VOLUME 8

PAGES 1177 - 1342

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE PHYLLIS J. HAMILTON, JUDGE

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE,	)	
PLAINTIFFS,	)	
VS.	)	NO. C 03-4872 PJH
JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY,	)	MONDAY, APRIL 12, 2004
	)	SAN FRANCISCO, CALIFORNIA
DEFENDANT.	)	

REPORTER'S TRANSCRIPT OF PROCEEDINGS

APPEARANCES:

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

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

(APPEARANCES CONTINUED ON NEXT PAGE)

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

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

MONDAY, APRIL 12, 2004 8:30 A.M.

P R O C E E D I N G S

THE COURT: ALL RIGHT. GOOD MORNING. BEFORE WE GET STARTED WITH THE FIRST WITNESS, I DO WANT TO GO OVER WITH YOU MY RULINGS ON THE VARIOUS DIFFERENT OBJECTIONS THAT YOU ALL SUBMITTED TO US LAST WEEK. I REVIEWED ALL OF THE ARTICLES AND STUDIES OVER THE WEEKEND AND THE TRANSCRIPTS. WE HAVE FOUR MATTERS THAT ARE PENDING.

YES? IS THERE A QUESTION?

MS. PARKER: NO.

THE COURT: WE HAVE FOUR MATTERS PENDING. ONE IS THE ADMISSIBILITY OF THE STUDIES BY DRS. DREY AND CHASEN. ONE IS THE ARTICLE BY DR. SPRANG. AND THEN, THERE ARE TWO REQUESTS TO STRIKE TESTIMONY. ONE, I BELIEVE, PORTION IS THE TESTIMONY OF DR. WESTHOFF, AND THE OTHER IS THE TESTIMONY OF DR. DOE. STARTING FIRST WITH THE ARTICLES --

MS. PARKER: YOUR HONOR, WE HAVE LOOKED AT THAT ISSUE OVER THE WEEKEND, AND WE WOULD BE WILLING TO WITHDRAW OUR MOTION TO HAVE THOSE ARTICLES COME INTO EVIDENCE.

THE COURT: YOU WISH TO WITHDRAW YOUR MOTION TO HAVE ANY --

MS. PARKER: OF THE DREY AND CHASEN ARTICLES PUT INTO EVIDENCE.

THE COURT: WHAT ABOUT THE SPRANG ARTICLE? ARE YOU

WITHDRAWING YOUR MOTION FOR THAT?

MR. SIMPSON: YES, YOUR HONOR.

THE COURT: OKAY. I CERTAINLY WISH YOU WOULD HAVE TOLD ME. I SPENT A GREAT DEAL OF MY TIME OVER THE WEEKEND --

MR. SIMPSON: WELL, YOUR HONOR, I'M SORRY. OUR WITHDRAWAL IS BASED ONLY ON PLAINTIFFS' WITHDRAWAL. I BELIEVE OUR DISCUSSION ON FRIDAY WAS THAT THE ONLY BASIS FOR BRINGING IN THE SPRANG ARTICLE WOULD BE IF THE COURT WERE GOING TO GRANT PLAINTIFFS' MOTION. I HAD NOT PLANNED TO WITHDRAW OUR REQUEST.

IN FACT, IF THE COURT IS INCLINED TO GRANT IT, THAT'S CERTAINLY FINE WITH US.

THE COURT: NO, I WAS NOT INCLINED TO GRANT IT.

INTERESTING. ALL RIGHT.

NOW, WITH REGARD, THEN, TO THE DEPOSITIONS, THE FIRST ONE WAS DR. DOE'S TESTIMONY REGARDING THE EFFICACY OF THE DIGOXIN AS OPPOSED TO THE SAFETY OF THE DIGOXIN. THE DEFENSE ARGUING THAT ITS CROSS WAS LIMITED TO ONLY QUESTIONS ABOUT THE SAFETY.

I HAVE READ YOUR PAPERS. I DO AGREE WITH THE DEFENSE THE QUESTIONS REGARDING THE EASE OF THE PROCEDURE ARE NOT TANTAMOUNT TO QUESTIONS ABOUT THE EFFICACY OF CAUSING FETAL DEMISE. I DID READ THE TRANSCRIPT OF DR. DOE IN ITS ENTIRETY ON THIS SUBJECT, AND IT SEEMS TO ME THE DEFENDANTS ARE PARSING IT A LITTLE BIT TOO FINALLY.

I THINK A FAIR ARGUMENT COULD BE THAT ASKING HIM

QUESTIONS ABOUT THE USE OF DIGOXIN AT ALL COULD GIVE RISE TO QUESTIONS ABOUT SAFETY AND EFFICACY. SIMILARLY, I THINK THAT ASKING QUESTIONS ABOUT THE DREY STUDY, THAT THE DREY STUDIES WHICH WERE AIMED TOWARDS ASSESSING EFFICACY AND SAFETY COULD OPEN THE DOOR.

BUT, MORE SIGNIFICANTLY, I THINK THAT THERE WAS A QUESTION ASKED BY THE DEFENSE COUNSEL AT PAGE 453, LINES NINE THROUGH 14, ESSENTIALLY THAT THE QUESTION WAS:

"IF A DOCTOR ENSURED FETAL DEMISE BY USING DIGOXIN OR KCL WOULD THAT PHYSICIAN BE IN VIOLATION OF THE ACT."

WHILE I CERTAINLY THINK THAT FAIRLY OPENS THE DOOR TO QUESTIONS ABOUT WHETHER OR NOT USING DIGOXIN DOES, INDEED, ENSURE FETAL DEMISE, WHICH IS A CONTESTED ISSUE IN THIS CASE. SO I AM DENYING THE MOTION TO STRIKE DR. DOE'S TESTIMONY. I BELIEVE THE REDIRECT WAS APPROPRIATE GIVEN THE NATURE OF CROSS.

AND WITH REGARD TO DR. WESTHOFF'S TESTIMONY, THE OBJECTION, AS I UNDERSTAND IT, HAD TO DO WITH ALSO THE QUESTION OF DIGOXIN. PLAINTIFFS HAD AGREED THAT, INDEED, THE QUESTION AND ANSWER AT PAGE 819, LINE 20, THROUGH 820, LINE 5 SHOULD, INDEED, BE STRICKEN.

AND THE REAL TESTIMONY WAS IN THE ENSUING 20 LINES OR SO, WHETHER OR NOT THE DECLARATION WAS SUFFICIENT.

I FIND THE DECLARATION IS SUFFICIENT SUCH THAT THOSE QUESTIONS SHOULD REMAIN. AND WITH RESPECT TO THE SPECIFIC

LINES AT 12 THROUGH 14 AND 17 THROUGH 20 ON PAGE 820, THAT THE DEFENDANT OBJECTED TO WITH REGARD TO THE ACTUAL FACTS OF WHAT OCCURRED ON THAT SPECIFIC OCCASION THAT DR. WESTHOFF HAD USED DIGOXIN I FIND THAT THOSE LINES SHOULD BE INCLUDED JUST AS THAT ENTIRE PORTION IS, BECAUSE IT'S PURELY FACTUAL DATA.

IT IS PURELY FACTUAL DATA DESCRIBING WHAT OCCURRED ON THE ONE TIME THAT SHE DID USE IT. I AM DENYING THE DEFENSE REQUEST TO STRIKE DR. WESTHOFF'S TESTIMONY, AS WELL.

ALL RIGHT. SINCE YOU NO LONGER -- NEITHER SIDE WANTS THE ARTICLES IN, WE ARE READY TO GO.

MS. GARTNER: I THINK WE WILL PROBABLY DISCUSS THE SAME ISSUE.

I THINK, YOUR HONOR, WE WANTED TO DISCUSS WITH YOU WHAT YOUR HONOR HAD IN MIND WITH RESPECT TO CLOSING ARGUMENTS ON FRIDAY. YOU SUGGESTED ON THE FIRST DAY THAT YOU WOULD ENTERTAIN THOSE. I THINK BOTH SIDES WOULD LIKE TO PRESENT CLOSING ARGUMENTS. BUT WE WANTED TO TALK ABOUT HOW THAT WOULD FIT IN WITH DR. CHASEN'S TESTIMONY AND HOW MUCH TIME YOUR HONOR WAS PREPARED TO GIVE US.

THE COURT: HOW MUCH TIME DO YOU ANTICIPATE THAT DR. CHASEN WILL TAKE ON FRIDAY?

MR. SIMPSON: ACTUALLY, YOUR HONOR, OUR DESIRE TO PRESENT CLOSING ARGUMENT IS BASED ONLY ON PLAINTIFFS' DESIRE TO DO SO. WE ACTUALLY DON'T THINK CLOSING ARGUMENT IS NECESSARY, BUT CERTAINLY IF PLAINTIFFS ARE GOING TO PRESENT CLOSING

ARGUMENT WE WOULD WANT TO DO SO, AS WELL.

THE COURT: WELL, ACTUALLY, I AM A LITTLE INTERESTED IN HEARING WHAT YOUR OVERALL PERSPECTIVE IS ON THE EVIDENCE. I KNOW YOU HAVE HEARD IT ALL BEFORE BECAUSE YOU HAVE TAKEN THE DEPOSITIONS AND YOU KNOW WHAT THE WITNESSES ARE GOING TO TESTIFY TO.

I WOULD LIKE TO HEAR, AFTER IT'S ALL IN, WHAT YOU BELIEVE THAT THE EVIDENCE BEFORE THE COURT HAS SHOWN. SO I WOULD LIKE TO HAVE CLOSING ARGUMENTS.

THE QUESTION IS WHETHER OR NOT YOU CAN DO THEM ON FRIDAY OR WHETHER OR NOT WE NEED SOME OTHER TIME. DO YOU THINK THAT DR. CHASEN WILL TAKE THE ENTIRE DAY?

MS. PARKER: NO, YOUR HONOR. I THINK DR. CHASEN'S DIRECT EXAMINATION WILL PROBABLY TAKE TWO HOURS IS MY BEST GUESS AT THIS TIME.

THE COURT: AND DOES CROSS TAKE A SIMILAR AMOUNT OF TIME?

MR. SIMPSON: I SUPPOSE SO, YOUR HONOR. I BELIEVE IT TOOK ALL DAY IN NEW YORK.

MS. GARTNER: THEY HAVE A MORE SPREAD OUT DAY. AND READING THE TRANSCRIPT, THERE IS A LOT MORE QUESTIONS BY THE COURT AND A LOT MORE OBJECTIONS. IT TAKES MUCH LONGER FOR ALL THE WITNESSES IN NEW YORK.

THE COURT: DO YOU WANT TO GIVE YOUR ARGUMENTS, ASSUMING WE HAVE A FULL DAY ON FRIDAY? WE CAN GO TO

4:00 O'CLOCK AND TAKE A LUNCH BREAK. WE CAN FINISH WITH DR. CHASEN, LIKE WE DID LAST MONDAY, AND THEN TAKE A LUNCH BREAK AND COME BACK AND GIVE YOUR ARGUMENTS, AN HOUR OR SO EACH, I WOULD IMAGINE YOU WOULD NEED.

WOULD YOU LIKE TO DO THAT OR WOULD YOU LIKE TO COME BACK ON MONDAY?

MR. SIMPSON: WE WOULD MUCH RATHER STAY ON FRIDAY.

THE COURT: YOU WOULD MUCH RATHER HAVE A LONGER DAY ON FRIDAY?

MS. GARTNER: YES, YOUR HONOR. I THINK MANY OF US WOULD LIKE TO GO HOME.

THE COURT: ALL RIGHT. I AM CERTAINLY WILLING TO DO THAT ON FRIDAY SO WE CAN CONCLUDE THE MATTER.

I DO WANT YOU ALL TO ADDRESS ONE OF THE ISSUES THAT I AM STILL THINKING ABOUT FROM THE PRETRIAL BRIEFS THAT YOU GAVE ME ON THE DEFERENCE ISSUE. YOU ALL HAVE THOROUGHLY BRIEFED THE ISSUE, SO I DON'T EXPECT THAT I WILL HEAR A LOT ABOUT THAT, ALTHOUGH YOU CAN CERTAINLY ARGUE WHATEVER -- YOU CAN ARGUE WHATEVER YOU WISH TO FRIDAY, BUT I AM NOT ASKING YOU TO SUBMIT ANY FURTHER BRIEFING.

BUT I WOULD LIKE THE DEFENDANT, HAVING REVIEWED YOUR PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW OVER THE LAST WEEK, I AM A LITTLE PUZZLED BY THE POSITION ADVANCED BY THE DEFENSE ON THE -- WITH REGARD TO HOW THE COURT IS TO VIEW THE CONGRESSIONAL RECORD IN THE CASE.

IN YOUR -- I BELIEVE IT WAS IN THE BRIEF ON DEFERENCE, THE DEFENSE HAS TAKEN THE POSITION THAT ESSENTIALLY THE TRIAL RECORD SUPPLEMENTS THE CONGRESSIONAL FINDINGS. AND I AM JUST A LITTLE BIT CONFUSED ABOUT HOW THAT REALLY IS SUPPOSED TO WORK, BECAUSE YOU -- BOTH SIDES HAVE ARGUED THAT THE CONGRESSIONAL FINDINGS AREN'T ADMISSIBLE EXCEPT THAT THE COURT MAY JUDICIALLY NOTICE THE RECORD. BUT IS NOT TO ACCEPT IT FOR THE TRUTH OF THE MATTER ASSERTED.

SO I AM NOT LOOKING AT THE CONGRESSIONAL RECORD FOR THE TRUTH OF WHAT IS CONTAINED THEREIN, YET I AM LOOKING AT THE EVIDENCE THAT HAS BEEN PRESENTED BEFORE ME, FOR THE TRUTH OF WHAT IS PRESENTED, I AM NOT EXACTLY SURE HOW WHAT HAPPENS HERE SUPPLEMENTS A RECORD THAT I AM ONLY NOTICING.

AND YOU ALL HAVE NOT EXPLAINED THAT. SO MAYBE YOU CAN GIVE THAT SOME THOUGHT AND ADDRESS IT ON FRIDAY IN YOUR CLOSING ARGUMENTS, BECAUSE WHILE I FOUND YOUR BRIEFS ON THE AMOUNT OF DEFERENCE FOR CONGRESS INTERESTING AND SOMEWHAT HELPFUL, NEITHER SIDE, I BELIEVE, ADEQUATELY ADDRESSED THE INTERPLAY BETWEEN THE FINDINGS BEFORE CONGRESS AND THE FINDINGS THAT THE COURT WILL MAKE AS I WOULD FOLLOWING ANY BENCH TRIAL IN THIS CASE.

I AM NOT EXACTLY SURE. WE HAVE THESE TWO PARALLEL TRACKS, BUT I AM NOT EXACTLY SURE THEY ARE REALLY EVEN PARALLEL. OKAY?

ANOTHER QUESTION I WOULD LIKE YOU TO ADDRESS, AS

WELL, IS SIMPLY THE QUALITY OF THE RECORD BEFORE -- THE QUALITY OF THE EVIDENCE OF THE RECORD BEFORE CONGRESS VERSUS THE QUALITY OF THE EVIDENCE THAT HAS BEEN PRESENTED HERE IN COURT.

I MEAN, I HAVE LOOKED AT IT AND IT SEEMS TO BE SIMILAR IN MANY RESPECTS. SOME OF THE SAME DOCTORS TESTIFIED BEFORE CONGRESS HAS TESTIFIED HERE. SOME OF THE SAME MATERIAL THAT THEY HAVE REFERRED TO IS ESSENTIALLY WHAT CONGRESS WAS -- INDEED, CONGRESS FACED ESSENTIALLY THE SAME KIND OF RECORD THAT THE COURT HAS.

SO I WOULD LIKE SOME COMMENT ON THAT, AS WELL. AND AS THE WEEK GOES ON IF OTHER QUESTIONS COME UP I WILL TELL YOU AND YOU WILL HAVE A LITTLE TIME TO THINK ABOUT IT BEFORE YOUR ARGUMENTS ON FRIDAY. OKAY?

ANY OTHER QUESTIONS OR THINGS WE SHOULD ADDRESS?

MR. QUINLIVAN: YES, YOUR HONOR.

MS. VAN RUNKLE: YOUR HONOR, I WANTED TO LET THE COURT KNOW THE CITY DOES PLAN ON PRESENTING CLOSING ARGUMENT.

THE COURT: SURE. YOU MAY.

MR. SIMPSON: YOUR HONOR, THE COURT SAID "ONE HOUR PER SIDE"?

THE COURT: WELL, WHAT I WAS THINKING OF -- WE WILL HAVE THE AFTERNOON. WE WILL TAKE THE LUNCH BREAK, AND I WOULD LIKE TO GET THE ARGUMENTS IN. ASSUMING WE FINISH WITH DR. CHASEN BY NOON, IF WE START AT 8:30 PERHAPS WE CAN, OR SOMETIME THEREABOUT, SAY BETWEEN ONE AND FOUR FOR CLOSING. THAT IS

THREE HOURS. THE CITY AND COUNTY OF SAN FRANCISCO HAS NOT REALLY PARTICIPATED TO A GREAT EXTENT AND HAS NOT REQUESTED ADDITIONAL TIME FOR ADDITIONAL WITNESSES. AND SO I WOULD CERTAINLY LIKE TO AFFORD THEM SOME OPPORTUNITY TO PARTICIPATE BY MAKING A CLOSING STATEMENT.

SO WHAT I WOULD LIKE IS TO PERHAPS AFFORD EACH OF YOU AN HOUR AND YOU AN HOUR.

IF YOU THINK THAT THAT IS NOT REALLY ENOUGH, THEN MAYBE YOU CAN TALK ABOUT IT AND SEE IF YOU CAN SPLIT UP A THREE-HOUR CHUNK OF TIME. OKAY?

MR. QUINLIVAN.

MR. QUINLIVAN: YES, JUST ONE MINOR MATTER, YOUR HONOR. I JUST WANTED TO ALERT THE COURT THAT ON THURSDAY OF THIS WEEK WE WILL BE JOINED BY PREEYA NORONHA, WHO IS A CO-COUNSEL IN THIS CASE FROM THE NEBRASKA CASE.

AND MS. NORONHA WILL BE EXAMINING DR. ANAND ON THURSDAY.

THE COURT: YES, ALL RIGHT. ARE YOU READY WITH YOUR NEXT WITNESS, MS. CLARK?

MS. CLARK: THE DEFENSE CALLS DR. ELIZABETH SHADIGIAN.

DR. ELIZABETH M. SHADIGIAN

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

THE WITNESS: I DO.

THE CLERK: PLEASE TAKE THE STAND.

PLEASE STATE YOUR NAME FOR THE COURT.

THE WITNESS: MY NAME IS DR. ELIZABETH SHADIGIAN.

THE CLERK: SPELL YOUR LAST NAME.

THE WITNESS: S-H-A-D-I-G-I-A-N.

THE CLERK: THANK YOU.

DIRECT EXAMINATION

BY MS. CLARK:

Q. GOOD MORNING, DR. SHADIGIAN.

A. GOOD MORNING.

Q. COULD YOU PLEASE TELL THE COURT WHAT YOU DO FOR A LIVING?

A. YES. I'M A FACULTY MEMBER AT THE UNIVERSITY OF MICHIGAN IN THE SCHOOL OF MEDICINE, AND I'M A PHYSICIAN, AN OBSTETRICIAN GYNECOLOGIST THAT TAKES CARE OF PREGNANT WOMEN AND WOMEN WHO AREN'T PREGNANT FOR THEIR GYNECOLOGICAL NEEDS.

Q. HOW LONG HAVE YOU BEEN AT THE UNIVERSITY OF MICHIGAN?

A. I WILL BE COMPLETING MY 10TH YEAR AT THE UNIVERSITY OF MICHIGAN IN JUNE OF 2004.

MS. CLARK: MAY I APPROACH, YOUR HONOR?

THE COURT: YES.

BY MS. CLARK:

Q. I'VE JUST SHOWN YOU WHAT HAS BEEN MARKED AS DEFENDANT'S EXHIBIT A-6. IS THIS A COPY OF YOUR C.V.?

A. YES, IT IS.

Q. DID YOU CREATE IT?

A. YES, I DID.
Q. DOES IT ACCURATELY REFLECT YOUR EDUCATION, WORK EXPERIENCE AND PUBLICATIONS?
A. YES, IT DOES.
MS. CLARK: DEFENDANT MOVES TO ADMIT INTO EVIDENCE DEFENDANT'S EXHIBIT A-6.
THE COURT: ANY OBJECTION?
MS. PARKER: NO.
MS. KRASNOFF: NO OBJECTION.
THE COURT: ADMITTED.
THE CLERK: A-6 INTO EVIDENCE.
(DEFENDANT'S EXHIBIT A-6 WAS RECEIVED IN EVIDENCE.)
BY MS. CLARK:
Q. DR. SHADIGIAN, WILL YOU EXPLAIN BRIEFLY YOUR EDUCATIONAL BACKGROUND?
A. YES. I WENT TO PURDUE UNIVERSITY FOR UNDERGRADUATE EDUCATION AND RECEIVED A BACHELOR OF SCIENCE DEGREE IN CHEMISTRY.
AND THEN, I WENT ON TO THE JOHNS HOPKINS SCHOOL OF MEDICINE AND RECEIVED MY MEDICAL DEGREE IN 1990. AND THEN, RECEIVED POSTGRADUATE TRAINING AT AN OBSTETRICS AND GYNECOLOGY RESIDENCY PROGRAM IN BALTIMORE CALLED FRANKLIN SQUARE HOSPITAL CENTER, AS WELL AS THE JOHNS HOPKINS HOSPITAL.
Q. DO YOU HAVE ANY BOARD CERTIFICATIONS?

A. YES.
Q. WHAT ARE THOSE CERTIFICATIONS?
A. I AM BOARDED IN OBSTETRICS AND GYNECOLOGY.
Q. AND ARE YOU LICENSED TO PRACTICE MEDICINE IN MICHIGAN?
A. YES, I AM.
Q. AND WAS IT IMMEDIATELY AFTER YOUR RESIDENCY THAT YOU CAME TO WORK AT THE UNIVERSITY OF MICHIGAN?
A. YES. I BECAME A FACULTY MEMBER BASICALLY RIGHT AFTER RESIDENCY.
Q. WHAT WAS YOUR INITIAL POSITION?
A. I WAS CLINICAL ASSISTANT PROFESSOR OF OBSTETRICS AND GYNECOLOGY.
Q. AND WHAT IS YOUR POSITION NOW?
A. I'M CLINICAL ASSOCIATE PROFESSOR OF OBSTETRICS AND GYNECOLOGY.
Q. DOES THAT MEAN YOU HAVE BEEN PROMOTED SINCE YOU HAVE BEEN AT THE UNIVERSITY OF MICHIGAN?
A. YES, IN 2002 I WAS PROMOTED.
Q. DR. SHADIGIAN, COULD YOU PLEASE EXPLAIN WHAT YOU DO AS A CLINICAL ASSOCIATE PROFESSOR AT THE UNIVERSITY OF MICHIGAN, FIRST WITH RESPECT TO YOUR CLINICAL PRACTICE?
A. YES. BASICALLY, I DO THREE THINGS AT THE UNIVERSITY OF MICHIGAN. ONE IS ACTUALLY TAKE CARE OF WOMEN IN TERMS OF MY SCOPE OF PRACTICE IN OBSTETRICS AND GYNECOLOGY. SO THAT IS THE CLINICAL CARE PIECE.

I ALSO TEACH MEDICAL STUDENTS AND RESIDENTS, AND I ALSO DO RESEARCH IN VARIOUS SUBJECTS.

Q. COULD YOU DESCRIBE THE KINDS OF PATIENTS THAT YOU TREAT?

A. YES, I CERTAINLY CAN. I HAVE A BROAD RANGE OF PRACTICE. I'M A GENERALIST. I DO HIGH RISK OBSTETRICS, SO I TAKE CARE OF WOMEN WITH DIFFERENT MEDICAL DISEASES IN PREGNANCY SUCH AS HIGH BLOOD PRESSURE, DIABETES, CERTAIN CONNECTIVE TISSUES DISORDERS OR RHEUMATOLOGICAL DISORDERS.

I TAKE CARE OF TWIN PREGNANCIES, AND I TAKE CARE OF NORMAL LOW RISK PREGNANCIES, AS WELL. I DO PRENATAL CARE OF THESE WOMEN, AS WELL AS THEIR DELIVERY AND POSTPARTUM OR AFTERCARE AFTER A PREGNANCY.

AND, IN ADDITION, I DO GENERALIST GYNECOLOGY, SO I TAKE CARE OF PATIENTS WITH CHRONIC PELVIC PAIN. I OPERATE ON WOMEN WHO NEED CERTAIN SURGICAL PROCEDURES. IN ADDITION, I DO FAMILY PLANNING, SUCH AS DISCUSS WITH WOMEN IF THEY WANT TO AVOID PREGNANCY WHAT OPTIONS THEY HAVE. AND ALSO JUST DO WELL WOMEN GYNECOLOGICAL CARE.

Q. APPROXIMATELY HOW MANY BABIES HAVE YOU DELIVERED IN THE LAST YEAR?

A. PROBABLY BETWEEN 100 AND 150.

Q. HOW MANY OF THOSE ARE VAGINAL DELIVERIES?

A. PROBABLY ABOUT EIGHTY PERCENT OF THEM.

Q. AND TWENTY PERCENT BY CESAREAN SECTION?

A. YES.

Q. AND HAVE YOU EVER VAGINALLY DELIVERED BABIES IN A BREECH PRESENTATION?

A. YES, I HAVE.

Q. WHEN WAS THE LAST TIME YOU DID THAT?

A. PROBABLY ABOUT TWO MONTHS AGO.

Q. CAN YOU BRIEFLY DESCRIBE A VAGINAL DELIVERY WHEN THERE IS A BREECH PRESENTATION?

A. YES. FIRST WE ASSESS WHAT PART OF THE BABY IS COMING DOWN, SO IF IT IS ACTUALLY THE FEET OR THE BOTTOM OR ONE FOOT OR TWO FEET AND WHERE THE FEET ARE WITH RESPECT TO THE BOTTOM.

AND THEN, WE GO AHEAD AND DELIVER THE PRESENTING PART. SO IF IT'S THE BOTTOM, WE WILL DELIVER THAT, AND THEN WE BRING THE FEET OUT. WE DELIVER UP TO ABOUT THE NAVEL AND THEN WE PULL THE BABY GENTLY DOWN IN A TOWEL, AND THEN WE REACH UP AND PUT OUR FINGERS DOWN THE HUMERUS OR UPPER ARM AND BASICALLY HOOK NEAR THE ELBOW THE BABY'S ARM AND HAVE IT COME OUT.

AND THEN, WE ROTATE THE BABY AND BRING OUT THE OTHER ARM. AND THEN, ONCE THE HEAD IS DELIVERED, ONCE THE -- EXCUSE ME -- THE SHOULDERS ARE DELIVERED, THEN WE WOULD GO AHEAD AND PROCEED TO DELIVER THE BABY'S HEAD. AND BASICALLY WE WANT TO DEFLEX OR TIP DOWN THE HEAD TO REDUCE THE DIAMETER OF THE BABY'S HEAD COMING OUT.

Q. ARE MOST OF THE PATIENTS THAT YOU SEE, ARE MOST OF THEM REFERRALS TO YOU?

A. SOME ARE REFERRALS BUT SOME ARE PATIENTS. I HAVE BEEN

THERE FOR 10 YEARS NOW, SO I HAVE A LOT OF WOMEN I HAVE FOLLOWED FOR MANY YEARS.

Q. DO YOU EVER REFER PATIENTS TO MATERNAL FETAL MEDICINE SPECIALISTS?

A. YES, I DO.

Q. WHAT KIND KINDS OF PATIENTS DO YOU REFER TO MFM'S?

A. THERE ARE SOME WOMEN WITH MORE SEVERE MEDICAL PROBLEMS, SUCH AS COMPLICATED CARDIAC DISEASE, WOMEN WHO MAY HAVE TRIPLETS OR QUADS, AND THREE OR FOUR BABIES INSIDE.

IN ADDITION, THERE ARE CERTAIN CONNECTIVE TISSUE DISORDERS LIKE SEVERE LUPUS, WHICH I WOULD REFER BECAUSE OF THEIR SPECIALIZED TRAINING AS WELL AS WOMEN WHO ARE HIV POSITIVE.

Q. DR. SHADIGIAN, YOU MENTIONED THAT YOU PROVIDE FAMILY PLANNING TO YOUR PATIENTS. WHAT KIND OF FAMILY PLANNING DO YOU PROVIDE TO THEM?

A. BASICALLY I PROVIDE THE FULL RANGE OF FAMILY PLANNING, SO ANYWHERE FROM EXPLAINING HOW NATURAL FAMILY PLANNING WORKS, OFFERING THEM BARRIER CONTRACEPTIVES SUCH AS DIAPHRAGMS AND CONDOMS, THROUGH BIRTHS CONTROL PILLS, INTRAUTERINE DEVICES AND STERILIZATION.

Q. DOCTOR, ARE THERE OCCASIONS WHEN CARING FOR A PATIENT YOU HAVE NEEDED TO TERMINATE A PREGNANCY?

A. YES, THERE HAVE BEEN.

Q. AND IN THOSE INSTANCES HAVE YOU EVER NEEDED TO TERMINATE A

PREGNANCY WHERE THE FETUS WAS ALIVE? THAT THE TERMINATION -- EXCUSE ME -- WAS NECESSARY TO TREAT A MATERNAL HEALTH CONDITION?

A. YES, I HAVE.

Q. WHAT REASONS HAVE YOU NEEDED TO TERMINATE A PREGNANCY?

A. THERE IS A WIDE VARIETY OF REASONS. ONE EXAMPLE MIGHT BE AN INFECTION IN THE MOTHER'S UTERUS OR AROUND THE BABY CALLED CHORIOAMNIONITIS. THERE ARE OTHER MEDICAL DISORDERS LIKE PREECLAMPSIA WHEN THERE IS HIGH BLOOD PRESSURE AND SWELLING IN THE WOMAN AS WELL AS PROTEIN IN THE URINE THAT MAY NECESSITATE AN EARLIER BIRTH.

AND THEN, THERE MAY BE SOME OTHER SITUATIONS WHERE A WOMAN MAY HAVE CANCER AND NEED TO INITIATE CHEMOTHERAPY AND THE BABY IS A FAR ENOUGH ALONG TO BE DELIVERED TO HELP CARE FOR THE MOTHER.

Q. DR. SHADIGIAN, HAVE YOU EVER DIAGNOSED FETAL ANOMALIES IN THE PREGNANT WOMEN THAT YOU HAVE TREATED?

A. YES.

Q. WHAT KINDS OF FETAL ANOMALIES HAVE YOU DETECTED?

A. AGAIN, A WIDE VARIETY IN THE LAST 14 YEARS. SOME THINGS ARE GENETIC LIKE TRISOMY 21, OR 18 OR 13. TURNER'S SYNDROME IS ANOTHER EXAMPLE OF A KIND OF GENETIC PROBLEM.

AND THEN, THERE ARE ACTUAL STRUCTURAL PROBLEMS, SO THINGS LIKE HAVING THE BOWELS OUTSIDE THE BABY, SUCH AS ENCEPHALOCELE OR GASTROSCHISIS ARE OTHER EXAMPLES OF ANOMALIES.

IN ADDITION, I HAVE TAKEN CARE OF A MOTHER WITH CONJOINED TWINS, WHICH IS WHERE INSTEAD OF TWO BABIES ARE SEPARATED THEY WERE CONNECTED BOTH AT THE CHEST WALL AND ABDOMEN, AS WELL.

Q. THROUGH YOUR TRAINING AND BACKGROUND AND YOUR CLINICAL EXPERIENCE, HAVE YOU BECOME FAMILIAR WITH DIFFERENT METHODS OF TERMINATING PREGNANCY?

A. YES, I HAVE.

Q. WHAT METHODS HAVE YOU UTILIZED TO TERMINATE PREGNANCY?

A. THE FULL RANGE OF METHODS ARE -- OR WHAT I WOULD USE GENERALLY, SOME THINGS ARE AS COMMON AND SIMPLE AS A CESAREAN SECTION DONE EARLIER THAN USUAL. AND OTHER WOULD BE PROCEDURES SUCH AS D&C'S, D&E'S, WHICH IS DILATION AND EVACUATION AND ALSO MEDICAL INDUCTION OF PREGNANCY. I SHOULD SAY OF LABOR AND PREGNANT.

Q. TAKING THE D&C FIRST, WHAT DO YOU MEAN BY "D&C"?

A. THE LETTERS D&C, THE ACRONYM STAND FOR DILATION AND CURETTAGE, WHICH IS THE FRENCH WORD "TO SCRAPE." AND SO THAT MEANS DILATING OR OPENING THE CERVIX OF A WOMAN AND THEN GOING AHEAD AND REMOVING THE CONTENTS OF THE UTERUS BY SHARP OR SUCTION CURETTAGE.

Q. AND WHAT IS YOUR EXPERIENCE WITH D&C -- WITH D&C'S GOING BACK TO MEDICAL SCHOOL?

A. IN MEDICAL SCHOOL I OBSERVED SEVERAL D&C'S ON LIVE BABIES FOR TERMINATION OF PREGNANCY THAT WERE ELECTIVE. HOWEVER, I

DIDN'T DIRECTLY PARTICIPATE BY HOLDING INSTRUMENTS. INSTEAD, I TOOK MY TRAINING IN THAT ON BABIES THAT HAD ALREADY DIED.

Q. AND APPROXIMATELY D&C'S HAVE YOU DONE IN YOUR CAREER?

A. I'M SURE IT IS IN THE HUNDREDS RANGE.

Q. AND DO YOU CONTINUE TO PERFORM D&C'S IN YOUR CURRENT PRACTICE?

A. YES, I DO.

Q. NOW, NEXT, TURNING TO THE D&E, WHAT DO YOU MEAN BY "D&E" OR DILATION AND EVACUATION?

A. THE WAY I USE THAT TERM IS GENERALLY WHEN THEY ARE IN THE SECOND-TRIMESTER OF PREGNANCY WHERE USUALLY LAMINARIA OR OSMOTIC DILATORS ARE USED THE DAY BEFORE THE PROCEDURE TO OPEN THE CERVIX OF THE WOMEN, AND GENERALLY THAT IS PLACED AS GENTLY AS POSSIBLE WITH THE LAMINARIA PLACED BEING INSIDE THE CERVIX, SOMETIMES WITH TRACTION ON THE CERVIX AND SOMETIMES WITHOUT.

AND THEN, THE NEXT DAY IN THE OPERATING ROOM A WOMAN IS TAKEN TO THE OPERATING ROOM, A SPECULUM IS PLACED IN THE VAGINA. THE LAMINARIA ARE REMOVED, AND THEN A DEVICE IS DECIDED UPON WHICH TO PUT TRACTION ON THE CERVIX TO STRAIGHTEN THE CERVIX ANGLE WITH THE REST OF THE UTERUS OUT, AND THEN WITH A SERIES OF INSTRUMENTS THE BABY IS DISARTICULATED OR REMOVED IN PIECES WITH CERTAIN KINDS OF FORCEPS. AND THEN, THE FLUID IN THE MEMBRANES AND THE PLACENTA IS ALSO REMOVED. AND SOMETIMES WE USE ULTRASOUND GUIDANCE FOR THIS PROCEDURE, AS WELL.

Q. COULD YOU PLEASE EXPLAIN TO THE COURT YOUR EXPERIENCE IN PERFORMING D&E'S?

A. YES. FIRST AS A STUDENT I WATCHED QUITE A FEW D&E'S BECAUSE I WAS INTERESTED IN FINDING OUT HOW THEY WERE PERFORMED AND WHY THEY ARE PERFORMED ON DIFFERENT KINDS OF WOMEN IN DIFFERENT SITUATIONS.

AND THEN, AS A MEDICAL STUDENT, ESPECIALLY AS A RESIDENT, I ACTUALLY MADE IT A POINT TO LEARN HOW TO DO THIS PROCEDURE PROPERLY. AND I TRIED TO PARTICIPATE IN AS MANY AS I POSSIBLY COULD AS A RESIDENT BECAUSE I KNEW THIS WAS MY WINDOW OF OPPORTUNITY TO LEARN.

SO I PROBABLY PARTICIPATED IN 30 TO 50 AS A RESIDENT OVER FOUR YEARS.

Q. AND APPROXIMATELY HOW MANY TIMES IN YOUR CAREER HAVE YOU PERFORMED A D&E PROCEDURE?

A. TOTAL NUMBER OF TIMES PROBABLY 60 TO 70.

Q. AND HAS THIS ALWAYS INVOLVED DISMEMBERMENT OF THE FETUS?

A. YES.

Q. IN THE D&E PROCEDURES THAT YOU HAVE PERFORMED OR PARTICIPATED IN, HAVE THOSE FETUSES BEEN ALIVE OR DEAD?

A. THE ONES I ACTUALLY HELD THE INSTRUMENTS AND ACTUALLY DID THE ACTUAL PROCEDURE THE BABY HAD BEEN DEAD.

Q. AND WHEN YOU OBSERVED AT ONE OF THOSE OBSERVATIONS, OBSERVATIONS OF D&E'S PERFORMED ON LIVE FETUSES?

A. YES, MANY WERE.

Q. IS THE EXTRACTION PART OF THE D&E PROCEDURE THAT YOU PERFORM WHEN THE FETUS HAS DIED DIFFERENT FROM THE D&E PROCEDURE PERFORMED ON A LIVE FETUS?
A. THE ACTUAL TECHNIQUE IS THE SAME, BUT THE WAY THE BABY'S DISARTICULATED, PULLED APART, WOULD PROBABLY BE SOMEWHAT EASIER WITH A DEAD BABY THAN IT WOULD BE ON A LIVE BABY.
Q. AND WOULD THAT DEPEND ON HOW LONG THE BABY HAS BEEN DEAD FOR?
A. YES, IT WOULD.
Q. UP TO WHAT GESTATIONAL AGE HAVE YOU OBSERVED A D&E ON A LIVING FETUS?
A. BETWEEN 20 AND 22 WEEKS.
Q. NEXT, TURNING TO THE INDUCTION PROCEDURE. IN GENERAL TERMS, WHAT DO YOU MEAN BY "MEDICAL INDUCTION"?
A. MEDICAL INDUCTION OF LABOR IS WHEN CERTAIN MEDICINES ARE GIVEN EITHER ORALLY, THROUGH THE MOUTH, VAGINALLY, OR EVEN INSTILLED INTO THE AMNIOTIC FLUID AROUND THE BABY THAT WILL MAKE THE BODY HAVE CONTRACTIONS AND EXPEL THE BABY PHYSIOLOGICALLY.
Q. WHAT IS YOUR EXPERIENCE WITH THE INDUCTION METHOD OF TERMINATION?
A. WELL, AS A STUDENT I ACTUALLY ROTATED AT SOMETHING CALLED THE FRANCIS SCOTT KEY MEDICAL CENTER OR THE COUNTY MEDICAL CENTER, AND THEY DID QUITE A FEW INSTILLATION MEDICAL INDUCTION PROCEDURES BECAUSE THEY ACTUALLY DID THE MOST NUMBER IN

BALTIMORE, SO I GOT DIRECT OPPORTUNITY TO SEE WHAT THEIR PROTOCOLS WERE, TO ACTUALLY TALK TO WOMEN UNDERGOING THE PROCEDURES. SO I OBSERVED SEVERAL DURING THAT TIME. PROBABLY TEN TO TWENTY OF THOSE AT THE FRANCIS SCOTT KEY.

