VOLUME 9

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE PHYLLIS J. HAMILTON, JUDGE

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE,	)	
PLAINTIFFS,	)	
VS.	)	NO. C 03-4872 PJH
JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY,	)	TUESDAY, APRIL 13, 2004
	)	SAN FRANCISCO, CALIFORNIA
DEFENDANT.	)	

REPORTER'S TRANSCRIPT OF PROCEEDINGS

APPEARANCES:

FOR PLAINTIFFS:
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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

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		WASHINGTON, D.C. 20530
	BY:	MARK THOMAS QUINLIVAN
		W. SCOTT SIMPSON,
		KAIJA MARIE CLARK,
		ASSISTANT U.S. ATTORNEYS

TUESDAY, APRIL 13, 2004 8:30 A.M.

P R O C E E D I N G S

THE COURT: ALL RIGHT. GOOD MORNING. ARE YOU READY WITH YOUR NEXT WITNESS?

MR. SIMPSON: YES, YOUR HONOR.

MS. CLARK: DEFENSE CALLS DR. CURTIS COOK.

THE CLERK: PLEASE RAISE YOUR RIGHT HAND.

DR. CURTIS COOK,

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. CURTIS COOK.

THE CLERK: SPELL YOUR LAST NAME.

THE WITNESS: C-O-O-K.

DIRECT EXAMINATION

BY MS. CLARK:

Q. GOOD MORNING, DR. COOK.

A. GOOD MORNING.

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

A. I AM A MATERNAL FETAL MEDICINE SPECIALIST, MEANING THAT I TAKE CARE OF COMPLICATED PREGNANCIES, GENERALLY COMPLICATED BY EITHER MATERNAL MEDICAL CONDITIONS, FETAL ABNORMALITIES OR

OBSTETRICAL COMPLICATIONS THAT DEVELOP DURING THE COURSE OF THE PREGNANCY.

Q. AND WHERE DO YOU WORK?

A. I WORK IN GRAND RAPIDS, MICHIGAN.

Q. AT WHAT HOSPITAL?

A. I'M BASED AT SPECTRUM HEALTH IN GRAND RAPIDS, BUT WE COVER A NUMBER OF HOSPITALS IN THE WEST MICHIGAN AREA.

MS. CLARK: MAY I APPROACH, YOUR HONOR?

THE COURT: YES.

BY MS. CLARK:

Q. I AM SHOWING YOU WHAT HAS BEEN IDENTIFIED AS DEFENDANT'S A-4. IS THIS A COPY OF YOUR CURRICULUM VITAE?

A. IT IS.

Q. DID YOU CREATE IT?

A. I DID.

Q. DOES THAT ACCURATELY REFLECT YOUR EDUCATION, WORK EXPERIENCE AND PUBLICATIONS?

A. I BELIEVE THAT IT DOES.

MS. CLARK: THE GOVERNMENT MOVES TO ADMIT INTO EVIDENCE DEFENDANT'S EXHIBIT A-4.

THE COURT: ANY OBJECTION?

MS. GARTNER: NO OBJECTION, YOUR HONOR.

THE COURT: ADMITTED.

THE CLERK: A-4 INTO EVIDENCE.

MS. CLARK: THANK YOU.

(DEFENDANT'S EXHIBIT A-4
WAS RECEIVED IN EVIDENCE.)

BY MS. CLARK:

Q. DR. COOK, ARE YOU BOARD CERTIFIED IN OB/GYN?

A. I AM.

Q. ARE YOU BOARD CERTIFIED IN MATERNAL FETAL MEDICINE?

A. I AM.

Q. AND CAN YOU EXPLAIN A LITTLE BIT MORE, WHAT IS MATERNAL FETAL MEDICINE?

A. WELL, MATERNAL FETAL MEDICINE IS A SUBSPECIALTY AREA OF INTEREST. AFTER COMPLETION OF OBSTETRICS AND GYNECOLOGY TRAINING, YOU CAN ELECT TO DO FURTHER TRAINING IN A SUBSPECIALTY AREA OF OBSTETRICS AND GYNECOLOGY.

YOU CAN TRAIN IN THE AREA OF FEMALE CANCERS, IN THE AREA OF INFERTILITY OR IN THE AREA OF COMPLICATED PREGNANCIES. AND GENERALLY, THAT ENTAILS ANOTHER THREE YEARS OF TRAINING BEYOND YOUR RESIDENCY PROGRAM TO COMPLETE THAT REQUIREMENT.

Q. AND WHAT COURSES OF INSTRUCTION DO YOU GO THROUGH TO BECOME A MATERNAL FETAL MEDICINE SPECIALIST?

A. DURING THE COURSE OF THAT TRAINING YOU ARE DEALING WITH THE MOST COMPLICATED OBSTETRICAL CASES. AGAIN, THOSE ARE COMPLICATED BY EITHER PREEXISTING MATERNAL CONDITIONS WHICH ENTAIL A VARIETY OF DISEASES AND PATHOLOGIES, FETAL CONDITIONS WHICH CAN ENTAIL A NUMBER OF STRUCTURAL ABNORMALITIES OR GENETIC OR CHROMOSOMAL ABNORMALITIES, AND, THEN, OBSTETRICAL

COMPLICATIONS THAT DEVELOP DURING THE COURSE OF THE PREGNANCY.

AS A RESULT OF THOSE COMPLICATIONS, YOU HAVE TO LEARN HOW TO CARE FOR WOMEN THROUGHOUT THE ENTIRE PREGNANCY, WHICH SOMETIMES ENTAILS HAVING TO DELIVER THE BABY PREMATURELY OR END OR TERMINATE THE PREGNANCY FOR THE BENEFIT OF THE MOTHER. AND, ADDITIONALLY, IT GENERALLY INCLUDES TRAINING IN FETAL SURGERY AND FETAL THERAPIES, AS WELL.

Q. HAVE YOU HAD TRAINING IN ABORTION TECHNIQUES?

A. I HAVE.

Q. WHAT KINDS OF TECHNIQUES?

A. WE HAVE BEEN TRAINED TO FIND WAYS TO EVACUATE THE UTERUS IN ALL THREE TRIMESTERS USING COMBINATIONS OF MEDICAL AND SURGICAL APPROACHES.

Q. AND WHAT ARE SOME OF THOSE KINDS OF SURGICAL APPROACHES THAT YOU HAVE BEEN TRAINED IN?

A. WELL, THEY INCLUDE SUCTION EVACUATION, SHARP CURETTAGE, DILATATION AND EVACUATION, INDUCTION OF LABOR WITH MEDICATIONS, HYSTEROTOMY OR CESAREAN DELIVERY.

Q. AFTER YOU FINISHED YOUR FELLOWSHIP IN MATERNAL FETAL MEDICINE, WHERE DID YOU GO ON TO BECOME EMPLOYED?

A. AFTER I COMPLETED MY FELLOWSHIP TRAINING I RETURNED TO GRAND RAPIDS IN WEST MICHIGAN WHERE I HAD DONE MY OBSTETRICS AND GYNECOLOGY TRAINING AND STARTED WORKING THERE AS A MATERNAL FETAL MEDICINE SPECIALIST.

Q. WHEN DID YOU BECOME EMPLOYED AT SPECTRUM HEALTH HOSPITAL?

A. IN 1995.
Q. WHAT DO YOU DO AT SPECTRUM HEALTH HOSPITAL?
A. WELL, I HAVE VARIOUS ROLES AND FUNCTIONS, BUT I SERVE AS THE ASSOCIATE DIRECTOR FOR MATERNAL FETAL MEDICINE. I ALSO HAVE A TEACHING APPOINTMENT WITH MICHIGAN STATE UNIVERSITY. AND PREVIOUSLY I HELPED ADMINISTER OUR OBSTETRICS AND GYNECOLOGY RESIDENCY TRAINING PROGRAM.

WE ALSO HAVE TEACHING POSITIONS IN TWO OTHER RESIDENCY PROGRAMS IN WEST MICHIGAN, AND WE SERVE ON THE STAFF OF MULTIPLE OTHER HOSPITALS IN WEST MICHIGAN.
Q. AND AS ASSOCIATE DIRECTOR OF MATERNAL FETAL MEDICINE AT SPECTRUM HEALTH, WHAT DOES THAT JOB RESPONSIBILITY ENTAIL?
A. WELL, THERE ARE SEVERAL AREAS OF RESPONSIBILITY. OBVIOUSLY, ONE IS JUST THE CLINICAL MANAGEMENT OF COMPLICATED PREGNANCIES. THAT INCLUDES SERVING A VERY WIDE RURAL AREA, BASICALLY ALL OF WESTERN AND NORTHERN MICHIGAN, WHERE WE NOT ONLY TAKE CARE OF PATIENTS REFERRED FROM THAT AREA, BUT WE ARE ALSO RESPONSIBLE TO GOING OUT AND LECTURING AND EDUCATING PHYSICIANS IN THAT REGION ABOUT THE MANAGEMENT OF COMPLICATED PREGNANCIES.

WE ALSO TRAIN AND SUPERVISE THE TRAINING OF OUR RESIDENTS IN COMPLICATED PREGNANCIES, AS WELL AS MICHIGAN STATE MEDICAL STUDENTS.

THEN, THERE ARE SOME RESEARCH AND ADMINISTRATIVE RESPONSIBILITIES, AS WELL.

Q. DO YOU HOLD A SPECIFIC POSITION AT MICHIGAN STATE UNIVERSITY?

A. YES, I AM AN ASSOCIATE CLINICAL PROFESSOR IN THE DEPARTMENT OF OBSTETRICS AND GYNECOLOGY.

Q. AND WHAT ARE YOUR DUTIES, SPECIFICALLY, IN THAT POSITION?

A. PREDOMINANTLY, THE CLINICAL TRAINING OF MEDICAL STUDENTS FROM MICHIGAN STATE, MOSTLY DURING THEIR THIRD-YEAR OBSTETRICS AND GYNECOLOGY CLERKSHIPS; OCCASIONALLY DURING THEIR FOURTH-YEAR ELECTIVES.

WE ALSO HAVE SOME FORMAL LECTURES THAT WE GIVE THAT THE MEDICAL STUDENTS ATTEND, AS WELL.

Q. DO YOU TEACH EITHER RESIDENTS OR MEDICAL STUDENTS ABOUT PREGNANCY TERMINATIONS IN ALL THREE TRIMESTERS OF PREGNANCY?

A. WE DO TRAIN THEM HOW TO EVACUATE THE UTERUS IN ALL THREE TRIMESTERS. SOMETIMES THAT INVOLVES MEDICAL STUDENTS. GENERALLY, IT INVOLVES PREDOMINANTLY OUR MEDICAL RESIDENTS.

Q. DOCTOR, WHAT KINDS OF MEDICAL CONDITIONS IN PREGNANCY DO YOU PROVIDE CARE FOR, INCLUDING CONDITIONS EXISTING BEFORE PREGNANCY AND CONDITIONS EXISTING AFTER PREGNANCY?

A. WELL, IN THE AREA OF JUST MATERNAL MEDICAL CONDITIONS, THE PREEXISTING CONDITIONS CAN BE A HOST OF MEDICAL CONDITIONS INVOLVING ONE OR MULTIPLE ORGAN SYSTEMS.

SO IT CAN INCLUDE CENTRAL NERVOUS SYSTEM ABNORMALITIES FOR THE MOTHER, CARDIOVASCULAR PROBLEMS, PULMONARY PROBLEMS, RENAL PROBLEMS, HEPATIC PROBLEMS OR LIVER

PROBLEMS. SO A NUMBER OF PREEXISTING MEDICAL CONDITIONS THERE. IT CAN INCLUDE MALIGNANCIES. IT CAN INCLUDE BLUNT OR PENETRATING TRAUMA TO A PREGNANT WOMAN. IT CAN ALSO INCLUDE DEVELOPED -- PROBLEMS THAT DEVELOP DURING THE COURSE OF THE PREGNANCY, LIKE HEAVY BLEEDING, SEVERE INFECTION, OTHER SURGICAL COMPLICATIONS THAT ARISE FROM ATTEMPTED PROCEDURES DURING PREGNANCY.

AND IT CAN ALSO INCLUDE THE DEVELOPMENT OF OBSTETRICAL COMPLICATIONS THAT ARE UNIQUE TO PREGNANCY, LIKE PREECLAMPSIA OR HIGH BLOOD PRESSURE PROBLEMS DURING PREGNANCY AND GESTATIONAL DIABETES, MULTIPLE GESTATION. IT CAN INCLUDE A WHOLE HOST OF COMPLICATIONS.

Q. AND WHAT KINDS OF FETAL CONDITIONS IN PREGNANCY DO YOU CARE FOR?

A. AGAIN, WE CARE FOR A WHOLE VARIETY OF FETAL COMPLICATIONS THAT GENERALLY CAN BE CATEGORIZED AS GENETIC OR CHROMOSOMAL ABNORMALITIES WHERE A BABY HAS INHERITED A GENETIC ABNORMALITY OR HAS AN ABNORMAL NUMBER OF CHROMOSOMES PRESENT. OR GENERALLY IN THE CATEGORY OF STRUCTURAL ABNORMALITIES WHERE A BABY MAY HAVE ONE OR MULTIPLE ORGAN SYSTEMS INVOLVED.

AND THEN, THERE ARE SEVERAL UNIQUE TYPE FETAL CONDITIONS THAT WE CARE FOR, LIKE MULTIPLE GESTATION, CONJOINED TWINS, TWIN-TO-TWIN TRANSFUSION, AND OTHER SORT OF UNIQUE FETAL CONDITIONS IN PREGNANCY.

Q. IN YOUR PRACTICE, DO YOU PERFORM MEDICAL PROCEDURES ON

LIVING FETUSES?

A. WE DO.

Q. CAN YOU DESCRIBE SOME OF THE CIRCUMSTANCES IN WHICH YOU PERFORM PROCEDURES ON LIVING FETUSES?

A. WE PERFORM A NUMBER OF MEDICAL AND SURGICAL PROCEDURES ON THE FETUS WHILE IT IS STILL INSIDE THE WOMB. THIS CAN INCLUDE TRYING TO CORRECT ABNORMAL FETAL HEART RATE RHYTHMS OR HEART RHYTHMS.

IT CAN INCLUDE TRYING TO CORRECT SEVERE FETAL ANEMIA. IT CAN INCLUDE TRYING TO BYPASS CERTAIN STRUCTURAL OBSTRUCTIONS IN THE BABY'S SYSTEM, SUCH AS THE URINARY SYSTEM.

IT CAN INCLUDE DECOMPRESSING ABNORMAL FLUID COLLECTIONS IN PORTIONS OF THE BABY.

IT CAN INCLUDE BIOPSIES OR OTHER SAMPLINGS. SO THERE IS A NUMBER OF DIFFERENT THERAPIES THAT ARE DEVELOPED IN THE AREA OF FETAL SURGERY OR FETAL MEDICATIONS.

Q. ARE ANY OF THESE PROCEDURES LIFE-SAVING PROCEDURES FOR THE FETUS?

A. MOST OF THE ONES THAT WE DO ARE, BECAUSE THERE ARE RISKS ASSOCIATED WITH DOING INTRAUTERINE PROCEDURES, SO GENERALLY THERE HAS TO BE A SIGNIFICANT BENEFIT IN ORDER TO ACCEPT THAT LEVEL OF RISK.

Q. DO YOU ALSO DELIVER BABIES?

A. WE DO.

Q. HOW MANY BABIES DO YOU DELIVER IN AN AVERAGE YEAR?

A. ON AN AVERAGE YEAR I PROBABLY DELIVER SOMEWHERE IN THE ORDER OF 100 TO 200 BABIES.

Q. IS IT FAIR TO SAY THAT YOU ARE DELIVERING BABIES IN THE CONTEXT OF HIGH-RISK PREGNANCIES?

A. YES, THAT WOULD BE A FAIR STATEMENT.

Q. DO YOU RECEIVE REFERRALS FROM OB/GYN'S OF PATIENTS WITH COMPLICATED PREGNANCIES?

A. YES. VIRTUALLY EVERY PATIENT WE SEE IS REFERRED FROM ANOTHER PHYSICIAN. SOMETIMES THOSE ARE NONOB/GYN PHYSICIANS. BUT THE MAJORITY DO COME FROM OBSTETRICIANS AND GYNECOLOGISTS.

Q. WHY IS THAT THE CASE?

A. IT IS BECAUSE THEY HAVE DEVELOPED A PROBLEM EITHER MATERNAL OR FETAL THAT IS BEYOND THEIR LEVEL OF TRAINING OR THEIR EXPERIENCE OR THEIR COMFORT LEVEL.

Q. WHAT IS THE GESTATIONAL AGE FOR PREGNANCIES THAT YOU TYPICALLY ARE INVOLVED WITH?

A. MOST OFTEN WE SEE PATIENTS IN THE MID-TRIMESTER OR LATER, IF IT IS A FETAL CONDITION. FOR MATERNAL CONDITIONS, WE SOMETIMES SEE THEM VERY EARLY ON, SUCH AS DIABETICS. BUT CERTAIN MATERNAL CONDITIONS LIKE PREECLAMPSIA ARE LATE-PREGNANCY PHENOMENA.

SO WE GET REFERRED PATIENTS IN ALL THREE TRIMESTERS THAT YOU CAN GENERALLY GROUP, DEPENDING ON THE KIND OF PROBLEM THAT THEY DEVELOP.

Q. DOCTOR, YOU DO NOT PERFORM ABORTIONS FOR ELECTIVE REASONS;

IS THAT RIGHT?
A. THAT IS CORRECT. I DO NOT.
Q. EVEN THOUGH YOU DO NOT PERFORM ELECTIVE ABORTIONS, DOES YOUR PRACTICE REQUIRE THAT YOU HAVE EXPERTISE IN THE SAFE AND EFFECTIVE METHODS FOR TERMINATING PREGNANCY?
A. YES, BECAUSE THERE ARE TIMES WHEN EMPTYING THE UTERUS OR TERMINATING THE PREGNANCY IS NECESSARY FOR THE BENEFIT OF THE MOTHER, SO YOU DO NEED TO BE FAMILIAR WITH THOSE TECHNIQUES, AND I AM.
Q. DOCTOR, DOES YOUR PRACTICE ALSO REQUIRE THAT YOU MAY HAVE TO END A PREGNANCY PREMATURELY SUCH THAT THE FETUS IS LIKELY TO DIE FROM TERMINATING THE PREGNANCY?
A. I AM SORRY. COULD I HAVE YOU RESTATE THE QUESTION?
Q. DOES YOUR PRACTICE REQUIRE THAT YOU MAY HAVE TO END THE PREGNANCY EARLY SUCH THAT THE FETUS IS LIKELY TO DIE FROM THAT PREMATURE TERMINATION OF THE PREGNANCY?
A. YES, THAT IS THE CASE AT TIMES.
Q. CAN YOU BE A MATERNAL FETAL MEDICINE SPECIALIST WITHOUT KNOWING HOW TO END A PREGNANCY EARLY?
A. I DON'T BELIEVE THAT YOU CAN JUST BECAUSE YOU ARE DEALING EXCLUSIVELY WITH COMPLICATED PREGNANCIES.
Q. DO YOU, AS A MATERNAL FETAL MEDICINE SPECIALIST, HAVE TO HAVE A FULL UNDERSTANDING OF THE METHODS TO EVACUATE THE UTERUS IN ALL THREE TRIMESTERS?
A. I BELIEVE THAT YOU DO.

Q. WHY IS THAT?
A. WELL, AGAIN, BECAUSE THE PROBLEMS THAT ARISE IN A MATERNAL FETAL MEDICINE PRACTICE, ESPECIALLY ONE OF OUR SCOPE AND VOLUME, ENTAILS FINDING WOMEN THAT HAVE SIGNIFICANT PROBLEMS IN ALL THREE TRIMESTERS. AND SOMETIMES THE ONLY CORRECT MANAGEMENT IN THOSE SITUATIONS IS ENDING THE PREGNANCY SUCH THAT THE WOMAN CAN START RECOVERING FROM THE COMPLICATIONS THAT PREGNANCY POSES TO THEIR HEALTH.
Q. DR. COOK, DOES YOUR SPECIFIC PRACTICE INVOLVE PREGNANCY TERMINATION?
A. IT DOES.
Q. HAVE YOU EVER HAD TO TERMINATE A PREGNANCY WHEN THE FETUS IS STILL LIVING?
A. I HAVE.
Q. COULD YOU DESCRIBE TO THE COURT THE CIRCUMSTANCES IN WHICH YOU HAVE HAD TO TERMINATE A PREGNANCY BOTH PREVIABILITY AND POSTVIABILITY?
A. WELL, THE PREVIABILITY LINE CONTINUES TO SHIFT TO EARLIER GESTATIONAL AGES, AND CURRENTLY IS APPROXIMATELY 23 WEEKS GESTATION. SO, THE TIMES THAT WE HAVE TO TERMINATE A PREGNANCY PRIOR TO 23 WEEKS HAS BECOME LESS AND LESS THAN IT WAS WHEN VIABILITY WAS 25 WEEKS OR 28 WEEKS.
BUT STILL, PROBABLY ABOUT 10 PERCENT OF THE TIME ARE WOMEN THAT WE CARE FOR DEVELOP A PROBLEM THAT IS EITHER SIGNIFICANTLY WORSENING OR NONRESPONSIVE TO OUR THERAPIES THAT

REQUIRE US TO DELIVER HER PREMATURELY, SOMETIMES EVEN PRIOR TO 23 WEEKS.

IN OUR PRACTICE, THAT MOST COMMONLY RESULTS FROM WOMEN THAT DEVELOP VERY SEVERE HYPERTENSIVE COMPLICATIONS OR SEVERE INFECTIOUS OR BLEEDING COMPLICATIONS.

Q. ARE THERE ANY DIFFERENCES, FOR EXAMPLE, THE DOSES OF MEDICINE IN WHICH -- IN THE WAY IN WHICH YOU PERFORM A TERMINATION WHEN THE FETUS IS PREVIABLE VERSUS POSTVIABLE?

A. YES. WHEN WE ARE TALKING ABOUT AN INFANT THAT IS 23 WEEKS OR GREATER, THEN THERE IS OBVIOUSLY A FETAL INTEREST AT PLAY, AS WELL. AND WE ARE MATERNAL FETAL MEDICINE SPECIALISTS, SO WE HAVE AT LEAST TWO PATIENTS IN ANY GIVEN PREGNANCY, AND SOMETIMES MORE WITH MULTIPLE GESTATION.

SO WE TRY TO EFFECT THE DELIVERY IN THE MANNER THAT IS SAFEST FOR THE MOTHER, YET STILL RETAINS THE BEST POSSIBILITY FOR A GOOD OUTCOME OF SURVIVAL FOR THE FETUS IF WE ARE DOING IT AT 23 WEEKS OR LATER.

IF WE ARE DOING IT LESS THAN 23 WEEKS, OBVIOUSLY THE FETAL INTERESTS HAVE LESS OF A CONCERN, SO WE MIGHT USE DIFFERENT TYPES OF MEDICATIONS OR HIGHER DOSES OF MEDICATIONS OR LESS MONITORING OF THE FETAL CONDITION.

THERE ARE A NUMBER OF ADJUSTMENTS WE MIGHT MAKE IN THAT SCENARIO.

Q. WHEN YOU ARE TERMINATING A PREGNANCY PREVIABILITY, WHAT IS YOUR PRIMARY CONCERN IN PERFORMING THAT TERMINATION?

A. OUR PRIMARY CONCERN IS TRYING TO FIND THE SAFEST AND MOST EXPEDITIOUS MANNER TO SEPARATE THE MOTHER FROM THE FETUS AND THE PLACENTA FROM THE MOTHER IN ORDER TO CONTINUE THE HEALING PROCESS OR RECOVERED PROCESS FROM THE PREGNANCY.

Q. DOCTOR, WHAT IS THE MOST COMMON METHOD OF PREGNANCY TERMINATION YOU CURRENTLY UTILIZE?

A. WELL, IN OUR PRACTICE BECAUSE MOST OF THESE CONDITIONS DEVELOP LATER IN GESTATIONAL AGES, OUR PREDOMINANT METHOD IS MEDICAL INDUCTION OF LABOR, WHICH OFFERS US MULTIPLE OTHER BENEFITS THAT ARE SOMEWHAT UNIQUE TO OUR SETTING IN THAT IT ALLOWS US AN INTACT FETUS FOR PATHOLOGIC EVALUATION. ALLOWS US TO DELIVER THE MOTHER IN MOST SAFEST, MOST NATURAL OR PHYSIOLOGIC WAY IN WOMEN THAT TYPICALLY HAVE SIGNIFICANT OTHER MEDICAL CONDITIONS. AND IT ALSO ALLOWS US TO MONITOR THE MOTHERS IN THE SAFEST MANNER.

Q. DOCTOR, HOW DO YOU PERFORM THE INDUCTION METHOD OF TERMINATION?

A. MOST OFTEN WE USE PROSTAGLANDIN, SUCH AS MISOPROSTOL OR PROSTAGLANDIN E1 SUPPOSITORIES.

Q. HOW DO YOU ADMINISTER THOSE PROSTAGLANDINS?

A. TYPICALLY, WE ADMINISTER THEM AS VAGINAL SUPPOSITORIES.

Q. DO YOU EVER USE THE INSTILLATION METHOD?

A. WE DO NOT.

Q. HAVE YOU EVER HAD TO PERFORM AN INDUCTION ON A LIVING FETUS?

A. I HAVE.
Q. DOES THE FETUS EVER DIE IN THE PROCESSES OF THE INDUCTION PROCEDURE?
A. IT DOES.
Q. HOW OFTEN DO YOU PERFORM INDUCTION, BOTH PREVIABILITY AND POSTVIABILITY?
A. WELL, POSTVIABILITY IT IS A VERY REGULAR PART OF OUR PRACTICE AND PROBABLY A WEEKLY PHENOMENA WHEN A WOMAN DEVELOPS A CONDITION WHEREBY WE THINK IT IS IN HER BEST INTEREST TO DELIVER PREMATURELY, MEANING LESS THAN 37 WEEKS GESTATION, BUT AFTER 23 WEEKS GESTATION.

AS FAR AS THE NUMBER THAT WE DO PRIOR TO 23 WEEKS GESTATION, THAT IS A MUCH LESSER PHENOMENA, EVEN IN OUR PRACTICE. AND THAT MAY OCCUR ONE OR TWO TIMES A MONTH.
Q. WHY IS INDUCTION THE PREDOMINANT METHOD OF PREGNANCY TERMINATION THAT YOU UTILIZE IN YOUR PRACTICE?
A. AGAIN, IT'S SORT OF RELATED TO THREE BASIC PHENOMENA. ONE IS THE GESTATIONAL AGE WITH WHICH WE ARE USUALLY WORKING WITH, WHICH IS USUALLY MORE THAN 20 WEEKS GESTATION. ALSO, IT HAS TO DO WITH THE PREEXISTING MATERNAL MEDICAL CONDITIONS WHERE WE WANT TO TRY TO AVOID SOME OF THE COMPLICATIONS THAT SURGERY WOULD POSE. SO WE WOULD PREFER A MEDICAL OR A VARIATION OF A NORMAL LABOR PROCESS.

THE THIRD WOULD BE BEING ABLE TO MAXIMIZE OUR ABILITY TO EVALUATE THE INTACT FETUS, INCLUDING AN INTACT

CENTRAL NERVOUS SYSTEM AFTER DELIVERY.

THERE ARE ALSO SOME BENEFITS IN BEING ABLE TO MONITOR HER LABOR MORE ACCURATELY WHEN SHE CAN CONTINUE TO GIVE US FEEDBACK ABOUT SYMPTOMS. WE CAN UTILIZE CERTAIN OTHER TYPES OF HIGHER TECHNOLOGY MONITORING DURING THE COURSE OF THOSE LABOR PROCESSES.

Q. BETWEEN WHAT GESTATIONAL AGES DO YOU PERFORM THE INDUCTION METHOD OF PREGNANCY TERMINATION?

A. BASICALLY, ANYWHERE FROM 16 WEEKS UNTIL TERM.

Q. IS IT FAIR TO SAY THAT YOU DO NOT OPPOSE HAVING TO ACT TO PROTECT WOMEN FROM A SERIOUS MEDICAL CONDITION EVEN IF THAT MEANS A LIVING FETUS MIGHT DIE?

A. I AM SORRY. COULD I HAVE YOU REPEAT THAT ONE MORE TIME?

Q. IS IT FAIR TO SAY THAT YOU DO NOT OPPOSE HAVING TO ACT TO PROTECT WOMEN FROM A SERIOUS MEDICAL CONDITION, MATERNAL MEDICAL CONDITION, EVEN IF THAT MEANS A LIVING FETUS MIGHT DIE?

A. YES, THAT IS A TRUE STATEMENT. WE WOULD NEVER SACRIFICE A MOTHER IN ORDER TO TRY TO SAVE A FETUS, ALTHOUGH FREQUENTLY WE DON'T HAVE TO MAKE THAT CHOICE. OFTENTIMES, WE CAN SUPPORT A MOTHER TO THE POINT AT WHICH HER BABY HAS A CHANCE FOR SURVIVAL, AS WELL, WITHOUT POSING ANY INCREASED OR SIGNIFICANT RISK TO HER HEALTH OR LIFE.

Q. HAVE YOU HAD AN OCCASION TO PERFORM AN ABORTION BY A METHOD OTHER THAN INDUCTION?

A. I HAVE.

Q. WHAT METHODS?
A. WELL, WE HAVE HAD SITUATIONS WHERE WE HAVE HAD TO EVACUATE THE UTERUS SURGICALLY ON INFANTS THAT NO LONGER ARE LIVING AT THAT TIME OR HAVE FAILED OTHER METHODS OF ATTEMPTED ABORTION.

WE HAVE ALSO DONE IT ON SITUATIONS WHERE WE HAVE TO USE A SURGICAL INCISION INTO THE UTERUS, SUCH AS A C-SECTION OR HYSTEROTOMY.

WE HAVE ALSO HAD SOME SITUATIONS WHERE WE WOULD HAVE TO DO SUCTION EVACUATIONS IN UNIQUE SITUATIONS BECAUSE OF PREGNANCY COMPLICATIONS.

Q. DOCTOR, SEPARATE FROM THE DISTINCT METHODS OF ABORTION THAT YOU HAVE PERFORMED, HAVE YOU IN YOUR PRACTICE EVER HAD TO PERFORM AN INTERNAL PODALIC VERSION ON THE FETUS?
A. YES. IN THE SITUATION OF MULTIPLE GESTATIONS, MOST OFTEN A TWIN PREGNANCY WHERE THE FIRST CHILD HAS ALREADY DELIVERED AND THE SECOND CHILD IS LYING IN A TRANSVERSE POSITION, WE WILL OFTENTIMES HAVE TO REACH IN AND TURN THE BABY TO A FEET FIRST POSITION IN ORDER TO FACILITATE THE DELIVERY.
Q. DOCTOR, IN YOUR PRACTICE HAVE YOU USED OSMOTIC DILATORS?
A. I HAVE.
Q. IN WHAT CONTEXT?
A. WELL, IN THE DAYS PRIOR TO SOME OF THE NEWER PROSTAGLANDIN FORMULATIONS, MEDICAL INDUCTIONS WERE MORE OFTEN DONE WITH OTHER TYPES OF MEDICATIONS, SUCH AS OXYTOCIN OR PITOCIN. IN THOSE SITUATIONS WE WOULD FREQUENTLY TRY TO PREPARE THE CERVIX

PREINDUCTION BY PLACING LAMINARIA INTO THE CERVIX THE DAY PRIOR TO THE INDUCTION.

Q. TURNING TO YOUR PROFESSIONAL ORGANIZATIONS THAT YOU BELONG TO, DO YOU BELONG TO ANY PROFESSIONAL ORGANIZATIONS?

A. I DO.

Q. WHAT ARE SOME OF THOSE ORGANIZATIONS?

A. THE AMERICAN MEDICAL ASSOCIATION, THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE SOCIETY OF MATERNAL FETAL MEDICINE, MICHIGAN STATE MEDICAL SOCIETY, CHRISTIAN MEDICAL AND DENTAL ASSOCIATION. THERE IS A NUMBER.

Q. YOU ARE A CO-FOUNDER OF PHYSICIANS' AD HOC COMMITTEE FOR TRUTH?

A. THAT IS CORRECT.

Q. WHAT IS OR WAS THAT GROUP?

A. THAT WAS AN AD HOC GROUP OR AN AD HOC COMMITTEE THAT EVENTUALLY GREW TO OVER 400 PHYSICIAN EDUCATORS IN THE AREA OF COMPLICATED PREGNANCIES AND PEDIATRIC MANAGEMENT THEREAFTER WHO GOT TOGETHER SPECIFICALLY FOR THE PURPOSE OF TRYING TO CORRECT A LOT OF THE MEDICAL MISINFORMATION THAT INITIALLY WAS BEING CIRCULATED REGARDING THIS PARTICULAR PROCEDURE.

SO THE GROUP'S FOCUS WAS SOLELY ON TRYING TO PROVIDE MEDICAL -- ACCURATE MEDICAL BACKGROUND, POSITION PAPERS ON SPECIFIC DETAILS OF THIS PROCEDURE. WE NEVER ADDRESSED OTHER ABORTION PROCEDURES. WE NEVER ADDRESSED OTHER ETHICAL ISSUES RELATED TO LIFE ISSUES, SUCH AS EMBRYONIC STEM CELL RESEARCH OR

ANYTHING LIKE THAT.

Q. AND IS "PHACT" THE ACRONYM, CORRECT?

A. THAT IS CORRECT.

Q. IS THAT STILL IN EXISTENCE?

A. WELL, I HAVEN'T BEEN AWARE OF ANY RECENT POSITION PAPERS OR INFORMATION THAT'S BEEN CIRCULATED FROM THAT ORGANIZATION FOR SOME TIME. INITIALLY, THERE WAS A LOT OF ACTIVITY AS WE TRIED TO ADDRESS EACH OF THE AREAS OF MEDICAL MISINFORMATION ONE AT A TIME: DID THE PROCEDURE EVEN EXIST? HOW OFTEN DID IT HAPPEN? IN WHAT SCENARIOS DID IT HAPPEN? THINGS OF THAT NATURE. WHAT THE POTENTIAL RISKS FOR THE PROCEDURE WERE.

AS I FEEL WE WERE SUCCESSFUL IN SORT OF CLARIFYING SOME OF THOSE ISSUES, THE GROUP REALLY DOESN'T HAVE A PURPOSE OR A ROLE AT THIS POINT.

Q. HAVE YOU WRITTEN ANY PEER-REVIEWED ARTICLES PUBLISHED IN THE FIELD OF OBSTETRICS AND GYNECOLOGY?

A. I HAVE.

Q. AND ARE THOSE REFLECTED IN YOUR C.V.?

A. I BELIEVE THAT THEY ARE. YES. IT SEEMS TO BE FAIRLY COMPLETE.

Q. HAVE YOU BEEN AN INVESTIGATOR IN ANY RANDOMIZED STUDIES?

A. I HAVE.

Q. CAN YOU BRIEFLY DESCRIBE YOUR EXPERIENCE WITH BEING AN INVESTIGATOR?

A. WELL, RESEARCH IS OFTEN DONE IN A COLLABORATIVE FASHION, SO

THERE ARE SOME RANDOMIZED TRIALS WHERE I WROTE THE PROTOCOLS, AND I PRESENTED IT TO THE INSTITUTIONAL REVIEW BOARD, AND I INITIATED THE STUDY FROM THE BEGINNING.

THERE IS OTHERS WHERE I JOINED THE PROCESS IN PROGRESS. AND THERE ARE SOME WHERE WE JUST BECAME THE LOCAL SITE FOR A MULTI-SITE STUDY. SO I HAVE BEEN INVOLVED IN VARIOUS DIFFERENT LEVELS AND VARIOUS DIFFERENT FORMS OF RANDOMIZED CONTROLLED TRIALS.

Q. CAN YOU PROVIDE THE COURT WITH ONE EXAMPLE OF A RANDOMIZED CONTROLLED STUDY IN WHICH YOU WERE AN INVESTIGATOR?

A. YES. I AM THE PRINCIPAL INVESTIGATOR ON AN ONGOING STUDY THAT WE HAVE NOW THAT IS AN INSTITUTION-SPECIFIC STUDY, MEANING JUST OUR INSTITUTION, LOOKING AT THE ISSUE OF PREMATURE LABOR FOLLOWING EARLY RUPTURE OF THE MEMBRANES AND COMPARING TWO DIFFERENT TREATMENTS FOR THAT PHENOMENA TO EVALUATE THE EVENTUAL MATERNAL AND FETAL OUTCOMES.

MS. CLARK: YOUR HONOR, DEFENDANT MOVES TO QUALIFY DR. COOK AS AN EXPERT IN OBSTETRICS, GYNECOLOGY AND PREGNANCY TERMINATION.

THE COURT: ANY OBJECTION OR REQUEST TO VOIR DIRE?

MS. GARTNER: YES, YOUR HONOR. WE WOULD LIKE TO VOIR DIRE THIS WITNESS.

THE COURT: ALL RIGHT.

MS. CLARK: WE WOULD ALSO LIKE TO QUALIFY HIM AS AN EXPERT IN MATERNAL FETAL MEDICINE.

THE COURT: ALL RIGHT. THANK YOU.

VOIR DIRE EXAMINATION

BY MS. GARTNER:

Q. GOOD MORNING, DR. COOK.

A. GOOD MORNING.

Q. SORRY. MY NAME IS EVE GARTNER. WE MET IN GRAND RAPIDS. AND HOW LONG HAVE YOU BEEN PRACTICING MEDICINE, DR. COOK?

A. WELL, I GRADUATED FROM MEDICAL SCHOOL IN 1989, AND GOT AN INSTITUTIONAL LICENSE FOR PRACTICING MEDICINE AT THAT TIME. I HAD MY FIRST STATE MEDICAL LICENSE IN MICHIGAN IN 1990.

Q. SO WOULD YOU SAY ABOUT 14 OR 15 YEARS?

A. I WOULD SAY MORE THAN 10 YEARS, BECAUSE YOU ARE IN A TRAINING PROGRAM DURING SOME OF THAT TIME.

Q. SO IN THAT 10-PLUS-YEAR PERIOD, YOU'VE PERSONALLY PERFORMED BETWEEN THREE AND FIVE D&E'S; IS THAT CORRECT?

A. THAT I MYSELF HAVE PERFORMED, THAT WOULD BE CORRECT.

Q. AND NONE OF THEM INVOLVED -- THAT YOU'VE PERFORMED, NONE OF THEM INVOLVED AN EXTRACTION OF A FETUS THAT WAS LIVING AT THE TIME THE PROCEDURE WAS DONE; IS THAT CORRECT?

A. RIGHT. MOST OF THEM INVOLVED BABIES THAT HAD BEEN LIVING WITHIN 24 HOURS, BUT NOT, THAT I AM AWARE OF, ONES WHO WERE ACTUALLY LIVING AT THE TIME THE PROCEDURE WAS PERFORMED.

Q. AND YOU'VE NEVER PERFORMED A D&E AT 20 WEEKS OR GREATER; IS THAT RIGHT?

A. NOT THAT I RECALL, NO.

Q. AND IN TERMS OF THE D&E'S THAT YOU'VE SUPERVISED, THOSE HAVE BEEN -- THERE HAVE BEEN LESS THAN 20 OF THOSE, TOTAL; IS THAT CORRECT?

A. THAT IS CORRECT. AND MY ROLE IN SOME OF THOSE WAS NOT NECESSARILY SUPERVISION. SOMETIMES IT'S PROVIDING ULTRASOUND GUIDANCE AND ASSISTING A TEAM OF PEOPLE WORKING ON THE CASE.

Q. OKAY. AND OF THOSE 20 OR SO D&E'S IN WHICH YOU EITHER SUPERVISED OR ASSISTED IN SOME WAY, FEWER THAN 10 OF THOSE INVOLVED A FETUS THAT WAS LIVING AT THE TIME OF THE PROCEDURE; IS THAT FAIR?

A. THAT WOULD BE CORRECT.

Q. AND AS FAR AS YOU KNOW, YOU'VE NEVER BEEN PRESENT FOR A D&E THAT TOOK PLACE AT 20 WEEKS OR GREATER?

A. NOT THAT I RECALL, NO.

Q. AND YOU DON'T CONSIDER YOURSELF AN EXPERT IN D&E TECHNIQUES BETWEEN 20 AND 24 WEEKS GESTATION?

A. NO, I CONSIDER MYSELF AWARE AND EXPERIENCED WITH THE VARIOUS TECHNIQUES THAT ARE INVOLVED. I JUST HAVEN'T PERSONALLY PERFORMED THEM AT THAT GESTATIONAL AGE.

Q. RIGHT. SO YOU ARE NOT AN EXPERT IN THEM, BECAUSE YOU HAVE NEVER DONE THEM?

A. I AM NOT AN EXPERT IN PERFORMING D&E AT 20 TO 24 WEEKS.

Q. YOU DON'T EVEN KNOW ANY PHYSICIANS THAT DO D&E BETWEEN 22 AND 24 WEEKS; IS THAT RIGHT?

A. I AM NOT SURE THAT IS CORRECT, NO.

Q. YOU TESTIFIED EARLIER ABOUT INDUCTION ABORTIONS THAT YOU'VE DONE IN YOUR PRACTICE. IS IT FAIR TO SAY THAT IN TERMS OF INDUCTIONS WHERE THE FETUS IS LIVING AT THE BEGINNING OF THE PROCEDURE AND THE INDUCTION IS DONE PRIOR TO VIABILITY, THAT COMES UP IN YOUR PRACTICE ONCE EVERY FEW MONTHS?

A. NO. I THINK I TESTIFIED IT COMES UP MORE THAN TWO TIMES A MONTH.

Q. I THINK THAT IS WHAT YOU SAID TODAY, AND I WASN'T SURE IF I UNDERSTOOD YOU, BECAUSE I THINK IN YOUR DEPOSITION YOU SAID "ONCE EVERY FEW MONTHS"; DO YOU RECALL THAT?

A. I DON'T RECALL. I KNOW IT IS NOT AS FREQUENT AS THE POSTVIABLE ONES, BUT I CAN RECALL TWO THAT I HAVE DONE IN THE LAST COUPLE OF WEEKS.

Q. OKAY.

A. SO TYPICALLY IT IS MORE LIKE ONE TO TWO A MONTH.

Q. OKAY. CAN I JUST SHOW YOU YOUR DEPOSITION AND SEE IF WE CAN CLARIFY WHAT I WAS MISUNDERSTANDING?

A. SURE.

MS. GARTNER: YOUR HONOR, DO YOU HAVE A COPY OF THIS?

THE COURT: NO.

MS. GARTNER: THERE YOU GO.

BY MS. GARTNER:

Q. WHY DON'T YOU LOOK AT PAGE 258?

MS. CLARK: WHICH PAGE?

MS. GARTNER: 258.
BY MS. GARTNER:
Q. IF YOU WANT TO START LOOKING AT PAGE 258, AT LINE 21 THROUGH 259, LINE 3.
A. I AM SORRY. WHAT LINE NUMBERS?
Q. I AM SORRY. 258, LINE 21 THROUGH 259, LINE 3.
A. YES. I AM SORRY. DID YOU WANT ME TO READ THAT?
Q. JUST TO YOURSELF.
A. OKAY.
Q. JUST TO REFRESH YOUR RECOLLECTION.
A. YES, I DID READ IT.
Q. DID YOU TESTIFY IN YOUR DEPOSITION THAT THE CIRCUMSTANCE OF AN INDUCTION ABORTION WHERE THE FETUS IS ALIVE AT THE BEGINNING PROBABLY COUPLES UP ONCE EVERY FEW MONTHS?
A. WELL, THE QUESTION WAS:
"DO YOU DO THIS THREE OR FEWER TIMES PER YEAR?"
AND MY RESPONSE WAS:
"IT'S NOT THAT SMALL, BUT IT IS NOT A LARGE NUMBER."
AND THEN, I MENTIONED I HAD DONE ONE, AS I HAD, JUST THE WEEKEND PRIOR TO THE DEPOSITION. AND I SAID:
"BUT IT PROBABLY COMES UP ONCE EVERY FEW MONTHS."
Q. IS THAT YOUR TESTIMONY?
A. WELL, THE NUMBER IS NOT CONTINUOUS IN THAT THERE MAY BE

SOME MONTHS WE DO SEVERAL. THERE MAY BE MONTHS WE DON'T DO ANY. BUT I THINK THE AVERAGE WOULD BE SOMEWHERE BETWEEN 10 AND 20 A YEAR, WHICH WOULD BE ONE TO TWO TIMES A MONTH. IT VARIES FROM YEAR TO YEAR.

IT IS JUST NOT AS FREQUENT AS THE POSTVIABLE ONES.

Q. OKAY.

A. AND ALSO HAS BECOME LESS FREQUENT, I THINK AS I TESTIFIED, JUST BECAUSE THE GESTATIONAL AGES ARE SO MUCH EARLIER. WHEN I STARTED INTO PRACTICE EVEN IN GRAND RAPIDS WE DIDN'T GENERALLY HAVE ANY BABIES THAT SURVIVED LESS THAN 24 WEEKS. AND EVEN THEN IT WAS A FEW NUMBER. SO OFTENTIMES ANY INDUCTION LESS THAN 25 WEEKS WAS OFTENTIMES CONSIDERED A PREVIABLE INDUCTION.

IN THE LAST SEVERAL YEARS WE NOW HAVE OBTAINED A SURVIVAL RATE OF 30 TO 40 PERCENT AT 23 WEEKS. SO SORT OF BY DEFINITION WE ARE DOING IT LESS FREQUENTLY THAN WE HAD IN YEARS PAST.

Q. OKAY. AND I THINK YOU TESTIFIED THAT YOU WILL ONLY PERFORM AN ABORTION IN THE CASE OF EITHER FETAL DEMISE OR WHERE THE WOMAN'S LIFE IS AT RISK; IS THAT CORRECT?

A. WHEN WE THINK THAT THE MOM'S AT RISK FOR SIGNIFICANT MEDICAL CONCERNS -- IT DOESN'T NECESSARILY HAVE TO BE IMMEDIATELY LIFE-THREATENING -- THEN WE WOULD END HER PREGNANCY EVEN IF IT WAS PREVIABLE FOR THE BABY.

