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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE PHYLLIS J. HAMILTON, JUDGE

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE,	)	
PLAINTIFFS,	)	
VS.	)	NO. C 03-4872 PJH
JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY,	)	THURSDAY, APRIL 8, 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 FEDERATIONF 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

APRIL 8, 2004 8:30 O'CLOCK A.M.

P R O C E E D I N G S

THE COURT: ALL RIGHT. GOOD MORNING.

ARE YOU READY WITH YOUR FIRST WITNESS?

MR. QUINLIVAN: WE ARE, YOUR HONOR.

MS. PARKER: WE HAVE TWO SMALL -- OTHER THAN DR. CLARK (SIC), WE HAVE CONCLUDED OUR CASE, YOUR HONOR.

HERE'S OUR OPPOSITION.

THE COURT: DR. CHASEN.

MS. PARKER: YOU'RE RIGHT, DR. CHASEN.

(LAUGHTER)

MS. PARKER: HERE IS OUR OPPOSITION TO DEFENDANT'S MOTION TO STRIKE.

AND THE SECOND WAS AT THE TIME OF THE PRETRIAL CONFERENCE, YOUR HONOR, YOU AND WE DISCUSSED SUBMITTING MR. KIM'S DEPOSITION TRANSCRIPT. WE TALKED ABOUT DOING A STIPULATION WITH THE GOVERNMENT IN LIEU OF SUBMITTING HIS TRANSCRIPT.

WE WERE UNABLE TO REACH AGREEMENT WITH THE GOVERNMENT ON ANY STIPULATION, AND THEN WE SUBMITTED WITH THE OTHER DEPOSITION TRANSCRIPTS MR. KIM'S. WE WANT TO MAKE SURE THERE IS NO OBJECTION TO THAT.

THE COURT: ALL RIGHT. I RECEIVED THAT. I THINK YOU EXPLAINED THAT IN A COVER LETTER.

MS. PARKER: WE DID. WE WANTED TO MAKE SURE THERE WAS NO PROBLEM WITH IT.

THE COURT: I URGED YOU TO REACH A STIPULATION. I THOUGHT THAT WAS PREFERABLE. SINCE YOU WEREN'T ABLE TO, WE HAVE LOOKED AT THE DEPOSITION.

MS. PARKER: ALL RIGHT. THANK YOU.

THE COURT: WITH REGARD TO THE TWO MATTERS EACH ONE OF YOU WANTED TO BRIEF A MATTER. I AM NOT SURE WE GOT YOUR OPPOSITION, EITHER. DID YOU FILE THAT LAST NIGHT?

MR. SIMPSON: YES, YOUR HONOR, WE DID.

THE COURT: YOU DID. WE HAVEN'T SEEN IT YET. SO I WILL GIVE YOU A RULING ON IT TOMORROW.

ALL RIGHT. ANYTHING ELSE?

ALL RIGHT. CALL YOUR FIRST WITNESS.

MR. QUINLIVAN: THANK YOU, YOUR HONOR. DEFENDANT CALLS DR. WATSON BOWES TO THE STAND.

THE CLERK: PLEASE RAISE YOUR RIGHT HAND.

DR. WATSON A. BOWES, JR.

CALLED AS A WITNESS FOR THE DEFENDANT, HAVING BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

THE WITNESS: I DO.

THE CLERK: PLEASE TAKE THE STAND.

PLEASE STATE YOUR NAME FOR THE COURT?

THE WITNESS: MY NAME IS WATSON A. BOWES, JUNIOR.

THE CLERK: SPELL YOUR LAST NAME.

THE WITNESS: B-O-W-E-S.

THE CLERK: THANK YOU.

DIRECT EXAMINATION

BY MR. QUINLIVAN:

Q. GOOD MORNING, DR. BOWES. WELCOME.

A. THANK YOU. GOOD MORNING.

Q. DR. BOWES, ARE YOU AFFILIATED WITH ANY ACADEMIC INSTITUTIONS?

A. YES, I AM. I AM EMERITUS PROFESSOR OF OBSTETRICS AND GYNECOLOGY AT THE UNIVERSITY OF NORTH CAROLINA IN CHAPEL HILL.

Q. CAN YOU TELL US WHAT THAT MEANS TO BE AN EMERITUS PROFESSOR?

A. IT ESSENTIALLY MEANS I HAVE RETIRED FROM MY CLINICAL PRACTICE, ALTHOUGH I STILL HAVE SOME OTHER RESPONSIBILITIES ON THE FACULTY.

Q. DOCTOR, ARE YOU LICENSED TO PRACTICE MEDICINE?

A. I AM.

Q. IN WHAT STATE OR STATES?

A. I AM LICENSED TO PRACTICE IN NORTH CAROLINA. I WAS PREVIOUSLY LICENSED TO PRACTICE IN COLORADO, AS WELL, BUT THAT LICENSE IS NOW INACTIVE.

Q. DOCTOR, ARE YOU BOARD CERTIFIED IN ANY FIELDS?

A. YES, I AM BOARD CERTIFIED IN OBSTETRICS AND GYNECOLOGY AND ALSO IN THE SUBSPECIALTY OF MATERNAL FETAL MEDICINE.

Q. CAN YOU BRIEFLY EXPLAIN WHAT THE SUBSPECIALTY OF MATERNAL

FETAL MEDICINE IS?

A. THE SUBSPECIALTY OF MATERNAL FETAL MEDICINE IS -- DEALS LARGELY WITH PROBLEMS OF FETAL DIAGNOSIS, FETAL THERAPY, IN OTHER ASPECTS AS HIGH RISK PREGNANCIES.

MR. QUINLIVAN: YOUR HONOR, MAY I APPROACH THE WITNESS?

THE COURT: YES.

BY MR. QUINLIVAN:

Q. DOCTOR, I AM SHOWING YOU WHAT HAS BEEN MARKED AS DEFENDANT'S EXHIBIT A-2, AND I WOULD LIKE YOU TO IDENTIFY THAT, PLEASE.

A. THIS IS MY CURRICULUM VITAE.

Q. DID YOU PREPARE IT?

A. YES, I DID.

Q. IS IT CURRENT?

A. YES, IT IS.

Q. IS THERE ANYTHING IN YOUR CURRICULUM VITAE THAT IS INACCURATE?

A. NOT TO MY KNOWLEDGE.

MR. QUINLIVAN: YOUR HONOR, AT THIS TIME I MOVE THE ADMISSION OF DEFENDANT'S EXHIBIT A-2.

THE COURT: ANY OBJECTION?

MS. KRASNOFF: NO OBJECTION, YOUR HONOR.

THE COURT: ADMITTED.

THE CLERK: A-2 INTO EVIDENCE.

(DEFENDANT'S EXHIBIT A-2
WAS RECEIVED IN EVIDENCE.)

BY MR. QUINLIVAN:

Q. DOCTOR, I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR PROFESSIONAL BACKGROUND. WHEN DID YOU RECEIVE YOUR MEDICAL DEGREE?

A. 1959.

Q. AND FOLLOWING MEDICAL SCHOOL, CAN YOU BRIEFLY SUMMARIZE YOUR POST-GRADUATE EDUCATION?

A. FOLLOWING MY GRADUATION FROM MEDICAL SCHOOL, I HAD AN INTERNSHIP AT THE MARY HITCHCOCK HOSPITAL IN HANOVER, NEW HAMPSHIRE, WHICH IS AFFILIATED WITH DARTMOUTH'S MEDICAL SCHOOL.

THEN, I HAD A ONE-YEAR RESIDENCY IN GENERAL PRACTICE AT THE UNIVERSITY OF COLORADO MEDICAL CENTER IN DENVER. THIS WAS FOLLOWED BY A ONE-YEAR FELLOWSHIP IN FETAL PHYSIOLOGY AT THE SAME INSTITUTION.

THEREAFTER, I SPENT THREE YEARS AS A RESIDENT IN OBSTETRICS AND GYNECOLOGY AT THE UNIVERSITY OF COLORADO MEDICAL CENTER IN DENVER. AND THAT COMPLETED MY FORMAL TRAINING.

Q. FOLLOWING YOUR POST-GRADUATE EDUCATION, DID YOU HAVE OCCASION TO PRACTICE IN THE FIELD OF OBSTETRICS AND GYNECOLOGY?

A. YES, I DID. FROM 1965 UNTIL 1967 I WAS IN A PRIVATE PRACTICE OF OBSTETRICS AND GYNECOLOGY IN DENVER, COLORADO, AND AT THE SAME TIME WAS A PART-TIME FACULTY MEMBER AT THE UNIVERSITY OF COLORADO MEDICAL CENTER.

Q. WHAT WERE YOUR RESPONSIBILITIES AS A PART-TIME FACULTY MEMBER AT THE UNIVERSITY OF COLORADO?
A. I WAS A MEMBER OF THE DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, AND MY PRIMARY RESPONSIBILITIES WERE IN THE TEACHING OF MEDICAL STUDENTS, AND DEVELOPING MEDICAL STUDENT CURRICULUM FOR OBSTETRICS AND GYNECOLOGY AND TEACHING RESIDENTS THAT WERE IN OBSTETRICS AND GYNECOLOGY.
Q. DOCTOR, FOLLOWING PRIVATE PRACTICE, YOU THEN JOINED THE MILITARY?
A. WELL, YES. I WAS INVITED TO PARTICIPATE IN 1967. I SPENT TWO YEARS IN THE U.S. ARMY MEDICAL CORPS DURING THOSE TWO YEARS, AND WAS STATIONED AT MADIGAN GENERAL HOSPITAL IN TACOMA, WASHINGTON.
Q. WHAT WERE YOUR RESPONSIBILITIES AT MADIGAN GENERAL HOSPITAL IN TACOMA, WASHINGTON?
A. FOR MOST OF THE TIME I WAS ASSIGNED TO THE OB/GYN SERVICE. AT THAT TIME IT WAS A LARGE TEACHING SERVICE WITH RESIDENTS, AND MY RESPONSIBILITIES WERE TO SUPERVISE AND TEACH RESIDENTS AT THAT SERVICE.
ANOTHER PORTION OF THE TIME I WAS ACTUALLY ASSIGNED TO SERVICES AS A GENERAL MEDICAL OFFICER.
Q. DOCTOR, WHAT WAS YOUR RANK DURING YOUR TENURE OR YOUR TIME IN THE U.S. MEDICAL CORPS?
A. WHEN I ENTERED THE MEDICAL CORPS, I WAS A CAPTAIN. AND WHEN I LEFT THE MEDICAL CORPS I WAS A MAJOR.

Q. WERE YOU HONORABLY DISCHARGED?
A. YES, I WAS.
Q. DOCTOR, FOLLOWING YOUR MILITARY SERVICE, DID YOU THEN CONTINUE YOUR CAREER IN ACADEMIA?
A. YES, I RETURNED TO DENVER, COLORADO, WHERE I WAS A FULL-TIME -- APPOINTED TO THE FULL-TIME FACULTY AT THE UNIVERSITY OF COLORADO MEDICAL CENTER IN THE DEPARTMENT OF OBSTETRICS AND GYNECOLOGY.
Q. AND WHAT POSITIONS OR ACADEMIC TITLES DID YOU HAVE WHILE AT THE UNIVERSITY OF COLORADO?
A. I WAS INITIALLY AN ASSISTANT PROFESSOR AND WAS PROMOTED OVER THE YEARS THERE TO ASSOCIATE PROFESSOR, AND FINALLY TO A FULL PROFESSOR IN THE DEPARTMENT.
Q. AND CAN YOU GIVE US A BRIEF DESCRIPTION OF YOUR RESPONSIBILITIES WHILE A FACULTY MEMBER AT THE UNIVERSITY OF COLORADO?
A. MY RESPONSIBILITIES INCLUDED THREE AREAS. ONE WAS THE TEACHING AND SUPERVISION OF MEDICAL STUDENTS, RESIDENTS AND FELLOWS IN OBSTETRICS AND GYNECOLOGY.

I WAS ALSO INVOLVED IN DOING RESEARCH, SUPERVISING RESEARCH, HELPING RESIDENTS AND FELLOWS DEVELOP RESEARCH PROTOCOLS AND SO FORTH.

AND I WAS ALSO A MEMBER OF THE GROUP PRACTICE OF FACULTY MEMBERS AT THE UNIVERSITY OF COLORADO WHICH WE OFFERED OR PROVIDED CARE FOR PATIENTS IN THAT PRACTICE.

Q. DOCTOR, YOU MENTIONED YOUR RESEARCH RESPONSIBILITIES OR ACTIVITIES. DID YOU FOCUS ON ANY PARTICULAR AREA OF RESEARCH WHILE AT THE UNIVERSITY OF COLORADO?

A. MY MAJOR AREA OF RESEARCH AT THE UNIVERSITY OF COLORADO WAS THE TREATMENT OF A DISEASE CALLED ERYTHROBLASTOSIS. THAT'S THE RH FACTOR AND ITS EFFECT ON FETUSES, RH INCOMPATABILITY BETWEEN MOTHERS AND BABIES. AND WE DEVELOPED THE FETAL TRANSFUSION TECHNIQUES FOR THAT DISEASE.

Q. DOCTOR, DID YOU HAVE OCCASION TO LEAVE THE UNIVERSITY OF COLORADO AT SOME POINT?

A. IN 1982, I JOINED THE FACULTY AT THE UNIVERSITY OF NORTH CAROLINA WHERE I HAVE BEEN SINCE THAT TIME.

Q. AND WHAT POSITIONS OR TITLES DID YOU HOLD WHILE AT THE UNIVERSITY OF NORTH CAROLINA?

A. WELL, THROUGHOUT MY TIME ON THE ACTIVE FACULTY THERE, I WAS A FULL PROFESSOR.

Q. AND CAN YOU BRIEFLY DESCRIBE YOUR RESPONSIBILITIES AS A MEMBER OF THE FACULTY AT THE UNIVERSITY OF NORTH CAROLINA?

A. WELL, MY RESPONSIBILITIES AT THE UNIVERSITY OF NORTH CAROLINA WERE QUITE SIMILAR TO THOSE AT THE UNIVERSITY OF COLORADO. I SUPERVISED OBSTETRICAL AND GYNECOLOGICAL RESIDENTS. I HELPED IN THE EDUCATION OF THE MEDICAL STUDENTS.

I WAS ACTIVE IN DEVELOPING RESEARCH PROTOCOLS AND PERFORMING RESEARCH, CLINICAL RESEARCH. AND I ALSO PARTICIPATED IN THE GROUP PRACTICE AMONG THE FACULTY MEMBERS

THAT PROVIDED CARE TO PATIENTS.
Q. DOCTOR, SIMILAR TO MY QUESTION ABOUT YOUR RESEARCH INTERESTS AT THE UNIVERSITY OF COLORADO, DID YOU FOCUS ON ANY PARTICULAR AREA OF RESEARCH WHILE AT THE UNIVERSITY OF NORTH CAROLINA?
A. WE WERE -- I PARTICIPATED IN THE FETAL THERAPY THAT WAS GOING ON AT THE TIME, INCLUDING THE TREATMENT OF RH DISEASE AND OTHER FETAL CONDITIONS AND ALSO WAS INVOLVED IN OTHER RESEARCH ON HIGH-RISK PREGNANCIES. THESE ARE PREGNANCIES WHICH INVOLVE MEDICAL DISEASES DURING PREGNANCIES, DIABETES AND SO FORTH.
Q. DOCTOR, DID YOU SERVE IS A MEMBER OF ANY REVIEW COMMITTEES WHILE AT THE UNIVERSITY OF NORTH CAROLINA?
A. YES. IN 1984, THE MEDICAL SCHOOL ESTABLISHED THE INFANT -- IT WAS ACTUALLY THE HOSPITAL CONNECTED WITH THE MEDICAL SCHOOL -- ESTABLISHED AN INFANT CARE REVIEW COMMITTEE. AND I WAS CHAIRMAN OF THAT COMMITTEE FROM 1984 UNTIL APPROXIMATELY 1995, WHEN THAT COMMITTEE WAS ABSORBED INTO A LARGER ETHICS COMMITTEE OF THE HOSPITAL.
Q. AND WHAT WAS THE INFANT CARE REVIEW COMMITTEE?
A. THE INFANT CARE REVIEW COMMITTEE HAD THE RESPONSIBILITY OF REVIEWING ALL CASES IN WHICH MEDICAL CARE WAS EITHER WITHHELD OR WITHDRAWN FROM A CRITICALLY-ILL INFANT.
Q. AND WHAT WERE YOUR RESPONSIBILITIES AS CHAIRMAN OF THAT COMMITTEE?
A. WE SUPERVISED -- I SUPERVISED AND LED THE DISCUSSIONS AT

THE MEETINGS IN WHICH THESE CASES WERE PRESENTED, INVITING THE INTERESTED PARTIES WHO COULD CONTRIBUTE TO THE CONVERSATION AND OVERSAW THE DELIBERATIONS OF THE COMMITTEE IN MAKING SOME DECISIONS ABOUT THOSE CASES.

Q. DOCTOR, YOU MENTIONED YOU ARE NOW RETIRED?

A. YES.

Q. DO YOU CURRENTLY SEE PATIENTS?

A. I DO NOT SEE PATIENTS CLINICALLY, NO, I DO NOT.

Q. AND WHEN WAS THE LAST TIME THAT YOU CLINICALLY SAW PATIENTS?

A. 1999.

Q. DO YOU STILL MAINTAIN AN ACTIVE ASSOCIATION WITH THE UNIVERSITY OF NORTH CAROLINA?

A. YES, I HAVE. I AM A MEMBER AND HAVE BEEN A MEMBER OF WHAT IS CALLED THE INSTITUTIONAL REVIEW BOARD. AND THAT IS THE COMMITTEE THAT OVERSEES OR REVIEWS RESEARCH PROTOCOLS THAT ARE SUBMITTED FOR APPROVAL BEFORE THOSE RESEARCH STUDIES ARE CONDUCTED.

Q. AND HOW LONG HAVE YOU BEEN A MEMBER OF THE INSTITUTIONAL REVIEW BOARD?

A. LITTLE OVER FIVE YEARS.

Q. AND OUTSIDE OF THE INSTITUTIONAL REVIEW BOARD, DO YOU HAVE ANY OTHER DUTIES OR RESPONSIBILITIES AS AN EMERITUS PROFESSOR?

A. I PARTICIPATE IN TEACHING CONFERENCES AND HAVE SMALL SEMINARS WITH THE OB/GYN RESIDENTS FROM TIME TO TIME.

Q. DOCTOR, OVER THE COURSE OF YOUR PROFESSIONAL CAREER, HAVE YOU HAD OCCASION TO BECOME FAMILIAR WITH THE MEDICAL TECHNIQUES TO PERFORM ABORTIONS?

A. YES I HAVE.

Q. CAN YOU DESCRIBE FOR THE COURT HOW YOU HAVE BECOME FAMILIAR WITH THOSE PROCEDURES?

A. I HAVE BEEN -- DURING MY RESIDENCY EDUCATION, WE WERE TAUGHT PROCEDURES THAT WERE INVOLVED IN COMPLETING WHAT WERE CALLED "INCOMPLETE SPONTANEOUS ABORTIONS" OR MISSED ABORTIONS. THIS IS WHERE THE FETUS DIES EARLY IN PREGNANCY. ALSO WE HAD PREGNANCY TERMINATIONS FOR FETAL DEATHS. AND ALSO DURING THAT TIME THERE WERE INDUCED ABORTIONS FOR MEDICAL COMPLICATIONS, MEDICAL OR PSYCHIATRIC COMPLICATIONS IN PREGNANCY.

Q. CAN YOU TELL US WHAT PARTICULAR TECHNIQUES OF ABORTION YOU WERE TAUGHT?

A. I WAS TAUGHT AT THAT TIME THREE TECHNIQUES: THE TECHNIQUE OF DILATATION CURETTAGE FOR EARLY ABORTIONS, LATER THE SUCTION CURETTAGE WAS INTRODUCED AS A TECHNIQUE THAT WAS USED. AND FOR SECOND-TRIMESTER ABORTIONS AT THAT TIME WE WERE DOING LABOR INDUCTION-TYPE OF ABORTIONS.

Q. AND HAVE YOU SUBSEQUENT OR SUBSEQUENT TO YOUR RESIDENCY DID YOU BECOME FAMILIAR WITH OTHER METHODS OF ABORTION?

A. YES, LATER -- AND THIS WAS WHEN I WAS AT THE UNIVERSITY OF NORTH CAROLINA -- THE D&E PROCEDURE HAD BEEN DEVELOPED AS AN ALTERNATIVE TO THE LABOR INDUCTION ABORTIONS IN THE

SECOND-TRIMESTER.

Q. CAN YOU TELL US WHAT A "D&E" MEANS?

A. D&E, IT'S -- THOSE TERMS MEAN DILATATION AND EVACUATION. DILATATION OF THE CERVIX, DILATING THE CERVIX OF THE UTERUS AND THEN EVACUATING THE CONTENTS OF THE UTERUS WITH EITHER INSTRUMENTS OR SUCTION DEVICES.

Q. DOCTOR, CAN YOU ESTIMATE HOW MANY ABORTION PROCEDURES YOU HAVE PERFORMED DURING YOUR CAREER?

A. WELL, IF WE CAN SEPARATE THOSE INTO THOSE PROCEDURES WE WERE COMPLETING PREGNANCIES WHICH A FETAL DEATH OR EARLY SPONTANEOUS DEATH OF A FETUS HAD OCCURRED, IN THE SECOND-TRIMESTER PROBABLY 150 OF THOSE PROCEDURES. OF PROCEDURES WHICH WERE DONE EARLIER IN PREGNANCY, MANY MORE THAN THAT, BECAUSE THAT IS A MUCH MORE COMMON COMPLICATION, SO I CAN'T GIVE YOU AN EXACT FIGURE.

FOR INDUCED ABORTIONS, ABORTIONS IN WHICH ABORTION WAS PERFORMED WITH A LIVING FETUS, FAR FEWER. MAYBE FIVE TO 10. I DON'T KNOW THE EXACT NUMBER, BUT IT IS A SMALL NUMBER DURING MY TIME AT THE UNIVERSITY OF NORTH CAROLINA IN WHICH THE PROCEDURES WERE PERFORMED. AND PROBABLY 10 OR 15 AT THE UNIVERSITY OF COLORADO.

Q. DOCTOR, YOU MENTIONED ONLY A SMALL NUMBER OF INDUCED ABORTIONS. DO YOU HAVE A PHILOSOPHICAL OR ETHICAL POSITION REGARDING THE CIRCUMSTANCES IN WHICH YOU WILL PERFORM ABORTIONS?

A. YES, I DO.
Q. CAN YOU TELL US WHAT THAT IS?
A. I BELIEVE THAT INDUCED ABORTIONS ARE INDICATED ONLY WHEN THERE ARE MEDICAL COMPLICATIONS THAT ARE A SERIOUS THREAT TO THE MOTHER'S LIFE.
Q. NOW, DOCTOR, HAVE YOU HAD OCCASIONS IN YOUR PRACTICE IN WHICH ONE OF YOUR PATIENTS CHOSE TO TERMINATE HER PREGNANCY FOR A CONDITION OTHER THAN ONE WHICH WOULD PUT HER LIFE AT RISK?
A. YES.
Q. WHAT WOULD YOU DO IN THOSE CIRCUMSTANCES?
A. IN THOSE CIRCUMSTANCES I'VE ALWAYS RECOMMENDED THE PATIENT SEE ONE OF MY COLLEAGUES WHO HAS DIFFERENT FEELINGS ABOUT ABORTION THAN I DO.

ALMOST ALL MY PATIENTS ARE WELL-AWARE OF MY FEELINGS ABOUT THIS. BUT I RECOMMEND THAT THEY GET CARE FROM ONE OF MY OTHER COLLEAGUES.

Q. DOCTOR, HAVE YOU EVER ADDRESSED THE ETHICAL OBLIGATIONS OF A PRO-LIFE OBSTETRICIAN AND GYNECOLOGIST IN ANY PUBLISHED WORK?
A. YES, A NUMBER OF YEARS AGO OR SEVERAL YEARS AGO, TWO OF MY COLLEAGUES AND I WROTE AN ARTICLE THAT WAS PUBLISHED IN THE NEW ENGLAND JOURNAL OF MEDICINE THAT WAS IN RESPONSE TO AN ARTICLE THAT HAD APPEARED SUGGESTING THAT A DOCTOR WHO WOULD NOT DO ABORTIONS SHOULD NOT BE A MATERNAL FETAL MEDICINE SPECIALIST. AND WE WERE SIMPLY RESPONDING TO THAT ASSERTION.
Q. DOCTOR, ARE YOU A MEMBER OF ANY PROFESSIONAL ASSOCIATIONS?

A. I AM A MEMBER OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AND THE SOCIETY FOR MATERNAL FETAL MEDICINE.
Q. IS THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS OFTENTIMES REFERRED BY THE ACRONYM ACOG?
A. YES, IT IS.
Q. HAVE YOU SEVERED IN ANY SPECIAL CAPACITY WITH ACOG?
A. YES. FOR FIVE YEARS I WAS A MEMBER OF THE ACOG'S COMMITTEE ON ETHICS. AND FOR THREE OF THOSE YEARS I CHAIRED THAT COMMITTEE.
Q. AND WHAT WERE YOUR RESPONSIBILITIES AS CHAIRMAN OF THAT COMMITTEE?
A. MY RESPONSIBILITY WAS TO ORGANIZE AND LEAD THE DISCUSSIONS OF THAT COMMITTEE THAT DEALT WITH VARIOUS ETHICAL ISSUES IN OBSTETRICS AND GYNECOLOGY, AND PREPARE WRITTEN REPORTS THAT WOULD THEN BE DISSEMINATED TO THE FELLOWSHIP OR THE MEMBERSHIP OF ACOG ON THOSE VARIOUS TOPICS.
Q. DOCTOR, ARE YOU --
THE COURT: EXCUSE ME.
MR. QUINLIVAN: YES.
THE COURT: I JUST WANT TO CLARIFY SOMETHING THE DOCTOR SAID.
YOU INDICATED THAT OF THE FIVE TO 10 INDUCED ABORTIONS THAT YOU HAVE PERFORMED, THAT THOSE WERE INDICATED BECAUSE OF MEDICAL PROBLEMS OR CONDITIONS OF THE MOTHERS, CORRECT?

THE WITNESS: YES, MA'AM. THESE ARE THE ONES AT THE UNIVERSITY OF NORTH CAROLINA.

THE COURT: OKAY. AND OF THE 150 OR SO OTHER PROCEDURES, I AM ASSUMING WE ARE REFERRING TO D&E'S; IS THAT CORRECT?

THE WITNESS: NO, MA'AM. SOME WOULD BE D&E'S. BUT SOME WERE ALSO PROCEDURES DONE BY THE LABOR INDUCTION METHODS. AND THOSE WERE PROCEDURES I WAS REFERRING TO IN WHICH THE FETUS HAD DIED. THESE WERE DONE TO COMPLETE A PREGNANCY WHEN A FETAL DEATH OCCURRED.

THE COURT: ALL 150 OF THOSE?

THE WITNESS: YES.

THE COURT: OKAY. ALL RIGHT. THANK YOU.

BY MR. QUINLIVAN:

Q. DOCTOR, JUST TO CLARIFY ONE POINT, YOU HAD MENTIONED FIVE TO 10 OCCASIONS IN WHICH YOU PERFORMED AN ABORTION IN WHICH THE LIFE OF THE MOTHER WAS AT RISK. DO YOU RECALL THE SPECIFIC NUMBER?

A. I DON'T RECALL THE EXACT NUMBER. I DON'T HAVE DOCUMENTS, BUT MY RECOLLECTION IS THAT I THINK TWO OR THREE WERE D&E'S IN WHICH I WAS THE SUPERVISING PHYSICIAN WITH THE RESIDENT. THE RESIDENT AND I PERFORMED THE PROCEDURE.

AND THE OTHERS WERE INDUCTION PROCEDURES.

Q. DOCTOR, ARE YOU CURRENTLY INVOLVED IN ANY SCHOLARLY ACTIVITIES IN THE FIELD OF OBSTETRICS AND GYNECOLOGY?

A. YES. MY PRIMARY SCHOLARLY ACTIVITY IS THE SERVING AS THE CO-EDITOR-IN-CHIEF OF THE JOURNAL ENTITLED OBSTETRICAL AND GYNECOLOGICAL SURVEY.

