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LAW CLERK: Lane, lane, WOL WOL, WOL WOL WOL, WOL WOL name, pan pan, pan pan pan, pan pan name.

THE DEPUTY CLERK: Mrs. Ready?

MR. HUT: Mrs. Are ready, sir.

THE DEPUTY CLERK: Defense ready?

MS. GOWAN: Defendants are ready.

THE DEPUTY CLERK: Counsel, please identify yourself for the record.

MR. HUT: For the plaintiffs, your Honor, Stephen H*UT, will PHER TKUT letter and pickering, with me are four colleagues whom I will ask to rise and introduce themselves to the court,.

Park park name, for the plaintiff. Good morning, your Honor,.

MS. STERNBERG: from the A C L RUFPLT reproductive freedom project pore the plaintiffs.

THE COURT: Good morning to you all.

MS. CHAITEN: From the bald bald foundation of A C L U of little ill for the plaintiffs.

THE COURT: Anybody else?

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MS. GOWAN: Good morning, your Honor, TKPWO*U TKPWO*U TKPWO*U on behalf of the defendant.

MR. LANE: Good morning, your Honor, SA*UPB Lane.

MS. WOLSTEIN: Good morning, your Honor. Elizabeth Wolstein for PAB pan name, good morning, your Honor, I think.

THE COURT: Good morning. I think you are outnumbered.

Just a few housekeeping matters. To the good people in the jury box, I believe the marshals have explained to you that you are welcome to utilize that space as and chairs as long as I understand it the request was it will help you to hear and see what is going on.

However, I will not tolerate any disruption of the proceeding or interference with the lawyers, therefore I think it's been explained to you the ground rules are once you're in, you stay there until there is a break in the proceedings. There will be no leaving, coming and going while the proceeding is going on.

And I would appreciate it if you would respect that. Otherwise we will have to change our format for dealing with things.

Also, I understand from a fax counsel from the New York -- I never can get the title straight, New York presi Presbyterian hospital or whatever the title is of the hospital, they're taking appeal with the communication to me does not

indicate whether they are asking for an expedited appeal or not. It is very vague on that question and I hope Ms. Go go you will check that out because I ordered the records produced, so if they're pursuing another route we should know about it, whether any stay has been issued with with regard to production.

MS. GOWAN: Your Honor,s this Ms. Gowan, may in.

THE COURT: Yes.

MS. GOWAN: We learned yesterday afternoon at approximately 9:30 Friday night New York Presbyterian had filed a notice of appeal of your Honor's order enforcing the subpoena and also of your Honor's order of Friday night requiring the production of the documents by noon today.

Counsel for Presbyterian told me that they were planning to seek a stay and an expedited hearing.

He advised that the government would be served with papers this morning by either 9:00 or 10:00. So far I'm not aware that we've been served with any papers.

We did call the Second Circuit motions clerk about half an hour, 45 minutes ago and were advised that no papers had yet been filed in the Second Circuit by the New York Presbyterian hospital.

THE COURT: I would appreciate it if you would keep the Court apprised of whatever is happening there.

All right, is there any other matter that any counsel



wishes to be heard on before we get under way?

MR. HUT: Nothing from the plaintiffs, your Honor.

MS. GOWAN: No, your Honor.

THE COURT: Mr. H*UT, you may make your opening statement,? You are going to present it.

MR. HUT: Thank you, your.

THE COURT: Will it be you Mr. H*UT.

MR. HUT: It will. Thank you, your Honor.

THE COURT: All right.

MR. HUT: May it please the court. This is an action for burglary tore and injunctive relief to set aside as unconstitutional the federal partial birth abortion ban act of 2003 which I shall refer to as the Act.

As your Honor knows, the act imposes criminal penalties, including two years in prison and a fine of up to $250,000 for each violation. The plaintiffs before you, your Honor, include the national abortion federation or NAF. NAF is a professional association comprising doctors and clinics representing the principal providers of abortion services throughout the country. Its members provide more than half of the induced abortions in the country.

In the courtroom today is NAF's executive director, SR*By supporta.

Also bringing the action as plaintiffs are seven doctors who perform abortions, three from New York City and

others from upstate from New Jersey, from Michigan and from Illinois.

The plaintiff doctors are all experienced obstetrician gynecologists. In addition to being experienced clinicians plaintiffs number among them professors at the nation's leading medical schools including Columbia, Cornell, University of Michigan and northwestern, and they treat patients at the areas and at the nations foremost hospitals including New York Presbyterian, St. Luke's Roosevelt. University hospital of Ann Arbor, university hospital of University of medicine and den TEU TEUS TREU in New Jersey and northwestern memorial in Chicago.

Plaintiffs here seek an injunction in order to forestall the threat of criminal prosecution and they seek an injunction as well to secure for their patients the right to reproductive freedom and to the best medical care that they seek to determinate a pregnancy.

Plaintiffs believe, and we will prove that the Act suffers from four defects, each of which alone renders it unconstitutional.

First, the act lacks a health exception despite the clear mandate of the Supreme Court of the United States in ST*EPBberg versus Car heart.

As this Court spelled out the STEPBberg standard, in its own March 17th 2004 order on summary judgment, a health



exception is required when there are responsible differences among, "highly qualified knowledgeable experts on both sides of the issue" such that the Court determines that "a significant body of medical opinion believes a procedure may bring with it greater safety for some patients and explains the medical reasons supporting that view."

Second, the Act uses terms like partial birth abortion which, as the Court observed in its March 17th memorandum opinion and order is not a precise term. It uses other terms that have no medical meaning and it is otherwise hopelessly unclear in defining the conduct that is prohibited.

The act is therefore unconstitutionally vague for it fails to give practitioners sufficient notice of prohibited conduct.

Third, to the extent the Act can be understood it puts doctors at risk for performing dilation and eSRABG situation, otherwise called D and E, of all types.

As the Supreme Court noted in ST*EPBberg, D and E is by far the most commonly performed abortion procedure in the second or midTREU moster of pregnancy.

The Act's prohibition reaches as well inductions, the only other relatively commonly used abortion method during the second tri-moster and the act reaches these procedures whether used for induced abortions or to treat spontaneous abortion which is otherwise called mis carriage.

Now, notwithstanding the arguments of some of the Act's proponents, the language Congress actually used in its definition of what is prohibited cannot be read as confined to any one specifically identifiable procedure. As a result, the ban imposes an undue burden on a woman's right to reproductive autonomy and it is therefore unconstitutional under the Supreme Court's holdings in planned parent hood versus Casey and under ST*EPBberg.

Finally, the Act is unconstitutional because it fails to serve either of the only two governmental interests that the Supreme Court V casey case said restriction on abortion could serve. It serves neither the interests in promoting internal health, nor the interest of preserving fetal life at a time when the fetus could survive outside the woman, nor does it serve any other legitimate state interest.

Now, before I turn to the evidence that the plaintiffs will present to your Honor I want to take a moment to back away and to characterize the evidence and to provide something in the nature of fair warning about it to the Court, to the courtroom staff and clerks and to visitors in the courtroom.

Much of the evidence that you will hear is the stuff of the practice of medicine. Terms used are technical and precise and their technical meaning is not always self-evident. This case may not involve rocket science but it surely involves medical science. We have asked our experts who will be



testifying here to use simple language but doctors sometimes lapse into the language of their medical training, it is the nature of the beast.

We will try to be vigilant about asking them to explain their meaning had they do that but I also urge the Court to interrupt the witnesses with requests if they or we assume an understanding of a term that may not be obvious or indeed for any other reason.

Moreover, and no less importantly, as with description of any invasive surgery, and this is what this case is about, the testimony presented will involve often graphic description of trauma to body, bleeding and other similarly offputting details.

In a word, much of the evidence that you will hear is very raw stuff. It is, at a minimum discomforting, at least to most of us who have not dealt with it extensively as doctors or students of medicine. Descriptions of surgery and surgical procedures are not for the faint of heart and these descriptions become, frankly, more problematic and I say this to the Court by way of con TP-GS more than anything else for men given our lack of instincttive familiarity with the originalians of the female anatomy that are affected by the procedures at issue.

And finally, and I say this candidly, the fact that these graphic and raw surgical procedures are performed on

second try moster human fetuses adds an element of emotion that may make the testimony even more difficult.

Now, if the Court please, let me turn to what we expect to show the Court by our evidence.

In plaintiff's case the Court will hear from up to 12 physicians who we expect to testify live and depending on subsequent rulings that the Court may make, from one to three additional doctors who will testify by deposition. These witnesses are extraordinarily well credentialed, highly qualified and knowledgeable physicians. They include certain of the plaintiffs, doctors like Dr. Westhoff W-S who is professor of object tech strict and gain KOL can I at Columbia, Dr. Cassing Hammond who is assistant professor of obstetrics and gynecology at northwestern University hospital in Chicago. Dr. Steven chasten who is Dr. of high risk obstetric at New York Presbyterian and associate professor at Wile Cornell medical college; Dr. Mark Evans who is professor of obstetrics and gynecology at Columbia and director of the institute for genetics and fetal medicine at St. Luke's Roosevelt hospital; Dr. Gerson Weiss who is professor an chair of department of obstetrics and gynecology women's hell at New Jersey medical school and Dr. Timly John WHOB who shares object object and gynecologist at University of Michigan and who also was the Court appointed expert in the case tried in Michigan concerning that state's partial birth abortion ban.



Plaintiffs' witnesses also include experienced maternal fetal medicine specialists and abortion providers like Dr. Am as groan aba who teaches at Cornell and practices at New York Wile Cornell medical center. Dr. Marlin Fred wicks internal fetal medicine specialist and former section head of general obstetric an gynecology at northern University medical school and who teaches at northwestern and provides medical services in private practice.

And Dr. Daniel SK*UP ski who is associate director of maternal fetal medicine at New York Wile Cornell medical center and director of internal fetal medicine as well as associate chair of the department of obstetrics and gynecology at New York hospital of Queens.

These plaintiffs witness -- andness a critical TEUS din shun between our witnesses and the governments -- actually do perform or have performed second tri moster induced abortions on a regular basis. They actually do perform dilation and evaluations or D and Es the procedure affected by this ban or have done so in the past.

For example, Dr. Westhoff personally performs or supervises about 30 D and E procedures each year SKHRUG approximately 10 to 20 using the intact D and E variation and she has performed abortions for over 20 yearsment.

Dr. Frederickson currently performs approximately 100 to 125 abortions per year and she has performed hundreds of

second TREU moster abortions many of which involve the D and E procedure.

Dr. Chaseen performs approximately 50 D and Es a year and he has performed between 300 and 400 D and E procedures a year in his life time.

By contrast the OB/GYN's the government intends to call of lows Dr. HRO*BG wood has never performed an abortion where the plaintiff was not already in prose says of spontaneous abortion or miscare rath. In his whole 35 year career defendants Dr. Strang has only performed D and E in the second TREU moster a few times.

Similarly during his 45or medical career from which he retired five years ago defendants Dr. Bows has performed abortions only where spontaneous abortion or miscare rath had already begun and these included only approximately four to six second TREU moster abortions in his career and only two to three D and Es.

Finally defendants Dr. Cook has only performed between three and five D and Es in the second TREU moster of his career, none after 20 weeks of pregnancy.

In short, your Honor, our experts, our expert on the issues that court and will inform the Court's decision on the claims before it.

The government's experts, its witnesses aren't.

Now, most of our witness testimony plus the testimony



of other physicians who are not abortion providers but who are pathologists or historians of surgery will be directed to the health exception question. More specifically, this testimony will address whether as ST*EPBberg and this Court pose the question, there is a significant body of medical opinion that intact D and E has STAEUFT advantages for some women in some circumstances.

But to place this question in better context, I want to begin this road map to the plaintiffs' evidence with these logically antecedent questions. What procedures are at issue? How do they proceed? And why is it that we say that the Act bans far more than a single procedure and that indeed it threatens virtually all second try moster abortions.

In answering these what how and why questions we will first show you, your Honor, through testimony of Dr. Westhoff, that abortion as practiced in this country today is extraordinarily safe. It is in fact generally safer than continuing a pregnancy through childbirth at term.

Over 90 percent of abortions in country are performed in the first TREU moster which extend to 13 weeks LMP, which stands for the start of the woman's last menstrual period. Those abortions are not at issue in this case. Nor is this case about the very, very few abortions performed in the last TREU moster of pregnancy. That is because 24 weeks LMP before the last TREU moster begins, is generally thought also to mark

the onset of fetal viability with many fetuses can survive outsued the you the Russ for some sustained period of time.

Under the laws of virtually every state it is unlawful to perform a post viability abortion unless the life or health of the woman is at risk. The individual plaintiff doctors in this case do not perform abortions at or after 24 weeks.

So it is totally a misnomer to say, as was said in Congress and in the poplar press, that this ban deals with so-called "midterm" abortions. It does not. And as the Court noted in its summary judgment order, the ban at issue here restricts and it is intended to restrict pre viability abortions.

Some 10 percent of abortions in this country are performed in the second TREU moster. They are performed for many reasons but one striking aspect you will hear described by the plaintiffs' witnesses, based on their patients' experiences is just how many second TREU moster abortions involve pregnancies that are in fact very much wanted pregnancies but that women decide to terminate because of fetal anomalies or because continuing pregnancy would jeopardize their own health or life.

Dr. TKPWR*UPB aBaum, for example, will explain that 95 percent of the patients for whom he performs abortions are terminating wanted pregnancies. The case loads of Dr. Evans, Dr. Johnson and Dr. Chasten are similar.



Now, according to statistics regularly compiled by the federal center for STKAOED control about which Dr. Westhoff will testify, some 95 percent or more of second try moster abortions proceed by D and E.

All of the witnesses agree on both sides that D and E is a safe procedure. D and E is a surgical procedure. In performing will first cause cervical dilation use OS motic dilater which by absorbing liquid gradually way the cervical or if the for most common type of Oz motic do I HRAEUGS is lamb I TPHAEUR yea a type of sea weed. Dilation prose for a period, usually one or two day PWRZ the D and E procedure.

In general, and I stress that all cases are different and proceed differently, the more dilation achieved the more smoothly the D and E will be to perform and the better for the patient.

D and Es can be and they often are performed in a non-hospital setting. Typically, as Dr. Westhoff will describe, a physician performing a D and E starting the surgical portion of the procedure will, first, stabilize the cervix which is the can a TPHATD at the base of the you the Russ, the doctor will do so by using an instrument called a ten ABG youlum, a type of clamp. The fizz EUGS uses the ten ABG youlum by calling the cervical opening down until it reaches or almost reaches the vaginal opening.

This is significant, your Honor, because the distance

between the cervical opening and the vagina that is quite short.

When the procedure begins after the TE in that case youlum has been asupplied, it is more foreshortened and some to say this a fetal part is outside the body of the woman in the language used in the Act is virtually equivalent to saying simply that a fetal part is outside the you the Russ.

Then, using instruments or manually, the doctor will typically reach into the you the Russ and applying gentle traction will extract the neat us.

In any D and E our witnesses will tell you and some of defendant's witnesses agree a if I EUGS tries to make as few passes with an instrument through the cervix into the uterus as possible.

The doctor does so PWAU the instruments can cause lag ration of SER SREUF and perforation of uterus and these in turn can cause hemorrhage, trauma and infection.

Since, in any D and E as the doctors will testify, the objective is to remove the fetus with fewest possible passes, this means as intact as possible. Now some physicians take steps to maximize the chances of intact removal. In general, the later ingestation that the D and E considers from about 19 or 20 weeks to 23 weeks the likelier it is that the fetus will be removed intact for at later ages fetal tissue is stronger and the cervix is more likely to dilate further. The more



dilated the cervix the more likely is intact removal.

But the doctors will tell your Honor they take the same steps to dilate the cervix whether they perform intact D and E or text and E involving dismess be the with Oz notic lamb TPHAEURa dilation is achieved only gradually and many doctors perform dilation over period of two days.

Other characteristics of the woman will affect the chance of intact removal including the condition of the vagina and the position of the uterus and the location and orientation of the fetus also affects the chances for intact removal.

So some doctors will manipulate the fetal body, usually manually, sometimes with instruments, in order to maximize the likelihood of an intact removal.

But D and E procedure may achieve intact removal depending on dilation, the position of the fetus, gestational age and the strength of fetal issue and other factors.

Whether the doctors doing them engage in such manipulation or not. In fact as plaintiffs' testimony will show a fetus can be removed intact in any D and E.

D and E like most surgery is almost inif I TPHEULTly variable and doctors who perform D and E do not know in advance how the fetus will be removed from the uterus. Indeed, doctors who performed text and Es typically do not know which variation of D and E they will use until just before the extraction of the fetus begins. That decision is made as some, like

Dr. Chaseen describe it, intraoperatively.
So what the plaintiffs witnesses and other authority call intact D and E which is sometimes call dilation and text D and X, intact D and X, that is one variation of D and E. THOS that is how the court directly described it in its summary judgment order.
In other D and Es the fetus is dismembered. For ease I will refer to this and our witnesses will usually describe it as dismemberment D and E. These are most typically performed at 18 weeks LMP and earlier and they're characterized by the use of for accepts to grab hold of the fetal part then exERPTing traction on the part to draw it through the SER is I value O*S and often disarticulating the part from the fetal body by counter traction against out Erin or cervical wall.
The physics must then reinsert the instrument through the cervix and into the uterus to grab another portion of the fetus. This dismemberment proceeds in this way until the fetus is removed from the uterus in its entirety. But, again, the aim is to do this with the fewest instrument passes as possible and fewest inSERLGS of any instruments.
In a D and E of any variation it usually HAPBZ that the fetal head will be too large to fit through the SER SREUFPL. The fetal head may be referred to in testimony by some of the doctors byked technical term call SRAEUR KWRAPL, and it is the largest fetal body at the gestational ages that



are involved with the procedures at issue in this case.
So, in virtually any D and E of any variation the doctor will have to take steps to compress the head so it can be removed, the eSRABG situation facilitated. This may be done by crushing with foreaccepts or by suction.
Why do I spend time on this and why will we offer testimony about the details of the D and E procedure and these too and other variations? Because these details are essential to understanding why the words of this act are so stunningly ill chosen to do anything except ban most D and Es and thereby put doctors at risk for performing the procedure used to accomplish 95 percent of all second TREU moster abortions as well as other second TREU moster procedures.
So I want next to preview for the Court the evidence on the overbreadth of the Act and the vagueness at the core of the act.
Unless the Court has any questions about it we propose to leave the absence of any legitimate governmental interest, which is the fourth grounds we assert and legal and nonevidentiary point for closing argument.
THE COURT: It's up to you Mr. hut. The court will not dictate how you conduct your opening.
MR. HUT: Thank you, your Honor.
First, plaintiffs will show you that not only intact D and Es but also D and Es involving dismemberment and even

inductions and management of spontaneous abortions may violate the ban.

Take TPRFPL a physician like plaintiff's Dr. Weiss or Dr. Evans who does D and Es but does not always perform all the steps that the intact D and E providers do that are designed to facilitate an intact D and E.

Nevertheless, intending to minimize the number of passes with instruments in the uterus, these doctors performed D and Es that often result in the extraction of the fetus intact, the lodging of the head and its depression. Thus, actions they take may well produce a result that is indistinguishable from an intact D and E and they will have done the procedure knowing that depending on the fetal tissue strength, the degree of dilation and other factors they will remove the fetus intact. They thus will have deliberate rattly and intentionally vaginally delivered a fetus beyond the navalel. They will then have deliberate a and intentionally performed an act, compression of the skull that the doctors know is lethal. In this way the dismemberment D and Es they do may SRAEU late the ban but this is not the only circumstance in which a D and E procedure that is any D and E may fall afoul of the act.

Suppose, for example, that a doctor, in performing a dismemberment D and E reaches into the uterus with foreaccepts and grabs a fetal leg, then pulls on and thereby disjoins the



leg, then grabs the second leg and in doing so PULTZ the rest of the fetal body outside the body of the woman up to the fetal head which lodges in the cervix. Suppose the doctor then collapses the skull which can kill the fetus. All this is done deliberately and intentionally, again, the doctor will have violated the act.

This Court will hear physicians testify to other ways in which a dismemberment D and E will proceed and it will hear how these scenarios would also violate the act with the result that doctors following their normal D and E practices will be subject to criminal conviction and to imprisonment and to massive fines and women who need D and Es of all variations will not be able to get them because, fearful of prison, doctors may refuse to provide them.

This act also sweeps within its terms some induction abortions. Induction is sometimes called a medical second TREU moster abortion to distinguish it from a surgical procedure like D and E.

Induction is the PREUFRPBGS pal method used in the five percent or so of second TREU moster abortions that are not done by D and E. An induction is the termination of a pregnancy by inducing labor to expel the fetus an inducing agent use a a PROS ant land like mess aPROS TAL is given intravenously or more cly intravaginally, this pre sip TATS dilation of the cervix and onset of forceful labor

contractions. The woman then goes through labor which may last as long as labor does at term.

Our evidence will show in some instances the fetus and induction may become entrapped and still living cannot pass completely through the cervical opening or O*S. Sometimes the umbilical cord may wraparound the fetal trunk impeding access or it may be that the fetal head is too large to pass through as with a hide are a is he fallic fetus with a abnormally enlarged head.

In such circumstances the doctor will perform an act like the cutting of the cord or the compression of the skull that he knows will be lethal. He will have done all of this deliberately so induction too can readily fall within the broad ban of the act, especially when viewed by a prosecutor retrospecttively.

And so, too, as Dr. Johnson will explain, can spontaneous abortions which frequently must be PH-Bed after onset by a physician through a D and E.

Now, your Honor, Congress could so easily have avoided this problem of imprecision and overbreadth and resulting undue burden if it had wanted to for in her concurring opinion insen TERG Justice O'Connor laid out with clarity a statute which did not suffer from unconstitutional overbreadth could have been drafted. Most objectionly nowhere in the act at issue here did Congress see fit even to use the word intact in describing what



is banned.

Congress could easily have much more precisely defined what it sought to ban.

For example, the policy statement issued by the American college of obstetricians and gynecologists called the acronym, A KOL define a procedure that it described as intact D and X. Congress did not use that definition as prohibited procedure or anything reasonably near to it. Congress professed to be concerned about a procedure described 12 years ago by Dr. Martin Haas cell but there was no attempt by Congress to define the ban in the procedure terms used by Dr. Haas cell.

Its own findings that precede the Act Congress described some as P-BGTS of the procedures that supposedly concerning it that describe the procedure that involve steps like using an instrument at the base of the skull and removing cranial contents but it then enacted a law in words that did not define the banned procedure by any of these characteristics and that, as we will show, bans far more.

Nor did Congress follow the guidelines supplied by Justice O'Connor model on an approach followed by awe few states and specifically and expressly exempt from the RAOEFPL of the ban a D and E performed by dismemberment. Indeed as testimony designated by the Rule 30 PWRFPLT 6 representative from the department of justice acknowledges department had

SKWAOEUTD specifically suggested that Congressional drafters look at such statutes as a model for federal legislation. If Congress followed the suction to look it surely did not make any changes to conform to bans in those states.

Now I want to say, your Honor, only a few words about a related claim that the act is void for vagueness.

It is not only the plaintiffs who will tell you why the law provides no clear notice to those who would have to obey it, so too will the chief lawyer at the Department of Justice responsible for enforcement in deposition testimony that will be offered Juan Kim, TKPWAOUT TPHEUPBT STOERPB general for civil rights, has acknowledged in deposition testimony that we will offer that the Justice Department has not made any decision, none, about the actual abortion procedures that will be covered by the act. He testified further that the Justice Department will have to make decisions as to the scope of certain language contained in the act.