Q. OKAY. NOW, YOU HAVE NOT WRITTEN ANY ARTICLES ABOUT THE RELATIVE SAFETY OF DIFFERENT ABORTION PROCEDURES; IS THAT

CORRECT?
A. NO, THAT'S NOT BEEN MY PRIMARY RESEARCH FOCUS.
Q. OKAY. AND YOU HAVE NOT WRITTEN ANY ARTICLES ABOUT ABORTION OTHER THAN ON THE TOPIC OF SO-CALLED "PARTIAL-BIRTH ABORTION"; IS THAT CORRECT?
A. AGAIN, IT IS A VERY BROAD AREA OF OBSTETRICS AND GYNECOLOGY, AND MY RESEARCH FOCUS HAS BEEN IN OTHER AREAS.
Q. AND AS FAR AS YOU KNOW NEITHER OF YOUR TWO OR -- AM I CORRECT YOU HAVE HAD THREE PUBLICATIONS IN THE AREA OF SO-CALLED "PARTIAL-BIRTH ABORTION," TWO OR THREE?
A. YES, IT IS JUST A SMALL NUMBER. IT'S AN ISSUE THAT I WAS NOT EVEN ASKED ABOUT UNTIL THE LAST FEW YEARS.
Q. SURE.
A. SO MY RESEARCH HISTORY PREDATED MY EVEN BEING AWARE OF PARTIAL-BIRTH ABORTION.
Q. SURE. AND NONE OF YOUR PUBLICATIONS IN THE AREA OF SO-CALLED PARTIAL-BIRTH ABORTION HAVE BEEN IN THE PEER-REVIEWED LITERATURE; IS THAT CORRECT?
A. WELL, THE TWO THAT I AM AWARE OF OFF THE TOP OF MY HEAD ARE BOTH IN PEER-REVIEWED PUBLICATIONS.
Q. AND YOU ARE REFERRING TO THE LETTER TO THE NEW ENGLAND JOURNAL OF MEDICINE?
A. WELL, THE ONE JOURNAL ISSUES OF LAW AND MEDICINE IS A PEER-REVIEWED AND ABSTRACTED AND AVAILABLE ON MEDLINE. AND THE NEW ENGLAND JOURNAL IS ALSO A PEER-REVIEWED JOURNAL.

Q. OBVIOUSLY, THE NEW ENGLAND JOURNAL IS A PEER-REVIEWED JOURNAL, BUT YOUR PUBLICATION, THAT WAS A LETTER TO THE EDITOR; IS THAT RIGHT?

A. WELL, YOU CANNOT WRITE A LETTER TO THE NEW ENGLAND JOURNAL AND JUST HAVE IT APPEAR LIKE AN EMAIL OR A COMMENT TO TIME MAGAZINE. IT HAS TO BE REVIEWED BY THE EDITOR. IT HAS TO BE ACCEPTED FOR ITS BASIS IN REASONABLE FACT.

IT HAS TO BE SUBMITTED FROM SOMEBODY THAT HAS REASONABLE EXPERTISE FOR AN OPINION THAT THEY THINK WOULD BENEFIT THE READERSHIP.

THEY HAVE A VERY STRICT EDITORIAL PRACTICE IN THE NEW ENGLAND JOURNAL SINCE IT IS A PREEMINENT MEDICAL JOURNAL. SO YOU JUST CAN'T HAVE ANYONE SUBMIT A LETTER AND HAVE IT PUBLISHED IN THE NEW ENGLAND JOURNAL OF MEDICINE.

Q. SURE. I UNDERSTAND THAT. BUT A LETTER TO THE EDITOR IS NOT PEER-REVIEWED IN THE WAY THAT WE USUALLY THINK OF A STUDY OR SOME OTHER PUBLICATION AS BEING PEER-REVIEWED BY A TEAM OF PHYSICIANS WHO REVIEW IT AND GIVE COMMENTS BACK; ISN'T THAT FAIR?

A. I THINK PROBABLY IT'S FAIR TO SAY THAT IT'S, YOU KNOW, REVIEWED BY THE EDITORS, BUT I AM NOT CERTAIN THAT IT IS SENT OUT FOR ANY REVIEW OTHER THAN THE EDITORS THAT ARE PRESENT AND THE STAFF AT THE NEW ENGLAND JOURNAL OF MEDICINE.

Q. OKAY. AND THE OTHER PUBLICATION THAT YOU ARE REFERRING TO WAS AN ARTICLE THAT APPEARED IN SOMETHING CALLED THE ISSUES IN

LAW AND MEDICINE; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. AND YOU ARE TELLING ME THAT IS A PEER-REVIEWED JOURNAL?

A. MY UNDERSTANDING IS THAT ALL PUBLICATIONS IN THAT JOURNAL ARE REVIEWED BY OUTSIDE REVIEWERS.

Q. AND ARE THOSE OUTSIDE REVIEWERS PHYSICIANS?

A. I AM NOT CERTAIN IF THEY ARE ATTORNEYS AND PHYSICIANS. I DON'T KNOW. I JUST KNOW IT IS A PEER-REVIEWED JOURNAL, AND I WROTE IT, AND THEY MADE SUGGESTIONS, AS ALL PEER-REVIEWED JOURNALS DO FOR EDITORIAL CONTENT.

AND THEN, YOU RESUBMIT IT, AND THEN THEY DECIDE THEY ARE GOING TO PRINT IT.

Q. THAT WAS A PUBLICATION THAT WAS CO-AUTHORED BY SOMEBODY NAMED JAMES BOPP; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. AND MR. BOPP IS WELL-KNOWN AS AN ATTORNEY WHO LITIGATES ON BEHALF OF ANTIABORTION GROUPS, SUCH AS THE NATIONAL RIGHT TO LIFE COMMITTEE; IS THAT RIGHT?

A. WELL, THAT WASN'T KNOWN TO ME AT THE TIME. I WAS JUST ASKED TO HELP PROVIDE MEDICAL BACKGROUND FOR AN ARTICLE, AND I AGREED TO DO THAT.

Q. AND DID YOU KNOW THAT THE PUBLICATION ISSUES IN LAW AND MEDICINE IS CO-SPONSORED BY A GROUP THAT'S CALLED THE "NATIONAL LEGAL CENTER FOR THE MEDICALLY-DEPENDENT AND DISABLED"?

A. I DID NOT HAVE A LOT OF FAMILIARITY WITH THIS JOURNAL, NOR

DO I TO THIS DAY, SINCE IT IS NOT A JOURNAL I GENERALLY REVIEW ON A REGULAR BASIS. BUT I HAVE WRITTEN ARTICLES FOR OTHER JOURNALS LIKE PHYTOCHEMISTRY THAT I DON'T SUBSCRIBE TO, EITHER.

Q. SURE. I GUESS I AM JUST TRYING TO UNDERSTAND WHETHER OR NOT IT WAS PEER-REVIEWED.

AND DID YOU KNOW THAT THE OTHER CO-SPONSOR OF THIS PUBLICATION IS A FOUNDATION CALLED "THE HORATIO STORER FOUNDATION," WHICH IS AN AFFILIATE OF THE NATIONAL RIGHT TO LIFE COMMITTEE?

A. I HAVE TO ADMIT YOU HAVE AN ADVANTAGE OVER ME ABOUT THE BACKGROUND OF THIS JOURNAL. I JUST DON'T KNOW THE SPECIFICS.

Q. OKAY. SO YOU DON'T REALLY KNOW WHETHER IT IS A PEER-REVIEWED JOURNAL?

A. NO, I KNOW IT PEER-REVIEWED BECAUSE I HAD IT PEER-REVIEWED.

Q. OKAY.

A. I SUBMITTED IT. IT CAME BACK WITH EDITORIAL COMMENTS FROM THE EDITORS. THEY ASKED ME TO MAKE MORE COMMENTS. I CORRECTED IT. I SENT IT BACK. IT IS THE SAME PROCESS I HAVE DONE FOR THE AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY, ANY OTHER JOURNAL THAT I SUBMITTED TO. JOURNAL MATERNAL FETAL MEDICINE, I GO THROUGH THE EXACT SAME PROCESS. YOU ARE NOT ALLOWED TO KNOW, FROM MY EXPERIENCE WITH JOURNALS, WHO YOUR OUTSIDE REVIEWERS ARE.

THEY PURPOSELY SEND YOU BACK A FORM OF YOUR ARTICLE WITHOUT ANYBODY'S IDENTIFICATION ON IT. AND THE REVIEWERS ARE

NOT SUPPOSED TO KNOW WHO IS SUBMITTING IT TO ELIMINATE OTHER BIASES.

SO THE PROCESS FOR THAT JOURNAL IS THE SAME AS THE PROCESS FOR EVERY OTHER JOURNAL I HAVE WRITTEN AN ARTICLE FOR --

Q. OKAY.

A. -- FROM MY EXPERIENCE.

Q. NOW, DR. COOK, YOU HAVE NOT PERFORMED ANY CLINICAL STUDIES OR RESEARCH RELATING SPECIFICALLY TO A METHOD OF ABORTION; IS THAT RIGHT?

A. THAT'S RIGHT. I THINK I STATED THAT MULTIPLE TIMES: IT IS NOT MY PRIMARY RESEARCH FOCUS.

Q. I UNDERSTAND THAT, AND I JUST NEED TO GO THROUGH THESE QUESTIONS TO MAKE THE RECORD CLEAR.

AND YOU HAVE SERVED GENERALLY AS A PEER-REVIEWER FOR MEDICAL PUBLICATIONS, CORRECT?

A. I HAVE IN THE PAST.

Q. OKAY. BUT YOU HAVE NEVER PEER-REVIEWED AN ARTICLE REGARDING A METHOD OF ABORTION; IS THAT RIGHT?

A. THAT IS CORRECT. GENERALLY, EDITORS WILL SEND YOU ARTICLES RELATED TO AREAS THAT YOU HAVE PREVIOUSLY PUBLISHED IN, SO MOST OF THE ARTICLES THAT I GET SENT HAVE TO DO WITH ISSUES WHERE I HAVE PUBLISHED OR DONE RESEARCH THAT IS KNOWN TO THE EDITORS, WHICH GENERALLY IS IN DIFFERENT AREAS.

Q. SURE. AND DO YOU PLAN TO OFFER TESTIMONY TODAY ABOUT THE

SAFETY OF A METHOD OF ABORTION THAT IS SOMETIMES CALLED "INTACT D&X" OR "INTACT D&E"?

A. I DO.

Q. OKAY. AND AT YOUR DEPOSITION I THINK YOU STATED THAT THE SOURCES FOR YOUR UNDERSTANDING OF HOW A SO-CALLED PARTIAL-BIRTH ABORTION OR INTACT D&E IS PERFORMED IS LIMITED TO DR. HASKELL'S PAPER, DR. MCMAHON'S PAPER -- I'M SORRY. I'M LOSING MY VOICE -- DR. MCMAHON'S PAPER AND TO THE ACOG STATEMENT OF POLICY ON INTACT D&X; IS THAT CORRECT?

A. WELL, MY DIRECT EXPERIENCE WITH THIS PROCEDURE STARTED WITH REVIEWING THE SUBMITTED TESTIMONY OF TWO HIGH-PROFILE PRACTITIONERS OF THE PROCEDURE.

Q. THAT IS DR. HASKELL AND DR. MCMAHON?

A. THAT IS CORRECT.

Q. OKAY.

A. ALTHOUGH, I HAVE SUBSEQUENTLY HAD OTHER EXPERIENCES WHERE I HAVE BEEN ASKED TO REVIEW OTHER PEOPLE'S CASES, OR IN THE CASE OF DR. HASKELL, I WAS ASKED TO REVIEW A VIDEOTAPE OF HIM PERFORMING THE PROCEDURE.

SO I HAVE HAD OTHER EXPERIENCES IN THAT REGARD. AND THE ELEMENTS OF THE PROCEDURE, AS DEFINED BY THE AMERICAN COLLEGE, ARE ELEMENTS THAT I DO PERFORM IN MY OWN PRACTICE.

Q. RIGHT. BUT MY QUESTION IS YOUR UNDERSTANDING OF THE PROCEDURE IS BASED ON DR. HASKELL'S AND DR. MCMAHON'S DESCRIPTIONS, THE ACOG DEFINITION, FOR LACK OF A BETTER WORD,

AND THE VIDEOTAPE YOU REVIEWED; IS THAT FAIR TO SAY?
A. THAT, AND ADDITIONALLY MY EXPERIENCE WITH ELEMENTS OF THE PROCEDURE.
Q. OKAY.
A. MY PERSONAL EXPERIENCE WITH ELEMENTS OF THE PROCEDURE.
Q. LET'S TALK ABOUT THOSE. IN TERMS OF YOUR EXPERIENCE WITH ELEMENTS OF THE PROCEDURE, I THINK YOU TESTIFIED EARLIER THAT YOU HAVE DONE INTERNAL PODALIC VERSION TECHNIQUES. OR I AM NOT SURE IF THAT THE RIGHT WORD, BUT --
A. IT'S IS A FAIR TERM.
Q. OKAY. IS THAT RIGHT?
A. THAT IS CORRECT.
Q. BUT HAVE YOU EVER DONE THAT IN THE CONTEXT OF AN ABORTION?
A. I HAVE NOT IN THE CONTEXT OF AN ABORTION.
Q. OKAY. NOW, LET'S TALK ABOUT THE VIDEO THAT YOU REVIEWED.
AM I CORRECT THAT YOU REVIEWED THAT A FEW YEARS AGO IN THE CONTEXT OF WHEN YOU WERE SERVING AS AN EXPERT WITNESS IN LITIGATION IN THE STATE OF MISSOURI?
A. THAT IS CORRECT.
Q. AND THAT VIDEO -- I AM REALLY SORRY ABOUT MY VOICE -- DID NOT INCLUDE THE PART OF THE PROCEDURE WHERE THE LAMINARIA WAS EITHER INSERTED OR REMOVED; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. IT WAS JUST THE EVACUATION PART OF THE PROCEDURE?
A. WELL, AND YOU COULD SEE THE MANIPULATION DONE TO BRING THE

BABY DOWN THROUGH THE CERVIX. AND THEN, YOU COULD SEE THE PORTION THAT INCLUDED THE PUNCTURING OF THE SKULL AND EVACUATION --

Q. SO THE EVACUATION PART; IS THAT FAIR?

A. WELL, THE EVACUATION PART IS THE END PART.

Q. OH, OKAY.

A. THERE'S STILL THE INTERNAL PODALIC VERSION, BRING THE BABY DOWN THROUGH THE CERVIX. THE ONLY PART, AS I RECALL -- AND IT HAS BEEN A NUMBER OF YEARS, AS YOU STATED -- THAT WAS NOT INCLUDED WAS THE CERVICAL PREPARATION PHASE.

Q. OKAY. AND THE VISUALIZATION ON THAT TAPE WAS NOT OPTIMAL; IS THAT RIGHT?

A. WELL, IT WASN'T AS OPTIMAL AS STANDING NEXT TO THE PRACTITIONER, BUT YOU COULD SEE WHAT WAS GOING ON.

Q. WELL, FOR EXAMPLE, AT YOUR DEPOSITION WHEN WE TALKED ABOUT THIS, YOU COULD NOT TELL ME WHAT PORTION OF THE FETAL HEAD OR NECK WAS PUNCTURED WITH AN INSTRUMENT; ISN'T THAT RIGHT?

A. WELL, THE NATURE OF THE WAY THAT THE PROCEDURE IS PERFORMED, IS THE PRACTITIONER IS PLACING THEIR HAND BETWEEN THE WOMAN'S CERVIX AND THE BABY'S HEAD, AND SO THE INSTRUMENT IS PASSING GENERALLY UNDERNEATH THEIR HAND IN THE BASE OF THE BABY'S SKULL.

SO I COULD SEE THAT IT WAS GENERALLY IN THE AREA OF THE BASE OF THE BABY'S SKULL. YOU JUST COULDN'T SEE THE EXACT PUNCTURE SITE --

Q. OKAY.
A. -- FROM THE VANTAGE POINT I HAD OF THE VIDEO.
Q. WELL, WHEN I ASKED YOU IF IT APPEARED -- WHEN I ASKED YOU AT YOUR DEPOSITION IF IT APPEARED THAT IT WAS BEING INSERTED IN THE BACK OF THE HEAD OR THE BACK OF THE NECK, YOU TOLD ME THAT YOU DIDN'T THINK YOU COULD SAY FROM MEMORY OF VISUALIZING THE VIDEOTAPE; AND THAT YOU HAD A LIMITED VISUALIZATION; AND IT WAS A NUMBER OF YEARS AGO; AND THAT YOU WOULD HAVE TO SEE THE VIDEOTAPE AGAIN, AND IN SOME TIME FRAME THAT IS CLOSER THAN SEVERAL YEARS AGO.

IS THAT -- ARE THOSE CORRECT STATEMENTS?

A. WELL, AS I RECALL THE QUESTION -- AND I CAN REVIEW THE SPECIFIC QUESTION IN THE DEPOSITION -- IT WAS COULD I SEE IF IT WAS IN THE NECK OR THE BASE OF THE SKULL.

WELL, THAT IS A VERY NARROW ANATOMIC RANGE. THAT I COULD SEE IT WAS GENERALLY IN THAT AREA, BUT I COULDN'T TELL YOU IF IT WAS CLOSER TO THE BASE OF THE SKULL OR CLOSER TO THE BASE OF THE NECK. YOU COULD TELL IT WAS IN THIS GENERAL ANATOMIC AREA FROM MID-HEAD TO ABOVE THE SHOULDERS.

Q. OKAY. BUT IS IT CORRECT, DR. COOK, THAT YOU DID HAVE A LIMITED VISUALIZATION OF THIS VIDEOTAPE?
A. WELL, I DID NOT, AGAIN, HAVE THE VISUALIZATION YOU WOULD HAVE IF YOU WERE STANDING NEXT TO THE INDIVIDUAL, BUT YOU COULD CERTAINLY SEE WHAT WAS GOING ON, PARTICULARLY IF YOU DELIVERED THOUSANDS OF BABIES, AS I HAVE. IT IS EASY TO RECOGNIZE AND

PUT INTO CONTEXT WHAT IS GOING ON.

Q. WHY DON'T WE GO AHEAD AND JUST LOOK AT YOUR DEPOSITION ON PAGE 235?

WHY DON'T YOU LOOK AT THE ENTIRETY OF YOUR TESTIMONY ON 235 AND TOP OF 236. JUST THROUGH LINE 1 ON PAGE 236.

A. I THINK I READ WHAT YOU WANTED AT THIS POINT.

Q. OKAY. AND WHEN I ASKED YOU:

"WHAT PORTION OF THE FETAL HEAD OR NECK WAS PUNCTURED WITH AN INSTRUMENT" AT PAGE 235, LINE 1, DID YOU SAY:

"WELL, THE VISUALIZATION OF THE TAPE, AS I RECALL, WAS NOT OPTIMAL. IT WAS NOT -- IT WASN'T LIKE THERE WAS A ZOOMED IN ON JUST THE BABY AND THE PERINEUM, SO IT'S NOT AN OPTIMAL SITUATION TO MAKE AN ASSESSMENT."

WAS THAT YOUR TESTIMONY?

A. WELL, THE COMPLETION OF THE STATEMENT, THAT IS TRUE. BUT THE COMPLETION OF MY ANSWER TO THAT VERY QUESTION WAS THAT:

"IT APPEARED TO BE SOMEWHERE IN THE BACK OF THE BABY'S HEAD."

Q. OKAY. AND THEN, DID I ASK YOU:

"DID IT APPEAR TO BE IN THE BACK OF THE HEAD OR BACK OF THE NECK?"

A. AND, AGAIN, THE RESPONSE JUST PRIOR TO THAT WAS:

"THE BABY'S SPINE IS UP. IT IS UNDERNEATH THE

OPERATOR'S HAND. I CAN'T NARROW THE FOCUS MORE THAN BASE OF SKULL, BACK OF NECK."

Q. OKAY.

A. WE ARE TALKING NOW A MATTER OF SONOMETERS SEPARATION HERE.

Q. SURE.

A. SO I GUESS I DON'T HAVE THAT AMOUNT OF PRECISION FROM MY VISUALIZATION, BUT IT CERTAINLY WAS A BABY WHO WAS SPINE UP. IT CERTAINLY WAS A BABY DELIVERED TO THE LEVEL OF THE AFTER-COMING HEAD. AND IT CERTAINLY WAS A PUNCTURE INTENTIONALLY AND VOLITIONALLY DONE BY THE PRACTITIONER GENERALLY IN THE AREA OF THE BACK OF THE BABY'S NECK.

Q. BUT MY QUESTIONS REALLY, DR. COOK, ARE NOT WHAT HAPPENED, BUT JUST HOW -- HOW EASY IT WAS FOR YOU TO ACTUALLY SEE WHAT HAPPENED GIVEN THAT THE VIDEOTAPE, ACCORDING TO YOUR TESTIMONY, WAS NOT OPTIMAL AND THAT IT WAS SEVERAL YEARS AGO.

SO LET ME JUST ASK YOU: WHEN I ASKED YOU IN YOUR DEPOSITION IF IT APPEARED TO BE IN THE BACK OF THE HEAD OR THE BACK OF THE NECK, DID YOU ANSWER ON LINE 12:

"I DON'T THINK I COULD SAY THAT FROM MY MEMORY OF VISUALIZING THE VIDEOTAPE. I WOULD HAVE TO SEE THE VIDEOTAPE AGAIN AND IN SOME TIME FRAME THAT IS A LITTLE CLOSER THAN SEVERAL YEARS AGO."

WAS THAT YOUR TESTIMONY?

A. YES. I JUST ASKED --

Q. OKAY.

A. -- THAT MY MEMORY BE REFRESHED BY REVIEWING IT AGAIN.
BUT, AGAIN, IT WAS QUITE CLEAR WHAT WAS GOING ON.
Q. NO, MY -- I AM ASKING YOU, DR. COOK, WAS THAT YOUR TESTIMONY AT LINES 12 TO 15 IN YOUR DEPOSITION?
A. YES. I STAND BY MY TESTIMONY.
Q. OKAY. THANK YOU.
NOW, DR. COOK, YOU HAVE NOT BEEN TAUGHT HOW TO PERFORM AN INTACT D&E, HAVE YOU?
A. I HAVE NOT BEEN INSTRUCTED IN THAT PROCEDURE.
Q. AND YOU HAVE NEVER TAUGHT ANY OF YOUR MEDICAL STUDENTS OR RESIDENTS HOW TO PERFORM AN INTACT D&E, HAVE YOU?
A. I HARDLY THINK IT IS SOMETHING I WOULD EVER WANT TO TEACH SOMEONE.
Q. OKAY. AND SO THE ANSWER IS: YOU HAVE NOT DONE SO?
A. THAT IS CORRECT. I HAVE NOT DONE SO.
Q. AND YOU HAVE NEVER SUPERVISED SOMEONE ELSE PERFORMING AN INTACT D&E; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. AND YOU HAVE NEVER PERSONALLY TREATED A WOMAN THAT YOU WERE AWARE HAD HAD AN INTACT D&E PROCEDURE; IS THAT RIGHT?
A. I HAVE BEEN CONTACTED BY A PERSON WHO HAD THE PROCEDURE DONE AND HAD A COMPLICATION RESULT FROM THAT --
Q. BUT YOU NEVER REVIEWED HER MEDICAL RECORD, DID YOU?
A. SHE WAS INTENDING ON SENDING ME HER MEDICAL RECORDS AND THEN OPTED NOT TO PURSUE LITIGATION, SO SHE DID NOT SEND ME THE

MEDICAL RECORDS, SO I DID NOT REVIEW HER RECORDS. I JUST REVIEWED HER ORAL RELAYING OF HER MEDICAL HISTORY TO ME ON A PHONE -- ON A PHONE CONVERSATION.

Q. OKAY. AND YOU HAVE NEVER PERSONALLY TREATED AS A PHYSICIAN A WOMAN THAT YOU WERE AWARE HAD HAD AN INTACT D&E?

A. NOT THAT I AM PERSONALLY AWARE OF AS BEING CONFIRMED AS AN INTACT D&E PROCEDURE.

Q. RIGHT. AND, IN GENERAL, YOU'VE NEVER REVIEWED ANY MEDICAL RECORDS RELATING TO AN INTACT D&E PROCEDURE; IS THAT RIGHT?

A. NO, I WOULD NOT SAY THAT IS CORRECT.

Q. YOU HAVE REVIEWED MEDICAL RECORDS OF PEOPLE WHO HAD UNDERGONE AN INTACT D&E PROCEDURE?

A. AS I WAS TESTIFYING IN FRONT OF CONGRESS, ON OTHER OCCASIONS PART OF THE REQUEST FROM THE COMMITTEES THAT I WAS TO APPEAR BEFORE WAS TO REVIEW AND SPECIFICALLY COMMENT ON THE MEDICAL NECESSITY OF THIS PROCEDURE IN CERTAIN UNIQUE -- I BELIEVE AT THAT TIME -- BOTH FETAL AND MATERNAL CONDITIONS.

AND SO THIS INCLUDED THE SUBMITTED MEDICAL TESTIMONY -- THE SUBMITTED TESTIMONY OF THE WOMEN'S MEDICAL HISTORY THAT THEY RELAYED IN THEIR PROCEDURES AS A JUSTIFICATION FOR THE PROCEDURE. I WAS THEN ASKED TO REVIEW THOSE SPECIFIC CASES AND THEN COMMENT ON THE NECESSITY OF THE PROCEDURE IN THOSE SPECIFIC CASES.

Q. SO YOU COMMENTED ON WOMEN'S STATEMENTS TO CONGRESS ABOUT WHY THEY HAD PARTICULAR ABORTION PROCEDURES; IS THAT RIGHT?

A. YES. THEY WERE QUITE DETAILED DESCRIPTIONS OF THEIR OWN MEDICAL HISTORY.

Q. THOSE WERE THE WOMEN'S OWN ACCOUNTS. YOU HAVE NOT REVIEWED MEDICAL CHARTS OF THOSE PROCEDURES; IS THAT FAIR?

A. NO, I VOLUNTEERED TO REVIEW MEDICAL CHARTS IF THEY FELT THAT WAS NECESSARY. AND IT WAS FELT NOT TO BE NECESSARY AT THE TIME.

Q. SO JUST TO BE CLEAR, YOU HAVE NOT REVIEWED MEDICAL CHARTS OF WOMEN WHO HAVE HAD AN INTACT D&E PROCEDURE; IS THAT RIGHT?

A. CORRECT. JUST PERSONALLY MEDICAL HISTORY, NOT MEDICAL CHARTS.

Q. OKAY. THANK YOU.

MS. GARTNER: YOUR HONOR, WE DON'T OBJECT TO DR. COOK BEING QUALIFIED AS AN EXPERT IN OB/GYN OR MFM, MATERNAL FETAL MEDICINE, GENERALLY. HOWEVER, AS WITH DR. SPRANG AND DR. SHADIGIAN, WE DON'T BELIEVE THAT DR. COOK HAS THE SPECIALIZED EXPERTISE IN INTACT D&E TO DESCRIBE HOW SUCH A PROCEDURE IS ACTUALLY PERFORMED.

HE HASN'T TAUGHT THE PROCEDURE. HE HASN'T SUPERVISED OR BEEN TAUGHT THE PROCEDURE. TO THE EXTENT HE HAS VIEWED THIS VIDEOTAPE, WE DON'T BELIEVE THAT HIS VISUALIZATION AT THE TIME WAS GOOD ENOUGH TO REALLY COMMENT ON HOW THE PROCEDURE WAS DONE. PLUS, HE HAS TESTIFIED IT WAS SEVERAL YEARS AGO. AND HE REPEATEDLY SAID IN RESPONSE TO MY QUESTIONS ABOUT IT AT HIS DEPOSITION THAT HE REALLY DIDN'T RECALL AND

WOULD NEED TO SEE IT AGAIN TO PROVIDE AN ACCURATE RESPONSE.

AS THE COURT HAS PERMITTED WITH DRS. SPRANG AND SHADIGIAN, WE DON'T OBJECT TO HIS PROVIDING HIS OPINION ABOUT THE SAFETY OF THIS PROCEDURE, BASED ON HIS GENERAL EXPERTISE IN OB/GYN AND MATERNAL FETAL MEDICINE, BUT WE WOULD OBJECT TO HIS SETTING FORTH ANY DETAILED DESCRIPTIONS OF THE PROCEDURE OTHER THAN AS NECESSARY FOR HIM TO PROVIDE HIS VIEWS ON THE SAFETY.

AND, OF COURSE, THAT WOULDN'T COME IN FOR THE TRUTH.

THE COURT: SO I WANT TO MAKE SURE I UNDERSTAND. HE WAS OFFERED AS AN EXPERT IN OB/GYN AND MATERNAL FETAL MEDICINE, AS WELL AS PREGNANCY TERMINATION. YOUR OBJECTION ONLY GOES TO THE PREGNANCY TERMINATION ASPECT, AND THEN ONLY TO THE EXTENT OF HIS QUALIFICATIONS ON THE TECHNIQUE OF INTACT --

MS. GARTNER: OF INTACT D&E. AND, ACTUALLY, YOUR HONOR, AS WELL, WE WOULD OBJECT TO HIS TESTIFYING ABOUT THE TECHNIQUE OF D&E IN THE 20 WEEK POST-TIME FRAME SINCE HE TESTIFIED HE HAS NEVER DONE AN ABORTION USING THE D&E TECHNIQUE AFTER 19 WEEKS. AND HE HIMSELF CONSIDERS HIMSELF NOT TO BE AN EXPERT IN D&E FROM THE 20 TO 24 WEEK TIME PERIOD.

THE COURT: ALL RIGHT. I UNDERSTAND.

RESPONSE?

MS. CLARK: CONSISTENT WITH DR. SPRANG AND DR. SHADIGIAN, WE WOULD GO ALONG WITH HIM NOT BEING QUALIFIED AS AN EXPERT WITH RESPECT TO THE SPECIFIC TECHNIQUES, BUT TO THE EXTENT SOME OF THE TECHNIQUES ARE CONSISTENT WITH OTHER

PRACTICES THAT HE DOES IN HIS OWN PRACTICE, SUCH AS INTERNAL PODALIC VERSION, INSERTING LAMINARIA, AND THOSE TECHNIQUES, THE SEPARATE PARTS, WE BELIEVE HE CAN TESTIFY TO THOSE SEPARATE PARTS.

AND WITH RESPECT TO THE D&E --

THE COURT: I DON'T KNOW WHAT PARTS YOU ARE TALKING ABOUT OTHER THAN THE PODALIC VERSION. HE DIDN'T TESTIFY AS TO ANY OTHER ASPECT.

MS. CLARK: WELL, WITH THE INTERNAL PODALIC VERSION AND THE INSERTING LAMINARIA, I BELIEVE THAT WAS HIS TESTIMONY EARLIER. AND THAT HE HAS PERFORMED BREECH PRESENTATION EXTRACTION, AND THE CASE OF WHEN THERE ARE TWINS AND OTHER THINGS OF THAT NATURE.

THE COURT: WELL, OBVIOUSLY, AS AN OBSTETRICIAN HE IS GOING TO HAVE TO TESTIFY ON VARIOUS DIFFERENT ASPECTS OF DELIVERY AND PREGNANCY TERMINATION WITHIN HIS LIMITED EXPERTISE.

BUT I THINK HIS TESTIMONY IS VERY CLEAR. HE HAS TESTIFIED HIMSELF THAT HE IS NOT AN EXPERT ON D&E IN THE LATER WEEKS, THAT IS 20 TO 24 WEEKS, IS THE QUESTION HE WAS SPECIFICALLY ASKED ABOUT. SO HE WILL NOT BE QUALIFIED AS AN EXPERT IN THE QUESTION OF D&E FOR 20 WEEKS PLUS.

IN ADDITION, HE WILL NOT BE QUALIFIED AS AN EXPERT IN THE TECHNIQUE OF INTACT D&E. AND HE MAY TESTIFY, HOWEVER, ON EITHER OF THOSE PROCEDURES TO THE EXTENT THAT HE HAS

REVIEWED OTHER PEOPLE'S DESCRIPTIONS OR REVIEWED THE VIDEOTAPE, TO THE EXTENT HE HAS ANY RECOLLECTION OF THAT, IN ORDER TO OPINE ON THE QUESTION OF THE SAFETY OF EITHER OF THOSE PROCEDURES.

OKAY. THAT IS IT. PLEASE RESUME YOUR DIRECT.

DIRECT EXAMINATION, CONTINUED

BY MS. CLARK:

Q. BRIEFLY, DOCTOR, WHEN DID YOU FIRST HEAR ABOUT THE PARTIAL-BIRTH ABORTION PROCEDURE? YOU ALLUDED TO THIS IN YOUR VOIR DIRE, BUT IF YOU WOULD GO OVER IT WITH THE COURT.

A. WELL, AS I CAN BEST RECOLLECT, THE FIRST TIME IT CAME TO MY ATTENTION WAS WHEN A PHYSICIAN WHO AT THAT TIME WAS HEADING UP THE SOCIETY OF OBSTETRICAL ANESTHESIA WAS CALLED UPON TO TESTIFY SPECIFICALLY ABOUT THE ISSUE OF ANESTHESIA POTENTIALLY CAUSING THE DEATH OF THE FETUS IN THESE PROCEDURES.

HE WAS THEN ASKED AS PART OF HIS LINE OF QUESTIONING ON THIS AREA ABOUT OTHER SPECIFICS RELATED TO THE PROCEDURE THAT HE WAS NOT COMFORTABLE ADDRESSING. AND SO HE MENTIONED MY NAME AS A PERSON WHO MIGHT BE ABLE TO PROVIDE ACCURATE MEDICAL BACKGROUND IN SOME OF THESE OTHER AREAS.

AND SOMEHOW -- I DON'T REMEMBER THE DETAILS -- THIS LED TO ME HELPING VARIOUS DIFFERENT STATES AND VARIOUS DIFFERENT LEVELS OF FEDERAL GOVERNMENT, AS WELL, IN TRYING TO CLARIFY THE SPECIFIC MEDICAL INFORMATION THAT THEN LED TO THE DEVELOPMENT PHACT ORGANIZATION FOR WHICH I WAS ASKED TO HELP

FORMULATE AND HAVE SORT OF A THOUGHTFUL, ACCURATE AND RESPECTED SORT OF POSITION IN ORDER TO KIND OF CLARIFY, AGAIN, THESE MEDICAL ISSUES.

SO IT IS HARD FOR ME TO REMEMBER SOMETIMES WHAT HAPPENED WHEN. I JUST SOMEHOW FOUND MYSELF WHERE I FIND MYSELF TODAY.

Q. BRIEFLY, WHAT DO YOU UNDERSTAND THE PARTIAL-BIRTH ABORTION PROCEDURE TO REFER TO?

A. I UNDERSTAND IT TO REFER TO A PROCEDURE THAT WAS DESCRIBED BY DR. HASKELL AT A NATIONAL ABORTION FEDERATION SEMINAR, WHICH WAS ESSENTIALLY IDENTICAL TO THE PROCEDURE BEING PERFORMED BY DR. MCMAHON AND SUBSEQUENTLY ACKNOWLEDGED TO BE PERFORMED BY OTHER PHYSICIANS MULTIPLE THOUSANDS OF TIMES A YEAR IN THIS COUNTRY, WITH SEVERAL SIMILAR ELEMENTS.

MOST OF THOSE ELEMENTS INCLUDE FIRST DELIVERING -- OR FIRST, I AM SORRY -- DILATING A CERVIX MORE SO THAN YOU WOULD WITH ANY OTHER ABORTION PROCEDURE, USING UP TO 25 OR MAYBE EVEN 30 DILATORS AT A TIME OVER AN ONE-TO-TWO DAY CERVICAL PREPARATION PERIOD. THEN, BRINGING THE WOMAN IN, GENERALLY ON THE THIRD DAY, AND CONVERTING THE BABY TO A BREECH POSITION, IF THE BABY IS NOT ALREADY PRESENTING IN A BREECH POSITION. DELIVERING THE BABY UP TO THE LEVEL OF THE AFTER-COMING-COMING HEAD.

THEN, ONCE THE AFTER-COMING HEAD IS DRAWN DOWN TO THE CERVIX, THE BASE OF THE SKULL IS THEN PUNCTURED WITH A

SHARP INSTRUMENT, GENERALLY A SCISSOR, AND THEN A SUCTION CURETTE IS INTRODUCED INTO THE CREATED DEFECT IN THE BASE OF THE BABY'S SKULL, AND INTRACRANIAL CONTENTS, THE BRAIN CONTENTS ARE THEN SUCTIONED OUT OR EVACUATED TO THEN CAUSE COLLAPSING OF THE SKULL BONES TO REDUCE THE DIAMETER OF THE BABY'S HEAD SIZE TO BE ABLE TO COMPLETE THE REMAINDER OF THE DELIVERY.

ALL OF THIS BEING DONE ON A PREVIOUSLY LIVING FETUS.

Q. DO YOU UNDERSTAND, DOCTOR, PARTIAL-BIRTH ABORTION D&X AND INTACT D&E GENERALLY TO BE INTERCHANGEABLE TERMS?

A. YES. WHEN THE PROCEDURE WAS FIRST DESCRIBED BY DR. HASKELL, IT WAS CALLED A "D&X PROCEDURE" TO DISTINGUISH IT FROM A "D&E PROCEDURE." AND IT WAS DESCRIBED FOR USE BY DR. HASKELL INITIALLY BETWEEN 20 AND 26 WEEKS.

DR. MCMAHON, DOING ESSENTIALLY THE SAME PROCEDURE, REFERRED TO IT AS AN "INTACT D&E," BECAUSE IT DID NOT REQUIRE DISMEMBERMENT. AND HE WOULD PERFORM THESE AT SIMILAR GESTATIONAL AGES, AND EVEN BEYOND 26 WEEKS.

SUBSEQUENTLY, THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY CREATED A SORT OF HYBRID TERM: "INTACT D&X," WHICH HAS BEEN OFTENTIMES USED INTERCHANGEABLY WITH ALL THE OTHER TERMS. SO THE TERM I PREFER IS "PARTIAL-BIRTH ABORTION," WHICH NOW DOES APPEAR IN THE MEDICAL LEXICON AS A DESCRIPTION OF THIS PROCEDURE.

Q. DR. COOK, DID YOU REVIEW BOTH THE HASKELL DESCRIPTION AND DR. MCMAHON'S DESCRIPTION BEFORE YOU TESTIFIED BEFORE CONGRESS?

A. I DID.
Q. AND DID YOU REVIEW THOSE BEFORE YOU PREPARED YOUR EXPERT REPORT IN THIS CASE?
A. I BELIEVE I DID REVIEW ELEMENTS OF IT, SPECIFICALLY DR. MCMAHON'S VERY DETAILED DESCRIPTION OF MEDICAL AND FETAL INDICATIONS, AS HE DESCRIBED THEM. BUT I HAVE REVIEWED THESE TECHNIQUES SO MANY TIMES I AM NOT CERTAIN IF I REREAD, FOR INSTANCE, DR. HASKELL'S DESCRIPTION BEFORE PROVIDING THIS EXPERT REPORT SINCE I HAVE DONE SIMILAR REPORTS FOR A NUMBER OF YEARS NOW.
Q. HAVE YOU DISCUSSED THE PARTIAL-BIRTH ABORTION PROCEDURE WITH YOUR COLLEAGUES?
A. I HAVE WITH SOME COLLEAGUES, YES.
Q. WHAT ABOUT THE PARTIAL-BIRTH ABORTION PROCEDURE HAVE YOU DISCUSSED WITH COLLEAGUES AT YOUR HOSPITAL AND OTHER OB/GYN PHYSICIANS?
A. WELL, WHEN I FIRST WAS ASKED TO TESTIFY SPECIFICALLY IN FRONT OF CONGRESS, I BELIEVE IN 1997, OTHER PEOPLE IN MATERNAL FETAL MEDICINE WOULD START ASKING ME ABOUT THIS PROCEDURE. AND MOST OF THEIR QUESTIONS WERE ALONG THE LINE:

"IS ANYBODY REALLY DOING THIS? WHY ARE THEY DOING THIS? HOW OFTEN ARE THEY DOING THIS?"

BECAUSE THEY WERE IN SIMILAR SITUATIONS THAT I HAD BEEN IN WHERE THEY TAKE CARE OF EXCLUSIVELY COMPLICATED PREGNANCIES, PREDOMINANTLY IN ACADEMIC SETTINGS. AND THEY HAD NEVER SEEN

THE NEED TO DO THIS PROCEDURE, SO THEY WERE A LITTLE INCREDULOUS IT WAS REALLY BEING DONE. AND THEN --

MS. GARTNER: YOUR HONOR, THIS IS HEARSAY FOR HIM TO BE TALKING ABOUT --

THE COURT: SUSTAINED.

BY MS. CLARK:

Q. DOCTOR, HAVE ANY OF THE CONVERSATIONS WITH OTHER PHYSICIANS -- IN THE CONTEXT OF THOSE CONVERSATIONS, HAVE YOU DISCUSSED THE MEDICAL NECESSITY OF THE PARTIAL-BIRTH ABORTION PROCEDURE?

A. YES. THAT'S WHERE MOST OF THE DISCUSSIONS STARTED.

Q. AND HAVE THESE CONVERSATIONS HELPED YOU TO INFORM YOUR OPINION ABOUT THE MEDICAL NECESSITY OF THE PARTIAL-BIRTH ABORTION PROCEDURE?

A. YES. I WANTED CONFIRMATION THAT I WAS NOT THE ONLY ONE THAT FELT THIS WAS NOT NECESSARY.

Q. DOCTOR, YOU'VE TESTIFIED THAT YOU PREVIOUSLY TESTIFIED BEFORE CONGRESS REGARDING THE PARTIAL-BIRTH ABORTION PROCEDURE. HOW MANY TIMES HAVE YOU TESTIFIED BEFORE CONGRESS REGARDING THIS PROCEDURE?

A. I BELIEVE TWICE. ONCE IN FRONT OF A SPECIAL JOINT SESSION OF THE HOUSE AND SENATE JUDICIARY COMMITTEES, AND ONCE IN FRONT OF A HOUSE SUBCOMMITTEE ON THE CONSTITUTION OF THE JUDICIARY, AS I RECALL.

Q. ARE THE OPINIONS THAT YOU WILL BE OFFERING TODAY CONSISTENT

WITH YOUR CONGRESSIONAL TESTIMONY?

A. THEY ARE.

Q. DOCTOR, WHAT IS YOUR OPINION AS TO WHETHER THE PARTIAL-BIRTH ABORTION PROCEDURE IS EVER MEDICALLY NECESSARY TO PROTECT THE HEALTH INTEREST OF WOMEN FACING HIGH-RISK PREGNANCIES?

A. I DON'T BELIEVE THAT IT IS EVER MEDICALLY NECESSARY. IT HAS EVEN BEEN STATED BY THE COLLEGE: THERE IS NO SITUATION -- THE AMERICAN COLLEGE OF OB/GYN -- THERE IS NO SITUATION WHERE THEY CAN THINK OF THAT THIS IS THE ONLY OPTION AVAILABLE.

THIS IS THE PREVAILING THOUGHT, THAT THERE ARE OTHER METHODS THAT ARE AVAILABLE, SAFER, WELL-ESTABLISHED METHODS. SO I DON'T BELIEVE IT HAS ANYTHING TO OFFER US IN THE AREA OF TREATMENT OF COMPLICATED PREGNANCIES.

Q. DR. COOK, WHAT IS YOUR OPINION AS TO WHETHER THE PARTIAL-BIRTH ABORTION PROCEDURE PRESENTS RISKS TO WOMEN UNDERGOING THAT PROCEDURE AS COMPARED TO OTHER METHODS OF PREGNANCY TERMINATIONS?

A. WELL, I HAVE GRAVE CONCERNS THAT ELEMENTS OF THE PROCEDURE HAVE RISKS FOR BOTH IMMEDIATE COMPLICATIONS AND LONG-TERM COMPLICATIONS THAT I DON'T FEEL JUSTIFY UTILIZING THE PROCEDURE WHEN YOU HAVE OTHER SAFE PROCEDURES AVAILABLE.

Q. DOCTOR, YOU TESTIFIED THAT YOU PERFORMED QUITE A FEW LESS D&E'S IN YOUR CAREER THAN INDUCTION; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. IS THERE SOMETHING ABOUT THE MATERNAL HEALTH CONDITIONS THAT YOU SEE IN YOUR PRACTICE THAT MAKES THE INDUCTION METHOD THE MOST APPROPRIATE PROCEDURE FOR PREGNANCY TERMINATIONS?

A. WELL, YES. AGAIN, MANY OF THE WOMEN THAT WE CARE FOR HAVE A SIGNIFICANT MEDICAL CONDITION, ESPECIALLY IF WE ARE GETTING TO THE POINT WHERE WE ARE NEEDING TO DELIVER THEM PREVIABILITY. BUT EVEN MANY THAT WE ARE DELIVERING POSTVIABILITY HAVE SIGNIFICANT MEDICAL CONCERNS, AND THAT'S WHY THEY ARE BEING DELIVERED PREMATURELY.

IN THE SETTING, FOR INSTANCE, OF PREECLAMPSIA, SEVERE PREECLAMPSIA FREQUENTLY HAS VERY LOW PLATELET COUNTS AND PLATELET DYSFUNCTION, WHICH MEANS THEY ARE AT INCREASED RISK FOR BLEEDING COMPLICATIONS.

SO I WOULD LIKE TO AVOID ANYTHING THAT WOULD HAVE AN INCREASED RISK FOR UTERINE TRAUMA OR CERVICAL LACERATION, OR POTENTIALLY UNCONTROLLED BLEEDING.

THERE ARE OTHER CONDITIONS WHERE THE WOMEN HAVE TO HAVE VERY CONTROLLED FLUID STATUS, SO WE ALSO WOULD NOT WANT THEM TO HAVE CERTAIN TYPES OF INFECTIOUS OR BLEEDING COMPLICATIONS, IF WE CAN PREVENT THEM.

Q. IS THERE SOMETHING ABOUT THE NATURE OF YOUR PRACTICE WITH RESPECT TO MATERNAL HEALTH CONDITIONS THAT MAKES THE INDUCTION METHOD A MORE APPROPRIATE METHOD?

A. YES. AGAIN, THERE ARE SEVERAL ELEMENTS THAT LEND ITSELF TO PREFERRING INDUCTION, PART OF WHICH IS THE GESTATIONAL AGE AT

WHICH MOST OF THESE DECISIONS ARE BEING MADE, AND WHEN THEY ARE REFERRED TO OUR OFFICE.

