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

Plaintiffs,

v. 03 Civ. 8695 (RCC)

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

Defendants.

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New York, N.Y.
April 15, 2004
9:55 a.m.

Before:

HON. RICHARD CONWAY CASEY

District Judge

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(Trial resumed)

THE COURT: Good morning. Please, be seated.

Ms. Gowan, are we continuing with the transcript or are we calling a witness?

MS. GOWAN: Good morning, your Honor.

THE COURT: Good morning.

MS. GOWAN: The government would like to call Dr. Clark. However, if the Court would prefer the conclusion of the ACOG testimony, we would be prepared to do that as well.

THE COURT: It's a hard choice, Ms. Gowan.

MS. GOWAN: I think I know the answer.

THE COURT: But let us not say that we dictate how you try your case, so go right ahead with whatever you want to do.

MS. GOWAN: The government calls Dr. Steven Clark.

THE COURT: All right.

STEVEN L. CLARK,

called as a witness by the Government,

having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. GOWAN:

Q. Dr. Clark, are you presently employed?

A. Yes.

Q. Where?

A. Inner Mountain Health Care at the University of Utah.

Q. And where is the Inner Mountain Health Care at University





of Utah.

A. Salt lake city, Utah.

Q. In what capacity are you employed there?

A. I am a practicing maternal fetal medicine specialist at one of the Inner Mountain Health Care facilities, LDS Hospital, and professor of obstetrics and gynecology at the Utah School of Medicine.

Q. How long have you held the position as professor of obstetrics and gynecology at the Utah School of Medicine?

A. 14 years.

Q. And would you briefly describe your duties and responsibilities as professor of obstetrics and gynecology?

A. Yes.

In my role as professor I oversee the portion of the medical school teaching program that occurs at LDS Hospital, which is a private community facility.

The medical students, residents and fellows in the University of Utah School of Medicine divide their time between the University Hospital and LDS Hospital. So, I oversee that portion of their obstetrical training at LDS Hospital. That involves patient care, it involves didactic teaching, lecturing and, of course, on-the-job teaching as I care for patients, along with the residents and students.

Q. Where did you receive your medical training?

A. University of Wisconsin in Madison.

Q. And when did you graduate from the University of Wisconsin?
A. Undergraduate, the degree in chemistry, 1975; and I graduated from medical school also from the University of Wisconsin in 1979.
Q. And where did you do your postgraduate training?
A. University of Southern California.
Q. And what type of postgraduate training did you do?
A. Internship and residency in obstetrics and gynecology and fellowship in maternal fetal medicine.
Q. What is maternal fetal medicine?
A. Maternal fetal medicine is the subspecialty of obstetrics that deals specifically with what you might call problem pregnancies or high risk pregnancy. So, this would be women who have medical complications of their pregnancy or who develop new pregnancy complications that could jeopardize the mother's life or health, and also fetal problems that develop in the range of lethal fetal abnormalities to fetal problems that can actually be treated while the baby is in utero and is life-prolonged in that way.

So, a gamut of fetal or maternal complications or pregnancy.
Q. As a maternal fetal specialist, do you consider both the woman -- the mother and the fetus, to be your patient?
A. Yes.
Q. Are you licensed to practice medicine?


A. Yes.
Q. And where?
A. Utah and Montana.
Q. Are you board certified?
A. Yes.
Q. And in what speciality or specialities?
A. In the speciality of obstetrics and gynecology, and in the subspecialty of maternal fetal medicine.
Q. Do you have a further speciality within the subspecialty of maternal fetal medicine?
A. No, I wouldn't say it's a subspecialty, but it's a special interest.

There are no more defined subspecialties than just maternal fetal medicine. But within the area of maternal fetal medicine, one of my principal interests and experience has been care of the critically ill mother.
Q. Is that called critical care obstetrics?
A. Critical care obstetrics, yes.
Q. Would you please tell the Judge what critical care obstetrics is?
A. Well, it's a term that I think was formally coined when we published the first edition of the textbook, Critical Care Obstetrics, back in the late 1980s.

It is a special interest within maternal fetal medicine which deals exclusively with women who have conditions

that might kill them complicated by pregnancy where in fact the very fact of them being pregnant places their life or health at significant risk, places them at risk for becoming critically ill and how to prevent that from happening. Or women who show up critically ill and are pregnant and how to prevent them from dying or to treat them.

Obviously there are a number of very complex issues when we have both critically mother and a baby, and they kind of are both in the same package, you might say. The treatment of one has to be the same as the treatment for the other. And so, that speciality, that area is what we call critical care obstetrics.

Heart disease in pregnancy, bad diabetes, bad high blood pressure, cancer in pregnancy, lung disease in pregnancy, allergic anaphylactic pregnancy reactions, these sorts of things are what we deal with in critical care obstetrics.