Q. AND HOW LONG HAVE YOU SERVED AS CO-EDITOR-IN-CHIEF OF THAT JOURNAL?

A. I SERVED IN THAT CAPACITY SINCE 1992, SO FOR 12 YEARS.

Q. CAN YOU TELL US WHAT OBSTETRICAL AND GYNECOLOGICAL SURVEY IS?

A. IT IS A JOURNAL NOW ABOUT OVER 50 YEARS OLD THAT PUBLISHES ABSTRACTS FROM THE WIDER MEDICAL LITERATURE ON TOPICS RELATED TO OBSTETRICS AND GYNECOLOGY. THESE ABSTRACTS ARE EACH FOLLOWED BY A COMMENTARY WRITTEN BY ONE OF THE FOUR CO-EDITORS.

AND THE JOURNAL ALSO PUBLISHES REVIEW ARTICLES, TWO OR THREE EACH MONTH, ON TOPICS RELATED TO SUBJECTS IN OBSTETRICS AND GYNECOLOGY.

Q. CAN YOU TELL US WHAT YOUR RESPONSIBILITIES AS A CO-EDITOR-IN-CHIEF OF THAT JOURNAL ARE?

A. MY RESPONSIBILITIES ARE THREEFOLD: ONE IS TO REVIEW THE MEDICAL LITERATURE AND SELECT THE ABSTRACTS THAT WE PUBLISH; SECOND, TO WRITE THE COMMENTARIES ABOUT THOSE ARTICLES; AND, THIRD, TO REVIEW MANUSCRIPTS THAT ARE SENT TO THE JOURNAL TO BE CONSIDERED FOR PUBLICATION AND TO ASSESS THOSE ARTICLES AND SELECT THOSE THAT WE WILL PUBLISH.

Q. HOW OFTEN IS OBSTETRICAL AND GYNECOLOGICAL SURVEY PUBLISHED?

A. MONTHLY.
Q. AND CAN YOU APPROXIMATE HOW MANY JOURNALS YOU REVIEW A MONTH IN YOUR SERVICE AS CO-EDITOR-IN-CHIEF?
A. WE REVIEW APPROXIMATELY 100 JOURNALS OVER A PERIOD OF TIME TO SELECT THE ARTICLES THAT WE WILL ABSTRACT FOR THE JOURNAL.
MR. QUINLIVAN: YOUR HONOR, MAY I APPROACH THE WITNESS?
BY MR. QUINLIVAN:
Q. DOCTOR, I AM HANDING YOU WHAT HAS BEEN MARKED AS DEFENDANT'S EXHIBIT 56. ARE YOU FAMILIAR WITH THAT DOCUMENT?
A. YES, I AM.
Q. AND WITHOUT COMMENTING ON THE SUBSTANCE, CAN YOU JUST TELL US WHAT THAT DOCUMENT IS?
A. THIS IS AN ARTICLE THAT -- A REVIEW ARTICLE THAT WE PUBLISHED IN THE OBSTETRICAL AND GYNECOLOGICAL SURVEY.
Q. AND IS THAT AN EXAMPLE OF THE KINDS OF REVIEW ARTICLES THAT YOU HAVE BEEN DISCUSSING?
A. YES, IT IS.
Q. DOCTOR, ARE YOU A PEER REVIEWER FOR ANY OTHER JOURNALS?
A. YES, I AM.
Q. AND WHAT JOURNALS WOULD THOSE BE?
A. I REVIEW ARTICLES PRIMARILY FOR TWO JOURNALS: OBSTETRICS AND GYNECOLOGY. THIS IS THE OFFICIAL JOURNAL OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AND ALSO FOR THE AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY.

Q. HOW LONG HAVE YOU BEEN A PEER REVIEWER FOR THOSE JOURNALS?
A. AT LEAST 10 YEARS.
Q. ARE YOU A PEER REVIEWER FOR ANY OTHER JOURNALS?
A. FROM TIME TO TIME ARTICLES ARE SENT TO ME FROM OTHER JOURNALS FOR REVIEW, SUCH AS THE JOURNAL OF MATERNAL FETAL MEDICINE, JOURNAL OF PEDIATRICS AND OTHERS.
Q. DOCTOR, HAVE YOU YOURSELF PUBLISHED SCHOLARLY ARTICLES IN THE FIELD OF OBSTETRICS AND GYNECOLOGY?
A. YES, I HAVE.
Q. CAN YOU TELL US HOW MANY?
A. I BELIEVE MY CURRICULUM VITAE LISTS 140 ARTICLES.
Q. AND HOW MANY OF THOSE WERE PUBLISHED IN PEER REVIEW JOURNALS?
A. ONE HUNDRED OF THOSE ARE IN PEER REVIEWED JOURNALS.
Q. DOCTOR, ARE YOU FAMILIAR WITH THE MEDICAL LITERATURE REGARDING ABORTION?
A. YES, I AM.
Q. HOW ARE YOU FAMILIAR WITH THAT LITERATURE?
A. WELL, I AM FAMILIAR WITH IT IN TWO OR THREE CAPACITIES. I REVIEW THE MEDICAL LITERATURE MONTHLY TO SELECT ARTICLES AS I HAVE DESCRIBED FOR OUR JOURNAL. AND IN DOING SO YOU COME ACROSS A NUMBER OF ARTICLES ABOUT ABORTION, WHICH I SCAN READ TO SEE IF THERE IS INTERESTING INFORMATION IN THERE, ALTHOUGH I AM NOT PRIMARILY THE PERSON ON OUR EDITORIAL GROUP THAT SELECTS ARTICLES IN THAT AREA.

I ALSO READ OUR CURRENT JOURNALS, TWO JOURNALS I MENTIONED FOR WHICH I REVIEW. I BOTH RECEIVE THOSE MONTHLY, AND THEY INCLUDE A NUMBER OF ARTICLES ABOUT ABORTION.

FROM TIME TO TIME I HAVE BEEN ASKED TO COMMENT ON OR TESTIFY ABOUT ABORTION, LIKE I AM HERE TODAY. SO I REVIEW ARTICLES ABOUT ABORTION WHEN I DO THAT. AND I HAVE DONE THAT IN THE PAST.

AND I HAVE ALSO READ THE TEXTBOOKS WHICH ARE PERTINENT TO THE SUBJECT, SUCH AS TEXTBOOK BY DR. -- THAT IS EDITED BY DR. MAUREEN PAUL AND DAVID GRIMES AND THEIR ASSOCIATES, AND THE TEXTBOOK BY DR. WARREN HUNTER.

SO THAT'S, IN GENERAL, HOW I HAVE BEEN FAMILIAR WITH THE LITERATURE.

MR. QUINLIVAN: YOUR HONOR, MAY I APPROACH THE WITNESS?

THE COURT: YES.

BY MR. QUINLIVAN:

Q. DOCTOR, I AM HANDING YOU WHAT HAS BEEN MARKED AS PLAINTIFF'S EXHIBIT 31. IS THAT THE PAUL TEXTBOOK TO WHICH YOU ARE REFERRING?

A. YES, IT IS.

Q. DO YOU OWN A COPY OF THAT TEXTBOOK?

A. YES, I DO.

Q. DOCTOR, DOES THE JOURNAL FOR WHICH YOU SERVE AS CO-EDITOR-IN-CHIEF PUBLISH ARTICLES ON ABORTION?

A. YES, IT DOES.

MR. QUINLIVAN: YOUR HONOR, AT THIS TIME I WOULD MOVE TO QUALIFY DR. BOWES AS AN EXPERT IN THE FIELDS OF OBSTETRICS AND GYNECOLOGY, IN THE FIELD OF MATERNAL FETAL MEDICINE AND THE MEDICAL LITERATURE REGARDING OBSTETRICS AND GYNECOLOGY.

THE COURT: ANY OBJECTION?

MS. KRASNOFF: NO, YOUR HONOR, AS LONG AS IT'S CLEAR HE'S NOT BEING QUALIFIED AS AN EXPERT IN ABORTION PRACTICE.

THE COURT: I BELIEVE --

MR. QUINLIVAN: I DID NOT MOVE FOR THAT.

THE COURT: HE WILL BE ACCEPTED AS AN EXPERT.

MR. QUINLIVAN: THANK YOU, YOUR HONOR.

BY MR. QUINLIVAN:

Q. DOCTOR, ARE YOU FAMILIAR WITH THE TERM "EVIDENCE-BASED MEDICINE"?

A. YES.

Q. CAN YOU TELL US OR DESCRIBE FOR US WHAT THAT TERMS MEANS?

A. "EVIDENCE-BASED MEDICINE" IS THE TERM THAT IS APPLIED TO THE CONCEPT OF DEVELOPING DATA AND STUDIES THAT SUPPORT VARIOUS PRACTICES OF MEDICINE AND TO ENSURE THAT NEW INNOVATIONS IN MEDICINE, OR EVEN OLDER PRACTICES, ARE SUPPORTED BY SUFFICIENT DATA TO CONFIRM THEIR EFFICACY AND THEIR SAFETY.

Q. DOCTOR, IN YOUR EXPERIENCE HAS EVIDENCE-BASED MEDICINE BECOME ACCEPTED IN THE MEDICAL COMMUNITY?

A. YES, IT HAS.
Q. AND COULD YOU EXPLAIN FOR THE COURT WHAT TYPES OF STUDIES ARE CONSIDERED RELIABLE UNDER THE RUBRIC OF EVIDENCE-BASED MEDICINE?
A. SEVERAL CATEGORIES OF STUDIES HAVE BEEN DESIGNATED AND BEGINNING WITH THE -- LET ME BEGIN WITH THOSE AT THE LOWEST RUNG OF THE LADDER, IF I MAY.

THERE IS WHAT IS CALLED A CASE REPORT. THIS IS A REPORT IN WHICH A SINGLE INTERESTING CASE HAVING TO DO WITH A DISEASE OR A MEDICAL COMPLICATION IS REPORTED BY A PHYSICIAN.

THE SECOND LEVEL IS THE SO-CALLED CASE SERIES. THIS IS WHEN A NUMBER OF CASES OF A SIMILAR NATURE ARE PUBLISHED WITH THE OUTCOME OF A DISEASE PROCESS. THIS WOULD BE THE DESCRIPTION OF HOW A DISEASE PROCESS WORKS OR A TREATMENT WORKS.

AND THESE DO NOT HAVE COMPARATIVE GROUPS. THEY DON'T COMPARE THE RESULTS TO ANYTHING.

THEN, THE NEXT LEVEL -- WE ARE GOING UP IN INCREASING EVIDENCE, QUALITY OF EVIDENCE -- ARE THE SO-CALLED RETROSPECTIVE STUDIES. AND THESE ARE STUDIES IN WHICH SOMEONE ACCUMULATES DATA ON A BROAD BASIS ABOUT A DISEASE, A MEDICATION, A SURGICAL PROCEDURE, AND THEN COMPARES THE TREATMENT OR THE OUTCOMES WITH THE GROUP THAT HAS NOT HAD THAT TREATMENT OR NOT HAD THAT OUTCOME.

AND THESE ARE CALLED "RETROSPECTIVE STUDIES." THERE

ARE TWO KINDS OF THOSE. THE FIRST IS CALLED "A CASE CONTROLLED STUDY." AND THAT IS WHERE YOU START WITH THE DISEASE OUTCOME.

IF I MAY USE AN EXAMPLE, LET'S SAY YOU WERE STUDYING CANCER OF THE LUNG. YOU WOULD TAKE A GROUP OF PATIENTS WHO HAD CANCER OF THE LUNG AND TAKE A GROUP OF PATIENTS WHO DID NOT HAVE CANCER OF THE LUNG AND LOOK BACK IN THEIR HISTORIES AND FIND OUT ALL OF THE DETAILS ABOUT THAT.

AND IN DOING SO, YOU WOULD FIND THAT THE PATIENTS, THE SUBJECTS WHO HAD CANCER OF THE LUNG HAD MORE OFTEN SMOKED FOR A NUMBER OF YEARS. THAT'S, IN FACT, HOW WE FOUND OUT THAT CANCER AND SMOKING WERE RELATED. THAT IS CALLED "A CASE CONTROLLED STUDY."

THEN, THERE IS "A COHORT STUDY." AND THAT'S A STUDY IN WHICH, AGAIN, USING RETROSPECTIVE DATA, YOU START WITH WHAT IS CALLED "THE EXPOSURE." USING THE SIMILAR EXAMPLE, YOU WOULD TAKE ALL INDIVIDUALS WHO SMOKED CIGARETTES IN A POPULATION AND TAKE ALL THE PATIENTS WHO DIDN'T SMOKE CIGARETTES. YOU WOULD FOLLOW THEM AND FIND OUT WHAT HAPPENED. YOU WOULD SEE WHAT HAPPENED TO THEM IN THEIR LIFE, AND YOU WOULD SEE THAT MORE PATIENTS WHO WERE SMOKERS, MORE OF THE SMOKERS DEVELOPED CANCER.

SO YOU WOULD BE LOOKING AT IT IN A FORWARD DIRECTION. THOSE ARE STILL RETROSPECTIVE STUDIES. OKAY. THOSE ARE MIXED.

NOW, THE ULTIMATE IN EVIDENCE-BASED MEDICINE IS WHAT

IS CALLED A "RANDOMIZED CONTROLLED TRIAL."

NOW, THE RANDOMIZED CONTROLLED TRIAL IS WHERE YOU IDENTIFY THE SUBJECT THAT YOU ARE STUDYING. LET'S TAKE A VERY SIMPLE EXAMPLE WOULD BE A DRUG. AND YOU WOULD WANT TO FIND OUT IF DRUG A IS BETTER THAN DRUG B FOR TREATING PNEUMONIA.

SO YOU WOULD TAKE PATIENTS WHO HAVE PNEUMONIA, AND YOU WOULD ASK THEM TO BE PART OF THIS STUDY. AND YOU ARE GOING TO TREAT THEM WITH ONE OR THE OTHER DRUG. NEITHER THEY NOR THE DOCTOR WOULD KNOW WHAT THE DRUG IS. AND YOU WOULD FLIP A COIN TO SEE WHICH GROUP THEY ARE IN. THAT IS, THEY ARE RANDOMIZED.

AND THEN THEY WOULD BE TREATED WITH THE DRUG THAT WAS INDICATED BY THE RANDOMIZATION, AND THEN YOU LOOK AT THE OUTCOME IT SEE AT WHAT POINT WHICH GROUP DID BETTER.

THAT IS CALLED THE "RANDOMIZED PROSPECTIVE CONTROLLED STUDY."

Q. DOCTOR, I THINK YOU MENTIONED THAT THAT IS AT THE TOP OF EVIDENCE-BASED MEDICINE IN TERMS OF RELIABILITY. CAN YOU JUST EXPLAIN WHY THAT IS?

A. THE MAJOR REASON IT IS LOOKED AT AS THE MOST ELEGANT TYPE OF EVIDENCE IS THAT THE RANDOMIZED CONTROLLED TRIAL ELIMINATES A LOT OF THE BIAS THAT CAN BE INTRODUCED IN THE STUDY WHEN YOU ARE LOOKING AT RETROSPECTIVELY.

BY "BIAS" I MEAN THE AGE DIFFERENCES IN SUBJECTS, RACIAL DIFFERENCES IN SUBJECTS, DISEASE, OTHER DISEASES THAT MIGHT CONFOUND IT. WHEN YOU RANDOMIZE SUBJECTS OVER A PERIOD

OF TIME AND THROUGHOUT THE STUDY, THOSE THINGS ARE RANDOMLY ASSIGNED TO EACH GROUP SO THEY DON'T MAKE -- HAVE AN IMPACT ON THE OUTCOME, BECAUSE THEY ARE RANDOMLY DISTRIBUTED BETWEEN THE TWO GROUPS.

SO ALL YOU HAVE THAT IS DIFFERENT BETWEEN THEM IS WHETHER THEY TOOK DRUG A OR DRUG B OR HAD PROCEDURE A OR HAD PROCEDURE B.

Q. DOCTOR, UNDER THE RUBRIC OF EVIDENCE-BASED MEDICINE, DOES PEER REVIEW PLAY ANY ROLE?

A. PEER REVIEW, WHICH SIMPLY MEANS A REVIEW OF THE SUBJECT RESEARCH PROTOCOL OR THE MANUSCRIPT, WHATEVER, BY THOSE IN THE PROFESSION WHO HAVE KNOWLEDGE AND EXPERTISE IN THAT AREA.

THAT'S CALLED "PEER REVIEW." AND IT OPERATES AT VARIOUS DIFFERENT LEVELS. IF YOU ARE DESIGNING A STUDY YOU ASK FOR PEER REVIEW TO BE SURE IT IS DESIGNED PROPERLY.

IF YOU ARE SUBMITTING A MANUSCRIPT TO A JOURNAL, ALL PEER REVIEW JOURNALS WILL THEN SUBJECT THAT MANUSCRIPT TO SCRUTINY BY SELECTED INDIVIDUALS ON THEIR REVIEW PANELS TO COMMENT ON THE QUALITY OF THE RESEARCH: WAS IT DONE PROPERLY? DID THEY CONSIDER THE CORRECT THINGS? AND OFTEN MAKE RECOMMENDATIONS ABOUT HOW THE RESEARCH OR THE MANUSCRIPT CAN BE IMPROVED BEFORE IT IS ACCEPTED FOR PUBLICATION.

Q. TAKING THE ISSUE OF PUBLICATION WHICH YOU JUST MENTIONED, DOES PUBLICATION ITSELF PLAY A ROLE IN -- UNDER THE RUBRIC OF EVIDENCE-BASED MEDICINE?

A. WELL, ULTIMATELY, STUDIES OR DATA THAT IS COLLECTED IN THE INTEREST OF EVIDENCE-BASED MEDICINE HAS TO BE DISSEMINATED TO THE MEDICAL COMMUNITY IN SOME WAY. AND IT IS THROUGH PUBLICATION AND PEER-REVIEWED JOURNALS THAT THAT IS DONE.

Q. NOW, DOCTOR, WE HAVE BEEN MENTIONING SEVERAL DIFFERENT TYPES OF STUDIES THAT ARE USED UNDER THE RUBRIC OF EVIDENCE-BASED MEDICINE. ARE THESE THE TYPES OF STUDIES THAT ARE DONE TO TEST THE DEVELOPMENT OF NEW SURGICAL PROCEDURES?

A. YES.

Q. ARE THESE THE TYPES OF STUDIES THAT ARE DONE IN THE FIELD OF OBSTETRICS AND GYNECOLOGY?

A. YES.

Q. DOCTOR, COULD YOU COMMENT ON WHAT ROLE, IF ANY, INTUITION PLAYS UNDER THE RUBRIC OF EVIDENCE-BASED MEDICINE?

A. WELL, INTUITION REALLY RELATES TO A PHYSICIAN OR FOR AN INDIVIDUAL DEVELOPING OR SUGGESTING HOW IMPROVEMENTS CAN BE MADE IN TREATMENTS OR IN DIAGNOSIS AND SO FORTH.

YOU INTUITIVELY SAY:

"THIS MIGHT IMPROVE THE OUTCOME IN THIS PARTICULAR DISEASE."

AND THAT'S THE WAY THESE NEW TECHNIQUES, OPERATIVE PROCEDURES, MEDICATIONS ARE OFTEN DEVELOPED, BY INTUITIVELY USING ONE'S EXPERIENCE AND INTUITIVELY DECIDING HOW IT MIGHT BE DONE BETTER.

Q. DOCTOR, DO YOU HAVE AN OPINION AS TO WHETHER A PHYSICIAN'S

INTUITIVE JUDGMENT ABOUT A TECHNIQUE'S SAFETY, FOR EXAMPLE, IS A RELIABLE INDICATOR OF WHETHER, IN FACT, THAT TECHNIQUE IS SAFE?

A. IT CAN'T BE THE FINAL ARBITER OF SAFETY OR EFFICACY. ONCE A NEW INNOVATIVE PROCEDURE OR MEDICATION OR DIAGNOSTIC TECHNIQUE IS INTRODUCED IT HAS TO BE SUBJECTED TO MORE THAN A SINGLE INTUITIVE RECOGNITION THAT THIS MIGHT BE BETTER. AND THAT IS WHERE EVIDENCE-BASED MEDICINE COMES INTO PLAY.

Q. AND YOU JUST MENTIONED THAT AN INTUITIVE ASSESSMENT HAS TO BE SUBJECTED TO STUDY. CAN YOU JUST ELABORATE ON THAT? WHY IS THAT YOUR OPINION?

A. WELL, WITHOUT SUCH A STUDY YOU MAY NOT RECOGNIZE OR YOU MAY NOT BE ABLE TO ASCERTAIN HOW THAT PARTICULAR INTUITIVE KNOWLEDGE WILL BE -- WILL APPLY TO ALL SITUATIONS. LET ME GIVE YOU -- MAY I USE AN EXAMPLE OF -- IN OUR OWN FIELD OF OBSTETRICS AND GYNECOLOGY, IT WAS INTUITIVELY -- INTUITIVELY, WE THOUGHT THAT DOING A PROCEDURE CALLED AN "EPISIOTOMY" WOULD BE BENEFICIAL TO PREGNANT WOMEN AND THEIR BABIES.

NOW, EPISIOTOMY IS WHERE THE OBSTETRICIAN MAKES AN INCISION IN THE BIRTH CANAL TO ALLOW MORE ROOM FOR A BABY TO DELIVER. IT WAS THOUGHT THAT WOULD PROTECT WOMEN FROM MORE SEVERE LACERATIONS OR INJURY TO THE BIRTH CANAL. FOR YEARS, ALMOST 30 OR 40 YEARS, IT WAS ROUTINE, PARTICULARLY IN WOMEN HAVING THEIR FIRST INFANT, TO MAKE THIS INCISION CALLED AN EPISIOTOMY, UNTIL FINALLY THIS WAS SUBJECTED TO A MODERN

EVIDENCE DAY TECHNIQUES AND SCRUTINY. AND A LARGE -- IN FACT, THERE HAVE BEEN SEVERAL LARGE RANDOMIZED CONTROLLED TRIALS, AS I DESCRIBED THEM, WHERE WOMEN WERE ASKED TO PARTICIPATE AND AGREED TO EITHER HAVE AN EPISIOTOMY PERFORMED WHEN THEIR BABY WAS BORN OR TO HAVE NO EPISIOTOMY.

AND LO AND BEHOLD IT TURNED OUT THAT HAVING NO EPISIOTOMY HAD A BETTER OUTCOME. HAVING AN EPISIOTOMY LED TO MORE SERIOUS LACERATIONS THAT RESULTED IN THINGS SUCH AS RECTAL INCOMPETENCE.

AND THAT WAS A RATHER ASTOUNDING FINDING, BUT IT SHOWED THAT INTUITION WAS ENTIRELY MISLEADING. AND IT TOOK AN ELEGANT STUDY TO ACTUALLY TEACH US OTHERWISE.

NOW, EPISIOTOMIES WHICH WERE DONE ALMOST ROUTINELY IN THE PAST ARE NOW DONE ONLY IN SELECTED PATIENTS, AND THERE ARE INDICATIONS FOR IT.

Q. DOCTOR, ARE YOU AWARE OF ANY OTHER EXAMPLES IN THE FIELD OF OBSTETRICS AND GYNECOLOGY WHERE AN INTUITIVE JUDGMENT THAT A PROCEDURE WAS SAFE HAS BEEN DISPROVEN AFTER THAT PROCEDURE WAS SUBJECTED TO STUDY?

A. YES, FETAL HEART RATE MONITORING WOULD BE AN EXAMPLE. THE STUDY OF BREECH DELIVERY WOULD BE AN EXAMPLE WHERE THESE TECHNIQUES INITIALLY WERE THOUGHT TO BE OF GREAT VALUE AND HAVE CERTAIN EFFICACY AND SAFETY THAT WAS PROVEN NOT TO BE TRUE WHEN SUBJECTED TO A RANDOMIZED CONTROLLED TRIAL.

Q. DOCTOR, NOW, GOING BACK A LITTLE BIT, I THINK YOU MENTIONED

THE WORD "CONFOUNDING." CAN YOU TELL US WHAT -- WELL, LET ME ASK YOU: ARE YOU FAMILIAR WITH THE TERM "CONFOUNDING FACTOR"?

A. YES.

Q. AND CAN YOU TELL US WHAT A "CONFOUNDING FACTOR" IS?

A. WELL, IN A MEDICAL STUDY, A RESEARCH STUDY, A CONFOUNDING FACTOR IS ANYTHING THAT MIGHT INFLUENCE THE OUTCOME OF THE STUDY, WHICH IS NOT RELATED TO WHAT YOU ARE STUDYING, PER SE.

IF I CAN GO BACK TO MY EXAMPLE OF LUNG CANCER. IF YOU WERE LOOKING AT OUTCOME OF LUNG CANCER RELATED TO SMOKING, CONFOUNDING FACTORS WOULD BE THE AGE OF THE PATIENTS WHEN THEY STARTED SMOKING, WHETHER THEY WERE WORKING IN AN INDUSTRY THAT ALSO CAUSED LUNG PROBLEMS, SUCH AS MINERS. THOSE WOULD BE CONFOUNDING FACTORS.

SOCIOECONOMIC STATUS, THAT IS A CONFOUNDING FACTOR. ALL THAT MEANS THAT THOSE THINGS CAN INFLUENCE THE OUTCOME AND MUST BE IN SOME WAY ACCOUNTED FOR IF YOU ARE LOOKING AT WHETHER OR NOT THE PRIMARY PROBLEM THAT YOU ARE STUDYING, NAMELY, SMOKING IN THIS CASE, IS REALLY RELATED TO THE OUTCOME OF LUNG CANCER.

MR. QUINLIVAN: YOUR HONOR, MAY I APPROACH THE WITNESS?

THE COURT: YES.

BY MR. QUINLIVAN:

Q. DOCTOR, I AM HANDING YOU WHAT'S BEEN MARKED AS DEFENDANT'S LEARNED TREATISE A-20. ARE YOU FAMILIAR WITH THAT DOCUMENT?

A. YES, I AM.
Q. CAN YOU TELL US WHAT IT IS?
A. THIS IS A STUDY THAT WAS RECENTLY PUBLISHED IN THE. AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY. THE TITLE IS: "PREGNANCY ASSOCIATED MORTALITY AFTER BIRTH, SPONTANEOUS ABORTION OR INDUCED ABORTION IN FINLAND, 1987 TO 2000."
Q. AND CAN YOU TELL US WHAT THE DESIGN OF THAT STUDY WAS?
A. THIS WAS A STUDY CONDUCTED IN FINLAND WHICH -- IN WHICH THEY USED SEVERAL REGISTRIES, HEALTH REGISTRIES, THE BIRTH REGISTRY, THE ABORTION REGISTRY AND THE HOSPITAL DEATH CERTIFICATES REGISTRY.

AND BY USING THOSE, THEY LOOKED AT ALL PREGNANCIES AND COMPARED PREGNANCIES THAT WERE ENDED BY ABORTION, EITHER SPONTANEOUS ABORTION OR INDUCED ABORTION, AS COMPARED TO PREGNANCIES THAT WERE ENDED BY WOMEN WHO HAD BIRTHS LATER IN PREGNANCY, SPONTANEOUS BIRTHS.

AND THEY COMPARED THE OUTCOMES OF THOSE RELATED TO MORTALITY -- WHETHER THE MOTHER LIVED OR DIED -- DURING THE ONE YEAR AFTER THOSE PREGNANCIES ENDED BY WHATEVER METHOD.
Q. AND WHAT CONCLUSION DID THE AUTHORS REACH?
A. WELL, INTERESTINGLY, THEY CAME TO THE CONCLUSION THAT IF LOOKING AT THE OVERALL -- LOOKING AT THE OVERALL DATA, WHICH CONTAINED HUNDREDS OF THOUSANDS OF PATIENTS, THAT THE MORTALITY WAS LOWER IF THE PREGNANCY WENT TO TERM, IF THE MOTHER GAVE BIRTH, THAN IF THE MOTHER HAD A SPONTANEOUS ABORTION OR AN

ABORTION -- INDUCED ABORTION, FOR WHATEVER REASON.

Q. DOCTOR, DOES THAT SUGGEST THAT THE MORTALITY RATES FOR WOMEN WHO HAD INDUCED ABORTION IS ACTUALLY HIGHER THAN FOR WOMEN WHO CARRY A PREGNANCY TO TERM?

A. WELL, ACCORDING TO THEIR RAW RESULTS, NO, IT DOES NOT.

Q. CAN YOU EXPLAIN THAT FOR US?

A. WELL, AS I SAID, THEY -- IF I UNDERSTAND YOUR QUESTION THEIR DATA SHOWED THAT THE MORTALITY INITIALLY WAS HIGHER IF ONE HAD AN ABORTION OR SPONTANEOUS ABORTION.

