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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
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NATIONAL ABORTION FEDERATION,
MARK I. EVANS, M.D.,
CAROLINE WESTHOFF, MD, MSC;
CASSING HAMMOND, MD,
MARC HELLER, MD,
TIMOTHY R.B. JOHNSON, MD,
STEPHEN CHASEN, MD,
GERSON WEISS, MD,
on behalf of themselves and
their patients,

Plaintiffs,

v. 03 Civ. 8695 (RCC)

JOHN ASHCROFT, in his official
capacity as Attorney General Trial
of the U.S., along with his
officers, agents, servant,
employees, and successors
in office,

Defendants.

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New York, N.Y.
April 12, 2004
9:45 a.m.

Before:

HON. RICHARD CONWAY CASEY

District Judge

APPEARANCES

AMERICAN CIVIL LIBERTIES UNION FOUNDATION
Attorneys for Plaintiffs
125 Broad Street, 18th floor
New York, New York 10004-2400
(212) 549-2600
BY: JULIE STERNBERG, ESQ.

APPEARANCES (continued)

THE ROGER BALDWIN FOUNDATION OF THE ACLU, INC.
Attorneys for Plaintiffs
180 N. Michigan Avenue, Suite 2300
Chicago, Illinois 60601
(312) 201-9740
BY: LORIE A. CHAITEN, ESQ.

WILMER CUTLER PICKERING LLP
Attorneys for Plaintiffs
2445 M Street, N.W.
Washington, D.C., 20037-14 20
(202) 663-6235
BY: A. STEPHEN HUT, JR.
AMY WIGMORE, ESQ.
KIMBERLY A. PARKER, ESQ.

SHEILA M. GOWAN, ESQ.
SEAN H. LANE, ESQ.
JOSEPH A. PANTOJA, ESQ.
ELIZABETH WOLSTEIN, ESQ.
Attorneys for Defendants
U.S. Department of Justice
86 Chambers Street, 3rd floor
New York, New York 10007
(212) 637-2800

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(Trial resumed)
THE COURT: Good morning.
Ms. Gowan, it is opening day for the Mets and it would likewise seem to be opening day for the government's case.
MS. GOWAN: Yes, it is, your Honor.
THE COURT: You may proceed.
MS. GOWAN: The government calls Dr. Charles Lockwood.

CHARLES LOCKWOOD,
called as a witness by the defendant,
having been duly sworn, testified as follows:
THE CLERK: Please state and spell your full name slowly for the record.
THE COURT: Charles Joseph Lockwood, L-O-C-K-W-O-O-D.
THE CLERK: Thank you, sir. Please be seated.t.

DIRECT EXAMINATION

BY MS. GOWAN:

Q. Good morning, Dr. Lockwood.
A. Good morning.
Q. Are you presently employed?
A. I am.
Q. Where?
A. At Yale University.
Q. In what capacity?
A. I'm the chairman of the department of obstetrics, gynecology, and reproductive sciences in the School of

Medicine.
Q. How long have you held that position?
A. Since July of 2002.
Q. Would you briefly describe for the Court your duties and responsibilities as the chair of the department of OB-GYN at Yale.
A. The academic chairs at Yale also serve, generally speaking, as the chiefs of service for Yale-New Haven Hospital. In those two capacities I oversee the education of our medical students, the training of our residents and fellows, the quality assurance of the clinical care that is provided, the financial and administrative aspects of our clinical practices and the full-time faculty, and also the research endeavors and efforts of the department.
Q. What did you do before assuming your position as chair of the department of OB-GYN at Yale?
A. I was the chairman of the department of obstetrics and gynecology at the NYU School of Medicine.
Q. How long did you hold that position?
A. For seven years.
Q. Would you briefly describe for us what your duties and responsibilities were as chair of the department at NYU.
A. Analogous.
Q. Where did you receive your medical training?
A. University of Pennsylvania.

Q. When did you graduate?
A. 1981.
Q. Where did you receive your post-graduate training?
A. I did my residency in obstetrics and gynecology at Pennsylvania Hospital in Philadelphia, my fellowship in maternal fetal medicine at Yale University School of Medicine in New Haven, and also a post-doctoral fellowship in coagulation and clotting at the Mount Sinai School of Medicine.
Q. Are you licensed the practice medicine, Dr. Lockwood?
A. I am.
Q. Where are you licensed?
A. Connecticut, New Jersey, and New York.
Q. How long have you been licensed to practice medicine?
A. Since 1981.
Q. Are you board certified?
A. I am.
Q. In what specialties?
A. Obstetrics and gynecology, with specialty certification in maternal fetal medicine.
Q. What is maternal fetal medicine?
A. That is the field of endeavor in which we manage patients with complicated pregnancies, either because of maternal medical conditions or complicated obstetrical conditions, such as toxemia pregnancy or preeclampsia, premature labor, or conditions of the fetus that require either diagnosis or

treatment or both.
Q. What is preeclampsia?
A. Preeclampsia is a disorder in which the mother's blood pressure is elevated and she has protein in her urine, and often she has other manifestations of organ dysfunction throughout the body. She could have a low platelet count, for example, abnormal liver function tests, her kidneys can have abnormalities, and so forth.
Q. As a maternal fetal medicine specialist, do you consider both the mother and the fetus to be your patients?
A. I do.
Q. Do you have an active practice in maternal fetal medicine?
A. I do.
Q. Could you briefly describe for the Court what your practice is.
A. It is a series of practices really. There is a prenatal diagnosis and treatment component that employs ultrasound and various other diagnostic modalities. There is a real practice practice, where we see patients throughout their pregnancy for reasons of maternal health complications or fetal complications. And there is an active term "transport program" where ill mothers or patients with premature labor and other conditions are transferred to Yale-New Haven Hospital.
Q. Do you conduct research?
A. I do.

Q. And in what areas?
A. Multiple areas. My primary clinical research areas are premature labor and premature delivery, prevention and detection, as well as recurrent pregnancy loss, as well as maternal clotting disorders. My basic science research areas that are supported by the National Institutes of Health are primarily in the area of what I would define as uterine biology, particularly the regulation of the formation of blood vessels in the uterus and clotting in the uterus.
MS. GOWAN: Your Honor, may I approach?
THE COURT: Surely.
Could I ask you, Doctor, do you do this research yourself along with others under your direction?
THE WITNESS: That's correct.
THE COURT: But you actually participate yourself, it is not just something done by your department?
THE WITNESS: Yes. I design all the experiments and craft the grants myself and write the papers myself, and so forth, correct.
THE COURT: Thank you, Doctor.
Go ahead, Ms. Gowan.
Q. Dr. Lockwood, I am handing you what has been marked as Government Exhibit Z6. Would you take a moment and look at that, please. Can you identify this document?
A. I can.

Q. What is it?
A. This is my curriculum vitae.
Q. Did you prepare it?
A. I did, or my secretary did, or both.
Q. Is it current, Dr. Lockwood?
A. Reasonably current. There are about 11 publications missing from it.
Q. Are those 11 publications that you have recently presented?
A. Obviously since this was prepared.
MS. GOWAN: Your Honor, the government moves the admission of Government Exhibit Z6.
THE COURT: Any objection?
MR. HUT: No objection, your Honor.
THE COURT: It will be received.
(Defendant's Exhibit Z6 received in evidence)
Q. Does your curriculum vitae identify your various published articles?
A. It does.
Q. Approximately how many articles have you published, Doctor?
A. I believe currently either already published or in press 150.
Q. Can you very generally describe for us some of the topics upon which you have published.
A. They are fairly wide-ranging, and they cover everything from ultrasound and ultrasound diagnoses to abnormal uterine

bleeding; the regulation of in vitro what we call hemostasis, or clotting, which is my real research passion, I guess; the regulation of endometrial blood vessel formation or what we call angiogenesis; and a variety of other topics, primarily focusing on prematurity and methods for detecting or delaying premature labor.

Q. Are you an expert in prematurity?

A. I think people would say I was.

Q. Have your articles been peer-reviewed?

A. They have been.

Q. Do you serve on the editorial boards of any publications?

A. I do.

Q. Can you generally describe for us some of the publications upon which you sit on the editorial board.

A. I have served twice now on the editorial board of the Journal of Clinical Endocrinology and Metabolism, which is the leading journal in both medical and reproductive endocrinology, as well as an assistant editor of the Journal for Maternal Fetal Medicine and the Journal of Maternal and Neonatal Medicine. I am the editor in chief of Contemporary OB-GYN, which is actually if not the leading then one of the two leading magazines, as we like to call it, read by obstetricians and gynecologists. My CV includes some of the others. There are a number of others.

Q. Have you ever served as a peer reviewer for studies

presented by other physicians?

A. I have.

Q. Do you recall which journals you have served as a peer reviewer for?

A. Quite a few.

Q. Are you a member of any professional organizations?

A. I am.

Q. Will you tell the Court about a few of them, please.

A. I am a member of the American College of Obstetricians and Gynecologists, the American Gynecological and Obstetrical Society, on which I am actually the chair of a subunit called the American Association of Obstetricians and Gynecologists Foundation, which oversees a training program for young scientists. In addition to that, I am a member of APOG, Association of Professors of Obstetrics and Gynecology, the AMA, local New Haven County Medical Society, the New York Obstetrical Society, New Haven Obstetrical Society, and a variety of others that are listed on that CV.

Q. Is the American College of Obstetrician and Gynecologists also known as ACOG?

A. It is.

Q. Have you ever served on ACOG committees?

A. I have.

Q. Can you briefly tell us about your work on ACOG committees.

A. I served for five years on the committee of obstetrical

practice, which is the committee that assesses new treatments and technologies and medical practice in obstetrics and makes recommendations usually in the form of something called a committee opinion. I also served for two years as chair of that committee. I am currently chair of the document review committee, which reviews all documents related to obstetrics. And I have served on a number of other committees, either as a liaison member or as an active member of approximately five or so other committees.

Q. Doctor, do you support a woman's right to choose to terminate her pregnancy?

A. I do.

Q. Why did you agree to be an expert witness for the government in this case?

A. I believe very strongly that, whether we are discussing panels that serve the government, the FDA, and others, or expert witnesses in trials and hearings, it is critical that experts be objective, provide unbiased data, and don't bring, I guess, their ideological slants to the table, if you will. And I felt that I could serve in a very objective way on this complex and delicate problem that we are discussing.

Q. Do you have any expertise concerning abortion, Dr. Lockwood?

A. That which I have acquired in my training.

Q. What is the basis for your expertise?

A. It would actually start probably with my undergraduate training in embryology and developmental biology and extend through exposures to both that and abortion practice in medical school, in residency in the form of lectures, as a resident observing D&E's and other abortion procedures.

I spent 10 weeks at Pennsylvania Hospital in the family planning service. Although I did not perform surgical abortions, I managed, if you will, patients undergoing medical abortions in whom someone else had placed the prostaglandin suppository. But I cared for them and would remove the placenta if retained, and so forth.

Subsequent to that time, I have certainly observed D&E's in all the different institutions I have been in. In addition to that, in cases of fetal demise I have performed suction and curettage as well as medical terminations.

Q. Do you regularly read the medical literature concerning abortion?

A. I regularly read the medical literature, which includes topics on abortion.

Q. Why do you do that?

A. As chairman of the department, I am expected to know both obstetrics and gynecology, and I am expected to speak intelligently at our morbidity and mortality rounds and oversee the quality of care provided by each of the different divisions and components of the department.

Q. Have you yourself ever performed an abortion on a live fetus?
A. No.
Q. Why is that?
A. I don't want to go on for a long period of time, but suffice to say that I feel that abortion does pose a real conundrum for society because it brings into conflict a woman's right to choose, really society's obligation to respect her autonomy as relates to reproduction and privacy versus society's obligation to protect the life, and I would add dignity, of its members.

Obviously, society has many views on this topic. To those that are pro life for religious reasons, all abortions and many forms of contraception would be viewed as always being immoral and should never be used. And for those that believe the woman's right to choose should extend to the third trimester, then really abortion should remain unfettered throughout pregnancy.

I would add that I think society has very few members that hold such extreme positions, that even those that believe in the sanctity of life would argue that abortion was permissible to save the life of the mother, perhaps some would add in cases of incest and rape. I would think there are very few people, no matter how pro choice they are, that would support abortion on demand in the third trimester.

I think obviously as an obstetrician gynecologist we are in a unique position, because we have to deal every day with this issue, and we have to balance the same rights and obligations and ethical duties to our patients, which include respecting their reproductive autonomy, respecting their choice, respecting their privacy in the case of the mother, and at the same time doing everything we can to ensure that fetuses are delivered to term and in a healthy state.

I would say that in coming to my somewhat paradoxical position of being sort of personally pro life, if you will, and publicly pro choice, I started with sort of the template or the basic axiom that human life was different perhaps than other animals, that humans had certain natural rights. I would say our founding fathers identified some of them quite well: Life for sure, liberty. And I would add, although it is very controversial these days, that humans are endowed with dignity.

That, of course, poses the issue of how do you counsel patients that may seek to have an abortion, should you perform an abortion, and how do you juxtapose and balance these potentially competing interests in the case of the mother of reproductive autonomy and privacy; in the case of the fetus, life and dignity.

I would say that in balancing that, I have chosen not to do abortions but to absolutely support a woman's right to choose, with certain limits. Just as society has limits on the

rights and its obligation to respect the rights of its citizens, I use as an example that we probably should not negotiate with terrorists to save a life and that folks shouldn't drive at 110 miles an hour on the highways, because although it is their liberty that would let them to that, they are putting others in danger.

I think the same is true in abortion. Abortion is not an absolute right for the mother, and the fetus I don't believe has an absolute right to life in this complex and conflicting ethical setting. I would say that we have to balance, therefore, these two competing interests, and I think a reasonable way to do that is to draw a line at 23 6/7 weeks, which, as I have said repeatedly in the past, is the point at which the fetus in the vast majority of cases has a potential for meaningful life outside the womb.

Q. Doctor, I want to ask you --

THE COURT: Ms. Gowan, did you want to ask the Court to recognize the doctor as an expert in any field?

MS. GOWAN: Your Honor, I was going to ask that. I did have a few more questions before I do that.

THE COURT: Go right ahead. I just wondered. You were moving away from the doctor's curriculum vitae. I wondered. Go ahead.

Q. Doctor, you mentioned before, I believe, that you do provide care to patients who have had miscarriage and

spontaneous abortion, is that right?

A. Correct.

Q. You mentioned suction curettage.

A. Correct.

Q. What is that, just briefly, for the Court?

A. Suction curettage is a procedure where the patient is -- would you like me to describe the procedure?

Q. Very briefly.

A. The patient -- this can be done in a hospital or in a an ambulatory setting. In brief, she is given pain medications pre-operatively, is then prepped and draped, as we call it, and rendered relatively aseptic with Betadine versus other antibacterial agents. Usually a pelvic exam is performed to assess the size of the uterus or an ultrasound is performed to identify in another way the relative size of the uterus and the position of the uterus.

At that point, a speculum is placed in the vagina. Generally speaking, we place a tenaculum on the cervix, which is a clamp-like device, then inject local anesthetic into the cervix, dilate the cervix with dilators. Then, after doing that, I will sound the uterus to see how long it is, and then place in a suction curette, a plastic tube, which is attached to a vacuum, and evacuate the uterus by doing that.

Then, often I will make several passes with a stainless steel curette to ensure that there is no residual

products. In my practice I usually will do an ultrasound to make sure there is no residual pregnancy products in the uterus. Most often I will send that specimen for a karyotype or pathology analysis.

At the completion of the procedure, I will see that the instruments are removed. Depending on the gestational age, I might begin oxytocin to facility contractions, reduce bleeding, as the studies support its use. I usually will give, depending on the gestational age, antibiotics -- again, the studies suggest that they reduce infection -- and pain medications, if I they are warranted.

Q. You mentioned D&E. What does that mean.

A. D&E is a dilatation and -- well, it can either mean extraction or evacuation, most often evacuation.

Q. Have you observed the performance of D&E abortion?

A. I have.

Q. Can you describe for the Court the circumstances under which you have observed that.

A. I have observed it to provide ultrasound guidance for the procedure. I have observed it in cases where I have developed a relationship with the patient and she wanted me to be there. So I was there as she went to sleep and performed the ultrasound for the physician. Generally in those kinds of settings.

Q. At what gestational ages have you observed D&E abortion?

A. Certainly up to 20 weeks.

Q. Have you ever observed an abortion being performed on a live fetus?

A. Yes.

Q. Would that be a D&E abortion?

A. That's correct.

Q. Have you ever written in connection with abortion?

A. I have.

Q. Could you please describe for the Court those types of writings that you have done.

A. The bulk of the articles focused on RU486, mefipristone, which is a medical form of termination, although it is now used in a variety of different settings in obstetrics and gynecology. We detail the mechanisms by which it caused endometrial disruption and bleeding, the disruption of the womb, the lining of the womb, lining of the uterus.

In addition to that, I also published an article with George Thomas, who was the first author, at Mount Sinai on the safety of D&E in patients with placenta previa, which is a condition where the placenta covers the entrance to the uterus.

Q. In connection with your work on that paper, did you have an opportunity to observe abortion by D&E?

A. I don't believe I specifically did for that paper.

Q. Was that study completed?

A. It was.

Q. Was it published?
A. It was.
Q. What were the results?
A. There was greater blood loss in patients with placenta previa, but the procedure was safe.
Q. Have you ever treated women who are experiencing complications after receiving abortion?
A. I have.
Q. Can you describe that for us, please.
A. A variety of complications, including death and uterine perforation requiring hysterectomy or repair of the uterus, retained placentas after both medical and surgical abortions, infections and sepsis. In one case, a case of clostridia, gangrene of the uterus. But in general they are either infectious or hemorrhagic complications.
THE COURT: Would you say in one case there was death?
THE WITNESS: One case of death, yes. They came to the emergency room and had already expired.
THE COURT: Had the abortion occurred in the hospital?
THE WITNESS: If I remember correctly, it had occurred in a fairly high volume out-patient setting.
THE COURT: But in an organized and legal clinic?
THE WITNESS: Correct.
THE COURT: Go ahead, Ms. Gowan.
Q. Doctor, while you were at NYU, did you have any

responsibility for abortion services?
A. I did.
Q. What were those responsibilities?
A. We organized a family planning/reproductive choice service. The family planning service had actually existed prior to my arrival. That section was charged with the duty of training our residents in abortions and providing abortion services at Bellevue Hospital, as well as to conduct clinical trials on contraceptives as part of the National Institutes of Child Health and Development -- Early Development -- Health and Development, rather, contraceptive network set of trials.
Q. Were you responsible for creating that program?
A. I was.
Q. Did you have day-to-day supervision or responsibility for the program?
A. Not day-to-day supervision, but overall responsibility.
Q. Did you have any role in deciding the methods of abortions that would be performed on that service?
A. No.
Q. Who did?
A. The director.
Q. Did you leave those decisions up to the director?
A. I did.
Q. Why did you do that?
A. The director was extremely competent, well trained, and I

had great -- I trusted her capacity to perform the procedures.
Q. Do you know the types of abortion services that are currently provided at NYU?
A. I do.
Q. What are those?
A. They range from a manual vaginal aspiration to intact dilatation and extraction, as well as medical abortions.
Q. I'm sorry. Medical abortions?
A. Correct.
Q. What do you mean by that?
A. That would be a procedure in which prostaglandins are placed in the vagina and essentially labor is induced and the fetus delivers.
Q. Is medical abortion the same thing as labor induction abortion?
A. Yes.
Q. Prior to your work in this case, had you ever heard the term "partial-birth abortion"?
A. Yes.
Q. Is that a medical term?
A. Not to my understanding anyway.
Q. Do you know what is meant by "partial-birth abortion"?
A. I do.
Q. What is it? What does it mean to you?
A. There are several potential definitions. One is the one in

the Act in question, and the other would be the definition put forth by the American College of Obstetricians and Gynecologists.
Q. To your knowledge, is that abortion procedure referred to by other names?
A. It is.
Q. What are those names?
A. It could be called an intact D&E or an intact D&X, dilatation and extraction.
Q. When did you first learn that D&X was performed at NYU?
A. I believe it was in December of 2003.
Q. How did it come about that you learned that D&X was performed at NYU?
A. I called the director and asked her what procedures were done and a number of other questions.
Q. Why did you call the director?
A. To prepare an expert report.
Q. Was that in connection with your expert work in this case?
A. Correct.
Q. Were you, in effect, performing some research in order to inform your views in this case?
A. That is correct.
Q. Do you know whether D&X was performed at NYU while you were the chairman of the department of OB-GYN?
A. I do.

Q. You do know that?
A. I do know that it was performed, correct.
Q. When did you learn that?
A. When I called the director and asked her.
Q. You did not know at the time you were chair at NYU, is that correct?
A. That is correct.
Q. How could that be that you did not know, Doctor?
A. The procedure is employed in about a third of the second trimester abortions that are occurring at NYU. I did not specifically ask the director the types of procedures that were done. I trusted in her judgment that she would be performing those that she had reasonable competency and training in performing, and she never let me down. So I think that my trust was well placed.
Q. While you were at NYU, did you recuse yourself at all from any decisions concerning abortion?
A. There was a standing policy that the chair had to adjudicate the appropriateness of procedures done at the point of threshold of viability, so those performed certainly after 22 weeks, and I recused myself from that decision.
Q. Did some other panel make the decision in those cases in which you recused yourself?
A. The Bellevue ethics panel or occasionally the director of obstetrics.

