1 IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

2

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,	4:03CV3385 April 1, 2004 9:00 a.m. Lincoln, Nebraska
Plaintiffs,	
vs.	
JOHN ASHCROFT, in his official capacity as Attorney General of the United States, and his employees, agents and successors in office,	
Defendant.	

3
4
5
6
7
8
9
10
11 --------------------------------

12

13

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

16

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

18 FOR THE PLAINTIFFS: PRISCILLA J. SMITH
JANET CREPPS
19 NAN E. STRAUSS
Attorneys at Law
20 Center for Reproductive
Rights
21 120 Wall Street, 14th Flr.
New York, New York 10005
22
JERRY M. HUG
23 Attorney at Law
1823 Harney Street, #1004
24 Omaha, Nebraska 68102

25

1 FOR DEFENDANT: ANTHONY J. COPPOLINO
TERRY M. HENRY
2 PREEYA M. NORONHA
ANDREW I. WARDEN
3 U.S. Department of Justice
Civil Division - Federal
4 Programs Branch
P.O. Box 883
5 Washington, DC 20044

6 COURT REPORTER: DAVID C. FRANCIS, RMR
Official Ct. Reporter (Ret)
7 6300 Briar Rosa Drive
Lincoln, Nebraska 68516
8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24 Proceedings recorded by manual stenograph, transcript

25 produced with computer.

1 (Thursday, April 1, 2004, at 9:00 a.m.)
2 THE COURT: Good morning. Counsel, you may call
3 your next witness.
4 MS. SMITH: Thank you, Your Honor. I would like to
5 call LeRoy Carhart to the stand, please.
6 LEROY CARHART, PLAINTIFFS' WITNESS, SWORN
7 THE COURT: You may inquire.
8 DIRECT EXAMINATION
9 BY MS. SMITH:
10 Q. Dr. Carhart, could you tell me what your medical
11 profession is, please. I'm sorry -- withdrawn. Could you
12 tell me your profession, please?
13 A. I'm a physician and surgeon.
14 Q. And where do you currently live?
15 A. In Bellevue, Nebraska.
16 Q. And for how many years have you lived here in Nebraska?
17 A. Going on 26.
18 Q. And, Doctor, if you would look in front of you at
19 Plaintiff's Exhibit 111, could you tell me what that is?
20 A. This is my CV.
21 Q. And is it up-to-date?
22 A. Yes, ma'am, it is.
23 Q. As of last night?
24 A. Yes, ma'am, it is.
25 Q. Thank you, Dr. Carhart.

1 MS. SMITH: Your Honor, I would like to introduce
2 Plaintiff's Exhibit 111 into evidence.
3 MR. COPPOLINO: No objection.
4 THE COURT: It's received.
5 BY MS. SMITH:
6 Q. Dr. Carhart, I would like you to briefly describe your
7 medical education starting where you obtained your medical
8 degree. That was at Hahnemann Medical College, is that
9 correct?
10 A. Yes, ma'am.
11 Q. That was in June of 1973?
12 A. Yes, ma'am.
13 Q. Did you complete your internship at the Malcolm Grow U.
14 S. Air Force Hospital?
15 A. Yes, ma'am.
16 Q. What was your internship in, Dr. Carhart?
17 A. It was officially designated as internal medicine
18 rotating 4, which --
19 Q. What does that mean?
20 A. That means I did four months of internal medicine and
21 then my other eight months could be in specialties of my
22 choosing.
23 Q. And what were those specialties?
24 A. General surgery, OB/GYN, anesthesia and radiology.
25 Q. Thank you, Doctor. Where did you complete your

1 residency training?
2 A. In Atlantic City Medical Center, Atlantic City,
3 Missouri. Excuse me. New Jersey.
4 Q. Was that also at Hahnemann?
5 A. That was an affiliate of Hahnemann Hospital. My first
6 30 months were in Hahnemann Hospital. My spent my last 18,
7 was six months of my normal residency, and 12 months as
8 chief resident in Atlantic City, New Jersey.
9 Q. That was a residency in general surgery, is that
10 correct?
11 A. Yes, ma'am. It was.
12 Q. That was in 1974, through approximately 1978, is that
13 right?
14 A. Yes, ma'am.
15 Q. Okay. And during your residency, Doctor, did you have
16 any experience with obstetrics and gynecology?
17 A. Yes, ma'am. I did.
18 Q. What was that experience?
19 A. As a medical student, I did several rotations on
20 obstetrics and gynecology. And as a resident -- I'm sorry.
21 As an intern, as I mentioned, I did two months of OB/GYN,
22 obstetrics and gynecology. And as an actual resident at
23 Hahnemann, I did, I believe it was two separate rotations on
24 gynecology, as part of my electives. And then at Atlantic
25 City Medical Center, as they did not have OB/GYN residence,

1 it was the general surgeon's responsibility to cover that
2 service also.
3 Q. Did you deliver any babies during that time period?
4 A. Yes, ma'am. I did.
5 Q. Do you remember how many?
6 A. I would say -- you're talking now from medical school?
7 Q. During your residency.
8 A. During my residency, I really don't remember. Well over
9 30, but I don't know the number.
10 Q. Thank you, Dr. Carhart. And you have been licensed to
11 practice medicine since 1973, is that correct?
12 A. '73 or '74. 1974, ma'am.
13 Q. 1974. I'm sorry, Doctor. Thank you. And where were
14 you licensed in 1974?
15 A. In Pennsylvania.
16 Q. And you have been licensed in seven other states by
17 reciprocity; is that correct?
18 A. That's correct.
19 Q. So you have eight licenses currently?
20 A. I do.
21 Q. And after you finished your residency in June of 1978,
22 what did you do next?
23 A. I was assigned to Offutt Air Force Base, the Ehrling
24 Bergquist Hospital there in Bellevue, Nebraska, as my
25 original appointment was chief of general surgery and

1 general surgeon.
2 Q. When you say you were assigned, was that by the United
3 States Air Force?
4 A. Yes, ma'am. It was.
5 Q. Doctor, I would like to ask you briefly about your
6 military background. You were first commissioned as a
7 Second Lieutenant in the Medical Service Core of the United
8 States Air Force, and that was in June of 1964; is that
9 correct?
10 A. That's correct.
11 Q. And is it true your medical education and your residency
12 was all done while you were on active duty with the Air
13 Force?
14 A. That's correct.
15 Q. You were promoted to Lieutenant Colonel in July of 1978?
16 A. Yes, ma'am.
17 Q. And, Doctor, you served in various positions at the
18 United States Air Force hospital at Offutt Air Force base in
19 Nebraska, from 1978 to 85; is that correct?
20 A. Yes, ma'am. It is.
21 Q. You started out as a general surgeon?
22 A. Yes, I did.
23 Q. And you became chief of general surgery and also chief
24 of emergency medicine; is that right?
25 A. Actually, I started out as a general surgeon and chief

1 of general surgery. I went there as the chairman of the
2 department or of general surgery, and then subsequently --
3 could you repeat the last part of your question? I got
4 lost on that part.
5 Q. Okay, Doctor. You started out as general surgeon and it
6 sounds like you started out as chief of emergency medicine
7 at the same time; is that right?
8 A. No, that is not right. I started out as a general
9 surgeon and chief of general surgery.
10 Q. And you became chief of emergency medicine?
11 A. That is correct.
12 Q. Then you also became chairman of the department of
13 surgery between which you served in that position from 1978
14 to '85; is that right?
15 A. The chairman of the department -- that was like I
16 believe 1982 or 1983, when I was promoted. I don't really
17 remember that date but I was promoted.
18 Q. And that would be reflected on your CV?
19 A. I believe so, yes.
20 Q. Thank you. In your position as chief of the department
21 of general surgery, chairman rather of the department of
22 general surgery, Doctor, did you have any experience with
23 obstetrics and gynecology?
24 A. I was responsible, with the chief of obstetrics and
25 gynecology, to formulate all of the operating plans or keep

1 them current for the hospital, and also for our deployment
2 unit. I also had, not the responsibility, but as a general
3 surgeon, frequently worked with all of the OB/GYN doctors
4 when there were combination cases where both disciplines
5 were involved.
6 Q. And did you also deliver babies at that time?
7 A. Yes, ma'am.
8 Q. And during the time you were at Offutt Air Force Base,
9 you also worked as an emergency medicine physician at St.
10 Joseph's in Omaha, and at Jenny Edmundson Hospital in
11 Council Bluffs, Iowa; is that right?
12 A. Yes, ma'am.
13 Q. And in your role as an emergency medical physician at
14 these two hospitals, did you also have experience with
15 obstetrics and gynecology?
16 A. Yes, I did.
17 Q. What was that experience?
18 A. At St. Joseph's Hospital, it was just taking care of
19 emergent admissions until the OB/GYN resident or staff
20 member could be available in the emergency room. At Jenny
21 Edmundson Hospital, I actually covered for one of the local
22 physicians and did his deliveries between 12 and 8; 12 p.m.
23 or 12 a.m. and 8:00 a.m.
24 Q. Thank you, Doctor. And you've retired from the Air
25 Force at the rank of Colonel; is that right?

1 A. Lieutenant Colonel.
2 Q. That was in 1985?
3 A. Yes, as a Lieutenant Colonel in 1985. February 1st.
4 Q. What did you do next?
5 A. I opened, I did two things. I opened a walk-in
6 emergency center in Bellevue, and I also took a position as
7 an emergency room, a fulltime emergency room physician with
8 Lutheran Hospital in Omaha, Nebraska.
9 Q. And the walk-in-service that you opened, was that the
10 only emergency walk-in-service available in Bellevue, at the
11 time?
12 A. Yes, ma'am. It was the first.
13 Q. Doctor, I would like to ask you a little bit about your
14 academic positions. You were an assistant professor in the
15 department of surgery at Creighton University school of
16 medicine in Omaha, from 1978 to '86; is that right?
17 A. That is correct.
18 Q. What were your duties in that position, Doctor?
19 A. Developing a training program for general surgery
20 residents and general surgery, or I'm sorry. Medical
21 students for their general surgery rotations while they were
22 at Offutt Air Force Hospital, and then attending
23 conferences, mortality and morbidity conferences and general
24 training conferences at Creighton, when they were at St. Joe
25 Hospital and Creighton Medical School, when they were being

1 held.
2 Q. And you were also -- you also became an Assistant
3 Professor in the Department of Surgery at the University of
4 Nebraska Medical Center; is that right?
5 A. Yes, I did.
6 Q. And what were your duties in that position?
7 A. They were the same to supervise residents and medical
8 students.
9 Q. Thank you.
10 A. And train them.
11 Q. And, Doctor, are you currently a member of the American
12 Medical Association?
13 A. Yes, I am.
14 Q. And the Association of Reproductive Health
15 Professionals?
16 A. That's correct.
17 Q. Are you currently a member of the Board of Directors for
18 Physicians for Choice, Physicians for Reproductive Health
19 and Choice?
20 A. Exactly. I am.
21 Q. And are you also on the National Board of Directors of
22 the Religious Coalition of Reproductive Choice?
23 A. Yes, ma'am. I am.
24 Q. Doctor, are you board certified?
25 A. No, ma'am. I'm not.

1 Q. Were you eligible to take the boards in general surgery?
2 A. I am still eligible to take the boards in general
3 surgery.
4 Q. Why did you never take the boards?
5 A. When I was assigned to Offutt in 1978, the staffing was
6 not adequate that I could go and do the final training
7 program; which you don't have to do, but there is a two-week
8 -- a two-week refresher course that one usually does before
9 the boards so they are prepared to take them. And I could
10 not get the time off to do that. And we postponed,
11 postponed until I reached the point where I thought it was
12 not worth the aggravation or the effort. I have never tried
13 to sit for the boards.
14 Q. Thank you, Doctor. Now, I would like to ask you about
15 your medical practice here in Nebraska. What's your current
16 position?
17 A. Currently, I'm the Medical Director for Bellevue Health
18 and Emergency Center.
19 Q. And have you held that position since 1985?
20 A. Yes, ma'am. I have.
21 Q. And are you a part owner of the clinic?
22 A. Yes, ma'am. I am.
23 Q. Can you tell me a little bit about your practice when
24 you first opened? What services did you provide?
25 A. As I saw that there was a need in the community for a

1 walk-in emergency room. We opened that in order to support
2 the practice, and I started out as a general surgeon, at the
3 same time, trying to build my general surgery practice.
4 Q. And what other services did you provide besides general
5 surgery, if any?
6 A. Well, I also had a general medicine clientele that
7 developed mostly from the walk-in practice, that we would
8 continue their care, and this included OB/GYN pre-delivery
9 of the -- prenatal care, it included delivery of the women
10 in the hospital, and it included taking care of the new born
11 infants, except I did not do high risk pregnancy. I still
12 took care of them, but I consulted with other physicians to
13 do that.
14 Q. Thank you, Doctor. Did you perform any gynecological
15 surgeries at the time?
16 A. Yes, I did.
17 Q. What types of surgeries?
18 A. Hysterectomy, oophorectomy to me.
19 Q. What's an oophorectomy to me?
20 A. It's usually done with a hysterectomy, using to remove
21 the ovaries at the same time. Also removing or operating on
22 tubal pregnancies. Also combined with the obstetrics and
23 gynecology, I would do, on oncology cases, where wider
24 dissections of the tissue other than what would be normally
25 considered OB/GYN tissue. I would scrub with those and not

1 really be the operating physician, but be the first
2 assistant. And then at times, if there was an entry to the
3 bowel or other complications or bladder, I would take over
4 and do that part to repair.
5 Q. Thank you, Doctor. Did you provide abortions at the
6 clinic at that time?
7 A. No, ma'am. I did not.
8 Q. Did there come a time when you began providing abortions
9 in Nebraska, Doctor?
10 A. Yes, ma'am. There did.
11 Q. When did you start providing abortions in Nebraska?
12 A. On May 1st of 1988.
13 Q. And why did you start performing them?
14 A. I was asked by one of my patients to help her at the
15 clinic as they were losing their doctor. After a very
16 prolonged consideration, I took that position.
17 Q. And how long did you provide abortion services at the
18 clinic? That is a clinic in Omaha, is that right?
19 A. Yes, ma'am.
20 Q. How long were you providing services there?
21 A. For four years.
22 Q. And during that time, you still had your active practice
23 in Bellevue?
24 A. Yes, I did.
25 Q. And did there come a time when you started doing

1 abortions in Bellevue?
2 A. Yes, ma'am.
3 Q. And when was that?
4 A. On May 1st of 1992.
5 Q. And can you briefly list for me the different types --
6 and you currently still provide abortions, is that right?
7 A. Yes, ma'am. I do.
8 Q. Can you briefly list for me -- we'll talk about them in
9 more detail later, Doctor. But can you just list for me
10 this types of abortion methods you currently provide?
11 A. We do the RU 486, Mifepristone abortions, however you
12 describe that.
13 Q. Those are early medical abortions, is that right?
14 A. Yes, ma'am. We do the vacuum aspiration abortions up
15 through the 12th through 14 weeks sometimes.
16 Q. Um-hm?
17 A. And we do the D & E abortions after the 14th week.
18 Q. And, Doctor, do you know approximately how many
19 abortions you perform in Nebraska each year?
20 A. I believe in 2003, it was in the neighborhood of 1,480.
21 I believe other years, it has been fairly close to 1,400 for
22 the last five years.
23 Q. And approximately how many of those procedures are
24 second trimester procedures, Doctor?
25 A. Well, if my recollection is correct, approximately 180.

1 Q. And are you currently providing abortions at a different
2 location, Doctor?
3 A. Yes, ma'am. I do.
4 Q. And where is that?
5 A. I actively work in Kansas on a regular schedule, but I
6 inactively cover practices in Pennsylvania and in Indiana.
7 Q. And when you say you inactively cover them, what does
8 that mean?
9 A. If the doctor is going on vacation or the doctor there
10 is ill, I have contracted where I have agreed to be able to
11 take over the care of their patients.
12 Q. So they know you're available if they need you?
13 A. Yes, ma'am.
14 Q. Doctor, is your clinic in Bellevue a member of the
15 National Abortion Federation?
16 A. Yes, ma'am. It is.
17 Q. Doctor, in order to become a member of the National
18 Abortion Federation, does a clinic have to meet certain
19 standards?
20 A. Yes, ma'am.
21 Q. And, generally, can you tell us what types of standards
22 those are?
23 A. The National Abortion Federation developed what -- and
24 it was developed by a board of very competent abortion
25 providers, a board of standards to set the minimum standard

1 of care that would be required in a well run abortion
2 clinic. In order to be a member, you have to meet those
3 standards of care.
4 Q. And how do they ensure that you do meet those standards
5 of care?
6 A. There is a mandatory inspection of the clinic at least
7 once every five years, and there is a provision for
8 emergency walk-in inspections at anytime.
9 Q. And do you also have to report your complications to the
10 National Abortion Federation?
11 A. Yes, ma'am. We do.
12 Q. Is your clinic also licensed by the State of Nebraska?
13 A. Yes, ma'am. It is.
14 Q. Doctor, I'm going to ask you a few questions about your
15 training and experience, initial experience with providing
16 abortions. When did you first learn how to do a D & C, for
17 example?
18 A. I actually learned to do D & Cs approximately 20 years
19 after I learned to do the saline, the saline infiltration
20 abortions. My first abortion was as a medical student and
21 during rotations in my senior year of -- well, actually my
22 sophomore and senior year of medical school, we were on a
23 different program at Hahnemann. The first year was basic
24 sciences, the second year was clinical, the third year was
25 basic sciences, the fourth year was clinical. During my

1 second and fourth year as a medical student, I was taught to
2 do the saline injection abortion.
3 Q. What gestational ages were those saline procedures?
4 A. After the 18th week of menstrual gestation.
5 Q. Did you learn the D & C technique if not for abortions,
6 for something else?
7 A. Yes, I did learned D & Cs but they were not abortion
8 related.
9 Q. Were those for incomplete or septic abortions?
10 A. Yes, ma'am. They were.
11 Q. When was that, early 70s?
12 A. That would be the same time when we worked as a medical
13 student in the emergency room environment, and also on my
14 rotations on the practice of OB/GYN in the OR with the
15 OB/GYN doctors.
16 Q. And were abortions illegal at that time, Doctor?
17 A. Yes, ma'am. They were in general. They were not in the
18 hospital that we worked.
19 Q. Okay. And what types of complications did you see from
20 illegal abortions at the time, Doctor?
21 A. The illegal abortions they usually presented to the
22 emergency room with -- in sepsis, with an infection, most
23 likely caused by retained products that had been secondarily
24 infected, and then that became the problem to empty the
25 uterus, or the infection was severe enough to actually

1 remove the uterus.
2 Q. And, Doctor, when did you first learn to do vacuum
3 aspirations?
4 A. In February of 1988.
5 Q. This is when you began to work for the clinic in Omaha?
6 A. Yes, ma'am.
7 Q. And how did you receive your training?
8 A. I told the clinic in Omaha that I would start working
9 for them if I could been adequately trained in abortions, as
10 I had not done one for the previous ten years, and I had
11 never done early abortions. Between the corporation that
12 owned that clinic and ourselves, we found a program in
13 Pittsburgh where I went three days a week for 12 consecutive
14 weeks and performed approximately 600 to 700 first trimester
15 abortions under supervision.
16 Q. Doctor, did you receive training at that time in any
17 other procedures?
18 A. Yes, ma'am. In the early D & Es.
19 Q. Early D & Es. Okay. Can you tell us how far in
20 gestation you were performing abortions at the clinic?
21 A. At the clinic, I was doing through 18 weeks, but very
22 rarely. Most of the time in the 14, 15 and 16-week range.
23 Q. And how did you learn to do D & Es further and further
24 in gestation?
25 A. After, well after the 19th week, it was several years

1 into the practice, and I had gone to meet with other
2 providers of second trimester abortions and worked with them
3 -- I should not say that. I observed them. In the states
4 where I was licensed, I actually did abortions under their
5 supervision. And that's continued actually til present. I
6 still do travel to other clinics where I'm licensed in that
7 state and do abortions under supervision, or I observe -- if
8 I'm not licensed, I will observe the practitioners.
9 Q. And you said you learned how to do saline infusions or
10 installations in Pennsylvania; is that right?
11 A. Yes, ma'am.
12 Q. Did you continue to perform those later in your career?
13 A. No, ma'am. I have never done that.
14 Q. And why not?
15 A. Well, knowing -- I was -- at first extremely unhappy
16 with the complication of saline infusions. I believe the
17 maternal death rate is close to 60 per 100,000. And it was
18 that in 1970 also. The complication rate, however, was far,
19 far greater than that with either acute hypotensive crisis,
20 acute infections or problems that required hysterectomy. It
21 just was -- I don't think it was a satisfactory solution.
22 Q. Were D & Es available at that time in the 70s?
23 A. D & Es were not done at that time. At least I was never
24 exposed to one and my mentors never did them, while I was on
25 their service. They only used the saline infusions.

1 Q. Okay. Doctor, in your current practice, do you
2 currently perform abortions for women with physical or
3 mental health conditions?
4 A. Yes, ma'am. I do.
5 Q. Can you tell me some of the medical reasons that women
6 are seeking to terminate their pregnancies?
7 A. Medical reasons are emotional severe depressions. When
8 I say emotional, not just being upset but psychiatric
9 conditions. Physiologic conditions would be diabetes,
10 severe, uncontrolled diabetes, hypertension, malignant
11 hypertension. I have done some for oncology reasons where
12 the attending physician that's caring for the cancer thought
13 in order for a woman to maintain a pregnancy, her body has
14 to lose its immune responses. So it allows cancers, when
15 they are present, to grow at a far accelerated pace. So
16 many, many oncologists are unhappy when a woman gets
17 pregnant during their treatment.
18 Q. Thank you, Doctor. Do you sometimes terminate pregnancy
19 for women with fetal anomalies?
20 A. Yes, sir. I do.
21 Q. About how many times a year does that happen?
22 A. In my practice in Nebraska, I would say in the
23 neighborhood of five, when that is the sole reason for the
24 termination.
25 Q. Okay?

1 A. An average of five. It's not always five. It could be
2 two one year and seven one year.
3 Q. Are these generally in the second trimester?
4 A. Yes, ma'am. They are.
5 Q. And, Doctor, do you ever perform abortions for women who
6 have actually tried to abort the pregnancy themselves?
7 A. Yes, ma'am. I have done that.
8 Q. And can you tell me any examples of that?
9 A. Just shortly before the deposition in February, we had a
10 woman who came to the hospital. I believe she was 14 to 15
11 weeks from her last menstrual period in her pregnancy. When
12 I was doing the injection, I noticed multiple deformities of
13 her cervix or what looked like small lacerations. I asked
14 her if she had recently had biopsies taken and she said no.
15 And I said well, have you done X, and have you done Y, or
16 have you had this, and the answer was no to all of those
17 questions. And I said well the only reason I'm worried is
18 your cervix appears very abnormal. And I think when we are
19 through today, you need to continue follow-up with your
20 provider, because they need to find out what's causing this
21 deformity in your cervix. And she started to cry and our
22 clinic allows partners to be with the patients in the
23 operating room and her friend, female, said that she had
24 tried to abort herself. And when I asked if there was a
25 reason why, or first I asked what she did. And she, again,

1 just was unable to tell me but, her friend said she had used
2 a chop stick to try to do that.
3 Q. Doctor, hopefully this is quite a rare occurrence, is
4 it?
5 A. It's rare that I recognized it. I honestly do not
6 believe the attempts are that rare.
7 Q. Doctor, I'm going to ask you now about your general
8 methods and procedures, and you previously indicated that
9 you perform suction curettage and medical abortions in the
10 first trimester; is that right?
11 A. Yes, I did.
12 Q. And D & Es you begin performing at what gestational age?
13 A. Intentionally at 14 weeks; however, occasionally at
14 earlier gestations in the 12 and 13-week range.
15 Q. Okay.
16 A. But I have had to use forceps as early down as eight
17 weeks, when a woman would not dilate at all. I had to use a
18 special technique, but 12 to 13 weeks. I would say rarely
19 -- eight weeks rarely. 12 to 13 weeks not quite as rare, and
20 above 14 weeks with everyone.
21 Q. Okay. And, Doctor, how late in gestational age do you
22 perform procedures?
23 A. That would depend on the circumstances but we have a
24 rule at our clinic that we do not go past the end of the
25 24th week for any reason.

1 Q. Okay. And do you perform elective abortions for women
2 throughout this time period?
3 A. I would have to say no to that.
4 Q. And when do you stop performing abortions for purely
5 elective reasons?
6 A. Purely elective at the beginning of the 23rd week.
7 Q. And what -- but you still do perform abortions in the
8 23rd and 24th weeks; is that right?
9 A. Yes, ma'am. We do.
10 Q. And what will cause you to go ahead with the procedure
11 at 23 and 24 weeks?
12 A. Generally with patients past the 23rd week, I meet with
13 them personally. I have to decide whether, in my mind, the
14 fetus is viable at all. That's the most important thing.
15 That's what I'm trying to do. And I secondly have to
16 entertain in my own mind a sense of the necessity for her
17 mental health reasons. If there has been a problem, if
18 there has been any kind of a suicide attempt, any kind of
19 depression that has been severe enough to cause her to stop
20 eating, which I have seen.
21 Q. And have you ever referred somebody to another abortion
22 provider at 23 and 24 weeks; you decided they did not meet
23 your additional criteria?
24 A. 23 weeks, occasionally, if it's in a later part of the
25 23rd week, and there does not appear to be any other reason

1 to keep them in Nebraska. If I don't feel that there is a
2 medical need, I refer them to another state for care. And
3 in the 24th week, we frequently -- at the end of the 24th
4 week, if there are no other evidences of a medical problem
5 or a psychological problem we would refer them.
6 Q. And approximately how many times a year do you refer
7 patients for that reason, Doctor; if you know?
8 A. I would have to say probably in the 23, 24 times a year,
9 between two and three times a month. Sometimes not at all,
10 sometimes maybe four and five, but we had one week where we
11 referred three people, but I think in general, over the
12 course of a year, it would be in the low 20s.
13 Q. Doctor, now I'm going to ask you about how you actually
14 perform your procedures. I would like to start with the
15 dilation process?
16 A. Yes, ma'am.
17 Q. And go through by gestational age the different methods
18 that you use. Can you tell me first in a 12 to 13 weeks, I
19 believe you said that was sometimes the time period in which
20 you might need to use forceps. Can you tell me at 12 to 13
21 weeks how you dilate?
22 A. At 12 weeks and up, we use Misoprostol, one dose. Or 12
23 to 13 weeks, we use a single dose of Misoprostol tablets,
24 400 micrograms which is two tablets buccally. For those
25 patients, normally that is adequately for me to insert a

1 cannula. After waiting for a period of time, approximately
2 an hour, that that causes enough cervical relaxation, that I
3 can enter a number 12 cannula.
4 Q. On the same day?
5 A. On the same day.
6 Q. Thank you, Doctor. At 14 to 15 weeks, how do you dilate
7 the cervix in those circumstances?
8 A. Actually, it's the same method. I use Misoprostol 400
9 micrograms in the buccal cavity, cheek or jaw, or however
10 you want to explain that, but I do a minimum -- well, not a
11 minimum. We do three consecutive doses an hour a part, so
12 they take the first one, say at 9:00 o'clock. The second at
13 10, the third at 11. Then at 12:00 o'clock, we would do
14 their procedure. And they, invariably, are open large
15 enough, I don't, in my practice, routinely use larger than a
16 number 12 cannula and they are well past that.
17 Q. Okay. And, Doctor, how about 16 up to 20 weeks, through
18 19 and six days?
19 A. Beginning with the 16th week, I normally do paracervical
20 blocks, and I use a long acting drug that's effective. The
21 manufacturers say 12 hours. I think it's closer to six or
22 seven, but we use Bupivacaine for the paracervical block,
23 and usually at that gestation, I can get a given number of
24 laminaria. And I do not normally use mechanical dilators.
25 Q. Okay. How many laminaria can you normally insert?

