TWM 4/14/04 NAF v. Ashcroft.
(Trial resumed)
THE COURT: Good morning. The government can call their next witness.
MS. WOLSTEIN: Thank you, your Honor. Elizabeth Wolstein speaking. The government calls Dr. LeRoy Sprang.
THE COURT: You will be questioning, Ms. Wolstein?
MS. WOLSTEIN: Yes, your Honor.
LEROY SPRANG,
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 WITNESS: M. Leroy, LE ca.
THE COURT: Doctor, would you would keep your voice up so everyone can hear you clearly.
Ms. Wolstein your case may inquire.
MS. WOLSTEIN: Thank you, your Honor.
DIRECT EXAMINATION S-

BY MS. WOLSTEIN:
Q. Good morning, Dr. Sprang.
A. Good morning.
Q. What is your profession, sir?
THE WITNESS: Excuse me, Doctor. Don't get too close

to the microphone. At least at that end of the room it can get distorted a little bit. Give yourself a little space between yourself and the microphone.
Go ahead, Ms. Wolstein. Sorry to interrupt.
Q. What is your profession, Dr. Sprang?
A. I'm an obstetrician and gynecologist.
Q. How long have you been practicing?
A. I have been in private practice in obstetrics and gynecology for 28 years.
Q. Do you treat patients?
A. I have a large private practice, yes.
Q. What kinds of things do you treat patients for?
A. I have a full range of obstetric and gynecologic practice, including most obstetric and gynecological procedures, including some high-risk obstetrics.
Q. In your work as an obstetrician gynecologist do you things TOERD treat patients?
A. I also have other interests. I spend about 20 percent of my time in teaching i am very involved in that. And I spent spend about 20 percent of my time in professional medical organizations.
Q. Where do you teach?
A. I'm an associate professor at Northwestern University medical school.
Q. Do you teach medicine in any other setting?

A. I teach both in my office, in the hospital, and in the classroom. I routinely have medical students and residents assigned to me that I mentor in the office teaching ambulatory care. I also have those residents and students in the hospital teaching them actually obstetric and gynecological procedures, and I teach in the classroom on a regular basis to Northwestern medical students.
Q. What subjects do you teach in the classroom?
A. There are various general. My emphasis is on OB-GYN surgical infections.
THE COURT: What was that last word?
THE WITNESS: Gynecological infections.
THE COURT: Infections?
THE WITNESS: Yes, sir.
Q. What national professional organizations do you belong to, if any?
A. I am a fellow of the American College of Obstetricians and gynecologists. I am a fellow of the American College of Surgeons and a fellow of the Chicago institute of medicine [> check above<]
Q. What, if any, state and local professional organizations do you belong to?
A. I belong to and am a member of the Chicago medical society, the Illinois state medical society, the American Medical Association, the American College of Obstetricians and

gynecologists, American College of Surgeons, American fertility society.
Q. Where did you go to medical school, Doctor?
A. I went to medical school at Loyola University STREUFP School of Medicine.
Q. When did you graduate?
A. I graduated in 1969.
Q. When did you do after graduating from medical school?
A. I started in obstetrics and gynecologic residency. I was in the first year, which was called internship at that time from '69 to '70. I then joined the United States Navy and spent two KRAERS assigned to the United States Marine Corps, and then went back to the residency from '72 to '75.
Q. Are you licensed to practice medicine?
A. I am licensed to practice medicine in the state of Illinois.
Q. Let me go back. What was your residency in?
A. My residency was in obstetrics and gynecology.
Q. Do you hold any board certifications?
A. I am board certified by the American Board of Obstetrics and Gynecology.
Q. When were you certified by that board?
A. 1977.
Q. Have you published any books or chapters of books?
A. I have published a chapter in a gynecologic textbook on

obstetric and gynecologic infections.
Q. Have you published any articles?
A. I have published numerous articles in peer-reviewed and nonpeer-reviewed journals.
Q. Were any of the articles in peer-reviewed journals on the subject of abortion?
A. Yes.
Q. What article or articles?
A. I published an article on late-term abortion, emphasizing the procedure knowns intact dilatation and extraction in the Journal of the American Medical Association.
Q. When was that?
A. In August of 1998.
THE COURT: What journal was that?
THE WITNESS: The Journal of the American Medical Association.
THE COURT: Thank you.
Q. Would you briefly describe for us the subject of that article.
A. Specifically, that article addressed late-term abortions. By that we were referring to abortions that take place between 20 and 27 weeks' gestation. It is broken into two parts. The emphasis was on intact dilatation and extraction.
Q. What specifically did the article address on the subject of intact D&X?

A. The paper was presented and broken down into different areas. We initially discussed what was going on in the public and why that subject was before the public eye, the legislation and numerous articles were being printed in the newspapers. We then broke it down specifically looking at maternal considerations, the fetal considerations, the ethical considerations. We looked at some of the legislative issues where it was, and then moved on to general late-term abortions including applications, risk, the risk by gestational age, and again looked at the fetal, ethical, and legal considerations.
Q. What sources of information did you use for information on the D&X procedure for that article?
A. I had several SOURGS sources of information. We looked at the DeCastro presentation from September of '92 where he made a presentation to the National Abortion Federation group. My interpretation of that presentation was that he was actually trying to teach people in the audience how to perform that procedure [> check the name<]. So it was a very specific step by step description of that procedure. The American College of Obstetricians and gynecologists had gotten involved in the area as well, and they had a group of physicians meet and give a specific definition of what they considered the definition of intact D&X.
I at that point looked at numerous articles and had done research before. I also sat on a committee, a special

task force of The American Medical Association that reviewed in depth the issues surrounding it. I can talk about that later, if you wish.
Q. What sources of information did you use on induction and D&E procedures for that article?
THE COURT: Could I just go back. Who did you say that the NAF doctor was actually teaching the procedure?
THE WITNESS: My interpretation of the Haskell presentation --
THE COURT: Oh, Dr. Haskell.
THE WITNESS: Yes.
THE COURT: I'm sorry. I misunderstood the name. I just didn't understand what you said.
THE WITNESS: The way he presented it, it looked like he was actually trying to teach the awe audience how to perform that procedure.
THE COURT: I missed that it was Dr. Haskell. I am familiar with that. Go ahead. I'm sorry, Ms. Wolstein. I just hisd the name. I thought it was a name I hadn't heard as yet.
THE WITNESS: I'm sorry. I will try to articulate better, sir.
THE COURT: Go ahead, Ms. Wolstein. I'm sorry for interrupting. I thought it was a totally new player.
THE WITNESS: Sorry.

BY MS. WOLSTEIN:
Q. For your article in the J AMA, what source or sources of information did you use about induction abortion and D&E abortion?
A. Some of the previous material we had said we looked at again specifically for the article. We had done a great deal of work on the special task force that I was on and that report was 32 pages long and had 50 references. Then I did research the literature as look at as many articles as I could find. There were not a number of articles on intact D&X at that point as it was a relatively new things. So you tried to take what you learned from other areas and apply them, and specifically again is the Haskell information.
Q. Did you conduct a review of other parts of the medical literature in order to prepare your article in J AMA?
A. Correct. We reviewed the literature through the library, through the Internet, and looked at different issues, specifically again from a ma maternal aspects mortality and PHORGDty, from the fetal aspects including fetal pain, from the ethical aspects, and read articles in journals on the ethical aspects of abortion in general, and again that was an issue that we discussed in some detail at the AMA special committee.
Q. Since publishing your article in 1998, have you kept up with the medical literature on abortion?
A. I have.

Q. What have you done to keep up with the medical literature on abortion?
A. In general, when you start developing an interest in an area and publish in an area, when you are reviewing other journals, you usually skim the table of contents. You almost always go to articles that are on the areas you are most interested in. I also was involved in the Ohio case in women's medical center v. Taft. Because I was involved in that in 2001, I again reviewed the literature and had the opportunity to then review new declarations and depositions and get much more information on the subject.
Q. When you say the Ohio case, what are you referring to?
A. In Ohio, the state of Ohio passed a ban on intact D&X which was challenged by Dr. Haskell, and that obviously went to court, and I was an expert for the defense in that case.
Q. What materials did you review in the course of your work on the Ohio case?
A. Again, reviewed my article, the board of trustees report at the AMA, intervening literature, and then the information that was presented in that case. I specifically read Dr. Haskell's declaration. I specifically read Dr. HEUB ert's declaration and deposition. He was the physician who worked with Dr. Haskell. S-
When you read the depositions, and obviously the attorneys are asking many questions, it gives you a great deal

of insight into the specifics of what they are doing and some of the nuances that you might not pick up from an article or a book chapter. So it was very useful information on details of what they do.
THE COURT: Doctor, when did that trial take place?
THE WITNESS: In 2001. I believe I testified at the very beginning of 2001, in January.
Q. Doctor, was medical data from Dr. Haskell's practice made available to you in your capacity as an expert in that case?
A. Yes, it was.
Q. What data was provided to you?
A. Some of the summaries, what the Attorney General did was they did give permission to go into the clinic and collect the actual patient charts and information for I believe two days of what transpired in the clinic. So we had summaries of things like gestational age, types of procedures that were performed, some of the summary sheets that they used for patients, some of the information on the follow-up they had on their patients.
Q. With when you say summary data, are you referring to something other than the medical records themselves?
A. We had some examples of the forms they give to the patients and the patientssh filled out T. Attorney General had reviewed some of the data. Some of what I saw were just summaries of some of that.
I saw the interrogatory responses of Dr. Haskell's

clinic, so gleaned information from, that like say specifically on the follow-up of the patients that they performed. Because many of the patients from out of state, they would send -- they would give them a form and ask them to send it back. Specifically in the Haskell interrogatories, his response was that 36 percent of the patients sent information back, which means almost two-thirds did not. That is significant when you are trying to look at complications of a procedure if you don't have data and on two-thirds of the patients, it really makes it difficult to say you know the complication rate.
Q. By that do you mean long-term complications?
A. Correct. Often our concerns are some of the long-term things. Even some short things, if the patient was out of state and probably have it even a couple of days later, they would probably see a physician in their local community, so they complications would not get recorded by the clinic. S-
THE COURT: Doctor, were these redacted records? In other words, did they have the patients' identity removed from these records?
THE WITNESS: Correct, sir.
THE COURT: So they removed all the identifying data and they were redacted so they protected under HIPAA the privacy of the patient?
THE WITNESS: Correct, sir.
THE COURT: Thank you. Had next question, Ms.

Wolstein.
MS. WOLSTEIN: Thank you.
Q. Did Dr. Haskell make available complication rates associated with his practice of D&X?
A. In one of his presentations he did. In general, he states basically by his recollection, he has very few complications.
THE COURT: I think the question, though, was did he make complication records available.
THE WITNESS: Because the records were rather sparse and because of the limited follow-up for the patients, I believe at some point he listed a couple of specific things he remembered, but there was no real specific good data, because it was really not information on the patients. As we said, two-thirds of them never responded, so we didn't see them.
THE COURT: So there really weren't records available?
THE WITNESS: Correct.
THE COURT: Go ahead, Ms. Wolstein.
MS. WOLSTEIN: Thank you.
Q. Other than the area of abortion, do you keep up with the medical literature on obstetrics and gynecology?
A. Yes.
Q. What do you do to keep up with the literature?
A. Both I read the Green journal and J AMA sometimes fertility and sterility. We also, being part of a teaching faculty, on a monthly basis review cases and sometimes review journals as

well and have a journal club. I am president of a 28-person OB-GYN group, and we have a monthly journal club where we review articles. In various ways like that.
Q. What TKOUPBL by the green journal?
A. That is, sorry, the journal of obstetrics and gynecology.
Q. Doctor, have you done any work in the field of medical E ethics?
A. I have been involved in the field of medical ethics.
Q. Could you describe or identify your involvement in medical ethics?
A. Going PWAB to at least 1991, I was the president and chief of staff of the professional group at EFPBston/Northwestern healthcare. I had also been president of the Chicago medical society and had the student to see what other hospitals were doing in that area and had some more formal programs on creating an ethical committee. I brought that information to my hospital and actually formalized an ethics committee in my institution.

Being interested in that, I also served on the ethical relations committee of the Chicago medical society, and since 1994 have been the chairman of the ethical relations committee for the Chicago medical society. In my service on the AMA special task force to look at specifically late-term abortions and intact D&X, a significant discussion in relationship to that considered the ethics, and I was involved in those

discussions actively.
Q. I would like to go through those one at a time. You mentioned EFPBston Northwestern healthcare. What institution that?
A. Northwestern University medical school has two major teaching hospitals, one downtown and one in the northern suburbs, which is where I practice, and it is called EFPBston Northwestern health care. They actually own three hospitals in a hospital complex. So it is a major teaching hospital of Northwestern.
Q. So it is one of north wet TERPBS --
A. One of two major teaching hospitals, correct.
Q. You mentioned that you were chairman of the ethical relations committee of the Chicago medical society, what is the nature and function of that committee?
A. The function of the committee is patients, other physicians, or insurance companies can make in writing ethical charges against a physician. Those charges would come to my committee. I would assign two or three of the members of the committee to review the charges to see if they felt there was sufficient severity to the charges and sufficient information to pursue it. They could make a decision to go forward or not go forward.

If they made a decision to go forward, we would notify the physician in writing that these charges had been made and

request a written resons from them, and then move forward with a hearing where the individual is there. The individual can bring a supporting person with them, and we would review the material much like a courtroom, with not as stringent rules of evidence of what gets introduced and what doesn't, but in that approach. Then the committee, with me as chair, deliberates whether we feel acquittal, censure, probation, or actually expelling the member from the medical society.
Q. What was your role in those hearings?
A. Throughout those as chairman i always actually run the hearing and make decisions on what is admissible and what is not, and ask the questions of the individuals involved.
Q. What are the sources of ethical principles that inform the panel's decision-making in cases as you described?
A. Most medical organizations at the county, at the state level, at the AMA level, and at national specialty organizations have some things in their bylaws that are general precepts to those principles. Still in medicine a lot of it is individualized. We look at individual circumstances as well. In individual care of a patient, that may be very much actually looking at that patient's chart as to whether the right things were done or not, because it is not broad enough, and you really have to look at the specifics.
Q. You mentioned several times the AMA committee appointed to review late-term abortions. What are you referring to?

A. A resolution was brought to the AMA house of delegates. How the resolution was handled was the board of trustees was directed to come back with a report to the following meeting. When that happens, the board will often say, rather than just the board do it, they will form, appoint, a committee to gather the information and then bring it back to the board.
THE COURT: How many members does the MA have?
A. MA now has approximately 300,000 members. The house of delegates represents about 500 members at each meeting, and those members represent, are elected by each of their states, by each of their specialty societies. The reality is if you count all the representation of all the delegates, we represent virtually all the physicians in the United States, because they all come through either the state or through their specialty societies.
The AMA is really the umbrella group over all the other, virtually all the other medical societies in the United States. Again, whether it is PHAERP College of surgeons or OB-GYN, or women's medical association, all send delegates to this meeting. It is a large, democratic body.
THE COURT: That is what I wanted to know. Are obstetricians and gynecologists who are members, is that correct?
THE WITNESS: Yes, numerous ones, through both ways. The American College of OB-GYN actually has the ability to send

ten delegates purely on their own from American College of Obstetricians and gynecologists. But then many states, say Illinois has 15 delegates, I happen to be an obstetrician/gynecology, so I am also there representing the state but I'm also an obstetrician/gynecologist. Many states have that, so there are PHRULTple obstetrician gynecologists along with family practice, pediatricians, internists.

So they are represented in two ways. They double dip. They get both their specialty delegates, but they also get delegates from the states that are from those specialties.

THE COURT: Thank you, Doctor.

Q. Doctor, did you serve on that committee that you referred to?

A. Yes, I did.

Q. What was the committee charged with doing?

A. As per the house of delegates directed was to review the material and come back with a scientific treatise with as much information we could have so the house would understand the issue better and to make recommendations to the house that they would then consider.

Q. This is on the subject of D&X abortion?

A. Late-term abortions primarily related to, and the reason it was established, was for intact D&X.

Q. Who else besides you was on that committee?

A. To try to have a broad base of people with expertise and

representing many specialties, the chairman of the board of trustees of the AMA decided to chair this committee, saying how significant the board thought it was, and then they picked a representative of each of their major councils, so there was a represent from the council on scientific affairs a representative from the council on ethics and judicial affairs, a council member from medical education, and a council member from legislation.

Then to reach out even more, they reached out to national organizations that they felt had an interest and expertise in this area. So there was a representative from the American College of Obstetricians and gynecologists, a representative from the American academy of family practice, and a representative from the American academy of pediatrics.

Then, to include the states, they look at at, obviously, 50 states. Two states had actually introduced resolutions on this issue, so they picked an individual from each of those two states, which were Illinois and Pennsylvania. I was the individual picked from Illinois.

Q. How many people total on that special committee?

A. Total 10 with the chairman of the committee actually being the chairman of the board of the AMA.

Q. What things did the special committee consider in studying the issue of intact D&X?

A. It was an extensive review, and the committee looked first

at medical things surrounding abortion. They looked at the number of abortions performed in the United States and at different gestational ages. They looked at the types of procedures that were performed, looked at the complication rates for various procedures, looked at the overall morbidity and mortality of different procedures at different gestational ages. They looked at the subsequent complications and tried to look at subsequent lay term complications, which is not easy to do.

They looked at other national organizations that have policies on this, took that into consideration. They looked at previous AMA positions on abortion in general. Then they looked at the legal aspects. They looked at -- we, I shouldn't say they -- we looked at former Supreme Court justice opinions. I believe I said other organizations' opinions. Then we had a significant discussion on the ethical aspects of intact D&X.

The AMA has an ethical and judicial committee which is staffed by full-timeeth sists that work for the AMA, and they are often involved in issues like this come up, so they made a summary report of the types of issues one would look at from an ethical point of view, and then we discussed it.

Q. Did you yourself consider the information you just identified in the course of your work on the special committee?

A. Considered all of that information in addition to other things that I had access to because of my interest in the

subject and other articles that I had looked at in general on abortion. [> ethicists<]

Q. In the realm of ethics, what exactly did the committee consider?

A. The way it is presentedeth sists have kind of general rules of ways of looking at things that apply to medicine. S- they have categories -- do you want me to list them?

Q. Sure.

A. Initially, some of the general areas that they talk about in relationship to ethics in medicine include various areas. One they call the autonomy argument. They look at malfeasance, be TPHEF sense, and justice. S- the ethics emphasis on the committee fetal that out of those four years the one that was most relevant to the abortion issue and to intact dilatation and extraction resolved around the autonomy issue. So we spent the most time looking at that issue S-

Q. Can you flesh out what the autonomy issue is in the context of abortion.

A. The autonomy issue, a basic right of a woman to have an abortion, a significant apportion of that argument is that the fetus is within the mother's body and the mother has control of her own body. So when the fetus is there, it is more ethically appropriate for her to have control of that circumstance.

Looking at various times in the autonomy argument, as gestation progression and you start getting at like 23 weeks,

part of the autonomy argument is the fetus is totally dependent on the mother, so that gives the mother more control. Once you pass 23 weeks, which is considered the current limit of viability of the fetus, then the fetus could be independent from the mother, so the autonomy argument loses some of its strength.

Specifically in the intact D&X procedure, another major issue to the autonomy argument is is the woman in control of what is in her body. In the intact D&X the delivery process is taking place and it is a delivery, and you are then removing the fetus from the mother. If the fetus was totally removed, the autonomy argument has no validity whatsoever, because you have got a a parent and a child. In intact D&X you are going through that process. If you carry out the process as Haskell described and then as several other individuals have described, you are doing a breech extraction on the fetus and delivering that either to the neck, which is what Haskell describes. Some of the other individuals who are describing it seem to be describing that the head is even further delivered so they can see it better, and depending on the amount of cervical dilation and the size of the head, the head may pe halfway delivered, so they can see it to perform the next portion of that.

So as it is further removed from the body, the awe topmy argument becomes less critical and actually on an inverse sliding scale the fetus starts having more autonomy, more

rights, has to be considered more. It is a major et cal distinction with intact D&X versus other surgical procedures where the fetus is being killed where it is mostly outside of the woman's body.

MS. PARKER: Your Honor, I would like to move to strike that answer. This witness hasn't been qualified as an expert in ethics, and he is testifying to his opinion with regard to the issue in the case.

THE COURT: I don't think there has been a request to recognize him in any expertise. However, he has testified as to his background and service in Chicago at the various medical associations. I am going to allow it.

Q. Doctor, do the special committee's study of D&X lead to a written report on the subject?

A. Yes.

Q. Did the report lay out all the matters considered and studied by the committee?

A. In a significant amount of detail. There was actually a 32-page report with over 50 references and then specific recommendations.

MS. WOLSTEIN: Your Honor, may I approach the witness?

THE COURT: You may. Where will WOL I am bringing the witness a binder of exhibits that I have also provided to plaintiffs' counsel.

THE COURT: Very well.

Q. Doctor, if you could turn to tab U4A, which is near the back. Tell me what you have found it.
A. I have it.
Q. Do you recognize Exhibit U4A?
A. Yes.
Q. What is that?
A. It is a copy of the board of trustees report that we were referring to before.
Q. You mentioned a couple of minutes ago that the or the offered a recommendation on the use of D&X.
A. Yes.
Q. What was the recommendation on the use of D&X in the special committee's report?
A. In a summary of the description by Nancy Dickee, the chairman of the --
THE COURT: What is the name again?
A. The summary by Nancy Dickee said that the conclusion of the report is to severely restrict the use of intact D&X at all times. S- if I can find the actual recommendation, I will read it. It is recommendation 3 that is in there. Sorry, I was looking for the page.
MS. CHAITEN: Objection, your Honor. This report is hearsay and the witness is purporting to read from it.
THE COURT: Are you going to offer the report, Ms. Wolstein?

