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 30, 2004 9:00 a.m. Lincoln, Nebraska

VOLUME II,
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:

FOR THE PLAINTIFFS:
PRISCILLA J. SMITH
JANET CREPPS
NAN E. STRAUSS
Attorneys at Law
Center for Reproductive Rights
120 Wall Street, 14th Flr.
New York, New York 10005

JERRY M. HUG
Attorney at Law
1823 Harney Street, #1004
Omaha, Nebraska 68102

FOR DEFENDANT:	ANTHONY J. COPPOLINO PREEYA M. NORONHA TERRY M. HENRY ANDREW I. WARDEN U.S. Department of Justice Civil Division - Federal Programs Branch P.O. Box 883 Washington, DC 20044
COURT REPORTER:	DAVID C. FRANCIS, RMR Official Ct. Reporter (Ret) 6300 Briar Rosa Drive Lincoln, Nebraska 68516

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(Tuesday, March 30th, 2004, at 9:00 a.m.)

THE COURT: Good morning. All right, Doctor, if you will retake the witness stand, wherever you are. There you are.

(Dr. Fitzhugh resumed the witness stand)

THE COURT: Ms. Crepps, you may inquire.

MS. CREPPS: Thank you, Your Honor.

BY MS. CREPPS:

Q. Dr. Fitzhugh, I'm going to remind you to speak up a little bit so everyone can hear you.

A. Sorry.

Q. We finished yesterday -- we were talking about the dilation processes that you used for second trimester abortions. And I'm going to ask you some more questions about that. Can you insert the same number of laminaria for every woman at the same gestational age for your second trimester procedures?

A. It depends on several things. Number one is the gestational age. Natural opening of the cervix occurs as the gestational age goes up. So whereas a -- ten weeks, you could get a minimum amount of laminaria in. And 24 weeks, you probably could get six to eight comfortably, given all circumstances. Now, the difference, as I said yesterday, may be, but the size of laminaria vary so -- and the size of the cervix varies with each individual woman. So -- and the

comfort level of a woman varies. So I may be able with the same size cervix put two laminarias comfortably in a lady, and in another one, I may be able to put three or four. So that will vary on her comfort level and the -- her ability to tolerate the discomfort associated with the procedure. It also determines on the condition of the cervix. Sometimes you'll have a speculum -- you'll have a cervical incompetence or a relative cervical incompetence. That means it's already open. You won't have to put any laminaria in, and you just wait for the next day. Sometimes she's had surgery on the cervix which allow more laminaria to be inserted, and sometimes she's had some cryo surgery where the cervix is tougher so you do not get as many in.

Q. In your opinion, Doctor, is it possible to force laminaria into the cervix?

A. Well, you know, always the answer is you can probably do anything, but you put it to the level of my comfort, which is that the number will go in fairly easily that you don't have to apply -- apply a lot of pressure. You don't want to apply enough pressure so that you would go through the uterus on the side and cause major bleeding or infection. And as I said earlier, as you start getting more laminaria in, the lady starts getting more uncomfortable. So you have to -- you have your limit there on her comfortability level.

Q. Do you use some kind of a pain killer when you insert

the laminaria?
A. No, ma'am. I suppose you could use xylocaine, but my experience in using xylocaine around -- which is a numbing agent, around the cervix is that you have just as much discomfort with the injections as you do putting the laminaria in. So I would rather put the laminaria that she's comfortable with me inserting into her cervix.
Q. So is -- are you getting some feedback from her about her comfort level, as you're inserting the laminaria?
A. Yes, ma'am. She's in an awake position and so -- so she's giving me immediate feedback and, you know, I tell them that this is going to be uncomfortable. The exam is uncomfortable. Many times you put laminaria into the uterus or the cervical cavity without really a significant amount of discomfort. Sometimes you have to put one in and you have to wait a little while and calm it down, then put one or two more in. Sometimes you have to place a tenaculum on the cervix to straighten the cervix out, which is a grasping instrument. It's got some sharp points on the center so you can stabilize the cervix to put some in, and that's relatively uncomfortable too.
Q. Have you ever had a situation where the laminaria did not provide enough dilation for you to remove the fetus?
A. I have had one, maybe two cases, that I can remember where on the next day, there was not enough dilation. And

we had to stop the procedure and we insert laminaria at that point and bring them back the following day. But that has only been once. I mean in 24 years.

Q. Do you ever use mechanical dilators after you remove laminaria?

A. I will if I cannot get the cervix open to a -- insert the number 14 Pratt dilator. So, yes, ma'am, I did do that occasionally.

Q. Have you ever had to use smaller instruments than you would prefer, because of the amount of dilation that you have gotten?

A. Yes, ma'am. I have done that too.

Q. And do you have an opinion about whether that's advantageous or disadvantageous to use smaller instruments?

A. It's more disadvantageous because it's a -- it's a longer, more complicated procedure to use smaller instruments.

Q. And, Dr. Fitzhugh, are you aware that some physicians routinely use serial laminaria, that is over two or three days with multiple insertions?

A. Yes, ma'am, I am aware.

Q. Are you also aware some physicians are using cytotech, either alone or in conjunction with their dilations?

A. Yes, ma'am. I am.

Q. Why have you chosen to stay with the procedure that you

have described, the one-day laminaria?
A. In my medical career, I have found out that the least that you do safely is the best. If we start adding things into the equation, you may have more complications. The serial laminaria would involve having the patient spend an extra day in the area, if she's not from the Richmond area, which many of my patients are not. And I don't use cytotech because I have occasional patients that will go in labor and deliver prior to the procedure the next day. And this is always an awkward position to be placed in for both patient and me.
Q. Okay. Let's talk now, after you remove the laminaria, what's typically your next step in the procedure?
A. Okay. Well, I place the laminaria in the day before, or my assistants place the laminaria in the day before. Then at the hospital, we go over routine things. And I only do my procedures in the hospital, as I might have mentioned yesterday. And that's the Virginia Commonwealth University and primary also Henrico Doctor's Hospital. We use not a general anesthesia for the most part. Occasionally we do, but I find that if I use general anesthesia, I have a little bit more blood loss than if I do what we call a standby or a conscience sedation. And that's given IV medications to relax and narcotics with that. So you're not all the way asleep, but if I say, Mrs. Jones, take a deep breath, she'll

take a deep breath. And if I cause some situation where she has more pain, severe, a lot of pain, she will respond to that by movement or -- so for me, that's a more comfortable position having her awake. She doesn't have the after effects of having a tube in her mouth or more anesthesia. If I were to do some perforation or grab a bowel or something like that, she would be awake enough to tell me I was doing something unusual.

Q. Okay. And then after she's received whatever anesthesia or pain management she's going to have, then what do you do next?

A. At that point, we place her up in a dorsal lithotomy position which is the old fashioned stirrups where the legs go up in the air, and then we -- what's called prep her, put some drapes on the patient and wash her off with Betadine, which is an antiseptic agent. I place a speculum in the vagina. We have sponges at the laminar, so it's laminaria and sponges. Then I wash the cervix off again. I then place local anesthetic around the cervix and grasp -- originally I grasp with a ring tenaculum, which is a sharp instrument. Now I use a ring forceps to stabilize the cervix which has less trauma to it. I might mention, at this point, that I tend to use a small speculum. Speculums come in different sizes. Most obstetricians are comfortable using larger speculums. Smaller speculums allow me less

distance from the operating site to where I am, so I'm more comfortable using smaller type speculums than larger.

Q. Let me ask you about the ring forceps that you just described. What do you actually do with the ring forceps and the cervix?

A. Initially, just grasp -- the cervix presents as a round sort of like putting my fingers together. So you just grasp the top part of the cervix and that stabilizes it and holds it for you. You have a tendency to pull down on the cervix as you stabilize it.

Q. And does the use of the speculum or the ring forceps ever change the distance between the cervix and the vaginal introitus?

A. It can, but as you look at the cervix, we think about the vagina being the same depth or something, but the cervix and depth of vagina varies with each individual person. I can have a large lady and her cervix be as much as eight inches from the outside of the vagina. And I could have a young -- and I find it more common in a young African-American and I open the cervix -- open the speculum and the cervix is right there at the introitus without pulling. So it varies from individual to individual. And I actually wouldn't say there is any average distance, length from the opening of the outside of the vagina to where the cervix is, after I have removed the sponges and the

laminaria.

Q. So you testified that the cervix could be right at the plane of the vaginal introitus or opening of the vagina. Does the cervix ever come past that?

A. Yes, ma'am. Occasionally what you do is prolapse. The actual where it comes outside of the vagina tends to be on a lady that's had more children. But certainly, as I said, pulled on it, I mean pulled on the cervix, because that sounds like I really tug on it, but it's just to stabilize it with your hand to hold things so you can work.

Q. Just to be clear, so when you attach the ring forceps, you're not actually pulling on the cervix but the effect can be to bring the cervix down?

A. Right.

Q. How frequently would you estimate that the distance between the cervix and the introitus is fewer than two centimeters, when you begin to remove the fetus during the second trimester abortion?

A. Well, I estimate on my first trimester, it happens one in seven. And I didn't do a study. I just -- over a period of days, sort of counted and how many there was. And then the second trimester, as much as one in three.

Q. Do you have an opinion as to why you think there is a difference in that -- you see the cervix closer to the introitus more frequently in second trimester abortions than

in first?
A. Well, as the uterus gross, the ligaments have to relax to accommodate the uterus to grow, and upward motion to accommodate the growth of the pregnancy, and growth of the infant. And so if it's going to be that loose to go up, it's that loose to come down. So it's a play in the ligaments as the pregnancy advances, and it's also maybe a little bit function of the anesthesia relaxing the ligaments also that you give the patient.
Q. Do you think that having little or no distance between the cervical os and the introitus changes the risks of the procedure at all?
A. No, ma'am. Although the cervix being closer to you allows the procedure to be carried out at a plane closer to you so that you are not -- I have -- at the hospital, I have what's called large instruments and small. So my standard tray contains a standard small ring forceps. And if I have a cervix that's far away from me and a lady that's a little bit heavy, I have to get out what's called the large instruments, which standard instrument is about 12 inches long. Large instrument is up to 18 to 19 inches long. So, yes, it's more safer working at a lower distance.
Q. Do you ever remove the ring forceps from the cervix either prior to or during the removal of the fetus?
A. Yes, ma'am. I frequently do, because I tend to place my

hands on the abdomen. So I'll remove the ring forceps and frequently use that ring forceps as the instrument I remove the pregnancy with. So the cervix will stay where it's positioned.

Q. So the distance between the ring forceps and the cervix doesn't move when you remove the ring forceps?

A. No, ma'am. It does not.

Q. During the gestational ages -- well, during second trimester abortions, can you tell the Court what the range is of the length of the fetus?

A. Range of length of the fetus? Well, I imagine it's approximate -- I have to stretch things out in my mind over the years, but as we do a 13-week pregnancy is probably about two inches or under. As I do a 20-week pregnancy you're talking about a length of, I would say, eight inches.

Q. All right. I would like to move now and have you describe for the Court your process for actually removing the fetus. And I would like to have you start by describing the different positions within the uterus that you might find the fetus, at the point that you're ready to begin removal.

A. I have to start out by answering that this is all a blind procedure, and I do not use ultrasound technique to determine the position of the fetus. And at this early gestation, I'm unable to feel abdominally the position of

the fetus. So I have no idea where the fetus is at the start of the procedure. But it can either be in a vertex position with the head down. It can be in a breech position with the buttocks down, or it can be a transverse with either head to the left or the right and the feet on the opposite direction.

Q. When you're in the process of removing the fetus, what is your first step?

A. The first step, after placing the xylocaine, is using the suction to remove the amniotic fluid which ruptures the amniotic sack; integrity of the amniotic sack. If I'm fortunate, two things will happen at this point. One of two things, if I'm fortunate. It's my own mind. I have done this long enough to do it almost any way or how, but I prefer that either a foot will come down into that suction, or the umbilical cord will come down into that suction.

Q. Before I have you talk about those circumstances, can you tell the Court why the first thing you do is to use the suction to remove the amniotic fluid?

A. Well, the fetus is in a sack, so you have to get that sack out to move the fluid and it comes as two things. One, it removes the fluid and the uterus gets smaller. So it's less of a -- the uterus will contract down as you remove the fluid. So you accomplish that, and also, you could just break the amniotic sack with a ring forceps too, but I like

the fluid. I get a lot of fluid out and fast, and there is something in the back of my mind that you'll get less fluid, you have the less risk that you have of an amniotic fluid emboli, which is fluid in the maternal circulation which causes sudden shock. And I guess that's the most dread that we all have of doing these procedures is having a severe reaction like that.

Q. All right. Going back now, I think you said in some instances when you use a suction cannula, that part of the fetus or the umbilical cord will come out through the cervix. Then what do you do at that point?

A. Well, if the umbilical cord comes down, I unattach that from its integrity. I just break it and pull on it. If a foot comes down, I grab the foot and pull down on that.

Q. If no part comes down, as a result of the suction, what do you do?

A. Then I have to place the ring forceps up into the uterus and find a part.

Q. And is there a particular part that you're trying to grasp, at that point?

A. I take whatever I can get, because I have really -- I have a feel of when you feel the cranium of the head, but that's about the only thing I have a feel of when you grasp until you pull it down.

Q. And when you grasp the part, can you describe to the

Court the motion that you use with the forceps?
A. I just pull down with the forceps and, you know, see what part you have, and see if you can get more of that part out. If you get more of the part out, you twist to try to get more tissue out. If that doesn't happen, then you pull hard enough that it will disarticulate at that point or break off at that point.
Q. Does the part that you have grasped pass through the cervix while still connected to the part of the fetus that's inside the uterus?
A. The majority of the time it does. Yes, ma'am.
Q. And does the grasped part ever pass the vaginal introitus while still connected to the part of the fetus that's inside of the uterus?
A. Yes, ma'am, because of those times where it's situated right there, it's going to be out where the cervix is right at the introitus.
Q. Does it ever occur that the part that you have grasped in the forceps breaks off from the rest of the fetus before entering the cervix at all? In other words, entirely inside the uterus?
A. Yes, it can. Remember, it's got to break off with pressure and you have to have -- it just won't break off because it's in the uterus. You have to pull it against something so it's going to be against the interior portion

of the uterus. So you have to have something pulling it. So if you have a limb that's on the interior of the -- on both sides of the uterus, and you pull on it, it will break off at that point.

Q. If you wanted to ensure that the dismemberment occurred entirely inside the uterus not through the cervix at all, how could you do that?

A. The only way I can imagine you do that is use two instruments. I can't use two instruments on the dilation which I have, for the most part.

Q. You would have to insert two instruments into the uterus?

A. Yeah, you would have to use one to stabilize and one to pull with.

Q. Do you think that would be a safe procedure?

A. I can't get two instruments in, for the most part.

Q. Is there an average number of passes that you have to make to fully remove the fetus or a range of number of passes?

A. No. If you are real lucky, everything comes out with one pass, which is infrequently. If you have a difficult situation where you have like a heavy person and everything is way high, you can make passes for 45 minutes, whereas the average procedure takes five to 10 minutes.

Q. In addition to removing the fetus, do you also remove

the placenta?

A. Yes, ma'am.

Q. Are there other steps that you take to complete the procedure?

A. Yes, ma'am. On a typical case, the procedure will occur that the placenta will come out, and then the cranium or the head will be the last thing that will come out. And at that point, the uterus is contracted down pretty good. So you're applying your suction, and you turn around and you feel that it's clean. The suction will grasp the uterus and it will, at that point, you realize it's clean. I know a lot of my colleagues will use a an instrument called a curette, but I do not because I'm a little worried about taking off too much of the myometrium where you get an Asherman's Syndrome, although I haven't really seen any. So I aspirate very little. I use my suction, and I realize the uterus is probably empty. The last thing I'll do after I remove the speculum, I will take my little finger, put it in and feel all inside the uterus that it feels intact.

Q. At that point, if you don't feel anything, do you consider the procedure complete?

A. Yes, ma'am. If she's not bleeding.

Q. You mention that you don't use ultrasound during your D & E procedures. Do you think that, in your practice, using ultrasound would reduce your rate of complications?

A. I think I have a very limited amount of complications. And the few times I have had to use ultrasound, it has been hard to get -- at the Medical College of Virginia Commonwealth University has to come from another building. Henrico Doctor's Hospital, it has to come from two floors up. So it has been relatively hard to get the use of ultrasound, and requires a person, another person, to be using the ultrasound. So in the instances where I have found ultrasound beneficial has been few and far between. One time six years ago, I think it was.

Q. Dr. Fitzhugh, you do -- I'm sorry. I didn't mean to interrupt you.

A. That's all right.

Q. No, go ahead.

A. I'm thinking.

Q. You're done. Sorry. You testified yesterday that you do D & E procedures to approximately 22 weeks. Do you have an opinion as to whether it's safer, it's safe to do D & E procedures past that time?

A. I like to stop at 20 weeks. My problem is I always get people that will have a story, a problem that want my help, and it's kind of hard. So sometimes you'll see 22 weeks. Sometimes -- I don't think -- I would say 23 weeks at times. Can I safely do it? Yes, I can safely do it.

Q. So your decision not to do procedures past that is not

based on safety concerns?

A. No.

Q. Now, I would like to go back and ask you some questions about something that you mentioned briefly a minute ago, which is that it sometimes occurs during a D & E procedure that the fetus comes through the cervix entirely or largely intact. Can you tell the Court how often the fetus comes through entirely intact, without you having to do anything more to remove it?

A. It happens about two to five times a year. And in those situations, it will occur one of two ways. One is that the ladies has had some labor up to that point. And when I remove the speculum, the laminaria and sponges from the vagina, she'll already have a foot in the vagina or two feet in the vagina. That's one of the times it happens. And the other time it happens is when I reach up and deliberately grasp for something. I will get a foot, bring it down, and the whole body will come down. And it happens about two to five times a year.

Q. And in that situation, is the entire fetus coming out or is it any part of it remaining in the uterus? Is the head --

A. It can happen either way. I would say one time out of those that I will pull and everything will come out. I'll pull and twist and everything will come out. And probably

two or three times, I'll have to pull and the head will get stuck against the cervix. So I'll have to use my ring forceps and crush the skull.

Q. And do you know, prior to beginning a procedure, whether or not the fetus is likely to come out?

A. I have no idea, unless I open -- open the speculum in there; there is the fetus in the speculum, in the vagina, or hanging outside the vagina.

Q. In those situations where it does come out intact, as you have described it, does it ever occur that the fetus passes the cervical os intact, past the navel with the head still in the uterus?

A. Yes, ma'am.

Q. Does it ever occur that the fetus can actually pass the vaginal introitus?

A. Yes, ma'am.

Q. You indicated that you use forceps to compress the skull; is that correct? In that situation?

A. Yes, ma'am.

Q. When you do that, why are you doing that?

A. I do that to reduce the size of the head.

Q. Do you have other concerns, when you find yourself in that situation, to cause you to use the forceps to compress the skull?

A. As I mentioned earlier, my preference is that when I use

a suction, my preference is that I obtain the umbilical cord and separate the umbilical cord. The one thing that I want -- and I don't want the staff to have to deal with is to have a fetus that you remove and have some viability to it, some movement of limbs, because it's always a difficult situation.

Q. So one of the reasons that you use the forceps to compress the skull is to ensure that the fetus is dead when you remove it?

A. That's one of the reasons.

Q. Now, are there other things that you could do at that point, when the head has been entrapped by the cervix, in order to remove the fetus?

A. I have heard of some use of drugs. I have never used drugs. I don't have any knowledge that they work. However, when we are in the operating room with constraints of anesthesia, and I guess you could, you could do damage to the cervix by cutting it. And as I have certainly done it trying to deliver a live fetus that has its head entrapped, and I have done that several times in my life. But I do that with the realization I'm going to damage the woman and I have to repair that, but I wouldn't do that in this situation.

Q. So other than drugs or making incisions in the cervix, could you simply detach the head at that point?

A. I guess you could, but then you would have to find it. And it's difficult because the head is a round object and as I said, sometimes I have used ultrasound, and that's about the only time you use ultrasound or have to use it is when you are totally unable to find the cranium in the uterus. You know the uterus contracts and sometimes it's contracts against or around the head and you have difficulty finding it sometimes. And that's when I have had, in the past, to get the ultrasound. I have just worked trying to get it and I couldn't get it. So, no, you don't like to lose it. You don't like to do that.

Q. Does it every happen that you would disarticulate a piece of the fetus, and then on the next pass, bring out the remainder of the fetus, except for the head?

A. Its happened that way, disarticulated up to a knee joint. You grab the next grasp and you brought most everything out.

Q. Okay. I'm going to ask you so speak up just a little.

A. I'm sorry.

Q. That's all right. Between removing the fetus in pieces and removing the fetus largely intact, do you have a preference?

A. The preference is to grab everything and remove it and be finished.

Q. And why is that?

A. It's time, it's relatively safer, you know. I do take all steps to remove everything, but certainly I have been called back about, I think three times now, where there is a piece of -- usually it's a piece of bone found in the uterus by either passing or ultrasound, and that's requires another -- so you don't want to do that. So even if you do all the steps to prevent, it's going to happen if you disarticulate enough.

Q. One of the issues you mentioned was the time. Why do you prefer a shorter operating time?

A. It's three things. One, it's just the time it takes to, you know, if you have been operating -- but there is always somebody scheduled behind. There is always somebody having another case to do. And they allot you a certain amount of time. That's a practical issue. That the patient issue is more anesthesia -- the more anesthesia she has, the more chance of aspirating or some other anesthetic risk, and more time it takes, the more bleeding you have.

Q. Doctor, why isn't there more of a risk of cervical, rupture, cervical laceration, if you are bringing out the fetus intact, presumably it's larger than if the fetus was brought out in pieces?