Q. Is your work in critical care obstetrics?

A. Today?

Q. Yes.

A. A lot of it is, but fortunately there aren't enough critically ill pregnant women to keep me busy and so I do a lot of standard high-risk obstetrics, preterm labor, this sort of thing, which really wouldn't involve direct critical care.

But I certainly do see probably more than my fair share of critically ill women because they are transported in





from outlying states for us to care for.

Q. Were you involved in writing the critical care obstetrics textbook that you mentioned?

A. Yes.

I was the lead editor for that book. In fact, it was my original concept. The lead editor for the first three editions, now the fourth edition which has just come out we have stepped back, we are still editors but we have chosen some of the young people in the field now to actually be the lead editors, so I'm still an editor of the fourth edition that just came out.

But we have turned over the major leadership of that to some people that I trained.

Q. Do you have an active medical practice in maternal fetal medicine and critical care obstetrics?

A. Yes.

Q. What percent of your time is spent in active clinical practice?

A. About half my time, plus night and weekend call would be me taking care of sick or potentially sick women and their unborn children.

The other, the remainder of the time is the formal teaching. My work as quality assurance chairman and things like that. Some research.

Q. Where are you quality assurance chairman?

A. At LDS Hospital.
Q. And what are your responsibilities as quality assurance chairman?
A. Well, there are certain criteria that have been set forth in advance which cause a medical chart to do what we call to fall out, that is, a bad maternal outcome or bad newborn outcome.

If those things happen in a chart, the charts fall out for review. I chair the committee that reviews those and then decides whether something should have been done differently that could have resulted in a better outcome for the mother and baby. Then the committee makes recommendations to the department in terms of whether a doctor needs to be proctored more, or that the care was perfectly fine, whether privileges need to be suspended. This sort of thing based upon those.

So I reviewed bad outcomes -- or my committee does -- and then recommend potential changes to avoid those in the future.
Q. How long have you chaired that committee?
A. Since I began in Salt Lake City in 1990.
Q. Do you consult on cases in addition to treating your own patients?
A. Yes.
Q. And could you briefly tell me what type of consulting work you do?



A. All sorts of -- many types.

The most common type would simply be women who are referred to me for, not for me to care for their entire pregnancy but who have a potential problem and they're referred to me by their obstetrician.

And I will see the patient, review the history, at times do examinations or tests, and then recommend back to the doctor: This is how you've got to handle this pregnancy. These are things you've got do in addition to your standard pregnancy care to try to achieve the best outcome.

I am called on the telephone. I do the first thing, that is, hands-on consulting on patients virtually every day.

Secondly, I receive telephone calls from doctors who want a less formal consultation. They just call me and say, Steve, I've got this patient whose got such and such, what do you suggest? And that's both locally and nationally, and in fact internationally.

I get phone calls a couple times a month from someone in the country or someone in the world who's got a particularly complex maternal situation and just wants my two cents' worth on it.

And then, I reviewed a number of cases and consulted for lawyers or insurance companies in terms of medical malpractice litigation.
Q. Now, you mentioned that you have some teaching

responsibilities?
A. Yes.
Q. In connection with your work as a professor, could you please describe for us what you do in teaching the residents?
A. Yes.
My teaching would -- one of two types. The most common type, which I do almost every day, would be the hands-on care. So, tomorrow morning, for example, at 7:00 a.m., I will show up on the high-risk anti-partum or, that is which is pre-delivery women or the high-risk women who need to be hospitalized are.
There will be a bunch of medical students and residents there and we will spend an hour or two seeing all of the high risk patients who have been admitted to the hospital or who are on labor and delivery. I'm the attending for the day, I will ask the residents and students what would you do and then tell them if they would do the right thing or they would do the wrong thing. They'll see what I actually do do and learn in that fashion.
Tomorrow at noon, at 12:15 actually, I will give a lecture, say formal didactic lecture which I do a couple of times a week, and that's pretty characteristic of my teaching activities.
Q. Are you a member of any professional societies?
A. Yes.