PART OF WHICH IS THE DESIRE TO BE ABLE TO OBTAIN OPTIMAL INFORMATION FROM THE FETUS IF IT IS DONE IN THE SETTING OF A FETAL ABNORMALITY, WHICH INCLUDED INTACT FETUS AND AN INTACT CENTRAL NERVOUS SYSTEM. PART OF WHICH WOULD BE WANTING TO UTILIZE THE MOST NATURAL PROCESS POSSIBLE IN ORDER TO EVACUATE THE UTERUS.

AND THEN, PART OF WHICH WOULD BE TRYING TO DO IT IN AS CONTROLLED A SETTING AS POSSIBLE.

Q. AND WHY IS IT IMPORTANT THAT YOU BE ABLE TO PERFORM THE TERMINATION IN A CONTROLLED SETTING OR AS CONTROLLED A SETTING AS POSSIBLE?

A. WELL, FREQUENTLY THESE WOMEN HAVE LIMITED RESERVE FOR COMPLICATIONS, SPECIFICALLY COMPLICATIONS OF BLEEDING, INFECTION, THINGS OF THAT NATURE.

IT IS ALSO PREFERABLE TO USE A VARIATION ON THEIR NORMAL PHYSIOLOGY, WHICH SURGERY IS NOT, IN ORDER TO EFFECT A DELIVERY WITH THE LEAST AMOUNT OF STRAIN ON THEIR SYSTEM.

Q. DOCTOR, IN PERFORMING INDUCTION PROCEDURES HAS THE BABY'S HEAD EVER GOTTEN STUCK AT THE INTERNAL CERVICAL OS DURING THE DELIVERY PART OF THE PROCEDURE?

A. YES, THAT HAPPENS ON OCCASION.

Q. WHAT HAVE YOU DONE IN ORDER TO ADDRESS THE ISSUE OF THE HEAD GETTING STUCK WHEN PERFORMING THE INDUCTION?

A. WELL, IF IT IS A SITUATION WHERE WE ARE AT LATER GESTATIONAL AGES, 23 OR 24 WEEKS AND BEYOND, WE GENERALLY WANT TO TRY TO DELIVER IN AS EXPEDITIOUS A MANNER AS POSSIBLE IN ORDER TO NOT JUST COMPLETE THE DELIVERY, BUT PROVIDE CARE TO THE FETUS.

SO IN THAT SITUATION WE HAVE A NUMBER OF MEDICAL AND SURGICAL OPTIONS AVAILABLE TO US. THAT MAY BE GIVING CERTAIN UTERINE RELAXING AND CERVICAL RELAXING MEDICAL AGENTS, SUCH AS NITROGLYCERIN. IT MAY INVOLVE USING FORCEPS TO FACILITATE DELIVERING OF THE AFTER-COMING HEAD.

IT MAY INVOLVE MAKING A SMALL CESAREAN INCISION ON A PORTION OF THE CERVIX TO RELAX THE CERVIX.

IF IT IS A SITUATION WHERE IT IS A PREVIABLE INDUCTION, THEN IT IS NOT AS NECESSARY TO DELIVER THE BABY IN A VERY RAPID FASHION. OUR EXPERIENCE IS THAT WE LEAVE THE BABY THERE, DELIVER IT UP TO THE LEVEL OF THE AFTER-COMING HEAD, THAT AFTER SEVERAL MINUTES, THE BABY, PREVIOUSLY LIVING, WILL NO LONGER BE LIVING. AND YOU CAN START GETTING COLLAPSING OF THE SKULL BONES SPONTANEOUSLY.

OR OFTENTIMES, WITH CONTINUED UTERINE ACTIVITY, THE FETUS WILL BE EXPELLED EVEN AFTER-COMING HEAD. SO OFTENTIMES I ENCOURAGE PEOPLE TO JUST WAIT, IF THE FETAL INTERESTS ARE NOT OF GREAT CONCERN, AND WE OFTENTIMES SEE THE BABY DELIVER SPONTANEOUSLY.

IF WE DON'T OR THE MOTHER STARTS DEVELOPING OTHER

PROBLEMS LIKE BLEEDING, THEN WE CAN UTILIZE SOME OF THE TECHNIQUES THAT I MENTIONED BEFORE.

Q. DOCTOR, USING THESE METHODS, HAVE YOU EVER BEEN ABLE TO COMPLETE THE INDUCTION METHOD -- WELL, I ASSUME, DOCTOR, USING THESE METHODS, HAVE YOU EVER NEEDED TO PUNCTURE THE BABY'S HEAD AND SUCTION OUT ITS INTRACRANIAL CONTENTS IN ORDER TO COMPLETE THE DELIVERY?

A. I HAVE NEVER HAD TO DO THAT, NO.

Q. HAVE YOU EVER PLACED THE MOTHER'S HEALTH AT RISK BY NOT PUNCTURING THE BABY'S HEAD WITH SCISSORS AND SUCTIONING OUT THE INTRACRANIAL CONTENTS?

A. NO. AGAIN, WE HAVE OTHER OPTIONS AVAILABLE TO US.

Q. DOCTOR, DO YOU CONSIDER RETAINED PLACENTA TO BE A COMPLICATION IN AN INDUCTION OF LABOR PROCEDURE?

A. WELL, RETAINED PLACENTA OCCURS GENERALLY ABOUT 10 PERCENT OF THE TIME IN INDUCED DELIVERY, AND IT THEN REQUIRES PLACENTAL REMOVAL. SO IN THAT SENSE, I GUESS YOU CONSIDER IT A COMPLICATION OR A KNOWN SIDE EFFECT OF INDUCTION.

BUT, GENERALLY, WHEN I THINK ABOUT COMPLICATIONS OF INDUCTION, I THINK ABOUT THINGS LIKE BLEEDING ENOUGH TO NEED A TRANSFUSION, OR INJURY TO OTHER ORGANS OR CONCERNING INFECTION, THINGS OF THAT NATURE.

AND YOU CAN GET RETAINED PLACENTAS WITH SURGICAL EVACUATION, AS WELL.

Q. TO THE EXTENT YOU CONSIDER RETAINED PLACENTA A COMPLICATION

AT ALL IN AN INDUCTION PROCEDURE, HOW WOULD YOU CHARACTERIZE IT AS IN TERMS OF WHAT KIND OF COMPLICATION IT IS?

A. WELL, I GUESS I WOULD CONSIDER IT A MORE OF A MINOR COMPLICATION IN THAT IT DOES INVOLVE THE NEED FOR ADDITIONAL MANIPULATION, USUALLY A SUCTION OR SHARP CURETTAGE OF THE REMAINING PLACENTA.

BUT IT'S NOT SOMETHING, GENERALLY, THAT I CONSIDER A COMPLICATION AS FAR AS THREATENING THE WOMAN'S HEALTH, UNLESS IT GOT TO THE POINT OF BLEEDING THAT WAS SEVERE ENOUGH TO REQUIRE A TRANSFUSION OR INFECTION.

Q. DOCTOR, HOW LONG DO YOU WAIT IN A MEDICAL INDUCTION PROCEDURE IF THE PLACENTA HAS NOT PASSED BEFORE TAKING ADDITIONAL STEPS TO DELIVER A PLACENTA?

A. WELL, IN AN OTHERWISE STABLE MOTHER, GENERALLY I LIKE TO SEE THE PLACENTA DELIVERED WITHIN TWO HOURS OR SO OF THE DELIVERY.

HOWEVER, IF SHE STARTS HAVING PROBLEMS LIKE BLEEDING OR INFECTION, THEN WE WOULD WANT TO MOVE FASTER TO DELIVERY OF THE PLACENTA.

Q. DOCTOR, NOW TURNING TO THE D&E ABORTION PROCEDURE, COULD YOU PLEASE DESCRIBE WHAT YOU UNDERSTAND THAT PROCEDURE TO BE?

A. WELL, THE HALLMARK OF A D&E PROCEDURE WOULD BE A DISMEMBERMENT OF THE FETUS AND WOULD ALSO INCLUDE AN ACCURATE COUNT OF THE FETAL PARTS AFTERWARDS TO MAKE SURE THAT ALL OF THE FETUS IS ACCOUNTED FOR; THAT YOU DON'T HAVE A RETAINED

PORTION OF THE FETUS, THE MOST COMMON ONE BEING A RETAINED FETAL SKULL. IT ALSO REQUIRES MORE CERVICAL DILATATION THAN WOULD BE REQUIRED FOR A FIRST-TRIMESTER SUCTION D&C, BUT LESS THAN IS DESCRIBED TO BE USED FOR THIS PARTIAL-BIRTH ABORTION PROCEDURE.

Q. ARE YOU FAMILIAR WITH THE NATURE OF FETAL TISSUE PRIOR TO 20 WEEKS?

A. I AM.

Q. AND WHAT IS THE NATURE OF FETAL TISSUE PRIOR TO 20 WEEKS?

A. GENERALLY, TISSUE PRIOR TO 20 WEEKS GESTATION IS MORE FRAGILE, MUCH MORE EASY TO CAUSE FETAL BRUISING OR FETAL LACERATION AT THESE EARLY GESTATIONAL AGES.

Q. HOW HAVE YOU BECOME FAMILIAR WITH THE TISSUE AT THAT GESTATIONAL AGE?

A. WELL, WE DO SEE FETUSES DELIVERED AT THAT GESTATIONAL AGE, FOR ONE. AND, IN FACT, WE FREQUENTLY USE THAT APPEARANCE TO HELP DATE A PREGNANCY.

FOR INSTANCE, BABIES IN THE 20 TO 24 WEEK RANGE OFTENTIMES HAVE A MUCH MORE TRANSLUCENCE -- I AM SORRY -- MUCH MORE TRANSPARENT SKIN APPEARANCE THAN DO KIDS BEYOND 24 WEEKS.

SO WE CAN HELP DATE A PREGNANCY JUST BY LOOKING AT THE FETUS. BUT, ALSO, FROM OUR EXPERIENCES DOING PROCEDURES ON FETUSES. SO BOTH DELIVERY EXPERIENCE AND INTRAUTERINE PROCEDURAL EXPERIENCE.

Q. AND WHAT ARE SOME OF THOSE INTRAUTERINE EXPERIENCES THAT

GIVE YOU A SENSE OF THE FETAL TISSUE, THE NATURE OF THE FETAL TISSUE?

A. WELL, FOR INSTANCE, WHEN WE DO INTRAUTERINE TRANSFUSIONS OR WE PUT IN CERTAIN TYPES OF SHUNTS INTO A FETUS IT IS MUCH EASIER TO PUT NEEDLES OR BIOPSY FORCEPS OR SHUNTS INTO THESE BABIES AT EARLIER GESTATIONAL AGES THAN IT IS AT THE LATER GESTATIONAL AGES BECAUSE OF THE INTEGRITY OF THEIR SKIN OR THEIR INTEGUMENTS, WE CALL IT.

Q. AND YOU WOULD AGREE THAT THESE PROCEDURES GIVE YOU A SENSE OF THE FETAL TISSUE BOTH BEFORE 20 WEEKS AND IN THE 20 TO 24 WEEK TIME FRAME?

A. YES, I WOULD SAY IN THE WORLD OF MATERNAL FETAL MEDICINE YOU ARE GENERALLY PRETTY FAMILIAR WITH HOW FETUS RESPONDS THROUGHOUT THE GESTATIONAL AGES.

Q. DOCTOR, IN YOUR PRACTICE WHEN IT'S MEDICALLY NECESSARY FOR THE MOTHER TO TERMINATE A PREGNANCY, ARE THERE SOME CIRCUMSTANCES IN WHICH THE D&E PROCEDURE WOULD BE THE PREFERRED METHOD FOR TERMINATION?

A. THERE MAY BE.

Q. AND WHAT MIGHT BE THAT KIND OF SITUATION?

A. WELL, GENERALLY, A SUCTION CURETTAGE TECHNIQUE IS NOT A TECHNIQUE THAT YOU COULD UTILIZE BEYOND 12 TO 14 WEEKS GESTATION. A D&E PROCEDURE BECOMES A MUCH MORE COMPLICATED PROCEDURE BEYOND 20 WEEKS GESTATION. BUT BETWEEN SPECIFICALLY 14 AND 18 WEEKS GESTATION, A D&E CAN BE SAFELY PERFORMED AND IS

FREQUENTLY PERFORMED AND MAY BE THE OPTION INVOLVED IN A SITUATION WHERE, FOR INSTANCE, THE FETAL PATHOLOGY IS NOT A CRITICAL ELEMENT, OR WE HAVE CONCERNS ABOUT THE MOTHER GOING THROUGH A LABORING PROCESS.

Q. IF YOU DETERMINED IN A CASE OF A FETAL ANOMALY WHERE THE MOTHER ELECTED TO TERMINATE HER PREGNANCY, AND YOU DETERMINED THAT A D&E PROCEDURE WAS THE SAFEST PROCEDURE FOR PREGNANCY TERMINATION, WOULD YOU REFER THAT WOMAN TO ANOTHER PHYSICIAN?

A. I AM SORRY. CAN I HAVE YOU GIVE ME THE WHOLE QUESTION ONE MORE TIME?

Q. SURE. IF YOU DETERMINED IN THE CASE OF A FETAL ANOMALY WHERE THE MOTHER HAD ELECTED TO TERMINATE THE PREGNANCY, AND YOU DETERMINED THAT A D&E PROCEDURE WAS THE SAFEST PROCEDURE FOR PREGNANCY TERMINATION, WOULD YOU REFER THAT WOMAN TO ANOTHER PHYSICIAN?

A. I WOULD.

Q. AND HAVE YOU, IN FACT, REFERRED WOMEN TO OTHER PHYSICIANS IN ORDER TO HAVE THE D&E PROCEDURE?

A. I HAVE, IF THE MATERNAL CONDITION IS STABLE.

Q. IF YOU HAD A SITUATION WHERE THE FETUS WAS PREVIABLE AND THE MOTHER'S HEALTH WAS DETERIORATING TO A POINT IN WHICH YOU FELT HER LIFE WERE AT RISK, AND YOU DETERMINED THAT THE D&E PROCEDURE WAS THE MOST APPROPRIATE OPTION TO TERMINATE THE PREGNANCY, WOULD YOU HAVE AN ETHICAL OBJECTION TO PERFORMING A D&E IN THAT CIRCUMSTANCE?

A. NO, I WOULD NOT.

JUST MAYBE TO CLARIFY, OUR GOAL AS MATERNAL FETAL MEDICINE SPECIALISTS IS TO TRY TO GET AN OPTIMAL OUTCOME FOR BOTH THE MOTHER AND FETUS. BUT IF THERE IS A CONFLICT THAT ARISES, WE ALWAYS TRY TO CONSIDER THE MATERNAL ISSUES AS PREDOMINANT OVER THE FETAL ISSUES.

SO IF IT POSED A RISK TO HER LIFE OR SIGNIFICANT HEALTH PROBLEMS, THEN WE WOULD DO WHATEVER IS NECESSARY TO SAFELY DELIVER HER. IF THAT WAS FELT TO BE D&E, WE WOULD DO D&E.

Q. NOW, IS IT FAIR TO SAY, GENERALLY SPEAKING, POST 16 WEEKS THE PREGNANCY HAS TO BE TERMINATED, THAT YOU WOULD RECOMMEND THE INDUCTION PROCEDURE?

A. GENERALLY, IN THE KIND OF CASES THAT WE SEE, WHERE THEY OFTENTIMES HAVE MATERNAL CONDITIONS INVOLVED, OR JUST DIAGNOSED IT, WE WOULD PREDOMINANTLY USE INDUCTION. AND, AGAIN, OFTENTIMES IT IS NECESSARY FOR US TO OPTIMIZE INFORMATION WE HAVE AVAILABLE TO US AFTER THE DELIVERY IN ORDER TO COUNSEL THAT PATIENT ABOUT POTENTIAL FUTURE PREGNANCIES AND RECURRENCE RISKS OF SIMILAR PROBLEMS.

SO WE WOULD USE INDUCTION PREDOMINANTLY, YES.

Q. AND OTHER THAN COUNSELING-WOMEN-REASONS, WHY WOULD YOU FAVOR A MEDICAL INDUCTION AS OPPOSED TO DISMEMBERMENT D&E WHEN IT IS CLEAR THAT THE FETUS IS NOT GOING TO LIVE, ANYWAYS? SO, FOR EXAMPLE, IF YOU ARE IN THE 16 TO 24 WEEK GESTATIONAL RANGE?

A. WELL, AGAIN, PATHOLOGY IS ONE ASPECT OF IT, BECAUSE IT HAS IMPLICATIONS NOT JUST FOR LETTING THE PATIENTS KNOW WHAT WAS HAPPENING THIS PREGNANCY, BUT POTENTIALLY FUTURE PREGNANCIES OR FUTURE FAMILY MEMBERS' PREGNANCIES.

AGAIN, THE ISSUE OF TRYING TO TAKE A WOMAN, ESPECIALLY IF SHE HAS A SIGNIFICANT MEDICAL CONDITION, THROUGH AS LEAST TRAUMATIC EXPERIENCE AS POSSIBLE FOR HER OTHERWISE COMPROMISED SYSTEM, AND LIMITED RESERVE FOR EXPERIENCING COMPLICATIONS, SUCH AS BLEEDING OR INFECTION. AND, AGAIN, THE MONITORING SITUATION IS OPTIMAL, I THINK, IN THAT INDUCED LABOR IN THE HOSPITAL.

Q. IS THERE ANYTHING ABOUT THE RISK OF INFECTION OR HEMORRHAGING THAT HAS ANYTHING TO DO WITH YOUR ANALYSIS?

A. WELL, THERE ARE CERTAIN MATERNAL CONDITIONS FOR WHICH IT WOULD BE, AGAIN, A VERY LIMITED CAPACITY THAT THAT PATIENT WOULD HAVE FOR EXPERIENCING THOSE TYPES OF COMPLICATIONS.

AND THAT MAY INCLUDE SOMEBODY WITH LOW PLATELET COUNTS OR SOMEBODY WITH CERTAIN CARDIAC CONDITIONS WHERE THEY CANNOT HANDLE LARGE FLUID VOLUME SHIFTS, OR ANY NUMBER OF REASONS.

IN THAT SITUATION WE WANT TO TRY TO DELIVER HER, AGAIN, IN AS NATURAL AND CONTROLLED AND AS MONITORED A SITUATION AS POSSIBLE.

Q. WOULD THAT MEAN THE INDUCTION PROCEDURE?

A. WHICH WOULD MEAN AN INDUCTION PROCEDURE IN A HOSPITAL,

SUPERVISED BY PEOPLE WHO TAKE CARE OF COMPLICATED PREGNANCIES.

MS. CLARK: MAY I APPROACH, YOUR HONOR?

THE COURT: YES.

BY MS. CLARK:

Q. DOCTOR, I HAVE JUST SHOWN YOU WAS THAT HAS BEEN MARKED AS LT A-28. DR. COOK, HAVE YOU SEEN THIS DOCUMENT BEFORE?

A. I HAVE SEEN IT SEVERAL TIMES, YES.

Q. WHEN DID THIS FIRST COME TO YOUR ATTENTION, THIS DOCUMENT?

A. AS I CAN BEST RECOLLECT, SOMEWHERE VERY EARLY ON IN THE PROCESS OF MY BEING ASKED TO COMMENT ON SPECIFICS OF THIS PROCEDURE, AND DEFINITELY PRIOR TO MY TESTIMONY IN FRONT OF CONGRESS IN 1997.

Q. ARE YOU RELYING UPON THIS DOCUMENT IN PROVIDING YOUR EXPERT TESTIMONY IN THIS CASE?

A. IT IS A PART OF THE MATERIAL THAT I USED FOR THIS EXPERT TESTIMONY, YES.

Q. AND DID YOU RELY UPON IT WHEN YOU TESTIFIED BEFORE CONGRESS?

A. I DID.

Q. DOCTOR, I DIRECT YOU TO PAGE 127. IF YOU WOULD READ THE FIRST PARAGRAPH OUT LOUD.

MS. GARTNER: YOUR HONOR, WE OBJECT TO HIS READING THIS INTO THE RECORD. THIS ENTIRE DOCUMENT IS HEARSAY, AND WE UNDERSTAND THAT HE MAY HAVE RELIED ON IT, I DON'T THINK IT NEEDS TO BE READ INTO THE RECORD.

THE COURT: IT IS CERTAINLY NOT A LEARNED TREATISE. WHAT WOULD BE YOUR AUTHORITY?

MS. CLARK: TO READ IT INTO THE RECORD, IT GIVES HIS PERSPECTIVE AND UNDERSTANDING OF THE PARTIAL-BIRTH ABORTION PROCEDURE. AND IT ESTABLISHES WHAT HIS BASIS OF KNOWLEDGE WAS WHEN HE TESTIFIED BOTH BEFORE CONGRESS AND HERE.

THE COURT: HE HAS ALREADY GIVEN US A VERY DETAILED DESCRIPTION OF WHAT HE BELIEVES TO BE THE PROCEDURE, BASED UPON THIS AND THE VIDEOTAPE AND MCMAHON'S ARTICLE, AS WELL.

I DON'T THINK IT ADVANCES IT. YOU CAN ASK HIM QUESTIONS ABOUT IT, BUT THERE IS NO REASON TO READ IT.

BY MS. CLARK:

Q. DOCTOR, BASED ON THIS DOCUMENT, DO YOU HAVE AN UNDERSTANDING AS TO WHEN THE D&X PROCEDURE IS DESIGNED TO BE USED?

A. I DO.

MS. GARTNER: OBJECTION, YOUR HONOR. I AM SORRY. THAT WOULD ALL BE HEARSAY.

SINCE HE WASN'T PARTICIPATING IN THE DESIGN OF THIS PROCEDURE, ANYTHING HE SAYS ABOUT WHAT IT WAS DESIGNED TO DO WOULD BE HEARSAY BASED ON EXTERNAL SOURCES.

MS. CLARK: I WOULD BE HAPPY TO DIRECT HIM TO WHERE IN THE PAPER THAT SHOWS THAT IT IS LATER IN THE PROCEDURE. BUT TO THE EXTENT --

THE COURT: LATER IN THE --

MS. CLARK: I AM SORRY. THAT'S LATER IN THE PREGNANCY, THE 20 WEEKS, 22 WEEKS, 24 WEEKS. AND TO THE EXTENT THAT HE IS GOING TO BE COMPARING THE RELATIVE SAFETY OF THE D&X PROCEDURE TO OTHER PREGNANCY TERMINATIONS, IT IS IMPORTANT FOR HIM TO ESTABLISH WHAT HE UNDERSTANDS THE PROCEDURE TO BE AND THAT HE IS NOT JUST MAKING IT UP, AND THAT HE OBTAINED THAT INFORMATION FROM A SOURCE OF INFORMATION.

THE COURT: OKAY.

MS. GARTNER: YOUR HONOR, I THINK IF THE GOVERNMENT WANTED TESTIMONY IN THIS CASE ABOUT THE DESIGN OF THE PROCEDURE, AT WHAT GESTATIONAL AGES IT WAS INTENDED TO BE USED, THEY COULD HAVE CALLED DR. HASKELL TO TESTIFY ABOUT HIS DESIGN IF, IN FACT, IT WAS HIS DESIGN.

BUT I DON'T THINK -- I MEAN, WE HAD TESTIMONY THROUGHOUT THE LAST FEW WEEKS ABOUT WHEN, IN FACT, IT IS USED. AND I THINK FOR HIM TO TALK ABOUT WHAT ONE PRACTITIONER IN OHIO INTENDS IT TO BE USED IS JUST HEARSAY, AND THERE IS NO BASIS FOR IT.

MS. CLARK: WELL, I AM NOT SURE IF WE COULD HAVE HAD DR. HASKELL COME HERE AND TESTIFY. HE IS CERTAINLY OUTSIDE THE SUBPOENA POWER OF THE COURT. AND THIS IS WHAT HE RELIED UPON WHEN HE TESTIFIED BEFORE CONGRESS. AND IT'S WHAT KICKED OFF -- WE HEARD LOT OF TESTIMONY ABOUT THIS PAPER THAT KICKED OFF THE DEBATE. IT KICKED OFF HIM TESTIFYING BEFORE CONGRESS, HIM BEING INVOLVED IN THE DEBATE.

AND IT IS IMPORTANT TO ESTABLISH THAT HE HAS SOME BASIS FOR WHY HE BELIEVES THAT THE PROCEDURE INVOLVES LOTS OF DILATION, 25 LAMINARIA OR MORE, AND THAT IT IS DONE IN THE LATER GESTATIONAL AGES OF SECOND-TRIMESTER PREGNANCY.

MS. GARTNER: I AM SORRY, YOUR HONOR. FIRST OF ALL, I AM NOT SURE THERE IS FOUNDATION FOR THIS. I AM NOT SURE THERE IS RELEVANCE. BUT I ALSO WANT TO POINT OUT THAT THE GOVERNMENT HAD, IN FACT, NOTICED DR. HASKELL'S DEPOSITION. IT WAS SCHEDULED TO TAKE PLACE. DR. HASKELL HAD CONSENTED TO BEING DEPOSED, EVEN THOUGH HE WAS BEYOND THE SUBPOENA POWER.

AND AT THE LAST MINUTE HIS DEPOSITION WAS CANCELLED. THAT WAS A LITIGATION JUDGMENT THAT WAS MADE. THEY CHOSE NOT TO BRING HIM HERE. I DON'T THINK THEY CAN GET IN HIS STATEMENTS THROUGH DR. COOK.

MS. CLARK: YOUR HONOR, OUR --

THE COURT: I DON'T THINK I NEED TO HEAR ANY MORE. I ALREADY RULED THIS PARTICULAR WITNESS IS NOT AN EXPERT. TO THE EXTENT THAT HE RELIED UPON THE INFORMATION CONTAINED IN THE REPORT IN FORMING HIS OPINIONS, I CERTAINLY PERMITTED HIM TO TESTIFY TO HIS OPINIONS.

HOWEVER, THE DETAILS ARE NOT GOING TO BE ADMISSIBLE THROUGH HIS TESTIMONY, THE ACTUAL DETAILS. HE HAS GIVEN US A FAIRLY DETAILED DESCRIPTION OF WHAT HE BELIEVES ARE THE FOUR COMPONENTS OF D&X. OTHER THAN THAT, I AM NOT GOING TO ALLOW MORE IN OF THIS ARTICLE.

MS. CLARK: OKAY.

THE COURT: IF YOU WOULD LIKE TO TAKE A FEW MINUTES TO GO OVER YOUR EXAMINATION OF HIM.

MS. CLARK: I CAN MOVE ON.

THE COURT: THIS IS PROBABLY AN APPROPRIATE TIME FOR OUR FIRST RECESS OF THE MORNING.

MS. CLARK: OKAY.

THE COURT: WE WILL BREAK FOR 15.

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

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

THE COURT: PLEASE CONTINUE.

BY MS. CLARK:

Q. DR. COOK, IN WHAT WAY DO YOU UNDERSTAND THE PARTIAL-BIRTH ABORTION PROCEDURE TO DIFFER FROM THE DILATION AND EVACUATION PROCEDURE?

A. THERE ARE MANY AREAS OF DIFFERENCE. ONE IS THE GESTATIONAL AGE AT WHICH THE PROCEDURE IS GENERALLY UTILIZED. THE WAY IT WAS DESCRIBED BY THE INITIAL PRACTITIONERS WOULD BE IT WOULD OCCUR AT 20 WEEKS AND BEYOND, WHICH WOULD OVERLAP WITH SOME D&E CASES. BUT A LOT OF D&E CASES ARE DONE AT LESS THAN 20 WEEKS GESTATION.

MS. GARTNER: YOUR HONOR, THERE IS NO FOUNDATION FOR THIS IN THE RECORD.

MS. CLARK: HE IS GOING TO BE TESTIFYING ABOUT THE RELATIVE SAFETY OF INDUCTION D&X, D&E.

THE COURT: THEN, WE NEED A FOUNDATION. ELICIT THE TESTIMONY AS TO WHAT -- UPON WHAT HIS OPINION IS BASED.

BY MS. CLARK:

Q. DOCTOR, I AM GOING TO ASK YOU TO COMPARE D&E TO D&X. AND IN DOING THAT, COULD YOU FIRST TELL THE COURT WHAT YOU UNDERSTAND THE D&E PROCEDURE TO BE, AND WHAT THAT -- WHAT YOUR UNDERSTANDING IS BASED UPON?

A. WELL, CLASSIC D&E PROCEDURE IS DISMEMBERMENT PROCEDURE USUALLY PERFORMED BETWEEN APPROXIMATELY 14 WEEKS GESTATION AND UP TO 22 WEEKS GESTATION, WITH MOST OCCURRING IN THE 14 TO 18 WEEK GESTATIONAL AGE PERIOD.

THE HALLMARK OF WHICH IS DISMEMBERMENT AND INVOLVES NECESSARILY MORE CERVICAL DILATION THAN YOU WOULD HAVE FOR A FIRST-TRIMESTER SUCTION PROCEDURE, BUT LESS THAN HAS BEEN DESCRIBED FOR A D&X PROCEDURE.

Q. WHEN YOU JUST TESTIFIED ABOUT THE D&E PROCEDURE, WHAT IS YOUR UNDERSTANDING OF THAT D&E PROCEDURE BASED UPON?

A. BASED UPON MULTIPLE PUBLICATIONS DESCRIBING WHAT A D&E PROCEDURE IS, BASED UPON HAVING OBSERVED PEOPLE DO A D&E PROCEDURE, AND BASED UPON HAVING DONE A D&E PROCEDURE OR PROCEDURES IN THE PAST.

Q. AND EVERY TIME IN WHICH YOU HAVE EITHER PERFORMED OR OBSERVED A D&E PROCEDURE HAS THERE BEEN A CERTAIN AMOUNT OF DISARTICULATION?

A. THERE HAS BEEN.

Q. AND WHAT ARE THE GESTATIONAL AGES IN WHICH YOU'VE WATCHED THE D&E PROCEDURE BEING PERFORMED?

A. GENERALLY, BETWEEN ABOUT 16 AND 18 WEEKS GESTATION, MAYBE UP TO, BUT I DON'T BELIEVE BEYOND, 20 WEEKS GESTATION.

Q. THANK YOU. AND, DOCTOR, JUST TO CLARIFY THE RECORD, WHEN YOU ARE TESTIFYING ABOUT THE PARTIAL-BIRTH ABORTION PROCEDURE, WHAT IS THE BASIS OF YOUR UNDERSTANDING OF THE PARTIAL-BIRTH ABORTION PROCEDURE?

A. MY BASIS IS BASED UPON THE SUBMITTED TESTIMONY AND DESCRIPTIONS IN DETAIL OF TWO HIGH-PROFILE PROVIDERS OF THE PROCEDURE, OBSERVATION OF A VIDEOTAPE, AND, AGAIN, PERFORMING ELEMENTS OF THE PROCEDURE IN OTHER SETTINGS.

Q. IN COMPARING THE D&E PROCEDURE TO THE PARTIAL-BIRTH ABORTION PROCEDURE, IN WHAT WAYS DO YOU UNDERSTAND THOSE TWO PROCEDURES TO BE DISTINCT PROCEDURES?

A. I THINK THE GREATEST DISTINCTION IS THE AMOUNT OF CERVICAL DILATION THAT THEY ATTEMPT TO ACHIEVE WITH THE D&X PROCEDURE, BEING A MUCH GREATER AMOUNT OF CERVICAL DILATION. AGAIN, USING UP TO 25 DILATORS OVER A TWO-DAY PREPARATORY PERIOD.

THE D&E PROCEDURES I AM FAMILIAR WITH AND THAT I HAVE SEEN DESCRIBED AND THAT I HAVE PERFORMED OR OBSERVED GENERALLY USE A LESSER NUMBER OF DILATORS, USUALLY SIX OR LESS, AND USUALLY FOR A SINGLE PREPARATORY DAY PRIOR TO DOING THE PROCEDURE.

THEY ALSO, AGAIN, DIFFER IN THE GESTATIONAL AGES

THAT THEY ARE TARGETED AT, AS I WAS SAYING BEFORE.

MS. GARTNER: OBJECTION, YOUR HONOR. THERE IS STILL NO FOUNDATION IN THE RECORD FOR ANY DIFFERENCE IN GESTATIONAL AGE RANGE.

THE COURT: SUSTAINED.

YOU NEED TO ESTABLISH A FOUNDATION.

MS. CLARK: RIGHT.

BY MS. CLARK:

Q. DOCTOR, WHAT IS YOUR UNDERSTANDING OF THE GESTATIONAL RANGE IN WHICH THE D&E PROCEDURE IS PERFORMED?

A. MY UNDERSTANDING, AS INITIALLY DESCRIBED BY DR. HASKELL IN HIS PAPER, THAT IT WAS DESIGNED FOR 20 TO 26 WEEKS GESTATION.

Q. AND JUST TO CLARIFY, THIS IS THE D&X PROCEDURE THAT YOU ARE TALKING ABOUT?

A. THIS IS THE D&X PROCEDURE.

Q. OKAY.

A. AND DR. HASKELL'S DESCRIPTION HE INCLUDED SOME CASES AT EARLIER GESTATIONAL AGES AND SOME THAT WENT BEYOND, BUT GENERALLY DESCRIBED IT AS A LATE SECOND-TRIMESTER ABORTION TECHNIQUE.

Q. WHAT IS YOUR -- WHAT IS THE BASIS OF YOUR UNDERSTANDING ABOUT THE GESTATIONAL AGES IN WHICH THE D&E PROCEDURE IS PERFORMED?

A. AGAIN, BASED UPON THE COMMONLY-KNOWN WAYS THAT THE PROCEDURE IS PERFORMED, HOW IT IS DESCRIBED IN TEXTBOOKS, HOW

IT IS DESCRIBED IN THE LITERATURE, AND, AGAIN, MY PERSONAL EXPERIENCES EITHER PERFORMING OR OBSERVING THE PROCEDURE.

Q. AND WHAT, SPECIFICALLY, PROVIDES YOU A BASIS FOR YOUR UNDERSTANDING THAT D&E IS PERFORMED UP TO A CERTAIN GESTATIONAL AGE?

A. WELL, THERE ARE A NUMBER OF SOURCES THAT ATTEMPT TO TRACK NUMBER OF D&E PROCEDURES PERFORMED AND AT WHAT GESTATIONAL AGES THEY ARE PERFORMED. AND THEY ARE PERFORMED MORE OFTEN IN THAT 16 TO 18 WEEK GESTATIONAL AGE RANGE THAN THEY ARE IN THE 20 TO 22 WEEK GESTATIONAL AGE RANGE.

AND PLUS, IT IS HARDER TO FIND PRACTITIONERS WILLING TO DO A D&E PROCEDURE BEYOND 20 WEEKS, BECAUSE IT IS A MORE COMPLICATED PROCEDURE.

Q. AND HOW DO YOU KNOW IT IS MORE DIFFICULT TO FIND PRACTITIONERS WHO ARE WILLING TO DO D&E'S PAST 20 WEEKS?

A. WELL, THERE ARE A NUMBER OF WAYS. THEY MAY INCLUDE EVEN LOOKING AT PEOPLE'S ADVERTISED PRACTICES WHERE THEY WILL OFFER D&E UP TO A GESTATIONAL AGE RANGE, BUT NOT BEYOND.

BUT MY PERSONAL EXPERIENCE WOULD BE WHEN I WAS WORKING AT OTHER UNIVERSITIES AND WE HAD PATIENTS THAT NEEDED D&E PROCEDURES AT CERTAIN LATE GESTATIONAL AGE RANGES WE OFTEN INVOLVED PRACTITIONERS THAT HAD DONE SOME OF THESE LATE GESTATIONAL AGE PROCEDURES BECAUSE THEY WERE FELT TO BE MORE COMPLICATED AND MORE RISKY PROCEDURES FOR THE MOTHERS.

Q. AND SO BASED ON THOSE EXPERIENCES, WHAT DO YOU

UNDERSTAND -- WHAT DO YOU UNDERSTAND THE GESTATIONAL AGES OF THE D&E PROCEDURE TO BE PERFORMED AT?

A. I UNDERSTAND THAT IT IS PREDOMINANTLY DONE BETWEEN 14 AND 18 WEEKS, BUT THERE ARE PEOPLE THAT PERFORM THEM UP TO 22 WEEKS GESTATION, AND THAT THEY ARE MORE COMPLICATED WHEN THEY ARE PERFORMED AT THOSE LATER GESTATIONAL AGES.

Q. AND BASED ON YOUR UNDERSTANDING OF THE D&E PROCEDURE VERSUS YOUR UNDERSTANDING OF THE D&X PROCEDURE, IS THERE SOMETHING ABOUT THE GESTATIONAL AGE THAT DISTINGUISHES THOSE TWO PROCEDURES?

A. YES. THERE IS SOME OVERLAP BETWEEN THE PROCEDURES, BUT D&E -- OR, I AM SORRY -- D&X WAS DESIGNED, AS STATED BY THE PRACTITIONERS WHO PROPOSE THESE TECHNIQUES AS AN ALTERNATIVE TO --

MS. GARTNER: OBJECTION, YOUR HONOR.

THE WITNESS: -- INDUCTION OF LABOR.

MS. GARTNER: THERE IS NO FOUNDATION THAT DR. HASKELL OR DR. MCMAHON PROPOSED THESE TECHNIQUES.

THE COURT: SUSTAINED.

BY MS. CLARK:

Q. IF YOU WOULD LIMIT IT TO YOUR UNDERSTANDING OF, RATHER THAN ASSERTING THAT THESE PHYSICIANS PROPOSED IT.

SO BASED ON YOUR UNDERSTANDING OF PARTIAL-BIRTH ABORTION PROCEDURE VERSUS YOUR UNDERSTANDING OF THE D&E PROCEDURE, DO YOU BELIEVE THAT ONE DIFFERENCE BETWEEN THE TWO

PROCEDURES HAS SOMETHING TO DO WITH GESTATIONAL AGE?
A. I DO.
Q. AND WHAT IS THAT DIFFERENCE?
A. THAT, IN GENERAL, A D&E PROCEDURE IS PERFORMED AT EARLIER GESTATIONAL AGES AND THAT THE D&X IS PERFORMED AT LATER GESTATIONAL AGES. AND I UNDERSTOOD THAT BECAUSE WHEN I WOULD READ THE DESCRIPTIONS OF THE PROCEDURE, DR. HASKELL, FOR INSTANCE, STATED IT WAS DONE AS AN ALTERNATIVE TO DOING INDUCTIONS OF LABOR LATE IN THE SECOND-TRIMESTER.
THAT IS HOW I BASED MY UNDERSTANDING.
Q. DOCTOR, TURNING BACK TO SOMETHING YOU TESTIFIED ABOUT EARLIER TO MAKE THE RECORD CLEAR, IN YOUR PRACTICE, SPECIFICALLY IN THE 20 TO 23 WEEK GESTATIONAL RANGE, HAVE YOU EVER PERFORMED AN INDUCTION IN WHICH THE HEAD OF THE BABY GOT STUCK AT THE INTERNAL CERVICAL OS DURING THE DELIVERY PART OF THE PROCEDURE?
A. I HAVE.
Q. AND HAVE YOU EVER NEEDED TO PUNCTURE THE HEAD AND SUCTION OUT THE CONTENTS OF THE BRAIN IN ORDER TO COMPLETE THE PREGNANCY TERMINATION?
A. I HAVE NOT.
Q. DOCTOR, NOW THAT YOU HAVE ESTABLISHED -- NOW THAT WE HAVE ESTABLISHED YOUR UNDERSTANDING OF INDUCTION D&E AND D&X, WOULD YOU PLEASE EXPLAIN TO THE COURT WHY IT IS YOUR OPINION THAT D&X IS NEVER MEDICALLY NECESSARY TO CARE FOR WOMEN WITH COMPLICATED

PREGNANCIES?
A. WELL, IT IS MY OPINION BASED UPON A NUMBER OF MATERIALS I HAVE REVIEWED OVER THE YEARS, AND MY EXPERIENCE IN DEALING WITH COMPLICATED PREGNANCIES ON A DAILY BASIS, THAT THERE ARE OTHER SAFER AND READILY AVAILABLE ALTERNATIVES TO EMPTYING A UTERUS IN THE LATE SECOND-TRIMESTER OR EVEN EARLY THIRD-TRIMESTER THAT ALLOW US THE OPTIMAL ABILITY TO CARE NOT ONLY FOR THE MOTHER AND ANY COMPLICATIONS SHE MAY HAVE, BUT ALSO THE OPTIMAL ABILITY TO GET HELPFUL INFORMATION FROM THE FETUS.

IN ADDITION, DO I NOT ONLY FEEL THIS PROCEDURE DOESN'T OFFER ANYTHING NEW TO WHAT WE HAVE AVAILABLE, THERE ARE ELEMENTS OF THE PROCEDURE THAT CONCERN ME FOR BOTH SHORT-TERM AND LONG-TERM POTENTIAL FOR COMPLICATIONS.
Q. AND WHAT ARE SOME OF THOSE ELEMENTS OF THE PROCEDURE THAT CONCERN YOU IN TERMS OF THE SHORT-TERM AND LONG-TERM RISKS?
A. WELL, IN THE SHORT-TERM, WHENEVER YOU ARE DOING AN EXCESSIVE AMOUNT OF CERVICAL MANIPULATION OR DILATION, IT DOES INCREASE YOUR RISK FOR BLEEDING, LACERATION AND INFECTION.

WHENEVER YOU ARE DOING INTRAUTERINE MANIPULATION OF THE FETUS TO THE EXTENT THAT YOU ARE DOING AN INTERNAL PODALIC VERSION, YOU INCREASE THE RISK FOR COMPLICATIONS, SUCH AS TRAUMA TO THE UTERUS OR BLEEDING OR INFECTION. AND WHENEVER YOU ARE POTENTIALLY EXPOSING A VERY VASCULARIZED CERVIX TO A COLLAPSING SKULL, BONEY SKULL, THERE IS THE POTENTIAL FOR INCREASING RISK FOR BLEEDING AND LACERATIONS AS PART OF SOME OF

THE SHORT-TERM CONCERNS.
Q. AND WITH RESPECT TO THE LONG-TERM CONCERNS THAT YOU TESTIFIED ABOUT?
A. IN REGARDS TO THE LONG-TERM CONCERNS, THEY ARE PREDOMINANTLY FOCUSED ON THE AREA OF THIS OVERDILATION, MASSIVE OVERDILATION OF THE CERVIX THAT CONCERNS ME FOR THE ABILITY TO MAINTAIN THE INTEGRITY OF THE CERVIX FOR SUBSEQUENT PREGNANCIES.
Q. AND WHY DOES THE OVERDILATION CONCERN YOU ABOUT FUTURE PREGNANCIES --
MS. GARTNER: OBJECTION, YOUR HONOR. WE OBJECT TO THE USE OF THE TERM "OVERDILATION." I DON'T THINK THERE IS ANY FOUNDATION FOR THE TERM "OVERDILATION" IN THIS CONTEXT.
THE COURT: SUSTAINED.
BY MS. CLARK:
Q. DOCTOR, WHEN YOU USE THE TERM "OVERDILATION," WHAT DID YOU MEAN BY THAT?
A. I GUESS WHAT I MEAN IS MANYFOLD GREATER THAN THE AMOUNT OF DILATION USED FOR ANY OTHER ABORTION TECHNIQUE.
Q. AND BASED ON YOUR UNDERSTANDING --
MS. GARTNER: I AM SORRY, YOUR HONOR. AGAIN, I THINK THERE IS LACK OF FOUNDATION THAT THERE IS MORE DILATION IN AN INTACT D&E THAN THERE IS WITH AN INDUCTION.
THE COURT: I AM GOING TO ALLOW HIM TO TESTIFY GIVEN HIS -- I CERTAINLY HEARD FROM OTHER DOCTORS TO THE CONTRARY

OVER THE LAST THREE WEEKS. I WILL GIVE THE TESTIMONY ON THIS ISSUE THE WEIGHT I BELIEVE IT IS ENTITLED TO.

MS. GARTNER: OKAY. THANK YOU.

BY MS. CLARK:

Q. DOCTOR, WHEN YOU SAY "OVERDILATION," WHAT IS YOUR BASIS FOR BELIEVING THERE IS A CERTAIN AMOUNT -- THERE IS OVERDILATION IN THE D&X PROCEDURE COMPARED TO OTHER ABORTION PROCEDURES?

A. WELL, AS I UNDERSTAND THE D&E PROCEDURE TO BE DESCRIBED AND AS I HAVE SEEN IT PERFORMED AND AS I HAVE PERFORMED IT, WE GENERALLY WOULD PLACE MAYBE UP TO SIX DILATORS AT A TIME, OR SIX LAMINARIA.

AND BY THE DESCRIPTION OF THE PRACTITIONERS WHO DO THE D&X PROCEDURE THEY ARE PLACING UP TO 25 DILATORS AT A TIME. SO, TO ME, THAT IS MANYFOLD MORE THAN WE WOULD USE FOR ANY OTHER ABORTION TECHNIQUE. IN THE FIRST-TRIMESTER WE DON'T USE LAMINARIA, GENERALLY. WE USE SMALLER MECHANICAL DILATORS WHERE WE ARE DILATING GENERALLY TO SOMEWHERE, EIGHT, NINE, TEN MILLIMETERS.

Q. AND HOW DOES THE AMOUNT OF DILATION RELATE TO THE LONG-TERM COMPLICATIONS YOU WERE TOUCHING ON A FEW MOMENTS AGO?

A. WELL, THERE'S AN INCREASING BODY OF EVIDENCE THAT PEOPLE WHO EVEN HAVE FIRST-TRIMESTER ABORTIONS DONE SUFFER AN INCREASED RISK OF PREMATURE DELIVERIES, MOSTLY SECONDARY TO CERVICAL-INCOMPETENCE-RELATED ISSUES WITH SUBSEQUENT PREGNANCIES.

AND IF THEY EXPERIENCE THAT WITH THE RELATIVELY SMALLER AMOUNT OF CERVICAL DILATION REQUIRED FOR A FIRST-TRIMESTER PROCEDURE, THEN I AM NECESSARILY CONCERNED ABOUT WHAT EXPERIENCES THEY MIGHT HAVE WHEN YOU ARE DILATING AT MANYFOLD GREATER THAN THAT.

Q. DOCTOR, IN YOUR OPINION AND BASED ON YOUR UNDERSTANDING OF THE D&X PROCEDURE, ARE THERE ANY MATERNAL HEALTH RISKS THAT ARE UNIQUE TO THE D&X PROCEDURE ITSELF THAT CAUSES YOU CONCERN WITH THE D&X PROCEDURE?

