IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

LEROY CARHART, M.D., WILLIAM G. FITZHUGH, M.D., WILLIAM H. KNORR, M.D., and JILL L. VIBHAKAR, M.D., on behalf of themselves and the patients they serve, Plaintiffs, vs. JOHN ASHCROFT, in his official capacity as Attorney General of the United States, and his employees, agents and successors in office, Defendant.	4:03CV3385 March 29, 2004 3:15 p.m. Lincoln, Nebraska

VOLUME I,
TRANSCRIPT OF TRIAL PROCEEDINGS,
BEFORE THE HONORABLE RICHARD G. KOPF,
UNITED STATES DISTRICT JUDGE

A-P-P-E-A-R-A-N-C-E-S:

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(Monday, March 29th, 2003, at 3:15 p.m.)

THE COURT: Good afternoon. We're on the record now in Carhart and others versus Ashcroft, 4:03CV3385. We are in the courtroom in Lincoln, Nebraska. Counsel, please now enter your appearance, first for the plaintiffs.

MS. SMITH: Yes, Your Honor. Priscilla Smith for the plaintiffs with Janet Crepps, Nan Strauss and Jerry Hug. Thank you.

THE COURT: Hello.

MR. COPPOLINO: Good afternoon, Your Honor. Anthony Coppolino with the Department of Justice for the defendant joined by Terry Henry, Preeya Noronha, Andrew Warden.

THE COURT: Thank you. What we will do this afternoon is to hear your opening statements, then take whatever evidence we have available to us this afternoon. I would like to -- I typically break at 4:30, but today we'll go to 5:00. Then we'll break at roughly 5:00 o'clock. I won't -- I'll give you as much time as you reasonably need to make your opening statements. Take whatever time you need.

For those of you who are in the courtroom, you need to know that this is a courtroom, and I will treat it as a courtroom which means that we won't have any outbursts, we won't have any actions that are inconsistent with the

dignity of this courtroom. All right. I'll hear from the plaintiffs first.

MS. SMITH: May it please the Court. Good afternoon, counsel. Your Honor, the Supreme Court has repeatedly insisted that the Government cannot prevent physicians from acting to protect the health of their patients. The right underlying this freedom, the freedom that all Americans enjoy is the constitutional protection of an individual's interest in privacy and liberty stemming from our rights to preserve our bodily integrity and our rights to make the important decisions that define our lives.

In the context of abortion, the Court has repeatedly insisted that the rights of pregnant women, no less than other Americans, include this right to protect our health interests, and indeed, this central feature of constitutional privacy and liberty interests has guided the Court for over 30 years since Roe vs. Wade and has become known in shorthand as the health exception. But what does the health exception mean in this case? The necessity to protect the health of pregnant women seeking abortions means different things in different contexts and has a different impact on the different types of restrictions on abortion passed by states and now by the Federal Government.

In the context of post-viability bans on abortion, then

it means that the woman must be able to obtain an abortion; the ban itself is nullified if she needs the abortion to protect her health.

In contrast, in the waiting period context, a health exception does not mean that every woman seeking an abortion to protect her health can avoid the waiting period altogether. It means only that a medical emergency exception must exist, so that if waiting for 24 hours would harm her health, she need not wait.

What does it mean in this case? Luckily, the Supreme Court has told us it means that the woman must be able to obtain, and the physician must be able to provide, the safest procedure available, the procedure that the physician judges is most likely to preserve the woman's reproductive health.

Now, the Court set some ground rules for this. They said a statute restricting abortion that lacks a health exception is unconstitutional absent evidence that a health exception would never be necessary to preserve the health of a woman, and where substantial medical authority supports the proposition that banning a particular procedure could endanger women's health, then KC and the constitution requires a health exception. Following the Court's decision, five courts of appeals have confirmed that the Supreme Court unequivocally held that any ban on intact D &

E must include a health exception for the health of the mother. The First, the Third, the Fourth, the Fifth, the Sixth Circuits, and, of course, the Eighth Circuit's decision was the one affirmed in Carhart.

What will the evidence show in this case? If we limit our discussion for a moment to the intact variation of the D & E procedure, a procedure that itself is performed differently by different physicians, and importantly, a procedure that is performed differently depending on the unique circumstances of each patient. The evidence in this case will show that the relevant indicia of safety and the advantages of removing the fetus intact are no different than they were four years ago when the Supreme Court affirmed this Court's findings, rejected contrary findings from the district court in Wisconsin, and heard from the American College of OB/GYN that the intact D & E was in some situations, the best and most appropriate procedure to preserve the health of the woman.

The plaintiffs will prevent the testimony of 12 experts who regularly perform second trimester abortions; some who the Court will hear live and some whose the testimony will be presented through trial testimony, through trial transcripts from the other two cases challenging the law. The experts will testify about the safety advantages of intact or near intact removal of the fetus.

These experts include Dr. Doe, an expert practicing and teaching in a university setting in a large metropolitan center; Dr. Carhart here in Nebraska; and the three other plaintiffs. Drs. Chasen, Westhoff, Hammond and Frederiksen practicing at Cornell Medical College, Columbia University, and Northwestern respectively.

Experts will testify that intact removal of the fetus can occur and is desirable as early as 12 to 15 weeks of pregnancy.

Additional evidence will be presented to the Court from the 30(b)(6) deposition of ACOG which stands behind its position as well as from the APHA and the American Medical Womens Association, all of whom oppose the act. The defendant's witnesses, on the other hand, none of whom personally perform second trimester abortions regularly and all of whom are personally opposed to abortion except for in extremely rare circumstances, will testify that the procedure is never the only one available to perform an abortion procedure. But that is not the standard. The standard is whether the procedure is safer in some circumstances and whether banning the method poses increased risks to a woman's health.

THE COURT: Tell me about the defendant's expert who is the chair of the OB-GYN department at Yale.

MS. SMITH: Yes. Dr. Lockwood actually admitted in

his deposition there was clearly a significant body of medical opinion that the D & X procedure was safer in some circumstances.

THE COURT: Now, my understanding is he was head of a similar -- had a similar position in New York and that D & Xs were performed in his department while he was the chair.

MS. SMITH: That's right.

THE COURT: Do I understand that correctly?

MS. SMITH: That's correct, Your Honor.

THE COURT: Wait a minute. Did he perform the D & X?

MS. SMITH: No, he did not. He does not perform abortions because he's personally opposed to them, but he did have people perform abortions on his watch, and he admitted that he would not allow unsafe procedures to be performed at NYU which is where he was at Bellevue Hospital. And he also testified that if he was in the process of hiring someone to provide abortion services at Yale, and that if that person provides the D & X procedure, and if this law is not in effect, then these procedures will be provided at Yale under his watch as well.

THE COURT: Now, my understanding from the defendant's brief is that the doctor, fellow from Yale, will testify that the D & X is never safer post-viability; is that right?

MS. SMITH: That is what he'll testify, that's right. And he will also testify that, I believe, that the Joxon can be performed. At the same time, though, he admits there are risks to the Joxon, and he also admitted the Joxon should be up to the patient's choice.

THE COURT: Well, of course, the Joxon would -- well, I don't know that. Typically when we are talking about the Joxon, we are talking about pre-viability; are we not?

THE WITNESS: Well, both, Your Honor, I think. But in this case the plaintiffs don't perform procedures post-viability. We are only talking about pre-viability procedures.

THE COURT: Let's be clear about what you just said to me. This is a facial challenge to both aspects of the ban.

MS. SMITH: This is a facial challenge to the Act. The plaintiffs in this case perform pre-viability abortions just as was true in the Carhart case, Your Honor.

THE COURT: Right. You recall what I held in the Carhart case, that I would not declare the statute unconstitutional on its face but only as applied.

MS. SMITH: Yes, Your Honor, and respectfully, that was the one piece of the Carhart case that you were not upheld on.

THE COURT: No, find anyplace where the circuit or the Supreme Court said I erred.

MS. SMITH: That's true; they didn't address it, Your Honor, but they did decide, they noted, the Eighth Circuit noted that you had struck down the law as applied, but that it was treating this case as a facial challenge and was striking down the statute on its face.

THE COURT: Right, but that's not what I did.

MS. SMITH: Right. I understand that.

THE COURT: Now, are you going to have anybody here who can tell me post-viability that this ban is going to cause anybody problems post-viability?

MS. SMITH: No, Your Honor, because all the plaintiffs and all the witnesses are going to be testifying about pre-viability procedures.

THE COURT: All right.

MS. Smith: There is some dispute --

THE COURT: What am I to make of that?

MS. SMITH: Well, Your Honor, there is an issue about how you would craft injunctive relief which is what I think Your Honor is addressing, and the problem is that if you were to carve out, let's say, an exception for the post-viability, that you would only strike it down pre-viability. You would leave post-viability applications of the law which I think is what you're getting at.