A. I might have mentioned yesterday, the cervix is an elastic organ. It's like a small band early on. It's a bigger band, rubberband-type thing as you go along. Always

assume a type of rubber band. For the procedure to be -- for me to be able to remove all of the fetus in one pass, there has to be more dilatation than normal from this bell-shaped curve, on the right side of the bell-shaped curve, so that the elasticity of the cervix, the biochemical changes of the cervix is greater. So it accommodates this without rupture of the cervix.

Q. Now, going back just for a moment to the testimony you just gave about operating time. When you say that you feel that removal of the fetus intact or largely intact results in a shorter operating time, is that based on your personal experience?

A. I base everything just on my personal experience. And I'm not one to go to meetings. I don't have much time for reading either so articles I like to read.

Q. So your testimony here is based on what you've seen in your experience?

A. Yes, ma'am.

Q. Now, we have discussed some various ways that the fetus can be removed during a D & E. Are there other factors besides the amount of dilation that can affect how the fetus is removed or how you're able to remove the fetus?

A. I'm sorry. My mind was back in Virginia.

Q. Let me ask the question again. In addition to the dilation that we have discussed, are there other factors

that can influence how removal of the fetus proceeds?
A. Certainly, the response of the mother to anesthesia is one. I firmly believe that anesthesia pitocin, which we use to contract the uterus, and how much response to that makes a difference. The size of the woman makes a difference; a tremendous amount of difference. Unfortunately the amount of sleep I have makes a difference.
Q. You have been performing D & Es, I think you said, since 1975?
A. Yes, ma'am, before that. Well, essentially we started in about 1975, learning how to perform.
Q. And for how much of that time has it been your preference to remove the fetus as intact as possible?
A. Well, ever since I started. I appreciated that the quicker I got done, the easier it was and the safer it was.
Q. And if you prefer to remove the fetus largely intact, why don't you increase the amount of dilation that you do in order to increase the likelihood of that occurring?
A. I don't do more because of -- I place a laminaria according to how the cervix's condition is at the time that I start the procedure, and the comfort level of the patient. And I don't think that for me, the safety issue of going in another day is not there.
Q. And before you begin to remove the fetus during a D & E procedure, is the fetus usually alive?

A. Well, in this condition we talk about what a life is. I do procedures, and I do a certain amount of fetal demise. Not a large amount, but probably one a week of fetal demises where the baby has died. And there is some that surprise me that I thought they were alive but they were dead at the time of the procedure.

Q. But some of them are alive at the time you do the procedure?

A. The majority of them are alive at the time.

Q. Now, is there any possibility for the weeks of pregnancy that you do abortions up to, I think you said, approximately 20 weeks, that the fetus could survive for a sustained period of time outside the womb?

A. Well, we take steps to try and ensure that by the ultrasound. The unfortunate part is that medicine is not an exact science. So the -- as I do largely on a referral basis, and largely use ultrasound technique. So ill get calls like I have this patient in Fredericksburg. Could you take care of her tomorrow, put the laminarias in? And I said well, she's 5-0, and I say fine. I come down and it's not. It maybe larger, it may be smaller. And the question of viability has us all -- because I practice in the major medical institution. Both of them have very good perinatologists. And when I bring one of these down that could survive, they probably would survive at the

institution that I have, if it was possible, because they have very active perinatal services.

Q. Is it ever your intent to do an abortion on a fetus that you think has reached viability?

A. No, that's against me personally. But because of this, I have been in situations where I did not like to be.

Q. And going back now to the actual performance of the D & E procedure what actions do you take during a D & E that would be fatal to the fetus?

A. Well, number one, I like to interrupt the umbilical cord. Number two, we are working on a young gestation, but that's not to do it. And we break up parts in the uterus and we crush skulls.

Q. Dr. Fitzhugh, what would be the earliest, if you can recall, when you have had a situation in which the fetus came down through the cervix intact, except for the head. What would be the earliest age that you've seen that?

A. I have seen 16 weeks.

Q. Now, the actions that you just discussed, separating the cord, crushing the skull, or disarticulation, do you know which of any of these would be immediately fatal?

A. No. I have no idea, because I don't -- I don't know.

Q. And you testified that your preference is to separate the cord. Are you always able to do that?

A. No, only about 25%.

Q. And why can't you do that every time?
A. Well, I do when I grasp or I do when the suction comes down. That happens about that many times.
Q. But if that doesn't occur, you don't take additional steps to try and grasp the cord?
A. No, ma'am.
Q. Why not?
A. Sometimes it's hard to find. It can be above the fetus, and I don't use ultrasound to find it, so it's all -- whatever I tend to pull.
Q. Okay. And you don't take steps to ensure fetal demise prior to beginning the D & E procedures; is that right, through an injection of Digoxin or KCL?
A. No, ma'am. Only those rare occasions where I'm asked to do a procedure where they think -- it occasionally occurs about once a year or maybe a little bit more; twice, three times, where you'll have a situation where a lady went to the doctor late and had the ultrasound and it showed a gross fetal abnormality. I'll get a call from the fetal maternal medicine man, wherever he might be, saying can you help me. I will say, well, if you can get the man in the maternal fetal medicine department to inject, I can do the procedure.
Q. So in those situations, you're not actually doing the injection?
A. No, ma'am. I'm uncomfortable enough doing the procedure

as it is without the injection; one. Two; I don't want to make that determination that that fetus needs injection. That's for somebody else to make that determination.

Q. Why don't you routinely induce intrauterine fetal demise for your D & E procedures?

A. I'm just comfortable doing it the way I am doing.

Q. Do you think that doing that could pose any risks to your patients?

A. It's an extra step, and I have found that extra steps -- even though people say are safe, are sometimes not safe. So if somebody shows me that might be safer, it's a lot easier on the operator to operate on a fetus that's already been dead than one that is living. But to me, the advantage has not been shown.

Q. In your obstetrics practice, do you personally perform amniocentesis?

A. No, I do not. I did for a long time but my partner, for a long time, founded the maternal fetal medicine department, so I just let him do it. Now, I'm not that great of an unltrasoundographer, so I allow him to do all those.

Q. What about other obstetricians in your area? Do they routinely do amniocentesis?

A. If they do, there is only one or two out of 40. Nobody in my hospital, in the Henrico Doctor's Hospital, performs amniocentesis.

Q. That is patients are all referred to a maternal fetal specialist?
A. Yes, ma'am.
Q. During an abortion procedure where you're able to remove the fetus intact, but for the head, do you consider that a distinct medical procedure from a D & E?
A. Well, if you look at my charts, I just do the same procedure all the time, and I don't categorize things. So to me, I just terminate a pregnancy. So whatever I do, I do.
Q. During your deposition in this case, you agreed with a statement by the Government that, "Dismemberment is the dominant characteristic of D & Es." What do you mean by that statement?
A. That the majority of time, I disarticulate the fetus.
Q. If you perform a D & E, in which you remove the fetus intact, except for compressing the skull with the forceps, do you still consider that procedure to be a D & E?
A. As I said, I terminate pregnancies. I don't categorize that. We don't have a separate charge for it and I don't have a separate charge for it. So as I dictated, I would probably dictate it as a suction and curettage. Sometimes I may say D & E. To me, I terminate a pregnancy.
Q. Do you believe that the D & E procedures that you perform, in which you remove the fetus intact, but for the

head and compress the skull, do you believe that poses serious risks to women's health?

A. No, ma'am.

Q. I would like to ask you now about some other methods of abortion. What other methods besides what you've described here at length, what other methods are available in the second trimester?

A. The second trimester primarily are inductions and the surgical types. The medical inductions, they use a cytotech, which is a Prostaglandin agent, to induct labor. I don't think anybody uses saline anymore. I have done one induction on a dead fetus not too long ago. I did it, it takes longer. It's more uncomfortable for the patient. It can be done. There is available hysterotomies, which is like a cesarean section. I haven't done any since the residency. We do have more bleeding. You do have more danger of infection. You do traumatize the uterus, so it's unable to do anything but a cesarean delivery afterwards. And there is a hysterectomy, which we call porro, p-o-r-r-o, hysterectomy, which is removal of the uterus in pregnancy. We did that this past year on a young lady that had I diagnosed at the time with a procedure of cervical cancer. And we wanted to operate on her before and then not terminate the pregnancy, so we performed a radical hysterectomy on her. Unfortunately, she subsequently died

not from the procedure but from the cancer.

Q. Do you have an opinion as to the relative safety of D & Es in the second trimester compared to induction abortions in the second trimester?

MR. HENRY: Your Honor, I'm going to object based on lack of foundation.

THE COURT: What foundation do you think is lacking.

MR. HENRY: Your Honor, he testified here today he's done one induction since, I believe, about 1979, when he switched to D & Es.

THE COURT: Do you wish to lay additional foundation?

MS. CREPPS: Your Honor, I believe we have laid an adequate foundation, but I will ask some additional questions.

THE COURT: Let me be specific. It would help me to know if the doctor considers it a part of his practice to do inductions if warranted.

MS. CREPPS: All right.

THE WITNESS: As a general matter as opposed to -- I know that he did one in one case.

THE WITNESS: The -- I don't personally do them foramenally because this is what I do any days are set up for this. But part of them, I'm in a group of doctors, three

doctors where if we have a situation where we need that, my partners will induce it. I have been in the care of them, so I don't know if that qualifies for me as an expert being in partnership with a group of people. I probably won't be an expert of doing them. I will be an expert of saline injections.

THE COURT: Well, Doctor, let me ask you this: If you are confronted with a situation in which you conclude, well, let me ask it different. Are you confronted with situations in which you are called upon to make the decision whether or not an induction abortion will be completed?

THE WITNESS: Yes. Yes, sir. What happens is that -- primarily what happens -- well, two things will happen. One is they'll want the fetus for genetic studies. Two will be the preference of the lady wanting her entire fetus to comfort at the time. So at those times, my partners will do the injections for me. I'll just follow along with them.

THE COURT: So in that circumstance, you make the decision about whether the induction will be performed but you refer it to a partner.

THE WITNESS: Yes, sir.

THE COURT: The objection is overruled. You may proceed.

BY MS. CREPPS:

Q. Doctor, based on your experience, do you have an opinion

as to the relative safety D & Es in the second trimester compared to induction procedures?

A. My personal feeling and just -- this is observation, is that they are both relatively safe.

Q. All right.

A. That the discomfort level for the patient is much higher with the induction. The hospitalization time is much greater, and the care is much greater.

Q. You mentioned early on that some of the abortions that you do for the second trimester come to you -- the patients come to you as a result of a referral, and some of those cases involve fetal anomalies. In those cases, do you know whether the patient has had the option of having a procedure done by induction or D & E?

A. About a third of the doctors that I know real well that refer to me, the others are from out of the area, so I don't know them as well. But those that refer to me, I do know that they have been given the option of an induction and the option of my surgical procedure.

Q. I would like to ask you some questions now about your treatment of miscarriages. You mentioned that you do -- treat women who are suffering from miscarriages. Is that both in the first and second trimester?

A. Yes, ma'am.

Q. How many times a year would you estimate you treat first

trimester miscarriages?
A. First trimester miscarriages occur in one out of eight pregnancies. My practice, I do about five deliveries a month, so I'll have one or two miscarriages a month of first trimesters. Maybe more than that because my partners are tending to take more call than I am, so my deliveries, my deliveries is skewed downwards from my partner's, so I'll see more patients. So it's probably on the order of three to four a month miscarriages that I will see.
Q. How do you care for a woman who is having a miscarriage, in the first trimester?
A. In the first trimester, in the ancient days, we would do D & Cs on all of them. Now, we do a speculum observation and they pass their own tissue, in their own home the majority of the time. And that we have to watch for infection, retained bleeding. So we do D & Cs on those, I would say on the order of 10 to 12%.
Q. Can you estimate how many women per month you see with miscarriages in the second trimester?
A. That's much less frequent. That's probably on the order of one every two or three months, and that number we include the women who come in with rupture of membranes and inevitable abortion.
Q. How do you treat women who are suffering miscarriage in the second trimester?

A. Frequently, most of them will -- one of three things will happen. One, they will be in labor and will continue that process. Two, we are able to put them in labor and continue that process and, three, I do surgical inductions on those.

Q. And is that similar to what you would do for a D & E?

A. Yes, ma'am.

Q. In the last several months, have you assisted in the treatment of a woman having a miscarriage?

A. Yes, yes, ma'am. You got me a little lost, but anyway, that was before Christmas. But anyway, I was called down to the Medical College of Virginia from the doctors which was about 20 minutes away, and I got a call from the OR that the doctor needed help. So I returned back and he had this patient they had tried a medical induction on the night before. It was a young lady that had ruptured membranes, and the temperature was 101, and they were trying to deliver her and it failed. So it was morning time now and the temperature was 103, and she was really sick. And they had a doctor who was fairly experienced but had called down asked me what to do. And, anyway, I came out and he had intentionally -- I guess with ultrasound, grabbed the foot and pulled the infant down, and he had what I see as this law referring to he had the body down, the head and the -- one of the things about determining viability or not

viability, but life on a fetus is that we never -- never do it. It always takes a third observer to look at say, yeah, that baby has got some movement on it or that fetus has got some movement on it. So we had to crush the skull and get it out.

Q. So when you came into the procedure, the fetus was out of -- out of the cervix except for the head, is that correct?

A. When we came in, it was hanging by the head on the cervix and the rest of it was out of the body.

Q. And to your observation, there were signs of life?

A. Yes, ma'am.

Q. And is it common that fetuses will still show some signs of life at the point that you begin to treat a woman for a miscarriage in the second trimester?

A. It happens sometimes, yes, ma'am.

Q. Doctor, I would like to have you look at Plaintiff's Exhibit 69, which is sitting right on the desk there and this is the Partial-birth Abortion Ban Act that we are here to discuss. Before I have you look at the specific language of the Act, I would like to ask you, Doctor, if the term, what the term partial-birth abortion means to you, without reference to the definition in the Act. Just as you understand it.

A. I think everybody, not everybody, but I think that when

I -- before I had any contact with any legal situation, the partial birth refers to a baby that is -- has viability. So to me, I get the same impression that most lay people do, that you're a doctor is delivering a late pregnancy and is trying to terminate that pregnancy or partial-birth. You get the baby -- he knows he doesn't want the baby to live so he has to do something to terminate that life of that baby.

Q. And looking at the language of the Act, do you think that the Act matches your original understanding of partial-birth?

THE COURT: I'm just going to inject here. For some of us, we realize the irony of using the phrase original understanding in the context of that question. Go ahead.

MS. CREPPS: All right. Thank you, Your Honor.

BY MS. CREPPS:

Q. The understanding you just described, how does that match up with the language of the Act?

A. Well, the Act has bothered me because -- the Act does not say this. It says does not have any dates on it.

Q. By dates, are you referring to gestational age?

A. It has no gestational age on the thing, so it can apply to any gestational age. And I don't know what deliberately and intentionally does. Everything I do is deliberately and intentionally, unless I'm asleep.

Q. Let's look at some other terms in the Act. Are there other terms in the Act, besides what you just mentioned, deliberately and intentionally, are there other terms or phrases in the Act that you have questions about?
A. I know one of the living fetus is. It has some sign of life or any sign of life. Does it have a heartbeat, does it have a cell reaction. Does it have something you can measure by EEG, which is how medically we define nonliving humans. I just -- so that -- that bothers me a lot. I guess anything that happens overt.
Q. I'm sorry. I cut you off. Were you finished?
A. I said overt. I guess that's anything that happens, so, yes. The language bothers me. It bothers me that it could be applied to things I do. It bothers me that -- that they won't allow me to do the things I do on the women that are sick. This doctor that I came upon, he probably used ultrasound so he probably deliberately intentionally grabbed a foot. Now, should he go to jail or should I go to jail for helping him or, you know, just a legal mess. I mean I'm sure these gentlemen don't mean to invoke us, but there is a lot of people out there that are not happy with what we do.
Q. Let me go back to something you said just a moment ago. That the Act could be applied to things you do. Do you believe that the Act could apply to the D & E procedures that you performed?

A. I believe it applies to D & E when you're bringing the fetus is down or the fetus is down to the introitus, and I have to crush the skull. I believe it could apply to that, yes, ma'am.

Q. That's a situation you have encountered in your practice?

A. Yes, ma'am.

Q. Do you think it's possible that induction procedures could be covered by the Act, abortion induction procedures?

A. Yes, I think that for those cases where we induce without using KCL, and KCL is primarily used for the purpose of making sure that you do not have a viable fetus when it is delivered. But on those cases where you don't use KCL, that you'll have cases -- I notice that when the doctor was going to induce a hydrocephalic, which is a large head, he said what happens if it gets stuck. I said I think under the law, this applies, because you'll have to do something to get the head out, and that maybe involved killing the fetus.

Q. In the example you just gave about the hydrocephalic fetus, is that an example you just got from another doctor?

A. Yes, ma'am. It was from another doctor to me.

Q. Do you think the Act could impact the way you treat miscarriages in the second trimester?

A. There where you have the impacted head, it could

possibly be invoked at that point too.
Q. I would like to draw your attention to the Act again which is on page S-6. I'm not sure which page you have in front of you. There is a sentence in there that states that the subsection does not apply to partial-birth abortion that's necessary to save the life of the mother. Do you see that language? Have you seen that language before?
A. Yes, ma'am.
Q. What do you think the term necessary means in that sentence to you as a practicing physician?
A. As a provider of care, it seems to limit it where the decision is strictly life or death, whether there is toxemia, whether the patient is comatose, that is unconscious or and severe cardiac failure to the heart. On those occasions, it would allow it, but I can't see in between life or death decision. I can't see where the lady that's bleeding real heavy -- when I have to intervene with hemoglobin gets to seven, or I can do it when it's nine. Those are decisions that would have to be made under life threatening situations.
Q. Going back to the example you gave us earlier about the woman who was suffering a miscarriage with a high temperature. Where do you think that situation would fall? Would it come within this or not, in your opinion?
A. It certainly, in modern medicine, we think we can cure

almost all high fevers, but we certainly do have people dying from infections. And so a high fever, some would say it's life endangering. Some would say it's just a threat to the health, and she may end up well. She may end up with some problems.

Q. Doctor, I would like to have you look to the next page of the Act in subsection D-1, it states that a defendant accused of an offense under this section may seek a hearing before the State Medical Board on whether the physician's conduct was necessary to save the life of the mother. Have you reviewed this language before?

A. Yes, ma'am, I have.

Q. Does this provision relieve any of your concerns about the Act?

A. No, ma'am.

Q. Why not?

A. The State Boards of Medicine is made up of various people, doctors, nurses, and they try to be fair but they are a group of doctors who have different views on different things. Since this is not going to be a cut and dried thing, they have to make the decision. And, frankly, I have seen some decisions good and I have seen some of the decisions bad.

Q. I would like to ask you just a few questions now about how enforcement of the act might impact you and your

patients. Do you think that enforcement of the Act would endanger the health of your patients?

A. The enforcement of the Act would limit my ability to care for those women who have problems.

Q. And can you estimate what percentage of the second trimester abortions you perform in Virginia?

A. Based on just my knowledge of what's going on around the Richmond area, I do 80% of the central Virginia area abortions, of second trimester abortions.

Q. Do you think it would be an option for women, if the Act were to become enforced, that they could switch over and get induction procedures?

A. My experience in trying to find doctors to do induction procedures is that it's very difficult to find one that will be willing to commit to do it. I can do it on those cases where there is some tragedy involved, 11-year-old being pregnant or severe fetal anomaly, but to ask my partners to do induction on a situation would be on a case-by-case. So I think it would be a limiting factor. And it takes a time commitment that I don't have at this age.

Q. Doctor, do you know what you would do at this point if the Act were to take effect in terms of your practice?

A. If the Act would take effect, I would probably continue until such time as I hear the enforcement or somebody is waking waves. And I don't know if the that would be too

late for me to be considered a defendant in that method or not. I would have to take my chances a little bit, I think.

Q. So you would risk jail time?

A. Probably.

MS. CREPPS: I don't have any other questions, Your Honor.

THE COURT: Mr. Henry, shall we take our break at this time? Would that be accept to you?

MR. HENRY: I don't have any problem with that.

THE COURT: Thank you. Doctor, you may step down. We'll stand in recess for 15 minutes.

(Recess from 10:21 to 10:40 a.m.; all parties present).

THE COURT: Counsel, it's a little cool in this courtroom. We'll try to pay our heat bill. I apologize. This courtroom is separately controlled for heating and air conditioning purposes and we have a difficulty of doing that but we'll try to get it more comfortable. Counsel, you may proceed.

CROSS-EXAMINATION

BY MR. HENRY:

Q. Thank you, Your Honor. Good morning, Doctor. I just have a few questions for you. You testified that you perform about five to second trimester abortions a week?

A. Yes, sir.

Q. I calculate that to be about 250, 350 per year. Does

that sound about right?
A. Sounds about right.
Q. And you have been doing approximately the same number of second trimester abortions per year since around 1979, 1980?
A. It certainly has decreased over the last several years. It steadily has decreased. And as I said earlier, the acceptance of stay at home mother's -- some people are a little bit better at birth control methods. I don't think all of them are, unfortunately, but that has caused a decline over the years. I have seen them go from 20 a week to 10 a week to -- I would say about now.
Q. Okay. But since probably the '79, '80 time frame, you have done thousands of second trimester abortions, would that be correct?
A. Yes, sir.
Q. Let me ask you this. How many abortions of first and second trimester have you done during the course of your career, if you can just estimate that?
A. I'm sure you're talking about hundred thousands.
Q. So the vast majority of the abortions that you have performed have been first trimester abortions; is that correct?
A. Yes, sir.
Q. And you have been doing your second trimester abortions in essentially the same way since the 1979-80 time frame?