Q. And which ones?
A. The Society for Maternal Fetal Medicine, the ACOG, the American Institute of Ultrasound in Medicine.
I believe those.
Q. What is ACOG?
A. The American College of Obstetricians and Gynecologists.
Q. And within the past five years or so, have you been a visiting professor at any medical schools?
A. Yes.
Q. And which medical schools?
A. Well, Brown University, Vanderbilt, a couple of schools within the University of California system, U.C. San Francisco, for example, University of Oregon.
Those are some I can think about.
Q. How does it come that you take on the role of visiting professor at various institutions in the United States?
A. Well, generally the chairman or division head will call me up and say, Steve, why don't you come out in October and give us some talks.
Or, the visiting professor activities can vary from talks to conferences with residents to occasionally even rounds with residents. It's a fairly informal situation.
Q. Can you give us an idea of the subject matter upon which you teach when you are a visiting professor?
A. In the vast majority of cases it will involve care of

critically ill women.
MS. GOWAN: Your Honor, may I approach?
THE COURT: You may.
Q. Dr. Clark, I'm showing you what has been marked as Government Exhibit Z4, would you please take a look at it?
A. Yes.
Q. Do you recognize this document?
A. Yes.
Q. What is it?
A. This is a copy of my curriculum vitae.
Q. Is it up to date?
A. No. But it's pretty close.
Q. And what is not up to date about it? What's missing?
A. Well, it says Revised 12 of 2002, so there are possibly -- I have given a few more talks, grand rounds. I may have published an additional chapter or paper or two, but not -- there is not much.
For the most part, this would hold.
MS. GOWAN: Your Honor, the government moves admission of Exhibit Z4.
THE COURT: Any objection?
MS. PARKER: No objection, your Honor.
THE COURT: It will be received.
(Government's Exhibit Z4 received in evidence)
BY MS. GOWAN:


Q. Dr. Clark, you mentioned you published some articles; are you referring to articles published in the medical literature?
A. Yes.
Q. Can you tell me how many, approximately, articles you have published?
A. Between -- around 175.
Q. Are these articles identified in your curriculum vitae?
A. Up through about a year ago, yes, they are.
Q. And are any of these articles, approximately 173, peer-reviewed?
A. Yes.
Q. Can you give us an idea of approximately how many have been peer-reviewed?
A. A believe a half to two thirds, that sort of number. A number of them are book chapters and those book chapters are review articles that are not necessarily reviewed.
But all of the articles that are published in peer-reviewed journals have been peer-reviewed.
Q. And can you tell us just generally some of the journals in which you have published peer-reviewed articles?
A. Sure. The American Journal of Obstetrics and Gynecology. Obstetrics and Gynecology. The Journal of Reproductive Medicine.
Q. Anything else?
A. Yes. I'm sure there are but those would be the main ones.

Q. And do you serve as editorial consultant for peer-reviewed journals?
A. Yes, I do.
Q. And which ones?
A. Well, over the years, the New England Journal of Medicine. The Obstetrics and Gynecology Journal, American Journal of Obstetrics and Gynecology.

All of the major journals in my speciality and some minor ones as well. I have reviewed for critical care journals, just general medical critical care journals as well and they're listed there on the CV. I think about 13 different peer-reviewed journals periodically sent me papers for peer-review and comment prior to publication.
Q. And are these papers that are prepared by other authors who seek to have their work published in the journal?
A. Yes.
Q. Have you received any honors for your review of articles that are submitted by other authors for publication?
A. Yes.
Q. And can you tell us what honor you have received?
A. Well, yes.

Last year the journal of the American College of Obstetrics and Gynecology, which is called Obstetrics and Gynecology, published a review. They reviewed the reviewers, put it that way. And I got a letter saying you have been named


in the top 10 percent of peer reviewers in terms of scientific -- I forgot exactly what terms they used but something to the effect of scientific accuracy and integrity, and you're --

so, I'm in the top 10 percent and that's it.
Q. Is that identified an your curriculum vitae?
A. Yes.
Q. And let's take a look at page number 4, item number 14, could you read that for us?
A. Named top 10 percent of special expert referees for obstetrics and gynecology in terms of manuscript quality reviews.
Q. Have you presented any research at scientific meetings?
A. Yes.
Q. Approximately how many times have you done that?
A. Oh, I think a dozen or so.

Let me be specific here for you. You know, I can't find that page, but somewhere in here it will list those, and I think --

THE COURT: Ms. Gowan, maybe you can point it out to the Doctor.
Q. Page 17, Doctor, starting at the bottom going on to page 19.
A. Oh, yes. Okay.

Okay, 26.

Q. Now, were you the principal author of the presentations at the meetings that are identified in your curriculum vitae?
A. They weren't yet published yet. I was the principal, I think more accurate would be that I was the principal author of the work that was, as it was presented, and that is to say I was the presenter.

There obviously have been many other articles that I have worked on and perhaps even been the senior investigator where I have let more junior people do the presenting to further their careers. But these would be situations in which I was at least the principal author.
Q. Can you give us a general idea of those types of presentations where you may have been a lead investigator or you may have been a co-author or worked on it but you allowed someone else to go ahead and take the credit as the principal author of the paper?
A. Well, in terms of presentation, sure.