1 A. I would normally like to put in at least 3 of number
2 seven or eight, and they are graduated. And they say that
3 that means millimeters diameter, but I find that rarely to
4 be true. But three -- I try to get at least three number
5 sevens, hopefully three number eights, and then Dr. McMahon,
6 in his original articles in 1985, mentioned using a key, and
7 we always put at least two or three very small dilators in
8 also, so that if the woman should not dilate adequately to
9 remove the laminaria, because as they expand, there is no
10 resistance on the very proximal end. There is no resistance
11 on the very distal end, so normally you have an hourglass
12 type expansion, if we don't get good dilation. If you can
13 remove the very, very small ones, it's much easier than
14 trying to get out a large one, because the amount of the
15 dumbell effect or the hour glass effect is much less. So I
16 would try to get at least three, three of the small ones. I
17 want six.
18 Q. And to what -- how large a diameter are you trying to
19 dilate to at that point?
20 A. I have two goals. I want to be a diameter of at least
21 45 French or 14 millimeters.
22 Q. Okay.
23 A. And actually 15 millimeters, except we don't have
24 anything to measure that. So I want to be able to
25 accommodate at least a 14 millimeter cannula. If I don't

1 receive that amount of dilation, I often will remove the
2 laminaria. Or if it feels like I'm not going to get there,
3 I won't put them in. I'll use mechanical dilators up to the
4 45 French, which, again, would be 15 millimeters.
5 Q. Okay. And at 17 to 18 weeks, does the procedure change
6 at all?
7 A. It changes in that the first day does not change at all,
8 but the second day does change, and those patients are kept
9 overnight with the dilation or with the laminaria in. Okay.
10 I'm confused. 14, 15 weeks we just do Misoprostol. 16 and
11 17 is a two-day procedure, that's correct, but 18 and 19
12 weeks is also the same as far as dilation, the same, but we
13 have other things that we do.
14 Q. Okay. But let's talk about 16 up until 18, Doctor.
15 A. Yes, they would be -- as far as dilation on the first
16 day, they would be identical.
17 Q. And what type of dilation are you trying to achieve, say
18 at 17 weeks?
19 A. I would like them to return -- at 17 weeks, I would
20 still like everything 16, 17, 18 and 19 to return with 65
21 French dilation, which would be slightly above 2.2
22 centimeters.
23 Q. Okay. Thank you. And in your 18 to 19 procedures, you
24 said you do something else. Can you tell me what that is?
25 A. Yes, ma'am. Beginning with the 18th week, we do an

1 injection into the fetus through the abdominal wall and
2 through the uterine wall of two drugs. I use Lidocaine, 600
3 milligrams, and I use Digoxin, 1,000 micrograms or one
4 milligram.
5 Q. Okay. Doctor, I will ask you more about the Digoxin
6 procedure later, but can you tell us, after starting at 18
7 to 19 weeks, approximately how much dilation are you seeking
8 to achieve?
9 A. My goal is at least two-thirds of the biparietal
10 diameter of the fetus.
11 Q. Is that true starting at 18 weeks on up through 24?
12 A. Pretty much starting at any period, even 14, 15 weeks
13 but by 18 weeks, it becomes much more -- to me, it becomes
14 much more important because my goal, again, is to remove the
15 fetus intact, or as intact as possible. And, of course, the
16 less resistance that you have from the cervix and the wider
17 the opening is from the cervix, the easier it is to
18 accomplish that.
19 Q. And, Doctor, can you predict how much dilation you're
20 going to get?
21 A. Unfortunately, I cannot.
22 Q. And what are the factors that influence the amount of
23 dilation that you'll see in a given patient?
24 A. I think the two most prominent factors are the parity of
25 the mother; how many children she's previously delivered

1 vaginally or parity actually can include C sections, but we
2 don't -- that doesn't tend to help us too much. So that the
3 number of vaginal deliveries that the mother has had and
4 also the age, the very young and the very -- I shouldn't say
5 very old, I'll get beat. But the women that are over 35 and
6 40 tend to dilate with greater resistance.
7 Q. I won't comment, Doctor.
8 A. I'm sorry.
9 Q. Can you tell us about the types of discomfort or side
10 effects that women experience from the insertion of the
11 laminaria?
12 A. As I said, we use a long acting block which gives them
13 comfort, total comfort in the emergency room. We don't use
14 any other intravenous sedation, any other intravenous
15 anesthetic or pain relievers except for tablets.
16 Q. After the women have had the laminaria placed, what do
17 they do?
18 A. We observe them for 20 to 30 minutes in the recovery
19 room. We require -- we have -- our clinic is built around a
20 square. It's approximately 60 feet on each side. We
21 require them to walk at least 15 laps around that circle
22 before we let them go to make sure they are stable, that
23 they are not dizzy, that they can be safe after they leave
24 the clinic.
25 Q. And are their activities restricted in any way once they

1 go home?
2 A. We ask them not to do any heavy lifting. We ask them
3 not to go swimming, not to take a bath. They may shower and
4 nothing in their vagina.
5 Q. Can they cook dinner?
6 A. Absolutely.
7 Q. Can they go to work?
8 A. Yes, ma'am.
9 Q. Can they take care of their children, if they have any?
10 A. Yes, they do.
11 Q. And how much, if any, discomfort do the laminaria cause
12 your patients?
13 A. We sent them home with three different medications,
14 Ibuprofen, Fioricet, which is a noncontrolled analgesic, and
15 Vistaril, and instructions to take their medications whether
16 they are having pain or not. Of those women that have taken
17 their medications, we, in 12 years, have never had a phone
18 call. In two patients who thought they felt fine and chose
19 not to take the medications, they did call with cramping.
20 On both of those, I tried to have them take their oral
21 medications. But with the severe cramping, they also get
22 nauseous. So with those two women, I asked them to come
23 back to the clinic. We reinjected them and ask them to
24 please go home and take their medication as directed and
25 they have done fine. Both of those were patients that were

1 going to be more than actually -- more than two days. They
2 were going to be three day patients, and their second night
3 was absolutely fine.
4 Q. And do you also see spotting or bleeding from the
5 laminaria?
6 A. Immediately after the laminaria are placed, because I
7 have done a paracervical block, there is seven or eight
8 injections into the vaginal or cervical wall, and also at
9 the -- where the vaginal wall and the cervix come together.
10 And like any other needle stick, especially in a very
11 vascular area, and the vagina is very closely related like
12 the nose or lips, they bleed for approximately five to 10
13 minutes. And since we are not doing this part of the
14 procedure for more than usually three to five minutes, there
15 is some bleeding in the immediate post-op period. After
16 that, all my patients have an instruction sheet which says
17 should there be any bleeding at all, you should call the
18 clinic. And, as I said, again, in the 12 years we have been
19 in our recent building, we have not had a call for that.
20 Q. Okay. And, Doctor, let's talk about what you do next.
21 After you have sufficient dilation, what's the next step in
22 performing the procedure?
23 A. Well, again, it depends on the gestation. If they are
24 over 19 weeks, then we, again, insert lams, and we repeat
25 the exact process from the day before, this time trying to

1 achieve greater dilation, if they are ready for delivery.
2 Q. Yes. Let's say you have got someone you achieved
3 sufficient dilation for the gestational age. Are there some
4 initial steps before the removal of the fetus that you
5 perform?
6 A. Okay. For the 16 and 17 week patients, no. They are
7 taken to the emergency room or taken to the operating room.
8 We do a paracervical block. We remove the laminaria, we
9 rupture the membranes and complete the D & C at that time or
10 D & E. I apologize. After the D & E, we do a D & C and
11 they go to the recovery room.
12 Q. And prior to rupturing the membranes, did you place any
13 instruments, use a speculum or tenaculum?
14 A. Normally, I would place a speculum, and normally I would
15 use a tenaculum to complete the block.
16 Q. Okay. And does the use of the speculum and the
17 tenaculum affect, in any way, the distance between the
18 cervix and the vaginal introitus?
19 A. Most of the abortion providers that I know have had a
20 revised speculums that are modified to be approximately an
21 inch to an inch-and-a-half, depending on what the
22 preferences are, to allow us to bring the cervix down
23 farther into the vaginal cavity.
24 Q. Sorry, Doctor.
25 A. I'm sorry.

1 Q. Did you finish your answer, Doctor? I'm sorry. I
2 interrupted?
3 A. To the vaginal cavity.
4 Q. What's the purpose of that bringing the cervix closer?
5 A. It makes it -- the length of the tunnel you're looking
6 through, as you're doing the procedure, the shorter it is,
7 the better the field of vision you have, and the better
8 illumination from the light source, number one; secondly,
9 many, many of my patients at 16 and 17 weeks are awake with
10 only oral medication. And if you are pulling their cervix
11 down against the metal speculum, which is in there and too
12 long, it becomes quite painful. So we either -- I use the
13 short speculum. And, very often, I will have to either
14 remove the speculum and use no speculum or work with it
15 two-thirds or three-quarters of the way out, and have one of
16 my assistants hold the speculum, so it doesn't come out the
17 rest of the way.
18 Q. Okay. And, Doctor, in these circumstances, how close is
19 the cervix to the vaginal introitus? Is it always at the
20 same place? Does it vary? What's the range?
21 A. It's not usually at the same place. The variance, I
22 would say, could be from six centimeters, which is difficult
23 up through being outside of the vaginal opening; outside of
24 the introitus.
25 Q. And how often do you see the cervix actually outside the

1 introitus, after you've brought it down using the tenaculum?
2 A. Totally outside? Probably not more than five times a
3 year, ten times a year. But at or very close to where I do
4 it without a speculum at all, probably two or three times a
5 week.
6 Q. Okay. Now, Doctor, after you've performed these steps,
7 can you describe the procedure that you perform to remove
8 the fetus? And let's start with the 12 to 13-week
9 gestational age.
10 A. At 12 to 13 weeks, of course, we have not placed
11 dilators, but we would still do the paracervical block. We
12 would use a number 12 cannula. I have larger, but I don't
13 like to use them. We use a number 12 cannula. If we can
14 get that in to remove the amniotic fluid, to hopefully
15 remove the fetus and the placenta. Following that, I would
16 use a relatively large curette, which is a spoon shaped
17 instrument with a sharp edge, to check the walls of the
18 uterus to make sure all the tissue had been removed.
19 Q. Now, in your 12 to 13-week procedures, Doctor, have you
20 ever seen the circumstances where the fetus has come all the
21 way out until the fetal calvarium has been lodged at the
22 cervical opening?
23 A. Yes, ma'am.
24 Q. And can you describe for me an incident where that
25 occurred?

1 A. In the early part of 19 -- I'm sorry. The early part of
2 2003, was one of the last times where we at -- I believe
3 this patient was 15 or 14 weeks. I don't remember the
4 exact --
5 Q. I'm just asking you about 12 to 13 weeks, Doctor.
6 A. The most common thing that will happen with a 12 to
7 13-week patient is if they have had children, sometimes the
8 one dose of Cytotec, not only gives me enough dilation to
9 get a cannula in, but it gives me -- that gives the patient
10 enough dilation that the membranes are bulging. And I have,
11 many times, either nicked the membranes with a needle as we
12 are doing injections, or as I went to rupture them, to
13 remove the pregnancy, the fetus would expel in total or in
14 part.
15 Q. And has it ever -- so sometimes it comes out only in
16 part, not completely out?
17 A. It does.
18 Q. What do you do at the point where it's only partly out
19 of the woman?
20 A. Normally, I would attempt to remove that part and then
21 complete the abortion.
22 Q. And is the fetus -- does the fetus have a heartbeat at
23 this point, before you take another step?
24 A. I don't check. I do not check on every occasion but
25 very, very frequently, we notice that it is. It's not a

1 formal part of my procedure. But all of my procedures,
2 regardless of gestation, from the fifth week through the
3 40th week, if I ever did that, but the 24th week in my
4 clinic is done under constant ultrasound observation.
5 Q. And so you could see a heartbeat on the ultrasound, is
6 that right, Doctor?
7 A. Yes, ma'am. You could.
8 Q. Now, Doctor, let's talk about your 14 to 17 week
9 procedures. Can you describe the process of removing the
10 fetus at that gestational age?
11 A. Again, I guess in total, even though we are doing one
12 one day and one at a second day, the 16 and 17s are a
13 two-day procedure. The actual removal process probably does
14 not change. With the 16 and 17 weeks, I would bring them
15 after they -- when they arrive on the second day, actually
16 they take home the Misoprostol or Cytotec tablets with them.
17 Two of them. We tell them to a half an hour before they
18 arrive at the clinic the second day -- this is the 15th and
19 17th. They take the medication home because we want -- I
20 don't normally see any kind of cramping or discomfort in the
21 first 30 minutes that they are using the Misoprostol, so we
22 did try to gain that time by putting it in. So after the
23 Misoprostol, we would dilate. I'm sorry. After the,
24 Misoprostol, we would, again, do a paracervical block,
25 rupture the membranes and remove the fetus.

1 Q. And in the 14 to 17 week procedures, have you ever had a
2 circumstance where the fetus comes out intact up to the
3 level of the calvarium?
4 A. I have experienced where the fetus comes out completely,
5 and I have experienced to where part of the fetus would
6 remove up to the calvarium, or upper trunk. I'm sorry. An
7 upper limb or a lower limb.
8 Q. Okay. Can you tell me about the circumstances where the
9 fetus has come out up to the calvarium, intact up to the
10 calvarium?
11 A. Yes, I can.
12 Q. And when was that?
13 A. You mean -- oh, a specific instance?
14 Q. Yeah, um-hm.
15 A. In my memory, it happens probably on the average of at
16 least once a month, if not more.
17 Q. Okay?
18 A. No, I really -- it's just -- it's an -- it happens and I
19 really don't take exceptional note of that.
20 Q. Okay. And, Doctor, is the fetus living at the point at
21 which it's stuck at the calvarium, lodged at the cervical
22 os?
23 A. Normally, my 16 and 17-week patients are -- the fetuses
24 are alive at the time of the final delivery.
25 Q. And what's your next step, at that point, if the fetus

1 has lodged at the cervical os?
2 A. Under 17 weeks, I would use a forcep. And my favorite
3 is a Finks, but I also do have Soffers and Bierers.
4 Depending on the amount of dilation, I would use a Finks
5 forcep, remove the part of fetus that was easily reachable.
6 Hopefully try to use small bites to work the way up and
7 remove the rest of the fetus so that it comes out intact.
8 If not, then remove whatever part that I could get easily
9 and then go back and remove the rest.
10 Q. Okay. Doctor, have you had a circumstance, and I think
11 this is what you're getting at, where the fetus has been not
12 intact, partially dismembered, and yet part of the fetal
13 trunk passed the navel passed the umbilicus, has come
14 outside the body of the mother?
15 A. I'm sorry. I probably should have said what I said more
16 clearly. But, certainly, when an upper extremity comes
17 through the vagina, and I have to remove it, at that point,
18 -- the shoulder, the shoulder joint actually tends to be
19 more substantial than other joints in the body. So mostly
20 if, I can grab above the elbow, I will get part of the
21 scapula, and sometimes even part of the chest wall from that
22 extremity; ribs, and possibly even lung tissue or other
23 tissue inside of the chest cavity.
24 Q. Are those parts of the fetal trunk above the umbilicus?
25 A. Most certainly.

1 Q. They have come outside the body of the mother. Is the
2 rest of the fetus still inside?
3 A. That's correct.
4 Q. What do you do, at that point?
5 A. I put down the part that we have removed and go back
6 with the same instrument, and go after the most easily
7 accessible portion of the fetus that's left.
8 Q. Okay. Doctor, what is your intent with regard to how
9 much of the fetus you're trying to remove in your 12 to
10 17-week procedures, your earlier D & Es, prior to the use of
11 Digoxin?
12 A. My intent is always to remove the fetus intact or as
13 intact as possible.
14 Q. And do you take any steps in terms of the manipulation
15 of your instruments, in order to increase your chances of
16 removing the fetus in larger pieces?
17 A. Yes. I think both by my own personal experience and
18 with guidance from my mentors, I have adapted -- I have
19 heard it referred to here as cork screw motion. I never
20 thought of it as that, but just a twisting motion which
21 helps the fetus adapt to the birth canal and to the cervical
22 -- the cervix and to be more likely to have the arms extend
23 above the head, which is the way most of my early
24 gestational patients -- fetuses are removed. And that
25 certainly aides in keeping the fetus intact.

1 Q. And so how often are you successful in removing the
2 fetus completely intact?
3 A. Through the 17th week, completely intact, I still would
4 have to say probably less than 5% of the time.
5 Q. Okay. And -- but you're saying that the motion that you
6 use assists you in removing the fetus in larger pieces even
7 if it's not coming out intact; is that right?
8 A. Correct. I mean most of the time, I can remove the
9 fetus through 17 weeks in three to four pieces.
10 Q. Okay. Doctor, now I would like to ask you about your
11 procedure starting at 18 weeks. You've indicated that you
12 use Digoxin, I believe, one or two days prior to the
13 procedure; is that right?
14 A. For 18 and 19-week patients, I use it for approximately,
15 -- well, anywhere from 24 to 30 hours, before the time they
16 will finish their procedure. And for above 20 weeks, they
17 have the Digoxin in for approximately 36 hours or more.
18 Q. Okay. And when they come back to the clinic, and you
19 see you have adequate dilatation, what's your next step in
20 that gestational age range?
21 A. Well, my first step after the 18th week is to bring them
22 to the procedure room, remove the laminaria that have
23 already been placed, and then do a paracervical block for
24 comfort. I'm sorry. Then remove the laminaria that have
25 already been placed. Then evaluate -- it's usually based on

1 how well the laminaria are expanded; if they are totally
2 expanded, I don't even attempt to measure the cervix because
3 I know that number of laminaria will give me the greater
4 than 65 millimeters I'm looking for on day two. If not,
5 then I will mechanically dilate the cervix with Pratt
6 dilators up to a minimum of 65, or as far as I can get
7 without feeling resistance. And then if they are 18 and 19
8 weeks, at that period of time, we would rupture the
9 membranes.
10 Q. Um-hm.
11 A. And we would place four Cytotec tablets in the rectum.
12 The reason I use the rectum is because once the membranes
13 are ruptured, for the next several hours, there is going to
14 be a flow of the water that surrounds the pregnancy through
15 the vagina. That's going to wash out the medications.
16 However rectally, the medication seems to work exactly as it
17 does if you use it vaginally.
18 Q. Okay. And what happens next after you've --
19 A. After that, we have already started an IV. If it looks
20 like they are going to finish that day, we would start an
21 IV. We keep them comfortable with IV sedation medicine.
22 They go to, they go to another area other than our standard
23 recovery. We have a small recovery room we use for our
24 patients that are waiting to expel the fetus. My normal
25 course is to wait for that woman to deliver the fetus

1 intact.
2 Q. And, in your experience, how often does the woman expel
3 the fetus without further assistance from you?
4 A. Actually depends. Seems to depend upon the day, but all
5 -- I would say almost always above 75%, and maybe the
6 numbers may be as high as 90%, but I would say somewhere
7 between 75 and 90%.
8 Q. And when the woman has expelled the fetus, what do you
9 do next?
10 A. Following that, she may have either expelled the fetus
11 alone, which we would call an incomplete expulsion, or she
12 may have expelled both the fetus and the placenta. If the
13 fetus and placenta have came out intact, I generally try to
14 wait half an hour or an hour for her to get relaxed again,
15 and then take her to the operating room and do a D & C. If
16 it's came out where the fetus is still -- I'm sorry, where
17 the placenta is still within the uterus, then I would take
18 her immediately to the surgery room. Again, remove the
19 remaining placenta, and do the D & C at that time. And I
20 forgot to add that once I rupture the membranes on the final
21 day, we start a Pitocin, Oxytocin drip. Oxytocin, although
22 in most papers is thought not to work before the 25th or
23 26th week, it seems after the woman has been on Misoprostol
24 for over an hour, it seems to somehow enhance the effects of
25 Oxytocin, so it works very, very well.

1 Q. So is your procedure kind of a combination of induction
2 techniques and surgical D & E techniques, Doctor?
3 A. I would describe it as that, yes.
4 Q. Okay. Why don't you just use induction techniques?
5 A. I think this probably goes back to my early experience
6 when I was in medical school in residency, and I think in
7 general, just normal delivery leaves placental fragments for
8 chorion, and other parts of the pregnancy behind. And,
9 again, it may be by general surgery training. I'm unhappy
10 with tissue that has been left into a cavity which is
11 subject to infection. So I'm probably more aggressive at
12 removing the chorion, and going back and doing a D & C than
13 many people are. But, conversely, with normal pregnancy,
14 it's expected that the 6 to 10 weeks of lochia, or white
15 discharge of what actually is dead material left behind from
16 the pregnancy delivery, is acceptable and our normal course
17 -- even in our latest patients that we do is that they
18 experience bleeding like the last three or four days of a
19 normal menstrual cycle. We tell them if it's greater than
20 that, we want to know about it immediately.
21 Q. So is it fair to say, Doctor, you use a surgical
22 techniques to take care of any retained tissue after the
23 induction procedure. That's why you do a D & C
24 immediately?
25 A. That, and I also want to be able to evaluate the

1 condition of the cervix to look for tears and repairing, if
2 there are any. And I want to be able to -- I understand the
3 complete status of the uterus. So I need to know what has
4 happened inside to know there is not a complicating factor
5 that I need to look at.
6 Q. And, Doctor, are there some women, I believe you said it
7 was a approximately 75%, correct me if I'm mischaracterizing
8 that, of women who will expel the fetus without further
9 assistance from you. And so I'm assuming that means that
10 there are some women, maybe 20, 25%, who don't expel the
11 fetus in the normal course of the induction. Is that right?
12 A. That's correct. If they haven't expelled the fetus
13 within three to four hours, then I would just go in and
14 remove it.
15 Q. And use your regular D & E techniques?
16 A. Use it exactly the way I had done the 14 to 15-week
17 patients.
18 Q. Doctor, you have been here, you've heard the testimony
19 of a number of other physicians in this trial, and you've
20 heard a significant variation among the procedures that the
21 physicians have discussed using in the second trimester. Do
22 you think everyone should perform your technique?
23 A. My opinion?
24 Q. Yes.
25 A. Is that, let's say, there are a hundred doctors in the

1 United States doing later, mid to second -- mid to late
2 second trimester D & Es. There are probably a hundred
3 different techniques being used in the United States. I
4 think every operating surgeon over a period of time develops
5 a protocol which works for them. My very first day of
6 medical -- I'm sorry. My very first day of my surgical
7 residency, at the staff meeting, we were introduced to the
8 chairman of the department who we managed to see about once
9 a year. His message to us was you're here to learn.
10 Everybody that you work with can teach you something. Even
11 if everything you see convinces you that you never want to
12 do anything the way they did, you still have learned
13 something. Your job, as you learn these things, is to put
14 them together to formulate a technique which works for you.
15 And that's -- as long as your results are as good or better
16 than what would be expected from other people, then you
17 should continue that course. I don't think that I have the
18 right to tell anyone how to do their procedures. I can show
19 them what I do. I can help them learn what I do, but they
20 have -- they are the person ultimately responsible for the
21 care of their patient, and they have to do what is
22 comfortable for them. I have worked in thoracic surgery
23 with many heart surgeons, and I have yet to see any two that
24 do something the same way.
25 Q. Thank you, Doctor. Doctor, I would like to ask you a

1 little bit about your opinion of the safety of your
2 technique. And, particularly, I would like to focus on the
3 procedures from 12 through 17 weeks, prior to the use of
4 Digoxin. Doctor, how would you characterize the degree of
5 dilation that you're achieving, in comparison with other
6 abortion providers, if you can characterize it. Is it more
7 or less the same?
8 A. Depends on the abortion providers I'm comparing to.
9 It's probably all over. I'm probably among the group that
10 does as much as possible. There are certainly providers
11 that are much less -- there are providers that believe they
12 can do 26 or 7 or eight-week patients. This is in Europe,
13 through an opening that I would be uncomfortable doing a 14
14 week. And they do it very well, but I wouldn't say that
15 they are wrong and I'm right. I just am uncomfortable when
16 I don't have adequate dilation.
17 Q. For you, Doctor, what do you think are the benefits of
18 obtaining a significant, the dilation that you seek to
19 achieve?
20 A. I think I see much less damage to the cervix.
21 Q. I'm sorry. Much less?
22 A. Damage to the cervix. I have to make far fewer passes
23 into the cervix than what my colleagues tell me they do, and
24 from what -- many of us videotape our procedures and share
25 those videotapes at meetings, and, you know, there are times

1 when I can only remove -- we go like a gram at a time that
2 does happen with very small dilations or very contorted
3 cervical canals. But in normal, my number of passes is
4 probably about a third of what the average physician would
5 do for 18 to 22 weeks. Again, there are not very many of us
6 doing this procedure after the 22nd week. There are
7 relatively few even after the 20th week.
8 Q. Doctor, focusing on your 12 through 17-week procedures,
9 can you tell me, does the cervical dilation that you achieve
10 have any effect on the size of the fetal parts that you're
11 able to remove?
12 A. Yes, ma'am. I can normally remove, virtually intact, as
13 I said two, three pieces. I can often get up to the base of
14 the skull then go back and remove the skull. I can often
15 get both lower extremities, and divide somewhere at the
16 upper part of the spinal cord, removing abdominal organs and
17 some even thoracic organs on the very first removal.
18 Q. What do you think -- do you think there are benefits to
19 removing the fetus in fewer pieces or intact?
20 A. I don't think that that's gestationally significant. I
21 think that that would be my goal at any gestation.
22 Q. Okay. But I'm asking you in your 12 to 17-week
23 procedures, Doctor, is there a safety advantage to removing
24 the fetus in fewer, as intact as possible, in as few parts
25 as possible?

1 A. I find that true in my practice. Yes, ma'am.
2 Q. And can you just list for me what you think the safety
3 advantages are of a intact or near intact removal are,
4 Doctor?
5 A. Surely. Okay to go on?
6 Q. Yes, please.
7 A. I'm sorry. The advantages that I find are less
8 infections, and that's retrospectively looking back, as I
9 have yet to have one. Less problems with uterine bleeding
10 and hemorrhage. My average blood less for 16 to 17-week
11 fetus is approximately 50 CCs or less, which most women lose
12 that much blood with their menstrual cycles. I'm sure that
13 by making less passes, I have obviously less chance of
14 perforating the uterus or developing a false passage, which
15 means you have somehow gotten out of the cervical canal and
16 you're creating a new tunnel through the cervix or through
17 the uterus. I just think it's innately safer.
18 Q. And, Doctor, you haven't performed any studies of your
19 own charts to determine the impact of your procedure is,
20 have you?
21 A. I have never compiled the information. I have tried on
22 my records to document as much information as possible,
23 hoping that some day I will find a resource that will give
24 me money to pay a research assistant. I have never had the
25 time or the money to do that myself.

1 Q. But, Doctor, on your charts, for example, are you
2 documenting every time the fetus comes out intact or how
3 many pieces it comes out in?
4 A. I never used to, no.
5 Q. Now, Doctor, I want to ask you a few questions about
6 your practice of using Digoxin to induce fetal demise
7 starting in the 18th weeks?
8 A. Yes.
9 Q. Are you aware of any other drugs that are used besides
10 Digoxin for this purpose?
11 A. I know the potassium chloride, KCL, which is a salt, is
12 commonly used among people that do it. I feel uncomfortable
13 with that drug. I'm not sure that it's any less beneficial,
14 anymore beneficial, any less risky. I'm just not
15 comfortable with that drug.
16 Q. Okay.
17 A. I'm also, myself, before I started using KCL with
18 instructions or with consultation with other doctors, I was
19 using Lidocaine alone. And I found that, at that time, with
20 10 CCs of Lidocaine, I was achieving fetal demise in all
21 virtually all of my patients.
22 Q. And, Doctor, why do you perform an injection of Digoxin
23 to induce fetal demise starting at 18 weeks?
24 A. I actually do the combination. My present technique is
25 a combination of Lidocaine and Digoxin. I use the Lidocaine

1 a general anesthetic. The fetus is instantly anesthetized.
2 And then I use the Digoxin to continue the fetal demise of
3 the patient.
4 Q. Of the fetus?
5 A. Thank you. Yes, ma'am.
6 Q. Okay. Doctor, do you feel there are any advantages to
7 performing an injection of Digoxin?
8 A. In my practice, I find it very helpful.
9 Q. And why is that?
10 A. It's -- in the patients that -- I didn't, obviously used
11 to do this all the time. And in patients where it may be
12 contraindicated at the present time, which I still do have a
13 few, the blood loss and the effort that I have to put into
14 removing the issues are both greatly reduced. And it's my
15 assumption that if I'm working less aggressively to remove
16 the tissue, then the patient's uterus and cervix are
17 suffering far less damage than trying to hold the tissue in.
18 Q. Doctor, why don't you induce fetal demise prior to 18
19 weeks?
20 A. At one point in time, I did do that, but now I feel, and
21 I did that -- I quit very soon. The risks and the benefits
22 did not weigh out in the patient's favor.
23 Q. And why is that? Is there something about the ease of
24 performing Digoxin or the difficulty of performing Digoxin
25 injections prior to 18 weeks that is different after 18

1 weeks?
2 A. It's another step that does carry a significant
3 mortality morbidity risk with it. The risks have been
4 described, as you said, by many of the physicians the last
5 couple of days here. But the risks include infection, they
6 include bleeding, both intrauterine bleeding. You can get
7 intra-amniotic bleeding if you happen to hit an artery
8 vessel in the placenta. You can have bleeding in the
9 uterine cavity. You can have bleeding in the abdominal
10 cavity. You can have bleeding in the abdominal walls.
11 There are many major vessels that we are trying to avoid.
12 Occasionally, you can avoid that, but occasionally you
13 cannot avoid them.
14 Q. Doctor, is it harder to perform an injection of Digoxin
15 prior to 18 weeks to induce fetal demise?
16 A. I'm not sure it's harder. At that point, it takes much
17 more talent. We are looking for a smaller structure.
18 Q. It's not harder for you, perhaps, but it's harder for
19 other people that don't have your skills? Is that what
20 you're saying?
21 A. It was certainly harder for me ten years ago. It's a
22 skill that I have only learned by doing many, many, many of
23 these procedures. And that's probably why my early
24 procedures were ineffective, because with the early
25 procedures, you're almost entirely doing intraamniotic

1 injections as opposed to intrafetal injections. And if you
2 are only going to wait a few hours to do the procedure, if
3 the fetus is alive a half or three-quarters of that time as
4 the medicine is slowly absorbed into the body, then you've
5 lost all the benefits of intrauterine fetal demise.
6 Q. Okay. Now, you believe that the injections that you're
7 performing on your patients after 18 weeks are generally
8 safe; is that right?
9 A. Yes, do I.
10 Q. You have discussed some of the risks. They are quite
11 low; is that right?
12 A. Unless you're that patient, yes.
13 Q. But in your hands, you feel that the risks to your
14 patients are very low; is that right?
15 A. I have had no complications, yes.
16 Q. And, Doctor, do you believe that all providers should
17 induce fetal demise starting at 18 weeks?
18 A. No, ma'am. I do not.
19 Q. And why not, if it offers such a benefit to you and your
20 procedures, why shouldn't everyone be using it?
21 A. My training is as a resident -- I had experience with
22 amniocentesis. My training as a resident, I had experience
23 with laparoscopy. I had experience with needle biopsies of
24 the liver. I had experiences with using the ultrasound for
25 guidance to do biopsies. I think all of that creates a

1 physician that may be able to learn the technique faster and
2 with greater accuracy and safety than the average person. I
3 have taught several physicians how to do this procedure.
4 Q. How many have you taught, Doctor?
5 A. I can recall by name four. I'm sure there were two
6 others, but for some reason, I guess I'm getting on 60 years
7 old. I have forgotten who they are, and I haven't been able
8 to come across the names. Of those four, I have a female
9 who that learned it and actually did fairly well with it,
10 but decided it was not right for her. She stopped using it
11 in her practice. I have another female physician that was a
12 general practitioner who never had any training past her
13 internship, as far as a formal residency, yet she is, to
14 this date, one of the most talented people I have seen do
15 the injection, and she still does it to this date. Doctor,
16 I'm sorry.
17 Q. Let's not use names.
18 A. Back east, I had a physician who had practiced for well
19 into 30 years without inducing fetal demise that called me
20 and said, will you come and show me how to do that? And I
21 spent four weeks with him, and it took him awhile. And he
22 was an OB/GYN. It took him awhile to get comfortable with
23 the procedure, but he called me back about six months later
24 and said I can't believe the difference this makes.
25 Q. And how about -- have you ever had anyone who just

1 couldn't learn it?
2 A. Yes. Well, I don't know. Maybe she could have. I
3 decided it probably wasn't going to happen, and I didn't
4 want to be responsible for training her, so I suggested she
5 do not learn the rest of that.
6 Q. Okay. Doctor, could you take Plaintiff's Exhibit 69,
7 which in front of you on the ledge there?
8 THE COURT: Counsel, just for your information, it
9 remains unclear to me why the doctor injects or causes fetal
10 demise at 18 weeks and later, and why he doesn't earlier.
11 MS. SMITH: Okay.
12 THE COURT: Is there -- I mean I think I can intuit
13 why, but that's not precisely clear to me, and perhaps I
14 wasn't listening carefully.
15 MS. SMITH: Thank you, Your Honor
16 BY MS. SMITH:
17 Q. Doctor, could you explain to us why you do not perform
18 the injection earlier than 18 weeks? You said something
19 about weighing the risks of that?
20 A. May I first tell you what the benefits are after 18
21 weeks so that what -- actually, the benefits also would be
22 present at 16 to 17 weeks?
23 MS. SMITH: Yes.
24 THE WITNESS: First of all, once the woman's body
25 recognizes the fetus is no longer alive, certain chemicals,

1 certain hormones change, and her body goes through changes.
2 Among these changes, the uterus is virtually always
3 contracted before I have given any other medications on the
4 second day of a three-day procedure, or the final day of a
5 two-day procedure. The uterus is usually, the pregnancy is
6 dropped very low into the pelvis. The uterus is dropped
7 lower into the pelvis. When I open -- when I do the second
8 day of insertions of laminaria in the patients that have had
9 fetal demise, it's much easier to insert more laminaria
10 giving me better dilation. Secondly, once the fetus, the
11 blood that transfuses or that flows through the placenta is
12 caused to flow by the heartbeat of the fetus. Once the
13 heart of the fetus has stopped, there is no blood flow in
14 the placenta. It tends to -- it tends to shrivel. It tends
15 to short of loosen the connection between the placenta and
16 the uterine wall. I find it, in these patients greatly --
17 in fact, most of my placentas separate and deliver intact.
18 They deliver completely with the fetus, so that when I go
19 back, I'm only removing a very, very small amount of debris
20 with my D & C. And I don't find that to be true in the
21 patients where the injection did not work or worked at a
22 later time. So I think that it's a better that way for me.
23 Also, if I do an injection on day one, and I'm getting to
24 two days later, if the fetus is dead, it's not going to
25 grow. If it's alive, it's still going to get bigger for

1 those next 48 hours, even though it's a small amount, it may
2 equal up to one or two millimeters. And the other benefit
3 when the fetus is dead, it's very much like -- and I
4 explained this to the patients, if we set a peach on a
5 window sill where the sun can hit it and it's warm, over a
6 period of two or three days, you'll see that fetus -- you'll
7 see that peach lose water and become smaller. And my
8 experience has been that I see -- virtually, in three-day
9 patients, I see a two-week decrease in the size of the
10 cranium.
11 BY MS. SMITH:
12 Q. So Doctor, in other words, you're saying there is a
13 softening of the issues?
14 A. Absolutely.
15 Q. And there is also --
16 A. Actually that's a different thing yet. As the fetus
17 shrinks, it's not only that the fetus has not been alive for
18 48 hours, or 36 to 40 hours, it's that it has been dead in a
19 warm environment. So the issues tend to destruct much more
20 rapidly than, say, if you put a fetus in the refrigerator.
21 It would stay intact much longer. So it's easier to mold
22 that fetus as you remove it, and I find that I have a much
23 greater chance of removing the fetus intact by doing it.
24 Q. So there is a softening of the issues and there is a
25 reduction in the size of the fetal calvarium?