A. WELL, THE ELEMENTS ARE UNIQUE IN THEIR COMBINATION, ALTHOUGH DIFFERENT ELEMENTS ARE PERFORMED IN OTHER SITUATIONS. BUT THE COMBINATION OF THE OVERDILATION OR THE MANYFOLD MORE DILATION OF THE CERVIX, TOGETHER WITH THE INTENTIONAL INTERNAL TURNING OF A SINGLETON PREGNANCY IN A LIMITED UTERINE ENVIRONMENT, AND THE POTENTIAL RISK FOR THE COLLAPSING SKULL, ALL POSE CONCERNS THAT I THINK GO OVER AND BEYOND OTHER ABORTION TECHNIQUES.

Q. DOCTOR, HOW LONG HAVE YOU BEEN PROVIDING CARE TO WOMEN WITH COMPLICATED PREGNANCIES?

A. WELL, WE STARTED CARING FOR COMPLICATED PREGNANCIES AT THE VERY BEGINNING OF MY RESIDENCY TRAINING IN 1989, BUT I AM MORE EXCLUSIVELY CARED FOR ONLY COMPLICATED PREGNANCIES FROM 1993 FORWARD.

Q. HAVE YOU EVER EXPERIENCED A CLINICAL SITUATION IN WHICH THE PARTIAL-BIRTH ABORTION PROCEDURE HAS EVER BEEN REQUIRED OR

NECESSARY?
A. I HAVE NOT.
Q. DOCTOR, YOU TESTIFIED EARLIER THAT IT IS SOMETIMES NECESSARY FOR MATERNAL HEALTH REASONS TO TERMINATE A PREGNANCY; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. WHAT ARE SOME OF THE SPECIFIC KINDS OF COMPLICATIONS THAT YOU SEE IN YOUR PRACTICE REQUIRING PREGNANCY TERMINATION?
A. WELL, THEY CAN INCLUDE PREEXISTING CONDITIONS IN THE MOTHER, SUCH AS CERTAIN MALIGNANCIES OR CERTAIN CARDIOVASCULAR DISEASES OR OTHER PREEXISTING DISEASES.

THEY MAY ALSO INCLUDE THE DEVELOPMENT OF COMPLICATIONS DURING THE COURSE OF THE PREGNANCY, SUCH AS SEVERE HYPERTENSIVE COMPLICATIONS, THINGS OF THAT NATURE.
Q. IS IT FREQUENT THAT YOU HAVE TO TERMINATE A PREGNANCY PREVIABILITY IN ORDER TO PROTECT THE HEALTH INTERESTS OF THE MOTHER?
A. EVEN IN OUR PRACTICE OF JUST REFERRED COMPLICATED PREGNANCIES, IT IS NOT THAT COMMON.
Q. WHY IS IT THAT TERMINATING A PREGNANCY PREVIABLE BECAUSE OF MATERNAL HEALTH INTERESTS IS SOMETHING THAT -- I THINK IN YOUR WORDS -- "IS NOT THAT COMMON"?
A. WELL, A NUMBER OF REASONS. ONE IS: WE HAVE IMPROVED IN OUR MEDICAL ABILITIES AND MEDICAL TECHNOLOGY TO BE ABLE TO SAFELY MONITOR AND MAINTAIN A PREGNANCY BETTER THAN IN DAYS

PRIOR, PARTICULARLY IN THE AREAS OF PREEXISTING MEDICAL CONDITIONS SUCH AS CARDIOVASCULAR DISEASE.

IN ADDITION, AS I HAD STATED BEFORE, THE VIABILITY LINE CONTINUES TO MOVE TO EARLIER GESTATIONAL AGES, SO WE DON'T HAVE TO ATTAIN AS LATE A GESTATIONAL AGE AS WE HAD IN YEARS PAST.

Q. BRIEFLY, WHY WOULD IT BE NECESSARY TO TERMINATE A PREGNANCY BECAUSE OF SOME OF THE HEALTH CONDITIONS THAT YOU'VE TESTIFIED ABOUT?

A. WELL, CONTINUATION OF THE PREGNANCY IN SOME SITUATIONS ALLOWS THE WOMAN TO BE AT AN INCREASING RISK. FOR INSTANCE, IF SHE HAS AN INFECTION THROUGHOUT HER UTERINE CAVITY, IF SHE STAYS UNDELIVERED DURING THAT PERIOD OF TIME, THERE IS A RISK THE INFECTION CAN SPREAD AND BECOME A SYSTEMIC INFECTION, SUCH AS SEPSIS, WHICH CAN THREATEN HER LIFE.

THERE ARE OTHER EXAMPLES, AS WELL.

Q. OKAY. AND WHEN YOU NEED TO TERMINATE A PREGNANCY FOR A COMPLICATION, DO YOU PROCEED DIFFERENTLY DEPENDING ON WHETHER THE FETUS IS PREVIABLE OR POSTVIABLE?

A. SOMEWHAT DIFFERENTLY. BUT, GENERALLY, IN A SIMILAR MANNER. WE MAY USE DIFFERENT MEDICATIONS OR DOSES OR DOSING INTERVALS OR ANALGESICS OR PAIN MEDICATIONS, IF FETAL INTERESTS ARE NOT AT PLAY.

Q. AND IF FOR A FETUS THAT YOU HAVE DETERMINED HAS A CHANCE OF SURVIVAL OUTSIDE THE MOTHER, HOW DO YOU APPROACH PREGNANCY

TERMINATION IN THAT SITUATION?
A. WELL, WE WOULD OBVIOUSLY CONTINUE TO MONITOR THE FETAL STATUS CLOSELY, AS WELL. IT MAY ENTAIL THE NEED FOR A LESS TRAUMATIC DELIVERY FOR THE FETUS, SUCH AS CESAREAN DELIVERY.

IT MAY ENTAIL A DIFFERENT TYPE OF DOSING REGIME AND ANALGESIC REGIME FOR THE MOTHER, IF FETAL IS ALSO OF CONCERN.
Q. DR. COOK, CAN YOU EXPLAIN HOW YOU WOULD EVALUATE MATERNAL HEALTH CONDITION DURING THE PREGNANCY IN MAKING THE DECISION WHETHER AND WHEN A PREGNANCY SHOULD END?
A. WELL, IT'S A COMPLEX EVALUATION. IT INVOLVES PHYSICAL EXAM, LABORATORY STUDIES, RADIOGRAPHIC STUDIES, INCLUDING ULTRASOUND.

IT INVOLVES OBSERVING TRENDS IN HER CARE AND RESPONSE TO CARE: IS SHE IMPROVING? IS SHE STABILIZING? IS SHE WORSENING IN HER CONDITION?

IT ALSO INVOLVES HOW MUCH FURTHER WE NEED TO TRY TO GET IN THE PREGNANCY TO HAVE A CHANCE FOR FETAL VIABILITY.
Q. WHEN DOES A MATERNAL HEALTH CONDITION MOVE FROM BEING A HEALTH PROBLEM TO SOMETHING MORE SERIOUS THAT CAN CAUSE SERIOUS DAMAGE TO THE WOMAN'S HEALTH AND POTENTIALLY JEOPARDIZE HER LIFE?
A. WELL, WHENEVER WE FEEL WE ARE IN A SITUATION THAT IS NOT RESPONDING TO OUR THERAPIES, AND IS NOT NEAR THE POINT OF FETAL VIABILITY AND IS CAUSING INSTABILITY IN THE MOTHER AND POTENTIALLY THREATENING HER LIFE, THEN WE HAVE TO CONSIDER THE

POSSIBILITY OF THE NEED TO TERMINATE THE PREGNANCY.
Q. DOCTOR, WHEN A PREGNANCY DOES HAVE TO BE ENDED PREMATURELY BECAUSE OF A HEALTH CONDITION OF THE MOTHER, IS IT EVER NECESSARY TO TAKE A DESTRUCTIVE ACT AGAINST THE FETUS IN ORDER TO PROTECT THE HEALTH INTEREST OF THE MOTHER?
A. IT IS NEVER NECESSARY TO DESTROY A FETUS TO PROTECT THE MOTHER. ALL THAT IS NECESSARY IS REVERSING THE PREGNANCY PROCESS, WHICH MEANS DELIVERING THE BABY OR SEPARATING THE BABY FROM THE MOTHER AND SEPARATING THE PLACENTA FROM THE MOTHER. THAT THEN STARTS THE RECOVERY PROCESS.

BUT THERE IS NOTHING INHERENT IN DESTROYING THE FETUS THAT AIDS OR FACILITATES THAT PROCESS.
Q. DR. COOK, YOU WANT TO UTILIZE, DON'T YOU, THE SAFEST METHOD OF TERMINATION POSSIBLE WHEN YOU HAVE TO TERMINATE PREVIABILITY, DON'T YOU?
A. THAT IS CORRECT.
Q. IN YOUR OPINION, WOULD THERE EVER BE A MEDICAL NEED TO USE THE PARTIAL-BIRTH ABORTION PROCEDURE TO TERMINATE A PREGNANCY SPECIFICALLY BECAUSE OF A PARTICULAR TYPE OF HEALTH CONDITION THAT THE WOMAN HAD DURING PREGNANCY?
A. I KNOW OF NO SUCH CONDITION.
Q. DOCTOR, NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT SPECIFIC HEALTH CONDITIONS. YOU PREVIOUSLY TESTIFIED ABOUT PREECLAMPSIA. AND HAVE YOU EVER TREATED A WOMAN -- AND I UNDERSTAND YOU HAVE TREATED A WOMAN WITH PREECLAMPSIA BASED ON

YOUR TESTIMONY?
A. YES, MANY TIMES WE TREAT PEOPLE WITH PREECLAMPSIA.
Q. AND PREECLAMPSIA CAN DEVELOP TO A POINT IN WHICH IT IS AN INDICATION FOR PREGNANCY TERMINATION?
A. IT CAN, YES.
Q. IN THAT SITUATION, WOULD PREECLAMPSIA THEN BECOME HELLP SYNDROME?
A. WELL, IT CAN. HELLP SYNDROME IS A VARIANT OF SEVERE PREECLAMPSIA.
Q. AND WHEN YOU HAVE THE HELLP SYNDROME, COULD PREGNANCY TERMINATION BE NECESSARY IN ORDER TO PROTECT THE HEALTH INTERESTS OF THE MOTHER?
A. YES, THAT CAN, INDEED, BE THE CASE.
Q. WOULD THE PARTIAL-BIRTH ABORTION PROCEDURE EVER BE NECESSARY TO TERMINATE A PREGNANCY BECAUSE A WOMAN IS SUFFERING FROM A FORM OF PREECLAMPSIA?
A. IT WOULD NOT BE NECESSARY.
Q. AND WHY NOT?
A. BECAUSE THERE ARE OTHER WELL-ESTABLISHED AND SAFER TECHNIQUES AVAILABLE. AND, AGAIN, THIS WOULD BE A WOMAN WHO WOULD NOT TOLERATE WELL ANY BLEEDING COMPLICATIONS.
Q. AND BECAUSE SHE WOULDN'T TOLERATE BLEEDING COMPLICATIONS, WHAT DOES THAT HAVE TO DO WITH THE MEDICAL NECESSITY OF THE PARTIAL-BIRTH ABORTION PROCEDURE?
A. IT WOULD MEAN YOU WOULD WANT TO PROCEED WITH THE SAFEST,

MOST NATURAL PROCESS AVAILABLE, AVOIDING OPERATIVE PROCEDURES, IF AT ALL POSSIBLE.

Q. WHEN YOU HAVE DEEMED IT NECESSARY TO TERMINATE A PREGNANCY IN A CASE OF PREECLAMPSIA, AND THE FETUS IS PREVIABLE, HOW HAVE YOU TERMINATED THAT PREGNANCY?

A. GENERALLY, BY MEDICAL INDUCTION OF LABOR.

Q. WOULD A SURGICAL TERMINATION EVER BE INDICATED?

A. IT COULD BE.

Q. AND IN WHAT SITUATION WOULD IT BE INDICATED?

A. WELL, IF YOU HAD A SITUATION WHERE YOU HAVE A MOLAR GESTATION, FOR INSTANCE, OR AN OVERPRODUCTION OF PLACENTAL TISSUE, WHICH CAN LEAD TO HYPERTENSIVE COMPLICATIONS AT EARLIER GESTATIONAL AGES, THEN A SURGICAL EVACUATION MAY BE THE BEST WAY TO PROCEED, BECAUSE OF THE RISK FOR BLEEDING THAT MAY BE INVOLVED IN INDUCING THAT PREGNANCY.

Q. AND WHAT KIND OF SURGICAL PROCEDURE ARE YOU REFERENCING?

A. IT COULD BE A SUCTION D&C, OR IN ADVANCE GESTATIONAL AGES, COULD EVEN REQUIRE A HYSTEROTOMY.

Q. DOCTOR, THROUGH YOUR PRACTICE HAVE YOU BECOME FAMILIAR WITH RENAL DISEASE?

A. I HAVE.

Q. WHAT IS RENAL DISEASE IN THE CONTEXT OF A COMPLICATED PREGNANCY?

A. GENERALLY, RENAL DISEASE MEANS PREEXISTING RENAL CONDITIONS THAT CAN BE WORSENED BY THE COURSE OF THE PREGNANCY BEING

SOMETIMES THEY ARE FROM INHERENT RENAL DISEASE, SUCH AS A GLOMERULONEPHRITIS, OR THERE MAY BE A SECONDARY RENAL DISEASE FROM A DISEASE SUCH AS DIABETES.

Q. HAVE YOU EVER TREATED A WOMAN WITH RENAL DISEASE DURING HER PREGNANCY?

A. I HAVE.

Q. COULD THE HEALTH OF A WOMAN WITH RENAL DISEASE DURING PREGNANCY, COULD HER PREGNANCY DETERIORATE -- COULD HER HEALTH CONDITION DETERIORATE TO SUCH A POINT THAT THERE MIGHT BE AN INDICATION FOR PREGNANCY TERMINATION?

A. YES, THAT IS POSSIBLE.

Q. WOULD THE PARTIAL-BIRTH ABORTION PROCEDURE EVER BE NECESSARY TO TERMINATE A WOMAN WITH THIS CONDITION?

A. IT WOULD NOT BE.

Q. WHY NOT?

A. AGAIN, IT'S A MEDICAL CONDITION WITH LITTLE MEDICAL RESERVE FOR COMPLICATIONS. SPECIFICALLY, IN RENAL DISEASE, THERE IS CONCERN ABOUT FLUID VOLUMES AND FLUID LOADS, SO YOU WOULD WANT TO REDUCE ANYTHING THAT WOULD SIGNIFICANTLY INCREASE THE RISK FOR BLEEDING OR INFECTION.

Q. AND JUST TO MAKE CLEAR, HOW DOES THE INCREASED RISK OF BLOOD LOSS AND INFECTION AFFECT YOUR OPINION ABOUT WHETHER OR NOT THE PARTIAL-BIRTH ABORTION PROCEDURE WOULD EVER BE NECESSARY IN A WOMAN WITH -- IN A WOMAN WITH RENAL DISEASE WHO IS PREGNANT AND REQUIRES PREGNANCY TERMINATION?

A. WELL, THERE ARE MULTIPLE LEVELS OF CONCERN. PEOPLE WITH SIGNIFICANT RENAL DISEASE GENERALLY HAVE VERY SIGNIFICANT ANEMIA OR A LOWER BLOOD COUNT RESERVE TO TOLERATE BLEEDING.

IN ADDITION, THEIR KIDNEYS DO NOT FUNCTION WELL IN DEALING WITH VOLUME LOADS. AND INCREASED VOLUME LOADS WOULD BE NECESSARY FOR TREATMENT OF INFECTION OR BLEEDING.

Q. DR. COOK, WHAT I AM GETTING AT -- AND I THINK I AM MISSING SOMETHING -- IS WHY IS THIS ABOUT THE LOW PLATELETS AND THE KIDNEYS THAT SPECIFICALLY WOULD NOT MAKE THE PARTIAL-BIRTH ABORTION PROCEDURE THE APPROPRIATE PROCEDURE TO USE WHEN A WOMAN HAS RENAL DISEASE AND IS PREGNANT AND THE PREGNANCY NEEDS TO BE TERMINATED?

A. I BELIEVE THAT THE PARTIAL-BIRTH ABORTION PROCEDURE POSES AN INCREASED RISK FOR BLEEDING OR INFECTION BECAUSE OF THE AMOUNT OF DILATION IN THE INTRAUTERINE MANIPULATION THAT WOULD NOT WARRANT ITS USE IN A PATIENT WHO WOULD NOT WELL TOLERATE BLEEDING AND INFECTION.

Q. HOW WOULD YOU DEAL WITH A WOMAN WHO IS PREGNANT AND HAD RENAL DISEASE AND BECAUSE OF MATERNAL COMPLICATIONS RELATED TO THE RENAL DISEASE AND HER PREGNANCY NEEDED TO TERMINATE HER PREGNANCY?

A. WE WOULD RECOMMEND MEDICAL INDUCTION OF LABOR WITH CLOSE MONITORING OF HER FLUID STATUS AND POTENTIALLY EVEN USE OF EVASIVE MONITORING.

Q. DOCTOR, ARE THERE ANY OTHER TYPES OF CARDIAC DISEASES THAT

WOULD SO COMPLICATE A PREGNANCY THAT THERE WOULD BE A NEED TO TERMINATE PRIOR TO TERM, SPECIFICALLY PREVIABILITY?

A. YES. THERE ARE SOME CONDITIONS WHICH ARE NOT VERY COMMON WHICH, IF THE WOMAN CONTINUED HER PREGNANCY, IT WOULD POSE A SIGNIFICANT RISK TO HER LIFE.

Q. AND WHAT ARE SOME OF THOSE CONDITIONS IN A SITUATION RELATING TO CARDIAC DISEASE?

A. THEY CAN INCLUDE PEOPLE WITH MARFAN SYNDROME, WITH A DILATED AORTIC ROUTE. THEY CAN INCLUDE PEOPLE WITH SEVERE PULMONARY HYPERTENSION OR LEFT-TO-RIGHT BLOOD FLOW SHIFTS.

THEY CAN INCLUDE PEOPLE WITH SEVERE AORTIC STENOSIS.

Q. HAVE YOU EVER TREATED WOMEN WITH THESE CONDITIONS?

A. I HAVE.

Q. WHAT IS MARFAN SYNDROME WITH AORTIC DILATION IN THE CONTEXT OF CARDIAC DISEASE?

A. MARFAN SYNDROME IS A GENETICALLY INHERITED DISEASE, THE HALLMARK OF WHICH IS CERTAIN SKELETAL ABNORMALITIES, CERTAIN AORTA ABNORMALITIES, AND CERTAIN OCULAR OR EYE ABNORMALITIES. SPECIFICALLY WITH THE AORTA, THERE CAN BE A DILATION OF THE AORTIC ROUTE AND ALMOST ANEURISMIC, LIKE AN ANEURISM-TYPE DILATION WHICH CAN PREDISPOSE TO SOMETHING REFERRED TO AS AORTIC ROUTE DISSECTION WHICH CAN BE A LIFE-THREATENING CONDITION WHEN IT OCCURS.

Q. DOCTOR WHAT IS SHUNTING OF THE BLOOD IN THE CONTEXT OF CARDIAC DISEASE?

A. IF YOUR PULMONARY HYPERTENSION GETS TO A POINT WHERE IT EXCEEDS YOUR SYSTEMIC BLOOD PRESSURE, THEN IT CAN SHIFT THE FLUID FLOW OR THE HEMODYNAMICS TO THE POINT WHERE YOU ARE CIRCULATING DEOXYGENATED BLOOD TO YOUR BODY, AND THUS COMPROMISING A PERSON'S HEALTH.

Q. IN SHORT, IS IT THE FLOW OF THE BLOOD IS GOING IN THE WRONG DIRECTION?

A. SORT OF A REVERSAL OF THE NORMAL BLOOD FLOW DIRECTION.

Q. AND WHAT IS PULMONARY HYPERTENSION IN THE CONTEXT OF A CARDIAC DISEASE?

A. PULMONARY HYPERTENSION IS WHEN THE PRESSURE BEING DELIVERED FROM THE PULMONARY ARTERIES INTO THE LUNGS IS INCREASED TO THE POINT WHERE IT MAY EVEN EXCEED THE OTHERWISE PERIPHERAL SYSTEMIC PRESSURE AND CAN CAUSE FLUID VOLUME SHIFTS OF BLOOD HEMODYNAMICS, SORT OF LIKE THIS LEFT TO RIGHT SHUNTING SITUATION.

Q. AND WHAT IS A STENOSIS IN THE CONTEXT OF A CARDIAC DISEASE?

A. AORTIC STENOSIS IS A SEVERE NARROWING OF THE VALVE TO THE MAJOR OUTFLOW ARTERY, THE AORTA, CAUSING A FIXED CARDIAC OUTPUT SITUATION SO THAT THE PREGNANCY COULD THREATEN YOUR ABILITY TO CONTINUE TO MOVE BLOOD FORWARD THROUGHOUT YOUR SYSTEM AND COULD CAUSE SUDDEN CARDIAC DEATH.

Q. WOULD EACH ONE OF THESE CONDITIONS -- COULD EACH ONE OF THESE CONDITIONS NECESSITATE TERMINATION OF PREGNANCY PRIOR TO VIABILITY?

A. THEY COULD.
Q. WOULD THE PARTIAL-BIRTH ABORTION PROCEDURE EVER BE MEDICALLY NECESSARY TO TERMINATE A PREGNANCY FOR THESE CARDIAC CONDITIONS OR ANY OTHER CARDIAC CONDITION?
A. IT WOULD NOT BE.
Q. HOW WOULD YOU TERMINATE A PREGNANCY IF A WOMAN PRESENTED WITH ONE OF THESE CONDITIONS?
A. WELL, IT WOULD DEPEND UPON THE GESTATIONAL AGE, BUT IF IT PRESENTED AT A LATER GESTATIONAL AGE, LATE MID-TRIMESTER FORWARD, WE WOULD RECOMMEND DOING A LABOR INDUCTION WITH ALMOST ASSUREDLY INVASIVE CARDIAC MONITORING, INCLUDING A CENTRAL VENOUS CATHETER TO EVALUATE FLUID PRESSURES, AND FLUID HEMODYNAMICS.
Q. DOCTOR, WOULDN'T AN INDUCTION PROCEDURE IMPOSE SOME PHYSIOLOGICAL STRESS ON THE MOTHER?
A. YES, IT WOULD, BUT IT IS A VARIATION OF A NORMAL PHYSIOLOGIC PROCESS AND WE GENERALLY ALWAYS WOULD UTILIZE OTHER AMELIORATING CIRCUMSTANCES, LIKE EPIDURAL ANESTHESIA AND POTENTIALLY EVEN SHORTENING OF THE SECOND STAGE OF LABOR IF NEED BE WITH DELIVERY FORCEPS IN ORDER TO PUT MINIMAL STRESS ON HER SYSTEM.
Q. WHY WOULD A SURGICAL TERMINATION OF THE PREGNANCY BE PREFERRED FOR THE WOMAN FACING ONE OF THESE KINDS OF CARDIAC HEALTH CONDITIONS?
A. AGAIN, WITH WOMEN WITH LIMITED CARDIAC RESERVE, WE

GENERALLY WANT TO DO THE LEASE INVASIVE PROCEDURE POSSIBLE UTILIZING THE MOST NATURAL OR NORMAL PHYSIOLOGIC PROCESS AS POSSIBLE BECAUSE, AGAIN, THEY HAVE A LIMITED RESERVE FOR TOLERATING ANY TYPE OF COMPLICATION.

Q. IN THE LIGHT OF THOSE CONCERNS, IN YOUR OPINION, MEDICAL INDUCTION IS A PREFERRED METHOD?

A. THAT IS CORRECT.

Q. DOCTOR, NEXT TURNING TO PERIPARTUM CARDIOMYOPATHY? WHAT IS THAT?

A. WELL, GENERALLY THAT REFERS TO DYSFUNCTION OF THE CARDIAC MUSCLE CONTRACTILITY OR ABILITY TO PUMP BLOOD. AND YOU CAN HAVE A CARDIOMYOPATHY FROM VARIOUS DIFFERENT CAUSES, INCLUDING HYPERTENSION OR DRUG INDUCED, BUT PERIPARTUM CARDIOMYOPATHY GENERALLY REFERS TO THAT WHICH OCCURS AROUND THE TIME OF DELIVERY. IT SEEMS TO SOMEHOW BE RELATED TO HAVING HAD A RECENT PREGNANCY.

Q. HAVE YOU EVER TREATED A WOMAN WITH PERIPARTUM CARDIOMYOPATHY?

A. I HAVE.

Q. WOULD A PARTIAL-BIRTH ABORTION PROCEDURE EVER BE NECESSARY TO TERMINATE A PREGNANCY WITH THIS CONDITION?

A. IT WOULD NOT BE.

Q. WHY IS THAT?

A. AGAIN, FOR VERY SIMILAR REASONS. LIMITED CARDIAC RESERVE, NEED FOR AS NONEVASIVE A PROCEDURE AS POSSIBLE, AS PHYSIOLOGIC

PROCEDURE AS POSSIBLE, AND INTENSE MONITORING AND CRITICAL CARE SUPPORT IN A SUPERVISED HOSPITAL SETTING.

Q. DOCTOR, WHAT IS PLACENTA PREVIA?

A. PLACENTA PREVIA IS THE CLINICAL SCENARIO WHERE THE PLACENTA IS IMPLANTED LOW OVER THE CERVICAL OPENING, OBSTRUCTING THE CERVICAL OPENING TO SOME EXTENT THEREBY PRECLUDING THE ABILITY FOR A BABY TO DELIVER VAGINALLY, AT LEAST WITHOUT SIGNIFICANT BLEEDING RISK.

Q. IS PLACENTA PREVIA AN INDICATION FOR PREGNANCY TERMINATION?

A. PLACENTA PREVIA IN AND OF ITSELF NOT AN INDICATION FOR TERMINATION.

Q. HAVE YOU EVER NEEDED TO TERMINATE A PREGNANCY WHERE A WOMAN WAS EXPERIENCING PLACENTA PREVIA?

A. I HAVE.

Q. AND WHAT METHOD OF PREGNANCY TERMINATION DID YOU UTILIZE?

A. WELL, WE HAVE UTILIZED DIFFERENT TECHNIQUES. OFTENTIMES IT'S A SURGICAL TECHNIQUE SUCH AS A HYSTEROTOMY OR CESAREAN DELIVERY. WE HAVE HAD SOME RARE INSTANCES WHERE WE WILL GIVE A MEDICATION TO TRY TO GET THEM TO RESORB THE EARLY PREGNANCY THAT MAY BE CAUSING THE PLACENTA PREVIA OR EVEN A CERVICAL PREGNANCY.

Q. WHY HAVE YOU OPTED TO USE THE HYSTEROTOMY METHOD OF TERMINATION?

A. WELL, IN THE LATER GESTATIONAL AGES, HYSTEROTOMY OR CESAREAN DELIVERY IS THE WAY TO DELIVER A BABY WITH PLACENTA

PREVIA.

IF YOU TRY TO DELIVER VAGINALLY, THEN YOU SIGNIFICANTLY PLACE AT RISK THE MOTHER AND THE FETUS SECONDARY TO SEVERE BLEEDING COMPLICATIONS.

Q. SO IS THERE SOMETHING ABOUT THE PLACENTA -- THE NATURE OF PLACENTA PREVIA THAT'S A SORT OF WELL CONTRAINDICATION TO DELIVERING VAGINALLY?

A. YES. PLACENTA PREVIA IS CONSIDERED A CONTRAINDICATION OF VAGINAL DELIVERY, AND IN SOME CIRCUMSTANCES IT'S CONSIDERED CONTRAINDICATION TO EVEN DOING A VAGINAL EXAM.

Q. A VAGINAL DELIVERY, DOES THAT ALSO MEAN VAGINAL DELIVERY BY SURGERY?

A. BY SURGERY OR BY INDUCTION.

Q. DOCTOR, WHAT IS SEPSIS?

A. SEPSIS IS AN INFECTION THAT HAS SPREAD FROM A LOCALIZED INFECTION TO A GENERALIZED INFECTION. IT CAN THEN LEAD TO COMPROMISE OF THE PATIENT INCLUDING LOW BLOOD PRESSURE AND POTENTIALLY EVEN DEATH.

Q. AND COULD THIS BE A -- COULD SEPSIS BE AN INDICATION FOR TERMINATION?

A. IT COULD BE, YES.

Q. WOULD THE PARTIAL-BIRTH ABORTION PROCEDURE EVER BE NECESSARY TO TERMINATE A PREGNANCY WITH THIS CONDITION?

A. NO, IT WOULD NOT.

Q. HOW WOULD YOU PROCEED TO DEAL WITH A PREGNANCY WHERE THE

WOMAN HAD THIS COMPLICATION?
A. IF A WOMAN HAD THIS COMPLICATION, WE WOULD, AGAIN, PLACE HER IN A CAREFULLY MONITORED SITUATION. WE WOULD INITIATE ANTIBIOTICS AND FLUID ADMINISTRATION AND THEN WE WOULD ATTEMPT TO INDUCE HER LABOR.
Q. IS THERE ANYTHING ABOUT THE INFECTION CONDITION OF THE MOTHER THAT WOULD MAKE A SURGICAL TERMINATION CONTRAINDICATED?
A. WELL, IF YOU HAVE A LOCALIZED INFECTION, WHICH MOST TIMES WHEN WE ARE TERMINATING IT'S PRIOR TO A GENERALIZED SYSTEMIC INFECTION OCCURRING. IF YOU HAVE A LOCAL INFECTION, YOU DO NOT WANT TO DO ANYTHING THAT WOULD INCREASE THE RISK FOR SEEDING OR EXPOSING OTHER AREAS TO THE INFECTION. SO, ANYTHING THAT WOULD INCREASE THE RISK FOR UTERINE TRAUMA, UTERINE PERFORATION, HEMATOGENOUS, OR BLOOD SPREAD OF INFECTION WOULD BE CONTRAINDICATED, AND THOSE ARE THE RISKS ASSOCIATED WITH SURGICAL PROCEDURES AT THOSE GESTATIONAL AGES.
Q. DOCTOR, WHEN YOU HAVE BEEN TESTIFYING THAT THE PARTIAL-BIRTH ABORTION PROCEDURE WOULD NEVER BE NECESSARY, IN EACH OF THESE EXAMPLES I HAVE GONE OVER WITH YOU, WOULD IT EVER BE NECESSARY TO TERMINATE A PREGNANCY IN WHICH THE CERVIX WAS DILATED AND THE FETUS WAS REMOVED UP TO THE HEAD AND THEN A SEPARATE PROCEDURE WAS TAKEN TO DECOMPRESS THE HEAD IN ORDER TO COMPLETE THE DELIVERY?
A. I AM SORRY, I AM GOING TO HAVE TO ASK YOU TO RESTATE THE QUESTION.

Q. IN EACH OF THESE DIFFERENT EXAMPLES THAT YOU HAVE GIVEN AND YOU TESTIFIED THAT THE PARTIAL-BIRTH ABORTION PROCEDURE WOULD NEVER BE NECESSARY, IN YOUR OPINION, WOULD IT EVER BE NECESSARY TO TERMINATE THE PREGNANCY BY A METHOD IN WHICH THERE IS DILATION SUCH THAT THE FETUS IS EXTRACTED VAGINALLY UP TO THE HEAD, AND THEN THE HEAD IS DECOMPRESSED IN ORDER TO COMPLETE THE DELIVERY WITH AN INTACT FETUS?

A. NO, THAT WOULD NOT BE NECESSARY.

Q. DR. COOK, HAVE YOU EVER NEEDED TO TERMINATE A PREGNANCY ON A WOMAN WHO HAS HAD A PREVIOUS UTERINE SCAR?

A. I HAVE.

Q. WHAT KINDS OF UTERINE SCARS HAVE YOU SEEN IN YOUR PRACTICE?

A. A VARIETY OF UTERINE SCARS. MOST COMMONLY THOSE THAT HAVE A LOW UTERINE SEGMENT OR LOW TRANSVERSE UTERINE SEGMENT SCAR, SOME OF WHICH HAVE VERTICAL SCARS THAT MAY EITHER BE IN THE LOWER SEGMENT OR THROUGHOUT THE CONTRACTILE PORTION, AS WELL AS PEOPLE WHO MAY HAVE HAD SCARS FROM OTHER UTERINE SURGERIES PERFORMED AT EARLIER STAGES IN THEIR LIVES.

Q. HAVE YOU EVER TREATED A WOMAN WHO HAS A SCAR FROM A MYOMECTOMY?

A. I HAVE.

Q. THE LOWER TRANSVERSE SCARS THAT YOU TESTIFIED ABOUT, ARE THOSE FROM CESAREAN SECTIONS?

A. ALMOST ALWAYS FROM CESAREAN DELIVERIES.

Q. IF A WOMAN'S PREGNANCY NEEDED TO BE TERMINATED PREVIABILITY

AND IN THE SECOND-TRIMESTER, AND SHE HAD A PREVIOUS UTERINE SCAR, HOW WOULD YOU PROCEED WITH THAT TERMINATION?

A. WELL, IF THERE WAS AN ASSESSMENT THAT THE PATIENT WAS A GOOD CANDIDATE TO TRY THE LABOR, MEANING THAT HER SCARS HAVE BEEN PREDOMINANTLY IN THE LOWER UTERINE SEGMENT, AND THAT POTENTIALLY SHE EVEN HAS HAD VAGINAL DELIVERIES SUBSEQUENTLY, THEN WE WOULD PROCEED WITH LABOR INDUCTION USING DIFFERENT TYPES OF PROSTAGLANDINS THAT WE MIGHT USE IN AN UNSCARRED UTERUS.

Q. WHAT KINDS OF PROSTAGLANDINS WOULD YOU USE?

A. GENERALLY WE WOULD AVOID THE E1 SERIES, THE CYTOTEC OR MISOPROSTOL, AND WE GENERALLY USE AN E2 TYPE OF PROSTAGLANDIN. OFTENTIMES ONE THAT IS CONTAINED WITHIN A DELIVERY SYSTEM THAT CAN BE REMOVED AS NECESSARY FAIRLY EASILY.

Q. JUST TO BE CLEAR, THE PGE2 PROSTAGLANDIN, THAT'S SOMETHING DIFFERENT THAN MISOPROSTOL?

A. CORRECT. THEY FALL IN THE GENERAL FAMILY OF PROSTAGLANDINS, BUT THEY ARE DIFFERENT AGENTS IN THE MANNER IN WHICH THEY CAUSE UTERINE ACTIVITY AND IN THEIR SITE-EFFECT PROFILES.

Q. DR. COOK, WITH THE OTHER EXAMPLES, WITH THE VERTICAL SCAR OR A MORE DEEPER SCAR IN THE WOMAN'S UTERUS, IF A WOMAN PRESENTED TO YOU WITH THAT SITUATION AND HER PREGNANCY NEEDED TO BE TERMINATED, HOW WOULD YOU GO ABOUT TERMINATING HER PREGNANCY?

A. GENERALLY WE WOULD GO ABOUT IT THE SAME WAY WITH SELECTED TYPES OF PROSTAGLANDINS AND CERTAIN TYPES OF DELIVERY SYSTEMS, WHILE DISCUSSING WITH HER THE POTENTIAL CONCERN FOR COMPLICATIONS SUCH AS AN UTERINE SCAR SEPARATION OR UTERINE RUPTURE, AND THEN WE MAY ALSO OFFER HER THE OPTION OF SURGICAL PROCEDURE AS WELL.

Q. WHAT KIND OF SURGICAL PROCEDURE WOULD YOU OFFER HER?

A. DEPENDING UPON THE SITUATION, IT MAY BE A HYSTEROTOMY PARTICULARLY IF SHE HAS HAD A HISTORY OF A PRIOR UTERINE RUPTURE.

Q. OKAY.

MS. CLARK: YOUR HONOR, MAY I APPROACH?

BY MS. CLARK:

Q. DOCTOR, I HAVE SHOWN YOU WHAT HAS BEEN IDENTIFIED AS DEFENDANT'S EXHIBIT LTA-10.

HAVE YOU SEEN THIS DOCUMENT BEFORE?

A. I HAVE.

Q. ARE YOU RELYING ON IT IN OFFERING YOUR OPINION TODAY?

A. IT IS ONE OF THE ARTICLES THAT WE USE TO DEMONSTRATE THE SAFETY OF PROSTAGLANDIN USE IN A PRIOR SCARRED UTERUS.

Q. WHAT IS THE NAME OF THIS ARTICLE?

A. IT'S ENTITLED "CERVICAL RIPENING AND LABOR INDUCTION AFTER PREVIOUS CESAREAN DELIVERY."

Q. WHERE AND WHEN WAS IT PUBLISHED?

A. IT'S PUBLISHED IN 1995 IN A SERIES CALLED CLINICAL

OBSTETRICS AND GYNECOLOGY.

Q. IF YOU WOULD TURN TO PAGE 289. THE FIRST COLUMN, VERY LAST FULL PARAGRAPH WHERE IT BEGINS "I CONCLUDE"?

ARE YOU THERE?

A. YES, ON THE FIRST COLUMN. YES, I SEE IT.

Q. 289, FIRST COLUMN.

WOULD YOU READ OUT LOUD THAT PARAGRAPH?

A. (READING)

"I CONCLUDE THAT EXOGENOUS APPLICATION OF PGE2 TO THE CERVIX OR VAGINA TO RIPEN THE CERVIX IS SAFE FOR TRIAL OF LABOR OR VAGINAL BIRTH AFTER CESAREAN PATIENTS. NO DATA IDENTIFIED CONSISTENTLY INCREASED RISK FOR MATERNAL OR PERINATAL MORBIDITY OR DEATH IN THIS SITUATION."

Q. DOES THIS CONCLUSION SUPPORT YOUR USE PROSTAGLANDIN PGE2 IN PERFORMING AN INDUCTION ON A WOMAN WITH A PRIOR UTERINE SCAR?

A. IT DOES.

Q. AND HOW SO?

A. WELL, THIS PARTICULAR SERIES REVIEWED ALL OF THE EXISTING LITERATURE AT THAT TIME IN TRIAL OF LABOR OR VAGINAL BIRTH AFTER CESAREAN AND PATIENTS SUBSEQUENTLY REQUIRING CERVICAL RIPENING WITH PROSTAGLANDINS.

THEY DID ACTUALLY ADD AS AN ADDENDUM SOME ADDITIONAL DATA THAT ALL CONCLUDE THE SAME THING; THAT THESE APPROACHES

ARE SAFE AND EFFECTIVE, AND NOT ASSOCIATED WITH SIGNIFICANT INCREASE CONCERNS FOR UTERINE RUPTURE OR URINE DEFICIENTS IF YOU'RE SELECTING YOUR PROSTAGLANDINS CAREFULLY.

Q. I THINK THIS WAS IMPLICIT IN YOUR TESTIMONY, DOES A PRIOR UTERINE SCAR OF THE UTERUS -- DOES THE PRIOR UTERINE SCAR INCREASE THE RISK FOR UTERINE RUPTURE DURING AN INDUCTION?

A. YES. JUST HAVING A UTERINE SCAR DOES PLACE YOU AT INCREASED RISK, BUT THE RISK IS FELT TO BE NEGLIGIBLE IF YOU SELECT THE CORRECT TIME OF PROSTAGLANDIN AND YOU DO IT IN A CLOSELY-MONITORED SITUATION.

Q. SO YOU MAY HAVE ANTICIPATED THIS QUESTION.

HOW DO YOU MANAGE THE RISK OF UTERINE RUPTURE THEN IF YOU HAVE A WOMAN WITH A PRIOR UTERINE SCAR WHO REQUIRES PREGNANCY TERMINATION?

A. IF IT'S A SITUATION WHERE WE THINK THEY'RE A GOOD CANDIDATE, AGAIN LOWER TRANSVERSE SEGMENT, POTENTIALLY SUCCESSFUL VAGINAL DELIVERY IN THE PAST, THEN WE WOULD DO IT WITH PROSTAGLANDIN E2, AGAIN, IN A CAREFULLY-MONITORED SITUATION.

IF WE THINK THAT THEY ARE A CANDIDATE BUT MAYBE AN INCREASE RISK FOR A UTERINE COMPLICATION, THEN WE WILL DISCUSS THE RISKS AND BENEFITS WITH THE PATIENT AND THEN SELECT A FINAL METHOD.

AND IF WE THINK THEY ARE AT HIGH RISK, AS IN THE CASE OF A PERSON WITH A PRIOR UTERINE RUPTURE, WE MAY RECOMMEND

HYSTEROTOMY.
Q. WOULD IT EVER BE MEDICALLY NECESSARY IN YOUR OPINION TO PERFORM A PARTIAL-BIRTH ABORTION PROCEDURE ON A WOMAN WITH A PREVIOUS SCAR WHO WAS REQUIRING PREGNANCY TERMINATION?
A. NO.
Q. AND WOULD IT EVER BE MEDICALLY NECESSARY IN YOUR OPINION TO PERFORM A PROCEDURE, A SURGICAL PROCEDURE TO TERMINATE THE PREGNANCY IN WHICH THE FETUS IS EXTRACTED VAGINALLY INTACT UP TO THE HEAD AND THE HEAD NEEDS TO BE COLLAPSED IN ORDER TO COMPLETE THE PREGNANCY TERMINATION?
A. NO.
Q. WOULD THE PARTIAL-BIRTH ABORTION PROCEDURE BE AN APPROPRIATE PROCEDURE IF A WOMAN'S HEALTH WAS DETERIORATING QUICKLY DURING A COMPLICATED PREGNANCY?
A. NO.
Q. AND WHY NOT?
A. BECAUSE WE HAVE OTHER SAFER AND READILY AVAILABLE ALTERNATIVES AT OUR DISPOSAL.
Q. WOULD A PARTIAL-BIRTH ABORTION PROCEDURE BE NECESSARY IF YOU WERE IN AN EMERGENT TIME SENSITIVE SITUATION WITH RESPECT TO THE HEALTH OF THE MOTHER?
A. I CANNOT ENVISION A CASE WHERE THAT WOULD BE.
Q. AND WHY IS THAT THE CASE?
A. BECAUSE WE CAN PROCEED TO A RAPID DELIVERY AT ANY POINT IF WE NEEDED TO WITH OTHER SURGICAL TECHNIQUES OR OFTENTIMES EVEN

OTHER MEDICAL TECHNIQUES.

Q. IS THERE SOMETHING SPECIFIC IN THE NATURE OF THE PARTIAL-BIRTH ABORTION PROCEDURE THAT YOU WOULD THINK WOULD MAKE IT AN UNNECESSARY PROCEDURE TO PERFORM IN AN EMERGENT SITUATION?

A. MOST EMERGENT SITUATIONS ARE EMERGENT BECAUSE OF SOME DETERIORATION OF MATERNAL HEALTH STATUS, MOST COMMONLY, SIGNIFICANT BLEEDING ISSUES OR SIGNIFICANT INFECTIOUS ISSUES. AND I BELIEVE THE PARTIAL-BIRTH ABORTION PROCEDURE HAS THE POTENTIAL TO WORSEN OR EXACERBATE THAT SITUATION AND THAT I WOULD RATHER USE OTHER ALTERNATIVE METHODS TO EMPTY THE UTERUS IN THAT SETTING PARTICULARLY.

MS. CLARK: YOUR HONOR, I WOULD LIKE TO APPROACH THE WITNESS AND HAND HIM A PART OF THE CONGRESSIONAL RECORD THAT'S SPECIFICALLY A LETTER WRITTEN FROM PHILLIP DARNEY, A PHYSICIAN TO SENATOR DIANNE FEINSTEIN. DR. COOK COMMENTED, RESPONDED TO CONGRESS AFTER READING THIS LETTER, AND IT SETS FORTH TWO EXAMPLES OF WHEN IT MAY BE NECESSARY TO DO THE PARTIAL-BIRTH ABORTION PROCEDURE, AND I WOULD JUST LIKE HIM TO COMMENT ON THAT.

IT IS NOT ON OUR EXHIBIT LIST, SO --

THE COURT: YOU NEED TO SHOW IT TO OPPOSING COUNSEL.

MS. CLARK: YES, I HAVE COPIES.

MS. GARTNER: YOUR HONOR, WE WOULD OBJECT TO THIS TESTIMONY. THIS WASN'T DISCLOSED ON DR. COOK'S EXPERT REPORT,

IT WASN'T DISCUSSED IN HIS DEPOSITION.

HAD WE KNOWN THAT HE WAS GOING TO COMMENT ON THIS, WE MIGHT HAVE SOUGHT REBUTTAL TESTIMONY FROM DR. DARNEY HIMSELF, WHO IS BASED HERE IN SAN FRANCISCO, TO RESPOND TO DR. COOK'S CRITIQUE OF HIS PROCEDURES.

THE COURT: IF IT IS NOT IN THE DEPOSITION OR EXPERT REPORT, I THINK MY RULING HAS BEEN CONSISTENT.

MS. CLARK: OKAY.

BY MS. CLARK:

Q. DR. COOK, CONSISTENT WITH YOUR TESTIMONY ABOUT THE MEDICAL NECESSITY FOR VARIOUS PROCEDURES, I WOULD LIKE YOU TO CONSIDER AN EXAMPLE OF A WOMAN WHO IS 25 YEARS OLD, SHE'S HAD TWO PREVIOUS VAGINAL DELIVERIES AND BLEEDING PLACENTA PREVIA AND A CLOTTING DISORDER AT 20 WEEKS.

AFTER CHECKING HER COAGULATION PARAMETERS, AND MAKING BLOOD AVAILABLE FOR TRANSFUSION, SHE -- HER CERVIX WAS DILATED OVERNIGHT WITH LAMINARIA, WITH PLAN UTERINE EVACUATION WHEN ADEQUATE DILATION WAS ACHIEVED, HER BLEEDING BECAME TOO HEAVY TO REPLACE.

WITHIN 12 HOURS, OF CERVICAL DILATION, SHE WAS DILATED TO 3 CENTIMETERS AND HEAVY BLEEDING HAD BEGUN. THE PLACENTA WAS REMOVED QUICKLY AND AN INTACT D&E APPROACH USED.

IN THAT SITUATION, IN YOUR OPINION, WOULD THE D&X PROCEDURE BE MEDICALLY NECESSARY?

