1 VOLUME

2 PAGES 993 - 1176

3 UNITED STATES DISTRICT COURT

4 NORTHERN DISTRICT OF CALIFORNIA

5 BEFORE THE HONORABLE PHYLLIS J. HAMILTON, JUDGE

6 PLANNED PARENTHOOD)
FEDERATION OF AMERICA, INC.)
7 AND PLANNED PARENTHOOD)
GOLDEN GATE,)
8)
PLAINTIFFS,)
9)
VS.) NO. C 03-4872 PJH
10)
JOHN ASHCROFT, ATTORNEY) FRIDAY, APRIL 9, 2004
11 GENERAL OF THE UNITED)
STATES, IN HIS OFFICIAL) SAN FRANCISCO, CALIFORNIA
12 CAPACITY,)
)
13 DEFENDANT.)
____________________________)
14

REPORTER'S TRANSCRIPT OF PROCEEDINGS

15

APPEARANCES:

16

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

20 PLANNED PARENTHOOD FEDERATION OF
AMERCIA
21 434 W. 33RD STREET.
NEW YORK, NEW YORK 10001
22 BY: EVE C. GARTNER, ESQUIRE

23

(APPEARANCES CONTINUED ON NEXT PAGE)

24

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

1 PLANNED PARENTHOOD FEDERATION OF AMERICA
2 1780 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 200036
3 BY: HELENE T. KRASNOFF, ESQUIRE
4
5
6 FOR INTERVENOR PLAINTIFFS CITY AND COUNTY OF SAN FRANCISCO: OFFICE OF THE CITY ATTORNEY
7 1390 MARKET STREET, SUITE 1008
SAN FRANCISCO, CALIFORNIA 94102
8 BY: KATHLEEN SUZANNE MORRIS,
ALEETA MARIE VAN RUNKLE,
DEPUTY CITY ATTORNEYS
9
10 FOR DEFENDANT: U.S. DEPARTMENT OF JUSTICE
20 MASSACHUSETTS AVENUE, N.W. ROOM 7128
11 WASHINGTON, D.C. 20530
BY: MARK THOMAS QUINLIVAN
12 W. SCOTT SIMPSON,
KAIJA MARIE CLARK,
13 ASSISTANT U.S. ATTORNEYS
14
15
16
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18
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20
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23
24
25

1 APRIL 9, 2004 8:30 O'CLOCK A.M.

2

3 P R O C E E D I N G S

4 THE COURT: ALL RIGHT. GOOD MORNING, COUNSEL. ARE

5 YOU READY WITH YOUR NEXT WITNESS?

6 MR. SIMPSON: YES.

7 MS. GARTNER: ACTUALLY, YOUR HONOR, I THINK WE HAD

8 ONE BUSINESS MATTER WHICH WE ACTUALLY OWED YOU YESTERDAY WHICH

9 WAS DURING DR. WESTHOFF'S TESTIMONY, DURING THE DIRECT

10 EXAMINATION, I ASKED HER SOME QUESTIONS ABOUT WHETHER SHE USED

11 DIGOXIN OR KCL AND SOME FOLLOW-UP QUESTIONS TO THAT.

12 AND MS. CLARK OBJECTED ON THE GROUNDS THAT

13 DR. WESTHOFF HAD NOT TESTIFIED IN HER DEPOSITION OR IN HER

14 EXPERT REPORT ABOUT THAT SUBJECT. AND WE WENT BACK AND LOOKED

15 AT THAT, AND DETERMINED THAT MS. CLARK WAS RIGHT, THAT IN HER

16 DEPOSITION AND EXPERT REPORT THERE HAD BEEN NO MENTION

17 SPECIFICALLY OF EITHER DIGOXIN OR KCL.

18 AND SO FOR THAT REASON, WE DO NOT OBJECT TO YOUR

19 HONOR'S STRIKING THE SPECIFIC PART OF THE TRANSCRIPT IN WHICH I

20 ASKED DR. WESTHOFF WHETHER SHE HAD USED THOSE AGENTS AND WHY

21 SHE DIDN'T.

22 THAT WAS ON PAGE 819, BEGINNING AT LINE 20 THROUGH

23 PAGE 820, LINE 5.

24 BUT AFTER THAT EXCHANGE WITH DR. WESTHOFF, I THEN

25 ASKED HER ABOUT WHETHER SHE HAD IN RECENT MEMORY USED ONE OF

1 THOSE AGENTS AND WHAT THE CIRCUMSTANCE WAS, AND SHE -- IF YOUR
2 HONOR RECALLS -- SAID THAT THE DAY OR SO BEFORE THE LAW WAS
3 SIGNED INTO -- SIGNED BY PRESIDENT BUSH, SHE HAD USED IT
4 BECAUSE OF CONCERN ABOUT WHETHER THE TRO WOULD BE ISSUED AND
5 WHAT EFFECT IT MIGHT HAVE ON HER PATIENT.
6 AND WE BELIEVE THAT THAT SET OF QUESTIONS AND
7 ANSWERS WAS CONTEMPLATED BY DR. WESTHOFF'S DECLARATION WHICH
8 WAS INCORPORATED INTO HER EXPERT REPORT IN THIS CASE.
9 AND SPECIFICALLY THAT IS IN PARAGRAPH 41 OF HER
10 DECLARATION IN WHICH IN SPECULATING WHAT MIGHT HAPPEN IF THIS
11 LAW WERE TO TAKE EFFECT, DR. WESTHOFF SAID:
12 "OTHER PHYSICIANS MAY TRY TO ALTER THEIR
13 PRACTICES WHICH WILL ALSO BE TO THE DETRIMENT OF
14 THEIR PATIENTS' HEALTH," WHICH IS SPECIFICALLY WHAT
15 DR. WESTHOFF WAS TESTIFYING ABOUT WHEN SHE SAID SHE HAD USED
16 KCL AND THERE WAS A COMPLICATION IN THE ABORTION.
17 AND IN PARAGRAPH 45 OF HER DECLARATION, DR. WESTHOFF
18 STATED:
19 "I HAVE" -- AND THIS WAS DATED NOVEMBER 4TH,
20 THE DAY BEFORE THE BILL WAS SIGNED INTO LAW. SHE
21 SAYS: "I HAVE AT LEAST TWO SUCH PATIENTS SCHEDULED
22 THIS WEEK, AT LEAST ONE OF WHOM WILL BEGIN THE
23 DILATION PROCESS TOMORROW."
24 SO SHE SPECIFICALLY RAISED THE CONUNDRUM SHE WAS
25 FACING. I THINK THAT WAS FAIR GAME FOR THE GOVERNMENT TO

1 INQUIRE ABOUT AT HER DEPOSITION WHAT, IN FACT, SHE DID WITH
2 RESPECT TO THOSE PATIENTS THAT WERE SCHEDULED AND WHETHER SHE
3 ALTERED HER PRACTICES, AS SHE ALLUDED TO IN HER DECLARATION.
4 SO, THEREFORE, WE WOULD ASK THAT THE COURT NOT
5 STRIKE THE QUESTIONS AND ANSWERS THAT ARE BEGINNING AT
6 PAGE 820, LINE 6, THROUGH PAGE 821, LINE 9.
7 AND I RAISED THIS WITH MS. CLARK YESTERDAY MORNING.
8 THE COURT: ALL RIGHT. DID YOU WISH TO RESPOND?
9 MS. CLARK: YES. YOUR HONOR, I THINK THAT THE
10 DECLARATION, IT DOES ALLUDE TO SOMETHING. I DON'T THINK THE
11 GOVERNMENT WAS ENTIRELY ON NOTICE BECAUSE IT COULD HAVE BEEN
12 INJECTIONS WITH A CHEMICAL AGENT; COULD HAVE BEEN REDUCING THE
13 AMOUNT OF DILATION, DILATION FOR ONE DAY VERSUS TWO DAYS.
14 WITH THAT SAID, WITH RESPECT TO PAGE 820, LINES SIX,
15 THROUGH PAGE 821, LINES NINE, TO THE EXTENT DR. WESTHOFF TALKED
16 ABOUT THAT SHE DID GIVE AN INJECTION AND WHAT SHE ACTUALLY DID
17 DO, THE GOVERNMENT WOULDN'T OBJECT.
18 BUT ON PAGE 820, LINES 12 THROUGH 14, SHE GOES ON TO
19 STATE:
20 "AND IN MY OPINION, BECAUSE OF THE RAPID
21 SOFTENING OF THE FETAL TISSUE, IT ACTUALLY MADE THE
22 D&E PORTION OF THE PROCEDURE MORE DIFFICULT."
23 THAT'S AN OPINION. AND TO THE EXTENT THAT IS AN
24 OPINION THAT WASN'T RAISED IN THE EXPERT REPORT, WE DON'T THINK
25 THAT THAT SHOULD BE -- WE STILL STAND ON OUR GROUND THAT THIS

1 SHOULD BE STRICKEN FROM THE RECORD.

2 THE COURT: WHAT WERE THE LINE NUMBERS?

3 MS. CLARK: EXCUSE ME?

4 THE COURT: THE LINE NUMBERS YOU DID OBJECT TO?

5 MS. CLARK: 820, LINES 12 THROUGH 14. THAT ONE

6 SENTENCE BEGINNING WITH THE WORD "AND."

7 AND THEN, WE WOULD ALSO MAINTAIN THAT ON THAT SAME

8 PAGE, 820, LINE 17 THROUGH 20, WHERE IT STATES:

9 "WHICH RESULTED IN INFECTION AND REQUIRED HER

10 TO HAVE AN ADDITIONAL PROCEDURE, HOSPITALIZATION AND

11 PROCEDURE TO EMPTY THE UTERUS AFTER A COUPLE --

12 AFTER A COUPLE OF WEEKS AFTER HER ORIGINAL D&E."

13 AGAIN, THIS IS CONCLUSORY, SO WE WOULD MOVE TO

14 STRIKE THAT, AS WELL.

15 SO, TO THE EXTENT SHE SAYS:

16 "I DID THIS PROCEDURE. I DID AN INJECTION."

17 AND EVEN THAT THE PART SHE SAID: "AND THE PATIENT

18 DID, IN FACT, HAVE RETAINED TISSUE," WE WOULDN'T

19 OBJECT TO THAT. BUT HER CONCLUSIONS WHAT RESULTED FROM THE

20 PROCEDURE, WE MOVE TO STRIKE THAT.

21 THE COURT: I DON'T QUITE UNDERSTAND WHAT THE

22 DISTINCTION IS. I CAN UNDERSTAND WITH REGARD TO HER OPINION

23 ABOUT WHICH YOU WERE NOT PREVIOUSLY APPRISED, BUT WITH REGARD

24 TO THE RESULT OF THE PROCEDURE WITH RESPECT TO ONE PATIENT,

25 THAT IS NOT AN OPINION.

1 MS. CLARK: WELL, I THINK IT IS THE CAUSE AND
2 EFFECT. SHE IS SAYING BECAUSE SHE DID THE INJECTION THAT
3 RESULTED IN AN INFECTION AND REQUIRED HOSPITALIZATION. SO THAT
4 CONCLUSION THAT SHE IS DRAWING BETWEEN THE INJECTION AND
5 HOSPITALIZATION, THE GOVERNMENT --
6 THE COURT: BUT WOULDN'T SHE BE IN THE POSITION TO
7 KNOW WHETHER THAT IS CORRECT OR NOT? YOU ARE NOT SUGGESTING
8 SHE IS SPECULATING ABOUT THE CAUSAL CONNECTION, ARE YOU?
9 MS. CLARK: I DON'T KNOW IF -- I AM NOT SURE IF SHE
10 DOES KNOW THAT THE INJECTION WAS THE CAUSE OF THE
11 HOSPITALIZATION.
12 SO, I AM NOT SURE IF SHE WAS SPECULATING OR IF SHE
13 DOES, IN FACT, KNOW AND WHAT HER BASIS FOR CONCLUDING THAT IT
14 REQUIRED THE HOSPITALIZATION.
15 THE COURT: ALL RIGHT. I WILL TAKE A LOOK AT THE
16 DECLARATION AND DEPOSITION TESTIMONY, AND I WILL GIVE YOU A
17 RULING ON ALL OF THESE ON MONDAY MORNING.
18 MS. GARTNER: THANK YOU, YOUR HONOR.
19 THE COURT: OKAY. ALL RIGHT. MR. SIMPSON?
20 MR. SIMPSON: THANK YOU, YOUR HONOR. THE DEFENDANT
21 CALLS DR. LEROY SPRANG.
22 THE CLERK: PLEASE RAISE YOUR RIGHT HAND.
23 DR. M. LEROY SPRANG
24 CALLED AS A WITNESS FOR THE DEFENDANT, HAVING BEEN DULY SWORN,
25 TESTIFIED AS FOLLOWS:

1 THE WITNESS: I DO.
2 THE CLERK: TAKE THE STAND.
3 THE WITNESS: THANK YOU.
4 THE COURT: GOOD MORNING.
5 THE CLERK: PLEASE STATE YOUR NAME FOR THE COURT.
6 THE WITNESS: M. LEROY SPRANG. L-E CAPITAL R-O-Y,
7 S-P-R-A-N-G.
8 DIRECT EXAMINATION
9 BY MR. SIMPSON:
10 Q. DR. SPRANG, HOW ARE YOU THIS MORNING?
11 A. WELL, THANK YOU.
12 Q. WHAT IS YOUR MEDICAL SPECIALTY, DOCTOR?
13 A. I AM A BOARD CERTIFIED IN OBSTETRICS AND GYNECOLOGY.
14 THE COURT REPORTER: IS THE MICROPHONE ON?
15 THE CLERK: YES.
16 THE COURT: YOUR VOICE IS --
17 THE WITNESS: I HAVE A VERY SOFT VOICE. IF THIS
18 DOESN'T WORK --
19 THE COURT: WELL, IT IS ON. IT DOESN'T AMPLIFY VERY
20 LOUDLY. I WILL ASK YOU TO SIT CLOSE TO IT. THAT'S FINE.
21 BY MR. SIMPSON:
22 Q. DOCTOR, YOU SAID YOU ARE BOARD CERTIFIED IN OBSTETRICS AND
23 GYNECOLOGY?
24 A. CORRECT.
25 Q. BRIEFLY, DOCTOR, COULD YOU TELL US WHAT YOUR ACTUAL MEDICAL

1 PRACTICE CONSISTS OF?
2 A. I HAVE A FULL-TIME PRIVATE ACADEMIC PRACTICE AT EVANSTON
3 NORTHWESTERN HEALTHCARE. I PROVIDE -- CAN YOU HEAR ME?
4 BARELY?
5 THE COURT REPORTER: BARELY. YOU PROVIDE?
6 THE WITNESS: I PROVIDE FULL GYNECOLOGIC SERVICES.
7 I'VE DELIVERED 3,000 PATIENTS, AND DONE NUMEROUS SURGICAL
8 PROCEDURES.
9 BY MR. SIMPSON:
10 Q. SO DO YOU DO A FULL RANGE OF OBSTETRICS AND GYNECOLOGY?
11 A. I DO A FULL RANGE OF OBSTETRICS AND GYNECOLOGY, YES.
12 Q. YOU MENTIONED PRACTICING AT EVANSTON NORTHWESTERN
13 HEALTHCARE IS THAT A HOSPITAL?
14 A. IT IS ACTUALLY A HOSPITAL SYSTEM. WE HAVE THREE HOSPITALS,
15 AND IT HAS A LARGE GEOGRAPHIC AREA WITH 1800 PHYSICIANS ON
16 STAFF.
17 Q. WHERE IS EVANSTON, DOCTOR?
18 A. EVANSTON IS A SUBURB DIRECTLY NORTH OF CHICAGO.
19 Q. FOR HOW MANY YEARS HAVE YOU BEEN PRACTICING OBSTETRICS AND
20 GYNECOLOGY?
21 A. I HAVE BEEN IN PRIVATE PRACTICE FOR 28 YEARS, AND ACTUALLY
22 STARTED TRAINING IN OBSTETRICS AND GYNECOLOGY IN 1968.
23 Q. DOCTOR, HAVE YOU HELD ANY FACULTY POSITIONS IN MEDICINE?
24 A. I AM CURRENTLY AN ASSOCIATE CLINICAL PROFESSOR AT PRITZKER
25 SCHOOL OF MEDICINE, NORTHWESTERN UNIVERSITY. I HAVE HELD OTHER

1 POSITIONS. I HAVE BEEN CHAIRMAN OF THE DIVISION OF OBSTETRICS
2 AND GYNECOLOGY FOR THE NATIONAL CENTER FOR CONTINUING MEDICAL
3 EDUCATION.
4 Q. DOCTOR, HOW LONG HAVE YOU BEEN ASSOCIATE CLINICAL
5 PROFESSOR?
6 A. I HAVE GONE THROUGH -- WELL, I WILL SAY ABOUT THE LAST FIVE
7 YEARS I WAS AN ASSISTANT PROFESSOR BEFORE THAT AND INSTRUCTOR
8 BEFORE THAT, SO I HAVE GONE THROUGH EACH OF THE STEPS FOR A
9 FULL PROFESSOR.
10 Q. SO WHEN DID YOU START YOUR TEACHING?
11 A. I STARTED TEACHING AS A RESIDENT AND STARTED TEACHING
12 MEDICAL STUDENTS PROBABLY IN 1972.
13 Q. AND YOU SAID YOU'RE AN ASSOCIATE CLINICAL PROFESSOR AT
14 NORTHWESTERN UNIVERSITY?
15 A. CORRECT, NORTHWESTERN UNIVERSITY HAS TWO MAJOR TEACHING
16 HOSPITALS, ONE DOWNTOWN, PRENTICE HOSPITAL, AND THE OTHER IN
17 EVANSTON CALLED EVANSTON NORTHWESTERN HEALTHCARE.
18 Q. WHAT DO YOU TEACH AT NORTHWESTERN, DOCTOR?
19 A. I HAVE MEDICAL STUDENTS AND RESIDENTS WITH ME ON A
20 CONTINUOUS BASIS, BOTH IN THE OFFICE AND IN THE HOSPITAL. SO I
21 AM TEACHING THE DAILY PRACTICE OF OBSTETRICS AND GYNECOLOGY. I
22 TEACH SURGICAL TECHNIQUES, THE FULL RANGE OF OBSTETRIC AND
23 OBSTETRIC PRACTICES.
24 Q. AND I YOU MENTIONED THE DIVISION OF CONTINUING -- HOW DID
25 YOU SAY THAT?

1 A. THE DIVISION OF CONTINUING MEDICAL EDUCATION. I -- FROM
2 ABOUT 1980, '81 TO ABOUT 1997, I WAS CHAIRMAN OF THE DIVISION
3 OF OBSTETRICS AND GYNECOLOGY IN A POSTGRADUATE CONTINUING
4 EDUCATION COURSE. I WAS PUTTING ON THREE TO FIVE ACTUAL
5 POSTGRADUATE COURSES ANNUALLY WITH HUNDREDS OF PHYSICIANS FROM
6 ALL OVER THE UNITED STATES AND THE WORLD ATTENDING THESE
7 CLASSES.
8 AND I WAS IN CHARGE OF PUTTING ON THE PROGRAMS,
9 PICKING BOTH THE TOPICS AND THE SPEAKERS FOR ABOUT A 20-YEAR
10 PERIOD OF TIME.
11 Q. DOCTOR, HAVE YOU BEEN AN OFFICER IN ANY STATEWIDE MEDICAL
12 ORGANIZATION?
13 A. YES. DIRECTLY OUT OF RESIDENCY I BECAME INVOLVED AND ALSO
14 PROFESSIONAL ORGANIZATIONS BOTH FOR THE BENEFIT OF OUR PATIENTS
15 AND OUR PROFESSION. I HAVE GONE THROUGH BOTH IN THE DEPARTMENT
16 LEVEL EACH AUTHORSHIP, INCLUDING PRESIDENT OF PROFESSIONAL
17 STAFF AT EVANSTON HOSPITAL. I HAD AUTHORSHIPS AND
18 CHAIRMANSHIPS OF THE ILLINOIS MEDICAL SOCIETY AND HAVE BEEN
19 CHAIRMAN OF THE BOARD AND PRESIDENT OF THE CHICAGO MEDICAL
20 SOCIETY. AND I'VE HAD AUTHORSHIPS AND CHAIRMAN OF THE BOARD
21 AND PRESIDENT OF THE ILLINOIS STATE MEDICAL SOCIETY.
22 AND I AM A DELEGATE FROM ILLINOIS TO THE AMERICAN
23 MEDICAL ASSOCIATION. AND I AM CURRENTLY CHAIRMAN OF THE
24 ILLINOIS DELEGATION TO THE AMERICAN MEDICAL ASSOCIATION, AND
25 MOST RECENTLY CHAIRMAN OF THE GREAT LAKES STATES COALITION,

1 WHICH REPRESENTS SEVEN STATES TO THE AMERICAN MEDICAL
2 ASSOCIATION.
3 Q. DOCTOR, WHEN DID YOU SERVE AS PRESIDENT OF THE ILLINOIS
4 STATE MEDICAL SOCIETY?
5 A. PRESIDENT IN 2000, 2001; CHAIRMAN OF THE BOARD FROM 1996 TO
6 '98.
7 Q. DOCTOR, ARE YOU A MEMBER OF ANY NATIONWIDE MEDICAL
8 ORGANIZATIONS?
9 A. I'M A FELLOW OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND
10 GYNECOLOGISTS; HAVE SERVED IN VARIOUS FORMATIONS AND FUNCTIONS
11 THERE. AND CURRENTLY INTERACT WITH THE AMERICAN COLLEGE OF
12 OB/GYNE DELEGATION TO THE AMA. AS BEING CHAIRMAN OF THE
13 ILLINOIS OB/GYNE WE FREQUENTLY WILL COME TOGETHER ON ISSUES
14 RELATED TO WOMEN'S HEALTH CARE AND WORK TOGETHER ON THOSE
15 ISSUES.
16 Q. WHEN YOU SAY "OB/GYNE" DO YOU MEAN OBSTETRICIAN AND
17 GYNECOLOGISTS?
18 A. YES. I CAN SAY THAT EACH TIME OR I CAN SAY "OB/GYNE,"
19 WHICHEVER THE COURT PREFERS.
20 THE COURT: "OB/GYNE" IS FINE.
21 THE WITNESS: IT IS JUST SHORTER.
22 BY MR. SIMPSON:
23 Q. DOCTOR, ARE YOU ALSO -- AND YOU SAID YOU ARE A FELLOW --
24 MAYBE I SHOULD GO BACK. THE AMERICAN COLLEGE OF OBSTETRICS AND
25 GYNECOLOGISTS, IS THAT ALSO KNOWN BY THE ACRONYM ACOG?

1 A. CORRECT.
2 Q. ARE YOU A FELLOW OF ACOG?
3 A. I AM A FELLOW OF ACOG.
4 Q. ARE YOU ALSO A FELLOW OF THE AMERICAN COLLEGE OF SURGEONS?
5 A. I AM ALSO A FELLOW OF THE AMERICAN COLLEGE OF SURGEONS.
6 Q. DOCTOR, IS IT YOUR UNDERSTANDING THAT THE MAJORITY OF
7 OB/GYN'S ARE NOT FELLOWS OF THE AMERICAN COLLEGE OF SURGEONS?
8 A. THAT IS CORRECT. IT IS A SEPARATE ORGANIZATION WHERE YOU
9 HAVE TO STAND BEFORE A SEPARATE COMMITTEE IN ORDER TO BE
10 APPROVED AS A FELLOW OF THAT ORGANIZATION, AS WELL.
11 Q. DOCTOR, DO YOU DO ANY WORK IN RELATION TO MEDICAL LIABILITY
12 INSURANCE?
13 A. I ALSO SIT ON THE BOARD OF THE LARGEST LIABILITY INSURANCE
14 CARRIER IN ILLINOIS AND ACTUALLY HAVE CHAIRED THAT BOARD, AS
15 WELL. WE ENSURE 14,000 PHYSICIANS IN THE STATE OF ILLINOIS.
16 AND WE HAVE PRACTICING A THOUSAND OBSTETRICIANS AND
17 GYNECOLOGISTS, AS A RESULT REVIEW ALL OF THE LIABILITY CASES IN
18 ILLINOIS ON A MONTHLY BASIS IN RELATION TO THOSE 14,000
19 PHYSICIANS.
20 Q. DOCTOR, I BELIEVE YOU SAID THAT YOU ARE A DELEGATE TO THE
21 AMERICAN MEDICAL ASSOCIATION?
22 A. I AM A DELEGATE, HAVE BEEN A DELEGATE FOR SOMETIME, AND NOW
23 I CHAIR THE DELEGATION. SO I SPEAK FOR THE DELEGATION AT THE
24 AMA HOUSE OF DELEGATES.
25 Q. HAVE YOU SERVED ON ANY COMMITTEES OF THE AMA?

1 A. I HAVE SERVED ON SEVERAL COMMITTEES OF THE AMA. I HAVE
2 SERVED ON REFERENCE COMMITTEES BEFORE THE HOUSE ON SEVERAL
3 OCCASIONS. I HAVE SERVED ON DIFFERENT SELECT COMMITTEES THAT
4 THEY HAVE PICKED. I CURRENTLY SERVE ON THE COMMITTEE THAT
5 SELECTS THE PUBLIC MEMBER OF THE BOARD OF TRUSTEES OF THE AMA.
6 AND I HAVE RECENTLY -- WAS SELECTED FOR A SPECIAL
7 TASK FORCE THAT THEY CREATED TO REVIEW INTACT D&X, AND PRESENT
8 THAT REPORT BACK TO THE DELEGATION, BACK TO THE HOUSE OF
9 DELEGATES.
10 Q. CAN YOU TELL US A LITTLE MORE, DOCTOR, ABOUT YOUR SERVICE
11 ON THAT SPECIAL COMMITTEE REGARDING INTACT D&X? FOR EXAMPLE,
12 HOW MANY PHYSICIANS SERVED ON THAT COMMITTEE?
13 A. THERE WERE A TOTAL OF 10 PHYSICIANS ON THAT COMMITTEE, NINE
14 APPOINTED AND THE CHAIRMAN OF THE COMMITTEE WAS THE CHAIRMAN OF
15 THE AMA BOARD OF TRUSTEES.
16 Q. SO HOW WERE YOU CHOSEN FOR THAT COMMITTEE?
17 A. RESOLUTIONS WERE INTRODUCED TO THE INTERIM MEETING OF THE
18 AMA IN DECEMBER OF '96. AND INSTEAD OF VOTING UP OR DOWN ON
19 THOSE RESOLUTIONS, THE HOUSE FELT IT WAS AN IMPORTANT ENOUGH
20 ISSUE TO APPOINT A COMMITTEE, A TASK FORCE, TO REVIEW THE
21 ISSUES AND BRING THAT REPORT BACK IN JUNE TO THE ANNUAL MEETING
22 OF 1997.
23 TO BE -- TO TRY TO COVER ALL THE BASES,
24 REPRESENTATIVES FROM ACOG, AMERICAN ACADEMY OF FAMILY PRACTICE,
25 AND AMERICAN ACADEMY OF PEDIATRICS, THROUGH THE ETHICAL AND

1 JUDICIAL COMMITTEE AND THE COUNCIL ON SCIENTIFIC AFFAIRS AND
2 TWO STATE REPRESENTATIVES, ONE FROM PENNSYLVANIA AND ONE FROM
3 ILLINOIS WERE ALSO SELECTED.
4 AND I WAS SELECTED FROM ILLINOIS TO REPRESENT
5 ILLINOIS AS A STATE REPRESENTATIVE ON THAT TASK FORCE.
6 Q. WHY DID THEY WANT TO HAVE AN ILLINOIS REPRESENTATIVE ON THE
7 TASK FORCE?
8 A. IN THE TWO RESOLUTIONS THAT WERE BROUGHT FORWARD TO THE
9 INTERIM MEETING OF THE AMA CAME FROM PENNSYLVANIA AND ILLINOIS.
10 AND BECAUSE THOSE STATES BROUGHT FORWARD THE RESOLUTIONS THEY
11 THOUGHT IT APPROPRIATE TO HAVE A REPRESENTATIVE FROM EACH OF
12 THOSE STATES.
13 Q. DOCTOR, HAVE YOU DONE ANY WORK IN THE FIELD OF MEDICAL
14 ETHICS?
15 A. I HAVE BEEN VERY INVOLVED IN MEDICAL ETHICS AT LEAST FOR
16 ABOUT THE LAST 15 YEARS. I DID CREATE THE ETHICAL COMMITTEE
17 FOR EVANSTON NORTHWESTERN HEALTHCARE. I HAVE BEEN AN INVITED
18 SPEAKER TO NATIONAL ORGANIZATIONS ON ETHICS OF MEDICINE, BOTH
19 NATIONAL AND REGIONAL AT VARIOUS LEVELS. I HAVE BEEN A
20 CHAIRMAN OF THE ETHICAL RELATIONS COMMITTEE FOR THE CHICAGO
21 MEDICAL SOCIETY FOR THE LAST 10 YEARS, AND HAD SERVED ON THAT
22 COMMITTEE PRIOR TO THAT.
23 I CHAIRED THE PHYSICIAN REVIEW COMMITTEE FOR THE
24 CHICAGO MEDICAL SOCIETY PRIOR TO THAT, AND NUMEROUS COMMITTEES
25 IN THE HOSPITAL. I HAVE BEEN IN CHARGE OF QUALITY ASSURANCE,

1 AUDIT, LOOKING AT ETHICAL ISSUES AT HOSPITAL LEVEL AND COUNTY
2 LEVEL AND THE NATIONAL LEVEL.
3 Q. CAN YOU DESCRIBE TO US A LITTLE BIT, DOCTOR, A LITTLE MORE
4 ABOUT WHAT YOUR SERVICE AS CHAIRMAN OF THE ETHICS COMMITTEE OF
5 THE CHICAGO MEDICAL SOCIETY INVOLVES?
6 A. SURE. EITHER THE PHYSICIAN REVIEW COMMITTEE, THE BOARD OF
7 TRUSTEES OF THE CHICAGO MEDICAL SOCIETY OR ANY OTHER PATIENT,
8 INSURANCE COMPANY OR PHYSICIAN CAN FILE ETHICAL CHARGES AGAINST
9 ANY MEMBER OF THE CHICAGO MEDICAL SOCIETY. THAT WOULD COME
10 BEFORE MY COMMITTEE. I WOULD ASSESS IT. I WOULD ASSIGN A
11 COUPLE OTHER MEMBERS OF THE COMMITTEE TO ASSESS IT.
12 IF WE FELT THERE WAS SUFFICIENT DATA TO GO FORWARD,
13 WE WOULD THEN HOLD A HEARING AND ACTUALLY BRING THAT PHYSICIAN
14 BEFORE THE COMMITTEE, REVIEW THE MATERIAL AND THEN MAKE
15 DECISIONS AS TO WHETHER WE THOUGHT IT WAS ETHICALLY APPROPRIATE
16 OR NOT.
17 THEN YOU HAVE OPTIONS OF CENSURE, PROBATION OR
18 EXPULSION FROM THE MEDICAL SOCIETY.
19 Q. DOCTOR, I WOULD LIKE TO SHOW YOU WHAT HAS BEEN MARKED AS
20 DEFENDANT'S EXHIBIT A-7 IN THIS CASE.
21 DOCTOR, DO YOU RECOGNIZE THAT DOCUMENT, EXHIBIT A-7?
22 A. YES, I DO.
23 Q. WHAT IS THAT?
24 A. IT IS MY CURRENT C.V.
25 Q. IS THAT A TRUE AND ACCURATE COPY OF YOUR CURRICULUM VITAE?

1 A. JUST CHECKING TO SEE HOW CURRENT IT IS, THE LAST PAGE. IT
2 DOES GO TO JANUARY, 2004, SO IT IS RATHER CURRENT.
3 Q. DOCTOR, ARE THE STATEMENTS MADE IN YOUR C.V. CORRECT?
4 A. TO THE BEST OF MY KNOWLEDGE, YES.
5 MR. SIMPSON: ALL RIGHT. YOUR HONOR, I WOULD LIKE
6 TO MOVE FOR THE ADMISSION OF A-7 INTO EVIDENCE.
7 THE COURT: ANY OBJECTION?
8 MS. GARTNER: NO OBJECTION.
9 THE COURT: ALL RIGHT, ADMITTED.
10 THE CLERK: A-7 INTO EVIDENCE.
11 (DEFENDANT'S EXHIBIT A-7
12 WAS RECEIVED IN EVIDENCE.)
13 BY MR. SIMPSON:
14 Q. DOCTOR, ARE YOU FAMILIAR WITH THE METHODS USED BY
15 OBSTETRICIANS AND GYNECOLOGISTS IN CONNECTION WITH TERMINATING
16 PREGNANCY?
17 A. YES, I AM.
18 Q. COULD YOU JUST LIST FOR US AT THIS POINT THE WAYS THAT YOU
19 HAVE BECOME FAMILIAR WITH THOSE METHODS? JUST LIST THEM FOR US
20 NOW, AND WE'LL ASK YOU SPECIFIC QUESTIONS ABOUT THEM.
21 A. CLEARLY, I HAVE BEEN IN PRIVATE PRACTICE SINCE 1975. I WAS
22 RESIDENT BEFORE THAT, IN MEDICAL SCHOOL BEFORE THAT. AND
23 THROUGHOUT THAT TRAINING HAD EXPERIENCE IN VARIOUS FORMS OF
24 ABORTIONS.
25 I WAS ACTUALLY A MEDICAL STUDENT AT COOK COUNTY, AND

1 WE HAD NUMEROUS PATIENTS THERE, IN RESIDENCY AND IN PRIVATE
2 PRACTICE, HAVE BEEN INVOLVED IN ABORTIONS, ABORTION
3 COMPLICATIONS, TAKING CARE OF PATIENTS WHO HAVE HAD ABORTIONS,
4 AND MY PATIENTS THEN RETURNED TO THE OFFICE AND TOOK CARE OF
5 THEM.
6 SO, EXPERIENCE, BECAUSE OF THE EXTRA EMPHASIS ON
7 THIS AREA IN ABOUT 1995 AND '96 WHEN IT BECAME MORE PUBLIC
8 KNOWLEDGE, I GOT INVOLVED AT OUR ORGANIZATION, THE STATE
9 MEDICAL SOCIETY. WE DID LITERATURE RESEARCH AS TO THAT. AND
10 THE RESOLUTIONS WENT TO THE AMA. AS THE CHAIRMAN OF THE
11 DELEGATION, I WAS SPOKESPERSON FOR ILLINOIS AND HAD TO DO
12 RESEARCH ON THAT.
13 I WAS LATER ASKED TO WRITE A JOURNAL ARTICLE IN
14 JAMA, WHICH IS THE MOST WIDELY PUBLISHED MEDICAL JOURNAL IN THE
15 WORLD. AND DID SIGNIFICANT RESEARCH REVIEW IN RELATIONSHIP TO
16 THE ARTICLE.
17 I WAS THEN ASKED TO BE AN EXPERT WITNESS IN THE CASE
18 IN OHIO AND DID EXPERT TESTIMONY THERE AND AGAIN REVIEWED THE
19 LITERATURE AND SPOKE WITH NUMEROUS OTHER PHYSICIANS, AGAIN, TO
20 PRESENT SOME OF THE PROGRAMS.
21 THERE WERE A LOT OF PHYSICIANS WHO I COULD DISCUSS
22 THE ISSUES WITH FROM ACROSS THE UNITED STATES. AND THEN, I WAS
23 ASKED TO BE AN EXPERT IN THIS CASE. AND SO, AGAIN, I REVIEWED
24 THE LITERATURE UP TO THE PRESENT.
25 AND THEN, BECAUSE OF THE INVOLVEMENT IN THIS CASE I

1 HAVE BEEN PROVIDED WITH PROBABLY DOZENS OF DECLARATIONS,
2 DEPOSITIONS, ARTICLES. SO I THINK I HAVE A VERY THOROUGH,
3 UP-TO-DATE REVIEW AND UNDERSTANDING OF THE PROCEDURES, THE
4 COMPLICATIONS AND HAVE FORMED OPINIONS ON THAT BASIS.
5 Q. DOCTOR, YOU MENTIONED YOUR OWN MEDICAL PRACTICE. HAVE YOU
6 YOURSELF HAD TO REMOVE THE PRODUCTS OF CONCEPTION BEFORE
7 PREGNANCY REACHES TERM?
8 A. YES, I HAVE. AS A PRACTICING OBSTETRICIAN, APPROXIMATELY
9 15 PERCENT OF ALL PREGNANCIES HAVE SPONTANEOUS ABORTIONS OR
10 MISCARRIAGES IN THE LATE TERM. HAVING DONE OVER 3,000
11 DELIVERIES, IF YOU TAKE 15 PERCENT OF THAT, YOU ARE GOING TO
12 END UP WITH ABOUT 450.
13 AND THOSE ARE BOTH THAT OCCURRED IN THE
14 FIRST-TRIMESTER, SECOND-TRIMESTER AND UNFORTUNATELY EVEN IN THE
15 THIRD-TRIMESTER.
16 I ALSO BECAUSE OF I HAVE SUCH A LARGE PATIENT BASE,
17 PATIENTS MAY GET REFERRED FOR ABORTIONS. AND IF THEY HAVE
18 ISSUES WILL OFTEN COME BACK TO ME BECAUSE I AM THEIR PRIMARY
19 DOCTOR, THEY FEEL MORE COMFORTABLE. SO I FREQUENTLY WILL HAVE
20 TO BE INVOLVED IN HANDLING ANY COMPLICATIONS IN THOSE
21 PROCEDURES.
22 Q. DOCTOR, THE INSTANCES WHEN YOU HAVE ACTUALLY REMOVED THE
23 PRODUCTS OF CONCEPTION BEFORE PREGNANCY REACHES TERM, HAVE ALL
24 OF THOSE BEEN INSTANCES IN WHICH THE FETUS HAD ALREADY DIED OF
25 NATURAL CAUSES OR NOT?

1 A. ESSENTIALLY, YES. AND IN MY EXPERT TESTIMONY I DID SAY
2 EACH OF THE CASES I WAS THINKING OF AT THE TIME THE FETUS HAD
3 DIED. AND ACTUALLY TALKING ABOUT IT AND THINKING ABOUT IT
4 MORE, THERE WAS AN EMERGENCY SITUATION WHERE I WAS INVOLVED
5 WHERE A FETUS HAD NOT DIED.
6 Q. COULD YOU TELL US ABOUT THAT CASE, PLEASE?
7 A. IT WAS ACTUALLY A PATIENT CAME INTO THE EMERGENCY ROOM, AND
8 PROBABLY 10 YEARS AGO. THAT IS WHY IT WASN'T AT THE TOP OF MY
9 MEMORY WHEN I WAS FIRST THINKING ABOUT IT.
10 SHE CAME INTO THE EMERGENCY ROOM. THEY CALLED THE
11 GENERAL SURGEONS FIRST. AND SHE WAS ACTIVELY BLEEDING
12 INTRAABDOMINALLY. AND SO THEY KNEW SHE HAD TO GO TO SURGERY.
13 AND THAT WAS PROBABLY BEFORE THE TIME OF OUR INSTANT DATA HCG'S
14 WHERE WE HAD INSTANT DATA OF THAT.
15 BUT THEY DID A SIMPLE PREGNANCY TEST IN ER, AND IT
16 DID COME BACK POSITIVE. SO THE GENERAL SURGEON SAID:
17 "NO ONE NOW. A GYNECOLOGIST NEEDS TO GO IN
18 THERE."
19 AND SO THEY CALLED ME, AND I OPENED UP AND TOOK HER
20 TO SURGERY, BECAUSE SHE WAS BLEEDING INTERNALLY. I OPENED UP
21 HER ABDOMEN. AND SHE WAS PROBABLY 10, 12 WEEKS PREGNANT. AND
22 SITTING ON THE UTERUS WAS A PINK, FLESHY MASS GROWING THROUGH
23 THE WALL OF THE UTERUS.
24 AND, AGAIN, I HAVE A LOT OF EXPERIENCE. I'M A
25 TRAINED GYNECOLOGIST. BUT I WAS CERTAINLY NOT SURE OF WHAT

1 THIS MASS WAS. AND I THOUGHT IT WAS A SARCOMA, A CANCER OF
2 SOME KIND. AND WE TOOK OFF A PIECE OF THE TISSUE AND SENT IT
3 DOWN FOR A FROZEN SECTION. AND IT CAME BACK "PLACENTA."
4 THERE IS -- I THINK DIFFERENT PEOPLE KNOW OF
5 DIFFERENT AREAS OF THE PLACENTA. THE PLACENTA CAN, ON
6 OCCASION, RARE OCCASION GROW A LITTLE BIT INTO THE WALL AND BE
7 A PLACENTA ACCRETA.
8 EVEN MORE RARELY IT CAN GROW INTO THE WALL. IT IS A
9 PLACENTA INCRETA. AND EVEN MORE RARELY THE PLACENTA, FOR SOME
10 CRAZY REASON, IS SO AGGRESSIVE IT ACTUALLY GROWS THROUGH THE
11 WALL AND OUT THE WALL, WHICH IS WHAT HAPPENED IN THIS CASE. SO
12 IT IS AN A PLACENTA PERCRETA.
13 YOU HAVE GOT A LIFE-THREATENING SITUATION. THE
14 WOMAN IS BLEEDING. YOU HAVE TO -- IN THAT CASE I COULDN'T
15 THINK OF ANYTHING ELSE TO DO OTHER THAN ACTUALLY DO A
16 HYSTEROTOMY, REMOVE THE PLACENTA, WHICH WAS GROWING THROUGH THE
17 WALL AND SUCTIONING OUT THE UTERINE CONTENTS.
18 SO I WAS DOING AN ABORTION ON A LIVE FETUS TO SAVE
19 THE LIFE OF THE MOTHER. AND THE ONLY OTHER POSSIBLE THING I
20 COULD HAVE DONE IS DO A HYSTERECTOMY, WHICH WOULD HAVE LEFT HER
21 WITHOUT HER UTERUS AND NO FUTURE POSSIBILITY TO CONCEIVE.
22 AND IN THAT CIRCUMSTANCE, I FELT IT WAS IN THE BEST
23 INTEREST OF THE MOTHER TO DO WHAT I DID.
24 AND IF THE MOTHER'S LIFE WAS AT RISK, THAT IS THE
25 DECISION I WOULD MAKE. IN THAT CIRCUMSTANCE I DID MAKE THAT

1 DECISION.
2 Q. SO WAS THE WOMAN'S UTERUS REMOVED IN THAT CASE?
3 A. THE WOMAN'S UTERUS WAS SAVED, ALMOST MIRACULOUSLY, BECAUSE
4 IT WAS KIND OF A GUTSY THING I WANTED TO DO. I ACTUALLY GOT --
5 I WAS CONCERNED ABOUT HOW WELL SHE WOULD DO POSTOP AND WHETHER
6 SHE WOULD GET INFECTION OR SHE WOULD CONTINUE TO BLEED, BECAUSE
7 WHAT I DID WAS KIND OF UNUSUAL TO TAKE OUT PART AND LEAVE PART,
8 BUT SHE DID DO VERY WELL.
9 AND I DID SEE HER FOR A COUPLE OF YEARS AFTER THAT,
10 THEN SHE MOVED OUT OF STATE.
11 Q. DOCTOR, WOULD A VAGINAL REMOVAL OF THE FETUS HAVE SUFFICED
12 IN THAT CASE?
13 A. NOT AT ALL, BECAUSE THE PLACENTA HAD GROWN THROUGH THE
14 WALL, SO I WOULD HAVE -- WHATEVER I HAD TO TAKE OUT, THAT PART
15 OF THE UTERINE WALL, WITH THE PLACENTA IN IT.
16 IN THOSE CIRCUMSTANCES, IT IS LIKE THE PLACENTA IS
17 ALMOST ACTING LIKE A CANCER. IT IS NOT RECOGNIZING ANY
18 BOUNDARIES, AND IT IS JUST GROWING THROUGH THE TISSUE.
19 YET, IT WAS SUPPOSED TO BE NORMAL BOUNDARIES. IT
20 STOPS AT THE LINING OF ENDOMETRIUM. FOR WHATEVER REASON, IN
21 THIS CASE IT JUST CONTINUED TO GROW THROUGH THE WALL.
22 THE COURT: EXCUSE ME. DID THE WOMAN KNOW SHE WAS
23 PREGNANT?
24 THE WITNESS: I DON'T THINK SO.
25 BY MR. SIMPSON:

1 Q. DOCTOR, I BELIEVE YOU SAID THIS ALREADY, THE FETUS WAS
2 ALIVE?
3 A. THE FETUS WAS ALIVE.
4 Q. BUT, OF COURSE, YOU SAID IT WAS TEN TO TWELVE WEEKS, SO THE
5 FETUS DID NOT LIVE?
6 A. WELL, ACTUALLY, NO, BECAUSE I SUCTIONED IT OUT.
7 Q. IT WAS PREVIABILITY?
8 A. YES.
9 Q. ALL RIGHT. NOW, DOCTOR, ASIDE FROM THAT PARTICULAR CASE,
10 CAN YOU LIST FOR US -- YOU DON'T NEED TO DESCRIBE THEM AT THIS
11 POINT -- BUT JUST LIST FOR US THE METHOD OR METHODS THAT YOU'VE
12 USED TO REMOVE THE PRODUCTS OF CONCEPTION.
13 A. GOING THROUGH THE GAMUT OF TYPICAL PROCEDURES UP TO 12
14 WEEKS MOST OF THEM ARE JUST SUCTION CURETTAGE. BEYOND 12, 13
15 WEEKS WE WOULD DO VARIATIONS OF D&E'S.
16 AND MOST COMMONLY IN MY PRACTICE BEYOND 18 TO 20
17 WEEKS WE WOULD USE INDUCTION.
18 Q. SO, APPROXIMATELY -- DID YOU SAY YOU HAVE USED THE D&E
19 METHOD?
20 A. CORRECT.
21 Q. APPROXIMATELY HOW MANY TIMES HAVE YOU DONE THAT?
22 A. I AM KIND OF GIVING A LOW ESTIMATE, BECAUSE I HAVEN'T
23 ACTUALLY GONE BACK AND LOOKED SPECIFICALLY. AND I THINK IN MY
24 EXPERT REPORT I SAID "MAYBE 20." I AM SURE IT IS ACTUALLY MORE
25 THAN THAT, BUT I WAS TRYING TO BE CONSERVATIVE RATHER THAN

1 SAYING I DID MORE THAN THAT.
2 THEN IF I TALKED ABOUT MORE AFTER THE 14 WEEKS, AND
3 ACTUALLY THE FIRST-TRIMESTER STOPS IN MOST PEOPLE'S TEXTBOOKS
4 AT 12 WEEKS. SO KIND OF THE 13, 14 WEEK IS KIND OF A GRAY
5 ZONE.
6 I WAS ACTUALLY TRYING TO SAY ONES THAT WERE ACTUALLY
7 FURTHER ADVANCED.
8 Q. DOCTOR, APPROXIMATELY HOW MANY TIMES HAVE YOU USED THE
9 INDUCTION METHOD TO REMOVE A DEAD FETUS?
10 A. THERE ARE, UNFORTUNATELY, MANY MORE THAN I WOULD LIKE.
11 ABOUT 3 PERCENT OF WOMEN DO HAVE MISCARRIAGES IN THE
12 SECOND-TRIMESTER. AND OFTEN YOU EITHER DO D&E'S OR INDUCTIONS,
13 DEPENDING ON HOW FAR ALONG THEY ARE. AND THERE ARE SOMETIMES
14 STILLBIRTH OR INTRAUTERINE FETAL DEMISE AT 20 TO 25.
15 SO THAT'S -- I SAID "20 TO 30," BUT IT DEPENDS ON
16 EXACTLY WHAT YOU COUNT. RECENTLY I HAVE LITERALLY HAD
17 UNFORTUNATELY TWO THAT THE BABY DIED AT 37, 38 WEEKS, WHICH IS
18 A REAL TRAGEDY. I AM NOT SURE IF IT'S -- IT'S OBVIOUSLY NOT
19 SECOND-TRIMESTER. IT IS THIRD-TRIMESTER. SO I AM NOT EXACTLY
20 SURE WHETHER YOU WANT ME TO COUNT THOSE OR NOT, BUT THEY ARE
21 THERE.
22 Q. LET'S INCLUDE NOT JUST THE SECOND-TRIMESTER, BUT ALSO THE
23 THIRD ON THE INDUCTION METHOD. SO HAVE YOU SAID 20 OR 30 TIMES
24 YOU HAVE USED INDUCTION FOR THAT PURPOSE?
25 A. AT LEAST.