I may have, for example, my fellow, he's now my partner, Dr. Porter, when he was a young -- when he was working with me on a fellowship we did some research and I would kind of direct that research, got the idea, put him on it, kind of oversaw things.

But he did much of the work involved in that and it was, I think, important from his career standpoint to get up in front of the national audience and present that research. And



so, he would have then actually done the presentation even though I was the senior investigator on the project.

And in fact I think it's been a few years, obviously, if you look at this list, earlier on I did more of these. More recently I do very few.

I would anticipate I may never present a paper again in my life because my task now academically is to bring other young investigators along. I don't need -- 170-plus publications, I don't need any more and I don't need any more oral presentations at meetings.

So, I think you can see that trend and that would be an example of why that would be done that way.
Q. Do you have specific areas of interest in research?
A. Yes.
Q. And what are those?
A. One, again, critically ill pregnant women, that is heart disease in pregnancy, severe infections in pregnancy, this sort of thing.

And a second has been how the fetus gets oxygen while it is inside the mother and what factors might deprive that baby of oxygen and how doctors might tell whether babies are getting enough oxygen and doing well inside or whether it's not doing well inside.

I have also done quite a bit of research on the concept of vaginal birth after caesarean. I have a number of

papers that were in the first batch back in the '80s that really introduced that concept to American medicine and I continue to publish on that, even in recent years.
Q. In addition to the critical care obstetrics textbook, are you the editor or are involved in any other books relating to obstetrics?
A. I have been, yes.
Q. And which books are those?
A. The -- well, there is a text called Williams Obstetrics, I was asked to join the 20th edition a few years ago and as an editor with some specific tasks in terms of bringing some of those areas in that textbook up-to-date.

I was also an editor of a text called Operative Obstetrics that described procedures.

And a text called Caesarian Delivery.

Q. In addition to the research, writing, clinical and teaching activities, have you participated in other professional activities?
A. Yes.
Q. And could you tell us briefly what some of those are?
A. I can tell you some of them, yes.

I have worked for the National Institutes of Health, the NIH on a number of occasions, both as a grant reviewer helping decide which university should get the money to do the research on specific projects that the NIH has set forth, which


universities are likely to do a good job and get a usable answer.

I served, a number of years ago, on an expert panel of the NIH on asthma in pregnancy, and a couple of years ago actually co-chaired an international symposium sponsored by the NIH on hemorrhage in pregnancy.

I served on a number of positions for the American College of Obstetricians and Gynecologists. I served on their technical bulletin committee for these years, served as chairman of the technical bulletin committee for an additional two years; have served both as chairman and as a writer for a little text they put on periodically called Prologue, which is kind of a summary you might say, of the top 150 or so topics in obstetrics -- what doctors need to know, to some extent, for the board exams.

I served on the board of directors for the Society for Maternal Fetal Medicine, which is the National Organization of Board Certified Maternal Fetal Medicine Specialists and served as their president in, I think it was '97 or '98, for my term there.

I headed a project for the U.S. Agency for International Development and it was jointly between a group called Feed the Children and the U.S. Agency for International Development to improve maternal child health care in Siberia. Made a couple of trips to Siberia, operated with the doctors

there, brought them over to the United States. They lived in my home and worked with me for about a month. We got them some equipment and so forth.

Those are some things.

Q. Can you just very briefly tell us about your work on the ACOG technical bulletin committee?

A. Sure.

The American College of OB/GYN has a committee which puts out educational bulletins. These are short, five to eight page documents which pick a topic, let's say, diabetes in pregnancy or heart disease in pregnancy, something like that, and set forth what is known as a summary of what is known about that condition and often will set forth one acceptable way to manage that condition.

There are, it's about a seven or eight member committee who chooses the topics, writes the documents, and then those documents are sent to all -- they were sent to all members of the American College of OB/GYN. They're now published in the journal rather than in a separate mailing.

So, that's the work of that committee.

Q. Can you, very briefly, tell us about the work of the ACOG Prologue committee?

A. Yes, that's -- it's somewhat similar. The two major differences are that the Prologue is not sent out periodically five or six times a year, it is redone every three or four


years and the coverage of the topics is much shorter. Rather than five to eight pages on a topic there may be one to two pages on each topic, a much more concise summary.

Also, the Prologue generally contains a question that is abused.

A patient comes in with such and such condition, what would be the best treatment, A, B, C, D, and then an explanation of why what the answer is.

Q. Have you recently written a Prologue sheet for ACOG?

A. Yes.

I'm writing a sheet -- I'm writing a topic right now, it's either Prologue or a similar document called Precis, P-R-E-C-I-S, and to be honest I can't remember which one it is for -- on heart disease and pregnancy. That's on my desk right now, reworking the final draft for the American College; yes.