Now I want to turn to highlighted the testimony that the Court will hear concerning the health exception or the lack of one.

We will show, your Honor that even if you construe the ban to reach only the intact variation of D and E, even then there is a significant body of medical opinion that there are safety advantages to intact D and E such that doctors must be permitted to perform them when doing so when it would be safer



for the health of a woman.

Indeed, one of defendants' principal experts, Dr. Charles HRO*BGwood of Yale medical school admitted in deposition testimony that there clearly is such a significant body and I expect he will testify similarly in this courtroom.

Your Honor will hear by deposition early in the plaintiff's case-in-chief, perhaps this afternoon the testimony of a representative of the American college of obstetricians and gynecologists. That representative is Dr. Joannea Cain. Dr. Cain is provesor and director of the center for whims's healthality or or health sciences university and she is medical school professor as obstetric ABZ gain KWROL as well as edge wicks.

ACog as Dr. Cain explains in her testimony is the professional association of more than 40,000 doctors who provide medical care to women in pregnancy including in connection with PREG Nan TKEU terminations. Acog members comprise a full 90 percent of board certified obstetrician gynecologists in this country.

Dr. Cane describes the development of the acog policy statement in 1997. Her deposition testimony stabs that acog took the same measures with this policy statement as it did with similar policy statements than it issues regularly. The 1997 policy statement was developed and written by a task force of well credentialed, knowledgeable and highly regarded members

versed in SPW-RGS procedures, some of whom had performed intact D and E.

The statement was then refined and adopted by the acog executive board also SKPRAOEUZed of distinguished TKRRZ, some experiences in abortion.

The acog statement discusses a procedure that was defined as having TPOERS Eves and what the statement call intact TKHRAEUGS and extraction or inSTAFPLT D and X, the forestep to which I made reference a moment ago defined by acog a moment ago is a form of intact D and E performed according to the specific acog steps.

The acog policy statement was before the Supreme Court in the STEPBberg case and it was before Congress when Congress passed the Act but Congress ignored acog. What acog said in 1997 was that an intact D and X "may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of the woman. And only the doctor in consultation watt patient, based upon the woman AETS particular circumstances, can make this decision."

Acog reaffirmed the 1997 statement in 2000 and again in 2002. Dr. Cain will testify that the 1997 view is the acog executive board's view today in addition this "intervention of legislative bodies into medical decision-making is ill appropriate -- excuse me, inappropriate, ill advised and dangerous.



Now, in the same 1997 policy statement, of course, ah cog also said that it could, "identify no circumstances under which an intact D and X would be the only option to save the life or preserve the health of the woman." these statements, your Honor, are entirely consistent with one another and they underscore extremely important point. Your Honor will hear the government ecothe finding of Congress that intact D and E is never "medically necessary."

The language of medical necessity comes from the Supreme Court in STP*EPBberg but the Court in ST*EPBberg was at pains to explain that medical necessity was in no sense an absolute or rigid concept and so it does not matter that as acog pointed out an intact D and E may not be the only procedure available to terminate a pregnancy safely and therefore may not be medically necessary in that sense.

For example, in any given situation a histerotomy which is abortion by Caesarean section or even a hysterectomy would be theoretically available but while his they are to the O my or even hysterectomy can be safe, there are many, many times we sear D and E and no doctor whose goal is to provide the best and safest care for the patient would recommend their use in any but the most unusual and extreme case. And no doctor would say that a D and E was not necessary in a particular case because a histerotomy were available.

Similarly, as ah cog noted, intact D and E will

frequently be a safer procedure even though there are others, like for example dismemberment text and E that may also be safe and because intact D and E will often be safer it is therefore necessary to keep in a physicians ARly men tear yea for performing second TREU moster abortions.

The Supreme Court in ST*EPBberg unquestionably agreed with this analysis, that is why it said it would determine the need for health exception by reference as this Court observed in EUS order of summary judgment to responsible differences among highly qualified and knowledgeable experts and it is why it said that, in answering this question, Courts would like to whether a significant body of medical opinion believes that a procedure may bring with it greater safety for some patients and explains the medical reasons supporting that view.

What did ah cog mean about D and Es and their greater safety? Acog later explained what it meant to the Supreme Court in ST*EPBberg in an ameek us brief. There if explained in words that were subsequently quoted in the opinion for the Court by Justice Breyer, it explained as follows.

D and X, it said, "presents a variety of potential safety advantages over other abortion procedures used during the same gestational period." compared to D and Es involving dismemberment D and X involves less risk of urine refer ration or sir is I value HRAGS lace because it requires the physicians to make fewer pass ages into the uterus with shorter instrument



and reduces sharp fetal bone fragment that can injury the uterus abSER SREUF.

There is also K-RL evidence that Z and X reTuesdays the risk of fee at tissue, skierous abortion complication that can cause maternal death and the D and X reduces the incidence of a free floating fetal head that can be difficult for a physician to grasp and remove and thus can cause maternal injury, that D and X procedures usually take less time than other abortion meds used in a comparable stage pregnancy can also have health advantage.

The shorter the procedure the less blood loss, trauma and exposure to anesthesia.

The intuitive safety advantages of inSTABGT D and E are supported by clinical experience especially for women with particular health conditions there is medical evidence that D and X may be safer than available alternatives.

As I said the Court P- justice Breyer's opinion accepted this explanation.

The acog ameek use brief too from which I quoted was before Congress when it enacted the Ban and it too was ignored.

Other medical groups the American pub will I go health association and the American medical whims' association will testify by deposition through designated representatives as to the same safety benefits. The American public health association explains that it opposes the act because it fails

to include adequate health exception language in instances where certain procedures may be determined by physician to be the benefit or most appropriate to preserve the health of the woman.

Similarly, the American whims' medical association circumstances is the safest, most appropriate alternative available to safe a life and health of the woman.

Your Honor will also hear about these same safety advantages testified to by plaintiffs' witnesses in this case. Your Honor will hear about these safety advantages from doctors who do D and E of all variations. They have together performed many hundreds of D and Es within the last few years, intact D and Es performed by plaintiffs witnesses one run from 50 in one case to hundreds. These physicians will testify that intact D and E is so important in D and E variation and so promotive of whims' health that the technique is now taught in many of the major medical schools of the country right here in New York alone it is taught at Columbia, at Cornell, at Albert Einstein. It is also taught at NYU where, until last year, one of the witnesses for the government, Dr. Lockwood, was the chair of the OB/GYN department.

Plaintiffs witnesses will testify to the safety advantages that intact D and E offers. Acog's brief in ST*EPBberg enumerated many of these, they include, first,



because an intact D and E involves fewer passes into the uterus, woman's cervix and are will he exposed to instruments that are used in dismemberment D and E because there is less exposure to instruments there will be less risk of laceration to the cervix and perforation of the uterus.

Second, a consequence of the dismemberment that characterizes a dismemberment D and E is the sharp TPRAEUGments of bone that make contact with the out Erin and cervical walls again with the risk of laceration or perforation.

Third, retained fetal tissue is a principal risk in dismemberment D and E can cause serious infection.

The government may suggest that this risk can be entirely avoided if the physician uses ultrasound to survey the uterus at the conclusion of the procedure. Our witnesses will say that the problem is not so easily addressed. They will testify that you will are a sound does not simply solve the problem because the tissue will not always be visible on ultrasound.

Fourth, you will hear from plaintiffs doctors and witnesses that all things equal, that is if the procedures were performed at the same gestational age for women with the same anatomy, the same health profile and the same degree of dilation, intact D and E is a typically shorter procedure than a dismemberment D and E, this means less risk of trauma, less terrific of bleeding during the procedure and briefer exposure

to anesthesia. All these are safe.
Fifth, the Court will hear from pathologist, Dr. RePWEBGTa beareden who will specifically address the subject of post procedure testing for the causes of fetal anomalies.
Dr. PWA*EURGen, as the Court will hear is professor of clinical pathology and laboratory medicine at Wile medical college of Cornell University. She is chief per I natal pediatric pathology at New York Presbyterian hospital. There her specialities include per I knital pathology and gain clothic pathology. Dr. Bearingen will testify how, in some cases, where wanted pregnancies are terminated because of fetal anomalies, pathological examination to try to determine the precise cause of the anomaly is essential.
Other plaintiffs will testify to the same effect. This can be critical it a doctor's ability to provide reassurance or if necessary guidance to the woman and to her family and advice concerning the risk of recurrence of the anomaly in the future. In this situation, therefore, an intact D and E would be more promotive of future maternal health.
Finally, in the case of unwanted pregnancies especially, some women want the fetus the better to grieve. The intact procedure can typically allow this while a dismemberment D and E typically will not.
These, your Honor, are general safety and health



advantages of intact D and E over dismemberment D and E and in the opinion of acog as SKPRSed in the ST*EPBberg amicus brief and as witnesses for plaintiffs will testify, they would and they do benefit all women having second TREU mister abortions. Indeed, the Court will hear some of the government's own witnesses agree that these are intuitive advantages of intact D and E.
Plaintiffs witnesses will additionally testify that there are also women with specific conditions who are particularly benefitted by intact D and E. For example, there are women who are particularly prone to hemorrhage. These women will particularly benefit from intact D and E for intact procedure reduces the risk of lacerations and bleeding. This would include women with certain blood disorders, for example, for women who are at risk for sepsis or infection, the intact procedure has immediate tangible safety advantages.
A woman for example suffering from a K-RPGS surgery from core yo am unite us which is a type of infection that arises during uterine pregnancy. Dr. Westhoff will testify that women whose health is especially compromises are those most likely to benefit from shorter operating time, lower risk of perforation or laceration or infection.
Now the government will suggest to you that there is a procedure that, like intact D and E, avoids STRAOUP TAEUGS, sharp fetal fragment and retained fetal tissue, namely

induction.
Induction, too, the government will argue permits fetal testing and facilitates grieving and so the argument would run an intact D and E is not necessary to achieve the safety benefits that I have just enumerated.
The witnesses for plaintiffs will tell your Honor that this is a meritless argument. If credited it would cause profound problems for maternal health.
It is no accident that more than 95 percent of second TREU moster abortions are accomplished by D and E, not induction. As our witnesses will testify, women disfavor inductions for numerous reasons. For one, inductions are no different from labor and childbirth. Indeed contractions are often more painful in a second TREU moster induction abortion than they are in labor at term and there is none of the fulfillment that at the end of the or deal attends a live birth. An inductions sometimes fail so women can go through hours of contractions and still need a D and E to go through termination. Women also addition favor inductions because they require hospitalization with overnight stay sometimes far from where they live at a greater cost. And especially for women with unwanted PRG Nancy being in a labor ward to terminate PREG TPHAFRPB is I by induction while surrounded by mothers giving birth brings its own enormous psycho anguish.
Apart from these issues that are T-PBGSs for which



inductions are medically advisable. These include women that have had a prior Caesarean section. Scars from prior C sections as with any scarring of the uterus increases the risk of uterine rupture which is a life threatening condition during labor.
Witnesses for plaintiffs will therefore tell you that induction is riskier than D and E for these women.
And your Honor it is worth noting that contrary to poplar conception or at least to my own pre conception, delivery by C section is quite common. The evidence will show that 25 percent of women deliver babies do so by Caesarean section, around one million each year.
Women who have undergone mull till says airons with more than one scar are especially at risk with induction. There are also other types of uterine caring that present the same contra KAEUBGSs for induction and for labor. These include scarring that results from a procedure to remove uterine fibroids or benign tumors, a procedure called bio mechanic to my.
As another example inductions are riskier for whims with certain types of cardiac disease because of the stress the labor puts on the heart.
The problems with induction helped inform the Supreme Court's diction in ST*EPBberg to condemn a procedure that would have banned all D and Es leaving women needing second TREU

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moster abortions only with the choice of induction. Such a choice is no better an alternative as a consequence of a federal ban before your Honor.

In short, plaintiffs evidence will show the Court first that intact D and E is generally safer than dismemberment D and E for the 95 5* percent of women who choose D and E.

And second, that many of these women would face severe risks to their health if D and E were not available to them or because inductions would seriously threaten their health P.

Let me briefly speak to and preview three other points we will address in our evidence, your Honor on health exception issue.

First, the government witnesses will say that even if the intact D and E has safety advantages those can be realized and the inTABLGT D and E there another performed consistently with the language of the act so long as the doctor first acts to cause fetal death before the vaginal delivery commences.

They will suggest that inSKPWREBGSs of either the chemical potassium chloride into the feet at HARBT or umbilical cord or injections of the chemical called TKEU SKWROFPLin into the am knee OTic sac will cause fetal death. They say such injections can be easily accomplished without any serious adverse affects to ma terrible health.

Plaintiffs witnesses like Dr. Hammond, Dr. Frederick and Dr. SKUP ski will testify this is not correct.

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In the first place positive TAS KWROUPL coloroid or die SKWROFPLy are additional procedures that bring no medical benefits and bring unnecessary medical risks.

Such injections, especially intrafetal injections can be risky. Not all physicians have the skill that is necessary to locate the fetal heart or umbilical cord by way of injection through PREG Nan woman's abdo men.

Even in skilled hands there are risks missing the fetus could result in perforating a bowel or doing great injury, nor do physician -- nor do all of them in any event, have the high resolution ultrasound that is necessary to facilitate intrafetal injection.

Moreover, plaintiffs witnesses will tell you such injections may be impossible to accomplish for some women including those that are excessively obese.

Finally, TKEU jockin inexs have proven adverse I'd effects to which without proven medical benefits.

Second, from some government's witnesses you can expect to hear that these safety advantages of intact D and E can be be reckoned in the health calculus because they are unproved by any scientific study. You will hear that they are only offered by doctors on the basis of the doctors' clinical experience and not established pursuant to any randomized controlled or trial.

There are at least two answers to this each sufficient

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as our evidence will show. The first is that this profoundly misunderstands how innovation and surgical procedures involved.

Plaintiffs will present expert testimony on surgery and in the history of medicine about this. As plaintiffs first witness, the Court will hear from Dr. SHER win new land of the Yale medical school in addition to practicing surgery for 30 years Dr. New land is a prize winning author of backs on medicine and its history. He is the winner of the narcotic book award and he is a PAOUL its list prize nominee, Dr. New land will testify that advantages in surgical techniques typically occur through gradual evolution. In most cases single physician or group of physicians introduces a new technique or variation and this comes often based on intuition gradually words gets out to other physicians who may in turn, adopt or modify the technique for their own practices.

Over time a sufficient number of physicians are familiar with and perform the procedure to allow for performance of studies and the completion of a peer review articles examining the safety and efficacy of the sec TPHAOEBG.

Dr. New land will testify that the completion of a controlled study subject to peer review is not a prerequisite to the use of a given surgical technique or variation of patients and indeed that composing such a requirement would

Second, there is, in any case, a recently concluded

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scientific study on point. It compares a group of women who had D and Es by dismemberment against a group of WEPL who will D and Es that proceeded relatively intact. This study was performed by one of the plaintiffs, Dr. Steven Chaseen of Cornell medical school at Cornell Wile medical center.

The study has been peer reviewed and an article describing the results has been accepted for publication in the American journal of obstetrics and gynecology over the leading OB/GYN professional journals in the nation. It is in press and scheduled to be published later this spring.

Dr. Chaseen will testify here about his study and about its results. The study showed at a level of statistical significance that there was no difference in complication in rates between intact D and E and D and E by dismemberment across all women in these two groups.

It also shows an a smaller population base that there was no difference in incidence of preterm delivery and subsequent pregnancy among groups of women who had received one variation or the other.

Interestingly, even thoughed study finds no difference of complication rates, the study confirms for many doctors as the number of plaintiffs witnesses will testify, the safety advantages of the intact D and E variation.

It confirms these safety advantages because in the study the average gestational age of the pregnancies in the

abortions are more difficult to perform and more complications would have been expected to occur based on that gestational age difference.

Third and finally, it is ironic that even as the government suggests that the safety advantages of intact D and E are unstudied and unproved, it defends as reasonable the findings of Congress that the intact D and E variation is inimI canable to women's hedge. The principal allegation here is that inthe tact D and E can lead to competence of the cervix which can later complicate pregnancies and cause premature delivery.

Other AGD complications apparently also credited by Congress in its findings include am knee OTic fetal emPWO HRUS, aPWRUPGS and others.

You will hear defendants' own experts however, including Dr. HRO*BGwood and Dr. PWO*ES acknowledge that there is no scientific evidence whatever for these purported medical findings. The findings are not only unsupported in the medical literature, they are contrary to the clinical experience of doctors who performed these abortions and indeed contrary to common sense. They are, to put it plainly, unsupported and they are untrue. And at the conclusion of our evidence, your Honor, we will ask the Court so to fine.

To sum up our evidence will show the Court that this

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act unTKAOUPBGSly compromises women's right to repro TKOUBGtive choice to abortion in two ways. First, it clearly eliminates the intact variation of D and E, a variation that a significant body of medical opinion believes offers safety advantages. Defendants own expert admits to such significant bodies's existence and second and it's a stunning breath, it would and it frankly seems intended to remove the range of abortion alternatives that are available to women in the second TREU moster, alternatives that are proven safe.

If the Court has no further questions, plaintiffs look forward to hearing from the government and then to qual on our first witness. Thank you.

THE COURT: We will take a 10 minute recess at this time.

(recess) TWM 3/29D/04 take 2NAF.

THE COURT: Ms. Gown, will you be opening for the government? Gown gown your Honor, Mr. Lane will be opening for the government. However, if I may, I would like to give you a brief report on what we have learned about the New York Presbyterian Hospital appeal.

THE COURT: Go right ahead. Gown gown we have learned that New York-Presbyterian Hospital has filed its papers with the Second Circuit seeking a stay and expedited review as well as we understand a mandamus of this Court. The government has been served with papers. We understand that plaintiffs'

counsel has been served with papers. And I understand also that our office was copied this morning on a letter to your Honor sent by New York-Presbyterian seeking a stay of your Honor's order of Friday night.

I have not seen that letter myself, your Honor. It had not arrived at the time I left the office to come to court this morning. But I do want to bring to your Honor's attention that yesterday, last night actually, Presbyterian's counsel asked for the government's consent of a stay of your Honor's order of last Friday night, and the government advised New York prettypy terian Hospital that it would not consent to any such stay of your Honor's ruling.

THE COURT: Thank you very much.

Mr. Lane, you may commence. Lane lane may it please the Court. My name is Sean Lane. I am an Assistant United States Attorney for the Southern District of New York on behalf of the government. We are here today for a trial on the constitutional challenge brought by the National Abortion Federation and its members to the partial birth abortion ban Act of 2003. This was a law enacted by a wide majority of both houses of Congress, a law enacted after eight years of study of the partial birth abortion issue, including hearing evidence from dozens of doctors on the relevant medical issues.

In this trial, the Court's role toys see through the eyes of Congress to determine if its factual findings in the

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Act are reasonable and base odd on substantial evidence. Thus, the evidence at trial will serve a narrow purpose: To assist the Court in assessing the reasonableness of Congress's factual findings and whether such findings are based on substantial evidence.

The evidence at trial will show exactly that. Most significantly, the evidence will confirm the reasonableness of three central findings made by Congress about partial birth abortion. First, there are no maternal or fetal medical conditions for which partial birth abortion is necessary for the health of the woman. Second, there are no proven safety advantages to partial birth abortion. Third, partial birth abortion blues the line between live birth and abortion is an inhumane and gruesome procedure that causes pain to the if he tus.

I will briefly discuss how the evidence to be presented at trial will confirm the reasonableness of these three central congressional findings and why the Court should reject plaintiffs' claim that the Act is unconstitutionally vague.

As to the first issue, the evidence at trial will confirm the reasonableness of Congress's critical conclusion that there is no maternal or feetal health conditions for which partial birth abortion is mess KAEL necessary for the health of a woman. You will hear testimony at trial from maternal

TPAOERLT specialists who specialize in treating maternal health conditions in preg TPHAEPBT William. These doctor will include Dr. Charles WAOBG HRAOBD, chairman of Oc stet REUBGS and KWAOEUPBL college at the Yale Medical School and Dr. Stephen Clarke co-author of a text entitled critical clear object stet tricks, well theses treatment of care and with him with serious and potentially fatal medical conditions. S- S-

These doctors and others will testify that it is never necessary to use the partial birth abortion procedure to treat I will pregnant women. They will say that never encountered an instance where partial birth abortion was necessary. Indeed, they cannot imagine any actually disease or hypothetical combination of me medical conditions for which partial birth abortion would be beneficial to the health of the mother.

This is true even in the most serious maternal health conditions such as cardiac disease, rental disease, severe pulmonary disease. In fact, you will hear that a surgical procedure like partial birth apportion would be a dangerous procedure for women with some conditions, and these include will you KAOUPLia and blow blood PHRAEULTS.

Not only is partial birth abortion not medically necessary, but these doctors will tell you that they can think of no are reason to AOUPB as untes $ procedure like partial birth abortion on a sick woman given the impressive and proven safety of other alternative abortion procedures like dilation



and SRABGulation also known as D&E, and labor induction. Thus the evidence will show that Congress considered and reasonably rejected the policy statement of the American College of Obstetrics and gynecology \{^ivities}\{^ists}, also known as ACOG, regarding this procedure. The unsigned ACOG policy statement does not identify any specific circumstance when partial birth abortion is necessary for maternal health. Indeed, the evidence will show that the ACOG statement is not based on any careful scientific study of the relevant medical issues but instead is nothing more than a statement of policy preference.

You will also hear evidence at trial about the treatment of pregnant women where the if he tus suffers from an anomaly. But just as in the case of maternal health conditions, the evidence will show that it is never necessary to use partial birth abortion to terminate a pregnancy involving feetal TPHAOPL license. The use of partial birth abortion in these circumstances would not provide any benefit to the health of the mother relating to the pregnancy as compared with other safe, proven abortion procedures.

You will hear that if an intact fee tus might be desirable to obtain additional genetic information that could be helpful to confirm or expand upon a diagnosis of fee tal TPHAOPL license, that the fee tus can and routinely is safely aborted using the TPHUBGS method. In fact, induction is a

method of abortion used by plaintiffs' doctors under these circumstances. Induction ace safe and effective method of abortion used in the late second trimster when partial birth abortion is used.

By contrast, you will hear that partial birth abortion does not result in an intact fee tus as opposed to induction because partial birth apportion becauses damage to the fee tal head and often results in the suctioning of brain tissue.

In those rare circumstances where induction cannot be used for some medical reason but an intact fee tus is desirable for diagnostic purposes, you will hear testimony that doctors can cause fee tal demise in advance of the abortion procedure through antics jection of a chemical agent through through the am not I can sack or directly into the fee tus. Indeed, such an injection is done by some of the PRFS' doctors in this case. And the risks of such injection are minimal and akin to amnioKREPB TAOEZ used dailyly by the medical profession.

As to Congress's second critical finding, the evidence will show that Congress reasonably concluded that partial birth abortion does not have any proven seafood advantages. The evidence will show that partial birth abortion has not been proven to have any safety advantages over other well-studied and medically acceptable methods of abortion like de and lane induction. There are no published studies comparing partial birth abortion with these other well-studied methods of



abortion. Plaintiffs claim only that partial birth abortion's benefits are intuitive. But you will hear testimony that practicing medicine based on intuition is folly. It is inconsistent with the idea of basing medical decisions on scientific evidence.