AND THEN, DURING RESIDENCY IS WHEN THINGS SHIFTED SOMEWHAT. AND INSTEAD OF JUST INSTILLATION, WE ALSO SHIFTED OVER TO MORE PROSTAGLANDINS. SO, OF COURSE, WE HAVE USED OXYTOCIN OR PITOCIN FOR MANY YEARS FOR INDUCTIONS OF LABOR.

Q. DO YOU CURRENTLY USE THE MEDICAL INDUCTION FOR TERMINATION OF PREGNANCIES?

A. YES, I DO.

Q. AND HOW FREQUENTLY DO YOU USE THAT METHOD?

A. DEPENDS ON THE CLINICAL SITUATION, BUT AS THE NEED ARISES SOMETIMES ON A WEEKLY BASIS WE NEED TO INDUCE WOMEN'S LABORS BECAUSE OF MEDICAL PROBLEMS OR PROBLEMS WITH THE BABY.

Q. CURRENTLY, WHAT AGENT OR AGENTS DO YOU USE WHEN PERFORMING AN INDUCTION FOR TERMINATION OF PREGNANCY?

A. THE MOST COMMON TWO MEDICATIONS WE USE ARE THE MISOPROSTOL, WHICH IS ONE OF THE PROSTAGLANDINS THAT WE HAVE BEEN TALKING ABOUT, AND THE OTHER ONE IS OXYTOCIN.

Q. IS OXYTOCIN IS A PROSTAGLANDIN?

A. NO, IT IS NOT. IT IS A SEPARATE CATEGORY OF MEDICATION.

Q. AND JUST TO BE CLEAR -- YOU TOUCHED ON THIS -- HOW ARE THOSE AGENTS, THE MISOPROSTOL AND OXYTOCIN, ADMINISTERED TO THE WOMEN?

A. THE MISOPROSTOL IS GIVEN EITHER ORALLY TO A WOMAN OR INTRAVAGINALLY, THE WAY WE USE IT. AND THEN, THE OXYTOCIN IS AN IV DRIP.

Q. WHEN YOU SAY AN "IV DRIP," IS THIS DIFFERENT THAN INSTILLATION?

A. YES. IT MEANS AN INTRAVENOUS GOING TO A WOMEN'S VEIN WITH A MIXTURE OF SOME KIND OF SALINE SOLUTION PLUS THE MEDICATION ITSELF: OXYTOCIN.

Q. AND FOR APPROXIMATELY HOW LONG HAVE YOU BEEN PERFORMING INDUCTIONS WITH PROSTAGLANDINS AND OXYTOCIN?

A. FOR MY ENTIRE CAREER OF PRACTICE, WITH ONE OR BOTH. FOURTEEN YEARS, APPROXIMATELY.

Q. WHEN WAS THE LAST TIME YOU PERFORMED AN INDUCTION USING AN INSTILLATION METHOD?

A. PROBABLY THE LAST TIME I SAW INSTILLATION METHODS WERE WHEN I WAS A RESIDENT.

Q. SO, APPROXIMATELY WHAT YEAR?

A. IN THE EARLY '90'S. AND IN MEDICAL SCHOOL IN THE LATE '80'S.

Q. AND WHEN THERE IS AN INSTILLATION, CAN YOU EXPLAIN WHERE THE INSTILLATION -- WHERE THE INJECTION IS INSTALLED INTO THE WOMAN?

A. SO GENERALLY, IT IS VERY SIMILAR TO AN AMNIOCENTESIS. INSTEAD OF FLUID BEING DRAWN OFF FROM AROUND THE BABY, INSTEAD MEDICATIONS WOULD BE INJECTED AROUND THE BABY INTO THE AMNIOTIC

FLUID.
Q. DO YOU CONSIDER INDUCTIONS WITH THE USE OF PROSTAGLANDINS AND OXYTOCIN DIFFERENT IN ANY MATERIAL WAY FROM THE INSTILLATION METHODS?
A. WELL, BECAUSE THE WOMEN'S UTERUS IS NOT PUNCTURED WITH A NEEDLE, IT IS A DIFFERENT PROCESS. AND SO ONE MIGHT ASSUME THAT THERE MIGHT BE DIFFERENT COMPLICATIONS AND DIFFERENT AMOUNTS OF MEDICATIONS USED, FOR EXAMPLE.
Q. HAVE YOU USED THE MEDICAL INDUCTION PROCEDURE WHEN THE FETUS IS PREVIABILITY?
A. YES, I HAVE.
Q. AND HAVE YOU USED THE MEDICAL INDUCTION PROCEDURE WHEN THE FETUS IS POSTVIABLE?
A. YES.
Q. WHAT DO YOU UNDERSTAND "PREVIABLE" TO MEAN?
A. GENERALLY, YOU SAY "PREVIABLE" IS ANY TIME BEFORE A BABY CAN SURVIVE OUTSIDE THE MOTHER'S UTERUS. SO IN CURRENT, GENERAL PRACTICE FOR NEONATAL PRACTICE WE USUALLY SAY VIABILITY IS AT APPROXIMATELY 23 WEEKS GESTATION.
Q. DO YOU CURRENTLY PERFORM MORE INDUCTIONS THAN D&E'S?
A. YES, I DO.
Q. WHY IS IT THAT YOU'VE HAD THE OCCASION TO PERFORM MORE INDUCTIONS THAN D&E'S IN YOUR PRACTICE?
A. IN GENERAL, THE WAY IT'S SET UP AT UNIVERSITY OF MICHIGAN, WE GET TRANSFERS OF VERY SICK WOMEN. AND I TAKE CALL WITH THE

RESIDENTS. WE CALL IT "SUPERVISORY CALL" AT NIGHTTIMES. SO WHENEVER THERE IS TRANSFERS OF SICK WOMEN, MANY OF THEM -- I WOULD SAY IN A YEAR WE HAVE A FEW IN THE LATE SECOND-TRIMESTER WHO ARE QUITE SICK. MANY MORE IN THE THIRD-TRIMESTER WHO ARE SICK AND, IN FACT, NEED TO BE DELIVERED.

AND BECAUSE WE HAVE A VERY HIGH LEVEL NEONATAL UNIT WE GET TRANSFERS ALL SOUTHERN MICHIGAN AND NORTHERN OHIO TO OUR INSTITUTION.

Q. AND WHAT DOES THAT HAVE TO DO WITH WHETHER OR NOT YOU PERFORM INDUCTION MORE THAN D&E?

A. THE DATA HAS SHOWN THAT IN THE LATE SECOND-TRIMESTER OF 20 WEEKS AND ABOVE THAT ACTUAL MEDICAL INDUCTION'S A SAFER PROCEDURE FOR WOMEN RATHER THAN THE DILATATION AND EVACUATION.

SO WHEN WE ARE PRESENTED WITH PATIENTS WHO HAVE MEDICAL PROBLEMS IN THE LATE SECOND-TRIMESTER, IT HAS BEEN OUR HABIT BECAUSE OF THE SAFETY DATA TO USE MEDICAL INDUCTION OF LABOR RATHER THAN D&E TO END A PREGNANCY.

Q. DR. SHADIGIAN, FOCUSING ON YOUR EXPERIENCE WITH PREGNANCY TERMINATIONS WHILE IN MEDICAL SCHOOL, AND IN YOUR RESIDENCE, DID YOU MAKE A SPECIAL EFFORT -- YOU HAVE ALREADY TOUCHED ON THIS, BUT DID YOU MAKE A SPECIAL EFFORT TO LEARN ABOUT PREGNANCY TERMINATION?

A. YES, I DID.

Q. WHY DID YOU MAKE THAT SPECIAL EFFORT?

A. I KNEW IT WAS SOMETHING THAT WAS REALLY COMMON FOR WOMEN TO

CHOOSE TO HAVE AN ABORTION, THAT IN THE FIRST OR SECOND-TRIMESTER WOMEN ELECTIVELY DECIDE TO HAVE AN ABORTION. AND THEY ALSO DECIDE BECAUSE OF PROBLEMS WITH THE BABY AND PROBLEMS WITH THEIR OWN HEALTH. SO I WANTED TO MAKE SURE I UNDERSTOOD ALL OF THE RAMIFICATIONS THAT MAKING THOSE DECISIONS WOULD HAVE ON A WOMAN.

AND BECAUSE ABOUT 43 PERCENT OF WOMEN HAVE AN ABORTION BY THE TIME THEY ARE AGE 45, I KNEW I WOULD HAVE A LOT OF WOMEN IN MY PRACTICE WHO HAD HAD ABORTIONS. AND SO I NEEDED TO KNOW HOW TO TAKE BEST CARE OF THEM, BOTH DURING THE TIME THEY ARE MAKING IMPORTANT DECISIONS AND AFTERWARDS, AND THEN IN THE LONG RUN.

Q. WHILE YOU WERE IN BALTIMORE TRAINING, AT WHAT INSTITUTIONS DID YOU WORK WHERE ABORTION SERVICES WERE PROVIDED?

A. AT THE JOHNS HOPKINS HOSPITAL I WAS A MEDICAL STUDENT AND FRANCIS SCOTT KEY MEDICAL CENTER, THE COUNTY HOSPITAL, AS WELL.

Q. AND --

A. AND ONE MORE THING. DID YOU ASK ME JUST FOR MEDICAL SCHOOL OR MEDICAL SCHOOL AND RESIDENCY?

Q. WELL, I WAS WONDERING DURING YOUR TRAINING JUST AT WHAT INSTITUTIONS DID YOU WORK WHERE ABORTION SERVICES WERE PROVIDED?

A. AND ALSO FRANKLIN SQUARE HOSPITAL, AS WELL.

Q. WHAT KINDS OF PATIENTS DID YOU SEE AND TREAT?

A. BASICALLY, THE FULL RANGE OF PATIENTS THAT THEY WOULD HAVE

AT THAT INSTITUTION, SO BOTH ELECTIVE TERMINATIONS, AS WELL AS WOMEN WHO WERE SICK AND WOMEN WHO HAD BABIES WITH ANOMALIES.

Q. DID YOU SEE WOMEN WITH TEEN PREGNANCIES, IN PARTICULAR?

A. YES. IN FACT IN MY RESIDENCY WE HAD THE UNFORTUNATE BUT NEEDED SERVICE OF PROVIDING PREGNANCY CARE AND LABOR AND DELIVERY CARE TO A HIGH PERCENTAGE OF TEEN WOMEN. IN FACT, BALTIMORE HAD AND STILL HAS ONE OF THE HIGHEST TEEN PREGNANCY RATES IN THE COUNTRY.

AND SO THAT WAS ONE OF THE THINGS THAT WE ESPECIALLY TOOK CARE OF WERE TEENS.

Q. WAS THE INDUCTION METHOD OF TERMINATION OF PREGNANCY, WAS THAT FREQUENTLY USED AT THE JOHNS HOPKINS MEDICAL CENTER?

A. YES, IT WAS.

Q. NOW, I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR TEACHING RESPONSIBILITIES. COULD YOU PLEASE GENERALLY DESCRIBE YOUR TEACHING RESPONSIBILITIES AT THE UNIVERSITY OF MICHIGAN?

A. THERE ARE BASICALLY FOUR SETS OF STUDENTS AND/OR RESIDENTS THAT I TEACH. ONE ARE UNDERGRADUATE STUDENTS WHERE I GUEST LECTURE IN WOMEN'S STUDIES COURSES, PSYCHOLOGY COURSES, SOCIOLOGY COURSES AND GRADUATE-LEVEL TEACHING IN THE NURSE MIDWIFERY PROGRAM AS WELL AS IN CERTAIN PSYCHOLOGY PH.D. THESIS I HAVE BEEN ON.

AND THEN, IN THE MEDICAL STUDENTS I LECTURE ON INTERPERSONAL VIOLENCE ISSUES, INCLUDING DOMESTIC VIOLENCE, SEXUAL ASSAULT, CHILD ABUSE AND ELDER ABUSE. I RUN A

SECOND-YEAR COURSE IN THIS.

THE THIRD YEAR I TEACH THE STUDENTS ROTATING THROUGH OUR DEPARTMENT IN OB/GYN BY BOTH HANDS-ON LEARNING AND TEACHING, AS WELL AS GIVING LECTURES EVERY SIX WEEKS IN BOTH BREAST-FEEDING AND MORE COMPLICATED DOMESTIC VIOLENCE ISSUES.

AND, THEN, FINALLY I RUN A FOURTH-YEAR MEDICAL STUDENT ELECTIVE CALLED "PRIMARY CARE OB/GYN" WHERE SENIOR STUDENTS GET TO PICK DIFFERENT TOPICS THEY ARE INTERESTED IN AND UNDERSTAND THEM FROM BOTH CLINICAL AND DIDACTIC ANGLES, BASICALLY.

AND THOSE ARE THE STUDENT AREAS. AND THEN, THE RESIDENTS I TEACH -- THE MOST TIME I TEACH ARE ACTUALLY OB/GYN RESIDENTS THAT WE HAVE IN OUR PROGRAM.

AND THEN, I HAVE HAD THE OCCASION ON AN ONGOING BASIS TO TEACH FAMILY PRACTICE RESIDENTS AND INTERNAL MEDICINE AND PEDIATRIC RESIDENTS, AS WELL.

Q. AND WITH THE RESIDENTS, WHAT KINDS OF THINGS DO YOU TEACH TO THE RESIDENTS?

A. JUST THE FULL RANGE OF WHAT I DO IN THE OFFICE SETTING AND IN THE INPATIENT SETTING, I WILL DISCUSS WITH THE RESIDENTS. BUT HOW IT SORT OF WORKS WHERE I AM SET UP IS THAT IT FEELS THAT IF YOU ARE A WOMAN COMING TO MY OFFICE IT FEELS LIKE A PRIVATE OFFICE. THAT YOU JUST SEE ME MOST OF THE TIME IN THE OFFICE.

SOMETIMES I WILL HAVE A STUDENT WITH ME, SOMETIMES I

WON'T. BUT THEN WITH THE RESIDENTS I AM DOING MORE INPATIENT WORK, MEANING SUPERVISING GYN PROCEDURES, LABOR AND DELIVERY PROCEDURES. AND THEN, SOMETIMES PEOPLE CONSULT ME, ESPECIALLY WOMEN WHO HAVE BEEN ABUSED, BECAUSE THAT IS MY OTHER AREA OF INTEREST.

Q. AND DO YOU SUPERVISE RESIDENTS IN PERFORMING PREGNANCY TERMINATIONS?

A. IF THE BABY HAS ALREADY DIED AND IT'S MY OWN PATIENT I WOULD HAVE HER COME TO THE OPERATING ROOM AFTER I'VE CONSENTED HER, AND ONE OF THE RESIDENTS WOULD SCRUB IN AND ASSIST ME IN MOST PROCEDURES.

AND, IN ADDITION, IF I AM ON CALL, SUPERVISORY CALL, AND SOMEONE IS TRANSFERRED IN AND THEY NEED TO HAVE A MEDICAL INDUCTION OF LABOR, THEN I WOULD SUPERVISE THE RESIDENTS IN THAT CASE, AS WELL.

Q. DOCTOR, DO YOU ALSO TEACH ABOUT ABORTION COMPLICATIONS?

A. YES, I DO.

Q. AND WHO DO YOU TEACH?

A. WELL, IT WOULD DEPEND AT THE TIME, BUT MANY TIMES WOMEN ARE READMITTED AFTER HAVING A TERMINATION OF PREGNANCY, FOR WHATEVER REASON, WITH A FEVER, WITH HEMORRHAGING, WITH OTHER COMPLICATIONS THAT ARE COMMON, AND WE NEED TO GO BACK AND DO ANOTHER PROCEDURE, SO A CURETTAGE OR SCRAPING TO GET THE REST OF THE PLACENTA OUT.

SO THERE IS THE HANDS-ON KIND OF TEACHING WHEN THE

WOMEN IS READMITTED.

AND THEN, THERE HAS BEEN OTHER OCCASIONS WHEN I HAVE BEEN ASKED TO SPEAK IN FRONT OF DIFFERENT GROUPS TO TALK ABOUT ABORTION COMPLICATIONS BECAUSE OF THE PAPER I HAVE WRITTEN.

Q. WHAT KINDS OF GROUPS ARE THOSE THAT YOU'VE LECTURED TO ABOUT ABORTION COMPLICATIONS?

A. I HAVE LECTURED TO DIFFERENT GROUPS OF ACOG, THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS. I HAVE GIVEN GRAND ROUNDS IN MEDICAL INSTITUTIONS. AND THEN, ANY GROUPS THAT HAVE ASKED ME TO COME, AND IF I CAN PUT THEM ON MY SCHEDULE I HAVE GONE AHEAD AND LECTURED TO DIFFERENT GROUPS.

Q. WHAT KINDS OF ABORTION COMPLICATIONS HAVE YOU TREATED IN YOUR PRACTICE?

A. THE MOST COMMON ONES ARE INFECTIONS AFTER AN ABORTION PROCEDURE, RETAINED PLACENTA, MEANING THAT THERE IS STILL SOME KIND OF PLACENTA OR DIFFERENT PARTS OF THE BABY THAT CAN BE LEFT INSIDE. AND THEN, THERE ARE OTHER THINGS THAT I DO ATTRIBUTE TO ABORTION, SUCH AS WOMEN WHO HAVE HAD EARLY BIRTHS IN ANOTHER PREGNANCY AND WOMEN WHO HAVE PLACENTA PREVIA, FOR EXAMPLE.

Q. I WOULD NOW LIKE TO TOUCH ON YOUR RESEARCH RESPONSIBILITIES. IN WHAT AREAS HAVE YOU PERFORMED RESEARCH AND WRITING?

A. MY TWO BIGGEST AREAS OF RESEARCH ARE ON VIOLENCE AGAINST WOMEN, SO I HAVE DONE DIFFERENT STUDIES AND THEN PUBLISHED THEM

ON ISSUES AROUND VIOLENCE AGAINST WOMEN. AND ALSO ON ABORTION COMPLICATIONS. ONE THING THAT I AM SORT OF SUBSPECIALIZED IN IS SOMETHING CALLED "SYSTEMATIC REVIEW," SO THAT WHEN WE LOOK AT PUBLICATIONS PREVIOUSLY PUBLISHED IN PEER REVIEWED JOURNALS I TRY TO TAKE NOT JUST ONE OR TWO ARTICLES AND SYNTHESIZE THEM, BUT DO A WHOLE LITERATURE SEARCH AND GATHER ALL THE ARTICLES ON A CERTAIN TOPIC AND THEN TRY TO MAKE SENSE OF WHAT THEY SHOW IN AGGREGATE.

SO I HAVE DONE THAT ON BOTH ISSUES AROUND VIOLENCE AGAINST WOMEN AND ISSUES AROUND ABORTION COMPLICATIONS.

Q. HOW DOES YOUR RESEARCH IN THE AREAS OF DOMESTIC VIOLENCE RELATE TO YOUR OB/GYN PRACTICE?

A. AGAIN, VIOLENCE AGAINST WOMEN IS A VERY COMMON PROBLEM, BOTH IN THE UNITED STATES AND WORLDWIDE. SO I KNEW WHEN I WAS A RESIDENT, A MEDICAL STUDENT THAT I WOULD SEE A LOT OF WOMEN WHO HAVE BEEN ABUSED.

AND SO, AGAIN, TO TAKE THE BEST CARE OF WOMEN I CAN, I NEED TO BE ABLE TO UNDERSTAND THEIR PERSONAL SITUATION IN TERMS OF: IS IT SAFE AT HOME? HAVE THEY POSSIBLY BEEN ASSAULTED AS A GIRL OR AS A YOUNG WOMAN, BECAUSE I AM GOING TO BE OPERATING ON THEM AND I AM GOING TO BE SOMEONE THAT THEY REALLY NEED TO TRUST.

AND IF THEY CAN'T TRUST THAT I CARE ABOUT THOSE VERY INTIMATE AND SCARY AREAS OF THEIR LIVES, THEN IT IS GOING TO BE HARD FOR THEM TO TRUST ME ABOUT THE MEDICAL THINGS.

SO I THINK THEY GO TOGETHER. AND THAT IS PART OF WHY I WANTED TO KNOW ABOUT ABORTION, BECAUSE, AGAIN, IT IS ONE OF THESE VERY INTIMATE AND PERSONAL AREAS WHERE, YOU KNOW, WOMEN NEED TO HAVE A LOT OF SUPPORT IN THEIR PHYSICIAN.

Q. HAVE YOU WRITTEN ANY ARTICLES ABOUT THE LONG-TERM COMPLICATIONS OF ABORTION?

A. YES, I HAVE.

Q. WHAT IS THAT ARTICLE?

A. IN JANUARY OF 2003, MYSELF AND TWO OTHER CO-AUTHORS FROM UNIVERSITY OF NORTH CAROLINA GOT PUBLISHED AN ARTICLE LOOKING AT THE LONG-TERM, BOTH PHYSICAL AND PSYCHOLOGICAL, COMPLICATIONS OF ABORTION, CALLED "A REVIEW OF THE EVIDENCE," WHICH IS, AGAIN, ONE OF THE SYSTEMATIC REVIEWS.

Q. WAS THAT PEER REVIEWED?

A. YES, IT WAS.

Q. ARE YOU A JOURNAL REVIEWER FOR ANY PUBLICATIONS?

A. YES.

Q. WHICH JOURNALS?

A. I HAVE BEEN ASKED TO BE JOURNAL REVIEWER FOR MANY. SOME EXAMPLES ARE THE GREEN JOURNAL, WHICH IS ONE OF THE MAJOR OB/GYN JOURNALS CALLED OBSTETRICS AND GYNECOLOGY. AND THEN, THE AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY, THE MAYO CLINIC PROCEEDINGS, THE FEMALE PATIENT AND SEVERAL OTHERS.

Q. DO YOU BELONG TO ANY PROFESSIONAL ORGANIZATIONS?

A. YES, I DO. PROBABLY THE ONE THAT IS MOST IMPORTANT TO ME AND THE ONE I AM MOST INTIMATELY INVOLVED IN IS THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS.

IN ADDITION, I'M PART OF MANY OTHER ORGANIZATIONS, AS WELL.

Q. ARE YOU ALSO A MEMBER OF AAPLOG?

A. YES. AAPLOG IS THE AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS AND GYNECOLOGISTS. AND, IN FACT, IS A PART OF ACOG, THE MAIN GROUP. IT'S A SPECIAL INTEREST GROUP OF ACOG.

Q. ARE YOU A FELLOW OF ACOG?

A. YES, I AM.

Q. BRIEFLY, WHY DID YOU DECIDE TO SPECIALIZE IN OBSTETRICS AND GYNECOLOGY?

A. WELL, WOMEN ARE NEAR AND DEAR TO MY HEART, I GUESS POSSIBLY BECAUSE I AM ONE, TOO. BUT JUST I WAS FASCINATED BY THE BREADTH OF WHAT WE DO TO TAKE CARE OF WOMEN, BOTH ON THE OBSTETRICAL END AND THE GYNECOLOGICAL END.

AND THAT I LIKED BEING ABLE TO FOLLOW WOMEN OVER TIME AND GIVE THEM TIME TO GET TO KNOW ME PERSONALLY AND SO I COULD HELP THEM WITH MAJOR LIFE DECISIONS AND BE A SOUNDING BOARD FOR MEDICAL INFORMATION, TOO.

Q. TURNING TO THE PARTIAL-BIRTH ABORTION PROCEDURE, WHAT DO YOU UNDERSTAND THE PARTIAL-BIRTH ABORTION PROCEDURE TO BE?

MS. KRASNOFF: OBJECTION, FOUNDATION.

THE COURT: SUSTAINED.

THE WITNESS: IN SHORT --
THE COURT: JUST A MOMENT.
THE WITNESS: OH, I'M SORRY.
THE COURT: SHE'LL ASK YOU A DIFFERENT QUESTION.
BY MS. CLARK:
Q. DR. SHADIGIAN, HAVE YOU HEARD THE TERM "PARTIAL-BIRTH ABORTION"?
A. YES, I HAVE.
Q. AND WHAT DO YOU UNDERSTAND "PARTIAL-BIRTH ABORTION" TO MEAN?
MS. KRASNOFF: OBJECTION, FOUNDATION. SHE'S NOT BEEN QUALIFIED TO TESTIFY ABOUT THAT AREA.
THE COURT: YOU HAVEN'T EVEN TOLD US YET WHAT YOU ARE OFFERING HER TO TESTIFY ABOUT.
MS. CLARK: I CAN JUMP TO THAT. YOUR HONOR, DEFENDANT OFFERS DR. SHADIGIAN AS AN EXPERT IN OBSTETRICS AND GYNECOLOGY, PREGNANCY TERMINATION AND ABORTION COMPLICATIONS.
THE COURT: ALL RIGHT. AND DO YOU HAVE AN OBJECTION?
MS. KRASNOFF: WE WOULD LIKE TO VOIR DIRE ON PREGNANCY TERMINATION.
THE COURT: AND NOT ABORTION COMPLICATIONS?
MS. KRASNOFF: NO, YOUR HONOR.
THE COURT: ALL RIGHT. YOU MAY DO SO.
MS. KRASNOFF: AS THEY RELATE TO SPECIFIC METHODS,

PERHAPS. BUT NOT --

THE COURT: OPPOSING COUNSEL IS GOING TO ASK A FEW QUESTIONS BEFORE I DETERMINE WHAT AREAS YOU ARE COMPETENT TO TESTIFY AS AN EXPERT IN.

VOIR DIRE EXAMINATION

BY MS. KRASNOFF:

Q. GOOD MORNING, DR. SHADIGIAN. I AM HELENE KRASNOFF. WE MET AT YOUR DEPOSITION.

IN YOUR CAREER, YOU HAVE PERFORMED BETWEEN 20 AND 40 PREVIABILITY ABORTIONS WHERE THE FETUS WAS ALIVE AT THE BEGINNING OF THE PROCEDURE; IS THAT CORRECT?

A. THAT'S APPROXIMATELY CORRECT, YES.

Q. AND YOU TESTIFIED ON DIRECT THAT YOU PERFORMED TERMINATIONS OF PREGNANCY WEEKLY, BUT THOSE ARE NOT PREVIABLE; IS THAT CORRECT?

A. CORRECT.

Q. ACTUALLY, ON PREVIABLE FETUSES YOU PERFORM ABOUT TWO OR THREE PER YEAR; IS THAT CORRECT?

A. THAT'S CORRECT.

Q. AND EACH AND EVERY ONE OF THOSE IS BY THE INDUCTION METHOD; IS THAT CORRECT, WHERE THE FETUS IS ALIVE?

A. WHERE THE FETUS IS ALIVE, THAT'S CORRECT.

Q. IN FACT, YOU HAVE NEVER PERFORMED A D&E PROCEDURE ON A LIVE FETUS; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. AND YOU HAVE NEVER PERFORMED A HYSTEROTOMY ON A LIVE FETUS; IS THAT CORRECT?
A. NOT THAT I CAN RECALL.
Q. SO YOUR ONLY EXPERIENCE PERFORMING D&E'S ARE ON FETUSES THAT HAVE ALREADY DEMISED; IS THAT CORRECT?
A. YES, EXCEPT FOR WHEN I WAS OBSERVING OTHERS DOING D&E'S ON LIVE BABIES.
Q. SO YOUR ONLY EXPERIENCE ACTUALLY PERFORMING THEM YOURSELF; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. AS A FACULTY MEMBER AT THE UNIVERSITY OF MICHIGAN OVER THE PAST 10 YEARS, YOU HAVE ONLY SUPERVISED OR PARTICIPATED IN BETWEEN 10 AND 20 D&E'S WHERE THE FETUS HAD DEMISED; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. SO, IF YOU AVERAGE THAT OUT THAT SUPERVISION WITH A DEMISED FETUS HAPPENS BETWEEN ZERO AND TWO TIMES EACH YEAR; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. AND THE LATEST GESTATIONAL AGE AT WHICH YOU HAVE ACTUALLY PERFORMED A D&E ON A DEAD FETUS AT THE UNIVERSITY OF MICHIGAN IN THE PAST 10 YEARS IS AT 17 OR 18 WEEKS; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. AND ISN'T IT TRUE THAT SOME D&E'S MAY REQUIRE SURGICAL SKILLS BEYOND YOUR PRACTICE SUCH THAT YOU WOULD REFER THOSE TO

THE MATERNAL FETAL MEDICINE SPECIALISTS?

A. THAT IS CORRECT.

Q. TURNING TO INTACT D&E, YOU YOURSELF HAVE NEVER PERFORMED AN INTACT D&E; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. AND YOU HAVEN'T SUPERVISED ANYONE ELSE PERFORMING AN INTACT D&E, HAVE YOU?

A. THAT IS CORRECT.

Q. YOU HAVEN'T OBSERVED AN INTACT D&E ABORTION BEING PERFORMED; IS THAT CORRECT?

A. NOT LIVE, THAT'S CORRECT. I HAVE NOT SEEN ONE LIVE; THAT IS CORRECT.

Q. AND YOU HAVEN'T BEEN TAUGHT THE INTACT D&E PROCEDURE, HAVE YOU?

A. THAT IS CORRECT.

Q. AND YOU HAVEN'T TAUGHT IT TO ANY MEDICAL STUDENTS OR RESIDENTS, EITHER, HAVE YOU?

A. THAT IS CORRECT.

Q. AND YOU HAVE NEVER DISCUSSED INTACT D&E WITH ANY PHYSICIAN WHO PERFORMS INTACT D&E, HAVE YOU?

A. THAT IS CORRECT.

Q. AND YOU DON'T ACTUALLY PERSONALLY KNOW ANY PHYSICIAN WHO PERFORMS INTACT D&E, DO YOU?

A. PROBABLY NOT.

Q. AND YOU HAVEN'T DISCUSSED THE INTACT D&E PROCEDURE WITH ANY

OTHER PHYSICIAN AT THE UNIVERSITY OF MICHIGAN, WHETHER HE OR SHE PERFORMS INTACT D&E OR NOT?

A. THAT IS CORRECT.

Q. AND PRIOR TO DECEMBER 22, 2003, YOU NEVER DONE A LITERATURE SEARCH ABOUT INTACT D&E ABORTIONS, HAD YOU?

A. THAT IS CORRECT.

MS. CLARK: YOUR HONOR I AM JUST GOING TO OBJECT. WE HAVEN'T SOUGHT TO QUALIFY HER AS AN EXPERT ON THE TECHNIQUE OF THE D&X PROCEDURE, SO I THINK IT IS OUTSIDE THE SCOPE AND NOT PARTICULARLY RELEVANT.

THE COURT: COUNSEL, THIS IS VOIR DIRE. THIS IS VOIR DIRE. SHE CAN ASK THOSE KINDS OF QUESTIONS.

BY MS. KRASNOFF:

Q. AND AT THAT TIME BACK IN DECEMBER, YOU ALSO HADN'T DONE A LITERATURE SEARCH FOR THE PURPOSE OF COMPARING THE SAFETY OF SECOND-TRIMESTER ABORTION PROCEDURES; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. SO IT WASN'T UNTIL AFTER YOU WERE CONTACTED TO TESTIFY IN THIS CASE THAT YOU PERFORMED THE LITERATURE REVIEWS WHICH FORM THE BASIS OF THE OPINIONS YOU ARE GOING TO OFFER TODAY; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. AND, IN FACT, IT WAS BECAUSE OF THAT UNFAMILIARITY THAT IT TOOK YOU MORE THAN 35 HOURS FROM THE TIME YOU WERE CONTACTED UNTIL YOUR EXPERT REPORT WAS PREPARED TO PREPARE IT; IS THAT

RIGHT?
A. I DON'T KNOW WHAT YOU MEAN.
Q. I COULD SHOW YOU SOMETHING THAT MIGHT REFRESH YOUR RECOLLECTION.
DR. SHADIGIAN, I HAVE SHOWN YOU AN INVOICE FOR THE TIME SPENT ON THIS CASE. DOES THAT REFRESH YOUR RECOLLECTION ABOUT THE TIME YOU SPENT PREPARING YOUR EXPERT REPORT?
A. I BELIEVE YOU ASKED THE QUESTION -- YES. BUT YOU ASKED A QUESTION ABOUT IF IT WAS JUST ALL SPENT ON LITERATURE SEARCH, I THOUGHT.
Q. OH, I'M SORRY. DID YOU NOT SPEND 35 HOURS OF WORK FROM WHEN YOU WERE FIRST CONTACTED UNTIL YOU SIGNED YOUR EXPERT REPORT ON JANUARY 16TH?
A. THAT IS CORRECT.
Q. AND YOU HADN'T PREVIOUSLY, PRIOR TO DECEMBER, DONE ANY RESEARCH RELATED TO THESE METHODS OF ABORTION IN THE SECOND-TRIMESTER; IS THAT RIGHT?
A. NOT FORMAL, YES.
MS. KRASNOFF: YOUR HONOR, PLAINTIFFS BELIEVE THAT DR. SHADIGIAN DOES NOT MEET THE STANDARD LAID OUT BY THE COURT LAST WEEK ON BEING ABLE TO TESTIFY ABOUT HOW INTACT D&E ABORTIONS ARE PERFORMED. SHE HAS NEVER PERFORMED, SUPERVISED, OBSERVED, TAUGHT, BEEN TAUGHT OR EVEN SPOKEN TO ANY PHYSICIAN WHO PERFORMS THAT PROCEDURE.
WE DO NOT OBJECT TO DR. SHADIGIAN BEING QUALIFIED AS

AN EXPERT IN OBSTETRICS AND GYNECOLOGY, GENERALLY. AND WE DO NOT OBJECT TO HER SPEAKING GENERALLY ABOUT HER RESEARCH IN THE COMPLICATIONS RELATED TO ABORTION. AS THEY RELATE TO SPECIFIC PROCEDURES, SUCH AS INTACT D&E, WE BELIEVE THERE IS NO BASIS FOR THAT.

HOWEVER, AS THE COURT PERMITTED LAST WEEK WITH DR. SPRANG, WE DON'T OBJECT TO HER PROVIDING EXPERT OPINION ON THE SAFETY OF INTACT D&E BASED ON HER GENERAL EXPERTISE IN OB/GYN, NOR HER BRIEFLY SETTING FORTH HER UNDERSTANDING OF THE PROCEDURE IN ORDER TO OFFER THOSE OPINIONS THAT ARE BASED ON EXTERNAL SOURCES ONLY.

BUT HER TESTIMONY REGARDING HOW INTACT D&E ABORTIONS ARE PERFORMED, WE SUBMIT, WOULD THUS NOT BE FOR THE TRUTH OF HOW THAT PROCEDURE IS, BUT RATHER THAT THOSE ARE THE BASES OF HOW SHE UNDERSTANDS IT FOR HER OPINIONS.

THE COURT: ALL RIGHT. ANY RESPONSE, MS. CLARK?

MS. CLARK: I MIGHT HAVE MISSED SOMETHING. I AM NOT SURE IF THEY ARE OBJECTING TO THE ABORTION COMPLICATIONS AND HER VIEWS ON ABORTION COMPLICATIONS. BUT I THINK HER RESEARCH -- SHE WROTE AN ARTICLE ABOUT -- SPECIFICALLY ABOUT ABORTION COMPLICATIONS. WHETHER AN EXPERT IS QUALIFIED IS BASED ON KNOWLEDGE, SKILL, EXPERIENCE AND TRAINING. AND SHE HAS HAD SUFFICIENT TRAINING IN ABORTION COMPLICATIONS. SHE HAS TREATED PATIENTS WITH ABORTION COMPLICATIONS.

WITH RESPECT TO PREGNANCY TERMINATION, AS SHE

TESTIFIED SHE HAS PERFORMED MEDICAL INDUCTION WHEN IT WAS BEEN NECESSARY FOR MEDICAL HEALTH CONDITIONS FOR THE WOMAN. SHE'S OBSERVED D&E'S ON LIVE FETUSES. SHE'S PERFORMED D&E'S --

THE COURT: I THINK YOU WEREN'T PAYING ATTENTION TO HER OBJECTION.

FIRST OF ALL, DID YOU OBJECT TO THE WITNESS BEING QUALIFIED ON THE QUESTION OF ABORTION COMPLICATIONS?

MS. KRASNOFF: NOT AS THEY RELATE TO ALL METHODS OF ABORTIONS. IN FACT, I WOULD HAPPY TO VOIR DIRE ON HER RESEARCH PARTICULARLY RELATED --

THE COURT: NO. I THINK THAT IS ACTUALLY SATISFACTORY.

HER OBJECTION WAS THE SAME AS WITH REGARD TO DR. SPRANG, WITH REGARD TO HER TESTIFYING AS AN EXPERT ON INTACT D&E. MY RULING WOULD BE THE SAME, UNLESS YOU HAVE SOME COMPELLING REASON WHY I SHOULD CHANGE MY RULING WITH RESPECT TO THIS DOCTOR.

