TRANSCRIPT HIGHLIGHTS
Planned Parenthood v. Ashcroft
U.S. District Court, Northern District of California
The Honorable Phyllis J. Hamilton, Judge

DAY ONE: Monday, March 29, 2004.
Excerpts from direct examination of Dr. Maureen Paul:

Q. And when you begin the evacuation, is the fetus ever alive?

A. Yes.

Q. How do you know that?

A. Because I do many of my procedures especially at 16 weeks under an ultrasound guidance, so I will see a heartbeat.

Q. Do you pay attention to that while you are doing the abortion?

A. Not particularly. I just notice sometimes.
~
Q. Okay. Does it every come out completely without the head becoming lodged?

A. Rarely it does.
~
Q. And you had said that sometimes when you apply traction to the fetus it comes out intact up to point where the calvarium lodges; is that correct?

A. Yes.

Q. In that circumstance, what do you do to complete the procedure?

A. Well, there are two things you can do. You can disarticulate at the neck, or what I prefer to do is to just reach in with my forceps and collapse the skull and bring the fetus out intact.
~
Q. You testified earlier, Dr. Paul, that the fetus can be alive when the evacuation begins; is that correct?

A. That's right.

Q. When in the course of the abortion does the fetus -- does fetal demise occur?

A. I don't know for sure. I certainly know that if I deliver intact and collapse the skull that demise occurs.

Excerpts from the Government's cross-examination of Dr. Paul:

Q. In performing a D&E at 20 weeks gestational age and above, in your previous capacity, was there ever a time when you saw any indication that the fetus was experiencing pain?

A. I have no idea what that means.

DAY TWO: Tuesday, March 30, 2004.
Excerpts from PPFA's direct examination of Dr. Katharine Sheehan:

Q. Okay. So after you have assessed the fetal presentation, what do you do next?

A. Then, a cervical block of local anesthetic is placed around the cervix, and the amniotic sac is ruptured, allowing the amniotic fluid to flow out. And, then, using the forceps, I begin the procedure if extracting the fetal part.

Q. And how do you go about doing that?

A. I generally try using the ultrasound to find the small parts of the fetus, "small parts" being considered the extremities. I really prefer it if the lower extremities are presented first. I can grasp the lower extremities of the fetus, and using gentle traction, extract the tissue.

Q. And after you have done that, what do you have? What happens next?

A. I continue to put traction on the fetus tissue. If the cervix is adequately dilated, then the fetus will generally slide down through the cervix, and I continue to extract the tissue until it is completely extracted. If the cervix is not so well dilated, then disarticulation and dismemberment happens.
~
Q. So do you ever use a chemical agent to cause fetal demise?

A. Yes.

Q. What is that agent?

A. The agent is Digoxin.

Q. What is Digoxin?

A. Digoxin is the name for Digitalis, which is a cardiac medicine that is typically used for specific cardiac conditions, most typically heart failure.

Q. And at what gestational age do you use Digoxin?

A. We start using it at 22 weeks.

Q. Why do you choose 22 weeks?

A. We like to prevent an eventuality of a live birth, and because it seems to make the procedure move along a little bit easier on the day of the procedure. …We administer the Digoxin with a needle through the abdominal wall of the woman intro the uterus. We are aiming to get it into the fetal heart, or at least into the fetal thorax. However, we are not able to do that every time. If we are not able to do that, then we attempt to put the Diogoxin into the amniotic fluid. And it seems to work less often when it is just put into the amniotic fluid.

Q. What percentage of time are you successful in getting the Digoxin into the fetal heart?

A. I would say approximately 50 percent.

~

Q. And what about the term "living fetus," what does that mean to you?

A. It would be a fetus that still has a heartbeat, and that would still apply to many of my cases.

Q. And in your practice do you bring the fetus to the point where the fetal trunk past the navel is outside the body of the woman?

A. Yes, I do. That's what I mainly do.

Q. And that happens often?

A. Yes.

~

Q. You testified yesterday, I believe, that you have performed approximately 30,000 surgical abortions throughout your career?