A. Well, the first three or four years, I did primarily saline injections, then gradually increased the length of my second trimesters after '79 probably.

Q. And the second trimester abortions after '79 would be the D & E abortions; is that what you're saying?

A. Yeah. As I said earlier, I have a hard time with terminology, but we'll let it be that.

Q. And the procedure we are talking about is the one you've talked about today where you use laminaria the day before the procedure, and then before the procedure to actually remove the fetus, then you use the suction cannula to remove amniotic fluid, and then you proceed with removing the fetus from the uterus; is that correct?

A. Yes, sir.

Q. Can I ask you this: Is there a gestational age where the using the suction alone is sufficient to remove the fetus in the second trimester?

A. It can be done up to 15, 16 weeks.

Q. But after that time, you have to use forceps to grasp the fetus and remove it from the uterus; is that correct?

A. Yes, sir.

Q. You don't use Misoprostol or other Prostaglandins when you're doing your D & E procedure?

A. No, sir.

Q. You use an ultrasound before starting the procedure to

get an approximate gestational age on the fetus; is that correct?

A. The day before the ultrasound has either been done by me or my assistant or the referral agency, so it has been a day before, yes, sir.

Q. But you don't use ultrasound, continuous ultrasound while you're actually doing the procedure in removing the fetus?

A. No, sir. I do not.

Q. Regarding the use of laminaria on these second trimester D & Es, there is no specific target amount of cervical dilation that you're trying to obtain through the use of the laminaria; is that correct? I don't mean to confuse you.

A. No, I'm sorry. I'm just trying to think. My initial answer is I want to be able to use that 14 suction cannula to remove the amniotic fluid, and use my ring forceps, and that's about the same size of -- the head of the ring forceps is about the same size as that 14. So if you say my aim, I would say yeah. If I have to do more dilation because the laminaria has not got to that point, then -- then I am not always happy because I know I have a little bit more instance of a chance of rupturing the cervix, because its elasticity hasn't increased greater. So I don't know if that answered it or not.

Q. There has actually only been one instance -- I think you

said in 24 years, where you have not been able to obtain sufficient dilation to use the cannula and the forceps; is that correct?

A. There was one instance where I had to -- where I felt that the dilatation was unsatisfactorily enough that I ran a risk, a greater than acceptable risk to me, and that's a three in a year of probably, at that time, 600 cases. So one in 200 chance of rupturing the uterus, so that one case that I felt that I needed to send the patient home. And at that point, sent the patient home. Stopped the anesthesia and telling them that they have to go home. I can't do the procedure that day. I want to put in more laminaria and come back tomorrow. That's one time. There has been many other times where I have had to dilate the cervix to a greater degree.

Q. And when you say you dilated to a greater degree, that's through mechanical dilation?

A. Yes, sir.

Q. So would that be using a Pratt dilator?

A. Yes, sir. Pratt is like a pencil type. It's the end of the pencil. It's gradual. The old fashioned type we used to use -- some people still do, are more like fingers, variations of fingers. So you use small, and so it's much -- probably more traumatic.

Q. Okay. So once you have dilation sufficient to use your

forceps or use a suction cannula, when you're using the forceps, you grasp whatever fetal part presents itself; is that correct?

A. Yes, sir.

Q. And I believe you testified earlier this morning that unless a fetal part comes through the cervix, the reason of using the suction, it's kind of blind as far as you're concerned. You don't know what fetal part you're going to grab when you reach in there, is that correct?

A. That's correct. As I said, I can identify easily a larger part like the skull with my ring forceps, but a small part, I have to reach blindly. And another condition would be the case where the tissue in the vagina, if there is any parts in the vagina.

Q. I believe you testified earlier, you prefer to be able to get the umbilical card first, if you can. Is that correct?

A. That would be my preference. Yes, sir.

Q. And I think you said that you had a preference for that, because you might have a fetus with, I believe you used the frame, some viability, and that created a difficult situation. Could you explain for me what the difficult situation is?

A. If -- it happens infrequent, but if I bring the fetus out and it has movement to it, the nurses, although they are

-- they aren't required to operate with me unless they have views that allow them to do this. So if they have very difficult views, they are not allowed to. They don't have to be -- but even still, if they have these views that they will accept that woman's need to have this abortion, if I have a fetus that has some viability on it, oohs and ahhs and they kind of act like -- really just being part of it is just uncomfortable.

Q. Doctor, when you're actually performing the removal of the fetus from the uterus, that process usually results in dismemberment of the fetus; is that correct?

A. Usually in my case. Yes, sir.

Q. In fact, it happens in the large majority of your cases?

A. The large majority of my cases. Yes, sir.

Q. In fact, I believe you testified that only in -- I believe you said two to five cases a year will the fetus come out largely intact, either completely intact or intact up to the head; is that correct?

A. That's approximately correct, sir.

Q. So when you're doing the D & E procedure that you do, you expect dismemberment to occur; is that correct?

A. It happens in the majority of cases, not expected, but it sure would be nice if it happened more often.

Q. Excuse me. What was your last statement? I'm sorry.

A. I'm sorry. It would be, you know, as I said, from the

usage it's what I expect, although it's not necessarily what you would like to have happen. I mean, you would like to --

Q. But you don't plan on obtaining the fetus intact; is that correct?

A. I don't expect it will happen because it doesn't happen often.

Q. In fact, you don't take any special steps to ensure that it comes out intact; is that correct?

A. No, sir.

Q. In fact, you would have to change the way you do the procedure to ensure that it comes out intact or largely intact; isn't that correct?

A. You would have to dilate more aggressively, right.

Q. By dilate more aggressively, you mean like using a second round of laminaria?

A. Yes, sir.

Q. For the second day?

A. Yeah, right.

Q. And when dismemberment, the dismemberment occurs in the D & Es as you do the -- that's caused by resistance or traction of the fetus against the uterus; is that correct?

A. Yes.

Q. It's against the internal os of the cervix; is that correct?

A. Yes, sir, which is usually comprised of the cervix and

the fundus of the uterus where the fundus comes into the cervix. The cervix technically is a port away from the fundus.

Q. There is an internal os to the cervix which is near the fundus of the uterus, right?

A. Right. The fundus ends at the end of the os. The uterus is bowl shaped and has an opening. Where the opening is called the internal os.

Q. Is there an external os to the cervix also?

A. External os is the portion you see of the vagina.

Q. So the traction or the resistance being caused or that goes on in the dismemberment where the fetus is or the traction occurs against the internal os, that can result in dismemberment just kind of right there at the internal os; is that correct?

A. Yes, sir. It can happen anywhere.

Q. So it can also be in the uterus itself, right?

A. Right.

Q. I wanted to ask you a question -- kind of go back to something you said just a minute ago. We were talking about that second round or second day of laminaria. I believe you testified earlier there is a safety issue in going through another day of using a laminaria. Can you tell me what that safety issue is?

A. Not -- I don't do it. I'm sorry. I haven't done it

because of my concerns about any time we put an additional step into medicine, that you inherently cause more problems. And so that's why I have been comfortable doing mine. If somebody else came and says it's really, really save and I have been doing it a hundred years, and I would have to counter that with what I do, I have been doing 30 years and it's really, really safe. And I know that if I try to transform what I do to what he does or he does to what I do, it probably is not going to be as safe a procedure.

Q. Can I ask you a question about the forceps you use, the ring forceps I believe you called them. Are they rounded on the working end of the forceps?

A. They are rounded to a little bit oblong. Some of them are all rounded, some of them are a little disshaped like egg shaped.

THE COURT: Mr. Henry, the television screen next to the doctor has a push technology that he can draw with his finger, if you want him to try to do that. But if it fails, it's your fault, not mine.

MR. HENRY: I'm comfortable with your answer, Doctor, unless you want to draw it for us.

THE WITNESS: I'm a terrible speaker and a worse drawer.

THE COURT: We have all this equipment here, and I'm always trying to encourage the lawyers to use it,

because it's your tax dollars at work, but we'll move on. Go ahead.

MR. HENRY: Thank you.

BY MR. HENRY:

Q. So, Doctor, the forceps, would you describe the working end of them as smooth and rounded? They are not sharp, are they?

A. No, they are not sharp, and they have a horizontal indentation in them. Probably, I would say, small, less than 16th of an inch on the inner surface of them.

Q. Those would be like ridges?

A. Ridges, yes, sir.

Q. Doctor, I believe you testified that you use a speculum in the vagina during the D & E; is that correct?

A. Yes, sir.

Q. And the function of that instrument is to hold the vagina open while you're doing your procedure?

A. Yes, sir.

Q. I believe you also testified that the cervix is drawn during the D & E procedure to where it is very close to or in line with the vaginal introitus, is that correct?

A. Yes, sir. Well, I believe I stated I frequently open the speculum. Sometimes I draw it into that plane, so it's about -- I don't know the percentage of times of each but doesn't happen very frequently or fairly frequently.

Q. I believe on the -- where you said one of the instances occurred one out of three times; is that where the cervix is drawn fairly close to the introitus?

A. That's in the second trimester, yes, sir.

Q. Second trimesters, yes. And you said that was based on you kind of counting occurrences of that happening over some period of time; is that right?

A. That was my original question, recollection. My original thought when I was originally asked that and subsequent to that, I thought maybe is that right or wrong and just over a period of a week or so, I just sort of informally counted how many times I did the procedure versus how many times the cervix --

Q. So that was over a week?

A. Over a week.

Q. In these situations where you talk about the cervix being drawn closer to the introitus, you're talking about the external os of the cervix, right?

A. Yes, sir.

Q. In those situation where the cervix is drawn closer to the introitus, does that ever cause the speculum to fall out or anything like that? In other words, does the cervix coming closer to the introitus interfere with the speculum's function?

A. That depends on the woman. For the most part, it does

not, but you talk about frequencies, and I like to think about times for a month or a year. And I would say about once a month, you pull down and the speculum would come out because the anterior vagina doesn't always support a speculum. You just work in the introitus or outside the introitus or right there with the ring forceps to hold things open.

Q. The second trimester D & Es you perform, you said they are performed in a hospital?

A. Yes, sir.

Q. And would those be done in an operating room?

A. Yes, sir.

Q. Okay. I want to ask you a few questions about the kind of upper gestational age range where you perform second trimester D & Es. I believe there is some questions about you do it up through about 20 weeks LMP; is that correct?

A. Yes, sir. My standard has always been I do them up to 20 weeks, but as you look at my reports, you'll find I have up to 22 weeks, and those are situations where somebody has asked me to do it on more advanced pregnancy.

Q. So you do do them up to 22 weeks?

A. We do it by ultrasound, so it's 5-2, that's my absolute cutoff.

Q. When you say 5-2, that refers to the?

A. Biparietal diameter.

Q. Does 5-2 correspond with about a 22 week old fetus?
A. I believe it does.
Q. Can you tell me why you have this 22 week cut off, if I could characterize it as that?
A. I have it for two reasons. One of the reasons is technically, it's easy for me at that point, I would say three reasons. Three reasons. Does the hospital nursing staff feel comfortable at that stage again, and the third reason is my desire not to get involved in the viability issue of the fetus issue.
Q. Let me ask you this: When do you think viability be begins for a fetus? Is there a gestational age?
A. I have to go back to my experience and I know we are doing C sections at 23 weeks to try to save babies. So it's somewhere around 23 to 24 weeks, you can get a viable pregnancy.
Q. You're giving yourself a little bit of a cushion; is that --
A. I like the cushion. Yes, sir.
Q. You mentioned the perinatology folks at the hospital or hospitals you practice at. Would they normally try to save, say, a 22 week old fetus?
A. They try to save a fetus that has a capability of life. If you deliver a fetus and it has no breathing, then they won't try to save it. If you have a patient, you deliver a

baby and it has any type of breath activity, they will make efforts to try to save it. So they will be called upon to make that decision. So it's a matter of them not looking at it and saying it's this gestation. It's a matter of them looking at it saying whether the eyes are fussed or whether the lungs are breathing or making an attempt to breathe.

Q. Now, you have done abortions using the D & E procedure beyond 22 weeks, but only in situations where the fetus is already dead; is that correct?

A. I may have mentioned earlier that the only other times would be where my referral and their ultrasounds were off, and I have started a procedure, and it has been further advanced than I would have thought it would have been, and I have to complete the procedure.

Q. So that was a situation where there was some miscalculations or error about the gestational age? Actually, my question was more along the lines where you know the fetus is beyond 22 weeks?

A. I don't normally do that.

Q. But you have done it where fetal demise has been done or occurred; is that correct?

A. Yes, sir.

Q. And those would be situations where another doctor has injected Digoxin or KCL to induce fetal demise?

A. Or a natural incurring.

Q. Or naturally incurring?
A. I have been asked to do a naturally occurring fetal demise at 27 weeks.
Q. In those situation where's fetal demise has occurred at gestational age of beyond the 22-week range, has the fetal demise made the D & E procedure easier?
A. Yes, sir.
Q. Is that because the fetal tissue is softer, easier to disarticulate?
A. The softer issue that we give is the fact that the ligaments at the joints are easier to disarticulate. So it's not touch soft. It's the disarticulation softness, easiness, I would say.
Q. But that results from the fact the fetus has been dead for awhile?
A. Yes, sir.
Q. Where you have a patient, who for some reason, wants to abort a live fetus who is beyond the 22-week gestational age point, you don't perform those abortions, do you?
A. No, I refer those to, I think Atlanta, and New York, and Kansas have a free facility that will do them further a long on a regular basis.
Q. So you're referring them to other abortion facilities; is that correct?
A. Yes, sir.

Q. Do you know what abortion methods or techniques those other abortion facilities use?
A. I have no idea, sir.
Q. Doctor, the D & E procedures, as you perform it, I believe you testified this morning is safe; correct?
A. Yes, sir.
Q. And it's safe throughout the gestational age range you perform the procedure?
A. Yes, sir.
Q. And you have used the procedure safely for abortions where the mother has suffered from let's say diabetes; is that correct?
A. Yes, sir.
Q. You did the procedure in essentially the same way as you normally do it; is that correct?
A. Yes, sir. On a diabetic, I will give antibiotics prophylactic afterwards, which I don't normally do during the procedure. I'm sorry.
Q. And you use the procedure safely for women with renal conditions; is that correct?
A. Yes, sir.
Q. And you do a procedure in basically the same way as you normally do?
A. Yes, sir.
Q. Same question for women with heart conditions?

A. Yes, sir.
Q. You have used it safely. You do the procedure in basically the same way?
A. Yes, sir.
Q. And women suffering from breast cancer?
A. Yes, sir.
Q. And for women suffering from pre-eclampsia?
A. Yes, sir.
Q. And how about for women suffering from uterine infection?
A. Yes, sir.
Q. You have also used the procedure safely for abortions involving fetuses that were suffering from some type of anomaly. I believe yesterday you referred to them as fetal indications; is that correct?
A. Yes, sir.
Q. And you have done it safely for fetuses that have genetic defects; is that correct?
A. Yes, sir.
Q. And you do the procedure essentially the same way in those situations; is that correct?
A. Yes, sir.
Q. You have done it for safely for fetuses involving a defect known as Trisomy 21; is that correct?
A. Yes, sir that's a genetic.

Q. Trisomy 21 is normally called Downs Syndrome; is that correct?
A. Yes, sir.
Q. And you do the procedure in essentially the same way?
A. Yes, sir.
Q. For fetuses involving Trisomy 13?
A. Yes, sir.
Q. Trisomy 18?
A. Yes, sir.
Q. Spina bifida?
A. Yes, sir.
Q. Have you done the procedure safely on fetuses that were hydrocephalic?
A. Yes, sir.
Q. And you do the procedure in basically the same way that you have described?
A. Yes, sir.
Q. Now, sometimes genetic or pathological testing is done on parts of the fetus after you have removed them from the woman; is that correct?
A. We send genetic tissue fairly frequently, once every two weeks, I would say, to the genetic lab. Pathological is very rarely done. We send chromosome, the issues for cases, for incest and rape. The pathological, I defer to my partners for inductions or other people who might do an

intact.
Q. In situations you've been involved in, you've only had to send out tissue samples for testing; is that correct?
A. That's right, sir.
Q. You've never had one where someone wanted the entire fetus; is that correct?
A. I have, but I have told them I could not provide it.
Q. Let me ask you some more questions about the safety of the D & E procedure that you used, Doctor. You've never had a situation where you perforated the woman uterus with your forceps, have you? And just before you answer, let me define perforation. I'm talking about putting the forceps or something through the uterine wall which I believe is how you talked about it yesterday.
A. Yes, sir. I have never had, that I can remember, and I'm getting old, but I think I should remember it that that has happened to me on a second trimester procedure. And that's probably because you are working on a lower plane and you have to -- but I have had where the cervix has been lacerated where the fetal part is too big or does not meet this elastic rubberband type situation, so it will break at the internal os. That has been reported out as a uterus has been perforated.
Q. But you would describe it as a cervical laceration or rupture?

A. I would describe it as a rupture of the cervix.
Q. And caused by the cervix not being sufficiently prepared to handle the size of the fetal part that's coming through?
A. Insufficient elastic to do it.
Q. And, Doctor, going back to talking about the way you define perforation of the uterus. That's actually more common in first trimester abortions, correct, than second trimester?
A. Yes, sir.
Q. Doctor, could you tell us, percentagewise, how many of your patients involved in second trimester abortions come to you by means of referrals?
A. I'm thinking it's about a third. I would be off a little bit, but approximately a third.
Q. Approximately a third. Do you remember giving a deposition in this case?
A. Yes.
Q. Back in February?
A. Yes.
Q. And?
A. I may have said a quarter then, but it's somewhere in that 25 to 30%. I don't remember what I said. I'm sorry.
Q. Okay. Actually, looking at page 69 of your deposition on line 14. I asked you with respect to your practice, your abortion practice, specifically in the second trimester,

even more specifically, how many of those did you perform are referrals as opposed to being your own patient? And your answer was I think the majority of the ones on this exhibit are referrals. The exhibit we were talking about there was the chart that's Exhibit 42 to your deposition, which may I bring it to the witness?

THE COURT: Sure. Counsel, do you have the exhibit in mind? Ms. Crepps, do you have the exhibit in mind.

MS. CREPPS: Yes, Your Honor, I do. I have mine.

THE COURT: All right.

BY MR. HENRY:

Q. And I think the exhibit we were talking about there in the deposition was Exhibit number 4 you're looking at and, specifically, the second page of that exhibit which is Bates numbered 2-2?

A. Yes, sir.

Q. I guess I'm just trying to understand. I believe you said the majority of the second trimester abortions referred to you on that exhibit, which purport to talk about the second trimester abortions performed down in your private practice were referrals. Now you're telling me it's only a third?

A. You know, I got a little confused by my thing in February, by my pages. But if you look at 2-2, these are the ones in my private office, and these are the ones that

are done on a referral basis. And if you compare that to Exhibit 42-1, you total those up. This will be about a third. 2-2 will be about a third of 2-1. 2-2 and 2-1 are the total number of abortions I do.

THE COURT: Pardon me for interrupting just a moment. If this is important, appreciate that our record is not going to be real clear because we are referring to a document that is not in the record. So it doesn't trouble me, but if it's important, you probably ought to have the thing we are referring to in evidence. If it's not, then just ignore me. Go ahead.

MR. HENRY: Okay. Thank you, Your Honor. May I have just a moment?

THE COURT: Of course. Sure. We can run a copy if that's what you're looking for.

MR. HENRY: I'm sorry, Your Honor. I'm just going to proceed for now.

THE COURT: That's fine.

MR. HENRY: We'll try to come back to it.

BY MR. HENRY:

Q. Doctor, with respect to your second trimester abortions, do you schedule any kind of follow up visit with the patients after the procedure is done?

A. They are all advised to come back for a three week follow up.

Q. And the majority of those patients don't come back; is that correct?
A. That's correct.
Q. And, Doctor, when we were talking just a moment ago about Exhibit number 4 to your deposition, I believe that that is Defendant's Exhibit 681. And if you will take that notebook right there and look at Exhibit 681?
A. Yes, sir.
Q. That's the same chart that you were talking about when we were --
A. Yeah, yes, sir.
THE COURT: Do you wish to offer 681?
MR. HENRY: Just one more question for the witness.
BY MR. HENRY:
Q. Dr. Fitzhugh, those are charts you produced to the defendant during discovery in this case; is that correct?
A. Yes, sir.
MR. HENRY: Your Honor, we would move Exhibit 681 into evidence.
MS. CREPPS: Your Honor, I don't have an objection to the exhibits coming in, except I don't think a very clear record has been made about exactly what these are because two pages and they are separate charts. I can do that on redirect, if you prefer.
THE COURT: Well, I think we have identified it

sufficiently then. If you think there is some lack of clarity, you can do that on redirect. 681 is received.

BY MR. HENRY:

Q. Dr. Fitzhugh, some questions about the situation you testified about in which the fetus comes out all except the head which lodges in the cervix. You said that those conditions happen, I believe, three to five times a year; is that correct?

A. Yes, sir.

Q. In that situation, you sometimes try to manipulate the position of the fetus in order to facilitate the head passing through the cervix; is that right?

A. That's right.

Q. Sometimes you try to turn the body of the fetus to try to get the head to come through; is that right?

A. That's right.

Q. And I believe you testified earlier that the D & Es you perform are done in a hospital operating room, right?

A. Yes, sir.

Q. And there are nurses and others with you in the operating room while you're doing the procedure?

A. Yes, sir.

Q. When there have been instances where the -- you have been doing a D & E and the fetus has come out intact, have you been aware of reactions from others in the operating

room?

MS. CREPPS: Your Honor, I'm going to post a relevance objection.