MS. CLARK: I THINK THE RULING IS CONSISTENT WITH DR. SPRANG'S RULING.

THE COURT: ALL RIGHT. THEN, THE DOCTOR WILL BE -- DR. SHADIGIAN?

THE WITNESS: SHADIGIAN, THAT'S RIGHT.

THE COURT: -- SHALL BE QUALIFIED TO TESTIFY AS AN EXPERT IN OBSTETRICS AND GYNECOLOGY AND ON PREGNANCY TERMINATION WITH THE EXCEPTION OF INTACT D&E AND ABORTION

COMPLICATIONS.

SHE MAY, HOWEVER, OPINE, OBVIOUSLY, AS TO THE SAFETY OF THE INTACT METHOD AND MAY TESTIFY AS TO WHAT HER UNDERSTANDING IS. THAT TESTIMONY OBVIOUSLY WILL NOT BE CONSIDERED FOR THE TRUTH OF THE MATTER GIVEN THAT SHE HAS NOT OBSERVED, TAUGHT, OR PERFORMED SUCH PROCEDURE HERSELF.

ALL RIGHT. YOU MAY CONTINUE.

DIRECT EXAMINATION RESUMED

BY MS. CLARK:

Q. DR. SHADIGIAN, WHAT DO YOU UNDERSTAND THE PARTIAL-BIRTH ABORTION PROCEDURE TO BE?

A. IN SHORT, THE PARTIAL-BIRTH ABORTION PROCEDURE CAN BE BROKEN DOWN INTO FOUR SEPARATE PARTS. ONE IS SERIAL DILATION OF THE CERVIX OVER TWO DAYS TO OPEN THE CERVIX OR DILATE IT.

THE SECOND IS THE INSTRUMENTAL CONVERSION OF FETUS OR BABY IN A NONBREECH PRESENTATION TO A BREECH PRESENTATION.

AND THEN, DELIVERY OF THE BABY UP TO THE BASE OF THE SKULL.

AND THEN, FINALLY, PLACING, FOR EXAMPLE, SCISSORS OR OTHER SUCH INSTRUMENTS IN THE BASE OF THE SKULL AND EXTRACTING THE CONTENTS OF THE SKULL, AND THEN DELIVERING THE REST OF THE BABY.

Q. WHAT MATERIALS HAVE YOU REVIEWED THAT FORM THE BASIS OF YOUR OPINION THAT WHAT YOU JUST DESCRIBED IS A PARTIAL-BIRTH ABORTION PROCEDURE?

A. I'VE REVIEWED DR. HASKELL'S INITIAL REPORT IN 1992. I REVIEWED DR. PAUL'S BOOK, WHICH DESCRIBES BOTH THE HASKELL CASES AS WELL AS MCMAHON'S CASES. AND THEN, I'VE ALSO LOOKED CAREFULLY AT THE ACOG DOCUMENT ABOUT D&X PROCEDURE.

Q. DO YOU UNDERSTAND THE TERMS "D&X" AND PARTIAL-BIRTH ABORTION? DO YOU USE THOSE TERMS INTERCHANGEABLY?

A. I DO, AND I ALSO INCLUDE INTACT D&E WITH ALL THE OTHER DEFINITIONS.

Q. DR. SHADIGIAN, IS IT YOUR UNDERSTANDING THAT A D&X PROCEDURE WOULD ALSO BE A SURGICAL ABORTION IN WHICH THE PHYSICIAN INTENTIONALLY EXTRACTS A LIVE FETUS INTACT IN A BREECH PRESENTATION UNTIL THE HEAD GETS LODGED AT THE WOMEN'S INTERNAL CERVICAL OS, AND THEN DECOMPRESSES THE HEAD IN ORDER TO VAGINALLY DELIVER A DEAD FETUS?

A. YES.

Q. DOCTOR, CAN YOU BRIEFLY -- WHAT IS YOUR OPINION AS AN EXPERT IN THE FIELD OF OBSTETRICS AND GYNECOLOGY ABOUT THE MEDICAL NECESSITY OF A PARTIAL-BIRTH ABORTION PROCEDURE?

A. I HAVE NEVER PERSONALLY HAD TO USE A PARTIAL-BIRTH ABORTION PROCEDURE TO TAKE CARE OF WOMEN, EVEN SICK WOMEN WITH MEDICAL CONDITIONS.

I NEVER SEEN ANY OF MY COLLEAGUES AT THE UNIVERSITY OF MICHIGAN USE IT, NOR HAVE I IN MEDICAL SCHOOL OR RESIDENCY EVER SEEN THIS USED TO TAKE CARE OF EVEN THE SICKEST WOMEN.

Q. DR. SHADIGIAN, WHAT IS YOUR OPINION AS AN EXPERT IN THE

FIELD OF OBSTETRICS AND GYNECOLOGY ABOUT WHETHER THE PARTIAL-BIRTH ABORTION PROCEDURE OFFERS SAFETY ADVANTAGES OVER OTHER METHODS OF ABORTION DURING THE SECOND-TRIMESTER OF PREGNANCY?

A. THE PARTIAL-BIRTH ABORTION PROCEDURE HAS NEVER BEEN STUDIED IN A SYSTEMATIC WAY AND REPORTED IN THE LITERATURE IN A PEER-REVIEWED PRESENTATION NOR IN A PEER-REVIEWED JOURNAL ARTICLE. SO, THERE IS NO SOUND BASIS TO SAY THERE IS ANYTHING SAFE ABOUT THE D&X PROCEDURE, ESPECIALLY WHEN THERE ARE OTHER PROCEDURES, LIKE THE D&E PROCEDURE AND THE MEDICAL INDUCTION PROCEDURE THAT ARE SAFE AND WELL-STUDIED IN THE MEDICAL LITERATURE.

Q. IS THERE ANYTHING IN YOUR TRAINING AND EXPERIENCE THAT YOU FOUND PARTICULARLY USEFUL IN EVALUATING THE MEDICAL NECESSITY OF THE PARTIAL-BIRTH ABORTION PROCEDURE?

A. WELL, I DID PERFORM BOTH A DOMESTIC AND INTERNATIONAL LITERATURE SEARCH JUST BECAUSE I WASN'T SURE IF THERE WERE ARTICLES THAT HAD BEEN PUBLISHED OR NOT. AND SO UP THROUGH THE BEGINNING OF JANUARY 2004, I PERFORMED A FULL LITERATURE SEARCH, AND I HAD SPECIALIZED LIBRARIANS HELP ME TO MAKE SURE I DIDN'T MISS ANY KEYWORDS. SO BECAUSE I ACTUALLY HAVE DONE THAT MYSELF I FEEL CONFIDENT SAYING THERE HADN'T BEEN ANY PUBLISHED DATA ON THE D&X PROCEDURE.

Q. AND IS THERE ANYTHING WITH RESPECT TO YOUR TRAINING OR CLINICAL EXPERIENCE THAT HELPS YOU FORM YOUR OPINION?

A. I'VE TAKEN CARE OF ONE PATIENT WHO HAD A D&X PROCEDURE, AND THEN I TOOK CARE OF HER IN THE NEXT PREGNANCY, SO I HAD THAT EXPERIENCE, AS WELL.

Q. DOCTOR, YOU TESTIFIED EARLIER THAT YOU HAVE SOMETIMES HAD TO TERMINATE A PREGNANCY IN ORDER TO IMPROVE A WOMAN'S HEALTH CONDITION; IS THAT CORRECT?

A. YES.

Q. HOW WOULD YOU CHARACTERIZE THE FREQUENCY OF THE NEED TO TERMINATE A PREGNANCY BECAUSE OF THE WOMAN'S HEALTH CONDITION?

A. IT'S NOT COMMON, BUT IT IS NOT RARE, EITHER. IF YOU CONSIDER BOTH LATE SECOND-TRIMESTER AND THIRD-TRIMESTER THERE ARE MANY MEDICAL CONDITIONS THAT WARRANT HAVING A BABY BORN EARLY TO IMPROVE THE HEALTH CONDITION OF A WOMAN.

Q. IS IT COMMON THAT A WOMAN'S PREGNANCY HAS TO BE TERMINATED BECAUSE OF HEALTH CONDITIONS THAT MANIFEST IN THE SECOND-TRIMESTER OF PREGNANCY?

A. IT IS MUCH MORE RARE IN THE SECOND-TRIMESTER AND ALMOST ALWAYS LIMITED TO THE END OF THE SECOND-TRIMESTER WHEN A WOMAN BECOMES SEVERELY ILL.

Q. HOW DO YOU KNOW THAT IT IS UNCOMMON THAT TERMINATION OF PREGNANCY IS RARELY MEDICALLY INDICATED IN THE SECOND-TRIMESTER?

A. BECAUSE I HAVE PRACTICED AT BIG TERTIARY CARE CENTERS WHERE THE EXPERIENCE HAS BEEN WE GET TRANSFERRED THE SICKEST PATIENTS. AND EVEN IN A SITUATION SUCH AS TERTIARY CARE

CENTER, WE STILL ONLY TAKE CARE OF A FEW PER YEAR, 10 TO 20 PER YEAR THAT ARE SO SICK THEY NEED TO BE TERMINATED.

IN ADDITION, JUST LOOKING AT THE MEDICAL LITERATURE, WE CAN LOOK AT INCIDENTS, RATES OF SEVERE PREECLAMPSIA AND OTHER MEDICAL CONDITIONS.

Q. OKAY. AND YOU'VE MENTIONED PREECLAMPSIA A COUPLE OF TIMES NOW. WHAT IS PREECLAMPSIA?

A. PREECLAMPSIA IS A MEDICAL CONDITION THAT IS LIMITED TO PREGNANCY, AND IT'S A CONSTELLATION OF BASICALLY THREE DIFFERENT MANIFESTATIONS.

ONE IS HIGH BLOOD PRESSURE IN PREGNANT WOMEN. THERE CAN BE PROTEIN IN THE URINE, WHICH IS WHEN THE KIDNEYS AREN'T WORKING PROPERLY. AND THEN THE WOMEN CAN GET GENERALLY SWELLING ALL OVER THEIR BODY. AND THERE ARE DIFFERENT SUBSETS OF PREECLAMPSIA THAT MAKE IT SEVERE. AND ONE OF THEM IS SOMETHING CALLED HELP SYNDROME, WHICH IS AN ACRONYM FOR WHEN THE BLOOD ISN'T WORKING PROPERLY, AS WELL.

Q. AND HAVE YOU EVER NEEDED TO TERMINATE A PREGNANCY WHEN A WOMAN IS SUFFERING FROM PREECLAMPSIA?

A. YES.

Q. AND HAVE YOU PERFORMED THE PREGNANCY TERMINATION YOURSELF?

A. YES.

Q. WHAT METHOD HAVE YOU EMPLOYED?

A. GENERALLY, WE WOULD DO A MEDICAL INDUCTION. BUT IF THE BABY IS VIABLE AND THE PATIENT WOULD PREFER, OR THERE WOULD BE

ANOTHER INDICATION, SOMETIMES WE DO A CESAREAN SECTION, AS WELL.

Q. YOU PREVIOUSLY TESTIFIED ABOUT CHORIOAMNIONITIS. WHAT IS CHORIOAMNIONITIS?

A. CHORIOAMNIONITIS IS AN INFECTION OF THE MEMBRANES AROUND THE BABY, BUT IT CAN ALSO INCLUDE THE FLUID AROUND THE BABY, THE BABY, HIM OR HERSELF, OR THE MOTHER.

Q. DOES THAT CONDITION -- WHEN THAT CONDITION IS PRESENTED DOES THAT EVER REQUIRE TERMINATION OF PREGNANCY?

A. YES, IT CAN.

Q. AND WHAT METHOD OF PREGNANCY TERMINATION HAVE YOU UTILIZED WHEN A PATIENT HAS PRESENTED WITH CHORIOAMNIONITIS REQUIRING THAT THE PREGNANCY BE TERMINATED?

A. GENERALLY, WE USE MEDICAL INDUCTIONS, AS WELL.

Q. WHEN FACED WITH THE NEED TO TERMINATE A PREGNANCY BECAUSE OF A MATERNAL HEALTH COMPLICATION, IS THAT SITUATION APPROACHED DIFFERENTLY DEPENDING ON WHETHER THE BABY IS PREVIABLE OR POSTVIABLE?

A. THE GENERAL APPROACH WOULD BE SIMILAR, BUT IN A PREVIABLE INFANT, WE MAY USE HIGHER DOSES OF SIMILAR MEDICATIONS BECAUSE WE ARE NOT CONCERNED THAT THE BABY COULD ACTUALLY SURVIVE THE INDUCTION.

Q. DOCTOR, HOW DO YOU EVALUATE THE MEDICAL HEALTH CONDITIONS DURING A PREGNANCY IN ORDER TO DETERMINE WHETHER AND WHEN YOU SHOULD END A PREGNANCY?

A. WELL, IT DEPENDS ON WHAT THE CONDITION IS, AND THEN WHAT A WOMAN'S HISTORY MIGHT BE AND WHAT HER CURRENT SITUATION IS IN TERMS OF BLOOD PRESSURE, DIFFERENT LABORATORY VALUES THAT WE MAY NEED TO EVALUATE DURING THE PREGNANCY.

SO IT DEPENDS ON THE PARTICULAR SITUATION.

Q. WHEN A PREGNANCY HAS TO BE ENDED PREVIABLE BECAUSE OF A MATERNAL HEALTH REASON, IS IT EVER NECESSARY TO TAKE A DESTRUCTIVE ACT AGAINST THE FETUS IN ORDER TO PROTECT THE HEALTH INTERESTS OF THE MOTHER?

A. NO, IT IS NOT.

Q. WHAT IS NECESSARY TO SERVE THE HEALTH INTEREST OF THE MOTHER WHEN SHE NEEDS HER PREGNANCY TO BE ENDED PREVIABILITY?

A. WHETHER IT IS PREVIABILITY OR POSTVIABILITY WHAT WE HAVE TO DO IS DELIVER THE BABY IN SOME WAY, AND SO THE ACTUAL ACT OF DELIVERING THE BABY IS WHAT -- AND PLACENTA -- IS WHAT ACTUALLY HELPS REVERSE THE MEDICAL CONDITION THAT IS MAKING A WOMAN SICKER AND SICKER.

Q. WHY IN THE SECOND-TRIMESTER OF PREGNANCY, WHEN PREGNANCY TERMINATION IS DEEMED TO BE NECESSARY TO PROTECT THE MOTHER'S HEALTH INTEREST, DO YOU USE THE INDUCTION METHOD?

A. WELL, THE REASON I AND OTHERS AT THE UNIVERSITY OF MICHIGAN DO IS BECAUSE OF THE SAFETY DATA. AFTER 20 WEEKS, IT IS ACTUALLY SAFER TO HAVE A MEDICAL INDUCTION FOR MOST WOMEN, LOOKING AT BOTH THE MORTALITY RATE, MEANING HOW MANY WOMEN DIE WITH A MEDICAL INDUCTION VERSUS A D&E PROCEDURE.

AND ALSO, NOW WE HAVE MISOPROSTOL, WHICH IS A MORE MODERN PROSTAGLANDIN, GIVES US EVEN BETTER SAFETY DATA.

Q. WHEN IT HAS BEEN MEDICALLY INDICATED TO TERMINATE A PREGNANCY, HAVE YOU EVER THOUGHT IT MIGHT BE HELPFUL IN TERMS OF THE HEALTH OF THE MOTHER TO PERFORM A D&X PROCEDURE?

A. NO.

Q. HAVE YOU EVER THOUGHT WHEN PERFORMING A VAGINAL SURGICAL REMOVAL OF A FETUS THAT IT WOULD BE PREFERABLE IN TERMS OF SAFETY TO THE MOTHER TO REMOVE THE FETUS INTACT UP UNTIL ITS HEAD GOT STUCK AT THE WOMAN'S INTERNAL CERVICAL OS?

MS. KRASNOFF: OBJECTION, YOUR HONOR. SHE'S NEVER PERFORMED A SURGICAL ABORTION ON A LIVE FETUS.

THE COURT: SUSTAINED.

BY MS. CLARK:

Q. DOCTOR, HAVE YOU PERFORMED INDUCTIONS FOR THE PURPOSE OF TERMINATION OF PREGNANCY ON A LIVE FETUS?

A. YES.

Q. HAVE YOU DONE THAT PREVIABILITY?

A. YES.

Q. AND IN PERFORMING AN INDUCTION PROCEDURE ON THE LIVE FETUS FOR THE PURPOSE OF TERMINATING A PREGNANCY, HAVE YOU EVER THOUGHT IT WOULD BE PREFERABLE IN TERMS OF THE SAFETY TO THE MOTHER TO REMOVE THE FETUS INTACT UP UNTIL ITS HEAD GOT STUCK AT THE WOMAN'S INTERNAL CERVICAL OS, AND THEN DECOMPRESS THE SKULL OF THE FETUS IN ORDER TO COMPLETE THE DELIVERY?

A. NO.
Q. ARE THERE, IN YOUR OPINION, SAFE AND EFFECTIVE METHODS TO TERMINATE A PREGNANCY FOR MATERNAL HEALTH REASONS WITHOUT THE D&X PROCEDURE?
A. YES.
Q. WOULD A D&X PROCEDURE EVER BE AN APPROPRIATE PROCEDURE TO TERMINATE A PREGNANCY IF THE CIRCUMSTANCE IN WHICH THE WOMAN'S HEALTH WAS RAPIDLY DETERIORATING?
A. NO, BECAUSE IT NEEDS THE DILATION OF THE CERVIX OVER TWO DAYS BEFORE IT CAN BE ACCOMPLISHED. SO WITH SICK WOMEN WE DON'T HAVE TWO OR THREE DAYS, MANY TIMES. THEY WOULD DECOMPENSATE AND BE NEAR DEATH AT THAT POINT.
Q. I NOW WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT FETAL ANOMALIES. DO YOU DIAGNOSE YOUR PATIENTS WITH FETAL ANOMALIES?
A. YES, I DO.
Q. HOW DO YOU GO ABOUT MAKING SUCH A DIAGNOSIS?
A. IT IS COMMON TO ORDER A SECOND-TRIMESTER ULTRASOUND, WHICH WOULD LOOK AT SPECIFIC ORGAN SYSTEMS OF THE BABY AND SEE IF THEY ARE WITHIN NORMAL LIMITS OR THEY MAY HAVE SOME KIND OF ORGAN ABNORMALITIES.
WE DO THIS BASICALLY WITH ALL OUR PREGNANT PATIENTS.
Q. WHAT HAPPENS WHEN ONE OF YOUR PATIENTS IS DIAGNOSED WITH A FETAL ANOMALY?
A. FIRST WHAT HAPPENS IS I WILL SIT DOWN FACE-TO-FACE AND EXPLAIN WHAT THE ULTRASOUND SHOWED. I MIGHT SHOW HER PICTURES.

I WOULD AFFORD THEM THE OPPORTUNITY, AFTER I EXPLAINED WHAT IT WAS, FOR THEM TO ASK QUESTIONS. AND THEN, MANY TIMES, I WILL MAKE CONSULTATIVE REFERRAL TO THE MATERNAL FETAL MEDICINE GROUP SO THAT THE WOMAN CAN HAVE A SECOND OPINION ABOUT THE FETAL ANOMALY AND WHAT IT MIGHT MEAN FOR HER AND THE BABY AND WHAT HER OPTIONS ARE.

Q. IN CASES INVOLVING A FETAL ANOMALY, CAN THERE BE MATERNAL HEALTH PROBLEMS ASSOCIATED WITH THE ANOMALY THAT MAY REQUIRE TERMINATION OF THE PREGNANCY IN ORDER TO PROTECT THE HEALTH INTERESTS OF THE MOTHER?

A. GENERALLY, THEY ARE SEPARATE CONDITIONS. THE FETAL ANOMALY IS ONE OPTION -- IS ONE SEPARATE SET OF ISSUES AROUND THE BABY. AND THEN, THE MATERNAL HEALTH CONDITION IS A SEPARATE ISSUE.

Q. DO YOU HAVE KNOWLEDGE ABOUT THE PROCEDURES THAT MAY BE USED TO TERMINATE A PREGNANCY FOR A FETAL ANOMALY?

A. YES.

Q. WHAT KINDS OF ABORTIONS ARE AVAILABLE FOR SECOND-TRIMESTER ABORTIONS AT THE UNIVERSITY OF MICHIGAN?

A. WOMEN ARE OFFERED BOTH THE D&E, THE DISARTICULATION PROCEDURE, AS WELL AS MEDICAL INDUCTIONS OF LABOR. AND THAT STARTS AS EARLY AS 16 WEEKS FOR MEDICAL INDUCTION OF LABOR WITH ANOMALIES.

Q. WHAT METHOD OF TERMINATION WOULD YOU RECOMMEND FOR A PREGNANCY TERMINATION INVOLVING A FETAL ANOMALY AFTER 20 WEEKS?

A. GENERALLY, WE ALMOST ALWAYS OFFER THE MEDICAL INDUCTION AS

OUR FIRST CHOICE.
Q. AND WHY DO YOU OFFER MEDICAL INDUCTION AS THE FIRST CHOICE AT 20 WEEKS OR LATER?
A. JUST BECAUSE THE SAFETY DATA IS SO MUCH BETTER AT 20 WEEKS AND GREATER, ESPECIALLY NOW THAT WE USE ALMOST EXCLUSIVELY MISOPROSTOL FOR INDUCTIONS, ALTHOUGH NOT EXCLUSIVELY.
Q. DO YOU CONTINUE TO TREAT YOUR PATIENTS AFTER THEY HAVE HAD A TERMINATION FOR A FETAL ANOMALY?
A. I MAKE IT REALLY CLEAR TO WOMEN THAT I AM THEIR DOCTOR, WHETHER THEY CHOOSE TO HAVE AN ABORTION FOR EITHER FETAL ANOMALIES OR ELECTIVELY OR FOR WHATEVER REASON; THAT I WANT TO CONTINUE TO BE THEIR DOCTOR AFTERWARDS. AND I HAVE DONE THAT ON MANY OCCASIONS.
Q. HAVE YOU DELIVERED BABIES FOR SOME OF YOUR PATIENTS AFTER THEY HAVE HAD A TERMINATION FOR MATERNAL COMPLICATION OR BECAUSE OF A FETAL ANOMALY?
A. YES, I HAVE.
Q. DOCTOR, IN YOUR OPINION, IS THE D&X PROCEDURE EVER NECESSARY TO TERMINATE A PREGNANCY IN WHICH THERE IS A FETAL ANOMALY?
A. NO.
Q. WHY NOT?
A. THERE ARE JUST OTHER BETTER METHODS, BOTH THE D&E DISARTICULATION METHOD AS WELL AS MEDICAL INDUCTION HAVE SAFETY DATA THAT WE KNOW ABOUT FROM MANY DIFFERENT SOURCES, FROM MANY

DIFFERENT INSTITUTIONS, BOTH NATIONALLY, INTERNATIONALLY, SO THAT WE HAVE SOME BASIS TO TALK ABOUT SAFETY WHEN WE TALK ABOUT THOSE TWO PROCEDURES.

Q. IN YOUR EXPERIENCE IN TREATING PATIENTS WITH FETAL ANOMALIES, IS THERE ANYTHING UNIQUE ABOUT THE FETAL ANOMALIES THAT YOU HAVE SEEN THAT WOULD REQUIRE AN INTACT EXTRACTION AS PERFORMED IN THE D&X PROCEDURE AS YOU UNDERSTAND THAT PROCEDURE?

A. NO, I HAVE NOT.

Q. HAVE YOU EVER HAD A PATIENT WITH THE FETAL ANOMALY OF CONJOINED TWINS?

A. YES, I HAVE.

Q. WHAT HAPPENED WITH THAT PATIENT?

A. THIS WAS A PATIENT OF MINE WHO I HAD HELPED WITH HER FIRST PREGNANCY, AND THIS WAS A SECOND PREGNANCY. AND SHE WAS DIAGNOSED ON HER ROUTINE ULTRASOUND OF HAVING TWO BABIES, AND TWO BABIES CONNECTED AT BOTH THE THORAX OR UPPER CHEST AND LOWER ABDOMEN. SO THERE WERE TWO BABIES, TWO HEADS, TWO SETS OF SHOULDERS, ET CETERA.

AND SO, WE TALKED IN THE OFFICE RIGHT AFTERWARDS, THAT THIS, BECAUSE OF THE KIND OF ANOMALY IT WAS, WASN'T SOMETHING THAT COULD BE FIXED BECAUSE OF HOW COMPLICATED THE HEART DEFECT WAS. AND IT WASN'T SOMETHING THAT YOU COULD JUST SEPARATE THE BABIES AND THEY WOULD BE FINE LATER; YOU KNOW, THAT IT PROBABLY WAS A LETHAL ANOMALY FOR THE BABIES.

SO WE WENT OVER THAT INFORMATION. WE TALKED ABOUT IT. I ANSWERED ALL HER QUESTIONS. AND THEN, I HAD HER GO SEE THE MATERNAL FETAL MEDICINE SPECIALIST, AS WELL.

AND THEN, IN THE END, WE TALKED AGAIN BEFORE SHE MADE HER DECISION AND SHE CHOSE TO HAVE A TERMINATION OF THE PREGNANCY. AND THE TECHNIQUE WAS USED WAS MEDICAL INDUCTION.

Q. DID YOU LATER TREAT THAT PATIENT?

A. YES. SHE LATER -- NOT ONLY DID I DO HER POSTPARTUM EXAM AFTER THE TERMINATION OF PREGNANCY, BUT ALSO IN ANOTHER PREGNANCY I TOOK CARE OF HER AND SHE DELIVERED AT TERM A HEALTHY BABY.

Q. DR. SHADIGIAN, AT THE UNIVERSITY OF MICHIGAN ARE YOU AWARE OF THE D&X PROCEDURE BEING TAUGHT TO MEDICAL STUDENTS?

A. NO, I AM NOT.

Q. TO RESIDENTS?

A. NO, I AM NOT.

Q. WOULD YOU KNOW IF THE D&X PROCEDURE WERE BEING TAUGHT?

A. YES, I PROBABLY WOULD, BECAUSE I ATTEND AS MUCH AS I CAN A WEEKLY CONFERENCE CALLED "MORBIDITY AND MORTALITY" WHERE WE GO OVER ALL THE DIFFERENT SURGICAL CASES AND ALL THE DIFFERENT LABOR COMPLICATIONS. SO THAT WOULD BE CONSIDERED A SURGICAL CASE, AND WE WOULD TALK ABOUT IT AT OUR WEEKLY MEETING.

Q. ARE YOU AWARE OF RESIDENTS BEING TAUGHT THEY SHOULD TRY TO REMOVE THE FETUS AS INTACT AS POSSIBLE WHEN PERFORMING A D&E PROCEDURE WITH A GOAL TOWARD AN INTACT REMOVAL?

A. NO, I AM NOT.
Q. HAVE YOU EVER PERFORMED A D&E PROCEDURE WHEN THE FETUS CAME OUT INTACT UP TO THE HEAD?
A. NO, I HAVE NOT.
Q. HAVE YOU EVER WITNESSED ANOTHER PHYSICIAN PERFORM A PROCEDURE IN WHICH THE FETUS WAS REMOVED INTACT UP TO THE HEAD?
A. NO, I HAVE NOT.
Q. DO YOU THINK THERE ARE BENEFITS TO PERFORMING THE D&X PROCEDURE ON WOMEN AT THIS TIME?
A. I DON'T KNOW.
Q. AND WHY DON'T YOU KNOW?
A. WELL, IN THE ABSENCE OF ANY SAFETY DATA, I CAN'T REALLY SAY THERE IS OR THERE ISN'T.
Q. IN YOUR MEDICAL OPINION, IF A PHYSICIAN WERE GOING TO SURGICALLY REMOVE A FETUS AS INTACT AS POSSIBLE, WHAT DO YOU THINK PATIENTS SHOULD BE TOLD ABOUT THE INTACT SURGICAL REMOVAL?
A. I THINK THAT THEY SHOULD BE TOLD THAT IT IS A DIFFERENT PROCEDURE THAN A DISARTICULATION D&E PROCEDURE; THAT THEY SHOULD BE SEPARATELY CONSENTED FOR THIS PROCEDURE. JUST LIKE D&C IS A FIRST-TRIMESTER PROCEDURE THAT REMOVES THE BABY AND THE PLACENTA FROM THE UTERUS, WE CALL IT A SEPARATE PROCEDURE TO CALL IT D&E PROCEDURE, EVEN THOUGH, IN ESSENCE, THEY ACCOMPLISH A SIMILAR TASK.
SO IN THE SAME VEIN, I WOULD TELL A PATIENT THAT A

D&X PROCEDURE IS A DIFFERENT PROCEDURE THAN THE D&E PROCEDURE, AND THAT IT DILATES THE CERVIX MORE. THAT IT IS USUALLY PERFORMED LATER IN A PREGNANCY, AND THAT IT INVOLVES A NONPHYSIOLOGIC PULLING THE BABY THROUGH THE CERVICAL OS AND THEN EXPLAINING THE WHOLE PROCEDURE IN TERMS OF WHAT HAPPENS WITH THE BABY'S HEAD, ET CETERA, SO THAT THEY COULD BE TRULY INFORMED OF WHAT IT IS.

Q. IN YOUR MEDICAL OPINION, IS IT SOUND FOR PHYSICIANS TO RELY ON THEIR OWN EXPERIENCE IN PERFORMING THE D&X IN DECIDING TO PERFORM A D&X ON A PATIENT?

A. NO.

Q. DOCTOR, THE COURT HAS HEARD PHYSICIANS TESTIFY WHO HAVE PERFORMED D&X PROCEDURES AND WHO PERFORMED SOME VARIATION OF THE D&X PROCEDURE. THEY HAVE TESTIFIED THAT THE PROCEDURE IS SAFE, BASED ON EXPERIENCE.

WHAT IS YOUR OPINION WITH RESPECT TO THE ASSERTIONS THAT THE D&X PROCEDURE IS INTUITIVELY SAFE BASED ON CLINICAL EXPERIENCES WITH THAT PROCEDURE?

A. WELL, I BELIEVE THAT THOSE ABORTION PROVIDERS ARE TELLING THE TRUTH; THAT THEY BELIEVE THAT THE D&X IS JUST AS SAFE AS A D&E DISARTICULATION PROCEDURE. BUT IT IS REALLY BASED ON ANECDOTE. IT'S JUST BASED ON DOING THIS PROCEDURE AT THE SAME TIME ON DIFFERENT PATIENTS.

SO THAT IT CAN BE CONSIDERED SORT OF LIKE A CASE, BUT IT CAN'T BE CONSIDERED LONG-TERM SAFETY DATA. IT CAN'T BE

CONSIDERED SHORT-TERM SAFETY DATA, ESPECIALLY BECAUSE MOST ABORTION PROVIDERS NEVER SEE THEIR PATIENTS BACK AFTER THE ABORTION PROCEDURE.

MS. KRASNOFF: OBJECTION, YOUR HONOR, FOUNDATION.

THE COURT: SUSTAINED.

MS. CLARK: IS IT SUSTAINED ON A PATIENT -- I MEAN, THEY NEVER SEE THEM BACK, THOUGH, THAT PART OF THE FOUNDATION?

THE COURT: THE FIRST PART OF THE QUESTION.

BY MS. CLARK:

Q. DOCTOR, YOU TESTIFIED THAT MANY PATIENTS DON'T GO BACK TO THE DOCTOR FOR WHOM THEY RECEIVE ABORTION FOLLOW-UP CARE; IS THAT CORRECT? OR SOMETHING TO THAT --

MS. KRASNOFF: I BELIEVE THAT WAS STRICKEN BASED ON THE OBJECTION.

THE COURT: THE OBJECTION WAS SUSTAINED. YOU NEED TO ESTABLISH A FOUNDATION THAT SHE HAS THAT KNOWLEDGE.

BY MS. CLARK:

Q. DOCTOR, DO YOU HAVE AN OPINION AS TO WHETHER OR NOT PATIENTS FREQUENTLY RETURN TO THEIR PHYSICIAN WHO PERFORMED THE ABORTION FOR FOLLOW-UP CARE? JUST DO YOU HAVE AN OPINION?

A. YES, I DO HAVE AN OPINION.

Q. WHAT IS THAT OPINION BASED ON?

A. THE OPINION IS BASED ON TWO THINGS: ONE, MY OWN PATIENTS WHO HAVE RECEIVED ABORTIONS FROM DIFFERENT PROVIDERS, AND SECOND FROM MEDICAL RESEARCH.

Q. AND WHEN YOU ARE REFERRING TO MEDICAL RESEARCH, WHAT MEDICAL RESEARCH ARE YOU REFERRING TO?

A. SPECIFICALLY THERE HAVE BEEN STUDIES LOOKING AT THE QUALITY OF ABORTION CARE AND HOW WOMEN PERCEIVE THEIR ABORTION CARE. AND ONE OF THE STUDIES I REVIEWED SPECIFICALLY FOR THIS, BUT I REVIEWED IT IN THE PAST, WAS SOMETHING CALLED A PICKER REPORT FROM 1999.

AND SPECIFICALLY THEY ASKED WOMEN -- WHICH WAS OVER A THOUSAND WOMEN -- IF THEY ACTUALLY GO BACK FOR THEIR FOLLOW-UP EXAM TO THE SAME PROVIDER THAT PROVIDED THE ABORTION. AND THEY SAID -- 29 PERCENT OF WOMEN SAID THAT THEY DID GO BACK TO THE SAME ABORTION PROVIDER. AND 71 PERCENT SAID THEY DID NOT.

MS. CLARK: MAY I APPROACH?

BY MS. CLARK:

Q. I AM SHOWING YOU WHAT HAS BEEN IDENTIFIED AS DEFENDANT'S EXHIBIT NUMBER LT A-42. IS THIS THE PICKER STUDY THAT YOU WERE MENTIONING?

A. YES, IT IS.

Q. IF YOU WOULD TURN TO PAGE 43.

A. I AM THERE.

Q. WHERE ON PAGE 43 DOES THIS SUPPORT YOUR OPINION THAT WOMEN DON'T RETURN FOR FOLLOW-UP AFTER AN ABORTION HAS BEEN PERFORMED?

A. ON QUESTION NUMBER 60, THE QUESTION ASKED:

"DID YOU GO BACK TO THIS CLINIC FOR A FOLLOW-UP VISIT?"

"YES," 30 PERCENT. "NO," 69 PERCENT. "DON'T KNOW" OR REFUSED TO ANSWER, ONE PERCENT.

Q. THANK YOU.

DOCTOR, HAVE YOU REVIEWED DR. HASKELL'S 1992 PAPER REGARDING THE D&X PROCEDURE?

A. YES, I HAVE.

Q. WOULD YOU AGREE IN THE PAPER DR. HASKELL REPORTED ON THE RESULT OF THE CASES HE HAD UNDERTAKEN USING THE D&X PROCEDURE, AND THAT HE FOUND NO COMPLICATIONS WITH THE PROCEDURE?

MS. KRASNOFF: OBJECTION, HEARSAY.

THE COURT: I AM SORRY. I CAN'T QUITE -- OKAY. THE QUESTION WAS -- COULD YOU REPEAT IT?

BY MS. CLARK:

Q. WOULD YOU AGREE THAT IN THAT DR. HASKELL PAPER THAT HE REPORTED ON THE RESULTS OF CASES HE HAD UNDERTAKEN USING THE D&X PROCEDURE AND THAT HE FOUND NO COMPLICATIONS WITH THE PROCEDURE?

THE COURT: OKAY. I WILL ALLOW THE QUESTION.

THE WITNESS: THAT'S WHAT DR. HASKELL DID SAY IN HIS PAPER.

BY MS. CLARK:

Q. ISN'T THAT A CASE REVIEW THAT PROVIDES SOME BASIS OF EVIDENCE FOR THE PROCEDURE'S SAFETY?

A. DR. HASKELL'S PAPER CAN BE CONSIDERED LIKE A SERIES OF CASES, YES.

Q. AND ASSUMING HIS REPORT ABOUT NO COMPLICATIONS IS CORRECT, IT'S TRUE, ISN'T IT, THAT IN UNDERSTANDING THE SAFETY OF A PROCEDURE THAT BEGINS WITH CASE REVIEWS SUCH AS DR. HASKELL'S; IS THAT RIGHT?

A. YES, MANY TIMES WHEN WE START EVALUATING A NEW PROCEDURE WE LOOK TO CASE REPORTS AS A FIRST LINE OF A NEW PROCEDURE.

Q. IN YOUR OPINION, IS IT SUFFICIENT TO RELY ON SUCH SELF-REPORTED CASE REVIEWS OF PHYSICIANS WHO ARE REPORTING A PROCEDURE AND EVALUATING THE SAFETY OF THE PROCEDURE?

A. NO, IT IS NOT.

Q. WHY NOT?

A. THERE ARE SEVERAL REASONS WHY THAT IS NOT ADEQUATE MEDICAL EVIDENCE-BASED MEDICINE. AND FIRST OF ALL, FOR EXAMPLE, DR. HASKELL NEVER EXPLAINS TO US HOW HE KNOWS THERE WERE NO COMPLICATIONS. HE DOESN'T EXPLAIN HOW WOMEN WERE FOLLOWED OR IF THEY EVEN GAVE A FOLLOW-UP PHONE CALL TO THE PATIENTS.

IN ADDITION --

MS. KRASNOFF: OBJECTION, HEARSAY.

THE COURT: I AM GOING TO PERMIT IT. WE ALL READ THE REPORT. YOU KNOWS WHAT IT SAYS. YOU KNOW IT DOESN'T EXPLAIN IT.

THE WITNESS: THE OTHER ISSUES ARE THAT THERE WERE NO CONTROL GROUPS FOR WHICH TO COMPARE THE NEW PROCEDURE, THE

D&X PROCEDURE, TO WELL-STUDIED AND WELL-EXPLAINED PROCEDURES SUCH AS A DISARTICULATION D&E OR MEDICAL INDUCTION, FOR EXAMPLE.

AND SO IT IS JUST A SERIES OF "I DID THIS PROCEDURE, AND THIS IS THE OUTCOME I REPORT."