THE COURT: Well, I don't even know what I'm getting at. What I'm telling you, just as kind of a simplistic, which is some years ago we were in the same position, I can do a pretty good job, I think, of describing what the witnesses tell me what they do, why they do it, whether what they do is, from my perspective, reasonable or not. It's very hard for me to make that judgment in the abstract, and yet you're wanting me to preclude enforcement of the law in the abstract post-viability, and my question to you, I mean, that just doesn't seem sensible to me. Why would it -- a Court ever do that?

MS. SMITH: Well, Your Honor, I looked into this question more because I know it is an issue that concerns you, and as we put in our trial brief, there is not a great deal of clarity in the case law.

THE COURT: Boy, that's right.

MS. SMITH: On this issue, that's for sure. What is clear is that every time a statute has been challenged where there are pre-viability and post-viability applications, and where it has been challenged on its face, it has been struck down in its entirety.

THE COURT: Yeah.

MS. SMITH: And I think the one rule that we were able to glean from the case law was the question of whether you're rewriting the statute, it's kind of a severability

analysis, whether the legislature, in this case, Congress, would have upheld the law if it was limited to post-viability in this case would be, that would be the question.

THE COURT: Um-hm.

MS. SMITH: And here we know clearly that that is not true because Congress rejected on a number of occasions amendments that would have applied, limited the statute to post-viability applications.

THE COURT: But I wouldn't be rewriting it, it seems to me, if I were to find that pre-viability enforcement was unconstitutional, but there wasn't anything in the evidence that would permit me in the abstract to conclude that post-viability was a problem. Why would I be rewriting the statute to enjoin enforcement of the one but not the other.

MS. SMITH: Because Congress said it was not willing to pass a statute if it was limited to post-viability.

THE COURT: Sure.

MS. SMITH: In fact, there are post-viability bans on abortion in 40 states already.

THE COURT: But the emphasis is on, in this circumstance, the adjective rewrite. That's a bad thing. I shouldn't put myself in the mind of Congress. I have got no

right to do that. But, and I understand that line of analysis, but simply declaring one portion of the statute unconstitutional and not the other doesn't -- I don't see why that is either disrespectful of Congress or a rewriting of the statute.

MS. SMITH: Well, Your Honor, I would agree with you if there were two separate provisions. If there was a provision that said this applies post-viability, this applies pre-viability, but here there isn't, so you would have to insert the word post-viability into the statute which I think is, respectfully, Your Honor, I do believe that's the definition of rewriting when you add words to a statute. The other thing I will say about this is there has been a lot of talk in this case about peri-viability, and there are people with different opinions about when viability begins. We have plaintiffs and other experts who perform procedures in the 24th week of pregnancy, and there is some dispute about those procedures. People who are performing them do not believe they are viability -- post-viability procedures, but there are some people who will argue that they are, but not to get us off the other issue, I think it is a difficult issue. I think there are different issues here than there may have been in some other cases, but I think that if that analysis were correct, then we would have all the statutes that we have been challenging

here in Nebraska and all over the country would have been limited to post-viability, and none of them were. They were all struck down in their entirety.

THE COURT: Well, I didn't strike it down.

MS. SMITH: I know you didn't, Your Honor.

THE COURT: Just to be clear about that.

MS. SMITH: I know, Your Honor.

THE COURT: I thought I was raising a huge red flag saying, will somebody please tell us what the difference between an applied challenge is and a facial challenge and when one is appropriate and the other isn't, and apparently the flag was not waved.

THE COURT: Well, the flag was raised -- was waved loud and clear, Your Honor, and I did try to find some more --

THE COURT: No, no, I mean in the earlier case.

MS. SMITH: Yeah. Yeah, but I have been trying to find some more guidance for the Court and for myself in this issue and simply haven't found much except for what we have put in the brief which was that you look at what the intent of the legislature would have been, and the idea is not to rewrite as a separation of powers issue.

THE COURT: Well, as a practical matter, we used to argue about as applied or facial because nobody knew whether you applied Salerno or not, and it was often a wiggly way

around Salerno. Now you say Salerno doesn't apply anyway, so it doesn't make any difference.

MS. SMITH: Salerno doesn't apply, and I think that's pretty well established at this point given that the Supreme Court didn't apply it. The Supreme Court knows the dispute is out there. That was briefed in that case.

THE COURT: I'm not -- I'm not here to argue with that, but now that if I assume that you are right, that Salerno doesn't apply, then there isn't any -- there isn't a, really, a tactical reason from your point of view, it would seem to me, and can we get to the sort of the juris prudential issue? What in the world does it -- some judge have -- Why in the world should I be speculating on these abstractions? Doctors in a variety of places, in a variety of circumstances, being confronted with a variety of problems, and you want me to enjoin the law when I don't have anybody here who are like those doctors.

MS. SMITH: Well, Your Honor, I guess I think of it, I'm coming at it from a different perspective which is that I'm here to show that the law is unconstitutional, and I'm showing it's unconstitutional with my plaintiffs and my witnesses and my experts.

THE COURT: Sure.

MS. SMITH: Once I have shown it's unconstitutional, I don't think the Court needs to speculate

about how it would be applied post-viability. The Court can say I don't know if it would be constitutional post-viability without a health exception although certainly --

THE COURT: If I don't know it --

MS. SMITH: -- it should be.

THE COURT: If I don't know it, why would I say it then?

MS. SMITH: Because the Court, you would be following the path of every Supreme Court and Circuit Court decision before you to address the constitutionality of an abortion restriction and in a facial challenge.

THE COURT: All right. Thank you. Go ahead.

MS. SMITH: Your Honor, to go on, you did ask me about Dr. Lockwood and his testimony, and as we discussed, he did supervise the procedures at NYU and thought they were safe. He also testified that the findings and the law that the intact D & E procedure was unsafe. He didn't agree with. He thought it was at least as safe as D & E. But does this mean that everyone can perform the intact D & E? No. Some of the plaintiffs will testify that they always try to remove the fetus as intact as possible, but they are unable to, in most instances, and their expectation is that the fetus may not come out intact. Dr. Fitzhugh has been performing D & Es for 30 years and he's not changed his

practice. But still he does find that in his practice the fetus comes out intact in some instances and largely intact in other instances.

Dr. Vibhakar from Iowa was actually taught how to perform D & E abortions in her residency at Beth Israel Hospital in New York. She believes it's the safest procedure, but the reality of her abortion practice and her busy schedule at the University of Iowa, her duties there, her teaching duties don't allow her to perform the procedure at the Emma Goldman Clinic because she would have to go there another day a week she doesn't have. At the same time, in the D & E procedures that she performs, the fetus comes out sometimes intact in rare circumstances, and largely intact in other circumstances, so this brings us to the second question which is about the scope of the Act.

What does this Act actually ban? The first thing I would look at here is what is the Government's position on this. In their papers and in some of their papers and through much of the questioning of the witnesses, the Government has implied that the Act bans intact D & Es and has placed great emphasis on whether or not the fetus has actually been delivered intact and in what circumstances.

However, the Department of Justice official charged with enforcement of the Act, Wan Kim, has testified that the Department of Justice has not yet determined which procedure

or procedures will subject the physician to violation of the Act, and he also recognized that the word intact is nowhere in the statute, nor is the statute limited on its face to any particular gestational age.

Could he change his mind? Yes, he could. But the Justice Department has not taken an official position at this point as to what procedure or procedures are covered.

Indeed, the plaintiffs and their experts will testify that the Act is broad in scope and could ban abortions as early as 12 to 15 weeks of pregnancy. They will testify that they hope to deliver as much of the fetus as possible in one pass, and sometimes the removal of the fetus will proceed in the manner described in the Act, even when a physician does not expect the fetus to be delivered intact and whether or not the fetus is actually delivered intact. And this can happen in a breech presentation and a transverse presentation, it can even sometimes, for some doctors, happen in a vertex presentation.

THE COURT: You mean head first.

THE WITNESS: Head first, yes. One of the difficulties in interpreting the Act, Your Honor, is that physicians provide these procedures in all different ways. As Your Honor knows, you've already heard this testimony in the past case, and you'll hear more in this case about the variation in the doctors' practices, and that's true whether

they intend to bring the fetus out intact or largely intact or not intact. In fact, second trimester surgical procedures are very specialized, in part because of the difficulty in performing them and because they are unpredictable. There is no real road map to this procedure. It's much less -- I have been trying to think of an analogy, and with the help of some of my colleagues, I have put it this way, Your Honor: It's much less like driving on a paved road where you know where you're going than it is like hiking in a forest. You may know the path you want to take, but you may come across a fallen tree that blocks your path, a waterfall may have destroyed another path, or a rock slide, and you have to adjust and go in a different direction, and that's really more -- more like what these procedures are like, that the ground will open a new path to you that may be better than you ever expected.