While the use of an unstudied procedure may be justified in exigent circumstances, where no other options are available, you will hear that that is not the case here. Here there are other well-studied abortion procedures that are proven safe, such as D&E. As Dr. Lockwood and others will tell you, D&E is an incredibly safe procedure with a risk of death at or below .05 percent. Where such safe and proven alternatives are available, there is simply no justifiable reason to use an unstudied procedure like partial birth abortion.

Moreover, as you will hear from Dr. Clark, medical decisions based on such intuition can often be wrong.

In addition, the use of partial birth abortion presents unanswered questions about its possible long-term health risks stemming from unique elements in the procedure. These elements include continue creased amount of TKHRAEUGS needed for partial birth delivery over and above the amount of dilation necessary for traditional D&E, the increased time needed to accomplish such dilation, the conversion of a fee tus to a breech position, and the use of an instrument to puncture

the fee tal skull.

In the 12 years since Dr. Haskell presented his paper on this procedure at an NAF meeting in 1992, the only information on partial birth abortion that plaintiffs can point to is a yet-to-be-published study done by plaintiff Dr. Stephen KHAEU sen comparing D&E and the partial birth abortion procedure. But this unPREURBD study does not conclude that partial birth abortion possesses any safety advantages over de.

In some, on this point, your Honor, based on eight years of study, Congress made a factual finding that there were no proven safety advantages to partial birth abortion. The evidence will show that that conclusion is correct. It cannot be this act of Congress should be struck down based upon the institution and anecdotal conclusions of several doctors about this procedure.

As the Congress's third central finding, the evidence will show that Congress reasonably concluded that partial birth abortion blurs the line between live birth and abortion and is an inhumane procedure that causes pain to the fee tus. The evidence will show that when a physician begins this procedure, he or she appears to be acting in the role of an obstetrician assisting a live delivery. The doctor appropriates the terminology and techniques used by obstetricians in the delivery of live children, and instead uses those technician to end the life of a partially born fee tus just inches from

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birth.

While plaintiffs' counsel this morning noted that the terms used at the trial will be graphic, in fact it is the nature of this procedure itself that gives discomfort.

Congress also had a reasonable basis and substantial evidence to find that the procedure imposes severe pain on a living fee tus. Dr. Can wallet at a TPHAPBD has special expertise on fee tal pain based on his work treating if he T-L infants and infan can't and his research on the treatment of pain S- S-. He will tell you that a fee tus of 20 weeks of gestation can and will feel pain as a result of this procedure. Moreover, as an expert in the pharmacology of anesthetic drugs, he will also testify that STHAERB administered to the mother will not prevent a partially delivered fee tus from feeling the pain of this procedure.

Given the reasonableness of Congress's central findings STKPWHRAOFRPBGTS anesthesia<], the Act does not run afoul of the Supreme Court's decision in sten berg versus car Hart. Sten berg vas car Hart said that the state cannot prohibit the use of a procedure which is necessary and appropriate in medical judgment. S- S-. Under sten berg consideration must be given to (1) whether the procedure is necessary for maternal health and (2) whether the procedure offers greater safety advantages. The evidence at trial will confirm the reasonableness of Congress's factual finding that

partial birth abortion is in fact never necessary for maternal heating APBTD does not offer any proven safety advantages, let alone the greater advantages that well-studied tested, safe, and routinely used methods something.

Thus, the Act is consistent with the Supreme Court's decision in sten berg.

Not only are Congress's findings reasonably based upon substantial evidence, but the act itself clearly prohibits a particular kind of procedure and thus does not suffer from vagueness. The question of vagueness ultimately must be evaluated as a legal matter based on the words of the statute and the SKRAOEPBTer in the Act T. Act narrowly and specifically defines partial birth abortion as a procedure where in the situation of a breech presentation a doctor deliberately and intentionally vaginally delivers a living fee tus until any part of the fee tal trunk past the naval is outside the body of the mother for the purpose of performing an overt act that the person knows will kill the partially delivered fee tus and then performs the overt act. Thus, the Act sets forth the intentional and sequential nature of the banned procedure.

First, the physician must deliberately and intentionally partially deliver a living fee tus. Second, in the case of a breech delivery, the partial delivery must be at least to the naval. Third, before delivery is completed, the living fee tus, which is now largely outside the mother, is



then killed by a separate overt act before it is removed from the mother.

Thus, plaintiffs are incorrect in claiming that the Act prohibits a wide variety of abortion procedures. The Act does not cover traditional D&E because that is a dismemberment procedure, and this is consistent with the legislative history where Congress made solicit its intent that the Act not cover the D&E method of abortion.

Nor does the Act cover an instance where an abortion procedure like D&E accidentally results in a partially delivered fee tus, because there is no intent to take the steps prohibited by the Act.

While plaintiffs complain that Congress used the legal term "partial birth abortion" in the Act, that term was used because of widespread confusion in the medical community over what to call this distinctive procedure.

As for plaintiffs' claim that the views of the Department of Justice are somehow relevant to this Court's decision, and as your Honor is aware the government strongly disagrees that such evidence is relevant, the fact of the matter is that this Act was enjoined from its very inception and therefore it is not at all unusual, as Mr. Kim testified, that guidelines would not be developed for its enforcement.

In conclusion, your Honor, Congress's inquiry into partial birth abortion started in 1995, 5 years before the

Supreme Court's decision in sten berg. During its inquiry Congress heard testimony and received letters on the medical issues associated with this procedure from dozens of doctors in addition to reviewing numerous articles and statements from medical organizations. The evidence at trial will illuminate the reasonableness of Congress's factual finding that partial birth abortion is never medically necessary and is an inhumane procedure that should be banned.

Thank you, your Honor.

THE COURT: Mr. Hut, you may call your first witness. I noted in your opening that you preferred referred to the technical language of the medical profession. I URPBL you, as I did to your colleagues months ago, I urge you to speak in simple language that anyone hearing this testimony, your questions, and the answers, or reading this transcript, that anyone can understand exactly what is going on. I am sure with your experience you will make that happen. Wig your Honor, this is Ms. Wigmore. The plaintiffs would like to call for our first witness, Dr. Sherwin B. new land.

THE COURT: Ms. Wigmore, then my admonition was directed to you. Since you have the first witness, go right head. Wig wig your Honor, we have two exhibits that we plan to use with this witness. With your permission, I would like to approach the witness with a binder containing them and provide copies to the clerk and to opposing counsel.

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THE COURT: What types of exhibits are they? Wig wig

THE COURT: All right.

THE CLERK: Mr. New land, please take the witness stand and remain standing.

NULAND,

called as a witness by the plaintiffs,

having been duly sworn, testified as follows:

THE CLERK: Please state and spell your full name slowly for the record.

THE WITNESS: My name is Sherwin new land, SHERWIN NULAND.

your Honor, at this time I approach the witness and provide the binder?

THE COURT: Any objection? Lane lane no objection, your Honor.

THE COURT: Go right ahead. TKPWR*BGS wig wig.

Q. TKPW-FPL, Dr. New land.

A. Good morning.

Q. What do you do for a living?

A. Right now I'm a writer and a lecturer and a teacher.

Q. On what subjects do you write?

A. The basic theme of most of my writing has to do with

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explaining medical topics or medical historical topics for the general reader.

Q. On what subjects do you provide lectures?
A. Primarily having to do with those areas as well as bioethics. And of course I write in bioethics as well.
Q. You mentioned that you are a teacher. Where do you teach?
A. I have taught since the early 1960's at the Yale School of Medicine. This past semester I have been an adjunct professor also at New York University.
Q. Over the course of your career, what subjects have you taught?
A. For 30 years I taught surgery, and beginning in the mid to late 1970's, in addition to that I began teaching medical history and increasingly bioethics.
Q. Are you currently teaching a class on medical history?
A. During the first semester of this academic year I taught a one-semester course at NYU, an that course or one similar to it will be taught in the fall semester at Yale next year.
Q. Would you please describe for us generally the subject matter of that medical history course.
A. The medical history course begins about 400B.C., at the time of hi po contrates and the Hippocratic philosophies of medicine and carries itself through until the middle or perhaps the late 1960's of the 20th century.
Q. Are you a medical doctor?

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A. Yes, I am.
Q. Have you practiced medicine?
A. Yes, I have.
Q. For how long did you practice medicine?
A. I was first licensed in 1956. I trained from '55 to '61 and functioned as an intending surgeon from 18961 until the very beginning of 1992.
Q. Did you have a specialty in your medical practice?
A. Yes, I did.
Q. What was that?
A. I was a surgeon.
Q. Did you specialize in any particular types of surgery?
A. Yes. I was what is generally known as general surgeon, which means that, for me at least, approximately two-thirds of my practice was abdominal surgery and about a third of it dealt with breast surgery.
Q. Dr. New land, do you understand that this case involves a challenge to the partial birth abortion ban Act of 2003?
A. Yes.
Q. Are you a plaintiff in this case?
A. No.
Q. Do you plan to offer expert opinions?
A. Yes, I do.
Q. I would like you, please, to refer to your exhibit binder, to the exhibit that is numbered Plaintiffs' Exhibit 69. Have

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you seen that document before, Dr. New land?
A. Yes, I have.

Q. If I could refer you, please, to the first page of that exhibit, do you see the words "Section 1 short title"?
A. Yes, I do.
Q. Would you please read for us the sentence that appears under that HAEGSD.
A. "This Act may be cited as the partial birth abortion ban Act of 2003."
Q. I want to direct your attention now to --
THE COURT: Has this exhibit been offered in evidence yet? Wig wig it has not, your Honor. But we would be prepared to do so at this point.
THE COURT: Don't you think you ought to have the witness identify it first? It is the normal course. I don't know what he is reading from except that it has a number.
Q. Dr. New land, can you identify Plaintiff's Exhibit 69.
A. The title of the exhibit is "an Act to prohibit the procedure commonly known as partial birth abortion."
Q. Have you reviewed this Act before, Dr. New land?
A. Yes, I have wig wig at this point plaintiffs would offer Plaintiffs' Exhibit 69 in evidence.
THE COURT: Any objection? Lane lane no o your Honor.
THE COURT: It will be received.
(Plaintiff's Exhibit 69 received in evidence)

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Q. Dr. New land, do you see the heading "Section 2" in the Act?
A. Yes, I do.
Q. What is the title of that section?
A. " findings."
Q. Would you please refer to the page that is marked S3-4 at the top. I would like to direct your attention to paragraph 14B of the findings which appears on that page. Would you please read for us the first three sentences of that paragraph.
Lane lane objection, your Honor. The basis for the objection is that that paragraph deals with the partial birth abortion procedure, and at his deposition this witness said he was not offering any opinion about abortion procedures, any particular abortion procedure, or comparing the efficacy or safety of one abortion procedure as against another. This particular paragraph talks about medical evidence regarding the partial birth abortions, whether they are safer orr as safe as other abortion procedures. Wig wig your Honor, if I may be heard?
THE COURT: Yes. Go right ahead. Wig wig the purpose of the question is simply to lay the foundation that this is a finding relating to the Congress's finding that there were no peer reviewed journal studies. That is simply setting up the context of Dr. New land's testimony. We don't intend to --
THE COURT: What Mr. Lane said, you didn't offer him to offer an opinion on what he is about to read, is that

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correct? You are just going to have him read it, is that it?
Wig wig that's correct. Lane lane your Honor, if I can, the

sentence that counsel is referring to is one sentence in this particular paragraph. The first sentence does not at all relate to what counsel mentioned. The first sentence, again, relates to the partial birth abortion procedure. I would just ask that counsel refer the witness or have the witness refer to the particular sentence that relates to his opinion. Wig wig that is fine. It.

Q. It would help, Dr. New land, if you could read the second sentence and the third sentence --

THE COURT: You can read it yourself. It is in evidence now. Go right ahead. But you are limited as far as the expertise which you are going to ask about. Wig wig understood.

THE COURT: I think Mr. Lane has a point there. Go ahead.

Q. Dr. New land, I will read for you the second two sentences of paragraph 14b of the Act, which says, "No controlled studies of partial birth abortions have been conducted, nor have any comparative studies been conducted, to demonstrate its safety and efficacy compared to other abortion methods. Furthermore, there have been no articles published in pier-reviewed journal that establish that partial birth abortions are superior in any way to established abortion procedures."

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Did I read that correctly?

A. Yes, you did.

Q. Dr. New land, do you have experience in evaluating the manner in which medical procedures evolve and develop?

A. Yes, I do.

Q. Do you have experience in evaluating what, if any, steps are necessary in order to establish that a medical procedure may be used on human patients?

A. Yes, I do.

Q. Would you please describe that experience for us.

A. The experience consists of several aspects. The first expect, of course, is having PEFRPBLly watched medical progress since the beginning of the 1950's, when I started medical school, and being not just an observer but a participant in several of the major changes in innovation that have occurred during that time.

The other aspect of it, of course, has to do with my study of medical history, which would involve not just following those innovations but extrapolating backward to their origins, perhaps even centuries ago, and extrapolating forward to the implications of the studies that went into determining the usefulness, their safety, and their long-term outcomes.

Q. Dr. New land, from where did you obtain your medical agree?

A. Yale University School of Medicine.

Q. In what year?

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A. 1955.

Q. Aside from your medical degree, do you have any other

medical training?
A. Yes.
Q. Could you describe that for us, please.
A. I trained for 6 years in general cardiac and thoracic surgery at the Yale New Haven Hospital and Yale training program.
Q. Did you have any fellowships?
A. I had an undergraduate fellowship in cardiac physiology during that time, undergraduate as a medical student I mean. I had a fellowship during one of the years of my training, which was in cardiac surgery, and I had a fellowship near the end of my training at TKPWAO*EUS Hospital in London on the thoracic unit.
Q. What is the thoracic unit?
A. "thoracic" refers to the part of the body that lies, if I may say, between the diagram and the neck, which would include, of course, the lungs, the heart, and the esophagus [> diaphragm<] SPWA what is cardiovascular surgery.
A. Cardia vas KHRER refers to heart and PWHRAOFLGS.
Q. Do you currently practice medicine?
A. No.
Q. When did you stop?
A. I stopped in January of 1992.

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Q. Why did you stop?
A. I had been in practice at that point for 30 years, and I was approached to write a book about death and dying in America, in fact in the western world. I considered that not just a worthy about a very important project, and I took a year's leave of absence to devote myself to doing that. During Considering how long I had spent in my surgical career, it seemed an appropriate point at which to transfer my work to that.
Q. Did you complete that book, Dr. New land?
A. Yes, I did.
Q. What is it called?
A. The book is called How We Die.
Q. Did you receive any honors or awards for that book?
A. Yes, I did.
Q. Could you describe those for us, please.
A. The book was awarded the National Book Award. It was the runner up for the pull lister prize and it was one of the finalists for the book critic circle award, and it won several lesser awards that are not commonly known about.
Q. Have you published any other books since how we die?
A. Yes, I have.
Q. On what topics?
A. Most of them have to do with that general topic of

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explaining medical history, the workings of the body, the way medicine has developed to the general public. Several of them have done that in the form of biographies, actually. There is

one book which is different from the others, and that is a memoir.
Q. Dr. New land, aside from the books you have written, have you done any other writing?
A. I have written numerous essays, I have written numerous book reviews.
Q. Have you written articles for medical journals?
A. Yes, I have.
Q. Which ones?
A. I have written for Cancer, I have written for the New England Journal of Medicine, I have written for Perspectives in Biology of Medicine. I was for 25 years one of the editors of the Connecticut state medical journal and wrote for them.
Q. Do you currently have any affiliation with any periodicals?
A. I am on the editorial board of the American Scholar which is a literary journal, on the editorial board of perspectives in biology and medicine, which ace general biology and medicine journal. I am on the editorial board as a contributing editor to the new republic S-
Q. Dr. , I would like to focus your attention for the moment on your medical practice before your retirement in 1992. You mentioned that you specialized in abdominal and breast surgery.

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For how long did you practice in those areas?
A. I practiced in those areas from 1962, approximately, until the very beginning of 1992.
Q. Did you have any board certifications?
A. Yes, I did.
Q. For what types of problems or conditions did you operate on patients?
A. Beginning with breast surgery, which, as I saying, was approximately a third of my practice, most of those women either had breast cancer or a manifestation of it or were being followed very closely to be sure that they did not develop breast cancer. The abdominal work, much \{^ivity}\{^ist} had to do with malignant disease of the intestine, the stomach, the pancreas. It also dealt with more benign disease: Peptic ul ter, dye ver tick lights, AE pend sights, something, hernia was another category. S- those were really the major areas in which I worked. I had a particular interest in the spleen and over a period of 4 or 5 years devoted a great deal of effort to the surgery of the spleen.
Q. Have you ever performed an abortion?
A. No.
Q. Approximately how many patients did you see throughout the course of your career as a surgeon?
A. Based on a little unofficial study I did after I stopped practicing, I had seen some 10,000 patients during that time.

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Q. Where did you perform surgery when you were a practicing surgeon?
A. The overwhelming volume of my surgery was done at the Yale

New Haven Hospital. Perhaps 5 percent of it was done at the hospital of St. Rafael in New Haven. And there was a 3-year period when I worked at a Community Hospital in Milford, Connecticut, a 160-bed hospital.
Q. Have you done any out-patient surgery?
A. Yes, I have.
Q. Where?
A. Most of my out-patient surgery was done at what was then a free-standing out-patient surgical unit called the temple surgical, it is now owned by the Yale New Haven Hospital. Some of it was done at the Hospital of St. Rafael, some of it was done intramurally within the Yale New Haven Hospital.
Q. Where is the Hospital of St. Raphael?
A. It is in New Haven, approximately a mile away from Yale New Haven.
Q. Did you have occasion to observe any surgeries while you were a practicing surgeon?
A. Yes, I did.
Q. Approximately how many?
A. Hundreds.
Q. Did you have any responsibility for training any other physicians?

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A. Yes, I did.
Q. Could you describe that responsibility for us.
A. Throughout the 30 years at Yale New Haven, it being an academic surgical university training program, those of us on the staff of course participated in the moment to moment training of surgeons, primarily in the operating room and on rounds, but sometimes through lectures and die dact I can material. I was for a year and a half actually the direc director of the free standing training program at the Hospital of St. RAF Raphael. That is 600-bed hospital on the other side of town.
Q. Are you a member of any professional associations?
A. Yes, I am.
Q. Which ones [> didactic<]
A. The American College of SurSKWROPBS, of which I am a fellow. I am a fellow of the American academy for the advancement of science. I am a member of The American Medical Association of the New England surgical society, of the Connecticut state medical society, of the New Haven county medical society, of the medical association of New Haven.
Q. Are you a member of the American association for the history of medicine?
A. Yes, I am.
Q. What, if any, steps do you take to remain current on developments in medicine?
A. The first and most obvious answer to that is reading the

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literature I. subscribe to several journals, the most prominent of which are the journal of the medical medical association, New England Journal of Medicine, and science, which is the

official or gain of the association for the advancement of science. I also read in perspectives in biology and medicine. And since I do remain part of the medical community, I am in constant contact with people actively practicing medicine and surgery. And of course I travel and lecture in medical schools all over the country, so I am always having the opportunity to learn what I can while I am there.
Q. Dr. New land, if you could refer, please, to what has been marked as Plaintiffs' Exhibit No. 114 in your exhibit binder.
A. Yes.
Q. Do you recognize that document?
A. Yes, I do.
Q. What is it?
A. It is my curriculum vitae.
Q. Is this document an accurate summary of your education and experience?
A. Yes, it is wig wig at this point, your Honor, we would offer Plaintiffs' Exhibit No. 114 into evidence.
THE COURT: Any objection? Lane lane no objection, your Honor.
THE COURT: It will be received.
(Plaintiff's Exhibit 114 received in evidence) wig wig

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at this point, your Honor, we would tender Dr. New land as an expert in medical history and the evolution of surgical procedures pursuant to Federal Rule of Evidence 702
THE COURT: Any objection or any request for voir dire? Lane lane your Honor, we have no objection to offering this witness on the evolution of surgery. The expert report, however, does not identify him as to just medical history in general. I realize it may be a fairly small distinction in this case.
THE COURT: I am not sure what it means. Wig wig your Honor, I think we would be comfortable in offering him as an expert in the evolution of surgical procedures f counsel for the defense has no objection. Lane lane we have no objection.
THE COURT: Their having no objection, he will be acknowledged as an expert in that limited field. Lane lane thank you, your Honor. Wig wig.
Q. Dr. New land, are you receiving any monetary compensation for your work in this matter?
A. No.
THE COURT: Pi pity.
Q. Have you formed an opinion regarding how surgical procedures change and develop?
A. Yes.
Q. What is your opinion?
A. Surgical procedures by their very nature historically and

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currently come to be by a process of evolution. What essentially happens is that based on the technology of the particular era in which surgeons are working, one or two or

several begin to conceive that a certain procedure might make some sense. It might make sense physiologically, might make sense therapeutically, might make sense technically, and might perhaps be done with a significant degree of safety.

They begin doing those procedures primarily historically on human beings rather than animal. They may test the technique itself on animals, but the important thing is that the physiological results can only be tested on humans. So that will be done.

When word gets out by word of mouth, medical meetings, perhaps a letter, perhaps a phone call, perhaps a very preliminary report in a journal, others will come to watch what they are doing, will meet with them at medical meetings, decide whether these procedures have the merit that the originators claim and then go back to their own institutions and do those things.

Ordinarily, it is customary to keep scrupulous records of the way these new procedures are being done so that in time, when there is a sufficient number of them to judge whether they have true value and are truly safe, in time there will be a publication.

Q. Doctor, can you give us any examples of surgical techniques

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that have evolved in the manner you have described?

A. Virtually everyr surgical technique has evolved precisely that way. We can take something as large as cardiac surgery in general, but why don't we restrict it to open-heart surgery, which I had the opportunity to be involved with at the very beginning, so that I can speak not only as an observer but as a participant.

Q. Can you describe for us how that developed.

A. The notion had long been about that if one could simply prevent blood from getting into the heart, certain diseased parts of the heart, whether they were congenital disease or acquired disease could be treated. A valve, for example, could be repaired or a hole between the two sides of the heart could be closed. But for that to happen, it was necessary that the heart be emptied of blood, then one could open it and do what was needed.

Of course, for that to happen a big piece of technology was required. Someone had to invent and build what is called a heart lung machine, a machine that could both pump the blood and oxygenate it at the same time, so that one could remove the blood from the body before it got to the heart, then return it beyond the anatomical point where the heart is and pump it at the same time.

That took many years in the development. Actually, there is one single person who eventually developed that

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technology, a man named John TKPWEUB bon in Philadelphia. His progress was watched by a lot of others. S- when that machine was satisfactorily conceived and built and he had operated on a

few patients, others began to engineer their own modifications of that equipment, go back to their own institutions, and operate on patients.

Some of those patients had been operated on before the machine was generally available, with so-called cross-circulation techniques, you would use another person's heart to pump the blood, another person's lungs to oxygenate it. But essentially what we were really waiting for was this heart lung machine.

So TKPWEUB bon creates it, engineers it, designs it, and everybody copies it. I well remember, as a young fellow in training, a fellow in the cardiac laboratory at that time, visiting other institutions to watch their innovations. Before we in our institution, actually I can tell you the date, it was December 8, 1956, finally went ahead and did our first procedure.