A. NO. NOT ONLY DO I THINK IT IS NOT MEDICALLY NECESSARY, I

THINK IT IS POTENTIALLY COMPRISING TO USE THAT APPROACH IN THAT SITUATION.

Q. WHY IS THAT YOUR OPINION?

A. WELL, WE NEVER WOULD RECOMMEND TRYING TO DO A SURGICAL PROCEDURE LET ALONE A VAGINAL SURGICAL PROCEDURE. LET ME TAKE THAT BACK.

WE WOULD NEVER RECOMMEND A VAGINAL PROCEDURE, LET ALONE A SURGICAL VAGINAL PROCEDURE IN A PATIENT WITH PLACENTA PREVIA, PARTICULARLY IF THERE IS ALREADY BLEEDING PRESENT AND ALREADY A KNOWN COAGULOPATHY, MEANING AN INTOLERANCE FOR BLEEDING.

Q. AND WOULD SOMETHING ABOUT THE WOMAN'S CLOTTING DISORDER WEIGH IN YOUR ANALYSIS OF WHETHER OR NOT THE PARTIAL-BIRTH ABORTION PROCEDURE WAS MEDICALLY NECESSARY?

A. YES. THE CLOTTING DISORDER WOULD MEAN THAT SHE HAS EVEN MORE LIMITED RESERVE FOR TOLERATING BLEEDING, SHE'S IN A VERY HIGH RISK SITUATION FOR BLEEDING WITH A KNOWN PREVIA AND, IN FACT, IS ALREADY BLEEDING, AND HER BLEEDING SITUATION WAS ONLY WORSENED BY THE CERVICAL PREPARATION, AT LEAST IN THE CASE THAT YOU JUST READ TO ME, AND SO I BELIEVE THAT THEY POTENTIALLY COMPRISED HER HEALTH AND HER LIFE WITH THAT APPROACH.

I DON'T KNOW ACTUALLY ANYONE THAT WOULD USE THAT APPROACH.

Q. NOW, ANOTHER EXAMPLE, DOCTOR, A 38 YEAR OLD WOMAN PRESENTS HERSELF TO YOU, SHE HAS HAD THREE PREVIOUS CESAREAN DELIVERIES

AND EVIDENCE OF PLACENTA ACCRETA, AND SHE WAS REFERRED FOR PREGNANCY TERMINATION AT 22 WEEKS GESTATION.

AND SHE WAS REFERRED FOR PREGNANCY TERMINATION BECAUSE HER RISK OF MASSIVE HEMORRHAGE AND HYSTERECTOMY AT THE TIME OF THE DELIVERY WAS CORRECTLY ESTIMATED AT 75 PERCENT.

AFTER THE SONOGRAPHIC STUDIES OR TESTS CONFIRMED PLACENTA PREVIA AND LIKELY ACCRETA, WOULD IT BE APPROPRIATE TO TAKE -- TO DILATE THE CERVIX WITH LAMINARIA, AND MAKE BLOOD AVAILABLE IN CASE TRANSFUSION WAS REQUIRED, AND THEN IN ORDER TO REDUCE THE 75 PERCENT PROBABILITY OF AN EMERGENCY HYSTERECTOMY, A DECISION WAS MADE TO EMPTY THE UTERUS AS QUICKLY AS POSSIBLE WITH INTACT D&E AND HEMORRHAGE, WOULD IT BE APPROPRIATE IN THIS SITUATION TO TREAT THAT PATIENT WITH THE PARTIAL-BIRTH ABORTION PROCEDURE?

A. IT WOULD BE MOST DECIDEDLY INAPPROPRIATE TO DO THAT.

Q. WHY IS THAT YOUR OPINION?

A. WELL, IT'S A VERY SIMILAR CASE TO THE CASE BEFORE, BUT WORSENED BY THE FACT THAT THE PLACENTA IS NOT ONLY OVERLYING THE CERVIX, BUT ALSO INTIMATELY INVOLVED WITH THE UTERINE MUSCLE, THUS SUCH THAT IT CANNOT BE SEPARATED EASILY FROM THE UTERINE MUSCLE WITHOUT CAUSING SIGNIFICANT BLEEDING RISK.

AND SO IN THAT SITUATION, INSTEAD OF TRYING TO HAVE A LOT OF BLOOD AVAILABLE AND BE PREPARED TO DO AN EMERGENT HYSTERECTOMY, WHICH WOULD BE THE HIGHEST RISK SITUATION TO PUT A PATIENT IN, WE WOULD RECOMMEND DOING HER SURGERY IN A

CONTROLLED SETTING WHICH IS WHAT I BELIEVE EVERYONE THAT I KNOW THAT TAKES CARE OF COMPLICATED PREGNANCIES WOULD DO, AND PERFORM A HYSTEROTOMY TO REMOVE THE BABY, TO ATTEMPT TO REMOVE THE PLACENTA. IF UNABLE TO REMOVE THE PLACENTA, TO TRY TO OVERSOW THE PLACENTAL INSERTION SITE AND RETAIN HER UTERUS, AND IF THAT DIDN'T WORK, THEN PROCEED WITH THE HYSTERECTOMY.

IF YOU WAIT TO THE POINT WHERE YOU HAVE ALREADY BEEN MANIPULATING THE PLACENTA VAGINALLY IN A SURGICAL MANNER AND WAIT UNTIL YOU ALREADY HAVE SIGNIFICANT BLEEDING, THAT DOESN'T RESPOND TO YOUR THERAPIES AND THEN TRY AND DO AN EMERGENT HYSTERECTOMY, YOU PUT HER AT SIGNIFICANT RISK FOR LOSS OF LIFE.

Q. DOCTOR, NOW I AM GOING TO TURN TO THE TOPIC OF FETAL ANOMALIES. YOU TESTIFIED THAT YOU TREAT AND HAVE TREATED PREGNANT WOMEN WITH FETAL ANOMALIES; IS THAT CORRECT?

A. THAT IS TRUE.

Q. IN YOUR OPINION, DO ANY FETAL ANOMALIES NECESSITATE THE PARTIAL-BIRTH ABORTION PROCEDURE?

A. THEY DO NOT.

Q. WHAT TYPES OF FETAL ANOMALIES DO YOU ENCOUNTER IN YOUR PRACTICE?

A. WE SEE A WIDE RANGE OF FETAL ANOMALIES OR ABNORMALITIES, GENERALLY CATEGORIZED AS GENETIC OR CHROMOSOMAL ISSUES OR AS SOME TYPE OF STRUCTURAL ABNORMALITY IN THE BABY THAT MAY INVOLVE ONE OR SEVERAL ORGAN SYSTEMS.

Q. DO PREGNANCIES INVOLVING FETAL ANOMALIES EVER THREATEN THE

HEALTH OF THE WOMAN?
A. THERE ARE SOME SITUATIONS THAT ARE NOT VERY COMMON WHERE THAT CAN BE THE CASE.
Q. WHAT ARE SOME OF THOSE SITUATIONS?
A. WELL, IF THERE IS A SITUATION WHERE THERE IS A PARTIAL MOLAR GESTATION WHERE THERE ARE BOTH FETAL COMPONENTS AND OVERGROWTH OF PLACENTAL COMPONENTS, THAT PREGNANCY CAN BE COMPLICATED BY BLEEDING, HYPERTENSION AND POTENTIALLY EVEN MALIGNANT INVOLVEMENT OF A PLACENTA. THERE ARE OTHER EXAMPLES AS WELL.
Q. DOCTOR, WITH THE MOLAR -- THE POTENTIAL MORAL GESTATION EXAMPLE THAT YOU JUST DESCRIBED, WOULD IT EVER BE NECESSARY IN ORDER TO PROTECT THE HEALTH OF THE MOTHER TO PERFORM A PARTIAL-BIRTH ABORTION PROCEDURE?
A. IT WOULD NOT BE.
Q. WHY IS THAT?
A. BECAUSE WE HAVE OTHER SAFE ALTERNATIVE OPTIONS AVAILABLE. AND ONE OF THE SIGNIFICANT RISK WHEN YOU EMPTY A UTERUS OF A MOLAR GESTATION IS THE RISK FOR BLEEDING COMPLICATIONS. SO, AGAIN, YOU WOULD LIKE TO TRY TO USE SOMETHING THAT WOULD HAVE MINIMAL INTRAUTERINE MANIPULATION, MINIMAL RISK FOR BLEEDING.
Q. ARE YOU FAMILIAR WITH THE FETAL ANOMALY OF TRIPLOIDY?
A. I AM.
Q. WHAT IS TRIPLOIDY?
A. TRIPLOIDY IS THE CHEMICAL SITUATION WHERE YOU HAVE THREE

COPIES OF SETS OF CHROMOSOMES RATHER THAN THE USUAL TWO SETS OF COPIES OF CHROMOSOMES.

Q. AND COULD THE CONDITION -- COULD THE FETAL CONDITION OF TRIPLOIDY EFFECT THE MOTHER'S HEALTH?

A. IT COULD. TRIPLOIDY IS THE CLINICAL SITUATION THAT GENERALLY MANIFESTS ITSELF AS A PARTIAL MOLAR GESTATION.

Q. AND, AGAIN, THEN, IF IT MANIFESTED ITSELF AS A PARTIAL MOLAR GESTATION AND THAT REQUIRED TERMINATION OF THE PREGNANCY IN ORDER TO PROTECT THE MOTHER'S HEALTH, WHAT METHOD OF TERMINATION WOULD YOU USE?

A. IT WOULD DEPEND UPON THE GESTATIONAL AGE.

AT LESS THAN 14 WEEKS, WE HAVE DONE SUCTION EVACUATIONS FOR THOSE PREGNANCIES. AT LATER GESTATIONAL AGES, WE WOULD USUALLY TRY AND DO AN INDUCTION OF LABOR MEDICALLY.

Q. WHEN IT'S PRE-14 WEEKS, HAS THE FETUS BEEN ALIVE WHEN YOU'VE PERFORMED THAT, THE SUCTION PROCEDURE?

A. THAT VERY WELL MAY BE THE CASE. WE TEND NOT TO FOCUS ON THAT SO MUCH SINCE WE CONSIDER THAT A NONSURVIVABLE SITUATION FOR THE FETUS WITH TRIPLOIDY.

Q. HAVE YOU EVER ENCOUNTERED A SITUATION IN WHICH A FETUS HAD TRISOMY DEFECT SUCH THAT IT AFFECTED THE MOTHER'S HEALTH?

A. I HAVE.

Q. COULD THE MOTHER'S HEALTH EVER BE SO ADVERSELY AFFECTED FROM THE TRISOMY THAT IT REQUIRED TERMINATION OF PREGNANCY?

A. IT COULD BE.

Q. CAN YOU DESCRIBE THAT KIND OF SITUATION?
A. WELL WE HAVE HAD ISSUES BEFORE WITH BABIES WHO HAVE CERTAIN TYPES OF ABNORMALITIES WHERE IT EITHER CAUSES MASSIVE ACCUMULATION OF AMNIOTIC FLUID VOLUME WITHIN THE UTERUS WHICH THEN CAN LEAD TO COMPROMISED OF THE PATIENT'S ABILITY FOR NORMAL RESPIRATION AND CAUSE INCREASING DISCOMFORT.

WE ALSO SEE THE SITUATION ON RARE OCCASIONS WHEN FETUSES CAN DEVELOP A HEART FAILURE TYPE SITUATION OR A NONIMMUNE HYDROPS SITUATION THAT CAN THEN SUBSEQUENTLY LEAD TO MATERNAL HYPERTENSIVE COMPLICATIONS IN THE NEED FOR DELIVERY.

Q. AND WHEN THERE IS THE NEED FOR DELIVERY, WHAT METHOD OF TERMINATION AS A MATERNAL FETAL MEDICINE SPECIALIST WOULD YOU USE TO TERMINATE THE PREGNANCY?
A. GENERALLY MEDICAL INDUCTION OF LABOR.
Q. DOCTOR, WOULD IT EVER BEEN NECESSARY TO TERMINATE A PREGNANCY BECAUSE OF A CLEFT LIP IN THE BABY?

MS. GARTNER: YOUR HONOR, THERE IS NO FOUNDATION IN THE RECORD THAT THAT OCCURS.

THE COURT: OVERRULED.

BY MS. CLARK:
Q. DOCTOR, WOULD IT EVER BE NECESSARY TO TERMINATE A PREGNANCY BECAUSE OF A CLEFT LIP IN THE BABY?
A. IT WOULD NEVER BE NECESSARY, NO.
Q. WHAT IS CLEFT LIP?
A. A CLEFT LIP IS A DEVELOPMENTAL DEFECT WHERE THERE IS

NONCLOSURE OF THE SKIN BETWEEN THE NOSE AND THE LIP AND INVOLVING THE LIP, IT MAY ALSO INVOLVE THE ROOF OF THE MOUTH OR WHAT WE CALL THE BONEY PALATE.

Q. DID YOU TESTIFY BEFORE CONGRESS ABOUT THE PARTIAL-BIRTH ABORTION PROCEDURE BEING PERFORMED ON BABIES WITH CLEFT LIP?

A. YES. AS PART OF MY TESTIMONY, I WAS ASKED TO REVIEW THE SUBMITTED FETAL INDICATIONS FOR THIS PROCEDURE, AND SOME OF THE INDICATIONS WERE TYPES OF CLINICAL SCENARIOS THAT WE DEAL WITH ON A QUITE REGULAR BASIS THAT ARE RELATIVELY MINOR, MANY OF WHICH ARE SURGICALLY REPAIRABLE.

ONE OF THE ONES I SPECIFICALLY TALKED ABOUT WAS CLEFT LIP. ANOTHER WAS VENTRICULAR SEPTAL DEFECT, WHICH IS A SMALL HOLE BETWEEN THE CHAMBERS OF THE FETAL HEART.

Q. AND WHY WAS IT THAT YOU TESTIFIED ABOUT CLEFT LIP IN PARTICULAR?

A. WELL, I TESTIFIED ABOUT A NUMBER OF SCENARIOS, INCLUDING THINGS LIKE ABNORMAL CORD INSERTIONS AND INCREASED AMNIOTIC FLUID VOLUMES AND OTHER SITUATIONS THAT DON'T ALWAYS NECESSARILY THREATEN THE MOTHER'S HEALTH, BUT I ALSO TALKED ABOUT THE SPECIFIC STRUCTURAL THINGS LIKE THE CLEFT LIP AND THE HEART DEFECT TO POINT OUT THAT THERE ARE, ONE, NOT A REQUIREMENT THAT THAT PREGNANCY BE TERMINATED AND, TWO, OTHER ALTERNATIVE OPTIONS FOR TERMINATING THE PREGNANCY IF THE WOMAN ELECTED TO PROCEED WITH THAT.

Q. WHY, IN PARTICULAR, DID YOU ADDRESS THE CLEFT LIP

SITUATION?
A. I BELIEVE I WAS TRYING TO PICK OUT THINGS THAT WERE VERY COMMONLY SEEN IN OUR PRACTICE AND OTHER PEOPLE'S PRACTICES AND POINT OUT THINGS THAT WE HAD A LOT OF PERSONAL EXPERIENCE WITH AND THINGS THAT MADE UP, YOU KNOW, LARGER NUMBERS OF SOME OF THE CASES THAT THEY WERE LISTING.
Q. AND WHAT DO YOU MEAN BY "THEY WERE LISTING"?
A. AGAIN, THIS WAS DERIVED EXCLUSIVELY FROM DR. MCMAHON'S SUBMITTED DATA OF WHAT HE CALLED HIS MATERNAL INDICATIONS AND HIS FETAL INDICATIONS FOR HIS PROCEDURE. AND I WAS ASKED TO REVIEW AND COMMENT ON THOSE.
SO MY COMMENTS WERE LIMITED JUST TO DR. MCMAHON'S SUBMITTED EXPERIENCE AND COMMENTING UPON FROM THE PERSPECTIVE OF MY HAVING TAKEN CARE OF MANY PATIENTS WITH SIMILAR DIAGNOSES.
Q. DOCTOR, HAVE YOU EVER TREATED A FETUS WHO HAD THE CONDITION OF HYDROCEPHALY?
A. I HAVE.
Q. WHAT IS HYDROCEPHALY?
A. HYDROCEPHALY IS USUALLY USED AS A TERM TO DESCRIBE AN ENLARGEMENT OF THE VENTRICULAR SYSTEM WITHIN THE BABY'S BRAIN THAT AT SOME POINT MAY POTENTIALLY LEAD TO MACROCEPHALY OR ENLARGEMENT OF THE BABY'S HEAD.
Q. DOES EITHER HYDROCEPHALY OR MACROCEPHALY IN THE FETUS, DOES THAT ANOMALY REQUIRE TERMINATION OF THE PREGNANCY?

A. IT DOES NOT.
Q. AND WHY NOT?
A. WELL, GENERALLY IT DOESN'T POSE AN ONGOING RISK TO THE MOTHER AND IT MAY REQUIRE ALTERNATIVE ROUTES OF DELIVERY, IF THE HEAD IS ENLARGED SO MUCH THAT WE CANNOT DO A SAFE VAGINAL DELIVERY, BUT IT DOESN'T NECESSARILY REQUIRE A TERMINATION OF PREGNANCY.
Q. CAN A FETUS WITH EITHER HYDROCEPHALY OR MACROCEPHALY BE TREATED FOR THAT CONDITION?
A. YES.
Q. HOW WOULD THAT CONDITION BE TREATED?
A. GENERALLY IT IS TREATED BY EVALUATING WHAT THE CAUSE IS, ESPECIALLY IF IT IS AN OVERPRODUCTION OF FLUID OR A BLOCKAGE OF NORMAL FLUID DRAINAGE. NORMALLY THAT IS TREATED WITH SOME TYPE OF SHUNTING PROCEDURE TO BYPASS THE OBSTRUCTION OR POSSIBLY WITH A PLACEMENT OF A RESERVOIR INTO THE VENTRICULAR SYSTEM IN ORDER TO DECOMPRESS THE SYSTEM.
Q. AND IS THE PROCEDURE CEPHALOCENTESIS EVER USED TO HANDLE A FETUS THAT HAS HYDROCEPHALY OR MACROCEPHALY?
A. SOMETIMES CEPHALOCENTESIS IS USED IF YOU HAD THE SITUATION OF NOT JUST ENLARGED VENTRICLES BUT ALSO ENLARGED HEAD IN ORDER TO REDUCE THE SIZE OF THE BABY'S HEAD AND FACILITATE THE ABILITY TO DELIVER VAGINALLY. IT'S BASICALLY USING IN UTERO THE PROCEDURE THAT WOULD BE DONE BY A NEONATOLOGIST AFTER A DELIVERY.

Q. AND IS HYDROCEPHALY OR MACROCEPHALY A LIFE-THREATENING CONDITION WITH RESPECT TO THE FETUS?
A. IT CAN BE A LIFE-THREATENING SITUATION IF THERE GETS TO BE PARTICULARLY INFECTION WITHIN THE VENTRICULAR SYSTEM, BUT IT IS NOT NECESSARILY A LIFE-THREATENING SITUATION.
Q. IS IT A CONDITION THAT YOU TREAT FETUSES FOR?
A. YES. IT'S A COMMON CAUSE FOR REFERRAL TO OUR OFFICE.
THE COURT: MS. CLARK, I AM GOING TO INTERRUPT YOU. I DON'T KNOW HOW MUCH MORE OF THIS YOU HAVE. YOU ALL INDICATED TO ME THAT YOU WANTED YOUR WITNESSES TO BE EXCUSED BY THE END OF THE DAY.
WE NOW HAVE LISTENED TO ALMOST THREE HOURS OF DIRECT ON THIS WITNESS. HE'S CERTAINLY WELCOME TO COME BACK ON THURSDAY, BUT WE NEED TO ADJOURN AT 1:30. IF YOU WANT HIM NOT TO HAVE TO COME BACK, YOU WILL HAVE TO GIVE OPPOSING SIDE SOME TIME TO CROSS.
YOU DECIDE. HE CAN COME BACK ON THURSDAY AND TAKE THE ENTIRE MORNING.
MS. CLARK: NO. I WOULD LIKE -- I THINK HE IS ONLY AVAILABLE TODAY, SO I WOULD LIKE TO TRY TO WRAP UP MY TESTIMONY WITH HIM.
HOW MUCH TIME ARE YOU THINKING OF NEEDING?
MS. GARTNER: POSSIBLY TWO HOURS. IT REALLY DEPENDS ON HOW RESPONSIVE HE IS TO MY QUESTIONS.
MS. CLARK: WOULD IT BE POSSIBLE TO TAKE THE

15-MINUTE BREAK NOW SO I CAN LOOK AT MY NOTES AND TRY AND STREAMLINE THIS AND WRAP UP AS QUICKLY AS POSSIBLE?

THE COURT: OKAY. FINE.

(RECESS TAKEN AT 11:35 A.M.)

(PROCEEDINGS RESUMED AT 11:50 A.M.)

MS. CLARK: SIX OR SEVEN QUESTIONS. SHOULD BE ABLE TO WRAP UP IN ABOUT FIVE OR 10 MINUTES. I KNOW ALSO MS. GARTNER TOLD ME SHE EXPECTS TO -- SHE HOPES TO BE ABLE TO WRAP UP IN AN HOUR-AND-A-HALF. WE NEVER KNOW HOW LONG IT WILL TAKE. AND WE BOTH BE ABLE TO STAY A LITTLE BIT LATER, IF NECESSARY.

THE COURT: I HAVE A LOT OF OTHER THINGS TO DO THIS AFTERNOON, SO I WILL GIVE YOU A LITTLE LEEWAY, BUT NOT MUCH. ALL RIGHT. SO LET'S TRY TO FINISH.

BY MS. CLARK:

Q. DR. COOK, PLAINTIFFS' EXPERT -- PLAINTIFFS' EXPERTS IN THIS CASE ASSERT THAT THE PARTIAL-BIRTH ABORTION PROCEDURE MAY BE SAFER THAN THE DILATION AND EVACUATION PROCEDURE BECAUSE AN INTACT EXTRACTION INVOLVES FEWER INSTRUMENT PASSES, LESS BLOOD AND LESS TIME.

DO YOU AGREE THAT THIS REASON IS A SOUND BASIS FOR FINDING THAT THE PARTIAL-BIRTH ABORTION PROCEDURE IS AS SAFE OR SAFER THAN OTHER AVAILABLE PREGNANCY TERMINATION METHODS?

A. WELL, INTUITIVELY, IF YOU ARE LOOKING AT THE EXACT SAME GESTATIONAL AGES FOR THE TWO PROCEDURES -- AND FREQUENTLY THEY

ARE NOT AT THE SAME AGES -- THEN, IT MIGHT BE REASONABLE TO CONCLUDE THAT THERE WOULD BE LESS NEED FOR INSTRUMENTATION INSIDE THE UTERUS FOR THE D&X VERSUS THE D&E.

BUT, LIKE I SAID, OFTENTIMES THEY ARE NOT THE SAME GESTATIONAL AGES. AND THAT DOESN'T ADDRESS THE LONG-TERM CONCERNS THAT I HAVE WITH THE OVERDILATION OF THE CERVIX.

Q. AND WITH RESPECT TO THE OVERDILATION OF THE CERVIX THAT YOU TESTIFIED YOU ARE CONCERNED ABOUT, WHAT, SPECIFICALLY, ARE YOU CONCERNED ABOUT WITH RESPECT TO THE D&X PROCEDURE?

A. WELL, THERE ARE SHORT-TERM CONCERNS WHEN YOU HAVE THAT AMOUNT OF DILATION WITH GREATER RISK FOR INFECTION AND BLEEDING. BUT MY PRIMARY CONCERN IS THE LONG-TERM CONCERNS I HAVE FOR THE MAINTAINING OF THE NORMAL INTEGRITY OF THE CERVIX WITH SUBSEQUENT PREGNANCIES.

Q. OKAY. IF THE DILATION IN THE D&X PROCEDURE IS DONE SLOWLY OVER MULTIPLE DAYS INVOLVING NATURAL OSMOTIC DILATORS, AS OPPOSED TO MECHANICAL DILATORS, IN YOUR OPINION COULD THAT POTENTIALLY LEAD TO LONG-TERM COMPLICATIONS FOR THE MOTHER?

A. YES.

Q. AND WHY IS THAT?

A. WELL, THE WORST SCENARIO WOULD BE TO TAKE RIGID DILATORS AND FORCIBLY DILATE THE CERVIX TO A GREAT DEGREE AT ONE SETTING. IT WOULD BE PREFERABLE TO DILATE OVER A PERIOD OF DAYS VERSUS DOING THAT DIRECT MECHANICAL DILATION.

HOWEVER, THE AMOUNT OF EVENTUAL DILATION YOU GET TO

IS AS CRITICAL AS TO HOW YOU GET THERE. AND SO IN MY SITUATION OF DISCUSSING D&X, I AM STILL CONCERNED ABOUT HOW MUCH DILATION THEY ARE TRYING TO ACHIEVE, NOT JUST HOW THEY ARE DOING IT.

Q. WOULD YOUR CONCERN ABOUT DILATION, THEN -- WOULD THAT POSE THE SAME CONCERNS WITH RESPECT TO AN INDUCTION PROCEDURE THAT'S PERFORMED AT THE SAME GESTATIONAL AGE?

A. NO, BECAUSE AN INDUCTION PROCEDURE INVOLVES UTERINE CONTRACTIONS INDUCING CERVICAL CHANGE THROUGH THE NORMAL PHYSIOLOGIC PROCESS, RATHER THAN TRYING TO FORCE OPEN THE CERVIX JUST IN THE AREA OF THE CERVIX.

Q. NOW, AND THAT IS EVEN THOUGH THE AMOUNT OF DILATION ACHIEVED IN AN INDUCTION PERFORMED AT 20 WEEKS WOULD BE MORE THAN THE DILATION NEEDED TO PERFORM A PARTIAL-BIRTH ABORTION PROCEDURE ON THE SAME FETUS AT 20 WEEKS?

A. YES. EVEN IF YOU ARE TRYING TO ACHIEVE YOU KNOW, FULLER DILATION ULTIMATELY WITH AN INDUCTION, YOU ARE TRYING TO ACHIEVE IT THROUGH THE UTILIZATION OF UTERINE CONTRACTION AND NORMAL PHYSIOLOGY RATHER THAN TRY TO FORCE IT OPEN WITH THE DILATORS.

Q. THANK YOU.

MS. CLARK: NO FURTHER QUESTIONS.

THE COURT: ALL RIGHT. CROSS?

CROSS-EXAMINATION

BY MS. GARTNER:

Q. DR. COOK, AS I UNDERSTOOD IT, THE FIRST OPINION YOU STATED

TODAY WAS THAT, IN YOUR OPINION, INTACT D&E IS NOT MEDICALLY NECESSARY FOR WOMEN WITH COMPLICATED PREGNANCIES; IS THAT A FAIR STATEMENT?

A. THAT WAS PART OF WHAT I THINK I STATED, YES.

Q. OKAY. THAT WAS ONE OF YOUR OPINIONS?

A. CORRECT.

Q. OKAY. I THINK YOU ALSO STATED THAT YOU'VE TALKED TO OTHER PHYSICIANS, OTHER MATERNAL FETAL MEDICINE SPECIALISTS, WHO HAVE CONCURRED WITH YOU IN THAT OPINION; IS THAT YOUR TESTIMONY?

A. THAT IS CORRECT.

Q. HAVE THE ATTORNEYS FOR THE GOVERNMENT SHARED WITH YOU EITHER THE TRIAL TESTIMONY OR THE DEPOSITION TESTIMONY OF ANY OF PLAINTIFFS' EXPERTS OR PLAINTIFFS IN ANY OF THE THREE CASES WHO THEMSELVES ARE MATERNAL FETAL MEDICINE SPECIALISTS WHO USE THE INTACT D&E PROCEDURE IN MEDICALLY-INDICATED CIRCUMSTANCES?

A. I AM NOT SURE I UNDERSTAND THE QUESTION.

Q. OKAY. I AM SORRY. IT HAD MANY PARTS TO IT. THE QUESTION WAS: HAVE YOU SEEN DEPOSITION TRANSCRIPTS OR TRIAL TRANSCRIPTS FROM WITNESSES OR PLAINTIFFS IN ANY OF THE THREE OF THESE CASES BY MATERNAL FETAL MEDICINE SPECIALISTS, SUCH AS YOURSELF, BUT ONES WHO ACTUALLY USE THE INTACT D&E PROCEDURE IN MEDICALLY-INDICATED CIRCUMSTANCES?

A. I DON'T BELIEVE I HAVE REVIEWED ANY TRIAL TRANSCRIPTS, AND I AM NOT EVEN CERTAIN I HAVE SEEN DEPOSITIONS. I HAVE SEEN THEIR SUBMITTED EXPERT REPORTS, POTENTIALLY SOME DEPOSITIONS

FROM INDIVIDUALS SUCH AS DR. JOHNSON, WHO AS I RECALL FROM MY READING OF THE PROCEDURE -- OF HIS MATERIAL -- DOES NOT PERFORM THIS PROCEDURE.

Q. MY QUESTION WAS SPECIFICALLY WHETHER YOU'VE REVIEWED TESTIMONY FROM MATERNAL FETAL MEDICINE SPECIALISTS WHO ACTUALLY DO USE THE INTACT D&E PROCEDURE IN MEDICALLY-INDICATED CIRCUMSTANCES?

A. NO, THE MATERNAL FETAL MEDICINE PEOPLE I READ FOR THIS CASE I DO NOT USE THIS PROCEDURE.

Q. OKAY. NOW, I WANT TO TRY TO UNDERSTAND WHAT YOU MEAN BY THE TERM "MEDICALLY NECESSARY" WHEN YOU ARE USING THAT IN THIS, IN THE CONTEXT OF THIS OPINION.

WOULD YOU AGREE WITH ME THAT A PROCEDURE COULD BE SAFE BUT NOT BE MEDICALLY NECESSARY?

A. I THINK WE HAVE DISCUSSED THIS BEFORE. A PROCEDURE COULD BE SAFE, BUT WE DESCRIBED BEFORE IS MEDICALLY REDUNDANT, MEANING NOT NECESSARY BECAUSE YOU HAVE OTHER PROCEDURES READILY AVAILABLE.

BUT MY CONCERNS ARE WITH THE SAFETY ISSUE, AS WELL.

Q. SURE. NO, I UNDERSTAND. BUT WHAT I WANT TO DO IS TRY AND FOCUS SPECIFICALLY RIGHT NOW ON THE "MEDICALLY NECESSARY" OPINION, AND THEN WE WILL MOVE -- AS I UNDERSTAND, YOU HAD TWO MAIN OPINIONS. ONE IS IT'S NOT MEDICALLY NECESSARY, AND ONE IT'S JUST NOT SAFE, IS THAT --

A. THAT IS A GOOD SUMMARY.

Q. -- ROUGH MEMORY.
A. YES.
Q. SO I WANT TO FOCUS ON THE MEDICALLY NECESSARY ONE AND ASK YOU, BECAUSE I WANT TO UNDERSTAND WHAT YOU MEAN BY "MEDICALLY NECESSARY."

AND DO YOU AGREE WITH ME THAT SOMETHING COULD BE NOT MEDICALLY NECESSARY BUT STILL BE SAFE?
A. YES, EXCEPT I THOUGHT WE WERE TALKING ABOUT "NECESSARY" NOT "SAFE." WHEN I SAY "NECESSARY," I MEAN THAT THERE IS ALREADY PREEXISTING OPTIONS AVAILABLE THAT ARE WELL-ESTABLISHED THAT HAVE READY ACCESS WHERE A PATIENT HAS READY ACCESS TO THEM, AND THEY HAVE ALREADY BEEN DEMONSTRATED TO BE SAFE.

SO IF SOMETHING ELSE THAT WOULD COME UP THAT WOULDN'T OFFER ANYTHING NEW -- YOU KNOW, LESS RISK, BETTER EFFICACY, LESS COST -- TO ME, IT IS NOT MEDICALLY NECESSARY. IT COULD BE MEDICALLY REDUNDANT.
Q. OKAY. MY SPECIFIC QUESTION IS: COULD SOMETHING BE SAFE BUT NOT MEDICALLY NECESSARY? A MEDICAL PROCEDURE TECHNIQUE COULD BE SAFE, BUT NOT MEDICALLY NECESSARY?
A. I SUPPOSE IT COULD.
Q. SO THAT WHEN YOU SAY A MEDICAL PROCEDURE IS NOT MEDICALLY NECESSARY, THAT IS NOT SYNONYMOUS WITH SAYING THAT IT IS NOT SAFE; IS THAT A FAIR STATEMENT?
A. NOT NECESSARILY. BECAUSE IN THE CONTEXT THAT I HAVE ALWAYS USED "NOT MEDICALLY NECESSARY," I HAVE ALWAYS SAID AS PART OF

THE CONTINUATION OF THAT STATEMENT:

"NOT MEDICALLY NECESSARY BECAUSE IT'S NOT SAFER OR NOT MORE EFFICACIOUS, OR NOT CHEAPER, OR NOT MORE EFFICIENT."

THOSE ARE CRITERIA I USE FOR MEDICAL NECESSITY. YOU HAVE TO BRING SOMETHING NEW TO THE TABLE TO BE MEDICALLY NECESSARY.

Q. OKAY. BUT MY QUESTION IS: WHEN YOU SAY SOMETHING IS NOT "MEDICALLY NECESSARY," THAT DOESN'T, IN AND OF ITSELF, MEAN IT IS NOT SAFE; IS THAT TRUE?

A. IT MEANS IT DOESN'T MEET ONE OF THOSE CRITERIA.

Q. OKAY. THANK YOU.

AND YOU AGREE THAT REASONABLE PHYSICIANS CAN DISAGREE ABOUT WHETHER A PARTICULAR TREATMENT IS MEDICALLY NECESSARY; IS THAT RIGHT?

A. YES. I THINK I SAID BOTH REASONABLE AND UNREASONABLE PHYSICIANS CAN DISAGREE ABOUT THAT.

Q. I THINK YOU DID SAY THAT.

AND YOU WOULD AGREE THAT LACK OF MEDICAL NECESSITY IS NOT, IN AND OF ITSELF, A REASON TO BAN A MEDICAL PROCEDURE; IS THAT RIGHT?

A. WELL, AGAIN, IN THE CONTEXT I USE "MEDICALLY NECESSARY," I INCLUDE ALL OF THOSE ELEMENTS. SO, I THINK IF YOU HAVE SOMETHING THAT IS NOT MEDICALLY NECESSARY AND SAFETY IS NOT PART OF THE CONSIDERATION, IT DOESN'T NECESSARILY REQUIRE A

BAN.

Q. SO IN AND OF ITSELF, LACK OF MEDICAL NECESSITY DOESN'T INDICATE THAT SOMETHING SHOULD BE BANNED?

A. NOT NECESSARILY.

Q. SO, WHAT I WANT TO DO IS JUST TALK ABOUT THE MEDICAL NECESSITY OF SOME OF THE PROCEDURES THAT COME UP IN YOUR PRACTICE.

NOW, I THINK YOU'VE -- THIS HAS BECOME CLEAR FROM YOUR TESTIMONY TODAY, BUT AM I RIGHT THAT PHYSICIANS WHO PRACTICE IN THE FIELD OF MATERNAL FETAL MEDICINE OFTEN SEE VERY RARE COMPLICATIONS OF PREGNANCY; IS THAT RIGHT?

A. YES AND NO. THEY ARE COMMON FOR US, BUT THEY WOULD BE RARE IN A GENERAL PRACTITIONER'S OFFICE.

Q. THAT IS WHAT I MEAN: RARE IN THE WORLD OF PREGNANCY. THE COMPLICATIONS THAT YOU ARE SEEING ARE GENERALLY RARE IN TERMS OF HOW LIKELY IT WOULD BE THAT ANY GIVEN PREGNANT WOMAN MIGHT ENCOUNTER THEM?

A. THAT WOULD BE CORRECT.

Q. OKAY. AND SOMETIMES A PREGNANT WOMAN CAN HAVE MORE THAN ONE UNDERLYING MEDICAL CONDITION; IS THAT FAIR?

A. THAT IS A FAIR STATEMENT.

Q. OR MORE THAN ONE PREGNANCY COMPLICATIONS; IS THAT --

A. YES, THAT IS A FAIR STATEMENT.

Q. OKAY. AND TREATMENT OF WOMEN WITH UNDERLYING MEDICAL CONDITIONS AND COMPLICATED PREGNANCIES CAN BE COMPLEX; IS THAT

A FAIR STATEMENT?
A. SOUNDS FAIR.
Q. OKAY. AND SOMETIMES YOU WOULD AGREE THAT THE SITUATIONS THAT PRESENT THEMSELVES ARE SO RARE THAT IT WOULD HAVE BEEN IMPOSSIBLE FOR IT TO HAVE BEEN THE SUBJECT OF CONTROLLED STUDY; WOULD YOU AGREE WITH THAT?
A. NOT NECESSARILY. I MEAN, THE ISSUES THAT WE ARE TALKING ABOUT, FOR INSTANCE, PREECLAMPSIA EFFECTS 10 PERCENT OF PREGNANCIES.
Q. SURE. WELL, I UNDERSTAND PREECLAMPSIA IS ONE OF THE MORE COMMON OF THE RARE CONDITIONS. BUT WHEN YOU START TALKING ABOUT CONSTELLATIONS OF CONDITIONS, FOR EXAMPLE, A WOMAN WITH MARFAN'S SYNDROME WHO HAD THREE PRIOR MYOMECTOMY SURGERIES AND POTENTIALLY HYPERTENSION, THAT WOULD BE A SITUATION THAT WOULD NOT EVER BE THE SUBJECT OF A CONTROLLED STUDY BECAUSE THE CONSTELLATION OF COMPLICATIONS IS FAIRLY UNUSUAL; WOULD YOU AGREE WITH THAT?
A. YES. ONCE YOU START ADDING MULTIPLE CRITERIA THEY HAVE TO MEET, THEY BECOME MORE AND MORE RARE AND MORE AND MORE DIFFICULT TO STUDY.
Q. AND PROBABLY IN THE LAST YEAR OR TWO YOU HAVE SEEN SITUATIONS IN YOUR PRACTICE OR YOUR -- YOUR PARTNERS' PRACTICE THAT WERE AT LEAST IN SOME RESPECT DIFFERENT THAN YOU HAD EVER SEEN BEFORE IN YOUR PRACTICE; IS THAT THE CASE?
A. IF I AM UNDERSTANDING THE QUESTION ARE YOU ASKING ME IN ANY

GIVEN YEAR DO I SEE SOMETHING I HAVE NEVER SEEN BEFORE?
Q. EXACTLY. WELL STATED.
A. THERE ARE OCCASIONS WHERE WE SEE VARIATIONS ON THINGS WE HAVE NEVER SEEN BEFORE. IT IS NOT VERY COMMON THAT WE SEE A WHOLE ENTITY THAT WE HAVE NEVER SEEN BEFORE, BUT IT COULD HAPPEN.
Q. I THINK YOU TESTIFIED IN YOUR DEPOSITION THAT IN YOUR 10-PLUS-YEAR CAREER IN PRACTICING MEDICINE, YOU HAVE PERSONALLY ONLY ONCE ENCOUNTERED A SITUATION WHERE YOU CONSIDERED A D&E ABORTION TO BE MEDICALLY NECESSARY; IS THAT CORRECT?
A. I AM NOT SURE I HAVE EVER SAID THAT. I TALKED ABOUT SITUATIONS WHERE I MYSELF HAVE DONE D&E'S BEFORE, AND I HAVE CERTAINLY REFERRED PATIENTS FOR D&E MANY TIMES, BUT NOT ONES THAT WERE REQUIRED BECAUSE OF MATERNAL HEALTH RISK.
Q. I AM FOCUSING ON THE MEDICALLY NECESSARY. AND I THOUGHT THAT YOU HAD TESTIFIED IN YOUR DEPOSITION THAT ONCE YOU DID DO A D&E THAT YOU CONSIDERED TO BE MEDICALLY NECESSARY, AND THAT WAS THE CASE OF THE WOMAN WITH THE ABNORMAL CERCLAGE. DID YOU CONSIDER THAT TO BE MEDICALLY NECESSARY SITUATION FOR D&E?
A. NOT NECESSARILY. I DID OFFER HER THE OPTION OF A REPEAT LAPAROTOMY AND REMOVAL OF THE BABY FROM ABOVE.
Q. AND LAPAROTOMY WOULD BE A SURGERY IN THE ABDOMEN?
A. CORRECT. AND I ALSO OFFERED HER A D&E. AND WE TALKED ABOUT THE ADVANTAGES OR DISADVANTAGES OF BOTH, AND TOGETHER FELT THAT D&E WAS THE BEST OPTION FOR HER.

Q. OKAY.
A. BUT IT WASN'T THE ONLY OPTION.
Q. HAVE YOU EVER CONSIDERED D&E TO BE MEDICALLY NECESSARY?
A. WELL, I HAVE CONSIDERED IT TO BE --
Q. IN YOUR PRACTICE?
A. YES, I HAVE CONSIDERED IT TO BE A MEDICAL OPTION, BUT I AM NOT CERTAIN THAT IT IS EVER THE ONLY OPTION AVAILABLE.
Q. SO WHEN YOU SAY THAT INTACT D&E IS NOT MEDICALLY NECESSARY, WOULD YOU ALSO AGREE THAT D&E IS NOT MEDICALLY NECESSARY?
A. WELL, NO, I WOULD NOT SAY THAT, BECAUSE I HAVE ALWAYS QUALIFIED WHEN I AM TALKING ABOUT "MEDICALLY NECESSARY" I AM NOT TALKING ABOUT TWO THINGS THAT ARE EQUIVALENT. I AM TALKING ABOUT ONE THING THAT OFFERS NOTHING NEW AND POTENTIALLY OFFERS GREATER RISK. AND THAT IS WHY I AM CONCERNED ABOUT D&X.

D&E COULD BE CONSIDERED AN EQUIVALENT OPTION WITH MAYBE SLIGHTLY DIFFERENT VARIATIONS ON RISK THAN WOULD BE OTHER OPTIONS AVAILABLE AT CERTAIN SITUATIONS.

AND SO I INVOLVE THE PATIENT. WE DISCUSS THE ADVANTAGES AND DISADVANTAGES OF BOTH. AND D&E MAY BE A MEDICAL OPTION. MAYBE IT IS INDUCTION. MAYBE IT IS ANOTHER TECHNIQUE.

BUT INTACT D&E OR D&X IS A DIFFERENT ISSUE, BECAUSE I DON'T CONSIDER IT AN EQUIVALENT OPTION, AND I CONSIDER IT POTENTIALLY A LESSER OPTION.

Q. I THINK YOU WENT THROUGH WITH MS. CLARK A SERIES OF MEDICAL CONDITIONS AND COMPLICATIONS. AND AS TO EACH OF THEM YOU

CONCLUDED THAT WHAT YOU CALL "PARTIAL-BIRTH ABORTION" IS NOT MEDICALLY NECESSARY; IS THAT ACCURATE?

A. THAT WAS MY TESTIMONY. YES.

Q. AND I AM WONDERING, IN THOSE SAME SITUATIONS WOULD YOU SAY THAT D&E WAS ALSO NOT MEDICALLY NECESSARY?

A. NO, I WOULD NOT SAY THAT.

Q. OKAY. BUT IN YOUR PRACTICE YOU HAVE NEVER CONSIDERED D&E TO BE MEDICALLY NECESSARY; IS THAT CORRECT?

A. NO, THAT IS NOT CORRECT.

Q. IN WHAT CIRCUMSTANCES IN YOUR PRACTICE HAVE YOU PERFORMED A D&E AFTER DETERMINING THAT D&E WAS MEDICALLY NECESSARY?

A. WELL, THERE HAVE BEEN MANY CIRCUMSTANCES WHERE I HAVEN'T PERFORMED IT, BUT I HAVE REFERRED PATIENTS FOR THE PROCEDURE.

Q. BECAUSE YOU DETERMINED IT WAS MEDICALLY NECESSARY?

A. BECAUSE I DETERMINED IT WAS ONE OF THE OPTIONS AVAILABLE THAT I CONSIDERED AN EQUIVALENT MEDICAL OPTION OR A VIABLE MEDICAL OPTION, AND THE PATIENT OPTED TO GO THAT ROUTE.

Q. I AM REALLY TRYING TO UNDERSTAND WHAT IT MEANS WHEN YOU SAY "PARTIAL-BIRTH ABORTION," IN YOUR WORDS, IS NOT MEDICALLY NECESSARY, I THINK WE ARE ENTITLED TO TRY TO UNDERSTAND WHAT THAT MEANS IN YOUR LEXICON.

SO DO YOU EVER CONSIDER IN YOUR MEDICAL PRACTICE D&E TO BE MEDICALLY NECESSARY?

A. IT MAY BE AT TIMES.

Q. AND HAVE YOU EVER FOUND IT TO BE IN YOUR PRACTICE?

A. I HAVE FOUND IT TO BE A MEDICAL OPTION. WHEN I SAY "MEDICALLY NECESSARY," OR NOT MEDICALLY NECESSARY, MEANING IT IS NOT JUST AN EQUIVALENT OPTION LIKE CHOICE A, B OR C.

THE COURT: YOU HAVE ALREADY EXPLAINED THAT HER.

THE WITNESS: OKAY.

THE COURT: HER QUESTION IS VERY, VERY STRAIGHTFORWARD. YOU HAVE A TENDENCY TO GIVE A LOT MORE INFORMATION THAN THE QUESTION CALLS FOR. WE HAVE A LIMITED AMOUNT OF TIME.

THE WITNESS: OKAY.

THE COURT: I WOULD LIKE YOU TO FOCUS DIRECTLY ON WHAT SHE IS ASKING YOU, AND IF YOU CAN ANSWER IT "YES" OR "NO," PLEASE DO SO.

THE WITNESS: I AM NOT SURE I UNDERSTAND THE QUESTION, YOUR HONOR.

THE COURT: WHY DON'T YOU REPEAT IT?

BY MS. GARTNER:

Q. OKAY. USING THE WORDS "MEDICALLY NECESSARY" AS YOU USE THEM IN THE CONTEXT OF YOUR OPINION, WHEN YOU SAY PARTIAL-BIRTH ABORTION, IN YOUR WORDS, IS NOT MEDICALLY NECESSARY, USING "MEDICALLY NECESSARY" AS YOU ARE USING IT IN THAT OPINION, CAN YOU TELL US WHETHER IN YOUR MEDICAL PRACTICE YOU HAVE EVER CONSIDERED D&E TO BE MEDICALLY NECESSARY FOR ONE OF YOUR PATIENTS?