Q. I see that your CV says that you have been named to the list of best doctors in America from 1992 to the present; how does somebody get on that list?

A. Well, I get -- every year I get a -- there is some organization and I don't know what the name of it is. So, they send out this little questionnaire to doctors and say why don't you list the top X doctors, five or six or 10 doctors in your speciality nationally.

And then they, my understanding is they get all of these back so I will list doctors I know are good doctors, I

will send it in. Then they take all of these and compile them and I guess you might say the top vote getters or something then get this little letter that says you've been named as the top doctors in America. And they make a little book that has that list then, I think.
Q. So, it is something that your peers have identified you as being?
A. Yes, correct.
Q. Have you received any awards for teaching?
A. Yes.
Q. And what awards have you received for teaching?
A. A number of years ago I received an award as the top medical educator. The past couple of years I received a national award called the American Professors of Gynecology and Obstetrics Award for Teaching.
Q. Besides your work in this case, have you ever testified in any court case involving challenges to partial-birth abortion?
A. No.
Q. Besides your work in this case, have you ever been involved in any way in a court case involving challenges to partial-birth abortion?
A. No.
Q. Have you ever been consulted by any state or local official concerning abortion laws?
A. Yes.


Q. And could you tell us about that?
A. Yes.
A number of years ago Utah had passed an abortion law and it was challenged and I got -- I was asked by the Utah Supreme Court to come away with them to the mountains for a week and talk to them.
And so we went up to some retreat in the mountains and spent a weekend -- did I say a week? If I did, I'm wrong. A weekend, and spent a weekend with the Supreme Court Justice and they just asked me all sorts of questions -- basic pregnancy questions and maternal health questions and I think just wanted to be informed about the basic issues. I believe they wanted to do that, before they heard this case, for some background.
But, for whatever reason, I spent a weekend with the Supreme Court Justice and we met and talked and I just answered their questions.
Q. Have you been consulted by any other government officials in connection with abortion laws?
A. Yes.
Q. And could you tell us about that?
A. Yes.
Utah just passed another kind of abortion law dealing with funding, public funding of abortions, and I was asked by the University to go, you might say, talk some sense into them.
The laws were, this new potential law was very

restrictive, it left no provision in there for terminating pregnancy for fetal abnormalities.

As it currently stands it would prevent federal funding -- excuse me, state funding for a woman, for example, who had a baby without a brain that was developing, that woman could not achieve, could not be funded and any institution that performed that abortion even for free would lose all state funding for all procedures. In my mind, a very unreasonable sort of thing.

And I went down and talked with the, some of the sponsors of the bill in the state legislature and tried to, as I say, to make them see that this was not a reasonable -- not a reasonable bill and was not a reasonable thing to restrict abortion in that fashion.

That's all.

Q. Have you ever been sued for malpractice?

A. Yes.

Q. How many times?

A. Once.

Q. What was the result?

A. Very early in the case -- I was named with a bunch of doctors, my insurance company gave them $1,000 and I was out of the case. That was back in about '86.

I understand there were other allegations against primary doctors who cared for this woman but for a thousand



bucks I didn't care to hang around and find out.

Q. Have you ever testified as an expert witness before in other kinds of cases?

A. Yes. Many times.

Q. And what kinds of cases? Medical malpractice cases?

A. Yes, cases that basically involve my research.

Lawyers seem to have been very interested over the years in those same topics I have written about medically -- critical ill mothers who may die and fetuses who, how fetuses get oxygen during labor and what events might result in brain damaged babies, for example.

Those have been areas I have written about for 20 years and lawyers seem as interested as doctors, or at least have a great interest in those. So, I have been asked to review and have testified on many occasions.

Q. Can you give us an idea of when you say many, approximately how many times have you done this over the years?

A. Oh, I'm sure over the years certainly I have reviewed hundreds of cases. I have testified in well over a hundred.

Q. Dr. Clark, did you testify in Illinois in a case involving the death of a 13-year-old girl from amniotic fluid embolism?

A. Yes.

Q. Do you have a special area of research into amniotic fluid embolism?

A. Yes.

Q. Could you just briefly describe for us, very briefly, what your work has been in amniotic fluid embolism?
A. Well, this is a devastating condition that is one of the leading causes of death among, in any western industrialized country where other causes have been reduced.

And back in the mid-'80s I and a number of co-investigators did some research which really showed that traditional concepts of this disease were probably not valid about how it happened, and we have published a lot on that over the years.

My co-investigators have done a lot of the work but I have kind of been the lead investigator on most of this work.
Q. Do you have a registry of amniotic fluid embolism?
A. Yes, and I was kind of the leader of the national amniotic fluid embolism registry.
Q. Did you receive peer-reviewed publication for your work in connection with that registry?
A. Yes. In fact it was more than peer reviewed. I was asked to present that work.