FINALLY, BECAUSE THERE WAS NO ONE ELSE COMPARING IT, MANY TIMES WE LIKE TO HAVE SURGEONS OR OTHER PEOPLE WHO DO A CERTAIN KIND OF PROCEDURE HAVE OTHER PEOPLE EVALUATE THE DATA SO IT LOOKS MORE BALANCED. AND THAT WASN'T DONE IN THE HASKELL REPORT, AS WELL.

BY MS. CLARK:

Q. NOW, WHAT IF A PHYSICIAN WHO IS PERFORMING THE PROCEDURE CONSULTS WITH OTHER PHYSICIANS WHO HAVE PERFORMED THE PROCEDURE AND COLLECTIVELY THOSE PHYSICIANS BELIEVE THAT THE PROCEDURE IS SAFE. IS THAT A WAY IN THE MEDICAL FIELD TO ASSESS THE SAFETY OF A PROCEDURE?

A. NO, IT IS NOT.

Q. AND WHY NOT?

A. IF I TALKED TO MY -- IF I AM DOING A NEW PROCEDURE THAT I THOUGHT UP OR DESIGNED, AND THEN I ASKED A COLLEAGUE TO DO IT AND TO ALSO TELL ME THEIR FEEDBACK ON IT, THAT IS CONSIDERED ANECDOTAL EVIDENCE OR NO DIFFERENT THAN CASE REPORT EVIDENCE. IT DOESN'T MEET AS A COMPARISON GROUP, AND IT HASN'T BEEN PEER REVIEWED, FOR EXAMPLE.

Q. WHAT IS YOUR RESPONSE TO THE ASSERTION THAT IN TRYING TO

COMPARE D&X TO DISMEMBERMENT D&E IN PROSPECTIVE STUDY, THAT IT WOULD BE DIFFICULT TO DO BECAUSE SOME WOMEN WOULD CHOOSE TO UNDERGO DISMEMBERMENT -- THAT SOME WOMEN WOULD NOT CHOOSE TO UNDERGO DISMEMBERMENT WHEN THE INTACT PROCEDURE IS AVAILABLE?

A. I WOULD SAY YOU WOULD BE ABLE TO DO A PROSPECTIVE TRIAL. AND WE HAVE EXAMPLES IN THE MEDICAL LITERATURE WHERE WE HAVE DONE SUCH THINGS, AND WE DIDN'T KNOW THE BEST OUTCOME FOR WOMEN.

FOR EXAMPLE, THERE IS SOMETHING CALLED A "TERM BREECH TRIAL" WHERE WOMEN WHO HAD -- WELL, WHERE THE MEDICAL COMMUNITY HAD SAID WITH RETROSPECT IN LOOKING BACK AT THE DATA THAT WE WEREN'T SURE IF IT WAS BETTER FOR WOMEN WITH A BREECH PRESENTATION AT TERM TO UNDERGO A C-SECTION TO DELIVER THE BABY OR HAVE A VAGINAL BREECH DELIVERY.

SO WE THOUGHT WE KNEW THE RIGHT ANSWER FROM THE MEDICAL LITERATURE, LOOKING BACKWARDS, BUT EVERYONE UNDERSTOOD, EPIDEMIOLOGICALLY, WE COULDN'T REALLY KNOW THE RIGHT ANSWER UNTIL WE DID A PROSPECTIVE TRIAL.

SO WHAT HAPPENED IS MANY MEDICAL CENTERS ALL OVER THE WORLD CAME TOGETHER AND SAID:

> "WE WANT TO DESIGN A STUDY WHERE WOMEN ARE RANDOMIZED OR ARBITRARILY PLACED IN ONE GROUP OR THE OTHER TO DELIVER BY BASICALLY PICKING OUT OF THE HAT A NUMBER."

AND SO WOMEN WOULD ACTUALLY SIGN ON TO THIS STUDY

AND SAY:

"YES, YOU MAY RANDOMIZE ME TO EITHER CESAREAN SECTION OR TO VAGINAL BREECH DELIVERY."

Q. DID YOU HAVE ANY PARTICIPATION AT ALL IN THAT RANDOMIZED TRIAL?

A. I WAS NOT A PRINCIPAL INVESTIGATOR, BUT I ACTUALLY HAD THE MOST NUMBER OF PATIENTS ENROLLED AT UNIVERSITY OF MICHIGAN IN THE TERM BREECH TRIAL.

Q. AND WITH YOUR PATIENTS, HOW DID YOU GO ABOUT EXPLAINING THE RISK OF THE TWO PROCEDURES IN THAT PROCEDURE TO YOUR PATIENTS?

A. SORT OF WHAT I JUST SAID. BASICALLY, THAT WE DON'T KNOW WHAT THE RIGHT ANSWER IS. AND THAT THAT IS WHY WE ARE DOING THIS TRIAL IS TO FIGURE OUT IS IT SAFER FOR WOMEN AND BABIES TO HAVE A C-SECTION WHEN THERE IS A BREECH PRESENTATION OR IS IT SAFER FOR WOMEN AND BABIES TO HAVE A VAGINAL BREECH DELIVERY?

SO JUST THAT I COULD EXPLAIN TO THEM THAT I DIDN'T KNOW WHAT THE RIGHT ANSWER WAS NOR DID OTHER PEOPLE IN THE FIELD KNOW WHAT THE TRUE, RIGHT ANSWER WAS UNTIL WE DO THIS PROSPECTIVE, RANDOMIZED TRIAL.

Q. AND WHY DID YOU PICK THIS BREECH VERSUS C-SECTION AS A COMPARISON TO A D&X RANDOMIZED TRIAL?

A. WELL, BECAUSE IT'S A SIMILAR KIND OF ISSUE. YOU ARE ASKING WOMEN:

"DO YOU WANT TO UNDERGO A PROCEDURE LOOKING AT A SURGICAL PROCEDURE VERSUS" -- YOU CAN GIVE AN

EXAMPLE A MEDICAL INDUCTION PROCEDURE. THAT WOMEN WOULD CONSENT TO BE RANDOMIZED TO SURGERY VERSUS MEDICAL INDUCTION OR POSSIBLY EVEN TWO DIFFERENT KINDS OF SURGERY.

Q. IN YOUR OPINION, DOCTOR, COULD THE D&X PROCEDURE BE COMPARED TO THE INDUCTION PROCEDURE IN RANDOMIZED PROSPECTIVE TRIAL?

A. YES.

Q. DR. SHADIGIAN, I NOW WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT LONG-TERM COMPLICATIONS OF ABORTION. HAVE YOU EVER WRITTEN ABOUT THIS ISSUE?

A. YES, I HAVE.

MS. KRASNOFF: YOUR HONOR, I WANT TO CLARIFY. I AM A LITTLE CONFUSED ABOUT THIS TESTIMONY. MY UNDERSTANDING THAT THE RESEARCH THAT DR. SHADIGIAN IS ABOUT TO DISCUSS LOOKS AT ALL METHODS OF ABORTION AND DOESN'T RELATE IN ANY WAY TO A SPECIFIC METHOD OF ABORTION OR A SPECIFIC GESTATIONAL AGE. AND I AM CONFUSED IF DEFENDANTS ARE SEEKING TO USE THIS BECAUSE THEY BELIEVE THAT THIS ARTICLE AND THESE COMPLICATIONS APPLY TO CERTAIN SPECIFIC SECOND-TRIMESTER ABORTION METHODS.

THE COURT: DO YOU HAVE AN ANSWER?

MS. CLARK: I AM GOING TO ASK DR. SHADIGIAN TO GO THROUGH HER ARTICLE THAT IS ABOUT LONG-TERM COMPLICATIONS OF ABORTION. AND THE MAIN PURPOSE OF IT IS TO ESTABLISH THAT THERE ARE LONG-TERM COMPLICATIONS OF ABORTION.

THE COURT: WHICH KIND OF ABORTION?

MS. CLARK: INDUCED ABORTION. AND IT IS NOT SPECIFIC TO D&X OR A PARTICULAR KIND OF ABORTION, BUT INDUCED ABORTION IN THE FIRST-TRIMESTER AND ALSO IN THE SECOND-TRIMESTER, I BELIEVE. AND TO THE EXTENT THAT SHE HAS WRITTEN AN ARTICLE ABOUT IT, THAT THAT ESTABLISHES THERE ARE LONG-TERM COMPLICATIONS TO ABORTION WHICH, IF STUDIED, MAY, IN FACT, APPLY TO THE D&X PROCEDURE.

THE COURT: BUT WE DON'T KNOW NOW WHETHER OR NOT IT DOES APPLY? I AM NOT PARTICULARLY INTERESTED IN THE LONG-TERM HEALTH EFFECTS OF FIRST-TRIMESTER ABORTIONS, FOR INSTANCE. THAT IS NOT AT ISSUE HERE.

MS. CLARK: WELL, I THINK IT IS TO ESTABLISH THAT THERE ARE LONG-TERM EFFECTS RATHER THAN JUST THE SHORT-TERM COMPLICATIONS, THAT THERE ARE LONG-TERM COMPLICATIONS FROM ABORTION PROCEDURES.

D&X HASN'T BEEN STUDIED WHETHER OR NOT THERE ARE LONG-TERM COMPLICATIONS. AND TO THE EXTENT THERE IS LONG-TERM COMPLICATIONS FROM OTHER ABORTIONS THAT SUGGESTS THAT THERE MAY WELL BE LONG-TERM COMPLICATIONS FROM THE D&X PROCEDURE.

THE COURT: ALL RIGHT. WHAT IS YOUR OBJECTION?

MS. KRASNOFF: THIS ARTICLE DOESN'T SEPARATE OUT ANY METHOD OF ABORTION FROM THE OTHER, SO IT WOULD APPLY EQUALLY TO ALL METHODS OF ABORTION. IN FACT, THE MAJORITY OF THE ABORTIONS INCLUDED IN THE STUDY ARE FIRST-TRIMESTER ABORTIONS.

UNLESS DEFENDANT IS SUGGESTING THAT THIS LAW APPLIES

TO ALL OF THOSE METHODS OF ABORTION, I DON'T SEE HOW IT IS RELEVANT.

THE COURT: I AM GOING TO ALLOW YOU TO DO IT, MS. CLARK. AND IT SEEMS TO ME THAT MOST OF YOUR ARGUMENT GOES TO THE WEIGHT ACCORDED THIS EVIDENCE. GIVEN THAT IT IS NOT CLEAR THAT IT APPLIES TO THE PROCEDURES WE ARE INTERESTED IN, I WOULD LIKE YOU TO TRY TO AVOID QUESTIONS THAT ARE GOING TO RESULT IN ANSWERS BASED UPON FIRST-TRIMESTER ABORTIONS.

I AM SIMPLY NOT INTERESTED IN HEARING THAT, AND I CAN'T IMAGINE HOW THAT WOULD AFFECT THE DECISION THAT NEEDS TO BE MADE HERE. TO THE EXTENT THAT YOU ARE TALKING GENERALLY ABOUT THE LONG-TERM EFFECTS OF SECOND-TRIMESTER ABORTIONS, THAT IS FINE, AND I WILL ACCORD WHATEVER WEIGHT I THINK IS APPROPRIATE, DEPENDING ON THE METHODS USED.

MS. CLARK: I GUESS I WOULD JUST OFFER THAT THERE MAY BE -- THE FACT THAT THERE IS COMPLICATIONS IN THE FIRST-TRIMESTER, THAT MAY PROVIDE A BASIS FOR ANALYSIS ABOUT WHETHER OR NOT THERE WOULD BE COMPLICATIONS RELATED TO AN ABORTION PERFORMED IN THE SECOND-TRIMESTER.

THE COURT: I WILL TELL THE DOCTOR: I AM INTERESTED MORE IN SECOND-TRIMESTERS THAN FIRST-TRIMESTERS, SO TO THE EXTENT THAT YOU CAN DIFFERENTIATE YOUR ANSWERS, THE DIFFERENCES BETWEEN THOSE TWO TRIMESTERS, I WOULD APPRECIATE IT.

THE WITNESS: NOTED.

MS. CLARK: MAY I APPROACH?

THE COURT: YES.

BY MS. CLARK:

Q. DR. SHADIGIAN, I HAVE JUST SHOWN YOU AND HANDED YOU WHAT HAS BEEN IDENTIFIED AS DEFENDANT'S EXHIBIT A-56. IS THAT THE ARTICLE THAT YOU HAVE CO-AUTHORED REGARDING ABORTION COMPLICATIONS?

A. YES, IT IS.

Q. WHAT JOURNAL WAS THIS ARTICLE PUBLISHED IN?

A. IT WAS PUBLISHED IN A JOURNAL CALLED THE OBSTETRICAL AND GYNECOLOGICAL SURVEY.

Q. WHEN WAS IT PUBLISHED?

A. IT WAS PUBLISHED IN JANUARY OF 2003.

Q. WHAT WAS THE FULL NAME OF THE ARTICLE?

A. "LONG-TERM PHYSICAL AND PSYCHOLOGICAL HEALTH CONSEQUENCES OF INDUCED ABORTION: REVIEW OF THE EVIDENCE."

Q. ARE YOU RELYING ON THIS ARTICLE IN PROVIDING YOUR OPINIONS TODAY?

A. YES, I AM.

Q. IN WHAT WAY ARE YOU RELYING ON THIS ARTICLE IN YOUR OPINIONS YOU ARE OFFERING TODAY?

A. THIS IS AN EXAMPLE OF WHAT WE CALL "A SYSTEMATIC REVIEW OF THE LITERATURE."

SO RATHER THAN JUST LOOKING AT ONE STUDY THAT MAY HAVE LOOKED AT JUST, FOR EXAMPLE, FIRST-TRIMESTER ABORTIONS, WE TRIED TO COMPILE ALL OF THE STUDIES LOOKING AT SEVEN SEPARATE

POSSIBLE LONG-TERM EFFECTS OF INDUCED ABORTION.

SO IT IS TO ACTUALLY GIVE PEOPLE A FEEL, A FLAVOR AND A COMPILATION OF WHAT LONG-TERM EFFECTS MAY OR MAY NOT BE ASSOCIATED WITH INDUCED ABORTION.

THE COURT: LET ME MAKE SURE I UNDERSTAND. THIS ARTICLE HAS NOTHING TO DO WITH D&E'S. IT IS ALL INDUCED ABORTION?

THE WITNESS: NO. I AM SORRY. WE ARE USING THE TERM DIFFERENTLY. THIS ARTICLE -- EACH INDIVIDUAL ARTICLE THAT IS IN THIS ARTICLE THAT WE LOOKED AT, SOME MAY LOOK AT SECOND-TRIMESTER D&E'S. SOME MAY LOOK AT D&C'S IN THE FIRST-TRIMESTER. BECAUSE OF WHEN THESE STUDIES WERE PERFORMED, IT IS A COMBINATION. AND THE WAY I USE THAT WORD "INDUCED ABORTION" IS DIFFERENT.

WE MEAN IT JUST REGULAR ELECTIVE TERMINATION OF PREGNANCY WHEN WE USE IT IN THIS ARTICLE.

SO IF YOU WOULD LIKE ME TO USE A DIFFERENT TERM JUST SO WE ARE CONSISTENT IN THE RECORD, I WOULD BE GLAD TO.

THE COURT: I MIGHT CONFUSE THAT WITH INDUCTION ABORTIONS.

THE WITNESS: RIGHT. I GOT YOU. SO WOULD YOU PREFER "ELECTIVE TERMINATION OF PREGNANCY"? WOULD THAT BE A BETTER TERM?

THE COURT: YES.

THE WITNESS: OKAY. I WILL BE GLAD TO DO THAT.

MS. CLARK: SO --

MS. KRASNOFF: YOUR HONOR, I DON'T WANT TO BE PICKY ABOUT THE TERMINOLOGY, BUT I DON'T BELIEVE THERE IS ANY EVIDENCE THAT THE ABORTIONS IN THE UNDERLYING STUDIES WERE ALL ELECTIVE.

THE COURT: IS THAT CORRECT? DO YOU KNOW?

THE WITNESS: WHICH QUESTION DO YOU WANT ME TO ANSWER?

THE COURT: DO YOU KNOW WHETHER OR NOT THE ARTICLES UPON WHICH THIS ARTICLE RELIES ONLY STUDIED ELECTIVE ABORTIONS OR NOT?

THE WITNESS: IN FACT, IT DEPENDS ON THE ARTICLE ITSELF. SO THERE IS QUITE A FEW ARTICLES FROM DIFFERENT -- EVEN INTERNATIONAL DATABASES. SO SOME WILL BE ELECTIVE TERMINATIONS AND SOME WILL NOT BE ELECTIVE TERMINATIONS. IT IS A MIX, BASICALLY, IS WHAT I AM TRYING TO SAY.

THE COURT: LET'S STAY AWAY FROM THAT TERM.

INSTEAD OF USING "INDUCED ABORTION," CAN YOU JUST USE "ABORTION"?

THE WITNESS: OKAY. THAT WOULD BE FINE. THANK YOU.

THE COURT: ALL RIGHT. START YOUR QUESTION OVER AGAIN.

BY MS. CLARK:

Q. WHAT KINDS OF THINGS DOES THIS ARTICLE ADDRESS?

A. BASICALLY, IT LOOKS AT THE ACTUAL TERMINATION OF A

PREGNANCY OR ABORTION AND TRIES TO SEE IF THERE IS A GREATER EFFECT LATER ON, MEANING GREATER THAN 60 DAYS AFTER THE PROCEDURE WITH SEVEN DIFFERENT POSSIBLE OUTCOMES.

Q. JUST AS A LITTLE BIT MORE BACKGROUND, HOW DID YOU GO ABOUT PREPARING AND WRITING THIS ARTICLE?

A. BASICALLY, WE STARTED WITH THE IDEA THAT WE WANTED TO SEE IF THERE WERE ANY LONG-TERM EFFECTS OF ABORTION. SO WE DECIDED TO DO A SYSTEMATIC REVIEW OF THE LITERATURE LOOKING AT MEDLINE, WHICH IS A DATABASE THAT COVERS MOST OF THE MAJOR, MAJOR JOURNALS IN THE INTERNATIONAL AND DOMESTIC OB/GYN AND EPIDEMIOLOGY LITERATURE.

AND THEN, WE DECIDED TO LOOK AT PAPERS THAT HAD AT LEAST A HUNDRED SUBJECTS IN IT SO IT WOULDN'T BE JUST THESE ANECDOTAL CASE REPORTS. IT WOULD BE ACTUALLY GOOD, FULL-FLEDGED STUDIES. AND TO LOOK AT THE GREATER THAN 60 DAYS, BECAUSE MOST OF THE STUDIES PRIOR TO THIS COMPILATION STUDY LOOKED AT JUST SHORT-TERM COMPLICATIONS. I MEAN, INFECTION RATES RIGHT AFTER THE PROCEDURE; HOW MANY RETAINED PRODUCTS WE WOULD HAVE; HOW MANY HEMORRHAGES.

SO IT IS TO DISTINGUISH BETWEEN THESE SHORT-TERM EFFECTS, WHICH WERE WELL STUDIED AND LONGER TERM EFFECTS THAT PRIOR TO THIS PUBLICATION HADN'T BEEN PUT TOGETHER IN THE SAME KIND OF WAY.

Q. SO WHEN YOU SAY "60 DAYS," YOU ARE LOOKING AT EFFECTS OF ABORTION THAT OCCURRED 60 DAYS AFTER THE ABORTION AND LATER; IS

THAT CORRECT?
A. YES, THAT IS CORRECT.
Q. AND DID YOU PARTICIPATE IN THE SYSTEMATIC REVIEW OF THE LITERATURE?
A. YES.
THE COURT: MS. CLARK, WE ARE LITTLE BIT PAST THE TIME FOR THE FIRST BREAK. WE WILL TAKE OUR 15-MINUTE BREAK.
(RECESS TAKEN AT 10:05 A.M.)
(PROCEEDINGS RESUMED AT 10:25 A.M.)
THE COURT: ALL RIGHT. PLEASE CONTINUE.
BY MS. CLARK:
Q. DR. SHADIGIAN, JUST TO BE CLEAR HERE, SOME OF THE UNDERLYING STUDIES RELIED UPON IN YOUR ARTICLE INVOLVE ABORTION COMPLICATIONS RESULTING FROM BOTH THE FIRST AND SECOND-TRIMESTER?
A. YES, THEY DO.
Q. IN THIS ARTICLE, YOU LOOKED AT SEVEN DIFFERENT COMPLICATIONS, DIFFERENT KINDS OF COMPLICATIONS. WHAT WERE THOSE COMPLICATIONS THAT YOU REVIEWED IN THIS ARTICLE?
A. THE SEVEN DIFFERENT COMPLICATIONS THAT WE LOOKED AT AGGREGATE STUDIES TO DETERMINE IF THERE WAS AN EFFECT OR NO LONG-TERM EFFECT WERE THE FOLLOWING: FIRST, SUBSEQUENT INFERTILITY OR NOT BEING ABLE TO GET PREGNANT AFTERWARDS; SUBSEQUENT SPONTANEOUS MISCARRIAGE. OTHER ONES WERE BREAST CANCER, PLACENTA PREVIA, PRE-TERM BIRTH, AND RISKS SUCH AS

DEPRESSION OR SELF-HARM.

AND, FINALLY, WE LOOKED AT ECTOPIC PREGNANCY, AS WELL.

Q. FOR ANY OF THE CONDITIONS THAT YOU EVALUATED IN THE SYSTEMATIC REVIEW, DID YOU FIND THAT THERE WAS INSUFFICIENT EVIDENCE TO SHOW THAT ABORTION LED TO ADVERSE HEALTH CONSEQUENCES?

A. YES. THREE OF THE HEALTH OUTCOMES WE EVALUATED THAT WERE GREATER THAN A HUNDRED DAYS -- SORRY -- GREATER THAN 60 DAYS AFTER THE TIME PERIOD WE LOOKED AT, THREE OF THEM DIDN'T SHOW ANY EFFECT OR A MINIMAL EFFECT. AND THOSE WERE ECTOPIC OR TUBAL PREGNANCIES, AND THEN, SUBSEQUENT MISCARRIAGES AND SUBSEQUENT INFERTILITY WERE NOT ASSOCIATED WITH ABORTION.

Q. AND, AGAIN, JUST TO MAKE THE RECORD CLEAR, IN THIS ARTICLE WHEN IT REFERS TO "ABORTION," WHAT DOES THAT REFER TO?

A. WE ARE TALKING ABOUT THE MIXTURE OF ABORTION FOR DIFFERENT ELECTIVE AND NONELECTIVE REASONS, AND IN THE FIRST AND SECOND-TRIMESTER.

Q. DOCTOR, WHAT ARE SOME OF THE LIMITATIONS IN TRYING TO DETERMINE THE HEALTH EFFECTS OF AN ABORTION?

A. THE IMPORTANT THINGS PEOPLE NEED TO REALIZE ARE THAT THESE ARE NOT ABSOLUTE CAUSATION EFFECTS. INSTEAD, WE SEE THAT THERE MAY HAVE BEEN A TIME AT A POINT IN TIME WHEN A CERTAIN PROCEDURE WAS DONE, FOR EXAMPLE, AN ABORTION. AND THEN, WE LOOK LATER TO SEE IF A WHOLE BUNCH OF WOMEN WHO HAD UNDERGONE

THE SAME KIND OF PROCEDURE HAD HEALTH EFFECTS THAT ARE DIFFERENT FROM WOMEN WHO DIDN'T UNDERGO THE SAME KIND OF PROCEDURE. SO THAT THE LIMITATIONS ARE THINGS LIKE: CAN WE FOLLOW THE WOMEN OVER A LONG PERIOD OF TIME? CAN WE ACTUALLY FIND THE WOMEN WHO HAD THOSE PROCEDURES MANY YEARS BEFORE, AND THEN, CAN WE LOOK AT THEIR HEALTH OUTCOMES?

Q. IS THE LACK OF FOLLOW-UP YOU TESTIFIED ABOUT EARLIER, IS THAT -- IN WHAT WAY IS THAT A LIMITATION IN STUDYING THE LONG-TERM COMPLICATIONS OF ABORTIONS?

MS. KRASNOFF: OBJECTION, YOUR HONOR. SHE HASN'T DONE ANY STUDIES. SHE HAS REVIEWED OTHER PEOPLE'S STUDIES.

THE COURT: SUSTAINED. REPHRASE.

BY MS. CLARK:

Q. DOCTOR, IN YOUR OPINION, IS THE LACK OF FOLLOW-UP YOU TESTIFIED ABOUT, IS THAT A LIMITATION IN TRYING TO DETERMINE THE LONG-TERM HEALTH EFFECTS OF ABORTION COMPLICATIONS ON WOMEN?

MS. KRASNOFF: SAME OBJECTION.

THE COURT: OVERRULED.

THE WITNESS: THAT IS ONE OF THE ISSUES WE NEED TO ALWAYS ADDRESS IN THESE KINDS OF STUDIES ARE: WHAT IS THE FOLLOW-UP CAN WE SEE FOR WOMEN?

FOR EXAMPLE, THERE IS NO DATABASE IN AMERICA THAT LOOKS AT ALL WOMEN WHO HAVE HAD INDUCED ABORTIONS AND WHAT THEIR HEALTH EFFECTS ARE. SO WE ARE LIMITED IN THIS COUNTRY

WITH NATIONAL DATABASES BECAUSE IT JUST DOESN'T EXIST HERE.

HOWEVER, IN MANY EUROPEAN COUNTRIES, THEY ACTUALLY DO HAVE ABORTION REGISTRIES AND ALSO HAVE NATIONAL HEALTH CARE. SO THEY ARE ABLE TO DO DIFFERENT KINDS OF STUDIES THAN WE ARE IN AMERICA.

BY MS. CLARK:

Q. DESPITE THESE LIMITATIONS, DOES THAT MEAN THAT LONG-TERM HEALTH CONSEQUENCES OF ABORTION CANNOT BE EVALUATED OR STUDIED?

A. NO, WE JUST NEED TO UNDERSTAND WHAT THE LIMITATIONS OF OUR STUDIES ARE AND WHAT THE POWER OF OUR STUDIES ARE SO THAT WE CAN DRAW CONCLUSIONS THAT MAKE MEDICAL SENSE, RATHER THAN JUST CONJECTURE.

Q. IN GENERAL TERMS, CAN YOU PLEASE DESCRIBE THIS ARTICLE AND WHAT IT CONCLUDES?

A. THE FINAL CONCLUSION OF THE ARTICLE IS THAT THERE ARE FOUR EFFECTS THAT WE NEED TO BE CONCERNED ABOUT IN THE LONG-TERM FOR WOMEN. AND THE ONE SPECIFIC ONE THAT IS ONE OF THE MOST CONCERNING ONES IS THE PRE-TERM BIRTH RATE THAT IS HIGHER FOR WOMEN WHO HAVE HAD AN ABORTION AS COMPARED TO WOMEN WHO HADN'T.

OTHER ONES WERE PLACENTA PREVIA WHERE THE PLACENTA CAN GROW OVER THE CERVIX. IT NECESSITATES A CESAREAN SECTION AND WILL GET INCREASED BLEEDING TO WOMEN. AND THEN, LONG-TERM PSYCHOLOGICAL EFFECTS, SUCH AS SELF-HARM AND SUICIDE OR SUICIDE ATTEMPTS. AND, FINALLY, BREAST CANCER THAT MAY BE INCREASED AFTER A WOMAN HAS HAD AN ABORTION AS COMPARED TO A WOMAN WHO

HAD NOT HAD AN ABORTION.

Q. DOCTOR, TURNING TO PAGE --

THE COURT: EXCUSE ME. IT DOESN'T MATTER WHAT KIND OF ABORTION; IS THAT CORRECT? WITH REGARD TO, FOR INSTANCE, THE PRE-TERM BIRTH RATE?

THE WITNESS: THE ANSWER IS THAT EACH STUDY DIVIDED IT UP DIFFERENTLY. SO YOU CAN LOOK AT INDIVIDUAL STUDIES TO IT HOW IT IS DIVIDED UP INTO FIRST-TRIMESTER ABORTION AND SECOND-TRIMESTER ABORTION.

THE COURT: WELL, WITHIN THE SECOND-TRIMESTER IS THERE A DISTINCTION BETWEEN INDUCTION ABORTION AND D&E'S?

THE WITNESS: IT WOULD DEPEND ON THE STUDY. I WOULD HAVE TO REVIEW THE ORIGINAL AGAIN TO BE ABLE TO ANSWER THAT ACCURATELY.

THE COURT: ALL RIGHT. AT SOME POINT DURING YOUR TESTIMONY I AM HOPING TO HEAR THAT. ALL RIGHT. YOU DON'T NEED TO DO IT RIGHT NOW.

BUT, COUNSEL, KEEP THAT IN MIND.

BY MS. CLARK:

Q. DOCTOR, IN THIS ARTICLE, DID YOU SEPARATE OUT WHETHER THE CONCLUSIONS WERE BASED ON FIRST-TRIMESTER OR SECOND-TRIMESTER ABORTIONS?

A. THAT WAS NOT DONE IN THIS PARTICULAR ARTICLE.

Q. DID YOU SEPARATE OUT WHETHER THE ABORTION WAS DONE BY AN INDUCTION METHOD OR A D&E METHOD?

A. THAT WAS NOT SEPARATED OUT IN THIS ARTICLE.
Q. AND IN WRITING THIS ARTICLE, DID YOU THINK IT WAS IMPORTANT TO SEPARATE OUT?
A. THE POINT OF THIS ARTICLE WAS TO LOOK AT ABORTION IN THE AGGREGATE. SO EVEN THOUGH INDIVIDUAL STUDIES MAY HAVE SEPARATED OUT, THERE WEREN'T ENOUGH OF THEM TO BE ABLE TO DO A SUBANALYSIS, SO THAT IS WHY THOSE WERE NOT DONE, SPECIFICALLY.
Q. DOCTOR, TURNING TO PAGE 74 OF THE ARTICLE, IF YOU TURN TO THE SECOND COLUMN ALMOST ALL THE WAY DOWN TO THE BOTTOM IT'S BEFORE THE LAST PARAGRAPH, AND THE SENTENCE BEGINNING:

"WOMEN DESERVE TO BE" -- DO YOU SEE THAT SENTENCE?

A. YES, I DO.
Q. CAN YOU READ THAT SENTENCE OUT LOUD, PLEASE?
A. YES.

"WOMEN DESERVE TO BE FULLY AND ACCURATELY INFORMED ABOUT POTENTIAL HEALTH EFFECTS OF ELECTIVE ABORTION, PREFERABLY IN A HEALTH EDUCATION CONTEXT SEPARATE AND DISTINCT FROM THE TIMEFRAME OF ACTUALLY BEING FACED WITH MAKING DIFFICULT DECISIONS ABOUT WHETHER TO CONTINUE OR END A PREGNANCY."

Q. DOES THAT SENTENCE REFLECT YOUR VIEWS AND OPINIONS ABOUT THE NEED TO INFORM WOMEN ABOUT THE HEALTH RISKS OF ABORTION?
A. YES.
Q. WHY DO YOU THINK IT IS IMPORTANT THAT WOMEN ARE FULLY

INFORMED?
A. WHEN A WOMAN CHOOSES TO HAVE AN ABORTION, IT'S IMPORTANT NOT TO JUST UNDERSTAND THE SHORT-TERM EFFECTS, BUT WHAT THAT WILL DO FOR THE REST OF HER LIFE IN TERMS OF IF SOME WOMEN WANT TO HAVE ANOTHER BABY LATER ON, THEY NEED TO KNOW THAT THEY MIGHT BE AT HIGH RISK OF A PRE-TERM BIRTH, OR THEY MIGHT HAVE A HIGH RISK OF A PLACENTA PREVIA WHERE THE PLACENTA GROWS OVER THE CERVIX. THAT THEY MIGHT HAVE A RISK OF WANTING TO HURT THEMSELVES, OR THEY MIGHT HAVE A RISK FOR MORE BREAST CANCER IN THEIR LIVES.
Q. DOES ANYTHING ABOUT THIS ARTICLE INFLUENCE THE WAY IN WHICH YOU COUNSEL YOUR PATIENTS ABOUT ABORTION?
A. IT DOES. IT MAKES ME ABSOLUTELY FEEL THAT I NEED TO TALK ABOUT LONG-TERM RISKS, NOT JUST SHORT-TERM RISKS, TO BE FULLY ACCOUNTABLE TO MY PATIENTS.
Q. AND WHICH FINDINGS IN THIS REVIEW DO YOU THINK IS MOST SIGNIFICANT WITH RESPECT TO THE PARTIAL-BIRTH ABORTION DEBATE?
A. I THINK THE TWO THINGS THAT WE NEED TO CAREFULLY LOOK AT ARE THE PRE-TERM BIRTH BEING HIGHER AFTER ABORTION AND THE PLACENTA PREVIA.
Q. WHAT IS "PRE-TERM BIRTH"?
A. "PRE-TERM BIRTH" IS WHEN A BABY IS BORN BEFORE THE 37TH WEEK OF GESTATION. AND THEN, WE ALSO CONSIDER VERY PRE-TERM BIRTH BEFORE 28 WEEKS OF GESTATION.
Q. AND IS PRE-TERM BIRTH THE SAME THING AS CERVICAL

INCOMPETENCE?

A. IT IS NOT THE SAME THING.

Q. AND DO THEY RELATE TO EACH OTHER IN ANY WAY?

A. CERVICAL INCOMPETENCE IS ONE OF THE THEORIES SET FORTH AS TO WHY PRE-TERM BIRTH MIGHT BE HIGHER AFTER ABORTION. THERE ARE OTHER THEORIES SUCH AS INFECTIONS BEING HIGHER AND SCAR TISSUE BEING HIGHER.

Q. DOCTOR, TURNING TO PAGE 75 OF THE ARTICLE, IF YOU WOULD READ OUT LOUD, BEGINNING ON THE LEFT-HAND COLUMN BEGINNING WITH THE PARAGRAPH THAT SAYS "ABORTION," AND READ OUT LOUD? I WILL JUST STOP YOU, BUT CONTINUE.

A. STARTING WITH "ABORTION IS A PROCEDURE" --

Q. THAT'S CORRECT.

A. OKAY.

"ABORTION IS A PROCEDURE MOST USED BY WOMEN AT THE OUTSET OF THEIR REPRODUCTIVE LIFE. MOST WOMEN HAVING AN INDUCED ABORTION ARE UNDER 30 YEARS OLD. PRETERM BIRTH IS COMMON, AFFECTING AROUND 10 PERCENT OF DELIVERIES IN THE WESTERN WORLD, AND IS THE LEADING CAUSE OF INFANT MORBIDITY AND MORTALITY. DESPITE SUBSTANTIAL INVESTIGATIVE EFFORT, PRIMARY PREVENTIVE MEASURES TO LOWER THE RATE OF PRETERM BIRTHS HAVE PROVEN FUTILE AND RATES HAVE BEEN STEADY OR INCREASED OVER THE PAST TWO DECADES. THE POPULATION-BASED STUDIES WE REVIEWED SUGGEST THAT

INDUCED ABORTION INCREASES THE RISK OF PRETERM BIRTH IN SUBSEQUENT PREGNANCIES."

Q. KEEP GOING.

A. "MOREOVER, THESE REPORTS SUGGEST THAT A DOSE-RESPONSE EFFECT IS PRESENT WITH INCREASING NUMBERS OF ABORTIONS ASSOCIATED WITH INCREASING RISK, AND THAT THE LINKAGE IS MOST STRONG WITH EXTREMELY PREMATURE DELIVERIES (LESS THAN 32 WEEKS), WHICH IS THE POPULATION OF NEWBORNS THAT EXPERIENCES THE BULK OF THE MORBIDITY AND MORTALITY THAT OCCUR FROM BEING BORN PREMATURELY."

Q. DOES THE STATEMENT YOU JUST READ REFLECT THE RESULTS OF THE RESEARCH YOU UNDERTOOK IN PREPARING THIS ARTICLE?

A. YES, IT DOES.

Q. AND WHAT DOES "DOSE-RESPONSE EFFECT" MEAN?

A. THAT MEANS THE MORE ABORTIONS A WOMAN HAS, THE HIGHER THE CHANCE THAT SHE'LL HAVE A PRE-TERM BIRTH. FOR EXAMPLE, IF ONE ABORTION WOULD DOUBLE RISK, TWO ABORTIONS MAY TRIPLE OR QUADRUPLE HER RISK.

Q. WOULD YOU SUMMARIZE FOR THE COURT WHAT YOUR ARTICLE CONCLUDES WITH RESPECT TO THE CONNECTION BETWEEN ABORTION AND PRE-TERM BIRTH IN SUBSEQUENT PREGNANCIES?

MS. KRASNOFF: OBJECTION. WE WOULD LIKE TO RENEW OUR OBJECTION NOW THAT SHE'S READ FROM THE ARTICLE; THAT IT CLEARLY IS NOT RELATED TO ANY METHODS OF ABORTION.

THE COURT: YES, IT DOESN'T -- IT CERTAINLY DOESN'T APPEAR TO ME TO BE. FRANKLY, I DON'T UNDERSTAND WHY YOU ARE PURSUING THIS PARTICULAR LINE OF QUESTIONING. I DON'T SEE THE BEARING THIS ARTICLE HAS ON THE ISSUE CURRENTLY BEFORE ME.

MS. CLARK: I MEAN, I CAN ASK DR. SHADIGIAN.

BY MS. CLARK:

Q. DR. SHADIGIAN, THIS ARTICLE, DOES THIS INFLUENCE YOUR OPINION AT ALL ABOUT THE SAFETY OF THE D&X PROCEDURE?

A. THE REASON I THINK THIS IS LINKED AND WHY IT CAN BE LINKED TO D&X IS UNTIL WE STUDY THE D&X PROCEDURE AND FOLLOW WOMEN WE ARE NOT SURE IF WOMEN ARE GOING TO BE ABLE TO CARRY EVEN INTO VIABILITY AFTER THE D&X PROCEDURE BECAUSE IT JUST HASN'T BEEN STUDIED.