Q. Is there a family planning and reproductive choice program at Yale?
A. Not yet.
Q. Are you planning to develop such a program?
A. I am.
Q. What are your plans for the service?
A. They would be quite analogous to what we did at Bellevue. The goal would be to provide services to train our residents, to facilitate research in contraception, to publish papers, and hopefully garner grants.
Q. Does Yale have an OB-GYN medical residency program?
A. It has an OB-GYN residency program and a medical residency program.
Q. Are you responsible for the OB-GYN program?
A. I am.
Q. Very briefly, could you tell the Court what your responsibilities are for that program.
A. The overall responsibility is to ensure that they are in compliance with the 80-hour work week regulations, to ensure that the curriculum that has been prepared is followed, that they receive adequate didactic training, that they have appropriate educational resources to learn, that the faculty is first rate and able to teach them, to review on a regular basis their performance, and to assess the performance of the faculty in teaching them, and also to assess the faculty's evaluation

of the residents, to help them prepare for their boards such that they pass them, and at the same time, perhaps unique to Yale and a few places, to encourage them to do research and to focus on academic medicine as a career and to complete subspecialty fellowships.
Q. Is instruction in abortion part of your program at Yale?
A. It is.
Q. Where is the instruction offered?
A. A variety of venues.
Q. Could you briefly describe those for us.
A. They include the hospital itself, where generally speaking more advanced procedures are done. They are also done at an out-patient facility called Williams Surgical Center. Those procedures are generally done by our community physicians. Usually RD means prior to 18 weeks. And our interns, when they are on our internal medicine rotation, have several afternoons a week that they can elect to go to Planned Parenthood to observe abortions being performed in that out-patient setting.
Q. Are you familiar with the medical and surgical techniques for abortion in the second trimester of pregnancy?
A. I am.
Q. What is the basis of your familiarity with those techniques?
A. In the case certainly of medical terminations, I perform medical terminations in the setting of dead fetuses. So I have

some personal experience with that. My experience with D&E's are my experience with the literature and through observations of others performing the procedure, through discussions with doctors, presentations at our morbidity and mortality conferences, and so forth.
Q. Could you very briefly describe for the Court how a D&E abortion is performed.
A. It varies from the description I gave of suction curettage in several ways and again depending on gestational age. A key component is cervical ripening, which is generally done with laminaria. One can also add misoprostol or cytotec 3 to 4 hours before the procedure to add additional cervical softening and dilation. There are some studies afoot to use RU486 as another method of inducing cervical ripening prior to surgical procedures. There are a lot more studies about its use in medical terminations.
After that period of cervical ripening, the patients are brought to the operating room. This presumes that they have had histories and physicals and appropriate lab tests done, appropriate counseling provided, and so forth. The laminaria are generally removed. The patient again is prepped and draped. She might be put to sleep. That is generally what we do at Yale-New Haven Hospital.
A pelvic exam will be performed after the physician has scrubbed and put on their gowns, and so forth. Depending

on the extent of the cervical dilatation, there may be need for additional cervical dilatation. Speculums of different types can be used, put in to expose the cervix, again depending on the patient's form of anesthesia. If this is being done with IV sedation rather than general anesthesia, a local anesthetic might be injected into the cervix. The uterus may be imaged with ultrasound during this procedure.

At that point the membranes are ruptured with an amnio hook, and a special type of forcep or clamp is then used to remove the fetus in parts. Following removal of the fetus -- and there are a variety of ways to confirm that it has been completely removed by looking at the specimen, seeing if it is intact, by doing an ultrasound -- there are various maneuvers that can be effected to further ensure that the uterus is empty. The placenta is removed by suction curettage, like in the earlier abortion I described, and the uterus is generally curetted with a sharp metal stainless steel curette to make sure that there are no residual products of conception in the uterus.

The instruments are removed. The patient returns to the recovery room and is almost always given oxytocin during this procedure to reduce blood loss, probably given antibiotics, and sent home with appropriate pain medication, antibiotics, and/or prescription for contraception.

Q. Doctor, when you say the fetus is removed in parts, do you

mean that the fetus is dismembered?

A. Correct.

Q. Can you briefly describe for us what the labor induction or medical abortion procedure is.

A. Actually, it is quite similar in its early stages. Cervical ripening is induced with laminaria and alternatively can be induced with RU486, and a variety of different doses of misoprostol can be used to induce the labor. Depending on the dose and depending on whether it is used in conjunction with RU486, the procedure can take longer or shorter.

For example, if one uses pretreatment with RU486 and 800 micrograms of misoprostol followed by 400 micrograms every 4 hours, the interval from the beginning of induction to delivery can be as short as 4 hours. Other reports of similar approaches suggest 6 hours. If one doesn't pretreat with RU486 and uses just 400 micrograms every 4 hours, the procedure usually takes an average of 12 hours. About a 90 percent success rate in that case, 95 to 100 in the first case I gave you.

Q. When you say 90 percent success rate, what do you mean?

A. The fetus delivers, the placenta may not. In the very aggressive regimen I just described with RU486, the placenta is retained in about 5 percent of the cases. In cases without RU486 it is retained in 10 to 20 percent of the cases.

Then you can use a low-dose regimen with 200

micrograms, which is very often what I will do, because many of my stillbirths are in the late second and early third trimester. That is given every 4 hours. I will often use even lower doses, 100 micrograms, 50, and occasionally even 25, depending on the clinical setting. One would expect that labor to last longer, 24 hours on average, in a very low-dose setting.

At any rate, the fetus is delivered, the placenta will either be removed spontaneously or manually. If it fails to come out of the uterus within an hour or two hours, depending on the clinical setting, I will do a D&C and remove it. Again, the patients generally are given an epidural so that they are comfortable during the procedure, and given appropriate pain medication, antibiotics, and/or whatever other medications or prescriptions would be required for their discharge.

Q. Doctor, do you have an understanding of what the D&X procedure is?

A. I do.

Q. What is the basis for your understanding?

A. Reading the American College of Obstetricians and Gynecologists description, reading the various expert reports, depositions, and testimony of the plaintiffs, the writings of Dr. Haskell and McMahon, would be the primary sources.

Q. How do you understand the procedure is performed?

A. In general, the procedures analogous to a D&E. There is a

prolonged precervical treatment, cervical ripening period with laminaria and/or misoprostol. The goal is to achieve a greater degree of cervical dilatation with the intact D&X.

This can be done with ultrasonic guidance or not. The notion is to grasp the feet with the same kind of clamp that is used for a D&E and either deliver the fetus directly if it is in a breech presentation or flip it to a breech presentation by doing what is called an internal podalic version. The fetus's head is often entrapped in the cervix, and the contents of the cranium are evacuated to effect delivery.

Q. Do you have an understanding of whether the fetus could also be extracted manually with the physician's hands instead of with the clamp as you have just described?

A. Correct.

MS. GOWAN: Your Honor, pursuant to Federal Rule of Evidence 702, the government offers Dr. Lockwood as an expert in obstetrics and gynecology and someone with the knowledge, skill, experience, training, and education to testify in the form of an opinion about abortion.

MR. HUT: No objection, your Honor.

THE COURT: He will be so recognized by the Court.

Q. Doctor, are you familiar with the published statistics comparing the risks of maternal mortality and maternal morbidity that is associated with abortion procedures?

A. I am.

Q. What is meant by "morbidity"?
A. Morbidity reflects adverse outcomes that can affect organ systems or actually, if they are serious, they can affect a person's health after their occurrence or the functions of an organ or limb, and so forth; as opposed to mortality, which, obviously, reflects death.
Q. Who publishes those statistics?
A. Actually, there are a number of sources. Probably the most reliable is published by the Centers for Disease Control.
Q. Do you consult those statistics during the regular course of your work activities?
A. I receive their MMWR report, yes.
THE COURT: What is that, Doctor? What does that stand for?
THE WITNESS: That would be, I believe, the morbidity and mortality weekly report. It can really cover the full range of America's health, from Lyme disease and West Nile virus infections to upsurges in sexually transmitted diseases or hepatitis, to terrorist attacks with bioactive agents. They cover, in addition, cardiovascular mortality, cancers, and in this case abortion.
MS. GOWAN: Your Honor, may I approach?
THE COURT: You may.
Q. Doctor, I am handing you what has been marked as Plaintiffs' Exhibit 28 in evidence. Are these the morbidity

and mortality weekly report statistics prepared by the CDC that you were just referencing?
A. They are.
Q. What is the period of publication for these statistics?
A. Yearly. For this specific set of statistics?
Q. Yes. What is the reporting period for these statistics?
A. I believe annually, but I am not sure that it is consistently produced on an annual basis.
Q. In particular, what is the reporting period that is encompassed by the statistics in Plaintiffs' Exhibit 28?
A. It provides both the data for the period of time from 1973 to 1997, but also provides additional data in '98, '99, and 2000.
Q. Is this the most recent available CDC data concerning abortion in the United States?
A. I believe it is.
Q. Does this data show how many abortions were performed at 21 weeks and beyond?
A. It does.
Q. What does it show, Doctor?
A. I know these numbers. In 1999 -- I'm sorry. In the year 2000, approximately 1.4 percent of all abortions were performed at or after 21 weeks.
THE COURT: Were performed what, Doctor?
THE WITNESS: At or after 21 weeks.

Q. Does the data show the number of abortions that were performed at or beyond 21 weeks?
A. Approximately 12,000.
Q. Can you tell from the statistics anything about the women who received the abortions at or beyond 21 weeks?
A. You can.
Q. What can you tell, Doctor?
A. In general, these patients were younger and more often minority race members.
Q. When you say these women were younger, what do you mean by that?
A. They were of younger reproductive age criteria. They were under 21 years of age.
Q. Are you able to draw any conclusion from the fact that the statistics show a higher incidence of younger women receiving abortion at 21 weeks and beyond?
A. Generally, that reflects method failure.
Q. What do you mean by that?
A. In general, it would reflect some breakdown in the use of contraception or it would suggest that these folks had less access to care, didn't know they were pregnant, or had trouble accessing an abortion earlier.
Q. Can you tell anything from the statistics about the reason that the women might have had abortion, the indication?
A. We can't have a specific explanation, but it is unlikely,

given the age group, that it is due to, for example, chromosomal abnormalities.
Q. Why do you say that, Doctor?
A. Because chromosomal abnormalities are much more common in older women.
Q. What do the statistics show in terms of mortality?
A. The mortality rate is probably even better defined by an even more recent publication from this database by Bartlett that literally just came out in Obstetrics and Gynecology this year. The overall mortality rate for abortions in the United States have dropped from 4.1 per 100,000 in 1973 to roughly .5 per 100,000 in 1999, I believe it was. So that really is a remarkable 85 percent reduction in the risk of mortality from abortions. Did I answer the question?
Q. Yes. Does the data show how many deaths were reported in 1999 for abortion?
A. 4.
Q. Does the data show the method of abortion that was used in the cases of those deaths?
A. Not to my knowledge in the MMWR.
Q. Does the data show the gestational age of the fetus in the case of those 4 deaths?
A. I don't believe so.
Q. Doctor, if you were to assume that all 4 deaths occurred in women carrying fetuses at 20 menstrual weeks or greater, what

would be the rate of death?
A. It would be approximately .05 percent.
Q. Does the data show the percentage of abortions performed after 21 weeks by D&E?
A. It does.
Q. What does it show?
A. In 1999 85 percent were performed by D&E, 2.4 percent were performed by instillation, saline instillation. That form of medical abortion was rarely used I thought. Another 2.4 percent were medical abortions. Almost certainly the majority of those in '99 were misoprostol. Approximately .2 percent were done by injections of prostaglandins directly into the amniotic fluid and about 10.1 percent were other, and that would include hysterotomies.
THE COURT: That would include what, Doctor?
THE WITNESS: Hysterotomy, which is the equivalent of a C-section on a nonviable fetus, an early C-section.
Q. Does the data for D&E break out any data for D&X?
A. No.
Q. Are there any reported statistics for the rate of D&X?
A. No.
Q. In your opinion, do the reported statistics for D&E tell us anything at all about D&X?
A. No.
Q. And why is that?

A. They just don't. It is not something the CDC has yet tracked.
Q. Can you draw any conclusions from this data as to the safety of D&E abortion?
A. I think that the key evidence that this report and the report in Obstetrics and Gynecology by Bartlett suggests is that gestational age is a critical determinant of the risk of the procedure. If one compares the risk of death in abortions performed at or before 8 weeks with those that are performed, for example, from 10 to 13 weeks, there is about a fifteenfold increase risk of death and an overall mortality rate of 1.7 per 100,000. I'm sorry. That is from 13 weeks to 15 weeks. From 16 weeks to 20 weeks, that number climbs to a thirtyfold increased risk of death from a given D&E procedure, and the overall mortality rate would be approximately 3.4 per 100,000. At or beyond 21 weeks, the increase in mortality is seventh-sixfold higher, with an approximately 8.9 per 100,000 risk of death.
Those numbers are for terminations at those gestational ages, and obviously, as I have already pointed out, the majority of those terminations are D&E's. But it doesn't specifically divide out the death rate for medical abortions versus surgical abortions.
Q. Doctor, what is meant by the term "viability" as it relates to the unborn fetus?

A. There are both legal and medical definitions. I would say that the best medical definition is that point where there is a reasonable probability that the fetus will survive and have a meaningful life or a relatively, as we call it -- I hate to use the term -- intact survival.
Q. From the medical point of view, when does fetal viability occur?
A. It is a subjective assessment. It is somewhat also confounded by co-morbidities in the mother. For example, if the mother is very ill and the fetus is small and acidotic, producing acid in its blood, and so forth, then that fetus might not survive if it is delivered at 28 weeks, whereas other fetuses can survive and have good survival at 24 weeks. So if you were to use a number that is a rolling average of all those different conditions, I think the number I gave you before of 23 6/7 weeks is appropriate.
Q. What do you mean by 6/7 weeks?
A. The end of the 23rd week.
Q. Doctor, do you have an opinion as to whether the death of a fetus at 23 6/7 completed weeks by abortion is ever required to preserve the health of a mother?
A. Beyond that point I would say no.
Q. Why is that?
A. There have been substantial advances in our ability to take care of critically ill mothers. There have been great

improvements in anesthesia for pregnant women. There have been remarkable improvements in neonatal intensive care and in the preparation of fetuses for early delivery. All those things make it very likely that fetuses born at or beyond 24 weeks will survive with a progressively higher rate of good outcomes. And the methods to promote that delivery, whether it is induction of labor or Cesarean section, are safe, well established, and reasonable to use.
That is not to say that there aren't circumstances where there is a lethal fetal anomaly that delivery should not be effected for sort of humane reasons for the mother. But in those conditions, obviously, the fetus can't survive. Anencephaly is an example of that.
Q. Aside from the case of anencephaly that you have just mentioned, can you conceive of any situation at 24 weeks or later where the health of the mother must exchanged for the life of the fetus or vice versa?
A. I cannot.
Q. Doctor, in your opinion, what can a physician do if a mother's life is in jeopardy and she is carrying a viable fetus?
A. Deliver the fetus and hopefully treat the underlying condition.
Q. Have you ever taken steps to deliver a mother of a preterm viable fetus when the mother's life was in jeopardy?

A. Many, many times.
Q. Have you been successful, Doctor?
A. Yes, I have.
Q. In your opinion, Doctor, is D&X ever medically necessary to preserve the health of a woman carrying a fetus at a gestational age of 24 menstrual weeks or greater?
A. No.
Q. In your opinion, Doctor, are there any circumstances relating to the health of the mother that may require termination of a pregnancy prior to fetal viability?
A. Yes.
Q. In these circumstances, will the death of the fetus always occur?
A. Yes.
Q. Why is that?
A. By definition, they are not viable.
Q. And the fetus cannot survive ex utero, is that right?
A. Exactly correct.
Q. In your opinion, how often are such circumstances presented?
A. It is hard to give you a precise number, but in general, if one looks at the occurrence of severe preeclampsia, infections, and a variety of other life-threatening medical conditions -- which by themselves are relatively rare, on the order of 1 in 10,000 or 1 in 20,000 -- I think a reasonable number would be

somewhere between 1 and 5 per thousand.
Q. Would it be fair to say, Doctor, in your opinion, that those circumstances where the health of the mother may require termination of pregnancy prior to fetal viability are rare?
A. Right.
Q. I would like to focus on abortion in those circumstances where, again, previability it may be necessary to preserve the woman's health. Focusing now on the 20 to 24 weeks' gestational age, in your opinion, has medical induction abortion been shown to be a safe and accepted method of abortion at these gestational ages?
A. Yes.
Q. Is its safety demonstrated in the scientific and medical literature?
A. Yes.
Q. Are the risks associated with medical induction abortion known?
A. Yes.
Q. And have they been studied?
A. They have.
Q. Does gestational age, in your opinion, have an effect on the risks associated with medical induction abortion?
A. Less studied. But I think the argument to be made here is that the closer one goes to term with an induction of labor, the lower the risk of complications such as retained placentas,

and so forth, faster labor. Therefore, you would expect that the morbidity and mortality would drop with increasing gestational age.
Q. Why do you say that, Doctor?
A. The biggest complication of medical termination, not the most severe but the biggest, most common rather, is retained placenta. As the pregnancy progresses, the likelihood of retained placenta decreases.
Q. Why is that?
A. They asked me that at the deposition as well. It is a complicated answer. To make a very, very, very long story short, the connecting proteins between the placenta and the uterine wall change in their chemical composition across gestation in a way that makes them very sticky early, which is what you would want, and somewhat slippery later, particularly near term. That sticky substance is called fetal fibrin actin, something I have studied fairly extensively. And the reason it changes its chemical nature is that extra sugar groups are attached to it as pregnancy progresses. That makes it less adherent and facilitates removal of the placenta.
Q. At what gestational age, approximately, does the placenta become less sticky?
A. It is a continuum. I can't give you a specific number. But the amount of carbohydrate increases by about threefold across gestation from the first to third trimester.

Q. Does the gestational age at which the retained placenta occurs decrease? Let me try that again.
At which gestational age does the complication or the occurrence of retained placenta decrease in connection with medical induction abortion?
A. With each week it would decrease. I think that, just from experience, the rate seems to start to decline rapidly after 20 weeks.
Q. How are cases of retained placenta managed?
A. Suction, aspiration of the placenta.
Q. Is that technique for removal of retained placenta any different from the technique that is used to remove a placenta during a D&E procedure?
A. No.
Q. Is there any difference in the risks that might be associated with removal of a retained placenta in medical induction abortion and D&E?
A. On the negative side, there might be a higher rate of infection, and that could increase the likelihood of perforation, although that is quite rare. On the positive side, the fact that the uterus is actively contracting down and emptied its cavity, and so forth, would suggest the wall would be thicker and might reduce the risk of perforation.
Perforation at the time of removal of the placenta for a retained placenta after a medical abortion is unbelievably

rare. I have never heard of a case, to be honest with you.
Q. How is infection treated, Doctor?
A. With antibiotics.
Q. In your opinion, has DEA by dismemberment at 20 to 24 weeks' gestational age been shown to be a safe method of abortion?
A. Yes.
Q. Has its safety been shown in the scientific and medical literature?
A. It has.
Q. Based on randomized trials and other study?
A. Well, based on what I would consider very good retrospective cohort studies, controlled case studies, and those types of studies.
Q. What is a cohort study, Doctor?
A. It is where you look at a series of patients who have had procedure A versus procedure B or some variation of the procedure and look at outcomes. You can correct for potential confounding biases with different statistical tools, and so forth.
Q. What is a case study?
A. A case study is where you actually match patients. Rather than relying on just getting a huge group of patients with procedure A versus procedure B, a case study would be where in fact you took the patients and matched them for age, parity,

the number of babies they had had, a variety of other potential confounding variables, and then looked at outcomes for the two procedures, for example.
Q. Are case studies and cohort studies commonly used in medicine to assess treatments?
A. Very commonly.
Q. Are the risks of D&E by dismemberment known?
A. They are.
Q. What are those risks, Doctor?
A. They include amongst a number of other risks hemorrhage, cervical laceration, and perforation.
Q. Do those risks increase or decrease with gestational age?
A. Since we know that the overall mortality rate of abortions, and 85 percent of them are D&E's, increase with increasing gestational age, we assume that there is an increased risk with increasing gestational age. That has certainly been reported in the literature and makes sense, because the uterine wall becomes progressively thinner, and the sharp, bony aspects of the fetus become sharper, and so on and so forth.
(Continued on next page)

BY MS. GOWAN:
Q. And what are the risks of D&E by dismemberment?
A. So the risks of hemorrhage, of severe hemorrhage requiring transfusion, varying in the literature from one percent to 1 per thousand, 1.5 per thousand.

The risk of cervical lacerations from 13 to 20 weeks are approximately 1.2 percent or thereabouts, which is slightly higher than it would be earlier in gestation. And the risk of a perforation is widely reported in the literature, there is a lot of numbers, but to give you the range would be anywhere from 1.4 percent to 0.2 per thousand.

And so, there is quite a large range. Ultrasound reduces the risk of perforation.
Q. Can you characterize at all what that risk of perforation is?
A. What would be the outcome of perforation, for example?
Q. Can you characterize that as a low risk or --
A. Well, it's a concerning risk. I think that it's hard to give a normative value to a number. It's what it is.
Q. In your opinion, how does the risk of infection in retained placenta in medical induction abortion compare to the risk of hemorrhage or laceration or perforation in D&E by dismemberment?
A. It is certainly numerically much more common and ranges from, as I have already mentioned with some of the more recent

techniques, 10 percent, to as high as 30 percent of the literature.

I think 30 percent is probably a reasonable number to use and obviously that's a much more common event than the surgical morbidities I have just described, surgical complications I have just described.