1 Q. DOCTOR, HOW WOULD YOU COMPARE THE TECHNIQUES USED TO REMOVE
2 THE PRODUCTS OF CONCEPTION WHERE THE FETUS HAS ALREADY DIED TO
3 THE TECHNIQUES USED TO DO THAT WHERE THE FETUS HAS NOT DIED?
4 A. THE TECHNIQUES ARE ACTUALLY THE SAME. AND IN READING THE
5 OTHER DEPOSITIONS OF OTHER EXPERTS IN THIS CASE, THEY DON'T
6 MAKE A DISTINCTION IN WHATEVER PROCEDURE THEY ARE USING.
7 SOMETIMES THE PHYSICIANS -- "PHYSICANS" -- SOMETIMES THE FETUS
8 IS ALIVE AND SOMETIMES IT IS NOT.
9 THE MORE COMMONLY IN A PROCEDURE FROM READING ALL
10 THE DEPOSITIONS, MORE COMMONLY THAT 26 TO 27 WEEK D&E'S, D&X'S
11 ARE MORE COMMONLY ON DEAD FETUSES. SO THEY ARE DOING THE SAME
12 THING.
13 MS. GARTNER: YOUR HONOR, I AM NOT CLEAR WHETHER HE
14 IS TALKING ABOUT HIS OWN PRACTICE OR WHETHER HE IS REPORTING ON
15 SOMETHING FROM OTHER PEOPLE'S DEPOSITIONS IN THIS CASE.
16 THE COURT: COULD YOU CLARIFY?
17 THE WITNESS: YES. I THOUGHT HE ASKED ME WHETHER
18 THE PROCEDURES WERE THE SAME, AND I WAS SAYING:
19 "YES, THEY ARE," AND KIND OF SHOWING THAT
20 OTHER PEOPLE -- YES, I BELIEVE THEY ARE. BUT IN OTHER
21 DEPOSITIONS THEY ARE ALSO -- THEY ARE DOING EXACTLY THE SAME
22 PROCEDURE. SO I THINK IT JUST CORROBORATES WHAT I SAID.
23 THE COURT: OKAY.
24 THE WITNESS: YES?
25 THE COURT: I AM A LITTLE UNCLEAR. YOU INDICATED

1 YOU YOURSELF HAVE PERFORMED APPROXIMATELY 20 D&E'S.
2 THE WITNESS: CORRECT.
3 THE COURT: AND APPROXIMATELY 20 TO 30 INDUCED
4 ABORTIONS, CORRECT?
5 THE WITNESS: YES, I AM LOWBALLING THOSE NUMBERS.
6 THE COURT: FINE.
7 THE WITNESS: YES. YES.
8 THE COURT: LET'S SAY ROUGHLY ABOUT 50 IN BOTH
9 CATEGORIES? IN BOTH CATEGORIES ARE WE TALKING ABOUT CASES IN
10 WHICH THE FETUS HAD ALREADY DIED?
11 THE WITNESS: CORRECT.
12 THE COURT: ALL RIGHT. AND THE ONLY INSTANCE
13 INVOLVING A LIVE FETUS IS THE HYSTEROTOMY YOU DESCRIBED IN THE
14 EMERGENCY ROOM.
15 THE WITNESS: CORRECT. I HAVE BEEN INVOLVED IN
16 CASES WHERE PATIENT COMES INTO THE EMERGENCY ROOM MAYBE AT 17,
17 18 WEEKS WITH AN INFECTION AND IS ACTUALLY STARTING TO BEGIN
18 LABOR ON HER OWN. AND SO YOU ARE TAKING CARE OF THAT
19 SITUATION, AND THE FETUS IS ALIVE. AND YOU ARE STARTING, BUT
20 YOU ARE STILL GOING TO END UP WITH A DELIVERED FETUS. THOSE
21 ARE KIND OF MORE -- YOU ARE IN THE PROCESS. THERE IS INFECTION
22 OF THE UTERUS. IT IS USUALLY CONTRACTING, ANYWAY.
23 SO YOU ARE IN THE PROCESS OF JUST EXTRACTING THE
24 FETUS DURING THE PROCESS OF WHAT IS REALLY A LABOR PROCESS
25 PREMATURELY THAT THE PATIENT STARTED.

1 THE COURT: ALL RIGHT.
2 BY MR. SIMPSON:
3 Q. DOCTOR, YOU ALSO MENTIONED HAVING TREATED COMPLICATIONS
4 FROM ABORTION WHERE WOMEN HAD RECEIVED AN ABORTION ON A LIVE
5 FETUS ELSEWHERE, AND THEN RETURNED TO YOU FOR TREATMENT FOR
6 COMPLICATIONS.
7 APPROXIMATELY HOW OFTEN DO YOU HAVE TO DO THAT?
8 A. THEY ARE -- GOING ALL THE WAY BACK TO BEING A MEDICAL
9 STUDENT AT COOK COUNTY HOSPITAL WHERE THEY HAD A SIGNIFICANT
10 NUMBER OF THOSE EVEN IN THE SHORT PERIOD OF TIME I WAS THERE.
11 BUT IN PRACTICE, PROBABLY AT LEAST A COUPLE OF
12 TIMES. TWO OR THREE TIMES A YEAR. IT IS NOT UNCOMMON, BUT IT
13 IS NOT SOMETHING WE SEE EVERY MONTH.
14 Q. DOCTOR, HAVE YOU CONSULTED WITH OTHER DOCTORS AT EVANSTON
15 NORTHWESTERN HEALTHCARE REGARDING THE PERFORMANCE OF ABORTIONS
16 ON LIVE FETUSES?
17 A. YES, I HAVE.
18 Q. DOCTOR, YOU ALSO MENTIONED HAVING STUDIED THE LITERATURE ON
19 ABORTION. AND YOU MENTIONED SEVERAL CONTEXTS IN WHICH YOU HAVE
20 DONE THAT.
21 FIRST OF ALL, THE SPECIAL AMA COMMITTEE ON INTACT
22 D&X, HOW DID THAT SERVICE EFFECT YOUR FAMILIARITY WITH THE
23 METHODS OF ABORTION?
24 A. IT PROBABLY WAS THE FIRST TIME THAT I GOT AS DEEPLY
25 INVOLVED, BECAUSE THAT COMMITTEE WAS APPOINTED. AND THEN, FOR

1 SEVERAL MONTHS REVIEWED THE LITERATURE, HAD MEETINGS, TELEPHONE
2 CONFERENCE CALLS, FAXES. A SIGNIFICANT AMOUNT OF WORK WENT
3 INTO PREPARING THAT TASK FORCE REPORT BECAUSE IT WAS A MAJOR
4 REPORT THAT WAS GOING TO GO BEFORE THE ENTIRE HOUSE OF
5 DELEGATES. AND SO A SIGNIFICANT LITERATURE RESEARCH BY A
6 PANEL, BY A STAFF, BY OTHER MEMBERS OF THE COMMITTEE, AND,
7 AGAIN, REPRESENTATIVES OF VARIOUS COUNSELS.
8 Q. DOCTOR, YOU ALSO MENTIONED WRITING AN ARTICLE FOR JAMA. IS
9 THAT THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION?
10 A. YES, IT IS.
11 Q. AND CAN YOU TELL US HOW YOU CAME TO WRITE THAT ARTICLE?
12 A. BECAUSE OF MY INVOLVEMENT ON THE TASK FORCE AND INVOLVEMENT
13 AT THE AMA HOUSE OF DELEGATES AND BECAUSE THE TOPIC WAS SO
14 POPULAR IN THE MEDIA AT THAT TIME -- THINGS WERE GOING ON AT
15 THE NATIONAL LEVEL. ACTUALLY, IN ILLINOIS, PEOPLE WERE TAKING
16 SURVEYS.
17 WHAT HAPPENED IS THAT DR. GRIMES WROTE A PAPER AND
18 SENT IT IN TO JAMA AS SUPPORTING THE CONTINUED NEED FOR THE
19 PROCEDURE THE EDITORS OF JAMA WANTED TO USE IT. THEY HAVE A
20 CONTROVERSY SECTION WHERE THEY HAVE ONE ARTICLE PRO AND ONE
21 ARTICLE CON ON AN ISSUE. AND THEY THOUGHT THIS WAS SUCH A
22 PROMINENT ISSUE IN THE MEDIA, IN THE PUBLIC AT THAT TIME THAT
23 THIS WOULD BE AN IDEAL SITUATION.
24 BECAUSE OF MY POSITION ON THE TASK FORCE, BECAUSE OF
25 MY ACTIVITY AT THE AMA HOUSE OF DELEGATES AT THE AMA. I WAS

1 WELL-RECOGNIZED IN THIS AREA. THEY HAD HEARD MY PRESENTATIONS.
2 AND THE EDITOR OF THIS PORTION OF JAMA CALLED ME AND SAID:
3 "WE HAVE THIS ONE ARTICLE. WE NEED THE ARTICLE
4 TAKING THE POSITION ON THE OPPOSITE SIDE. AND WOULD
5 YOU BE WILLING TO DO THIS?"
6 RECOGNIZING IT WAS A GREAT DEAL OF WORK TO DO THIS
7 AND WOULD REQUIRE A GREAT DEAL OF RESEARCH, I DID KIND OF THINK
8 ABOUT IT FOR AWHILE. AND THEN, I DID SAY I WOULD BE WILLING TO
9 DO THE WORK TO PREPARE THAT ARTICLE.
10 MR. SIMPSON: YOUR HONOR, I WOULD LIKE TO SHOW THE
11 WITNESS EXHIBIT A-55. BUT WE WOULD LIKE TO MAKE A SUBSTITUTION
12 HERE, IF WE COULD.
13 I AM AWARE THAT THE COPY OF A-55 THAT IS IN THE
14 EVIDENCE BINDERS IS A COPY OF DR. SPRANG'S ARTICLE FROM THE
15 CONGRESSIONAL RECORD. BUT THE PRINT IN THAT COPY IS VERY, VERY
16 SMALL.
17 WITH THE COURT'S PERMISSION, I WOULD LIKE TO
18 SUBSTITUTE A COPY OF A REPRINT OF THAT ARTICLE WITH MORE
19 READABLE TYPE.
20 THE COURT: I AM SURE THAT IS FINE.
21 YOU ARE RIGHT. I CAN'T READ THAT.
22 THE WITNESS: I LOOKED AT IT. I COULDN'T READ IT,
23 EITHER.
24 MR. SIMPSON: COULD I APPROACH THE WITNESS, PLEASE,
25 YOUR HONOR?

1 THE COURT: YES, YOU MAY.
2 MAY I JUST DISCARD THIS ONE?
3 MR. SIMPSON: YES. THAT WOULD BE FINE.
4 BY MR. SIMPSON:
5 Q. DOCTOR, I HAVE SHOWN YOU WHAT IS NOW EXHIBIT A-55 IN THIS
6 CASE. DO YOU RECOGNIZE THAT DOCUMENT?
7 A. YES, I DO.
8 Q. WHAT IS THAT?
9 A. IT IS THE ARTICLE I WROTE FOR JAMA IN 1998.
10 Q. DOCTOR, COULD YOU -- WE ARE GOING TO BE TALKING IN SOME
11 DETAIL ABOUT THE CONTENT OF THE ARTICLE. BUT COULD YOU AT THIS
12 POINT JUST KIND OF BRIEFLY DESCRIBE IT TO US?
13 A. BASICALLY, MY EMPHASIS -- AND REALLY I HAD NOT BEEN
14 INTERESTED IN THE ABORTION ISSUE BEFORE. BUT MY ONLY INTEREST
15 WAS REALLY IN THE PART, THE INTACT D&X. AND THAT'S KIND OF
16 WHAT I WANTED TO WRITE ABOUT.
17 BECAUSE THE OTHER ARTICLE WAS MORE BROAD AND
18 INCLUDED ALL OF THE LATER TERM ABORTIONS, THEY ASKED ME TO KIND
19 OF TRY TO INCLUDE OTHER THINGS BESIDES INTACT D&X. SO I
20 ACQUIESCED, RELUCTANTLY.
21 SO I ACTUALLY KIND OF DIVIDED THIS ARTICLE INTO THE
22 FIRST PORTION, WHICH SPECIFICALLY ADDRESSED INTACT D&X, AND
23 THEN I HAD TO INCLUDE A SECOND PORTION. AND THERE IS A LOT OF
24 OVERLAP IN THE SAME COMPLICATION RATES AND INDICATIONS AND WHEN
25 THEY DO IT. SO, ACTUALLY, IT IS BROKEN INTO TWO PARTS. ONE:

1 INTACT D&X, AND THEN, IN GENERAL, JUST ABORTIONS THAT ARE
2 PERFORMED, I WOULD SAY, LATE IN THE SECOND-TRIMESTER. AND BY
3 "LATE IN THE SECOND-TRIMESTER" I WILL PROBABLY SAY 20 TO 27
4 WEEKS.
5 Q. OKAY.
6 A. SO IT IS DIVIDED THAT WAY.
7 THEN, I KIND OF OBVIOUSLY NEEDED TO TAKE SOME
8 FORMAT, SOME WAY OF SETTING IT OUT. SO I SET IT OUT AS KIND OF
9 FIRST DEFINING, SAYING WHAT BROUGHT THIS ISSUE TO THE
10 FOREFRONT, WHAT WAS KIND OF GOING ON IN THE MEDIA.
11 THEN, I KIND OF USED ACOG DEFINITIONS AND TRIED TO
12 USE OTHER DEFINITIONS SO EVERYBODY WOULD KNOW WHAT WE WERE
13 TALKING ABOUT.
14 THEN, I BROKE IT INTO MATERNAL CONSIDERATIONS, FETAL
15 CONSIDERATIONS, ETHICAL CONSIDERATIONS AND WHAT WAS GOING ON IN
16 THE VARIOUS PROFESSIONAL ORGANIZATIONS, LEGISLATIVE AND PUBLIC.
17 BECAUSE BY THIS POINT 27 STATES HAD PASSED BANS ON INTACT D&X.
18 AND SO THERE WERE ALL DIFFERENT AREAS.
19 SO JUST TO HAVE A REASONABLE WAY OF PRESENTING
20 INFORMATION, I BROKE IT INTO THOSE AREAS. AND THEN, I DID THE
21 SAME THING FOR TERMINATION OF LATE TERM PREGNANCIES, IN
22 GENERAL, BECAUSE THAT IS WHAT THE EDITORS WANTED ME TO DO.
23 Q. THANK YOU, DOCTOR.
24 DOCTOR, YOU MENTIONED DOING RESEARCH INTO -- AM I
25 SAYING THIS CORRECTLY? DID YOU DO RESEARCH REGARDING ABORTION

1 METHODS TO WRITE THIS ARTICLE?
2 A. CORRECT.
3 Q. RESEARCH INTO THE MEDICAL LITERATURE?
4 A. CORRECT.
5 Q. DOCTOR, DOES THAT ARTICLE INCLUDE DISCUSSION OF THE HUMAN
6 FETUSES' REACTION TO PAINFUL STIMULI?
7 A. IT DOES.
8 Q. SO, HAVE YOU DONE RESEARCH INTO THE MEDICAL LITERATURE ON
9 THAT TOPIC, AS WELL?
10 A. I HAVE. ALSO IN MY FORMAL TRAINING, I DID SPEND TIME IN
11 ANESTHESIA, WHICH IS OBVIOUSLY PAIN MANAGEMENT AND SPENT SOME
12 TIME THERE, AS WELL. BUT SPECIFICALLY FOR THIS I LOOKED FOR
13 ARTICLES ON FETAL PAIN. I WAS LOOKING AT BOTH THE ANATOMIC
14 PROGRESSION OF WHEN NERVES GO TO DIFFERENT AREAS AND HOW THEY
15 PROGRESS UP TO THE THALAMUS AND THE BRAIN.
16 I LOOKED AT VARIOUS STUDIES THAT SHOWED CHANGES THAT
17 HAD BEEN DONE IN DIFFERENT STUDIES IN ULTRASOUND ON BLOOD FLOW
18 AND ACTUALLY MEASURING HORMONES. AND I WILL ALSO SAY THAT I
19 HAVE BEEN IN NURSERIES WITH ACTUALLY -- WAS IN A NURSERY IN ST.
20 JOHN'S THAT HAD THREE 0R FOUR BABIES THAT WERE DELIVERED THAT
21 WERE 23 WEEKS OR 24 WEEKS.
22 AND SO THEN AT THAT POINT THEY ARE BABIES, NOT
23 FETUSES, BUT DURING THE SAME TIME FRAME THAT WE ARE TALKING
24 ABOUT, DURING THE 23, 24 WEEK TIME FRAME. AND IN THE NURSERY
25 AT THAT LEVEL, YOU CAN SEE THE RESPONSE TO PAIN. IF THE

1 NEONATOLOGISTS ARE PERFORMING PROCEDURES, THEY GIVE -- THEY USE
2 ANESTHESIA. AND IT IS THE SAME TIME FRAME WE ARE TALKING
3 ABOUT.
4 MS. GARTNER: OBJECTION, YOUR HONOR. I AM NOT SURE
5 IF HE IS GIVING TESTIMONY ABOUT FETAL PAIN OR NOT AT THIS
6 POINT. BUT HE HASN'T BEEN QUALIFIED AS AN EXPERT IN ANY AREA
7 YET, SO I DON'T KNOW IN THE CONTEXT OF TRYING TO HAVE HIM
8 QUALIFIED, IF HE IS ACTUALLY GETTING INTO THE AREA OF GIVING
9 TESTIMONY.
10 THE COURT: LET'S LET MR. SIMPSON EXPLAIN. YOU
11 HAVEN'T MOVED TO QUALIFY HIM IN ANY PARTICULAR AREA. IS THIS
12 ONE OF THE AREAS IN WHICH YOU ARE ATTEMPTING TO QUALIFY HIM?
13 MR. SIMPSON: YES, WE ARE, YOUR HONOR. AND I WAS
14 ABOUT TO GET TO THE POINT OF ASKING HIM TO BE QUALIFIED.
15 BUT LET'S MOVE ON TO THE NEXT TOPIC, AND THEN I WILL
16 ASK HIM TO BE QUALIFIED AND STATE THE SUBJECTS OF THAT
17 QUALIFICATION.
18 THE COURT: OKAY.
19 BY MR. SIMPSON:
20 Q. DOCTOR, YOU ALSO MENTIONED HAVING TESTIFIED IN COURT
21 REGARDING ABORTION METHODS. NOW, YOU MENTIONED THIS CASE, FOR
22 ONE THING.
23 HAVE YOU TESTIFIED IN EITHER OF THE OTHER CASES THAT
24 ARE CURRENTLY ONGOING REGARDING INTACT D&X?
25 A. I HAVE TESTIFIED IN LINCOLN, NEBRASKA.

1 Q. WERE YOU QUALIFIED AS AN EXPERT IN THAT CASE?
2 A. CORRECT.
3 Q. HAVE YOU TESTIFIED IN THE NEW YORK CASE?
4 A. I HAD --
5 MS. GARTNER: OBJECTION, YOUR HONOR. I AM SORRY,
6 BUT I -- AND I APOLOGIZE FOR OBJECTING SO MUCH -- BUT I BELIEVE
7 THAT, IN FACT, IN THE NEBRASKA CASE, THE COURT IS NOT ACTUALLY
8 QUALIFYING WITNESSES AS EXPERTS, BUT IS SIMPLY TAKING ALL OF
9 THE EXPERTS THAT ARE PRESENTED, TAKING THEIR TESTIMONY. AND
10 THE COURT HAS INDICATED HE WILL GIVE THE WITNESSES THE WEIGHT
11 THAT HE THINKS IS APPROPRIATE.
12 BUT, IN FACT, NOBODY IN THAT CASE HAS BEEN PROFFERED
13 AS AN EXPERT OR QUALIFIED AS AN EXPERT.
14 MR. SIMPSON: I WAS UNAWARE OF THAT, YOUR HONOR.
15 THE COURT: OKAY.
16 BY MR. SIMPSON:
17 Q. AND, DOCTOR, WILL YOU BE TESTIFYING IN THE NEW YORK CASE,
18 AS WELL?
19 A. CORRECT.
20 Q. I THINK YOU MENTIONED ANOTHER CASE. YOU SAID "THE OHIO
21 CASE." WAS THAT A CASE CHALLENGING THE OHIO STATUTE ON WHAT
22 ARE CALLED "PARTIAL-BIRTH ABORTIONS"?
23 A. IT WAS A CASE CHALLENGING AN OHIO BAN ON INTACT D&X. AND I
24 WAS, TO THE BEST OF MY KNOWLEDGE, WAS QUALIFIED AS AN EXPERT IN
25 THAT CASE. AND I DID TALK ABOUT BOTH THE MEDICAL ASPECTS, THE

1 ETHICAL ASPECTS AND FETAL PAIN AT SOME LENGTH.
2 Q. DOCTOR, WAS THAT OHIO CASE --
3 A. I WAS CHALLENGED BY THE PLAINTIFF'S BAR, AND THE JUDGE IN
4 THAT CASE DID ALLOW ME TO TESTIFY.
5 Q. DOCTOR, WAS THAT OHIO CASE WOMEN'S PROFESSIONAL MEDICAL
6 CORPS VERSUS TAFT?
7 A. CORRECT.
8 Q. THAT WAS IN THE FEDERAL COURT IN OHIO?
9 A. CORRECT.
10 Q. AND DID THAT EXPERIENCE AFFECT THE LEVEL OF YOUR
11 FAMILIARITY WITH ABORTION METHODS?
12 A. AGAIN, SAME REASONS. OBVIOUSLY, BEFORE YOU ARE INVOLVED IN
13 SOMETHING LIKE THAT, YOU RESEARCH THE LITERATURE.
14 AND, AGAIN, YOU ARE GIVEN THE OPPORTUNITY TO READ
15 DECLARATIONS AND DEPOSITIONS, WHICH I JUST FIND ACTUALLY
16 READING A 200 OR 300-PAGE DEPOSITION IN GREAT DETAIL ON
17 INDIVIDUALS WHO ACTUALLY ARE PERFORMING THEM ON A DAY-TO-DAY
18 BASIS GIVES YOU A GREAT DEAL OF INSIGHT INTO EXACTLY WHAT THEY
19 ARE DOING, HOW THEY ARE DOING IT, AND WHY THEY ARE DOING IT,
20 BECAUSE THEY ARE RESPONDING TO VERY SPECIFIC QUESTIONS. SO,
21 YES.
22 MR. SIMPSON: YOUR HONOR, WE WOULD LIKE TO MOVE TO
23 QUALIFY DR. SPRANG AS AN EXPERT IN OBSTETRICS AND GYNECOLOGY,
24 INCLUDING THE METHODS USED TO REMOVE THE PRODUCTS OF CONCEPTION
25 BEFORE TERM AND THEIR RISKS AND COMPLICATIONS, THE ETHICAL

1 CONSIDERATIONS THAT GUIDE OBSTETRICAL PRACTICE AND THE REACTION
2 OF THE FETUS TO PAINFUL STIMULI.
3 THE COURT: THE SECOND CATEGORY?
4 MR. SIMPSON: THE ETHICAL CONSIDERATIONS THAT GUIDE
5 OBSTETRICAL PRACTICE.
6 THE COURT: NO, BEFORE THAT.
7 MR. SIMPSON: JUST PART OF THE FIRST PART,
8 OBSTETRICS AND GYNECOLOGY, INCLUDING THE METHODS USED TO REMOVE
9 THE PRODUCTS OF CONCEPTION BEFORE TERM AND THEIR RISKS AND
10 COMPLICATIONS.
11 THE COURT: ALL RIGHT. IS THERE ANY OBJECTION ON
12 THOSE CATEGORIES?
13 MS. GARTNER: YES, YOUR HONOR. WE HAVE OBVIOUSLY NO
14 OBJECTION TO DR. SPRANG BEING QUALIFIED AS AN EXPERT GENERALLY
15 IN THE AREA OF OBSTETRICS AND GYNECOLOGY.
16 BUT, YOUR HONOR, I WOULD LIKE TO DO SOME VOIR DIRE
17 TO SEE IF WE CAN DEFINE THE SCOPE OF HIS TESTIMONY.
18 THE COURT: YOU MAY.
19 MS. GARTNER: THANK YOU.
20 VOIR DIRE EXAMINATION
21 BY MS. GARTNER:
22 Q. GOOD MORNING, DR. SPRANG.
23 A. GOOD MORNING.
24 Q. IT IS GOOD TO SEE YOU AGAIN. MY NAME IS EVE GARTNER.
25 A. I KNOW.

1 Q. AND WE MET AT EVANSTON, RIGHT?
2 DR. SPRANG, YOU HAVE DONE NO CLINICAL RESEARCH IN
3 THE AREA OF ABORTION; IS THAT RIGHT?
4 A. I AM THINKING BECAUSE I AM INVOLVED IN HELPING THE STUDENTS
5 DO A LOT OF DIFFERENT THINGS, AS WELL. I DON'T BELIEVE I HAVE
6 ACTUALLY BEEN INVOLVED IN A PAPER, THOUGH I DO WORK WITH THE
7 STUDENTS, AND SOME OF THEM ARE DOING RESEARCH ON THAT.
8 Q. AND YOU DON'T GIVE FORMAL, PLANNED LECTURES ON ABORTIONS TO
9 MEDICAL STUDENTS OR RESIDENTS, DO YOU?
10 A. I HAVE. YES AND NO. ON THE ETHICAL ASPECTS OF IT I HAVE
11 GIVEN PRESENTATIONS TO RESIDENTS AND STUDENTS ON THE ETHICS OF,
12 ESPECIALLY INTACT D&X.
13 Q. HAVE YOU EVER GIVEN A FORMAL, PLANNED LECTURE ON HOW
14 ABORTIONS ARE PERFORMED TO MEDICAL STUDENTS OR RESIDENTS?
15 A. WE HAD THIS DISCUSSION BEFORE. I HAVE GIVEN PRESENTATIONS
16 AT LUNCHEON MEETINGS WHICH ARE SCHEDULED. I WON'T SAY HOW
17 FORMAL THEY ARE. BUT WE HAVE DISCUSSED THIS WITH THE RESIDENTS
18 AT LUNCHEON MEETINGS. AND THE QUESTION IS, OBVIOUSLY: IS THAT
19 FORMAL OR NOT?
20 MS. GARTNER: YOUR HONOR, MAY I HAND THE WITNESS HIS
21 DEPOSITION?
22 THE COURT: YES.
23 MS. GARTNER: I WILL HAND YOU ONE, AS WELL.
24 BY MS. GARTNER:
25 Q. DR. SPRANG, I AM HAND HANDING YOU THE DEPOSITION THAT WAS

1 TAKEN OF YOU IN THIS CASE IN FEBRUARY. IF YOU COULD TURN TO
2 PAGE 47 OF THE DEPOSITION.
3 AND IF YOU COULD LOOK AT THE ANSWER THAT YOU GAVE ON
4 LINES 22 TO 24 OF YOUR DEPOSITION. AND LET ME ASK YOU, AGAIN:
5 DO YOU GIVE FORMAL, PLANNED LECTURES ON ABORTION TO THE MEDICAL
6 STUDENTS OR THE RESIDENTS?
7 A. I WILL ANSWER DIRECTLY. WHAT I SAID WAS:
8 "I DO NOT GIVE FORMAL, PLANNED LECTURES."
9 THE DISTINCTION I AM MAKING IS THESE LECTURE ARE NOT
10 ALWAYS THAT FORMAL, BUT THEY ARE LUNCHEON LECTURES. SO, YES.
11 BUT SPECIFICALLY IF YOU ARE ASKING ME FORMAL, NO. OKAY?
12 Q. OKAY.
13 A. IT IS A DISTINCTION, BUT IT IS REAL.
14 Q. OKAY. AND OTHER THAN THE PIECE THAT YOU WERE JUST TALKING
15 ABOUT THAT WAS PUBLISHED IN THE JOURNAL OF THE AMERICAN MEDICAL
16 ASSOCIATION, JAMA, YOU HAVE NOT PUBLISHED IN THE AREA OF
17 ABORTION; IS THAT RIGHT?
18 A. YES AND NO, BECAUSE WHEN YOU PUBLISH SOMETHING LIKE THIS
19 THERE ARE THEN LETTERS TO THE EDITOR. AND THEN YOU DO RESPONSE
20 TO THAT. SO I HAVE HAD OTHER PUBLISHED RESPONSES TO THE LETTER
21 TO THE EDITOR IN JAMA. I HAVE GIVEN PRESENTATIONS ON THE
22 ETHICS IN THE GENERAL AREA OF INTACT D&X AT BIOETHICS SEMINARS.
23 Q. OKAY. WHAT I SPECIFICALLY --
24 A. IT IS PUBLISHED.
25 Q. OKAY.

1 A. THAT IS WHERE I'M GOING WITH IT. SO IT IS PUBLISHED.
2 Q. OKAY. SO YOU HAVE, AFTER THIS ARTICLE WAS PUBLISHED IN
3 JAMA, THERE WAS SOME LETTERS TO THE EDITOR RESPONDING, AND THEN
4 YOU REPLIED TO THOSE LETTERS?
5 A. CORRECT.
6 Q. IS THAT CORRECT?
7 A. AND IN THE BIOETHICS SEMINAR IN INDIANA THEY THEN PUBLISH
8 THE COMMENTS FROM THAT PRESENTATION IN THEIR HOSPITAL-WIDE
9 MAGAZINES OR JOURNALS.
10 Q. OKAY. SO THAT WAS PUBLISHED IN A HOSPITAL MAGAZINE? IT
11 WASN'T A PEER-REVIEWED JOURNAL?
12 A. CORRECT.
13 Q. OKAY. AND THIS, THE ARTICLE THAT WAS PUBLISHED IN JAMA --
14 IS IT OKAY IF I CALL IT "THE JOURNAL OF THE AMERICAN
15 ASSOCIATION," JAMA?
16 A. YES, CERTAINLY.
17 Q. OKAY. SO THAT WAS AN OPINION PIECE, CORRECT?
18 A. I WOULD NOT SAY THAT. IT IS DEFINITELY A PEER-REVIEWED
19 JOURNAL ARTICLE. IT WAS NOT AN OPINION. IT WAS SCIENTIFICALLY
20 BASED. AND WHEN THEY -- ACTUALLY, THE FIRST DRAFT, WHICH IS
21 OFTEN THE CASE, I SAID:
22 "I PROBABLY SHOULD GET MORE OPINIONS."
23 AND THEY SAID:
24 "NO. WE WANT MORE SCIENTIFIC LITERATURE AND
25 MORE BACKING AND MORE FACTUAL INFORMATION."

1 SO THAT I ACTUALLY HAD TO THEN TAKE ANOTHER MONTH OR
2 TWO AND REDRAFT IT AND PICK AT LEAST ANOTHER 10 JOURNAL
3 ARTICLES WHICH SUBSTANTIATED THE COMMENTS I MADE IN THAT
4 ARTICLE.
5 SO I WOULD NOT CALL IT "AN OPINION PIECE."
6 Q. OKAY. BUT ISN'T IT CORRECT AS YOU TESTIFIED JUST A FEW
7 MINUTES AGO, THAT THE WAY THIS CAME ABOUT IS THAT DR. DAVID
8 GRIMES HAD DRAFTED AN OPINION PIECE FOR JAMA, OPPOSING
9 RESTRICTIONS ON LATER ABORTION METHODS, AND THE JOURNAL WAS
10 LOOKING FOR SOMEBODY TO WRITE A PIECE TAKING THE OPPOSITE
11 POSITION TO PUBLISH WITH DR. GRIMES?
12 AND WEREN'T THEY, IN FACT, PUBLISHED IN A SECTION OF
13 JAMA CALLED "CONTROVERSIES"?
14 A. CORRECT. BUT, I WILL NOT AGREE WITH YOU THAT IT IS AN
15 OPINION PIECE. IT IS A SCIENTIFIC PIECE BASED ON THE
16 SCIENTIFIC LITERATURE.
17 Q. THERE WERE COMPETING PIECES TAKING OPPOSITE VIEWPOINTS ON
18 THIS; IS THAT CORRECT?
19 A. CORRECT.
20 Q. OKAY. NOW, YOU HAD TESTIFIED EARLIER IN RESPONSE TO JUDGE
21 HAMILTON'S QUESTIONS ABOUT THE NUMBERS OF ABORTIONS YOU'VE
22 PERFORMED AT THE GESTATIONAL -- THE NUMBER OF ABORTIONS YOU'VE
23 PERFORMED AND THE METHODS YOU'VE USED, CORRECT?
24 A. CORRECT.
25 Q. NOW, YOU HAVE NOT PERFORMED -- EVEN IN THE CASE OF A

1 DEMISED FETUS, YOU HAVE NOT DONE AN ABORTION USING THE D&E
2 METHOD AFTER APPROXIMATELY 17 WEEKS OF PREGNANCY; IS THAT
3 RIGHT?
4 A. THAT IS CORRECT.
5 Q. AND THAT'S BECAUSE YOU BELIEVE THAT A PHYSICIAN MUST HAVE
6 SIGNIFICANT EXPERTISE TO DO A D&E AFTER THAT TIME PERIOD; IS
7 THAT CORRECT?
8 A. I BELIEVE THERE IS MORE RISK INVOLVED UNLESS YOU REALLY DO
9 THEM ON A DAILY BASIS, CORRECT.
10 Q. BUT YOU WOULD BELIEVE A PHYSICIAN MUST HAVE SIGNIFICANT
11 EXPERTISE TO DO A D&E AFTER 18 WEEKS, RIGHT?
12 A. SIGNIFICANT EXPERIENCE AND EXPERTISE, CORRECT.
13 Q. AND YOU HAVE MANY AREAS OF EXPERTISE; ISN'T THAT RIGHT,
14 DR. SPRANG?
15 A. RIGHT.
16 Q. BUT DOING POST-18 WEEK D&E'S IS NOT ONE OF YOUR AREAS OF
17 EXPERTISE, IS IT?
18 A. I WILL HAVE TO SAY: CORRECT.
19 Q. DR. SPRANG, DO YOU PLAN TO OFFER TESTIMONY TODAY ABOUT THE
20 SAFETY OF A METHOD OF ABORTION CALLED "INTACT D&X" OR "INTACT
21 D&E"?
22 A. BASED ON MY LITERATURE REVIEW AND TALKING TO PHYSICIANS WHO
23 PERFORM THEM, YES.
24 Q. NOW, IT IS YOUR UNDERSTANDING, RIGHT, THAT THIS METHOD OF
25 ABORTION IS USED PRIMARILY AFTER 18 WEEKS OF PREGNANCY?

1 A. AFTER SPECIFICALLY -- AND, AGAIN, A GOOD DEAL OF RESEARCH
2 AND HASKELL'S REPORT, WHICH HE PRESENTED TO THE NATIONAL
3 ABORTIONS FEDERATION IN '92 SAYS THIS IS PRIMARILY USED BETWEEN
4 20 AND 26 WEEKS.
5 Q. AND THAT'S A TIME PERIOD IN WHICH YOU HAVE NOT DONE A D&E,
6 CORRECT?
7 A. CORRECT.
8 Q. AND YOU HAVE NEVER PERFORMED AN INTACT D&E PROCEDURE; IS
9 THAT CORRECT?
10 A. THERE IN -- ACTUALLY, IN 16, 17 WEEKS I HAVE ON A DEAD
11 FETUS WHO ALSO -- SHE HAD STARTED TO GO INTO LABOR HERSELF.
12 AND I WOULD SAY, ESSENTIALLY, IT WAS AN INTACT D&X.
13 Q. BUT YOU JUST TESTIFIED THAT IN YOUR UNDERSTANDING IS THAT
14 INTACT D&E IS USED AFTER 19 WEEKS OF PREGNANCY.
15 A. PRIMARILY.
16 Q. OKAY. SO, YOU -- AND IN THAT INTACT D&E PROCEDURE THAT YOU
17 DID, HOW WAS THE -- CAN YOU DESCRIBE HOW THE PROCEDURE WENT?
18 A. FORTUNATELY, AS I SAID, IT WAS A FETUS HAD ALREADY BEEN
19 DEAD. WE ACTUALLY SCHEDULED HER FOR SURGERY. AND JUST BETWEEN
20 LIKE SCHEDULING IT AND ACTUALLY BRINGING HER TO THE OPERATING
21 ROOM, THE CERVIX HAD STARTED TO DILATE. AND AT THAT POINT SHE
22 WAS PARTIALLY DOING IT SPONTANEOUSLY.
23 THE FETUS WAS STILL INSIDE. AND IT WAS VERY -- AT
24 THAT POINT VERY EASY TO JUST EXTRACT THE FETUS.
25 Q. SO, WHEN YOU SAID YOU DID AN INTACT D&E, YOU BASICALLY USED

1 TRACTION TO PULL THE FETUS OUT OF THE UTERUS?
2 A. THAT'S MY UNDERSTANDING OF AN INTACT D&X.
3 Q. YOU DIDN'T HAVE TO DO ANYTHING TO REDUCE THE SIZE OF THE
4 FETAL HEAD?
5 A. BECAUSE OF THE SOFTNESS OF THE FETUS AND THE AMOUNT OF
6 DILATATION, THAT IS CORRECT.
7 Q. OKAY. AND YOU -- SO THAT'S A DIFFERENT -- THAT IS NOT
8 REALLY A D&E PROCEDURE IN THE WAY THAT YOU UNDER -- I AM SORRY.
9 THAT IS NOT REALLY AN INTACT D&E THE WAY YOU
10 UNDERSTAND, BASED ON YOUR LITERATURE REVIEW; IS THAT CORRECT?
11 A. IT'S NOT TOTALLY CONSISTENT WITH THE DEFINITION THAT THEY
12 USUALLY HAVE TO DO SOMETHING ELSE TO THE CRANIUM, THE FETAL
13 SKULL AT THE --
14 Q. AND YOU HAVE NEVER DONE THAT, RIGHT? YOU HAVE NEVER HAD TO
15 DO ANYTHING TO THE FETAL SKULL TO COMPLETE THE DELIVERY?
16 A. MAY I FINISH THE FIRST --
17 Q. SURE. I AM SORRY.
18 A. WELL, REPEATEDLY, IN LOOKING AT THOSE DECLARATIONS -- AND
19 IT IS MORE INFORMATION FOR ME NOW -- OFTENTIMES THEY DON'T HAVE
20 TO DO ANYTHING, EITHER. THE FETAL SKULL ACTUALLY JUST
21 DELIVERS.
22 AND ACTUALLY IN ONE OF THE EXPERT DEPOSITIONS THEY
23 ACTUALLY SAY THAT IS THEIR PREFERENCE. THAT THE CERVIX IS
24 DILATED ENOUGH THAT THEY CAN JUST SIMPLY DELIVER THE FETUS THE
25 SAME WAY I WOULD DO IT FOR BREECH EXTRACTION. AND I HAVE DONE

1 A HUNDRED OF THOSE. YOU DON'T NEED -- IF IT IS DILATED ENOUGH,
2 YOU DON'T NEED TO DO ANYTHING TO THE SKULL. YOU MANEUVER
3 CALLED THE MAURICEAU-SMELLIE-VIET -- THEY NEVER SPELL IT
4 CORRECTLY -- TRY TO FLEX THE FETAL HEAD TO MAKE IT A SMALLER
5 DIAMETER. YOU CAN ACTUALLY, IF THE CERVIX IS DILATED ENOUGH,
6 DELIVER IT.
7 Q. AND YOU HAVE --
8 A. AND THAT IS WHAT IS BEING DONE IN THIS PROCEDURE BECAUSE
9 I'VE SEEN SEVERAL OF THE DECLARATIONS IN DEPOSITIONS THAT SAY
10 THAT. AND ACTUALLY ONE OF THE EXPERTS ACTUALLY SAYS THAT IS
11 THE IDEAL SITUATION.
12 Q. AND WHEN YOU --
13 A. SO THEY ARE --
14 Q. -- SAY YOU'VE DONE A TOTAL BREECH EXTRACTION A HUNDRED
15 TIMES, YOU ARE SPEAKING ABOUT AT TERM TO DELIVER A LIVE BABY,
16 RIGHT?
17 A. HERE, AGAIN, NOT NECESSARILY AT TERM, BECAUSE DEFINITION OF
18 "AT TERM" WOULD BE BEYOND 37 WEEKS. AND PEOPLE GO INTO
19 PREMATURE LABOR AT 32 WEEKS, AT 34 WEEKS. TWINS MORE COMMONLY
20 GO INTO PREMATURE LABOR IN THAT TIME FRAME.
21 SO I HAVE DONE TOTAL BREECH EXTRACTIONS VARIOUS
22 TIMES FRAMES, WHICH CAN ALL BE CONSIDERED TO BE PREMATURE.
23 AND, AGAIN, I HAVE BEEN DOING THIS LONG ENOUGH BEFORE SOME OF
24 THE CURRENT THINKING THAT THAT IS NOT ALL WE DO NOW. WE WOULD
25 DO A CESAREAN SECTION. BUT AT THAT POINT IN TIME WE DID

1 EXTRACTIONS.

2 I HAD A SET OF TWINS THAT I DID A --

3 Q. I AM SORRY, DR. SPRANG. I AM JUST AFRAID WE ARE NEVER GOING

4 TO GET --

5 MR. SIMPSON: I'M SORRY, YOUR HONOR. I NEED TO

6 OBJECT TO MS. GARTNER INTERRUPTING THE WITNESS. IT HAS

7 HAPPENED --

8 THE COURT: I AM NOT SURE HE IS RESPONSIVE TO HER

9 QUESTIONS. SHE IS TRYING TO QUALIFY HIM.

10 THE WITNESS: YOU HAVE TO --

11 THE COURT: I THINK I'M GOING TO ASK YOU JUST TO

12 ANSWER THE QUESTIONS AS DIRECTLY AS YOU CAN.

13 THE WITNESS: YES, MA'AM.

14 THE COURT: YOU, OBVIOUSLY, WILL GET ANOTHER CHANCE

15 TO TALK.

16 THE WITNESS: OKAY.

17 BY MS. GARTNER:

18 Q. YES. AND I DON'T MEAN TO CUT YOU OFF. I JUST -- I THINK --

19 I DON'T WANT YOU TO HAVE TO GO TO THE EFFORT TO KEEP TALKING

20 ABOUT SOMETHING THAT IS NOT REALLY THAT RELEVANT HERE.

21 AND MY QUESTION REALLY -- I MIGHT HAVE MISSPOKEN IN

22 SAYING "AT TERM."

23 BUT LET ME JUST ASK YOU: THE BREECH EXTRACTIONS

24 YOU'VE DONE HAVE BEEN TO DELIVER A LIVE BABY; IS THAT CORRECT?

25 A. CORRECT.

1 Q. THANK YOU.
2 NOW, YOU HAVE NEVER WITNESSED AN INTACT D&E ABORTION
3 BEING PERFORMED, HAVE YOU?
4 A. CORRECT.
5 Q. AND FROM LISTENING TO YOUR TESTIMONY THIS MORNING, FROM
6 OBVIOUSLY BEING PRESENT AT YOUR DEPOSITION EARLIER IN THIS
7 CASE, AND FROM READING THE TRANSCRIPT OF YOUR TESTIMONY IN THE
8 NEBRASKA CASE EARLIER THIS WEEK, I'VE IDENTIFIED WHAT I THINK
9 ARE SIX BASES FOR YOUR FAMILIARITY WITH THE INTACT D&E
10 ABORTIONS.
11 AND I HAVE TRIED TO BE AS LIBERAL IN MY
12 UNDERSTANDING OF YOUR TESTIMONY AS POSSIBLE. AND I WOULD LIKE
13 TO LIST FOR YOU WHAT I UNDERSTAND TO BE THE BASES FOR YOUR
14 TESTIMONY ABOUT INTACT D&E.
15 AND IF YOU COULD JUST TELL ME WHETHER I AM CORRECT
16 ABOUT THAT, THAT THAT IS, IN FACT, PART OF THE BASIS FOR YOUR
17 TESTIMONY. AND THEN, I WOULD LIKE TO GO THROUGH THEM IN A
18 LITTLE MORE DETAIL, IF THAT IS OKAY WITH YOU.
19 SO MY UNDERSTANDING IS FROM YOUR DEPOSITION YOU SAID
20 THAT PART OF YOUR FAMILIARITY WITH THIS PROCEDURE IS BASED ON A
21 CONVERSATION WITH THE PHYSICIAN WHO WAS THE PRESIDENT OF ACOG
22 AT THE TIME THAT ACOG ISSUED ITS STATEMENT OF POLICY REGARDING
23 WHAT IT CALLS "INTACT D&X" IN 1997? IS THAT PART OF THE BASIS?
24 A. NO.
25 Q. OKAY. THAT'S GOOD.