NOW, WHEN THEY LOOKED AT THE -- AND HERE IS WHERE WE GET INTO CONFOUNDING FACTORS. IF THEY EXCLUDED ALL OF THE WOMEN WHO HAD ABORTIONS FOR MEDICAL COMPLICATIONS, IN OTHER WORDS, THEY HAD SOME MEDICAL DISEASE, AND THAT MIGHT MEAN THAT THOSE MEDICAL DISEASES HAD SOMETHING TO DO WITH WHY THE WOMEN DIED.

IF THEY EXCLUDED THOSE, THEN THE ABORTION -- THE DEATH RATES AFTER ABORTION WERE ACTUALLY LOWER THAN THE DEATH RATES AFTER HAVING A BIRTH.

SO, IF YOU ADJUSTED IT IN THAT WAY, IT CHANGES THE OUTCOME.

NOW, WHAT THEY DIDN'T DO IS THEY DIDN'T ALSO ADJUST THE DATA FOR THE WOMEN WHO GAVE BIRTH WHO HAD MEDICAL DISEASES. SO YOU ALSO HAVE HAD TO DO THAT. IT JUST POINTS OUT THAT HOW CONFOUNDING FACTORS CAN OFTEN CONFOUND THE RESULTS. AND YOU HAVE TO ACCOUNT FOR THEM.

YOU HAVE TO MAKE SOME ASSURANCES THAT YOU CORRECTED THE DATA FOR THOSE.

Q. DOCTOR, NOW I WOULD LIKE TO TURN YOUR ATTENTION TO THE ISSUE OF WHAT HAS BEEN KNOWN AS "PARTIAL-BIRTH ABORTION."

LET ME ASK YOU FIRST: IS "PARTIAL-BIRTH ABORTION" A TERM THAT CAN BE FOUND IN THE MEDICAL LITERATURE?

A. YES, IT IS.

Q. WHERE, IF ANYWHERE, HAVE YOU SEEN IT IN THE MEDICAL LITERATURE?

A. WELL, AMONG OTHER -- I THINK I HAVE SEEN IT IN THE NEW ENGLAND JOURNAL OF MEDICINE, WHICH IS A REPUTABLE JOURNAL.

Q. ARE YOU FAMILIAR WITH OTHER TERMINOLOGY OR TERMS THAT ARE USED FOR THE PARTIAL-BIRTH ABORTION PROCEDURE?

A. YES, I AM.

Q. AND WHAT ARE THOSE?

A. OTHER TERMS HAVE BEEN USED, SUCH AS INTACT DILATATION AND EXTRACTION. IT IS ALSO BEEN CALLED INTACT D&X, TO SHORTEN THE TERM. AND THOSE TWO TERMS SEEM TO BE USED SYNONYMOUSLY WITH PARTIAL-BIRTH ABORTION.

Q. AND, DOCTOR, CAN YOU DESCRIBE FOR THE COURT WHEN YOU FIRST BECAME AWARE OF THE ISSUE OR CONTROVERSY ABOUT PARTIAL-BIRTH ABORTION?

A. WELL, I BELIEVE I FIRST BECAME AWARE OF IT IN 1995, WHEN I WAS ASKED BY CONGRESSMAN CANADY, OR SOMEONE IN HIS OFFICE -- I DIDN'T SPEAK TO THE CONGRESSMAN -- BUT TO COMMENT UPON SOME

ASSERTIONS THAT WERE BEING MADE ABOUT THIS PROCEDURE WHEN THERE WERE HEARINGS ABOUT IT BEFORE CONGRESS. AND I WROTE A LETTER TO THAT EFFECT.

Q. DID YOU HAVE ANY OTHER CONTACT WITH CONGRESSMAN CANADY AFTER YOU SUBMITTED THAT LETTER?

A. NO.

Q. DID YOU HAVE ANY CONTACT WITH ANY OTHER MEMBER OF CONGRESS OR MEMBER OF THE UNITED STATES SENATE IN 1995, DURING THAT PERIOD?

A. WELL, ABOUT THE SAME TIME THE -- SENATOR HATCH'S OFFICE ASKED IF I WOULD SUBMIT A SIMILAR RESPONSE TO ASSERTIONS. IT WAS ESSENTIALLY THE SAME LETTER, BUT ADDRESSED TO HIS OFFICE.

Q. AND, DOCTOR, JUST TO CLARIFY, IN THOSE LETTERS DID YOU TAKE A POSITION ON THE MERITS OF THE BILLS THAT WERE THEN PENDING BEFORE CONGRESS?

A. NO, I DID NOT.

Q. SINCE YOU SUBMITTED THOSE TWO LETTERS HAVE YOU HAD ANY OTHER CONTACT OR CORRESPONDENCE WITH A MEMBER OF CONGRESS OR UNITED STATES SENATOR REGARDING THE PARTIAL-BIRTH ABORTION ISSUE?

A. YES. I WAS ASKED BY SENATOR SANTORUM TO COMMENT ON SOME OF THE ASSERTIONS BEING MADE ABOUT THE DELIBERATIONS OF THE ACT THAT WE'RE DISCUSSING TODAY. THAT WAS ROUGHLY A YEAR AGO. AND I WROTE A BRIEF LETTER RESPONDING TO THAT.

Q. SIMILAR TO MY QUESTION REGARDING THE LETTERS IN 1995, DID

YOU TAKE A POSITION IN YOUR LETTER WITH SENATOR SANTORUM REGARDING THE MERITS OF THE BILL THEN PENDING BEFORE CONGRESS?

A. NO.

Q. OTHER THAN SUBMITTING THOSE THREE LETTERS TO CONGRESS, HAVE YOU BEEN OTHERWISE INVOLVED IN THE PARTIAL-BIRTH ABORTION ISSUE IN ANY WAY?

A. YES. I HAVE BEEN ASKED TO TESTIFY IN SEVERAL OF THE SITUATIONS IN WHICH STATUTES IN STATES, LAWS THAT HAVE BEEN PASSED REGARDING THIS WERE ENJOINED, AND THERE WERE CIVIL LITIGATIONS ABOUT THAT.

Q. AND DID YOU TESTIFY ON BEHALF OF THE STATES IN THOSE CASES?

A. YES.

Q. TO YOUR KNOWLEDGE, WERE YOU QUALIFIED AS AN EXPERT IN THOSE CASES?

A. I BELIEVE I WAS, YES.

Q. IN ANY OF THOSE CASES TO YOUR KNOWLEDGE WERE YOU DISQUALIFIED FROM TESTIFYING AS AN EXPERT?

A. NO.

Q. DOCTOR, TURNING BACK TO THE INTACT D&X PROCEDURE, CAN YOU BRIEFLY DESCRIBE FOR US WHAT YOU UNDERSTAND THAT TERM TO MEAN?

A. IT HAS BEEN VARIOUSLY DESCRIBED, SO IT, IN GENERAL, IS A PROCEDURE WHICH BEGINS IN A WOMAN WHO HAS INDICATION FOR OR HAS REQUESTED AN ABORTION. BY DILATING THE CERVIX TO THE UTERUS BY INSERTING SMALL DEVICES CALLED LAMINARIA OR DILAPAN.

THESE TERMS SIMPLY ARE DESCRIBING SUBSTANCES WHICH

EXPAND WHEN THEY ARE BY WATER, AND THEREBY, IN EXPANDING THEY DILATE THE CERVIX.

THAT IS DONE OVER A PERIOD OF 24 TO 48 HOURS. WHEREUPON, THE PATIENT IS THEN BROUGHT TO THE OPERATING AREA. AND THE FETUS, AFTER THE CERVIX IS SUFFICIENTLY DILATED, GENERALLY THE BAG OF WATER IS RUPTURED, AND THE FETUS IS MANIPULATED INTO A POSITION IN WHICH IT CAN BE DELIVERED PARTIALLY, USUALLY, IN MY UNDERSTANDING OF IT, AS A BREECH, THAT IS, THE BOTTOM OR LEGS ARE DELIVERED, THE BUTTOCKS OR LEGS ARE DELIVERED FIRST UP TO THE POINT AT WHICH THE HEAD, WHICH IS THE LARGEST PART OF THE FETUS WILL NOT PASS THROUGH THE CERVIX.

AND AT THAT POINT, AN INCISION IS MADE INTO THE BASE OF THE SKULL OF THE BABY AND A SUCTION DEVICE IS INTRODUCED THAT REMOVES THE FETAL BRAIN BY SUCTION, AND THAT COLLAPSES THE SKULL SO THAT THE BABY'S SKULL IS SMALL ENOUGH AND THE HEAD IS SMALL ENOUGH THAT IT WILL PASS THROUGH THE PARTIALLY DILATED CERVIX.

Q. DOCTOR, HAVE YOU REVIEWED THE EXPERT REPORTS SUBMITTED BY THE PLAINTIFFS IN THIS CASE AND IN THE NEBRASKA AND NEW YORK CASES?

A. YES, I HAVE.

Q. DO YOU KNOW HOW MANY YOU HAVE REVIEWED?

A. I BELIEVE IT'S 36 SEPARATE DOCUMENTS.

Q. DOES THAT INCLUDE BOTH EXPERT REPORTS AND REBUTTAL EXPERT REPORTS?

A. YES.
Q. HAVING REVIEWED THOSE EXPERT REPORTS, ARE YOU FAMILIAR WITH THE ASSERTION THAT THERE ARE CERTAIN SAFETY ADVANTAGES TO THE INTACT D&X PROCEDURE AS COMPARED TO WHAT'S DISARTICULATION D&E PROCEDURE?
A. I BELIEVE SO, YES.
Q. AND CAN YOU SUMMARIZE WHAT YOU UNDERSTAND THOSE CLAIMED SAFETY ADVANTAGES TO BE?
A. AS I UNDERSTAND FROM READING THESE DECLARATIONS, THERE'S THREE MAJOR ADVANTAGES THAT THEY ASSERT.

ONE IS THAT THE PROCEDURE RESULTS IN FEWER PASSAGES OF INSTRUMENTS INTO THE UTERUS THEREBY REDUCING THE POTENTIAL DAMAGE TO THE UTERINE WALL FROM THESE INSTRUMENTS.

THE SECOND IS THAT IT TENDS TO BE A SHORTER PROCEDURE AND ASSOCIATED WITH LESS BLOOD LOSS.

AND THE THIRD IS THAT IT DOESN'T LEAVE BEHIND BITS OF THE FETAL, BITS OF FETAL PARTS, PARTICULARLY BONEY PARTS THAT MIGHT LATER BE A PROBLEM.

Q. NOW, DOCTOR, YOU TALKED ABOUT THE VARIOUS TYPES OF STUDIES IN THE MEDICAL LITERATURE. ARE YOU AWARE OF ANY PUBLISHED PEER REVIEWED STUDIES THAT HAVE COMPARED THE SAFETY OF THE INTACT D&X PROCEDURE WITH A DISARTICULATION D&E PROCEDURE?
A. NO, I AM NOT.
Q. DOES THAT INCLUDE PROSPECTIVE RANDOMIZED TRIALS?
A. YES.

Q. DOES THAT INCLUDE RETROSPECTIVE CASE CONTROL SERIES?
A. YES.
Q. DOES THAT INCLUDE RETROSPECTIVE COHORT STUDIES?
A. YES.
Q. DOCTOR, I WOULD LIKE TO TURN YOUR ATTENTION BACK TO PLAINTIFFS' EXHIBIT 31, WHICH IS THE PAUL TEXTBOOK. IF YOU COULD DIRECT YOUR ATTENTION TO PAGE 136 AND 137.

LET ME ASK YOU FIRST, DOCTOR, ARE YOU FAMILIAR WITH CHAPTER 10 OF THAT TEXTBOOK?
A. YES.
Q. CAN YOU JUST TELL US WHAT THAT CHAPTER IS ENTITLED?
A. IT IS ENTITLED "ABORTION PROCEDURES AND TECHNIQUES."
Q. YOU HAVE READ THAT CHAPTER?
A. I HAVE.
Q. DOCTOR, TURNING YOUR ATTENTION TO PAGE 136 AND 137, THE AUTHORS REPORT ON THE EXPERIENCE OF DR. MCMAHON AND DR. HASKELL WITH INTACT D&X OR INTACT D&E PROCEDURES.

DOCTOR, HOW WOULD YOU CHARACTERIZE THE DATA REPORTED BY DR. MCMAHON AND DR. HASKELL AS REPORTED IN THAT CHAPTER?
A. BOTH OF THESE REFER TO, BOTH OF THESE REFERENCES REFER TO CASE SERIES SUBMITTED BY THE RESPECTIVE DOCTORS.
Q. DO YOU HAVE AN OPINION ABOUT THE RELIABILITY OF THE DATA REPORTED BY DR. MCMAHON AND DR. HASKELL?
A. IT'S RELIABLE INSOFAR AS IT IS THEIR REPORT ON A SERIES OF CASES THAT THEY PERFORMED AND THE OUTCOMES.

NEITHER STUDY OR NEITHER SERIES INVOLVED A COMPARISON GROUP THAT WAS COLLECTED UNDER SIMILAR CIRCUMSTANCES TO COMPARE THIS PROCEDURE WITH OTHERS.

ALSO, YOU NEVER KNOW IN A SERIES LIKE THIS WHAT SELECTION BIAS WAS INVOLVED.

Q. LET ME STOP YOU THERE.

WHAT DO YOU MEAN BY "SELECTION BIAS"?

A. WELL, WERE THERE ANY PATIENTS WHO WERE ACTUALLY NOT INCLUDED IN THE SERIES FOR ONE REASON OR ANOTHER. THEY DIDN'T, THEY COULDN'T FIND ALL THE RECORDS ON A PATIENT, SO THEY DIDN'T PUT THAT PATIENT IN.

THIS IS OFTEN WHAT YOU HAVE TO BE CAUTIOUS OF WHEN YOU'RE EVALUATING A SERIES, A CASE SERIES.

Q. YOU MENTIONED THE TERM "BIAS" BEFORE. ARE THERE ANY OTHER FORMS OF BIAS THAT MIGHT BE APPLICABLE TO THESE TWO CASE SERIES?

A. WELL, YOU'RE ALWAYS CONCERNED ABOUT NOT ONLY SELECTION BIAS, THAT IS, WHO GETS INTO THE STUDY, BUT THERE'S ALSO, THERE IS ALSO REPORTING BIAS.

IN OTHER WORDS, WERE ALL OF THE COMPLICATIONS OR WHATEVER OUTCOME YOU ARE LOOKING AT, WERE ALL OF THEM REPORTED. THAT IS, WAS THERE SOME BIAS IN NOT -- SOME PATIENT MAY HAVE MOVED AWAY OR SOMETHING HAPPENED AND WE ARE NOT ABLE TO FOLLOW UP THAT PATIENT. THAT IS CALLED BIAS IN REPORTING THE ACTUAL OUTCOME.

Q. DOCTOR, DO YOU HAVE AN OPINION AS TO WHETHER THESE CASE SERIES ESTABLISH THE COMPARATIVE SAFETY OF THE INTACT D&X PROCEDURE AS COMPARED TO THE DISARTICULATION D&E PROCEDURE?
A. YES.
Q. WHAT IS YOUR OPINION?
A. MY OPINION IS THAT THESE DO NOT ESTABLISH THE RELATIVE SAFETY OF THESE PROCEDURES.
Q. CAN YOU JUST ELABORATE ON YOUR OPINION A LITTLE MORE?
A. WELL, SIMPLY BECAUSE THEY ARE NOT COMPARED TO ANYTHING, THEY ARE NOT COMPARED TO A COMPARABLE GROUP OF PATIENTS IN THE -- SO YOU DON'T KNOW WHETHER THEY ARE A GREATER SAFETY, LESSER SAFETY, LESS EFFICACY, GREATER EFFICACY UNLESS YOU HAVE A COMPARISON GROUP.

NOW, IN ONE CASE, I BELIEVE DR. MCMAHAN OR DR. HASKELL SAID RELATED TO OTHER PROCEDURES AS REPORTED IN THE LITERATURE, BUT YOU ACTUALLY HAVE TO GO BEYOND THAT BECAUSE THOSE WERE QUITE DIFFERENT SETTINGS, QUITE DIFFERENT POPULATIONS OF PATIENTS, SO YOU DON'T REALLY HAVE THE KIND OF COMPARISON YOU WOULD WANT IN AN EPIDEMIOLOGICALLY SOUND RETROSPECTIVE STUDY.

Q. NOW, DOCTOR, WE HAVE BEEN TALKING ABOUT THE ABSENCE OF PUBLISHED PEER-REVIEWED STUDIES COMPARING THE SAFETY OF THE INTACT D&X PROCEDURE WITH THE DISARTICULATION D&E. DURING THE COURSE OF THIS CASE HAVE YOU BECOME AWARE OF ANY UNPUBLISHED STUDIES THAT COMPARE THE SAFETY OF THE INTACT D&X PROCEDURE

WITH THE DISARTICULATION D&E?

A. YES, I HAVE.

MR. QUINLIVAN: YOUR HONOR, MAY I APPROACH THE WITNESS?

THE COURT: YES.

BY MR. QUINLIVAN:

Q. DOCTOR, I AM SHOWING YOU WHAT'S BEEN MARKED PLAINTIFFS' EXHIBIT 19. I AM SORRY, PLAINTIFFS' EXHIBIT 19.

FOR THE RECORD, THIS IS A STUDY ENTITLED "DILATION AND EVACUATION AT GREATER THAN OR EQUAL TO 20 WEEKS: COMPARISON OF OPERATIVE TECHNIQUES."

THE AUTHORS ARE DR. STEPHEN T. CHASEN, ET AL. THIS IS AN ARTICLE WHICH IS IN PRESS AND SCHEDULED FOR PUBLILCATION IN AN UPCOMING ISSUE OF THE AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY, COPYRIGHT 2004, ELSEVIER.

DOCTOR, HAVE YOU SEEN THIS DOCUMENT BEFORE?

A. YES, I HAVE.

Q. HAVE YOU REVIEWED IT?

A. I HAVE -- YES, I REVIEWED THIS AND A MANUSCRIPT THAT WAS ESSENTIALLY THIS SAME.

THIS IS A PROOF PAGE, I BELIEVE.

Q. CAN YOU DESCRIBE THE DIFFERENCE TO ME, BETWEEN A PROOF --

A. THE MANUSCRIPT IS WHAT THE AUTHOR ACTUALLY SUBMITS. AFTER IT IS ACCEPTED, THEY MAKE A PROOF, CALLED A PROOF PAGE. IT'S WHAT IT IS TO LOOK LIKE WHEN IT'S IN THE JOURNAL FOR THE AUTHOR

TO REVIEW.

Q. HAVE YOU REVIEWED ANY COMMENTS BY PEER REVIEWERS TO THIS STUDY?

A. YES, I HAVE.

Q. AND HAVE YOU REVIEWED DR. CHASEN AND HIS COLLEAGUE'S RESPONSES TO THOSE PEER REVIEW COMMENTS?

A. YES, I HAVE.

Q. HAVE YOU REVIEWED THE UNDERLYING DATA FOR THE CHASEN STUDY?

A. YES.

Q. HAVE YOU SUBMITTED A SUPPLEMENTAL EXPERT REPORT IN THIS CASE SETTING FORTH YOUR OPINIONS ABOUT THE CHASEN STUDY?

A. I DID.

Q. THANK YOU, DOCTOR.

I AM GOING TO ASK YOU SOME SPECIFIC QUESTIONS ABOUT THAT STUDY.

FIRST OFF, CAN YOU JUST EXPLAIN THE STUDY DESIGN FOR THE COURT?

A. THIS WAS A STUDY OF PATIENTS WHO HAD HAD ABORTIONS BY ONE OR THE OTHER OF THESE TECHNIQUES. DILATATION AND EVACUATION, D&E, AND THE PROCEDURE INTACT DILATATION AND EXTRACTION.

THERE WERE 383 TOTAL PATIENTS IN THIS EXPERIENCE. THERE WERE 120 WHO HAD THE INTACT D&X PROCEDURE PERFORMED, AND THE REMAINDER HAD HAD THE D&E PROCEDURE PERFORMED.

THESE WERE LARGELY -- THESE WERE PERFORMED BY TWO OF THE AUTHORS, THE ACTUAL PROCEDURES WERE PERFORMED BY TWO OF THE

AUTHORS, AND THEN THE OUTCOME PARTICULARLY RELATED TO TWO THINGS. SURGICAL COMPLICATION OF THE TWO PROCEDURES AND TWO BIRTHS IN PREGNANCY SUBSEQUENT TO THAT PARTICULAR PREGNANCY. IN OTHER WORDS, AFTER THE PATIENT HAD THIS PROCEDURE AND FOLLOWED UP IN A SUBSEQUENT PREGNANCY.

WHAT THE AUTHORS FOUND WAS NO DIFFERENCE IN THE COMPLICATION RATE BETWEEN -- WELL, YOU DIDN'T ASK ME --

Q. WE WILL GET TO THAT, DOCTOR.

LET ME JUST ASK YOU, WE TALKED ABOUT THE DESCRIPTION OF THE VARIOUS TYPES OF STUDIES RANDOMIZED CONTROL TRIALS, CASE SERIES, COHORT STUDIES, WHAT WOULD THIS STUDY -- HOW WOULD YOU DESCRIBE THIS STUDY?

A. THIS IS A COHORT, RETROSPECTIVE COHORT STUDY. IN OTHER WORDS, THEY STARTED WITH THE PATIENTS WHO HAD ONE OR THE OTHER PROCEDURE AND THEN LOOKED AT WHAT HAPPENED TO THEM AFTER THAT. SO THAT'S CALLED A RETROSPECTIVE COHORT STUDY.

Q. GOING BACK TO THE QUESTION THAT I THINK YOU ANTICIPATED, WHAT WAS THE AUTHORS' CONCLUSION REGARDING THE COMPLICATION RATES BETWEEN THE TWO GROUPS?

A. THEIR CONCLUSIONS WERE THAT THE INCIDENTS OF COMPLICATION, WHICH WAS ABOUT 5 PERCENT IN EACH GROUP, WAS SIMILAR. THEIR OTHER MAJOR INTEREST WAS THE OUTCOME OF THE SUBSEQUENT PREGNANCY, AND THEY FOUND NO INCREASE IN PREMATURE BIRTH IN SUBSEQUENT PREGNANCIES FOLLOWED UP AFTER THIS PARTICULAR PROCEDURE WAS DONE.

Q. DOCTOR, TURNING YOUR ATTENTION TO THE FOURTH PAGE, OR PAGE 4 OF THE CHASEN STUDY.

A. I HAVE IT.

Q. LEFT-HAND COLUMN IN THE MIDDLE OF THE PAGE, THE PARAGRAPH BEGINNING, "OUR APPROACH." AND IT READS:

"OUR APPROACH IN PERFORMING INTACT DILATION AND EXTRACTION WHENEVER POSSIBLE IS INTENDED TO MINIMIZE THE USE OF FORCEPS IN EXTRACTING THE FETUS. WE BELIEVE THAT THE USE OF FORCEPS TO GRASP THE FETUS CAN CAUSE INADVERTENT TRAUMA TO THE UTERINE WALL AT THESE GESTATIONAL AGES EVACUATION OF A FETUS CAN REQUIRE MULTIPLE INSERTIONS OF FORCEPS AND INTACT DILATION AND EXTRACTION AVOIDS THIS."

DO YOU SEE THOSE SENTENCES, DOCTOR?

A. YES, I DO.

Q. DOCTOR, DOES THE DATA RECORDED BY THE AUTHORS OF THE CHASEN STUDY SUPPORT THE SAFETY ADVANTAGES THAT ARE SET FORTH IN THAT PARAGRAPH?

A. NO, IT DOESN'T.

Q. DOCTOR, YOU TESTIFIED THAT HAVING REVIEWED THE EXPERT REPORTS SUBMITTED BY THE EXPERTS IN THIS CASE AND IN THE NEBRASKA AND NEW YORK CASES YOU'RE AWARE OF A CLAIM BEING MADE THAT THE INTACT D&X PROCEDURE OFFERS SAFETY ADVANTAGES OVER THE D&E PROCEDURE BECAUSE IT RESULTS IN A SHORTER PROCEDURE; IS

THAT RIGHT?

A. YES.

Q. DID THE CHASEN STUDY FIND ANY DIFFERENCE IN PROCEDURE TIME BETWEEN THE INTACT D&X GROUP AND THE D&E GROUP?

A. IT DID NOT.

Q. DOCTOR, HOW DID THE CHASEN STUDY COMPARE THE PROCEDURE TIMES BETWEEN THE TWO GROUPS?

A. THEY RECORDED THE MEDIAN -- THEY RECORDED THE TIMES IN EACH PROCEDURE THEY HAD THAT DATA AND THEN THEY REPORTED IN THE STUDY THE MEDIAN TIME FOR THAT GROUP.

Q. AND, DOCTOR, IN YOUR OPINION, IS THAT THE APPROPRIATE MEASURE OF ANALYSIS IN COMPARING THE PROCEDURE TIMES?

A. YES, IT'S ONE APPROPRIATE MEASURE. IT'S CERTAINLY AN ACCEPTABLE ONE.

Q. DOCTOR, TURNING YOUR ATTENTION TO PAGE 3 AND, IN PARTICULAR, TABLE 3 OF THE CHASEN STUDY, WHAT WAS THE MEDIAN PROCEDURE TIME FOR THE D&E GROUP AS REPORTED?

A. TWENTY-TWO MINUTES.

Q. AND WHAT WAS THE MEDIAN PROCEDURE TIME FOR THE INTACT D&X GROUP AS REPORTED?

A. TWENTY-TWO MINUTES.

Q. NOW, DOCTOR, LOOKING AT THAT SAME TABLE, DO YOU ALSO SEE THAT IN ADDITION TO REPORTING ON THE MEDIAN PROCEDURE TIME, THE AUTHORS ALSO REPORTED ON THE RANGE OF PROCEDURE TIMES BETWEEN THE D&E GROUP AND THE INTACT D&X GROUP?

A. YES.
Q. AND WHAT WAS THE RANGE OF PROCEDURE TIMES FOR THE D&E GROUP?
A. THE RANGE OF TIMES FOR THE D&E GROUP WAS 60 TO 60 MINUTES.
Q. AND WHAT WAS --
A. SIX TO 60 MINUTES.
Q. WHAT WAS THE RANGE OF PROCEDURE TIMES FOR THE INTACT D&X GROUP?
A. SIX TO 45 MINUTES.
Q. DOCTOR, IN YOUR OPINION, DOES THE FACT THAT THE LONGEST D&E PROCEDURE TOOK 60 MINUTES WHILE THE LONGEST INTACT D&X PROCEDURE TOOK 45 MINUTES SUGGEST THAT THE INTACT D&X PROCEDURE IS A COMPARATIVELY SHORTER PROCEDURE?
A. NO. THOSE ARE INDIVIDUAL TIMES. AND ONE OUTLINER DOESN'T NECESSARILY DEFINE THE ENTIRE GROUP. THAT IS, THE ONE LONG PROCEDURE IN EACH GROUP WAS 60 MINUTES VERSUS 45 MINUTES.

THE IMPORTANT THING IS THE ANALYSIS OF THE ENTIRE SPECTRA OF DATA. IF YOU WILL NOTICE, THERE IS THE TEST OF SIGNIFICANCE, WHICH IS JUST TO THE RIGHT OF THAT DATA, AND THIS TEST OF SIGNIFICANCE MEANS, IS THERE ANY DIFFERENCE IN THESE TWO GROUPS.

AND THAT'S DONE BY A TEST THAT THE AUTHORS SELECTED CALLED THE MANN-WHITNEY TEST. THAT'S SIMPLY A STATISTICAL TEST FOR TAKING THE ENTIRE GROUP OF THOSE TWO PATIENTS, SUBJECTING IT TO THIS TEST, AND THOSE TWO DISTRIBUTIONS OF TIME ARE NOT

STATISTICALLY DIFFERENT.

Q. DOES THE MANN-WHITNEY TEST TAKE INTO ACCOUNT THE RANGE OF PROCEDURE TIMES IN REACHING A CONCLUSION?

A. YES, IT DOES.

Q. DOCTOR, I BELIEVE YOU'VE ALSO TESTIFIED HAVING REVIEWED THE EXPERT REPORTS IN THIS CASE AND IN THE NEBRASKA AND NEW YORK CASE YOU ARE AWARE OF AN ASSERTION BEING MADE THAT THE INTACT D&X PROCEDURE OFFERS SAFETY ADVANTAGES OVER THE D&E PROCEDURE BECAUSE IT RESULTS IN LESS BLOOD LOSS; IS THAT RIGHT?