On the other hand -- so, quantitatively, it is greater but qualitatively I would say it is a less severe complication.
Q. You mentioned a moment ago surgical techniques; is D&E by dismemberment considered a surgical abortion?
A. Yes.
Q. Would D&X also be considered a surgical abortion?
A. Yes.
Q. How do the risks of induction abortion compare to the risks of D&E by dismemberment prior to 20 weeks?
A. I would say that, in general, since there is a higher rate of retained placentas and perhaps a slightly higher rate of infection with medical abortions and since we believe the incidence of perforation and hemorrhage is likely less, quite a bit less, the earlier in gestation one goes that while they're probably generally comparable, the overall quantitative differences in complication rates are, definitely favor surgical abortion.
Q. And what about after 20 weeks, Doctor?
A. Well, at best they're comparable. And for the reasons I

outlined before I suspect medical abortions are slightly safer.
Q. Is that your opinion?
A. Correct.
Q. Dr. Lockwood, in your view, do safe and effective methods of abortion exist to terminate a pregnancy for a maternal health reason prior to viability without the need for resort to a D&X procedure on a living fetus?
A. Generally, yes.
Q. And would those be labor induction abortion or D&E by dismemberment?
A. Correct.
Q. In your view is D&X abortion ever necessary to protect the health of a woman who needs to terminate her pregnancy?
A. I can't think of a reason why it would be.
Q. And, in your opinion, are anecdotal evidence and the use of intuition a sound way to practice medicine, Doctor?
A. That phrase comes back to haunt me from my deposition. I would agree with my comments in the deposition.
Q. And why is that?
A. It really speaks to the whole basis for evidence-based medicine.

We make progress in medicine often by being innovative and by thinking of new procedures and new techniques, and it's important to do that. That shouldn't be in any way discouraged but that those innovations should be subjected to rigorous

study. At a minimum, with retrospective study and the maximized randomized clinical trials with doing whatever it is you would want to be doing.

And the risks of not doing that are well known. Thalidomide and its effects on limb reduction when used in Europe. It was the F.D.A.'s prudence in not allowing it to be imported in the United States without such study. That prevented that catastrophe from happening here.

DS, I think, is a better example. I think I mentioned that in the deposition as well where a drug was used, huge numbers of women were exposed to it and it was only some 30 years later when we really did careful outcome analysis that we showed that it was not beneficial in preventing prematurity and that it had long-term health consequences, specifically terrible effects on a woman's risk of prematurity and also a risk of cancer.
Q. You mentioned a few moments ago evidence-based medicine what did you mean by that?
A. It's the assumption that our medical practice ought to be founded on evidence put in the simplest way possible.
Q. Are you aware of any evidence in the medical literature that shows that D&X offers any safety advantage over medical induction abortion?
A. Nothing that has appeared in print.
Q. Well, Doctor, is there any evidence that D&X has a greater

safety advantage than medical induction abortion?
A. None that I'm aware of.
Q. Is there any evidence in the literature that D&X has a greater safety advantage than D&E by dismemberment?
A. No.
Q. Doctor, are you convinced that the D&X procedure is safer than D&E by dismemberment?
A. No.
Q. Are you convinced that the D&X procedure is safer than the labor induction method of abortion?
A. It would somewhat depend on gestational age. But in general, after 20 weeks, no.
Q. And do you believe the D&X procedure presents potential long-term safety concerns?
A. I am concerned that it may present long-term health concerns.
Q. And what are those concerns?
A. Primarily prematurity.
Q. And would you please tell us about that?
A. This is a highly contentious topic and one that obviously has significant political overtones as well as medical overtones. And there is a great deal of contradictory literature on the association between induced abortions and subsequent prematurity.
I would say that the literature taken as a whole is

not completely convincing one way or another, that there are two large studies that we have discussed in the past at the deposition, from France and Denmark, that suggest that there is a higher rate of prematurity associated with induced abortions, a study from France by Henriet and Kaminsky, was published in the British Journal of OB/GYN in 2001, looked at a snapshot of the French population in 1995 and examined 12,000 patients and found about a 13-fold increased risk of prematurity in women that had an induced abortion and about a, if I remember correctly -- well, a 19-fold risk if they had had two induced abortions.
And the Danish study, which I think had different advantages and disadvantages by Zhou et al. in Obstetrics and Gynecology in 1999 looked at a 15,000 patient cohort used their national databases to correlate outcomes and found a 19-fold higher rate of prematurity with one induced abortion and a 26-fold higher risk with two.
That study had the advantage of knowing that 92 percent of the procedures were D&Es -- rather were surgical in that sense, were D&Cs but only 7 percent were D&Es. It doesn't tell us where the suction D&C versus the D&E posed the greater risk and we have no way of knowing.
And argument could be made both ways that with a suction D&C the cervical dilatation is more traumatic, mechanical, and that with -- you could also argue though that

the degree of cervical dilatation is substantially greater with a D&E and I think that I would like to see further study drilling down deep on that specific issue to get a better idea of which procedure is actually putting patients at risk.

I think that there are two other good french studies and they all show about the same odds ratio for prematurity.

I am concerned there is a link between induced abortion and prematurity and I would like to know exactly where it is and is it with early procedures or later procedures. Is it related to mechanical trauma or in fact related to something totally unrelated, not in fact a simple mechanical abnormality but a biological phenomena.

And I think it's an area that does need extensive additional study and one that probably the Europeans are in better shape to perform because they have interchangeable databases, linked databases and so forth that can try to identify patients that have had the different procedures and look at the subsequent pregnancies.

Q. Is it your understanding that there is a greater cervical dilation with D&X than with D&E by dismemberment?

A. There is.

Q. In your opinion what would be required to establish the safety of D&X?

A. Well, ideally a randomized clinical trial. But I think it would be very reasonable to do cohort studies.

There are now multiple centers performing the procedure accruing an ever larger number of patients. And over the course of a 10-year period these patients, we can look at the short-term complication rates versus D&E, we can do logistic regression to adjust for factors such as greater cervical dilatation or more advanced gestational age, and then to look at subsequent pregnancies and try to determine whether one procedure or another is associated with higher rates of prematurity.

Q. And would looking at subsequent pregnancies help you know the answer to your question about whether D&X has an effect on preterm delivery?

A. Yes.

Q. Do you think that -- I think I heard you say that you believed that D&X could be subject to randomized trial, is that right?

A. Yes.

Q. How would you set that up?

A. Well the, it would have to be an intent to treat study because obviously patients that may start off in one category may not end up in the same category at the end of the procedure, but presumably there would be some difference in the duration of cervical ripening, additional numbers of laminaria placements and/or in a pretreatment with mifepristone or misoprostol. And the patients would be randomized prior to

that event and then, obviously, the physicians would make a decision one way or the other about which procedure they would do but having generated greater cervical dilatation in the D&X group presumably more would be done in that group, and then you would follow the outcomes. The doctor's intent was to do this, how many times did they do it, what were the outcomes and so forth. And the same on the other side.
Q. Are you describing evidence-based medicine?
A. I am.
Q. Is it your view that evidence-based medicine is the way to go in assessing the safety of D&X as compared to D&E by dismemberment?
A. It's the way to go in medicine.
Q. And of the three procedures that we have been discussing today, medical induction abortion, D&E by dismemberment and D&X, do you have an opinion as to which method is the safest for the woman after 20 weeks?
A. I think they're roughly comparable. I would -- my bias is in favor of medical termination.
Q. When you say roughly comparable, are you referring to short-term outcome, Doctor?
A. Yes.
Q. You have no way of knowing in terms of long-term outcome, is that right?
A. That's correct.

Q. And is that because it hasn't been studied?
A. That's correct.
Q. Now, have you discussed the use of D&X with any of the physicians that you interviewed for the head of your new family planning service at Yale?
A. I think I have talked at the last one about the fact that I would be an expert for the government but assured her that I was committed to the service and that she would be given the same autonomy that the directors at NYU had.
Q. Let me ask you about that, Doctor.
Have you, in -- has your professional practice been affected at all by the fact that you have agreed to testify on behalf of the government in this case?
A. Well not my practice --
MR. HUT: Objection, your Honor. Relevance.
THE COURT: I will allow it.
THE WITNESS: My practice, I don't believe has been affected. My patients generally don't come to me because they're interested in termination, so no to that.
Q. How about your standing in the professional community, has that been affected in any way?
A. Well, I wouldn't view it as a career enhancing move being here today, no. I think that I have certainly heard from a number of my friends their spirited opinion of me being here and but, you know, I think that as I have stated at the

beginning that if one is not willing to provide evidence that's empirically derived that's not normative, that's not ideological. The system doesn't facilitate that, doesn't permit it whether the system is an F.D.A. panel or an E.P.A. panel or a hearing before a judge, then we are in deep trouble in this country.
Q. Prior to giving your deposition in this case had it even occurred to you to think about whether you would address the use of D&X with the new director at Yale?
A. No.
Q. And so when Mr. Hut asked you for the first time at your deposition what you would do if D&X were legal at Yale, what did you tell him?
A. I would certainly allow her to, or him, to make the decision about what methods to use based on their expertise and knowledge.
Q. And why would you do that?
A. Well, I would do that for each of my divisions. It would be analogous to me telling the in vitro fertilization program how many embryos he can transfer.

I have my bias about that and I would like it to be one because I'm the one that takes care of the multiple gestations and I, in fact, although he hears me nag him repeatedly on the topic, I give him full reign to do what he believes to be in the best interest of his patients.

So, I would say the same, that certainly I see no perilous short-term data that suggests that a D&X is a dangerous procedure such that I would encourage her or him not to do the procedure. I certainly as a perinatologist, whose primary career focus is prematurity, I am very interested in whether or not the long-term outcomes that are untoward were and if they were, if there was a higher rate of prematurity, then I actually would interpose myself into the decision-making and tell them not to do it.
Q. And if you were the director of the family planning service and performed abortions you wouldn't use D&X, would you?
A. I wouldn't be doing abortion, I would be a very bad director I would suggest. But my bias would be against it, to be honest with you.
Q. And that's because you're worried about the long-term consequences, is that right?
A. That's correct.
Q. Can you conceive of any circumstance where after 20 weeks there would be an advantage to D&X over D&E by dismemberment?
A. We have talked about this extensively in the deposition and I admit to not being omnipotent and there might be some condition that I am unaware of where the situation would be such that it would be a preferred procedure, but in those cases, if the law were in effect, you could still inject potassium chloride into the heart or digoxin or lidocaine into

the heart -- you could inject into the heart lidocaine, potassium chloride or digoxin; or you could inject digoxin or hyperosmolar urea into the fetus, or digoxin into the amniotic fluid.
Q. Before we get to those, Doctor, I just want to make clear, is it your testimony, sitting here today, that you cannot conceive of any circumstance in which after 20 weeks there would be an advantage to D&X over D&E by dismemberment?
MR. HUT: Objection. Leading, your Honor.
THE COURT: I will allow it.
A. No.
Q. And sitting here today, can you think of any circumstance where D&X would be necessary to preserve maternal health?
A. No.
Q. Now, you mentioned the use of potassium chloride and digoxin; is potassium chloride also known as KCL?
A. Correct.
Q. What is that?
A. That is an electrolyte that in high concentrations will cause the heart to stop beating.
Q. And have you ever heard of the use of potassium chloride or KCL in connection with performing second trimester abortion?
A. I have.
Q. In what circumstances?
A. It is frequently used as a way of ensuring that a live born

fetus doesn't result from a medical termination or, for that matter, to avoid having to perform either procedure, either surgical abortion on a living fetus.
Q. Is KCL used at NYU?
A. It was.
Q. And is KCL used at Yale?
A. It is.
Q. What's digoxin?
A. Digoxin is a cardiac medication that decreases the heart rate, an anti-chonotrope and increases the strength of contractions, an inotrope, and it is used in, generally in patients with congestive heart failure and in certain patients with rhythm abnormalities of the uterus -- of the heart. I am an obstetrician.
Q. Is digoxin used at NYU?
A. No.
Q. Is it used at Yale?
A. No.
Q. To your knowledge, is it used in connection with second trimester abortion?
A. Yes.
Q. And how is the injection of digoxin performed?
A. It could be performed directly into the heart giving a milligram. It could be injected into the muscle of the fetus if you couldn't access the heart, or it could be injected into

the amniotic fluid all at the same dose.
Q. Does the injection of digoxin require skill?
A. Well, it would --
Q. Pardon me?
A. Progressively less in the three methods I just described.
Q. Okay, why do you say that?
A. It takes a little bit more skill -- it would take a lot of skill to inject it into the umbilical cord, I mentioned that, but that's another possibility, and that would gain access to the fetal vasculature that way.

It could be injected into the heart directly. And that requires more skill but -- less skill than the umbilical cord puncture but more than just injecting it sort of blindly into the fetal muscle or body cavity.

And then injecting it into the amniotic fluid would be simple.
Q. Could injection of digoxin be performed by nurse or physician's assistant?
A. As an amniocentesis it probably could be.
Q. Are there any risks to the injection of potassium chloride?
A. None that we know of.
Q. Does the amount of KCL that's used to ensure the death of the fetus pose any risk to the woman?
A. No.
Q. Why do you say that?

A. It is a very small amount. It's on the order of five MLs of a two ML equivalent per liter solution, right. It is not enough potassium chloride. You are injecting that into five liters of blood in the case of a pregnant woman.
Q. Is there any risk to the injection into maternal structures other than the fetus during the course of the procedure?
A. In the injecting potassium chloride?
Q. Yes.
A. It would burn.
Q. I'm sorry?
A. It would burn.
Q. And what would that result be?
A. Discomfort.
Q. Can you -- anything else?
A. If you have ever had an IV infiltrate in your hand -- a lot of people have had that -- it would be very similar.
Q. What about the risk of digoxin, is there any risk associated with that injection?
A. Well, there seems to be -- there are some studies on its form of kinetic properties, pharmacokinetics product, and it seems to produce a level when injected into the amniotic fluid that is at a low level of therapeutic range for pregnant women.

Injecting it into the fetal muscle or perhaps even directly into the fetal heart, since it has very poor transplacental passage, would likely result in even lower

levels.
Q. Have you ever heard that there was a risk of vomiting or nausea with the injection of digoxin?
A. Yes.
Q. And can you treat nausea or vomiting in connection with the injection of digoxin?
A. Yes.
Q. What would you do, doctor?
A. We would give the patient and anti-emetic.
Q. Doctor, did you testify in Nebraska last week on behalf of the government?
A. I did.
Q. At that time were you asked whether the use of KCL presented risks to a woman who was HIV positive or who had hepatitis?
A. I did, yes.
Q. And what did you say, Doctor?
A. I think I had a little brain cramp.

The question was really -- my mind was focusing on amniocentesis and, in general, since one has to do amniocentesis to perform, if you will, any of these procedures, any of these injections that, in general, we try to avoid amniocenteses on HIV positive moms and Hepatitis-B and C positive moms because you can infect the fetus.

And so, in focusing on that I said, well, you probably

avoid doing it.

But, in reality, we are talking about abortion, we are talking about an amniocentesis for genetic analysis. Since the fetus is going to be killed anyways it doesn't matter much, I suppose, if it is, if the virus is transmitted.
Q. So, you wouldn't see a risk to a woman who is HIV positive with the use of potassium chloride or digoxin to ensure fetal death prior to abortion, is that right?
A. Not as long as the fetus is, you know, the plan is to have the fetus die; yes.
Q. That's the intent, the abortion is the intent?
A. Yes. Right.
Q. Do you perform amniocentesis, Doctor?
A. Yes.
Q. Approximately how many have you performed?
A. Very, very many.
Q. Is there any risk to amniocentesis?
A. There is a very small risk.

May I just add that that risk is the risk of abortion, of miscarriage.
Q. Does the fact that there may be less passes with instruments with D&X than there are with D&E by dismemberment affect your opinion that D&X does not have safety advantages over D&E by dismemberment?
A. I think I made it clear in the deposition that having fewer

passes is certainly a good thing.
Q. But what are the risks of D&X, for example?
Do you believe, is it your opinion that there is a risk in connection with the internal podalic conversion?
A. You would be concerned that since it is a fairly uterine distending procedure that there is a risk of tearing the lateral wall of the uterus, particularly in advanced gestational ages and so actually laceration either the cervix or more likely the uterus in that setting.
Q. How is that performed? What is that, an internal podalic conversion?
A. You literally flip the fetus around.
Q. So, would you agree?
THE COURT: Would you describe that in a little more detail?
A. It actually is. Pretty much that's what it is because I do it pretty regularly externally at term, to flip the fetus around with my hands.
I think the added risk here is that there is a metal instrument being used internally to flip the fetus so the concern would be, at least the theoretical --
THE COURT: You are trying to get it to a breech position?
THE WITNESS: Exactly.
THE COURT: Or a cranial position.

THE WITNESS: Trying to take a fetus whose head is down and flip it all around so that the feet are down.
THE COURT: So that the feet are down, you have a breech presentation.
THE WITNESS: Correct.
THE COURT: Is that what you are trying to do?
THE WITNESS: Desperately trying to say but not very articulately.
BY MS. GOWAN:
Q. Do you understand that sometimes the internal podalic conversion is done by the physician's hand as opposed to with an instrument? You just mentioned an instrument.
A. That works in my opinion. Probably be a safer way to do it.
Q. Would there still be some risk, in your view, associated with doing the internal podalic conversion manually?
MR. HUT: Objection to leading, your Honor.
THE COURT: Overruled.
A. Less.
Q. But some?
MR. HUT: Objection.
A. Maybe.
THE COURT: Overruled.
Jeez, if you don't understand the distinction I can't do it for you.

Q. In your view, is there any risk associated with the incision of the skull of the fetus and the puncturing with the scissors in connection with D&X abortion?
A. Well, certainly any time a sharp instrument is used in a uterus there is always the risk that you could lacerate or tear. I think I a lot of that would have to do with how well one imaged the target, if you will, and had good hands. That would be important too.
Q. When you say how well one imaged the target, are you referring to the use of sonogram?
A. No. In this case actually physically looking at the base of the fetal neck. And this was a procedure done for millennia to effect the delivery of obstructed labors with the fetus the other way around.

And clearly a hundred years ago it was associated with a very high mortality rate but in this setting the fetus is smaller, it's delivered to the point of the base of the neck being actually out beyond the level of the cervix.

I would say that if the procedure has to be done further into the uterus obviously there would be created greater risk but the key would be the skill of the practitioner, the level to which the head had descended, and the ability to actually directly visualize what one was ensizing.
Q. And the risk would vary depending upon the presence or

absence of those factors?
A. Correct.
Q. Are there risks of retained placental fragment with D&X?
A. Presumably lower than with D&E.
Q. Have you ever heard of a placenta coming out completely intact after D&X?
A. Well, I don't have any frame of reference.

I mean, generally speaking after a D&E, which I assume would be comparable, you suction aspirate the placenta so it doesn't come out intact. I don't know why it would matter one way or the other.
Q. And you would use instruments in connection with the removal of the placenta in D&E by dismemberment?
A. All three would be the same, medical, D&E and D&X.
Q. What is amniotic fluid embolism?
A. A condition where amniotic fluid enters into the mother's blood stream and causes cardiovascular collapse and coagulation abnormalities.
Q. And is there a risk of amniotic fluid embolism with surgical abortion?
A. Small, but yes.
Q. It is a rare condition?
A. It is.
Q. Does surgical abortion carry a greater risk of amniotic fluid embolism as opposed to induction abortion?

A. That's the presumption.
Q. Why is that?
A. Because you have a greater opportunity to cause an injury to the wall of the uterus with the various instruments that are used and theoretically the cause of this is the exposure of a uterine vein to amniotic fluid, and that sucks the amniotic fluid in and that causes the, for a variety of different theoretical reasons, the conditions.
THE COURT: Mr. Gowan, is this a convenient time to take the morning break or could you have more questions in this area?
MS. GOWAN: Your Honor, it is a convenient time.
THE COURT: We will take our morning recess.
(Recess)
THE COURT: Ms. Gowan, you may inquire.
BY MS. GOWAN:
Q. Doctor, before the morning break we were talking generally about risk. In your view, Congress may have exaggerated some of the risks to women in some of the specific findings in section 14A, is that right?
A. Correct.
Q. Would you agree that the absence of data proving the specific risks that Congress identified in Section 14A proved the absence of harm?
MR. HUT: Objection. Vague and ambiguous.

THE COURT: Overruled.
THE WITNESS: Not that I am agreeing of course with the plaintiff attorney, but could you repeat it again? I think.
THE COURT: Madam reporter, would you reread the question?
(Record read)
THE WITNESS: I think I would actually have to go line by line and determine which specific finding was in question.
Q. Well, as a general matter, if there isn't any data showing a specific harm does that, in your view, mean that a harm doesn't exist?
A. Certainly in general I would agree with that statement.
Q. And you would like to have issues particularly relating to the long-term risks associated by D&X study, correct?
A. Yes.
Q. And your view as to the findings in 14A that they may be exaggerated doesn't affect your view that the procedure is not medically necessary, is that right?
A. Correct.
Q. Do you have an opinion on the best method of abortion for purposes of facilitating pathological assessment of the fetus, if required, for genetic counseling?
A. It would depend on the condition in question.
Q. And, why is that?

A. Well, in general, most patients prefer to have D&Es that I have counseled. And unless there is a central nervous system finding that I would be very eager to have evaluated, I very rarely see any need for full anatomic surveillance. We are pretty good at ultrasound particularly at Yale, and D&E can be obtained from the fluid or placenta, as can chromosomal studies.

And so, in general, unless there really is a specific abnormality in the brain that I think is vital to the diagnosis, it doesn't really matter to me what the procedure is.

Q. And in those cases where the brain is necessary for analysis, would you prefer abortion by labor induction method?

A. Of course.

Q. Is the use of D&E by dismemberment for purposes of pathological assessment studied in the literature?

A. It has been.

Q. And the it's supported in the literature, is that right?

A. Correct.

Q. Doctor, you told us before that you had observed D&E abortions on live fetuses, is that right?

A. Correct.

Q. And at what gestational ages have you observed that?

A. 16 to 20 or earlier.

Q. And on those occasions in which you have witnessed a D&E

abortion on a live fetus, have you ever seen the fetus withdraw from the grasping instrument?

A. I have.

Q. And at what gestational ages have you witnessed that, Doctor?

MR. HUT: Objection, your Honor. We are getting into an area here that is not disclosed in the expert report.

THE COURT: Ms. Gowan, is this a factual witness as well as an expert?

MS. GOWAN: Your Honor, the government is offering Dr. Lockwood as an expert witness. Certainly he opined extensively about D&E by dismemberment in his expert report and he was deposed upon it. I am merely asking him to tell us an observation that he had had while he was witnessing the performance of a procedure in which he has opined extensively.