A. That is my best guess.

Excerpts from the Government's cross-examination Dr. Sheehan:

Q. Thank you. If I could read that to you, page 101 [of Dr. Sheehan's deposition], starting on line 22.and I should say first this question refers to your expert report; is that correct?

A. Uh-huh.

Q. "Question: Could you describe, doctor, what you mean in paragraph 4 by your 'best efforts to remove the fetus intact?

Answer: I think I already described that, but what I attempt to do is to grasp the fetal feet with the instrument, and putting gentle traction on that fetal extremity, I try to tease the tissue down so that the fetus comes down feet first through the cervix, the pelvis and the thorax, and I actually get the arms out and just use

gentle traction, rather than using the kind of crushing and compressing gestures that one would use to do the disarticulation."

Is that what you said?

A. Yes.

Excerpts from direct examination of Dr. Eleanor Drey:

Q. And was there a time frame of when [Digoxin] was given?

A. When we first started giving it, we always gave it at the time that we were doing our pre-operative evaluation, so that the patient would get the laminaria placed. And then, after that, she would have the Digoxin injection. At that time we were waiting two days with the laminaria in place. And, so, initially we were giving Digoxin two days before D&E.

Q. And did you ever change that procedure, that time schedule?

A. We did. What started happening was we had an unfortunate number of women who were spontaneously going into labor and delivering at hospitals sort of all over the bay area, and it was distressing to everyone.

DAY THREE: Thursday, April 1, 2004:
Excerpts from direct examination of Dr. "Doe" (testifying under a pseudonym):

Q. Do some women deliver the fetus partially as a result of the misoprostol?

A.. Yes, they can.

Q. And when that happens, could the fetus be outside the uterus past the navel of the fetus?

A. Outside the uterus, yes, and potentially even outside the vagina.

Q.. And could it be alive?

A. Yes.

Q.. And when that happens, how do you complete the procedure?

A. Usually, if the fetus is coming out, the easiest method is to try to do how we would do a breech. It often comes out in a breech presentation. And, again, that is feet first, head second. We do the similar maneuvers that we would do to do a breech delivery. However, sometimes the cervix is not dilated enough to allow the calvarium to pass.

Q. And what do you then do?

A. I would separate the calvarium from the body.

~

Q. And when during in induction does fetal demise occur; do you know?

A. I don't know. It really depends on gestational age, and sometimes the fetus is born alive.

~

Q. And do you ever -- do patients ever ask you whether there is something they could use to cause fetal demise?

A. Yes. I would -- I don't know what percentage of my patients, but a certainly small number of patients ask could there be fetal demise prior to the procedure. When I talk to them about what it would entail to do, most of them do not want to proceed with that. And I don't think they are particularly worried about the effects. They don't think -- I think about the infection risk. They don't think about the infection risk. They just don't want to go through that procedure, to have a needle placed, and under ultrasound guidance maybe see the ultrasound and see the fetus again. The vast majority of the patients don't want to have that done.

Excerpts from cross-examination of Dr. "Doe":

Q. And I think you testified earlier that in about 15 percent of the d&e's you perform, the fetus is delivered partially intact so that the calvarium gets stuck in the cervix; is that correct?

A. It was – I think my testimony, I believe, is approximately 15 percent would be delivered intact. Not all of those that the calvarium would be stuck; some would deliver completely intact.

Q. Do you have a -- can you give me an estimate of that 15 percent how many are delivered where the calvarium does get stuck in the cervix?

A. I would probably say at least 80 percent the calvarium would be stuck in the cervix.

Q. And just to be clear, the calvarium, again, is just the fetus' head, correct?

A. Correct.

Q. In those cases in which you are doing a D&E and the fetus delivers partially intact except for the calvarium getting stuck in the cervix, you have to insert forceps and crush the calvarium; is that right?

A. I would separate the calvarium from the fetal -- how I would perform the procedure is, I would separate the calvarium from the fetal body, thorax, and then insert the forceps to crush the calvarium to be able to deliver it.