At that point there were short papers, well, there were also long papers, but there were short groups, rather small groups of patients that had been operated on at different centers. The primary center at that time was the University of Minnesota under the leadership of pioneers in this field.

THE COURT: Under whose?

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THE WITNESS: The leadership of certain pioneers in the field.

Q. Do you have any other examples of surgical techniques that evolved in the manner you are describing?

A. There are numerous such techniques in more modern times, almost contemporary times. There is the technique of what we call minimally invasive surgery. Until the late 1980's if one needed to have one's KPWAL bladder removed, for example, it required a long incision underneath the rib cage and a direct exploration of the area of the gall bladder underneath the liver. Patients would stay in the hospital for a week and be debill dated for six weeks.

There had been always the hope that there should be a better way to do this. For decades surgeons had been trying to develop a technique just to see inside the abdominal cavity by blowing it up with air and hadn't succeeded. But we are now getting into the era of fiber optics and getting into the era of new sorts of imaging W. the new technology it seemed like an appropriate time to attack this again, and there were a few surgeons, I believe it was in France, I'm not really sure, who were doing a few of things. One American surgeon, not even from a university or teaching hospital but from a small southern hospital on his own with his partner went to see this being done, and in that small southern city started doing this PROERB.

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The most remarkable thing about that procedure was how the word got out. The word got out very little among physicians but very much among patients. In fact, at the very

beginning, knowing that this fellow Eddie are a Dick was doing those operations --ed deincidentally was his official Christian name, was doing these procedures, patients with ask for them. My first contact with this operation came when a patient asked to have it, and I contacted colleagues, colleagues that I thought were well read, who said they had found nothing in the literature about it, and neither had I.
Q. Over time did physicians begin to perform this procedure?
A. Yes. What actually happened was that an instrument maker, the United States surgical Company in nor walk, Connecticut, got wind of it. They were the ones who introduced surgical staplers some years before and realized there was a financial bonanza there with patient demand, and began giving courses on SH-G for surgeons to learn how to use the instrumentation and bit by bit this grew.
So here is an enormous change in surgery that does not even grow out of the academic, tested atmosphere and has overtaken surgery, as you know.
Q. Dr. , based on your experience, are you familiar with the concept of peer review?
A. Yes.
Q. What is peer review?

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A. It is a term we use and we like to think we know exactly what it means, but let me describe the way it is used. Ordinarily, TAOUSd in two senses. One sense has to do with publication. A group of physicians will write a report or a research paper. They will submit it to a journal. It will then be submitted to physicians who are thought to be the peers of the group that is doing the work. Those Pierce will peers will look the work over. They will determine first if it is publishable at all, second if it is publishable with certain changes, third if it does and says what it purports to say. They are really the gatekeepers to decide in that particular journal whether this paper will be published. That is one form of peer review.
Another simply has to do with funding. When one submits an application let's say to the national institutes of health to fund a major research project, that application is sent to a committee meant to be peers who will look it over and determine whether the project is indeed worthy of being fund STKPWHRD Dr. New land, do you have an opinion as to whether a study establishing the safety of a surgical technique must be published in a peer review journal before that surgical technique may be used on human patients?
A. I do have such an opinion.
Q. What is your opinion?
A. My opinion is that there is really no need nor is there any

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history of our most commonly done surgical procedures having appeared in peer reviewed journals at a time when they were already widely being used and studied.

Q. Why is that the case?
A. By the very nature of what surgery is. Clearly, one can't peer review a procedure done on human beings. They can only be studied in human beings unless there is a significant number of human beings who have already undergone this procedure. WHRFP actually, if I may give an example, we are in the beginning stages of a procedure familiar to everyone here I'm sure, so-called bariat Rick surgery, surgery for morbid oh piece tee, people who weigh 400, 450 pounds. S-

In an article published in the New England Journal of Medicine just about two weeks ago it was pointed out that more than 1,000 such procedures have been done, done by and large in major centers, although some have been done in other places, and we do not yet have sufficient information to know about complications, value.

So surgeons continue doing these procedures as long as in their own personal experience they seem safe in their hands, that they seem to fulfill the expectations that doctor and patient have, and they look as though in the long run they will bear out. We are just beginning with actually a society for bariat Rick surgery that was recently formed, we are just beginning, they are just beginning, to establish criteria by

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which to more rigidly test this. But, once again, it cannot be tested until there have been a sufficient number of patients who have chosen to have TKH- operation.
Q. Dr. New land, earlier you gave us the example of the evolution of minimally invasive gall bladder surgery. Do you recall that?
A. Yes.
Q. Were there peer reviewed studies published concerning that technique before it became widely used?
A. Not at all.
Q. Were there any complications associated with minimally invasive gall bladder surgery after it became widely used?
A. Yes.
Q. Could you describe for us generally what those complications were.
A. Essentially, the problem was that ordinary gall bladder surgery is surgery characterized by a very, very low rate of complications and death. When surgeons began doing the minimally invasive procedures, it was noticed, after some good long time, many months as a matter of fact, that there was a slight increase in the number of bile duct injuries, for example. A surgeon who had never had a bile duct injury? 500 00 gall bladder operations would report one in his 25 minimally invasive gall bladder operations.

Another problem was hemorrhage that required this

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minimally invasive procedure to be converted to one with an incision where the bleeding had to be stopped.

It was recognized at that time not that this kind of

complication meant the procedure shouldn't be done but that the typical what we call learning curve was in effect. When there is a new procedure involving a totally new technology, and in this case a new skill set, one has to expect that even though in the long run this procedure may be preferable, there may be a few patients who don't do as well as they did with the previous procedure.
Q. Do you have an opinion as to whether the completion of a peer reviewed study before the widespread production of minimally invasive gall bladder surgery would have prevented those complications?
A. I think those complications were absolutely necessary to the development of the procedure. A peer reviewed study, I can't imagine how that would have prevented those complication.
THE COURT: Excuse me, Doctor. When you said some patients didn't do as well, did some of them die?
THE WITNESS: There were several deaths.
THE COURT: Thank you.
Q. Dr. New land, are you familiar with the concept of a controlled study?
A. Yes.
Q. What is a controlled study?

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A. Once again, that is a term that actually covers a genre of ways of studying phenomena. Ordinarily, what we mean when we say a controlled study is to take a procedure, a medication or a therapy, and test it against either no therapy at all, a previous therapy, an accepted therapy, several SAEPD THAERPS, so that there is so-called controlled group [> accepted therapies<] maybe I can illustrate it by the very first controlled study that was ever done.
Q. Please go ahead.
A. When British sailors were getting SKUR vi, a certain physician named Robert lind -- James lind, on one of the British ships got it into his head that if he gave limes to the sailors they would not get SKUR vi. So what he did was to take six patients, six of his sailors, and not give them limes, give them other things, and six sailors and give them lemons and limes. Lo and behold the six who got the limes did not get SKUR describe, the other six did. This is an approximation of the experiment, which is why we call the British limeees today.
The point is that was the very first controlled experiment. What I am TRAOEULGT describe is we use one group against the other. One group we have some idea of what the outcome will be, and the group that we are testing.
Q. In your opinion, would it be reasonable to require a controlled study demonstrating the safety of a surgical technique before allowing that technique to be widely used on

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human patients?
A. I consider that a contradiction in terms, because how can in surgery a controlled study be done unless there have been a

statistically significant number of people who have undergone that procedure?
Q. Doctor, you answered the judge's question about deaths that occurred injunction with minimally invasive gall bladder surgery. Do you recall that?
A. Yes.
Q. Are patients thus part of the evolution of surgical procedures?
A. That has been the evolution of card wrack surgery certainly [> check the question<]. It has been the evolution of cancer surgery. It has been the evolution of surgery for peptic ulcer disease. Surgery is a technique done by human beings with their ten fingers, and there is this learning curve.
Q. Are surgical techniques amenable to controlled studies?
A. In general, and I am sure someone might find an exception and there have been one or two notable exceptions, in general they are not amenable to controlled studies, for a number of reasons.
Q. Who are those reasons?
A. ***[STRIKE]***.
Q. What are those reasons?
A. One of them is what I indicated before, that you really

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need an awful lot of patients before you start your controlled study. The second is something that is distinctive and unique to any surgical procedure. It is sometimes difficult for people to recognize unless they hang around operating rooms a lot. If you watch five surgeons doing what is theoretically the same procedure, including all of the steps, you will recognize it is being done in five different ways. Whenever you try to standardize an operation, you essentially end up with a great degree of frustration, because as you go from room to room with surgeons trained in the same way, even surgeons within ten years of each others' age, you recognize that they are not doing exactly the same operation. So how can you in surgery have a controlled experiment? This is not like giving someone a dose of digital is where we have some good idea of what the physiology will be.
In addition to TH-RBGS it is not just the surgeon who is different, it is the team that is different and the kind of help one gets. It is the patient's anatomy that is different in each case. It is the extent of anatomical disease that is different in each case. And if I may use a very simple example of this, how many apdeck TOEUPLS have I done as a general surgeon? Many. As you can imagine. I have never done two appen deck tome in the same way.
Q. Doctor, are there any geographic differences in the manner in which surge is performed?

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A. There are not only geographic differences in the way surgery is performed, but there are geographic differences that have been documented in the medical literature about which

operations are chosen [> surgery is performed, above<] there are studies, well known, frequently quoted, by a man named John WEPB berg who is at Dartmouth, in which he compares surgery done in Boston and in New Haven, for example. His statistics indicate, and experience indicates the same thing, that if you are a person living in New Haven, you are twice as likely if you have cardiac disease to get a coronary artery bypass graft than you are in Boston. If you are a woman with men truly difficulties were his trek to him tome is considered, you are 50 percent more likely to have a hysterectomy in New Haven than in Boston.

The statistics for hip replacement are exactly the opposite. Boston does 50 percent fewer hip replacements, per capita, and twice as many operations on the carotid artery to prevent strokes.

These are just two examples of two cities that are academically similar except with respect to volume but it is taken down per capital.

We know, I know from traveling to various medical communities, that procedures are really quite different one from the other.

Q. Doctor, what impact, if any, do the variations you have

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just described for us have on the ability to design controlled studies for surgical techniques?

A. It frustrates a real controlled study, because the very basis of a controlled study means that two groups must be treated exactly the same way, including the kinds of candidates that are in those groups, with the exception of the therapy being studied. Surgery is simply not amenable to that kind of thing.

Q. Does the level of scrutiny concerning the safety of a surgical technique depend on whether the tech TPHAOEG is a brand new innovation or simply a variation on an existing technique?

A. Yes, it does.

Q. In what way does it various?

A. If one is introducing a whole new concept like minimal invasive surgery or open heart surgery, you can be sure that the eyes of the entire medical community of the country will be watching you. If you are introducing a new operation t scrutiny will also be high.

If you are introducing a different way of doing a standardized procedure, it is virtually certain that the scrutiny will be considerably less.

Q. Why is that the case?

A. Because it has long been accepted that when a surgeon is based with a number of ways of solving a problem there in the

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operating room, she has to make a decision about what she is going do, that her decision has to do with many factors, some of which are personal on the part of the patient, some of which

have to do with the instruments that are available, some of them have to do with her conception at that instant of what in the long term will be best for that person. These are not only technical decisions, they are human, moral, emotional decisions.
Q. Doctor, do the preliminary results associated with the initial use of a surgical technique have any impact on the forward?
A. Certainly. If a procedure is introduced in an institution by people who are well respected and as it is being watched by colleagues, because peer pressure of course in medicine is the ultimate pressure, as it is being watched by colleagues and the results are good, one can be sure not only that the scrutiny will relax in time but that those peers are very likely to take it up procedure themselves.
Q. Aside from controlled studies, are there any other ways to evaluate the safety of new surgical techniques?
A. What has traditionally been done is that within an institution very accurate records are kept on anything that is new. As we say, the bigger the procedure, the more likely those records will be. They will be reported at departmental

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meetings. They will be reported in literature as they become available, at regional meetings.
Q. Dr. New land, I want you to assume for a moment that there is a new variation on an existing surgical procedure. I want you to assume further that a legislative body bans that variation that for peer review studies relating to the safety of the variation have been published. What effect, if any, would the legislative ban have on one's ability to evaluate the safety of the variation? S-
A. The question is -- lane lane objection, your Honor.
THE COURT: Sustained.
Q. Doctor, I am going to ask you to assume that a particular procedure is band. What impact, if any, would that have on the ability to evaluate a procedure's safety? Lane lane objection?
THE COURT: Sustained.
Q. Doctor, in order to evaluate the safety of a procedure,r can you tell us whether or not you need continued experience with that procedure?
A. Yes.
Q. Why is that the case?
A. Because unless you have continued experience with a procedure and evaluate what is happening as that procedure evolves in slight technical changes perhaps or as more people are doing it, there is nothing that you can say about its value. Not only that, but should such a ban remain in

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existence, you can imagine the STAOEUFLG effect such a thing thing will have on innovation of any kind. [> stifling<] wig wig thank you, Doctor. I have no further questions at this time.
THE COURT: Mr. Lane, you may cross-examine, if you

are conducting the cross-examination. Lane lane yes, I am, your Honor.

THE COURT: You may proceed.

CROSS-EXAMINATION S-

Q. Good afternoon, Dr. New land.
A. Good afternoon, Mr. Lane.
Q. You are not offering any opinion in this case about particular abortion procedures, are you?
A. I am not.
Q. So you are not offering any opinion about how long a particular abortion procedure may have been practiced by the medical community?
A. That's true.
Q. In fact, your surgical specialty was abdominal surgery and breast surgery?
A. True.
Q. That was the focus of your surgical practice throughout your career?
A. Yes.
Q. In fact, you do not have any training in obstetrics?

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A. That is true.
Q. You also do not have any training in gynecology?
A. Also true.
Q. In fact, during your entire medical career you did not have any experience performing any abortion procedure?
A. Also true.
Q. Dr. New land, I think you testified on direct you no longer practice surgery, is that correct?
A. Yes.
Q. You have stopped practicing surgery in 1992?
A. January 1992 [> you had stopped<]
Q. Since that time you have not made an attempt to keep current with surgical techniques?
A. I think the terminology needs clarification. Keep current, I of course continue to study the evolution of surgical techniques. I have not kept current in the sense of learning those techniques myself, because clearly I would not be doing them. But I do know of them.
Q. Dr. New land, do you recall giving a deposition in this case?
A. Yes.
Q. At that time I asked you questions and you provided answers to my questions?
A. Yes.
Q. You were under oath at that time?

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A. Yes lane lane if I could have one moment, your Honor, to pull out the relevant page.

THE COURT: Surely. Lane lane your Honor, if I may approach the witness with a copy of his deposition transcript?

THE COURT: You may.
Q. Dr. New land, I would ask you to look at page 123 of your deposition transcript. I would refer you to line 14 of that page.
"Q. January of 1992, what, if anything, KOUD since that time to keep up with surgical techniques and to keep current?
"A. I do not attempt to keep current with surgical techniques.
."
A. That is part of the answer. Wig wig I object to. There is more to the answer. Lane lane I was going to read the rest of the answer.
THE COURT: Please, one at a time. Wig wig my objection is that he did not read the complete answer.
THE COURT: You have a shot at redirect, too. Go ahead. Overruled.
Q. Dr. New land, you do read some current periodicals on medical literature that relate to the practice of medicine?
A. I do read a significant number of current periodicals on the practice of medicine, yes.
Q. But you did testify that you do not attempt to keep current with surgical techniques, is that correct?

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A. May I clarify the statement that is here in this case in which it was given and the meaning that I intended at that time.
Q. Dr. New land, your lawyer after I am done here will have an opportunity to ask you questions.
A. Yes.
provide that information.
A. May I read the rest of the statement? I can't do that?
THE COURT: Doctor --
THE WITNESS: Sorry.
THE COURT: Ms. Wigmore will ask you further questions. Just respond to Mr. Lane's question.
Q. Dr. New land, I would like to ask you a few questions about how surgical innovation should be handled by the medical profession. In your opinion, after a surgical innovation occurs as it becomes more widely used, you would expect to see more surgical centers doing it and more patients available for study, is that correct?
A. Yes.
Q. As to how information is disseminated within the medical profession as a procedure becomes more widely used, you would expect patients to be studied to see whether the procedure accomplished what was intended E and to look at complications?
A. I would expect that to be part of the process, yes.

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Q. You expect attempts to compare the innovative procedure against another operation intend to do have the same results?
A. The question of comparison, you see, is a difficult one, because sometimes the comparison is deliberate and sometimes the comparison simply occurs because it is quite obvious fairly

early on to everyone that something you have just introduced has significant advantages over other ways, previous ways, of doing things.
Q. Dr. New land, I would like you to look at page 31 of your deposition, starting at line 9.
A. Page 31?
Q. Yes.
"Q. Is there anything that changes in terms of the way information is disseminated or studies that are done as a procedure becomes more widely used?
"A. As it becomes more widely used, there are of course more centers doing it, but there are more patients available to study. And the way those patients are usually studied is to look at the results of the intended therapy: Did the procedure accomplish what was intended for it and also to look at the complications. And also there are attempts to compare it against another operation that was intended to get the same result."
A. Yes.
Q. So, Doctor, you would agree, then, that there would be

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attempts to compare the innovative procedure against another operation intended to have the same results?
A. If you read this answer as is given --
Q. Doctor, if I could ask if you could just answer the question yes, your Honor.
A. That is one of the factors.
Q. Thank you, Doctor.
A. That is one of the factors.
Q. In fact, there could be multicenter studies, because any center with a new innovation might not find itself with enough case to say reach any real conclusions?
A. Yes.
Q. I believe you touched in your direct testimony, but you would like to know that the surgeon performing the inno innovative surgical procedure or recent innovation would document everything that is being done in an operative note?
A. Yes.
Q. You would expect one would have very accurate documentation of the technique every time that it was done?
A. Insofar as is POBLG, possible, yes.
(Continued on next page) 3/29/04 take 3 of national
"Q Dr. Nuland would you agree aa surgeon should obtain informed consent of a patient before I being sure that the patient understands all the consequences of a given procedure both good and bad?

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"A that is a very complex question. And if I may be permitted I would like to answer it in a complex manner
"Q well, doctor, could you -- for purposes of this question I would ask if you could answer the question yes or no
A. Would you repeat the question.

THE COURT: Mr. reporter, will you please read the question.

Q. Can you answer that question yes or no, doctor?
A. If it must be a yes or no answer, I would say yes.
Q. For you personally in an instance where you knew ahead of time that you were going to use an innovative procedure, that is something you would have informed the patient about?
A. Yes.
Q. In fact you have personal experience with procedures that, where you perform something that you considered innovative?
A. Yes.
Q. And one of those was an instance where it was technically impossible to remove the spleen and you decide instead to rid the, get rid of the function of the spleen by cutting off its blood supply?
A. Yes.
Q. And in that case you dissected out the artery of the spleen and tied it off?

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A. Yes.
Q. And did you that because if seemed to you there was no other alternative available?
A. Yes.
Q. You have had a second instance where you did something that you considered innovative which involved the removal of a spleen in a patient with Hodgkin's' disease, is that correct?
A. I'm not certain what you are referring to, Mr. lane.
Q. Fine, doctor. Let me see if I can provide more details?
A. Yes.
Q. The instance I'm talking about is removal of a spleen in a patient with lodge KEUPBZ' disease where you had to mark out the places on the spleen so that a radio therapist, in giving x-ray treatment would know exact will where the field of treatment was?
Q. But you consider that an innovative procedure?
A. Yes.
Q. And in that case you did that innovative procedure because it was something you had to do because of the way you had to mark the area for the radio?
A. Yes.
Q. The radiologist. Thank you, doctor.
And there was a third instance where you used an innovative technique where you tied off an artery to the liver,

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the so-called help atic artery in cases of bleeding, isn't that correct?
A. Yes.
Q. And in that case you performed the technique because there was no other alternative because the person was massively
A. I performed that technique because in my judgment that was

the safest thick to do for that patient.
There was an alternative with a high complication and a high death rate.
Q. And other than these three procedures you can't think of any other occasions where you did something that was, you would consider an innovative procedure?
A. Yes.
In the year 1963 or 1964, before we were routinely removing large sections of liver, whether for trauma or for malignancy and at our hospital, as far as I knew at that time, no bit of liver had ever been removed. I was TPAEUFSed with a woman after a severe automobile accident who was having PHAGSive hemorrhage from a severely torn liver and rather than use the standard technique which would have been to pack it again with high complication at the time of mortality, I elected to remove that portion of liver, which was an innovative thing under those circumstances.
Q. Doctor, I would like to refer you to page 45 of your

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deposition, starting at line 3:
"Q okay, certainly I don't want to put any words in your mouth. Three procedures where you did something that would be innovative, is that a safer term?
"A yes.
"Q other than those three instances can you think of any others?
"A I can't really."
Is that correct testimony from your deposition, Dr. Nuland?
A. That is precisely what's written here.
Q. Dr. Nuland, the American college of surgeons is an organization that you belong to?
A. Yes.
Q. And that's an organization that other physicians and members of the community look to and that hospitals look to in determining whether a physician will become a member of a staff at a hospital?
A. It's one of the criteria that is used; yes.
Q. And the American college of surgeons has created a protocol for the appropriate way to train surgeons?
A. The real protocol comes from the American Board of surgery which is a separate body. But there are recommendations from the American college of surgeons, there is no question about that.

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Q. Well, Doctor, wouldn't you agree that the American college train surgeons?
A. The protocol for training surgeons comes from the American Board of surgery, the American college of surgeons, I have to explain that these are not two totally independent groups of people, they dove tail with each other so for the purposes that your question is leading to, the answer is yes.

Q. Well, Doctor, let me just refer you again to your deposition, this time on the bottom of page 14 starting at line 20.
A. 14?
Q. Yes, Doctor, page 14, starting at line 20:
"Q well that's a good segue to my next topic which is obviously your opinion in this case is based on, in part, in large part and your experience as a surgeon, can you explain to me, based on your last question, how it is that one gets credentialed as a surgeon?"
There is an objection, Ms. Wigmore objection to form. Go ahead
that the American college of surgeons has created a protocol for the appropriate way to train surgeons."
A. I misspoke. It is in fact the American --
Q. Doctor, if you would just let me ask the question. That

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was your testimony at your deposition?
A. That was my testimony. That was my testimony, yes.
Q. Thank you, Doctor.
And the American college of surgeons is a group that virtually every appropriately trained surgeon in the United States belongs to?
A. Yes.
Q. And that's something that a surgeon trys to achieve within three or four years of completing his or her training?
A. Yes.
THE COURT: As is this convenient time for us to take luncheon break.
MR. LANE: Certainly, your Honor.
THE COURT: I didn't want to break in on you.
MR. LANE: Not at all, your Honor. This is a perfectly fine time.
THE COURT: We will recess at this time and reconvene at 2:00. P- 3/29D/04 continuation of cross of Nuland by Lane

THE COURT: Mr. Lane, you may resume cross scam.
MS. GOWAN: Your Honor, this is Ms. Gowan, if I may before we resume I would like to report on this morning's event is in the Second Circuit.
THE COURT: Surely.
MS. GOWAN: The circuit has ordered a temporary stay

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pending determination of New York PRO*EUB Hospital's motion for a stay and has set the matter for hearing on Tuesday, April 20th, 2004.
Your Honor, as you know, Dr. Westhoff is expected to testify as the next witness to be called by plaintiffs in this matter. Dr. Chasen shortly thereafter, within days.
In light of the ruling by the Second Circuit and the possibility that the government may not have the benefit of the medical records relating to the treatment that Dr. Westhoff and Dr. Chasen gave to their patients and at which is at issue in

this case by virtue of the statements that they have made in requests the opportunity now to renew its motion in limine to preclude Doctors Westhoff and Chasen from testifying as to medical necessity partial birth apportion.