1 NOW, THE OTHER THING I IDENTIFIED IS THAT YOU --
2 PART OF YOUR BASIS IS FROM THE WORK YOU DID ON THE AMA TASK
3 FORCE THAT YOU WERE DISCUSSING WITH MR. SIMPSON; IS THAT
4 CORRECT?
5 A. CORRECT.
6 Q. NOW, I THINK MR. SIMPSON HAD REFERRED TO THAT AS A TASK
7 FORCE ON INTACT D&X. BUT IT WASN'T, IN FACT, A TASK FORCE ON
8 INTACT D&X, WAS IT?
9 A. I WOULD SAY: YES.
10 Q. WAS IT NOT A TASK FORCE MORE GENERALLY ON LATE TERM
11 PREGNANCY TERMINATION TECHNIQUES?
12 A. THE REASON THE TASK FORCE WAS SET UP WAS TO LOOK AT INTACT
13 D&X. THAT WAS THE RESOLUTION THAT CAUSED THE TASK FORCE TO BE
14 SET UP.
15 Q. DID THE TASK FORCE PREPARE A REPORT ON ITS WORK?
16 A. YES. IT LOOKED AT MORE BROAD INFORMATION AS A BASIS TRYING
17 TO GET THE COMPLICATION RATES, THE NUMBER OF PROCEDURES. BUT
18 THE REASON FOR THE TASK FORCE BEING SET UP IS INTACT D&X.
19 Q. OKAY. AND IN ADDITION, AN ADDITIONAL BASIS FOR YOUR
20 TESTIMONY IS CONVERSATIONS YOU'VE HAD WITH A FEW PHYSICIANS WHO
21 PERFORM INTACT D&X; IS THAT CORRECT?
22 A. CORRECT.
23 Q. OKAY. AND AN ADDITIONAL BASIS IS A PAPER THAT WAS
24 PRESENTED BY DR. MARTIN HASKELL TO THE NATIONAL ABORTION
25 FEDERATION IN 1992; IS THAT CORRECT?

1 A. CORRECT.
2 Q. AND ANOTHER BASIS IS THE DECLARATION AND DEPOSITIONS OF
3 PHYSICIANS IN BOTH THE FEDERAL COURT CASE IN OHIO WHERE YOU
4 TESTIFIED AND OTHER PHYSICIANS WHO HAVE TESTIFIED IN THIS CASE;
5 IS THAT CORRECT?
6 A. CORRECT.
7 Q. AND I THINK YOU ALSO MENTIONED THIS MORNING AN ADDITIONAL
8 BASIS IS THE OPINION PIECE YOU DID OR THE PIECE YOU DID -- I AM
9 SORRY -- FOR JAMA?
10 A. CORRECT.
11 Q. IS THERE ANYTHING I HAVE OMITTED FROM THIS LIST IN TRYING
12 TO IDENTIFY THE BASES FOR YOUR TESTIMONY?
13 A. I THINK OTHER ARTICLES ARE OUT THERE, AS WELL, IN GENERAL.
14 AND I STARTED TALKING ABOUT D&E. AND OBVIOUSLY THE MOST RECENT
15 ARTICLE -- IN THE DECLARATION OF CHASEN THE MOST RECENT ARTICLE
16 THAT WAS INTRODUCED ON HIS ARTICLE ON TRYING TO COMPARE THE
17 TRADITIONAL D&E AND INTACT D&X.
18 Q. OKAY. SO LET'S GO BACK THROUGH SOME OF THESE BASES IN JUST
19 A LITTLE BIT MORE DETAIL. THE AMA TASK FORCE, I THINK YOU
20 TESTIFIED THAT THERE WERE 10 PHYSICIANS ON THAT TASK FORCE; IS
21 THAT CORRECT?
22 A. CORRECT.
23 Q. TEN INCLUDING YOURSELF?
24 A. CORRECT.
25 Q. OKAY. NOW, WERE ANY OF THE PHYSICIANS ON THE TASK FORCE

1 PHYSICIANS WHO PERFORM INTACT D&E?
2 A. I DON'T KNOW THAT FOR A FACT. I DO KNOW THAT AT LEAST FOUR
3 OF THEM ARE OBSTETRICIAN GYNECOLOGISTS. I BELIEVE THAT IS
4 CORRECT.
5 Q. DURING THE MEETINGS OF THE TASK FORCE DID ANY OF THE
6 OBSTETRICIAN EVER INDICATE THEY PERFORMED AN INTACT D&E?
7 A. NOT TO MY RECOLLECTION.
8 Q. NOW, DID -- IN PREPARING THAT REPORT, DID THE TASK FORCE
9 MEET WITH ANY PHYSICIANS WHO PERFORMED INTACT D&E'S?
10 A. I DON'T BELIEVE WE MET WITH ANY. WHETHER DID THEY
11 INTERVIEW? WAS THERE INFORMATION FROM INTERVIEWS WITH
12 PHYSICIANS WHO PERFORMED THEM? I AM NOT A HUNDRED PERCENT
13 SURE.
14 MR. SIMPSON: YOUR HONOR, I DON'T KNOW HOW MANY MORE
15 QUESTIONS THERE ARE ON THE AMA TASK FORCE, BUT I BELIEVE WE ARE
16 GETTING BEYOND VOIR DIRE HERE AND INTO DISCOVERY REGARDING THE
17 AMA TASK FORCE.
18 MS. GARTNER: WELL, YOUR HONOR, I THINK IF THE
19 PARTICIPATION IN THE AMA TASK FORCE IS A SIGNIFICANT PART OF
20 THE BASIS FOR HIS OPINION, I THINK WE NEED TO UNDERSTAND
21 WHETHER THE TASK FORCE, IN FACT, DID AN INVESTIGATION THAT
22 WOULD VALIDLY LEAD TO HIS HAVING FIRSTHAND KNOWLEDGE ABOUT
23 THESE PROCEDURES.
24 THE COURT: I WILL ALLOW YOU TO GO FURTHER.
25 MS. GARTNER: THANK YOU.

1 BY MS. GARTNER:
2 Q. DID THE TASK FORCE SPEAK DIRECTLY WITH ANY PHYSICIANS WHO
3 PERFORM INTACT D&E'S?
4 A. DID I PERSONALLY? NO. DO I BELIEVE REPRESENTATIVES FROM
5 ACOG, FROM OTHER COUNCILS? I DO BELIEVE THEY DID, BECAUSE THEY
6 TALK MORE SPECIFICALLY ABOUT IT, SO YES.
7 Q. BUT DID ANYONE ON THE TASK FORCE SPEAK WITH PHYSICIANS WHO
8 PERFORM INTACT D&E'S?
9 A. YES, I BELIEVE THEY DID.
10 Q. OKAY. BUT YOU DID NOT?
11 A. I DID NOT.
12 Q. AND DID ANYONE --
13 A. I HAD SPOKEN WITH PEOPLE PRIOR TO THAT WHO DID DO INTACT
14 D&X.
15 Q. LET'S TALK ABOUT THAT. WITH RESPECT TO THOSE PHYSICIANS
16 THAT YOU HAVE SPOKEN TO THAT PERFORM WHAT YOU ARE CALLING
17 INTACT D&X, AM I RIGHT THAT THERE IS ONLY TWO INCIDENTS WHERE
18 YOU CAN ACTUALLY REMEMBER TALKING TO AN INDIVIDUAL WHO PERFORMS
19 INTACT D&X, RIGHT?
20 A. YES AND NO. THERE WERE TWO THAT I SPENT A SIGNIFICANT MORE
21 TIME WITH THAT WERE MORE MEMORABLE DISCUSSIONS BECAUSE I TALKED
22 TO THEM AFTER THE MEETINGS, AS WELL, AND GOT MORE INFORMATION.
23 THERE WERE SEVERAL -- AND I BELIEVE I SAID THIS IN
24 MY DEPOSITION. WHEN I AM PUTTING ON PROGRAMS AND PUTTING ON
25 HIGH RISK FETAL MEDICINE PROGRAMS, OFTEN A CASE EXAMPLE WOULD

1 BE A PATIENT COMES IN AT 23 WEEKS WITH A RUPTURED BAG OF
2 WATERS. WHAT ARE THE DIFFERENT WAYS OF HANDLING THAT
3 SITUATION?
4 YOU ARE TALKING ABOUT A FETUS AT THAT POINT THAT HAS
5 MAYBE A 15 PERCENT VIABILITY AT 23 WEEKS. IF YOU CAN CARRY IT
6 A LITTLE FURTHER YOU WOULD HAVE GREATER VIABILITY: 50 TO
7 75 PERCENT.
8 SO YOU GET DIFFERENT OPINIONS FROM DIFFERENT
9 MATERNAL FETAL MEDICINE PHYSICIANS AS TO SOME WOULD TRY TO WAIT
10 AND CARRY IT A LITTLE FURTHER.
11 SO IN DISCUSSIONS OF THOSE YOU GET DIFFERENT
12 OPINIONS FROM PHYSICIANS IN THE AUDIENCE WHO ARE FROM ALL OVER
13 THE UNITED STATES. AND SOME OF THEM MIGHT HAVE MORE AGGRESSIVE
14 ROLES, AGGRESSIVE POSITIONS, BECAUSE THEY ARE MORE FAMILIAR
15 WITH DOING THESE D&X'S THAN, SAY, THE WAY THEY WOULD HANDLE IT
16 THAN JUST TERMINATE THE PREGNANCY AND THEN LET THE PATIENT GET
17 PREGNANT AGAIN.
18 THE MAJORITY OF PHYSICIANS IN THOSE SITUATIONS WOULD
19 SAY IF THERE IS NOT A FEVER, ADMIT THE PATIENT TO THE HOSPITAL,
20 KEEP THEM AT BED REST FOR A COUPLE OF WEEKS AND TRY TO GET IT
21 FURTHER ALONG.
22 SO YOU ARE TALKING ABOUT THESE PROCEDURES. AND YOU
23 ARE TALKING ABOUT IT WITH PHYSICIANS WHO ARE GIVING THEIR
24 OPINION OF HOW THEY WOULD HANDLE THAT SITUATION. AND ONE OF
25 THE WAYS IS TO DO A D&E OR INTACT D&X.

1 Q. NOW, LET'S TALK SPECIFICALLY ABOUT WHAT YOU REFER TO AS THE
2 TWO MEMORABLE OCCASIONS IN WHICH YOU'VE SPOKEN WITH PHYSICIANS
3 ABOUT INTACT D&X.
4 WITH RESPECT TO THOSE TWO INDIVIDUALS, YOU ACTUALLY
5 CAN'T RECALL THE NAMES OR LOCATIONS OR DATES INVOLVED WITH ANY
6 OF THOSE CONVERSATIONS, CORRECT?
7 A. CORRECT. AS I SAID, IF YOU ARE GIVING THREE TO FIVE
8 PROGRAMS A YEAR TO HUNDREDS AND ULTIMATELY THOUSANDS OF
9 PHYSICIANS, IT IS VERY HARD TO REMEMBER EVEN WHAT CITY IT WAS
10 IN.
11 Q. RIGHT. SO THESE WERE THE MEMORABLE CONVERSATIONS ABOUT
12 INTACT D&X, BUT YOU DON'T REMEMBER WHO THE PHYSICIANS WERE?
13 A. THE INFORMATION WAS MEMORABLE. THAT IS WHAT I WAS LOOKING
14 FOR WAS TRYING TO ACQUIRE INFORMATION.
15 Q. NOW, LET'S TALK ABOUT DR. HASKELL'S PRESENTATION IN 1992 TO
16 THE NATIONAL ABORTION FEDERATION.
17 WERE YOU PRESENT WHEN HE MADE HIS PRESENTATION?
18 A. I WAS NOT.
19 Q. HAVE YOU EVER MET DR. HASKELL?
20 A. I MAY HAVE SEEN HIM IN OHIO. I DON'T RECALL, BECAUSE HE
21 WAS -- IN THE OHIO CASE HE WAS ACTUALLY ONE OF THE PLAINTIFFS.
22 Q. HAVE YOU EVER SPOKEN WITH DR. HASKELL?
23 A. I COULD HAVE, BECAUSE I SPOKE -- I COULD HAVE. I COULD
24 HAVE SAID "HELLO" IN THE COURTROOM. I DON'T REMEMBER.
25 Q. OKAY. BUT IF YOU SPOKE TO HIM IT WAS JUST TO SAY "HELLO"?

1 A. YES.
2 Q. DO YOU HAVE ANY FIRSTHAND KNOWLEDGE OF WHETHER DR. HASKELL
3 STILL PERFORMS ABORTIONS TODAY IN THE WAY HE DESCRIBED IN HIS
4 PAPER IN 1992?
5 A. I KNOW WHAT HE WAS DOING AT THAT POINT IN TIME. DO I KNOW
6 EXACTLY WHAT HE IS DOING AT THIS POINT IN TIME? I DO NOT.
7 Q. OKAY. NOW, WITH RESPECT TO THE DECLARATIONS AND
8 DEPOSITIONS IN THE OHIO CASE AND THIS CASE, THIS IS -- YOU'VE
9 READ THE DECLARATIONS AND DEPOSITIONS, CORRECT?
10 A. CORRECT.
11 Q. HAVE YOU MET THE PEOPLE WHOSE DECLARATIONS AND DEPOSITIONS
12 YOU'VE READ OTHER THAN MAYBE TO SAY "HELLO" TO THEM IN THE
13 COURTROOM?
14 A. I KNOW SOME OF THEM PERSONALLY, YES.
15 Q. OKAY. DO YOU HAVE ANY FIRSTHAND KNOWLEDGE ABOUT HOW THEY
16 PERFORM ABORTIONS OTHER THAN READING THEIR DEPOSITIONS AND
17 DECLARATIONS?
18 A. TO SOME EXTENT, YES, BECAUSE SOME OF THEM ARE IN MY
19 INSTITUTION AND I DO KNOW WHAT THE RESIDENTS SAY ABOUT WHAT IS
20 GOING ON. SO TO SOME EXTENT YES.
21 Q. SO YOU ARE REFERRING SPECIFICALLY TO DR. HAMMOND AND DR.
22 FREDERIKSEN?
23 A. YES, CORRECT.
24 Q. OTHER THAN DR. HAMMOND AND DR. FREDERIKSEN, YOU DON'T HAVE
25 ANY FIRSTHAND KNOWLEDGE OF HOW THEY DO ABORTIONS; IS THAT

1 RIGHT?
2 A. HOW THEY -- CORRECT.
3 Q. AND WITH RESPECT TO DR. HAMMOND AND DR. FREDERIKSEN WHAT
4 YOU KNOW ABOUT HOW THEY DO ABORTIONS IS FROM RESIDENTS IN YOUR
5 INSTITUTION?
6 A. CORRECT.
7 Q. AND THEN, NOW TURNING TO THE ISSUE ABOUT FETAL PAIN, YOU
8 ARE NOT AN EXPERT ON FETAL PAIN, ARE YOU?
9 A. ONLY INSOFAR AS I DID TAKE AS -- PART OF MY TRAINING AND
10 RESIDENCY WAS IN ANESTHESIA. AGAIN, IN WRITING THE PAPERS, I
11 REVIEWED LITERATURE, REVIEWED A NUMBER OF ARTICLES ON THE
12 ANATOMIC PROGRESSION OF THE NERVE SUPPLY IN THE FETUS. AND I
13 UNDERSTAND THAT. I UNDERSTAND THE GROWTH OF THE NERVES TO THE
14 SKIN AND WHERE THE NERVES ARE GOING TO THE THALAMUS AND THEN
15 THEY REACH THE SUBCORTEX.
16 I HAVE BEEN INVOLVED TO THAT EXTENT.
17 Q. BUT YOU ARE NOT A NEUROLOGIST, ARE YOU?
18 A. I AM NOT A NEUROLOGIST.
19 Q. AND YOU ARE NOT AN ANESTHESIOLOGIST?
20 A. I DID HAVE TRAINING IN ANESTHESIA.
21 Q. YOU HAVE DONE NO CLINICAL RESEARCH YOURSELF IN THE AREA OF
22 FETAL PAIN, HAVE YOU?
23 A. THE CLINICAL RESEARCH I'VE DONE IS WHEN I AM DOING AN
24 AMNIOCENTESIS AT 16 WEEKS AND POKE THE BABY WITH THE NEEDLE AND
25 THE BABY'S ARM RETRACTS.

1 Q. YOU TESTIFIED IN YOUR DEPOSITION, DR. SPRANG, THAT PART OF
2 THE BASIS FOR YOUR OPINIONS ABOUT FETAL PAIN IS THE TESTIMONY
3 THAT WAS GIVEN IN THE OHIO CASE BY AN ANESTHESIOLOGIST; IS THAT
4 CORRECT?
5 A. I DID READ THE DEPOSITION OF THE ANESTHESIOLOGIST, AND I
6 BELIEVE FROM VANDERBILT WHERE THEY ARE ACTUALLY DOING
7 INTRAUTERINE SURGERY AT 20, 21, 22 WEEKS. AND THEY, I BELIEVE
8 AS YOU KNOW IN THOSE CASES ACTUALLY OPEN UP THE ABDOMEN --
9 Q. MY QUESTION, DOCTOR --
10 A. THEY HAVE THE FETUS IN FRONT OF THEM.
11 Q. I AM NOT ASKING YOU WHAT HE TESTIFIED. I AM ASKING YOU
12 WHETHER READING THAT DEPOSITION IS PART OF THE BASIS FOR YOUR
13 TESTIMONY ABOUT FETAL PAIN?
14 A. CORRECT.
15 Q. BUT YOU DON'T REMEMBER EXACTLY WHO THAT ANESTHESIOLOGIST
16 WAS OR WHERE HE WORKED, DO YOU?
17 A. I COULD EASILY GET THAT INFORMATION.
18 Q. BUT YOU DON'T RECALL, DO YOU?
19 A. NO.
20 MS. GARTNER: YOUR HONOR, AS I SAID, WE AGREE
21 DR. SPRANG IS AN EXPERT IN OBSTETRICS AND GYNECOLOGY, BUT WE
22 DON'T BELIEVE THAT HE MEETS THE REQUIREMENTS UNDER RULE 702 OR
23 703 TO OFFER OPINIONS REGARDING THE SAFETY OF INTACT D&E OR
24 FETAL PAIN. RULE 702 REQUIRES THAT EXPERT TESTIMONY BE BASED
25 ON SUFFICIENT FACTS OR DATA.

1 AND WHILE A PHYSICIAN MAY BE AN EXPERT IN HIS OR HER
2 SPECIALTY AREA, AS DR. SPRANG CLEARLY IS, THAT PHYSICIAN CAN
3 ONLY OFFER EXPERT TESTIMONY WHERE HE BASES HIS OPINION UPON
4 SPECIALIZED KNOWLEDGE OR EXPERIENCE ON THE PARTICULAR SUBJECT.
5 AND DR. SPRANG HAS NO SPECIALIZED KNOWLEDGE
6 REGARDING INTACT D&E PROCEDURES.
7 ESSENTIALLY, DR. SPRANG BASES HIS OPINION ON
8 CONVERSATIONS WITH OTHER MEDICAL PROFESSIONALS, ON A
9 PRESENTATION GIVEN BY DR. HASKELL, ON DECLARATIONS AND
10 DEPOSITIONS OF EXPERTS IN THIS CASE AND IN ANOTHER CASE. AND
11 THESE SOURCES ARE ALL HEARSAY.
12 AND WHILE DR. SPRANG IS PERMITTED TO BASE HIS
13 OPINION TESTIMONY ON HEARSAY, HE CAN'T SIMPLY SUMMARIZE THESE
14 SOURCES FOR THE COURT AND ESSENTIALLY SERVE AS NOTHING BUT A
15 CONDUIT FOR THE HEARSAY EVIDENCE, WITHOUT ADDING ANYTHING TO
16 IT.
17 AND WE WOULD SUBMIT THAT THAT IS REALLY WHAT WOULD
18 HAPPEN IF DR. SPRANG TESTIFIED ABOUT INTACT D&E: HE WOULD BE A
19 CONDUIT FOR REPORTING TO THE COURT ABOUT OTHER PEOPLE'S
20 EXPERIENCES, WHICH HE UNDERSTANDS SIMPLY FROM READING ABOUT
21 THEM.
22 AND, IN ADDITION, BECAUSE DR. SPRANG CAN'T REMEMBER
23 THE NAMES, HE BASES HIS TESTIMONY, IN PART, ON CONVERSATIONS
24 WITH TWO PHYSICIANS, BUT HE CAN'T REMEMBER THEIR NAMES.
25 SO THERE WAS NO WAY FOR PLAINTIFFS TO ATTEMPT TO

1 VERIFY WHETHER THESE WERE RELIABLE SOURCES OR NOT OR ATTEMPT TO
2 CONTACT THOSE PHYSICIANS TO FIND OUT EXACTLY WHAT THEY
3 UNDERSTOOD THEIR CONVERSATIONS TO HAVE BEEN ABOUT.
4 SO FOR THOSE REASONS WE WOULD ASK THE COURT TO
5 RESTRICT DR. SPRANG'S TESTIMONY ABOUT ABORTION PRACTICE AND
6 SAFETY TO THOSE ABORTION METHODS THAT HE HAS ACTUALLY PERFORMED
7 AT THE GESTATIONAL AGES THAT HE HAS PERFORMED THEM.
8 AND IN ADDITION WE WOULD ASK THE COURT TO FIND THAT
9 DR. SPRANG IS NOT AN EXPERT IN FETAL PAIN. I UNDERSTAND THAT
10 THE GOVERNMENT HAS ANOTHER EXPERT DIRECTLY RELATING TO FETAL
11 PAIN. HE WILL BE TESTIFYING NEXT WEEK.
12 DR. SPRANG IS NOT AN EXPERT IN FETAL PAIN, AND WE
13 BELIEVE HE SHOULD NOT BE PERMITTED TO TESTIFY ON THAT SUBJECT.
14 THE COURT: THANK YOU.
15 MR. SIMPSON, YOUR RESPONSE?
16 MR. SIMPSON: YOUR HONOR, COULD I ASK A FEW
17 FOLLOW-UP QUESTIONS TO THE WITNESS AND MAKE SOME ARGUMENT,
18 PLEASE?
19 CONTINUING DIRECT EXAMINATION
20 BY MR. SIMPSON:
21 Q. DR. SPRANG, MS. GARTNER ASKED YOU ABOUT READING DR.
22 HASKELL'S PRESENTATION. HAVE YOU READ ANY OTHER PRESENTATIONS
23 ON INTACT D&X?
24 A. I HAVE, AND VARIOUS ARTICLES, AND, AGAIN, IN DECLARATIONS
25 AND DEPOSITIONS.

1 Q. HAVE YOU READ A PRESENTATION BY DR. MCMAHON ON INTACT D&X?
2 A. I HAVE.
3 Q. DOCTOR, EARLIER YOU TESTIFIED AS SERVING AS THE CHAIRMAN OF
4 THE BOARD AND PRESIDENT OF THE ILLINOIS STATE MEDICAL SOCIETY.
5 HAS THAT SERVICE AFFECTED YOUR FAMILIARITY WITH ABORTION
6 METHODS?
7 A. IT HAS, AGAIN, BECAUSE OF THE CASE REVIEWS AND BECAUSE OF
8 REVIEWING QUALITY ASSURANCE THINGS AT THAT LEVEL, YOU ARE
9 PRESENTED CASES LIKE THAT.
10 Q. DOCTOR, HAVE YOU BEEN -- AT LEAST AT TIMES -- THE ONLY
11 OBSTETRICIAN GYNECOLOGIST ON THE BOARD OF THE ILLINOIS STATE
12 MEDICAL SOCIETY?
13 A. MOST OF THE TIME I AM THE ONLY OBSTETRICIAN GYNECOLOGIST ON
14 THE BOARD. AND, SIMILARLY, WITH THE LIABILITY INSURANCE
15 CARRIERS AS CHAIRMAN OF THE BOARD, AND BEING THE ONLY OB/GYNE
16 MOST OF THOSE CASES HAVE ALWAYS BEEN PRESENTED TO ME.
17 Q. SO HOW HAS YOUR BEING THE ONLY OBSTETRICIAN GYNECOLOGIST IN
18 THOSE CONTEXTS AFFECTED YOUR FAMILIARITY WITH ABORTION METHODS?
19 A. ANY OF THE CASES THAT RESOLVE AROUND THAT AREA ARE BROUGHT
20 TO ME.
21 MR. SIMPSON: YOUR HONOR, DR. SPRANG OBVIOUSLY HAS A
22 VAST EXPERIENCE AND BACKGROUND IN OBSTETRICS AND GYNECOLOGY, IN
23 GENERAL. HE HAS, BESIDES THAT, THAT GENERAL EXPERIENCE AND
24 KNOWLEDGE OF FEMALE ANATOMY AND HOW THINGS WORK AND IN
25 PROVIDING TREATMENT IN THOSE CONTEXTS.

1 HE HAS, AS HE HAS TESTIFIED, REMOVED THE PRODUCTS OF
2 CONCEPTION HIMSELF MANY TIMES AND HAS TREATED COMPLICATIONS OF
3 ABORTIONS A NUMBER OF TIMES.
4 HE HAS DONE AN EXTENSIVE STUDY ON ABORTION METHODS,
5 INCLUDING INTACT D&X. HE HAS TESTIFIED IN TWO OTHER CASES
6 RELATING TO INTACT D&X. AND HE HAS READ MANY MATERIALS FROM
7 PHYSICIANS IN CONNECTION WITH THOSE CASES.
8 HE HAS SPOKEN -- AS WE HAVE HEARD, HE HAS SPOKEN TO
9 PHYSICIANS WHO PERFORM THIS PROCEDURE. AND I SHOULD POINT OUT
10 IN THAT REGARD, YOUR HONOR, THE WAY IN WHICH DOCTORS TYPICALLY
11 GAIN MUCH OF THEIR KNOWLEDGE IS BY DISCUSSING WITH OTHER
12 PHYSICIANS AND LEARNING IN THAT WAY.
13 HE DOES PERFORM INDUCTION ABORTIONS AFTER 16, 17, 18
14 WEEKS. AND, YOUR HONOR, I WOULD POINT OUT THAT UNDER 702, A
15 WITNESS -- IT SAYS:
16 "A WITNESS MAY BE QUALIFIED AS AN EXPERT BY
17 KNOWLEDGE, SKILL, EXPERIENCE, TRAINING OR
18 EDUCATION."
19 I THINK PLAINTIFFS' ARGUMENT AMOUNTS TO SAYING THAT
20 A WITNESS HAS TO HAVE ALL OF THOSE ASPECTS OF EXPERTISE. BUT,
21 OBVIOUSLY, DR. SPRANG HAS -- EVEN IF WE ARE ONLY LIMITING IT TO
22 INTACT D&X, HE HAS THE KNOWLEDGE, EVEN IF HE DOESN'T HAVE THE
23 EXPERIENCE IN PERFORMING THAT PRECISE PROCEDURE.
24 I SHOULD SAY FINALLY, TOO, YOUR HONOR, PLAINTIFFS'
25 COUNSEL'S ARGUMENT WOULD APPEAR TO AMOUNT TO AN ARGUMENT THAT

1 DEFENDANT IN THIS CASE CAN ONLY CALL PHYSICIANS WHO HAVE
2 PERFORMED INTACT D&X.
3 AND I'M SURE THE COURT CAN APPRECIATE THE DIFFICULTY
4 OF FINDING A PHYSICIAN WHO HAS PERFORMED INTACT D&X WHO WOULD
5 TESTIFY THAT IT IS MEDICALLY UNNECESSARY AND UNSAFE.
6 THE COURT: OKAY. ALL RIGHT. YOU ALL HAVE BEEN
7 FULLY HEARD ON THE QUALIFICATIONS OF THIS DOCTOR.
8 MR. SIMPSON: YES, YOUR HONOR.
9 THE COURT: I HAVE SOME CONCERNS. I DON'T DOUBT
10 THAT DR. SPRANG IS A VERY WELL-QUALIFIED AND EXPERIENCED
11 OBSTETRICIAN AND GYNECOLOGIST.
12 MY PROBLEM, MR. SIMPSON, IS NOT THAT HE DOESN'T HAVE
13 ANY HANDS-ON EXPERIENCE PERFORMING D&X. I APPRECIATE THE
14 DIFFICULTY THAT THAT WERE THE CASE. HE DOESN'T APPEAR TO HAVE
15 ANY PERSONAL EXPERIENCE WITH LATE TERM ABORTION PROCEDURES THAT
16 ARE AT ISSUE HERE.
17 HE HAS TESTIFIED THAT HE HAS ONLY PERFORMED
18 PROCEDURES ON 6 TO 17-WEEK FETUSES. HE HAS NOT ONLY HIMSELF
19 NEVER PERFORMED AN INTACT PROCEDURE, ASIDE FROM THE ONE
20 HYSTEROTOMY, BUT HE HAS NEVER OBSERVED THE PERFORMANCE OF THAT
21 PROCEDURE.
22 IT WOULD SEEM TO ME THAT IF I WERE TO ACCEPT HIM AS
23 AN EXPERT ON INTACT D&X, THAT THAT WOULD NECESSARILY MEAN THAT
24 ANYONE WHO IS AN OB/GYN WOULD BE ABLE TO REVIEW ARTICLES, TALK
25 TO OTHER PHYSICIANS, AND THEREBY BE AN EXPERT.

1 I KIND OF THINK 702 REQUIRES A LITTLE BIT MORE THAN
2 THAT. SO, I AM NOT GOING TO QUALIFY HIM AS AN EXPERT IN THE
3 SUBJECT OF INTACT D&X. THEREFORE, HE MAY NOT GIVE AN OPINION
4 THEREON.
5 WITH REGARD TO FETAL PAIN, I DON'T BELIEVE THAT HIS
6 EXPERIENCE AS AN ANESTHESIOLOGIST OR HIS TRAINING IN
7 ANESTHESIOLOGY IS IN AND OF ITSELF ENOUGH TO QUALIFY HIM AS AN
8 EXPERT IN THAT REGARD, PARTICULARLY WHEN I COMPARE HIS
9 BACKGROUND AND TRAINING AND EXPERIENCE WITH THAT OF THE EXPERT
10 THAT YOU PROFFERED ON THAT SUBJECT, WHO I HAVE APPROVED, AT
11 LEAST TENTATIVELY, TO TESTIFY ON THAT AREA.
12 BUT THE DOCTOR CERTAINLY CAN TESTIFY AS A PERCIPIENT
13 WITNESS ON THE QUESTION OF FETAL PAIN. HE CAN CERTAINLY
14 TESTIFY AS TO WHAT HE HIMSELF HAS OBSERVED. BUT HE CANNOT
15 TESTIFY AS AN EXPERT IN OFFERING AN OPINION ON FETAL PAIN.
16 SO WITH THAT SAID, HE MAY TESTIFY AS ONLY A
17 PERCIPIENT WITNESS ON THOSE TWO AREAS, AND NOT ON AN EXPERT.
18 YOU OFFERED HIM AS AN EXPERT ON THE QUESTION OF THE METHODS OF
19 REMOVAL OF PRODUCTS OF CONCEPTION.
20 TO THE EXTENT THAT THAT INCLUDES INTACT D&X, HE MAY
21 NOT TESTIFY ON THAT LIMITED AREA. BUT HE MAY TESTIFY ON THE
22 OTHER AREAS, BECAUSE HE DOES HAVE EXPERIENCE ON THE OTHER
23 METHODS OF REMOVAL OF PRODUCTS OF CONCEPTION.
24 MR. SIMPSON: YOUR HONOR, OBVIOUSLY THE CORE ISSUES
25 HERE ARE THE SAFETY OF INTACT D&X AND ITS RELATIVE SAFETY IN

1 RELATION TO DISMEMBERMENT D&X AND INDUCTION, AND ALSO SECONDLY
2 THE MEDICAL NECESSITY, OR LACK THEREOF, FOR USING THE INTACT
3 D&X PROCEDURE IN ANY PARTICULAR MEDICAL CIRCUMSTANCES.
4 YOUR HONOR, IF I CAN ASK THIS. YOUR HONOR, DOES THE
5 COURT'S RULING MEAN THAT THE COURT IS GOING TO PRECLUDE US FROM
6 ASKING DR. SPRANG REGARDING HIS EXPERT OPINION ON THE MEDICAL
7 NECESSITY, IF ANY, OF INTACT D&X AND THE RELATIVE SAFETY OF
8 INTACT D&X VERSUS OTHER PROCEDURES?
9 THE COURT: WELL, MY THOUGHTS WERE PRIMARILY WITH
10 REGARD TO THE ACTUAL TECHNIQUE ITSELF. I WASN'T FOCUSING SO
11 MUCH ON THE SAFETY OF THAT TECHNIQUE. BUT YOU ALL CAN ADDRESS
12 THAT BEFORE I MAKE A FINAL DETERMINATION AS TO WHAT THAT
13 LIMITATION ENTAILS.
14 ARE YOU OFFERING A PROOF OF SOME KIND THAT HE DOES
15 HAVE EXPERT TESTIMONY THAT IS NOT AFFECTED BY HIS LACK OF
16 EXPERIENCE IN D&X THAT MIGHT BE PERTINENT ON THE QUESTION OF
17 THE MEDICAL SAFETY ASPECT OF IT?
18 MR. SIMPSON: ABSOLUTELY.
19 THE COURT: WHAT IS THAT?
20 MR. SIMPSON: WELL, YOUR HONOR, BASED ON HIS BROAD
21 KNOWLEDGE OF OBSTETRICS AND GYNECOLOGY IN GENERAL, AND HIS
22 BROAD KNOWLEDGE FROM MANY DIFFERENT SOURCES AS TO HOW INTACT
23 D&X IS PERFORMED, WE BELIEVE THAT HE CAN GIVE AN EXPERT OPINION
24 AS TO WHETHER THAT PROCEDURE IS SAFE, SAFER, LESS SAFE THAN
25 OTHER ABORTION METHODS, AND REGARDING WHETHER THAT PROCEDURE

1 NEEDS TO BE USED IN ANY PARTICULAR MEDICAL CONTEXT.
2 THE COURT: ALL RIGHT. RESPONSE?
3 WHAT I AM TRYING TO FIGURE OUT IS THERE A WAY TO
4 PARSE THIS SO HE COULD -- OBVIOUSLY, THE DEFENSE WANTS HIS
5 TESTIMONY ON VARIOUS DIFFERENT SUBJECTS. I HAVE RULED THAT
6 WITH REGARD TO THE TECHNIQUES INVOLVED HE HAS NO EXPERTISE.
7 HOWEVER, THERE IS THE QUESTION OF WHETHER OR NOT,
8 NOTWITHSTANDING HIS PERSONAL EXPERIENCE AND EXPERTISE IN
9 PERFORMING IT, WHETHER OR NOT THERE IS STILL ROOM FOR HIM TO
10 GIVE HIS OWN LEGITIMATE OPINION. INDEED, I GUESS COULD ANY
11 OB/GYN OPINE ON THE SAFETY OF IT.
12 IT WOULD SEEM TO ME THAT MOST PRACTITIONERS DO FORM
13 OPINIONS ABOUT THE SAFETY BASED OF PROCEDURES UPON THE KIND OF
14 ACTIVITY THAT DR. SPRANG IS ENGAGED IN, AND THAT IS BY
15 REVIEWING REPORTS AND THAT KIND OF THING.
16 MR. SIMPSON: IF I CAN MAKE TWO OTHER POINTS,
17 PLEASE, YOUR HONOR.
18 AS I THINK I MENTIONED EARLIER, IF THE COURT IS
19 GOING TO PRECLUDE US FROM ASKING DR. SPRANG ABOUT THOSE TWO
20 CORE AREAS, BECAUSE HE HAS NOT DONE INTACT D&X PROCEDURE,
21 THAT --
22 THE COURT: IT IS NOT BECAUSE HE HAS NOT DONE THE
23 PROCEDURE. I DO NOT REQUIRE THAT IN ORDER FOR A WITNESS TO BE
24 QUALIFIED TO GIVE THAT KIND OF OPINION THAT HE ACTUALLY HAVE
25 PERFORMED IT, BUT HE ACTUALLY HAS TO HAVE SOME PERSONAL

1 KNOWLEDGE. IT IS NOT JUST A MATTER OF TALKING TO OTHERS AND
2 MAKING A DECISION ABOUT THE ACTUAL PROCEDURE.
3 SAFETY OF A PROCEDURE IS A LITTLE BIT DIFFERENT,
4 THOUGH, BECAUSE I WOULD IMAGINE MOST DOCTORS GIVE THEIR
5 EXPERIENCE IN BEING ABLE TO DETERMINE WHETHER OR NOT SOMETHING
6 IS SAFE FROM READING AND TALKING TO OTHERS. THAT'S A LITTLE
7 BIT DIFFERENT.
8 THERE IS TESTIMONY HERE ABOUT THE ACTUAL TECHNIQUE
9 AND HOW IT IS PERFORMED, ET CETERA. THAT'S SEPARATE AND APART
10 FROM WHETHER OR NOT THAT TECHNIQUE IS SAFE.
11 MS. GARTNER: YOUR HONOR, I THINK WE WOULD HAVE NO
12 PROBLEM WITH THE WAY THAT YOUR HONOR HAS ARTICULATED IT. BUT
13 OUR CONCERN WAS THAT DR. SPRANG ISN'T IN A POSITION TO DESCRIBE
14 FOR THE COURT HOW THIS TECHNIQUE IS DONE BECAUSE HE HAS NOT
15 DONE IT OR WITNESSED IT.
16 BUT WE DON'T HAVE A PROBLEM WITH HIM AS AN
17 OBSTETRICIAN GYNECOLOGIST TESTIFYING ABOUT HIS OPINION OF THE
18 SAFETY. AND YOUR HONOR CAN JUDGE HOW WEIGHTY THAT OPINION IS
19 GIVEN HE HAS NO EXPERIENCE WITH IT.
20 THE COURT: CERTAINLY.
21 MS. GARTNER: THANK YOU.
22 THE COURT: THEN, I THINK THAT THAT'S HOW I WILL
23 RESOLVE THE ISSUE. HE WILL NOT BE QUALIFIED TO TESTIFY ABOUT
24 HOW THE TECHNIQUE IS PERFORMED, BUT TO THE EXTENT THAT HE HAS A
25 VIEW ABOUT HOW IT IS PERFORMED BASED UPON WHAT HE HAS READ, HE

1 MAY GIVE AN OPINION ABOUT HOW SAFE THAT IS RELATIVE TO THE
2 OTHER PROCEDURES THAT WE HAVE BEEN DISCUSSING HERE.
3 MR. SIMPSON: THANK YOU, YOUR HONOR.
4 THE COURT: WE ARE GOING TO TAKE A BREAK, AND THEN
5 MAYBE YOU CAN REFORMULATE YOUR QUESTIONING. I'M SURE THE
6 RULING WILL HAVE SOME EFFECT ON HOW YOU WANT TO APPROACH YOUR
7 EXAMINATION.
8 WE WILL BREAK FOR 15 MINUTES.
9 (RECESS TAKEN AT 10:00 A.M.)
10 (PROCEEDINGS RESUMED AT 10:15 A.M.)
11 THE COURT: OKAY. NOW, JUST TO MAKE SURE THAT
12 BEFORE YOU GET STARTED THAT WE ALL UNDERSTAND THE PARAMETERS, I
13 MADE THE FINDING THAT THE DOCTOR DOESN'T HAVE SUFFICIENT
14 PERSONAL EXPERIENCE TO QUALIFY HIM AS AN EXPERT IN HOW D&X OR
15 INTACT D&E'S PERFORMED.
16 THAT IS BASED NOT ONLY UPON THE FACT THAT HE HASN'T
17 PERFORMED THE PROCEDURE, BUT ALSO THAT HE HASN'T SUPERVISED
18 ANYBODY ELSE PERFORMING IT. HE HASN'T OBSERVED IT BEING
19 PERFORMED BY ANYBODY ELSE. HE HAS NOT BEEN TAUGHT THE
20 PROCEDURE, NOR HAS HE HIMSELF TAUGHT THE PROCEDURE TO SOMEONE
21 ELSE.
22 THE WITNESS MAY OPINE, HOWEVER, ON THE SAFETY OF THE
23 PROCEDURE BASED UPON HIS UNDERSTANDING OF WHAT THE PROCEDURE
24 ENTAILS AND BASED UPON HIS INDEPENDENT STUDY AND REVIEW OF THE
25 PROCEDURE. HE MAY OFFER AN OPINION ON HOW SAFE IT IS OR UNSAFE

1 IT IS.
2 MR. SIMPSON: THANK YOU, YOUR HONOR.
3 THE WITNESS: MAY I ASK YOU A QUESTION?
4 THE COURT: NO. THAT IS NOT A GOOD IDEA. YOU
5 SHOULD ASK MR. SIMPSON DURING THE BREAK.
6 THE WITNESS: THANK YOU.
7 MR. SIMPSON: YOUR HONOR, IF I COULD DO A
8 HOUSEKEEPING MATTER FIRST. I SHOULD HAVE DONE THIS EARLIER.
9 EXHIBIT A-55, DR. SPRANG'S JAMA ARTICLE. WE HAD INTENDED TO
10 MOVE THAT INTO EVIDENCE.
11 WE LISTED THAT ON OUR EXHIBIT LIST, AND THERE WAS NO
12 OBJECTION PLACED ON THE EXHIBIT LIST BY PLAINTIFFS' COUNSEL,
13 SO WE HAD INTENDED TO MOVE IT IN.
14 THE COURT: IS THERE AN OBJECTION?
15 MS. GARTNER: THERE IS AN OBJECTION. YOUR HONOR, WE
16 DON'T -- THIS MAY BE A LEARNED TREATISE. IT IS A PUBLISHED
17 ARTICLE. WE DON'T THINK IT FALLS WITHIN ANY HEARSAY EXCEPTION.
18 THE COURT: WOULDN'T IT FALL WITHIN THE SAME
19 EXCEPTION THAT THE REPORTS YOU ARE TRYING TO GET IN FALL IN?
20 MS. GARTNER: WE DON'T BELIEVE SO, YOUR HONOR,
21 BECAUSE DR. DREY'S STUDIES AND DR. CHASEN'S STUDIES ARE REPORTS
22 ON RESEARCH DONE, AND THEY INCLUDE DATA. AND UNDER THE CASES
23 THAT WERE CITED IN THE BRIEF THAT WAS FILED TWO NIGHTS AGO, I
24 BELIEVE, THOSE ARE THE TYPES OF STUDIES AND PUBLICATIONS THAT
25 FALL WITHIN THE RESIDUAL EXCEPTION TO THE HEARSAY RULE.