MS. WOLSTEIN: No, your Honor. The report is in the Congressional Record. I am not offering it in evidence. I am asking the doctor about the recommendations.
THE COURT: Do you remember what the recommendation is? If not, you can refresh his recollection. [> it was Ms. Chaiten, not Ms. Parker<]
Q. Do you remember what the recommendation was?
A. I can say it in general, but if I read what it says, it is even more specific.
Q. Would reading the recommendation help you remember what it was?
A. Yes, it would.
Q. Could you tell us what the recommendation was.
MS. CHAITEN: Your Honor, I would object to the witness reading it out loud; he can certainly use it to refresh his recollection r but it is hearsay.
THE COURT: Overruled.
A. According to the scientific literature there did not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion. Ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman." It does go on to be totally objective in everything it says. "The physician should retain the discretion to make that judgment and within

standards of good medical practice and the best I put of the patient." [> check<]
Q. Doctor, since that report was issued by the special committee, has another committee of the AMA ever studied the subject of D&X?
A. No.
Q. Doctor, have you ever served as a peer reviewer?
A. Yes, I have.
THE COURT: Excuse me. What was the date of the committee's report?
THE WITNESS: It came out in May of 1997.
THE COURT: Very well. Go ahead, Ms. Wolstein.
Q. What journal or journals did you serve as a peer reviewer for?
A. I have been a peer reviewer for things like Chicago medicine and hospital journals as well. Specifically at the national level I have been a peer reviewer for the American journal ofistics and gynecology.
Q. Is that the journal that will be establishing Dr. KHAEUPS's study?
A. Correct.
Q. When you were a peer reviewer for the American Journal of Obstetrics and Gynecology, did you expect that if aban author submitted an article and the author had a conflict of interest in the subject matter, that the conflict would be disclosed to

you?
A. Yes. [> Dr. Chasen<]
Q. Why did you have that expectation?
A. As I said also in my involvement in medical ethics, I was , an invited presenter at two national AMA leadership conferences, and my presentations were on that subject, on conflict of interest in dealing with pharmaceutical companies, other issues.
The ethical approach to that is if a physician is giving a presentation either orally or in writing, if there is or perceived a conflict of interest, it would be in the best interest of the audience to be aware of that so when they are listening to that presentation or reading that article, they would take that conflict of interest into account in interpreting what is being said. That is generally what is done in meetings where you are giving presentations to audiences.
MS. CHAITEN: Your Honor, I move to strike that response. This is beyond the scope of his expert report, both his initial expert report as well as his supplemental report specifically directed at Dr. Chasen's study.
THE COURT: Overruled.
Q. Doctor, do you hold any board certifications?
A. I am board certified in obstetrics and gynecology and, as we said, a fellow of both OB-GYN and the American College of

Surgeons.
Q. Could I direct you in your binder to Exhibit Z as in zebra, 3, which is towards the end.
A. I have that.
Q. Do you recognize Exhibit Z3 for identification?
A. Yes, I do.
Q. What is it?
A. It is my curriculum vitae.
Q. Is Exhibit Z3 an accurate and up to date statement of your education, training, and other professional qualifications?
A. It does appear to be, yes.
MS. WOLSTEIN: Your Honor, the government offers in evidence Exhibit Z3, Dr. Sprang's curriculum vitae.
THE COURT: Any objection?
MS. CHAITEN: No objection, your Honor.
THE COURT: It will be received.
(Defendant's Exhibit Z3 received in evidence)
Q. Doctor, are you familiar with methods for terminating pregnancy in the second trimester?
A. I am.
Q. What are the second trimester methods for terminating pregnancy?
A. The most common procedures would be D&E induction and in more recent years intact D&X.
Q. Do you have an understanding of the D&X or intact D&X

method of PWAORS?
A. Yes, I do.
Q. What is the basis of your understanding of that procedure?
A. The extensive descriptions given by Dr. Haskell, the descriptions given by the American College of Obstetricians and gynecologists. There have been descriptions more recently in a textbook, the Clinician's Guide to surgical and medical abortions. And now, having served as an expert, reading numerous declarationrs and depositions which I think give great insight into the details and the nuances of how that procedure is performed SP-P.
Q. Do you have an understanding of the induction method of abortion?
A. I do.
Q. What is the basis of your understanding of that procedure?
A. When I perform those procedures for when a fetus is dead, that is my most common method of using it late in pregnancy. But, again, numerous readings of the articles and in reviewing the articles for both the committee and for the article that I wrote, I did an extensive review of the literature.
Q. Do you have an understanding of the D&E method of abortion?
A. I do, for similar reasons.
Q. Have you yourself performed abortions on live fetuses?
A. The only in what I would in general exceedingly rarely. I have performed an abortion on a live fetus on one occasion.

Q. Have you performed an abortion or emptied the uterus in cases of a dead TPAOERTS?
A. On numerous occasions.
Q. What methods have you used in those circumstances?
A. Early on, most of those were section curettage and what we really call a D&C, up to about 13, 14 weeks. It is the same types of procedures that we do all the time on women who have abnormal uterine bleeding, only in this case it is a pregnancy, you are dilating the cervix and removing the fetus and the placenta tissue with both suction curettage and sharp occur tang.
Q. How about in the second trimester; have you performed abortions on dead fetuses in the second trimester?
A. I have. As the gestation progression, the fetus is obviously HRAERPBL, and sometimes you do need to use laminaria to dilate the cervix a little more. Then you can still in some parts start out with suction curettage, try as get such as you can, and removing the remaining portion using forceps. Later in the second trimester, when it would come to say certainly beyond 18 to 20 weeks, my preference and the preference of my hospital would be to do inductions.
Q. Is the technique for the surgical portion of a D&E different when it is done on a live fetus versus a dead fetus -FRPLTS the techniques are the same. There may be some truth to the literature that if the fetus is dead, the procedure may

be sometimes easier to do, because the body is starting to recognize the fetus is dead, maybe the cervix is a little softer so it is easier to dilate, the fetus is probably softer and easier to disarticulate. The same could be said for inductions: They probably respond a little faster, a little easier in those circumstances.
Q. Doctor, why don't you perform abortion on live fetuses ?
A. I tend to be a very positive person and like the positive aspects of medicine. I picked the subject or the specialty of obstetrics and gynecology for the most part because it is positive. We do have some sad occurrences where the mother has her problems and the fetus dies. But for the most part it is more positive things.
I wouldn't personally feel comfortable killing a fetus. The only time, in the one circumstance I said I did was life threatening to the mother, and she actually presented with intraabdominal bleeding, and when we opened up the abdomen there was a mass growing outside of the uterus, which I actually thought was cancer at the time. We sent it down for a frozen section, and it was actually the placenta growing through the uterine wall, which is a very rare situation. It is called placenta perKREU at a S-, but it is aggressive and usually ends up in hysterectomy. I was able to rePHROF the placenta and suction out the contents of the uterus from above and sew over that area. So in that case it was to save the

life of the mother.
MS. WOLSTEIN: Your Honor, pursuant to Federal Rule of Evidence 702, the government offers Dr. Sprang as an expert in obstetrics and gynecology and with the knowledge, skill, experience, and training to testify concerning abortion and the medical ethics relating to abortion.
THE COURT: Any objection?
MS. CHAITEN: Your Honor, we do object to Dr. Sprang being qualified as an expert in the area of intact D&E or intact D&X and would like an opportunity to voir dire him.
THE COURT: Go right ah
MS. CHAITEN: I think I will do it from counsel table, given all the binders that Ms. Wolstein has, if that is OK with the Court.
THE COURT: Go right ahead. V. Examination.
BY MS. CHAITEN:
Q. Dr. Sprang, good morning.
A. Good morning.
Q. Doctor, you have never performed a D&E on a live fetus, is that correct?
A. That is correct.
Q. And you have never induced fetal demise prior to beginning an abortion procedure, right?
A. That is correct.
Q. Even on an already demised fetus, you have only performed

approximately 20 D&E's in your entire career, is that right?
A. It is purely an approximation. I probably performed more than that, but I used a low number. But it is an approximation, yes.
Q. So approximately 20?
A. Yes.
Q. The same applies to induction procedures to remove a dead fetus in the second trimester, is that right, about 20?
A. It is an approximation, but I have performed hundreds of inductions at various times on live fetuses for delivery of the fetus.
Q. You don't perform abortions on live fetuses because you have a moral and ethical objection to them, is that correct?
A. I did not testify to that. I said I would be uncomfortable killing a fetus.
Q. Doctor, did you testify -- I think you testified earlier that you gave testimony in the Taft case in Ohio, is that correct?
A. Correct.
Q. That was in January of 2001?
A. Correct.
Q. Doctor, was the following question asked and did you give the following answer in that testimony:
"Q. Am I correct, Doctor, that because of what you deem your own personal, moral, and ethical views, you personally do not

perform elective abortions at any week of gestation?
"A. I personally do not perform elective abortions."
THE COURT: Again, is this Ms. Chaiten?
MS. CHAITEN: Yes, it is, your Honor.
THE COURT: Of course, the appropriate use of such a statement is to show inconsistency. There is no inconsistency. The witness testified as to what he said this morning and he was correct in what he said. You are using that. He did not say it in this testimony here. Therefore, it S-P inconsistent.
Q. Dr. Sprang, did you say that under oath in the Ohio case?
THE COURT: He already said that. Next qui.
Q. Doctor, you have never performed a D&E at a gestational age beyond 17 weeks, have you?
A. That's correct.
Q. You generally use vacuum aspiration or suction techniques to remove a dead fetus through about 14 weeks, correct?
A. Correct.
Q. So your experience in performing D&E's even on dead fetuses is limited to approximately 14 weeks to approximately 16 or 17 weeks' gestation, is that right?
A. Please repeat the question.
Q. Your experience in performing D&E's on even a dead fetus is limited to approximately 14 weeks' gestation to approximately 16 or 17 weeks' gestation, is that right?
A. Correct.

Q. You don't perform D&E's after approximately 17 weeks because you believe a physician must have significant expertise and experience to do a D&E at that gestational age, right?
A. I believe if somebody is going to do it, I would want somebody who has significant experience in doing it. I would probably -- I would do an induction even at 17 or 18 WEPBGS. So I would handle the patient. But if the patient wanted a D&E, then at this point in time there are physicians in my hospital who have more expertise at doing that, and I would think it in the best interests of the patient to let them do that.
Q. So you don't have the expertise to perform a D&E beyond about 17 weeks, correct?
A. Relatively, I could probably do it. But I think it is in the best interests of the patient to have the people with the most experience do it.
Q. Doctor, you have testified that you are the president of a large practice or partnership, is that right?
A. Correct.
Q. None of the other physicians in your practice do D&E's on live fetuses, do they?
A. Correct.
Q. You have testified that you perform induction procedures in the second trimester but again only on fetuses that have already died, right?

A. No. I have done inductions on live fetuses for medical reasons that may have been 25, 26, 27 weeks, which is still the second trimester. But they had significant enough medical reasons that it was safer to remove the child. But then you are doing a delivery. You are trying to solve the problem and the child at that point is a child, goes to the nursery, and they take care of them then.
Q. But prior to 24 weeks you have never performed an induction procedure on a live fetus, correct?
A. Not that I recall.
Q. You mostly only perform inductions to remove dead fetuses after 20 weeks, though maybe sometimes as early as 18 or 19 weeks, right?
A. Correct.
Q. And at earlier AEUPBLS you prefer D&E, right?
A. Correct.
Q. You personally own perform inductions to remove a dead fetus one or two times a year, is that right?
A. Correct.
Q. In total, you have only performed 20, approximately 20, I think you said, right?
A. Correct.
Q. Doctor, you have done no clinical research in the area of abortion, is that right?
A. I have done research in the literature and descriptions.

I'm not sure -- tell me what you mean by clinical research.
Q. You have reviewed medical literature?
A. Correct.
Q. But you have never done your own study, for example, in a clinical setting?
A. Correct.
Q. You don't give formal planned lectures to medical students or residents on how abortions are performed, do you?
A. No.
Q. Other than the article you published in the Journal of the American Medical Association called rational for banning abortions late in pregnancy, you have published no other articles in the area of abortion, is that correct?
A. There was an article published on my presentation at the bioethics seminar in Indiana which was specifically on intact D&X, both the medical and ethical aspects. There have been synopses in some of the presentations I have given at the national youth leadership conference on intact D&X.
Q. But no articles in peer-reviewed journals, correct?
A. Correct.
Q. The article you published in JAMA was published in a section of J AMA called "Controversies," is that right?
A. Correct.
Q. It was in response to an opinion piece written by David Grimes opposing restrictions on late abortion, is that right?

A. I'm not sure if it was an opinion piece or not. It was the controversy aspects, so it was one aspect discussing D&X from a positive point of view and one from a contrary point of view. [> check the question<]
Q. Dr. Sprang, you have never performed an intact D&E or intact D&X, have you?
A. Correct.
Q. In fact, you have never seen one, right?
A. Correct.
Q. You never even want to see one, do you?
A. I would probably be ut accept at seeing the brain avenue 23-week fetus being suctioned out. It would not be a pleasant experience. I'm not sure it is a pleasant experience for the physicians who are doing it.
Q. It is your understanding that intact D&E's are PEFRPLDZ 18 weeks after gestation, is that right?
A. I'm SOEURPL.
Q. Isn't it your understanding that intact D&E's are performed primarily after 18 weeks' gestation?
A. Because I use the term intact D&X, I believe that is what you are talking about, my understanding from Haskell and from other readings is that it is primarily done in the 20 to 26-week time frame. [> check the prior question<]
Q. That is a time period in which you have not performed any type of D&E, right?

A. Correct.
Q. Dr. Sprang, you testified last Friday in San Francisco at a trial in a case challenging the same statute at at issue in this case, right?
A. Correct.
Q. During that testimony you identified a number of bases for your familiarity with intact D&E abortions, right?
A. Correct.
Q. Many of those were the same as the bases that you identified this morning, is that right?
A. Yes.
Q. You included the work you did on the AMA task force as a basis for your understanding of intact D&X?
A. I'm not sure. I don't believe I specifically talked about lectures at the TPHAGS at youth leadership conference or lectures at the bioethics committee report in Indiana. But I don't think as much was said about my teaching through those mechanisms.
THE COURT: Doctor, were you recognized as an expert in San Francisco last week?
THE WITNESS: I was recollectiond as an expert to talking to presentations but not specifically as an expert in intact D&X. [> recognized as an [> can I make another comment?
THE COURT: Counsel will ask you.
MS. CHAITEN: Your Honor, I would request that Dr.

Sprang be so limited here in that he had discussed the subject, obviously, but he is not an expert in the technique itself and how it is done, and I would request that he be limited from testifying in that way.

THE COURT: Overruled. Under your rationale, only an abortionist would qualify as an expert to opine on it, Ms. Chaiten. Your objection is overruled.

Ms. WOL steep, you may continue.

MS. WOLSTEIN: Thank you, your Honor.

THE COURT: And the Court so recognizes the witness.

BY MS. WOLSTEIN:

Q. Doctor, are D&E's performed at Evanston Northwestern healthcare?

A. Yes.

Q. At what gestational ages?

A. From approximately 15 to 20 weeks [> this is direct examination continued<]

Q. Do you know how intact D&E's are typically performed at Evanston Northwestern healthcare?

A. Yes, I do.

Q. What is the basis for your knowledge?

A. There are the individuals who perform them I discuss with, recently because of-it has been more in the public, more emphasis on this issue, the head of the department of maternal fetal medicine and I have had a discussion on what they are

currently doing.

Q. How are D&E's typically currently performed at your hospital?

A. They are using the typical dilation of the cervix with laminaria. A recent addition to their technique is that they now use potassium chloride feet side injections, and I have talked to them about that in their experience. [> TPET I side<]

Q. When did potassium chloride start to be used by the doctors in your hospital?

A. They have offered it on occasion in the past, and they use it sometimes in what is called selective reduction, which is another procedure which they times perform. So they have experience in using it. In the past, in the beginning of the procedure they would just cut the umbilical cord at the beginning of the procedure. Having reviewed more of the literature and looked at it, they have decided to actually are you TAOEPBL now use feat side injections and they inject directly into the fetal heart only about 2cc's, a small amount of potassium chloride. They are doing it right while they are looking at the ultrasound. They can see med KWRAELT ceasation of the fetal heart, so they know within minutes or seconds that the heart is stopped. By doing that, they feel there is a comfort level for both them and the patient, and if there is some evidence that the procedure is actually easier to do after that, because there is some softening of the tissue and there

has been some -- they have said that they feel it is easier to do AEFD, and that both they and the patient prefer it that way.

STKPWHREUFRPBLGTS no if<]
Q. You never did in your answer to selective reduction. What does that refer to?
A. Unfortunately, sometimes when, with all the in SREUT ro fertilization, they place 5 or 6 embring owes back in the uterus and they don't know how many will take, they are hoping obviously to get viable pregnancys for that couple who want to have a baby. Sometimes all five or six take, and then the concern is that it would be very difficult for the mother to carry, say, five fetuses to term. That in fact rarely happens. So they have a discussion with the mother about considering what they call selective reduction do increase the chances for the rePHAEUPG fetuses to go to term and survive. Again, lots of ethical issues and questions, but again, shell decide to SHREUFL reduce maybe two of the fetuses. In those circumstances they actually object the potassium chloride into two of the fetuses' hearts relatively early in the gestation, and those two fetuses pass away, die, and are kind of reabsorbed. The two or three remaining fetuses have much more of a chance to getting to term and delivering more at 36 or 37 weeks in a healthier condition for them.

So it is a sensitive issue. But in the past what would happen is oftentimes they would just abort all of them and just say carrying five or six is just too difficult, you are not likely going to succeed, and they would abort all of them and then just try again. So this is a decision that has been made. In the past they were using potassium chloride with other fetuses actually in the uterus, and that tells you the feeling they have of the safety.
They reviewed an article with 400 cases where that was done with successful outcomes as far as fetal demise and not harming the mother.
Q. At your hospital is the use of potassium chloride in the context of selective reduction considered safe?
A. Correct.
Q. Are induction abortions performed at Evanston Northwestern healthcare?
A. Yes.
Q. At what gestational ages?
A. Primarily beyond 20 weeks. I would say the maternal fetal medicine physicians at Evanston are not comfortable performing D&E's beyond that, and they would feel more comfortable with induction, and that is what is done.
Q. How are induction abortions typically performed at your hospital between 20 and 24 weeks?
A. Similar to an induction later at term, they may, again, use

laminaria to try to soften the cervix and maybe expedite the delivery. The patient is then brought in and often misoprostol, which ace prostaglandin, is used. There are little tablets that can be placed at 4-hour or 6-hour intervals that essentially creates the normal process of labor. In an induction, the uterus contracts, and at some point the strength of the uterine contractions and the dilation of the cervix will be such that the fetus is expelled into the vagina.
Q. Doctor, have you formed an opinion about whether D&X or the D&X procedure poses risks to the woman?
A. Yes, I have.
Q. What is your opinion?
A. My concern is because of the greater cervical dilation because of the fact that the serial laminaria over a couple of days, there is greater risk of infection. And some of the procedures involved in actually performing the intact D&X in the description of Haskell and the American College of OB-GYN adds some additional risks.
THE COURT: Adds some what, Doctor?
THE WITNESS: Some additional risk.
Q. Are there other aspects of the D&X procedure that pose risks to the woman other than what you have just mentioned?
A. I think I mentioned laminaria, TKHRAOEUGT the cervix greater, the procedure itself of internal podalic version and extraction, and then as part of it they were also using

scissors to pierce the head.
Q. We will address those in turn. What is your opinion based on?
A. There are several things you can see. We know that because of ininfectious disease is my area of expertise, putting a foreign body in the cervix, laminaria, and leaving them there for two days ace known risk for increased infection. There are numerous articles in the literature that say that the greater the cervical dilation, the greater the risk of later the cervix not being able to hold a pregnancy. They may have an incompetent cervix or the patient may be at greater risk of premature labor. That is pretty well established in the literature.
The exact causes of the cervical dilatation and the trauma still require some additional information.
The actual procedures of doing an internal podalic version, which is doing a somersault with the baby inside, causes a certain amount of trauma. How much detail do you want me to go into at this point?
Q. That is fine, Doctor.
A. OK. When you are doing the internal podalic version, and I have done many of those on the second twin over my 28 years of practice, and it is a very physical, forceful event, you are literally making the fetus do somersaults in a confined space and then extracting them. Twins will sometimes deliver at 30

weeks or something so you can do it in that range. Here we are talking about 23 or 24 weeks, so it is a smaller fetus. But the uterus is also smaller, too. I am not saying that the risk is exactly the same, but it is certainly similar.

One of the most respected textbooks in obstetrics and gynecology, Williams textbook of obstetrics, says that there are few, if any, indications for internal podalic version, turning the head, other than for the second twin. In various editions of that textbook they even go so far as to say the most common cause of uterine rupture from trauma is the podalic version.

Once you accomplish the podalic version, you are then basically doing a breech extraction, and I have done a significant number of those in my practice. We do fewer of them now because, as the thickening changes, we do more Cesarean sections now. But in the actual process of a breech extraction, you are grabbing the legs and twisting and turning the body. Depending on the amount the cervix is translate dilated, you may actually be doing some trauma to the TPAETS with the pelvis, the object do men, even with the shoulders trying to twist and turn to get both arms out. So those are all potentially mechanical trauma to the cervix.

Is there strong evidence on that? We don't have the data. It just raises those questions and concerns, because we don't feel the patient should need to undergo those extra

potential risks.

Then actually delivering the head. If the head comes down and is trapped at the cervix, the way Haskell describes it, he reaches in and by feel pushes the cervix up a little bit and with his fingers tries to feel the area where he wants to insert scissors. So you are in that case doing it somewhat blindly and there is some risk of laceration to the cervix. In that area, either side of the cervix, the uterine blood supply, major blood vessels.

Some of the more recent depositions I have read, they describe, including Chasen's description, maybe they have greater cervical dilation so the head even comes out further and they have greater visibility of what they are doing. Chasen specifically describes that he has an assistant pulling on the fetus so that there may be greater visibility. Clearly if there is greater visibility of what you are doing, the fetus at that point is almost completely delivered but it is also going to be safer because you can see what you are doing. It is still possible that if you hit the skull bone of the fetus t scissors could slide to the rest or to the right and still hit a blood vessel. I am not saying that is a highly likely thing, but it is a possibility.

So these are just things that are different between the D&E and the D&X.

Q. Doctor, are you aware that the plaintiffs in this case are

claiming that D&X is safer than D&E because it involves fewer passes of instruments through the uterus?
A. I am.
Q. Assuming that is true, in other words, assuming that D&X involves fewer passes of instruments through the uterus than D&E, do fewer instrument passes mean that D&X is safer than D&E?
A. Of and by itself, I think this is a little overstated in that I think it is a little too simplistic.
THE COURT: Sorry. Could I have that answer again?
A. In and of itself, I think --
Q. Doctor?
THE COURT: I was just asking the reporter to repeat it.
(Answer read)
THE COURT: Next question.
Q. Could you elaborate what you mean by it is too simplistic?
A. It is not just the number of passes. If you are doing it with ultrasound guidance and you see Haskell says you directly see when you go reaching in to grab a leg or something, you can see it. You can do the same thing in D&E where you are specifically seeing the parts you are grabbing. [> check<] if you can see the instruments in the uterus with the ultrasound and whether you grab the leg once, twice, or three times, you can see what you are doing, the number itself doesn't really

increase the risk. If you can't see what you are doing and you don't know where things are, then theoretically there is a greater risk. P.m. I would use the argument that when we do D&C's or other similar procedures for abnormal bleeding we use multiple passes of instruments like curettes and we don't normally count the number of instruments we are putting in or the number of times we are, because that is not what is considered the risk. As long as you can feel and see kind of where you are going. You just want to make sure you are accomplishing your KPWOEL, in the case of abnormal bleeding, removing flips, or fibroids. But woe don't count the number of times we do it. It is not one to one. That is just a little too simplistic way of looking at it.
(Continued on next page) 4/14/04 Judge Casey take 2 direct of male doctor.
BY MS. WOLSTEIN:
Q. And when you use a curette, as you referred to just a minute ago in and out of the uterus, can you take steps to assure that passing that instrument through the uterus is done safely?
A. In a -- yes N a large part by the experience of the individual, if you know the angles of the uterus and you are pulling down and you know where the cavity is, it is a very safe procedure.
You would have to actually obviously not realize where you are to pierce the wall of the uterus and the

recommendations for D&E are to do it under ultrasound guidance and there has been a reported study that going from not doing it with ultrasound guidance to doing it with ultrasound guidance, you can lower the risk of perforation to the uterus 1.4 percent to .2 percent.

