VOLUME 5

PAGES 697 - 868

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,	)	TUESDAY, APRIL 6, 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

		PLANNED PARENTHOOD FEDERATION OF AMERICA
		1780 MASSACHUSETTS AVENUE, N.W.
		WASHINGTON, D.C. 200036
	BY:	HELENE T. KRASNOFF, ESQUIRE
FOR INTERVENOR PLAINTIFFS CITY AND COUNTY OF SAN FRANCISCO:		OFFICE OF THE CITY ATTORNEY
		1390 MARKET STREET, SUITE 1008
		SAN FRANCSICO, CALIFORNIA 94102
	BY:	KATHLEEN SUZANNE MORRIS,
		ALEETA MARIE VAN RUNKLE,
		DEPUTY CITY ATTORNEYS
FOR DEFENDANT:		U.S. DEPARTMENT OF JUSTICE
		20 MASSACHUSETTS AVENUE, N.W. ROOM 7128
		WASHINGTON, D.C. 20530
	BY:	MARK THOMAS QUINLIVAN
		W. SCOTT SIMPSON,
		KAIJA MARIE CLARK,
		ASSISTANT U.S. ATTORNEYS

TUESDAY, APRIL 6, 2004 8:30 A.M.

P R O C E E D I N G S

THE COURT: GOOD MORNING, COUNSEL.

GOOD MORNING, DOCTOR.

THE WITNESS: GOOD MORNING.

THE COURT: ARE YOU READY TO CONTINUE?

MS. PARKER: I HAVE ONE HOUSEKEEPING MATTER, YOUR HONOR. WE HAVE A BRIEF ON THE ISSUE OF THE SUBMISSION OF THE TWO DREY STUDIES, AS WELL AS THE CHASEN STUDY. THIS IS NOTWITHSTANDING OUR ATTEMPT TO GET IT IN UNDER THE EXCEPTION TO THE HEARSAY RULE FOR PRESENT SENSE EXCEPTION, ON FURTHER RESEARCH IT LOOKS LIKE THE RESIDUAL EXCEPTION IS THE APPROPRIATE ONE. AND THERE IS ACTUALLY FAIRLY EXTENSIVE CASE LAW THAT PRESENTS THAT.

THE COURT: I WOULD ASSUME THAT THE DEFENSE WOULD LIKE TO LOOK AT THE MOTION AND FILE AN OPPOSITION?

MR. SIMPSON: YES, YOUR HONOR.

THE COURT: YOU ALL CAN FILE YOUR OPPOSITION TOMORROW AS WELL AS PLAINTIFFS' OPPOSITION ON THE MOTION TO STRIKE DR. DOE'S TESTIMONY.

DO YOU HAVE YOUR BRIEF?

MR. QUINLIVAN: I DO, YOUR HONOR.

THE COURT: HAVE YOU PROVIDED A COPY TO PLAINTIFF?

MR. QUINLIVAN: I AM GOING TO DO THAT RIGHT NOW.

THE COURT: ALL RIGHT.

ALL RIGHT, MS. KRASNOFF.

MS. KRASNOFF: YES.

(THEREUPON, DR. CREININ RESUMED THE STAND.)

DIRECT EXAMINATION

BY MS. KRASNOFF:

Q. GOOD MORNING, DR. CREININ.

A. GOOD MORNING.

Q. YESTERDAY YOU GAVE SOME TESTIMONY. I JUST WANTED TO CLARIFY ONE THING ABOUT THAT.

YOU STATED THAT YOU BELIEVE THERE MAY BE LIVER PATIENTS FOR WHOM AN INTACT REMOVAL OR AN ATTEMPT TO REMOVE THE FETUS INTACT MAY BE PREFERABLE. IS THERE A REASON WHY YOU BELIEVE IN YOUR PRACTICE YOU WOULD SEE THOSE SORT OF PATIENTS?

A. WELL, PATIENTS WITH LIVER TRANSPLANTS OR LIVER PROBLEMS. AT THE UNIVERSITY OF PITTSBURGH WHERE I PRACTICE IS PRETTY MUCH THE LIVER TRANSPLANT CAPITAL OF THE WORLD.

IT IS WHERE THINGS PRETTY MUCH WERE DEVELOPED AND STARTED, AND SO THEY GET PATIENTS WHO COME FROM ALL OVER THE WORLD TO GET THEIR LIVER TRANSPLANTS AND OTHER TRANSPLANTS.

Q. AND WHEN WE BROKE YESTERDAY WE WERE TALKING ABOUT CERVICAL INCOMPETENCE AND ABOUT -- WE HAD JUST FINISHED DISCUSSING THE STUDY BY DRS. KALISH AND CHASEN AND OTHERS ABOUT D&E ABORTIONS AND WHETHER THEY LEAD TO CERVICAL INCOMPETENCE.

ARE YOU FAMILIAR WITH OTHER STUDIES THAT RELATE

SPECIFICALLY TO D&E ABORTIONS AND THAT ISSUE?
A. THERE IS ONE OTHER STUDY BY SCHNEIDER, WHICH IS A SERIES SIMILAR TO THE KALISH STUDY, WHICH JUST COMMENTS ON FOLLOW-UP WITH PATIENTS AFTER D&E, SHOWING THAT -- I BELIEVE IT WAS AROUND 60 ODD PATIENTS.

MS. KRASNOFF: IF I MAY, APPROACH YOUR HONOR.

THE COURT: YES.

MS. KRASNOFF: THIS IS LEARNED TREATISE FOUR.

BY MS. KRASNOFF:
Q. DR. CREININ, THIS IS AN ARTICLE BY DR. SCHNEIDER AND SEVERAL OTHERS, ENTITLED:

"ABORTION AT 18 TO 22 WEEKS BY LAMINARIA DILATION AND EVACUATION," PUBLISHED IN VOLUME 88 OF OBSTETRICS AND GYNECOLOGY IN SEPTEMBER, 1996.

IS THIS THE STUDY YOU WERE REFERRING TO?
A. YES.
Q. CAN YOU EXPLAIN THAT STUDY BRIEFLY AND ITS CONCLUSIONS?
A. THIS WAS A CASE SERIES OF 171 DILATION AND EVACUATION ABORTIONS. AND IN THE FINDINGS, IN THE RESULTS AT THE TIME OF THE REPORT THERE WERE 61 WOMEN WHO WERE PREGNANT FOLLOWING THE D&E PROCEDURE, AND NONE OF THOSE WOMEN HAD CERVICAL INCOMPETENCE. AND THE AUTHORS SPECIFICALLY COMMENT ON IT ON THE LAST PAGE OF THE ARTICLE.
Q. AND THOSE WOMEN HAD ABORTIONS BY THE D&E METHOD; IS THAT CORRECT?

A. YES, IT IS.
Q. AND WHAT WERE THE GESTATIONAL AGES OF THE WOMEN WHEN THEY HAD THE ABORTION?
A. EIGHTEEN TO 22 WEEKS.
Q. NOW, WE HAVE TALKED ABOUT THESE TWO CASE SERIES WHICH DEMONSTRATE OR CONCLUDE THAT THERE'S NO INCREASE INCIDENCES OF CERVICAL INCOMPETENCE OR AT LEAST SUGGEST THAT; IS THAT CORRECT?
A. YES.
Q. DO YOU KNOW OF ANY DATE THAT SUGGESTS THAT OSMOTIC DILATION PRIOR TO A D&E DOES LEAD TO CERVICAL INCOMPETENCE?
A. NO.
Q. AT THE BEGINNING OF YOUR TESTIMONY YESTERDAY, YOU TESTIFIED THAT YOU HAVE CONDUCTED GYNECOLOGIC RESEARCH YOURSELF; IS THAT CORRECT?
A. YES.
Q. WHAT IS A PROSPECTIVE RANDOMIZED TRIAL?
A. THAT'S A STUDY WHERE THERE ARE TWO OR MORE GROUPS ASSIGNED TO A SPECIFIC TREATMENT OR INTERVENTION, AND THAT ASSIGNMENT IS RANDOM, EITHER BY LIKE SIMILAR TO FLIPPING A COIN, AND MOST COMMONLY TODAY WE USE COMPUTER-GENERATED TABLES TO PROVIDE THE RANDOMIZATION.
AND THE TREATMENT OR THE INTERVENTION IS ONE IN WHICH THE STUDY PARTICIPANT AND THE PEOPLE PERFORMING THE STUDY HAVE NO CHOICE OR SAY ON WHAT TREATMENT OR INTERVENTION THEY

GET.

AND THEN, THE PARTICIPANTS ARE FOLLOWED PROSPECTIVELY, MEANING FROM THE TIME OF THE INTERVENTION FORWARD, TO SEE WHAT HAPPENS FROM THE INTERVENTION OR TREATMENT.

Q. AND HAVE YOU YOURSELF EVER DESIGNED AND CONDUCTED PROSPECTIVE RANDOMIZED TRIALS?

A. YES.

Q. HOW MANY HAVE YOU BEEN THE PRINCIPAL INVESTIGATOR FOR?

A. EIGHT FOR WHICH I HAVE BEEN THE PERSON WHO DESIGNED, CARRIED OUT, NOT JUST BEING A PRINCIPAL INVESTIGATOR AT MY CENTER FOR A STUDY THAT IS GOING ON IN A LOT OF OTHER CENTERS, BUT ACTUALLY EIGHT THAT I HAVE BEEN IN CHARGE OF COMPLETELY.

Q. IN ADDITION TO THE EIGHT THAT YOU HAVE BEEN IN CHARGE OF, HAVE YOU BEEN INVOLVED IN OTHERS?

A. YES.

Q. DO YOU KNOW APPROXIMATELY HOW MANY?

A. MORE THAN 20.

Q. AND HAVE YOU EVER DESIGNED AND CONDUCTED, WHERE YOU WERE THE PRINCIPAL INVESTIGATOR, A PROSPECTIVE RANDOMIZED TRIAL SPECIFICALLY RELATED TO ABORTION METHODS?

A. YES.

Q. AND CAN YOU DESCRIBE THAT STUDY, PLEASE?

A. THAT WAS A STUDY LOOKING AT EARLY ABORTION METHODS, MEDICAL ABORTION VERSUS SURGICAL ABORTION. AND THIS WAS A STUDY IN

WOMEN UP TO SEVEN WEEKS OF PREGNANCY, SO IT WAS VERY EARLY. BUT THE STUDY WAS LOOKING AT RANDOMIZING WOMEN TO ONE OF THE TWO TREATMENTS. AND THE CRITERIA FOR ENROLLMENT IN THE STUDY WAS THAT WOMEN HAD TO HAVE NO PREFERENCE FOR WHICH METHOD THEY WANTED.

THEY, THE WOMEN, WENT THROUGH COUNSELING FIRST ABOUT THE DIFFERENT OPTIONS. AND THEN, IF THEY TRULY FELT THEY HAD NO PREFERENCE, AND THEY MET THE OTHER ENTRY CRITERIA THEY COULD BE ENROLLED IN THE STUDY.

Q. AND HOW MANY WOMEN WERE YOU TRYING TO ENROLL IN THE STUDY?

A. THE SAMPLE SIZE ESTIMATES -- SAMPLE SIZE ESTIMATES FOR THE OUTCOMES I WAS LOOKING AT WERE ABOUT A HUNDRED WOMEN TOTAL.

Q. WHAT WAS YOUR EXPERIENCE IN TRYING TO DO THAT?

A. AFTER TWO YEARS WE STOPPED THE STUDY EARLY BECAUSE WE COULD ONLY ENROLL 50 WOMEN AFTER TWO YEARS. WE INTERVIEWED OR HAD NOT INTERVIEWED, BUT HAD APPROXIMATELY A THOUSAND WOMEN CONTACT US ABOUT THE STUDY. AND AFTER REVIEWING THE OPTIONS WITH THEM AND THE DIFFERENT OPTIONS FOR ABORTION, ONLY 50 AFTER TWO YEARS FELT THAT THEY TRULY HAD NO PREFERENCE.

Q. AND YOU SPOKE TO ALL OR SOMEONE SPOKE WITH ALL THOUSAND OF THOSE WOMEN?

A. CORRECT.

Q. BASED ON YOUR EXPERIENCE WITH THIS STUDY, DO YOU HAVE AN OPINION ABOUT WHETHER IT WOULD BE FEASIBLE TO CONDUCT A PROSPECTIVE RANDOMIZED TRIAL ABOUT ABORTION METHODS AFTER 16

WEEKS OF GESTATION?

A. YES, I DO.

Q. AND WHAT IS THAT OPINION?

A. IF I GO BACK TO THE STUDY A LITTLE BIT, EVEN FOR THOSE 50 WOMEN, ONCE THEY ENROLLED IN THE STUDY, I THEN DID FURTHER VERY SOPHISTICATED TESTING TO SEE IF THEY TRULY HAD A PREFERENCE. AND ACTUALLY 35 OF THE 50 REALLY DID HAVE A PREFERENCE ONCE YOU COULD FIGURE IT OUT.

SO THERE WERE TRULY ONLY 15 WOMEN WHO HAD NO REAL PREFERENCE AS TO WHICH METHOD THEY PREFERRED OUT OF A THOUSAND OVER TWO YEARS. AND THIS IS IN WOMEN UP TO SEVEN WEEKS. AND THERE IS A MUCH LARGER POOL OF WOMEN AVAILABLE IN THE U.S. WHEN YOU LOOK AT THE NUMBER OF ABORTIONS DONE IN THE U.S. AND AT WHAT GESTATIONAL AGES.

SO WHEN YOU START TO LOOK, THEN, AT LATER GESTATIONAL AGES, THE ONES WE ARE TALKING ABOUT AFTER 16 WEEKS, THERE IS RELATIVELY SIGNIFICANTLY FEWER WOMEN WHO ARE HAVING ABORTIONS AT THAT TIME.

SO TO HAVE A PROSPECTIVE RANDOMIZED TRIAL WOULD BE UNFEASIBLE, UNREASONABLE AND IMPOSSIBLE TO DO.

Q. AND IF YOU WERE TRYING TO PROVE SAFETY, SPECIFICALLY, OF VARIOUS METHODS OF ABORTION AFTER 16 WEEKS, IS THERE A REASON THAT THAT WOULD BE DIFFICULT, AS WELL?

A. ALL THE LABOR INDUCTION, D&E, THEY ARE ALL VERY SAFE METHODS. AND WE HAVE HEARD THERE IS A LOT THAT GOES INTO A

WOMEN'S DECISION AS TO WHICH METHOD SHE PREFERS. AND IN AN INDIVIDUAL CIRCUMSTANCE, BOTH PERSONALLY FOR HER, AS WELL AS MEDICALLY. AND WHEN YOU START TO LOOK AT OUTCOMES, WHEN THE OUTCOMES YOU ARE LOOKING AT ARE VERY RARE OR THEY DON'T OCCUR VERY FREQUENTLY, IF YOU ARE LOOKING AT SERIOUS MORBIDITIES -- WITH ANY OF THESE METHODS YOU ARE LOOKING AT THINGS THAT ARE 1 TO 2 PERCENT AT THE GREATEST.

SO FOR METHODS THAT ARE VERY SAFE, VERY EFFECTIVE, IN GENERAL TO TRY AND PROVE A DIFFERENCE OR PROVE THAT ONE IS BETTER THAN ANOTHER FOR ALL COMERS, FOR ALL PEOPLE WOULD BE IMPOSSIBLE. THE SAMPLE SIZES WOULD BE HUGE.

I HAVE DONE SOME CALCULATIONS, CAN I --

Q. SURE.

A. I AM HAPPY TO SHARE THIS.

THE COURT: HAS THIS BEEN MADE --

MR. SIMPSON: THIS HAS NOT.

THE WITNESS: I DID THIS ON MY COMPUTER A COUPLE DAYS AGO, AND I AM HAPPY TO SHARE IT. BUT IT'S JUST THAT IF YOU HAD AN OUTCOME THAT WAS 1 PERCENT FOR ONE GROUP AND ONE-HALF OF ONE PERCENT FOR ANOTHER GROUP THAT YOU WERE TRYING TO SAY THERE IS A DIFFERENCE THOSE OUTCOMES, YOU WOULD NEED OVER 5,000 WOMEN PER GROUP TO PROVE THAT WAS STATISTICALLY SIGNIFICANTLY DIFFERENT.

SO, IF YOU WERE AT 2 PERCENT VERSUS 1 PERCENT, YOU ARE STILL OVER 2500 WOMEN PER GROUP. AND THEN, TO GET PEOPLE

WHO COULD DO RESEARCH AND TO GET WOMEN WHO THEN WERE INTERESTED AND WILLING TO BE RANDOMIZED, IT IS JUST A COMPLETELY UNFEASIBLE STUDY.

THERE IS ANOTHER STUDY WE JUST FINISHED THAT WAS FUNDED BY THE NIH, WHERE IT WAS LOOKING AT MISCARRIAGE AND THE TREATMENT OF EARLY MISCARRIAGE. AND WOMEN WERE RANDOMIZED TO MEDICAL OR SURGICAL TREATMENT. AND THERE WERE FOUR VERY LARGE, WELL-RESPECTED CENTERS THAT WERE AWARDED THE CONTRACT BY THE NIH TO DO THE STUDY WITH THE GOAL THAT WE WOULD ENROLL 800 WOMEN OVER ABOUT A YEAR-AND-A-HALF BETWEEN THE FOUR CENTERS.

AND IN OVER TWO YEARS THE FOUR CENTERS COULD ONLY GET A LITTLE OVER 600 WOMEN. AND WE RECALCULATED OUR SAMPLE SIZE NEEDS AND FELT THAT WAS ENOUGH. BUT THAT WAS IN EARLY MISCARRIAGE.

SO TO GET WOMEN TO SAY THEY ARE WILLING TO BE RANDOMIZED BETWEEN SURGICAL AND MEDICAL METHOD BECAUSE THEY HAVE PREFERENCES AND THERE ARE DIFFERENCES FOR THEM AS INDIVIDUALS, IS, AGAIN, UNFEASIBLE AT THE GESTATIONAL AGES WE ARE TALKING ABOUT FOR D&E VERSUS LABOR INDUCTION.

BY MS. KRASNOFF:

Q. AND OTHER THAN YOUR OWN EXPERIENCES, DO YOU RELY ON ANY OTHER STUDIES IN REACHING THE CONCLUSION THAT A STUDY OF PROCEDURES AFTER 16 WEEKS WOULD BE EXTREMELY DIFFICULT?

A. THERE WAS A STUDY JUST PUBLISHED BY DAVID GRIMES FROM NORTH CAROLINA THAT LOOKED AT THE FEASIBILITY OF THIS ISSUE AND --

Q. WOULD IT HELP IF I SHOWED IT TO YOU?
A. YES.
MS. KRASNOFF: IF I MAY APPROACH, I WOULD ALSO LIKE TO SHARE HIS NOTES WITH COUNSEL.
THE COURT: IF YOU WOULD. AND WHAT IS IT YOU ARE REFERRING TO?
MS. KRASNOFF: THIS IS LEARNED TREATISE 11.
BY MS. KRASNOFF:
Q. DR. CREININ, THAT IS A STUDY BY DR. GRIMES AT THE UNIVERSITY OF NORTH CAROLINA AND OTHERS ENTITLED:
"MIFEPRISTONE AND MISOPROSTOL VERSUS DILATION AND EVACUATION FOR MIDTRIMESTER ABORTION: A PILOT RANDOMISED, CONTROLLED TRIAL."
THIS WAS PUBLISHED IN THE BRITISH JOURNAL OF OBSTETRICS AND GYNECOLOGY JUST THIS FEBRUARY, 2004, IN VOLUME 111.
IS THIS THE ARTICLE YOU ARE REFERRING TO?
A. YES.
Q. WHAT WAS DR. GRIMES COMPARING?
A. THE PRIMARY OBJECTIVE OF THE STUDY WAS TO ASSESS THE FEASIBILITY OF RANDOMIZING U.S. WOMEN TO THESE TWO METHODS OF ABORTION. SO LABOR INDUCTION PROCESS VERSUS DILATION AND EVACUATION.
Q. OKAY.
A. AND THE GOAL WAS IN ASSESSING THE FEASIBILITY TO -- THEY

CALCULATED THE SAMPLE SIZE OF 60 WOMEN THAT THEY WOULD NEED TO COMPARE THE TWO FROM A FEASIBILITY STANDPOINT, AND THEY ALSO ESTABLISHED THAT IF THEY COULD NOT ENROLL AT LEAST 20 WOMEN IN TWELVE MONTHS, OR 40 WOMEN IN 24 MONTHS, THEY WOULD CONSIDER IT UNFEASIBLE AND STOP THE STUDY.

Q. WHAT WAS THEIR EXPERIENCE?

A. IN TWELVE MONTHS, THEY COULD ONLY ENROLL 18 WOMEN, BECAUSE THE MAJORITY HAD A PREFERENCE FOR WHAT THEY WANTED TO HAVE AS FAR AS THEIR METHOD OF ABORTION.

Q. WHAT WAS THE GESTATIONAL AGE RANGE THAT DR. GRIMES WAS LOOKING AT?

A. THESE WERE WOMEN, I BELIEVE, UP TO 20 WEEKS, BUT I NEED TO -- 14 TO 19 WEEKS. SO BETWEEN 14 AND 20 WEEKS.

Q. AND WHY DOES DR. GRIMES' EXPERIENCE SUPPORT YOUR VIEW ABOUT THE FEASIBILITY OF RANDOMIZED TRIALS AFTER 16 WEEKS?

A. IF YOU WERE GOING TO DO STUDIES OF THIS NATURE YOU WOULD NEED WELL-RESPECTED RESEARCHERS AND WELL-RESPECTED INSTITUTIONS THAT KNOW HOW TO PERFORM RESEARCH APPROPRIATELY. AND THE INSTITUTION WHERE DR. GRIMES IS AND DR. GRIMES HIMSELF IS AN INCREDIBLY WELL-RESPECTED MENTOR, RESEARCHER, TEACHER.

AND I CAN THINK OF NOBODY WHO WOULD BE A GREATER EXAMPLE OF HOW TO CONSTRUCT SUCH A STUDY. AND IF THEY COULDN'T FIND IT FEASIBLE THERE, I WOULDN'T -- AND "FEASIBLE" MEANING 20 PEOPLE IN A YEAR. AND THEY COULDN'T EVEN GET THAT.

SO I CAN'T SEE THIS AS BEING FEASIBLE ANYWHERE.

Q. I WANT TO SWITCH GEARS A LITTLE BIT NOW AND TALK TO YOU ABOUT INDUCTION ABORTIONS.

YOU TESTIFIED YOU NO LONGER DO INDUCTIONS; IS THAT CORRECT?

A. YES.

Q. BUT YOU DID TESTIFY YOU ARE ALSO THE CO-AUTHOR OF A CHAPTER IN A TEXTBOOK ABOUT INDUCTIONS; IS THAT CORRECT?

A. I AM AN AUTHOR, AND THE UPDATE IS AS A CO-AUTHOR.

Q. WHY DO YOU NOT DO INDUCTIONS AS A PART OF YOUR CURRENT PRACTICE?

A. BECAUSE IN MY CURRENT PRACTICE I BELIEVE IN MY HANDS THAT A D&E IS SAFER FOR A WOMAN THAN A LABOR INDUCTION. AND WHEN WE LOOK AT THE PRACTICE AT MY INSTITUTION, BECAUSE IN OUR DEPARTMENT WE ALSO, IN GENERAL, FEEL THAT SAME WAY.

THE MAJORITY, VAST MAJORITY OF WOMEN AT OUR INSTITUTION, WHETHER IT BE FOR ELECTIVE OR MATERNAL OR FETAL INDICATIONS THAT HAVE A TERMINATION AT THIS POINT IN PREGNANCY HAVE A D&E PROCEDURE, OR ARE COUNSELED ABOUT THE OPTIONS AND CHOOSE A D&E.

RELATIVELY FEW INDUCTIONS ARE PERFORMED. BECAUSE THERE ARE SO FEW, IT'S MY FEELING, THAT IT'S BEST LEFT AT THAT POINT TO THE PEOPLE WHO ARE DOING THEM MORE THAN ME.

THERE'S ALSO AN ISSUE OF OBSTETRICS MALPRACTICE COVERAGE. BUT THAT BECAME SECONDARY BECAUSE THAT ONLY BECAME AN ISSUE ABOUT TWO YEARS AGO. BUT I HAVEN'T DONE INDUCTIONS

FOR NEARLY 10 YEARS JUST BECAUSE THERE ARE SO FEW. I WOULD MUCH RATHER HAVE THE MATERNAL FETAL MEDICINE SPECIALIST DO THOSE PROCEDURES, WHEREAS MY PARTNERS AND I WOULD DO THE -- PROVIDE THE DILATION AND EVACUATION SERVICES ARE THE PEOPLE WHO PROVIDE THOSE SERVICES.

AND THE VAST MAJORITY OF PEOPLE ARE REFERRED TO US FOR D&E AFTER COUNSELING, AND PRIMARILY BY THE MATERNAL FETAL MEDICINE SPECIALISTS AND GENETIC SPECIALISTS.

Q. DO YOU EVER REFER ANY OF YOUR PATIENTS FOR INDUCTIONS?

A. YES.

Q. AND IN WHAT CIRCUMSTANCES?

A. IT'S NOT UNUSUAL FOR PATIENTS TO BE REFERRED TO ME BY THEIR OBSTETRICIAN/GYNECOLOGIST, AND THEY HAVEN'T HAD FULL CONSULTATION WITH GENETICS OR MATERNAL FETAL MEDICINE OR BOTH.

SO AN IMPORTANT PART OF MY COUNSELING WITH THEM IS TO GO OVER THEIR OPTIONS, AS I DO WITH EVERY WOMAN. AND THERE ARE PEOPLE WHO FEEL, WHETHER IT BE FOR THEIR INDIVIDUAL, PERSONAL REASONS OR WHATEVER THE CIRCUMSTANCES MAY BE, THAT THEY PREFER A LABOR INDUCTION ABORTION. AND BY ALL MEANS I WOULD NOT DENY THAT TO THEM.

SO THEN THE MATERNAL FETAL MEDICINE SPECIALIST PERFORM THE LABOR INDUCTION.

Q. IF YOU CAN APPROXIMATE HOW FREQUENTLY AFTER COUNSELING DO WOMEN CHOOSE INDUCTION?

MS. CLARK: OBJECTION, LACK OF FOUNDATION, UNLESS HE

IS TALKING ABOUT HIS OWN PRACTICE.

THE WITNESS: IN MY OWN PRACTICE?

BY MS. KRASNOFF:

Q. YES.

A. ABOUT A YEAR, ONE PATIENT A YEAR. AGAIN, MOST OF THESE PATIENTS ALREADY -- A LOT OF THESE PATIENTS ALREADY HAD BEEN COUNSELED, BUT I CAN SPEAK IN GENERAL FOR OUR INSTITUTION. IT IS VERY RARE THAT WE PERFORM LABOR INDUCTION ABORTIONS.

Q. ARE THERE MEDICAL SITUATIONS WHERE YOU THINK A SURGICAL ABORTION WOULD BE PREFERABLE FOR A PATIENT TO AN INDUCTION?

A. YES.

Q. CAN YOU GIVE SOME EXAMPLES OF THOSE?

A. IF A WOMAN HAS HAD PRIOR SURGERY ON HER UTERUS, THEN DEPENDING ON WHAT KIND OF SURGERY AND WHERE THE SURGERY WAS, IT WOULD BE DEFINITELY PREFERABLE NOT TO HAVE HER LABOR, IF AT ALL POSSIBLE.

CAN I GO UP TO THE DIAGRAM?

THE COURT: YES.

THE WITNESS: IN THE -- WHEN THE UTERUS IS CONTRACTING, WHETHER IT BE AT TERM OR IF WE GIVE MEDICINES TO MAKE THE UTERUS CONTRACT TO CAUSE LABOR, THE STRONGEST PART OF THE UTERUS IS THE PART UP AT THE TOP. AND THE PART THAT IS LOWER DOESN'T CONTRACT AS STRONGLY. AND IT MAKES SENSE. THE UTERUS WANTS TO CONTRACT FROM THE TOP DOWN TO EXPEL THE FETUS, AS PART OF GOING THROUGH LABOR OR INDUCTION ABORTION.

AND SO THIS MUSCLE UP HERE (INDICATING) CONTRACTS MUCH MORE STRONGLY. IF AN INCISION HAS BEEN MADE IN THE UPPER PART OF THE UTERUS, LIKE WITH A MYOMECTOMY WITH FIBROIDS HAVE BEEN REMOVED IN THE PAST, OR IF A WOMAN HAD A CESAREAN SECTION WITH A SCAR INCLUDED THE UPPER PART OF THE UTERUS, WE RECOMMEND -- IN FACT, WE ALMOST INSIST WITH WOMEN THAT IF THEY ARE LOOKING AT HAVING A DELIVERY THAT THEY CANNOT HAVE A VAGINAL DELIVERY.

AND WE WILL GO TO LARGE EXTENTS IN GENERAL OBSTETRICS PRACTICE TO PREVENT THEM FROM GOING INTO LABOR BY CHECKING FETAL LUNG MATURITY EARLY, BEGINNING AROUND 36 WEEKS SO THAT THEY DON'T EVER GO INTO LABOR.

IF THE FETUS LUNGS ARE MATURE, THEN WE DO THEIR C-SECTION SO THEY NEVER HAVE TO HAVE LABOR IF THEY HAVE HAD AN INCISION UP HERE (INDICATING).

AND THE SAME THING APPLIES FOR LABOR INDUCTION ABORTION. WHERE A WOMAN HAS HAD SURGERY IN THIS PART OF THE UTERUS, I WOULD NOT WANT TO GIVE HER MEDICINES THAT WOULD MAKE HER CONTRACT SO STRONGLY THAT IT PUTS HER AT THOSE SAME RISKS.

IF A WOMEN INSISTS THAT SHE IS WILLING TO TAKE THAT RISK, THEN WE WOULD STILL DISCUSS IT FURTHER. I HAVE NEVER MET A PATIENT WHO HAS SAID:

"I INSIST ON TAKING THAT RISK AS OPPOSED TO HAVING A D&E."

BUT THOSE WOULD SITUATIONS -- THAT WOULD BE ONE

SITUATION WHERE THERE IS A TRUE, STRONG RELATIVE CONTRAINDICATION TO LABOR INDUCTION, AND A D&E PROCEDURE WOULD BE THE -- MEDICALLY, THE WISER CHOICE, AND EVEN COMMON SENSICALLY, THE WISER CHOICE.

BY MS. KRASNOFF:

Q. DOES A WOMAN EVERY HAVE ANY UNDERLYING MEDICAL CONDITIONS THAT WOULD MAKE INDUCTION RISKIER?

A. THERE ARE A LOT OF WOMEN WHO HAVE SIGNIFICANT MEDICAL PROBLEMS, AND THAT'S ONE OF THE REASONS THAT THEY ARE HAVING A PROCEDURE AT THIS POINT.

AND IT IS NOT JUST THAT THEY WERE -- THE MEDICAL PROBLEMS WERE JUST DISCOVERED, BECAUSE THERE ARE A LOT OF WOMEN WHO HAVE MEDICAL PROBLEMS AND HAVE WORKED REALLY HARD TO PLAN A PREGNANCY AND TRY AND GET A PREGNANCY TO A POINT WHERE THEY COULD CONTINUE IT.

BUT AS THE PREGNANCY PROGRESSES, JUST THINGS ARE WORSENING IN THEIR MEDICAL SITUATION, AND THEY REALIZE IT IS JUST NOT IN THEIR BEST MEDICAL INTEREST IN CONSULTATION WITH THEIR DOCTOR.

SO VERY OFTEN, THESE ARE VERY DESIRED PREGNANCIES. IN AND THOSE SITUATIONS, IF THERE'S SEVERE HEART DISEASE OR RESPIRATORY DISEASE, THERE ARE A LOT OF THINGS ABOUT LABOR INDUCTION WHICH, FROM FLUID SHIFTING, FROM THE MEDICINES THAT YOU NEED TO GIVE IN THE VERY PROLONGED TIME COURSE OF AN AVERAGE LABOR INDUCTION THAT A VERY SHORT, CONTROLLED PROCEDURE

WOULD BE SAFER FOR THE WOMAN, KEEPING -- I SAID THIS YESTERDAY. AN OPERATING ROOM IS LIKE AN INTENSIVE CARE UNIT IN THAT SENSE.

I WOULD MUCH RATHER HAVE A PROCEDURE PERFORMED MEDICALLY, IN MY OPINION, PERFORM A PROCEDURE UNDER VERY CONTROLLED CIRCUMSTANCE, GIVEN ALL OF HER MEDICAL ISSUES, THAN TO HAVE A PROLONGED PROCESS WHERE I CAN'T EVEN GUARANTEE WHEN AND IF IT WILL BE SUCCESSFUL.

Q. AND WHAT ARE THE COMPLICATIONS THAT GO WITH INDUCTION ABORTION?

A. BLEEDING, BLEEDING SIGNIFICANTLY ENOUGH TO REQUIRE TRANSFUSION. THE BLEEDING CAN OCCUR FROM ABRUPTION, AS WE TALKED ABOUT YESTERDAY, INFECTION, CERVICAL INJURY, UTERINE INJURY. WE ARE MAKING THE UTERUS CONTRACT AT A TIME WHEN IT DOESN'T WANT TO CONTRACT.

SO WE HAVE TO GIVE VERY HIGH DOSES OF MEDICINES, MUCH HIGHER THAN YOU WOULD GIVE AT TERM, JUST BECAUSE WE ARE TRYING TO OVERRIDE THE FACT THAT THE UTERUS DOESN'T WANT TO DO THIS PROCESS. SO YOU HAVE TO MAKE THE UTERUS CONTRACT SO STRONGLY THAT IT CAN JUST BREAK APART, TO PUT IT IN SIMPLISTIC TERMS.

AND FAILURE OF THE INDUCTION METHOD, INABILITY TO SUCCESSFULLY COMPLETE AN INDUCTION. AND THEN, RETAINED TISSUE REQUIRING A SURGICAL INTERVENTION, ANYWAY, ANYWHERE FROM 20 TO 70 PERCENT, DEPENDING ON THE STUDY AND THE METHODOLOGY USED.

Q. WHEN YOU SAY "RETAINED TISSUE," CAN THAT BE A RETAINED

PLACENTA?

A. PRIMARILY IT IS A RETAINED PLACENTA.

Q. AND WHAT PERCENTAGE AGAIN?

A. IT CAN VARY FROM 20 TO 70 PERCENT, DEPENDING ON THE METHODOLOGY. YOU CAN LOOK AT STUDIES THAT SAY:

"IN OUR SITUATION, THIS IS WHAT WE FOUND."

BUT ESPECIALLY WITH THE MORE MODERN TECHNIQUES, THE STUDIES ARE INCREDIBLY SMALL. SO YOU HAVE TO, JUST LIKE I MENTIONED WITH THE STUDIES EARLIER WITH INCOMPETENCE THAT THEY ARE SMALL, BUT IT IS THE BEST WE HAVE, AND WE HAVE TO LOOK AT THEM FOR WHAT THEY ARE WORTH.

SAME THING WITH THE MODERN ABORTION OR MODERN LABOR INDUCTION ABORTION TECHNIQUES. THE STUDY SIZES ARE INCREDIBLY SMALL. SO WHEN YOU LOOK AT THE PERCENTAGES OF WOMEN WHO HAD RETAINED PLACENTA AND NEEDED INTERVENTION, YOU HAVE TO LOOK AT THAT WITHIN THE REALM OF: THEY ARE SMALL STUDIES, SO IT CAN HAVE A WIDER RANGE.

Q. WHEN YOU SAY "NEED INTERVENTION," WHAT DOES THAT MEAN?

A. USUALLY A PROCEDURE LIKE THE D&E, JUST TO REMOVE THE PLACENTA, BECAUSE THE PLACENTA RARELY CAN FIT THROUGH A SUCTION CANNULA. AT THAT POINT, YOU REALLY HAVE TO -- IF IT IS AT 20 WEEKS, YOU WOULD HAVE TO GRASP WITH A GRASPING INSTRUMENT THE SAME WAY TO REMOVE THE PLACENTA. SO IT IS TOO LARGE TO FIT THROUGH A SUCTION CANNULA.

Q. WHAT IS DIC?

A. DIC IS DISSEMINATED INTRAVASCULAR COAGULOPATHY, WHICH MEANS IT'S WORDS. IT'S NOT JUST LETTERS. BUT IT'S A SITUATION WHERE MOST COMMONLY BECAUSE OF PROLONGED BLEEDING OR HEAVY BLEEDING THAT IS GOING ON FOR A LONG PERIOD OF TIME, THAT THE BODY IS NOT ONLY LOSING BLOOD CELLS, BUT IT'S ALSO LOSING THE CLOTTING FACTORS THAT ARE IN THE BLOOD. AND THE LIVER CAN ONLY MAKE THESE CLOTTING FACTORS SO QUICKLY.

SO WHEN THERE IS A LOT OF BLEEDING OVER A SHORTER, PROLONGED PERIOD OF TIME, THE BODY NO LONGER IS ABLE TO CLOT. AND THERE IS A NORMAL BALANCE THAT WE ALL HAVE BETWEEN CLOTTING AND NOT CLOTTING. IT GOES ON ALL THE TIME IN OUR BODY. AND DIC IS THE SITUATION WHERE YOU'VE LOST THE BALANCE. YOU'VE LOST THE RACE.

Q. DO YOU HAVE AN OPINION ON WHETHER A SURGICAL ABORTION AFTER, SAY, 16 WEEKS VERSUS A LABOR INDUCTION CARRIES A GREATER RISK OF DIC?

A. I THINK OVER ALL BOTH OF THEM HAVE AN INCREDIBLY LOW RISK. IF I HAD TO SAY WHICH ONE WOULD BE GREATER, IN MY OPINION IT WOULD BE THAT THE LABOR INDUCTION WOULD HAVE THE GREATER RISK JUST BECAUSE IT IS A MORE PROLONGED PROCEDURE, BLEEDING OVER A LONGER PERIOD OF TIME.

DIC IS, AGAIN, JUST INCREDIBLY RARE IN A VERY SHORT, CONTROLLED SURGICAL PROCEDURE.

Q. IN YOUR OPINION, DR. CREININ, HAVE THERE BEEN IMPROVEMENTS IN THE MEDICATIONS USED TO INDUCE INDUCTION ABORTIONS IN THE

PAST 20 YEARS?
A. NOT SIGNIFICANT IMPROVEMENTS AT ALL.
Q. HAVE THE COMPLICATIONS THAT WE WENT OVER, HAVE THOSE CHANGED IN THE PAST 20 YEARS?
A. NOT SIGNIFICANTLY, BASED ON THE STUDIES THAT ARE AVAILABLE.
Q. AND IS YOUR TESTIMONY ABOUT INDUCTION BASED IN PART ON THE RESEARCH YOU DID IN ORDER TO PREPARE YOUR BOOK CHAPTER?
A. PRIMARILY, ALONG WITH DISCUSSIONS WITH MY CO-AUTHOR. ONE OF THE REASONS THAT I DECIDED TO CO-AUTHOR THE UPDATE RATHER THAN JUST DO IT MYSELF WAS THAT DR. GOLDBERG, WHO IS MY CO-AUTHOR, HAS A LOT MORE EXTENSIVE EXPERIENCE WITH MISOPROSTOL, THE METHODS THAT MANY INDIVIDUALS CHOOSE TO USE FOR INDUCTION.