A. YES.

Q. DID THE CHASEN STUDY FIND ANY DIFFERENCE IN BLOOD LOSS BETWEEN THE INTACT D&X GROUP AND THE D&E GROUP?

A. NO.

Q. DOCTOR, TURNING YOUR ATTENTION, AGAIN, TO TABLE 3.

WHAT WAS THE MEDIAN ESTIMATED BLOOD LOSS FOR THE D&E GROUP?

A. ONE HUNDRED MILLILITERS.

Q. WHAT WAS THE ESTIMATED BLOOD LOSS FOR THE INTACT D&X GROUP?

A. ONE HUNDRED MILLILITERS.

Q. DOCTOR, DO YOU HAVE AN OPINION REGARDING WHETHER THERE ARE ANY METHODOLOGICAL LIMITATIONS TO THE CHASEN STUDY?

A. YES.

Q. CAN YOU TELL US WHAT YOU BELIEVE THOSE LIMITATIONS ARE?

A. THERE ARE SEVERAL WHICH I MENTIONED IN THAT SUPPLEMENTAL REPORT.

Q. LET'S GO -- TAKE THEM IN TURN. SO LET'S START WITH -- WHAT IS ONE METHODOLOGICAL LIMITATION?

A. ONE, AND I THINK THE MOST IMPORTANT ONE, IS THAT THE NUMBER OF PATIENTS IN THIS STUDY, THE NUMBER OF SUBJECTS WAS NOT SUFFICIENTLY LARGE TO CONFIRM STATISTICAL SIGNIFICANCE OF THEIR BEING NO DIFFERENCE IN THESE POPULATIONS FOR THESE OUTCOMES.

AND THAT'S JUST A MATTER OF, A VERY IMPORTANT MATTER OF STATISTICAL VALIDITY. IN OTHER WORDS, THEY ARE NOT -- YOU CAN'T EXCLUDE THE POSSIBILITY THAT IF YOU HAD DONE A GREATER NUMBER OF PATIENTS THERE WOULD HAVE DEVELOPED ONE OR THE OTHER GROUP WOULD HAVE SHOWN MORE COMPLICATIONS.

I AM NOT SAYING WHICH ONE, BUT YOU SIMPLY CAN'T CONFIRM THAT THESE ARE ABSOLUTELY VALID, STATISTICALLY VALID NONDIFFERENCES.

Q. DID THE AUTHORS OF THE CHASEN STUDY ACKNOWLEDGE THIS LIMITATION?

A. YES, THEY DID. THEY WERE, IN SOME OF THE REVIEWERS' REMARKS THIS WAS BROUGHT UP AND THEY ACKNOWLEDGED AND PUT A SENTENCE IN THEIR ON THEIR STUDY ACKNOWLEDGING THAT, YES.

Q. DOCTOR, CAN YOU TELL US WHAT IS ANOTHER METHODOLOGICAL LIMITATION?

A. ANOTHER METHODOLOGICAL STUDY IS THAT THE GROUPS OF PATIENTS WERE QUITE HOMOGENEOUS IN TERMS OF A NUMBER OF THINGS, THEIR AGES IN THE TWO GROUPS WERE DIFFERENT, THE DURATION OF GESTATION AT WHICH TIME THE ABORTION WAS PERFORMED WERE

DIFFERENT, THE MEAN GESTATIONAL AGE; THERE WAS QUITE A DIFFERENCE IN THE INDICATIONS FOR PERFORMING THE PREGNANCY TERMINATION THROUGH ABORTIONS WERE QUITE DIFFERENT.

NOW, AGAIN, THESE ARE THOSE CONFOUNDING FACTORS, AND THERE WAS NO ATTEMPT TO CORRECT FOR THOSE. AND THERE WAS NOT SUFFICIENT NUMBERS OF PATIENTS TO APPLY THE STATISTICAL ANALYSIS THAT WOULD DO THAT.

Q. DOCTOR --

A. BUT THAT MEANS, TO SOME EXTENT, COMPARING APPLES AND ORANGES HERE.

Q. DOCTOR, YOU MENTIONED THERE WAS A DIFFERENCE IN GESTATIONAL AGES. WHAT WAS THE MEAN GESTATIONAL AGE FOR THE INTACT D&X GROUP?

A. I THINK IT WAS 20 -- FOR THE D&X?

Q. THE D&X.

A. TWENTY-THREE WEEKS GESTATION.

Q. WHAT WAS THE MEDIAN GESTATIONAL AGE FOR THE D&E GROUP?

A. TWENTY-ONE WEEKS.

Q. DOCTOR, GIVEN THAT YOU TESTIFIED THAT THE COMPLICATION RATES WERE SIMILAR, DOESN'T THE FACT THAT THE INTACT D&X GROUP INVOLVED WOMEN WITH A HIGHER MEDIAN GESTATIONAL AGE, DOESN'T THAT SUGGEST THAT IT, IN FACT, OFFERS SAFETY ADVANTAGES AS COMPARED TO THE D&E GROUP?

A. WELL, HERE, AGAIN, INTUITIVELY, THAT MIGHT MAKE SOME SENSE, BUT LET ME STRESS THAT OVERALL THE ASSERTION THAT THERE WAS NO

DIFFERENCE IN THESE GROUPS CANNOT BE CONFIRMED STATISTICALLY. SO WE DON'T KNOW THAT THEY WEREN'T DIFFERENT. SO TO SAY THAT THAT IMPLIES SIMPLY THAT THE LATER GESTATIONAL AGE SUGGESTS THAT THIS IS A SAFER PROCEDURE, I JUST DON'T THINK YOU CAN SUPPORT THAT WITH THE DATA IN THIS MANUSCRIPT OR IN THIS STUDY.

Q. DOCTOR, YOU MENTIONED THAT THESE DIFFERENCES BETWEEN THE TWO GROUPS ARE CONFOUNDING FACTORS. IS THERE A WAY IN CONSTRUCTING A MEDICAL STUDY TO CONTROL FOR DIFFERENCES, SAY, IN GESTATIONAL AGES OR OTHER FACTORS?

A. YES, IF THE STUDY IS LARGE ENOUGH AND THE DATA IS AVAILABLE, YOU APPLY STATISTICAL METHODS KNOWN AS REGRESSION ANALYSIS. THIS IS WHERE EACH ONE OF THOSE FACTORS IS SEPARATELY TAKEN OUT AND THEN THE DATA REANALYZED TO SEE WHAT EFFECT THAT WOULD HAVE WITH OR WITHOUT THAT FACTOR IN THE MIX.

I AM NOT A BIOSTATISTICIAN, AND I COULD NOT SIT DOWN AND DO THAT FOR YOU, BUT THERE ARE TECHNIQUES FOR DOING THAT. AND THEY WERE NOT UTILIZED IN THIS STUDY FOR GOOD REASON.

Q. DOCTOR, YOU MENTIONED THE LACK OF SUFFICIENT NUMBERS AND THE DIFFERENCES BETWEEN THE TWO GROUPS. IN YOUR OPINION ARE THERE ANY OTHER METHODOLOGICAL LIMITATIONS TO THIS STUDY?

A. ANOTHER IN THE METHODS AND MATERIALS THERE IS A SECTION IN EVERY STUDY WHERE THEY DESCRIBE HOW THEY DID THE STUDY. AND THEY FAILED TO DESCRIBE THEIR FOLLOW-UP PROCEDURES, THEIR FOLLOW-UP. BY THAT, I MEAN, HOW OFTEN DO THEY SEE THESE PATIENTS AFTER THE ABORTION PROCEDURE? WERE ALL THE PATIENTS

SEEN? AND THAT GETS TO THE POINT OF: DID THEY OVERLOOK COMPLICATIONS THAT WEREN'T INCLUDED IN THE DATA ITSELF?

IN OTHER WORDS, A PATIENT MAY HAVE HAD A COMPLICATION AND WENT TO ANOTHER HOSPITAL OR ANOTHER FACILITY FOR TREATMENT, SO WE DON'T KNOW HOW WELL THEY FOLLOWED UP THOSE PATIENTS. PERHAPS THEY GOT ALL OF THEM, BUT YOU SHOULD SAY SOMETHING ABOUT THAT.

Q. YOU JUST MENTIONED THE FOLLOW-UP FOR SURGICAL PROCEDURES. ANY -- OUTSIDE THE YOUR CONCERN ABOUT OR LIMITATION OF DESCRIBING THE FOLLOW-UP FOR SURGICAL PROCEDURES, ARE THERE ANY OTHER METHODOLOGICAL LIMITATIONS?

A. WELL, ON WHICH THE AUTHORS READILY ADMITTED WAS IN THEIR FOLLOW-UP OF PATIENTS WHO HAD SUBSEQUENT PREGNANCIES -- FIRST OF ALL, THERE WERE VERY FEW PREGNANCIES. AND THEY ADMITTED THAT NOT ALL OF THOSE PATIENTS CAME BACK TO THEIR FACILITY FOR OBSTETRICAL CARE. AND THEY USED ONLY THEIR OWN MEDICAL RECORDS.

SO WE DON'T KNOW HOW MANY OTHER PATIENTS HAD PREGNANCIES, AND HAD PREGNANCIES -- OR WHAT THE OUTCOMES OF THOSE WERE. SO THEY ARE BASING THEIR CONCLUSION THAT THERE WAS NO DIFFERENCE IN PREMATURE BIRTH ON A FAR TOO SMALL PROPORTION OF THE PATIENTS THAT ACTUALLY HAD THE ABORTION PROCEDURES AND THOSE WITH INADEQUATE FOLLOW-UP.

SO I THINK THEY -- THAT WAS NOT JUSTIFIED TO MAKE THAT CONCLUSION.

Q. AND IN ADDITION TO THE CONCERNS OR LIMITATIONS THAT YOU HAVE JUST DISCUSSED, ARE THERE ANY OTHER METHODOLOGICAL LIMITATIONS, IN YOUR OPINION, TO THE CHASEN STUDY?

A. WELL, ONE LIMITATION -- THIS -- MOST OF THESE, AS I SAY, WERE MENTIONED BY THE REVIEWERS -- WAS, WELL, IS THAT THERE WAS NO CLEAR-CUT DESCRIPTION OF HOW THE PATIENTS WERE SELECTED FOR ONE PROCEDURE OR THE OTHER.

IN GENERAL, THEY SAID IT HAD TO DO WITH WHETHER THERE WAS -- HOW FAR THE CERVIX WAS DILATED AND WHAT POSITION THE BABY WAS IN, BUT THEY DIDN'T DESCRIBE IT BEYOND THAT.

SO IT WAS HARD TO KNOW WHETHER THERE WAS, AS I SAY, A SELECTION BIAS IN SELECTING A PATIENT FOR THIS PROCEDURE VERSUS THAT ONE.

AND THAT'S, AGAIN, INHERENT IN A RETROSPECTIVE STUDY. AND I THINK IT ALSO EFFECTS WHAT WE CALL GENERALIZED ABILITY.

Q. WHAT IS GENERALIZED ABILITY?

A. WELL, GENERALIZED ABILITY IS WHERE THE RESULTS OF THE STUDY ARE PUBLISHED. AND HOW DOES THIS RELATE TO PRACTICE ELSEWHERE? AND HOW CAN THESE RESULTS BE EXTRAPOLATED INTO THE GENERAL MEDICAL CARE PATIENTS FOR THESE PROCEDURES? BECAUSE WE DON'T KNOW HOW THEY SELECTED THE PATIENTS, NO ONE ELSE WOULD KNOW PRECISELY HOW TO DO IT TO REPRODUCE THEIR RESULTS.

SO THAT'S A LIMITATION, I THINK, OF SELECTION OF PATIENTS THAT WE JUST NEEDED MORE INFORMATION ABOUT.

Q. DOCTOR, ARE YOU FAMILIAR WITH THE PRINCIPAL AUTHOR OF THE STUDY, A DR. STEPHEN T. CHASEN?
A. ONLY THROUGH MY RECOGNITION -- ACKNOWLEDGMENT THAT HE WROTE THIS PAPER, AND I READ IT. AND THAT HE WAS INVOLVED IN THIS AS A WITNESS, BECAUSE I READ HIS DECLARATION WHEN I RECEIVED IT.
Q. IS THAT ONE OF THE EXPERT REPORTS THAT YOU REVIEWED?
A. YES.
Q. DO YOU HAVE AN OPINION, IF ANY, AS TO WHAT ROLE DR. CHASEN'S STATUS AS A WITNESS IN THIS CASE OR IN ONE OF THE OTHER CASES PLAYS IN RELATION TO HIS STUDY?
A. I DON'T KNOW WHETHER THAT HAD ANY RELATIONSHIP AT ALL TO DR. CHASEN DOING THE STUDY. I THINK I WOULDN'T FOR A MINUTE SUGGEST OR IMPUGN THE FACT -- HIS MOTIVATIONS FOR DOING IT, BUT I DO THINK THAT HIS ROLE IN THIS UNUSUAL CIRCUMSTANCE AND THE COINCIDENCE OF THIS ARTICLE APPEARING AND HIS RELATIONSHIP TO THIS CASE AS A WITNESS, THAT SHOULD HAVE BEEN DISCLOSED TO THE EDITORS AS A POTENTIAL -- I DON'T SAY AN ACTUAL -- A POTENTIAL CONFLICT OF INTEREST, JUST AS AN AUTHOR WHO --
MS. KRASNOFF: OBJECTION, YOUR HONOR, LACK OF FOUNDATION. IT WAS NOT DISCLOSED TO PUBLICATION.
THE COURT: SUSTAINED.
BY MR. QUINLIVAN:
Q. DOCTOR, DO YOU KNOW WHETHER OR NOT DR. CHASEN DISCLOSED HIS STATUS AS AN EXPERT IN THIS, IN THIS OR THE OTHER CASES, TO THE -- EITHER TO THE JOURNAL OR TO THE PEER REVIEWERS?

A. WELL, HE MAY HAVE DISCLOSED IT, BUT IT IS NOT DISCLOSED -- IT'S NOT DISCLOSED IN THE FINAL PROOF. THIS WOULD BE THE ARTICLE THAT THE READERS WOULD SEE. THE READERS WOULD HAVE NO IDEA OF HIS INVOLVEMENT.

Q. DOCTOR, I BELIEVE YOU TESTIFIED -- AND I AM GOING BACK AGAIN, HAVING READ THE EXPERT REPORTS OF THE PLAINTIFFS IN THIS CASE AND IN THE NEBRASKA AND NEW YORK CASES -- THAT YOU'RE AWARE OF THE CLAIMED SAFETY ADVANTAGES OF THE INTACT D&X PROCEDURE AS COMPARED TO THE D&E PROCEDURE, AND THAT THOSE ALLEGED SAFETY ADVANTAGES INCLUDE THE FEWER NUMBER OF PASSES INTO THE UTERUS, THE SHORTER PROCEDURE TIME AND LESS BLOOD LOSS, AND THE LESS RISK THAT A PART OF THE FETUS WILL REMAIN IN THE UTERUS.

DO YOU HAVE AN OPINION ABOUT THE VALIDITY OF THOSE CLAIMS FROM AN EVIDENCE-BASED MEDICINE PERSPECTIVE?

A. YES.

Q. WHAT IS THAT OPINION?

A. I DON'T THINK THOSE CLAIMS HAVE BEEN ESTABLISHED WITH GOOD MEDICAL EVIDENCE AS OF NOW.

Q. DOCTOR, DO YOU THINK -- DO YOU HAVE AN OPINION AS TO WHETHER IT WOULD BE FEASIBLE TO CONSTRUCT A STUDY COMPARING THE INTACT D&X PROCEDURE WITH A D&E PROCEDURE?

A. I THINK IT WOULD BE FEASIBLE.

Q. WHAT KIND OF STUDIES COULD BE DONE?

A. ALTHOUGH THEY ARE NOT EASY TO DO IN THIS SETTING, YOU COULD

DO A RANDOMIZED CONTROLLED TRIAL, THE MOST ELEGANT OF EVIDENCE-BASED MEDICINE STUDIES.

Q. LET ME STOP YOU THERE. HOW WOULD YOU GO ABOUT CONSTRUCTING A RANDOMIZED CONTROLLED TRIAL COMPARING INTACT D&X PROCEDURE WITH THE D&E PROCEDURE?

A. WELL, TO BEGIN WITH, YOU WOULD HAVE TO SELECT A NUMBER OF INSTITUTIONS TO COOPERATE, A NUMBER OF GROUPS TO COOPERATE TO ENSURE THAT THERE WERE SUFFICIENT NUMBER OF PATIENTS TO AVOID THE PROBLEMS THAT I HAVE JUST MENTIONED IN THE STUDY BY DR. CHASEN AND HIS COLLEAGUES.

THEN, YOU WOULD HAVE THE PHYSICIANS WHO WERE PARTICIPATING IN THE ABORTION PROCEDURES AGREE TO RANDOMIZE PATIENTS OR OFFER RANDOMIZATION TO PATIENTS SELECTED FOR ABORTION. AND YOU WOULD WANT TO INCLUDE PHYSICIANS WHO WERE FAMILIAR WITH BOTH OF THESE PROCEDURES AND WERE CAPABLE OF PERFORMING THEM IN A SATISFACTORY MANNER.

THEN, YOU WOULD RANDOMIZE PATIENTS AGAIN BY TECHNIQUES OF RANDOM TABLES, LIKE FLIPPING A COIN, SO THAT THE INTENTION OF PERFORMING THEIR PROCEDURE WOULD EITHER BE BY D&X, THAT IS INTACT D&X, OR BY THE TRADITIONAL D&E.

THEN, YOU WOULD COLLECT ALL OF THE DATA ON THESE PATIENTS GOING FORWARD, ALL OF THE COMPLICATIONS, THE BLOOD LOSS, ALL OF THE THINGS THAT WERE MENTIONED IN HERE, TIME OF THE PROCEDURE, AND THEN YOU WOULD ANALYZE THAT DATA AFTER THE STUDY WAS COMPLETED.

Q. DOCTOR, WOULD IT BE DIFFICULT TO GET WOMEN TO AGREE TO BE RANDOMIZED WHEN THEY DON'T KNOW WHICH ABORTION PROCEDURE THEY WOULD BE UNDERGOING?

A. YES, IT IS DIFFICULT, BUT IT IS DEFINITELY ACCOMPLISHABLE AS WE KNOW FROM OTHER STUDIES OF EQUAL DIFFICULTY THAT HAVE ACTUALLY BEEN DONE IN OBSTETRICS.

Q. CAN YOU GIVE ME AN EXAMPLE OF ONE OF THOSE STUDIES?

A. WELL, THE STUDY ON BREECH DELIVERY, WHICH WAS DONE. FOR YEARS IT WAS FELT, FOR YEARS BREECH DELIVERIES -- THAT IS, A BREECH IS A BABY WHO IS PRESENTING AT THE TIME IT IS GOING TO BE DELIVERED WITH ITS BUTTOCKS OR ITS FEET RATHER THAN ITS HEAD.

AND THOSE WERE OFTEN DELIVERED AND MOST FREQUENTLY DELIVERED IN THE NORMAL SPONTANEOUS WAY THROUGH THE VAGINA. ALTHOUGH AS YEARS WENT ON, THERE WAS SOME EVIDENCE THAT IT WAS MORE SAFER TO DELIVER THOSE BABIES BY CESAREAN DELIVERY. BUT THAT WAS -- THERE WAS SO MUCH DATA ON BOTH SIDES THAT FINALLY A RANDOMIZED CONTROLLED TRIAL WAS CONSTRUCTED. IT WAS MULTI-CENTERED, INVOLVED MANY CENTERS BOTH IN THIS COUNTRY AND ELSEWHERE. PHYSICIANS AGREED TO RANDOMIZE THEIR PATIENTS EITHER TO INTEND TO DELIVER THEM WITH A CESAREAN DELIVERY OR INTEND TO DELIVER THEM AFTER THEY WENT INTO LABOR VAGINALLY.

AND WOMEN AGREED TO BECOME SUBJECTS IN THIS STUDY TO THE EXTENT THAT SEVERAL THOUSAND PATIENTS WERE INCLUDED.

AND AT THE END THEY LOOKED AT OUTCOME, NAMELY DEATHS

OF THE INFANTS, MORBIDITY OR COMPLICATIONS TO THE INFANTS, COMPLICATIONS TO THE MOTHERS.

AND WHAT THEY FOUND WAS, IN FACT, THERE WAS A STATISTICALLY SIGNIFICANT IMPROVEMENT IN OUTCOME BY USING INTENTIONAL CESAREAN DELIVERY TO DELIVER.

NOW, THIS IS, I THINK, SOMEWHAT COMPARABLE TO THIS SITUATION WITH EVALUATING THESE TWO ABORTION PROCEDURES. YOU HAVE TO BEGIN WITH WHAT YOU CALL CLINICAL EQUIPOISE. THAT IS A TERM THAT MEANS WE DON'T KNOW WHICH IS BETTER. WE ARE TRYING TO ESTABLISH THAT.

AND SO A PATIENT WOULD BE TOLD THAT IN GOOD CONFIDENCE THAT:

> "WE DON'T KNOW WHICH OF THESE PROCEDURES IS SAFER FOR YOU OR BETTER FOR YOU, MORE EFFECTIVE FOR YOU."

AND SO IF THEY WOULD AGREE TO BE RANDOMIZED THEY WOULD HAVE ONE OR THE OTHER DONE IN THE MANNER I DESCRIBED.

Q. DOCTOR, ISN'T IT POSSIBLE, THOUGH, THAT IF YOU HAD WOMEN RANDOMIZED INTO AN INTACT D&X GROUP AND A D&E GROUP THAT THERE MIGHT BE SITUATIONS IN WHICH, SAY, A WOMAN WHO WAS IN THE INTACT D&X GROUP ACTUALLY HAS A D&E PROCEDURE?

A. YES. OH, YES. AND THAT'S WHY YOU DO A RANDOMIZED CONTROLLED TRIAL BASED ON INTENT TO PERFORM A PROCEDURE OR TO DO A TREATMENT.

JUST AS IN THE BREECH STUDY, THE STUDY OF BREECH

DELIVERY, A NUMBER OF WOMEN WHO THEY INTENDED TO DO CESAREAN DELIVERIES ON, FOR ONE REASON OR ANOTHER, ENDED UP HAVING A VAGINAL BIRTH. THEY DIDN'T GET TO THE HOSPITAL SOON ENOUGH, FOR ONE REASON OR ANOTHER. AND THE SAME WOULD BE TRUE IF YOU WERE STUDYING THESE TWO PROCEDURES.

THE VAGARIES OF THE CLINICAL SITUATION WOULD DICTATE THAT SOME PATIENTS WOULD NOT BE ABLE TO BE DELIVERED OR HAVE THEIR ABORTION PROCEDURE PERFORMED BY THE INTENDED PROCEDURE.

AND THAT -- BUT THE RANDOMIZED CONTROLLED TRIAL ACTUALLY ACCOUNTS FOR THAT. AND YOU ANALYZE THE RESULTS NOT ON WHAT PROCEDURE THEY ACTUALLY HAD, BUT ON THE INTENT THAT THEY ENTERED -- WHAT PROCEDURE THEY WERE INTENDED TO HAVE. THAT IS EPIDEMIOLOGICALLY THE WAY THESE GOOD STUDIES ARE PERFORMED.

THE COURT: I'M SORRY. I DON'T GET. I DON'T UNDERSTAND. I THOUGHT THE IDEA WAS THAT YOU WERE TRYING TO GET AN EQUAL NUMBER IN EACH OF THE TWO CONTROL GROUPS.

THE WITNESS: YES.

THE COURT: ISN'T THAT IDEALLY WHAT YOU ARE ATTEMPTING TO DO, CORRECT?

THE WITNESS: YES, MA'AM.

THE COURT: AND AT LEAST WE HEARD TESTIMONY FROM THE DOCTORS WHO PERFORM THESE PROCEDURES THAT YOU CAN'T ALWAYS TELL UNTIL THE COMMENCEMENT OF THE PROCEDURE WHETHER OR NOT THERE IS GOING TO BE SUFFICIENT DILATATION FOR AN INTACT PROCEDURE.

SO I AM NOT -- I AM A LITTLE UNCLEAR ABOUT WHAT YOU

MEAN BY YOU ANALYZE THE INTENT. EITHER -- DO YOU KNOW WHAT I MEAN?

THE WITNESS: YES, I UNDERSTAND WHAT YOU MEAN, YOUR HONOR. THIS IS PROBABLY THE MOST DIFFICULT PART OF THE RANDOMIZED CONTROLLED TRIAL IS TO UNDERSTAND, BECAUSE INTUITIVELY IT SEEMS WRONG.

BUT IF THE STUDY IS LARGE ENOUGH -- AND THAT IS WHY IT WOULD HAVE TO BE LARGE ENOUGH -- OVER TIME THOSE THINGS THAT CAME UP AT THE TIME OF SELECTION YOU WOULD HAVE TO DEFINE HOW THE DOCTORS WERE GOING TO SELECT PATIENTS.

IN OTHER WORDS, YOU WOULD SAY THE CERVIX HAS TO BE SO FAR DILATED BEFORE TRYING ONE PROCEDURE OR ANOTHER.

DOCTORS WOULD ALL AGREE HOW TO CONFORM TO THAT. ACTUALLY, AT THE TIME OF THE PROCEDURE SOME OF THOSE PATIENTS WOULDN'T FULFILL THOSE CRITERIA. AND YOU WOULD END UP HAVING THE OTHER PROCEDURE DONE, EITHER THE D&E OR D&X, BUT THEY WOULD NOT BE IN THE GROUP THAT THEY HAD INTENDED TO BE IN.

NOW, WHEN YOU ANALYZE DATA AFTER THIS, YOU HAVE TO ANALYZE IT BY WHAT THEY INTENDED TO DO, BECAUSE THAT IS EXACTLY WHAT HAPPENS IN REAL LIFE. THE PATIENT GOES IN WITH A DOCTOR TRYING TO DECIDE WHICH OF THESE PROCEDURES IS THE PATIENT GOING TO HAVE.

AND THEN, SELECTING IT BASED ON THE CRITERIA THAT YOU SET UP.

SO, IT IS THE INTENTION THAT REALLY IS BEING

STUDIED. AND I KNOW THAT --

THE COURT: THAT SOUNDS TO ME LIKE WHAT HAPPENS IN THIS STUDY, THE RETROSPECTIVE COHORT STUDY. I ASSUME THAT THE INTACT PROCEDURE WAS PERFORMED ON THOSE WOMEN WHO PRESENTED IN SUCH A MANNER THAT IT COULD BE PERFORMED. AND YOU END UP WITH 250 IN ONE CATEGORY AND 120 IN THE OTHER CATEGORY.

THE WITNESS: YES, MA'AM. THAT'S CORRECT. BUT WHAT THE PROBLEM IS WE DON'T KNOW THE BIASES THAT WERE INVOLVED IN MAKING THAT SELECTION. AND THERE WERE CERTAINLY DIFFERENCES IN GESTATIONAL AGE THAT WERE INVOLVED HERE, AND SO FORTH. SO THE DATA WHEN YOU ANALYZE IT AT THE END YOU DON'T KNOW WHETHER THOSE CONFOUNDING FACTORS MIGHT HAVE, IN FACT, INFLUENCED OUTCOME.

WHEREAS, IF YOU DO THE RANDOMIZED CONTROLLED TRIAL, YOU RANDOMIZE ALL THOSE CONFOUNDING FACTORS BECAUSE THE PATIENTS ARE RANDOMLY ASSIGNED TO ONE GROUP OR THE OTHER.

SO YOU ASSUME THAT THAT SELECTION PROCESS IS GOING TO BE AS OFTEN EFFECTING GROUP A AS IT'S GOING TO BE EFFECTING GROUP B.

THE COURT: OKAY.

THE WITNESS: I HOPE I AM NOT BEING TOO CONFUSING.

BY MR. QUINLIVAN:

Q. NO. AND LET ME JUST ASK TO CLARIFY IT.

IN A RANDOMIZED CONTROLLED TRIAL, IS THE FACT THAT SOMETIMES A -- SOMEBODY OR SAY A WOMAN WHO HAS BEEN RANDOMIZED

IN ONE GROUP ACTUALLY UNDERGOES A PROCEDURE IN THE OTHER GROUP, IS THAT CONTROLLED IN THE STUDY?

A. YES. WELL, IT IS ACCOUNTED FOR. I MEAN, IT IS CONTROLLED, YES.

THE COURT: OKAY. I WOULD LIKE TO TAKE A SHORT BREAK.