So, there are other ways to try to make it safer and effective that are available in the literature that are book chapters say that.

THE COURT: Doctor, what is a curette.

THE WITNESS: It's kind AEUF rounded instrument.

When I kind of explain it to the residents it is rounded and blunt so there is not a lot of risk of perforating the uterus but it's also on the edges, it's sharp.

So what I kind of tell them is to kind of think you are shaving in the morning. Know exactly where the wall of the uterus is in your face and stay perpendicular to it and shave off the tissue.

The reason is relatively safe but because it is round and curved, if you did hit the wall you are hitting it with a broader area.

Concerns for most of the perforations are real small instruments, initially we sound uterus aa smaller device to tell us how long it is. That is a greater risk than the rounded cure yet because it is small you could pierce the wall easier.

So it is broad enough that it is relatively safe but yet the edges are sharp but you are using those perpendicular to the lining to remove tissue or polyps or if you are doing a D&E if there is placental tissue left, you can use that to scrape off the wall of the tissue you want removed.

THE COURT: Next question.

Q. Doctor, are you aware that the plaintiffs in this case are claiming that D&X is safer than D&E because it reduces the number of bony parts passing through the uterus and cervix?

A. I am.

Q. And assuming that that's true for the moment, does the reduction in the number of bony parts passing through the uterus provide any safety advantages to D&X over D&E?

A. My belief, and again I have done D&Es, it's a very, very three O receiptic possibility. I am not aware of any article in the literature that ever says serve call trauma from a bony part.

If you think about the fetus an depending how far along, it is relatively still soft cartilage.

If you, in a major portion of a D&E is you are twisting and turning and breaking off parts. If you grab an extremity and twist and turn the most likely place it is going to break off would be at a joint or something which is smoother anyway and when you do break it off there is still going to be soft tissue surrounding it.

And so I think that's a minimal risk, and again, I am not aware of any article or any evidence that bony parts damage the cervix.
Q. Doctor, does the fact that some abortion providers who perform D&X believe that it has safety advantages over D&E affect your opinion concerning the safety and the risk of D&X?
A. I think you have to be fair-minded and try to take into account their arguments and stuff. But as I have said when I look at the things they are saying, they seem to be overstated and there is no data that I am aware of, other than the Chasen study, which I am sure we will talk about later and I have a lot of questions and concerns about that study.
Q. Doctor, is there any physio logic reason that the placenta should come out spontaneously and intact with a D&X more so than with a D&E?
A. There is no physio logic basis in which I could explain that.
If in the D&E you are scraping off parts of the placenta then are you going to break it off that way but the reality is you need to move the placenta one way or the other and unless you are using other things to contract the uterus, whether it is petocin and PROS TA TKPWHRAPBZ din and you can do that either then the uterus may be able to push out the placenta but I am not aware of a fizz why logic that one would work better than the other.

Q. Doctor, you mentioned the study by the plaintiff, Dr. Chasen in this case, are you familiar with that study?
A. Yes, ma'am, I am.
Q. Could you turn to tab 23A in your binder, near the beginning?
A. Yes.
Q. Do you recognize tab 23A, Plaintiff's Exhibit 23A?
A. Yes, I do.
Q. What is that?
A. It is the article by Stephen Chasen, etal, on dilatation and evacuation at or greater than 20 weeks comparison of operative techniques.
Q. That's the article you are familiar with?
A. Correct.
Q. What is your understanding of what outcomes the authors were studying in that article?
A. What they say is the object of the study is to compare the relative safety two of techniques for surgical abortion, namely D&E, and D&X.
Q. And does the Chasen study change your opinion that D&X does not offer safety advantages over D&E?
A. It does not change my opinion.
Q. I am going to ask you why it doesn't and if there is more of a reason you can just identify the reason and we will go back to that.

A. When you look at the study, initially I do think there is method logical flaws. I do think the number of cases that they have are small enough that it is really difficult to come to significant statistically significant conclusions.

They did end up with 383 patients that they said met their inclusion criteria, they don't really say what their inclusion criteria were.

They had 120 cases of intact D&X and 263 in intact D&E.

Their descriptions of how the patients they put in the one arm of the study or the other arm of the study are somewhat difficult to interpret and I would say not consistent with a general definitions by both Haskell and by ACOG of the definition of intact D&X.

Their descriptions remind me more of the descriptions that are in the law than, what is published in the medical community.

Their criteria for complications seem somewhat vague and they chose to just use any event that was unanticipated,.

Again, people can set their criteria but that's kind of more difficult criteria to recognize.

They then compared the numbers and came to conclusions and my interpretation of the data they present, I would not come to those conclusions.

Q. Okay, let me stop you so we can back up.

A. Yes.

Q. Why is it -- you stated that the study lacks power and the numbers are small, what do you mean by that or why is it significant to the study?

A. In a given study, and it is a retrospective study looking at charts and in relationship to that in reading his deposition it was kind of what struck me as a little odd, the study went to June '03 and he started the study in March of '03, so it just seemed a little odd to continue to add cases for another three months after you already knew you were doing a study and you were going to look back at that data.

It certainly doesn't prove anything but if you continue to add another three months of cases to the study, that could influence which arm of the study the patient is you put it in and could influence the data as well, so it was just another concern I had.

Q. And as to the small numbers and the lack of power, could you elaborate on the SEUG KARPBS of that?

A. Depending on the frequency of complications, you need a certain number of patients in each arm of a study for the likelihood of getting statistically significant difference.

Now we are really talking about a lot of statistics in many hospitals and universities have actually statisticians that will give you the formulas for how many patients you would need in each arm to pick up a statistically significant

difference for given complications. And they didn't have adequate numbers, that's why in their study they say they didn't have enough power, they couldn't really divide out various gestational weeks, they had to kind of KHRUFRP it to together and that's a shortcoming.
Q. You mentioned that the description or definition of what is an intact procedure in the study differs from other accounts of the, what the procedure consisted of, could you elab rate on what you are talking about?
A. Again, the initial descriptions were from HA*GS cell, from ACOG, and there are other experts who, in their depositions, kind of described things similar to that.
This, the description, at least when I read it, seems more similar to the description that's in the law.
THE COURT: Which law are you referring to, Doctor?
A. To the current ban on intact D&X.
THE COURT: The one Congress passed in November?
THE WITNESS: Correct, sir.
Q. Well, what is the definition in the article of what constituted and intact procedure?
A. They used intact even if the fetus delivered to the um bill like us intact. Obviously most of the other descriptions go to the head.
The other ones talk more about breech and stopping at the neck.

They also talk about vertex deliveries and those are more things that are talked about in the law rather than in the other descriptions.
Q. And are there other ways that the study decided to group one group of patients in the intact versus in the dismemberment group other than this definition you referred to?
A. They looked back at operative report but what I found interesting too is they also looked back at pathology reports and just from the amount of intactness of a fetus sometimes use that to put it into one or the other, so that just seems like kind of another more unusual way of deciding which arm of the STAOUDy you are putting it in, which is a very significant factor and what the outcome, if you are going to try to compare complications in two arms, in a very good criteria for putting in one arm of the study or the other.
Q. Is it the case that the pathology report doesn't tell you whether it's an intact or a dismemberment procedure?
A. In the operating room would probably tell you more than just looking at the pathology report.
It did seem like in their descriptions a number of the patients that were put into the intact D&X arm were patients who actually maybe more came in in labor. In fact, one of the patients that were in their D&X arm was completely dilated. They were 10 centimeters dilated.
It would have seemed if they had just waited a short

period of time that fetus would have just delivered spontaneously.

So, it was kind of they were putting people in the one arm where you are not going to get complications or cervical trauma because the cervix is already completely dilated.

Q. And you mentioned earlier that the conclusions you might draw from the data would be different than the conclusions the study draws; could you explain what you are talking about?

A. Again, when you look at it because the numbers were so small it's hard to draw meaningful conclusions and they conclude that the outcomes appear similar between the patients undergoing D&E and D&X. They did not say superior, they just said similar.

But as I look at a thing that I find very important, the subsequent outcome, and again the numbers there were very, very small and I believe there were only -- I am going to look for the numbers here -- there are a total of 62 subsequent pregnancies and it's another flaw because they were only able to look at those patients who later delivered in their hospital. The majority of patients they did these procedures on went elsewhere.

So, this is just a small selected group of that overall study in 62 pregnancys in a very small number. And in fact they only ended up with 17 pregnancies in the D&X group in 45 in the D&E evaluation.

Although the numbers are small, they said in the intact D&X there was an 11.8 percent premature labor and delivery. In the D&E there was a 4.4 premature labor and delivery. That's almost a 3 to 1 ratio making the D&E look better.

Now, none of that is statistically significant because the numbers are so small so the trend, if I looked at this as I would say the trend would say that D&E was safer and but to be able to say that scientifically you would have to have many, much bigger study, much more numbers, and if anything that would just tell me do a much bigger study TPWR you could actually come to a conclusion.

But the trend is that D&E was better.

If you look at some of the other complications, cervical and genital tract trauma, which to me is a very significant thing because part of why I am saying why I am worried about D&X is you are delivering the fetus intact, potentially more likely to traumatized cervix and genital tract.

If you look at those numbers specifically and I am kinding doing this from memory, the general tract lacerations, cervix andgen are a tract were about 3.3 percent for D&X and I believe only one and a half percent for D&E.

So, again, it would make it look like what I had said before about increased risk of cervical and vaginal trauma,

this data, the trend would say that there was more trauma in the D&X patients.
So, rather than saying they're similar or saying D&E is in any way superior, I would say the trends of the data actually show that D&E is superior.
These are small numbers, it's not statistically significant. You could not present that and say that is a valid scientific fact but the trend goes that way.
So I would say to kind of not say that and then just say they're similar and to move on from that raises some questions.
Q. And would looking at the, speaking about --
THE COURT: Ms. Wolstein, is this a convenient time to take the morning break?
MS. WOLSTEIN: Yes, your Honor, it is a convenient time.
THE COURT: It is?
MS. WOLSTEIN: Yes.
THE COURT: We will take the morning recess.
(recess).
THE COURT: Ms. Wolstein, you may inquire.
MS. WOLSTEIN: Thank you, your Honor.
Q. Doctor, before the break you mentioned that in regard to the cervical trauma data in the article you were testifying from memory about some percentages. Do you remember that?

A. Correct.
Q. What percentages were you talking about?
A. When I looked at their list of complications they specifically had genital tract lacerations, cervical lacerations and labial lacerations for both D&X and D&E.
What I took was the numbers of cervical lacerations over the number of cases in that category and actually came up with a percent.
Q. Was the percent in the study itself?
A. The percent is not in the study itself. It was taking their numbers, it was a mathematical computation.
Q. And so what did your percentages indicate to you about the complications in the two groups?
A. If you looked TAT from the point of view genital tract lacerations, D&X versus intact D&X procedures had 3.3 percent incidence of genital tract lacerations; D&E had 1. 5 percent.
If you looked at cervical lacerations I believe the numbers were like 2.4 percent cervical lacerations for D&X and .8 percent cervical lacerations for D&E, which is about a 3 to 1 ratio with D&X having more lacerations.
Now those are small numbers and the most you could say from that is the trend, if anything, would say that D&X causes more cervical and genital tract lacerations but the numbers are so small that you couldn't say that scientifically valid or statistically significant.

Just because the trend is the opposite and would you want that maybe in subsequent studies it would be looked at further, but I just don't think it's appropriate to then say that they're similar or that in any way obviously D&X is superior because I think it tends to show that D&X has the potential to cause more trauma to the cervix.
Q. And, again, those were percentages that you yourself derived are based on numbers in the study, is that right?
A. Correct. Correct.
Q. The percentages were not in the study?
A. Correct.
THE COURT: Do you consider that a fault not to put those percentages in for the reader?
THE WITNESS: Probably what they did, and I think even in his declaration they kind of asked him why didn't he break down the data more, why didn't he look at some of those things and look at gestational age and his answer was somewhat legitimate, the numbers are so small, as you break them down like that you can't really say it is statistically significant because the overall numbers in the study are small.
But because it was directly related to our concerns about cervical trauma, I think at least mentioning the trend made some sense.
THE COURT: Is the number so small to render the report or the study useless? Or just as to the weight it

should be given?
THE WITNESS: Clearly to the weight, and I think it's very difficult to really put much interpretation and much weight on it because the numbers are so small and I believe that's why they just kind of just said similar and at best maybe it calls attention that obviously we need more studies in this area if we are really going to say the thing is scientifically valid.
THE COURT: Going back to one thing before I forget.
You mentioned that it's a retrospective but that they added these three months on, does that distort things when you do that?
THE WITNESS: It looks unusual to me as a reviewer for this journal, and it certainly, I'm not trying to intimate that something was specifically done, if just gives the appearance that it could have been that when you are adding another three months of cases after you start the study, even subjectively without consciously thinking of it, does it somehow affect which arm of the study some patients get put in.
It is just an unusual way to look at it.
THE COURT: Ms. Wolstein, you may inquire.
MS. WOLSTEIN: Thank you, your Honor. Wolstein.
Q. Doctor, when you were earlier talking about the study before the break you referred to the data showing a trend in premature labor and delivery. Do you remember that?

A. Correct.
Q. How does premature labor and delivery relate to preterm birth?
A. They are the same thing. I think those are just two ways of describing premature labor and delivery is a preterm birth. By definition 37 weeks is term so if you deliver prior to that it's a pre-term birth.
Q. Doctor, did the study by Dr. Chasen show data on blood loss in the two groups intact versus dismemberment?
A. It did.
Q. What was the data on blood loss?
A. The means for both of those procedures were very -- the mean blood loss was very similar.
Q. And did the study provide data on the procedure time in both groups, intact and dismemberment?
A. It did.
Q. What was the data on procedure time?
A. Again, the procedure time, the meantime was very similar.
Q. Doctor, turning back to the subject of ethics of the D&X procedure, what aspects of the D&X procedure raised ethical concerns?
A. Specifically for that procedure the two most obvious aspects are both the timing in which it is done as was, as was said in Mr. Haskell said in his report, it is typically used in the 20 to 26 week gestational week time frame. Many

authorities, including American Academy of pediatrics would put the limit of viability at this point in time at 23 weeks in recognizing, as medical science improves that is expected to go down.

So the fact that that is kind of midrange of when this there is more likelihood of fetal viability of being the issue and that's part of the ethics of it.
Q. What's the second issue you alludeed to?
A. The second issue is we talked about the autonomy argument that edge I sifts used when they're talking about this, a strong part of the reason for allowing it is that if the fetus is in the mother's body the mother has more control of her own body and that's a given.

In this procedure, which makes it unique is the fetus is actually being delivered so it's in the process of delivery and in some ways very similar to a, if we did a breach extraction.

As the fetus is delivered it attains more autonomy of its own and the autonomy of the mother decreations.

Obviously if it was completely delivered it would be an infant and the mother would have the relationship of being a parent and it would have a totally different relationship.

Because it's almost delivered edge I sifts would say it does have more rights, it has to be looked at more, especially if it is also viable but depending on how far along.

So among the ethical community it raises its own unique ethical questions and concerns because of that and it would certainly have concerns for me personally and other edge I sifts that I have spoken with have concerns on it and in fact when the AMA board of trustees looked at it and came to the conclusion they did, they did say a large part of it was because of the ethical concerns of this procedure.
Q. How does the process of delivery in a D&X compare to the process of delivery in a live birth at term?
A. It would very much be the same as if you are delivering a second twin and you had to do an internal podalic version and then bring down the legs, the body, bring out the shoulders, and then we would deliver the head through obstetrical techniques of trying to flex the head so it comes out easier.
So very much so, it's just their, where it stops is they stop just before there is complete delivery of the head and then pierce the skull and remove the intercranial contents so very similar to that point. The same.
Q. And on the viable issue, is the ethical concern also raised by an induction or D&E done at 23 weeks?
A. If you look at just the viability issue, yes, that's a criteria.
But because in this case we are looking at both the autonomy and the viability and the position, less so, but I can't say that it's not a factor.

Q. So, what is it that makes D&X special in terms of the ethical concern that the viability concerns at present with D&E and induction at 23 weeks?
A. The location of the fetus when it is killed in relationship to the mother.
MS. WOLSTEIN: No further questions, your Honor.
THE COURT: One question Doctor before you are crossed.
Medical edge I sifts concern themselves with whether or not in the D&X the puncture of the fetus' skull with scissors inflicts pain on the fetus?
THE WITNESS: It is a consideration in the ethical community, yes.
THE COURT: All right, you may ininquire, cross examination.
MS. CHAITEN: Thank you, your Honor. It is Stephen Chasen for the plaintiffs.Ful take one minute to allow Ms. Wolstein to move away from the podium and move over.
CROSS-EXAMINATION

BY MS. CHAITEN:
Q. Dr. Strang, you testified that the work that you did on the AMA task force on late term pregnancy techniquess contributed to your understanding of intact D&X, that is correct?
A. Correct.

Q. Another basis for your familiarity with intact D&E is some conversations you have had with a few physicians performing intact D&E, is that right?
A. Correct.
THE COURT: Excuse me, can I have that statement read, the question of (record read).
BY MS. CHAITEN:
Q. You have also referred to a paper that was presented by Dr. Martin Haas quell to the National Abortion Federation in 1992, is that right?
A. Correct.
Q. And you base your familiarity with intact D&E on declarations and depositions of physicians and the federal court case in Ohio where you testified and also in this case, is that right?
A. Correct.
THE COURT: I think he said part.
MS. CHAITEN: Excuse me?
THE COURT: I believe he testified in part, he didn't say totally.
MS. CHAITEN: I agree, your Honor. I am simply trying to refocus. I apologize.
Q. Part of your familiarity is based on those declarations and depositions, is that correct?
A. Correct.

Q. Thank you.
And you also testified that the piece you prepared for jamba helped to form the basis of your familiarity with intact D&E, is that right?
A. Correct.
Q. And when I say jamba, you understand that to be the journal of the American Medical Association?
A. Correct, yes.
Q. You are not going to make me say that every time?
A. No.
Q. Thank you.
And then of course you have also testified about this recent article by Dr. Stephen Chasen, is that right?
A. Correct.
Q. Doctor, there were 10 physicians on the AMA task force, is that right?
A. Correct.
Q. And you don't know for a fact whether any of those physicians perform intact D&E, is that right?
A. That's correct.
Q. And to the best of your recollection, none of the members of that committee ever said they performed intact D&E, correct?
A. Correct.
Q. And you never met with any physicians who performed intact D&E in order to prepare the task force report, is that right?

A. I didn't meet with any, no. I don't know if anybody else did.
Q. But you personally didn't?
A. Correct.
THE COURT: Unless they were on the committee of course?, correct?
THE WITNESS: Correct.
Q. In fact, you never met with any physicians who performed intact D&E as a part of any of the work you did for the AMA task force, is that right?
A. I -- I did tell you that I spoke with physicians who did have I and certainly any information that I gleaned from that would be used in my thought process working on the committee.
Q. But not at the time you were serving on the committee, is that correct?
A. Correct.
Q. And we will get to the conversation with those few physician in a little bit, Doctor.
THE COURT: Receipt me just interject one question.
Doctor, did you or anyone ask the members of the committee whether or not they had performed a TKPWAO*EFPL or intact D&E?
THE WITNESS: We did not.
THE COURT: Was this a prerequisite to be on the committee?

THE WITNESS: It was not to my knowledge.
THE COURT: Was the fact that you didn't do them a prerequisite to be on the committee?
THE WITNESS: It was not.
THE COURT: Next question.
Q. Doctor, you were chosen for that committee because of your involvement on the issue in support of the partial-birth abortion legislation in Illinois, is that correct?
THE COURT: Sustained.
How can he testify to that?
Q. I will move on.
Doctor, you testified earlier that you were the representative from Illinois on the task force, is that correct?
A. Correct.
Q. And Illinois had actually submitted a resolution to the AMA, is that right? A proposed resolution. I apologize?
A. Did you say to the A M A?
Q. Yes, to the A M A?
A. Yes, I did.
Q. And Pennsylvania had also submitted a proposed resolution in support of partial-birth abortion bans, is that correct?
A. Correct.
Q. And the task force included both a representative from Illinois as well as one from Pennsylvania, is that correct?

A. Correct.
Q. Doctor, getting back to your conversations with the, a few other physicians that you've talked to who performed intact D&E, two such conversations are memorable to you, is that right?
A. Correct.
Q. And with respect to those two individuals, you actually can't recall the names of either of those physicians, can you?
A. Unfortunately --
THE COURT: Not very memorable, are they?
THE WITNESS: Correct. The fact remember PWRABL, the encounters occurred at large meetings in different areas and I don't remember the names.
Q. And you can't recall the dates on which either of those conversations occurred, can you?
A. That is correct.
Q. And you don't remember where they took place?
A. As I said, at meetings and programs that I had put on in that environment. Specifically which meeting, no.
Q. Doctor, turning to the Haskell presentation in 1992, you weren't present at that conference, were you?
A. I was not.
Q. And other than to perhaps say hello in the courtroom during the Ohio litigation, you have never even met Dr. Haskell, have you?

A. Correct.
Q. You have never observed Dr. Haskell perform an abortion, is that right?
A. Correct.
Q. In fact, at this time you don't know what he is doing in his abortion practice currently, is that right?
A. Correct.
Q. And you have no first hand knowledge of whether Dr. Haskell still performs procedures as he described them in 1992, do you?
A. Correct.
Q. And of course the Haskell presentation at the 1992 NAF conference was 12 years ago, was it not?
A. Almost. It was September, so not quite.
Q. 11 and a half years ago, give me that?
A. That would be more accurate.
Q. Thank you.
You've testified that you have relied on declarations and depositions of physicians who have testified in this and the Ohio case for your understanding of intact D&E, right?
A. I said that was part of my understanding.
Q. In part, I understand.
And two of those physicians practice at Northwestern Memorial Hospital in Chicago, don't they?
A. Correct.
Q. And that would be Dr. Marilyn Frederiksen and Dr. Cassing

Hammond, is that right?
A. Correct.
Q. As to Drs. Frederiksen and Hammond, what you know about how they do abortions is based on what the residents say is going on, is that right?
A. No, that's not right.
Q. Well that's one of the ways that you know about how they do abortions, is that right?
A. It is one of the ways I know, correct.
Q. And the other is from reading their testimony?
A. Reading their depositions, correct.
Q. And no other way, right?
A. Hearing from other physicians, not just the residents, from other attending northwestern as well.
Q. As to the other physicians whose depositions and declarations you have reviewed, you have no first hand knowledge of how they perform abortions do you?
A. The first hath knowledge from their, what they say, is said under oath in their depositions.
Q. You haven't observed any of them perform an abortion, have you?
A. I have not.
Q. Doctor, it's your view that intact D&E involves the use of mechanical dilators to open the cervix before placement of laminaria, is that right?

