURE TO A PATIENT AT 18 WEEKS,
6 YOU WOULD TELL HER THAT THE FETUS WOULD PROBABLY BE REMOVED IN
7 PARTS?
8 A. PROBABLY WILL BE REMOVED IN PARTS.
9 Q. IN PERFORMING A DISMEMBERMENT D&E, DOCTOR, YOU PULL ON THE
10 FETUS WITH A TWISTING MOTION, CORRECT?
11 A. SOMETIMES. SOMETIMES NOT.
12 Q. DOCTOR, WERE YOU A PLAINTIFF IN A CASE -- I BELIEVE THIS
13 WAS REFERRED TO EARLIER -- IN A CASE THAT CHALLENGED A
14 WISCONSIN STATE LAW REGARDING WHAT THAT LAW CALLED
15 "PARTIAL-BIRTH ABORTION"?
16 A. YES, I DID.
17 Q. THAT CASE WAS FILED IN THE FEDERAL COURT IN WISCONSIN?
18 A. CORRECT.
19 Q. DID YOU SUBMIT A DECLARATION IN THAT CASE?
20 A. I DID.
21 MR. SIMPSON: I WOULD LIKE TO SHOW THE WITNESS, YOUR
22 HONOR, WHAT HAS BEEN MARKED AS EXHIBIT A-57.
23 COULD I APPROACH THE WITNESS, YOUR HONOR?
24 YOUR HONOR, COULD I APPROACH THE WITNESS?
25 THE COURT: YES.

1 BY MR. SIMPSON:
2 Q. DOCTOR, I HAVE HANDED YOU EXHIBIT A-57 IN THIS CASE. IS
3 THAT A DECLARATION THAT YOU SIGNED IN THE WISCONSIN CASE?
4 A. YES, I DID.
5 Q. YOU TOLD THE TRUTH IN THAT DECLARATION?
6 A. I DID.
7 Q. I AM GOING TO START, DOCTOR, BY READING PARAGRAPH 1 OF THE
8 DECLARATION. WOULD YOU LIKE TO READ THAT, PLEASE, SILENTLY TO
9 YOURSELF?
10 A. "I AM ONE OF THE PLAINTIFFS IN THIS ACTION. I SUBMIT THIS
11 DECLARATION TO ADDRESS A FACTUAL QUESTION CONCERNING
12 THE DILATATION AND EVACUATION METHOD OF ABORTION."
13 Q. SO THIS DECLARATION DESCRIBES THE D&E PROCEDURE?
14 A. CORRECT.
15 Q. I AM GOING TO READ ALSO THE FIRST SENTENCE OF THE THIRD
16 PARAGRAPH. IF YOU CAN READ THAT SILENTLY TO YOURSELF, PLEASE,
17 DOCTOR, PARAGRAPH 3, FIRST SENTENCE.
18 HAVE YOU DONE THAT?
19 A. YES.
20 Q. DOES THAT SENTENCE SAY:
21 "THUS, AFTER DILATION OF THE CERVIX I WILL
22 GAIN A HOLD ON WHATEVER PORTION OF THE FETUS IS
23 CLOSEST TO THE CERVICAL OPENING AND WILL TWIST AND
24 PULL THAT PORTION TO EXTRACT IT."
25 DOES IT SAY THAT?

1 A. IT SAYS THAT.
2 Q. SO IN PERFORMING A D&E YOU PULL ON THE FETUS WITH A
3 TWISTING MOTION, CORRECT?
4 A. YOU SOMETIMES TWIST. YOU SOMETIMES PULL. YOU SOMETIMES DO
5 BOTH.
6 Q. IN DESCRIBING THE D&E PROCEDURE TO THE FEDERAL COURT IN
7 WISCONSIN, YOU DESCRIBED THE D&E PROCEDURE AS TWISTING AND
8 PULLING, CORRECT?
9 A. I DID.
10 Q. AND YOU TOLD THE TRUTH AT THAT TIME?
11 A. I THOUGHT I TOLD THE TRUTH AT THAT TIME, YEAH.
12 Q. DOCTOR, YOU'VE DONE --
13 MR. SIMPSON: STRIKE THAT, PLEASE.
14 BY MR. SIMPSON:
15 Q. DOCTOR, THERE ARE INSTRUMENTS THAT YOU USE THAT ARE
16 SPECIFICALLY MEANT FOR DISMEMBERMENT, CORRECT?
17 A. WELL, THEY ARE GRASPING AND CRUSHING INSTRUMENTS, AND THEY
18 OFTEN WILL CAUSE DISMEMBERMENT.
19 MR. SIMPSON: I AM SORRY, YOUR HONOR. IF I COULD
20 HAVE JUST A MOMENT.
21 (PAUSE IN THE PROCEEDINGS.)
22 BY MR. SIMPSON:
23 Q. THERE ARE INSTRUMENTS SPECIFICALLY MEANT FOR DISMEMBERING
24 THE FETUS?
25 A. THERE ARE INSTRUMENTS TO GRASP AND CRUSH. AND DURING THE

1 PULLING, EXTRACTING, TWISTING, DISARTICULATION MAY TAKE PLACE.
2 Q. DOCTOR, DID YOU GIVE A DEPOSITION IN THIS CASE?
3 A. YES, I DID.
4 Q. I TOOK YOUR DEPOSITION, CORRECT?
5 A. YES, YOU DID.
6 Q. DID YOU TELL THE TRUTH IN THAT DEPOSITION?
7 A. I DID.
8 Q. DID YOU RECEIVE A COPY OF THE TRANSCRIPT OF THE DEPOSITION
9 LATER?
10 A. YES, I DID.
11 Q. DID YOU READ IT?
12 A. I READ IT.
13 Q. DID YOU, IN FACT, MAKE SOME CORRECTIONS TO IT?
14 A. I MADE SOME CORRECTIONS TO IT.
15 Q. AND YOU SIGNED IT?
16 A. AND I SIGNED IT.
17 Q. I WOULD LIKE TO SHOW YOU, DOCTOR, A COPY OF YOUR
18 DEPOSITION.
19 MR. SIMPSON: MAY I APPROACH THE WITNESS, YOUR
20 HONOR?
21 THE COURT: YES.
22 MR. SIMPSON: YOUR HONOR, COULD I HAND UP A COPY OF
23 DR. BROEKHUIZEN'S DEPOSITION?
24 BY MR. SIMPSON:
25 Q. DOCTOR, IF I COULD REFER YOU, PLEASE, TO PAGE 47 IN YOUR

1 DEPOSITION.
2 A. YES.
3 Q. AND IF YOU COULD READ SILENTLY, PLEASE, LINES 20 THROUGH 24
4 ON THAT PAGE.
5 A. I AM READING THEM.
6 Q. IS THAT WHAT YOU TESTIFIED?
7 A. YES, I DID.
8 Q. AND YOU SAID AT LINE 20:
9 "QUESTION: WELL, I CAN GO ON, JUST GO ON WITH
10 THE QUESTION. TO FOLLOW UP ON THAT, ARE THERE
11 INSTRUMENTS THAT YOU USE FOR D&E THAT ARE
12 SPECIFICALLY MEANT FOR DISMEMBERING THE FETUS?
13 "ANSWER: YES, I DO. YES, THEY EXIST."
14 THAT IS WHAT YOU SAID?
15 A. YES.
16 Q. SO THERE ARE INSTRUMENTS SPECIFICALLY MEANT FOR
17 DISMEMBERING THE FETUS?
18 A. YES.
19 Q. DOCTOR, YOU'VE DONE APPROXIMATELY FOUR OR 500 D&E
20 ABORTIONS; IS THAT CORRECT?
21 A. THAT'S CORRECT.
22 Q. WHAT PERCENTAGE OF THOSE ABORTIONS, OF THOSE D&E'S INVOLVED
23 SOME DEGREE OF DISMEMBERMENT OF THE FETUS?
24 A. I WOULD SAY OVER 90 TO 95 PERCENT OF THE MAJORITY OF CASES.
25 Q. AS FAR AS YOU KNOW, DOCTOR, YOU HAVE NEVER LEFT FETAL PARTS

1 AFTER A D&E, HAVE YOU?
2 A. TO THE BEST OF MY KNOWLEDGE I DON'T, AND I TRY TO ASCERTAIN
3 THAT I DIDN'T LEAVE ANY PARTS AT THE END OF THE PROCEDURE.
4 Q. AND TO THE BEST OF YOUR KNOWLEDGE YOU HAVE NOT?
5 A. TO THE BEST OF MY KNOWLEDGE I HAVE NOT.
6 Q. DOCTOR, YOU BELIEVE THAT A PHYSICIAN CAN AVOID LEAVING
7 FETAL PARTS IN THE UTERUS BY DOING A CAREFUL PROCEDURE IN
8 INSPECTING THE PARTS CAREFULLY AFTER EVACUATION, CORRECT?
9 A. I THINK CAREFUL INSPECTION ALLOWS FOR ASCERTAINING THAT
10 EXTREMITIES, TRUNK, FETAL HEAD ARE THERE. I AM NOT SO SURE
11 THERE WOULD NOT BE PART OF FETAL ORGANS OR SMALL PARTS THAT ARE
12 STILL IN THE UTERUS.
13 Q. THE PHYSICIAN SHOULD BE ABLE TO AVOID THAT BY DOING A
14 CAREFUL PROCEDURE AND INSPECTING THE PARTS CAREFULLY
15 AFTERWARDS.
16 A. YES. THE GOAL IS TO MAKE SURE THAT THERE ARE NO LARGE --
17 THAT TO THE BEST OF YOUR ABILITY TO SEE, MOST LARGE PARTS ARE
18 REMOVED. IT'S SIMILAR LOOKING AT ALL THE PLACENTAL PARTS. ONE
19 TRIES TO RECONSTRUCT AND FEEL ALL THE PLACENTAL PARTS ARE
20 THERE.
21 AND ACTUALLY IT'S THE FEEL INSIDE THE UTERUS. I USE
22 A BLUNT CURETTE FOR THAT. THAT GIVES ME THE MOST COMFORT LEVEL
23 THAT I HAVEN'T LEFT ANY FETAL PARTS OR PLACENTAL TISSUE BEHIND
24 IN ADDITION TO THE INSPECTION.
25 Q. AND BY DOING A CAREFUL PROCEDURE AND A CAREFUL INSPECTION

1 AFTERWARDS THE PHYSICIAN SHOULD BE ABLE TO AVOID LEAVING ANY
2 FETAL PARTS INSIDE THE UTERUS?
3 A. THE INCIDENCE OF LEAVING FETAL PARTS OR PLACENTAL PARTS
4 SHOULD BE MINIMAL, BUT IT IS NEVER ZERO.
5 Q. DOCTOR, IF I COULD REFER YOU TO PAGE 83 OF YOUR DEPOSITION.
6 A. YES.
7 Q. IF YOU COULD READ TO YOURSELF LINES 20 ON THAT PAGE THROUGH
8 LINE 4 ON PAGE 84.
9 A. WHICH? WHERE DO YOU WANT ME TO START?
10 Q. AGAIN, SILENTLY, PAGE 83, LINE 20, THROUGH PAGE 84, LINE 4.
11 IS THAT WHAT YOU TESTIFIED?
12 A. THAT IS WHAT I TESTIFIED.
13 Q. YOU SAID, QUESTION ON LINE 20:
14 "IS ONE OF THE POTENTIAL COMPLICATIONS OF D&E
15 THE RETAINED FETAL PARTS?
16 "ANSWER: THAT WOULD BE A COMPLICATION IF -- I
17 WOULDN'T CONSIDER IT A COMPLICATION. I THINK
18 UNDER -- IF ONE DOES A CAREFUL PROCEDURE, ONE SHOULD
19 BE ABLE TO NOT HAVE THAT HAPPEN BY CAREFUL
20 INSPECTION OF ALL OF THE TISSUE AND PRODUCTS THAT
21 HAVE BEEN EVACUATED. SO I ALWAYS VERY CAREFULLY
22 INSPECT WHAT HAS BEEN REMOVED AND TRY TO AVOID THAT
23 FROM HAPPENING."
24 IS THAT WHAT YOU SAID?
25 A. THAT IS WHAT I SAID.

1 Q. SO THE PHYSICIAN SHOULD BE ABLE TO AVOID LEAVING FETAL
2 PARTS BY DOING A CAREFUL PROCEDURE AND A CAREFUL INSPECTION?
3 A. THAT IS WHAT I SAID. I AM READING AHEAD OF MYSELF HERE,
4 WHAT I SAID, BUT IN THE NEXT ANSWER I SAID:
5 "IT IS POSSIBLE THAT IT CAN HAPPEN." BUT --
6 Q. AND YOU ALSO SAID, DID YOU NOT, DOCTOR, ON LINE 7 0N
7 PAGE 84:
8 "I THINK THAT ONE IS NOT SUPPOSED TO LEAVE
9 ANYTHING BEHIND," CORRECT?
10 A. THAT'S CORRECT.
11 Q. NOW, DOCTOR, USUALLY -- I BELIEVE YOU'VE TESTIFIED THAT
12 AFTER DOING A D&E YOU EXAMINE THE FETAL PARTS, CORRECT?
13 A. CORRECT.
14 Q. USUALLY IN EXAMINING THE FETAL PARTS YOU DON'T ACTUALLY SEE
15 THE BONES, DO YOU? YOU USUALLY SEE THE LIMB AND THE ACTUAL
16 BONE IS IN THE LIMB?
17 A. YOU CAN SOMETIMES SEE BONE. SOMETIMES YOU CAN SEE JUST THE
18 LIMB.
19 Q. BUT USUALLY YOU JUST SEE THE LIMB, AND THE ACTUAL BONE IS
20 IN THE LIMB?
21 A. ACTUALLY, WHEN DISARTICULATION TAKES PLACE IN THE JOINT ONE
22 CAN CERTAINLY SEE THE END OF THE BONE ON INSPECTION.
23 Q. THE END OF THE BONE. BUT USUALLY THE REST OF THE BONE IS
24 INSIDE THE LIMB?
25 A. THERE ARE SITUATIONS WHERE ACTUALLY THE BONE IS CRUSHED IN

1 THE MIDDLE OF THE LIMB. AND UNDER THOSE CIRCUMSTANCES ONE CAN
2 SEE PART OF THE BONE.
3 Q. BUT USUALLY YOU DON'T SEE THE BONE OTHER THAN THE END OF
4 THE BONE?
5 A. I DON'T KNOW WHAT IS USUAL OR UNUSUAL UNDER THESE
6 CIRCUMSTANCES.
7 Q. IF I COULD REFER YOU, DOCTOR, TO PAGE 88 IN YOUR
8 DEPOSITION. IF YOU COULD PLEASE READ SILENTLY PAGE 88, LINES 1
9 THROUGH 4.
10 A. I AM READING.
11 Q. DID YOU TESTIFY TO THAT EFFECT, DOCTOR?
12 A. YES, I DID.
13 Q. AND IT SAYS, LINE 1:
14 "QUESTION: BUT, I MEAN, IN EXAMINING THE FETAL
15 PARTS AFTER A D&E CAN YOU SEE THE BONES?
16 "ANSWER: OCCASIONALLY, RIGHT, BUT YOU SEE A
17 LIMB AND THE ACTUAL BONE IS IN THE LIMB."
18 IS THAT WHAT YOU SAID?
19 A. THAT IS WHAT I SAID.
20 Q. AND THAT IS TRUTHFUL TESTIMONY?
21 A. THAT IS TRUTHFUL TESTIMONY.
22 Q. DOCTOR, YOU ALSO BELIEVE THAT THE USE OF ULTRASOUND MAKES
23 THE D&E MUCH SAFER AND MUCH EASIER?
24 A. IT MAKES IT SAFER. IT CAN MAKE IT EASIER. BUT I THINK
25 SAFETY IS THE MAIN REASON WHY I WOULD USE IT.

1 Q. IS IT TRUE, DOCTOR, THAT THE USE OF ULTRASOUND MAKES THE
2 D&E MUCH SAFER AND MUCH EASIER?
3 A. THE USE OF ULTRASOUND CAN MAKE IT SAFER AND CAN MAKE IT
4 EASY.
5 Q. IF I CAN REFER YOU, DOCTOR, TO YOUR DEPOSITION, PAGE 86,
6 PLEASE.
7 IF YOU COULD READ SILENTLY PAGE 86, LINE 19, THROUGH
8 PAGE 87, LINE 10.
9 A. WHICH LINES?
10 Q. I AM SORRY. PAGE 86, LINE 19 THROUGH PAGE 87, LINE 10.
11 A. YES.
12 THE COURT: COUNSEL, HOW IS THAT DIFFERENT FROM WHAT
13 HE TESTIFIED TO YOU? I ASSUME YOU ARE USING THIS TO IMPEACH
14 HIS TESTIMONY?
15 MR. SIMPSON: YES, I THINK. HE IS HEDGING ON
16 WHETHER THE USE OF ULTRASOUND MAKES IT MUCH EASIER AND MUCH
17 SAFER.
18 THE COURT: YOU DIDN'T ASK HIM THAT. YOU ASKED HIM
19 IF HE IT MADE IT EASIER AND SAFER. AND HERE HE SAYS:
20 "YES, IT CAN MAKE IT EASIER AND SAFER."
21 AND HERE HE SAYS:
22 "IT CAN MAKE IT EASIER AND SAFER."
23 MR. SIMPSON: YOUR HONOR, THERE MAY NOT BE A HUGE
24 DIFFERENCE HERE, BUT HE SAID:
25 "MUCH SAFER AND MUCH EASIER," AND HE HAS NOT

1 AGREED WITH THAT STATEMENT.
2 THE COURT: OKAY. ALL RIGHT.
3 BY MR. SIMPSON:
4 Q. DOCTOR, IS IT TRUE AFTER READING THIS TESTIMONY THAT THE
5 USE OF ULTRASOUND MAKES THE D&E MUCH EASIER AND MUCH SAFER?
6 MS. GARTNER: YOUR HONOR, I AM SORRY. I THINK
7 MR. SIMPSON HAS MISCHARACTERIZED THE DEPOSITION TESTIMONY. AND
8 SO AS WHAT MR. OR DR. BROEKHUIZEN STATED WAS ON PAGE 87, LINES
9 SEVEN, EIGHT, NINE AND TEN:
10 "THAT THERE ARE UNUSUAL SITUATIONS WHERE THE
11 ULTRASOUND MAKES IT MUCH SAFER AND HAS MADE THE
12 PROCEDURE MUCH EASIER."
13 MR. SIMPSON: I WILL MOVE ON TO THE NEXT QUESTION.
14 THE COURT: THANK YOU.
15 BY MR. SIMPSON:
16 Q. DR. BROEKHUIZEN, THE USE OF ULTRASOUND DECREASES THE RISK
17 OF INJURING THE PATIENT WITH YOUR INSTRUMENTS, CORRECT?
18 A. CAN YOU REPEAT THAT?
19 Q. THE USE OF ULTRASOUND DECREASES THE RISK OF INJURING
20 PATIENTS WITH YOUR INSTRUMENTS?
21 A. THE USE OF ULTRASOUND WILL ALLOW ME TO AVOID MISDIRECTING
22 THE INSTRUMENTS THAT I PLACE IN THE UTERUS.
23 Q. THUS REDUCING THE RISK OF INJURING THE PATIENT WITH YOUR
24 INSTRUMENTS?
25 A. THAT'S CORRECT.

1 Q. IN ANY EVENT, DOCTOR, I THINK YOU TESTIFIED TO THIS ON
2 DIRECT, IN ALL THE FOUR OR 500 D&E'S THAT YOU HAVE DONE YOU
3 HAVE INJURED PATIENTS WITH YOUR INSTRUMENTS ONLY TWICE?
4 A. YES.
5 Q. AND THOSE WERE JUST SMALL CERVICAL LACERATIONS?
6 A. WELL, ONE WAS PRETTY GOOD SIZE. THE OTHER ONE WAS
7 RELATIVELY SMALL.
8 Q. DID YOU TESTIFY IN YOUR DEPOSITION, DOCTOR, THAT IN BOTH OF
9 THOSE INSTANCES THEY WERE SMALL CERVICAL LACERATIONS?
10 A. WELL, I AM SURE THAT IS WHAT I SAID. "SMALL" IS IN THE EYE
11 OF THE BEHOLDER. I DON'T LIKE ANY LACERATIONS. ALL I CAN DO
12 IS BY MY MEMORY. ONE WAS TWO-AND-A-HALF CENTIMETERS. THE
13 OTHER ONE WAS ONE CENTIMETER. I THINK TWO-AND-A-HALF
14 CENTIMETER, FOUR CENTIMETER LENGTH IS LONG. BUT IT IS REALLY
15 NOT ALL THAT LONG, AS WELL. SO --
16 Q. DOCTOR, YOU JUST TESTIFIED THAT IN YOUR DIRECT EXAMINATION
17 THAT D&E BY DISMEMBERMENT IS A VERY SAFE, CORRECT?
18 A. I THINK THE TRACK RECORD OF D&E, IF I LOOK AT MY PERSONAL
19 EXPERIENCE OR IF I -- WHAT I CAN GET OUT OF A REVIEW OF THE
20 LITERATURE, I WOULD SAY THAT D&E PROCEDURE IS A SAFE PROCEDURE.
21 Q. DOCTOR, YOU PREFER TO USE INDUCTION OF LABOR RATHER THAN
22 D&E AFTER 20 WEEKS GESTATION, CORRECT?
23 A. THAT'S CORRECT.
24 Q. AND THAT PREFERENCE APPLIES GENERALLY TO CASES IN WHICH THE
25 ABORTION IS INDICATED BECAUSE OF MATERNAL HEALTH CONDITIONS OR

1 FETAL ANOMALIES?
2 A. THAT'S CORRECT. THERE ARE SOME EXCEPTIONS WHICH I THINK I
3 TESTIFIED TO EARLIER THAT IF THERE ARE CIRCUMSTANCES IN WHICH
4 AN INDUCTION METHOD WOULD BE -- CARRIED MORE RISK AND BE -- I
5 CONSIDER IT RELATIVE CONTRAINDICATION.
6 Q. DOCTOR, APPROXIMATELY HOW MANY INDUCTION ABORTIONS HAVE YOU
7 DONE IN YOUR CAREER?
8 A. I REALLY DON'T KNOW. BUT I KNOW I HAVE DONE MORE INDUCTION
9 ABORTIONS THAN D&E PROCEDURES.
10 Q. AND YOU'RE STILL DOING INDUCTIONS NOW?
11 A. CORRECT.
12 Q. YOU WOULDN'T BE DOING INDUCTIONS IF YOU THOUGHT THEY WERE
13 UNSAFE IN GENERAL, WOULD YOU?
14 A. NO, I WOULDN'T.
15 Q. IN FACT, YOU BELIEVE THAT INDUCTION PRESENTS LESS RISK OF
16 INJURY FROM INSTRUMENTATION THAN DOES D&E?
17 A. THAT'S TRUE.
18 Q. YOU ALSO BELIEVE THAT THERE IS LESS RISK OF TRAUMA TO THE
19 UTERUS IN AN INDUCTION THAN IN A D&E?
20 A. THAT'S TRUE.
21 Q. DOCTOR, IF THE INTENT IN AN ABORTION IS TO HAVE AN INTACT
22 FETUS, DO YOU THINK THE PATIENT WOULD CHOOSE AN INDUCTION
23 METHOD?
24 A. THAT'S ACTUALLY TRUE IN MOST PATIENTS I ENCOUNTER. BUT
25 THERE ARE CIRCUMSTANCES, AS THE CASES I DESCRIBED, WHERE THAT

1 WOULD NOT BE TRUE.
2 Q. BUT IN GENERAL, WHERE THE PATIENT WANTS AN INTACT FETUS,
3 YOU WOULD THINK THE PATIENT WOULD CHOOSE AN INDUCTION?
4 A. I THINK THAT IS TRUE. THE MAJORITY OF PATIENTS WHERE THAT
5 IS AN IMPORTANT GOAL WOULD CHOOSE AN INDUCTION IN MY PRACTICE.
6 Q. DOCTOR, IF AN INFECTION WERE TO ARISE DURING THE COURSE OF
7 AN INDUCTION METHOD OF AN INDUCTION ABORTION, YOU CAN START AN
8 ANTIBIOTIC BY IV DURING THE INDUCTION, CORRECT?
9 A. THAT'S CORRECT.
10 Q. IN FACT, WHEN YOU BEGIN AN INDUCTION, YOU PLACE AN IV IN
11 ALL CASES, CORRECT?
12 A. IT IS CORRECT.
13 Q. I BELIEVE IN YOUR DIRECT EXAMINATION YOU USED THE PHRASE
14 THAT YOU CAN GIVE LIBERAL PAIN RELIEF IN AN INDUCTION?
15 A. I DON'T KNOW IF I USED THE WORD "LIBERAL," BUT YOU CAN GIVE
16 ADEQUATE PAIN RELIEF, FOR SURE.
17 Q. AND ONE OF THE CONSIDERATIONS IS THAT WHEN YOU ARE
18 PREPARING FOR AN ABORTION THERE IS NO CONCERN ABOUT THE EFFECT
19 OF THE MEDICATION ON THE FETUS.
20 A. THAT'S CORRECT.
21 Q. YOU'VE JUST TESTIFIED, IN FACT, I BELIEVE IN YOUR DIRECT
22 THAT INDUCTION IS VERY SAFE?
23 A. I THINK INDUCTION AND D&E PROCEDURES ARE BOTH SAFE.
24 Q. DOCTOR, ONE POINT I BELIEVE YOU TESTIFIED THAT THE USE OF
25 MISOPROSTOL FOR INDUCTION MAY BE CONTRAINDICATED BECAUSE OF AN

1 ALLERGY TO PROSTAGLANDINS?
2 A. NO, I DON'T THINK I SAID "ALLERGY." IF I SAID THAT, IT
3 WOULDN'T BE THE RIGHT TERM.
4 I THINK THERE ARE CERTAIN CONDITIONS WHERE, WITH
5 SOME OF THE PROSTAGLANDINS MAY EXACERBATE, MAY CAUSE
6 BRONCHIOSPASM. AND SO IT IS NOT AN ALLERGY. IT WOULD BE MORE
7 BODILY REACTION, A SMOOTH MUSCLE CONSTRICTION.
8 Q. AND IF A PATIENT WAS PRONE TO HAVE THAT REACTION TO
9 MISOPROSTOL OR ANOTHER PROSTAGLANDIN, SHE WOULD ALSO BE PRONE
10 TO HAVE THAT REACTION IF YOU USED A PROSTAGLANDIN FOR D&E,
11 CORRECT?
12 A. THAT'S CORRECT. AND IN THOSE CIRCUMSTANCES I WOULD USE
13 LAMINARIA AND NOT MISOPROSTOL.
14 Q. YOU COULD ALSO, THOUGH, IF YOU WANTED TO INDUCE A PATIENT
15 LIKE THAT, YOU COULD CHOOSE A DIFFERENT INDUCING AGENT SUCH AS
16 OXYTOCIN?
17 A. YES, ONE CAN USE HIGH DOSE OXYTOCIN.
18 Q. DOCTOR, IF YOU WANTED TO HAVE AN INTACT FETUS FOR
19 PATHOLOGY, INDUCTION WOULD GIVE YOU AN INTACT FETUS FOR THAT
20 PURPOSE, CORRECT?
21 A. THAT'S CORRECT.
22 Q. CRUSHING OR DECOMPRESSING THE HEAD IN THE COURSE OF AN
23 ABORTION WOULD DESTROY THE BRAIN OF THE FETUS?
24 A. THAT'S CORRECT.
25 Q. AND DESTROYING THE BRAIN WOULD ELIMINATE THE ABILITY TO

1 EXAMINE THE BRAIN FOR PATHOLOGICAL PURPOSES?
2 A. THAT'S CORRECT.
3 Q. ISN'T IT TRUE YOU SOMETIMES CHOOSE TO USE A SURGICAL
4 ABORTION PROCEDURE IN WHICH YOU PURPOSELY DELIVER THE FETUS
5 INTACT UP TO THE HEAD?
6 A. CAN YOU REPEAT THAT QUESTION?
7 Q. CERTAINLY. ISN'T IT TRUE THAT YOU SOMETIMES CHOOSE TO USE
8 A SURGICAL ABORTION PROCEDURE IN WHICH YOU PURPOSELY DELIVER
9 THE FETUS INTACT UP TO THE HEAD?
10 A. I DON'T THINK I -- I THINK I HAVE ANSWERED THE QUESTION ON
11 THE DIRECT. I THINK IN A SURGICAL PROCEDURE MY GOAL IS TO
12 EVACUATE THE UTERUS IN THE SIMPLEST AND SAFEST WAY. AND THAT
13 IT CAN OCCUR THAT WITH SUFFICIENT DILATATION I CAN DELIVER THE
14 BODY UP TO THE HEAD.
15 BUT THAT IS NOT NECESSARILY THE PURPOSE OF THE D&E
16 PROCEDURE.
17 Q. LET'S MAKE SURE, FIRST OF ALL, DOCTOR, THAT WE HAVE DEFINED
18 ONE OR TWO TERMS. BY "SURGICAL ABORTION," WE MEAN ABORTION
19 WITH INSTRUMENTATION, CORRECT?
20 A. CORRECT.
21 Q. INDUCTION IS NOT SURGICAL ABORTION?
22 A. THAT'S CORRECT.
23 Q. DOCTOR, DO YOU SOMETIMES CHOOSE TO USE A SURGICAL ABORTION
24 PROCEDURE IN WHICH YOU PURPOSELY DELIVER THE FETUS INTACT UP TO
25 THE HEAD?

1 A. I HAVE CHOSEN -- YES. THE ANSWER IS: YES. THE CASES IN
2 PATIENTS WITH SCLERODERMA AND SKELETAL DYSPLASIA, IT WAS THE
3 SERIAL DILATATION PART THAT WOULD CONSIDER THE SURGICAL IF ONE
4 WERE TO DEFINE IT AS A SURGICAL ABORTION OR PART OF A SURGICAL
5 ABORTION. THAT WAS THE MAINSTAY OF THAT APPROACH.
6 BUT THERE THE GOAL WAS TO DELIVER AS MUCH OF THE
7 FETAL BODY IN THE PARTICULAR CIRCUMSTANCES OF THAT CASE, THAT'S
8 CORRECT.
9 Q. AND, DOCTOR, THIS PROCEDURE IN WHICH YOU PURPOSELY DELIVER
10 THE FETUS INTACT UP TO THE HEAD, YOU REFER TO THAT AS "INTACT
11 D&E," CORRECT?
12 A. I DON'T THINK I HAVE USED THE WORD "INTACT D&E" TODAY. I
13 MAY HAVE USED IT IN PREVIOUS DEPOSITION, BUT I DON'T RECALL
14 THAT I USED THAT PARTICULAR TERM TODAY.
15 Q. YOU DO REFER TO THAT PROCEDURE AS "INTACT D&E." I AM NOT
16 TALKING ABOUT TODAY, NECESSARILY, BUT JUST IN GENERAL?
17 A. YEAH. I MAY HAVE REFERRED TO THAT PROCEDURE IN THAT SENSE.
18 Q. AND THEN, WHEN YOU CHOOSE TO USE THAT PROCEDURE YOU THEN
19 SOMETIMES HAVE TO COMPRESS THE HEAD TO COMPLETE THE DELIVERY,
20 CORRECT?
21 A. SOMETIMES DECOMPRESS, SOMETIMES DECOMPRESS AND COMPRESS.
22 Q. DOCTOR, YOU TESTIFIED EARLIER THAT SOMETIMES PARENTS WANT
23 AN INTACT FETUS FOR BLESSING OR BURIAL. HAVE YOU EVER HAD THE
24 PARENT EXPRESS THAT DESIRE WHERE YOU HAD COMPRESSED THE HEAD OF
25 THE FETUS TO COMPLETE THE DELIVERY?