~

Q. Let me just ask you. Can you describe for us how you get the forceps around the calvarium before crushing it?

A. In a situation where the fetus is delivered up until the calvarium?

Q. That's right.

A. Again, as I testified, I would separate the calvarium from the fetus, so --

Q. Let me stop you right there. How would you separate the calvarium from the fetus?

A. Under direct visualization, I would use, seeing outside of the cervix within the vagina that I can see directly, I would use scissors to cut the neck and separate the -- I am not in the uterus, I am in the vagina, separating the fetal calvarium from the fetal body.

Q. And after you've done that, the calvarium is still in the cervix?

A. Or in the lower uterine segment.

Q. Okay. Then what is the next step that you do?

A. The next step I would use is to put the bierer forceps -- is what I most likely would be using in the situation – into the uterus, get around, open them wide, get around the calvarium, and crush the calvarium. Just as if it were higher up and not stuck in the cervix, I would be doing it just the same way.

Q. And is it fair to say that the calvarium is one of the largest parts of the fetus?

A. Yes.

Q. It is also one of the widest parts of the fetus?

A. Yes.

Q. Is it fair to say that when you are opening the forceps to get around the calvarium, you are opening them wider than you would if you were attempting to grasp a fetal limb?

A. Yes.

Q. Could there potentially be risks to the cervix when you are opening the forceps wide enough to get around the calvarium?

A. Yes.

Q. In fact, one of those risks might be a perforation or a laceration of the cervix, right?

A. Yes.

Q. And another risk might be a perforation or a laceration of the lower uterine segment?

A. Yes.

~

Q. And let's talk about that a little bit. Are the -- can the bones of the calvarium, can they be sharp?

A. Yes.

Q. Are they in any -- are they sharper say than the bones of the fetal leg or are they roughly comparable?

A. It depends on how -- if it's a disarticulation of how it went. A calvarium could be crushed and there are not sharp edges and the femur, which is a leg bone, could be broken and be sharper. I think you can't predict that. But I think any of the major long bones, certainly not ribs, but femur, humorous could be sharper than a calvarium that has been crushed.

Q. And when you are crushing the calvarium, there is the same risks that we talked about earlier, possible perforation or laceration of the cervix, the lower uterine segment, or the uterus; is that right?

A. Yes.

Q. And a cervical or uterine laceration, it can be relatively minor or it could be relatively severe; is that right?

A. Yes.

Q. If it's severe enough, there are some cases where a woman might exsanguinate and die, right?

A. Yes.

Q. Can you tell us what exsanguinate means?

A. To bleed to death.

Excerpts from re-cross examination of Dr. "Doe":

Q. And Ms. Parker asked you a question about why some of your patients don't prefer a labor induction abortion. I think one of the reasons you gave was that your -- the woman may not want to see the fetus; is that right?

A. Yes.

Q. Now, in a labor induction abortion you are not showing the fetus to the mother in every case,

are you?

A. No, we are not. But with a labor induction, it is often kind of unpredictable when the fetus delivers. And it is probably a minority of times the physician is actually there at the time to deliver the fetus. Often you don't have the normal kind of cervical dilation that you might have in a term labor. You have nothing, nothing, nothing. And then, all of a sudden, she goes: "I have got to push," and the fetus kind of pops into the bed.

DAY FOUR: Monday, April 5, 2004.
Excerpts from cross- examination of Dr. Fredrik Broekhuizen:

Q. Usually in examining the fetal parts you don't actually see the bones, do you? You usually see the limb and the actual bone is in the limb?

A. You can sometimes see bone. Sometimes you can see just the limb.

Q. But usually you just see the limb, and the actual bone is in the limb?

A. Actually, when disarticulation takes place in the joint one can certainly see the end of the bone on inspection.

Q. The end of the bone. But usually the rest of the bone is inside the limb?

A. There are situations where actually the bone is crushed in the middle of the limb. And under those circumstances one can see part of the bone.
~
Q. Doctor, you testified earlier that sometimes parents want an intact fetus for blessing or burial. Have you ever had the parent express that desire where you had compressed the head of the fetus to complete the delivery?