A. Not particularly.
It is a portion in both in both the way I have seen people do it, the way I have done it and what I have reacted.
Some people in either D&E or D&X in the initial portion will mechanically dilate the cervix so that they can put additional laminaria in place. It's not essential if the cervix was more dilated in either D&E or D&X you wouldn't need mechanical dilation. It can be a part of it.
Q. And you believe an intact D&E involves dilation over a period of two days, is that right?
A. That is the description by Haskell and by different people. Some try to do it more quickly.
Q. And you also believe that an intact D&E requires at least five centimeters dilation, is that right?
A. From the reading I have done some -- some will just say they try to get the maximum amount they can.
The most common numbers I have seen in various reports and depositions is TPHAOEUFB to six. I have seen them as high as eight. And as I said in Chasen's study, he reports a patient who was 10 centimeters.
Q. Who was in premature labor, is that correct?
A. Presumably. I don't know how she got to 10 cent PHAORTS.
Q. Dr. Sprang, my PAEUP SER moving around here. Story.
Dr. Sprang, you have testified that you performed D&Es on dead fetuses up to about 15 or S-F weeks gestation and that

after that time you would perform an induction because you believe that induction is safer, is that right?
A. Correct.
Q. And in fact you feel so strongly about your preference for induction after 20 weeks that if you had a patient who had a fetal death in utero after 20 weeks, you probably wouldn't even bring up D&E when you are discussing the procedure that will be performed because you believe that induction is safer at that age, is that right?
A. Because in my institutions we do do between deal after 20 weeks, maternal fetal medicine physicians don't do that. Everybody in my institution, everybody in my institution would only do induction.
THE COURT: Would when you say your institute are you talking about north Western in enSTO*PB STPHEUFRPBLGTS correct.
Q. So you don't raise the possibility of D&E after 20 weeks, do you N. that discussion with your patient?
A. In general. I won't say that I never V I won't say that I haven't given patient options. I, as I am sitting here I I can't think of a patient who had a significant anomaly picked up on amniocentesis and indeed she was sent probably to Northwestern downtown to have a D&E.
Q. But typically you would not even raise the question of D&E, you would simply tell your patient to have an induction, is that right?

A. More -- my usual approach would be to tell them that I think this is the safest method and I usually try to do what I think is the safest for my patients.
Q. And you believe that in terms of deciding which procedure to choose the only prudent thing for an intelligent woman who trusts her doctor to do is to strongly rely on what her doctor is saying because patients don't have enough of the background to understand the nuances of the recommendations, is that right?
THE COURT: Could I have that question read, please?
(record read).
THE COURT: Would you like to rephrase that, Ms. Chaiten?
MS. CHAITEN: I will break it in part, your Honor.
THE COURT: Good thinking.
BY MS. CHAITEN:
Q. You believe that in terms of deciding which procedure to choose the only prudent thing for an intelligent woman who trusts her doctor to do is to strongly rely on what her doctor says, is that correct?
THE COURT: Don't you see the objection coming to that Ms. KHAEUT KHEUT.
By your statement, what is an intelligent woman?
MS. CHAITEN: Well, your Honor I am simply.
THE COURT: I mean, really.

MS. CHAITEN: I am using the doctor's own words, your Honor.
THE COURT: You can still ask for definition.
BY MS. CHAITEN:
Q. You don't believe that patients have enough background to understand the nuances of a medical recommendation in this context, do you?
A. I think we are looking at it in two different ways.
I am looking at it in my patient population and I am fortunate that I practice in an area where I have doctors and nurses and teachers as my patients. I have a very good rapport with my patients. I will describe things in, and try to lay it out in an open fashion and ask them what they wanted do do. And nine out of 10 times my patients will look at me and say, what would you do if it was your wife. That's the kind of relationship I have with my patients and I try to make the same decision for them as if it was my wife or my daughter.
Q. And you make that decision for them in that way, correct?
A. I tell them what I would do if it was my wife and they say of course that's what I want you to do.
Q. And would you agree the physician must retain the discretion to make judgments acting within standards of good medical practice and in the best interest of the patient, is is that correct?
A. Please repeat that? You said it so fast I didn't hear

everything you said. I want to make sure I understand it.
THE COURT: Reporter, please read the question.
(record read).
THE WITNESS: We have an obligation to act in the best interest of the patient, correct.
I'm not sure that the first part of the question -- I'm not sure I understood, maintain the discretion. I'm not sure I understood your meaning.
THE COURT: Well, Doctor, do you have an obligation as physician to make full disclosure to a patient when considering various medical procedures?
THE WITNESS: The way it is usually said is what would a reasonable physician say to a reasonable patient under those circumstances. Yes.
THE COURT: But I mean full disclosure.
THE WITNESS: There -- I think what you get to is you could say if somebody had surgery they could die from the anesthesia but that is so remote that we usually don't say that as part of it because a usual physician won't say that.
If the patient asked before that yes, we would say it.
But when some things are so remote you don't put it out there because it just, it creates unnecessary anxiety for the patient.
THE COURT: Well, does an abortionist have the obligation if they recommend D&E to explain to a woman that

this entails dismemberment, that they're going to tear a leg or an arm off the woman's fetus?
THE WITNESS: In relationship to that I think the woman should understand what is being done to the fetus and maybe give her the opportunity to then use a feet I side to make it more humane for the fetus.
THE COURT: And similarly if they do a D&X should the doctor have an obligation to explain that this involves puncturing the skull of the fetus and sucking the brain out?
THE WITNESS: I do believe the patient should know that, again for the same reason. Because I think they will TPAOEPL more comfortable that in that probably in doing it in as human a way as possible if it involved a feet I side I think they should be given that information.
And I think Lee Roy Carhart who does a large number of these says that at 15 weeks, he mentions it to all his patients, and essentially does a feet I side in all his patients at 18 weeks and he makes the comment that my patients almost always do what I suggest.
THE COURT: Next question.
BY MS. CHAITEN:
Q. Doctor, when you are performing a D&E to rePHEFB a dead fetus in the midtrimester do you tell your patient that you are going to defendant and turn the limbs and tear them off?
A. I tell them that I will have to take the fetus out and it

may come out in parts, yes.
Q. But you don't say twist and turn and tear the HREUPLSZ off, do you?
THE COURT: It's a dead fetus, right Ms. Chaiten?
MS. CHAITEN: Yes, your Honor, it is a dead fetus.
THE COURT: Yes.
Q. Do you tell your patients that?
A. I tell them especially because it is dead it will probably come out in pieces and we do have to grasp them and when we grasp and pull it will most likely come out in pieces.
Q. So you say it will come out in pieces?
A. Yes.
Q. Doctor, part of the reason you prefer induction to D&E after 20 weeks is because the as gestational age increases D&E becomes harder to do, is that right?
A. That is part of the reason, yes.
Q. And it requires more skill?
A. That is part of the reason as well.
Q. And in your view only a relatively small number of physicians in the United States have the skills to do a D&E after 20 weeks' gestation, correct?
A. Correct.
Q. But if the physician had the skills to do a D&E after 20 weeks you believe that in terms of safety D&E and induction would be comparable at that gestational age, wouldn't you?

A. No.
Q. Doctor, you testified in California last week, I think we have discussed previously, is that right?
A. Correct.
Q. It was five days ago.
Doctor, were you asked the following question and did you give the following answer:
"Q you believe that if the physician did have the skills to do a post-20 week D&E that such procedures would be as safe or safer than induction procedures in that time frame, is that right?
"A I do not believe they would be safer.
"Q do you believe they would be as safe?
"A comparable."
Is that your testimony?
A. Yes.
Can I explain it at all.
Q. I think you will have an opportunity to do that on redirect with your counsel if your counsel thinks?
A. I did say it was comparable because in general that's what the literature says.
Q. Doctor, are you not aware of any randomized trial comparing D&E with induction using misoprostol, are you?
A. You know, I am sure you are aware of the A*UT restudy but that wasn't specifically misoprostol on a regular basis, that I

am aware of.
Q. I am referring to studies that involved randomized trials comparing D&E with induction using misoprostol in the induction?
A. Correct.
Q. You are not aware of any such studies??
A. Correct.
Q. Doctor, your view as to the relative safety of D&E and induction in the period after 20 weeks' gestation is based at least in part on your intuitive knowledge, education and experience, is that right?
A. Primarily a personal experience at my hospital, yes.
Q. But it is based at least in part on your intuitive knowledge, education and experience, that's correct, isn't is it?
A. Correct.
General background, training, knowledge and experience.
Q. Doctor, in your expert report in this case you stated that one of the reasons you believe that induction is safer at 20 weeks than D&E is because it does not necessarily involve the introduction of instruments into the uterus, is that right?
A. Correct.
Q. And your preference for induction is also based on your belief that it's more imitating nature and you think that's a good thing, is that right?

A. Correct.
Q. Dr. Sprang, it's true, is it not, that there is not quantifiable information out there that would support your belief that induction is safer than D&E after 20 weeks, is that right?
A. Correct.
Q. And there is no real hard data that says that?
A. Most of the data says they're comparable.
Q. And in part your view is to the relative safety of D&E and induction after 20 weeks' gestation is based on the experience at your hospital because they only do inductions at that gestational age and you respect maternal fetal medicine physicians there, is that correct?
A. Correct.
Q. You are not a maternal fetal medicine specialist are you, Doctor?
A. I do not have a subspecialty in that but before that subspecialty existed I was one one of the maternal fetal medicine physicians at *EFP STO*PB hospital hospital.
When they first started when they only had one when that maternal feed at medicine physician was on vacation I served asthma term fetal medicine physician for Evans hospital hospital.
Q. You have never been a fellow in maternal feet add medicine, are you.

Q. And are you not certified adds maternal fetal medicine specialist, are you?
A. Correct.
Q. But you do work with a lot of maternal fetal medicine specialists at Evans hospital, don't you?
A. Correct.
Q. And you are influenced by the fact that those maternal fetal medicine specialist do not perform D&Es after 20 weeks, is that right?
A. If does have an influence on me.
Q. You are aware, are you not, that your maternal fetal medicine colleagues at Evans hospital regularly refer patients to Dr. Cassing Hammond for D&Es after 20 weeks' gestation?
A. I am aware of that.
Q. In fact, the coauthor of your jama article, Dr. Mark near who have is a part of a practice that refers patients to Dr. Hammond for D&Es after 20 weeks?
A. He is a part of a practice. I don't know if he has ever referred anybody there. There are 12 maternal fetal medicine physicians in that practice.
Q. You don't have any reason to dispute that, do you?
A. Knowing him I would find it less likely that he would.
Q. That he personally would?
A. Correct.
Q. But I'm asking you whether you have any reason to dispute

that his practice regularly refers patients to --
A. We've already established that I think. I I agreed to that when you said it earlier.
Q. Doctor I'm going to be.
Q. I need to finish my question if we talk over each other?
THE COURT: Ms. Chaiten, don't pull that again. You will wait until an answer is complete and then you will ask it.
You don't talk over a witness. It's for you to wait.
Is that clear? KHRFRPBLGTS that's clear, your Honor I was SEUPLfully trying to finish my question.
THE COURT: Is it clear.
MS. CHAITEN: It is clear, your Honor.
THE COURT: Good. Now you may inquire. KRFRPBLGT.
Q. And are you aware, of course, that a number of physician perform D&Es after 20 weeks' gestation at Prentice women's hospital of northwestern?
A. I'm aware of two.
Q. And that's the other major teaching hospital that's affiliated with enSTO*PB Northwestern as a part of Northwestern University medical school, is that correct?
A. Correct.
Q. Doctor, you know, don't you, that intact D&E is in fact taught at Northwestern University medical school?
A. I am aware of that.
Q. And that's the same medical school where you teach,

correct?
A. Correct.
Q. It's unlikely, is it not, that unsafe medical procedures would be taught at Northwestern University medical school, isn't it?
A. I would hope not.
Q. And you would agree that among the faculty at mother Northwestern medical school there is no consensus about the appropriateness of banning intact D&E abortions, is that right?
A. Correct.
Q. And in fact you would agree that there is a variation of opinion in the general medical community about the appropriateness of banning intact D&E, is that right?
MS. WOLSTEIN: Objection.
THE COURT: Sustained.
Q. Doctor, you believe that there is no absolute proof that D&X is less safe than D&E by dismemberment, is that right?
A. I don't believe there is enough data out there for absolute proof.
Q. I'm sorry I didn't hear you?
THE COURT: Can you keep your voice up Doctor.
MS. CHAITEN: Your Honor, can the.
THE COURT: Reporter, would you read the answer, if there is one.
(record read (TPAERPB.

Q. And you don't believe that there is an established fact that D&Xs have complications -- I'm sorry, I need to restate that. I apologize.
You don't believe that there is an established fact that D&Xs have more complications than D&Es, do you?
THE COURT: May I have that question read.

THE COURT: Do you want to reTPHRAEUZ, please?
Q. You don't believe that it has been established that D&Xs have more complications than D&Es, is that correct?
A. Correct.
Q. Doctor, it's your preference to use misoprostol for mid-trimester inductions, is that right?
A. Correct.
Q. And it's fair to say that the PROLT KOLs for misoprostol have been evolving over the past few years, is that right?
A. Correct.
Q. You haven't seen any prospective clinical studies on the use of misoprostol for induction, have you?
A. I have read various protocols and some comparisons. I don't believe they are prospective.
I do not believe they are prospective, correct.
MS. CHAITEN: Your Honor.
THE COURT: Try to keep your voice you.
THE WITNESS: Your question was on prospective,

correct?
THE COURT: Are you getting too close to the microphone, Doctor, it disTPORTS your voice.
THE WITNESS: Sewer reyour question was on prospective studies was that your question.
MS. CHAITEN: Your Honor, I would like to hear the answer back that he gave, if that's okay.
THE COURT: May we have the question and answer.
Question.
(record read.
MS. CHAITEN: STKPWHRU are you not doing any such STEUDies at Evanston hospital, are you.
THE COURT: You mean the doctor personally.
Q. Yes?
A. I am not personally doing any studies at that.
Q. And you are not aware of any studies comparing D&E with misoprostol inductions after 20 weeks or later, are you?
A. I am not.
Q. In using misoprostol in the context of inductions is an off label use, is that right?
A. Correct.
Q. Doctor you agree don't you that for some women D&E might be PREF RAPBL RABL to induction?
A. I don't know that.
Q. Your goal in doing a midtrimester procedure for a woman

whose fetus has died is to make it as humane as possible for the patient who must undergo the procedure to remove the dead fetus, is that right?
A. Correct.
Q. And for some women D&E may be more humane and others induction may be more emotionally satisfactory, is that right?
MS. WOLSTEIN: Objection.
THE COURT: Was there an objection?
MS. WOLSTEIN: Yes, your Honor.
THE COURT: Sustained.
Q. Doctor, based on your experience for some women one procedure may be more humane than the other and one may be more emotionally satisfied or comforted with a procedure than the other, is that correct?
THE COURT: Sustained. Sustained.
You should listen to your own question but go ahead. Ask the next question.
MS. CHAITEN: I will try to do that, your Honor.
Q. Doctor, prior to 18 or 19 weeks you believe a D&E is safer than induction, is that right?
A. Correct.
Q. In fact, before 20 weeks D&E has an advantage in terms of morbidity and mortality, is that right?
A. I think there is conflicting data. I think some of the comparisons which are older studies I'm not as aware of as many

newer studies with the newer techniques.
Q. But those older studies suggest that D&E has advantages in terms of morbidity TEU and more STALT, is that right?
A. Correct.
Q. Ened good.
Q. Sand are you not aware of any newer studies that change that, is that right?
A. Correct.
Q. Dr. Sprang, in your expert report you stated that one of the reasons that induction is? General the safest method of abortion after 20 weeks is because it does not necessarily involve the introduction of instruments into the out use. We talked about that before, is that right?
A. Correct.
Q. Isn't it in fact a known outcome when you do an induction procedure that statistically 15 to 20 percent of the time to complete the full removal of the products of conception one will need to use instruments to remove the placenta?
A. The numbers I would use are in the 10 to 20 percent range, that is correct.
I also in my deposition said that it is very rarely an occurrence in my hands and I do think it depends on whether you give another dose of the misoprostol or PROS continue and you more likely spontaneously expel the placenta. And sometimes in my hands I can just tease it out with my TPEUPBGSers so I don't

need to use instruments but sometimes instruments are used.
But in a D&E they're always used.
Q. Doctor, you did testify in your deposition that 15 -- statistically 15 to 20 percent of the time one has to use instruments to remove the placenta following an induction in the midtrimester, is that right?
A. It's an average number out there in the literature, yes.
Q. And the risks involved in doing so are the risks of a D&E, is that right?
A. I would not say the same because first of all the fetus is already out so you need to remove much less. Most of the time we just use a cure yet and scrape it out so I wouldn't say it is exactly the same as if you are doing a full D&E.
Q. Excuse me for one second, I need to grab your deposition.
Doctor, you were deposed in this case on I believe February 11th, is that right?
A. I'm not sure of the date but that sounds about right.
Q. You were at a hotel in *EFPBSton, is that right?
A. Correct.
Q. And you were asked the following questions and you gave the following answer, is that right? Let me read it:
THE COURT: Until he hears it he can't say is that right. KRFRPBLGT that's why I suggested that I read it, your Honor:
"Q are there risks involved in that procedure, the

procedure of using instruments to remove the placenta?
"A now wore' getting into obvious lip the risk of a D&E and the risk of infection, bleeding, damaging the uterus, perforation of the uterus by putting instruments in."
Is that the answer that you gave?
A. That is the answer.
Q. So the risks would include the risk of infection, bleeding, damaging the uterus, perforation of the uterus by putting instruments in, is that right?
MS. WOLSTEIN: Objection to the form.
THE COURT: Sustained.
Q. Doctor, you believe that the risks of a D&E include infection, is that right?
A. Correct.
Q. And bleeding?
A. Correct.
Q. Damaging the uterus?
A. Correct.
Q. Perforation of the uterus by putting instrument in?
A. A very small risk.
Q. And you believe that utero perforation is in fact one of the most common serious complications of D&Es, is that right?
A. Different studies would say different things.
Some would say infections, some would say scar tissue. The average risks that are quoted for perforation are anywhere

from .2 percent to 1.4 percent with the .2 percent being the more common risk if ultrasound is used, so that's a very low incidence of that application.
Q. But Doctor, your testimony has been that uterine perforation is one of the most common serious complications of D&E, right?
A. As I comment, serious, because it has more risk than some of the, if you had hemorrhage that you could control readily would not be as serious.
Q. So that would be yes?
A. I will say yes.
Q. And if you are going to perform a D&E and remove a dead fetus you tell your patient that there is risk of uterine perforation, don't you?
A. I tell them that's a remote risk.
Q. But you would tell them about it?
A. Correct.
Q. You wouldn't necessarily use an ultrasound for that procedure, would you?
A. More commonly I would.
Q. You don't always use an ultrasound, do you?
A. More recently, yes.
In the past, not always. No.
Q. Doctor, you don't tell your patients before you perform an induction to remove a dead fetus in the second trimester that

there is a risk that the placenta will be retained and that you may have to use instruments to remove the placenta, do you?
A. Because in my hands it's happened only once it's not something that I would routinely concern them with.
Q. So you don't tell them about that statistical Rick, do you?
A. I have on occasion. I'm not sure I do it every time, no.
Q. You generally wait to see if it happens and then you get their consent for whatever steps are necessary, is that right?
A. In general, that's correct.
Q. You've testified, and I think you might have said it in your expert report, that you don't believe retained will a SEPB TA is a complication of induction, is that right?
A. When 10 to to percent of the time it happens it is certainly a common part of it. I will say different individuals would consider it a complication. I don't.
Q. Doctor, you testified that you have had some success with adding an extra prostaglandin suppository during an induction procedure after the fetus has delivered in order to help to expel the placenta from the uterus, is that correct?
A. Correct. That's how I was taught.
Q. And you used this technique based on your skill and experience as a physician who has practiced obstetrics and gynecology for many years, is that right?
A. And that's what I was taught as a resident so I always have done it.

Q. And it makes sense to do that, right?
A. Correct.
Q. Doctor, there are no randomized studies concerning the safety of using that extra prostaglandin suppository once the fetus has delivered, are there?
A. Not that I'm aware of.
Q. No peer-reviewed articles?
A. Not that I'm aware of.
Q. Doctor, in all aspects of medicine there are constant efforts by practitioners to revise and improve techniques, is that right?
A. Correct.
Q. And you are always trying to improve what you are doing, right?
A. Correct.
Q. Doctor, what are the complications of indeduction is uterine rupture, is that right?
A. Correct.
Q. Because any time you increase the strength of uterine contraction there is a risk of uterine rupture, is that right?
A. It can happen but I have never had that happen.
THE COURT: Ms. Chaiten, it is now 12:30. Do you have a bit more to go?
MS. CHAITEN: I do, your Honor.
THE COURT: Okay, we will take our luncheon recess and

reconvene at 2:00.
(luncheon recess).
PARPB continued on next page) TWM 4/14/04.
AFTERNOON SESSION
2:00 p.m.
M. LEROY SPRANG, resumed.
THE COURT: Good afternoon. Ms. Chaiten, you may inquire.
MS. CHAITEN: Thank you, your Honor.
Cross-examination (continued)
BY MS. CHAITEN:
Q. Good afternoon, Dr. Sprang.
A. Good afternoon.
Q. Their, there is an increased risk of uterine rupture when using prostaglandins in an induction procedure for a woman who had had a prior uterine surgery, is that correct?
A. It depends on the type of prior uterine surgery.
Q. Doctor, at your deposition you testified to the following question:
"Q. Are there any contraindications for the use of prostaglandin?
"A. The major concerns, and this is a relatively recently recognized concern, is if there is previous uterine surgery, if the patient had a previous Cesarean section, the concern is because you are causing stronger contractions, is there a

greater risk of uterine rupture."
Was that your testimony?
A. Specifically I said Cesarean section.
Q. Doctor, preterm labor is distinct from cervical incompetence, is that correct?
A. It could be on a sliding scale, if you have a certain amount of damage to the cervix, the dilatation may occur in midtrimester or it may occur later depending on the amount of damage to the cervix.
Q. But they are not the same thing, correct?
A. They occur in different trimesters, correct.
Q. And there are multiple reasons for preterm birth, correct?
A. Yes.
Q. So it is favorites that a woman could have preterm birth without having cervical incompetence, is that right?
A. Correct.
Q. The majority of the times that you are aware of incompetence of the cervix, there has been some kind of cervical trauma, is that right?
A. Correct.
Q. There has been some damage to the cervix that has weakened it?
A. Correct.
Q. That could happen, for example, from a procedure knowns HRAO*EP, is that right?