WE WILL BREAK FOR 15 MINUTES.

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

(PROCEEDINGS RESUMED AT 10:18 A.M.)

THE COURT: PLEASE CONTINUE.

MR. QUINLIVAN: THANK YOU, YOUR HONOR.

BY MR. QUINLIVAN:

Q. DOCTOR, FOLLOWING UP ON THE QUESTION THE COURT ASKED YOU, WHEN YOU'RE DOING A RANDOMIZED CONTROL TRIAL, ARE YOU TESTING -- AND I AM TAKING THE EXAMPLE OF INTACT D&X VERSUS D&E -- ARE YOU COMPARING WOMEN WHO ACTUALLY HAVE UNDERGONE AN INTACT D&X VERSUS A D&E, OR ARE YOU TESTING SOMETHING DIFFERENT?

A. WELL, YOU ARE NOT TESTING THE DIFFERENCE BETWEEN ALL OF THE PATIENTS WHO HAD INTACT D&E AGAINST ALL THE PATIENTS WHO HAD D&X, RIGHT? WHAT YOU ARE ACTUALLY TESTING IS THE INTENT TO PERFORM ONE OR THE OTHER PROCEDURE.

AND IN THE PROCESS OF THE RANDOMIZED CONTROL TRIAL, SOME OF THE PATIENTS ACTUALLY DO NOT HAVE THE PROCEDURE FOR A VARIETY OF CLINICAL REASONS THAT THEY WERE INTENDED TO HAVE AT

THE OUTSET.

BUT, IN FACT, THAT ACTUALLY CHARACTERIZES CLINICAL MEDICINE. YOU NEVER SIMPLY BLINDLY PROCEED TO DO ONE PROCEDURE OR ANOTHER. AND THE CLINICAL CIRCUMSTANCES WILL MODIFY HOW YOU ACTUALLY APPLY THAT. AND SO THE RANDOMIZED CONTROL TRIAL ACTUALLY TAKES THAT INTO ACCOUNT BY ANALYZING IT WITH INTENT TO TREAT IT.

Q. AND IF THERE ARE SITUATIONS IN WHICH A PATIENT IS PUT INTO ONE OR RANDOMLY ASSIGNED TO ONE GROUP AND ACTUALLY UNDERGOES THE OTHER PROCEDURE, HOW IS THAT REFLECTED IN THE DATA OR THE REPORT OF STUDY?

A. THERE ARE TWO WAYS. THE MAJOR OUTCOME IS THE INTENT. SO THAT PATIENT WILL APPEAR IN THE GROUP THAT WAS INTENDED TO HAVE THE PROCEDURE, EVEN THOUGH SHE MAY HAVE HAD THE OTHER ONE. AND HER OUTCOMES WILL BE ANALYZED WITH THE GROUP THAT WAS INTENDED TO HAVE THE D&X OR RESPECTIVELY THE D&E.

SOME AUTHORS ALSO PUBLISH THE DATA IN TWO WAYS. THEY WILL SAY -- THEY WILL PUT ALL OF THE PATIENTS TOGETHER WHO HAD THE SPECIFIC PROCEDURES THAT YOU ARE STUDYING, IRRESPECTIVE OF WHAT THEY INTENDED. AND THEN, THEY WILL SHOW YOU THE OUTCOMES THAT WAY.

BUT, ALL EPIDEMIOLOGISTS AGREE THAT INTENTION TO TREAT IS THE PROPER WAY TO ANALYZE THE STUDY.

Q. DOCTOR, YOU'VE MENTIONED THAT THERE ARE OTHER METHODS OF STUDY BESIDES A RANDOMIZED CONTROL TRIAL. IN YOUR OPINION,

WOULD IT BE POSSIBLE TO CONSTRUCT A RETROSPECTIVE COHORT STUDY COMPARING THE RELATIVE SAFETY OF THE INTACT D&X PROCEDURE AS COMPARED TO A DISARTICULATION D&E PROCEDURE?

A. I BELIEVE YOU COULD, YES.

Q. IS THE STUDY CONDUCTED BY DR. CHASEN AN EXAMPLE OF SUCH A RETROSPECTIVE COHORT STUDY?

A. YES, IT IS.

Q. NOW, DOCTOR, IF YOU WERE TO CONSTRUCT SUCH A RETROSPECTIVE COHORT STUDY COMPARING INTACT D&X VERSUS DISARTICULATION D&E, WHAT KIND OF DATA WOULD YOU BE LOOKING AT?

A. WELL, YOU WOULD WANT TO HAVE DATA FROM CLINICS OR INSTITUTIONS THAT WERE PERFORMING THESE TWO PROCEDURES SIMILAR TO THE STUDY THAT DOCTOR -- THE GROUP THAT DR. CHASEN REPRESENTED. I BELIEVE IT IS CORNELL -- COLUMBIA. I CAN'T REMEMBER, BUT, ANYWAY, HIS GROUP. YOU WOULD HAVE TO HAVE ENOUGH GROUPS ANALYZING DATA FROM ENOUGH GROUPS TO HAVE SUFFICIENT NUMBERS OF PATIENTS OR A LONG ENOUGH EXPERIENCE AT ONE OR THE OTHER INSTITUTION TO INCLUDE THAT MANY PATIENTS.

AND THEN DO THE STUDY VERY MUCH LIKE DR. CHASEN DID HIS STUDY WITH APPLYING THE VARIOUS STATISTICAL METHODS TO ACCOUNT FOR OR CORRECT FOR THESE VARIOUS CONFOUNDING FACTORS THAT WE DISCUSSED.

Q. WHERE WOULD ACTUALLY THE DATA THAT YOU WOULD BE LOOKING AT IN A RETROSPECTIVE COHORT STUDY, WHERE WOULD YOU ACTUALLY FIND THAT DATA?

A. YOU WOULD FIND IT AT INSTITUTIONS THAT WERE PERFORMING THESE PROCEDURES AND KEEPING DATA ON THEIR PATIENTS AND FOLLOWING THE PATIENTS, PRESUMABLY, FOR -- PRESUMABLY FOLLOWING THE PATIENTS FOR THE OUTCOMES THAT YOU WOULD BE INTERESTED IN, WHICH IS COMPLICATIONS OF THE PROCEDURE. AND IN THEIR CASE, SUBSEQUENT PREGNANCIES FOR PREMATURE BIRTH, OR WHATEVER YOU SELECTED AS OUTCOME VARIABLES.

Q. WOULD THAT DATA COMMONLY BE REFLECTED IN THE MEDICAL RECORD?

A. IT WOULD.

Q. WOULD YOU NEED TO LOOK AT THE MEDICAL RECORDS FOR WOMEN WHO HAVE UNDERGONE BOTH THE INTACT D&X AND THE D&E PROCEDURE?

A. YES, YOU WOULD.

Q. AND IF YOU DIDN'T HAVE ACCESS TO THOSE MEDICAL RECORDS WOULD YOU BE ABLE TO DO THE RETROSPECTIVE COHORT STUDY?

A. NO, NOT UNLESS THE SURGEONS HAD KEPT SEPARATE RECORDS ON EACH PATIENT. BUT IN THIS DAY AND AGE, I AM AFRAID THAT WOULD ALSO BE INCLUDED AS PART OF THEIR MEDICAL RECORDS. SO THE ANSWER IS: NO.

Q. DOCTOR, ARE YOU FAMILIAR WITH A STUDY BY DR. DAVID GRIMES, ET AL, ENTITLED:

"MIFEPRISTONE AND MISOPROSTOL VERSUS DILATION AND EVACUATION FOR MIDTRIMESTER ABORTION: A PILOT RANDOMISED CONTROLLED TRIAL," THAT WAS PUBLISHED IN THE BRITISH JOURNAL OF OBSTETRICS?

A. YES, I AM.
Q. LET ME ASK YOU FIRST, DOCTOR, DO YOU KNOW DR. DAVID GRIMES?
A. I DO.
Q. HOW DO YOU KNOW HIM?
A. WELL, HE IS A MEMBER OF OUR FACULTY AT THE UNIVERSITY OF NORTH CAROLINA, AND I HAVE KNOWN DR. GRIMES FOR A NUMBER OF YEARS, ESPECIALLY MORE RECENTLY WHEN HE JOINED OUR FACULTY.
MR. QUINLIVAN: YOUR HONOR, MAY I APPROACH THE WITNESS?
THE COURT: YOU MAY.
BY MR. QUINLIVAN:
Q. DOCTOR, I AM SHOWING YOU WHAT HAS BEEN MARKED AS PLAINTIFFS' LEARNED TREATISE 11. IS THIS THE STUDY BY DR. GRIMES, ET AL, THAT I WAS JUST REFERENCING?
A. YES.
Q. AND CAN YOU BRIEFLY SUMMARIZE WHAT THE ARTICLE IS ABOUT?
A. THIS IS A STUDY WHICH DR. GRIMES DESCRIBED AS A FEASIBILITY STUDY. HE SET OUT TO COMPARE TWO ABORTION PROCEDURES, ONE WHICH WAS A LABOR INDUCTION PROCEDURE USING THESE TWO DRUGS CALLED MIFEPRISTONE AND MISOPROSTOL USED TOGETHER TO INDUCE ABORTION THROUGH A LABOR INDUCTION METHOD.
COMPARE THAT WITH THE ABORTION PROCEDURE CALLED D&E. AND HIS OBJECTIVE WAS TO RANDOMIZE PATIENTS TO ONE OF THOSE PROCEDURES OR THE OTHER, AS WE HAVE DESCRIBED, IN A RANDOMIZED CONTROLLED TRIAL.

Q. AND WHAT WERE THE RESULTS AS REPORTED BY DR. GRIMES AND HIS COLLEAGUES?
A. HE FOUND THAT IN APPROACHING 49 SUBJECTS, POTENTIAL SUBJECTS FOR THIS STUDY, THAT ONLY 18 AGREED TO BE RANDOMIZED TO ONE PROCEDURE OR THE OTHER.
Q. DOCTOR, ARE YOU AWARE THAT AN ASSERTION HAS BEEN MADE THAT THE GRIMES STUDY DEMONSTRATES THAT IT WOULD BE DIFFICULT, IF NOT IMPOSSIBLE, TO DO A RANDOMIZED TRIAL COMPARING INTACT D&E VERSUS D&X -- INTACT D&X VERSUS D&E?
A. YES, I BELIEVE I HAVE HEARD THAT.
Q. AND DO YOU HAVE AN OPINION ABOUT THAT ASSERTION?
A. YES. I DON'T THINK THAT THIS STUDY PRECLUDES OR IS EVIDENCE THAT SUGGESTS YOU COULD NOT DO SUCH A STUDY.
Q. AND WHAT IS THE BASIS OF YOUR OPINION?
A. WELL, DR. GRIMES' FEASIBILITY STUDY SHOWED THAT IN THE SETTING IN WHICH HE WAS TRYING TO DO THE STUDY YOU COULDN'T ACCOMPLISH IT. THERE ARE A LOT OF CONSTRAINTS ON HIS STUDY.

AND THE FACT THAT THE WOMEN DID NOT AGREE TO ENROLL IN SUFFICIENT NUMBERS TO ACCOMPLISH IT TO GET THE NUMBER OF PATIENTS YOU WOULD NEED FOR STATISTICAL VALIDITY IN THIS SETTING DOESN'T MEAN THAT IN SOME OTHER SETTING YOU WOULDN'T BE ABLE TO DO THAT.

IN FACT, DR. GRIMES MENTIONS THAT VERY THING IN THIS ARTICLE THAT GIVEN A DIFFERENT SETTING, DIFFERENT POPULATION GROUPS, THAT YOU PROBABLY COULD, AND ACTUALLY SHOULD DO THAT

STUDY TO PROVE THE EFFICACY OF THESE TWO PROCEDURES COMPARED TO ONE ANOTHER.

Q. DOCTOR, DID DR. GRIMES AND HIS COLLEAGUES EXPLAIN SOME OF THE REASONS WHY IT WAS DIFFICULT TO ENROLL SUFFICIENT NUMBER OF WOMEN FOR THE STUDY?

A. YES, I BELIEVE THEY DID.

Q. IF YOU COULD TURN YOUR ATTENTION TO I BELIEVE WHAT IS PAGE 152 OF THE GRIMES STUDY?

TURNING TO THE LEFT-HAND COLUMN IN THE MIDDLE OF THE PAGE, DO YOU SEE A PARAGRAPH BEGINNING, QUOTE:

"RECRUITMENT TO THIS TRIAL WAS SLOW FOR SEVERAL REASONS"?

A. YES.

Q. CAN YOU TELL US WHAT THE FIRST REASON DR. GRIMES AND HIS COLLEAGUES GAVE THAT RECRUITMENT TO THE TRIAL WAS SLOW?

A. WELL, HE STATED THAT IN NORTH CAROLINA THERE ARE -- AS HE PUTS IT:

"PATIENT POPULATION IS WELL SERVED BY ABORTION CLINICS," AND THEREFORE THEY ARE CONFINING THEIR OWN -- THEIR STUDY TO THEIR OWN CLINIC AT UNC HOSPITAL, AND THE POPULATION VOLUME IS NOT LARGE. AND THEY DIDN'T ADVERTISE OUTSIDE THE POPULATION THAT WAS COMING TO THE CLINIC. THEY DIDN'T ADVERTISE FOR PATIENTS FOR THE STUDY.

Q. DOCTOR, WHEN A RANDOMIZED CONTROLLED TRIAL IS DONE ARE THERE SOMETIMES OR IS THAT TRIAL SOMETIMES ADVERTISED?

A. YES.
Q. DOCTOR, WHAT IS THE SECOND REASON GIVEN BY THE AUTHORS, BY DR. GRIMES AND HIS COLLEAGUES, FOR THE SLOW ENROLLMENT?
A. THEY WERE LIMITED WHEN THEY SUBJECTED THE -- OR WHEN THEY SUBMITTED THE STUDY TO THE IRB, THE INSTITUTION REVIEW BOARD THAT I DESCRIBED BEFORE, THEY REQUIRED THAT HE LIMIT IT TO PATIENTS WHO ARE OVER 18 YEARS OF AGE. THEY DIDN'T WANT THEM TO INCLUDE MINORS IN THE STUDY.

AS HE POINTED OUT, A NUMBER OF THESE PROCEDURES ARE PERFORMED ON MINORS. THEREFORE, THAT LIMITED HIS POPULATION. SO THAT WAS ANOTHER RESTRICTION ON IT. AND THEN --
Q. WELL, CONTINUING ON, WHAT IS THE THIRD REASON THAT DR. GRIMES AND HIS COLLEAGUES GAVE?
A. HE SAID THAT THEY ELIMINATED ALL PATIENTS WHO HAD A PREVIOUS CESAREAN DELIVERY, BECAUSE THOSE PATIENTS WOULD BE AT INCREASED RISK, POTENTIALLY INCREASED RISK OF A COMPLICATION OF A RUPTURE OF THE UTERUS.

THEY ELIMINATED THOSE. I.E., THEY WERE TRYING TO ELIMINATE A CONFOUNDING FACTOR.

AND SINCE A FOURTH OF ALL PATIENTS WHO HAVE HAD A DELIVERY HAD A CESAREAN SECTION, THAT WAS A SIZEABLE NUMBER OF PATIENTS.
Q. DOCTOR, CONTINUING ON, WHAT WAS THE FOURTH REASON GIVEN BY DR. GRIMES AND HIS COLLEAGUES FOR THE SLOW ENROLLMENT IN THE STUDY?

A. THEN THEY LIMITED THEIR POPULATION TO WOMEN WHO WERE 19 WEEKS OR LESS GESTATION. AND THEY DID THAT, AS DR. GRIMES SAYS HERE, BECAUSE THE NURSING SERVICE DIDN'T WANT TO TAKE THE RISK OF THEIR BEING A LIVE BABY BORN AFTER THE ABORTION PROCEDURE.

SO THAT FURTHER RESTRICTS HIS POPULATION DOWN TO THE LIMITS THAT WE HAVE DESCRIBED.

Q. DOCTOR, CONTINUING ON, WHAT IS THE SIXTH REASON GIVEN BY DR. GRIMES AND HIS COLLEAGUES FOR THE SLOW ENROLLMENT IN THE STUDY?

A. WELL, IT IS AN INTERESTING ONE. HE SAYS:

"THE HIGH PROPORTION OF WOMEN WITH FETAL INDICATIONS FOR ABORTION LIMITED PARTICIPATION SINCE THESE WOMEN WERE LESS LIKELY TO ENROLL THAN WERE WOMEN HAVING ABORTIONS FOR OTHER REASONS."

Q. WHY DO YOU SAY THAT'S SURPRISING?

A. WELL, IT'S SURPRISING TO SOME EXTENT BECAUSE THE FETAL INDICATIONS IS OFTEN SUGGESTED AS ONE REASON FOR DOING AN INTACT PROCEDURE. THAT IS IN DELIVERING A BABY THAT CAN BE EXAMINED BY A PATHOLOGIST TO CONFIRM THE ACTUAL DIAGNOSIS THAT WAS MADE OR FIND OUT OTHER EVIDENCE RELATED TO THOSE DISEASES.

AND HERE ALL THOSE WOMEN SAID:

"WELL, WE WOULD RATHER HAVE A D&E," IN WHICH CASE YOU END UP WITH A DISARTICULATED SPECIMEN, WHICH IS, ACCORDING TO SOME PATHOLOGISTS, NOT AS HELPFUL IN MAKING THOSE DIAGNOSES. THAT IS A CURIOUS THING.

Q. DOCTOR, YOU MENTIONED THE SIX FACTORS THAT DR. GRIMES AND HIS COLLEAGUES IDENTIFIED AS BEING AT LEAST, IN PART, RESPONSIBLE FOR THE SLOW ENROLLMENT.

WOULD THOSE SIX FACTORS BE APPLICABLE IN ANY POTENTIAL RANDOMIZED CONTROLLED TRIAL THAT, SAY, IF YOU WERE TRYING TO COMPARE INTACT D&X VERSUS D&E?

A. NO.

Q. DOCTOR, IN YOUR OPINION, DOES THIS STUDY CAST DOUBT ON THE ABILITY TO CONSTRUCT A RANDOMIZED CONTROLLED TRIAL COMPARING INTACT D&X VERSUS D&E?

A. NO. IT CERTAINLY POINTS OUT SOME OF THE LIMITATIONS THAT YOU WOULD HAVE TO AVOID TO DO THE STUDY, AND AT LEAST DR. GRIMES DESCRIBED THEM, AS WELL.

Q. DOCTOR, LET ME ASK YOU, GOING BACK TO WHEN YOU WERE FIRST OR FIRST LEARNED OF THE PARTIAL-BIRTH ABORTION ISSUE IN 1995, DID YOU BECOME AWARE AT SOME TIME OF WHEN THE TECHNIQUE OF PARTIAL-BIRTH ABORTION OR INTACT D&X WAS FIRST DESCRIBED IN ANY FORM IN THE MEDICAL LITERATURE?

A. IN THE MEDICAL --

MS. KRASNOFF: OBJECTION, YOUR HONOR, TO THE FORM. WE HAVE NO PROBLEM ASKING WHEN HE FIST LEARNED OF IT, BUT NOT -- UNLESS HE KNOWS WHEN IT WAS FIRST --

MR. QUINLIVAN: I WILL REPHRASE, YOUR HONOR.

THE COURT: OKAY.

BY MR. QUINLIVAN:

Q. DOCTOR, IN RESPONDING TO THE INQUIRY FROM CONGRESSMAN CANADY'S OFFICE, DID YOU HAVE OCCASION TO REVIEW ANY MATERIALS DESCRIBING AN INTACT D&X PROCEDURE?

A. YES, I DID.

Q. CAN YOU TELL US WHAT THOSE MATERIALS WERE?

A. I REVIEWED MANUSCRIPTS OF PRESENTATIONS THAT WERE MADE BY DR. HASKELL AND DR. MCMAHON AT MEETINGS IN WHICH THEY DESCRIBE THESE PROCEDURES.

MR. QUINLIVAN: MAY I APPROACH THE WITNESS?

THE COURT: YES.

BY MR. QUINLIVAN:

Q. DOCTOR, I AM HANDING YOU WHAT HAS BEEN MARKED AS DEFENDANT'S LEARNED TREATISE A-28.

ARE YOU FAMILIAR WITH THIS DOCUMENT?

A. YES, I AM.

Q. IS THIS THE WRITTEN RECORDING OF THE PRESENTATION GIVEN BY DR. HASKELL THAT YOU REVIEWED?

A. YES, IT IS.

Q. AND, DOCTOR, IS THERE A DATE ON WHICH THAT DOCUMENT RECORDS THAT DR. HASKELL GAVE HIS PRESENTATION?

A. THIS STATES THAT THE DATE OF THE PRESENTATION WAS SOMEPLACE BETWEEN SEPTEMBER 13TH OR 14TH, 1992, AT A MEETING IN DALLAS, TEXAS.

Q. DOCTOR, DO YOU HAVE AN OPINION WHETHER A RANDOMIZED CONTROLLED TRIAL OR RETROSPECTIVE COHORT STUDY COULD HAVE BEEN

CONDUCTED COMPARING THE INTACT D&X PROCEDURE WITH THE D&E PROCEDURE SOMETIME SINCE DR. HASKELL MADE HIS PRESENTATION IN 1992?

A. THE ANSWER IS: I THINK IT COULD HAVE BEEN DONE.

Q. GOING BACK TO THE GRIMES STUDY, I BELIEVE YOU TESTIFIED THAT THE DESIGN OF THAT STUDY WAS TO COMPARE A METHOD OF LABOR INDUCTION WITH THE D&E PROCEDURE?

A. YES.

Q. DO YOU HAVE AN OPINION WHETHER IT WOULD BE EASIER TO CONSTRUCT A TRIAL COMPARING INTACT D&X VERSUS D&E, AS COMPARED TO WHAT THEY WERE STUDYING IN THE GRIMES STUDY?

A. WELL, CERTAINLY THE GRIMES STUDY WAS COMPARING ONE METHOD, WHICH WAS LABOR INDUCTION, WITH ONE METHOD, WHICH WAS SURGICAL INDUCTION -- SURGICAL PROCEDURE. AND THERE'S SOME EVIDENCE THAT WOMEN WOULD PREFER HAVING A SHORTER PROCEDURE, NAMELY THE D&E, TO A MUCH -- A LONGER LABOR, A LONGER PROCEDURE INVOLVING GOING THROUGH LABOR.

WHEREAS, IF YOU ARE COMPARING D&E TO D&X, YOU ARE COMPARING TWO SURGICAL PROCEDURES IN WHICH NEITHER -- IN NEITHER CASE THE WOMEN HAVE TO GO THROUGH LABOR.

SO, AGAIN, INTUITIVELY HERE I WOULD THINK THAT THEY WOULD PROBABLY BE EASIER TO RANDOMIZE THEM TO ONE OR TWO SURGICAL PROCEDURES THAN BETWEEN A SURGICAL PROCEDURE OF RELATIVELY SHORT DURATION AND A LABOR WHICH MIGHT GO ON FOR SEVERAL HOURS.

Q. DOCTOR, JUST A COUPLE OF FINAL QUESTIONS: DO YOU RECALL TESTIFYING EARLIER TODAY THAT -- I BELIEVE YOU SAID ON FIVE OR 10 OCCASIONS DURING YOUR TENURE AT THE UNIVERSITY OF NORTH CAROLINA YOU PERFORMED INDUCED ABORTIONS WHERE THE LIFE OF THE MOTHER WAS AT RISK?

A. I BELIEVE I SAID THAT, YES.

Q. DID YOU HAVE OCCASION TO REVIEW YOUR DEPOSITION DURING THE BREAK?

A. YES.

Q. AND DID THAT REFRESH YOUR RECOLLECTION AS TO HOW MANY PROCEDURES YOU MAY HAVE PERFORMED OR SUPERVISED WHILE AT THE UNIVERSITY OF NORTH CAROLINA?

A. IT WASN'T QUITE THAT MANY.

Q. DO YOU RECALL HOW MANY?

A. OH, MY. YOU ARE CALLING FOR MY SHORT-TERM MEMORY. FIVE TO SIX. I MEAN, IT WAS LESS THAN -- THE UPPER LIMIT WAS LESS THAN 10.

MR. QUINLIVAN: THANK YOU, DOCTOR.

THE WITNESS: IN BOTH CASES. VERY FEW.

MR. QUINLIVAN: THANK YOU, DOCTOR.

THANK YOU, YOUR HONOR. I HAVE NOTHING FURTHER.

THE COURT: CROSS-EXAMINATION?

MS. KRASNOFF: YOUR HONOR, ONE POINT OF CLARIFICATION. WE HAVE NO OBJECTION ABOUT HOW THIS DOCUMENT FROM DR. HASKELL WAS USED, BUT IT IS ON DEFENDANT'S LEARNED

TREATISE LIST, AND WE OBJECT THAT IT IS NOT A LEARNED TREATISE. IT HAS NOT BEEN PUBLISHED, AND IT DOESN'T MEET THE LEARNED TREATISE EXCEPTION, SO WE OBJECT. THEY TRIED TO USE IT AS A LEARNED TREATISE.

MR. QUINLIVAN: YOUR HONOR, I USED IT JUST TO REFRESH HIS RECOLLECTION AS TO WHEN THE PRESENTATION WAS MADE. I AM CERTAINLY NOT OFFERING IT INTO EVIDENCE, NOR DID I INTEND OR DID I USE IT FOR ANY OTHER PURPOSE.

THE COURT: WELL, NONE OF THE LEARNED TREATISES WILL BE ADMITTED INTO EVIDENCE UNLESS WE HAVE SOME FURTHER DISCUSSION ABOUT THAT.

AND WITH REGARD TO THE EXHIBIT REFERRED TO, MR. QUINLIVAN, I ACTUALLY ONLY HAVE THE COVER SHEET AND THE FIRST PARAGRAPH. THE ENTIRE EXHIBIT IS NOT IN AT LEAST THE COURT'S EXHIBIT BINDER. SO, IF THERE IS AN EXTRA COPY SOMEWHERE?

MR. QUINLIVAN: I DO HAVE AN EXTRA COPY, YOUR HONOR. I DO APOLOGIZE FOR THAT.

THE COURT: ALL RIGHT.

CROSS-EXAMINATION

BY MS. KRASNOFF:

Q. GOOD MORNING, DR. BOWES.

A. GOOD MORNING.

Q. I AM HELENE KRASNOFF. WE MET AT CHAPEL HILL --

A. YES, WE DID.

Q. -- AT YOUR DEPOSITION. AND I APPRECIATE THAT YOU HAVE NOT YET SAID ANYTHING TO ME TODAY ABOUT SATURDAY NIGHT'S DEMISE OF MY BLUE DEVIL.

I WOULD LIKE TO START, DR. BOWES, BY TALKING TO YOU ABOUT HOW A PHYSICIAN CHOOSES THE APPROPRIATE ABORTION METHOD FOR HIS OR HER OWN PATIENT.

YOU WOULD AGREE, DOCTOR, THAT IN STARTING AN ABORTION PROCEDURE, WHETHER IT BE AN INDUCTION, A D&E, AN INTACT D&E OR SOME OTHER PROCEDURE, THAT THE PHYSICIAN'S INTENT IS TO END THE PREGNANCY IN THE WAY SAFEST FOR THE WOMAN, WOULDN'T YOU?

A. YES.

Q. AND YOU WOULD AGREE THAT THE SAFEST AND MOST APPROPRIATE ABORTION PROCEDURE FOR A PARTICULAR WOMAN DEPENDS, IN PART, ON THE GESTATIONAL AGE OF THE PREGNANCY?

A. YES.

Q. AND YOU WOULD AGREE, ALSO, THAT THE SAFEST AND MOST APPROPRIATE ABORTION PROCEDURE FOR A PARTICULAR WOMAN DEPENDS, IN PART, ON HER UNDERLYING HEALTH?

A. YES.

Q. AND YOU WOULD ALSO AGREE THAT THE SAFEST AND MOST APPROPRIATE ABORTION PROCEDURE FOR ANY INDIVIDUAL WOMAN WOULD DEPEND, IN PART, ON ANY MEDICAL CONTRAINDICATION THAT SHE MIGHT HAVE?

A. YES.

Q. AND YOU WOULD AGREE THAT THE SAFEST AND MOST APPROPRIATE ABORTION PROCEDURE FOR A PARTICULAR WOMAN DEPENDS, IN PART, ON HER PRIOR SURGICAL HISTORY, IF ANY?