1 A. YES.
2 Q. WAS ANYTHING DONE IN THOSE INSTANCES, DOCTOR, TO IMPROVE
3 THE APPEARANCE OF THE FETUS' HEAD AFTER DECOMPRESSION?
4 A. YES.
5 Q. WHAT WAS DONE?
6 A. THE FETUS WAS -- JUST LIKE A NEWBORN -- IT WAS DRESSED AND
7 KIND OF HAD A LITTLE HAT PLACED ON IT SO THAT ONLY THE FACE WAS
8 VISIBLE.
9 Q. SO ARE YOU SAYING, DOCTOR, THAT THE EVIDENCE OF THE
10 DECOMPRESSION OF THE HEAD DID NOT APPEAR ON THE FACE?
11 A. CORRECT.
12 Q. NOW, DOCTOR, THIS PROCEDURE THAT YOU SOMETIMES CHOOSE TO DO
13 IN WHICH YOU PURPOSELY DELIVER THE FETUS INTACT UP TO THE HEAD,
14 THAT IS A NEW PROCEDURE, CORRECT?
15 A. NOT FOR ME.
16 Q. ARE YOU FAMILIAR, DOCTOR, IN THE MEDICAL LITERATURE WITH
17 REFERENCES TO WHAT IS SOMETIMES CALLED "INTACT D&E," SOMETIMES
18 CALLED "INTACT D&X"?
19 A. I AM FAMILIAR WITH THE LITERATURE AND THE TERMINOLOGY.
20 Q. AND THAT IS A NEW PROCEDURE?
21 A. IT IS DESCRIBED. I DON'T KNOW. IT IS NOT A NEW PROCEDURE
22 IN MY PRACTICE. I HAVE HAD TO DEAL WITH SITUATIONS IN MY
23 PRACTICE IN AFRICA IN THE '70'S. AND I HAVE HAD TO DEAL WITH
24 FETAL ANOMALIES IN THE EARLY '80'S, THAT ARE SIMILAR TO THE
25 SITUATIONS THAT I DESCRIBED. AND I HAVE USED VERY SIMILAR

1 METHODS AND PARTS OF TECHNIQUES, ALBEIT DIFFERENT MEDICATIONS
2 AND DIFFERENT INSTRUMENTATION. AND SO CONCEPTUALLY FOR ME THIS
3 IS NOT NEW.
4 WHAT IS NEW IS THE FACT THAT IT WAS KIND OF
5 DESCRIBED AS NEW OR DIFFERENT FROM THE DESTRUCTIVE D&E
6 PROCEDURE BY OTHER PEOPLE WHO DESCRIBED IT.
7 Q. DOCTOR, DURING YOUR DEPOSITION DID I SHOW YOU A COPY OF A
8 PRESENTATION BY A DR. MARTIN HASKELL ON WHAT HE CALLED:
9 "DILATION AND EXTRACTION," OR "D&X"?
10 A. YOU SHOWED ME.
11 Q. DID I ALSO SHOW YOU A STATEMENT BY THE AMERICAN COLLEGE OF
12 OBSTETRICIANS AND GYNECOLOGISTS REGARDING WHAT THAT STATEMENT
13 CALLED "INTACT DILATATION AND EXTRACTION"?
14 A. YOU DID.
15 Q. THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGISTS IS
16 ALSO KNOWN BY THE ACRONYM "ACOG," CORRECT?
17 A. THAT'S CORRECT.
18 Q. IF I COULD REFER YOU TO YOUR DEPOSITION, PLEASE, DOCTOR.
19 PAGE 161.
20 PAGE 161, IF YOU COULD READ TO YOURSELF, PLEASE,
21 DOCTOR, LINES ONE THROUGH 17.
22 THE COURT: IS THERE A QUESTION PENDING? I AM
23 SORRY. IS THERE A QUESTION PENDING THAT YOU ARE USING THIS TO
24 IMPEACH HIM WITH?
25 MR. SIMPSON: YES. THE QUESTION IS:

1 "IS THIS A NEW PROCEDURE?"
2 THE WITNESS: OKAY.
3 THE COURT: ALL RIGHT. GO AHEAD.
4 THE WITNESS: YES.
5 BY MR. SIMPSON:
6 Q. YOU HAVE READ THAT? AND IF I CAN READ THAT TO YOU, PLEASE,
7 DOCTOR, ON LINE 1:
8 "QUESTION: DOCTOR, IF WHAT DR. HASKELL
9 DESCRIBES AND WHAT ACOG DESCRIBES IN TURNING THE
10 FETUS, IF THAT IS SIMPLY A PART OF A D&E WHY DO THEY
11 DESCRIBE IT?"
12 AND YOUR ATTORNEY MADE AN OBJECTION:
13 "OBJECTION. ASKING INFORMATION BEYOND WHAT
14 THIS WITNESS COULD POSSIBLY ANSWER."
15 AND YOU ANSWERED:
16 "I DON'T KNOW WHY THEY DESCRIBED IT. AS I
17 STATED BEFORE, I THINK THE DESCRIPTION OF DR.
18 HASKELL AND WHAT IS MOST IMPORTANT IN THESE FOUR
19 STEPS, AND I THINK WHAT IS DIFFERENT IN THE NEW
20 PROCEDURE IS THE AMOUNT OF DILATION AND THE TIME TO
21 ACHIEVE IT, AND THE INTENT TO DELIVER AS MUCH OF THE
22 BODY INTACT. THAT IS THE DIFFERENCE BETWEEN THE D&E
23 PROCEDURE. THE OTHER STEPS OFTEN OCCUR DURING THE
24 D&E PROCEDURES, AND THE INDUCTION METHODS, AS I SAID
25 BEFORE."

1 SO, DOCTOR, IS IT CORRECT TO SAY THAT THE INTACT D&E
2 PROCEDURE IS A NEW PROCEDURE?
3 A. I DON'T WANT TO SOUND LIKE A LAWYER. I THINK I AM
4 ANSWERING HERE TO YOUR TERM OF USING THE NEW PROCEDURE. AND I
5 AM DESCRIBING WHAT IS DIFFERENT IN THE NEW PROCEDURE AS
6 REFERRING TO YOUR DEFINITION OF A NEW PROCEDURE. I DO NOT
7 THINK THAT I AM REALLY GIVING YOU ANY DIFFERENT ANSWER HERE.
8 AND I WOULD KIND OF MAINTAIN THAT I ALREADY GAVE YOU
9 THE ANSWER ABOUT WHAT I CONSIDER NEW OR NOT NEW IN MY PREVIOUS
10 ANSWER.
11 Q. AS YOU SAY HERE, DOCTOR, THE INTENT -- THE USE OF SERIAL
12 DILATATION TO ACHIEVE SUFFICIENT DILATATION TO REMOVE THE FETUS
13 IN INTACT IS A NEW PROCEDURE?
14 A. I HAVE PROBLEMS ANSWERING THIS QUESTION. THE PATIENTS WITH
15 SCLERODERMA, I PERFORMED THE PROCEDURE BEFORE I EVER READ ABOUT
16 DR. HASKELL'S NEW PROCEDURE.
17 I WOULD THINK THAT ANYBODY WHO HAS PERFORMED
18 PREGNANCY TERMINATIONS FOR THE INDICATIONS -- AND I HAVE BEEN
19 PERFORMING THEM FOR THE LAST 20 YEARS, RIGHT -- HAS UTILIZED
20 ELEMENTS OF WHAT DR. HASKELL DESCRIBES.
21 I HAVE NEVER, YOU KNOW, STARTED SOME PREGNANCY
22 TERMINATION LISTING CONCEPTS:
23 "I JUST READ ABOUT A NEW PROCEDURE WRITTEN BY
24 DR. HASKELL, AND I AM GOING TO DO EXACTLY WHAT HE
25 WAS DESCRIBING THERE."

1 AND I THINK THAT WOULD BE TRUE FOR MANY PHYSICIANS
2 WHO PERFORM PREGNANCY TERMINATIONS IN THE LAST 20 YEARS FOR THE
3 INDICATIONS THAT I DESCRIBED.
4 Q. DR. HASKELL GAVE HIS PRESENTATION IN 1992, CORRECT?
5 A. I DON'T KNOW. I FORGOT.
6 Q. ARE YOU AWARE, DOCTOR, OF ANY DESCRIPTIONS EITHER IN
7 PRESENTATIONS OR LITERATURE, ANY DESCRIPTIONS OF DR. HASKELL'S
8 PROCEDURE BEFORE HE MADE HIS PRESENTATION?
9 A. NO. I AM UNAWARE. ALL I KNOW IS THERE ARE THINGS THAT
10 DR. HASKELL DESCRIBED THAT I KNOW I DID BEFORE. MAYBE NOT IN
11 THE SEQUENCE AS DESCRIBED OR IN THE SEQUENCE DESCRIBED BY THE
12 ACOG.
13 Q. DOCTOR, THE INTACT D&E PROCEDURE AS YOU USE IT IS
14 CHARACTERIZED BY SERIAL USE OF OSMOTIC DILATORS TO ACHIEVE A
15 GREATER DEGREE OF DILATATION THAN YOU WOULD DO FOR A D&E BY
16 DISMEMBERMENT, CORRECT?
17 A. THAT'S CORRECT.
18 Q. SO YOU DO NOT NORMALLY USE SERIAL USE OF OSMOTIC DILATORS
19 IN SURGICAL ABORTION IN THE SECOND-TRIMESTER?
20 A. I WILL ONLY USE SERIAL DILATATION IF I FIND THAT AFTER THE
21 FIRST DILATATION THAT I HAVE NOT ACHIEVED SUFFICIENT DILATATION
22 TO PROCEED IN A SAFE MANNER FOR THE PROCEDURE.
23 Q. AND YOU ALWAYS USE SERIAL DILATION WHEN YOU HAVE CHOSEN TO
24 USE A PROCEDURE IN WHICH YOU PURPOSELY DELIVER THE FETUS INTACT
25 UP TO THE HEAD?

1 A. YES.

2 THE COURT: ALL RIGHT, MR. SIMPSON. I THINK WE ARE
3 GOING TO NOW TAKE A LUNCH BREAK. SINCE I AGREED TO GO LATER
4 TODAY, I THINK WE NEED SOME TIME OFF.

5 WE WILL BREAK FOR ONE HOUR. EVERYONE RETURN AT
6 1:00 O'CLOCK.

7 (LUNCHEON RECESS WAS TAKEN AT 12:00 P.M.)

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1 AFTERNOON SESSION 1:00 O'CLOCK P.M.
2 THE COURT: ALL RIGHT, MR. SIMPSON.
3 MR. SIMPSON: THANK YOU, YOUR HONOR.
4 BY MR. SIMPSON:
5 Q. DR. BROEKHUIZEN, I WOULD LIKE TO ASK YOU A FEW QUESTIONS
6 ABOUT THOSE THREE CASES YOU TESTIFIED TO EARLIER.
7 THOSE ARE THREE CASES IN WHICH YOU BELIEVED THAT
8 PURPOSEFUL INTACT REMOVAL UP TO THE HEAD WOULD BE IN THE BEST
9 INTEREST OF THE PATIENT?
10 A. THAT'S CORRECT.
11 Q. THOSE ARE THE SAME PARTICULAR CASES DESCRIBED IN YOUR
12 DECLARATION, CORRECT?
13 A. CORRECT.
14 Q. YOU CHOSE THOSE THREE CASES AS EXAMPLES TO ILLUSTRATE YOUR
15 BELIEF THAT INTACT SURGICAL REMOVAL IS SOMETIMES BEST AND
16 SAFEST FOR THE PATIENT?
17 A. WELL, SAFE AND BEST ARE TWO -- IN SOME CASES THEY ARE
18 CLEARLY THE SAFEST. BEST WOULD BE IN THE JUDGMENT OF THE
19 PATIENT.
20 Q. DOCTOR, YOU FILED A DECLARATION -- SUBMITTED A DECLARATION
21 FOR THIS CASE, DIDN'T YOU?
22 A. YES, I DID.
23 Q. I WOULD LIKE TO SHOW YOU A COPY OF YOUR DECLARATION,
24 PLEASE.
25 MR. SIMPSON: COULD I APPROACH THE WITNESS, YOUR

1 HONOR?

2 THE COURT: WHAT EXHIBIT NUMBER?

3 MR. SIMPSON: IT IS EARLIER IN THE RECORD. IT IS

4 HIS DECLARATION THAT HE SUBMITTED ON THE TRO.

5 THE COURT: OKAY.

6 MR. SIMPSON: I DO HAVE A COPY TO HAND UP TO THE

7 COURT.

8 BY MR. SIMPSON:

9 Q. DR. BROEKHUIZEN, I HAVE GIVEN YOU A COPY OF YOUR

10 DECLARATION IN THIS CASE. DO YOU RECOGNIZE THAT?

11 A. YES, I DO.

12 Q. COULD YOU TURN TO PARAGRAPH 17, PLEASE, ON PAGE 6?

13 I AM GOING TO READ THE FIRST SENTENCE OF THAT

14 PARAGRAPH.

15 "THERE HAVE BEEN OTHER OCCASIONS WHERE IT HAS

16 BEEN MY MEDICAL JUDGMENT THAT AN ABORTION IN WHICH I

17 PURPOSELY DELIVERED THE FETUS INTACT UP TO THE HEAD

18 WOULD BE THE SAFEST AND BEST PROCEDURE FOR MY

19 PATIENT."

20 THAT IS WHAT YOU WROTE IN YOUR DECLARATION, CORRECT?

21 A. THAT'S CORRECT.

22 Q. NOW, THE FIRST OF THOSE THREE CASES I BELIEVE YOU TESTIFIED

23 EARLIER WAS A WOMAN AT 23 WEEKS, ONE DAY, WHO HAD SCLERODERMA?

24 A. CORRECT.

25 Q. AND ONE OF THE REASONS THAT YOU WANTED TO DO AN INTACT

1 REMOVAL IN THAT CASE WAS THAT A D&E INVOLVING DISARTICULATION
2 REQUIRES MORE INSTRUMENTATION THAN INTACT D&E, CORRECT?
3 A. AND MORE ANESTHESIA.
4 Q. AND YOU BELIEVE THAT INTACT D&E CARRIED LESS RISK OF
5 CAUSING DAMAGE TO THE UTERUS?
6 A. IN THAT PARTICULAR CASE, A SURGICAL PROCEDURE LIKE
7 HYSTEROTOMY, INDUCTION AND A D&E, CONVENTIONAL D&E PROCEDURE
8 ALL IN THE OPINION OF PHYSICIANS TAKING CARE OF HER CARRIED
9 MORE RISK THAN THE SERIAL DILATATION IS THE PURPOSE OF AVOIDING
10 ANY OF THE ANESTHESIA, PROSTAGLANDINS, AND ALLOW PARTIAL
11 DELIVERY AND THEN COMPRESSING OF THE FETAL HEAD, WHICH
12 ULTIMATELY WASN'T NECESSARY.
13 Q. AND YOU BELIEVE THAT INTACT D&E CARRIED LESS RISK IN
14 CAUSING DAMAGE TO THE UTERUS?
15 A. THAT WAS NOT THE PRIMARY REASON. IN THIS PARTICULAR CASE,
16 IT WAS THE FACT THAT, ONE, IF COMPLICATIONS WERE TO OCCUR, LIKE
17 BLEEDING DURING THE PROCEDURE OR THE ANESTHESIA AND ANALGESIA
18 NECESSARY WOULD MAKE THE PATIENT MORE UNSTABLE THAN IF THIS
19 HAPPENED WITHOUT UTILIZING ANY OF THESE TECHNIQUES.
20 Q. USING LESS INSTRUMENTATION WAS PART OF YOUR CONSIDERATIONS
21 IN THAT CASE.
22 A. THE INSTRUMENTATION WOULD TAKE PLACE IN THE CONTEXT OF A
23 D&E PROCEDURE, WHICH WOULD TAKE CERTAIN TIME AND REQUIRE
24 CERTAIN MEDICATIONS FOR ANESTHESIA.
25 Q. DOCTOR, IF I COULD REFER TO YOU PARAGRAPH 20 OF YOUR

1 DECLARATION.
2 DO YOU SEE THAT?
3 A. YES.
4 Q. DOES THAT PARAGRAPH DISCUSS THE CASE THAT WE HAVE BEEN
5 TALKING ABOUT?
6 A. YES.
7 Q. I AM GOING TO READ TO YOU, DOCTOR, THE SENTENCE THAT GOES
8 FROM THE BOTTOM OF PAGE 7 TO THE TOP OF PAGE 8.
9 "IN ADDITION, BECAUSE D&E IN WHICH THE FETUS
10 IS REMOVED IN PIECES REQUIRES MORE INSTRUMENTATION
11 IN THE UTERUS THAN INTACT D&E. I BELIEVE THAT
12 INTACT D&E CARRIED LESS RISK OF CAUSING DAMAGE TO
13 THE UTERUS, ESPECIALLY AT THIS GESTATIONAL AGE."
14 DID I READ THAT CORRECTLY?
15 A. THAT'S CORRECT.
16 Q. THAT IS WHAT YOU WROTE IN YOUR DECLARATION?
17 A. THAT'S CORRECT. IT IS ONE OF THE REASONS TO CHOOSE THIS
18 PARTICULAR TECHNIQUE.
19 Q. DOCTOR, ARE YOU AWARE OF ANY PUBLISHED PEER-REVIEWED
20 STUDIES THAT HAVE EVALUATED WHETHER INTACT D&E REDUCES THE RISK
21 OF INJURY BECAUSE OF A REDUCTION IN INSTRUMENTATION?
22 A. NO, THERE IS NO -- THERE'S NO -- THERE'S NO RANDOMIZED
23 CLINICAL TRIAL OR EVEN --
24 Q. EVEN RETROSPECTIVE?
25 A. -- EVEN RETROSPECTIVE ANALYSIS THAT I COULD USE TO SUPPORT

1 THAT STATEMENT.
2 Q. YOUR BELIEF, THEN, IN THAT REGARD IS BASED ON INTUITION; IS
3 THAT CORRECT?
4 A. BASED ON 20 YEARS OF EXPERIENCE. IT IS BASED ON THE COMMON
5 SENSE THAT THE LESS INSTRUMENTS ONE PLACES IN THE UTERUS THE
6 LESS PROBABILITY IS THAT THAT COULD DO SOME DAMAGE.
7 Q. DOCTOR, THIS PATIENT WITH SCLERODERMA WAS AWAITING
8 DILATATION FOR APPROXIMATELY 30 HOURS, CORRECT?
9 A. I KNOW THAT I PLACED THREE SET OF LAMINARIA. I REALLY DO
10 NOT RECALL.
11 Q. MAY HAVE BEEN 30 HOURS?
12 A. I DON'T THINK IT WAS 30 HOURS. IT WAS, I THINK, SOMEWHERE
13 BETWEEN 18 AND 24 HOURS THAT WE FOUND OUT THAT SHE WAS -- HAD
14 DELIVERED.
15 Q. DOCTOR, YOU STILL HAVE YOUR DEPOSITION THERE IN FRONT OF
16 YOU?
17 A. MY DEPOSITION, YES.
18 Q. IF I COULD ASK YOU TO LOOK AT PAGE 132, PLEASE.
19 IF YOU COULD READ STARTING ON PAGE 132, STARTING ON
20 LINE 25, AND THEN READ THROUGH PAGE 133, LINE 14, PLEASE.
21 IF YOU COULD READ THAT SILENTLY.
22 A. I AM READING IT.
23 Q. YOU HAVE READ THAT?
24 A. YES.
25 Q. MY QUESTION FOR YOU THERE, DOCTOR, WAS:

1 "QUESTION: DO YOU REMEMBER ON THE SCLERODERMA
2 PATIENT HOW LONG IT TOOK FROM WHEN YOU FIRST PLACED
3 THE FIRST SET OF LAMINARIA TO WHEN YOU STARTED THE
4 EXTRACTION?"
5 I WOULD LIKE TO TRY TO AVOID READING THE ENTIRE
6 ANSWER, SINCE IT IS A BIT LONG. BUT AM I CORRECT THAT AT THE
7 END OF THAT ANSWER YOU SAY:
8 "THAT MAY HAVE BEEN 30 HOURS, BUT TRULY, I AM
9 NOT SURE."
10 IS THAT YOUR TESTIMONY?
11 A. YES, I AM SURE THAT -- THAT I WASN'T SURE; THAT IT COULD
12 HAVE BEEN UP TO 30 HOURS BECAUSE I FORGOT THE EXACT TIME
13 PERIOD.
14 Q. DOCTOR, THE NORMAL RANGE OF TIME FOR AN INDUCTION ABORTION
15 IS ABOUT EIGHT TO 27 HOURS, CORRECT?
16 A. NO. I COUNSEL PATIENTS THAT THE SHORTEST I HAVE SEEN IS
17 EIGHT HOURS AND THE LONGEST IS 72 HOURS.
18 Q. THE NORMAL RANGE IS EIGHT TO 27 HOURS, CORRECT?
19 A. I DON'T KNOW WHAT THAT IS BASED ON. IN MY DEPOSITION IT
20 SAYS "27," BUT IT REALLY SHOULD HAVE BEEN "72." I THINK THAT
21 IS A MISSTATEMENT.
22 Q. DOCTOR, IF I COULD ASK YOU TO LOOK AT YOUR DECLARATION.
23 NOT YOUR DEPOSITION, YOUR DECLARATION.
24 IN PARAGRAPH 13 --
25 MS. GARTNER: YOUR HONOR, I DON'T KNOW. IN

1 DR. BROEKHUIZEN'S DEPOSITION HE STATED THAT THIS PRECISE PART
2 OF HIS DECLARATION WAS A TYPOGRAPHICAL ERROR, AND THE "27"
3 SHOULD HAVE BEEN "72." FOR THE RECORD, I DON'T --
4 THE COURT: THAT WILL BE NOTED. HE JUST SAID THAT.
5 THE WITNESS: I SAID IT IN MY DEPOSITION, AS WELL.
6 THE COURT: OKAY. I WILL TAKE NOTE OF THAT.
7 BY MR. SIMPSON:
8 Q. ALL RIGHT. DOCTOR, LET'S TAKE A LOOK AT YOUR DEPOSITION,
9 PLEASE.
10 IS IT CORRECT, DOCTOR, THAT THE AVERAGE LENGTH OF
11 TIME FOR AN INDUCTION IS ABOUT 18 HOURS?
12 A. THAT'S THE NUMBER THAT I WILL COUNSEL PATIENTS. BUT MORE
13 IMPORTANT TO THEM IS THE RANGE. THE SHORTEST AND THE LONGEST I
14 HAVE SEEN IT, BECAUSE IT REALLY IS A MEANINGLESS NUMBER FOR THE
15 INDIVIDUAL PATIENTS SINCE I CAN'T PREDICT HOW LONG IT WILL
16 TAKE.
17 Q. DOCTOR, IF YOU WOULD LOOK AT YOUR DEPOSITION, PAGE 93. IF
18 YOU COULD READ SILENTLY, PLEASE, PAGE 93, LINES 1 THROUGH 3.
19 DID YOU TESTIFY THERE, DOCTOR, LINE ONE:
20 "QUESTION: I ASSUME -- AM I CORRECT IN
21 ASSUMING THAT EIGHT TO 27 HOURS IS THE NORMAL RANGE?
22 "ANSWER: YEAH, THE AVERAGE WOULD BE ABOUT 18."
23 IS THAT WHAT YOU TESTIFIED?
24 A. YES, THAT IS WHAT I TESTIFIED.
25 Q. DOCTOR, THIS PATIENT WITH SCLERODERMA, DID SHE GET ANY

1 ANESTHESIA FOR THE SURGICAL PART OF THE PROCEDURE?
2 A. SHE NEVER -- THE PURPOSE WAS NOT TO GIVE HER ANY ANESTHESIA
3 FOR THAT PART, BECAUSE WE WERE EXPECTING THAT IT WOULD BE
4 EASILY EXTRACTED, AND WE NEVER GOT TO THAT PART IN THE
5 PROCEDURE.
6 BUT IF THAT WOULD HAVE BEEN NECESSARY, WE WOULD HAVE
7 GIVEN HER.
8 Q. YOU WERE PLANNING TO GIVE HER ANESTHESIA?
9 A. WE WOULD -- WE WERE PLANNING TO ASSESS THE SITUATION,
10 EXAMINE HER TO SEE HOW WE WERE, AND THEN MAKE A DECISION WITH
11 THE ANESTHESIOLOGIST ABOUT HOW TO PROCEED.
12 Q. IN THE NORMAL CASE WHERE THE FETUS IS NOT EXPELLED
13 SPONTANEOUSLY, AS HAPPENED HERE, WHERE THAT DOES NOT HAPPEN YOU
14 WOULD GIVE THE WOMAN ANESTHESIA?
15 A. I WOULD NOT GIVE THE WOMAN ANESTHESIA. I WOULD DISCUSS
16 WITH THE ANESTHESIOLOGIST WHAT WOULD BE THE BEST WAY OF GIVING
17 ANALGESIA OR ANESTHESIA.
18 Q. AND IN THE NORMAL CASE THE WOMAN WOULD BE GIVEN ANESTHESIA
19 OR ANALGESIA?
20 A. THAT'S CORRECT.
21 Q. SO ACTUALLY, IN A SENSE, DOCTOR, THIS ABORTION TURNED OUT
22 TO BE AN INDUCTION ABORTION?
23 A. ULTIMATELY TOTAL EXPULSION WAS ACHIEVED.
24 Q. AND THE PATIENT SUFFERED NO ILL EFFECTS THAT SHE WOULD NOT
25 HAVE SUFFERED IF YOU HAD REMOVED THE FETUS INSTRUMENTALLY,

1 CORRECT?
2 A. I DON'T UNDERSTAND YOUR QUESTION.
3 Q. YOUR INTENT WAS TO GO IN AND REMOVE THE FETUS
4 INSTRUMENTALLY?
5 A. MY INTENT WAS TO HOPEFULLY FIND THE CERVIX SUFFICIENTLY
6 DILATED THAT I WOULD USE NO INSTRUMENTS OR MINIMAL
7 INSTRUMENTATION.
8 Q. YOUR INTENT WAS TO DO AN INDUCTION?
9 A. MY INTENT WAS TO DO SERIAL DILATATION AND ACHIEVE
10 SUFFICIENT DILATATION THAT I COULD DO A TOTAL OR PARTIAL
11 EXTRACTION.
12 Q. AND THE PATIENT SUFFERED NO ILL EFFECTS AS A RESULT OF THAT
13 PROCEDURE?
14 A. NO. THE PATIENT'S RECOVERED FROM THE PROCEDURE AND
15 ACTUALLY BECAME BETTER. HER MEDICAL CONDITION IMPROVED. SHE
16 WAS ABLE TO BE EXTUBATED.
17 SHE DIED FROM HER -- I HAPPENED TO KNOW THAT SHE
18 DIED FROM HER DISEASE 18 MONTHS LATER.
19 Q. SO, REALLY, DOCTOR, AS IT TURNED OUT AN INDUCTION COULD
20 HAVE BEEN PERFORMED FROM THE OUTSET IN THAT INSTANCE?
21 A. NO, I WOULD STRONGLY DISAGREE WITH THAT.
22 Q. ARE YOU TELLING ME, DOCTOR, THAT THE SERIAL DILATATION OF
23 THE CERVIX DID NOT LEAD TO ANY UTERINE CONTRACTIONS?
24 A. I AM SURE THE SERIAL DILATATION LED TO SOME DEGREE OF
25 UTERINE CONTRACTIONS, BUT THIS SIGNIFICANT LESS SIDE EFFECTS OR

1 POTENTIAL ADVERSE EFFECTS THAN THE MEDICATION THAT ONE WOULD
2 HAVE TO USE IF ONE SET OUT TO DO AN INDUCTION.
3 Q. DOCTOR, HOW LONG -- I AM SORRY. HOW LONG AGO DID THAT CASE
4 OCCUR?
5 A. YOU KNOW, IT IS IN THE MID-'90'S, BUT I DON'T KNOW THE
6 EXACT --
7 Q. SO --
8 A. NO, IT WAS EARLY '90'S OR MID '90'S, BUT IT WAS BEFORE
9 MISOPROSTOL OR BEFORE I WAS USING MISOPROSTOL.
10 Q. WAS DIGOXIN USED IN THAT CASE?
11 A. NO.
12 Q. YOUR SECOND EXAMPLE, DOCTOR, THE PATIENT WAS AT 20 WEEKS
13 AND THE FETUS HAD A LETHAL ANOMALY. NOW, YOUR USUAL PRACTICE
14 IN THAT SITUATION WOULD HAVE BEEN TO PERFORM AN INDUCTION,
15 CORRECT?
16 A. THAT'S CORRECT.
17 Q. BUT THE PATIENT DIDN'T WANT THE FETUS TO BE DISMEMBERED,
18 AND SHE HAD AN INORDINATE FEAR OF LABOR PAINS?
19 A. THIS PATIENT REALLY DID NOT WANT AN INDUCTION.
20 Q. YOU SET OUT TO DO A D&X PROCEDURE BY SERIAL DILATATION?
21 A. I SET OUT TO DO SERIAL DILATATION WITH THE GOAL OF DOING A
22 TOTAL OR PARTIAL EXTRACTION. THE END RESULT WAS THE SAME AS IN
23 THE FIRST PATIENT.
24 Q. YOU SET OUT BY DOING A D&X BY SERIAL DILATATION?
25 A. I DID NOT USE THE WORD -- THE WORD "D&X" HADN'T APPEARED IN

1 THE LITERATURE AT THE TIME I DID THIS, I THINK. BUT I SET OUT
2 EVACUATION OF THE UTERUS. WE WERE PREPARED TO DO A PROCEDURE
3 ON THE FETAL HEAD IF THAT DIDN'T PASS SPONTANEOUSLY, FROM
4 CONTRACTIONS OF THE CERVIX AFTER SERIAL DILATATION.
5 Q. DOCTOR, IF I COULD ASK YOU, AGAIN, PLEASE, TO LOOK AT YOUR
6 DECLARATION, THE SMALLER DOCUMENT. I AM SORRY, YOUR
7 DECLARATION.
8 A. OKAY.
9 Q. IN PARAGRAPH 21. TWENTY-ONE.
10 A. TWENTY-ONE?
11 Q. THE NEXT TO THE LAST SENTENCE OF THAT PARAGRAPH, I AM GOING
12 TO READ IT. IT SAYS:
13 "AND SO, AT HER REQUEST, WE SET OUT TO DO A D&X
14 PROCEDURE BY SERIAL DILATATION."
15 IS THAT WHAT YOU WROTE THERE?
16 A. THAT IS WHAT I WROTE THERE. I WOULD NOT -- BY THE TIME
17 THAT THESE DECLARATIONS ARE WRITTEN I AM BEING DEPOSED THE WORD
18 "D&X" IS THERE.
19 I AM SURE IF YOU WERE -- YOU WERE TO LOOK AT THE
20 RECORDS YOU WOULD NEVER FIND THE WORD "D&X" WRITTEN IN THAT
21 RECORD.
22 Q. DOCTOR, IN THAT CASE AN INDUCTION WAS NOT MEDICALLY
23 CONTRAINDICATED, CORRECT?
24 A. THE PATIENT HAD ONE PREVIOUS UTERINE SCAR. IT WAS NOT -- I
25 DO NOT CONSIDER A PREVIOUS UTERINE SCAR AN ABSOLUTE

1 CONTRAINDICATION. SO IT WAS NOT ABSOLUTELY CONTRAINDICATED.
2 IT WAS REALLY THE PATIENT'S REQUEST.
3 Q. AND, IN FACT, I BELIEVE YOU TESTIFIED TO THIS EARLIER: THE
4 SERIAL DILATATION PROMPTED LABOR TO START, AND SHE DELIVERED
5 THE FETUS INTACT WITHOUT YOUR USING ANY INSTRUMENTATION?
6 A. THAT'S CORRECT.
7 Q. SO IT REALLY BECAME AN INDUCTION?
8 A. IT BECAME A TOTAL EXPULSION OF THE FETUS WITHOUT USING THE
9 USUAL MEDICATIONS FOR AN INDUCTION, WHICH WOULD BE A
10 PROSTAGLANDIN OR HIGH-DOSE OXYTOCIN.
11 Q. WASN'T MISOPROSTOL USED IN THAT CASE, DOCTOR?
12 A. NO.
13 Q. ARE YOU TELLING US, DOCTOR, THAT YOU DISAGREE WITH THE
14 STATEMENT THAT THAT PROCEDURE KIND OF CONVERTED INTO AN
15 INDUCTION?
16 A. NO. I THINK ULTIMATELY -- I -- MY DEFINITION OF WHAT AN
17 INDUCTION IS THAT ONE FROM THE ONSET USES MEDICATION TO START
18 CONTRACTIONS THAT THEN LEADS TO DILATATION AND EXPULSION OF THE
19 FETUS.
20 ALL RIGHT. THIS IS -- I WOULD DESCRIBE THIS AS A
21 SERIAL DILATATION WITH THE INTENT OR WITH THE GOAL TO DO AN
22 EXTRACTION THAT LED TO ENOUGH PROSTAGLANDIN RELEASE THAT LED TO
23 SPONTANEOUS EXPULSION AND NEUTRON ACTIVITY, WHICH I THINK IS
24 DIFFERENT, WHICH ARE TWO DIFFERENT STARTING POINTS AND TWO
25 DIFFERENT END POINTS.