1 A. Um-hm.
2 Q. Are the benefits greater, Doctor, the more time there is
3 between the injection and the performs of the removal of the
4 fetus?
5 A. Okay. You may remember, if you read my previous
6 testimony in 1997, I was stopping at 20 weeks. Because I
7 had originally done these injections up through, from 15
8 weeks through the 24th week. And I saw very little of
9 improvement in the procedure in those early patients. But
10 now, because I'm getting, you know, that was what I was
11 doing intraamniotic injections, getting fetal demise six or
12 eight hours after they left the clinic.
13 Q. What's different about what you're doing now?
14 A. Now, I'm doing intracardiac on probably 95% of my
15 patients; intrafetal on the rest. And I'm seeing fetal
16 demise before they leave the clinic, which is usually 20 to
17 30 minutes later.
18 Q. So there are some things that have changed. In other
19 words, your ability to improve your own skills and the
20 placement of the needle in performing the injection causes
21 fetal demise to occur earlier and, therefore, there is more
22 softening of the tissue, more reduction in the skull size
23 and greater benefit overall; is that right?
24 A. That is right.
25 Q. Doctor, are there any other issues with performing the

1 procedure earlier, in terms of the placement of the position
2 of the uterus, that make the injection more difficult?
3 A. Yes. I think I covered this in my declaration, and I
4 should have mentioned it today. The smaller the uterus is,
5 the deeper it lies within the pelvis, and the more other
6 structures in front of it. And this can be ovary, it can be
7 tubes, it can be bowel, it can be bladder. As the uterus
8 gross out of the pelvis, you know, of course, there is a
9 retrospective presentation of the uterus, and there is an
10 anteflexion position of the uterus. But as the uterus
11 grows, everybody goes to be antiflexed. So as that uterus
12 moves up, it displaces bowel, and it displaces other things
13 from the anterior wall.
14 Q. Does that increase the safety of the injection, in your
15 opinion, Doctor?
16 A. I feel that if you -- I use a very small needle. With
17 amniocentesis, we were taught to use number 20s. Actually
18 number 18s. Some people use -- I use a 23 needle to do any
19 procedures, which is virtually half the size of that. And
20 it's accepted that if you perforate the bowel with a 23
21 gauge needle, that it won't be a problem. So it's much more
22 difficult to find the fetus. You're much mover likely to
23 cause another problem.
24 Q. Okay. Thank you, Doctor.
25 MS. SMITH: Your Honor, is that clear things up a

1 bit, I hope?

2 THE COURT: Yes, thank you.

3 MS. SMITH: Thank you, thank you, Your Honor.

4 BY MS. SMITH:

5 Q. Doctor, could you look at Plaintiff's Exhibit 69?

6 A. Yes.

7 Q. And have you seen this before?

8 A. Yes, ma'am, I have.

9 Q. It's the Partial-Birth Abortion Ban Act of 2003, is that

10 right?

11 A. Yes, ma'am.

12 Q. And, Doctor, could you look at page -- is there a

13 problem, Doctor?

14 A. Well, I just saw the bottom of this. Yes, it is. Okay.

15 I looked at it and it said Stenberg versus Carhart, and I

16 thought it was an older version. But, yes, this is the

17 Partial-Birth Abortion Ban of 2003.

18 Q. And, Doctor, could you look at page S-6, at the top of

19 the page I believe the numbers are?

20 A. S 3-6, is that correct.

21 Q. Yes. Sorry.

22 A. I have that page.

23 Q. Do you see the prohibition section of the Act, Doctor?

24 A. Section 1531. Yes, ma'am. I do.

25 Q. And, Doctor, have you read this before?

1 A. Frequently.
2 Q. And are there specific terms in the Act that you don't
3 understand?
4 A. I think there are terms in this Act that I both do not
5 understand and that have many definitions. So I have no
6 idea which definition to accept.
7 Q. And which of those terms are you thinking of?
8 A. First of all, the overall title of Partial-Birth
9 Abortion. And that's about defined by various states in
10 various different ways, and it's never been defined by a
11 medical entity. So I have to say that there are probably at
12 least 21 different procedures that that verbiage covers, but
13 I'm not sure I could tell you which ones they are.
14 Q. In the specific way that it's defined in this Act,
15 Doctor, could you tell me about the language of this Act?
16 A. To me, this Act, Partial-Birth Abortion, includes every
17 D & E that I do.
18 Q. Are there specific terms in the Act, Doctor, that you
19 find difficult to understand?
20 A. Well, I guess in subparagraph A, where it says
21 deliberately intentionally vaginally delivers. I don't
22 think one can do an abortion without doing that, so it
23 probably covers every abortion. I don't understand why that
24 is there. I don't understand what an overt act is. To me,
25 everything that I do to cause an abortion is an overt act.

1 There was another question I have here too.
2 Q. That's fine, Doctor, if there is no others.
3 A. No, there are others. I'm blocking. I'm sorry. Go
4 ahead.
5 Q. Well, the definition starts at 1531-A, Doctor, so that's
6 the functional section of the Act?
7 A. Again, any part of the fetal trunk to me means the
8 shoulder, means the rib. If I only remove one rib, I have
9 removed a portion of the trunk above the umbilicus, or if my
10 forcep, when I go in, only grabs the chest wall, say on
11 something that did not prolapse; an arm, which I may do. I
12 have removed a portion of the trunk above the umbilicus
13 because there is no ribs below the umbilicus.
14 Q. Any other terms, Doctor, that are -- sounds like you
15 understand that term, but it has a broad meaning in your
16 mind. Why don't we move on, Doctor. Do you believe any
17 abortions, abortions that you perform, would be prohibited
18 by the Act, and you said something about your D & E
19 procedures? Can you tell me which of your D & E procedures
20 you believe would be affected?
21 A. I believe not only mine, but every D & E procedure would
22 be done would be affected. Every. Whether it's 14 weeks --
23 and not that every time I do the procedure am I going to
24 break the law, but with every procedure that I do, there is
25 a potential to break the law. And I find that unacceptable.

1 I could lose two years of time and the monetary damages and
2 fines, in order to provide safe care, does not seem proper
3 to me.
4 Q. Do you believe that the Act would affect the procedures
5 you do when you perform -- induce fetal demise, prior to the
6 removal of the fetus?
7 A. My reading of this Act is that it would, that those
8 procedures would not be affected.
9 Q. And why is that?
10 A. Because the word living is used throughout this, and in
11 my fetal demise patients, I have already determined that
12 they are not alive.
13 Q. So in your practice, which D & Es would the Act affect
14 in your opinion?
15 A. It would affect normally 14 to 17 weeks, occasionally 12
16 to 13 to 17 weeks, or until I could safely induce fetal
17 demise.
18 Q. And, Doctor, if the act were to go into effect, what
19 would you do?
20 A. Well, I guess I'm not as happy about going to jail as
21 some of my colleagues have mentioned, but I would stop doing
22 abortions at the 13th week, and I would just go back to
23 where we were in 1969, and have my patients come back to the
24 hospital or come back to our facility at 18 weeks and do
25 their abortion.

1 MS. SMITH: Thank you, Doctor. Your Honor, just a
2 moment to consult with counsel.
3 BY MS. SMITH:
4 Q. Dr. Just one point of clarification, you talked earlier
5 about dilating greater than 65 millimeters. By that, did
6 you mean 65 French?
7 A. I do that all the time. Yes, ma'am. I do mean 65
8 French.
9 Q. And, Doctor, does the injection of fetal demise, the
10 injection of Digoxin to cause fetal demise, does it always
11 work and cause fetal demise?
12 A. When I was doing intraamniotic injections, no, it did
13 not always work. I don't know how many times, but several
14 times a year, maybe five or ten times a year, it would not
15 work.
16 Q. Okay. But now that you're performing the intrafetal and
17 your skills increased, you have not had that problem?
18 A. I have not had that happen.
19 MS. SMITH: Okay. Thank you, Your Honor. I have
20 no further questions at this time.
21 THE COURT: Mr. Coppolino, shall we take our break?
22 MR. COPPOLINO: Yes, Your Honor.
23 THE COURT: Is that agreeable with you, Ms. Smith.
24 MS. SMITH: I'm sorry, Your Honor.
25 THE COURT: I asked whether that was agreeable with

1 you.

2 MS. SMITH: Oh, yes, absolutely. We'll take our

3 15-minute break.

4 THE COURT: Doctor, you may step down.

5 (Recess from 10:34 to 10:50 a.m.; all parties present).

6 THE COURT: Counsel, you may inquire. Doctor, if

7 you will retake the witness stand, please.

8 (Witness resumed the witness stand).

9 MR. COPPOLINO: Your Honor, I have no questions.

10 That's my little April fool's day joke for you.

11 THE COURT: You know, Mr. Coppolino, speaking of

12 April fool's jokes, you should never give me an opportunity

13 to do these. In 1992, when I was hopeful that the President

14 would call me and tell me that he was going to nominate me,

15 the people in your office who handle that sort of thing

16 called and said be prepared on April 1st to have the call,

17 and I waited with baited breath, of course, all day on April

18 1st, and the call came on April 2nd. So I have always been

19 real sensitive to Justice Department lawyers who make April

20 fool's jokes.

21 MR. COPPOLINO: Seemed like a good idea at the

22 time.

23 THE COURT: So if you want to talk about that in

24 some greater detail, be my guest. You may proceed.

25 CROSS-EXAMINATION

1 BY MR. COPPOLINO:
2 Q. Good morning, Doctor. You remember me from your
3 deposition?
4 A. Good morning, Mr. Coppolino.
5 Q. Anthony Coppolino with the Justice Department. Doctor,
6 is it fair to say that you believe it should be left to the
7 discretion of the physician to use the method of abortion
8 that he or she believes is the most appropriate, in their
9 medical judgment?
10 A. Within the realms of safety. I would not want them to
11 have some bizarre conception of what would be acceptable. I
12 think as long as they stayed within the NAF standards, any
13 method they would do would be okay.
14 Q. You state in your deposition and your declaration that
15 you filed in this case, that as a physician, I should not
16 have to choose among alternatives each of which I consider
17 to be medically and ethically unacceptable. Is that your
18 view, Doctor?
19 A. That is correct.
20 Q. You also state in your declaration that you filed
21 earlier in this case, that the only way to ensure the best
22 standard of care in abortion practice, and ultimately the
23 best medical care for women with unwanted pregnancies, is to
24 trust the physician to use the method of abortion most
25 appropriate in his best medical judgment, given the

1 patient's physical condition, her gestations age and
2 reproductive history, the physician skills and all other
3 relevant factors. Is that your view, Doctor?
4 A. The view I was trying to convey is that every abortion
5 -- every patient is different, and one has to do what they
6 are talented enough to do to effect the best outcome.
7 Q. Should that judgment, as to what the best outcome, how
8 to ensure the best outcome, should that judgment be
9 entrusted to the physician who is performing the abortion?
10 A. As opposed to?
11 Q. Well, I was about to ask you that. Do you think
12 Congress should have any role in evaluating the safety of
13 abortion procedures?
14 A. If there would be a Congress that would have the medical
15 knowledge to make a good decision, I might be able to accept
16 that, but for political reasons, I cannot accept that. I
17 think that the decision has to be made between the patient
18 and the physician as to what's the safest mechanism to
19 effect her procedure.
20 Q. I'm sorry. I'm not quite sure I understood your
21 question. Do you believe that Congress should have any role
22 in evaluating the safety of abortion methods?
23 A. Not the sitting Congress.
24 Q. So you're referring to the present Congress?
25 A. That's correct.

1 Q. How about the Nebraska Legislature? Should they have
2 any role in evaluating the safety of abortion methods?
3 A. Definitely should not be the sitting Legislature.
4 Q. Do you think elected representatives, either in Congress
5 or State Legislature, should have any role in evaluating the
6 ethics of a particular abortion method?
7 A. I'm not sure I understand your line of questioning. I
8 think one goes to medical school to learn how to take care
9 of patients. I think one goes to college to learn to be a
10 politician. I'm not sure that, at any point, that line
11 crosses.
12 Q. Just so that we are clear then, do you think an elected
13 Legislature, national or state, should be making judgments
14 about the ethics of a particular abortion method?
15 A. I think that every medical decision should be entrusted
16 to the physician and her patient, and his or her patient.
17 Q. Doctor, you also say in your declaration that because
18 each patient is different, it's impossible to know in
19 advance exactly how a particular abortion method will
20 progress. Do you recall making that statement?
21 A. I'm not sure I recall it, but I certainly concur with
22 it. I would have made that statement.
23 Q. It's here. I can show you if you feel you need to see
24 it, sir. It is possible, however, to describe the general
25 steps that you might take in a particular abortion method;

1 is that fair to stay, Doctor?
2 A. Could you -- I'm not sure I understand your question,
3 sir.
4 Q. Let me ask it this way. You would agree that it's
5 possible to describe different methods of abortion, as you
6 have done here this morning when Ms. Smith asked you some
7 questions about that?
8 A. Can I describe different methods?
9 Q. Yes, sir.
10 A. Yes, sir.
11 Q. You described in your declaration and this morning, on
12 Ms. Smith's questioning, the vacuum aspiration method. Is
13 that correct?
14 A. I believe I did. Yes, sir.
15 Q. And I believe you described the dilation and evacuation,
16 the so-called D & E method; is that correct?
17 A. I do. I do remember that, yes.
18 Q. Do you recall using a phrase in your declaration and
19 when we met at our deposition, do you recall using the term
20 intact D & E?
21 A. No, I don't, but I'm sure that I might have.
22 Q. I was just looking at your declaration again. And the
23 last sentence of paragraph 12 is sometimes when I'm
24 successful in removing the fetus intact, I perform what is
25 known as the quote, intact D & E, unquote. Do you remember

1 using that term in your declaration, Doctor?
2 A. Again, I don't particularly remember, but I would have
3 used it if you had asked.
4 Q. Now, your declaration also refers to the so-called
5 intact D & X procedure that was described by the American
6 College of Obstetricians and Gynecologists. Do you recall
7 discussing that in your --
8 A. I think -- I mean I recall discussing it, but I do not
9 remember the context of what I was discussing with it or
10 where we were going.
11 MR. COPPOLINO: May I approach the witness, Your
12 Honor?
13 THE COURT: Sure.
14 MR. COPPOLINO: Your Honor, I was going to refer to
15 the witness's declaration. Do you need a copy of it?
16 THE COURT: I don't unless it's going to be real
17 extensive, but I'll count on you to be accurate. Go ahead.
18 BY MR. COPPOLINO:
19 Q. If you take a look at paragraph 24, Doctor, on page
20 eight of your -- by the way, let's just identify it for the
21 record. This document I have handed you is marked -- is
22 described as the Declaration of LeRoy H. Carhart M.D., filed
23 in this lawsuit, LeRoy Carhart et al. Versus John Ashcroft.
24 Is this the declaration you filed, Doctor, in connection
25 with your application for a temporary restraining order?

1 A. Yes, sir, I believe it is.
2 Q. Near the end of the document, it's not quite the last
3 page, but the last page of the declaration text there is a
4 signature page. If you could just flip through and tell us
5 if that's --
6 A. Just a second. Yes, sir. That is my signature.
7 Q. It's the page after page 21?
8 A. I have it, sir. It is my signature.
9 Q. Now, you described in paragraph 24 a four-step process
10 called intact D & X, by the American College of OB/GYNs.
11 You do not follow the ACOG definition of intact D & X in
12 your own practice, is that correct; Doctor?
13 A. I don't really use the term intact D & X in my practice
14 at any time. I may have referred to it. I know this item
15 is out there, but I do not do what the American College of
16 Obstetrics and Gynecology describes as a D & X.
17 Q. In fact, don't -- isn't it correct to say that you
18 strongly disagree with parts of the ACOG definition of
19 intact D & X?
20 A. I don't disagree with it at all. That is their
21 definition.
22 Q. I'm saying you strongly disagree with elements of the
23 procedure in the ACOG definition for an intact extraction.
24 Is that correct?
25 A. I think that the ACOG definition would require me to do

1 certain things that I have rarely found to be of any benefit
2 to my procedure.
3 Q. There are some elements of this definition that you
4 strongly disagree with, Doctor?
5 A. There are some elements that I feel are unnecessary most
6 of the time.
7 Q. All right. Doctor, I'm going to show you your
8 deposition. May I --
9 THE COURT: Yes, you may.
10 MR. COPPOLINO: Standing permission, Your Honor.
11 THE COURT: Yes, you may
12 BY MR. COPPOLINO:
13 Q. Would you turn to page 167?
14 A. Where are the numbers. Oh, I see. It's the small ones.
15 Yes, sir, I have that page.
16 Q. All right. In looking down at lines 10 to 15, I don't
17 mean to be a stickler on this point, Doctor, but you told me
18 at your deposition, after we went through the four-step ACOG
19 definition that -- this is on line 14, I strongly disagree
20 with some parts of it. Now, is that your testimony at your
21 deposition, Your Honor -- Dr. Carhart?
22 A. What I said is, I think other than that, I strongly
23 disagree. What I disagree with is setting out with a road
24 map that you have to take exactly, no matter what the pit
25 falls may be along that course, or no matter what short cuts

1 you might find while you're on that course. I think what
2 I'm trying to say here is, and I think I thought I used this
3 expression in my declaration or in my deposition, but I
4 don't remember, is that with every abortion I have a point
5 A, where the woman presents to me that she's pregnant. With
6 every abortion, my intention is to remove the fetus as
7 intact as possible. And I feel that it's most appropriate
8 to go to point A and point B the way that I find it to be
9 the safest and the most expedient.
10 Q. Just so that the record is clear, Doctor, I want to read
11 this entry. Question on line five . Where are the
12 differences between your approach to an intact fetal
13 extraction and the way ACOG has defined it? Do you know the
14 four-step process that I'm -- answer; exactly, and I think
15 that's the entire difference. I don't believe I have a
16 process. I have a beginning point and an end point. I
17 think ACOG did this so that we would have a level playing
18 field to talk about, but I think that other than that, I
19 strongly disagree with some parts of it. Now, that was your
20 testimony at your deposition, correct?
21 A. Exactly. I think the parts that I disagree with are
22 that we have a road map that we have to follow exactly
23 regardless of what's happening.
24 Q. You agree, Doctor, that the result of the ACOG, the
25 process the ACOG describes would be an intact extraction,

1 but you believe there are safer ways to get there than ACOG
2 has described it; isn't that correct?
3 A. I believe that what they described may -- may and I want
4 to emphasize may provide you with an intact extraction. I
5 do not believe that it's very necessary to do all these
6 steps to get that. If, in a given patient, at a given
7 gestation, at a given time, I had to do those four steps,
8 and I thought that would be the safest way to do it, then I
9 would complete it that way. I just, in my training, I have
10 always been taught that you take the situation and make the
11 best of it with the least risk to the patient.
12 Q. Doctor, what I'm trying to establish is, do you believe
13 there are safer ways to do intact extraction than ACOG has
14 described?
15 A. No, because I think their way is very safe.
16 Q. Well, do you still have your deposition open?
17 A. I'm on 167.
18 Q. On 167. Further down, let me read this. This is right
19 after the portion we just read a moment ago. Says starting
20 on line 18, this is your testimony. A large number of the
21 people doing abortions between the 20th and 24th week would
22 concur that this is not exactly what we would refer to as an
23 intact D & E. I mean the result is the same. We end up
24 with an intact fetus, but there are safer ways to get there.
25 Was that your testimony at your deposition, Doctor?

1 A. That's what I read, yes, sir.
2 Q. And is that a true and correct statement?
3 A. I think what I said here is a true and correct
4 statement. I think the way you're interpreting it is not
5 the same as the way I wrote it.
6 Q. This is what you testified to?
7 A. I have no question about what I said. You know I'm
8 willing to stipulate this is exactly what I said, but I
9 think when I say may, and I say when we end up with, and
10 there are safer ways, that I can imply that most of the time
11 that may be true. But there may be a time when it's not
12 true, and I certainly do not accept that you can't do this
13 any more than I accept the fact that you have to do this.
14 Q. Doctor, you believe that you should never attempt to do
15 an intact extraction without this fetal euthanasia process
16 you described?
17 A. No.
18 Q. You don't believe that?
19 A. Well, restate your question.
20 Q. Do you believe that you should never attempt to do this
21 without fetal euthanasia?
22 A. That's absolutely not true.
23 Q. Let's take a look on page 168 of your deposition. My
24 question -- I'm sorry. Bottom of page 167, line 24
25 question: First of all, was there something about the

1 procedure described by ACOG that you consider to be unsafe?
2 We are on page 168 now, line 2. Well, first of all, I think
3 it's my own, my own thoughts that are that you should never
4 attempt to do this without fetal euthanasia. Was that your
5 testimony at your deposition, Doctor?
6 A. I guess it was. It's certainly not what I thought I
7 said, and it's not what I feel. I certainly think I would
8 not do that. I think in my hands, in my patients, in my
9 practice, in my office, that I do that, but I also know that
10 when I travel to other communities, I work in other people's
11 offices. I sometimes do not do that. So in my practice, my
12 way, this would be my goal, but to say that it's wrong for
13 anybody else is A, not my parameters, and B, not my belief.
14 Q. I'm just asking you if you felt that the omission of
15 that step in the ACOG's definition is something that you
16 disagree with, first of all. The admission of the fetal
17 euthanasia step?
18 A. No.
19 Q. You don't think that's a flaw in the process that ACOG
20 has described?
21 A. I think you have to understand why ACOG tried to
22 describe this, and I think it was just to put a description
23 on what had been taken and ran in 300 directions with Dr.
24 Haskell's original paper. Do I think, do I think for me
25 that it's necessary? I think that for me, I would prefer

1 it. I have not used it occasionally because of patient
2 requirements, but if I said -- and I obviously did, that
3 this is the way it is, that is not what I believe and I
4 apologize, and I have to take whatever consequences that
5 would bring.
6 Q. Okay. So you describe the omission of this fetal
7 euthanasia process as a flaw at your deposition. The
8 omission from the ACOG deposition, but you don't think it's
9 a flaw?
10 A. What I meant to say, in my practice, I think it gives me
11 better results. But I can't tell you what Dr. J has
12 happened in his practice or her practice because things may
13 be different. I don't know. I think every abortion, as I
14 said just before that, you have to have a road map. In
15 general, I would like to do fetal euthanasia or induce fetal
16 demise. I think that that's probably desirable, but I don't
17 think it's necessary, and I don't think it should be
18 required by me of even people that would work for me in my
19 office. I don't think it should be required of me by the
20 Legislature, and I don't think that ACOG, in their
21 description, says that this is the only way one should do
22 it. It says this is what they feel, if you are going to use
23 the phrase intact D & X, that you should do. Now, if you
24 decide to add something to that, including intrauterine
25 fetal demise, I don't see that as a problem.