THE COURT: For interest the words in limine never appeared in the federal rules despite common HRAUS Y this is words in commentary but there is no such motion but if you want to preclude, fine, I will reserve on that.

If you want to file any additional papers the date you say that the Court of Appeals set for hearing is April 20th?

MS. GOWAN: That's correct, your Honor. And I might add.

THE COURT: Is the government going to make any application to move that hearing up?

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MS. GOWAN: The government will seek reconsideration and expedite a review tomorrow, your Honor.

THE COURT: It being the 29th of March, that hearing would render all ABG STKEPLic, wouldn't it or pretty close to it.

MS. GOWAN: Yes, your Honor.

THE COURT: How much time do you want to file any additional papers? And of course the plaintiffs can do as well.

MS. GOWAN: We would be willing to supplement within 24 hours, your Honor.

THE COURT: I would ask the plaintiffs to do the same.

And as I requested, the plaintiffs to do, to see if they could adjust their witness schedule to try and reach this question, I hope they will, otherwise I will consider keeping the witnesses open for recall depending on what may happen in the Second Circuit.

MS. GOWAN: Your Honor, pending the filing of our supplemental papers within 24 hours we would request that to the extent Dr. Westhoff takes the stand today that she not be permitted to testify about the alleged medical necessary of partial birth abortion.

THE COURT: Well, I would prefer the plaintiffs voluntarily change their schedule in light of what has happened and it seems to me that Dr. Westhoff is here locally as well

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and I don't see the burden to the plaintiffs and I warned them of this last week so that they might have some adjustment in light of that but I never heard any response to it.

Mr. Hut?

MR. HUT: This is Mr. Hut, your. We obviously took very seriously and thought long and hard with respect to your Honor's suggested, inTKPAOED your urge STHAG we revise the order of the witnesses. We would propose to go forward with Dr. Westhoff after Dr. Nuland for two reasons:

First, it was always our contemplation that Dr. Westhoff would testify to facts that lay the groundwork for

everything that follows. We would propose that you testify -- a non-jury situation. It is not that crucial, witnesses can be taken out of order and I hope the Court can place them in proper perspective. I understand that, your Honor. The second problem, frankly, and we will again reconvene this evening to look at this once more, the second problem is frankly moving in other witnesses.

Yes, I believe that Dr. Westhoff who is local could return for testimony on the question of safety but the problem is --

THE COURT: If the records get turned over she will return, let me assure you.

MR. HUT: Your Honor has made that crystal clear and

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that was indeed our suggestion. The government suggest it had and we concurred with it. We have no problem with that.

THE COURT: I think it would be a much smoother transition if witnesses testify all at one time. It is also less inconvenient to them as well, so I would hope you would take that serious consideration STHAO let me ask clarification with respect to the Court's last comment, your Honor, and that is it is the thrust of Ms. Gowan's renewed motion to preclude that the doctor be precluded only with respect to her testimony on the safety of the various procedures, what the government describes as medical necessity.

We would hope, subject to the doctor's availability then to be able to put her on with respect to all of the other evidentiary issues on which she and we propose to have her give testimony than to come back.

THE COURT: What I am suggesting to you is you call the doctor once and that you would hope to adjust your schedule a little bit for the moment, see in what direction we go, and that you call her and the other witnesses of what she applies to and we put them on and we finish it with direct and cross examination, as little inconvenience it all of us and to the parties and the Court.

MR. HUT: The Court has made that point clear. We will do everything we can to convenience the parties and Court.

THE COURT: I think it's the prove way to approach it

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Mr. Hut. Sometimes, if you can, you don't always, as our mothers taught us, we always don't get it just the way we like but as we grow up and hopefully mature a little bit we learn to adjust to the little bumps in the road.

But still, try and do it in a professional manner and as smoothly as possible.

MR. HUT: Then let me advise the Court as well that this afternoon it is our expectation, though we never know how these things will unfold, that we would have gotten to Dr. Westhoff. If we do then I would request possibly adjournment before the 4:30 hour so that we can, as the Court has requested, reconsider the order of our witnesses and see

what we can do.
THE COURT: The Court will try and be flexible with that.
MR. HUT: Thank you, your Honor.
THE COURT: And we probably will go until 5:00 but in any event we will see what happens. But yes, I understand that. Sometimes you get caught without a witness. I understand that, Mr. Hut and that is fine.
Well, with that and I hope everybody will give it some evaluation and hopefully you will keep us apprised of whatever you all work out, then we can continue W-S cross-examination.
MR. LANE: Thank you, your Honor.
CROSS-EXAMINATION

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BY MR. LANE:
Q. Good afternoon, Dr. Nuland.
A. Good afternoon.
Q. This morning we were talking, we left off talking about the American college of surgeons, of which you are a member; is that correct?
A. A fellow, yes, the term, yes.
THE COURT: Excuse me, what's the difference between a fellow and a member, if there is one?
THE WITNESS: Well, a member actually ordinarily initiates his own membership, a fellow is elected, sometimes by election per se, sometimes by being examined and achieving what is called the fellowship.
It's considered a distinction as opposed to a member.
THE COURT: Thank you, Doctor.
BY MR. LANE:
Q. And doctor, the American college of surgeons occasionally issues statements, do they not?
A. Yes, they do.
Q. And a statement by the American college of surgeons is a series or single recommendation about how surgical departments and individual surgeons should comport themselves in the relationship to practice in the art of surgery?
A. Yes.

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MR. LANE: Your Honor, if I may approach?
THE COURT: You may.
Q. I would like to hand you what's been marked as Government Exhibit E-7 Wigmore name your Honor, I object to this exhibit as hearsay?
THE COURT: I don't know what it is yet, TP-S a little hard for me to Judge.
MR. LANE: I am going to proceed to hand it to the witness and explain to the Court the intention for which it is offered.
THE COURT: All right.
Q. Government Exhibit E-7 is *EPBL titled statements of the

college and is, your Honor, is not an exhibit that we intend to move into evidence but rather vehicle for eliciting testimony from this witness, your Honor.

THE COURT: That's its purpose? Overruled. I will allow it.

BY MR. LANE:

Q. Dr. Nuland, you have been handed what's been marked as Government Exhibit E-7 which is a statement of the American college of SURLGons, is that correct?

A. Yes.

Q. And that statement is entitled statement on emerging surgical technologies and evaluation of credentials?

A. Yes.

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Q. And this statement you saw as part of the monthly bulletin you received as a fellow from the American college of surgeons?

A. I saw it, yes.

Q. And this morning in your testimony you cited the lap RO scopic gallbladder procedure as an example of how surgical innovation occurs and has spread within the medical community, is that correct?

A. Yes.

Q. And this statement of the American college of surgeons was issued, its your understanding, as a result of the use of the lap RO scopic gallbladder procedure, is that correct?

A. It grew out of some of the issues involved there; yes.

Q. When you say some of the issues, is it correct to say that those issues include the fact that the lap RO scopic gallbladder procedure operation, after having been performed hundreds of times, it was discovered that it was result engine higher complications and deaths than the procedure it was replacing, is that correct?

A. That was one of the issues, yes.

Q. And this lap RO scopic gallbladder procedure that you testified to earlier and that was a motivating factor for this statement was widely used before it had been studied, is that correct?

A. Was widely used before it had been studied and any determined organized and consecutive manner; yes.

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Q. And as a result of the -- partially as a result of the lap RO scopic gallbladder procedure and the results of its use, the American college thought it appropriate to issue this statement, is that correct?

A. That's my impression, yes.

Q. In fact when you first saw this statement of the American College you thought it was important, is that correct?

A. I have to admit when I first saw it I just skimmed it very quickly.

THE COURT: Can we have the date of this?

MR. LANE: Yes, your Honor. The document itself is on the last page, notes that its reprinted from the bulletin of the American College of surgeons and it KREUTS a volume and

number with a date of June 1994.
Q. And this statement was the first clear statement on how important it was to follow a procedure as if developed, is that correct?
A. As far as I know, yes.
Q. And looking at numbered paragraph 3 of that statement, there is a statement that says widespread application of new technologies must be continually assessed and compared with alternative therapies to ensure appropriateness and cost effectiveness throughout studies. STKPWHROEUFRPBLGTS throughout come studies.
And awe grow with that statement, don't you?

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A. Yes, I do.
Q. And in your opinion in fact there is a great and important movement in American medicine to do these outcome studies?
A. Yes.
Q. And when you say outcome studies you mean specific long-term evaluation of all facets of a therapy?
A. Outcome studies, the term outcome actually has a definition and the definition came about some 10 years ago when it was realized on a national basis that although we knew how procedures went and what results were over a period of two, three, four years, we really didn't know over long periods of time whether these were the best procedures for any individual patient or group of patients.
So, the decision was made that much longer term is studies should be done in a systematic way.
Q. Well, Doctor, if you could just answer the question I'm asking which is, you understand outcome studies to mean specific long-term evaluation of all facets of a therapy.
Is that correct?
A. Long-term, yes.
Q. And the purpose of an outcome study is in fact so that one can determine whether it's a good therapy, a bad therapy, what the problems are and what's likely to happen much later in life?
A. Yes.

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Q. And by the word therapy, that would include anything intended to treat?
A. Exactly.
Q. And this would include surgical procedures?
A. Yes.
Q. In fact, in your view again and again in medicine there are examples where procedures, whether they be therapeutic or diagnostic, it seemed to make perfect sense but that when subjected to long-term evaluation make less sense than was originally thought?
A. That's a fair statement, yes.
Q. And what the American college of surgeons is doing here in

your view is part of a 200-year-old attempt to put surgery on the same scientific basis as physics or internal medicine?
A. I think the crucial word here is attempt." yes.
Q. And you think that that's so because surgeons enter the laboratory more and more and study statistics more and more for their basic scientific research that they are more and more impressed by the validity of statistical methods as they should be?
A. At this moment in time surgeons are very impressed with statistical methods. I cannot guarantee to you that we will feel the same way 10 years from now because the history of surgery shows us that we have swung back and forth between criteria for evaluating our own work.

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Q. Well you would agree that currently that surgeons are more and more impressed by the validity of statistical PHEPLGZ?
A. Yes.
Q. As they should be?
A. That is true.
MR. LANE: If I may approach, your Honor?
THE COURT: You may.
Q. Doctor, you have been handed what's been marked Government Exhibit E-8 Wigmore name your Honor, at this point I have the same objection to E-7 to the extent we object to offer for its truth hearsay?
THE COURT: It's not being offered at the moment he is showing it to him, there is a difference. Overruled.
BY MR. LANE:
Q. Dr. Nuland this Exhibit E-8 is yet another statement of the American College of surgeons, is that correct?
A. Yes.
Q. And this is a statement that you have also seen in the past?
A. Exactly.
Q. And this statement is entitled statement on issues to be considered before new surgical technology is applied to the care of patients?
A. Yes.
Q. And you would agree with the sentence in the first

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paragraph of this statement that as major new biomedical technology is developed and made available for use, its worth is measured on the basis of the value and safety it confers for patients.
A. Yes.
Q. And you would also agree that part of this process and evaluation would include a comparison with existing and established technologiess that deal with similar clinical problems?
A. Yes.
MR. LANE: No further questions, your Honor.
Thank you, Dr. Nuland.

THE COURT: Ms. Wigmore, you may.
MS. WIGMORE: Yes, I have a few questions.
REDIRECT EXAMINATION

BY MS. WIGMORE:
Q. Dr. Nuland, do you still have your deposition transcript in front of you?
A. Yes, I do.
Q. Would you refer, please, to page 123 of your transcript? Do you have that page?
A. Yes, I do.
Q. Do you recall on direct Mr. Lane -- on your cross-examination, excuse me, when Mr. Lane directed your

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attention to the question and answer beginning at page 123, line 14?
A. Yes.
Q. And he had ever read to you the first line, the first sentence of your answer to that question; do you recall that?
A. Yes, I do.
Q. Could you please read for me, Dr. Nuland, both the entire question and the entire answer beginning at page 123, line 14 and concluding at page 123, line 23?
MR. LANE: Objection, your Honor.
THE COURT: I will allow it.
Q. Please go ahead?
A. What, if anything do you do since that time, January of 1992, when I stopped doing surgery, to keep up with surgical techniques and to keep current?
"A I don't attempt to keep current with surgical techniques. What I know of surgical techniques comes from the fact that I subscribe tow and read New England SKWROURPBLD of medicine, the journal of the American Medical Association, I read science, perspective in biology and medicine. This is my way of keeping up with medicine."
Q. Thank you, Doctor.
Do you recall when Mr. Lane read to you the first sentence, you asked for an opportunity to clarify that sentence?

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A. Yes.
Q. Could you please read that sentence again for us and then provide the clarification you asked to provide?
A. The sentence reads: "I don't attempt to keep current with surgical tech TPHAOEGZ."
On the face of it, take it out of context as it was done.
THE COURT: All right, please, Doctor, don't editorialize, just absence the question.
THE WITNESS: Sorry, your Honor.
THE COURT: Go ahead.
A. As the sentence stands, it would be interpreted as meaning

precisely what it says, I don't keep up with surgical techniques. However, my meek is very clear from the following sentences, I believe and my meaning is, that I keep up with evolving surgical techniques but I don't keep up with them in the sense of learning how to do them, I am not doing them. I, if I had to pass a theoretical examination on surgery I could probably pass it just as well today as I could in 1992 simply because of reading the journals, being in contact with academic colleagues constantly and following the progress of surgery.
BY MS. WIGMORE:
Q. Doctor, do you recall on cross examination discussing with Mr. Lane examples of cases in which you performed innovative surgical procedures so save a patient's life?

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A. Yes.
Q. Are there circumstances other than life or death cases in which surgical innovations have developed?
A. Oh, certainly.
One may realize during the course of a procedure that choosing an option which was not considered before is more appropriate for a particular patient, whether it's his or her lifestyle, whether it has to do with a period of recovery, whether it has to do with perhaps certain dietary restrictions that one may think that person simply can't put up with.
There are many considerations at the time of choosing one path or another during an operation that don't have to do with technique alone.
Q. Can you provide us with an example of a surgical development that evolved not for purposes of saving the patient's life, but for other reasons?
A. Well, one of those that we spoke about this morning has to do with the treatment of Hodgkin's disease where the surgical innovation had more to do with diagnosis of the extent of disease than with this dramatic thing we call saving a life.
Can I expand on that?
Q. Yes, please.
A. It was determined in the late 1960s that Hodgkin's disease, which we had always thought with a disease spread throughout the entire body from the time of its inception, it turns out

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that it actually begins in one place, in one focus and spreads from that focus.
Well, its easy enough with CAT scans and x-rays to know where it is in the chest but it is impossible to know where it is in the abdomen, even with good CAT scans, at least it was at that time. It still is, I believe.
In order to find out whether there is a hidden deposit of it in the spleen one must remove the spleen so working with the x-ray therapists who were at that time using the new 2 million electron volt equipment, we put together a procedure in which we would remove the spleen, dissect out the arteries to the spleen and the area of what's called the a ORTDa, the main

blood vessel running down the center of the abdomen and mark them with metalic clips so the radio therapist could design his/her therapy to include only those areas where the Hodgkin's disease was.

And I was the person that the hospital who did all of those, it just fell to me to do all of them and I organized a particular protocol for that purpose.

So, one cannot say that this is life saving but diagnostically in the long-term it made a huge difference in therapy, kept many people from getting either excessive radio therapy or chemotherapy they didn't need, and essentially made it possible for the first two stages of Hodgkin's, so-called A and B, to be cured in more than 80 percent of instances.

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Q. Doctor, do you recall answering questions from Mr. Lane about informed consent?
A. Yes.
Q. Based on your experience, does informed consent require the physician to disclose to the patient every detail of what will transpire during a surgical procedure?
A. No. As a matter of fact I think it's sometimes contraindicated and let me tell you why.

If one stays in the strictly legalistic sense of informed consent one is probably more interested in protecting one's self than protecting the patient.

One of my ways and most surgeons ways of protecting the patient from going eTPHOURPL your Honor psyche I can trauma of operation is to share with them what is probable and not to share details that may be either very distasteful to a patient, may not come up in an operation SK-PT in some vague possibility, or may bring a patient to an operating room in a rather terrified state.

So, I have always considered this as most surgeonss do, a matter of judgment. There are certain things a patient must know. They must know the general risk they are taking. They must know the general plan you have for this operation. They must know your ways of perhaps going in a different direction.

That's what they must understand.

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But the basis of informed consent is really trust and if I can convey, and I believe virtually every surgeon would say the same, if I can convey it a patient a sense of trust, I bring that patient to the operating room in a state of he can WA anymority, a state of peace, and we all know that that affects the outcome of our work.

(continued on next page) TWM 3/29/04 take 4 Dr. New land on direct<]
Q. Doctor, do you recall Mr. Lane providing you with exhibits E7 and E8, which are the statements of the American College of Surgeons?
A. Yes.

Q. In one of your answers do you recall saying that the critical word is "attempt"?
A. Yes.
Q. What did you mean by that?
A. What I meant is that organizations, overall um WREL la organizations like the American College of Surgeons, attempt to approach our craft, our art -- it is not a science, as you know, even internal medicine is not a science -- our craft, our art, attempt to approach it from an idealistic viewpoint of what could conceivably be possible, realizing that we can approach this ideal but almost never attain it.
Of course, if you are evaluating a new therapy, what is ideal is a prospective, randomized, controlled study, the so-called golden mean of medical therapy, medical diagnosis.

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I would submit to you that that is impossible in surgery. We have sometimes approached it, but rarely. And there are many reasons for that. I can elaborate if you want me to.
I applaud the American College of Surgeons for establishing these guidelines, knowing perfectly well that these are lofty goals that are unattainable. But if lofty goals are not written down and submitted, the probability of remaining within less lofty attainments diminishes. Wig wig thank you, Doctor. I have no further questions.
THE COURT: Mr. Lane, any recross? Lane lane no, your Honor. No further questions.
THE COURT: Doctor, if they are all finished, I have a couple of questions. You talked about new developments. I believe, forgive me if I can't quote it to you, but I believe you said it is imperative that people develop new techniques or procedures in surgery that they take detailed notes of, is that correct.
THE WITNESS: Yes, that is true.
THE COURT: In substance, am I repeating what you said?
THE WITNESS: Keep detailed records, yes.
THE COURT: I believe you talked about the fact that it may be a little town in I think you said Alabama or it could be a prestigious teaching institution like Yale, correct?

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THE WITNESS: Yes.
THE COURT: They still should keep these details?
THE WITNESS: Yes, sir.
THE COURT: I believe you said then the word spreads and others come and observe and they take the new technique and go home to their areas. Is it continuing evolution that those who participate in this evolution, that they continue to take notes so that the profession can benefit from this development?
THE WITNESS: That is the ideal. It must be confessed that some physicians do not keep that scrupulous a record, but that is what we attempted to, yes.

THE COURT: Like in every field?
THE WITNESS: Exactly.
THE COURT: Some are better note takers than others, some are more tee tailed, some are more perfectist, etc. We are human beings. But that is the ideal?
THE WITNESS: Yes.
THE COURT: That they take notes so we can evaluate how this new procedure is working out, right?
THE WITNESS: Notes and sharing of that information, yes.
THE COURT: I take it that also encompasses risks such as you mentioned in the gall bladder; after a period of time you started realizing there were some problems to the new surgery, right.

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THE WITNESS: Precisely.
THE COURT: So it is important that those notes be kept whether it be in Alabama or in New Haven, is that correct?

PW-PBLG yes.
THE COURT: To evaluate all that, you would have to be able to look at them, right?
THE WITNESS: Yes.
THE COURT: No further questions. You may step down. Thank you very much.
(Witness excused)
PLF. COUNSEL:
PLF. COUNSEL: Your Honor-as the next order of business we had proposed to present the deposition testimony of the American College of Obstetricians and gynecologists by its Dr. SKWRAOPB a cane. My colleague misParker will, as the Court's chambers requested last week, examine a reader, who will read for Dr. Cane from the transcript. That will be my colleague ania Manuel. Ms. Parker has a couple of preliminaries with respect to that process that she will address to the Court momentarily.
THE COURT: All right. Ms. Parker or Mr. Hut or whoever, approximately how many pages or what sort of volume are we talking about? Parker Parker your Honor, the

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designations are somewhat lengthy. We think that they will
THE COURT: OK. That will be fine. When we come to our normal afternoon break, I will inquire of you so as not to interfere with a logical spot. You let me know. Parker Parker absolutely I. am going to move myself to the podium.
THE CLERK: Ms. Manual, please take the witness stand and remain standing.
THE COURT: You don't have to swear her. We are just reading the transcript.
THE CLERK: You can just take the stand. Parker Parker your Honor, the preliminary issues that I wanted to

raise and seek your guidance on relate to how you would like to proceed here. There are two issues. The first is a number of pages of this deposition were designated confidential pursuant to the protective order enterd in this case. With those pages of the testimony, we can proceed in a number of ways. We could seal the courtroom and read them aloud, we could submit those pages in writing to you, or we could read them in chambers or proceed in any other manner in which your Honor wishes to proceed.

THE COURT: Have you worked out an agreement with the government as to how you want to do this together? It doesn't make a great deal of difference to me. What is the government's position? Pan pan your Honor, Joseph pan to ja.

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My concern is with respect to the names of particular doctors or panel members that were part of the task force on acould go that draftd this statement in January 1997. A solution for that would be to designate, for example, a number to a particular document, proceed with the testimony by referring consistently to the numbers assigned to the doctors or panel members. For example, there is an eight-member panel. A doctor will be consistently referred to as panel member number 1, panel member number 2, and proceed accordingly. PAURBG PAURBG your Honor, we have no objection to that. The only problem with it is it is not just the name that is the subject of the protective order, it is other identifying information as well, and it is the American College of Obstetricians and gynecologists that designated these pages of the transcript confidential, not the plaintiffs. They have designated the entire portion, not just the name. Pan pan my understanding, the government's understanding, is that the concern was with the names, identifying the names of the individuals. We can take it on a case-by-case basis, but it seems that if we substitute the names by some other nonidentifying information, like panel member number 1, panel member number 2, it should address that concern Parker Parker your Honor, perhaps we could do that.

THE COURT: I really think you should have worked this out in advance, and I hope in the future we won't have to do to to 20040329

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do this if you know this is coming, please give it to me earlier.

Does this continue all the way through the transcript where you are going to have to be either designating a name or submitting to me separately an identification? Is this all the way through these things? Parker Parker no, your Honor. It occurs three time in the transcript, but the first time it goes on for about 30 pages.

THE COURT: Pray tell, how many pages are you pants paying that you are going to read? Parker Parker your Honor, I apologize, but the designations are somewhat lengthy. This is an important deposition, being the professional association of doctors in this field.

THE COURT: I understand that they are very important, but nonetheless I want to make it so that it is meaningful rather than us looking at some number 1 said, number 2 said. Tell you what. Will you please show the transcript to my law clerk. We will take a five-minute break R. we will go in the robing room, not with you but just ourselves, and go over it and see if there is some fashion that we can think of to make this a more meaningful reading into the transcript, since we are sort of caught, at least I was, not having been made aware that you had these problems with the transcript. Why don't you show that to my law clerk, Ms. Parker, and we will take a five-minute recess here. Parker Parker yes, your Honor.