MR. HUT: Your Honor, this gets into the question, if I may be heard, about fetal reflex, fetal reaction to stimuli. It is completely beyond the report as I think Ms. Gowan's answer to your question implicitly acknowledges.

THE COURT: I disagree.

I will allow it up to a point.

THE WITNESS: I have seen the foot withdraw from a forcep, yes.

BY MS. GOWAN:

Q. At what gestational age?

A. 16 weeks.
THE COURT: Let me ask you this, Doctor.
In your experience as an obstetrician/gynecologist and with the experience you have previously described in observing abortions and supervising other doctors, do you believe an obstetrician should make full detailed disclosure to a woman who is considering an abortion?
THE WITNESS: Your Honor, that's a wonderful and very tough question.
I think that physicians have an ethical obligation to disclose the risks of a procedure to the patient and the options that have available to them as they relate specifically to the health of the patient.
I think that the information about the fetal patient, if you will, is relevant obviously when the interventions are designed to benefit the fetus and particularly, for example, should the patient have a caesarean section versus a vaginal delivery.
The intent is to kill the fetus, then I think the physician is challenged with two conflicting ethical obligations, beneficence and nonmalfeasance to the patient and nonautonomy and from data being given to the patient to give an appropriate informed consent.
While the latter would suggest that information about the fetus should be conveyed to the patient so that you are

being honest and fully up front with the patient, she can better make a decision about what she should do. She might elect to have a medical abortion, she might elect to have potassium chloride, she might elect not to have the abortion at all.
On the other hand, potential to increase the patient's guilt and feelings of stress and anxiety would likely be increased by that conversation.
So, I would suggest that in this tortured ethical argument the answer probably would be that the information should be given so she can make an informed consent that's fully valid and with all the information required for risks and benefits. But probably graphic details about how the fetus will be killed isn't ethically justifiable.
THE COURT: Don't you think the woman who is making this very serious decision should know, say, for example, if she were choosing a D&E procedure, that the limbs of her baby are being torn off?
THE WITNESS: Well, now you know why I don't do abortions, but I --
THE COURT: How can you call it informed consent if you don't tell her exactly what she is ordering you to do?
THE WITNESS: Your Honor, there are two patients, and your obligation, since she is obviously not going to allow the other patient to survive, are to your remaining patient, and I

would argue that from an ethical perspective the greater harm potentially, and I have no data to support this, but my gut feeling would be that the potential harm to the patient long-term might be greater if one gave graphic details.

Now, on the other hand, I think you need to provide some information and I think if the patient inquires, well, what exactly do you do, you need to be incredibly honest with the patient and describe it in detail. Clearly --

THE COURT: But if you are doing a D&X that you are going to put a hole in the base of the skull.

THE WITNESS: I think if the patient asks, yes.

THE COURT: And suck the brain out?

THE WITNESS: I think so.

I mean, to be blunt, your Honor --

THE COURT: The mother is ordering you to do this.

THE WITNESS: Well, yeah. That's --

THE COURT: And one of the --

THE WITNESS: Not me, but --

THE COURT: And one of the options you mentioned before was to carry the child to term.

THE WITNESS: Well, I think the --

THE COURT: Don't you think when you put that moral obligation there with full disclosure, shouldn't it be complete and detailed?

THE WITNESS: I will tell you what I tell the patients

because I am sort of, in some ways, the first contact because we're often the person that makes the diagnosis. I give all the information about whatever the diagnosis would be.

Let's say for example spina bifida, outcomes, IQs, the ability to walk and so forth and lay out the different options for them. Continuing the pregnancy, continuing the pregnancy and vaginal delivery and c-section, what are the advantages and disadvantages of those two procedures.

Then I would say another option would be to terminate the pregnancy. I try to be very valueless in that assessment and I can tell you that at least half the patients with spina bifida I see elect not to terminate I think because in large part it is a very objective. They meet the neuro surgeons and are fully informed about the decision.

But I do not then give them information about the types of terminations other than to mention them in general, surgical versus medical and refer them to the person that's doing it.

I would suggest also, since I don't do abortions, that I probably would not be the best person to counsel a patient about the procedure, not that I am trying to cop out of your question, but --

THE COURT: We have had a lot of testimony here and a lot of doctors who talk in terms of disarticulation.

THE WITNESS: Well --

THE COURT: Do you think the average woman has a clue who comes in as a patient what you are talking about when you use terms like that?
THE WITNESS: I mean -- yeah, I think you have to respect her dignity, I guess in that sense.
THE COURT: Do you think she understands the word?
THE WITNESS: No. Probably not.
THE COURT: Do you discuss fetal pain with patients?
THE WITNESS: I do in the context of procedures we do to preserve the life of the fetus.
So, for example, when I am putting a chest tube in a fetus I will, we actually pre-medicate everyone so that there is no pain and I will discuss the notion of pain, I will discuss the difference between having the noxious stimuli transmitted to your brain and actually being sentient and cognizant of what that pain means. Having done a view of these procedures I think certainly after 24 weeks pain is pain for the fetus, particularly if you are putting a one centimeter tube in the fetus' chest.
So, I do fully inform the patients about that and whether or not the procedure works, what are the potential outcomes and so on and so forth to help her make that decision. Although I have to say, when the choice is for potential fetal death versus pain, most patients would rather you put the procedure in and --

THE COURT: Would rather what?
THE WITNESS: Put the procedure in and save the fetus' life than put the -- for example, the tube in the chest to drain fluid, whatever the particular procedure might be, more often it's the kidney.
But I do discuss pain at length with patients in that sense.
THE COURT: Are you aware that there are have been studies done on fetus pain?
THE WITNESS: I am.
THE COURT: Would you consider that a legitimate factor when you talk about full disclosure?
THE WITNESS: Well, my bias, as I alluded to at the very beginning of my testimony is that before, to crudely summarize it, before 20 weeks and abortion, ought to be between the physician and the patient; that after 24 weeks I don't see any need for termination of pregnancy under any circumstances.
Termination of the pregnancy may be needed but not killing the fetus intentionally in the process.
And I feel strongly that between 20 and 24 weeks procedures and -- procedures ought to be designed to minimize fetal pain either through the use of analgesia, anesthesia or the actual technique.
And the argument really is that a purely ethical argument that says that one must respect the dignity of this

fetus, this potential patient, this potential human, and although there is a conflict between the mother's reproductive autonomy and her options and her privacy and her choice and the fetus' life and dignity and opportunity to achieve that potential, while it may be appropriate to terminate the pregnancy before 24 weeks and while there is good evidence, I would argue that the fetus is sentient after 24 weeks, 20 to 24 weeks is a gray area for both the concept of sentience and of pain and that we should do our best to minimize any discomfort to the fetus.

Does that answer your question?

THE COURT: I think it helps.

Ms. Gowan?

BY MS. GOWAN:

Q. Doctor, have you ever testified in any cases before involving partial-birth abortion?

A. I have now.

Q. Is this the first case, is that right?

A. In Nebraska, yes.

Q. The federal law, the Partial-Birth Abortion Ban Act of 2003?

A. Correct.

Q. Did there come a time when you wrote a draft editorial about the Partial-Birth Abortion Ban Act of 2003?

A. There was such a time.

Q. And how did it come about that you wrote that?

A. I'm the editor of, as I mentioned before, the editor in chief of Contemporary OB/GYN, and that is a magazine that provides review articles and news and opinions about the field and I am required, as part of my job, to write an editorial every month.

I am not limited as to what I could write on but I thought this would be an excellent topic because it brought out some fascinating legal and ethical issues that I thought ought to be open to debate, certainly by 40,000 obstetricians and gynecologists.

Q. Did you ever publish that?

A. I did not.

Q. Did your draft editorial express any views about the language of the act, in particular the act that was prohibited, the D&X procedure?

A. It did.

Q. And at the time you wrote the draft editorial, had you reviewed any materials relating to this case?

A. I believe that I had reviewed some literature and I believe some of the expert reports of the plaintiffs.

Q. Some of the declarations that have been provided by the plaintiffs?

A. Okay.

Q. And had you reviewed anything that had been prepared by the

government?
A. I do not believe I had at that time.
Q. And have your views about the language of the Act, as it relates to the procedure that is prohibited, have they changed in any way since you wrote that draft editorial?
A. Some have and some have not.
Q. And the ones that have changed, what's changed?
A. I think that the issues that -- I don't have the draft in front of me and I haven't read it in quite a while -- but I think that the things that appear to me to be relevant to that opinion in that editorial are the issues of the necessity of the procedure, vis-a-vis the alternatives.
Q. And that hasn't changed, is that right?
A. And that has not changed.

And the issue of vagueness. Would this law restrict a woman's access to abortions before 24 weeks, before whatever the state in question limits; and was it, is the language clear enough that a reasonable attorney -- and I won't comment on that adjective -- would interpret in such a way as to be able to implement the law without prejudice against physicians or patients -- obviously patients aren't going to be affected by the law directly -- to not prosecute them for, for example a D&E. Or medical termination for that matter.

And what I think I learned, primarily as a result of the report that you prepared for the Court, was that this

really became a legal issue, one that revolved around the issue of intent and this concept of mens rea and that, in all likelihood, would represent far more of a legal issue than a medical issue.

I think my position was that, remains that the law is interpreted in a way that restricts access to abortion, not that I'm a judge or have any authority. I would think it should be unconstitutional.

If it were interpreted in a way that allowed unfettered access to a D&E, medical termination up to the point that it is legally available in any given state, and certainly to 23 and six sevenths weeks, that the law would likely be constitutional and acceptable.
Q. Well, you mentioned the word mens rea and intent. What is your understanding about that in terms of the Act?

MR. HUT: Objection. Calls for legal conclusion.

Q. Well let me ask it this way, Doctor.

THE COURT: All right.

Q. Do you agree that a physician can make a decision to perform a D&X procedure?
A. Yes.
Q. Doctor, you were asked at your deposition whether you believed, in light of the declaration submitted by the plaintiffs and the ACOG policy statement, whether there was a "significant body of medical opinion that, in some

circumstances for some women," an intact D&E may be a safer method of abortion than another option.

Do you recall being asked that question?

A. I do.

Q. Do you recall agreeing with Mr. Hut in response to that question?

A. I do.

Q. What did you understand you were being asked by Mr. Hut?

A. Well, in light of the expert reports that I have read from the plaintiffs and knowledge that this was a procedure that was viewed by those that perform abortions in the mid-to-late second trimester as necessary under certain circumstances that there was in fact a body, i.e., these individuals who supported its use and considered it to be the safer, quote unquote, procedure.

Q. And that body was the plaintiffs' experts?

A. Right.

MS. GOWAN: Your Honor, I have no further questions.

THE COURT: Mr. Hut?

CROSS EXAMINATION

BY MR. HUT:

Q. Good morning, Doctor.

A. Good morning.

Q. We met at your deposition in New Haven, do you recall?

A. I do.

Q. Dr. Lockwood, you are aware, aren't you, that there is a debate among doctors experienced in abortion concerning whether D&X may be safer than other abortion procedures for some women in some circumstances?

A. Correct.

Q. You agree, don't you, that there are responsible doctors who believe that intact D&X in the second trimester HAS safety benefits?

A. Correct.

Q. You read the deposition in this case filed by Carolyn Westhoff and Stephen Chasen, correct?

A. Correct.

Q. You agree that Dr. Westhoff and Dr. Chasen expressed the view that intact D&E may be the safest way to perform a D&E?

A. Yes.

Q. You also agree that both doctors are knowledgeable in the area of abortion practice, correct?

A. Correct.

Q. And both are well respected?

A. Correct.

Q. Both are accomplished?

A. Well, define accomplished; but certainly Carolyn is very accomplished and Steve eventually will be.

THE COURT: Can I have that answer, please?

(Record read)

THE COURT: Do you know them both?
THE WITNESS: I do.
THE COURT: Have you observed them operate?
THE WITNESS: No, not at all. I know only their academic reputations and, to lesser extent Steve's reputation as maternal fetal medicine clinician. And he is a young -- younger guy, needs a little bit more seasoning.
THE COURT: Okay, next question.
BY MR. HUT:
Q. Dr. Lockwood, the doctor that you hired to lead the reproductive choice program at NYU performed intact D&Es, right?
A. Correct.
Q. You are extremely confident in the clinical skills and abilities of that doctor, correct?
A. Right.
Q. That doctor was knowledgeable, in your judgment, right?
A. Correct.
Q. And that doctor was accomplished, right?
A. Well, with the same limitations that I apply to Steve.
Relatively junior, still needs more academic seasoning but very competent clinically.
Q. And intact D&Es are currently provided at NYU, correct?
A. Correct. Well, at Bellevue Hospital.
Q. And you are aware that in 1997, Dr. Lockwood, ACOG, in a

policy statement, said that an intact D&X may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of the woman, correct?
A. Correct.
Q. And ACOG added that only the doctor, in consultation with the patient and based on the patient's particular circumstances, can make this decision, correct?
A. Correct.
Q. And you know, don't you, that the policy statement has been reaffirmed twice since by ACOG?
A. Yes.
Q. So, Dr. Lockwood, yes or no; based on your review of the plaintiff's declarations including those by Drs. Westhoff and Chasen, your experience at NYU and your familiarity with the program there, the ACOG policy statement; you agree, don't you, that there is clearly a significant group of second trimester abortion providers who believe that, in some circumstances for some women, an intact D&X may be safer than available abortion options?
MS. GOWAN: Objection, your Honor.
THE COURT: The objection?
MS. GOWAN: Significant group. I don't know what that means. It's a vague question.
THE COURT: Can you rephrase it, Mr. Hut?
(Continued on next page)

Q. Let me ask you exactly the question that Ms. Gowan examined you about a moment ago. Based on your review of the declarations, based on your experience at NYU as head of the reproductive choice program there, and based on the ACOG policy statement, you would agree that there is a significant body of opinion among second trimester abortion providers that in some circumstances for some women an intact D&X may be safer than available options?

MS. GOWAN: Objection, your Honor. That is Mr. Hut's question, and I objected to its form at the deposition, and I object to it again here today.

THE COURT: Sustained.

MR. HUT: Your Honor, she elicited questions about the very statement on direct.

THE COURT: Just rephrase it, Mr. Hut.

Q. Based on all of the criteria, all of the factors that I identified in the previous question, you would agree, wouldn't you, that there are a substantial number of second trimester abortion providers who agree that in some circumstances for some women an intact D&X is a safer procedure than available alternatives?

MS. GOWAN: I object to the form of the question.

THE COURT: I will allow it.

A. Yes.

Q. Doctor, it is true, isn't it, that in your career you have

never performed an abortion on a living fetus?

A. Correct.

Q. In fact, as a matter of policy, you do not perform abortions, based on personal philosophical reasons?

A. Right.

Q. You have performed suction curettage procedures on patients who suffered miscarriages, is that right?

A. Correct.

Q. And performed dilation in connection with that procedure?

A. Correct.

Q. But even to treat miscarriage, you have only rarely performed other methods of abortion, correct?

A. D&E's, for example?

Q. For example, yes.

A. Correct.

Q. You have performed a DEA on more than one occasion on a fetus that has already died following a miscarriage, true?

A. Correct.

Q. But you wouldn't claim as a result of that to have expertise in performing D&E's, would you?

A. No.

Q. You have never performed an intact D&E on a demised fetus, have you?

A. No, clearly not.

Q. The D&E's that you have observed, Dr. Lockwood, have

involved only dismemberment, is that right?
A. That's correct.
Q. You have never observed an intact D&E, correct?
A. Correct.
Q. You have also never performed an induction abortion where spontaneous abortion or miscarriage had not already begun, correct?
A. Correct, although I have certainly observed them.
Q. And you do not personally teach induced abortion on living fetuses to medical students or residents at the present, correct?
A. Correct.
Q. And you never have, is that right?
A. Not to my knowledge.
Q. You have never before been qualified as an expert in abortion practice or procedure in any court, have you?
A. Correct.
MS. GOWAN: I object to the form of the question, your Honor.
THE COURT: A little late. The answer was out. What is your objection? It came out on direct, did it not?
MS. GOWAN: I don't think in the specific way that Mr. Hut just elicited in his question. But I will withdraw the objection, your Honor. Thank you.
THE COURT: It has been recognized now, for whatever

it is worth.
Q. Until your testimony in Nebraska this past Friday, you have never given testimony in any case in any capacity on abortion, have you?
A. That is correct.
Q. You can't recall, Dr. Lockwood, can you, whether you have ever served as a peer reviewer on any articles concerning abortion, right?
A. I have certainly served as a peer reviewer for articles involving RU486.
THE COURT: Concerning what, sir?
THE WITNESS: Mifepristone, a medical preparation.
Q. Let me recast the question. You can't recall, can you, serving as a peer reviewer for any article on abortion as performed in the second trimester, can you?
A. No.
Q. When you prepared your expert report in this case, you wrote a description of abortion practice in the first and second trimesters, correct?
A. Correct.
Q. In writing that description, you got input concerning abortion practice from someone else who had actually performed abortions, correct?
A. It depends on the section that you are talking about.
Q. Fair. Why don't you tell me and tell the Court which

sections you got input on, Doctor.
A. Clearly, I can do suction curettage, so I can describe that. I'm pretty good at doing C-sections, so I can describe hysterotomy pretty well. I certainly understand how to do a medical termination as well as anyone in the plant, since I am considered an expert on the subject of misoprostol.
I would say for the sections on D&E and particularly for D&X, as I disclosed at my deposition, I reviewed written materials, I reviewed the papers, and so forth, my own up-to-date Obstetrics, and discussed with the people that had extensive experience in that area.
Q. That included the doctor who had chaired the reproductive choice program at NYU, correct?
A. Correct.
Q. You got details from that doctor concerning the D&E and intact D&E procedures, correct?
A. Correct.
Q. As we have seen, that doctor in fact performed intact D&E's while you chaired the department at NYU, right?
A. Correct, we think.
Q. Dr. Lockwood, you have been sued more than one time for malpractice, correct?
A. I have.
Q. In one of those cases you were dropped as a defendant?
A. I believe I have been dropped three times. I believe I

have been sued seven times. Three have been dropped, two of them I assume are about to disappear, and there are two current ones, to neither of which I was remotely related, which is sort of typical for a chairman, remotely related to the actual quote-unquote occurrence. But that is our tort system.
Q. In those that were dropped or about to disappear, do you know whether those involved settlements by the hospitals or other defendants?
A. No, none of them have.
THE COURT: Did any of them involve you, I assume they didn't since you don't perform them, involve you performing an abortion?
THE WITNESS: Absolutely not.
Q. With respect to the tort system, you would agree, Dr. Lockwood, wouldn't you, that it is not uncommon for obstetrician/gynecologists these days to be sued for malpractice, correct?
A. That is the crisis.
Q. Because of the plethora of malpractice suits against obstetricians/gynecologists, there are some states where it is difficult for them to obtain malpractice insurance, correct?
A. Sir, you are waving red meat in front of a bull here. You know how I feel about this topic. I think at some long -- and I am not going to rise to it except to say I agree with everything you have said much more than you can possibly

imagine.
Q. I'm on your side on this one, Doctor.
A. All right.
Q. You were chair of the OB-GYN department at NYU for seven or eight years, from 1995 to 2002, correct?
A. Seven years, correct.
Q. As chair, you hired physicians who performed, taught, and supervised abortions, right?
A. Correct.
Q. As we have discussed, you hired doctors to direct the NYU reproductive choice program?
A. Correct.
Q. At least one of those doctors performed intact D&E procedures herself, right?
A. Correct.
Q. As to the other doctor that you hired, you just don't know if that doctor performed intact D&E procedures while she was there, correct?
A. That's correct.
Q. You relied on these doctors, Dr. Lockwood, to exercise their judgment in deciding what kinds of abortions to perform, correct?
A. Correct.
Q. They were trusted colleagues of yours, correct?
A. Correct.

Q. You gave them wide latitude to do D&E's, correct?
A. Correct.
Q. And wide latitude to train residents in doing them, correct?
A. Correct.
Q. You relied on them to determine what abortion procedures and variations to teach, right?
A. Correct.
Q. Although you may not actually have known that the doctor who performed intact D&E's was doing them, you would have allowed her to do them if you had known, correct?
A. Correct.
Q. You were confident that that doctor would have provided the procedures to the patients that that doctor thought safest, correct?
A. Yes.
Q. In your experience, your former NYU colleague whom you hired to chair the reproductive choice program provides sound medical care to her patients, correct?
A. Yes.
Q. Including the intact D&E's that she performs, correct?
A. Correct.
Q. You agree that that doctor makes an assessment of what care is safest for a patient given that patient's particular circumstances, correct?

A. Correct.
Q. In your last year at NYU, Dr. Lockwood, approximately 900 abortions were performed at Bellevue, right?
A. Correct.
Q. One-third of those, approximately, were performed in the second trimester, correct?
A. Correct.
Q. That is about 300 a year, correct?
A. Yes.
Q. That averages out, if I have done the arithmetic right, to about 25 a month, correct?
A. Sounds right.
Q. Of those 300 or so second trimester abortions per year, there was about one induction or medical abortion per month, right?
A. Correct.
Q. Of the 300 second trimester abortions, approximately 25 to 35 percent were D&E's in which the fetus was removed intact, correct?
A. Correct.
Q. Doing the arithmetic again, about 75 to 100 abortions in your last year of NYU were performed using the intact D&E procedure at that institution, right?
A. We are not exactly sure whether it was the part of the year I was there or not, but I think it is a reasonable assumption

that during the course of the year 2002 that is what happened.
Q. As chair of the department, you were responsible for what happened in your department, correct?
A. Very much so.
Q. You were responsible for making sure that the abortions as performed at NYU were safe, right?
A. Correct.
Q. You were responsible for making sure that the best gynecological care was given to your patients, right?
A. Correct.
Q. You wouldn't allow, Dr. Lockwood, would you, any unsafe procedure to be performed in your department?
A. I wouldn't stay as chair very long if I did.
Q. You wouldn't allow any innovation in technique for patient surgery that you thought was unsafe, would you?
A. Correct.
Q. At the time the NYU reproductive choice department was performing intact D&E's under your chairmanship, there were no completed peer-reviewed studies concerning its safety, were there?
A. Correct.
MS. GOWAN: Objection, your Honor. I don't think there is any evidence that the procedure was being performed at the time that Dr. Lockwood was the chair.
THE COURT: I believe the witness said that there was.