IT COULD BE THAT IT IS JUST AS SAFE AS A D&E PROCEDURE OR MEDICAL INDUCTION, BUT IT COULD BE AND IT IS VERY POSSIBLE TO HAVE IT INCUR A VERY HIGH RISK FOR PREMATURE DELIVERY BECAUSE OF HOW MUCH MORE DILATED A WOMAN'S CERVIX IS WITH THE D&X PROCEDURE, AND HOW MUCH FARTHER IN GESTATION D&X PROCEDURES ARE PERFORMED.

SO THAT IS THE RELEVANCE IS THE CONCERN FOR SAFETY FOR WOMEN BECAUSE IT HASN'T BEEN STUDIED YET. AND THAT WE KNOW PRE-TERM BIRTH AND INDUCED ABORTION HAS BEEN STUDIED, AND IT IS WORRISOME.

Q. AND, DOCTOR, EVEN THOUGH THE STUDY DOESN'T FOCUS EXCLUSIVELY ON SECOND-TRIMESTER ABORTIONS, WHY, IF YOU DO, WHY

DO YOU THINK THIS ARTICLE IS IMPORTANT WITH RESPECT TO EVALUATING THE SAFETY OF THE D&X PROCEDURE?

A. WELL, THIS ARTICLE IS THE FIRST ONE IN AGGREGATE TO EVER PUT FORTH WHAT THE RISKS MAY BE OF ANY ABORTION. AND SO, IN FACT, D&X IS A FORM OF ABORTION. AND THIS IS SOMETHING THAT WE WILL NEED TO STUDY WITH THE D&X PROCEDURE, AS WELL AS THE OTHER PROCEDURES.

SO IT IS IMPORTANT BECAUSE OF WHAT I SAID PREVIOUSLY WITH THE TWO ISSUES AROUND D&X AND ALSO BECAUSE OF JUST ACKNOWLEDGING THAT THERE CAN BE LONG-TERM EFFECTS. AND, IN FACT, THEY ARE THINGS THAT WOMEN CARE ABOUT WHEN THEY ARE MAKING CHOICES.

THE COURT: EXCUSE ME. WITH REGARD TO THE PRE-TERM BIRTH RATE BEING HIGHER IN WOMEN WHO HAD ABORTIONS, IS THAT IN WOMEN WHO HAVE HAD ABORTIONS AS COMPARED TO WOMEN WHO HAVE NOT HAD ABORTIONS? OR WOMEN WHO HAVE HAD ABORTIONS IN COMPARISON TO WOMEN WHO HAD PREVIOUS BIRTHS? OR WHAT IS THE COMPARISON HERE?

THE WITNESS: IT DEPENDS ON THE STUDY, BUT IT DOES COMPARE WOMEN WHO HAD CHILDBIRTH AND ABORTIONS, AND IT DOES COMPARE WOMEN WHO HAVE HAD ABORTION AND NO PREGNANCY WHATSOEVER.

SO IT DEPENDS ON THE PARTICULAR STUDY. SO I CAN'T, IN AGGREGATE, GIVE YOU AN ANSWER, BUT IT DEPENDS ON THE STUDY. AND MANY OF THEM SEPARATE THEM OUT SO WE CAN LOOK AT THEM

INDIVIDUALLY.

THE COURT: OKAY. GO AHEAD.

BY MS. CLARK:

Q. DOCTOR, BASED ON YOUR REVIEW OF DR. HASKELL'S REPORT AND BASED ON YOUR REVIEW OF ACOG AND ALSO READING DR. PAUL'S BOOK, WHAT IS YOUR UNDERSTANDING OF THE DILATION PROCESS IN A D&X PROCEDURE?

A. MY UNDERSTANDING OF THE DILATION PROCESS IS THAT IT USUALLY INVOLVES DILATION OF THE CERVIX WITH OSMOTIC DILATORS OR LAMINARIA OVER TWO DAYS WHERE A SET IS PLACED INSIDE THE CERVIX. A WOMAN RETURNS TO THE DOCTOR'S OFFICE OR THE HOSPITAL. THE NEXT DAY, HAVE THOSE REMOVED AND PLACED AGAIN. AND THEN, ON THE THIRD DAY, HAVE THE ACTUAL PROCEDURE PERFORMED.

Q. NOW, ISN'T IT THE CASE THAT D&X REQUIRES LESS DILATION THAN AN INDUCTION PROCEDURE IF THE PROCEDURES ARE PERFORMED AT THE SAME GESTATIONAL AGE?

A. THAT IS CORRECT.

Q. SO WHY WOULDN'T D&X, IN YOUR OPINION, BE LESS HARMFUL THAN INDUCTION WHEN PERFORMED AT THE SAME GESTATIONAL AGE?

A. THERE ARE TWO REASONS. ONE IS THE ACTUAL PHYSICAL PUTTING THE DILATORS IN ACTUALLY FORCING THEM IN IS NOT PHYSIOLOGICAL. IT IS NOT LIKE THE MEDICAL INDUCTION WHERE A WOMAN'S NATURAL BODY WITH THE MEDICINES, IT JUST MAKES THE MYOMETRIUM, MUSCLE FIBERS OF THE UTERUS CONTRACT, AND THAT GENTLY, SLOWLY DILATES

THE CERVIX IN A PHYSIOLOGICAL MANNER.

AND WITH ANY KIND OF LAMINARIA, WHETHER IT'S IN THE FIRST-TRIMESTER OR, YOU KNOW, D&X, STILL IS A DILATION THAT INVOLVES PUSHING IN A FOREIGN OBJECT INTO THE CERVIX.

Q. SO, TO SUMMARIZE FOR THE COURT, WHAT ARE YOUR SPECIFIC CONCERNS ABOUT THE D&X WITH RESPECT TO THE DILATION PROCEDURE?

A. ONE IS THAT THE PROVIDERS OF ABORTION SERVICES USING THE D&X PROCEDURE HAVE SAID, AND I HAVE READ IN THEIR DIFFERENT EITHER EXPERT REPORTS OR ARTICLES, THAT THEY DILATE THE CERVIX MANY TIMES TO ABOUT 5 CENTIMETERS, AND THAT THEY NEED TO PULL THE BABY THROUGH THE CERVIX. SO EVEN AFTER THE HEAD IS CRUSHED OR THE CONTENTS OF THE INTRACRANIUM ARE REMOVED, THEY STILL NEED TO PULL IT THROUGH IN A NONPHYSIOLOGICAL WAY.

Q. IS THE DILATION PROCESS OF THE D&X PROCEDURE, IS THAT SOMETHING THAT REQUIRES FURTHER STUDY IN YOUR OPINION?

A. YES.

Q. WHY IS THAT THE CASE?

A. WELL, IT MAY BE THAT THE D&X DILATION IS SAFER THAN JUST DOING IT OVER ONE DAY OR IT MAY BE THAT IT IS LESS SAFE. WITHOUT REAL STUDIES, WE CAN'T REALLY SAY IF IT IS SAFE OR NOT SAFE.

SO, AGAIN, IT NEEDS TO BE BASED NOT ON ANECDOTE, ON WHAT I SAY OR WHAT DR. HASKELL SAYS, BUT, IN FACT, ON LOOKING AT GROUPS OF WOMEN STUDIED WITH CONTROLLED GROUP SO THAT WE CAN MAKE SOME KIND OF MEANINGFUL MEDICAL JUDGMENT ABOUT USE OF

LAMINARIA AND USE OF MISOPROSTOL AND WHAT THE SHORT AND LONG-TERM EFFECTS MAY BE.

Q. IN YOUR OPINION, HOW SHOULD ONE GO ABOUT DETERMINING WHETHER ABORTION RESULTS IN LONG-TERM RISKS, SUCH AS PRE-TERM BIRTH?

A. THE BEST WAY TO GO ABOUT THOSE KINDS OF DETERMINATIONS ARE LOOKING AT CASE CONTROL OR RETROSPECTIVE STUDIES AND THEN DOING THE PROSPECTIVE STUDIES LOOKING INTO THE FUTURE AND HAVING A CONTROL GROUP OF WOMEN WHO HAVE HAD A PROCEDURE AND WHO HAVEN'T, OR MAYBE HAD A DIFFERENT KIND OF PROCEDURE, AND THEN, FOLLOWING THEM OVER TIME.

Q. AND IN YOUR OPINION IS IT FEASIBLE TO CONDUCT SUCH A STUDY OF EVALUATING THE LONG-TERM RISKS OF WOMEN UNDERGOING A D&X ABORTION PROCEDURE?

A. YES, IT IS.

Q. DOCTOR, IN EVALUATING THE NECESSITY OF THE D&X PROCEDURE, WHAT METHOD OF PREGNANCY TERMINATION DO YOU THINK D&X SHOULD BE COMPARED AGAINST?

A. WELL, THE BEST PROCEDURE TO COMPARE D&X AGAINST IS PROBABLY THE MEDICAL INDUCTION, BECAUSE IT IS DONE AT GREATER GESTATIONAL AGES AND BECAUSE IT MAY BE DONE FOR SIMILAR INDICATIONS.

Q. DOCTOR, IN YOUR OPINION, CAN YOU USE THE SAFETY DATA OF THE D&E PROCEDURE TO ACCURATELY PORTRAY THE SAFETY OF A D&X PROCEDURE?

A. NO, YOU CANNOT.
Q. AND WHY NOT, IN YOUR OPINION?
A. WELL, THEY ARE JUST SEPARATE PROCEDURES AND THEY USE MORE DILATION OR LESS DILATION, AND THEY INVOLVE BRINGING, FOR EXAMPLE, THE D&X PROCEDURE, A LARGER BODY PART THROUGH THE CERVIX.

IN OTHER WORDS, NOT PIECEMEAL OR SMALLER PARTS, BUT WITH A QUITE A BIT LARGER PIECE: THE HEAD.

Q. AND IS THERE SOMETHING ALSO ABOUT THE GESTATIONAL AGE WITH RESPECT TO THE COMPARISON OF D&E TO D&X THAT MAKES D&E AN INSUFFICIENT BASIS TO MAKE AN EVALUATION OF D&X?
A. IF, IN GENERAL, AS I UNDERSTAND IT, D&X IS USED WITH GREATER GESTATIONAL AGES.

MS. KRASNOFF: OBJECTION, LACK OF FOUNDATION.

THE COURT: SUSTAINED.

THE WITNESS: WHEREAS DNA --

THE COURT: I SAID I SUSTAINED THE OBJECTION.

THE WITNESS: OH, I AM SORRY.

BY MS. CLARK:
Q. DOCTOR, BASED ON REVIEWING DR. HASKELL'S REPORT, DOCTOR PAUL'S WRITINGS IN HER BOOK, AND ALSO THE ACOG, WHAT IS YOUR UNDERSTANDING OF WHEN THE D&X PROCEDURE IS PERFORMED? AT WHAT GESTATIONAL AGE?
A. GENERALLY, AS I UNDERSTAND IT, IT HAS BEEN AFTER 20 WEEKS THAT THE D&X PROCEDURE IS MOST PERFORMED.

Q. SO IS THERE SOMETHING ABOUT THE GESTATIONAL AGE IN COMPARING D&E TO D&X THAT LIMITS THE ABILITY OF DRAWING CONCLUSIONS OF D&X BASED ON THE D&E PROCEDURE?

A. YES, BECAUSE THE D&E'S GENERALLY USED FROM 13 UP TO 24 WEEKS, AND THE D&X IS USUALLY USED ONLY 20 AND UP WEEKS. SO IT IS HARD TO USE EARLIER DATA FROM SMALLER BABIES IN COMPARING THEM TO OLDER BABIES.

Q. BUT EVEN IF YOU WERE TO USE D&E, WHAT WOULD YOU CONCLUDE ABOUT THE SAFETY OF D&X AS COMPARED TO THE SAFETY OF INDUCTION?

A. SO IF I WAS TO USE THE DATA WE NOW HAVE ON D&E AS A BASIS FOR THE D&X PROCEDURE, WE STILL HAVE GOOD DATA SHOWING THAT MEDICAL INDUCTION IS SAFER AFTER 20 WEEKS, AS COMPARED TO A D&X PROCEDURE THAT IS BOTH BASED ON MORTALITY, MOM'S DYING, AND MORBIDITY OR COMPLICATIONS OF THE PROCEDURE.

THE COURT: WAIT. I AM SORRY. I THOUGHT HER ANSWER WAS THAT THERE IS GOOD DATA SHOWING THAT INDUCTION IS SAFER AS COMPARED TO D&X?

THE WITNESS: NO, I SAID IF YOU USE D&E AS A COMPARISON. WE DON'T HAVE ANY DATA ON THE D&X, BUT IF WE ARE GOING TO USE THAT AS A COMPARISON, THEN I CAN SAY THAT.

OTHERWISE, WE DON'T HAVE ANY DATA. THANK YOU.

BY MS. CLARK:

Q. NOW, WOULD THE FACT THAT THERE WOULD BE LESS DILATION NECESSARY IN A D&X AS COMPARED TO INDUCTION, WOULD THAT WEIGH AS AN ADVANTAGE OF D&X OVER INDUCTION?

A. WE JUST DON'T KNOW.
Q. NOW, DR. SHADIGIAN, I WOULD LIKE TO ASK YOU SOME MORE POINTED QUESTIONS ABOUT THE INDUCTION PROCEDURE AS IT'S USED IN THE SECOND-TRIMESTER OF PREGNANCY TO TERMINATE A PREGNANCY.
WHAT IS THE LATEST GESTATIONAL AGE THAT YOU HAVE PERFORMED AN INDUCTION?
A. I GUESS 42 WEEKS OF GESTATION.
Q. WHAT IS THE LATEST AGE, GESTATIONAL AGE, THAT YOU PERFORMED AN INDUCTION ON A PREVIABLE FETUS?
A. WELL, UP TO 23 WEEKS IS PREVIABLE, SO RIGHT BEFORE 23 WEEKS.
Q. NOW, YOU TALKED TODAY BEFORE ABOUT INDUCTION BEING THE PRIMARY METHOD OF PREGNANCY TERMINATION THAT YOU USE; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. AND, AGAIN, WHY IS THAT THE METHOD THAT YOU GENERALLY CHOOSE?
A. BECAUSE OF MY PRACTICE WE SEE SICKER WOMEN AT THE UNIVERSITY OF MICHIGAN, AND THEY ARE GENERALLY OVER 20 WEEKS. SO NOT JUST MINE, BUT THE ENTIRE FACULTY'S GENERAL WAY OF PRACTICE IS TO USE MEDICAL INDUCTION BECAUSE OF THE BETTER SAFETY DATA WITH AN INDUCTION AS COMPARED WITH D&E AFTER 20 WEEKS.
Q. DOCTOR, YOU TESTIFIED EARLIER ABOUT PREECLAMPSIA. HAVE YOU EVER HAD ANY PATIENTS WITH PREECLAMPSIA?

A. YES.
Q. AND DO ALL OF YOUR PATIENTS WHO DEVELOP PREECLAMPSIA NEED TO HAVE THEIR PREGNANCY TERMINATED TO PROTECT THE MOTHER'S HEALTH INTEREST?
A. ONLY IF THEY HAVEN'T GONE INTO SPONTANEOUS LABOR. MANY WOMEN ACTUALLY GO INTO SPONTANEOUS LABOR AND NATURE TAKES ITS COURSE.
Q. BUT DOES THE FACT THAT A WOMAN HAS PREECLAMPSIA, DOES THAT NECESSARILY REQUIRE PREGNANCY TERMINATION?
A. NO, IT DOES NOT, IN MILD CASES.
Q. AND YOU HAVE HAD SOME PATIENTS WHO HAVE HAD PREECLAMPSIA AND HAVE REQUIRED TERMINATION OF PREGNANCY?
A. YES, I HAVE.
Q. AND HOW HAVE YOU TERMINATED THOSE PREGNANCIES?
A. GENERALLY THEY HAVE BEEN MOSTLY WITH MEDICAL INDUCTION OF LABOR, BUT SOME PEOPLE REQUIRE CESAREAN SECTION, AS WELL.
Q. FOR THOSE PATIENTS WHY HAVE YOU CHOSEN INDUCTION WHEN THEY HAVE HAD PREECLAMPSIA AND REQUIRED TERMINATION OF PREGNANCY?
A. ARE YOU LIMITING IT TO THE SECOND-TRIMESTER OR NOT?
Q. YES, IN THE SECOND-TRIMESTER.
A. BECAUSE OF THE SAFETY DATA OF MEDICAL INDUCTION OF THE LATE SECOND-TRIMESTER IT WAS DEEMED HEALTHIER FOR THE MOM TO GO AHEAD WITH A MEDICAL INDUCTION, AND IT WOULDN'T TAKE TWO OR THREE DAYS AS IT MIGHT WITH A SERIAL LAMINARIA AND GREATER DILATION WITH A D&E PROCEDURE.

Q. HAVE YOU EVER PERFORMED A PREGNANCY TERMINATION ON A WOMAN WHO HAS HAD PREECLAMPSIA USING THE D&E METHOD?
A. I HAVE NOT, PERSONALLY.
Q. AND WHY HAVE YOU NOT PERFORMED A D&E OR OTHER SURGICAL PROCEDURE ON A WOMEN PRESENTING WITH PREECLAMPSIA NEEDING HER PREGNANCY TO BE TERMINATED?
A. BECAUSE USUALLY THEY ARE 21, 22, ALMOST 23 WEEKS PREGNANT, SO THEY ARE IN THE LATER HALF OF THE SECOND-TRIMESTER.
Q. WHEN PREECLAMPSIA DEVELOPS PREVIABILITY, IS A MOTHER'S HEALTH THE ONLY ISSUE THAT YOU CONSIDER?
A. THE MOTHER'S HEALTH IS THE MAIN ISSUE ALWAYS IN THAT SITUATION.
Q. AND IN DECIDING TO TERMINATE HER PREGNANCY PREVIABILITY, IS A MOTHER'S HEALTH INTEREST THE ONLY ISSUE THAT YOU HAVE -- THAT YOU CONSIDER?
A. IF I CAN BE COMPLETELY SURE THAT THAT BABY CAN'T LIVE OUTSIDE MOM, EVEN WITH INTENSIVE NEONATAL CONSIDERATIONS, THEN, YES, THAT IS WHAT I AM GOING TO BE FOCUSED ON.
Q. DOCTOR, NOW, EARLIER YOU TESTIFIED THAT IT MAY BE NECESSARY TO TERMINATE A PREGNANCY OF A WOMAN WHO A UTERINE INFECTION OR CHORIOAMNIONITIS; IS THAT RIGHT?
A. THAT IS CORRECT.
Q. HAVE YOU EVER HAD TO TERMINATE A PREGNANCY BECAUSE A WOMAN HAD AN UTERINE INFECTION?
A. YES.

Q. IS IT COMMON THAT A PREGNANCY HAS TO BE TERMINATED BECAUSE OF AN UTERINE INFECTION?
A. IT'S FAIRLY UNCOMMON, BUT AT THE TERTIARY CARE CENTER WE SEE IT MORE OFTEN.
Q. WHY IS IT YOU SEE IT MORE OFTEN AT THE TERTIARY CARE CENTER?
A. BECAUSE WOMEN ARE REFERRED IN TO HAVE INVASIVE TESTS MORE LIKE AMNIOCENTESIS AND CVS SO WE ACTUALLY DO MORE PROCEDURES WHERE WE INSERT INSTRUMENTS INTO THE UTERUS, LIKE A NEEDLE, AND THAT MAY ACTUALLY INTRODUCE THE INFECTION TO THE WOMEN.
Q. HOW WOULD YOU TERMINATE A PREGNANCY WHEN IT IS REQUIRED BECAUSE OF UTERINE INFECTION?
A. FIRST, WE NEED TO MAKE AN ACCURATE DIAGNOSIS AS TO REAL INFECTION AND NOT JUST, FOR EXAMPLE, PREMATURE RUPTURE OF MEMBRANES. PREMATURE RUPTURE OF MEMBRANES IS ONE OF THE FIRST THINGS WE SEE SOMETIMES WHEN THERE IS AN UTERINE INFECTION.
SO FIRST WE MAKE THE ACCURATE DIAGNOSIS. AND THEN, BECAUSE THERE IS ALREADY INFECTION GOING ON, WE TRY TO AVOID SURGERY WHEN THERE IS AN INFECTION GOING ON, RATHER THAN GO IN AND POSSIBLY SPREAD THE INFECTION TO MOTHER MORE.
Q. AND SO IF YOU TERMINATE THE PREGNANCY, THEN WHAT METHOD WOULD YOU USE?
A. WE GENERALLY USE A MEDICAL INDUCTION METHOD.
Q. AND IF THERE IS PREMATURE RUPTURE OF MEMBRANES, DOES THAT REQUIRE TERMINATION OF PREGNANCY?

A. NO, IT DOES NOT, IN AND OF ITSELF.
Q. AND IF YOU CAN EXPLAIN A LITTLE BIT MORE -- YOU TOUCHED ON THIS -- WHY WOULD YOU USE INDUCTION METHOD OF TERMINATION PREGNANCY IN A SITUATION IN WHICH A WOMAN PRESENTED WITH AN UTERINE INFECTION?
A. BECAUSE IT WOULD MOST LIKELY LIMIT THE INFECTION AND NOT SPREAD IT TO THE REST OF THE MOTHER'S BODY IF WE DID A MEDICAL INDUCTION. ALSO, IT MAY BE QUICKER TO GO AHEAD AND INDUCE THE LABOR AND GET HER DELIVERED SO THAT THE INFECTION DOESN'T CONTINUE FOR LONGER PERIODS OF TIME.
Q. ARE YOU FAMILIAR WITH THE METHOD OTHER OB/GYN'S USE AT UNIVERSITY OF MICHIGAN WHEN THEY ENCOUNTER A WOMAN WITH AN UTERINE INFECTION THAT REQUIRES TERMINATION OF PREGNANCY?
A. YES.
Q. WHAT METHOD DO THEY USE?
A. AS I UNDERSTAND IT MOST PHYSICIANS IN MY INSTITUTION WHERE I PRACTICE ALSO USE MEDICAL INDUCTIONS OF LABOR.
Q. DR. SHADIGIAN, HOW LONG DOES IT TAKE YOU TO PERFORM AN INDUCTION PROCEDURE, APPROXIMATELY, IN THE PREVIABILITY STAGE?
A. USING MISOPROSTOL, ON AVERAGE, TAKING BETWEEN FOUR AND 24 HOURS.
Q. DR. SHADIGIAN, YOU'VE TESTIFIED TODAY ABOUT THE GESTATIONAL AGE OF THE FETUS WHEN YOU ARE TERMINATING THE PREGNANCY. AND IN WHAT WAY DOES THE GESTATIONAL AGE OF THE FETUS HAVE A BEARING ON THE METHOD OF PREGNANCY TERMINATION USED TO, IN

FACT, TERMINATE THE PREGNANCY?
A. WELL, WHAT WE TRY TO DO IS LOOK AT THE EVIDENCE AND STUDIES. SO WHAT WE TRY TO DO IS LOOK AT, YOU KNOW, D&E PROCEDURE AT DIFFERENT GESTATIONAL AGES AND MEDICAL INDUCTION PROCEDURE AT DIFFERENT GESTATIONAL AGES, AND SEE IF WE CAN DRAW SOME KIND OF CONCLUSIONS FROM ACTUAL STUDIES. NOT JUST AT U OF M, BUT PEOPLE'S STUDIES ACROSS THE COUNTRY AND ACROSS THE WORLD, SO THAT WE CAN LOOK AT DATA AND KNOW THAT WE ARE OFFERING OUR PATIENTS THE BEST MEDICAL CARE POSSIBLE AND TRY TO REDUCE THE AMOUNT OF MORBIDITY AND MORTALITY THAT A WOMAN MAKES DURING THIS FROM THE CHOICES AROUND INDUCTION OR D&E PROCEDURE.
MS. CLARK: YOUR HONOR, MAY I APPROACH?
THE COURT: YES.
BY MS. CLARK:
Q. DOCTOR, I HAVE JUST SHOWN YOU WHAT HAS BEEN IDENTIFIED AS DEFENDANT'S EXHIBIT LT A-15. HAVE YOU SEEN THIS ARTICLE BEFORE?
A. YES, I HAVE.
Q. AND DOES THIS ARTICLE SUPPORT YOUR OPINION IN ANY WAY ABOUT THE SAFETY OF INDUCTION AT THE LATER STAGES IN THE -- OF THE SECOND-TRIMESTER OF PREGNANCY?
A. YES, IT DOES.
Q. I DIRECT YOU TO TABLE NUMBER 4, WHICH IS ON PAGE 727.
DOES THIS TABLE SUPPORT YOUR OPINIONS IN ANY WAY?
A. YES. THIS TABLE LOOKS AT D&E, OR DILATION AND EVACUATION,

PROCEDURE VERSUS LABOR INDUCTION. AND IT SHOWS THAT LABOR INDUCTION IS SAFER AT 21 WEEKS AND GREATER. AND THIS IS USING EVEN THE OLD INSTILLATION METHODS, NOT THE MORE MODERN MISOPROSTOL.

Q. WHAT IS THE SIGNIFICANCE OF USING THE EARLY METHODS AS OPPOSED TO THE MISOPROSTOL DRUG USED WITH LABOR INDUCTION?

A. WELL, THE NEWER STUDIES HAVE SHOWN MISOPROSTOL IS, IN FACT, EVEN SAFER THAN OLD INSTILLATION METHODS. SO THAT WE CAN SAFELY ASSUME THAT IF THIS IS DONE WITH MISOPROSTOL MODERNLY, WE WOULD HAVE EVEN LOWER RATES OF MORTALITY FOR WOMEN AT 21 WEEKS AND GREATER.

Q. AND THIS DATA, WHAT YEAR WAS THIS DATA BASED UPON?

A. THIS WAS BASED ON EARLY DATA FROM 1972 TO 1987.

Q. IF YOU LOOK AT TABLE 4, I THINK IT -- I WILL JUST LEAVE THAT.

NOW, DOCTOR, ARE THERE OTHER STUDIES OR ARTICLES THAT YOU HAVE RELIED UPON IN FORMING YOUR OPINION THAT INDUCTION IS AS SAFE OR SAFER THAN THE D&E PROCEDURE AT CERTAIN STAGES IN THE SECOND-TRIMESTER OF PREGNANCY?

A. YES.

Q. AND ARE THOSE THE GRIMES STUDIES?

A. YES.

MS. CLARK: YOUR HONOR, MAY I APPROACH?

THE COURT: YES.

BY MS. CLARK:

Q. DR. SHADIGIAN, I HAVE HANDED YOU WHAT HAS BEEN MARKED AS DEFENDANTS EXHIBIT LT A-25. IS THIS ONE OF THE GRIMES STUDIES YOU WERE REFERRING TO?

A. YES, IT IS.

Q. WHAT YEAR WAS THIS STUDY PUBLISHED?

A. THIS STUDY WAS PUBLISHED IN 1985.

Q. IF I COULD HAVE YOU RETURN TO PAGE 93. AND IN THE SECOND FULL PARAGRAPH, THE PARAGRAPH BEGINS:

"THE GREATER COMPARATIVES."

A. YES.

Q. IF YOU READ THAT SECOND SENTENCE IN THAT PARAGRAPH, WOULD YOU READ THAT SECOND SENTENCE OUT LOUD?

A. CERTAINLY.

"AT GREATER THAN OR EQUAL TO 16 WEEKS GESTATION THE RISKS OF DEATH FROM D&E AND FROM INSTILLATION ABORTION ARE SIMILAR AND STATISTICALLY INDISTINGUISHABLE."

Q. AND DOES THIS SENTENCE SUPPORT YOUR OPINION ABOUT THE RELATIVE SAFETY OF D&E AND INDUCTION?

A. YES, IT DOES.

Q. AND DOES THE CHANGE IN THE USE OF MISOPROSTOL EFFECT THE STUDY IN ANY WAY, DO YOU THINK, WITH RESPECT TO INDUCTION PROCEDURE?

A. WELL, JUST WITH THE NEWER MISOPROSTOL, IN FACT, IT HAS BEEN SHOWN IT IS EVEN SAFER THAN INSTILLATION METHODS, SO WE SHOULD

FIND THAT MORTALITY IS LOWER WITH MODERN USE OF PROSTAGLANDINS, AS COMPARED TO D&E.

Q. NOW, WHAT IS YOUR BASIS FOR YOUR OPINION THAT MISOPROSTOL HAS IMPROVED THE METHOD OF INDUCTION?

A. THERE ARE SEVERAL ARTICLES AND SEVERAL STUDIES THAT HAVE BEEN PERFORMED AROUND THE WORLD THAT ARE HOW I BASE MY OPINION ABOUT MISOPROSTOL.

MS. CLARK: MAY I APPROACH THE WITNESS?

THE COURT: YES.

BY MS. CLARK:

Q. THIS IS DEFENDANT'S LT A-27.

DR. SHADIGIAN, I HAVE HANDED YOU WHAT HAS BEEN IDENTIFIED AS DEFENDANT'S EXHIBIT LT A-27.

A. YES, I HAVE IT.

Q. IF YOU WOULD LOOK AT THE FIRST COLUMN, TURNING TO THE SECOND PARAGRAPH WHERE IT BEGINS:

"THE DETAILS OF THE BENEFICIAL EFFECTS."

DO YOU SEE THAT?

A. YES.

Q. WOULD YOU READ OUT LOUD THE SECOND SENTENCE IN THAT PARAGRAPH, BEGINNING WITH "HOWEVER"?

A. "HOWEVER, FOR ONE SPECIFICATION INDICATION, CERVICAL RIPENING AS A PRELUDE TO INDUCTION OF LABOR, MISOPROSTOL HAS BEEN USED SO FREQUENTLY AND EFFECTIVELY THAT IT HAS BECOME THE TREATMENT OF

CHOICE."
Q. WOULD YOU AGREE WITH THAT STATEMENT?
A. YES, I DO.
Q. IF YOU TURN TO THE NEXT PAGE, THE LEFT-HAND COLUMN, AT THE VERY BOTTOM THE SENTENCE BEGINNING:
"YET WE REAFFIRM." WOULD YOU BEGIN WITH "WE REAFFIRM," AND READ THAT SENTENCE?
A. "WE REAFFIRM THAT MISOPROSTOL IS A SAFE AND EFFECTIVE DRUG FOR CERVICAL RIPENING AND INDUCTION OF LABOR WHEN USED APPROPRIATELY."
Q. AND DO YOU AGREE WITH THAT STATEMENT?
A. YES, I DO.
MS. CLARK: MAY I APPROACH?
THE COURT: YES.
BY MS. CLARK:
Q. I AM HANDING YOU WHAT HAS BEEN IDENTIFIED AS PLAINTIFFS' 31. I WOULD LIKE YOU TO TURN TO PAGE 142, PLEASE. AND THE "ABORTION BY LABOR INDUCTION" CHAPTER.
IF YOU LOOK UNDER THE SECTION "MORBIDITY AND MORTALITY," IN THAT FIRST PARAGRAPH, WOULD YOU READ OUT LOUD THE VERY LAST SENTENCE?
A. STARTING WITH "ALTHOUGH"?
Q. OH, I AM SORRY. NO. STARTING WITH -- WE'RE ON PAGE 142, UNDER "MORBIDITY AND MORTALITY," THE FIRST FULL PARAGRAPH. THE SENTENCE THAT BEGINS:

"AN INCREASE USE, INCREASED USE OF VAGINAL PROSTAGLANDINS."

A. OKAY. "INCREASED USE OF VAGINAL PROSTAGLANDINS. IMPROVEMENTS IN TECHNIQUE AND BETTER CERVICAL PREPARATION HAVE PROBABLY REDUCED MORTALITY FROM INDUCTION ABORTIONS."

Q. AND DO YOU AGREE WITH THAT SENTENCE?

A. YES, I DO.

Q. DO YOU UNDERSTAND THAT SENTENCE TO REFER TO IMPROVING IT FROM THE INSTILLATION METHOD OF INDUCTION?

A. YES. THEY HAVE TABLES ABOUT INSTILLATION METHODS ON THE SAME PAGE, EVEN.

Q. AND IS MISOPROSTOL A PROSTAGLANDIN?

A. YES, IT IS.

Q. DO YOU KNOW IF OTHER PHYSICIANS BESIDES YOURSELF ARE USING MISOPROSTOL IN CONNECTION WITH THE INDUCTION METHOD OF PREGNANCY TERMINATION?

A. YES, I DO.

Q. HOW DO YOU KNOW THAT?

A. BECAUSE I PRACTICE AT U OF M, AND I HAVE TO TAKE OVER AFTER THEY HAVE STARTED AN INDUCTION, AND I KNOW WHAT TECHNIQUES THEY ARE USING.

IN ADDITION, WE HAVE A WEB SITE WHERE WE HAVE DIFFERENT PROTOCOLS. AND ONE OF THE PROTOCOLS IS ABOUT MISOPROSTOL.

Q. DO YOU HAVE AN UNDERSTANDING ABOUT THE METHODS USED TO TERMINATE PREGNANCY AT THE UNIVERSITY OF MICHIGAN?
A. YES, I DO.
Q. WHAT IS YOUR UNDERSTANDING ABOUT THE METHODS USED TO TERMINATE PREGNANCY AT THE UNIVERSITY OF MICHIGAN IN THE SECOND-TRIMESTER OF PREGNANCY?
A. THAT BOTH D&E IS USED AND INDUCTION OF LABOR TECHNIQUES.
Q. DO YOU HAVE AN IDEA AS GESTATIONAL AGE INCREASES WHAT THE OTHER PHYSICIANS AT UNIVERSITY OF MICHIGAN ARE USING IN THE SECOND-TRIMESTER?
A. AS I UNDERSTAND IT, BASICALLY AFTER 20 WEEKS D&E'S AREN'T BEING OFFERED IN MOST SITUATIONS.
MS. CLARK: YOUR HONOR, MAY I APPROACH?
THE COURT: YES.
BY MS. CLARK:
Q. I AM SHOWING YOU PLAINTIFFS LT-15. DOCTOR, HAVE YOU SEEN THIS ARTICLE BEFORE?
A. I BELIEVE SO.
Q. IF YOU PLEASE TURN TO TABLE 3.
MS. KRASNOFF: WHAT EXHIBIT?
MS. CLARK: LT-15.
BY MS. CLARK:
Q. DOCTOR, IF YOU WOULD TURN TO TABLE 3, PLEASE.
A. YES.
Q. AND WHAT IS SET FORTH IN TABLE 3?

A. THE TITLE OF TABLE 3 IS:

"ABORTION MORTALITY RATES BY GESTATIONAL AGE AND PROCEDURE IN THE UNITED STATES."

MS. KRASNOFF: OBJECTION, YOUR HONOR. THIS ARTICLE WAS NOT DISCUSSED BY DR. SHADIGIAN IN HER EXPERT REPORT OR TALKED ABOUT AT DEPOSITION.

MS. CLARK: YOUR HONOR, IT WASN'T IN HER EXPERT REPORT OR DEPOSITION, BUT TO THE EXTENT DR. PAUL TESTIFIED ABOUT IT, THIS IS IN RESPONSE TO DR. PAUL'S TESTIMONY.

THE COURT: SO YOU ARE USING IT AS REBUTTAL?

MS. CLARK: YES.

THE COURT: I WILL PERMIT IT.

BY MS. CLARK:

Q. DR. SHADIGIAN, IF YOU -- I THINK YOU WERE REFERRING TO TABLE 3. AND WHAT DOES TABLE 3 SET FORTH?

A. IT SETS FORTH ABORTION MORTALITY RATES BY GESTATIONAL AGE AND PROCEDURE IN THE UNITED STATES IN TWO TIME FRAMES: FROM 1972 TO '76, AND THEN FROM 1977 TO '81.

Q. AND ARE THESE TABLES, IN YOUR OPINION, VALID TODAY?

A. THEY ARE IN THAT THESE ARE TECHNIQUES THAT WERE USED DURING THAT PERIOD OF TIME. HOWEVER, WE DON'T USE INSTILLATION TECHNIQUES ALMOST AT ALL ANY MORE.

SO, IN EFFECT, IT DOESN'T REALLY REFLECT MODERN PRACTICES MUCH.

Q. ARE THE INSTILLATION METHODS OF INDUCTION -- OF TERMINATION

OF PREGNANCY BY INDUCTION METHOD IN THE SECOND-TRIMESTER INSTILLATION METHOD USED AT THE UNIVERSITY OF MICHIGAN?

A. IT IS NOT ANYMORE.

Q. ARE YOU AWARE OF ANY OB/GYN'S USING THE INSTILLATION METHOD OF INDUCTION?

A. NOT PERSONALLY, NO.

Q. WOULD YOU KNOW IF OTHER PHYSICIANS WERE USING INSTILLATION?

A. I WOULD BECAUSE I GO TO OUR WEEKLY CONFERENCES AND HEAR ABOUT WHAT OTHER PHYSICIANS DO IN MY OWN INSTITUTION.

Q. YOU'RE AWARE THAT THE CENTER FOR DISEASE CONTROL REPORTS ON THE NUMBER OF ABORTIONS THAT ARE PERFORMED IN THE UNITED STATES?

A. YES, I DO.

Q. IN YOUR OPINION IS A CDC INFORMATION RELIABLE?

A. IT IS NOT RELIABLE.

Q. WHY DON'T YOU THINK IT IS RELIABLE?

A. BECAUSE THE CENTER FOR DISEASE CONTROL DOES NOT EVEN GET MORTALITY DATA FROM ALL 50 STATES. IT IS LIMITED TO ABOUT 39 STATES, IT RECEIVES ANY INFORMATION FROM. AND IT IS NOT REQUIRED OR MANDATED BY LAW TO ACTUALLY GIVE THE INFORMATION TO THE CDC, SO THAT THERE ARE MANY HOLES IN THE SYSTEM.

Q. DO YOU HAVE AN OPINION ABOUT WHETHER THE INDUCED CONTRACTIONS SEEN IN AN INDUCTION METHOD FOR TERMINATION OF PREGNANCY, WHETHER THEY ARE TRAUMATIC PHYSICALLY AND EMOTIONALLY TO THE PATIENT?

A. I WOULD THINK CONTRACTIONS ARE CONTRACTIONS. THEY ARE SOMETHING TO BE AWARE OF AND TAKE NOTE OF, BUT I WOULDN'T CALL THEM "TRAUMATIC."