A. Yes.

Q. Was anything done in those instances, doctor, to improve the appearance of the fetus' head after decompression?

A. Yes.

Q. What was done?

A. The fetus was -- just like a newborn -- it was dressed and kind of had a little hat placed on it so that only the face was visible.
~
Q. You have seen the fetus' legs move before crushing the head, haven't you?

A. I have seen that before compressing/decompressing the head.

Q. And that is while the head is lodged in the internal os?

A. Correct.

Q. The rest of the body is outside the cervix?

A. Correct.

Excerpts from direct examination of Dr. Mitchell Creinin:

Q. If that happens and you remove the dilators and you find you have more than two, two and a half centimeters, is that a bad outcome?

A. No. … I want -- I judge the number of Dilapan based on making sure I get the minimum amount without putting in so many that I make her uncomfortable or get more dilation than I absolutely need, which I have found at times can cause patients to go into labor or deliver.

~

Q. What do you do to evacuate the contents of the uterus?

A.. . . If it is head first, it's very, very, very difficult to try and grasp the head as the very first thing. So, with every D&E, the way I have been taught, the way I have always done it, the way I have always taught it is to try and grab a lower limb to convert the position to breech and then proceed with the evacuation. If it's already breech, or if it's transverse, that's easier to grab a lower extremity. After grabbing the lower extremity, I am going to pull the pregnancy or pull whatever part I have grasped through the open cervix until there is resistance from the lower uterine segment and the internal os. My goal is to try and remove the fetus as intact as possible. The fewer passes, the safer it is for the woman. So, as I pull down, the uterus is going to tell me how far I can go just by the resistance I get. So when I meet resistance, I will continue to pull, and it's the pressure of the fetus against the lower uterine segment that actually results in dismemberment of the fetus. And where that is going to happen on the fetus will vary from patient to patient.

~

Q. So, moving along, once you've located and grasped the lower extremities and turn the fetus if you need to, what do you do next?

A. Pull with the instrument that I am using to remove the fetus with the attempt to remove the fetus in as few passes as possible. So until I meet resistance from the lower uterine segment, I will continue to pull.

Q. Why --

A. And once I meet resistance, I will then, while holding on to the fetus -- minimal rotation, but just kind of try and ease those parts through the cervix to allow whatever's meeting resistance to try and slowly get through the cervix. The fetus will either continue to come or will begin to break apart. It will break apart wherever or whatever it is. It may be in the middle of the leg, it may be at the abdomen, it may be at the chest, just depending on the dilation and the size of the

fetus, et cetera, just on that individual case.
~
Q. Does it ever happen that in grasping the fetus you're able to remove the fetus intact or relatively intact all the way up to the calvarium?

A. Yes, on occasion.

Q. If that happens, would you do anything differently to complete the procedure?

A. If the fetus is intact up to the calvarium, there's two things I could do. One would be to continue to pull, and usually it comes apart at the level of the neck, or I can insert, what I would I have done is insert scissors through that part of the head under direct visualization, inserted the 11-millimeter cannula that I used before and drain the brain tissue and then the head comes through the opening.

DAY FIVE: Tuesday, April 6, 2004
Excerpts from Government's cross-examination of Dr. Mitchell Creinin:

Q. Now, you have encountered situations in which you are performing a D&E and the fetus is removed intact except that the head of the fetus gets stuck at the internal cervical os, correct?

A. Correct.

Q. When that has happened you have preceeded with the D&E procedure in one of three ways, correct?

A. If you can tell me the three ways I would be happy to.

Q. One method would be to pull on the baby so that the head breaks off from the rest of the body; is that right?

A. Yes.

Q. And then, you will go inside the uterus with the forceps and remove the head?

A. Correct.

Q. The next method is that you would use scissors to puncture the base of the skull?

A. Correct.

Q. And the, you will stick a suction cannula into the opening and drain the brain tissue, and then you will have the head come out.