There is a very prestigious research organization called -- well, professional research organization, the name is probably irrelevant, American Gynecologic and Obstetric Society which is by invitation only, and you're asked to present a major piece of work there and it's not only peer reviewed in the standard fashion but they get right to the nitty-gritty and



grind it up and spit people back out. But, if it's successful then you are in that organization.

And they asked me to come present that work, present and defend that work to that organization and in fact it received high accolades and really --
Q. Did you receive an award in connection with your work in connection with the amniotic fluid embolism?
A. I think so, yeah.
Q. In that Illinois case, was your work on the amniotic fluid embolism registry challenged?
A. Sure.
Q. Do you recall very briefly what the issue was?
A. Yes. I know the only people who -- this has never been challenged in a scientific forum but by lawyers who don't like the results sometimes -- I mean, some of the results are good for the defense, some of the results are bad for the defense and good for the plaintiff, either way. And so, there have been obviously a lot of pot shots taken about this in legal matters.

My understanding -- I'm not sure, I think what they were belly aching about in this case was the fact that after doing the research -- or that a number of the cases were in litigation and in fact a couple of the cases not only had I collected this data but actually had been asked to serve as an expert. There was a statement made as I recall that I was an

expert in 75 percent of the cases, that's absolutely wrong, but I believe 75 percent of the cases were in litigation and in some of those I had asked to be an expert on.

So, they dug into that in an attempt to discredit the research but, again, no credible scientific group has ever -- you know, that's -- that's lawyers.

Q. Do you know what happened to that Illinois case?

A. Yes. They found for the defense, that was decided. Some Court said send it back and then it was ultimately dismissed.

Q. Why did you agree to testify on behalf of the government in this case?

A. Well, I think fairly simply I am trying to bring some scientific rationale into this, into this whole question.

I mean, there may be -- it's a big issue, it's a big issue socially, and I can see reasons that some people might favor this bill and I can see some reasons that people might oppose this bill, but there may be valid reasons to oppose it but don't give me this health of the mother nonsense.

That's the basic thing. That's absolute hype. Absolute spin. I did in fact write the book on the subject in this case and I just hate to see the scientific accuracy compromised for the sake of politics and my -- again, I'm trying to bring some -- people can't discuss abortion rationally in America because everybody takes an extreme position and I'm just trying to bring the scientific truth of


this matter in terms of the effect of this procedure on maternal health and I think that may be a contribution to the overall debate in the country.

Q. Are you being paid for your work on behalf of the government in this case?

A. No.

Q. And was that your decision, Doctor?

A. Yes.

Q. Do you provide abortions as part of your patient care?

A. Yes, if they're medically needed.

Q. Can you just tell us briefly under what circumstances would an abortion be medically needed in terms of the kinds of care that you provide to patients?

A. Well, there would be three categories.

One would be a situation where the fetus has died already inside and obviously there is no point in the mother carrying that fetus further if the child is already dead, and so -- yes. Since most of my patients would be potentially seriously ill in addition to having the dead fetus you might require some special expertise to take care of that.

There would be other conditions where the baby is perfectly fine but in fact carrying that pregnancy further places the mother's life and health in jeopardy and in fact under those circumstances it may absolutely be necessary to preserve the life and health of the mother to terminate the

pregnancy.

And so, when that's necessary we do it at all gestational ages prior to viability, the baby can't live on the outside. After viability the baby can live but we put about maybe 15 to 20 percent of new babies in a newborn intensive care unit, they're put there on purpose by people like me who have delivered this child early because continuing to get this baby further time for maturity would place the mother's life and health in jeopardy.

And so, we do that all the time, deliver the babies early when the mother's health is in risk, or if it happens very early in pregnancy, actually do a termination.

The third category would be where there are fetal abnormalities not compatible with life on the outside. The baby developing without a brain, for example, where continuing that pregnancy may have some particular hazards to the mother and there are no benefits to the baby -- whether it's born now or born later it will die and we can tell that by prenatal testing.

And those would be, that would be the third category of conditions where I might provide, either provide or assist in providing pregnancy termination.

Q. What kinds of pregnancy termination methods have you used?

A. Well, D&C early on, medical induction of labor later on, or this D&E procedure later on.



And of course, once you get to the point where the baby can live on the outside, again medical induction of labor in most cases. And, at times, caesarian section.

Q. Can you just give us an idea of approximately how many labor induction abortions you have performed?

A. Sure.

You say labor induction abortions and so I'm restricting this answer then to those situations that occur prior to what might be called fetal viability, prior to 23-24 weeks.