1 Q. DOCTOR, IF I COULD HAVE YOU LOOK AT YOUR DEPOSITION,
2 PLEASE. THE LONGER DOCUMENT, THE DEPOSITION.
3 A. YEP.
4 Q. I AM SORRY. THE LONGER DOCUMENT THAT IS BOUND.
5 A. OKAY.
6 Q. NOW, PAGE 131, PLEASE.
7 IF YOU COULD READ SILENTLY, DOCTOR, THE BOTTOM OF
8 PAGE 131, LINE 24.
9 IF YOU COULD READ THAT NEXT SENTENCE, PLEASE.
10 A. "THE PATIENT AFTER" --
11 THE COURT: DOCTOR, JUST READ IT TO YOURSELF.
12 THE WITNESS: OKAY.
13 BY MR. SIMPSON:
14 Q. YOU HAVE READ THAT, DOCTOR?
15 A. I READ IT.
16 Q. I WILL READ AT LEAST THE FIRST PART OF THAT SENTENCE THAT
17 STARTS AT THE BOTTOM OF PAGE 131:
18 "THE PATIENT, THE SECOND PATIENT, AFTER TWO
19 PLACEMENTS STARTED TO HAVE ENOUGH UTERINE ACTIVITY
20 THAT IT KIND OF CONVERTED INTO AN INDUCTION."
21 IS THAT WHAT YOU TESTIFIED?
22 A. THAT IS WHAT I SAID.
23 Q. DOCTOR, WAS DIGOXIN USED IN THAT SECOND CASE?
24 A. NO.
25 Q. FINALLY, YOUR THIRD EXAMPLE, THAT PATIENT WAS AT 28 WEEKS

1 AND THE FETUS WAS HYDROCEPHALIC, CORRECT?
2 A. CORRECT.
3 Q. HYDROCEPHALY IS AN EXCESS OF FLUID IN THE SKULL, CORRECT?
4 A. CORRECT.
5 Q. IT IS NOT NECESSARILY FATAL TO THE FETUS, HYDROCEPHALY?
6 A. NOT NECESSARILY. BUT IN THIS SITUATION IT WAS ASSOCIATED
7 WITH A CHROMOSOMAL ANOMALY, YES.
8 Q. DOCTOR, ONE CAN DELIVER A LIVING HYDROCEPHALIC INFANT
9 VAGINALLY BY DRAINING THE EXCESS FLUID WITH A NEEDLE, CORRECT?
10 A. NOT NECESSARILY.
11 Q. AND IN WHAT CASES CAN THAT NOT BE DONE?
12 A. IT REALLY DEPENDS ON HOW -- IT REALLY DEPENDS ON HOW
13 MACROCEPHALIC THE HEAD IS AND HOW EXTENSIVE THE CALVARIUM IS
14 DISTENDED.
15 ONE CAN DRAIN THE FLUID, BUT THAT -- THERE IS THE
16 POINT O REACCUMULATION OF THE FLUID. AND THAT WILL HAPPEN
17 DURING AN INDUCTION PERIOD. AND THERE IS THE ISSUE THAT
18 SOMETIMES EVEN WHILE THE FLUID IS DRAINED THE SKULL MAY NOT
19 SIMULTANEOUSLY COLLAPSE. IT STILL MAY REQUIRE SOME TRACTION OR
20 SOME ADDITIONAL MANIPULATION.
21 Q. DOCTOR, HAVE YOU EVER DELIVERED A LIVE INFANT WITH
22 HYDROCEPHALY?
23 A. YES, I HAVE.
24 Q. DID YOU HAVE TO DRAIN THE FLUID FROM THE SKULL BEFORE
25 DELIVERING THE BABY?

1 A. I'VE HAD ON TWO OCCASIONS, MAYBE THREE OCCASIONS, DONE
2 THAT, BUT THAT WAS IN THE CONTEXT OF A CESAREAN SECTION, WHICH
3 I WAS TRYING TO AVOID A LARGER INCISION THAN WOULD BE
4 NECESSARY.
5 Q. THAT PROCEDURE IS CALLED CEPHALOCENTESIS, CORRECT?
6 A. THAT PROCEDURE IS CALLED CEPHALOCENTESIS.
7 Q. SO YOU PERFORM THE CEPHALOCENTESIS IMMEDIATELY BEFORE
8 EXTRACTING THE FETUS, THE BABY?
9 A. BEFORE -- WELL, IN THE C-SECTION SCENARIO, THAT WOULD BE,
10 YEAH, BEFORE DELIVERING THE BABY.
11 Q. IN THOSE TWO OR THREE CASES, DOCTOR, WHERE YOU PERFORMED
12 CEPHALOCENTESIS IS IN THE COURSE OF A LIVE DELIVERY, THROUGH
13 WHAT PART OF THE HEAD DID YOU INSERT THE NEEDLE?
14 A. WELL, YOU TRY TO ACTUALLY AVOID THE POSTERIOR PART OF THE
15 SKULL.
16 Q. BY "POSTERIOR," YOU MEAN THE BACK OF THE HEAD?
17 A. BACK, HERE (INDICATING).
18 Q. WHERE DID YOU --
19 A. YOU TRY TO AVOID THE AREA OF THE BRAIN STEM AND THE
20 POSTERIOR FOSSA. YOU NEED TO TRY TO ACTUALLY DRAIN THE AREA
21 THAT YOU WOULD TRY TO FIND THE MOST FRONTAL PART, BECAUSE THIS
22 IS IN THE CONTEXT OF EFFECTING DELIVERY AND DOING THE LEAST
23 DAMAGE.
24 NEUROSURGEONS CAN EVALUATE IN THE FUTURE COURSE OF
25 ACTION --

1 Q. DOCTOR, YOU WERE TOUCHING THE TOP OF YOUR HEAD, SO YOU ARE
2 SAYING WHEN YOU WANT TO PERFORM A CEPHALOCENTESIS FOR A LIVE
3 DELIVERY YOU TRY TO INSERT THE NEEDLE IN THE TOP OF THE HEAD?
4 A. YOU PROBABLY, IF YOU COULD, WOULD TRY TO FIND THE ANTERIOR
5 FONTANELLE, AS THE MOST LOGICAL ENTERING POINT. THAT IS NOT --
6 THAT MAY NOT ALWAYS BE POSSIBLE.
7 Q. AND CEPHALOCENTESIS IS NOT NECESSARILY FATAL TO THE INFANT
8 OR FETUS, CORRECT?
9 A. THAT'S CORRECT. THAT IS WHY IT IS BEING USED IN THE
10 SCENARIOS I JUST DESCRIBED.
11 Q. BUT IN THIS CASE, DOCTOR, THE CASE WE WERE TALKING ABOUT
12 WHERE THE WOMAN WAS AT 18 WEEKS AND THE FETUS WAS HYDROCEPHALIC
13 YOU DIDN'T USE A NEEDLE THROUGH A FONTANELLE, DID YOU?
14 A. NO, BECAUSE THAT WOULD HAVE BEEN PHYSICALLY IMPOSSIBLE. IF
15 ONE WERE TO DECOMPRESS AND DRAIN THE FLUID AND DRAIN VAGINALLY,
16 YOU KNOW, WHEN THE HEAD IS ENTRAPPED, BECAUSE THE PART THAT IS
17 EXPOSED IS ACTUALLY THE LOWER PART OF THE SKULL IN THE BACK.
18 Q. CEPHALOCENTESIS IS SOMETIMES DONE THROUGH THE WALL OF THE
19 UTERUS, CORRECT?
20 A. THAT CAN BE DONE. IT'S VERY SELDOM DONE IN THIS DAY AND
21 AGE BECAUSE IT'S NOT FELT THERE IS MUCH OF A THERAPEUTIC
22 ADVANTAGE THERE TO DO THAT.
23 Q. BUT IT IS SOMETIMES DONE?
24 A. I DON'T THINK IT HAS BEEN DONE IN MY INSTITUTION WHERE I
25 HAVE WORKED FOR THE LAST 15 YEARS.

1 Q. IT IS SOMETIMES DONE ELSEWHERE?
2 A. IT MAY VERY WELL.
3 Q. NOW, DOCTOR, INSTEAD OF USING A NEEDLE THROUGH THE
4 FONTANELLE IN THIS CASE WE WERE TALKING ABOUT, YOU PUSHED A
5 TROCAR INTO THE BACK OF THE FETUS' HEAD, CORRECT?
6 A. THAT'S CORRECT.
7 Q. YOU WOULD NEVER DO THAT IF YOUR INTENT WAS TO DELIVER A
8 LIVING BABY. YOU'VE SAID THAT.
9 A. NO. I WAS DOING THIS IN THE CONTEXT OF PREGNANCY
10 TERMINATION, NOT IN THE CONTEXT OF DELIVERING A LIVING BABY.
11 Q. IN REALITY, DOCTOR, YOU PERFORMED THE ABORTION IN THE WAY
12 THAT YOU DID IN ORDER TO AVOID HAVING A LIVE BIRTH, DIDN'T YOU?
13 A. NO. I DID THAT PROCEDURE IN ORDER TO AVOID THE CESAREAN
14 SECTION.
15 Q. DOCTOR, FETAL VIABILITY BEGINS AROUND 24 WEEKS, CORRECT?
16 A. YES.
17 Q. AND THIS FETUS WAS AT 28 WEEKS?
18 A. CORRECT.
19 Q. THAT FETUS WAS ALIVE BEFORE YOU DECOMPRESSED THE HEAD,
20 CORRECT?
21 A. THAT'S CORRECT.
22 Q. YOU KNEW THAT BECAUSE THE FETUS MOVED?
23 A. CORRECT.
24 Q. WAS DIGOXIN USED IN THAT CASE, DOCTOR?
25 A. NO, IT WASN'T.

1 Q. DOCTOR, WHERE A FETUS HAS FETAL ANOMALY THAT IS NOT FATAL,
2 THE WOMAN MAY CHOOSE TO CONTINUE THE PREGNANCY WITHOUT HEALTH
3 RISK TO HERSELF, CORRECT?
4 A. THAT MAY BE TRUE IN MANY CIRCUMSTANCES.
5 Q. NOW, DOCTOR, YOU'VE GIVEN AN INJECTION TO CAUSE FETAL
6 DEMISE BEFORE AN INDUCTION ABORTION, CORRECT?
7 A. I SOMETIMES DO.
8 Q. BUT NEVER BEFORE A D&E, CORRECT?
9 A. I'VE NEVER DONE IT BEFORE A D&E.
10 Q. AND AS I BELIEVE YOU'VE TESTIFIED IF THERE IS NOT ENOUGH
11 DILATION FOR THE HEAD TO PASS YOU CRUSH THE HEAD, CORRECT?
12 A. CORRECT.
13 Q. YOU'VE SEEN THE FETUS -- BESIDES THE THIRD CASE WE JUST
14 DISCUSSED, YOU HAVE SEEN THE FETUS SHOW SIGNS OF LIFE BEFORE
15 YOU'VE CRUSHED THE HEAD UNDER THOSE CIRCUMSTANCES, CORRECT?
16 A. I'VE SEEN THAT -- YOU HAVE TO -- IN THE CONTEXT OF A --
17 WHERE WE STARTED OUT AS AN INDUCTION OR IN THE CONTEXT OR WHERE
18 WE STARTED OUT AS A D&E?
19 Q. EITHER ONE.
20 A. YEAH, THEN, I HAVE SEEN IT.
21 Q. SO WE ARE TALKING ABOUT WHERE THE HEAD IS LODGED IN THE
22 CERVIX, CORRECT?
23 YOU HAVE SEEN THE FETUS SHOW SIGNS OF LIFE WHILE THE
24 HEAD IS LODGED IN THE CERVIX?
25 A. IN A FEW OCCASIONS, AS LIKE THE THIRD CASE I DESCRIBED WAS

1 AN INDUCTION. AND IN VERY RARE OCCASION IN THE CONTEXT OF A
2 D&E WE HAD SO MUCH DILATATION THAT PARTIAL DELIVERY OCCURRED.
3 Q. YOU HAVE SEEN THE FETUS' LEGS MOVE BEFORE CRUSHING THE
4 HEAD, HAVEN'T YOU?
5 A. I HAVE SEEN THAT BEFORE COMPRESSING/DECOMPRESSING THE HEAD.
6 Q. AND THAT IS WHILE THE HEAD IS LODGED IN THE INTERNAL OS?
7 A. CORRECT.
8 Q. THE REST OF THE BODY IS OUTSIDE THE CERVIX?
9 A. CORRECT.
10 Q. NOW, DOCTOR, IF THE ENTIRE FETUS WERE TO COME OUT AT THAT
11 POINT INSTEAD OF THE HEAD BEING LODGED, IF YOU WERE AT 24
12 WEEKS, YOU WOULD HAVE POTENTIALLY A LIVING INFANT, CORRECT?
13 A. YES. BUT AT 24 WEEKS, IN MY PRACTICE THERE WOULD BE A
14 LETHAL FETAL ANOMALY.
15 Q. YOU SAY "LETHAL FETAL ANOMALY," DOCTOR. ARE YOU INCLUDING
16 "ANENCEPHALY" IN THAT TERM?
17 A. I WOULD INCLUDE THAT IN THE TERM.
18 Q. THERE ARE SOME ANENCEPHALIC INFANTS WHO LIVE FOR A NUMBER
19 OF MONTHS, CORRECT?
20 A. THAT'S CORRECT.
21 Q. DOCTOR, WHERE YOU HAVE SEEN THE LEGS MOVE WHILE THE HEAD IS
22 LODGED IN THE CERVIX, AND THEN YOU CRUSH THE SKULL TO COMPLETE
23 THE DELIVERY, DOES THE BODY JERK OR TWITCH WHEN YOU CRUSH THE
24 SKULL?
25 A. THE OCCASIONS SHOULD BE CLEAR FROM MY TESTIMONY HAVE BEEN

1 SO RARE THAT I COULDN'T REALLY ANSWER THAT QUESTION. GIVEN THE
2 CIRCUMSTANCES THAT IS NOT REALLY WHAT I AM FOCUSING ON.
3 Q. DOCTOR, I AM ASKING YOU WHETHER ON THOSE OCCASIONS WHERE
4 YOU HAVE SEEN THE LEGS MOVE AND YOU CRUSH THE SKULL TO COMPLETE
5 THE DELIVERY, HAS THE BODY JERKED OR TWITCHED WHEN YOU'VE
6 CRUSHED THE SKULL?
7 A. I REALLY COULDN'T TELL YOU. I REALLY COULDN'T TELL YOU.
8 MY FOCUS IS ON EXPEDITING THE DELIVERY IN THE SAFEST POSSIBLE
9 WAY, NOT TO OBSERVE. I MAY HAVE OBSERVED THAT THERE WAS FETAL
10 MOVEMENT, BUT I CERTAINLY WASN'T GOING TO OBSERVE THE NATURE OF
11 THOSE MOVEMENTS.
12 THIS IS A DIFFICULT ENOUGH PROCEDURE FOR ME TO
13 PERFORM, AS WELL. YOU KNOW, AND I AM NOT REALLY FOCUSING ON
14 THAT ASPECT.
15 Q. AND REALLY, DOCTOR, YOU ARE NOT REALLY INTERESTED IN
16 WHETHER THE FETUS IS ALIVE OR DEAD WHEN YOU BEGIN AN ABORTION,
17 CORRECT?
18 A. NO. I AM INTERESTED IN THE INDICATION AND WHAT THE PATIENT
19 HAS CHOSEN TO DO, AND IN THE SAFETY OF THE PROCEDURE.
20 Q. YOU ARE NOT INTERESTED IN WHETHER THE FETUS IS ALIVE OR
21 DEAD?
22 A. I AM INTERESTED IN WHAT THE PATIENT WANTS AND THE PATIENTS
23 WHO CHOOSE TO HAVE DIGOXIN IN THE INDUCTION METHODS ARE
24 INTERESTED IN NOT HAVING A LIVE BIRTH. THE PATIENTS WHO CHOOSE
25 NOT TO ARE NOT INTERESTED.

1 Q. IF I COULD REFER YOU, DOCTOR, TO YOUR DEPOSITION, PLEASE.
2 THAT IS THE ONE YOU HAVE IN FRONT OF YOU. IF YOU COULD TURN TO
3 PAGE 78, PLEASE.
4 PAGE 78, IF YOU COULD READ SILENTLY, DOCTOR, LINES
5 10 THROUGH 16.
6 A. UH-HUH.
7 Q. AND I WILL READ THAT LINE 10:
8 "QUESTION: IN PERFORMING A D&E WOULD IT BE
9 FAIR TO SAY THAT YOU DON'T NECESSARILY INTEND FOR
10 THE FETUS TO BE ALIVE WHEN YOU START EXTRACTING IT?
11 "ANSWER: NO, I AM REALLY NOT INTERESTED TO
12 KNOW IF THE FETUS IS ALIVE OR NOT AT THAT TIME. BUT
13 I KNOW IT IS MORE LIKELY TO BE ALIVE THAN NOT IN THE
14 SCENARIO YOU DESCRIBED."
15 IS THAT WHAT YOU TESTIFIED, DOCTOR?
16 A. YES, I DID.
17 Q. NOW, DOCTOR, WHERE A TERMINATION OF PREGNANCY IS INDICATED
18 BECAUSE OF A MATERNAL HEALTH CONDITION, IT IS NEVER MEDICALLY
19 NECESSARY TO KILL THE FETUS IN THE PROCESS, CORRECT?
20 A. I DON'T UNDERSTAND YOUR QUESTION.
21 Q. DOCTOR, YOU'VE TESTIFIED THAT THERE ARE OCCASIONS IN WHICH
22 A PREGNANCY FOR MEDICAL REASONS SHOULD BE TERMINATED BECAUSE OF
23 A HEALTH CONDITION OF A MOTHER, CORRECT?
24 A. CORRECT.
25 Q. BUT IN THOSE INSTANCES IT'S NEVER MEDICALLY NECESSARY FROM

1 THE STANDPOINT OF THE MOTHER TO KILL THE FETUS IN THE PROCESS,
2 CORRECT?
3 A. IT'S -- YOU ARE NOW REFERRING TO PREGNANCY TERMINATIONS
4 BEFORE 24 WEEKS?
5 Q. OR AFTER 24 WEEKS, IF THERE IS SOME REASON FOR IT.
6 A. AFTER 24 WEEKS, IF THERE WAS A LETHAL FETAL ANOMALY, RIGHT,
7 WE WOULD -- THAT WOULD BE IN THE CONTEXT OF THE PALLIATIVE OF
8 CARE, AND THAT WOULD BE A DIFFERENT SCENARIO.
9 IF IT WAS AFTER 24 WEEKS AND THERE WAS NO FETAL
10 ANOMALY, RIGHT, AND PREGNANCY TERMINATION AT THAT POINT WAS
11 NECESSARY, OBVIOUSLY I WOULD MAKE ALL THE EFFORT TO ACTUALLY
12 MAKE SURE THAT THE BABY HAD ALL THE OPTIONS TO SURVIVE.
13 AT LESS THAN 24 WEEKS, RIGHT, THAT WOULD BE NOT
14 NECESSARY.
15 Q. SO JUST TO CLARIFY, CONCRETE EXAMPLE. LET'S SAY THE FETUS
16 IS ANENCEPHALIC, ALL RIGHT? THE WOMAN IS AT 24 WEEKS, AND THE
17 DECISION IS MADE TO TERMINATE THE PREGNANCY. THERE IS NO
18 MEDICAL REASON FROM THE MOTHER'S STANDPOINT TO ENSURE THAT THE
19 FETUS DIES IN THE COURSE OF THE ABORTION.
20 A. THAT WOULD BE CORRECT IN THAT SCENARIO.
21 Q. NOW, DOCTOR, YOU'VE TESTIFIED, I BELIEVE, THAT YOU BELIEVE
22 INTACT D&E REDUCES THE USE OF ANESTHESIA, REDUCES BLOOD LOSS
23 AND REDUCES THE RISK OF COMPLICATIONS AS COMPARED TO D&E BY
24 DISMEMBERMENT? FOR EACH OF THOSE RISKS--
25 A. I THINK I SAID "IT MAY." I THINK I SAID AS WELL THAT WE

1 REALLY HAVE NO COMPARATIVE SERIES THAT WE COULD CALL TO SOME
2 RELIABILITY.
3 Q. DOCTOR, YOUR BELIEF REGARDING THE USE OF ANESTHESIA IS
4 BASED ON A BELIEF THAT INTACT REMOVAL IS QUICKER THAN
5 DISMEMBERMENT, CORRECT?
6 A. THAT'S CORRECT.
7 Q. NONE OF YOUR PATIENTS WHO HAVE HAD A D&E BY DISMEMBERMENT
8 HAVE EVER HAD A COMPLICATION FROM ANESTHESIA; ISN'T THAT RIGHT?
9 A. THAT'S CORRECT.
10 Q. SO IT WOULD BE FAIR TO SAY IN YOUR VIEW AS FAR AS
11 ANESTHESIA IS CONCERNED, THAT INTACT D&E PRESENTS A
12 HYPOTHETICAL BENEFIT, CORRECT?
13 A. WELL, THE TWO PATIENTS OUT OF THE THREE NEVER -- REALLY,
14 NONE OF THESE PATIENTS EVER HAD ANESTHESIA.
15 Q. I AM NOT TALKING --
16 A. SO I COULDN'T CONCLUDE FROM THERE.
17 Q. I AM NOT TALKING JUST ABOUT THOSE THREE, DOCTOR. I AM
18 TALKING ABOUT YOUR EXPERIENCE, IN GENERAL. WOULD IT BE FAIR TO
19 SAY THAT YOUR VIEW AS TO D&E, INTACT D&E REDUCING THE USE OF
20 ANESTHESIA THAT IS A HYPOTHETICAL BENEFIT, CORRECT?
21 A. I THINK I REFER TO IT EARLIER AS COMMON SENSICAL
22 CONCLUSION, BUT IT IS HYPOTHETICAL IN THE SENSE THAT I DO NOT
23 HAVE PEER-REVIEWED DATA OR METHOD ANALYSIS TO SUPPORT IT.
24 Q. YOU ARE NOT AWARE OF ANY STUDIES SHOWING THAT INTACT D&E IS
25 QUICKER, ARE YOU?

1 A. I AM NOT AWARE.
2 Q. YOU ALSO TESTIFIED, DOCTOR, THAT YOU BELIEVE INTACT D&E MAY
3 DECREASE THE POTENTIAL AMOUNT OF BLOOD LOSS AS OPPOSED TO D&E
4 BY DISMEMBERMENT. IN YOUR VIEW IS THAT BECAUSE INTACT D&E USES
5 LESS INSTRUMENTATION?
6 A. LESS INSTRUMENTATION AND LESS TIME.
7 Q. BUT YOU HAVE NEVER -- IN YOUR OWN PRACTICE, YOU HAVE NEVER
8 QUANTIFIED IN ANY WAY THE AMOUNT OF BLOOD LOSS AS BETWEEN YOUR
9 PATIENTS WHO HAVE HAD AN INTACT PROCEDURE AND THOSE WHO HAVE
10 NOT, CORRECT?
11 A. I HAVE NEVER DELIBERATELY STUDIED IT NOR KEPT STATISTICS ON
12 IT, BUT I THINK IN MY EXPERIENCE OVER THE YEARS, WHEN THE MORE
13 WAS THE FIRST EXTRACTION, THE FARTHER I COULD DELIVERY MORE OF
14 THE FETAL BODY AND LESS PASSES I HAD TO DO, THE LESS TIME IT
15 TOOK AND LESS BLEEDING I HAD.
16 I MEAN, I CANNOT QUANTIFY IT, SO IT WOULDN'T STAND
17 UP TO PUBLICATION IN THE LITERATURE, BUT IT CERTAINLY WOULD --
18 I AM VERY COMFORTABLE MAKING THAT STATEMENT BASED ON MY
19 EXPERIENCE DEALING WITH DIFFERENT DEGREES OF DILATATION.
20 Q. DOCTOR, YOU ARE NOT AWARE OF ANY --
21 A. -- AND LENGTH OF PROCEDURES. AND LENGTH OF THE PROCEDURE I
22 OBSERVED.
23 Q. DOCTOR, YOU ARE NOT AWARE OF ANY STUDIES SHOWING THAT THERE
24 IS LESS BLOOD LOSS IN INTACT D&E, ARE YOU?
25 A. NO, I THINK I ALREADY ANSWERED THAT QUESTION.

1 Q. DOCTOR, ARE YOU FAMILIAR WITH CERVICAL INCOMPETENCE?
2 A. YES, I AM.
3 Q. THAT IS THE INABILITY OF THE CERVIX TO RESIST THE FORCE OF
4 GRAVITY TO KEEP THE PREGNANCY IN THE UTERUS?
5 A. THAT'S A SIMPLISTIC DEFINITION OF THE CONDITION.
6 Q. AND A WOMAN WITH AN INCOMPETENT CERVIX MAY SUFFER A
7 SPONTANEOUS ABORTION WITHOUT WARNING; CORRECT?
8 A. PATIENTS WITH CERVICAL INCOMPETENCE WILL HAVE PAINFUL -- OR
9 PATIENTS WITH CERVICAL INCOMPETENCE OR CERVICAL INSUFFICIENCY
10 WILL HAVE PAINFUL CERVICAL DILATION THAT ULTIMATELY WILL LEAD
11 TO MISCARRIAGE OR EARLY DELIVERY.
12 BUT IN THE LAST 10 YEARS, I THINK WE HAVE KIND OF
13 SEEN A CONTINUUM FROM THE CLASSICAL CERVICAL INCOMPETENCE IN
14 THE SECOND-TRIMESTER TO THE CURRENT EARLY PREMATURE DELIVERIES.
15 AND SO IT IS PROBABLY NOT JUST A MECHANICAL OR A STRUCTURAL
16 DEFICIENCY IN THE CERVIX. IN SOME PATIENTS IT MAY ACTUALLY BE
17 BIOCHEMICAL OR AN ISSUE OF CONNECTIVE TISSUE THAT VARIES FROM
18 PATIENT TO PATIENT, BECAUSE PEOPLE CAN HAVE THIS CONDITION
19 WITHOUT EVER HAVING INSTRUMENTATION TO THEIR CERVIX THROUGH A
20 CERVICAL LACERATION.
21 Q. I BELIEVE YOU TESTIFIED ON DIRECT, DOCTOR, THAT SERIAL
22 DILATATION OF THE CERVIX MAY LEAD TO MORE RISK OF CERVICAL
23 INCOMPETENCE, CORRECT?
24 A. I THINK I TESTIFIED EARLIER TODAY THAT I DO NOT BELIEVE
25 THAT THAT IS THE CASE PRIOR TO 20 WEEKS. BUT THERE IS ENOUGH

1 EVIDENCE THERE TO STATE THAT THAT IS NOT A MESSAGE OF
2 DILATATION IN EVERY CASE, AND I THINK I TESTIFIED THAT I AM NOT
3 SURE FOR BOTH METHODS, INDUCTION OR D&E PROCEDURES, THAT THAT
4 IS TRUE AFTER -- BETWEEN 20 AND 24 WEEKS. AND THEREFORE I
5 COUNSEL PATIENTS ON THE POSSIBILITY OF CERVICAL INCOMPETENCE
6 AND SUBSEQUENT PREGNANCY.
7 Q. NOW, DOCTOR, WHEN YOU EMPLOY SERIAL USE OF OSMOTIC
8 DILATORS, YOU PUT A GREATER NUMBER OF DILATORS INTO THE CERVIX
9 EACH TIME, CORRECT?
10 A. THAT'S CORRECT.
11 Q. YOU HAVE PUT AS MANY AS 20 OR 25 DILATORS INTO A WOMAN'S
12 CERVIX AT ONE TIME?
13 A. THAT'S CORRECT.
14 Q. DOCTOR, IF ONE WANTED TO STUDY WHETHER THE CERVICAL
15 DILATATION NEEDED FOR AN INDUCED ABORTION INCREASES THE RISK OF
16 CERVICAL INCOMPETENCE IN PRE-TERM LABOR, YOU WOULD HAVE TO
17 FOLLOW A GROUP OF WOMEN WHO HAD UNDERGONE AN INDUCED ABORTION,
18 YOU WOULD HAVE TO FOLLOW THEM INTO A SUBSEQUENT PREGNANCY,
19 CORRECT?
20 A. THAT WOULD BE -- YOU WOULD HAVE TO FOLLOW THEIR -- INTO A
21 NEXT PREGNANCY.
22 Q. AND THE LARGER THAT GROUP OF WOMEN THE MORE RELIABLE THAT
23 STUDY WOULD BE?
24 A. THAT'S TRUE. I THINK PROBABLY IMPOSSIBLE TO EVER CONDUCT A
25 STUDY OF THAT KIND.