A. YES.

Q. AND CAN YOU DESCRIBE THAT CIRCUMSTANCE FOR US?
A. IT MAY BE A SITUATION LIKE I WAS REFERRED THE DAY BEFORE I LEFT FOR THE TRIAL WHERE THE MOTHER HAS A FETAL CONDITION THAT HAS MULTIPLE FETAL ANOMALIES. SHE'S OPTING NOT TO CONTINUE HER PREGNANCY. SHE IS CURRENTLY 17, MAYBE 18 WEEKS GESTATION. SHE WAS REFERRED TO AN OUTSIDE CLINIC FOR TERMINATION OF HER PREGNANCY.

IT IS MY UNDERSTANDING THAT SHE WILL BE UNDERGOING A D&E PROCEDURE. THIS WAS A CASE THAT WAS ADDRESSED WITH ME ON MONDAY MORNING.

Q. OKAY. AND YOU FOUND D&E TO BE MEDICALLY NECESSARY FOR HER, AS YOU ARE USING IT IN YOUR OPINION THAT PARTIAL-BIRTH ABORTION IS NOT MEDICALLY NECESSARY?
A. YES, AS I AM USING IT IN THE SITUATION OF PARTIAL-BIRTH ABORTION, I DID FIND IT TO BE MEDICALLY NECESSARY.
Q. AND WHAT ABOUT THAT WAS MEDICALLY NECESSARY?
A. THE FACT THAT IT IS CONSIDERED A VIABLE OPTION, AN OPTION THAT HAS AN ESTABLISHED SAFETY RECORD, AN OPTION THAT HAS BEEN UTILIZED IN THE PAST, AND AN OPTION THAT CAN BE UTILIZED AT THAT GESTATIONAL AGE, AND AN OPTION IN WHICH THE PATIENT DESIRED IT AND WAS NOT INTERESTED IN PATHOLOGY EVALUATION OTHER THAN CHROMOSOMES.

WE MADE ARRANGEMENTS AS I LEFT MONDAY MORNING WITH THE CLINIC DOING THE PROCEDURE TO OBTAIN MATERIAL FOR CHROMOSOME EVALUATION AFTER THE PROCEDURE IS DONE.

Q. SO IF ALL OF THOSE CONSIDERATIONS WERE PRESENT IN THE CASE OF AN INTACT D&E, IF IT WAS A VIABLE OPTION, MEANING THAT THERE WAS A PROVIDER WHO WAS AVAILABLE TO PROVIDE IT, A PROVIDER WITH GOOD SKILL IN THE PROCEDURE, IF THE WOMAN UNDERSTOOD HER OPTIONS, CONSENTED TO IT, WOULD YOU CONSIDER PARTIAL-BIRTH ABORTION, THEN, TO BE MEDICALLY NECESSARY FOR THAT WOMAN?

A. I WOULD NOT.

Q. AND WHY IS THAT?

A. BECAUSE THERE ARE SEVERAL ASSUMPTIONS THAT I DON'T AGREE WITH.

Q. OKAY. I AM ASKING YOU TO ASSUME MY ASSUMPTIONS. IT IS A HYPOTHETICAL QUESTION. IF IT WAS A VIABLE OPTION, MEANING THERE WAS A PROVIDER AVAILABLE WHO WAS SKILLED IN THE PROCEDURE, WHO WAS WILLING TO TREAT THIS WOMAN, IF THE WOMAN MADE AN INFORMED DECISION TO SELECT THAT PARTICULAR PROCEDURE, THERE WAS NO MEDICAL CONTRAINDICATION TO THE PROCEDURE, WOULD THAT BE MEDICALLY NECESSARY FOR HER?

A. IT WOULD NOT.

Q. AND WHY NOT?

A. BECAUSE IN YOUR ASSUMPTIONS THAT YOU GAVE ME YOU DID NOT INCLUDE AN ESTABLISHED SAFETY RECORD OF THAT PROCEDURE.

Q. OKAY. AND WHAT IF THERE WAS AN ESTABLISHED SAFETY RECORD FOR THAT PROCEDURE?

A. THEN IT COULD BE POTENTIALLY MEDICALLY NECESSARY.

Q. I WANT TO FOCUS IN WITH YOU A LITTLE BIT ON SOME OF THE

PARTICULAR CONDITIONS THAT YOU TESTIFIED ABOUT. I THINK YOU TESTIFIED ABOUT SEVERE PREECLAMPSIA OCCURRING PREVIABILITY.

I THINK YOU ALSO MENTIONED HELLP SYNDROME, WHICH I GUESS IS A VARIANT OF SOME SORT ON PREECLAMPSIA.

YOU TALKED ABOUT, I BELIEVE, LEUKEMIA, BUT MAYBE NOT, AND RENAL CONDITIONS. AND I THINK YOU SAID WITH ALL OF THOSE, WITH THE PREECLAMPSIA, THE HELLP SYNDROME AND THE RENAL CONDITIONS, WOMEN WOULD BE AT PARTICULAR RISK FOR BLEEDING; IS THAT A FAIR STATEMENT OF YOUR TESTIMONY?

A. NO.

Q. OKAY. I AM SORRY. YOU SAID THAT SIGNIFICANT BLOOD LOSS FOR THOSE WOMEN COULD BE DANGEROUS; IS THAT A FAIR STATEMENT OF YOUR TESTIMONY?

A. THAT IS A FAIR STATEMENT.

Q. OKAY. SO FOR THOSE WOMEN, THE WOMEN WITH PREECLAMPSIA, HELLP SYNDROME OR RENAL CONDITIONS, YOU WANT TO DO -- IF SHE HAS TO HAVE AN ABORTION YOU WANT TO DO IT IN A WAY THAT WOULD MINIMIZE BLOOD LOSS; IS THAT A FAIR STATEMENT?

A. IT IS AN INCOMPLETE STATEMENT. I WANT TO DO SOMETHING THAT IS GOING TO REDUCE THE RISK FOR REVERSIBLE FORMS OF BLEEDING, MEANING LACERATIONS, TEARS, BLEEDING THAT CANNOT BE WELL CONTROLLED. I ALSO WANT TO REDUCE THE RISK OF INFECTION.

Q. OKAY. LET'S FOCUS ON THE BLOOD LOSS PART OF IT. YOU WANT TO DO A PROCEDURE THAT IS GOING TO REDUCE THE RISK FOR BLOOD LOSS; IS THAT A FAIR STATEMENT AS FAR AS IT GOES?

A. BLOOD LOSS IS RELATED TO SITUATIONS THAT CANNOT BE MEDICALLY CORRECTED.

Q. I AM SORRY. I DON'T KNOW WHAT THAT MEANS.

A. WELL, THERE'S BLOOD LOSS THAT OCCURS FROM A LACERATION OR PERFORATION WHICH REQUIRES ANOTHER ADDITIONAL SURGICAL PROCEDURE WHICH GENERALLY INVOLVES LAPAROTOMY, WHICH GENERALLY INVOLVES GREATER DELAY IN TREATMENT, WHICH GENERALLY INVOLVES MORE BLEEDING.

THEN, THERE IS BLEEDING THAT OCCURS FROM UTERINE APNEE (PHONETIC), WHICH MEANS THE UTERUS NOT CLAMPING DOWN ADEQUATELY.

WE HAVE MEDICAL OPTIONS AVAILABLE THAT CAN BE INSTITUTED IMMEDIATELY WITHOUT THE REQUIREMENT OF A LAPAROTOMY AND WITHOUT A DELAY.

SO IT IS MORE THAN ABSOLUTE BLOOD LOSS. IT IS HOW THE BLOOD LOSS OCCURS AND HOW QUICKLY AND EFFECTIVELY IT CAN BE TREATED.

Q. OKAY.

OKAY. LET ME ASK YOU THIS. I THINK I UNDERSTAND WHERE YOU ARE GOING WITH WHAT YOU JUST SAID, BUT IN THE CONTEXT OF THESE CONDITIONS PREECLAMPSIA, HELLP SYNDROME, SERIOUS RENAL CONDITIONS WHERE YOU ARE TRYING TO MINIMIZE THE RISK OF BLOOD LOSS FOR THE REASONS THAT YOU'VE EXPLAINED, ONE OF THE REASONS THAT YOU PREFER INDUCTION IN THOSE SITUATIONS IS THAT YOU'RE NOT PUTTING INSTRUMENTS IN THE UTERUS AND YOU ARE NOT PUTTING

THE WOMAN AT RISK OF UTERINE PERFORATION WHICH WOULD CAUSE BLOOD LOSS; IS THAT A FAIR STATEMENT?

A. I BELIEVE IT IS A FAIR STATEMENT, ALTHOUGH IT IS A COMPLEX STATEMENT, BUT I THINK I AGREE WITH ALL OF IT.

Q. DID YOU WANT ME TO RESTATE IT? DID YOU FOLLOW IT?

A. IT WOULD BE MORE HELPFUL, MAYBE, IF YOU SAY IT ONE MORE TIME.

Q. OKAY. FOR THOSE WOMEN: PREECLAMPSIA, HELLP SYNDROME, RENAL CONDITIONS WHERE YOU ARE TRYING TO MINIMIZE THE RISK OF BLOOD LOSS, ONE OF THE REASONS YOU PREFER INDUCTION FOR THOSE WOMEN IF THEY ARE TERMINATING IS BECAUSE IN THE INDUCTION METHOD YOU ARE NOT PUTTING INSTRUMENTS IN THE WOMAN'S UTERUS, SO YOU ARE NOT PUTTING HER AT RISK OF PERFORATION FROM THOSE INSTRUMENTS; IS THAT A FAIR STATEMENT?

A. THAT IS A FAIR STATEMENT.

Q. OKAY. SO IF YOU HAD A PATIENT WITH ONE OF THOSE CONDITIONS, AND YOU WERE JUST FOCUSING ON THE POTENTIAL RISK FROM BLOOD LOSS AND NO OTHER COMPLICATION, AND IF THE WOMAN ABSOLUTELY REFUSED TO HAVE AN INDUCTION ABORTION, WOULDN'T YOU AGREE THAT INTACT D&E WOULD BE SAFER FOR HER THAN A D&E, SPECIFICALLY IN TERMS OF REDUCING THE INSTRUMENTATION IN THE UTERUS?

A. YES, I ASSUME WE ARE TALKING ABOUT --

Q. AT COMPARABLE GESTATIONAL AGES?

A. YES, AT COMPARABLE GESTATIONAL AGES, THEN INTUITIVELY IT

WOULD MAKE SENSE THAT ANYTHING THAT INVOLVES LESS INSTRUMENTATION WOULD REDUCE THE RISK OF LACERATION OR PERFORATION.

Q. OKAY. AND THEN, WITH RESPECT TO -- I THINK YOU TESTIFIED ABOUT VARIOUS CARDIAC OR MAYBE CARDIOVASCULAR CONDITIONS, AND YOU MENTIONED MARFAN'S SYNDROME WITH DILATED AORTIC ROUTE?

A. YES.

Q. SIGNIFICANT PULMONARY HYPERTENSION AND LEFT-TO-RIGHT SHUNTING DISORDER. DID I GET THOSE RIGHT?

A. YES. THE LAST ONE HAS A NAME. I WAS TRYING TO AVOID USING IT. IT IS EISENMENGER'S SYNDROME.

Q. AND I THINK YOU TESTIFIED THAT FOR THESE WOMEN AS WELL INDUCTION WOULD BE PREFERABLE TO A SURGICAL PROCEDURE; IS THAT RIGHT?

A. YES.

Q. I ACTUALLY WANT TO FOCUS ON THAT LAST ONE THE EISENMENGER'S SYNDROME OR THE LEFT-TO-RIGHT SHUNTING DISORDER, BECAUSE I AM ACTUALLY NOT CLEAR ON YOUR OPINION.

YOU THINK INDUCTION IS SUPERIOR TO D&E OR INTACT D&E FOR WOMEN IN THAT CIRCUMSTANCE; IS THAT RIGHT?

A. YES.

Q. OKAY. BUT DIDN'T YOU ALSO TESTIFY IN YOUR DEPOSITION THAT FOR PEOPLE WITH THAT CONDITION THAT INDUCTION WOULD NOT BE OPTIMAL?

A. NO, I SAID THOSE ARE THE PEOPLE -- AT LEAST AS I RECALL --

THAT ARE THE MORE COMPLICATED ONES THAT DELIVER BY ANY MANNER AND DO REQUIRE VERY CAREFUL DILATION OF FLUID VOLUMES AND INVASIVE MONITORING.

Q. BUT DID YOU NOT SAY IN YOUR DEPOSITION THAT INDUCTION WOULD NOT BE OPTIMAL WITH A WOMAN WITH LEFT-TO-RIGHT SHUNTING DISORDER?

A. WELL, ANYTHING THAT IS A LABORING PROCESS MAKES HER DISEASE POTENTIALLY WORSE. EVEN CONTINUING HER PREGNANCY MAKES HER DISEASE POTENTIALLY WORSE. SO, WHAT YOU HAVE TO CHOOSE FROM IS MULTIPLE BAD OPTIONS. AND ONE OF THE BAD OPTIONS WOULD BE TO TRY TO DO AN INDUCTION OF LABOR IN A CLOSELY-MONITORED AND CAREFULLY-SUPPORTED SITUATION.

Q. OKAY. WHY DON'T YOU GO AHEAD AND LOOK AT YOUR DEPOSITION? PAGE 185, BEGINNING AT LINE 15. DO YOU SEE THAT, FROM 15 TO 21?

A. I DO.

Q. AND DID YOU SAY THAT:

"FOR A WOMAN WITH, FOR EXAMPLE, EISENMENGER'S SYNDROME INDUCTION WOULDN'T BE OPTIMAL"?

A. YES. THERE WAS -- THE QUESTION PUT TO ME WAS:

"IT ABSOLUTELY CONTRAINDICATED?"

AND MY RESPONSE IS:

"IT IS NOT ABSOLUTELY CONTRAINDICATED, BUT IT WOULDN'T BE OPTIMAL."

Q. IT WOULDN'T BE OPTIMAL. OKAY. THANK YOU.

AND THEN, I THINK WE CONTINUED THE DISCUSSION. AND I WILL JUST HAVE YOU LOOK BACK AT YOUR DEPOSITION AT PAGE 187. ACTUALLY, LET ME ASK YOU FIRST: DO YOU RECALL THAT IN YOUR DEPOSITION YOU TESTIFIED THAT, IN FACT, THE SAFEST ABORTION PROCEDURE FOR A WOMAN WHO WAS 22 WEEKS PREGNANT AND WHO HAD TO TERMINATE THE PREGNANCY DUE TO EISENMENGER'S SYNDROME OR LEFT-TO-RIGHT SHUNTING, THAT THE SAFEST PROCEDURE FOR HER WAS A SURGICAL PROCEDURE, EITHER VAGINAL OR ABDOMINAL, IN A CONTINUOUSLY-MONITORED ENVIRONMENT, AND IT WAS NOT PREFERABLE TO DO AN INDUCTION PROCEDURE FOR HER?

A. WELL, I WOULD HAVE TO REVIEW THE SPECIFIC QUESTIONS AND THE EXCHANGE. BUT, GENERALLY, WHATEVER WE CAN DO TO EFFECT A VAGINAL DELIVERY USING NORMAL UTERINE ACTIVITY IS ALWAYS OUR FIRST OPTION.

IF WE HAVE A PATIENT THAT IS SO COMPROMISED THAT WE DON'T THINK THAT SHE CAN TOLERATE THAT AT ALL, THEN WE WOULD PROBABLY PROCEED WITH A CESAREAN DELIVERY OR HYSTEROTOMY.

Q. WHY DON'T YOU GO AHEAD AND LOOK, BECAUSE I THINK YOU DID TESTIFY IN YOUR DEPOSITION THAT VAGINAL -- THAT A SURGICAL TECHNIQUE, EITHER VAGINAL OR ABDOMINAL, WAS PREFERABLE IN THAT SITUATION.

IF YOU LOOK AT PAGE 187, STARTING ON LINES EIGHT THROUGH LINE 19.

A. YES, I SEE THAT.

Q. OKAY. AND I SAID TO YOU:

"WOULD YOU SAY THAT IN A WOMAN WITH, FOR EXAMPLE, THE LEFT-TO-RIGHT SHUNTING HISTORY THAT YOU DESCRIBED, THAT IF SHE WERE 22 WEEKS PREGNANT AND HER CONDITION DETERIORATED IN SOME WAY, AND SHE NEEDED TO END HER PREGNANCY, WOULD D&E BE A SAFE PROCEDURE FOR HER?"

AND YOUR ANSWER WAS:

"IT WOULD NOT BE A SAFE PROCEDURE, BUT IT WOULD BE AN OPTION AS A PROCEDURE."

WAS THAT YOUR TESTIMONY?

A. THAT WAS.

Q. AND THEN, I CONTINUED. I SAID:

"WHAT WOULD BE THE SAFEST PROCEDURE FOR HER?"

AND YOU ANSWERED:

"THE SAFEST PROCEDURE FOR HER WOULD BE TO BE ABLE TO EFFECT HER DELIVERY SURGICALLY, WHETHER VAGINAL OR ABDOMINAL, IN A CONTINUOUSLY-MONITORED ENVIRONMENT."

WHAT WAS THAT YOUR ANSWER?

A. AS I UNDERSTOOD THE QUESTION --

Q. WELL, WAS THAT YOUR ANSWER, DR. COOK?

A. IT WAS THE ANSWER TO THE QUESTION THAT WAS PUT TO ME.

Q. OKAY.

A. WHICH WAS THAT SHE WAS DETERIORATING RAPIDLY.

Q. OKAY. AND YOUR ANSWER WAS:

"IN THAT CONTEXT WHERE A WOMAN HAS EISENMENGER'S SYNDROME AND IS DETERIORATING RAPIDLY, THAT THE SAFEST WAY TO DELIVER HER IS A SURGICAL TECHNIQUE, WHETHER VAGINAL OR ABDOMINAL"; IS THAT CORRECT?

A. YES, BECAUSE IT IS THE FASTEST WAY TO DELIVER HER WHEN SHE IS DETERIORATING, BUT IT IS NOT THE GENERAL APPROACH FOR JUST EISENMENGER'S SYNDROME, IN GENERAL.

Q. OKAY. AND A SURGICAL VAGINAL APPROACH TO ABORTION IS A D&E; IS THAT NOT CORRECT?

A. THAT IS CORRECT.

Q. OKAY.

A. THAT IS WHY I SAID IT WAS AN OPTION.

Q. OKAY. SO IN YOUR DIRECT TESTIMONY YOU SAID THAT IN A WOMAN WITH LEFT-TO-RIGHT SHUNTING DISORDER YOU WOULD DO AN INDUCTION PROCEDURE. BUT IS IT NOW REALLY THE CASE THAT IN A WOMAN WITH EISENMENGER'S SYNDROME, IF HER CONDITION WAS DETERIORATING YOU MIGHT OPT FOR A D&E?

A. YES. MY TESTIMONY IS CONSISTENT. IF IT IS EISENMENGER'S SYNDROME, MY FIRST OPTION IS MEDICAL INDUCTION. IF IT IS EISENMENGER'S SYNDROME WHERE SHE IS RAPIDLY DETERIORATING AND TIME IS OF THE ESSENCE, THEN I WANT TO TRY AND DELIVER HER AS RAPIDLY AS POSSIBLE. MY FIRST OPTION WOULD BE ABDOMINAL SURGERY, MEANING HYSTEROTOMY. BUT IT ALSO COULD INCLUDE A D&E PROCEDURE.

Q. SO YOU WOULD DO -- IN THAT SITUATION YOUR FIRST OPTION WOULD BE HYSTEROTOMY; IS THAT RIGHT?
A. CORRECT.
Q. AND HYSTEROTOMY, IS THAT LIKE A CESAREAN SECTION, RIGHT?
A. BASICALLY, IT IS A CESAREAN DELIVERY.
Q. BUT IS IT A LOW TRANSVERSE INCISION OR IS IT ONE OF THE VERTICAL-TYPE INCISIONS?
A. IT IS USUALLY LIKE A CLASSICAL CESAREAN DELIVERY, VERTICAL INCISION.
Q. IF THE WOMAN HAS A HYSTEROTOMY IN THAT CIRCUMSTANCE, THAT MAKES IT UNLIKELY THAT SHE WOULD EVER HAVE A VAGINAL DELIVERY IN FUTURE PREGNANCIES; IS THAT FAIR?
A. IT WOULD MAKE IT UNLIKELY. I HAVE DELIVERED PEOPLE WITH VERTICAL INCISIONS VAGINALLY.
Q. BUT A VERTICAL INCISION PUTS A WOMAN AT MUCH HIGHER RISK FOR UTERINE RUPTURE IN FUTURE PREGNANCIES; IS THAT FAIR?
A. IT INCREASES THE RISK TO ABOUT FIVE TO 10 PERCENT.
Q. FIVE TO 10 PERCENT OF WOMEN THAT DELIVER WITH A CLASSICAL CESAREAN SECTION WILL HAVE AN UTERINE RUPTURE?
A. UTERINE RUPTURE, CORRECT.
Q. JUST TO SUMMARIZE THIS, YOU WOULD AGREE THAT FOR SOME WOMEN WITH CARDIOVASCULAR CONDITIONS UNDER SOME CIRCUMSTANCES D&E MAY BE A SUPERIOR TECHNIQUE TO INDUCTION?
A. IT MAY BE A SUPERIOR TECHNIQUE TO INDUCTION --
Q. OKAY.

A. -- IN SOME SPECIAL CIRCUMSTANCES.
Q. RIGHT, UNDERSTOOD. OKAY. I THINK YOU ALSO TESTIFIED ABOUT THE CIRCUMSTANCES OF WOMEN WHO DEVELOP AN INFECTION OF THE UTERUS; IS THAT RIGHT?
A. THAT'S RIGHT.
Q. IS THAT ALSO CALLED CHORIOAMNIONITIS?
A. YES, THAT IS CORRECT.
Q. OKAY. AND DO SOME WOMEN WITH CHORIOAMNIONITIS ALSO HAVE A PREMATURE RUPTURE OF THEIR MEMBRANES?
A. THEY OFTEN DO, YES.
Q. AND IS CHORIOAMNIONITIS WITH PREMATURE RUPTURED MEMBRANES SOMETIMES ASSOCIATED WITH CERVICAL DILATION?
A. IT OFTEN IS.
Q. AND IS IT ALSO SOMETIMES ASSOCIATED WITH CERVICAL SOFTENING?
A. IT CAN BE, YES.
Q. AND IF A WOMAN PRESENTS TO YOU CHORIOAMNIONITIS AND PREMATURE RUPTURED MEMBRANES AND HER CERVIX IS SOFT AND PARTIALLY DILATED, IS IT POSSIBLE THAT SOMETIMES YOU CAN ACTUALLY SEE FETAL PARTS PRESENTING AT THE CERVICAL OS?
A. I SUPPOSE THAT IS POSSIBLE.
Q. AND IF THAT WERE THE CASE, WOULDN'T IT BE PREFERABLE IF IT COULD BE DONE EASILY TO SIMPLY -- IF THE WOMAN NEEDED A TERMINATION, IF THE INFECTION WAS SO BAD -- TO JUST SIMPLY PULL THE FETUS THROUGH THE PARTIALLY DILATED CERVIX RATHER THAN

PUTTING HER THROUGH AN INDUCTION OF LABOR?
A. NO.
Q. SO EVEN IF SHE IS PARTIALLY DILATED ALREADY AND THE FETAL PARTS ARE PRESENTED AT A PARTIALLY DILATED CERVIX, YOU WOULD STILL INDUCE LABOR RATHER THAN EVACUATING THE FETUS EITHER WITH INSTRUMENTS OR JUST WITH YOUR HAND?
A. NO.
Q. I AM SORRY. WHAT WOULD YOU DO IN THAT CIRCUMSTANCE?
A. IN THAT CIRCUMSTANCE IF YOU ARE ALREADY DILATED AND YOU ARE ALREADY PRESENTING WITH FETAL PARTS, THEN YOU'RE ALWAYS HAVING UTERINE ACTIVITY. THE INFECTION, IN AND OF ITSELF, CAUSES UTERINE IRRITATION IN LABOR. SO ALL I WOULD DO IS CONTINUE TO SUPPORT THE WOMAN DURING THE PROCESS, POTENTIALLY AUGMENT HER ALREADY EXISTING LABOR AND DELIVER VAGINALLY.

IN MY EXPERIENCES, ONCE YOU ARE AT THAT POINT YOU ARE ALREADY IN LABOR AND YOU ARE GOING TO PROGRESS RAPIDLY TO DELIVERY.

I WOULD DO ANYTHING TO AVOID INTRAUTERINE MANIPULATIONS. NO MATTER HOW EASY IT LOOKS, IT IS NEVER THAT EASY.

Q. SO THAT WOULD EVEN BE THE CASE IN A WOMAN WITH CHORIOAMNIONITIS WHERE SHE IS INFECTED AND YOU HAVE A RISK THAT SHE IS GOING TO DEVELOP SEPSIS IN THAT CIRCUMSTANCE UNLESS THE UTERUS IS EVACUATED RAPIDLY; ISN'T THAT THE CASE?
A. IN MY EXPERIENCE IN THE CASE THAT YOU'VE PRESENTED THEY DO

DELIVER RAPIDLY, WITHIN AN HOUR OR TWO. AND IT'S STILL THE SAFEST, MOST NATURAL, LEAST RISKY PROCEDURE.

Q. SO I JUST WANT TO BE CLEAR. SO IF YOU HAD A WOMAN WITH CHORIOAMNIONITIS, HER CERVIX IS DILATED. THE FETAL PARTS ARE PRESENTING AT THE UTERUS. YOU WOULD LET HER CONTINUE TO LABOR FOR A FEW MORE HOURS RATHER THAN SIMPLY EVACUATING THE FETUS AT THAT MOMENT, EVEN WHEN IT IS PRESENTING?

A. THAT IS CORRECT.

Q. OKAY. NOW, I THINK YOU INDICATED THAT ONE OF THE REASONS THAT YOU PREFER INDUCTION IN THE CONTEXT OF THESE KINDS OF MEDICALLY-COMPLICATED PREGNANCIES IS THAT YOU BELIEVE IT CAN BE DONE -- INDUCTION CAN BE DONE IN A CONTROLLED AND MONITORED FASHION; IS THAT A FAIR STATEMENT OF YOUR TESTIMONY?

A. THAT IS ONE ELEMENT OF IT.

Q. AND WHAT IS -- JUST VERY BRIEFLY, I WANT TO -- WHAT -- WHAT ARE SOME OF THE OTHER ELEMENTS OTHER THAN THE CONTROLLED AND MONITORED ASPECT OF IT?

A. AS FAR AS WHY I PREFER INDUCTION?

Q. WHY YOU PREFER INDUCTION, LEAVING ASIDE -- WELL, ACTUALLY WHAT --

MS. GARTNER: LET ME WITHDRAW THAT QUESTION.

BY MS. GARTNER:

Q. LET'S TALK ABOUT WHY YOU PREFER INDUCTION BECAUSE IT CAN BE DONE IN A CONTROLLED AND MONITORED WAY.

A. LOOKING ONLY AT THAT PORTION OF IT.

Q. EXACTLY. ONLY AT THE CONTROLLED AND MONITORED PORTION.
A. WELL, I BELIEVE IN MANY OF THESE COMPLEX MEDICAL CONDITIONS IT IS PREFERABLE TO BE TREATED BASICALLY IN AN INTENSIVE CARE TYPE OF ENVIRONMENT VERSUS BEING ON AN OFF-SITE CLINIC, FOR INSTANCE. BEING CARED FOR BY PEOPLE WHO HAVE CRITICAL CARE TRAINING AND TRAINING IN COMPLICATED PREGNANCIES, BEING CONTROLLED IN A TEAM MANAGED FASHION, WHICH USUALLY INCLUDES OBSTETRICAL ANESTHESIA, OTHER CRITICAL CARE SUPPORT PEOPLE AND POTENTIALLY OTHER MEDICAL SPECIALISTS.

IT INVOLVES THE USE OF OTHER TYPES OF MONITORING SITUATIONS. IT INVOLVES THE PATIENT BEING ABLE TO RELATE TO US HER SYMPTOMS AND HOW SHE IS PROGRESSING. IT ALLOWS US TO UTILIZE OTHER TECHNIQUES, LIKE EPIDURAL ANESTHESIA, THINGS OF THAT NATURE.

Q. OKAY.
A. SO THERE IS A WHOLE CLINICAL SCENARIO THAT WOULD BE INCORPORATED.
Q. OKAY. LET'S TAKE THOSE -- WHAT YOU JUST STATED ONE BY ONE. FOR INSTANCE, FIRST OF ALL I THINK YOU SAID THAT ONE OF THE BENEFITS FOR INDUCTION IS THAT SHE CAN BE IN AN INTENSIVE CARE TYPE SITUATION, IS THAT --
A. NO. I --
Q. -- WHAT YOU SAID?
A. THAT ISN'T EXACTLY WHAT I SAID.
Q. OKAY.

A. I SAID IF YOU HAVE A PATIENT -- AND I AM ASSUMING WE ARE TALKING ABOUT SOME OF THESE VERY COMPLICATED MEDICAL SITUATIONS --

Q. YES.

A. -- THEY REQUIRE, IN ORDER TO BE DELIVERED SAFELY, THAT THEY ARE IN A SITUATION WHERE THEY HAVE VERY SOPHISTICATED MONITORING AND VERY HIGHLY-TRAINED SUPPORT STAFF AVAILABLE TO TREAT THEM, TO RECOGNIZE THE PROBLEMS AND TO DO DEFINITIVE THERAPIES, AS REQUIRED, AS OPPOSED TO BEING DELIVERED IN AN OUTSIDE CLINIC BY A PRACTITIONER WHO MAY HAVE LIMITED OR NO EXPERIENCE WITH THESE TYPES OF MEDICAL CONDITIONS.

Q. AND LET ME JUST TRY TO SHORT CIRCUIT THIS AND ASK YOU: IS THERE ANYTHING ABOUT D&E OR INTACT D&E THAT PRECLUDES IT FROM BEING DONE, AS FAR AS YOU UNDERSTAND, IN A HOSPITAL SETTING, IN AN INTENSIVE CARE SETTING, BY PEOPLE WITH CRITICAL CARE TRAINING, AND BY A WHOLE TEAM OF PEOPLE THAT HAVE THE RELEVANT KNOWLEDGE AND BACKGROUND AND SKILL TO TREAT A WOMAN WITH A MEDICALLY- COMPLICATED PREGNANCY?

A. I DON'T BELIEVE THAT IS WHAT I WAS IMPLYING.

Q. OKAY. WELL, I AM TRYING TO UNDERSTAND, BECAUSE I THINK IN YOUR DIRECT TESTIMONY YOU SUGGESTED THAT INDUCTION WAS SUPERIOR TO D&E FOR WOMEN WITH MEDICALLY-COMPLICATED PREGNANCIES IF SHE HAS TO TERMINATE. AND ONE OF THE THINGS YOU SAID WAS THAT WHAT IS BETTER ABOUT INDUCTION IS IT CAN BE DONE IN A CONTROLLED AND MONITORED FASHION.

IS THAT FAIR? THAT IS ONE OF THE THINGS THAT IS BETTER ABOUT INDUCTION FOR VERY SICK WOMEN?

A. THAT IS ONE PART OF WHAT I SAID, YES.

Q. OKAY. AND WHAT I AM TRYING TO UNDERSTAND IS WHY COULDN'T THE CONTROLLED AND MONITORED FASHION THAT YOU ACHIEVE IN YOUR HOSPITAL FOR WOMEN WHO ARE HAVING INDUCTIONS, WHY COULDN'T THAT BE ACHIEVED FOR WOMEN WHO ARE HAVING D&E OR INTACT D&E?

A. WELL, IT COULD POSSIBLY BE DUPLICATED. BUT THAT IS, BY THE WAY, NOT MY ONLY CONCERN ABOUT D&E VERSUS INDUCTION.

Q. OKAY. BUT I AM JUST TRYING TO FOCUS IN PARTICULARLY.

SO TO THE EXTENT YOUR PREFERENCE FOR INDUCTION OVER D&E OR INTACT D&E FOR VERY SICK WOMEN IS BASED ON THE FACT THAT INDUCTION CAN BE DONE IN A CONTROLLED AND MONITORED FASHION, WOULD YOU AGREE WITH ME THAT D&E AND INTACT D&E COULD BE DONE IN A SIMILARLY CONTROLLED AND MONITORED FASHION?

A. D&E COULD BE DONE IN A SIMILAR FASHION.

Q. THANK YOU.

AND THEN, I THINK ANOTHER PART OF YOUR TESTIMONY WAS THAT YOU THINK INDUCTION -- I THINK THIS COMES UP REPEATEDLY IN YOUR TESTIMONY -- THAT YOU THINK INDUCTION IS PREFERABLE THAN D&E OR INTACT D&E FOR SICK WOMEN BECAUSE IT IS A MORE NATURAL AND PHYSIOLOGIC PROCESS; IS THAT ANOTHER PART OF YOUR OPINION?

A. IT IS. SURGERY IS DECIDEDLY NONPHYSIOLOGIC PHENOMENA.

Q. AND, AGAIN, LET ME JUST TRY TO MAKE SURE THAT I UNDERSTAND THAT OPINION. SO WHAT YOU ARE SAYING IS THAT FOR A SICK WOMAN,

A WOMAN IN A MEDICALLY-COMPROMISED SITUATION -- IS THAT A FAIR CHARACTERIZATION OF IT, OF THE WOMEN YOU TREAT?

A. THAT WOULD BE A FAIR CHARACTERIZATION.

Q. FOR THEM YOU BELIEVE IT WOULD BE LESS PHYSICALLY STRESSFUL TO BE IN THE HOSPITAL IN LABOR FOR 24 HOURS, OR POSSIBLY LONGER, AND DURING THAT TIME TO BE EXPERIENCING CONTRACTIONS, TO HAVE A SPINAL EPIDURAL, TO POTENTIALLY BE ON A NARCOTIC DRIP OR RECEIVE NARCOTIC DRUGS IN SOME OTHER FASHION, AFTER WHICH SHE WOULD DELIVER THE FETUS.

AND THEN, IF SHE IS LUCKY SHE WOULD EXPEL THE PLACENTA IN TWO TO FOUR HOURS, BUT IF SHE DIDN'T YOU WOULD TAKE HER TO THE OPERATING SUITE AND REMOVE THE PLACENTA INSTRUMENTALLY, THAT THAT PROCEDURE WOULD BE MORE NATURAL AND PHYSIOLOGIC THAN IF THE WOMAN RECEIVED LAMINARIA FOR A PERIOD OF TIME SUFFICIENT FOR DILATION, AND THEN SHE UNDERWENT AN EVACUATION PROCEDURE THAT TOOK AT THE MOST FROM 15 MINUTES TO 60 MINUTES, AFTER WHICH THE SURGERY WOULD BE OVER.

YOU ARE SAYING THE LONGER PROCESS OF CONTRACTIONS, EPIDURAL, NARCOTIC DRIP WOULD BE MORE EASY FOR THE WOMAN TO TOLERATE THAN THE D&E PROCEDURE; IS THAT CORRECT?

A. THAT'S THE LONGEST QUESTION I HAVE EVER BEEN ASKED. AND THE ANSWER IS: NO, IT IS NOT CORRECT.

Q. OKAY. WHY DON'T YOU EXPLAIN IT TO ME, THEN?

A. AN INDUCTION ON AVERAGE LASTS 12 HOURS. WE WOULDN'T USE SPINAL ANESTHESIA. WE WOULD USE EPIDURAL ANESTHESIA IN ORDER

TO PROVIDE HER ADEQUATE ANALGESIA AND HAVE THE LEAST STRAIN ON HER SYSTEM.

AND, YES, LABOR INDUCTION -- NOT JUST MY OPINION BUT ANY MAJOR OBSTETRICAL OR OBSTETRICAL ANESTHESIA WILL CONFIRM -- IS THE BEST WAY TO TREAT PEOPLE THAT HAVE COMPLICATED UNDERLYING MEDICAL CONDITIONS.

Q. BUT I GUESS THAT IS YOUR CONCLUSION, AND I AM TRYING TO UNDERSTAND WHAT ARE THE PIECES THAT GO INTO THE INDUCTIONS. AND AM I CORRECT YET WHEN YOU SAY ON AVERAGE IT TAKES 12 HOURS, BUT IT COULD TAKE UP TO 48 OR 72 HOURS; ISN'T THAT CORRECT?

A. THAT IS NOT CORRECT.

Q. YOUR TESTIMONY IS THAT AN INDUCTION NEVER TAKES UP TO 48 OR 72 HOURS TO COMPLETE?

A. TWO STANDARD DEVIATIONS BEYOND THE MEAN FOR INDUCTION IS 24 HOURS. THAT MEANS 96 PERCENT OF ALL PREGNANCIES THAT ARE INDUCED ARE DELIVERED WITHIN 24 HOURS.

Q. OKAY.

A. MOST ARE DELIVERED ACTUALLY SIX TO 12 HOURS.

Q. OKAY.

A. RETAINED PLACENTA OCCURS IN 10 PERCENT OR LESS OF THOSE PREGNANCIES. ANALGESIA CAN BE VERY SAFELY PERFORMED USING EPIDURAL ANESTHESIA.

SO IT IS REALLY A TRUE VARIANT OF LABOR IN A VERY CONTROLLED SETTING WHERE YOU, BY ADEQUATE ANALGESIA, CAN PUT THE LEAST STRAIN ON HER SYSTEM AND IS THE SAFEST WAY TO DELIVER

PATIENTS WITH UNDERLYING MEDICAL COMPLICATIONS.
Q. SO UP TO 24 HOURS, THAT 96 PERCENT WILL DELIVER IN 24 HOURS; 10 PERCENT WILL HAVE A RETAINED PLACENTA REQUIRING AN ADDITIONAL SURGICAL TECHNIQUE; THE WOMAN WILL BE UNDER SPINAL EPIDURAL AND IF SHE IS STILL IN PAIN YOU WOULD PROBABLY GIVE HER SOME KIND OF NARCOTICS; IS THAT FAIR?
A. WELL, THERE IS NO SUCH THING AS SPINAL EPIDURAL.
Q. OKAY.
A. BUT SHE WOULD BE UNDER EPIDURAL --
Q. EPIDURAL.
A. -- WHICH IS DIFFERENT FROM SPINAL. AND, YES, SOMETIMES WE DO GIVE THEM ADDITIONAL NARCOTIC MEDICATIONS, AS WELL.
Q. OKAY. AND YOU THINK THAT THAT PROCEDURE IS MORE NATURAL AND PHYSIOLOGIC AND LESS STRESSFUL THAN A D&E PROCEDURE IN WHICH THE WOMAN HAS LAMINARIA AND SOME CRAMPING, AND THEN 15 TO 45 MINUTE SURGICAL EVACUATION?
A. ABSOLUTELY.
Q. OKAY. I THINK IN YOUR TESTIMONY YOU ALLUDED OR YOU AND MS. CLARK DISCUSSED A STUDY THAT YOU ARE CURRENTLY WORKING ON. I THINK IT IS A RANDOMIZED STUDY OF MANAGEMENT OF PREMATURE RUPTURE OF MEMBRANES; DO YOU REMEMBER THAT?
A. YES, I DO.
Q. AND THE STUDY IS COMPARING TWO DIFFERENT TREATMENT OPTIONS FOR PREMATURE RUPTURE OF MEMBRANES; IS THAT CORRECT?
A. THAT IS CORRECT.

Q. AND ONE OF THE TREATMENT OPTIONS IS TOCOLYSIS WITH MAGNESIUM SULFATE; IS THAT RIGHT?
A. THAT IS CORRECT.
Q. AND THE OTHER TREATMENT OPTION IS NO TOCOLYSIS, BUT ROUTINE MANAGEMENT, SUCH AS WITH ANTIBIOTICS; IS THAT CORRECT?
A. YES, EXCEPT THEY ARE ALLOWED TO HAVE TOCOLYSIS FOR TRANSPORT.
Q. OKAY. THAT'S RIGHT. OKAY.
FIRST OF ALL, CAN YOU JUST VERY BRIEFLY TELL US WHAT IS "TOCOLYSIS"?
A. TOCOLYSIS IS THE INSTILLATION OR INFUSING OF A MEDICATION IN ORDER TO CAUSE UTERINE QUIESCENCE OR QUIETING OF UTERINE CONTRACTIONS.
Q. AND AM I RIGHT THAT THE PURPOSE OF YOUR STUDY IS TO SEE WHETHER THE SHORT-TERM DELAY FOR WOMEN WITH PREMATURE RUPTURE -- WHETHER TO SEE -- I AM SORRY.
THE PURPOSE IS TO ASSESS IN WOMEN WITH PREMATURE RUPTURE OF MEMBRANES WHETHER THE SHORT-TERM DELAY THAT MAY BE ACHIEVED WITH TOCOLYSIS HAS A POTENTIAL BENEFIT; IS THAT A FAIR STATEMENT?
A. IT IS A FAIR GENERAL STATEMENT OF THE STUDY, YES.
Q. OKAY. YOU WOULD AGREE THAT CURRENTLY THERE IS NO DEFINITIVE ANSWER IN THE MEDICAL COMMUNITY AS TO WHETHER THAT SORT OF SHORT-TERM DELAY IN DELIVERY BY MEANS OF TOCOLYSIS HAS A BENEFIT; IS THAT RIGHT?

A. THAT IS CORRECT. I PREVIOUSLY PUBLISHED IN THE FORMER TRIAL SHOWING THAT LONG-TERM TOCOLYSIS DID NOT HAVE BENEFIT, BUT SHORT-TERM IS AN UNANSWERED QUESTION AT THIS POINT.

Q. THAT IS WHY YOU ARE DOING YOUR STUDY, RIGHT?

A. EXACTLY.

Q. NOW, IN THE ABSENCE OF A DEFINITIVE ANSWER, DIFFERENT DOCTORS MAY MANAGE PREMATURE RUPTURE OF THE MEMBRANES DIFFERENTLY; IS THAT RIGHT?

A. THAT IS CORRECT.

Q. AND YOU WOULD AGREE THAT IN YOUR PRACTICE THERE IS NOT A CONSISTENT METHOD OF TREATMENT OF PREMATURE RUPTURE OF MEMBRANES EXCEPT FOR THE WOMEN WHO ARE PARTICIPATING IN THE STUDY; IS THAT RIGHT?

A. WELL, THERE ARE MULTIPLE THINGS THAT ARE VERY CONSISTENT IN THEIR MANAGEMENT, BUT SPECIFICALLY IN THE ISSUE OF TOCOLYSIS THERE IS NOT CONSISTENCY.

Q. THAT IS RIGHT, AND THAT IS WHAT I MEANT.

SO OUTSIDE OF THE WOMEN THAT ARE PARTICIPATING IN YOUR STUDY, THERE IS NO CONSISTENCY IN WHETHER OR NOT YOU USE TOCOLYSIS WHEN THEY HAVE PREMATURE RUPTURE OF MEMBRANES; IS THAT RIGHT?

A. WELL, IT IS NOT DICTATED TO THEM OTHERWISE; IS THAT WHAT YOU ARE ASKING?

Q. CORRECT.

A. OKAY.

Q. THERE IS NO REQUIREMENT?
A. CORRECT.
Q. I GUESS WHAT I AM GETTING AT IS THE DECISION OF WHETHER TO USE TOCOLYSIS FOR AN INDIVIDUAL WOMAN, IF SHE IS NOT PART OF YOUR STUDY, IS BASED ON AN INDIVIDUAL ASSESSMENT OF HER SITUATION; IS THAT CORRECT?
A. YES.
Q. AND THAT ASSESSMENT OF WHETHER TO USE TOCOLYSIS MIGHT INCLUDE SUCH FACTORS AS THE GESTATIONAL AGE OF THE FETUS; IS THAT RIGHT?
A. CORRECT.
Q. THE MATERNAL HEALTH CONDITION?
A. THAT IS CORRECT.
Q. THE PATIENT PREFERENCE?
A. THAT IS CORRECT.
Q. AND YOU WOULD NOT SUPPORT A LAW THAT WOULD REQUIRE TOCOLYSIS IN ALL SITUATIONS OF PREMATURE RUPTURE OF MEMBRANES, WOULD YOU?
A. I WOULD NOT.
Q. LET ME JUST -- JUST A POINT OF CLARIFICATION FROM YOUR DIRECT TESTIMONY. WHEN YOU WERE TALKING ABOUT THE ORGANIZATION CALLED, PHACT, P-H-A-C-T, NOT ALL OF THE MEMBERS OF PHACT WERE ACTUALLY MATERNAL FETAL MEDICINE SPECIALISTS OR PEDIATRIC SPECIALISTS, WERE THEY?
A. I BELIEVE THAT I TESTIFIED THAT ALL WERE PHYSICIANS

INVOLVED IN TEACHING AND TRAINING, GENERALLY IN THE AREA OF COMPLICATED PREGNANCIES OR PEDIATRIC MANAGEMENT AFTERWARDS.
Q. SO NONE OF THEM WERE JUST GENERAL PHYSICIANS WITHOUT A SPECIFIC TRAINING IN MATERNAL FETAL MEDICINE CONDITIONS OR PEDIATRIC CONDITIONS?
A. MY UNDERSTANDING WAS THAT THEY WERE OBSTETRICIAN GYNECOLOGISTS, MATERNAL FETAL MEDICINE SPECIALISTS, PEDIATRICIANS OR PEDIATRIC SUBSPECIALISTS. THAT WOULD BE THE VAST MAJORITY OF THE GROUP, BUT I DON'T EVEN KNOW ALL THE MEMBERS OF THE GROUP.
Q. SO, REALLY, YOU DON'T KNOW WHAT THE SPECIALTIES OF ALL OF THE MEMBERS OF PHACT WERE?
A. I KNOW THAT EVERY ONE THAT I AM AWARE OF THAT IS INVOLVED, WHICH IS SEVERAL DOZEN, ARE ALL THOSE CRITERIA.
Q. OKAY.
A. AND I AM TOLD BY THE PERSON WHO PUTS THE LIST TOGETHER THAT THAT MAKES UP THE -- WHAT THE LIST IS. I HAVE NOT GONE BACK AND CONFIRMED INDIVIDUALLY ON MY OWN THAT, INDEED, WHAT I WAS TOLD WAS TRUE OR NOT TRUE. I JUST KNOW THAT EVERY ONE THAT I KNOW DOES MEET THAT CRITERIA.
Q. OKAY. OF THE SEVERAL DOZEN YOU KNOW?
A. RIGHT.
Q. OKAY. NOW, LET'S -- I WANT TO TALK TO YOU ABOUT YOUR, I THINK, SECOND PRIMARY OPINION HERE TODAY WHICH RELATED TO THE SAFETY OF INTACT D&E, OR AS YOU CALL IT "PARTIAL-BIRTH

ABORTION," AND, SPECIFICALLY, YOUR CONCERNS ABOUT THE SAFETY OF THAT PROCEDURE OVER AND ABOVE YOUR CONCERNS ABOUT THE SAFETY OF THE D&E METHOD.