And I think that physicians have learned to expect the unexpected, to adapt and modify their techniques as the situations present during the procedure so that their intent may actually change during the procedure as a situation arises, and they always have the goal of enhancing the safety of the procedure and reducing the discomfort of their patients.

Now, what of the congressional findings? The evidence will show that D & X is not dangerous to women, and even

defendant's experts have admitted that this, that D & X is at least as save as D & E and the findings were exaggerated in this regard. The evidence will show that to the contrary, contrary to the finding that D & X is never medically necessary, that sometimes D & X is sometimes necessary.

On fetal pain, Your Honor, the evidence will show it has not been definitively established whether there is consciousness of pain in the fetus and defendant's witnesses have also stated that in any case the D & X would not be more painful than other abortion procedures and may be less so.

That's the evidence will show, that even if the Court accords deference, some deference to the findings, they are unreasonable.

That's all I have, Your Honor.

THE COURT: Thank you. Mr. Coppolino?

MR. COPPOLINO: Good afternoon, Your Honor.

THE COURT: Good afternoon.

MR. COPPOLINO: Your Honor, today in this courtroom and others in this country, we begin the process of examining this ban on partial-birth abortion. The Court will do so against the backdrop of a record and findings made by Congress which are extensive and which reflect the decision that a line had to be drawn in banning this

procedure.

The record that the Government will present to you in this trial, Your Honor, before its conclusion, will be far different from the one that was before the Court several years ago. It will include not only the detailed Congressional Record but extensive testimony in support of that record from experts that we believe you will find both distinguished and finally informed.

THE COURT: Mr. Coppolino, let me interrupt you for just a moment. You were good enough to provide me a number of books and the Congressional Record, and as you know, I have read them. And I heard from Ms. Smith that perhaps some of the Senate, I think I'm remembering this correctly, that some of the remarks on the floor of the Senate were not included in those books. I know I'm going to get the Congressional Record here. It would help me if you would put that record in the same sort of format that you gave it to me at the time of the preliminary injunction or the TRO hearing just so that -- because I had, as you know, summarized that in some detail, so what -- I guess what I'm saying is, to the extent that you can just give me another book, that will be helpful. Pardon me for interrupting you. Go ahead.

MR. COPPOLINO: That's fine, Your Honor. I believe we may have already done that because we have added to our

exhibit list a number of Congressional materials, and I will check with our team to make sure we may already have that book prepared for you, and if we do not, we will prepare it for you because we did include floor statements and other materials that were before Congress in addition to the hearings record, and I will seek to identify and provide that to the Court.

THE COURT: That will be great. Thank you.

MR. COPPOLINO: Just as I was saying, we'll provide you with testimony in support of that report from experts that I think you will find distinguished and well informed, and we will intend to counter what we believe Congress concluded were assertions about the alleged safety of this procedure which has simply been unverified.

I think you will find, Your Honor, that after how many years has it been since your trial in the Stenberg case was it? 1997 or '8, six or seven years, you'll find the evidence they are presenting is largely the same, and I think you heard some of that already in this case.

The assertion is going to boil down to, on the plaintiffs' side, that based on intuition and personal experience, there is this view that this procedure has some intuitive safety advantages such as fewer instrument passes, fewer fetal fragments potentially left behind. We don't believe that evidence is going to stand up to scrutiny for a

variety of reasons, and we look forward to presenting it to you.

The ban, as you know, identifies a procedure in which the physician knowingly removes the fetus to a point, to a specified point outside the body of the mother deliberately and intentionally for the purpose of then performing a separate act to kill other than the completion of delivery.

Before this trial is concluded, we will seek to confirm three basic findings that Congress made. First, that there are no maternal health conditions that require this procedure; second, that there are no proven safety advantages to the procedure and, the ones that have been advanced that I alluded to a moment ago are conjecture and unverified.

Several years after the Court heard this testimony, you're going to hear it basically again and may wonder why in seven years there hasn't been further analysis. However, you might view the Congressional Record in its adequacy, Congress at least tried to step into the breach. It brought doctors forth on both sides of the issue, not necessarily all live, but some live, and in numerous written submissions from doctors on both sides, and it evaluated the evidence and it concluded it just didn't stand to reason --

THE COURT: Mr. Coppolino, let me ask you this, and it puts you in an awkward position and it's not my intent

intentionally to do that, but in this case, I have had the benefit of your work and the benefit of Ms. Smith's work and in compiling your experts, and you're just marvelous lawyers on both sides, well prepared, marvelous experts, really bright, capable, well-intentioned people. I have to tell you, I don't see that Congress spent anywhere near the kind of effort that you folks have spent in honestly trying to give me a fair picture of the medical situation.

Assume that I'm right on that, what deference, then, do I give Congress and its findings?

MR. COPPOLINO: I think under the law, the Court is to give deference to those findings if there is a reasonable basis and substantial evidence, and I think that's legal speak for you need to evaluate them based on the evidence that you hear in this courtroom, in part, and in part on the evidence that is in that record.

THE COURT: I mean, I think that's the point. If I evaluate it based on the evidence in this courtroom, I'm likely to say that all Congress said, it's close enough for government work.

MR. COPPOLINO: Your Honor, I think we will certainly be able to put that record, the record of Congress itself forward to you in a manner which demonstrates that they did have a comprehensive and detailed record on many of these issues.

That said, the law doesn't require that Congress has to have a detailed comprehensive record as you might find in an Article III court with ten lawyers on either side examining 30 expert witnesses. The law requires that there be a basis in fact for the law, not necessarily whether their hearings transcripts were as well cross-examined as I or Ms. Smith might cross-examine a witness. That's not the requirement. The requirement is whether you can discern after the evidence is presented in this case and after reading the record, the record contains a reasoned judgment based on facts that exist, that exist in this country based on the medical expertise that you will hear --

THE COURT: In that regard, does Congress need to approach that task objectively?

MR. COPPOLINO: Well, you know, that's an interesting question, Your Honor. Does it need to approach the task objectively? If Congress wishes to have laws that are based on facts, in part, upheld, then it needs to, then it needs to ensure that its judgments are well reasoned.

Now, I think it has done so here, and I think that the evidence that we will present demonstrate that. I don't believe there are any actual requirements on Congress along these lines, it being a political institution and a legislative body that gathers the facts as it will and makes the judgments that it makes. Yet it recognizes that

particularly in the area of abortion, the judgments that it makes are going to be reviewed, and to the extent they are based on medical evidence, they want to ensure that their medical findings are sound.

In that record, you're going to hear from some of the same witnesses on that witness stand that would be before Congress. You're going to hear from some others, and you're going to see they had before them experts in this field who could carefully present that information to them and who did so.

THE COURT: Who will appear here and who testified before Congress?

MR. COPPOLINO: Dr. Curtis Cook is one of our witnesses.

THE COURT: Who else?

MR. COPPOLINO: Dr. Watson Bowes provided substantial written material in the Congressional Record.

THE WITNESS: Right.

THE COURT: Dr. Sprang also provided written material for the record. Who am I forgetting? I know I thought Dr. Anand who was our fetal pain expert did not appear live but submitted enormous amounts of material to Congress which was cited and relied on. We didn't bring everybody.

The hearings record went back eight years, and we wanted

to give you some fresh basis as well, but you're going to get three to four people who contributed to that Congressional Record.

THE COURT: All right. Thank you.

MR. COPPOLINO: I think one of benefits of bringing them live is that it will put a personal face on that record to some extent. You'll see Dr. Curtis Cook, you'll meet him. You'll hear him in person, and you'll come to a better appreciation of the views which he presented to Congress. Likewise with Dr. Watson Bowes who I don't believe appeared live but was certainly well represented in the record. You'll hear from him live, and you'll get the benefit of his expertise as a professor emeritus at the University of North Carolina with a particular expertise in studying the medical literature with respect to obstetrical issues and abortion. His testimony will impress you as well.

In addition to medical issues, there are ethical issues Congress looked at, and they are not irrelevant in our view as the plaintiffs may suggest, and the evidence that we will present, the medical evidence will affirm those ethical considerations as well that this is a termination of a life that a appropriates the process of delivery, termination of a life near viability which is very significant because you will hear testimony, as you already have, that the measure of viability is not certain, and that you get past that 20,

21, two week period, it's not entirely certain whether that fetus is actually viable or not, and that is the danger zone, and that animates the concern that Congress has with respect to this procedure, because it was specifically designed to extend the period in gestation when you could easily perform an abortion, and it was justified in ways that have not proven to be true.