Q. DOCTOR, ARE YOU FAMILIAR WITH AN ARTICLE WRITTEN RECENTLY COMPARING D&E TO INDUCTION BY AUTRY, ENTITLED:

"A COMPARISON OF MEDICAL INDUCTION AND DILATION AND EVACUATION FOR SECOND-TRIMESTER OF PREGNANCY"?

A. YES, I AM AWARE OF THAT ARTICLE.

MS. CLARK: MAY I APPROACH?

THE COURT: YES.

BY MS. CLARK:

Q. THIS IS PLAINTIFFS' EXHIBIT LT 5. DO YOU RECOGNIZE WHAT I HAVE JUST HANDED YOU?

A. YES, I DO.

Q. IS THAT THE AUTRY ARTICLE?

A. YES.

Q. HAVE YOU REVIEWED IT PRIOR TO TODAY?

A. YES, I HAVE.

Q. HAVE YOU RELIED UPON IT IN PROVIDING YOUR EXPERT TESTIMONY HERE TODAY?

A. YES, I HAVE.

Q. COULD YOU SUMMARIZE THE CONCLUSIONS IN THIS ARTICLE?

A. THE ARTICLE CONCLUDED THAT DILATION EVACUATION IS THE SAFEST METHOD OF SECOND-TRIMESTER ABORTION. MISOPROSTOL IS

SAFER THAN OTHER METHODS FOR MEDICAL ABORTION.
Q. DO YOU AGREE WITH THE CONCLUSIONS IN THIS ARTICLE?
A. I DO NOT AGREE WITH THE CONCLUSION THAT DILATION AND EVACUATION IS THE SAFEST METHOD FOR SECOND-TRIMESTER ABORTION.
Q. AND WHY DO YOU NOT AGREE WITH THE CONCLUSIONS REACHED IN THIS ARTICLE, SPECIFICALLY?
A. THERE WERE SEVERAL SERIOUSLY FLAWED METHODOLOGIES USED TO COME TO THIS CONCLUSION. SOME OF THEM INCLUDE THE FOLLOWING: FIRST, THEY COUNTED AS A COMPLICATION RETAINED PLACENTA, WHICH IS WHERE THE PLACENTA DOESN'T COME OUT RIGHT AFTER THE BABY DOES. HOWEVER, IT NEVER DEFINED WAS A WHAT A RETAINED PLACENTA WAS.

IN GENERAL PRACTICE, WE SAY RETAINED PLACENTA AT TERM IS ABOUT 30 MINUTES, AND IN THE SECOND-TRIMESTER ABORTION WE CONSIDER IT UP TO TWO HOURS AS A RETAINED PLACENTA, AFTER TWO HOURS IT HAS BEEN INSIDE. BUT THEY DON'T DEFINE WHAT EACH INDIVIDUAL PHYSICIAN DID WITH THE PATIENTS IN THIS.

AND THE OTHER MAJOR CONCERN WITH THIS ARTICLE IS THAT THE TWO GROUPS THAT THEY LOOKED, AT THE MEDICAL INDUCTION GROUP AND THE SURGICAL INDUCTION GROUP HAD A VERY STATISTICALLY SIGNIFICANT DIFFERENCE IN THE GESTATIONAL AGE OF THE WOMEN IN EACH SUBGROUP. SPECIFICALLY, THAT WITH MEDICAL INDUCTION IT WAS ALMOST 20-AND-A-HALF-WEEKS OF GESTATION AND IN THE SURGICAL GROUP IT WAS ABOUT 18-AND-A-HALF.

SO, JUST THE CONCLUSION COULD BE FOUND IF -- I AM

SORRY. STARTING AGAIN. THE CONCLUSION FOUND BY THE ARTICLE COULD BE EXPLAINED BY JUST THE FACT THAT THE GESTATIONAL AGES ARE DIFFERENT IN THE TWO GROUPS.

Q. DOCTOR, YOU MENTIONED THAT YOU WILL WAIT UP UNTIL ABOUT TWO HOURS TO REMOVE THE PLACENTA IN AN INDUCTION TERMINATION. AND IS THIS THE PRACTICE AT THE UNIVERSITY OF MICHIGAN?

A. YES, IT IS.

Q. AND IF THERE IS RETAINED PLACENTA AFTER TWO HOURS, WHAT IS DONE TO REMOVE THE RETAINED PLACENTA?

A. SEVERAL DIFFERENT METHODS ARE USED TO REMOVE THE RETAINED PLACENTA. USUALLY, WE TAKE A WOMAN BACK TO THE OPERATING ROOM WHEN WE ARE GOING TO REMOVE A PLACENTA AND IT HASN'T COME OUT IN TWO HOURS OR MORE, WHERE WE MAY REACH UP WITH A GLOVED HAND AND REMOVE THE PLACENTA BY SHEERING IT OFF THE SIDE OF THE UTERUS.

SOMETIMES WE ACTUALLY HAVE TO USE INSTRUMENTS AND ULTRASOUND GUIDANCE TO REMOVE THE PLACENTA IN PIECES OR IN WHOLE.

Q. AND IN THE INSTANCES IN WHICH YOU HAVE TO USE INSTRUMENTS TO REMOVE THE RETAINED PLACENTA, IS THIS ANY DIFFERENT THAN THE WAY IN WHICH PLACENTA IS REMOVED IN A D&E PROCEDURE?

A. IT IS THE SAME PROCEDURE.

Q. SO SURGERY IS DONE TO REMOVE THE PLACENTA AFTER AN INDUCTION, WHAT IS BEING DONE IS THE SAME THING AS THE PROCEDURE THAT IS DONE IN ALL D&E'S; IS THAT CORRECT?

A. THAT IS CORRECT.
Q. IN YOUR OPINION IS RETAINED PLACENTA A RISK FACTOR FOR INDUCTION?
A. IT IS SOMETHING THAT DOES HAPPEN, BUT I WOULDN'T CONSIDER IT A RISK.
Q. AT SOME POINT WOULD YOU EVER CONSIDER RETAINED PLACENTA TO BE A RISK OR COMPLICATION IN A MEDICAL INDUCTION?
A. I WOULD CONSIDER IT A COMPLICATION ONLY IF WE DID SOMETHING LIKE PERFORATE THE UTERUS DURING AN ATTEMPT TO REMOVE THE PLACENTA OR HAD SOME KIND OF INCREASED INFECTION RATES BECAUSE OF A RETAINED PLACENTA.
Q. IN YOUR OPINION HAS THE INCLUSION OF RETAINED PLACENTA IN THIS STUDY SKEWED THE COMPARISON OF THE SAFETY OF D&E VERSUS INDUCTION?
A. YES, IT HAS.
MS. CLARK: YOUR HONOR, NO FURTHER QUESTIONS.
THE COURT: ALL RIGHT. CROSS-EXAMINATION.

CROSS-EXAMINATION

BY MS. KRASNOFF:
Q. DR. SHADIGIAN, I WOULD LIKE TO TALK WITH YOU ABOUT D&E ABORTIONS. IN A D&E THE CERVIX IS DILATED OVER A PERIOD OF TIME; IS THAT CORRECT?
A. YES.
Q. AND SOMETIMES THE PHYSICIAN USES ONE SET OF LAMINARIA, BUT SOMETIMES THEY MAY DO MORE THAN ONE INSERTION OF LAMINARIA; IS

THAT CORRECT?

A. SOMETIMES.

Q. AND THAT'S REFERRED TO AS "SERIAL DILATION"; IS THAT RIGHT?

A. THAT IS CORRECT.

Q. AND YOU YOURSELF HAVE USED SERIAL LAMINARIA BEFORE A D&E, HAVEN'T YOU?

A. RARELY, YES.

Q. AND YOU WOULDN'T USE TECHNIQUES OR PROCEDURES THAT YOU BELIEVE WERE UNSAFE FOR YOUR PATIENTS, WOULD YOU?

A. I DON'T UNDERSTAND THE QUESTION.

Q. DO YOU USE ANY TECHNIQUES OR PROCEDURES ON YOUR PATIENTS THAT YOU BELIEVE WERE NOT SAFE?

A. ARE YOU SPEAKING OF LAMINARIA OR SOMETHING ELSE?

Q. IN GENERAL.

A. I GUESS IT WOULD DEPEND ON THE PARTICULAR SITUATION.

Q. DO YOU BELIEVE THAT THE SERIAL USE OF LAMINARIA IS UNSAFE?

A. NO.

Q. YOU ARE ALSO CONSIDERING USING MISOPROSTOL ALONG WITH LAMINARIA IN THE FUTURE; IS THAT RIGHT?

A. YES, AND MANY PHYSICIANS USE THAT ALREADY AT THE UNIVERSITY OF MICHIGAN.

Q. AND YOU AGREE THAT THAT MIGHT HOLD SAFETY ADVANTAGES FOR THE DILATION PROCESS; IS THAT CORRECT?

A. YES, IT MAY.

Q. WHEN USING LAMINARIA, IT IS POSSIBLE, IS IT NOT, TO SPEED

THE DILATION PROCESS BY CHANGING THE LAMINARIA MORE FREQUENTLY?
A. YES.
Q. AND YOU WOULD AGREE, WOULD YOU NOT, IF THERE WERE TWO WOMEN AT 20 WEEKS GESTATIONAL AGE, BOTH ARE GOING TO HAVE D&E ABORTIONS, AND BOTH GET THE SAME DOSES OF MISOPROSTOL AND THE SAME NUMBER OF LAMINARIA, YOU WILL NOT NECESSARILY GET THE SAME AMOUNT OF DILATION IN EACH OF THOSE TWO WOMEN; IS THAT CORRECT?
A. YES.
Q. NOW, YOU AGREE, WOULD YOU NOT, THAT IN PERFORMING A D&E THE PHYSICIAN MAY APPLY TRACTION TO THE FETAL PART THAT HE OR SHE IS GRASPING AND BE ABLE TO PULL IT THROUGH THE CERVICAL OS?
A. YES, THAT CAN BE DONE.
Q. AND IF THAT HAPPENS, THE PART THAT HAS BEEN BROUGHT THROUGH THE CERVIX MAY DISARTICULATE AT THE INTERNAL CERVICAL OS DUE TO THE TRACTION; IS THAT CORRECT?
A. YES, IT MAY.
Q. BUT YOU AGREE IT IS POSSIBLE IN THAT SITUATION IF THERE IS ADEQUATE DILATION THAT THE PHYSICIAN WOULD BE ABLE TO EXTRACT THE FETUS UP TO THE TORSO; IS THAT CORRECT?
A. POSSIBLY.
Q. AND IF THAT HAPPENED AND YOU WERE SUPERVISING A RESIDENT IN A D&E, YOU WOULD TELL THEM TO DISARTICULATE, WOULD YOU NOT?
A. YES.
Q. AND IF THE FETUS WERE ALIVE AT THE POINT IT EMERGED UP TO THE TORSO THAT DISARTICULATION WOULD BE A LEGAL ACT, WOULD IT

NOT?
A. I WOULDN'T BE PERFORMING THAT PROCEDURE IF IT WAS A LIVE BABY.
Q. WELL, CAN YOU OFFER AN OPINION IF ANOTHER PHYSICIAN WERE PERFORMING THAT AND THAT SITUATION PRESENTED ITSELF WHERE THE FETUS HAD EMERGED IN A D&E UP TO THE TORSO, AND THEN THE PHYSICIAN DISARTICULATED, WOULD THAT BE A LETHAL ACT?
A. IT COULD BE, BUT IT WOULDN'T NECESSARILY BE.
Q. AND WHEN WOULD IT NOT BE?
A. WELL, DISARTICULATION TAKES SEVERAL PASSES, SO IT IS NOT WHEN YOU JUST TWIST A FOOT OFF THAT THE BABY IS GOING TO DIE IMMEDIATELY. IN FACT, IT IS GOING TO HEMORRHAGE OVER A PERIOD OF TIME. SO IT WILL DEPEND ON HOW MANY OTHER PASSES YOU TAKE AND DISARTICULATION MOVES YOU DO.
Q. WELL, IN THIS EXAMPLE, IT HAD BEEN REMOVED ALL THE WAY TO THE TORSO. COULD YOU DISARTICULATE AT THE TORSO AND HAVE THE FETUS SURVIVE?
A. NOT FOR MANY MINUTES.
Q. YOU TESTIFIED EARLIER YOU'VE ONLY PERFORMED D&E'S ON DEMISED FETUSES; THAT'S CORRECT?
A. YES, THAT IS CORRECT.
Q. AND SOMETIMES THOSE FETUSES HAVE BEEN DEMISED FOR A DAY OR TWO; IS THAT RIGHT?
A. YES.
Q. I THINK YOU MENTIONED THIS, BUT THE FRIABILITY OF THE FETUS

IS EFFECTED BY FETAL DEMISE SUCH THAT IT BREAKS APART MORE READILY WHEN THERE HAS BEEN FETAL DEMISE; IS THAT CORRECT?

A. YES, COMPARED TO LIVE BABIES.

Q. AND YOU WOULD AGREE, WOULD YOU NOT, THAT THERE IS ALWAYS A RISK OF DAMAGE TO THE CERVIX OR TO THE UTERUS WHENEVER INSTRUMENTS ARE PASSED INTO THE UTERUS?

A. YES.

Q. IT IS TRUE THAT ONE RISK OF D&E IS THAT FETAL BONES MAY BE EXPOSED WHICH PRESENTS A RISK OF PUNCTURING OR LACERATING THE UTERUS; IS THAT CORRECT?

A. YES.

Q. AND YOU WOULD AGREE THAT REMOVAL OF THE FETUS INTACT DURING A SURGICAL ABORTION WOULD REDUCE THAT RISK, WOULDN'T IT?

A. YES.

Q. AND NOW I AM GOING TO SWITCH GEARS A BIT AND TALK IN GENERAL ABOUT INDUCTIONS.

I BELIEVE YOU HAVE TALKED ABOUT TWO DIFFERENT KINDS OF INDUCING AGENTS TODAY, OXYTOCIN OR PITOCIN AND PROSTAGLANDINS, SUCH AS MISOPROSTOL; IS THAT CORRECT?

A. YES.

Q. IT'S POSSIBLE WITH OXYTOCIN THAT THE WOMAN CAN HAVE TOO MANY UTERINE CONTRACTIONS OR TETANY; IS THAT RIGHT?

A. YES.

Q. AND TETANY CAN RESULT IN UTERINE RUPTURE; IS THAT CORRECT?

A. YES.

Q. AND YOU WOULD AGREE THAT OXYTOCIN MAY BE CONTRAINDICATED OR AT LEAST RELATIVELY CONTRAINDICATED IF A WOMEN HAS A PREVIOUSLY SCARRED UTERUS, WOULD YOU NOT?

A. I WOULD SAY RELATIVELY, BUT NOT ABSOLUTELY.

Q. AND THAT WOULD ESPECIALLY BE THE CASE IF THE SCAR IS WHAT IS KNOWN AS A VERTICAL OR CLASSICAL CESAREAN SECTION SCAR; IS THAT RIGHT?

A. YES, IT COULD BE.

Q. AND PROSTAGLANDINS, LIKE MISOPROSTOL, ARE ALSO CONTRAINDICATED FOR A WOMAN WHO HAS A PRIOR CESAREAN SECTION; ARE THEY NOT?

A. NOT ABSOLUTELY, BUT THAT IS OUR GENERAL PRACTICE NOT TO USE THEM.

Q. AND YOU WOULD AGREE THAT AN INDUCTION MAY NOT BE ADVISABLE FOR SOME WOMEN WITH SERIOUS MEDICAL CONDITIONS SUCH AS A SERIOUS HEART CONDITION, BECAUSE THE CONTRACTIONS COULD COMPROMISE HER CARDIOPULMONARY SITUATION; IS THAT RIGHT?

A. THAT IS POSSIBLE.

Q. AND SOME WOMEN MAY HAVE AN ALLERGY TO THE MEDICINES THAT ARE USED IN INDUCTION MAKING THAT METHOD NOT APPROPRIATE FOR THEM; IS THAT CORRECT?

A. YES.

Q. SO, YOU WOULD AGREE WITH ME, THEN, THAT THERE MAY BE SITUATIONS WHERE AN INDUCTION WOULD NOT BE THE OPTIMAL FORM OF ABORTION FOR A WOMAN?

A. THERE COULD BE.
Q. AND YOU WOULD AGREE THERE ARE CERTAIN RISKS ASSOCIATED WITH INDUCTION; IS THAT RIGHT?
A. YES.
Q. AND THOSE INCLUDE, I BELIEVE, CHORIOAMNIONITIS OR INFECTION?
A. YES.
Q. EXCESSIVE BLOOD LOSS FROM HEMORRHAGING?
A. YES.
Q. AND POTENTIAL RUPTURE OF THE UTERUS?
A. YES.
Q. INDUCTIONS ARE INPATIENT PROCEDURES, AREN'T THEY?
A. YES.
Q. THAT MEANS THEY ARE PERFORMED IN HOSPITALS, RIGHT?
A. YES.
Q. AND THE WOMAN IS IN THE HOSPITAL THE ENTIRE TIME OF THE PROCEDURE; IS THAT RIGHT?
A. YES.
Q. AND I THINK YOU TESTIFIED EARLIER THAT THE AVERAGE LENGTH OF TIME USING THE MEDICATIONS THAT YOU USE IS -- FOR AN INDUCTION IS BETWEEN FOUR AND 24 HOURS; IS THAT CORRECT?
A. YES.
Q. BUT IN YOUR EXPERIENCE AN INDUCTION HAS TAKEN AS LONG AS TWO-AND-A-HALF DAYS; IS THAT CORRECT?
A. YES.

Q. WOULD YOU AGREE WITH ME THAT INDUCTION, THEREFORE, IS UNPREDICTABLE IN LENGTH?
A. NOT NECESSARILY.
Q. BETWEEN -- WOULD YOU AGREE IT IS NOT PREDICTABLE BETWEEN FOUR HOURS AND TWO-AND-A-HALF DAYS?
A. ONE MIGHT BE ABLE TO PREDICT DEPENDING ON WHAT MEDICATIONS ARE USED AND WHAT RISK FACTORS A WOMAN HAS.
Q. AND ARE THOSE -- DO YOU BELIEVE YOU CAN PREDICT ACCURATELY HOW LONG THE INDUCTION WILL LAST?
A. I THINK IT IS EASIER TO PREDICT IF YOU DIVIDE UP THE SAMPLE SIZE. FOR EXAMPLE, IF YOU JUST LOOKED AT WOMEN WHO USED MISOPROSTOL YOU MIGHT BE ABLE TO MAKE A FAIRLY ACCURATE PREDICTION. AND IF YOU TOOK OXYTOCIN AS A SEPARATE ONE, AND MAKE A DIFFERENT ONE.
Q. WELL, COULD YOU TRY AND DO THOSE? THAT DOES CHANGE YOUR FOUR TO 24 HOURS FIGURES? WOULD IT BE DIFFERENT FOR EACH OF THOSE?
A. IT MIGHT BE.
Q. DO YOU HAVE AN OPINION ON WHAT IT MIGHT BE?
A. I THINK WHEN I SAID "FOUR TO 24 HOURS," I WAS THINKING MORE ABOUT MISOPROSTOL. AND THE ONES I HAVE SEEN THAT HAVE TAKEN LONGER HAVE BEEN WOMEN WITH SCARRED UTERUSES THAT WE COULDN'T USE PROSTAGLANDINS, AND THEY MAY TAKE LONGER.
Q. AND WHAT ABOUT OXYTOCIN? WHAT IS THE AVERAGE THAT WOULD TAKE?

A. AGAIN, IT DEPENDS ON IF IT IS A WOMAN'S FIRST BIRTH OR IF IT MIGHT BE THE SECOND OR THIRD BIRTH.
Q. CAN YOU GIVE ME A RANGE?
A. OXYTOCIN MAY RANGE BETWEEN SIX AND ONE TO TWO DAYS, SIX HOURS AND ONE TO TWO DAYS.
Q. WE TALKED JUST A FEW MINUTES AGO ABOUT HOW IN THE ABORTIONS YOU HAVE PERFORMED THERE HAS BEEN FETAL DEMISE BEFORE YOU REMOVE A FETUS IN D&E WOULD YOU AGREE THAT LABOR IS INDUCED MORE QUICKLY IN AN INDUCTION ABORTION WHEN THE FETUS IS DEMISED?
A. IT CAN BE.
Q. YOU ALSO TESTIFIED THAT THERE ARE PROTOCOLS FOR THE PERFORMANCE OF INDUCTION ABORTIONS AT THE UNIVERSITY OF MICHIGAN; IS THAT CORRECT?
A. THERE HAVE BEEN.
Q. BUT THESE PROTOCOLS ALLOW FOR INDIVIDUAL PHYSICIANS TO TAILOR THE PROCEDURE TO THE INDIVIDUAL PATIENT; IS THAT RIGHT?
A. YES.
Q. FOR EXAMPLE, A PHYSICIAN COULD OPT TO PRETREAT THE CERVIX OR NOT?
A. YES.
Q. OR THEY CAN ADD LAMINARIA IF THEY FOUND THEY WEREN'T GETTING ENOUGH DILATION; IS THAT CORRECT?
A. YES.
Q. OR THEY COULD ADD A DOSE OF A DIFFERENT KIND OF AGENT?

A. YES.
Q. AND YOU WOULD NOT SUPPORT HAVING PROTOCOLS THAT ARE SO STRICT THAT THE PHYSICIAN IS NOT ABLE TO MAKE THESE SORT OF ADJUSTMENTS, WOULD YOU?
A. NO.
Q. THAT IS BECAUSE YOU BELIEVE IT IS BEST TO LEAVE THOSE SORTS OF DECISIONS TO THE PHYSICIAN'S JUDGMENT; IS THAT RIGHT?
A. YES, I DO.
Q. AND WOULD YOU AGREE EVEN IN THE ABSENCE OF A CONTRAINDICATION THE EXPERIENCE OF UNDERGOING AN INDUCTION ABORTION VERSUS UNDERGOING A D&E PROCEDURE WOULD BE QUITE DIFFERENT FOR SOME WOMEN?
A. YES.
Q. AND SOME WOMEN WOULD FIND SURGERY MORE PREFERABLE TO LABOR INDUCTION; WOULD THEY NOT?
A. SOME MAY.
Q. AND WOULD YOU AGREE THAT SOME OF THE CONSIDERATIONS A WOMAN MIGHT GIVE TO HER CHOICE OF ABORTION PROCEDURE ARE COST, CONVENIENCE AND COMPASSION?
A. THEY MAY BE.
Q. AND YOU BELIEVE WITH FULLY INFORMED CONSENT WOMEN SHOULD RETAIN DISCRETION ABOUT WHETHER OR NOT TO HAVE A D&E OR AN INDUCTION; IS THAT CORRECT?
A. THEY SHOULD BE NOTIFIED OF THE POTENTIAL RISKS AND BENEFITS, YES.

Q. BUT THEN THEY SHOULD BE ABLE TO RETAIN DISCRETION ABOUT WHICH THEY CHOOSE; IS THAT CORRECT?
A. IF THEY ARE ABLE TO DO SO, YES.
Q. AND WHY WOULD THEY NOT BE ABLE TO DO SO?
A. WELL, IF A WOMAN IS, FOR EXAMPLE, VERY SICK AND MAY BE ALMOST COMATOSE, IT IS GOING TO BE THE DOCTOR'S JUDGMENT WHAT THE BEST THING TO DO FOR THE PATIENT AT THE TIME IS.
Q. UNDERSTOOD. IF A WOMAN IS CONSCIOUS AND CAN UNDERSTAND AND MAKE HER OWN DECISION --
A. YES.
Q. -- IT IS LEFT TO HER JUDGMENT, RIGHT?
A. YES.
Q. AND YOU WOULDN'T SUPPORT A LAW THAT REQUIRED EVERY WOMAN WHO HAD AN ABORTION AFTER 20 WEEKS TO HAVE AN INDUCTION INSTEAD OF A D&E, WOULD YOU?
A. NO.
Q. AND THAT'S BECAUSE YOU BELIEVE AN INDIVIDUAL PATIENT, ANY INDIVIDUAL PATIENT MAY NOT BE AN APPROPRIATE CANDIDATE FOR ONE KIND OF PROCEDURE VERSUS THE OTHER, AND SUCH A LAW WOULD MAKE IT DIFFICULT TO FIGURE OUT WHAT WOULD BE BEST FOR THOSE WOMEN; IS THAT RIGHT?
A. COULD YOU RESTATE THE QUESTION, PLEASE?
Q. SURE. THE REASON YOU WOULDN'T SUPPORT SUCH A LAW IS BECAUSE YOU BELIEVE THAT FOR ANY INDIVIDUAL PATIENT ONE PROCEDURE MIGHT BE BETTER THAN THE OTHER; IS THAT CORRECT?

A. YES.
Q. YOU'VE OFFERED SEVERAL OPINIONS TODAY ABOUT INTACT D&E OR I THINK YOU CALLED IT "D&X." IS IT OKAY IF I USE THE TERM "INTACT D&E"? DO YOU UNDERSTAND THAT TO BE THE SAME THING?
A. YOUR HONOR, I DON'T KNOW IF I AM ALLOWED TO DO THAT.
Q. DO YOU UNDERSTAND IT?
THE COURT: YOU CAN USE WHATEVER TERM YOU WISH. WE NEED TO MAKE SURE THAT YOU UNDERSTAND THAT SHE'S TALKING ABOUT WHAT YOU WOULD REFER TO AS D&X.
THE WITNESS: I UNDERSTAND, YES.
BY MS. KRASNOFF:
Q. SO IF I USE "INTACT D&E," YOU WILL UNDERSTAND WHAT I AM SAYING?
A. YES.
Q. OKAY. YOU WOULD AGREE THERE IS NO PARTICULAR GESTATIONAL AGE IN WHICH INTACT D&E IS EXCLUSIVELY PERFORMED, WOULD YOU NOT?
A. AS I UNDERSTAND IT, NO, IT IS NOT BASED ON GESTATIONAL AGE.
Q. AND YOU HAVE OFFERED THREE SPECIFIC OPINIONS TODAY ABOUT INTACT D&E. AND I WOULD LIKE TO TAKE THEM ONE AT A TIME.
FIRST, YOU TESTIFIED THAT YOU KNOW OF NO CIRCUMSTANCE IN WHICH AN INTACT D&E IS MEDICALLY NECESSARY TO TREAT A WOMAN WITH MEDICAL PROBLEMS; IS THAT CORRECT?
A. YES.
Q. BUT YOU WOULD AGREE, WOULD YOU NOT, THAT THE PROCEDURE

BEING NECESSARY IS NOT THE SAME THING AS SAYING THAT IT IS NOT A SAFE PROCEDURE; IS THAT CORRECT?

A. CORRECT.

Q. AND YOU TESTIFIED IN THE CASE OF A MATERNAL HEALTH PROBLEM, IT IS NEVER NECESSARY TO TAKE A DESTRUCTIVE ACT AGAINST THE FETUS; IS THAT CORRECT?

A. COULD YOU RESTATE THAT, PLEASE?

Q. I BELIEVE YOUR TESTIMONY WAS THAT IN PERFORMING A TERMINATION OF PREGNANCY WHEN THE WOMAN HAS A MATERNAL HEALTH PROBLEM, IT IS NEVER NECESSARY TO TAKE A DESTRUCTIVE ACT AGAINST THE FETUS?

A. THAT IS CORRECT.

Q. BUT YOU WOULD AGREE WITH ME THAT REGARDLESS OF HOW THE ABORTION IS PERFORMED, IF THE ABORTION IS DONE PRIOR TO FETAL VIABILITY THE FETUS WILL DIE AS A RESULT OF THE ABORTION?

A. YES, THAT IS CALLED A SECONDARY EFFECT.

Q. AND WOULD YOU AGREE THAT PRIOR TO FETAL VIABILITY A WOMAN SHOULD NOT BE REQUIRED TO CHOOSE A NONDESTRUCTIVE ABORTION METHOD THAT CARRIES GREATER HEALTH RISKS OVER A DESTRUCTIVE ABORTION METHOD THAT IS SAFER?

A. WHAT DO YOU MEAN BY "REQUIRED"? I AM NOT UNDERSTANDING.

Q. FORCED.

A. LEGALLY REQUIRED?

Q. YES.

A. COULD YOU RESTATE IT WITH A "LEGALLY REQUIRED" IN THERE? I

AM SORRY.

Q. SURE. IT IS A HYPOTHETICAL.

A. OH.

Q. IF THERE ARE TWO ABORTION METHODS, ONE WAS A NONDESTRUCTIVE METHOD THAT HAD GREATER HEALTH RISKS, AND ONE WAS A DESTRUCTIVE METHOD THAT IS SAFER --

A. OKAY.

Q. -- WOULD YOU SUPPORT REQUIRING A WOMAN TO HAVE THE LESS SAFE METHOD PRIOR TO FETAL VIABILITY?

A. NO.

Q. AND YOU YOURSELF DO NOT TAKE CARE OF SOME OF THE MOST SICK PREGNANT WOMEN AT THE UNIVERSITY OF MICHIGAN; IS THAT RIGHT?

A. I TAKE CARE OF SOME OF THEM, BUT NOT ALL OF THEM.

Q. SOME OF THEM ARE TAKEN CARE OF BY THE MATERNAL FETAL MEDICINE SPECIALIST; IS THAT RIGHT?

A. YES.

Q. AND YOU ARE NOT TRAINED IN MATERNAL FETAL MEDICINE; IS THAT RIGHT?

A. YES.

Q. AND, DR. SHADIGIAN, WHO IS THE CHAIR OF YOUR DEPARTMENT AT THE UNIVERSITY OF MICHIGAN?

A. HIS NAME IS DR. TIMOTHY R.B. JOHNSON.

Q. AND HE IS A SPECIALIST IN MATERNAL FETAL MEDICINE; IS HE NOT?

A. YES, HE IS.

Q. AND YOU RESPECT DR. JOHNSON AS A PHYSICIAN, DON'T YOU?
A. YES, I DO.
Q. AND YOU ARE ALSO AWARE THAT DR. JOHNSON IS A PLAINTIFF IN THE CASE PENDING IN NEW YORK WHICH CHALLENGES THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003, ARE YOU NOT?
A. I AM AWARE OF THAT.
Q. IN FACT, YOU HAVE REVIEWED HIS EXPERT REPORT, HAVE YOU NOT?
A. I BELIEVE I HAVE REVIEWED PORTIONS OF IT.
Q. WELL, I AM GOING TO SHOW YOU YOUR DEPOSITION, IF THAT IS OKAY WITH YOU. COULD I ASK YOU TO TURN TO PAGE 68?
MS. CLARK: I AM SORRY. WHAT PAGE?
MS. KRASNOFF: SIXTY-EIGHT. AND I BELIEVE IT IS LINES -- I AM ON THE WRONG PAGE -- 16 TO 17.
BY MS. KRASNOFF:
Q. DOES THAT REFRESH YOUR RECOLLECTION WHETHER OR NOT YOU HAVE REVIEWED DR. JOHNSON'S EXPERT REPORT IN THE NEW YORK CASE?
A. I DIDN'T KNOW I NEEDED REFRESHING. I DON'T UNDERSTAND THE QUESTION.
Q. THE QUESTION THAT WAS ASKED YOU AT THE DEPOSITION:
"HAVE YOU REVIEWED DR. JOHNSON'S EXPERT REPORT?"
AND YOUR RESPONSE WAS:
"YES."
TODAY YOU SAID YOU ONLY REVIEWED PARTS OF IT. HAVE YOU REVIEWED IT ALL?

A. I CAN'T RECALL HOW MUCH OF WHICH REPORT I'VE REVIEWED HOW MUCH OF. I HAVE LOOKED AT SO MANY REPORTS. I AM SURE I REVIEWED HIS REPORT. I DON'T KNOW IF I READ EVERY "A" AND "THE," BUT I REVIEWED IT.

Q. OKAY. AND ARE YOU AWARE, BASED ON THAT REVIEW, THAT IT'S DR. JOHNSON'S REMOVED?

BY MS. KRASNOFF:

Q. ARE YOU AWARE BASED ON YOUR REVIEW OF THAT REPORT THAT IT IS DR. JOHNSON'S OPINION THAT INTACT REMOVAL OF A FETUS DURING A D&E MAY BE SAFEST AND MOST APPPROPRIATE FOR TERMINATING A PREGNANCY FOR SOME WOMEN?

A. I GUESS BEFORE I WOULD AGREE TO THAT I WOULD LIKE TO SEE IT, BECAUSE I ASSUME YOU ARE READING IT FROM HIS REPORT, BUT I DON'T KNOW THAT.

Q. WELL --

A. I CAN'T REMEMBER WHAT HE SAID, EXACTLY.

Q. -- IF YOU LOOK AT PAGE 172 OF YOUR DEPOSITION, LINES FOUR THROUGH EIGHT.

A. OKAY.

Q. YOU WERE ASKED:

"DO YOU UNDERSTAND THAT IT IS HIS OPINION THAT IN SOME CIRCUMSTANCES D&X MAY BE THE SAFEST AND MOST APPROPRIATE METHOD FOR TERMINATING A PREGNANCY?"

AND YOU ANSWERED:

"IF THAT IS IN HIS REPORT, I DID READ THAT."

A. YES. I STILL STAND BEHIND THAT.

I THINK I WAS GETTING CONFUSED BETWEEN "DEPOSITION" AND "REPORT," BECAUSE HIS DEPOSITION IS VERY LONG.

Q. YES. AND I ONLY ASKED ABOUT HIS REPORT --

A. YES.

Q. -- WHICH WAS PRIOR, I BELIEVE, TO YOUR --

A. RIGHT. THAT IS WHY I WAS CONFUSED. THANK YOU.

Q. SO YOU HAVE REVIEWED THE REPORT --

A. YES. YES. I CERTAINLY HAVE.

Q. -- WHICH, UNFORTUNATELY, I DON'T HAVE TO SHOW YOU TODAY.

SO GIVEN DR. JOHNSON'S PARTICIPATION IN NEW YORK, YOU WOULD AGREE THAT RESPONSIBLE PHYSICIANS COULD REACH DIFFERENT CONCLUSIONS AS TO THE MEDICAL APPROPRIATENESS OF BANNING THE PROCEDURES COVERED BY THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003; IS THAT TRUE?

A. YES.

Q. YOU WOULD ALSO AGREE THERE IS NO CONSENSUS IN THE MEDICAL COMMUNITY THAT THE PROCEDURES BANNED BY THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003 ARE NOT SAFER FOR SOME WOMEN IN SOME CIRCUMSTANCES THAN OTHER AVAILABLE PROCEDURES?

A. THE OPINION IS DIVERSE.

Q. SO THERE IS NO CONSENSUS?

A. YES.

Q. THE SECOND OPINION YOU'VE OFFERED TODAY IS THERE IS NO

BASIS IN THE MEDICAL LITERATURE TO CONCLUDE INTACT D&E IS SAFER THAN ANY OTHER PROCEDURE; IS THAT CORRECT?

A. YES.

Q. BUT THERE IS NO BASIS IN THE LITERATURE TO PROVE IT IS ANY LESS SAFE, EITHER, IS THERE?

A. THAT IS CORRECT. THERE IS NO LITERATURE ON WHICH D&X HAS BEEN STUDIED WHATSOEVER TO BASE ANY OF THOSE THINGS.

Q. SO IT IS JUST UNSTUDIED; IS THAT CORRECT?

A. YES, IT IS UNSTUDIED.

Q. YOU THINK INTACT D&E SHOULD BE STUDIED; IS THAT CORRECT?

A. IF WE ARE GOING TO PERFORM D&X PROCEDURES ON WOMEN AND OFFER IT AS ANOTHER PROCEDURE, THEN, YES, IT SHOULD BE STUDIED.

Q. AND IN THE ABSENCE OF STUDIES, DO YOU AGREE THAT THE CLINICAL EXPERIENCE OF BOARD CERTIFIED OB/GYN'S WHO ROUTINELY PERFORM SURGICAL SECOND-TRIMESTER ABORTIONS IS OF SOME VALUE IN ASSESSING THE SAFETY OF A SECOND-TRIMESTER SURGICAL ABORTION METHOD?

A. NO.

Q. SO IT IS OF NO VALUE?

A. IT'S NOT OF VALUE IN ASSESSING SAFETY IN THE SHORT OR LONG-TERM.

Q. SO THEIR OPINIONS, YOU WOULD SAY, CARRY NO VALUE AS TO THE SAFETY AT ALL OF THOSE PROCEDURES?

A. NO, I WOULD SAY THAT THERE IS -- MAY BE SOME INITIAL ANECDOTAL EVIDENCE OF THE SAFETY AT THE TIME OF THE PROCEDURE,

BUT NOT IN THE SHORT-TERM LEADING UP TO SIX WEEKS. JUST UP TO SIX WEEKS AFTER THE PROCEDURE, NOR IN THE LONG-TERM, WHICH WOULD BE GREATER THAN SIX WEEKS.

Q. WE DISCUSSED AN ARTICLE BY DAN EPNER, ENTITLED "LATE TERM ABORTION," WHICH WAS PUBLISHED IN A JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION IN AUGUST OF 1998.

DO YOU HAVE THAT HANDY UP THERE?

A. YES.

Q. THAT ARTICLE STATES, IN PART, QUOTE:

"INTACT D&X MAY MINIMIZE TRAUMA TO THE WOMAN'S UTERUS, CERVIX AND OTHER VITAL ORGANS."

YOU AGREE WITH THAT STATEMENT, DON'T YOU?

A. YES, IT MAY.

Q. AND, DR. SHADIGIAN, YOU TESTIFIED YOU THINK IT IS FEASIBLE TO PERFORM A PROSPECTIVE, RANDOMIZED TRIAL COMPARING INTACT D&E WITH OTHER ABORTION METHODS; IS THAT CORRECT?

A. YES.

Q. AND THE EXAMPLE YOU OFFERED FOR WHY THAT IS FEASIBLE IS A RECENT STUDY ON BREECH DELIVERY THAT WAS PUBLISHED IN THE LANCET IN 2000; IS THAT CORRECT?