AND SO WE DECIDED TO DO THIS TOGETHER. AND WE BOTH CAME TO THE CONCLUSION THAT THE DATA THAT'S AVAILABLE COMPARED TO THE DATA FROM DECADES AGO, 10, 15 YEARS AGO, METHODS THAT WERE USED BEFORE THAT, THAT THERE REALLY ISN'T MUCH PROVEN DIFFERENCE.

NOTHING THAT IS BETTER. IT DOESN'T MEAN THAT IT IS BAD METHOD, BUT THERE IS JUST NOTHING THAT IS BETTER.

Q. BASED ON THAT MEDICAL LITERATURE, SPECIFICALLY, WHAT IS YOUR CONCLUSION ABOUT THE RELATIVE SAFETY OF SURGICAL ABORTIONS AS THEY ARE PERFORMED TODAY AND INDUCTIONS AS THEY ARE PERFORMED TODAY?
A. BASED ON THE LITERATURE, I THINK THEY'RE EQUALLY SAFE. I

HAVE -- I THINK THERE IS A LOT OF TRENDS TOWARDS MORE SAFETY WITH D&E. BUT, AGAIN, THAT DATA HAS TO BE TAKEN WITHIN THE REALM OF HOW CONCLUSIVE ONE CAN BE BY LOOKING AT THE DATA.

I THINK THERE'S SOME RECENT PUBLICATIONS LOOKING AT MORTALITY FROM THE CDC, THAT SHOW THAT THERE'S NO DIFFERENCE IN MORTALITY, BUT A SIGNIFICANT TREND TOWARDS LESS WITH D&E.

BUT THE STATISTICS, THE SAMPLE SIZE DOESN'T ALLOW YOU TO SAY THERE IS A BIG DIFFERENCE. AND I THINK ALL OF THE LITERATURE IS PRETTY SIMILAR IN THAT REALM, THAT ONE IS NOT BETTER, NECESSARILY, THAN THE OTHER. BUT THERE ARE SIGNIFICANT TRENDS TOWARDS D&E BEING BETTER.

AND I THINK THAT A LOT OF IT COMES DOWN TO INDIVIDUAL CIRCUMSTANCES. AND THERE ARE DEFINITELY MEDICAL CIRCUMSTANCES AND PERSONAL CIRCUMSTANCES WHERE ONE PROCEDURE, LIKE A D&E, WOULD BE OBVIOUSLY PREFERABLE. AND I WOULD WANT -- I THINK TO BEST SERVE MY PATIENTS, I WOULD NEED TO PROVIDE HER WITH THE OPTIONS THAT WOULD BE BEST IN THAT INDIVIDUAL'S CIRCUMSTANCE.

Q. ARE THERE ANY PARTICULAR STUDIES THAT YOU HAVE RELIED ON COMPARING THE MODERN METHODS OF SURGICAL VERSUS INDUCTION ABORTIONS?

A. THERE IS NOT A LOT OF STUDIES AT THIS GESTATIONAL AGE RANGE. BUT THE ONLY ONE THAT'S --

Q. WHAT GESTATIONAL AGE RANGE?

A. I'M SORRY. BEYOND 18 WEEKS, 18 TO 24 WEEKS.

THERE IS ONE STUDY BY AUTRY, ET AL, THAT IS A COMPARATIVE STUDY, AND IT'S PROBABLY THE BEST THING WE HAVE TO LOOK AT THE ISSUE.

MS. KRASNOFF: THAT IS LEARNED TREATISE FIVE. IF I MAY I APPROACH, YOUR HONOR?

THE COURT: YES.

BY MS. KRASNOFF:

Q. DR. CREININ, I HAVE HANDED YOU LEARNED TREATISE FIVE, WHICH IS AN ARTICLE BY DR. AUTRY, AND OTHERS, WHICH IS ENTITLED:

"COMPARISON OF MEDICAL INDUCTION AND DILATION AND EVACUATION FOR SECOND-TRIMESTER ABORTION," PUBLISHED IN VOLUME 187 OF THE AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY, IN 2002.

ARE YOU FAMILIAR WITH THAT STUDY?

A. YES, I AM.

Q. AND WHAT METHODS OF ABORTION WAS IT COMPARING?

A. THIS STUDY COMPARED LABOR INDUCTION METHODS VERSUS DILATION AND EVACUATION FOR ABORTION BETWEEN 14 AND 24 WEEKS OF PREGNANCY. AND THE MOST COMMONLY USED MEDICAL ABORTION REGIME WAS A MISOPROSTOL REGIME. NOT ALL OF THE WOMEN HAD THAT METHOD USED. BUT I BELIEVE IT WAS THE VAST MAJORITY, 75 PERCENT, ROUGHLY. I WOULD HAVE TO LOOK FOR CLARIFICATION, BUT I BELIEVE IT WAS 75 PERCENT HAD MISOPROSTOL INDUCTIONS.

Q. AND THAT IS THE SAME MEDICATIONS THAT ARE COMMONLY USED TODAY?

A. YES.
Q. WHAT CONCLUSIONS DO YOU DRAW FROM THE AUTRY STUDY?
A. WHEN THEY -- WHEN THE AUTHORS COMPARED D&E VERSUS LABOR INDUCTION ABORTION WITH THE MODERN TECHNIQUES THAT ARE USED -- MISOPROSTOL, PRIMARILY, AND STILL SOME OTHERS -- THAT THE OVERALL COMPLICATION RATE WAS MUCH LOWER WITH D&E VERSUS LABOR INDUCTION.

AND THOSE WERE JUST OVERALL COMPLICATIONS. WHEN YOU LOOK AT SEVERE COMPLICATIONS THEY DIDN'T REALLY TALK ABOUT THOSE AS SIGNIFICANTLY.

THEY DID -- THERE WAS A LOT OF ANALYSIS LOOKING AT WOMEN WHO HAD BLOOD LOSS OF MORE THAN 500 CC'S, SPENDING MORE TIME IN THE HOSPITAL, THOSE SORTS OF THINGS.

BUT THIS STUDY TELLS ME D&E APPEARS SAFER. BUT TO TALK ABOUT IT WITH CONCLUSIVENESS, YOU WOULD -- YOU HAVE TO TAKE THIS WITHIN THE REALM IT IS A RETROSPECTIVE STUDY. THERE WERE A LOT OF THINGS THAT WERE NOT CONTROLLED FOR.

SO IT GOES ALONG WITH THE IDEA THAT I CAN SAY:

"THE BEST DATA I HAVE AVAILABLE TELLS ME D&E IS BETTER."

Q. AND ARE YOU --
A. BUT I STILL HAVE TO TAKE IT WITH A GRAIN OF SALT, SAYING:

"BUT I CAN'T SAY WITH 100 PERCENT CERTAINTY THAT IT IS ALWAYS BETTER FOR EVERY PERSON."

Q. ARE YOU AWARE OF ANY DATA THAT DEMONSTRATES THAT AFTER 18

OR 20 WEEKS INDUCTION IS A BETTER METHOD?
A. NOT AT ALL.
Q. IN YOUR OPINION, HOW WOULD YOU DECIDE FOR ANY PARTICULAR PATIENT WHETHER SHE SHOULD HAVE A SURGICAL ABORTION OR AN INDUCTION?
A. WELL, I DON'T. I AM NOT THE ONE WHO ULTIMATELY MAKES THAT DECISION; THE PATIENT IS.
Q. DR. CREININ, DO YOUR PATIENTS EVER ASK YOU IF THE FETUS IS ABLE TO FEEL PAIN?
A. YES, THEY DO.
Q. AND WHAT DO YOU TELL THEM?
A. IT'S ACTUALLY RELATIVELY A COMMON QUESTION. I TELL THEM THAT THE BEST DATA THAT WE HAVE AVAILABLE, IF YOU LOOK AT ALL THE DATA, SAYS THAT FETUSES ARE UNABLE TO FEEL PAIN IN THE WAY THAT WE, AS HUMANS, FEEL PAIN, UNTIL 26 WEEKS.
Q. WHAT IS THAT DATA THAT YOU ARE REFERRING TO?
A. IT'S A COMPILATION REVIEW BY THE ROYAL COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS FROM 1997.
MS. KRASNOFF: THIS IS LEARNED TREATISE NINE, YOUR HONOR, IF I MAY GIVE IT TO THE WITNESS?
THE COURT: YES.
MS. CLARK: YOUR HONOR, I JUST WANT TO RAISE AN OBJECTION. I AM ANTICIPATING THAT SHE IS GOING TO ASK FOR AN OPINION ABOUT FETAL PAIN, AND HE WASN'T BEEN QUALIFIED TO OPINE ON FETAL PAIN.

THE COURT: IS THAT --

MS. CLARK: I THINK HE CAN TALK ABOUT WHAT HE SAYS TO HIS PATIENTS, BUT --

MS. KRASNOFF: HE IS ONLY GOING TO REPORT WHAT HE TELLS TO HIS PATIENTS. HE IS NOT, IN FACT, AN EXPERT ON FETAL PAIN.

THE COURT: GO AHEAD.

BY MS. KRASNOFF:

Q. DR. CREININ, THIS IS LEARNED TREATISE NINE, WHICH WAS PUBLISHED BY THE ROYAL COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AND IS CALLED:

"FETAL AWARENESS: REPORT OF A WORKING PARTY," FROM 1997. IS THIS THE DATA YOU ARE REFERRING TO?

A. YES.

Q. AND WHAT IS THE ROYAL COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS?

A. THAT'S THE GROUP OR COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS IN THE UK, THAT IS THE EQUIVALENT OF WE KNOW AS THE AMERICAN COLLEGE OF OB/GYN, OR ACOG. AMERICAN COLLEGE OF OB/GYN OR ACOG.

Q. AND DO YOU KNOW WHY THIS REPORT WAS PREPARED?

A. THERE WERE ACTUALLY SOME QUESTIONS RAISED BY HEALTH CARE PROVIDERS, AS WELL AS BY PARLIAMENT, WHICH IS LIKE OUR CONGRESS. I GUESS I DIDN'T NEED TO SAY THAT HERE.

BUT JUST QUESTIONS RAISED. THERE WASN'T ANY DOGMA

THAT SAID TO THE ROYAL COLLEGE:

"YOU NEED TO LOOK AT THIS."

BUT THERE WERE ENOUGH QUESTIONS BEING RAISED, BOTH PRIVATELY AMONGST THE HEALTH CARE PROVIDERS, AND PUBLICLY, THAT THE ROYAL COLLEGE FELT THAT A LEARNED GROUP OF INDIVIDUALS NEEDED TO BE BROUGHT TOGETHER AND FORM A WORKING PARTY TO REVIEW THE EVIDENCE IN AN UNBIASED FASHION.

Q. AND WHO WAS IN THAT WORKING PARTY, WHAT KIND OF SPECIALISTS?

A. THERE WERE FETAL AND NEONATAL MEDICINE SPECIALISTS, ANESTHESIOLOGISTS, BIOLOGISTS, NEUROLOGISTS AND A THEOLOGIAN AND A LAWYER.

Q. WHAT DID THE ROYAL COLLEGE WORKING GROUP CONCLUDE ABOUT FETAL PAIN AND THE ABILITY OF A FETUS TO FEEL PAIN?

A. CAN I READ FROM WHAT THEY SAID?

Q. SURE.

A. THERE ARE TWO MAIN POINTS.

MS. CLARK: I OBJECT. THIS IS BEYOND WHAT HE TELLS HIS PATIENTS.

THE WITNESS: NO, THIS IS -- I AM SORRY.

THE COURT: YES. AND YOU ARE NOT A LAWYER, EITHER.

THE WITNESS: NO, I AM. THAT'S WHY I APOLOGIZED.

THE COURT: OKAY. YOUR RESPONSE? SHE HAD OBJECTED BEFORE ABOUT THE USE OF THE TREATISE INSOFAR AS HE WAS GOING TO EXPRESS AN OPINION ON FETAL PAIN. YOU INDICATED HE WAS ONLY

GOING TO TESTIFY AS TO WHAT HE TELLS HIS PATIENTS. NOW HE IS READING FROM A TREATISE. WHERE ARE YOU GOING?

MS. KRASNOFF: I WOULD JUST WOULD LIKE TO KNOW BASED ON THIS DOCUMENT IF THIS IS WHAT HE RELIES ON AND WHAT HE TELLS HIS PATIENTS BASED ON THIS.

THE COURT: DO YOU HAVE AN OBJECTION TO THAT?

MS. CLARK: FOR THAT SIMPLE QUESTION, NO.

MS. KRASNOFF: OKAY.

THE COURT: ALL RIGHT.

THE WITNESS: THIS IS WHAT I TELL -- ROUGHLY WHAT I TELL MY PATIENTS. I CAN JUST TELL YOU WHAT I TELL MY PATIENTS.

BY MS. KRASNOFF:

Q. YES, SURE. JUST TELL ME AS IF I WERE A PATIENT.

A. THAT THERE ARE MULTIPLE THINGS THAT ARE NECESSARY -- THE SIMPLE THING I TELL MY PATIENTS, AND THEN I WILL TELL YOU WHEN THEY WANT TO KNOW FURTHER DETAIL EXACTLY WHAT THE WORKING PARTY FOUND.

BUT THE SIMPLE WAY I TELL IT TO THEM IS THAT PAIN IS SOMETHING THAT WE UNDERSTAND AS CONSCIOUS BEINGS, AND THAT PAIN REQUIRES US TO NOT ONLY SENSE SOMETHING, BUT TO PROCESS IT AS PAINFUL.

AND A GOOD WAY OF UNDERSTANDING IT IS IF YOU OR SOMEONE YOU KNOW HAS HAD MAJOR SURGERY AND HAS BEEN PUT UNDER GENERAL ANESTHESIA, THAT YOU DON'T FEEL PAIN DURING THE SURGERY. IT IS ONLY ONCE YOU WAKE UP FROM THE SURGERY THAT YOU

FEEL THE PAIN.

SO THERE HAS TO BE A CONSCIOUSNESS IN ORDER TO FEEL PAIN. AND WHAT THE WORKING PARTY FOUND IS WHAT I BASE THAT ON IS THAT YOU CAN LOOK AT THE DEVELOPMENT OF NERVE FIBERS IN THE PERIPHERY, AND YOU CAN LOOK AT THE DEVELOPMENT OF NERVES THAT GO UP TO THE BRAIN, BUT THEN --

MS. CLARK: I WILL OBJECT. I AM NOT SURE IF THIS IS WHAT HE ACTUALLY TELLS HIS PATIENT OR IF HE'S EXPLAINING HOW HE FORMS THE DECISION TO TELL HIS PATIENTS. I THINK HE CAN TESTIFY AS TO WHAT HE TELLS HIS PATIENTS, BUT NOT WHY HE TELLS HIS PATIENTS THAT. THAT SEEMS TO BE EXPERT TESTIMONY.

THE COURT: I DISAGREE WITH THAT, COUNSEL. I THINK THAT I AM GOING TO ALLOW HIM TO EXPLAIN TO ME WHY HE TELLS HIS PATIENTS WHAT HE TELLS THEM.

THE WITNESS: SO, THAT THE NERVES NEED TO ALSO DEVELOP THAT GO UP TO THE BRAIN. AND THEN, WITHIN THE BRAIN ITSELF, THERE HAS TO BE THE CONNECTIONS THAT FORM FOR THE BRAIN TO PROCESS THIS AS SOMETHING PAINFUL. AND A LOT OF -- AND I DO HAVE PATIENTS THAT ASK ME, BECAUSE THEY HAVE LOOKED ON THE INTERNET AND HEARD ABOUT STUDIES THAT HAVE SHOWN THAT FETUSES FEEL PAIN.

AND WHAT A LOT OF THOSE -- VIRTUALLY ALL THE STUDIES LOOK AT ARE THINGS CALLED AUTONOMIC REFLEXES OR AUTOMATIC REFLEXES.

AND, AGAIN, THE WAY I EXPLAIN THAT TO PATIENTS WOULD

BE IF YOU WERE IN A COMA, AND I TAPPED YOUR KNEE, MOST PEOPLE KNOW THAT THE KNEE REFLEXES. YOU HIT THE KNEE AND THE LEG POPS UP.

IF YOU WERE IN A COMA, YOU WOULD STILL HAVE THAT REFLEX, BECAUSE THE NERVES GO FROM YOUR KNEE TO YOUR SPINAL CORD, AND THEN RIGHT BACK. IT IS AN AUTOMATIC REFLEX. IT DOESN'T REQUIRE PROCESSING IN YOUR BRAIN TO SAY:

"I FELT PAIN IN MY KNEE, THEREFORE I AM GOING TO KICK." IT IS AN AUTOMATIC REFLEX.

SO THAT IN NO WAY SAYS THAT YOU FELT PAIN. IT IS AN AUTOMATIC RESPONSE. AND THAT IS WHAT MOST OF THE STUDIES ON FETAL PAIN SHOW.

SO WHEN PATIENTS ASK ME ABOUT WHAT THEY READ, THAT IS WHAT I TELL THEM.

BY MS. KRASNOFF:

Q. AND BASED ON WHAT YOU READ, AND FOR YOUR PRACTICE ONLY, DO YOU FEEL YOU NEED TO DO ANYTHING DIFFERENT FOR ABORTIONS PRIOR TO 24 WEEKS, BASED ON THE ISSUE OF FETAL PAIN?

A. I DON'T FEEL I NEED TO. AND ALSO, WHEN I READ IN THE LITERATURE, THE WORKING PARTY SUMMARIZES -- CONCLUDES YOU DON'T NEED TO, BASED ON ALL OF THESE THINGS, ALSO.

Q. DR. CREININ, DO YOU EVER UTILIZE A CHEMICAL AGENT TO CAUSE FETAL DEMISE PRIOR TO PERFORMING AN ABORTION?

A. NO.

Q. AND WHY NOT?

A. BECAUSE I DON'T FEEL THERE IS ANY BENEFIT TO MY PATIENTS TO DOING SO BEFORE THE PROCEDURE. AND IT ADDS AN EXTRA STEP. AND IF THERE IS NO BENEFIT, AND I HAVE TO DO SOMETHING, THEN I JUST GET RISK WITHOUT BENEFIT.

Q. WHAT ARE THE RISKS THAT COULD ARISE FROM THAT INJECTION?

A. IN PUTTING A NEEDLE INTO SOMEBODY'S BELLY, FIRST THERE IS THE PHYSICAL PAIN ISSUE OF IT. THERE IS THE -- FOR SOME WOMEN -- THE TRAUMA OF SEEING THAT I AM DOING SOMETHING, BECAUSE A LOT OF WOMEN ASK:

"AM I GOING TO SEE ANYTHING DURING THE ABORTION? I DON'T WANT TO SEE ANYTHING."

SO EVEN PUTTING THE NEEDLE IN WOULD BE PART OF WHAT THEY WOULD SEE.

THE NEEDLE CAN GO THROUGH BLOOD -- LARGE BLOOD VESSELS THAT FEED THE UTERUS, AND SPECIFICALLY THE PLACENTA. SO YOU COULD HAVE SIGNIFICANT BLEEDING. YOU COULD CAUSE INFECTION BECAUSE YOU ARE PUTTING A NEEDLE IN. AND ALBEIT, MANY OF THESE RISKS ARE SMALL, IF THERE IS NO BENEFIT THEN ALL I GET IS RISK.

MS. CLARK: YOUR HONOR, I WILL OBJECT ON A LACK OF FOUNDATION. HE SAID HE DOESN'T DO ANY INJECTIONS THAT CAUSE FETAL DEMISE. I DON'T UNDERSTAND WHAT HIS BASIS IS. HE DOESN'T HAVE A BASIS FOR THOSE OPINIONS.

THE COURT: I THINK THAT HE SAID THAT HE DOESN'T DO IT BECAUSE OF THE RISK. IT SEEMS TO ME THE BASIS WOULD BE HIS

PRIOR ANALYSIS OF THOSE RISKS IN ORDER TO GIVE ADVICE TO HIS CLIENTS.

MS. CLARK: I MEAN, IT MAY BE -- I DON'T THINK -- I DON'T THINK A FOUNDATION HAS BEEN LAID.

THE COURT: WHY DON'T YOU LAY AN APPROPRIATE FOUNDATION?

MS. KRASNOFF: WE ARE ACTUALLY DONE WITH THIS TOPIC, BUT THAT IS PRECISELY WAS HE WAS TESTIFYING TO. IS THAT --

BY MS. KRASNOFF:

Q. DR. CREININ, IS THAT THE REASON WHY?

A. THOSE ARE THE REASONS WHY I DON'T DO THAT PROCEDURE.

Q. AND ARE YOU FAMILIAR BASED ON YOUR PRACTICE TREATING PATIENTS WHO ARE PREGNANT WITH DOING A SIMILAR TYPE PROCEDURE?

A. YES, WITH AMNIOCENTESIS.

Q. DO YOU EVER PERFORM ABORTIONS FOR WOMEN WHO NEED AN ABORTION FOR A LIFE-THREATENING CONDITION?

A. YES.

MS. KRASNOFF: MAY I PUT UP A BLOWUP?

BY MS. KRASNOFF:

Q. IF I COULD AS YOU TO READ THE SECOND SENTENCE WHICH STARTS WITH THIS SUBSECTION TO YOURSELF.

"BASED ON THAT, THE PARTIAL-BIRTH ABORTION BAN ACT, WOULD ALLOW YOU TO PERFORM A BANNED ABORTION WHEN IT IS NECESSARY TO SAVE THE LIFE OF A MOTHER WHOSE LIFE IS ENDANGERED BY A PHYSICAL DISORDER,

PHYSICAL ILLNESS OR PHYSICAL INJURY."

WOULD YOU FEEL COMFORTABLE PERFORMING THE LIFE SAVING ABORTIONS YOU PERFORM NOW UNDER THIS EXCEPTION?

A. NOT TOTALLY COMFORTABLE. I WOULD HAVE TO HOPE THAT OTHER PEOPLE AGREED WITH ME OR WITH THE PATIENT'S PRIMARY HEALTH CARE PROVIDERS, THAT THEY AGREED. IF IT LEAVES IT OPEN TO SPECULATION BY OTHER PEOPLE, THERE IS NO DEFINITION OF "LIFE ENDANGERMENT," LIKE: HOW MUCH DOES IT NEED TO BE? DOES IT NEED TO BE THAT THERE IS A 50 PERCENT CHANCE SHE'LL DIE? DOES IT NEED TO BE A 20 PERCENT SHE'LL DIE. I DON'T -- IT IS NOT CLEAR TO ME.

Q. AND DR. CREININ, ONE OF THE FINDINGS OF THE PARTIAL-BIRTH ABORTION BAN ACT IS THAT THAT ACT WILL ADVANCE THE INTEREST OF THE MEDICAL PROFESSION. DO YOU BELIEVE THAT THIS ACT THAT IS AT ISSUE IN THIS CASE ADVANCES THE INTEREST OF THE MEDICAL PROFESSION?

A. NOT AT ALL.

Q. WHY NOT?

A. PART OF BEING A MEDICAL PROFESSIONAL IS TO PROVIDE CARE AS BEST AS POSSIBLE FOR IN THAT INDIVIDUAL PERSON, AND EVERY CIRCUMSTANCE IS DIFFERENT. AND I CAN'T EVER LAY A GENERAL RULE THAT EVERYTHING WILL ALWAYS BE THE SAME FOR EVERYBODY. THERE IS THINGS I SEE EVERY MONTH OR TWO THAT I HAVE NEVER SEEN BEFORE IN THE LAST 10 TO 11 YEARS. SO THERE IS NO WAY I COULD LAY A GENERAL RULE.

SO PREVENTING ME FROM PROVIDING SERVICE -- AND THE LAW, AS IT IS WRITTEN, IS NOT ABOUT A SPECIFIC PROCEDURE. IT IS ABOUT TECHNIQUES THAT ARE USED DURING SURGICAL -- DURING SURGICAL PROCEDURES, SO THAT THIS WOULD PREVENT ME FROM PROVIDING METHODS OF ABORTION THAT ARE WELL-PROVEN TO BE SAFE FOR WOMEN.

SO I DON'T THINK THIS ADVANCES MEDICINE. I THINK IT HINDERS -- SEVERELY HINDERS THE PRACTICE OF MEDICINE.

MS. KRASNOFF: THANK YOU, DR. CREININ. I DON'T HAVE ANYTHING ELSE.

THE COURT: ALL RIGHT. MS. CLARK, CROSS-EXAMINATION?

CROSS-EXAMINATION

BY MS. CLARK:

Q. GOOD MORNING, DR. CREININ.

A. GOOD MORNING.

Q. YOU PERFORM APPROXIMATELY 500 ABORTIONS A YEAR; IS THAT CORRECT?

A. CORRECT.

Q. YOU HAVE BEEN PROVIDING ABORTIONS FOR APPROXIMATELY 20 YEARS; IS THAT RIGHT?

A. NO.

Q. YOU STARTED YOUR RESIDENCY IN 1984; IS THAT RIGHT?

A. NO.

Q. YOU WEREN'T A RESIDENT FROM UCSF FROM 1984 TO 1998?

A. NO.
Q. WHAT YEARS WERE YOU IN YOUR RESIDENCY?
A. 1988 TO 1992.
Q. OKAY. SO YOU'VE BEEN APPROXIMATELY -- YOU'VE BEEN PERFORMING ABORTIONS FOR APPROXIMATELY HOW MANY YEARS?
A. THIRTEEN-AND-A-HALF TO 14.
Q. SO WOULD YOU SAY YOU'VE PERFORMED IN THE NEIGHBORHOOD OF SOMEWHERE APPROACHING 10,000 ABORTIONS IN YOUR CAREER?
A. NO.
Q. APPROXIMATELY HOW MANY ABORTIONS HAVE YOU PROVIDED IN YOUR CAREER?
A. 5,000.
Q. OKAY. DOCTOR, OF ALL THE D&E ABORTIONS THAT YOU HAVE PERFORMED IN YOUR CAREER, 20 WEEKS GESTATIONAL AGE AND LATER, 99 PERCENT OR MORE OF THOSE ABORTIONS HAVE RESULTED IN THE FETUS BEING DISARTICULATED TO SOME EXTENT; ISN'T THAT RIGHT?
A. YES.
Q. AND, DOCTOR, YOU HAVE NOT DELIVERED A BABY SINCE 1994, RIGHT?
A. CORRECT.
Q. IN YOUR OPINION, YOU DO NOT THINK IT IS APPROPRIATE FOR CONGRESS TO LEGISLATE AT ALL ABOUT THE ABORTION PROCEDURE THAT PHYSICIANS CAN AND CANNOT PERFORM PRE-VIABILITY; ISN'T THAT CORRECT?
A. YES.

Q. AND YOU WOULD OPPOSE ANY LEGISLATION PASSED BY CONGRESS THAT RESTRICTED THE KINDS OF ABORTIONS THAT A PHYSICIAN COULD DO; ISN'T THAT CORRECT?

A. TO THE BEST OF MY ABILITY RIGHT NOW, BUT "ANY" IS A LARGE TERM. BUT MOST LIKELY, YES.

Q. YOU OPPOSE THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003, RIGHT?

A. YES.

Q. AND ONE OF THE PRIMARY REASONS THAT YOU OPPOSE THAT ACT IS BECAUSE ON PRINCIPLE YOU BELIEVE THAT CONGRESS SHOULD NOT BE LEGISLATING ON MEDICAL ISSUES?

A. CAN YOU -- BY "PRIMARY" YOU MEAN MAIN, THEN, NO. THAT IS ONE OF THE REASONS, BUT THE MAIN REASON IS BECAUSE THE WORDING OF THE ACT IS NOT -- DOES NOT SERVE THE BEST INTEREST OF WOMEN AND THEIR HEALTH CARE PROVIDERS.

Q. DOCTOR, DID YOU TESTIFY IN YOUR DEPOSITION THAT ONE OF THE PRIMARY REASONS YOU OPPOSE THE ACT IS BECAUSE ON PRINCIPLE YOU BELIEVE THAT CONGRESS SHOULD NOT BE LEGISLATING ON MEDICAL ISSUES?

A. YES. YOU HAD SAID ONE OF -- I SAID "ONE OF THE PRIMARY." YOU JUST ASKED ME "THE PRIMARY," WHICH IS "BECAUSE THE WORDING OF THE ACT IS NOT GOOD FOR HEALTH CARE PROVIDERS OR WOMEN."

Q. WOMEN'S HEALTH SERVICES PROVIDES ABORTION ONLY THROUGH 18 WEEKS OF PREGNANCY, CORRECT?

A. YES.

Q. AND THAT'S BECAUSE WHS OR WOMEN'S HEALTH CENTER -- OR WOMEN'S HEALTH SERVICES ONLY PROVIDES ABORTION SERVICES IN A SINGLE DAY?

A. CORRECT.

Q. AND IF WHS WANTED TO PROVIDE ABORTION SERVICES AT A LATER GESTATIONAL AGE, IT IS YOUR OPINION THAT TO PERFORM THE ABORTION SAFELY WHS WOULD HAVE TO PROVIDE OVERNIGHT DILATORS AND WOULD HAVE TO HAVE PATIENTS COME BACK ON THE SECOND DAY; IS THAT CORRECT?

A. FOR THE METHODS THAT WE USE AT THAT FACILITY FOR OUR PATIENTS, YES.

Q. AFTER 18 WEEKS YOU WOULD WANT TO DILATE THE WOMAN FOR 18 TO 36 HOURS, CORRECT?

A. USING THE METHODS THAT WE USE AT THAT FACILITY, YES, THAT IS CORRECT.

Q. WHEN YOU WERE PERFORMING SURGICAL EXTRACTION OF THE FETUS THROUGH D&E PROCEDURE IN THE 18 TO 24 WEEK TIME PERIOD, THE GESTATIONAL AGE INFLUENCES THE WAY YOU PERFORM THE PROCEDURE; IS THAT RIGHT?

A. IF YOU MEAN: DOES PART OF THE PROCEDURE INCLUDE THE -- FROM THE DILATION FORWARD, THEN, YES, IT DOES, BECAUSE IT PRIMARILY INFLUENCES THE NUMBER OF DILATORS THAT I INTEND TO PLACE.

Q. SO AS THE GESTATIONAL AGE INCREASES YOU INCREASE THE NUMBER OF DILATORS?

A. CORRECT.
Q. AND IF YOU WANT TO BE SURE THAT THE DILATION IS ADEQUATE IN ORDER FOR INSTRUMENTS TO GO INTO THE UTERUS -- EXCUSE ME. AND YOU WANT TO BE SURE THAT THE DILATION IS ADEQUATE IN ORDER FOR THE INSTRUMENTS TO GO INTO THE UTERUS, BUT ALSO FOR THE FETAL TISSUE TO BE REMOVED; IS THAT RIGHT?
A. YES.
Q. DOCTOR, YOU WOULD AGREE THAT IN A INTACT D&E CONSISTS OF FOUR MAIN ELEMENTS; ISN'T THAT RIGHT?
A. IF YOU COULD LIST ME THE FOUR, I WOULD BE HAPPY TO AGREE WITH THEM.
Q. THE FIRST ELEMENT, WHICH IS DELIBERATE DILATION OF THE CERVIX USUALLY OVER A SEQUENCE OF DAYS?
A. USUALLY, YES.
Q. SECOND: INSTRUMENTAL CONVERSION OF THE FETUS TO A FOOTLING BREECH?
A. YES.
Q. THIRD: BREECH EXTRACTIONS OF THE BODY, EXCEPTING THE HEAD?
A. YES.
Q. AND FOURTH: PARTIAL EVACUATION OF THE INTRACRANIAL CONTENTS TO EFFECT VAGINAL DELIVERY OF AN OTHERWISE INTACT FETUS?
A. YES. MOSTLY INTACT. DOESN'T HAVE TO ALWAYS BE COMPLETELY INTACT.
Q. AND "EVACUATION OF THE INTRACRANIAL CONTENTS" MEANS

EVACUATION OF THE CONTENTS OF THE BABY'S HEAD, CORRECT?
A. UM-HUM. YES.
Q. AND YOU HAVE PERFORMED AN INTACT D&E ACCORDING TO THIS FOUR-PART DEFINITION APPROXIMATELY THREE TIMES IN YOUR CAREER?
A. YES.
Q. YOU UNDERSTAND "INTACT D&E" TO BE THE SAME THING AS "D&X"?
A. IN MY UNDERSTANDING, YES.
Q. AND WHEN YOU HAVE PERFORMED THE D&X PROCEDURE, THE FETUSES HAVE BEEN IN THE 20 TO 24 WEEK TIME FRAME.
A. FROM INTACT D&E, YES.
Q. AND WHEN YOU HAVE PERFORMED THE D&X PROCEDURE, AS YOU ALSO CALL IT, "INTACT D&E," THE FETUSES HAVE BEEN IN THE 20 TO 24 WEEK TIME FRAME.
A. YES.
Q. IN YOUR OPINION, THE INTACT D&E OR THE D&X IS A DIFFERENT PROCEDURE FROM THE D&E PROCEDURE THAT YOU PERFORM; IS THAT RIGHT?
A. YES.
Q. AND, AGAIN, ONE DIFFERENCE IS THAT THE INTACT D&E WOULD REQUIRE MULTIPLE DAYS OF DILATION?
A. THAT CAN BE, BUT THE PRIMARY DIFFERENCE -- AND THIS IS ONE OF THE THINGS THAT YOU CAN'T TELL UNTIL AFTERWARDS, BECAUSE, FOR EXAMPLE, THE THREE CASES YOU BROUGHT UP --
Q. I ASKED YOU ONE DIFFERENCE, IS THAT THE INTACT WOULD REQUIRE MULTIPLE DAYS OF DILATION.

A. THAT IS ONE OF MANY DIFFERENCES.
Q. AND THE D&E PROCEDURE THAT YOU OFFER REQUIRES ONLY ONE DAY OF DILATION.
A. MOSTLY, BUT NOT ALWAYS.
Q. AND ONE OF THE REASONS THAT YOU DO NOT PERFORM AN INTACT D&E IS BECAUSE YOU ARE NOT TRAINED TO UNDERSTAND THE NUANCES OF WHAT HAPPENS OVER MULTIPLE DAYS OF DILATION; ISN'T THAT CORRECT?
A. MULTIPLE DAYS OF DILATION WHEN THE OBJECTIVE IS TO REMOVE THE FETUS INTACT.
Q. AND YOU ARE NOT TRAINED TO ANSWER QUESTIONS IF PROBLEMS ARISE UNDER THE D&X PROCEDURE.
A. DURING THE DILATION PORTION.
Q. AND IF A PATIENT SEEKING ABORTION WANTS AN INTACT FETUS THROUGH A TRANSVAGINAL SURGICAL METHOD, YOU WOULD REFER HER TO SOMEBODY ELSE, WOULDN'T YOU?
A. AT THE CURRENT TIME, YES.
Q. BUT IF YOU HAD TO, YOU COULD PERFORM THE INTACT D&E PROCEDURE, COULDN'T YOU?
A. THERE'S LOTS OF THINGS IN MEDICINE I COULD DO IF I HAD TO, BUT PART OF BEING A GOOD HEALTH PROVIDER IS KNOWING YOUR LIMITATIONS.
Q. DOCTOR --
A. AND I NEVER WOULD -- I WOULD NEVER PERFORM SOMETHING ON A PATIENT EXCEPT IN AN ABSOLUTE EMERGENCY THAT I WASN'T

APPROPRIATELY TRAINED OR PREPARED TO HANDLE.
Q. DOCTOR, YOU TESTIFIED IN YOUR DEPOSITION THAT IF YOU HAD TO YOU COULD PERFORM THE INTACT D&E PROCEDURE; ISN'T THAT CORRECT?
A. AND, I WOULD -- YES, AND I WOULD DEFINE "HAD TO" AS AN EMERGENCY SITUATION.
Q. THAT'S CORRECT. AND THAT MEANS IF YOU HAD TO, YOU COULD ENSURE THAT THE FETUS WAS REMOVED INTACT, EXCEPT FOR THE HEAD, IN PERFORMING -- EXCEPT -- I WILL START OVER.
IN OTHER WORDS, IF YOU HAD TO, YOU COULD ENSURE THAT THE FETUS WAS REMOVED INTACT EXCEPT FOR THE HEAD IN PERFORMING A SURGICAL TRANSVAGINAL ABORTION IN THE SECOND-TRIMESTER, CORRECT?
A. YES.
Q. BUT IT WOULD REQUIRE MORE CERVICAL DILATION THAN WHAT YOU CURRENTLY PROVIDE?
A. YES.
Q. NOW, YOU WOULD DESCRIBE D&E IN THREE MAIN PARTS; IS THAT RIGHT?
A. IF YOU WANT TO READ ME THE THREE PARTS.
Q. FIRST: DELIBERATE DILATION OF THE CERVIX USING OSMOTIC DILATORS?
A. YES.
Q. SECOND: EVACUATION OF THE FETUS BY DISARTICULATION THROUGH A DILATED CERVIX?
A. YES.

Q. THIRD: REMOVAL OF THE PLACENTA WITH SUCTION AND CURETTAGE?
A. AND SUCTION CURETTAGE, YES.
Q. WHEN YOU SAY "AND SUCTION CURETTAGE," DO YOU DO TWO THINGS TO REMOVE THE --
A. THE PLACENTA USUALLY IS REMOVED AS PART OF THE EVACUATION OF THE FETUS USING FORCEPS. AS I DESCRIBED EARLIER, I DO A SUCTION AT THE END TO ENSURE THAT THE LINING OF THE UTERUS THAT'S BEEN BUILT UP FROM THE PREGNANCY AND ANY POTENTIAL PARTS OF THE PLACENTA THAT ARE STILL REMAINING ARE REMOVED.
Q. AND YOUR GOAL IN DOING A D&E IS NOT TO REMOVE THE FETUS INTACT, CORRECT?
A. YES.
Q. IF THAT WERE YOUR GOAL, YOU WOULD TAKE DIFFERENT STEPS THAN THE STEPS YOU CURRENTLY TAKE IN PERFORMING D&E PROCEDURE?
A. COULD YOU REPEAT THE QUESTION?
Q. IF THAT WERE YOUR GOAL OF REMOVING THE FETUS INTACT, YOU WOULD TAKE DIFFERENT STEPS THAN THE STEPS YOU CURRENTLY TAKE IN CARRYING OUT THE D&E PROCEDURE?
A. CORRECT.
Q. YOU WOULD PUT IN MORE DILATORS?
A. MOST LIKELY, YES.
Q. AND BEFORE PERFORMING A D&E ABORTION, AS YOU TESTIFIED TODAY, YOU DESCRIBE THE PROCEDURE TO YOUR PATIENT, CORRECT?
A. YES.
Q. AND YOU TELL YOUR PATIENTS THAT THE FETUS COMES OUT IN

PIECES?