I would like to touch on that, if I may, just for a moment. From the plaintiffs' perspective, and I say this with respect, they view this as largely an issue of surgery. Abortion is, of course, legal in this country, and it is a common surgical practice.

Dr. Carhart and his colleagues perform surgery. From their perspective they should have the discretion to judge the manner in which they perform surgery, if they think it is as safe as possible. You will hear that this procedure, the so-called intact D & E procedure is a minor variation that they regard as intuitively safer. Our evidence will, I think, cast great doubt on that, but first and foremost, it will demonstrate this is not mere surgery to evacuate tissue.

The Supreme Court itself has clearly recognized that when a life is at stake, the Government can take into account that interest, and that is what is going on here. The law does not provide that physicians have complete

discretion to decide what is safe with respect to their own abortion practices as Ms. Smith pointed out. There is this notion of substantial medical authority, and as much as plaintiffs wish to anoint themselves that they are reflecting substantial and medical authority which you will find is that they are no more than a group of doctors with opinions, opinions that are untested, unreliable and will prove to be without adequate foundation to permit this procedure to proceed. Mere differences of opinion are not enough and certainly should not be enough to judge whether or not this particular procedure should go forward in the face of serious questions as to its efficacy and as to its ethics.

Congress heard both sides, and it decided that it was not necessary to advance the health interests of women who were facing complicated pregnancies that there were potential and unstudied risks, and it took into account ethical considerations, and those are the three pillars of the law.

They are profound considerations, and they are not going to simply turn on whether at the end of the surgery there were fewer fetal fragments in the womb. There is much more at stake than that.

As to the medical necessity issues, I think the plaintiffs are going to try to limit the playing field to

solely one issue, whether this procedure is safer than others or hold some possible safety advantages. We believe the evidence will show that it is not, but that is not the only issue.

Congress addressed a much broader medical issue in the first instance, and it is certainly one that the Supreme Court has looked to as well. And that is whether the procedure is needed to serve the health interests of the mother. Congress took a great deal of testimony on this, in part because this procedure was repeatedly justified as one needed to deal with complicated pregnancies, pregnancies in which women were sick because of some serious ailments such as preeclampsia or infection or renal disease or cardiac disease, and it was justified on this basis, and that argument seems to be receding.

Now the argument is simply collapsed to it's a safer procedure.

Well, Congress looked at the broader issue, and you will hear from the doctors who handled these high risk cases, and they will testify uniformly this procedure is not needed, and indeed, poses enough sufficient risk they would not use it. Now, these are not doctors that are testifying on the basis of their moral convictions. These are doctors that care for sick, pregnant women. These are doctors that perform terminations prior to viability in that tragic

circumstance when it is necessary to end the pregnancy before the fetus is viable in order to serve the health interest of the mother. Our doctors serve the health interests of pregnant women who are facing complicated and difficult pregnancies, and they are the ones who are going to tell you, as they told Congress, that this procedure is not needed for maternal health considerations. I don't think that issue is going to be seriously in dispute at the end of this trial.

With respect to plaintiffs' narrower issue as to whether the procedure itself is safer, Congress found, of course, it's never been adequately studied. It does still continue to amaze me the six years or so after your trial that remains the case. Judging from our own exhibit notebooks, you will see that there are legion studies in the area of abortion. Virtually everything has been studied, and we have put some of those studies in the record to the extent we think they might be useful to assist the Court or our witnesses, and yet you would think at some point the medical community, besides the plaintiffs, would have grappled with this issue, but they have failed to do so, and weighing that against the fact that some data that does exist out there with respect to the complications of induced abortion is enough to give one pause, because this procedure that is at issue is a procedure which is not a mere variation of the

existing D & E procedure. The most significant difference is, it is a procedure that is used later in gestation when all experts agree the risks of pregnancy termination increase. It is also a procedure which all experts will also agree involves a greater degree of dilation over a longer period of time. Those are two very significant medical facts which affect an evaluation of the potential complications of this procedure, and it has not been studied, and it's not like there aren't cases out there that could have been studied. The data suggests that this partial-birth abortion procedure, whether you call that or intact D & E has been around quite awhile.

THE COURT: What do you think Dr. McMahon's statistics that are in the Congressional Record, what do you make of them if it's not a study?

MR. COPPOLINO: I'm sorry. I didn't hear the last part, Your Honor.

THE COURT: Dr. McMahon's numbers are in the Congressional Record. Now, certainly wasn't a controlled study. But those numbers are fairly large, fairly significant by a guy who is pretty, claimed to be pretty experienced. What do you make of those?

MR. COPPOLINO: What I make of them is they have not been independently evaluated and verified.

THE COURT: It has been studied but not

independently verified in a peer reviewed sort of a way.

MR. COPPOLINO: It was a case review. It was a situation --

THE COURT: That's how surgeons do it all the time. Surgeons do case reviews all the time to evaluate the efficacy of their procedures.

MR. COPPOLINO: I understand, but whether a case review can be relied upon without independent review and analysis, I think you will hear the experts say --

THE COURT: Well, did anybody, did Congress ask Mc Mahon? He wrote the lawyer for the majority and said here are my numbers. Did anybody go to McMahon and say let's look at your data.

MR. COPPOLINO: I don't know if they asked him to testify before he passed away. I don't even know when he passed away, so I don't know the answer to that specific question. What I can say, though, is that no one will refute the point that the McMahon and Haskell data, while they are case series have not been independently scrutinized, and you'll hear from our experts that in evaluating a procedure, it ought to be and needs to be independently scrutinized. Peer review is a common practice in the medical field and in obstetrics as well, and scrutiny by independent analysts to determine whether or not a procedure has potential risks is common, and it should occur

for a procedure which is taking place later in gestation and where the dilation is greater and where data already exists to suggest that there is a connection between the new abortion and subsequent pregnancy complications notably pre-term birth, and this is a combination we are going to put forward to this Court, where you have a markedly different procedure later in gestation with greater dilation that has not been independently verified. Congress was certainly correct in finding that that was the case and was correct in expressing the concern that there are potential long-term complications here which have not been fully evaluated.

THE COURT: Mr. Coppolino, let me be as blunt as I can with you, not intentionally blunt. The question really is, did Congress really care about whether this was safe or unsafe? And I don't expect you to be in a position to answer that question, but one of the things I'm going to be interested in knowing is whether surgical techniques have, in the past, or are now being subjected to the sort of randomized studies that I think you're talking about. My understanding from your briefs is that there will be some disagreement between a medical historian and another physician about what is being done now. Why don't you address yourself to that question for me?

MR. COPPOLINO: I think we have just the witnesses for you, Your Honor, because that issue will be joined

before this Court. I think the plaintiffs would suggest that surgical procedures evolve informally. And certainly to some extent there is some trial and success which plays a role in the development of surgical techniques. You'll hear from witnesses on our side, specifically Dr. Mazariegos and Dr. Bowes who will address that issue, and you will hear testimony that in evaluating current medical practices, including surgery, evaluating the evidence matters. It is not simply a case that surgical procedures just evolve by trial and error and word of mouth and NAF Conferences. The current trend in surgery and in medicine in general is for evidence-based analysis of procedures, particularly where those procedures represent some significant changes in the current practice, which this one does, given its period in gestation and the amount of dilation; and secondly, most importantly, particularly where there are existing safe alternatives. You will hear evidence, for instance, that where there are no existing safe alternatives and the particular condition is extremely dangerous and people are dying from it, you're going to have a greater degree of unverified testing initially before you treat people.

At the same time, however, you will hear that there is almost invariably follow-up analysis. Even if you innovate, the medical community typically studies in the surgical field and elsewhere in order to assess whether what it's

doing whether it's great innovations are really working, and you're going to hear testimony when they have gone back and looked at some of these procedures, surgical and otherwise, they have found what they thought were innovations were not that good, that they needed to be tweaked, they needed to be stopped, or that they needed to be changed. Study matters, and I was about to say when you asked me about Drs. McMahon and Haskell, it's not for lack of cases to review here. Since the early 90s when this procedure came about, it has been occurring at a fairly substantial pace. The Guttmacher Institute, I think, estimated about three thousand a year. We can verify that number if I'm mistaking it, but over the past decade there has certainly been thousands of these cases where there could have been some effort made to study them to verify what would be the long-term effect on pre-term birth. For example, where we already have numerous studies, you will hear about from one of our experts who suggested that is a very significant complication. What is so sacrosanct about this procedure it can go unstudied when you have existing save alternatives which the plaintiffs concede that we do, and you've already heard testimony about that, that there are existing safe alternatives both as to D & E and as to medical induction at this period in gestation.

THE COURT: You don't dispute, do you, that D & E has been studied in a way that is sufficiently well grounded

that one can conclude that during the relevant gestational ages that D & E is the safest procedure, or at least among the safest procedures.