1 WHEREAS --
2 THE COURT: THE DEFENSE HAS POINTED OUT THAT THE
3 CASES THAT YOU RELY UPON DEAL WITH STUDIES THAT WERE PERFORMED
4 SPECIFICALLY FOR THE PURPOSE OF THE LITIGATION AT ISSUE. AND
5 ONE OF THE REASONS YOU'VE ADVANCED HERE IS THAT THE DREY AND
6 CHASEN STUDIES WEREN'T PREPARED FOR THE PURPOSES OF THE
7 LITIGATION THAT IS AT ISSUE.
8 SO, I AM NOT SO SURE THAT THIS STUDY SHOULD BE
9 TREATED ANY DIFFERENTLY THAN YOUR STUDIES.
10 MS. GARTNER: WELL, THIS ACTUALLY ISN'T -- I THINK
11 THE DIFFERENCE, YOUR HONOR, IS THAT DR. SPRANG'S PUBLICATION
12 ISN'T, IN FACT, A STUDY. IT IS HIS OPINIONS. AND HE IS HERE
13 TODAY, AND HIS -- WHAT HIS TESTIMONY IS HERE IS REALLY THE BEST
14 EVIDENCE OF WHAT HIS OPINIONS ARE. AND HE CAN REPORT THOSE
15 OPINIONS TO THE COURT.
16 THE COURT: ALL RIGHT. I UNDERSTAND THE OBJECTION.
17 I WILL ADVISE YOU ON MONDAY MORNING WHEN I ADVISE YOU ON ALL
18 THE OTHER VARIOUS OBJECTIONS THAT YOU HAVE GIVEN ME. BUT IT IS
19 LIKELY I WILL TREAT THEM SIMILARLY.
20 MR. SIMPSON: THANK YOU, YOUR HONOR.
21 BY MR. SIMPSON:
22 Q. DR. SPRANG, TWO ADDITIONAL QUESTIONS ON YOUR BACKGROUND,
23 PLEASE. WHY -- I BELIEVE YOU'VE TESTIFIED THAT OTHER THAN THE
24 ONE CASE THAT YOU TOLD US ABOUT INVOLVING PLACENTA PRECRETA,
25 YOU HAVE NOT PERFORMED AN ABORTION ON A LIVE FETUS. WHY IS

1 THAT?
2 A. MY KIND OF PHILOSOPHY ON LIFE HAS BEEN -- I AM A VERY
3 POSITIVE PERSON. I TAKE MEDICINE AND SPECIFICALLY TAKE
4 OBSTETRICS AND GYNECOLOGY BECAUSE IT IS MORE POSITIVE. I
5 CERTAINLY ENJOY DELIVERING BABIES AND TAKING CARE OF OTHERS AND
6 THEIR BABIES. I WOULDN'T BE COMFORTABLE ACTUALLY TAKING THE
7 LIFE OF THE FETUS.
8 IN MY PRACTICE, IF PATIENTS WANT TO HAVE AN
9 ABORTION, THEY ARE REFERRED TO ABORTION PROVIDERS. THAT IS
10 CARRIED OUT, AND USUALLY THEY WILL COME BACK TO ME FOR CARE AND
11 CONTINUE IN MY PRACTICE.
12 I AM JUST NOT COMFORTABLE DOING THAT.
13 Q. DOCTOR, OTHER THAN LAWS ON INTACT D&X, HAVE YOU EVER BEEN
14 ACTIVELY INVOLVED IN SUPPORTING ANY OTHER RESTRICTIONS ON
15 ABORTION?
16 A. I HAVE NOT.
17 Q. DOCTOR, WE HAVE DISCUSSED ALREADY SEVERAL DIFFERENT METHODS
18 OF ABORTION. ONE OF THOSE WAS DILATION AND EVACUATION, D&E; IS
19 THAT CORRECT?
20 A. CORRECT.
21 Q. CAN YOU DESCRIBE TO US BRIEFLY HOW INTACT -- HOW D&E WORKS?
22 A. WHAT YOU NEED TO DO, IN EACH OF THE CASES YOU NEED TO MAKE
23 SURE THERE IS ENOUGH CERVICAL DILATIONS THAT CAN GET INTO THE
24 UTERINE CAVITY. TYPICALLY WITH A D&E -- AND IT VARIES. SOME
25 PEOPLE WOULD DO IT JUST ONE DAY BEFORE. SOME PEOPLE DO

1 MULTIPLE SERIAL LAMINARIA. THE IDEA IS JUST TO DILATE THE
2 CERVIX ADEQUATELY TO GET INSTRUMENTS IN. DEPENDING ON EXACTLY
3 HOW MANY WEEKS, YOU WILL STILL OFTEN USE SUCTION CURETTAGE,
4 BECAUSE YOU ARE GETTING A FLUID. AND OFTEN YOU CAN JUST
5 ACTUALLY SUCTION DOWN AND GET THE UMBILICAL CORD. SO EVEN IF
6 IT IS A LIVE FETUS, YOU CAN CUT THE CORD IN THAT PLACE, AND
7 THEN CONTINUE.
8 THE SUCTION DEVICE IS PRETTY STRONG, I'D SAY, VACUUM
9 CLEANER. SO YOU CAN REMOVE PARTS OFTEN AT VARIOUS GESTATIONAL
10 WEEKS YOU CAN ACHIEVE MOST OF THE PROCEDURE JUST THAT, EVEN IF
11 IT GETS FURTHER ALONG.
12 Q. IS THE FETUS, DOCTOR, DISARTICULATED IN A D&E?
13 A. IT IS DISARTICULATED IN THE UTERUS WITH VARIOUS METHODS.
14 SOMETIMES THE SUCTION ITSELF -- AND I DON'T WANT TO GET GRAPHIC
15 HERE -- BUT YOU CAN REMOVE PORTIONS OF IT. AND THEN, SOMETIMES
16 ONLY SOME PORTIONS ARE STILL LEFT. THE CRANIUM, THE SPINAL
17 CORD, AND REACH IN THERE WITH FORCEPS AND EXTRACT THOSE, AS
18 WELL.
19 AS GESTATION PROGRESSES, THE FETUS, THE TISSUE IS
20 MORE TENACIOUS. IT IS NOT AS FRAGILE OR FRIABLE. AND SO THEN
21 YOU HAVE MORE DIFFICULTY KIND OF BREAKING PIECES AND CRUSHING
22 TRYING TO BRING THEM THROUGH SMALLER OPENINGS TO TRY TO GET IT
23 DELIVERED.
24 IS THAT WHAT YOU ARE ASKING? AM I MISSING --
25 THE COURT: ACTUALLY, THE QUESTION WAS SIMPLY:

1 "IS THE FETUS DISARTICULATED IN A D&E?"
2 AND I THINK YOU GAVE A LITTLE BIT MORE OF AN ANSWER.
3 DR. SPRANG, I WILL ASK YOU, IF YOU WOULD, JUST TRY
4 TO LIMIT YOUR QUESTIONS, BECAUSE YOUR ATTORNEY IS KIND OF
5 CONTROLLING THE DIRECTION OF THE EXAMINATION. AND I THINK YOU
6 ARE GETTING A LITTLE AHEAD OF YOURSELF.
7 THE WITNESS: THANK YOU.
8 BY MR. SIMPSON:
9 Q. DOCTOR, YOU MENTIONED REACHING IN WITH FORCEPS. WHERE YOU
10 HAVE TO DO THAT, WHEN YOU ARE DISARTICULATING THE FETUS, CAN
11 YOU DESCRIBE TO US THE MOTION THAT YOU WOULD USE WITH THE
12 FORCEPS?
13 A. TYPICALLY -- AND YOU OFTEN CAN DO IT IF YOU ARE CONCERNED
14 AT ALL UNDER DIRECTION OF ULTRASOUND GUIDANCE. AND YOU HAVE A
15 TECHNICIAN THERE, SO YOU CAN SEE AS YOU ARE INTRODUCING THE
16 FORCEPS INTO THE UTERUS. OFTEN YOU CAN ACTUALLY SEE THE
17 FORCEPS BECAUSE THEY REFLECT. GRASP A FETAL PART. AND USING A
18 TWISTING MOTION, TRY TO EXTRACT IT.
19 AND YOU ESSENTIALLY ARE DISARTICULATING THE FETUS IN
20 THE UTERUS AND TRYING TO REMOVE IT IN PORTIONS THAT ARE SMALL
21 ENOUGH TO FIT THROUGH THE CERVIX WITHOUT TRAUMATIZING THE
22 CERVIX.
23 Q. WHY DO YOU USE A TWISTING MOTION?
24 A. IF YOU JUST PULL DOWN ON IT YOU ARE GOING TO GET THE ENTIRE
25 FETUS. IF YOU ARE TRYING TO TWIST OFF SMALLER PORTIONS,

1 BECAUSE YOU ARE TRYING TO DO IT -- THE PIECE OF MATERIAL YOU
2 ARE TRYING TO REMOVE IDEALLY SHOULD BE SMALLER THAN THE
3 CERVICAL OPENING SO IT FITS, OTHERWISE YOU WOULD BE POTENTIALLY
4 TRAUMATIZING THE CERVIX.
5 Q. NOW, DOCTOR, YOU SAID THIS USUALLY INVOLVES
6 DISARTICULATION. IS THERE ANYTHING THAT THE PHYSICIAN CAN DO TO
7 TRY TO AVOID LEAVING PIECES OF THE FETUS INSIDE THE UTERUS?
8 A. WELL, IF YOU ARE DOING BOTH, ESPECIALLY IF YOU HAVE
9 ULTRASOUND GUIDANCE, YOU ARE SEEING EACH OF THE PIECES. WHEN
10 YOU REMOVE THEM, YOU CAN THEN TAKE THE PIECES AND PLACE THEM ON
11 A STERILE TOWEL ON THE TABLE AND KIND OF RECONSTRUCT THE FETUS.
12 IN ADDITION, YOU ARE LOOKING AT THE ULTRASOUND TO
13 MAKE SURE THERE IS NOTHING ELSE THERE. AND OFTEN WHAT WE DO IS
14 JUST TAKE A LARGE CURETTE AND CURETTE OUT THE UTERINE CAVITY.
15 AND WITH EXPERIENCE I -- BECAUSE I HAVE DONE
16 THOUSANDS OF D&C'S, TOO. YOU WANT TO GET ALL THE ENDOMETRIAL
17 TISSUE IN THAT CASE. YOU CAN FEEL WHAT ELSE IS THERE.
18 I CAN FEEL IF THERE IS A PART. I CAN FEEL IF THERE
19 IS A SUBMUCOUS FIBROID. BY FEEL, BY ULTRASOUND, AND THEN
20 RECONSTRUCTING YOU KNOW THAT YOU HAVE ALL OF THE MATERIAL.
21 Q. DOCTOR, DOES THE FETUS BECOME MORE -- YOU MAY HAVE SAID
22 THIS ALREADY -- DOES THE FETUS BECOME MORE DIFFICULT TO
23 DISARTICULATE AS PREGNANCY ADVANCES?
24 A. YES.
25 Q. WHY IS THAT?

1 A. AS THE FETUS IS MATURING IT STARTS OUT WITH VERY, VERY SOFT
2 FRAGILE, FRIABLE TISSUE. THE EXTREMITIES ARE MORE CARTILAGE
3 THAN BONE. THE LIGAMENTS ARE SOFTER.
4 AS IT GROWS, LIKE ANY EMBRYOLOGY, TO DEVELOPING INTO
5 A FETUS, THE TISSUE GETS STRONGER AND HAS MORE TENACITY, MORE
6 TENACIOUS.
7 Q. AT WHAT POINT IN GESTATION DOES THE FETUS BECOME QUITE
8 DIFFICULT TO DISARTICULATE?
9 A. IT IS A RELATIVE THING. UP TO ABOUT -- BOTH IN EXPERIENCE
10 AND IN TALKING TO ALL THE PEOPLE THAT DO IT -- UP TO ABOUT 16,
11 17, 18 WEEKS THEY CAN STILL PRETTY READILY DISARTICULATE AND
12 BRING IT IN PIECES. AS IT BECOMES STRONGER, AND BETWEEN 18 AND
13 20, A LITTLE MORE DIFFICULT.
14 BEYOND 20, MANY PEOPLE WOULD JUST SAY THE
15 DIFFICULTY, THE TENACIOUSNESS OF IT MAKES IT HARD TO
16 DISARTICULATE.
17 Q. DOCTOR, YOU ALSO MENTIONED INDUCTION ABORTION. CAN YOU
18 DESCRIBE INDUCTION TO US, PLEASE?
19 A. FOR THE MOST PART, IN INDUCTIONS YOU ARE TRYING TO DO THE
20 SAME PHYSIOLOGICAL PROCESSES THAT WE WOULD DO AT TERM. YOU ARE
21 TRYING TO HAVE UTERINE CONTRACTIONS THAT EXPEL THE PRODUCT OF
22 CONCEPTION.
23 Q. WHAT AGENTS ARE USED FOR THAT?
24 A. THERE ARE -- THERE HAS BEEN TREMENDOUS VARIATION OVER TIME
25 AND A LOT OF OLDER STUDIES, '70'S, '80'S THEY WERE ACTUALLY

1 INJECTING THINGS LIKE SALINE OR UREA INTO THE UREA INTO THE
2 UTERUS WHICH DID POSE MORE RISKS BECAUSE THOSE WERE PRETTY
3 CAUSTIC AGENTS.
4 AND THAT IS HOW PROBABLY HOW THEY WERE DOING IT AT
5 THAT TIME. SOME OF THE OLD DATA, IT IS NOT THERE TO LOOK AT
6 THAT, AS FAR AS WHAT WE ARE DOING TODAY AT ALL.
7 TODAY THE MOST COMMON THINGS ARE DONE ARE
8 PROSTAGLANDINS. AND SOME PEOPLE WILL USE HIGH DOSE PITOCIN,
9 WHICH IS THE SAME THING WE USE AT TERM TO INDUCE LABOR.
10 Q. DOCTOR --
11 A. IN MY --
12 Q. DOCTOR, YOU SAID "PROSTAGLANDINS." IS THE DRUG MISOPROSTOL
13 A PROSTAGLANDIN?
14 A. THE DRUG MISOPROSTOL IS A PROSTAGLANDIN. THERE ARE A FEW
15 OF THEM. AGAIN, IT HAS EVOLVED. WHEN I STARTED WE WERE USING
16 PROSTAGLANDINS SUPPOSITORIES BEFORE MISOPROSTOL WAS AVAILABLE,
17 AND IT WORKED REASONABLY WELL.
18 MY EXPERIENCE WITH MISOPROSTOL IT IS RIGHT NOW
19 PROBABLY THE MOST EFFECTIVE MEDICATION WE HAVE. AND I HAVE
20 ACTUALLY WRITTEN A PROTOCOL FOR MISOPROSTOL USE AT EVANSTON
21 NORTHWESTERN HEALTHCARE, ESPECIALLY WHEN THERE BECAME A LOT OF
22 INTEREST IN IT.
23 INITIALLY, SEARLE, WHO MAKES IT, SENT OUT A FLIER, A
24 WARNING TO ALL PHYSICIANS NOT TO USE IT, BECAUSE ONE OF THE
25 WARNING BOXES IN THE PDR SAID THIS SHOULD NOT BE USED IN

1 PREGNANT WOMAN, BECAUSE WHAT THEY ARE LOOKING AT IT IS IT COULD
2 CAUSE CONTRACTIONS AND LABOR. AND THAT IS NOT WHAT IT IS
3 APPROVED FOR ON THE MARKET.
4 BUT BECAUSE WE OFTEN USE IT, WE OFTEN USE A NUMBER
5 OF DRUGS OFF LABEL. THE AMERICAN COLLEGE OF OB/GYNE ACTUALLY
6 TALKED TO SEARLE, AND AFTER CORPORATE DISCUSSIONS GOT THEM TO
7 CHANGE SOME OF THE WARNINGS AND TAKE OUT SOME OF THE WARNING
8 BOXES ABOUT ABSOLUTELY NOT USING IT, AND SAYING IT WAS NOT
9 APPROVED FOR OFF USE.
10 BUT THEN IT IS USED FOR OFF LABEL, SO IT BECAME
11 READILY ACCEPTED TO BE ABLE TO USE THAT.
12 Q. WOULD YOU SAY, DOCTOR, THAT MISOPROSTOL IS THE AGENT MOST
13 FREQUENTLY USED TODAY FOR INDUCTION ABORTIONS?
14 A. I BELIEVE THAT. I WOULD SAY IT IS MY OPINION THAT IT IS
15 THE SAFEST AND BEST DRUG WE HAVE. I WOULD ALSO SAY WE ARE
16 CONTINUALLY CHANGING THE DOSE WE USE TO TRY AND GET THE SAFEST
17 DOSE AT THE SAFEST INTERVALS, SO IT IS A WORK-IN-PROGRESS.
18 Q. WHAT IS MISOPROSTOL ACTUALLY APPROVED FOR?
19 A. IT'S ACTUALLY FOR PEOPLE WHO ARE TAKING THE NONSTEROIDAL
20 ANTIINFLAMMATORIES THAT WILL BURN YOUR STOMACH, BECAUSE IT HAS,
21 IN FACT, A DECREASE IN PROSTAGLANDINS, THEY ARE ACTUALLY MEANT
22 TO PROTECT YOUR STOMACH.
23 AND IT JUST HAPPENS THAT THE SAME MECHANISMS ARE
24 ALSO VERY USEFUL IN STARTING THE PROSTAGLANDIN PROCESS IN THE
25 CERVIX, WHICH IS WHAT REALLY TRIGGERS LABOR.

1 Q. DOCTOR, HOW WOULD YOU COMPARE THE PREPARATION OF THE CERVIX
2 FOR AN INDUCTION ABORTION TO THE PREPARATION OF THE CERVIX IN
3 CHILDBIRTH?
4 A. MANY SIMILARITIES. AGAIN, WHAT YOU ARE TRYING TO DO,
5 DEPENDING ON -- I WILL USE THE WORD: "IS THE CERVIX RIPE OR
6 NOT?"
7 BY THAT WE MEAN: IS IT SOFT? IS IT STARTING TO
8 EFFACE? IS IT STARTING TO GET SHORTER SO THAT IT WOULD BE AN
9 EASIER PROCESS TO DILATE AND DELIVER THE PRODUCTS OF
10 CONCEPTION?
11 THERE MAY BE SLIGHTLY DIFFERENT WAYS OF DOING IT.
12 YOU ARE TRYING TO SOFTEN, EFFACE OF THE CERVIX, AND THEN HAVE
13 REGULAR, NORMAL, PHYSIOLOGIC UTERINE CONTRACTIONS TO PUSH OUT
14 THE PRODUCTS OF CONCEPTION.
15 Q. DOCTOR, LET'S COMPARE FOR A MOMENT D&E AND INDUCTION AT
16 LEAST IN ONE RESPECT. IS THERE ANY DIFFERENCE IN THE USUAL
17 DEGREE OF MATERNAL BLOOD LOSS BETWEEN D&E AND INDUCTION?
18 A. THERE IS INFORMATION IN DOING INDUCTIONS AND D&E'S IN THE
19 EARLIER MID-TRIMESTER UP TO ABOUT 18, 20 WEEKS. PROBABLY THE
20 MOST OF THE LITERATURE WOULD SAY THAT D&E IS ACTUALLY THE
21 PREFERRED METHOD AT THAT TIME FRAME.
22 ONCE YOU START GETTING TO THE 18 TO 20 WEEK TIME
23 FRAME, THERE ARE DIFFERENT BOOK CHAPTERS, ARTICLES THAT WOULD
24 SAY THEY ARE VERY COMPARABLE.
25 Q. ARE YOU SAYING THEY WOULD BE COMPARABLE LATE IN THE

1 SECOND-TRIMESTER?
2 A. CORRECT.
3 Q. LET'S ASSUME, DOCTOR, A SPECIFIC MEDICAL SITUATION WITH A
4 PATIENT. IF YOU HAD A PATIENT WHO WAS TAKING ANTICOAGULANT
5 MEDICATIONS, IN YOUR OPINION WHICH WOULD BE PREFERABLE, D&E OR
6 INDUCTION ABORTION?
7 A. BOTH OF THOSE SITUATIONS PRESENT LEGITIMATE CONCERNS,
8 BECAUSE BOTH COULD HAVE GREATER BLOOD LOSS. AND OFTEN WHAT WE
9 DO IS IF THEY ARE ON HEPARIN OR COUMADIN, BECAUSE THEY NEED TO
10 BE AND THOSE ARE BLOOD THINNING AGENTS, OFTEN WE WILL STOP
11 THEM, ESPECIALLY THINGS LIKE HEPRIN, WHICH HAS A VERY SHORT
12 HALF-LIFE, STOP THEM FROM THE PROCEDURE AND THEN RESTART THEM
13 AGAIN AFTER.
14 Q. WHAT DID YOU MEAN BY "STOP, STOP THE PROCEDURE"?
15 A. STOP, STOP GIVING THE MEDICATION.
16 Q. OH, TAKE THEM OFF THE ANTICOAGULANT?
17 A. CORRECT.
18 Q. I SEE.
19 A. CORRECT, FOR A BRIEF PERIOD OF TIME, SO THERE IS LESS BLOOD
20 LOST DURING THE PROCEDURE, AND THEN START THEM RIGHT BACK ON
21 IT.
22 Q. WHAT IF THE PATIENT --
23 THE COURT: HE DIDN'T ANSWER THE QUESTION. WHICH OF
24 THE TWO IS SAFER FOR THAT PATIENT?
25 THE WITNESS: I WOULD SAY THEY ARE COMPARABLE.

1 WELL, I GUESS I WAS THINKING I WAS ANSWERING, BECAUSE IF YOU
2 STOP THE MEDICATION, IT IS NOT REALLY AN ISSUE.
3 BY MR. SIMPSON:
4 Q. BUT WHAT IF THE PATIENT'S CONDITION WAS SUCH THAT YOU COULD
5 NOT STOP THE ANTICOAGULANT MEDICATION, WHICH PROCEDURE WOULD
6 YOU PREFER?
7 A. BECAUSE IT WOULD HAVE TO BE AN EXTREMELY URGENT CASE,
8 BECAUSE IT EITHER CAN CAUSE BLEEDING. THE INDIVIDUAL, THE
9 HEMATOLOGIST THAT I WORK WITH WOULD STOP THE MEDICATION,
10 BECAUSE YOU COULD HAVE SIGNIFICANT BLOOD LOSS WITH EITHER OF
11 THOSE PROCEDURES.
12 Q. DOCTOR, YOU MENTIONED DILATING THE CERVIX IN THE COURSE OF
13 A D&E. IS THAT DONE IN YOUR UNDERSTANDING NORMALLY WITH
14 OSMOTIC DILATORS?
15 A. CORRECT.
16 Q. IS ONE TYPE OF OSMOTIC DILATOR CALLED "LAMINARIA"?
17 A. CORRECT.
18 Q. IS THAT THE MOST COMMON TYPE OF OSMOTIC DILATOR?
19 A. IN THE UNITED STATES TODAY, CORRECT.
20 Q. WOULD YOU EVER USE OSMOTIC DILATORS TO DILATE A CERVIX IN
21 ORDER TO DELIVER A BABY?
22 A. RARELY WOULD WE ACTUALLY DO THAT. WE DO SIMILAR THINGS IN
23 THAT WE HAVE A PROCESS WE CALL EASI, E-A-S-I. AND IT REFERS TO
24 AN EXTRA AMNIOTIC SALIENT INFUSION.
25 YOU BRING THE PATIENT IN THE EVENING BEFORE. LET'S

1 JUST SAY THAT YOU WANT TO INDUCE, BUT THE CERVIX IS NOT
2 FAVORABLE AT ALL. IT IS LONG, THICK AND CLOSED. AND YOU WANT
3 TO TRY TO MAKE THE INDUCTION IN AS REASONABLE A PERIOD OF TIME
4 AS YOU CAN.
5 YOU INJECT -- IT IS LIKE A FOLEY CATHETER WE PUT IN
6 THE CERVIX. SO THERE'S A MECHANICAL THING THERE. YOU LET THE
7 NORMAL SALINE RUN OVERNIGHT. THE SALINE IS KIND OF STIMULATING
8 THE CERVICAL CANAL, BASICALLY TRYING TO START THE PROSTAGLANDIN
9 PRODUCTION BY THE MOTHER, AND THEN SOFTENING THE CERVIX AND
10 EFFACING IT SO THE NEXT MORNING WHEN YOU START YOUR PITOCIN OR
11 YOUR CYTOTEC, WHICH IS MISOPROSTOL, YOU ARE HOPING FOR A
12 SMOOTHER, MORE EXPEDITIOUS INDUCTION.
13 Q. IN ADDITION --
14 A. IN SOME WAYS IT IS SIMILAR TO DOING THE SAME THINGS WITH
15 THE LAMINARIA. THE LAMINARIA ARE A LITTLE MORE CONCERNED IN
16 THAT THEY GO THROUGH LITTLE STICKS THAT YOU ARE PUTTING IN
17 THERE, AND THEY GO THE FULL LENGTH TO THE END OF THE CERVIX.
18 SO WE ARE WORRIED ABOUT PERFORATING THE AMNIOTIC
19 FLUID OR RISK OF INFECTION.
20 Q. SO YOU WOULD NORMALLY NOT USE LAMINARIA FOR A CHILDBIRTH?
21 A. NORMALLY, WHAT WE ARE DOING WHEN WE INTEND TO DO A NORMAL
22 INDUCTION, WE NORMALLY WOULD NOT.
23 Q. DOCTOR, YOU TOLD US YOU PRACTICED AT EVANSTON NORTHWESTERN
24 HEALTHCARE HOSPITAL. ARE BOTH D&E'S AND INDUCTION ABORTIONS
25 PROVIDED AT THAT HOSPITAL?

1 A. CORRECT.
2 Q. IS EITHER OF THOSE METHODS USED MORE OFTEN AFTER THE 20
3 WEEKS GESTATION?
4 A. AT EVANSTON NORTHWESTERN, WE HAVE MATERNAL FETAL MEDICINE
5 PHYSICIANS WHO ARE EXPERIENCED IN DOING D&E'S, BUT THEY, FOR
6 VARIOUS REASONS, WILL EITHER STOP DOING THOSE AT 18 OR 20
7 WEEKS, AND THEY WILL DO INDUCTIONS AFTER THAT POINT.
8 Q. DOCTOR, WE HAVE ALSO DISCUSSED INTACT DILATION AND
9 EXTRACTION, INTACT D&X. BASED ON WHAT YOU HAVE READ AND
10 UNDERSTAND REGARDING THAT PROCEDURE, COULD YOU DESCRIBE TO US
11 THE INTACT D&X PROCEDURE AS YOU UNDERSTAND IT?
12 MS. GARTNER: OBJECTION, YOUR HONOR.
13 THE COURT: SUSTAINED.
14 MS. GARTNER: I THINK THIS IS PRECISELY --
15 THE COURT: SUSTAINED. WE HAVE GONE THROUGH THIS.
16 MR. SIMPSON: OKAY. WELL, THE PURPOSE OF THIS
17 QUESTION, YOUR HONOR, IS SIMPLY TO ESTABLISH HIS UNDERSTANDING
18 AS TO WHAT THE PROCEDURE IS, SO, YOU KNOW, AS BACKGROUND FOR
19 HIS OPINION AS TO ITS SAFETY OR LACK OF SAFETY.
20 THE COURT: OKAY. ALL RIGHT. I WILL PERMIT A
21 LIMITED AMOUNT OF QUESTIONS. AND IT'S -- JUST SO THAT IT IS
22 CLEAR, IT IS BASED SIMPLY UPON WHAT HE HAS READ OF THE
23 PROCEDURE AND HOW THE PROCEDURE IS DESCRIBED.
24 MR. SIMPSON: I UNDERSTAND THAT, YOUR HONOR.
25 THE COURT: ALL RIGHT.

1 BY MR. SIMPSON:
2 Q. COULD YOU, DOCTOR, DESCRIBE YOUR UNDERSTANDING OF THAT
3 PROCEDURE?
4 A. YES. AND I DID SPECIFICALLY READ HASKELL'S DESCRIPTION --
5 I'M SORRY -- DR. HASKELL'S DESCRIPTION, AND SPECIFICALLY THE
6 AMERICAN -- ACOG'S DESCRIPTION. AND THAT IS THE DEFINITION
7 THAT WAS USED IN THE AMA REPORT THAT WE DID DISCUSS AT LENGTH
8 IN THAT COMMITTEE MEETING.
9 Q. COULD YOU DESCRIBE YOUR UNDERSTANDING OF THAT PROCEDURE?
10 A. YES. THE SPECIFIC DEFINITION ACOG USES IS THAT IT INVOLVES
11 FOUR STEPS. THE FIRST STEP, USUALLY OVER SEVERAL DAYS, IS
12 DILATING THE CERVIX. YOU WANT ME TO DESCRIBE HOW THEY DO IT?
13 Q. WE HAVE ALREADY DISCUSSED DILATION, SO YOU CAN MOVE ON.
14 A. OKAY. THE SECOND STEP IS ONCE THERE IS ADEQUATE DILATION,
15 WHICH IS A THREE-DAY PROCESS. THEN, ON THE THIRD DAY YOU BRING
16 THE PATIENT IN, REMOVE THE LAMINARIA, SUCTION OUT THE FLUID.
17 AND IF THE FETUS WAS IN A BREECH PRESENTATION, AND THE FEET
18 WERE THERE, YOU WOULD JUST START PULLING DOWN ON THE FEET.
19 IF THE FEET ARE -- IF THE FETUS IS IN A VERTEX
20 PRESENTATION WITH THE FEET UP, IN THIS PROCEDURE, THEY
21 ROUTINELY WOULD GRASP THE FEET AND DO AN INTERNAL PODALIC
22 VERSION TO CONVERT THE VERTEX PRESENTATION TO A BREECH
23 PRESENTATION, WHICH I HAVE DONE ON NUMEROUS OCCASIONS.
24 ONCE IT IS IN A BREECH PRESENTATION, YOU THEN DO A
25 BREECH EXTRACTION, WHICH I HAVE PERFORMED A HUNDRED TIMES.

1 AND WHAT YOU ARE DOING IS -- CAN I DESCRIBE HOW YOU
2 DO IT?
3 THE COURT: YOU CAN DESCRIBE HOW YOU HAVE READ IT IS
4 DONE.
5 THE WITNESS: I HAVE DONE. I HAVE DONE IT A HUNDRED
6 TIMES.
7 THE COURT: BUT YOU HAVE NEVER DONE AN INTACT
8 ABORTION PROCEDURE, WHICH IS WHAT HE IS ASKING FOR. HE IS NOT
9 ASKING FOR DELIVERY, DOCTOR.
10 THE WITNESS: IT'S A BREECH EXTRACTION IS WHAT THEY
11 ARE DOING, AND THAT I HAVE DONE A HUNDRED TIMES.
12 THE COURT: JUST ANSWER HIS QUESTION. I BELIEVE HIS
13 QUESTION PERTAINED ONLY TO AN INTACT D&X; IS THAT CORRECT?
14 BY MR. SIMPSON:
15 Q. DOCTOR, IF YOU CAN DESCRIBE TO US YOUR UNDERSTANDING,
16 BRIEFLY, AS TO HOW A PHYSICIAN DOING AN INTACT D&X PERFORMS A
17 BREECH EXTRACTION.
18 A. BREECH EXTRACTION IS YOU GRAB BOTH FEET AND YOU ARE PULLING
19 AND TWISTING AND TURNING THE FETUS, BECAUSE THAT IS HOW YOU GET
20 THE PELVIS OUT OF THE UTERUS. AND IT IS THE MOST EFFECTIVE WAY
21 OF DOING IT IS A TWISTING, TURNING MOTION. YOU BRING -- YOU
22 CONTINUE TO EXTRACT THE FETUS.
23 AND ONCE YOU GET TO THE SHOULDERS YOU GOT TO KIND OF
24 DO A TWISTING. IT'S ONE SIDE COMES OUT. YOU TRY TO GET ONE
25 ARM. YOU TRY TO TWIST IT THE OTHER WAY TO GET THE OTHER ARM.

1 AND SO THEN YOU, WITH A BREECH EXTRACTION, HAVE
2 DELIVERED THE FETUS TO THE POINT WHERE THE BODY IS OUTSIDE OF
3 THE CERVIX, OUTSIDE OF THE MOTHER'S WOMB, AND THE HEAD IS STILL
4 WITHIN THE UTERUS.
5 AS DR. HASKELL SAYS, OFTEN IT WILL STAY THERE.
6 SOMETIMES IT DOES COME DOWN BECAUSE OF DILATATION. IT IS NOT
7 SUCH -- IF IT IS ADEQUATE ENOUGH, THE HEAD WILL JUST DELIVER.
8 BUT WHEN IT COMES DOWN WHERE IT STAYS AT THE CERVIX,
9 THEY THEN -- AND HE DESCRIBES THIS VERY WELL IN HASKELL'S
10 ARTICLE -- PUT THEIR FINGERS IN, PUT TWO FINGERS ON THE
11 SHOULDERS, LIKE THIS, (INDICATING), PUT THE MIDDLE FINGER AT
12 THE CERVIX, LIFT THE CERVIX WITH THE OTHER HAND, FOLLOW ALONG
13 THE SPINAL COLUMN, AND BY FEEL, FEELING WHERE THEY REACH THE
14 SKULL. SO THAT THEY ARE TRYING TO STAY IN THE MIDDLE OF THE
15 SKULL. THEY INSERT SCISSORS INTO THE BASE OF THE SKULL AT THAT
16 POINT TO CREATE AN OPENING IN THE SKULL. THEY OPEN UP THE
17 SCISSORS TO MAKE MORE ROOM.
18 YOU THEN REMOVE THE SCISSORS. YOU TAKE A SUCTION
19 CURETTAGE, THE SAME KIND OF SUCTION CURETTAGE WE DO IN A
20 SUCTION ABORTION OR SUCTION D&C. PLACE THE SUCTION DEVICE IN
21 THE UTERINE CAVITY -- CORRECTION -- IN THE INTRACRANIAL CAVITY,
22 AND SUCTION OUT THE INTRACRANIAL CONTENTS.
23 BY DOING THAT, YOU ARE COLLAPSING THE SKULL, BECAUSE
24 THE SKULL IS VERY SOFT IN A FETUS, EVEN AT TERM, BUT ESPECIALLY
25 AT 22 TO 24 WEEKS.

1 SO IT BECOMES SIGNIFICANTLY SMALLER. SO YOU THEN
2 REMOVE AN INTACT, BUT OTHERWISE -- OTHERWISE INTACT FETUS,
3 EXCEPT FOR THE INTRACRANIAL CONTENTS BEING REMOVED, AND GOING
4 FROM THEN A LIVE TO A DEAD FETUS, AND COMPLETE REMOVAL OF THE
5 FETUS.
6 Q. DOCTOR, YOU USED THE WORD "CURETTAGE." YOU SAID THAT THE
7 DOCTOR INSERTS A SUCTION CURETTAGE INTO THE BASE OF THE SKULL.
8 A. IT IS WHAT WE CALL -- IT'S A SUCTION CANNULA. AND IT WORKS
9 THAT WAY. BASICALLY, YOU ARE REMOVING THE FLUID. AND IN THIS
10 CASE, YOU ARE REMOVING THE INTRACRANIAL CONTENTS.
11 Q. DOCTOR, YOU SAID THAT THE DILATION IS USUALLY DONE OVER --
12 I BELIEVE YOU SAID -- SEVERAL DAYS. IS IT YOUR UNDERSTANDING
13 THAT THE PHYSICIAN INSERTS ONE SET OF LAMINARIA, AND LETS THOSE
14 EXPAND FOR SEVERAL DAYS? OR IS THERE SOME OTHER WAY OF DOING
15 IT?
16 MS. GARTNER: OBJECTION, YOUR HONOR. I THINK THAT
17 THIS LEVEL OF DETAIL ISN'T REQUIRED FOR DR. SPRANG TO OPINE
18 ABOUT THE SAFETY OF THE PROCEDURE.
19 THE COURT: I AGREE.
20 MR. SIMPSON: YOUR HONOR, PART OF THE -- I BELIEVE
21 DR. SPRANG IS GOING TO TESTIFY THAT PART OF THE POTENTIAL
22 INJURY TO THE MOTHER IS THROUGH THE SERIAL USE OF LAMINARIA, AS
23 THE COURT HAS HEARD IN PRIOR TESTIMONY.
24 AND SO I BELIEVE THAT DR. SPRANG WILL BE ABLE TO
25 SAY --

1 THE COURT: AND WHERE DOES THE INFORMATION ABOUT THE
2 SERIAL USE OF LAMINARIA COME FROM FROM DR. SPRANG'S EXPERIENCE?
3 BY MR. SIMPSON:
4 Q. DOCTOR, ARE YOU ABLE TO ANSWER THE QUESTION I ASKED AS TO
5 WHETHER ONE SET OF LAMINARIA IS INSERTED --
6 THE COURT: WELL, FIRST, WHY DON'T YOU ANSWER MY
7 QUESTION, WHICH IS: BASED UPON THIS DOCTOR'S EXPERIENCE, WHERE
8 DOES THE SERIAL USE OF LAMINARIA COME IN?
9 I DON'T BELIEVE THAT THAT WAS REFERRED TO IN THE
10 HASKELL REPORT. I HAVE READ THE HASKELL REPORT. IT HAS BEEN
11 AWHILE, SO IF IT IS IN THERE, POINT IT OUT TO ME.
12 MR. SIMPSON: ACTUALLY, YOUR HONOR, I BELIEVE THIS
13 IS --
14 THE COURT: I DON'T HAVE IT IN FRONT OF ME.
15 MR. SIMPSON: IT'S LT-A-28.
16 THE COURT: BUT WE DON'T HAVE THE FULL ONE. AND THE
17 COPY THAT MR. QUINLIVAN GAVE ME I LEFT --
18 MR. SIMPSON: THAT'S CORRECT, YOUR HONOR.
19 I DO HAVE A COPY FOR YOUR HONOR.
20 THE COURT: THANK YOU.
21 ALL RIGHT.
22 MR. SIMPSON: IF THE COURT COULD LOOK AT PAGE 129,
23 PLEASE, YOUR HONOR.
24 THE COURT: OKAY.
25 MR. SIMPSON: AND I BELIEVE THE COURT HAS HEARD

1 BEFORE THAT DILAPAN IS A SYNTHETIC SUBSTITUTE FOR LAMINARIA.
2 THE COURT: YES, I HAVE.
3 OKAY. ON THE BASIS OF THIS REPORT, WHICH HE HAS
4 RELIED UPON, OBVIOUSLY, HE CAN DESCRIBE IT. BUT I DON'T SEE
5 WHY THAT IS NECESSARY. I HAVE READ THE REPORT. WHY IS IT
6 NECESSARY FOR HIM TO DESCRIBE THIS PROCEDURE?
7 MR. SIMPSON: AGAIN, YOUR HONOR --
8 THE COURT: HE DOESN'T HAVE ANY PERSONAL KNOWLEDGE
9 OF IT. HE SIMPLY HAS READ THAT THIS IS HOW IT IS DONE. I HAVE
10 READ THIS IS HOW IT IS DONE. WHY DO YOU NEED TESTIMONY ON
11 THAT?
12 MR. SIMPSON: AGAIN, YOUR HONOR, I THINK DR. SPRANG
13 TESTIFIED THAT PART OF THE POTENTIAL INJURY TO THE WOMAN'S
14 CERVIX COMES FROM THE SERIAL USE OF LAMINARIA AND THE NUMBER OF
15 LAMINARIA THAT ARE PLACED.
16 THE COURT: ALL RIGHT. GO AHEAD.
17 BY MR. SIMPSON:
18 Q. DOCTOR, CAN YOU TELL US, PLEASE, IN YOUR UNDERSTANDING AS
19 TO THE INTACT D&X PROCEDURE, DOES A PHYSICIAN PLACE LAMINARIA
20 ONCE OR MULTIPLE TIMES?
21 A. MULTIPLE TIMES.
22 Q. APPROXIMATELY HOW MANY TIMES, IF YOU KNOW?
23 A. WITH HASKELL'S DESCRIPTION, THE FIRST DAY HE DILATES THE
24 CERVIX MECHANICALLY, AS HE SAYS, FROM 10 TO 11 MILLIMETERS IN
25 ORDER TO PLACE FIVE OR SIX LAMINARIA IN THE CERVIX. AND THE

1 PATIENT GOES BACK TO HER HOME OR BACK TO THE HOTEL WHERE THE
2 CERVICAL SECRETIONS EXPAND THE LAMINARIA AND START TO DILATE --
3 EXPAND THE LAMINARIA AND START TO DILATE THE CERVIX CAUSING
4 EARLY LABOR CONTRACTIONS, CRAMPING AND DILATING THE CERVIX.
5 THE NEXT DAY THE PATIENT COMES BACK TO HIS OFFICE.
6 THOSE LAMINARIA ARE REMOVED AND ADDITIONAL LAMINARIA ARE PLACED
7 IN THE CERVIX.
8 BY HIS DESCRIPTION, HE PLACES 20 TO 25 LAMINARIA
9 INTO THE CERVIX AT THAT POINT, AGAIN, TRYING TO GET IN AS MANY
10 AS YOU CAN SO THAT THEY START OUT SNUG SO THAT WHEN THEY
11 FURTHER EXPAND THEY FURTHER DILATE THE CERVIX.
12 Q. THANK YOU, DOCTOR. JUST TO MAKE THE RECORD CLEAR --
13 MR. SIMPSON: CAN I APPROACH THE WITNESS, PLEASE,
14 YOUR HONOR?
15 THE COURT: YES.
16 MR. SIMPSON: I AM GOING TO GIVE THE WITNESS
17 EXHIBIT LT-A-28.
18 BY MR. SIMPSON:
19 Q. DOCTOR, IS THAT THE HASKELL PRESENTATION THAT YOU HAVE
20 REFERRED TO?
21 A. I BELIEVE IT IS A MUCH SMALLER PRINT, SO YOU CAN'T REALLY
22 READ IT THAT WELL.
23 Q. OTHER THAN IT BEING SMALL PRINT, IS THAT THE ONE YOU ARE
24 REFERRING TO?
25 A. CORRECT.

1 Q. DOCTOR, DO YOU HAVE AN OPINION AS TO WHETHER THE INTACT D&X
2 PROCEDURE PRESENTS SIGNIFICANT RISKS TO THE WOMAN?
3 A. I DO.
4 Q. WHAT IS THAT OPINION?
5 A. I DO PRESENT -- I HAVE THE OPINION THAT IT PRESENTS SERIOUS
6 SAFETY RISK TO THE MOTHER.
7 Q. DO YOU HAVE AN OPINION OR OPINIONS AS TO WHAT THOSE RISKS
8 ARE, YES OR NO?
9 A. I DO.
10 Q. COULD YOU JUST AT THIS POINT, DOCTOR, LIST THOSE RISKS FOR
11 US, IN YOUR OPINION? JUST LIST THEM AT THIS POINT, AND WE WILL
12 ASK SPECIFIC QUESTIONS ABOUT THEM.
13 A. THE RISK OF THE SERIAL DILATION IN THE CERVIX, THE EXTENT
14 TO WHICH THE CERVIX IS DILATED, THE RISK OF INFECTION FROM THE
15 LAMINARIA, THE RISK OF TRAUMA FROM DOING AN INTERNAL PODALIC
16 VERSION, THE RISK OF TRAUMA FROM USING A SHARP INSTRUMENT,
17 MAINLY SCISSORS, IN DOING THIS PROCEDURE.
18 Q. DOCTOR, FIRST OF ALL, LET'S GO THROUGH EACH OF THOSE. YOU
19 MENTIONED THE RISK OF THE DILATION OF THE CERVIX.
20 CAN YOU DESCRIBE FOR US WHY YOU -- WHY IT IS YOUR
21 OPINION THAT DILATION OF THE CERVIX FOR INTACT D&X PRESENTS
22 RISK TO THE WOMAN?
23 A. IN EACH OF THE STEPS WE TALKED -- IN EACH OF THE STEPS WE
24 SPOKE OF, BY FIRST MECHANICALLY DILATING IT FROM 10 TO
25 11 MILLIMETERS, WHICH IS WHAT HE SAYS HE DOES, THAT IS A

1 CERTAIN AMOUNT OF CERVICAL MECHANICAL DILATION AND TRAUMA.
2 PLACING LAMINARIA IN, BOTH A CERTAIN AMOUNT OF
3 TRAUMA FROM THE LAMINARIA, AND THEN FROM THE DILATION WITH
4 LAMINARIA, THE POTENTIAL FOR TRAUMA TO THE CERVIX.
5 AGAIN, PLACING 20, 25, 30 LAMINARIA IN THE SECOND
6 DAY, AGAIN, THE AMOUNT OF DILATATION IS MUCH GREATER, AND
7 THEREFORE NUMEROUS ARTICLES IN THE PAST HAVE SAID THE AMOUNT OF
8 CERVICAL DILATATION DOES HAVE THE POTENTIAL FOR DAMAGING THE
9 CERVIX AND THE POTENTIAL FOR EITHER LEADING TO INCOMPETENCE OR
10 PREMATURE LABOR AND DELIVERY IN SUBSEQUENT PREGNANCIES.
11 Q. DOCTOR, YOU MENTIONED CERVICAL INCOMPETENCE. CAN YOU KIND
12 OF DESCRIBE TO US WHAT THAT IS?
13 A. WHAT HAPPENS IN VARIOUS PROCEDURES IS IN THE PROCESS OF
14 DILATING THE CERVIX, SOME ACTUAL TRAUMA IS DONE TO THE TISSUE
15 OF THE CERVIX SO THAT IN A SUBSEQUENT PREGNANCY AS THE UTERUS
16 AND THE PREGNANCY PROGRESSES, TYPICALLY AT ABOUT 14, 15, 16
17 WEEKS, BECAUSE THE CERVIX IS WEAKER, THE AMOUNT OF PRESSURE IN
18 THE UTERUS CAUSES IT TO JUST PASSIVELY DILATE, AND THEREBY
19 LOSING THAT PREGNANCY.
20 Q. DOCTOR, YOU ALSO MENTIONED PREMATURE LABOR. CAN YOU
21 DESCRIBE TO US WHAT THAT IS?
22 A. IF YOU -- AGAIN, IF YOU DAMAGE THE CERVIX, THEN EVEN IF IT
23 DOESN'T CAUSE AN INCOMPETENT CERVIX IN LOSS MID-TRIMESTER, IT,
24 AS THE PREGNANCY PROGRESSES, THE INTRAUTERINE CONTENTS CLEARLY
25 ARE INCREASING IN SIZE AND MASS AND WEIGHT, AND THE CERVIX

1 WHICH NORMALLY MAY BE ABLE TO GO TO 40 WEEKS, MAY, BECAUSE OF
2 ITS WEAKNESS, START GOING INTO LABOR OR HAVE CONTRACTIONS AT
3 ANYTHING THAT I WILL CALL PREMATURE LABOR, AT ANYWHERE FROM 27,
4 28 WEEKS ON TO 37 WEEKS, WHICH IS THE DEFINITION OF PREMATURE
5 LABOR AND DELIVERY.
6 Q. THANK YOU, DOCTOR.
7 I WOULD LIKE TO READ A COUPLE OF SENTENCES TO YOU
8 FROM YOUR JAMA ARTICLE. DO YOU STILL HAVE THAT IN FRONT OF
9 YOU, EXHIBIT A-55?
10 A. I DO.
11 Q. I WOULD LIKE TO READ A COUPLE OF SENTENCES FROM THAT AND
12 ASK YOU A FEW QUESTIONS ABOUT THEM. ON THE THIRD PAGE THERE IS
13 A HEADING TOWARD THE TOP OF THE PAGE THAT SAYS:
14 "TERMINATION OF LATE TERM PREGNANCIES."
15 DO YOU SEE THAT?
16 A. YES.
17 Q. I AM GOING TO READ AT THE BOTTOM OF THAT LEFT-HAND COLUMN.
18 THERE'S A SENTENCE THAT STARTS:
19 "DILATION AND EVACUATION PROCEDURES."
20 DO YOU SEE THAT?
21 A. CORRECT.
22 Q. "DILATION AND EVACUATION PROCEDURES COMMONLY USED IN
23 INDUCED MIDTRIMESTER ABORTION MAY LEAD TO CERVICAL
24 INCOMPETENCE, WHICH PREDISPOSES TO AN INCREASED RISK
25 OF SUBSEQUENT SPONTANEOUS ABORTION, ESPECIALLY IN

1 THE MIDTRIMESTER. CERVICAL INCOMPETENCE IS MORE
2 PREVALENT AFTER MIDTRIMESTER TERMINATION OF
3 PREGNANCY THAN FIRST TRIMESTER TERMINATION BECAUSE
4 THE CERVIX IS DILATED TO A MUCH GREATER DEGREE."
5 ARE THOSE YOUR WORDS, DOCTOR?
6 A. CORRECT. AND I GAVE THE REFERENCES IN THERE. THAT IS THE
7 LOW -- THE NUMBERS AFTER THAT ARE THE ARTICLES THAT WOULD
8 SUBSTANTIATE WHAT I SAID.
9 Q. AND IS THAT YOUR TESTIMONY TODAY?
10 A. THAT IS MY TESTIMONY TODAY.
11 Q. DOCTOR, JUST TO MAKE ONE THING CLEAR THAT EXCERPT USES THE
12 TERM "MIDTRIMESTER." DOES THAT SIMPLY MEAN THE SAME THING AS
13 SECOND-TRIMESTER?
14 A. CORRECT.
15 Q. DOCTOR, IF AN ABORTION WERE TO CAUSE CERVICAL INCOMPETENCE
16 OR PRE-TERM LABOR, WOULD THE EXISTENCE OF THAT CONDITION BE
17 DISCOVERED AT THE TIME OF THE ABORTION?
18 A. NO, IT WOULD NOT.
19 Q. LET'S SEE. YOU ALSO MENTIONED INFECTION AS A POTENTIAL
20 RISK OF INTACT D&X. BEFORE I ASK YOU ABOUT THAT, COULD I ASK
21 YOU, DOCTOR, WHAT EXPERTISE YOU HAVE IN ANY -- IF ANY,
22 REGARDING OBSTETRIC AND GYNECOLOGICAL INFECTION?
23 A. OBSTETRIC AND GYNECOLOGICAL INFECTION HAS BEEN A SPECIAL
24 INTEREST AND EXPERTISE OF MINE FOR APPROXIMATELY 20 YEARS. I
25 HAVE BEEN GIVING PRESENTATIONS AS AN INVITED SPEAKER FOR ABOUT

1 20 YEARS AT AT LEAST THREE TO FIVE NATIONAL PROGRAMS ANNUALLY.
2 I AM USED AS AN EXPERT IN MY HOSPITAL BY OTHER PHYSICIANS.
3 I HAVE PATIENTS REFERRED TO ME WITH INFECTIOUS
4 DISEASE PROBLEMS FROM OUT-OF-STATE BECAUSE OF PRESENTATIONS I
5 HAVE GIVEN THAT PEOPLE HAVE HEARD AND REFER INFECTIOUS DISEASE
6 PATIENTS TO ME.
7 Q. DOCTOR, ARE YOUR WRITINGS AND PRESENTATIONS ON INFECTION
8 REFLECTED IN YOUR CURRICULUM VITAE?
9 A. THERE ARE NUMEROUS, YES. YOU WANT ME TO SAY ANY MORE?
10 Q. THANK YOU.
11 A. YES.
12 Q. THANK YOU, DOCTOR. THAT'S GOOD.
13 NOW, COULD YOU TELL US, PLEASE, WHY IT IS YOUR
14 OPINION THAT INTACT D&X PRESENTS A RISK OF INFECTION?
15 A. SEVERAL REASONS. ONE, THAT NORMALLY IN THE VAGINA, JUST
16 LIKE ON THE SKIN IN THE MOUTH WE HAVE NUMEROUS BACTERIA
17 PRESENT. BUT PARTICULARLY IN THE VAGINA THERE ARE GENERALLY
18 FIVE TO NINE ORGANISMS THAT OCCUR IN VERY LARGE NUMBERS, LIKE
19 10 TO THE NINTH. AND THAT IS WHERE THEY BELONG, AND THEY DON'T
20 DO ANY HARM THERE.
21 IF YOU ADD A FOREIGN BODY, TWIGS, STICK SEAWEED, YOU
22 ARE GOING A GET A CERTAIN AMOUNT OF TRAUMA TO THE TISSUE WHICH
23 ENHANCES THE BACTERIAL GROWTH. AND THE WAY THE LAMINARIA WORK,
24 THEIR LENGTH IS SUCH THAT YOU ARE TAKING THEM FROM THE OUTSIDE
25 OF THE VAGINA, PLACING THEM THROUGH THE CERVICAL CANAL.