A. CORRECT.

Q. YOU DON'T TELL YOUR PATIENTS THAT THE FETUS WILL COME OUT INTACT?

A. NO.

Q. AND IN A D&E PROCEDURE THE FETUS IS REMOVED IN PIECES TO BE AS SAFE AS POSSIBLE FOR HER?

A. I TELL HER THAT'S THE REASON WE ARE DOING THE PROCEDURE THAT WAY.

Q. YOU WOULDN'T TELL YOUR PATIENT ANYTHING THAT IS INCORRECT, WOULD YOU?

A. TO THE BEST OF MY KNOWLEDGE, I WOULD NOT.

Q. AND YOU REMOVE THE FETUS IN PIECES BECAUSE YOU WANT TO MINIMIZE THE AMOUNT THAT THE CERVIX IS OPEN, CORRECT?

A. CORRECT.

Q. AND YOU MINIMIZE THE AMOUNT OF DILATION IN A D&E PROCEDURE IN ORDER TO PERFORM AN ABORTION THAT IS AS SAFE AS POSSIBLE?

A. CORRECT.

Q. AND WHEN YOU ARE DOING A D&E THAT INVOLVES DISMEMBERMENT OF THE FETAL PARTS, YOU PERFORM A GENTLE TWISTING MOTION WHEN YOU MEET RESISTANCE, CORRECT?

A. CORRECT.

Q. AND THE PURPOSE OF THE TWISTING IS TO AVOID TEARING THE CERVIX, RIGHT?

A. NOT ENTIRELY.

Q. DID YOU TESTIFY IN YOUR DEPOSITION THAT THE PURPOSE OF THE TWISTING IS TO AVOID TEARING THE CERVIX?
A. IF YOU SAY I DID, I DID. THAT IS JUST PART OF WHAT YOU DO, BUT, YEAH. SO, "YES," AND OTHER THINGS.
Q. DOCTOR, YOU WOULD AGREE THAT WHEN YOU PERFORM A D&E DISARTICULATION ABORTION, FOR AN AVERAGE PATIENT WITHOUT SPECIFIC LIMITATIONS, THE AVERAGE AMOUNT OF TIME IT TAKES YOU TO COMPLETE THE EXTRACTION PART OF THE PROCEDURE IS FIVE MINUTES?
A. APPROXIMATELY.
Q. AND THE LONGEST IT HAS EVER TAKEN YOU TO EXTRACT A FETUS IS 15 TO 20 MINUTES?
A. NOT THE LONGEST. I CAN THINK BACK MANY YEARS. THERE HAVE BEEN VERY DIFFICULT CASES THAT MAY HAVE GONE ON LONGER. BUT IN MY CURRENT PRACTICE, I WOULD SAY THE LONGEST CURRENTLY IS ROUGHLY ABOUT 15 MINUTES.
SINCE YOU BROUGHT UP MANY YEARS I CAN THINK OF CASES WHEN I WAS A RESIDENT THAT WENT ON FOR 40 MINUTES.
Q. WOULD YOU AGREE THAT YOU TESTIFIED IN YOUR DEPOSITION THAT THE LONGEST IT HAS EVER TAKEN YOU TO EXTRACT A FETUS WAS 15 TO 20 MINUTES?
A. IF YOU ARE READING FROM MY DEPOSITION, THEN I WOULD HAVE TO AGREE WITH IT. IF I SAID IT, IT'S IN THERE.
Q. DO YOU AGREE OR WOULD YOU LIKE ME TO SHOW YOU A COPY OF YOUR DEPOSITION?

A. IF YOU ARE TELLING ME I SAID THAT, THEN, YES, I SAID THAT.
Q. AT 18 WEEKS GESTATION YOU GENERALLY USE FOUR DILAPAN FOR DILATION PURPOSES; IS THAT CORRECT?
A. GENERALLY, YES.
Q. AND ON AVERAGE, AT 18 WEEKS USING FOUR DILAPAN, YOU ARE ABLE TO DILATE THE CERVICAL OS APPROXIMATELY 1.75 TO 2 CENTIMETERS?
A. ROUGHLY, BUT EVERY WOMAN'S DIFFERENT. SO, AGAIN, THAT IS AN AVERAGE. SO MOST WILL BE ABOUT THAT, SOME WILL BE MORE. THAT IS AN AVERAGE.
Q. AT 18 WEEKS, IN FACT, YOU SEEK TO ACHIEVE 1.75 TO 2 CENTIMETERS DILATION?
A. I SEEK THAT AS A MINIMUM, YES.
Q. AT 18 WEEKS WHEN YOU HAVE DILATED 1.75 CENTIMETERS, YOU WILL VIRTUALLY ALWAYS HAVE RESISTANCE WHEN EVACUATING THE UTERUS, CORRECT?
A. IF THAT IS THE AMOUNT THAT ENDED UP HAPPENING THEN THE ANSWER WOULD BE: YES.
Q. AND DISARTICULATION OF THE FETUS?
A. YES.
Q. AT 19 WEEKS, YOU SEEK TO DILATE APPROXIMATELY THE SAME THING: 1.75 TO 2 CENTIMETERS, CORRECT?
A. CORRECT.
Q. AT 20 TO 21 WEEKS, YOU SEEK TO DILATE APPROXIMATELY 2 CENTIMETERS, CORRECT?

A. CAN YOU -- GESTATIONAL AGE RANGE AGAIN?
Q. 20 AND 21 WEEKS?
A. YES.
Q. AT 22 WEEKS, YOU GENERALLY USE FIVE TO SIX DILAPAN INSTEAD OF FOUR?
A. GENERALLY, YES.
Q. AND YOU USE DILAPAN BECAUSE IN USING DILAPAN YOU CAN BE ASSURED THAT YOU WILL GET THE SAME DILATION, GET DILATION FROM EVERY DILAPAN, CORRECT?
A. YES.
Q. BUT SOMETIMES BY PULLING A FETAL PART THROUGH THE CERVIX YOU CAN STRETCH OR DILATE THE CERVIX MORE THAN WHAT YOU INITIALLY DILATED?
A. IF THE CERVIX -- IN A PARA WOMAN, SOMEBODY WHO HAS HAD CHILDREN BEFORE, SHE MAY -- SHE WILL VERY COMMONLY RESPOND TO THE DILATORS DIFFERENTLY, SO THE CERVIX WOULD BE MORE DILATED AND ALSO SOFTER, SO IT WILL GIVE MORE EASILY AS THE FETAL PARTS ARE MOVING THROUGH.
I TESTIFIED TO THAT ON DIRECT.
Q. MORE DILATORS COULD RESULT IN A WOMAN GOING INTO LABOR AND DELIVERING THE FETUS SPONTANEOUSLY; ISN'T THAT CORRECT?
A. "MORE" MEANING MORE THAN WHAT I SAID TO YOU, THEN, YEAH. YES.
Q. AND MORE DILATORS ALSO RESULT IN SIGNIFICANT PAIN TO THE WOMAN, CORRECT, OR WOULD RESULT IN SIGNIFICANT PAIN TO THE

WOMAN?
A. I DON'T UNDERSTAND WHAT YOU MEAN BY "SIGNIFICANT."
Q. IF YOU INCREASE THE NUMBER OF DILATORS THAN WHAT YOU USE, THAT INCREASE IN DILATORS WOULD INCREASE THE LEVEL OF PAIN THAT THE WOMAN WOULD EXPERIENCE; IS THAT CORRECT?
A. IT COULD, BUT NOT ALWAYS.
Q. IS IT INCREASE IN THE LEVEL OF PAIN ONE OF THE REASONS WHY YOU DON'T INCREASE THE NUMBER OF DILATORS?
A. FOR MY PATIENTS IN MY SITUATION, YES.
Q. AND MORE DILATORS ALSO COULD CAUSE INJURY TO THE WOMAN'S CERVIX; ISN'T THAT CORRECT?
A. MORE OF ANYTHING CAN CAUSE INJURY TO ANYTHING. THAT IS A GIVEN.
Q. SO MANY YOUR ANSWER WOULD BE "YES" TO THAT QUESTION?
A. IT'S NOT -- YES, THAT'S BECAUSE IT IS AN OBVIOUS QUESTION.
Q. YOU DON'T SET OUT TO DILATE THE CERVIX MORE IN ORDER TO INCREASE THE LIKELIHOOD THAT YOU WILL BE ABLE TO REMOVE THE FETUS INTACT; IS THAT CORRECT?
A. IN ORDER TO REMOVE THE FETUS COMPLETELY INTACT, THAT'S CORRECT.
Q. AND IT IS YOUR OPINION THAT IN YOUR HANDS IT IS SAFER FOR YOU TO PERFORM A D&E ABORTION INVOLVING DISMEMBERMENT OF THE FETUS THAN IT IS TO PERFORM AN INTACT D&E?
A. CORRECT.
Q. NOW, YOU HAVE ENCOUNTERED SITUATIONS IN WHICH YOU ARE

PERFORMING A D&E AND THE FETUS IS REMOVED INTACT EXCEPT THAT THE HEAD OF THE FETUS GETS STUCK AT THE INTERNAL CERVICAL OS, CORRECT?

A. CORRECT.

Q. WHEN THAT HAS HAPPENED YOU HAVE PROCEEDED WITH THE D&E PROCEDURE IN ONE OF THREE WAYS, CORRECT?

A. IF YOU CAN TELL ME THE THREE WAYS I WOULD BE HAPPY TO.

Q. ONE METHOD WOULD BE TO PULL ON THE BABY SO THAT THE HEAD BREAKS OFF FROM THE REST OF THE BODY; IS THAT RIGHT?

A. YES.

Q. AND THEN, YOU WILL GO INSIDE THE UTERUS WITH THE FORCEPS AND REMOVE THE HEAD?

A. CORRECT.

Q. THE NEXT METHOD IS THAT YOU WOULD USE SCISSORS TO PUNCTURE THE BASE OF THE SKULL?

A. CORRECT.

Q. AND THEN, YOU WILL STICK A SUCTION CANNULA INTO THE OPENING AND DRAIN THE BRAIN TISSUE, AND THEN YOU WILL HAVE THE HEAD COME OUT.

A. DID YOU SAY "DRAIN THE BRAIN TISSUE"?

Q. THEN, YOU WILL DRAIN THE BRAIN TISSUE?

A. YES.

Q. AND HAVE THE HEAD COME THROUGH THE SUCTION CANNULA?

A. I AM SORRY. WHAT WAS THE LAST THING YOU SAID?

Q. AND THEN YOU WOULD HAVE THE HEAD COME THROUGH THE CANNULA?

A. NO, THE HEAD THEN COMES THROUGH THE CERVIX.
Q. AND THE THIRD METHOD IS THAT YOU TAKE A CRUSHING INSTRUMENT, PHUT THAT INSTRUMENT INSIDE THE CERVICAL OS, CRUSH THE BABY'S HEAD, AND PULL THE HEAD THROUGH THE CERVIX, CORRECT?
A. THAT WOULD BE THE THIRD POSSIBLE, ALTHOUGH PHYSICALLY THAT WOULD VIRTUALLY NEVER BE THE CASE.
IT WOULD BE ONE OF THE FIRST TWO. THOSE ARE MY THREE OPTIONS, BUT IT WOULD BE ONE OF THE FIRST TWO THAT I COULD REALISTICALLY DO.
Q. WHEN YOU HAVE HAD THE HEAD LODGE IN THE CERVIX, HAVE YOU PERFORMED THOSE THREE METHODS FOR DEALING WITH THE HEAD?
A. JUST THE FIRST TWO.
Q. FROM NOVEMBER 1, 2002 THROUGH NOVEMBER 1, 2003, YOU HAVE BEEN PRESENTED WITH PATIENTS IN WHICH THE BABY'S HEAD GOT STUCK AT THE INTERNAL CERVICAL OS APPROXIMATELY FIVE TO TEN TIMES, CORRECT?
A. YES.
Q. IN YOUR CAREER, YOU'VE HAD THIS HAPPEN APPROXIMATELY 50 TIMES?
A. YES.
Q. IN THESE SITUATIONS IN THE LAST YEAR WHERE THE HEAD GOT STUCK, THERE IS NO MATERNAL HEALTH CONDITION THAT CAUSED THE HEAD OF THE FETUS TO GET STUCK, CORRECT?
A. THAT CAUSED THE HEAD TO GET STUCK? NO. THAT IS PART OF THE ABORTION PROCEDURE.

Q. THERE IS NOTHING UNIQUE ABOUT THE FETUS THAT PRESENTED THE SITUATION?

A. NO.

Q. NONE OF THE FETUSES HAD HYDROCEPHALY?

A. NO.

Q. IN YOUR CAREER IN APPROXIMATELY FIVE TO TEN TIMES THE CERVIX HAS ACTUALLY BEEN SO DILATED DURING A SURGICAL TRANSVAGINAL ABORTION THAT THE ENTIRE FETUS WAS REMOVED INTACT WITH HAVING TO COLLAPSE THE SKULL.

LET ME REPEAT IT FOR THE COURT REPORTER. IN YOUR CAREER IN APPROXIMATELY FIVE TO TEN TIMES, THE CERVIX HAS ACTUALLY BEEN DILATED SO MUCH DURING A SURGICAL TRANSVAGINAL ABORTION THAT THE ENTIRE FETUS WAS REMOVED INTACT WITHOUT HAVING TO COLLAPSE THE SKULL?

A. CORRECT.

Q. AND THE FETUS WAS SOMEWHERE BETWEEN 16 AND 24 WEEKS?

A. CORRECT.

Q. DOCTOR, IF A WOMAN'S CERVIX WAS SO DILATED THE FETUS COULD BE DELIVERED IN INTACT IT WOULD NOT BE NECESSARY TO COLLAPSE THE SKULL BECAUSE THE FETUS COULD PASS THROUGH THE CERVIX, RIGHT?

A. CORRECT.

Q. BUT YOU WOULD NOT ALLOW THE FETUS TO PASS INTACT IF THE FETUS WERE AT OR ABOUT 24 WEEKS IN GESTATION, CORRECT?

A. CORRECT.

Q. BECAUSE IF THE FETUS WERE CLOSE TO 24 WEEKS, AND YOU WERE PERFORMING A TRANSVAGINAL SURGICAL ABORTION YOU WOULD BE CONCERNED ABOUT DELIVERING THE FETUS ENTIRELY INTACT BECAUSE THAT MIGHT RESULT IN A LIVE BABY THAT MAY SURVIVE, CORRECT?

A. YOU SAID I WAS PERFORMING AN ABORTION, SO SINCE THE OBJECTIVE OF THE ABORTION IS TO NOT HAVE A LIVE FETUS, THEN THAT WOULD BE CORRECT.

Q. IN YOUR OPINION, IF YOU WERE PERFORMING A SURGICAL ABORTION AT 23 OR 24 WEEKS AND THE CERVIX WAS SO DILATED THAT THE HEAD COULD PASS WITHOUT COMPRESSION, YOU WOULD DO WHATEVER YOU NEEDED TO DO IN ORDER TO MAKE SURE THAT THE LIVE BABY WAS NOT DELIVERED, WOULDN'T YOU?

A. WHATEVER I NEEDED, MEANING WHATEVER SURGICAL PROCEDURES I NEEDED TO DO AS PART OF THE PROCEDURE? YES. THEN, THE ANSWER WOULD BE: YES.

Q. AND ONE STEP YOU WOULD TAKE TO AVOID DELIVERY OF A LIVE BABY WOULD TO BE TO DELIVER OR HOLD THE FETUS' HEAD ON THE INTERNAL SIDE OF THE CERVICAL OS IN ORDER TO COLLAPSE THE SKULL; IS THAT RIGHT?

A. YES, BECAUSE THE OBJECTIVE OF MY PROCEDURE IS TO PERFORM AN ABORTION.

Q. AND THAT WOULD ENSURE THAT YOU DID NOT DELIVER A LIVE BABY?

A. CORRECT.

Q. YOU WOULD AGREE THAT A D&E IN THE SECOND-TRIMESTER PREGNANCY IS AN EXTREMELY SAFE PROCEDURE, RIGHT?

A. YES.
Q. AND YOU WOULD AGREE THAT THE FORCEPS USED IN A D&E DO NOT POSE A RISK OF DAMAGING THE CERVIX?
A. NO, I DON'T AGREE WITH THAT.
MS. CLARK: YOUR HONOR, MAY I APPROACH?
BY MS. CLARK:
Q. DR. CREININ, I TOOK YOUR DEPOSITION ABOUT A MONTH AGO; ISN'T THAT CORRECT?
A. MONTH-AND-A-HALF, YES.
Q. AND YOU TOLD THE TRUTH IN THAT DEPOSITION, RIGHT?
A. YES.
Q. AND YOU HAD THE OPPORTUNITY TO REVIEW YOUR DEPOSITION TRANSCRIPT, RIGHT?
A. YES.
Q. AND YOU SIGNED THAT DEPOSITION TRANSCRIPT AFTER MAKING A FEW CHANGES; ISN'T THAT RIGHT?
A. YES.
Q. I WOULD LIKE TO DIRECT YOUR ATTENTION TO PAGE 147, LINE 22.
MS. KRASNOFF: I AM SORRY. WHAT LINE AGAIN?
MS. CLARK: LINE 22.
BY MS. CLARK:
Q. IF YOU WOULD READ TO YOURSELF THROUGH PAGE 148, LINE 4.
A. YES.
Q. WOULD YOU NOW AGREE THE FORCEPS USED IN A D&E DOES NOT POSE A RISK OF DAMAGING THE CERVIX?

A. NO, I WOULD NOT AGREE.
Q. DOCTOR, YOU TESTIFIED STARTING AT LINE 22, PAGE 147:
"QUESTION: HOW COULD THE FORCEPS DO DAMAGE TO THE CERVIX?
"ANSWER: WHEN THE -- IT IS NOT THE FORCEPS ITSELF. IT IS THE PROCESS OF REMOVING THE TISSUE. IT IS DURING THE USE OF THE FORCEPS. THE CERVIX CAN TEAR WHILE THE TISSUE IS BEING REMOVED. ALTHOUGH THAT OCCURS VERY RARELY, IT CAN HAPPEN."
A. RIGHT.
Q. WAS THAT YOUR TESTIMONY?
A. YES.
YOU CURRENTLY WERE ASKING ME IF FORCEPS CAN INJURE THE CERVIX. IF I GRABBED ONTO THE CERVIX WITH THE FORCEPS AND DID SOMETHING WITH THE CERVIX, I COULD INJURE THE CERVIX.
IN MY DEPOSITION YOU WERE ASKING ME ABOUT THE PROCESS OF A D&E PORTION. AND IN A D&E ABORTION I WOULDN'T GRAB THE CERVIX WITH MY FORCEPS. THE FORCEPS CAN INJURE THE CERVIX. IN THE WAY I USE THEM DURING THE D&E, IT WOULD -- THE DEPOSITION IS TRUE. THE WAY I WOULD USE THE FORCEPS WOULD NOT INJURE THE CERVIX. IT'S THE PROCESS ITSELF.
Q. DOCTOR, YOU WOULD AGREE THAT IN PERFORMING A D&E PROCEDURE IF ANY SMALL SCRAPES OR TEARS OCCURRED IN THE LOWER UTERINE SEGMENT, THE BODY NORMALLY WOULD BE ABLE TO STOP BLEEDING ON ITS OWN WITHOUT ANY COMPLICATIONS?

A. FROM MOST. FOR VIRTUALLY ALL WOMEN, YES.
Q. DOCTOR, FOR THE SURGICAL ABORTIONS THAT YOU PERFORM 18 WEEKS AND ONE DAY, AND LATER, MOST OF YOUR PATIENTS DO NOT RETURN TO YOU FOR FOLLOW-UP CARE, CORRECT?
A. CORRECT.
Q. SO, IF YOU PERFORMED AN ABORTION, AND IF THE WOMAN HAD A SUBSEQUENT PREGNANCY, SAY, TWO YEARS LATER, AND EXPERIENCED A PRE-TERM BIRTH DURING HER SUBSEQUENT PREGNANCY, YOU ARE UNLIKELY TO KNOW ABOUT THAT?
A. CORRECT.
Q. DOCTOR, IN YOUR DIRECT TESTIMONY YOU TESTIFIED ABOUT WHETHER CERVICAL INCOMPETENCE IS A COMPLICATION THAT A WOMAN MAKE SUFFER AS A RESULT OF HAVING A SURGICAL ABORTION; IS THAT RIGHT?
A. I AM SORRY. CAN YOU REPEAT THE QUESTION?
Q. I AM TRYING TO GO SLOW.

IN YOUR DIRECT TESTIMONY, YOU TESTIFIED ABOUT WHETHER CERVICAL INCOMPETENCE IS A COMPLICATION THAT A WOMAN MAY SUFFER AS A RESULT OF HAVING A SURGICAL ABORTION, RIGHT?
A. CORRECT.
Q. AND IS IT CORRECT THAT CERVICAL INCOMPETENCE DOES NOT MANIFEST ITSELF UNTIL A SUBSEQUENT PREGNANCY?
A. CORRECT.
Q. DOCTOR, ONE OF THE ARTICLES YOU RELIED UPON IN FORMING YOUR OPINION ABOUT THE POSSIBILITY OF A RISK OF CERVICAL

INCOMPETENCE WAS AN ARTICLE BY KALISH AND CHASEN TITLED:
"IMPACT OF MIDTRIMESTER DILATION AND EVACUATION ON SUBSEQUENT PREGNANCY OUTCOME"?
A. YES.
Q. YOU ARE FAMILIAR WITH THAT ARTICLE?
A. YES.
Q. DOCTOR, THE KALISH AND CHASEN STUDY WAS A RETROSPECTIVE STUDY, RIGHT?
A. YES.
Q. AND THAT STUDY EVALUATED PATIENTS WHO UNDERWENT D&E'S AT 14 TO 24 WEEKS?
A. CAN I HAVE THE ARTICLE IF YOU ARE GOING TO ASK ME QUESTIONS ABOUT IT?
Q. THIS IS PLAINTIFFS' 17.
MS. CLARK: MAY I APPROACH?
THE WITNESS: THANK YOU.
BY MS. CLARK:
Q. WHAT I HAVE JUST HANDED YOU IS PLAINTIFFS' EXHIBIT 17. THIS IS THE KALISH AND CHASEN ARTICLE; IS THAT RIGHT?
A. YES.
Q. IF YOU DIRECT YOUR ATTENTION TO PAGE 882, WHICH IS THE FIRST PAGE --
A. YES.
Q. -- THE STUDY EVALUATED PATIENTS WHO UNDERWENT D&E'S AT CORNELL DURING THE 14 TO 24 WEEK TIME FRAME?

A. CORNELL MEDICAL CENTER, YES.
Q. AND OF THE 600 SECOND-TRIMESTER D&E ABORTIONS IDENTIFIED, ONLY THE 96 SUBSEQUENT PREGNANCIES WERE IDENTIFIED FOR EVALUATION, CORRECT?
I DIRECT YOUR ATTENTION TO PAGE 883, AT THE BOTTOM OF THE FIRST COLUMN.
A. YES.
Q. AND THE STUDY DID NOT ASSESS SUBSEQUENT PREGNANCY OUTCOMES FOR THE PATIENTS WHO LATER DELIVERED AT OTHER INSTITUTIONS, CORRECT?
DIRECT YOUR ATTENTION TO 884.
A. I AM READING THROUGH IT.
Q. OKAY.
A. YES, THAT IS CORRECT.
Q. AND DIRECTING YOUR ATTENTION TO PAGE 887, SECOND COLUMN --
A. EXCUSE ME. PAGE NUMBER?
Q. 887.
A. THERE IS NO 887.
Q. YOU'RE RIGHT. OKAY.
DIRECT YOUR ATTENTION TO 884, IN THE SECOND COLUMN THERE.
A. YES.
Q. FIRST FULL PARAGRAPH: THIS STUDY DID NOT INCLUDE AS A COMPLICATION ANY FIRST-TRIMESTER PREGNANCY LOSS THAT OCCURRED IN A SUBSEQUENT PREGNANCY; IS THAT RIGHT?

A. YES.
Q. NOW, DOCTOR, ANOTHER ARTICLE THAT YOU RELIED UPON IN FORMING YOUR OPINIONS WAS THE HENRIET AND KAMINSKI STUDY?
A. HENRIET, YES.
Q. HENRIET. HENRIET. HENRIET STUDY, TITLED:
"IMPACT OF INDUCED ABORTIONS ON SUBSEQUENT PREGNANCY OUTCOME THE 1995 FRENCH NATIONAL PERINATAL SURVEY"; IS THAT RIGHT?
A. YES.
Q. THE STUDY BY HENRIET SUPPORTS THE OPINION THAT AN INDUCED ABORTION CAN RESULT IN A WOMAN NOT BEING ABLE TO CARRY A SUBSEQUENT PREGNANCY TO TERM; IS THAT CORRECT?
A. NO.
Q. DOCTOR, I DIRECT YOUR ATTENTION TO YOUR DEPOSITION, PAGE 229.
A. CAN I ALSO HAVE THE ARTICLE, SINCE YOU ARE TALKING ABOUT IT, PLEASE?
MS. CLARK: THIS IS DEFENDANT'S EXHIBIT LTA-29. YOUR HONOR, MAY I APPROACH?
THE COURT: YES.
BY MS. CLARK:
Q. DOCTOR, TURNING TO YOUR DEPOSITION TESTIMONY, PAGE 229, LINE 3, IF YOU WOULD READ TO YOURSELF THREE THROUGH 12.
A. YES.
Q. THAT READS:

"QUESTION: AND HAVE YOU READ THE HENRIET AND KAMINSKI STUDY?

"ANSWER: YES.

"AND IS IT YOUR OPINION THAT THE STUDY SUPPORTS THE FACT THAT INDUCED ABORTION CAN RESULT IN A WOMAN NOT BEING ABLE TO CARRY A PREGNANCY TO TERM?

"ANSWER: IN MY OPINION, THE RESULTS THEY PRESENTED SUPPORT THAT. IT COULD EFFECT A WOMAN'S ABILITY TO BRING A PREGNANCY TO TERM."

THAT WAS YOUR TESTIMONY, RIGHT?

MS. KRASNOFF: YOUR HONOR, I OBJECT. SHE DIDN'T READ THE COMPLETE ANSWER TO THE QUESTION.

THE COURT: ALL RIGHT. YOU MAY READ THE COMPLETE ANSWER.

NOW. YOU MAY READ THE COMPLETE ANSWER NOW.

MS. KRASNOFF: OH, I AM SORRY. THE REST OF THE ANSWER SAYS:

"IT IS AN AWFUL STUDY. YOU CAN'T MAKE ANY REAL BASIS ON THAT -- ON THE OPINION."

THE COURT: OKAY. ALL RIGHT.

BY MS. CLARK:

Q. SO, DOCTOR, YOU AGREE THAT THE STUDY, IN FACT, SUPPORTED THAT AN ABORTION CAN CAUSE CERVICAL INCOMPETENCE, RIGHT?

A. NO.

IT IS AN AWFUL STUDY, AND YOU CAN'T MAKE ANY REAL

BASIS --

Q. BUT THE STUDY DOES, IN FACT, CONCLUDE THAT INDUCED ABORTION RESULTS IN CERVICAL INCOMPETENCE?

A. THE STUDY CONCLUDES THAT.

Q. OKAY. THAT STUDY LOOKED AT VIRTUALLY ALL BIRTHS OVER A SERIES OF DAYS IN FRANCE; ISN'T THAT CORRECT?

A. YES.

Q. AND THE STUDY'S POPULATION CONSISTED OF 12,432 WOMEN; ISN'T THAT RIGHT?

A. YES.

Q. AND IN DOING THAT STUDY IT ASKS THOSE WOMEN -- IT ASKED WHETHER THOSE WOMEN PREVIOUSLY HAD HAD AN INDUCED ABORTION, RIGHT?

A. CORRECT.

Q. AND TURNING YOUR ATTENTION TO PAGE 1041, UNDER THE "CONCLUSIONS" SECTION, THAT STUDY STATES OR THAT CONCLUSION STATES, AND I QUOTE:

"A SIGNIFICANT ASSOCIATION BETWEEN PREVIOUS INDUCED ABORTIONS AND PRE-TERM DELIVERY IN SUBSEQUENT PREGNANCIES WAS OBSERVED, THE RISK INCREASING WITH THE NUMBER OF PREVIOUS INDUCED ABORTIONS."

THAT WAS THE CONCLUSION, RIGHT?

A. YES.

Q. NOW, IN FORMING YOUR OPINIONS TODAY, SPECIFICALLY WITH

RESPECT TO CERVICAL INCOMPETENCE, YOU ALSO RELIED UPON A ZHOU STUDY TITLED:

"ARE COMPLICATIONS AFTER AN INDUCED ABORTION ASSOCIATED WITH REPRODUCTIVE FAILURES AND SUBSEQUENT PREGNANCY"; IS THAT CORRECT?

A. YES.

MS. CLARK: YOUR HONOR, MAY I APPROACH?

THE COURT: WHERE IS THE LOCATION?

BY MS. CLARK:

Q. YES, I AM SHOWING WHAT HAS BEEN MARKED, IDENTIFIED AS PLAINTIFFS' LT8.

DIRECTING YOUR ATTENTION TO THE FIRST PAGE.

A. YES.

Q. THIS IS A STUDY THAT YOU DID, IN FACT, RELY UPON IN YOUR REBUTTAL REPORT; IS THAT RIGHT?

A. YES.

Q. DIRECTING YOUR ATTENTION TO PAGE 1, THIRD FULL PARAGRAPH OF THAT ARTICLE.

A. YES.

Q. THAT STATES:

"WE HAVE PREVIOUSLY STUDIED LONG-TERM CONSEQUENCES OF AN INDUCED ABORTION IN A SUBSEQUENT PREGNANCY AND FOUND A SLIGHTLY INCREASED RISK OF LOW BIRTH WEIGHT AND PRE-TERM BIRTH, AS WELL AS PLACENTA COMPLICATIONS"; IS THAT RIGHT?

A. YES.
Q. AND DO YOU KNOW WHAT PREVIOUS STUDY THE ARTICLE IS REFERRING TO?
A. IT WOULD BE THE ARTICLES THAT ARE REFERENCED, SO THEY WOULD BE REFERENCES THREE, FOUR AND FIVE.
Q. AND HAVE YOU SEEN ANY OF THOSE ARTICLES THREE, FOUR AND FIVE?
A. TO THE BEST OF MY ABILITY I CAN'T REMEMBER REVIEWING THEM PRIOR TO TODAY.
Q. ARE YOU FAMILIAR WITH THE ZHOU ARTICLE, THE ONE THAT IS LISTED NUMBER 4 IN THE REFERENCES:
"INDUCED ABORTION AND SUBSEQUENT PREGNANCY DURATION"?
A. NO.
Q. NOW, YOU ARE NOT AWARE OF ANY STUDIES THAT HAVE SPECIFICALLY CONSIDERED WHETHER THE INTACT D&E PROCEDURE LEADS TO HIGHER RATES OF CERVICAL INCOMPETENCE OR PRE-TERM LABOR THAN OTHER AVAILABLE PROCEDURES, CORRECT?
A. CAN YOU REPEAT THE QUESTION? I AM SORRY.
Q. YOU ARE NOT AWARE OF ANY STUDIES THAT HAVE SPECIFICALLY CONSIDERED WHETHER THE INTACT D&E PROCEDURE LEADS TO HIGHER RATES OF CERVICAL INCOMPETENCE OR PRE-TERM LABOR THAN OTHER AVAILABLE PROCEDURES, CORRECT?
A. NO.
Q. YOU YOURSELF HAVE NOT CONDUCTED ANY FOLLOW-UP WITH WOMEN

WHO HAVE UNDERGONE AN INTACT D&E THROUGH THEIR NEXT PREGNANCY TO SEE IF THERE MIGHT BE A HIGHER RATE OF CERVICAL INCOMPETENCE FROM THAT PROCEDURE, AS OPPOSED TO A DISARTICULATION D&E, RIGHT?

A. NO, I WOULD BE UNABLE TO DO SO SINCE I TESTIFIED I HAVE ONLY DONE IT THREE TIMES. AND THAT WOULD NOT GIVE ME ENOUGH OF A SAMPLE TO LOOK AT MY OWN PATIENTS.

Q. DOCTOR, IN YOUR DIRECT EXAMINATION, YOU RELIED UPON ON THE SCHNEIDER ARTICLE:

"ABORTION AT 18 TO 22 WEEKS BY LAMINARIA D&E";

IS THAT RIGHT?

A. YES.

MS. CLARK: THAT'S BEEN IDENTIFIED AS PLAINTIFFS LT4, FOR THE RECORD.

BY MS. CLARK:

Q. DIRECTING YOUR ATTENTION TO PAGE 414, THAT ARTICLE CONCLUDES THAT:

"DILATION AND EVACUATION FOR LATE SECOND-TRIMESTER TERMINATION SEEMS TO BE SAFE. INTRA- AND POSTOPERATIVE COMPLICATIONS ARE NEGLIGIBLE."

A. YES.

Q. AND DIRECTING YOUR ATTENTION TO PAGE 414, THE THIRD FULL PARAGRAPH?

A. YES.
Q. IF YOU'LL BRIEFLY READ THROUGH THAT TO THE EXTENT YOU NEED TO TO REFRESH YOUR MEMORY.
A. YES.
Q. THE MEAN DIAMETER FOR THE DILATION FOR THE PATIENTS IN THE STUDY WAS 2.9 CENTIMETERS, PLUS OR MINUS .9 MILLIMETERS; ISN'T THAT CORRECT?
A. THAT IS WHAT THEY REPORTED.
Q. AND THIS STUDY DID NOT --
A. NO, THEY SAID "2.9 MILLIMETERS." YOU SAID "CENTIMETERS," I BELIEVE? I MAY HAVE MISHEARD YOU.
Q. I DID SAY "CENTIMETERS," BUT YOU MAY BE RIGHT. SO IT'S 2.9 MILLIMETERS, PLUS OR MINUS?
A. IT IS WHAT THEY REPORT, SO THIS MAY BE A TYPO, AND I HAVE NO IDEA. SO NONE OF THIS SEEMS TO MAKE SENSE. IT IS PROBABLY AN ERROR IN THE REPORT. SO I CAN'T REALLY COMMENT ON IT.
Q. WELL, IT REPORTS "2.9 MILLIMETERS, PLUS OR MINUS .9 MILLIMETERS"; IS THAT RIGHT?
A. THAT IS WHAT IT REPORTS.
Q. AND THIS STUDY DID NOT EVALUATE -- THIS STUDY DID NOT EVALUATE THE INTACT D&E PROCEDURE, CORRECT?
A. TO THE BEST OF MY KNOWLEDGE, NO, IT DID NOT.
Q. YOU HAVE BEEN PRESENTED -- TURNING TO ANOTHER TOPIC. YOU HAVE BEEN PRESENTED WITH SITUATIONS --
THE COURT: EXCUSE ME, MS. CLARK. BEFORE WE TURN TO

ANOTHER TOPIC, WHY DON'T WE TAKE OUR BREAK?

MS. CLARK: SURE.

THE COURT: ALL RIGHT, 15 MINUTES.

(RECESS TAKEN AT 10:00 A.M.)

(PROCEEDINGS RESUMED AT 10:15 A.M.)

THE COURT: ALL RIGHT. LET'S RESUME.

BY MS. CLARK:

Q. DOCTOR, YOU HAVE HAD SITUATIONS IN WHICH YOU ARE PERFORMING A SURGICAL ABORTION IN WHICH THE FETUS PRESENTED IN A VERTEX POSITION, CORRECT?

A. YES.

Q. AND YOU TESTIFIED YESTERDAY THAT WHEN PRESENTED WITH THOSE SITUATIONS YOU ATTEMPT TO REACH AROUND THE HEAD AND GRAB ANOTHER FETAL PART TO CONVERT THE PRESENTATION TO A BREECH POSITION; IS THAT CORRECT?

A. YES.

Q. BUT YOU HAVE BEEN PRESENTED WITH A SITUATION WHERE THE FETUS PRESENTED HEADFIRST AND YOU ARE NOT ABLE TO CONVERT THE FETUS TO A BREECH POSITION, SO YOU NEEDED TO COLLAPSE THE SKULL IN ORDER TO PROCEED WITH THE SURGICAL PROCEDURE, CORRECT?

A. RARELY, BUT, YES.

Q. AND IN YOUR EXPERIENCE, WHEN YOU'VE HAD TO COLLAPSE THE SKULL IN THAT KIND OF SITUATION, YOU HAVE NEVER COLLAPSED THE SKULL AFTER IT HAD PASSED FROM THE UTERUS THROUGH THE INTERNAL CERVICAL OS, CORRECT?

A. NO, IF IT IS HEADFIRST AND I AM COLLAPSING THE SKULL, IT IS STILL GOING TO BE IN THE UTERUS WHEN I DO SO.
Q. DOCTOR, YOU DON'T INDICATE ON A PATIENT'S MEDICAL CHART THE NUMBER OF FETAL PARTS THAT WERE REMOVED, DO YOU?
A. IF YOU MEAN HOW MANY PARTS THE FETUS IS IN, IS THAT WHAT YOU MEAN?
Q. WHETHER IT WAS REMOVED IN FIVE PARTS OR EIGHT PARTS OR TWO PARTS?
A. NO.
Q. AND NOTING THE WAY IN WHICH A FETAL HEAD WAS COLLAPSED IS NOT SOMETHING THAT YOU FIND IMPORTANT TO WRITE A PATIENT'S CHART, CORRECT?
A. TO WRITE ON A PATIENT'S CHART, NO.
Q. AND YOU DON'T INDICATE ON THE CHART WHETHER THE FETUS WAS REMOVED INTACT, DO YOU?
A. INCOMPLETELY INTACT? WHAT WAS YOUR QUESTION?
Q. YOU DON'T INDICATE ON THE MEDICAL CHART THAT THE FETUS WAS REMOVED INTACT, DO YOU?
A. WHEN IT IS REMOVED COMPLETELY INTACT? YES, I DO.
Q. YOU DON'T INDICATE THE NUMBER -- ON THE MEDICAL CHART YOU DON'T INDICATE THE NUMBER OF PASSES YOU MADE WITH INSTRUMENTS?
A. NO.
Q. IT WOULDN'T MATTER HOW MANY PASSES YOU MADE WITH INSTRUMENTS?
A. NO.

Q. AND EVEN IF THE FETUS WERE REMOVED INTACT TO THE HEAD, YOU WOULD INDICATE MULTIPLE PASSES ON A PATIENT'S CHART, CORRECT?
A. CORRECT.
Q. BECAUSE YOU WOULD ALWAYS HAVE MULTIPLE PASSES EVEN WHEN THE HEAD IS STUCK; ISN'T THAT CORRECT?
A. "MULTIPLE" MEANS MORE THAN ONE, SO, YES.
Q. AND ONE OF THOSE PASSES WOULD BE GOING BACK INSIDE THE MOTHER AND TAKING OUT THE PLACENTA; IS THAT CORRECT?
A. YES.
THE COURT: EXCUSE ME. I DIDN'T UNDERSTAND. YOU ORIGINALLY SAID YOU DON'T INDICATE ON THE CHART THE NUMBER OF PASSES THAT IT TAKES FOR YOU TO REMOVE THE ENTIRE FETUS?
THE WITNESS: NO.
THE COURT: OKAY. AND THEN, HER QUESTION WAS:
"EVEN IF THE FETUS IS INTACT, YOU WOULD INDICATE THE MULTIPLE PASSES ON THE PATIENT'S. CHART."
AND YOU SAID:
"CORRECT."
THE WITNESS: WELL, BUT SHE ASKED THE QUESTION OF "COMPLETELY INTACT." WHEN THE -- IN REMOVING -- IN THE RARE INSTANCES THAT THE FETUS IS REMOVED COMPLETELY INTACT, I STILL WOULD HAVE TO GO BACK INTO THE UTERUS WITH MY FORCEPS AND REMOVE THE PLACENTA. SO, THERE IS ALWAYS MULTIPLE PASSES TO REMOVE THE UTERINE CONTENTS.