THE COURT: That will be overruled. You may answer.

THE WITNESS: Yes, they certainly show more interest in that when it happens than they do on a routine situation.

BY MR. HENRY:

Q. In fact, they gasp, don't they, when that kind of thing happens?

A. Some of them gasp, yes, sir.

Q. Your impression in those situations is that they were probably having a harder time dealing with that situation; is that correct?

A. Yes, sir.

Q. Dr. Fitzhugh, a couple of questions on the injection of Digoxin and KCL. You don't do those injections yourself, do you?

A. No, sir.

Q. So you're not familiar with any details about the risk that those injections may pose; is that correct?

A. Only as I can extrapolate from my experience when I injected saline many times in the past.

Q. And that was before the 1979-1980 time frame?

A. Yes, sir.
Q. And you have never studied the risk of KCL-Digoxin injections in an academic fashion, have you?
A. I can't recall doing any academic investigations.
Q. Doctor, can I ask you a question about miscarriage? Can you tell me what exactly is a miscarriage?
A. A miscarriage and the term abortion are in medical literature simultaneously. The procedure we are talking about is induced abortion as compared to abortion whereby a fetal loss occurs. Usually, historically, as I learned in medical school, it's a pregnancy that terminates prior to 20 weeks.
Q. And can you tell me what causes a miscarriage or what some of the causes may be?
A. Unfortunately for the most part, we don't know the reason. A few of them are called cervical incompetence, where the cervix doesn't stay open. A few of them is a woman's inability to hold a pregnancy for some reason. Some are drug use. Cocaine has been associated with miscarriages. Use of tobacco has been associated with more frequent miscarriages and pregnancy loss. Abnormalities to the uterus has been associated with miscarriages or abortions, spontaneous abortions. Infections have been associated. And there is a series of new ones which are thromboembolic associated with various clotting genetics

factors that women sometimes have that just come on the horizon, just recently being popularized.

Q. And you talk about some of the causes for a miscarriage, but is a miscarriage, is it started when the woman's body essentially goes into the type of labor, is that what starts the process of a miscarriage or how does that work?

A. Well, there is a whole gamut of miscarriage or the medical term is abortions, but there is a spontaneous abortion where everything is complete at one time. There is an inevitable, where she might rupture membranes or cervix is dilated, or by-products goes in through the cervix. That was one of them I'm forgetting about. Inevitable, spontaneous abortions. I guess I'm thinking of recurrent. Some people do this more than once.

Q. Okay. Doctor, concerning the Act, that Partial-birth Abortion Act, that's at issue in this case and the effect on your practice, do you feel the Act has no effect on your performance of first trimester abortions; is that correct?

A. That's correct.

MR. HENRY: Your Honor, may I confer with counsel?

THE COURT: Certainly.

BY MR. HENRY:

Q. Just one final question. Doctor, you gave some testimony a little bit earlier about situations where there is a miscalculation or mis judgment in the gestational age

of the fetus. So once you start a procedure, you get in there and you realize that the fetus may be older than 22 weeks in gestational age. I just want to ask you, how do those misjudgments or miscalculations, how does that occur?

A. They occur because the ultrasound machine is good but it's not precise. Occasionally, the referring physician that refers has made a mistake in measurement of the fetal skull. Occasionally the growth of the fetus is smaller or retarded. I'm not sure what the word -- I'm at a loss here. We use the word smaller than dates. Maybe a placental insufficiency, but those two things can make an error in the calculation offhand.

Q. Do you know what the range of error would be in doing these ultrasound measurements?

A. The standard range at 20 weeks is two weeks. That's within the accepted norm of a pregnancy. So one ultrasound is 20 weeks, but that's giving optimal technician readout or doing -- that means the operator had done a correct job.

Q. I'm just trying to understand. So you're saying there is a two week error range; is that correct?

A. Yes, sir.

Q. Do you mean it could be -- the fetus could be two weeks older or two weeks younger?

A. Week older or week younger is what I'm saying, under normal circumstance.

MR. HENRY: No further questions, Your Honor.

THE COURT: Redirect?

REDIRECT EXAMINATION

BY MS. CREPPS:

Q. Thank you, Your Honor. Dr. Fitzhugh, let me have you take a look at Defendant's Exhibit 681. Is that still in front of you?

A. Yes, sir. Yes, ma'am.

Q. And that, can you tell the Court what these pages are?

A. I'm afraid we didn't do a very good job, but I have two places where I provide abortion services where we intake abortion services. One at my office at Henrico Doctor's and one at Richmond Medical Center for Women, where I do the first trimester abortions and provide services. So the first page, 2-11 was compiled by my staff there. So that's probably the numbers of -- that's the numbers of people that were referred directly there. And for the most part, they are indications provided by the patient, although, there are some, there is some crossover to both of them, and the second pages is 2-2, is compiled by my staff in Henrico Doctor's Hospital. And those are the number of abortions that I do, that they intake -- the patients come to the office they counsel them there at the office, and it's charged through that office. Now, unfortunately, there is two or three others there that come directly in, too, but

the numbers are not significant.

Q. Now, as between the second trimester abortions that you do through Richmond Medical compared to the ones you do in your private practice, your private office, can you estimate or compare where the women who are coming to you by referral from other physicians, which of those two practices are more likely to land in?

A. The physician referrals and internal fetal medicine referral are primarily to my private office, so that would be page 2-12.

Q. So the percentage of abortions that you do by the result of referrals is higher at your private office than Richmond Medical; is that correct?

A. Yes, sir.

Q. Doctor, I just want to clear up a little bit of some of the language that you have been using. When you use the term viability, but you also use the term viable fetuses, do you have, do you distinguish between the term viable fetuses and viability?

A. If I have used the term viable or showing some life or viable in the sense that I'm trying to -- I have some concerns that it may be presented as a live birth, so I'm not sure if I answered your question. I'm confused.

Q. This goes back to some earlier questions you answered that I think may now be a little confusing.

THE COURT: Ms. Crepps, I understood the doctor, if this helps at all. I understood the Doctor to say or at least imply that from his perspective, there is a difference between viability, the legal definition, the medical legal definition of viability and a fetus who exhibits some signs of life.

MS. CREPPS: Right.

THE COURT: I understood him to say that. Go ahead.

MS. CREPPS: I'll only make it worse if I go ahead so I'll skip that part.

THE COURT: Thank you.

MS. CREPPS: Thank you.

BY MS. CREPPS:

Q. You were asked if you expect that the fetus will be dismembered when removed during a second trimester abortion. Do you recall that?

A. Yes, ma'am.

Q. What is your intent in bringing the fetus out in pieces or as intact as possible when you begin to remove the fetus in a second trimester abortion?

A. My only intent when I start is to finish in the quickest manner. I answered that question on the basis that the majority of them will come out as a non-whole fetus. Incidentally, I would prefer the other way.

Q. And you were asked some questions about dismemberment and where dismemberment occurred. And I believe your testimony was that dismemberment occurs when the fetus is brought to the internal os. And I guess my question for you is, does it take more than simply having the fetus come into the position where it is up against the internal os in order for dismemberment to occur?

A. It's a traction principle. So it has to have traction against something. So the traction can be the body against -- holding against the internal os, or it could be traction inside the uterus where a portion is lodged from side-to-side against the internal os. So you would dismember it for that reason.

Q. And it can also occur when part of the fetus passes through the internal os?

A. Right. You'll frequently have a part that will break off after it comes through the internal os, and that's really nice because then you can find the other part and gradually work your way up. So it's a little bit easier.

Q. You were asked about the situations in which you have a fetus that comes out intact but for the head, and whether you attempted to manipulate the fetus in order to bring it out. Do you recall those questions?

A. Right.

Q. When you were talking about three to five fetuses a

year, earlier in your testimony, were you referring to fetuses on which you would attempt to remove them by manipulation, or fetuses that you had already attempted the manipulation on?

A. I said three to five a year where the situation where I have an almost whole fetus comes through the os, at the internal os. Probably one, younger age I can get out whole, and the two others, I probably have to crush the skull, somewhere in that range, or I crush the skull.

MS. CREPPS: Your Honor, I don't have any other questions.

EXAMINATION

THE COURT: Doctor, real briefly before you step down, I understood you to say that you only did second trimester abortions in a hospital setting; is that right?

THE WITNESS: Yes, sir.

THE COURT: Will you tell me again which hospitals you do second trimester abortions at?

THE WITNESS: The Virginia Commonwealth University Medical College, Virginia, which is our teaching facility in Virginia, Richmond. And Henrico Doctor's Hospital, Henrico County.

THE COURT: Are both of those facilities state facilities?

THE WITNESS: The Medical College of Virginia is a

state facility. Henrico is an overall ACA complex.

THE COURT: So it's a for profit?

THE WITNESS: For profit.

THE COURT: Privately operated corporation.

THE WITNESS: Yes, sir.

THE COURT: Why do you do those second trimester abortions in hospitals?

THE WITNESS: It's required by law in Virginia, I believe.

THE COURT: All right. So you're doing that because the state law requires you to do it in a hospital; is that right.

THE WITNESS: Yes, sir.

THE COURT: Okay. Are there surgical review committees in both those hospitals?

THE WITNESS: There is mortality and morbidity committee reviews.

THE COURT: So are your procedures customarily reviewed in the mortality and morbidity committees? Are your charts available to them?

THE WITNESS: Well, the chart is part of the hospital, but I can't remember of any that have been reviewed or received any letters of notification of that happening.

THE COURT: Okay. I think what you're telling me

is if there is no mortality or morbidity, there is no reason for the mortality or morbidity committees to look at the charts?

THE WITNESS: Yes, sir. If you were having, I would say, a run on hospital admissions, they would review your --

THE COURT: Okay. Is there any other review of your charts, other than through the mortality or morbidity committees of those two hospitals, in the hospital setting?

THE WITNESS: No, sir.

THE COURT: All right, thank you. I'm going to let the lawyers follow up. First for the plaintiffs, then the Government, then the plaintiffs. Counsel, you may inquire if you wish.

MS. CREPPS: I don't have any questions, Your Honor.

THE COURT: Counsel.

MR. HENRY: No questions.

THE COURT: Thank you, Doctor. You may step down. Ms. Smith? We'll go until about noon, counsel, then we'll stop then.

MS. SMITH: Thank you, Your Honor. I would like to call Dr. Jill Vibhakar to the stand, please.

JILL VIBHAKAR, PLAINTIFFS' WITNESS, SWORN

THE COURT: Doctor, if I could trouble you to put

your elbows sort of on the table in front of you. That chair does not move, so it's awkward and I apologize. That will force you into the microphones and if you pull the microphones about the same level as your mouth there, then we'll be able to hear you, I hope. Go ahead

DIRECT EXAMINATION

BY MS. SMITH:

Q. Thank you, Your Honor. Dr. Vibhakar, can you tell us what your profession is?

A. I'm a physician.

Q. Where do you currently practice?

A. At the University of Iowa.

Q. Is that in Iowa city?

A. Yes.

Q. Where are you from originally?

A. I'm from Iowa city.

Q. Thank you. Have you ever testified in court before, Doctor?

A. No, I have not.

Q. Doctor, Your Honor, may I approach to just help the witness with the binders of the exhibits I'm going to have?

THE COURT: Sure. You may have continuing leave.

MS. SMITH: Thank you.

BY MS. SMITH:

Q. And, Doctor, could you look at Plaintiff's Exhibit 102,

please? And do you recognize that document?
A. Yes, I do.
Q. And what is it?
A. It's my CV.
Q. And is it current and up-to-date?
A. It's dated December, 2002, so it's a little outdated, but it still reflects for the most part my current CV status.
Q. Thank you, Doctor. Doctor, you went to the University of Iowa Medical School, is that correct?
A. Yes.
Q. And you got your degree in 1995?
A. Yes.
Q. And you did your residency in OB-GYN at Beth Israel in New York; is that right?
A. Correct.
Q. That was in 1995 to '99; is that right?
A. Yes.
Q. And after your residency, what position did you take next?
A. I took a staff position at the University of Iowa as an Assistant Professor in the Department of Obstetrics and Gynecology.
Q. Is that your current position?
A. Yes.

Q. And are you licensed to practice medicine in Iowa?
A. Yes.
Q. Any other states, Doctor?
A. Not at present.
Q. And are you a member of the American College of OB-GYNs?
A. Yes.
Q. Are you actually a fellow of that organization?
A. Yes, I am.
Q. Do you have any board certifications?
A. Yes, I do, in the specialty of obstetrics and gynecology.
Q. When did you receive your board certification, if you remember, Doctor?
A. In January of 2002.
Q. Can you describe for the Court what your duties are associated with your current position?
A. I participate in a private OB-GYN practice within the University of Iowa. I also have a variety of clinical assignments that vary from day-to-day and week-to-week, and include supervising labor and delivery, working the ambulatory surgical center, doing outpatient procedures, also staffing the Veterans Administration Medical Center Gynecology Clinic, the procedure clinic where we do colposcopies, cryo therapies and Leeps.
Q. What was the last thing and Leeps?

A. L-e-e-p.
Q. Is that a gynecological procedure?
A. Yes, electrical surgical procedure.
Q. Thank you, Doctor. What other clinical assignments?
A. The Emma Goldman Clinic, I help to supervise the resident continuity of CARE Clinic.
Q. Do you also work in the fibroid clinic?
A. Yes.
Q. Did you set that up?
A. I did.
Q. Doctor, you said you work on the labor delivery floor and you have a private practice, and so does that mean you deliver babies as part of your obstetrical practice?
A. Yes.
Q. Approximately how many babies do you deliver a year?
A. Approximately between 50 and 75 babies a year, I would say.
Q. And do you also teach as part of your duties at the University?
A. Yes.
Q. Is that both didactic and clinical teaching?
A. Yes, the majority is clinical.
Q. I'll ask you a little bit about your didactic teaching first. Can you tell me how many lectures you give approximately?

A. I give a lecture to the third year medical students who rotate through our specialty every six weeks. I give approximately two lectures a year to the gynecology residents and the medical students on the rotation at the time. And about every two years, I give a Grand Rounds Presentation.

Q. What topics do you lecture on?

A. I have given talks on topics such as ectopic pregnancy, pelvic pain, elective induction of labor, medical and surgical abortions. First trimester bleeding, normal and abnormal uterine bleeding. Those types of topics.

Q. Okay. Now I would like to ask you about your clinical teaching responsibilities. What does that entail?

A. In the various clinics, I described surgical and labor delivery assignments. I work with medical students and residents. I supervise them performing deliveries, procedures, surgeries. I also work with them in the clinics.

Q. Okay. Doctor, can you tell me what percentage of your time, if you can estimate it, you currently spend on your teaching responsibilities at the University?

A. The question was asked of me during my deposition. I believe I said approximately 75% of my time is devoted to teaching. I use that number because there is really only about one full day a week that I'm seeing private patients

by myself. However, I do not include office time that is built into my schedule where I do a lot of private patient follow up. So I guess it probably would be closer to 50 to 75% of my time.

Q. Okay. Doctor, I would like to ask you about your medical practice. You provide a full range of OB-GYN services; is that right?

A. Yes.

Q. And you see OB patients -- I think I just want to be clear, in your private practice on the labor and delivery floor, and in supervising OB patients, supervising residents at the Continuity Care Clinic, is that correct?

A. Correct.

Q. Do you treat women with high risk pregnancies, as part of your practice?

A. Yes.

Q. Can you tell us what type of high risk pregnancies you have experience with?

A. Multiple disstation, diabetes, hypertension, pre-term labor.

Q. All right. And if one of your obstetric patients is high risk, do you also refer her to a maternal fetal specialist?

A. On occasion.

Q. And would you remain involved in her care?

A. Sometimes I consult them more informally and then continue to primarily manage the patient myself.
Q. Okay. And you mentioned the Emma Goldman Clinic, I believe. Could you tell us what that is?
A. That's an independent nonprofit women's clinic located in Iowa City and they provide a variety of services including basic gynecology services, family planning services, and abortion services.
Q. And what's your role at the clinic?
A. I staff approximately two half days a month at the clinic and perform abortions during that time.
Q. And do you also supervise the performance of abortions by residents?
A. Yes.
Q. Why do you only give two half days a month to the clinic?
A. The University of Iowa Department of OB-GYN has a contract with the clinic whereby we provide staff two half days a week providing us a venue to carry out medical-student and resident education. And that was worked up because that was believed to be a sufficient amount of time but not take away too much from our other responsibilities.
Q. Okay. And do you perform abortions anywhere other than at the Emma Goldman Clinic?

A. I have performed them at the University of Iowa hospitals and clinics.
Q. How many abortions do you provide in that setting?
A. Approximately one to three a month.
Q. Okay. And at the clinic, can you estimate how many abortions you provide at the clinic? We could talk about first trimester first.
A. I would estimate approximately 100 first trimester procedures.
Q. And how about second trimester?
A. I would refer to the statistics that the clinic compiled for me.
Q. And so you need to refresh your recollection. Let's look at Defendant's Exhibit 675. Does that refresh your recollection, Doctor?
A. Yes.
Q. So can you answer the question?
A. Yes, so between 2001 and 2003, I performed a total of 264 second trimester procedures at the Emma Goldman Clinic.
Q. Okay. So is the percentage of second trimester abortions that you provide, is that a high percentage compared to other providers?
A. Yes, while some providers do not perform second trimester abortions, and because I'm one of a handful that does in Iowa do the second trimester abortions.

Q. Do you know how many providers there are in Iowa that provide second trimester abortions?
A. Currently, I would estimate about five or six.
Q. How far in pregnancy do you provide abortions at the clinic? To what gestational age at the Emma Goldman Clinic?
A. By performing second trimester, you mean D & E. There are probably more in our hospital that participate in induction and that was your last question.
Q. How far gestational age do you provide abortions at the clinic, at the Emma Goldman Clinic?
A. Through 19 weeks gestation.
Q. And how about at the University?
A. Up until 23 weeks gestation.
Q. Okay. And can you list for me the types of abortion procedures you currently provide?
A. At the Emma Goldman Clinic, we provide medical abortions through nine weeks gestation, and also suction procedures and D & E procedures and at the University. We also perform induction terminations.
Q. And I'm going to ask you some questions about your practice. Can you tell me what some of the reasons are that women seek abortions in the second trimester?
A. Sometimes there is a delay in the diagnosis of the pregnancy. Sometimes a fetal abnormality has not been diagnosed until later in the pregnancy. Sometimes the woman

needs time to make the decision or to obtain finances to have the abortion, money to pay for the abortion. Sometimes social circumstances change.

Q. And do you treat women who are seeking abortions for fetal anomaly?

A. Yes.

Q. What kinds of fetal anomalies have you seen in your practice?

A. Some of the abnormalities such as Trisomy 13, Trisomy 18, Trisomy 21, Monosomy X. Also fetal defects such as hypo plastic heart, anacephaly, even some deficiencies such as Fabry's disease and bilateral renal agenesis.

Q. Okay. And do you sometimes terminate pregnancies for women with health conditions themselves?

A. Yes.

Q. And what kinds of health conditions have you seen in your practice, where women are terminating their pregnancies?

A. Severe pre-eclampsia. Also I had a case involving an intracranial hemorrhage, chorioamnionitis.

Q. And of the second trimester abortions you perform, can you estimate how many are for fetal indications or for maternal health problems?

A. I would estimate between 10 to 20%.

Q. All right. Doctor, you testified that you perform

abortions using suction curettage method and also the dilation and evacuation method; is that right?

A. Yes.

Q. How late in pregnancy do you perform suction and curettage typically?

A. Typically, I use that method in the first trimester. Sometimes I'm able to complete a procedure using that method in the early second trimester through 16 weeks, but often are usually at the greater than 14 weeks, I need to use forceps to complete the procedure.

Q. And is that, is that how you define when you're starting to do what you call a D & E, is when you use forceps?

A. Yes.

Q. Doctor, what involvement, if any, do you have in induction abortions, labor induction abortions?

A. At the University of Iowa hospitals and clinics, some women are offered that option and counseled accordingly. And if they choose that option, it's carried out. I typically am not involved in the counseling process, but I may be supervising a part of the process when I'm assigned to the labor floor either during the day or nights when I'm on call. So I may be there at the start, in the middle, or at the end, but not usually throughout the entire process.

THE COURT: Counsel, let me interrupt you now. We are approaching noon. You tell me when would be a good time

to stop.

MS. SMITH: If you let me ask two more questions, then we should stop because they know we are about to get into something bigger. Okay.

THE COURT: Sure. Go ahead

BY MS. SMITH:

Q. Thanks. What types of induction techniques are used at the hospital?

A. I use a variety of induction agents including Oxytocin, Misoprostol, with or without laminaria, osmotic dilators or intrauterine Foley bulbs.

Q. Are these considered modern techniques for labor induction?

A. Yes.

Q. Did you say before that you gave a lecture -- one of the lectures you gave in teaching was on labor induction or was that on medical abortions?

A. I did give a Grand Rounds Presentation on elective induction of labor. I focused less on the method than the indications.

Q. Okay. Thank you, Doctor.

MS. SMITH: This would be a good time to break.

THE COURT: Is that agreeable with you, Mr. Henry, or Mr. Coppolino?

MR. COPPOLINO: Pardon me, Your Honor?

THE COURT: Is that agreeable with the Government.

MR. COPPOLINO: Yes.

THE COURT: We'll take our break. We'll be in recess until 1:30. I do have other -- I have criminal matters in here over the noon hour. You may leave your things but if you have anything that's particularly sensitive, I suppose you should take imprisonment. We'll be in recess until 1:30. Doctor, you may step down.

(Recess at 11:59 to 1:30 p.m.; all parties present).

THE COURT: Doctor, if you will retake the witness stand.

(Witness resumed the witness stand).