ACTUALLY, JUST ANOTHER POINT OF CLARIFICATION. YOUR OPINION ABOUT THE SAFETY OF INTACT D&E, ARE YOU LIMITING THAT OPINION TO WOMEN WITH THE KIND OF COMPLICATED PREGNANCIES THAT YOU TREAT IN YOUR PRACTICE?

A. NOT NECESSARILY. MY CONCERNS ARE FOR THE PROCEDURE ITSELF. THOSE CONCERNS WOULD BE EVEN GREATER IN A WOMAN WHO HAS LIMITED ABILITY TO TOLERATE THOSE TYPE OF COMPLICATIONS.

Q. SO I THINK YOU ACTUALLY TESTIFIED THAT YOU AGREE THAT INTACT D&E MAY APPEAR TO OFFER SOME BENEFITS WHEN COMPARED TO DISARTICULATION D&E AT THE SAME GESTATIONAL AGE AS FAR AS THE AMOUNT OF INSTRUMENTATION THAT IS REQUIRED; IS THAT CORRECT?

A. AS RELATED SPECIFICALLY TO INSTRUMENTATION.

Q. RIGHT.

A. BUT, AGAIN, I HAVE TO THINK OF THE WHOLE PROCEDURE AND THE WHOLE REALM OF COMPLICATIONS. AND A LOT OF THOSE CONCERNS ARE THE LONG-TERM COMPLICATIONS.

Q. WE ARE GOING TO GET TO THAT. I NEED TO -- FOR MY QUESTIONS I NEED TO BREAK IT INTO PIECES.

SO JUST IT TERMS OF JUST THE INSTRUMENTATION PART, YOU WOULD AGREE THAT WITH RESPECT TO THE INSTRUMENTATION, COMPARING D&E WITH INTACT D&E AT THE SAME GESTATIONAL AGE, THERE MAY APPEAR TO BE SOME BENEFITS TO INTACT D&E; IS THAT A

FAIR STATEMENT?

A. AS RELATED TO INSTRUMENT PASSING?

Q. AS RELATED ONLY TO INSTRUMENT -- THE INSTRUMENTATION IN THE UTERUS.

A. YES, THAT IS TRUE.

Q. AND I THINK YOU'VE ACTUALLY -- I THINK YOU ACTUALLY TESTIFIED IN NEBRASKA THAT YOU THINK THAT THAT ASPECT OF THE PROCEDURE, JUST THE INSTRUMENTATION IN THE UTERUS, WOULD BE SAFER IN AN INTACT D&E THAN A DISARTICULATION D&E; IS THAT CORRECT, AT THE SAME GESTATIONAL AGE?

A. INTUITIVELY, THAT WOULD MAKE SENSE. I DON'T KNOW OF DATA ONE WAY OR ANOTHER ON THAT SPECIFIC ISSUE.

Q. OKAY. AND THEN, I THINK IN TERMS OF WHAT YOU ALLUDED TO AS YOUR LONG-TERM CONCERNS, YOUR FIRST -- YOUR PRIMARY LONG-TERM CONCERN IS THE IMPACT ON THE CERVIX FROM THE CERVICAL DILATION; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. OKAY. NOW, I THINK YOU TESTIFIED AT ONE POINT TODAY THAT -- I THINK YOU STATED THAT THERE IS EVIDENCE THAT FIRST-TRIMESTER ABORTIONS PUT WOMEN AT RISK OF SUBSEQUENT PRE-TERM DELIVERY AND POTENTIALLY LOW BIRTH WEIGHT BABIES? DID YOU TESTIFY TO THAT?

A. YES, THE DATA APPEARS TO BE STRONGER FOR PRE-TERM DELIVERY THAN LOW BIRTH WEIGHT.

Q. OKAY. BUT THAT IS BASED ON FIRST-TRIMESTER ABORTIONS,

CORRECT?
A. WELL, THE VAST MAJORITY OF THE DATA THAT I AM AWARE OF HAS BEEN DONE ON FIRST-TRIMESTER BECAUSE THAT IS WHEN MOST OF THE ABORTIONS ARE DONE.
Q. RIGHT. AND IN THE FIRST-TRIMESTER TYPICALLY DILATION IS ACHIEVED WITH MECHANICAL DILATION; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. OKAY. NOW, YOU'RE NOT AWARE OF ANY STUDIES THAT CONCLUDE THAT THERE IS A CORRELATION BETWEEN SLOW OSMOTIC CERVICAL DILATION AND CERVICAL INCOMPETENCE; IS THAT CORRECT?
A. THAT IS NOT CORRECT.
Q. OKAY. AND WHAT STUDIES -- IF THAT IS NOT CORRECT, CAN YOU EXPLAIN WHY THAT IS NOT CORRECT?
A. WELL, THERE ARE STUDIES THAT HAVE IMPLIED THAT SECOND-TRIMESTER TERMINATIONS OF PREGNANCY THAT INVOLVE A GREATER AMOUNT OF CERVICAL DILATION, ALMOST EXCLUSIVELY DONE WITH OSMOTIC DILATORS, HAVE A HIGHER RISK THAN THOSE DONE IN THE FIRST-TRIMESTER.
Q. WHICH STUDIES ARE YOU REFERRING TO?
A. WELL, THESE WOULD BE STUDIES THAT HAVE BEEN DEVELOPED SINCE THE LATE '70'S AND ONWARD, SOME WITH MIXED RESULTS, BUT HAVE BEEN REFERENCED IN GENERAL REVIEW ARTICLES TALKING ABOUT THE ISSUE OF PREGNANCY COMPLICATIONS RELATED TO TERMINATION OF PREGNANCY.
Q. NOW, IN YOUR EXPERT REPORT IN THIS CASE YOU CITED TWO

ARTICLES THAT YOU RELY ON FOR YOUR OPINION ABOUT CERVICAL INCOMPETENCE; IS THAT RIGHT?

A. NO, I GAVE A LIST OF ARTICLES THAT WERE SUPPORTIVE OF MY EXPERT REPORT, NOT ARTICLES SPECIFICALLY SUPPORTIVE OF CERVICAL INCOMPETENCE.

Q. OKAY. DID YOU CITE TWO ARTICLES IN YOUR EXPERT REPORT IN YOUR LIST OF REFERENCES AT THE END OF YOUR EXPERT REPORT THAT IN YOUR DEPOSITION YOU TOLD ME WERE INTENDED TO SUPPORT YOUR OPINION THAT THERE MAY BE SOME CONCERN ABOUT CERVICAL INCOMPETENCE AFTER ABORTION?

A. AGAIN, TRYING TO BE SPECIFIC, I LISTED, AS I RECALL, THREE ARTICLES. ONE TO SUPPORT THE ISSUE OF THE SAFETY OF PROSTAGLANDINS, ONE TO ESTABLISH THE CONCERN OF SUBSEQUENT PRE-TERM DELIVERY AND PREGNANCY LOSS AFTER TERMINATION OF PREGNANCY, AND ONE TO ATTEMPT TO SUPPORT THE ISSUE OF AN INCREASING CONCERN FOR MID-TRIMESTER LOSSES OF PREGNANCY.

Q. OKAY.

A. BUT AS I THINK MAYBE WE HAVE DISCUSSED OR WE WILL DISCUSS THAT THE THIRD ARTICLE WAS AN INAPPROPRIATE PLACEMENT, MEANING THAT I MISREAD THAT ARTICLE AT THE TIME THAT I WAS UNDER PRESSURE TRYING TO PROVIDE SOME QUICKLY OBTAINABLE RESEARCH SUPPORT FOR PORTIONS OF MY EXPERT REPORT.

Q. OKAY. I UNDERSTAND THAT. AND JUST TO MAKE THE RECORD CLEAR ON THAT, BECAUSE I THINK IT'S POSSIBLE YOU AND I ARE THE ONLY PEOPLE IN THE ROOM THAT UNDERSTAND WHAT YOU JUST SAID, I

WANT TO GO THROUGH AND MAKE THAT CLEAR FOR THE RECORD.

SO THE TWO STUDIES YOU ARE REFERRING TO NOW, YOU CITED IN YOUR EXPERT REPORT, ONE FOR THE CONCERN ABOUT PRE-TERM BIRTHS AND ONE ABOUT THE CONCERN ABOUT MID-TRIMESTER ABORTIONS.

THOSE WERE THE AUDU AND HENRIET STUDIES; IS THAT CORRECT, OR AUDU AND HENRIET PAPERS?

A. YES, REVERSED THE OTHER WAY AROUND, BUT THE HENRIET ARTICLE WAS THE ARTICLE LOOKING AT THE FIRST-TRIMESTER LOSSES, AND THE AUDU ARTICLE IS THE ONE WITH THE SECOND-TRIMESTER LOSSES.

Q. OKAY. LET ME JUST SHOW THESE TO YOU.

MS. GARTNER: YOUR HONOR, THESE ARE DEFENDANT'S LEARNED TREATISES A-7 AND A-29.

THE COURT: ALL RIGHT. THANK YOU.

MS. GARTNER: MAY I APPROACH THE WITNESS?

THE COURT: YES.

BY MS. GARTNER:

Q. DR. COOK, BEFORE WE TALK ABOUT THESE TWO STUDIES IN PARTICULAR, DO YOU RECALL THAT AT YOUR DEPOSITION I ASKED YOU WHETHER THERE WERE ANY OTHER ARTICLES OR DATASETS OTHER THAN THESE TWO THAT YOU RELY ON FOR YOUR OPINION THAT THERE MAY BE CONCERNS ABOUT THE CERVICAL DILATION IN THE INTACT D&E PROCEDURE?

A. I AM SORRY? WHAT IS YOUR QUESTION?

Q. MY QUESTION IS: DO YOU RECALL THAT I ASKED YOU WHETHER THESE ARE THE ONLY TWO ARTICLES OR DATASETS THAT YOU RELY ON?

DO YOU RECALL THAT I ASKED YOU THAT?
A. I RECALL SOME DISCUSSION. I DON'T KNOW IF THAT WAS IN REGARDS TO FORMATION OF MY EXPERT REPORT OR IN FORMATION OF MY OPINION EVER.

I DON'T RECALL THE SPECIFICS OF THAT QUESTION.

Q. OKAY.
A. OBVIOUSLY, WE MAKE OUR OPINIONS MEDICALLY BASED UPON MORE THAN JUST A HANDFUL OF ARTICLES.
Q. SURE. AND I GUESS MY QUESTION AT THE DEPOSITION AND MY QUESTION TO YOU NOW IS: ARE THESE -- OR LET ME ASK YOU THIS.

AT YOUR DEPOSITION I ASKED YOU WHETHER THESE TWO ARTICLES ARE THE ONLY ARTICLES -- I UNDERSTAND THERE IS ADDITIONAL THINGS LIKE YOUR CLINICAL EXPERIENCE -- BUT IN TERMS OF ARTICLES THAT YOU RELY ON, WERE THESE THE ONLY TWO ARTICLES THAT YOU RELIED ON TO FORM YOUR OPINION THAT THERE MAY BE CONCERNS ABOUT CERVICAL INCOMPETENCE OR PRE-TERM BIRTHS IN FUTURE PREGNANCIES AS A RESULT OF THESE INTACT D&E PROCEDURE?
A. I AM NOT SURE IT'S ACCURATE TO SAY THESE ARE THE ONLY ARTICLES.

AND AS I UNDERSTOOD THE QUESTION, IT WAS "DATASETS AND ARTICLES." SO WHEN I INCLUDE AN ARTICLE, I INCLUDE THE ARTICLES AND ITS SUPPORTIVE BIBLIOGRAPHY.

I INCLUDED THESE AS EXAMPLES OF THINGS THAT I THOUGHT SUPPORTED MY EXPERT TESTIMONY, BUT I AM NOT SURE THERE AREN'T OTHER ARTICLES THAT WOULD ALSO SUPPORT THE EXPERT

TESTIMONY.
Q. DO YOU RECALL IN YOUR DEPOSITION WHEN I ASKED YOU TO IDENTIFY ANY OTHER ARTICLES OR DATASETS AND YOU WERE UNABLE TO DO THAT AT YOUR DEPOSITION, THAT SUPPORTED THAT OPINION?
A. I AM CERTAIN AT THAT TIME WHEN ASKED I COULD NOT PRODUCE IMMEDIATELY OTHER ARTICLES THEN AND THERE OTHER THAN THE ONES THAT I SUBMITTED AND THE SUPPORTING BIBLIOGRAPHIES OF THOSE ARTICLES.
I SUBSEQUENTLY COULD STATE OTHER ARTICLES, BUT THAT IS BECAUSE I HAVE DONE MORE RESEARCH THAN IN THE LIMITED TIME I HAD BEFORE THE DEPOSITIONS.
Q. SO AT THE DEPOSITION THESE WERE THE ARTICLES THAT YOU PRODUCED ACTUALLY TO US IN ANTICIPATION OF THE DEPOSITION THAT YOU RELIED ON IN FORMING YOUR OPINIONS STATED IN YOUR EXPERT REPORT?
A. CORRECT. THEY ARE PART OF THE ARTICLES I USED TO SUPPORT THE EXPERT REPORT.
Q. OKAY. LET'S TALK FIRST ABOUT THE AUDU STUDY, WHICH IS LEARNED TREATISE A-7. DO YOU NOW -- IS IT NOW YOUR BELIEF, DR. COOK, THAT THIS ARTICLE DOESN'T REALLY HELP YOU WITH YOUR OPINION IN THIS CASE?
A. WELL, IT DOESN'T ADD INFORMATION IN THE AREA THAT I HAD THOUGHT IT WOULD ADD INFORMATION, INITIALLY, PARTLY BECAUSE OF THEIR TERMINOLOGY OF CONTINUING TO REFER TO "MID-TRIMESTER ABORTION."

AND, IN A MORE CAREFUL EVALUATION AND METHODOLOGY THEY ARE USING THAT TERM FOR PREDOMINANTLY SPONTANEOUS ABORTIONS.

THEY DID HAVE INDUCED ABORTIONS, IN THIS GROUP, AS WELL, BUT FROM MY READING OF THIS SUBSEQUENTLY, THOSE WERE ALL DILATION AND CURETTAGE ABORTIONS. SO, TO ME THIS DOESN'T DISPROVE ANYTHING, IT JUST DOESN'T ADD OR SHED ANY ADDITIONAL LIGHT, SPECIFICALLY IN THE AREA OF MID-TRIMESTER INDUCED ABORTIONS.

Q. IN FACT, OF THE 141 WOMEN IN THIS STUDY THAT HAD CERVICAL CERCLAGE, ONLY SEVEN OF THE 141 HAD ACTUALLY HAD A MID-TRIMESTER ABORTION; IS THAT RIGHT?

A. ACTUALLY, I WOULD READ THAT AS THEY HAD FIRST-TRIMESTER ABORTIONS.

Q. OKAY. SO SEVEN WOMEN HAD AN INDUCED ABORTION OF ANY KIND?

A. CORRECT.

Q. OUT OF THE 141. SO, REALLY, THIS DOESN'T ILLUMINATE THE MATTERS AT HAND; IS THAT CORRECT?

A. RIGHT. I WOULD CONSIDER IT NONINFORMATIVE --

Q. OKAY.

A. -- IN RETROSPECT.

Q. OKAY. AND THEN, THE OTHER -- THE OTHER STUDY THAT YOU CITED IN YOUR EXPERT REPORT AND YOU RELIED ON IN FORMING THE OPINIONS IN YOUR EXPERT REPORT WAS THE HENRIET STUDY?

A. CORRECT.

Q. OKAY. AND THAT IS DEFENDANT'S LEARNED TREATISE A-29.

NOW, THIS ARTICLE ALSO ONLY DISCUSSES THE POTENTIAL FUTURE IMPACTS OF FIRST-TRIMESTER ABORTIONS; ISN'T THAT CORRECT?

A. WELL, NOT NECESSARILY. THEY DO DISCUSS THE OTHER EXISTING DATA THAT REFERS TO OTHER GESTATIONAL AGES. AND THEN, THERE ARE SOME REFERENCES TO THAT. BUT THIS DATASET INCLUDES, AS I UNDERSTAND IT, PREDOMINANTLY FIRST-TRIMESTER PREGNANCY TERMINATIONS.

Q. RIGHT. AND THIS WAS -- THIS WAS A STUDY FROM FRANCE; IS THAT CORRECT?

A. CORRECT.

Q. AND I THINK IN HERE THAT THEY SAY THAT 96 PERCENT OF THE ABORTIONS AT ISSUE IN THIS DATASET WERE PERFORMED BEFORE 11 WEEKS OF PREGNANCY; IS THAT CORRECT?

A. I WOULD HAVE TO LOOK AT THE "11 WEEKS," BUT THAT SOUNDS CORRECT.

Q. OKAY. AND THE AUTHORS OF THIS ARTICLE DON'T DISCUSS WHAT TYPE OF DILATION WAS USED IN THE ABORTIONS THAT WERE DISCUSSED IN THIS -- THAT WERE AT ISSUE IN THIS DATASET; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. SO WOULD YOU AGREE WITH ME THAT NO CONCLUSION CAN BE DRAWN FROM THIS PARTICULAR STUDY ABOUT ANY CONNECTION BETWEEN INTACT D&E AND CERVICAL INCOMPETENCE?

A. NO, I WOULD NOT AGREE WITH THAT.

Q. OKAY. WHAT WOULD YOU SAY? HOW WOULD YOU SAY THAT THIS HENRIET STUDY OF FIRST-TRIMESTER ABORTION ILLUMINATES YOUR OPINIONS?

A. WELL, YOU HAVE TO REMEMBER THE SETTING IS THAT THERE HAS BEEN MIXED DATA THAT HAS BEEN AVAILABLE ABOUT ANY ASSOCIATION OF PRIOR INDUCED ABORTIONS IN SUBSEQUENT PREGNANCY LOSSES.

AND THIS WAS A DATASET WHERE THERE WAS VERY COMPLETE DATA, WHERE THEY FELT THAT PEOPLE WERE REVEALING INFORMATION FREELY BECAUSE OF THE WAY THE SITUATION IS SET UP IN FRANCE, THAT THEY HAD ELIMINATED A LOT OF BIASES OTHER STUDIES MAY HAVE INCLUDED. AND THIS DID DEMONSTRATE UNEQUIVOCALLY THE INCREASED RISK FOR SUBSEQUENT PREGNANCY LOSSES ASSOCIATED WITH TERMINATION OF PREGNANCY. AND THE RISK --

Q. BUT -- I'M SORRY -- BASED ON A FIRST-TRIMESTER PREGNANCY; IS THAT RIGHT?

A. CORRECT. AND THE ISSUE AT ODDS HERE IS NOT THAT THEY ARE AT HIGHER RISK FOR INFERTILITY, NOT THAT THEY ARE HIGHER RISK FOR UTERINE RUPTURE FROM PRIOR TRAUMA, BUT THEY ARE AT HIGHER RISK FOR PRE-TERM DELIVERY. AND THOSE PRE-TERM DELIVERIES ARE FREQUENTLY SECONDARY TO CERVICAL ISSUES IN THEIR INABILITY TO RETAIN A PREGNANCY.

AND CERVICAL ISSUES ARE RELATED TO CERVICAL TRAUMA OR MANIPULATION. AND SO I DO THINK IT IS EASY TO INFER THAT IF YOU HAVE SIGNIFICANT RISK FROM MINIMAL CERVICAL DILATION OF FIRST-TRIMESTER, THEN HOW MUCH GREATER POTENTIALLY COULD BE THE

RISK IF YOU HAVE EVEN GREATER DILATION?
Q. THE FIRST-TRIMESTER DILATION WOULD BE DONE WITH MECHANICAL METHODS, CORRECT?
A. GENERALLY THAT IS TRUE, YES.
Q. AND WOULDN'T YOU AGREE THAT OSMOTIC DILATION MAY BE GENTLER ON THE CERVIX THAN MECHANICAL DILATION?
A. IT MAY BE. BUT, AGAIN, IT IS NOT JUST HOW YOU ARE DOING IT, BUT HOW MUCH YOU ARE DOING IT.
Q. AND WOULDN'T YOU AGREE THAT IF THE DILATION IN THE SECOND-TRIMESTER USED MISOPROSTOL TO ACHIEVE THE DILATION THAT THAT MIGHT ACTUALLY LESSEN THE RISK OF ANY POTENTIAL FUTURE CERVICAL INCOMPETENCE?
A. WELL, MISOPROSTOL IS BASICALLY DOING AN INDUCTION, AND THAT IS WHAT I HAVE BEEN SUPPORTING THROUGHOUT THIS WHOLE PROCESS.
Q. OKAY. BUT ARE YOU AWARE OF THE FACT THAT MANY PHYSICIANS IN THIS COUNTRY USE MISOPROSTOL AS A CERVICAL RIPENING AGENT PRIOR TO PERFORMING A D&E ABORTION?
A. YES, BUT THE MECHANISM IS CAUSING UTERINE ACTIVITY AND SUBSEQUENT CERVICAL RIPENING, WHICH IS AN INDUCTION.
Q. OKAY. BUT IF THE PHYSICIAN PREPARATORY TO A D&E USED MISOPROSTOL TO PREPARE THE CERVIX, YOU WOULDN'T BE CONCERNED ABOUT THAT FOR POTENTIAL CERVICAL INCOMPETENCE; IS THAT CORRECT?
A. I WOULD BE MUCH LESS CONCERNED THAN I AM ABOUT THE OTHER METHODS OF CERVICAL DILATION.

Q. OKAY. I THINK YOU ALSO SAID THAT OTHER THAN YOUR LONG-TERM CONCERN ABOUT THE CERVICAL ISSUES THAT YOUR OTHER PRIMARY CONCERN FOR THE IMMEDIATE HEALTH RISK TO THE WOMAN FROM INTACT D&E IS THAT IN ANY SORT OF SURGICAL PROCEDURE DONE VAGINALLY AT LATER GESTATIONAL AGES CARRIES A HIGH RISK OF BLEEDING, INFECTION AND UTERINE PERFORATION; IS THAT YOUR OPINION?

A. I AM SORRY. I GOT LOST A LITTLE BIT IN THE QUESTION.

Q. I AM SORRY. LEAVING ASIDE THE LONG-TERM COMPLICATIONS, THE CERVICAL ISSUES THAT YOU ARE CONCERNED ABOUT, IS YOUR -- YOU ALSO HAVE CONCERNS ABOUT THE SAFETY OF INTACT D&E THAT ARE MORE IMMEDIATE; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. AND ARE THOSE IMMEDIATE CONCERNS YOUR CONCERNS ABOUT BLEEDING, INFECTION AND UTERINE PERFORATION?

A. YES, AND TRIPLE LACERATIONS.

Q. OKAY. AND WOULD YOU AGREE THAT AT THE SAME GESTATIONAL AGES YOU WOULD HAVE THE SAME CONCERNS IN A DISARTICULATION D&E AS YOU WOULD IN AN INTACT D&E?

A. TO A CERTAIN EXTENT I WOULD FOR THE ISSUE OF CERVICAL LACERATION. THERE IS A DIFFERENT LEVEL OF INTRAUTERINE MANIPULATION INVOLVED IN GRASPING A FETUS AND BRINGING A FETUS DOWN THAN THERE IS IN TRYING TO CONVERT A FETAL POSITION WITHIN THE UTERUS.

Q. SO THAT WOULD ONLY BE A DIFFERENCE IN THOSE INSTANCES WHERE

CONVERSION WAS NECESSARY; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. SO IN THE CIRCUMSTANCES LEAVING ASIDE THE LONG-TERM COMPLICATIONS IN TERMS OF THE IMMEDIATE CONCERNS YOU HAVE, YOU WOULD SAY THAT THE CONCERNS IN THE CASE WHERE THE FETUS PRESENTS ALREADY IN A BREECH POSITION, THAT YOUR CONCERNS ABOUT INTACT D&E WOULD BE THE SAME AS YOUR CONCERNS ABOUT D&E AT THE SAME GESTATIONAL AGE; IS THAT FAIR?

A. I THINK SO.

Q. OKAY.

A. AGAIN, THE QUESTION -- I GET LOST IN THE QUESTION. I THINK I CAN SIMPLIFY IT FOR YOU.

Q. OKAY. GO AHEAD.

A. I HAVE JUST TWO CONCERNS UNIQUE TO D&X.

Q. OKAY.

A. THE LONG-TERM CERVICAL DILATION, WHICH I CONSIDER TO BE DIFFERENT THAN D&E.

Q. OKAY.

A. AND SHORT-TERM INTERNAL PODALIC VERSION, WHICH I CONSIDER TO BE DIFFERENT FROM D&E.

Q. OKAY.

A. OTHER THAN THAT, MY CONCERNS SHORT-TERM AT SAME GESTATIONAL AGES ARE VERY SIMILAR.

Q. OKAY.

A. D&E AND D&X.

Q. OKAY. THAT IS VERY HELPFUL.
A. DOES THAT SIMPLIFY IT?
Q. YES. THANK YOU. SOMETIMES THE QUESTION AND ANSWER PROCESS CAN BE CUMBERSOME.
SO IN THOSE CIRCUMSTANCES WHERE INTERNAL PODALIC VERSION ISN'T NECESSARY BECAUSE THE FETUS PRESENTS BREECH, IN TERMS OF THE SHORT-TERM COMPLICATIONS YOU WOULD SEE D&E AND INTACT D&E AS COMPARABLE; IS THAT FAIR?
A. I BELIEVE THAT IS FAIR.
Q. BUT YOU ALSO TESTIFIED THAT YOU HAD ACTUALLY SEEN SOME ADVANTAGES TO INTACT D&E COMPARED TO D&E AT THE SAME GESTATIONAL AGE BECAUSE THERE IS LESS INSTRUMENTATION IN THE UTERUS; IS THAT CORRECT?
A. I SAID INTUITIVELY IT WOULD MAKE SENSE, AND IT IS NOT PROVEN, AND POTENTIALLY THAT MAY BE THE CASE.
Q. OKAY. I WANT TO TALK TO YOU A LITTLE BIT ABOUT YOUR VIEWS ON INDUCTION ABORTIONS.
I THINK IT WAS PRETTY CLEAR FROM YOUR TESTIMONY, BUT IN GENERAL YOUR VIEW IS THAT INDUCTION IS BETTER SAFER, FOR WOMEN WITH COMPLICATED MEDICAL SITUATIONS THAN D&E ABORTIONS; IS THAT A GENERALLY FAIR STATEMENT?
A. YES.
Q. NOW, ARE THERE, TO YOUR KNOWLEDGE, ANY RANDOMIZED CLINICAL TRIALS ESTABLISHING THAT INDUCTION IS SAFER THAN D&E AFTER 20 WEEKS GESTATION, USING MODERN TECHNIQUES OF D&E AND INDUCTION?

A. I BELIEVE THERE HAVE BEEN SOME RECENT PUBLICATIONS LOOKING AT SURGICAL ABORTIONS LATE IN TRIMESTER AND CARRYING THEM WITH INDUCTION.

Q. AND WERE THOSE RANDOMIZED STUDIES?

A. NO, I DO NOT BELIEVE THEY WERE RANDOMIZED.

Q. AND YOU TESTIFIED ABOUT THIS ON DIRECT, BUT YOU AGREE THAT A PRIOR UTERINE SCAR INCREASES THE RISK OF UTERINE RUPTURE DURING AN INDUCTION ABORTION; IS THAT CORRECT?

A. IT DOES DURING ANY LATE PROCESS.

Q. RIGHT. FOR A WOMAN WHO HAS A SCAR FROM A LOW TRANSVERSE CESAREAN SECTION -- WELL, ACTUALLY, LET ME GO BACK.

AM I CORRECT THAT A LOW TRANSVERSE CESAREAN SECTION IS THE MOST COMMON TYPE OF PRIOR UTERINE SCAR?

A. THAT IS CORRECT.

Q. AND FOR A WOMAN WITH THAT TYPE OF SCAR, THE RISK OF UTERINE RUPTURE DURING AN INDUCTION ABORTION IS APPROXIMATELY 1 IN 200; IS THAT CORRECT?

A. NOT NECESSARILY. THAT IS THE RISK OF RUPTURE AT TERM FOR A NORMAL LABOR PROCESS.

Q. OKAY. AND DO YOU HAVE A SENSE OF WHAT THE RISK WOULD BE AT A 20 TO 24 WEEK INDUCTION ABORTION?

A. I WOULD SUSPECT IT WOULD BE LESS.

Q. I THINK YOU ALSO -- YOU CONSIDER THOSE TO BE ACCEPTABLE RISKS; IS THAT CORRECT?

A. I DO IN THE SITUATION WHERE YOU CAN ADDRESS THE

COMPLICATION, MEANING THAT OB ANESTHESIA OR CAPABILITY, TRAINED PERSONNEL TO DEAL WITH IT.

FOR INSTANCE, A LOT OF SMALLER HOSPITALS IN THE UNITED STATES ARE NO LONGER DOING VBAC'S BECAUSE THEY DON'T HAVE THE ABILITY TO ADDRESS EVEN A RARE COMPLICATIONS VERY RAPIDLY.

Q. FOR THE RECORD WHY DON'T YOU EXPLAIN WHAT A VBAC IS?

A. I AM SORRY, A VAGINAL BIRTH AFTER CESAREAN DELIVERY.

Q. AND IT IS AN ACRONYM, VBAC?

A. IT IS, YES.

Q. SO YOU ARE SAYING THAT THAT IS A -- THE RISK OF UTERINE RUPTURE IS ACCEPTABLE IF YOU HAVE THE CAPACITY TO TREAT THE WOMAN AFTER THE RUPTURE; IS THAT CORRECT?

A. CORRECT.

Q. AND WOULD THAT TEND TO RESULT IN THE NEED FOR A HYSTERECTOMY?

A. NOT NECESSARILY. MOST TIMES WE DO NOT HAVE TO DO HYSTERECTOMIES FOR UTERINE RUPTURES.

Q. OKAY. BUT OBVIOUSLY IT RESULTS IN SOME SIGNIFICANT BLOOD LOSS AND OTHER COMPLICATIONS?

A. IT DOES REQUIRE ADDITIONAL SURGERY MOST TIMES.

Q. OKAY. I THINK YOU INDICATED THAT FOR A WOMAN WITH A PRIOR UTERINE SCAR YOU WOULD STILL CONSIDER DOING AN INDUCTION ABORTION, BUT YOU WOULD JUST USE DIFFERENT PROSTAGLANDINS THAN YOU ORDINARILY WOULD TO INDUCE HER; IS THAT CORRECT?

A. THAT IS CORRECT. OUR MAINSTAY PROSTAGLANDIN NOW FOR INDUCTIONS IS MISOPROSTOL OR PROSTAGLANDIN E1, BUT THE SAME THING THAT MAKES IT EFFICACIOUS ALSO MAKES IT RISKIER WHEN YOU HAVE A SCARRED UTERUS. SO WE WOULD SELECT OTHER PROSTAGLANDINS THAT WE HAD USED FOR YEARS PRIOR TO MISOPROSTOL IN THAT SITUATION.

Q. OKAY. AND WOULD ONE OF THOSE BE PROSTAGLANDIN E2?

A. THAT WOULD BE ONE, YES.

Q. OKAY. AND THAT YOU WOULD USE THAT TO INDUCE AN ABORTION IN A WOMAN WITH A PRIOR UTERINE SCAR?

A. THAT IS CORRECT.

Q. OKAY. AND I BELIEVE YOU SAID ON DIRECT THAT, IN PART, YOU RELY ON THE CHEZ ARTICLE FOR SUPPORT FOR THAT PRACTICE; IS THAT CORRECT?

A. IN PART, THAT IS CORRECT.

Q. OKAY. DO YOU HAVE THAT ARTICLE UP THERE WITH YOU?

A. I DO.

MS. GARTNER: YOUR HONOR, THIS IS DEFENDANT'S LEARNED TREATISE A-10.

BY MS. GARTNER:

Q. ACTUALLY, BEFORE WE TURN TO THIS ARTICLE, LET ME ASK YOU, WOULD YOU ALSO DO AN -- IF NECESSARY, PERFORM AN INDUCTION ON A WOMAN WHO HAD TWO PRIOR LOW TRANSVERSE UTERINE SCARS?

A. YES, IN MOST CIRCUMSTANCES I WOULD.

Q. AGAIN, USING THE PGE2 PROSTAGLANDIN?

A. CORRECT. I THOUGHT THAT WAS ASSUMED, BUT, YES.
Q. YES, IT WAS. I AM JUST VERIFYING.
CAN YOU REMIND US OF THE DATE ON THE CHEZ ARTICLE?
A. 1995.
Q. AND YOU BELIEVE THAT THIS ARTICLE SUPPORTS YOUR CONCLUSION THAT IT IS APPROPRIATE TO INDUCE LABOR IN A WOMAN WITH A PRIOR UTERINE SCAR USING PGE2?
A. THIS WAS THE FIRST ARTICLE TO TRY TO ACCUMULATE A LOT OF DIFFERENT ARTICLES OF DATA ON THE USE OF PROSTAGLANDINS. AT THIS TIME, PROSTAGLANDIN 2, PREDOMINANTLY, IN THE USE OF PEOPLE WITH PRIOR SCARRED UTERUSES. SO IT WAS SORT OF A LANDMARK AT THE TIME ARTICLE FOR THIS ISSUE.
THERE HAVE CERTAINLY BEEN OTHER ARTICLES DEMONSTRATING THE SAFE USE OF CERTAIN PROSTAGLANDINS SUBSEQUENTLY. AND AS I UNDERSTAND IT, THE AMERICAN COLLEGE HAS MADE AN ADVISORY STATEMENT REGARDING THE USE OF MISOPROSTOL IN THIS SITUATION, BUT HAS NOT INCLUDED THE OTHER PROSTAGLANDINS IN THE RECOMMENDATIONS.
Q. OKAY. WHY DON'T WE ACTUALLY LOOK AT THAT?
MS. GARTNER: YOUR HONOR, MAY I APPROACH THE WITNESS?
THE COURT: YES.
BY MS. GARTNER:
Q. DR. COOK, WHAT I HAVE JUST HANDED YOU IS AN ACOG COMMITTEE OPINION, OPINION NUMBER 271, FROM APRIL OF 2002, WHICH IS

ENTITLED: "INDUCTION OF LABOR FOR VAGINAL BIRTHS AFTER CESAREAN DELIVERY."

IF YOU CAN -- FEEL FREE TO TAKE YOUR TIME TO TAKE A LOOK AT THAT. BUT I WANT TO PARTICULARLY DRAW YOUR ATTENTION TO THE LAST PARAGRAPH.

A. YES.

Q. COULD YOU READ THE FIRST SENTENCE OF THE LAST PARAGRAPH, PLEASE?

A. "THE PURPOSE OF THIS DOCUMENT IS TO DISCOURAGE USE OF PROSTAGLANDINS FOR CERVICAL RIPENING OR INDUCTION IN LABOR IN WOMEN ATTEMPTING VBAC."

Q. AND SO DO YOU READ THAT -- DO YOU UNDERSTAND FROM THAT THAT ACOG DISCOURAGES THE USE OF ANY PROSTAGLANDIN IN A WOMAN WITH A PRIOR UTERINE SCAR?

A. NO, I DO NOT.

Q. OKAY. WHY DON'T YOU UNDERSTAND THAT?

A. BECAUSE YOU HAVE TO READ THE ENTIRE THING.

Q. OKAY.

A. AND THE ENTIRE THING IS BASED PREDOMINANTLY UPON A RECENTLY PUBLISHED ARTICLE THAT THEY USE FOR THEIR SUPPORT FOR THIS ISSUE WHICH DID NOT SEPARATE OUT THE TYPE OF PROSTAGLANDIN.

ALSO, IT SAYS THAT THE USE OF VARIOUS PROSTAGLANDIN COMBINATIONS MAY BE A CONCERN. AND THEY ADMIT THERE IS A LIMITATION IN THIS STUDY BECAUSE OF SEVERAL PROBLEMS WITH THE STUDY, INCLUDING HOW THEY WERE ABLE TO DETERMINE A PERSON

ACTUALLY HAD AN UTERINE RUPTURE. AND AT THE VERY END, THEY SAY THAT:

"THE COMMITTEE ON OBSTETRICAL PRACTICE REITERATES THEIR PREVIOUS STATEMENT THAT MISOPROSTOL SHOULD NOT BE USED IN PATIENTS WITH PREVIOUS CESAREAN DELIVERY."

Q. OKAY. SO DO YOU NOT UNDERSTAND THIS LAST PARAGRAPH AS MEANING THAT MISOPROSTOL SHOULD ABSOLUTELY NOT BE USED IN A WOMAN WITH A PRIOR UTERINE SCAR, BUT THAT ANY PROSTAGLANDIN IS DISCOURAGED IN THAT CONTEXT?

A. I UNDERSTAND IT TO SAY THAT THERE SHOULD BE CAUTION DONE, AND THEY DO STATE THAT THESE CAN BE USED IN CERTAIN SITUATIONS, ESPECIALLY IF THERE IS COMPELLING CLINICAL INDICATION, WHICH THEY DO STATE. BUT THAT THE SPECIFIC USE OF MISOPROSTOL SHOULD NOT BE CONSIDERED EVEN IN THAT SITUATION.

Q. RIGHT.

A. SO I INTERPRET THIS TO BE A STATEMENT REITERATING PREDOMINANTLY THEIR CONCERN ABOUT MISOPROSTOL USE, AND THEIR GENERAL WARNING THAT ALL PROSTAGLANDINS SHOULD BE USED WITH A CERTAIN EXERCISE OF CAUTION, WHICH IS WHAT WE DO.

Q. AND THAT, IN FACT, IT IS DISCOURAGED; IS THAT NOT THEIR LANGUAGE?

A. IT IS DISCOURAGED, AGAIN, WITH THE STATEMENT ABOVE "IF THERE IS NOT COMPELLING CLINICAL INDICATION."

Q. OKAY.

A. AND IN MANY OF THE SITUATIONS PUT TO ME THERE ARE COMPELLING CLINICAL INDICATIONS.

Q. OKAY. THANK YOU.

NOW, I WANT TO -- SORRY. MY VOICE IS GIVING OUT.

I WANT TO ASK YOU SOME QUESTIONS ABOUT CIRCUMSTANCES THAT I THINK YOU ALLUDED TO IN YOUR DIRECT TESTIMONY WHERE INDUCTION METHODS FAIL.

AM I CORRECT THAT ON AN APPROXIMATELY TWO TO THREE OCCASIONS IN YOUR CAREER AN INDUCTION ABORTION FAILED COMPLETELY TO DELIVER THE FETUS AND THE PROCEDURE HAD TO BE CONVERTED TO A D&E PROCEDURE?

A. YES AND NO. I WAS NOT INVOLVED IN THE EARLIER STAGES OF THAT. I WAS ASKED TO COME IN TO HELP THEM AT A POINT AT WHICH IT WAS DETERMINED BY OTHER PRACTITIONERS THAT THE PATIENT WAS NOT RESPONDING TO PROSTAGLANDINS.

Q. OKAY.

A. AND AT THAT TIME, I THEN ASSISTED THEM WITH THE D&E. SUBSEQUENTLY, I NOW GENERALLY RECOMMEND THAT PEOPLE USE A DIFFERENT TYPE OF PROSTAGLANDIN, IF YOU HAVE NOT RESPONDED TO THE E SERIES. NOW, I RECOMMEND THEY USE THE PROSTAGLANDIN F SERIES AS A FOLLOW-UP, AND HAVE HAD QUITE GOOD SUCCESS WITH THAT.

Q. BUT IN YOUR CAREER ON TWO OR THREE OCCASIONS YOU'VE BECOME INVOLVED IN AN ABORTION WHERE THE ATTEMPT TO INDUCE THE ABORTION FAILED AND THE PROCEDURE WAS CONVERTED TO A D&E

TECHNIQUE; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. AND IN SOME OF THOSE CASES I THINK YOU ACTUALLY PERFORMED THE D&E, AND IN OTHERS YOU EITHER SUPERVISED OR ASSISTED; IS THAT CORRECT?
A. RIGHT. OFTENTIMES, I WAS ASKED SPECIFICALLY TO BE THERE TO PROVIDE THE ULTRASOUND GUIDANCE FOR THE PROCEDURE.
Q. OKAY. AND YOU'RE ALSO AWARE OF CASES WHERE THE FETUS WAS PARTIALLY EXPELLED DURING AN INDUCTION, BUT THE INDUCTION COULD NOT BE COMPLETED WITHOUT INSTRUMENTS OF SOME KIND; IS THAT CORRECT?
A. I AM NOT SURE I KNOW EXACTLY WHAT YOU MEAN BY THAT. I HAVE HAD BABIES THAT ARE BREACHED-DELIVERED BABIES THAT HAVE STUCK AFTER-COMING HEADS, AND WE HAVE DONE AFTER-COMING FORCEPS. IS THAT WHAT YOU ARE IMPLYING?
Q. I THINK THAT MIGHT BE RIGHT. I AM REFERRING TO IN YOUR DEPOSITION WHEN YOU AGREED THAT YOU ARE AWARE OF CASES IN WHICH THE FETUS WAS PARTIALLY EXPELLED DURING AN INDUCTION, BUT THE INDUCTION COULDN'T BE COMPLETED WITHOUT INSTRUMENTS.
A. YES, I BELIEVE --
Q. DO YOU RECALL THAT?
A. I BELIEVE WHAT I WAS REFERRING TO -- AND I WOULD HAVE TO LOOK AT THE CONTEXT, BUT IN ORDER NOT TO DELAY THINGS I WILL ASSUME IT WAS TALKING ABOUT THE SITUATION OF A VAGINAL BREECHED DELIVERY WITH A NOT IMMEDIATELY DELIVERING AFTER-COMING HEAD --

Q. I THINK THAT IS WHAT YOU WERE TALKING ABOUT.
A. YES.
Q. YES. THAT IS WHAT YOU WERE TALKING ABOUT, BECAUSE YOU WERE CALLED IN TO GIVE ADVICE ABOUT WHAT TO DO IN THAT SITUATION WHERE THE FETUS HAD DELIVERED UP TO THE HEAD; IS THAT CORRECT?
A. I THINK THOSE ARE TWO DIFFERENT SCENARIOS. I HAVE BEEN CALLED IN BEFORE ON PEOPLE THAT WERE TRYING TO INDUCE A PREGNANCY, AND THEN THE BABY WOULD BE DELIVERED TO THE LEVEL OF THE AFTER-COMING HEAD AND THEY WOULD ASK MY ADVICE WHAT TO DO AT THAT POINT.

AND MOST OFTEN MY ADVICE HAS BEEN TO DO NOTHING BECAUSE THE BABY GENERALLY WILL DELIVER ON ITS OWN SOON THEREAFTER. BUT THERE HAVE BEEN TIMES I HAD TO ASSIST THE DELIVERY EITHER MEDICALLY OR SURGICALLY.

Q. OKAY. AND I THINK WHAT WE TALKED ABOUT IN YOUR DEPOSITION WAS THERE WOULD BE SITUATIONS WHERE THAT OCCURS WHERE THE FETUS IS DELIVERED TO THE POINT OF THE AFTER-COMING HEAD AND, IF THE PATIENT STARTED DEVELOPING SOME SORT OF UNSTABLE SITUATION, SUCH AS BLEEDING OR INFECTION, THEN YOU WOULD RECOMMEND PROGRESSING TO DEFINITIVE COMPLETION OF THE DELIVERY RATHER THAN WAITING FOR HER TO DELIVER ON HER OWN; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. AND YOU WOULD HAVE SEVERAL OPTIONS FOR HOW TO EFFECTUATE THAT; IS THAT CORRECT?
A. THAT IS CORRECT.

Q. AND ONE OF THOSE OPTIONS WOULD BE MANUALLY DELIVERING THE HEAD WITH FORCEPS; IS THAT -- I AM SORRY -- MANUALLY. ONE OPTION WOULD BE MANUALLY DELIVERING THE FETUS; IS THAT CORRECT?
A. "MANUALLY" MEANING FORCEPS?
Q. USING MANIPULATIONS WITH YOUR HANDS TO DELIVER THE HEAD?
A. YES, THAT IS ONE OPTION.
Q. OKAY. AND ANOTHER OPTION WOULD BE USING FORCEPS TO EFFECT THE DELIVERY?
A. THAT WOULD BE ANOTHER OPTION.
Q. OKAY. NOW, IF YOU ATTEMPTED -- AND THEN ANOTHER OPTION WOULD BE TO MAKE INCISIONS ON THE WOMAN'S CERVIX; IS THAT CORRECT?
A. AN INCISION. BUT, GENERALLY, THOSE WOULD BE AFTER I HAVE TRIED MEDICAL OPTIONS, FIRST.
Q. SURE. OKAY. BUT IN THAT CASE WHERE THE WOMAN WAS BLEEDING OR INFECTED AND HER SITUATION WAS UNSTABLE, IF YOU GAVE HER NITROGLYCERIN AND IT DIDN'T WORK FAIRLY RAPIDLY, THEN YOU WOULD HAVE TO MOVE TO ANOTHER STEP; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. AND IN THAT CONTEXT, IF YOU COULDN'T DELIVER THE HEAD WITH YOUR HANDS, YOU WOULD THEN HAVE TO CONSIDER EITHER THE USE OF FORCEPS OR THE USE OF DUHRSSEN'S INCISIONS; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. OKAY. AND IN YOUR PRACTICE WHEN YOU HAD THE CHOICE BETWEEN FORCEPS AND DUHRSSEN'S INCISIONS, YOU WOULD PROBABLY

CHOOSE DUHRSSEN'S INCISIONS; IS THAT CORRECT?
A. IT WOULD DEPEND ON THE CLINICAL SITUATION. IF IT IS A VIABLE BABY, I GENERALLY WOULD DO FORCEPS.
Q. OKAY.
A. IF IT IS PREVIABLE BABY, THEN I MIGHT MORE FREQUENTLY GO TO AN INCISION, IF ALL THE OTHER ELEMENTS HAVE FAILED PRIOR TO THAT.
Q. OKAY. AND AM I CORRECT THAT WHEN YOU MAKE THE -- WHEN YOU DO THE DUHRSSEN'S INCISION PROCEDURE, YOU MAKE ANYWHERE FROM ONE TO THREE INCISIONS ON THE WOMAN'S CERVIX?
A. THAT IS CORRECT.
Q. OKAY. AND THE LARGEST INCISION YOU MIGHT HAVE TO MAKE IS MAYBE 2 CENTIMETERS IN LENGTH?
A. ONE TO 2 CENTIMETERS, YES.
Q. AND IT IS THE FULL DEPTH OF THE CERVIX?
A. NO.
Q. IT IS NOT THE FULL DEPTH OF THE CERVIX?
A. IT IS THE FULL DEPTH OF THE COMPLETELY EFFACED CERVIX. BUT ONCE THE CERVIX RETAINS ITS NORMAL LENGTH, AGAIN, THEN IT MAKES UP A VERY SMALL PORTION JUST THE END OF THE CERVIX. THE NORMAL CERVICAL LENGTH IN PREGNANCY IS 3 TO 4 CENTIMETERS.
Q. OKAY.
A. SOMETIMES MORE.
Q. OKAY. DO YOU WANT TO JUST TAKE A LOOK AT YOUR DEPOSITION AT PAGE 195? DO YOU WANT TO LOOK AT LINES ONE THROUGH SIX? I

ASKED YOU:

"WHAT IS THE LARGEST INCISION YOU HAVE TO MAKE?"