1 FOR THEM TO BE EFFECTIVE, THEY HAVE TO COVER THE
2 ENTIRE LENGTH OF THE CERVICAL CANAL WITH A PORTION OF THEM
3 REMAINING IN THE VAGINA SO YOU CAN RETRIEVE THEM, AND THE OTHER
4 PORTION GOING RIGHT UP AGAINST THE AMNIOTIC SAC.
5 IF YOU DON'T DO THAT, YOU ARE NOT GOING TO
6 COMPLETELY DILATE THE CERVIX THE ENTIRE LENGTH, AND IT WILL
7 LEAD TO MAJOR PROBLEMS.
8 SO WHAT HAPPENS IN THE FIRST DAY, A CERTAIN AMOUNT
9 OF TRAUMA FROM THE LITTLE STICKS, AS THEY DILATE, EVEN MORE
10 TRAUMA. BUT THEN THE BACTERIA IN THE VAGINA WORK THEIR WAY UP
11 THOSE LITTLE STICKS AND ARE THEN AT THE LEVEL OF THE INTERNAL
12 OS AND SITTING RIGHT NEXT TO THE AMNIOTIC SAC.
13 SO THAT IT IS MOVING THEM FROM THE NORMAL POSITION
14 TO AN ABNORMAL POSITION, WHICH INCREASES THE RISK OF INFECTION.
15 Q. DOES THE LENGTH OF TIME OVER WHICH THE DILATION FOR INTACT
16 D&X OCCURS, DO YOU THINK THAT ALSO INCREASES THE RISK OF
17 INFECTION?
18 A. IT INCREASES THE RISK BECAUSE THE LENGTH OF TIME A FOREIGN
19 BODY IS THERE, THE GREATER THE RISK OF BRINGING BACTERIA FROM
20 THE VAGINA TO THE CERVIX, EITHER ON THE FIRST APPLICATION OR ON
21 THE SUBSEQUENT APPLICATIONS OF THE LAMINARIA.
22 SOMETIMES THE ACTUAL LITTLE STICKS WILL BREAK THE
23 AMNIOTIC SAC, TOO, WHICH SIGNIFICANTLY INCREASES THE RISK OF
24 INFECTION BECAUSE THEN YOU HAVE THE BACTERIA GOING FROM THE
25 VAGINA TO THE UTERINE CAVITY.

1 AND I KNOW THAT HAPPENS JUST OBVIOUSLY INTUITIVELY
2 IT HAPPENS, BUT THE DIFFERENT AUTHORS, INCLUDING HASKELL,
3 DESCRIBES IT IN HIS PAPER THAT SOMETIMES IT BREAKS AND
4 SOMETIMES IT DOESN'T. AND THE NEXT DAY WHEN THEY REMOVE THEM
5 AND PROCEED TO THE NEXT STEP OF THE PROCEDURE, IF IT HAS -- HIS
6 COMMENT IS "IF IT HASN'T ALREADY RUPTURED," WHICH OBVIOUSLY
7 TELLS YOU SOMETIMES IT DOES, THEN HE RUPTURES THE MEMBRANES.
8 SO YOU HAVE ANOTHER SIGNIFICANT RISK OF INFECTION
9 THERE, ESPECIALLY IF IT BROKE. YOU INSERTED THEM ON DAY TWO,
10 AND YOU WAITED TO DAY THREE TO DO THE PROCEDURE, YOU'VE GOT A
11 RUPTURED BAG OF WATERS WITH FOREIGN BODIES SITTING IN THE
12 CERVIX FOR POTENTIALLY 24 HOURS.
13 Q. DOCTOR, YOU SAID SOMETHING A FEW MINUTES AGO ABOUT THE
14 AMOUNT OF BACTERIA IN THE VAGINA. WHAT I THINK YOU SAID WAS:
15 "10 TO THE NINTH"?
16 A. YES. IT IS A MATHEMATICAL TERM. AND YOU ADD 10, AND ADD
17 NINE ZEROS. THAT IS THE NUMBER.
18 Q. DOCTOR, I THINK YOU ALSO MENTIONED THE INTERNAL PODALIC
19 VERSION AS PRESENTING A RISK TO THE PATIENT. WHY IS IT YOUR
20 OPINION THAT THAT MANEUVER PRESENTS A RISK TO THE PATIENT?
21 A. HAVING DONE IT AS WELL, THERE IS A STRONG MECHANICAL FORCE
22 IN TAKING THE FETUS AND BASICALLY FORCING IT TO DO A
23 SUMMERSAULT WITHIN THE UTERINE CAVITY. THESE ARE NOT LITTLE
24 THINGS THAT YOU JUST KIND OF PUSH GENTLY, AND IT JUST TURNS.
25 IT DOESN'T WORK THAT WAY.

1 YOU ARE USING A GREAT DEAL OF FORCE IN TURNING IT
2 UPSIDE-DOWN THAT DOES TRAUMA TO THE UTERINE CAVITY AND COULD
3 DISRUPT THE PLACENTA AND CAUSE BLEEDING. AND RARELY THINGS
4 LIKE AMNIOTIC FLUID EMBOLUS. THOSE ARE NOT COMMON THINGS THAT
5 COULD HAPPEN, BUT RARELY THEY COULD. AND, IN FACT, IN
6 WILLIAMS' TEXTBOOK OF OBSTETRICS, WHICH IS ONE OF THE MOST
7 PREMIERE, RESPECTED OBSTETRICAL TEXTBOOKS FOR TEACHING MEDICAL
8 STUDENTS, WHEN I WAS A STUDENT WAS THE PRIMARY TEXTBOOK, IT
9 SPECIFICALLY SAYS THAT THERE ARE VERY FEW, IF ANY, INDICATIONS
10 TO DO INTERNAL PODALIC VERSION OTHER THAN THE SECOND TWIN.
11 AND IN VARIOUS EDITIONS HE ACTUALLY SAYS IT IS
12 POTENTIALLY HARMFUL. HE SAYS THAT IT IS THE MOST COMMON CAUSE
13 OF TRAUMATIC UTERINE RUPTURE.
14 Q. DOCTOR, IF I CAN ASK A FEW FOLLOW-UP QUESTIONS ON THOSE
15 THINGS. YOU MENTIONED DISRUPTING -- THE POTENTIAL FOR
16 DISRUPTING THE PLACENTA. WHAT CAN THAT LEAD TO?
17 A. AGAIN, THESE ARE RARE SITUATIONS, BUT THERE IS POTENTIAL
18 TRAUMA IF YOU DISRUPT THE PLACENTA AT THAT POINT. THERE WILL
19 BE BLEEDING. AND YOU ARE ALSO -- YOU HAVE GOT VERNIX PARTS,
20 WHITE STUFF ON THE FETUS. THERE IS NOT AS MUCH THAT EARLY IN
21 PREGNANCY.
22 YOU HAVE STILL GOT SOME AMNIOTIC FLUID AROUND. WHEN
23 YOU DISRUPT THE PLACENTA, SOME OF THAT MATERIAL CAN GET INTO
24 THE MATERNAL CIRCULATION, WHICH COULD CAUSE AN AMNIOTIC FLUID
25 EMBOLISM IN THE MOTHER, WHICH IS A VERY SERIOUS SITUATION.

1 Q. IS THERE ANY RISK IN THAT INTERNAL PODALIC VERSION OF
2 CAUSING MATERNAL BLEEDING?
3 A. BECAUSE IF YOU DO SEPARATE THE PLACENTA, ALL THE BLOOD
4 SUPPLY TO THE UTERUS GOES TO THE SURFACE OF THE PLACENTA AND
5 STOPS THERE. IF THE PLACENTA STARTS TO SEPARATE, YOU, IN FACT,
6 HAVE AN ABRUPTION OF A PLACENTA, AND THERE WOULD BE INTERNAL
7 HEMORRHAGE.
8 Q. ABRUPTION OF THE PLACENTA, IS THAT COMPLETE SEPARATION?
9 A. IT COULD BE A PARTIAL OR A TOTAL ABRUPTION. AND A PORTION
10 CAN BE SEPARATED AND A REMAINING PORTION STILL ATTACHED.
11 Q. DOCTOR, WOULD THE DEGREE OF RISK -- YOU'VE TESTIFIED TO THE
12 FACT THAT YOU HAVE DONE THE INTERNAL PODALIC VERSION. AND I
13 ASSUME YOU MEAN IN DELIVERING BABIES?
14 A. CORRECT. IN SIMILAR TIME FRAMES, BECAUSE IF YOU ARE DOING
15 AN INTACT D&X AT 23 OR 24 WEEKS, WHEN WE HAVE TWINS THEY COULD
16 GO INTO LABOR AT 28 WEEKS. THEY ARE VERY CLOSE IN PROXIMITY TO
17 SIZE. AND IF -- I HAVE DONE INTERNAL PODALIC VERSIONS.
18 I HAVE ACTUALLY DELIVERED BOTH OF THEM BREECH. I
19 ACTUALLY DELIVERED THE FIRST BABY WITH INTERNAL PODALIC
20 VERSION, AND THEN DID A BREECH DELIVERY. AND THEN WENT IN AND
21 GRABBED THE SECOND BABY AND DID A BREECH EXTRACTION OF THE
22 SECOND BABY.
23 SO, YES, I HAVE DONE THAT.
24 Q. DOCTOR, YOU QUOTED A COUPLE OF SENTENCES FROM
25 WILLIAMS' OBSTETRICS, THE TEXTBOOK THAT YOU MENTIONED?

1 A. CORRECT.
2 Q. DID YOUR EXPERT REPORT IN THIS CASE QUOTE BOTH OF THOSE
3 SENTENCES?
4 A. CORRECT.
5 Q. AND IS IT YOUR UNDERSTANDING THAT THE SECOND OF THOSE
6 SENTENCES HAS BEEN DROPPED FROM A MORE RECENT EDITION OF
7 WILLIAMS' OBSTETRICS?
8 A. CORRECT.
9 Q. DO YOU HAVE ANY VIEW AS TO WHY THAT SENTENCE WAS DROPPED
10 BETWEEN EDITIONS?
11 A. I HAVE BEEN AN EDITOR AND ASSISTANT EDITOR FOR TEXTBOOKS
12 AND AN EDITOR FOR JOURNALS. AND OFTEN THE NUMBER OF WORDS YOU
13 USE -- YOU WANT TO MAINTAIN A REASONABLE SIZE CHAPTER, A
14 REASONABLE SIZE BOOK.
15 OVER TIME, BECAUSE OF THE CURRENT THINKING AND THE
16 CIRCUMSTANCES AS I SAID BEFORE WHERE I DID BREECH EXTRACTIONS
17 AND INTERNAL PODALIC VERSIONS, MOST LIKELY TODAY THAT WOULD NOT
18 BE THE STANDARD OF CARE. THOSE PATIENTS WOULD HAVE CESAREAN
19 SECTIONS. SO THOSE ARE USED MUCH LESS COMMONLY TODAY. AND
20 WHAT IS DISCUSSED MUCH MORE NOW ARE EXTERNAL VERSION, WHERE YOU
21 TRY TO TURN THE FETUS EXTERNALLY.
22 SO WHAT I BELIEVE THEY DID IS TOOK LESS -- AND THEY
23 STILL INCLUDED PART OF IT, BUT THEY USED LESS BASE FOR THE
24 INTERNAL PODALIC VERSION, WHICH WE REALLY DON'T DO ANYMORE, AND
25 USE THAT SPACE TO TALK MORE ABOUT EXTERNAL VERSION, BECAUSE

1 THAT IS WHAT WE DO TODAY. IT IS MORE CURRENT.
2 Q. IN OBSTETRICS, DOCTOR, YOU SAID THAT NORMALLY THERE WOULD
3 BE EITHER A C-SECTION, OR AN EXTERNAL PODALIC VERSION. WHY HAS
4 THERE BEEN THAT SWITCH FROM INTERNAL PODALIC VERSION TO
5 EXTERNAL?
6 A. THE RISK IS PERCEIVED NOW TO BE GREATER. AND BECAUSE THE
7 RISK IS GREATER, IT IS NOT CONSIDERED A SAFE THING TO DO. SO
8 WE ARE -- OUR CESAREAN SECTION RATE HAS GONE UP. WE BASICALLY
9 DON'T EVEN DO BREECH DELIVERIES FROM BELOW ANYMORE. WE DO --
10 MAYBE NOT BREECH DELIVERIES FROM BELOW. WE DO CESAREAN
11 SECTIONS, SO IT IS NOT RELEVANT TODAY.
12 WHEN A WOMAN HAS A BREECH DELIVERY -- I SHOULDN'T
13 SAY "DELIVERY" -- A BREECH PRESENTATION AND SHE'S 36, 37 WEEKS
14 PREGNANT, WHAT SOME OBSTETRICIANS WILL NOW TRY TO DO IS
15 EXTERNALLY, PHYSICALLY FORCIBLY TRY TO CONVERT THE BREECH
16 PRESENTATION TO A VERTEX PRESENTATION.
17 YOU ARE STILL TRYING TO TURN THE BABY UPSIDE-DOWN,
18 BUT YOU ARE DOING IT EXTERNALLY. AND SO NOW THAT'S WHAT WE ARE
19 DOING. AND SO THEY SPEND A LOT MORE TIME DESCRIBING THAT. AND
20 THEY DESCRIBE THE RISK TO THAT OF ABRUPTION TO THE UTERUS,
21 PULMONARY EMBOLISM, FETAL DEATH.
22 THEY TALK ABOUT ALL THOSE, BUT NOW THEY ARE TALKING
23 ABOUT THEM IN RELATION TO EXTERNAL VERSION, BECAUSE THAT IS
24 WHAT WE DO TODAY.
25 Q. THANK YOU, DOCTOR. YOU MENTIONED, LASTLY, A RISK TO THE

1 PATIENT FROM PIERCING THE BACK OF THE FETAL SKULL IN AN INTACT
2 D&X. WHY DO YOU BELIEVE THAT PRESENTS A RISK TO THE MOTHER?
3 A. AGAIN, SPECIFICALLY USING HASKELL'S DESCRIPTION IN HIS
4 PAPER, WHAT HE -- AS HE DESCRIBES IN DETAIL, IS IF THE HEAD IS
5 TRAPPED AT THE CERVIX, WHAT HE DOES IS TRY TO HOLD -- PUTS SOME
6 TRACTION ON THE FEET, PUT TWO FINGERS ON THE SHOULDERS TO LIFT
7 THE CERVIX SO IT IS OUT OF THE WAY SO IT IS LESS LIKELY TO GET
8 TRAUMATIZED.
9 WITH THE OTHER HAND -- AND MY IMPRESSION WOULD BE IT
10 IS MORE BLINDLY. I AM SURE SOMETIMES IT IS LOW ENOUGH THAT YOU
11 CAN ACTUALLY SEE IT. IF YOU CAN GET ENOUGH TRACTION AND BRING
12 IT DOWN LOW ENOUGH, BUT HIS DESCRIPTION IS THAT BY FEEL YOU
13 FOLLOW THE SPINAL CORD UP THE CENTER TO THE BASE OF THE SKULL.
14 AND THEN BY FEEL, YOU ARE JABBING. NO. "JABBING"
15 IS NOT A GOOD WORD. YOU ARE PUSHING THE SCISSORS THROUGH THE
16 FETAL SKULL.
17 IF YOU STAY DIRECTLY AT THE MIDLINE, THAT IS A
18 RELATIVELY AVASCULAR AREA. IT SHOULD BE RELATIVELY SAFE. BUT
19 WHEN YOU CAN'T SEE THAT WELL WHAT YOU ARE DOING, AND YOU ARE
20 FORCING THEM IN ON THE FETAL SKULL, IT IS CERTAINLY NOT
21 INCONCEIVABLE THAT BECAUSE THE SKULL -- PART OF IT IS BONE --
22 IT CAN SLIDE A LITTLE TO THE LEFT OR TO THE RIGHT.
23 AND IF THAT HAPPENS TO BE THE LOCATION WHERE THE
24 UTERINE ARTERIES COME INTO THE CERVIX, AND IF YOU WERE
25 UNFORTUNATE ENOUGH TO ACTUALLY GO SIDEWAYS IN EITHER DIRECTION,

1 COULD HAVE SIGNIFICANT HEMORRHAGE IN THAT SITUATION.
2 Q. YOU SAID "SIGNIFICANT HEMORRHAGE," AND YOU MENTIONED THE
3 UTERINE ARTERY. DO YOU THINK THERE IS A POTENTIAL FOR ACTUALLY
4 PIERCING THE UTERINE ARTERY?
5 A. I DO BELIEVE THAT POTENTIAL IS THERE. YOU HAVE GOT
6 SCISSORS. YOU HAVE GOT CLOSE PROXIMITY. AND YOU ARE FORCIBLY
7 PUSHING THE SCISSORS THROUGH THE SKULL. IF YOU HIT A SOFT
8 SPOT, THAT SHOULD BE EASY. IF YOU HAPPEN TO GET A FIRM SPOT,
9 THE SCISSORS COULD JUST AS EASILY SLIDE ONE DIRECTION OR THE
10 OTHER.
11 AND A PREGNANT UTERUS AT TERM GETS A PINT OF BLOOD A
12 MINUTE GOING TO IT. SO IT IS LESS THAN THAT AT 23 OR 24 WEEKS,
13 BUT A VERY SIGNIFICANT AMOUNT OF BLOOD SUPPLY.
14 Q. THANK YOU, DOCTOR.
15 DO YOU HAVE AN UNDERSTANDING -- YOU MAY HAVE
16 MENTIONED THIS EARLIER -- DO YOU HAVE AN UNDERSTANDING AS TO
17 THE GESTATIONAL AGE AT WHICH INTACT D&X IS USUALLY USED?
18 A. AGAIN, SPECIFICALLY, IT IS STATED IN HASKELL'S
19 PRESENTATION. AND HE SAYS THIS PROCEDURE IS OFTEN USED IN THE
20 TWENTY -- IN FACT, HE SAYS IT IS CONVENIENT TO USE IN THE 20 TO
21 26 WEEK TIME FRAME.
22 Q. NOW, I BELIEVE YOU SAID EARLIER, DOCTOR, THAT
23 DISARTICULATION OF THE FETUS IN A D&E WOULD BECOME QUITE
24 DIFFICULT, I BELIEVE YOU SAID, AFTER 20 WEEKS?
25 A. IT BECOMES MORE AND MORE DIFFICULT WITH EACH PASSING WEEK

1 AFTER THAT. SOME PEOPLE I KNOW WHO DO THEM ARE EVEN
2 UNCOMFORTABLE AT 18 WEEKS, BECAUSE IT IS HARDER. BUT AT 20
3 WEEKS IT IS HARDER. AT 22 WEEKS, AGAIN, IN READING ONE OF THE
4 DEPOSITIONS FROM THE OHIO CASE, THEY SAID IT WAS VERY DIFFICULT
5 AFTER 22 WEEKS, AND THEY WOULD HAVE A GREAT DEAL OF DIFFICULTY
6 DOING THEM.
7 MS. GARTNER: YOUR HONOR, WE OBJECT TO SOME OF THIS
8 AS HEARSAY.
9 THE COURT: SUSTAINED. CERTAINLY THAT LAST
10 REFERENCE IS.
11 MR. SIMPSON: THANK YOU, YOUR HONOR.
12 BY MR. SIMPSON:
13 Q. DOCTOR, YOU TESTIFIED EARLIER THAT -- AM I CHARACTERIZING
14 THIS CORRECTLY -- THE MOST COMMON METHOD OF ABORTION AFTER 20
15 WEEKS AT YOUR HOSPITAL IS INDUCTION?
16 A. THAT IS CORRECT.
17 Q. DOCTOR, HOW WOULD YOU COMPARE THE SAFETY OR RISKS OF
18 INDUCTION ABORTION VERSUS THE SAFETY OR RISKS OF INTACT D&X?
19 A. PLEASE REPEAT THE QUESTION.
20 Q. HOW WOULD YOU COMPARE THE SAFETY OR RISKS OF INDUCTION
21 ABORTION VERSUS THE SAFETY OR RISKS OF INTACT D&X?
22 A. MY BELIEF IS THAT INDUCTION WOULD BE SAFER. THERE ARE
23 SEVERAL IN CHAPTERS IN TEXTBOOKS THAT WOULD SAY THAT, AS WELL.
24 AND DEPENDING, AGAIN, ON THE EXPERTISE, IN SOME CASES THEY
25 COULD BE COMPARABLE.

1 INDUCTION -- THE REASON I SAY IT IS SAFER BECAUSE
2 YOU ARE BASICALLY TRYING TO CREATE THE SAME PHYSIOLOGIC PROCESS
3 AS A NORMAL LABOR. YOU ARE TRYING TO SOFTEN THE CERVIX, ALLOW
4 THE MOTHER TO GO INTO LABOR, AND THEREBY HAVE THE SAME
5 COMPLICATIONS OF A NORMAL LABOR, BUT NOT EXTRA COMPLICATIONS.
6 AND LESS LIKELY THAT YOU ARE GOING TO NEED ANY INSTRUMENTATION
7 AT ALL, EVEN THOUGH SOMETIMES YOU WOULD.
8 Q. DOCTOR, DO YOU HAVE ANY UNDERSTANDING AS TO THE MEDICAL
9 SETTINGS IN WHICH INTACT D&X IS USUALLY PERFORMED?
10 A. YOU MEAN, WHERE THEY ARE DONE?
11 Q. EXACTLY.
12 A. MY UNDERSTANDING IS THEY ARE USUALLY PERFORMED IN
13 OUTPATIENT CLINICS. THAT MAY NOT ALWAYS BE THE CASE. BUT --
14 MS. GARTNER: OBJECTION, YOUR HONOR. HE HAS NO
15 BASIS FOR THIS TESTIMONY.
16 THE COURT: SUSTAINED.
17 BY MR. SIMPSON:
18 Q. DOCTOR, DO YOU KNOW OF ANY PUBLISHED DATA REGARDING THE
19 SAFETY OR RISKS OF INDUCTION ABORTION?
20 A. I AM AWARE OF PUBLISHED DATA ON INDUCTION ABORTIONS.
21 Q. DO YOU KNOW OF ANY PUBLISHED DATA REGARDING THE SAFETY OR
22 RISKS OF INTACT D&X? I SAID "PUBLISHED."
23 A. I AM NOT AWARE OF ANY PUBLISHED DATA ON THAT.
24 Q. DO YOU KNOW OF ANY PUBLISHED DATA REGARDING THE SAFETY OR
25 RISKS OF D&E?

1 A. I AM AWARE OF PUBLISHED DATA ON THAT.
2 Q. DOCTOR, DO YOU HAVE ANY OPINION REGARDING THE EXTENT TO
3 WHICH EXTENT TO WHICH THE DATA ON D&E COULD BE USED TO INDICATE
4 THE SAFETY OR RISKS OF INTACT D&X?
5 A. I DO BELIEVE THAT THEY ARE TWO DIFFERENT PROCEDURES. AND
6 THE DESCRIPTIONS BY HASKELL SAYS THERE ARE TWO DIFFERENT
7 DESCRIPTIONS. AND THE DESCRIPTIONS IN ACOG AND THE AMA ALL
8 WOULD DESCRIBE THEM AS TWO DIFFERENT PROCEDURES.
9 Q. DOCTOR, ARE YOU FAMILIAR WITH A STUDY BY DR. AUTRY AND
10 OTHERS -- THAT'S A-U-T-R-Y -- COMPARING INDUCTION TO OTHER
11 METHODS OF ABORTION?
12 A. I AM.
13 MR. SIMPSON: MAY I APPROACH THE WITNESS, YOUR
14 HONOR?
15 THE COURT: YES.
16 MR. SIMPSON: I AM GOING TO SHOW THE WITNESS
17 PLAINTIFFS' EXHIBIT LT-5.
18 BY MR. SIMPSON:
19 Q. WE WERE JUST MENTIONING, DOCTOR, A STUDY BY DR. AUTRY AND
20 OTHERS. IS THIS THE AUTRY STUDY THAT WE WERE REFERRING TO?
21 A. CORRECT.
22 Q. DOCTOR, AS I SAID, THIS ARTICLE -- AND I BELIEVE YOU SAID
23 "YES" TO THIS QUESTION -- COMPARES INDUCTION TO OTHER METHODS
24 OF ABORTION.
25 DO YOU HAVE ANY REASONS, DOCTOR, TO QUESTION THE

1 RELIABILITY OF THIS STUDY?
2 A. I DO HAVE SOME QUESTIONS AND CONCERNS WITH THE DATA AND THE
3 CONCLUSIONS.
4 Q. COULD YOU DESCRIBE THOSE, PLEASE?
5 A. I WAS TRAINED TO LOOK AT THE SUMMARY AND ALSO ACTUALLY LOOK
6 AT THE MATERIALS AND THE ACTUAL FACTS. IN THE STUDY THEY HAD
7 297 WOMEN. AND THERE WERE TWO GROUPS. THEY HAD 158 WOMEN IN
8 THE MEDICAL INDUCTION, AND 139 IN THE SURGICAL INDUCTION. THEY
9 COVERED FROM 14 TO 24 WEEKS, AND CERTAINLY MORE OF THE
10 INDUCTIONS WOULD BE DONE IN THE LATER TIME FRAMES. THERE ARE
11 SOME VARIATIONS THERE.
12 ONE CONCERN IN MOST STUDIES -- IT IS A RETROSPECTIVE
13 STUDY, SO IT IS NEVER QUITE AS CONSIDERED AS EVIDENCE-BASED AS
14 OTHER STUDIES.
15 A MAJOR CONCERN I HAD WAS IN THEIR DEFINITION OF
16 WHAT THEY CALL "COMPLICATIONS." AND THEY DO DISCUSS THAT
17 THEMSELVES IN THE CONCLUSIONS. DIFFERENT PEOPLE MIGHT USE
18 DIFFERENT DEFINITIONS OF WHAT A COMPLICATION IS.
19 MY MAIN CONCERN IN THIS PARTICULAR STUDY IS THAT
20 THEY SAID THAT IF YOU STARTED THE MEDICAL INDUCTION AND HAD
21 REMAINING PLACENTAL TISSUE AND NEEDED TO REMOVE THAT IN ANOTHER
22 FASHION, THAT WAS A COMPLICATION.
23 IT IS COMMONLY RECOGNIZED IN MEDICAL INDUCTIONS THAT
24 TEN TO TWENTY PERCENT OF THE TIME THERE MAY STILL BE PLACENTA
25 LEFT. IN MY HANDS OR MY INSTITUTIONS THAT WOULD EASILY JUST BE

1 THEY ARE TWEEZED OUT WITH YOUR FINGERS OR RIGHT IN THE DELIVERY
2 ROOM TAKE A SHARP CURETTE AND FINISH THE PROCEDURE.
3 Q. WHAT OTHER CONCERNS DO YOU HAVE ON THIS?
4 A. THE REASON THAT IS A VERY, VERY MAJOR ONE IS THAT
5 75 PERCENT OF THE COMPLICATIONS WERE THAT. SO IF YOU TAKE THAT
6 PART OUT, IT'S -- THERE IS NOWHERE NEAR THE DIFFERENCE IN THE
7 COMPLICATIONS.
8 THEY ALSO LOOKED AT -- THERE WAS AN UTERINE
9 PERFORATION, AND IT STARTED OUT AS AN INDUCTION, BUT THEN THE
10 UTERINE PERFORATION OCCURRED WHEN THEY WENT AHEAD AND DID A
11 D&E.
12 SO IT'S ACTUALLY THE INDUCTION DIDN'T CAUSE THE
13 PERFORATION; THE D&E DID.
14 THEY ALSO -- AND THEY SAY THIS IN THEIR PAPER -- THE
15 INDUCTION PATIENTS ARE IN THE HOSPITAL WHERE THEY HAVE A
16 HOSPITAL CHART AND MORE CAREFUL FOLLOW-UP.
17 WHEN YOU ARE DOING D&E'S, MOST COMMONLY AND IN THIS
18 CASE, THEY WERE DONE IN OUTPATIENT CLINICS. AND OFTEN YOU
19 DON'T HAVE THE SAME FOLLOW-UP ON THOSE PATIENTS.
20 AGAIN, PERSONAL EXPERIENCE AND IN SUMMARIES THAT I
21 HAVE SEEN SPECIFICALLY THERE IS MAYBE A 30 PERCENT FOLLOW-UP.
22 SO THE D&E PROCEDURES MAY HAVE HAD COMPLICATIONS
23 THAT DID NOT GET PICKED UP BECAUSE THOSE PHYSICIANS (SIC) WENT
24 BACK TO THEIR INITIAL PRIMARY CARE PHYSICIAN. AND, AGAIN,
25 PERSONAL EXPERIENCE --

1 MS. GARTNER: OBJECTION, YOUR HONOR.
2 THE WITNESS: -- AND CHARTS AND ARTICLES SAY THAT.
3 THE COURT: EXCUSE ME. SHE IS ENTITLED TO MAKE AN
4 OBJECTION, OKAY?
5 THE WITNESS: OH, I DIDN'T -- I AM SORRY.
6 THE COURT: LET ME HEAR WHAT THE OBJECTION IS, AND
7 THEN I WILL RULE ON IT.
8 THE WITNESS: I AM SORRY.
9 MS. GARTNER: I AM SORRY, YOUR HONOR. HE'S
10 SPECULATING ABOUT WHETHER OR NOT THERE WAS FOLLOW-UP, AND HE
11 SHOULDN'T BE SPECULATING ABOUT THAT.
12 THE COURT: DO YOU HAVE A RESPONSE?
13 MR. SIMPSON: COULD I ASK THE WITNESS A QUESTION OR
14 TWO TO, I THINK, TAKE CARE OF THAT PROBLEM?
15 THE COURT: OKAY.
16 BY MR. SIMPSON:
17 Q. DOCTOR, YOU TESTIFIED THAT YOU HAVE TREATED COMPLICATIONS
18 FROM ABORTIONS THAT WERE PROVIDED ELSEWHERE. DO YOU KNOW IN
19 WHAT SETTINGS THOSE ABORTIONS WERE PROVIDED?
20 A. CORRECT.
21 Q. WHERE WERE THEY PROVIDED?
22 A. THE ABORTIONS WERE PROVIDED IN OUTPATIENT CLINICS, AND THEN
23 THE FOLLOW-UP WAS DONE IN THE PRIMARY CARE PHYSICIAN'S OFFICE.
24 Q. I AM SORRY. WHAT WE ARE TALKING ABOUT ARE CASES IN WHICH
25 YOU HAD TREATED COMPLICATIONS OF ABORTION. DO YOU KNOW IN

1 THOSE CASES WHERE YOUR PATIENTS RECEIVED THE ABORTIONS?
2 A. IN ABORTION CLINICS.
3 Q. IS IT YOUR VIEW, THEN, DOCTOR THAT D&E ABORTIONS ARE
4 NORMALLY PROVIDED IN ABORTION CLINICS?
5 A. CORRECT.
6 THE COURT: ALL RIGHT. WERE WE TALKING SPECIFICALLY
7 ABOUT -- MS. GARTNER, ARE WE TALKING SPECIFICALLY ABOUT WHAT IS
8 REFLECTED IN THE AUTRY REPORT? IS THAT WHAT YOUR OBJECTION IS?
9 MS. GARTNER: YES, YOUR HONOR, THAT HE CAN'T SAY
10 ANYTHING BASED ON THE AUTRY REPORT ABOUT WHETHER OR NOT
11 PARTICULAR PATIENTS GOT FOLLOW-UP IN A PARTICULAR LOCATION.
12 THE COURT: WELL, THAT DOESN'T REALLY TAKE CARE OF
13 THE PROBLEM WITH SPECULATION AND WITH RESPECT TO THE WOMEN THAT
14 ARE REPRESENTED IN THIS REPORT, COUNSEL, SO I WILL SUSTAIN THE
15 OBJECTION.
16 MR. SIMPSON: ALL RIGHT.
17 BY MR. SIMPSON:
18 Q. THE IMPORTANT PART -- LET ME ASK THE WITNESS A CONTINUING
19 QUESTION, PLEASE.
20 DOCTOR, DOES THE AUTRY STUDY INDICATE THAT THE D&E
21 ABORTIONS UNDER STUDY THERE WERE PERFORMED IN ABORTION CLINICS?
22 A. IT DOES SAY THEY WERE IN ABORTION CLINICS. IT DOES SAY
23 THEY HAD TROUBLE WITH FOLLOW-UP.
24 Q. AND DOES IT SAY THAT THE INDUCTION ABORTIONS UNDER STUDY
25 HERE WERE PERFORMED IN A HOSPITAL?

1 A. CORRECT.
2 Q. DOCTOR, ONE OTHER QUESTION ABOUT THAT STUDY: IS THERE ANY
3 DIFFERENCE IN YOUR UNDERSTANDING BETWEEN IN THE RECORDKEEPING
4 BY HOSPITALS VERSUS CLINICS?
5 A. YES. AND I HAVE SEEN THE CHARTS FROM BOTH HOSPITALS AND
6 FROM ABORTION CLINICS. AND THE CHARTS IN HOSPITALS BY --
7 BECAUSE OF ALL THE HOSPITAL REGULATIONS -- ARE MUCH MORE
8 EXTENSIVE, MUCH MORE THOROUGH. AND I HAVE SEEN CHARTS FROM
9 ABORTION CLINICS WHICH HAVE MUCH LESS INFORMATION ON IT.
10 Q. DOCTOR, ARE YOU AWARE OF ANY UNPUBLISHED STUDIES -- YES OR
11 NO -- REGARDING THE SAFETY OF INTACT D&X?
12 A. I AM AWARE OF A NONPUBLISHED STUDY.
13 MR. SIMPSON: I WOULD LIKE TO SHOW THE WITNESS WHAT
14 HAS BEEN MARKED AS PLAINTIFFS' EXHIBIT 19.
15 AND, FOR THE RECORD, THIS IS AN ARTICLE IN PRESS
16 SCHEDULED FOR PUBLICATION IN AN UPCOMING ISSUE OF THE AMERICAN
17 JOURNAL OF OBSTETRICS AND GYNECOLOGY, COPYRIGHT 2004, ELSEVIER.
18 I SHOULD ALSO SAY ON THIS DOCUMENT, YOUR HONOR -- I
19 HOPE THIS DOESN'T CREATE A PROBLEM -- BECAUSE THE WITNESS IS
20 ACCUSTOMED TO SEEING THE MANUSCRIPT VERSION OF EXHIBIT 19, THAT
21 IS THE ONE I HAVE SHOWN TO THE WITNESS. I KNOW THAT
22 PLAINTIFFS' COUNSEL HAS REPLACED THAT WITH A PROOF VERSION.
23 BUT IF IT IS ALL RIGHT WITH THE COURT, I WOULD LIKE TO REFER TO
24 THE MANUSCRIPT VERSION.
25 THE COURT: AS LONG AS WE CAN FOLLOW, THAT IS FINE.

1 BY MR. SIMPSON:
2 Q. DOCTOR, HAVE YOU SEEN EXHIBIT 19 BEFORE?
3 A. I HAVE.
4 Q. CAN YOU JUST SUMMARIZE FOR US, PLEASE, DOCTOR, VERY
5 BRIEFLY, HOW THAT STUDY WAS CONSTRUCTED AS DESCRIBED IN
6 EXHIBIT 19?
7 A. IT WAS, AGAIN, DESIGNED AS A RETROSPECTIVE REVIEW OF
8 PATIENTS WHO UNDERWENT SURGICAL ABORTIONS EQUAL TO OR GREATER
9 THAN 20 WEEKS FROM '96 TO 2003.
10 IT IS MY UNDERSTANDING IT ADDED ADDITIONAL PATIENTS,
11 BUT THEY ALSO USED THE PATIENTS FROM A PREVIOUS STUDY AND
12 COMBINED THAT DATA. THEY LOOKED AT 383 PATIENTS FROM BOTH NEW
13 DATA AND OLD DATA IN THE OLD STUDY.
14 D&X WAS PERFORMED IN 120 OF THESE, AND D&E WAS
15 PERFORMED IN 263. THEY THEN LOOKED AT -- TRIED TO COMPARE THE
16 COMPLICATION RATES OF THE TWO. AND THEN, THEY WENT FURTHER AND
17 LOOKED AT A RELATIVELY SMALL NUMBER OF PATIENTS WHO HAD THESE
18 PROCEDURES WHO ALSO HAPPENED TO DELIVER IN THEIR INSTITUTION.
19 SO THEY ONLY LOOKED AT THOSE PATIENTS, NOT THE
20 ENTIRE PATIENT POPULATION. AND THEN, THEY LOOKED AT THOSE
21 PATIENTS AND SAW WHAT HAPPENED TO THEM SUBSEQUENTLY AND TRIED
22 TO TRACK IF THEY WERE PREGNANT LATER; WHAT WAS THE OUTCOME IN
23 THAT PREGNANCY; AND THEN, TRIED TO COMPARE THAT INFORMATION, AS
24 WELL.
25 Q. DOCTOR, WHAT IS YOUR UNDERSTANDING AS TO WHICH -- YOU'VE

1 MENTIONED PRE-TERM LABOR. WHAT -- OTHER THAN PRE-TERM LABOR,
2 WHAT OTHER OUTCOMES WERE THE AUTHORS TRYING TO STUDY?
3 A. THEY LOOKED AT THE LENGTH OF TIME OF THE PROCEDURE. THEY
4 LOOKED AT THE BLOOD LOSS. THE COMPARED THINGS LIKE GESTATIONAL
5 AGE AND CERVICAL DILATATION.
6 BUT I THINK THEY SAID THOSE WERE THE END POINTS THEY
7 WERE LOOKING AT.
8 Q. DOCTOR, DO YOU HAVE ANY OPINIONS REGARDING THE METHODOLOGY
9 OF THIS STUDY?
10 A. YES, I DO.
11 Q. CAN YOU EXPLAIN THOSE TO US, PLEASE?
12 A. MY CONCERNS, AGAIN, WERE THEN ON EXACTLY WHO THE INCLUSION
13 CRITERIA OR WHO IS INCLUDED. THE TOTAL NUMBERS IN COMPILING
14 TWO DIFFERENT STUDIES, THERE MAY BE ONE OBJECTIVE IN THE FIRST
15 STUDY, AND THEN ANOTHER OBJECTIVE OR PRIMARY END POINT, SO YOU
16 ARE KIND OF MIXING THAT SOMEWHAT, BECAUSE ULTIMATELY THE ONES
17 THAT WERE THE MOST INTERESTED AND ALSO DELIVERED AT THEIR
18 HOSPITAL, YOU STARTED GETTING VERY SMALL NUMBERS.
19 AND AS THEY DESCRIBE IN THEIR ARTICLE THAT THE STUDY
20 HAS NO POWER. BY THAT, I MEAN THE NUMBERS ARE SO SMALL THAT
21 YOU CAN'T MAKE STATISTICALLY SIGNIFICANT DIFFERENCES FROM ONE
22 ARM OF THE STUDY OR THE OTHER.
23 Q. DO THE AUTHORS REFER TO THAT LACK OF POWER IN THE ARTICLE?
24 A. THEY DO. THEY ACKNOWLEDGE THE LACK OF POWER IN THAT MOST
25 OF THE INFORMATION IS NOT STATISTICALLY SIGNIFICANT, WHICH IS

1 UNUSUAL FOR A STUDY.
2 THEY ALSO DID KIND OF AVERAGE OUT SOME OF THE
3 NUMBERS AND GAVE SOME NUMBERS, BUT THEN THEY KIND OF CONCLUDED
4 THAT THEY WERE SIMILAR, AND, THEREFORE, KIND OF NOT WORTHY OF
5 DISTINCTION. AS I LOOK AT THE NUMBERS, THEY DON'T LOOK VERY
6 SIMILAR TO ME. AND, AGAIN, I WAS TAUGHT TO LOOK AT THE
7 MATERIAL, NOT JUST THE CONCLUSIONS THAT THE AUTHOR CHOSE TO
8 MAKE.
9 AND IF I LOOK AT THE SAME DATA, THESE ARE NOT THE
10 CONCLUSIONS I WOULD COME TO.
11 Q. DOCTOR, IF I COULD HAVE YOU RETURN TO THE -- TURN TO THE
12 "RESULTS" SECTION THAT STARTS AT THE BOTTOM OF PAGE 6. THEN, I
13 WOULD LIKE TO READ A FEW SENTENCES FROM PAGE 7 IN THE "RESULTS"
14 SECTION.
15 AND, IN FACT -- WELL, I SHOULD PROBABLY ASK YOU
16 ABOUT THIS, PLEASE, DOCTOR.
17 ON PAGE 7, THE SECOND FULL PARAGRAPH, WHAT DO THE
18 AUTHORS SAY ABOUT THEIR COMPARISON OF PROCEDURE TIMES AND
19 ESTIMATED BLOOD LOSS?
20 DO YOU SEE WHERE I AM? IT'S THE PARAGRAPH THAT
21 STARTS: "INTRAOPERATIVE VARIABLES."
22 A. "NO DIFFERENCES WERE NOTED IN PROCEDURE TIME OR ESTIMATED
23 BLOOD LOSS BETWEEN THE TWO GROUPS."
24 Q. NOW, WHY WOULD THOSE OUTCOMES BE RELEVANT IN COMPARING D&E
25 AND INTACT D&X?

1 A. OBVIOUSLY, SOME PEOPLE MAY SAY D&E IS BETTER. SOME PEOPLE
2 MAY SAY D&X IS BETTER. AT LEAST IN THOSE TWO CRITERIA THEY
3 LOOKED AT, THEY WERE COMPARABLE.
4 Q. DOES THIS STUDY PROVE, THEN, THAT D&E AND D&X WILL
5 GENERALLY RESULT IN EQUAL PROCEDURE TIME AND EQUAL BLOOD LOSS?
6 A. IT TENDS TO DO THAT. BUT, AGAIN, BECAUSE THE NUMBERS ARE
7 SMALL AS THEY ARE, I WOULD SAY LIKE IN MOST THINGS IN MEDICINE
8 WILL REQUIRE ADDITIONAL STUDIES TO SEE IF THESE IDEAS ARE
9 CONFIRMED.
10 IT'S -- IT WOULD BE WORTHY OF KIND OF ANOTHER STUDY,
11 A BIGGER STUDY WITH MORE POWER TO KIND OF ACTUALLY KNOW WHAT IS
12 GOING ON.
13 Q. DOCTOR, IF I COULD REFER YOU ALSO TO THE BOTTOM HALF OF
14 THAT SAME PAGE, PAGE 7. AND AM I READING THIS CORRECTLY?
15 THERE IS A PARAGRAPH THAT STARTS "IN THE ENTIRE GROUP," AND
16 THEN I AM LOOKING BOTH AT THAT PARAGRAPH AND THE NEXT
17 PARAGRAPH. AM I READING THIS CORRECTLY THAT THERE WERE FOUR
18 GENITAL TRACT LACERATIONS IN THE D&X COHORT AND FOUR GENITAL
19 TRACT LACERATIONS IN THE D&E COHORT?
20 A. THAT IS CORRECT.
21 Q. DOES THAT MEAN THAT THE RATE OF GENITAL TRACT LACERATIONS
22 WERE THE SAME IN THE TWO COHORTS?
23 A. IT DOES NOT, BECAUSE THERE WERE DIFFERENT NUMBERS OF CASES
24 IN EACH OF THOSE. IF YOU ACTUALLY BREAK THEM DOWN IN A
25 PERCENTAGE BASIS, WHICH WOULD BE THE MORE APPROPRIATE WAY TO DO

1 IT, THERE WERE ACTUALLY 3.3 PERCENT GENITAL TRACT LACERATIONS
2 IN THE D&X, AND ONE-AND-A-HALF PERCENT GENITAL LACERATIONS IN
3 THE D&E, WHICH WOULD, IF ANYTHING, NOT BE STATISTICALLY
4 SIGNIFICANT BECAUSE THE NUMBERS ARE SO SMALL.
5 BUT THE TREND WOULD SAY THAT D&X HAS GREATER TRAUMA
6 TO THE GENITAL TRACT, WHICH IS ONE OF OUR CONCERNS.
7 Q. DOCTOR, IF I COULD REFER YOU, ALSO, TO PAGE 8, PLEASE, THE
8 NEXT PAGE. I AM GOING TO READ THE FIRST FULL PARAGRAPH ON THAT
9 PAGE. IT STARTS OUT "THREE PATIENTS." ARE YOU WITH ME?
10 A. CORRECT.
11 Q. "THREE PATIENTS, ALL OF WHOM UNDERWENT DILATION AND
12 EVACUATION, HAD COMPLICATIONS REQUIRING ADMISSION TO
13 THE SURGICAL INTENSIVE CARE UNIT. ONE PATIENT, WITH
14 A FETAL DEMISE, HAD AN AMNIOTIC FLUID EMBOLUS WITH
15 DISSEMINATED INTRAVASCULAR COAGULATION REQUIRING
16 TRANSFUSION OF BLOOD AND CLOTTING FACTORS. ONE
17 PATIENT WAS DIAGNOSED WITH SEPSIS AND PULMONARY
18 EMBOLUS. ONE PATIENT HAD A UTERINE PERFORATION AT
19 THE SITE OF A CESAREAN DELIVERY SCAR, AND REQUIRED
20 EXPLORATORY LAPAROTOMY AND BLOOD TRANSFUSION."
21 DID I READ THAT CORRECTLY?
22 A. CORRECT.
23 Q. DOCTOR, THESE ARE THE MOST SERIOUS COMPLICATIONS REPORTED
24 IN THE STUDY, CORRECT?
25 A. CORRECT.