MR. COPPOLINO: I don't dispute that. Although we have to look carefully at what those studies actually show, and for example, I haven't seen a recent study comparing the benefits of D & E to, say, a medical induction in the prior study, some of which you cited in your prior opinion were more nuance than that, that they certainly recognized that D & E had a fairly remarkable safety record. You have already recited some of that data today.

THE COURT: That hasn't changed. I mean --

MR. COPPOLINO: I don't think the safety record of D & E, as it has been understood, the process of a dismemberment extraction, has gotten any worse. If anything, it may have gotten better or it's about the same, but .5 out of a hundred cases is very low as you've already heard, so there is no evidence that D & E is dangerous; yet here the plaintiffs' experts could suggest that D & E is dangerous when they start talking about the potential complication of sharp bony fragments or uterine perforation or more blood loss. It sounds as if this is a dangerous procedure that has to stop.

THE WITNESS: Honestly, I don't think they are saying that. I just think they are saying when you don't

have to undergo that risk, one ought not to take it, but go ahead.

MR. COPPOLINO: And yet they will also say, as I think you have already heard, that in skilled hands, that procedure can be safely performed and can be performed without risk to the woman, and is being performed without risk to the woman, as some of the plaintiffs themselves will attest.

THE COURT: Are you going to have any new numbers on D & E or inductions?

MR. COPPOLINO: No, Judge. I don't know about D & E on inductions. What we will have that is new that was not in your last record is we'll have witnesses who use modern, current induction termination.

THE COURT: Well, surely they have done a statistical study to tell me about its efficacy and its safety.

MR. COPPOLINO: We'll have to ask them that, Your Honor, but the fact of the matter is induction terminations are not numerous in number.

THE COURT: Well, there are thousands of them done every year, I mean, about the same number, I think, as intact D & Es.

MR. COPPOLINO: Your Honor, I think these will be questions we should put to the experts as to whether, what

is the basis of their view that these procedures are safe.

THE COURT: Go ahead.

MR. COPPOLINO: It may well be that some of our experts will say it is, based on their clinical experience, or they may well have some studies, and so clinical experience may cut both ways, but ultimately, you have to evaluate where, you know, where the true safety is going to lie, and where the best judgment lies here, and the point I started to make was that the existence of safe alternatives is a very critical factor in evaluating whether an untested unverified procedure should be permitted.

Your Honor, I would like to address some of the ethical issues the plaintiffs raised. This is a procedure which does appropriate both the language, the techniques of childbirth. The plaintiffs, you will hear testimony on that, and there is not likely to be any dispute, and that presents a very serious ethical concern because when you put all of the factors together, the existence of safe alternatives, the lack of a specific health need, the potential risks, and the ethical concerns such as the extraction of the fetus, while it is still alive, to a point outside the body of the mother before it is then killed, that presents some very serious medical problems and is also a painful procedure. Those are the four pillars that Congress legislated on and those are the four considerations

that the Court needs to take account of in evaluating this legislation.

With respect to the plaintiffs' arguments concerning the vagueness or the scope of the Act, we will address those concerns as well. They, initially, I think almost uniformly say that partial-birth abortion is not a medical term, but I think you will find, you may already have gleaned this, that the plaintiffs have a bit of a terminology issue themselves. They refer to the procedures that they use in the second trimester by multiple different names, and it's completely unreasonable to expect Congress would have picked one or excluded one when we can't seem to get a common term either. Sometimes there is no term. It's all just a D & E. Sometimes it's intact D & E. Sometimes it's D & X. Then there was intact D & X which is ACOG's definition which has been uniformly cast aside by virtually everyone as far too narrowly describing the procedures that are actually occurring out there. Today we heard another one, intact variation of D & E procedure. The name issue is just simply not going to factor in this because Congress looked at this landscape of so-called medical terms and said we can't pick any one of those because we don't know what they mean, because the medical community doesn't know what they mean, because they have got so many of them, so we are going to define a procedure as best we can clearly and anatomically,

and that's what they did in the Act. The plaintiffs say that the Act isn't precise enough because it hasn't, for example, specified that a sharp instrument must be used to puncture the skull or that the skull has to be suctioned. What you're going to find in hearing these medical experts that different techniques and, indeed, different instruments are used to accomplish exactly the same thing, and you will find as a result of that evidence that it stands to reason that Congress didn't try to specify procedures such as scissors and puncturing and suctioning because the end result would be the same. The fetus is brought out to a specified point alive and outside the body of the mother and then killed prior to the completion of the delivery.

The plaintiffs will try to argue, as I think Ms. Smith has, that all D & Es are covered by this band. They make that argument by taking pieces of the definition somewhat out of context in my view. The evidence will not support their arguments on that. The plaintiffs' doctors who do perform intact extraction, and not all of them set out to do this, but the plaintiff doctors who do intend to do an intact extraction do so in a manner that with minor variations is remarkably similar to the manner Congress described in the Congressional Record. There are a few changes, but you've already heard testimony about how the fetus comes out, the head lodges in the cervical os, they

puncture the back of the skull, they either drain or suction the cranial contents. That's exactly what Congress described in the Congressional Record. It indicates they know very clearly what procedure is at issue.

The plaintiffs' arguments are vagueness are a bit of the moving target. They say we don't know what's banned, but it's definitely safer that's a nonsequitur. They know it's banned because they do it, and they do it clearly, and they do it intentionally, at least some of them do. Some of these doctors don't seek to do intact extractions and that's a bit of a different category.

In that category there is concern expressed there may be a procedure in which the circumstances that are described in the Act happen unexpectedly, and that's something you're going to hear testimony about as well, but I have never seen a law with the words knowing, intentional, deliberate and purposeful in a shorter space of time than in the Partial-Birth Abortion Act.

Congress has used every adjective it could to describe that this procedure applies when a physician knowingly performs it, and knowingly is then described further as deliberately, intentionally, and deliberately and intentionally is then described further as having the purpose of doing it.

THE COURT: Let me ask you just kind of a practical

question. Seventeen weeks, generous dilation, breech presentation, but with the thought I'm going to do a D & E, reaches up, grasps the leg of the fetus, pulls and twists, and the fetus, save for the head, lodges, say, for the head, is into the vaginal cavity or out of the vaginal cavity for that matter. If the physician at that point then collapses the skull, does the physician violate the Act?

MR. COPPOLINO: My only answer to you can be with respect to the Act itself first and then the facts of the case. As you have described those facts, and as limited to the facts that you have described, it sounds to me that it was not knowingly performing a separate procedure which is then defined, which is then defined as deliberately and intentionally vaginally delivering the living fetus until it's in the vertex position or the head is outside or in the breech position until it's out at least of the torso for the purpose of then performing an act to kill it and then performing it. That didn't sound like what you just described to me, and it doesn't sound like what some of the plaintiffs are describing in their cases, and yet for others it sounds exactly what they are doing, the intentional, deliberate act, so I would certainly not say to the Court that a procedure which is not knowing, deliberate or intentional is covered because the law doesn't say that, and I think what we have to do to sort this out first of all, is

to gather the evidence with respect to those circumstances, to understand what the facts are when the plaintiffs say that that occurs, and then to evaluate that, weigh it against the law, and my last point on that would be to say for the Court to make a construction of the law, Ms. Smith made the point that the Department has not yet said what's covered by this Act, but of course, this Act was enjoined hours before it even took effect, and we are now in a process before the federal courts of this country where the Act will be before you for an interpretation, and the law is quite clear that where a constitutional interpretation is possible, one should be rendered, and I don't think there should be any assumption that an interpretation by this Court, ultimately by the Supreme Court, would not be followed, and you will be in interpreting a law which makes clear that a knowing and intentional act is at issue and when so indicated, that would be the limitation and the parameter of prosecution if there is to be a prosecution under this law.

Your Honor, in the days ahead, as I said at the outset, we are going to present to you a very robust record, I hope. I know you'll give us a full and fair hearing. That is all we ask, and we ask also that I think that the Court take into account that the evidence you're going to receive here is going to be far broader than you heard before, and that

you weigh it fresh and come to an independent judgment with respect to this act, particularly in light of the fact that the nation's legislators have acted with a great deal of consensus, they have done so with a great deal of study, and reflect also that it's quite difficult to ask judges to sort out what are essentially legislative facts. There is no particular reason why in the area of abortion, the analysis of medical fact really should be a judicial process only. Legislative process is well suited to analyze those medical facts. Congress has attempted to do that.