THE COURT: Before we begin, some of us have soft voices, both lawyers and witnesses, and I don't much care if people in the back can't hear, but I need to hear and my clerks need to hear, so everybody needs to speak up.

MS. SMITH: We are going to try to raise the level a little bit.

THE WITNESS: Now, I can play around a little bit with the volume control.

MS. SMITH: I meant me, my own level I would try to raise.

THE COURT: That would be good, but actually we can hear you pretty well.

MS. SMITH: Okay. Good.

THE COURT: We have a little trouble with Mr. Henry. Mr. Henry, you were over -- where are you, Mr. Henry? There you are. You're hiding again. You were speaking over the mike, so if you raise it a little bit and because of that goofy chair in the witness box, it's bolted down and won't move. It's awkward for witnesses, so if they can lean into the mic that would be helpful to us. And I have found that mechanically, if you just put your elbows kind of as I said yesterday, it's not polite but put your elbows on the table. That will physically force you into the mic. All right. Pardon me for the interruption. Go ahead.

BY MS. SMITH:

Q. Thank you, Your Honor. Doctor, we were just talking about the modern abortion techniques that are used at the University of Iowa. I was wondering if you are aware or could you tell the Court if you are aware of any recent studies comparing the safety of modern induction techniques with D & E procedures after 20 weeks?

A. Yes. In the context of abortions, there was a paper published by Dr. Autry in 2002, that was a retrospective cohort looking at the complication rates of D & E procedures compared with induction abortions.

Q. Would you look in the -- it's the first of the binders of the plaintiff's exhibits. It's exhibit, Plaintiff's

Exhibit 19. Doctor, do you see the article at Plaintiff's Exhibit 19?

A. Yes.

Q. Is that the article that you're referring to?

A. Yes, it is.

Q. It's an article entitled A Comparison of Medical Induction and Dilation and Evacuation for Second-Trimester Abortion; is that correct?

A. Correct.

Q. Can you tell me what journal that was published in?

A. It was published in the American Journal of Obstetrics and Gynecology.

Q. Is that a peer review journal?

A. Yes, it is.

Q. Is it a well respected journal in your field?

A. Yes, it is.

Q. Is it perhaps the most well respected journal in your field?

A. It's one of the most respected journals in my field.

Q. Thank you, Doctor. Can you summarize briefly for the Court the findings in that -- of that study, Dr. Autry's study?

A. Yes. As I said, it compared the complication rate retrospectively between D & E abortions between 14 and 24 weeks, and medical induction abortions. And it found a

higher complication rate with the latter. There were approximately 4% complications D & E groups compared with 29% in the induction groups, and they defined complications as failed medical abortion, hemorrhage that required transfusion, infection that required intravenous antibiotics, retained products of conception that requires a D & C, organ damage, including uterine perforation that included additional surgery and cervical lacerations that required repair and readmission to the hospital.

Q. Doctor, on page 394 of that study under section entitled results, I think it's the second paragraph, is that where you find the data you're referring to the 4% versus the 29%?

A. Yes.

Q. Did this study specifically look at induction techniques using Misoprostol, Doctor?

A. Yes, when they looked at the inductions that used Misoprostol as the agent compared with D & Es, there was still a high complication rate in inductions, 22% versus 4% in the D & E group.

Q. And is that a statistically significant difference?

A. Yes, it is.

Q. And, Doctor, is this study, is it consistent with your clinical experience with inductions and D & E abortions in the second trimester?

A. Yes, it is.

Q. And how so?
A. I have been involved in inductions that indeed have required antibiotic use for infection and additional procedures of D & C for retained placenta, and also for hemorrhage. And I have experienced more cases of significant blood loss and infection with inductions as compared to D & E.
Q. Do you believe that retained placenta is a complication of medical induction abortions?
A. I do because it adds a procedure with all of the inherent risks associated with that procedure, as well as to the induction.
Q. And do you have any experience with treating a woman who has retained placenta after a medical induction abortion?
A. Yes.
Q. And have any of those been in emergent situations?
A. Yes, several have been in emergent situations to control hemorrhage.
Q. Can you describe one of those cases for us?
A. For instance, one patient had delivered the fetus and the placenta didn't deliver immediately. She was given more of the Misoprostol or Oxytocin to accomplish delivery. It took time. In the mean time, she continued to bleed varying amounts, but the bleeding became heavier and she became hypotensive and needed to be brought back to the operating

room to undergo an emergency D & C to control hemorrhage.

Q. Were you called in to do that D & C?

A. Yes.

Q. Doctor, are there any limitations regarding the studies findings or methodology?

A. Well, it is a retrospective study so there is selection by us, but even when they control for gestational age, which tended to be higher in the induction group than the D & E group, there was still a higher complication rate in the induction group. I would also be interested to know how they defined retained products of conception. More details of the induction method, etc.

Q. So it's not perfect?

A. No.

Q. It's not a perfect study?

A. No.

Q. Is it still useful?

A. Yes.

Q. Doctor, are you aware of any other recent prospective comparing D & Es versus inductions?

A. Yes. Dr. Grimes recently published an article that described his attempt to perform a prospective -- control trial comparing complications between medical abortion and D & Es in the second trimester.

Q. Doctor, can you look at tab 44 in the same binder,

Plaintiff's Exhibit 44. Is that the paper you're referring to?

A. Yes, it is.

Q. And that's a paper by David Grimes and others entitled Mifepristone and Misoprostol versus dilation and evacuation from mid trimester abortion: A pilot randomized controlled trial; is that right?

A. Yes.

Q. What journal was that published in?

A. It was published in the British Journal of Obstetrics and Gynecology in February of 1994.

Q. So it's a very recent study?

A. Yes.

Q. Is the British journal, is that a peer review journal, do you know?

A. Yes, it is.

Q. Is it a well respected journal?

A. Yes, it is.

Q. And who is Dr. Grimes. Do you know who Dr. Grimes is?

A. Yes, I do.

Q. Who is Dr. Grimes?

A. He's an expert in abortion and epidemiology.

Q. Is he well respected in the field?

A. Yes, he is.

Q. And could you summarize for the Court the findings of

this paper?
A. Well, they terminated the study because they had trouble recruiting people into the medical abortion group. When people were randomized to that method, they ended up declining for their participation in the study because they didn't want to have a termination via that method.
Q. Does Dr. Grimes make any recommendations about how one might be able to design a study that would work where you could get people to agree to be randomized?
A. What I believe -- in the conclusion they suggested that it be done in a setting where labor induction abortion is the norm.
Q. And where would that be? Is there somewhere in the United States where labor induction is the norm?
A. There are probably places where it is the norm. I mean I have mentioned before we do perform them at the University of Iowa. I'm not sure you would call it the norm because, again, women still have the option of a D & E.
Q. Do you know what the percentage of labor induction abortions is in the United States versus D & Es roughly?
A. It's very low. It's under 5%.
Q. Of the second trimester procedures?
A. Yes.
Q. All right. Given these two articles and what you've stated about the safety issues, relative safety of D & E

abortions versus induction abortions, Doctor, why do you offer induction abortions at the University?

A. Some patients, after counseling regarding the risk versus benefits of either method, still opt to have the induction. So it, in large part, is patient -- rather large part is patient preference and informed consent. Sometimes because we are doing these in the majority of cases when there is a fetal anomaly, the pregnancy might have been very desired and the patient might find the induction method of termination psychologically easier. Then they can have an intact fetus with photos taken, and that can help with the grieving process.

Q. Are there any other issues in terms of the staff available to perform D & Es versus inductions at the University?

A. Yes. They haven't always had that many physicians who are skilled in performing D & Es, and even though now we do have several who are skilled in doing D & Es, they might not always be available given their schedules.

Q. Would you say there is a shortage of D & E providers?

A. Yes.

Q. And, Doctor, are there women for whom induction abortion is contraindicated or relatively contraindicated?

A. Yes, for example, if the woman has chorioamnionitis and is sick, then you would like to evacuate the uterus as soon

as possible to decrease her use of sepsis. Also sometimes we want to perform the termination in a more controlled setting, avoid significant changes in fluid balance and avoid pain and elevated blood pressure.

Q. Why would you want to control changes in fluid balance. What does that mean?

A. Well, sometimes there may be a maternal medical condition that could be worsened by rapid fluctuations in the -- her fluid balance.

Q. And have you ever performed a D & E on someone who was referred to you because of a maternal health condition?

A. Yes.

Q. And can you give us an example of that?

A. I remember one case where the patient had atypical severe pre-eclampsia at about 19 weeks, and she had pulmonary edema and her respiratory status was worsening. She was already undergoing an induction termination procedure but it was taking time, and it did not appear that she would deliver in the near future, so I was asked to perform a D & E. I did and she improved, clinically improved rapidly after that.

Q. And is it unusual for a woman to develop pre-eclampsia at 19 weeks. Is that why you call it atypical?

A. Yes. And in retrospect, she was diagnosed with antiphospholipid antibody syndrome, I believe.

Q. What is that. What is -- I won't try to say it. What is it?

A. Some women have certain types of antibodies in their blood such as anti cardiolith and antibodies or lupus anticoagulants, and it puts them at higher risk for developing conditions such as pre-eclampsia or spontaneous abortion or pregnancy loss and also thromboembolic events.

Q. Thank you, Doctor. Have you performed D & Es on any other patients who have been referred to you with medical conditions that were contraindications for medical inductions?

A. There was another patient who was approximately 20 weeks pregnant when she developed headache and loss of vision and was diagnosed with five to six centimeter intracranial hemorrhage due to a ruptured AVM, arterial venus malformation. And she wanted to terminate the pregnancy. She was counseled that she would be at risk of the AVM rebleeding should she carry the pregnancy to term and labor. She was also rather, the neuro surgeons at the University of Iowa did not want to treat the AVM. They did not want to ligate it or embolize it until after pregnancy. And my maternal fetal medicine colleague and the neuro surgeons in consultation with each other decided the best method for termination would be a D & E as opposed to an induction because it could be more controlled procedure.

Q. Thank you, Doctor. Now, I would like to talk a little bit about your D & E abortions. Could you tell me what the first step is in the D & E abortion?

A. Well, after the patient has been counseled and decides to go ahead with that method, she has an ultrasound, if she hasn't already, to confirm that gestational age. And she has one to two laminaria, sets of laminaria placed the day prior to the procedure at our institution at the Emma Goldman Clinic.

Q. And is that at -- what gestational age are you talking about?

A. Typically at 15 to 16 weeks, we insert one set of laminaria. At 17 weeks, two sets of laminaria are placed the day prior to the D & E.

Q. And what about prior to 15 weeks. Would any of those be D & Es or are those all suction?

A. At 13 to 14 weeks, at the Emma Goldman Clinic, we start administering the patients Misoprostol. Buccally.

Q. What does that mean?

A. In the checks or oral cavity without swallowing. Prior, the morning prior to the procedure.

Q. Okay. So for 13 and 14 week gestational age, you use Misoprostol buccally the morning of the procedure?

A. Typically, if they don't have a history of a previous C section or abdominal myectomy because there have been some

case reports with uterine rupture using the Misoprostol in the second trimester.

Q. Okay. By the way, Doctor, if there is case reports of uterine rupture for Misoprostol in -- is that in D & E procedures or would be a term, those case reports?

A. That includes cases in the second trimester either undergoing medical induction or with cervical ripening prior to extraction.

Q. So would that be a contraindication for a Misoprostol induction as well?

A. It could be, yes.

Q. And at 15 weeks, you said you start to use one to two sets of laminaria starting the day before. Is that correct?

A. Um-hm.

Q. And then do you use Misoprostol also in those procedures?

A. Yes. Typically we also administer Misoprostol buccally the morning of the actual D & E.

Q. Do you ever use mechanical dilators?

A. Sometimes.

Q. In what cases?

A. It's -- the cervical preparation which I just described did not achieve adequate dilatation to do the suction and extraction, then I would use metal dilators.

Q. Okay. Doctor, I want to ask you a little bit about how

much dilation you seek to achieve in your procedures, and I would like to go by gestational age just to make it clear for the record. And let's start with 13 to 14 weeks in these procedures. How much dilation are you trying to get?

A. Typically, I'm trying to dilate at least to 12 to 14 millimeters, so I can insert a suction cannula of that size.

Q. And will you be using forceps also in that procedure?

A. Most of the time not, but sometimes I do need to complete the procedure using forceps, mainly for retaining calvarium.

Q. And those are the procedures for you using the Misoprostol buccally, correct?

A. Yes.

Q. How long does it take to achieve that dilation with the Misoprostol in the morning?

A. Typically we administer it one to two hours prior to the procedure, and then at the time of the dilatation, their cervix is dilated such that we don't typically get resistance with the metal dilators until 29 or 31 French and then --

Q. What is that. We don't know -- you have to explain to us what 29 or 31 French is.

A. Okay. It's a measurement system used in medicine that takes pi, P-I, into account, and so it's really -- you divide it by approximately three you'll get the size in

millimeters of the dilators.
Q. Those are the metal dilators that you use. Are those the metal dilators that you use that you're referring to?
A. Yes.
Q. It's just different sizes of the metal dilators; is that correct?
A. Right. So dilate up to the number in French. That's three times the size in millimeters of the suction cannula you want to use. And using the Misoprostol, even though we still have to use the metal dilators to dilate up that far, it makes the process easier and faster and less uncomfortable for the patient.
Q. Thank you, Doctor. At 15 to 16 weeks, how many dilation are you trying to achieve in that instance, in those cases?
A. Then I need to dilate to approximately 15 to 16 millimeters to insert a suction cannula of that size into the uterus.
Q. Are you seeking to achieve -- so is that one-and-a-half to two centimeters for 15 to 16-week procedure?
A. About one-and-a-half centimeters, yes.
Q. Is that the minimum? What would you like to achieve?
A. Well, ideally I would have greater dilatation because it makes the procedure easier and faster, in my opinion; less uncomfortable for the patient if they are having it done under local anesthesia, especially, and also you have -- can

remove larger pieces of the fetus in general with less fragments and smaller parts that could cause injury.

Q. So if one-and-a-half centimeters is a minimum at which you'll do the procedure, what is your ideal?

A. For 17 weeks and up, I prefer two to four centimeters dilatation.

Q. At 17 weeks on up?

A. Um-hm.

Q. All right. Okay. At 17 weeks up, how many sets of laminaria are you using?

A. Typically two sets of laminaria the day prior.

Q. The day prior?

A. Um-hm.

Q. Okay. And why do you prefer to get a larger dilation? Why would you prefer two to four? Is four ideal? Is that what you're saying?

A. Using the cervical preparation method I just described, that's unusual, but it is nice when we have that amount of dilatation. It makes the procedure again faster, in my opinion, safer, less uncomfortable for the patient, etc.

Q. And how common is it to get two or three centimeters of dilation?

A. It varies quite a bit. I would say it's more common now that I'm using the Misoprostol.

Q. Okay. And, Doctor, you were starting to say why you

prefer the larger dilation. Can you answer that? I'm not sure if I got your whole answer to that. I'm sorry.

A. In my opinion, it makes the procedure faster, safer, easier to perform, less uncomfortable to the patient, safer.

Q. Why is it safer, in your opinion?

A. I believe there is less blood loss and, again, less chance of having to remove the fetus in small pieces which, in my opinion, can increase the chance of cervical injury or uterine perforation.

Q. Okay. Can you control the amount of dilation you get?

A. No.

Q. Why not?

A. Let's see. Using the cervical preparation method I described, there is just a wide range of dilatation achieved. Often, if the woman is parous, has already had delivered children vaginally, the cervix dilates better. The patient is very young, it might be harder to dilate.

Q. So those are some of the factors that will influence how easy or hard it is to get dilation; is that right?

A. Right.

Q. Why, if you prefer to get four centimeters of dilation for example, why don't you send women away for a third day?

A. We are limited in terms of our staffing ability. Logistically, it would be very difficult to introduce that to a recurrent system. Again, we only spend X amount of

time at the Emma Goldman Clinic. Plus these patients are often traveling far distances and may be staying in a hotel nearby in some cases, and it makes the procedure more expensive and more of a burden to them without gaining that much more medically.

Q. Doctor, I think I neglected to ask you whether you always insert the same number of laminaria when you're inserting your laminaria?

A. No. I generally insert as many as the cervix will accommodate without forcing the laminaria.

Q. Does that vary from patient to patient?

A. It does.

Q. And what factors influence whether the cervix will take more or less laminaria, do you know?

A. Again, parity is the main determinant.

Q. And the other factors that you mentioned, would those apply here as well?

A. Um-hm.

Q. Doctor, after you've removed the laminaria and you have determined you have sufficient dilatation to proceed, what's your next step?

A. Then I place the speculum in the vagina and cleanse the cervix with an antiseptic solution, and then usually start the local anesthetic injection and place the tenaculum on the cervix.

Q. What's the purpose of the tenaculum?
A. To provide traction on the cervix and straighten the cervical canal.
Q. Does it have -- does the tenaculum and the placement of the tenaculum have any impact on the location of the cervix in relation to the vaginal introitus?
A. Yes. When we pull on the tenaculum to straighten the cervix, it pulls the cervix closer to the introitus.
Q. And how close, how close is it?
A. Well, it varies quite a bit.
Q. What's the range?
A. The range, well, it also varies. It can depend on the length of the woman's vagina. It can depend on the location of the cervix in the vagina. Sometimes with an inverted vagina, the cervix will be inverted and closer to the vagina even prior to the placement of the tenaculum. It depends on the woman's parity and gestational age. So it can range from being virtually at the introitus to many inches away from the introitus.
Q. And how common is it for the cervix to be all the way right at the introitus?
A. Not very common.
Q. How about within, say, four centimeters?
A. I would say that's not uncommon.
Q. Is there any way you can give the Court a sense of how

often that happens?
A. It's difficult, because it's not something I necessarily keep track of during the procedure or gauge while I'm performing the D & E, but I know that, you know, sometimes the speculum is halfway out of the vagina with the traction applied to the cervix, so that would make the cervix probably within four centimeters of the introitus. I would say that probably occurs maybe about 10% of the time.
Q. Thank you, Doctor. Is it clinically significant, the position of the cervix, vis-a-vis the vaginal introitus, does that have any clinical relevance to you?
A. Not really unless it were very high in the vagina and did not come down much, and if it were far away, then it makes the procedure more difficult.
Q. Why does it make it more difficult?
A. Because then you can only open the forceps so widely if -- the majority of the length of the forceps is within the speculum, and it makes it harder to reach within the uterus if the length of the forceps is limited by the speculum. I mean the length is not limited, but you can't insert your hand in the vagina because of the speculum being there so you can only reach so far in the uterus.
Q. What factors influence how much the cervix will come down? I think you said the length of the woman's vagina at rest, as it were, would be one of the factors. Are there

other factors as well?
A. In the position of the cervix and the vagina, and the patient's parity plays a major role.
Q. Okay. And you said you think it's about 10% and I understand that's your attempt to make a good faith guess or estimate, really, of the amount of times that happens. Is that frequency the same as with first trimester abortions?
A. No. It's more common to have greater descensus further on --
Q. Further on in the pregnancy?
A. -- in the pregnancy due to the relaxation of the supporting ligaments.
Q. So there is a relaxation of the ligaments as the pregnancy progresses; is that right?
A. I believe so.
Q. Do you think when the cervix is brought down to the vaginal introitus, do you think that's because there is the too much force being put on the cervix?
A. No.
Q. Doctor, when you begin the process of removing the fetus, what's your first step?
A. The first step is to insert the suction cannula and evacuate the amniotic fluid from the uterus, and to bring the products of conception closer to the cervix.
Q. Okay. And what do you do next typically?

A. Then I insert the grasping forceps and start removing pregnancy tissue.

Q. And how much of the fetus are you trying to remove with each grasp?

A. As much as possible.

Q. If the fetus is not to come out intact, what's the best case scenario for you?

A. To remove as large pieces as possible at one time.

Q. Okay. And what, if anything, do you do in the process of removing the fetus that would facilitate your ability to remove larger pieces? I'm talking about what you do in the manipulation of instruments in particular?

A. Well, if I have a purchase on something.

Q. If you have a what?

A. A purchase on something and I'm pulling it through and it's not coming easily, then I will regrasp and change the direction to try to allow a fetal part to come through the cervix more intact. And if I start recognizing a fetal part coming through the cervix, then I will regrasp higher in the cervix or the uterus to try to bring out as much as possible and not to disarticulate it until I have gotten to the higher level.

Q. And why do you need to regrasp higher? What would happen if you simply kept pulling?

A. Well, sometimes it would become disarticulated in the

vagina, and also sometimes, I would just kind of twist the forceps to help bring something through rather than applying more traction at a certain point where it might disarticulate sooner than I would like.

Q. So you try to twist rather than just applying with the traction, is that what you said?

A. If it's not coming easily, yes.

Q. And in your experience, does that facilitate the removal of larger pieces of the fetus?

A. Sometimes, yes.

Q. Okay. And is that something that you teach your residents?

A. Yes. If anything, their tendency is to once they have pulled something into the vagina, just to keep pulling without regrasping higher on the fetus. So I instruct them to -- not to do that and to regrasp higher to protect -- also to protect what's coming through the cervix to try to prevent injury to the cervix, but also to prevent the fetus coming out in smaller pieces.

Q. And does the grasp part, the part that you have got ahold of, does that ever pass the introitus while it's still connected to part of the fetus that remains inside the uterus?