AND YOU SAID:

"MAYBE TWO CENTIMETERS IN LENGTH."

AND I ASKED YOU:

"HOW ABOUT IN DEPTH?"

AND YOU ANSWERED:

"IT IS A FULL DEPTH, AND IT IS ALL THE WAY THROUGH THE CERVIX, SO PROBABLY THE LENGTH IS THE BEST WAY TO EVALUATE HOW MUCH IS THERE."

WAS THAT YOUR TESTIMONY?

A. THAT WAS MY UNDERSTANDING OF DEALING WITH THE EFFACED CERVIX, WHAT I UNDERSTOOD YOU ASKED ME RIGHT NOW IS: WHAT DOES THAT REPRESENT AS A PORTION OF THE TOTAL CERVICAL LENGTH?

Q. OKAY. AND AM I RIGHT THAT YOU WOULD MAKE THAT KIND OF INCISION WITH SCISSORS?

A. USUALLY, YES.

Q. AND YOU'VE PERFORMED THIS TYPE OF PROCEDURE, RIGHT?

A. I HAVE.

Q. AND YOU BELIEVE THAT A DUHRSSEN'S INCISION IS MORE GENTLE THAN DILATION USING OSMOTIC DILATORS?

A. I DON'T AGREE WITH THAT. THOSE ARE NOT -- THAT IS NOT AN OPTION IN THAT SITUATION TO USE OSMOTIC DILATORS.

Q. OKAY. BUT IN GENERAL, IN TERMS OF LOOKING AT THE IMPACT

ON THE CERVIX, YOU BELIEVE THAT A DUHRSSEN'S INCISION IS MORE GENTLE THAN OSMOTIC DILATION; IS THAT CORRECT?

A. IN RELATION TO LONG-TERM POTENTIAL COMPLICATIONS WITH THE CERVIX, YES.

Q. OKAY. AND YOU BELIEVE THAT A DUHRSSEN'S INCISION IS PART OF THE NATURAL PHYSIOLOGIC PROCESS; IS THAT CORRECT?

A. NOT EXACTLY. WHAT I SAID WAS THAT CERVICAL LACERATIONS OCCUR FREQUENTLY AS A RESULT OF A NORMAL LABOR PROCESS, AND THE AMOUNT OF CERVICAL LACERATION THAT WE SEE IS VERY SIMILAR TO THE CONTROLLED SURGICAL INCISION WE MAKE ON THE CERVIX.

Q. DID YOU TESTIFY IN NEBRASKA LAST WEEK THAT DUHRSSEN'S -- YOU WERE ASKED:

"DOCTOR, IS IT PART OF THE NATURAL" --

MS. CLARK: CAN I GET A PAGE NUMBER?

MS. GARTNER: SURE. LET ME HAND THIS --

THE WITNESS: I THINK I CAN ANSWER YOUR QUESTION, THOUGH. I BELIEVE I WAS ASKED, YOU KNOW, "IS IT MORE TRAUMATIC," AND THINGS OF THAT NATURE.

AND I SAID:

"IT IS A VARIATION ON A NORMAL PROCESS,"

MEANING THAT WE ACTUALLY HELP THE CERVIX DO WHAT IT WOULD SOMETIMES DO ON ITS OWN WHEN IT CAUSES LACERATION TO FACILITATE DELIVERY.

BY MS. GARTNER:

Q. OKAY. YES. I THINK THAT IS WHAT YOU TESTIFIED TO IN

NEBRASKA.

A. OKAY. I AM TRYING TO SAVE TIME.

Q. OKAY. SO, JUST TO BE CLEAR ABOUT THAT, YOU WOULD AGREE OR YOU WOULD -- YOU WOULD -- IT IS YOUR OPINION THAT INCISIONS IN THE CERVIX THAT COULD BE UP TO 2 CENTIMETERS LONG, AND THERE COULD BE ANYWHERE FROM ONE TO THREE OF THEM, THAT DOING THAT TYPE OF INCISION WOULD BE MORE PHYSIOLOGIC THAN OSMOTIC DILATION WITH LAMINARIA?

A. THAT IS CORRECT.

Q. AND IT IS YOUR BELIEF THAT THAT TYPE OF INCISION HAS NO IMPLICATION FOR THE WOMAN'S FUTURE CHILD BEARING?

A. THAT IS CORRECT.

Q. AND IT IS YOUR BELIEF THAT THAT TYPE OF INCISION, OR SEVERAL INCISIONS, HAS NO IMPLICATION FOR POTENTIAL FUTURE CERVICAL INCOMPETENCE; IS THAT CORRECT?

A. THAT IS CORRECT. THERE CERTAINLY -- THERE ARE REASONS TO BE CONCERNED ABOUT THAT, AND THIS IS AN AREA OF ACTIVE RESEARCH. PEOPLE WITH CERVICAL LACERATIONS, EVEN PEOPLE WITH CERVICAL CONIZATION, WHERE THEY REMOVE THE WHOLE LOWER PORTION OF THE CERVIX, AND THEY HAVE NOT BEEN ASSOCIATED WITH INCREASED RISK OF CERVICAL INCOMPETENCE.

OSMOTIC DILATORS OR DILATORS OF ANY SORT AFFECT THE ENTIRE ENDOCERVICAL CANAL, THE ENTIRE THREE OR FOUR CENTIMETERS OF CERVICAL LENGTH, NOT JUST THE LOWER ONE OR TWO SONOMETERS. SO IT IS A DIFFERENT ISSUE.

Q. OKAY. I WANT TO SWITCH GEARS AND TALK ABOUT D&E PROCEDURES. AM I CORRECT THAT IN GRAND RAPIDS WHERE YOU PRACTICE THERE ARE NO HOSPITAL-BASED PROVIDERS OF D&E'S AFTER 20 WEEKS GESTATION?

A. I AM NOT CERTAIN THAT'S THE CASE.

Q. OKAY. I THINK -- DID YOU TESTIFY IN YOUR DEPOSITION THAT IF YOU HAVE A PATIENT WHO NEEDS A HOSPITAL-BASED D&E AFTER CERTAIN GESTATIONAL AGE YOU WOULD SEND HER TO ANN ARBOR OR DETROIT OR LANSING?

A. I DON'T REMEMBER THE SPECIFICS OF THE QUESTION. I DON'T GENERALLY RECOMMEND ANYBODY HAVE A D&E BEYOND 20 WEEKS OFF-SITE OR OUT OF THE HOSPITAL, BECAUSE I AM CONCERNED ABOUT THE INCREASED RISK FOR BLEEDING OR COMPLICATIONS.

SO IF A PATIENT IS GOING TO HAVE A D&E DONE BEYOND 20 WEEKS, MY PREFERENCE IN THE TYPE OF PATIENTS WE TAKE CARE OF IS THAT IT IS DONE IN A HOSPITAL.

Q. AND WHAT HOSPITAL WOULD YOU TEND TO SEND YOUR PATIENTS TO?

A. WELL, IF IT'S NOT DONE FOR A MATERNAL INDICATION OR A LETHAL FETAL ANOMALY, THEN WE MAY REFER THEM TO A NUMBER OF OTHER HOSPITALS. WE HAVE REFERRED THEM TO DETROIT, TO LANSING, TO ANN ARBOR.

Q. AND THOSE CITIES ARE SEVERAL HOURS AWAY FROM GRAND RAPIDS; IS THAT CORRECT?

A. LANSING IS WITHIN AN HOUR. ANN ARBOR WOULD BE TWO HOURS. AND DETROIT WOULD BE UP TO THREE HOURS.

Q. AND YOU DON'T KNOW OF ANY PHYSICIANS WHO PERFORM D&E'S AFTER 22 WEEKS GESTATION; IS THAT CORRECT?
A. I DON'T KNOW ANY PHYSICIANS WHO PERFORM D&E'S AFTER 22 WEEKS GESTATION ANYWHERE.
Q. OKAY. YOU THINK TO THE EXTENT THAT THERE ARE PHYSICIANS WHO DO D&E'S AFTER 22 WEEKS, YOU THINK THAT THEY ARE EXCEEDINGLY RARE AND ARE PUSHING THE ENVELOPE OF SAFETY; IS THAT CORRECT?
A. I THINK THEY ARE PUSHING THE ENVELOPE OF MANY THINGS BECAUSE AFTER 22 WEEKS BABIES HAVE A 30 TO 40 PERCENT SURVIVAL. BUT ALSO WE KNOW THAT THE RISKS DO INCREASE WITH ADVANCE IN GESTATIONAL AGE. SO, YES, I DO BELIEVE THERE ARE MATERNAL SAFETY CONCERNS, AND I THINK THERE ARE PREVAILING FETAL INTERESTS, ONCE YOU GET TO BE 23 WEEKS.
Q. AND IF YOU HAD A PATIENT WHO NEEDED TO END HER PREGNANCY BETWEEN 20 AND 24 WEEKS GESTATION, YOU WOULD NOT OFFER D&E TO HER AS AN OPTION, WOULD YOU?
A. GENERALLY NOT, DEPENDING ON WHAT THE SITUATION IS. GENERALLY, WE WOULD OFFER MEDICAL INDUCTION OF LABOR.
Q. AND IT'S YOUR OPINION -- AND I THINK YOU HAVE REALLY SAID THIS -- THAT D&E BETWEEN 22 AND 24 WEEKS POSES SIGNIFICANT RISKS FOR MATERNAL MORTALITY; IS THAT CORRECT?
A. WELL, SIGNIFICANT RISK FOR COMPLICATIONS. I DON'T KNOW IF I SAID "MATERNAL MORTALITY." BUT IT'S A SIGNIFICANT RISK FOR COMPLICATIONS. ALSO, I DON'T KNOW OF PEOPLE DOING D&E'S BEYOND

22 WEEKS.
Q. WHY DON'T YOU LOOK AT YOUR DEPOSITION AT PAGE 189, LINES 23 TO 25?
A. YES.
Q. DID I ASK YOU:
"DOCTOR, SO IS IT YOUR OPINION THAT D&E BETWEEN 22 AND 24 WEEKS POSES SIGNIFICANT RISKS FOR MATERNAL MORTALITY?"
AND YOU ANSWERED:
"THAT IS MY FEELING, YES."
WAS THAT YOUR TESTIMONY?
A. I STAND BY -- IN THE CONTEXT OF THE QUESTION I WAS ASKED, ABOUT INCREASING GESTATIONAL AGE, DOES IT INCREASE THE RISK FOR MORTALITY, I SAID "YES."
Q. OKAY. AND IN THAT TIME FRAME OF 22 TO 24 WEEKS, YOU CONSIDER D&E TO BE RISKIER THAN INDUCTION; IS THAT CORRECT?
A. YES, I DO.
PARTICULARLY IN THE PATIENTS THAT WE CARE FOR.
Q. RIGHT. AND YOU ALSO IN THAT SAME TIME FRAME CONSIDER D&E TO BE RISKIER THAN HYSTEROTOMY; IS THAT CORRECT?
A. D&E TO BE RISKIER THAN HYSTEROTOMY IN THE SETTING OF 20 TO 24 WEEKS?
Q. CORRECT.
A. IT DEPENDS ON THE SITUATION. HYSTEROTOMY CAN BE A PROCEDURE THAT IS NOT ENTERED INTO LIGHTLY, SO WE WOULD NOT

CHOOSE HYSTEROTOMY. WE WOULD CHOOSE INDUCTION OF LABOR.
Q. BUT I UNDERSTAND THAT YOU WOULD CHOOSE INDUCTION OF LABOR. BUT IN A SITUATION WHERE, FOR WHATEVER REASON, EITHER PATIENT REFERENCE OR SOME OVERRIDING MEDICAL CONCERN INDUCTION WAS NOT AN OPTION, BETWEEN 22 AND 24 WEEKS, YOU DO BELIEVE HYSTEROTOMY IS SAFER THAN D&E; IS THAT CORRECT?
A. IN THE CLINICAL SCENARIO YOU ARE ASKING ME, YES.
Q. AND, AGAIN, THE HYSTEROTOMY WOULD HAVE IMPLICATIONS FOR THE WOMAN'S ABILITY TO HAVE VAGINAL DELIVERIES IN THE FUTURE; IS THAT CORRECT?
A. YES.
Q. IN YOUR TESTIMONY YOU EXPRESSED A VIEW THAT YOU CONSIDER INTACT D&E TO BE A DISTINCT PROCEDURE FROM D&E; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. OKAY. AND ONE OF THE RESPECTS IN WHICH YOU SEE THESE AS DISTINCT IS IN THE DILATION PROCESS; IS THAT CORRECT?
A. THAT IS CORRECT.
Q. OKAY. AND IN YOUR EXPERT REPORT IN THIS CASE, YOU STATED THAT A PHYSICIAN -- AND HERE I WILL QUOTE FROM YOUR EXPERT REPORT:

> "PLANNING TO PERFORM A D&E WOULD TAKE STEPS TO LIMIT THE AMOUNT OF DILATION OF THE CERVICAL OS IN ORDER TO PROVIDE TRACTION TO ASSIST IN THE DISMEMBERMENT PROCESS."

DO YOU RECALL SAYING THAT?

A. I DO RECALL HAVING IT IN MY EXPERT REPORT.

Q. AND IS THAT YOUR OPINION?

A. IT IS. I THINK THAT IT COULD BE MISCONSTRUED IN SUBSEQUENT READING OF IT.

Q. OKAY.

A. MEANING THAT THAT IS NOT THE ONLY REASON THAT I FEEL THAT THEY LIMIT THE AMOUNT OF CERVICAL DILATION. I BELIEVE ONE OF THE REASONS THEY LIMIT THE AMOUNT OF CERVICAL DILATION IS FOR MATERNAL DISCOMFORT ISSUES. AND ONE IS FOR POTENTIAL RISK OF LATER COMPLICATIONS. SO YOU DON'T WANT TO DILATE MORE THAN YOU HAVE TO. BUT IN THIS CONTEXT, I WAS TRYING TO EXPLAIN THAT YOU DON'T NEED AS MUCH CERVICAL DILATION, BECAUSE YOU ARE PULLING THE BABY OUT IN PIECES, AND USE THAT LIMITED CERVICAL DILATION AS YOUR TRACTION IN ORDER TO DISARTICULATE.

SO, IN RETROSPECT, IT WASN'T AS ARTFULLY PHRASED AS IT COULD HAVE BEEN.

Q. HAVE YOU EVER SEEN A PHYSICIAN WHO WAS DOING A D&E TAKE STEPS TO LIMIT THE AMOUNT OF DILATION THEY ACHIEVE?

A. WHAT I MEANT BY "TAKING STEPS TO LIMIT," THEY DON'T PUT IN 25 OSMOTIC DILATORS.

Q. AS A PHYSICIAN WHO DOES D&E'S EVER TOLD YOU THAT HE OR SHE TAKES STEPS TO LIMIT THE AMOUNT OF DILATION THEY ATTEMPT TO ACHIEVE --

A. YES.

Q. -- IN DOING A D&E?
A. THEY TELL ME THAT THEY ONLY ATTEMPT TO PLACE LIKE SIX DILATORS, OR WHAT HAVE YOU, AND THEY DO IT OVER A ONE-DAY PREPARATORY PERIOD.
Q. HAS A PHYSICIAN EVER EXPRESSED TO YOU THAT THEY ARE UNHAPPY IN DOING A D&E IF THEY ACHIEVE MORE DILATION THAN IS NECESSARY TO PERFORM THE PROCEDURE?
A. NOPE, THAT WAS NOT WHAT I WAS IMPLYING. I WAS IMPLYING WHAT THEY WOULD DO VOLITIONARY ON THEIR OWN TO CAUSE MORE CERVICAL DILATION, MEANING HOW MANY DILATORS THEY WOULD PLACE.
IF YOU GET MORE DILATION THAN THAT, THEN I HAVE NEVER HEARD ANYONE COMPLAIN ABOUT THAT.
Q. OKAY. AND YOU WOULD AGREE, DR. COOK, THAT THERE ARE CLEARLY RISKS TO THE WOMAN IF THE PHYSICIAN UNDERDILATES THE CERVIX, RIGHT?
A. I AM NOT SURE I KNOW WHAT YOU MEAN BY "RISKS TO THE WOMAN."
Q. THERE COULD BE COMPLICATIONS IN TERM OF HOW THE PROCEDURE IS DONE IF THE CERVIX IS UNDERDILATED. THERE MAY BE INJURY TO THE WOMAN IN THE EXTRACTION PROCESS IF THERE IS UNDERDILATION OF THE CERVIX?
A. I AM NOT SURE THAT IS THE CASE. IT IS NOT THAT IT IS UNDERDILATED. IT IS THE AMOUNT OF INTRAUTERINE MANIPULATION THAT IS REQUIRED.
Q. HAVE YOU EVER TREATED A WOMAN WHO EXPERIENCED A COMPLICATION IN AN ABORTION DUE TO INADEQUATE CERVICAL

DILATION?
A. NOT FROM WHAT I WOULD CONSIDER INADEQUATE CERVICAL DILATION. I HAVE SEEN WOMEN FROM WHAT I WOULD INTERPRET WAS AN INACCURATE ASSESSMENT OF GESTATIONAL AGE, MEANING THAT WE GET PATIENTS REFERRED TO US IN THE HOSPITAL THAT HAD ATTEMPTED D&E PROCEDURES ELSEWHERE. AND IN RETROSPECT, THEY UNDERESTIMATED THE GESTATIONAL AGE, AND OFTENTIMES EITHER HAD PERFORATIONS OR RETAINED FETAL PARTS.
Q. DR. COOK, IN THE INDUCTION ABORTION PROCEDURES THAT YOU HAVE PERFORMED, YOU HAVE NEVER USED DIGOXIN OR KCL TO INDUCE FETAL DEMISE BECAUSE YOU ALWAYS CONSIDERED IT UNNECESSARY IN THOSE PROCEDURES; IS THAT RIGHT?
A. THAT IS CORRECT.
Q. AND IN YOUR OPINION THERE IS SOME WOMEN FOR WHOM INJECTION OF DIGOXIN OR KCL WOULD CARRY RISKS OVER AND ABOVE THE SMALL RISK THAT WOULD BE PRESENT FOR ALL WOMEN; IS THAT RIGHT?
A. I AM NOT SURE I KNOW WHAT YOU MEAN BY THE "SMALL RISK" PART OF IT.
Q. IS IT YOUR BELIEF THAT ANY TIME YOU INJECT KCL OR DIGOXIN THERE MAY BE SOME SMALL RISK TO THE WOMAN?
A. I SUPPOSE.
Q. OKAY. AND OVER AND ABOVE THAT SMALL RISK THAT WOULD BE PRESENT FOR ANY WOMAN, IS IT YOUR BELIEF THERE ARE SOME WOMEN FOR WHOM THE INJECTION WOULD CARRY GREATER RISKS?
A. YES.

Q. OKAY. SO, FOR EXAMPLE, WOMEN WITH KNOWN VIRAL DISEASES, SUCH AS HIV AND HEPATITIS MAY BE AT GREATER RISK IF THEY RECEIVE AN INJECTION OF DIGOXIN OR KCL THAN OTHER WOMEN; IS THAT A FAIR STATEMENT?

A. NOT EXACTLY. MY CONCERN WASN'T NECESSARILY THAT IT WAS KCL OR DIGOXIN. THE CONCERN WAS HAVING AN INVASIVE PROCEDURE IN LIGHT OF VIRAL DISEASE.

Q. OKAY. THAT IS WELL-TAKEN. SO FOR A WOMAN WITH HIV OR HEPATITIS, AN INJECTION THROUGH THE ABDOMEN INTO THE UTERUS WOULD POSE GREATER RISKS THAN FOR A WOMEN WITHOUT THOSE DISEASES; IS THAT CORRECT?

A. IN THEORY, THE RISK IS BEING INFECTING THE FETUS, THAT BEING THE RISK. NOT THE RISK TO THE MOTHER'S HEALTH, PER SE.

FOR INSTANCE, WE TRY TO AVOID INVASIVE PROCEDURES, FOR INSTANCE, GENETIC AMNIOCENTESIS, IN AN HIV POSITIVE WOMAN IN ORDER TO TRY TO REDUCE THE RISK OF VERTICAL TRANSMISSION OF THAT VIRAL DISEASE TO THE FETUS.

Q. I SEE. SO -- BUT IN YOUR DEPOSITION DID YOU NOT SAY THAT YOU WOULD BE CONCERNED ABOUT INJECTING DIGOXIN OR KCL IN A WOMAN WITH HIV OR HEPATITIS?

A. YES, BUT I BELIEVE I WAS ASKED A NUMBER OF POTENTIAL CONCERNS OF DOING AN INJECTION. THAT WASN'T MEANT TO IMPLY THAT IT'S THE KCL OR THE DIGOXIN. IT IS HAVING THE ADDITIONAL PROCEDURE DONE THAT I WAS REFERRING TO.

Q. OKAY. AND HAVING THAT ADDITIONAL PROCEDURE WOULD BE A

GREATER CONCERN IN A WOMAN WITH HIV OR HEPATITIS?
A. YES, BUT FOR A FETAL CONCERN, NOT NECESSARILY MATERNAL CONCERN. I WOULD HAVE TO REVIEW HOW THE QUESTION WENT.
Q. OKAY. YEAH. WHY DON'T WE DO THAT TOGETHER? WHY DON'T YOU LOOK AT PAGE 198 AND 199 OF YOUR DEPOSITION, STARTING ON PAGE 198, AT LINE 17.
A. OH, I AM SORRY. WHAT LINE?
Q. I AM SORRY. 198, LINE 17.
A. OKAY. I AM SORRY. ARE YOU ASKING ME TO READ IT?
Q. JUST READ IT TO YOURSELF.
A. I DID READ IT.
Q. OKAY. SO THEN, LET ME ASK YOU: ON LINE 17 OF PAGE 198, DID I ASK YOU:

"ARE THERE WOMEN FOR WHOM AN INJECTION OF EITHER DIGOXIN OR KCL TO INDUCE FETAL DEMISE PRIOR TO AN INJECTION WOULD CARRY MORE THAN A SMALL RISK BECAUSE THE WOMAN HAD A PREEXISTING MEDICAL CONDITION."

MR. COPPOLINO OBJECTED, AND YOU ANSWERED:

"YES. THERE ARE SOME SITUATIONS WHERE THE RISK WOULD BE GREATER THAN FOR OTHER WOMEN."

AND I ASKED YOU:

"CAN YOU GIVE ME EXAMPLES OF SITUATIONS WHERE THE RISK WOULD BE GREATER?"

AND YOU STATED:

"YES. IN A SITUATION WHERE YOU ARE CONCERNED ABOUT INFECTION, THEN THERE IS THE CONCERN OF SEEDING OTHER ASPECTS OF HER VASCULATURE, OR WHAT HAVE YOU, TO CAUSE SYSTEMIC INFECTION. IN A SITUATION WHERE IT MAY BE TECHNICALLY DIFFICULT BECAUSE OF SIGNIFICANT MATERNAL OBESITY. AND THEN THERE ARE OTHER SCENARIOS WHERE, FOR INSTANCE, WE DON'T GENERALLY RECOMMEND INVASIVE PROCEDURES IF WE CAN AVOID THEM. PEOPLE WITH KNOWN VIRAL DISEASES, HEPATITIS AND HIV, THINGS OF THAT NATURE, IF WE CAN AVOID ADDITIONAL PROCEDURES, THEN WE WOULD."

WAS THAT YOUR TESTIMONY?

A. YES.

Q. OKAY. AND YOU OBVIOUSLY TESTIFIED TODAY AT GREAT LENGTHS ABOUT THE MATERNAL RISKS, THE RISK TO THE WOMAN OF INTACT D&E; IS THAT FAIR?

A. SORRY?

Q. YOU HAVE TESTIFIED TODAY ABOUT THE MATERNAL RISKS OF DOING INTACT D&E'S?

A. CORRECT.

Q. BUT YOU WOULD AGREE, WOULDN'T YOU, THAT THE WAY IN WHICH THE FETAL HEAD IS DELIVERED IN AN INTACT D&E MAY IN SOME RARE INSTANCES BE THE MOST EFFECTIVE WAY TO COMPLETE AN ABORTION PROCEDURE IF THE FETUS IS NOT LIVING; ISN'T THAT CORRECT?

A. IT MAY BE AN OPTION. BUT, AGAIN, I HAVE BEEN ASKED TO COME

IN ON THOSE VERY SCENARIOS AND NOT FOUND THAT I HAVE EVER HAD TO UTILIZE THAT AS AN OPTION.

Q. SO YOU DON'T THINK THERE ARE SOME SCENARIOS IN WHICH THAT WOULD BE THE MOST EFFECTIVE WAY TO COMPLETE THE ABORTION?

A. WELL, THE PROBLEM IS IN MEDICINE YOU ALWAYS HAVE TO MEASURE RISK AND BENEFITS. AND THERE IS A RISK IN CRUSHING A SKULL OR EVACUATING A SKULL IN A VERY VASCULAR AREA OF THE CERVIX. SO WE WOULD RATHER PROCEED WITH THE LEAST INVASIVE AND LEAST TRAUMATIC WAY TO DO THAT.

Q. OKAY. DO YOU RECALL IN YOUR DEPOSITION WE HAD A DISCUSSION ABOUT WHY CONGRESS WOULD HAVE CHOSEN TO BAN INTACT D&E'S WHEN THE FETUS WAS LIVING, BUT NOT WHEN THE FETUS HAD ALREADY DIED, GIVEN THAT THE MATERNAL HEALTH RISKS SEEMED AS IF THEY WOULD BE COMPARABLE, REGARDLESS OF WHETHER THE FETUS WAS LIVING? DO YOU RECALL THAT CONVERSATION?

A. I DO.

Q. AND IN ANSWER TO MY QUESTION TO YOU ABOUT WHY YOU THOUGHT CONGRESS MIGHT HAVE DRAFTED IT IN THAT WAY, DO YOU RECALL INDICATING THAT CONGRESS MAY HAVE WANTED TO GIVE PHYSICIANS LEEWAY TO FREELY USE THAT TECHNIQUE TO COMPLETE THE DELIVERY IN THE MOST EFFECTIVE WAY?

A. I THINK I MOSTLY RECALL SAYING I HAD NO WAY OF KNOWING WHAT CONGRESS WAS THINKING. BUT THEN I THINK WHEN PUSHED I SAID THAT WAS A POSSIBLE CONSIDERATION OF WHAT THEY MAY HAVE TAKEN INTO ACCOUNT.

Q. WHY DON'T YOU LOOK AT YOUR DEPOSITION AT PAGE 257, STARTING -- I AM SORRY. THAT MIGHT NOT BE THE RIGHT PAGE.

I AM SORRY.

A. I DON'T THINK THAT IS THE RIGHT PAGE.

Q. I AM SORRY. IT IS ACTUALLY AT THE BOTTOM OF PAGE 247, TO THE TOP OF 248.

A. I AM THERE.

Q. IF YOU START ON 247, AT LINE 19, AND READ THROUGH 248, AT LINE 10. JUST READ IT TO YOURSELF.

A. YES, I HAVE READ IT.

Q. OKAY. AND WOULD YOU AGREE THAT -- WELL, LET ME READ IT TO YOU. I SAID TO YOU:

"OKAY, DR. COOK. WOULD YOU AGREE THAT IF CONGRESS HAD BEEN PRIMARILY CONCERNED ABOUT THE IMPACT OF THIS PROCEDURE ON MATERNAL HEALTH, IT WOULD HAVE BANNED ITS USE REGARDLESS OF WHETHER THE FETUS WAS DEAD OR LIVING?

"ANSWER: I DON'T AGREE WITH IT.

"QUESTION: OKAY. WHY IS THAT?

"ANSWER: WELL, I THINK IF I WAS WRITING THIS PORTION OF THE BILL, ONE OF THE PURPOSES IN DEFINING SPECIFICALLY A LIVING FETUS VERSUS A NONLIVING FETUS IS TO ALLOW A PHYSICIAN IN A SETTING WHERE FETAL INTERESTS NO LONGER COME TO BEAR, MEANING A BABY IS NO LONGER ALIVE, THAT YOU MIGHT HAVE GREATER LEEWAY

WITH CERTAIN, YOU KNOW, OPTIONS AVAILABLE TO YOU.
AND IF ONE OF THOSE OPTIONS WOULD BE POTENTIALLY THE NEED TO DECOMPRESS OR PRESS THE SKULL OF A NONLIVING FETUS IN ORDER TO MOST EFFECTIVELY, YOU KNOW, COMPLETE THE DELIVERY, THAT THEY SHOULD BE ABLE TO FEEL LIKE THEY HE CAN DO THAT FREELY."
WAS THAT YOUR TESTIMONY?

A. YES.

Q. AND WOULD YOU AGREE BASED ON THAT, THAT THERE MAY BE SITUATIONS IN WHICH IT WOULD BE MOST EFFECTIVE TO COMPLETE THE DELIVERY TO USE A DECOMPRESSION TECHNIQUE OR A TECHNIQUE THAT CRUSHES THE SKULL OF A NONLIVING FETUS?

A. COULD YOU REPEAT THE LAST QUESTION, AGAIN.

MS. GARTNER: COULD YOU ACTUALLY READ BACK THE LAST QUESTION?

(RECORD READ AS FOLLOWS:

"AND WOULD YOU AGREE BASED ON THAT, THAT THERE MAY BE SITUATIONS IN WHICH IT WOULD BE MOST EFFECTIVE TO COMPLETE THE DELIVERY TO USE A DECOMPRESSION TECHNIQUE OR A TECHNIQUE THAT CRUSHES THE SKULL OF A NONLIVING FETUS?)

THE WITNESS: NO.

BY MS. GARTNER:

Q. IF THAT WOULDN'T BE A BENEFIT TO PHYSICIANS, WHY DO YOU THINK PHYSICIANS WOULD WANT TO BE ABLE TO DO THAT FREELY, AS

YOU SAID IN THAT ANSWER?
A. WELL, AS I UNDERSTOOD THE QUESTION PUT TO ME AND READ BY THE COURT REPORTER, IT WAS: WOULD IT BE THE MOST EFFECTIVE METHOD, WHICH WAS NOT WHAT I WAS -- WHICH WAS WHAT I WAS ANSWERING. AND, NO, IT WOULD NOT BE THE MOST EFFECTIVE METHOD. IT MIGHT BE AN OPTION AVAILABLE IF FETAL INTERESTS ARE NO LONGER AT PLAY, WHICH I BELIEVE IS WHAT I TESTIFIED TO AT MY DEPOSITION.
Q. OKAY. THOUGH YOU DID USE THE TERM "MOST EFFECTIVELY" ON LINE 8 OF YOUR DEPOSITION, DID YOU NOT?
A. I SAID "POTENTIALLY THE NEED OF THAT IN ORDER TO MOST EFFECTIVELY, IN THAT PERSON'S OPINION, EFFECT A DELIVERY."
IN MY OPINION, IS IT THE MOST EFFECTIVE METHOD? NO.
Q. BUT YOU WOULD AGREE THAT THERE ARE PHYSICIANS WHO WOULD CONSIDER THAT TO BE THE MOST EFFECTIVE TECHNIQUE IN THAT CIRCUMSTANCE; IS THAT CORRECT?
A. THERE MAY BE PHYSICIANS WHO AREN'T AWARE OF OTHER TECHNIQUES, AND TO THEM, THAT IS THEIR MOST EFFECTIVE WAY TO DO IT. AND I WOULDN'T BEGRUDGE THEM THAT IF THEY WERE IN THE SETTING OF A NO LONGER LIVING FETUS.
HOWEVER, THAT IS A FAR CRY FROM A D&X PROCEDURE.
Q. WELL, THAT WASN'T THE QUESTION.
A. OKAY.
MS. GARTNER: YOUR HONOR, I THINK JUST TWO OR THREE

MORE MINUTES, OKAY?

BY MS. GARTNER:

Q. DR. COOK, YOU HAVE PREVIOUSLY TESTIFIED IN TWO CASES, TESTIFIED IN COURT.

LEAVING ASIDE THE NEBRASKA CASE IN WHICH YOU TESTIFIED LAST WEEK, YOU TESTIFIED IN TWO CASES INVOLVING STATE LAWS THAT BAN SO-CALLED PARTIAL-BIRTH ABORTION; IS THAT CORRECT?

A. TESTIFIED AT --

Q. IN COURT?

A. IN COURT, YES.

Q. AND THOSE WERE IN MICHIGAN AND IN MISSOURI?

A. YES, I BELIEVE I TESTIFIED MORE THAN ONE TIME IN MISSOURI, BUT --

Q. OKAY. AND YOU SUBMITTED DECLARATIONS IN TWO OTHER CASES INVOLVING STATE LAWS BANNING SO-CALLED PARTIAL-BIRTH ABORTION; IS THAT CORRECT?

A. AS I BEST RECALL.

Q. THOSE WERE WISCONSIN AND ALASKA?

A. YES.

Q. AND YOU TESTIFIED THAT ON TWO OCCASIONS YOU TESTIFIED BEFORE CONGRESS IN SUPPORT OF FEDERAL LEGISLATION BANNING SO-CALLED PARTIAL-BIRTH ABORTION?

A. YES.

Q. AND CONGRESSIONAL STAFF SOUGHT YOUR INPUT INTO THE DRAFTING

OF THIS PARTICULAR LAW, THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003; IS THAT CORRECT?

A. CERTAIN ELEMENTS OF IT, YES.

Q. AND AM I CORRECT THAT CONGRESSIONAL STAFF PERSONS SOUGHT YOUR ADVICE IN SOME SPECIFIC AREAS OF LANGUAGE AND SOME ASPECTS -- WELL, LET ME JUST STOP WITH THAT.

AM I CORRECT THAT CONGRESSIONAL STAFF PERSONS SOUGHT YOUR ADVICE IN SOME SPECIFIC AREAS OF LANGUAGE?

A. YES.

Q. AND SOME OF THOSE ASPECTS THAT THEY SOUGHT YOUR ADVICE ON, WERE INCORPORATED INTO THE FINAL VERSION OF THE LAW; IS THAT CORRECT?

A. YES.

Q. OKAY. AND ONE OF YOUR SUGGESTIONS THAT YOU DISCUSSED WITH CONGRESSIONAL STAFF PERSONS WAS THAT THEY INCLUDE A PROVISION THAT WOULD LIMIT THE APPLICABILITY OF THIS LAW TO 20 WEEKS GESTATION AND LATER; IS THAT CORRECT?

A. THAT IS CORRECT.

Q. AND THAT SUGGESTION WAS ULTIMATELY NOT INCLUDED IN THIS LEGISLATION AS FAR AS YOU KNOW; IS THAT CORRECT?

A. CORRECT.

MS. GARTNER: I HAVE NO FURTHER QUESTIONS, YOUR HONOR.

THE COURT: ALL RIGHT. YOU ARE EXCUSED.

THANK YOU.

MS. CLARK: I HAVE ONE QUESTION.

THE COURT: ONE QUESTION?

MS. CLARK: YES.

THE COURT: YOU MAY ASK ONE QUESTION.

REDIRECT EXAMINATION

BY MS. CLARK:

Q. DR. COOK, WITH THE SUGGESTION YOU JUST TALKED ABOUT WITH MS. GARTNER ABOUT THE 20 WEEK LIMITATION, WHY WAS IT THAT YOU MADE THAT 20 WEEK GESTATIONAL AGE RECOMMENDATION TO CONGRESS?

A. WELL, THE PORTIONS OF THE BILL LANGUAGE THEY ASKED ME TO HELP WITH WERE THE PORTIONS TO MOST NARROWLY DEFINE THE PROCEDURE TO JUST THIS PROCEDURE SINCE THAT WAS ONE OF THE AREAS SPECIFICALLY ADDRESSED IN PREVIOUS LITIGATION.

AND SO I MADE SUGGESTIONS THAT I THOUGHT WOULD LIMIT THE PROCEDURE TO JUST THIS PROCEDURE. AND THAT INCLUDED THINGS WE MENTIONED LIKE ANATOMIC LANDMARKS AND VOLITIONAL OR ACTIVE DESTRUCTIVE PROCEDURE, THESE SORT OF THINGS.

I ALSO SUGGESTED 20 WEEKS GESTATION BECAUSE THERE WAS A LOT OF DISCUSSION ABOUT:

"WELL, THIS BILL COULD INCLUDE FIRST-TRIMESTER PREGNANCY LOSSES," OR OTHER ARGUMENTS THAT I DIDN'T THINK -- THAT I THOUGHT WERE DISINGENUOUS ARGUMENTS.

SO I THOUGHT JUST AS A POINT OF FACILITATION IF YOU DRAW THE LINE AT 20 WEEKS, WHICH IS HOW HASKELL AND MCMAHON BOTH DEFINE THEIR PROCEDURES, IF YOU JUST DEFINE IT AT 20

WEEKS, THEN YOU CAN JUST DISCARD ALL THE OTHER CONCERNS AND ARGUMENTS ABOUT PATIENTS LESS THAN 20 WEEKS.

SO IT WAS BASICALLY TO TRY TO FACILITATE THE PROCESS.

MS. CLARK: THANK YOU.

THE COURT: ALL RIGHT. THANK YOU.

YOU ARE EXCUSED.

ALL RIGHT. I JUST WANT TO MAKE A COUPLE OF POINTS FOR YOU ALL. TOMORROW IS OUR DOWN DAY -- AT LEAST FOR YOU ALL. AND WE ARE GOING TO WRAP IT UP ON THURSDAY AND FRIDAY. I DIDN'T MEAN TO SUGGEST THAT YOU ALL WEREN'T GOING TO BE WORKING; JUST THAT YOU WEREN'T GOING TO BE HERE.

WITH REGARD TO THE RECORD EVIDENCE THAT WE WILL RELY UPON, THAT WILL INCLUDE THE TESTIMONY OF THE WITNESSES PRESENTED HERE IN COURT, AS WELL AS THE DEPOSITIONS THAT YOU ALL HAVE SUBMITTED IN LIEU OF THEIR LIVE TESTIMONY.

I WONDERED WITH RESPECT TO THE -- AND ALSO ANY EXHIBITS THAT HAVE BEEN ADMITTED HERE IN COURT.

AND I AM WONDERING WITH REGARD TO THE DECLARATIONS THAT WERE SUBMITTED PRIOR TO TRIAL, AS WELL AS THE -- THERE WERE SOME DEPOSITIONS, AS WELL, A FEW DEPOSITIONS AS WELL, OF WITNESSES THAT HAVE ACTUALLY APPEARED HERE, AND IN ADDITION THE EXPERT REPORTS, ALL OF WHICH YOU FILED. TYPICALLY, THEY ARE NOT FILED IN CASES, AND THEY ARE NOT ADMITTED INTO EVIDENCE.

I JUST WANT TO MAKE SURE THAT YOU ALL ARE PROCEEDING

IN TERMS OF SUPPLEMENTING YOUR FINDINGS ON THE ASSUMPTION THAT UNLESS THERE IS A STIPULATION, THE DEPOSITIONS OF WITNESSES WHO HAVE APPEARED HERE WILL NOT BE ADMITTED NOR WILL THEY BE RELIED UPON. THE EXPERT REPORTS, EVEN THOUGH THEY WERE FILED, WILL NOT BE RELIED UPON. AND THE DECLARATIONS SUBMITTED IN CONJUNCTION WITH PRIOR MOTIONS WILL NOT BE RELIED UPON.

IS EVERYONE PROCEEDING UNDER THAT UNDERSTANDING?

MR. QUINLIVAN: YES.

MS. PARKER: YES.

THE COURT: ALL RIGHT. THEN, IN TERMS OF THE SUPPLEMENTATION, THEN, OF YOUR PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW, I INDICATED TO YOU I WOULD LIKE TO, RATHER THAN JUST SUBMIT POSTTRIAL BRIEFING, TO SIMPLY SUPPLEMENT THOSE.

WHAT I WOULD LIKE IS REFERENCES TO THE EXHIBITS THAT ULTIMATELY HAVE BEEN ADMITTED INTO EVIDENCE AND THE TRIAL TRANSCRIPT, WHICH YOU ALL HAVE BEEN RECEIVING ON A DAILY BASIS.

THAT WILL CERTAINLY FACILITATE MY REVIEW OF THE ENTIRE RECORD. BUT IT WILL ONLY DO SO IF I RECEIVE IT QUICKLY, BECAUSE WE ARE GOING TO START ON THIS IMMEDIATELY. SO WHAT I WOULD LIKE IS TO AFFORD YOU ALL AN ADDITIONAL WEEK TO DO THAT.

DO YOU ALL THINK --

MS. PARKER: WEEK FROM FRIDAY?

THE COURT: A WEEK FROM FRIDAY.

MS. PARKER: IF WE CAN DO IT A WEEK FROM MONDAY, I

THINK THAT -- SO IT WOULD BE --

THE COURT: YOU WOULD HAVE A FULL WEEK TO DO IT.

MS. PARKER: EXACTLY.

THE COURT: OKAY. THAT WOULD BE FINE, IF WE CAN GET IT THE FOLLOWING MONDAY. THAT WOULD BE ONE FULL WEEK TO DO THE SUPPLEMENTATION.

IN ADDITION, THERE ARE A COUPLE OF OTHER POINTS. I RAISED A COUPLE OF ISSUES WITH YOU THE OTHER DAY, AND I PROBABLY WILL HAVE A FEW MORE ON THURSDAY OR FRIDAY.

IF YOU WISH TO SUPPLEMENT THE FINDINGS FURTHER TO ADDRESS THOSE, TO THE EXTENT YOU CANNOT ADDRESS THEM IN YOUR CLOSING ARGUMENT, THAT WILL BE FINE. BUT YOU ARE STILL ONLY GOING TO GET THE ONE FULL WEEK TO DO THAT.

MS. GARTNER: WE HAVE A QUESTION, YOUR HONOR, ABOUT THE EXHIBITS THAT WERE SUBMITTED WITH THE DEPOSITIONS.

THE COURT: OH, THAT'S RIGHT. THAT IS ANOTHER ISSUE I WANTED TO RAISE. SOME OF THE EXHIBITS WERE ACTUALLY -- ACTUALLY, SOME OF THE EXPERT REPORTS WERE INCORPORATED BY THE TESTIMONY. WHAT IS YOUR -- DO YOU HAVE A JOINT POSITION ON THAT? DO YOU WISH ME TO CONSIDER THOSE?

MS. PARKER: I DON'T THINK -- FROM OUR POSITION, I DON'T THINK IT WAS THE EXPERT REPORTS, NECESSARILY, BUT MAYBE WE SHOULD GO BACK AND DOUBLE-CHECK THAT WITH THE DEPOSITIONS.

WE SHOULD DOUBLE-CHECK THAT. BUT I THINK WE DID WANT THE EXHIBITS, WHICH IS WHY WE DID PUT THE DEPOSITION

DESIGNATIONS IN THE AUTHENTICATION.

THE COURT: AUTHENTICATION OF THE EXHIBITS?

MS. PARKER: YES.

THE COURT: WHY DON'T WE JUST BRING OUT -- YOU ALL CAN TAKE A LOOK AT -- I HAVE THE ORIGINALS THAT WILL BE ADMITTED AS SORT OF LIKE EXHIBITS FOR THE APPELLATE RECORD.

AND THEY HAVE APPENDED TO THEM THE EXHIBITS. I ACTUALLY WOULD LIKE YOU TO TAKE THE EXHIBITS THAT ARE NOT MEANT TO BE INCLUDED, SO I DON'T HAVE TO CONSIDER WHETHER OR NOT THEY SHOULD BE INCLUDED.

MS. GARTNER: WE ATTEMPTED TO.

THE COURT: YOU DID THAT, ALL RIGHT.

MS. PARKER: YES, WE ACTUALLY TRIED TO DO THAT AND WE JUST GAVE YOU THE EXHIBITS THAT WE WANTED TO BE INCLUDED IN THE RECORD.

THE COURT: IS THAT TRUE WITH BOTH SIDES?

MR. SIMPSON: YES, YOUR HONOR, I BELIEVE SO.

THE COURT: YOU DON'T HAVE TO DO ANYTHING. WE WILL LOOK AT THEM.

OBVIOUSLY, I WILL GIVE ANY WEIGHT TO THOSE THAT I THINK ARE APPROPRIATE, AND I WON'T TO THOSE I DON'T.

MS. GARTNER: POINT OF CLARIFICATION ON THAT, YOUR HONOR. IN SOME INSTANCES WE DON'T THINK THE EXHIBITS WERE ACTUALLY PROBATIVE.

IT WAS JUST TO GIVE YOU THE CONTEXT OF WHAT WAS

BEING DISCUSSED IN THE DEPOSITION.

THE COURT: SURE, OKAY.

ALL RIGHT.

ANYTHING ELSE BEFORE WE ADJOURN?

ALL RIGHT. THEN, WE WILL SEE YOU THURSDAY MORNING.

(THEREUPON, THIS TRIAL WAS CONTINUED UNTIL THURSDAY, APRIL 15, 2004, AT 8:30 O'CLOCK A.M.)

I N D E X