MS. GOWAN: I think, your Honor, he said that he didn't know if it was performed, because he had left during the year, and he wasn't sure whether it was actually performed when he was there.

THE COURT: Doctor, do you know whether it was performed while you were there?

THE WITNESS: No.

THE COURT: You don't know?

THE WITNESS: I am guessing that, given the volume --

THE COURT: No, no. Do you know of your own knowledge?

THE WITNESS: I do not know.

THE COURT: Then I will sustain the objection.

Q. Based on your judgment concerning the volume, Dr. Lockwood, do you believe that as many as 75 to 100 intact D&E procedures were performed at NYU during your last year of chairmanship?

MS. GOWAN: Objection.

THE COURT: Sustained. Next question.

Q. You know, Dr. Lockwood, don't you, that the chair of the reproductive choice program has performed D&E's, intact, within the past, say, year and a half?

A. I don't know that, but I am assuming that she has.

THE COURT: Don't assume anything, Doctor. If you don't know, you don't know. That's it.

THE WITNESS: I don't know.

THE COURT: Next question.

Q. While you were at NYU, Dr. Lockwood, there were no completed peer-reviewed studies concerning the safety of the intact D&E procedure, were there?

A. Correct.

Q. Those at NYU-Bellevue who were performing intact D&E procedures were relying on their skill, judgment, and experience, right?

A. And training.

MS. GOWAN: Objection.

THE COURT: How does he know that?

MS. GOWAN: Thank you, your Honor. I'm just rising.

THE COURT: Sustained. Mr. Hut, you know better than that.

Q. Dr. Lockwood, while you were at NYU, profit considerations never determined the choice of the obstetric/gynecological surgical option made available to patients, did it?

A. Not at Bellevue Hospital.

Q. That applies to the choice of abortion surgeries, too, doesn't it, Doctor?

A. Not at Bellevue Hospital, that is correct.

Q. The doctor that you hired to head the reproductive choice program at NYU never preferred D&E's because they earned her more money than inductions, did she?

MS. GOWAN: Objection, your Honor.

THE COURT: Sustained. You know how to properly ask the question, Mr. Hut. I assume you do. If so, do so.
Q. Are you aware of any evidence, Dr. Lockwood, to suggest that the person who headed the reproductive choice program at NYU ever made a choice among procedures based on what those procedures would earn her?
MS. GOWAN: Objection, your Honor.
THE COURT: Sustained. Mr. Hut, just ask, did she tell him that.
Q. Did she ever tell you anything like that?
A. The structure of Bellevue is a little unusual.
THE COURT: No, Doctor, please. The question is did that woman tell you she made the choice based on that?
A. Absolutely no.
THE COURT: Next question.
Q. Never told you that she made any such choice because it earned the hospital more money, did she?
A. Not to my knowledge.
Q. In fact, you thought the reproductive choice program at NYU was so successful that you were planning to develop a similar reproductive choice program at Yale, correct?
A. Correct.
Q. You wouldn't let unsafe procedures be performed in your department now, would you?
A. Correct.

Q. That would be a violation of your professional obligations, correct?
A. Correct.
Q. Doctor, it is your view, isn't it, that based on the available data, the safety of D&E's and medical abortions after 20 weeks is comparable, right?
A. I think that broadly speaking, yes. But I believe that the risk of common complications may be still more common with medical abortions and the risk of more serious but much rarer complications would be more common with surgical abortions. But for purposes and the way in which you are asking, I believe the answer is yes.
Q. Dr. Lockwood, even though the procedures are comparable in terms of their safety, most abortions performed at or after 21 weeks are surgical D&E's, correct?
A. Correct.
Q. And not inductions, correct?
A. Correct.
Q. At NYU, Dr. Lockwood, your department performed but 12 inductions out of some 300 second trimester abortions in your last year, right?
A. That is at Bellevue. The number would have been probably the opposite at NYU.
Q. At Bellevue. One reason for more surgical abortions than medical abortions as performed after 20 weeks is that patients

tend to prefer surgical terminations, right?
MS. GOWAN: Objection.
A. Correct.
THE COURT: Sustained.
Q. Have you discussed with patients and with staff at Yale and NYU the subject of patient preference with respect to second trimester abortions?
A. I have discussed with patients when they are confronting the choice.
Q. Based on those discussions, you understand that patients in fact prefer surgical abortions to medical terminations, right?
MS. GOWAN: Objection.
THE COURT: Sustained.
Q. One reason there are more surgical abortions chosen than medical abortions is because it is unpleasant for patients to be admitted to a hospital and have to go through labor for 24 hours instead of -- up to 24 hours, I should say, instead of undergoing a 30-minute surgical procedure, right?
MS. GOWAN: Objection.
THE COURT: Sustained.
Q. You would agree, Dr. Lockwood, would you not, that medical abortions are virtually invariably performed in a hospital or hospital-level setting, right?
A. Generally speaking, yes.
Q. Hospitals may or may not be far from a patient's home,

correct?
A. Hopefully, yes.
Q. You testified on direct, did you not, that patients preferred D&E to induction?
A. My patients do.
Q. Why is that?
A. For the reasons you have outlined.
Q. That includes the reason of a longer procedure?
A. Correct.
Q. Longer procedure, that is, for the medical abortion?
A. Correct.
Q. From your understanding through your patients, Doctor, is another reason for the preference for surgical abortions that the pain involved, unless mediated, is substantially the same as labor at term?
MS. GOWAN: Objection.
THE COURT: I will sustain it. But there is pain, is that correct?
THE WITNESS: There is, but these patients are generally given epidurals, so the pain is reduced.
THE COURT: When you talk about your patients who prefer the D&E, going back to my question we had earlier this morning, do you tell them in that D&E that the legs are going to be torn off the fetus?
THE WITNESS: No, your Honor.

THE COURT: Do you tell them that the arms of their baby are going to be torn off?
THE WITNESS: No, your Honor.
THE COURT: So it is a little hard to judge preferences isn't it, when you don't tell them the real facts of what is happening?
THE WITNESS: Well, I would restate --
THE COURT: Sugar-coated. They prefer no pain and quickness, right?
THE WITNESS: That would certainly be one interpretation of the current state of affairs.
THE COURT: Next question.
Q. Dr. Lockwood, you recall preparing an expert report in this matter, do you not?
A. I do.
Q. Didn't you state in your expert report, Doctor, that of the approximately 900 abortions performed in your last year at NYU, 25 to 35 percent were D&E in which the fetus was removed intact?
A. Correct.
Q. In fact, is it your understanding, Dr. Lockwood, with respect to pain, that the pain is worse in labor during a second trimester induction than it is in spontaneous labor at term?
A. I don't recall ever having testified to that.

Q. I am not asking whether you testified to it, Doctor. I am asking whether that is your understanding.
A. Not at all. I deliver a very large number of women, and I can tell you that it hurts; it hurts at term, it hurts at 20 weeks. But I can't tell you that it hurts more at term or 20 weeks.
Q. You would agree, Dr. Lockwood, that patient preference based on the length of the procedure, the availability of hospitals near home, or comfort level is appropriately taken into account by the woman and by her doctor in choosing the best method for terminating her pregnancy, correct?
THE COURT: Sustained. That calls for multiple assessment of the mental processes of doctors and the patients.
MR. HUT: Let me ask the question, your Honor, because I certainly didn't intend to.
Q. Based on your judgment concerning how a patient should or properly goes about selecting a procedure, is it your judgment, Dr. Lockwood, that patient preference based on the length of the procedure, the availability of hospitals, or the pain level is appropriately taken into account by the patient and by the patient's doctor in selecting a procedure?
THE COURT: Do you want to read that question?
MS. GOWAN: Objection, your Honor.
THE COURT: Sustained. Maybe it would help if you read the question, please.

(Question read)
THE COURT: Sustained. Try again.
Q. Let me try to break it down, Dr. Lockwood, for you. Based on your experience and your judgment, is it appropriate for a patient's doctor, in consultation with the patient, to choose a procedure based on the length of the procedure?
A. Yes.
Q. Is it appropriate for a patient, in consultation with the patient's doctor, to choose a procedure based on accessibility to hospitals?
A. You got me on that one. Are you trying to ask me if it is based on the need to be in a hospital or the desire not to be in a hospital?
Q. The desire not to have to travel long distances, if that were necessary, to a hospital.
A. Why would you assume --
THE COURT: You mean if there is one across the street? Mr. Hut, try again. This is ridiculous.
A. It could be the abortion clinic is further away than the hospital.
Q. Right. In the event that an out-patient clinic were closer by to the patient and the hospital was at some remove, would it be appropriate for the patient and the patient's doctor to take that into consideration in evaluating choices and options?
A. I would answer that by saying it would depend on the

procedure, the gestational age, and the chance and probability of complications. Clearly, if it were a more advanced gestational age, with a surgical procedure I think the patient should be counseled that there is a finite risk, say on the order of 5 per thousand, of a perforation. Should that occur, let's say a 1.5 per thousand risk of a life-threatening hemorrhage, should either of those events occur, the base place would be a hospital.
Q. So it may or may not be, assuming full disclosure to the patient of the matters you just identified?
A. Correct.
Q. Similarly, is it appropriate, in your medical judgment, Dr. Lockwood, for a patient, in consultation with her doctor, to take into account comfort level in choosing the procedure for pregnancy termination?
MS. GOWAN: Objection to "comfort level," your Honor.
THE COURT: Sustained.
Q. Then to the level of anticipated pain?
MS. GOWAN: Objection, your Honor.
THE COURT: Sustained.
Q. In your judgment, a woman should be given an option to have a D&E or an induction after 20 weeks, right?
A. I think the patient should be presented with all the appropriate information, much of which you just described, and the decision ought to be hers, assuming equal competence in the

procedure by the practitioner.
Q. The patient should be free to choose a surgical procedure if she and her doctor view it as preferable for any other reason?
A. And he is competent or she is competent to perform the procedure.
Q. Indeed, including the particular skill set or experience of the doctor, correct?
A. Correct.
THE COURT: Mr. Hut, is this a convenient time to take our luncheon break?
MR. HUT: Sure, your Honor.
THE COURT: We will take our luncheon recess until 2 o'clock.
(Luncheon recess)

AFTERNOON SESSION
2:10 p.m.
CHARLES LOCKWOOD, resumed.
THE COURT: Good afternoon.
Mr. Hut, you may inquire.
CROSS-EXAMINATION (continued)
BY MR. HUT:
Q. Good afternoon, Doctor.
A. Good afternoon.
Q. During the time that the 75 to 100 intact D&E procedures that your report indicates were performed at NYU under your chairmanship were done, there were no published peer-reviewed studies concerning intact D&E's at that time, were there?
MS. GOWAN: Objection.
THE COURT: Keep your voice up, Mr. Hut. This is not a whispering contest.
Is there an objection?
MS. GOWAN: Yes, your Honor. I object to the form of the question.
THE COURT: Let me hear the question.
(Question read)
MS. GOWAN: Again, your Honor, there is no foundation that the witness knows that any of the procedures were performed at the time that he was the chairman.
MR. HUT: On the contrary, your Honor. I thought we

had established that shortly before the lunch hour. His report states that in his last year at NYU, and I am reading from page 2, 900 abortions were performed at Bellevue Hospital, one-third in the second trimester, and of those, 25 to 35 percent were D&E in which the fetus was removed intact.
THE COURT: It seems like this is a favorite objection of both sides. Why is it no foundation? What do you think that means?
MS. GOWAN: There is no fact in evidence to support the question.
THE COURT: Do you think there has to be a fact in evidence in order for a lawyer to ask a question?
MS. GOWAN: This particular question counsel is asking the witness to agree with, and it is not an established fact. In fact, in response to a question from your Honor, the witness said he did not know whether any of the procedures had been performed while he was chairman.
THE COURT: Then I will sustain it. Next question. Mr. Hut, how about breaking them down a little bit. You have about 47 clauses in every question.
Q. Dr. Lockwood, you don't dispute that that is what you wrote in your expert report, do you?
A. No, not at all.
Q. You don't dispute that that is the fact, do you?
THE COURT: We don't know what the fact is.

A. The only comment I would make, if I can comment, is that in the year 2002 I was only there for six months.
Q. During those six months you have no doubt that some intact D&E's were performed while you were there, is that right?
THE COURT: Do you know?
THE WITNESS: I don't know for certain.
THE COURT: It is unimportant whether he doubts it or not. If he knows, he know. If he doesn't, he doesn't.
MR. HUT: He wrote it, your Honor. That's my problem.
THE COURT: You can ask him what he bases it on, Mr. Hut. Cross-examination isn't that hard.
Q. What did you base that statement in your expert report on?
A. We asked her for the numbers for 2002.
Q. What did you base the proposition that that was during your last year at NYU?
A. I just picked year sort of at random. I could have asked her for the year before. But I had to be there, so I asked her for the last year I was there.
Q. She told you that during that last year 25 to 35 percent of the 300 were intacts, rightly?
A. Correct.
Q. You have no reason to doubt that that was the case, do you, Doctor?
A. No.
Q. So during the last year when those intact D&E's were

performed under your chairmanship, were there any published peer-reviewed studies?
A. For the third or fourth time, no, there were not, to my knowledge.
Q. The Bellevue Hospital reproductive choice program had a very low complication rate, correct, Doctor?
A. Correct.
Q. An intact D&E was taught to NYU residents, was it not, during your chairmanship?
A. Correct.
Q. In fact, it was taught to enhance resident training, correct?
A. Correct.
Q. The choice of a surgical procedure in the second trimester to terminate a pregnancy should be chosen by a physician and patient in consultation with one another based in part on the patient's ability and right to choose the least risky type of surgical procedure, correct?
MS. GOWAN: Objection.
THE COURT: Sustained.
Q. Dr. Lockwood, the choice made by a patient in consultation with a physician --
THE COURT: Do you have to add all those clauses in to every question? If you did it in pieces, it would be so much easier, so much better form.

Q. The choice of a surgical procedure should include the ability to choose the least risky type of procedure, should it in the?
A. Assuming comparable benefits. That is part of the elements of informed consent.
Q. You would agree that in considering any procedure, the most important consideration is the health of the woman, correct?
A. It depends on what the procedure is being done for. If the procedure is an obstetrical procedure to maximize fetal outcome, the patient may be willing to sacrifice some increased risk to her for the benefit of the fetus. But I think in this context you are correct.
Q. With respect to an abortion procedure?
A. Correct.
THE COURT: Does it depend on what period of gestation it is?
THE WITNESS: Obviously, beyond 26 weeks it is unlawful to perform abortions in New York State. So that eliminates the issue. I think that prior to that time the elements of informed consent include knowledge of the risks of the procedure, knowledge of alternatives. The patient, having been informed of those two elements in conjunction with their physician, would make a decision.
THE COURT: Doesn't ethics require, medical ethics, that it be knowledge of what the procedure is and what it

entails?
THE WITNESS: Yes.
Q. In your judgment, Doctor, the informed consent procedure should be guided by a doctor's own best judgment based on his or her own knowledge or understanding of the patient's circumstances, right?
A. As long as it is not paternalistic.
THE COURT: It is the choice of the patient, isn't it? It is not the doctor who makes the decision, is it?
THE WITNESS: That's correct.
THE COURT: That would be offensive to a lot of people if a doctor were to make the decision.
THE WITNESS: It would be. It would be unethical. It would be considered paternalistic.
THE COURT: And unethical?
THE WITNESS: And unethical, because it basically violates the requirements for informed consent.
THE COURT: It would hardly be informed consent in that case, would it?
THE WITNESS: It would be paternalism. It would be the doctor telling the patient what to do.
THE COURT: Thank you. Next question.
Q. The question of what facts to inform the patient about are typically left to the physician's own best judge based on his or her knowledge of the patient, isn't that right?

THE COURT: Keep your voice up.
A. There are certain elements that are required for informed consent of the patient. The patient must be aware of the procedures, their benefits, the alternatives, the risks for each of the different alternatives. The physician obviously can give his recommendation or her recommendation by saying that he or she believes that this particular procedure is better for the following reasons. But ultimately the patient has to trust her doctor and has to believe that he or she is objective and precise and accurate and looking out for her best interests.
THE COURT: It is hardly informed consent if the patient doesn't know what they are consenting to, is it?
THE WITNESS: By definition it is not informed consent.
THE COURT: That is what I thought. Thank you. Next question.
Q. In considering the choice of a selection of abortion procedure, an important issue is whether the procedure under consideration is riskier than other procedures used at a similar gestational age, correct?
A. Correct.
Q. If the procedure is not riskier, the woman in consultation with her doctor ought to be able to choose it, correct?
A. Correct.

Q. Retained placenta is a potential complication of induction, correct?
A. Correct. Retained placenta is a potential complication of all abortion procedures.
Q. Included amongst those is medical abortion, right?
A. Correct.
Q. In fact, with medical abortion in the second trimester, there is a 10 to 30 percent chance of retained placenta, right?
A. Correct.
Q. Without having observed intact D&E, Dr. Lockwood, what is your basis for saying that a retained placenta is not sometimes removed intact in an intact D&E?
A. How could a retained placenta be removed intact? By definition it is retained.
Q. In an intact D&E you have no reason to think that it is sometimes removed intact after its retention?
A. I think with any of those procedures there is always the potential for spontaneous abruption and separation of the placenta, for sure. I would say that given the physical parameters involved in extracting the fetus, there is no reason a priori to believe that the placenta is magically going to fall out of the uterus. It is either going to abrupt and separate as it can in all three procedures, or it has to be removed. It can be removed manually, it can be removed by instruments, whatever the physician can do and thinks the

safest.
Q. It can be removed more intact in an intact D&E, correct?
A. Again, unless my concepts of spacetime continuum are being violated here, here on earth the D&E and a D&X in terms of placenta ought to be pretty identical. There is nothing about removing the fetus, whether it is in pieces or intact, that alters the topography of the placenta in the uterus, that alters the intactness of the placenta in the uterus.

If you track on the cord, you may be more successful. D&X's are done later in gestation, a higher probability it will separate spontaneously. Traction on the cord may be more likely to have it separate, not really spontaneously but with assistance. So those are certainly theoretical advantages more related to age than the procedure.

The procedure -- and I must say I don't understand this, maybe I am missing some key concept here -- but the procedure is a procedure on the fetus. It is to remove the fetus intact. It is not a procedure on the placenta. The placenta is embedded in the wall of the uterus. It may separate during the course of the procedure -- it does during D&E's, it does during medical abortions -- but it may not and may require a suction curettage.

THE COURT: Next question.

Q. There are certain women, Doctor, for whom you would agree inductions are relatively contraindicated, correct?

A. Correct.
Q. For example, you would agree that there might be an advantages to performing a surgical abortion and not an induction on a woman who had had a previous C-section, correct?
A. Correct.
Q. Or who had had scarring from other uterine surgery, correct?
A. Correct.
Q. That is because agents frequently used in induction abortions might increase the risk of rupture, right?
A. There is about a .5 percent risk of rupture in that setting.
THE COURT: It is pretty small, isn't it?
THE WITNESS: It is comparable to the risk of perforation with a surgical abortion.
Q. And the inducing agents are what causes or create or give rise to that risk, right?
A. Correct.
Q. The risk of uterine rupture in a patient that has had a previous Cesarean section is not present to the same degree in a surgical abortion, is it, Doctor?
A. Correct.
Q. There are more than a million Cesarean sections performed in the country each year, right?
A. That's correct.

Q. You would also agree, and I think you testified on direct, Doctor, that a hysterotomy parallels a Cesarean section?
A. Correct.
Q. You agree that when a patient has a hysterotomy, because of the potential risk that the uterine scar may rupture during labor, such patients may need to have any future births by Cesarean section, correct?
A. Correct.
Q. So induction abortions may also be less preferable for a woman who had had a previous hysterotomy, correct?
A. Correct.
Q. You would also agree, Dr. Lockwood, wouldn't you, that hysterotomy is a less safe option for terminating pregnancy in the second trimester at the same gestational age than is D&E?
A. Assuming all other factors are held constant, yes.
THE COURT: What does that mean, Doctor?
THE WITNESS: There might be certain circumstances where it is physically impossible to access the uterine cavity, so you can't do a cervical termination by a D&E nor can you effectively empty the uterine contents by labor induction. For example, a fibroid can be blocking the entrance to the womb, to the cervix, and under those circumstances you have no choice but to do a hysterotomy.
THE COURT: Thank you, Doctor.
Q. You agree, don't you, Doctor, that there may be compelling

arguments that surgical abortion is preferable to medical abortion for women with placenta previa, correct?

MS. GOWAN: I object to the form of the question.

THE COURT: What is wrong with the question?

MS. GOWAN: "Compelling arguments."

THE COURT: Rephrase.

MR. HUT: Let me rephrase it.

Q. You would agree that there are reasons why surgical abortion may be preferable to medical abortion for women with placenta previa, right?

A. You picked the one topic I have written about, so I guess I would agree with it, correct.

Q. You used the words "compelling arguments," did you not?

A. I don't believe I used the words "compelling arguments" in my articles, no.

Q. You used it in your testimony under oath in Nebraska, right?

A. I don't remember ever using in my life "compelling arguments".

Q. Do you remember giving trial testimony just this past Friday in the Nebraska case?

A. If I used it, I suspect that I used it to compare some phrase that one of you folks probably threw at me.

Q. Were you asked the following question and did you give the following answer:

"Q. Is the D&E" --

MS. GOWAN: Page, please.