THE COURT: OKAY. DO YOU WRITE DOWN ON A PATIENT'S CHART THE NUMBER OF PASSES FOR EITHER OF THOSE PROCEDURES?

THE WITNESS: NO. JUST "MULTIPLE PASSES" ARE INDICATED.

THE COURT: OKAY.

THE WITNESS: AND I ACTUALLY NEVER WRITE ANYTHING. IT IS DICTATED. BUT THE FEW INSTANCES THAT IT TRULY IS COMPLETELY INTACT, THE FEW TIMES, VAGINALLY, OR IN THE RARE CIRCUMSTANCES WHERE I HAVE DONE A HYSTEROTOMY ABORTION, WHICH THOSE ARE COMPLETELY INTACT, IT IS INDICATED THAT IT IS INTACT.

THE COURT: OKAY. AND EARLIER YOU SAID THAT THERE WERE THREE INSTANCES IN WHICH YOU HAD PERFORMED A, WHAT --

THE WITNESS: AN INTACT D&E.

THE COURT: INTACT D&E.

THE WITNESS: CORRECT.

THE COURT: AND IN BOTH OF THOSE INSTANCES WHAT WAS NOTED ON THE CHART -- ON THREE OF THOSE INSTANCES?

THE WITNESS: THEN THE PROCEDURE THAT WAS PERFORMED WAS DICTATED WITH THE FETUS BEING REMOVED UP TO THE HEAD, AND THEN SCISSORS USED.

THE COURT: OKAY.

THE WITNESS: SO, I MEAN, IT WAS DICTATED AS HOW THE PROCEDURE WAS DONE.

THE COURT: OKAY.

THE WITNESS: SO I GUESS MAYBE I AM CONFUSED IN MY

ANSWER.
BY MS. CLARK:
Q. MAYBE I CAN CLARIFY ONE POINT. YOU WILL WRITE ON THE PATIENT'S CHART OR IT WILL BE DICTATED ON THE PATIENT'S CHART THE WORDS "MULTIPLE PASSES," CORRECT?
A. CORRECT.
Q. AS OPPOSED TO "THREE PASSES" OR "FOUR PASSES" OR "FIVE PASSES"?
A. RIGHT.
Q. IS THAT RIGHT?
THE COURT: OKAY. I UNDERSTOOD.
THE WITNESS: SORRY.
BY MS. CLARK:
Q. DOCTOR, YOU CANNOT QUANTIFY THE RELATIVE RISK OF HAVING A CERVICAL TEAR IN A DISMEMBERMENT D&E PROCEDURE COMPARED TO AN INTACT D&E PROCEDURE, CORRECT?
A. ARE YOU ASKING ME TO DO THAT BASED ON MY EXPERIENCE OR BASED ON THE LITERATURE OR WHAT ARE YOU ASKING ME TO QUANTIFY THAT ON?
Q. ARE YOU ABLE TO QUANTIFY THE RISK OF HAVING A CERVICAL TEAR IN A DISMEMBERMENT D&E PROCEDURE COMPARED TO AN INTACT D&E PROCEDURE?
A. IT'S HARD TO, BECAUSE THERE'S TWO WAYS TO LOOK AT A D&E VERSUS AN INTACT D&E. ONE IS THE OBJECTIVE THAT YOU START OUT WITH. AND THERE ARE CIRCUMSTANCES WHERE THE OBJECTIVE OF THE

PROCEDURE IS TO REMOVE THE FETUS INTACT, SO THERE WOULD BE MORE DILATORS, AS WE TALKED ABOUT EARLIER.

FOR EXAMPLE, THE THREE CASES THAT I HAVE DONE AN INTACT REMOVAL, I DIDN'T SET OUT TO DO IT, BUT IT HAPPENED THAT WAY. SO IT'S VERY OFTEN -- IT IS NOT UNTIL AFTER THE PROCEDURE THAT YOU CAN DECIDE OR YOU CAN UNDERSTAND WHAT REALLY THE PROCEDURE IS THAT WAS DONE.

SO IN BEING ABLE TO QUANTIFY IT, I AM STILL -- I'M -- THE PROCEDURE THAT I AM DOING FOR MY PROCEDURES THEY WOULD START OUT THE SAME.

SO, I HAVE TO TAKE WHATEVER -- HOWEVER IT COMES. SINCE MY GOAL IS TO REMOVE THE FETUS AS INTACT AS POSSIBLE, IF IT HAPPENS TO COME OUT INTACT UP TO THE LEVEL OF THE HEAD, THEN IT HAS. IF IT HASN'T, THEN IT HASN'T.

SO FOR MY PATIENTS WHEN I AM PERFORMING THE PROCEDURE, THERE IS -- THEY ARE KIND OF, IN THAT SENSE FOR ME, ONE AND THE SAME, BECAUSE IT IS JUST HOW THE PROCEDURE ENDS UP.

I HOPE I MADE THAT CLEAR.

Q. SO YOU ARE NOT ABLE TO QUANTIFY THE RELATIVE RISK OF HAVING A CERVICAL TEAR IN A DISMEMBERMENT D&E PROCEDURE COMPARED TO AN INTACT D&E PROCEDURE, ARE YOU?

A. I CAN'T, BECAUSE IN MY PRACTICE IT WOULD BE ONE AND THE SAME AS FAR AS THE WAY THE PROCEDURE IS DONE, IN THAT SENSE.

Q. SO YOU CAN'T QUANTIFY THAT.

A. I AM SAYING I CAN'T BECAUSE -- CORRECT.

Q. AND YOU CANNOT QUANTIFY THE RISK OF HAVING A PERFORATION IN AN INTACT PROCEDURE VERSUS IN A DISMEMBERMENT D&E PROCEDURE, CAN YOU?
A. FOR THE SAME REASONS, NO.
Q. AND YOU CAN'T QUANTIFY THE RISK OF HAVING AN INFECTION IN AN INTACT D&E PROCEDURE COMPARED TO A DISARTICULATION D&E PROCEDURE, CAN YOU?
A. FOR THE SAME REASONS, NO.
Q. AND YOU CANNOT QUANTIFY WHAT YOU BELIEVE IS AN INCREASED RISK OF HEMORRHAGE IN AN INTACT D&E PROCEDURE, CAN YOU?
A. CAN YOU REPEAT HOW YOU WORDED THAT, PLEASE?
Q. YOU CAN'T QUANTIFY THE LIKELIHOOD OF HAVING -- THE INCREASED LIKELIHOOD OF HEMORRHAGING IN AN INTACT D&E PROCEDURE COMPARED TO A DISMEMBERMENT D&E PROCEDURE, CAN YOU?
A. SO BY YOUR QUESTION, THOUGH, YOU ARE IMPLYING THAT THE INTACT HAS AN INCREASED RISK COMPARED TO A REGULAR D&E?
Q. DOCTOR, TO THE EXTENT YOU BELIEVE THAT THERE IS AN INCREASED LIKELIHOOD OF HEMORRHAGE, TO THE EXTENT YOU BELIEVE THAT, YOU CAN'T QUANTIFY THAT, CAN YOU?
A. I DON'T BELIEVE THERE IS AN INCREASED LIKELIHOOD OF HEMORRHAGE WITH EITHER, WITH ONE COMPARED TO THE OTHER.
Q. OKAY. THANK YOU.

DOCTOR, TURNING TO INDUCTION NOW. YOU WOULD AGREE THAT INDUCTION USING MISOPROSTOL AS AN AGENT FOR WOMEN UNDERGOING ABORTION IN THE 13 TO 23 WEEK TIME FRAME IS A SAFE

OPTION?
A. YES.
Q. AND YOU UNDERSTAND THAT IN YOUR INSTITUTION THE MATERNAL FETAL MEDICINE DOCTORS MOST COMMONLY USE MISOPROSTOL AS AN AGENT IN PERFORMING INDUCTIONS, CORRECT?
A. YES.
Q. AND AS YOU SAID IN YOUR DIRECT TESTIMONY YOU DON'T CURRENTLY PERFORM INDUCTIONS, DO YOU?
A. NO.
Q. AND THE LAST TIME WAS JUNE 1994, CORRECT?
A. APPROXIMATELY.
Q. DOCTOR, VIRTUALLY ALL OF YOUR PATIENTS ARE REFERRALS, CORRECT?
A. YES, EITHER BY THEMSELVES OR BY THEIR HEALTH CARE PROVIDER. OR FROM THEMSELVES OR HEALTH CARE PROVIDER.
Q. AND FOR YOUR PATIENTS YOU EXPLAIN THE OPTION OF LABOR INDUCTION. BUT THEY ALMOST ALWAYS CHOOSE D&E, CORRECT?
A. CORRECT.
Q. AND YOU WOULD AGREE THAT ONE OF THE MAIN REASONS YOUR SECOND-TRIMESTER PATIENTS CHOOSE D&E OVER AN INDUCTION IS BECAUSE MOST OF THE PATIENTS HAVE HAD THAT OPTION PREVIOUSLY PRESENTED TO THEM, AND THEY HAVE BEEN REFERRED TO YOU FOR PURPOSES OF PERFORMING A D&E PROCEDURE?
A. YOU ARE TALKING ABOUT THE GESTATIONAL AGE. YOU MENTIONED 14 TO 24 WEEKS, YES.

Q. IN FACT, IN THE LAST FIVE YEARS, THERE HAS ONLY BEEN FIVE TO TEN INSTANCES WHEN A PATIENT OF YOURS HAS SELECTED AN INDUCTION OVER A D&E, CORRECT?
A. CORRECT.
Q. AND, DOCTOR, YOU WOULD AGREE THAT IF A WOMAN HAD A PRIOR UTERINE SCAR, A SURGICAL PROCEDURE WOULD BE MORE RISKY THAN IF SHE HADN'T HAD THAT PRIOR UTERINE SCAR, CORRECT?
A. IF SHE IS FACING THE DECISION OF MAKING AN ABORTION, YOU HAVE TO COMPARE THE SURGICAL ABORTION TO SOMETHING ELSE. SO THE SURGICAL ABORTION WOULD BE MORE RISKY THAN WHAT?
Q. DOCTOR, IF YOU HAD A WOMAN WITH A PRIOR UTERINE SCAR AND YOU HAD A WOMAN WITHOUT A PRIOR UTERINE SCAR, THE WOMAN WITH THE PRIOR UTERINE SCAR IS GOING TO HAVE A HIGHER RISK OF HAVING COMPLICATIONS IF SHE UNDERGOES THE SURGICAL PROCEDURE?
A. I HAVE NO DATA TO CONFIRM THAT AT ALL. BUT I CAN SAY THAT SHE WOULD HAVE A HIGHER RISK WITH A LABOR INDUCTION IF SHE HAD A PRIOR SCAR COMPARED TO IF SHE HAD A SURGICAL ABORTION.
Q. AND IN CASES WHEN PATIENTS HAVE, IN FACT, CHOSEN TO DO AN INDUCTION PROCEDURE, YOU HAVE REFERRED THOSE PATIENTS TO SOMEBODY ELSE; IS THAT CORRECT?
A. TO THE MATERNAL FETAL MEDICINE SPECIALISTS IN THE DEPARTMENT THAT I WORK WITH.
Q. NOW, DOCTOR, WHEN I WAS TAKING YOUR DEPOSITION THE ONLY MEDICAL CONDITION THAT YOU IDENTIFIED AS AN INDICATION FOR AN INTACT SURGICAL ABORTION WOULD BE A CASE IN WHICH A WOMAN HAD A

CURRENT PULMONARY EMBOLUS AND REQUIRED ANTICOAGULANTS; IS THAT CORRECT?

A. I SAID THAT AT THE TIME THAT WAS THE ONLY THING I COULD THINK OF, BUT THERE COULD BE MORE.

Q. NOW, DOCTOR, YOU HAVE NEVER HAD A PATIENT WHO HAS BEEN RECEIVING ANTICOAGULANTS ON WHOM YOU PERFORMED A D&E ABORTION WHERE THE FETUS CAME OUT INTACT; IS THAT CORRECT?

A. CORRECT.

Q. IN FACT, THE ONE PATIENT YOU HAD WHO IS RECEIVING ANTICOAGULANTS WAS ABLE TO HAVE THE ANTICOAGULATION STOPPED AND THE PATIENT HAD A HYSTEROTOMY PERFORMED; ISN'T THAT CORRECT?

A. I DON'T REMEMBER THAT BEING THE CASE.

Q. I WILL DIRECT YOUR ATTENTION TO YOUR DEPOSITION, PAGE 191, LINES 22 TO 24.

A. THAT WAS A CASE WHERE THE PATIENT HAD A FETAL DEMISE, SO I WASN'T DOING AN ABORTION. SO IT IS A LITTLE DIFFERENT.

Q. BUT WHEN YOU TALKED ABOUT THE HYSTEROTOMY AT YOUR DEPOSITION THIS WAS IN THE CONTEXT OF YOUR EXAMPLE WITH THE WOMAN WITH THE ANTICOAGULANTS; ISN'T THAT CORRECT?

A. RIGHT. BUT YOU ASKED ME SPECIFICALLY IF -- ABOUT A HYSTEROTOMY ABORTION I DID. THE PATIENT I WAS TALKING ABOUT IN HERE HAD A FETAL DEMISE SO THAT'S --

Q. BUT THAT WAS A PATIENT YOU WERE CONSIDERING WHEN YOU WERE GIVING ME --

A. RIGHT.

Q. -- THE EXAMPLE, RIGHT?
A. YEAH.
Q. AND ISN'T IT TRUE THAT YOU WANT TO AVOID ANY SURGICAL PROCEDURE IN A WOMAN TAKING ANTICOAGULANTS?
A. YOU HAVE TO LOOK AT THE OPTIONS, IF SHE HAS A MEDICAL PROBLEM, OF WHAT THE DIFFERENT CHOICES ARE. AND IN A WOMAN WHO IS ACTIVELY ANTICOAGULATIVE AND REQUIRES EVACUATION OF HER UTERUS, THE OPTIONS ARE MEDICAL OR SURGICAL.

AND IN THOSE SITUATIONS, I WOULD WANT TO EVACUATE THE UTERUS FROM BELOW SURGICALLY AND NOT INDUCE LABOR.

SO IT IS NOT AN ALL OR NONE. IT IS ALWAYS A "COMPARED TO"; WHAT IS THE OTHER OPTION?

Q. NOW, TURNING TO YOUR DIRECT TESTIMONY ABOUT DIGOXIN, YOU TESTIFIED ABOUT INJECTING WOMEN WITH A CHEMICAL AGENT IN YOUR DIRECT TESTIMONY, CORRECT?
A. CORRECT.
Q. AND YOU HAVE NEVER INSERTED A CHEMICAL AGENT IN ORDER TO EFFECT INTRAUTERINE DEMISE, HAVE YOU?
A. NO.
Q. THE LAST TIME YOU PERFORMED AN AMNIOCENTESIS WAS PRIOR TO 1994, CORRECT?
A. IT MAY HAVE BEEN IN 1994, BUT IT HAS BEEN A NUMBER OF YEARS.
Q. ROUGHLY 1994?
A. CORRECT.

Q. AND YOU CANNOT REMEMBER ANY COMPLICATIONS RESULTING FROM AN AMNIOCENTESIS THAT YOU PERFORMED, CORRECT?
A. THERE MAY HAVE BEEN PATIENTS. A LOT OF AMNIOCENTESES INCLUDE AMNIOCENTESIS AT TERM FOR FETAL LUNG MATURITY. AND I CAN THINK OF PATIENTS THAT HAVE RUPTURED MEMBRANES AFTER THE AMNIOCENTESIS.

AGAIN, THIS IS GOING BACK 10 YEARS. BUT, NONE OF THE ONES THAT I DID FOR GENETIC INDICATIONS CAN I REMEMBER COMPLICATIONS. BUT I CAN CERTAINLY REMEMBER RUPTURE OF MEMBRANES AT TERM FROM TAPS FOR FETAL LUNG MATURITY.

Q. DOCTOR, YOU TESTIFIED IN YOUR DEPOSITION THAT YOU CANNOT REMEMBER ANY COMPLICATIONS RESULTING FROM AN AMNIOCENTESIS THAT YOU PERFORMED, DIDN'T YOU?
A. YES. THEN, I JUST CORRECTED MYSELF.
Q. DOCTOR, YOU TESTIFIED ON DIRECT EXAMINATION ABOUT ONE OF THE ARTICLES, THE GRIMES ARTICLE:

"MIFEPRISTONE AND MISOPROSTOL VERSUS DILATION AND EVACUATION FOR MIDTRIMESTER ABORTION."

A. YES.
Q. "A PILOT RANDOMISED CONTROLLED TRIAL," CORRECT?
A. YES.
Q. AND THAT IS PLAINTIFFS' LT11.

NOW, ON PAGE 1, THE SECOND FULL PARAGRAPH, WHERE IT BEGINS, YOU WOULD AGREE WITH THE STATEMENT:

"UNLIKE D&E, LABOUR-INDUCTION ABORTION HAS

CHANGED SUBSTANTIALLY OVER THE PAST SEVERAL DECADES," WOULDN'T YOU?

A. I WOULD GIVEN THE QUALIFICATIONS OF WHAT FOLLOWS.

I WOULD BE HAPPY TO READ IT SO THAT I COULD FINISH MY ANSWER, THEN, TO GIVE THE QUALIFICATIONS OF WHAT FOLLOWS THAT STATEMENT.

Q. DOCTOR, YOU WOULD AGREE WITH THE FIRST STATEMENT, WOULDN'T YOU?

A. ONLY IF YOU TAKE IT IN THE CONTEXT OF WHAT FOLLOWS IN THAT PARAGRAPH.

Q. OKAY. AND YOU WOULD AGREE THAT:

"THE USE OF MIFEPRISTONE FOLLOWED BY MISOPROSTOL FEATURES LOW MORBIDITY RATES AND SHORTER INDUCTION-TO-ABORTION TIMES THAN WERE SEEN WITH THE USED OF INTRAAMNIOTIC HYPERTONIC SOLUTIONS"; IS THAT CORRECT?

A. YES, AND FOR THE USE OF MISOPROSTOL BY ITSELF. IT IS A GREAT METHOD OF LABOR INDUCTION THAT IS NOT AVAILABLE IN THE UNITED STATES.

MS. CLARK: YOUR HONOR, I AM GOING FOG MOVE TO STRIKE THAT AS NONRESPONSIVE.

THE COURT: OVERRULED.

BY MS. CLARK:

Q. AND, IN THE TRIAL PERFORMED BY GRIMES, THIS TRIAL, THIS STUDY WE ARE LOOKING AT, AT NORTH CAROLINA, THIS TRIAL FIRST

RECEIVED INSTITUTIONAL REVIEW BOARD APPROVAL BEFORE THE TRIAL BEGAN, CORRECT?

A. CORRECT.

Q. AND IN THE GROUP OF PATIENTS PARTICIPATING IN THE STUDY, SOME OF THE PATIENTS HAD EXPERIENCE FETAL DEATH, CORRECT?

DIRECT YOUR ATTENTION TO PAGE 2, THE SECOND FULL PARAGRAPH.

A. YES.

Q. AND FETAL DEATH IS NOT A DISQUALIFIER FOR PARTICIPATION?

A. NOT IN THIS STUDY, NO. THEY STILL COULD ONLY GET 18 PEOPLE IN A YEAR. SO WHEN THEY INCLUDED MORE PEOPLE THAN JUST THE PEOPLE THAT WERE HAVING ELECTIVE ABORTIONS THEY STILL COULD ONLY GET -- OR I SHOULD SAY "NONFETAL DEATH ABORTIONS," THE PROCEDURES, THEY STILL COULD ONLY GET 18 PEOPLE.

MS. CLARK: AND I WILL MOVE TO STRIKE AS NOT RESPONSIVE TO ANY QUESTION POSED.

THE COURT: SUSTAINED.

THE WITNESS: I AM SORRY FOR THOSE, CONTINUED APOLOGIES.

BY MS. CLARK:

Q. AND, DOCTOR, YOU TESTIFIED YOU BELIEVE IT WOULD BE INFEASIBLE TO CONSTRUCT A RANDOMIZED CONTROL TRIAL COMPARING ABORTION METHODS; IS THAT A CORRECT CHARACTERIZATION?

A. NO, IT IS NOT. I THOUGHT IT WOULD BE UNFEASIBLE TO PERFORM ONE. I CAN CONSTRUCT ONE, BUT TO ACTUALLY CARRY IT OUT WOULD

BE UNFEASIBLE.

Q. DOCTOR, ARE YOU FAMILIAR WITH THE MEDICAL JOURNAL ENTITLED "THE LANCET"?

A. YES.

Q. AND DO YOU CONSIDER THE LANCET TO BE A RESPECTABLE JOURNAL?

A. YES.

Q. DOCTOR, ARE YOU AWARE OF A RANDOMIZED CONTROLLED TRIAL THAT WAS CONDUCTED TO COMPARE ROUTINE VERSUS ELECTIVE EPISIOTOMY AND WHICH WAS PUBLISHED IN THE LANCET?

A. NO.

Q. DOCTOR, ARE YOU AWARE OF A RANDOMIZED CONTROLLED TRIAL THAT WAS CONDUCTED TO COMPARE PLANNED CESAREAN SECTION VERSUS PLANNED VAGINAL BIRTH FOR BREECH PRESENTATION AT TERM?

A. YES, IF YOU ARE REFERRING TO THE CANADIAN STUDY.

Q. A STUDY THAT WAS PUBLISHED IN THE LANCET?

A. IF THAT IS THE CANADIAN STUDY. YOU WOULD HAVE TO SHOW IT TO ME FOR ME TO SAY THAT IS THE STUDY I AM FAMILIAR WITH.

MS. CLARK: YOUR HONOR, MAY I APPROACH?

THE COURT: YES. WHAT EXHIBIT NUMBER?

MS. CLARK: THIS IS NOT AN EXHIBIT ON OUR LIST. I AM USING IT FOR IMPEACHMENT PURPOSES. I HAVE COPIES FOR THE COURT.

BY MS. CLARK:

Q. IS THIS THE ARTICLE THAT YOU HAD IN MIND?

A. YES, IT IS.

Q. AND THAT STUDY WAS ABLE TO ENROLL 2,088 WOMEN; ISN'T THAT RIGHT?

A. CORRECT.

AT 121 CENTERS IN 26 COUNTRIES THAT WAS FUNDED. SO I WOULD --

Q. DOCTOR, 2,088 WOMEN WERE ENROLLED IN THAT STUDY; IS THAT CORRECT?

A. CORRECT.

Q. AND, DOCTOR, THIS STUDY COMPARED PLANNED CESAREAN SECTION AREA VERSUS PLANNED VAGINAL BIRTH FOR BREECH PRESENTATION AT TERM, RIGHT?

A. CORRECT.

Q. AND IF YOU LOOK AT THE "METHOD" SECTION, DOES IT NOT REFLECT THAT THE STUDY WAS ABLE TO RANDOMLY ASSIGN 2,088 WOMEN?

A. CORRECT.

Q. NOW, IN YOUR DIRECT EXAMINATION, YOU TESTIFIED THAT YOU RELIED UPON THE AUTRY ARTICLE; IS THAT RIGHT?

A. YES.

Q. AND THAT IS LT5. THE AUTRY ARTICLE IS NOT A RANDOMIZED STUDY, CORRECT?

A. CORRECT.

Q. AND THE MOST RECURRING COMPLICATION FOR THE INDUCTION GROUP WAS RETAINED PRODUCTS OF CONCEPTION; ISN'T THAT RIGHT?

AND I WILL DIRECT YOUR ATTENTION TO TABLE 2, ON PAGE 395.

A. YES.
Q. AND RETAINED PLACENTA IS CONSIDERED A PRODUCT OF CONCEPTION, RIGHT?
A. CORRECT.
Q. THE ARTICLE DIDN'T INDICATE HOW LONG THE OPERATORS WAITED UNTIL THEY CONCLUDED THAT THERE WAS A RETAINED PRODUCT OF CONCEPTION COMPLICATION, CORRECT?
A. NO, THEY DID NOT.
Q. AND THE PATIENTS IN THE MEDICAL INDUCTION GROUP RECEIVED DILATION AND CURETTAGE IF THEY HAD RETAINED PRODUCTS OF CONCEPTION; AM I CORRECT?
A. YES, THAT'S WHAT THEY INDICATED.
Q. AND IN A D&E BY DISARTICULATION, AND IN AN INTACT D&E, THERE VIRTUALLY ALWAYS IS A SURGICAL INSTRUMENTAL REMOVAL OF THE PLACENTA, CORRECT?
A. YES.
Q. IN FACT, YOU YOURSELF PERFORM SUCTION CURETTAGE AT THE END OF THE D&E PROCEDURE, RIGHT?
A. YES.
Q. NOW, DOCTOR, NONE OF YOUR PUBLICATIONS ADDRESSES THE ISSUE OF FETAL PAIN; ISN'T THAT RIGHT?
A. CORRECT.
Q. AND YOU YOURSELF HAVE NOT CONDUCTED A STUDY ON THE ISSUES OF FETAL PAIN, CORRECT?
A. NOPE.

Q. YOU HAVE NOT RECEIVED ANY GRANT AWARDS IN ORDER TO STUDY THE ISSUE OF FETAL PAIN?
A. NO.
Q. AND YOU WOULD AGREE YOU ARE NOT AN EXPERT IN DOING RESEARCH ON FETAL PAIN?
A. NO.
Q. YOU WOULD AGREE WITH THAT?
A. YES, I WOULD AGREE THAT I AM NOT.
Q. AND YOU ARE NOT A NEUROLOGIST?
A. NO.
Q. YOU ARE NOT A PEDIATRICIAN?
A. NO.
Q. AND YOU ARE NOT A NEONATOLOGIST, RIGHT?
A. NO.
Q. YOU ARE NOT A NEONATOLOGIST; IS THAT CORRECT?
A. YES, THAT'S CORRECT.

MS. CLARK: NOTHING FURTHER.

THE COURT: ANY REDIRECT?

MS. KRASNOFF: YES.

REDIRECT EXAMINATION

BY MS. KRASNOFF:
Q. DR. CREININ, I WOULD LIKE TO START WITH THIS ARTICLE WHICH I BELIEVE YOU SAID IS THE CANADIAN STUDY, THE:

"PLANNED CAESAREAN SECTION VERSUS PLANNED VAGINAL BIRTH FOR BREECH PRESENTATION AT TERM: A

RANDOMISED MULTICENTRE TRIAL."

AND IF YOU COULD EXPLAIN WHY YOU THINK THIS ARTICLE IS NOT RELEVANT TO YOUR OPINION THAT A RANDOMIZED TRIAL OF ABORTION METHODS AFTER 16 WEEKS GESTATIONAL AGE WOULD NOT BE FEASIBLE?

A. WELL, FIRST, I COULD PRESENT MANY RANDOMIZED TRIALS THAT ARE IN THE LITERATURE THAT HAVE BEEN PERFORMED. THEY DON'T PERTAIN TO ABORTION PROCEDURES. THE DATA THAT IS AVAILABLE ON ABORTION PROCEDURES, EVEN LOOKING AT FIRST-TRIMESTER ABORTION PROCEDURES, SHOWS THAT WOMEN DON'T WANT TO BE RANDOMIZED. THEY HAVE A PREFERENCE.

SECONDLY, THIS IS A STUDY AT 121 CENTERS IN 26 COUNTRIES, AND WAS FUNDED. SO PART OF THE FEASIBILITY OF DOING THE STUDY WOULD BE TO HAVE SUFFICIENT FUNDING FROM A LARGE SOURCE, LIKE OUR GOVERNMENT, TO FUND SUCH A STUDY.

SO THAT'S PART OF THE FEASIBILITY. AND THEN TO GET -- AND THEN THE METHODS FOR VAGINAL BREECH DELIVERY AND THE METHODS FOR CESAREAN SECTION ARE PRETTY STANDARD. WITH A D&E PROCEDURE VERSUS A LABOR INDUCTION THERE IS A LOT OF ALONG-THE-WAY THINGS THAT YOU HAVE TO FIGURE OUT.

SO TO STANDARDIZE THINGS SO THAT IT IS DONE THE SAME WAY EVERYWHERE ALSO IS PART OF THE INFEASIBILITY. AS WE TALKED ABOUT, THAT D&E PROCEDURE MAY START OUT AS A D&E, BUT MAY END UP BEING AN INTACT D&E. OR YOU MAY START OUT WITH AN INTACT D&E AND ACTUALLY HAVE THE FETUS PASS.

SO YOU CAN GO BY INTENTION TO TREAT, BUT THE REAL CRUX OF IT IS THIS IS ABORTION, PATIENTS SEEKING ABORTION SERVICES, NOT PATIENTS WHO ARE SEEKING A DELIVERY.

THERE ARE PATIENTS WHO HAVE HEART DISEASE THAT ARE ABLE TO BE RANDOMIZED BETWEEN A MEDICAL TREATMENT AND A SURGICAL INTERVENTION. BUT THAT DOESN'T MEAN THAT WE CAN DO THAT FOR ABORTION.

WE DO HAVE STUDIES THAT SHOW US WITHIN THE ABORTION LITERATURE THAT IT'S IMPRACTICAL, UNFEASIBLE, UNREASONABLE AND IF -- THEN, WE ALSO KNOW THE ISSUE OF GETTING FUNDING FOR SUCH A LARGE STUDY WOULD BE UNLIKELY.

I DON'T THINK -- I WON'T OPINE ON MY POSITION OF THE U.S. GOVERNMENT IN FUNDING FOR ABORTION STUDIES.

Q. THAT'S ALL RIGHT. NOW, I'LL SWITCH.

MS. CLARK ASKED YOU ABOUT THE HENRIET STUDY RELATING TO CERVICAL INCOMPETENCE. AND I READ YOUR DEPOSITION THAT YOU THINK THAT THAT IS AN AWFUL STUDY?

A. CORRECT.

Q. IS THAT YOUR OPINION?

A. CORRECT.

Q. IF YOU COULD TAKE A LOOK AT THAT AND EXPLAIN THE BASIS FOR YOUR OPINION THAT THAT IS AN AWFUL STUDY?

A. WELL, THE REASON I SAID IT WAS AN AWFUL STUDY IS THAT I WAS BEING ASKED ABOUT THE STUDY IN THE CONTEXT OF ABORTIONS AT 18 WEEKS OR GREATER. AND THERE ARE A COUPLE OF THINGS TO KEEP IN

MIND.

FIRST, THE STUDY WAS A STUDY THAT IN A POPULATION OF WOMEN WHERE THE ABORTIONS THAT WERE PERFORMED, 96 PERCENT OF THEM WERE IN THE FIRST-TRIMESTER OR IN EARLY ABORTIONS. AND THAT IS BECAUSE THAT'S -- AND IT IS BROUGHT OUT IN THE ARTICLE ABOUT THAT IS WHEN ABORTIONS ARE PERFORMED IN FRANCE.

SO --

Q. IN FACT, IF I DIRECT YOUR ATTENTION TO PAGE 1041.

A. RIGHT. IT SAYS --

Q. IT SAYS THAT ONLY 4 PERCENT OF WOMEN FOR THE STUDY HAD ABORTIONS AFTER 11 WEEKS GESTATIONAL AGE?

A. CORRECT. SO IT IS NOT RELEVANT TO WHAT WE ARE TALKING ABOUT. IT IS A DIFFERENT GROUP OF WOMEN.

AND THEN, WHEN YOU LOOK AT THE ISSUE OF CERVICAL -- WELL, MORE SPECIFICALLY ABOUT THE STUDY, IT WAS ALSO A RETROSPECTIVE STUDY THAT ASKED WOMEN WHO HAD A DELIVERY:

"CAN YOU TELL US ABOUT WHAT HAPPENED IN THE PAST?"

AND RECALL BIAS IS SO STRONG IN STUDIES OF THAT NATURE. I MEAN, A GREAT EXAMPLE --

Q. CAN YOU EXPLAIN WHAT "RECALL BIAS" IS?

A. RECALL BIAS IS WHEN YOU ASK SOMEBODY ABOUT WHAT HAPPENED TO THEM IN THE PAST. THEY ARE MORE LIKELY TO RECALL EVERYTHING IF THEY HAD A BAD OUTCOME AND NOT RECALL EVERYTHING IF THEY HAVE NOT HAD A BAD OUTCOME, BECAUSE THEY ARE LOOKING FOR YOU TO HELP

THEM EXPLAIN WHY THEY HAD THEIR BAD OUTCOME.

A GREAT EXAMPLE IS THE BREAST CANCER AND ABORTION LITERATURE. THE NATIONAL CANCER INSTITUTE CAME OUT WITH A LARGE -- WITH A REVIEW OF ALL OF THE LITERATURE SAYING THERE IS NO RELATIONSHIP BETWEEN ABORTION AND BREAST CANCER.

THERE ARE SOME STUDIES IN THE LITERATURE THAT HAVE SUGGESTED THAT, AND THEY ARE JUST FILLED WITH RECALL BIAS, BECAUSE IF YOU HAD BREAST CANCER OR ANY OTHER -- NOT YOU, SPECIFICALLY -- A WOMAN HAD BREAST CANCER, I APOLOGIZE -- AND I CAME TO HER SAYING:

"I AM DOING A STUDY AND TRYING TO FIGURE OUT WHY YOU MIGHT HAVE HAD BREAST CANCER. TELL ME, DID YOU HAVE EAT FISH? DID YOU EVER HAVE AN ABORTION? DID YOU EVER DO X, Y OR Z?"

SHE IS MUCH MORE LIKELY TRYING TO SPEND A LOT OF TIME TRYING TO REMEMBER ALL THE DETAILS THAN SHE WOULD IF YOU HAD JUST SAID:

"YOU ARE A HEALTHY PERSON. CAN YOU TELL ME ABOUT ALL OF THOSE THINGS?"

AND THEY ARE ALSO LESS LIKELY TO ADMIT IT. AND THAT IS VERY WELL-ESTABLISHED IN THE MEDICAL LITERATURE ABOUT THE PROBLEMS WITH RECALL BIAS.

SO WHEN YOU ADD THAT TO THE FACT THAT THIS IS PRIMARILY FIRST-TRIMESTER PATIENTS, IT DOESN'T HAVE ANY RELEVANCE.

THE OTHER ISSUE IS THAT WHEN YOU ARE LOOKING AT A WOMAN FACING AN ABORTION BETWEEN 18 AND 24 WEEKS, YOU HAVE TO HAVE THE APPROPRIATE COMPARATOR.

THIS IS LOOKING AT THE RISK OF SUBSEQUENT PREGNANCY OUTCOME BASED ON WOMEN WHO HAD AN ABORTION IN THE PAST. THE OTHER OPTION WAS TO NOT HAVE AN ABORTION, AND THAT IS, IN A SENSE, THE COMPARISON.

IF WE ARE TAKING A WOMAN WHO BETWEEN 18 AND 24 WEEKS IS FACING -- IS LOOKING AT HAVING AN ABORTION AND SHE'S DECIDING BETWEEN METHODS, THAT IS NOT COMPARING IT TO NOT HAVING AN ABORTION. IT IS COMPARING THE TWO METHODS.

SO THIS STUDY IS NO WAY IS RELEVANT TO THE DISCUSSION WE ARE HAVING. DID I MAKE --

THE COURT: I UNDERSTAND.

THE WITNESS: OKAY.

BY MS. KRASNOFF:

Q. AND, FINALLY, THERE'S ONE MORE STUDY. THIS IS A STUDY OF PRE-TERM DELIVERY. IS PRE-TERM DELIVERY THE SAME THING AS CERVICAL INCOMPETENCE?

A. NO, NOT AT ALL. CERVICAL INCOMPETENCE IS PAINLESS DILATION OF THE CERVIX WHICH CAN RESULT IN PRE-TERM DELIVERY. BUT THE MAJORITY OF PRE-TERM DELIVERIES IS FROM PRE-TERM LABOR, WHICH IS A SEPARATE ENTITY.

SO YOU CAN'T BUNDLE THEM INTO ONE ENTITY WHEN, IN FACT, THE VAST MAJORITY OF PRE-TERM DELIVERIES IN OUR COUNTRY

ARE RELATED TO PRE-TERM BIRTH, AND RARELY CERVICAL INCOMPETENCE.

Q. THERE WAS SOME TESTIMONY ABOUT INTACT D&E VERSUS REMOVING THE FETUS INTACT VERSUS MULTIPLE PASSES. AND I JUST WANT TO TRY TO CLARIFY SOME OF THAT.

CORRECT ME IF I AM WRONG. YOU ARE DIFFERENTIATING BETWEEN AN INTACT D&E, REMOVAL OF THE FETUS INTACT WITH NO COMPRESSION OF THE HEAD, AND THEN A THIRD CATEGORY, WHICH IS EVACUATING THE FETUS WHERE IT COMES OUT TO THE POINT OF THE AFTERCOMING HEAD, AND YOU HAVE TO DISARTICULATE, WHICH WOULD BE A D&E; IS THAT CORRECT?

ARE THEY DIFFERENT CATEGORIES OF PROCEDURE?

MS. CLARK: I AM GOING TO OBJECT AS VAGUE. I DIDN'T UNDERSTAND.

THE COURT: SUSTAINED. I DIDN'T UNDERSTAND.

THE WITNESS: I AM SORRY. I DIDN'T UNDERSTAND, EITHER.

BY MS. KRASNOFF:

Q. YOU WERE DISCUSSING MULTIPLE PASSES VERSUS INTACT. IS ONE CATEGORY OF PROCEDURE WHERE YOU REMOVE THE FETUS COMPLETELY INTACT WITHOUT HAVING TO TAKE OR TO COMPRESS THE HEAD?

A. CORRECT.

Q. A DIFFERENT CATEGORY WHICH YOU WERE CALLING INTACT D&E, IS WHERE YOU REMOVED THE FETUS UP TO THE CALVARIUM, AND YOU USE A SCISSORS AND SUCTION TO REMOVE THE FETUS; IS THAT CORRECT?