1 Q. So we are clear, Doctor, I wasn't asking you if you felt
2 the fetal euthanasia process would be required. My specific
3 question was whether you felt the description of the intact
4 D & X procedure by ACOG was a flawed description, because it
5 didn't make reference to that process?
6 A. No, I don't think there is anything wrong with their
7 description.
8 THE COURT: Let me interject here for just a moment
9 and this may be -- my point may be obvious or it may not be.
10 One could have a flawed description in the sense that it
11 does not accurately describe the objective facts. That's
12 one series of questions. And one could have a flawed
13 description in that the description of what it describes,
14 while accurate, is not safe or preferable. And I don't
15 know, to be candid, whether you all are making those
16 distinctions. I just point that out to you.
17 BY MR. COPPOLINO:
18 Q. Doctor --
19 THE COURT: And I leave it to you to pursue or not.
20 BY MR. COPPOLINO:
21 Q. Doctor, item two of the ACOG definition refers to
22 instrumental conversion of the fetus to a footling breech.
23 This is back in your declaration, paragraph 24, item two of
24 the ACOG definition. Instrumental conversion?
25 A. I'm sorry, declaration. I'm sorry. Paragraph 22, I

1 mean page 22?
2 Q. Page eight, paragraph 24. You list the four-step ACOG
3 definition of an intact D & X?
4 A. Okay.
5 Q. And item two is instrumental conversion of the fetus to
6 a footling breech. Do you see that item?
7 A. I do. I mean I will. I know it's there.
8 Q. All right. Do you see?
9 A. Yes. I see those four definitions or four steps.
10 Q. Is it correct to say that you see no reason to do the
11 internal podalic version in your intact extractions; is that
12 correct?
13 A. I think what I said is that I would never do it,
14 intentionally do it. If I can't say that it would never be
15 the thing to do, because I don't know that I might not be
16 there some day. If that's the way it's going to come out
17 the best, then that's the way I want to do it.
18 Q. Now, you describe the step in the ACOG definition of
19 including the instrument conversion of the fetus to a
20 footling breech as the second flaw in ACOG's definition. Is
21 it a flaw in ACOG's definition?
22 A. I honestly don't believe that I ever mentioned the fact
23 that it was flawed. I think I might have said many times
24 that it wasn't what I do or that I don't see a need to do
25 this, or to me, it works better another way. But I don't

1 think I'm in any position to comment on what ACOG thinks is
2 appropriate. I don't use this procedure as the law, the way
3 I practice medicine. I know it's out there. I think it
4 gives everyone to say that, you know, and I think possibly
5 what ACOG was trying to do with this definition is to show
6 that most of us don't do that. And it probably doesn't
7 exist. Granted, Dr. Haskell does the procedure the way they
8 explained it, and I think ACOG defined it this way to give
9 us a playing field so that we know what Dr. Haskell is
10 describing and then we know what we do. I don't think they
11 are saying it's bad or it's good either way. This is what
12 Dr. Haskell said. I think that's what ACOG was trying to
13 accomplish and I think they did it well.
14 Q. You don't believe in the instrumental conversion of the
15 fetus to a footling breech?
16 A. I do not normally do that.
17 Q. You don't believe in that practice?
18 A. I did not say that.
19 Q. Page 169 of your deposition, Doctor, line five, is this
20 part of your answer?
21 A. 169, line five. Okay, I have that.
22 Q. Again, we are talking about this is your testimony on
23 the ACOG definition, and at line five on page 169, you state
24 I do not believe in the instrumental conversion of the fetus
25 to a footling breech. Was that your testimony at your

1 deposition, Doctor?
2 A. Obviously.
3 Q. And was that a true and correct statement?
4 A. No, it is not. What my intent with that statement is to
5 again say is that I do not believe that converting it to a
6 footling breech is necessary, in my practice as an absolute
7 rule. It may certainly be possible in my practice, but I
8 don't enter into a procedure to do that.
9 Q. You once worked with Dr. Haskell, didn't you?
10 A. I certainly did.
11 Q. You had a bit of a falling out with him over this very
12 issue of the internal podalic version. Is that correct?
13 A. Again, I did. And the reason being that he said that I
14 had to do it on every patient.
15 Q. Right. You decided to stop working with him because you
16 had a disagreement over whether you should be required to
17 use the internal podalic version; is that correct?
18 A. That is absolutely correct.
19 Q. And you felt that your theories and his theories were
20 too vastly different for you to work there comfortably for
21 him; is that correct?
22 A. I told him that I thought that I didn't want to do
23 patients of the gestation where he would expect me to do
24 that, but -- and eventually, though, it may well prove
25 beneficial in the rare patient. It certainly was not

1 something I wanted to force to happen. And I do think much
2 as if I told you that you had to walk to the roof to take
3 the elevator down, yes, you're going to get to the bottom of
4 the roof or I mean from the roof, but why would you want to
5 do it? If it's not necessary, why would I do it. Now, if
6 the door was broken on this floor, I may choose to do that.
7 Q. Doctor, you testified at your deposition that my
8 theories, your theories and his theories were two vastly
9 different for me to work there comfortably?
10 A. I think I just said that.
11 Q. That's a true statement then?
12 A. Yes.
13 Q. I believe you -- is it also your view, Doctor, the big
14 difference you had with him, you always had to do the
15 internal podalic version, and you simply don't believe that,
16 is that correct?
17 A. I don't think it's a requirement to do a safe abortion.
18 Q. And is it correct that he told you that's the way he
19 wanted you to do it, and you said you were not going to do
20 it and you stopped working for him; is that correct?
21 A. That would accurately describe the situation, yes.
22 Q. I believe you may have testified this morning?
23 A. I'm sorry. If I may, that happened over a period of
24 time. What the agreement was that I stop doing terminations
25 after the 22nd week, and he was -- and I just said, I'm not

1 going to do this. And as soon as you can work out the
2 schedule, I'll quit. But I didn't walk out the door that
3 day and leave him.
4 Q. I believe you may have testified this morning and I'm
5 fairly certain you told this Court in 1998, that you take
6 the fetus as it's presenting; is that correct?
7 A. Yes.
8 Q. If the fetus is presenting in the breech position, you
9 proceed in that manner; is that correct?
10 A. I certainly try to, yes.
11 Q. You do not perform the internal podalic version with an
12 instrument; is that correct?
13 A. Normally, I would not do that.
14 Q. You have never seen a case where you thought the
15 internal podalic version was a positive option?
16 A. I have never been in a position that I had to do that.
17 Q. Have you ever seen a case where you thought the internal
18 podalic version was presented as a positive option?
19 A. For me, I have not seen that happen, yes.
20 Q. It's also correct to say, isn't it, Doctor, you believe
21 doing the internal podalic version goes against your way of
22 thinking and teaching?
23 A. I certainly think that it's unnecessary to force it. I
24 don't necessarily believe that at sometime -- if I go in and
25 I have a transverse lie with a patient, I end up grasping

1 the foot and bring it down, that's what I have done. I have
2 done that, it happens. Is it wrong, no. Is it necessary?
3 Probably not all the time. Is it necessary some of the
4 time, yes.
5 Q. I understand. I'm not trying to be too stickler with
6 words, Dr. Carhart?
7 A. I'm trying to make sure that what I'm doing is what
8 you're understanding. That's all.
9 Q. You told me at your deposition that the internal podalic
10 version was against your way of thinking and teaching?
11 A. The required podalic version is against my
12 understanding, and I thought that's where we were at the
13 deposition. I may have been wrong. If that's not where we
14 were, then I apologize to the Court. My feeling is that one
15 should not be forced to do something in medicine that may
16 not be required, because everything one does in medicine has
17 both benefits and risks. And if there are no benefits, then
18 no matter how small the risk, it's not justified.
19 Q. Well, let's just take a look at the whole quote and so
20 that's clear on the record.
21 A. I mean, I'm not arguing what I said here I said here.
22 If my understanding was improper, I apologize, but that is
23 not my belief. And I can't today say it is my belief when
24 you have made it more clear than it was clear at the time of
25 the deposition.

1 Q. And it's also your view, Doctor, that you wouldn't do
2 something like the internal podalic version just because
3 somebody thought it was part of the routine; is that a
4 correct statement?
5 A. I think that would be fair statement. Yes, sir.
6 Q. It's also correct, Doctor, that you believe that the
7 safety concerns of the internal podalic version have been
8 fairly documented. Is that a fair statement?
9 A. No, I think it has been fairly documented in full term.
10 I don't know that anyone has ever attempted to document it
11 in abortion.
12 Q. All right. In fairness, my question to you at your
13 deposition is, do you have any concerns as to the safety of
14 the procedure? And your testimony was I think that's fairly
15 documented.
16 A. It's fairly well documented but only in full term
17 deliveries.
18 Q. With respect to an abortion procedure, you don't believe
19 it's a good idea to do it, if you don't have to. Is that
20 correct?
21 A. That would be a fair statement.
22 Q. And is it your feeling, Doctor, that the internal
23 podalic version may lead to perforation because you might
24 grab the side of the uterine wall instead of the fetal foot?
25 A. Yes, I'm sure anything I do -- actually anything you do

1 in an abortion may lead to uterine perforation.
2 Q. You specifically believe that the internal podalic
3 version may lead to perforation because you might grab the
4 side of the uterine wall instead of the fetus with forceps?
5 A. No more than grabbing any part of the fetus, yes, I
6 believe that.
7 Q. But you believe it specifically with respect to the
8 internal podalic version; is that correct?
9 A. Not to the extent that it's any different than anything
10 else. I think it can happen with that. I believe that was
11 your question. Yes. It can happen and if it's not -- we
12 are back to the original concept. If it's not providing a
13 benefit, then no risk is acceptable.
14 Q. And just to close the point on this, Doctor, you share
15 the concern that you might inadvertently grab the uterine
16 wall and perforate it in the process of trying to do an
17 internal podalic version with an instrument. You certainly
18 agree that's a concern, correct?
19 A. I'm always concerned about doing damage to the uterus
20 while doing an abortion, yes.
21 Q. You believe one of the ways you can do damage to the
22 uterus is by using an instrument to convert a fetus to an
23 internal podalic position?
24 A. That's a possibility that could happen, yes.
25 Q. You're concerned about that?

1 A. I think one should always be concerned to provide the
2 best. I'm not going to narrow it any better than that. I
3 think I said what I believe and it doesn't matter to me how
4 you ask that question. I'm not going to change my beliefs.
5 Q. Now, you also disagreed with the procedure described by
6 Dr. Haskell, because you prefer to use real time ultrasound;
7 isn't that correct?
8 A. That is correct.
9 Q. And is it also correct that you disagreed with Dr.
10 Haskell's procedures because you believe there should be
11 fetal euthanasia, as you put it, beforehand; is that
12 correct?
13 A. I have to go back, because Dr. Haskell normally used
14 real time ultrasound. When I was in his clinic, we always
15 had real time ultrasound. So I have to go back and see that
16 statement. Let's just take a look. Is this the declaration
17 or are we back into the deposition?
18 Q. All right. We'll go back to the deposition, page 119.
19 And I was asking you about the procedure Dr. Haskell
20 described in the paper he presented to NAF, and part of your
21 answer was with better availability of sonography, my
22 protocol certainly would be vastly different from this;
23 referring to go Dr. Haskell's procedure.
24 THE COURT: Procedure or paper.
25 MR. COPPOLINO: The procedure described in his

1 paper.

2 THE COURT: Okay.

3 BY MR. COPPOLINO:

4 Q. Maybe just to cut this short, you felt the procedure
5 described in his paper was not adequate, because you prefer
6 to use real time ultrasound?

7 A. Well, first of all, I'm not sure that he excluded real
8 time ultrasound in his paper. I don't believe that he did,
9 and I'm trying to go back and understand why I said that we
10 would have used real time ultrasound before we did anything
11 to the patient and --

12 Q. I'm willing to move on from the point, Doctor.

13 A. Okay. Again, I'm talking about today versus 1991. I
14 think that things are vastly different in abortion practice
15 today than in 1991. I do believe that Dr. Haskell was one
16 of the original providers, along with myself and Dr. Tiller,
17 to use ultrasound with all of our patients, so even
18 though -- I don't know. I guess if you ask me, do you think
19 we should always use ultrasound, the answer is yes. Do I
20 think all providers do that? No. Do I fault them? No.

21 Q. Let's jugs talk a moment about the fetal euthanasia
22 procedure. In every case that you handle over 20 weeks,
23 Doctor, I'm not going to refer to the deposition right now
24 unless we need to.

25 A. Thank you.

1 Q. In every case you handle over 20 weeks, you would use
2 fetal demise; is that correct?
3 A. That was my practice in 1995 and 6 and 7. At the
4 present time, my intent is to induce fetal demise in every
5 patient after the 18th week.
6 Q. I understand. But let me just rephrase my question a
7 bit. If the patient comes to you and seeks an abortion
8 that's -- and the patient is over 20 weeks gestation and
9 does not agree to an injection for fetal demise, you'll not
10 do that abortion; is that correct?
11 A. If that is an elective decision, yes. If it's not an
12 elective decision, if she has a reason why it can't be done,
13 then I would not punish her for that, but I do feel in
14 treating the average patient, if we can do -- I'm not
15 willing to take the risk. If I can accomplish something
16 that I know and that I believe is better, I'm not willing to
17 just go short because there is a mental objection.
18 Q. Well, just to clarify the point, Doctor, I asked you at
19 your deposition if there was any cases you did after 20
20 weeks for which fetal demise was not induced. And you told
21 me zero, none, because you would not do the abortion if they
22 did not have --
23 A. You were asking retrospectively. And, retrospectively,
24 I would tell you, yes, that is true. I have not been this
25 that position. But should somebody come to me today or

1 tomorrow, would I force them to go somewhere else because I
2 could not do an injection? No. I wouldn't do that.
3 Q. Doctor, I believe you testified this morning that the
4 Partial-Birth Abortion Act ban of 2003, would not affect
5 those patients who are eligible and receiving intrauterine
6 fetal demise; is that correct?
7 A. Again, I'm at an attorney, and I surely would review
8 this greatly. But I think the way I read the Act, it talks
9 about living fetuses. And I think that if my fetus is not
10 alive, it does not apply.
11 Q. You said this in paragraph 39 of your declaration, you
12 said my patients that are eligible for and consent to IUFD
13 will be unaffected by the Act. Is that your view?
14 A. Again, I believe that to be the truth, but I have never
15 -- I mean I think that I would be safe. And I have
16 discussed it with other people, and they think that I would
17 probably be safe. But should the Act take affect, I'm going
18 to do a much more detailed evaluation before I decide what
19 I'm going to do.
20 Q. You know in 1998, at the Stenberg case, you told the
21 Court that you did not think intrauterine fetal demise was
22 justified prior to 20 weeks; is that correct?
23 A. That's certainly true.
24 Q. Now, you think it's medically justified after 18 weeks;
25 is that correct?

1 A. That is true.
2 Q. You have seen -- since that time, you have seen the
3 benefits of performing that procedure after 18 weeks; is
4 that correct?
5 A. I think the benefit after 18 weeks was always there,
6 because those that were talented enough to do it. I,
7 certainly at the time in 1997, when I was here, I did not
8 have that experience. And for me, it was not a benefit. I
9 had done some, but because I was doing intraamniotic
10 injections, the fetal demise occurred much later than
11 whether were in my office. And I think that three or four
12 hours or five hours of fetal demise is probably ineffective.
13 I think that 16 or 17 hours is a vastly different subject.
14 Q. And as I think you told Ms. Smith this morning, among
15 the benefits of the intrauterine fetal demise injection is
16 the softening of the tissue, softening of the fetal tissue?
17 A. Yes, I did say that.
18 Q. Another benefit is the reduction in the size of the
19 fetal skull?
20 A. I have seen that to be very common. Yes, sir.
21 Q. Why do you call your procedure euthanasia? What do you
22 mean by that?
23 A. It's a statement that I heard once. I use it
24 interchange -- what I try to call it is intrafetal uterine
25 demise to induce fetal death. Is it fetal euthanasia? I

1 have heard it said that way. Do I think that's really a
2 great expression? Probably not. I use it interchangeably
3 without thinking most of the time, or some of the time. I'm
4 sorry.
5 Q. You have now -- I believe you testified this morning
6 that you have done this procedure thousands of times without
7 any complication; is that correct? The intrauterine fetal
8 demise procedure?
9 A. So far.
10 Q. You have had zero bowel perforations?
11 A. I have had -- I guess to the extent they were
12 recognized, yes.
13 Q. Zero infections?
14 A. Yes, that is correct.
15 Q. I believe it's also your view, that while the dose of
16 the medication you administer is toxic to the fetus, it's
17 not harmful to the mother; is that correct?
18 A. I think it's generally considered in the cardiac circles
19 that one milligram of Digoxin is the proper diluting dose
20 for an adult female.
21 Q. You're able now to inject near 100% of the time to the
22 fetus directly; is that correct?
23 A. That is correct, sir.
24 Q. All right. Turning to another topic, Doctor. In your
25 declaration on page seven, paragraph 19, it says my goal in

1 dilating the cervix is to achieve enough dilation to allow
2 the issues of the fetus and the placenta to safely pass
3 through but no more than necessary to reduce the risk of
4 later maternal complications such as incompetent cervix. Do
5 you see that statement, Doctor?
6 A. Yes, I do.
7 Q. Do you have a concern that the dilation process for
8 second trimester surgical abortions should risk future
9 cervical incompetence?
10 A. I think if one were to rapidly dilate the cervix to a
11 large opening, then one would increase that risk.
12 Q. Is it your opinion that the risk of cervical
13 incompetence arises from the speed of dilation, not the
14 amount?
15 A. I think that that's a much -- that speed is a much more
16 important factor in the causing problems than degree.
17 Q. Okay. Degree may also be a factor, but you think speed
18 is the most important factor in risking cervical
19 incompetence?
20 A. My belief is based upon a woman that normally achieves
21 ten centimeters of dilation or greater for delivery, without
22 causing an incidence of incompetent cervix. Again, that is
23 a slow dilation. In women that have had rapid expulsions
24 deliveries where they have had severe lacerations, that
25 tends to be a cause of cervical incompetence. So do I know

1 of any studies that actually say that this is true? No, I
2 don't. I know both those facts are true. And if I can
3 avoid a speed bump, I'll trying to go around it.
4 Q. Do you know if a generous dilation of the cervix
5 achieved, in part through the use of medical mechanical
6 dilators, is just as safe as dilation with osmotic dilators?
7 A. Can you restate that, please.
8 Q. Sure. Do you know if generous dilation achieved, in
9 part through the use of metal mechanical dilators, is just
10 as safe as dilation achieved with exclusively osmotic
11 dilators?
12 A. I'm not sure that I know that anyway, that it has been
13 published somewhere. That has been my experience.
14 Q. Okay. So do you know if the risks associated with
15 dilation are the same for osmotic dilators and mechanical
16 dilators?
17 A. It has been in my practice.
18 Q. In your own practice, Doctor, if you feel you have not
19 achieved enough dilation with osmotic dilators, I believe
20 you testified this morning that you would then use a
21 mechanical dilator that will fit and then dilate
22 mechanically; is that correct?
23 A. That would be my normal option, but I have also inserted
24 dilators, again, and sent them home for another day.
25 Q. Doctor, this morning, in your testimony, you were

1 referring to, I believe, a 65 French dilator; is that
2 correct?
3 A. Yes, sir. I believe I said centimeter, and I was
4 corrected, yes.
5 Q. Sir?
6 A. I think I said centimeter, and I was corrected.
7 Q. Now, in your deposition testimony where you were talking
8 about this issue, you referred to the use of a 79 French
9 dilator. When would you use a 79 French dilator?
10 A. I think in our deposition, if I remember our discussion
11 at the time, you asked me how I could be exactly sure that
12 you said that 79 was a very exact number, how was I sure of
13 that. And I reapplied that it's the largest dilator that I
14 have in my armamentarium, if you want to look at it that
15 way. It certainly, would I like to be there with every
16 patient after 16 weeks? Absolutely. But now how are you --
17 what are you asking me?
18 Q. Between 22 and 24 weeks.
19 A. Um-hm.
20 Q. When you're doing dilation, do you use the 79 French
21 dilator to measure the adequacy of dilation?
22 A. I rarely use it. If I'm concerned after doing the
23 pelvic exam that I may not have enough dilation, yes, sir, I
24 do use it. But I don't -- any more than we are doing
25 podalic version. I don't do it as an absolute mandatory

1 thing.

2 Q. Right. Let me just ask you, Doctor, just for the

3 purposes its measuring dilation between the 22nd and 24th

4 week, do you attempt to insert the 79 French dilator to

5 determine if you have got adequate dilation?

6 A. I think I said somewhere that probably less than 10% of

7 my patients, I use mechanical dilators at all for second

8 trimester patients. Can I use it? You asked, again, I

9 don't think -- I would have to see the part of the

10 transcript, but my recollection is that I examine them to

11 see that they are beyond 79 millimeters. If I can get three

12 or four fingers in the cervix, if I have four centimeters of

13 dilation, if I'm at 120 millimeters, I'm sorry. 120 French,

14 I do not have to use dilators to confirm that. If I'm

15 worried -- if I think I may have to add another day to the

16 patient's care, then I certainly may use a dilator to

17 determine whether or not she's there. My experience has

18 been if they are dilated better than 79, they'll probably go

19 on to completion without a problem. It has been that if

20 it's less than 79, that's not true. But I do not use that

21 dilator every time to confirm exactly where I am.

22 Q. How often do you have to add a mechanical dilator to

23 increase dilation in your cases between 14 and 20 weeks?

24 A. Between 14 and 20, maybe one or two times a year.

25 Q. How often do you have to add a mechanical dilator to

1 increase dilation between 20 and 24 weeks?
2 A. I know it has happened, but, again, it's extremely rare.
3 Probably one to two times in the past that I can remember.
4 Q. Doctor, am I correct that all of your post-16-week cases
5 involve two days of dilation with osmotic dilators?
6 A. That would be my goal. That's correct.
7 Q. And what is the range of the number of osmotic dilators
8 that you insert on the first day? I understand the number
9 may vary?
10 A. Absolutely. I have been as few as one, I have been as
11 many as 12 and 13. It depends. Again, I mean if I see a
12 patient that delivered a child 16 or 17 weeks ago and is now
13 back with a 14 or 15-week pregnancy, I probably wouldn't do
14 anything, but not use dilators and just do it. There are
15 exceptions. I think what I'm trying to say with my whole
16 testimony is that everything that one does in surgery does
17 not apply to any one patient. There is a general goal, a
18 general practice, that one has to be able to decide what
19 they are going to do.
20 Q. I'm just trying to understand the range of the number?
21 A. It can be one, it could be zero, okay.
22 Q. Let me just state the question, so it's clear that your
23 answering the question I'm asking?
24 A. Okay. Go ahead.
25 Q. On the first day?

1 A. On day one.
2 Q. Okay. This is termination after 16 weeks. What's the
3 range of the number of osmotic dilators you would insert?
4 From zero to what?
5 A. 12, 13, 14.
6 Q. And the higher range would be the range in which you
7 feel that you're going to need more osmotic dilators to
8 dilate the cervix?
9 A. On the first day, as long as I can get past 45 French,
10 which I can accomplish with three number eight dilators, and
11 three number three dilators, laminaria; after that, I only
12 put enough laminaria in to keep them from falling out and
13 not accomplishing anything. It may take one or two. It may
14 not take anymore. I may have a patient that I don't need to
15 do anything to get 45, in which case, I'll treat her and
16 we'll move up a day.
17 Q. Why do some get 10 to 12 osmotic dilators on the first
18 day?
19 A. Because I think I just said that if you have a woman
20 that's had a child, say, 20 weeks ago, and maybe she's had
21 three children before that. If this is her fourth delivery
22 and her fifth pregnancy, if I don't put enough in to keep
23 the dilators in, they are going to fall out. I'm not going
24 to accomplish anything. So I have to put enough in that
25 they feel tight. And, you know, I have goals in mind but I

1 don't know what that's going to be. I try to keep it as
2 minimal as possible, but if they are not contained within
3 the cervix so that they won't fall out, they will fall out.
4 Q. Does the range of the number of osmotic dilators you put
5 in on the first day differ as between 16 to 20 weeks and 20
6 to 24 weeks?
7 A. Probably not.
8 Q. All right. So then what is the range of osmotic
9 dilators you would put in the cervix on the second day?
10 A. My goal, again it depends. That depends more on
11 gestation. Again, I'm going to start with where I am, and
12 if I can't get in at least five number nine dilators, which
13 is usually what I can get with a 79 French, I will use -- I
14 may use mechanical dilators to open the cervix to that
15 degree. And then I'll place whatever dilators I can get in.
16 I don't -- when I say that this is a three-day procedure,
17 that's normal. As I said, I will do it maybe
18 three-and-a-half days, I may send her back home tell her to
19 come back at 4:00 o'clock at night. I may send her back
20 home and tell her to come back at 9:00 o'clock at night, or
21 come back tomorrow. I have to do what that patient
22 requires.
23 Q. I would just like you to give the Court a general range
24 of low number on the second day to high number on the second
25 day of osmotic dilators?

1 A. I would be unhappy with less than 14, and I have gone as
2 high as in the mid to high 20s.
3 Q. Can you give us an estimate of the amount of dilation
4 that you feel you need between 20 and 24 weeks to extract
5 the fetus intact, at least to the after coming head getting
6 lodged in the internal cervical os?
7 A. Say that again.
8 Q. Sure. Can you give us an estimate of the amount of
9 dilation you need between 20 and 24 weeks to extract the
10 fetus intact to at least the after coming head getting stuck
11 in the cervical os?
12 A. The gestation you're talking about?
13 Q. Did I not say 20 to 24 weeks?
14 A. My normal desires at 20 to 24 weeks is not to have to
15 extract that fetus. My normal desire is that that fetus
16 will expel on its own. So to that extent, I can't -- the
17 answer is no, there is not. I mean, if I know for a fact
18 that if I have over four centimeters, that inducing the
19 contractions using Oxytocin and using Misoprostol, that most
20 of if time, they will expel the fetus within four hours, but
21 that's not the final dilation. The final dilation is done
22 by the fetal structures.
23 Q. Can you give us an estimation of the amount of dilation
24 you seek in a 20 to 24 week period in a procedure in which
25 you're intending to have the fetus deliver intact?

1 A. It's normal on the third day for the woman to return
2 between three and four centimeters dilated.
3 THE COURT: Mr. Coppolino, it may or may not -- it
4 is not obvious to me, in Dr. Carhart's procedures, whether
5 when you were counting the number of laminaria for each day;
6 whether the laminaria are removed after the first day and
7 other laminaria are used, or whether that's -- I'll leave
8 that up to you.
9 MR. COPPOLINO: I'll clarify that point, Your
10 Honor. It's a very good question.
11 BY MR. COPPOLINO:
12 Q. As the judge has just alluded to you, Dr. Carhart, is it
13 the case when you do a two-day dilation procedure, you
14 typically remove the dilators and insert -- dilators that
15 you inserted on the first day, and insert a fresh set on the
16 second day? Is that how the procedure works?
17 A. In my office, that is typical. I do know in the hands
18 of other providers that they just add to, and that has been
19 well described, and I can't fault that. I have this
20 underlying belief that if you take out all sources of
21 infection and start again, that you may be reducing the
22 bacteria, but there is no experience based on that to
23 justify that belief.
24 Q. Do you know what some of the circumstances are that
25 would lead a physician to simply add dilators rather than

1 taking them out?
2 A. I'm not sure of the circumstances.
3 Q. Let me finish the question. Rather than taking them out
4 and putting in a fresh set?
5 A. As I started to say, I'm not sure there are any
6 circumstances. I think it's just personal choice.
7 Q. When a patient comes in for an abortion in your
8 facility, Doctor, does she undergo a sonogram?
9 A. Yes, sir.
10 Q. Okay. And is that sonogram take the measure of
11 something called the biparietal diameter?
12 A. That's one of the measurements we try to take.
13 Q. That's the measurement of the fetal head across the
14 skull from ear to ear; is that correct?
15 A. Approximately.
16 Q. In your deposition, do you recall testifying that your
17 quote, whole game plan, is based on the biparietal diameter?
18 A. It is.
19 Q. That's the best indicator of the gestational age; is
20 that correct?
21 A. That's the indicator I use. There are others, and other
22 people may think theirs are better and I wouldn't argue with
23 that, but for me, that gives me the most information about
24 what I need to do.
25 Q. I believe you testified this morning --

1 A. Actually, the biparietal diameter, no. But as far as
2 the whole -- everything over 16 weeks, we do three
3 measurements. The biparietal diameter. If you ask me is
4 the size of the fetal head a determining factor of what I'm
5 going to do, yes, it is. But I mean biparietal, there are
6 skulls that are very narrow and very long. Especially after
7 three days of fetal demise, the skull may be a perfectly
8 round ball. It may be egg-shaped. You can see the plates
9 over ridden in, the plates that make up the skull on the
10 ultrasound of the third day, you can see they are over
11 ridden. And what the final shape is, I'm going not to know.
12 It used to be acceptable that the biparietal diameter was a
13 good exception. I think the overall head circumference and
14 the overall volume, which the sonogram will compute, is what
15 the determining factor is, is what I'm going to do.
16 Q. Other than for determining the gestational age, is there
17 any other reason to that it's important for you to know the
18 biparietal diameter before you proceed?
19 A. I think, first of all, I think the biparietal diameter
20 is probably not a good determination of fetal gestation.
21 It's one of the measurements that one should consider, but
22 it's definitely a consideration that I need to know what
23 dilation I need to remove that fetal skull.
24 Q. I believe you testified this morning that you attempt to
25 dilate to two-thirds of the biparietal diameter; is that

1 correct?
2 A. That's generally, that's where I try to get, yes, sir.
3 Q. And I believe you testified a moment ago that regardless
4 of the amount you have dilated, the cervix is further
5 expanded in the process of extracting the fetus?
6 A. It normally is, yes.
7 Q. Doctor, it's your view, your method of dilating in
8 second trimester abortions poses -- with Misoprostol, using
9 Misoprostol, poses no long term threat to women; is that
10 correct?
11 A. It has been my experience in my practice, and my
12 evaluation of others that use this medication, that there is
13 very little, if any, effect by using slow dilation.
14 Q. You told me in your deposition that the overall follow
15 up between abortion providers and their patients is about
16 33%; is that correct?
17 A. I believe that's the NAF reported statistics from the
18 National Abortion Federation.
19 Q. Yours is a little better than that. I think you
20 testified that yours is about 35%?
21 A. We see a much greater -- we see a biased population in
22 abortion, in our practice, because of referrals and our
23 patients are generally more concerned about their health in
24 the second trimester. So we see a much greater extent of
25 our second trimester patients back than the average. And I

1 think that skews our average. And our first trimester
2 patients, we are probably right where everybody else is.
3 Q. Your overall average about 35% for follow up for your
4 patients?
5 A. I believe that was the last numbers that we submitted.
6 Q. Is it fair to say you don't hear again from 65% of your
7 patients, your abortion patients?
8 A. Well, let me go back. Are you saying follow up in my
9 clinic or follow up in general?
10 Q. Follow up by you of your patients that you perform the
11 termination on?
12 A. The last time we did statistical analysis, my average
13 patient travels four hours in each direction to obtain an
14 abortion. It's my policy to tell them that we will see them
15 back at no a additional charge, if that's possible, and if
16 it's not possible, we strongly recommend they see their own
17 physician, and that he contact us if he has any concerns.
18 Q. I think we -- it's correct, Doctor, that you get
19 patients from different parts of the country, as you just
20 suggested. Is that right?
21 A. That is correct.
22 Q. And you have patients not only from Nebraska but
23 patients from Iowa?
24 A. I think in my deposition, I said that we have had
25 patients from every state, and I don't -- again, I mentioned

1 in my deposition that since my clinic is less than a half a
2 mile from the border of Offutt Air Force Base, that everyone
3 of my patients may have resided on Offutt Air Force Base,
4 but I don't know that.
5 Q. Well, you know that patients travel to your clinic from
6 -- let me just give you a couple of states. I'm not going
7 to run through all 50 of them, but do patients travel to
8 your clinic from Iowa?
9 A. I'm sure they do.
10 Q. Colorado?
11 A. I'm sure, yes.
12 Q. North and South Dakota?
13 A. All the time.
14 Q. Canada?
15 A. Yes, sir.
16 Q. Idaho. You mentioned Idaho?
17 A. I think I did, yes. Yes, we had one from Idaho, I can
18 remember and Montana.
19 Q. I was -- you anticipated me, Doctor. In fact, you
20 advertise in the yellow pages in phone books outside the
21 state of Nebraska; is that correct?
22 A. Outside the state of Nebraska, most certainly.
23 Q. But you don't follow up with patients that come from
24 states outside of the state of Nebraska, do you?
25 A. Well, Iowa, certainly many of those patients come to me

1 depending on -- St. Joe -- we have patients drive down from
2 Sioux Falls routinely. We have patients, we have some
3 patients, if they live -- especially in Nebraska, and I mean
4 in rural communities outside of Nebraska, if they are
5 uncomfortable with their own local doctor knowing they had a
6 procedure, they'll travel that distance to be checked.
7 Q. What's your rate of follow up with patients who had a
8 second trimester abortion who are at a distance of more than
9 four hours from your clinic?
10 A. I have never computed that.
11 Q. It's also fair to say, Doctor, you have never published
12 a study on the long term complications of abortions, is that
13 correct?
14 A. Based on my data, I couldn't, because I have had none.
15 Q. Based on any data, have you prepared any study on the
16 long term complications of abortion?
17 A. Have I prepared a study? No.
18 Q. Has anyone, to your knowledge, studied your particular
19 method of second trimester abortion that uses Misoprostol to
20 achieve greater dilation in the manner in which you use it?
21 A. The problem -- could we design a study to do that? And
22 we have talked about that? Sure we could. Could we get
23 people to volunteer to have it done, when I have to tell
24 them there are other, that the control group -- that there
25 is something else that's much more dangerous, if we can

1 offer that to you, do you want to be part of this research
2 group? I doubt we would have any takers. So I don't think
3 -- even though we could design that, I doubt that that is a
4 study that any caring practitioner would ever want to
5 participate in, because I'm not going to say we can offer
6 you this procedure that's virtually 100% effective or this
7 one that's 98% effective. Which are you going to choose?
8 Q. So the answer to my question is?
9 A. My answer is I don't believe that study could be done
10 effectively.
11 Q. Doctor, you have not published an article in a medical
12 journal or other peer article reviewing some of your own
13 abortion cases; is that correct?
14 A. That is correct.
15 Q. Have you ever presented a paper on your own second
16 trimester abortion cases which discusses your method of
17 dilation that say a NAF conference or another conference
18 like Dr. Haskell did?
19 A. Well, first of all, I think after Dr. Haskell, nobody is
20 going to go there, because of the way it was taken out of
21 context. But at provider conferences? In NAF, there are
22 probably 50 providers of second trims abortions. I'm sorry
23 later second trimester abortions. We generally have what's
24 called a round table discussion during every meeting at
25 which all of us go around and tell each other what we're

1 doing. That's probably 50% of our peer group, and it's not
2 necessarily the same group each time. So within two years,
3 I would think we talk to pretty much all of us and we know
4 what each other is doing. I'm be honest. The journals and
5 nobody, you know, the journals are not interested in
6 publishing articles that are going to polarize people one
7 way or the other, and I don't think you want to get that
8 information published.
9 Q. Have you sought to publish an article that provides your
10 meth old of dilation in second trimester abortions?
11 A. No, sir.
12 Q. I understand that you discuss these issues at NAF
13 conferences, but have you ever put a paper together
14 describing your second trimester method of dilation?
15 A. Myself and another provider have worked out a protocol
16 that we use in his practice. But other than that, no.
17 MR. COPPOLINO: Your Honor, I think this is a good
18 breaking point for me, if it is for you.
19 THE COURT: That would be fine. Is that agreeable
20 with you, Counsel?
21 MS. SMITH: Yes, Your Honor.
22 THE COURT: We'll stand in recess at this time
23 until 1:30. We are now in recess. Doctor, you may step
24 down.
25 (Recess from 11:56 to 1:35 p.m.; all parties present)

1 THE COURT: Doctor, will you retake the witness
2 stand, please?
3 (Dr. Carhart resumed the witness stand)
4 THE COURT: You may inquire.
5 BY MR. COPPOLINO:
6 Q. Thank you, Your Honor. Dr. Carhart, did I understand
7 your testimony this morning correctly that you always intend
8 to remove the fetus intact or as intact as possible in a
9 second trimester abortion?
10 A. Yes, sir, I think I said that. I know I said that.
11 Q. And that is your present intention, and you expect will
12 be your intention in the abortion practice throughout into
13 the future; is that correct?
14 A. I have changed my practice so many times from what I
15 have learned, so do I want to commit to that? No. But at
16 the present state, if nothing else would change, that would
17 be my decision.
18 Q. And I think you also testified this morning that there
19 is -- you don't always succeed in removing the fetus
20 completely intact; is that correct?
21 A. That is correct.
22 Q. And I believe you testified that sometimes the fetus is
23 in the breech extraction, the fetus's head gets stuck in the
24 internal os, and then you take some steps to reduce the size
25 of the skull; is that correct?