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(Recess) test test test
THE COURT: Ms. Parker, as I understand it, you all have worked it out. You will submit an unredacted transcript to the Court which we will keep sealed. You will give us a list, identify the individuals by letter I believe was the final agreement, and we will have no identification of location other than the generic reference to "hospital." Is that correct?
MS. PARKER: That is correct. We will give the general city, but not the specific hospital.
THE COURT: That is fine. You will give us a copy of that legend which we will seal.
MS. PARKER: Yes, your Honor.
THE COURT: With that understanding, then you can go ahead and commence reading the transcript.
MS. PARKER: Thank you. Your Honor, this is the designated deposition testimony for the American College of Object STE TRAEUGSs and gynecologists, or ACOG, as presented through their Rule 30(b)(6) designee Joanna Cain MD. Dr. Cain was deposed by the government on February 10, 2004, at the office -FS of the Department of Justice in Washington. Mr. Anthony kappaly no from the Department of Justice questioned Dr. Cain for the government.s in Suzanne no SRABG from the center for reproductive rights also conducted some questioning on behalf of the plaintiffs in all three of the cases

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challenging the Act. My colleague from Wilmer Cutleral ma manual will be reading the part of Dr. Cain. I will be reading the parts of Mr. Caply no and Ms. No SRABG.
THE COURT: Very well.
MS. PARKER: Very well. You may proceed.
MS. PARKER: Thank you.
"Q. You are the chairman of the department of OB-GYN at -- let me get this right -- or gone health science University?
"A. That is correct.
"Q. You are also the director for the center for women's health?
"A. That is correct.
"Q. I'd like to show you what has been marked Exhibit 2, which

I would represent was taken off the website of OHSU. Doctor, on the first page of the document marked Exhibit the A*EUF handed you is a very briefly biography of you, is that correct?
"A. That is correct.
"Q. It says that your special STEUFRBGSs are boy medical ethics, OB-GYN and gynecologic oncology, is that correct?
"A. That is correct.
"Q. Is the treatment of gynecologic cancer your specialty?
"A. That's correct.
"Q. Do you have any other practice specialties?
"A. Boy medical ethics and ethics consulting.
"Q. Would you just give AUS summary of your experience as an

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OB-GYN. What have you done throughout your career in that field?
"A. I was a medical student at cry ton University in Omaha, Nebraska. I did a residency at the University of Washington in Seattle Washington. I did a fellowship at the ne moral Sloan-Kettering cancer cent in New York City. I then went back to the University of Washington as faculty. I then went to pen state University as the professor and chair. And then I went to or gone health sciences university as professor and chair and director for the extent for women's health.
Q. What areas are you taught as a professor?
A. In my career or as a tenured professor?
"Q. Let's start with as a tenured professor?
"A. OK. As a tenured proffer I teach throughout the School of Medicine everything from undergraduate infectious STKAEUGs inincluding APC cancers. I teach medical ethics in the broad scope of medical ethics and the issues particularly in obstetrics and gynecology. And I teach in GYN oncology and in general oncology and end of life issues.
"Q. Doctor, do you have any practice experience in the care of pregnant women?
"A. Yes.
"Q. Could you describe that, please?
"A. Starting from my residency, actually TPWR medical school, I had the rotations on obstetrics and gynecology and special

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rotations in obstetrics and gynecology. At the University of Washington of course the residency is in obstetrics and gynecology and involves significant care of pregnant women, including second trim ter abortions. A Memorial Sloan-Kettering the care of TPREG TPHAEPBT women primarily included women with ma anything SAEPBSs at the time they were PREPBLGT and including action AOPBs TPEURPBTS and second trem tus abortion realty to do that. And my same scope in my practice at present and beyond my fellowship.
Q. Have you delivered babies?
A. Yes.
Q. Due, how many babies have you delivered, could you guess, estimate?

"A. A very large number.
"Q. You mentioned a moment ago second trimster abortions. Could you describe your experience in performing abortions.
"A. During my residency this was taught within the residency, and I participated in second trimster abortions. During my fellowship, the abortions would have been related to diseases, cancers of the pla sen at a or other cancers that required abortion to allow for treatment of the mother. And that scope would be the scope I participate in now.
"Q. When you say participate in, does that mean you perform them or observe them?
"A. Participate in, assist in.

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"Q. Assist in. Is there usually another primary surgeon who is PERPLG the procedure?
"A. Now, yes.
"Q. And in the past, have you been the primary surgeon performing the procedure? Let me just say primary physician perform the procedure.
"A. Yes.
"Q. Could you just briefly tell us what methods you have utilized in perform abortions?
"A. We've used D&E, hysterectomy. That would be primarily in the case of several cal cars no, I am, his trot tome in one case and induction of labor.
"Q. It says on Exhibit 2 that you are the director of the women's health at or gone health science University. Did I get that correct?
"A. I'm the director of the center for women's health.
"Q. Center, that's right. What does the center do?
MR. PANTOJA: Objection, your Honor. Relevance. SP-P.
MS. PARKER: Your Honor, may I be heard?
THE COURT: I thought we had an understanding on transcripts that if you had objections I should know about them in advance and I will rule on them. Is this going to be the course that we are going to be objecting all the way through?
MR. PANTOJA: Yes. They are in the pretrial order,

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your Honor. Our objections are in the pretrial order. We had a discussion with your law clerk. Our understanding was that your practice is generally when the transcripts are read into the record that it is treated as if it were live testimony and objections are conon a question-by-question basis.
THE COURT: What is your objection?
MR. PANTOJA: Relevance, your Honor. There is no relevance to what the center for women's health does in this action.
THE COURT: I will allow it for a little bit for background. I thought you had some other objection.
You may proceed up to a point on background. I think the purpose for which you offered this transcript is not

necessarily what the or gone center for women is or does other than for a limited amount of background. So keep that in mind as you read, because this is not all to do with this witness but rather her speaking for the organization, correct?
MS. PARKER: That's correct, your Honor.
THE COURT: I will allow a little latitude.
MS. PARKER: Thank you.
Repeating that question:
"Q. Now, it says on Exhibit 2 that you are the director of the women's health at or gone health sciences University. Did I get that direct?
"A. I'm the director of the center for women's heating.

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"Q. Center -RPLT that's right. What does the center do?
"A. The center is an integrated comprehensive center that takes care of women throughout life, all AEUPBGS, stages of a woman's life. TAS multidisciplinary center.
Q. Does the center provide abortion-related services?
"A. Yes.
"Q. OK."
Skipping ahead, your Honor --
THE COURT: Good idea. I was just leaning over your shoulder a little bit. As best as a blind man can. Go ahead.
MS. PARKER: Skipping forward to page 27.
"Q. When did the center start performing intax TK*BGS?"
MR. PANTOJA: Objection, your Honor.
THE COURT: Sustained. Let's move on to what the lady has been called for.
MS. PARKER: Page 30.
"Q. Now, you were on the task force created by ACOG in 1996 specifically to review late term abortion procedures, is that correct?
"A. That is correct.
"Q. Let me first mark as number 3 the January 1997 statement of ACOG policy on -- staple onto intact dilatation and extraction."
Your Honor, we are not proposing to offer these exhibits now, but at the conclusion of Dr. Cain's testimony

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after the foundation for the exhibits has been laid. Is that appropriate?
THE COURT: It is going to slow things down a bit. We are going to have to go back and reference the transcript again.
MS. PARKER: For purposes -FPT transcript to make clear, Dr. Cain Deposition Exhibit 3 is --
THE COURT: Tell you what you could do. If you had given these to us in advance, we could probably rule on them as we go through with the transcript, and I hope we will do that in the future. I would rather not slow this down. For this one time we will see how it works. You go ahead and read. The only trouble is then does the come in through the testimony?

MS. PARKER: Several questions are asked about these documents. But because we would propose to admit these as business records, the found aches of Dr. Cain's testimony will be necessary before we try to move them into evidence.
THE COURT: It seems to me that you will lay the foundation and offer them as we go along.
Have you objected to all of these?
MR. PANTOJA: Your Honor, we object to the admission of the KPHEUBTS into -FD. There is no foundation as a business record.
THE COURT: No foundation?
MR. PANTOJA: Yes, it has not been established that it

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is a business record. K-PL tell you what. You go ahead and read them are give me the records overnight and we will decide whether there is any foundation. If there is, we may have to strike it in the morning.
MS. PARKER: Thank you, your Honor.
THE COURT: If there is no foundation.
MS. PARKER: Page 38.
"Q. Let me first mark as number 3 the January 1997 statement of ACOG policy, statement on intact dilatation and extraction. I'm going to mark as Exhibit 4 ACOG statement of policy on abortion policy. I think I'll mark one more thing while we're at it. I'm going to mark fact sheet on January 1997 ACOG policy statement regarding intact dilatation and extraction as number 5."
Your Honor, these are plaintiffs' Trial Exhibits 6, 5, and 8 for your reference.
"Q. Does ACOG have an established structure of committees to consider policy on different issues regarding obstetrics and gynecology?"
THE COURT: Excuse me. Please, if we are going to do that, use the the trial exhibits in reading the TREUPBTS. Otherwise, we are going to have chaos.
MS. PARKER: Understood.
THE COURT: We are going to have two transcripts, two different sets of exhibits. Try and interpose the trial

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exhibit number, if you would. Now that you have put on the record what the identified records are, maybe just do it again.
MS. PARKER: Do it again?
THE COURT: State what the three exhibits are and what their trial exhibit numbers are.
MS. PARKER: Yes, your Honor.
THE COURT: Three exhibits, right?
MS. PARKER: That's right. The three exhibits are the January 1997 statement of ACOG policy. That has been marked as plaintiffs' Trial Exhibit 6.
THE COURT: In the transcript it is what?
MS. PARKER: It is Exhibit 3 to the deposition.
THE COURT: And the next?

MS. PARKER: Exhibit 4 to the deposition is the ACOG statement of policy on abortion that is the 2000 policy, and that has been marked as plaintiffs' Trial Exhibit 5.

Exhibit 5 to the deposition is the fact sheet on the January 1997 ACOG policy statement, and that has been marked as plaintiffs' Trial Exhibit 8.

THE COURT: OK. Go ahead with the trial exhibits, if you would, please.

MS. PARKER: I will. On page 41.

"Q. $ACOG have an established structure of committees to consider policy on different issues regarding obstetrics and gynecology?

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"A. It has an established structure. In addition, it uses task forces as necessary.

"Q. Maybe to make the question a little clearer, does the have a set standing committees on particular issues?

"A. Yes.

"Q. Let me just finish the question. On particular issues involving obstetrics and gynecology?

"A. Yes.

"Q. Do you happen to know what they are?

"A. I know a few of them. I chair the ethics committee.

Q. All right. Do you know --

"A. And I chair the grievance committee.

"Q. What does it mean to be an ACOG fellow?" ?

MR. PANTOJA: Objection, your Honor. The question calls for an irrelevant answer?

THE COURT: What relevance does this have to anything, Ms. Parker?

MS. PARKER: The relevance is that it was ACOG fellows who made up the task force that issued the statement of policy. So this is just a background on what it means to be an ACOG fellow. [> ACOG is ACOG<]

MR. PANTOJA: Your Honor, I don't understand the relevance of what the background is.

THE COURT: I will let her lay a foundation of who the people are who are making certain policy recommendations, I

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assume. I will allow it.

MS. PARKER:

"Q. What did it mean to be an ACOG TPOEL le? Is that the right term, that you can be a fellow of ACOG?

"A. That is correct.

"Q. What does that mean?

"A. To be a fellow of the American College of Object STE STREUGSs and TKPWAOEULG college \{^ivities}\{^ists}, you must have received certification in the TKEUPBS PHREUPB of obstetrics and gynecology and youmy apply for fellowship.

"Q. Does ACOG itself provide for certification in OB-GYN?

"A. No.

"Q. That is provided by?

"A. The American Board of Object and TKPWAOEUPB.
"Q. Are ACOG fellows at all involved in the process of the development of ACOG policy?
"A. Yes.
"Q. How so?
"A. All the committees of ACOG consist of fellows of the American College of Object STREUGSs and TKPWAOEUPB KOLGTS.
"Q. I have asked you generally about policy development. I want to ask you specifically about this 1997 statement on dilatation and extraction. What was the process by which this statement was developed? I'm referring to plaintiffs' Trial Exhibit 6, Doctor.

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"A. The process was similar to the process in other committees, in that materials that might provide some background were sent out before the task force met. The task force was carefully selected to provide a broad range of expertise and viewpoints. The committee then met, reviewed the materials, reviewed relevant experiencets and expertise in the area."
THE COURT: Excuse me. Do you ever identify or is it identified in the transcript how many people make up the task force of the committee?
MS. PARKER: Your Honor, I think that comes later in the designation.
THE COURT: OK. Go ahead.
"A. In the case of the task force, as is true of other committees, the actual writing occurred within the committee.
"Q. When you say committee, Doctor, you are referring to the task force?
"A. The tasks for.
"Q. OK, go ahead. The actual writing occurred where in the committee?
"A. The task force.
"Q. Let's use the word task force. I've seen the word select panel used as well. Can we stipulate that committee, select panel, and tasks force are the same thing?
"A. Yes.
"Q. And we'll use task force -- when I interrupted your answer,

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you were saying that the actual writing was done by the task force and you were describing the process by which the 1997 statement was developed.
"A. That is correct.
"Q. Anything further to add to your answer?
"A. After the writing the writing would be brought back to the task force to be read aloud, and any editing after that reading would be done within the task force. Following that, the results of the task force would be forwarded to the executive board.
"Q. And what would happen at that stage?
"A. As we discussed previously, the board would have the material t recommendation of the task force or committee to

review prior to its meeting. It would be discussed within -- presented and discussed within the meeting. If there was any editorial concerns, those would be presented at that meeting by the executive board members and the final document would be produced after the agreement of the board members. So it's a process with many checks and balances.
"Q. You said that the task force, I believe you said that the task force statement would be presented to the board. Is there someone that actually goes and makes a presentation are to the board with respect to the proposed statement developed by the task force?
"A. I believe it TKPEPBTDZ on the statements.

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"Q. What happened in this case?
"A. In this case it was presented to the board by Dr. Fred TPREUG let to.
"Q. Was Dr. TPREULGT the president of ACOG at the time?
"A. That is correct.
"Q. Does the board, in considering a proposed statement -- let me just ask this first without reference to this document. Then I'll ask it with reference to the document. That is, plaintiffs' Trial Exhibit 6. Do you know, does the board typically conduct an independent review of the facts that are at issue in a particular policy statement when one is presented to it?
"A. I don't know that I can answer that. What I can say is the board consists of clearly leadership PHEPBS of the college with expertise in a broad area and they would bring that expertise to any something that came before the executive board.
"Q. Did the process you described for the development of the proposed statement on intact dilatation and extraction by the task force, did that process conform with the process that ACOG utilizes in the development of other policy statements?
"A. I can only speak from my experience as the chair of the ethics committee, and the answer would be for many of those statements yes.
"Q. When you said for many of those statements, you are referring to many of the statements that the ethics committee

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developed?
"A. That is correct.
"Q. And do I understand your answer to mean that for many of the statements that the ethics committee developed, the process of the ethics committee followed was similar to the process that was followed in the development of the statement on intact dilatation and extraction? S-
"A. Yes.
"Q. Are you aware of any instances in which the policy, the process for developing a policy statement for another policy differed from the process by which the policy on intact dilatation and extraction, intact dilatation and extraction was developed?

"A. No, I'm not aware of those circumstances.
"Q. With respect to the statement on intact dilatation and extraction in Plaintiffs' Exhibit 6, once it was approved by the board, the executive board of ACOG, is there any additional process that occurs within ACOG with respect to that policy statement?
"A. With any policy statement of ACOG, it then becomes available to the membership or the fellowship of ACOG.
Q. Do I understand correctly that once it is made available to the membership of ACOG, it is already approved at that point? Is that correct?
"A. That is correct.

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"Q. Is there at that point any opportunity for the membership of ACOG, and I'm referring to the fellows -- are those two terms synonymous, membership of ACOG, fellows of ACOG?
A. Yes, almost.
"Q. Is there any process by which the membership of ACOG can debate a policy statement after it has been approved by the board?
"A. Just like any other statement of any other organization or governmental actions, people are free to hold symposia and discuss and debate.
"Q. Within any ago could is there any process or established forums where the membership of ACOG can debate a policy statement after it's been approvedpy the board?
"A. Certainly the annual clinical meeting often includes controversial topics.
"Q. How did you come to be selected to the task force that developed the proposed statement on intact daily TAEUGS and extraction in plaintiffs' Trial Exhibit 6?
"A. Like the other members of the task force, we were chosen to represent geographic gender diversity, different points of view, and expertise. In particular, my expertise would have been the area of medical ethics and presenting that perspective to the task force.
"Q. Did you volunteer for this or were you asked for join?
"A. I was asked and I was pleased to be a part of it.

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"Q. Who asked you to join the task force?
"A. I believe it would have been Dr. TPREULGT.
"Q. Since you raised the topic a minute ago, why don't we just go through the list of the task force members very quickly. I'd like you to tell me who these SREUTDZ are. Dr. G, listed as the chair of the task force, is he the current president of ACOG?
"A. Yes.
"Q. Could you tell, I don't expect you to have the biographies of all these people down, but Dr. G, do I understand correctly he is an OB-GYN in the Hartford, Connecticut, area, is that correct?
"A. I believe that's correct.

"Q. What expertise was Dr. G bringing to the task force?
"A. One of the areas that it did not include in my list was that Dr. F considers as important both academic and general object STREUGSs, gynecologists. So Dr. G had come from a less academic background. He also came from a Catholic perspective.
"Q. What point of view did Dr. G bring to the proceedings?
"A. A general practice point of view.
"Q. Dr. B?
"A. Dr. B, who was unable to attend the actual meeting, would have added diversity somewhat and an AEBG dim I can point of view.
"Q. Who is Dr. B? Do you know where he is an OB-GYN I take it?

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"A. I believe at that time he was in New York.
"Q. Is he an OB-GYN?
"A. Yes.
"Q. He was in New York. Is he associated with a particular institution?
"A. Yes, but I couldn't tell you which.
"Q. You mentioned diversity. What does that mean?
"A. He is African-American.
"Q. All right. What expertise did he bring to the proceedings?
immigrant population in New York.
"Q. And what PAOEUF view did he bring to the proceedings?
"A. I think that's a fairly distinctive point of view."
MR. PANTOJA: Objection: Not responsive, the answer.
THE COURT: I will allow it.
"Q. When you say point of view, are you referring to point of view about intact dilatation and extraction?
"A. For purposes of the task force, yes.
"Q. And then let's back up. What was Dr. G's point of view on intact dilatation and extraction?
"A. As I said, as a practicing generalist and from Dr. F's recollection, also from a Catholic point of view.
"Q. Did he have a particular opinion about intact dilatation and extraction that he expressed in the proceedings?
"A. I don't remember his particular opinion.

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"Q. How would you describe the point of view of Dr. B to the extent it is different from your description of his expertise? Did he have a particular point of view on the issue of intact dilatation and extraction?
"A. I think his examples and his experience would include that of uninsured and immigrant.
"Q. Dr. D, who is Dr. D?
"A. Dr. D is a practicing OB-GYN. At that point I believe she was in San Francisco.
"Q. Associated with a particular institution or hospital?
"A. I believe she was at the hospital.
"Q. What was her particular expertise?
A. Maternal fetal medicine, ultrasound.
Q. Let's run through these names again. I'm going to ask you

if any of these people had abortion experience. Dr. G, do you know if he had a abortion experience?
"A. I don't know.
"Q. Dr. B?
"A. I believe so.
"Q. Dr. D?
"A. I believe so.
"Q. Do you know what Dr. B's abortion experience was?
"A. No.
"Q. Dr. D, do you know what her abortion experience was?
"A. I would think it was in regard to high-risk pregnancies.

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"Q. But you're not sure?
"A. No, not at this point.
"Q. Dr. TPREUG let to was the president of ACOG. But did he come to satisfy any of the particular criteria of the selection of the task force?
"A. Dr. TPREULGT had significant experience as the chief of brick ham and women's, Harvard's medical facility in Boston, long experience in the area.
"Q. Do you know if Dr. F had experience in abortion?
"A. Yes.
"Q. Do you know what the extent of his experience is?
"A. I don't know the extent, but I know he has significant experience.
Q. Did he bring a particular point of view to the proceedings?
"A. His primary point of view was concern regarding maternal health.
Q. Who was Dr. J?
A. Dr. J is a practicing object begin S-. At that time held have been in Louisiana.
"Q. Dr. N, who is she?
"A. She is the chair of the TKPHARPLT of obstetrics and gynecology at the university. She is a maternal fetal medicine expertr who has written textbooks in the area.
"Q. Of maternal fetal medicine?
"A. Uh-huh.

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"Q. And was that the area of expertise that she brought to the panel?
"A. She also was a senior woman on the panel.
"Q. Do you know if she had any abortion expertise?
"A. Yes.
"Q. Dr. R?
"A. Was a practicing object begin.
"Q. Where was she from?
"A. I don't remember.
"Q. You don't remember any institutions she was associated with?
"A. No.
"Q. Did she have a particular expertise?
"A. She had a particular expertise in providing abortions.

"Q. Did you want to clarify some answers for the record, Doctor?
"A. Yes. We remember there also was in here a copy of the fact sheet on partial birth legislation, the questions and answers that had been faxed to me as a task force member. And I faxed it back with changes suggested. And the other thing we identified in terms of task force membership was that I did not make clear that some of the personal stands on abortion varied among the different members. So that, for example, Dr. G personally is opposed to abortion and Dr. J would have been representing Louisiana, where there was a strong sentiment

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against abortion."
MR. PANTOJA: Objection, your Honor, mo move to strike that part of the answer at page 70/lines 13 through 20 as unresponsive. There is also no foundation to show that the witness had personal knowledge of the matters of which she had been asked. And also it is beyond the scope of the 30(b)(6) notice and direct. And it is also speculative.
THE COURT: And what?
MR. PANTOJA: It was also speculative.
THE COURT: Speculative? Yes. I will allow it for the moment.
"Q. What were the sentiments on abortion of the other doctors? Let's start with Dr. B.
"A. I think for all the remaining physicians there was support for abortionl for the life and the health of the mother."
MR. PANTOJA: Objection, KWROUFPLT there has been no foundation. It has not been established that the witness had personal knowledge about those views.
THE COURT: I believe it is established she is a member of this task force.
MR. PANTOJA: With respect to the particular views in question, the personal views of this member.
THE COURT: She is giving her personal assessment of the committee. I will allow it.
"Q. Are you aware of any ACOG policy statements that are

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aPHROFD through a process other than simply board approval?
"A. Of policy statements?
"Q. Yes.
"A. No.
"Q. Would you describe for me the process, just? General terms, by which the task force deliberated on the statement of intact dilatation and extraction when you got together on October 5th and 6th.
"A. As I noted before, materials were sent out ahead of time. The committee members reviewed those to get a general sense of the background. It is Dr. TPREUG let to's memory and mine that at the working dinner we reviewed those documents and we were given homework for the evening, although I don't remember what that homework was. So we worked beyond the time that we were

together.
"We met the next day and went through the agenda, reviewing each area in detail, and then crafting together language which we felt represented expert opinion at that time and issues of concern to the fellowship. A staff member then typed that so it was available for us to read, and it was then edited in committee.
"Q. OK. And how did the discussion and deliberations and the writing by individual members come together to form the words on this piece of paper?
"A. The committee started with the background, so that would

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have related to the first paragraph. The committee identified the fact that the general materials at the time had such broad and inconsistent definitions for what was being called partial-birth abortion that for purposes of the committee and the college we needed a very clear definition that made some medical sense. So that's where that would have come from and the sequence."
THE COURT: Let me stop you right TR. Ms. Parker, is there any at any point in this transcript a statement as to how many members of the committee there are, whether a vote was taken, and what that vote was? Parker park your Honor, there is no statement of the number. There is ohm a statement of who was on the committee by which you can add the number.
THE COURT: There is no identification -- I understand there was a deposition, which caused me to launch into a long dissertation of what I think is discovery in the hands of some people. Nonetheless, there is no description of how many are on this committee, how many were present, whether there was a vote, or what that vote was? Are.
MS. PARKER: There is -- the government took this deposition, your Honor.
THE COURT: I understand. But someone from your side asked a few questions, too. I understand that. That I heard T. I am merely asking you for clarification whether or not we ever get to a resolution of the questions I asked you.