A. SCISSORS TO PUNCTURE THE SKULL TO DRAIN, RIGHT. CORRECT.
Q. THE THIRD CATEGORY WHICH I THINK YOU CALLED A D&E, YOU MAY REMOVE THE FETUS UP TO THE POINT OF THE AFTERCOMING HEAD, BUT THEN DISARTICULATE FURTHER. THAT WOULD BE A D&E?
A. CORRECT, AND ANY OF THE --
THE COURT: I DIDN'T UNDER THE DISTINCTION BETWEEN THE SECOND AND THIRD.
MS. KRASNOFF: HE'S --
THE COURT: SECOND AND THIRD CATEGORY.
MS. KRASNOFF: OH, THE SECOND WAS SPECIFICALLY USING A SCISSORS TO PIERCE THE BASE OF THE SKULL AND THE SUCTION INSTRUMENT TO REMOVE THE INTRACRANIAL CONTENTS.
THE COURT: OKAY. THE THIRD WAS --
MS. KRASNOFF: THE CRANIUM LODGES AND USES DISARTICULATION TO REMOVE THE FETAL TRUNK, AND THEN REMOVE THE SKULL, THEREAFTER.
THE COURT: ALL RIGHT. AND, DOCTOR, THE CATEGORY IN WHICH YOU DESCRIBED THREE PRIOR EXPERIENCES, WAS THAT IN THE FIRST CATEGORY OR THE SECOND CATEGORY?
THE WITNESS: SECOND.
THE COURT: THE SECOND CATEGORY?
THE WITNESS: THE SECOND WAS INTACT. THAT IS WHAT IS MEDICALLY CALLED AN INTACT D&E PROCEDURE.
THE COURT: OKAY. AND YOU HAVE NOT HAD ANY EXPERIENCE WITH THE FIRST CATEGORY?

THE WITNESS: NO.
BY MS. KRASNOFF:
Q. YOU TOOK OUT ONE, TWO AND THREE.
A. THE FIRST CATEGORY BEING THAT THE FETUS COMES OUT COMPLETELY INTACT?
THE COURT: RIGHT.
THE WITNESS: THERE HAVE BEEN SITUATIONS, MOST COMMONLY IF THERE IS A MULTIPLE PREGNANCY AND THE FIRST ONE IS REMOVED BY D&E, AND THEN THE SECOND ONE BECAUSE THE CERVIX IS VERY PLIABLE AT THAT POINT WILL COME OUT COMPLETELY INTACT.
THE COURT: HAVE YOU HAD THAT EXPERIENCE?
THE WITNESS: YES. IN ALL OF THOSE SITUATIONS, THOUGH, REGARDLESS OF WHETHER THE FETUS COMES OUT COMPLETELY INTACT, INTACT UP TO THE HEAD, AND I DO A PROCEDURE ON THE BASE OF THE SKULL, OR I DIS -- OR IT COMES OUT COMPLETELY AT THE LEVEL OF THE HEAD, AND I DISARTICULATE IT, ALL OF THOSE HAVE AT TIMES GONE INTACT OR RELATIVELY INTACT TO THE LEVEL OF THE UMBILICUS OR GREATER AND WOULD VIOLATE THE LAW.
THE COURT: OKAY.
BY MS. KRASNOFF:
Q. AND DO YOU KNOW AT THE OUTSET WHETHER IT IS GOING TO BE ONE OF THOSE THREE?
A. NO.
Q. I THINK YOU TESTIFIED ABOUT THIS ON DIRECT A LITTLE BIT. WHY DO YOU IN THE ABORTIONS YOU DO NOT SEEK TO GET MORE

DILATION?
A. BECAUSE I'M TRYING TO BALANCE THE PATIENT'S DESIRES AND NEEDS AND COMFORT SO THAT I CAN PUT IN -- SO I AM TRYING TO MAKE IT SO WHEN SHE GOES HOME, SHE IS AS COMFORTABLE AS POSSIBLE, WITH BALANCING WITH ME GETTING ENOUGH DILATION TO DO THE PROCEDURE. AND THAT MY GOAL IS TO GET ENOUGH DILATION TO SAFELY DO THE PROCEDURE, REALIZING SOMETIMES IT MAY BE MORE.

BUT MY PRIMARY OBJECTIVE IS FOR HER TO GO HOME WITH A LOW LIKELIHOOD OF DELIVERING AT HOME, BECAUSE SHE DOESN'T WANT THAT. WE TALKED ABOUT THAT AHEAD OF TIME, AND WITH HER BEING COMFORTABLE.

Q. MISS CLARK USED THE WORD "MINIMIZING THE DILATION."

DO YOU CONSIDER WHAT YOU ARE DOING TO BE MINIMIZING THE AMOUNT OF DILATION?

A. I THINK MINIMIZING REQUIRES COMPARISON. I THINK IT IS MORE THAT I AM TRYING TO ACHIEVE AN AMOUNT THAT I CONSIDER TO BE A MINIMAL AMOUNT TO SUCCESSFULLY DO THE PROCEDURE, BUT I AM NOT TRYING TO MINIMIZE THE AMOUNT.

Q. I BELIEVE YOU TESTIFIED THAT -- ABOUT TAKING ACTS TO PREVENT DELIVERY OF A LIVE FETUS. WOULD YOU EVER DO THAT IF IN YOUR MEDICAL JUDGMENT THE FETUS WAS VIABLE?

A. NO, I WOULDN'T BE DOING THIS PROCEDURE ON A VIABLE FETUS.

Q. YOU DON'T PERFORM ANY ABORTIONS ON VIABLE FETUSES, DO YOU?

A. NO, I DON'T. BY LAW IN PENNSYLVANIA I CANNOT.

Q. AND IS IT POSSIBLE FOR A FETUS TO BE ALIVE, BUT ALSO NOT

VIABLE?

A. YES, ACCORDING TO THE WAY THE LAW IS WRITTEN.

SO, YES. I MEAN --

Q. BECAUSE IT MAY SHOW SIGNS OF LIFE?

A. I THINK IT'S A CATCH-22. IT DEPENDS ON HOW YOU DEFINE A LIFE. IF YOU WANT TO SAY CAN THE FETUS HAVE CARDIAC ACTIVITY AND NOT BE VIABLE? YES. ALIVE IS -- BECAUSE IT DEPENDS ON HOW YOU WOULD WANT ME TO, I MEAN --

THE COURT: WELL, AT WHAT POINT CAN YOU DETECT CARDIAC ACTIVITY IN THE FETUS?

THE WITNESS: I MEAN, IN A FETUS? IN A FETUS BEGINS AT 10 WEEKS. SO THERE'S EMBRYONIC LIVE, EMBRYONIC STAGE BEFORE THAT. AND THE AREA THAT IS GOING TO DEVELOP INTO THE HEART, YOU CAN START TO SEE ACTIVITY IN THAT AREA BEGINNING AT SIX WEEKS.

IT DOESN'T DEVELOP INTO WHAT WE WOULD THINK OF AS A HEART IN ITS EARLIEST FORM UNTIL ABOUT 10 WEEKS, EIGHT TO 10 WEEKS.

SO IF YOU CONSIDER THAT THEN ALIVE IN LEGAL TERMS, THEN, YES, IT IS ALIVE, BUT IT IS NOT VIABLE.

THE COURT: OKAY.

MS. KRASNOFF: NOTHING FURTHER.

THE WITNESS: OKAY.

THE COURT: I UNDERSTAND.

ANY RECROSS?

MS. CLARK: I HOPE ONE BRIEF QUESTION.

RECROSS-EXAMINATION

BY MS. CLARK:

Q. DOCTOR, JUST TO BE CLEAR HERE, ABORTIONS IN THE FIRST-TRIMESTER REQUIRE LESS CERVICAL DILATION THAN ABORTIONS IN THE SECOND-TRIMESTER; ISN'T THAT RIGHT?

A. YES.

MS. CLARK: THANK YOU.

MS. KRASNOFF: CAN I ASK ONE MORE QUESTION ABOUT THAT.

FURTHER REDIRECT EXAMINATION

BY MS. KRASNOFF:

Q. ARE THE METHODS OF DILATION USED IN THE FIRST-TRIMESTER, MIGHT THOSE BE DIFFERENT FROM THE SECOND-TRIMESTER?

A. YES.

Q. AND IN THAT OSMOTIC DILATION AS USED IN A D&E OVER A PERIOD OF TIME WOULD NOT BE USED IN THE FIRST-TRIMESTER; IS THAT CORRECT?

A. MOST COMMONLY NOT. BUT, AGAIN, YOU ARE NOT COMPARING FIRST TO SECOND. YOU ARE TAKING A WOMAN AT 20 WEEKS WHO SAYS:

"I WANT TO HAVE AN ABORTION, AND MY OPTIONS ARE D&E VERSUS LABOR INDUCTION."

AND SO YOU CAN'T COMPARE D&E VERSUS NOT HAVING AN ABORTION AT ALL OR LABOR INDUCTION VERSUS NOT HAVING AN ABORTION AT ALL. YOU HAVE TO COMPARE THOSE TWO, IF YOU ARE

LOOKING AT THE RELATIVE RISKS. NOT FIRST VERSUS SECOND OR ANY OF THOSE OTHER THINGS.

THE COURT: ANYTHING FURTHER?

DR. CREININ, YOU ARE EXCUSED.

THE WITNESS: THANK YOU, YOUR HONOR.

THE COURT: PLAINTIFFS' NEXT WITNESS?

MS. GARTNER: YOUR HONOR, WE INTEND TO CALL DR. CAROLYN WESTHOFF. I WANTED TO RAISE WITH YOUR HONOR THE ISSUE OF TIME AND THE FACT THAT WE HAVE APPROXIMATELY TWO-AND-A-HALF ADDITIONAL HOURS PLUS THE 15-MINUTE BREAK.

DR. WESTHOFF CAN'T STAY TO RETURN TO COURT THURSDAY MORNING. I UNDERSTAND THE GOVERNMENT HAS WITNESSES ARRIVING THURSDAY MORNING. SO WHAT WE WOULD PROPOSE TO DO TO ENSURE THAT DR. WESTHOFF CAN LEAVE IS THAT WE WOULD DIVIDE THE REMAINING TIME TODAY IN HALF TO GIVE THE GOVERNMENT AN EQUAL OPPORTUNITY TO QUESTION DR. WESTHOFF.

AND I JUST WANTED TO MAKE SURE THAT WITH THAT ARRANGEMENT WE WOULD TAKE UP THE TIME THAT DR. WESTHOFF WOULD THEN BE FREE TO LEAVE AFTER WE CONCLUDE TODAY.

THE COURT: YES.

MS. CLARK: THAT SOUNDS FAIR.

MS. GARTNER: OKAY. SO PLAINTIFFS WOULD CALL DR. CAROLYN WESTHOFF TO THE STAND.

DR. CAROLYN WESTHOFF,

CALLED AS A WITNESS FOR THE PLAINTIFFS, HAVING BEEN DULY SWORN,

TESTIFIED AS FOLLOWS:

THE WITNESS: I DO.

THE CLERK: PLEASE STATE YOUR NAME FOR THE RECORD?

THE WITNESS: CAROLYN WESTHOFF.

THE CLERK: PLEASE SPELL YOUR LAST NAME.

THE WITNESS: W-E-S-T-H-O-F-F.

DIRECT EXAMINATION

BY MS. GARTNER:

Q. GOOD MORNING, DR. WESTHOFF.

A. GOOD MORNING.

Q. ARE YOU A BOARD CERTIFIED OB/GYN?

A. YES, I AM.

Q. AND WHERE ARE YOU CURRENTLY EMPLOYED?

A. I AM A PROFESSOR AT COLUMBIA UNIVERSITY AT NEW YORK CITY.

Q. AND WHAT ARE YOU A PROFESSOR OF?

A. I AM A PROFESSOR OF OBSTETRICS AND GYNECOLOGY IN THE COLLEGE OF PHYSICIANS AND SURGEONS. AND I'M ALSO PROFESSOR OF EPIDEMIOLOGY AND OF POPULATION AND FAMILY HEALTH IN THE MAILMAN SCHOOL OF PUBLIC HEALTH.

Q. AND ARE YOU AN EPIDEMIOLOGIST IN ADDITION TO BEING AN OB/GYN?

A. YES, I AM.

Q. AND ARE YOU AFFILIATED WITH ANY HOSPITAL?

A. I AM ATTENDING PHYSICIAN AT THE NEW YORK PRESBYTERIAN HOSPITAL.

Q. AND IN ADDITION TO BEING AN ATTENDING PHYSICIAN AT NEW YORK PRESBYTERIAN HOSPITAL, DO YOU HAVE OTHER POSITIONS?
A. I AM THE MEDICAL DIRECTOR OF OUR FAMILY PLANNING CLINICS, AND I'M ALSO THE DIRECTOR OF THE SPECIAL GYN SERVICES.
Q. AND IS THAT THE SPECIAL GYN SERVICES AT A PARTICULAR INSTITUTIONS?
A. THE SPECIAL GYN SERVICES IS AT ALLEN PAVILION, WHICH IS A BUILDING THAT IS PART OF NEW YORK PRESBYTERIAN HOSPITAL.
Q. AND DID NEW YORK PRESBYTERIAN HOSPITAL USED TO BE CALLED COLUMBIA PRESBYTERIAN HOSPITAL?
A. YES, ABOUT SIX OR EIGHT YEARS AGO WE MERGED WITH NEW YORK HOSPITAL, SO THERE ARE MULTIPLE CAMPUSES NOW THAT ARE ALL PART OF NEW YORK PRESBYTERIAN.
Q. AND DO YOU HAVE A PRIVATE MEDICAL PRACTICE?
A. I AM PART OF THE FACULTY PRACTICE IN THE DEPARTMENT OF OB/GYN.
Q. AND WHAT SERVICES DO YOU OFFER IN THAT PRIVATE PRACTICE?
A. MY PRIVATE PRACTICE IS A HALF DAY A WEEK, AND THAT IS FOCUSED ON PROVIDING CARE FOR ABORTIONS, MISCARRIAGES AND CONTRACEPTIVE CONSULTATION.
Q. AND WHAT SERVICES ARE PROVIDED BY THE SPECIAL GYN SERVICES PROGRAM?
A. SPECIAL GYN SERVICES PROVIDES CARE FOR MISCARRIAGE AND ABORTION UP UNTIL 24 WEEKS, AND TUBAL LIGATIONS.
Q. AND APPROXIMATELY HOW MANY PATIENTS DO YOU SEE ANNUALLY AT

THE SPECIAL GYN SERVICES?

A. THERE ARE A TOTAL OF BETWEEN TWO TO 3,000 VISITS. THERE ARE ABOUT -- THEY ARE DIVIDED AMONG THE VARIOUS SERVICES WE OFFER.

Q. IN YOUR PRIVATE PRACTICE APPROXIMATELY HOW MANY PATIENTS DO YOU SEE A YEAR?

A. SEE ABOUT 500 PATIENTS.

Q. AND AT THE SPECIAL GYN SERVICES, ARE THERE OTHER PHYSICIANS BESIDES YOURSELF THAT ARE PROVIDING SERVICES?

A. YES. THERE ARE ABOUT FIVE PHYSICIANS WHO ARE PART OF MY CORE GROUP, PART OF MY ACADEMIC DIVISION. AND THEN, THERE ARE ANOTHER SIX OR EIGHT DOCTORS WHO ARE PART OF THE DEPARTMENT OF OB/GYN WHO MAY WORK WITH US ONE DAY A WEEK OR ONE HALF DAY A WEEK.

Q. AND DO YOU SUPERVISE ALL OF THOSE PHYSICIANS?

A. YES, I DO.

Q. DO YOU YOURSELF PERFORM ABORTIONS?

A. YES, I DO.

Q. FOR HOW LONG HAVE YOU BEEN PERFORMING ABORTIONS?

A. I STARTED PERFORMING ABORTIONS DURING MY RESIDENCY TRAINING STARTING IN 1978.

Q. AND WHAT TYPE OF ABORTION PROCEDURES ARE OFFERED AT THE SPECIAL GYN SERVICES?

A. WE PROVIDE SURGICAL ABORTION IN THE FIRST AND SECOND-TRIMESTER. WE ALSO PROVIDE MEDICAL ABORTION USING

MIFEPRISTONE OR METHOTREXATE IN THE FIRST-TRIMESTER.
Q. DO YOU PERFORM INDUCTION ABORTIONS AT SPECIAL GYN SERVICES?
A. THE SPECIAL GYN SERVICES IS COMPLETELY OUTPATIENT SERVICE, AND WE DON'T PROVIDE INDUCTIONS ON THAT UNIT.
Q. HAVE YOU EVER PROVIDED INDUCTIONS IN YOUR CAREER?
A. YES, I HAVE.
Q. AND WHY DON'T YOU CURRENTLY PROVIDE INDUCTIONS?
A. THERE IS CURRENTLY NOT NEED FOR ME TO OFFER INDUCTION SERVICES. IN OUR DEPARTMENT OF OB/GYN THERE ARE MANY OTHER PHYSICIANS, PARTICULARLY THOSE IN MATERNAL FETAL MEDICINE, WHO KNOW HOW TO PROVIDE AN INDUCTION ABORTION. AND THEY OCCASIONALLY DO SO FOR THEIR PATIENTS. BUT THEY REFER ALL PATIENTS REQUESTING D&E TO OUR SERVICE.
Q. AND IN YOUR PRACTICE, WHAT ARE -- I THINK -- DID YOU TESTIFY TO WHAT GESTATIONAL AGE YOU PROVIDE D&E'S AT SPECIAL GYN SERVICES?
A. WE PROVIDE D&E'S THROUGH 28 WEEKS, WHICH IS THE LEGAL LIMIT IN NEW YORK STATE.
Q. THROUGH TWENTY-EIGHT WEEKS?
A. DID I MISSPEAK? I'M SORRY.
Q. YES, DOCTOR.
A. THROUGH 23 WEEKS.
Q. THROUGH 23 WEEKS. IS THAT 23 AND SIX-SEVENTHS --
A. YES.
Q. -- WEEKS. OKAY.

AND WHAT ARE SOME OF THE CIRCUMSTANCES IN YOUR PRACTICE THAT WOMEN ARE HAVING SECOND-TRIMESTER ABORTIONS, JUST GENERALLY?

A. WELL, WE CERTAINLY SEE SOME WOMEN WHO HAVE PERSONAL AND SOCIAL CATASTROPHES. AND WE SEE MANY WOMEN WHO HAVE GENETIC ABNORMALITIES OR ANATOMICAL ABNORMALITIES OF THE FETUS THAT ARE DIAGNOSED IN THE SECOND-TRIMESTER.

AND WE ALSO SEE WOMEN WHO HAVE MEDICAL ILLNESSES THAT MAKE CONTINUING ON TO PARENTHOOD AT THIS TIME MORE DANGEROUS FOR THEM WHO DECIDE TO ABORT.

Q. DO YOU KNOW APPROXIMATELY WHAT PERCENTAGE OF YOUR PATIENTS ARE TERMINATING THE PREGNANCY DUE TO A SERIOUS FETAL ABNORMALITY?

A. IT IS APPROACHING HALF OF THE PATIENTS.

Q. AND DOES COLUMBIA UNIVERSITY OFFER ANY TRAINING IN ABORTION PROCEDURES?

A. YES, WE DO.

Q. WHAT TYPE OF ABORTION PROCEDURES ARE TAUGHT?

A. ALL OF THE TYPES THAT I JUST DESCRIBED.

Q. AND DO YOU TEACH THE INTACT VARIANT OF THE D&E PROCEDURE AT COLUMBIA?

A. YES, WE DO.

Q. HAVE YOU AUTHORED ANY PUBLICATIONS?

A. YES, I HAVE.

Q. JUST GENERALLY, WHAT SUBJECT AREAS HAVE YOU AUTHORED

PUBLICATIONS IN?
A. MY MAIN FOCUS HAS BEEN IN THE AREA OF FAMILY PLANNING, SO CONTRACEPTIVE DEVELOPMENT EFFECTIVENESS, CONTRACEPTIVE EVALUATION, EARLY MEDICAL ABORTION. AND I ALSO AM INTERESTED IN OVARIAN TUMOR AND HAVE DONE A NUMBER OF STUDIES LOOKING AT OVARIAN CANCER AND BENIGN OVARIAN CYSTS AND TUMORS.
Q. AND ARE THE PUBLICATIONS LISTED ON YOUR CURRICULUM VITAE?
A. YES, THEY ARE.
Q. DO YOU SIT ON ANY GOVERNMENTAL ADVISORY COMMITTEE PANELS AT ANY LEVEL?
A. YES, I DO.
Q. COULD YOU STATE SOME OF THEM FOR US?
A. YES. I JUST COMPLETED FIVE YEARS AS A MEMBER OF THE U.S. PREVENTIVE SERVICES TASK FORCE.

I HAVE SERVED ON NIH STUDY SECTION TO EVALUATE GRANT APPLICATIONS. AND I AM ALSO A MEMBER OF OR CHAIR OF SEVERAL DATA SAFETY AND MONITORING BOARDS FOR A NUMBER OF NIH-SPONSORED CLINICAL TRIALS.

MS. GARTNER: YOUR HONOR, MAY I APPROACH THE WITNESS TO HAND HER HER CV?

THE COURT: GO AHEAD.

BY MS. GARTNER:
Q. DR. WESTHOFF, I AM GOING TO HAND YOU WHAT IS EXHIBIT 67.

MS. GARTNER: YOUR HONOR, BECAUSE WE DIDN'T KNOW IF DR. WESTHOFF WAS GOING TO BE TESTIFYING IN PERSON, WE

DESIGNATED THIS EXHIBIT IN THE WAY THAT IT WAS. THIS IS HER CURRICULUM VITAE. AND THE WAY THAT IT WAS USED IN HER DEPOSITION TESTIMONY, AND FOR SOME REASON I DON'T FULLY UNDERSTAND, IT IS STAPLED TOGETHER. IT'S A COPY OF DR. WESTHOFF'S EXPERT REPORT AND HER CV, AND HER DECLARATION IN THE NEW YORK CASE.

SO JUST SO YOU UNDERSTAND, WE ARE REALLY ONLY USING IT FOR THE CV, BUT IT WAS DESIGNATED AS THREE DOCUMENTS STAPLED TOGETHER.

BY MS. GARTNER:

Q. DR. WESTHOFF, IF YOU TURN TO THE THIRD PAGE OF THAT DOCUMENT, IS THIS YOUR CURRICULUM VITAE?

A. YES, IT IS.

Q. IS THIS DOCUMENT AN ACCURATE SUMMARY OF YOUR EDUCATION AND EXPERIENCE?

A. YES, IT IS.

MS. GARTNER: PLAINTIFFS WOULD MOVE EXHIBIT 67 INTO EVIDENCE.

THE COURT: ANY OBJECTION?

MS. CLARK: NO OBJECTION. AND, YOUR HONOR, I WOULD JUST SUGGEST WE CAN KEEP THE LABELING PURPOSES AND MAYBE TAKE APART THE REPORT AND THE BACKGROUND, AND JUST SUBMIT THE CV.

MS. GARTNER: THAT'S FINE WITH US, YOUR HONOR.

THE COURT: ALL RIGHT. WE CAN DEAL WITH THIS LATER WHEN WE DEAL WITH ALL OF THE EXHIBITS.

WE WILL ADMIT IT AT THIS TIME.

THE CLERK: SIXTY-SEVEN INTO EVIDENCE.

(PLAINTIFFS' EXHIBIT 67
WAS RECEIVED IN EVIDENCE.)

MS. GARTNER: AND, YOUR HONOR, WE WOULD MOVE TO QUALIFY DR. WESTHOFF AS AN EXPERT IN OBSTETRICS AND GYNECOLOGY, ABORTION PRACTICE AND EPIDEMIOLOGY.

THE COURT: ANY OBJECTION?

MS. CLARK: NO OBJECTION.

THE COURT: ALL RIGHT. SHE'LL BE ACCEPTED AS SUCH.

BY MS. GARTNER:

Q. DR. WESTHOFF, DO YOU HAVE AN OPINION REGARDING THE SAFETY OF D&E'S IN WHICH THE FETUS IS EXTRACTED INTACT?

A. YES, I DO.

Q. AND WHAT IS THAT OPINION?

A. THAT IT IS AN EXTREMELY SAFE WAY IN WHICH TO ACCOMPLISH SECOND-TRIMESTER ABORTION.

Q. AND WHAT IS THE -- IN WHAT WAY DO YOU THINK INTACT EXTRACTION IS A SAFE WAY TO ACCOMPLISH SECOND-TRIMESTER ABORTION?

A. OKAY. IN CONTRAST TO DISMEMBERMENT D&E? THE BENEFITS THAT I ATTRIBUTE TO THIS APPROACH, BASED ON MY EXPERIENCE USING THIS APPROACH WITH MY PATIENTS, IS THAT IT MINIMIZES THE PASSAGE OF INSTRUMENTS INTO AND OUT OF THE UTERUS, AND THEREFORE MINIMIZES THE RISK OF PERFORATION WITH THOSE INSTRUMENTS.

IT ALSO MINIMIZES THE CREATION OF SHARP FETAL FRAGMENTS THAT MAY LEAD TO LACERATION DURING EXTRACTION. AND THAT, IN ADDITION, IT MAY SOMETIMES BE QUICKER AND, THEREFORE, LEAD TO LESS BLOOD LOSS IN MY PATIENTS.

Q. AND IN WHAT WAY DOES IT -- LOOKING AT THE REDUCTION IN THE RISK OF INJURING THE WOMAN WITH THE SHARP, BONEY FRAGMENTS, IF YOU CAN EXPLAIN IN A LITTLE MORE DETAIL HOW THAT HAPPENS?

A. WELL, I NEED TO EXPLAIN THAT BY CONTRASTING IT TO A D&E THAT INVOLVES DISARTICULATING THE FETUS. WHEN THE FETUS IS DISARTICULATED, THE SKIN AND SOFT TISSUE COVERING THE BONES IS DISRUPTED, SO SHARP FRAGMENTS OF BONE ARE EXPOSED.

AND IN THE PROCESS OF EXPOSING THEM, GRASPING THEM AND REMOVING THEM FROM THE UTERUS THERE IS THE POSSIBILITY THAT THOSE BONEY FRAGMENTS CAN LACERATE AT ANY LEVEL OF THE UTERUS AND THE CERVIX ITSELF DURING EXTRACTION.

WHEN THE FETUS IS REMOVED INTACT, THE ENTIRE FETUS REMAINS COVERED WITH SKIN AND SOFT TISSUE. THERE ARE NO BONEY FRAGMENTS. THEREFORE, THERE IS MINIMAL OR PERHAPS ZERO RISK OF CREATING SUCH LACERATIONS DURING THE EXTRACTION.

Q. CAN THE BONEY PARTS PERFORATE THE UTERUS IN ADDITION TO LACERATING IT?

A. YES, THEY CAN.

Q. HAVE YOU EVER OBSERVED UTERINE PERFORATION OR LACERATION OR CERVICAL LACERATION AS A RESULT OF INSTRUMENT PASSES IN A D&E WITH DISARTICULATION?

A. YES.
Q. HAVE YOU EVER OBSERVED THAT HAPPENING AS A RESULT OF SHARP FETAL PARTS?
A. YES, I HAVE.
Q. HAVE YOU EVER OBSERVED UTERINE PERFORATION OR CERVICAL LACERATION IN A D&E WHERE THE FETUS WAS EXTRACTED INTACT?
A. BASED ON OUR EXPERIENCE ON OUR OWN SERVICE OVER THE PREVIOUS FIVE YEARS OR SO WE HAVE NOT HAD ANY PERFORATION OR LACERATIONS OCCUR FOLLOWING -- DURING OR FOLLOWING AN INTACT D&E.

BUT WE HAVE HAD THOSE COMPLICATIONS OCCUR DURING AND FOLLOWING DISMEMBERMENT D&E.

Q. IS THERE AN ADVANTAGE TO INTACT D&E IN TERMS OF NOT HAVING RETAINED TISSUE IN THE UTERUS AFTER THE PROCEDURE?
A. YES, THERE IS.
Q. WHAT IS THE -- WHAT IS THAT -- CAN YOU EXPLAIN THAT ADVANTAGE IN A LITTLE MORE DETAIL?
A. YES. WHEN THE FETUS IS REMOVED IN PARTS WE ATTEMPT TO ACCOUNT FOR ALL THE PARTS ON THE OPERATING TABLE AT THE COMPLETION OF THE CASE. BUT IT IS ENTIRELY POSSIBLE THAT SMALL FRAGMENTS OF SOFT TISSUE CAN REMAIN INSIDE THE UTERUS THAT WE CAN'T BE SURE OF.

AND EVEN WITH, FOR INSTANCE, THE SONOGRAPHIC SCAN, WE MAY NOT BE ABLE TO DETECT THOSE, AND THAT CAN LEAD TO SUBSEQUENT INFECTION OR HEMORRHAGE ON THE PART OF THE PATIENT.

WE HAVE, IN FACT, ON OUR SERVICE HAD A CASE WITH A SMALL FRAGMENT OF RETAINED SKULL LEADING TO THOSE VERY DIFFICULTIES AND REQUIRING A SECOND PROCEDURE SUBSEQUENTLY TO RELIEVE THOSE SYMPTOMS.

Q. DO YOU KNOW WHETHER THAT PARTICULAR PROCEDURE WAS DONE WITH ULTRASOUND GUIDANCE?

A. I DON'T RECALL WITH CERTAINTY.

Q. AND YOU ALSO INDICATED THAT A POTENTIAL ADVANTAGE OF THE INTACT EXTRACTION IS THE SHORTER PERIOD OF TIME FOR THE PROCEDURE; IS THAT RIGHT?

A. YES. THAT MAY BE TRUE.

Q. AND WHY WOULD A SHORTER PROCEDURE TIME BE AN ADVANTAGE?

A. IN GENERAL, PATIENTS MAY BE BLEEDING THROUGHOUT THESE PROCEDURES TO SOME DEGREE, AND THE SHORTER THE PROCEDURE IS, THE LESS BLOOD LOSS THERE MAY BE.

FOR A PATIENT WHO STARTS A PROCEDURE MEDICALLY COMPROMISED DUE TO SOME ILLNESS, PATIENT WHO PERHAPS STARTS THE PROCEDURE ANEMIC FROM THE VERY BEGINNING, REDUCING BLOOD LOSS REDUCES THE DIFFICULTIES THAT THE PATIENT MAY EXPERIENCE.

THAT IS ONE REASON WHY THE POTENTIAL FOR SHORTER OPERATING TIME BENEFITS THE PATIENT.

Q. AND IS THERE AN ADVANTAGE TO THE INTACT EXTRACTION IN TERMS OF HOW THE FETAL HEAD IS REMOVED FROM THE UTERUS?

A. THE COLLAPSING OF THE FETAL SKULL BY USING AN INCISION AT THE BASE OF THE SKULL IS, IN MY OPINION, BASED ON MY

EXPERIENCE, A SAFER APPROACH, BECAUSE THE SKULL, THE BASE OF THE SKULL IS AT THE LEVEL OF THE CERVICAL OS, AND I CAN VISUALIZE IT DIRECTLY WHEN I MAKE THAT INCISION.

SO THERE IS NO BLIND USE OF INSTRUMENTS, AND THEREFORE, MINIMAL OR NO RISK FROM THE USE OF THE INSTRUMENTS.

IN CONTRAST, WHEN I AM RETRIEVING A FETAL SKULL THAT IS FLOATING FREE IN THE UTERINE CAVITY, I MUST PASS INSTRUMENTS IN AN ATTEMPT TO GRASP IT INSIDE THE UTERUS. AND THAT IS A BLIND USE OF INSTRUMENTS, WHICH HAS MORE POTENTIAL FOR PERFORATION.

Q. AND DR. WESTHOFF, IN YOUR OPINION, DOES THE INTACT VARIANT OF D&E IN ANY WAY FACILITATE THE GRIEVING PROCESS OF WOMEN THAT ARE ENDING THEIR PREGNANCY, THAT WAS A WANTED PREGNANCY BUT THEY ARE ENDING IT DUE TO AN ANOMALY OR A MATERNAL HEALTH CONDITION?

A. YES, IT DOES. IN A PARTICULAR CASE IN THE LAST YEAR, AS AN EXAMPLE, A PATIENT WHO WAS ABORTING TWINS DUE TO COMPLICATIONS DURING THE PREGNANCY ABSOLUTELY DID NOT WANT TO GO THROUGH LABOR AND DIDN'T WANT TO GO THROUGH AN INDUCTION, BUT EXPRESSED THE DESIRE TO HOLD THESE BABIES AFTER THE PROCEDURE.

WE WERE ABLE TO DELIVER BOTH OF THEM INTACT AND PRESENT THEM TO THE WOMAN TO HOLD WITH CLERGY AND HER FAMILY PRESENT. AND SHE WAS VERY GRATEFUL FOR THAT OPPORTUNITY.

AND IT IS VERY SIMILAR TO HOW ON OUR OBSTETRIC UNIT WE MAY ALLOW A PATIENT TO HOLD A STILLBORN FETUS.

Q. AND WE HAVE HAD QUESTIONS PREVIOUSLY IN THIS CASE ABOUT WHETHER WHEN YOU ARE DOING THAT TYPE OF PROCEDURE WHERE YOU ARE REDUCING THE FETAL HEAD BY PUNCTURING IT IN THE BACK, DOES THAT -- DOES THE FETAL FACE REMAIN INTACT IN A WAY THAT THE PARENT CAN HOLD IT AND NOT FEEL DISTURBED?

A. YES. IT MAY NOT BE ANATOMICALLY OBVIOUS HERE. THE INCISION IN THE BASE OF THE SKULL LEADS TO A COLLAPSE OF THE TOP AND THE BACK OF THE SKULL. THE SKULL REMAINS COVERED BY SCALP, AND -- BUT IT COLLAPSES IN THE BACK.

THE FACE IS NOT DISTURBED AT ALL, AND IT IS JUST THAT THE BACK OF THE HEAD THEN APPEARS COLLAPSED, WITH A SORT OF WRINKLED SCALP COVERING IT. AND IT IS NOT AS DISTORTED AS ONE MIGHT FEAR.

Q. AND IS IT -- OTHER THAN THAT CASE THAT YOU DESCRIBED OF THE WOMAN WHO WAS TERMINATING THE PREGNANCY WITH THE TWINS, DO OTHER PATIENTS ALSO SEEK TO HOLD THE FETUS IN YOUR PRACTICE?

A. YES, WE DO. YES. THAT IS THE MOST RECENT PATIENT WHO I REMEMBER, BUT WE HAVE SEVERAL PATIENTS EVERY YEAR WHO EXPRESS THIS DESIRE, AND WE ARE ABLE TO ACCOMMODATE THAT.

Q. IS IT THE CASE, DR. WESTHOFF, THAT INDUCTION ABORTIONS ALSO WOULD TYPICALLY RESULT IN AN INTACT FETUS?

A. YES. AN INDUCTION IS SUCCESSFUL WOULD RESULT IN AN INTACT FETUS.

Q. SO WHY THEN, GIVEN THAT A WOMAN COULD OBTAIN AN INTACT FETUS WITH INDUCTION METHOD, WHY IS THE INTACT D&E -- WHY DOES

THAT OFFER ADVANTAGES TO HER?
A. IN THE UNITED STATES AS A WHOLE, 90 TO 95 PERCENT OF WOMEN CHOOSE D&E OVER INDUCTION. AND THE REASONS MY PATIENTS TELL ME THAT THEY DO NOT WISH TO UNDERGO AN INDUCTION IS THEY DON'T WANT TO GO THROUGH THE EXPERIENCE OF LABOR.
Q. DR. WESTHOFF, HAVE YOU OFFERED EXPERT TESTIMONY IN OTHER COURT CASES BEFORE THIS FEDERAL LAW WAS PASSED RELATING TO BANS ON SO-CALLED PARTIAL-BIRTH ABORTION?
A. YES, I HAVE.
Q. AND WAS THE FIRST TIME IN 1997, IN A CASE IN MICHIGAN?
A. YES, IT WAS.
Q. SINCE 1997, WHEN YOU FIRST TESTIFIED IN THE CASE RELATING TO THE SUBJECT OF SO-CALLED PARTIAL-BIRTH ABORTION, HAS YOUR MEDICAL PRACTICE WITH RESPECT TO THE ABORTIONS THAT YOU PERFORMED AND THE GESTATIONAL AGES AT WHICH YOU PERFORM THEM, HAS THAT CHANGED?
A. YES, IT HAS. AT THE TIME I FIRST TESTIFIED IN MICHIGAN, WE DID NOT HAVE A FULL-SCALE ABORTION SERVICE AT WHAT WAS THEN COLUMBIA PRESBYTERIAN. AND IN THE YEAR SINCE THEN, I BEGAN THE SERVICE THAT NOW EXISTS, SO THAT WE CAN OFFER ABORTION CARE TO ALL THE PATIENTS OF ALL THE DOCTORS IN OUR MEDICAL CENTER, AS WELL AS PATIENTS IN OUR LOCAL COMMUNITY.
AND SO, I HAVE A GREAT DEAL MORE EXPERIENCE WITH THIS TECHNIQUE NOW THAN I DID IN 1997 WHEN I FIRST TESTIFIED IN MICHIGAN.

Q. IS THE INTACT D&E TECHNIQUE A ROUTINE PART OF YOUR ABORTION PRACTICE NOW?
A. YES, IT IS A ROUTINE PART OF MY PERSONAL PRACTICE, AND THE OTHER ATTENDING PHYSICIANS WHO ARE PART OF OUR GROUP ALL STRONGLY PREFER TO USE THE INTACT METHOD WHENEVER POSSIBLE FOR PATIENTS IN THE SECOND-TRIMESTER.
Q. AND AS A RESULT OF THE DEVELOPMENT OF YOUR MEDICAL PRACTICE, HAS YOUR THINKING ABOUT D&E'S, AND, IN PARTICULAR, YOUR THINKING ABOUT INTACT D&E'S, EVOLVED?
A. YES, IT HAS.
Q. CAN YOU EXPLAIN THAT A LITTLE BIT?
A. I THINK THAT IN THE LATE 1990'S, I DEFINITELY SAW POTENTIAL ADVANTAGES OF INTACT D&E, BUT I NOW FEEL MORE CERTAIN THAT THOSE ADVANTAGES ARE, IN FACT, REAL ADVANTAGES BASED ON MY PERSONAL EXPERIENCE USING THE TECHNIQUE.
Q. AND, DOCTOR, ARE YOU AWARE OF ANY STUDIES COMPARING THE RELATIVE SAFETY OF THE INTACT VARIANT OF D&E WITH THE DISARTICULATION VARIANT OF D&E?
A. YES.
Q. AND WHAT STUDY OR STUDIES ARE YOU AWARE OF?
A. DR. CHASEN, WHO IS ALSO AT NEW YORK PRESBYTERIAN HOSPITAL, BUT AT FACULTY AT CORNELL, HAS A REPORT THAT IS CURRENTLY IN -- HAS BEEN ACCEPTED FOR PUBLICATION IN THE PEER REVIEW JOURNAL, AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY. AND THAT ARTICLE IS CURRENTLY IN PRESS.

MS. GARTNER: YOUR HONOR, MAY I APPROACH THE WITNESS?

THE COURT: YES.

MS. CLARK: WE OBJECT. SHE ISN'T LISTED ON THE LIST AS A SPONSORING WITNESS FOR THE CHASEN STUDY.

MS. GARTNER: YOUR HONOR --

THE COURT: IS THAT WHAT YOU WERE GOING TO GIVE HER?