1 A. Yes, sir, that is correct.
2 Q. And am I correct, Doctor, that you on occasion will, in
3 that scenario where you're seeking to remove the fetus
4 intact in the breech position and the head gets stuck in the
5 cervical os, you'll either seek to drain the contents of the
6 skull in some manner or compress the skull in some manner in
7 order to reduce its size so the delivery can be completed;
8 is that correct?
9 A. Most of these -- Could you give me an idea of what
10 gestations you're talking about, sir?
11 Q. Well, does your method for reducing the size of the
12 skull vary by gestational age?
13 A. I believe it does.
14 Q. All right. What -- Let me just lay out two approaches
15 that I had understood you testified to. Is it true that in
16 some circumstances that when the fetus, the head of the
17 fetus gets stuck in the os in the breech extraction process,
18 there is some occasions where you will open the back of the
19 skull and seek to allow the contents of the brain to drain?
20 Are there some circumstances where you will do that?
21 A. My problem with that is, you're using the word
22 extraction, and many times I do not do the extraction, but
23 the mother would have expelled the fetus to the point of the
24 skull. Should that happen and it appeared to be inevitably
25 hung up at that position, then, yes, sir, I would open the

1 back of the skull and drain it. However, I don't always do
2 it the way the article states.
3 Q. All right. And just to be clear, my line of questioning
4 for the moment goes to the method for reducing the skull,
5 and so if the fetus expels to the -- to the -- and gets
6 stuck in the cervical os without any intervention, or if you
7 bring it down yourself with your instrumentation or with
8 your hands and then the head gets stuck, I want to just
9 establish the different procedures you might use at that
10 point to reduce the size of the skull. One of those
11 procedures, Doctor, would be that you could open the skull
12 and let the contents of the cranial -- the cranial contents
13 drain; is that correct?
14 A. Yes, sir, that's correct.
15 Q. And another procedure you might use in that circumstance
16 where the fetal head has gotten stuck in the cervical os is
17 to compress it in some manner; is that correct, Doctor?
18 A. Yes, sir, that is correct.
19 Q. Now, Doctor, is it sometimes the case when you're
20 performing a second trimester abortion that you proceed by
21 dismembering the fetus into several parts; is that correct?
22 A. There are occasions when that becomes necessary.
23 Q. And is it the case, Doctor, that up through the 19th
24 week of gestation, a very small percentage of the fetuses
25 actually come out completely intact?

1 A. No, sir, I don't believe that's true.
2 Q. Could you take a look at paragraph 27 of your
3 declaration? This is on page 10. Paragraph 27 on page 10
4 of your declaration you submitted in this case states:
5 "Although my intention is always to remove the fetus intact,
6 I'm not usually able to do so. In fact, up through the 19th
7 week a very small percentage will actually come out
8 completely intact."
9 That's a statement in your declaration?
10 A. That is a statement in my deposition.
11 Q. Declaration, Doctor?
12 A. Yes, I'm sorry. Thank you.
13 Q. Doctor, is it the case that prior to 19 weeks, you would
14 characterize fetal tissues as week and unlikely to stay
15 together during the process of extraction?
16 A. I would say that through the 17th week, and I think my
17 statement from between the 17th and 19th weeks, at other
18 places, that I may be delivering 75% of them intact, and
19 without reading this back, I think the combined -- if you
20 take everybody between 17 and 19, yes, there is probably a
21 small percentage, but it's much, much smaller for the 16 and
22 17 group, and it's significantly larger for the 18 and 19
23 group. I think it depends on how you put those numbers
24 together, but yes, if I said -- when we say up through the
25 19th week, I'm looking at everybody from 14 to 19. It is a

1 small percentage.
2 Q. And is it the case, Doctor, that a small percentage will
3 actually come out intact because the fetal tissue is very
4 week and unlikely to stay together during the actual
5 procedure of removing the fetus?
6 A. I'm not sure I'm happy with your words. I think it is
7 true that in patients under 17 weeks, that due to the lack
8 of integrity of the fetal tissue, that it will break up upon
9 removal most of the time. After 18 weeks, number one, I'm
10 not attempting removal in all my patients. Most of them I'm
11 trying to have labor. On those that I have to use
12 extraction, some of the -- most of those will come out in
13 pieces, but the ones that come out actually being delivered
14 are intact, and that is, in my 18 and 19 group, a fairly
15 large number.
16 Q. Doctor, at your deposition I asked you about this
17 question, and I would like to just call your attention to
18 the -- your response. This is on page 70 of your deposition
19 transcript, and on page 70, I called your attention to the
20 paragraph we just discussed, paragraph 27 of your
21 declaration in which you said that up through the 19th week
22 a very small percentage come out intact, and then at the
23 bottom of the page starting on line 23, I asked you, why is
24 it the case that only a very small percentage will actually
25 come out completely intact, and your answer beginning on 71,

1 line 1, because the tissues are very week and they are
2 unlikely to stay together during the actual procedure of
3 removing them. However, it does occur. Was that your
4 testimony at your deposition, Doctor?
5 A. The question you're presenting right now is not the same
6 question I believe you asked at the deposition. You asked
7 up through the 19th week, and I took that to mean every D &
8 E abortion I do including 12s, 13s, 14s, 15s, 16s and 17s,
9 and 18s and 19s. If you want that entire range, then yes, a
10 very small portion comes out intact. If, however, you want
11 to talk about the 18 and 19 weeks, then I think we are in a
12 number I could not characterize as a small percentage.
13 Q. Okay. Let's talk about the 18th and 19th weeks. What
14 happens starting at the 18th and 19th weeks which increases
15 the percentage of the fetuses coming out intact? Let me
16 rephrase the question. Is there something about the fetal
17 tissue starting about the 18th or 19th week that increases
18 the percentages of fetuses coming out intact?
19 A. Well, I think the integrity of the fetus is a continuum
20 that goes on from day one to day 40, or week 40, but I think
21 no. I think the more, the more explicit cause of what is
22 happening is because with the overnight dilation, I have
23 much less resistance against the removal or against the
24 expulsion from the patient.
25 Q. Do you agree with the statement, Doctor, that

1 dismemberment at 20 weeks and beyond is difficult due to the
2 toughness of the tissue at that stage of the development?
3 A. I think it's fair to say that, yes, sir.
4 Q. And would you agree that it's fair to say that because
5 of the progress and the ossification and calcification of
6 the fetal bones as gestation increases, it becomes more
7 difficult to dismember the fetus after 19 weeks?
8 A. You know, going back to what you asked now and what you
9 asked before, I think you're more correct in saying more
10 difficult. I don't think that up through 24 weeks anybody
11 would say that it's truly a difficult procedure. It's more
12 difficult as the gestation increases.
13 Q. Doctor, in 1998 when you testified before this court,
14 you were asked how many intact D & Es you performed between
15 14 and 20 weeks, and I believe you answered at that time
16 that intact D & Es were about 5 to 10% of your cases and
17 most of those were between 19 and 20 weeks. Do you have any
18 -- Do you recall that that's generally the testimony you
19 gave to Judge Kopf at that time?
20 A. I don't recall it, but I think that would be a very true
21 statement.
22 Q. All right. Now, as of today, let's just say between 18
23 and 24 weeks, how many total number of D & Es that you
24 perform are intact?
25 A. I think I have said that. I'm thinking that we said

1 approximately 75% come out intact. I'm almost positive
2 that's my previous statement.
3 Q. This morning or --
4 A. Well, yes, I guess. Well, no, prior to the last break
5 during the cross-examination, I believe.
6 Q. And that's between 18 and 24 weeks, you say
7 approximately 75% will come out intact?
8 A. Not at all. That's not what I said. You just said 18
9 and 24 where a few moments ago, you said 18 and 20. Please
10 tell me what you're talking about.
11 Q. Let's do 18 and 20.
12 A. Eighteen and 20, probably -- 18 to 19.6, not including
13 20 on, approximately 75% of my patients will expel the
14 pregnancy without having any further surgery other than the
15 D & C at the end.
16 Q. Seventy-five percent?
17 A. Of the 18 and 19 weeks, yes, sir.
18 Q. Now, at your deposition -- All right. Now, does that
19 number include fetuses that have expelled completely,
20 fetuses that have expelled at least to the head or both?
21 A. If they expel to the head and the head came out still
22 attached to the fetus, it would include that group. That
23 doesn't mean that I might not have used forceps at that
24 point to bring it out intact because I would still consider
25 that an intact delivery.

1 Q. I just wanted to understand what was, in your
2 percentage, was complete extraction without any intervention
3 and those you may have intervened to bring the head out,
4 please.
5 A. Please understand I want you to understand it, but I
6 don't want to misquote and say something I don't truly
7 believe.
8 Q. Now, also in your declaration, you describe the process
9 of a D & E when you're disarticulating a fetus, and this is
10 on paragraph 28, page 10. In the middle of that paragraph
11 it says --
12 A. Yes, sir.
13 Q. -- it says, in fact, disarticulation usually occurs
14 because of the traction of my instrument on a fetal
15 structure opposed by the counter-traction of the internal
16 cervical os, the structure separating the uterus from the
17 cervix. Do you see that statement, Doctor?
18 A. Yes, I do.
19 Q. Is that a statement of how disarticulation occurs in a
20 procedure when you're dismembering the fetus?
21 A. I think disarticulation requires a traction and a
22 counter-traction, and I believe that my forcep and hands,
23 the traction and the internal cervical os is providing the
24 counter-traction. I thought that's what I said here, and
25 that's the way I would want to keep it.

1 Q. So would you agree, Doctor, that in the process of
2 disarticulating a fetal part is a process of traction,
3 counter-traction, grasping what you can get ahold of,
4 pulling it down through the cervical os and rotating to
5 dismember the part; is that a fair statement?
6 A. If one is trying to disarticulate, yes.
7 Q. Now, let's talk for a moment about those situations in
8 which you seek to bring the fetus out intact or as intact as
9 possible. There was a point in time in your practice where
10 you did begin, you modified your procedure for second
11 trimester abortions in order to try to do more intact
12 extractions; is that correct?
13 A. Well, I became immersed in the first part of your
14 question. As I said, that I always try to remove the fetus
15 attached, so if you take that part and go on, because you
16 said in those that I do attempt it, and that would be a
17 subset of all my patients that have D & Es.
18 Q. Was there a point of time in your practice when you
19 modified your procedure in order to try to do more intact
20 extractions in the second trimester?
21 A. According to my staff, that happens every week, yeah. I
22 learn something new today, I will use it tomorrow. If I
23 believe it, if it works, I'll keep it until I find something
24 better, so yes, my practice is modified probably 360 degrees
25 from 1996, probably 180 degrees since 2000, and probably 90

1 degrees since last week.
2 Q. In the time in which you have been performing abortions
3 in your career?
4 A. Yes, sir.
5 Q. There came a point, did there not, where you modified
6 your practice in order to try to seek more intact
7 extractions?
8 A. I honestly don't believe there is a point. I think
9 there is an evolution. I think I saw some things go from A
10 to B, but I can't tell you on the 13th of June, X-X-Y, that
11 that is when that happened because of some brilliant stroke
12 of genius. It's just an evolution that happened.
13 Q. Let's take a look at your deposition, page 71.
14 A. Go ahead.
15 Q. Line 10. This is my question. What I'm trying to get
16 at is this: Was there a point in time when you modified
17 your practice and made a decision to try to bring the fetus
18 out intact? Line 14, Answer: Yes. And what was that point
19 in time, Doctor? Answer: It was the early 90s, probably.
20 It was before I presented a paper in '91, so it had to be
21 not much after the early 1990s would be my guess?
22 A. But as we continue that discussion, Mr. Coppolino, I
23 think I clarified it both in the deposition, and I'll try to
24 reclarify it today. I didn't really change very much. I
25 said the same way I perform it today on line 21. My intent

1 is still to dilate the cervix and laminaria. My intent is
2 still to rupture the membranes and remove the fetus. In the
3 early 90s, I was aided because a drug became available that
4 that was previously not available. That certainly helped my
5 desires and goals, but it wasn't any point of change in my
6 practice. My practice changed but it wasn't because I said,
7 oh, my God, here we are. It's because I started to use
8 Cytotec and I started to use it in small quantities, and
9 over the last ten years I have increased those quantities
10 dramatically for different gestations.
11 Q. Was the -- Isn't it the case, Doctor, that the
12 availability of Cytotec and the amount of dilation and
13 cervical preparation that that provided for you gave you an
14 ability to perform more intact extractions?
15 A. I think that's a true statement.
16 Q. Doctor, I believe you testified this morning that one
17 of the effects of the Cytotec is to induce contractions that
18 assist in expelling the fetus; is that true?
19 A. It depends upon the route of the administration. There
20 are multiple routes of administration, and you can both
21 increase the amount of cervical dilation which we try to do
22 with low dose, low absorption Cytotec. And after we have
23 adequate dilation or dilatation, we can give higher doses
24 recctally or vaginally which will cause fairly aggressive
25 uterine contractions, yes, sir.

1 Q. I believe Ms. Smith asked you and you agreed that you
2 would describe your procedure now as partial form of
3 induction. Let me just ask you directly because I don't
4 remember the precise question she said, but would you agree
5 your procedure could be characterized as a partial form of
6 induction?
7 A. I think parts of my procedure may be considered by
8 others to be induction. I certainly don't -- I don't think
9 I'm doing inductions. I think I'm doing a D & E. I'm
10 trying to have the woman deliver the fetus intact, yes, and
11 that's probably as close as the word induction gets, but the
12 induction process that I use, I don't believe any of the
13 OB/GYNs would consider that to be an induction process, so I
14 don't think I can characterize that myself as an induction
15 process. The best, the closest I could come is probably it
16 may be a combination surgical/induction procedure, but I
17 don't think I could go any farther than that.
18 Q. Doctor, all of your abortions in the second trimester
19 involve the administration of Misoprostol to induce
20 contractions; is that correct?
21 A. They have so far. There may a contraindication, but I
22 have not had to face that yet.
23 Q. Do you use Misoprostol differently at different stages
24 of gestation in the second trimester?
25 A. I use it differently at different stages of each

1 individual patient. Those stages don't seem to change
2 between, say, even 14 weeks and 22 weeks. The difference is
3 the number of times that I may repeat it, but I'm still
4 using it at approximate -- as the process changes, I'm using
5 different amounts of the medication but not really any
6 differently.
7 Q. Between 18 to 24 weeks, could you give us an indication
8 of the range of doses that you would use?
9 A. I would say between 18 and 20 weeks, for the 18 and 19
10 week patients, normally, there would be one to two oral
11 doses, the rectal dose, and there may be another oral dose
12 and there may not. After we get into the 21st or into the
13 20th week and above, even though we have had one more day of
14 dilation, they probably would require a few more doses
15 post-rupturing membranes and placing the rectal Misoprostol.
16 However, I have had patients expel the pregnancy within 20
17 minutes. I have had patients when I ruptured membranes
18 expel the pregnancy at 24 weeks, or I'm sorry, over 20
19 weeks, so I don't know for sure that I can answer that the
20 way you're asking it, but that's as close as I think I can
21 get.
22 Q. You testified that in large majority of your cases, I
23 think you said 75% of your cases after 20 weeks, the fetus
24 expels without the need for any instrumentation on your
25 part; is that correct?

1 A. I would hope I said more than 90% of the time after 24
2 weeks.
3 Q. I said after 20, Doctor.
4 A. I'm sorry. Yes, after 20, exactly. I would have to
5 look in the deposition to see how I said that, but my
6 experience has been it's more up in the 90th percentile.
7 Q. Well, let's just take a look, maybe refresh your
8 recollection on that. Maybe 169.
9 A. Yes, sir.
10 Q. Starting on line 9, you testified that after the 20th
11 menstrual week, me physically extracting it happens probably
12 only one in five of my patients or one in four. The rest of
13 them labor the pregnancy out and deliver it with my
14 assistance and then we do a surgical D & C. So it was based
15 on your testimony that one in four or one in five after the
16 20th week labor out that I asked you what was the
17 percentage, about 25% after 20 weeks that require your
18 intervention?
19 A. Where do we see the one in four?
20 Q. It's on line 11, Doctor, probably about one in five of
21 my patients or one in four?
22 A. Okay. I'm sorry. I didn't go down to line 12.
23 Q. I'm just trying to establish --
24 A. If I look back, if I look back at my practice on any
25 given day, yes, sometimes one out of four or one out of five

1 may have to have some assistance, but in the general, my
2 general remembrance of how my procedures go, my goal is much
3 higher than 75 or 80%, and I think it would approach 90 or
4 higher.
5 Q. So for, let's just say, then, your estimate, 90% of your
6 cases after 20 weeks, no intervention on your part to expel
7 the fetus?
8 A. Not to expel the fetus, but I always do a D & C.
9 Q. All right. So then the remaining cases, let's say if we
10 use your 90% estimate, then, after 20 weeks, the remaining
11 10% of terminations that you perform after 20 weeks require
12 some intervention on your part; is that correct, prior to
13 the extraction?
14 A. Yes, sir, they may well.
15 Q. And are those the cases where it is likely that the
16 fetal head is going to get stuck in the cervical os, that
17 10% after 20 weeks?
18 A. That's one of the complications or, in fact, the head
19 could be stuck and it's never going to come through or not
20 come through, so -- or it could be more than both of those.
21 It may be that the fetus is lying transverse in the uterus.
22 Q. Would it be fair to stay then, Doctor, in most of your
23 post 20-week terminations 90% of them, the head does not get
24 stuck in the cervical os?
25 A. I think that's a fair statement, yes, sir.

1 Q. You believe that outcome is preferable; that is, an
2 extraction, an expulsion without the need to intervene with
3 instrumentation in order to remove a head that's struck in
4 the cervical os?
5 A. For me, I think that's the best way for it to happen in
6 my clinic and my practice. Yes, I believe that's true.
7 Could I say that if I went to your clinic and did the same
8 thing that I would want to do it the same way, and that may
9 or may not be true because it takes the whole -- It's, as I
10 said earlier, it's a continuum. If we change something
11 early in the process, it may not work later in the process
12 the same way I'm doing it, so --
13 Q. In those instances then, where the head is stuck in the
14 os you testified a moment ago you'll either compress or open
15 the skull to drain; correct?
16 A. Yes, sir, if traction alone, yeah, compressing, grabbing
17 and bringing it down that alone doesn't work, yes, sir.
18 Q. You try the compression and grabbing first?
19 A. I usually try to remove it manually before I use any
20 instruments, yes, sir.
21 Q. And what informs your decision on whether either to open
22 the skull and have the fetus drained or have the head
23 drained or use forceps or some other means of compressing
24 the skull?
25 A. Well, I don't know if I can put that into words. It's a

1 judgment call at the time. Very often when the head is
2 tightly impacted into the cervix, there is going to be a
3 chance of causing damage to try to put forceps around the
4 skull to grab ahold of it to bring it out. If, indeed,
5 enough of the posterior nuchal region of the head is
6 exposed, assuming that we are talking about a foot-first
7 presentation, that I can safely and adequately drain the
8 cavity of the fetus, then if I'm fairly sure by ultrasound
9 and other pelvic evaluation it's not going to come out on
10 its own, then I would elect to open the skull. If, on the
11 other hand, if the cervix is relaxed enough which I can get
12 around the skull and I can grasp it which obviously wouldn't
13 be too often, it might just pass if it was relaxed enough,
14 but if I could do that I would prefer to do that.
15 Q. Your declaration says you use a sharp instrument to open
16 the skull on those occasions on which you do it?
17 A. I have to see that. I don't even own a sharp instrument
18 in my clinic. I think that's the way ACOG described it.
19 Where are we?
20 Q. Let me find it. I think it's paragraph 22.
21 A. Oh, declaration.
22 Q. Yeah, 22, last, second-to-last sentence, I use a sharp
23 object either under direct visualization or with real-time
24 ultrasonography to penetrate or enter the fetal skull.
25 A. Well, my actual choice is a uterine packing forcep, but

1 I would accept that that could be, by some, considered
2 sharp. I'm not saying there is anything wrong with this.
3 Q. You consider that forcep to be more of a blunt
4 instrument; is that correct, Doctor?
5 A. I generally like to open the tissue slowly and dissect
6 it apart the same way much like you're doing surgery because
7 you're less likely to involve any other structures, and if
8 you do, you're not causing a vast amount of problems. It's
9 rather limited.
10 Q. And that instrument that you use isn't necessarily
11 characterized as sharp though?
12 A. It's pointed, it's tapered, it's probably 4 millimeters
13 across the top but it's not a narrow point or a V point. I
14 think you could characterize it probably as a sharp,
15 somehow, somehow penetrating the skull, and I don't
16 particularly like very sharp instruments, but it's not a
17 round router or something like that.
18 Q. The next sentence of your declaration says you place a
19 cannula into the skull and remove the fetal cranial
20 contents. Do you always use a cannula?
21 A. No, sir. I very rarely use a cannula, but I may use a
22 cannula, and I often, if I use a cannula may or may not use
23 suction, I very rarely use the suction. By the time I would
24 get it hooked up, usually the skull is passed.
25 Q. Is it fair to say, Doctor, that at the point the fetal

1 head becomes lodged in the cervical os, you will either
2 drain or compress, you may suction or you may not, you may
3 use a cannula or you may not; is that correct?
4 A. That's correct, sir.
5 Q. All right. When you are seeking to remove the fetal
6 body intact, when that is your objective, you proceed
7 differently from the dismemberment process; is that fair to
8 say, Doctor?
9 A. Well, I guess I have to reiterate once again that I
10 always try to do it intact. It's only after intact has
11 failed that I go to dismemberment, so how does that fit with
12 your question? If you will reask it, I'll go from there.
13 Q. My question is, simply, I want to get to the actual
14 process that you utilize in trying to bring the fetus out
15 intact. Is it fair to say that when you are trying to make
16 the intact extraction, you attempt to take hold of the fetus
17 in a more gentle manner than you do when you're trying to
18 dismember that fetus?
19 A. I rarely try to dismember a fetus after the 20th week.
20 I'm not sure I understand how to get my point and what I'm
21 doing to be understood. If I -- If nothing is coming
22 through the os and nothing has came through the os and it
23 appears to me that waiting another hour or four hours is
24 going to not produce any different change than what I have
25 seen already, at that point we will put the patient in the

1 operating room and remove the fetus. I may well grab a foot
2 and bring it down. Now, I don't truly think that is total
3 version, but some people would argue that it is, but
4 whatever I happen to get, I would bring down. If I bring an
5 arm down and bring it outside of the uterus and possibly
6 even outside of the vagina, depending on where the uterus
7 is, I'm not going to put that arm back inside of the woman's
8 body to take that bacteria back inside, so I'll remove that
9 arm, but even at that point, I'm not going to have an intact
10 dilation, but I'm still going to try to bring the rest of it
11 out intact, so I very rarely go in with the actual idea that
12 I'm going to break the fetus up.
13 Q. I'm asking a different question, Doctor.
14 A. I guess that's my problem. I don't understand.
15 Q. I'm asking you, when you are seeking to bring the fetus
16 out as intact as possible, isn't it true that you try to
17 limit the force that you are using in pulling that fetus out
18 in order to keep it as intact as possible?
19 A. Well, I'm going to use exactly the amount of force that
20 it needs to do it, and yes, I would like to keep it to be
21 the minimal amount because I don't want to, if I subject the
22 fetus to destruction, I'm also subjecting the uterine cervix
23 to destruction, so I would attempt to use the minimal amount
24 of force required.
25 Q. Is it true, Doctor, that the when you're attempting to

1 do this intact extraction, you do this in the breech
2 position; is that correct?
3 A. Not necessarily.
4 Q. Let's look about when you do it in the breech position.
5 A. When I do it -- Okay. Yes, sir.
6 Q. The first part you bring down, I would say quite
7 obviously, would be the legs; is that correct?
8 A. Not always. Sometimes the buttocks will actually come
9 through the cervix first, and the fetus will be doubled up
10 and we have to use a finger or some other method or some
11 other mechanism to actually withdraw the legs out first and
12 then bring the rest of the fetus down, so given that
13 exception, yes. If I can get the feet out first, that would
14 be what I would ideally do, and very often one or both of
15 the feet may already be out by the time we decide to go
16 ahead and complete the extraction manually rather than
17 allowing the patient to deliver.
18 Q. The feet have come out first, and you're trying to bring
19 the rest of the fetus out intact?
20 A. Yes, sir.
21 Q. What do you do next?
22 A. I would continue with -- I would put a gauze sponge
23 around my hand and around the legs of the fetus, and in
24 almost all of these cases, there is to no speculum in, and
25 the traction brings the cervix down at or near the opening,

1 so that I don't need a speculum, but there would be no room
2 for it anyway. I continue to apply traction until I'm down
3 to the shoulders. Sometimes the shoulders will pass. If
4 not, then I have to reach up with my finger inside, and
5 about the same as you would deliver a wanted pregnancy in a
6 normal delivery, but given the fact that I can dislocate the
7 shoulder without causing any additional problems, if I can
8 dislocate the shoulder and bring it down to a lesser space,
9 I will. If not, I will try to sweep it across the body to
10 bring it out but yet to keep the fetus intact. After one or
11 the other shoulders is out, whichever one is lower, then I
12 will go back and try the same thing with the other shoulder
13 if I need to to bring the rest of the fetus out. If,
14 indeed, the head gets hung up, and it looks like I'm either
15 going to have the stretch the cervix another half a
16 centimeter or centimeter or millimeter, and I have a clear
17 access to open the skull and remove the contents, and you
18 have to remember at my practice, this fetus has been dead
19 for 48 hours already anyway. It's quite easy to open it
20 with a blunt instrument. It's quite easy to evacuate the
21 brain contents.
22 Q. You mentioned legs. I believe you mentioned the thorax
23 and the shoulders. What about the arms? What steps do you
24 take to try to extract the arms in an intact procedure so
25 they come out?

1 A. I thought I just said that. I'm sorry.
2 Q. You said shoulders specifically.
3 A. I have to go around the shoulders to grasp the arm to
4 bring it down. That's what brings the arms out normally.
5 Now, if we are talking about a woman who's -- instead of the
6 buttocks presenting, the arm presenting, then it's entirely
7 different.
8 Q. You said something in your answer that you attempt to do
9 this procedure in roughly the same way that you would
10 attempt to do a regular breech extraction and delivery; is
11 that correct?
12 A. I believe that's true.
13 Q. Doctor, on those occasions in which, because of the way
14 the fetus is presenting and the way you have decided to
15 proceed, you are now in the process of taking the fetus out
16 in parts instead of intact, I would like to ask you some
17 questions about that. I would like to ask you first, when
18 you have to break the fetus in parts, what -- You take steps
19 in doing that to ensure that fetal bones do not harm the
20 woman; is that correct?
21 A. I wish I could say I do things to ensure that. I do
22 things to attempt to make that true, and I have been
23 successful, but I have no way of being a hundred percent
24 certain once I start to do a dismemberment that I'm not
25 going to do that.