A. Yes.

Q. And after the grasp part passes through the cervix, what

typically happens then?
A. At some point, the more proximal part of the fetus that remains in the uterus becomes too large to fit through the cervix, and so it becomes, pulls apart from the rest of the body and becomes -- or it becomes disarticulated.
Q. Okay. Is there an average number of times that you reach into the uterus? Can you characterize that for us in any given procedure?
A. No. It generally requires multiple passes.
Q. And does it vary according to how much -- well, tell me if it varies and what factors would influence --
A. It varies quite a bit. And the main determining factor is the degree of dilatation at the start of the procedure. So if the cervix is two or three centimeters dilated, that will require less passes into the uterus because you can extract more larger pieces at one time.
Q. Have you ever had a fetus come out completely intact in one of your second trimester D & E procedures?
A. Not after residency training.
Q. Have you had it come out intact up to the calvarium?
A. Yes, I have.
Q. And how often has that happened?
A. On occasion, once or twice.
Q. Okay. And at what gestational age was that?
A. It was about 19, 18 to 19 weeks gestation.

Q. And what did you do at that point?
A. Then I disarticulated the body from the calvarium, and then compressed the calvarium with the forceps and extracted the calvarium.
Q. And have you ever had the fetus come out not completely intact, but where part of the fetal trunk passed the umbilicus has come outside the body of the mother while the rest of the fetus is still inside?
A. Yes. I was supervising a D & E with one of our residents, and she extracted an upper extremity, then on the next pass, had a lower extremity, and the remainder of the fetus came out to the level of the calvarium. And then I had her disarticulate the body from the calvarium and compress the calvarium just like the previous case.
Q. And have you had any situations where the fetus is not necessarily coming out feet first but where part of the fetal trunk past the naval has come outside the mother?
A. Yes, I guess it would depend how you define fetal trunk, because the upper extremity is removed included the shoulder area, and sometimes when -- sometimes when we are doing the D & E, some of the first things that are removed are maybe a portion of skin from the trunk or even ribs or other trunk contents.
Q. And do you consider those part of the fetal trunk above the umbilicus?

A. Yes.
Q. And you've taken them outside the body of the mother?
A. Yes.
Q. Or the woman?
A. Yes.
Q. And can the fetus still be living in that it has a heartbeat or other signs of life at that time?
A. Possibly, yes.
Q. Now, Doctor, are you familiar with the term intact D & E or intact D & X?
A. Yes.
Q. And are you familiar with ACOG's definition of intact D & X?
A. Yes.
Q. Doctor, were you ever taught during your residency a procedure that was similar to that?
A. Yes. One of the physicians with whom I trained when I did an elective at our woman's clinic preferentially used that method for doing D & Es.
Q. What was that procedure called during your residency?
A. A D & E.
Q. So you didn't -- your teacher, professor, didn't distinguish between that D & E and other D & Es? They were all just D & Es?
A. No, I don't remember them giving it a different name.

Q. Okay. And what were you taught?
A. Well, he would do a breech extraction up until the level of the calvarium, and then a puncture at the base of the skull, and then suction the cranial contents and then extract the calvarium attached to the body.
Q. And in the D & E procedures that you learned how to do during your residency, including that one, but also ones that you were taught by other professors, what were you taught with relation to the amount of dilation you should seek?
A. More is better, and it's ideal to remove as large pieces as possible. We know from -- scratch that. Don't remember what I was going to say.
Q. Are you finished with your answer, Doctor?
A. I am. I am.
Q. And why were you taught to remove larger pieces, if possible, and why are were you taught that more is better in terms of dilation?
A. It was thought to be safer.
Q. Why was that?
A. Less -- less manipulation within the uterus, so less risk of perforation, less chance of retained tissue, less chance of small fetal parts causing injuries such as cervical lacerations.
Q. And so you -- which of those procedures are you still

performing? Are you performing the more is better dilation?
A. I'm performing the D & E, and though I'm skilled to do the procedure with the minimum amount of dilatation necessary, it gets much easier and safer, in my opinion, if you have greater dilatation.
Q. So you're able to do it through a smaller dilatation?
A. I am.
Q. But you feel it's safer in larger; is that right?
A. Safer to do it with more dilatation, yes.
Q. And why do you not currently perform the intact D & X procedure? I know it wasn't called that during your residency, but you described a procedure with a breech delivery and puncturing the skull, and you said you don't currently perform that. Why is that?
A. Because typically, I don't have the adequate, the amount of dilatation necessary to perform the procedure that way, and also, now I feel more experienced doing the dismemberment D & E.
Q. Okay. And do you feel your D & E procedures you perform are safe?
A. Yes.
Q. And do you feel there is any benefit to try to remove the fetus intact?
A. Yes.
Q. If you could remove the fetus intact through a larger

dilation, would that make your procedure safer?
A. Yes.
Q. Okay. Now, Doctor, we have discussed various scenarios that occur when you remove a fetus during a D & E. Do you know which way the procedure will proceed when you set out?
A. No. If the cervix is well dilated, there is a higher chance that that larger pieces will come out and that the fetus might come out predominantly intact, but I can't predict that at the beginning of the procedure necessarily.
Q. Okay. Doctor, before you start performing, removing the fetus during a second trimester D & E, is the fetus alive?
A. Yes.
Q. And how do you know that?
A. We have the ultrasound performed the previous day if it's at the Emma Goldman Clinic. At the University, usually an ultrasound for dating, rather an ultrasound has been performed within a couple of weeks of the procedure, and I do not necessarily document a fetal heart beat at the beginning of the procedure so there is a small chance that she could have had a fetal demise, but it's unlikely.
Q. Do you know when the removal of the fetus, fetal demise occurs?
A. No, I don't.
Q. Is there any clinical significance to when you cause fetal demise during the procedure?

A. Not in my opinion.
Q. Now, is it possible, have you heard of a procedure to induce fetal demise prior to a procedure using a medication?
A. Yes. Sometimes intrauterine or intrafetal Digoxin or KCL is injected to cause fetal demise.
Q. Do you use Digoxin or KCL the Emma Goldman Clinic?
A. No, we do not.
Q. Why don't you?
A. It's not deemed necessary, and it would add an increased burden to the girl/woman with an additional procedure and small risk associated with that, and more anxiety, and discomfort, and expense, and time involved.
Q. Is Digoxin or KCL injection used at the University to perform procedures?
A. Sometimes. Typically for induction terminations at 22 weeks or greater, my colleagues will inject intracardiac KCL.
Q. And why is that, do you know?
A. To prevent the birth of a living fetus.
Q. Now, you mentioned a very small risk associated with the injections. Can you tell the Court what those risks are?
A. Well, in general, serious complications associated with amniocentesis are very rare, but you can have infection, bleeding and even death.
Q. Doctor, are you aware of any case reports concerning

complications associated with amniocentesis?

A. Yes. There was an article published recently out of Israel that listed two cases in which maternal death occurred following amniocentesis in the second trimester.

Q. Can you look in the third plaintiff's binder at tab 110. Do you have that in front of you, Doctor?

A. Yes. 110.

Q. Is that the article, Doctor?

A. Yes, it is.

Q. That's an article by Dr. Uriel Elchalal. I'm not sure if I'm pronouncing his name correctly, and others, entitled Maternal Mortality Following Diagnostic 2nd Trimester Amniocentesis; is that right?

A. Yes.

Q. It's in a journal called Fetal Diagnosis and Therapy?

A. Yes.

Q. Do you know when this was published?

A. This was published in 2004.

Q. So sometime earlier this year?

A. Yes.

Q. Do you know if that's a peer review journal, by the way?

A. Yes.

Q. It is?

A. Yes.

Q. And, Doctor, can you just summarize the case reports

that are discussed there?
A. They describe two cases in which women died due to sepsis shortly after having an amniocentesis performed for routine indications in the second trimester of pregnancy.
Q. Now, those are pretty significant complications but thousands and thousands of women get amniocentesis every year, correct?
A. Correct.
Q. Is there a difference between the amniocentesis risks and risks from Digoxin?
A. If intraamniotic or intrafetal Digoxin or KCL is injected, it involves the performance of an amniocentesis. So the risk of an amniocentesis to remove fluid would be similar to performing those injections. With the injections, you have the added risk, so they are very minute of the chemical agents you're introducing.
Q. Of the actual medications versus the injection?
A. Right, versus the amniocentesis itself, yes.
Q. Could you compare the volume or incidents of amniocentesis in this country as compared with the incidents of KCL or Digoxin injections? Are there more or less is what I'm trying to ask in a very unartful way.
A. Much more amniocentesis are performed without injecting KCL or Digoxin.
Q. So if the risk is very small, for example, that a woman

is going to suffer significant complications from amniocentesis, what would the impact be of requiring women, all women, to have Digoxin or KCL injections in second trimester abortions? Would that increase the incidents of complication from those procedures?

A. If you were to increase the amount of amniocentesis being performed, the absolute number of complications would go up even though they are small.

Q. Okay. Now, Doctor, you've said that your D & E procedure is generally a low risk surgical procedure; is that right?

A. Yes.

Q. Even when the fetus doesn't come out intact?

A. Yes.

Q. So is there any reason to try to make it safer?

A. Yes.

Q. And why?

THE COURT: Counsel, do you need that exhibit anymore?

MS. SMITH: No.

THE COURT: Perhaps you could help the witness so she doesn't have to sit there holding it.

THE WITNESS: That's fine. Safer. Yes, and also as I mentioned, in my experience the procedure is less uncomfortable to the patient when the fetus is removed

predominantly intact.

BY MS. SMITH:

Q. Okay. Thank you. Doctor, I would like you to look at Plaintiff's Exhibit 69 which is in the binder I just placed on the ledge there. Oh, it's not there? Oh. Exhibit 69. Thank you. Have you seen this document before?

A. Yes, I have.

Q. This is the Act, the Partial-birth Abortion Ban Act of 2003; is that correct?

A. Yes.

Q. And could you turn to page S-6, and if you look at the language of the prohibition section, Doctor, have you read this before?

A. Yes.

Q. And do you think any of the abortion procedures that you currently perform are covered by the Act?

A. Yes. I think on occasion, the D & Es I perform would fall under the Act.

Q. And why is that?

A. Because it's vague, and I have already described a couple of cases where I had the fetus come out up until to the level of the umbilicus, and then continued to perform the D & E or commit overt acts that would -- could result in fetal death.

Q. Doctor, you said it was vague. What about the Act do

you think is vague. What don't you understand about it?
A. Well, it doesn't specify whether the fetus has to be intact up unto the level of the umbilicus or delivery of a portion of the trunk. And sometimes during a D & E, you can remove a portion of the trunk early in the procedure and then continue to -- to do things which could result in fetal death.
Q. So it's the definition overall you think is vague; is that right?
A. Yes.
Q. Are there any particular terms within the definition that you think are vague?
A. Well, I do think the term overt act is vague, and any part of the fetal trunk past the navel is outside the body is vague, and the -- yeah.
Q. Okay. Thank you, Doctor. I believe you have been talking about your D & E procedures. Do you think any of the induction procedures that you supervise would be covered by the Act?
A. Possibly.
Q. And how would that be true?
A. Sometimes in the case of an induction, a part of the fetus will deliver and part of the fetus will still be inside the uterus. And in trying to facilitate delivery of the rest of the fetus, the umbilical cord could become

compressed, and that could cause fetal death or the fetus could become disarticulated, and that could cause fetal death.

Q. Thank you, Doctor. Doctor, do you believe that enforcement of the Act would affect your patients?

A. Yes.

Q. In what way?

A. Well, then to bypass the Act, one alternative would be to use intraamniotic or intrafetal of KCL or Digoxin, and I think that would be riskier and more burdensome to the patients and might be prohibitively more expensive. And I might not be willing to incorporate that into my practice and, therefore, might discontinue doing second trimester terminations.

Q. When we were seeking an injunction back in the fall, had you made a decision about what you were going to do if we were unsuccessful in obtaining an injunction?

A. I was going to cease from performing second trimester abortions.

Q. Did you make that decision yourself?

A. Yes.

MS. SMITH: Can I just take one moment to consult, Your Honor?

THE COURT: Sure.

MS. SMITH: Your Honor, I have just been informed I

neglected to move to admit Dr. Vibhakar's CV, which is Plaintiff's Exhibit 102.

MR. WARDEN: No objection.

THE COURT: 102 is received.

MS. SMITH: I have no further questions at this time.

THE COURT: Is it your intent to offer 19, 44, the journal article.

MS. SMITH: Well, Your Honor, yes. I will offer Plaintiff's Exhibit 19, Plaintiff's Exhibit 14 and Plaintiff's Exhibit 110.

MR. WARDEN: Which numbers are those?

MS. SMITH: 19, 14 and 110 which are the three articles we discussed.

MR. WARDEN: Your Honor, I'll object on hearsay grounds to those articles mentioned.

MS. SMITH: Your Honor, I'll just say that given this is a judge trial and Your Honor might like to have the articles, I think the harm here of introducing learned treatises is significantly reduced.

THE COURT: Well, I mean it's still hearsay.

MS. SMITH: I offer them really for the Court's convenience, Your Honor.

THE COURT: Well, I understand that, but anyway, the imposition of the hearsay objection to 19, 44 and 10 is

going to require me to look at a couple of things. I will tell you that it seems to me that if you -- on subsidiary questions, the effect of a good hearsay objection to a lot of these things would be to extend the trial on both sides. It would seem to me, because the alternative is then you go get the author. But let me look at a couple of things, so I'll withhold the ruling on 19, 44 and 110.

MS. SMITH: Thank you, Your Honor.

THE COURT: All right. Counsel, would you like to take your break now and then begin your examination?

MR. WARDEN: That would be preferable, Your Honor, yes.

THE COURT: Is that agreeable with you, counsel.

MS. SMITH: Yes, Your Honor.

THE COURT: Doctor, you can step down. We are going to take a 15-minute break and we'll start again shortly before three. We stand in recess.

(Recess from 2:39 to 2:58 p.m.; all parties present)

THE COURT: Counsel, before we begin, why don't we take up this issue of studies, and Mr. Coppolino, you may be the one to speak for the Government because we talked about it during the -- I'm not directing a question at you yet, Mr. Coppolino. I'm just warning you that you're probably the one.

MR. COPPOLINO: I was going to do it anyway.

THE COURT: Okay. It seems to me the hearsay objection is a good one unless you've given notice under the residual exception, and I take it that you haven't.

MS. SMITH: I'm sorry. Notice of the what?

THE COURT: Under the residual exception to the hearsay rule.

MS. SMITH: No, Your Honor.

THE COURT: Okay. So I permitted the witness and I'll permit others to essentially recite portions of the report into the record under the learned treatise exception to the extent that the documents are established as authoritative in my opinion. In any event, there was no objection, so it looks to me like the hearsay objection is good, but we have got a whole list of these articles that go to -- I don't want to say they are unimportant questions -- but they are subsidiary questions, it seems to me.

The question then becomes what do you want your record to be like? I'm perfectly ambivalent, but if there are peer-reviewed studies on both sides of this issue, one wonders in a bench trial, I mean, if you go back and look at the learned treatise exception to the hearsay rule, the reason we have that is so jurors aren't improperly influenced by having people dump books on them and say, well, look, some expert said this in a book, and we are fearful that jurors won't understand that it's like anything

else.

In a bench-tried case, where you're dealing with scientific or medical evidence, and as we were talking earlier where studies may make a difference, but yet it is probably inefficient to call all these authors or to take depositions of them and try to do it that way, I leave it to you all whether you think it makes sense to exclude those exhibits, and one probably couldn't make a global determination of that anyway, that all of them ought to come in or all of them ought to stay out necessarily.

I simply ask you all to consider whether for these studies on subsidiary questions, and I suppose we could fight about what that means, subsidiary, but you know as I told you at the pretrial conference, I look at my job very much as a softball pitcher. I'm to make the roundest softball possible so other folks can hit it out of the ballpark to the Court of Appeals or someone else. It doesn't make much difference to me. I get paid the same money no matter what the record looks like. The question really for you as litigators is what do you want your record to look like? And here we have some studies that on the face of them appear to be, you know, done by -- well, Grimes, for example, we have heard of Grimes before in the other case. I presume that he's somebody who knows what he's doing, and he's done a study that tells us some things.

As the record exists, we have an expert giving us essentially a summary, but we don't have the underlying analysis, his words. Is that the kind of record that you want to present in this perfectly round softball that I hope to create for other people to look at? And only you all as good lawyers, as really good lawyers, as you all are, can know that, but I just urge you not to be reflexive in asserting perfectly good objections, so I'm prepared to rule that 19, 44 and 110 ought to be excluded on hearsay grounds. The objection is technically correct, but I'll hear the parties if you want -- if you have anything else you would like to tell me on this or related subjects, and I'm not trying to suggest Let's-Make-a-Deal. You all, but it's something worth thinking about before you just decide that these things aren't coming in.

MS. SMITH: Well, Your Honor, the only thing I would notice that, clearly, they are articles and learned treatises on both sides, and perhaps I wasn't exactly going to say Let's-Make-a-Deal, but I was going to say perhaps we should consult and counsel should consult and see if we can come to some agreement about learned treatises or not and inform the Court as soon as possible of what that is. Now, perhaps Mr. Coppolino will say forget it. No deal right now, and then that's it, and that's fine, but if not, and counsel was amenable, we could talk about it and come back

to the Court.

THE COURT: That's perfectly okay with me. Mr. Coppolino?

MR. COPPOLINO: I don't think I have ever said forget it, no deal, to Ms. Smith. I actually think it's a good idea. I think your objection, I think your ruling should stand because they are hearsay and should be admitted, and then I think since we have other articles that witnesses will be addressing, we'll put our heads together and see if there is some limited basis on which they could be admitted so that the Court has access to them and that they are available on the record for a limited purpose, but it's something we obviously have to consider very carefully because here the learned treatise exception is quite clear that you have to read portions into the record.

THE COURT: Well, essentially, I have allowed the witness to do that. You all didn't object, and I understood that. Ms. Smith, do you think you've gotten a fair shot at the learned treatise exception on 19, 44 and 110? I think you have.

MS. SMITH: I think so, Your Honor.

THE COURT: So you don't need to reopen to do that?

MS. SMITH: No.

THE COURT: I mean, the physical process of having your witness read the thing, I permitted her to summarize

it.

MS. SMITH: That's fine with me, Your Honor.

THE COURT: All right. Mr. Coppolino, go ahead. Pardon me.

MR. COPPOLINO: I was just going to say we'll consider the admissibility under that exception, and we could advise the Court sort of what our global position is on all of these articles that experts will be considering throughout the trial because the exception is quite clear that while statements may be read, the articles are not to be admitted as exhibits, and so there is that, at least, and then further, if the articles are to be admitted then, they would have to be admitted subject to some specific limitation, so the long and short of it is, why don't we just think about it a bit and then advise the Court of what our views are on how we would treat these articles with witnesses.

THE COURT: That's fine. Why don't you take a day or so or think about it or whatever time you reasonably need. As I say I'm perfectly ambivalent. Doesn't make any difference to me, but I can just see somebody else asking where is that Grimes article, and then it won't be here. All right?

MS. SMITH: Yes. The only thing I would like to add, Your Honor, I understand you have sustained the

objection to those exhibits, and I would understand that I could renew my --

THE COURT: Offer?

MS. SMITH: -- my offer if we come to some agreement for those three.

THE COURT: Oh, sure. Yeah.

MS. SMITH: Thank you.

THE COURT: I was just saying by the objection, I have done nothing with the testimony. The testimony in the record stands as it is. There was no objection to it and so it's in the record, so we have a partial summary.

MS. SMITH: Thank you.

THE COURT: Okay. All right. Counsel, you may inquire.

CROSS-EXAMINATION

BY MR. WARDEN:

Q. Doctor, you're not board certified in maternal field medicine; is that correct?

A. Correct.

Q. You're not board certified in the subspecialties of obstetrics and gynecology; is that correct?

A. Correct.

Q. You were recently certified in obstetrics and gynecology in 2002; correct?

A. Correct.

Q. Doctor, you perform second trimester abortions using the D & E method; correct?
A. Yes.
Q. You're comfortable performing D & Es up to 23 weeks; correct?
A. Yes, and I would consider it up until 24 weeks to save the life or health of a mother.
Q. And, Doctor, when you perform a second trimester D & E, you encounter fetal dismemberment, disarticulation 100% of the time; is that correct?
A. Yes.
Q. And I believe you testified since your residency, you have never removed a fetus completely intact while performing a second trimester D & E; correct?
A. Correct.
Q. Doctor, in dilating the cervix during your second trimester D & E procedures, I believe on direct you testified that between 13 and 16 weeks, you want the cervix to be dilated at least to accept the same size millimeter cannula as the fetus is in gestational age; is that accurate?
A. Yes. There is some leeway there, but as a general rule, yes.
Q. Just, for example, like for 15 week fetus, you would want to dilate enough for the cervix to accept a 15

millimeter cannula; is that correct?
A. Correct, except those aren't available right now where I practice, so I might use a 14 millimeter instead.
Q. A 15 millimeter cannula is not available; is that correct?
A. Where I currently practice, yes.
Q. Doctor, to achieve that dilation, you would begin the extraction procedure; correct?
A. Yes.
Q. And at 16 weeks and above, the same rule applies that you would want to dilate a cervix at least to accept a 16 millimeter cannula; is that right?
A. Yes.
Q. And if you achieve that degree of dilation, you would begin the extraction procedure?
A. Yes. Again, there is some leeway.
Q. Okay, so, for example, on a 19 or 20 week fetus, if the fetus would accept a 16 millimeter cannula, you would then begin the extraction procedure?
A. Yes.
Q. And you have the skill to perform a D & E on fetuses 16 to 20 weeks with 15 and 16 millimeters of dilation; is that correct?
A. Yes.
Q. And at these -- at 16 millimeters in dilation and a

fetus 16 weeks and older, the fetus will come out in smaller pieces; is that correct?

A. Typically, yes.

Q. Doctor, is as a general rule, if you have at least one-half of the biparietal diameter and dilation, you begin the extraction procedure; is that correct?