A. Correct.
Q. HRAO*EP stands for loop electrocardy OEU O*EU --
THE COURT: Could you ask that again? The doctor caught up with you but the reporter didn't. We will have to clear up this record. Would you ask the question again.
Q. Doctor, why don't you use what HRAO*EP stands TPOFPLTS?
A. It is a large electrical incision and procedure, large loop electrical incision procedure, HRAO*EP.
Q. Doctor, a HRAO*EP procedure is a procedure in which abnormal cervical cells are removed, is that right?
A. Correct. [> check that answer<]
Q. Doctor beings when you are removing a dead fetus in the first trimester, you may use metal dilators, is that right?
A. Yes.
Q. In those cases you actually may use metal dilators to dilate the cervix to as much as 10 millimeters, is that right?
A. Correct.
Q. For second trimester procedures, you use misoprostol, correct?
A. Correct, and laminaria.
Q. Misoprostol is your primary drug for that gestational age range, is that right?
A. Exactly what range are you talking about?
Q. In the midtrimester. I'm sorry. I was carrying forward from the previous question.

A. Yes.
Q. Doctor, you testified that you also used laminaria in the midtrimester, correct?
A. Correct.
Q. In some cases you will place the laminaria the day before you administer the misoprostol and allow the patient to go home, is that right?
A. With laminaria, yes. With the misoprostol, no.
Q. My question was that you will place the laminaria the day before you give the misoprostol and allow the patient to go home after the laminaria is placed, is that correct?
A. Correct.
Q. The next day the patient returns to the hospital, and that is when you administer the misoprostol?
A. Correct.
Q. You sometimes use mechanical dilators prior to inserting laminaria in order to make enough space to place the laminaria, is that right?
A. Correct.
Q. When you insert the laminaria, you put in as many as you can reasonably fit, depending on the size of the cervix when you start out, is that right?
A. Can reasonably fit is an important part of that question, yes.
Q. So that is yes, then?

A. Yes.
Q. You have to take each patient as she comes and decide at the point of inserting the laminaria how many you can reasonably put in, is that right?
A. Correct.
Q. You agree that every woman's cervix varies and there is going to be variation in how women respond to laminaria, right?
A. Correct.
Q. Doctor, you may have supervised a resident placing serial laminaria, and by that I mean that the patient has laminaria inserted, goes home, comes back the next day, and has additional laminaria inserted, is that right?
A. Correct.
Q. But aside from possibly assisting a resident, you have never personally done serial laminaria, is that correct?
A. I don't recall any occasions when I had to do that.
Q. Some of your partners do serial laminaria, though, right?
A. Correct.
Q. The purpose of serial laminaria is to get greater dilation than can be achieved with a single set, is that right ?
A. Correct.
Q. The risks of laminaria, I believe you testified, are infection and trauma to the cervix, is that right?
A. Correct.
Q. Those risks are present when there is a single insertion of

lambiar in a, right?
A. Correct.
Q. You can reduce the risks of infection from laminaria with prophylactic antibiotics, is that right?
A. To some extent.
Q. Do you always give antibiotics the to patients from the time you insert laminaria?
A. I would, yes.
Q. In every case?
A. Correct.
Q. Doctor, the risks associated with the use of laminaria for dilation before an induction are the same as those associated with the use of laminaria before a dilation and evacuation procedure, is that correct?
A. Yes and no, because you are often with a D&E you are using more laminaria and in some physicians bill use it on more occasionts. The more times you use it t more risk of trauma, more risk of trauma to the cervix. The longer the laminaria are in, the greater the risk.
Q. But that is dependent on how much laminaria you use, right, not the procedure?
A. The procedure in a way, because depending on how many, if you are force to go the maximum amount, and some people would tend to do that, if you traumatize the cervical tissue more, there is a greater risk of infection.

Q. Do you force to the maximum amount?
A. I do not, but I have certainly heard that done.
Q. Do the risks associated with the use of laminaria, in your view, \exist\exits regardless of whether the fetus is alive or dead?
A. Correct.
Q. Doctor, you believe, do you not, that there is some feeling recently that the more gently dilation is done t more it is done by sea we did and the more gradual the dilation, it does not pose the same risk as if they are forcing the cervix open, is that right?
MS. WOLSTEIN: Objection.
THE COURT: Is there an objection?
MS. WOLSTEIN: Objection as to form.
THE COURT: Sustained. [> check the question<]
Q. Doctor, do you agree that the more gently one dilates, the less risk from the use of laminaria?
A. The more gradual and gentle, yes. But I don't think it has been established how much risk there is for just the normal dilation there is of laminaria. I believe it is an open question at this point.
Q. I apologize. I just could not hear your answer.
THE COURT: Try and keep your voice up, please, Doctor, if you would.
A. Yes, sir. Would you repeat the question?

THE COURT: Mr. Reporter, would you read the answer back.
(Answer read)
Q. Doctor, it is fair to say, is it not, that the causes of cervical incompetence have been studied but are not well understood?
A. I think that is a fair question -- a fair --
THE COURT: How can he possibly --
A. It is a fair statement.
Q. Doctor, you have testified that you believe a second trimester induction procedure to remove a dead fetus using misoprostol can take as little as 4 to 6 hours, haven't you?
A. Correct.
Q. Are you aware of any randomized controlled studies looking at whether completion of an induction abortion within 4 hours could lead to cervical incompetence?
A. I am not.
Q. You don't know of any studies looking at the effect of laminaria dilation during the second trimester on cervical incompetence, do you?
A. I know of studies where they have used multiple things, but laminaria alone, no.
Q. And there are no studies looking at the effect of laminaria and misoprostol use together on cervical incompetence, are there?

A. Not that I am aware of.
Q. Doctor Sprang, you believe at this point that we don't have enough facts to know whether there is a link between the use of osmotic dilators and cervical incompetence, isn't that right?
A. I think the information on cervical dilatation would lead one more to think that there is than there isn't, but I don't think there is absolute information.
Q. So we just don't know, right?
A. We don't know definitively.
Q. Doctor, at the time of your deposition, your belief was that it was clearly evident by most of the information that we have that mechanical dilation is more likely to traumatize the cervix, was it not?
A. We have more information on that, yes.
Q. Doctor, you testified this morning about the report prepared by the American Medical Association task force on which you served. Do you remember that?
A. Yes, I do.
Q. You are aware, are you not, that the report concludes that cervical incompetence and KPROPLZd subsequent pregnancies are important but unresolved concerns related to abortions performed in the second trimester, is that right? [> unresolved<]
A. Correct.
Q. The report also concludes that, unfortunately, there is

little research on whether these complications are more likely to result from D&E or intact D&X or from labor induction techniques, is that right?
A. That is correct.
Q. Doctor, you have never had a patient experience infection associated with the use of laminaria, have you?
A. Correct.
Q. And you have never treated a woman who had laminaria that resulted in ruptured membranes, have you?
A. Not to my recollection, no.
THE COURT: Could I have that answer again?
(Answer read)
Q. Doctor, you have never personally caused intrauterine fetal demise by an injection of digoxin or KCl, have you?
A. Correct.
Q. In fact, you have never personally caused intrauterine fetal demise by an injection of any sort of feticidal agent, have you?
A. Correct.
Q. And you have never caused fetal demise by cutting the umbilical cord, have you?
A. In that one case I talked about, I am sure I cut the um Billy cal cord when I suctioned on the the TPRAUTS in the AO*URTS.
Q. But you have never etc. etc. prior to initiating an

abortion procedure -- I'm sorry. Let me stay that again. You have never intentionally caused fetal demise during the course of performing an abortion procedure other than in that one situation?
A. Correct S-
Q. Doctor, your expert report says that demise might not occur for 10 to 15 minutes after the cord is cut, is that right?
A. It is an approximation. I would say in 5 to 10 minute range.
Q. So somewhere from 5 to 15 minutes maybe, is that where you are on this now?
A. Correct.
Q. Would the physician then typically wait for fetal demise before carrying through with the D&E if he or she was using cutting the cord as a way to effect fetal demise?
A. No.
Q. If the physician wanted to ensure that fetal demise occurred before he or she began to remove the fetus, either in parts or by performing an intact procedure, what would the woman be doing after the cord had been cut?
A. There would be no reason to do that, because cutting thed cord is the act that would kill the fetus. Depending on however along gestational age, the total blood supply in the fetus at 14 weeks or 18 weeks, even at 22 weeks, is relatively small. It would not take much of a blood loss, a few ounces,

where there wouldn't be enough blood circulate in the fetus for the heart to be carrying any oxygen to the brain, and the fetus would very quickly die.
Q. Within 5 to 15 minutes, correct -FRPLTS the procedure that caused that death would be cutting the cord, that would have already been accomplished, and there is no reason to wait. You would just move on with the remainder of the procedure.
Q. Doctor, you testified that there is a new policy just in the last few weeks at Evanston Hospital regarding the use of KC KCl to effect fetal demise, is that correct KREUFRPBLGTS.
Q. You PWHRAOEUPL that poll cise I to use KCl to effect fetal demise before second trimester abortions?
A. Correct.
Q. That is done by maternal fetal medicine specialists at Evanston Hospital?
A. Correct.
Q. You are not sure, Dr. Sprang, whether this new policy applies to both inductions and D&E's, is that right?
A. What I was told by the division head of maternal fetal medicine is that the division members met, they have decided that they will use po TASiam chloride injections in all D&E's prior to 15 weeks. They are still looking at medical inductions and considering doing them in all medical inductions 22 weeks and beyond, but they haven't confirmed that yet.
Q. So they haven't completely decided what they are going to

do, right?
A. They have for D&E's. They have not for medical inductions.
Q. You don't know if patients who have HIV or any other condition that might put them at high risk if they have an infection are exempted from this policy, do you?
A. Why would somebody who had HIV having a needle put into the fetal heart put them at any increased risk?
Q. So is it your testimony that they are not?
THE COURT: He asked you a question, ma'am. Are you going to respond to it? Chaiten chant I wasn't planning to. I was planning to try and understand his testimony, your Honor.
THE COURT: He returned your we with a question, trying to understand what you were saying, and you seemed to just ignore it.
MS. CHAITEN: I didn't ignore it. I was asking a follow-up question.
THE COURT: If that is what you call it, go ahead.
Q. So is it your testimony that maternal health conditions are not in any way exempted from this policy?
A. That is not the question you asked me.
Q. I am asking you a different question.
THE COURT: Perhaps you could answer his question so that he could understand yours. KHAEUBT Chaiten your Honor, maybe I question wasn't a good question, so I thought I would restate it.

THE COURT: Well, it didn't work. But try again.
Q. Dr. Sprang, are you aware of any exemption from this policy based on maternal health conditions -FRPLTS I am not aware of any medical health conditions that would make this policy inappropriate. If there was, I presume I would consider that.
Q. So you don't believe there is an exception to be made for patients who are particularly obese?
A. I do not.
Q. Is this a mandatory policy? Do patients have to have this injection?
A. I think it is the protocol they are using, and I'm not sure they would proceed if they didn't use that protocol.
Q. Have you seen a written policy?
A. Something, but this procedure has been SOP recently introduced. As I said, the department, the division heads, and the division met, concluded that this would be their policy. I am not sure they put it on paper yet. S-
Q. Is it your ***[STRIKE]***.
Q. Doctor, you can't say, can you, whether all maternal fetal medicine specialists at Evanston Hospital have been told about this policy, can you?
A. Yes, I can. They were all at the meeting.
Q. Is it your belief that all doctors who perform second trimester abortions including D&E have been told about the policy?

A. At Evanston Hospital?
Q. At Evanston Hospital.
A. Correct.
Q. Do you know whether the nursing staff has been told about the policy?
THE COURT: Is there some relevance to that?
MS. CHAITEN: I believe so, your Honor.
A. To the extent that I know what has been told by both the head of maternal something medicine and something medicine physician whose practice it, there has been great relief among the physicians and the nursing staff who do this, and they are finding the procedure easier to do, and everybody in the room, including the nursing staff, are much more comfortable. So yes, they must know.
MS. CHAITEN: Your Honor, I would move to strike that answer as nonresponsive and hearsay.
THE COURT: I think your question invited it. Did the people in the parking lot get told that? Next question, please.
Q. You have never seen such a policy for abortions performed at Prentiss women's Hospital, have you?
A. I believe in Frederick's deposition they does say they do that. But I don't think they do it routinely. They do it sometimes.
Q. You have never seen such a policy, was my question?

A. I have never seen the policy, correct. [> Frederiksen's first name also<]
Q. Doctor, you are aware, are you not, that the task force, the AMA task force report addresses safety advantages that some believe intact D&E offers, is that right?
A. They may PHEBGS that there is some listed. There was certainly no conclusion by that task force that that was true.
Q. I think you still have the binder in front of you. Let me tell you the exhibit. It is Government Exhibit U4A. Do you see that tab?
A. Yes, I do.
Q. Doctor, can you please turn to page 19 6 and look at the paragraph at the bottom of the page that carries over to the next page. Are you with me?
A. Yes, I am.
Q. Can you read the first sentence, please.
A. "to minimize uterine and cervical perforation either from instruments or during the D&E or through piercing the fetal parts, some physicians use a form of D&E that has been referred to in the popular press as intact TKEULG TK*EUL TAEUGS and extraction."
Q. That's fine. Thanks. Does that refresh your recollection that the report actually addresses some of the safety advantages?
A. I think it just says that some people believe that and do

that. I don't think it says the committee believes that. I think that is the reason some people do it, but that doesn't mean the committee agreed that --
THE COURT: Next question.
MS. CHAITEN: Sorry, your Honor. I am having trouble reading it. It is very fine print. I need to get to the next question.
THE COURT: Do you write them out?
MS. CHAITEN: I am reading the document, your Honor.
Q. Doctor, would you turn to page 197, please.
A. Yes.
Q. Look at the paragraph, it is the first full paragraph on the page beginning " hysterotomy."
A. Correct.
Q. Can you read that first sentence for us, please.
A. "Hysterotomy and hysterectomy have been used to terminate pregnancy but are not used routinely as a form of abortion, because maternal mortality and morbidity associated with these procedures are significantly greater than those associated with other procedures to induce abortions."
Q. That is fine, just the first sentence.
A. Yes.
Q. Did your committee conclude that in some situations hysterotomy and hysterectomy are not appropriate?
A. The reason was said here. Obviously, there are

well-established accepted medical facts that there is great morbidity and mortality from those.
Q. Doctor, turning to your views about internal podalic conversion. You have never performed internal podalic conversion at less than 24 weeks, have you?
A. Not less than 24 weeks. Obviously numerous times at longer gestation STKPWHRS one of the concerns about doing an internal podalic conferring at term or where one is attempting to deliver a live baby is the risk of harm to the baby, is that right.
A. The primary concern is risk to the mother. You are actually doing the internal podalic version to protect the baby. You usually do it because something else is going wrong with the baby's heart rate. You have a choice of either doing an emergency Cesarean section or quickly trying to remove the baby. Any mechanical things could harm the baby. But in that situation you are doing it to help the baby. [> conversion, not conversion [> [>
Q. Doctor, you testified last week in California, is that right?
A. Correct.
Q. You were asked, "and you would agree that one of the risks of doing an internal podalic conversion at term or where you were attempting to deliver a live baby is the risk of harm to the fetus, right?"

And S- wer is "Correct."
Is that your testimony from California last week?
A. There is a risk to the baby. But your risk benefit ratio, you are doing it because you think there is less risk if you don't do it. You are trying to help the baby. There is a risk, but that is not what you are trying to do in that -- I'm sorry. Go ahead.
Q. Was that your testimony from California, Doctor?
A. I don't recall that. But if you have it in front of you, I will have to say that must have been what I said.
THE COURT: Would you like to see it first, Doctor?
THE WITNESS: Please. KHAEUPT Chaiten may I approach, your Honor?
THE COURT: Of course.
Q. Doctor, you are looking at page 1135/line 25, carrying over to 1136/line 4. Were you asked that question and did you give that answer?
A. What line on 1135?
Q. 25.
A. Will you read at the risk of doing an internal podalic version at term are where your attempting to deliver a live baby is a risk of harm to the fetus, right.
"A. Correct.
"Q. And that's not a concern in the context of abortion?
"A. Correct." S-

Q. Is that your testimony?
A. Correct. But it was yes, there is a risk but you are doing it to protect the baby. Yes. I will leave it at that. I'm not sure what your point is, but go ahead.
MS. CHAITEN: Your Honor, may I approach to retrieve the deposition?
THE COURT: Yes, if you are finished with it.
Q. Uh Doctor, you have testified that you would have less concern about the maternal risks you believe are associated with inserting a sharp instrument into the fetal skull if it were done under direct visualization, is that right?
A. Correct.
Q. You are not aware of any maternal complications that have resulted from a physician inserting a sharp instrument into the fetal skull during a an intact D&E, are you?
A. I don't know of any publications where that has been presented, no.
Q. Doctor, you have testified that in your view intact D&E abortions are unethical, is that right?
A. Not that I am aware of. Please repeat it. I'm sorry. Repeat the question.
(Question read)
A. When you use D&E, I think D&E, I use a different word than that. I use D&X. That is why you threw me.
Q. You can feel free to substitute D&X for intact D&E if you

would like?
A. When I hear D&E, that is is not what I think of. Yes, I did say that intact D&X's are unethical.
Q. Doctor, turning again to your work on the American Medical Association task force, the task force considered the ethical issues related to D&E and other related abortion procedures, right?
A. Correct.
Q. The task force concluded that the ethical arguments about intact D&E or D&X do not lead to one clearly preferred ethical position, is that right? S-
A. I'm not sure that I agree with that statement. The written report says that, but in the report to the board of trustees -- this is, again, a board of trustees report, so we give them the information and they interpret it. Their interpretation was that there were significant ethical considerations, and felt so strongly that they then supported HR1133, which was the ban on partial-birth abortion. In their cover letter and in their later response to why they did that, they specifically used that argument that they did feel intact D&X raised significant ethical questions, and it was for that reason why they supported the partial-birth abortion ban in Washington.
Q. Doctor, would you turn to page 208 of the report, please.
A. Surely.
Q. Look at the last paragraph, please. Doctor, does reviewing

that paragraph refresh your recollection that the ethical issues were open, remained open, after this report?
A. No.
THE COURT: He just finished testifying to it. Are you not listening? KHAEUBT Chaiten your Honor, yes, I am.
THE COURT: Next question.
Q. Doctor, your ethical concerns relate to the fact that the fetus is outside the mother when demise occurs, is that correct?
A. Correct.
Q. You consider the fetus to be delivered when a part of the fetal body is outside the pregnant woman, is that right?
A. Yes and no.
Q. Is it your testimony that when you do a normal vaginal delivery, the fetus is considered delivered when the head and shoulder come out so the rest of the body is still insight, but that is what we put down as the time of delivery?
A. That is correct.
Q. Doctor, you recognize, don't you, that in doing a D&E by dismemberment, part of the fetus might actually be brought out of the uterus through the KEFR cal os, and still be attached to what is left in the uterus, is that right?
A. Correct.
Q. In a situation where an induction abortion is occurring and a fetal part becomes stuck, isn't it also possible that a part

of the fetus might actually be outside of the uterus and through the os while another part is still within the uterus?
A. Correct.
Q. Couldn't your ethical concern apply to that situation, where the patient was, for example, bleeding or became infected and something had to be done to extract the fetal head as quickly as possible, and that something led to fetal demise?
A. What typically happens is literally as the fetus is being delivered in the natural process of induction, as the fetus is coming down the cervix and the vagina, the cord is squeezed and it does -- the fetus dies because of cord compression.
Q. But, Doctor, that is not the example I gave you.
A. Please give it to me again so I understand what your question is.
MS. CHAITEN: Your Honor, can we have the court reporter read the question back, please.
(Question read)
A. If the fetus was killed outside of, mostly delivered, in all ethical considerations you take into account the entire event. If the event was also involving saving the mother's life, that aspect of it would be considered in the ethical deliberation, and that change in circumstances would change the ethical conclusion.
Q. What if it was to preserve had he ever health, Doctor, for example, to avoid doing a dur kins incision?

A. As I just said, it would be done if it was -- if she wasn't bleeding, if there wasn't something endangering her life, you would just wait for the contraction to continue to push it out.
Q. Even if it was endangering her health?
A. I am not aware of a circumstance that that fits.
Q. Doctor, how long would you wait while the head is stuck in the uterus?
A. While you are waiting in all likelihood if you give it any reasonable period of time, the fetus would die because the cord would be being compressed, so you wouldn't have to do anything.
Q. Is it your testimony that that would have no effect on the pregnant woman?
A. That the fetus was sitting there for a while?
Q. That she was waiting with the fetal head stuck in her uterus while you waited for demise?
A. It would absolutely be my testimony, because that is what we do all the time. Most of the time we don't know -- when you are doing inductions early like this, you are not examining the patient on a regular basis. You wait for the cervix and uterus to push out the fetus. Patients aren't being checked. They They aren't on a monitor. So you really don't know it is there until the patient says, I feel the pressure, and you see it and it is there. The natural PROSZ is it is commonly sitting there, and that is how that process works. As it is sitting in the pelvis, sitting partially in the uterus, partially in the

vagina, the cord is getting compresses, and that is what causes fetal demise in an induction in which you did not do potassium chloride beforehand. So I would precaution an appropriate thing to do if the fetus was 22 weeks or mo would be to have injected TPET side so that none of those become issues. S-
Q. Doctor, are you aware of a report prepared by Booz, Allen & Hamilton regarding the American Medical Association process of determining its support for partial-birth abortion bans?
A. I believe that was one issue that report looked at. I believe the primary issue was a totally separate issue, and that was just part of the report.
Q. It is true, is it not, that Booz Allen concluded that the most critical, controversial, and high visibility policy issue was addressed using the least democratic, least researched, and least systematic decision-making process?
A. You may have a better recollection of that report than I. I was at the meeting. I did hear the report. It was certainly controversial. Do I know if that was the wording? No, I do not.
THE COURT: Do you know who hired Booz Allen, Ms. Chaiten?
MS. CHAITEN: Do I know who hired Booz Allen?
THE COURT: Yes.
MS. CHAITEN: I believe it was the American Medical Association, your Honor.