You asked before whether we should assume Congress cared or was objective, but it is our legislative body, and there is a -- there should be a presumption of deference in good faith for what they do. You'll scrutinize that, and if they are completely off the mark, you may so rule. I think you will find, though, based on the evidence you hear from the experts that we present, that they were far from off the mark, that many of their basic conclusions were correct, and if there is an expert that disagrees with one point or another, it's only because we are bringing in neutral, honest people here to tell you exactly what they think. We didn't ask people to come if they agreed with everything. We didn't ask people to come if they were just pro-life. You're going to find people of different persuasions here, and I think you're going to get a very balanced, expert

presentation. Thank you, Your Honor.

THE COURT: Before you step down, I asked Ms. Smith, and I want to ask you, am I going to hear anybody who does post -- I realize that viability, there are times when it's difficult to know, but am I going to hear from anybody who does post-viability abortions?

MR. COPPOLINO: Well, I think you heard from one this morning in the context of 24 weeks fetal demise. Twenty-four weeks is pretty well established as post-viable or the viability line is 23 weeks, 23 weeks, six days or so. I'm not accusing him of anything. I'm simply pointing out that there are instances, and particularly in the fetal anomaly area, where terminations may occur after 24 weeks. Now, the question is whether the plaintiffs are seeking to justify this law post-viability, and the answer seems that they are not.

You asked about the facial challenge versus as applied challenge, and I would certainly like the opportunity to assess the law and weigh in on that.

THE COURT: I really want the Government's help on that, because quite apart, I'm really bothered by trying to assess this dispute in the abstract, and I'll be very interested in hearing from the Government about how I ought to approach this whole idea of facial and as opposed to an applied, and I don't really even care about that so much

anymore, but whether -- what is the proper juris prudential role for the Court in a circumstance where it is not presented with physicians or at least very much evidence from physicians who perform these procedures or any procedures post-viable. What is the proper -- how does the Court deal with that.

MR. COPPOLINO: We'll address that, Your Honor, and I think there are various considerations. Relief is typically limited to the circumstances of the parties before the Court. You may find that one reason this issue has never really been joined is that it's never really been well raised. There has been a presumption if a law is invalid in one application, it just gets struck down when it has a substantially permissible application otherwise, that it could be upheld for, and that the parties who were before the Court didn't really have a stake in the interest, that had only a stake in the specific interest and not in the other interest that it could have been withheld. You'll also hear, as Ms. Smith points out, is it an issue of simply rewriting the law, or is it an issue of revalidating it as applied. If you find it should be validated, I don't believe there are grounds to validate it pre-viability.

THE COURT: I didn't mean to put you in a box in any way about that. But I do -- I'll be interested in having the Government's advice on that.

MR. COPPOLINO: We will, Your Honor.

THE COURT: Then I asked you that 17-week question. I'm going to ask you that again at the end of the trial. Make it as simple as you can, and then I'm going to ask you is this the person who does that procedure that I have described to you. Make those facts as simple as you wish. Will that person violate the Act, and I understood you to say essentially, given the hypothetical, I can't answer it because there aren't enough facts there, but I'm going to be asking you that again, so be thinking about it.

MR. COPPOLINO: I will, Your Honor. We'll gather the facts and then in our post-trial analysis we'll give you our construction of the law as it would apply to those facts. Thank you.

THE COURT: Thank you. All right. Ms. Smith, well, who is going to go first?

MS. CREPPS: Your Honor, I'm ready to call, if you would like to have evidence.

THE COURT: We'll go to -- What do you want to go to, five o'clock?

MS. CREPPS: Yes. If I get to a good stopping point --

THE COURT: I won't punish you. Call your first witness please.

MS. CREPPS: We would like to call Dr. William

Fitzhugh.

WILLIAM FITZHUGH, PLAINTIFF'S WITNESS, SWORN

THE COURT: You may inquire.

DIRECT EXAMINATION

BY MS. CREPPS:

Q. Thank you, Your Honor. Dr. Fitzhugh, can you tell the Court what state you live in?

A. I live in Virginia.

Q. And what is your profession?

A. I'm a physician of obstetrics and gynecology.

Q. I would like to have you open the notebook, the one that I believe is closest to you and flip to Plaintiff's Exhibit 92. Can you identify this document?

A. This is my curriculum vitae.

Q. And does this CV accurately reflect your experience and educational background?

A. Yes, ma'am.

Q. I'm going to ask you some questions off this, and I would like to start with having you describe your educational background starting with medical school.

A. I attended the Medical College of Virginia, graduated in 1966.

Q. And did you follow that with an internship?

A. Yes, ma'am. I did a straight medicine internship at the Indiana University Medical Center, straight medicine.

Q. And how long was the internship? Did you say straight medicine?

A. Yes. It's one year, ma'am.

Q. Okay. And then did you follow that with a residency?

A. 1969, obtained a residency in obstetrics and gynecology at the Medical College at the Virginia Commonwealth University.

Q. Do you also hold a Master's in Public Health?

A. Yes, ma'am. I obtained one in 1975 from Johns Hopkins University.

Q. Why did you get an M.P.H. in addition to your medical degree?

A. I found medicine was dealing more with patients coming to you and public health was looking at the whole population in general, and I have an interest in the whole population in general.

Q. Now, while you were receiving some of your medical training, were you in the military?

A. Yes, ma'am. I went in the military under the Barry plan right after my straight medicine internship in 1966 and stayed until 1975 which would include my residency. I was on active duty at that time.

Q. And in what branch of the military?

A. United States Air Force.

Q. And so during that time, were you practicing as an

obstetrician/gynecology?

A. The first year I was a flight surgeon in New Jersey. The last three years I was an officer at the Malcolm Will Medical Center in Washington, DC.

Q. And what type of medicine were you doing for the last three years?

A. Obstetrics/gynecology primarily.

Q. What positions did you hold there?

A. I was assistant chief of the obstetrics/gynecology department at that time.

Q. And when did you leave the Air Force?

A. On about 1975.

Q. So how many years were you in the Air Force?

A. Eight years.

Q. What rank did you hold when you left?

A. Lieutenant Colonel.

Q. Where are you licensed to practice medicine?

A. Currently licensed in the State of Virginia.

Q. And when were you first licensed in Virginia?

A. I believe it was 1966.

Q. Are you board certified in obstetrics and gynecology?

A. Yes, ma'am, I am.

Q. Are you a member of ACOG?

A. Yes, ma'am, I am.

Q. Are you a member of any other medical organizations?

A. Yes, ma'am. I am.
Q. Can you tell the Court, give the Court the names of some of those?
A. I'm a member of the Medical Society of Virginia, member of the Richmond Academy of Medicine, member of the Richmond Obstetrical and Gynecological Society, member of the Virginia Obstetrical and Gynecology Society. I believe I dropped the Infertility Society.
Q. Okay. I'm going to ask you just to speak up a little bit.
THE COURT: Doctor, I'll tell you what. That chair is bolted down, so even try as hard as you like, you aren't going to move it, so --
THE WITNESS: I'm a little nervous, sir.
THE COURT: I understand. If you pull -- the mics kind of like this together, and then even though our mothers told it wasn't polite to put our elbows on the table, if you will put your elbows sort of like this, that will force you into the mics. There you go.
THE WITNESS: Thank you, sir.
THE COURT: Go ahead.
BY MS. CREPPS:
Q. I would like to have you tell the Court, describe your medical practice since leaving the Air Force.
A. Since leaving Air Force I started my practice in

Richmond, Virginia. It's currently divided in almost half timewise, probably, and one-half is the routine general practice of obstetrics and gynecology, delivering babies, infertility, surgery. The other half is, I started the provision of abortion services in Richmond, Virginia under the auspices of Richmond Medical Center for Women, and I have facilities in Roanoke, Virginia, which is about 180 miles, and Newport, Virginia, which is about 70 miles away.

Q. And what is your position with the Richmond Medical Center for Women?

A. Essentially the owner.

Q. Okay. And in addition to abortions, are there other services provided at those centers?

A. Well, the Richmond Medical Center for Women, we provide family planning, we provide abortion services of both types. We, just this past year, because of inability for the Spanish immigrants to find maternal care, we are providing -- I'm providing maternal care for a group of people that cannot afford maternal care.

Q. When you say maternal care, is that for women who are pregnant?

A. Yes, ma'am. That means they are pregnant and they want to deliver a baby, so I assume their care and deliver them and do the post-partum care.