1 Q. DOES THIS PARAGRAPH MEAN THAT SERIOUS COMPLICATIONS ARE
2 MORE LIKELY WITH D&E THAN WITH D&X?
3 A. YOU CAN'T COME TO THAT CONCLUSION STATISTICALLY IN ANY WAY
4 OR I AM SURE THEY WOULD HAVE PRESENTED THAT. THESE
5 COMPLICATIONS ARE SO UNCOMMON YOU WOULD PROBABLY NEED THOUSANDS
6 OF PATIENTS IN BOTH ARMS TO SEE IF THERE ARE ANY STATISTICALLY
7 SIGNIFICANT DIFFERENCE. THESE ARE THINGS THAT ARE JUST, I
8 WOULD SAY, A FLUKE.
9 THE DISSEMINATED INTRAVASCULAR COAGULATION WAS, AS
10 THEY POINTED OUT, WAS IN A DEAD FETUS, AND IF THERE WAS --
11 THE COURT REPORTER: I'M SORRY --
12 THE WITNESS: -- AND IT WOULD BE RELATED TO THAT,
13 AND NOT RELATED TO THE PROCEDURE. AND I THINK IN THIS PAPER
14 THEY IN NO WAY BROUGHT UP THAT THEY CONTINUALLY THOUGHT THE
15 DIFFERENCE IN THE PROCEDURE WAS THE CAUSE OF THESE.
16 SO IT IS JUST THE STUDY DOES NOT HAVE ANYWHERE NEAR
17 ENOUGH NUMBERS TO LOOK AT THINGS THAT ARE THIS RARE TO SAY
18 THERE IS NO MEANINGFUL DIFFERENCE.
19 BY MR. SIMPSON:
20 Q. THE NEXT PARAGRAPH ON PAGE 8, WHICH IS THE SECOND FULL
21 PARAGRAPH ON THE PAGE, IF I COULD READ THE FIRST PART OF THAT:
22 "45 WOMEN (17.1 PERCENT) IN THE DILATION AND
23 EVACUATION GROUP AND 17 WOMEN (15.0 PERCENT) IN THE
24 INTACT DILATION AND EVACUATION (SIC) GROUP HAD A
25 SUBSEQUENT PREGNANCY AND RECEIVE CARE IN OUR MEDICAL

1 CENTER. THERE WERE NO SECOND-TRIMESTER SPONTANEOUS
2 ABORTIONS IN EITHER GROUP. SPONTANEOUS PRE-TERM
3 BIRTH" -- IF I COULD STOP THERE FOR A MOMENT,
4 DOCTOR, CAN YOU EXPLAIN TO US THE DIFFERENCE BETWEEN
5 SPONTANEOUS ABORTION AND SPONTANEOUS PRE-TERM BIRTH?
6 A. TYPICALLY BY PROTOCOL SPONTANEOUS ABORTION WOULD HAVE TO
7 HAPPEN BEFORE 20 WEEKS. ONCE YOU GO BEYOND 20 WEEKS IT WOULD
8 BE CONSIDERED A PRE-TERM LABOR.
9 Q. OKAY. CONTINUING ON QUOTATION:
10 "SPONTANEOUS PRE-TERM BIRTH OCCURRED IN
11 SEVEN" -- OR, I AM SORRY -- "2 OF 17 (11.8 PERCENT)
12 PREGNANCIES IN THE INTACT DILATION AND EXTRACTION
13 GROUP COMPARED TO 2 OF 45 (4.4 PERCENT) IN THE
14 DILATION AND EVACUATION GROUP."
15 DOCTOR, IS THIS DIFFERENCE IN THE RATE OF
16 SPONTANEOUS PRE-TERM BIRTHS STATISTICALLY SIGNIFICANT IN THE
17 CONTEXT OF THIS STUDY?
18 A. AGAIN, BECAUSE THE NUMBERS WERE SO SMALL, IT DOESN'T HAVE
19 THE POWER TO DEMONSTRATE THAT. YOU CAN SEE THAT BY THE FACT
20 THAT THEY SAID THE P VALUE WAS .3. FOR IT TO BE A
21 STATISTICALLY SIGNIFICANT THE P VALUE WOULD HAVE TO BE UNDER
22 .05. AND YOU CAN'T DEMONSTRATE THAT WHEN YOU HAVE SUCH SMALL
23 NUMBERS.
24 Q. CAN YOU DRAW ANY INFERENCES AT ALL FROM THESE FIGURES?
25 A. WHAT I WOULD HAVE TO SAY IS, AGAIN, YOU ARE SAYING THAT

1 11.8 PERCENT, ALMOST 12 PERCENT OF WOMEN WHO HAD AN INTACT D&X
2 HAD A PREMATURE LABOR AND DELIVERY.
3 THE WOMEN WHO HAD A D&E, 4.4 PERCENT HAD A PREMATURE
4 LABOR AND DELIVERY. THAT IS ALMOST A THREE-TO-ONE INCREASE.
5 IT IS CLEARLY A TREND. IT WOULD CERTAINLY GET MY INTEREST AND
6 I WOULD BE CONCERNED. AND, AGAIN, IF ANYTHING, IT WOULD TEND
7 TO SAY D&X IS MORE RISKY FOR THE MOTHER AND MORE LIKELY TO
8 CAUSE PREMATURE LABOR, WHICH IS ONE THE MOST SERIOUS
9 COMPLICATIONS IN OBSTETRICAL SITUATIONS.
10 Q. DOCTOR --
11 A. IT IS NOT STATISTICALLY SIGNIFICANT, BUT IT IS CERTAINLY A
12 TREND THAT WE SHOULD LOOK AT. AND, AGAIN, FURTHER STUDIES
13 SHOULD BE CARRIED OUT, BECAUSE IF THIS TREND IS TRUE THAT WOULD
14 BE STRONG EVIDENCE THAT INTACT D&X IS NOT AS SAFE FOR THE
15 MOTHER.
16 Q. DOCTOR, IS IT YOUR UNDERSTANDING THAT THE CHASEN ARTICLE
17 HAS NOT YET BEEN PUBLISHED?
18 A. TO MY KNOWLEDGE IT HAS NOT BEEN.
19 Q. DOES THAT STATUS AFFECT AT ALL YOUR VIEWS TO THE STRENGTH
20 OF THE STUDY?
21 A. THE REASON WE LIKE TO ACTUALLY REVIEW PUBLISHED STUDIES IS
22 THEN THEY ARE OUT IN THE GENERAL MEDICAL COMMUNITY. IN A STUDY
23 LIKE THIS IT WOULD DEFINITELY BE DISCUSSED AT JOURNAL CLUBS.
24 YOU GET MORE INPUT AND FEELING OF THE MEDICAL COMMUNITY ON THE
25 SIGNIFICANCE OF THIS. AND SOMETIMES CONTROVERSIAL ARTICLES

1 EVEN GENERATE LETTERS TO THE EDITOR. YOU WILL HAVE MORE
2 DISCUSSION AND MORE FEEDBACK ON THE ISSUES AT HAND.
3 Q. DOCTOR, BEFORE WE LEAVE THE CHASEN STUDY, IF I CAN ASK YOU
4 TO TURN TO PAGE 4.
5 THE THIRD PARAGRAPH THERE STARTS OUT:
6 "A VARIANT OF DILATION AND EVACUATION."
7 DO YOU SEE THAT?
8 A. I SEE THAT.
9 Q. IN DESCRIBING INTACT D&X IN THAT PARAGRAPH, DO THE AUTHORS
10 REFER TO TURNING THE LIE OF THE FETUS?
11 A. CORRECT.
12 Q. AND WHAT TERM DO THEY USE TO REFER TO THAT MANEUVER?
13 A. INTERNAL PODALIC VERSION.
14 Q. DOCTOR, IN YOUR PRACTICE HAVE YOU EVER CONSIDERED WHETHER A
15 PARTICULAR PREGNANCY SHOULD BE TERMINATED BECAUSE OF THE
16 MOTHER'S HEALTH CONDITION?
17 A. I NEVER HAD A PATIENT THAT WAS THAT SICK THAT WE HAD TO DO
18 IT. I HAVE HAD PATIENTS WITH BREAST CANCER, WITH SITUATIONS
19 THAT THERE WAS A SERIOUS CONSIDERATION.
20 IN THOSE CIRCUMSTANCES WHERE THEY WERE IN THE
21 PREGNANCY AND CAREFUL DISCUSSION WITH THE CHEMOTHERAPIST AND
22 MEDICAL ONCOLOGIST, SURGICAL ONCOLOGIST AND THE MOTHER'S
23 WISHES, WE CARRIED THE PREGNANCY FAR ENOUGH ALONG TO BE
24 RELATIVELY SURE THE FETUS WOULD SURVIVE, DID THE DELIVERY AND
25 TERMINATED THE PREGNANCY IN A DELIVERY MODE WITH A VIABLE

1 FETUS.

2 AND THEN, THE MOTHER WENT TO ADDITIONAL CHEMOTHERAPY

3 AND ADDITIONAL THINGS WERE DONE.

4 Q. SO YOU HAVE NEVER ENCOUNTERED A SITUATION WHERE THE

5 PREGNANCY HAD TO BE TERMINATED BEFORE VIABILITY BECAUSE OF A

6 MATERNAL HEALTH CONDITION?

7 A. I HAVE NOT.

8 Q. YOU MAY HAVE SAID THIS ALREADY, DOCTOR. HOW MANY LIVE

9 BABIES HAVE YOU DELIVERED?

10 A. WELL OVER 3,000.

11 Q. DOCTOR, HAVE YOU EVER CONSIDERED WHETHER A PARTICULAR

12 PREGNANCY SHOULD BE TERMINATED BECAUSE OF A FETAL ANOMALY?

13 A. THERE I HAVE HAD PATIENTS THAT I DO GENETIC AMNIOCENTESIS.

14 I DO GET THE INFORMATION BACK AT 18, 19 WEEKS. I HAVE HAD

15 PATIENTS WHO, BECAUSE OF THE INFORMATION THAT WAS RECEIVED,

16 HAVE DECIDED TO TERMINATE THE PREGNANCY.

17 AND THEY ARE REFERRED TO MY MATERNAL FETAL MEDICINE

18 PHYSICIANS. AND THOSE ARE CARRIED OUT.

19 Q. DOCTOR, ARE THERE MATERNAL HEALTH CONDITIONS FOR WHICH A

20 TERMINATION OF PREGNANCY WOULD BE INDICATED TO SAVE THE LIFE OF

21 THE MOTHER?

22 A. THERE ARE. THERE ARE FORTUNATELY VERY FEW AND FAR BETWEEN,

23 AND VERY REMOTE. MOST OF THE TIME AS BOTH IT SAYS IN MY

24 ARTICLE AND IN MY QUOTES FROM STUBBLEFIELD'S CHAPTER, THAT

25 THERE ARE VERY FEW INDICATIONS IF YOU ARE IN THE TIME FRAME AT

1 ALL CLOSE TO 20 WEEKS WHERE YOU COULDN'T WAIT A FEW WEEKS.
2 I AM SURE A GREATER CHANCE OF VIABILITY OF THE FETUS
3 AT 25 WEEKS IN MY INSTITUTION THE FETUS HAS AN 80 PERCENT
4 SURVIVABILITY, AND THEN JUST DELIVER THE CHILD. SO YOU DON'T
5 NEED TO KILL THE FETUS. YOU JUST NEED TO REMOVE THE FETUS FROM
6 THE MOTHER SO THAT WHATEVER NEGATIVE EFFECTS THAT PREGNANCY IS
7 HAVING ON THE MOTHER ARE RESOLVED.
8 THAT WOULD BE THE MOST COMMON CASE. YOU -- THIS
9 COULD BE SERIOUS ENOUGH, CARDIAC CONDITIONS OR SOMETHING THAT
10 COULD HAPPEN EARLIER THAN THAT, WHERE IT MAY NOT BE FEASIBLE TO
11 GO AHEAD. AND IN THAT CASE, AN ABORTION MAY HAVE -- MAY BE
12 BENEFICIAL TO THE MOTHER. AND IN THAT CASE, IT WOULD BE
13 CARRIED OUT.
14 Q. DOCTOR, ARE YOU AWARE OF ANY MATERNAL HEALTH CONDITIONS
15 THAT WOULD REQUIRE TERMINATING PREGNANCY BY THE INTACT D&X
16 METHOD?
17 A. AND AFTER CAREFUL REVIEW AND AFTER SITTING ON BOTH THE
18 ACOG -- CORRECTION -- AMA TASK FORCE, WE COULD NOT FIND ANY
19 MEDICAL CONDITIONS THAT WOULD REQUIRE AN INTACT D&X.
20 THE ACOG PANEL COULD NOT COME UP WITH ANY SITUATIONS
21 THAT WOULD REQUIRE AN INTACT D&X. AND, IN FACT, IN READING
22 EACH OF THE NUMEROUS DECLARATIONS AND DEPOSITIONS I HAVEN'T
23 SEEN ANY PHYSICIAN --
24 MS. GARTNER: YOUR HONOR --
25 THE WITNESS: -- ANY EXPERT --

1 MS. GARTNER: -- THIS IS HEARSAY FOR HIM TO BE
2 TESTIFYING ABOUT WHAT OTHER PHYSICIANS SAID IN THEIR
3 DECLARATIONS OR DEPOSITIONS.
4 THE COURT: SUSTAINED.
5 BY MR. SIMPSON:
6 Q. DOCTOR, IN YOUR PRACTICE HAVE YOU SEEN A NEED FOR THE USE
7 OF THE INTACT D&X METHOD?
8 A. I HAVE NEVER SEEN A SITUATION WHERE AN INTACT D&X METHOD
9 WAS NECESSARY TO BE PERFORMED.
10 Q. WE MENTIONED EARLIER CONDITIONS WHERE PREGNANCY TERMINATION
11 MAY BE INDICATED TO SAVE THE LIFE OF THE MOTHER. ARE THERE
12 ALSO MATERNAL HEALTH CONDITIONS FOR WHICH TERMINATION OF
13 PREGNANCY WOULD BE INDICATED TO PRESERVE THE HEALTH OF THE
14 MOTHER?
15 A. THAT IS POSSIBLE.
16 Q. DOCTOR, DOES YOUR PRACTICE INVOLVE HIGH RISK OBSTETRICS AT
17 ALL?
18 A. MY PRACTICE DOES INVOLVE HIGH RISK PRACTICE.
19 Q. WHAT IS HIGH RISK OBSTETRICS?
20 A. DEPENDING -- AND THERE ARE VARIOUS DEFINITIONS, BUT THE
21 SEVERITY OF THE PATIENT, DIABETES IN PREGNANCIES, SOME HEART
22 CONDITIONS.
23 I HAVE A PATIENT NOW THAT HAS A BILIARY -- IT IS THE
24 TRACT FROM THE LIVER -- AND HAS SIGNIFICANT POTENTIAL RISK.
25 BUT SHE HAS BEEN A PATIENT OF MINE. THIS IS A NOT USUAL

1 CONDITION. I HAD HER SEE A MATERNAL FETAL MEDICINE PHYSICIAN
2 IN CONSULTATION, BUT SHE RETURNS TO ME FOR CARE.
3 WHEN WE STARTED, THE SUBSPECIALTY OF MATERNAL FETAL
4 MEDICINE DID NOT EVEN EXIST. SO INITIALLY WE WERE THE TREATING
5 MATERNAL FETAL MEDICINE PHYSICIANS DE FACTO.
6 Q. DOCTOR, HOW MANY PHYSICIANS ARE THERE IN YOUR PRACTICE
7 GROUP?
8 A. THERE ARE, IN MY WIDER GROUP, 28 OBSTETRICIANS AND
9 GYNECOLOGISTS.
10 Q. HAVE YOU HEARD OF ANY CIRCUMSTANCES IN YOUR PRACTICE GROUP
11 THAT CALL FOR THE USE OF INTACT D&X?
12 A. I HAVE NOT.
13 Q. DOCTOR, ARE THERE EMERGENCY SITUATIONS IN WHICH A FETUS OR
14 INFANT MUST BE REMOVED AS QUICKLY AS POSSIBLE TO SAVE THE
15 MOTHER'S LIFE OR HEALTH?
16 A. THERE COULD BE ACUTE HEMORRHAGE, THOSE KINDS OF THINGS,
17 THAT YOU WOULD NEED TO RESOLVE THAT ISSUE.
18 Q. COULD THE INTACT D&X METHOD BE USED FOR THOSE SITUATIONS?
19 A. IT COULD BE USED, BUT IT WOULD NEVER BE THE ONLY CHOICE AND
20 NEVER BE THE BEST CHOICE.
21 Q. BASED ON YOUR UNDERSTANDING OF THE LENGTH OF TIME THAT IT
22 TAKES TO PREPARE FOR AN INTACT D&X, COULD IT BE USED IN AN
23 EMERGENCY SITUATION?
24 A. IT COULD NOT BE USED IN AN EMERGENCY SITUATION BECAUSE, AS
25 I SAID IT, TAKES THREE DAYS TO DO THAT PROCEDURE.

1 Q. DOCTOR, ARE YOU AWARE OF ANY FETAL ANOMALIES THAT WOULD
2 REQUIRE TERMINATING PREGNANCY BY THE INTACT D&X METHOD?
3 A. I AM NOT AWARE OF ANY FETAL ANOMALIES THAT REQUIRE INTACT
4 D&X METHOD.
5 Q. ARE YOU FAMILIAR WITH HYDROCEPHALY?
6 A. I AM.
7 Q. WHAT IS HYDROCEPHALY?
8 A. LITERAL TERMINOLOGY OF HYDROCEPHALY IS WATER ON THE BRAIN.
9 WHEN ACCUMULATING, THIS IS A BLOCKAGE IN THE SPINAL FLUID DUCT,
10 SO SPINAL FLUID GETS INTO THE SKULL AND CAN'T GET BACK OUT. SO
11 IT ACCUMULATES LIKE A WATER BALLOON.
12 Q. IS THE HEAD ENLARGED?
13 A. THE HEAD IS ENLARGED BECAUSE THE FETAL HEAD, EVEN AT TERM
14 AT DELIVERY THE FETAL BONES IN THE SKULL ARE NOT FUSED. THEY
15 ARE MOBILE AND THEY CAN FLOAT. THEY ARE NOT CONNECTED, SO THEY
16 CAN STRETCH OUT. IF YOU PUT FLUID IN THERE, IT WILL EXPAND.
17 Q. IN A HYDROCEPHALUS FETUS MIGHT THE HEAD BE TOO LARGE TO
18 PASS THROUGH THE CERVIX DURING AN ABORTION?
19 A. THE HEAD MIGHT BE TOO LARGE TO PASS THROUGH THE CERVIX,
20 CORRECT.
21 Q. IS THERE ANYTHING THAT THE PHYSICIAN CAN DO TO REDUCE THE
22 SIZE OF THE HEAD TO ALLOW IT TO PASS?
23 A. THERE IS, AND I HAVE PERFORMED THAT PROCEDURE ON A COUPLE
24 OF OCCASIONS. AND WHAT YOU DO IS JUST PASS A SPINAL NEEDLE,
25 ABOUT A 20 GAUGE, A THIN, BUT LONG SPINAL NEEDLE EITHER THROUGH

1 THE ABDOMINAL WALL OR THROUGH THE VAGINAL WALL AROUND THE
2 CERVIX, PIERCE THE SKULL, THEN WITHDRAW THE FLUID. YOU ARE NOT
3 DAMAGING THE FETUS. YOU ARE NOT DAMAGING THE BRAIN. YOU ARE
4 RELEASING THE FLUID.
5 Q. IS THAT NECESSARILY FATAL TO THE FETUS?
6 A. IT SHOULD NOT BE AT ALL. AND WHATEVER DAMAGE THE FLUID HAS
7 ALREADY DONE IS THERE, BUT REMOVING THE FLUID IS OBVIOUSLY
8 BENEFICIAL TO THE FETUS, BECAUSE YOU ARE REMOVING THE PRESSURE
9 ON THE BRAIN.
10 Q. DOCTOR, IS IT POSSIBLE FOR A PHYSICIAN INTENDING TO PERFORM
11 AN ABORTION TO CAUSE THE DEATH OF THE FETUS BEFORE REMOVING THE
12 FETUS FROM THE UTERUS?
13 A. YES.
14 Q. HOW CAN THAT BE DONE?
15 A. THERE ARE VARIOUS WAYS OF DOING THAT. THE ONES THAT HAVE
16 BECOME MUCH MORE COMMON TODAY ARE EITHER INTRA-AMNIOTIC OR
17 INTRACARDIAC INJECTIONS.
18 OR YOU COULD AT THE START OF THE PROCEDURE, WHICH IS
19 WHAT THE PHYSICIANS IN MY INSTITUTION USED TO DO, IS WHEN YOU
20 ARE PUTTING IN YOUR SUCTION CANNULA, BRING DOWN THE UMBILICAL
21 CORD AND CUT THE CORD. THAT WAS THE NATURAL PROCEDURE IN OUR
22 HOSPITAL UP UNTIL VERY RECENTLY.
23 Q. DOCTOR, YOU ALSO MENTIONED CHEMICAL AGENTS. DID YOU
24 MENTION WHAT AGENTS THOSE --
25 A. I DID NOT. I WILL IF YOU WISH.

1 Q. PLEASE DO.
2 A. THE TWO MOST COMMON AGENTS THAT ARE USED ARE DIGOXIN, WHICH
3 CAN BE USED EITHER IN THE AMNIOTIC SAC OR INTRACARDIAC, IN THE
4 FETAL HEART, OR POTASSIUM CHLORIDE, WHICH IS USUALLY USED AS AN
5 INJECTION IN THE FETAL HEART.
6 Q. IS EITHER OF THOSE AGENTS USED AT EVANSTON NORTHWESTERN
7 HEALTHCARE TO CAUSE FETAL DEMISE?
8 A. CORRECT.
9 Q. WHICH ONE?
10 A. AT THIS POINT IN TIME THEY ROUTINELY ARE USING POTASSIUM
11 CHLORIDE.
12 Q. YOU SAID "ROUTINELY USING." WHAT CIRCUMSTANCES DO THEY DO
13 THAT BEFORE AN ABORTION?
14 A. AT THIS POINT IN TIME AFTER HAVING REVIEWED THE LITERATURE,
15 AND THEY HAVE HAD EXPERIENCE, THEY DO SELECTIVE REDUCTIONS. IF
16 A MOTHER HAD TWINS AND ONE OF THE TWINS HAD AN ABNORMALITY AND
17 THE OTHER DIDN'T, OR IF THEY HAD AN IDF SITUATION WHERE THERE
18 WERE FIVE FETUSES IN THE UTERUS AND YOU ARE CONCERNED THAT THE
19 MOTHER COULDN'T CARRY ANY OF THEM TO TERM, THEY WILL, UNDER
20 ULTRASOUND GUIDANCE, TAKE POTASSIUM CHLORIDE AND SELECTIVELY
21 REDUCE A COUPLE OF THE FETUSES.
22 THE SIGNIFICANCE OF THAT IS OBVIOUSLY THEY ARE SAFE
23 ENOUGH TO USE IT WHEN OTHER FETUSES ARE IN UTERUS. AND THE WAY
24 THAT POTASSIUM CHLORIDE WORKS, UNDER DIRECT VISUALIZATION YOU
25 ONLY NEED TO PUT TWO OR THREE CC'S DIRECTLY INTO THE HEART.

1 YOU SEE IMMEDIATE CARDIAC CESSATION. SO YOU KNOW THERE IS AN
2 IMMEDIATE EFFECT. AND THEY HAVE BEEN DOING THAT SUCCESSFULLY
3 WITH SUCCESSFUL OUTCOMES IN PREGNANCIES.
4 AND THERE IS ACTUALLY PUBLISHED ARTICLES IN THAT
5 SHOWING THAT IT IS DONE SUCCESSFULLY IN 400 CASES AND 150
6 CASES.
7 Q. DOCTOR, IS IT POTASSIUM CHLORIDE THAT IS NOW USED AT
8 EVANSTON NORTHWESTERN FOR ABORTION?
9 A. CORRECT.
10 Q. AND SINCE WHEN HAS THAT BEEN DONE?
11 A. REALLY OVER THE LAST COUPLE OF WEEKS, IN LOOKING AT WHAT IS
12 GOING ON. AS I SAID BEFORE, THEY WOULD JUST CUT THE CORD.
13 NOW THEY ARE TRYING TO DO IT EVEN EARLIER IN THE
14 PROCESS TO BE SURE TO CAUSE FETAL DEMISE PRIOR TO THE D&E. AS
15 I SAID, WITH POTASSIUM CHLORIDE YOU HAVE INSTANT RESULTS
16 BECAUSE YOU ARE INJECTING IT INTO THE HEART, AND YOU WATCH THE
17 HEART MUSCLE STOP LITERALLY IMMEDIATELY.
18 SO THEY KNOW THEY HAVE ACCOMPLISHED THEIR GOAL.
19 THEY HAVE REPORTED TO ME THAT PATIENTS ARE --
20 MS. GARTNER: OBJECTION, YOUR HONOR. THIS IS
21 HEARSAY.
22 THE COURT: SUSTAINED.
23 BY MR. SIMPSON:
24 Q. DOCTOR, IF I CAN MOVE ON TO SOMETHING ELSE.
25 NOW, IF A PHYSICIAN WANTED TO INJECT -- YOU SAID

1 DIGOXIN INTO THE AMNIOTIC FLUID. IF A PHYSICIAN WANTED TO
2 INJECT DIGOXIN INTO THE AMNIOTIC FLUID, COULD THAT BE DONE
3 WITHOUT ULTRASOUND?
4 MS. GARTNER: OBJECTION, YOUR HONOR. THERE IS NO
5 FOUNDATION THAT HE KNOWS ABOUT DIGOXIN. HE TESTIFIED THAT KCL
6 IS USED IN HIS INSTITUTION, BUT THERE IS NO FOUNDATION FOR
7 DIGOXIN.
8 THE COURT: SUSTAINED.
9 BY MR. SIMPSON:
10 Q. DOCTOR, ARE YOU FAMILIAR WITH THE PROCEDURE KNOWN AS
11 AMNIOCENTESIS?
12 A. CORRECT.
13 Q. IS AMNIOCENTESIS THE REMOVAL OF AMNIOTIC FLUID FROM A
14 PREGNANT UTERUS USING A SYRINGE?
15 A. CORRECT.
16 Q. FOR WHAT PURPOSES IS THAT DONE?
17 A. MOST COMMONLY WE DO IT ABOUT 16 WEEKS FOR GENETIC STUDIES.
18 IT ALSO DONE LATER IN PREGNANCY TO DETERMINE MATURITY OF THE
19 FETUS.
20 Q. HAVE YOU EVER PERFORMED AN AMNIOCENTESIS?
21 A. I HAVE PERFORMED OVER A HUNDRED AMNIOCENTESES.
22 Q. DOCTOR, DO YOU BELIEVE THAT THAT LEVEL OF EXPERIENCE WITH
23 AMNIOCENTESIS IS TYPICAL OF OB/GYN'S, IN GENERAL?
24 A. I BELIEVE IT IS A VERY COMMON AMOUNT.
25 Q. WOULD THAT BE TYPICAL OF THE PHYSICIANS IN YOUR GROUP?

1 A. CORRECT.

2 Q. DOCTOR --

3 THE COURT: IT'S TIME FOR US TO TAKE A BREAK. WE

4 DEFINITELY NEED TO TAKE ONE. I AM LITTLE CONCERNED ABOUT THE

5 TIME.

6 DR. SPRANG ACTUALLY HAS A VERY HARD TIME ANSWERING

7 THE QUESTIONS DIRECTLY, AND HE IS TAKING MUCH MORE TIME THAN I

8 THINK HE SHOULD, IN GIVING US ANSWERS TO YOUR QUESTION.

9 I AM GOING TO AFFORD PLAINTIFFS' COUNSEL JUST AS

10 MUCH TIME AS YOU HAVE HAD THE LAST HOUR AND A HALF ON THE

11 EXAMINATION. IF YOU DO NOT WISH THIS WITNESS TO RETURN ON

12 MONDAY, YOU ARE GOING TO NEED TO FINISH UP PRETTY QUICKLY.

13 MR. SIMPSON: I DON'T HAVE MUCH MORE.

14 THE COURT: ALL RIGHT. LET'S BREAK FOR 15.

15 (RECESS TAKEN AT 11:45 A.M.)

16 (PROCEEDINGS RESUMED AT 12:02 P.M.)

17 THE COURT: ALL RIGHT. PLEASE CONTINUE.

18 BY MR. SIMPSON:

19 Q. DOCTOR, WE WERE DISCUSSING AMNIOCENTESIS.

20 HAVE YOU EVER PERFORMED AMNIOCENTESIS ON OBESE

21 WOMEN?

22 A. I HAVE.

23 Q. CAN YOU TELL US ABOUT THOSE CIRCUMSTANCES?

24 A. THE MOST RECENT ONE I DID WAS ON A WOMAN WHO IS 5 FEET TALL

25 AND 260 POUNDS. ALL WE DID WAS USE A LONGER NEEDLE TO DO IT

1 AND IT WORKED QUITE WELL.
2 Q. WHAT IS THE -- HAVE YOU EVER DONE AN AMNIOCENTESIS ON A
3 PATIENT WEIGHING MORE THAN 260 POUNDS?
4 A. YES.
5 Q. HOW MUCH DID THAT PATIENT WEIGH?
6 A. CLOSER TO 300 POUNDS.
7 Q. WAS SHE ALSO OBESE?
8 A. YES.
9 Q. HOW DID YOU ACCOMPLISH THAT AMNIOCENTESIS?
10 A. EXACT SAME WAY; YOU JUST SIMPLY NEED A LONGER NEEDLE.
11 Q. THANK YOU, DOCTOR.
12 DOCTOR, YOU ALSO MENTIONED CUTTING THE CORD TO CAUSE
13 FETAL DEMISE. DO YOU KNOW APPROXIMATELY HOW LONG IT TAKES
14 AFTER CUTTING THE CORD FOR FETAL DEMISE TO OCCUR?
15 A. THERE IS A RELATIVELY SMALL BLOOD SUPPLY IN THE FETUS. SO
16 IF YOU CUT THE CORD VERY QUICKLY, YOU EXSANGUINATE THE FETUS.
17 Q. VERY QUICKLY DO YOU HAVE AN APPROXIMATE TIME?
18 A. FIVE OR 10 MINUTES.
19 Q. DOES THAT PRESENT ANY RISK TO THE MOTHER?
20 A. BECAUSE YOU ARE -- NO.
21 Q. DOES THE MOTHER BLEED FROM THE UMBILICAL CORD?
22 A. THEY ARE TWO ENTIRELY DIFFERENT CIRCULATION, SO NO.
23 Q. DOCTOR, WHAT IS THE EARLIEST GESTATIONAL AGE OF WHICH YOU
24 HAVE KNOWN A BABY TO SURVIVE BIRTH AND BE KEPT IN THE NURSERY?
25 A. TWENTY-THREE WEEKS.

1 Q. TWENTY-FOUR WEEKS?
2 A. TWENTY-THREE WEEKS.
3 Q. TWENTY-THREE WEEKS.
4 DO NEONATES AT THAT GESTATIONAL AGE RECEIVE
5 TREATMENTS OR PROCEDURES THAT AN ADULT OR CHILD WOULD CONSIDER
6 PAINFUL?
7 A. THEY DO.
8 Q. AT THE HOSPITALS WHERE YOU PRACTICE, ARE BABIES OF 23 AND
9 24 WEEKS GIVEN MEDICATION FOR THE MANAGEMENT OF PAIN?
10 A. THEY ARE.
11 Q. DOCTOR, ARE YOU FAMILIAR WITH THE CONCEPT OF MEDICAL
12 ETHICS?
13 A. I AM.
14 Q. I THINK YOU HAVE TESTIFIED THAT YOU ARE CURRENTLY THE
15 CHAIRMAN OF THE ETHICS COMMITTEE OF THE CHICAGO MEDICAL
16 SOCIETY?
17 A. CORRECT.
18 Q. HAVE BEEN FOR 10 YEARS?
19 A. CORRECT.
20 Q. DOCTOR, IS MEDICAL ETHICS TYPICALLY A PART OF
21 DECISION-MAKING IN MEDICINE?
22 A. I'D SAY IT IS AN ESSENTIAL PART. THE PROFESSION WOULDN'T
23 EXIST WITHOUT IT.
24 Q. DOCTOR, DOES YOUR JAMA ARTICLE ADDRESS ETHICAL
25 CONSIDERATIONS?

1 A. IT DOES.
2 Q. I'D LIKE TO READ A FEW SENTENCES FROM YOUR JAMA ARTICLE.
3 THAT'S EXHIBIT A-55. IF YOU CAN JUST TURN TO THAT TO MAKE SURE
4 I AM READING IT CORRECTLY.
5 I WILL READ FROM THE SECOND PAGE LEFT HAND COLUMN,
6 THE LAST PARAGRAPH IN THAT COLUMN.
7 "BEYOND THE ARGUMENT OF POTENTIAL VIABILITY,
8 MANY PRO-CHOICE ORGANIZATIONS AND INDIVIDUALS
9 ASSERT THAT A WOMAN SHOULD MAINTAIN CONTROL
10 OVER THAT WHICH IS PART OF HER OWN BODY (I.E.,
11 THE AUTONOMY ARGUMENT). IN THIS CONTEXT, THE
12 PHYSICAL POSITION OF THE FETUS WITH RESPECT TO
13 THE MOTHER'S BODY BECOMES RELEVANT. HOWEVER,
14 ONCE THE FETUS IS OUTSIDE THE WOMAN'S BODY, THE
15 AUTONOMY ARGUMENT IS INVALID. THE INTACT D&X
16 PROCEDURE INVOLVES LITERALLY DELIVERING THE
17 FETUS SO THAT ONLY THE HEAD REMAINS IN THE
18 CERVIX. AT THIS JUNCTURE, THE FETUS IS MERELY
19 INCHES FROM BEING DELIVERED AND OBTAINING FULL
20 LEGAL RIGHTS OF PERSONHOOD UNDER THE U.S.
21 CONSTITUTION?"
22 ARE THOSE YOUR WORDS, DOCTOR?
23 A. CORRECT.
24 Q. IS THAT YOUR TESTIMONY TODAY?
25 A. CORRECT.

1 MR. SIMPSON: THAT'S ALL I HAVE, YOUR HONOR.
2 THE COURT: THANK YOU.
3 CROSS-EXAMINATION?
4 CROSS-EXAMINATION
5 BY MS. GARTNER:
6 Q. HELLO, AGAIN, DR. SPRANG.
7 A. HELLO.
8 Q. WE ARE GOING TO TRY TO GET YOU OUT OF HERE AT 1:30, BUT IT
9 WOULD HELP IF YOU COULD TRY AND FOCUS IN ON MY QUESTIONS.
10 A. I WILL TRY.
11 Q. GREAT. THANK YOU VERY MUCH.
12 I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT THE
13 RELEVANT BENEFITS OF D&E'S AND INDUCTION PROCEDURES.
14 NOW, YOU TESTIFIED THAT BEGINNING AT ABOUT 20 WEEKS
15 IT'S YOUR CLEAR PREFERENCE TO PERFORM ABORTIONS IF THEY ARE
16 NEEDED.
17 AND BY THAT, I INCLUDE ABORTIONS WHERE THE FETUS IS
18 DEMISED USING THE INDUCTION METHOD; IS THAT CORRECT?
19 A. CORRECT.
20 Q. AND, IN FACT, YOU FEEL SO STRONGLY ABOUT THE PREFERABILITY
21 OF INDUCTION TO D&E AFTER 20 WEEKS THAT IF YOU HAVE A PATIENT
22 THAT HAS A FETAL DEATH IN UTERO AFTER 20 WEEKS YOU PROBABLY
23 WOULDN'T EVEN BRING D&E UP BECAUSE YOU THINK THERE IS, IN YOUR
24 BELIEF, INDUCTION IS THE SAFER PROCESS FOR THE PATIENT AT 20
25 WEEKS OR GREATER; ISN'T THAT RIGHT?

1 A. CORRECT.
2 Q. AND IF A DISCUSSION OF D&E VERSUS INDUCTION DID COME UP,
3 YOU WOULD ENCOURAGE YOUR PATIENT TO HAVE AN INDUCTION BECAUSE
4 YOU THINK IT'S SAFER?
5 A. CORRECT.
6 Q. OKAY.
7 AND YOU BELIEVE THAT IN TERMS OF DECIDING WHICH
8 PROCEDURE TO CHOOSE, THE ONLY PRUDENT THING FOR AN INTELLIGENT
9 WOMAN WHO TRUSTS HER DOCTOR TO DO IS TO STRONGLY RELY ON WHAT
10 HER DOCTOR IS SAYING BECAUSE PATIENTS DON'T HAVE ENOUGH OF THE
11 BACKGROUND TO UNDERSTAND THE NUANCES OF THE RECOMMENDATION.
12 IS THAT RIGHT?
13 A. CORRECT.
14 Q. AND PART OF THE REASON YOU PREFER INDUCTION TO D&E AFTER 20
15 WEEKS IS BECAUSE AS THE GESTATIONAL AGE INCREASES, D&E GETS
16 HARDER TO DO, RIGHT?
17 A. CORRECT.
18 Q. AS YOU UNDERSTOOD IT, THERE'S ONLY A SMALL MINORITY OF
19 PHYSICIANS IN THE UNITED STATES WHO WOULD HAVE THE SKILLS TO DO
20 A D&E AFTER 20 WEEKS, CORRECT?
21 A. I BELIEVE I -- DID I SAY D&E OR D&X?
22 THERE ARE FEWER, I WOULDN'T NECESSARILY SAY SMALLER
23 MINORITY, I AM NOT SURE I WOULD BE THAT NARROW IN WHAT I WOULD
24 SAY.
25 Q. LET ME DOUBLE-CHECK WHAT YOU SAID.

1 I THINK, LET ME HAND YOU YOUR TESTIMONY --
2 A. RELATIVELY SMALL, YES. YES.
3 Q. OKAY.
4 BUT YOU BELIEVE THAT IF THE PHYSICIAN DID HAVE THE
5 SKILLS TO DO A POST-20-WEEK D&E, THAT SUCH PROCEDURES WOULD BE
6 AS SAFE AS OR SAFER THAN INDUCTION PROCEDURES IN THAT TIME
7 FRAME; IS THAT RIGHT?
8 A. I DO NOT BELIEVE THEY WOULD BE SAFER.
9 Q. DO YOU BELIEVE THEY WOULD BE AS SAFE AS?
10 A. COMPARABLE.
11 Q. IF THE PHYSICIAN HAD THE SKILLS?
12 A. CORRECT.
13 Q. YOU ARE NOT AWARE OF ANY RANDOMIZED TRIALS COMPARING D&E
14 WITH MISOPROSTOL INDUCTION ABORTIONS, ARE YOU?
15 A. PLEASE REPEAT THE QUESTION.
16 Q. ARE YOU AWARE OF ANY RANDOMIZED TRIALS COMPARING D&E
17 ABORTIONS WITH INDUCTION ABORTIONS USING MISOPROSTOL AS THE
18 INDUCING AGENT?
19 A. I AM AWARE THERE IS A STUDY OUT THERE COMPARING IT. I
20 DON'T THINK THEY ONLY USED MISOPROSTOL.
21 Q. YOU ARE REFERRING TO THE AUTRY STUDY. AND I AM ASKING ARE
22 THERE ANY RANDOMIZED TRIALS?
23 A. PROSPECTIVE, DO YOU MEAN BY THAT?
24 I THINK IF THAT IS WHAT YOU MEAN BY THAT, THE ANSWER
25 IS YES.

1 Q. I MEAN RANDOMIZED -- DO YOU KNOW WHAT A RANDOMIZED --
2 A. RANDOMIZED USUALLY MEANS PROSPECTIVE.
3 Q. RIGHT. WHERE THE PATIENTS ARE RANDOMIZED TO ONE TECHNIQUE
4 OR THE OTHER?
5 A. IT'S GOT TO BE PROSPECTIVE TO DO THAT, SO, YES.
6 Q. OKAY.
7 ARE YOU AWARE OF ANY RANDOMIZED TRIALS COMPARING D&E
8 WITH INDUCTION USING MISOPROSTOL?
9 A. I CANNOT THINK OF ANY AT THIS TIME.
10 Q. OKAY.
11 AND ISN'T IT TRUE, DOCTOR, THAT YOUR OPINION ABOUT
12 THE RELATIVE SAFETY OF INDUCTION COMPARED TO D&E'S IS BASED
13 PRIMARILY ON YOUR INTUITIVE KNOWLEDGE, EDUCATION, AND
14 EXPERIENCE?
15 A. ONLY IN PART. IT'S BASED ON THE EXPERIENCE AT MY HOSPITAL
16 BECAUSE THAT'S THE ONLY THING THEY WOULD DO IN A VERY LARGE
17 INSTITUTION, AND I RESPECT MATERNAL FETAL MEDICINE PHYSICIANS
18 THERE AND THEY CHOOSE NOT TO DO IT. SO I AM BEING PARTLY
19 INFLUENCED BY THEM.
20 Q. I THINK YOU TESTIFIED ON DIRECT THAT THERE ARE TWO MAJOR
21 TEACHING HOSPITALS THAT ARE PART OF NORTHWESTERN UNIVERSITY
22 SCHOOL OF MEDICINE; IS THAT RIGHT?
23 A. YES.
24 Q. YOU ARE AT ONE OF THE TWO AND THAT'S EVANSTON?
25 A. YES.