MS. GARTNER: YES, YOUR HONOR. BUT SHE TESTIFIED ABOUT THIS AT LENGTH IN HER DEPOSITION.

THE COURT: ALL RIGHT.

MS. GARTNER: YOUR HONOR, THIS IS EXHIBIT 19.

BY MS. GARTNER:

Q. DR. WESTHOFF, I HAVE HANDED YOU WHAT IS AN ARTICLE ENTITLED:

"DILATION AND EVACUATION AT GREATER THAN OR EQUAL TO 20 WEEKS: COMPARISON OF OPERATIVE TECHNIQUES," BY STEPHEN CHASEN, ET AL.

MS. GARTNER: FOR THE RECORD, I WILL SAY:

"THIS IS AN ARTICLE IN PRESS, SCHEDULED FOR PUBLICATION IN AN UPCOMING ISSUE OF THE AMERICAN JOURNAL OF THE OBSTETRICS AND GYNECOLOGY. COPYRIGHT 2004 ELSEVIER."

BY MS. GARTNER:

Q. IS THIS THE ARTICLE THAT YOU WERE REFERRING TO?

A. YES, IT IS.

Q. HAVE YOU READ IT?
A. YES, I HAVE.
Q. AND IS THE JOURNAL THE AMERICAN JOURNAL OF OB/GYN A PEER REVIEWED JOURNAL?
A. YES, IT IS.
Q. DR. WESTHOFF, CAN YOU DESCRIBE FOR US WHAT DR. CHASEN AND HIS CO-INVESTIGATORS SOUGHT TO DO IN THIS STUDY?
A. THEY STATE THAT THEIR OBJECTIVE IS TO EVALUATE RELATIVE SAFETY OF D&E USING THE DISMEMBERMENT VARIATION IN COMPARISON TO D&E USING THE INTACT VARIATION.
Q. AND WHAT TYPE OF STUDY WAS IT -- IS IT?
A. THIS STUDY IS A COHORT OF ALL THE PATIENTS THEY PROVIDED CARE TO AT A SINGLE MEDICAL CENTER DURING -- LET'S SEE. I HAVE TO TELL YOU WHICH YEARS -- YEARS 1996 TO 2003.
Q. IS IT A RETROSPECTIVE STUDY?
A. YES, IT IS A RETROSPECTIVE COHORT.
Q. IN YOUR OPINION, IS A RETROSPECTIVE STUDY AN APPROPRIATE WAY TO CONDUCT A MEDICAL STUDY COMPARING THE SAFETY OF TWO TECHNIQUES?
A. YES, IT IS.
Q. AND IN YOUR OPINION, WERE THE METHODOLOGY AND THE DATA USED IN DR. CHASEN'S STUDY SUFFICIENT TO DRAW RELIABLE CONCLUSIONS ABOUT THE RESPECTIVE STUDY -- EXCUSE ME -- THE RESPECTIVE SAFETY OF THE TWO TECHNIQUES?
A. YES.

Q. IS THIS THE KIND OF STUDY THAT YOU WOULD RELY ON IN YOUR PRACTICE?

A. YES.

Q. CAN YOU SUMMARIZE FOR US WHAT WERE THE RESULTS OF DR. CHASEN'S STUDY REGARDING THE COMPARATIVE COMPLICATION RATES OF INTACT D&E WITH D&E THAT RESULTED IN DISARTICULATION?

A. YES. OVERALL FOR THE SUBJECTS IN THE STUDY -- AND THERE WERE ABOUT 400 IN TOTAL IN THE STUDY -- THE OVERALL COMPLICATION RATE WAS ABOUT 5 PERCENT. AND THIS WAS THE SAME FOR THE INTACT AND THE DISARTICULATION VARIETIES.

WHAT GOT MY ATTENTION IN THE TWO GROUPS IS THAT, FIRST OF ALL, THE GESTATIONAL AGE WAS GREATER FOR THE WOMEN WHO UNDERWENT INTACT D&E. AND WE KNOW IN INDUCED ABORTION THAT COMPLICATION RATES INCREASE WITH GESTATIONAL AGE.

SO FOR THE GROUP WITH THE ADVANCED GESTATIONAL AGE TO HAVE THE SAME 5 PERCENT COMPLICATIONS AS THE GROUP WITH THE LESSER GESTATIONAL AGE, IS, I THINK, A RESULT THAT FAVORS THE INTACT D&E APPROACH.

Q. LET ME JUST INTERRUPT YOU FOR ONE MINUTE. DO YOU RECALL WHAT THE DIFFERENCE IN THE MEDIAN GESTATIONAL AGE WAS IN THE TWO GROUPS?

A. REPORTED HERE IN THE ARTICLE IT WAS 21 WEEKS FOR THE DISMEMBERMENT GROUP AND 23 WEEKS FOR THE INTACT GROUP. SO THERE'S A TWO-WEEK DIFFERENCE.

Q. AT THAT GESTATIONAL AGE IS THAT TWO-WEEK DIFFERENCE A

SIGNIFICANT DIFFERENCE, IN YOUR OPINION?
A. I THINK THAT IS A SUBSTANTIAL DIFFERENCE, AND IT'S A CLINICALLY IMPORTANT DIFFERENCE.
Q. SO WOULD YOU -- IF YOU HAD TWO GROUPS OF PATIENTS, ONE AT A MEDIAN AGE OF 21 WEEKS AND ANOTHER AT MEDIAN GESTATIONAL AGE OF 23 WEEKS, BOTH HAVING DISARTICULATION-TYPE D&E'S, WOULD YOU EXPECT TO SEE A DIFFERENCE IN COMPLICATION RATES?
A. I WOULD EXPECT THAT IF A WOMAN HAD THE SAME TECHNIQUE USED TO SEE MORE COMPLICATIONS IN THE SUBGROUP WITH THE MORE ADVANCED GESTATIONAL AGE.
Q. SO WHAT CONCLUSIONS, IF ANY, CAN YOU DRAW FROM THE FACT THAT IN DR. CHASEN'S STUDY THE WOMEN HAVING THE ABORTIONS AT 23 WEEKS BY INTACT VARIANT HAD THE SAME PERCENTAGE OF COMPLICATIONS AS THE WOMEN HAVING DISARTICULATION D&E'S AT A TWO-WEEK EARLIER GESTATIONAL AGE?
A. THE FINDING THAT THE COMPLICATION RATE DID NOT INCREASE WITH ADVANCING GESTATIONAL AGE SUGGESTS A BENEFIT FOR THE WOMEN IN THE SUBGROUP THAT HAD INTACT D&E.
Q. AND HOW MANY COMPLICATIONS, IF YOU CAN RECALL, WERE RECORDED IN TOTAL IN DR. CHASEN'S STUDY?
I CAN WITHDRAW. I DON'T WANT TO WASTE YOUR TIME LOOKING FOR THAT NUMBER.
A. YES. I THINK IT WAS 19, BUT I WOULD HAVE TO REFER TO THE ARTICLE TO FIND THE NUMBER FOR SURE.
WHAT IMPRESSED ME ABOUT THE COMPLICATIONS IS THAT

THERE WERE ONLY A FEW SERIOUS COMPLICATIONS, SUCH AS PERFORATION, SEPSIS AND AMNIOTIC FLUID EMBOLUS. AND ALL OF THE SERIOUS COMPLICATIONS OCCURRED IN THE DISARTICULATION D&E GROUP. NONE OF THE MORE SERIOUS COMPLICATIONS OCCURRED IN THE INTACT D&E GROUP, WHICH I THINK, AGAIN, IMPLIES A POTENTIAL BENEFIT TO BEING A MEMBER OF THE INTACT D&E GROUP.

AND THIS DISTRIBUTION OF COMPLICATIONS IS SIMILAR TO WHAT WE HAVE OBSERVED IN OUR OWN PRACTICE AT OUR CAMPUS OF NEW YORK PRESBYTERIAN.

Q. DR. WESTHOFF, IF YOU RECALL, DID DR. CHASEN ALSO STUDY IN THIS -- IN THIS PUBLICATION, DID HE STUDY THE IMPACT ON SUBSEQUENT PREGNANCIES OF THE TWO VARIANTS OF D&E?

A. YES, HE DID.

Q. AND BASED ON YOUR REVIEW OF THE STUDY, WHAT DID THEY CONCLUDE?

A. FOR ALL OF THE PATIENTS WHO WENT ON TO HAVE ANOTHER PREGNANCY THAT WAS CARED FOR AT THE SAME MEDICAL CENTER THEY FOLLOWED UP FOR THE OUTCOME OF THE SUBSEQUENT PREGNANCY. AND THERE WAS NOT A STATISTICALLY-SIGNIFICANT DIFFERENCE IN PREMATURE DELIVERY BETWEEN THE TWO GROUPS.

AND, IN FACT, THE WOMEN WHO, IN THE INTACT D&E GROUP SUBSEQUENTLY HAD A PREMATURE DELIVERY HAD, IN FACT, PREEXISTING PROBLEMS WITH PREMATURE DELIVERY PRIOR TO THE INTACT D&E.

SO, THAT IS -- REDUCES CONCERN ABOUT THAT ISSUE.

Q. REDUCES CONCERN. CAN YOU JUST EXPLAIN THAT A LITTLE MORE?

A. REDUCES CONCERN THAT INTACT D&E MAY LEAD TO MORE PREMATURE DELIVERIES IN THE FUTURE.

Q. AND BASED ON YOUR REVIEW OF THE STUDY, DO YOU AGREE WITH DR. CHASEN'S CONCLUSIONS?

A. I THINK THAT AS I INTERPRET THE DATA, I FIND HIS CONCLUSIONS TO BE VERY CONSERVATIVE.

AND MY INTERPRETATION OF HIS DATA IS THAT IT TENDS TO FAVOR INTACT D&E. AND HIS CONCLUSIONS ARE ONLY THAT THE TWO APPROACHES ARE SIMILAR IN SAFETY.

Q. AS AN EPIDEMIOLOGIST, IN YOUR OPINION WAS THE NUMBER OF THE SUBSEQUENT PREGNANCIES THAT WERE FOLLOWED IN THE STUDY A SUFFICIENT NUMBER ON WHICH TO BASE A CONCLUSION?

A. THE NUMBER OF PREGNANCIES THAT WERE FOLLOWED WOULD BE ENOUGH TO DETECT LARGE DIFFERENCES BETWEEN THE TWO GROUPS. IF THERE ARE MODEST DIFFERENCES BETWEEN THE TWO GROUPS, ONE WOULD NEED TO OBSERVE A LARGER NUMBER OF PREGNANCIES TO DETECT VERY MODEST DIFFERENCES.

Q. DR. WESTHOFF, I WOULD LIKE YOU TO DESCRIBE FOR ME BRIEFLY HOW YOU IN YOUR SERVICE DO D&E ABORTION BEGINNING AT APPROXIMATELY 18 OR 19 WEEKS GESTATION.

A. WE FIRST DO AN ASSESSMENT OF THE PATIENT ONE AND OFTEN TWO DAYS PRIOR TO THE SCHEDULED SURGERY. WE ASSESS HER GESTATIONAL AGE AND THE REASONS SHE IS BEING REFERRED. AND, IN FACT, ASSESS HER DESIRES FOR D&E VERSUS INDUCTION.

AND AS DR. CREININ TESTIFIED, NOT EVERY WOMAN

ARRIVES TO OUR SERVICE WITH AN ADEQUATE AMOUNT OF INFORMATION ABOUT THE ALTERNATIVES. AND IF THE PATIENT THEN WANTS TO GO FORWARD WITH A D&E, WE AT THAT POINT WILL COMPLETE THE PROCESS OF INFORMED CONSENT BOTH REGARDING THE USE OF OSMOTIC DILATORS, SUCH AS LAMINARIA, AS WELL AS THE SURGICAL PROCEDURE ITSELF.

ON COMPLETION OF THE ASSESSMENT IN THOSE STEPS, WE WILL DO OUR FIRST INSERTION OF LAMINARIA USING LOCAL ANESTHETIC AT THE TIME OF LAMINARIA INSERTION.

FOR PATIENTS WHO ARE PAST 20 WEEKS AND FOR PATIENTS WHO HAVE NEVER GIVEN BIRTH BEFORE AFTER 18 OR 19 WEEKS, WE GENERALLY WILL USE TWO DAYS OF LAMINARIA INSERTION.

FOR PATIENTS WHO HAVE GIVEN BIRTH PREVIOUSLY WE MAY ONLY DO ONE DAY OF LAMINARIA INSERTION.

WE MAKE THAT ASSESSMENT BASED ON BOTH THE GESTATIONAL AGE AND THE CONDITION OF THE WOMAN'S CERVIX WHEN WE EXAMINE HER FOR THE FIRST TIME. IF SHE IS GOING TO HAVE TWO DAYS OF LAMINARIA, SHE'LL RETURN ON THE SECOND DAY FOR A BRIEF VISIT DURING WHICH WE REMOVE THE FIRST SET OF LAMINARIA AND, AGAIN, USING LOCAL ANESTHESIA, INSERT A SECOND SET OF LAMINARIA.

THE PATIENT THEN RETURNS ON THE OPERATIVE DAY WITH AN EMPTY STOMACH AS ASSESSED BY OUR ANESTHESIA DOCTORS.

AND AT THESE GESTATIONAL AGES, OUR ANESTHESIOLOGISTS -- AND WE CONCUR -- PREFER TO USE GENERAL ANESTHESIA FOR THESE CASES.

AFTER INDUCTION OF GENERAL ANESTHESIA, WE REMOVE THE LAMINARIA, ASSESS THE STATE OF THE CERVIX, AND THEN IN THE SAFEST APPROACH POSSIBLE, WE WILL REMOVE ALL OF THE FETUS, THE MEMBRANES AND THE PLACENTA.

Q. WHEN YOU DO THE D&E, AFTER YOU'VE REMOVED THE LAMINARIA, DO YOU USE ANY INSTRUMENT TO BRING THE CERVIX CLOSER TO THE VAGINAL INTROITUS?

A. WE USE AN INSTRUMENT CALLED A TENACULUM WHICH GRABS THE CERVIX. AND THE REASON WE DO THIS IS BECAUSE THE UTERUS IS NOT ATTACHED INSIDE A WOMAN'S BODY BY ANY BONES. THE UTERUS IS ONLY ATTACHED WITH LIGAMENTS.

AND, THEREFORE, IT IS -- CAN POSSIBLY FLOP AROUND A LITTLE BIT INSIDE THE WOMAN'S PELVIS. IN ORDER TO STABILIZE THE UTERUS AND HOLD IT STEADY AND STRAIGHTEN THE CERVICAL CANAL, WE USE A TENACULUM TO PULL DOWN ON THE UTERUS SO THAT IT REMAINS AS STATIONARY AS POSSIBLE DURING THE PROCEDURE.

AND IT IS ONLY THEN THAT WE WOULD BEGIN TO -- BEGIN THE PROCEDURE INSIDE THE UTERUS.

Q. AND HOW CLOSE DOES THE CERVIX COME TO THE VAGINAL OPENING AFTER YOU PULL IT?

A. OKAY. EVERY WOMAN IS DIFFERENT. IT MAY BE AT OR SLIGHTLY ABOVE OR BELOW THE VAGINAL OPENING. AND THIS IS DIFFERENT FOR EACH PATIENT.

Q. OKAY.

AND HOW FAR DOES THE CERVIX DILATE DURING THE D&E?

A. OUR CERVICAL PREPARATION IS THE SAME FOR ALL OF OUR PATIENTS, BUT EACH PATIENT INDIVIDUALLY CAN RESPOND QUITE DIFFERENTLY TO THE LAMINARIA. SO IF SOME PATIENTS WILL ON THE OPERATIVE DAY HAVE 1 OR 2 CENTIMETERS DILATION. OTHER PATIENTS WILL HAVE THREE OR FOUR, FIVE CENTIMETERS DILATION, WHICH, IN OUR EXPERIENCE, IS JUST LARGELY DETERMINED BY HOW THE WOMAN'S BODY RESPONDS TO THE LAMINARIA.

Q. AND IS GETTING TOO MUCH DILATION A CONCERN?

A. I HAVE NEVER BEEN IN A SITUATION WHERE I FELT THE WOMAN HAD TOO MUCH DILATION.

Q. TALKING NOW ABOUT THE EVACUATION PART OF THE PROCEDURE, APPROXIMATELY HOW MANY INSTRUMENTAL PASSES DOES IT TYPICALLY TAKE TO EVACUATE THE UTERUS COMPLETELY?

A. THERE IS A WIDE RANGE. I CAN, OF COURSE, IN SOME CASES EITHER WITH MY FINGERS OR WITH AN INSTRUMENT BRING DOWN THE FETUS ON MY FIRST ATTEMPT. AND AS I CONTINUE THE EXTRACTION, I MAY NEED TO DO NO ADDITIONAL INSERTIONS OF FINGERS OR INSTRUMENTS INSIDE THE UTERUS, BUT AM ABLE TO COMPLETE THE ENTIRE ABORTION IN A SINGLE PASS.

IN CONTRAST AT THE OTHER EXTREME, WE CAN INSERT GRASPING FORCEPS INTO THE UTERUS AND HAVE MULTIPLE PASSES WHERE EVEN ON THE FIRST FEW PASSES WE DO NOT GRASP ANY PART OF THE FETUS SUCCESSFULLY, BUT NEED TO MAKE MULTIPLE PASSES, 10 OR 20 PASSES IN ORDER TO COMPLETE THE DELIVERY OF THE FETUS IN PARTS.

Q. YOU SAID THAT YOU WOULD USE EITHER FORCEPS OR YOUR FINGERS;

IS THAT CORRECT?

A. THAT'S RIGHT.

Q. HOW WOULD YOU DECIDE WHICH APPROACH YOU ARE GOING TO USE?

A. WELL, I FIRST EXAMINE THE CERVICAL OPENING THAT BOTH THE LENGTH AND THE DILATION OF THE CERVIX WITH MY FINGERS, AND IT MAY BE THAT I CAN IMMEDIATELY PALPATE FETAL PARTS WITHIN REACH OF MY FINGERS. AND IN WHICH CASE I WILL USE MY FINGERS RATHER THAN AN INSTRUMENT.

IF I CANNOT REACH ANY FETAL PARTS WITH MY FINGERS, THEN I WILL USE AN INSTRUMENT INSTEAD.

Q. AND ONCE YOU START THE PROCEDURE WITH INSTRUMENTS, DO YOU COMPLETE IT WITH INSTRUMENTS? OR MIGHT YOU BRING OUT A PRESENTING PART WITH AN INSTRUMENT, AND THEN SWITCH TO YOUR FINGERS?

A. YES. EACH PROCEDURE PROCEEDS VERY INDIVIDUALLY, AND SO EACH STEP OF THE PROCEDURE WILL DEPEND REALLY ON JUST WHAT HAPPENED IN THE ONE STEP BEFORE IT. AND FOR EACH STEP OF THE PROCEDURE I WANT TO DO WHAT IS GOING TO BE SAFEST AT THAT MOMENT.

SO, YES, IN FACT, I HAVE HAD CASES WHERE I MAY BRING DOWN AND EXTRACT A LEG WITH AN INSTRUMENT AND DISARTICULATE THAT LEG, BUT BECAUSE THE POSITION OF THE FETUS COMES DOWN IN THE UTERUS DURING THAT MANEUVER, I MAY THEN BE ABLE TO BRING DOWN THE NEXT LEG WITH MY FINGERS. AND, IN FACT, THE REST OF THE FETUS WILL FOLLOW.

SO, SIMILARLY, I COULD START WITH MY FINGERS AND THEN IN ADDITION NEED TO USE INSTRUMENTS. SO THE COMBINATION OF MANEUVERS I USE ARE DETERMINED ONE AT A TIME ON AN INDIVIDUAL BASIS TO MINIMIZE THE TOTAL NUMBER OF PASSES AND MAXIMIZE PATIENT SAFETY AT EACH STEP OF THE WAY.

Q. AND WHY DO YOU WANT TO MINIMIZE THE NUMBER OF PASSES?

A. EACH PASS OF INSTRUMENTS INTO THE UTERUS, IN MY OPINION, CARRIES WITH IT AT LEAST THE POTENTIAL RISK OF PERFORATING OR LACERATING THE UTERUS. SO THE FEWER PASSES, THE SMALLER THAT RISK WILL BE.

Q. AND IN YOUR PRACTICE DO YOU EVER REMOVE THE FETUS INTACT TO THE POINT WHERE THE CALVARIUM LODGES AT THE CERVICAL OS?

A. YES, I DO.

Q. AND DO YOU ATTEMPT TO DO THE D&E IN SUCH A WAY THAT THAT OCCURS?

A. YES, I DO.

Q. AND AT WHAT POINT IN THE PROCEDURE DO YOU KNOW IF YOU WILL BE SUCCESSFUL IN DOING THE D&E IN THAT WAY?

A. IN A SENSE WE DON'T ACTUALLY KNOW UNTIL IT IS OVER, BECAUSE EACH CASE PROCEEDS ON AN INDIVIDUAL BASIS. SO I WILL ONLY KNOW THAT I HAVE COMPLETED AN INTACT D&E AT THE VERY END WHEN I HAVE COMPLETED IT.

I REALLY DO NOT KNOW EACH STEP OF THE WAY EXACTLY WHAT THE NEXT STEP IS GOING TO BE OR THE RESULTS OF THE NEXT STEP UNTIL IT HAS BEEN ACCOMPLISHED.

Q. SO IN THAT CIRCUMSTANCE WHERE THE CALVARIUM LODGES AT THE OS, HOW DO YOU COMPLETE THE PROCEDURE IN AN INTACT D&E?
A. WITH CONTINUED TRACTION ON THE CERVIX THAT WE DESCRIBED EARLIER, I CAN WITH DIRECT VISUALIZATION INCISE THE BASE OF THE SKULL WITH SCISSORS.

AT THAT POINT IN SOME CASES THE CONTENTS OF THE SKULL WILL DRAIN SPONTANEOUSLY. IN OTHER CASES WE WILL INSERT A SUCTION TUBE TO DRAIN THE SKULL CONTENTS. BECAUSE THE BONES OF THE SKULL ARE VERY SOFT AT THIS STAGE OF GESTATION, AS SOON AS THE SKULL IS EMPTY, IT WILL COLLAPSE. AND WHEN THE DIAMETERS ARE THEREFORE REDUCED, THE ENTIRE SKULL WILL FIT THROUGH THE CERVICAL OPENING WITHOUT ANY FURTHER MANIPULATION. AND THAT WILL COMPLETE THE PROCEDURE.
Q. AND DO YOU ALSO TEND TO HAVE TO REDUCE THE DIAMETERS OF THE CALVARIUM WHEN YOU ARE DOING A DISARTICULATION-TYPE D&E?
A. YES. THE SKULL IS THE LARGEST DIAMETER OF THE FETUS, AND THEREFORE IT IS THE LEAST LIKELY PART TO BE ABLE TO FIT THROUGH THE CERVIX.

IF WE ARE PROCEEDING IN THE FASHION OF A DISARTICULATION D&E, IT IS QUITE COMMON IN MY EXPERIENCE THAT THE SKULL WILL BE THE LAST PORTION THAT WE REMOVE. AND IN ORDER TO REDUCE THE DIAMETERS, WE'LL INSERT GRASPING FORCEPS INTO THE UTERUS, OFTEN USING SONOGRAPHIC GUIDANCE TO HELP US AS MUCH AS POSSIBLE TO LOCATE THE SKULL.

WE'LL OPEN THE INSTRUMENTS WIDE ENOUGH SO THAT THEY

CAN ACCOMMODATE THE FULL DIAMETER OF THE SKULL, AND WE WILL THEN CRUSH THE SKULL. AND AFTER THE CONTENTS OF THE SKULL HAVE BEEN EXTRUDED BECAUSE OF THE CRUSHING MOTION, MAINTAIN THE SKULL IN THE GRASP OF THE INSTRUMENTS AND ATTEMPT TO PULL IT THROUGH THE CERVIX.

SOMETIMES WE CAN DO THAT IN ONE PIECE. SOMETIMES WE REMOVE IT IN SEVERAL PIECES.

Q. THE PROCESS OF INCISING THE BASE OF THE SKULL, IS THAT A BLIND PROCEDURE?

A. NO. WE DO THAT WITH DIRECT VISUALIZATION. THE BASE OF THE SKULL IS VISIBLE AT THE CERVICAL OPENING.

Q. AND IN TERMS OF THE DILATION PROCESS FOR THE D&E'S YOU ARE DOING, AT THE SAME GESTATIONAL AGE, SO, FOR EXAMPLE, AT 20 OR 21 WEEKS, IS THERE ANY DIFFERENCE IN THE DILATION PROCESS THAT YOU USE BETWEEN A DISARTICULATION D&E AND AN INTACT D&E?

A. WE PROCEED IN THE SAME FASHION IN TERMS OF OUR APPROACH TO LAMINARIA FOR ALL OF OUR PATIENTS.

WHILE AS I SAID WE DO PREFER INTACT D&E, WE DON'T KNOW THAT WE ARE GOING TO DO AN INTACT D&E UNTIL AFTER IT IS DONE. ALL OF OUR PATIENTS GET THE SAME APPROACH TO DILATION USING LAMINARIA.

AS GESTATIONAL AGE ADVANCES, THE CERVIX TENDS TO BE SOMEWHAT SOFTER BECAUSE OF BIOCHEMICAL CHANGES IN THE CERVICAL COLLAGEN AND IN THE FIBROUS TISSUE OF THE CERVIX.

SO AS GESTATION ADVANCES, THE CERVIX TYPICALLY

ACCOMMODATES SOMEWHAT MORE LAMINARIA. AND THE CERVIX OFTEN HAS A GREATER RESPONSE TO THE LAMINARIA, AND IT ACHIEVES FURTHER DILATION.

Q. IN YOUR PRACTICE OR AT THE PRACTICE IN THE SPECIAL GYN SERVICES WHERE YOU ARE SUPERVISING THE PHYSICIANS, HOW OFTEN ARE YOU ABLE TO ACHIEVE AN INTACT DELIVERY IN A D&E?

A. I HAVEN'T TABULATED THIS, BUT BASED ON MY EXPERIENCE AND WHAT MY COLLEAGUES REPORT AFTER -- AT OR AFTER ABOUT 19 WEEKS GESTATION, I THINK WE ACHIEVE AN INTACT D&E LESS THAN HALF THE TIME. PERHAPS IT IS ABOUT ONE-THIRD OF THE TIME.

Q. SO WOULD YOU SAY IT IS SOMEWHERE BETWEEN A THIRD AND A HALF?

A. PERHAPS. MAYBE CLOSER TO ONE-THIRD. IN THAT NEIGHBORHOOD.

Q. AND YOU SAID THAT THAT IS BEGINNING AT AROUND 19 WEEKS GESTATION?

A. YES.

Q. DOES IT EVER HAPPEN THAT YOU ACHIEVE AN INTACT EXTRACTION PRIOR TO 19 WEEKS?

A. YES, IT DOES.

Q. DR. WESTHOFF, DO YOU MAKE IT A PRACTICE EITHER TO EFFECT FETAL DEMISE WITH POTASSIUM CHLORIDE OR KCL OR DIGOXIN PRIOR TO PERFORMING A D&E PROCEDURE?

A. IT IS NOT MY ROUTINE PRACTICE.

Q. WHY IS THAT?

A. THAT IS IMPOSING ON THE PATIENT AN ADDITIONAL PROCEDURE

WHICH CAN BE DIFFICULT TO CARRY OUT WHICH MAY, IN FACT, REQUIRE ME TO CALL IN ADDITIONAL COLLEAGUES TO HELP WITH THE PROCEDURE.

IT IS NOT ALWAYS SUCCESSFUL. IT CARRIES A SMALL RISK OF ITS OWN COMPLICATIONS, AND IT OFFERS NO BENEFIT TO MY PATIENT.

Q. CAN YOU THINK OF A TIME IN RECENT MEMORY WHERE YOU DID PERFORM A D&E AFTER FETAL DEMISE HAD BEEN INDUCED WITH A CHEMICAL AGENT?

A. YES. THE WEEK THE PBA BAN WAS SIGNED, AND BEFORE WE KNEW IF WE WERE GOING TO HAVE A TRO, WE DID ARRANGE TO HAVE KCL INJECTION FOR PATIENTS. IN PARTICULAR, A PATIENT I TOOK CARE OF THAT WEEK HAD KCL. AND IN MY OPINION BECAUSE OF THE RAPID SOFTENING OF THE FETAL TISSUE IT ACTUALLY MADE THE D&E PORTION OF THE PROCEDURE MORE DIFFICULT.

AND IN THIS PARTICULAR PATIENT THE RESULT WAS A DISMEMBERMENT-TYPE OF D&E DUE TO THE TISSUE SOFTENING. AND THE PATIENT DID, IN FACT, HAVE SOME RETAINED TISSUE, WHICH RESULTED IN INFECTION AND REQUIRED HER TO HAVE AN ADDITIONAL PROCEDURE, HOSPITALIZATION AND PROCEDURE TO EMPTY THE UTERUS AFTER -- A COUPLE OF WEEKS AFTER HER ORIGINAL D&E. SO --

Q. AND WAS THE PROCEDURE DONE UNDER ULTRASOUND GUIDANCE?

A. YES, I BELIEVE IT WAS, BUT I DON'T RECALL FOR CERTAIN.

Q. AND DID YOU DO THE KCL INJECTION YOURSELF IN THAT CASE?

A. NO, I OBTAINED THE KCL INJECTION FROM -- WITH THE ASSISTANCE OF A COLLEAGUE IN MATERNAL FETAL MEDICINE IN OUR

DEPARTMENT.
Q. AND WHY DIDN'T YOU DO THE INJECTION YOURSELF?
A. WELL, THAT HAS NOT BEEN MY PRACTICE IN THE PAST. I DO NOT AT THIS MOMENT CONSIDER MYSELF SKILLED IN DOING THAT. AND TO MAXIMIZE THE BENEFIT OF THE PATIENT I WANTED TO ENLIST THE ASSISTANCE OF SOMEONE WHO IS SKILLED IN FETAL INTRACARDIAC INJECTION.
Q. AND IN YOUR OPINION WAS THE COMPLICATION OF RETAINED TISSUE CORRELATED WITH THE USE OF KCL?
MS. CLARK: I WILL OBJECT, LACK OF FOUNDATION. I DON'T KNOW IF THERE HAS BEEN ESTABLISHED A BASIS FOR HER TO MAKE THAT CORRELATION JUDGMENT.
MS. GARTNER: IT WAS A PROCEDURE SHE DID.
THE COURT: THIS IS A PROCEDURE SHE PERFORMED; IS THAT CORRECT?
MS. GARTNER: YES.
THE WITNESS: YES.
THE COURT: OBJECTION OVERRULED.
THE WITNESS: WELL, IF I AM NOT -- I CAN'T BE CONFIDENT THAT THIS WOULD HAVE BEEN AN INTACT D&E WITHOUT THE KCL. BUT, IT COULD HAVE BEEN. AND IN MY EXPERIENCE, IN MY OPINION THE RISK OF FETAL FRAGMENTS IS MINIMIZED OR PERHAPS ZERO WHEN THE FETUS IS INTACT.
IN THIS PARTICULAR CASE, THERE WAS DEFINITELY FETAL SOFTENING DUE TO THE FETAL DEMISE, AND SO IT IS CLEAR TO ME

THAT THE FACT THAT THIS WAS -- DID PROCEED AS A DISARTICULATION D&E WAS BECAUSE OF THE EXTRA FETAL SOFTENING. AND THAT, AT LEAST, PERMITTED THE OCCURRENCE OF LEAVING PART OF THE FETAL TISSUE BEHIND.

BUT, OF COURSE, IN THE MAJORITY OF DISARTICULATION CASES THOSE COMPLICATIONS DO NOT OCCUR.

MS. GARTNER: YOUR HONOR, MAY I PUT THE CHART UP?

BY MS. GARTNER:

Q. DR. WESTHOFF, I AM GOING TO SHOW YOU A CHART WHICH CONTAINS THE DEFINITION OF SO-CALLED PARTIAL-BIRTH ABORTION AS IT IS STATED IN THE ACT THAT IS AT ISSUE IN THIS CASE, AND ASK YOU IF YOU WANT TO JUST REFRESH YOUR RECOLLECTION OF WHAT IT SAYS.

YOU CAN JUST READ IT TO YOURSELF.

DR. WESTHOFF, AFTER REFRESHING YOUR RECOLLECTION OF THE DEFINITION OF THE TERM "PARTIAL-BIRTH ABORTION" IN THIS LAW, CAN YOU TELL US WHETHER YOU FEAR PROSECUTION UNDER THIS ACT FOR THE D&E'S THAT YOU PERFORM WHERE THE FETUS IS EXTRACTED INTACT?

A. YES, I DO.

Q. CAN YOU EXPLAIN WHY THAT IS?

A. IN THE SORT OF PROCEDURE WE WERE JUST DISCUSSING, I DO, IN FACT, I THINK, FULFILL ALL THE GENERAL CONDITIONS THAT ARE DESCRIBED HERE, WHICH IS THAT ALL MY ACTIONS ARE DELIBERATE AND INTENTIONAL. THE PROCEDURE IS GOING FORWARD AS A VAGINAL DELIVERY. THE FETUS HAS A HEARTBEAT AND IS THUS LIVING IN THE

CASE.

AND I THINK SKIPPING FOR THE MOMENT THE VERTEX PRESENTATION, IN THE MORE COMMON CASE OF BREECH PRESENTATION, MUCH OF THE FETAL TRUNK, INCLUDING TRUNK PAST THE UMBILICAL -- THE INSERTION OF THE UMBILICAL VESSELS IS, IN FACT, OUTSIDE THE BODY OF THE WOMAN.

AND AT THAT POINT I WILL PERFORM ONE OR MORE OVERT ACTS, SUCH AS COLLAPSING THE SKULL AND CUTTING THE CORD THAT I KNOW WILL KILL THE FETUS.

SO I THINK THAT MY CARRYING OUT A PROCEDURE IN THIS WAY IS A DEFINITE VIOLATION OF THE BAN, AND I WOULD BE SUBJECT TO PROSECUTION.

Q. DR. WESTHOFF, DO YOU FEAR PROSECUTION UNDER THIS ACT FOR THE D&E'S THAT YOU DO WHERE THE FETUS IS DISARTICULATED IN THE COURSE OF THE EVACUATION?

A. YES, I DO. THE BAN ITSELF, THE LANGUAGE HERE DOES NOT SPECIFY THAT THE FETUS MUST BE INTACT. AND THERE ARE CASES SUCH AS WE DISCUSSED PARTLY A MOMENT AGO IN WHICH I MAY FIRST REMOVE A FOOT OR A LEG, AND THEN -- SO I PARTLY DISMEMBER THE FETUS, BUT THEN PROCEED TO BRING DOWN THE BREECH.

AND I BELIEVE THAT WOULD AGAIN FULFILL THE CONDITIONS STATED IN PART A OF THE BAN.

THERE ARE ALSO CASES IN WHICH PERHAPS THE FIRST PART OF THE FETUS I REMOVE MIGHT BE PART OF THE BACK OR THE RIBCAGE, WHICH ARE, IN FACT, PART OF THE FETAL TRUNK PAST THE NAVEL.

AND IT APPEARS THEN FOR ME TO CONTINUE TO CARRY OUT THE D&E WOULD VIOLATE THE BAN AS IT IS STATED HERE.

Q. THANK YOU, DR. WESTHOFF.

DO YOU EVER TREAT WOMEN WHO PRESENT TO YOU IN THE MIDST OF A SPONTANEOUS SECOND-TRIMESTER ABORTION?

A. YES, I DO.

Q. IS THAT ALSO CALLED A MISCARRIAGE SPONTANEOUS ABORTION?

A. YES, IT IS.

Q. HOW DO YOU TREAT THOSE CIRCUMSTANCES?

A. I WILL PROCEED TO EMPTY THE UTERUS. AND A DIFFERENCE FROM SOME OF THE PROCEDURES I WAS DESCRIBING A FEW MINUTES AGO IS OFTEN THE WOMAN WILL NEED LITTLE OR NO CERVICAL DILATION USING LAMINARIA.

THE CERVIX MAY ALREADY BE SOFT AND MAY ALREADY BE DILATED, ALTHOUGH IN SOME CASES THE WOMAN WILL STILL NEED LAMINARIA.

THE UTERUS MAY BE INFECTED. THE AMNIOTIC FLUID SAC MAY BE RUPTURED. THE FETUS MAY HAVE STOPPED GROWING. AND OTHER PROCESSES ARE IN PROGRESS THAT SIGNAL INEVITABLE END OF THIS PREGNANCY, BUT IT IS UP TO ME TO ACTUALLY EMPTY THE UTERUS.

AND I WOULD THEN PROCEED WITH EMPTYING THE UTERUS SURGICALLY FOLLOWING THE SAME STEPS THAT I WAS DESCRIBING PREVIOUSLY. AND, THEREFORE, IN THOSE CASES, AS WELL, I BELIEVE I WOULD BE VIOLATING THE BAN AS WRITTEN HERE.

MS. GARTNER: YOUR HONOR, I WAS GOING TO MOVE TO ONE LAST SECTION. I DON'T KNOW IF YOU INTENDED TO TAKE A BREAK.

THE COURT: YES. WE ARE GOING TO TAKE A BREAK.

MS. GARTNER: I THINK I COULD COMPLETE THIS IN 10 MINUTES.

THE COURT: WHY DON'T WE GO TO 12:00 AND START THE CROSS-EXAMINATION WITH THE DEFENDANT AFTER THE BREAK?

MS. GARTNER: OKAY. THANK YOU.

YOUR HONOR, I WOULD LIKE TO APPROACH THE WITNESS TO GIVE HER A COPY OF THE LAW.

THE COURT: SURE.

MS. GARTNER: THIS IS EXHIBIT 1. THIS IS A COPY OF THE LAW THAT IS AT ISSUE IN THE CASE.

BY MS. GARTNER:

Q. BEFORE WE TALK ABOUT THAT, DR. WESTHOFF, I JUST WANTED TO CLARIFY WITH YOU: IS IT YOUR OPINION THAT IN DOING A DISARTICULATION D&E THAT IT IS POSSIBLE TO LEAVE FETAL TISSUE IN THE UTERUS EVEN IF THE PROCEDURE IS BEING PERFORMED UNDER ULTRASOUND GUIDANCE?

A. YES, IT IS.

Q. OKAY. THANK YOU.

DR. WESTHOFF, IF YOU COULD TURN TO PAGE S.3-4 OF THIS LAW. THE NUMBERS ARE ON THE TOP OF THE PAGE.

A. GOT IT.

Q. DR. WESTHOFF, ARE YOU AWARE OF THE FACT THAT AT THE TIME

THAT CONGRESS PASSED THIS LAW CONGRESS MADE CERTAIN FACTUAL FINDINGS?

A. YES, I AM AWARE.

Q. I AM GOING TO ASK YOU TO LOOK AT SOME OF THE FACTUAL FINDINGS THAT CONGRESS MADE AND TELL US WHETHER OR NOT YOU AGREE WITH THOSE PARTICULAR FINDINGS.