Q. And is that at all three locations, or is that more

limited?
A. Just in Richmond.
Q. All right. And in your private OB/GYN practice, I believe you stated that you also treat pregnant women. Is that correct?
A. Yes, ma'am. I deliver currently about five babies a month. Before that, before I had my -- I brought in three partners this past two years. Before that we were doing -- I was doing up to 20 to 30 deliveries a month.
Q. And can you estimate about how many patients you see a week from your private practice, your private OB/GYN practice?
A. Private OB-GYN practice, I probably see about 75 patients a week.
Q. As part of that practice, do you treatment women with high risk pregnancies?
A. Yes, ma'am, I do.
Q. And if one of your obstetric patients is high risk, do you also refer her to a maternal fetal specialist?
A. Yes, ma'am. We are very close working with the maternal fetal service. One was my former partner who started the service, so we are very close, but at the same time I have done this for many years and handle a lot of problems myself sometimes.
Q. And if you do refer one of your patients to the maternal

fetal service, do you still remain involved with her care?
A. Yes, ma'am. We do it in conjunction. They don't do any delivery, so we would seek their advice and follow their advice if it was deemed appropriate.
Q. So you would still do the delivery in those cases?
A. Yes, ma'am.
Q. Do you ever induce labor for your pregnant patients?
A. Yes, ma'am.
Q. And can you tell the Court what drugs or what types of drugs you would typically use for that?
A. The various types of Prostaglandins, Prostaglandin gel, Prostaglandin tape and a pill Cytotec, Misoprostol for induction.
Q. And do you provide any services at other locations than the three Richmond Medical Centers you have described and your private practice?
A. Yes, ma'am. There is about two main hospitals I primarily use which is the Medical College of Virginia which I hold a clinical instructor's appointment. I was on the fulltime staff from 1995 approximately to 1998 or '9, and Medical Doctors Hospital, Richmond Regional Memorial Hospital, three other hospitals I sometimes use.
Q. Any other locations?
A. Outside of hospitals? I also work at the Fan Free Clinic. It's a clinic I started in 1969 when I was a

resident, provided indigent services, and we provide routine gynecological services for indigent patients. I'm the medical director right now.

Q. Now, I would like to go back to something you mentioned just a moment ago which was that you were on the faculty of the Medical College of Virginia from, I believe you said 1995 to '98 or '99. Can you tell the Court what that position involved?

A. That position involved instruction of all aspects of obstetrics and gynecology from delivering babies to monitoring the maternity ward to assistant residency and gynecology patients, obstetrical patients, to doing surgery, hysterectomies, laparoscopes, treat patients in emergency room, waking up in the middle of the night, answering the resident's problems, many problems.

Q. Do you retain any position at the University's Medical College?

A. I'm a clinical instructor right now which means I have privileges to admit patients to the service if they have a problem at the Virginia Commonwealth or University. I sometimes interchange at the Medical College Virginia Commonwealth because I got my degree from the Medical College of Virginia and Virginia Commonwealth University merged, so it's sometimes a little confused. I'm sorry, but so I have a position, and that means that while I'm doing

surgery, if a resident wishes to become part of my procedure in observing and being instructed, that I do that.

Q. So that's mostly an observational?

A. Mostly observation.

Q. Opportunity for the physician?

A. As they desire. There is no requirement for them to come be with me.

Q. All right. Doctor, I would like to ask you now some questions about your abortion services. You provide abortions in both the first and second trimester; is that correct?

A. Yes, ma'am.

Q. Up to approximately how late in pregnancy do you provide abortions?

A. Typically up to about 20 weeks. I do up to 22 weeks.

Q. And when you say 22 weeks, can you tell the Court how you're measuring that?

A. By the -- We use ultrasound and measure by the last menstrual period.

Q. And that would be you would refer to that and LMP?

A. Yes, ma'am.

Q. Can you tell the Court what types of abortion procedures you currently provide?

A. We provide early medical abortion. We provide first trimesters, D & C, second trimester, D & E, and I do have a

problem of terminology because I generally just terminate pregnancies, and I don't have in my mind a procedure that I use, so --

Q. But generally, those are the terms that you would apply?

A. Generally, most of the time I just say I'm terminating a pregnancy.

Q. Can you estimate how many first trimester abortions you perform in a year?

A. Currently, I do about 70 a week. It's too late for me to multiply that out.

Q. That's fine. If you would rather estimate in weeks, by week, that's fine, so approximately 70 a week?

A. Approximately 70 a week, yes.

Q. What about first second trimester abortions?

A. Second trimester abortions, I do about five to seven a week.

Q. Do any of your second trimester abortion patients come to you by referral?

A. Yes, sir, approximately a third, 25% to 30% are referrals.

Q. And for what reasons are women referred to you for these procedures?

A. Most of my referrals are from maternal fetal medicine physicians due to maternal reasons and due to fetal reasons.

Q. And when you say maternal reasons, can you tell the

Court what you mean by that?
A. Maternal indications is where the maternal fetal medicine or the person who has referred them to the maternal fetal medicine feels like the pregnancy would endanger the health of the mother, and the fetal indications are various types of genetic types, they are various types of structural like hydrocephalic, encephalic, too large of a head, too small of a head, lacking kidneys.
Q. And can you give the Court some examples of some of the maternal conditions that you have seen, like for your second trimester abortion patients?
A. I have seen diabetes, I have seen left heart failure, I have seen right heart failure, I have seen infection, I have seen breast cancer, I have seen suicidal, I have seen schizophrenics, I have seen Hodgkin's disease where we felt the mother needed to be treated prior to the end of her pregnancy. These are the ones, I don't know if I mentioned infections of the mother.
Q. All right. Thank you.
MS. CREPPS: Your Honor, at this time I would like to move into evidence Plaintiff's Exhibit 92 which is Dr. Fitzhugh's CV?
MR. HENRY: No objection, Your Honor.
THE COURT: 92 is received.
BY MS. CREPPS.

Q. Dr. Fitzhugh, I'm going to ask you some more questions about your abortion practice. Do you recall what year you first started providing abortions?

A. I first started in 1969 prior to the enactment of Roe vs. Wade while I was a resident at the Medical College of Virginia, Virginia Commonwealth University.

Q. And at that time before Roe versus Wade was decided, under what circumstances could you perform abortions?

A. We could perform abortions to protect the life of the mother.

Q. And during that time before Roe was decided, did you ever treat women for a complications from illegal abortions?

A. Yes, ma'am, they had an active service in Richmond, Virginia, so we had a lot of we had a lot of retained fetal parts. We had a lot of retained instruments, we had some septic patients. That means they got infected. We went the various gamut of problems.

Q. And why did you decide to include abortions in your practice after the Roe vs. Wade decision?

A. Well, I really started before the Roe vs. Wade because the -- the amount of faculty members at the medical college was very small, so the services were very divided, so there was a very rich-poor disparity going on at that time, probably currently somewhat, but I saw a lot of women that were able to get abortions by going through the

psychological evaluations, and I had several indigent patients that I felt was just as traumatized by their pregnancies, that I presented them to the committee, and then I was the one that was chosen to continue the providing of abortions, and I did so because I believe in women's reproductive rights.

Q. Are your second trimester abortion patients only from the Richmond area?

A. No, ma'am. We serve a large geographical area. The majority are as far as Fredericksburg which is about 60 miles from Richmond to outside of Stanton which is about a hundred miles, to Newport News which is about 70 miles. We have others from the Washington-Maryland area and from the Carolina area, North Carolina. I'm sorry.

Q. I need to back up and have you clarify something for the Court. Where physically do you perform your second trimester abortion?

A. They are all performed at the hospital at the Medical College of Virginia, Commonwealth University, or the Interactive Doctors Hospital, and one of the two or three various hospitals on infrequent occasions.

Q. So the second trimester abortions are not performed, for example, at your Roanoke or Newport News Clinic or Richmond Center for Women in Richmond?

A. No, because Virginia law currently mandates that the

second trimester be performed in a hospital.
Q. What is the age range of women for whom you perform second trimester abortions?
A. I have performed them as early as 12 and as late as 49.
Q. Can you tell the Court some of the reasons why your second trimester patients are terminating their pregnancies in addition to the fetal internal that you have already discussed?
A. We have a few, probably not a few, but I say two to five, but it may be a little bit more because it seems the -- of rapes, we have two to five incest per year and the various gamut of problems that we deal with, and emotional stress that women -- When I was younger I was able to talk to a woman and determine whether she needed it or not needed it. Based now, one can decide if she's doing it on a reasonable basis and allow her to make her decision.
Q. Going back for a moment to the second trimester abortions you perform for maternal health situations, you mentioned cardiac problems in diabetes which sound to me like preexisting health issues. Are there problems that arise because of the pregnancy for which women seek second trimester abortion from your service?
A. Yes, one of the recent ones was with a young lady that had developed this preeclamptics about 21 weeks, and that was hypertension of pregnancies, toxemia pregnancy is

another term that's used, but she developed high blood pressure and decreased kidney output at 22 weeks, and it was requested that I terminate her pregnancy.