A. Let me think about that. I guess as a general rule, I don't think about it that way. I know that if I can insert a 16 millimeter suction curette that I can complete the procedure with the -- for the gestational ages we have been talking about.

Q. And when dilating the cervix between 13 and 16 weeks, you generally use one set of laminaria the day before the procedure; is that correct?

A. Typically, yes.

Q. And you prefer to have the laminaria in between 12 and 24 hours; is that correct?

A. If I'm using one set, yes.

Q. And after that 12- to 24-hour period, the patient would then return to the clinic; correct?

A. Yes.

Q. Then on the second day, Misoprostol would be administered about an hour or two before the extraction procedure; correct?

A. Yes.

Q. And after the Misoprostol, you would then begin extraction after that one to 2-1hour period; correct?
A. Typically, yes.
Q. And for fetuses that are 16 weeks and older, you generally use two sets of laminaria within that 24-hour period; is that correct?
A. Seventeen weeks and older, sometimes use a single set for 16, especially if the patient is parous.
Q. And then you would insert one set initially, and then the second set, I believe you said, about four hours after that?
A. Yes.
Q. And that's on the same day; correct?
A. Yes.
Q. And then on the second day, the woman then would return to the clinic; correct?
A. Yes.
Q. And she would receive Misoprostol approximately one to two hours before the procedure; correct?
A. Typically, yes.
Q. Doctor, I believe you testified on direct that if you don't obtain sufficient dilation we just talked about, that you occasionally use metal dilators; is that correct?
A. Yes.
Q. And it's about 5% of the time that you have to resort to

the metal dilators; is that correct?

A. Possibly.

Q. And, Doctor, would you agree that metal dilators increase the risk of uterine perforation?

A. Yes, there is some evidence that suggest that a slower preparation or dilatation of the cervix decreases the risk of uterine injury in general.

Q. Doctor, there are other side effects associated with Misoprostol; is that correct?

A. Yes.

Q. Would the risk of allergic infection, excuse me, risk of allergic reaction be one of the side effects?

A. Yes.

Q. Chills?

A. Yes.

Q. Nausea?

A. Yes.

Q. Diarrhea?

A. Yes.

Q. Fever?

A. Yes.

Q. And --

A. Most -- Go ahead.

Q. Side effects occur fairly frequently; correct?

A. Yes. They are typically mild.

Q. And, Doctor, you typically give the same dosage of Misoprostol to all your second trimester abortion patients; is that correct?
A. Yes.
Q. You don't vary the amount depending on the gestational age of the fetus; correct?
A. In the context of cervical preparation for D & Es, yes.
Q. And, Doctor, Misoprostol causes uterine contractions; correct?
A. Yes.
Q. And in your experience, you've noticed the use of Misoprostol caused the fetal tissue to bulge through the cervix; is that correct?
A. It causes the fetal tissue to be lower in the uterus in general which is very helpful to me, and sometimes I do see pregnancy tissue bulging.
Q. And that's evidence of the uterine contractions?
A. I believe so.
Q. Doctor, when you begin the extraction procedure during your second trimester D & Es, the first thing you do is insert this suction cannula and remove the amniotic fluid; is that correct?
A. The first thing I do?
Q. Yeah, when you begin your extraction procedure.
A. Typically, I mean, sometimes if the membranes are

bulging, then I will rupture them with a different instrument, but yes.

Q. And the purpose of the suction is to vacuum the amniotic fluid; is that correct?

A. Yes, and to bring pregnancy tissue closer to the cervix.

Q. And for 13 and 14 week fetuses, suction alone will remove most of the fetal tissue; is that correct?

A. Yes, in my experience.

Q. And then for 15 and 16 week fetuses, sometimes a majority of the fetus will come through just using that initial suction; is that correct?

A. Yes.

Q. At 17 weeks, the fetal limbs are sometimes -- can come through that initial suction; correct?

A. Yes.

Q. And, Doctor, you use a tenaculum during your second trimester D & E procedures; is that correct?

A. Yes.

Q. And the purpose of that instrument is to provide traction on the cervix; is that correct?

A. Yes, and to straighten the canal.

Q. Okay. Doctor, if you could open the binder in front of you to Defendant's Exhibit 677, please. Would you tell me what this is, Doctor, this document?

A. This is some educational material about a D & E

procedure that's given to clients at the Emma Goldman Clinic.

Q. And did you produce this document to the Government in the course of discovery?

A. Did I produce this document to the Government in the course of discovery? As fulfilling your request, yes.

Q. Yes.

A. Yes.

Q. And does this document fairly reflect information and materials that are given to women who receive second trimester abortions at the Emma Goldman Clinic?

A. Yes.

Q. Doctor, if you could turn to page 4-65? There is some illustrations. We have talked a lot about different technical tools. Just like to put a picture with some of them. There are two pictures of laminaria. Does that accurately reflect the laminaria that you have been talking about today?

A. Yes.

Q. And the picture on the right under placement of laminaria in the cervix, is that typically how you would insert laminaria in the cervix during your second trimester D & E procedures?

A. I'm not sure I understand the question.

Q. Well, Does this picture accurately reflect the placement

of laminaria in the cervix in the second trimester D & E procedure?

A. More or less.

Q. Doctor, could you turn to page 4-66, please? There is a device in this diagram labeled cervical stabilizer. Is that a tenaculum?

A. Well, yes. If you read above it, it says the doctor will attach a tenaculum, a clamp that holds the uterus steady during the procedure, and they are trying to -- they tried to produce a representation of that tenaculum.

Q. Does that fairly reflect how you use a tenaculum during your second trimester D & E procedures?

A. Again, I'm not sure I understand the question. Does what I do look like the picture? I guess it pretty much does.

Q. Okay. Doctor, there is also on that diagram a weighted speculum, and what does that instrument do?

THE COURT: Once again, counsel, we have all this fancy equipment. If you want to project it on the television screen and have the doctor testimony from there, feel free to do that, but I leave it to your good judgment?

MR. WARDEN: Thank you, Your Honor.

THE WITNESS: I do not typically use a weighted speculum. I use a bivalve speculum. On occasion I have used a weighted speculum.

BY MR. WARDEN:

Q. Could you flip to page 4-64? What type there is -- what type of speculum is that?

A. That's a bivalve speculum.

Q. That's, is that a diagram an accurate reflection of the bivalve speculum you use in your second trimester abortion procedures?

A. It's an accurate depiction of a speculum. It's not an exact representation of the type of speculum I use in regard to shape and size and components.

Q. Okay.

A. But it is a picture of a speculum.

Q. Okay. Thanks. Doctor, with respect to the use of the tenaculum, you place that on the cervix before you begin the initial suction; is that correct?

A. Yes.

Q. Okay. And after performing your initial suction, you would remove the tenaculum, then insert the grasping forceps; is that correct?

A. Could you repeat the question?

Q. Sure. After you perform your initial suction, you then remove the suction then insert the grasping forceps; correct?

A. Yes.

Q. So the forceps and the cannula are not inside the cervix

or the uterus at the same time?
A. Correct.
Q. So it's one or the other?
A. Yes.
Q. Okay. Doctor, with the tenaculum, I believe you said you were pulling the cervix closer to the vaginal introitus; is that correct?
A. Yes.
Q. I think you testified on direct that you consider that descensus, is that correct, is that the proper term?
A. Yes.
Q. And that's because you're using an instrument to pull the cervix closer; is that correct?
A. Yes.
Q. Doctor, instrumental descensus of the cervix is distinct from a condition known as uterine prolapse; is that correct?
A. Yes, but if they have, if the patient has preexisting uterine prolapse, you're likely to get much greater descensus when you apply the tenaculum and apply traction.
Q. Doctor, when you are pulling on the cervix with the tenaculum, is the cervix in place at that point?
A. Yes.
Q. When you're pulling, does the speculum ever fall out?
A. On occasion, yes.
Q. Why does that happen?

A. Because pulling the cervix down pushes the speculum out of the vagina.
Q. So as you're pulling the cervix closer to the vaginal introitus, is it more likely the speculum will fall out?
A. I don't understand the question.
Q. As you're pulling -- You said you were pulling the cervix closer to the vaginal introitus. If you are pulling it further and further, is it more likely the speculum will fall out if you are pulling further?
A. I guess the better way of phrasing it would be if -- the more descensus you have and the further you can pull the cervix down or the closer you can pull it to the introitus, the more likely the speculum is to fall out, yes.
Q. How often, in your experience, does the speculum fall out during your second trimester D & E procedures?
A. Just on occasion.
Q. A little more specific than that? Could you give a percentage perhaps?
A. Perhaps 1% of the time it actually falls out and needs to be replaced. I mean, often, it's partially outside of the vagina but doesn't completely fall out.
Q. So it would become dislodged on occasion but not fall to the ground, for instance?
A. It might even fall to the ground, but it can become dislodged, but more often just the portion of it comes out

of the vagina, not the entire speculum.
Q. How frequently would it occur that you would have to -- that it would become dislodged such that you would have to readjust the speculum?
A. Again, I would estimate maybe 1% of the time.
Q. One percent?
A. Um-hm.
Q. If you could, from the informed consent materials, if you could flip back to page 4-67, please. Could you tell me what that is a picture of?
A. It's a picture of grasping forceps used for a D & E.
Q. Is this drawing an accurate depiction of the forceps you use during your second trimester D & E procedures?
A. More or less. I mean, to me it looks like a Soffer forceps, but I would have to actually place the picture of the Soffer next to it to see if maybe the screw is in the right location. I don't know if it's an exact representation to that level of detail, but yes, it's a picture of forceps similar to that that we use.
Q. And, Doctor, when you begin to extract the fetal tissue with the forceps, I believe you testified that you reach in and grab whatever fetal part is presenting on that specific occasion; is that correct?
A. That's correct. I reach in and grasp whatever my forceps reach, and it might not actually be the official

presenting part.
Q. Um-hm.
A. But whatever I run into first.
Q. You don't try to grab a specific fetal part; is that correct?
A. Yes, that's correct.
Q. And you don't manipulate the fetus into a certain position before beginning the extraction procedure with the forceps; correct?
A. Correct.
Q. And once you have grasped a part, I believe you testified you pull on it and use firm traction to remove it; is that correct?
A. Yes.
Q. And that traction is obtained against the cervical os; is that correct?
A. Yes.
Q. And is it the resistance between the cervical os and the grasped part, that's what causes the disarticulation; is that correct?
A. Yes, though the disarticulation can also occur in the vagina and in the cervix, so beyond the internal os, but the majority of the time it occurs at the level of the internal os.
Q. So it's an internal disarticulation; correct?

A. I don't know -- I don't use that term, so could you define that?
Q. Well, let's just let that one go?
A. Okay.
Q. Doctor, if the part doesn't want to come, you use a twisting motion on occasion; is that correct?
A. Yes. Sometimes I find that that helps me figure out which direction it will come more easily.
Q. If you encounter resistance, you may compress the tissue with the forceps; is that correct?
A. Yes, or in the process, I'll start regrasping, yes.
Q. You're squeezing firmly so you compress that tissue; is that right?
A. Yes.
Q. And, Doctor, when you're extracting the tissue, dismemberment typically occurs around the joints of the fetus; is that correct?
A. Yes.
Q. And, Doctor, once you remove all the large parts of the fetus, you use suction at the end of the procedure to remove the smaller pieces of the tissue; is that correct?
A. Yes.
Q. And what other steps do you take in your procedure to avoid retained fetal tissue?
A. If I'm not sure I have retrieved all the major parts

during the procedure, I will use an ultrasound to check for retained tissue. I also check the fetal tissue after the procedure to make sure I have an adequate amount and try to identify all the major parts. Those are the main things.

Q. And do you check the fetal tissue that's come through the suction machine as well to make sure you have all the fetal parts; is that correct?

A. If I am not sure that I have obtained it without the suction.

Q. You may use a curette on some occasions to ensure all fetal tissue has been removed?

A. Sometimes, yes, but I use a curette only on a minority of cases, a sharp or blank curette as opposed to the suction curette.

Q. Doctor, D & E is a safe procedure; correct, Doctor?

A. Yes.

Q. But there are some potential complications with D & E; correct?

A. Yes.

Q. And the likelihood of encountering one of those complications is about 1% or less; is that correct?

A. Could you restate that question, please?

Q. Sure. The likelihood of encountering a complication during a D & E procedure is 1% or less; is that correct?

A. Of encountering a major complication, I would agree that

that's about right. It's perhaps about 1% or less for possible infections or possible perforation, so I guess if somebody had two complications, it might be more frequently than that, so yeah.

Q. So for things like infection, hemorrhage, uterine perforation, cervical laceration, it would be 1% or less?

A. One percent or less, yeah.

Q. That's based on your understanding of the medical literature and your experience?

A. Yes.

Q. Doctor, in your experience, you have never had a case of uterine perforation during a second trimester D & E while you have performed the procedure; correct?

A. Not to my recollection, correct.

Q. And, in fact, you take a number of steps to avoid uterine perforation while you're performing your D & E; is that right?

A. Yes.

Q. Use ultrasound when necessary; is that correct?

A. Yes.

Q. And you try to minimize the amount of instrumental manipulation; is that correct?

A. Within the uterus, yes.

Q. And typically, Doctor, there isn't much blood loss during a second trimester D & E; is that correct?

A. Correct.
Q. And you have never encountered an infection while performing a second trimester D & E; is that correct?
A. It's not to my recollection. It's possible that, for instance, somebody at the -- who had had a D & E at the University or the Emma Goldman Clinic followed up elsewhere with an infection we didn't get to know about, but I'm not aware of any off the top of my head.
Q. Okay. And you have never had a surgical laceration that's caused a hemorrhage during a second trimester D & E; is that correct?
A. I have. I don't remember the gestational age. I believe it was -- there was a case about 14 weeks, I believe, and the majority was completed via the suction and then a calvarium was retrieved with ring forceps and the ultrasound's guidance, and following that, there was profuse bleeding from the cervix, and then I placed a clamp on the cervix to control the bleeding. We had the patient transferred to the University because it was done at the Emma Goldman Clinic and did a laparoscopy to make sure there were no perforations or entrapped abdominal bleeding, and she had received agents to cause uterine contraction to prevent bleeding, but she kept bleeding until I inserted a Foley bulb into the uterus and put traction against the cervix, so my suspicion was she might have had a high

cervical laceration that I could not see under direct visualization.

I know it was early in the second trimester. Might have been even 13 weeks. I do not recall specifically. She did lose a fair amount of blood through all this. I don't remember, but I think she may have required a blood transfusion, and that is one case I can recall there was excessive bleeding with the D & E.

Q. Doctor, on direct, you testified that you studied under a physician who would perform a second trimester abortion by, I believe, attempting to remove the fetus entirely intact and would puncture the base of the skull and suction the cranial contents; is that correct?

A. Yes.

Q. And you participated in several of those abortions during your residency; is that right?

A. Yes.

Q. Since your residency, you have never performed an abortion in that fashion; is that correct?

A. Correct.

Q. Doctor, in performing your second trimester D & Es, you just said the 16 millimeter cannula is the cannula you use to suction the fetal tissue when the fetus is 16 weeks or older; is that correct?

A. Yes, sometimes 15 weeks, but generally 16 millimeters, I

mean 15 millimeters, but generally 16 millimeters.
Q. And in order to puncture the skull and evacuate the cranial contents, you would have to use a much smaller cannula; is that correct?
A. Yes. In fact, I don't remember the size of the cannula that we use, but I think it was a 9 or a 10 millimeter cannula or a smaller even.
Q. Those types much cannula tubes aren't on the tray of instruments that you use when you perform your second trimester D & E procedures; is that correct?
A. They are available in the clinic, but it would require switching the tubing, and I don't request that.
Q. Okay. Doctor, you testified on direct that you've encountered several occasions where you extracted the entire body of the fetus except for the head, and the head was lodged; is that correct?
A. Yes. I clearly remember one case where the body was intact up to the level of the calvarium and another where one extremity was removed; otherwise, the body was intact up to the level of the calvarium.
Q. You can only remember one specific occasion; is that correct?
MS. SMITH: Objection, Your Honor. Mischaracterizes her testimony. I think she just testified about two occasions.

THE COURT: The objection will be sustained. But you can go back and clarify it. I understand why.

MR. WARDEN: Sure.

BY MR. WARDEN.

Q. You've only encountered two occasions, Doctor, that you remember where this situation has happened?

A. Yes.

Q. Doctor, you didn't specifically try to extract the entire body of the fetus and have the head get stuck during that procedure; correct?

A. No, but I considered it a good thing.

Q. Right. And the gestational age of the fetus in those situations where the body was out and the head was stuck was 18 to 20 weeks; is that correct?

A. The one, I believe, was 18 to 19 weeks and at the Emma Goldman Clinic, and the one at the University was 21 weeks.

Q. And in those situations, you used your typical dilation protocol, the two sets of laminaria and the Misoprostol; is that correct?

A. I believe so. Sometimes we don't use the Misoprostol in the case of a previous C section or abdominal laminectomy, but I believe we used in those two cases, and I believe that's why we had the greater disarticulation.

Q. In those particular situations you disarticulated the body from the head; is that correct?

A. I take that back. The first one at the Emma Goldman Clinic occurred shortly after I started there, and we weren't using the Misoprostol initially, so probably just the two sets of laminaria for one of those.

Q. Okay. When the head was stuck, you disarticulated the body from the head; is that correct?

A. Yes.

Q. And you removed the body, compressed the head and removed the head; is that correct?

A. Yes.

Q. And in decompressing the skull, you're trying to reduce its sides so it can fit through the cervix?

A. Yes.

Q. And when you are doing this, you're trying to remove skull pieces so the liquid brain will empty from the cranium and the head will decrease in size; is that correct?

A. And in compressing it, if it doesn't fit, and in my experience it hasn't fit without decompressing it in the process of crushing it or grasping it, it becomes punctured enough so that the cranial contents will drain, and then it will fit through the cervix.

Q. When you compress the skull in that fashion, it creates skull fragments; is that correct?

A. Sometimes, yes.

Q. Those fragments can cause lacerations; correct?

A. Yes.
Q. You testified earlier, Doctor, that you perform second trimester abortions on fetuses with anomalies and malformations; is that correct?
A. Yes.
Q. And about, I think you said, 10 to 20% of the abortions you perform are for fetal anomalies; is that correct?
A. Plus maternal medical conditions.
Q. Oh. Okay. What percentage of your cases involves solely fetal anomalies?
A. Solely fetal anomalies?
Q. Is that 10%?
A. Yeah, of that about 90 or 95% would be for fetal anomalies rather than maternal medical conditions.
Q. So that's 95% of the ten to 20%?
A. Yeah.
Q. Okay. You have had experience performing abortions on fetuses of a variety different anomalies; correct?
A. Yes.
Q. You testified neurotubule defects?
A. Yes.
Q. There is chromosomal defects; is that right?
A. Yes.
Q. Various organ malformations; is that correct?
A. Yes.

Q. You performed a D & E in all those situations; correct?
A. I have performed D & Es in those situations. I have also been involved in induction termination for similar indications.
Q. Doctor, you have had experience performing abortion on fetus with hydrocephalus; is that correct?
A. Yes.
Q. You performed a D & E on that fetus?
A. Yes, it was mild hydrocephalus, and I performed a D & E.
Q. You don't have to modify your D & E procedure because of the hydrocephalus?
A. No.
Q. Dr. In cases of fetal anomaly, you're usually not the physician who diagnoses the anomaly; is that correct?
A. Correct.
Q. Typically women who come to the University of Iowa, they are referred from an outside physician who would diagnose that anomaly, and they are referred to the University; is that correct?
A. Yes, or it's diagnosed or they are referred to the University for testing, and it's diagnosed at our Fetal Diagnosis and Therapy Center.
Q. Um-hm. What is Fetal Diagnosis and Therapy Center?
A. What is it?
Q. Yeah.

A. It's a clinic run by a maternal fetal medicine specialist. It includes sonographers and genetic counselors and MFMs.

Q. So a woman with a fetal anomaly referred to the University of Iowa would initially go to that Fetal Diagnosis and Testing Center; is that correct?

A. The FTC Center, typically, yes.

Q. Then the physicians in that center would then counsel the woman regarding her options of continuing the pregnancy; is that correct?

A. Yes.

Q. Then if the woman elected to terminate the pregnancy, then they would call you or bring you in to perform the termination procedure; is that accurate?

A. Or one of my colleagues if it's a D & E. If it's an induction termination, then they just set it up and who's ever covering the labor floor supervises that process, and it might change several hands because it can be sometimes a long process.

Q. Doctor, in the cases of fetal anomalies, it's the mother's choice to have the abortion; is that correct?

A. Yes.

Q. A portion for fetal anomaly is not necessitated by health reasons; is that correct?

A. Correct.

Q. Doctor, in cases of fetal anomalies at the University of Iowa, the extracted tissue is taken for a pathology exam; is that correct?
A. Typically, yes.
Q. Prior to the pathology exam, you, as the physician who is performing the abortion, has some information about the anomaly; is that correct, an initial diagnosis, perhaps?
A. Yes. Just a second. You lost me. Is this for -- Can you back up again two questions back?
Q. Sure. In the case of fetal anomalies, when you're performing the termination procedure, you had some information, you, as the physician who is performing the termination procedure, about that anomaly either from the amniocentesis or sonography; is that correct?
A. Yes.
Q. Okay. In your experience, the additional information provided by the subsequent pathology exam is not required to diagnose that anomaly; is that correct?
A. Yes. I can't think of an instance where it was required. Now, sometimes the patient has declined an amniocentesis, and then they are still interested in obtaining a chromosome analysis so then that will be performed on the fetal tissue if possible. If there was a certain genetic syndrome that the FDT staff were concerned about and they wanted additional information from the fetus

after it has been -- that would be taken into consideration.
Q. And the information obtained, in your experience, from the pathology exam doesn't add to any of the genetic counseling that occurs in relationship to that anomaly; is that direct?
A. Correct.
Q. Doctor, you can confirm a chromosomal anomaly with a disarticulated part of the fetus; is that correct?
A. Yes.
Q. Doctor, you're comfortable performing D & Es in cases where continuing the pregnancy is contraindicated for maternal health reasons; is that correct?
A. Could you repeat the question?
Q. Sure. You're comfortable performing D & E abortions in cases where continuing the pregnancy is contraindicated for maternal health reasons; is that correct?
A. Yes.
Q. And you've performed abortions D & E abortions on women with maternal health complications; is that correct?
A. Yes.
Q. I believe you testified about one case involving severe pre-eclampsia earlier?
A. Yes.
Q. And you performed a D & E abortion on that woman; is that correct?