A. YES, THAT IS ONE REASON TO CONCLUDE THAT IT COULD BE STUDIED.

Q. IS THAT THE STUDY FROM THE LANCET THAT YOU WERE REFERRING TO?

A. YES, I BELIEVE IT IS.

Q. WOULD IT HELP IF I SHOWED IT TO YOU?
A. YES.
MS. KRASNOFF: MAY I APPROACH?
THE COURT: YES.
IS THIS AN EXHIBIT?
MS. KRASNOFF: NO, IT IS NOT. AND HERE IS A COPY.
THE COURT: I ACTUALLY ALREADY HAVE A COPY. THAT IS WHAT I THOUGHT.
MS. KRASNOFF: IT IS NOT IN THE BINDER.
BY MS. KRASNOFF:
Q. IS THAT THE STUDY YOU WERE REFERRING TO?
A. YES.
Q. AND THAT STUDY INVOLVED 121 DIFFERENT CENTERS IN 26 DIFFERENT COUNTRIES, DID IT NOT?
A. YES.
Q. YOU WOULD AGREE, WOULD YOU NOT, THAT IT WOULD BE DIFFICULT TO FIND 121 DIFFERENT CENTERS IN 26 DIFFERENT COUNTRIES WHERE SECOND-TRIMESTER CERVICAL ABORTION IS WIDELY AVAILABLE?
A. NO.
Q. YOU BELIEVE THAT SECOND-TRIMESTER ABORTION IS WIDELY AVAILABLE IN 121 DIFFERENT CENTERS IN 26 DIFFERENT COUNTRIES?
A. YES.
Q. WELL, DO YOU THINK THAT CESAREAN SECTION AND VAGINAL DELIVERIES, WHICH WERE COMPARED IN THE LANCET STUDY ARE MUCH MORE COMMON EVENTS AROUND THE WORLD THAN SECOND-TRIMESTER

SURGICAL ABORTIONS?
A. YOU CAN LOOK AT THE DATA TO DETERMINE THAT.
Q. DO YOU HAVE AN OPINION SITTING HERE TODAY ABOUT THAT?
A. I COULDN'T SAY ONE WAY OR ANOTHER WHAT THE ACTUAL INCIDENCE RATE IS IN DIFFERENT COUNTRIES AROUND D&E WITHOUT LOOKING AT THAT PARTICULAR COUNTRY. BUT, IN FACT, IT IS NOT BANNED IN MANY, MANY COUNTRIES AROUND THE WORLD.
Q. WELL, LET'S JUST TAKE THIS COUNTRY WHERE IT IS NOT BANNED.
DO YOU BELIEVE THAT THERE ARE MORE ABORTIONS IN THIS COUNTRY THAN DELIVERIES?
A. NO.
Q. AND YOU WOULD AGREE THAT BOTH CESAREAN SECTION AND VAGINAL DELIVERY, WHICH ARE THE STUDY OF THIS ARTICLE, ARE BOTH STILL BEING DONE TODAY IN THE INDICATIONS OF BREECH PRESENTATION; IS THAT CORRECT?
A. I WOULD SAY THAT BASED ON THIS STUDY THE VAGINAL BREECH IS VERY, VERY RESTRICTED IN THIS COUNTRY NOW, BASED ON THIS STUDY.
Q. BUT IT IS SOMETIMES USED, IS IT NOT?
A. YES.
Q. AND YOU WOULDN'T SUPPORT BANNING ITS USE, WOULD YOU?
A. NO.
Q. DR. SHADIGIAN, YOU YOURSELF HAVE NEVER DESIGNED OR BEEN THE PRINCIPAL INVESTIGATOR OF A PROSPECTIVE RANDOMIZED TRIAL, HAVE YOU?
A. I HAVE NOT HAD ONE FUNDED AND EXECUTED, BUT I HAVE PLANNED

THEM.
Q. SO THERE IS NO PUBLISHED STUDIES OF WHICH YOU HAVE BEEN THE PRINCIPAL INVESTIGATOR IN A PROSPECTIVE RANDOMIZED TRIAL; IS THAT CORRECT?
A. CORRECT.
Q. AND YOU HAVE NEVER DONE ANY CLINICAL RESEARCH YOURSELF RELATED TO ABORTION PROCEDURES, HAVE YOU?
A. I DON'T UNDERSTAND THE QUESTION.
Q. ANY RESEARCH BASED ON PATIENTS WHICH YOU SAW RELATED TO SPECIFICALLY ABORTION PROCEDURES?
A. ACTUALLY, SOME OF MY PATIENTS HAVE BEEN ENROLLED IN STUDIES LOOKING AT ABORTION PROCEDURES.
Q. AND WERE YOU YOURSELF INVOLVED IN COMPLETING THAT STUDY?
A. I WAS NOT THE PRINCIPAL INVESTIGATOR, NO.
Q. THE THIRD OPINION YOU OFFERED TODAY IS THAT THERE IS NO SOUND BASIS ON WHICH TO SAY INTACT D&E IS A SAFER ABORTION PROCEDURE THAN INDUCTION; IS THAT CORRECT?
A. YES.
Q. IN FACT, YOU TESTIFIED YOU BELIEVE THAT INDUCTION IS SAFER THAN INTACT D&E; IS THAT RIGHT?
A. YES, IF YOU USED D&E AS A COMPARISON, SINCE WE DON'T HAVE ANY DATA ON D&X.
Q. WELL, THAT IS EXACTLY MY NEXT QUESTION. YOU HOLD THAT OPINION EVEN THOUGH THERE ARE NO PUBLISHED PEER REVIEWED MEDICAL STUDIES THAT COMPARE INTACT D&E TO INDUCTION; IS THAT

RIGHT?

A. THAT IS CORRECT.

Q. AND, THEREFORE, YOU WOULD AGREE YOUR OPINION ABOUT THAT IS OF THE SAME ILK AS THE EXPERTS WHO DISAGREE WITH YOU; WOULD YOU NOT?

A. YES, IT IS BASED ON THE SAME DATA.

Q. AND YOUR CONCLUSION THAT INDUCTION IS SAFER IS BECAUSE YOU BELIEVE AFTER 20 WEEKS INDUCTION IS SAFER THAN D&E; IS THAT RIGHT?

A. MINE IS BASED ON MEDICAL LITERATURE, MY OPINION.

Q. AND THE MEDICAL LITERATURE THAT IS AVAILABLE IS ABOUT D&E; IS THAT RIGHT?

A. YES, IT IS.

Q. SO, IT'S FAIR TO SAY THAT YOUR CONCLUSION THAT INDUCTION IS SAFER IS BECAUSE YOU BELIEVE THAT AFTER 20 WEEKS D&E IS SAFER THAN INDUCTION; IS THAT CORRECT?

A. NO.

Q. WHY NOT?

A. YOU SAID IT BACKWARDS.

Q. OH, BECAUSE I SAID IT BACKWARDS? LET'S TRY IT AGAIN, THEN.

IS IT FAIR TO SAY THAT YOUR CONCLUSION THAT INDUCTION IS SAFER IS BECAUSE THAT YOU BELIEVE AFTER 20 WEEKS INDUCTION IS SAFER THAN D&E ABORTIONS; IS THAT CORRECT?

A. YES.

Q. IN FACT, YOU DON'T FIND INTACT D&E ANY MORE OBJECTIONABLE

THAN D&E, DO YOU?

A. WHAT DO YOU MEAN BY "OBJECTIONABLE"?

Q. IF YOU COULD PLEASE TURN TO YOUR DEPOSITION, PAGE 242, LINES 18 TO 20.

YOU WERE ASKED:

"DO YOU FIND D&X OR PARTIAL-BIRTH ABORTIONS MORE OBJECTIONABLE THAN D&E?"

AND YOU RESPONDED:

"NO."

A. YES. I DID SAY THAT.

Q. DO YOU BELIEVE THAT?

A. YES.

Q. NOW, MS. CLARK ASKED YOU ABOUT SEVERAL ARTICLES IN SUPPORT OF YOUR OPINION ABOUT THE SAFETY OF INDUCTION VERSUS D&E. AND ONE WAS THE EPNER ARTICLE WE ALREADY DISCUSSED. WOULD YOU AGREE THAT THE CONCLUSION REACHED BY THE AUTHORS OF THAT ARTICLE WAS ACTUALLY THAT MORTALITY RATES FOR D&E AND INDUCTION AT OR AFTER 21 WEEKS IS COMPARABLE?

A. THAT'S THEIR CONCLUSION THAT THEY DREW BASED ON THE DATA IN THAT TABLE.

Q. AND WILL YOU AGREE IN THE GRIMES STUDY THAT WE LOOKED AT IT SAYS -- I BELIEVE YOU ACTUALLY READ THIS -- THE MORTALITY RATE IS STATISTICALLY INDISTINGUISHABLE BETWEEN D&E AND INDUCTION AT THAT GESTATIONAL AGE?

A. THEY SAID, ACTUALLY, AT 16 WEEKS AND GREATER, IN THE GRIMES

STUDY.
Q. AND GIVEN THE SMALL NUMBER OF WOMEN HAVING ABORTIONS AT 21 WEEKS OF GESTATION OR GREATER, CAN YOU STATE WITH ANY CERTAINTY THAT THE DIFFERENCE IN THE MORTALITY RATES THAT ARE STATED IN TABLE 3 OF THE EPNER ARTICLE ARE OF STATISTICAL SIGNIFICANCE?
THE COURT: WHERE IS THAT IN THE --
MS. KRASNOFF: I DON'T HAVE AN EXHIBIT NUMBER ON IT.
THE COURT: IT WAS PREVIOUSLY REFERRED TO.
MS. KRASNOFF: IT'S CALLED "LATE TERM ABORTION."
MS. CLARK: IT'S DEFENDANT'S LT A-15.
MS. KRASNOFF: SHE REFERRED TO TABLE 3, I BELIEVE. OR MAYBE NOT.
I AM SORRY, IT'S TABLE 4. THAT'S ON PAGE 727, WHICH I BELIEVE SHOWS THAT MORTALITY RATE AT GREATER THAN 21 WEEKS IS 11.9 FOR DILATION AND EVACUATION, AND 10.3 FOR LABOR INDUCTION.
BY MS. KRASNOFF:
Q. AND BASED ON THE FACT THAT THE AUTHORS INCLUDE THAT THOSE RATES ARE COMPARABLE, I AM ASKING YOU WITH ANY CERTAINTY YOU CAN STATE THAT THAT IS A STATISTICALLY SIGNIFICANT DIFFERENCE.
A. WE COULD ACTUALLY DO THE NUMBERS AND FIND THAT IT IS BECAUSE THE N IS QUITE LARGE. THE NUMBER OF WOMEN IN THE STUDY IS NOT INSIGNIFICANT. IT IS 175,395. AND I BELIEVE IF YOU ACTUALLY DID THE T TEST IT WOULD BE STATISTICALLY SIGNIFICANT. HOWEVER, IN THIS STUDY THEY DID NOT DO THAT T TEST.
Q. AND YOU YOURSELF ARE NOT AN EPIDEMIOLOGIST, ARE YOU?

A. THAT IS CORRECT.
Q. YOU HAVE NO FORMAL TRAINING IN EPIDEMIOLOGY?
A. I HAVE COURSES I HAVE TAKEN, AND I HAVE TAKEN POSTGRADUATE COURSES, IN FACT, BY DR. GRIMES ON EPIDEMIOLOGY.
Q. DO YOU HAVE A MASTER'S DEGREE OR ANY OTHER DEGREE IN EPIDEMIOLOGY?
A. NO, I DO NOT.
Q. DO YOU HAVE AN APPOINTMENT IN TEACHING EPIDEMIOLOGY AT THE UNIVERSITY OF MICHIGAN?
A. NO, I DO NOT.
Q. DESPITE YOUR VIEW THAT INDUCTIONS ARE SAFER THAN D&E'S, WOULD YOU ALSO AGREE THAT THE VAST MAJORITY OF ABORTIONS PERFORMED IN THE UNITED STATES AFTER 16 WEEKS ARE SURGICAL ABORTIONS?
A. THAT IS CORRECT.
Q. AND WILL YOU AGREE THERE IS NO CONSENSUS IN THE MEDICAL COMMUNITY ABOUT WHICH PROCEDURE, D&E OR INDUCTION, IS SAFER AFTER 20 WEEKS?
A. I DON'T KNOW.
Q. DO YOU THINK THAT SOME REASONABLE PHYSICIANS MAY BELIEVE THAT THERE ARE COMPARABLE SAFETY?
A. THERE MAY BE.
Q. ONE OF THE SPECIFIC CONCERNS YOU EXPRESSED ABOUT THE SAFETY OF INTACT D&E IS ABOUT CERVICAL TRAUMA; IS THAT CORRECT?
A. YES.

Q. AND THOSE CONCERNS RELATE IN PART TO THE USE OF LAMINARIA; IS THAT CORRECT?
A. YES.
Q. IN PARTICULAR, YOU TESTIFIED ABOUT THE RISK OF INFECTION AND OF TRAUMA TO THE CERVIX FROM INSERTING THE LAMINARIA; IS THAT CORRECT?
A. YES.
Q. AND THOSE RISKS ARE PRESENT AT ANY TIME LAMINARIA ARE INSERTED, AREN'T THEY?
A. YES, THEY ARE.
Q. AND THOSE RISKS ARE PRESENT IN ANY D&E ABORTION, AS WELL AS ANY INTACT D&E; IS THAT CORRECT?
A. YES, IF LAMINARIA ARE USED, THEN IT WOULD BE.
Q. SO YOUR OPINIONS ABOUT THAT TRAUMA TO THE CERVIX FROM LAMINARIA WOULD APPLY EQUALLY TO D&E PROCEDURES WHERE LAMINARIA ARE USED AS THEY DO TO INTACT D&E; IS THAT CORRECT?
A. NO.
Q. WHY NOT?
A. BECAUSE THE INTACT D&E ACTUALLY USES MORE LAMINARIA OVER TWO DAYS, AND GENERALLY FOR REGULAR D&E IT IS JUST USED FOR ONE DAY. AND PUT IT IN ONE DAY, AND THEN THE PROCEDURE IS DONE ON THE SECOND DAY.
Q. AND THAT IS ONLY BASED ON THOSE FEW ARTICLES THAT YOU READ?
A. NO, IT IS BASED ON MY PRACTICE, TOO.
Q. WELL, YOU HAVE NEVER PERFORMED AN INTACT D&E, HAVE YOU?

A. NO.
Q. AND YOU HAVE NEVER TALKED TO ANY PHYSICIAN WHO HAS PERFORMED AN INTACT D&E, HAVE YOU?
A. NO, BUT YOU ASKED ME ABOUT D&E VERSUS INTACT D&E, UNLESS I DIDN'T UNDERSTAND YOU.
Q. RIGHT. AND MY POINT IS ONLY THAT YOUR UNDERSTANDING OF THE DILATION THAT OCCURS IN AN INTACT D&E IS ONLY BASED ON THE ACOG STATEMENT, THE HASKELL PAPER, WHICH YOU READ, THE MCMAHON PAPER, WHICH YOU READ. AND THERE WAS A FOURTH: SOME OF THE TESTIMONY, I BELIEVE, IN THIS CASE; IS THAT CORRECT?
A. YES, IT'S BASED ON THOSE THINGS.
Q. THE OTHER CONCERN THAT YOU --
THE COURT: EXCUSE ME. COULD I ASK A FOLLOW-UP QUESTION SO I MAKE SURE THAT'S YOUR OPINION?
WOULD YOUR OPINION BE THE SAME ABOUT RISK OF TRAUMA TO THE CERVIX IF THE INTACT PROCEDURE WAS NOT PRECEDED BY SERIAL LAMINARIA, BUT JUST BY ONE SETTING OF LAMINARIA?
THE WITNESS: I WOULD SAY THAT THOSE ARE TWO DIFFERENT KINDS OF THINGS TO COMPARE, BECAUSE THE SERIAL LAMINARIA ACTUALLY DILATED THE CERVIX TO A GREAT MUCH GREATER DEGREE OVER TWO DAYS THAN A SINGLE SET OF LAMINARIA.
THE COURT: SO THAT WOULD CHANGE YOUR OPINION?
THE WITNESS: YES, IT WOULD.
BY MS. KRASNOFF:
Q. AND TO FOLLOW THAT UP, IF YOU THOUGHT THERE WAS ONLY ONE

SET OF LAMINARIA, THAT WOULD ME THAT YOU THOUGHT IT WAS POTENTIALLY SAFER THAN IF THERE WAS SERIAL LAMINARIA; IS THAT CORRECT?

A. IT WOULD DEPEND ON HOW DILATED AND HOW LAMINARIA THERE WOULD BE. I AM TALKING ABOUT AVERAGES, AS I UNDERSTAND IT.

Q. THE OTHER CONCERN YOU EXPRESSED WAS ABOUT PULLING FETAL PARTS THROUGH THE CERVICAL OS. THAT WOULD APPLY TO A D&E, WOULD IT NOT?

A. SPECIFICALLY, I WAS TALKING ABOUT THE HEAD BEING A BIGGER PART THAN THE OTHER PARTS BEING PULLED THROUGH.

Q. BUT THE HEAD HAS TO BE PULLED THROUGH IN A D&E, DOESN'T IT?

A. YES, BUT IT IS DISARTICULATED AND ACTUALLY TAKEN OUT IN PIECES, WHICH IS NOT TRUE FOR A D&X.

Q. AND IF IN A D&E THE HEAD WERE NOT TAKEN OUT IN PIECES BUT WERE JUST REDUCED WITH FORCEPS AND BROUGHT THROUGH, THAT WOULD BE THE SAME; IS THAT CORRECT?

A. THE SAME AS WHAT?

Q. AS IN AN INTACT D&E?

A. THAT IS THE DESCRIPTION OF THE INTACT D&E, YES.

Q. NOW, WE TALKED SOME --

THE COURT: I AM NOT SURE. IT WASN'T CLEAR ENOUGH FOR ME, EXACTLY --

MS. KRASNOFF: LET'S TRY IT AGAIN, THEN.

THE WITNESS: YOUR HONOR, MAY I ASK COULD WE HAVE ANOTHER BREAK? OR ARE WE NOT GOING TO --

THE COURT: YES, WE CAN HAVE ANOTHER BREAK.
AND WHY DON'T YOU REFORMULATE YOUR QUESTION --
MS. KRASNOFF: AND THEN, WE WILL BREAK?
THE COURT: NO, WE WILL TAKE IT AFTER THE BREAK.
MS. KRASNOFF: OH, OKAY. GREAT. I UNDERSTAND.
THE COURT: WE WILL TAKE A BREAK NOW.
MS. KRASNOFF: THE LAST QUESTION.
THE COURT: THE WITNESS NEEDS A BREAK. WE WILL TAKE A BREAK. 15 MINUTES.
THE WITNESS: THANK YOU, YOUR HONOR.
THE COURT: YOU ARE WELCOME.
(RECESS TAKEN AT 11:50 A.M.)
(PROCEEDINGS RESUMED AT 12:05 P.M.)
THE COURT: ALL RIGHT. NOW YOU WERE GOING TO --
MS. KRASNOFF: I WILL TRY THIS AGAIN.
BY MS. KRASNOFF:
Q. LET'S TRY AGAIN.
ONE OF THE CONCERNS YOU EXPRESSED ABOUT INTACT D&E WAS ABOUT COLLAPSING AND PULLING THE FETAL SKULL THROUGH THE CERVICAL OS; IS THAT CORRECT?
A. YES.
Q. AND IF I REPRESENTED TO YOU THAT IN A D&E THE FETUS WAS DISARTICULATED UP TO THE FETAL SKULL BUT THEN FORCEPS WERE INSERTED INTO THE UTERUS, THE FETAL SKULL WAS COLLAPSED AND REMOVED IN ONE PASS, WOULD THAT PRESENT THE SAME RISK THAT YOU

ARE SPEAKING OF?

A. AS COMPARED TO AN INTACT?

Q. YES.

A. YES.

Q. THERE HAS BEEN A LOT OF BACK AND FORTH ABOUT THIS, BUT I WOULD LIKE TO ASK ABOUT YOUR REVIEW ARTICLE.

THAT ARTICLE DOES NOT SEPARATE OUT WHAT METHOD OF ABORTION THE WOMEN HAD; IS THAT CORRECT?

A. THE INDIVIDUAL ARTICLES MAY HAVE SEPARATED FROM FIRST AND SECOND TRIMESTER, BUT THERE WEREN'T ENOUGH OF THEM TO BE ABLE TO DRAW CONCLUSIONS BY SEPARATING OUT BY TRIMESTER.

Q. SO YOUR REVIEW ARTICLE DOESN'T SEPARATE THEM OUT, DOES IT?

A. CORRECT.

Q. YOUR REVIEW ARTICLE DOESN'T LOOK AT THE GESTATIONAL AGE OF THE FETUS AT THE TIME OF THE ABORTION, DOES IT?

A. NOT SPECIFICALLY.

Q. WELL, IN FACT, WHEN IT TALKS ABOUT SAY, FOR EXAMPLE, PRE-TERM BIRTH, THERE IS NO MENTION OF METHOD OF PROCEDURE OR GESTATIONAL AGE, IS THERE, IN THE REVIEW?

A. NOT IN MY PAPER.

Q. AND SO THAT CONCLUSION, THE ARTICLE'S CONCLUSION APPLY TO ALL METHODS OF ABORTION AT ALL GESTATIONAL AGES; IS THAT CORRECT?

A. I WOULD SAY YOU CAN'T GENERALIZE TO ALL ABORTION METHODS AT ALL GESTATIONAL AGES NECESSARILY, BUT THE WHOLE GIST OF IT IS

THAT WE NEED TO BE AWARE THAT THERE ARE LONG-TERM COMPLICATIONS. AND, IN FACT, IT WOULD BE NICE TO HAVE BETTER STUDIES SO WE CAN JUST, AS YOU IMPLIED, WE CAN LOOK AT FIRST-TRIMESTER VERSUS SECOND-TRIMESTER AND WHAT ACTUAL METHOD WAS USED.

Q. BUT YOU DIDN'T DO THAT?

A. I DID NOT DO THAT.

Q. THE CONCLUSIONS IN YOUR ARTICLE APPLY THE WAY IT WAS WRITTEN WITH EQUAL FORCE TO ALL ABORTIONS AT ALL GESTATIONAL AGES?

A. I WOULD SAY YES.

Q. AND, IN FACT, THE MAJORITY OF THE ABORTIONS IN THE STUDIES THAT FORM THE BASIS OF YOUR REVIEW ARTICLE, THOSE LOOK AT FIRST-TRIMESTER ABORTIONS, DON'T THEY?

A. THEY LOOK AT A MIX, BUT MOSTLY FIRST-TRIMESTER JUST BECAUSE IT IS MORE COMMON.

Q. YOUR ARTICLE DID NOT LOOK SPECIFICALLY AT CERVICAL INCOMPETENCE, BUT RATHER LOOKED AT PRE-TERM BIRTH; IS THAT CORRECT?

A. YES. IT LOOKED AT PRE-TERM BIRTH AND LOW BIRTH WEIGHT WHICH IS A CORRELATE.

Q. YOU TESTIFIED ABOUT THIS ON DIRECT, BUT YOU AGREE THAT PRE-TERM BIRTH AND CERVICAL INCOMPETENCE ARE NOT THE SAME THING; IS THAT CORRECT?

A. THAT'S CORRECT.

Q. THERE ARE MANY RISK FACTORS FOR PRE-TERM BIRTH BESIDES CERVICAL INCOMPETENCE; ISN'T THAT CORRECT?
A. YES.
Q. SOME WOMEN HAVE PRE-TERM BIRTHS EVEN IF THERE ARE NO RISK FACTORS PRESENT, DON'T THEY?
A. YES.
Q. YOUR ARTICLE FOUND AN ASSOCIATION BETWEEN ABORTION AND PRE-TERM BIRTH, BUT AN ASSOCIATION IS NOT THE SAME THING AS A CAUSE; IS THAT CORRECT?
A. YES, THAT IS CORRECT.
Q. AND BECAUSE MOST OF THE ABORTIONS THAT WERE IN THE STUDIES THAT MAKE UP YOUR REVIEW ARTICLE WERE FIRST-TRIMESTER ABORTIONS, IT'S MOST LIKELY THAT THE DILATION WOULD HAVE BEEN MECHANICAL DILATION AND NOT OSMOTIC DILATION; IS THAT CORRECT?
A. YES.
Q. YOU, YOURSELF, WHEN YOU PERFORM A D&C PROCEDURE OR A VACUUM ASPIRATION TO REMOVE A DEAD FETUS --
THE REPORTER: I'M SORRY.
BY MS. KRASNOFF:
Q. YOU, YOURSELF, IF YOU PERFORM A D&C PROCEDURE OR A VACUUM ASPIRATION TO REMOVE A DEAD FETUS, YOU, YOURSELF, USE THE MECHANICAL DILATION; IS THAT CORRECT?
A. YES, I DO.
Q. ISN'T PURELY HYPOTHETICAL TO SAY, BASED ON THE STUDIES THAT ARE IN YOUR ARTICLE, THAT DILATION OVER A PERIOD OF HOURS OR

DAYS WITH OSMOTIC DILATORS IS ANY MORE DANGEROUS THAN THE DILATION FROM AN INDUCTION?

A. NO.

Q. IN FACT, AT YOUR DEPOSITION YOU TESTIFIED THAT YOUR OPINION ABOUT TRAUMA TO THE CERVIX IS BASED ON YOUR INTUITION, YOUR UNDERSTANDING OF INDUCTION PROCEDURES, AND YOUR UNDERSTANDING OF MATERNAL PHYSIOLOGY; IS THAT CORRECT?

A. I DON'T RECALL USING THE WORD "INTUITION," BUT IF YOU TELL ME IT IS IN THERE --

Q. WE CAN TAKE A LOOK.

IT IS PAGE 199, LINE 25.

199, LINE 25, THE QUESTION WAS:

"AND SO YOUR OPINION ON THAT," AND "THAT" BEING ABOUT THE DILATION IN COMPARISON TO AN INDUCTION VERSUS INTACT AN D&E, "YOUR OPINION ON THAT IS INTUITIVE BASED ON YOUR UNDERSTANDING OF INDUCTION PROCEDURES AND YOUR UNDERSTANDING OF THE D&X PROCEDURE?

AND YOUR ANSWER WAS:

"YES, AND MY UNDERSTANDING OF MATERNAL PHYSIOLOGY."

SO, IS IT CORRECT THAT YOUR OPINION ABOUT TRAUMA TO THE CERVIX IN AN INDUCTION VERSUS AN INTACT D&E IS BASED ON INTUITION, YOUR UNDERSTANDING OF INDUCTION PROCEDURES, AND YOUR UNDERSTANDING OF MATERNAL PHYSIOLOGY?

A. YES.

Q. AND ARE THOSE THINGS, INTUITION, YOUR UNDERSTANDING OF THE PROCEDURES, AND YOUR UNDERSTANDING OF MATERNAL PHYSIOLOGY, ARE THOSE THINGS SUFFICIENT BASES UPON WHICH YOU CAN OFFER YOUR OPINIONS?

A. JUST AS MUCH AS ABORTION PROVIDERS CAN, YES.

Q. IF A WOMAN DOES NOT DESIRE TO HAVE ANOTHER CHILD ARE EITHER CERVICAL INCOMPETENCE OR PRE-TERM BIRTH CONCERNS FOR HER?

A. YES.

Q. WHY IS THAT?

A. BECAUSE WOMEN CHANGE THEIR MINDS.

Q. IF THE WOMAN DOES NOT CHANGE HER MIND AND SHE KNOWS SHE DOESN'T WANT TO HAVE ANOTHER CHILD, ARE THEY CONCERNS?

A. IF SHE DOESN'T CHANGE HER MIND IT WOULDN'T BE, BUT WE KNOW HOW MANY TIMES THAT CAN HAPPEN.

Q. LET'S JUST ASK ABOUT -- IF A WOMAN DOES NOT HAVE ANOTHER CHILD, ARE CERVICAL INCOMPETENCE OR PRE-TERM BIRTH CONCERNS FOR HER?

A. NO.

Q. YOU TESTIFIED THAT ONE OF THE BASES FOR YOUR BELIEF THAT INDUCTION IS SUPERIOR IS THAT AFTER 20 WEEKS OF PREGNANCY THAT'S WHAT IS PERFORMED AT THE UNIVERSITY OF MICHIGAN; IS THAT CORRECT?

A. THAT'S ONE OF THE BASES, YES.

Q. AND YOUR OPINION IS BASED SOLELY ON A CONVERSATION YOU HAD WITH THE CHAIR OF MATERNAL FETAL MEDICINE; IS THAT RIGHT?

A. NO.
Q. WHO ELSE DID YOU SPEAK WITH?
A. NO ONE.
Q. SO, IT IS BASED ON YOUR PRACTICE AS WELL AS THAT CONVERSATION?
A. AND GOING TO THE M & M CONFERENCES EVERY WEEK, YES.
Q. YOU DIDN'T SPEAK WITH DR. JOHNSON, THE CHAIR OF YOUR DEPARTMENT, ABOUT THE ABORTION PRACTICES AT THE UNIVERSITY OF MICHIGAN IN ORDER TO PREPARE YOUR EXPERT REPORT OR OFFER THAT OPINION, DID YOU?
A. THAT IS CORRECT.
Q. NOR DID YOU ASK ANY OF THE OTHER DOCTORS AT THE UNIVERSITY OF MICHIGAN WHO PERFORM ABORTIONS WHAT GESTATIONAL AGE THEY PERFORM ABORTIONS TO, DID YOU?
A. THAT IS CORRECT.
Q. OR ANY OTHER DOCTOR AT THE UNIVERSITY AT ALL, OTHER THAN THE CHAIR OF MATERNAL FETAL MEDICINE; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. AND IF I TOLD YOU THAT DR. JOHNSON TESTIFIED IN THE NEW YORK TRIAL THAT D&E'S ARE DONE UP TO 22 WEEKS AT THE UNIVERSITY OF MICHIGAN, WOULD YOU HAVE ANY REASON TO BELIEVE THAT'S NOT TRUE?
MS. CLARK: OBJECTION, HEARSAY.
THE COURT: OVERRULED.
THE WITNESS: NO.

BY MS. KRASNOFF:
Q. SO IF I TOLD YOU THAT HE TESTIFIED TO THAT, YOU WOULD BELIEVE IT'S TRUE?
A. I WOULD BELIEVE IT MIGHT BE TRUE. HE LOOKED AT ALL THE RECORDS.
Q. SO WOULD HE HAVE A STRONGER BASIS UPON WHICH TO INCLUDE -- TO CONCLUDE TO WHAT GESTATIONAL AGE ABORTIONS ARE BEING PERFORMED AT THE UNIVERSITY OF MICHIGAN BY D&E?
A. YES.
Q. AND IF ONE OF YOUR OWN PATIENTS IS SEEKING AN ABORTION AFTER 20 WEEKS, DO YOU TELL THEM THAT D&E AND INDUCTION ARE BOTH OPTIONS AT THE UNIVERSITY OF MICHIGAN?
A. YES.
Q. IN YOUR DIRECT TESTIMONY WE TALKED ABOUT THE PICKER REPORT.
I BELIEVE THAT YOU RELY ON THAT REPORT FOR YOUR BELIEF THAT WOMEN DO NOT FOLLOW UP WITH THEIR ABORTION PROVIDERS; IS THAT CORRECT?
A. THAT IS PART OF THE BASIS OF MY OPINION, YES.
Q. AND JUST LOOKING AT THAT REPORT, THAT DOESN'T LOOK AT WHETHER THEY FOLLOWED UP WITH ANY HEALTH CARE PROVIDER; RATHER IT ONLY LOOKS IF THEY FOLLOWED UP IN THE CLINIC IN WHICH THEY HAD THE ABORTION; IS THAT CORRECT?
A. YES, THAT'S WHAT IT SAYS.
Q. AND IT ONLY IS A SURVEY OF CLINICS, IT DOESN'T INCLUDE HOSPITAL-BASED PRACTICES; IS THAT CORRECT?

A. I BELIEVE THAT IS CORRECT.
Q. IF I CAN ASK YOU TO FIND THE REPORT UP THERE.
A. I HAVE IT.
Q. IF I CAN ASK YOU TO LOOK AT PAGE 31 OF THE REPORT UNDERNEATH THE CHART.
IS IT CORRECT THAT THE REPORT ALSO CONCLUDED THAT 86 PERCENT OF WOMEN REPORTED THAT A STAFF MEMBER OFFERED TO MAKE THEM AN APPOINTMENT FOR A FOLLOW-UP VISIT?
A. WHICH FIGURE ARE YOU REFERRING TO, PLEASE?
Q. RIGHT UNDER THE CHART ON PAGE 31.
"MOST, 86 PERCENT OF PATIENTS REPORT THAT A STAFF MEMBER OFFERED TO MAKE THEM AN APPOINTMENT FOR A FOLLOW-UP VISIT"; IS THAT CORRECT?
A. I MUST BE ON THE WRONG PAGE. I'M SORRY, WHAT PAGE DID YOU ASK FOR?
MS. CLARK: I DON'T --
THE WITNESS: CAN I JUST LOOK AT YOURS?
MS. KRASNOFF: SURE. I HAVE A COPY. AM I ON THE WRONG PAGE FOR YOU, TOO, YOUR HONOR?
THE COURT: I CAN'T FIND THE EXHIBIT.
MS. KRASNOFF: LET'S START WITH THAT.
MS. CLARK: THE EXHIBIT IS LTA-42.
THE COURT: THIS ISN'T THE SAME ONE, AT LEAST THE COVER SHEET IS NOT THE SAME ONE.
MS. CLARK: LET ME HAVE ANOTHER LOOK.

MS. KRASNOFF: I GAVE HER THE NEW ONE.

MS. PARKER INFORMS ME IT IS ON PAGE 33 OF THE VERSION IN THE BINDERS AND ON PAGE 31.

THE COURT: IT'S THE FIRST COUPLE OF SHEETS, THE COVERS -- YOU CAN GIVE THIS BACK -- THAT ARE DIFFERENT. IT IS OTHERWISE THE SAME.

BY MS. KRASNOFF:

Q. DR. SHADIGIAN, I'M SORRY ABOUT THIS CONFUSION. IT IS THE TEXT IMMEDIATELY UNDER FIGURE 22 IT APPEARS IN BOTH VERSIONS OF THE DOCUMENT.

DO YOU SEE THAT IT BEGINS WITH "MOST"?

A. YES.

Q. AND THIS DOCUMENT CONCLUDED THAT MOST, OR 86 PERCENT, OF PATIENTS REPORT THAT A STAFF MEMBER OFFERED TO MAKE THEM AN APPOINTMENT FOR A FOLLOW-UP VISIT; IS THAT CORRECT?

A. YES.

Q. AND GOING ON TO THE NEXT SENTENCE, IT ALSO CONCLUDED THAT NEARLY ALL, OR 97 PERCENT, OF WOMEN SAY THEY WERE TOLD WHO TO CALL IF THEY NEED MORE HELP OR HAD QUESTIONS AFTER THEY LEFT THE CLINIC; IS THAT CORRECT?

A. THAT'S WHAT THAT SENTENCE SAYS. YES.

Q. THAT IS WHAT THIS REPORT CONCLUDED; IS THAT CORRECT?

A. YES.

Q. NOW, I NEED YOU TO LOOK AT ANOTHER PORTION WHICH, OF COURSE, MIGHT CAUSE SOME PROBLEM HERE.

PAGE 13 OF THE REPORT, WHERE IT STARTS, "FINDINGS." IS THAT AT THE BEGINNING OF YOUR COPY AS WELL?

THE COURT: DO YOU HAVE THAT?

MS. KRASNOFF: PAGE 12 --

THE WITNESS: COULD I ASK WHICH COPY WE ARE USING?

MS. KRASNOFF: I KNOW WHAT PAGE IT IS ON BOTH. SHOW ME WHICH ONE YOU ARE LOOKING AT.

THE WITNESS: I HAVE YOUR COPY.

BY MS. KRASNOFF:

Q. IT'S ON PAGE 13 AT THE TOP OF THE PAGE "FINDINGS," IN CASE THE COURT HAS THE OTHER ONE. IT'S PAGE 12 IT'S THE HEADING "FINDINGS."

THE COURT: I HAVE IT.

BY MS. KRASNOFF:

Q. DR. SHADIGIAN, IF YOU CAN READ THE FIRST TWO PARAGRAPHS UNDER "FINDINGS" FOR ME.

A. (READING)

"OVERALL SATISFACTION WITH ABORTION CARE.

ABORTION PATIENTS REPORT HIGH LEVELS OF SATISFACTION WITH THEIR CARE: 60 PERCENT OF WOMEN SAY THEIR CARE WAS EXCELLENT AND ANOTHER THIRD (38 PERCENT) SAY IT WAS VERY GOOD OR GOOD. TWO PERCENT OF WOMEN SAY THAT THEIR CARE WAS FAIR AND LESS THAN 1 PERCENT SAY IT WAS POOR. PATIENT'S OVERALL RATING OF THEIR CARE

DID NOT DIFFER BY A WOMAN'S AGE, RACE, INSURANCE STATUS OR LENGTH OF PREGNANCY."

Q. COULD YOU READ THE NEXT PARAGRAPH AS WELL?

A. YES.

"NEARLY ALL PATIENTS, 97 PERCENT, FEEL THE INFORMATION THEY RECEIVED THAT DAY WAS EXCELLENT, VERY GOOD OR GOOD. MOST (94 PERCENT) THOUGHT THE STAFF'S OVERALL ATTENTION TO THEIR PRIVACY WAS SIMILARLY EXCELLENT, VERY GOOD OR GOOD. ALL PATIENTS THOUGHT THE CLINIC WAS CLEAN, 100 PERCENT, INCLUDING EIGHT IN 10 WHO THOUGHT IT WAS VERY CLEAN 79 PERCENT."

Q. THANK YOU.

DR. SHADIGIAN, YOU, YOURSELF, WILL ONLY PERFORM AN ABORTION IF THE WOMAN IS SO SICK THAT THE ONLY WAY SHE IS GOING TO SURVIVE IS TO HAVE THE PREGNANCY ENDED; IS THAT CORRECT?