1 Q. AND THE OTHER HOSPITAL IS?
2 A. PRENTICE.
3 Q. PRENTICE HOSPITAL?
4 A. PRENTICE WOMEN'S HOSPITAL.
5 Q. PRENTICE WOMEN'S HOSPITAL.
6 AND YOU ARE AWARE THAT AT PRENTICE WOMEN'S HOSPITAL,
7 THE OTHER MAJOR TEACHING HOSPITAL OF NORTHWESTERN THAT, IN
8 FACT, PHYSICIANS DO PERFORM D&E'S UP TO OR PAST 23 WEEKS
9 GESTATION?
10 A. CORRECT.
11 MR. SIMPSON: IF I CAN SAY, I'M NOT SURE THAT LAST
12 QUESTION WAS CLEAR. SHE SAID "UP TO OR PAST 23 WEEKS."
13 THE COURT: HE AGREED, SO IT WAS CLEAR ENOUGH FOR
14 HIM. HE SAID "CORRECT."
15 MS. GARTNER: OKAY.
16 BY MS. GARTNER:
17 Q. AND ISN'T IT ALSO TRUE, DR. SPRANG, THAT ANY ATTEMPT ON
18 YOUR PART TO QUANTIFY THE DIFFERENCE IN RISK BETWEEN D&E AT 20
19 WEEKS AND INDUCTION AT 20 WEEKS OR LATER, WOULD JUST BE
20 SPECULATION ON YOUR PART?
21 A. I DO NOT BELIEVE THERE IS ANY QUANTIFIABLE INFORMATION OUT
22 THERE.
23 Q. AND IN YOUR EXPERT REPORT IN THIS CASE, AND I THINK
24 ACTUALLY ALSO EARLIER TODAY, YOU STATED THAT ONE OF THE REASONS
25 THAT YOU BELIEVE THAT INDUCTION IS SAFER THAN D&E AFTER

1 APPROXIMATELY 20 OR 22 WEEKS IS THAT IT DOES NOT NECESSARILY
2 INVOLVE THE INTRODUCTION OF INSTRUMENTS INTO THE UTERUS; IS
3 THAT RIGHT?
4 A. I SAID IT IS MORE PHYSIOLOGIC AND IT DOES NOT NECESSARILY
5 REQUIRE INSTRUMENTATION.
6 Q. RIGHT. OKAY. AND THAT'S YOUR TESTIMONY, CORRECT?
7 A. CORRECT.
8 Q. AND, IN FACT, YOU BELIEVE THAT THERE IS A RISK WHENEVER YOU
9 PUT AN INSTRUMENT INTO THE UTERUS; IS THAT RIGHT?
10 A. A VERY SMALL RISK IF IT'S DONE WELL.
11 Q. YOU BELIEVE THAT PUTTING AN INSTRUMENT INTO THE UTERUS DOES
12 CARRY RISK?
13 A. MINIMAL.
14 Q. AND BECAUSE THERE IS THAT MINIMAL RISK, YOU WOULD AGREE
15 THAT IN DOING A DISARTICULATION D&E THE PHYSICIANS SHOULD
16 STRIVE TO REDUCE THE NUMBER OF INSTRUMENTAL PASSES INTO THE
17 UTERUS; IS THAT RIGHT?
18 A. I BELIEVE THAT WITH ULTRASOUND IT'S NOT JUST THE NUMBER. I
19 THINK THE NUMBER IS JUST TOO SIMPLISTIC.
20 IF YOU ARE DOING IT WITH ULTRASOUND, I BELIEVE IT'S
21 SAFE ENOUGH THAT YOU CAN DEFINITELY USE INSTRUMENTS AND SEE
22 WHAT YOU ARE DOING.
23 Q. BUT THAT WASN'T MY QUESTION.
24 MY QUESTION IS: GIVEN THAT THERE IS MINIMAL RISK OF
25 INSERTING INSTRUMENTS INTO THE UTERUS, ISN'T IT YOUR VIEW THAT

1 YOU SHOULD DO THAT AS FEW TIMES AS NECESSARY TO ACCOMPLISH WHAT
2 YOU NEED TO DO?
3 A. THE QUALITY OF THE WAY YOU ARE DOING IT IS MORE IMPORTANT
4 THAN THE NUMBER.
5 Q. THAT'S NOT MY QUESTION.
6 MY QUESTION IS: GIVEN THAT EACH PASS INTO THE
7 UTERUS HAS MINIMAL RISK, WOULDN'T IT BE BETTER FOR THE
8 PHYSICIAN TO MINIMIZE THE NUMBER OF INSTRUMENTAL PASSES INTO
9 THE UTERUS?
10 A. IF THE RISK IS SO MINIMAL, IT'S PROBABLY NOT RELEVANT.
11 THE COURT: SO IS YOUR ANSWER "NO"?
12 THE WITNESS: CORRECT.
13 BY MS. GARTNER:
14 Q. DR. SPRANG, I WANT TO JUST CONFIRM WITH YOU THAT THE
15 OPINIONS THAT YOU OFFERED TODAY ABOUT INTACT D&E ARE BASED
16 EXCLUSIVELY ON YOUR UNDERSTANDING OF THE PROCEDURE AS IT IS
17 DESCRIBED BY DR. HASKELL IN HIS PAPER; IS THAT RIGHT?
18 A. THAT IS NOT CORRECT.
19 Q. LET ME CLARIFY MY QUESTION.
20 WHAT I -- I UNDERSTAND THAT YOU HAVE A BROADER RANGE
21 OF BASES FOR YOUR OPINIONS, BUT IN TERMS OF THE DETAILS OF HOW
22 THE PROCEDURE IS PERFORMED, ARE YOU BASING THAT ON ANYTHING
23 BESIDES DR. HASKELL'S DESCRIPTION?
24 A. CORRECT.
25 Q. I AM SORRY. YOU ARE LIMITING IT TO DR. HASKELL'S --

1 A. I AM NOT.
2 Q. YOU ARE NOT, OKAY.
3 WHAT OTHER DESCRIPTIONS OF THE PROCEDURE ARE YOU
4 BASING YOUR TESTIMONY ON?
5 A. I BELIEVE WE ALREADY SAID THAT, BUT ALL THE PROCEDURES THAT
6 I HAVE READ BY EACH OF THE INDIVIDUALS WHO HAVE DECLARATIONS,
7 DEPOSITIONS AT LENGTH AND THEY HAVE ALL DESCRIBED IT, AND I
8 PROBABLY HAVE READ A DOZEN OF THOSE. SO IT CLEARLY IS
9 INFLUENCING THE NUANCES OF HOW IT'S DONE.
10 Q. OKAY.
11 AND, DR. SPRANG, I WANT TO TALK A LITTLE MORE ABOUT
12 THE AMA, THE TASK FORCE THAT YOU SAT ON.
13 WAS THAT IN 1997 THAT THE TASK FORCE WAS CONVENED?
14 A. CORRECT.
15 Q. AND THE TASK FORCE SPECIFICALLY LOOKED AT LATE TERM
16 PREGNANCY TERMINATION TECHNIQUES; IS THAT RIGHT?
17 A. IT WAS SPECIFICALLY DESIGNED TO LOOK AT INTACT D&X. THAT
18 WAS THE PRIMARY OBJECTIVE -- THE REASON IT WAS ESTABLISHED.
19 Q. AND THE TASK FORCE WROTE A REPORT; IS THAT CORRECT?
20 A. CORRECT.
21 Q. AND THE REPORT REFLECTS THE CONSENSUS VIEW OF THE
22 COMMITTEE; IS THAT CORRECT?
23 A. IT REPRESENTS A NUMBER OF ISSUES. SOME OF THEM WERE MORE
24 CONSENSUS, SOME OF THEM THE CHAIRMAN OF THAT COMMITTEE, THE
25 CHAIRMAN OF THE BOARD OF TRUSTEES AND WANTED TWO OF US TO GO

1 BACK TO THE BOARD FOR FURTHER DISCUSSION BY THE BOARD BEFORE IT
2 ALSO -- SO IT COULD BE DISCUSSED AT THE HOUSE OF DELEGATES.
3 Q. SO, I AM NOT CLEAR ON YOUR ANSWER. LET ME SHOW YOU THE
4 REPORT.
5 A. I BELIEVE I KNOW THE REPORT.
6 Q. I AM CERTAIN YOU DO, DR. SPRANG. I AM GOING TO ASK YOU TO
7 LOOK AT IT ANYWAY. I AM GOING TO ASK YOU SOME SPECIFIC
8 QUESTIONS ABOUT IT.
9 MS. GARTNER: YOUR HONOR, MAY I APPROACH?
10 THE COURT: YES.
11 MS. GARTNER: YOUR HONOR, THIS DOCUMENT IS NOT ON
12 OUR EXHIBIT LIST. WE ARE NOT ACTUALLY SEEKING TO INTRODUCE IT.
13 I ADVISED DEFENDANT'S COUNSEL LAST WEEK THAT WE WOULD BE
14 EXAMINING DR. SPRANG ABOUT IT.
15 IT'S PART OF THE CONGRESSIONAL RECORD AND IT'S IN
16 THE BINDERS THAT WE SUBMITTED TO THE COURT. THIS PARTICULAR
17 COPY IS ACTUALLY TAKEN FROM THE HOUSE REPORT FROM JULY 2002,
18 AND THAT'S WHERE THE NUMBERING SYSTEM COMES FROM.
19 THE COURT: ALL RIGHT.
20 BY MS. GARTNER:
21 Q. DR. SPRANG, IS THIS THE REPORT THAT THE TASK FORCE
22 PRODUCED?
23 A. IT IS BOTH TOO SMALL FOR ME TO READ AND I DON'T KNOW IF
24 IT'S ALL HERE.
25 Q. DO YOU HAVE GLASSES OR SOMETHING THAT WOULD ENABLE YOU TO

1 READ THIS?
2 A. THIS IS TINY PRINT.
3 Q. I APOLOGIZE. THIS IS WHAT CAME OUT --
4 THE COURT: DO YOU THINK USING THE ELMO YOU COULD
5 MAGNIFY IT?
6 MS. GARTNER: EXCELLENT THOUGHT.
7 BY MS. GARTNER:
8 Q. DR. SPRANG, I AM NOT GOING TO ASK YOU TO REPRESENT TO ME
9 THAT THIS IS THE COMPLETE REPORT, BUT IF YOU COULD JUST, IF
10 POSSIBLE, LOOK AT THE COVER AND TELL ME IF THIS APPEARS TO BE
11 THE REPORT THAT WAS PRODUCED BY THE TASK FORCE?
12 A. IT APPEARS TO BE.
13 Q. OKAY. WE WILL WAIT FOR THIS TO WARM UP. APPARENTLY IT
14 TAKES A FEW MINUTES.
15 LET ME ASK YOU, AGAIN, DOES THIS REPORT -- LET ME
16 STRIKE THAT AND START AGAIN.
17 THIS REPORT DOES REFLECT THE CONSENSUS VIEW OF THE
18 COMMITTEE; IS THAT CORRECT?
19 A. THE TOTAL CONSENSUS, NO. THERE WERE STILL ISSUES THAT WERE
20 PRESENTED AND CONTINUED TO BE DISCUSSED, BUT WE HAD TO GO
21 FORWARD WITH SOMETHING, AND THIS WAS THE ULTIMATE OF WHAT WAS
22 SENT FORWARD.
23 Q. I AM SORRY, THIS WAS THE ULTIMATE?
24 A. REPORT THAT WAS SENT TO THE HOUSE.
25 Q. SO THIS REPORT WAS SENT TO THE HOUSE OF DELEGATES OF THE

1 AMA?
2 A. CORRECT.
3 Q. BY THE TASK FORCE?
4 A. CORRECT.
5 Q. OKAY.
6 AND THE REPORT, AS YOU REMEMBER IT, LOOKED AT THE
7 ISSUE OF LATE ABORTIONS FROM SEVERAL ANGLES; IS THAT CORRECT?
8 A. CORRECT.
9 Q. IT LOOKED AT THE MEDICAL ANGLE AND THE LEGAL ANGLE AND
10 ETHICAL PERSPECTIVES?
11 A. CORRECT.
12 MS. GARTNER: YOUR HONOR, I DON'T KNOW HOW TO
13 ACCOMPLISH HAVING HIM REVIEW -- I MEAN, IT IS QUITE LENGTHY FOR
14 HIM TO REVIEW EVERY PAGE ON THE ELMO MIGHT NOT MAKE SENSE.
15 THE WITNESS: IF THERE ARE SPECIFIC AREAS?
16 BY MS. GARTNER:
17 Q. THERE ARE SPECIFIC PLACES. IT'S JUST THAT IF YOU WANTED TO
18 LOOK AT THE WHOLE THING TO VERIFY THAT IT IS COMPLETE.
19 A. TELL ME THE AREAS YOU WANT ME TO LOOK AT, AND I WILL DO
20 THAT.
21 Q. LOOK AT PAGE 196.
22 CAN YOU READ THAT ON THE SCREEN, DR. SPRANG?
23 A. I AM GOING TO TRY TO READ IT FROM HERE. THAT'S NOT
24 HELPING, SO I'LL TRY AND DO IT FROM HERE.
25 Q. OKAY.

1 WHAT I WOULD LIKE YOU TO LOOK AT ON PAGE 196 IS THE
2 PARAGRAPH THAT BEGINS AT THE BOTTOM OF THE PAGE.
3 A. 196?
4 Q. 196 IS THE NUMBER IS ON THE TOP OF THE PAGE.
5 DO YOU SEE 196 ON THE TOP OF THE PAGE?
6 IF YOU CAN LOOK AT THE PARAGRAPH THAT BEGINS AT THE
7 BOTTOM OF THE PAGE AND CONTINUES TO THE TOP OF THE NEXT PAGE.
8 I WAS GOING TO ASK YOU TO READ THIS, BUT IF IT WOULD
9 HELP, I CAN READ IT TO YOU AND YOU CAN CONFIRM THAT THAT'S WHAT
10 IT SAYS. WOULD THAT BE BETTER?
11 A. SURE.
12 Q. LET ME READ THIS TO YOU. THE REPORT OF THE TASK FORCE
13 STATES AT THE BOTTOM OF PAGE 196:
14 "TO MINIMIZE UTERINE OR CERVICAL PERFORATION
15 EITHER FROM INSTRUMENTS USED DURING THE D&E OR
16 THROUGH PIERCING BY FETAL PARTS, SOME
17 PHYSICIANS USE A FORM OF D&E THAT HAS BEEN
18 REFERRED TO IN THE POPULAR PRESS AS INTACT
19 DILATION AND EXTRACTION, (D&X)."
20 I AM GOING TO SKIP THE NEXT SENTENCE WHICH SETS
21 FORTH ACOG'S DEFINITION OF THAT PROCEDURE, AND I WILL CONTINUE
22 TO READ AT THE BOTTOM OF THE PAGE.
23 "THIS PROCEDURE MAY MINIMIZE TRAUMA TO THE
24 WOMAN'S UTERUS, CERVIX, AND OTHER VITAL ORGANS.
25 INTACT D&X MAY BE PREFERRED BY SOME PHYSICIANS,

1 PARTICULARLY WHEN THE FETUS HAS BEEN DIAGNOSED
2 WITH HYDROCEPHALY OR OTHER ANOMALIES
3 INCOMPATIBLE WITH LIFE OUTSIDE THE WOMB."
4 DID I READ THAT CORRECTLY, DR. SPRANG?
5 A. YES.
6 Q. AND THIS WAS WHAT THE AMA TASK FORCE REPORT STATED; IS THAT
7 CORRECT?
8 A. CORRECT.
9 Q. AND THEN WHILE WE ARE ON THIS PAGE 197, DR. SPRANG, WHY
10 DON'T WE LOOK AT THE PARAGRAPH, I THINK IT IS TWO PARAGRAPHS
11 DOWN THAT BEGINS WITH THE WORD "HYSTEROTOMY AND HYSTERECTOMY."
12 DO YOU SO THAT?
13 A. YES.
14 Q. LET ME JUST READ TO YOU THE FIRST SENTENCE OF THAT
15 PARAGRAPH AND YOU CAN TELL ME IF THIS WAS WHAT THE AMA TASK
16 FORCE WROTE. NOW I AM READING:
17 "HYSTEROTOMY AND HYSTERECTOMY HAVE BEEN USED TO
18 TERMINATE PREGNANCY BUT ARE NOT USED ROUTINELY
19 AS A FORM OF ABORTION BECAUSE MATERNAL
20 MORTALITY AND MORBIDITY ASSOCIATED WITH THESE
21 PROCEDURES ARE SIGNIFICANTLY GREATER THAN THOSE
22 ASSOCIATED WITH OTHER PROCEDURES USED TO INDUCE
23 ABORTION."
24 AND IS THAT -- DID I READ THAT CORRECTLY DR. SPRANG?
25 A. CORRECT.

1 Q. THAT IS WHAT THE AMA TASK FORCE WROTE, CORRECT?
2 A. CORRECT.
3 Q. AND DOES THAT REFLECT THE CONSENSUS VIEW OF THE AMA TASK
4 FORCE?
5 A. CORRECT.
6 Q. I WOULD LIKE TO TALK TO YOU -- YOU CAN PUT THAT DOWN FOR
7 NOW, DR. SPRANG. WE WILL COME BACK TO IT.
8 TALK TO YOU BRIEFLY ABOUT YOUR TESTIMONY REGARDING
9 WHAT YOU REFERRED TO AS INTERNAL PODALIC VERSION OR THE PORTION
10 OF THE INTACT D&E PROCEDURE WHERE A PHYSICIAN MAY CONVERT THE
11 FETUS FROM A HEAD FIRST POSITION TO A BREECH POSITION.
12 YOU SAID YOU'VE DONE THAT TECHNIQUE, A VERSION
13 TECHNIQUE, RIGHT?
14 A. CORRECT.
15 Q. BUT YOU'VE NEVER DONE IT AT LESS THAN 24 WEEKS GESTATION,
16 HAVE YOU?
17 A. EARLIEST IS LIKE 26, 27.
18 Q. SO YOU HAVE NEVER DONE IT AT LESS THAN 24 WEEKS GESTATION,
19 RIGHT?
20 A. CORRECT.
21 Q. YOU WOULD AGREE THAT IN ANY D&E PROCEDURE, WHETHER IT'S AN
22 INTACT D&E OR A DISARTICULATION D&E, THAT THE PLACENTA IS
23 SEPARATED AND DISRUPTED DURING THE PROCEDURE, RIGHT?
24 A. CORRECT.
25 Q. AND YOU WOULD AGREE THAT ONE OF THE RISKS OF DOING AN

1 INTERNAL PODALIC VERSION AT TERM OR WHERE THE -- YOUR
2 ATTEMPTING TO DELIVER A LIVE BABY, IS THE RISK OF HARM TO THE
3 FETUS, RIGHT?
4 A. CORRECT.
5 Q. AND THAT'S NOT A CONCERN IN THE CONTEXT OF ABORTION, RIGHT?
6 A. CORRECT.
7 Q. I WANT TO TALK TO YOU BRIEFLY ABOUT YOUR TESTIMONY RELATING
8 TO THE USE OF INSTRUMENTS TO REDUCE THE SIZE OF THE CALVARIUM
9 OF THE FETUS IN AN INTACT D&E PROCEDURE.
10 YOU WOULD AGREE THAT IF THE PHYSICIAN INSERTED A
11 SHARP INSTRUMENT UNDER DIRECT VISUALIZATION, YOUR CONCERNS
12 ABOUT INJURY TO THE WOMAN WOULD BE ALLAYED; IS THAT CORRECT?
13 A. I WOULD HAVE LESS CONCERN, BUT NOT AN ABSENCE OF CONCERN.
14 Q. OKAY.
15 NOW, TO THE EXTENT, IF ANY, THAT THERE ARE ANY
16 PHYSICIANS OUT THERE WHO DO INSERT INSTRUMENTS BLINDLY INTO THE
17 CALVARIUM OF THE FETUS IN THE COURSE OF DOING AN INTACT D&E,
18 YOU ARE NOT AWARE OF ANY COMPLICATIONS THAT HAVE RESULTED FROM
19 THAT, ARE YOU?
20 A. CORRECT.
21 Q. I WANT TO TALK TO YOU A LITTLE BIT ABOUT CERVICAL DILATION.
22 AM I RIGHT THAT IT'S YOUR OPINION THAT INDUCTION
23 ABORTIONS ARE SAFER FOR THE CERVIX THAN D&E OR INTACT D&E
24 ABORTIONS; IS THAT CORRECT?
25 A. CORRECT.

1 Q. THAT'S REALLY JUST AN IMPRESSION THAT IT'S SAFER, RIGHT?
2 YOU DON'T ACTUALLY HAVE STUDIES TO SUPPORT THAT OPINION, DO
3 YOU?
4 A. THERE ARE NUMEROUS STUDIES THAT SAY MID-TRIMESTER ABORTIONS
5 OVER THE YEARS USING VARIOUS TECHNIQUES HAVE A GREATER RISK OF
6 CAUSING CERVICAL INCOMPETENCE --
7 THE REPORTER: I'M SORRY, I COULDN'T HEAR YOU.
8 THE WITNESS: THERE ARE NUMEROUS STUDIES THAT SAY
9 MID-TRIMESTER ABORTIONS THAT DILATE THE CERVIX MORE AT A
10 GREATER RISK OF INCOMPETENCE CERVIX THAN SURGICAL TRAUMA.
11 BY MS. GARTNER:
12 Q. AND SO THOSE STUDIES THAT YOU ARE REFERRING TO EITHER DON'T
13 INVOLVE THE USE OF OSMOTIC DILATORS OR DON'T SPECIFY THE TYPE
14 OF DILATORS USED; IS THAT CORRECT?
15 A. I BELIEVE THERE ARE ONES THAT INCLUDE ALL THE DIFFERENT
16 METHODS, BUT THEY DO LOOK OVER TIMES MANY DIFFERENT METHODS.
17 Q. I AM SORRY, I AM NOT UNDERSTANDING YOU AT ALL.
18 A. I BELIEVE SOME OF THE STUDIES THAT STUDIES GO OVER DECADES
19 DO INVOLVE VARIOUS METHODS.
20 Q. BUT DO ANY OF THE STUDIES -- LET ME ASK YOU, FIRST: THE
21 STUDIES THAT YOU CITED IN THE FOOTNOTES IN YOUR PIECE IN JAMA,
22 NONE OF THEM WAS MORE RECENT THAN 1986, WERE THEY?
23 DO YOU WANT A COPY OF THAT?
24 A. I HAVE GOT IT.
25 Q. OKAY.

1 A. THE ARTICLE IS FROM '97, '98.
2 Q. LET'S LOOK SPECIFICALLY AT THE SENTENCE THAT -- MR. SIMPSON
3 DIRECTED YOUR ATTENTION TO A SENTENCE IN THE TEXT ON PAGE 746
4 OF THE ARTICLE, AND THERE'S A SENTENCE AT THE BOTTOM OF THE
5 LEFT-HAND COLUMN THAT STATES:
6 "DILATION AND EVACUATION PROCEDURES COMMONLY USED IN
7 INDUCED MID-TRIMESTER ABORTION MAY LEAD TO CERVICAL
8 INCOMPETENCE." AND THERE ARE THREE ARTICLES CITED, THREE
9 NOTES, 26, 32 AND 33.
10 AM I CORRECT ABOUT THAT?
11 A. CORRECT.
12 Q. AND IF YOU LOOK AT THE REFERENCES AT THE BACK OF YOUR
13 ARTICLE, SPECIFICALLY AT 26, 32 AND 33, MY QUESTION TO YOU IS,
14 ARE ANY OF THOSE CITED REFERENCES LATER OR MORE RECENT THAN
15 1986?
16 A. THOSE PARTICULARLY ARE NOT, BUT I DID NOT USE ALL OF THE
17 REFERENCES THERE, AND THERE ARE OTHER REFERENCES FROM '93 ON
18 MID-TRIMESTER INDUCTION ABORTIONS.
19 I DIDN'T LIST THEM ALL THERE. SOME OF THE OTHER
20 ARTICLES ALSO ADDRESS THOSE ISSUES.
21 Q. I AM SORRY, SOME OF THOSE OTHER ARTICLES ADDRESS THOSE
22 ISSUES?
23 A. CORRECT.
24 Q. YOU CHOSE NOT TO REFERENCE THEM?
25 A. RATHER THAN LIST SIX, EIGHT, TEN REFERENCES DIDN'T MAKE

1 SENSE.
2 Q. ARE YOU REPRESENTING THAT THE OTHER ARTICLES THAT YOU
3 DIDN'T LIST SPECIFICALLY ADDRESS THE POTENTIAL LINK BETWEEN
4 OSMOTIC DILATION AND CERVICAL INCOMPETENCE?
5 A. SPECIFICALLY WHAT THOSE SAY IS THERE ARE DIFFERENT METHODS
6 OF DILATING THE CERVIX AND WE DON'T HAVE AS MUCH DATA SO WE
7 DON'T KNOW.
8 Q. OKAY.
9 A. I BELIEVE AT THIS POINT WE DON'T HAVE ENOUGH FACTS TO SAY
10 THAT. THEY MAY BE SAFER, AND I AM NOT SAYING THEY ARE NOT,
11 THEY MAY NOT, I AM SAYING WE DON'T KNOW.
12 Q. WHEN YOU SAY "THEY" YOU ARE REFERRING TO?
13 A. LAMINARIA.
14 Q. LAMINARIA.
15 A. CORRECT.
16 Q. BECAUSE THE STUDIES THAT YOU REALLY ARE, THE OLDER STUDIES
17 INVOLVED MECHANICAL DILATION, CORRECT?
18 A. SOME, BUT SOME USE -- LAMINARIA HAS BEEN USED FOR A LONG
19 TIME AS WELL. NEWER ONES RELY MORE ON LAMINARIA WERE HOPEFUL
20 THAT THEY DID LESS TRAUMA, AND I DON'T THINK ANY HAS BEEN
21 CONFIRMED.
22 Q. MY QUESTION IS, ARE THERE ANY STUDIES OUT THERE THAT
23 SPECIFICALLY LOOK AT LAMINARIA, AND THE USE OF LAMINARIA AS AN
24 OSMOTIC DILATOR AND ITS IMPACT ON CERVICAL INCOMPETENCE?
25 A. I WOULD SAY THE CHASEN STUDY WHICH IS SIGNIFICANT LAMINARIA

1 DID SHOW GREATER RISK OF CERVICAL TRAUMA.
2 SO, I WOULD SAY THAT STUDY IN PART SAYS THAT
3 LAMINARIA MAY CAUSE CERVICAL TRAUMA.
4 Q. CAN I HAVE YOU LOOK -- DO YOU HAVE YOUR DEPOSITION UP THERE
5 WITH YOU?
6 A. I DO NOT.
7 Q. YOU DO NOT.
8 IF YOU COULD TURN TO PAGE 159 OF YOUR DEPOSITION,
9 AND LOOK AT THE QUESTION AND ANSWER THAT BEGIN AT LINES 10 AND
10 GO THROUGH LINES 25.
11 A. CORRECT.
12 AT THAT POINT I DON'T BELIEVE I HAD SEEN THE CHASEN
13 STUDY YET.
14 Q. OKAY. LET MY JUST TRY TO NAIL THIS DOWN.
15 IS IT YOUR TESTIMONY IN YOUR DEPOSITION THAT MOST OF
16 THE CONCERN YOU HAVE ABOUT THE RISKS OF DILATION IN THE INTACT
17 D&E PROCESS RELATE TO THE MECHANICAL DILATION, NOT TO THE
18 LAMINARIA BECAUSE IT IS YOUR VIEW THAT THERE IS NOT REAL GOOD
19 DATA AS FAR AS THE DIRECT CONNECTION BETWEEN LAMINARIA AND
20 THOSE KINDS OF THINGS AND HOW FAR YOU DILATE THE CERVIX?
21 A. THE LAMINARIA CAN CAUSE MECHANICAL DAMAGE AS WELL BY BOTH
22 PLACING AND, DEPENDING ON HOW FAST THEY DILATE, CAUSE
23 MECHANICAL AS WELL. PLUS, AGAIN, I DIDN'T HAVE THE CHASEN
24 STUDY --
25 Q. RIGHT.

1 BUT IN YOUR DEPOSITION DID YOU TESTIFY THAT THERE IS
2 NOT REAL GOOD DATA ABOUT THE LINK, IF ANY, BETWEEN LAMINARIA
3 AND CERVICAL INCOMPETENCE?
4 A. AT THE DATE OF THIS, YES. THERE IS NEW DATA SINCE THEN.
5 Q. I AM JUST TRYING TO CLARIFY THIS.
6 AS OF MID-FEBRUARY OF THIS YEAR, IT WAS YOUR OPINION
7 THERE IS NO REAL GOOD DATA OUT THERE LINKING LAMINARIA AND
8 CERVICAL INCOMPETENCE; IS THAT CORRECT? AS OF FEBRUARY --
9 A. WHETHER IT'S HARMFUL OR BENEFICIAL, CORRECT.
10 Q. THAT'S RIGHT. OKAY.
11 AND SINCE YOUR DEPOSITION WAS TAKEN YOU HAVE NOW
12 READ THE CHASEN STUDY AND THAT HAS CHANGED YOUR VIEWS TO SOME
13 EXTENT, CORRECT?
14 A. IT MAKES ME QUESTION IT MORE. CORRECT.
15 Q. OKAY, THAT'S FINE.
16 THE COURT: I AM STILL A LITTLE LOST. THE THREE
17 ARTICLES THAT YOU CITE FOR THIS PROPOSITION OF THE LINK BETWEEN
18 THE TWO ARE FROM 1982 AND 1986. WERE THOSE ARTICLES BASED UPON
19 A PRIOR MECHANICAL PROCEDURE FOR DILATION OR WERE THEY BASED
20 UPON THE USE OF LAMINARIA?
21 THE WITNESS: ALL OF THE ABOVE. MECHANICAL
22 LAMINARIA AND EVEN INDUCING LABOR BECAUSE THEY INJECTED SOME
23 THINGS LIKE UREA AND SALINE THAT STARTED THE PROCESS, TOO.
24 THE COURT: SO THE USE OF LAMINARIA WAS PREVALENT IN
25 1986?

1 THE WITNESS: NOT AS PREVALENT. PEOPLE WERE USING
2 IT, THEY WERE USING EACH OF THESE THINGS.
3 THE COURT: AND THE SPECIFIC STUDIES, DID THEY REFER
4 TO THE USE OF LAMINARIA, THE STUDIES YOU RELIED ON?
5 THE WITNESS: I DON'T HAVE THOSE STUDIES IN FRONT OF
6 ME RIGHT NOW, SO I WOULDN'T WANT TO SAY UNDER OATH WHETHER THEY
7 DID OR DIDN'T.
8 THE COURT: ALL RIGHT.
9 BY MS. GARTNER:
10 Q. SO, DR. SPRANG, EVEN FOR AN OB/GYN SUCH AS YOURSELF THAT
11 DON'T DO ABORTIONS ON LIVE FETUSES, SOMETIMES MECHANICAL
12 DILATION AND OSMOTIC DILATION ARE PART OF YOUR PRACTICE, RIGHT?
13 A. CORRECT.
14 Q. FOR EXAMPLE, YOU HAVE USED MECHANICAL DILATORS IN YOUR
15 PRACTICE, RIGHT?
16 A. CORRECT.
17 Q. AND YOU HAVE USED MECHANICAL DILATORS TO DILATE AT LEAST TO
18 10 MILLIMETERS AND MAYBE TO 12 MILLIMETERS, RIGHT?
19 A. NORMALLY 10.
20 Q. YOU OCCASIONALLY USE LAMINARIA, RIGHT?
21 A. CORRECT.
22 Q. AND IT WAS YOUR ESTIMATE, I THINK, THAT YOU HAVE USED IT
23 HALF A DOZEN TIMES?
24 A. IT'S AN UNDERESTIMATE, BUT YES.
25 Q. I'M SORRY, IT'S A WHAT ESTIMATE?

1 A. IT'S AN UNDERESTIMATE.
2 Q. SO MORE THAN HALF A DOZEN TIMES, OKAY.
3 YOU HAVE NEVER HAD A PATIENT WHO EXPERIENCED AN
4 INFECTION ASSOCIATED WITH THE USE OF LAMINARIA, RIGHT?
5 A. I HAVE NEVER USED THEM FOR MORE THAN ONE DAY.
6 Q. YOU HAVE NEVER SEEN A PATIENT WHO, EVEN IF YOU DIDN'T PLACE
7 THE LAMINARIA, YOU HAVE NEVER SEEN A PATIENT TO EXPERIENCE AN
8 INFECTION AS A RESULT OF LAMINARIA, RIGHT?
9 A. I HAVE SEEN PATIENTS COME BACK WITH INFECTIONS AFTER
10 ABORTIONS.
11 I CAN'T SAY THAT IT WAS SPECIFICALLY THE LAMINARIA,
12 OR THE PROCEDURE, OR THE TRAUMA, BUT, YES, I HAVE SEEN
13 INFECTIONS IN PATIENTS THAT HAVE LAMINARIA PLACED.
14 Q. YOU DON'T KNOW WHETHER THE INFECTION WAS THE RESULT OF THE
15 LAMINARIA?
16 A. THERE IS NO WAY TO KNOW THAT.
17 Q. OKAY.
18 AND YOU AGREE THAT WHEN INSERTING LAMINARIA, YOU
19 HAVE TO TAKE EACH PATIENT AS SHE COMES AND DECIDE AT THAT POINT
20 HOW MANY LAMINARIA YOU CAN REASONABLY PUT IN, RIGHT?
21 A. CORRECT.
22 Q. AND YOU WOULD AGREE THAT EVERY WOMAN'S CERVIX VARIES AND
23 THERE'S GOING TO BE VARIATION IN HOW WOMEN RESPOND TO
24 LAMINARIA, RIGHT?
25 A. CORRECT.

1 Q. AM I RIGHT THAT THE TERM "SERIAL LAMINARIA" REFERS TO
2 PLACING ONE SET OF LAMINARIA, LEAVING THEM IN FOR A PERIOD OF
3 TIME, TAKING THAT LAMINARIA OUT AND INSERTING ANOTHER SET OF
4 LAMINARIA?
5 A. FOR THE MOST PART, YES. SOME PEOPLE WILL LEAVE THE ONES
6 THAT ARE IN THERE AND THEY ADD MORE IN. SO IT CAN BE SERIAL
7 LAMINARIA.
8 Q. THE POINT OF DOING SERIAL LAMINARIA IS TO GET GREATER
9 DILATION THAN CAN BE ACHIEVED WITH A SINGLE SET; IS THAT RIGHT?
10 A. CORRECT.
11 Q. AND YOU, AS YOU HAVE JUST SAID, HAVE NOT PERSONALLY DONE
12 SERIAL LAMINARIA, RIGHT?
13 A. NOT THAT I RECALL.
14 Q. BUT YOU HAVE SUPERVISED RESIDENTS WHO HAVE DONE IT?
15 A. CORRECT.
16 Q. AND YOU'RE THE PRESIDENT, I THINK YOU SAID THIS, OF A LARGE
17 PRACTICE OR PARTNERSHIP; IS THAT RIGHT?
18 A. CORRECTED.
19 Q. SOME OF YOUR PARTNERS WILL OCCASIONALLY DO SERIAL
20 LAMINARIA, RIGHT?
21 A. CORRECT.
22 Q. AND PRE-TERM DELIVERY IS DISTINCT FROM CERVICAL
23 INCOMPETENCE, RIGHT?
24 A. CORRECT.
25 Q. NOT ALL WOMAN WHO HAVE PRE-TERM DELIVERIES HAVE AN

1 INCOMPETENT CERVIX; IS THAT RIGHT?
2 A. I WOULD SAY IT'S A GRADATION. IF YOU HAVE AN INCOMPETENT
3 CERVIX, YOU HAVE REALLY SEVERE TRAUMA TO THE CERVIX, IT CAN'T
4 EVEN GO BEYOND EVEN 16 WEEKS, WHEREAS PRE-TERM LABOR IN SOME
5 CASES IS THAT THE STRENGTH IS SUCH ONCE YOU START TO GET TO 34,
6 35 WEEKS, THE AMOUNT OF PRESSURE IS SUCH THAT THE CERVIX CAN NO
7 LONGER MAINTAIN IT. SO IT'S A GRADATION.
8 Q. A WOMAN CAN HAVE A PRE-TERM BIRTH WITHOUT HAVING AN
9 INCOMPETENT CERVIX, CORRECT?
10 A. THERE ARE MULTIPLE REASONS FOR PRE-TERM BIRTH.
11 Q. YOU ANTICIPATED MY NEXT QUESTION.
12 SO, I AM CORRECT, RIGHT, THAT YOU CAN HAVE A
13 PRE-TERM BIRTH WITHOUT HAVING AN INCOMPETENT CERVIX, RIGHT?
14 A. CORRECT.
15 Q. AND WOMEN WHO HAVE NEVER HAD AN ABORTION CAN HAVE AN
16 INCOMPETENT CERVIX, CORRECT?
17 A. MUCH LESS LIKELY, BUT CORRECT.
18 Q. THAT WOMEN CAN HAVE INCOMPETENT CERVIX WITHOUT EVER HAVING
19 HAD AN ABORTION?
20 A. THE MAJORITY OF TIMES THAT I AM AWARE OF INCOMPETENCE
21 CERVIX, THERE WAS SOME CERVICAL TRAUMA. IT MAY NOT BE AN
22 ABORTION, IT MAY HAVE JUST BEEN A D&C, BUT THEY HAD SOME DAMAGE
23 TO THE CERVIX THAT WEAKENED IT --
24 Q. IT COULD HAVE BEEN A LEEP PROCEDURE?
25 A. ABSOLUTELY, AND I PUBLISHED A PAPER ON THAT.

1 Q. OR THERE COULD HAVE BEEN NO TRAUMA TO THE CERVIX, CORRECT?
2 A. MOST OF THE TIME THERE IS TRAUMA.
3 Q. BUT I AM ASKING YOU, COULD A WOMAN HAVE INCOMPETENCE CERVIX
4 WITHOUT TRAUMA TO THE CERVIX?
5 A. I WANT TO BE -- THE OTHER WAY WOULD BE A D&X EXPOSURE SO
6 THAT WILL CAUSE TRAUMA, BUT IN A DIFFERENT WAY.
7 Q. NOW, IS IT FAIR TO SAY THAT THE CAUSES OF CERVICAL
8 INCOMPETENCE HAVE BEEN STUDIED, BUT ARE NOT WELL UNDERSTOOD?
9 A. I WOULD SAY MOST TIMES THERE IS TRAUMA OF SOME KIND OR
10 WEAKENING OF THE CERVICAL TISSUE. THAT WOULD BE THE MOST
11 LIKELY.
12 Q. DID YOU TESTIFY IN NEBRASKA EARLIER THIS WEEK?
13 A. I DID.
14 Q. I WILL HAND YOU YOUR TESTIMONY.
15 MS. GARTNER: I AM SORRY, YOUR HONOR. HAD I GIVEN
16 YOU A COPY OF THIS?
17 THE COURT: NO.
18 BY MS. GARTNER:
19 Q. I WILL ASK YOU TO LOOK AT PAGE 1184, DR. SPRANG, LINE 3.
20 AND DID YOU TESTIFY THAT IT WAS FAIR TO SAY THAT THE
21 CAUSES OF CERVICAL INCOMPETENCE HAVE BEEN STUDIED, BUT ARE NOT
22 WELL UNDERSTOOD?
23 A. I WILL STILL SAY NOT WELL UNDERSTOOD, BUT THEY ARE
24 UNDERSTOOD TO SOME EXTENT.
25 Q. OKAY.

1 REGARDLESS OF THE CAUSES OF INCOMPETENCE CERVIX, AM
2 I CORRECT THAT INCOMPETENCE CERVIX, THE CONDITION, IS ONLY A
3 CONCERN IF THE WOMAN WANTS TO HAVE ADDITIONAL CHILDREN?
4 A. CORRECT.
5 Q. SO IT IS NOT A CONCERN FOR A WOMAN WHO DOES NOT WANT TO
6 HAVE ANY MORE CHILDREN?
7 A. CORRECT.
8 Q. DR. SPRANG, I AM GOING TO ASK YOU, AGAIN, I'M GOING TO TEST
9 YOUR EYESIGHT AND ASK YOU TO LOOK BACK AT THE AMA REPORT, AND
10 LOOK SPECIFICALLY AT PAGE 199. THE THIRD, I THINK IT'S THE
11 THIRD PARAGRAPH ON THAT PAGE BEGINS WITH THE WORD "CERVICAL
12 INCOMPETENCE."
13 DR. SPRANG, CAN WE DO IT AGAIN? I WILL READ IT TO
14 YOU AND TELL ME IF I'VE READ IT CORRECTLY?
15 A. SURE.
16 Q. THE REPORT, AND THIS IS, AGAIN, FROM THE AMA TASK FORCE
17 REPORT:
18 "CERVICAL INCOMPETENCE AND COMPROMISED
19 SUBSEQUENT PREGNANCIES ARE IMPORTANT, BUT
20 UNRESOLVED CONCERNS RELATED TO ABORTIONS
21 PERFORMED IN THE SECOND OR THIRD-TRIMESTER.
22 UNFORTUNATELY, THERE IS LITTLE RESEARCH ON
23 WHETHER THESE COMPLICATIONS ARE MORE LIKELY TO
24 RESULT FROM D&E (OR INTACT D&X) OR FROM LABOR
25 INDUCTION TECHNIQUES."

1 AND THAT'S WHAT THE AMA TASK FORCE WROTE ON THIS
2 SUBJECT; IS THAT CORRECT?
3 A. CORRECT.
4 Q. DOES THIS REFLECT THE CONSENSUS VIEW OF THE AMA TASK FORCE?
5 A. IT IS UNRESOLVED, IN FACT, IT IS UNRESOLVED AND I AGREE
6 WITH IT.
7 Q. DR. SPRANG, I WANT TO TALK TO YOU A LITTLE BIT ABOUT THE
8 AUTRY STUDY.
9 DO YOU STILL HAVE THAT UP THERE WITH YOU?
10 A. LET ME LOOK.
11 THE COURT: WHAT IS THE NUMBER OF THAT?
12 MS. GARTNER: I'M SORRY, YOUR HONOR, IT IS LT-5.
13 THE WITNESS: I DO.
14 MS. GARTNER: YOU DO. OKAY, GOOD.
15 BY MS. GARTNER:
16 Q. DID YOU SAY YOU DO OR DO NOT?
17 A. I DO.
18 Q. OKAY.
19 DR. SPRANG, AM I CORRECT THAT YOU -- THE GOVERNMENT
20 GAVE YOU A COPY OF THIS ARTICLE IN CONNECTION WITH YOUR WORK AS
21 AN EXPERT ON THIS CASE?
22 A. CORRECT.
23 Q. YOU HADN'T SEEN IT BEFORE, RIGHT?
24 A. CORRECT.
25 Q. AND AM I CORRECT THAT YOUR MAIN CRITICISM OF THIS STUDY IS

1 THE FACT THAT THE AUTHORS CATEGORIZED RETAINED PLACENTA AS A
2 COMPLICATION OF INDUCTION ABORTIONS?
3 A. IT IS ONE OF THE MAJOR ONES. I WILL NOT SAY IT'S THE MAIN
4 ONE.
5 Q. OKAY, I'M SORRY. BUT THAT IS ONE OF YOUR MAIN CRITICISMS?
6 A. CORRECT.
7 Q. OKAY.
8 BUT YOU WOULD AGREE THAT RETAINED PLACENTA WAS NOT
9 THE ONLY COMPLICATION REPORTED FOR INDUCTION ABORTIONS IN THIS
10 STUDY, RIGHT?
11 A. IT REPRESENTED 77 PERCENT, SO THE VAST MAJORITY.
12 Q. RIGHT. BUT THERE WERE -- BUT PATIENTS HAVING INDUCTIONS
13 HAD OTHER COMPLICATIONS OTHER THAN RETAINED PLACENTA; IS THAT
14 CORRECT?
15 A. I HAVE QUESTIONS ON SOME OF THOSE AS WELL. SO, IF YOU WANT
16 TO GO THROUGH THEM, THAT WILL BE FINE.
17 Q. MY QUESTION, DR. SPRANG, WAS: ISN'T IT THE CASE THAT THERE
18 WERE PATIENTS UNDERGOING INDUCTION ABORTIONS WHO WERE PART OF
19 THIS STUDY WHO HAD COMPLICATIONS OTHER THAN RETAINED PLACENTA?
20 A. CORRECT, BUT I HAVE QUESTIONS ON THOSE COMPLICATIONS.
21 Q. AND THE ANSWER IS "CORRECT"?
22 A. CORRECT.
23 Q. THANK YOU.
24 NOW, YOUR VIEW IS THAT RETAINED PLACENTA IS JUST A
25 PART OF INDUCTION, AND IT'S NOT A COMPLICATION; IS THAT

1 CORRECT?
2 A. CORRECT.
3 Q. BUT YOU WOULD AGREE THAT THAT VIEW IS NOT A UNIVERSAL VIEW,
4 RIGHT?
5 A. I AM SURE IT IS SUBJECT TO INTERPRETATION OF INDIVIDUALS.
6 Q. AND YOU WOULD AGREE THAT IN THE MEDICAL LITERATURE, THE
7 RATE OF RETAINED PLACENTA THAT'S REPORTED FOR INDUCTION
8 ABORTIONS IS ABOUT TEN TO TWENTY PERCENT?
9 A. CORRECT.
10 Q. ARE YOU FAMILIAR, DR. SPRANG, WITH A PROGRAM THAT WAS RUN
11 UNDER THE AUSPICES FOR THE CENTER OF DISEASE CONTROL IN THE
12 1970'S CALLED THE "JOINT PROGRAM FOR THE STUDY OF ABORTION"?
13 A. I HAVE THE DATA, BUT I DON'T REMEMBER THAT SPECIFIC NAME,
14 BUT GO AHEAD.
15 Q. WERE YOU AWARE OF THE FACT THAT IN THE 1970'S, THE CDC
16 UNDER THE AUSPICES OF THE CDC SEVERAL MULTICENTER STUDIES OF
17 ABORTION METHODS WERE PERFORMED?
18 A. THROUGH THE ALAN GUTTMACHER INSTITUTE AS WELL?
19 Q. WELL, I THINK THE TESTIMONY HERE HAS BEEN IT WAS, THERE
20 WERE TWO CO-DIRECTORS, DAVID GRIMES AND WILLARD CATES AND IT
21 WAS RUN OUT OF THE CENTERS FOR DISEASE CONTROL. IT WAS A
22 MULTICENTER STUDY?
23 A. OFTEN THEY GET SOME OF THEIR DATA FROM THE ALAN GUTTMACHER
24 INSTITUTE AS WELL. AND I THINK THEY DID FROM THAT INSTITUTE IN
25 THAT INSTANCE.