A. Did you say "Drain the brain tissue"?

Q. Then, you will drain the brain tissue?

A. Yes.

~

Q. And the third method is that you take a crushing instrument, put that instrument inside the cervical os, crush the baby's head, and pull the head through the cervix, correct?

A. That would be the third possible, although physically that would virtually never be the case. It would be one of the first two. Those are my three options, but it would be one of the first two that I could realistically do.

~

Q. Doctor, if a woman's cervix was so dilated the fetus could be delivered in intact it would not be necessary to collapse the skull because the fetus could pass through the cervix, right?

A. Correct.

Q. But you would not allow the fetus to pass intact if the fetus were at or about 24 weeks in gestation, correct?

A. Correct.

Q. Because if the fetus were close to 24 weeks, and you were performing a transvaginal surgical abortion you would be concerned about delivering the fetus entirely intact because that might result in a live baby that may survive, correct?

A. You said I was performing an abortion, so since the objective of the abortion is to not have a live fetus, then that would be correct.

Q. In your opinion, if you were performing a surgical abortion at 23 or 24 weeks and the cervix was so dilated that the head could pass without compression, you would do whatever you needed to do in order to make sure that the live baby was not delivered, wouldn't you?

A. Whatever I needed, meaning whatever surgical procedures I needed to do as part of the procedure? Yes. Then, the answer would be: Yes.

Q. And one step you would take to avoid delivery of a live baby would to be to deliver or hold the fetus' head on the internal side of the cervical os in order to collapse the skull; is that right?

A. Yes, because the objective of my procedure is to perform an abortion.

Q. And that would ensure that you did not deliver a live baby?

A. Correct.

Excerpts from Planned Parenthood's re-direct examination of Dr. Creinin:

The witness: There have been situations, most commonly if there is a multiple pregnancy and the first one is removed by D&E, and then the second one because the cervix is very pliable at that point will come out completely intact.

The Court: Have you had that experience?

The Witness: Yes. In all of those situations, though regardless of whether the fetus comes out completely intact, intact up to the head, and I do a procedure on the base of the skull, or I did – or it comes out completely at the level of the head, and I disarticulate it, all of those have at times gone intact or relatively intact to the level of the umbilicus or greater and would violate the law.

Excerpts from Planned Parenthood's direct examination of Dr. Carolyn Westhoff:

Q. And in what way does it – looking at the reduction in the risk of injuring the woman with the sharp, boney fragments, if you can explain in a little more detail how that happens?

A. Well, I need to explain that by contrasting it to a D&E that involves disarticulating the fetus. When the fetus is disarticulated, the skin and soft tissue covering the bones is disrupted, so sharp fragments of bone are exposed. And in the process of exposing them, grasping them, and removing them from the uterus there is the possibility that those boney fragments can lacerate at any level of the uterus and the cervix itself during extraction.

~

Q. Can the boney parts perforate the uterus in addition to lacerating it?

A. Yes, they can.

Q. Have you ever observed uterine perforation or laceration or cervical laceration as a result of instrument passes in a D&E with disarticulation?

A. Yes.

Q. Have you ever observed that happening as a result of sharp fetal parts?

A. Yes, I have.

~

Q. Is there an advantage to intact D&E in terms of not having retained tissue in the uterus after the procedure?

A. Yes, there is.

Q. What is the – what is that – can you explain that advantage in a little more detail?

A. Yes. When the fetus is removed in parts we attempt to account for all the parts on the

operating table at the completion of the case. But it is entirely possible that small fragments of soft tissue can remain inside the uterus that we can't be sure of. And even with, for instance, the sonographic scan, we may not be able to detect those, and that can lead to subsequent infection or hemorrhage on the part of the patient. We have, in fact, on our service had a case with a small fragment of retained skull leading to those very difficulties and requiring a second procedure subsequently to relieve those symptoms.

~

A. … In contrast, when I am retrieving a fetal skull that is floating fee in the uterine cavity, I must pass instruments in an attempt to grasp it inside the uterus. And that is a blind use of instruments, which has more potential for perforation.