1 Q. DOCTOR, TO FOLLOW THE SUBJECTS INTO A SUBSEQUENT PREGNANCY
2 YOU WOULD NOT WANT TO RELY SIMPLY ON THE SUBJECTS REPORTING
3 BACK TO THE AUTHORS OF THE STUDY VOLUNTARILY, CORRECT?
4 A. NO. I MEAN, IN A WELL-CONTROLLED, RANDOMIZED TRIAL, ONE
5 WOULD ASCERTAIN THE FOLLOW-UP AS A RESEARCH.
6 Q. DOCTOR, YOU SAID YOU THINK IT WOULD BE IMPOSSIBLE TO TO
7 CONSTRUCT SUCH A STUDY. ARE YOU SPEAKING SIMPLY OF A
8 PROSPECTIVE STUDY? ARE YOU SAYING IT WOULD BE IMPOSSIBLE TO
9 CONSTRUCT A RETROSPECTIVE STUDY ON THAT ISSUE?
10 A. WELL, FOR A RETROSPECTIVE STUDY STILL ONE WOULD NEED
11 PROBABLY GET SEVERAL INSTITUTIONS AND SEVERAL PHYSICIANS
12 PERFORMING THAT PROCEDURE. THE PROBLEM WOULD BE THEIR
13 INCONSISTENCY AND VARIABILITY AMONG DIFFERENT PHYSICIANS.
14 FOR ONE PHYSICIAN TO COLLECT PROBABLY ENOUGH
15 NUMBERS, THOUGH I HAVE NEVER MADE THE CALCULATION, WOULD
16 PROBABLY BE UNREALISTIC. IN THE CONTEXT OF MY PRACTICE, TO
17 ORGANIZE A RANDOMIZED CLINICAL TRIAL, COMPARING D&E VERSUS
18 INDUCTION, D&E INTACT OR NOT INTACT VERSUS INDUCTION BETWEEN 20
19 AND 24 WEEKS WOULD BE IMPOSSIBLE BECAUSE THE MAJORITY OF
20 PATIENTS WOULD HAVE VERY STRONG FEELINGS ABOUT ONE METHOD OR
21 THE OTHER, AND WOULD NOT WANT TO BE RANDOMIZED.
22 Q. DOCTOR, MY QUESTION DID NOT RELATE TO PROSPECTIVE STUDY.
23 MY QUESTION NOW RELATES TO RETROSPECTIVE STUDY. WOULD IT BE
24 POSSIBLE TO CONSTRUCT A RETROSPECTIVE STUDY SHOWING WHETHER THE
25 DILATATION NEEDED FOR SECOND-TRIMESTER ABORTION INCREASES THE

1 RISK OF CERVICAL INCOMPETENCE AND PRE-TERM LABOR?
2 A. I THINK IT WOULD BE POSSIBLE TO DO A STUDY IN WHICH ONE
3 WOULD LOOK IN RETROSPECT BACK, BUT ONE WOULD HAVE TO SET UP A
4 PROTOCOL VERY TIGHT AND MULTIPLE INSTITUTIONS TO PROSPECTIVELY
5 COLLECT THE DATA SO THAT THERE WOULD BE INTERNAL CONSISTENCY
6 ABOUT IT.
7 Q. ARE YOU AWARE OF ANY STUDIES LIKE THAT, DOCTOR?
8 A. I ACTUALLY THINK VERY -- I DON'T HAVE THEM OFF THE TOP OF
9 MY HEAD, BUT I THINK THERE ARE ONE OR TWO STUDIES VERY RECENTLY
10 HAVING TO ADDRESS RETROSPECTIVELY SOME OF THE ISSUES. BUT IT
11 HAS NEVER REALLY -- THIS HAS NOT BEEN AN ISSUE FOR ME. I AM
12 COMFORTABLE WITH THE KNOWLEDGE ABOUT THE ISSUE OF CERVICAL
13 INCOMPETENCE UP TO 20 WEEKS.
14 AND I AM QUITE COMFORTABLE WITH THE LOW INCIDENTS,
15 IF IT WERE TO BE THERE, AND RELATIVELY MINOR DIFFERENCES
16 BETWEEN INDUCTION AND D&E PROCEDURE THAT I THINK THE PATIENTS
17 CAN MAKE VERY WELL THE RIGHT DECISION BETWEEN THE TWO
18 PROCEDURES BASED ON THE INFORMATION I PROVIDE THEM.
19 Q. DOCTOR, YOU MENTIONED THAT YOU THINK THERE MIGHT BE A
20 COUPLE OF STUDIES, RETROSPECTIVE STUDIES ALONG THOSE LINES. DO
21 THOSE STUDIES AS FAR AS YOU KNOW SUGGEST A POSITIVE CORRELATION
22 BETWEEN CERVICAL DILATATION AND PRE-TERM BIRTH OR CERVICAL
23 INCOMPETENCE?
24 A. I REALLY DON'T KNOW.
25 MR. SIMPSON: COULD I APPROACH THE WITNESS, PLEASE,

1 YOUR HONOR?
2 THE COURT: YES. ALL RIGHT. GO AHEAD.
3 MR. SIMPSON: THANK YOU, YOUR HONOR.
4 BY MR. SIMPSON:
5 Q. DOCTOR, I'VE SHOWN YOU --
6 MR. SIMPSON: YOUR HONOR, I APOLOGIZE. I AM USING
7 THIS ARTICLE FOR IMPEACHMENT, AND I THOUGHT I HAD MULTIPLE
8 COPIES OF IT WITH ME. THIS ARTICLE IS NOT IN OUR ARTICLE LIST,
9 AND I DON'T BELIEVE IT IS IN THE PLAINTIFFS' ARTICLE LIST.
10 THIS IS THE ONE ENTITLED: "INDUCED ABORTION AND
11 SUBSEQUENT PREGNANCY DURATION."
12 MS. KRASNOFF: WE DON'T HAVE THAT AT ALL.
13 MR. SIMPSON: I APOLOGIZE, YOUR HONOR. I THOUGHT I
14 HAD MULTIPLE COPIES OF THIS WITH ME. IT IS NOT ON OUR LIST, AS
15 I SAID. I AM USING IT ONLY FOR IMPEACHMENT. AND I COULD GET
16 IT BACK FROM THE WITNESS TO SHOW IT TO PLAINTIFFS' COUNSEL SO
17 THEY CAN SHOW WHAT I AM SHOWING TO HIM.
18 THE COURT: THEY HAVE TO AT LEAST SEE IT BEFORE YOU
19 CAN USE IT.
20 MR. SIMPSON: DOCTOR, IF I CAN GET THAT BACK FROM
21 YOU, PLEASE.
22 YES, YOUR HONOR. WHY DON'T I MOVE ON TO SOMETHING
23 ELSE? AND MEANWHILE MY CO-COUNSEL CAN GET ANOTHER COPY OF
24 THAT.
25 BY MR. SIMPSON:

1 Q. DOCTOR, IF I COULD SHOW YOU A DIFFERENT ARTICLE, PLEASE.
2 THIS ONE IS DEFENDANT'S LEARNED TREATISE A-29. THIS IS AN
3 ARTICLE ENTITLED:
4 "IMPACT OF INDUCED ABORTIONS ON SUBSEQUENT
5 PREGNANCY OUTCOME, THE 1995 FRENCH NATIONAL
6 PERINATAL SURVEY."
7 MR. SIMPSON: AND, AGAIN, YOUR HONOR, THIS IS
8 DEFENDANT'S LEARNED TREATISE A-29.
9 BY MR. SIMPSON:
10 Q. DOCTOR, IF YOU LOOK AT THE ABSTRACT ON THE FIRST PAGE OF
11 THAT ARTICLE, IT SAYS:
12 "POPULATION 13,432 WOMEN WHO HAD A SINGLETON
13 LIVE BIRTH DURING ONE WEEK." WOULD YOU CALL THAT A
14 LARGE STUDY?
15 A. IT IS A LARGE NUMBER OF PATIENTS.
16 Q. IF I COULD READ THE FIRST PART OF THAT ABSTRACT. THE
17 OBJECTIVE SAYS: "TO STUDY" -- BEFORE I DO THIS, DOCTOR, HAVE
18 YOU SEEN THIS STUDY BEFORE?
19 A. NO.
20 Q. "OBJECTIVE: TO STUDY THE IMPACT OF PREVIOUS INDUCED
21 ABORTIONS ON PRE-TERMED DELIVERY SMALL FOR
22 GESTATIONAL AGE AND LOW BIRTH WEIGHT IN SUBSEQUENT
23 PREGNANCIES. DESIGN: SURVEY OF A NATIONAL SAMPLE
24 OF BIRTHS IN FRANCE IN 1995. SETTING: ALL PUBLIC
25 AND PRIVATE MATERNITY HOSPITALS IN FRANCE.

1 POPULATION" I JUST READ. "METHODS: DATA WERE
2 COLLECTED DURING THE WOMEN'S POSTPARTUM STAY IN
3 HOSPITAL, PARTLY OBTAINED BY INTERVIEW AND PARTLY
4 ABSTRACTED FROM HOSPITAL MEDICAL RECORDS. RATES OF
5 PRE-TERM DELIVERY, SMALL FOR GESTATIONAL AGE AND LOW
6 BIRTH WEIGHT WERE COMPARED ACCORDING TO EXISTENCE
7 AND NUMBER OF PREVIOUS INDUCED ABORTIONS. MATERNAL
8 AGE, PARITY, HISTORY OF PREVIOUS ADVERSE PREGNANCY
9 OUTCOME, MATERNAL WEIGHT BEFORE PREGNANCY, MARITAL
10 STATUS, EDUCATIONAL LEVEL, MATERNAL EMPLOYMENT
11 STATUS DURING PREGNANCY, NATIONALITY, SMOKING DURING
12 THE THIRD-TRIMESTER OF PREGNANCY, AND ANTENATAL CARE
13 WERE CONTROLLED FOR USING MULTIPLE LOGISTIC
14 REGRESSION AND POLYTHOMAS (PHONETIC) LOGISTIC
15 REGRESSION."
16 IS IT TRUE, DOCTOR, NOW AS YOU UNDERSTAND WHAT THEY
17 ARE SAYING HERE, DO YOU UNDERSTAND THAT THEY ARE LOOKING AT
18 THREE POTENTIAL RESULTS OF INDUCED ABORTION IN A SUBSEQUENT
19 PREGNANCY? THAT IS, PRE-TERM LABOR, WHETHER THE SUBSEQUENT
20 BABY WAS BORN SMALL FOR HIS OR HER GESTATIONAL AGE, AND WHETHER
21 THE BABY HAD A LOW BIRTH WEIGHT? AS YOU ARE READING THAT
22 ABSTRACT, IS THAT HOW YOU UNDERSTAND THAT, WHAT YOU UNDERSTAND
23 THEY ARE LOOKING FOR?
24 MS. GARTNER: YOUR HONOR, OBJECTION, PLEASE. I
25 DON'T THINK IT IS FAIR TO THIS WITNESS TO ASK HIM TO COMMENT ON

1 A STUDY THAT HE HAS TESTIFIED HE HAS NEVER SEEN BEFORE, THAT IS
2 MANY PAGES LONG, BASED ON MR. SIMPSON'S HAVING READ TO HIM A
3 SUMMARY AT THE FRONT OF THE STUDY. I THINK HE REALLY NEEDS --
4 THE COURT: SUSTAINED. IF YOU WANT TO ASK HIM
5 QUESTIONS ABOUT IT YOU WILL HAVE TO LET HIM READ THE ARTICLE.
6 BY MR. SIMPSON:
7 Q. DOCTOR, IF THERE WERE A STUDY THAT WERE -- ASIDE FROM WHAT
8 THIS ARTICLE SAYS, MY QUESTION FOR YOU IS -- BEFORE -- LET ME
9 GO BACK.
10 AND IF I COULD ASK YOU, DOCTOR, TO READ SILENTLY THE
11 RESULTS AND THE CONCLUSION IN THAT ABSTRACT.
12 IN FACT, HAVE YOU ALREADY READ THAT IN THE ABSTRACT?
13 A. I READ THE CONCLUSION IN THE ABSTRACT.
14 Q. YOU READ THE CONCLUSION AND --
15 A. I READ THE CONCLUSION IN THE ABSTRACT. I AM NOT IN A
16 POSITION TO DETERMINE IF I WOULD AGREE OR DISAGREE WITH THAT
17 CONCLUSION.
18 Q. COULD YOU READ, PLEASE, DOCTOR, THE RESULTS? READ IT TO
19 YOURSELF THE RESULTS IN THE ABSTRACT.
20 HAVE YOU READ THAT, DOCTOR?
21 A. YES.
22 Q. I WOULD LIKE TO ASK YOU, DOCTOR, TO EXPLAIN TO US WHAT PART
23 OF THIS MEANS.
24 MS. GARTNER: YOUR HONOR, I AM SORRY, BUT I HAVE THE
25 CONTINUING OBJECTION THAT ASKING THIS DOCTOR TO TESTIFY ABOUT

1 THE RESULTS OF A STUDY THAT HE HAS NEVER READ --
2 THE COURT: SUSTAINED.
3 MS. GARTNER: -- SEEMS TO BE HIGHLY UNFAIR.
4 THE COURT: SUSTAINED.
5 I DON'T KNOW EXACTLY WHAT YOU ARE GETTING AT,
6 COUNSEL, BUT AS I INDICATED, IF YOU ARE GOING TO ASK HIM
7 SPECIFIC QUESTIONS ABOUT THIS STUDY YOU ARE GETTING READY TO
8 ASK HIM FOR THE MEANING OF WORDS HE HAS NEVER SEEN, MUCH LESS
9 HAD TO DO WITH PREPARING.
10 IF YOU WANT TO DO THAT, YOU ARE GOING TO HAVE TO
11 GIVE THE WITNESS AN OPPORTUNITY TO READ IT AND STUDY THE
12 ARTICLE.
13 MR. SIMPSON: IF I COULD ASK ONE GENERAL QUESTION,
14 YOUR HONOR.
15 BY MR. SIMPSON:
16 Q. DOCTOR, WOULD YOU AGREE THAT THIS IS A STUDY THAT LOOKS AT
17 WHETHER INDUCED ABORTION INCREASES THE RISK OF PRE-TERM
18 DELIVERY IN SUBSEQUENT PREGNANCIES?
19 THE COURT: I HAVE ALREADY SUSTAINED THE OBJECTION.
20 HE HAS NOT READ IT. HOW IS HE GOING TO OPINE ON SUCH A BROAD
21 QUESTION AS THAT?
22 MR. SIMPSON: OKAY.
23 BY MR. SIMPSON:
24 Q. DOCTOR, YOU YOURSELF HAVE NOT CONDUCTED ANY FORM OF
25 FOLLOW-UP WITH WOMEN WHO HAVE UNDERGONE AN INTACT D&E THROUGH

1 THEIR NEXT PREGNANCY TO SEE IF THERE MIGHT BE A HIGHER RATE OF
2 CERVICAL INCOMPETENCE OR PRE-TERM DELIVERY IN SUBSEQUENT
3 PREGNANCIES, HAVE YOU?
4 A. NO, I HAVE NOT.
5 Q. SO SITTING HERE TODAY YOU DON'T KNOW FOR SURE WHETHER D&E'S
6 THAT RESULT IN INTACT DELIVERY MIGHT LEAD TO HIGHER RATES OF
7 CERVICAL INCOMPETENCE THAN D&E'S THAT RESULT IN
8 DISARTICULATION?
9 A. I AM QUITE COMFORTABLE WITH MY STATEMENTS UP TILL 20 WEEKS,
10 AND YOU ARE JUST CAN STATING WHAT I HAVE SAID BEFORE, THAT I
11 DON'T KNOW BETWEEN 20 AND 24 WEEKS.
12 Q. YOU HAVE NEVER RESEARCHED THE LITERATURE ON THAT SUBJECT?
13 A. OBVIOUSLY, I HAVE -- AS A PRACTICING PHYSICIAN, I TRIED TO
14 KEEP ABREAST OF THE LITERATURE. I COULD NOT BE ABLE TO QUOTE
15 YOU VERBATIM ALL THE ARTICLES PERTAINING TO THAT SUBJECT, BUT I
16 THINK THERE ARE -- AND I HAVE NOT BEEN ASKED TO PROVIDE THE
17 MATERIAL AND STUDIES TO SUPPORT WHAT I THINK IS THE TENET THAT
18 I USE WHEN I PRACTICE. AND THAT IS THAT THE MODERN METHODS OF
19 HYGROSCOPIC DILATION THAT WE HAVE NO EVIDENCE BY THESE MODERN
20 METHODS IN THE UNITED STATES THAT THERE IS AN INCREASED
21 INCIDENCE OF CERVICAL INCOMPETENCE AND IMPAIRMENT OF FUTURE
22 PREGNANCY OUTCOME.
23 I WOULD HAVE TO DEFER TO OTHER EXPERTS WHO HAVE BEEN
24 ASKED TO PROVIDE THAT INFORMATION. BUT I THINK THAT IS WHAT
25 THE MAJORITY OF MY COLLEAGUES WHO PERFORM PREGNANCY

1 TERMINATIONS GO BY AS A SYNTHESIS OF WHAT WE KNOW IS IN THE
2 LITERATURE THERE. AND --
3 Q. YOU HAVE NEVER LOOKED SPECIFICALLY FOR WHETHER THERE IS
4 LITERATURE SUGGESTING THAT INDUCED ABORTION INCREASES THE RISK
5 OF PRE-TERM DELIVERY OR CERVICAL INCOMPETENCE?
6 A. I AM SURE I HAVE READ SEVERAL STUDIES ON THAT SUBJECT, AND
7 I AM AWARE OF STUDIES WHERE -- ASSOCIATIONS WERE FOUND. I AM
8 AWARE OF STUDIES WHERE ASSOCIATIONS WERE NOT FOUND.
9 AND IN MANY OF THESE CIRCUMSTANCES, RIGHT, AND A
10 RANDOMIZED CLINICAL TRIAL OR A VERY WELL CASE-CONTROLLED
11 RETROSPECTIVE STUDY IS NECESSARY TO COME UP WITH THE ANSWER OR
12 ANALYSES. BUT IT IS NOT LIKE I NEVER READ ON THIS SUBJECT.
13 Q. SO DOCTOR, YOU ARE TESTIFYING NOW THAT YOU ARE AWARE OF
14 STUDIES THAT HAVE FOUND A POSITIVE CORRELATION BETWEEN INDUCED
15 ABORTION AND SUBSEQUENT PRE-TERM BIRTH OR CERVICAL
16 INCOMPETENCE?
17 A. I AM -- OVER THE YEARS THAT I HAVE BEEN PRACTICING AND HAVE
18 PERFORMED PREGNANCY TERMINATIONS OVER THE LAST 24 YEARS THERE
19 IS ALWAYS -- THERE IS THIS QUESTION OF: WHAT ARE THE LONG-TERM
20 EFFECTS OF PREGNANCY TERMINATIONS HAS BEEN THERE. THERE HAVE
21 BEEN CONFLICTING STUDIES.
22 THERE ARE STUDIES THAT HAVE IMPLIED MECHANICAL
23 DILATATION AS BEING ASSOCIATED WITH -- ESPECIALLY WITH
24 GESTATIONS. AND I TEND TO SUPPORT IT. AT THE SAME TIME I --
25 MY UNDERSTANDING OF THE CURRENT KNOWLEDGE IS THAT WITH THE

1 MODERN METHODS UP TO 20 WEEKS THERE IS NO ASSOCIATION, AND I
2 HAVE ALREADY MENTIONED TO YOU WHAT I BELIEVE. I DON'T KNOW OR
3 WE DON'T KNOW COLLECTIVELY BETWEEN 20 AND 24 WEEKS AND HOW I
4 COUNSEL MY PATIENTS ON THAT ISSUE.
5 Q. ARE YOU AWARE OF A STUDY PUBLISHED IN 1999 BY A DR. ZHOU,
6 Z-H-O-U, ENTITLED:
7 "INDUCED ABORTION AND SUBSEQUENT PREGNANCY
8 DURATION"?
9 A. I THINK THAT IS THE ARTICLE YOU SHOWED ME BEFORE. IT IS
10 THE FIRST TIME I HAVE SEEN IT.
11 Q. DOCTOR, ISN'T IT TRUE THAT THE SERIAL USE OF LAMINARIA
12 INCREASES THE RISK OF INFECTION?
13 A. I THINK THE LONGER -- I THINK THE RISK OF INFECTION, RIGHT,
14 LIKELY WILL INCREASE WITH LENGTHS OF TIME THAT ONE WOULD USE
15 LAMINARIA FOR DILATION.
16 Q. DOCTOR, LAMINARIA SLOWLY FORCE THE CERVIX OPEN BY THEIR
17 EXPANSION, CORRECT?
18 A. CORRECT.
19 Q. WHEN YOU INSERT LAMINARIA THEY HAVE TO PASS THROUGH THE
20 INTERNAL OS OF THE CERVIX?
21 A. WELL, YOU PASS THEM THROUGH THE EXTERNAL OS AND THROUGH THE
22 INTERNAL OS, CORRECT.
23 Q. AND YOU PUSH EACH LAMINARIA IN AS FAR AS YOU CAN?
24 A. THAT'S CORRECT.
25 Q. A GOOD NUMBER OF THE LAMINARIA MAKE CONTACT WITH THE

1 AMNIOTIC MEMBRANE?
2 A. THAT'S CORRECT.
3 Q. THE PLACEMENT OF OSMOTIC DILATORS, DOCTOR, SOMETIMES CAUSES
4 THE AMNIOTIC MEMBRANE TO RUPTURE?
5 A. I HAVE SEEN THAT HAPPEN.
6 Q. AND THAT INCREASES THE RISK OF INFECTION?
7 A. THAT IS CORRECT.
8 Q. DOCTOR --
9 A. AGAIN, THAT IS DEPENDENT ON THE TIME IT TAKES FROM THAT
10 MOMENT ON UNTIL FINALIZING OF THE PROCEDURE. AND INFECTION IS
11 A RISK THAT IS ASSOCIATED WITH ANY PREGNANCY TERMINATION AND
12 WITH ANY CHILDBIRTH.
13 Q. DOCTOR, WHILE THE PATIENT IS AWAITING SERIAL DILATATION
14 WITH THE OSMOTIC DILATORS IN HER SHE EXPERIENCES UTERINE
15 CRAMPING, CORRECT?
16 A. SHE MAY OR SHE MAY NOT. THE PERCEPTION OF UTERINE CRAMPING
17 IS VERY INDIVIDUAL, AGAIN.
18 Q. DID YOU TESTIFY IN YOUR DEPOSITION, DOCTOR, THAT, YES, THE
19 PATIENT EXPERIENCES UTERINE CRAMPING DURING THAT TIME?
20 A. I DON'T KNOW WHAT I TESTIFIED IN MY DEPOSITION, BUT I AM
21 SURE I SAID THAT SOME PATIENTS MAY OR MAY NOT. WITH
22 MISOPROSTOL THERE IS CLEARLY MORE CRAMPING THAN THERE IS WITH
23 LAMINARIA.
24 Q. IF I CAN ASK YOU, DOCTOR, TO TURN TO PAGE 143 OF YOUR
25 DEPOSITION.

1 IF YOU COULD READ SILENTLY, PLEASE, PAGE 143, LINES
2 17 THROUGH 19. WE ARE SPEAKING HERE, ARE WE NOT, DOCTOR, ABOUT
3 THE PERIOD DURING WHICH THE WOMAN IS AWAITING SERIAL
4 DILATATION?
5 A. ACTUALLY, I THINK WE ARE TALKING AT THIS STAGE ABOUT
6 PATIENTS WHO ARE GOING TO HAVE A D&E PROCEDURE.
7 Q. WHO ARE AWAITING DILATATION, CORRECT?
8 A. WHO HAVE LAMINARIA PLACED OR MISOPROSTOL PLACED A COUPLE OF
9 HOURS BEFORE THE SURGICAL PROCEDURE.
10 Q. IF I COULD ASK YOU TO READ SILENTLY LINES SIX THROUGH 16,
11 AS WELL, PLEASE.
12 A. YES.
13 Q. I WILL READ THAT ALOUD, SIX THROUGH 19:
14 "QUESTION: OKAY. NOW, WHILE THE PATIENT IS
15 WAITING -- LET'S TALK PARTICULARLY ABOUT SERIAL USE
16 OF OSMOTIC DILATORS -- WHILE THE PATIENT IS WAITING
17 THROUGH EACH, YOU KNOW, DURING THE PERIOD THROUGH
18 EACH INSERTION OF LAMINARIA, DOES THE PATIENT
19 EXPERIENCE BLEEDING DURING THAT TIME?
20 "ANSWER: THEY MAY HAVE SOME SPOTTING, BUT
21 USUALLY IT IS NOT -- IF THEY HAD -- IF THIS HAPPENED
22 AWAY FROM A HEALTH CARE FACILITY AND THEY
23 EXPERIENCED SIGNIFICANT BLEEDING, THEY CERTAINLY
24 WOULD BE COUNSELED TO COME BACK.
25 "QUESTION: DOES THE PATIENT EXPERIENCE UTERINE

1 CRAMPING DURING THAT TIME?
2 "ANSWER: YES."
3 IS THAT WHAT YOU TESTIFIED, DOCTOR?
4 A. I OBVIOUSLY DID.
5 Q. DOCTOR, THE PLACEMENT OF OSMOTIC DILATORS SOMETIMES CAUSES
6 THE WOMAN TO GO INTO LABOR, CORRECT?
7 A. YES, IT CAN.
8 Q. DOCTOR, TURNING A FETUS FROM A HEADFIRST PRESENTATION TO A
9 BREECH PRESENTATION, WHEN THAT IS DONE AT PART OF CHILDBIRTH AT
10 TERM, THAT IS CLEARLY ASSOCIATED WITH CAUSING UTERINE RUPTURE,
11 CORRECT?
12 A. ESPECIALLY AFTER THE MEMBRANES HAVE BEEN RUPTURED, CORRECT.
13 Q. BUT IT WOULD NOT BE POSSIBLE TO TURN THE FETUS BY REACHING
14 IN THROUGH THE CERVIX UNLESS THE MEMBRANES HAVE RUPTURED?
15 A. ACTUALLY, THE ORIGINAL INTERNAL PODALIC VERSION, RIGHT, IS
16 DESCRIBED TO ENTER, TO ACTUALLY TRY TO FIND A FOOT, WHILE THE
17 MEMBRANES ARE STILL INTACT, GRAB THE FOOT, THEN RUPTURE THE
18 MEMBRANES, AND THEN DO THE INTERNAL PODALIC VERSION, BECAUSE
19 THAT WOULD REDUCE THE -- FIRST OF ALL, INCREASE THE SUCCESS OF
20 THAT MANEUVER. BUT IT WOULD REDUCE THE RISK OF, YOU KNOW,
21 CAUSING AN UTERINE RUPTURE.
22 Q. BUT, NEVERTHELESS, WHEN THAT IS DONE AT TERM, IT IS CLEARLY
23 ASSOCIATED WITH CAUSING UTERINE RUPTURE?
24 A. UTERINE RUPTURE -- UTERINE RUPTURE CAN OCCUR DURING THE
25 PROCESS OF INTERNAL PODALIC VERSION OR TURN. NOW, I HAVE NOT

1 DONE AN INTERNAL --
2 THE COURT: I AM SORRY. I DON'T UNDERSTAND YOU.
3 THE WITNESS: THIS KIND OF RUPTURE CAN OCCUR AS A
4 RESULT OF INTERNAL PODALIC VERSION AT TERM.
5 BY MR. SIMPSON:
6 Q. IF I CAN REFER YOU, PLEASE, TO YOUR DEPOSITION, DOCTOR. DO
7 YOU STILL HAVE THAT IN FRONT OF YOU? PAGE 164, PLEASE?
8 IF YOU COULD READ SILENTLY, PLEASE, PAGE 164,
9 LINE 24 THROUGH PAGE 165, LINE 5.
10 A. WHAT LINES?
11 Q. I AM SORRY. 164, LINE 24 THROUGH 165, LINE 5.
12 MS. GARTNER: OBJECTION, YOUR HONOR. I DON'T SEE
13 HOW THAT IS IMPEACHING THE TESTIMONY THAT DR. BROEKHUIZEN HAS
14 JUST PRESENTED.
15 THE COURT: CAN YOU EXPLAIN?
16 MR. SIMPSON: I BELIEVE I HAVE ASKED TWO OR THREE
17 TIMES, YOUR HONOR, FOR THE DOCTOR TO CONFIRM THAT INTERNAL
18 PODALIC VERSION IS CLEARLY ASSOCIATED WITH UTERINE RUPTURE.
19 AND I BELIEVE HE HAS REFUSED TO GO ALONG WITH THAT TWICE.
20 THE COURT: I DON'T BELIEVE -- WHY DON'T YOU REPEAT
21 THE QUESTION THAT YOU BELIEVE HE DIDN'T ANSWER.
22 MR. SIMPSON: CERTAINLY.
23 THE COURT: CONSISTENTLY.
24 BY MR. SIMPSON:
25 Q. DOCTOR, IS IT TRUE THAT TURNING THE LIE OF THE FETUS FROM

1 HEADFIRST TO BREECH WHEN THAT IS DONE AT TERM, IS IT TRUE THAT
2 THAT IS CLEARLY ASSOCIATED WITH CAUSING UTERINE RUPTURE?
3 A. I THINK I HAVE TESTIFIED EARLIER TODAY AND ONLY A FEW
4 MINUTES AGO THAT THE RISK OF INTERNAL PODALIC VERSION, ONE OF
5 THE RISKS IS AN UTERINE RUPTURE.
6 Q. AND DOCTOR, IS IT ALSO TRUE THAT TURNING THE LIE OF THE
7 FETUS AT TERM IS ALSO CLEARLY ASSOCIATED WITH ABRUPTION OF THE
8 PLACENTA?
9 A. I THINK I TESTIFIED EARLIER TO THAT TODAY, A TURN, THAT
10 THAT WOULD BE THE CASE.
11 Q. ABRUPTION OF THE PLACENTA MEANS A SHEARING OF THE PLACENTA
12 FROM THE UTERINE WALL, CORRECT?
13 A. THAT'S CORRECT.
14 Q. ABRUPTION OF THE PLACENTA CAUSES INTERNAL BLEEDING?
15 A. THAT'S CORRECT.
16 Q. NOW, DOCTOR, YOU DON'T KNOW OF ANY STUDIES ON WHETHER
17 CHANGING THE LIE OF THE FETUS IN AN ABORTION PRESENTS RISKS TO
18 THE MOTHER, DO YOU?
19 A. MY ANSWER TO THIS QUESTION IS THE SAME AS THE ANSWER I GAVE
20 TO THE QUESTIONS REGARDING THE MARCIE-SMELLIE-VEIT PROCEDURE
21 AND SOME OF THE OTHER OBSTETRICAL PROCEDURES THAT ARE BEING
22 USED AT TERM, AT LATER GESTATIONS.
23 AND I DO NOT SEE HOW THEY COULD APPLY TO ANY
24 PROCEDURE THAT COULD OCCUR DURING D&E PROCEDURE OF LESS THAN 20
25 TO 24 WEEKS. AND IN THE CONTEXT OF AN INDUCTION, I THINK THESE

1 PROCEDURES WOULD BE IMPOSSIBLE TO BE DONE BECAUSE ONE REQUIRES
2 SIGNIFICANT DILATATION TO PLACE A HAND THROUGH THE CERVIX.
3 MR. SIMPSON: YOUR HONOR, I WOULD LIKE TO REPEAT THE
4 QUESTION THAT I HAVE ASKED THE WITNESS. AND THEN I WOULD LIKE
5 TO MOVE THE HAVE THE ANSWER STRICKEN AS NONRESPONSIVE. MY
6 QUESTION WAS:
7 "YOU DON'T KNOW OF ANY STUDIES ON WHETHER
8 CHANGING THE LIE OF THE FETUS IN AN ABORTION
9 PRESENTS RISKS TO THE MOTHER?"
10 THE COURT: ALL RIGHT. YOUR REQUEST IS GRANTED.
11 THE ANSWER IS UNRESPONSIVE.
12 ARE YOU AWARE OF STUDIES? THAT IS WHAT HE IS ASKING
13 YOU FOR. THAT SEEMS TO BE A "YES" OR "NO."
14 THE WITNESS: I AM NOT AWARE OF ANY STUDIES, BUT I
15 HAVE LOOKED AT THAT QUESTION, NOR DO I SEE A NEED FOR IT.
16 MR. SIMPSON: THANK YOU, DOCTOR.
17 BY MR. SIMPSON:
18 Q. DOCTOR, WHERE YOU USE A SURGICAL PROCEDURE FOR ABORTION IN
19 WHICH YOU PURPOSEFULLY DELIVER THE FETUS INTACT UP TO THE
20 HEAD -- I BELIEVE WE HAVE TALKED ABOUT THIS EARLIER -- YOU
21 SOMETIMES INSERT A SHARP INSTRUMENT INTO THE FETAL SKULL TO
22 REMOVE THE BRAIN TISSUE BEFORE DELIVERING THE HEAD, CORRECT?
23 A. THAT'S CORRECT.
24 Q. THE FETAL HEAD IS LODGED IN THE WOMAN'S CERVIX WHEN YOU
25 INSERT THAT SHARP INSTRUMENT, CORRECT?