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MS. PARKER: There is no statement in the deposition of the must be on the committee, only the names by which one could add the number.
THE COURT: There is a description of A, B, and so forth, but it doesn't say they were there. Parker park it says they were all there except for one, who they make clear that he didn't come.
THE COURT: I don't know that that said that at all. It showed the diversity and make-up of the various members, but I didn't hear anything that said who was there and participated and what the vote was.
MS. PARKER: You are correct, your Honor, there is no testimony on what the vote was in the task force.
THE COURT: The witness, I realize it is not Ms.

Manual, who is just reading, about but that the witness gave various identifying background of certain members designated by letter, but there is nothing more that I heard that said they were in fact in TAEPDance and what the vote was. Go ahead, for whatever it is worth.
from the place of now the defined procedure within the practice of obstetrics. The next would have come from materials available to the committee about general safety and use of second trimster previolate of abortions. And the last was the conclusion of the experts and the committee about concerns

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regarding this, particularly one of the major concerns of the fellowship at the time that prohibiting any specific medical practice by doing so could outlaw techniques that are critical to the lives and the health of American women.
"Q. I understand the topical areas that are covered in the document as you have just described them. What I am not clear on yet, if you can try to help me with, is specifically how did these words that appear on the paper get created. Was somebody assigned to a particular paragraph or topic and proposed a paragraph?
"A. Assigned at the time of the discussion. A discussion would occur. Somebody would volunteer to try to codify the discussion in words. It would then be read and edited by the committee after they would actually see it in print.
"Q. So it is the case that different members of the task force may have ten different parts of this statement *PBLG that is correct.
"Q. Do you know which members of the task force originally drafted portions of this?
"A. No.
"Q. But is it the case that for each element of this statement, each paragraph of this statement a member of the tack force did the original drafting, which was then commented on?
"A. They would have put down what they thought would have been appropriate in that area, yes.

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"Q. Were paragraph portions circulateled among the task force members for discussion?
"A. As I said, everything that was written was reviewed by the entire task force.
"Q. What was not? Let me ask it in this way. What material did you feel was appropriate to be considered by the task force?
"A. We felt the numerous examples the task force itself could put on the table regarding their experience or need for this procedure, the textbooks, published information about the safety of D&E, and this as a subset of D&E, and the significant background and experience of the people at the table, and also information about the safety and alternatives and the safety of alternatives.
"Q. OK, Doctor. On the issue of documents a little bit further

you mentioned that there was a side table at the in October of 1996, the meeting of the task force. To the best of your recollection, what was on that side table?
"A. I don't remember the exact textbooks, but they would have been the general textbooks in obstetrics and gynecology at the time.
Q. Do you recall how many texts there were?
"A. No, I don't.
"Q. There are textbooks OPBD obstetrics and gynecology?
"A. Right.

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"Q. Do you recall anything else about the textbooks?
"A. Other than the fact that they were picked because they included abortion as a part of the material covered.
"Q. Was reference made to information in textbooks during the task force discussions?
"A. Yes.
"Q. Do you recall what references were made to the textbooks?
"A. I believe if there was any question about a particular procedure or how it had been described in the literature previously, we might have referred to it.
"Q. What role did Dr. G play during the meetings as chairman?
"A. He played sure we stayed on the agenda. He made sure that everybody's opinions and examples and expertise were heard and that there was a full discussion of every aspect.
"Q. Did the task force gather all published materials about this procedure?
"A. The task force had it in the materials we had. We believe at the time they tried to gather anything that would include references to the procedure. It is possible in the world that there was published material that we did not find or see.
"Q. Is it your understanding that through ACOG staff an effort was made to gather all published material about the intact TK*BGS procedure?
"A. Yes, with the material that was published in books.
"Q. And the result of that effort together all published

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material on intact TK*BGS was material that we have discussed today that was before the committee?
"A. And the books on the side table.
"Q. And the books on the side table?
"A. Uh-huh.
"Q. And that was as of October 1996, correct?
"A. Right. But remember the intent of the materials for the task force was to identify the issue. The expertise that was being relied on was the individuals on the task force.
"Q. What did the tax force discuss with respect to safety?
"A. Numerous examples were raised by the members of the task force regarding different procedures and specific cases and issues of safety. For example, in GYN oncology the most pertinent example would be trip HROEUdy, which is a form of cancer of the pla sen at a often diagnosisd in the second

trimster with severe preaKHREUFRPSia. In that case the least amount of instrumentation possible of the ut rin wall is desirable. So it is much safer for the woman to have an intact TK*EBGS to remove the mo lar pregnancy. So multiple issues were used to explore issues of safety at the time and in comparison to other procedures. S- S-
"Q. Does the statement on Exhibit 7, the draft proposed statement, does this statement reflect the conclusions of the task force with respect to intact dilatation and extraction?
"A. Yes.

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"Q. OK. Did the task force identify any study which discussed a the relative safety of intact TK*BGS versus another method of abortion?
"A. No, not as we had described it for purposes of our debate.
"Q. Did the task force identify any study on the relative safety of abortion procedures in general which it relied on in reaching its conclusions about this procedure?
"A. The CDC data, the ongoing data documents, the safety.
"Q. Of -- in what way?
"A. D&E second trimster abortions.
"Q. OK. And you mentioned the CDC data. What was it about the CDC data which informed the task force's views with respect to the safety of intact TK*BGS?
"A. The overall safety in the second trimster.
"Q. Of D&E?
"A. D&E because TK*BGS was not separately coded.
"Q. Well, if you want to look at Exhibit 7, I'll go a little above that, 'terminating a pregnancy is indicated in some circumstances to save the life or preserve the health of the mother.' This was obviously a conclusion of the select panel, is that correct?
"A. That is correct, and we could identify numerous circumstances in which this might be the best procedure for that. Rare, but still numerous.
"Q. Where does it say in the statement that this would be the

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best procedure to do that? Would you agree with me it doesn't say in this statement that it might be the best procedure in some circumstances?
"A. Right. Dr. TPREULGT and I discussed that actually on Saturday, because the amended final statement which includes the executive committee statement does include a sentence between the sentence you read and notwithstanding this conclusion, quote, ACOG strongly believes that decisions about medical treatment must be made by the doctor in consultation with the patient, end quote. And both of us agreed that it was clearly the sense of the committee, we just thought it spoke for itself, and that we were glad that the executive board had put that phrase in.
"Q. I want to ask you about that in a second, but I just want to confirm that the sentence that, quote, a select panel could

identify no circumstances under which this procedure would be the only option to save a life or preserve the health of the woman, end quote, was that the conclusion of the select panel as REFGTd in this document?
"A. Correct.
"Q. Now let's talk about that added sentence. This is in the final statement. And you can look at Plaintiffs' Exhibit 6 if you would like to have it in front of you.
"A. I have Plaintiff's Exhibit 5.
"Q. It's the same thing. The final statement proofed by the

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board, a sentence is added, quote an intact TK*BGS, however, may be the best or most appropriate procedure in a particular circumstance to save a life or preserve the health of a woman, end quote. And to complete the sentence, quote, and only the doctor in consultation with the patient based upon the woman's particular circumstances can make this decision, end quote. Who added that sentence?
"A. The executive board edited the sentence.
"Q. Were you a part of the deliberations in adding that?
"A. No, I was not.
"Q. Was this additional sentence presented to the task force for it is consideration?
"A. No. Although it was very much in the sense of a discussion at the task force.
"Q. Do you have any knowledge of the deliberations that resulted in the addition of this sentence?
"A. I have information from Dr. TPREULGT about his recollections and also from Dr. Hale.
Q. Was it Dr. TPREUG let to that proposed adding the sentence?
"A. I don't believe that Dr. TPREULGT -- I know that Dr. TPREULGT could not remember who proposed the sentence.
"Q. Have you, other than Dr. TPREULGT, you said you discussed how the sentence came to be added with Dr. TPREULGT?
"A. That's correct.
"Q. And did you discuss it with Dr. Hale?

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"A. Not specifically with Dr. Hale, but I'm aware of his memory.
"Q. Was there any debate at the task force over this sentence?
"A. I don't remember this sentence coming up.
"Q. Was anyone -- do you know if anyone in particular was an advocate for adding this sentence?
"A. I don't remember this sentence coming up at the task force meeting.
"Q. Do you know if Dr. TPREULGT was an advocate at the board for adding the sentence?
"A. I don't know.
"Q. Do you know if Dr. Hale was an advocate at the board for adding the sentence?
"A. I don't know. This is a statement that was added by the entire executive board STKPWHRL do you know if Dr. Gibbon was

an advocate for adding the sentence.
"A. I don't know if he was an advocate at the time of the executive board. It is very much in keeping with the sense and the discussion of the task force.
"Q. Then why isn't it in the draft of the task force?
"A. As I said, when Dr. TPREULGT and I discussed that, we came to the same conclusion that we -- because we had talked about it so much, to us the, quote, notwithstanding this conclusion t decisions about a medical treatment based upon the woman's particular circumstances, end quote, covered that. It is a

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matter of phrasing. To us, we were already there. We assume in medicine that our choices are made for the life and the health of our patients.
"Q. Why did the select panel find that there were no circumstances -- why was the select panel unable to identify circumstances under which the intact D&X procedure was the only option to save the life or preserve the health of a woman?
"A. Because there are multiple procedures available. It was simply a factual statement. There are other things that are available. They may not be the best for that individual patient.
"Q. Are you aware of any analysis or study -- let's strike that and say, are you aware of any study which supports the conclusion that intact TK*BGS may be the best or most appropriate procedure in certain circumstances?
"A. I'm not aware of a study. I am well aware of multiple circumstances that an expert panel could identify at the time of the task force, where it was clearly the best choice, including in my field, where the other options led to a higher likelihood of death or recurrence of disease.
"Q. Are there any case reports that you're aware of documenting that intact TK*BGS may be the best or most appropriate procedure in certain circumstances?
"A. I consider the case reports brought to the table as significant.

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"Q. By -- you mean the case reports of Dr. Haskell and McMahon?
"A. No, by the members of the task force.
"Q. As far as you know, there have been no prospective studies demonstrating that intact TK*BGS may be the best or most appropriate procedure in certain circumstances, are there? Let's back up. At the time of the task force report.
"A. Not to my knowledge. But a random AOEUDZd controlled prospective trial would not be ethical in some of these circumstances.
MR. PANTOJA: November to have strike the end of that sentence as not responsive. Everything after not to my knowledge. It is also an improper characterization of a randomized controlled trial is.
THE COURT: Let me hear the words.
MS. PARKER: Do you want the question as well?

THE COURT: Yes.
MS. PARKER: The question was, "As far as you know, there have been no prospective studies demonstrating that certain circumstances, are there? Let's back up. At the time of the task force report.
"A. Not to my knowledge, but a randomized controlled prospective trial would not be ethical in some of these circumstances."
THE COURT: What is it you are moving to strike?

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Ethical?
MR. PANTOJA: Yes. Everything after not to my knowledge. The part that says but a randomized controlled prospective trial would not be ethical.
THE COURT: Are you objecting because it is not responsive?
MR. PANTOJA: It is not responsive to the question and it also mischaracterizes what a randomized trial is.
THE COURT: I don't know about that. But I will grant you to strike that portion of the answer as to it wouldn't be ethical.
You may continue.
"Q. I asked you this PWHORPBG whether you had understood whether Dr. Go about PWOPBS had any experience in perform AORGS termination and I believe you said you didn't know. Is that correct?
"A. That's correct.
"Q. Who among this panel, AOPL I I'm aware that he in general was --
"A. I'm A*EURPL aware that he in general was in opposition to abortion.
MR. PANTOJA: Ou yo. That answer was unresponsive. There was no completed question.
(Record read)
THE COURT: I will strike that part. It is not

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responsive to the question. Go ahead.
"Q. Etc. etc. test of this statement in 1996?
MR. PANTOJA: Objection your case. The question is confusing and there is no foundation that the witness has PERBL knowledge with respect to the matters she is being asked about.
MS. PARKER: Your Honor, this is the government's question. They asked it at the deposition. So the objection to the question is late.
THE COURT: It is a little hard to do that, sir.
MR. PANTOJA: Your Honor --
THE COURT: From now on, you are going to have the night before every one of these questions that you want to object to -- this is childish, where you asked the question. The lawyer on your own team and you are objecting to his question. We aren't going to repeat that. OK? And get up to my chambers all your objections.

Go ahead. I will let you ask that question and answer. Continue.
"A. Who performed procedures that would fall within this newly defined criteria? It would have been Dr. TPREULGT would have overseen it, Dr. R. I need to look at the list.
"Q. Dr. D?
"A. Dr. D probably. I don't know for sure.
"Q. Dr. J?
"A. I don't believe so.

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"Q. Dr. N?
"A. She would have overseen.
"Q. You said Dr. F would have overseen? Dr. N would overseen, Dr. R, you believe?
"A. Performed them. And I believe Dr. F performed intact TK*BGS's at the time.
"Q. Is that the list, then, of the people on the panel that you think you either oversaw or performed intact TK*BGS's as of 1997?
"A. Uh-huh.
"Q. F, R, N, and D?
"A. Uh-huh.
"Q. Did B as well?
"A. Yes.
"Q. All these doctors said at the time of the task force that they had performed intact TK*BGS?
"A. They did not say that they had performed an intact TK*BGS. They said they would have had experience with procedures that would fall in that category.
"Q. Let me just make sure I understand. You came one a four-part definition of intact TK*BGS. And what I want want know is did any of the TKARBGTS that were on the select panel discussing this procedure that the panel described as intax TK*BGS, had they actually performed that procedure?
"A. Yes.

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"Q. And those are the five doctors we just identified, Dr. R, F, N, D, and B?
"A. Uh-huh. "HAO*EU.
THE COURT: Ms. Parker, about how much more do you have to go?
MS. PARKER: Approximately parts of 20 pages.
THE COURT: Parts of 20 pages. We will take our afternoon recess for 5 minutes.
(Recess) 3/29/04 Judge Casey take 5 reading deposition testimony of Joanne aCain. Obstetrician obstetric obstetric obstetrician goggle TKPW-BG TKPW-BGT guideline TKPWHRAOEUPB
MR. HUT: Your Honor, Stephen Hut for the plaintiff.
THE COURT: Yes, Mr. Hut.
MR. HUT: Before we resume with the deposition testimony of Dr. Cain I wonder if I could raise a housekeeping

matter or two.
THE COURT: Sure.
MR. HUT: With respect to subsequent proceedings.
At the break Ms. Gowan asked the plaintiffs whom we expected to call tomorrow. Since SWRE concluded to abide tomorrow by the Court's request and not call Dr. Westhoff as our second witness. I TPH-FRPBD Ms. Gowan that we will be calling Dr. Grunebaum, and we will. She then wanted to know who would follow. It is my intent if at all possible to follow Dr. Grunebaum with Dr. Cassing Hammond of northwestern memorial

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Hospital.
I asked Ms. Gowan whether it was the intention of the government to renew its motion to preclude as to Dr. Hammond. The Court will recall that northwestern filed a motion to quash the government's subpoena. That motion was granted by Chief Judge KA* KO*R rugs and then last week the Court of Appeals for the seventh circuit affirmed the order quashing.
It seems to me that under the circumstances there is nothing really more that Dr. Hammond could do and although predictions in this sort of thing, as I'm sure the Court appreciates may not always be reliable, my suspicion is that neither the Court of Appeals en banc or the Supreme Court is going to have a look at that.
So I don't think that the Court is likely to have, the government is likely to get records with respect to Dr. Hammond. We would like to have him testify if he can make it. If he cannot, we are really someone at sixes and sevens. I don't think there is any merit to the motion to renew with respect to him and I wanted to put that to the Court.
THE COURT: Why don't you stick that in your papers. I must say that at first blush I think Mr. Hut has a point. I don't know what more can happen that.
MR. HUT: With respect to the papers that was the next housekeeping point I was going to raise and I'm glad you anticipated me your Honor but you may have anticipate me beyond

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what I was going to ask and I have my answer.
We had hoped to be able to respond sequentially to the government to oppose whatever renewal submission they may wish to make after they make it. We can repeat what we have said before but if they have anything new to suggest I would like an opportunity to see that and oppose or respond to it.
THE COURT: I will -- you never get the whole loaf, right Mr. Hut?
MR. HUT: Absolutely right, your Honor.
THE COURT: You're in New York you do a little adjustment.
MR. HUT: A slice of rye or two would be great now.
THE COURT: I am on the record again, I am always get engine trouble.
I tell you what I'm going to do. You get a little bit

of time to answer but hold off on the witness because that might be prejudging what I am going to decide and try and do a swap there and you get the next morning to respond, okay?
MR. HUT: The only difficult thing with that your Honor then is we will not ask Dr. Hammond to come tomorrow and we may be out of witnesses at the end of the day.
THE COURT: Well see what you can get in. You have got some others, don't you think think that are fairly local.
MR. HUT: They are but they've got surgeries or they're out of town. We have Dr. Chasen but he presents the

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same problem.
THE COURT: Well I would try -- you know what I would suggest and I think highly of every one of your team, why don't you dispatch one of them to go back and start making phone calls and see whether or not somebody can help you in your hour of need.
MR. HUT: We have actually begun that your Honor and we will continue THAOPB assiduously.
THE COURT: Why don't we play it that way for the moment, we can reSTEUFT in the morning, okay.
MR. HUT: Very well, your Honor.
THE COURT: At the moment, try and juggle your schedule and I will give you more time. That's our deal though.
MR. HUT: It's a deal.
THE COURT: Okay.
MS. GOWAN: Your Honor, Ms. Gowan. We will address the matter TPH-FT papers to be filed tomorrow with respect to Dr. Hammond.
THE COURT: All right, but we have to play a little bit of New York ball here and trade off a little bit. By the way, is anybody -- I don't think anybody listened, is anybody being called from ACOG live from either side?
MS. GOWAN: ACOG, your Honor.
THE COURT: Yous' I I have never been good at acronym

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in any event ignore me but is anyone going to be called.
MS. GOWAN: The government is not calling anyone from ah cog life, your Honor.
MS. PARKER: Your Honor, the plaintiffs request that ACOG appear live at trial and we were informed that they were not willing to appear, unfortunately, we would very much have liked to have them here live, to answer your questions.
THE COURT: I have been known to say a word or two about the American College of pretrial lawyers and I think I have said more than I should say about live testimony and this sort of thing and this afternoon is a good example of why it's far better to have the live witness here.
In any event, with that said, people can evaluate that. You have certain powers in your hands too. There might even be a person within a hundred miles of this court house who

is a member of ACOG. That said, Ms. Parker, can you stimulate us for another hour?
MS. PARKER: Hopefully it won't be that.
THE COURT: It would be Broadway for you.
MS. PARKER: I may have a few tricks.
THE COURT: Please don't take me, that I am not taking this, and believe me I am, in the most serious way. But in this world of litigation you have to have a mile now and then.
MS. PARKER: I agree.
THE COURT: You may proceed.

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MS. PARKER: Page 200:
"Q in Dr. TPH-FRPBLGTS's case she only oversaw them?
"A that would be my understanding or my memory
"Q did any of these doctors say how many they had participated in or overseen? How many intact TKW*EFPLs as defined by ACOG that had he had participated in or overseen?
"A no
THE DEFENDANT: Do you have any indication of the numbers.
"A question STKPWUSed specific cases
"Q how many specific cases did you discuss, just numbers?
"A would I guess, given the variation of diagnosis and the fact that most people saw referral cases that we talked about at a minimum, 25 to 30 different types of cases
"Q Doctor, do you consider the statement of the select panel to be a statement of medical expertise?
"A it is a statement of medical experts.
"Q and were the views of the select panel with respect to intact D&X based on their own clinical experience
"Q did he ever say, did you ever hear him say that when he was asked, when he was asked why the statement said the procedure may be the best in some cases, do you know it to be Dr. Frig O leto's view that it may not be?

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MR. PANTOJA: Objection, your Honor. The question calls for a hearsay answer.
THE COURT: I will allow it.
"A I think that was the view of all of us, if it's interpreted in a sense that it is an individual decision for an individual patient with with the circumstances of her disease process, her needs and her risks so that any procedure that may be appropriate for diagnosis may be appropriate for some and not for others, even though the data on safety is the same between the two procedures. Medicine is a highly individualized practice.
MR. PANTOJA: Your Honor, objection, your Honor. The answer was unresponsive and confusing.
THE COURT: Oh, you'll find it a longer litigation that a lot of answers are confusing. Most of them are.
MR. PANTOJA: Thank you, your Honor.

THE COURT: Go right ahead.
MS. PARKER:
"Q let's assume Dr. Frig frig was referring to the intact D&X procedure and my question is, is there any data to say that the intact D&X procedure is safer that be another method of abortion
MR. PANTOJA: Your Honor, if I may object. The question assumes a fact not in evidence.
THE COURT: Read it to me again, please, Ms. Recorder.