THE COURT: Kuhn?
MS. CHAITEN: That is my understanding.
Q. Dr. Sprang, do you know who hired Booz Allen?
A. Yes, I do.
Q. Who hired Booz Allen?
A. Actually, the house of delegates wanted the report because of a different issue, because of a something issue. And when they were looking at that, they looked at the mechanisms of the way governments this goes on in a large organization like the AMA and the roles of the house of delegates and the role of the board of trustees, and that was addressed as well S-
MS. CHAITEN: Your Honor, may I approach the witness?
THE COURT: You may. [> governance<]
Q. I am just trying to find the report for you. Doctor, have you seen this document before?
A. I would need more time to look at it. At the AMA meeting this was presented. It was a number of years ago. I testified that this is the actual report? No, I can't. Do I know it exist STPH-D yes.
Q. This is what has been marked as Plaintiffs' Exhibit 13. Doctor, if you turn to page D21 and read the last paragraph, please. You can read it to yourself.
A. I have read it.
Q. Doctor, does this refresh your recollection that in connection with the AMA process of determining its support for

partial-birth abortion ban legislation, that Booz Allen concluded that the most critical, controversial and high visibility policy issue was addressed using the least democratic, least researched, and systematic decision-making process?
A. That is what it says.
Q. Does that refresh your recollection?
A. That is what it says.
Q. Doctor, would you turn to the cover page of Exhibit 13, please, that you have in front of you. Could you read what it says just for identification purposes, please.
A. I'm sorry?
Q. The front page of Exhibit 13.
THE COURT: Reading from it is for identification purposes? Chaiten chant I am just asking him to read the title, your Honor.
THE COURT: Why don't you just ask him to look at the document and ask what it is.
Q. Doctor Sprang, what is the title of the document?
THE COURT: Isn't what I suggestd. What is the document you have in your hand, do you know, Doctor?
THE WITNESS: It is an appendix to a case study.
THE COURT: Who is it authored by?
THE WITNESS: It is probably, and I don't know that for sure, but it is probably authored by Booz Allen. But I

can't testify to that. I haven't seen the entire document.
THE COURT: So your answer is you don't know?
THE WITNESS: I do not know.
Q. You did testify earlier that you had seen the document before, is that correct?
A. No. I just testified that I was at the meeting where a report was presented. I don't know if this is the actual report. I have no way of recollecting that.
Q. Dr. Sprang, did the general membership of The American Medical Association vote on the policy regarding late-term abortion?
A. Yes, they did.
Q. The entire membership of The American Medical Association?
A. As represented by their 500 delegates, yes, they did, and they did support what the board of trustees did.
Q. Doctor, did the individual members of The American Medical Association vote on the policy regarding late-term abortion?
THE COURT: He answered your question. He said the delegates who were elected by the members did.
MS. CHAITEN: Your Honor, my question was whether the individual members had voted.
THE COURT: Next question. That was his answer.
Q. Doctor, the AMA did not support the law that is at issue in this case, did it?
A. Currently I believe they are not supporting this law.

Q. Doctor, I would like to turn your attention now to the study by Dr. Stephen Chasen and others that you testified about earlier. Is it OK with you if we refer to that as "the Chasen study" for short?
A. Correct. Can you give me the number where it is it's OK. I have it.
Q. Have you got it there? It is Plaintiffs' Exhibit 23A Doctor, you have stated in your supplemental report in this case that the number of cases included in the study is too small to reach any reliable conclusions, is that right?
A. Correct.
Q. Doctor, you are aware, are you not, that there are hundreds and perhaps thousands of retrospective studies that assess smaller numbers of cases than this?
A. Clearly what is important is whether it is statistically significant or not depends on the frequency of the complication, specific -- the statisticians look at the numbers and give you whether it is less than .05, whether it is significant or not. They point out that the power of this study was too low for them to make those kinds of conclusions. Even though there was a trend for a greater premature labor after D&X, the P val was too low, so it wasn't statistically significant [> check the .5<]
MS. CHAITEN: Your Honor, I would move to strike the answer as nonresponsive.

THE COURT: Overruled.
Q. You have stated that the authors reference a lack of power in the study. You refer to page 10. That is on the manuscript version of it. I think what you have before you in Plaintiffs' Exhibit 23A is actually a galley.
A. I have not seen this, so I don't know where it is on this presentation of it.
Q. This is the document that you testified about this morning, is that right?
A. What I reviewed when I made my comments was the other form, where it was over ten pages, and I knew where those were. On this I don't know where that line is, if that is what you are asking me to find.
THE COURT: Why don't you give the witness the other exhibit.
MS. CHAITEN: I can do, that your Honor.
[STRIKE].
MS. CHAITEN: I can do that, your Honor.
Q. Dr. Sprang, I am handing you Government Exhibit 27A., which I believe is the copy of this that you reviewed at the time that you prepared your supplemental report. Is that your testimony?
A. Correct.
Q. Doctor, the reference to lack of power appears at the end of the first full paragraph on that page, is that right?

A. Correct.
Q. That paragraph discusses, and I am quoting, "the relatively small number of patients receiving prenatal care at our hospital in subsequent pregnancies," does it not?
A. Correct.
Q. Is it fair to say, is it not, that this paragraph address it is number of subsequent pregnancies the authors were able to observe and not the complication rates from the termination procedures, is that right?
A. The complication rate, actually the reason for doing the study included very much when was long-term complication rate.
Q. But Doctor --
THE COURT: Please let the witness finish. We aren't going to through that again, I hope. Doctor.
A. Because they didn't follow them, that is why they only have like a power on the subsequent premature labor, yes.
Q. But not on the complications relating to the actual termination procedure, is that correct?
A. Their numbers were small as well. My concern, as I said, is they didn't break it down at all. They just looked at overall complication rates, which they defined in an unusual way.
Q. Doctor, you said in your report that the authors acknowledged a lack of power.
A. Correct.

Q. That acknowledgement is limited to the subsequent pregnancies that they were able to observe, is that correct?
A. Correct.
Q. In fact, while the authors expressed the view that significant bias would be unlikely as a result of the small number of returning patients, they acknowledge a lack of power to conclude no difference in subsequent pregnancy outcomes, is that right?
A. If there is a difference. It is 3-to-1. So I'm not sure where -- I don't agree with that statement. The difference is 3-to-1 [> there is a difference, at the beginning<]
Q. We are talking about your position that the authors acknowledged this.
THE COURT: Please rephrase the question.
MS. CHAITEN: I will move on, your Honor.
Q. The overall complication rate across both groups studied, intact and dismemberment, was 5 percent, is that right?
A. Approximately, yes.
Q. You have got no basis to dispute that at these gestational ages, that is a low rate of complication, do you?
A. It is a reasonable rate. I have seen ranges anywhere from a couple of percent to 25 percent. So it is a reasonable rate.
Q. In fact, complications occurred with similar frequency in each of the groups observed, both intact and dismemberment, is that right?

A. Through the selection of complications they chose, yes. [> for the selection<]
(Continued on next page) 4/14/04 Judge Casey take 4 cross of Sprang
BY MS. CHAITEN:
Q. Well, Doctor, you criticize the study for defining complications using the term any situation requiring unplanned intervention, is that right?
A. Correct.
Q. And you say this is a vague term, is that right?
A. Correct.
Q. Or vague phrase?
A. Correct.
Q. But doesn't the study actually define what that means?
A. But they took mild things and said some people would consider them TKPHREUBGSs some people would.Ment C D C has guidelines for complications. They certainly did not use those, so I would say their list of complications was somewhat arbitrary.
Q. Doctor, your criticism was that that phrase was vague, is that right?
That's what you said in your testimony this morning and that's what you said in your report?
A. Vague, and I will say arbitrary.
Q. And, Doctor, if you look at, if you go to Exhibit 23A that's in your binder, the one that you testified from this

morning at page, you will see a little Bates Number at the bottom, SC 0159?
A. Yes.
Q. And look at the top of the second column, the first full paragraph in the second column, does it not state that the complications that they addressed included unplanned hospital admission, repair of genital tract lacerations, return to the operating room for additional procedures and blood transfusions?
A. Correct. And we did not obtain followup on patients ROU TAOEPBT R*EU *Rally, which I think is very important. In subsequent pregnants and had pre natal care in other places, if these individuals were, had their complications other places they wouldn't know the complications.
MS. CHAITEN: Your Honor, I move to strike as nonresponsive.
THE COURT: Disagree. Denied.
Q. Doctor, if you turn to page 3 and look at the first column, do you see where I am?
A. Tell me what paragraph you are in.
Q. Table one at the top?
A. Okay.
Q. Could you please read the second sentence out loud? Starting with complications?
THE COURT: The exhibit is in evidence, correct?

MS. CHAITEN: Yes.
A. So you're on page --
THE COURT: Just a member, Doctor.
MS. CHAITEN: This exhibit was admitted into evidence during Dr. Chasen's testimony, your Honor.
THE COURT: The exhibit number is KRFRPBLGT Exhibit 23A, plaintiffs.
THE COURT: Just verifying that it is in evidence before you read from it.
MS. GOWAN: Yes.
MS. CHAITEN: It is, your Honor.
THE WITNESS: Tell me exactly where you want me to read.
BY MS. CHAITEN:
Q. Column on page page 3?
THE COURT: Why don't you walk up here and point to it Ms. Chaiten and save yourself and hopefully the Court some time.
Can you please read the sentence beginning complications?
A. Complications occurring with similar frequency in dilatation and evacuation and in the intact D&X groups. The six complications --
Q. No, no, no, you need to finish that sentence.
Can you please read what's in the parentheses?

A. You want -- sure.
Q. Then you can stop at the end of the paren they says?
A. Complications occur with STKPWHRAOEUFRPBLTS note note KHREUBGS occurred in similar frequency in the dilation and evacuation and in the intact D&X TKPWRAO*PZ. (4.9 percent versus 5 percent P value greater than .999 (STKPWHRAERPB Doctor, the reference to P value greater than .999 sets forth the level of statistical significance for the rate of complications, isn't that right?
A. Correct.
Q. And P is greater than .999 means that the difference between 4.9 percent and 5 percent doesn't represent a statistically significant difference, isn't that right?
A. Correct.
Q. Now, the authors present similar information in connection with the issue that you've spoken about previously spontaneous pre-term birth in subsequent pregnancy, is that right?
A. Correct.
Q. And again, if you look again at Exhibit 23A, page 3 in the second column or on the same page, looking at the second column, -- your Honor, if I might approach I will point out the sentence I am looking for?
THE COURT: Very well.
It's the carry over sentence.
Can you please just read the carry over sentence from

column 1 to column 2, please?
A. Spontaneous preterm abortions in either -- STRAFP that.
Spontaneous preterm birth occured in 2 of 17 (11.8 percent pregnancies in the intact D&X group compared with 245 (4.4 percent) in the dilatation and evacuation group. The P value for that is (P equal .3 .)
Q. The authors determined that the percentage of preterm births in subsequent pregnancies was not statistically significant, is that right?
A. That is what I said in my direct but I said there was a trend because it is still 3 to 1 and it would require further study. That's what I said in my direct.
Q. Doctor, to be statistically significant it has to be less than .05, is that right, P value?
A. Correct.
Q. And a trend is typically considered in the medical literature is recognized when you have a P value between .05 and .10RBGS is that right?
A. Not necessarily a trend. It can be, if you look at the numbers directly and you see a ratio of it being three times greater in one than the other, it would be reasonable to say that indicates a trend but it needs further study.
Q. Well, Doctor, the P value of .30 means that there is a 30 percent likelihood that the measured results occurred by chance, is that right?

A. That is correct. But when you have small values and it is the only thing you have it's what you have to go by.
Q. But it is in that area where the P value is .30 where the authors acknowledge the lack of power, is that right?
A. They did acknowledge the lack of power there.
Q. And it wasn't with regard to the overall complication rate, as you stated, is that right?
A. I believe that's right. I don't recall it well enough to answer that definitively but I believe you're right.
Q. Doctor, looking at the woman who had preterm birth -- the women, I'm sorry, who had preterm birth and subsequently note note STKPWHROEUFRPBLGTS in subsequent pregnancies, both of those women --
THE COURT: There are were two?
MS. CHAITEN: Excuse me?
THE COURT: There were two?
BY MS. CHAITEN:
Q. Well I'm looking at the two women who were in the intact group.
Both of the women from the intact D&E group who had preterm birth in subsequent pregnancies were already at high risk for prematurity, weren't they?
A. Potentially.
Q. One underwent intact D&X because of premature preterm rupture of membranes at 23 weeks' SKWRES TAEULGS, right?

A. And that may have been, as you said before, various reasons why somebody could go into premature labor.
Q. I'm sorry, I did not hear KWROU?
A. As you said before, there are various reasons people could go into premature labor.
Q. And the other one underwent intact D&X because the cervical incompetence, is that right?
A. I don't have a specific recollection for it. I will take your word for it.
Q. I think if you look again at page 3 in that column there is a description of these women. Do you see the paragraph where you were just reading from?
A. Yes.
Q. Both spontaneous preterm births in the intact D&X group occurred in women at high risk for prematurity. One woman who underwent D&X caused by PPROM at 23 weeks gestation subsequently delivered at 32 weeks and the other underwent intact D&X at 23 weeks' gestation because the cervical incompetence with advanced cervical dilation and subsequently delivered at 35 weeks.
Is that what it says?
A. Correct.
Q. Could that possibly be infretted to mean that in fact there are subsequent pregnancy outcomes were improved by the fact that they underwent an intact D&X given that they were able to

carry their subsequent pregnancies to 32 and 35 weeks?
A. Seeing how I don't know if they had a sir KHRAPBLG and I think that's a real stretch and I have no why note note no idea had incervical incompetence or further advanced dilation of the cervix in the D&E group.
Q. But I'm talking about the outcomes for these two women. I'm not doing a comparison to the dismemberment group right now, let's talk about these two a minute?
THE COURT: Slow down, please.
Q. I apologize, your Honor?
A. Without comparison it's not meaningful.
Q. Each of these conditions would, of course, place these women at higher risk for future preterm birth, wouldn't they?
A. But if they there were the same number in the other group it would be totally meaningless and so you can't look at bits and pieces and say that that's significant.
Q. Doctor, would you agree, wouldn't you, that amniotic fluid embolus is a serious complication of D&E?
A. I would say it's a serious complication of any obstetrical situation, delivery, miscarriage, abortion, D&E, D&X. Anything.
Q. As is disseminated intravascular coagulation, right?
A. They are serious complications, extremely rare.
Q. And sepsis is also a serious complication?
A. Sepsis is a serious complication.

Q. As is pulmonary embolus?
A. Didn't you already say PE? Didn't you say amniotic fluid emPWO bus.
Q. I did.
You think those are the same? Thank you for the medical lesson.
Of course you already testified that out REUFPB perforation is one of the most common serious complications of D&E, right?
A. I didn't say common. Serious complication varying from .2 to 1 and a half percent.
Q. And these serious complications all occurred in the dismemberment group, didn't they?
A. Corrects.
Q. And none of the serious complications requiring admission to surgical intensive care occurred in the intact group, is is that correct?
A. Correct.
Q. The authors of course do not purport to conclude that intact D&E prevents such serious complications, do they?
A. Because they know beyond any reasonable doubt that you would have to have thousands of patients in each arm of the study for it to be at all significant. When something that rare happens in that small group it's a fluke and actually you even Chasen says there is no way that they thought it would have

been any different if those patients had D&Es or D&Xs. That's just a fluke.
Q. The number --
THE COURT: Lets minimum fin.
Q. Sore re. The numbers are too small, aren't they?
A. For complications that occur that rarely you would literally, for it to be meaningful, have to have thousands of patients in each arm.
Q. Doctor, under your analysis, though, this might be a trend, mighten it, since none occurred in dismemberment D&E?
A. No, because these are so rare that you would, if -- would you have one in the first thousand you could do the next 2000 and have none.
So, because the rarity of the complication the numbers would have to be much more meaningful to even indicate anything.
MS. CHAITEN: Your Honor, if I might just have a minute?
THE COURT: You may.
MS. CHAITEN: I have no further questions at this time, your Honor.
May I approach the witness to retrieve my exhibit?
THE COURT: Oh, by all means.
MS. CHAITEN: Thank you. Thank you, Dr. Sprang.
THE COURT: Any redirect?

MS. WOLSTEIN: Yes, your Honor. Briefly.
REDIRECT EXAMINA
THE COURT: Is it brief or should we take our afternoon recess.
MS. WOLSTEIN: That's fine, your Honor.
THE COURT: KPWHAFR you want. If it is going to be a minute or two I will hold off, whatever is yours --
MS. WOLSTEIN: We can take a break.
MS. CHAITEN: Your Honor, I apologize but I realize I have just like two more questions that I forgot to do when we come back from the break might I ask those.
THE COURT: Let's have at least one portion finished. Ask the two questions.
MS. CHAITEN: Okay, I apologize.
THE COURT: Two, you can't have three, two.
MS. CHAITEN: I will try do it in two.
As I cleaned up I realized I forgot.
Doctor, you testified earlier about the potential for conflict of interest in connection with the Chasen study, is that right?
A. Correct.
Q. You are aware, of course, that the American journal of obstetrics and gynecology has an expressed conflicts of interest policy, is that right?
A. I served as a reviewer of that. And they may have changed

it since I served as reviewer. And where I haven't I don't know exactly what it is now.
Q. Your Honor, may I approach just to show the witness a copy of it?
THE COURT: Sure.
A. Is this the most current?
Q. Doctor, I'm showing you a document that is entitled American Journal of obstetrics and gynecology copyright 2003 information for authors. If you turn to the second page in the second column there is a paragraph labeled conflict of interest. Could you take a look at this and tell me whether there is anything within that policy that you believe was violated in connection with this study?
MS. WOLSTEIN: Objection.
THE COURT: I will allow it.
THE WITNESS: Out loud? Sir do you want me to read it OUD light.
THE COURT: No, just read it to yourself.
THE WITNESS: Okay.
One, there might be a question on where it says and consultant activities as being a plaintiff in a legal case being a consultant in that legal case and obviously being a witness in that legal case, could come under a consultant in those activities. So I would say it's questionable.
Q. Even if the consultant, the so-called consultant is

receiving no monetary gain?
A. I think is receiving gain insofar as he is a plaintiff in a case and that would even be maybe more than monetary gain, it is maybe more meaningful.
Q. Very no further questions, your Honor.
THE COURT: All right, we will take our afternoon recess.
(recess).
THE COURT: Ms. Wolstein, I believe?
MS. WOLSTEIN: Thank you, your Honor.
THE COURT: You may ininquire.
MS. WOLSTEIN: Thank you.
REDIRECT EXAMINATION

BY MS. WOLSTEIN:
Q. Doctor, back to the subject of conflict of interest that we were speaking about with Ms. Chaiten. If you were to assume that one of the authors on the Chasen study was serving as a consultant expert for the plaintiffs in this case, would that give rise to a conflict of interest?
A. I think that more informing the editorial board.
I think when there is a question of either conflict of interest or the appearance of conflict of interest, the smart OEFT thing to do is given that information.
If when you give it they don't feel it is important

there is no harm done. But that's the safest thing to do.
Q. Now, directing you to the Chasen study itself that you were looking at with Ms. Chaiten, and if you could go to the one marked 27A in Plaintiff's trial Exhibit 23 which is the format you testified you looked at before coming here today, do you have it?
A. I have it.
Q. Could you turn to the page stamped SC 0041 on the bottom right.
Do you have it in front of you?
A. I have it.
Q. Could you read aloud, please, the last sentence on that page that carries over onto page SC 0042?
A. Because our approach is to perform intact dilatation and extraction when possible based on cervical dilatation in fetal position, it is unlikely that intact dilatation and extraction could have been performed in these patients undergoing dilatation and evacuation who experienced severe complications.
Q. And, Doctor, is that an acknowledgment by the authors of the study that they could not do D&X on the patients that had the most serious complications?
A. That is how I interpreted it.
Q. Doctor, you were asked on cross examination whether you were aware of any complications from scissors, do you remember that?

A. I believe so, yes.
Q. And you testified that you are not aware?
A. Correct.
Q. Are there two organizations that collect morbidity and mortality data concerning abortions that you are familiar with?
A. There are two large national organizations, the CDC and the Ellen good broker note note note note Allen good mocker institute.
Q. And does the CDC report data on complications for an intact D&X?
A. They, to my knowledge they still have not really distinguished. When they talked about D&Es they haven't had a separate category for D&X so it makes it very difficult to actually get good data.
Q. And does the Allen good macer institute report data on intact D&X, on KPWHREUBGSs?
A. Any data that I have seen so far as not included that.
Now obviously this is a new procedure and it is certainly possible that they will try to start looking at that but not yet, that I'm aware of.
Q. Doctor, turning back to the AMA report, if you could turn to page 197 that you were looking at with Ms. Chaiten and that is the, you read aloud a sentence on hysterotomy and hysterectomy and the sentence was his TPERotomy and hysterectomy have been used to terminate pregnancy but are not

used routinely as a form of abortion because maternal more TKALT and morbidity associated with these procedures are significantly greater than those associated with other procedures used to induce abortion.
Do you see that?
A. I do.
Q. Are there citations to the medical literature after that sentence?
A. There are.
26, 34, 41 and 42.
Q. Those are four footnotes?
A. Correct.
Q. And could you now turn to page 196? And looking at the sentence you read with Ms. Chaiten about D&X where it says, to minimize uterine or cervical perforation either from instruments used during D&E or through piercing by fetal parts, that some physicians use a form of D&E that has been referred to in the poplar press as intact dilation and extraction (D&X .)
Do you see that?
A. Do I.
Q. Are there any citations to medical literature following that sentence?
A. There are not.
Q. Doctor, going back to the Booz Allen report, wasn't it the

case in fact that the Booz Allen report was criticizing the board of trustees' support for the partial birth abortion legislation and not the board of trustees' adoption of the special committee's report?
A. Correct.
MS. CHAITEN: Objection, leading.
THE COURT: I will allow it.
Do you know, Doctor?
THE WITNESS: Yes, I do.
Q. And if you turn to the exhibit you are looking at Plaintiff's Exhibit 13, towards the back there is a page, it's on the bottom right, D:A 2?
A. Is that this book? I'm not sure had a book.
Q. I don't know what book it is. I can approach, your Honor?
THE COURT: Why don't you get up and help the witness and direct his attention to the exhibit you wish him to focus on.
MS. WOLSTEIN: Thank you.
MS. CHAITEN: Your Honor, we have an extra copy I can give to Ms. Wolstein.
MS. WOLSTEIN: I don't see it here on the witness box.
THE COURT: All right, thank you.
MS. WOLSTEIN: Thank you.
Q. If you could turn to page D:A 2 towards the end, it's the second page of a time line of events that annex A?

A. Very it.
Q. The second page, D:A 2, and on the entry for May 19th, 1997, what does that say?
You can --
A. May 19, 1997, it says board of trustees convened for a conference call meeting. The board voted to support HR 1122.
Q. And that was something distinct from the board adopting the report of the special committee you served on, wasn't it?
A. That's correct.
Q. And you testified in your cross examination that the house of delegates voted on the policy recommendations that your special committee came up with and that were forwarded by the board of trustees to the house of delegates, is that right?
A. That is correct.
Q. And what functions the house of delegates serving in voting on that those recommendations?
A. The house of delegates is the policy-making body when they're in session, for the AMA.
Committee and resolution reports refer to them, ultimately they make the decision to accept a recommendation.
When they accept it, that then becomes the policy of the AMA.
Q. So do individual -- do the AMA's 300,000 individual members ever vote on policies adopted by the AMA?
A. They do not.