1 A. THAT'S CORRECT.
2 Q. DOCTOR, IF YOU ACCIDENTALLY PUSHED THAT SHARP INSTRUMENT
3 INTO THE MOTHER'S BODY, YOU COULD PERFORATE THE UTERUS AND
4 CAUSE SIGNIFICANT BLEEDING, CORRECT?
5 A. IF ONE MISPLACED THE INSTRUMENT IN THE WRONG SPOT WITHOUT
6 DIRECT OBSERVATION OR VISUALIZATION, I THINK THAT WOULD BE
7 POSSIBLE. BUT THAT'S NOT GOING TO HAPPEN GIVEN THE SCENARIO I
8 WILL BE USING THAT INSTRUMENT.
9 Q. DOCTOR, IF I COULD REFER YOU TO YOUR DEPOSITION, PLEASE.
10 PAGE 168.
11 PAGE 168, IF YOU COULD READ SILENTLY LINE 23 THROUGH
12 PAGE 169, LINE 9.
13 A. WHICH LINE SHOULD I READ?
14 Q. 168, LINE 23?
15 A. OKAY.
16 Q. THROUGH 169, LINE 9. OKAY. IF I COULD READ THAT OUT LOUD.
17 "QUESTION: YOU SAID IT'S PREFERABLE TO BE
18 ABLE TO SEE IF YOU ARE USING A TROCAR OR SOMETHING
19 LIKE THAT. WHY WOULD IT BE PREFERABLE TO SEE?
20 "ANSWER: BECAUSE YOU WANT TO KNOW EXACTLY
21 WHERE YOU GUIDE AND DIRECT THE TROCAR TO.
22 "QUESTION: WOULD IT BE POSSIBLE IN THOSE
23 CIRCUMSTANCES TO INJURE THE MOTHER WITH THE TROCAR?
24 "ANSWER: SURE, IT'S POSSIBLE.
25 "QUESTION: WHAT WOULD HAPPEN IF YOU WERE TO

1 PUSH THE TROCAR INTO THE MOTHER'S BODY?
2 "ANSWER: YOU COULD HAVE -- YOU COULD
3 PERFORATE HER UTERUS. YOU COULD CAUSE SIGNIFICANT
4 BLEEDING."
5 IS THAT WHAT YOU TESTIFIED, DOCTOR?
6 YES OR NO?
7 A. YES, I DID, BUT I WAS ANSWERING YOUR HYPOTHETICALS.
8 Q. IN FACT, THE MAIN UTERINE ARTERY IS RIGHT THERE AT THE
9 CERVIX, CORRECT?
10 A. NO, YOU ARE NOT CORRECT.
11 Q. ARE YOU SAYING THAT THE MAIN UTERINE ARTERY IS NOT AT THE
12 CERVIX?
13 A. THERE ARE TWO MAIN UTERINE ARTERIES AND THEY ARE LATERAL TO
14 THE CERVIX. AND THE SCENARIO WHERE THE BODY OF THE TRUNK IS
15 DELIVERED AND THE HEAD IS LODGED INTO THE CERVIX, THE PLACE
16 THAT ONE WOULD PLACE THE TROCAR WOULD BE AT 12:00 O'CLOCK, NOT
17 AT FOUR AND 8:00 O'CLOCK.
18 Q. SO THE UTERINE ARTERY IS AT FOUR AND 8:00 O'CLOCK. UTERINE
19 ARTERIES ARE AT FOUR AND 8:00 O'CLOCK?
20 A. AND 8:00 O'CLOCK. AND SO THE PLACEMENT OF THE TROCAR WOULD
21 BE AT 12:00 O'CLOCK AS I -- IF THERE WOULD BE A -- IF UNDER
22 DIRECT PALPATION AND VISUALIZATION THE ODDS OF INJURING THE
23 MOTHER WOULD BE CLOSE TO NIL. BUT NOTHING IS EVER IMPOSSIBLE
24 IN MEDICAL PRACTICES.
25 Q. DOCTOR --

1 A. SECONDLY, IT WOULD NOT COME CLOSE. THE INJURY WOULD NOT
2 COME CLOSE TO THE LEFT AND RIGHT UTERINE ARTERY.
3 Q. DOCTOR, YOU HAVE GIVEN AN INJECTION OF DIGOXIN TO CAUSE
4 FETAL DEMISE BEFORE AN INDUCTION ABORTION AT LEAST 30 OR 40
5 TIMES?
6 A. THAT'S CORRECT.
7 Q. NOW, YOU WOULDN'T, OF COURSE, DO THAT IF YOU THOUGHT THE
8 INJECTION WAS UNSAFE TO THE MOTHER?
9 A. THAT'S TRUE.
10 Q. DOCTOR, IN THE TIMES THAT YOU'VE USED DIGOXIN FOR FETAL
11 DEMISE YOU HAVE NEVER SEEN ANY MATERNAL COMPLICATIONS FROM ITS
12 USE?
13 A. I HAVEN'T.
14 Q. YOU THINK THAT THERE WOULD RARELY BE ANY SIGNIFICANT RISK
15 TO THE MOTHER EVEN IF THE DIGOXIN WAS ACCIDENTALLY INJECTED IN
16 THE MATERNAL BLOODSTREAM?
17 A. I THINK THAT IS CORRECT WITH THE DOSE WE USE.
18 Q. YOU HAVE ALWAYS INJECTED DIGOXIN INTO THE AMNIOTIC FLUID,
19 CORRECT, NEVER INTO THE HEART?
20 A. THAT'S CORRECT.
21 Q. ALL RIGHT. DOCTOR, THE EFFECTIVENESS OF CAUSING FETAL
22 DEMISE IN THAT WAY IS PRETTY GOOD, ISN'T IT?
23 A. IT'S -- I DO NOT KNOW IN MY OWN EXPERIENCE HOW THE
24 EFFECTIVENESS IS, BECAUSE I HAVEN'T STUDIED IT. BUT I HAVE HAD
25 AT LEAST TWO FAILURES. I AM -- I KNOW THERE IS LITERATURE OUT

1 THERE THAT WILL BE ABLE TO TELL US THE EFFECT OF THIS, BUT I
2 COULDN'T QUOTE IT RIGHT AT THIS MOMENT OFF THE TOP OF MY HEAD.
3 BUT I THINK IT IS QUITE EFFECTIVE.
4 Q. IF I CAN REFER YOU, PLEASE, DOCTOR, TO PAGE 29 OF YOUR
5 DEPOSITION. I AM SORRY. I SAID "29," 209. IF YOU COULD READ
6 SILENTLY, DOCTOR, PAGE 209, LINES 10 THROUGH 15.
7 A. WHAT NUMBER?
8 Q. PAGE 209, LINES 10 THROUGH 15.
9 A. OKAY.
10 Q. IT SAYS:
11 "QUESTION: WITH DIGOXIN, WHY HAVE YOU NOT USED
12 INTRACARDIAC INJECTION?
13 "ANSWER: BECAUSE I NEVER REALLY SAW -- I THINK
14 THE EFFECTIVENESS OF CAUSING FETAL DEATH IS PRETTY
15 GOOD. IN COMBINATION WITH MISOPROSTOL IT WOULD BE
16 VERY RARE THAT IT WOULD FAIL."
17 DID YOU SAY THAT IN YOUR DEPOSITION, DOCTOR?
18 A. YES, I DID.
19 Q. DOCTOR, YOU WOULD AGREE, WOULD YOU NOT, THAT THE
20 PARTIAL-BIRTH ABORTION BAN ACT WOULD NOT APPLY WHERE THE
21 PHYSICIAN HAS CAUSED FETAL DEMISE BEFORE ENTERING THE UTERUS?
22 A. I WOULD AGREE WITH THAT.
23 Q. DOCTOR, YOUR DECLARATION IN THIS CASE -- I BELIEVE WE READ
24 THIS SENTENCE TOGETHER BEFORE. YOUR DECLARATION, PARAGRAPH 17,
25 SAYS:

1 "THERE HAVE BEEN OTHER OCCASIONS WHERE IT HAS
2 BEEN MY MEDICAL JUDGMENT THAT AN ABORTION IN WHICH I
3 PURPOSELY DELIVER THE FETUS INTACT UP TO THE HEAD
4 WOULD BE THE SAFEST AND BEST PROCEDURE FOR MY
5 PATIENT"; IS THAT CORRECT?
6 A. THAT'S CORRECT.
7 Q. NOW, OBVIOUSLY, DOCTOR, SINCE YOU WROTE THAT, IT IS CLEAR
8 TO YOU WHAT IT SAYS, CORRECT?
9 IN OTHER WORDS, YOU THINK THAT LANGUAGE IS CLEAR?
10 A. I BETTER READ IT BEFORE I SAY "YES" TO THAT.
11 THE COURT: WHAT WAS THE PARAGRAPH?
12 MR. SIMPSON: SEVENTEEN, YOUR HONOR.
13 BY MR. SIMPSON:
14 Q. YOU ARE TALKING JUST ABOUT THE FIRST SENTENCE OF THAT
15 PARAGRAPH 17, DOCTOR?
16 A. CORRECT.
17 Q. OBVIOUSLY, SINCE YOU WROTE THAT IT IS CLEAR TO YOU WHAT IT
18 SAYS?
19 A. IT IS CLEAR WHAT IT SAYS.
20 Q. DOCTOR, YOU WERE TESTIFYING EARLIER REGARDING THE LANGUAGE
21 OF THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003. AND AM I
22 CHARACTERIZING YOUR TESTIMONY CORRECTLY IF I SAY THAT YOU FIND
23 THE FOLLOWING LANGUAGE FROM THE STATUTE TO BE UNCLEAR, QUOTE:
24 "THE PERSON PERFORMING THE ABORTION
25 DELIBERATELY AND INTENTIONALLY VAGINALLY DELIVERS A

1 LIVING FETUS," CLOSE QUOTE.
2 YOU FIND THAT TO BE VAGUE?
3 A. I DON'T KNOW WHERE THAT LANGUAGE IS COMING FROM THAT YOU
4 ASK ME TO COMMENT ON NOW.
5 Q. IF I COULD USE PLAINTIFFS' DEMONSTRATIVE EXHIBIT HERE.
6 THIS IS PART OF THE LANGUAGE OF THE PARTIAL-BIRTH ABORTION BAN
7 ACT. AND THERE WHERE IT SAYS PARENTHESIS, "(A)," CLOSE
8 PARENTHESIS, RIGHT BEFORE THAT IT SAYS:
9 "A PERSON PERFORMING THE ABORTION DELIBERATELY
10 AND INTENTIONALLY VAGINALLY DELIVERS A LIVING
11 FETUS."
12 IS THAT LANGUAGE CLEAR TO YOU --
13 A. WELL, I THINK I UNDERSTAND THE LANGUAGE. I THINK IT'S --
14 IT SELDOM IS DELIBERATELY. WHAT IS FAKE ABOUT IT WOULD SUGGEST
15 THAT IN ALL THE CASES -- IN THE CASES THAT I CONSIDERED INTACT
16 D&E THAT THE PURPOSE WAS TO DELIBERATELY DELIVER THE FETUS
17 UNTIL THE HEAD WAS THERE WAS THE INTENT PURPOSE OF DOING -- OF
18 GOING TO THE OVERT ACT.
19 Q. WE ARE TALKING NOW, DOCTOR, ABOUT THE FIRST PART OF THAT
20 LANGUAGE WHEN IT SAYS:
21 "THE PERSON PERFORMING THE ABORTION
22 DELIBERATELY AND INTENTIONALLY VAGINALLY DELIVERS A
23 LIVING FETUS."
24 ARE YOU SAYING THAT THAT IS CLEAR TO YOU?
25 A. I GUESS IT IS CLEAR TO ME.

1 Q. OKAY. GOOD. THANK YOU. DOCTOR.
2 THE COURT: ALL RIGHT.
3 ANY REDIRECT?
4 MS. GARTNER: YES, YOUR HONOR. SORRY.
5 THE COURT: I UNDERSTOOD THAT YOU HAD YET ANOTHER
6 WITNESS FOR TODAY.
7 MS. GARTNER: WE DO, YOUR HONOR. I THINK IT IS
8 IMPORTANT, THOUGH, BECAUSE I WILL TRY TO KEEP THE REDIRECT --
9 THE COURT: I DIDN'T SAY ANYTHING. JUST KEEP GOING.
10 MS. GARTNER: WE DO, YOUR HONOR. BUT HE CAN ALSO
11 COME BACK TOMORROW MORNING.
12 REDIRECT EXAMINATION
13 BY MS. GARTNER:
14 Q. DR. BROEKHUIZEN, I WANT TO JUST GO BACK OVER SOME OF THE
15 DEPOSITION PASSAGES THAT YOU WENT OVER WITH MR. SIMPSON,
16 BECAUSE I THINK THERE WERE ANSWERS IN THE SURROUNDING PARTS
17 THAT MAYBE CLARIFIED SOME OF YOUR ANSWERS.
18 SO IF YOU WOULD TURN BACK TO YOUR DEPOSITION TO THE
19 BOTTOM OF PAGE 52 AND THE TOP OF PAGE 53, EARLY ON DURING THE
20 CROSS-EXAMINATION MR. SIMPSON WAS ASKING YOU ABOUT INSTRUMENTS
21 THAT YOU USE AND WHETHER THEY ARE USED FOR DISMEMBERING THE
22 FETUS.
23 AND I WONDER IF YOU COULD JUST READ THE ANSWER THAT
24 YOU GAVE THAT BEGINS ON THE TOP OF PAGE 53, STARTING WITH
25 LINE 3 THROUGH THE END OF THAT ANSWER.

1 FIFTY-THREE, LINE 3.
2 A. YOU WANT ME TO READ IT?
3 Q. IF YOU WOULD, OUT LOUD, PLEASE.
4 A. "WELL, WHEN YOU DO A D&E PROCEDURE YOU WILL USE THE SOFTER
5 INSTRUMENTS TO GRIP WHATEVER PART ONE CAN FIND
6 CLOSE TO THE CERVIX, AND YOU BASICALLY PULL IT. THE
7 PURPOSE IS NOT NECESSARILY DISARTICULATION AND
8 DISMEMBERMENT. IT'S TO BRING THE FETUS AS FAR AS
9 POSSIBLE THROUGH THE CERVICAL WALLS AND DURING THE
10 PROCESS DISMEMBERMENTS OR DISARTICULATION OR
11 DECOMPRESSION WILL OCCUR. SO THE INSTRUMENT IS
12 REALLY MORE USED AS AN EXTRACTION. PRIMARILY, THE
13 FIRST FUNCTION IS EXTRACTION. THE SECOND PART MAY
14 BE DISARTICULATION OR DISMEMBERMENT.
15 Q. THANK YOU. AND THEN, DR. BROEKHUIZEN, IF YOU COULD GO TO
16 PAGE 169 OF YOUR DEPOSITION. YOU AND MR. SIMPSON TALKED ABOUT
17 THE POSSIBILITY THAT YOU COULD INJURE THE WOMAN IN USING THE
18 TROCAR. I THINK WITH MR. SIMPSON YOU READ FROM THE TOP OF
19 PAGE 169 THROUGH LINE 9. AND LET ME JUST READ TO YOU THE
20 QUESTION THAT BEGINS AT LINE 10:
21 "HAVE YOU IN INSTANCES IN WHICH YOU'VE USED A
22 TROCAR OR SIMILAR INSTRUMENT TO EXTRACT THE CONTENTS
23 OF THE SKULL, HAVE THERE BEEN INSTANCES WHEN YOU'VE
24 DONE THAT WHEN YOU COULD NOT SEE WHERE YOU ARE
25 PUSHING IT IN?"

1 AND WHAT WAS YOUR RESPONSE?
2 A. "NO. I HAVE NEVER DONE THAT. I HAVE ALWAYS KNOWN WHERE I
3 INSERTED IT."
4 Q. AND IN YOUR DEPOSITION, MR. SIMPSON ASKED:
5 "KNOWN BY SEEING IT"?
6 AND WHAT DID YOU RESPOND?
7 A. "BY SEEING IT."
8 Q. THANK YOU.
9 YOU ALSO DISCUSSED WITH MR. SIMPSON YOUR USE OF
10 DIGOXIN WITH SOME PATIENTS; IS THAT CORRECT? AND THAT IS ON
11 PAGES 208 AND 209 OF YOUR DEPOSITION.
12 AND DOWN ON LINE -- WITH MR. SIMPSON, YOU READ THE
13 BEGINNING OF THE ANSWER TO THE QUESTION THAT BEGINS ON LINE 12
14 OF PAGE 209.
15 A. YES.
16 Q. COULD YOU READ THE CONTINUATION OF THAT ANSWER WHICH BEGINS
17 ON LINE 15 WHERE IT BEGINS "SECONDLY"? IF YOU CAN JUST READ
18 THAT OUT LOUD THROUGH LINE 22.
19 A. "SECONDLY, IF IT WERE TO OCCUR, IT WAS SOMETHING THAT THE
20 PATIENTS WERE AWARE OF IN TRYING TO INJECT DIGOXIN
21 UNDER ULTRASOUND GUIDANCE REQUIRES SIGNIFICANTLY
22 MORE PERSONNEL AND EXPERTISE. AND IT IS NOT THAT I
23 WOULDN'T HAVE THE SKILL TO DO THAT, BUT IT WOULD
24 ONLY ADD TO THE PROCEDURE. AND IN MY COUNSELING OF
25 PATIENTS MANY PATIENTS DON'T REALLY WANT THAT. IN

1 WISCONSIN ONE OF THE" --
2 Q. ACTUALLY THAT IS OKAY.
3 AND WHAT WERE YOU -- WHEN YOU SAY -- WHEN YOU ARE
4 TALKING ABOUT SOMETHING WOULD ADD TO THE SKILL OR THAT
5 SOMETHING WOULD ADD TO THE COMPLICATION OF THE PROCEDURE, WHAT
6 WERE YOU REFERRING TO?
7 A. THIS ANSWER WAS REALLY IN ANSWER TO THE QUESTION DOES
8 DIGOXIN NOT USED INTRACARDIAC INJECTION. AND SO THIS WAS NOT
9 THE QUESTION TO BE INTRA-AMNIOTIC.
10 Q. AND IS IT RIGHT THAT WITH THE INTRA-AMNIOTIC INJECTION YOU
11 HAD TWO FAILURES WHERE YOU KNEW THE DIGOXIN DID NOT WORK?
12 A. THAT'S CORRECT.
13 Q. DID YOU TESTIFY TO THAT IN YOUR DEPOSITION AT THE BOTTOM OF
14 PAGE 208?
15 A. YES, I DID.
16 Q. OKAY. I WANT TO CLARIFY, DR. BROEKHUIZEN, A LITTLE BIT
17 ABOUT YOUR MEDICAL PRACTICE. IF A WOMAN WERE OVER 24 WEEKS
18 PREGNANT AND NEEDED TO END HER PREGNANCY DUE TO A MATERNAL
19 HEALTH CONDITION, WHAT WOULD YOU DO? HOW WOULD YOU TREAT THAT
20 SITUATION?
21 A. WELL, I WOULD -- AFTER 24 WEEKS I WOULD HAVE TWO PATIENTS.
22 I WOULD HAVE THE UNBORN AND I WOULD HAVE THE MOTHER. DIFFERENT
23 HEALTH CONDITIONS WOULD HAVE DIFFERENT URGENCIES FOR DELIVERY.
24 BUT EVEN IN SOME OF THE URGENT SITUATIONS THERE MAY BE ENOUGH
25 TIME TO ACTUALLY GIVE STEROIDS TO THE MOTHER TO IMPROVE THE

1 OUTCOME FOR THE NEONATE. THEN ONE WOULD HAVE TO MAKE A
2 DECISION ABOUT WHAT WOULD BE THE SAFEST METHOD OF DELIVERY.
3 AND THAT WOULD AGAIN BE THE CESAREAN SECTION VERSUS THE VAGINAL
4 DELIVERY, WHICH IN THAT CASE WOULD BE INDUCTION METHOD, BUT A
5 VERY DIFFERENT INDUCTION METHOD WITH MUCH MORE PHYSIOLOGICAL
6 UTILIZATION OF OXYTOCIC DRUGS. AND THE POINT WOULD BE TO END
7 THE PREGNANCY AND UNDO THE RISK FOR THE MOTHER. AND AT THE
8 SAME TIME OPTIMIZE THE OUTCOME FOR THE NEONATE.
9 Q. IF YOU ARE ENDING A PREGNANCY AFTER 24 WEEKS BECAUSE OF A
10 MATERNAL HEALTH CONDITION, DO YOU EVER USE A DESTRUCTIVE ACT
11 WITH RESPECT TO THE FETUS?
12 A. I WOULD NEVER USE A DESTRUCTIVE ACT. ONLY TIME I WOULD
13 USE -- WOULD USE THE WORD PREGNANCY'S TERMINATION" OR INDUCTION
14 WITH PALLIATIVE CARE BEING IN THE CONTEXT OF LETHAL FETAL
15 ANOMALY.
16 Q. SO TO CLARIFY THAT, YOU DO ON OCCASION END A PREGNANCY FOR
17 A LETHAL FETAL ANOMALY AFTER 24 WEEKS?
18 A. THAT'S CORRECT.
19 Q. AND HOW, IN THOSE INSTANCES, IN YOUR PRACTICE, HOW WOULD
20 YOU GO ABOUT DOING -- JUST VERY BRIEFLY, HOW DO YOU END THE
21 PREGNANCY FOR A LETHAL FETAL ANOMALY AFTER 24 WEEKS?
22 A. ALMOST EXCLUSIVELY THAT WOULD BE AN INDUCTION METHOD.
23 PRETEND THERE ARE THESE SITUATIONS WHERE ONE WOULD HAVE TO
24 POTENTIALLY CONVERT TO A D&E PROCEDURE OR TO SOME ELEMENTS OF A
25 D&E PROCEDURE OR WHERE ONE CAN ANTICIPATE A DISPROPORTION

1 DURING VAGINAL BIRTH WOULD REQUIRE A DECOMPRESSING METHOD AS
2 DESCRIBED IN THE HYDROCEPHALY OR IN THE FETAL ASCITES OR
3 NONIMMUNE HYDROPS EARLIER TODAY.
4 Q. BUT THOSE ARE ALL LETHAL FETAL ANOMALIES; IS THAT CORRECT?
5 A. THOSE ARE LETHAL FETAL ANOMALY. AND IN MY INSTITUTION, IN
6 FROEDTERT HOSPITAL THAT WOULD BE THE RULE. ALL OF THOSE
7 PATIENTS ACTUALLY WOULD HAVE HAD CONSULTATIONS BY A
8 NEONATOLOGIST AND BY PEDIATRIC SUBSPECIALTIES IN REGARDS TO
9 CONDITION OF THE FETUS AND WHAT THEY COULD EXPECT AS FAR AS
10 WHEN DEATH WOULD OCCUR AND WHAT KIND OF SUPPORTIVE CARE UNTIL
11 DEATH WOULD BE PROVIDED.
12 Q. AND HAVE YOU EVER DONE AN ABORTION FOR A NONLETHAL FETAL
13 ANOMALY AFTER 24 WEEKS?
14 A. NEVER.
15 Q. JUST SPECIFICALLY WITH RESPECT TO THE SCENARIO THE PATIENT
16 YOU TALKED ABOUT WHO -- WHERE THE FETUS WAS EXTREMELY
17 MACROCEPHALIC AND SHE WAS APPROXIMATELY 28 WEEKS PREGNANT AND
18 YOU TO USE THE TROCAR TO REDUCE THE SIZE OF THE FETAL HEAD, WAS
19 THAT A LETHAL FETAL ANOMALY IN HER INSTANCE?
20 A. YES, IT WAS.
21 Q. AND WAS THAT -- WHAT WAS -- WHAT -- WAS THERE SOMETHING
22 BESIDES HYDROCEPHALY THAT MADE THIS LETHAL?
23 A. IT WAS LETHAL CHROMOSOMAL ANOMALY. I FORGET. IT WAS 13 OR
24 18. IT WAS ONE OF THOSE.
25 Q. AND DOES THAT MEAN TRISOMY 13 OR TRISOMY 18?

1 A. CORRECT.

2 Q. AND ALSO, JUST TO CLARIFY THE RECORD, DR. BROEKHUIZEN, IN
3 THE DISCUSSION WITH MR. SIMPSON ABOUT CERVICAL IMPACTS OF
4 ABORTION PROCEDURES, YOU USED TWO PHRASES. YOU USED A PHRASE
5 "MECHANICAL DILATION," AND ALSO USED THE "HYGROSCOPIC
6 DILATION."

7 A. HYGROSCOPIC.

8 Q. HYGROSCOPIC.

9 A. H-Y-G-R-O-S-C-O-P-I-C.

10 Q. OKAY. CAN YOU JUST BRIEFLY TELL US WHAT MECHANICAL
11 DILATION IS AND WHAT HYGROSCOPIC DILATION IS?

12 A. HYGROSCOPIC DILATION WOULD BE THE USE OF LAMINARIA OR
13 DILAPAN WHERE THE JAPANESE SEAWEED OR THE SYNTHETIC MATERIAL
14 SWELLS UP AND THEREBY DILATES THE CERVIX. MECHANICAL DILATION
15 MEANS UTILIZING METAL DILATORS WITH INCREASING DIAMETER TO
16 FORCIBLY DILATE THE CERVIX TO ACHIEVE A CERTAIN AMOUNT OF
17 DILATATION.

18 Q. IN THE D&E PROCEDURES THAT YOU TYPICALLY DO, DO YOU USE
19 MECHANICAL DILATION?

20 A. ON RARE OCCASIONS I HAD TO USE A MECHANICAL DILATOR TO ADD
21 TO SOME OF THE DILATION. I MUST SAY THAT SINCE WE HAVE USED --
22 MISOPROSTOL HAS BEEN AROUND AND IT'S COMBINATION OF LAMINARIA
23 AND MISOPROSTOL, I HAVE TO GO BACK A GOOD NUMBER OF YEARS IN
24 HISTORY WHERE I ACTUALLY HAD TO USE MECHANICAL DILATATION IN
25 D&E'S UP TO 20 WEEKS.

1 MS. GARTNER: THANK YOU, DOCTOR.
2 NOTHING FURTHER, YOUR HONOR.
3 THE COURT: ANYTHING FURTHER?
4 MR. SIMPSON: NO QUESTIONS.
5 THE COURT: DOCTOR, YOU ARE EXCUSED NOW. THANK YOU.
6 WE WILL TAKE OUR 15-MINUTE BREAK, AND THEN I AM WILLING TO GO
7 TO FOUR IF YOU WANT TO GET STARTED ON YOUR NEXT WITNESS.
8 MS. GARTNER: THANK YOU, YOUR HONOR.
9 THE COURT: ALL RIGHT.
10 (RECESS TAKEN AT 2:35 P.M.)
11 (PROCEEDINGS RESUMED AT 2:48 P.M.)
12 THE COURT: ALL RIGHT. YOU MAY PROCEED.
13 MS. KRASNOFF: YOUR HONOR, THE PLAINTIFFS CALL
14 DR. MITCHELL CREININ.
15 THE CLERK: PLEASE RAISE YOUR RIGHT HAND.
16 MITCHELL CREININ,
17 CALLED AS A WITNESS FOR THE PLAINTIFF, HAVING BEEN DULY SWORN,
18 TESTIFIED AS FOLLOWS:
19 THE WITNESS: I DO.
20 THE CLERK: PLEASE TAKE THE STAND.
21 PLEASE STATE YOUR NAME FOR THE COURT.
22 THE WITNESS: MITCHELL CREININ, C-R-E-I-N-I-N.
23 DIRECT EXAMINATION
24 BY MS. KRASNOFF:
25 Q. GOOD AFTERNOON, DR. CREININ.

1 MS. KRASNOFF: YOUR HONOR, MAY I APPROACH THE
2 WITNESS?
3 THE COURT: YES.
4 BY MS. KRASNOFF:
5 Q. DR. CREININ, I AM HANDING YOU WHAT IS EXHIBIT 28, WHICH IS
6 A COPY OF YOUR CURRICULUM VITAE.
7 DID YOU PREPARE THIS DOCUMENT?
8 A. YES, I DID.
9 Q. IS THE INFORMATION ON THIS TRUE AND CORRECT?
10 A. IT IS TRUE AND CORRECT THROUGH JANUARY 15TH, 2004.
11 SUBSEQUENTLY, I HAVE BEEN PROMOTED TO PROFESSOR OF
12 EPIDEMIOLOGY IN THE GRADUATE SCHOOL OF PUBLIC HEALTH AT THE
13 UNIVERSITY OF PITTSBURGH, COINCIDENT WITH MY PROMOTION TO
14 PROFESSOR IN MY PRIMARY DEPARTMENT, AND THERE IS A FEW
15 PUBLICATIONS THAT WERE IN PRESS THAT ARE NOW PUBLISHED, AND A
16 FEW MORE THAT ARE IN PRESS, AND A FEW MORE STUDIES THAT I HAVE
17 FUNDING FOR.
18 Q. AND WITH THOSE EXCEPTIONS, IS THIS ACCURATE?
19 A. YES, IT IS.
20 MS. KRASNOFF: WE WOULD LIKE TO MOVE EXHIBIT 28,
21 DR. CREININ'S C.V. INTO EVIDENCE.
22 MS. CLARK: NO OBJECTION.
23 THE COURT: ALL RIGHT.
24 THE CLERK: 28 INTO EVIDENCE.
25

1 (PLAINTIFFS' EXHIBIT 28
2 RECEIVED IN EVIDENCE)
3 BY MS. KRASNOFF:
4 Q. YOU CAN JUST LEAVE THAT UP THERE.
5 DR. CREININ, WHERE DID YOU DO YOUR MEDICAL TRAINING?
6 A. I WENT TO A MEDICAL SCHOOL AT NORTHWESTERN UNIVERSITY AND
7 DID MY RESIDENCY AT THE UNIVERSITY OF CALIFORNIA SAN FRANCISCO.
8 Q. AND DO YOU HAVE SPECIAL TRAINING BEYOND YOUR OB/GYN
9 RESIDENCY IN PERFORMING ABORTIONS?
10 A. I DID A FELLOWSHIP IN FAMILY PLANNING AT THE UNIVERSITY OF
11 CALIFORNIA SAN FRANCISCO.
12 Q. WHAT IS A FAMILY PLANNING FELLOW?
13 A. A FELLOW IS A PERSON WHO HAS COMPLETED THEIR RESIDENCY
14 TRAINING AND THEN HAS GONE ON AFTER RESIDENCY TRAINING TO SPEND
15 TIME TRAINING IN BOTH CLINICAL CARE AND RESEARCH RELATED TO
16 ABORTION AND CONTRACEPTIVE SERVICES, AND OTHER EARLY PREGNANCY
17 ISSUES THAT ARE SIMILAR. FOR EXAMPLE, MISCARRIAGE AND ECTOPIC
18 PREGNANCY.
19 Q. HOW MANY FAMILY PLANNING FELLOWS ARE THERE IN THE COUNTRY?
20 A. THERE ARE 12 FELLOWSHIP SITES, AND MOST OF THE FELLOWSHIP
21 SITES HAVE BOTH A FIRST-YEAR AND A SECOND-YEAR FELLOW. SO
22 THERE ARE ROUGHLY ABOUT 24 FELLOWS CURRENTLY.
23 Q. HOW MANY WERE THERE WHEN YOU WERE A FELLOW?
24 A. ONE.
25 Q. WAS THAT YOURSELF OR ONE IN ADDITION TO YOU?

1 A. THERE WAS JUST MYSELF.
2 Q. AND YOU STATED, I THINK, YOU WERE A FELLOW AT UCSF; IS THAT
3 RIGHT?
4 A. THAT'S RIGHT.
5 Q. IS ONE OF THE OTHER FELLOWSHIPS TODAY AT NORTHWESTERN?
6 A. YES, IT IS.
7 Q. WHO IS THE DIRECTOR OF THAT?
8 A. CASSING HAMMOND.
9 Q. IS ONE OF THOSE FELLOWSHIPS AT COLOMBIA, AS WELL?
10 A. YES, IT IS.
11 Q. WHO DIRECTS THAT FELLOWSHIP?
12 A. CAROLYN WESTHOFF.
13 Q. IS A THIRD ONE OF THOSE FELLOWSHIPS AT OREGON HEALTH
14 SCIENCES UNIVERSITY?
15 A. YES, IT IS.
16 Q. AND, IF YOU KNOW, DR. CREININ, IS JOANNE CAIN THE CHAIR OF
17 THE OB/GYN DEPARTMENT AT OREGON HEALTH SCIENCES UNIVERSITY?
18 A. YES, SHE IS.
19 Q. AND, ALSO IF YOU KNOW, TODAY ARE THERE STILL FELLOWS AT
20 UCSF?
21 A. YES, THERE ARE.
22 Q. IN YOUR CURRENT PRACTICE, DO YOU CURRENTLY SUPERVISE A
23 FELLOW?
24 A. I HAVE TWO FELLOWS, A FIRST-YEAR AND A SECOND-YEAR FELLOW.
25 Q. WHAT KIND OF TRAINING DO FAMILY PLANNING FELLOWS RECEIVE

1 THAT OTHER OBSTETRICIAN/GYNECOLOGISTS DO NOT RECEIVE IN THEIR
2 TRAINING?
3 A. MOST OF THE FELLOWS, INCLUDING AT MY CENTER, RECEIVE
4 SPECIALIZED TRAINING IN RESEARCH, IN GETTING MASTER'S DEGREE IN
5 EITHER PUBLIC HEALTH OR A MASTER'S OF SCIENCE DEGREE IN
6 RESEARCH. SO THEY LEARN A LOT MORE ABOUT APPROPRIATE WAYS TO
7 DO RESEARCH AND THEY ALSO DO RESEARCH AS PART OF THEIR
8 FELLOWSHIP IN THE AREAS THAT WE HAVE DISCUSSED.
9 THE CLINICAL TRAINING IS SPECIALIZED TRAINING IN
10 ABORTION SERVICES BETWEEN FOUR AND 24 WEEKS, INCLUDING BOTH
11 MEDICAL ABORTIONS BETWEEN FOUR AND NINE WEEKS AND SURGICAL
12 ABORTION PROCEDURES THROUGH 24 WEEKS. AND THEN BOTH RESEARCH
13 AND CLINICAL CARE IN ASSOCIATED AREAS LIKE ECTOPIC PREGNANCY
14 AND MISCARRIAGE, SO THERE IS THE BALANCE BETWEEN CONTRACEPTION
15 AND ABORTION AND BETWEEN RESEARCH AND CLINICAL CARE.
16 Q. ARE YOU A BOARD CERTIFIED OBSTETRICIAN/GYNECOLOGIST?
17 A. YES, I AM.
18 Q. WHERE DO YOU CURRENTLY PRACTICE MEDICINE?
19 A. AT THE UNIVERSITY OF PITTSBURGH.
20 Q. IS THERE A NAME OF A HOSPITAL THAT YOU WORK AT?
21 A. MAGEE WOMEN'S HOSPITAL AT THE UNIVERSITY OF PITTSBURGH.
22 Q. PLEASE DESCRIBE YOUR PRACTICE AT THE UNIVERSITY OF
23 PITTSBURGH?
24 A. I SPEND ABOUT 40 PERCENT OF MY TIME PERFORMING CLINICAL
25 RESEARCH, AND ABOUT 20 PERCENT OF MY TIME AS AN ADMINISTRATOR

1 AND TEACHER, AND 20 PERCENT OF MY TIME IN PRIVATE PRACTICE,
2 SEEING PATIENTS IN PRIVATE PRACTICE, AND ANOTHER 20 PERCENT OF
3 MY TIME AT PLANNED PARENTHOOD AS THE MEDICAL AND LABORATORY
4 DIRECTOR.
5 Q. HOW LONG HAVE YOU BEEN AT THE UNIVERSITY OF PITTSBURGH?
6 A. ALMOST 10 YEARS.
7 Q. AND DO YOU PERFORM ABORTIONS AT THE UNIVERSITY OF
8 PITTSBURGH?
9 A. YES, I DO.
10 Q. BY WHAT METHODS AND WHAT GESTATIONAL AGE RANGES?
11 A. I PROVIDE MEDICAL ABORTION SERVICES UP TIL NINE WEEKS OF
12 PREGNANCY, NINE WEEKS' GESTATION AND SURGICAL ABORTION SERVICES
13 FROM FOUR TO 23 AND SIX-SEVENTH'S WEEKS.
14 Q. THOSE ARE MEASURED BY THE FIRST DAY OF THE WOMEN'S LAST
15 MENSTRUAL PERIOD?
16 A. CORRECT OR AS ADJUSTED BY ULTRASOUND TO MENSTRUAL AGE.
17 Q. WHAT METHODS OF SURGICAL ABORTION DO YOU PROVIDE?
18 A. SUCTION ABORTION TYPICALLY THROUGH 14 TO 15 WEEKS AND IT
19 VARIES BY PATIENT AS FAR AS WHETHER IN THAT RANGE OF 14 TO 15
20 IF THE SUCTION ABORTION IS PERFORMED OR DILATION AND EVACUATION
21 IS PERFORMED, AND, AGAIN, THAT'S AN INDIVIDUAL CIRCUMSTANCE AND
22 BEGINNING AT ABOUT 14 TO 15 WEEKS THROUGH 23 AND SIX-SEVENTH'S
23 WEEKS, THEN IT'S A DILATION AND EVACUATION PROCEDURE.
24 Q. AND YOU MENTIONED 23 AND SIX-SEVENTH'S. DO YOU USE
25 ANYTHING EXCEPT GESTATIONAL AGE TO DETERMINE THE LIMIT TO WHICH

1 YOU PERFORM ABORTIONS?
2 A. NO. WHEN LOOKING AT THE UPPER LIMIT, I ALSO USE ULTRASOUND
3 CRITERIA TO LOOK AT THE BIPARIETAL DIAMETER, WHICH IS THE
4 DIAMETER OF THE HEAD. AND ANYTHING MORE THAN 56 MILLIMETERS IN
5 DIAMETER IS SOMETHING THAT I DON'T FEEL I CAN DO ROUTINELY BY
6 DILATION AND EVACUATION.
7 Q. FIFTY-SIX MILLIMETERS OF BIPARIETAL DIAMETER, CAN YOU TELL
8 THE COURT HOW LARGE THAT IS IN BOTH INCHES AND CENTIMETERS?
9 A. THAT'S 5.6 CENTIMETERS, WHICH IS ABOUT TWO AND A HALF, TWO
10 AND A HALF INCHES. IT'S ABOUT LIKE THAT (INDICATING).
11 Q. WHERE DO YOUR ABORTION PATIENTS COME FROM?
12 A. IN MY PRIVATE PRACTICE, THE PATIENTS ARE REFERRED TO ME BY
13 EITHER THEMSELVES OR BY THEIR HEALTH CARE PROVIDER, WHICH IS --
14 AND MOST COMMONLY IT'S THEIR OBSTETRICIAN/GYNECOLOGIST.
15 Q. AND WHAT GEOGRAPHIC DISTANCE DO YOU SEE PATIENTS FROM?
16 A. IN THE PITTSBURGH AREA, THERE'S -- THERE ARE ABORTION
17 PROVIDERS IN OUR CITY. THE VAST MAJORITY OF WHICH ALSO
18 PRACTICE AT MY HOSPITAL, ALTHOUGH THERE'S NOT A TREMENDOUS
19 NUMBER.
20 ONCE YOU GET OUTSIDE OF OUR AREA, THERE ARE NO
21 ABORTION PROVIDERS. AND IT'S -- WE HAVE A CATCHMAN AREA OF
22 APPROXIMATELY THREE HOURS AROUND THE PITTSBURGH AREA IN TRAVEL
23 TIME, WHICH INCLUDE WOMEN FROM SOUTHERN NEW YORK, EASTERN OHIO,
24 NORTHERN VIRGINIA AND ALL THE WAY INTO PENNSYLVANIA TO
25 APPROXIMATELY THE MID-PORTION OF THE STATE.