A. Yes.
Q. In your opinion, the D & E procedure was the safest way to evacuate the fetus from the mother in that particular situation; is that correct?
A. Yes.
Q. And I believe you testified that you've performed abortions on women with history of pulmonary embolus; is that correct?
A. I have.
Q. And I believe you testified earlier you've performed a D & E abortion in the case of, I believe it was a ruptured brain aneurysm; is that correct?
A. Yeah. Actually, in my deposition, I said it was a ruptured aneurism, and then after that we reviewed the information I had, and it was a ruptured AVM, but the management is similar.
Q. Doctor, if the fetus is near viability and the mother has a severe maternal health complication, say, pre-eclampsia, for example, how do you treat the mother and the fetus in that situation?
A. We weigh the risks of continuing the pregnancy with the mother with the risk of prematurity to the fetus with delivery.
Q. How do you evaluate those risks?
A. That's a broad question, and I can give you examples?

Q. Sure.
A. Can you or can you -- We counsel the patients regarding the prognosis of the fetus with premature delivery. That's usually done by our NICU staff. Counsel the patient regarding the risk to her health in terms of how do we evaluate those risks, we look at the medical literature and also the our local experience.
Q. Doctor, you don't perform induction abortions at the Emma Goldman Clinic; is that correct?
A. Yes.
Q. You have never performed an induction abortion on one of your private patients; is that correct?
A. Yes.
Q. And I think you said that you have never performed induction abortion from start to finish, but you may occasionally be involved in steps along the way; is that accurate?
A. Can you repeat that question?
Q. Sure. I think you testified on direct you have never performed an induction abortion from start to finish, but you have been there either supervising or aiding in the process along the way; is that correct?
A. Never say never. I don't know that I would use that terminology. If I did, it was a mistake because I may have been involved from start to finish in a very quick

induction, or if I were on a 24-hour-plus call, I can't recall specifically any instances, but I probably have been involved from start to finish excluding the initial counseling session.

Q. And in your opinion, there is some circumstances in which an induction abortion is contraindicated for one reason or another; is that correct?

A. Yes.

Q. In those situations, you perform a D & E abortion; correct?

A. Correct.

Q. Doctor, in cases where neither the D & E or induction method is contraindicated, the decision between the two procedures is a matter of informed consent for the patient; is that correct?

A. Yes, and also a matter of availability of staff and a matter of logistical considerations. Again, we don't perform induction terminations at the Emma Goldman Clinic, so they are not even offered there to the patient as an option because we don't have a facility and staff available 24 hours of the day.

Q. At the University of Iowa, if either a D & E or induction is contraindicated, both those options would be presented in the informed consent; is that correct?

A. Again, if we have staff available, occasionally people

are at conferences. There was one instance where one of our faculty who doesn't normally perform them agreed to perform one on the labor floor, and then her mother needed emergency surgery, and in order to allow her to be with her mother, I came off my maternal leave to complete the D & E, so again, staff availability can be an issue sometimes.

Q. Doctor, you consider the labor induction method to be a safe method of abortion; is that correct?

A. Yes.

Q. Doctor, I believe for induction abortions at the University of Iowa, you testified that Misoprostol is typically the induction agent that's used; is that correct?

A. More recently, yes.

Q. And research has proven that Misoprostol is safe for the labor induction process; is that correct?

A. Yes.

Q. And in your experience, Misoprostol is faster than the other Prostaglandins available; is that correct?

A. In general, yes.

Q. In your experience, you have seen a lower rate of retained placenta through the use of Misoprostol than the other agents; is that correct?

A. Yes.

Q. Doctor, you testified on direct that you've never performed an injection of Digoxin or KCL or potassium

chloride to induce fetal demise before beginning an abortion procedure; is that correct?

A. Correct.

Q. You're not very familiar with medical literature regarding risk of Digoxin; is that correct?

A. Correct, just a general sense knowing risks are small but not absent.

Q. Doctor, the skill required to do an intraamniotic injection of Digoxin would take no more skill than the skill required to do a basic amniocentesis; is that correct?

A. It would take -- it depends if you wanted to do an intrafetal injection or intraamniotic.

Q. Intraamniotic?

A. So that is correct.

Q. And an intracardiac injection, that would be simple for a practitioner to learn, too; correct?

A. Yeah. It would take a little more skill but yes.

Q. Doctor, you said when performing induction abortions at the University of Iowa, is it a general policy to induce fetal demise after 22 weeks; is that correct?

A. Yes.

Q. And the purpose of that policy is to avoid a live fetus that could be viable; is that correct?

A. Not necessarily viable but just living at the time of birth. Even if it's truly 22 weeks and nonviable, it

involves less, might be less traumatic on the mother, and then if it is, if the dating is off, there is poor dating or because ultrasound dating can be off by 20%, then it avoids confusion on the part of the staff in regard to resuscitation issues.

Q. You said the dating of the gestational age of the fetus can be imprecise; is that correct?

A. Yes. We prefer to have ultrasound dating as much as last menstrual period dating. Sometimes we have IVF dating, invitro fertilization dating. Obviously that is very good dating, but a woman might have regular cycles, not know when her last period was. She might not have had one if she was -- certain types of contraception and what not.

Q. And that dating could be off by up to two weeks on some occasions; is that correct?

A. Yes.

Q. So, for example, a 23 week fetus could, in actuality, be 25 weeks; correct?

A. In some cases, yes.

Q. Doctor, have you studied the risks of Digoxin versus amniocentesis?

A. Have I studied the risks of Digoxin versus amniocentesis. Can you rephrase that some way? I'm not sure I understand your question.

Q. Sure. Let me ask it this way. Have you seen any data

comparing the risks of amniocentesis to the risks of Digoxin with -- Strike that. Have you seen any data comparing the risks of amniocentesis to the risks of Digoxin?

A. Of Digoxin injection via amniocentesis?

Q. Um-hm?

A. Because injection involves an amniocentesis, so have I looked at data comparing the rates of complications with one versus the other? I have seen data on complications of amniocentesis in general, and I have seen data on complications of amniocentesis Digoxin injections, but I haven't seen them compared head-to-head.

Q. There has been no published data that would compare the amniocentesis, the risks or safety of an amniocentesis versus the risks associated with injecting Digoxin to induce fetal demise; is that correct?

A. I'm not sure I understand what you mean by no published data. I mean, they might in a review article, they might. I mean, I guess I'm not --

Q. You're not aware of any such studies or data; is that correct?

A. That look at them side-by-side, no.

Q. Doctor, you are a member of the National Abortion Federation; is that correct?

A. Yes.

Q. And you're a member of the National Abortion and

Reproduction Rights Action League; is that correct?

A. Yes.

MR. WARDEN: One moment, Your Honor. That's all, Your Honor. Thanks.

THE COURT: You're welcome. Redirect?

REDIRECT EXAMINATION

BY MS. SMITH:

Q. Thank you, Doctor. We are almost done. Doctor, you said that on cross-examination, you just testified that disarticulation happens 100% of the time; is that correct?

A. In my experience.

Q. And by that, you're not excluding the cases that you discussed previously where the fetus came down intact up to the cranium?

A. Right, because I count that as disarticulation.

Q. Because when you either remove the fetal body, that's disarticulation, or when you're compressing the skull, you would include that in disarticulation?

A. Well, when I'm removing the fetal body from the calvarium, then I count that as disarticulation, yes.

Q. So completely intact means a fetus that has not had any distortion to it, no trauma at all; is that what you mean?

A. I guess I would mean --

MR. WARDEN: Objection, Your Honor.

THE COURT: And the basis?

MR. WARDEN: She's leading the witness.

THE COURT: That will be overruled.

MS. SMITH: Thank you, Your Honor.

THE WITNESS: Completely intact to me would mean no missing major pieces.

BY MS. SMITH:

Q. Okay. Now, you also talked about the amount of dilation that you want in order to begin a procedure, a D & E procedure. Is there a difference between the minimum amount and the ideal amount of dilation?

A. Most definitely in my opinion.

Q. And what's the minimum amount you will accept and go ahead and do the procedure? Let's say at 16 weeks.

A. Right. So minimum, probably about sufficient dilatation to insert a 14 millimeter cannula and then --

Q. What would be the ideal?

A. Ideal would be -- I'll just talk about 16 to 20 weeks. At 16 weeks, maybe one-and-a-half centimeters; and 17 to 20 weeks, two to four centimeters would be ideal to me.

Q. And why do you prefer the two to four centimeters?

A. Because then fetus, then, for instance, will be more likely to come out predominantly intact. I have a better chance of the body coming out predominantly intact up to the level of the calvarium, at least, and that procedure then just involves, you know, one or two passes into the uterus,

no small fragments. It's faster, shorter, it's less uncomfortable to the patient, and there is less chance of uterine injury.

Q. Thank you, Doctor. Now, you also testified that dismemberment typically occurs around the joint. Is that true that it sometimes occurs at other places?

A. Yes. I mean, just dismemberment could occur at other places. Like I said, I typically use the word disarticulation if it is occurring at a joint, but smaller pieces might be removed that don't necessarily involve the joints.

Q. So when you say disarticulation, you're using that as a very specific term to mean taking a part at the joints; is that right, and dismemberment means something different?

A. I guess so. I don't use these terms in my practice at all. I use them in the context of this trial as this language has -- is being used.

Q. Okay. Now, you also testified about steps that you take to reduce the risk of uterine perforation?

A. Can I just go back? I do use the word disarticulation sometimes but not to the detail that we are discussing it right now. Okay. Go ahead.

Q. Okay. Doctor, you testified about steps that you take to reduce the risks of uterine perforation in your D & Es?

A. Yes.

Q. And you said you wanted to minimize the amount of instrumentation in the uterus. Do you do you that? How do you minimize the amount of instrumentation?

A. Well, number one, prepare the uterus to receive adequate dilatation and also avoid blindly reaching in and grabbing. If you don't feel anything, using the suction to bring more tissue down closer, using the ultrasound, if necessary, that type of thing.

Q. Okay. Thank you, Doctor. Now, you also testified that when you have to compress the skull, in the two situations that you discussed where the fetus has come out intact up to the head and you have had to compress the skull, that that exposes some bony fragments on the skull. Now, when you're performing a D & E where the fetus does not come out intact up to the head, do you sometimes also have to compress the skull?

A. Typically, I have to compress the skull.

Q. So are you exposing --

A. Can't think of a time when it's come out without being compressed.

Q. So in your regular D & Es where you're not taking the fetus out intact, you're still having to expose bony fragments in the skull; is that true?

A. Yes.

MS. SMITH: One moment, Your Honor. I have nothing

further, Your Honor.

EXAMINATION

THE COURT: Doctor, before you step down, tell me a little bit about the Emma Goldman Clinic. Physically, where is it situated?

THE WITNESS: It's located in downtown Iowa City and it's five minutes from the University of Iowa Hospital Clinic by car and about 12 minutes by foot.

THE COURT: Okay. Thank you. Can you give me a sense of its -- what's inside it? For example, does it have surgical suites, that sort of thing?

THE WITNESS: It has exam rooms and procedure rooms with examining tables, the suction machines, a sink, an exam light, it has separate sterilizing room.

THE COURT: All right.

THE WITNESS: And procedures are performed there under local anesthesia and oral or intramuscular with oral or intramuscular analgesia.

THE COURT: Is the clinic owned by the University.

THE WITNESS: No.

THE COURT: Who owns the clinic?

THE WITNESS: Who owns the clinic?

THE COURT: Well, let me ask you this: I don't much care, to be honest with you, but what I want to know, is it owned by a state entity or a private entity, or do you

know?

THE WITNESS: No. An independent nonprofit --

THE COURT: Okay.

THE WITNESS: Clinic.

THE COURT: All right. And the University has some sort of a relationship by which it provides your services as a part of its medical outreach and teaching responsibilities; is that right?

THE WITNESS: Correct.

THE COURT: Okay. So you aren't -- Are you paid by Emma Goldman, or are you paid by the University?

THE WITNESS: I'm on salary, and my paycheck comes from the University. There is a contract between the University and Emma Goldman Clinic, and they reimburse the University, the department of OB-GYN, a certain amount of money for the procedures we perform there.

THE COURT: All right.

THE WITNESS: That doesn't go into my pocket.

THE COURT: Okay. If you wanted to perform the procedures that you perform at Emma Goldman at the University Hospital, could you do that?

THE WITNESS: Well, we do do that when the patient falls out of the medical inclusion criteria for the procedures to be performed at the Emma Goldman Clinic, they are a member of the National Abortion Federation, and they

have certain guidelines that they follow, and if the clients have medical conditions that don't meet the inclusion criteria, then those terminations would be performed at the University in most cases.

THE COURT: All right. Let's assume that you have someone at Emma Goldman who would otherwise fit the admission criteria at Emma Goldman but for some reason or another would prefer to have the procedure done by you at the University. Will the University permit you to do that procedure at the University?

THE WITNESS: In general, we are discouraged from doing elective terminations at the University, but there is some physician discretion. So, for instance, once we had a very young girl who was very anxious, and it was thought that -- or they can't even tolerate an exam unless it's done under anesthesia, and then we ended up at the University and that might not meet the strict NAF exclusion criteria, but the physician, being that it was reasonable to do at the University instead of the Emma Goldman Clinic.

THE COURT: And the University discourages you because do you know why.

THE WITNESS: I don't know the specific details. I know we used to have our own clinic similar to the Emma Goldman Clinic that wasn't physically located within the University Hospital or across the street and where elective

terminations were performed including second trimester procedures, but the arrangement with the Emma Goldman Clinic was made, I believe, the year before my arrival on staff, and part of the reason was because the administration at that time did not want to put any more money or resources into the facilities at the University-run clinic. Also, that we just want to make sure that no state money goes towards elective procedures. So I think that's part of the concern, too.

THE COURT: Were you here during the testimony of Dr. Fitzhugh?

THE WITNESS: Today, yes.

THE COURT: Um-hm, and he testified that he was required under state law to do his procedures in a hospital. Do you recall that?

THE WITNESS: Right. Yes.

THE COURT: Okay. If you had the choice, where would you prefer to do the procedure?

THE WITNESS: I don't know. I think that it's safe, very safe to perform them in this -- at the Emma Goldman Clinic, so I don't have a problem with performing them there.

THE COURT: I didn't mean to suggest a problem. I just was interested in whether everything being equal, whether you would have a preference.

THE WITNESS: I guess it would be nice for the patients to have the option of the University because we have more staff available including staff that can supervise sedation if the patient should choose sedation or even general anesthesia. Of course, that would make the procedure much more expensive. We also have more specialized ultrasound equipment, but that's rarely needed.

THE COURT: And the last question or couple of questions. Is the quality of care that you provide at the clinic reviewed by the University medical bureaucracy?

THE WITNESS: I don't know if that's done in a formal way. I serve as a liaison between the University and the Emma Goldman Clinic, and you know, the residents will discuss complications at our weekly M & M conferences. I mean, on rare occasions that there are complications.

THE COURT: M & M is Mortality and Morbidity?

THE WITNESS: Right, but -- yeah, and at these I attend the medical director quarterly meetings at the Emma Goldman Clinic, and the Emma Goldman Clinic staff produce their complication statistics, and I'm aware of those.

THE COURT: All right. Thank you, Doctor. I'm going to let the lawyers follow up briefly related only to my questions, and then we'll get you out of here. Counsel, do you have any questions?

REDIRECT EXAMINATION

MS. SMITH: I just have one or two questions to clarify, Your Honor.

THE COURT: Go ahead.

BY MS. SMITH:

Q. Are there any reasons some patients would prefer to receive services at the Emma Goldman Clinic versus the hospital?

A. Yes.

Q. And what are they?

A. Less expensive. They might consider it more private or convenient, and plus there is a very woman-centered care philosophy there that is attractive to some people.

Q. And just because I don't know if it was clear in your testimony earlier, do you provide training for residents at the hospital and at the Emma Goldman Clinic or just one location or the other?

A. At both.

Q. At both, so you train them in abortion services at the Emma Clinic?

A. Yes, and at the University hospital.

Q. Do you perform D & Es in both locations?

A. Yeah.

Q. And do you perform inductions or supervise inductions in both locations?

A. No, just at the University of Iowa Hospital and the

clinic.

MS. SMITH: Thank you.

THE COURT: Counsel?

RECROSS-EXAMINATION

BY MR. WARDEN:

Q. Just a few questions, Your Honor. Doctor, are there certain pregnancy conditions where performing a second trimester abortion in a hospital setting is preferable?

A. Yes.

Q. What are those conditions?

A. If the patient has severe cardiac disease and might even need an invasive monitoring, that needs to be done in the hospital.

Q. Any others besides severe cardiac disease?

A. Yes. Well, I can say part of the Emma Goldman Clinic exclusion criteria includes things like uncontrolled diabetes, uncontrolled seizure disorders, things of that nature.

Q. And can you describe, to the best of your knowledge, what the conditions are in the exclusion criteria?

A. Well, the ones I just mentioned. Also, if the patient has a history of uncontrolled asthma, I believe -- I don't have these all memorized because the Emma Goldman Clinic staff regularly refers to them when clients call in, and if there is a question that's not on the list, that's when they

consult me, but I do have the list in my office. Also, if there is a relative complication, might be if the patient has a large uterine fibroid that makes the procedure difficult, and I'm sorry, I can't think of them all at the moment.

Q. Doctor, are there certain pregnancy complications that arise during a second trimester abortion at the Emma Goldman Clinic where you would have to refer the patient to the University of Iowa hospitals and clinics?

A. Are there certain --

Q. Are there ever any circumstances in which you would be performing a second trimester abortion at the Emma Goldman Clinic in which a complication would arise and you would then have to take the patient for treatment at the University of Iowa hospitals and clinics?

A. Yes.

Q. Could you describe some of the circumstances?

A. Well, if there is complication of excessive bleeding, then that patient would be transferred to the University. If there is a known perforation, depending on the circumstances, that patient may be referred to the University.

Q. Is the Emma Goldman Clinic equipped to perform a blood transfusion?

A. No.

Q. Doctor, general anesthesia is not available at the Emma Goldman Clinic; correct?
A. Correct.
Q. It's available at the University of Iowa; correct, for second trimester abortions?
A. Yes.
Q. Just so we are clear, general anesthesia is not available at the Emma Goldman Clinic for second trimester abortions; is that correct?
A. Correct.
Q. And general anesthesia is available at the University of Iowa hospitals and clinics for second trimester abortions; is that correct?
A. Yes.

MR. WARDEN: That's all, Your Honor.

THE COURT: Redirect?

REDIRECT EXAMINATION

BY MS. SMITH:
Q. Thank you, Your Honor. Just one point of clarification that I'm afraid has gotten a little muddled here. Can you do elective second trimester abortions at the University of Iowa Hospital?
A. Yes.
Q. And are there certain restrictions on those abortions that you can perform at the University of Iowa Hospital?

A. Well, again, they have to fall outside of the inclusion criteria of the Emma Goldman Clinic or the Planned Parenthood Clinic.

Q. What are those exclusion criteria clinic for the Emma Goldman Clinic or the Planned Parenthood Clinic?

A. I don't have them all memorized, but again, things like severe cardiac disease, uncontrolled asthma, uncontrolled diabetes.

Q. In other words, if they have one of those conditions?

A. Right.

Q. Then they fall out of the exclusion criteria and they can't be seen at Emma or Planned Parenthood?

A. Right.

Q. And then they are allowed to be seen at University of Iowa?

A. Yes.

Q. Even if it's an elective?

A. Yes.

Q. So it has to be if it's an elective, it has to also have one of these other criteria. That means that it can't be performed at the clinic?

A. Yes.

MS. SMITH: Thank you, Doctor.

THE COURT: All right. May the doctor be excused?

MR. WARDEN: Yes. Your Honor, I neglected to move

to admit Defendant's Exhibit 677 during my examination. I would like to move to admit that at this time, if I may.

THE COURT: All right. May the doctor step down and be excused if she likes?

MS. SMITH: Yes. I'm sorry, yes. I'm sorry, Your Honor.

THE COURT: I would run, Doctor, if I were you. They said you could go. Now, the question is, do we receive into evidence 677?

MS. SMITH: May I have one moment, Your Honor?

THE COURT: Sure.

MS. SMITH: I have no objection, Your Honor, and I'm sorry to keep you waiting.

THE COURT: That's not a problem. 677 is received, counsel. It's about 20 minutes after 4:00. It would be my sense that may be we ought to take a break for the evening. What do the lawyers think?

MS. SMITH: Yes, I think that makes sense, Your Honor.

THE COURT: All right.

MR. COPPOLINO: Fine with me, Your Honor.

THE COURT: All right. We'll stand in recess until 9:00 o'clock in the morning.

(Recess at 4:20 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 30, 2004

Official Court Reporter (Ret)

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