IF YOU WOULD LOOK ON THE PAGE I DIRECTED YOU TO, S.3-4, THERE IS A PARAGRAPH THAT STARTS 14, AND THEN UNDER THAT THERE IS LARGE A.

A. YES.

Q. I AM GOING TO READ THAT FINDING TO YOU. IT SAYS:

"PARTIAL-BIRTH ABORTION POSES SERIOUS RISKS TO THE HEALTH OF A WOMAN UNDERGOING THE PROCEDURE. THOSE RISKS INCLUDE, AMONG OTHER THINGS, AN INCREASE IN A WOMAN'S RISK OF SUFFERING FROM CERVICAL INCOMPETENCE, A RESULT OF CERVICAL DILATION MAKING IT IMPOSSIBLE" -- I AM SORRY -- "MAKING IT DIFFICULT OR IMPOSSIBLE FOR A WOMAN TO SUCCESSFULLY CARRY A SUBSEQUENT PREGNANCY TO TERM."

I AM GOING TO STOP THERE.

IF WE ASSUME THAT THE PROCEDURE THAT'S BEING REFERRED TO HERE IS AN INTACT D&E -- LET'S SAY ASSUME THAT FOR NOW -- BASED ON YOUR EXPERIENCE DO YOU AGREE WITH THE STATEMENT THAT INTACT D&E INCREASES THE WOMAN'S RISK OF SUFFERING FROM CERVICAL INCOMPETENCE?

A. I DO NOT AGREE.
Q. CAN YOU EXPLAIN BRIEFLY WHY YOU DON'T AGREE WITH THAT?
A. AND I DON'T HAVE ANY PERSONAL EXPERIENCE WITH THAT COMPLICATION WITH RELATION TO MY PRACTICE, AND I AM NOT AWARE OF ANY LITERATURE THAT HAS FOUND SUCH AN INCREASED RISK.

ALSO, ON BIOLOGICAL GROUNDS, I THINK IT IS IMPLAUSIBLE. THE DILATION THAT WE USE FOR D&E IS ACTUALLY LESS THAN THE DILATION THAT IS ACHIEVED IN AN INDUCTION ABORTION, FOR INSTANCE, WHERE THE CERVIX MUST DILATE ENOUGH TO ACCOMMODATE THE FETAL HEAD.

AND ALSO, THE LESSER DILATION THAT WE ACHIEVE FOR THESE PROCEDURES IS ACCOMPLISHED OVER A LONGER PERIOD OF TIME THAN THE DILATION THAT OCCURS DURING AN INDUCTION.

SO I THINK COMPARED TO THE ALTERNATIVES IN THE SECOND-TRIMESTER, IT IS IMPLAUSIBLE THAT THIS PARTICULAR TECHNIQUE WOULD HAVE HAD GREATER, IF ANY, DAMAGE TO THE CERVIX IN COMPARISON TO THE ALTERNATIVES.

Q. THANK YOU.

READING ON IN THIS PARAGRAPH 14A, IT STATES THAT:

"AMONG THE RISKS ARE AN INCREASED RISK OF UTERINE RUPTURE, ABRUPTION, AMNIOTIC FLUID EMBOLUS, AND TRAUMA TO THE UTERUS AS A RESULT OF CONVERTING THE CHILD TO A FOOTLING BREECH POSITION, A PROCEDURE WHICH, ACCORDING TO A LEADING OBSTETRICS TEXTBOOK, THERE ARE VERY FEW, IF ANY, INDICATIONS FOR, OTHER

THAN DELIVERY OF A SECOND TWIN."

DO YOU SEE THAT?

A. YES, I DO.

Q. BASED ON YOUR CLINICAL EXPERIENCE AND READING OF THE MEDICAL LITERATURE, DO YOU AGREE THAT THOSE ARE RISKS OF INTACT D&E?

A. I DO NOT AGREE.

Q. WHY IS THAT?

A. THERE ARE SEVERAL REASONS, INCLUDING THAT I HAVE NOT OBSERVED THESE PARTICULAR COMPLICATIONS IN MY EXPERIENCE OR HEARD ABOUT THEM.

BUT, IN PARTICULAR, AT NINE MONTHS THE FETUS OCCUPIES A GREAT DEAL MORE SPACE IN THE UTERUS, AND SO THE DIFFICULTIES OF DOING A VERSION AT TERM ALLUDED TO IN THE OBSTETRICS TEXTBOOK MAY NOT BE RELEVANT TO WHAT IS GOING ON IN THE MIDTRIMESTER.

DURING THE MIDTRIMESTER THE FETUS IS FLOATING MORE FREELY IN THE UTERINE CAVITY, AND THE MAJORITY OF THE TIME MAY ALREADY BE IN A BREECH POSITION OR IN A TRANSVERSE POSITION, WHICH IS COMPLETELY DIFFERENT FROM WHAT OCCURS AT TERM.

AND SO THEREFORE IT MAY ALREADY BE IN A BREECH POSITION, VERSION IS NOT NECESSARY. AND IF THERE IS A VERSION IN THE COURSE OF THE PROCEDURE, IT IS DONE WITH A SMALL FETUS IN A MORE FREELY FLOATING ENVIRONMENT.

SO I THINK THE RISKS THAT HAVE BEEN DESCRIBED AT

TERM DO NOT APPLY IN THIS SETTING.

Q. THANK YOU.

MS. CLARK: I AM JUST GOING TO OBJECT. IT'S NOT MY UNDERSTANDING THAT SHE TESTIFIED ABOUT THIS IN HER DEPOSITION OR THAT SHE DISCUSSES IN HER EXPERT REPORT.

THE COURT: "THIS" MEANING WHAT, SPECIFICALLY? THIS PARTICULAR FINDING?

MS. CLARK: THIS PARTICULAR PART OF THE FINDING WITHIN 14A, ABOUT THE VERSION.

THE COURT: AS WITH ALL THE OTHER OBJECTIONS I HAVE TO DEPEND UPON YOU ALL TO POINT OUT THE PARTS OF THE -- EITHER EXPERT TESTIMONY OR DEPOSITION WHERE IT WAS RAISED.

MS. GARTNER: YOUR HONOR, I THINK THE SUM TOTAL OF DR. WESTHOFF'S TESTIMONY IN HER DECLARATION AND IN HER DEPOSITION IS HER BELIEF THAT THE INTACT D&E VARIANT IS THE SAFEST WAY TO DO THE PROCEDURE, AND THAT THAT IS WHAT SHE DOES IN HER PRACTICE.

CONGRESS SPECIFICALLY CRITICIZED THAT PROCEDURE IDENTIFYING THREE CONCRETE CONCERNS THAT ARE STATED IN PARAGRAPH 14A. SO I THINK IT IS INHERENT IN HER OPINION THAT THIS IS SAFE, THAT SHE DISAGREES WITH THE SPECIFIC CONGRESSIONAL CRITICISMS.

THE COURT: DID YOU ASK HER SPECIFICALLY ABOUT -- I AM SORRY. DID THE DEFENDANT ASK HER SPECIFICALLY ABOUT THESE FINDINGS DURING HER DEPOSITION?

MS. CLARK: YOUR HONOR, I DON'T BELIEVE -- IT WAS MS. GOWAN IN NEW YORK WHO TOOK THE DEPOSITION. AND AFTER REVIEWING IT, I DON'T BELIEVE SHE DID.

IT IS NOT MY UNDERSTANDING THAT SHE DID ASK ABOUT THESE.

MS. GARTNER: I AM HAPPY TO LEAVE THIS FOR NOW.

THE COURT: THANK YOU. JUST LEAVE IT.

MS. GARTNER: OKAY. YES.

BY MS. GARTNER:

Q. DR. WESTHOFF, I WOULD ASK YOU TO TURN BACK ONE PAGE. ACTUALLY, NO. YOU CAN STAY ON THAT PAGE. I AM SORRY. AT THE VERY TOP OF THIS PAGE S.3-4, IS A CONTINUATION OF FINDING 13. AND THE VERY LAST SENTENCE OF THIS, OF THAT FINDING, STATES:

"THESE FINDINGS REFLECT THE VERY INFORMED JUDGMENT OF THE CONGRESS THAT A PARTIAL-BIRTH ABORTION IS NEVER NECESSARY TO PRESERVE THE HEALTH OF A WOMAN, POSES SERIOUS RISKS TO A WOMAN'S HEALTH AND LIES OUTSIDE THE STANDARD OF MEDICAL CARE AND SHOULD, THEREFORE, BE BANNED."

WHAT I WOULD LIKE TO ASK YOU, DR. WESTHOFF, IS WHETHER YOU AGREE -- ASSUMING THAT THIS IS A REFERENCE TO INTACT D&E'S -- WHETHER YOU AGREE THAT INTACT D&E LIES OUTSIDE THE STANDARD OF MEDICAL CARE?

A. NO. IT LIES WITHIN THE STANDARD OF MEDICAL CARE.

Q. CAN YOU EXPLAIN THAT?

A. THIS IS A PROCEDURE WE CARRY OUT, WE OFFER TO OUR PATIENTS, CARRY OUT AND TEACH SAFELY AT COLUMBIA UNIVERSITY, AS WELL AS A NUMBER OF OTHER UNIVERSITY-BASED ABORTION SERVICES WHERE IT IS USED AND TAUGHT, AND I THINK DISCUSSED BY COLLEAGUES AND WIDELY ACCEPTED AMONG ACADEMICALLY-BASED ABORTION PROVIDERS. AND, THUS, I THINK IT IS WITHIN THE STANDARD OF CARE.

Q. THANK YOU.

CAN YOU TELL US WHAT OTHER ACADEMIC INSTITUTIONS THAT YOU ARE AWARE OF WHERE INTACT D&E PROCEDURES ARE BEING TAUGHT AND PERFORMED?

A. THE PROCEDURES ARE BEING PERFORMED --

MS. CLARK: I AM JUST GOING TO OBJECT ON LACK OF FOUNDATION. I DON'T KNOW HOW SHE KNOWS THAT THESE OTHER INSTITUTIONS ARE OR NOT PERFORMING AND --

THE COURT: WELL, WE WILL LIMIT IT TO OBVIOUSLY HER OWN PERSONAL KNOWLEDGE.

BY MS. GARTNER:

Q. AND, DR. WESTHOFF, PLEASE, IF CAN YOU TELL ME, DO YOU SPEAK WITH COLLEAGUES, FELLOW OB/GYN'S AT OTHER INSTITUTIONS AROUND THE COUNTRY?

A. YES, I DO.

Q. DO YOU SPEAK WITH THEM ABOUT THEIR ABORTION PRACTICE?

A. YES, I DO.

Q. AND BASED ON THOSE CONVERSATIONS AND YOUR PERSONAL KNOWLEDGE, CAN YOU TELL US WHAT OTHER ACADEMIC INSTITUTIONS ARE

CURRENTLY TEACHING INTACT D&E TECHNIQUES?
A. BASED ON SPECIFIC CONVERSATIONS WITH COLLEAGUES I KNOW THE TECHNIQUE IS BEING USED AND TAUGHT AT NEW YORK UNIVERSITY, AT CORNELL, AT ALBERT EINSTEIN COLLEGE OF MEDICINE, AT NORTHWESTERN UNIVERSITY, AND THAT IT IS CERTAINLY BEING TAUGHT ABOUT IN ADDITIONAL MEDICAL CENTERS AROUND THE COUNTRY.
Q. THANK YOU, DR. WESTHOFF.
AND ONE FINAL QUESTION: IF THIS LAW WERE TO BE ENFORCED, WHAT IMPACT WOULD IT HAVE ON YOUR PRACTICE AND ON YOUR PATIENTS?
A. WELL, I WOULD CERTAINLY FEAR PROSECUTION IF I WERE TO CONTINUE MY CURRENT PRACTICE. AND I THINK IT WOULD REQUIRE CONVERSATIONS BETWEEN ME AND OUR HOSPITAL ABOUT WHAT THE SCOPE -- OUR SCOPE OF PRACTICE COULD BE IN THE FUTURE.
AND THERE WOULD HAVE TO BE DISCUSSIONS ABOUT DISCONTINUING OFFERING D&E'S ALTOGETHER.
ONE OF MY COLLEAGUES IN ANOTHER INSTITUTION RIGHT NOW, SINCE THE PASSAGE OF THE LAW, HER HOSPITAL HAS FORBIDDEN HER FROM DOING ANY D&E'S IN THAT INSTITUTION.
I WOULD FEAR THAT WE MIGHT BE SUBJECT TO THE SAME CHANGE IN PRACTICE.
MS. CLARK: OBJECTION, HEARSAY: ANOTHER COLLEAGUE IN ANOTHER INSTITUTION.
THE COURT: SHE DIDN'T TESTIFY AS TO OUT-OF-COURT STATEMENTS. I AM GOING TO OVERRULE THE OBJECTION.

ALL RIGHT. WE ARE GOING TO TAKE -- ARE YOU FINISHED?

MS. GARTNER: I AM FINISHED, YOUR HONOR. I WOULD ASK THAT TO THE EXTENT I USED LESS THAN HALF OF THE REMAINING TIME --

THE COURT: YOU HAVE ABOUT FIVE MINUTES.

MS. GARTNER: I COULD USE THAT FOR REDIRECT.

THE COURT: WE WILL BREAK FOR 15 MINUTES.

(RECESS TAKEN AT 12:00 P.M.)

(PROCEEDINGS RESUMED AT 12:15 P.M.)

THE COURT: ALL RIGHT, MS. CLARK.

MS. CLARK: YOUR HONOR, BEFORE BEGINNING THE CROSS-EXAMINATION, MY CO-COUNSEL AND I HAVE BEEN LOOKING AT THE DEPOSITION TRANSCRIPT JUST TO CONFIRM. AND IT IS OUR UNDERSTANDING THAT DR. WESTHOFF DID NOT TALK AT ALL ABOUT INJECTING A CHEMICAL AGENT DURING HER DEPOSITION. AND ON THAT BASIS WE WOULD MOVE TO STRIKE HER TESTIMONY.

THE COURT: WHY DON'T WE ENTERTAIN ARGUMENT AFTER. WE HAVE LIMITED TIME TODAY.

CROSS-EXAMINATION

BY MS. CLARK:

Q. DR. WESTHOFF, MY NAME IS MS. KAIJA CLARK, AND I AM ONE OF THE CO-COUNSELS FOR THE DEFENDANT IN THIS CASE. I HAVEN'T MET YOU.

A. HOW DO YOU DO?

Q. THIS IS YOUR THIRD CASE IN WHICH YOU HAVE BEEN INVOLVED THAT RELATES TO THE PARTIAL-BIRTH ABORTION. THAT'S CORRECT, RIGHT?

A. YES.

Q. IN 1997, YOU SERVED AS AN EXPERT FOR THE PLAINTIFFS IN THE MICHIGAN CASE; IS THAT RIGHT?

A. YES.

Q. AND IN 1997, YOU ALSO SERVED AS AN EXPERT FOR THE PLAINTIFFS IN A CASE CHALLENGING NEW JERSEY'S PARTIAL-BIRTH ABORTION BAN ACT; ISN'T THAT RIGHT?

A. YES.

Q. AND SOME OF THE LAWYERS FOR THE PLAINTIFFS IN THE MICHIGAN CASE ARE THE SAME LAWYERS REPRESENTING YOU AND THE OTHER PLAINTIFFS IN THE CURRENT PARTIAL-BIRTH ABORTION CASE IN NEW YORK; ISN'T THAT RIGHT?

A. THAT'S RIGHT.

Q. AND SOME OF THE LAWYERS FOR YOU AND THE OTHER PLAINTIFFS IN THE NEW YORK CASE ARE THE LAWYERS INVOLVED IN THE NEW JERSEY CASE; ISN'T THAT CORRECT?

A. YES.

Q. PLANNED PARENTHOOD OF CENTRAL NEW JERSEY WAS ONE OF THE PLAINTIFFS IN THE MICHIGAN CASE, CORRECT?

A. I AM SORRY?

Q. PLANNED PARENTHOOD OF CENTRAL NEW JERSEY, WAS THAT ONE OF THE PLAINTIFFS IN THE NEW JERSEY CASE?

A. YES.
Q. YOU ARE ON THE BOARD OF DIRECTORS FOR PLANNED PARENTHOOD NEW YORK CITY; ISN'T THAT RIGHT?
A. YES, I AM.
Q. AND YOU HAVE BEEN A MEMBER OF THE BOARD OF DIRECTORS SINCE 1994?
A. THAT'S RIGHT.
Q. AND YOU WERE A MEMBER OF THE MEDICAL ADVISORY COMMITTEE FOR PLANNED PARENTHOOD BEFORE BECOMING A BOARD OF DIRECTOR MEMBER?
A. YES.
Q. BEGINNING IN 1991?
A. YES.
Q. DOCTOR, SINCE 1997 TO THE PRESENT YOU HAVE BEEN ON THE ADVISORY COMMITTEE FOR THE NARAL FOUNDATION; IS THAT RIGHT?
A. YES.
Q. AND THAT ACRONYM STANDS FOR NATIONAL ABORTION RIGHTS AND ACTION LEAGUE?
A. YES.
Q. YOU ARE A MEMBER OF THE NATIONAL ABORTION FEDERATION; IS THAT RIGHT?
A. YES, I AM.
Q. YOU ATTEND NAF MEETINGS?
A. I DO.
Q. DOCTOR, AM I CORRECT THAT PRIOR TO 2001, YOU HAD NEVER DELIVERED A FETUS INTACT WHILE PERFORMING A D&E?

A. THAT'S PROBABLY CORRECT, BUT WE DID HAVE A SMALL SERVICE AT PRESBYTERIAN IN THE YEARS PRECEDING 2001, PRECEDING OUR PRESENT PRACTICE. AND I MAY HAVE PARTICIPATED IN SOME CASES IN A COUPLE OF YEARS JUST BEFORE 2001. I AM NOT SURE OF THAT.

SO BUT I DEFINITELY HAVE INCREASED MY INVOLVEMENT IN PROVIDING THIS KIND OF CARE SINCE 2001 WITH OUR NEW SERVICE AT THE HOSPITAL.

Q. WOULD YOU SAY THAT 2001 IS THE FIRST TIME, AS YOU SIT HERE TODAY, THAT YOU CAN SPECIFICALLY RECOLLECT HAVING PERFORMED AN INTACT D&E YOURSELF?

A. OKAY, THAT'S REASONABLE.

Q. IS THAT REASONABLE?

A. SURE.

Q. IN YOUR CURRENT CLINICAL PRACTICE, YOU BEGIN USING THE INTACT D&E ABORTION PROCEDURE AT THE 19 TO 20 WEEK GESTATIONAL AGE?

A. APPROXIMATELY, RIGHT.

Q. SO AT 19 OR 20 WEEKS THERE IS A DECISION TO CHANGE SOMETHING IN THE PROCEDURE IN ORDER TO DELIVER THE FETUS?

A. I WOULDN'T DESCRIBE IT EXACTLY THAT WAY.

Q. AT 19 OR 20 WEEKS, YOU DILATE THE CERVIX WITH LAMINARIA FOR A PERIOD OF TWO DAYS; ISN'T THAT RIGHT?

A. THAT'S RIGHT.

Q. AND PRIOR TO 19 OR 20 WEEKS, YOU DON'T DO THE TWO-DAY DILATION?

A. RIGHT. PRIOR TO 19 OR 20 WEEKS, BECAUSE THE FETUS IS MUCH SMALLER, ONE DAY OF DILATION GIVES US AMPLE DILATION FOR THE COMPLETION OF THE ABORTION PROCEDURE. AND BECAUSE OF THE LARGER SIZE OF THE FETUS IT REQUIRES MORE DILATION AT THE MORE ADVANCED GESTATIONAL AGE.

Q. SO AT 19 OR 20 WEEKS YOU HAVE GOT TWO DAYS OF DILATION, AND BEFORE THAT YOU HAVE ONE DAY OF DILATION?

A. IN GENERAL. BUT EVERY CASE -- WE DO THIS ON AN INDIVIDUAL BASIS, BASED ON THE PATIENT'S ANATOMY AND CONDITION OF HER CERVIX, WHAT IS MOST APPROPRIATE FOR THAT INDIVIDUAL.

Q. AND YOU ARE AWARE THAT SOME PHYSICIANS PREPARE THE CERVIX OVER A THREE-DAY PERIOD; IS THAT CORRECT?

A. I HAVE HEARD SO, YES.

Q. NOW, WHEN YOU ARE PERFORMING A DISARTICULATION D&E, AFTER YOU GRAB THE FETAL PART TO BE DISARTICULATED, YOU DISARTICULATE THAT FETAL PART BY A TWISTING MOTION; ISN'T THAT RIGHT?

A. WE USE A COMBINATION OF TWISTING AND TRACTION AND -- TO ACCOMPLISH THE MANEUVER.

Q. AND WHEN YOU PERFORM AN INTACT D&E PROCEDURE, AFTER YOU GRAB THE FETAL PART YOU DON'T USE THE TWISTING MOTION BUT INSTEAD WITH A GENTLE TRACTION YOU PULL THE PART OR PARTS, AND THE FETUS WILL EMERGE THROUGH THE CERVICAL CANAL; IS THAT RIGHT?

A. YES, THAT IS REASONABLE.

Q. WHEN YOU PERFORM THE INTACT PROCEDURE, YOU PERFORM A

DISTINCT MANEUVER THAT YOU WOULD CHARACTERIZE AS SWEEPING THE ARMS OF THE FETUS; IS THAT RIGHT?

A. YES, WE MAY DO THAT.

Q. YOU ORIENT THE FETUS SO THE BACK IS UP TOWARDS YOU?

A. YES.

Q. AND THEN, YOU FOLLOW THE BACK OF THE FETUS WITH YOUR FINGER?

A. YES.

Q. THEN, BECAUSE THE ARMS WILL USUALLY EXTENDED YOU WILL FOLLOW WITH YOUR FINGER ALONG THE BABY'S SHOULDER?

A. WE MAY DO THAT.

Q. AND THEN YOU WILL SWEEP THE FIRST ARM OF THE FETUS ACROSS THE CHEST OF THE FETUS?

A. YES.

Q. AND BECAUSE OF THE WAY IN WHICH YOU SWEEP THE ARM DOWN AND AROUND, THE ARM WILL COME THROUGH THE CERVIX?

A. YES.

Q. AND THEN, YOU REPEAT THE SAME SWEEPING MANEUVER ON THE OPPOSITE SIDE OF THE BODY?

A. YES.

Q. AND THIS IS NOT SOMETHING THAT IS DONE IN A DISMEMBERMENT PROCEDURE, IS IT?

A. THERE IS A REAL RANGE IN HOW THESE PROCEDURES OCCUR. AND SOME PROCEDURES ARE COMPLETELY DISMEMBERMENT AND SOME PROCEDURES ARE MORE COMPLETELY INTACT. BUT FOR MANY CASES

THERE IS A RANGE IN-BETWEEN WHERE THE FETUS IS, YOU COULD SAY, PARTIALLY INTACT. SO THERE CAN BE SOME PARTS, PORTIONS OF THE PROCEDURE THAT OCCUR WITH DISMEMBERMENT, AND OTHER PORTIONS OF THE PROCEDURE THAT OCCUR INTACT.

SO SOME OF THE MANEUVERS THAT YOU ARE DESCRIBING RIGHT NOW MAY STILL BE UTILIZED, IN PART, DURING A PROCEDURE THAT IS ALSO CHARACTERIZED BY DISMEMBERMENT.

Q. WHEN YOU DO THE ARM SWEEPING MANEUVER, WOULD IT BE FAIR TO SAY THAT WHEN YOU DO THIS PROCEDURE THAT THE FETUS WOULD BE MOSTLY INTACT? WOULD THAT BE THE -- WOULD THAT BE THE SITUATION IN WHICH YOU WOULD DO THE ARM SWEEPING MANEUVER?

A. NOT NECESSARILY.

EVERY CASE REALLY PROCEEDS INDIVIDUALLY. AND TO USE THAT MANEUVER JUST DEPENDS ON THE RELATIVE POSITION OF THE TRUNK. AND ONE ARM AND SHOULDER AT A MOMENT DOES NOT DEPEND ON WHETHER ANY OF THE OTHER PARTS OF THE FETUS ARE INTACT.

Q. DOCTOR, IF YOU HAD DISMEMBERED THE ARMS, YOU WOULDN'T DO THE SWEEPING MANEUVER, WOULD YOU?

A. IF BOTH ARMS WERE ALREADY DISMEMBERED, I WOULD NOT DO THE SWEEPING, NO.

Q. NOW, WHEN PERFORMING THE INTACT PROCEDURE THE THORAX OF THE FETUS USUALLY WILL NOT PASS THROUGH THE CERVIX WITHOUT PERFORMING THIS DIGITAL ARM SWEEPING MANEUVER; ISN'T THAT CORRECT?

A. I THINK THAT IS USUALLY CORRECT.

Q. AFTER YOU SWEEP THE ARMS, THEN THE NECK OF THE FETUS WILL BE IN THE CERVIX, BUT THE HEAD OF THE FETUS WILL BE IN THE UTERUS; IS THAT CORRECT?

A. YES.

Q. AND IN PERFORMING THE INTACT D&E PROCEDURE, WHEN THE HEAD IS STILL IN THE UTERUS, YOU DO NOT ENTER THE UTERUS WITH FORCEPS, BUT YOU MAKE AN INCISION WITH SCISSORS AT THE BASE OF THE SKULL?

A. MY GENERAL PREFERENCE WOULD AT THAT POINT BE TO MAKE AN INCISION AT THE BASE OF THE SKULL, THAT'S RIGHT.

Q. AND WHEN YOU ARE DOING THE D&E DISMEMBERMENT PROCEDURE YOU DON'T MAKE THAT SAME INCISION AT THE BASE OF THE FETUS' HEAD. INSTEAD YOU WOULD DECOMPRESS THE SKULL BY CRUSHING IT, CORRECT?

A. THAT IS GENERALLY CORRECT, YES.

Q. IS IT CORRECT THAT AT THE ALLEN PAVILION, THAT -- IS IT CORRECT THAT AT THE ALLEN PAVILION YOU HAVE BEEN PERFORMING ABORTIONS THERE FOR THE LAST THREE YEARS?

A. YES, WE PERFORM SOME ABORTIONS THERE. IN YEARS FROM THE MID-90'S FORWARD. BUT THE SERVICE AS I DESCRIBED IT HAS EXISTED AT THE ALLEN PAVILION SINCE 2001. BUT THERE WERE ABORTIONS PERFORMED THERE, YOU KNOW, IN LESSER NUMBERS IN YEARS PRECEDING 2000.

FROM ABOUT 1995 FORWARD THERE WERE CERTAINLY SOME ABORTIONS PERFORMED AT THE ALLEN PAVILION. MAYBE ONE HALF DAY A WEEK OR ONE DAY A WEEK IN THE PRECEDING YEARS.

Q. OKAY. AND YOU HAVE STARTED COLLECTING DATA ON WHETHER A FETUS WAS REMOVED INTACT OR BY DISMEMBERMENT; ISN'T THAT RIGHT?
A. I HAVE NOT ROUTINELY COLLECTED OR COLLATED DATA ON THAT.
Q. ARE YOU PLANNING TO START COLLECTING THAT DATA?
A. YES.
Q. THAT IS BECAUSE YOUR STAFF RECOMMENDED TO START COLLECTING THOSE NUMBERS; IS THAT RIGHT?
A. THAT'S RIGHT. WITH ALL THE INTEREST AND DISCUSSION AROUND THIS CASE, WE THOUGHT MAYBE WE SHOULD START COLLECTING THIS DATA IN THE FUTURE AND GET A MORE FORMAL ASSESSMENT OF OUR OWN OUTCOMES.
Q. DOCTOR, YOU WOULD AGREE THAT DILATION IS AN EXTREMELY IMPORTANT PART IN CARRYING OUT AN INTACT D&E?
A. DILATION IS AN IMPORTANT PART OF ALL SURGICAL ABORTION CARE.
Q. IN PERFORMING AN INTACT D&E ABORTION IT IS POSSIBLE, ISN'T IT, THAT YOU COULD DILATE THE CERVIX TOO MUCH AND CAUSE SOME INJURY TO THE CERVIX?
A. COULD YOU REPEAT THAT, PLEASE?
Q. IN PERFORMING AN INTACT D&E ABORTION, IT IS POSSIBLE, ISN'T IT, THAT YOU COULD DILATE THE CERVIX TOO MUCH AND CAUSE INJURY TO THE CERVIX?
A. THE DILATION PART OF THE WHOLE PROCESS PRECEDES, OF COURSE, THE EXTRACTION PART. SO, THE DILATION IS REALLY DONE AND OVER WITH BEFORE WE KNOW WHETHER THE EXTRACTION IS GOING TO BE

INTACT OR BY DISMEMBERMENT.

SO, I MEAN, IS YOUR QUESTION WHETHER DILATION ALL BY ITSELF IS TOO MUCH? BECAUSE DILATION OCCURS SEPARATELY FROM EXTRACTION.

Q. RIGHT. DOCTOR, ISN'T IT TRUE THAT WHEN A FETUS IS AT 18, 19 OR 20 WEEKS OF GESTATION, THE MOTHER'S CERVIX IS NOT SOFT, AND IT DOES NOT NECESSARILY RESPOND TO ATTEMPT -- DOES NOT NECESSARILY RESPOND TO ATTEMPTS TO DILATE IT SO WELL?

A. WELL, THERE ARE MULTIPLE DIFFERENCES AS GESTATIONAL AGE GOES ON. AND AS GESTATIONAL AGE INCREASES, THE CERVIX TENDS TO BE SOFTER. SO THE CERVIX TENDS TO DILATE MORE READILY AND HAVE A GREATER RESPONSE TO LAMINARIA WITH INCREASING GESTATIONAL AGE.

DID THAT ANSWER YOU?

Q. YES. I THINK SO.

NOW, IN PERFORMING AN INTACT D&E, YOU DON'T TRY TO DILATE TO THE WIDEST PART OF THE BABY'S HEAD, DO YOU?

A. NO, WE DO NOT. FOR ANY D&E WE DO NOT ATTEMPT TO DILATE THAT FAR.

Q. AND THAT IS BECAUSE YOU CAN COLLAPSE OR CRUSH THE HEAD, SO YOU DON'T NEED TO DILATE ANY MORE, RIGHT?

A. THAT'S RIGHT.

Q. SO YOU WOULD CHOOSE TO CRUSH THE HEAD AND SUCK OUT THE CONTENTS INSTEAD OF DILATING MORE; IS THAT RIGHT?

A. FOR ALL D&E'S WE REDUCE THE DIAMETERS OF THE HEAD.

Q. BUT YOU WOULD AGREE, WOULDN'T YOU, THAT IF YOU WANTED TO YOU COULD DILATE THE CERVIX SO MUCH THAT YOU DIDN'T HAVE TO CRUSH THE HEAD?

A. WELL, FOR INSTANCE, WITH AN INDUCTION, THE CERVIX WILL DILATE MORE, AND THE HEAD WILL BE DELIVERED WITHOUT REDUCING ITS DIAMETERS.

I HAVE NEVER DONE THIS, BUT I IMAGINE IT WOULD BE POSSIBLE TO CONTINUE USING LAMINARIA FOR ADDITIONAL SERIAL TREATMENTS OVER TIME AND ACHIEVE GREATER DILATION TO THE POINT WHERE THE CERVIX IS AS FAR DILATED AS THE DIAMETER OF THE FETAL HEAD.

SO I HAVE NEVER DONE THAT, SO I CAN'T SAY FOR SURE.

Q. DOCTOR, IF YOU WANTED TO DETERMINE THE SAFETY OF INTACT D&E VERSUS A DISMEMBERMENT D&E IN TERMS OF CERVICAL INCOMPETENCE, AT A MINIMUM YOU WOULD NEED TO FOLLOW THE WOMEN THROUGH THEIR NEXT PREGNANCY; ISN'T THAT RIGHT?

A. SINCE CERVICAL INCOMPETENCE IS, IN FACT, DETERMINED BY OUTCOME OF THE FUTURE PREGNANCY, YOU DON'T HAVE OUTCOMES UNTIL THE WOMEN HAVE ANOTHER PREGNANCY.

Q. SO YOU WOULD HAVE TO FOLLOW WOMEN INTO THEIR NEXT PREGNANCY --

A. RIGHT.

Q. -- IN ORDER TO MAKE A DETERMINATION?

A. YES, GIVEN THAT NOT ALL WOMEN ARE GOING TO BE HAVING A FUTURE PREGNANCY, YOU CAN ONLY FOLLOW THE SUBSET THAT DOES HAVE

A FUTURE PREGNANCY.
Q. AND AT THIS TIME, YOU DO NOT KNOW WHAT THE RESULTS OF A STUDY COMPARING THE LONG-TERM COMPLICATION OF CERVICAL INCOMPETENCE WOULD BE IF YOU COMPARED DISMEMBERMENT D&E TO INTACT D&E; ISN'T THAT RIGHT?
A. I AM SORRY. CAN I HEAR THAT ONE MORE TIME?
Q. AT THIS TIME YOU DON'T KNOW WHAT THE RESULTS OF A STUDY WOULD BE OF COMPARING DISMEMBERMENT D&E AND INTACT D&E WITH RESPECT TO CERVICAL INCOMPETENCE; ISN'T THAT RIGHT?
A. I DO NOT KNOW THE RESULTS OF A STUDY THAT HAS NOT YET BEEN DONE, THAT'S CORRECT.
Q. AND, DOCTOR, IN PERFORMING A RELIABLE STUDY YOU WOULD WANT TO FOLLOW ALL THE PATIENTS THROUGH THE NEXT PREGNANCY, NOT SOME OF THEM; ISN'T THAT CORRECT?
A. I AM JUST PONDERING IF I CAN FIND A DIFFERENT WORD THAN "RELIABLE," BECAUSE "RELIABLE" MEANS IN REALLY EPIDEMIOLOGICAL TERMS IS IF YOU DO A STUDY ONCE, FOR INSTANCE, AND YOU DO A STUDY A SECOND TIME AND YOU GET THE SAME RESULTS THE SECOND TIME, THEN YOU HAVE DONE A RELIABLE STUDY. AND I DON'T THINK THAT IS WHAT YOU ARE ACTUALLY ASKING ME.
Q. IF YOU DO ONE STUDY.
A. ONE AND ONLY ONE STUDY.
I WOULD LIKE TO GET THE MOST INFORMATION FROM A STUDY, IF YOU HAVE OUTCOME INFORMATION ON THE LARGEST PROPORTION OF SUBJECTS. AND SO I WOULD -- IN DOING ANY STUDY,

I WOULD LIKE TO HAVE AS MUCH OUTCOME INFORMATION AS POSSIBLE IN ORDER TO LEARN SOMETHING FROM THE RESULTS.

Q. SO YOU WOULD PREFER TO EVALUATE ALL OF THE WOMEN WHO HAD A SUBSEQUENT PREGNANCY, WHO HAD SUBSEQUENT PREGNANCIES, RATHER THAN ONLY SOME OF THEM WHEN EVALUATING CERVICAL INCOMPETENCE?

A. IF IT IS POSSIBLE TO GET THAT INFORMATION THAT WOULD BE VALUABLE INFORMATION TO HAVE.

Q. NOW, YOU STATED IN YOUR NOVEMBER 4TH, 2003 DECLARATION SUBMITTED IN CONNECTION WITH THE NEW YORK CASE THAT YOU DO NOT BELIEVE INTACT D&E WOULD CAUSE CERVICAL INCOMPETENCE; IS THAT RIGHT?

A. THAT'S RIGHT.

Q. AND YOUR BELIEF THAT D&X OR INTACT D&E WOULD NOT LEAD TO CERVICAL INCOMPETENCE IS SIMPLY A BELIEF, RIGHT?

A. THERE ARE NOT AT THIS POINT VERY MUCH DATA, SO I AM BASING THAT MORE ON MY KIND OF INTERPRETATION OF THE BIOLOGY OF WHAT HAPPENS MORE THAN ON THE RESULTS OF STUDIES, WHICH, AS YOU KNOW, HAVE NOT YET BEEN DONE TO ANY LARGE DEGREE.

Q. AND AS AN EPIDEMIOLOGIST, YOU DON'T GIVE MUCH WEIGHT TO SOMEONE'S BELIEF IN THE TOTAL ABSENCE OF STUDIES, DO YOU?

A. WELL, IN FACT, IN EPIDEMIOLOGY THERE IS CERTAINLY A HIERARCHY. AND CLINICAL EXPERIENCE AND BIOLOGICAL PLAUSIBILITY CERTAINLY DO INFORM PRACTICE IN MY UNDERSTANDING OF THE WORLD.

IF I HAVE STUDIES, I WOULD BE MORE INCLINED TO RELY ON RESULTS OF THE STUDY THAN TO RELY ON BELIEF THAT EXISTS JUST

IN MY OWN HEAD, CERTAINLY.
Q. AND IN THE FIELD OF EPIDEMIOLOGY, INTUITION IS NOT ACCEPTED AS A VALID METHOD OF PROOF OR ANALYSIS, IS IT?
A. IF ONE IS LOOKING AT A STUDY, YOU USE STATISTICAL METHODS TO ANALYZE THE STUDY. YOU DON'T USE INTUITION TO ANALYZE THE STUDY.
BUT IF THERE IS NO STUDY AT ALL, ONE MUST RELY ON BIOLOGICAL PRINCIPLES AND CLINICAL EXPERIENCE IN ORDER TO FORMALIZE A BASIS FOR PRACTICE.
Q. BUT IN THE FIELD OF EPIDEMIOLOGY, INTUITION IS NOT ACCEPTED AS A VALID METHOD FOR PROOF AND ANALYSIS, IS IT?
A. IF ONE IS ANALYZING A STUDY, ONE NEEDS A STATISTICAL, ANALYTICAL METHOD. ONE DOESN'T USE INTUITION TO ANALYZE THE RESULTS OF A STUDY.
Q. IT IS CORRECT THAT YOU PERFORMED D&E'S BY DISARTICULATION AT 23 WEEKS; ISN'T THAT RIGHT?
A. I HAVE DONE SO, YES.
Q. AND IN YOUR OPINION, A DISARTICULATION PROCEDURE AT 23 WEEKS IS SAFE?
A. IT IS SAFE.
Q. AND IT IS SAFE AT 21 WEEKS?
A. YES. SAFETY IS ALWAYS RELATIVE TO WHAT THE ALTERNATIVES ARE. AND SAFE IN THE SENSE THAT THE OVERALL COMPLICATION RATES ARE LOW, BUT ONE MUST ALSO THINK WHAT THE ALTERNATIVES ARE.
Q. DOCTOR, YOU DO NOT TAKE STEPS TO ENSURE THAT THE FETUS IS

REMOVED INTACT BECAUSE OF MATERNAL COMPLICATIONS, RIGHT?
A. I AM SORRY. CAN YOU REPEAT THAT?
Q. DOCTOR, YOU DO NOT SET OUT TO TAKE STEPS TO ENSURE THAT A FETUS IS REMOVED INTACT BECAUSE OF MATERNAL COMPLICATIONS, RIGHT?
A. IN GENERAL WITH D&E'S I DO PREFER TO REMOVE THE FETUS INTACT IF I CAN SAFELY COMPLETE THE PROCEDURE THAT WAY. AND AS I STATED EARLIER, WE DON'T DO INTACT PROCEDURE FOR MORE THAN HALF OF OUR PATIENTS, SO THAT IS NOT ALWAYS POSSIBLE.