1 Q. AND THEY COME FROM SO FAR AWAY BECAUSE THERE ARE NO OTHER
2 PROVIDERS; IS THAT CORRECT?
3 A. CORRECT.
4 Q. AND YOU MENTIONED THAT YOU ARE A PROFESSOR AS WELL. AS A
5 PROFESSOR, DO YOU TEACH ALL THE METHODS OF ABORTION THAT YOU
6 DESCRIBED THAT YOU PROVIDE?
7 A. YES, I DO TO STUDENTS AND RESIDENTS, OB/GYN RESIDENTS AND
8 INTERNAL MEDICINE RESIDENTS AT TIMES IF THEY WANT TO LEARN, AND
9 THEN TO THE FELLOWS ALSO.
10 Q. I THINK YOU MENTIONED THIS IN UPDATING YOUR CURRICULUM
11 VITAE, BUT IS YOUR ONLY FACULTY APPOINTMENT IN THE MEDICAL
12 SCHOOL?
13 A. NO, IT'S NOT.
14 Q. WHAT IS YOUR OTHER APPOINTMENT?
15 A. I HAVE AN APPOINTMENT AT THE DEPARTMENT OF EPIDEMIOLOGY AT
16 THE GRADUATE SCHOOL OF PUBLIC HEALTH.
17 Q. YOU MAY HAVE MENTIONED THIS A LITTLE BIT IN RELATION TO
18 YOUR FELLOWSHIP ALSO, BUT DO YOU HAVE SPECIAL TRAINING THAT
19 RELATES TO EPIDEMIOLOGY?
20 A. I DO. WHEN I WAS DOING MY FELLOWSHIP IN FAMILY PLANNING, I
21 ALSO DID A FELLOWSHIP AT THE UNIVERSITY OF CALIFORNIA SAN
22 FRANCISCO IN CLINICAL RESEARCH. THAT WAS A ONE-YEAR
23 FELLOWSHIP. AND THAT WAS WHAT WAS AVAILABLE AT THE TIME.
24 CURRENTLY THAT SAME TYPE OF FELLOWSHIP IS THE TYPE OF WORK THAT
25 EARNS A MASTER'S OF SCIENCE DEGREE, JUST AT THAT TIME IT DID

1 NOT EARN THAT TYPE OF DEGREE, BUT IT IS THAT SAME TRAINING.
2 Q. AND YOU ALSO MENTIONED YOU WORK AT PLANNED PARENTHOOD OF
3 WESTERN PENNSYLVANIA. WHAT IS YOUR JOB THERE?
4 A. I AM THE MEDICAL AND LABORATORY DIRECTOR AT PLANNED
5 PARENTHOOD WOMEN'S HEALTH SERVICES, WHICH IS ONE OF THE CLINICS
6 WITHIN THE PLANNED PARENTHOOD OF WESTERN PENNSYLVANIA SYSTEM.
7 Q. AND HOW LONG HAVE YOU HELD THAT POSITION?
8 A. NEARLY 10 YEARS.
9 Q. AND DOES PLANNED PARENTHOOD WOMEN'S HEALTH SERVICES PROVIDE
10 ABORTION SERVICES?
11 A. YES.
12 Q. TO WHAT GESTATIONAL AGE?
13 A. TO 18 WEEKS AND ZERO DAYS.
14 Q. DO YOU YOURSELF PROVIDE THOSE SERVICES?
15 A. YES, I DO.
16 Q. BY WHAT METHODS?
17 A. MEDICAL ABORTION UP TIL NINE WEEKS' GESTATION, AND SURGICAL
18 ABORTION BETWEEN FOUR WEEKS AND 18 WEEKS, ZERO DAYS.
19 Q. AND SURGICAL ABORTION, DO THE PROCEDURES THAT YOU DO BREAK
20 DOWN BY GESTATIONAL AGE THE SAME AS AT THE UNIVERSITY OF
21 PITTSBURGH?
22 A. CORRECT. 14 TO 15 WEEKS AT THE BREAKING POINT FOR SUCTION
23 AND THEN 14 TO 15 TO 18 WEEKS FOR DILATION AND EVACUATION.
24 Q. YOU TESTIFIED THAT YOU TEACH AND PERFORM MEDICAL AND
25 SURGICAL ABORTIONS. DO YOU HAVE ANY EXPERIENCE WITH INDUCTION

1 PROCEDURES?
2 A. YES, I DO.
3 Q. WHAT IS THAT EXPERIENCE?
4 A. I LEARNED AND PERFORMED INDUCTION ABORTIONS WHEN I WAS A
5 RESIDENT IN OBSTETRICS AND GYNECOLOGY, ALSO DURING MY
6 FELLOWSHIP, AND THEN ALSO FOR THE ONE YEAR WHEN I WAS ON
7 FACULTY AT THE UNIVERSITY OF CALIFORNIA SAN FRANCISCO BEFORE I
8 MOVED TO PITTSBURGH, AND ONCE I MOVED TO PITTSBURGH, I NO
9 LONGER PERFORMED THEM.
10 Q. DO YOU HAVE ANY PUBLICATIONS RELATED TO INDUCTION?
11 A. I DO. I HAVE A BOOK CHAPTER IN GYNECOLOGY AND OBSTETRICS,
12 WHICH IS A TEXTBOOK BY, EDITED BY JACK SCIARRA, S-C-I-A-R-R-A,
13 AND THAT WAS PUBLISHED IN -- THAT WAS PRINTED IN 1999, AND
14 THERE'S AN UPDATED VERSION THAT IS COMING OUT THAT IS OF THE
15 SAME CHAPTER.
16 Q. AND AM I CORRECT YOU WERE THE AUTHOR OF THE CHAPTER IN
17 1999?
18 A. CORRECT.
19 Q. AND YOU ARE CO-AUTHOR OF THE CHAPTER THAT'S IN PRESS NOW?
20 A. CORRECT.
21 Q. IS IT YOUR UNDERSTANDING THAT THAT'S A WELL-REGARDED
22 TEXTBOOK IN THE MEDICAL COMMUNITY?
23 A. YES, IT IS.
24 Q. OTHER THAN THAT TEXTBOOK, DO YOU HAVE OTHER PUBLICATIONS IN
25 THE FIELD OF GYNECOLOGY?

1 A. YES. I HAVE ABOUT 70 PUBLICATIONS IN PEER-REVIEWED
2 JOURNALS, EITHER FIRST AUTHORED OR CO-AUTHORED, AND THEN
3 NUMEROUS OTHER INVITED REVIEW ARTICLES, MANY IN PEER-REVIEWED
4 JOURNALS, AND BOOK CHAPTERS AND A COUPLE OF BOOKS THAT I AM AN
5 EDITOR OR CO-EDITOR OF.
6 Q. WHAT ARE THE MAJOR SUBJECTS THAT YOU'VE PUBLISHED AS AN
7 AUTHOR OR CO-AUTHOR?
8 A. CONTRACEPTION, ABORTION, ECTOPIC PREGNANCY, MISCARRIAGE ARE
9 THE BULK OF THE AREA. THERE ARE SOME EARLY PUBLICATIONS
10 RELATED TO MULTIPLE PREGNANCIES BUT PRIMARILY THE FOCUS IS ON
11 ABORTION AND CONTRACEPTION.
12 Q. AND YOU MENTIONED YOU ALSO CONDUCT RESEARCH AT THE
13 UNIVERSITY OF PITTSBURGH. CAN YOU DESCRIBE THE GENERAL AREAS
14 IN WHICH YOU PERFORM RESEARCH?
15 A. THE SAME AREAS, CONTRACEPTION, ABORTION, ECTOPIC PREGNANCY,
16 MISCARRIAGE.
17 Q. IS BOTH YOUR RESEARCH AND YOUR PUBLICATIONS, ARE THEY
18 REFLECTED ON YOUR CURRICULUM VITAE?
19 A. YES, THEY ARE.
20 Q. SO WE'VE TALKED ABOUT A BUNCH OF COMPONENTS OF YOUR
21 PRACTICE AND YOU GAVE ME A BREAK DOWN, I THINK, AT THE
22 BEGINNING, A PERCENTAGE.
23 WHAT PERCENT OF YOUR PRACTICE OVERALL INVOLVES
24 SEEING PATIENTS OR PATIENT CARE?
25 A. ROUGHLY 90 PERCENT. I HAVE ONLY ABOUT 10 PERCENT OF TIME

1 THAT'S PURELY ADMINISTRATIVE.
2 Q. SO WHEN YOU SAY YOU ARE DOING RESEARCH OR TEACHING, THAT
3 INVOLVES PATIENT CARE AS WELL; ISN'T THAT RIGHT?
4 A. RIGHT. IT'S CLINICAL RESEARCH WITH HUMAN SUBJECTS AND THE
5 TEACHING IS, ALTHOUGH PART OF IT IS LECTURES, THE BULK OF IT IS
6 WORKING WITH RESIDENTS AND STUDENTS WHILE SEEING PATIENTS OR
7 TAKING CARE OF PATIENTS.
8 Q. DR. CREININ, HAVE YOU EVER PROVIDED EXPERT TESTIMONY BEFORE
9 IN A CASE INVOLVING A STATUTE THAT REGULATES ABORTION?
10 A. NO, I HAVE NOT.
11 Q. AND OTHER THAN YOUR OUT-OF-POCKET EXPENSES, ARE YOU BEING
12 COMPENSATED FOR YOUR TESTIMONY IN THIS CASE?
13 A. NO.
14 MS. KRASNOFF: THE PLAINTIFFS WOULD LIKE TO MOVE TO
15 QUALIFY DR. CREININ AS AN EXPERT WITNESS IN THE AREA OF
16 GYNECOLOGY AND THE SUBSPECIALTY OF ABORTION PRACTICE.
17 THE COURT: ALL RIGHT. ANY OBJECTION?
18 MS. CLARK: NO OBJECTION.
19 THE COURT: ALL RIGHT. HE WILL BE ACCEPTED AS
20 PROFFERED.
21 BY MS. KRASNOFF:
22 Q. DR. CREININ, YOU ARE HERE TODAY TO OFFER EXPERT OPINIONS
23 ABOUT THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003; IS THAT
24 CORRECT?
25 A. YES.

1 Q. ARE YOU FAMILIAR WITH THAT ACT?
2 A. YES.
3 Q. IS IT YOUR OPINION THAT THAT ACT WILL BAN SOME OF THE
4 ABORTIONS THAT YOU PERFORM?
5 A. YES, IT WILL.
6 Q. I WANT TO TALK TO YOU ABOUT HOW YOU PERFORM -- THOSE ARE BY
7 D&E METHOD; IS THAT CORRECT?
8 A. YES.
9 Q. AND I WOULD LIKE TO TALK TO YOU ABOUT HOW YOU PERFORM D&E
10 ABORTIONS AND WHY YOU THINK IT IS THAT SOME OF THOSE ABORTIONS
11 WOULD VIOLATE THE ACT. SO I WANT YOU TO WALK US STEP BY STEP
12 HOW YOU PERFORM A D&E ABORTION.
13 SO, LET'S START WITH THE DILATION. WHAT DO YOU DO
14 TO DILATE THE CERVIX FOR WOMEN WITH A GESTATIONAL AGE OF 14
15 WEEKS LMP OR GREATER?
16 A. MOST COMMONLY BETWEEN 14 AND 18 WEEKS, I WILL USE A TYPE OF
17 DILATOR CALLED THE LAMICEL, L-A-M-I-C-E-L, WHICH COMES IN TWO
18 SIZES, 3 MILLIMETERS AND 5 MILLIMETERS.
19 AND IT'S A FIRM DILATOR THAT WHEN IT -- WHEN THE
20 WATER IS APPLIED TO IT OR IT GETS MOIST, ACTUALLY WHEN IT GETS
21 MOIST AFTER IT IS PUT IN THE CERVIX AND IT GETS MOIST, IT
22 IMMEDIATELY SOFTENS. THE PRIMARY FUNCTION OF THE DILATOR IS
23 THAT IT'S IMPREGNATED WITH MAGNESIUM, AND PUTTING IT IN THE
24 CERVIX ALLOWS THE MAGNESIUM TO LOCALLY WITHIN THE CERVIX TO
25 SOFTEN IT AND IT ACTIVATES ENZYMES PRESENT IN THE CERVIX TO

1 SOFTEN THE CERVIX. NORMALLY THE CERVIX IS PRETTY FIRM LIKE THE
2 END OF YOUR NOSE AND THE LAMICEL WILL CAUSE A CERVIX OVER A
3 PERIOD OF AS LITTLE AS TWO HOURS AND AS MUCH AS 24 HOURS TO
4 SOFTEN SIGNIFICANTLY, AND THE LENGTH OF TIME WILL VARY
5 DEPENDING UPON THE GESTATIONAL AGE, THE HISTORY OF THE PATIENT,
6 OTHER FACTORS THAT WILL COME INTO PLAY.
7 BEYOND 18 WEEKS, THEN MOST COMMONLY I WILL USE
8 DILAPAN, D-I-L-A-P-A-N, DEPENDING ON THE PATIENT'S PARITY AND
9 OTHER FACTORS, FOR EXAMPLE, SHE'S HAD PRIOR CERVICAL SURGERY, I
10 MAY FIRST USE LAMICEL FOR A COUPLE OF HOURS TO SOFTEN THE
11 CERVIX TO ALLOW ME TO PUT AN ADEQUATE NUMBER OF DILAPAN
12 DILATORS IN, AND THEN THE DILATORS WILL BE LEFT IN PLACE ON
13 AVERAGE ABOUT 24 HOURS THOUGH THAT MAY VARY DEPENDING ON WHEN I
14 SAW HER IN THE OFFICE, WHEN SHE IS SCHEDULED IN THE OPERATING
15 ROOM, IF THE OPERATING IS DELAYED A LITTLE, SO THERE CAN BE A
16 LITTLE VARIANCE.
17 Q. WE HAVE HEARD TESTIMONY ABOUT OSMOTIC DILATORS. THAT'S ONE
18 TERM PEOPLE HAVE USED. ARE LAMICEL AND DILAPAN OSMOTIC
19 DILATORS?
20 A. YES. OSMOTIC MEANS ABSORBS OR LIKES WATER. SO THE MOMENT
21 THEY GET MOIST, THEY BEGIN TO FUNCTION.
22 Q. AND MOST OF THE OTHER TESTIMONY HAS ALSO BEEN ABOUT
23 LAMINARIA. ARE LAMICEL AND DILAPAN THE SAME OR DIFFERENT FROM
24 LAMINARIA?
25 A. THEY ARE OSMOTIC DILATORS LIKE LAMINARIA BUT THEY'RE

1 DIFFERENT. LAMINARIA IS ROLLED SEAWEED AND WILL SERVE THE SAME
2 FUNCTION AS DILAPAN, BUT THEY ARE JUST DIFFERENT.
3 Q. AND WHY DO YOU PREFER DILAPAN OR LAMICEL?
4 A. ESPECIALLY THE DIFFERENCE IS REALLY BETWEEN THE DILAPAN AND
5 THE LAMINARIA. I PREFER DILAPAN BECAUSE I FOUND IN MY TRAINING
6 AND IN MY CLINICAL EXPERIENCE THAT WITH DILAPAN I DON'T NEED TO
7 PUT AS MANY DILATORS IN TO ACHIEVE THE SAME AMOUNT OF DILATION
8 THAN I WOULD GET WITH LAMINARIA.
9 AND IT ALSO MAKES IT A LOT EASIER BOTH FOR ME, AS
10 THE CLINICIAN, AND FOR THE PATIENT IN THAT I CAN USUALLY GET IN
11 A SUFFICIENT NUMBER OF DILATORS WITH ONE ATTEMPT AS OPPOSED TO
12 WITH LAMINARIA, WE MAY NEED MULTIPLE TIMES, ESPECIALLY IN
13 SOMEBODY WHO HAS NEVER BEEN PREGNANT BEFORE.
14 Q. DO YOU ALWAYS TRY TO INSERT THE SAME NUMBER OF DILAPAN?
15 A. NO.
16 Q. FOR AN ABORTION AT SAY 20 WEEKS, FOR EXAMPLE, HOW MANY
17 DILAPAN WOULD YOU INSERT?
18 A. ROUGHLY FIVE, BUT IT, THAT'S THE -- EVERY PATIENT IS A
19 LITTLE DIFFERENT. SO THERE MAY BE TIMES WHEN I ONLY PUT IN
20 FOUR AND FEEL THAT IN THAT PATIENT'S SITUATION THAT FOUR WILL
21 BE SUFFICIENT. AND, AGAIN, THERE IS THOSE KINDS OF FACTORS,
22 BUT ROUGHLY FIVE IS WHAT I ATTEMPT TO PUT IN.
23 Q. HOW LONG DO YOU LEAVE THE DILAPAN IN?
24 A. ROUGHLY 24 HOURS AS STATED BEFORE.
25 Q. AND WHAT HAPPENS TO THE WOMAN AFTER THE DILAPAN ARE

1 INSERTED?
2 A. SHE THEN CAN GO HOME. WE GIVE HER VERY THOROUGH
3 INSTRUCTIONS ABOUT WHAT TO EXPECT AFTER BOTH DILATORS ARE
4 PLACED, AS WELL AS WHAT SHE CAN EXPECT FOR AFTER THE ABORTION
5 SO THAT SHE HAS ALL OF THESE INSTRUCTIONS IN WRITING WITH HER.
6 OBVIOUSLY, LONG BEFORE THIS, WE WENT OVER THE
7 PROCEDURE AND THE OPTIONS, ET CETERA, SO THESE ARE JUST
8 INSTRUCTIONS NOW FOR ONCE WE HAVE STARTED THE PROCESS.
9 SO, FOR MOST WOMEN, THEY WILL EXPERIENCE VERY MILD
10 CRAMPING. THEY ARE INSTRUCTED JUST TO USE ADVIL OR ALEVE AS
11 THEY WOULD FOR MENSTRUAL CRAMPING. THEY'RE INSTRUCTED TO CALL
12 US IF THEY HAVE SEVERE CRAMPS THAT REQUIRE MORE ATTENTION. I
13 WOULD SAY ONCE OR TWICE A YEAR I GET A PHONE CALL FROM A
14 PATIENT SAYING THAT SHE NEEDS SOMETHING MORE THAN THE ADVIL OR
15 THE ALEVE.
16 WHENEVER THE PATIENTS COME BACK AT THE SCHEDULED
17 TIME FOR THEIR SURGERY, I ALWAYS DISCUSS WITH THEM IF THEY HAD
18 ANY PROBLEMS. AND NONE OF MY PATIENTS HAVE SAID, "WELL, I
19 PROBABLY SHOULD HAVE CALLED, BUT I DIDN'T." SO, AGAIN, IT'S
20 VERY RARE THAT THERE'S ANYTHING OF ANY SIGNIFICANCE FROM THE
21 DILATOR PLACEMENT. USUALLY THEY CAN GO HOME AND DO NORMAL
22 ACTIVITIES.
23 Q. DO YOU EVER REQUIRE THE WOMAN TO COME BACK FOR ANOTHER
24 INSERTION OF DILAPAN?
25 A. IN INDIVIDUAL CIRCUMSTANCES, IF I FEEL I DIDN'T GET ENOUGH

1 DILAPAN IN HER CERVIX THAT I WOULD SAFELY BE ABLE TO PERFORM A
2 PROCEDURE, THEN I HAVE TO START AGAIN INDIVIDUALIZING, AND
3 THERE IS NOT A NUMBER OF THINGS I COULD DO, THE MOST COMMON
4 THING I WOULD DO IS EITHER HAVE HER COME BACK THE NEXT MORNING,
5 PUT IN MORE DILAPAN AND DO THE PROCEDURE MUCH LATER IN THE DAY
6 OR EVEN THEN DELAY THE PROCEDURE, HAVE HER COME BACK, PUT IN
7 MORE DILAPAN AND DO THE PROCEDURE A DAY LATER.
8 THERE HAVE BEEN A FEW INSTANCES WHERE BASED ON
9 CIRCUMSTANCES RELATED TO HOW FAR SHE LIVED AWAY, OR HER MEDICAL
10 CONDITION, I CAN'T REMEMBER THE SPECIFICS, BUT THERE HAVE BEEN
11 A FEW CIRCUMSTANCES WHERE I HAVE ALSO GIVEN HER MISOPROSTOL
12 VAGINALLY A FEW HOURS BEFORE THE PROCEDURE TO AID THE DILAPAN,
13 BUT, AGAIN, THESE ARE INDIVIDUAL CIRCUMSTANCES WHERE I HAVE TO
14 USE MY CLINICAL JUDGMENT.
15 Q. DO YOU ROUTINELY USE MISOPROSTOL?
16 A. NO.
17 Q. YOU SAID THAT -- YOU TESTIFIED THAT YOU PREFER DILAPAN
18 BECAUSE YOU FIND IT IS MORE RELIABLE.
19 CAN YOU PREDICT WHEN YOU INSERT THE DILAPAN EXACTLY
20 HOW MUCH DILATION YOU ARE GOING TO BE ABLE TO GET?
21 A. NO.
22 Q. ON AVERAGE, HOW MUCH DILATION WILL YOU TRY TO ACHIEVE FOR
23 AN ABORTION AFTER SAY 18 WEEKS?
24 A. FOR MY PATIENTS WHEN I DO PROCEDURES, AFTER 18 WEEKS,
25 SOMEWHERE BETWEEN ABOUT TWO TO TWO AND A HALF CENTIMETERS IS

1 WHAT I REQUIRE.
2 AND WHEN I REMOVE THE DILAPAN, DURING THE PROCEDURE,
3 THE FIRST THING I DO IS ASSESS TO SEE IF I FEEL THERE'S AT
4 LEAST A MINIMUM AMOUNT, ENOUGH THAT I AM CONTENT WITH THAT I
5 FEEL I CAN SAFELY PROCEED AND IT'S NOT UNUSUAL TO HAVE MORE
6 THAN THAT. AGAIN, THAT IS GOING TO VARY BY PATIENT BASED ON
7 HER PARITY AND PAST MEDICAL HISTORY, ET CETERA.
8 Q. WHAT IS HER PARITY?
9 A. PARITY IS HOW MANY DELIVERIES SHE HAS HAD.
10 Q. IF THAT HAPPENS AND YOU REMOVE THE DILATORS AND YOU FIND
11 YOU HAVE MORE THAN TWO, TWO AND A HALF CENTIMETERS, IS THAT A
12 BAD OUTCOME?
13 A. NO. THAT WOULD MAKE THE PROCEDURE EVEN EASIER. I AM MORE
14 INTERESTED IN THE MINIMAL AMOUNT, NOT THE MAXIMUM THAT I
15 OBTAIN.
16 I WANT -- I JUDGE THE NUMBER OF DILAPAN BASED ON
17 MAKING SURE I GET THE MINIMUM AMOUNT WITHOUT PUTTING IN SO MANY
18 THAT I MAKE HER UNCOMFORTABLE OR GET MORE DILATION THAN I
19 ABSOLUTELY NEED, WHICH I HAVE FOUND AT TIMES CAN CAUSE PATIENTS
20 TO GO INTO LABOR OR DELIVER.
21 AND IN TALKING WITH THE PATIENTS AHEAD OF TIME, THEY
22 ARE CHOOSING A D&E PROCEDURE RATHER THAN A LABOR INDUCTION
23 BECAUSE THEY DON'T WANT TO GO THROUGH LABOR. SO, I AM TRYING
24 TO BALANCE ALL OF THOSE FACTORS AND DECIDING HOW MANY DILAPAN I
25 INSERT FOR THAT INDIVIDUAL PATIENT.

1 Q. NOW, I WANT YOU TO GO THROUGH WHAT YOU DO STEP BY STEP
2 AFTER THE CERVIX IS ADEQUATELY DILATED. IF IT HELPS YOU AT ANY
3 POINT, WE HAVE THESE DIAGRAMS FOR YOU TO REFER TO.
4 A. BEYOND 18 WEEKS, I ONLY PERFORM THOSE PROCEDURES IN THE
5 OPERATING ROOM AT MAGEE WOMEN'S HOSPITAL. I DON'T DO THOSE
6 PROCEDURES AT PLANNED PARENTHOOD.
7 MOST COMMONLY THE PATIENT GETS A -- HAS CONSCIOUS OR
8 DEEP SEDATION BY AN ANESTHETIST OR ANESTHESIOLOGIST -- I SHOULD
9 IS SAY ANESTHESIOLOGIST BECAUSE IT CAN BE AN ANESTHETIST
10 WORKING WITH THE ANESTHESIOLOGIST. IN RARE CIRCUMSTANCES, THE
11 PATIENT WILL RECEIVE A SPINAL ANESTHETIC OR EVEN MORE RARE
12 GENERAL ANESTHETIC BUT THIS IS ALL DECIDED AHEAD OF TIME IN
13 CONSULTATION WITH THE PATIENT AND THE ANESTHESIOLOGIST.
14 ONCE WE ARE IN THE OPERATING ROOM AND SHE'S PLACED
15 WITH HER LEGS UP IN STIRRUPS IN A LITHOTOMY POSITION AND SHE
16 HAS RECEIVED HER ANESTHETIC, I WILL PUT IN A SPECULUM AND
17 REMOVE THE DILATORS.
18 I WILL THEN USE A STERILE CLEANSING SOLUTION, MOST
19 COMMONLY IODINE, TO CLEAN THE CERVIX AND VAGINA, AND THE AREA
20 RIGHT AROUND THE INTROITUS. AND THEN I WILL GIVE A LOCAL
21 ANESTHETIC WHICH ALSO CONTAINS A SMALL AMOUNT OF VASOPRESSIN,
22 WHICH IS A MEDICINE TO HELP CONSTRICT THE BLOOD VESSELS IN THE
23 CERVIX, IN THE LOWER PORTION OF THE UTERUS.
24 I WILL THEN USE A GRASPING INSTRUMENT TO HOLD ON TO
25 THE CERVIX, WHICH IS CALLED A TENACULUM, AND THEN I WILL PULL

1 ON THE TENACULUM -- ACTUALLY, I WILL PULL ON THE TENACULUM TO
2 BOTH STABILIZE THE CERVIX, I CAN HOLD ON TO IT, BUT I ALSO WANT
3 TO CHANGE THE POSITION OF THE UTERUS.
4 IS IT OKAY IF I GET UP?
5 THE COURT: SURE.
6 THE WITNESS: SO THIS DIAGRAM IS KIND OF DIFFICULT
7 BECAUSE THE VAGINA REALLY ISN'T THIS LONG AND THE UTERUS IS
8 BIGGER BECAUSE IT HAS A PREGNANCY IN IT, BUT THE UTERUS DOES
9 SIT AT AN ANGLE TO THE VAGINA. AND ACTUALLY IN AN ENLARGED
10 UTERUS AT 18 WEEKS, THE SACRUM, WHICH IS HERE, THE
11 SACROPROMONTORY, THE UTERUS HAS GROWN TO HERE (INDICATING)
12 WHERE IT'S ALWAYS GOING TO BE TIPPED UP BECAUSE IT HITS THIS
13 BONE AND MOVED UP.
14 SO IT IS IMPORTANT WITH THE TENACULUM TO PULL DOWN
15 ON THE CERVIX TO STRAIGHTEN THAT ANGLE MORE SO THAT THE
16 INSTRUMENTS WHEN THEY PASS INTO THE UTERUS ARE GOING STRAIGHT
17 INTO THE UTERUS AS OPPOSED TO TRYING TO MANEUVER THIS ANGLE.
18 THAT'S ALL TO TRY AND REDUCE THE RISK OF PERFORATION.
19 NOW, THE SPECULUM, WHICH HAS BLADES -- ACTUALLY, IF
20 YOU IMAGINE THIS STRAIGHTENED OUT, THAT WILL FIT INTO THE, WHAT
21 IS CALLED THE FORNICES. AND ACTUALLY AT TIMES, ALMOST PREVENT
22 THE UTERUS FROM COMING DOWN, SO IT'S NOT INFREQUENT THAT I WILL
23 ACTUALLY EVEN REMOVE THE SPECULUM AND DO THE PROCEDURE WITHOUT
24 A SPECULUM OR USE A WEIGHTED SPECULUM, WHICH IS AN INSTRUMENT
25 THAT JUST KIND OF HANGS ON THE PERINEUM.