A. YES.

Q. AND YOU WOULD AGREE THE SAFEST AND MOST APPROPRIATE ABORTION PROCEDURE FOR A PARTICULAR WOMAN DEPENDS, IN PART, ON THE TRAINING, SKILL AND EXPERIENCE OF HER PHYSICIAN?

A. YES.

Q. AND YOU WOULD AGREE, ALSO, THAT THE SAFEST AND MOST APPROPRIATE ABORTION PROCEDURE FOR ANY PARTICULAR WOMAN DEPENDS, IN PART, ON WHETHER SHE OR HER DOCTOR DESIRES TO REMOVE THE FETUS INTACT TO PERMIT COMPLETE PATHOLOGICAL TESTING.

A. YES.

Q. AND YOU WOULD AGREE THAT WITH RESPECT TO A MEDICAL EMERGENCY EXCEPTION TO AN ABORTION RESTRICTION A PHYSICIAN SHOULD BE PERMITTED TO RELY ON HIS OR HER OWN BEST MEDICAL JUDGMENT TO DETERMINE IF THERE IS SUCH AN EMERGENCY?

A. YES.

Q. NOW, I WOULD LIKE TO SWITCH A LITTLE BIT AND TALK TO YOU SPECIFICALLY ABOUT D&E ABORTIONS. WOULD YOU AGREE WITH ME IN A D&E IF REMOVAL OF THE FETUS CAN BE ACCOMPLISHED WITH FEWER RATHER THAN MORE INSTRUMENTAL PASSES THAT THAT WOULD BE HELPFUL?

A. INTUITIVELY, YES, I WOULD AGREE WITH THAT.

Q. AND WOULD YOU ALSO AGREE THAT WHEN A PHYSICIAN PERFORMS A D&E HE OR SHE IS TRYING TO DO SO WITH AS LITTLE TRAUMA AND BLOOD LOSS AS POSSIBLE FOR THE WOMAN; IS THAT RIGHT?
A. YES, I WOULD AGREE.
Q. AND HE OR SHE TRIES WITHIN THE BOUNDS OF SAFETY TO COMPLETE THE PROCEDURE AS QUICKLY AS POSSIBLE; IS THAT CORRECT?
A. YES.
Q. AND WOULD YOU AGREE THE PHYSICIAN TRIES TO INSERT THE FORCEPS INTO THE UTERUS AS FEW TIMES AS POSSIBLE IN ORDER TO COMPLETE THE PROCEDURE?
A. YES.
Q. AND I THINK THAT YOU ALLUDED TO THIS IN YOUR PRIOR ANSWER, BUT YOU WOULD AGREE INTUITIVELY, EVEN IF NOT CONCLUSIVELY, THAT A TECHNIQUE THAT REDUCES THE NUMBER OF INSERTIONS OF INSTRUMENTS INTO THE UTERUS MIGHT OFFER SOME SAFETY ADVANTAGES?
A. YES.
Q. AND YOU AGREE DURING THE COURSE OF A D&E IT MIGHT HAPPEN ON SOME OCCASION THAT THE PHYSICIAN IS ABLE TO EXTRACT THE FETUS UP TO THE CALVARIUM WITH ONE PASS OF INSTRUMENTS INTO THE UTERUS?
A. YES.
Q. DO YOU AGREE THAT THE RISKS OF D&E INCREASE AS GESTATIONAL AGE ADVANCES?
A. YES. I THINK THERE IS EVIDENCE THAT IT DOES.
Q. AND IF YOU HAD TWO LARGE GROUPS OF WOMEN HAVING D&E'S, ONE

GROUP HAVING THEM AT 20 WEEKS AND ONE WHO WAS HAVING THEM AT 22 WEEKS, WOULD YOU EXPECT TO SEE MORE COMPLICATIONS IN THE 22 WEEK GROUP?

A. INTUITIVELY, YES, YOU WOULD.

Q. YOU AGREE, DON'T YOU, THAT OVERALL D&E IS A SAFER PROCEDURE THAN INDUCTION?

A. I BELIEVE IT'S BEEN ESTABLISHED THAT IT IS.

Q. AND THAT'S PART BASED ON THE DATA OF THE CENTERS FOR DISEASE CONTROL?

A. YES.

Q. AND IT'S ALSO, IN PART, BASED ON THE RESEARCH OF DR. GRIMES?

A. YES.

Q. AND I THINK YOU HAVE TESTIFIED TO THIS, BUT YOU KNOW DR. GRIMES WELL, DON'T YOU?

A. I DO.

Q. AND HE IS ON THE FACULTY AT YOUR INSTITUTION; IS THAT CORRECT?

A. YES, THAT'S CORRECT.

Q. AND HE'S A WELL-RESPECTED PRACTITIONER, ISN'T HE?

A. YES, HE IS.

Q. AND HE'S ALSO A VERY COMPETENT RESEARCHER?

A. YES, HE IS.

Q. AND I THINK YOU ALSO ALLUDED TO THIS ON YOUR DIRECT, BUT YOU AGREE THAT THERE IS EVIDENCE THAT WOMEN PREFER D&E TO

INDUCTION ABORTIONS BECAUSE D&E ABORTIONS DO NOT REQUIRE THE WOMEN TO BE IN LABOR; IS THAT CORRECT?

A. GENERALLY, THAT IS CORRECT, YES.

Q. AND YOU WOULD AGREE THAT THERE ARE CERTAIN CONTRAINDICATIONS FOR INDUCTION IN THE SECOND-TRIMESTER OF PREGNANCY?

A. YES.

Q. AND ONE OF THOSE WOULD BE A CLASSICAL UTERINE SCAR OR A MYOMECTOMY? A SCAR FROM A MYOMECTOMY.

A. A SCAR FROM A MYOMECTOMY, YES, MA'AM.

Q. AND A MYOMECTOMY IS SURGERY TO REMOVE UTERINE FIBROIDS; IS THAT CORRECT?

A. YES, THAT'S CORRECT.

Q. AND DO YOU BELIEVE THAT RETAINED PLACENTA IS A COMPLICATION OF INDUCED ABORTION?

A. YES.

Q. I AM SORRY. AND THAT IS SPECIFICALLY OF INDUCTION ABORTIONS. I MISSPOKE. IT'S A COMPLICATION OF INDUCTION ABORTIONS?

A. YES.

Q. AND WOULD YOU AGREE THAT ON RARE OCCASIONS INDUCTION ABORTIONS MAY NOT ALWAYS BE SUCCESSFUL?

A. ON RARE OCCASION, YES.

Q. AND ON THOSE RARE OCCASIONS, IF IT IS NOT SUCCESSFUL, THE PHYSICIAN MAY HAVE TO PERFORM A SEPARATE SURGICAL PROCEDURE IN

ORDER TO COMPLETE THE ABORTION; IS THAT CORRECT?
A. THAT'S CORRECT.
Q. AND WOULD YOU AGREE THAT AT 20 OR 21 WEEKS THE UTERUS USUALLY DOESN'T CONTRACT SPONTANEOUSLY, OR IF IT DOES, THE CONTRACTIONS ARE SPORADIC AND DON'T CAUSE CERVICAL DILATION?
A. IN GENERAL, THAT IS CORRECT, YES.
Q. AND WOULD YOU AGREE THAT THE DRUGS USED IN INDUCTION ABORTION TO CAUSE UTERINE CONTRACTIONS OVERRIDE THAT PROCESS?
A. YES, THEY DO.
MR. QUINLIVAN: YOUR HONOR? YOUR HONOR, I WILL OBJECT TO THIS LINE OF QUESTIONING. I DIDN'T ASK ANY QUESTIONS COMPARING LABOR INDUCTION TO D&E, SO IT SEEMS TO ME THAT THIS LINE OF QUESTIONING IS BEYOND THE SCOPE.
MY ONLY QUESTION IN THIS REGARD WAS WHETHER YOU WOULD BE ABLE TO CONSTRUCT A STUDY -- THE COMPARATIVE EASE OF CONSTRUCTING A STUDY OF INTACT D&X VERSUS D&E, LABOR INDUCTION VERSUS D&E, BUT I DID NOT ASK ANY QUESTIONS BEARING ON THE SAFETY OF INDUCTION VERSUS D&E.
SO I OBJECT TO THIS LINE OF QUESTIONING.
THE COURT: RESPONSE?
MS. KRASNOFF: WELL, YOUR HONOR, WE HAVE -- THIS CAME UP WITH ONE OF OUR WITNESSES. WE HAD LISTED ON OUR WITNESS LIST ALL OF THE DEFENDANT'S WITNESSES, AND I HAVE NOT ASKED ANY QUESTIONS THAT ARE BEYOND WHAT WAS ASKED OF DR. BOWES IN HIS DEPOSITION IN FEBRUARY, SO DEFENDANT WAS ON NOTICE THAT

THESE QUESTIONS COULD ARISE.

MR. QUINLIVAN: WELL, I HAVE TWO ANSWERS TO THAT. FIRST OFF, I DON'T BELIEVE THAT ANY OF -- FOR EXAMPLE, THE PLAINTIFFS HAVE DESIGNATED DEPOSITION TRANSCRIPTS FROM DR. LOCKWOOD. THEY DID NOT DO SO WITH DR. BOWES.

SECONDLY, WHAT MATTERS CAME UP IN THE DEPOSITION ARE ENTIRELY DISTINCT FROM BEING BEYOND THE SCOPE OF DIRECT EXAMINATION.

YOUR HONOR RECALLS DURING THE TESTIMONY OF DR. PAUL I ASKED SOME QUESTIONS REGARDING FETAL PAIN, AND I WAS DIRECTED NOT TO GO INTO THAT SUBJECT MATTER BECAUSE --

THE COURT: I UNDERSTAND THE POINT, MR. QUINLIVAN, BUT IF, INDEED, BOTH SIDES HAVE CROSS-DESIGNATED WITNESSES, MY PREFERENCE IS THAT THE WITNESS BE EXAMINED ONCE AND NOT HAVE TO BE RECALLED.

I DON'T HAVE YOUR WITNESS LIST IN FRONT OF ME. IF YOU TELL ME YOU CROSS-DESIGNATED HIM AS A WITNESS THAT YOU MIGHT CALL, YOU WOULD BE ENTITLED TO CALL HIM AT SOME POINT, SO I WILL ALLOW LATITUDE IN THE CROSS-EXAMINATION.

MS. KRASNOFF: AND WE RESERVED THE RIGHT TO CALL ANY OF THE DEFENDANT'S WITNESSES IF NEED BE.

THE COURT: ALL RIGHT, THEN. EVEN THOUGH IT IS BEYOND THE SCOPE -- LET ME JUST CHECK MY LIST.

MS. KRASNOFF: IT'S WE RESERVED THE RIGHT TO CALL ANY WITNESSES ON PAGE 2 OF OUR WITNESS LIST AT LINES SIX AND

SEVEN.

THE COURT: OKAY. ALL RIGHT. I AM GOING TO PERMIT IT, THEN.

BY MS. KRASNOFF:

Q. ACTUALLY, I ONLY HAD ONE MORE QUESTION RELATED TO THIS, ANYWAY, BUT -- THE PREVIOUS QUESTION I HAD ASKED BEFORE MR. QUINLIVAN AND I ENGAGED IN THIS CONVERSATION WAS THAT I BELIEVE YOU SAID THAT YOU AGREE THAT THE DRUGS USED IN AN INDUCTION ABORTION TO CAUSE UTERINE CONTRACTIONS OVERRIDE THIS GENERAL PROPOSITION THAT AT 20 OR 21 WEEKS THE UTERUS DOES NOT CONTRACT; IS THAT CORRECT?

A. THAT'S CORRECT, YES.

Q. AND IN THAT WAY, WOULD YOU AGREE THAT INDUCTION ABORTION IS NOT A NATURAL OR PHYSIOLOGIC PROCESS?

A. I WOULD AGREE WITH THAT, YES.

Q. WE REFERRED TO DR. MAUREEN PAUL'S TEXTBOOK. YOU WOULD AGREE THAT THAT TEXTBOOK IS AUTHORITATIVE, WOULD YOU NOT?

A. YES.

Q. AND YOU ALSO KNOW CAROLYN WESTHOFF BY REPUTATION; DO YOU NOT?

A. I DO.

Q. AND WOULD YOU AGREE WITH ME THAT HER REPUTATION IN THE MEDICAL AND OBSTETRIC AND GYNECOLOGIC COMMUNITY IS HIGH?

A. YES.

Q. DR. BOWES, I WOULD LIKE TO TALK TO YOU ABOUT THE TESTIMONY

ABOUT VARIOUS STUDY METHODS THAT ARE USED IN MEDICINE THAT YOU GAVE THIS MORNING.

YOU ARE NOT AN EPIDEMIOLOGIST, ARE YOU?

A. NO, I AM NOT.

Q. AND DO YOU HAVE ANY SPECIAL, FORMAL TRAINING IN EPIDEMIOLOGY?

A. NO, I DON'T.

Q. YOU GAVE SOME TESTIMONY ABOUT LEARNED TREATISE 11, WHICH IS THE GRIMES ARTICLE. AND THAT WAS PUBLISHED IN THE BRITISH JOURNAL OF OBSTETRICS AND GYNECOLOGY IN FEBRUARY OF 2004; IS THAT CORRECT?

A. YES, THAT'S CORRECT.

Q. AND THAT'S A REPUTABLE JOURNAL; IS IT NOT?

A. IT CERTAINLY IS.

Q. AND I THINK YOU TESTIFIED TO THIS, BUT THAT ARTICLE DOCUMENTED DR. GRIMES' ATTEMPTS TO CONDUCT A RANDOMIZED PROSPECTIVE STUDY REGARDING THE SAFETY OF D&E VERSUS INDUCTION ABORTION?

A. THAT'S CORRECT.

Q. AND DR. GRIMES DISCONTINUED HIS STUDY BECAUSE HE COULD NOT GET SUFFICIENT PATIENTS WHO WOULD AGREE TO THE RANDOMIZATION; IS THAT CORRECT?

A. THAT'S CORRECT.

Q. AND YOU AGREE THAT, IN GENERAL, IT WOULD BE VERY DIFFICULT IN ANY SETTING IN THE UNITED STATES TO DO A RANDOMIZED

PROSPECTIVE STUDY TO COMPARE INDUCTIONS AND D&E'S; IS THAT NOT TRUE?

A. IT WOULD BE DIFFICULT AS ALL RANDOMIZED CONTROLLED TRIALS ARE DIFFICULT. BUT I DON'T THINK I WENT BEYOND THAT. IT WOULD BE DIFFICULT.

Q. WELL, IN FACT, DR. GRIMES POINTED OUT IN HIS STUDY THAT THE STUDY THAT HE WAS TRYING TO COMPLETE WOULD HAVE TO BE PERFORMED IN ANOTHER COUNTRY, DIDN'T HE?

A. YES. BUT, OF COURSE, HE WAS NOT COMPARING TWO SURGICAL PROCEDURES. HE WAS COMPARING THE LABOR INDUCTION PROCEDURE TO A D&E PROCEDURE.

Q. AS WAS I. I WAS ACTUALLY JUST LIMITING IT AT THIS POINT TO THE STUDY HE WAS TRYING TO PERFORM, COMPARING D&E AND INDUCTION.

A. YES.

Q. DO YOU AGREE THAT THAT WOULD HAVE TO BE DONE IN ANOTHER COUNTRY?

A. WELL, I AGREE THAT DR. GRIMES SUGGESTED THAT THAT WAS THE PLACE IT WOULD BE BEST BE DONE.

Q. YOU DON'T AGREE THAT IS TRUE?

A. I WOULD AGREE WITH THAT.

Q. SO IT WASN'T SOMETHING ABOUT NORTH CAROLINA SPECIFICALLY THAT LIMITED THE ABILITY TO DO THE STUDY THAT DR. GRIMES WAS TRYING TO DO; IS THAT CORRECT?

A. WELL, I BELIEVE HE SAID THAT ONE OF THE THINGS IS -- ONE OF

THE LIMITATIONS TO THE STUDY WAS THAT THERE ARE SO MANY ABORTION PROVIDERS IN NORTH CAROLINA THAT THERE WAS NOT A LARGE ENOUGH POPULATION AT HIS CLINIC TO PERFORM THAT STUDY IN THAT SETTING THAT HE STARTED OUT.

Q. SO I GUESS I AM CONFUSED, BECAUSE YOU AGREED THAT -- YOU AGREED THAT IT WOULD HAVE TO BE DONE IN ANOTHER COUNTRY, SO I AM CONFUSED ABOUT WHAT IS IT THAT IS SPECIFIC ABOUT NORTH CAROLINA THAT WOULD MAKE IT POSSIBLE TO DO IT SOMEWHERE ELSE IN THE UNITED STATES.

MR. QUINLIVAN: OBJECTION. MISCHARACTERIZES THE WITNESS' TESTIMONY.

THE COURT: I THINK IT KIND OF DOES, AS WELL.

COULD YOU JUST REPEAT THE EARLIER QUESTION?

BY MS. KRASNOFF:

Q. SURE. YOU AGREED WITH ME THAT THE STUDY COMPARING D&E AND INDUCTIONS COULD NOT BE PERFORMED IN THIS COUNTRY; IS THAT CORRECT?

A. YES.

Q. SO, THEREFORE, THERE IS NOTHING SPECIFIC ABOUT NORTH CAROLINA AS COMPARED TO THE OTHER STATES IN THE UNITED STATES LIMITING HIS ABILITY TO DO THIS STUDY?

A. NO. I UNDERSTAND. I MISUNDERSTOOD THE QUESTION. I AGREE WITH THAT.

Q. OKAY. AND THAT'S BECAUSE I THINK YOU TESTIFIED ABOUT HOW YOU DO TRIALS, YOU NEED EQUIPOISE BETWEEN TWO METHODS. SO WHEN

YOU CONSENT THE PATIENT INTO THE STUDY YOU CAN TELL THEM THAT YOU ARE NOT SURE WHICH IS THE BEST METHOD OF TREATMENT FOR THEM; IS THAT CORRECT?

A. THAT'S CORRECT.

Q. AND THERE IS JUST NOT THAT SORT OF EQUIPOISE IN THIS COUNTRY BETWEEN D&E AND INDUCTION ABORTIONS; IS THAT CORRECT?

A. YES, WITH ONE CAVEAT, IF I MAY.

Q. SURE.

A. DR. GRIMES POINTED OUT THAT THE INDUCTION METHOD WHICH HE WAS OFFERING THE PATIENTS IS A NEW INDUCTION METHOD WHICH IN HIS -- IT'S HIS IMPRESSION THAT IT WOULD BE LESS RISKY, MORE EFFICIENT AND LESS RISKY THAN THE OTHER INDUCTION PROCEDURES TO WHICH D&E HAS PREVIOUSLY BEEN COMPARED.

Q. AND THE METHOD THAT DR. GRIMES WAS USING, THAT IS NOT AVAILABLE IN THE UNITED STATES EXCEPT FOR HIS STUDY, IS IT?

A. THE DRUGS ARE AVAILABLE, AND IT WOULD HAVE TO BE DONE UNDER STUDY CONDITIONS UNDER THE AUSPICES OF A TRIAL THAT HAD BEEN APPROVED, IF I UNDERSTAND YOUR QUESTION CORRECTLY.

Q. YES, BUT ONE OF THE DRUGS, MIFEPRISTONE, IS NOT FDA-APPROVED FOR THE PURPOSE FOR WHICH DR. GRIMES WAS USING IT; IS THAT NOT CORRECT?

A. THAT'S CORRECT.

Q. AND IN THE METHODS THAT ARE APPROVED FOR USE IN INDUCTION, YOU WOULD AGREE THAT WE DON'T HAVE EQUIPOISE TODAY IN THIS COUNTRY BETWEEN D&E AND INDUCTION?

A. I AGREE WITH THAT, YES.
Q. BECAUSE D&E IS A SUPERIOR METHOD OF SECOND-TRIMESTER ABORTION; IS THAT CORRECT?
A. I AGREE WITH THAT.
Q. ANOTHER REASON IT WOULD BE VIRTUALLY IMPOSSIBLE TO CONDUCT THE STUDY WE ARE TALKING ABOUT IN THE UNITED STATES IS BECAUSE 96 PERCENT OF ALL SECOND-TRIMESTER ABORTIONS ARE PERFORMED BY D&E; IS THAT CORRECT?
A. CORRECT.
Q. LEAVING LABOR INDUCTION BEHIND, YOU TESTIFIED ON DIRECT THAT ONE OF THE THINGS THAT SUPPORTS YOUR BELIEF ABOUT THE FEASIBILITY OF PERFORMING A PROSPECTIVE RANDOMIZED TRIAL COMPARING THE TWO SURGICAL TECHNIQUES, D&E WHERE THE FETUS IS DISARTICULATED VERSUS D&E WHERE THE FETUS IS REMOVED INTACT, IS A RECENT STUDY ON BREECH DELIVERY THAT WAS PUBLISHED; IS THAT CORRECT?
WAS THAT STUDY PUBLISHED IN THE LANCET IN THE YEAR 2000?
A. YES.
Q. IN FACT, I THINK YOU SAID IT WAS A SIMILAR OR COMPARABLE SITUATION TO D&E WHERE THE FETUS WAS REMOVED INTACT VERSUS WHERE THE FETUS IS DISARTICULATED; IS THAT CORRECT?
A. WELL, BY "COMPARABLE" I DIDN'T MEAN THAT THERE WERE SURGICAL PROCEDURES THE SAME. I MEANT THAT IT INVOLVED OFFERING THE PATIENTS TWO OPTIONS ABOUT AN OBSTETRICAL

SITUATION OR OUTCOME.
Q. YOU THOUGHT THAT THE DIFFICULTY IN PERFORMING THOSE STUDIES WOULD BE COMPARABLE?
A. YES.
Q. IS IT NOT TRUE THAT THE LANCET STUDY INVOLVED 121 DIFFERENT CENTERS IN 26 DIFFERENT COUNTRIES?
A. THAT'S CORRECT.
Q. WOULD YOU AGREE THAT IT WOULD BE DIFFICULT TO FIND 121 DIFFERENT CENTERS IN 26 DIFFERENT COUNTRIES WHERE A SECOND-TRIMESTER SURGICAL ABORTION IS WIDELY AVAILABLE AND WHERE PHYSICIANS ARE CAPABLE IN BOTH -- IN PERFORMING BOTH THE D&E WITH DISARTICULATION AND THE D&E WHERE THE FETUS IS REMOVED INTACT?
A. I SUSPECT IT WOULD BE DIFFICULT, ALTHOUGH NOT NECESSARILY A PREREQUISITE OF PERFORMING THE STUDY. YOU WOULD NEED MULTIPLE INSTITUTIONS, NOT NECESSARILY THE SAME NUMBER OR SAME COUNTRIES THAT THE BREECH STUDY WAS CONDUCTED.
Q. ARE YOU AWARE IF THERE ARE 26 DIFFERENT COUNTRIES IN THE WORLD WHERE SURGICAL ABORTIONS ARE PERFORMED BY D&E AND INTACT D&E?
A. NO, I AM NOT AWARE OF THAT.
Q. SPEAKING GENERALLY NOW ABOUT PROSPECTIVE RANDOMIZED TRIALS, WOULD YOU AGREE THAT SOME PROSPECTIVE TRIALS ARE ATTEMPTING TO LOOK AT THE GENERAL SAFETY OF A PARTICULAR TREATMENT OR INTERVENTION IN THE GENERAL POPULATION?

A. COULD YOU REPEAT THAT QUESTION, PLEASE?
Q. SURE. WOULD YOU AGREE THAT SOME PROSPECTIVE TRIALS THE PURPOSE IS TO LOOK AT A SPECIFIC INTERVENTION OR TREATMENT IN THE GENERAL POPULATION?
A. YES.
Q. AND THOSE ARE OFTEN A FIRST STEP IN ESTABLISHING THE SAFETY OF AN INTERVENTION OR TREATMENT; IS THAT CORRECT?
A. NOW, IF YOU MEAN BY "PROSPECTIVE TRIAL" THE RANDOMIZED TRIAL THAT I HAVE DESCRIBED?
Q. YES.
A. AND IF YOU MEAN BY "GENERAL POPULATION" THE POPULATION OF INDIVIDUALS THAT HAVE THE CONDITION OR TREATMENT, YES.
Q. YES.
AND ISN'T IT THE CASE IF A POTENTIAL PARTICIPANT IN ONE OF THOSE TRIALS HAS A VERY SERIOUS HEALTH CONDITION WHICH IS UNRELATED TO WHAT IS BEING STUDIED, THAT HE OR SHE MIGHT BE EXCLUDED FROM THE STUDY?
A. YES.
Q. IN FACT, I DON'T KNOW IF YOU REMEMBER, BUT IN THE LANCET STUDY WE WERE JUST TALKING ABOUT, MULTIPLE GESTATIONS WERE EXCLUDED; IS THAT CORRECT? AND WOMEN WITH A GESTATIONAL AGE LESS THAN 37 WEEKS WERE EXCLUDED; IS THAT CORRECT?
A. YES.
Q. AND IF THE FETUS WAS JUDGED TO BE CLINICALLY LARGE OR TO HAVE AN ESTIMATED FETAL WEIGHT OF 400 GRAMS OR MORE THEY WERE

EXCLUDED?

A. YES.

Q. AND IF THERE WAS A FETAL ANOMALY OR CONDITION THAT MIGHT CAUSE A MECHANICAL PROBLEM AT DELIVERY, SUCH AS HYDROCEPHALUS THEY WERE EXCLUDED?

A. I AM AWARE OF THAT, YES.

Q. AND THAT IS TYPICAL IN GENERAL SAFETY STUDIES TO EXCLUDE PEOPLE WITH CONDITIONS?

A. YES.

Q. THAT ARE UNRELATED TO THE TREATMENT, CORRECT? YES?

A. YES.

Q. SO IS IT FAIR, THEN, TO SAY THAT A PROSPECTIVE RANDOMIZED TRIAL SUCH AS THAT WOULD NOT TELL YOU HOW THE TREATMENT OR INTERVENTION BEING STUDIED WOULD BE TOLERATED BY A PERSON WITH ONE OF THOSE MEDICAL CONDITIONS THAT IS NOT THE SUBJECT OF THE STUDY?

A. IF IN CONSTRUCTING THE STUDY YOU ELIMINATED CERTAIN PATIENTS, INDEED, THE STUDY WOULD NOT APPLY -- THE RESULTS OF THE STUDY WOULD NOT APPLY TO THOSE PATIENTS WHO HAD BEEN EXCLUDED.

Q. AND EVEN THEN IF THE STUDY SHOWED THAT THAT TREATMENT OR INTERVENTION HAD CERTAIN ADVANTAGES IN THE GENERAL POPULATION, IT MIGHT BE THE CASE THAT PEOPLE WITH A CERTAIN SERIOUS UNDERLYING MEDICAL CONDITION SHOULD NOT HAVE THAT TREATMENT; ISN'T THAT TRUE?

A. THAT'S TRUE.
Q. AND BY THE SAME TOKEN, IF THAT SORT OF TRIAL DEMONSTRATED A TREATMENT OR INTERVENTION DID NOT BENEFIT THE GENERAL POPULATION, IT STILL MIGHT BE BETTER FOR ANY SPECIFIC PATIENT WITH A SPECIFIC HEALTH CONDITION; ISN'T THAT RIGHT?
A. I THINK THAT IS RIGHT.
THERE ARE A LOT OF CONDITIONS THERE.
Q. DO YOU WANT ME TO REPEAT IT?
A. NO, MA'AM. I THINK I UNDERSTAND IT.
Q. YOU OFFERED SOME TESTIMONY ABOUT THE SAFETY ADVANTAGES OR WHETHER OR NOT THERE WERE SAFETY ADVANTAGES ABOUT D&E ABORTIONS WHERE THE FETUS IS REMOVED INTACT UP TO THE CALVARIUM. HAVE YOU EVER PERSONALLY OBSERVED OR SUPERVISED A D&E WHERE THE FETUS WAS REMOVED INTACT UP TO THE CALVARIUM?
A. NO, MA'AM.
Q. AND YOU'VE NEVER SPOKEN TO ANY PHYSICIAN WHO PERFORMS INTACT D&E'S ABOUT THOSE ABORTIONS, HAVE YOU?
A. NO.
Q. AND THE ONLY MATERIALS YOU REVIEWED TO PREPARE YOUR ORIGINAL EXPERT REPORT WERE DR. PAUL'S TEXTBOOK, THE HASKELL PAPER THAT YOU WERE JUST LOOKING AT, AND ANOTHER NONPUBLISHED PAPER; IS THAT CORRECT?
A. AS RELATES TO THE ABORTION ASPECTS. I REVIEWED OTHER THINGS BECAUSE THE QUESTIONS WENT BEYOND THAT TO SUCH THINGS AS THE INCIDENCE OF NEONATAL DEATH AFTER LATE GESTATIONAL AGE.