~

Q. And Dr. Westhoff, in your opinion, does the intact variant of D&E in any way facilitate the grieving process of women that are ending their pregnancy, that was a wanted pregnancy but they are ending it due to an anomaly or a maternal health condition?

A. Yes, it does. In a particular case in the last year, as an example, a patient who was aborting twins due to complications during the pregnancy absolutely did not want to go through labor and didn't want to go through an induction, but expressed the desire to hold these babies after the procedure. We were able to deliver both of them intact and present them to the woman to hold with clergy and her family present. And she was very grateful for that opportunity.

~

Q. Dr. Westhoff, do you fear prosecution under this act for the D&E's that you do where the fetus is disarticulated in the course of the evacuation?

A. Yes, I do. The ban itself, the language here does not specify that the fetus must be intact. And there are cases such as we discussed partly a moment ago in which I may first remove a foot or a leg, and then -- so I partly dismember the fetus, but then proceed to bring down the breech. And I believe that would again fulfill the conditions stated in part a of the ban. There are also cases in which perhaps the first part of the fetus I remove might be part of the back or the ribcage, which are, in fact, part of the fetal trunk past the navel and it appears then for me to continue to carry out the D&E would violate the ban as it is stated here.

~

Q. And once you start the procedure with instruments, do you complete it with instruments? Or might you bring out a presenting part with an instrument, and then switch to your fingers?

A. Yes. Each procedure proceeds very individually, and so each step of the procedure will depend really on just what happened in the one step before it. And for each step of the procedure I want to do what is going to be safest at that moment. So, yes, in fact, I have had cases where I may bring down and extract a leg with an instrument and disarticulate that leg, but because the position of the fetus comes down in the uterus during that maneuver, I may then be able to bring down the next leg with my fingers. And, in fact, the rest of the fetus will follow. So, similarly, I could start with my fingers and then in addition need to use instruments. So the combination of maneuvers I use are determined one at a time on an individual basis to minimize the total number of passes and maximize patient safety at each step of the way.

DAY SIX: Thursday, April 8, 2004

Excerpts from Government's direct examination of Dr. Watson Bowes:

Q. Doctor, I am showing you what has been marked as plaintiffs' learned treatise 11. Is this the study by Dr. Grimes, et al, that I was just referencing?

A. Yes.

Q. And can you briefly summarize what the article is about?

A. This is a study which Dr. Grimes described as a feasibility study. He set out to compare two abortion procedures, one which was a labor induction procedure using these two drugs called mifepristone and misoprostol used together to induce abortion through a labor induction method. Compare that with the abortion procedure called D&E. And his objective was to randomize patients to one of those procedures or the other, as we have described, in a randomized controlled trial.

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Q. Doctor, did Dr. Grimes and his colleagues explain some of the reasons why it was difficult to enroll sufficient number of women for the study?

A. Yes, I believe they did.

~

Q. Doctor, continuing on, what was the fourth reason given by Dr. Grimes and his colleagues for the slow enrollment in the study?

A. Then they limited their population to women who were 19 weeks or less gestation. And they did that, as Dr. Grimes says here, because the nursing service didn't want to take the risk of their being a live baby born after the abortion procedure. So that further restricts his population down to the limits that we have described.

DAY SEVEN: Friday, April 9, 2004

Excerpts from Government's direct examination of Dr. M. Leroy Sprang:

Q. . . . Now, could you tell us, please, why it is your opinion that intact D&X presents a risk of infection?

A. Several reasons. One, that normally in the vagina, just like on the skin in the mouth we have numerous bacteria present. But particularly in the vagina there are generally five to nine organisms that occur in very large numbers, like 10 to the ninth. And that is where they belong, and they don't do any harm there. If you add a foreign body, twigs, stick seaweed, you are going a get a certain amount of trauma to the tissue which enhances the bacterial growth. And the way the laminaria work, their length is such that you are taking them from the outside of the vagina, placing them through the cervical canal. For them to be effective, they have to cover the entire length of the cervical canal with a portion of them remaining in the vagina so you can retrieve them, and the other portion going right up against the amniotic sac. If you don't do that, you are not going to completely dilate the cervix the entire length, and it will lead to major problems. So what happens in the first day, a certain amount of trauma from the little sticks, as they dilate,

even more trauma. But then the bacteria in the vagina work their way up those little sticks and are then at the level of the internal os and sitting right next to the amniotic sac. So that it is moving them from the normal position to an abnormal position, which increases the risk of infection.