1 Q. Is one of the ways you attempt to reduce the damage to
2 the woman that might occur from bone fragments is that you
3 try to bring the tissue straight out of the cervix rather
4 than laterally?
5 A. If you mean by changing the axis of the fetus to be the
6 same as the axis of the cervical canal, yes, I do, but I'll
7 use a rotating motion, I will use a changing -- The cervix
8 is virtually never a straight line even when you have
9 traction pulling it down. Sometimes you have to aid the
10 fetus through that serpentine canal.
11 Q. Right. So if you found yourself in an occasion where
12 you have to bring out a bony fragment, explain to the Court
13 what you will do to do that in the safest manner possible.
14 A. I think obviously you're saying the safest manner
15 possible has already failed. At that point, then, I think
16 you have to try to -- I watch the piece or the tissue that
17 I'm bringing out on the ultrasound. I want to have the long
18 bone or the bone that we're worried about parallel to the
19 uterine canal and then attempt to cover the end of that bone
20 with a forceps and slowly rotate it and bring it down. Is
21 that what you mean? Yes, sir.
22 Q. Doctor, you agree that the danger of bony fragments is
23 not the same at every gestational age; correct?
24 A. Sure, yes, I do.
25 Q. Before the bones are calcified, they probably pose no

1 risk whatsoever?
2 A. I don't believe that's necessarily true. There is --
3 Calcification is an ongoing process, and there are times
4 when they are cartilaginous with some calcification. Some
5 bones may be dangerous while others are not in the same
6 fetus. I just think you have to be protected all the time.
7 The plates of the fetal skull are probably as worrisome as
8 are the long bones because these plates can often be the
9 size of a quarter, half dollar even, and unless one does
10 something to wrap them around, then there is always a
11 potential that they can lacerate the cervix.
12 Q. You agree before the bones are calcified, they present
13 no risk?
14 A. I don't believe that that happens, that would happen
15 before the 20th week, but if we are after the 20th week, I
16 think we have to assume the bones are already to a point
17 they would cause damage.
18 Q. Right. At what point do you believe the calcification
19 of the bones present a risk if they have to be dismembered
20 and extracted in a dismembered fashion?
21 A. You know, I don't think I have ever thought of that, and
22 I'm not sure that I have the talents to make that decision.
23 I just assume that at any point in time, if we're
24 protective, then I don't really need to worry about the
25 degree of calcification.

1 Q. And you would agree, Doctor, that if you have been
2 successful in inducing fetal demise, the risk or the danger
3 of bony fragments coming out is less because the dead fetus
4 is much softer and much more pliable; is that correct?
5 A. No, I don't think there is any change at all in the bone
6 density when the fetus has been dead for 24 hours. I think
7 that the fact that the fetus has been dead for 24 hours, it
8 becomes much more malleable and you have a much greater
9 chance of removing it intact, but I'm not sure it does
10 anything for the change in bony structures.
11 Q. Well, let's take a look at page 147.
12 A. Wait a minute. That's of the deposition?
13 Q. Yes, sir. Line 18. Question: Is the risk of a sharp
14 bone fragments reduced after the 18 week period through the
15 use of the injection of Digoxin? Answer: It is my opinion
16 that they are. Question: Okay. And why is that? Answer:
17 Well, I was telling Ms. Smith at lunch today that, you know,
18 we are talking about a fetus that's not only been dead for
19 48 hours, but we are talking about a fetus that has been
20 dead for 48 hours in essentially a warming oven or crockpot.
21 It has been kept at a hundred degrees for 48 hours, and if,
22 you know, that's enough, that's enough temperature to cook
23 meat, so we are not only dealing with a fetus that has been
24 dead in my practice, we are dealing with a fetus that's both
25 dead and soft, so it's much more pliable. Is that your

1 testimony at your deposition?
2 A. That's my testimony today also, and that's not the
3 question you asked me.
4 Q. I thought the question I had asked you is, would it
5 reduce the bony fragments after the injection of Digoxin,
6 reduce the risks. Would there be less of a risk of bony
7 fragments after the injection of Digoxin?
8 A. I'm going to need to you read back your question.
9 That's not the way I heard it, and it's not my intent to
10 answer it that way. If one gets to a disarticulation and if
11 one gets to the point that there are bony fragments exposed,
12 I don't believe the 48 hours changes the bony fragments at
13 all. What I think happens with the fetus that has been dead
14 for 48 hours, it is much more malleable, and you probably
15 will not expose those bony fragments.
16 Q. With respect to the risk of bony fragments, are we
17 talking about a frequency of risk that is less than one in
18 2000 patients in your experience?
19 A. Nationally, the risk of perforation is less than one in
20 2000, so if you are asking the bony fragment causing
21 perforation, I would have to agree with you. As far as
22 causing minor lacerations and tears, no, I don't. You know,
23 I can't say that's true.
24 Q. One in 2000 risk of perforation nationally; is that
25 right?

1 A. Absolutely.
2 Q. And, Doctor, would you agree that in skilled hands, D &
3 E in which a surgeon dismembers the fetus is safe up to 24
4 weeks?
5 A. It has to be because people do that all the time.
6 Q. Now, you use ultrasound; is that correct, Doctor?
7 A. I do.
8 Q. You recommend the use of ultrasound?
9 A. If -- I think for second trimester D & E, it would be
10 considered not within the standard of care to not have
11 obtained an ultrasound. I don't think there is a standard
12 of care that involves the real-time, as you're doing it,
13 ultrasound. I know many, many, many doctors do not do that,
14 they do very well. I also know that I sleep better at night
15 when I know what I've done.
16 Q. And would you recommend the use of ultrasound for a
17 second trimester surgical procedure during the operative
18 portion yourself?
19 A. If your practice would allow $30,000 to be designated
20 for that, I think it would be wonderful.
21 Q. Do you believe ultrasound makes the procedure safer;
22 that is, the operative procedure of removing the fetus?
23 A. I don't think I think say it makes it safer. It
24 certainly in my hands and my practice makes me feel much
25 better because if I have a problem, I know about it. I

1 think that's one thing that maybe makes it safer because it
2 is certainly possible without the ultrasound to have made a
3 passage and not recognize it. The only uterine perforation
4 I ever had, I did recognize immediately when it happened,
5 and we did admit that patient. We laparoscoped her and sent
6 her home the next morning and did nothing. I would be
7 concerned, you know. Now, you can talk to OB/GYNs that have
8 done this for a year, they are going to tell you I'm
9 absolutely insane. I agree with that. To them I probably
10 am. I just have to take the skills I have and do what I
11 feel is necessary to make me feel comfortable with what I'm
12 doing.
13 Q. To you, you find the use of ultrasound infinitely
14 valuable; is that correct?
15 A. In my practice, to me, yes, sir, it is infinitely
16 valuable.
17 Q. Doctor, you have not had a DIC in all of your many
18 abortions; is that correct?
19 A. That is correct, sir.
20 Q. When the fetal head gets lodged in the cervical os
21 during an intact extraction and you decide that you have to
22 compress the skull to remove it, do you try, you try to
23 avoid draining the brain consents of the uterine cavity; is
24 that correct?
25 A. My preference would be to have them expelled through the

1 vagina, yes, sir.
2 Q. It's the case, however, that sometimes in trying to
3 compress a fetal head, the brain contents may spill into the
4 uterine cavity?
5 A. Absolutely, especially in the earlier patients.
6 Q. And that can happen in both a D & E in which you're
7 seeking to dismember the fetus and a D & E in which you're
8 seeking to bring the fetus out intact?
9 A. I think with a D & E where you're seeking to dismember
10 it, it's a given it's going to be intrauterine.
11 Q. And it can also happen in an extraction that's intact.
12 When you use forceps to compress the skull, there may be an
13 occasion in which the brain contents spill into the uterine
14 cavity?
15 A. Again, yes, sir, it would be early patients.
16 Q. That's also the case, Doctor, that the plates of the
17 fetal skull as you mentioned a moment ago can be quite
18 sharp; is that right?
19 A. They certainly can be.
20 Q. I think you basically said they are about the size of a
21 quarter when they rupture?
22 A. Depends on the gestation of the fetus, but at 20 weeks
23 they are about the size of a quarter.
24 Q. And after a 20-week pregnancy, those --
25 A. At 22, they grow continually. The fetal skull increases

1 about three millimeters in diameter.
2 Q. Let me finish the question.
3 A. I'm sorry. Go ahead.
4 Q. After 20 weeks, the fragments of the fetal skull are apt
5 to be quite sharp if they rupture; is that correct?
6 A. That is true.
7 Q. Okay. One of the benefits of keeping the head intact as
8 possible is to avoid the potential harm of the ruptured
9 fetal skull; is that correct?
10 A. Both the contamination of the in internal uterine cavity
11 with the brain contents and also to reduce the trauma to the
12 cervix, yes, sir.
13 Q. Now, when it happens that fetal skull ruptures and the
14 sharp fragments and the contents of the brain end up in the
15 uterine cavity, you have vacuum suction immediately
16 available to you; is that correct?
17 A. Yes, sir, I do.
18 Q. Okay. And in fact, you have a suction running and the
19 cannula tube is right there, and you can stick it in and
20 suction the uterine cavity in a matter of seconds; is that
21 correct?
22 A. Many times it's already running, but if not, by the time
23 many times I can get the cannula in, my assistant has turned
24 on the suction and is handing me the tube, yes, sir.
25 Q. So if that circumstance arises for you where sharp fetal

1 fragments have gone into the uterus and brain tissue has
2 gone into the uterus, you can suction that fairly quickly;
3 is that correct?
4 A. The brain contents, I'm not sure that you can suction
5 the fragments because the plates will certainly not go
6 through the canal. The bony fragments may. Go through the
7 cannula. I'm sorry, sir.
8 Q. And you would also do sharp curettage at that point?
9 A. No, I would think at that time I would use the forceps
10 and try to remove the individual pieces intact, or not
11 intact, but remove the individual pieces that are there.
12 Again, once I'm through with that, I would definitely do the
13 D & C.
14 Q. Doctor, when you are expelling the fetus, attempting to
15 remove the fetus through the use of the Misoprostol, I think
16 you said that in 90% of the cases, the fetus just expels on
17 its own; is that correct?
18 A. With Misoprostol and Oxytocin, yes, sir.
19 Q. Is there ever an instance in which you or one of your
20 assistants puts pressure on the woman's abdomen to assist in
21 the expulsion process?
22 A. There is always a never, and there is never a never.
23 Okay? So yes. Yes.
24 Q. On the day of the procedure that you're going to
25 actually try to remove the fetus, that's usually the third

1 day of the procedure; is that correct?
2 A. If we are talking about 20 weeks, yes, sir.
3 Q. All right. About 20 weeks, it's usually the third day
4 of the procedure that you try to remove this fetus?
5 A. Yes, sir.
6 Q. Is it -- It's true that the woman is in your office
7 usually about four to five hours which is the time between
8 the Misoprostol is administered and the time waiting to
9 expel the fetus?
10 A. I would say that would be the absolute minimum, yes,
11 sir.
12 Q. And if the woman has not expelled the fetus by
13 contractions within four to five hours on the third day, is
14 that when you decide to intervene in some manner with
15 instruments to remove the fetus?
16 A. That is when I would decide to intervene in some manner.
17 However, it may be that I only reinsert laminaria and have
18 her come back the following day.
19 Q. You would have her come back the following day?
20 A. Or later that afternoon or evening, depending on just
21 where we were with that given patient.
22 Q. Are there circumstances in which you intervene with
23 instruments to try to remove if fetus after a certain period
24 of time?
25 A. Surely.

1 Q. How much time do you typically wait?
2 A. I don't think that there is any time that I typically
3 wait. It's a matter of how I feel, what's happening with
4 the cervix, is it going to go on, is it not, and if it
5 appears that we are not going to gain anything by doing
6 another delay, or if by doing another insertion of
7 laminaria, or we are not going to gain anything by waiting
8 any longer, I will do the instrument, but that's extremely
9 rare. I will normally do things to get better dilation and
10 do things to get a little better uterine contraction so that
11 it does, indeed, go ahead and complete spontaneously.
12 Q. It's your preference to let the normal process of having
13 the fetus expel, spontaneously take its course?
14 A. Mother Nature is much better at this than I am, yes,
15 sir.
16 Q. I believe you testified this morning, Doctor, that you
17 perform abortions for some maternal health reasons; is that
18 correct?
19 A. I have.
20 Q. And you also perform abortions for fetal anomalies; is
21 that correct?
22 A. I have.
23 Q. And, Doctor, you are not either an OB/GYN or maternal
24 fetal medical specialist; correct?
25 A. I'm neither of those, but I receive referrals from them

1 at all times.
2 Q. Is it common in this country that doctors who primarily
3 perform abortions may not be OB/GYNs?
4 A. That's very true, yes, sir.
5 Q. You do not diagnose any maternal physical health problem
6 that may have led to an abortion, Doctor; is that correct?
7 A. No, sir.
8 Q. You get referrals from somebody to perform the abortion?
9 A. If I diagnose it, if it's one of my patients, I would
10 still refer them to our second opinion before I went ahead
11 and did the abortion, if that's what your question is.
12 Q. Do you primarily get referrals for terminations from
13 maternal physical health reasons?
14 A. Yes, sir, I do.
15 Q. Do you know how common it is for a pregnancy to be
16 terminated for a maternal physical health reason?
17 A. Not in the United States. In my practice in Omaha or in
18 Nebraska, my practice. It's fairly rare. I'm not sure that
19 I could put a number nationally. I may have known that at
20 one time but I don't recall it right now.
21 Q. For fetal anomalies, it's the case, Doctor, that
22 sometimes you get a referral, and sometimes you happen to
23 notice a fetal anomaly on the sonogram; is that correct?
24 A. That is correct.
25 Q. Either way, Doctor, do you agree that terminations for

1 fetal anomalies are elective terminations?
2 A. Depending on the gestation of the fetus, yes, sir. I
3 think they all can be and none of them may be. If -- I
4 think what I said in my deposition, if I have a patient that
5 comes to me with a fetal anomaly, yet she is within the
6 elective range to decide to terminate, I don't require her
7 to go through the necessary expense of having another
8 consult to say yes, the heart was bad, but you're only 18
9 weeks so we can take this out anyway.
10 Q. By elective range, you're referring to someone who may
11 come in with an anomaly that is post-24 weeks?
12 A. I don't believe I said that, no, sir.
13 Q. What are you referring to?
14 A. Less than 23 weeks.
15 Q. I just want to check something here, Doctor.
16 A. Surely.
17 Q. Doctor, when you are performing second trimester
18 abortion and when you are seeking to bring the fetus out
19 intact through some manner, prior to the commencement of the
20 procedure, do you undertake any procedure which would allow
21 you to determine that the fetus is alive?
22 A. When you say prior to the commencement of the procedure,
23 are you talking about day one of the ultrasound?
24 Q. Yeah. Let me strike that and go back to day one with
25 the ultrasound. You take an ultrasound, and through that

1 ultrasound you're able to determine whether the fetus is
2 alive?
3 A. Yes, to determine whether or not the fetus is living, we
4 always do, and I think I said that in my declaration, and my
5 reasoning for that is for the woman's comfort. If she has a
6 fetus that is not alive and she may well have insurance that
7 will cover her in that instance, she needs to know she can
8 go somewhere else and seek care. She also needs to know if,
9 indeed, the fetus is not alive, she's really not aborting
10 that fetus, and I think for most women, if that's true, they
11 need to know about it.
12 Q. Have you ever had occasion to perform a determination in
13 which a living fetus has been delivered intact, at least to
14 the head, to a point outside the woman's body and showed
15 some signs of life?
16 A. Can you rephrase that, because I have one instance that
17 I have to have in mind. Go ahead.
18 Q. Have you ever had occasion to perform determination
19 where a living fetus was delivered at least to the head in a
20 breech position? Let's add that in, Doctor, in a breech
21 position to a point outside the woman's body that showed
22 some signs of life.
23 A. If you are including 14 through 24 weeks, yes, I have
24 had that happen.
25 Q. And in that circumstance, what signs of life did you

1 observe?
2 A. I think looking at the fetus, there really are no signs
3 of life. Looking at the ultrasound, I'm aware of what the
4 heart is doing, what's going on.
5 Q. The ultrasound would indicate to you that there is a
6 heartbeat?
7 A. I can see that.
8 Q. In cases in which you bring about fetal demise, I take
9 it that there is no signs of life during the extraction
10 process?
11 A. Yes, sir, that's very true.
12 MR. COPPOLINO: Your Honor, may I confer for one
13 minute, please?
14 THE COURT: Yes.
15 MR. COPPOLINO: Your Honor. Thank you. I have no
16 further questions.
17 MS. SMITH: Just one moment, Your Honor.
18 THE COURT: Okay.
19 MS. SMITH: Your Honor, I have no redirect.
20 EXAMINATION
21 THE COURT: All right. Doctor, before you step
22 down, I have a couple of questions and forgive me if I'm not
23 artful about these, but first question, and I want to use a
24 year period of time, and I don't really care what, whether
25 it's a year, but just as a measuring point, so with that in

1 mind, a year period of time. I would like to know prior to
2 18 weeks but after 13 weeks in your more recent practice,
3 how many fetuses are removed intact or to the point where
4 the fetal body, save for the head, is in the vaginal cavity
5 or outside the woman's body?
6 THE WITNESS: As to the intact question, I would
7 say probably not more than five or six times a year, maybe
8 less than that. Maybe four to five. As far as a
9 significant, and again, I can't say up to the shoulders, but
10 I mean, I can't say up to the head, but up to the shoulders
11 where I have to go in and do something else, that probably
12 happens -- I'm trying to think of the number that we do --
13 probably, that probably happens 25 to 40 times a year.
14 THE COURT: Okay. Now, in all of those
15 circumstances, you have not been able to, at least it is not
16 your practice to have administered Digoxin to the fetus; is
17 that right.
18 THE WITNESS: That has been my current practice,
19 yes, sir.
20 THE COURT: At least as of now, anything before 18
21 weeks, you will not be seeking fetal demise through an
22 injection?
23 THE WITNESS: The only time I would do that is if
24 the patient requested it and we had a long talk and
25 explained the fact there may not be any significant benefit,

1 and the reason I bring that up, we have had an occasion
2 where a woman using judicial bypass wanted to be certain
3 that at 16 weeks the fetus was not alive, and I think we
4 were able to do that. It was certainly not alive the next
5 day, but I'm not sure that gave me any other medical
6 benefit.
7 THE COURT: All right. A moment ago you said that,
8 if I understood you correctly, during this relevant time
9 that you and I are talking about after 13 weeks and before
10 18 weeks, maybe five times a year the fetus will come out
11 intact.
12 THE WITNESS: Before the 18th week. I hope that's
13 what I said yes, sir.
14 THE COURT: Before the 18th week.
15 THE WITNESS: Yes.
16 THE COURT: Right. You have not administered
17 Digoxin at that time, and when the fetal, when the fetus
18 comes out intact, what is the method of death?
19 THE WITNESS: I think it's oxygen deprivation
20 because the fetus, if it comes out intact, they have usually
21 done this when I rupture the membranes, and many times, I
22 think and sometimes I'm absolutely certain that the fetus
23 has died on its own overnight, and I think that the
24 medications we use for paracervical block, the amount of
25 anesthesia or Lidocaine that we use and some of the other

1 medicines that we use, the Misoprostol and the two to three
2 hours before, cause enough construction of the uterus on the
3 fetus to minimize circulation and at least obtund the fetus,
4 make it so it's not conscious so that we don't really see
5 signs. I don't think, I cannot say honestly I have ever
6 seen signs of movement on a fetus even though we may well
7 have a very slow heartbeat. The fetus, if, indeed, alive is
8 probably unconscious.
9 THE COURT: Okay. During this time again before 18
10 weeks but after 13 weeks -- Let me change it for just a
11 moment. What I'm getting at is a question that the lawyers
12 asked you about, and it's awkward to phrase. After 13 weeks
13 and before 18 weeks when you are doing the procedure that
14 you typically do, however you would describe it, I want to
15 know whether you do anything differently manually or from an
16 instrumental point of view when the fetus comes out in two
17 or more pieces as opposed to coming out either wholly intact
18 or intact to the point where the skull is lodged in the
19 cervical os.
20 THE WITNESS: If I may go back, and this has not
21 came up in any of the previous questions, and I don't think
22 I mentioned it, if, indeed, after rupturing the membranes
23 the cord prolapses.
24 THE COURT: Right.
25 THE WITNESS: I will divide the cord. If, indeed,

1 the cord is available for me to reach inside and I see it
2 easy, I will pull it down and divide the cord, but I don't
3 go fishing. If that's not going to happen easily, then I
4 don't worry about it. I mean, that's when we are starting
5 to induce more risk than benefit. I have to quit.
6 THE COURT: And I appreciate that you have
7 clarified now that you may have an opportunity to cause
8 fetal demise by virtue of cutting the cord.
9 THE WITNESS: Yes.
10 THE COURT: That was the point of that comment; is
11 it right?
12 THE WITNESS: Yes, that's why I do that, and
13 that's, I do try that if it's at all possible.
14 THE COURT: Okay. Okay. Now, I want to go back to
15 my question now. In the circumstance after the 13th week
16 and before the 18th week when you're doing the procedure,
17 however you wish to describe it, and the fetus either comes
18 out intact or intact up to the head in the cervical os or
19 comes out in two or more pieces, what, if anything, either
20 manually, how you hold your hands, how you move your hands,
21 or instrumentally do you do that's different?
22 THE WITNESS: Different as opposed to breaking the
23 fetus up or different as opposed to how I get it out? I'm
24 not sure. I'm sorry, sir.
25 THE COURT: No. If I were to videotape just your

1 hands and your instruments and you were doing this procedure
2 between after 13 weeks and before 18 weeks, and I were to
3 see you extract the fetus in two or more pieces, how, if at
4 all, would that look differently than if you did that
5 procedure but the fetus came out entirely intact or intact
6 to the point where the calvarium is stuck in the fetal os
7 (sic)?
8 THE WITNESS: As to what you watched me do with my
9 hands and the instrument, I do not believe there would be
10 anything different. It's just -- I still try to take small
11 bites, I still try to progress the fetus through the canal.
12 I try to be as gentle as possible whether or not it's going
13 to be intact.
14 THE COURT: Okay. Now, we have just talked now
15 about manual things, instrumental things, hard things.
16 What's in your mind as between those two events? Is there
17 any difference between sensing that you may have an
18 opportunity to deliver entirely intact or -- and here when I
19 use deliver, I mean --
20 THE WITNESS: I understand.
21 THE COURT: -- in a surgical sense. What, is
22 there any different cognitive process that's going on in
23 your mind as between the circumstance after 13 weeks, before
24 18 weeks, where you have the fetus in two or more parts as
25 opposed to wholly intact or the skull is lodged in the

1 cervical os?

2 THE WITNESS: I think one of the most difficult
3 things that not only I, but most providers, encounter in
4 this gestational period is should the head become separated
5 and stuck in the upper part of the uterus, it can become
6 virtually impossible to get out.

7 THE COURT: That's called the floating head?

8 THE WITNESS: Yes, sir. We can identify it, we can
9 localize it, but again, it's like if you took -- I don't
10 know how to describe it, but if you took a softball in your
11 hand and held it as tight as you could, it's still trying to
12 get around that tight to get ahold of the head to bring it
13 out, so if there is any way for me to avoid that, and again,
14 yes, I'm doing it for the patient, but I'm also doing it for
15 the ease and safety of the procedure. If I don't have to
16 get into that position, I have saved both the patient and
17 myself a lot of worry and aggravation, so I try as long as I
18 can, even if I have got, you know, three pieces of each leg
19 and half the abdomen in 14 different pieces, I still try to
20 keep the rest of it as intact as possible because I don't
21 want to leave, I would like not to lose something to grab
22 onto, to get a purchase of, as they say, to bring it down.

23 THE COURT: Thank you. This may be fairly obvious,
24 and if it is, I mean no disrespect to anyone by asking this,
25 but at 17 weeks or before, why not just dilate just slightly

1 more than the biparietal diameter to effectuate the
2 abortion; in other words, if you can achieve dilatation, as
3 you describe it, sufficiently to deliver the fetus and the
4 skull of the fetus, why don't you do that?
5 THE WITNESS: Sir, I think I do do that. I think
6 that's what my intent is in trying to obtain the maximum
7 dilation. There is just -- I think there is a law of
8 diminishing returns where at 15, 16 weeks, putting laminaria
9 again and waiting another day, the risks of infection
10 overnight, the risks of, you know, fetal skin breaking up,
11 of all of these things, I have to apologize. The best I can
12 say, it's just from my experience in what I have done that
13 it's probably not in the woman's best interest to do that.
14 Can I put a reason why? I probably cannot, and I think
15 that's probably as the time, you know, I have mentioned that
16 frequently, maybe 20, 25% of the time as I rupture the
17 membranes, things do come out, and I'm able to effect the
18 rest of the delivery quite simply. That would be my goal in
19 every patient. It does not, unfortunately, always happen
20 that way, and there are things that make it probably not
21 worth waiting because of, you know, other medical problems
22 that can exist with infection or with bleeding or other
23 things.
24 THE COURT: I think I heard you say that you
25 normally try to achieve dilatation equal to two-thirds. Did

1 I understand that as a biparietal diameter?
2 THE WITNESS: That's the minimum I would like to
3 have. I hope to obtain much more than that, but until I
4 have two-thirds of the biparietal diameter, then I'm fairly
5 well convinced that I'm going to do something additional to
6 dilate the cervix further.
7 THE COURT: Let me ask you this question: Once
8 again, I mean no disrespect to you or anybody else, and it's
9 a blunt question. But do you intentionally seek not to
10 achieve dilatation sufficient -- Now, once again, I'm
11 talking now about the relevant time you and I have been
12 talking about after 13 weeks and before 18 weeks.
13 THE WITNESS: Right.
14 THE COURT: Do you intentionally try not to achieve
15 dilatation sufficient to pass the head?
16 THE WITNESS: No, sir, I think exactly the opposite
17 would be the correct statement. I try to achieve enough
18 dilation that the fetus will pass. I rarely get there, and
19 again, that's just -- what may happen with a later fetus
20 where you can grab it and just get it directed and have it
21 come out on its own, with earlier pregnancies, it just
22 doesn't happen. The tissue breaks up, but if I could, if I
23 could get two centimeters of dilation on a 15 week fetus, I
24 would be extremely happy, and the fetus would come out with
25 very little deformities.

1 THE COURT: Now, I want to switch time frames with
2 you for a moment and ask you -- Well, before I get to that,
3 what do you consider from a gestational age point of view
4 viability to be as we sit here today?
5 THE WITNESS: I'm not sure that you can put a
6 gestational, you can't -- I don't think you can ever use the
7 gestation as the sole measure of viability. In my opinion,
8 you have to take into concern the overall health of the
9 mother, the overall health of the fetus, and if it's already
10 infected, if the membranes have already ruptured, if other
11 things are going on, then what's viable for one 23 week
12 infant may not even be remotely possible, or the fetus may
13 have already died with another 23 week infant. The other
14 thing I think that is important is the location of where you
15 are, and I'm not sure that we can control that. I know that
16 should a woman come into my emerge center in labor and
17 precipitously deliver at 23, 24, possibly even 25 weeks,
18 unless the University of Nebraska has a lot of empty beds,
19 which they usually have not even any empty beds, I have
20 nothing that I can do for that fetus as much as I try to
21 keep it alive, because most of these times when that
22 happens, these are wanted fetuses and we don't want to hurt
23 it. We want to do everything we can. I do have oxygen
24 available, I do have a way to keep it warm, to keep it
25 comfortable, but probably short of that, nobody is going to

1 take that fetus from me, and all I can do is help support it
2 until it passes away.
3 THE COURT: Okay. Well, with that, that's a fair
4 qualification. And given that qualification, though, do you
5 have a general gestational age that you --
6 THE WITNESS: After the beginning of the 23rd week,
7 sir, I want to have another thing just -- I don't want this
8 to be a purely elective termination. I need to have some
9 kind of supporting from mother, from, you know, and mental
10 health may be the same. I'm not saying that I would turn
11 away a 23 week, six day patient that the mother, that the
12 young infant mother, not infant, but a 14, 15-year-old woman
13 with her mother there that's saying that she's just not
14 eaten for the last week which happens, or that she just
15 won't go to her school, she's in her room, she's totally
16 distraught, if the young woman is truly serious about the
17 fact this is destroying her life, I don't think I would send
18 that patient for a psychiatric consult. If that patient
19 came to me at 24 plus weeks, in all likelihood I would
20 probably, rather than send her for a psychiatric consult, I
21 would refer her to another clinic where they can do this
22 without having the state laws be a problem.
23 THE COURT: Now, obviously, you have been in this
24 courtroom before in the prior case. I understood you, I
25 think, in the prior case to tell me that you did not

1 intentionally perform abortions after viability.
2 THE WITNESS: I absolutely do not. If I think the
3 fetus is viable, no, sir, I do not, and I will refer that
4 patient to someone else.
5 THE COURT: So that practice hasn't changed?
6 THE WITNESS: No, sir, that practice has not
7 changed at all.
8 THE COURT: Okay. From 18 weeks, then, to 24 weeks
9 when you customarily administer Digoxin to kill the fetus
10 and you seek, I'll call it, labor expulsion of the dead
11 fetus, how does your practice differ from a hospital
12 induction procedure.
13 THE WITNESS: I have had some patients that I have
14 followed that were -- that went through attempted induction
15 in a hospital and subsequently ended up with hysterotomies.
16 I think the biggest difference, as far as the actual care
17 for the patient, we have tried everything in our clinic to
18 be as close to hospital-based care as we can. We do, I have
19 called the blood bank. One of the clinics I work at has a
20 blood bank in the clinic. I called the Red Cross and asked
21 them about that to try to establish it here, and they said
22 they would guarantee that we could have blood in 20 minutes
23 if we needed it, and to me, that's every bit -- it doesn't
24 justify the expense. I have never needed it, but I know
25 that it's available. I know also, and in a hospital it

1 takes 20 minutes to warm the blood, anyway, before it's
2 crossed and ready for you, so if I send a cab to get the
3 blood and they give a blood specimen and we get the right
4 type and we get a confirmative match, we can probably give
5 it as quickly as they could actually give it in the
6 hospital. We have the same monitoring capabilities that the
7 emergency rooms have or that the operating rooms have in the
8 hospital. We have cardiac monitors, we have pulse
9 oxymeters, and our clinic, I'm speaking what I have because
10 I honestly don't know what other clinics have in this area.
11 THE COURT: I'm only asking you.
12 THE WITNESS: Exactly, sir. As far as supervisory
13 personnel, I have one registered nurse, but I have a staff
14 that has umpteen years of experience of dealing with women
15 that are terminating pregnancies up through the 24th or 23rd
16 or 22nd week, and they very often note things and tell me
17 things that are happening before, to tell me what's going
18 on. They are right and we can do that. To this day I don't
19 think we have sent four patients to the emergency room if
20 from my clinic. All four of them had been reported on the
21 anti news as abortion complications. None of them have been
22 abortion complications in fact family practice or family
23 medicine patients that I have referred one was an abortion
24 patient that came in with a blood pressure of 240 over 70
25 she was admitted to intensive care. We try to do everything

1 as close to a hospital setting as possible.
2 THE COURT: There are times, however -- well, thank
3 you for that. My question is perhaps a more mechanical one.
4 Do you do anything mechanically, manually, instrumentally,
5 in these procedures between 18 and 24 weeks where you're
6 hoping to expel the fetus by labor?
7 THE WITNESS: If one considers the fact that you
8 can't do abortions in any of the hospitals in Omaha, then
9 everything I do is different, sir, but if there was a
10 hospital that provided, like Dr. Vibhakar can do in Iowa, if
11 we had a hospital that, indeed, would allow abortions to be
12 done in the hospital, I do not think there is any difference
13 in the practice scenario.
14 THE COURT: And that was going to be my next
15 question. Are there any hospitals in which you could
16 perform the procedure that you do between 18 and 24 weeks?
17 THE WITNESS: No, sir, there is not.
18 THE COURT: In Nebraska?
19 THE WITNESS: Not in -- I don't know about the
20 whole state, but I know from Lincoln east that that is not a
21 possibility.
22 THE COURT: Okay. Now, once again, in the ages
23 that we are talking about here, the later ages, 18 weeks to
24 24 weeks, are there any circumstances where you in the
25 recent past have been unable to cause fetal demise by use of

1 injection?