Q. When you first started doing abortions in the second trimester, what methods did you use?

A. Came to my residency and we did them in the residency program. We did the safest procedure called a saline injection for a termination. You inject a hypertonic or strong salt solution into the amniotic for the fluid around the baby, and this has caused contractions and deliver them. Then about when I first came out of the military in 1975, I was doing maybe 20 to 25 a week at that time. It wasn't quite as acceptable as it is now to be a single parent, so it was a lot more higher numbers, and I think we have gotten better use of contraception so that my numbers have progressively reduced. However, I did a large number of saline inductions at that time, and the trauma to the mother, the side effects that I had made me stop that procedure and go to a completely suction or remove the fetus vaginally.

Q. And about when did you start to move away from using inductions and using -- is it fair to call the other procedures you started to use surgical procedures?

A. Yes, ma'am. It would approximately be 1979, 1980, probably '79.

Q. And at that time, were you doing some surgical abortion?
A. Yes, I have done always done first trimester surgical abortions, and so I started doing second trimesters.
Q. And how did you change your practice so that you could start doing second trimester abortions using surgical techniques?
A. Well, I just started gradually progressing on the amount of dilatation I did. And the -- then after awhile, after awhile, after several complications, I started using laminaria. That was found to be safer, and I currently use laminaria without the progressive dilation that I did earlier.
Q. And in addition to changing over to use the laminaria for dilation, did you use any additional instruments as you started to do abortions in the second trimester?
A. As you get past 12 weeks or 11 weeks, you then have to use an instrument we call ring forceps. It's a round instrument that we insert into the uterus. We use that to grasp the fetus.
Q. So as your practice evolved to perform abortions later in the second trimester, then you used more dilation and started to use the ring forceps; is that correct?
A. Yes, ma'am.
Q. I would like to ask you several questions now about the dilation that you use for second trimester abortions. And I

would like to have you start by describing for the Court the basic process that you use to achieve dilation in the second trimester.

A. The basic process that I use is the osmotic dilators called laminaria. It's a Japanese seaweed. This is placed on the day before a procedure is being performed at the Medical College of Virginia. First, we -- the patient has been evaluated and had an ultrasound and the biparietal diameters and is correlated with the abdominal circumference and the femur length which gives approximately gestational age. It gives a fairly accurate gestational age, I think, and under no anesthesia, the woman is -- the laminaria is inserted into the woman's cervix after it has been cleaned off with a Betadine and septic solution.

Q. And why is the method of dilation important during an abortion?

A. The cervix is designed so that it holds the pregnancy in until term. Then it starts dilating and opening, so it's relatively inelastic earlier and more elastic later. The final picture is a small rubber band, really, and a large rubber band later on. If, and earlier on when I was learning, when we did not use the laminaria early on, we would dilate the cervix, and that small rubber band would break. As we were extracting fetuses or fetal parts, we would have to repair the cervix sort of like a cesarean

section. Would happen about three times a year.
Q. The condition that you're describing, is that what you would call a rupture of the cervix?
A. Yes, sir. I call that ruptured. It happens to about, it's a level where the vessels are in the uterus. It's a little confusing because some people say it's a perforation of the uterus, but I consider perforations when you actively put something through the uterus as compared to a mechanical rupture of the cervix.
Q. Just so we can be clear on our terms, can you tell the Court what a cervical laceration is as compared to a cervical rupture?
A. To me, a cervical laceration is when you have a tear on the external portion of the cervix. This can continue upward into the uterine cavity a little bit, but it's visible externally for the most part.
Q. And I believe you said that in order to fix a cervical rupture, you had to go in through the abdomen as like a cesarean section. How do you fix a cervical laceration?
A. Actually, you put a suture into the -- stitch into the cervix.
Q. Now, can you tell the Court how the laminaria affect the cervix?
A. The laminaria absorbs fluid from the mother, female, at that point in the cervix. We think of it working primarily

as a mechanical dilator, but it's not. It's more of a as-time-goes-by, the cervix makes the changes that it normally would during the induction period. That is, it became -- the protein becomes different, and the cervix has more stretchability. I commonly might say the cervix is softer but it really has more stretchability, more elastic, more elastibility, more elastic.

Q. And the fact that the cervix becomes more elastic, how does that affect its ability to accept pressure from either fetal parts or instruments?

A. As it becomes more elastic, it allows structures, well, the mechanical process does open it up, and you are allowed to put instruments into the uterus, and those products inceptions that you remove from the uterus are allowed to safety be removed from the uterus, so the incidents drop from three a year where I would have to operate to maybe one in the past one or two in the past five years.

Q. So the use of laminaria has decreased the incidents of cervical rupture?

A. Yes, ma'am.

Q. Do all laminaria -- Well, let me start by asking, do laminaria come in more than one size?

A. A laminaria is a -- I'm sorry. I haven't looked up how they produce or make it, but it comes in a variety of shapes. The one is identical to the other as far as about

the same length of each one of them, but the different sizes from I would say an eighth of an inch up to a quarter of an inch, and they'll absorb, about a quarter-inch will go past about a cigarette size when you remove it.

Q. And if you had two laminaria that were about a quarter of an inch when you started out, do they expand exactly the same?

A. No, ma'am. They expand -- expansion is variable.

Q. If you put the same number of laminaria of similar sizes in a hundred women, what would you expect in terms of the amount of dilation that you would see in those women?

A. Well, each would be different. In medicine, we speak of this bell-shaped curve where the majority is in the middle, but there is some on either side. Some, it hasn't dilated enough or about the same or more dilates more than you would like, and I wouldn't say more than you would like but more than you expect.

Q. More than average; is that what you --

A. More than the typical.

Q. And what influences the amount of dilation that you would get?

A. It's primary how the mother or the woman responds to the material, probably has something to do with how much fluid she has in the cervix, also has to do with gestational age. Has something to do with parity which is the amount of

babies that she has, although frequently, how we get a greater than expected dilation with a young individual who has never had a child.

Q. And does the insertion of laminaria ever cause some women to go into labor?

A. Yes, ma'am, it will.

Q. Does that happen every time or occasionally? Can you quantify that for the Court at all?

A. Other ones, I do somewhere around, I would say it happens three times a year.

Q. And how does that affect the dilation that you get?

A. You'll get more dilation.

Q. Now, when you mentioned that one of the effects of insertion of the laminaria is increased elasticity in the cervix, or I think you described it as a softening of the cervix. Is that something that you can assess when you remove the laminaria?

A. I get some kind of a feeling for it when I remove it and you have -- we have some difficulty removing laminaria, you realize it hasn't dilated as much as you have ease or they fall out on you, so but looking at the cervix, I generally cannot tell.

Q. And I gave you an example earlier of putting the same number of dilation in a hundred women, but in your experience inserting laminaria for second trimester

abortions, can you, in fact, insert the same number of laminaria for every woman?

A. No, ma'am. There's two variables. One is the condition of the cervix. That has something to do with whether she's had children to some extent, but -- because it's never -- it's never the same. We have a young 12-year-old that you think would have a lot of difficulty putting one laminaria in, and suddenly you're able to put four laminaria in, so it's so much individual variation of women that you aren't able to make a determination beforehand, but only while you're doing the insertion of the laminaria, and some women will be able to tolerate you putting one laminaria in because we are doing it under a local, and we try to minimize the pain level to her or even her tolerability to certain laminaria that sometimes I'm limited to where she might have been 20 weeks, I might have thought, gee, I'll put four laminarias, and I have only been able to put two laminarias in.

MS. CREPPS: Your Honor, I'm at a good spot to stop for today if that suits you.

THE COURT: It does. Is that agreeable with you, Mr. Coppolino?

MR. COPPOLINO: Yes.

THE COURT: We'll take our break now, and we'll start again at 9:00 o'clock in the morning. Let me see the

lawyers at the bench or a lawyer from each side at the bench here for just a minute, please.

(Side bar)

THE COURT: Do you have any security issues you want to take up?

MS. SMITH: I think we are fine so far. There wasn't much. Dr. Carhart and Dr. Fitzhugh walked over there together today. Would you tell us, and I think that made it fine as long as they stay away from us.

THE COURT: Well, I'll leave it to you. If either one of you need, have any concerns, let me know. I'll make certain the marshal service handles it.

MR. COPPOLINO: We encountered one heckler coming in who thought we were on your side, but in any event, she was heckling us. She didn't threaten us in any way.

MS. SMITH: Saw a few trucks and signs going on, but I haven't seen anything else.

THE COURT: Would you let us know, either one of you if you have any concerns. We'll do whatever we can. We'll see you in the morning.

THE COURT: All right. Ms. Bunjer, I'll see you and the agent if you want to come forward now.

(End of side bar)

THE COURT: We are off the record and we'll see you in the morning at 9:00 o'clock.

(Recess at 5:01 p.m.)

C E R T I F I C A T E

I, David C. Francis, certify that the foregoing is an accurate transcription of the record of proceedings made in the above-entitled matter.

s/ David C. Francis DATE: March 29, 2004

Official Court Reporter (Ret)

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