I DO THINK MY PATIENTS WITH MEDICAL PROBLEMS HAVE MORE TO BENEFIT FROM AN INTACT APPROACH, BUT IT DOESN'T -- THE FACT THAT THEY HAVE THE POTENTIAL TO BENEFIT THE MOST FROM AN INTACT APPROACH DOESN'T NECESSARILY MEAN THAT I AM MORE CAPABLE OF ACHIEVING AN INTACT APPROACH IN THOSE PATIENTS.

I MAY STILL DO A DISMEMBERMENT APPROACH BECAUSE AT THE TIME OF THE PROCEDURE THAT'S THE SAFEST THING I AM ABLE TO ACCOMPLISH.

Q. MY QUESTION WAS: YOU DO NOT TAKE SPECIFIC STEPS TO ENSURE THAT THE FETUS IS REMOVED INTACT BECAUSE OF MATERNAL COMPLICATIONS; ISN'T THAT RIGHT?
A. I TAKE THE SAME STEPS TO ACCOMPLISH THE PROCEDURE SAFELY IN ALL OF MY PATIENTS ON AN INDIVIDUAL BASIS.
Q. SO I AM CORRECT THAT THERE IS NO DIFFERENT STEPS THAT YOU TAKE TO ENSURE THAT THE FETUS IS REMOVED INTACT BECAUSE OF MATERNAL COMPLICATIONS, RIGHT?

A. RIGHT. I FOLLOW THE SAME STEPS WITH EACH PATIENT, BUT ON AN INDIVIDUAL BASIS TO HAVE THE SAFEST POSSIBLE PROCEDURE.

Q. YOU HAVE CO-AUTHORED A CHAPTER IN DR. MAUREEN PAUL'S BOOK:

"A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION"; IS THAT CORRECT?

A. YES, THAT'S RIGHT.

Q. THE CHAPTER IS TITLED "PROCEDURE SELECTION"; IS THAT RIGHT?

A. THAT'S RIGHT.

Q. THIS IS PLAINTIFFS' 68 FOR IDENTIFICATION PURPOSES.

A. THANK YOU.

Q. DOCTOR, IF YOU WOULD LOOK AT THE EXHIBIT THAT I JUST HANDED YOU, IS THAT A COPY OF YOUR CHAPTER?

A. YES, IT IS.

Q. AND IN THAT CHAPTER YOU DISCUSS INTACT D&E, CORRECT?

I WILL DIRECT YOUR ATTENTION TO PAGE 68 UNDER "SURGICAL TECHNIQUES."

A. YES.

Q. NOW, ON PAGE 68 UNDER "SURGICAL TECHNIQUES," THE SECOND PARAGRAPH, I AM LOOKING AT THE LAST SENTENCE. IT STATES:

"INTACT D&E MAY BE BENEFICIAL WHEN WOMEN UNDERGOING ABORTION FOR FETAL OR MEDICAL INDICATIONS WISH TO SEE OR HOLD THE FETUS AS PART OF THE GRIEVING PROCESS."

IS THAT CORRECT? IS THAT WHAT IT SAYS?

A. YES.

Q. YOU DO NOT SAY ANYTHING IN YOUR CHAPTER ABOUT THE INTACT D&E BEING THE MOST MEDICALLY NECESSARY FOR THE PARTICULAR MATERNAL COMPLICATION, RIGHT?
A. CAN I REVIEW THE PARAGRAPH FOR A MOMENT?
Q. YES.
A. IN THIS PARAGRAPH I DON'T SAY ANYTHING ABOUT USING INTACT IN THE PRESENCE OF MATERNAL COMPLICATIONS -- IN THE PRESENCE OF MATERNAL ILLNESS.
Q. AND AS FAR AS YOU KNOW, NO STUDY HAS CONCLUDED THAT INTACT D&E IS EVER MEDICALLY NECESSARY?
A. I AM NOT AWARE OF ANY STUDY THAT HAS EVALUATED D&E, DIFFERENT D&E TECHNIQUES WITH REGARD TO MEDICAL NECESSITY.
Q. DOCTOR, IS IT FAIR TO SAY THAT YOU HAVE PERFORMED OR SUPERVISED APPROXIMATELY 10 TO 20 INTACT D&E'S IN THE LAST THREE YEARS?
A. I THINK THAT MIGHT BE IN THE LAST YEAR, BUT, YES. SO, THEREFORE, CERTAINLY IN THE LAST THREE YEARS, AS WELL.
Q. LET ME ASK IT THIS WAY: IN THE LAST THREE YEARS APPROXIMATELY HOW MANY INTACT D&E'S DO YOU BELIEVE THAT YOU HAVE PERFORMED OR SUPERVISED?
A. AS I STATED EARLIER WE HAVEN'T BEEN IN THE HABIT OF ACTUALLY KEEPING DIRECT RECORDS WITH REGARD TO THAT, BUT I WOULD THINK OVER THE LAST THREE YEARS THAT THE NUMBER HAS BEEN 30 OR MORE.
Q. BUT ROUGHLY 30. WHEN YOU SAY "30 OR MORE," YOU DON'T MEAN

30 OR A HUNDRED; YOU MEAN AROUND 30 AS A BALLPARK?
A. YES.
Q. NOW, YOUR BASIS, SEPARATE FROM YOUR CLINICAL EXPERIENCE FOR YOUR OPINIONS ABOUT THE INTACT D&E PROCEDURE, ARE BASED ON DR. HASKELL'S PAPER, DR. MCMAHON'S PAPER AND THE CHASEN STUDY THAT YOU DISCUSSED IN YOUR DIRECT TESTIMONY; IS THAT CORRECT, SEPARATE FROM YOUR CLINICAL EXPERIENCE?
A. ALSO BASED ON OBSERVATION OF MY COLLEAGUES AND DISCUSSION WITH MY COLLEAGUES OF HOW TO TAKE CARE OF PATIENTS AND THE PROCEDURES THAT THEY USE. SO, ALL THAT AND MY CLINICAL EXPERIENCE TAKEN TOGETHER WITH THOSE PREVIOUS REPORTS TOGETHER IS THE BASIS OF MY OPINIONS, YES.
Q. BUT AS FAR AS WRITTEN REPORTS ARE TAKEN INTO CONSIDERATION, AS HASKELL, MCMAHON AND CHASEN; IS THAT RIGHT?
A. YES, THAT'S RIGHT.
MS. CLARK: AND FOR THE RECORD, I'LL NOTE THE CHASEN STUDY THAT I HAVE JUST MENTIONED AND WE WILL BE DISCUSSING IS SCHEDULED FOR PUBLICATION IN AN UPCOMING ISSUE OF THE AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY.
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BY MS. CLARK:
Q. IN THE CHASEN STUDY YOU TESTIFIED ABOUT IN YOUR DIRECT EXAMINATION, THE PATIENTS IN THAT STUDY WERE NOT ASSIGNED TO TREATMENT AT RANDOM, WERE THEY?
A. THAT'S RIGHT.

Q. THEY WEREN'T RANDOMLY ASSIGNED; IS THAT CORRECT?
A. THAT'S RIGHT.
Q. AND EVERY PATIENT IN THE STUDY RECEIVED A TREATMENT BASED ON THE PHYSICIAN'S JUDGMENT?
A. THAT'S CORRECT.
Q. AND THE LACK OF RANDOMIZATION REDUCES THE RELIABILITY OF THE STUDY, CORRECT?
A. AGAIN, I HAVE A LITTLE DIFFICULTY WITH THE USE OF THE TERM "RELIABILITY." THAT IT IS WHAT IT IS. THE DOCTOR DECIDED WHICH TREATMENT TO USE WITH EACH PATIENT. SO IN CASES WHERE THE DOCTOR DECIDED TO OR WAS ABLE TO USE THE INTACT APPROACH, THEY GOT THE RESULTS THAT ARE REPORTED.

AND IN OTHER CASES WHERE THE DOCTOR DECIDED TO OR WAS ABLE TO USE A DISMEMBERMENT APPROACH, THEY GOT THE OTHER RESULTS THAT THEY REPORTED.

AND SO WHAT I DO KNOW IS THAT THAT, THOSE RESULTS ARE DUE TO VARIOUS FACTORS IN A RANDOMIZED TRIAL. CHANCE WOULD DISTRIBUTE WOMEN EQUALLY IN THE TWO GROUPS. IN THIS STUDY, THAT IS NOT HOW IT WAS CARRIED OUT.

Q. DOCTOR, YOU WOULD PREFER TO HAVE A RANDOMIZED -- GIVEN THE CHOICE, YOU WOULD PREFER TO HAVE A RANDOMIZED STUDY AS OPPOSED TO A RETROSPECTIVE STUDY; ISN'T THAT CORRECT?
A. YES, RANDOMIZED TRIALS ARE PARTICULARLY USEFUL TO MAKE SURE THAT ALL OF THE ADDITIONAL FACTORS THAT WE KNOW ABOUT AND EVEN ADDITIONAL FACTORS WE DON'T KNOW ABOUT ARE DISTRIBUTED EQUALLY

IN THE GROUPS OF A STUDY.

AND AS WE DISCUSSED A LITTLE EARLIER IN THIS STUDY, FOR INSTANCE, THE WOMEN STUDIED IN THE TWO GROUPS DIFFERED WITH REGARD TO GESTATIONAL AGE. IF IT HAD BEEN A RANDOMIZED STUDY ONE WOULD EXPECT THE TWO GROUPS TO BE COMPARABLE WITH REGARD TO GESTATIONAL AGE.

SO, THAT'S A WAY IN WHICH THIS IS DIFFERENT FROM RESULTS THAT MIGHT EMERGE FROM A RANDOMIZED TRIAL.

Q. SO, I GUESS THE ANSWER IS "YES," YOU WOULD PREFER A RANDOMIZED OVER A RETROSPECTIVE STUDY?

A. IF IT IS POSSIBLE TO DO A RANDOMIZED TRIAL, I CERTAINLY WOULD LIKE TO HAVE SUCH A TRIAL, YES.

Q. YOU WOULD AGREE THAT THE CHASEN STUDY DID NOT FIND THAT THERE WERE LOWER RATES OF CERVICAL TEARS TO THE WOMEN UNDERGOING INTACT DILATION AND EXTRACTION COMPARED TO THOSE UNDERGOING DILATION AND EVACUATION, CORRECT?

A. IS IT ALL RIGHT IF I REFER TO THE PAPER?

Q. YES.

A. BECAUSE I DON'T -- THEIR OVERALL COMPLICATIONS THAT THEY REPORT SUBSUME A VARIETY OF PARTICULAR COMPLICATIONS, AND I DON'T REMEMBER THE DETAILS OF SOME OF THOSE.

Q. IF I DIRECT YOU TO THE "RESULT" SECTION?

A. I HAVE GOT IT. I AM READING IT.

Q. OKAY.

A. THE AUTHORS SPECIFIED THAT IN THE INTACT GROUP THERE WERE

WHAT THEY DESCRIBE -- THERE WERE THREE CERVICAL MUCOSAL LACERATIONS. AND IN THE DISMEMBERMENT D&E GROUP THERE WERE TWO CERVICAL LACERATIONS.

I DON'T HAVE ENOUGH DETAIL HERE TO KNOW WHY ONE GROUP WAS DESCRIBED AS MUCOSAL LACERATIONS AND THE OTHER AS CERVICAL LACERATIONS. MUCOSAL LACERATION USUALLY REFERS TO A SUPERFICIAL LACERATION, JUST THE MOST SUPERFICIAL LAYER OF THE CERVIX.

SO THIS SUGGESTS THAT IN THE INTACT GROUP THERE WERE THREE SUPERFICIAL CERVICAL LACERATIONS, AND IN THE OTHER GROUP THERE WERE TWO CERVICAL LACERATIONS, WHICH WEREN'T MODIFIED BY THE USE OF THE WORD "MUCOSAL." SO THAT MAY INDICATE THAT THEY WERE DEEPER LACERATIONS THAN THE OTHER GROUP.

Q. BUT, DOCTOR, WHAT THE STUDY DID, IN FACT, NOTE WAS THAT THERE WERE FOUR GENITAL TRACT LACERATIONS.

A. IN EACH GROUP.

Q. IN EACH GROUP, RIGHT?

A. THAT'S RIGHT.

Q. AND THERE WERE MORE PARTICIPANTS IN THE D&E DISMEMBERMENT GROUP; ISN'T THAT CORRECT?

A. YES, THAT'S RIGHT.

Q. APPROXIMATELY DOUBLE OR MORE THAN DOUBLE?

A. THAT'S RIGHT.

Q. RIGHT? SO THERE IS A HIGHER FREQUENCY OF THESE KIND OF GENITAL TRACT LACERATIONS IN THE DISMEMBERMENT D&E GROUP; ISN'T

THAT RIGHT?

A. THE DISTRIBUTION OF COMPLICATIONS WAS DIFFERENT IN THE TWO GROUPS.

Q. AND THERE IS A HIGHER FREQUENCY OF LACERATIONS IN THE ENTIRE GROUP, CORRECT?

A. THE FREQUENCY IS ACTUALLY THE SAME. BECAUSE IT IS FOUR, THE RATE IS SLIGHTLY DIFFERENT.

Q. THE RATE IS SLIGHTLY HIGHER?

A. YES, IT IS.

Q. AND THE CHASEN STUDY DID NOT FIND THAT THERE WERE LOWER RATES OF HEMORRHAGE FOR THE INTACT GROUP; IS THAT RIGHT?

A. LET ME LOOK.

I AM SORRY. NOW THAT I FOUND THE PART -- I AM SORRY. ALL THE COMPLICATIONS ARE DESCRIBED IN SEVERAL PARAGRAPHS OF TEXT. AND SO IT IS JUST TAKING ME A MINUTE TO FIND THE EXACT ONES THAT YOU ARE ASKING ME ABOUT.

Q. SURE.

A. NOW, WHAT WAS YOUR QUESTION AGAIN?

Q. THE CHASEN STUDY DID NOT FIND THAT THERE WERE LOWER RATES OF HEMORRHAGE FOR THE INTACT GROUP; ISN'T THAT RIGHT?

A. THEY DIDN'T REPORT ON HEMORRHAGE RATES SEPARATELY FROM OVERALL COMPLICATIONS. AND THE NUMBERS OF CASES OF WHAT THEY DESCRIBE AS EXCESSIVE BLEEDING ARE SIMILAR IN THE TWO GROUPS.

I HAVEN'T SEEN THEM USE THE WORD "HEMORRHAGE." IT MAY BE HERE, BUT I HAVEN'T FOUND THE WORD "HEMORRHAGE" IN THE

DESCRIPTION OF ANY OF THE COMPLICATIONS.
Q. ON THE FIRST PAGE UNDER THE -- TURN TO THE FIRST PAGE OF THE STUDY IN THE "RESULTS" SECTION ON -- IN THE "RESULTS" SECTION OF THE ABSTRACT.
A. UH-HUH.
Q. IT STATES THERE THAT THERE IS NO DIFFERENCE IN PROCEDURE TIME OR ESTIMATED BLOOD LOSS IN THE TWO GROUPS; ISN'T THAT RIGHT?
A. YES, THAT IS WHAT THE ABSTRACT SAYS.
Q. AND, IN FACT, THE CHASEN STUDY CONCLUDED THE OUTCOMES APPEAR TO BE SIMILAR BETWEEN PATIENTS UNDERGOING DILATION AND EVACUATION AND INTACT DILATION AND EXTRACTION AFTER 20 WEEKS GESTATION?
A. YES, THAT IS WHAT THE AUTHOR'S CONCLUSIONS ARE.
I THINK THAT IN TABLE 3, FOR INSTANCE --
Q. I AM JUST GOING TO ASK YOU TO ANSWER MY QUESTIONS, PLEASE.
A. OKAY.
Q. AND THE DATA IN THE CHASEN STUDY ALSO AFFIRMED THAT ABORTION AFTER 20 WEEKS GESTATION WITH INTACT DILATION AND EXTRACTION APPEARS TO HAVE SIMILAR COMPLICATION RATES AS DILATION AND EVACUATION WHEN PERFORMED BY EXPERIENCED PHYSICIANS, CORRECT?
AND IF YOU GIVE ME A SECOND, I HAVE A DIFFERENT COPY. I DIDN'T GET THAT COPY UNTIL THIS MORNING. I AM LOOKING AT THE VERY END OF THE ARTICLE IN THE CONCLUSION.

A. IN THE FINAL PARAGRAPH?
Q. YES.
A. YES. THAT'S WHAT THE AUTHORS STATE. AND AS I SAID EARLIER, I THINK THIS IS A CONSERVATIVE KIND OF INTERPRETATION OF THEIR DATA, BECAUSE LOOKING AT THE DETAILS PROVIDED IN THE TABLES AND IN THE TEXT, THE MOST SERIOUS COMPLICATIONS DID OCCUR IN THE GROUP UNDERGOING THE DISMEMBERMENT-TYPE OF D&E.
Q. DOCTOR, THE AUTHORS, THOUGH, CONCLUDED THAT:

"OUR DATA AFFIRMED THAT ABORTIONS AFTER 20 WEEKS GESTATION WITH INTACT D&X APPEARS TO HAVE SIMILAR COMPLICATION RATES AS DILATION AND EVACUATION WHEN PERFORMED BY EXPERIENCED PHYSICIANS," RIGHT?

A. YES. THAT IS WHAT THE AUTHORS CONCLUDE.
Q. THIS ARTICLE HAS BEEN PEER REVIEWED; ISN'T THAT CORRECT?
A. YES, IT HAS.
Q. AND IF I CAN DIRECT YOUR ATTENTION STILL ON THAT LAST PAGE, IT IS IN THE FIRST COLUMN, THE THIRD FULL PARAGRAPH, THE LAST SENTENCE STATED IN THIS STUDY STATES:

"THOUGH WE BELIEVE OUR LOW COMPLICATION RATE VALIDATES OUR APPROACH, WE ACKNOWLEDGE THAT THE RETROSPECTIVE NATURE OF THIS STUDY PRECLUDES US FROM CONCLUDING WITH CERTAINTY THAT INTACT D&X PREVENTED ADVERSE OUTCOMES"; IS THAT RIGHT?

A. THAT IS WHAT THE AUTHORS STATE IN THAT PARAGRAPH. YES,

THAT'S CORRECT.
Q. AND, DOCTOR, AS YOU TESTIFIED BEFORE THERE IS A DIFFERENCE IN THE NUMBER OF WOMEN WHO ARE EVALUATED AND THE INTACT GROUP AND IN THE DISMEMBERMENT GROUP, CORRECT?
A. THAT'S RIGHT.
Q. AND THE DISMEMBERMENT GROUP HAD MORE WOMEN IN THAT GROUP BY ABOUT TWO TIMES AS MUCH AS THE DISMEMBERMENT GROUP, RIGHT?
A. THAT'S RIGHT.
Q. IF YOU HAD A STUDY WITH 20 PEOPLE IN ONE GROUP AND ONE PERSON IN THE OTHER GROUP, WHICH I THINK YOU TESTIFIED IN YOUR DEPOSITION, THE STUDY WOULD HAVE LESS POWER THAN A STUDY WITH 10 PEOPLE IN EACH GROUP FOR PURPOSES OF MAKING A COMPARISON; ISN'T THAT RIGHT?
A. IN A SMALL STUDY A RATIO OF 20 TO ONE DOES DEFINITELY LIMIT YOUR ABILITY TO DRAW CONCLUSIONS. I STAND BY MY EARLIER STATEMENT TO THAT EFFECT.
Q. AND THE RATIO OF TWO-TO-ONE DOES, IN FACT, HAVE SOME EFFECT ON THE STUDY; ISN'T THAT TRUE?
A. YES. THIS STUDY HAD 380 PATIENTS. SO IF THERE WERE EXACTLY 190 IN EACH GROUP, THE COMPARISONS WOULD HAVE SLIGHTLY MORE STATISTICAL POWER.
I HAVEN'T DONE THE CALCULATIONS TO FIGURE OUT EXACTLY HOW MUCH THE DIFFERENCE IS, BUT THERE WOULD BE A MODEST BENEFIT IN TERMS OF THE POWER OF STATISTICAL ANALYSIS.
THAT I MUST ADD, THOUGH, THAT THE ADDITIONAL POWER

IS ONLY A BENEFIT TO COMPARE RESULTS WHERE ACTUAL DIFFERENCES HAVE BEEN OBSERVED. WHAT THE AUTHORS HERE ARE MOSTLY REPORTING ON IS THAT THE COMPLICATION RATES WERE THE SAME.

AND WHEN THE COMPLICATION RESULTS ARE THE SAME, CHANGING THE BALANCE OF THE PATIENTS SLIGHTLY OR EVEN INCREASING THE OVERALL SIZE OF THE STUDY TO SOME DEGREE IS NOT GOING TO CHANGE WHAT THEY FOUND.

THE ISSUE OF THAT BALANCE IS IMPORTANT IF THERE IS IN A SMALL STUDY A DIFFERENCE BETWEEN TWO GROUPS. AND IN ORDER TO, IN AN ANALYSIS, IDENTIFY IF DIFFERENCES ARE STATISTICALLY SIGNIFICANT, THEN IT IS USEFUL TO HAVE EITHER A LARGER STUDY OR A STUDY WITH A ONE-TO-ONE BALANCE OF SUBJECTS IN THE TWO GROUPS.

WHICH IS TO SAY THAT I DON'T THINK IN ACTUALITY GIVEN THE RESULTS THEY OBTAINED IN THE STUDY THAT WE ARE LOOKING AT RIGHT HERE THAT THE TWO-TO-ONE IMBALANCE IS A STATISTICAL DRAWBACK.

Q. BUT YOU THINK THAT THERE WOULD BE SOME -- IF I UNDERSTOOD YOUR TESTIMONY, THERE IS SOME STATISTICAL SIGNIFICANCE BECAUSE OF THE FACT THAT THERE IS THE RATIO OF TWO-TO-ONE, ISN'T THERE?

A. STATISTICAL SIGNIFICANCE IS A TERM THAT IS CONVENTIONALLY USED IN A SETTING OF HYPOTHESIS TESTING TO DESCRIBE THE PROBABILITY THAT AN OBSERVED RESULT COULD HAVE OCCURRED BY CHANCE.

AND SO THAT IS ACTUALLY NOT RELEVANT TO THE

PARTICULAR OUTCOMES AND THE PARTICULAR FREQUENCIES THAT THEY ARE REPORTING HERE.

Q. AND THAT IS BECAUSE YOU THINK THE COMPLICATIONS WERE THE SAME?

A. IF THEY ARE REPORTING 5 PERCENT IN EACH GROUP AND 5 PERCENT IS THE SAME WITH 120 VERSUS 260, 5 PERCENT WILL STILL BE THE SAME IF YOU ARE COMPARING 190 TO 190.

Q. BUT, DOCTOR, YOU WOULDN'T -- ALL THINGS BEING EQUAL, YOU WOULD PREFER TO HAVE TWO GROUPS WITH THE SAME NUMBER OF PARTICIPANTS IN EACH GROUP; ISN'T THAT CORRECT?

A. WELL, BUT ALL THINGS ARE NOT EQUAL HERE. THE STUDY IS ALREADY DONE. IF THIS WAS 190 IN EACH GROUP, IT WOULD NOT CHANGE THEIR RESULTS STATISTICALLY, AND IT WOULD NOT CHANGE MY INTERPRETATION OF THEIR RESULTS.

IF YOU ARE STARTING FROM SCRATCH DESIGNING A STUDY, YOU DON'T KNOW HOW IT IS GOING TO TURN OUT.

Q. IF YOU STARTED FROM SCRATCH AND DOING A RETROSPECTIVE STUDY, YOU WOULD PREFER TO HAVE A STUDY THAT COMPARED 190 TO 190 RATHER THAN 263 TO 120; ISN'T THAT CORRECT?

A. IN A RETROSPECTIVE STUDY, YOU CAN'T ACTUALLY CONTROL HOW MUCH PATIENTS ARE IN EACH GROUP. IT IS NOT POSSIBLE BECAUSE ALL OF THE EVENTS HAVE ALREADY OCCURRED. YOU CAN ONLY CONTROL THE ALLOCATION RATIO OF YOUR PATIENTS IF YOU ARE DOING A PROSPECTIVE STUDY AND STARTING AT THE BEGINNING.

IT IS NOT POSSIBLE TO CONTROL THE ALLOCATION RATIO

IN A RETROSPECTIVE STUDY.

Q. DOCTOR, I WANT TO DIRECT YOUR ATTENTION TO THE LAST PAGE OF THIS ARTICLE, THE FIRST COLUMN, THE FOURTH PARAGRAPH. THE PARAGRAPH THAT BEGINS: "ANOTHER IMPORTANT LIMITATION."

A. YES.

Q. AND THE LAST SENTENCE THERE, WHICH STATES:

"THOUGH WE ARE REASSURED BY THE LOW NUMBER OF COMPLICATIONS IN SUBSEQUENT PREGNANCIES IN BOTH GROUPS, WE ACKNOWLEDGE OUR LACK OF POWER TO CONCLUDE THAT SUBSEQUENT PREGNANCIES -- THAT SUBSEQUENT PREGNANCY OUTCOMES ARE NOT DIFFERENT."

SO, AT LEAST WITH RESPECT TO SUBSEQUENT PREGNANCY OUTCOMES, THE AUTHORS RECOGNIZED THAT IT LACKS SUFFICIENT POWER TO MAKE A CONCLUSION; ISN'T THAT RIGHT?

A. YES, I AGREE.

Q. AND WOULD YOU ALSO AGREE THAT --

MS. CLARK: STRIKE THAT.

BY MS. CLARK:

Q. NOW, DOCTOR, YOU TESTIFIED EARLIER THAT THERE ARE ADVANTAGES OF THE INTACT D&E PROCEDURE BECAUSE IN YOUR OPINION IT IS A SHORTER PROCEDURE; IS THAT CORRECT?

A. YES. IN MY EXPERIENCE, IF THINGS GO SMOOTHLY, THE -- BOTH PROCEDURES ARE FAIRLY SHORT, BUT WHEN THE PROCEDURE IS DIFFICULT IT IS THE DISMEMBERMENT PROCEDURE THAT CAN TAKE A

GREAT DEAL MORE TIME.
Q. AND THE CHASEN STUDY FOUND NO DIFFERENCE BETWEEN THE TIME OF THE PROCEDURE FOR THE WOMEN IN THE INTACT GROUP AND THE WOMEN IN THE DISMEMBERMENT GROUP; ISN'T THAT RIGHT?
A. WELL, I DISAGREE SLIGHTLY WITH THAT CHARACTERIZATION OF THE RESULTS IN TABLE III AT MEDIAN PROCEDURE TIME. SO WHAT THEY FIND IS THAT THE 50TH PERCENTILE IS 22 MINUTES IN EACH GROUP. BUT YOU WILL SEE THAT THEY ALSO GIVE THE RANGE. AND IN THE INTACT GROUP, THE LONGEST PROCEDURE WAS 45 MINUTES. BUT IN THE DISARTICULATION D&E GROUP, THE LONGEST PROCEDURE WAS 60 MINUTES.

IT IS THE LONGEST PROCEDURE WHICH IS REALLY AN INDICATOR OF WHAT IS HAPPENING AND ALSO DIFFICULT PROCEDURE. YOU CAN SEE FOR BOTH TYPES THE SHORTEST PROCEDURES WERE SIX MINUTES. THE MEDIAN PROCEDURE WAS 22 MINUTES. BUT THERE WAS A DIFFERENCE IN THE LONGER PROCEDURE. AND THEY CHOSE TO PRESENT THEIR RESULTS AS A COMPARISON OF MEDIANS, WHICH IS FAIR AND REASONABLE THING TO DO.

BUT WHAT CONCERNS ME WITH TAKING CARE OF PATIENTS IS HOW LONG DOES THE HARDEST PROCEDURE TAKE? AND THAT WAS LONGER IN DISARTICULATION GROUP.
Q. AND, DOCTOR, FOR WHAT MAY BE THE ONE PROCEDURE THAT TOOK THE 45 -- THAT TOOK THE 60 MINUTES, YOU HAVE NO IDEA WHAT THE CIRCUMSTANCES WERE SURROUNDING THAT PATIENT, DO YOU?
A. YOU'RE RIGHT. THEY DID NOT PRESENT THE DATA SURROUNDING

THAT.
Q. AND SO IT IS IMPORTANT -- WHAT IS IMPORTANT TO REPORT IS THE MEDIAN -- IS THE MEDIAN LENGTH OF TIME TO PERFORM THE PROCEDURE; ISN'T THAT CORRECT?
A. I THINK THERE IS REALLY A LEGITIMATE VARIETY OF WAYS TO REPORT OUTCOMES, AND AVERAGES ARE ONE OF THEM. I THINK AVERAGES CAN BE REPORTED AS MEANS OR MEDIANS, FOR INSTANCE.
I THINK IT'S LEGITIMATE TO KNOW HOW LONG ARE THE LONGEST, MOST DIFFICULT PROCEDURES. THERE ARE A VARIETY OF THINGS. THEY CHOSE TO PRESENT ONE. AND THE ONE THEY CHOSE TO PRESENT IS PERFECTLY LEGITIMATE. BUT I WAS INTERESTED IN READING THIS AT LOOKING AT HOW LONG THE LONGEST PROCEDURES TOOK.
Q. AND YOU ALSO TESTIFIED THAT THERE ARE ADVANTAGES OF THE INTACT D&E PROCEDURE, AND THAT IT HELPS MINIMIZE BLOOD LOSS, CORRECT?
A. YES, I DID.
Q. AND YOU TESTIFIED EARLIER, THE CHASEN STUDY FOUND NO DIFFERENCE IN THE BLOOD LOSS BETWEEN THE WOMAN IN THE INTACT GROUP AND THE WOMAN IN THE DISMEMBERMENT GROUP, RIGHT?
A. YES. SIMILARITY, AGAIN, IN TABLE III, THEY REPORTED THE MEDIANS. AND THE MEDIANS ARE EXACTLY THE SAME. AND FOR BOTH CASES THE RANGES ARE A LITTLE DIFFERENT WITH THE INTACT GROUP HAVING A RANGE FROM 20 TO 1200 CC'S OF BLOOD, AND THE DISARTICULATION GROUP HAVING A RANGE FROM 40 TO

1500 MILLILITERS OF BLOOD.

SO THE DISARTICULATION GROUP, ALSO, THE WORST PATIENT HAD 300 ML'S MORE OF BLOOD LOSS OR ONE UNIT ADDITIONAL BLOOD LOSS COMPARED TO THE INTACT GROUP.

Q. BUT --

A. AND I THINK IT IS FAIR TO PRESENT THIS IN THE WAY THAT THEY HAVE PRESENTED IT, BUT BY PROVIDING THE RANGE THEY, YOU KNOW, ALLOW ME TO EVALUATE THAT OUTCOME, AS WELL.

Q. BUT, IN ANY EVENT, THE MEDIAN ESTIMATED BLOOD LOSS IN BOTH GROUPS WAS 100 MILLILITERS?

A. YES, IT WAS.

Q. OKAY. AND YOU TESTIFIED THAT YOU DO NOT BELIEVE THAT THE INTACT PROCEDURE WOULD LEAD TO A HIGHER RATE OF PRE-TERM BIRTHS, RIGHT?

A. YES, I DID.

Q. AND, IN FACT, THE STUDY ACTUALLY FOUND A HIGHER RATE OF PRE-TERM BIRTHS IN THE INTACT GROUP AS COMPARED TO THE D&E GROUP?

A. YES, THEY DID. AS THEY POINT OUT IN THE TEXT THE INTACT GROUP EXPERIENCES HAD TWO PRE-TERM BIRTHS OUT OF THE 17 SUBSEQUENT BIRTHS. AND THE OTHER GROUP EXPERIENCED TWO PRE-TERM BIRTHS IN 45 SUBSEQUENT BIRTHS.

THEY GO ON TO POINT OUT IN THE TEXT THAT BOTH OF THE PRE-TERM BIRTHS IN THE INTACT GROUP OCCURRED IN WOMEN WHO HAD PREEXISTING RISK OF PREMATURITY, WHICH IS TO SAY PREEXISTING

RISK PRIOR TO THE INTACT D&E.

SO I THINK THAT SPEAKS FOR ITSELF.

Q. I APPRECIATE THAT, BUT THE STUDY DID, IN FACT, FIND A HIGHER RATE OF PRE-TERM BIRTHS IN THE INTACT D&X GROUP AS COMPARED TO THE D&E GROUP; ISN'T THAT RIGHT.

A. THEY FOUND TWO OUT OF 17 COMPARED TO TWO OUT OF 45, YES.

MS. CLARK: NO FURTHER QUESTIONS.

THE COURT: ALL RIGHT. THANK YOU.

DO YOU HAVE ANYTHING FURTHER?

MS. GARTNER: JUST A FEW MORE, YOUR HONOR.

THE COURT: ALL RIGHT.

REDIRECT EXAMINATION

BY MS. GARTNER:

Q. DR. WESTHOFF, IF YOU HAVE YOUR BOOK CHAPTER HANDY, IF YOU CAN TURN BACK TO PAGE 68, AND LOOK AT IN THE SAME COLUMN WITH WHICH YOU WERE READING WITH MS. CLARK, THE PARAGRAPH, THE FOURTH ONE DOWN, THAT STARTS "IN PATIENTS."

DO YOU SEE WHERE I AM?

A. YES.

Q. CAN YOU JUST READ THE FIRST SENTENCE OF THAT PARAGRAPH?

A. "IN PATIENTS WITH SERIOUS MEDICAL PROBLEMS, SURGICAL ABORTION WITH MONITORED ANESTHESIA CARE IS OFTEN PREFERABLE TO LABOR INDUCTION METHODS."

Q. IS THAT YOUR OPINION?

A. YES, IT IS.

Q. AND I THINK YOU TESTIFIED IN ANSWER TO ONE OF MS. CLARK'S QUESTIONS THAT IN YOUR OPINION INTACT D&E WOULD BE ESPECIALLY BENEFICIAL FOR WOMEN WITH MATERNAL HEALTH CONDITIONS; IS THAT CORRECT?

A. YES, I THINK SO.

Q. CAN YOU EXPLAIN WHY THAT IS?

A. WELL, IF A WOMAN HAS A SERIOUS MEDICAL PROBLEM AT THE TIME SHE BEGINS HER CARE, SHE IS -- WILL BE VULNERABLE. AND IF THAT WOMAN EXPERIENCES A COMPLICATION, THAT COMPLICATION IN HER CASE MAY BE CATASTROPHIC COMPARED TO A WOMAN WHO GOES TO HAVE A D&E WITHOUT PREEXISTING MEDICAL PROBLEMS.

AND IT IS SIMPLY THAT, FOR INSTANCE, A PERFORATION OR LACERATION OR HEAVY BLEEDING WILL REQUIRE ADDITIONAL INTERVENTIONS. AND THE WOMAN WHO STARTS THE CASE WITH MEDICAL PROBLEMS SIMPLY DOESN'T HAVE THE STABLE CONDITION AND PHYSIOLOGIC RESERVE TO COPE WITH THE COMPLICATION. SO AVOIDING MAJOR COMPLICATIONS IS PARTICULARLY IMPORTANT FOR THAT WOMAN'S HEALTH.

Q. AND DR. WESTHOFF, THERE HAS BEEN A LOT OF DISCUSSION ABOUT THE RISK -- THE POSSIBLE CONNECTION BETWEEN INTACT D&E AND THE RISK OF CERVICAL INCOMPETENCE IN FUTURE PREGNANCIES.

AND WHAT I WANTED TO ASK YOU IS IF IT TURNED OUT BASED ON FUTURE STUDIES OR FUTURE RESEARCH THAT THERE WAS SOME SLIGHT RISK, INCREASED RISK OF CERVICAL INCOMPETENCE AS A RESULT OF HAVING AN INTACT D&E, WOULD THAT BE OF MEDICAL

CONCERN TO WOMEN WHO DON'T PLAN TO HAVE ANOTHER PREGNANCY?
A. I THINK THAT WOULD BE -- THE CONCERN ABOUT THAT WOULD BE LIMITED TO WOMEN WHO ARE INTENDING TO HAVE FUTURE PREGNANCIES AFTER THE D&E.
Q. AND SIMILARLY -- MAYBE SIMILARLY -- IF IT TURNED OUT UPON FUTURE STUDY THAT INTACT D&E POSED SOME RISKS TO MATERNAL HEALTH, SUCH AS POTENTIALLY CERVICAL INCOMPETENCE, IN YOUR OPINION WOULD THOSE RISKS BE REDUCED IN ANY WAY IF FETAL DEMISE WERE INDUCED BEFORE THE EVACUATION PART OF THE ABORTION BEGAN?
A. IF SUCH RISKS TURNED OUT TO EXIST, INDUCING FETAL DEMISE PRIOR TO THE D&E WOULD NOT MITIGATE THOSE RISKS.
MS. GARTNER: THANK YOU.
I HAVE NO FURTHER QUESTIONS, YOUR HONOR.
THE COURT: ALL RIGHT. ANY FURTHER RECROSS?
MS. CLARK: NOTHING FURTHER.
THE COURT: THANK YOU, DOCTOR. YOU ARE EXCUSED.
ALL RIGHT. ARE THERE OTHER THINGS WE NEED TO TALK ABOUT BEFORE WE ADJOURN FOR THE DAY? YOU HAD RAISED ONE QUESTION, AND I SAID TO PUT IT OFF. WHAT WAS THAT?
MS. CLARK: THAT WAS I WOULD LIKE TO MOVE TO STRIKE THE TESTIMONY ABOUT THE INJECTION OF THE CHEMICAL AGENT ON THE BASIS THAT THE DEFENDANT HADN'T BEEN PUT ON NOTICE ABOUT THAT, AND SHE DIDN'T TESTIFY ABOUT IT IN HER DEPOSITION. IT IS NOT IN THE EXPERT REPORT. AND SO I MOVE TO STRIKE THOSE PORTIONS OF HER TESTIMONY.

THE COURT: OKAY.

MS. GARTNER: YOUR HONOR, WE WOULD REQUEST THE OPPORTUNITY TO LOOK AT THAT AND ADVISE YOUR HONOR THURSDAY MORNING ABOUT WHAT WE FOUND.

THE COURT: ALL RIGHT.

MS. GARTNER: THANK YOU.

THE COURT: WE ARE ADJOURNED, THEN, UNTIL THURSDAY MORNING.

THE DEFENSE WILL BE PREPARED WITH THEIR FIRST WITNESS ON THURSDAY MORNING?

MR. QUINLIVAN: YES, WE WILL, YOUR HONOR.

THE COURT: ALL RIGHT. WE WILL SEE YOU THEN.

(THEREUPON, AT 1:20 P.M. COURT WAS RECESSED UNTIL THURSDAY, APRIL 8, 2004, AT 8:30 O'CLOCK A.M.)

I N D E X