2 THE WITNESS: Yes, sir, there was one incident

3 where that happened with a 21 week twin pregnancy, and can I

4 describe --

5 THE COURT: Please do.

6 THE WITNESS: And I don't remember the exact time

7 frame. There are people here that would be able to tell me,

8 but I don't remember, and I think the charts may be in the

9 box that you have.

10 THE COURT: I have got lots of boxes.

11 THE WITNESS: I know. I think that the documents

12 are here. I think it was in the time frame we supplied

13 records, but we had a 21 week patient that had previously

14 had children, she was not primagravida. She was a

15 multi-parous patient, and I attempted with her to do the

16 fetal injection first which used to be my practice. I

17 thought I had obtained adequate, that I had obtained that,

18 and I started to place laminaria and very shortly. By the

19 time I had put in the third or fourth laminaria, I started

20 to get bleeding, and it just became worse and worse as time

21 went on. We immediately gave her the maximum dose of

22 Misoprostol. I gave her a drug called Hemabate or

23 H-e-m-a-b-a-t-e , Hemabate. We gave her Pitocin, we gave

24 her everything to try to constrict the uterus because if you

25 can impact the fetus into the uterus, you can cause enough

1 construction to slow the blood flow down, and we were able
2 to control the blood flow long enough to give about 20
3 minutes. However, one of the twins had, I thought, probably
4 was dead. The other one, I'm sure, was not, but I had to
5 remove both of those fetuses in virtually a nibble-nibble
6 fashion. I don't know how else to describe it, because I
7 had an opening, the maximum I could get was like maybe
8 one-and-a-half to two centimeters which was not adequate to
9 deliver the fetuses. Did they come out up to the head
10 intact? No. In that case it didn't, but I think in that
11 case it certainly was a possibility that it could have.
12 THE COURT: And those were -- Why couldn't you
13 administer the injection? Just didn't work?
14 THE WITNESS: Well, I didn't have any time. I
15 think it probably would have worked if we had half an hour
16 or an hour or two hours, I probably would have been fine,
17 but she was bleeding to the extent I didn't have five
18 minutes to wait just to take effect. We just had to go, and
19 we did.
20 THE COURT: And that was because she came in --
21 THE WITNESS: Because she was bleeding. As I put
22 the laminaria in, she started to bleed, I think she must
23 have had a partial placenta previa that I knocked off a
24 piece of placenta or perhaps putting a laminaria in, I might
25 have caused trauma that caused the problem. I don't think

1 that was the case, but there is any number of scenarios, but
2 we were able to get the fetus out, and then I put clamps
3 around the cervix very high up by the internal os, and the
4 bleeding stopped, and we waited 10 minutes, and her probable
5 blood loss was still less than 200 cc's which in Dr. Grimes'
6 article is what was expected in 1985, but that certainly
7 would not be tolerated now as the average, so I think we did
8 okay, but at that time, I could not wait for fetal demise.
9 THE COURT: So, it simply, you didn't have time to
10 do it because something else happened, and you couldn't have
11 caused the fetal demise because of a matter of time.
12 THE WITNESS: Yes, sir.
13 THE COURT: Okay. And as you sit here today,
14 that's the only circumstance that you can remember in the
15 recent past where you have been unable to do -- cause fetal
16 demise.
17 THE WITNESS: In the over 18 week group, yes, sir.
18 THE COURT: All right. Thank you. I'm going to
19 let the lawyers follow up, first for the plaintiff, then the
20 defendant, then the plaintiff.
21 REDIRECT EXAMINATION
22 BY MS. SMITH:
23 Q. Thank you, Your Honor. Dr. Carhart, the Court was
24 asking you about the difference between your induction
25 procedures 18 weeks and up where you use surgical techniques

1 as well and whether there was any difference between those
2 procedures and inductions performed in the hospital, and you
3 said there was no difference. But aren't there surgical
4 techniques that you perform at the end of the induction?
5 A. I misunderstood that question. I thought he asked if I
6 did anything different in the clinic that I would do at the
7 hospital, and the answer was no, I would do the same thing.
8 And I think there are people that would do a D & C at the
9 end of an induction in the hospital. I basically think a
10 20%, which is the numbers given, a 20% incidence of retained
11 tissue after an induction, I don't see how anybody can
12 justify that as good medicine.
13 Q. Does that indicate that no D & C was done at the end of
14 those induction procedures?
15 A. At my patients, no.
16 Q. No, I'm not talking about your patients, Doctor.
17 A. Oh.
18 Q. When you were talking about the complication rate of 20%
19 retained tissue.
20 A. That study that I'm thinking of, they did not do D & Cs
21 and they just had a 20% complication. Well, I mean, but I
22 have never had a patient that I didn't go back and do a D &
23 C on that I didn't get out tissue. It's just not happened.
24 Q. So that would be a difference between your technique in
25 that you always ensure that the placenta is removed through

1 a D & C at the end of induction?
2 A. It's not always the placenta. It could be chorion, it
3 could be other products of conception, not even fetal parts
4 but other parts of the pregnancy, not necessarily the
5 placenta that could cause infection and cause problems.
6 Q. So that been would be a difference between your
7 technique and an induction technique where no D & C was
8 performed and placental tissue remained; is that correct?
9 A. Possibly true, but I do believe there are some OB/GYN
10 doctors now who also believe you should do a D & C after the
11 induction and I'm hoping that catches on.
12 Q. Thank you, Doctor. I also have a question about in
13 follow-up to the Court's question. In your 14 to 17 week
14 procedures.
15 A. Yes, ma'am.
16 Q. What is your intent when you begin to extract the fetus
17 with regard to how large of pieces you would like to have
18 come out with each pass?
19 A. My intent is everything with the first pass. That's my
20 goal.
21 Q. Always would like to achieve an intact fetus?
22 A. That is correct.
23 Q. And if, when you begin to remove the fetus, a piece
24 dismembers, what's your intent with the next pass?
25 A. Well, I may not, if I see a piece starting to dismember,

1 I probably will not remove the instrument. I probably would
2 go back in and get a better grasp. If, indeed, I have
3 separated the piece I have ahold of from the remainder of
4 the tissue, then I might as well bring that out. All it's
5 going to do is get in the way and possibly cause problems,
6 then go back and again try to grasp what's left.
7 Q. Those are the steps you take to try to ensure larger
8 pieces coming out?
9 A. Rather, I don't just grab it and tear it off and pull it
10 out. My goal is to reap keep it relatively intact, go back
11 and get a better grasp on what's left.
12 Q. Thank you, Doctor. The procedure you talk about from 14
13 to 17 weeks where you were able to remove the fetus intact
14 or largely intact up to the calvarium, if the next step was
15 the compression or collapsing of the skull, whichever method
16 you use to do that, could that cause fetal demise?
17 A. I think it eventually would. It may not cause immediate
18 fetal death though. I mean, the fetus is going to die.
19 Q. So you're not sure which step you take in the course of
20 the procedure is going to cause fetal demise; is that right?
21 A. I don't think you can tell that.
22 Q. One other follow-up on the induction, and I should have
23 asked you this before. I'm sorry to jump back and forth
24 with you, Doctor, but is there also a difference between
25 your induction technique and a hospital induction technique

1 in terms of the time limit you set on the amount of time you
2 let a woman labor to try to get the fetus out?
3 A. The only, the bad result I remember from a hospital
4 admission was a 19 week pregnant woman that had fetal
5 problems. The hospital decided to do induction, and they
6 used the Prostaglandin suppositories and they used the
7 Misoprostol and they waited over nine days for her to expel
8 the pregnancy. She did not do that, and they eventually
9 ended up doing a hysterotomy. I know in my practice that
10 would have been complete within 48 hours.
11 Q. So you would set a 48 hour time limit on your induction
12 procedures?
13 A. I'm not saying I set time limits. It's just that what
14 happens, they are done by then. I would probably, yes, if I
15 had gotten with a 19 week pregnancy and we were at the end
16 of the second day, and the dilation was good enough, I could
17 remove it pretty much intact, I would go ahead and do that.
18 If it was so small I would have to do the nibble-nibble
19 technique that Dr. Joeri van de Bergh talks about, then I
20 would not do that. I would put in more laminaria, send her
21 home, try again tomorrow or later tonight.
22 Q. Doctor, I think this is my last question for you. On
23 the issue of dilation of the cervix, is it true that there
24 are two aspects to cervical dilation, both in terms of the
25 size of the opening that you'll get as well as in some

1 change to the cervix?
2 A. The shortening.
3 Q. The shortening?
4 A. Okay. There are two things that we are definitely
5 looking for. One -- actually three, I guess you could say.
6 The softness of the tissue, one which is called ripening or
7 softening so the tissue will stretch rather than tear. The
8 second is the degree of relaxation or how much, how open is
9 the cervix, how many fingers can you get in the cervix to
10 know where you are; and thirdly is the length of the cervix,
11 and all three of those factors come into play as to how
12 easily the fetus is going to be delivered, and usually the
13 dilation is relatively predictable, but the effacement or
14 the shortening is not that predictable, and often that is
15 the major constraint to get the fetuses out intact.
16 Q. And what about the ripening? Is that also a variable
17 factor?
18 A. I think it is, depending on, you know, a very young
19 woman, a woman over the age of 35, say, both have cervixes
20 that are more -- even if they have had children, if it has
21 been 20 years, the cervix may be very hard. One of the most
22 things that I hate to see on the chart in the history is
23 where they have had surgery either, most commonly a leep,
24 most commonly a leep procedure because it causes cervical
25 scarring, makes the chances of getting adequate dilation

1 very, very difficult.
2 Q. So, Doctor, if you have the same amount of dilation in
3 terms of the opening of the cervix, the amount of fingers
4 you could put in, say?
5 A. Um-hm.
6 Q. Would the cervixes respond the same as you try to remove
7 the fetus, or is there a difference?
8 A. There can be a difference.
9 Q. And that can affect whether the fetus comes out intact
10 or in larger pieces or smaller pieces; is that right?
11 A. Yes, ma'am.
12 MS. SMITH: Okay. Just one moment, Your Honor.
13 Thank you. I have no further, Your Honor.
14 THE COURT: Mr. Coppolino?
15 MR. COPPOLINO: No questions. Thank you.
16 THE COURT: Thank you, Doctor. You may step down.
17 Now, it's about three o'clock, Ms. Smith. Tell me what the
18 remainder of the day has in store for us.
19 MS. SMITH: Your Honor, I just have a little
20 business to conduct before I rest my case. I have no
21 further witnesses to call live here in Lincoln. I did want
22 to move into evidence the deposition transcripts, the
23 designated portions of which we discussed at the pretrial
24 conference and which are reflected in the pretrial order for
25 the deposition of Wan Kim, the Department of Justice --

1 THE COURT: Hold on just a minute.
2 MS. SMITH: Okay.
3 THE COURT: Just for housekeeping purposes, I take
4 it you're also going to be offering, for example, the
5 testimony of -- and I'll probably mispronounce that -- but
6 she's not here so she won't know, Rebecca Baergen.
7 MS. SMITH: Yes, the trial transcripts of eight
8 witnesses who are listed there including Dr. Baergen.
9 THE COURT: Do you have those available?
10 MS. SMITH: I don't have them yet, Your Honor. As
11 we discussed at the pretrial conference, those are coming in
12 as we speak. Those trials are going on, and the eight
13 witnesses that the plaintiffs have offered should be
14 finished with their testimony by next Friday. All of those
15 should be in. We are getting -- this was a question I had
16 for Your Honor. We are getting dailies from those trials,
17 and so we could submit them to you piecemeal, or we could
18 submit them to you all in one fell swoop at the end of the
19 case here. All of those transcripts are coming in in toto
20 except for the transcript of Dr. Mitchell Creinin that we
21 discussed, we need to designate portions of because we just
22 designated it as rebuttal, and the defendants may have some
23 objections to some of our designations, but if Your Honor
24 would like to get them as they come in in the other two
25 cases, we'll certainly supply them that way, or we'll supply

1 them at the end of trial, whichever you would prefer.
2 The one difficulty with doing them before the end would
3 be that just the difficulty of getting all the exhibits.
4 THE COURT: Yeah. Let me suggest this to you by
5 procedurally.
6 MS. SMITH: Um-hm.
7 THE COURT: That you go ahead and make your offer,
8 and you will have identified it orally, and then when you
9 have all of the physical things ready to go, let's
10 separately mark them as exhibits and then identify them.
11 MS. SMITH: Okay.
12 THE COURT: At sometime during the process.
13 MS. SMITH: Okay.
14 THE COURT: So that we can match up your offer with
15 a specific exhibit, and that way no one will be -- at least,
16 that way I won't be confused. All right?
17 MS. SMITH: All right. Why don't I just make clear
18 for the record now, then, that we are moving into evidence
19 the depositions of Wan Kim, the 30(b)(6) depositions of
20 ACOG, APHA and AMWA.
21 THE COURT: Hold it. What was -- AMWA --
22 THE WITNESS: The American Medical Women's
23 Association.
24 THE COURT: Okay. I thought that's what you meant.
25 Go ahead.

1 THE WITNESS: The APHA is the American Public
2 Health Association. ACOG, you know. The trial transcripts
3 are for Dr. Rebecca Baergen, Dr. Steven Chasen, Cassing
4 Hammond, Carolyn Westhoff, Dr. Frederiksen's first name is
5 Marilyn, Marilyn Frederiksen, Dr. Maurine Paul from the San
6 Francisco case, Dr. Broekhuizen from the San Francisco case,
7 Dr. Mitchell Creinin from the San Francisco case, the first
8 five are from the New York case.
9 THE COURT: All right. So to reiterate, from the
10 two other trials, it's Drs. Westhoff, Paul, Hammond,
11 Frederiksen, Creinin, Chasen, Broekhuizen, Baergen; and the
12 depositions from this case of Wan Kim, the Government's
13 30(b)(6) designee, deposition of Alan Baker from the
14 American Public Health Association, the deposition of Meghan
15 Kissell from the American Medical Women's Association, the
16 deposition of Joanna Cain, once again 30(b)(6) deposition
17 from ACOG. Do I have those correctly?
18 MS. SMITH: That's right, Your Honor.
19 THE COURT: All right. At some point in time, I'll
20 ask you to visit with counsel for the defendant and the
21 courtroom deputy and assign plaintiffs' exhibit numbers to
22 each of those things, and then we should identify them on
23 the record.
24 MS. SMITH: Yes, sir.
25 THE COURT: All right. Now, we have gone over the

1 depositions and the trial transcripts from other cases.
2 Would you like an opportunity to check the exhibit list to
3 make certain that you think -- what you think is in evidence
4 is, in fact, in evidence?
5 MS. SMITH: Yes, Your Honor. I would love that
6 opportunity.
7 THE COURT: One of the questions, I suppose, is
8 where there are no objections, do you wish to have me simply
9 receive those in the pretrial conference order? Sometimes
10 lawyers have listed a whole lot of stuff. There is no
11 objection, but they decide they don't want something in, so
12 why don't we take a break here and we can come back. How
13 much time do you think you'll need?
14 MS. SMITH: Just five or ten minutes, Your Honor.
15 THE COURT: We'll take our normal 15-minute break.
16 Let me ask you, have you all worked on the question about
17 whether I am to read peer-reviewed journal articles from
18 Namibia or other places?
19 MS. SMITH: We spoke about it briefly this morning,
20 Your Honor, and I think the defendant's position remains
21 that these are hearsay documents; is that correct? I don't
22 want to characterize it.
23 MR. COPPOLINO: I think, and I understood this to
24 be the plaintiffs' position as well, but our view on the
25 articles is they are hearsay. There is no exception that

1 would permit them to be admitted for the truth content, that
2 the only exception would be the learned treatise exception
3 where they could be used with a witness and portions read.
4 If the issue is simply an issue of convenience of reference,
5 they are, the Court has them, and we don't think they need
6 to be admitted as exhibits for that.

7 THE COURT: Well, here, let me be entirely blunt
8 and candid with you. One of the arguments in this case has
9 to do with the degree to which I should defer to Congress.
10 Congress was presented with a lot of information, some of
11 which provided you, for example, a summary that I have done,
12 are peer review journal articles. Congress is not subject
13 to the hearsay rule. It can take anything it wants, no
14 matter how looney or no matter how thoughtful, so you have
15 that record.

16 Now, you're creating a record in a different place under
17 different rules. Doesn't make any difference to me. I'm
18 governed by the rules of evidence, and I don't care
19 particularly one way or another personally or as a judge
20 what's in the record or what isn't in the record. I only
21 point out that to the extent that the parties don't share in
22 the building of a good record. Well, I'll just be blunt. I
23 mean, what happens if I conclude that the Government relied
24 on a hearsay objection because it didn't want me to read an
25 article that would have contributed to the -- materially

1 contributed to the debate, or at least from the title of it?
2 What if I concluded the same thing from the plaintiff? I
3 mean, those are inferences that might or might not be
4 proper, but that's the circumstance that I want you to be
5 sure about. As I say, I don't care, and I understand why it
6 is you -- It's very difficult for lawyers to try to deal
7 with these things because you don't have a witness there,
8 you have not had an opportunity to depose them. You don't
9 know a lot of things, but understand that you're going to
10 have, in a sense, a mismatch in the way in which records are
11 -- the records upon which decisions are being made quite
12 differently, and that may help your side or hurt it. As
13 long as you've thought it through, I don't care, so I take
14 it you have thought it through.
15 MR. COPPOLINO: I'm perfectly willing to continue
16 to think it. If you feel a decision needs to be made today
17 and now, I'm not going to change my position, but we still
18 have a week to go, and I think the problem is that the shoes
19 are on both feet. I think there are articles that we would
20 submit that they would regard as suspect and would challenge
21 and vice versa, and some that are -- just simply haven't
22 been corroborated, and the best way to do that is to talk
23 with a witness about it who is an expert on the subject, so
24 I think that's kind of where we both may be on that.
25 THE COURT: I agree. I'm perfectly happy to

1 consider this again at some other time, but plaintiffs are
2 at the point where they need to rest, and, you know, this
3 being a nonjury case, we don't have to worry about Rule 50
4 motions. I mean, if you want to go ahead and make some
5 motions, I suppose you can, but it's not like I have got to
6 make a determination of whether the case goes to the jury,
7 but it is something that I think is worth a good deal of
8 thought, so thank you, counsel.
9 So my understanding is the plaintiff has now offered
10 into evidence the depositions and those transcripts. Is
11 there any objection?
12 MR. COPPOLINO: I would like to just make my
13 position on that clear, if I may, Your Honor. We do not
14 object to the submission of the designated portions of the
15 transcripts identified by the plaintiffs in the pretrial
16 order for ACOG, APHA and AMWA, and Mr. Kim. Those
17 designations are subject to two things: One, our counter-
18 designations which are also in the pretrial statement.
19 THE COURT: And I would intend to receive those as
20 well.
21 MR. COPPOLINO: Very well. And also, I believe
22 both sides have made objections to each others'
23 designations. We have designated abortion of ACOG
24 deposition as well, and I think there are objections there,
25 too, so there is no objection subject to the counter-

1 designations, the stated objections, and then hopefully
2 prior to the time the actual exhibit is prepared for the
3 Court, we can review objections and see if we would recede
4 on some or just indicate what those objections are in the
5 margin, and as you indicated at the pretrial, you could
6 consider your position on those objections as you read the
7 deposition, so subject, with that understanding, I have no
8 objection to the --
9 THE COURT: And my inclination is not to make a
10 separate ruling. If I don't write something either in the
11 form of a memorandum or write sustained on the deposition
12 transcript, it will simply be denied.
13 MR. COPPOLINO: The second important point to
14 qualify, though, is that in some instances, those
15 deposition designations refers to an exhibit to the
16 designation, and I believe the parties have listed the
17 exhibits that they would wish to offer separately on the
18 exhibit list, and we have stated objections to, for example,
19 the ACOG deposition. There is a raft of exhibits to which
20 we would object to the admission as independent exhibits, so
21 right now, my position is with reference solely to the
22 testimony portions of the deposition designations subject to
23 the counter-designations, and the objections to that, not to
24 exhibits though those designations which would have to come
25 in separately.

1 THE WITNESS: Had those exhibits -- and I don't
2 know what technique you use. Did you offer them -- did
3 anybody formally offer them in the deposition such that I
4 will have the offer in front of me?
5 MR. COPPOLINO: No, unfortunately, I think -- I
6 mean, I took the ACOG deposition, for example, and I think
7 that as is typical in the deposition, you simply placed the
8 exhibit in front of the witness. It's not actually offered
9 or moved into evidence.
10 THE COURT: Some people do it differently, and if
11 you think it's going to be a trial deposition, you can offer
12 it, and I don't know what your stipulations were, but I take
13 it that did not occur.
14 MR. COPPOLINO: It did not, and I can tell you that
15 with respect to the ACOG deposition, it would not have
16 occurred. They were not, the witness was not examined for
17 the purpose of us offering an exhibit for its truth content.
18 She was examined for the purpose of discussing why the
19 select task force looked at particular documents, but many
20 of those documents we would object to their admission for
21 the truth of the content.
22 THE COURT: All right. So I think, Mr. Coppolino,
23 what you just told me is that there are exhibits attached to
24 the deposition, you don't care if I look at the exhibits,
25 but they are not received for substantive purposes unless

1 counsel, plaintiff's counsel in this case stands up and
2 offers them or has otherwise identified them on the exhibit
3 list and there is no objection.
4 MR. COPPOLINO: I think that's exactly right
5 because I think for those exhibits, in particular, for ACOG,
6 there is an objection, and yes, you do need to receive the
7 exhibits so you can understand the deposition and the role
8 of those exhibits in connection with ACOG's analysis of
9 their policy statement. I think you put it exactly
10 correctly. They are not being offered. They have to be
11 offered separately in evidence subject to whatever
12 objections we have identified on the exhibit list here.
13 THE COURT: Okay.
14 MR. COPPOLINO: Thank you, Your Honor.
15 THE COURT: You're welcome.
16 MS. SMITH: Your Honor, in light of that, I will
17 offer those exhibits.
18 THE COURT: All the ones attached to the
19 deposition?
20 MS. SMITH: The ones attached to the deposition.
21 THE COURT: Have you separately identified them?
22 MS. SMITH: They have been identified on the
23 exhibit list, but if we have our 15-minute break, then I'll
24 be able to state clearly for the Court which ones those are
25 before I rest, if that's an appropriate procedure.

1 THE COURT: But counsel has had an opportunity
2 under Rule 26, you have made these --
3 MS. SMITH: They are all on the exhibit list and
4 they have listed their objections thereto, yeah.
5 THE COURT: So I need to think about whether I can
6 withhold ruling on that. I mean, I presume you don't think
7 I can rule on those now because I don't have the depositions
8 in front of me.
9 MS. SMITH: Exactly. From my perspective, you can
10 withhold ruling until you have the benefit of the color
11 coded copies of the deposition transcripts so you can review
12 the testimony and the exhibits at the same time and rule on
13 those objections as listed on the list. If that's an
14 appropriate procedure, that would be a way to proceed.
15 THE COURT: Is that all right with you, Mr.
16 Coppolino?
17 MR. COPPOLINO: Yes. I wasn't expecting we would
18 go through every one of them in court, and she would offer,
19 and I would say objection, and you would rule. The
20 objections listed on the exhibit list in the case of the
21 ACOG exhibits, they are all hearsay, and there is no
22 exception that will permit them to be admitted for the truth
23 content, and so, you know, in a objection, and as you look
24 at the exhibit, then I would assume that you would rule, but
25 if there is a need to discuss the substance of the objection

1 with respect to a particular exhibit, then perhaps we ought
2 to do that. Otherwise, on that one, we have identified the
3 objection hearsay in some cases.
4 THE COURT: Unless you all think there is something
5 in here that is unique and you want to argue it to me, no,
6 just submit it on the exhibit list.
7 MR. COPPOLINO: A relevance objection is one the
8 Court can judge on its own. A hearsay objection seems to
9 be, unless there is an exception shown by the offering
10 party, per se, exclusion, you couldn't consider it for its
11 truth content.
12 THE COURT: Well, okay. Now, then that brings use
13 to the interesting issue on the transcripts. If --
14 transcripts of trial.
15 MS. SMITH: Um-hm.
16 THE COURT: A witness is testifying, there is an
17 objection, the presiding judge --
18 MS. SMITH: Makes a ruling, yeah.
19 THE COURT: The presiding judge makes a ruling that
20 allows the testimony to come in. Do you want -- How do you
21 want -- What do you want to do? You want to offer it into
22 evidence the way in which either Judge Casey or Judge
23 Hamilton decided? Whatever they decided is all right with
24 you?
25 MS. SMITH: I believe that's what we had discussed

1 was that we would be subject to the evidentiary rulings made
2 by the two courts and would put the trial, would offer the
3 trial transcripts as they had come in in those courts. That
4 would include rulings on -- evidentiary rulings on exhibits
5 that were offered and to the extent that exhibits were
6 accepted into evidence, then we would offer them here
7 without objection to the Court.
8 THE COURT: That makes sense to me.
9 MS. SMITH: Makes sense to me, too.
10 THE COURT: But I could see you doing it the other
11 way, but Mr. Coppolino, do you have a view?
12 MR. COPPOLINO: Well, I'm not sure how much choice
13 we would have in the matter because if the Court, if the
14 other district judge has excluded evidence, then certainly
15 in the case where the other district judges excluded
16 evidence, if you disagreed with that ruling, there would be
17 no way to get the evidence now anyway.
18 THE COURT: Except if there was an offer of proof,
19 and you know, I just don't know, and if it regarded an
20 exhibit that you went through and laid all the foundation
21 for and the exhibit was offered but not received but the
22 Court maintained possession of it --
23 MR. COPPOLINO: I guess I'm kind of thinking about
24 this at the moment as we go, and if there was a, for
25 example, a hearsay or relevance objection that was overruled

1 and the evidence was received and as you read the
2 transcript, you perceive the matter to be either hearsay or
3 irrelevant, and the evidence should be excluded, I don't see
4 any reason why, since the transcript is in front of you, you
5 couldn't reach a different ruling on the matter as to
6 whether that evidence which was received should not have
7 been received or didn't have a proper evidentiary
8 foundation. I don't know why you shouldn't necessarily be
9 precluded from second guessing that. As I say, I'm kind of
10 thinking about it.
11 THE COURT: Except that I won't know whether you as
12 a lawyer would want to stand on that. I mean, there may be
13 perfectly good objections that a judge blows. I do it all
14 the time, and another lawyer says, you know, I like the
15 answer. I wouldn't have asserted the objection, and I won't
16 know that, so my sense is, just give it to me and I'll
17 accept it on face value unless I presume you're talking to
18 the folks in the other cases, unless something blows up that
19 is worth fighting about, then I'll just take it on the face
20 of the transcript.
21 MR. COPPOLINO: That may be the most sensible way
22 to leave it because I think when we all agreed to use the
23 file transcripts on both sides, we were basically putting
24 our trust in our colleagues to ask the right questions and
25 make the right objections. Now, if there was a major issue

1 of significance that affects the quality of the transcript,
2 an issue they lost or an issue we lost, and we think it's
3 material, then perhaps we can raise that with the Court
4 either at the time the exhibit is submitted or in the
5 pretrial (sic) brief.
6 THE COURT: I think that's fine. Let's do this.
7 Before, well, of course, you won't have -- Yeah, I think
8 that's fair. If something in these trial transcripts is
9 really a killer, you know, a real big problem, I'll give you
10 leave to assert the objection in your post-trial briefs, but
11 it's got to be something -- Well, you make whatever
12 objection you want, but just from a tactical point of view,
13 I wouldn't suggest that you would try my patience with a
14 whole bunch of foundational objections. Okay. All right.
15 Why don't we take our break then? You review the exhibit
16 list, and we'll come back and have you specify what
17 exhibits, if you haven't offered, that you want to offer,
18 and then we'll take the plaintiff's rest. I'll turn to Mr.
19 Coppolino and see if he has any motions to make. Otherwise
20 we'll take our recess and we'll start again on Monday. All
21 right. We'll stand in recess for 15 minutes.
22 (Recess from 3:27 to 3:47 p.m.; all parties present)
23 THE COURT: I want to check something here. Thank
24 you. Ms. Crepps?
25 MS. CREPPS: Yes, Your Honor. At this time we

1 would like to inform the Court of which exhibits to the
2 designated depositions that we would like to move into
3 evidence, and the defendant's objections to these, if they
4 have made them, are all on the exhibit list.
5 THE COURT: All right. Before we get to that,
6 pardon me for -- Are you satisfied that aside from those
7 that you're about to talk about, that all the exhibits that
8 you wanted to offer are in evidence?
9 MS. CREPPS: Yes, Your Honor. We have cross
10 checked the list, so the only remaining question is the two
11 learned treatise articles which are at this point not
12 admitted but which may be revisited.
13 THE COURT: Okay. Let me be specific. For
14 example. I want you to look at Plaintiff's Exhibit 40.
15 That is the Department of Justice's memorandum re: Partial
16 Birth Abortion Act of 2003 dated November 5 of 2003. There
17 was no objection made to that, but it was not independently
18 offered, I don't think.
19 MS. CREPPS: Your Honor, that's among the exhibits
20 that I would offer at this point. I have a list of exhibits
21 that are associated with the designated depositions that I
22 wanted to offer now.
23 THE COURT: All right. Okay. I just don't want to
24 be in a circumstance -- What I want you to do is
25 affirmatively offer any exhibit that you want in evidence

1 that has not been referred to during our trial today, even
2 if there is no objection listed on the exhibit list, so we
3 can make certain that there is no dispute about that.
4 MS. CREPPS: Yes, and I'm prepared to do that, Your
5 Honor.
6 THE COURT: Then you may proceed.
7 MS. CREPPS: Thank you. At this time the
8 plaintiffs would offer the following exhibits: Exhibit 3,
9 4, 5 --
10 THE COURT: Hang on just a minute, please. 3, 4
11 and 5.
12 MS. CREPPS: 6, 7, 8, 9, 10, 11, 14, 15, 16, 17,
13 18, Exhibit 40, Exhibit 42, 38.
14 THE COURT: 38 is defendant's document subpoena?
15 MS. CREPPS: Yes, Your Honor.
16 THE COURT: Okay.
17 MS. CREPPS: 39.
18 THE COURT: All right.
19 MS. CREPPS: And 83.
20 THE COURT: All right.
21 MS. CREPPS: And, Your Honor, I believe the record
22 is clear at this point, that there are the other outstanding
23 exhibits that would be associated with the trial testimony
24 from the other cases which I understand would be coming in
25 as a single exhibit attached to the -- it would be the trial

1 testimony and the relevant exhibits together as one
2 document.
3 THE COURT: Well, what I understood you all to
4 agree is that if an exhibit was offered during and received
5 during the trial, the other two trials, then that exhibit is
6 offered and received in this case subject, however, to a
7 later objection if you think it's a big deal, and we'll
8 resolve it in the trial briefs. That said, even though an
9 exhibit may be in that packet of materials simply because it
10 was identified with that witness but not received, while
11 that exhibit may be there, unless it's shown affirmatively
12 received by the judge in the other case, it's not received
13 in this case.
14 MS. CREPPS: That's my understanding. Just to
15 clarify, would you like us to then number those as
16 additional exhibits on our list, the ones that are received
17 in association with the trial testimony?
18 THE COURT: Well, I think you should.
19 MS. CREPPS: Okay.
20 THE COURT: So that the record is clear and you
21 might put a parenthetical designation. Hang on just a
22 minute. Pardon me. Go ahead.
23 MS. CREPPS: Your Honor, that's all that we have at
24 this point unless there are other questions about the
25 exhibits.