Q. THOSE WERE THE ONLY MATERIALS THAT RELATED TO REMOVAL OF A FETUS INTACT DURING A D&E; IS THAT CORRECT?
A. YES.
Q. AND DESPITE THAT YOU HAVE DR. GRIMES, WHO IS AN EXPERT ON INDUCED ABORTION AT UNC, YOU HAVEN'T SPOKEN TO HIM ABOUT HIS OPINIONS ABOUT INTACT D&E, HAVE YOU?
A. NO, I HAVE NOT.
Q. YOU ACTUALLY HAVEN'T SPOKEN TO HIM ABOUT HIS OPINIONS ABOUT D&E ABORTIONS, EITHER, HAVE YOU?
A. I DON'T THINK I HAVE SPOKEN TO HIM DIRECTLY. I HAPPEN TO KNOW HIS LITERATURE WELL, AND HE'S WRITTEN EXTENSIVELY ABOUT IT, SO I THINK I HAVE SOME IDEA ABOUT WHAT HIS IMPRESSIONS ARE.
Q. WOULD YOU AGREE WITH ME, DOCTOR, THOUGH, THAT THERE IS A BODY OF MEDICAL OPINION WHICH CONSISTS OF RESPONSIBLE GROUP OF PHYSICIANS THAT HOLD THE OPINION THAT INTACT REMOVAL OF A FETUS DURING A SURGICAL ABORTION MAY BE THE SAFEST PROCEDURE FOR SOME WOMEN IN SOME CIRCUMSTANCES?
A. YES.
Q. AND YOU WOULD AGREE THAT THERE IS NO CONSENSUS IN THE MEDICAL COMMUNITY THAT REMOVAL OF THE FETUS DURING A D&E IS NEVER MEDICALLY NECESSARY; IS THAT RIGHT?
A. THAT'S CORRECT.
Q. AND YOU'VE OFFERED SOME CRITICISMS OF DR. CHASEN'S STUDY TODAY, BUT IT IS NOT YOUR VIEW THAT HIS STUDY IS OF NO USE, IS IT?

A. NO, THAT IS NOT MY VIEW.
Q. INDEED, YOU BELIEVE THAT HIS STUDY WOULD HELP A PHYSICIAN DESIGN A PROSPECTIVE RANDOMIZED TRIAL; ISN'T THAT RIGHT?
A. YES.
Q. AND WOULD YOU AGREE WITH ME THAT A STUDY LIKE DR. CHASEN'S IS OFTEN THE FIRST STEP IN THE PROCESS TOWARDS A RANDOMIZED CONTROLLED TRIAL?
A. I WOULD AGREE WITH THAT.
Q. AND LEAVING DR. CHASEN'S STUDY ASIDE, YOU BELIEVE THAT A VERY CREDIBLE, RESPECTIVE COHORT STUDY COULD BE CONDUCTED COMPARING D&E WHERE THE FETUS IS REMOVED INTACT TO WHERE THE FETUS IS REMOVED IN A D&E BY DISARTICULATION?
A. YES, I BELIEVE THAT.
Q. AND THAT STUDY WOULD BE VERY SIMILAR TO DR. CHASEN'S, RIGHT?
A. YES.
Q. AND YOU BELIEVE THAT A PROPERLY CONDUCTED STUDY SUCH AS THAT IS A VALID AND ACCEPTABLE BASIS ON WHICH A PARTICULAR PROCEDURE COULD BECOME WIDELY USED IN THE POPULATION, DON'T YOU?
A. I DO.
Q. AND I AM CORRECT, AREN'T I, THAT YOU CAN'T PROPERLY CONDUCT A RETROSPECTIVE CASE CONTROLLED STUDY UNTIL THE TECHNIQUE HAS BEEN USED IN AN APPROPRIATELY LARGE NUMBER OF CASES?
A. CORRECT.

Q. AND IN ORDER TO CONDUCT THAT STUDY, SOME PASSAGE OF TIME MUST OCCUR AFTER THE TECHNIQUE IS INTRODUCED SO THAT A SUFFICIENT NUMBER OF THOSE CASES HAVE OCCURRED; ISN'T THAT CORRECT?

A. THAT'S CORRECT.

Q. AND THAT PERIOD OF TIME COULD BE YEARS; IS THAT RIGHT?

A. YES.

Q. AND THE PERIOD OF TIME WOULD DEPEND ON THE FACTS AND CIRCUMSTANCES OF THE ACTUAL TECHNIQUE THAT IS INVOLVED IN THE STUDY; ISN'T THAT CORRECT?

A. THAT'S CORRECT.

Q. AND YOU AGREE THAT IF A PROCEDURE IS OUTLAWED BEFORE IT HAS BEEN PERFORMED THAT NUMBER OF TIMES, THEN SUCH A STUDY COULD NEVER BE CONDUCTED; ISN'T THAT RIGHT?

A. WELL, IT COULDN'T BE CONDUCTED IN AREAS WHERE THE PROCEDURE WAS OUTLAWED.

Q. AND DO YOU WANT TO EXPLAIN WHAT YOU MEAN BY THAT?

A. WELL, IN ANOTHER SETTING YOU MIGHT BE ABLE TO PERFORM A STUDY OF THESE TWO PROCEDURES WHERE THE PROCEDURE HAD NOT BEEN OUTLAWED.

Q. IF IT WAS OUTLAWED IN THE UNITED STATES, WOULD THE ONLY WAY TO STUDY IT WOULD BE TO DO IT IN ANOTHER COUNTRY?

A. YES, OR ALTER THE PROCEDURE IN SOME WAY SO YOU MODIFY THE PROCEDURE SO IT WOULD NOT -- IT WOULD NOT VIOLATE THE LAW, IF THERE WAS A LAW, ALTHOUGH YOU WOULD NOT BE STUDYING THE

ORIGINAL PROCEDURE ON A LIVE BABY. YOU WOULD NOT BE ACTUALLY DOING A STUDY ON ABORTIONS OF LIVE INFANTS. LIVE FETUSES. EXCUSE ME. LIVE FETUSES.

Q. AND IS THE REFERENCE TO A "LIVE FETUS" SOMETHING ABOUT THE LAW AT ISSUE IN THIS CASE?

A. YES, I BELIEVE IT IS.

Q. AND CAN YOU EXPLAIN WHAT YOU MEAN BY MODIFYING SO YOU DON'T HAVE A LIVE BABY?

A. WELL, THERE ARE CERTAIN ABORTION PROCEDURES IN WHICH PHYSICIANS INJECT MEDICATIONS THAT INTENTIONALLY KILL THE FETUS PRIOR TO AN ABORTION PROCEDURE. SO THAT YOU NOW HAVE A FETAL DEATH.

AND IT IS MY UNDERSTANDING THAT THESE RESTRICTIONS DO NOT APPLY TO SITUATIONS IN WHICH THE FETUS IS NOT ALIVE, IS DEAD.

Q. OKAY. I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT THE INJECTION OF THE CHEMICAL AGENT THAT YOU HAVE REFERENCED.

IN THE FEW D&E ABORTIONS THAT YOU HAVE PERFORMED SINCE YOUR RESIDENCY WHERE THE FETUS WAS ALIVE AT THE OUTSET, YOU DIDN'T INJECT EITHER POTASSIUM CHLORIDE INTO THE FETAL HEART OR DIGOXIN INTO THE AMNIOTIC SAC TO CAUSE FETAL DEMISE BEFORE YOU BEGAN THE PROCEDURE, DID YOU?

A. NO, I DID NOT.

Q. AND YOU AGREE THAT THERE IS NO MEDICAL BENEFIT TO THE WOMAN FROM INJECTING THOSE SUBSTANCES IN ORDER TO CAUSE FETAL DEMISE;

ISN'T THAT CORRECT?

A. I AGREE WITH THAT.

Q. IN FACT, YOU WOULD AGREE THAT THERE ARE RISKS TO THE WOMAN EVEN IF THOSE RISKS ARE VERY SMALL ASSOCIATED WITH THOSE INJECTIONS?

A. YES, I AGREE.

Q. AND THAT THERE IS NO MEDICAL REASON TO SUBJECT THE WOMAN TO THOSE RISKS?

A. THAT'S CORRECT.

Q. AND YOU WOULD AGREE THAT THOSE INDICATIONS CAN'T BE GIVEN TO ALL WOMEN IN ALL SITUATIONS; IS THAT CORRECT?

A. THOSE MEDICATIONS?

Q. YES.

A. I AGREE WITH IT, YES.

Q. FOR EXAMPLE, IT WOULD BE MORE DIFFICULT TO USE THOSE INJECTIONS ON A MORBIDLY OBESE WOMAN; ISN'T THAT RIGHT?

A. THAT'S CORRECT.

Q. SPEAKING SPECIFICALLY ABOUT INJECTIONS OF POTASSIUM CHLORIDE INTO THE FETAL HEART, YOU WOULD AGREE, WOULD YOU NOT, THAT ALL PHYSICIANS DO NOT HAVE THE SKILL TO PERFORM THAT INJECTION?

A. I AGREE WITH THAT.

Q. IN FACT, WHEN YOU PREPARED YOUR EXPERT REPORT, COUNSEL FOR THE DEFENDANT ASKED YOU TO STATE IN THAT REPORT THAT IT IS EASY TO ADMINISTER POTASSIUM CHLORIDE INTO A FETAL HEART AND YOU

FELT THAT WAS NOT AN APPROPRIATE STATEMENT; IS THAT CORRECT?

A. CORRECT.

MR. QUINLIVAN: OBJECTION, YOUR HONOR.

THE COURT: WHAT IS THE OBJECTION?

MR. QUINLIVAN: LACK OF FOUNDATION, THAT I --

THE COURT: PARDON ME?

MR. QUINLIVAN: LACK OF FOUNDATION.

THE COURT: WELL, IT IS BASED ON HIS EXPERT REPORT; IS IT NOT?

MR. QUINLIVAN: NO. SHE WAS ASKING ABOUT THE DRAFT EXPERT REPORT.

THE COURT: OKAY. WHAT IS YOUR RESPONSE?

MS. KRASNOFF: I CAN REPHRASE. I CAN GO TO HIS DEPOSITION WHERE HE TESTIFIED ABOUT IT.

THE COURT: WHY DON'T YOU GO TO HIS DEPOSITION?

MR. QUINLIVAN: YOUR HONOR, JUST FOR THE RECORD, I WANT TO NOTE THAT WE HAVE NOW GONE FAR BEYOND ANYTHING -- I DIDN'T MENTION ANYTHING ABOUT INJECTIONS OF DIGOXIN OR POTASSIUM CHLORIDE DURING MY OPENING. AND CONSISTENT WITH YOUR RULING WITH RESPECT TO DR. PAUL, IT SEEMS TO ME THAT THE PLAINTIFFS ARE BEING ALLOWED TO QUESTION THE WITNESS FAR BEYOND THE SCOPE OF DIRECT EXAMINATION.

THE COURT: OKAY.

MS. KRASNOFF: YOUR HONOR, I ACTUALLY DIDN'T ASK ABOUT FETAL DEMISE UNTIL HE SUGGESTED THAT WAS THE WAY TO

MODIFY IT.

THE COURT: SHE ONLY WENT THROUGH THE DOOR AFTER HE OPENED IT. AND YOU DIDN'T OBJECT AT THAT TIME.

I AM GOING TO PERMIT IT. AS I INDICATED, SINCE YOU DID CROSS-DESIGNATE -- I KNOW THAT YOU -- I BELIEVE YOU DID, AS WELL, YOU CROSS-DESIGNATED THEIR WITNESSES. AND I DON'T RECALL THERE BEING AN OBJECTION BY THE PLAINTIFFS AS TO BEYOND THE SCOPE OF YOUR EXAMINATION.

MR. QUINLIVAN: ACTUALLY, DURING DR. PAUL'S EXAMINATION I HAD ASKED HER SOME QUESTIONS ABOUT FETAL PAIN, AND THE PLAINTIFFS' COUNSEL OBJECTED AS THAT BEING BEYOND THE SCOPE OF DIRECT EXAMINATION. AND THAT OBJECTION WAS SUSTAINED.

THE COURT: WAS THAT SOMETHING ABOUT WHICH SHE WAS QUESTIONED IN HER DEPOSITION?

MR. QUINLIVAN: OFF THE TOP OF MY HEAD, I CAN'T REMEMBER.

MS. GARTNER: YOUR HONOR --

THE COURT: I THOUGHT THAT THAT WAS THE BASIS OF THE OBJECTION. WHAT I AM TRYING TO GET AT HERE, COUNSEL, IS SIMPLY THIS IS A TRIAL BEFORE THE COURT. THERE IS NO JURY. THE RULES ARE RELAXED. I WOULD LIKE TO HEAR AS MUCH INFORMATION WITHOUT HAVING TO CALL WITNESSES BACK A SECOND TIME. THE ONLY CONSTRAINTS THAT I HAVE ENFORCED -- I HOPE CONSISTENTLY -- IS THAT THE -- THAT BOTH SIDES HAVE GIVEN NOTICE WHAT SUBJECT MATTERS ARE THE SUBJECT OF THE TESTIMONY.

AND THAT MEANS IF YOU WERE GIVEN AN OPPORTUNITY TO DEPOSE THE WITNESS ON THE SUBJECT OR IF -- OR IF THEIR EXPERT REPORT REFLECTS AN OPINION ON THE SUBJECT, THEN I THINK THE QUESTIONS ARE FINE FROM BOTH SIDES.

THAT'S THE ONLY RESTRAINT.

MR. QUINLIVAN: VERY WELL, YOUR HONOR.

THE COURT: IF YOU HAVE BOTH CROSS-DESIGNATED, I HAVE, I THINK, AFFORDED SOME LATITUDE IN ASKING QUESTIONS.

OKAY. AND, INDEED, THE FORM OF THE QUESTION, THERE HAVE BEEN VERY FEW OBJECTIONS AS TO THE FORM OF THE QUESTIONS. I HAVE GIVEN LEEWAY ON CROSS AND DIRECT AS TO THE FORM.

OKAY. GO AHEAD.

MS. KRASNOFF: IF I MAY GIVE THE WITNESS A COPY OF HIS DEPOSITION.

HERE IS ONE FOR THE COURT.

PAGES 197 AND 198, BEGINNING AT 197, AT LINE 20.

BY MS. KRASNOFF:

Q. GIVE YOU TIME TO FIND THAT.

A. PAGE WHAT?

Q. PAGES 197, LINE 20.

DR. BOWES, WAS A DRAFT OF YOUR EXPERT REPORT PREPARED BY COUNSEL FOR THE DEFENDANT IN THIS CASE?

A. YES, IT WAS.

Q. AND DID THAT DRAFT INCLUDE THE PHRASE THAT IT IS EASY TO ADMINISTER POTASSIUM CHLORIDE INTO A FETAL HEART?

A. YES.
Q. AND DID YOU REMOVE THAT FROM YOUR EXPERT REPORT?
A. YES.
Q. AND WAS THE REASON THAT YOU REMOVED THAT IS BECAUSE YOU DIDN'T THINK IT IS APPROPRIATE?
A. YES. I DON'T THINK IT IS EASY.
Q. IN FACT, YOU BELIEVE THAT ONE NEEDS EXPERTISE TO ADMINISTER POTASSIUM CHLORIDE INTO A FETAL HEART; IS THAT CORRECT?
A. YES, I DO.
Q. YOU YOURSELF HAVE NEVER DONE THAT?
A. THAT'S CORRECT.
Q. NOR HAVE YOU TAUGHT YOUR STUDENTS TO DO IT?
A. THAT'S CORRECT.
Q. AND AT THE UNIVERSITY OF NORTH CAROLINA, POTASSIUM CHLORIDE INJECTIONS ARE GIVEN ONLY BY MATERNAL FETAL MEDICINE SPECIALISTS AND NOT BY THE ATTENDING OB/GYN; ISN'T THAT RIGHT?
A. THAT'S CORRECT.
Q. TURNING TO DIGOXIN, YOU HAVE NEVER PERSONALLY USED OR OBSERVED DIGOXIN BEING USED TO CAUSE FETAL DEMISE, HAVE YOU?
A. I HAVE NOT.
Q. AND YOU WOULD IMAGINE, WOULDN'T YOU, THAT IN A WOMAN WITH SEVERE HEART DISEASE YOU MIGHT WANT TO AVOID THE USE OF DIGOXIN; ISN'T THAT TRUE?
A. YES.
Q. AND YOU AGREE THAT NAUSEA AND VOMITING ARE KNOWN SIDE

EFFECTS OF DIGOXIN?

A. I AM AWARE OF THAT.

Q. AND YOU AGREE THAT ALL THINGS BEING EQUAL, THE PHYSICIAN WOULD LIKE TO AVOID THOSE SORT OF UNPLEASANT SIDE EFFECTS WHEN POSSIBLE?

A. YES.

Q. AND BEFORE WE MOVED TO THIS TOPIC WE WERE STILL TALKING ABOUT HOW YOU COULD PERFORM A RETROSPECTIVE CASE CONTROLLED STUDY.

AND WOULD YOU AGREE WITH ME THAT AS LONG AS THERE ISN'T A HIGH RATE OF COMPLICATIONS FROM A NEW TECHNIQUE OR VARIATION OF A TECHNIQUE THAT UNTIL THERE IS A SUFFICIENT NUMBER OF TIMES IN WHICH IT HAS BEEN PERFORMED, SUCH THAT IT CAN BE PROPERLY STUDIED, IT IS APPROPRIATE TO LEAVE ITS USAGE TO THE INFORMED JUDGMENT OF RESPONSIBLE PHYSICIANS?

A. YES.

Q. YOUR PRIMARY CRITICISM OF DR. CHASEN'S STUDY IS THAT IT DOESN'T HAVE SUFFICIENT PATIENTS, AND THEREFORE IT DOESN'T HAVE THE POWER TO PROVE THAT THERE IS NO DIFFERENCE BETWEEN THE D&E WITH DISARTICULATION VERSUS THE INTACT D&E GROUP; IS THAT CORRECT?

A. THAT'S CORRECT.

Q. BUT YOU YOURSELF HAVEN'T FIGURED OUT HOW MANY D&E'S WHERE THE FETUS WAS REMOVED INTACT VERSUS WHERE THE FETUS WAS DISMEMBERED YOU WOULD NEED IN ORDER FOR TO YOU CONSIDER IT

RELIABLE, HAVE YOU?

A. I HAVE NOT DONE WHAT IS CALLED A FORMAL POWER ANALYSIS TO KNOW PRECISELY HOW MANY PATIENTS WOULD BE REQUIRED.

Q. WOULD YOU AGREE THAT AN EPIDEMIOLOGIST MIGHT BE MORE OF AN EXPERT IN ASSESSING THE NUMBER OF PATIENTS NEEDED IN ORDER TO MAKE THAT KIND OF STUDY RELIABLE?

A. A BIOSTATISTICIAN WOULD CONDUCT THAT KIND OF -- CONDUCT THAT KIND OF ANALYSIS.

Q. AND HE OR SHE WOULD HAVE MORE EXPERTISE THAN YOU IN DOING THAT?

A. THAT'S CORRECT.

Q. WOULD YOU AGREE THAT IF A RETROSPECTIVE STUDY IS PUBLISHED IN A WELL-RESPECTED PEER REVIEWED JOURNAL THAT THE PROCESS OF PEER REVIEW AT LEAST PROVIDES SOME ASSURANCE THAT THE STUDY HAD BEEN RESPONSIBLY AND RELIABLY CONDUCTED?

A. SOME ASSURANCE.

Q. THAT IS ONE OF THE PURPOSES OF PEER REVIEW, IS IT NOT?

A. YES, IT IS.

Q. ANOTHER CRITICISM THAT YOU HAVE WITH DR. CHASEN'S STUDY IS THAT YOU BELIEVE THERE WAS INSUFFICIENT FOLLOW-UP WITH THE PATIENTS; IS THAT RIGHT?

A. I BELIEVE THAT THE FOLLOW-UP WAS NOT ADEQUATELY DESCRIBED. I DON'T KNOW HOW -- YOU JUST DON'T KNOW ABOUT IT.

Q. MIGHT FOLLOW-UP WITH PATIENTS BE A PROBLEM IN MANY RETROSPECTIVE STUDIES?

A. YES.
Q. AND THAT WOULDN'T NECESSARILY BE UNIQUE TO DR. CHASEN'S STUDY?
A. NO.
Q. I BELIEVE THE OPINION THAT YOU'RE EXPRESSING TODAY IS THAT DR. CHASEN'S STUDY DOESN'T DEMONSTRATE THE SUPERIORITY OF D&E WHERE THE FETUS IS REMOVED INTACT VERSUS WHERE IT IS DISMEMBERED; IS THAT CORRECT?
A. YES, THAT'S CORRECT.
Q. BUT YOU WOULD AGREE, WOULD YOU NOT, THAT DR. CHASEN'S STUDY CERTAINLY DOES NOT SUGGEST THAT D&E WHERE THE FETUS IS REMOVED INTACT IS ANY LESS SAFE THAN WHERE THE D&E IS DISARTICULATED?
A. I AM AWARE OF THAT.
Q. AND YOU ARE NOT AWARE OF ANY EVIDENCE-BASED MEDICINE THAT ESTABLISHES THAT THE REMOVAL OF THE FETUS INTACT DURING THE D&E IS LESS SAFE THAN A D&E WITH DISARTICULATION, ARE YOU?
A. I AM NOT AWARE OF ANY.
Q. AND YOU ARE NOT AWARE OF ANY STUDY THAT ESTABLISHES THAT REMOVAL OF THE FETUS INTACT DURING A D&E IS ANY LESS SAFE THAN AN INDUCTION ABORTION, ARE YOU?
A. I DON'T KNOW OF ANY STUDY THAT HAS COMPARED THOSE.
Q. YOU WOULD NOT SAY THAT A HYSTEROTOMY IN ALL BUT VERY RARE CIRCUMSTANCES WOULD BE PREFERABLE TO A D&E WHERE THE FETUS IS REMOVED INTACT, WOULD YOU?
A. COULD YOU REPEAT THAT, PLEASE?

Q. SURE. YOU WOULDN'T SAY THAT A HYSTEROTOMY IN ALL BUT A VERY RARE CIRCUMSTANCE WOULD BE PREFERABLE TO DOING A D&E WHERE THE FETUS IS REMOVED INTACT, WOULD YOU?

A. I WOULD NOT SAY THAT. I MEAN, I THINK I AGREE WITH WHAT YOU JUST SAID.

Q. YOU WOULD AGREE THAT IN MOST CASES AN INTACT D&E WOULD BE PREFERABLE TO A HYSTEROTOMY?

A. YES.

Q. AND YOU AGREE THERE IS NO RELIABLE MEDICAL BASIS UPON WHICH TO SAY THAT INTACT REMOVAL OF A FETUS DURING A D&E IS ANY MORE DANGEROUS TO A WOMAN THAN ANY OTHER ABORTION METHOD; ISN'T THAT RIGHT?

A. I BELIEVE THAT DATA IS NOT AVAILABLE.

Q. SO IN SOME WAYS -- IF I AM MISCHARACTERIZING YOUR TESTIMONY, PLEASE CORRECT ME -- THE BOTTOM LINE OF YOUR OPINION IS REALLY THAT THERE'S NO EVIDENCE-BASED MEDICINE THAT YOU DEEM RELIABLE EITHER WAY ABOUT THE SAFETY OF D&E WHERE THE FETUS IS REMOVED INTACT; IS THAT RIGHT?

A. THAT'S CORRECT.

Q. YOU TESTIFIED ON YOUR DIRECT EXAM THAT EPISIOTOMY IS A PROCEDURE THAT WAS THOUGHT TO BE SAFE AND EFFECTIVE, BUT THAT WAS LATER PROVEN TO BE UNTRUE FOR THE GENERAL POPULATION; IS THAT CORRECT?

A. IT IS EFFECTIVE. IT IS ITS SAFETY THAT I AM QUESTIONING OR THE STUDY IS QUESTIONING.

Q. AND IS THAT BASED ON ANY PARTICULAR STUDY?
A. THERE ARE SEVERAL WHAT WE CALL "RANDOMIZED CONTROLLED TRIALS." ONE VERY LARGE STUDY DONE IN ARGENTINA, ANOTHER ONE DONE IN CANADA, AND THE UNITED STATES AT VARIOUS INSTITUTIONS WHICH EFFECTIVELY SHOWED THE SAME THING.
Q. AND DESPITE THOSE STUDIES YOU WOULD AGREE THAT EPISIOTOMIES ARE STILL FREQUENTLY PERFORMED IN THE UNITED STATES, JUST NOT IN ALL CASES; IS THAT CORRECT?
A. WELL, THEY ARE PERFORMED IN SELECTIVE CASES RATHER THAN BEING PERFORMED MORE OR LESS ROUTINELY IN ALL PATIENTS. WHEREAS, THEY WERE FORMERLY DONE IN ALMOST ALL WOMEN, PARTICULARLY THOSE HAVING THEIR FIRST BABIES. THAT IS NO LONGER TRUE.
Q. BUT IT IS UP TO THE PHYSICIAN'S JUDGMENT IN ANY CASE WHETHER OR NOT TO USE EPISIOTOMY; IS THAT CORRECT?
A. YES.
Q. AND YOU WOULD AGREE THERE IS STILL A ROLE FOR EPISIOTOMY IN MEDICINE DESPITE THE STUDIES THAT YOU ARE TALKING ABOUT?
A. YES.
Q. AND YOU WOULDN'T SUPPORT A CRIMINAL BAN ON EPISIOTOMIES, WOULD YOU?
A. NO, I WOULDN'T.
Q. AGAIN, IT IS A PERFECTLY APPROPRIATE TECHNIQUE TO USE WHEN THE PHYSICIAN FEELS IT IS BEST FOR HIS OR HER PATIENT?
A. THAT'S CORRECT.

Q. SIMILARLY, YOU DISCUSSED ELECTRONIC FETAL MONITORING. AND WOULD YOU ALSO AGREE THAT THAT TECHNIQUE IS STILL USED IN THIS COUNTRY, BUT JUST NOT IN ALL CASES?

A. YES, IT IS.

Q. AND YOU AGREE THERE IS STILL A ROLE FOR ELECTRONIC FETAL MONITORING IN MEDICAL, EVEN THOUGH THE STUDIES YOU RELY ON HAVE JUST PROVED THAT IT SHOULDN'T BE USED IN EVERY CASE?

A. YES.

Q. YOU WOULDN'T SUPPORT A CRIMINAL BAN ON ELECTRONIC FETAL MONITORING, WOULD YOU?

A. NO, I WOULDN'T.

Q. AND YOU ALSO THINK THAT ELECTRONIC FETAL MONITORING IS PERFECTLY APPROPRIATE WHEN THE PHYSICIAN FEELS IT IS BEST FOR HIS OR HER PATIENTS?

A. YES.

Q. I WOULD LIKE TO TALK TO YOU ABOUT THE FINDINGS OF THE PARTIAL-BIRTH ABORTION BAN ACT.

MS. KRASNOFF: MAY I APPROACH THE WITNESS?

THE COURT: YES.

BY MS. KRASNOFF:

Q. THIS IS PLAINTIFF'S EXHIBIT 1. DR. BOWES, IF YOU WOULD TAKE A LOOK AT FINDING NUMBER 2, WHICH IS ON THE FIRST PAGE OF THIS DOCUMENT. DO YOU SEE THAT?

A. YES, MA'AM.

Q. THAT FINDING STATES, QUOTE:

"PARTIAL-BIRTH ABORTION REMAINS A DISFAVORED PROCEDURE THAT IS NOT ONLY UNNECESSARY TO PRESERVE THE HEALTH OF THE MOTHER, BUT, IN FACT, POSES SERIOUS RISKS TO THE LONG-TERM HEALTH OF WOMEN, AND IN SOME CIRCUMSTANCES THEIR LIVES," UNQUOTE.

YOU DON'T AGREE WITH THAT FINDING, DO YOU?

A. I DON'T. I DO NOT.

Q. AND, IN FACT, NO VALID SCIENTIFIC EVIDENCE SUPPORTS THAT FINDING, DOES IT, DR. BOWES?

A. NOT IN MY VIEW.

Q. IF YOU COULD TURN TO PAGE 4, WHICH IS MARKED S3-4. AND YOU CAN READ FINDING 14 (A) TO YOURSELF. THAT IS QUITE LONG. IF YOU COULD LET ME KNOW WHEN YOU HAVE FINISHED.