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THE COURT: Your objection?
MR. PANTOJA: It's assuming the fact that Dr. Frig frig.
THE COURT: It's your own colleague. Do you want me to rule that your colleague asked the incomprehensible question?
MR. PANTOJA: Your Honor the purposes of a deposition was just not to obtain necessarily admissible -- the purpose of the deposition was to try to do discovery for any possible relevant information. The questions that might have been asked and the responses there to might still be objectionable themselves for the purpose of admission at it trial.
Travel if I witness satisfied I heard someone says said say we can depose someone else identify but the statement is hearsay and the nature of the objection I am making here and the other objections on hearsay are based on that, despite the fact that our colleague of my office obviously asked the questions this way.
THE COURT: I will overrule it.
THE WITNESS:
"A I believe I believe my testimony in that has been fairly consistent which is that the data for TKAO*EFPL was not well defined it was there another not capture as separate data however the expert panel can think of individual patient

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circumstances when it was a SPWER voice for individual patients
"Q the very last sentence of the intax D&X Section says "the intervention of legislative POEDy into med ill inill in in my copy that's in bold, did the task force agree with that statement?
"A strongly
"Q that their most strongly held -- was that, would you say, the most strongly held conviction of the task force?
"A it was a strongly held conviction of the task force.
"Q how much was this aspect of ACOG's position on legislative interference discussed by the task force?
"A legislative interference? The primary concern of the fellowship and a strong reason to put the task force together was a concern of fizz cisions that legislation, particularly legislation that was illdefined prohibiting a

certain procedure, would have the perhaps unintended side effect of harming women who would need elements or parts of the procedure and that our primary concern remained with the health and well being of women.
"Q is it fair to say, Doctor, based on this statement, that as a matter of policy, ACOG does not want the legislative body interfering in medical decisions on abortion procedures
"A I think it's fair to say as a result of this that

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physicians and the college as represented here are concerned about decisions that have the potential of creating harm for women as patients.
Q. My.
"Q my question was receivingly does cog propose the intervention of legislative body in medical decision making
"A ACOG represents here the concern that the intervention is inappropriate, ill advised and dangerous because it can result in harm or death to women.
"Q is it fair to describe
THE COURT: Do you want to object to that one?
MR. PANTOJA: Your Honor, we did not object to this, to that statement.
THE COURT: It's not responsive but go ahead.
"Q is it TPAEURB to describe ACOG and favoring leaving it to the doctor and the patient's discretion are with respect to decisions on reproductive chair
"A it is fair in regard to that aKAG favors medical good? Circumstances of patient physician relationship. Note note note note
"Q do you have exhibits 27, 28 and 29 in front of you?
MS. PARKER: Your Honor, these are just the 30(b)6 deposition notices and we don't intend to move them into evidence we are just.

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THE COURT: You offered them.
MS. PARKER: We are neither offering them nor moving them.
THE COURT: Good idea.
"A yes
"Q and if you could turn, you can look at them all at the same time, please, under the subject matter of examination. I believe the subject matter is identical on all three notices but I would like you to look at them
"A okay
"Q do have you the three exhibits in front of you
"A I believe so
"Q do you see the subject matter examination? Do they look all the staple to you on the three documents?
"A yes
"Q and first subject matter of examination, "ACOG's

position on partial birth abortion legislation as reflected in its 1997 statement of policy on intact D&X, which was reaffirmed in 2000.
Do you see that subject matter?
"A yes
"Q and do you see ah cog's position on the safety of intact D&E, also known as TKW*EFPL or dilation and extraction as reflected in 1997 statement of policy on intact D&X, which was reaffirmed in 2000?

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"A yes
"Q and do you see "the makeup organization and purposes of ACOG?
"A yes
"Q are you qualified to answer questions on all three of those topics?
"A yes.
"Q Plaintiff's trial exhibit of, do you recognize this document
"A yes
"Q and what is it?
"A it is the statement on intack dilatation and extraction of the American College of OB/GYN is P-RPBLGTS your Honor I should have made clear this this portion of the deposition, the questioning is being conducted by Ms. Know SRABG, no longer by Mr. cop O lean yo of the government
"Q have you seen it before today?
"A yes
"Q when did you first see it
"A when we created it in the task force
"Q and do you know who prepared this document
"A the American College of OB/GYN KW-FRBGTS were you part of the task force that wrote it
"A yes
"Q when did you write it
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"A we wrote it October 5 and 6, 1996
"Q was this document prepared in the normal course of ACOG's business?
"A yes.
"Q did the drafting of this statement go through the same general drafting processes of statements of policy at ah cog that you testified about earlier?
"A to my understanding.
"Q was this statement adopted through the same general aTKOPGS processes for statements of policy at ACOG that you testify PW-D earlier?
"A to my understanding.
"Q I would like you to turn to plaintiff's trial Exhibit 5, please
"A yes.
"Q can you look at that document and tell me whether you recognize it?

"A  I REUZ it
"Q  what is the document?
"A  it is the ACOG statement of policy as issued by the executive board, abortion policy
"Q  have you seen it before today
"A  Yes
"Q  when
"A  mull TPEUPL times

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"Q  do you know who prepared this document
"A  the American College of OB/GYN
"Q  do you know when it was written
"A  the legend at the back notes that the general policy was adopted or written in January 1993.  It was reaffirmed and he advised in July 1997.  Intact D&X statement was January 1997 and they were combined and reaffirmed in September of 2000.
"Q  and I believe you kind of just testified to this, but so, does plaintiff's trial Exhibit 5 incorporate plaintiff's trial Exhibit 6?
"A  yes
"Q  the document you just testified about?  And why was this document written?  Do you know, plaintiff's trial Exhibit 5?
"A  the intact D&X or the entire document?
"Q  the entire document.
"A  I don't know the original intent of the abortion policy statement, why it was written
"Q  and do you know why the intact D&X part of it was written?
"A  yes, it was in response to concerns expressed by the fellowship at that time regarding a poorly defined PRER for partial birth abortion and potential legislation
"Q  was this document prepared in the normal course of

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aconstitution's business?
"A  do my understanding
"Q  and did the drafting of plaintiff's Exhibit 5 go through the same general drafting process of statements of policy at ACOG that you testified about earlier?
"A  to my understanding
"Q  was the statement adopted through the same general aTKOPGS policies for statements of policy at ACOG that you testified to earlier?
"A  to my understanding.
"Q  does is this statement reflect ACOG's current abortion policy?
"A  to my understanding
"Q  what is the American College of obstetricians and gynecologist
A.  S the American College of obstetricians and gynecologists is a professional membership organization or gag SKWRAEUZ 1951

that is concerned with PRAFL probable cause and education in the health care of women.
"Q and in what forms does it demonstrate its dedication to the health of women? What type of work does is it do
"A its misss are ongoing education of EULGTS membership, research and advocacy of the health care of women
"Q is it a nonprofit organization

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"A yes, K-S
"Q is it a membership organization
"A yes, K-S
"Q How many members does ACOG represent
"A I believe it's now over 44,000 "QUESTION where are the members located
"A throughout the United States and adjacent countries, Canada and Mexico.
"Q what call physicians must a person have to become a member of ACOG
"A me must hold a current license to plaque. They must be SERD TPAOEU by the American Board of obstetricians and gynecologist and ore 90 percent of the certified OB/GYves are members of ACOG
"Q can you explain how ACOG is organizationized at the national REUFL
"A STKREUBGS, these STKPWHRAOEUFRPBLGS note note national organization and they're incorporated within the national organization. Each district has individual states as subsections. The executive board consists of officers and representatives from each of the districts of ACOG.
"Q how many members are there on the executive board
"A there are currently 22 members of the executive board. In January 1997 there were 19
19

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"Q do you know how many districts there are?
"A 10.
"Q in approximations
"A yes
"Q how does one come to certain on the exec TEUFRB board
"A you can be HREBGD through the district process oar you can be HREBGD after nomination as an officer
"Q can you explain the difference, please?
"A the district process is entirely within the membership of the district. Officers are nominated, can be nominateed from any -- they can nominate themselves or can be nominated by another person
The nominations are evaluated through a panel of nominations an the final nomination is put forward to the membership from which they are elected. District leaders are elected within the district. National officers are elected by

the entire fellowship
"Q so every member of the executive board is elected, is that correct?
"A that is correct
"Q and the executive board represents all districts within ACOG, is that correct?
"A yes
"Q and what is the duty or the task of the executive

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board? I'm sorry, let me rephrase
What is the executive board's purpose
"A I don't know that I can fully frame it but I will give you some elements of it purpose, which is to oversee the actions and the activities of the American College of OB/GYN
"Q and does the executive board through its, through the officers represent all members of ACOG
"A yes, it's a representative process
"Q and I believe earlier you testified that ACOG
"A that is correct.
"Q who sets up the task forces?
"A generally task forces are set up by the executive board of the American College of object begin
"Q as far as you know was the task force that you sat on that we are discussing HAOERD today about so-called partial birth abortion was that set up in the same manner as other task forces at ACOG are set up
"A yes
"Q I would like you to take a look at Exhibit Number 5 which is plaintiff's trial Exhibit Number 8
"A I have it
"Q is it it correct that plaintiff's trial exhibit numberel is entitled fact sheet on the January 1997 ACOG statement regarding intact dilation and extraction

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A. Yes.
Q. What is this document?
A. It's questions note note note questions answers answer regarding STKPWHRAEUPLT have you seen this document before today?
A. Yes.
Q. When did you first see it?
A. I saw it in draft form when it was sent to members of the task force for comment.
"Q do you know who prepared the documents
"A I believe it was prepared by staff
"Q was this document prepared in the normal course of ACOG's business
"A this would be typical for ACOG
"Q which was why was this document written
"A to further SKPHREUPB and explore the issues for fellowship of ACOG
"Q the issues regarding what

"A  the intact dilation and exTRAEUGS statement
"Q  did the drafting of this, of Plaintiff's Exhibit 8, go through the same general drafting processes of fact sheets at ACOG
"A  to my understanding
"Q  and was this fact sheet, was this adopted by the board?  I'm sorry let me withdraw that.  Do fact SHAOEGTS get



adopted by the board
"A  I don't believe so.
"Q  okay.  So is it correct ACOG issues statements and some have TOBG adopted by the bored and some are not, is that correct
"A  policies must be adopted by the executive board
"Q  and plaintiff's trial Exhibit 6 and 5 fall under that category?  Is that correct?
"A  that is correct.
"Q  are the members of the task force, were they familiar with the research and literature on abortion at the time of the task force
"A  yes.
"Q  did the members of the task force discuss their experience with respect to abortions during your deliberations
"A  yes.
"Q  and what information -- I believe you testified earlier that the members of the task force relied on certain documents in drafting the statement on intact D&X, for instance like the documents produced to Department of Justice we have seen today and some documents on the side table.
Did I correctly characterize your earlier testimony
"A  essentially
"Q  and did the members of the task force all have sufficient expertise to sit on that task force and create a



draft proposed statement on intact D&X
"A  yes
"Q  and did the task force consider ethical components during their deliberations and in creating the statement on intact D&X
"A  yes
"Q  I would like you to look at plaintiff's trial Exhibit 6, please.  Do you have Exhibit 6 in front of you
"A  yes
"Q  I would like to direct your attention to the last paragraph OPBLG that page
"A  on the first page
"Q  yes, on the first page.  Never mind.  Generally, what are some of the considerations that a physician takes into account when determining what the best or most appropriate abortion procedure is in a particular circumstance to save the life or preserve the health of a woman
"A  within the context of the statement?

"Q  no, in general.  What types of considerations does the doctor look at when determining what abortion procedure would be best for a patient, determine with the patient what would be best for her either to preserve her health or save her life?
"A   the similar things to those we would have discussed within the committee which are the patient's general

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state of health, the nature of the disease process, the options available and the particular risks in light of that individual patient's medical circumstances.  And the patient's ought ton O mouse choice among the options presented
"Q  okay.  And what are some aspects of the D&X procedure that might lead a physician to conclude that D&X is the best or most appropriate abortion procedure to save the life or preserve the health of a woman
"A   one of the element that came up among the different and numerous scam -Pies was the TKES crude instrumentation and ability to preserve relatively intact fetus for evaluation, SPHRARly for some genetic based congenital anomalies
"Q  why would less instrumentation be beneficial
"A   it TKPEPDZ on the circumstance, in the circumstance of septic abortions ineven cries in instrumentation might increase the ability of back tearo to enter the blood stream
In the case of trop O blastic disease, increased instrumentation is likely to transport trop O blastic disease which is a form of cancer to other areas such as the lung.
"Q  and I believe you testified earlier, correct me if I am misstating your testimony, that the annual clinical meeting each year members have an opportunity if they want to discuss policy statements.

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Is that correct?
"A   to discuss areas around policy statements, yes.
"Q  was there an annual clinical meeting held after the approval of the 1997 statement, plaintiff's trial Exhibit 6
"A   there is an annual clinical meeting held on an annual basis
"Q  it wasn't skipped after the statement was written, correct?
"A   no.
"Q  and the same holds TRA for after the 2000 statement was written?  Was there an annual clinical meeting after that one
"A   that would be correct.
"Q  if I represent to you that Congress claims that an ethical consensus exists that the practice of partial birth abortion "is a gruesome and inhumane procedure that should be prohibited," as a member of the ACOG task force on partial birth abortion do you believe there is such an ethical

consensus
"A no
MR. PANTOJA: Objection, your Honor, calls for lay opinion.
THE COURT: I will allow it.
"Q if I represent to you that Congress claims that partial birth abortion confuses the ethical duties of

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physicians to preserve and promote life as a member of the ACOG TPAFBG force on partial birth abortion, do you agree that the ethical duties of physicians are confused in that way?
"A no.
"Q Plaintiff's trial Exhibit 5, I would like you to look at Exhibit 5, please.
As far as you know are all of the statements in Exhibit 5 currently the position of ACOG today?
"A it is my understanding.
"Q what is ACOG's current position regarding how, if at all, the federal partial birth abortion ban act of 2003 would affect the physician patient relationship
MR. PANTOJA: Objection, your Honor. Beyond the scope of the 30(b)6 notice and direct.
THE COURT: How so.
MR. PANTOJA: The subject matters are two topped KWREUBGSZ of the 30(b)6 notice to ACOG was January 1997 issue on TKEU lation and extraction and how that has has been revised subsequently by ACOG. And the second topic, your Honor, was the bases for the statistics, data and other information that informed them in drafting that particular statement in the ACOG statement that's, that dilation and extraction can be the safest or most appropriate procedure in certain circumstances.
MS. PARKER: Your Honor, that might have been the Department of Justice's 30(b)6 notice but there were

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cross-notices and in fact in the cross-notices by the plaintiffs the first topic of examination was the position of the American College of obstetricians and gynecologists on legislation banning PA*B as reflected in the ACOG policy statement and this line of questioning is squarely within that examination topic.
THE COURT: Is that so, sir.
MR. PANTOJA: Your Honor, the question.
THE COURT: Is it in the cross-notice.
MR. PANTOJA: I'm sorry.
THE COURT: Is it in the cross-notice?
MR. PANTOJA: I do not believe so, your Honor.
THE COURT: Show it to him, Ms. Parker. Part Pan pain name your Honor -- I understood policy statement.
THE COURT: Is it in the notice.
MR. PANTOJA: The subject matter that's asked here in the cross-notice is ACOG's position on partial birth abortion legislation as reflected in its 1997 statement of policy on

intact KWAO*EFPL which was reaffirmed in 2000.
The question here is with respect to, my understanding is, policy statement.
THE COURT: Read the question.
Please Ms. Reporter, read the question.

MR. PANTOJA: Your Honor, my understanding of the

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testimony by ACOG is that its position, position of organization such as ACOG is reflected in policy statements. A very specific vehicle. That is beyond the scope of the 30(b)6 with respect to ACOG.
THE COURT: Overruled.
"A I believe that the statement of policy continues the same with the statement that the intervention of legislative bodies into medical decision making is inappropriate, ill advised and dangerous and that is in regards to interfering in the physician patient relationship.
"Q did the task force report to the board on the ethical considerations of intact D&X
"A not as a separate statement but the statement incorporated those considerations
"Q where did it incorporate those considerations Doctor? Let's look at plaintiff's trial Exhibit 6, the ethical considerations of the procedure, what are you referring to? Just tell me the sentence that you are saying reflects the EPLG call considerations regarding the procedure.
"A the physician in consultation with the patient must choose the appropriate method based upon the patient's individual circumstances.." That represents Ben I TPEURBTS and nonmalhe TPEURBTS
"Q that's the sentence that refers to the consideration of ethical considerations?

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"A I think that's the cop inclusion of the discussion around the multiplicity of issues. It also represents autonomy TAZ represents consultation with the patient.
Those are the three key elements of medical ethics in the United States and worldwide
MS. PARKER: Your Honor, that completes the STKEG TPHAEGSs. We would now want to move the three documents into evidence, plaintiff's trial Exhibit 5, plaintiff's trial Exhibit 6 and plaintiff's trial Exhibit 8.
MR. PANTOJA: Your Honor, we object to the admission of those documents into evidence for failure to satisfy federal rule of evidence 803.6 as business record, exception to the hearsay rule.
There has been no foundation that it was the directed policy business of ACOG to prepare policy statements on abortions and that such policies were kept in the course of regularly conducted business activity of ACOG.

And two of the exhibits --
THE COURT: I don't think that's quite accurate sir, is it?
MR. PANTOJA: I'm sorry?
THE COURT: I will ask you to send me overnight references to the page in the transcript, you are getting daily transcript, correct?

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MR. PANTOJA: Yes.
THE COURT: And I think there has been that foundation and I will ask both sides to send me --
MR. PANTOJA: Your Honor, even assuming that they can meet the prepared in the regular already course of business activity prong of the exception to the hearsay rule, the sources of the information for the statements at issue and the circumstances under which these statements were prepared do not indicate trust worthiness in this case.
Dr. Cain did not know whether the statements were based on reviews of the facts by the board of examiners that were on the task force. That was at pages 49, lines 8 to 20.
Dr. Cain could not say that the process for developing policy statements was followed on any committee other than the one she was on, which was an ethics committee and that was on pages 50, lines 21 through 51, line 7.
She also cannot say whether the task force members, which task force members were present at any vote and how many task force members actually vetted on the statement.
She also did in the know who wrote specific portions of the statement and that was throughout the transcript.
She also did not remember which textbooks were available. She mid a reference to textbooks on the side table but she could not identify what matters were referred to in those textbooks and THES at page 143.

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THE COURT: The issue she raised, I'm not sure that they make the statements unreliable except it may point out the inadequacy of the question asked of the witness., that could have been asked.
MR. PANTOJA: Your Honor, there was further testimony by Dr. Cain that she could not identify whether any specific material in the textbooks, as in publications, whether they were referred to.
And she also could not -- she also confirmed that the panel, the board did not find any --
THE COURT: Do you think that that knocks it out, because they didn't bother to reference the text even though they were siting there?
MR. PANTOJA: Your Honor, Dr. Cain was unable to specify the basis on which the statement was based, the January 1997 statement and the other statements that I the plaintiffs sponsor to admit in this case and therefore there is no way of substantially.

THE COURT: But her organization voted for it, regardless of whether they did adequate homework or not. I think it may go to the weight of it but I don't know it attacks admissibility.
MR. PANTOJA: Your Honor the reason it is crucial here is because ACOG is an advocacy group, it is in the a research-based group, it is an advocacy group and this is

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basically a statement of policy. We have policy statements that are being sought to be admitted here.
THE COURT: Did you bring that out, or your colleague in the transcript that it's an advocacy group?
MR. PANTOJA: Yes.
THE COURT: Please reference that to me overnight.
MR. PANTOJA: Yes, your Honor.
THE COURT: I will reserve on the ruling on its admissibility but I think you have a road to hoe, sir.
MR. PANTOJA: Your Honor, if I may add one more thing?
THE COURT: Sure.
MR. PANTOJA: Dr. Cain specifically noted that the board did not find any studies on the relative safety of the D&X procedure as compared to other abortion procedures, which would have been crucial, it's our position that that would have been crucial thing to look at if you are going to issue a statement of policy on intact D&X.
THE COURT: Doesn't that again go to the weight? They issued it, the question is, you could argue as to the weight and are you going to read more tomorrow I take it, right?
MR. PANTOJA: Your Honor, we believe it also goes to trust worthiness of the statement and whether it's worth I of being considered an exception to the hearsay rule.
THE COURT: I think you could argue to me on that. I think you have a road to hoe as far as admissibility but it is

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certainly, I think you may have a valid point as to the weight it should be given especially by organization that chooses not to be here.
So, all right.
MR. PANTOJA: Thank you, your Honor.
THE COURT: Thank you, sir, very much. It is late in the day, I hope I am not too hard on you and that goes for both sides. I am trying to be even-handed but when you get to this hour in the day sometimes my responses are a little abbreviated.
Ms. Parker that is the conclusion of this witness.
MS. PARKER: Yes, it is, your Honor. And we will submit these exhibits and we will both sides will submits their arguments overnight on admissible?
THE COURT: Yes.
MS. PARKER: Thank you, your Honor.
THE COURT: If you would please because I try to keep all of this in my head and I know that it will give you the

shot to check the transcript and you can let me know.
MS. PARKER: Thank you, your Honor.
MR. PANTOJA: Your Honor?
THE COURT: Yes.
MR. PANTOJA: The government has short cross counter designations they would like to read into the record at this time.

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THE COURT: Okay.
MR. PANTOJA: Very short, your Honor, it's only a page.
THE COURT: If you want to do it as part of your case.
MR. PANTOJA: Yes, counter designations now, your Honor.
THE COURT: Put someone up here as witness seat in the same fashion.
MR. PANTOJA: Yes assistant U.S. attorney Elizabeth Wolstein will.
THE COURT: Ah yes. Ms. Wolstein, have a seat.
MS. WOLSTEIN: Thank you, your Honor. Opinion pan name and I will be reading, your Honor, from page 71 of the Dr. Cain transcript, line 4, through page 72, line 4.
"Q
Ms. Poll Wolstein are you ready
THE WITNESS: Had page did you say pain.
MR. PANTOJA: Page 71.
THE COURT: Are you all set WOL well name yes now I'm set, thank you, your Honor.
THE COURT: You have the line and all? Okay, let err rip.
MR. PANTOJA:
"Q let me just say, let me recast the question since you may not know what the personal views of any of these people

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are: Did any of the doctors expressly view on the issue of abortion in particular as to abortion, abortion rights when you were deliberating?
"A I don't know that I could say that specifically.
"Q other than for Dr. G and Dr. J, how would you know that these individuals had a different personal stand on the issue of abortion?
"A primarily from my discussion with Dr. Frig frig about how many people -- sorry -- about how people were chosen for the committee
"Q did he say how he knew what the personal stance
"A no, he did not
"Q let me just finish the question so it is clear.
"A sorry
"Q did he say how he knew what the personal stance of these individuals was on abortion?
"A no, he did not."
MR. PANTOJA: Thank you. That's all, your Honor, for

the counter STKPEUG nation.
THE COURT: As of right now we know of no one coming live from this organization to testify to make selection numbers or even those opposed?
MR. PANTOJA: That is correct, as far as the government is concerned.
THE COURT: Okay.

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MS. PARKER: Your Honor we have asked them to come. We certainly would like them to be here but unfortunately they've declined to produce a witness.
THE COURT: Well I have to weigh that too, I guess. Is that it for today, Mr. Hut.
MR. HUT: I believe so, your Honor.
THE COURT: Okay.
MR. HUT: Could I ask one further matter of clarification. You referenced earlier your preference to sit to 5:00 on most days. The Court had earlier issued an order that hours would be from 9:30 to 4:30 we are fine either way but.
THE COURT: Let me know which law clerk and I will fire him, simple as that.
MR. HUT: I shall point no finger.
THE COURT: I will do it in front of the Pearl Street hang. One good hanging is a lesson to the rest. It keeps them all if line.
I think we best do this, if we start getting no advance to long-windedness and let me know if we are on pace. I hate this early in a hearing or trial to say that we won't do that. I might be a little flexible if you tell me you are about to wrap up. I don't mean the final days but I will be flexible but I hate to get caught and all of a sudden -PBT I don't have any time.

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MR. HUT: Understood, your Honor.
THE COURT: Let's stick with 5:00 at the moment and feel free. We can talk informally too, we don't necessarily have to be on the record as far as logistical questions but let's stick with this for the next few days and we quill see how it's going, okay?
MR. HUT: Thank you, your Honor.
THE COURT: People, have a lovely evening. See you all tomorrow. Thank you for all your help.
(adjourned to March 30, 2004 at 9:30 a.m.)