The way it is set up is they are the representatives, just like hiring or electing -- they are elected -- our representatives in Congress to represent us in Washington.
Q. So, how are members represented, AMA membered represented in the AMA policy-making process?
A. They each, the states elect members depending on how many members they have. The national organizations elect members depending on how many members they have so it's a very democratic, very representative body that go back and get elected by the grassroots in their state or in their speciality society and as I said there is over 500 delegates representing virtually probably all of physicians -- essentially all the physicians in the United States.
Q. Was Booz Allen ever critical of the board of trustees' adoption of the special committee's policy and recommendation on D&X?
A. I do not believe they were critical of that, of adopting -- the board report. It was simply of their making the decision without going to the house first.
Q. And to your knowledge did the board of trustees vote to support the band on partial-birth abortion that was then in front of Congress without going to the house of delegates?
A. Correct.
Q. Doctor, you testified on your cross examination earlier on that you are aware of two physicians at Northwestern Memorial

Hospital who perform D&E after 20 weeks, do you remember that?
A. Correct.
Q. Was one of those doctors you are referring to Dr. Cassing Hammond?
A. Correct.
Q. He is the plaintiff in this case?
A. Correct.
Q. And was the other doctor you were referring to to Dr. Marilyn Frederikson?
A. Correct.
Q. And she is one of the plaintiff's experts in this case?
A. Correct.
Q. I may have misspoke just now on my question. Actually, withdrawn.
MS. WOLSTEIN: No further questions.
THE COURT: Any recross?
MS. CHAITEN: Yes. Just a brief question, your Honor.
RECROSS-EXAMINATION

BY MS. CHAITEN:
Q. Doctor, the AMA does not focus exclusively on obstetrical and gynecological issues, does it?
A. Correct.
Q. The pre eminent organization in the country representing obstetricians and gynecologists, isn't that the American

College of Obstetricians and Gynecologists, is it not?
A. Correct.
MS. CHAITEN: Thank you. No further questions.
THE COURT: Doctor, you were talking about conflicts before.
In your experience, is it appropriate for someone who is doing a medical study, a physician, to submit a study to appear-review journal without telling them that the study had been rejected by another journal?
THE WITNESS: I don't think they always do that. That probably is, would be acceptable because it's, there is not a requirement to say that it had been accepted or it had been rejected by another journal.
THE COURT: So there is no requirement.
THE WITNESS: Correct.
THE COURT: You consider it appropriate to do so? Or just not one way or the other.
THE WITNESS: Probably most physicians wouldn't do that for obvious reasons.
THE COURT: You might get two, huh.
All right, very well. Doctor, you may step down. Thank you.
THE WITNESS: Thank you, sir.
THE COURT: Ms. Gowan, is the next line of testimony

I'm afraid to note note note note I fear to ask, transcript?
MS. GOWAN: Your fears are justified. It will be the reading of Dr. Cain's testimony, your Honor.
THE COURT: All right, fine. If it's worth doing it let's do it quickly.
MR. PANTOJA: Your Honor, Joseph Pantoja for the government. I will be reading the questions and my colleague from the office, Michael Jane will be reading the answers.
I want to note just for the record indicate that we will be following the same procedure we have agreed on earlier which is during the confidential portions of the transcript we will refer to individuals by the first initial of their last name.
THE COURT: Very well, if that's what have you agreed upon. Note note J A M E S. Note note.
MR. PANTOJA: At page 19, line 16:
"Q we are going to be talking today about a procedure called intact dilation and extraction, intact D&X; have you performed that procedure in any of the terminations you have performed?
"A no."
MR. PANTOJA: Page 30, line 21:
"Q now, you were on the task force created by ACOG in 1996, specifically to review late term abortion procedures, is is that correct?

"A that is correct.
"Q and is that why you were asked to testify today on behalf of ACOG?
"A that is correct
"Q who called you and asked you to testify on behalf of ACOG?
"A Dr. Ralph Hale
"Q and WHAFTS your conversation with Dr. Hale?
"A He gave me the facts of the request and asked if I would consider it since I was a part of that committee.
"Q Dr. Hale is who?
"A the executive vice president of the American College of obstetrics and gynecology.
"Q Do you know how long he has been executive director?
"A no, I do not
"Q what were you told at the deposition note note that was deposition was going to be about
"A about the facts regarding the development of the statement by the task force
"Q did you meet with anyone prior to today's deposition to talk about the deposition?
"A Yes. I met with ACOG's attorneys yesterday.
"Q anyone et cetera?
"A no one else I met with

"Q who did you meet with at ACOG? Did you meet with Ms. Rut ledge
"A no with the many rut rut with Sarah and TKA*PBLT Edel PHA*FPB
Q. That's all you met with yesterday?
A. Am misdemeanor STKPWHROEUFRPBLGTS page 33, line 6.
Q. Did you talk with admin at else sat can KO* about your deposition tomorrow other than counsel that you mentioned.
"A I talked with Fred Frigoletto by phone,
Q. Dr. Frigoletto is Massachusetts, is that correct?
"A that's correct
"Q what did you talk with Dr. Frigoletto about?
"A I wanted to be sure that my recollection of the work of the committee were accurate so I went over questions I had to make sure that his recollection and mine were SHRARP
"Q what questions did have you for them?
"A a variety. I'm not sure I could remember them all right now
"Q do you remember any of them?
"A one was whether or not we had a side table with additional materials, textbooks and such because my memory said we did and he confirmed that
"Q and the other thing you remember talking to Dr. Frigoletto
"A checking the methods where he used to create the

document
"Q anything else you remember talking to Dr. Frigoletto about
"A the individuals on the task force
"Q other than meeting with the counsel you've identified in talking with Dr. Frigoletto, did you do anything else to prepare for your deposition?
"A I read the materials.
"Q What materials?
"A the same materials that were given to you, and additional items
"Q and the additional materials you read are contained in your notebook in front of you, is that correct?
"A that is correct.
"Q page 39, line 10:
"Q Let's take them SPRAETly, Doctor
Firstly, Plaintiff's trial Exhibit 6, the 1997 statement on intact dilation and extraction, you have seen this statement before, is that correct?
"A that is correct
"Q and Plaintiff's trial Exhibit 5, the statement on abortion policy, you have seen that document before -- excuse me -- you have seen that statement before?
"A that is correct
"Q and Plaintiff's trial Exhibit 8, the fact sheet on

the January 1997 ACOG policy statement, have you seen that one before, Doctor?
"A yes, I have.
"Q did you review these materials prior to today's deposition?
"A yes.
"Q okay, how were ACOG policy statements ordinarily developed in 1996 and 1997?
"A policy statements generally were put together, either by a committee or a task force of experts in a particular area
They then were proposed to the executive board of the American College of Obstetricians and Gynecologists who then reviewed them, made any editorial changes yes felt appropriate and adopted them if they felt they were worthy of being adopted.
"Q what did you mean by editorial changes that the board would make?
"A the executive board had the ability, with any policy statement, to change wording if it felt it was unclear or there are other concerns that were not adequately represented.
"Q could the board change the sentence of the statement note note note note substance of the statement, now Dr. Cain's original answer follows:

"A I believe the board has the freedom to go so, to my knowledge. That was not a common practice or even a practice of the board.
"Q
THE COURT: It's not STKPWHRAO Dr.
Q. Dr. Cain's advised answer follows?
THE COURT: That's not text, is it.
Q. PO*EUG should I say?
THE COURT: Identify it as such other ways when you start I think you are giving me testimony and I think the reporter does too.
THE COURT: Let me STRAOEU and understand. You are reading the testimony as it's recorded in the transcript and then you are reading.
MR. PANTOJA: The advised answer by errata.
THE COURT: I think you better say it's errata if that's the way you are going to read this.
MR. PANTOJA: Okay.
THE COURT: Because otherwise the reader of this transcript, namely me, is going to get no flavor of it at all, and I believe what was submitted to me was a substantial errata and that's why the case involved it's to point out when are original answers and the sort of corrections which raise questions of the testimony but if I don't know what it is and which itser rat KWRAU can you you better say clearly errata

then when you read the other.
MR. PANTOJA: May I propose your Honor the cue will be original answer and then I will user rata answer.
THE COURT: Thank you that makes it easier and can you get together unless counsel has an objection and the little bit that's gone ahead of this, would you correct that so that it aids me in reading this transcript of that transcript?
MR. PANTOJA: Okay.
THE COURT: Because otherwise I'm not going to know what it is.
MR. PANTOJA: Your Honor, may I reread this particular question and answer so we have the scheme in place.
THE COURT: Sure. But I think it has to clearly say errata and then I will understand when I read the transcript.
MR. PANTOJA: Thank you, your Honor.
At page 40, line 13:
"Q what did you mean by editorial changes that the board would make?
"A the executive board had the ability, with any policy statement, to change wording if it felt it was unclear or there were any other concerns that were not adequately represented.
"Q could the board change the substance of the statement?
Original answer

"A I believe the board has the freedom to do so, to my knowledge. That was not a common practice, or even a practice of the board
Q. Rat rat answer.
"A yes, the board can chance the substance of a proposed statement.
MR. PANTOJA: Page 42, line 2:
"Q are there any established or existing practice related committees at ACOG that deal specifically with the issue specifically of abortion
"A not to my knowledge
"Q are any practice related committees at ACOG that deal with the issue of dealing with medical complications and pregnant women, to your knowledge?
"A that would probably fall under one of the obstetric related committees.
MR. PANTOJA: Page 43, line 10:
"Q doctor, could you tell us how the committees that exist in ACOG interact in order to develop policy statements?
"A I don't believe I could give you an adequate answer on that.
"Q could you tell us what you do now?
"A I can tell you about this particular task force and its relationship to forwarding its work to the executive board as a part of policy development.

"Q were any other committees of ACOG involved in developing the 1997 follow is I statement on intact D&X?"
Objection by counsel
"A no, other than the executive board pain pain page 45, line 7
"Q are policy statements at ACOGtypically shared with the fellows that are not on the committees before they're develop or as they are being developed or before they are approved?
"A they would not be shared until they have been reviewed by the executive board.
"Q does ACOG have meetings, conventions of its fellows?
"A yes
"Q are policy statements ever considered or debated at these meetings or conventions of ACOG fellows among the membership, among the fellows of ACOG?
"A I'm not quite sure what you are asking.
"Q let me try it again
Is there ever an occasion on which those who are fellows of ACOG get together and discuss proposed policy STHAEUPLTS ACOG is thinking of issuing?
"A I'm still not sure. Let me answer you from this direction. If you are a member of a committee or a task force and there is a product, a policy, a guideline, whatever, it is

not discussed outside the committee setting until it is accepted by the college.
"Q you mean by the board?
"A yes.
"Q I'm asking generally about policy development. I want to ask you specifically about this 1997 statement on dilatation and extraction.
What was the process by which this statement was developed? *EU
I am referring to plaintiff's trial Exhibit 6, doctor
"A the process was similar to the process in other committee in that materials that might SPHOEU some background were sent out before the frank force met.
The task force was carefully selected to provide a broad range of expertise and viewpoint. The committee then met, reviewed the materials, reviewed relevant experiences and expertise in the area.
In the case of the task force, SAZ true of other committees, the actual writing occurred within the committee.
Q. When you say committee, Doctor, you are referring to the task force?
"A the task force
"Q okay, go ahad he. The actual writing occurred where in committee?
"A the task force

"Q let's use the word task force. I have seen the word select panel used as well. Can we stipulate that committee select panel and task force are the same thing?
"A yes
"Q and we will use task force. When I interrupted your answer you were saying that the actual writing was done by the task force and you were describing the process by which the 1997 statement was developed
"A that is correct.
"Q anything further to add to your answer?
"A after the writing, the writing would be brought back to the task force to be read aloud and any editing after that reading would be done within the task force.
Following that the results of the task force would be forwarded to the executive board.
"Q and what would happen that the stage?
"A as we discussed previously, the board would have the material, the recommendations of the task force or committee to review prior to its meeting. It would be discussed within, presented and discussed within the meeting. If there was any editorial concerns those would be presented at that meeting by the executive board members and the final document would be produced after the agreement of the board members
So it's a process with many economics and balances

"Q you say that the task force, I believe you said that the task force statement would be presented to the board, is there someone that actually goes and make a presentation to the board with respect to the proposed statement developed by the task force?
"A I believe it depends on the statements.
"Q what happened in this case
"A in this case it was presented to the board by Dr. Fred Frigoletto
Q. Was Dr. Frigoletto the president of ACOG at the time.
"A that is correct.
"Q does the board, in considering the proposed statement -- let me just ask this first without reference to this document and TH-PB I will ask you if with reference to the document that is Plaintiff's Exhibit 6
Do you know, does the board typically conduct an inched TPEPBT review of the facts that are at issue in a particular policy statement when one is presented to it?
"A I don't know that I can answer that. What I can say is the board consists of clearly leadership members of the college with expertise in a brought area and they would bring that expertise to any documents that came before the executive boards.
"Q was any additional investigation of the intact dilatation and extraction issue done by the board when it

considered the proposed statement presented to it by the task force?
"A I don't know the absence to that. I was not there at the executive board
"Q do you know if the members of the board had access to the underlying materials that were reviewed by the task force in developing the statement on intact dilatation and extraction at plaintiff's trial Exhibit 6?
"A I don't know.
"Q you don't know if they had access to those materials?
"A considering they were common materials they would have had access. Whether they had them in hand I don't know
"Q do you know if the board reviewed any of the materials that the task force reviewed in investigate proposed statement on intact dilatation and extraction in plaintiffs trial Exhibit Number 6?
A. I do not know.
"Q did the proceed says you described for the develop. Of the proposed statement on intact dilatation and extraction by the task force, did that process conform request the process that ACOG utilizes in the development of other policy statements?
"A I can only speak for my experience as the chair. Ethics committee and the answer would be for many of those

statements, yes.
"Q when you said for many of those statements, you are referring to many of the statements that the ethics committee developed?
"A that is correct.
"Q and do I understand your answer to mean that for many of the statements that the ethics committee developed, the process that the ethics committee followed were similar to the process that was followed in the development of the statement on intact dilatation and extraction?
"A yes
"Q are you aware of any instances in which the policy, the process for developing a policy statement for another policy differed from the process by which the policy on intact dilatation and extraction was, intact dilatation was developed?
"A no, I'm not aware of those circumstances
"Q page 53, line 1:
"Q with respect to the statement on intact dilatation and extraction in plaintiff's trial Exhibit 6, once it was approved by the board the executive board of ACOG, is there any additional process that occurs within ACOG with respect to that policy statement?
"A with any policy statement of ACOG it then becomes available to the membership or the fellowship of ACOG.

"Q do I understand correctly that once it is made available to the membership of ACOG it is already approved that the point, is that correct?
"A that is correct.
"Q is there at that point any opportunity for the membership of ACOG, and I'm referring to the fellows, are those two terms synonymous, membership of aKWOG and fellows of ACOG
"A yes, almost
"Q there any process by which the membership of ACOG can debate policy statement after it has been approved by the board
"A just like any other statement of any organization or governmental actions, people are free to hold SEUPL posea and discuss and debate.
"Q within ACOG, is there any process or established forums where the membership of ACOG can debate a policy statement after it's been approved by the board?
"A certainly the annual clinical meeting often includes controversial topics.
"Q any other policy or forum at which policy statements might be discussed by the membership of ACOG after they have been approved, that is, process formed within ACOG
"A not to my knowledge
"Q is there any form in which the statement on intact dilatation and extraction was discussed by the membership of

ACOG after it was approved?
Comment by counsel
"A I don't know that I can answer that accurately. I don't know awe the educational forums that existed at the time and what was included on the programs.
"Q do you know of any forum in which the statement on intact dilatation and extraction in plaintiff's trial Exhibit Number 6, an ACOG forum was discussed among its membership
"A formally or informally
"Q let's start with formal
"A I don't know
"Q informally. Was there a discussion of this statement in ACOG forums after it was approved?
"A I would be surprised if physicians didn't discuss virtually anything in informal settings
"Q do you know whether this statement was discussed in any ACOGforum formerly or informally after it was approved?
"A no.
Page 60, line 18:
"Q did Dr. Hale participate in deliberations of the task force?
"A no.
"Q page 66, line 2. Let's one back through these names again and I am going to ask you if any of these people had abortion experience. Dr. G, do you know if he had abortion

experience?
"A I don't know.
"Q Dr. B?
"A I believe so.
"Q Dr. D
"A I believe so.
"Q do you know what Dr. B's abortion experience was?
"A no.
"Q Dr. D, do you know what her abortion experience was?
"A I would think it was in regard to high risk pregnancies
"Q but you're not sure?
"A no, not at this point.
MR. PANTOJA: Comments by counsel:
"Q Dr. Frigoletto was the president of can a cog did he come to satisfy any of the particular criteria of the selection of the task force?
"A Dr. Frigoletto had significant SKPERience as the chief of brig ham and women's Harvard's medical facility in Boston. Long SKPER yen in the area
"Q do you know if Dr. Frigoletto had experience in abortion
"A yes
"Q do you know what the extent of his experience

was -- is
"A I don't know the extent but I know he has significant experience
"Q did he bring a particular point of view to the proceedings?
"A his primary point of slew was concern regarding ma TPERPBL health
"Q who is Dr. J?
"A Dr. J is a practicing OB/GYN. At that time he would have been in HRAOUZ HRAOUZ
"Q is he associated with a particular since TEU TAOUGS
"A I don't know
"Q do you know if he had abortion experience KAFRPBLGTS I don't know
"Q any particular point of view that he brought to the proceedings?
"A a general practice point of view, experience with maternal complications
"Q Doctor N, who is she?
"A she is the chair of the department of obstetrics and gynecology at the university. She's a maternal fetal medicine expert who has written textbooks in the area.
"Q on maternal fetal medicine?
"A uh-huh

"Q was that the area of expertise that she brought to the panel?
"A she also was a senior woman on the panel
"Q do you know if she had any abortion experience?
"A yes.
"Q Dr. R?
"A was a practicing O*B gain
"Q where was she from?
"A I don't remember
"Q you don't remember any institution she was associated with
"A no
"Q did she have a particular expertise
"A she had a particular expertise in providing abortions.
MR. PANTOJA: Page 74, line 14:
"Q Doctor, you have before you plaintiff's trial Exhibit 6 and I believe plaintiff's trial Exhibit Number 5, statements of policy concerning abortion policy.
Are there any other statements of policy ACOG has issued concerning abortion policy that are not reflected in plaintiff's trial Exhibit 6 and 5?
"
MR. PANTOJA: Comments by counsel.
"A not to my knowledge.

"Q so, for example, your ethics committee, did your ethics committee deliberations ever result in the issuance of a statement of policy that touched on the issue of abortion?
"A not during my tenure as chair.
MR. PANTOJA: Page 76, line 19:
"Q I want to go back to a couple of topics we talked about earlier this morning and wrap up a couple of points. Was there any kind of a formal effort to obtain broader approval of the intact dilatation and extraction policy statement once it was approved by the board among the ACOG membership?
"A I don't understand your question. The approval process at ACOG is the executive board
"Q so I take it that the policy statement on intact dilatation and extraction was not put to any kind of vote of any kind outside of the executive board."
Comment by counsel
"A the approval process is through the executive board
"Q are you aware of any ACOG policy statements that are approved through a process other than simply board approval?
"A of policy statements?
"Q yes.
"A no.
"Q are ACOG knell lows made aware if a policy is

under development and given an opportunity to comment to the select panel?
"A they are not made. They are not requested to make statements it a select panel.
"Q are they made aware that a select panel exists and is considering a policy in a particular area?
"A I think they may be in some circumstances.
"Q were they in this instance?
"A I don't know.
"Q you don't know?
The fact sheet at plaintiff's trial Exhibit 5, do you know who wrote this fact sheet?
"A I believe that college staff did on the basis of the document.
"Q did the TPAFBG force have any involvement in writing the fact sheet?
"A the task force reviewed it and in fact as I noted, my comments regarding that are in here that the college had.
"Q did the entire task force review if?
"A it was sent to the entire task force.
"Q was the task force asked to approve it or simply comment on it
"A simply comment on it
"Q how many times did the task force meet in person

"A it met over two days
"Q just one time?
"A yes
"Q if you look at cane deposition Exhibit 6 it indicates October 5 and October 6 of 1996 was the -- was that the sometime that the task force met?
"A that is correct.
"Q were there any other times in which the task force met as a group by telephone?
"A not to my remembrance
"Q would you describe for me the process, just in general terms, by which the task force deliberated on a statement of intact dilatation and extraction when you got together on October 5th and 6th
"A as I noted before, materials were sent out ahead of time. The committee members reviewed those to get a general sense of the background.
It is Dr. Frigoletto's memory and mine that at the working dinner we reviewed those documents and we were given homework for the evening, although I don't remember what that home diagnosis work was.
So, we worked beyond the time that we were together.
We met the next day and went through atgen da reviewing each area in detail and then crafting together language which we felt represented expert opinion at the time

and issues of concern to the fellowship. A staff member then typed that so it was available for to us read and it was then edited in committee.
"Q in the task force committee?
"A that is correct.
"Q Doctor, do you recognize the document marked as Cain deposition Exhibit 7?
"A yes.
"Q could you say what it is?
"A it's a statement on intact TKEUL aface and extraction. It is a draft copy from the committee. I believe this was a copy that was sent to executive board members prior to their meeting.
"Q so is it fair to say that this draft statement of cane deposition Exhibit 7 is the proposed statement approved by the task force on intact dilatation and extraction?
"A it is a draft statement from the task force. That is correct.
"Q I was just trying to establish, this is the one that the task force settled on, approved and sent to the executive board "QUESTION this is the one they sent forward to the executive board
"Q were there other versions? Let me put it this way. Were there prior drafts of this statement that were circulated among the task force

"A at the sometime of the meeting, question
"Q do you know what happened to those
"A they would have been disposed of since they were not a final draft from the committee or the task force
"Q do you know that they were in fact disposed of?
"A I can't say I know for sure but I would say it it's highly likely page 28, line 8
Q. Okay, how did the drafting process KEUZly work? Eye mean who, I'm not talking about who typed it but how did this text come about? I'm talking about about the text at Cain deposition Exhibit 7. I assume at some point you have to come up with language. How did you do that.
"A in the committee our memory would be that someone would be writing as discussion went on in an area and that would be written up and reviewed.
"Q who was assigned to do the writing as discussion went along?
"A I think it varies around the room. Everybody got the opportunity
"Q okay. And how did the discussion and deliberations and the writing by individual members come together to form the words on this piece of paper?
"A the committee started with the background so that would have related to the first paragraph. The committee identified the fact that the general materials at the time had

such broad and inconsistent definitions for what was being called partial birth abortion that for the purposes of the commitee and the college we needed a very clear definition that made some medical sense. So that's where that would have come from and the sequence.

"the third would have come from the place of now the defined procedure within the practice of obstetrics.

"the next would have come from materials available to the committee about general safety and use of second trimester pre viable of abortions.

"and the last was the conclusion of the experts in the committee about the concerns regarding this, particularly one of the major concerns of the fellowship at the time that prohibiting any specific medical practice by doing so could outlaw techniques that are critical to the lives and the health of American women.

"Q was the task force presented with a working draft of a statement that they commented on? Or did the task force itself create the statement from the beginning?

"A it was our memory that we created the statement at the time of the meeting.

"Q October 5 and 6,1996?

"A that is correct.

"Q and just so I'm clear about this, at the end of that meeting on October 6, 1996, this document existed?

"A that is correct

"Q I understand the topical areas that are covered in the document as you have just described them. What I am not clear on yet, if you can try to help me with, is specifically how did these words that appear on this paper get created.

Was somebody assigned to a particular paragraph or topic and proposed a paragraph?