1 Q. I AM NOT CERTAIN THAT THE ALAN GUTTMACHER INSTITUTE EXISTED
2 AT THIS TIME, BUT I DON'T THINK THAT'S AN IMPORTANT POINT FOR
3 US TO DEBATE.
4 ARE YOU FAMILIAR WITH THE FACT THAT THE CDC STUDIED
5 ABORTION IN THE 1970'S?
6 A. YES. I HAVE SEEN SOME OF THE DATA. I DIDN'T REALIZE YOU
7 SAID '70S. I THOUGHT YOU SAID '90S.
8 Q. IN THE 1970'S, THE CDC STUDIED ABORTION METHODS SOON AFTER
9 THE LEGALIZATION OF ABORTION TO ASSESS ITS SAFETY?
10 A. I HAVE READ THE DATA, YES.
11 Q. OKAY, GOOD.
12 I WOULD LIKE YOU TO LOOK -- LET ME ASK YOU, FIRST,
13 ARE YOU AWARE OF THE FACT THAT IN THOSE STUDIES THAT THE CDC
14 PERFORMED LOOKING AT D&E ABORTIONS AND INDUCTION ABORTIONS,
15 THAT THE CDC CONSIDERED RETAINED PLACENTA TO BE A COMPLICATION
16 WHEN IT OCCURRED IN THE CONTEXT OF AN INDUCTION?
17 A. I DIDN'T SEE THAT, SO NO.
18 Q. LET'S TAKE A LOOK AT IT.
19 MS. GARTNER: YOUR HONOR, IF I MAY APPROACH THE
20 WITNESS TO SHOW HIM LT, LEARNED TREATISE, 7?
21 THE COURT: YES.
22 BY MS. GARTNER:
23 Q. DR. SPRANG, I AM HANDING YOU WHAT IS AN ARTICLE ENTITLED
24 "MIDTRIMESTER ABORTION INTRA-AMNIOTIC INSTILLATION OF
25 HYPEROSMOLAR UREA AND PROSTAGLANDIN F2 BETTA VERSUS DILATION

1 AND EVACUATION."

2 THIS WAS PUBLISHED IN THE JOURNAL OF THE AMERICAN

3 MEDICAL ASSOCIATION ON FEBRUARY 17TH, 1984, VOLUME 251,

4 NUMBER 7, AND THE AUTHORS ARE KAFRISSEN, SCHULZ, GRIMES, GRIMES

5 AND CATES.

6 HAVE YOU EVER SEEN THIS ARTICLE BEFORE?

7 A. I SAW SUMMARIES FROM THE CDC. I DO NOT REMEMBER SEEING

8 THIS ARTICLE.

9 Q. DO YOU WANT TO LOOK AT THE BOTTOM LEFT-HAND CORNER?

10 DO YOU SEE WHERE IT SAYS, "FROM THE DIVISION OF

11 REPRODUCTIVE HEALTH, CENTER FOR HEALTH PROMOTION AND EDUCATION,

12 CENTERS FOR DISEASE CONTROL, ATLANTA"?

13 A. CORRECT.

14 Q. ARE YOU FAMILIAR WITH THE NAME DR. DAVID GRIMES?

15 A. I AM.

16 Q. ARE YOU FAMILIAR WITH THE FACT THAT HE IS ONE OF THE

17 PREEMINENT RESEARCHERS IN THE AREA OF ABORTION?

18 A. I KNOW HE'S PUBLISHED A NUMBER OF ARTICLES, YES.

19 Q. WERE YOU AWARE THAT HE WAS A CO-DIRECTOR OF THE UNIT IN THE

20 CDC THAT STUDIED ABORTION?

21 A. I WAS NOT.

22 Q. ARE YOU FAMILIAR WITH THE NAME DR. WILLARD CATES?

23 A. I HAVE SEEN ARTICLES, YES.

24 Q. WHAT I WANTED TO DO, DR. SPRANG, IS HAVE YOU LOOK AT THE

25 THIRD PAGE OF THIS ARTICLE. IT IS PAGE 918 OF TABLE 2, AND ASK

1 YOU, AS YOU READ IT, DOES THIS TABLE PURPORT TO LIST THE RATES
2 AND RELATIVE RISKS OF SPECIFIC COMPLICATIONS?
3 MR. SIMPSON: OBJECTION, YOUR HONOR.
4 IF COUNSEL IS GOING TO ASK THE WITNESS ABOUT THIS
5 ARTICLE, HE HAS SAID HE HAS NEVER SEEN IT BEFORE, SHE NEEDS TO
6 GIVE HIM TIME TO REVIEW IT.
7 THE COURT: I AGREE.
8 MS. GARTNER: OKAY. IN THE INTEREST OF TIME, YOUR
9 HONOR, I WILL JUST MOVE ON OR --
10 THE WITNESS: IT WILL TAKE SOME TIME. AS I SAID, I
11 WAS TRAINED, I DON'T --
12 THE COURT: I SUSTAINED THE OBJECTION. YOU DON'T
13 HAVE TO READ IT.
14 THE WITNESS: THANK YOU.
15 BY MS. GARTNER:
16 Q. LET'S LEAVE ASIDE, DR. SPRANG, THE QUESTION OF WHETHER OR
17 NOT RETAINED PLACENTA IS A COMPLICATION, WHAT I WANT TO FOCUS
18 ON IS WHAT ACTUALLY HAPPENS WHEN A WOMAN IS HAVING AN INDUCTION
19 ABORTION AND RETAINED PLACENTA OCCURS.
20 WHEN A PATIENT AT EVANSTON HOSPITAL, YOUR HOSPITAL,
21 IS HAVING AN INDUCTION AND THE PLACENTA STAYS WITHIN HER AFTER
22 THE FETUS HAS BEEN COMPLETELY EXPELLED, SHE WOULD BE TAKEN TO
23 THE OPERATIVE SUITE; IS THAT CORRECT?
24 A. NOT CORRECT.
25 Q. WELL, I UNDERSTAND YOU WOULD WAIT FOR A CERTAIN PERIOD OF

1 TIME; IS THAT CORRECT?
2 A. NO. WHAT I WOULD DO IS IF SHE WAS -- SAY WE WERE USING
3 MISOPROSTOL. I'D SEE WHEN THE LAST DOSE WAS, AND I THINK THAT
4 IS FREQUENTLY AN ERROR MADE IN HOW THEY ARE PERFORMED.
5 MANY PHYSICIANS WILL FOLLOW THE PROTOCOL, BUT AS
6 SOON AS THE FETUS IS OUT, THEY STOP THE PROTOCOL. WHAT IS MUCH
7 MORE EFFECTIVE AND THE WAY I WAS TRAINED IS YOU CONTINUE THE
8 PROTOCOL.
9 IF THE LAST MEDICATION WAS GIVEN THREE HOURS AGO,
10 THE FETUS IS OUT, AND SHE'S DUE FOR ANOTHER DOSE, YOU GIVE
11 ANOTHER DOSE, AND THAT'S WHAT PUSHES THE PLACENTA OUT.
12 MOST PHYSICIANS DO NOT DO THAT, BUT IT IS VERY
13 EFFECTIVE.
14 Q. YOUR TESTIMONY WAS THAT ACCORDING TO THE LITERATURE IN TEN
15 TO TWENTY PERCENT OF CASES WHEN A WOMAN HAS AN INDUCTION
16 ABORTION THE PLACENTA IS RETAINED; IS THAT CORRECT?
17 A. CORRECT BECAUSE THEY ARE NOT DOING WHAT I JUST SAID.
18 Q. I AM SORRY, SAY THAT LAST PART?
19 A. BECAUSE THEY ARE NOT GIVING THE NEXT DOSE, THE CYTOTEC SO
20 THAT WOULD PUSH --
21 THE COURT: DR. SPRANG, I'M GOING TO ASK YOU, IN THE
22 INTEREST OF THE TIME, SHE DIDN'T --
23 THE WITNESS: I THOUGHT.
24 THE COURT: THAT WAS NOT RESPONSIVE TO THE QUESTION.
25 YOU ALREADY ANSWERED THE QUESTION. THERE IS NO NEED FOR YOU TO

1 ADD ADDITIONAL INFORMATION. WE DON'T HAVE VERY MUCH TIME AND
2 YOU ARE ESSENTIALLY WASTING THE TIME THAT SHE HAS TO COMPLETE
3 HER EXAMINATION.
4 BY MS. GARTNER:
5 Q. DR. SPRANG, IN THOSE OCCASIONS WHEN THE PLACENTA IS
6 RETAINED AFTER THE INDUCTION, IN YOUR HOSPITAL, AM I CORRECT,
7 THAT THE WOMAN WOULD BE TAKEN TO THE OPERATING SUITE?
8 A. NO. WHAT YOU WOULD DO --
9 THE COURT: THAT ANSWERS THE QUESTION.
10 THE WITNESS: NO.
11 BY MS. GARTNER:
12 Q. WHY DON'T WE LOOK AT YOUR DEPOSITION, DR. SPRANG, AT
13 PAGE 118. WHY DON'T YOU LOOK AT PAGES 118 AND 119 OF YOUR
14 DEPOSITION AND THEN I WILL ASK YOU SOME QUESTIONS. JUST
15 REFRESH YOUR RECOLLECTION.
16 A. 118 AND 119?
17 Q. IF YOU COULD START AT 118, LINE 23 WHERE THE QUESTION WAS:
18 "IF A PHYSICIAN IS REQUIRED TO GO IN OR MAKES
19 THE DECISION TO GO IN AND REMOVE RETAINED
20 PLACENTA, WHAT IS THE PROCESS FOR THAT?"
21 AND THEN YOU GIVE YOUR ANSWER ON PAGE 119.
22 OKAY?
23 HAVE YOU HAD A CHANCE TO LOOK AT IT?
24 A. CORRECT.
25 Q. SO, AT EVANSTON HOSPITAL, IF A WOMAN IS HAVING AN

1 INDUCTION, THE FETUS IS EXPELLED, THE PLACENTA HAS BEEN
2 RETAINED, SEVERAL HOURS HAVE PASSED, THE PLACENTA HAS STILL
3 BEEN RETAINED, LET'S SAY SHE IS BLEEDING A LITTLE BIT, THERE IS
4 A LITTLE BIT OF CONCERN, THE DECISION IS MADE THE PLACENTA HAS
5 TO BE REMOVED.
6 SHE WOULD BE TAKEN TO THE OPERATING SUITE; IS THAT
7 CORRECT?
8 A. FIRST, I WOULD TRY TO DO IT THERE. FIRST, I WOULD TRY TO
9 TWEEZE IT OUT WITH MY FINGERS OR GRASP IT WITH RING FORCEPS.
10 IF I WASN'T SUCCESSFUL AT THAT, THEN I WOULD GO BACK TO THE
11 OPERATING ROOM.
12 Q. OKAY.
13 A. I WOULD TRY TO DO THE MORE MINIMAL THING FIRST, AND IF THAT
14 DIDN'T WORK, THEN GO TO THE NEXT STEP.
15 Q. YOU WOULD TRY AND DO IT FIRST WITH YOUR FINGERS; IS THAT
16 RIGHT?
17 A. FINGERS WOULD BE THE EASIEST. SOMETIMES WE WOULD USE THE
18 RING FORCEPS, THAT KIND OF THING. IF THAT DIDN'T WORK, WE
19 WOULD GO --
20 Q. YOU WOULD DO IT FIRST WITH YOUR FINGERS BECAUSE IF YOU CAN,
21 YOU WOULD RATHER NOT PUT AN INSTRUMENT IN HER UTERUS, RIGHT?
22 A. IT'S THE MOST IN GENERAL AND IT'S WHAT WE DO ALL THE TIME.
23 WE ARE GYNECOLOGISTS AND WE'RE VERY FAMILIAR WITH HOW THINGS
24 FEEL THERE. IF I CAN GRASP IT, I CAN SLIDE MY FINGERS UNDER
25 THE PLACENTA AND JUST SLIDE IT OUT, WHICH IS THE SAME THING WE

1 DO AT TERM.
2 Q. RIGHT. BUT JUST GOING BACK TO MY QUESTION, YOU WOULD DO IT
3 WITH YOUR FINGERS IF YOU COULD BECAUSE YOU WOULD RATHER NOT PUT
4 AN INSTRUMENT IN HER UTERUS IF YOU DIDN'T HAVE TO, RIGHT?
5 A. IT'S MORE GENTLE, YES.
6 Q. OKAY.
7 SO IN THIS HYPOTHETICAL, THE WOMAN, THE PLACENTA HAS
8 BEEN RETAINED, YOU HAVE DETERMINED THAT IT HAS TO BE REMOVED,
9 YOU HAVE ATTEMPTED TO REMOVE IT WITH YOUR FINGERS AND IT HASN'T
10 COME OUT, YOU BRING HER TO THE OPERATING SUITE; IS THAT
11 CORRECT?
12 A. CORRECT.
13 Q. AND SHE'S GIVEN ANESTHESIA; IS THAT CORRECT?
14 A. PROBABLY MAC.
15 THE REPORTER: I'M SORRY?
16 THE WITNESS: MAC MONITORED ANESTHESIA CARE, MAC.
17 BY MS. GARTNER:
18 Q. SO THAT WOULD BE LIKE A CONSCIOUS SEDATION?
19 A. CORRECT.
20 Q. THEN YOU WOULD USE SOME KIND OF INSTRUMENT, A CURETTE OR
21 AND YOU WOULD REMOVE THE REMAINING CONTENTS OF THE UTERUS,
22 RIGHT?
23 A. CORRECT.
24 Q. AND IF EVERYTHING WENT WELL, THE WOMAN COULD GO HOME IN A
25 FEW HOURS?

1 A. CORRECT.
2 Q. WHEN THIS HAPPENS, YOU CONSIDER IT TO BE A CHANGE FROM AN
3 INDUCTION TO A D&E TYPE PROCEDURE, RIGHT?
4 A. CORRECT.
5 Q. BECAUSE YOU ARE USING INSTRUMENTS IN THE UTERUS?
6 A. CORRECT.
7 Q. IF THIS HAPPENS, SOME OF THE BENEFIT THAT YOU ATTRIBUTE TO
8 THE INDUCTION METHOD IS LOST; ISN'T THAT RIGHT?
9 A. CORRECT.
10 Q. BUT YOU DON'T TELL YOUR PATIENTS BEFORE THE INDUCTION
11 STARTS THAT THIS IS A POTENTIAL OCCURRENCE IN THE INDUCTION
12 PROCEDURE, RIGHT, BECAUSE YOU WAIT TO SEE IF IT DOES HAPPEN.
13 AND THEN, IF IT DOES, YOU GET THEIR CONSENT TO TAKE WHATEVER
14 STEPS ARE NECESSARY?
15 A. CORRECT.
16 Q. NOW, DR. SPRANG, YOU HAVE NEVER PERSONALLY CAUSED
17 INTRAUTERINE FETAL DEMISE BY AN INJECTION OF DIGOXIN OR KCL,
18 HAVE YOU?
19 A. CORRECT.
20 Q. YOU HAVE NEVER CAUSED FETAL DEMISE BY CUTTING THE UMBILICAL
21 CORD, HAVE YOU?
22 A. CORRECT.
23 Q. AND I THINK YOU TESTIFIED THAT IF THE PHYSICIAN DID INDUCE
24 FETAL DEMISE BY CUTTING THE CORD IT COULD BE FIVE TO 10 MINUTES
25 BEFORE A DEMISE ENSUED?

1 A. CORRECT.
2 Q. DURING THAT TIME IF IT WAS DURING THE COURSE OF AN ABORTION
3 PROCEDURE, DURING THAT FIVE OR 10 MINUTES IF THE PHYSICIAN
4 WANTED TO WAIT FOR DEMISE TO BEGIN BEFORE STARTING THE
5 PROCEDURE, THE WOMAN WOULD BE LYING ON THE OPERATING TABLE IN
6 THE LITHOTOMY POSITION FOR FIVE OR 10 MINUTES, CORRECT?
7 A. CORRECT. BUT USUALLY YOU WOULDN'T WAIT.
8 Q. OKAY. BUT IF -- OKAY. BUT IF THE PHYSICIAN DID DETERMINE
9 FOR WHATEVER REASON THAT HE OR SHE WASN'T COMFORTABLE BEGINNING
10 THE PROCEDURE UNTIL FETAL DEMISE HAD OCCURRED, THEN HE OR SHE
11 WOULD HAVE TO WAIT FIVE OR 10 MINUTES AFTER CUTTING THE CORD TO
12 BEGIN THE PROCEDURE, CORRECT?
13 A. IF THE PHYSICIAN CHOSE TO DO THAT, YES.
14 Q. DURING THAT TIME THE WOMAN WOULD BE ON THE TABLE IN THE
15 LITHOTOMY POSITION, CORRECT?
16 A. CORRECT.
17 Q. AND SHE MIGHT BE UNDER ANESTHESIA?
18 A. CORRECT.
19 Q. SHE MIGHT BE UNDER CONSCIOUS SEDATION?
20 A. WELL, AT OUR INSTITUTION IT WOULD BE CONSCIOUS SEDATION.
21 WE DON'T USE GENERAL ANESTHESIA BECAUSE OF THE RISKS OF GENERAL
22 ANESTHESIA.
23 Q. OKAY. YOU TESTIFIED THAT THERE IS A NEW POLICY, AM I
24 RIGHT, AT EVANSTON HOSPITAL?
25 A. CORRECT.

1 Q. THAT POLICY IS TO USE KCL BEFORE SECOND-TRIMESTER
2 ABORTIONS?
3 A. CORRECT.
4 Q. AND THAT IS TO INDUCE FETAL DEMISE?
5 A. CORRECT.
6 Q. AND AT EVANSTON HOSPITAL, ARE THE PHYSICIANS WHO ARE USING
7 KCL, WHO ARE ACTUALLY DOING THE INJECTION, ARE THEY MATERNAL
8 FETAL MEDICINE SPECIALISTS?
9 A. CORRECT.
10 Q. AND DOES THIS POLICY APPLY BOTH TO D&E AND INDUCTION
11 ABORTIONS?
12 A. I AM NOT A HUNDRED PERCENT SURE OF THAT.
13 Q. ARE PATIENTS EXCEPTED, E-X-C-E-P-T-E-D, FROM THE POLICY IF
14 THEY HAVE HIV OR HEPATITIS OR OTHER CONDITIONS THAT PUT THEM AT
15 HIGH RISK IF THEY HAVE AN INFECTION?
16 A. I HAVEN'T SEEN A WRITTEN POLICY, AND THE POLICY IS NEW
17 ENOUGH THAT I AM NOT SURE. IT MAY BE IF THEY RAN INTO A CASE
18 WHERE IT WAS A CONCERN THEY WOULD THEN TALK TO THE PATIENT
19 INDIVIDUALLY. I HAVE HAVEN'T SEEN A WRITTEN POLICY.
20 Q. IS THERE A WRITTEN POLICY?
21 A. IT IS SO NEW. THIS HAPPENED OVER THE LAST COUPLE OF WEEKS.
22 AND I HAVE BEEN BUSY DOING OTHER THINGS, SO I DON'T KNOW.
23 Q. UH-HUH. HOW DO YOU KNOW THAT THERE IS A NEW POLICY?
24 A. WELL, BECAUSE I SPOKE WITH THE HEAD OF MATERNAL FETAL
25 MEDICINE, AND HE ASSURED ME THAT THAT IS WHAT THEY WERE DOING.

1 Q. OKAY. AND YOU TESTIFIED EARLIER THAT, AGAIN, THERE IS THE
2 OTHER MAJOR TEACHING HOSPITAL AT NORTHWESTERN IS PRENTICE --
3 A. CORRECT.
4 Q. -- WOMEN'S HOSPITAL?
5 A. CORRECT.
6 Q. THERE IS NO POLICY REQUIRING KCL INJECTIONS BEFORE
7 ABORTIONS AT PRENTICE WOMEN'S HOSPITAL, IS THERE?
8 A. IN READING DR. MARILYNN FREDERIKSEN'S -- IN READING --
9 Q. I AM ACTUALLY ASKING YOU, DR. SPRANG, BASED ON YOUR
10 UNDERSTANDING, NOT ABOUT SOMETHING YOU READ. DO YOU HAVE AN
11 UNDERSTANDING THAT THERE IS ANY POLICY AT PRENTICE WOMEN'S
12 HOSPITAL REQUIRING KCL INJECTIONS?
13 A. SHE SAID SHE DID HAVE A POLICY DOING THAT, SO --
14 Q. I AM NOT ASKING YOU ABOUT DR. FREDERIKSEN'S POLICY. I AM
15 JUST ASKING YOU IF YOU KNOW WHETHER AT PRENTICE MEMORIAL -- IS
16 IT "MEMORIAL" -- PRENTICE HOSPITAL THERE IS A POLICY REQUIRING
17 KCL INJECTIONS BEFORE ABORTIONS?
18 A. I NEVER SEEN A POLICY LIKE THAT.
19 Q. OKAY. AND JUST TO BE CLEAR YOU DON'T KNOW IF THERE ARE
20 EXCEPTIONS TO THE POLICY AT EVANSTON HOSPITAL?
21 A. CORRECT.
22 Q. AND YOU HAVE NOT SEEN ANYTHING IN WRITING ABOUT THE POLICY?
23 A. CORRECT.
24 Q. DR. SPRANG, YOU TESTIFIED EARLIER ABOUT ETHICAL CONCERNS
25 ABOUT INTACT D&E, CORRECT?

1 A. CORRECT.
2 Q. AND, IN FACT, IT IS YOUR BELIEF THAT INTACT D&E ABORTIONS
3 ARE UNETHICAL; ISN'T THAT RIGHT?
4 A. CORRECT.
5 Q. NOW, I APOLOGIZE. I SAID WE WERE DONE WITH THE AMA REPORT,
6 AND WE ARE NOT. SORRY.
7 THE AMA TASK FORCE ON WHICH YOU SERVED GAVE THOROUGH
8 CONSIDERATION TO ETHICAL ISSUES RELATED TO BOTH INTACT D&E AND
9 OTHER LATE ABORTION PROCEDURES; IS THAT CORRECT?
10 A. CORRECT.
11 Q. OKAY. AND I WOULD LIKE YOU TO TAKE A LOOK AT PAGE 208 OF
12 THAT REPORT.
13 DO YOU WANT TO TAKE A LOOK AT THE LAST PARAGRAPH ON
14 THAT PAGE, DR. SPRANG.
15 A. DO YOU WANT ME TO READ IT?
16 Q. WELL, NO. I AM JUST GOING TO ASK YOU A QUESTION. AND IF
17 WE NEED TO, WE WILL READ IT. BUT LET ME ASK YOU: IT IS TRUE,
18 IS IT NOT, THAT THE REPORT STATES THAT THE ETHICAL ARGUMENTS
19 ABOUT INTACT D&E DO NOT LEAD TO ONE CLEARLY PREFERRED ETHICAL
20 POSITION?
21 A. THE WAY THE REPORT IS WRITTEN IT LEFT IT OPEN.
22 Q. RIGHT. SO -- AND THE COMMITTEE WRITING THE REPORT DID NOT
23 REACH CONSENSUS ABOUT THE ETHICS OF INTACT D&E; IS THAT RIGHT?
24 A. CORRECT.
25 Q. THIS IS JUST A --

1 A. THIS WAS A BOARD OF TRUSTEES REPORT. IT WENT BACK TO THE
2 BOARD OF TRUSTEES FOR THEIR FINAL APPROVAL.
3 Q. OKAY. BUT MY QUESTION FOR YOU IS WHETHER THE TASK FORCE
4 THAT YOU WERE ON THAT WROTE THIS REPORT, YOU DID NOT REACH
5 CONSENSUS ABOUT THE ETHICS OF INTACT D&E, DID YOU?
6 A. CORRECT.
7 Q. NOW, I THINK IN YOUR DEPOSITION, DR. SPRANG, YOU TESTIFIED
8 THAT YOU HAVE TWO ETHICAL CONCERNS WITH INTACT D&E. I THINK
9 YOU SAID THAT THE FIRST ONE IS THAT YOU BELIEVE IT IS UNETHICAL
10 TO CAUSE FETAL DEMISE ONCE ANY PART OF THE FETUS IS OUTSIDE OF
11 THE UTERUS; IS THAT RIGHT?
12 A. IS THAT AN ACTUAL QUOTE? I WOULD NOT HAVE SAID "ANY PART
13 OF THE FETUS." I WOULD HAVE SAID I BELIEVE IT IS UNETHICAL TO
14 KILL THE FETUS OUTSIDE OF THE MOTHER, WHEN THE FETUS IS OUTSIDE
15 OF THE MOTHER. SO THE WORDING IS RELEVANT.
16 Q. SO YOUR TESTIMONY IS YOU THINK THE ETHICAL CONCERN COMES
17 ABOUT WHEN THE DEMISE OCCURS WHEN ANY PART OF THE FETUS IS
18 OUTSIDE THE BODY OF THE MOTHER?
19 A. YOU KEEP ADDING "ANY PART OF THE FETUS."
20 Q. I'M SORRY.
21 A. AND I SAID: "WHEN THE FETUS IS OUTSIDE OF THE MOTHER."
22 Q. OKAY. SO, YOU MEAN, THAT THE ETHICAL CONCERN IS WHEN THE
23 ENTIRE FETUS IS OUTSIDE OF THE BODY OF THE MOTHER?
24 A. SUFFICIENT TO MOUNT THAT IT IS IN THE PROCESS OF DELIVERY
25 WHERE IT BECOMES A QUESTION OF: IS IT OR IS IT NOT DELIVERED?

1 WHEN WE DO A NORMAL VAGINAL DELIVERY, THE FETUS IS
2 CONSIDERED DELIVERED WHEN THE HEAD AND THE SHOULDER COME OUT.
3 SO THE REST OF THE BODY IS STILL INSIDE, BUT THAT IS WHAT WE
4 PUT DOWN AS "TIME OF DELIVERY."
5 Q. YOU RECOGNIZE, RIGHT, THAT IN DOING A DISARTICULATION D&E
6 PROCEDURE PART OF THE FETUS MAY ACTUALLY BE BROUGHT OUT OF THE
7 UTERUS THROUGH THE OS AND STILL BE ATTACHED TO WHAT IS LEFT IN
8 THE UTERUS IN THE COURSE OF A DISARTICULATION D&E, CORRECT?
9 A. CORRECT.
10 Q. SO, DO YOU UNDERSTAND THAT EVEN IN DOING A DISARTICULATION
11 D&E, WHEN PART OF THE FETUS STILL ATTACHED CAN COME OUT OF THE
12 UTERUS THAT, IN FACT, THE ETHICAL CONUNDRUM THAT YOU HAVE MAY
13 OCCUR EVEN IN A DISARTICULATION D&E?
14 A. I BELIEVE THE WAY I AM LOOKING AT IT A CLEAR DISTINCTION
15 BETWEEN D&E AND D&X IS WHERE THE FETUS IS KILLED.
16 Q. BUT YOU UNDERSTAND THAT IN A DISARTICULATION D&E, PARTS OF
17 THE FETUS CAN BE BROUGHT OUTSIDE OF THE WOMAN'S UTERUS BEFORE
18 DISARTICULATION OCCURS, AND THEY CAN BE STILL ATTACHED TO WHAT
19 IS IN THE UTERUS, AND THE FETUS CAN STILL BE LIVING SO THAT
20 FETAL PARTS CAN BE OUTSIDE THE UTERUS AND OUTSIDE THE WOMAN'S
21 BODY BEFORE DEMISE OCCURS IN A DISARTICULATION D&E, CORRECT?
22 A. YOU WILL NO LONGER FIT MY DISTINCTION BETWEEN D&E AND D&X.
23 I AM DEFINING D&X AS WHEN THE FETUS IS KILLED OUTSIDE THE
24 MOTHER'S BODY TO A SIGNIFICANT DEGREE TO CALL IT "A DELIVERY."
25 I AM TRYING TO MAKE A CLEAR DISTINCTION BETWEEN D&X AND D&E.

1 AND THAT IS WHY I AM OPPOSED TO D&X. A LARGE PART OF THE
2 REASON IS JUST ETHICALLY IF IT IS DELIVERED, YOU CAN NO
3 LONGER -- WE'RE BREAKING THE LINE BETWEEN KILLING A FETUS AND
4 KILLING A BABY. KILLING A BABY IS UNETHICAL.
5 Q. AND EVEN IF THAT OCCURS IN A DISARTICULATION D&E, YOU WOULD
6 HAVE ETHICAL CONCERNS WITH IT?
7 A. IF IT WAS KILLED OUTSIDE THE MOTHER, I WOULD SAY IT'S A
8 D&X. SO I WOULD CALL IT A DIFFERENT THING. I WOULD USE IT AS
9 A DISTINCTION BETWEEN KILLING A FETUS AND KILLING A BABY.
10 Q. AND YOUR ETHICAL CONCERN WOULD ALSO APPLY IN AN INDUCTION
11 ABORTION, CORRECT, WHERE THE FETUS WAS DELIVERED PARTLY AND
12 THEN THE HEAD BECAME ENTRAPPED AND WOMAN BECAME INFECTED OR
13 BLEEDING AND SOMETHING HAD TO HAPPEN TO SPEED THE PROCEDURE UP.
14 YOU WOULD CONSIDER THAT TO BE UNETHICAL; IS THAT CORRECT?
15 A. IF THE FETUS WAS KILLED OUTSIDE OF THE MOTHER, YES.
16 Q. OKAY.
17 A. BUT I HAVE NEVER SEEN THAT HAPPEN IN AN INDUCTION.
18 Q. SO, DR. SPRANG, YOU WOULD AGREE, OBVIOUSLY, THAT
19 NORTHWESTERN UNIVERSITY MEDICAL SCHOOL IS ONE OF THE LEADING
20 MEDICAL SCHOOLS IN THIS COUNTRY, RIGHT?
21 A. I WILL HAVE TO THINK ABOUT THAT. YES.
22 Q. OKAY. AND YOU WOULD AGREE THAT SOME OF THE FINEST
23 PHYSICIANS IN THE COUNTRY TEACH AND PRACTICE THERE, CORRECT?
24 A. NOT NECESSARILY.
25 Q. WELL, LET ME ASK YOU: YOU ARE AWARE THAT TWO OF YOUR

1 COLLEAGUES ON THE FACULTY AT NORTHWESTERN, DR. CASSING HAMMOND
2 AND DR. MARILYNN FREDERIKSEN, WHO YOU ALLUDED TO TODAY, ARE
3 TESTIFYING IN THE NEW YORK CASE CHALLENGING THIS LAW, CORRECT?
4 A. CORRECT.
5 Q. AND YOU KNOW DR. FREDERIKSEN, DON'T YOU?
6 A. VERY MINIMALLY.
7 Q. I AM SORRY?
8 A. VERY MINIMALLY.
9 Q. VERY MINIMALLY, OKAY. BUT YOU HAVE MET HER?
10 A. IF I SAW HER IN THE ROOM I WOULDN'T BE SURE THAT I WOULD
11 RECOGNIZE HER.
12 Q. I THINK YOU MENTIONED IN THE NEBRASKA TRANSCRIPT THAT YOU
13 KNEW HER?
14 A. I AM SURE I HAVE SEEN HER AT COCKTAIL PARTIES OR SOMETHING.
15 Q. OKAY.
16 A. SO THAT I DON'T KNOW IF I COULD PICK HER OUT OF THE ROOM.
17 Q. AND YOU KNOW THAT BOTH DR. FREDERIKSEN AND DR. HAMMOND ARE
18 ASSOCIATE PROFESSORS IN THE DEPARTMENT OF OB\GYN AT
19 NORTHWESTERN?
20 A. ARE THEY BOTH ASSOCIATE PROFESSORS?
21 Q. THEY ARE.
22 A. I THOUGHT DR. HAMMOND WAS AN ASSISTANT PROFESSOR, BUT ...
23 Q. AND ARE YOU AWARE -- I DON'T KNOW IF YOU ARE -- BUT ARE YOU
24 AWARE THAT BOTH DR. HAMMOND AND DR. FREDERIKSEN PROVIDE D&E
25 ABORTIONS TO BETWEEN 23 AND 24 WEEKS GESTATION AT PRENTICE

1 HOSPITAL AT NORTHWESTERN?
2 A. I BELIEVE THEY PROVIDE THEM LATER THAN THAT.
3 Q. OKAY. BUT YOU ARE AWARE THEY PROVIDE D&E ABORTIONS TO AT
4 LEAST BETWEEN 23 AND 24 WEEKS GESTATION AT PRENTICE HOSPITAL?
5 A. CORRECT.
6 Q. ARE YOU AWARE THAT DR. HAMMOND TEACHES INTACT D&E ABORTIONS
7 AT NORTHWESTERN MEDICAL SCHOOL?
8 A. I AM. I KNOW ONE OF THE STUDENTS.
9 THE COURT REPORTER: I AM SORRY?
10 THE WITNESS: YES, PERIOD.
11 BY MS. GARTNER:
12 Q. AND WOULD YOU AGREE THAT AT AN INSTITUTION OF THE CALIBER
13 OF NORTHWESTERN IT IS UNLIKELY THAT UNSAFE MEDICAL PROCEDURES
14 ARE BEING TAUGHT?
15 A. SUBJECT TO OBVIOUSLY INTERPRETATION OF WHAT IS SAFE AND
16 WHAT ISN'T SAFE, MOST OF THE INFORMATION WE HAVE SEEN AND
17 CERTAINLY THE MOST RECENT ARTICLE WOULD SAY THEY ARE SIMILAR,
18 D&E AND D&X WERE SIMILAR IN THEIR COMPLICATION RATE. BUT THERE
19 MIGHT BE A TREND FOR THE D&X TO HAVE MORE COMPLICATIONS. BUT
20 IT IS CERTAINLY NOT AN ESTABLISHED FACT.
21 Q. SO YOU WOULD AGREE THAT D&E AND INTACT D&E ARE COMPARABLY
22 SAFE?
23 A. I AM NOT SURE I WOULD GO THAT FAR. I WOULD SAY THERE IS
24 NOT ABSOLUTE PROOF THAT D&X IS LESS SAFE.
25 Q. IF I TOLD YOU THAT DR. HAMMOND AND DR. FREDERIKSEN HAVE

1 TESTIFIED THAT THE ABORTIONS THAT THEY DO WOULD VIOLATE THE LAW
2 THAT IS AT ISSUE IN THIS CASE, AND IN THE NEW YORK CASE, WOULD
3 YOU BE COMFORTABLE THAT YOU'RE TESTIFYING IN SUPPORT OF A LAW
4 THAT COULD BE USED TO PROSECUTE YOUR FELLOW FACULTY MEMBERS AT
5 NORTHWESTERN MEDICAL SCHOOL FOR THEIR MEDICAL PRACTICE?
6 MR. SIMPSON: OBJECTION, YOUR HONOR. I THINK THIS
7 IS BEYOND THE SCOPE OF DIRECT. I DON'T BELIEVE HE HAS
8 TESTIFIED REGARDING THE INTERPRETATION OF THE ACT.
9 THE COURT: ONCE, AGAIN, WAS HE CROSS-DESIGNATED?
10 MS. GARTNER: HE WAS, YOUR HONOR.
11 THE COURT: I WILL PERMIT IT.
12 THE WITNESS: KNOWING THEM, IN PART, THEY ARE SMART
13 ENOUGH THAT IF THE LAW IS PASSED THEY WILL USE FETICIDE AND
14 THEY WILL NOT BREAK THE LAW. THEY WON'T DO THAT. THEY ARE TOO
15 SMART TO DO THAT.
16 BY MS. GARTNER:
17 Q. BUT YOU WOULD BE -- IF THEY CHOSE NOT TO, YOU WOULD BE
18 COMFORTABLE THAT YOUR TESTIMONY COULD BE USED TO UPHOLD THE LAW
19 THAT COULD BE USED TO PROSECUTE YOUR FELLOW FACULTY MEMBERS?
20 A. IF SOMETHING IS UNETHICAL AND ILLEGAL A PHYSICIAN SHOULD BE
21 SMART ENOUGH NOT TO DO THAT.
22 Q. BUT YOU WOULD -- I AM LEAVING THIS -- YOU WOULD AGREE,
23 WOULDN'T YOU, DR. SPRANG, THAT AT LEAST AMONG THE FACULTY AT
24 NORTHWESTERN THERE IS NO CONSENSUS ABOUT THE APPROPRIATENESS OF
25 BANNING INTACT D&E ABORTIONS?

1 A. CORRECT.
2 Q. I THINK, DR. SPRANG, YOU TESTIFIED ABOUT A RESOLUTION THAT
3 WAS PASSED BY THE ILLINOIS MEDICAL SOCIETY SUPPORTING A BAN ON
4 INTACT D&E?
5 A. CORRECT.
6 Q. ARE YOU AWARE OF THE FACT THAT ACOG, THE AMERICAN COLLEGE
7 OF OB/GYN, HAS CONSISTENTLY TAKEN THE POSITION THAT BANNING
8 INTACT D&E IS AN IMPERMISSIBLE INTRUSION INTO MEDICAL PRACTICE?
9 A. CORRECT.
10 Q. YOU ARE AWARE THAT THE CALIFORNIA MEDICAL ASSOCIATION HAS
11 CONSISTENTLY TAKEN THE POSITION THAT BANNING INTACT D&E'S IS AN
12 IMPERMISSIBLE INTRUSION INTO MEDICAL PRACTICE?
13 A. I WAS NOT AWARE OF THAT.
14 Q. WERE YOU AWARE OF THE FACT THAT THE CALIFORNIA MEDICAL
15 ASSOCIATION, THE CMA, HAS FILED WHAT IS CALLED AN AMICUS BRIEF
16 IN THIS CASE URGING THE COURT TO STRIKE DOWN THE LAW?
17 A. I WAS NOT AWARE OF THAT.
18 Q. ARE YOU AWARE OF THE FACT THAT ANY OTHER STATE MEDICAL
19 ASSOCIATIONS OTHER THAN THE CMA, THE CALIFORNIA MEDICAL
20 ASSOCIATION, HAVE OPPOSED THIS TYPE OF LEGISLATION?
21 A. I KNOW ANOTHER STATE HAD PASSED BILLS --
22 Q. THAT IS NOT MY QUESTION, THOUGH.
23 WERE YOU AWARE THAT THE RHODE ISLAND MEDICAL SOCIETY
24 HAD SPECIFICALLY TAKEN A POSITION OPPOSING THIS TYPE OF
25 LEGISLATION?

1 A. I WAS NOT.
2 Q. GIVEN THE DIFFERING POSITIONS BETWEEN THE ILLINOIS MEDICAL
3 SOCIETY OF WHICH YOU HAVE A CLOSE ASSOCIATION, OBVIOUSLY, AND
4 ACOG, WOULD YOU AGREE THAT THERE IS NO MEDICAL CONSENSUS THAT
5 INTACT D&E'S SHOULD BE BANNED?
6 A. THERE IS A VARIATION OF OPINION, YES.
7 MS. GARTNER: I HAVE NOTHING FURTHER, YOUR HONOR.
8 THE COURT: ALL RIGHT. REDIRECT?
9 MR. SIMPSON: THANK YOU, YOUR HONOR. I WILL BE VERY
10 BRIEF?
11 THE COURT: ALL RIGHT.
12 REDIRECT EXAMINATION
13 BY MR. SIMPSON:
14 Q. DOCTOR, MS. GARTNER HAS READ TO YOU SEVERAL EXCERPTS FROM
15 THE AMA REPORT. DO YOU STILL HAVE THAT IN FRONT OF YOU?
16 A. I DO.
17 Q. IF I COULD ASK YOU TO LOOK AT PAGE 203, PLEASE.
18 IS IT TRUE, DOCTOR, THAT AT THE BOTTOM OF PAGE 202,
19 THE SPECIAL COMMITTEE'S RECOMMENDATIONS BEGIN?
20 A. CORRECT.
21 Q. AND DO THOSE RECOMMENDATIONS CONTINUE ON TO PAGE 203?
22 A. CORRECT.
23 Q. I WOULD LIKE TO READ FROM PARAGRAPH 3 OF THE
24 RECOMMENDATIONS.
25 "ACCORDING TO THE SCIENTIFIC LITERATURE, THERE

1 DOES NOT APPEAR TO BE ANY IDENTIFIED SITUATION IN
2 WHICH INTACT D&X IS THE ONLY APPROPRIATE PROCEDURE
3 TO INDUCE ABORTION, AND ETHICAL CONCERNS HAVE BEEN
4 RAISED ABOUT INTACT D&X. THE AMA RECOMMENDS THAT
5 THE PROCEDURE NOT BE USED UNLESS ALTERNATIVE
6 PROCEEDS POSE MATERIALLY GREATER RISK TO THE WOMAN."
7 DID I READ THAT CORRECTLY?
8 MS. GARTNER: OBJECTION, YOUR HONOR. I WOULD ASK
9 THAT MR. SIMPSON READ THE REMAINING SENTENCE OF THAT NUMBERED
10 PARAGRAPH.
11 MR. SIMPSON: YOUR HONOR, SHE WILL HAVE THE
12 OPPORTUNITY TO RECROSS.
13 THE COURT: SUSTAINED. THAT'S RIGHT. FRANKLY, I
14 HAVE READ THE OTHER SENTENCE AND HE IS ENTITLED TO EXAMINE ON
15 WHATEVER PORTION HE WISHES.
16 MR. SIMPSON: THANK YOU, YOUR HONOR.
17 BY MR. SIMPSON:
18 Q. DID I READ THAT CORRECTLY, DR. SPRANG?
19 A. CORRECT.
20 Q. IS IT YOUR UNDERSTANDING THAT WAS PART OF THE
21 RECOMMENDATIONS OF THE COMMITTEE?
22 A. CORRECT.
23 Q. DOCTOR, MS. GARTNER ASKED YOU ABOUT INTERNAL PODALIC
24 VERSION AND THE POTENTIAL FOR RUPTURE OF THE PLACENTA. AND YOU
25 HAVE SAID THAT YOU HAVE DONE INTERNAL PODALIC VERSION AS EARLY

1 AS I THINK YOU SAID 26 WEEKS?
2 A. IN THAT RANGE, CORRECT.
3 Q. IF YOU WERE DOING AN INTERNAL PODALIC VERSION AT 26 WEEKS
4 AND ABRUPTION OF THE PLACENTA OCCURRED IN THE COURSE OF DOING
5 THE INTERNAL PODALIC VERSION, WOULD YOU BECOME CONCERNED ABOUT
6 THE OUTCOME FOR THE MOTHER?
7 A. I WOULD BE CONCERNED FOR THE OUTCOME OF THE MOTHER AND --
8 Q. WHY WOULD YOU BE CONCERNED FOR THE OUTCOME OF THE MOTHER?
9 A. BECAUSE ONCE YOU HAVE AN ABRUPTION, YOU ARE NO LONGER
10 TALKING ABOUT FETAL CIRCULATION, YOU ARE TALKING ABOUT THE
11 MATERNAL CIRCULATION.
12 AS I SAID, THE UTERUS GIVES OUT A PINT OF BLOOD A
13 MINUTE GOING TO THE PLACENTA. ONCE THE PLACENTA SEPARATES,
14 THAT BLOOD IS POURING OUT OF THE MOTHER.
15 Q. AND WOULD YOUR CONCERN ARISE BECAUSE AT THAT POINT YOU HAD
16 NOT YET REMOVED THE FETUS OR THE BABY?
17 A. CORRECT, AND YOU ARE MOVING AS EXPEDITIOUSLY AS YOU COULD.
18 MR. SIMPSON: THANK YOU, DOCTOR.
19 MS. GARTNER: I WAS UNCLEAR ON YOUR RULING. COULD I
20 ASK DR. SPRANG TO READ THAT SENTENCE INTO THE RECORD, THE ONE
21 THAT --
22 THE COURT: YOU MAY READ IT INTO THE RECORD.
23 MS. GARTNER: THANK YOU.
24 FOR THE RECORD, THE FINAL PARAGRAPH OF THE THIRD
25 RECOMMENDATION OF THE AMA TASK FORCE STATES:

1 "THE PHYSICIAN MUST, HOWEVER, RETAIN THE
2 DISCRETION TO MAKE THAT JUDGMENT ACTING WITHIN
3 STANDARDS OF GOOD MEDICAL PRACTICE AND IN THE
4 BEST INTEREST OF THE PATIENT."
5 THANK YOU.
6 THE COURT: ALL RIGHT. YOU HAVE NO FURTHER
7 QUESTIONS OF THE DOCTOR ON THIS PARTICULAR PARAGRAPH?
8 MS. GARTNER: THAT'S CORRECT, YOUR HONOR.
9 THE COURT: OR AT ALL?
10 MS. GARTNER: CORRECT, YOUR HONOR.
11 THE COURT: ALL RIGHT. THANK YOU, DR. SPRANG. YOU
12 ARE EXCUSED.
13 THE WITNESS: THANK YOU.
14 THE COURT: YOU ARE WELCOME.
15 ALL RIGHT. I THINK THAT WE HAVE REACHED THE END OF
16 OUR DAY AND WEEK. I JUST WANT TO CLARIFY ONE THING BEFORE I
17 TAKE A LOOK THIS WEEKEND OVER THE VARIOUS DIFFERENT OBJECTIONS
18 THAT YOU SUBMITTED THIS WEEK.
19 ON THE ARTICLE, DR. SPRANG'S ARTICLE, WHAT IS YOUR
20 BASIS FOR HAVING THAT MOVED INTO EVIDENCE?
21 MR. SIMPSON: WELL, YOUR HONOR, THE MAIN BASIS WAS
22 THAT WE HAD LISTED ON OUR EXHIBIT LIST AND PLAINTIFFS DID NOT
23 PLACE AN OBJECTION ON THERE, SO WE BELIEVED THAT THERE WAS
24 GOING TO BE NO OBJECTION.
25 AND, IN FACT, I BELIEVE THE COURT'S ORDER REGARDING

1 DOING THE EXHIBIT LISTS SAID THAT IF THERE IS NOT AN OBJECTION
2 STATED ON THE LIST, THEN THE OBJECTION WOULD BE WAIVED.
3 THE COURT: I ALSO TOLD YOU ON THE VERY FIRST DAY
4 THAT YOU ALL WROTE THE PRETRIAL ORDER AND ADDED THAT PROVISION.
5 I SIMPLY SIGNED IT. I NEVER REQUIRE COUNSEL TO SUBMIT
6 OBJECTIONS TO EXHIBITS IN ADVANCE, BECAUSE, ONE, I HAVE NO TIME
7 TO LOOK AT THE OBJECTIONS IN ADVANCE. AND TWO, THE OPPOSING
8 PARTY MIGHT NOT KNOW FOR WHAT PURPOSE THEY ARE BEING OFFERED OR
9 HOW THEY ARE GOING TO BE USED.
10 YOUR BRIEF DESCRIPTION OF WHAT IT IS ISN'T REALLY
11 ENOUGH TO PUT COUNSEL, IN MY VIEW, ON NOTICE AS TO EXACTLY HOW
12 IT IS GOING TO BE USED AT TRIAL.
13 SO I WILL PERMIT OBJECTIONS DURING THE COURSE OF MY
14 TRIAL. SO, I AM NOT GOING TO LET IT IN JUST BECAUSE THEY
15 DIDN'T OBJECT PRETRIAL. SO YOU STILL NEED TO ESTABLISH A BASIS
16 FOR ADMISSION.
17 MR. SIMPSON: LET ME JUST SAY THIS, YOUR HONOR, IF I
18 COULD. I THINK -- I HOPE THIS WILL BE ACCEPTABLE TO THE COURT
19 BASED ON WHAT THE COURT SAID EARLIER REGARDING THAT ARTICLE,
20 THE COURT'S GOING TO RULE ON PLAINTIFFS' REQUEST TO SUBMIT
21 THEIR THREE ARTICLES. AND THE COURT HAS, IN FACT -- I HOPE I
22 CHARACTERIZE THIS CORRECTLY -- LINKED OUR SUBMISSION OF THE
23 JAMA -- OF DR. SPRANG'S JAMA ARTICLE TO THEIR REQUEST --
24 THE COURT: THERE ARE SOME SIMILARITIES IN MY MIND.
25 MR. SIMPSON: WE ARE WILLING, YOUR HONOR, TO ABIDE

1 BY WHATEVER RULING -- WE ARE WILLING TO ABIDE BY IN RELATION TO
2 THE JAMA ARTICLE BY WHATEVER RULING THE COURT MAKES IN RELATION
3 TO PLAINTIFFS' REQUEST.
4 THE COURT: ALL RIGHT. YOU HAVE NO OTHER BASIS FOR
5 MOVING IT INTO EVIDENCE, RIGHT?
6 MR. SIMPSON: WELL, YOUR HONOR, MY THOUGHT WAS TO
7 MOVE IT INTO EVIDENCE SIMPLY TO SHOW DR. SPRANG'S
8 QUALIFICATIONS AND BACKGROUND, TO SHOW THAT HE HAS WRITTEN
9 THIS; NOT FOR THE TRUTH OF THE MATTER ASSERTED. I LEAVE IT TO
10 THE COURT AS TO WHETHER THAT IS A SUFFICIENT BASIS.
11 THE COURT: ALL RIGHT. LET'S ADJOURN.
12 SEE YOU AT 8:30 MONDAY MORNING.
13 DO YOU KNOW YET WHO YOUR WITNESS WILL BE ON MONDAY?
14 MS. CLARK: WE WILL BE CALLING ELIZABETH SHADIGIAN.
15 THE COURT: HAVE A GOOD WEEKEND.
16 (THEREUPON, AT 1:20 P.M. COURT WAS RECESSED UNTIL
17 MONDAY, APRIL 12, 2004, AT 8:30 O'CLOCK A.M.)
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1 I N D E X

2 DEFENSE WITNESSES

3 DR. M. LEROY SPRANG

4 DIRECT EXAMINATION BY MR. SIMPSON PAGE 999

5 VOIR DIRE EXAMINATION BY MS. GARTNER PAGE 1028

6 DIRECT EXAMINATION CONTINUED BY MR. SIMPSON PAGE 1049

7 CROSS-EXAMINATION BY MS. GARTNER PAGE 1122

8 REDIRECT EXAMINATION CONTINUED BY MR. SIMPSON PAGE 1170

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11 EXHIBITS

12 DEFENDANT'S EXHIBIT A-7 INTO EVIDENCE PAGE 1009

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