1 THE COURT: And with regard to the exhibits, some
2 of them that you've offered have objections, and it's your
3 joint request that I rule on those at some point.
4 MS. CREPPS: Yes, in the context of reviewing the
5 designations with the objections and the exhibits.
6 THE COURT: All right. Now, my law clerks and I
7 were talking during our break, and they are both a lot
8 smarter than I am, and one of them said to me, Judge, you
9 know -- those journal articles may not be relevant to prove
10 the truth of the matter asserted but rather be admissible
11 not to prove the truth of the matter asserted but rather
12 because, whether true or not, they describe a debate, and
13 that seems to me to have some force.
14 The Supreme Court, for example, made it clear that --
15 that a good faith medical debate is relevant even though one
16 might not be able, a judge might not be able to resolve that
17 good faith medical debate, so it seems to me that some of
18 these journal articles, many of them, as a matter of fact,
19 while not received for the truth of the matter asserted,
20 that is to say, to prove that the D & Es are safer than
21 inductions, that Grimes thought that D & E was safer than
22 induction may be relevant and not hearsay. What is your
23 thought on that?
24 MS. CREPPS: Your Honor, I do think that that is --
25 THE COURT: Well, it cuts both ways.

1 MS. CREPPS: I understand that, but I do think that
2 that is relevant to the issue of whether there is
3 substantial medical authority, and we would like to offer
4 the exhibits that we had previously offered on those
5 grounds. I think we are getting the numbers.
6 THE COURT: Well, but it's not simply those
7 exhibits because there is more than that you've offered that
8 weren't identified here. I think maybe I can help you,
9 counsel. If there is -- if you have offered an objection
10 and there is a hearsay objection, and it is a journal or
11 other like article, I understand you want me to consider it,
12 one, for the truth of the matter asserted, and if I won't do
13 that, you want me to consider it on the question of whether
14 there is a good faith medical debate. Is that right?
15 MS. CREPPS: Yes, Your Honor.
16 THE COURT: Okay.
17 MS. CREPPS: We would then be prepared to offer
18 additional exhibits at this point, Your Honor, but I think
19 Mr. Coppolino may want to address your point before we do
20 that.
21 THE COURT: Okay. Mr. Coppolino?
22 MR. COPPOLINO: The first point I just want to
23 address is on the exhibits, the initial set of exhibits Ms.
24 Crepps identified. Exhibits 40 and 42, there were no
25 objection to those. The other exhibits that she identified,

1 I believe, all had a hearsay objection.

2 THE COURT: At least.

3 MR. COPPOLINO: At least, and our position on that
4 is that first, we hold to that objection; and secondly,
5 absent a showing that there is an exception to the hearsay
6 rule, it couldn't come in, so my assumption is that, as Ms.
7 Crepps suggested, that post-trial briefing being the most
8 likely vehicle to identify an exception and counter-argument
9 on that, but as of this point, I take it that these exhibits
10 are being taken by the Court subject to the objection and
11 that the objection is not being ruled upon at this point.
12 Is that correct?

13 THE COURT: Well, as we stand at this moment,
14 that's right. Now, the question is what do you want me to
15 do? Do you want me to withhold ruling on all of these until
16 some later time? And if that's your desire, that's fine.

17 MR. COPPOLINO: Well, I think certainly with
18 respect to hearsay, the showing has to be made that an
19 exception exists, and so --

20 THE COURT: Except no showing needs to be made if
21 it's not hearsay. I mean, if definitionally, it's not, you
22 know, if they are offering it one to prove the truth of the
23 matter asserted, and two, if they lose that, they are
24 offering it not to prove the truth of the matter asserted
25 but to prove something else, then it's not hearsay.

1 MR. COPPOLINO: Right. On that point, first of
2 all, I think they would have to indicate the basis for the
3 exhibit being offered so that that's clear on the record.
4 Secondly, with respect to the point you made or the
5 observation you made with respect to the existence of a
6 medical debate, my response to that is that the existence of
7 a medical debate is a truth issue, and it seems to me that
8 an article could come in solely for the fact of its
9 existence, and I think we may end up at the same place. The
10 fact that, for example, David Grimes wrote an article in
11 1985 is a fact, and the fact that that article concluded it
12 had certain data about the relative safety of D & E
13 induction is a fact. It's not in for the truth, but it's in
14 for the fact that Mr. Grimes -- Dr. Grimes wrote the article
15 and the article concluded this, and so that since it's not
16 being offered for its truth content, it is not hearsay. I'm
17 more comfortable with that proposition than the proposition
18 that the articles are being offered to prove the existence
19 of a debate which is itself a factual issue in dispute, and
20 therefore, in my view, that offer of existence goes to
21 truth.
22 THE COURT: Well --
23 MR. COPPOLINO: As I say, if it's offered for the
24 fact that it's existing, then I think you may get to the
25 same place. To say that it shows that there is a debate, it

1 seems to me goes beyond the mere fact that the article
2 exists.
3 THE COURT: Well -- well, I think we're -- although
4 perhaps you are -- I think we're talking about the same
5 thing. The fact that an article exists may be offered, and
6 in that sense it's not hearsay.
7 MR. COPPOLINO: I agree with that.
8 THE COURT: But it's not relevant either simply
9 because it exists. It only becomes relevant, it seems to
10 me, if the existence of that fact goes, makes it more likely
11 than not that something relevant exists or does not exist,
12 and the something relevant here is potentially a debate, and
13 that's how -- that's how I could see it argued.
14 MR. COPPOLINO: I think that's a truth issue,
15 Judge. That's the way I perceive it, and I grant you I
16 might be perhaps being overly formalistic, but the reason
17 for that is that there are enormous numbers of articles with
18 enormous numbers of conclusions that haven't been tested. I
19 think it's fair to say on both sides we regard some of these
20 articles as quite poor. We have seen in this area of law,
21 and in others, particularly at the appellate level, district
22 courts don't tend to do this. District courts tend to
23 follow a little more strictly, but we have seen articles and
24 law review articles and such put in, even at appellate
25 levels, where they have not been tested or cross-examined.

1 There is no probative value to them. They have been relied
2 on.
3 THE COURT: Even in Congress.
4 MR. COPPOLINO: Yes, but --
5 THE COURT: And I'm not being cute with you. That
6 is a perfectly legitimate point.
7 MR. COPPOLINO: I agree. If the Congressional
8 material is inserted for the truth of the matter asserted
9 and not subject to any opportunity under the rules of
10 evidence to examine that, that is a problem as well, and we
11 so indicated in our exhibit list.
12 THE COURT: But it seems to me when we start
13 getting into peer-reviewed journal articles, that concern
14 becomes less so. I mean, a letter written by a physician
15 offered by the plaintiffs may well be so inherently
16 unreliable because for the reasons that you indicated that I
17 ought not to receive it, not because its hearsay, not
18 because the subject it addresses is not relevant but because
19 we question, without the writer of it, his foundation to
20 engage in a good faith medical debate.
21 MR. COPPOLINO: Yes, but, Your Honor, I don't think
22 that reliability, even if one would assume for the moment
23 that a peer-reviewed article has a greater indicia of
24 reliability than a letter to a Congressman, I don't think
25 reliability by itself renders any type of exception to

1 hearsay, and I'm not suggesting you're saying that, but I
2 think -- when you consider the learned treatise exception,
3 most of that applies to highly reliable materials, and yet
4 even for that, the rules require that the treatise itself
5 cannot be admitted, but it can be discussed by an expert who
6 can then be cross-examined on precisely that point regarding
7 the contents of that material.
8 THE COURT: Of course, the purpose of that has
9 nothing to do with a bench-tried case, but that aside, your
10 point is, Judge, just simply because somebody said it
11 doesn't mean there is a good faith medical dispute, and that
12 may also be true even if it's in some peer-reviewed medical
13 journal because, Judge, you don't know the degree to which
14 that medical journal might not be just some reflection of
15 some oddballs, and you can create all sorts of debate by
16 simply offering stuff. We have the internet. Create all we
17 want on the internet, and that doesn't mean the debate is
18 genuine. I understand that point. Some of these articles,
19 however, I think are, on their face, it would be difficult
20 to make that argument. I mean, they may be entirely wrong,
21 but in any event --
22 MR. COPPOLINO: It also goes to somewhat, what is
23 the purpose of the article being received for? If you
24 assume, if you even accept the idea that it would be
25 received for the purpose of showing a debate, at that point,

1 what is the status of the contents of the article? I can
2 give you an example. There are articles, I'm pretty sure,
3 on our list on the issue of pre-term birth. There is an
4 article which says based on whatever population sample it
5 reviewed, that they don't see a particular problem, and then
6 there is another article that says that reviewing numerous
7 studies would suggest that there is a particular problem, a
8 different expert will address both of those.
9 You could put those articles side-by-side and say, well,
10 there seems to be a bit of a difference of opinion here.
11 There is a debate here, and if the articles were in for the
12 fact of their existence, one could infer that there is a
13 difference of opinion on this topic that some doctors think
14 there is no problem with pre-term birth, subsequent pre-term
15 birth, and others do, but if they are in for more than that,
16 then the finder of fact, when the appellate courts could
17 then look at the content of the article and say, well, that
18 study seems to be better than that study, so we are going to
19 rely on that study for its truth content. That's what I
20 need to avoid here.
21 THE COURT: Oh, and I think that's fair. I mean, I
22 don't -- there is a study here that, what, compares
23 inductions with D & Es.
24 MR. COPPOLINO: Right, the Autry article, and I
25 think that might have come up with one of the witnesses.

1 THE COURT: Yeah. I mean, as a mechanical matter,
2 if I were to receive that for, quote, debate, I could not
3 write an opinion and conclude, based on that article, that D
4 & Es were safer than induction because the article wasn't
5 received for that purpose. I could only say, at most, the
6 article may indicate that there is a good faith medical
7 dispute about that issue. I take it that is your point.
8 Now, you worry that some appellate judge may say, okay,
9 this is in the record. Here are all these numbers. That
10 proves that D & Es are safer than inductions. That is a
11 risk, but I suppose I can't, as much as I would like to,
12 tell the appellate judges how to review the record.
13 MR. COPPOLINO: But I think where I come out on
14 this, Your Honor, is that if you have before you in the
15 record two articles or several articles which are in just
16 for the fact of their existence, not their truth content,
17 which is the formulation I would suggest is the proper
18 formulation under the rules, and the one that I could
19 certainly not object to, then I think that whether or not
20 they demonstrate the existence of the debate is something
21 for the Court to conclude on its own rather than for us to
22 say this is evidence submitted for the purpose of showing a
23 debate because from the plaintiffs' standpoint, based on the
24 Supreme Court ruling in Stenberg, they find some legal
25 significance to the notion that if there is a debate and

1 difference of opinion on the issue of partial birth abortion
2 that cuts in favor of them legally, so as a matter of law
3 they may argue that so long as there is any debate then they
4 prevail. We don't agree with that I'm not sure they are
5 actually going to argue that, but that is something I have
6 seen pasted on some language Justice Breyer has in that
7 Stenberg opinion. Therefore, that really precludes me from
8 saying I can agree to something being admitted to prove a
9 very legal point that they want proven, and that's my
10 hesitation, and that's why I would object to that.
11 Now, if you put in two articles on pre-term birth or
12 whatever, induction versus D & E, and you hear testimony on
13 that, and then if the Court concludes that there is a
14 difference of opinion, that's different. That's a finding
15 by the Court based on facts, not based on something that has
16 any evidentiary, independent evidentiary value.
17 THE COURT: I don't think you and I are saying
18 anything different, but I understand your concern. If your
19 concern is that by admitting it, I'm making a Rule 104
20 determination of preliminary determination that there is, in
21 fact, a debate, then I can understand you being concerned
22 about that.
23 MR. COPPOLINO: If that's a conclusion you draw
24 from the evidence and the evidence of facts include the
25 existence of articles that express different points of view,

1 then, and without crediting the truth content of those
2 articles, you simply observe as a factual matter, there are
3 people that have different opinions in these journal
4 articles, then that's a factual finding by the Court based
5 on facts. It's not something that we would, that the
6 evidence would be offered for a particular purpose beyond
7 the fact of its existence and certainly not for its truth
8 content.
9 THE COURT: I don't think that I disagree with you.
10 I think the existence of the article, to the extent that it
11 shows disagreement on its face, does not show that -- does
12 not necessarily prove as a legal matter that there is
13 disagreement or that the disagreement is relevant or
14 important.
15 MR. COPPOLINO: Taking the Autry article as an
16 example, before the trial concluded, you're going to hear
17 criticism of that article and its methodology. For that
18 reason, there is no denying the fact the article exists and
19 others that may encounter it exist. Your conclusion of your
20 factual findings on that subject would take into account the
21 testimony, the existence of a study and what the experts
22 have said about that study. What it would not do, however,
23 is simply accept that study in for any kind of truth content
24 or any other evidentiary purpose such as proof of the
25 existence of a debate because proof of the existence of a

1 debate is something they want to prove. They have made that
2 very clear, and in their pretrial brief, among the things
3 that they want to prove to you is not only that they are
4 right on the medical issues, but that there is a difference
5 of opinion on the medical issues, and that's a fairly easy
6 thing to prove since you have got one slate of witnesses one
7 week disagreeing with the witnesses coming the next week.
8 Afortiorari, you have a difference of opinion, and that's
9 why I'm reluctant to agree to something going to a proof of
10 a matter of something that they want to prove.
11 THE COURT: I think the dissents in the first case
12 made it clear their concern that you can create a debate
13 about anything and that if that's the test, well, then hell,
14 you can't regulate anything.
15 MR. COPPOLINO: I think that's right, and I'm
16 highly skeptical that the ultimate resolution of the case is
17 going -- that the Supreme Court is going to be a difference
18 of opinion. I think the substantial medical authority means
19 something other than people disagree. I think that there is
20 an absence of unanimity, but that is obviously something we
21 will see if the Court gets this case and then says, well, we
22 are just simply going to go with this difference of opinion
23 as the new legal standard for regulating an abortion
24 practice, then that will be the outcome, but for purposes of
25 admission of evidence, I think we have to stick with the

1 basic rules. If it's offered for truth content, it can't
2 come in. If it's offered for its factual existence and not
3 for truth content so the Court would just observe there is
4 this article, and this article says this, I think that's not
5 hearsay, and I have done it myself. I said, well, I'm not
6 offering something for truth content. And to double back to
7 the ACOG exhibits, just to give you an example, I think that
8 those articles, those exhibits to that deposition can and
9 should come in as fact exhibits, because I would intend to
10 show, look at the kinds of things that this select panel
11 relied on.
12 Now, one of them is the ACOG statement itself which is
13 separate. I think that's just clear hearsay; but secondly,
14 the various things that that panel relied on, we laid out in
15 that record everything that they produced that was before
16 the panel, and it was various and sundry materials from NAF,
17 NARAL. They had some stuff on the other side. They had
18 summaries of the executive of the Congressional Record and
19 so on, and the point of that is to simply say, look, as a
20 factual matter what they have got, and then you can comment
21 on that as you see fit, and I will comment on what I -- on
22 the adequacy of the evidence that ACOG had before it without
23 giving away my hand, but that's why that is in there. It's
24 to show what the ACOG select panel had before it, and that
25 was the only reason it was in there.

1 THE COURT: Or the lack of what it had.
2 MR. COPPOLINO: Exactly, or the lack of evidence to
3 judge the medical issues in conjunction with facts that we
4 elicited from the witness regarding those deliberations.
5 THE COURT: Um-hm.
6 MR. COPPOLINO: So that is their fact exhibits is
7 what I'm trying to say. If offered as fact exhibits, there
8 would not be an objection. I intend to cite them as fact
9 exhibits, but if offered for truth content, we clearly would
10 object because there is a number of things in there that are
11 from advocacy groups that are, you know, clearly matters
12 that would be contested, and that's why they shouldn't come
13 in for their truth content.
14 THE COURT: Well, let me suggest that you're going
15 to have to help me figure out a way to resolve these issues
16 mechanically.
17 MR. COPPOLINO: I was thinking about that.
18 THE COURT: And I'm perfectly willing, it's -- I'll
19 be around here tomorrow. I don't know when you all are
20 leaving.
21 MR. COPPOLINO: We are here through the weekend,
22 but I think we may need to think a little harder than maybe
23 give you an answer tomorrow because, for example, if the
24 plaintiffs were to offer these, and let's just take the ACOG
25 deposition exhibits, as I have been saying, I think they

1 have to try to show some hearsay exception, and then the
2 question is mechanically, how do we get that before the
3 Court in conjunction with the submission of the evidence,
4 because we would need an opportunity to comment on that as
5 well, you know. I would like to think about it, Your Honor,
6 because in some cases, I have had -- The logistical way you
7 do that is you just have a separate day where you set aside
8 to discuss evidentiary objections that you want the Court to
9 rule on. As I say, a matter of relevancy and foundation is
10 not something the judge can decide, but hearsay and whether
11 there is an exception is often something that turns on
12 issues of law and argument.
13 THE COURT: Well, yeah, and I can understand why
14 you would want me to understand very clearly if I'm going to
15 admit something on a limited basis that I articulate what
16 the limitation is, both so that other people can be made
17 aware of that limitation and so I'm reminded of it.
18 MR. COPPOLINO: Right, and another example would be
19 the ACOG policy statement itself which they may seek to
20 admit as a business record. That's obviously an issue we
21 would contest and maybe even something you would need some
22 briefing on, hopefully limited briefing, but that's another
23 example of does that exception apply to that particular
24 document, and there has to be something that applies to that
25 particular document or else it has to be admitted for a

1 limited purpose, and really, the most obvious limited
2 purpose is the fact of its existence. Thank you.
3 THE COURT: You're welcome.
4 MS. SMITH: Your Honor, just a few brief points.
5 Using the ACOG exhibits as an example, I think they are not
6 being offered for their truth. They are being offered for
7 the fact that that is the position of ACOG, and that's
8 relevant to the issue of whether there is not just a
9 disagreement, of course, any disagreement would not be --
10 rise to the Supreme Court standard that it set in Stenberg.
11 But if there is a significant body of medical opinion and
12 where that significant body of medical opinion holds that a
13 procedure is safer, and as the Court said, where that
14 opinion is supported by logical, rational testimony as it
15 was in the Stenberg case, then that's what the Court is
16 looking for, and I think that's what this Court would be
17 looking for in this case, not just any old two people, you
18 know, they say one thing, we say another, but is there a
19 significant body saying it's safer and a significant body
20 that's supportable in some way, and so the ACOG exhibits
21 come in as not for the truth of the matter therein because,
22 of course, that's the heart of the issue this Court is
23 deciding.
24 Is it sometimes safer? But really for the fact that
25 that's ACOG's position, and who is ACOG? And you'll read

1 that deposition, you'll read what they relied on. You know
2 my opponent here has characterized ACOG's process. I would
3 characterize it somewhat differently. The Court, of course,
4 will read that deposition and see for itself what that
5 process was and what it was reliable and whether that is
6 something valid and stands by itself or with other opinions
7 as part of a significant body or not, and that is what we
8 would offer it for.
9 I think it's also perhaps relevant to the issue of what
10 Congress turned its back on. It's one of the things that
11 Congress had in front of it and seems to have disregarded.
12 THE COURT: Well, as a practical matter, the ACOG
13 statement is going to be in evidence in the Congressional
14 Record.
15 MS. SMITH: Through the Congressional Record,
16 that's right, so anyway, so those are the things.
17 THE COURT: I'm a whole lot less concerned about
18 dealing with the ACOG statement --
19 MS. SMITH: Right.
20 THE COURT: -- as I'm concerned about journal
21 articles that you offer that, to my way of thinking, are
22 obviously hearsay.
23 MS. SMITH: Right.
24 THE COURT: And cannot be received for the truth of
25 the matter asserted, but may have some independent relevance

1 either as I, in sort of a shorthand way, put it in respect
2 to the question on the debate or, as counsel for the
3 defendant said, they may be relevant simply because of their
4 existence. The question of whether there is a debate is
5 something the Court itself must resolve at the beginning of
6 the trial, not in some back-handed Rule 104 way.
7 MS. SMITH: Right. As a practical matter, Your
8 Honor, I think it would be helpful to do some briefing on
9 these issues, perhaps in this post-trial briefing if Your
10 Honor was amenable to that. I think we had a suggestion of
11 doing that previously, and that certainly would be fine with
12 us.
13 THE COURT: What I would like you to do, and I
14 would like you and Mr. Coppolino or your colleagues, Mr.
15 Coppolino's colleagues to sit down, and I don't expect you
16 to agree on the evidentiary rulings, but why don't you put
17 together a process that you think is fair and not too labor
18 intensive for me, and I don't care how labor intensive it is
19 for you, and then propose that, and if it's sensible, then
20 I'm happy to adopt it.
21 MS. SMITH: Okay. Okay. Your Honor, at this time
22 I would just like to preserve my ability to offer some
23 exhibits into evidence as well that I think my colleague
24 hadn't mentioned. Plaintiff's Exhibit 19, 44 and 45 which
25 were the learned treatises that you sustained an objection

1 to before, and I would just renew my motion now as we are
2 discussing this issue again, subject to this further
3 briefing and consideration by the Court and by the parties.
4 THE COURT: 19, 44?
5 MS. SMITH: And 45.
6 THE COURT: Okay.
7 MS. SMITH: And also, Your Honor --
8 THE COURT: And you're offering them both to prove
9 the truth of the matter asserted, and if not to prove the
10 truth of the matter asserted, you believe they are relevant
11 and not hearsay because they relate to the question of
12 whether there is a substantial body of medical opinion
13 joining an issue.
14 MS. SMITH: That's right, Your Honor, and I think
15 also there is --
16 THE COURT: Disagreement on issue.
17 MS. SMITH: Yes, whether there is a substantial
18 body of medical opinion, and whether there is a disagreement
19 and if there is a disagreement as, the Court said in
20 Carhart, the tie goes to the runner, as it were.
21 I would also offer Plaintiff's Exhibit 25, 26, 27, 28,
22 30, 64 -- sorry, going too fast. 25, 26, 27, 28, 30, 64 and
23 Plaintiff's Exhibit 110, all as evidence of this, not for
24 the truth -- well, for the truth, Your Honor, but then if
25 not for the truth, for the limited reason that they are

1 relevant to whether there is a substantial body of medical
2 opinion supporting the fact that the banned procedures are
3 sometimes the safest.
4 THE COURT: Thank you.
5 MS. SMITH: Thank you.
6 THE COURT: And I take it that you're happy to have
7 me resolve those additional exhibits as well pursuant to
8 this agreed process?
9 MS. SMITH: Exactly.
10 THE COURT: That you're going to try to enter into
11 a treaty with the Government on.
12 MS. SMITH: Exactly, Your Honor, and at that point,
13 then, plaintiffs will rest their case.
14 THE COURT: All right.
15 MS. SMITH: Thank you.
16 THE COURT: In other words, you've rested -- Well,
17 you've rested. You haven't reserved your rest?
18 MS. SMITH: Except for rebuttal time, Your Honor.
19 THE COURT: Yeah. Yeah. Okay. All right. Okay.
20 I'm going to want you to remind me at the end of the trial
21 what your agreement is about these exhibits, how you want me
22 to handle them because I don't want you leaving. I'll want
23 to put a briefing order, I will -- Pardon me. I'll want you
24 to bring this up so that at the end of the trial so that I
25 can issue a briefing order that addresses how you're going

1 to address these exhibit issues so that you have something
2 at the end of the trial.
3 MS. SMITH: Thank you, Your Honor.
4 THE COURT: My law clerk advises me that Dr.
5 Carhart's CV has been variously referred to as Exhibit 111
6 for which there is no designation on the exhibit list, and
7 it also appears as Exhibit 84, and she also advises me that
8 Plaintiff's Exhibit 111 bearing -- I apparently have the
9 original CV, and it does bear Exhibit 111.
10 MS. SMITH: Yes, Your Honor. We brought a
11 corrected copy of the CV with us today and added it to the
12 end of the exhibit list with defendant's permission.
13 THE COURT: So you want us to add another
14 designation.
15 MS. SMITH: As Plaintiff's Exhibit 111, and we
16 would withdraw the previous exhibit.
17 THE COURT: And I have previously received 111.
18 MS. SMITH: Yes, Your Honor.
19 THE COURT: All right.
20 MS. SMITH: Thank you. Ms. Rempe? Are you
21 satisfied now? Thank you. Is there anything further we
22 should take up at this time? All right. We'll see you back
23 here on Monday. We stand in recess.
24 (Recess at 4:26 p.m.)
25 C E R T I F I C A T E

1 I, David C. Francis, certify that the foregoing is an
2 accurate transcription of the record of proceedings made in
3 the above-entitled matter.
4 s/ David C. Francis DATE: April 1, 2004
5 Registered Merit Reporter (Ret)
6 INDEX
7 PLAINTIFFS' WITNESSES:

8 Dr. LeRoy Carhart Direct by Ms. Smith........582
Cross by Mr. Coppolino.....644
9 Examination by Court.......727
Redirect by Ms. Smith......743
10
Discussion of evidentiary matters.....................750
11 Plaintiff rests.......................................787

12 EXHIBITS:

			Offered	Received
13				
14	3.	ACOG "Statement"	766	Withheld
15	4.	ACOG "On Subject"	766	Withheld
16	5.	ACOG Statement of Policy	766	Withheld
17	6.	ACOG Statement of Policy	766	Withheld
18	7.	ACOG "Fact Sheet"	766	Withheld
19	8.	ACOG "Meeting Agenda"	766	Withheld
20	9.	ACOG Technical Bulletin 109	766	Withheld
21	10.	ACOG "Task Force Report"	766	Withheld
22	11.	ACOG Frigoletto Memorandum	766	Withheld
23	14.	AMWA letter to Nadler	766	Withheld
24	15.	AMWA letter to Chabot	766	Withheld
25	16.	AMWA's response to subpoena	766	Withheld

1 17. APHA letter to House of Reps. 766 Withheld

2 18. APHA Attachment A 766 Withheld

3 19. Amy Autry August 2, 2002, article 785 Withheld

4 25. Chasen article, draft one 786 Withheld

5 26. Chasen article, draft two 786 Withheld

6 27. Chasen article 786 Withheld

7 28. Chasen: Chart representing data 786 Withheld

8 30. Cornell University letter to Chasen 766 Withheld

9 38. Defendant's subpoena of AMWA docs. 766 Withheld

10 39. DOJ letter from Henry to Edelman 766 Withheld

11 40. DOJ Memo re: Implementation of Act 766 Withheld

12 42. FBI Memo re Civil Rights Program 766 Withheld

13 44. David Grimes article 785 Withheld

14 45. David Grimes & Schulz article 785 Withheld

15 64. McMahon article 786 Withheld

16 83. Dr. Joanna Cain's CV 786 Withheld

17 110. Elchlal article 786 Withheld

18 111. Dr. Carhart's CV 583 583

19

20

21

22

23

24

25