A. I HAVE READ IT.

Q. AND, DR. BOWES, THERE IS NO RELIABLE SCIENTIFIC EVIDENCE THAT DEMONSTRATES THAT PARTIAL-BIRTH ABORTION POSES ANY OF THE RISKS ENUMERATED IN THAT FINDING ON A MORE SERIOUS OR FREQUENT BASIS THAN ANY OTHER ABORTION PROCEDURE, IS THERE?

A. NOT THAT I KNOW OF.

Q. AND IF YOU COULD FLIP THE PAGE TO PAGE 5 AND TAKE A LOOK AT FINDING 14 (F). DO YOU SEE THAT? IT ACTUALLY JUST SAYS "F" BECAUSE THE "14" IS ON THE PREVIOUS PAGE.

A. OKAY.

Q. THAT STATES, QUOTE:

"A BAN ON THE PARTIAL-BIRTH ABORTION PROCEDURE WILL THEREFORE ADVANCE THE HEALTH INTERESTS OF PREGNANT WOMEN SEEKING TO TERMINATE A PREGNANCY."

IN YOUR OPINION, DR. BOWES, THERE IS NO VALID, RELIABLE SCIENTIFIC EVIDENCE THAT SUPPORTS THAT STATEMENT, IS THERE?

A. I BELIEVE THERE IS NOT.

Q. AND, IN FACT, YOUR SUPPORT FOR THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003 IS NOT BASED ON ANY CONCERNS FOR PROTECTING MATERNAL HEALTH, IS IT?

A. NO, I DON'T THINK THOSE HAVE BEEN ESTABLISHED.

Q. RATHER, YOUR SUPPORT FOR THE ACT IS BASED ON YOUR ETHICAL OPPOSITION TO ABORTION IN GENERAL AND PARTICULARLY TO INTACT D&E BEING PERFORMED POST-VIABILITY OTHER THAN TO SAVE THE LIFE OF THE WOMAN; IS THAT CORRECT?

A. THAT'S CORRECT.

Q. AND YOUR ETHICAL OPPOSITION TO ABORTION PROCEDURES PRE-VIABILITY IS NOT IN ANY WAY PARTICULAR TO THE INTACT D&E PROCEDURE AS OPPOSED TO OTHER METHODS OF ABORTION; IS THAT CORRECT?

A. THAT'S CORRECT.

Q. AND YOU WOULD SUPPORT A BAN ON ALL ABORTIONS AS LONG AS IT CONTAINED AN EXCEPTION FOR WHEN THE WOMAN'S LIFE WAS AT RISK, WOULD YOU NOT?

A. YES, I WOULD.

Q. AND ISN'T IT TRUE YOU WOULD NOT PERFORM AN ABORTION TO SAVE THE LIFE OF ONE OF YOUR PATIENTS UNLESS YOU WERE SATISFIED THAT THE LIKELIHOOD THAT SHE WOULD DIE IS MORE THAN 50 PERCENT?

A. YES.

Q. WOULD YOU AGREE WITH ME THAT IN ANY GIVEN CASE OTHER PHYSICIANS MIGHT DISAGREE ABOUT THAT PERCENTAGE OR WHAT THE LIKELIHOOD IS THAT A WOMAN MIGHT DIE?

A. YES.

Q. AND YOU WOULD FAVOR A BAN ON ABORTIONS EVEN IN CASES WHERE THE PREGNANCY WAS THE RESULT OF RAPE AND INCEST; ISN'T THAT RIGHT?

A. I HAVE STATED THAT, YES.

Q. I WANT TO CLARIFY ONE THING FROM YOUR DIRECT TESTIMONY, WHICH IS THAT YOU STATED THAT THE TERM "PARTIAL-BIRTH ABORTION" APPEARED IN THE NEW ENGLAND JOURNAL OF MEDICINE. AM I CORRECT THAT THAT WAS IN A LETTER THAT WAS WRITTEN?

A. NO.

Q. IT WAS -- WAS IT IN AN ARTICLE THAT WAS PEER REVIEWED?

A. WELL, IT WAS AN -- THE ARTICLE I AM RECALLING WAS NOT A STUDY, THAT IS A SCIENTIFIC STUDY. IT WAS A DESCRIPTION OF THE PROCEDURE AND THE IMPLICATIONS OF THE LEGISLATION, AND SO FORTH, THAT WAS BEING DESCRIBED.

BUT IT WAS -- IN FACT, I THINK THE TITLE OF IT WAS "PARTIAL-BIRTH ABORTION."

Q. AND --

A. SO THOSE TYPES OF ARTICLES ARE NOT SUBJECT TO PEER REVIEW. THESE ARE DECISIONS MADE BY THE EDITORS TO -- BUT NOT NECESSARILY SUBJECTED -- THE MANUSCRIPT HAS NOT BEEN SUBJECTED TO PEER REVIEW. THESE ARE COMMENTARIES.

Q. SO JUST TO BE CLEAR, THIS WAS NOT SUBJECTED TO PEER REVIEW; IS THAT CORRECT?

A. THAT'S CORRECT.

Q. GOING OVER SOME OF YOUR EXPERIENCE WITH ABORTION PROCEDURES, YOUR ONLY FORMAL TRAINING IN ABORTION TECHNIQUES WAS DURING YOUR RESIDENCY WHICH WAS BETWEEN 1962 AND 1965; IS THAT RIGHT?

A. THAT'S CORRECT.

Q. AND THE ONLY SECOND TRIMESTER ABORTION METHOD THAT YOU RECEIVED TRAINING IN DURING YOUR RESIDENCY WAS THE INDUCTION METHOD; IS THAT CORRECT?

A. YES.

Q. AND YOU WERE NOT TRAINED IN THE DILATION AND EVACUATION OR D&E PROCEDURE DURING YOUR RESIDENCY; IS THAT RIGHT?

A. THAT'S CORRECT.

Q. AND THAT'S BECAUSE D&E WASN'T BEING PERFORMED IN COLORADO IN THE 60'S, RIGHT?

A. THAT'S CORRECT.

Q. AND YOU HAVEN'T RECEIVED ANY FORMAL TRAINING ON ABORTION TECHNIQUES OR PROCEDURES SINCE BEING 1965; IS THAT RIGHT?

A. THAT'S CORRECT.

Q. AND IN THE CLOSE TO 40 YEARS SINCE YOU COMPLETED YOUR RESIDENCY YOU HAVE ONLY PARTICIPATED IN BETWEEN FOUR TO SIX TO 10 -- FEWER THAN 10 -- SECOND-TRIMESTER ABORTIONS WHERE THE FETUS WAS ALIVE AT THE BEGINNING OF THE PROCEDURE; IS THAT CORRECT?

A. THAT'S CORRECT.

Q. AND YOU YOURSELF DID NOT PERFORM THESE ABORTIONS; IS THAT CORRECT?

A. NO, I WAS SUPERVISING THE ABORTION WITH THE RESIDENT.

Q. SO YOU SUPERVISED THEM, RIGHT?

A. YES.

Q. AND IN NONE OF THESE FIVE TO 10 INDUCED ABORTIONS THAT YOU SUPERVISED DID THE FETUS HAVE A GESTATIONAL AGE THAT WAS GREATER THAN 20 WEEKS LMP; IS THAT RIGHT?

A. I BELIEVE THAT'S CORRECT, YES.

Q. AND YOU TESTIFIED ON DIRECT THAT OF THE 10, ONLY TWO OR THREE WERE ACTUALLY BY THE D&E METHOD; IS THAT RIGHT?

A. THAT'S CORRECT.

Q. THE REMAINING SEVEN OR EIGHT WERE BY INDUCTION?

A. YES.

Q. GIVEN THE FACT THAT YOU HAVEN'T PERFORMED ANY YOURSELF AND HAVE SUPERVISED TWO OR THREE D&E'S ON FETUSES THAT HAVE NOT NATURALLY DEMISED, WOULD YOU EXPERIENCE YOUR EXPERIENCE IN D&E'S ON A LIVE FETUS IS QUITE LIMITED?

A. I WOULD AGREE.

Q. I FORGOT TO ASK YOU THIS, BUT YOU HAVE NEVER PERSONALLY OBSERVED OR SUPERVISED A D&E WHERE THE FETAL WAS REMOVED FROM THE UTERUS INTACT UP TO THE CALVARIUM?

A. I HAVE NOT.

Q. AND YOU TESTIFIED YOU'VE BEEN INVOLVED IN THE PERFORMANCE OF 150 SECOND-TRIMESTER ABORTIONS ON FETUSES THAT HAVE ALREADY DEMISED BEFORE THE PROCEDURE HAD BEGUN; IS THAT CORRECT?

A. YES. THOSE AREN'T TECHNICALLY CALLED "ABORTIONS," BUT THEY ARE PREGNANCY TERMINATIONS IN THE SITUATION OF FETAL DEATH.

Q. THOSE 150 WERE OVER A 40-YEAR PERIOD; IS THAT RIGHT?

A. YES.

Q. AND MOST OF THOSE WERE DONE BY INDUCTION; IS THAT RIGHT?

A. YES.

Q. IN FACT, APPROXIMATELY ONE OR TWO PER YEAR THAT WERE DONE USING THE D&E METHOD; IS THAT RIGHT?

A. THAT'S CORRECT.

Q. AND IN THE ONE-- IN THE TWO D&E'S PER YEAR THAT YOU WERE INVOLVED IN, THE RESIDENT WAS ACTUALLY PERFORMING THE PROCEDURE AND YOU WERE SUPERVISING; IS THAT RIGHT?

A. THAT'S CORRECT.

Q. AND SOMETIMES IN THESE SITUATIONS OF FETAL DEATH, THE FETUS WOULD HAVE BEEN DEAD FOR HOURS BEFORE THE PROCEDURE BEGAN; IS THAT RIGHT?

A. YES.

Q. AND SOMETIMES THE FETUS HAD BEEN DEAD FOR A DAY OR MORE

BEFORE THE PROCEDURE BEGAN; IS THAT CORRECT?
A. YES.
Q. AND THE PASSAGE OF TIME AFTER DEMISE CHANGES THE NATURE OF THE FETAL TISSUE; DOES IT NOT?
A. YES, IT DOES.
Q. AND AM I CORRECT THAT THAT PROCESS IS CALLED "MACERATION"?
A. YES.
Q. AND YOU WOULD AGREE THAT FOLLOWING A FETAL DEATH THE COMPOSITION AND CONSISTENCY OF THE FETAL BODY IS DIFFERENT THAN IT WAS THAN WHEN AN ABORTION WAS BEGUN ON A LIVING FETUS; WOULD YOU NOT?
A. YES.
Q. AND YOU AGREE THAT THERE ARE SOME DIFFERENCES IN THE CASE OF FETAL DEMISE IN AN INDUCTION ABORTION COMPARED TO WHEN THE FETUS IS LIVING AT THE OUTSET; IS THAT RIGHT?
A. COULD YOU RESTATE THAT? I AM NOT -- I WANT TO BE SURE I UNDERSTAND THAT QUESTION.
Q. SURE. ARE THERE ANY DIFFERENCES IN AN INDUCTION ABORTION BETWEEN WHEN IT IS -- IN YOUR EXPERIENCE -- BETWEEN WHEN IT IS DONE ON A LIVING FETUS AND WHEN IT IS DONE ON A FETUS THAT HAS BEEN DEMISED FOR A DAY OR TWO?
A. I AM NOT SURE THAT THAT IS TRUE OR NOT. I DON'T KNOW THAT THAT REALLY HAS BEEN STUDIED. IN MY EXPERIENCE, THE LABOR IS PRETTY MUCH THE SAME IN BOTH OF THOSE SITUATIONS.
Q. IN YOUR EXPERIENCE THE UTERUS IS EQUALLY RESPONSIVE

WHETHER -- TO THE INDUCING AGENTS, WHETHER THE FETUS IS ALIVE OR NOT?

A. IN MY EXPERIENCE, YES.

Q. AND YOU'VE NEVER TAUGHT ABORTION DIDACTICALLY, HAVE YOU?

A. NOT BY "DIDACTICALLY" IF YOU MEAN IN LECTURE AND SOME SUCH THINGS, NO. I HAVE TAUGHT ABORTION PROCEDURES TO AND THE TECHNIQUES FOR PERFORMING THE VARIOUS THINGS THAT WE HAVE DESCRIBED TO RESIDENTS IN CLINICAL SETTINGS, IF THAT IS WHAT YOU MEAN. IF I CAN QUALIFY THAT BY YOU WHAT MEAN BY "DIDACTIC."

Q. THAT'S FINE.

YOU TESTIFIED THAT YOU SIT ON AN INSTITUTIONAL REVIEW BOARD AT THE UNIVERSITY OF NORTH CAROLINA. NONE OF THE RESEARCH PROJECTS THAT HAVE COME BEFORE YOU AS A MEMBER OF THE INSTITUTIONAL REVIEW BOARD HAVE INVOLVED ABORTION, HAVE THEY?

A. NOT THAT I RECALL, NO.

Q. YOU HAVE NOT AUTHORED ANY ARTICLES ABOUT ABORTION PROCEDURE, HAVE YOU?

A. NO, I HAVE NOT.

Q. AND YOU HAVEN'T CONDUCTED ANY PEER REVIEW FOR ANY JOURNAL WITH RESPECT TO ANY ARTICLES ABOUT ABORTION PROCEDURE, HAVE YOU?

A. NO.

Q. AND YOU HAVE NOT PARTICIPATED IN, CONDUCTED OR BEEN OTHERWISE INVOLVED IN ANY STUDIES OF ANY METHOD OF ABORTION

PROCEDURE, HAVE YOU?
A. I HAVE NOT.
Q. AND YOU RETIRED FROM THE PRACTICE OF MEDICINE IN 1999, I BELIEVE YOU SAID?
A. I DID.
Q. AND I ASSUME I'M CORRECT THAT WOULD MEAN YOU HAVEN'T PERFORMED ANY ABORTIONS ON DEMISED FETUSES, OR OTHERWISE, SINCE THAT TIME; IS THAT CORRECT?
A. THAT'S CORRECT.
Q. DR. BOWES, IS IT NOT TRUE THAT WHEN YOU WERE FIRST ASKED IN YOUR DEPOSITION IF YOU CONSIDERED YOURSELF TO BE AN EXPERT ON ABORTION OR ABORTION TECHNIQUE THAT YOU RESPONDED "NO"?
A. THAT I RESPONDED "NO" WHEN I WAS FIRST ASKED?
Q. YES.
A. I DON'T RECALL EXACTLY WHAT I SAID, BUT I AM NOT AN EXPERT ON ABORTION TECHNIQUES.
Q. AND YOU ALSO AGREE YOU ARE NOT AN EXPERT ON INDUCED ABORTION AT ALL; IS THAT RIGHT?
A. I AM NOT CONSIDERED AN EXPERT ON INDUCED ABORTION.
Q. AND YOU WOULD AGREE THAT SOMEONE WHO HAS MORE EXPERIENCE PERFORMING INDUCED ABORTIONS THAN YOU DO WOULD HAVE GREATER EXPERTISE IN THAT AREA, DO YOU NOT?
A. YES.
Q. AND, DR. BOWES, THIS IS NOT THE FIRST CASE REGARDING AN ABORTION RESTRICTION IN WHICH YOU HAVE OFFERED AN OPINION IN

FAVOR OF THAT RESTRICTION, IS IT?

A. NO, THIS IS NOT THE FIRST CASE.

Q. IN FACT, YOU HAVE MANY TIMES BEEN AN ADVOCATE FOR OTHER RESTRICTIONS AND PROHIBITIONS ON ABORTIONS; IS THAT CORRECT?

A. SEVERAL TIMES.

Q. YOU'VE OFFERED SOME SORT OF SWORN TESTIMONY IN SIX DIFFERENT CASES WHERE A STATE HAD BANNED WHAT THEY CALLED "PARTIAL-BIRTH ABORTION"; IS THAT NOT CORRECT?

A. YES, THAT'S CORRECT.

Q. AND YOU'VE TESTIFIED UNIFORMLY IN SUPPORT OF THOSE BANS, HAVE YOU NOT?

A. YES.

Q. AND, IN PARTICULAR, YOU OFFERED TESTIMONY IN SUPPORT OF RHODE ISLAND'S BAN ON PARTIAL-BIRTH ABORTION?

A. YES.

Q. AND WISCONSIN'S?

A. YES.

Q. AND WEST VIRGINIA'S?

A. YES, MA'AM.

Q. AND NEW JERSEY'S?

A. YES.

Q. AND VIRGINIA?

A. YES.

Q. AND LAST ONE, MONTANA; IS THAT CORRECT?

A. YES.

Q. AND IN EACH OF THOSE SIX CASES YOU OPINED THAT THE BAN DID NOT POSE A THREAT TO THE WOMEN'S HEALTH; DID YOU NOT?
A. YES.
Q. AND YOU ALSO FIND THAT THE BAN DID NOT REACH EITHER D&E OR INDUCTION ABORTIONS IN EITHER OF THOSE CASES, DID YOU NOT?
A. YES.
Q. NOW, YOU TESTIFIED ON DIRECT THAT YOU SENT A LETTER TO REPRESENTATIVE CANADY IN 1995 EXPRESSING YOUR SUPPORT FOR A PREVIOUS VERSION OF THE FEDERAL PARTIAL-BIRTH ABORTION BAN ACT; IS THAT CORRECT?
MR. QUINLIVAN: OBJECTION. MISCHARACTERIZES HIS TESTIMONY.
THE COURT: I WILL ALLOW THE QUESTION. HE CAN CLARIFY.
THE WITNESS: MY LETTER TO DOCTOR -- EXCUSE ME -- TO REPRESENTATIVE CANADY WAS IN RESPONSE TO SPECIFIC QUESTIONS ABOUT ASSERTIONS THAT HAD BEEN MADE REGARDING THE ACT. SO I -- IF I RECALL MY LETTER CORRECTLY, IT WAS ONLY RESPONDING TO THOSE SEVERAL QUESTIONS. SUCH THINGS AS NEONATAL SURVIVAL AT VARIOUS GESTATIONAL AGES, ASSERTIONS THAT ALL THE FETUSES WERE DEAD THAT HAD RECEIVED ANALGESIA THE MOTHER -- ANALGESIA GIVEN TO THE MOTHER ALWAYS KILLS THE FETUS, AND SUCH THINGS AS THAT.
I SIMPLY RESPONDED TO THAT.
BY MS. KRASNOFF:
Q. AND WAS YOUR LETTER IN 2003 IN SUPPORT OF THE CURRENT

VERSION OF THE BAN TO SENATOR SANTORUM, WAS THAT ALSO SIMPLY RESPONDING TO QUESTIONS THAT WERE ASKED OF YOU?

A. YES. I THINK SENATOR SANTORUM, THE QUESTION RELATED TO ASSERTIONS MADE BY DR. PHILIP DARNEY ABOUT THIS PROCEDURE.

Q. BUT NO ONE IN CONGRESS SOUGHT YOUR OPINION ON WHETHER YOU THOUGHT THE FINDINGS IN THE BILL WERE ACCURATE OR NOT, DID THEY?

A. NO, THEY DID NOT.

Q. IF THEY HAD WOULD, YOU HAVE TOLD THEM WHAT YOU TOLD US HERE TODAY, THAT THEY WERE NOT ACCURATE?

A. YES.

MS. KRASNOFF: WE HAVE NOTHING FURTHER.

THE COURT: ALL RIGHT. REDIRECT?

REDIRECT EXAMINATION

BY MR. QUINLIVAN:

Q. DOCTOR, I BELIEVE IN RESPONSE TO A QUESTION FROM MS. KRASNOFF YOU AGREED WITH THE -- AT LEAST THE INTUITIVE ASSESSMENT THAT THE FEWER NUMBER OF PASSES OF FORCEPS INTO THE UTERUS MIGHT OFFER A SAFETY ADVANTAGE IN DOING AN ABORTION PROCEDURE.

DO I RECALL YOUR TESTIMONY CORRECTLY?

A. I BELIEVE SO, YES.

Q. AND JUST TO CLARIFY, WHAT IS YOUR OPINION ABOUT THE VALIDITY OF INTUITIVE ASSESSMENTS ABOUT ANY PROCEDURE SAFETY?

A. WELL, THEY ARE JUST THAT. THEY ARE CONJECTURE FROM A

PERSON'S EXPERIENCE AND NEED TO BE VALIDATED BY THE VARIOUS -- ONE OR MORE OF THE VARIOUS METHODS OF EVIDENCE-BASED MEDICINE THAT I DESCRIBED.

Q. AND I BELIEVE MS. KRASNOFF ASKED YOU A FEW QUESTIONS ABOUT YOUR DISAGREEMENT WITH THE CONGRESSIONAL FINDINGS ABOUT THE RELATIVE OR WHAT CONGRESS FOUND TO BE SOME OF THE POSSIBLE HARMS TO THE INTACT D&X PROCEDURE.

IS YOUR DISAGREEMENT WITH THOSE CONGRESSIONAL FINDINGS CONSISTENT WITH YOUR TESTIMONY THAT THERE HAS BEEN NO VALID SCIENTIFIC EVIDENCE DEMONSTRATING THE SUPERIORITY OR COMPARATIVE SAFETY OF THE INTACT D&X PROCEDURE?

A. YES, IT IS. OR YES, THEY ARE.

Q. DOCTOR, LET ME ASK YOU A COUPLE OF QUESTIONS GOING BACK TO THE GRIMES STUDY. AND I THINK WE TALKED A LITTLE BIT ABOUT THE SITUATION OF EQUIPOISE. IS THERE A REASON WHY THERE MAY NOT HAVE BEEN A SITUATION OF EQUIPOISE IN THE GRIMES STUDY, TO YOUR KNOWLEDGE?

A. WELL, KNOWING THE SITUATION IN THE UNITED STATES AND IN NORTH CAROLINA AND KNOWING DR. GRIMES' INFLUENCE ON HAVING ESTABLISHED THAT D&E'S ARE, IN GENERAL, A SAFER ABORTION METHOD THAN INDUCTION METHODS, IT WAS NOT TOO SURPRISING TO ME THAT THE PATIENTS -- THAT THERE IS SORT OF A CULTURE OUT THERE THAT ACCEPTS THAT IMPRESSION, AND I THINK A WELL-DOCUMENTED ONE BY DR. GRIMES.

AND SO THE FACT THAT WOMEN DID NOT WANT TO CONSENT

TO AN ABORTION PROCEDURE DONE BY A LABOR INDUCTION METHOD WAS NOT TOO SURPRISING.

NOT THAT THESE PATIENTS HAVE ALL READ DR. GRIMES' ARTICLES, BUT IT'S JUST THAT IN TALKING TO FRIENDS AND ASSOCIATES AND THEIR OWN DOCTORS, THAT IS WHAT THEY WOULD HAVE LEARNED. AND I DON'T THINK DR. GRIMES' IMPRESSION THAT THE INDUCTION PROCEDURE THAT HE WAS OFFERING IN HIS STUDY WAS SUBSTANTIALLY DIFFERENT, I DON'T THINK THAT WAS APPRECIATED.

NOW, THAT IS ALL ENTIRE CONJECTURE ON MY PART, BUT IF I MAY.

Q. DOCTOR, YOU TALKED ABOUT THE -- THAT EVERY PHYSICIAN WOULDN'T HAVE TRAINING IN PERFORMING AN INJECTION OF POTASSIUM CHLORIDE.

LET ME ASK YOU: WOULD EVERY OB/GYN HAVE TRAINING IN PERFORMING AN AMNIOCENTESIS?

A. YES.

Q. HAVE YOU PERFORMED AMNIOCENTESES DURING YOUR CAREER?

A. MANY OF THEM, YES.

Q. CAN YOU GIVE ME AN APPROXIMATION OF HOW MANY?

A. OVER A THOUSAND.

Q. AND WOULD THE PROCESS OF GIVING AN AMNIOCENTESIS BE SIMILAR TO THAT OF GIVING AN INJECTION OF POTASSIUM CHLORIDE OR AN INTRACARDIAC INJECTION OF DIGOXIN?

A. WELL, ACTUALLY INJECTING A SUBSTANCE DIRECTLY INTO AN ORGAN OF THE FETUS IS SOMEWHAT MORE DIFFICULT AND REQUIRES MORE

EXPERTISE THAN JUST INJECTING IT INTO THE AMNIOTIC FLUID.

NOW, THIS WOULD NOT APPLY TO DIGOXIN, WHICH IS SIMPLY INJECTED INTO THE AMNIOTIC FLUID. THAT WOULD REQUIRE ONLY AN AMNIOCENTESIS, THAT IS PUTTING THE NEEDLE INTO THE AMNIOTIC CAVITY.

DIRECTING IT INTO A FETAL ORGAN IS SOMEWHAT MORE TECHNICALLY DIFFICULT.

Q. DOCTOR, I THINK MS. KRASNOFF ASKED YOU A QUESTION ABOUT WHAT SITUATIONS YOU WOULD PERFORM AN ABORTION IN WHICH THE LIFE -- THERE WAS A QUESTION AS TO THE WHETHER THE LIFE OF THE WOMAN WAS AT RISK.

IF YOU DECIDED FOR YOUR OWN PURPOSES THAT YOU WOULD NOT PERFORM THE ABORTION, WHAT WOULD YOU DO?

A. WELL, I THINK I STATED BEFORE THAT I WOULD CERTAINLY RECOMMEND THAT THE PATIENT HAVE CONSULTATION WITH OTHER PHYSICIANS WHO FELT DIFFERENTLY ABOUT IT THAN I DID.

Q. DOCTOR, I THINK I ASKED YOU THIS THIS MORNING, BUT JUST TO CLARIFY: DOES THE JOURNAL FOR WHICH YOU SERVE AS CO-EDITOR-IN-CHIEF, OBSTETRICAL AND GYNECOLOGICAL SURVEY, DOES THAT JOURNAL PUBLISH ARTICLES ABOUT ABORTION FROM TIME TO TIME?

A. YES, IT DOES.

Q. AND SOMETIMES DO THOSE ARTICLES SUPPORT WHAT IS POPULARLY KNOWN AS THE "PRO-CHOICE POSITION"?

A. YES.

Q. AND HAVE YOU EVER TAKEN ANY STEPS TO PROHIBIT THOSE

ARTICLES FROM APPEARING IN YOUR JOURNAL?

A. NO.

Q. AND, DOCTOR, IS THERE SOME STUDY IN THE MEDICAL LITERATURE WHICH YOU ARE NOT TELLING US ABOUT ESTABLISHING THE SAFETY OF INTACT D&E COMPARED TO -- INTACT D&X COMPARED TO D&E BECAUSE OF YOUR PRO-LIFE VIEWS?

A. NO.

MR. QUINLIVAN: NOTHING FURTHER.

THANK YOU, DOCTOR.

THE COURT: ANYTHING FURTHER?

MS. KRASNOFF: NO, YOUR HONOR.

THE COURT: THANK YOU, DR. BOWES. YOU ARE EXCUSED.

ALL RIGHT. NOW, YOU ADVISED ME LAST WEEK THAT YOU WOULD BE IN A POSITION OF CALLING ONE OF YOUR WITNESSES EACH DAY BECAUSE OF THEIR TRAVEL SCHEDULES.

MR. QUINLIVAN: THAT'S RIGHT. OUR NEXT WITNESS, DR. SPRANG, IS IN TRAVEL TODAY. AND HE WILL BE APPEARING TOMORROW MORNING. WE HAVE SCHEDULED A WITNESS FOR EACH ONE OF THE DAYS. WE DON'T ANTICIPATE ANY OF THOSE WITNESSES WILL BE GOING LONGER THAN ONE DAY. AND THAT WILL ALLOW SUFFICIENT TIME FOR THE PLAINTIFFS TO EXAMINE DR. CHASEN. THEY WILL HAVE THE ENTIRETY OF FRIDAY THE 16TH.

THE COURT: ALL RIGHT. WE ARE ADJOURNED UNTIL TOMORROW MORNING AT 8:30.

(WHEREUPON, THE PROCEEDINGS WERE ADJOURNED AT

11:40 A.M.)

I N D E X

DEFENDANT'S WITNESSES:	PAGE	VOL.
BOWES, WATSON		
DIRECT EXAMINATION BY MR. QUINLIVAN	872	6
CROSS-EXAMINATION BY MS. KRASNOFF	942	6
REDIRECT EXAMINATION BY MR. QUINLIVAN	986	6

DEFENDANT'S EXHIBIT:	EVD.
A-2	875