Q. Page 1689/line 19 to 24.

"Q. Is the D&E procedure ever necessary to safely terminate a pregnancy for a woman who has placenta previa?

"A. I think that there are compelling arguments that surgical abortion, which is a surgical abortion, is preferable to medical abortion in that setting."

A. I did not realized I was so articulate, but I accept those words.

Q. Doctor, after 21 weeks, as we have seen, most women and physicians choose surgical abortions over induction abortions, right?

A. Correct.

THE COURT: Could I have that read again. Once again, I think you like to scoop everything up, Mr. Hut. Could we have that question again.

(Record read)

MS. GOWAN: Having given me the opportunity, your Honor, I object.

THE COURT: Sustained. Strike the question. Next question.

Q. You would agree, Doctor, that in your view, after 20 weeks LMP, induction abortions and D&E's are relatively safe procedures?

A. I think I answered this before, that the over all rate of complications for medical abortion might actually be slightly higher, but the gravity of the complications might be slightly less, than surgical abortions, and those complications are quite rare. I have given you the numbers before. They are certainly not incredibly rare.
Q. You have testified that they are roughly equal in terms of safety, right?
A. More or less, right.
Q. And that is your testimony here today, right?
A. Correct.
Q. By the way, Doctor, are you aware of any randomized controlled studies showing any greater safety advantage to medical abortion over surgical abortion after 20 weeks LMP?
A. Not specifically after 20 weeks.
Q. It is your view, Doctor, that the theoretical benefit to the D&X is fewer manipulations inside the uterus, correct?
A. Correct.
Q. That might reduce the risk of perforation, right?
A. Correct.
Q. By fewer manipulations, you mean fewer passes of instruments in the uterus, right?
A. Correct.
Q. And fewer passes of instruments also means less risk of uterine perforation, correct?

A. It should.
Q. The risk of perforation during a dismemberment D&E is not insubstantial, correct?
A. I'm sorry?
MS. GOWAN: Objection.
A. Could you repeat that?
Q. The risk of perforation --
THE COURT: Please don't.
(Question read)
A. I think I have given you those numbers already. The numbers range from 1.4 percent to 0.2 per thousand. I leave it to you to decide whether or not you consider those significant or not or substantial or not.
Q. Do you recall giving the following testimony in Nebraska at page 1712/line 21:
"Q. What do you see, Doctor, as the potential risks of a D&X procedure, both long and short term?
"A. Well, short term they would be identical to those of D&E. I think the theoretical benefit of an intact D&E is fewer manipulations, which might reduce the risks of perforation. Risk of perforation is not insubstantial. It can be as high in some studies as 1.4 percent, in others as low as .2 percent, but it is the most feared complication. So that I think is the great appeal of the procedure. So that's at least a theoretical advantage, the second part of your question was."

Were you asked that question and did you give that answer, Doctor?
A. I would answer the same way today.
Q. You would therefore answer that perforation is indeed the most feared complication during D&E, is that correct?
A. Without a doubt.
Q. That is during a dismemberment D&E, right?
A. During any procedure involving intrauterine manipulation, perforation is going to be the most serious complication.
Q. Fewer passes with instruments means less risk of cervical laceration, correct?
A. That remains to be seen, because there are other procedures related to an intact D&X that might increase the risk of laceration: Greater cervical rotation, the destructive procedure on the fetal calvarium in proximity to the cervix. I think, again, retrospective studies would help us define whether cervical lacerations are more or less common with that procedure.
Q. Doctor, do you recall giving at your deposition on February 17th in New Haven the following testimony --
MS. GOWAN: Page, please.
Q. Page 105 at line 23.
"Q. And fewer passes would mean less risk of infection or perforation or laceration, right?
"A. Correct."

Were you asked that question and did you give that answer?
A. I would say --
THE COURT: I don't think that contradicts what he said here.
THE WITNESS: I don't think so either.
THE COURT: That is what reading a prior statement is all about, Mr. Hut. I'm afraid that doesn't qualify.
Q. You would agree, Dr. Lockwood, would you not, that fewer passes with instruments also reduces the risk of infection?
A. True.
Q. Given those risks from instrument passes, you would agree that in any D&E, including by dismemberment, it is medically appropriate to try to make as few passes into the uterus or cervix as possible, correct?
A. I would agree, as I did in deposition.
Q. In a D&X procedure, the uterus and cervix are also less likely to be exposed to sharp fetal bone and skull fragments, correct?
A. Correct.
Q. You would agree, Dr. Lockwood, that, all other things equal, the shorter the surgical procedure, the better for a patient, correct?
A. Always.
Q. All things equal, a shorter procedure carries less risk of

bleeding, correct?
A. It may. It depends on what the two procedures are, I would say. But certainly I think that the operative time, if operative time is reduced, you would expect less risk of infection and perhaps less risk of bleeding.
Q. And perhaps less risk of trauma, correct?
A. Again, it depends on the procedures.
Q. A shorter exposure to anesthesia, correct?
A. For sure.
Q. You would agree, would you not, that another complication of dismemberment D&E is retained fetal head in utero?
A. Right.
Q. Which you treated as a complication of dismemberment D&E, correct?
A. Correct.
Q. If a woman's uterus, Dr. Lockwood, is infected because of chorioamnionitis, the uterine wall may be damaged and thinned, correct?
A. Potentially.

(Continued on next page)

BY MR. HUT:
Q. And there may, in this circumstance, be a theoretical advantage to minimum numbers of passes when the uterine wall is damaged and thin, right?
A. Correct.
Q. So there may be an advantage to D&X if a woman has chorioamnionitis, correct?
A. Medical abortion might be an equally attractive alternative, however.
Q. Can a woman with prior uterine scarring from c-section contract chorioamnionitis?
A. She can.
Q. And induction would be relative or absolutely contraindicated for such a woman, correct?
A. Correct.
Q. And a surgical abortion would therefore be preferable, right?
A. Correct.
Q. And because the uterine wall may also be damaged and thin from chorioamnionitis, in that circumstance D&X may be the safest procedure, correct?
A. I don't have any data one way or the other but, logically speaking, less manipulations may reduce the risk of uterine rupture.
Q. You believe that the use of D&X or intact D&E is reasonable

in some circumstances don't you, Doctor?
A. I would say that particularly in the settings you've outlined with prior uterine scars, yes.
Q. You acknowledge, don't you, Doctor, that there are intuitive or theoretical advantages to intact D&E?
A. Certainly the ones you've described.
Q. And in fact you use a somewhat intuitive process to decide when a pregnancy termination may be safest for your patients, don't you?
A. We usually call it delivery, but yes.
Q. So intuition has a role to play when knowledgeable physicians consider what steps might be preferable for their patients, doesn't it?
A. Certainly part of our clinical decision making.
Q. Now, you have expressed the view in your direct testimony this morning that converting the fetus to a breech position may create some risk to the woman; you agree, would you not, Dr. Lockwood, that as you understand the definition of partial-birth abortion contained in the Act, that coverage of the Act is not limited to situations where the fetus is converted to breech?
A. Correct.
Q. You would agree, Doctor, that sometimes a fetus is already presenting in breech when the doctor begins an intact D&E procedure, would you not?

A. Correct.
Q. In fact, approximately one third of the fetuses present in breech during the second trimester, don't they?
A. That is correct.
Q. In those instances there would be no need to convert the fetus to breech in order to perform an intact D&E, correct?
A. Correct.
Q. And so, any risk that might result from conversion would not be a problem in a case in which the fetus presents in breech already, correct?
A. By definition.
Q. You would agree, would you not, Doctor, that the documented risks of conversion relates to patients at or close to term?
A. Well, that -- I'm not even sure I would view these two things as comparable.
Q. My question, Doctor, is the documented risks of conversion relate to situations closer to term delivery, don't they?
A. Maybe I'm missing something.
THE COURT: Could I have that question read again? I'm sure I don't understand it.
(Record read)
THE COURT: Do you understand that?
THE WITNESS: I do.
Maybe I could expound just for three seconds. The significant risk to internal podalic version at term are to the

fetus. Our concern is that we may injure the fetus in doing that and that's primarily why it's been abandoned as a procedure. Obviously that's done with our hands, it's not done with a sharp or potentially sharp instrument or any instrument for that matter.

And there is some risk, presumably, of uterine rupture associated with an internal podalic version at term, but our focus is far more on the fetus, clearly that's not relevant with an intact D&X.

Q. At term, Dr. Lockwood, am I right in thinking that the uterine wall is much thinner than it is at the second trimester?

A. Correct.

Q. So, to the extent that conversion poses risk to the uterine wall at term, that risk would be reduced the second trimester, correct?

A. Assuming all the things are held constant that one is doing this with their hands, etc.; correct.

Q. In your expert report, Doctor, and I think again on direct this morning you indicate your concern that converting the fetus to breech may create risk to the woman, and by that you are referring to some increased risk of amniotic fluid embolism, is that right?

A. I don't believe I linked the internal podalic version specifically to an amniotic fluid embolism.

I think the risk of perforation is certainly high. Perhaps, again, maybe I didn't emphasize this enough, amniotic fluid embolism is an incredibly rare event. It is unlikely that you will see it in many hundreds or thousands of D&Es or intact D&Xs. I think the likelihood of lacerating the cervix and or perforating the uterus might be a far more common event.

Q. In your expert report, Dr. Lockwood, did you state that in both the D&E and D&X the use of instruments increases the risk of disruption of the blood vessels in the lower segment of the uterus or cervix?

A. Correct.

Q. But you have no evidence, do you, Doctor, that the risk from disruption of blood vessels is greater with the dismemberment variation of D&E -- excuse me, is greater with the intact variation of D&E than it is with the dismemberment variation, do you?

A. No.

Q. In your expert report you also state that in order to quantify the risk of amniotic fluid embolism from abortion procedures from a meaningful statistical point of view you have to examine between 50,000 and a hundred thousand abortion procedures, correct?

A. At least.

Q. And you do not point to any study that is ever undertaken to do that, do you?

A. I don't think that there will be one and I don't think, frankly, given the rarity of the event, that it would be needed.
Q. So, you can't posit any increased risk of amniotic fluid embolism from use of the intact D&E procedure, can you?
A. No.
Q. Whatever risk there may be is no different than the small risk of amniotic fluid embolism from dismemberment D&E as you earlier stated it, correct?
A. Shrug -- sorry. Yes.
Q. You agree that there may be less use of instrumentation with an intact D&E as compared with a dismemberment D&E, especially if the fetus can be extracted manually, right?
A. Correct.
Q. In fact, aren't instruments used in a number of inductions as well?
A. Well they're used after, most often after delivery of the fetus.
Q. To remove a placenta for example?
A. Correct.
Q. And how about to deal with a failed induction where there is no expulsion of the fetus?
A. Then essentially that would be a D&E or whatever. Whatever surgical procedure you do.
Q. And sometimes a D&E is required in that circumstance, is it

not?
A. Correct.
Q. I think you agreed on direct, Dr. Lockwood, that the statistical reports about the incidence of D&E compiled by the center for disease control include intact D&E with D&E in general, correct?
A. Correct.
Q. You agree, do you not, from your examination of the CDC data, that complications occurring with D&E have gone down over time, correct?
A. The answer would depend on the gestational age that you are talking about.

I mentioned over all the mortality rate, maternal mortality rate had dropped 85 percent, but if you look at specifically terminations at or after 21 weeks there has been approximately a 50 percent decline but it was not statistically significant.

So, the sense is, obviously the inadequate power to confirm this one way or the other -- the sense is that it is probably lower but we don't have actual statistical support for that statement.

Q. And over the same period at which there is a discernible if not statistically significant decline, you would agree that more doctors are performing intact D&E, correct?
A. That would be my gestalt, as we say.

Q. And gestalt is the equivalent for your belief?
A. Guess; right.
Q. Now, Doctor, last December before you prepared your expert report you took or drafted some notes as you read materials to inform your views, correct?
A. Correct.
Q. And you reviewed some materials that bore on the relative safety of intact D&E and dismemberment D&E, correct?
A. Correct.
Q. And you wrote in your notes, did you not, that after 21 weeks D&X is probably safer than D&E?
A. I don't remember the exact notation but something to that effect.
Q. And by D&X you included intact D&E, didn't you?
A. Correct.
Q. By D&E, you mentioned dismemberment D&E, didn't you?
A. Correct.
Q. When you made that statement in your notes, that after 21 weeks D&X is probably safer than D&E, that reflected your viewpoint then, didn't it?
A. Well, it reflected whatever I had just read. I was taking notes on my reading.
Q. And the basis for your belief about the safety of D&X was that dismemberment D&E would involve multiple passes of the forceps into the uterus, whereas D&X would involve hopefully

one pass, correct?
A. I don't have the deposition in front of me but if I remember correctly I think I was referring to the ACOG position that said under certain circumstances that it might be the appropriate procedure to be done.
I think that these notes were in reference to the policy statement by the college but now you are really testing my memory.
Q. Dr. Lockwood, developed evidence-based medicine retrospective studies usually precede prospective randomized controlled studies, don't they?
A. Correct.
Q. If a particular procedure were banned, how would you conduct any retrospective studies?
A. It would be very difficult.
Q. Dr. Lockwood, you agree, don't you, that administering digoxin to a morbidly obese woman in order to effect fetal demise before surgical extraction may be difficult to do?
A. I would agree that everything that one tries to do in a morbidly obese patient is difficult to do.
Q. And so that would include, as well as digoxin, the administration of KCL intracardiacly, correct?
A. Correct.
Q. And, in fact, a KCL injection requires some skill to be administered to any patient, correct?

A. Intracardiac injection, correct.
Q. And you agree that there is difficulty with a morbidly obese woman in making sure that injection of KCL or digoxin ends up in its intended lobes, correct?
A. Correct.
Q. You're aware of a published peer review study titled digoxin to facilitate late second trimester abortion, a randomized mass placebo controlled trial, are you not?
A. Is this the Jackson study?
Q. Yes, sir.
A. Yes.
Q. Indeed, you read that study on the evening before your deposition, did you not, Doctor?
A. I did.
Q. You're aware that the authors of the study conclude that digoxin in second trimester abortions did not decrease procedure time, difficulty or pain compared to the placebo, aren't you?
A. Correct.
Q. And you're aware that the study showed increase of vomiting among the women that received digoxin, correct?
A. Correct.
Q. And so you would advise any patient, based on this study, about the prospect of increased nausea and vomiting, of digoxin?

A. Well, we don't use digoxin so it probably won't come up in our setting.
Q. And you don't routinely use KCL either, do you?
A. I don't routinely do anything, but KCL is the drug of choice. Intracardiac, it is drug of choice to conduct feticide at Yale, that's for sure.
Q. But in addition to that at Yale you don't routinely effect feticide, do you?
A. It's not the way to do 5,000 deliveries so we would have, hopefully, plenty of live births.
Q. I'm talking with second trimester abortions.
A. Important point.
Q. Appreciate the clarification.
THE COURT: It helps.
Q. The answer to the question is you don't routinely do that?
A. Yes, I agree with you.
Q. And but for possible application of the Partial-Birth Abortion Ban Act of 2003, you would leave it to the woman to choose whether to receive an injection of digoxin or undergo a surgical abortion procedure without it, wouldn't you?
MS. GOWAN: Objection, your Honor.
THE COURT: Your objection?
MS. GOWAN: Form of the question -- but for the existence of the Partial-Birth Abortion Ban Act.
THE COURT: All right, rephrase it, Mr. Hut.

Q. If a doctor didn't have to worry about the possible application of the Act, you would think it would be appropriately left to the woman to choose whether to receive an injection of digoxin or undergo a surgical abortion procedure in the second trimester without it?
MS. GOWAN: Same objection, your Honor.
THE COURT: Sustained.
Q. Wouldn't you leave the choice to the woman, Dr. Lockwood, whether to undergo digoxin injection or surgical abortion procedure without it?
A. If I can answer. Yes.
Q. And the same is true for an injection of KCL, right?
A. Correct.
Q. And you would not advise injection of a toxic substance into the uterus of a woman infected with chorioamnionitis, would you?
A. Well, we do pretty routine amniocentesis in that setting to make the diagnosis of infection. I don't think that poses any significant risk.
Q. With respect to the brain cramp I think you indicated in your direct examination, you did testify --
A. That is a technical term, sir.
Q. Medical term; you did testify under oath, didn't you, that an injection of digoxin would be inadvisable for a woman suffering from hepatitis, didn't you?

A. For an amniocentesis, yes. For a termination, no.
Q. What about a woman who, by virtue of hepatitis or HIV is suffering from some depression of her immune system? Would you think that an injection, either intraamniotically or intracardiacly -- if that's the word -- would be advisable?
A. No.
Q. And you would agree that the question whether to receive an injection either of KCL or digoxin should be decided by the informed choice of the woman, correct?
A. Well my -- as a matter, it's like asking me if I support motherhood and apple pie. Yes, I would agree but it would be somewhat dependent on my recommendation to consider. It would be somewhat dependent on the status of this law.
Q. And KCL injections were recommended but not required for D&Es at NYU under your chairmanship after 20 weeks LMP, right?
A. Yes, absolutely.
My -- my bias was that it was a more humane approach to the fetus, we had evidence that in fact we had created on fetal stress responses that endorphin and I thought that I strongly encouraged people to consider doing it. And you could see the results of my encouragement were not very effective but, nonetheless, that was my rationale.
Q. And before 20 weeks' LMP there was no recommendation one way or the other at NYU, was there?
A. No.

Q. Now, you would agree, Dr. Lockwood, wouldn't you, that there are no published peer review studies that examine any correlation between second trimester abortions and heightened risk for cervical incompetence?
A. Well, actually there are several.
The Schneider et al., I am sure you are familiar with, that one; and Kalish -- if I am saying his name correctly -- both looked at second trimester D&Es.
In the Kalish study there were 600 patients, there were 171 in the Schneider paper and neither of those showed a higher rate of prematurity.
Q. And there are no published per review studies that examine such a correlation that show higher rates of prematurity, are there?
A. Correct.
Q. No peer reviewed data that would support any correlation showing higher rates of prematurity, correct?
A. For that specific group, correct.
Q. The French study by Henriet that you cited in your direct examination did not concern second trimester abortions, did it?
A. We have no idea what it concerned.
Q. Well you are aware, aren't you, Doctor, that there really is no abortion performed in France after the first trimester, correct?
A. I am now.

Q. Well I'm not asking you to agree with me, Doctor. I'm asking whether, on the basis of your examination of the study or otherwise, you are aware of that fact?
A. I believe in the French system approval be obtained from the local ethics committee for terminations after 12 weeks.
Their rate of termination, to my knowledge, is pretty close to what ours is, so I assume that they probably mirror our statistics.
Q. Well, doesn't the Henriet study itself disclose that 96 percent of all abortions in France are performed before or at 11 weeks' LMP?
A. I believe it does.
Q. And you don't know what portion of the 4 percent remaining in France is performed after 11 weeks, do you?
A. Correct; or how they're performed.
Q. And you would assume that it is less than 4 percent, wouldn't you?
A. Well, that doesn't mean that doesn't represent a significant proportion of the preterm deliveries but it is a low percentage.
Q. And you don't know what types of abortion procedures are most common in France after the first trimester, do you?
A. No.
Q. And in surgical abortions performed in France after the second trimester you don't know what techniques are used for

it, do you?
A. No.
Q. You don't know the most common dilation techniques used in France, do you?
A. No.
Q. You don't know whether doctors use osmotic dilators or mechanical dilators?
A. No.
Q. You don't know if they use osmotic whether they use laminaria?
A. I think it's clear that I am not au courant with the French abortion system.
Q. Touche.
You agree that laminaria are generally safer than mechanical dilators, don't you?
A. I do.
Q. And you don't know what types of dilation were used with women who underwent first trimester abortion evaluated in the Henriet study, do you?
A. No.
Q. Henriet was a retrospective cohort study?
A. Yes.
Q. Was the Zhou Danish study you made reference to as well?
A. Correct.
Q. Now, the Zhou study of Danish women did not involve second

trimester abortions at all, did it?
A. If I remember correctly, about 7 percent of the patients were in the second trimester, 7 percent were done by D&E.
Q. Correct.
Doesn't the study itself state that second trimester abortions were excluded from the examination?
A. I don't recall that. It's possible, if you give me the recall I can help you with it.
Q. Let me try to accommodate you, Doctor.
May I approach, your Honor?
THE COURT: You may.
Q. This is Government Trial Exhibit J-2, Doctor; have you ever seen it before?
A. This article?
Q. Yes, sir.
A. Yes.
Q. What is it?
A. This is an article published in Obstetrics and Gynecology by Zhou, et al., in 1999.
Q. And directing your attention to the second sentence under methods in the first column of the first page of Government Trial Exhibit J-2, do you see that it states: "A total of 15,727 women whose pregnancies were terminated by first trimester induced abortions were compared with 46,026 pregnancies that were not terminated by induced abortions."

A. I'm not with you.
Q. This is under methods in the first column of the first page.
A. Uh-huh.
Q. In the precis or abstract?
A. Oh. I was looking at the actual methods section.
Q. Do you see the sentence to which I just made reference?
A. I do.
Q. And then, directing your attention to the second column on page 1, the second -- well, the last full paragraph on the page, Doctor, about four lines up from that paragraph, do you see the sentence that states: "Women were excluded if first pregnancies were terminated later than the first trimester."
A. I'm sorry, yes, but I don't recall having said specifically, and maybe if I did I misspeak, that either of these studies were of second trimester D&Es. I don't even think that I specifically stated what kind of abortion they were.
Q. And you may not have, Doctor, I'm just trying to clarify that not only because the data studied not second trimester D&Es but it eliminated second trimester abortions from the universe examined, right?
A. I understand.
But I also believe that my argument earlier this morning, and maybe it was so long ago that you have forgotten

it, was that while the technique employed in first trimester abortions could potentially be more traumatic to the cervix because of the lack of laminaria, one could also argue the opposite, that rapid -- over the course of several hours -- dilation by laminaria, particularly serial laminaria could be equally disruptive and damaging to the cervix, and thus the need for the studies that I suggested should be done.
Q. But you can't tell from the Zhou study, can you, what kind of dilation was used for women undergoing first trimester abortions in Denmark, can you?
A. Presumption was that it was mechanical dilatation.
Q. But you don't know one way or the other, do you?
A. Not at all.
Q. And if it were mechanical dilators you don't know which type, do you?
A. I do not.
Q. And the study in question takes data from procedures done in the very earliest years of the 1980s, doesn't it?
A. That's correct.
Q. And you regard that as a disadvantage, don't you?
A. That's correct. I think I've stated that several times now.
Q. And with respect to the evacuations that are described in this study, I think as you testified earlier this morning those total some seven -- 7.4 percent, correct?