Q. Are you doing that because you refer to labor induction then for purposes of live birth?

A. Yes.

Q. Okay.

A. Beyond that we try to save -- we try to save the baby. Right. Even though we may have to deliver because the mother is really sick we, of course, try to save the baby.

Certainly less than 20 labor induction abortions, in my life.

Q. And what about abortions by D&E?

A. At most, a dozen.

Q. When you say D&E, are you referring to D&E by dismemberment?

A. Yes.

Q. Do you review the literature concerning abortion?

A. Sure.
Q. And why do you do that?
A. Well, if it's in any of the leading journals I read them every month so I can't help it.

Furthermore, of course this is important to somebody who spends his life caring for -- really to a large extent -- really, really sick mothers. Knowing the latest info on ways to terminate the pregnancy in those rare cases where it is necessary to preserve the health of the mother is an important thing.

Q. Have you ever provided care to patients who had a miscarriage or spontaneous abortion?
A. Sure.
Q. And in those circumstances, what method have you used to complete the miscarriage?
A. Well, either D&E or medical inductions. I think for the -- well, let me put it this way, D&C would certainly be the most common. Medical induction is probably second-most common.
Q. Can you give us an idea of approximately how many times you provided care to patients who have had miscarriage or spontaneous abortion?
A. Sure, hundreds of times in women where the fetus was already dead or they're miscarrying right now. Lots of times. And I'm not including that in my previous answer that only dealt with live fetuses.



Q. Can you just, very briefly describe for the Court, how D&E by dismemberment is performed?
A. Well, sure.

The cervix is dilated, there are different ways this can be done and then the, an instrument is introduced into the uterus and the fetus is pulled out in parts.

Q. After the fetus is removed, is there any other steps taken to complete the procedure?
A. Well, sure. Then you've got to deal with the placenta and typically the placenta does not deliver quickly in these early pregnancies and no matter how you, once the baby is out either medically or by D&E, then you're in the same situation. There is the empty uterus except for the placenta and then you have to way for the placenta to come out and often that also has to be taken out also with instruments.
Q. How do you remove the placenta with instruments?
A. By pulling it out with the same sort of forceps instruments called sulfur forceps.

THE COURT: Doctor, when you say this procedure that parts of the fetus are pulled out, they have to be torn off, do they not?

THE WITNESS: Yes, they do.

THE COURT: I mean, it's not in parts in the mother's uterus, right?

THE WITNESS: That's correct.

THE COURT: They have to be torn off and removed?
THE WITNESS: Yes, they do.
THE COURT: I know it's harder to say, but that's the fact of how it's done?
THE WITNESS: That's the absolute fact. The baby is torn limb from limb and, if it's alive, it dies as its limbs are being torn off.
THE COURT: That's what I want this record to be clear on.
THE WITNESS: Absolutely true.
THE COURT: Thank you.
BY MS. GOWAN:
Q. Doctor, what do you tell your patients if you are going to perform a D&E by dismemberment procedure on them?
A. Well, remember we only are going to do this if -- I'm only going to do this if the mother has a good chance of dying if we don't, in which case the baby will die too.
And so, it's really not mother versus baby, it's the baby is going to die either now or after its mother dies. Or, the baby will die now but the mother will live, okay?
So, I just think I want to make that very clear that I do not do these things electively, only when it is absolutely necessary.
So, the first thing we do is try to make sure it is in fact necessary, and that's very, very rare. In most cases the


medical conditions can be treated, it's not.
But when in fact those situations arise, and they do arise and I have this conversation with women where in fact there is an excellent chance they will die unless they terminate this pregnancy, I simply explain to them the procedure in just the way I have explained it to you.
The cervix is dilated and then the baby is pulled out in pieces.
And very often they will specifically ask the question that the Judge just asked now and, yes, I tell them in exactly those words, yes, we will pull it apart limb by limb and that will kill it.
THE COURT: Is that your obligation, to tell a patient under medical ethics, complete disclosure?
THE WITNESS: Absolutely.
THE COURT: Thank you.
Go ahead, Ms. Gowan.
BY MS. GOWAN:
Q. Would you please describe for us medical induction abortion, briefly?
A. Sure. That simply involves administering some sort of drug, and there are a variety of things that can be used, which cause the uterus to contract and you might say mimic the more natural process of labor in which case the fetus is delivered.
So, the same sort of labor that would occur under most

circumstances at full-term occur, are made to occur very much earlier.
Q. What are these agents called that you have just referred to?
A. Well, there are two basic classes. One is called oxytocin.
Oxytocin is simply a synthetic version of a hormone which is naturally released to cause labor but it's not generally released until later on and we inject it earlier on.
The second are a group of agents called prostaglandins and there are two classes E prostaglandin and F prostaglandins. And the difference between E and F might not seem like much but actually there are some major physiologic distinctions between which patients can use E prostaglandins and F prostaglandins.
Q. Can some patients use E but not F prostaglandins?
A. Yes.
Q. Would that then be called the patient having a contraindication for F prostaglandin?
A. Yes.
Q. But it would be safe to use E prostaglandin for that patient?
A. Yes.
Q. Have you ever heard of something called misoprostol?
A. Sure.
Q. What is that?
A. PGE-1, so that's one of the E prostaglandins.