1 THE COURT: OTHER DOCTORS HAVE TESTIFIED AS TO
2 BRINGING THE CERVIX DOWN ALMOST TO THE INTROITUS.
3 HOW DOES THAT HAPPEN IF THERE IS A SPECULUM INSIDE?
4 THE WITNESS: THE SPECULUM ACTUALLY ALMOST GETS
5 PUSHED OUT. SO, DEPENDING ON THE WOMAN'S PARITY, HOW MANY
6 DELIVERIES SHE HAS HAD, THE MORE PARA SHE IS, THE MORE IT COMES
7 DOWN. THAT'S WHY IN THOSE SITUATIONS YOU NEED TO EITHER SIT
8 THERE WITH THE SPECULUM HALFWAY OUT OR REMOVE IT AND USE EITHER
9 A WEIGHTED SPECULUM OR NO SPECULUM.
10 THE CERVIX VERY COMMONLY ENDS UP VERY CLOSE TO THE
11 OPENING, IF NOT ALL THE WAY DOWN AT THE OPENING. AND, AGAIN,
12 YOU HAVE TO JUDGE INDIVIDUALLY WHAT HAPPENS. SO THAT'S WHAT
13 THE TENACULUM DOES.
14 AND THEN --
15 BY MS. KRASNOFF:
16 Q. WHAT DO YOU DO TO EVACUATE THE CONTENTS OF THE UTERUS?
17 A. THE FIRST STEP I TAKE IS, AGAIN, MOST COMMONLY IN EVERY
18 PATIENT I HAVE TO SOMETIMES DO VARIATIONS BASED ON WHATEVER IS
19 GOING ON.
20 MOST COMMONLY THE NEXT STEP WOULD BE TO RUPTURE THE
21 AMNIOTIC SAC USING A CANNULA. OBVIOUSLY IF SHE HAS ALREADY HAD
22 RUPTURED MEMBRANES, I WOULDN'T DO THAT. MOST COMMONLY I WOULD
23 THEN TAKE AN 11 MILLIMETER CANNULA AND INSERT THAT IN THE
24 CERVICAL OPENING WHILE UNDER DIRECT VISUALIZATION WITH
25 ULTRASOUND, AND USE THAT WITH THE SUCTION ON IT TO BREAK THE

1 AMNIOTIC SAC TO DRAIN THE AMNIOTIC FLUID SO ALL OF THE FLUID IS
2 REMOVED FIRST.
3 IN SITUATIONS WHERE I CAN'T WITH THE CANNULA BREAK
4 THE AMNIOTIC SAC, I WILL ACTUALLY, WITH A SMALL RING FORCEPS,
5 JUST GRAB THE SAC AND PULL ON IT TO BREAK THE SAC. SO THEN THE
6 FLUID CAN DRAIN, I CAN THEN PUT THE CANNULA IN AND DRAIN ALL OF
7 THE AMNIOTIC FLUID. IT IS IMPORTANT TO DRAIN THE FLUID FIRST
8 TO -- WHEN THE UTERUS DECOMPRESSES, IN OTHER WORDS, REMOVE THE
9 FLUID, THE UTERUS, THE FIRST THING IT WILL DO IS TO CONTRACT
10 AND THAT BRINGS ALL OF THE FETAL PARTS DOWN INTO THE LOWER PART
11 OF THE UTERUS BECAUSE MY GOAL IS JUST TO INSTRUMENT IN THE
12 LOWER PART OF THE UTERUS. I DON'T WANT TO REACH UP HIGH
13 BECAUSE THAT'S HOW YOU CAN CAUSE UTERINE INJURY.
14 SO, AFTER I DRAIN THE AMNIOTIC FLUID, I'LL THEN MOST
15 COMMONLY USE BIERER FORCEPS, THAT'S B-I-E-R-E-R, ALTHOUGH FOR
16 GESTATIONAL AGES THAT ARE CLOSER TO 18 WEEKS OR AT TIMES WHERE
17 I MAY NOT HAVE -- WHERE I'VE PUT IN, THE SIMPLEST WAY TO SAY IT
18 IS IN GESTATIONS CLOSER TO 18 WEEKS SOMETIMES THE DILATION IS
19 ADEQUATE ENOUGH FOR SOPHER FORCEPS, BUT NOT BIERERS. THEY ARE
20 VERY SIMILAR, JUST THE SIZE IS DIFFERENT. SOPHERS ARE ABOUT
21 1.5 TO 1.6 CENTIMETERS IN DIAMETER AND BIERER ARE MOST COMMONLY
22 ABOUT 1.9 CENTIMETERS. SO EITHER ONE CAN BE USED. OBVIOUSLY,
23 THE MORE ADVANCED THE GESTATION, THE MORE DILATION THERE IS,
24 AND THE BIGGER FORCEPS WOULD BE USED.
25 USING THE FORCEPS, THEN I WOULD OPEN THEM, INSERT

1 THEM THROUGH THE CERVIX OPENING. AS I GET CLOSE TO THE -- AS I
2 BEGIN TO ENTER THE UTERUS, SO THAT I CAN OPEN THE INSTRUMENT AS
3 WIDELY AS POSSIBLE IN THE LOWER UTERINE SEGMENT, AND IT IS NOT
4 VERY WIDE, YOU ARE LIMITED BY THE UTERUS ITSELF, BUT JUST
5 STAYING IN THE LOWER UTERINE SEGMENT, IF POSSIBLE, TO GRASP
6 WHATEVER IS THERE. THAT'S THE BASIC CONCEPT, BUT THEN YOU HAVE
7 TO USE ALL -- BECAUSE ALL OF THIS IS DONE UNDER ULTRASOUND
8 GUIDANCE, MY GOAL IS REALLY TO GRAB A LOWER EXTREMITY OR SOME
9 OTHER PORTION OTHER THAN THE HEAD. SO WHAT I AM GOING TO DO IS
10 VARY BY THE FETAL POSITION.
11 IF IT IS HEAD FIRST, IT'S VERY, VERY, VERY DIFFICULT
12 TO TRY AND GRASP THE HEAD AS THE VERY FIRST THING. SO, WITH
13 EVERY D&E, THE WAY I HAVE BEEN TAUGHT, THE WAY I HAVE ALWAYS
14 DONE IT, THE WAY I HAVE ALWAYS TAUGHT IT IS TO TRY AND GRAB A
15 LOWER LIMB TO CONVERT THE POSITION TO BREECH AND THEN PROCEED
16 WITH THE EVACUATION. IF IT'S ALREADY BREECH, OR IF IT'S
17 TRANSVERSE, THAT'S EASIER TO GRAB A LOWER EXTREMITY.
18 AFTER GRABBING THE LOWER EXTREMITY, I AM GOING TO
19 PULL THE PREGNANCY OR PULL WHATEVER PART I HAVE GRASPED THROUGH
20 THE OPEN CERVIX UNTIL THERE IS RESISTANCE FROM THE LOWER
21 UTERINE SEGMENT AND THE INTERNAL OS. MY GOAL IS TO TRY AND
22 REMOVE THE FETUS AS INTACT AS POSSIBLE. THE FEWER PASSES, THE
23 SAFER IT IS FOR THE WOMAN.
24 SO, AS I PULL DOWN, THE UTERUS IS GOING TO TELL ME
25 HOW FAR I CAN GO JUST BY THE RESISTANCE I GET. SO WHEN I MEET

1 RESISTANCE, I WILL CONTINUE TO PULL, AND IT'S THE PRESSURE OF
2 THE FETUS AGAINST THE LOWER UTERINE SEGMENT THAT ACTUALLY
3 RESULTS IN DISMEMBERMENT OF THE FETUS. AND WHERE THAT IS GOING
4 TO HAPPEN ON THE FETUS WILL VARY FROM PATIENT TO PATIENT.
5 AS THE FETUS -- TISSUE THAT I AM HOLDING ON TO
6 GETS -- IS IN --
7 Q. I WANT TO BREAK IT DOWN. YOU JUST TOLD US A LOT OF THINGS
8 YOU DO.
9 A. I AM JUST PROCEEDING THROUGH.
10 Q. THAT'S OKAY. I AM GOING TO STOP YOU AND ASK YOU SOME
11 QUESTIONS ABOUT HOW MUCH -- WHAT YOU'VE TOLD US SO FAR.
12 A. OKAY.
13 Q. I JUST WANT TO MAKE IT CLEAR, YOU ARE ALWAYS DOING POST-18
14 WEEK PROCEDURES UNDER ULTRASOUND GUIDANCE; IS THAT CORRECT?
15 A. CORRECT. I USE ULTRASOUND GUIDANCE FOR ALL OF MY
16 PROCEDURES WHERE ANY INSTRUMENTS ARE PLACED IN THE UTERUS OTHER
17 THAN A SUCTION CANNULA.
18 Q. CAN YOU EXPLAIN WHY IT IS THAT YOU THINK IT IS BENEFICIAL
19 TO GRASP A LOWER EXTREMITY REGARDLESS OF THE PRESENTATION OF
20 THE FETUS?
21 A. AS I SAID EARLIER, IT'S INCREDIBLY DIFFICULT TO GRASP THE
22 HEAD FIRST. THE HEAD, UNTIL ABOUT 34 WEEKS OF PREGNANCY, IS
23 MUCH LARGER THAN ANY OTHER PART OF THE FETUS.
24 SO, IF I AM TRYING TO GRASP THE HEAD AND THERE'S
25 OTHER SMALL PARTS BEHIND IT, IT JUST BECOMES A PHYSICAL

1 DIFFICULTY IN GRASPING THE HEAD.
2 SO, AGAIN, FROM THE WAY I WAS TAUGHT FROM THE VERY
3 BEGINNING, AND IT IS ALMOST COMMON SENSE IF YOU THINK ABOUT IT,
4 YOU CONVERT THE FETUS TO BREECH SO THAT'S WHERE ESPECIALLY
5 USING ULTRASOUND GUIDANCE, THE SAFETY COMES IN BECAUSE I AM
6 GOING TO WATCH MY INSTRUMENT, GUIDE IT TO AN EXTREMITY, SO THAT
7 WHEN I TEACH THE PROCEDURE OR I EVER TALK ABOUT IT, THIS IS A
8 STANDARD WAY OF DOING DILATION AND EVACUATION.
9 Q. SO IS IT SOMETIMES THE CASE THAT THE FETUS IS PRESENTING IN
10 A HEAD FIRST OR VERTEX PRESENTATION AND YOU WOULD GRASP A LOWER
11 EXTREMITY AND ROTATE THE FETUS SO THAT IT IS FEET FIRST?
12 A. VIRTUALLY ALL THE TIME. IT IS ON RARE CIRCUMSTANCES THAT I
13 GET THE HEAD FIRST AND IT'S USUALLY ONLY BECAUSE THE HEAD IS SO
14 APPLIED TO THE CERVIX I CAN'T REALLY GET PASSED IT TO TRY AND
15 GET A LOWER EXTREMITY. AND I CAN THINK OF ONCE OR TWICE IN MY
16 ENTIRE CAREER THAT I CAN THINK THAT I HAVE DONE THAT.
17 Q. THIS IS BECAUSE YOU THINK IT IS SAFER FOR THE WOMAN TO
18 GRASP THE LOWER EXTREMITIES FIRST; IS THAT CORRECT?
19 A. YES, THAT'S THE WAY THE PROCEDURE IS DONE.
20 Q. ARE YOU AWARE, DR. CREININ, THAT ONE OF THE CONGRESSIONAL
21 FINDINGS OF THE ACT THAT'S AT ISSUE IN THIS CASE STATES THAT
22 CONVERTING THE FETUS TO A BREECH PRESENTATION INCREASES CERTAIN
23 RISKS AND SOME OF THE RISKS THEY NAME ARE UTERINE RUPTURE,
24 ABRUPTION AND AMNIOTIC FLUID EMBOLUS.
25 DO YOU AGREE WITH THAT FINDING?

1 A. NOT AT ALL.
2 Q. I WANT TO GO THROUGH EACH OF THOSE RISKS AND HAVE YOU
3 EXPLAIN WHAT THEY ARE AND WHY YOU THINK IT IS THAT THAT FINDING
4 IS INCORRECT.
5 A. OKAY.
6 Q. WHAT IS ABRUPTION?
7 A. ABRUPTION IS PREMATURE SEPARATION OF THE PLACENTA FROM THE
8 UTERUS. AND THAT WOULDN'T APPLY IN THE SITUATION BECAUSE MY
9 GOAL IS TO REMOVE THE PLACENTA AS PART OF THE PROCEDURE.
10 AND SOMETIMES IT COMES OUT AS ONE OF THE FIRST
11 THINGS I REMOVE, SOMETIMES IT COMES OUT IN THE MIDDLE OF THE
12 PROCEDURE, I AM GOING TO GRASP WHATEVER I AM GRASPING, AND WHEN
13 I GET AHOLD OF IT, I AM GOING TO REMOVE IT.
14 SO THOSE FINDINGS APPLY TO CASES WHERE A DELIVERY IS
15 BEING DONE WITH THE INTENT OF A LIVE FETUS BEING BORN, BUT
16 SEPARATING THE PLACENTA FROM THE UTERUS IS AN INNATE PART OF
17 THE D&E AND HAS NO IMPLICATION HERE AT ALL.
18 THE COURT: EXCUSE ME. IN A LIVE BIRTH SITUATION,
19 YOU DON'T WANT THE PLACENTA TO COME OUT EVEN IN PART BEFORE THE
20 BABY COMES OUT.
21 THE WITNESS: EXACTLY BECAUSE THE FETUS IS GETTING
22 ITS OXYGEN AND NUTRIENTS THROUGH THE PLACENTA. AND AN EXAMPLE
23 WOULD BE A WOMAN AT 30 WEEKS OF PREGNANCY STARTS TO HAVE
24 BLEEDING BECAUSE THE PLACENTA SEPARATES PREMATURELY. SHE CAN
25 NOT ONLY LOSE A LOT OF BLOOD, BUT THE BABY COULD DIE. SO THAT

1 THAT WOULD BE A POTENTIALLY CATASTROPHIC SITUATION.
2 OR THERE ARE MANEUVERS DONE AT TERM, FOR INSTANCE,
3 INTERNAL PODALIC VERSION, WHICH YOU HAVE HEARD ABOUT, AT TERM
4 AND THE PLACENTA SEPARATED AND THE FETUS WAS UNABLE TO BE
5 REMOVED RIGHT AWAY, BUT THE FETUS WOULD BE STUCK IN THE UTERUS
6 WITH THE PLACENTA SEPARATED AND NO WAY TO GET OXYGEN. SO AT
7 TERM, THAT WOULD BE IMPORTANT, BUT AS PART OF AN ABORTION
8 PROCEDURE, IT'S COMPLETELY IRRELEVANT.
9 MS. CLARK: YOUR HONOR, I AM GOING TO OBJECT ON THE
10 BASIS THAT THE RISKS, SO-CALLED RISKS ASSOCIATED WITH OR LACK
11 OR NOT -- RISKS OR NO RISKS OF CONVERTING THE FETUS, THAT
12 WASN'T SET FORTH IN THE EXPERT'S REPORT, WE DIDN'T TALK ABOUT
13 IT AT THE DEPOSITION. I THINK THIS IS OUTSIDE THE SCOPE OF HIS
14 EXPERT REPORT.
15 MS. KRASNOFF: HIS MAIN OPINION IS THAT THE BANNED
16 PROCEDURES ARE THE SAFEST WAY FOR HIM TO DISPUTE THE ACT WHICH
17 IS THAT IT'S UNSAFE FOR THE WOMAN TO HAVE THE PROCEDURE
18 PERFORMED IN THE MANNER SET FORTH IN THE ACT.
19 THE COURT: WELL, IS THIS ONE OF THE THINGS THAT WAS
20 DISCUSSED? I MEAN, I DON'T HAVE ALL OF THE MATERIALS IN FRONT
21 OF ME. I WILL HAVE TO DEPEND UPON YOU ALL TO LET ME KNOW.
22 HER OBJECTION IS ONE OF LACK OF NOTICE, I ASSUME?
23 MS. CLARK: YES.
24 THE COURT: THIS IS ONE OF THE AREAS THAT YOU WERE
25 GOING TO BRING OUT THROUGH THIS DOCTOR?

1 MS. KRASNOFF: I BELIEVE IT WAS DISCUSSED IN HIS
2 DEPOSITION. I BELIEVE WE CAN SEARCH THE DEPOSITION.
3 THE COURT: DO YOU REMEMBER?
4 THE WITNESS: YES. SHE ASKED ME EXACTLY HOW I
5 PERFORMED THE PROCEDURES, AND I TOLD HER THIS IS PART OF WHAT I
6 PERFORMED, HOW I PERFORM THE PROCEDURE.
7 THE COURT: MS. CLARK?
8 THE WITNESS: YES.
9 THE COURT: LET THEM JUST FIND IT, THE REFERENCE.
10 (PAUSE IN THE PROCEEDINGS.)
11 MS. KRASNOFF: PAGE 87, LINE 5. HE SAYS, "IDEALLY
12 GRASP LOWER EXTREMITY TO CONVERT THE FETUS TO A BREECH
13 PRESENTATION."
14 THE COURT: WAS HE ASKED WHY HE DOES THAT?
15 MS. KRASNOFF: ON PAGE 163, LINE 6, MS. CLARK ASKED:
16 "IN DOING THAT, AM I CORRECT TO ASSUME YOU WERE
17 ABLE TO CONVERT IT TO BREECH?"
18 AND HER NEXT QUESTION IS:
19 "IN DOING THAT, IS THERE ANY CONCERN BY
20 REACHING AROUND AND GRASPING A PART WITH THE
21 FORCEPS WHICH WOULD CAUSE -- BY THE SHIFTING OF
22 THE FETUS INSIDE THE UTERUS, WOULD THIS CAUSE
23 ANY DAMAGE TO THE WOMAN?
24 AND DR. CREININ ANSWERED: "NOT AT ALL."
25 MS. CLARK: I WITHDRAW MY OBJECTION.

1 THE COURT: YOU WITHDRAW YOUR OBJECTION?
2 MS. CLARK: I WITHDRAW IT.
3 THE COURT: ALL RIGHT.
4 BY MS. KRASNOFF:
5 Q. MOVE ON TO AMNIOTIC FLUID EMBOLUS.
6 DR. CREININ, WHAT IS AMNIOTIC FLUID EMBOLUS?
7 A. THAT'S WHEN THE AMNIOTIC FLUID ENTERS THE WOMAN'S
8 CIRCULATION USUALLY THROUGH A SINUS, WHICH IS A LARGE OPENING,
9 IN THE LINING OF THE UTERUS THAT WOULD BE PART OF THE WAY THE
10 BLOOD WAS GETTING TO THE PLACENTA FROM THE WOMAN.
11 SO, AGAIN, AT A D&E PROCEDURE, SINCE THE FIRST PART
12 IS TO REMOVE THE AMNIOTIC FLUID, THAT'S A MOOT POINT SINCE IT'S
13 ALREADY BEEN REMOVED AS PART OF THE PROCEDURE.
14 Q. SO, JUST TO BE CLEAR, IT'S YOUR OPINION THAT TURNING THE
15 FETUS IN UTERO WOULD BREECH THE PRESENTATION IN A D&E DOESN'T
16 CAUSE ANY GREATER RISK OF AMNIOTIC FLUID EMBOLUS THAN IF YOU DO
17 NOT DO THAT CONVERSION?
18 A. FIRST OF ALL, AMNIOTIC FLUID EMBOLUS IS SO INCREDIBLY RARE,
19 IT WOULD BE HARD TO SHOW ANY INCREASE RISK AT THIS GESTATIONAL
20 AGE.
21 THE COURT: CAN YOU DESCRIBE WHAT IT IS AGAIN?
22 THE WITNESS: I AM SORRY. THE AMNIOTIC FLUID, WHEN
23 IT GETS INTO THE WOMAN'S BLOODSTREAM, SO IT GETS IN THROUGH
24 SOME OPENINGS IN THE UTERUS. SO IF IT GETS INTO HER
25 BLOODSTREAM, IT WILL FIRST GO UP TO THE HEART AND THEN INTO THE

1 LUNGS. AND IN THE LUNGS, I APOLOGIZE, I DIDN'T SAY THIS
2 EARLIER, IN THE LUNGS IT CAUSES AN INCREDIBLY FAST TISSUE
3 REACTION THAT WILL CAUSE HER TO QUICKLY NOT BE ABLE TO EXCHANGE
4 AIR ACROSS HER LUNGS. SHE WILL BECOME HYPOXIC, WHICH MEANS HAS
5 LOW OXYGEN, GO INTO A RESPIRATORY ARREST AND THEN CARDIAC
6 ARREST. IT CAN LEAD TO -- THE HEART HAS ITS OWN LITTLE BRAIN
7 THAT MAKES IT PUMP OR IT MAKES IT BEAT AT CERTAIN RATES SO THE
8 ELECTRICAL SYSTEM OF THE HEART CAN STILL BE WORKING, BUT THE
9 HEART MUSCLE ITSELF DOESN'T RESPOND TO IT AT ALL. SO IF AN EKG
10 MONITOR WAS ON THE WOMAN, IT WOULD LOOK LIKE EVERYTHING IS
11 NORMAL, BUT HER HEART ISN'T PUMPING. THESE ARE THINGS THAT CAN
12 OCCUR WITH AMNIOTIC FLUID EMBOLUS.
13 THE COURT: IS IT FAIR TO ASSUME THEN, IF THERE WAS
14 SUCH AN OCCURRENCE, THAT THAT WOULD NECESSARILY FOLLOW FROM A
15 PERFORATION OF THE WALL OF THE UTERUS? IS THERE ANY OTHER WAY
16 FOR IT TO GET --
17 THE WITNESS: NOT REALLY. IT'S JUST FROM THE
18 OPENINGS THAT ARE THERE, WHERE MOST COMMONLY WHERE THE PLACENTA
19 IS ATTACHED. SO, IT'S NOT FROM A HOLE IN THE UTERUS, IT COULD
20 JUST BE THAT WHEN THE PLACENTA DETACHES AND SOME OF THOSE
21 OPENINGS ARE EXPOSED THAT AMNIOTIC FLUID COULD GET IN.
22 AGAIN, WITH D&E PROCEDURES, THE AMNIOTIC FLUID IS
23 PRIMARILY REMOVED FIRST BEFORE ANY OF THOSE THINGS OCCUR.
24 THE COURT: OKAY.
25 THE WITNESS: IT'S AN INCREDIBLY RARE OCCURRENCE AT

1 TERM LET ALONE EVEN AT THIS GESTATIONAL AGE.
2 THE COURT: THANK YOU.
3 BY MS. KRASNOFF:
4 Q. WHAT WOULD BE THE DIFFERENCE OF WHY THAT WOULD OCCUR AT
5 TERM VERSUS IN A D&E? YOU'VE TESTIFIED TO THIS, BUT JUST TO
6 MAKE IT CLEAR.
7 A. AT TERM, THE AMNIOTIC FLUID IS, NUMBER ONE, STILL THERE,
8 AND THEN EVEN IN A WOMAN WITH RUPTURED MEMBRANES, THE AMNIOTIC
9 FLUID PRIMARILY COMES FROM THE FETAL URINE, SO THE FETUS IS
10 STILL PEEING INSIDE. AND ALSO AS A WOMAN GOING THROUGH
11 DELIVERY, IF YOU CAN IMAGINE THE HEAD GOING THROUGH THE CERVIX
12 AT TERM, IT WEDGES IN, SO AS IT PEES INSIDE, THE FLUID IS GOING
13 TO REBUILD UP INSIDE THE UTERUS. SO THAT IF ABRUPTION WAS TO
14 OCCUR DURING DELIVERING, THERE STILL WOULD BE FLUID THERE.
15 WHEREAS, AGAIN, DURING AN ABORTION AT THIS POINT IN PREGNANCY,
16 IT IS RELATIVELY A MOOT POINT. IT IS AN INCREDIBLY RARE
17 OCCURRENCE TO START WITH.
18 MS. CLARK: YOUR HONOR, I JUST WANT TO MAKE MY
19 OBJECTION. I AGREE WITH COUNSEL THAT ON PAGE 163 THE QUESTION
20 WAS: IN DOING THAT, WAS THERE ANY CONCERN BY REACHING AROUND
21 THE PART WITH FORCEPS --
22 THE COURT: SLOW DOWN.
23 MS. CLARK: I'M SORRY.
24 I AM REREADING FROM THE DEPOSITION PAGE 163, LINES 9
25 THROUGH 14. AND I THINK THE TESTIMONY OF CONVERTING THE BREECH

1 AT TERM VERSUS CONVERTING TO A BREECH POSITION DURING AN
2 ABORTION, I THINK THAT GOES BEYOND THE SCOPE OF HIS DEPOSITION
3 TESTIMONY.
4 THE COURT: WELL, COUNSEL, I WILL ALLOW IT AT THIS
5 TIME. YOU WITHDREW YOUR OBJECTION PREVIOUSLY. IT SEEMED THE
6 APPROPRIATE THING TO DO IS GIVEN THE EXCERPT, PERHAPS WE WILL
7 MOVE ON TO SOME ANOTHER SUBJECT, I AM NOT GOING TO STRIKE HIS
8 TESTIMONY.
9 MS. KRASNOFF: A FEW MORE QUESTIONS ABOUT TURNING
10 THE FETUS, THEN I WILL BE MOVING RIGHT ALONG.
11 BY MS. KRASNOFF:
12 Q. DOES TURNING THE FETUS INCREASE THE RISK OF RUPTURE OR
13 TRAUMA TO THE UTERUS?
14 A. NOT AT ALL. THAT'S A PART OF D&E PROCEDURES. SO ALL OF
15 THE DATA THAT HAS EVER BEEN PUBLISHED INCLUDES THAT
16 INFORMATION.
17 AND THE ACT ITSELF POTENTIALLY COULD CAUSE UTERINE
18 RUPTURE, BUT ANY PROCEDURE, ANY PART OF THE PROCEDURE, JUST
19 LIKE LABOR INDUCTION, JUST LIKE ANYTHING ELSE, SO IT'S MORE OF
20 A RELATIVE TERM. COULD IT INCREASE AT MORE THAN SOMETHING
21 ELSE? NO. IT'S JUST THAT THE ACT ITSELF CAN CAUSE RUPTURE OF
22 THE UTERUS JUST LIKE ANY OTHER PART OF THE D&E COULD.
23 Q. JUST TO BE CLEAR, BY "ACT" YOU MEAN LITTLE "A" ACT OF
24 TURNING THE FETUS, YOU'RE NOT TALKING ABOUT THE ACT AS WE'VE
25 TALKED ABOUT IN THIS CASE?

1 A. I'M SORRY, THE ACTION.
2 Q. I JUST WANTED TO BE CLEAR.
3 MY FINAL QUESTION ON THIS TOPIC, IS THAT THE
4 CONGRESSIONAL FINDINGS STATE THAT A LEADING OBSTETRICS TEXTBOOK
5 SAYS THERE ARE FEW, IF ANY, INDICATIONS FOR TURNING THE FETUS
6 IN UTERO OTHER THAN FOR DELIVERING OF THE SECOND TWIN.
7 ARE YOU FAMILIAR WITH THAT?
8 A. YES, I AM.
9 Q. IS THAT RELEVANT HERE?
10 A. NO. AGAIN, THAT --
11 MS. CLARK: OBJECTION ON THE BASIS OF WHO'S TO SAY
12 WHAT IS RELEVANT OR NOT RELEVANT. I THINK THAT CALLS FOR A
13 LEGAL CONCLUSION.
14 THE COURT: SUSTAINED. REPHRASE.
15 BY MS. KRASNOFF:
16 Q. DO YOU THINK THAT THERE -- THAT THAT STATEMENT THAT THERE
17 ARE INDICATIONS IN A D&E FOR TURNING THE FETUS IN UTERO?
18 A. I DON'T AGREE WITH WHAT WAS STATED IN THE CONGRESSIONAL
19 FINDINGS THAT -- I AM CONFUSED.
20 I DON'T AGREE WITH THE CONGRESSIONAL FINDINGS. IS
21 THAT SUFFICIENT?
22 Q. THE CONGRESSIONAL FINDINGS SAY THERE ARE FEW, IF ANY,
23 INDICATIONS. BUT YOU'VE TESTIFIED THAT YOU DO TURN IT. SO, I
24 AM ASKING IF YOU BELIEVE THERE ARE INDICATIONS --
25 A. DOING A D&E IS A INDICATION FOR TURNING IT.

1 Q. AND IS THAT -- ARE YOU FAMILIAR WITH THAT TEXTBOOK?
2 A. YES, I AM.
3 Q. IS THAT SPEAKING ABOUT DELIVERY AT TERM?
4 A. YES, IT IS.
5 Q. SO, MOVING ALONG, ONCE YOU'VE LOCATED AND GRASPED THE LOWER
6 EXTREMITIES AND TURN THE FETUS IF YOU NEED TO, WHAT DO YOU DO
7 NEXT?
8 A. PULL WITH THE INSTRUMENT THAT I AM USING TO REMOVE THE
9 FETUS WITH THE ATTEMPT TO REMOVE THE FETUS IN AS FEW PASSES AS
10 POSSIBLE. SO UNTIL I MEET RESISTANCE FROM THE LOWER UTERINE
11 SEGMENT, I WILL CONTINUE TO PULL.
12 Q. WHY --
13 A. AND ONCE I MEET RESISTANCE, I WILL THEN, WHILE HOLDING ON
14 TO THE FETUS -- MINIMAL ROTATION, BUT JUST KIND OF TRY AND EASE
15 THOSE PARTS THROUGH THE CERVIX TO ALLOW WHATEVER'S MEETING
16 RESISTANCE TO TRY AND SLOWLY GET THROUGH THE CERVIX.
17 THE FETUS WILL EITHER CONTINUE TO COME OR WILL BEGIN
18 TO BREAK APART. IT WILL BREAK APART WHEREVER OR WHATEVER IT
19 IS. IT MAY BE IN THE MIDDLE OF THE LEG, IT MAY BE AT THE
20 ABDOMEN, IT MAY BE AT THE CHEST, JUST DEPENDING ON THE DILATION
21 AND THE SIZE OF THE FETUS, ET CETERA, JUST ON THAT INDIVIDUAL
22 CASE.
23 Q. DOES IT EVER HAPPEN THAT YOU ARE ABLE TO EXTRACT THE FETUS
24 INTACT OR RELATIVELY INTACT UP BEYOND THE NAVEL?
25 A. YES. THE LEVEL OF THE UMBILICUS, YES.