"A assigned at the time of the discussion a discussion would occur. Somebody would volunteer to try to codify the discussion in words. They would then be read and edited by the committee after they could actually see it in print

"Q so is it the case that different members of the task force may have pend different parts the statement?

"A that is correct.

"Q do you know which members of the task force originally drafted portions of this

"A no.

"Q but is it the case that for each element of the statement each paragraph of the statement, a member of the task force did the original drafting which was then commented on?

"A they would have put down what they thought would have been appropriate in that area, yes.

"Q were paragraph portions circulated among the task force members for discussion

"A as I said, everything that was written was reviewed by the entire task force
"Q what I meant to ask you were the paragraphs considered spately?
"for example, when you were discussing the terminology issue, was there a separate paragraph circulated for discussion on that point?
"A I believe that it was circulated both separately and then as part of the final document.
"Q just with respect to -- let's just say the last paragraph of the document beginning terminating a pregnancy, do you see that paragraph, Doctor?
"A yes
"Q did one member of the task force originally draft that paragraph that was commented on and end ited by the others
"A I'm not sure whether one or several because it may not have been in this paragraph form in the original draft
"Q you said that, I believe you said you had a working dinner in which you reviewed documents and then you had some home work that first night and then you came back the next day and went through the agenda.
At what point did text start being developed in the process
"A the actual text that we reviewed together probably would have been the next day, the morning.

"Q was there any text on any particular point reviewed on the Saturday that you arrive?
"A not that I remember, other than what existed in other documents
"Q when text was developed it did it touch upon every TPOPic that is task for -- did it touch upon every topic that's reflected in the final statement
"A I'm not sure what your question means
"Q let me STRAOEU that again, I may have asked this before but I'm not sure of your answer, so let me just try it Ben
"were portions of text circulated separately for consideration by the task force that eventually came together as one document?
"A right. As I said, the process included writing a piece, reviewing a piece, as well as reviewing the entire piece as it came together.
"Q page 88, line 13:
"Q Dr. , Cain deposition Exhibit 8 is a document produced by ACOG. It's Bates stamped at the bottom ACOG 0008 through 10. It appears to be a letter from President Clinton to Ralph Hale executive director of ACOG dated July 3rd, 1996, THAEPS the first page, ACOG, 000el -RBGTS often ACOG OPL00 the is a White House statement from the office of the press secretary dated April 10th, 1996 P-FR Doctor, have you soon

this document before?
"A yes
"Q Whether did you first see it?
"comment by counsel.
"Q have you seen that?
"A yes
"Q when did you first see it
"A I'm sure I saw it in my pact as a member of the task force
"Q was this document before the task force before it issued its proposed statement on intact dilatation and extraction?
"A yes.
"Q was the document considered by the task force in developing its proposed policy statement?
"A yes.
"Q was it relied on in any way in developing the statement?
"A many of these documents were used to help the committee formulate the kinds of questions and the concerns that were present in the public at large and this would be an example of that regarding this area of practice.
"Q so to put it another way, what role did PHREUPB's letter play in the task forces deliberations?
"A the task force would have used this to ask itself

what is the concern or the question being raised about the practice that this reflects as a part of the general population
"Q any other way in which the document was used?
"A that would have been the primary way.
Pain pan TPHAEUPBLG page 94, line 12:
"Q that's right, did you see this document as a member of the task force?
"A yes
"Q was the document considered by the task force in developing its proposed policy statement on intact dilatation and extraction?
"A yes.
"Q was it relied on in any way in developing the policy statement?
"A it was relied on. As I have noted for the prior documents to assure that we fully considered issues and questions on the table.
"Q did this document play any other role in the deliberations of the task force?
"A can you clarify your question?
"Q well I have been asking you, I have been trying to ascertain what role a particular document played and you have been identifying, we have only done I think one or two so far.
What I am trying to ascertain is what role did a particular document play? How did it inform the deliberations

of the task force. In response to prior questions you indicated, for example, on the White House document that it identified issues of concern that the task force looked at and so I'm going to ask you a series of questions request respect to a series of documents and what I would like to know is what role did this document play. And I believe you previously said that as with prior documents one of the roles it played was to assure consideration of the issue that you were --

"A that is correct

"Q now, since Dr. Grimes is a doctor and was chief of obstetrics at you call San Francisco, I would just like to know if this letter to senator Byrd played any more of a role in your deliberations that you described

"A not the letter, per se

"Q okay, did the task force rely on this letter, in particular, as a source of medical information?

"A no. Although Dr. Grimes is a well regarded expert in the area and had written significantly in that area. His other writings would be considered the foundation of medical knowledge in that area.

"Q let me turn to that in a second, but with respect to this document, it was not a source of medical information for the task force, is that correct?

"A no. It would have been used to make sure that all the issues were on the table.

"Q when you say on the table, would it be to make sure --

"A to be considered by the task force.

"Q so if I could, I don't want to mischaracterize your testimony. Please tell me if I do, but would it be fair to say that this document was used for the purposes of issues spotting, that is to say identifying issues that the task force was then going to discuss?

"A yes both medical and edge KWAL issues

"Q while we are on the subject of Dr. Grimes, do you recall any other specific written material that Dr. Grimes authored that was considered by the task force?

"A not specific.

"Q and just to perhaps slightly rephrase the question so there is no confusion, did you consider any articles written by Dr. Grimes during the deliberations of the task force?

"A I do remember, as I noted before, that we had a side table with texbooks from that period of time. I do not WREB whether chap THERZ were authored by Dr. Grimes

"Q okay and go you remember any specific article that Dr. Grimes wrote that was reviewed by the task force

"A not a specific article by Dr. Grimes

"Q okay.

Do you remember any specific research that Dr. Grimes conducted that was discussed by the task force?

"A only as it would appear wane chapter as a citation."
(continued on next page) TWM take 5 somebody's deposition being read<]
"Q. OK. So is there anything that the task force discussed associated with Dr. Grimes' research or writing that you can specifically remem
remember?
"A. No, although it would be unusual that a chapter regarding midtrimester abortion did not SKHRU statistics or work from Dr. Grimes as one of the leading authorities.
"Q. OK. Do you know if the executive board reviewed the letter from Dr. Grimes to Senator bird in cane Deposition Exhibit No. 9?
"A. I do not.
"Q. Do you know if they relied on it in any way?
"A. I do not.
"Q. Do you know if they discussed it?
"A. I do not.
"Q. Did the task force discuss the letter?
"A. As they did all of the materials.
"Q. Do you recall anything in particular about the discussion of Dr. Grimes' letter?
"A. No.
"Q. Do you recall anything generally about the discussion of Dr. Grimes' letter?

A. No."
Page 99/line 19.
"Q. Dr. Cain, did you see the document marked as cane Deposition Exhibit 10 when you were a member of the TKAFBG force?
"A. Yes.
"Q. Was this among the documents that was reviewed by the task force before it issued its proposed statement?
"A. Yes.
"Q. And just for the record, this appears to be a question and answer sheet prepared by the National Abortion Federation entitled later abortions questions and answers.' Is that correct, Doctor?
"A. Correct.
"Q. By the way, this is ACOG 0017200 24. Doctor was this document considered by the task force in developing its proposed policy statement?
"A. Yes.
"Q. In what role did this document play in the development of the policy statement [> and<]
"A. It identified the common questions that the task force needed to consider.
"Q. Did the document play any other role that you can identify in the task force's deliberations?
"A. No.

"Q. Was the document relied on in any way by the task."
Comment by counsel.
"A. In regard to identifying important questions that needed to be raised.
"Q. Was it relied on in any other way?
"A. No.
"Q. Was the document considered a source of medical information for the task force?
"A. No.
"Q. Was the document considered a source of medical expertise?
"A. That's a different question, is it not?
"Q. I believe it is.
"A. My understanding is the National Abortion Federation is a national professional association of abortion providers. That would indicate expertise.
"Q. Did the task force rely on the expertise of the National Abortion Federation in developing its proposed statement?
"A. No. It relied on the expertise of the members of the task force.
"Q. Do you know if the document was reviewed by the executive board?
"A. No.
"Q. Do you know if it was relied on in any way by the executive board?
"A. No.

"Q. Was this document, cane Deposition Exhibit No. 10, discussed by the task force?
"A. Yes.
"Q. Do you recall anything specifying about the discussion of this document by the task force?
"A. No.
"Q. Do you recall anything in general about the discussion of this document?
"A. No."
Page 102/line 19.
"A. Oh. One of the things that we did look at were examples, and this does include examples.
"Q. Examples of what, Doctor?
"A. Of patients for whom this would be an appropriate procedure or the most appropriate procedure.
"Q. Could you refer me to the portion of this document you're referring to?
"A. It would be ACOG number 0018.
"Q. There's one over on 19 as well, is that the case?
"A. That is correct.
"Q. OK. Did the task force have any more information about these specific cases than is presented in these two pages?
"A. No.
"Q. And just so the record's absolutely clear, did the task force have any medical records associated with these cases that

were discussed on ACOG 0018 and 19?
"A. No, not the specific cases."
Page 103/line 22.
"Q. Doctor, cane Deposition Exhibit 11 is a document that appears to be a statement made by in a RAL, NARAL, which as I understand is the national abortion rights action league, is that correct?
"A. I believe so. That's what it says.
"Q. In a RAL, and it's entitled third trimester abortion, the myth of abortion on demand.' Did you see this document as a member of the task force?
"A. Yes.
"Q. And was this document before the task force as a part of its deliberations before it made its proposed policy statement on intact D&X?
"A. Yes.
"Q. Was it considered by the task force in developing its proposed policy statement?
"A. Yes.
"Q. What role did this document play in your deliberations?
"A. Similar to the prior ones. It also contains examples of women, and these examples really were used by the committee to consider in their own practice and experience whether or not these were circumstances that would require as the most appropriate intact D&X. The committee could think of numerous

other ones S-, but these certainly were examples that the committee would have added to that.
"Q. Any other role this document played in the task force's deliberations?
"A. No.
"Q. Now, you're referring to the examples on page ACOG 0026?
"A. Correct, and 27, ending on 27, I think. I think we're missing a page. I think we are we were missing that at the time.
Q. So we have an exact replica. The only examples that I see here on 0026, do you agree?
"A. I agree.
"Q. Did the task force have access to the medical records of these patients that are discussed on 0026?
A. No.
Q. Did the task force have any more information about the -- about these patients and their situation other than as is described on 0026?
"A. Not these specific patients.
"Q. Did the task force rely on this document as a source of medical information?
"A. No, other than the examples of patients. It wasn't relied on as medical information.
"Q. And did the task force rely on the examples provided by in a RAL with respect to these particular case studies described

on 0026?"
Comment on counsel.
"A. We would not AEUF relied on them. We would have considered whether they were reasonable examples and appropriate and used them to understand the place of this procedure in obstetrics."
Page 106/line 22.
"Q. The document marked as Exhibit 12 is labeled fact sheet: Abortion after 12 weeks.' It appears to be, Doctor, of the National Abortion Federation. There are names indicated at the bottom of the document. This is ACOG 0028 to 0029. Doctor, did you see this document as a part of your deliberations on the task force?
"A. Yes.
"Q. Was it considered by the task force before it issued its proposed statement on intact D&X?
"A. Yes.
"Q. What role did this document play in your consideration?
"A. To identify areas for the task force to review.
"Q. Was the document considered a source of medical information?
"A. No.
"Q. Was the document considered a source of medical expertise?
"A. The document was considered as produced by medical experts in abortion, STEUPBS National Abortion Federation is a group of professionals in that regard.

"Q. So let me ask the question this way. Did the task force rely on the medical expertise of the National Abortion Federation?
"A. No.
"Q. Did the task force rely on the medical expertise of the national abortion rights action league as reflected in, to the extent it's reflected in the document labeled Exhibit 11?
"A. No.
"Q. Do you know if this document was reviewed by the board?
"A. No.
"Q. Do you know if it was relied on by the board?
"A. No.
"Q. Was this document discussed by the task force?
"A. Yes.
"Q. Any PEFBG recollection of the discussion of this document??
"A. No.
"Q. Any general recollection of it, of the discussion of the document?
"A. Yes. As part of the discussion of the documents in general.
"Q. But nothing comes to mind about -- nothing comes to mind with respect to a discussion of this particular document?
"A. That's correct."
Page 109/line 15.
"Q. The document marked as cane Deposition Exhibit 13 is titled

'second trimester abortion from every angle, fall list management seminar, September 13th through 14th, 1992, Dallas, Texas.' It appears to be a document of the National Abortion Federation. There is, by the way, this document is ACOG 0030 to ACOG 0039. There's a table of contents on page ACOG 0031, and the paper actually attached here to Exhibit 13 is a paper by Martin Haskell presented at the National Abortion Federation risk management seminar September 13, 1992.

"Doctor, did you see this document as a member of the task force considering the statement of ACOG on intact dilatation and extraction?

"A. Yes.

"Q. Was this document considered by the task force in developing its proposed policy statement on intact dilatation and extraction?

"A. Yes.

"Q. And what role did this document play in the task force's deliberations?

"A. This document played both a background role, but also was an example of a writer who was providing service or an abortion that was called D&E [> a professor<], dilatation and extraction, and was used as background information on the variety of descriptions of that procedure in the general common usage.

"Q. If you take a look at ACOG 0032, the third PHAEUPBLG of the

document, I believe a moment ago you used the term D&E. Did you misspeak? Because Dr. Haskell in his paper says he coins the term D&X to distinguish it from dismemberment type D&E's. So just for purposes of clarification-

"A. D&X.

"Q. Is it a discussion of Dr. Haskell's D&X procedure, is that correct?

"A. That's correct.

"Q. Other than as a document which described the D&X procedure, was there any other role that the document played in the task force's deliberations?

"A. Describing the D&X from his point of view, that would be it.

"Q. That's it? Did the task force rely on Dr. Haskell's paper as a source of medical information?"

Comment by counsel.

"A. We used it for the purpose of defining one way in which D&X was defined and used at that point in time.

"Q. Did the task force, if I could use the word 'extract' from Dr. Haskell's paper any other medical information that informed its decision in drafting the policy statement on intact D&X?

"A. Other than the procedural elements, no.

"Q. And did the task force rely on the medical expertise of Dr. Haskell as reflected in his paper in developing its proposed policy statement on intact D&X?

"A. I'm not sure in what context you're speaking. He described the procedure. It was one of a number of ways of describing a procedure. We used that to inform our thinking on how that procedure should best be described for the fellowship.
"Q. So in typical lawyer like fashion I've asked the question about four times, and the bottom line is you only relied on this paper for a description of the procedure, is that correct?
"A. That was the primary use of this paper, correct.
"Q. What were other uses of the paper?
"A. Background questions regarding the issues."
Page 115/line 3.
"Q. If you take a look at the second two pages of the document, ACOG 0040 and 41, this document appears to be a brochure of the Wisconsin right to life education fund, and it is entitled 'the D&X abortion procedure, scientific development or human rights abuse.' It purports to describe what D&X is an how it is performed. What role did this document play in the task force's deliberations?
"A. As with other documents, it would have been information that we used to assure that we raised the questions and reviewed the yea adequately in light of what was in the general population and questions at that time.
"Q. So to try to summarize it -- and please, if I missing characterize you -RBS telling me if I have -- was this an issue-spotting document? Maybe let me put it differently. Was

this a' document that you used to identify issues to discuss?
"A. Yes.
"Q. OK. Did it play any other role besides identifying issues to discuss?
"A. This is another document that has a description of D&X, and therefore it would have been informed a discussion about what sort of descriptions existed of D&X in the general population.
"Q. Was this document relied upon -- let me rephrase that. Was this document considered a source of medical information by the task force?
"A. No.
"Q. Was this document discussed by the task force?
"A. Yes.
"Q. Do you recall any specific discussion about this document?
"A. No.
"Q. Unlike the other documents we've seen, this document appears to have some graphic depictions of the procedure, is that correct?
"A. Yes.
"Q. Was there no discussion that you can recall of these depictions of the procedure?
"A. I could imagine discussions, but I don't remember the exact discussion.
"Q. Well, don't imagine. And let me just ask you if you recall. You may not recall the exact discussion. That would

be a pretty high standard to hold you to. But do you recall any discussion about these depictions of the procedure?
"A. I recall that they were discussed. If I recall anything, it would be just sequence and, you know, comparison to other descriptions in the literature about whether or not this was an appropriate nomenclature for that sort of procedure.
"Q. Do you know if the executive board reviewed this document?
"A. No.
"Q. And do you know if they considered information in this document to any extent?
"A. No."
Page 118/line 4.
"Q. Doctor, I believe cane Deposition Exhibit 15 is an article from the New York Times written by Alan Rosen field, is that right?
"A. That is correct.
"Q. Do you know Dr. Rosen field?
"A. He is an obstetrician gynecologist and at the time was Dean of the Columbia school of public health, probably the preeminent school of public health in the United States.
"Q. Did you see this document as a member of the task force?
"A. Yes.
"Q. And it was before the task force as it was liberating the policy statement on intact D&X?
"A. Yes.

"Q. And what role did this document play in the task force's consideration?
"A. It again as general background. In this particular circumstance, the colleges mentioned, and particularly the concern of the college about Congress superseding professional medical judgment and the potential for harm to women. [> college is mentioned<]
"Q. Did the information in the document -- was the information in the document. Let me strike that and start over on this one. Was there any other role that this document played in the task force's deliberation other than the one you just described?
"A. That was -- that would be the role, as a part of the general background.
"Q. Was the document considered a source of medical information as the task force deliberated on intact dilatation and extraction?
"A. No.
"Q. Why not?
"A. It didn't contain statistical material or other material that we felt were appropriate. It was used as these other documents were used, to provide background information. That doesn't mean the material is not factual. It means its use in the committee was to provide background questions to be sure we reviewed.

"Q. You said it contained no statistical information or other material that you felt it was appropriate?
"A. We didn't use it by itself for that.
"Q. Right. What was not -- let me ask it this way. What material did you feel was appropriate to be considered by the task force?
"A. We felt the numerous examples the task force itself could put on the table regarding their experience or need for this procedure, the textbooks, published information about the safety of D&E, and this as a subset of D&E, and the significant background and experience of the people at the table, and also information about the safety and alternatives and the safety of alternatives.
"Q. OK. Thank you. Let's take a look at the other New York Times. This is an editorial titled 'abortion politics.' This is Exhibit 16 of course ACOG 0043. This document was before the task force during your deliberations?
"A. Yes.
"Q. What role did it play, Doctor?
"A. This one, again, provided general background. In this case it again raised the issue that the terminology that was being utilized was nots recognized by the medical community.
"Q. Any other role that this document played other than identifying that issue as one to be considered, that terminology?

"A. That would be the primary role.
"Q. This document was obviously not relied on as a source of medical information, is that fair to say?
"A. That is correct.
"Q. Or medical expertise?
"A. That is correct."
Page 126/line -- excuse me -- line 6.
"Q. Did the task force consider Dr. McMahon's data that was presented to Congress in its deliberations on the statement of intact D&X?
"A. Yes."
Page 127/line 1.
"Q. This purports to be data submitted by Dr. McMahon to Congress, is that your understanding?
"A. Yes.
"Q. My question is the data that purportedly was submitted by Dr. McMahon to Congress, that was considered by task force in preparing its proposed statement on intact dilatation and extraction?
"A. Yes.
"Q. And what role did it play in your deliberations?
"A. The maternal and fetal indications, much like the cases or examples, would have been reviewed by the committee to remind them of other areas or patients they might have seen with that and whether or not this was an appropriate procedure.

"Q. For those indications?
"A. Right, much like the other cases, to expand the discussion.
"Q. Any other role this document played in the consideration of the task force?
"A. Again, identifying issues the ensure the committee had addressed all the issues and reviewed them.
"Q. Was Dr. McMahon's data submitted to Congress regarded as medical information used to inform the task force's deliberations?
"A. It was used in the sense that it raised questions, for example, about complications or other issues.
"Q. Did the task force in any way rely on Dr. McMahon's data in attempting to resolve those questions?
"A. No.
"Q. Do you know if the executive board saw this document?
"A. No."
Page 129/line 11.
"Q. Cane Deposition Exhibit 18 is ACOG 0045 is the first page. ACOG 0047, 48, 49, and 50 is the remainder of the document. ACOG 0045 is a memorandum to task force on third trimester abortion from Kathy Brieant, associate director, department of government relations, I assume ACOG, background material for 10/5-6 meeting. Dr. Cain, I take it you've seen this document before and it was among the materials that the task force consi

considered?
"A. Yes.
"Q. Could you further describe Kathy Brieant's role during the task force deliberations.
"A. She was a staff person. She would have done a lot of the typing and bringing things back to the table, clarifying if we didn't understand something in terms of where documents had come from or something like that.
"Q. Do you have an understanding that -- it says here in the memo, it says JD. Do you have an understanding that she was counsel, she was a lawyer or is a lawyer?
"A. She was a lawyer. For purposes of the committee, she was a staff member.
"Q. Miss PWRAOEUPBTS had a memo dated September 24, 1996, ACOG 0047 to 48, and the memo appears to be discussing a document produced by ACOG district 2, which appears to be the document at 0049-50.
"A. Correct.
"Q. And Miss Brieant's memo of September 24, 1996, was specifically to Dr. Frigoletto. What I wanted to ask first of all was whether or not the task force reviewed Ms. Brieant's memo to Dr. Frigoletto.
"A. Yes.
"Q. And in conjunction with that memo, did the task force review the statement at ACOG 0049 and 50 prepared by ACOG

district 2 titled 'medical questions and answers on third trimester termination procedures,' was that also considered by the task force?
"A. Yes.
"Q. Did the task force have before it any other memos prepared by ACOGstaff on the issues that the task force was considering similar to the one here at cane Deposition Exhibit 18, pages 47 and 48?
"A. Separate from the materials that we're putting in the file, whatever is in the file would be whatever was before us."
THE COURT: Excuse me. Is this a convenient time for you to break STPH-P it is 5 minutes of 5:00, and I have a criminal conference at 5 o'clock. I guess it a logical place to break or not?
MR. PANTOJA: I have two more questions and answers to read in, which will take 20 seconds.
THE COURT: Go right ahead, if that is what you have, finish that unthen.
MR. PANTOJA: At page 131/line 16.
"Q. I guess I'm not sure I understand your answer. It's probably because my question wasn't very clear. So let me try to make it clearer. Lawyers always ask a confusing and then they figure out what a more clear question is. Did Ms. Brieant write any more memos to the task force?
"A. Separate from the ones that are in this joint set of

materials, that we would have had at the committee at the time, it is my understanding that the materials we are reviewing are those that were available to the committee at that time. I do not remember other things.
"Q. Right. Do you remember reviewing any other memos that Ms. Miss Brieant wrote that were related to your deliberations on the intact dilatation and extraction statement?
"A. No."
That concludes. We can stop here and continue tomorrow. Conditional fine. Thank you, sir.
Approximately how much more do we have to go in the transcript? Can you give me a guesstimate?
MR. PANTOJA: A half hour.
THE COURT: Fine. That is all I am asking for. We will recess at this point in time and reconvene at 9:30 tomorrow morning.
(Adjourned to 9:30 a.m., April 15, 2004)