A. IF YOU MEAN ABORTION ON A LIVE INFANT, YES.

Q. YES, I DO MEAN ON A LIVE FETUS.

IS THAT CORRECT?

A. YES.

Q. AND YOU WOULD AGREE, WOULD YOU NOT, THAT ANY PHYSICIAN CAN'T KNOW 100 PERCENT IF SOMEONE IS GOING TO DIE OR NOT WHEN FACED WITH A VERY SICK PREGNANT WOMAN; IS THAT CORRECT?

A. THAT'S CORRECT.

Q. YOU WOULD AGREE THAT THE DECISION OF WHETHER THERE IS A THREAT TO THE WOMAN'S LIFE MUST BE LEFT TO THE PHYSICIAN'S BEST MEDICAL JUDGMENT; IS THAT CORRECT?

A. YES.

Q. YOU AGREE, DON'T YOU, THAT THE SAFEST AND MOST APPROPRIATE ABORTION PROCEDURE FOR A PARTICULAR WOMAN DEPENDS IN PART ON THE GESTATIONAL AGE OF THE FETUS AT THE TIME OF THE ABORTION; IS THAT CORRECT?

A. YES.

Q. AND YOU AGREE, DON'T YOU, THAT THE SAFEST AND MOST APPROPRIATE ABORTION PROCEDURE FOR A PARTICULAR WOMAN DEPENDS IN PART ON THAT WOMAN'S HEALTH AT THE TIME OF THE ABORTION?

A. YES.

Q. AND YOU AGREE THAT THE SAFEST AND MOST APPROPRIATE ABORTION PROCEDURE FOR A PARTICULAR WOMAN DEPENDS IN PART ON ANY MEDICAL CONTRAINDICATIONS SHE MIGHT HAVE TO A PARTICULAR PROCEDURE OR PART OF A PROCEDURE?

A. YES.

Q. AND YOU AGREE THAT THE SAFEST AND MOST APPROPRIATE ABORTION PROCEDURE FOR A PARTICULAR WOMAN DEPENDS IN PART ON HER PRIOR HISTORY OF GYNECOLOGIC SURGERY?

A. YES.

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

ABORTION?

A. YES.

Q. AND YOU AGREE, DON'T YOU, THAT EVEN IF TWO ABORTION PROCEDURES ARE SIMILAR IN TERMS OF STATISTICAL RISKS, WHICH PROCEDURE WILL, IN FACT, BE SAFER FOR ANY PARTICULAR WOMAN DEPENDS ON HER INDIVIDUAL CIRCUMSTANCES?

A. YES.

Q. DR. SHADIGIAN, THIS IS NOT THE FIRST TIME YOU'VE TESTIFIED IN SUPPORT OF A LAW THAT REGULATES ABORTION, IS IT?

A. NO.

Q. IN FACT, YOU HAVE OFFERED SWORN TESTIMONY OF SOME SORT AND SUPPORT OF A VARIETY OF STATE LAWS THAT RELATE TO ABORTION, HAVEN'T YOU?

A. I HAVE TESTIFIED ONE TIME IN ALASKA.

Q. YOU'VE OFFERED DECLARATIONS AS WELL?

A. EXPERT REPORTS, YES.

Q. AND THOSE ARE SWORN STATEMENTS?

A. YES.

Q. AND YOU HAVE GIVEN DEPOSITION TESTIMONY AS WELL?

A. YES.

Q. AND THAT WAS UNDER OATH?

A. YES.

Q. AND SO YOU HAVE OFFERED SWORN TESTIMONY IN SUPPORT OF AN ALASKA LAW REQUIRING A MINOR TO OBTAIN PARENTAL CONSENT BEFORE AN ABORTION; IS THAT CORRECT?

A. YES.
Q. YOU'VE OFFERED SWORN TESTIMONY IN SUPPORT OF LAWS THAT REQUIRE MANDATORY DELAY BEFORE A WOMAN CAN HAVE AN ABORTION IN INDIANA, ALABAMA, AND OHIO; IS THAT CORRECT?
A. YES.
Q. AND YOU TESTIFIED IN FAVOR OF A FLORIDA LAW THAT REQUIRED A WOMAN TO RECEIVE CERTAIN STATE-MANDATED INFORMATION BEFORE SHE COULD HAVE AN ABORTION; IS THAT CORRECT?
A. YES.
Q. AND YOU'VE UNIFORMLY OFFERED YOUR OPINION IN SUPPORT OF THOSE LAWS?
A. IN THOSE PARTICULAR CIRCUMSTANCES, I DID. YES.
Q. IN ADDITION TO THE CASES WE JUST DISCUSSED, YOU'VE ALSO OFFERED YOUR OPINION IN A CASE BROUGHT AGAINST PLANNED PARENTHOOD FEDERATION OF AMERICA, WHO IS A PLAINTIFF IN THIS CASE, TRYING TO FORCE PLANNED PARENTHOOD TO INFORM WOMEN SEEKING ABORTIONS THAT ABORTION INCREASES THE RISK OF BREAST CANCER; IS THAT CORRECT?
A. YES.
Q. ARE YOU AWARE THAT BOTH THE TRIAL COURT AND THE COURT OF APPEALS DISMISSED THAT CASE?
A. IF YOU TELL ME THEY DID, I AM SURE THEY DID.
Q. IN FACT, YOU YOURSELF BELIEVE THAT HAVING AN INDUCED ABORTION INCREASES A WOMAN'S RISK OF DEVELOPING BREAST CANCER, DON'T YOU?

A. YES.
Q. ARE YOU AWARE THAT IN FEBRUARY OF 2003, THE NATIONAL CANCER INSTITUTE CONVENED A WORKSHOP OF WHAT THEY DEEMED TO BE MORE THAN 100 OF THEIR WORLD'S LEADING EXPERTS WHO STUDIED PREGNANCY AND BREAST CANCER RISKS TO LOOK AT THAT ISSUE?
A. YES.
Q. AND ARE YOU AWARE THAT THAT GROUP FOUND THAT INDUCED ABORTION IS NOT ASSOCIATED WITH AN INCREASE IN BREAST CANCER RISK?
A. NO.
Q. THEY DID FIND THAT?
A. THEY HAD TWO FINDINGS. ONE IS THAT THEY DIDN'T BELIEVE IN AN INDEPENDENT EFFECT, BUT THEY DID AGREE THAT THERE WAS A PROTECTIVE EFFECT THAT IS LOST WHEN A WOMAN HAS AN INDUCED ABORTION AS COMPARED TO GOING TO TERM.
Q. SO THEY DID NOT CONCLUDE THAT HAVING AN ABORTION DOES NOT INCREASE A WOMEN'S SUBSEQUENT RISK OF DEVELOPING BREAST CANCER?
A. IT'S JUST AS I JUST STATED IT.
MS. KRASNOFF: I AM SORRY, I DON'T HAVE ANY OTHER COPIES OF THIS.
IF I MAY APPROACH THE WITNESS AND REFRESH HER RECOLLECTION?
THE COURT: WHAT IS IT? FIRST OF ALL, LET DEFENSE COUNSEL SEE IT.
MS. CLARK: THAT'S FINE TO REFRESH HER RECOLLECTION.

YOUR HONOR, I AM GOING TO MAKE AN OBJECTION. I THINK THIS IS WELL BEYOND THE SCOPE GETTING INTO THE BREAST CANCER. I DON'T THINK THAT -- BREAST CANCER WASN'T TALKED ABOUT IN HER EXPERT REPORT, AND I DON'T BELIEVE IT CAME UP IN HER DEPOSITION.

THE COURT: IT CAME UP IN HER TESTIMONY. SHE IS THE ONE THAT LISTED IT AS ONE OF THE SEVEN FACTORS. THIS IS CERTAINLY FAIR CROSS-EXAMINATION.

YOU MAY SHOW HER THE DOCUMENT. WHETHER OR NOT IT IS ADMISSIBLE IS ANOTHER QUESTION, BUT YOU CAN CERTAINLY LOOK AT IT.

BY MS. KRASNOFF:

Q. IF I COULD ASK YOU TO LOOK -- THIS IS A "SUMMARY REPORT, EARLY REPRODUCTIVE EVENTS AND BREAST CANCER" WORKSHOP FROM THE NATIONAL CANCER INSTITUTE'S WEBSITE.

IF I CAN ASK YOU TO LOOK AT THE SIXTH BULLET. COULD YOU READ THAT FOR US?

THE COURT: READ IT TO YOURSELF AND THEN SHE'LL ASK YOU ANOTHER QUESTION.

THE WITNESS: AM I ALLOWED TO READ THE ENTIRE THING?

THE COURT: NO, NOT FOR THIS PURPOSE. IT'S ONLY BEING USED TO REFRESH YOUR RECOLLECTION WITH RESPECT TO THE QUESTION SHE ASKED YOU.

READ THE BULLET POINT. IF IT DOESN'T REFRESH YOUR RECOLLECTION, YOU CAN TELL US.

THE WITNESS: OKAY. YOU ARE ASKING FOR THE SIXTH BULLET POINT?
BY MS. KRASNOFF:
Q. YES.
A. YES, I DID READ IT NOW.
Q. AND WAS ONE OF THE CONCLUSIONS OF THAT WORKSHOP THAT INDUCED ABORTION IS NOT ASSOCIATED WITH AN INCREASE IN BREAST CANCER RISK?
A. THAT'S WHAT THAT SENTENCE SAYS.
Q. AND YOU BELIEVE THAT IS NOT AN OPINION EXPRESSED BY THE WORKSHOP FROM THE NATIONAL BREAST CANCER INSTITUTE?
A. I DIDN'T SAY THAT.
Q. SO, IT IS ONE OF THEIR OPINIONS?
A. YES. IT IS NOT THEIR ONLY OPINION. AS YOU CAN SEE, THERE ARE 10 OPINIONS.
Q. THAT IS ONE OF THEM; IS THAT CORRECT?
A. YES.
Q. ARE YOU ALSO AWARE THAT IN JUST THE PAST FEW WEEKS AN ARTICLE HAS BEEN PUBLISHED IN THE LANCET ABOUT THIS ISSUE, ABORTION AND BREAST CANCER?
A. YES.
Q. AND THAT ARTICLE IS ENTITLED "BREAST CANCER AND ABORTION COLLABORATIVE REANALYSIS OF DATA FROM 53 EPIDEMIOLOGIC STUDIES INCLUDING 83,000 WOMEN WITH BREAST CANCER FROM 16 COUNTRIES"; IS THAT CORRECT?

A. I BELIEVE THAT'S THE TITLE.
Q. AND THAT ARTICLE SPECIFICALLY CONSIDERED THE REVIEW ARTICLE THAT YOU TALKED ABOUT TODAY, DID IT NOT?
A. I DON'T KNOW.
Q. HAVE YOU READ THE NEW ARTICLE?
A. I HAVE SKIMMED IT THROUGH.
Q. YOU DIDN'T NOTICE THAT FOOTNOTE 82 WAS YOUR ARTICLE?
A. I DIDN'T NOTICE THAT.
Q. DID YOU NOTICE THE LANCET REACHES THE OPPOSITE CONCLUSION OF YOUR ARTICLE; THAT IS, THAT PREGNANCIES THAT END AS AN INDUCED ABORTION DO NOT INCREASE A WOMAN'S RISK OF BREAST CANCER; IS THAT CORRECT?
A. I AM SORRY, COULD YOU READ IT AGAIN?
Q. DOES THE -- ARE YOU AWARE THAT THE LANCET ARTICLE REACHES THE OPPOSITE CONCLUSION OF YOUR REVIEW ARTICLE; THAT IS, THE CONCLUSION THAT PREGNANCIES THAT END AS AN INDUCED ABORTION DO NOT INCREASE THE RISK OF A WOMAN HAVING BREAST CANCER?
A. NO.
Q. THEY DO REACH THAT CONCLUSION?
A. I THINK THE ISSUE IS WE HAVE TWO CONCLUSIONS IN OUR PAPER, AND ONE IS ABOUT THE INDEPENDENT EFFECT OF ABORTION ON BREAST CANCER AND THE OTHER IS THE DELAY IN THE FIRST FULL-TERM BIRTH. SO THERE IS NOT JUST ONE CONCLUSION WE REACH.

WE HAVE A TABLE IN OUR STUDY, IF YOU WOULD LIKE ME TO GO OVER IT.

Q. I WOULD LIKE YOU TO LOOK AT THE LANCET ARTICLE THAT CAME OUT IN THE LAST FEW WEEKS.

THE COURT: DO YOU HAVE COPIES?

MS. KRASNOFF: I DO.

THE WITNESS: YOUR HONOR, I HAVEN'T HAD A CHANCE TO REVIEW THE ENTIRE ARTICLE.

THE COURT: I UNDERSTAND THAT AND I AM NOT GOING TO ALLOW HER TO ASK YOU ABOUT THE ENTIRE ARTICLE EITHER.

MS. KRASNOFF: MAY I APPROACH?

THE COURT: YES.

FOR WHAT PURPOSE ARE YOU GIVING HER THIS DOCUMENT? WHAT IS THE PURPOSE OF YOUR --

MS. MORRIS: SHE SAYS SHE BELIEVES IT DID NOT CONCLUDE THAT INDUCED ABORTION CAUSED AN INCREASE RISK OF BREAST CANCER. AND I WANT TO REFRESH HER RECOLLECTION OF WHETHER OR NOT IT DID DO THAT.

THE COURT: HAVE YOU SEEN THIS ARTICLE BEFORE?

THE WITNESS: I HAVE SEEN THE ARTICLE, BUT I HAVEN'T READ AND ANALYZED IT LIKE I HAVE THE OTHER ARTICLES IN MY REPORT, FOR EXAMPLE.

THE COURT: WE WILL SEE HOW MUCH DETAIL IS REQUESTED HERE.

BY MS. KRASNOFF:

Q. IF YOU WOULD TURN TO THE VERY LAST SENTENCE OF THE ARTICLE WHICH APPEARS ON PAGE 1,014.

WOULD YOU AGREE THE AUTHORS OF THIS CONCLUDE:

"HENCE, THE TOTALITY OF THE WORLDWIDE EPIDEMIOLOGICAL EVIDENCE INDICATES THAT PREGNANCIES ENDING AS EITHER SPONTANEOUS OR INDUCED ABORTIONS DO NOT HAVE ADVERSE EFFECTS ON WOMEN SUBSEQUENT RISK OF DEVELOPING BREAST CANCER."

A. THAT'S THE SENTENCE YOU JUST READ. IT WAS THE LAST SENTENCE.

Q. DO YOU AGREE THAT IS WHAT THIS STUDY CONCLUDED?

A. THAT IS THEIR LAST SENTENCE, SO I AM GOING TO ASSUME THAT.

MS. KRASNOFF: I HAVE NOTHING FURTHER, YOUR HONOR.

THE COURT: REDIRECT?

MS. CLARK: JUST A FEW QUESTIONS. JUST A MOMENT.

REDIRECT EXAMINATION

BY MS. CLARK:

Q. DR. SHADIGIAN, JUST A FEW QUESTIONS.

ON CROSS-EXAMINATION YOU TESTIFIED ABOUT, IN THE D&X THERE BEING FEWER FETAL BONE PIECES AND FEWER INSTRUMENT PASSES. IS THIS A SOUND BASIS ON WHICH TO CONCLUDE THAT THE D&X PROCEDURE OF ABORTION IS A SAFE ABORTION PROCEDURE?

A. NO.

Q. AND WHY NOT?

A. BECAUSE THERE MAY BE OTHER MITIGATING FACTORS LIKE THE ADVANCE DILATION OF THE CERVIX THAT IS NECESSARY TO PERFORM THE

D&X PROCEDURE AS WELL AS THE TRAUMA OF PULLING THE HEAD THROUGH EVEN ALMOST INTACT, THROUGH THE CERVIX DILATING IT MORE.

SO THAT IS JUST AN ASSERTION AND IS NOT BASED IN ANY KIND OF STUDY.

Q. WHEN A WOMAN IS HAVING AN INDUCTION TERMINATION OF PREGNANCY AND SHE'S PREVIABLE, IF SHE'S AT THE HOSPITAL, ARE THE DOCTORS AND NURSES, ARE THEY ABLE TO MONITOR HER DURING THE ENTIRE TIME OF THE PROCEDURE?

A. YES.

Q. IS THAT IMPORTANT TO YOU IN YOUR CONSIDERATION OF THE SAFETY OF INDUCTION VERSUS D&E AND D&X?

A. YES.

Q. NOW, I BELIEVE YOU TESTIFIED THAT THE LEVEL OF EITHER OXYTOCIN OR THE PROSTAGLANDINS THAT YOU WOULD ADMINISTER IN A PREVIABILITY INDUCTION METHOD OF PREGNANCY TERMINATION, THAT THEY WOULD VARY AS COMPARED TO A POSTVIABILITY INDUCTION PREGNANCY TERMINATION; IS THAT CORRECT?

A. YES, THEY MAY.

Q. AND BECAUSE YOU'RE DOING THE PREVIABILITY INDUCTION -- IN SITUATIONS WHERE YOU ARE DOING THE PREVIABILITY INDUCTION METHOD, YOU WOULD BE ABLE TO USE GREATER DOSES OF OXYTOCIN, FOR EXAMPLE; ISN'T THAT CORRECT?

A. YES.

Q. AND ONE OF THE REASONS IS BECAUSE YOU WOULDN'T BE CONCERNED ABOUT WHETHER OR NOT THE FETUS COULD SURVIVE AFTER THE

PROCEDURE BECAUSE THERE WOULDN'T BE ANY WAY THAT THE FETUS COULD SURVIVE IN ANY EVENT; ISN'T THAT CORRECT?

A. THAT IS CORRECT.

Q. AND, THEREFORE, YOU CAN INCREASE THE DOSES OF THE OXYTOCIN AND THE PROSTAGLANDINS?

A. YES, YOU AN.

Q. WOULD THAT INCREASE IN THE DOSE OF THE OXYTOCIN OR THE PROSTAGLANDINS INCREASE THE SPEED AT WHICH THE INDUCTION PROCEDURE CAN BE ACCOMPLISHED START TO FINISH?

A. IT MAY MAKE IT FASTER.

Q. NOW, DR. JOHNSON HAS YOU ON HIS STAFF, DOESN'T HE?

A. YES.

Q. HE TRUSTS YOU TO CARE FOR THE PATIENTS AT THE UNIVERSITY OF MICHIGAN, DOESN'T HE?

A. YES, HE DOES.

Q. AND, DOCTOR, YOU WOULD AGREE THAT THERE IS A LOT OF CONTROVERSY IN THE MEDICAL LITERATURE ABOUT WHETHER OR NOT BREAST CANCER HAS ANY RELATION -- OR WHETHER ABORTION HAS ANY RELATION TO BREAST CANCER, WOULDN'T YOU?

A. I WOULD SAY THAT THERE ARE TWO DIFFERENT ISSUES AT HAND. ONE IS CONTROVERSIAL AND ONE IS ABSOLUTELY NOT CONTROVERSIAL.

MS. CLARK: THANK YOU. I WILL LEAVE IT AT THAT.

NO FURTHER QUESTIONS.

THE COURT: ANYTHING ELSE FROM PLAINTIFF?

MS. KRASNOFF: NO.

THE COURT: ALL RIGHT.

DR. SHADIGIAN, YOU'RE EXCUSED.

THE WITNESS: THANK YOU VERY MUCH, YOUR HONOR.

THE COURT: ALL RIGHT.

NOW, ARE -- YOU MAY STEP DOWN AND JUST LEAVE EVERYTHING UP THERE.

ARE THERE ANY OTHER WITNESSES THAT WE ARE GOING TO HEAR FROM TODAY?

MR. SIMPSON: TODAY, YOUR HONOR, NO.

THE COURT: SO DR. COOK WILL APPEAR TOMORROW MORNING?

MR. SIMPSON: YES.

THE COURT: AND ON THURSDAY DR. ANAND?

MR. SIMPSON: YES.

THE COURT: AND DR. CHASEN ON FRIDAY IN THE MORNING AND CLOSING ARGUMENTS.

ALL RIGHT. IS THERE ANYTHING ELSE THAT YOU ALL WISH TO DISCUSS?

ONE THING I WOULD LIKE TO REVISIT, AND THAT IS THE QUESTION OF THE STUDIES. I AM LOOKING AHEAD TO HOW I AM GOING TO GO ABOUT PREPARING THE FINDINGS IN THIS CASE. WE HAVE A MASSIVE AMOUNT OF INFORMATION, AND I WOULD FRANKLY PREFER TO HAVE THESE STUDIES IN EVIDENCE.

PLAINTIFFS HAVE WITHDRAWN THEIR REQUEST, AND I'D SIMPLY LIKE TO REVISIT THAT. WE WILL TALK ABOUT THE SPRANG

ARTICLE SEPARATELY.

IS THERE SOME PARTICULAR REASON WHY THE COURT COULD NOT -- SHOULD NOT ADMIT THESE?

MS. PARKER: LET ME ADDRESS THE TWO DREY ARTICLES. I LOOKED OVER THE TESTIMONY OF DR. DREY LAST WEEK AND IT SEEMED THAT HER TESTIMONY WAS QUITE LENGTHY ABOUT THE ARTICLES AND THE ARTICLES THEMSELVES REALLY DIDN'T ADD THAT MUCH ADDITIONAL EVIDENCE.

BUT IF YOUR HONOR WANTS TO ADMIT THOSE TWO INTO EVIDENCE, WE HAVE NO OBJECTION TO THAT.

THE COURT: THE ISSUE FOR ME IS PRIMARILY THE DATA THAT IS INCLUDED IN THE TABLES. SHE DID GIVE LENGTHY TESTIMONY, BUT BOTH SIDES HAVE ASKED A NUMBER OF WITNESSES ABOUT THOSE TABLES, AND IT'S GOING TO BE A LITTLE LOGISTICALLY DIFFICULT FOR US TO HAVE TO KEEP GOING BACK TO TRANSCRIPTS TO FIND OUT WHERE THE TABLES ARE DESCRIBED.

IT'S CERTAINLY MUCH EASIER TO HAVE THE INFORMATION IN A FORM THAT IF WE NEED TO, WE CAN FIND IT AND CITE TO IT AS NECESSARY.

MS. PARKER: WE WOULD HAVE NO OBJECTION TO THEM COMING INTO EVIDENCE. OBVIOUSLY WE ORIGINALLY MOVED TO HAVE THOSE TWO COME IN.

THE COURT: THERE IS NO OTHER REASON BECAUSE I CERTAINLY DON'T WANT TO --

MS. PARKER: WE WERE WORRIED ABOUT THE

CONSISTENCY -- THE CONSISTENT APPROACH ACROSS THE BOARD WITH THE DIFFERENT ARTICLES AND STUDIES.

THE COURT: THAT'S A SEPARATE ISSUE.

SINCE -- SO, WILL PLAINTIFFS RE-MOVE THOSE INTO EVIDENCE?

MS. PARKER: YES. WE WILL RE-MOVE THE TWO DREY ARTICLES.

THE COURT: THE DEFENDANTS HAVE OBJECTED ON ALL THE VARIOUS DIFFERENT GROUNDS YOU'VE INCLUDED IN YOUR PAPERS, AND EVEN THOUGH I HAVE ALREADY TOLD YOU THAT I WOULD PREFER TO HAVE THE MATTERS IN EVIDENCE, I CERTAINLY NEED TO STATE FOR THE RECORD WHETHER OR NOT I FIND THE RESIDUAL EXCEPTION APPLIES IN THE CASE, AND I DO FIND THAT THE RESIDUAL EXCEPTION APPLIES.

I KNOW THAT YOU ALL HAVE RELIED UPON ONE OF THE THREE CITED CASES IN THIS AREA THAT WE WERE ABLE TO FIND. THERE ARE ONLY THREE. AND I DIDN'T FIND THE TURNER DECISION THAT YOU ALL HAD RELIED UPON TO BE TOTALLY DISPOSITIVE OF THE CASE BECAUSE THAT CASE INVOLVED MEDICAL -- THE FACTS WERE DIFFERENT. IT INVOLVED MEDICAL TEXT, IT WAS IN THE CONTEXT OF A CRIMINAL CASE AND THE PROBLEM WAS THAT THERE WASN'T AN EXPERT THROUGH WHICH TO GET IN THE INFORMATION UNDER THE LEARNED TREATISE EXCEPTION.

AND IN THIS CASE, IT SEEMS TO ME THE LEARNED TREATISE EXCEPTION GENERALLY APPLIES TO INFORMATION WRITTEN BY SOMEONE ELSE THAT A TESTIFYING EXPERT HAS RELIED UPON IN SOME

WAY IN FORMING HIS OR HER OPINION.

WHAT WE HAVE HERE IS VERY DIFFERENT. WE HAVE INFORMATION, SCIENTIFIC AND MEDICAL INFORMATION THAT WAS ESSENTIALLY DERIVED THROUGH THE EFFORT OF THE TESTIFYING WITNESS WHO IS THE AUTHOR OR CO-AUTHOR OF THE PARTICULAR STUDY. SO I DON'T FIND THAT THE COURT'S REASONING FOR -- AND THAT IS, TO PREVENT EXCEPTION TO THE LEARNED TREATISE EXCEPTION REALLY APPLIES TO THIS KIND OF SITUATION.

THE TWO CASES WE WERE ABLE TO FIND IN WHICH THE TWO DISTRICT COURTS DID PERMIT THE USE OF THE RESIDUAL EXCEPTION FOR MEDICAL INFORMATION WERE MORE AKIN TO THIS CASE IN WHICH THERE WAS SOME PARTICIPATION ON THE PART OF THE TESTIFYING WITNESS IN THE PREPARATION OF THE STUDIES, AND IN THE FACT THAT THE STUDIES WERE PEER REVIEWED AND PUBLISHED IN PEER REVIEW JOURNALS.

SO I THINK WHEN I CONSIDER THE REQUIREMENTS OF THE RESIDUAL EXCEPTION TRUSTWORTHINESS BEING THE HALLMARK OF THE EXCEPTION, I HAVE TO FIND THAT IRRESPECTIVE OF THE OBJECTIONS WITH REGARD TO THE METHODOLOGICAL LIMITATIONS THAT THE STUDIES ARE TRUSTWORTHY BECAUSE OF THE ACTUAL AND DIRECT PARTICIPATION AND OBSERVATIONS OF THE DOCTORS.

ADDITIONALLY, AT LEAST WE HAVEN'T HEARD FROM DR. CHASEN, BUT AT LEAST WITH REGARD TO THE DREY STUDY, SHE WAS HERE SUBJECT TO CROSS-EXAMINATION BOTH AT LENGTH IN HER DEPOSITION AND AT TRIAL, AND THE STUDIES WERE NOT CONDUCTED IN

CONNECTION WITH THIS PARTICULAR LITIGATION, SO THERE IS ABSOLUTELY NO REASON NOT TO FIND THAT THEY WERE INDEED TRUSTWORTHY.

ONCE AGAIN, I THINK THAT THE ARGUMENTS ON THE PROBATIVE VALUE OF THOSE REALLY GO TO THE WEIGHT TO BE ACCORDED AND NOT TO WHETHER OR NOT THEY HAVE SOME PROBATIVE VALUE AND ARE ADMISSIBLE UNDER THE SECTION.

NEITHER SIDE REALLY ADDRESSED THE QUESTION OF WHETHER OR NOT THE GENERAL APPLICATION OF THE HEARSAY RULE ARE ADDRESSED BY THE ADMISSION OF THESE PARTICULAR DOCUMENTS, BUT I DO FIND THAT THE PRIMARY RATIONALE FOR NOT ADMITTING THEM UNDER THIS EXCEPTION, WHICH HAS TO DO WITH WHETHER OR NOT A JURY MIGHT BE OVERLY IMPRESSED WITH INFORMATION CONTAINED IN MEDICAL TEXT OR LEARNED TREATISE, DOESN'T APPLY IN THIS SITUATION.

AND THE TWO OTHER, I THINK MOST SIGNIFICANT REASONS THAT I WISH TO HAVE THEM IS BECAUSE, AS I INDICATED, WE NEED TO HAVE AN EASY WAY TO HANDLE ALL THIS INFORMATION THAT YOU ALL HAVE GIVEN US, AND WE NEED THE TABLES.

SECONDLY, I HAVE ALREADY READ ALL OF THESE REPORTS. I HAD TO READ THEM IN ORDER TO RULE ON THIS PARTICULAR OBJECTION. IT IS NOT LIKE WHEN THE COURT REACHES AN ASSESSMENT AS TO WHETHER OR NOT THEY SHOULD BE PRESENTED TO A JURY, I HAVE ALREADY READ THEM. AND TO THAT EXTENT, I SEE NO BASIS WHATSOEVER TO NOT APPLY THE RESIDUAL EXCEPTION TO THE STUDIES.

AND I WOULD INCLUDE THE CHASEN STUDY, ASSUMING HE IS

ALSO SUBJECTED TO CROSS-EXAMINATION. I KNOW HE WAS AT HIS DEPOSITION BECAUSE I BELIEVE YOU ALL SUBMITTED A COPY OF HIS DEPOSITION BEFORE THE TRIAL COMMENCED THAT I LOOKED AT, AND ASSUMING HE IS SUBJECT TO CROSS-EXAMINATION ON THE STUDY, WHICH I WOULD ANTICIPATE HE WILL BE, I SEE NO REASON WHY IT SHOULDN'T GO TO HIS AS WELL.

NOW, I KNOW YOU ALL HAD CONCERNS ABOUT THE SPRANG ARTICLE, SO I AM GOING TO ADMIT THE STUDIES AS EVIDENCE.

MS. GARTNER: FOR POINT OF CLARIFICATION, ARE YOU ADMITTING THE CHASEN STUDY AS WELL OR JUST THE DREY STUDY?

THE COURT: YES. I LOOKED AT ALL OF THEM ON THE BASIS OF THE PAPERS YOU SUBMITTED AND THE ARGUMENTS YOU'VE MADE AND I CAME TO THE CONCLUSION THAT THOSE THREE SHOULD COME IN FOR THE SAME REASON.

ALL RIGHT. NOW --

MS. GARTNER: ACTUALLY, I AM SORRY, YOUR HONOR. I THINK THAT IF YOU DON'T MIND, LATER TODAY WE WOULD -- I THINK THERE WERE SOME STATEMENTS IN OUR REQUEST THAT WAS FILED LAST WEEK WITH RESPECT TO THE CHASEN STUDY THAT WE DON'T ACTUALLY THINK WERE FULLY ACCURATE AND WERE DONE BECAUSE WE WERE TRYING TO BRIEF THINGS AT THE SAME TIME THAT WE ARE PREPARING WITNESSES, SO WITH YOUR HONOR'S PERMISSION WE WOULD FILE AN ERRATA TO THAT LATER TODAY WITH THE UNDERSTANDING THAT THE MOTION HAS ALREADY BEEN GRANTED WITH RESPECT TO THE CHASEN STUDY?

THE COURT: MAYBE I SHOULDN'T GRANT THE MOTION UNTIL I SEE THE ERRATA. I DON'T KNOW HOW SIGNIFICANT IT'S GOING TO BE.

IS THIS SOMETHING YOU ALL HAVE TALKED ABOUT THIS.

MS. GARTNER: NO. I THINK IT'S REALLY JUST TO CLARIFY. I DON'T THINK IT IS A SUBSTANTIVE CHANGE IN WHAT WAS STATED, BUT I THINK THERE WERE JUST SOME STATEMENTS IN THE BRIEF THAT COULD BE TAKEN AS -- THEY WEREN'T INTENDED THIS WAY, THEY COULD BE TAKEN AS SUGGESTING THAT THE STUDY ITSELF WOULD BE MORE RELIABLE THAN DR. CHASEN'S TESTIMONY ABOUT IT, AND WE DON'T WANT IN ANY WAY TO SUGGEST THAT THAT'S THE CASE.

THE COURT: I AGREE THAT THE DOCTORS' TESTIMONY ABOUT THE STUDY, EITHER CHASEN, OR DREY, OR SPRANG, THEIR TESTIMONY IS REALLY WHAT IS MOST IMPORTANT HERE. THE STUDIES, AS THEY ARE WRITTEN, ASSIST THE COURT BECAUSE IT CAPTURES ALL OF THE UNDERLYING MATERIAL IN A VERY COHERENT FASHION FOR THE COURT.

MY FINDING IS BASED NOT UPON THE FACT THAT THE WRITTEN MATERIALS ARE SUPERIOR IN ANY WAY TO THE OPINIONS --

MS. GARTNER: OKAY.

THE COURT: -- OF THE DOCTORS.

MS. GARTNER: I THINK THAT'S CLEAR ENOUGH. WE WANTED TO BE CLEAR THAT IN NO WAY DO WE THINK THE STUDY REPLACES WHAT DR. CHASEN WILL TESTIFY TO.

THE COURT: NO. I CERTAINLY WOULDN'T COME TO THAT

CONCLUSION.

NOW, THE SPRANG ARTICLE IS A LITTLE DIFFERENT. I INDICATED EARLIER IT WAS MY INCLINATION TO NOT ALLOW IT IN AND THAT'S BECAUSE I DON'T FIND IT TRUSTWORTHY, AS TRUSTWORTHY BECAUSE IT IS BASED, WHEN I LOOK ON HIS BIBLIOGRAPHY, THERE ARE MORE NEWSPAPER ARTICLES AND WEEKLY PERIODICALS CITED THAN THERE ARE LEARNED MEDICAL TREATISES, ALTHOUGH THERE ARE SOME OF THOSE SO BECAUSE HE DIDN'T PARTICIPATE, HE DID THE RESEARCH, HE DIDN'T ACTUALLY PARTICIPATE IN THE UNDERLYING STUDIES, I DON'T FIND THAT HIS ARTICLE IS SO TRUSTWORTHY THAT IT SHOULD FIT UNDER THE RESIDUAL EXCEPTION.

BUT, AS I INDICATED, AND THERE IS ONLY ONE TABLE IN HIS, AND SO THE TABLE IN HIS PARTICULAR PIECE DEALS WITH THE DIFFERENT STATUS OF THE LAW ON INTACT ABORTION FROM STATE TO STATE WHICH IS NOT AN ISSUE ABOUT WHICH I AM AT ALL CONCERNED IN TERMS OF THE ISSUES THAT I HAVE TO DECIDE HERE.

BUT I DO -- THE ONE THING I DID NOTE WAS THAT IT DOES APPEAR THAT CONGRESS HAS CITED VERY LIBERALLY FROM THE DOCTOR'S ARTICLE IN ITS FINDINGS, AND TO THAT EXTENT, IT MIGHT BE HELPFUL TO HAVE THAT AS PART OF THE RECORD AS WELL.

SO, NOTWITHSTANDING THAT YOU HAVE NOT OFFERED AN EXCEPTION THAT I THINK SQUARELY APPLIES, BECAUSE I HAVE READ IT, I HAVE READ EVERY WORD OF IT, I SEE NO REASON NOT TO ALLOW IT IN AT THIS TIME, EVEN THOUGH THERE PERHAPS MIGHT NOT BE AN EXCEPTION THAT APPLIES EXACTLY.

SO I AM GOING TO ALLOW THEM ALL IN AND DECIDE WHAT WEIGHT TO GIVE THEM.

MS. CLARK: YOUR HONOR, BASED ON YOUR RULING, I WOULD ALSO MOVE TO ADMIT DR. SHADIGIAN'S ARTICLE AS WELL, DEFENDANT'S A-56.

IN TERMS OF RELIABILITY, SHE HAS 101 DIFFERENT REFERENCES. THEY ARE NOT OF THE NEWSPAPER TYPE, KIND OF THING, SUBSTANTIVE ARTICLES, AND I WOULD MOVE IT INTO EVIDENCE ON THE BASIS THAT IT IS RELEVANT WITH RESPECT TO THE LONG-TERM COMPLICATIONS AND THAT IT ALSO WOULD HELP THE COURT IN REACHING ITS CONCLUSIONS.

THE COURT: I DON'T FIND THAT THE LONG-TERM COMPLICATIONS, GIVEN THAT THERE HAS BEEN NO DELINEATIONS BETWEEN ABORTIONS IN THE FIRST- OR SECOND-TRIMESTER OR THE METHODS USED IS AT ALL HELPFUL TO ME IN THIS REGARD.

SO TO THE EXTENT I HAVE ALLOWED IN DR. SPRANG'S REPORT, EVEN THOUGH IT DOESN'T SQUARELY FIT UNDER THE RESIDUAL EXCEPTION, I JUST DON'T SEE THE PROBATIVE VALUE ON THIS ON THE ISSUES THAT I HAVE TO DECIDE.

SO I CERTAINLY LISTENED TO HER TESTIMONY AND HER OPINION ON IT, IT'S PART OF THE RECORD AND TO THE EXTENT THAT OPINION ON LONG-TERM EFFECTS IS IMPORTANT, I CAN RELY UPON THAT, BUT I AM NOT GOING TO ALLOW HER REPORT IN.

AND THE NUMBERS OF THOSE WILL BE IDENTIFIED. I WOULD HAVE TO LOOK THEM UP.

CAN YOU PROVIDE ME WITH THE EXHIBIT NUMBERS JUST SO WE CAN KNOW?

MS. GARTNER: FOR THE DREY STUDIES IT'S EXHIBIT 34, EXHIBIT 30 AND FOR THE CHASEN STUDY IT IS EXHIBIT 19.

THE COURT: FOR THE SPRANG?

MR. SIMPSON: SPRANG IS A-55, YOUR HONOR.

THE COURT: ALL RIGHT. THOSE FOUR EXHIBITS ARE ADMITTED AT THIS TIME.

ALL RIGHT. WE ARE -- UNLESS THERE IS ANYTHING ELSE, WE ARE ADJOURNED UNTIL TOMORROW MORNING AT 8:30.

(PROCEEDINGS ADJOURNED AT 12:48 P.M.)

THE CLERK: EXHIBITS 30, 34, 19 AND A-55 ADMITTED INTO EVIDENCE.

(PLAINTIFFS' EXHIBITS 19, 30 & 34 RECEIVED IN EVIDENCE)

(DEFENDANT'S EXHIBIT A-55 RECEIVED IN EVIDENCE)

I N D E X