Q. Does the length of time over which the dilation for intact D&X occurs, do you think that also increases the risk of infection?

A. It increases the risk because the length of time a foreign body is there, the greater the risk of bringing bacteria from the vagina to the cervix, either on the first application or on the subsequent applications of the laminaria. Sometimes the actual little sticks will break the amniotic sac, too, which significantly increases the risk of infection because then you have the bacteria going from the vagina to the uterine cavity.
And I know that happens just obviously intuitively it happens, but the different authors, including Haskell, describes it in his paper that sometimes it breaks and sometimes it doesn't. And the next day when they remove them and proceed to the next step of the procedure, if it has -- his comment is "if it hasn't already ruptured," which obviously tells you sometimes it does, then he ruptures the membranes. So you have another significant risk of infection there, especially if it broke. You inserted them on day two, and you waited to day three to do the procedure, you've got a ruptured bag of waters with foreign bodies sitting in the cervix for potentially 24 hours.

Q. Doctor, you said something a few minutes ago about the amount of bacteria in the vagina. What I think you said was: "10 to the ninth"?

A. Yes. It is a mathematical term. And you add 10, and add nine zeros. That is the number.

Q. Doctor, I think you also mentioned the internal podalic version as presenting a risk to the patient. Why is it your opinion that that maneuver presents a risk to the patient?

A. Having done it as well, there is a strong mechanical force in taking the fetus and basically forcing it to do a summersault within the uterine cavity. These are not little things that you just kind of push gently, and it just turns. It doesn't work that way.

You are using a great deal of force in turning it upside-down that does trauma to the uterine cavity and could disrupt the placenta and cause bleeding. And rarely things like amniotic fluid embolus. Those are not common things that could happen, but rarely they could. And, in fact, in Williams' textbook of obstetrics, which is one of the most premiere, respected obstetrical textbooks for teaching medical students, when I was a student was the primary textbook, it specifically says that there are very few, if any, indications to do internal podalic version other than the second twin. And in various editions he actually says it is potentially harmful. He says that it is the most common cause of traumatic uterine rupture.

Q. Doctor, if I can ask a few follow-up questions on those things. You mentioned disrupting -- the potential for disrupting the placenta. What can that lead to?

A. Again, these are rare situations, but there is potential trauma if you disrupt the placenta at that

point. There will be bleeding. And you are also -- you have got vernix parts, white stuff on the fetus. There is not as much that early in pregnancy. You have still got some amniotic fluid around. When you disrupt the placenta, some of that material can get into the maternal circulation, which could cause an amniotic fluid embolism in the mother, which is a very serious situation.

Q. Is there any risk in that internal podalic version of causing maternal bleeding?

A. Because if you do separate the placenta, all the blood supply to the uterus goes to the surface of the placenta and stops there. If the placenta starts to separate, you, in fact, have an abruption of a placenta, and there would be internal hemorrhage.

~

Q. So you have never encountered a situation where the pregnancy had to be terminated before viability because of a maternal health condition?

A. I have not.

~

Q. Doctor, are you aware of any maternal health conditions that would require terminating pregnancy by the intact D&X method?

A. And after careful review and after sitting on both the ACOG -- correction -- AMA task force, we could not find any medical conditions that would require an intact D&X. The ACOG panel could not come up with any situations that would require an intact D&X. And, in fact, in reading each of the numerous declarations and depositions I haven't seen any physician [here a hearsay objection was sustained]

Q. Doctor, in your practice have you seen a need for the use of the intact D&X method?

A. I have never seen a situation where an intact D&X method was necessary to be performed.