A. Correct.
Q. And we don't know how, if at all, evacuation practice in Denmark in 1980, '81 and '82, may vary from D&E for example in this country today, do we?
A. I'm even less au courant about the Danish abortion methods.
Q. Can you say that in Danish, Doctor?
A. I can't do that, though.
Q. Both D&E by dismemberment and intact D&E involve osmotic dilation of the cervix, correct, Doctor?
A. It's very dangerous to put papers before me because I am obsessive-compulsive and I need to read the entire paper now and review it.
I'm sorry, what was your question?
Q. You can put the study aside unless Ms. Gowan wants to come back to it.
Both D&E by dismemberment and intact D&E involve osmotic dilation of the cervix, correct?
A. Correct.
Q. Based on conversations with doctors who head the reproductive choice program at NYU, you know that at the same gestational age the preparations a doctor would take to perform a D&X and perform a D&E would be similar, right?
A. Correct.
Q. Adequate dilation reduces the risk of cervical tearing and bleeding, right?

A. Correct.
Q. And it similarly reduces the time to empty the uterus, right?
A. Correct.
Q. And at the same gestational age, the degree of dilation sought to be achieved would be the same whether the D&E was intact or by dismemberment, wouldn't it?
MS. GOWAN: Objection, your Honor.
THE COURT: May I have the question, please?
(Record read)
THE COURT: Your objection?
MS. GOWAN: Your Honor, it's overbroad.
THE COURT: See if you can rephrase it, Mr. Hut.
Q. When a physician approaches -- let me withdraw that and say it again.
In D&E practice, the amount of dilation sought to be achieved would depend on the gestational age of the fetus, wouldn't it?
A. Well, I think you have asked actually two questions. I will answer your first question.
The extent of cervical dilatation in fact often determined whether or not the intact D&X would be used versus the D&E with greater degrees of cervical dilatation encouraging the physician to perform the intact D&X and lesser degrees encouraging her to perform a D&E.

Q. You have read the trial testimony of the plaintiffs here, haven't you?
A. Some of them.
Q. Some of their deposition testimony?
A. Some of them.
Q. And on the basis of that review and on the basis of your conversations with the reproductive choice head at NYU, you know that the decision whether to do intact -- excuse me, whether to effect intact extraction or not is made intraoperatively, don't you?
THE COURT: Whoa, whoa, whoa. Can I have the question, please?
(Record read)
MS. GOWAN: Thank you, your Honor. Objection.
THE COURT: Sustained.
BY MR. HUT:
Q. When a doctor approaches a D&E the doctor decides whether to effect an intact extraction or dismemberment extraction at the time of examination and the degree of dilation intraoperatively, right?
MS. GOWAN: Objection, your Honor.
THE COURT: Sustained.
Q. The decision whether to effect intact extraction during a D&E is made intraoperatively, isn't it?
MS. GOWAN: Objection.

THE COURT: If you know, Doctor. Is that question meaningful to you?
THE WITNESS: It is, more or less.
THE COURT: Not more or less, Doctor. Either it is or it isn't. It's Mr. Hut's obligation to phrase the question.
THE WITNESS: It is a bit of a trick question but then I think that the --
THE COURT: Then say it's confusing.
THE WITNESS: I don't think it's confusing, I think it's a trick question.
I think the answer is that very often physicians will set out to do an intact D&X for a variety of reasons, some of which you have articulated earlier. Other times the setting will be such that they may have intended to do a D&E but it would be easier to facilitate a D&X and they pursue that.
So, I think that the answer is some of the time that is in fact what happens but not all the time.
THE COURT: Would you say, Doctor, more often than not, a physician knows the procedure that he intends to carry out and does so?
THE WITNESS: I don't know if it is more often than not, to be honest.
I think that my sense is that their goal really is to minimize the number of passes and if it, they can do it with a single pass, they'll do that. If it requires multiple

disarticulations, they'll do that.
But I do agree with the plaintiffs that the goal is to minimize the number of passes of instruments.
BY MR. HUT:
Q. The amount of laminaria used depend on the gestational age and not what variation D&E would be performed, right?
A. Well, both.
I think that, in general, the greater the gestational age the greater the number of laminaria and the more serial laminaria placement.
But, clearly, if someone's goal for anatomic purposes or they have set out -- whatever their intent was to perform an intact D&X, they would intend to use more aggressive laminaria placement, more frequent possibly will use misoprostol on top of that.
Q. Now, among the second trimester abortion procedures, the degree of cervical dilation achieved is most dramatic in an induction, is it?
A. It's actually pretty comparable.
Very often the cervix gets to four or five centimeters from labor and -- but occasionally, depending on the size of the fetus, it could be substantially greater than that.
Q. Your long-term concern about cervical dilation is a concern about all induced abortions, isn't it?
A. Correct.

Q. In some cases, Doctor, even for a practitioner that does not regularly perform an intact D&E, the cervix can become very dilated, correct?
THE COURT: May I have that question read again?
(Record read)
THE WITNESS: Because of cervical ripening measures taken?
Q. Correct.
A. Yes.
Q. If that is the case an intact extraction can result, correct?
A. Potentially.
Q. And in fact, in your experience at NYU, the practitioner often made the decision about whether to perform D&E or D&X during the performance of the procedure to reflect the needs to teach, correct?
A. Correct.
Q. Now, I think you agreed earlier Dr. Lockwood that procedures that begin as induction abortions sometimes fail, correct?
A. Correct.
Q. In performing a pre-viability induction it sometimes happens that the fetus is partly expelled in breech presentation, but before the head is delivered the woman sustains excess bleeding and the procedure must be completed

with instruments, right?
A. Correct.
Q. And in the event that bleeding occurred and the procedure was completed with instruments, one of the options available to the doctor would be to compress the fetal skull with forceps and facilitate the completion of the delivery, correct?
A. Correct.
Q. The fetus could have indications of life before the skull was compressed, right?
A. Correct.
Q. And when a physician begins an induction, the physician may know at the outset that circumstances might occur that would necessitate the instrumental completion that we've just discussed, correct?
A. It's possible.
Q. Dr. Lockwood, do you agree that before legislation bans a procedure as less humane you would want reliable evidence that the procedures left available to a doctor were in fact more humane?
MS. GOWAN: Objection, your Honor.
THE COURT: What's your objection?
MS. GOWAN: It's a vague, ambiguous question, your Honor.
THE COURT: Overruled.
THE WITNESS: Well, it's a wonderful question. I had

to think about it.
I would say that particularly between 20 and 24 weeks, given what I have argued is a fetus with progressively greater neurological function and the potential to perceive pain, that everything that we can conceivably do to minimize discomfort ought to be done, whether that's anesthesia or analgesia, or identifying procedures that are, from the fetus' perspective, least noxious, albeit obviously not putting the patient at risk.
So, I guess my answer to you is, yes.
Q. Any of the procedures that were left available to doctors in fact inflicted more pain on the fetus, that would not justify a ban on a particular procedure, would it?
MS. GOWAN: Objection, your Honor.
THE COURT: What's the objection?
MS. GOWAN: I don't understand what the purpose of the question is. A justification in whose mind for banning the procedure, what kind of ban, and in the context of which procedures?
THE COURT: All right, rephrase it, Mr. Hut.
Q. Doctor, in your medical judgment, if the procedures that were left available to doctors by the legislature inflicted more pain on the fetus than a procedure the legislature chose to ban, there would be no justification for the ban, would there?

A. First I would suggest you take up this objection with the house and the Senate and not Charlie Lockwood because I am powerless to alter the Act and I didn't vote on it myself. But as a rule of thumb, I think your logic is unassailable.
If you have banned one procedure that is less humane -- I mean more humane in favor of one that is less humane, you have defeated the purpose of -- presumably defeated the purpose of your legislation.
Q. Or if you have banned the procedure but the ones available are no less humane, there is no purpose for the legislation either, is there?
MS. GOWAN: Objection, your Honor.
THE COURT: I think it would be easier if you put it in context of the legislation you are talking about and the procedures.
MR. HUT: Very well, your Honor.
Q. You know of no studies, do you, Doctor, that have inquired into the question of which of intact D&E or dismemberment D&E is more painful for the fetus, do you?
MS. GOWAN: Objection, your Honor. As to relevance.
THE COURT: Overruled.
THE WITNESS: No.
Q. And you have made no such assessment, have you?
A. I'm not sure how I could do that.
Q. And you know of no basis to distinguish between

dismemberment D&E and D&X from the perspective of fetal pain, do you?
A. Well, theoretically I suppose I could but I know of no empirical evidence.
Q. And the Act does not require the administration of an anesthetic to the fetus at any gestational age for a D&E that would not be banned, does it, Doctor?
A. Not to my knowledge.
Q. And you are not aware of any studies comparing any pain felt by a fetus during induction abortion in the second trimester to pain felt from an intact D&E, are you, Doctor?
A. Presumably there would be no different than labor, and we have evidence that certainly reasonable evidence that labor, although stressful for the fetus, doesn't seem to evoke enormous amounts of pain.
However, imagine trying to fit my head through a tight space and being pushed out may be uncomfortable. We know that labor is a stressful event but common sense and intuition, which you seem to favor in some of your previous questions to me, suggest to me that tearing a fetus to shreds with instruments or sucking its brains out is likely to be less painful than an induction of labor.
Q. But you are not aware of any studies that have made such examination, are you?
A. No, I'm not.

Q. And you have not made such empirical assessment yourself, have you?
A. No.
Q. And you would agree, Doctor, that pain is not experienced without consciousness, correct?
A. Consciousness is a requirement for pain.
Q. And there is no certainty, is there, that fetuses at 20 weeks LMP have the consciousness necessary to experience pain, is there?
A. That's correct.
Q. And in fact, have you stated that at 20 weeks it is possible that a fetus feels pain, don't you?
A. That's correct.
Q. Whereas at 24 weeks you think it is rather more likely, correct?
A. That's correct.
Q. You have not made any assessment, have you, Doctor, where the fetus with brain or nervous system anomalies would feel pain in an abortion, have you?
MS. GOWAN: Objection. This is way beyond the scope of the direct.
THE COURT: Is it beyond the doctor's report?
MS. GOWAN: And that too, your Honor.
THE WITNESS: I don't remember.
THE COURT: If it is not in the report it will be

stricken.
MR. HUT: I will go on, your Honor.
BY MR. HUT:
Q. You testified on direct that you observed a dismemberment D&E in which the fetus responded to the touch or grasp of the forceps, correct?
A. That's correct.
Q. Do you know what anesthesia was used in that procedure?
A. General anesthesia. However, the patient was not intubated and I suspect that the level of anesthesia was not equivalent to that which could be achieved by endotracheal intubation.
Q. You would agree with me, Doctor, wouldn't you, that the definition of partial birth abortion as contained in the Act is not limited to the specific procedure described as an intact D&X by ACOG?
A. Correct.
Q. The definition in the Act makes no specific mention of deliberate dilation, does it?
A. Correct.
Q. It makes no specific mention of any requirement for instrumental conversion, does it?
A. Correct.
Q. Or of any requirement for breech extraction all the way to the head, correct?
A. I think it describes it to the navel.

Q. But not --
THE COURT: Could I have that answer read, please.
(Record read)
Q. And not to the head?
A. Correct.
Q. And it doesn't define any procedure with respect to any gestational age, does it?
A. Correct.
Q. Would you agree, Dr. Lockwood, that after the use of laminaria in a D&E abortion depending on the degree of cervical dilation and gestational age, some additional mechanical dilation may sometimes be needed?
A. Correct.
Q. You would also agree, Dr. Lockwood, would you not, that there might be some circumstances where an intact D&E would allow better diagnostic information than a D&E involving dismemberment, correct?
A. It's possible.
Q. When medical induction is contraindicated absolutely or relatively for a particular patient, it is not a safe means of attaining an intact fetus for pathological assessment, is it?
A. It may be a less safe means.
Q. If the time between an injection of KCL or digoxin and delivery of second trimester abortion is too long, then the use of KCL or digoxin can negatively impact the ability to make a

pathological assessment, correct?
A. Potentially.
Q. Dr. Lockwood, you would not advocate, would you, the use of nitroglycerin to facilitate the delivery in an induced abortion of an aftercoming fetal head?
A. No.
Q. Would you advocate use of a Duhrssen's incision to effect the delivery of an aftercoming fetal head of induced abortion?
THE COURT: Mr. Hut, please.
MR. HUT: Absolutely, your Honor.
THE COURT: Either get closer to the microphone if you insist often whispering or do something.
MR. HUT: I do have occasion, and I apologize to the Court, to back away from the podium and I appreciate your Honor's interruptions.
Q. Dr. Lockwood, you would not recommend, would you, Duhrssen's incision as a means of delivering an aftercoming lodged fetal head in a second trimester induced abortion, would you?
MS. GOWAN: Objection, your Honor. Beyond the scope of the direct examination.
THE COURT: Well, it's cross-examination. I'm not going to be so uptight.
You may answer the question.
THE WITNESS: No.

Q. Dr. Lockwood, I think you indicated on direct examination that you were a member of the American College of Obstetricians and Gynecologists, correct?
A. Correct.
Q. And I believe you said that you were a member of a number of the committees of the College, correct?
A. Correct.
Q. You are a board examiner for ACOG, is that right?
A. Well, for the American Board of OB/GYN.
Q. Sorry. Is that related to the American College?
A. No.
Q. You consider the College to be a reliable source on obstetrics and gynecology, don't you?
A. Yes.
Q. And are you still a member of certain ACOG committees, aren't you?
A. Correct.
Q. You're familiar with the 1997 policy statement on intact dilation and extraction issued by the college?
A. I am.
Q. And its executive board?
A. I am.
Q. You read the statement at or around the time it was issued, did you not?
A. I believe I did.

Q. You are aware that the policy statement says, in substance, that an intact D&X may be best or more appropriate procedure in particular circumstances to save the life or prevent the health of a woman, and only the doctor, in consultation --
THE COURT: Prevent the health?
Q. Preserve the health. Sorry, your Honor.
-- preserve the health, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision?
A. I have read the deposition over and you did say prevent there too, a Freudian slip. But I would --
Q. I take this opportunity to correct myself.
THE COURT: Qualified by psychology and psychiatry, no opinion.
THE WITNESS: It does indeed say that, but it also says that the panel could find no circumstance where it would be the only procedure that would be necessary to effect a termination, or words to that effect.
Q. And taken in its entirety, including both observations to which you have testified, you agreed with the statement when ACOG made it in 1997, didn't you?
A. I think, as I have said in my deposition, I have no opinion one way or the other when the statement was issued.
Q. Did you testify at your deposition and were you asked this question and did you give this answer:

"Q With respect to the statement that I just read, did you agree with the statement at the time you first read the policy statement?

"A I am not sure I don't agree with it, no."

A. And I would reiterate that yet again.

Q. And you are not sure that you don't agree with it today, right?

A. The panel statement is, you can see by its nature, a political statement.

Q. Am I right or wrong, Doctor?

THE COURT: Please don't, Mr. Hut. Don't interrupt the witness. Allow him to finish his answer. That technique is not allowed nor appreciated in this courtroom.

Doctor, you may finish your answer.

THE WITNESS: There are aspects of the policy that I agree with and aspects that I am neutral about and aspects that I don't agree with. But I do feel that, as a rule of thumb, physicians should make decisions about their patients without governmental interference.

THE COURT: Doctor you started to say, I thought, when you were interrupted, that it's a political statement?

THE WITNESS: I think it is.

I think that policy statements by their design and nature are different than the other communications that emanate from the College and they do intend to address political

issues. They're policy statements in fact. And this one was an attempt to reconcile a fellowship which is divided on the topic of abortion, divided on the topic of partial-birth abortion if you will, and yet wanted to be -- wanted to have a statement that could be employed by those who felt that this act threatened the availability of abortions to their own end.

THE COURT: And does this threaten their livelihood?

THE WITNESS: Well, the vast majority of College members don't perform abortions so it doesn't affect the bulk of fellows of the American College of Obstetricians and Gynecologists.

Would banning abortions impact the careers and or salaries of those that exclusively perform abortions? The answer is obviously yes.

Would this Act affect their income? Depends on how the act is applied, it depends on the guidelines that are used by the Justice Department to enforce it, depends on the murky area of vagueness and intent and deliberativeness that the Court will have to resolve.

THE COURT: Doctor, the body that makes these policy statements, how many people are on that group, committee or board? Whatever it is?

THE WITNESS: That's a very good question. It would depend on the committee.

Committees are cross-sections of the fellowship, they

include academic and nonacademics. Folks from community hospitals, junior fellows in many cases.
The attempt is to create a cross-section of the entire College. However, policies that are generated by ad hoc committees don't necessary meet that sort of cross-sectional orientation. I have no idea who was a member of that -- he'll probably show me in a second -- but I have no idea who was a member of the ad hoc committee that issued the policy statement.
But I would say, again, that there are certainly many aspects of that policy statement that I support.
THE COURT: But how many people? Would you have any idea who are involved in it?
THE WITNESS: Does it say?
THE COURT: And does such a policy statement require approval vote of the membership?
THE WITNESS: No. It does require approval by the executive committee of the American College of Obstetricians and Gynecologists.
THE COURT: And would there be any way of knowing how many on that committee are abortionists?
THE WITNESS: No way that I can conceive of.
THE COURT: So like 20 or 30 people could speak for this organization that I believe earlier in this trial I heard had a membership of 40,000 or something.

THE WITNESS: That's correct.
THE COURT: In other words, the majority of that committee -- say it was 25 -- 13 could speak for the College?
THE WITNESS: The College prefers to make policy and opinions and so forth when there is a consensus of the entire group. But I don't know what happened in this particular case.
THE COURT: We have no way of knowing.
THE WITNESS: No way of knowing.
THE COURT: And the policy statement doesn't say, as far as you know?
THE WITNESS: Not to my knowledge.
THE COURT: And it took no vote of the membership as far as you know?
THE WITNESS: We never do.
THE COURT: So, in theory, a simple majority could dictate an issue of policy that does not necessarily reflect the thinking of the membership.
I believe you just said it never does.
THE WITNESS: We would hope that it normally does but I can't guarantee that it always does.
THE COURT: So, theoretically, if you had 13 abortionists take over the committee tasked with making this policy statement, they could speak for the 40,000?
THE WITNESS: Well, I think there is sort of a two -- a two-step process here. The first step was this ad hoc

committee and I have no idea who the members of it were, but presumably there were those who were actively involved in the topic and in the area of abortions and so forth.

But the second step would have been by the executive committee, which is really a much broader cross-section of the College including its elected officials both at a district level and at the national offices.

THE COURT: How many would we be talking about?

THE WITNESS: I don't actually know how many serve on the executive committee. Could be on the range of 12 but they generally reflect a fairly broad cross-section.

To my knowledge there might be a maternal fetal medicine specialist or two or three and several gynecologists maybe a GYN oncologist and generalist, a large number of generalist.

THE COURT: But, again, a simple majority, as far as you know, could approve such a policy statement?

THE WITNESS: The general approach to the College is to try to get complete consensus on almost all the documents that it released.

So, if there were really a significant body of discord in voices, my guess is they probably would not have issued the policy statement.

THE COURT: But you don't know that.

THE WITNESS: Absolutely do not know that.

THE COURT: Or if you know, a simple majority could control an issue.

THE WITNESS: I think it is theoretically possible but unlikely.

THE COURT: But you were never consulted?

THE WITNESS: Definitely not.

THE COURT: And as far as you know, no vote of the membership is normally taken on such a policy issue?

THE WITNESS: No, not routinely.

THE COURT: Next question.

(Continued on next page)

MR. HUT: Your Honor, with respect to the answer of the doctor that it was a political matter, I move to strike it. It was not responsive to my question, and his testimony has just indicated he has no foundation for it. He has not spoken to members of the ad hoc committee.

THE COURT: All right. Since I asked it again, I will allow it. Next question.

MR. HUT: It was not with respect to your Honor's question. It was with respect to the question that he responded to me.

THE COURT: I know. I put it in another question, so it is in there anyway. Go ahead.

MR. HUT: I was not seeking to strike the response to your question, sir.

THE COURT: It's quite all right.

BY MR. HUT:

Q. You never spoke to any member of the executive committee or the executive board about the issuance of the statement, did you?

A. Never.

Q. And you know that the executive board in fact issued the policy statement based on the recommendation of the special committee, right?

A. By definition.

Q. And you know that --

THE COURT: He knows this or he has read it in that statement. Obviously, I would say from his testimony he has no personal knowledge of it, Mr. Hut. He has read the policy statement and it says so, he knows that. But he is not on the ad hoc committee, he is not on the executive committee, at least that has been brought out, so I doubt he can testify to all these things you want him to.

Q. Dr. Lockwood, when ACOG issues policy statements with which a member disagrees, the member can object by writing a letter to the editor of the journal, and a member or the chair of the relevant committee will respond, right?

A. That's correct.

Q. You never did so, did you?

A. No, I have not.

Q. You testified earlier with respect to a study concerning the impact of midtrimester dilation and evacuation on subsequent pregnancy outcome by Dr. Kalish and others, correct?

A. Correct.

THE COURT: Just a minute. Mr. Hut, before we get into Dr. Kalish's study, is this a convenient time for our afternoon break?