1 Q. CAN YOU EXPLAIN WHAT THAT IS?
2 A. THERE ACTUALLY IS NO NAVEL IN A FETUS. YOU AND I HAVE A
3 NAVEL BECAUSE OUR UMBILICAL CORD WAS GONE. THE FETUS HAS AN
4 UMBILICUS, BUT NO NAVEL BECAUSE IT STILL HAS THE UMBILICAL CORD
5 ATTACHED.
6 Q. AT THAT POINT WHEN THE FETUS HAS BEEN REMOVED, WE ARE GOING
7 TO USE "PAST THE NAVEL" BECAUSE THE ACT USES THAT.
8 A. CORRECT.
9 Q. YOU UNDERSTAND --
10 A. I UNDERSTAND THE INTENT, CORRECT.
11 Q. YOU UNDERSTAND IT TO BE THE UMBILICUS?
12 A. YES.
13 Q. WOULD THE FETUS STILL HAVE A HEART BEAT?
14 A. YES.
15 Q. THEN WHAT WOULD YOU DO NEXT?
16 A. I WOULD REACH INTO THE LOWER UTERINE SEGMENT AND GRASP
17 WHATEVER PART IS THERE AND THEN CONTINUE TO REMOVE THE FETUS.
18 IF, ONCE -- USUALLY, IF THE FETUS HAS BEEN
19 DISMEMBERED, THE LAST PART IS THE CALVARIUM, THE HEAD. AT THAT
20 POINT, I WILL GRASP THE HEAD AND CRUSH IT LIKE OTHER PARTS OF
21 THE FETUS AND REMOVE THAT.
22 I WILL THEN, IF THE PLACENTA HASN'T BEEN REMOVED,
23 REACH UP AND REMOVE THE PLACENTA. I'LL THEN, USING THE SUCTION
24 CANNULA, SUCTION THE LINING OF THE UTERUS TO ENSURE THAT THE
25 LINING THAT WAS THERE AS PART OF THE PREGNANCY HAS BEEN REMOVED

1 AND ANY PARTS OF THE PLACENTA THAT STILL MAY BE PRESENT ARE
2 REMOVED.
3 I WILL THEN TAKE A REALLY A BLUNT CURETTE, DULL
4 CURETTE TO FEEL THE LINING OF THE UTERUS, AGAIN, STILL UNDER
5 ULTRASOUND GUIDANCE TO ENSURE THAT IT FEELS LIKE EVERYTHING HAS
6 BEEN REMOVED TO ME, AND THEN LOOK AND MAKE SURE THAT THE
7 BLEEDING IS AT A LEVEL THAT I WOULD EXPECT IT TO BE, REMOVE THE
8 TENACULUM FROM THE CERVIX, MAKE SURE THERE'S NO CERVICAL TEARS
9 OR LACERATIONS. IF THERE IS A SPECULUM, I WOULD REMOVE IT AT
10 THAT POINT AND THEN THE PROCEDURE IS COMPLETED.
11 Q. DOES IT EVER HAPPEN THAT IN GRASPING THE FETUS YOU'RE ABLE
12 TO REMOVE THE FETUS INTACT OR RELATIVELY INTACT ALL THE WAY UP
13 TO THE CALVARIUM?
14 A. YES, ON OCCASION.
15 Q. IF THAT HAPPENS, WOULD YOU DO ANYTHING DIFFERENTLY TO
16 COMPLETE THE PROCEDURE?
17 A. IF THE FETUS IS INTACT UP TO THE CALVARIUM, THERE'S TWO
18 THINGS I COULD DO.
19 ONE WOULD BE TO CONTINUE TO PULL, AND USUALLY IT
20 COMES APART AT THE LEVEL OF THE NECK, OR I CAN INSERT, WHAT I
21 WOULD I HAVE DONE IS INSERT SCISSORS THROUGH THAT PART OF THE
22 HEAD UNDER DIRECT VISUALIZATION, INSERTED THE 11-MILLIMETER
23 CANNULA THAT I USED BEFORE AND DRAIN THE BRAIN TISSUE AND THEN
24 THE HEAD COMES THROUGH THE OPENING.
25 I HAVE DONE THAT ON A FEW OCCASIONS. MOST COMMONLY

1 IT'S THE FIRST.
2 Q. THE FIRST MEANING?
3 A. JUST THAT IT SEPARATES, THE BODY SEPARATES FROM THE HEAD.
4 Q. AND BACK TO THE EXAMPLE WHERE IT IS REMOVED INTACT OR
5 RELATIVELY INTACT UP TO THE NAVEL, HOW FREQUENTLY, IN YOUR
6 PRACTICE, DOES THAT HAPPEN?
7 A. AT LEAST ONCE A MONTH.
8 Q. DOES IT EVER HAPPEN THAT YOU'VE DISARTICULATED SOME PART OF
9 THE FETUS, BUT THEN ON ANOTHER PASS WITH THE INSTRUMENTS YOU
10 ARE ABLE TO REMOVE THE FETUS PASSED THE UMBILICUS?
11 A. YES. SOMETIMES I'VE MADE AN INITIAL GRASPING, HAVE A FOOT
12 OR PORTION OF THE LOWER EXTREMITY COME OFF, AND THEN WITH THE
13 SECOND GRASP, IT WOULD STILL COME OUT PAST THE LEVEL OF THE
14 UMBILICUS. SO IT STILL WOULD BE MOSTLY INTACT.
15 Q. COULD IT STILL HAVE A HEARTBEAT AT THAT TIME?
16 A. YES.
17 Q. AND WHAT WOULD YOU DO NEXT IF THAT HAD HAPPENED?
18 A. I'D STILL CONTINUE IN THE SAME METHODOLOGY BECAUSE MY
19 OBJECTIVE IS TO REMOVE THE PREGNANCY FROM THE UTERUS.
20 Q. AND WHEN YOU BEGIN THE PROCEDURE, CAN YOU ANTICIPATE HOW
21 MUCH OF THE FETUS YOU ARE GOING TO BE ABLE TO EXTRACT WITHOUT
22 DISARTICULATION?
23 A. NOT AT ALL. IT IS GOING TO VARY FROM WOMAN TO WOMAN BASED
24 ON HER PARITY AND HOW THE CERVIX RESPONDED TO THE DILATORS. MY
25 MAIN OBJECTIVE IS THE MINIMAL AMOUNT.

1 Q. WOULD YOU EVER TAKE ANY STEPS TO MAKE SURE THAT IT'S NOT
2 REMOVED INTACT?
3 A. CAN YOU -- INTACT UP TO THE LEVEL OF THE UMBILICUS YOU
4 MEAN?
5 Q. YES.
6 A. NO.
7 Q. DO YOU THINK THERE IS ANYTHING SAFE ABOUT REMOVING THE
8 FETUS INTACT UP TO THE UMBILICUS OR TO THE CALVARIUM?
9 A. THE FEWER PASSES, I FEEL THE SAFER IT IS. YES, I FEEL IT'S
10 SAFE.
11 Q. I ACTUALLY ASKED IF IT WAS UNSAFE.
12 A. I AM SORRY, I THOUGHT YOU SAID SAFE.
13 DO I THINK IT IS UNSAFE? NO.
14 Q. YOU MENTIONED THAT SOMETIMES YOU USE SCISSORS TO INSTRUMENT
15 IN THE BASE OF THE SKULL.
16 IS THERE ANYTHING THAT IS UNSAFE ABOUT THE INSERTION
17 OF SCISSORS INTO THE BASE OF THE CALVARIUM?
18 A. WHEN I DO IT FOR MY PATIENTS, NO, IT IS UNDER DIRECT
19 VISUALIZATION.
20 Q. HAVE YOU EVER HAD AN INJURY OR A COMPLICATION FROM AN
21 ABORTION WHERE THE FETUS WAS REMOVED INTACT UP TO THE
22 CALVARIUM?
23 A. NO.
24 Q. AND YOU SAID -- WE TALKED ABOUT THE PROCEDURE IS COMPLETE.
25 HOW LONG AFTER YOU COMPLETED THE PROCEDURE BEFORE THE WOMAN CAN

1 GO HOME?
2 A. ON AVERAGE IT'S ABOUT TWO HOURS.
3 Q. I WANT TO PUT UP ON THE EASEL --
4 MS. KRASNOFF: IF I MAY I APPROACH, YOUR HONOR?
5 THE COURT: YES.
6 BY MS. KRASNOFF:
7 Q. -- COPY OF THE OPERATIVE PORTION OF THE ACT.
8 IF YOU WOULD READ THAT, DR. CREININ, NOT OUT LOUD,
9 TO YOURSELF IS FINE.
10 WE TALKED AT SOME LENGTH ABOUT THE D&E ABORTIONS
11 THAT YOU PERFORMED. I WOULD LIKE YOU TO EXPLAIN TO THE COURT
12 WHY IT IS THAT YOU THINK SOME OF THE D&E'S THAT YOU PERFORMED
13 WOULD VIOLATE THIS DEFINITION OF PARTIAL-BIRTH ABORTION?
14 A. WELL, PRIMARILY IT'S IN THE CASE OF A BREECH PRESENTATION,
15 THAT ANY PART OF THE FETAL TRUNK PAST THE NAVEL IS OUTSIDE OF
16 THE BODY OF THE MOTHER. AS I WAS ALLUDING TO EARLIER WITH THE
17 OTHER DIAGRAM, IT IS VERY COMMON FOR THE CERVIX TO BE DOWN FAR
18 IN THE VAGINA SO THAT AS THE FETUS IS BEING REMOVED THROUGH THE
19 CERVIX, THE FETUS WOULD BE, HAVE THE FETAL TRUNK PAST THE NAVEL
20 OUTSIDE OF THE BODY OF THE MOTHER RELATIVELY COMMONLY.
21 SO THAT RIGHT THERE WOULD VIOLATE THE ACT BECAUSE
22 THE PURPOSE OF MY ACT IS TO KILL THE PARTIALLY-DELIVERED LIVING
23 FETUS BECAUSE THAT'S THE OBJECTIVE OF THE ABORTION. AND
24 ANYTHING I WOULD DO ONCE IT'S PAST THE LEVEL OF THE NAVEL,
25 WOULD BE AN OVERT ACT BECAUSE I WOULD BE DOING SOMETHING

1 BECAUSE THE GOAL OF MY PROCEDURE IS TO PERFORM AN ABORTION.
2 Q. WOULD THOSE BE LETHAL ACTS TO THE FETUS?
3 A. IT WOULD BE LETHAL TO THE FETUS.
4 Q. AND WOULD THIS DEFINITION COVER THE SITUATION YOU DISCUSSED
5 WHERE YOU ACTUALLY ALREADY DISARTICULATED PART OF THE FETUS BUT
6 THEN ARE ABLE TO REMOVE PAST THE NAVEL?
7 A. WELL, IT DOESN'T STATE THAT IT HAS TO BE COMPLETELY INTACT,
8 SO THAT I THINK OF A FOOT IS REMOVED AND EVERYTHING ELSE IS
9 INTACT, I WOULD TAKE IT TO MEANING OKAY. OTHERWISE THEN WE --
10 YES. SO I WOULD TAKE IT AS THAT WAY.
11 Q. WHAT IS A SPONTANEOUS MISCARRIAGE?
12 A. A SPONTANEOUS MISCARRIAGE IS WHEN A WOMAN WILL BEGIN TO
13 PASS THEIR PREGNANCY TISSUE WITHOUT ANY ACTION BY AN OUTSIDE
14 PERSON. SO WITHOUT TREATMENT OF SOME KIND TO CAUSE IT TO PASS.
15 Q. DO YOU TREAT PATIENTS THAT PRESENT IN THE MIDST OF A
16 SPONTANEOUS MISCARRIAGE OR AA PRE-TERM LABOR BETWEEN 16 AND 24
17 WEEKS?
18 A. YES.
19 Q. DO YOU THINK THAT YOU COULD EVER VIOLATE THE ACT BASED ON
20 WHAT YOU DO IN THAT SESSION?
21 A. PATIENTS WOULD BE REFERRED TO ME IN THAT SITUATION
22 SOMETIMES ACUTELY FOR A D&E IF THE -- IF THEIR OBSTETRICIAN OR
23 FETAL MEDICINE CONSULT HAS TALKED TO THEM ABOUT WHAT THEIR
24 OPTIONS ARE. THAT'S WHEN I SEE THOSE PATIENTS. AND BECAUSE
25 THOSE PATIENTS COMMONLY HAVE ADVANCED DILATION THEN, YES, I

1 WOULD VIOLATE THE ACT.
2 Q. AND IS IT CORRECT THAT WHEN YOU SEE AND TREAT THOSE
3 PATIENTS, YOU ARE COMPLETING THE REMOVAL OF THE PREGNANCY BY
4 D&E?
5 A. CORRECT.
6 Q. BEFORE WE TALKED ABOUT THIS DEFINITION, YOU SAID THAT YOU
7 DON'T ROUTINELY TAKE EXTRA STEPS TO ENSURE THAT YOU HAVE
8 ADEQUATE DILATION IN ORDER TO BE ABLE TO REMOVE THE FETUS
9 INTACT UP TO THE CALVARIUM.
10 ARE THERE ANY CIRCUMSTANCES IN WHICH YOU WOULD TAKE
11 EXTRA STEPS TO MAKE SURE THAT YOU COULD DO THAT?
12 A. I WAS PRESENTED WITH A PATIENT WHERE I WANTED TO AVOID
13 DISMEMBERMENT AS MUCH AS POSSIBLE AND A NORMAL PART OF THE
14 PROCEDURE IF THE -- WHEN THE FETUS DOES PULL APART WITH THE D&E
15 IS THAT THERE ARE BONEY FRAGMENTS. THAT'S JUST PART OF IT.
16 AND THE GOAL, ONE OF THE GOALS OF PUTTING OF THE
17 INSTRUMENT IS NOT ONLY TO GRASP THE FETAL PARTS, BUT TO BE
18 AROUND THE FETAL PARTS TO PROTECT THE LOWER UTERINE SEGMENT AND
19 THE CERVIX AS YOU ARE PULLING THOSE PARTS THROUGH THE CANAL, SO
20 IT IS THE SAFEST AS POSSIBLE FOR THE WOMAN.
21 THOSE BONEY FRAGMENTS THOUGH CAN TEAR THE LOWER
22 UTERINE SEGMENT OF THE CERVIX SLIGHTLY NOT THROUGH THE CERVIX
23 OR THROUGH THE LOWER UTERINE SEGMENT, BUT TEAR AS THEY ARE
24 DRAGGING THROUGH. THAT'S PARTLY WHY WE INCLUDE VASOPRESSIN,
25 THAT MEDICINE THAT CONSTRICT THE BLOOD VESSELS IN THE CERVICAL

1 ANESTHETIC.
2 FOR A WOMAN WHO IS ANTICOAGULATED, WHICH MEANS HER
3 BLOOD WAS THINNED SO THAT SHE WOULDN'T CLOT, AND SHE HAD TO
4 STAY ON THAT ANTICOAGULATION -- LIVING IN PITTSBURGH WE SEE A
5 LOT OF WOMEN WITH LIVER FAILURE, THE LIVER MAKES THE PRODUCTS
6 THAT ARE NECESSARY FOR THE BLOOD TO CLOT. SO THAT IF SHE WAS
7 ANTICOAGULATED FOR THAT REASON, THEN I WOULD NOT WANT BONEY
8 FRAGMENTS TO BE THERE, AND I WOULD WANT TO REMOVE THE FETUS AS
9 INTACT AS POSSIBLE.
10 MS. CLARK: YOUR HONOR, WE WOULD OBJECT ON
11 FOUNDATION GROUNDS. I DON'T THINK THAT THERE'S A PROPER
12 FOUNDATION LAID THAT HE HAS EVER HAD ONE OF THESE
13 COMPLICATIONS. IN THE DEPOSITION, AS I RECALL, HE GAVE AN
14 ANTICOAGULATION EXAMPLE AND A HYSTEROTOMY WAS ACTUALLY
15 PERFORMED. I AM NOT SURE A PROPER FOUNDATION HAS BEEN LAID
16 THAT HE'S EVER HAD ANY PATIENTS IN WHICH HE WOULD DO THIS.
17 THE COURT: OKAY. ESTABLISH A FOUNDATION.
18 MS. KRASNOFF: HE IS TESTIFYING AS AN EXPERT GIVING
19 AN OPINION OF WHEN HE WOULD TREAT A PATIENT HE HAS SEEN.
20 BY MS. KRASNOFF:
21 Q. HAVE YOU SEEN WOMEN WHO ARE ANTICOAGULATED?
22 A. YES, BUT I HAVE NEVER DONE A HYSTEROTOMY ABORTION ON AN
23 ANTICOAGULATED WOMAN.
24 Q. HAVE YOU HAD TO PERFORM --
25 THE COURT: CLEAR THIS UP. I DON'T HAVE THE

1 TRANSCRIPTS, SO I AM GOING TO HAVE TO TAKE YOUR REPRESENTATIONS
2 AS TO WHAT HE HAS TESTIFIED TO PREVIOUSLY.
3 THE DOCTOR JUST INDICATED HE HAS NEVER PERFORMED A
4 HYSTEROTOMY, SO I AM NOT EXACTLY SURE AS FAR AS EXACTLY WHAT IT
5 IS --
6 MS. KRASNOFF: I THINK --
7 THE COURT: -- YOUR OBJECTION IS.
8 MS. CLARK: MY OBJECTION IS LACK OF FOUNDATION AND
9 IT MAY NOT HAVE BEEN HIM THAT PERFORMED THE HYSTEROTOMY, BUT IF
10 MY RECOLLECTION IS CORRECT, I AM REVIEWING THE DEPOSITION NOW,
11 IS THAT THE ONE CASE WHERE ANTICOAGULATION WAS RAISED AS AN
12 EXAMPLE AND DISCUSSING INTERNAL COMPLICATIONS WITH HIM THAT THE
13 PATIENT HAD A HYSTEROTOMY.
14 THE COURT: WAS THE QUESTION BASED UPON HIS PRIOR
15 EXPERIENCE?
16 MS. KRASNOFF: IT IS HIS OPINION AS AN EXPERT BASED
17 ON THE PATIENTS THAT HE HAS SEEN THAT THIS IS A CIRCUMSTANCE IN
18 WHICH HE BELIEVES THAT INTACT WOULD BE BETTER. THAT IS IN HIS
19 ORIGINAL EXPERT REPORT. HE HAS NOT SEEN -- HE HAS SEEN
20 ANTICOAGULATED PATIENTS, BUT NOT IN THIS SPECIFIC SCENARIO. HE
21 IS OPINING ON WHEN THIS MIGHT BE PREFERABLE.
22 THE COURT: I'M SORRY. MY QUESTION IS, DID YOU ASK
23 SPECIFICALLY BASED UPON HIS PATIENTS OR DID YOU ASK HIM A MORE
24 GENERAL QUESTION. I DON'T REMEMBER WHAT YOUR QUESTION IS.
25 MS. KRASNOFF: I CAN LIMIT IT TO HIS PATIENTS.

1 MS. GARTNER: HE TESTIFIED ABOUT THIS IN HIS
2 DEPOSITION AT PAGE 166, LINE 6.
3 THE COURT: OKAY.
4 LET'S ALLOW HIM TO FINISH THIS.
5 THE WITNESS: THIS IS A THEORETICAL EXAMPLE, BUT
6 PART OF IT IS THAT PRETTY MUCH ABOUT EVERY MONTH I SEE A
7 PATIENT LIKE I HAVE NEVER SEEN BEFORE. SO THAT IF YOU WERE TO
8 SAY, HAVE YOU EVER SEEN A PATIENT LIKE THIS, IF YOU WERE TO ASK
9 ME TWO MONTHS FROM NOW, I COULD TELL YOU ABOUT PATIENTS I'VE
10 SEEN IN THE LAST TWO MONTHS THAT I HAVE NEVER SEEN BEFORE. SO
11 I SEE THINGS ALL THE TIME REFERRED TO ME THAT I'VE NEVER SEEN
12 BEFORE.
13 SO, THIS WAS A SCENARIO OF A SITUATION WHERE IN MY
14 PRACTICE I WOULD PREFER, IF I SAW A PATIENT LIKE THIS, TO
15 REMOVE THE FETUS INTACT AND I WOULD HATE TO BE ABLE TO TELL A
16 WOMAN I COULDN'T DO WHAT I FELT WAS BEST FOR HER.
17 THE COURT: YOU WEREN'T TESTIFYING YOU INDEED HAD
18 SEEN A PATIENT OF THAT NATURE, JUST THE QUESTION TO YOU WAS, I
19 BELIEVE, TO DESCRIBE THE SITUATION IN WHICH YOU WOULD PREFER TO
20 USE AN INTACT PROCEDURE.
21 THE WITNESS: THAT'S RIGHT.
22 THE COURT: IS THAT WHAT YOU WERE RESPONDING TO?
23 THE WITNESS: YES.
24 THE COURT: ALL RIGHT. OBJECTION OVERRULED.
25 ///

1 BY MS. KRASNOFF:
2 Q. ACTUALLY, BASED ON YOUR EXPERIENCE, YOU MENTIONED THE LIVER
3 TRANSPLANT AS WELL. IS THERE ANOTHER CASE, AN ACTUAL PATIENT
4 THAT COMES TO MIND THERE?
5 A. THERE WAS -- I HAVE HAD A PATIENT WHO HAD FETAL DEMISE
6 WHERE THE SITUATION AROSE, AND IN THAT SITUATION, I WOULD HAVE
7 CHOSEN TO DO AN INTACT REMOVAL IF WE GOT TO THAT POINT, BUT SHE
8 PASSED AWAY.
9 Q. AND CAN YOU EXPLAIN WHY IN THAT CASE INTACT REMOVAL WOULD
10 HAVE BEEN PREFERABLE?
11 A. BECAUSE HER LIVER HAD COMPLETELY FAILED, AND SHE HAD NO WAY
12 OF CLOTTING.
13 Q. WOULD IT HAVE BEEN SAFE TO DO AN INDUCTION IN THAT CASE?
14 A. NO, THAT WOULD HAVE KILLED HER WITHOUT A DOUBT IN TRYING TO
15 GET HER THROUGH THE INDUCTION.
16 YOU HAVE -- INDUCTIONS IS A VERY PROLONGED PROCESS,
17 AND THERE IS GOING TO BE BLEEDING THROUGHOUT THE INDUCTION. SO
18 AS THE FETUS BEGINS TO PASS THROUGH THE BIRTH CANAL OR THE
19 PLACENTA BEGINS TO SEPARATE, HERE IS A WOMAN WHO CAN'T CLOT AT
20 ALL. I WOULD WANT TO DO A PROCEDURE ON HER UNDER VERY
21 CONTROLLED CIRCUMSTANCE THAN TO MAKE THE PROCEDURE GO QUICKLY.
22 YOU HAVE A PERIOD OF BLEEDING, BE A SHORT TIME, TO HAVE SUPPORT
23 PEOPLE AROUND. THERE IS A BENEFIT OF BEING IN AN OPERATING
24 ROOM WHERE IT'S LIKE AN INTENSIVE CARE UNIT, IN A SENSE. YOU
25 HAVE THE ABILITY TO HANDLE THINGS ACUTELY.

1 SO A PROCEDURE IN THAT SITUATION WOULD BE
2 PREFERABLE. AND THESE ARE SITUATIONS ALSO WHERE THE MATERNAL
3 FETAL MEDICINE SPECIALISTS IN OUR DEPARTMENT ARE PART OF THE
4 CONSULTING TEAM, AND THE MAJORITY OF THE PATIENTS LIKE THIS
5 THAT HAVE SEVERE, ACTUALLY ALMOST ALL OF THE PATIENTS WITH
6 SEVERE MEDICAL CONDITIONS ARE REFERRED TO ME BY THE MATERNAL
7 FETAL MEDICINE SPECIALISTS IN OUR DEPARTMENT.
8 Q. WE ARE GOING TO SWITCH TOPICS A LITTLE BIT.
9 I KNOW YOU WERE LOOKING AT THE CLOCK, YOUR HONOR.
10 DO YOU WANT TO GO TO FOUR?
11 THE COURT: I AM ASSUMING YOU WILL BE FINISHED BY
12 FOUR WITH THE DIRECT?
13 MS. KRASNOFF: WITH THE DIRECT? YES, YOU'RE
14 INCORRECT.
15 THE COURT: WE WILL GO TO FOUR.
16 MS. KRASNOFF: CLOSE THOUGH.
17 BY MS. KRASNOFF:
18 Q. WE ARE GOING TO SWITCH AND TALK ABOUT CERVICAL
19 INCOMPETENCE.
20 WHAT IS CERVICAL INCOMPETENCE?
21 A. CERVICAL INCOMPETENCE IS A WEAKENING OF THE STRUCTURE OF
22 THE CERVIX THAT WOULD NOT ALLOW IT TO STAY CLOSED WITH PRESSURE
23 FROM A GROWING PREGNANCY.
24 SO, THE CERVIX IS ACTUALLY ABOUT 80 PERCENT
25 CONNECTIVE TISSUE AND 20 PERCENT MUSCLE, WHEREAS THE UTERUS IS

1 ALL MUSCLE, OR VIRTUALLY ALL MUSCLE. SO THAT CONNECTIVE
2 TISSUE, ALSO CALLED GROUND SUBSTANCE, AND IT'S VERY STRONG
3 TISSUE. SO, THE INABILITY OF THAT STRONG TISSUE TO JUST
4 MAINTAIN ITS STRUCTURE WHEN THERE IS A LOT OF PRESSURE FROM A
5 GROWING PREGNANCY, CERVICAL INCOMPETENCE, AND IT RESULTS IN
6 PAINLESS DILATION OF THE CERVIX.
7 Q. ARE YOU AWARE, DR. CREININ, THAT THE FINDINGS OF THE
8 PARTIAL-BIRTH ABORTION BAN ACT STATE THAT THE AMOUNT OF
9 DILATION NEEDED IN ORDER TO BE ABLE TO REMOVE A FETUS INTACT UP
10 TO THE CALVARIUM INCREASES THE RISK OF CERVICAL INCOMPETENCE?
11 A. YES, I AM.
12 Q. DO YOU AGREE WITH THAT FINDING?
13 A. NO, I DON'T.
14 Q. CAN YOU EXPLAIN WHY NOT?
15 A. WELL, FIRST, THERE IS A PHYSIOLOGIC BASIS. LABOR IS A
16 PROCESS WHERE THE CERVIX DILATES TO 10 CENTIMETERS, IF YOU TAKE
17 A WOMAN AT TERM. IT'S USUALLY 10 CENTIMETERS OVER A RELATIVELY
18 SHORT PERIOD OF TIME.
19 MOST WOMEN GO THROUGH LABOR WOULD HOPE IT WOULD BE A
20 VERY SHORT PERIOD OF TIME, BUT IN A D&E PROCEDURE, WE ARE
21 TALKING ABOUT SLOW DILATION TO TWO TO TWO AND A HALF
22 CENTIMETERS OVER A PERIOD OF 24 HOURS. SO, IT DOESN'T EVEN
23 MAKE PHYSIOLOGIC SENSE THAT IT WOULD CAUSE MORE DAMAGE TO A
24 CERVIX TO HAVE A SLOWER DILATION IN A LONGER PERIOD OF TIME OR
25 SLOW DILATION TO A LESSER AMOUNT COMPARED TO A GREATER DILATION

1 IN A SHORTER PERIOD OF TIME. SO, THERE IS NO PHYSIOLOGIC BASIS
2 FOR IT.
3 THEN THE LITERATURE THAT IS AVAILABLE, WHEN YOU LOOK
4 AT THE LITERATURE, THERE ARE A COUPLE OF STUDIES THAT ARE --
5 THAT REPORT ON A FEW PREGNANCIES, RELATIVELY FEW, 60 TO A
6 HUNDRED OR SO, OF WOMEN WHO HAD PROCEDURES AND THEN HAD
7 SUBSEQUENT PREGNANCIES. AND THE RATES, THERE WAS NO INCREASED
8 RATE OF PRE-TERM BIRTH OR PRE-TERM DELIVERY OR CERVICAL
9 INCOMPETENCE IN THOSE WOMEN.
10 NOW, THOSE STUDIES AREN'T LARGE ENOUGH TO MAKE
11 CONCLUSIONS, BUT IF YOU TAKE THOSE STUDIES THAT ARE AVAILABLE
12 ALONG WITH THE COMMON SENSE PHYSIOLOGY OF WHAT'S GOING ON, I
13 THINK THERE IS NO WAY YOU COULD DETERMINE THAT THERE WOULD BE
14 CERVICAL INCOMPETENCE. THERE IS DEFINITELY NO STUDIES TO SAY
15 IT DOES, AND IT DOESN'T MAKE ANY SENSE TO SAY THAT IT WOULD
16 HAPPEN. AND YOU WOULD -- BECAUSE THE COMMON SENSE PART OF IT
17 IS THAT IT WOULDN'T HAPPEN, YOU WOULD NEED REALLY LARGE STUDIES
18 TO PROVE THAT IT DOES.
19 MS. KRASNOFF: MAY I APPROACH, YOUR HONOR?
20 THE COURT: YES.
21 BY MS. KRASNOFF:
22 Q. EXHIBIT 17, THE KALISH ARTICLE.
23 DR. CREININ, I HANDED YOU WHAT HAS BEEN MARKED AS
24 EXHIBIT 17, WHICH IS AN ARTICLE BY DOCTORS KALISH, CHASEN AND
25 SEVERAL OTHERS, WHICH IS ENTITLED "IMPACT OF MID-TRIMESTER

1 DILATION AND EVACUATION ON SUBSEQUENT PREGNANCY OUTCOME." THIS
2 ARTICLE WAS PUBLISHED IN THE AMERICAN JOURNAL OF OBSTETRICS AND
3 GYNECOLOGY, VOLUME 187 IN OCTOBER OF 2002.
4 ARE YOU FAMILIAR WITH THAT ARTICLE, DR. CREININ?
5 A. YES, I AM.
6 Q. IS THAT ONE OF THE STUDIES YOU TALKED ABOUT THAT USE
7 RELATIVELY SMALL NUMBERS OF WOMEN?
8 A. YES, IT IS.
9 Q. CAN YOU TELL THE COURT, PLEASE, ABOUT THAT STUDY?
10 A. IN THIS STUDY IT WAS A RETROSPECTIVE REVIEW, WHICH MEANS
11 THEY LOOKED BACK ON CHARTS OF 600 WOMEN WHO HAD D&E PROCEDURES,
12 AND 96 OF THESE WOMEN HAD SUBSEQUENT PREGNANCIES. SO THEY
13 LOOKED AT THOSE 96 PREGNANCIES, AND -- TO SEE WHAT THE OUTCOMES
14 WERE, AND SPECIFICALLY RELATED AS CERVICAL INCOMPETENCE.
15 THERE WERE FIVE WOMEN -- I AM SORRY, THERE WERE 10
16 DELIVERIES THAT WERE BEFORE 37 WEEKS, FIVE OF WHICH WERE
17 OBSTETRIC OR MATERNAL INDICATIONS FOR THEM. THERE WERE FIVE
18 WOMEN WHO HAD PROPHYLACTIC CERCLOGES, WHICH ARE STITCHES IN THE
19 CERVIX TO KEEP THEM CLOSED. THOSE FIVE -- FOUR OF THOSE WOMEN
20 HAD A HISTORY OF CERVICAL INCOMPETENCE THAT PRECEDED THE D&E
21 THAT THEY HAD PREVIOUSLY, AND ONE OTHER PERSON HAD DES
22 EXPOSURE, AND THAT'S WHY HER DOCTORS CHOSE TO PUT IN THE
23 CERCLAGE. THAT'S ALSO AN INCREASE RISK FACTOR FOR CERVICAL
24 INCOMPETENCE.
25 SO NONE OF THOSE PATIENTS HAD EVIDENCE OF CERVICAL

1 INCOMPETENCE. AND THERE WERE NO PATIENTS WHO RECEIVED ANY
2 EMERGENCY CERCLAGES MEANING THAT EXPERIENCED CERVICAL
3 INCOMPETENCE, SO WHAT THEY FOUND IN THESE 96 WOMEN IS THAT
4 THERE WAS NO EVIDENCE OF CERVICAL INCOMPETENCE.
5 AS I SAID, THAT IS A SMALL STUDY, BUT AT LEAST IT
6 GIVES YOU SOME IDEA THAT IT FITS IN THE THEORETICAL
7 UNDERSTANDING OF WHAT YOU WOULD EXPECT PHYSIOLOGICALLY.
8 Q. JUST TO BE FAIR, WHAT WERE THE GESTATIONAL AGES OF THE
9 WOMEN INVOLVED IN THIS STUDY?
10 A. FOURTEEN TO 24 WEEKS.
11 Q. WHAT KIND OF ABORTION PROCEDURES HAD THEY HAD?
12 A. DILATION AND EVACUATION.
13 Q. IS IT YOUR UNDERSTANDING THAT THEY RECEIVED OSMOTIC
14 DILATION PRIOR TO THE PROCEDURE?
15 A. FOR THE DILATION AND EVACUATION?
16 Q. YES.
17 A. YES, IT IS.
18 THE COURT: ALL RIGHT. I THINK THIS IS AN
19 APPROPRIATE TIME TO STOP.
20 MS. KRASNOFF: OKAY.
21 THE COURT: IT'S 4:00 O'CLOCK. ALL RIGHT.
22 DOCTOR, YOU ARE EXCUSED. YOU MAY STEP DOWN.
23 WE WILL ADJOURN UNTIL TOMORROW MORNING AT 8:30, AND
24 WE WILL HAVE A REGULAR DAY TIME-WISE TOMORROW.
25 MS. KRASNOFF: THAT WON'T BE A PROBLEM.

1 THE COURT: ANY PROBLEM?
2 MR. QUINLIVAN: NO, NO. NOT A PROBLEM. IF I CAN
3 RAISE ONE ISSUE WITH YOUR HONOR.
4 DURING THE TESTIMONY OF DR. DOE ON -- AT REDIRECT, I
5 HAD OBJECTED TO QUESTIONS ABOUT TWO STUDIES. YOUR HONOR HAD
6 INITIALLY SUSTAINED MY OBJECTION, AND THEN BASED ON A
7 REPRESENTATION OF PLAINTIFFS' COUNSEL, ALLOWED THE TESTIMONY TO
8 GO FORWARD.
9 WE NOW HAVE THE TRANSCRIPT, AND IF I MIGHT SUGGEST,
10 IF I CAN ASK LEAVE OF THE COURT TO FILE A SHORT LETTER BRIEF ON
11 A MOTION TO STRIKE, AND I CAN GO INTO THE DETAILS THEN, AND I
12 WILL, OF COURSE, PROVIDE THE COURT WITH THE RELEVANT PAGES OF
13 THE TRANSCRIPT.
14 THE COURT: CAN YOU DO THAT TOMORROW OR DO YOU WANT
15 TO WAIT UNTIL THURSDAY MORNING?
16 MR. QUINLIVAN: I WILL DO THAT TOMORROW.
17 MS. PARKER: YOUR HONOR, WILL WE HAVE AN OPPORTUNITY
18 TO FILE A RESPONSE TO IT?
19 THE COURT: YES. YOU CAN FILE ONE ON WEDNESDAY, AND
20 I WILL GIVE YOU A RULING ON THURSDAY.
21 MS. PARKER: THANK YOU.
22 MR. QUINLIVAN: THANK YOU, YOUR HONOR.
23 THE COURT: WE ARE ADJOURNED UNTIL 8:30.
24
25 (PROCEEDINGS ADJOURNED AT 4:00 P.M.)

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