MR. HUT: Absolutely, your Honor.

THE COURT: We will recess.

(Recess)

THE COURT: Mr. Hut, you may inquire.

MR. HUT: Thank you, your Honor.
BY MR. HUT:
Q. Doctor, before I ask you about the Kalish study, in your direct examination this morning did you make reference to a French study other than the one by Henriet and Kaminski?
A. Yes. There were several others.
MR. HUT: Your Honor, those studies were not disclosed to us in the expert's report as anything he relied on. I asked Ms. Gowan for those prior to the lunch break, and they were not supplied. I would move to strike that portion of the doctor's answer that made reference to those studies. I don't know what they contained. I don't know whether they helped me or hurt me. I only know that I have not seen them and could not prepare any examination about them.
THE COURT: I would have to look at the transcript, which I will overnight. But I don't know that the doctor --
Did you say you relied on these studies in preparing your testimony?
THE WITNESS: No. No, your Honor.
THE COURT: Then why should his testimony be stricken? Should everything he has ever read since medical school that is not produced to you be stricken?
MR. HUT: To the extent they informed his opinions --
THE COURT: He said that it didn't. He just said that.

MR. HUT: I thought that the Court asked whether he relied on them in preparing his expert report. Perhaps I misunderstood the Court.
THE COURT: Obviously, if he said forming his opinions, you would have to take everything since medical school. I assume his entire medical education and experience is a portion of what he relies on in his medical thinking. But unless he used it to prepare his expert report, I don't see that it has any relevancy. Declined. Move on. Next question.
BY MR. HUT:
Q. Doctor, with respect to the Kalish study that you mentioned earlier, that was a study of second trimester D&E procedures, correct?
A. Correct.
Q. As performed at Weill Cornell Medical Center, correct?
A. Correct.
Q. It was published in the American Journal of Obstetrics and Gynecology, correct?
A. Correct.
Q. That is a peer-reviewed journal?
A. Correct.
Q. It examined certain D&E procedures performed during the years 1996 to 2000, correct?
A. Correct.
Q. The cervical dilation in the D&E's studied there was

achieved by laminaria, right?
A. Correct.
Q. The Kalish study concluded that second trimester D&E at later gestational ages appeared to be associated with a lower risk of preterm birth in subsequent pregnancies, correct?
A. Correct.
MS. GOWAN: Objection, your Honor, to counsel testifying about what a document concludes or not.
THE COURT: Let me hear the question. I think he is asking the witness. The witness can either agree with him or disagree. It is cross-examination.
(Question read)
THE COURT: The witness is capable of agreeing, disagreeing, asking to see the report, or whatever he wants. Overruled.
MR. HUT: I think witness answered the question, correct?
A. The prevalence of preterm birth is lower than I would have expected. It is not an ideal study, but certainly it was reassuring.
Q. And it was associated with a lower risk of preterm birth in subsequent pregnancies, right?
A. Right.
THE COURT: What was wrong with the study, Doctor?
THE WITNESS: The overall preterm birth rate was 6.5

percent. That certainly was a lower number than I would have anticipated it being. If they had actually had an ideal match for patients, which would have probably been impossible to do, that had had the same number of pregnancies without the termination and had been matched for innumerable other characteristics, that might have added additional weight. But I certainly view it as a reassuring finding.
THE COURT: Next question.
Q. Greater preoperative cervical dilation as reported in the Kalish study was positively correlated with advancing gestational age at D&E, correct?
A. I can't recall that, but that makes sense.
Q. And greater preoperative cervical dilation as recorded in the Kalish study was also positively correlated with greater gestational age at subsequent delivery, correct?
A. I believe that was the conclusion.
Q. On direct you testified about an op-ed piece that I think you said you prepared in approximately December 2003, right?
A. Correct.
Q. You authored that for your magazine Contemporary OB-GYN?
A. Correct.
Q. The fax line on the document supplied to us bore a December 19, 2003 date, correct?
A. Right.
Q. You drafted it on or around that time, Doctor?

A. Correct.
Q. At or around that date you sent it to Ms. Gowan, correct?
A. Correct.
Q. This was during a time you were discussing with the government the possibility that you might serve as a witness for the government in this matter, right?
A. Correct.
Q. The point of sending the op-ed piece was to convey to the government your views about the Act and about the issues surrounding the Act, right?
A. Correct.
Q. It accurately reflected your views in mid December 2003 when you wrote it, correct?
A. Correct.
Q. You didn't ultimately publish it, did you?
A. No.
Q. Since you wrote it, you have met periodically, either in person or by phone, with government counsel, right?
A. Correct.
Q. You met with them a number of times during the preparation of your expert report, right?
A. Correct.
Q. Another meeting or two before your deposition, right?
A. I think there were total of three.
Q. Did you meet with government counsel before your testimony

in Nebraska?
A. Oh, I'm sorry. That was at my deposition.
Q. I am moving to another question.
A. I see. Did I meet with them? I had breakfast with the attorneys.
Q. And you talked about issues in the case and your testimony, right?
A. Correct.
THE COURT: What was the first time you met them? Breakfast the day you testified?
THE WITNESS: I had met them at three of the prior meetings and had spoken to them on the phone. In fact, actually one of the attorneys picked me up at the airport, and we had a very brief conversation. Basically, it was late at night in Lincoln, Nebraska, and I just wanted to go to sleep.
Q. Government counsel had prepared a written outline for your use in preparing your expert report, right?
A. A written outline?
Q. Correct.
A. If they had, I haven't seen it.
Q. You didn't testify to that at deposition?
A. A written outline?
Q. Correct.
A. Oh, I'm sorry. For preparation of my expert report?
Q. Correct.

A. You have now mixed up deposition, preparing of the expert report, and my testifying in Lincoln. I guess it is getting late in the afternoon and I am getting progressively more confused.
Yes, absolutely.
Q. Did you talk to or speak with government counsel over the weekend in preparation for your testimony here?
A. I flew back with Sheila Gowan, so I had some opportunity to speak with her then. But I did not talk until I arrived today, this morning.
Q. You didn't speak briefly this morning?
A. We did.
Q. Some of your views have changed since you wrote the op-ed piece in December 2003, right?
A. Correct.
Q. And some of the op-ed piece still accurately reflects your views today, correct?
A. Correct.
Q. For example, you still agree that the Act has serious flaws, as you stated in the first paragraph of the op-ed piece, correct?
A. I would agree.
Q. In December you thought that any legislation that banned D&E's on 14-week fetuses with lethal anomalies would improperly burden women seeking abortions in the second trimester,

correct?
A. Correct.
Q. You still agree that legislation that bans D&E on 14-week fetuses with lethal anomalies would improperly burden such women, right?
A. If such legislation did in fact do that, yes.
Q. In December you found distressing the Act's imposition of penalties on doctors, right?
A. Still do.
Q. You think that the imposition of criminal penalties unravels the physician's social contract with his or her patients, right?
A. Correct.
Q. Because part of that contract is a right of patients to expect doctors to do their very best for them, right?
A. Correct.
Q. You also thought in mid December 2003 that it was entirely unconscionable for Congress to incur civil suits, right?
A. Very much so.
Q. And you still do, right?
A. Very much so.
Q. In December, before you spoke with counsel for the government, you believed that the Act's language was so imprecise that it just doesn't prohibit intact D&E's but also threatens all abortions, right?

A. Correct.
Q. So when you first read the Act as a practicing physician without conferring with government lawyers, you believed it was written in a way that threatened all abortions, right?
A. I wrote what I wrote.
Q. And you did believe that, right?
A. Correct. To be fair to all sides, I had reviewed the expert reports of your plaintiffs, and that may have added to my sense of urgency and concern.
Q. In fact, in your opinion, the wording of the Act is such that you can certainly understand why the plaintiffs' experts opined as they did concerning the Act's threat, right?
A. Correct.
Q. You still agree, don't you, Dr. Lockwood, that if the Act is not interpreted the way you believe appropriate, it is not only vague but worse, right?
A. If it is interpreted in a way that leads to a lack of access to pregnancy terminations, that would be a problem.
Q. Did you say a minute ago, Doctor, that the reading of the plaintiffs' declarations had affected your views of the Act at the time you wrote the op-ed piece?
A. That's correct.
Q. Dr. Lockwood, in your trial testimony in Nebraska last Friday, were you asked the following questions and did you give the following answers? This is page 1730/line 1.

"Q. Doctor, at the time you wrote the draft editorial, had you reviewed any materials related to the Act?
"A. From who?
"Q. From the plaintiffs.
"A. No.
"Q. You don't recall reviewing plaintiff affidavits prior to writing this?
"A. I do not recall that, no."
Were you asked those questions and did you give those answers?
A. I was wrong.
THE COURT: Please. Now, Doctor, you may answer the question.
A. I was wrong when I said that. It was obviously my recollection at the time. I was reminded that in fact I had been granted access to and had read the plaintiffs' expert reports.
Q. In December 2003, when you wrote your draft op-ed piece, you thought that the ban should not be applied before viability because the congressional findings failed to provide rigorous evidence that the procedure posed greater health risks than alternative abortion procedures, correct?
A. It sounds correct.
Q. You still agree that the congressional findings exaggerate the risk of the D&X procedure, correct?

A. Correct.
Q. In fact, you agree with very little in the findings that Congress made about the potential risks of partial-birth abortion, right?
A. That is correct.
Q. You think that there might be a slightly reduced risk of trauma in a D&X than in a D&E involving dismemberment, right?
A. Correct.
Q. In December 2003 you thought that a ban on abortions previability should only be made when a procedure is clearly dangerous to the mother's health and there were safe alternatives, correct?
A. Yes. That was a legal interpretation based on my attempts to understand Roe v. Wade and the subsequent Supreme Court rulings on the topic: Specifically, Roe v. Wade's trimester paradigm in which essentially first trimester terminations were to be unrestricted, second term abortions would be restricted in those cases to ensure maternal health, and that third trimester terminations could be restricted to protect what I believe Roe v. Wade called the state's obligation to protect the potentiality of life with the health and life exceptions that were included.
Q. Doctor, you are not aware of any evidence that intact D&E is clearly dangerous to the mother, are you?
A. Certainly no evidence in terms of short-term risk to the

mother, no.
Q. You are not aware of any specific evidence of risk in the long term, are you?
A. Not to the mother.
Q. In fact, you think intact D&E is comparable in safety to induction and dismemberment D&E, don't you?
A. More or less.
Q. If the law were upheld, you understand that your trusted colleague from NYU could be prosecuted for performing a procedure that she regarded or regards as most appropriate in some circumstances, don't you?
A. Correct.
Q. That is not a result that you favor, is it?
A. I do not favor prosecuting physicians for performing medical treatments that are done, obviously, in a way that they believe are maximizing patient outcomes, period.
Q. You think that there are compelling enough arguments as to the safety of intact D&E that you would not want to prohibit its use today in your institution, correct?
A. Not unless additional data suggested otherwise.
MR. HUT: Your Honor, I have no further questions of the witness.
THE COURT: Ms. Gowan, any redirect?
MS. GOWAN: Just very briefly, your Honor.
REDIRECT EXAMINATION

BY MS. GOWAN:
Q. Dr. Lockwood, are the opinions that you are offering here today your own?
A. They are.
Q. They are not the government's opinions, are they?
A. No, they are not.
Q. They are not Sheila Gowan's opinions?
A. I hope not.
Q. Doctor, I just wanted to clear something up from the record. When you were answering counsel's question about the pain that the fetus experiences, he was asking you about induction abortion and D&E by dismemberment and D&X. I believe that you said that it seems to you to suggest that the tearing of a fetus to shreds with instruments or sucking its brains out is likely to be less painful than induction of labor. You meant the opposite, didn't you?
A. I meant the opposite, of course, right.
Q. It would be more painful, correct?
THE COURT: Was your answer "yes" to that, Doctor?
A. Yes. Clearly that would be more painful than an induction D&E. But that is intuition. I don't have empirical evidence to support that assumption.
Q. And that is that the tearing of the fetus and the sucking out of the brains would be more painful than were the fetus to be aborted by the labor induction method?

A. Correct.
Q. I also wanted to clear up for the record when counsel was asking you about when you had first seen the ACOG policy statement and whether you had expressed an opinion about it at the time that you first saw it. He read part of your deposition testimony on that subject. I just wanted to read the remainder. I am reading now from page 101 of the transcript, where Mr. Hut was asking the witness about the ACOG 1997 statement.
"Q. It goes on to say, 'The potential exists that legislation prohibiting specific medical practices, such as intact D&X, may outlaw techniques that are critical to the lives and health of American women.' Do you agree with that now as well?
"A. No.
"Q. Why not?
"A. Well, you know, I think --
"Q. Let me withdraw that. Sorry. Did you agree with it at the time you first read it?
"A. I am quite confident I never expressed a position one way or another on this topic. In fact, I can quite guarantee that I never expressed an opinion one way or the other."
Were you asked those questions and did you give that answer at your deposition in this case?
A. I believe that comports with what I said today as well.
Q. Doctor, would you agree if the intent of the physician in

the placement of the forceps during the procedure is to disarticulate the fetus, that then it is a D&E by dismemberment?
MR. HUT: Objection: Leading, vague, and ambiguous.
THE COURT: Overruled.
A. If the intent is to disarticulate, then clearly that is the intent.
Q. To perform a D&E by dismemberment?
A. If the intent in placing the forceps on an extremity or some other aspect of the fetus is to disarticulate it or remove it, dismember it, what-have-you, then I believe that not many people would dispute that that would be consistent with a D&E.
Q. Would you agree that if the intent of the placement of the forceps or the hands is to perform an internal podalic version with intent to partially deliver the fetus and then perform a destructive procedure that results in the fetus's death and the physician then performs that, that that would be an intact D&X or D&X procedure?
A. Correct.
Q. Would you agree that in the event the physician did not have to perform the internal podalic version because the fetus was already in a breech position, if the intent of the physician was to remove the fetus intact, partially deliver the fetus intact, and then perform a destructive procedure that would result in its death, that that would be a D&X?

A. Correct.
Q. You don't believe that there is any established scientific evidence demonstrating that the D&X procedure is a safer procedure than medical induction abortion or D&E by dismemberment, do you?
A. Not definitively.
Q. You also believe that the procedure requires further study in order to determine whether there are long-term complications, specifically, preterm birth issues, right?
A. Correct.
Q. You believe that there are safe and effective alternative methods for caring for maternal complications other than use of the D&X procedure?
MR. HUT: Objection: Leading.
A. Right.
THE COURT: Sustained.
Q. Do you believe that labor induction abortion is a safe and effective method for caring for maternal complications in terminating pregnancies?
A. In most cases.
Q. Do you believe that D&E by dismemberment is a safe and effective method for caring for maternal complications in abortions?
A. Yes.
Q. Can you envision a circumstance in which D&X would be

required as opposed to D&E or medical induction abortion for terminating a pregnancy?
A. No.
MS. GOWAN: I don't have any further questions, your Honor. Thank you.
THE COURT: Any recross?
MR. HUT: Very briefly, Judge Casey.
RECROSS EXAMINATION
BY MR. HUT:
Q. Dr. Lockwood, you were aware that the ACOG policy statement was reaffirmed two times since its initial issuance in 1997, correct?
A. Correct.
THE COURT: I think this is outside of the scope of redirect.
MS. GOWAN: Yes, your Honor.
Q. Doctor, in an intact D&E, suction of the brain or intracranial contents takes less than a minute, doesn't it?
A. Correct.
Q. How long does the evacuation take on average in an induction abortion?
A. It depends on the method used and the medications used to effect it.
Q. What are the parameters from the low side to the high side?
A. For example, using 200 micrograms of misoprostol every 12

hours, it could take a range of 24 to 30 hours. Using 400 micrograms every 3 to 4 hours could take in the range of 12 to 15 hours. Using mifepristone prior to the procedure, 36 to 48 hours prior to the procedure, 800 micrograms of mifepristone vaginally and 400 every 4 hours either orally or vaginally, the average interval I believe was 4.3 hours from initiation to delivery. There was another study suggesting that number was around 6 hours.
Q. In an induction abortion, can a fetus die by asphyxiation?
MS. GOWAN: Your Honor, beyond the scope of the redirect.
MR. HUT: She asked extensively about inductions, your Honor.
THE COURT: Let's hear the question.
(Question read)
A. Yes.
THE COURT: You did inquire of that.
MS. GOWAN: I did on direct, but not on redirect. This is recross.
THE COURT: I'm sorry. I disagree with you. I will allow the question.
MR. HUT: I think the witness has answered. I have no further questions of the witness, your Honor.
THE COURT: Doctor, going back, I want to ask you a little bit about this afternoon. ACOG. Did ACOG, in issuing

its policy statements, indicate in that statement how many of the executive board -- I believe that is made up of 12 people?

THE WITNESS: I made that number up. But in that range.

THE COURT: Is that the correct title am I using, executive board?

THE WITNESS: Right.

THE COURT: Did they identify how many of the board were abortionists?

THE WITNESS: No.

THE COURT: Did they disclose how many of the ad hoc committee are abortionists.

THE WITNESS: I don't believe that they released the names of the ad hoc committee.

THE COURT: They made no statement as to whether or not the members of the committee or the executive committee or the ad hoc committee were in fact abortionists or abortion providers, whatever is the preferred name?

THE WITNESS: If somebody gives me a copy, I can look. But I don't believe I recall any names or any --

THE COURT: Did they identify them as such? Whether you know personally some of them perform abortions, that is something else.

THE WITNESS: Correct.

THE COURT: But the average obstetrician wouldn't have

or she wouldn't have any way of knowing?

THE WITNESS: That's correct.

THE COURT: All right. Doctor, thank you very much. You may step down.

(Witness excused)

THE COURT: Ms. Gowan, does the government have another witness?

MS. GOWAN: Your Honor --

THE COURT: I realize it is a little late.

MS. GOWAN: I have some good news for your Honor and some bad news, which we can put off to tomorrow. The good news is I think the Mets are winning 10 to nothing.

THE COURT: That is always appreciated.

MS. GOWAN: The bad news is what we were going to do next was read into the record some ACOG testimony that the government had designated for its affirmative case. If your Honor would like, we can put that off until tomorrow, or we would be prepared to proceed with that today. We do not have a live witness for this afternoon.

THE COURT: Are you on track timewise, as far as you can tell? I realize this is just the first day.

MS. GOWAN: We certainly are.

THE COURT: I realize you, I think, have perhaps a couple of fewer witnesses than the plaintiffs did. But you are on track. Maybe we should spare all of us until tomorrow

morning. One of the great delights in life is hearing deposition testimony. Unless somebody has some objection. As long as we are on schedule, we will recess until 9:30 tomorrow morning.

MS. PARKER: Your Honor, Ms. Parker.

THE COURT: Yes?

MS. PARKER: One brief housekeeping matter with respect to the ACOG deposition. We have provided your clerk today with a list of our objections to the government's testimony, if you are able to rule on those before.

THE COURT: Sure.

MS. PARKER: The other issue is I just learned today that the government has taken issue with some of the errata designations that ACOG made several weeks ago to their deposition and I think is proposing that both the original deposition answers and the errata be read into the report. The plaintiffs object to that and don't believe there is a basis for doing that. But that might be another issue that you could rule on prior to the reading.

THE COURT: Was that indicated on the materials you submitted to my clerks?

MS. PARKER: I don't believe so, because we just learned today that the government was planning to do that. We have not made any mention of that in the materials we gave to your clerk.

THE COURT: How much material are you talking about?

MS. PARKER: Your Honor, I am frankly not sure, since I just learned today that the government was planning to take issue with that errata.

THE COURT: Ma'am, do you know to how much you and your witness objected?

MS. PARKER: Your Honor, I'm sorry. ACOG is not the plaintiffs' witness. They made some changes to the errata --

THE COURT: They refused to appear, but their deposition was taken.

MS. PARKER: Right. And these are the designations that the government is presenting for ACOG in their case. I am not sure how many errata that the government takes issue with.

THE COURT: Ms. Parker, let's try this over again. When they were deposed, did you represent the person from ACOG?

MS. PARKER: No, we did not. ACOG was represented by their own lawyer.

THE COURT: You know, however, how much they did in the way of corrections to their answers?

MS. PARKER: Absolutely, your Honor. There is errata noted on the errata sheet that was provided by ACOG's attorneys.

THE COURT: Let's go back. We will do it in pieces. I'm a believer in that. How much is objected to? What is the volume of objections, Ms. Parker?

MS. PARKER: There was approximately a page and a quarter of errata at the end of the deposition that was provided by ACOG's counsel.

THE COURT: Has that been given to us, to my clerk?

MS. PARKER: No. but we can give it to your clerk right now and the government can provide the pages on which they object to the errata.

THE COURT: All right. Otherwise, I don't know how I am supposed to rule. Do we have the transcripts themselves?

MS. PARKER: Yes, we do, your Honor.

THE COURT: Do I have them? Do my clerks have them?

MS. PARKER: Your Honor, this is not the plaintiffs' designations. It is the government's.

THE COURT: Ma'am, I am aware of that.

MS. PARKER: I don't know whether the government has provided the transcripts to your clerk, but we can provide them to him today.

THE COURT: I assume you know if the transcripts are in our possession. You don't know that?

MS. PARKER: I don't know whether the government's designations are in your possession.

THE COURT: Do we have the transcripts?

THE LAW CLERK: No, Judge, we don't.

THE COURT: We don't have the transcripts.

MS. PARKER: We can provide them today.

THE COURT: It is very hard for us to rule unless we have the transcripts themselves.

MS. PARKER: Understood.

THE COURT: Thank you, Ms. Parker. I appreciate that. As long as we have the transcripts and the designated portions, the objections, and witness's corrections. A page and a half of them makes one wonder who is testifying.

Is there anything else? The Court will stand in recess until 9:30 tomorrow morning.

(Adjourned to 9:30 a.m., April 13, 2004)

INDEX OF EXAMINATION

DEFENDANT EXHIBITS