Q. Is misoprostol used for medical induction abortion?
A. Yes.
Q. Have you ever heard of the expression "off-label" in connection with a drug?
A. Yes. Sure.
Q. What does that mean?
A. That just means that the drug is being used for a purpose for which the drug company did not develop it.
Misoprostol, for example, was developed to treat ulcers but it was found to be very effective in causing contractions and therefore is used widely both in full-term -- full-term pregnancies when something comes up and you want to induce labor, misoprostol is used all the time. And it's also used in earlier terminations, both when the baby is dead and in the rare case where the baby is still alive.
Q. So then would its use in connection with terminations be called an off-label use --
A. Sure.
Q. -- of misoprostol?
A. Sure, it would.
Q. And are drugs commonly used off-label by physicians practicing in the United States?
A. Well, sure they are.
I think that the best example of that would be for preterm birth. There is one drug approved for use in treating

preterm labor in the United States. It is a drug called Ritadrin and I haven't seen that drug used for preterm labor in almost a decade now and I treat preterm labor all the time and so does everything else.

All of the drugs that are commonly used in America today to treat preterm labor are off-label drugs. Every single one of them.

Again, I'm not even sure if they make Ritadrin anymore, so that's just an example of drugs that were -- all these drugs were initially developed and labeled for use in other conditions but have been found, for example, to be useful in delaying pre-term labor and so they're used off-label, yes. Another example.

Q. In your view, is abortion by medical induction a safe abortion procedure?

A. Sure.

Q. And is it a recognized abortion procedure?

A. Yes.

Q. And has it been studied?

A. Yes.

Q. And is it safely documented in the literature?

A. Yes.

MS. PARKER: Your Honor, I think Ms. Gowan is offering, is asking for opinions before she's qualified this witness as an expert. We have no objection to him being


qualified.

THE COURT: I wouldn't think you would, but I don't know that it's necessarily an expert opinion at this level. But if you wish to go through the procedure, or is it an exercise because it's done in the movies regularly, objections?

Do you wish to offer the witness as expert, Ms. Gowan?

MS. GOWAN: Your Honor, I was going to do that very shortly after I ask the witness to tell us.

THE COURT: Overruled then. Go at your own pace.

BY MS. GOWAN:

Q. Dr. Clark, are you familiar with the dilation and extraction abortion method or D&X?

A. Yes.

Q. And what's the basis of your familiarity with that procedure?

A. I have read about it.

Q. What have you read?

A. Well, I have read the original descriptions of the, I think it was Dr. McMahon and Haskell who, my understanding, kind of developed this procedure, and I have read how the fathers of that procedure described it and how it's done.

I have read a number of expert disclosures in this case, I think they were called expert disclosures, something from plaintiff experts who performed the procedure, and they talked about all sorts of things.

Q. Are you referring to the plaintiff's declarations that were provided to you by the government in connection with your work in this case?
A. I think I am, yes.
And then I reviewed kind of a pre-publication draft of an article by Dr. Chasen and colleagues and, you know, have -- those would be the main sources of my information on this topic.
Q. Have you ever witnessed the performance of the D&X procedure?
A. No.
Q. Do you know anyone who performs it?
A. I'm not sure that I do. I mentioned in deposition that I know this Dr. Evans and so if he -- if he performs them then I know someone.
Q. You think he may but you are not sure?
A. I'm not sure, yes.
Q. Do you have an understanding of the approximate gestational age at which the procedure is performed?
A. Yes, second trimester.
And in reading the, my recollection is that one of these -- one of these McMahon or Haskell things, I think there was a fetus out to 32 weeks. I mean, it seems unbelievable but as I recall there was some description that it was performed that late. My understanding is that these days that would be



very unusual but I believe it's performed out to 27, 28 weeks sometimes.
Basically second trimester and occasionally beyond, is my understanding.
(Continued on next page)

Q. Can you describe very briefly what you understand the procedure to involve.
A. Sure. The cervix is dilated by, again, a variety of methods. The fetus is then extracted feet first. Once the fetus has been extracted to the point of the head, a hole is put in the head, you put in a suction device, suck out the brain, pull out the baby. Then you have still got the placenta the same way you would regardless of how the fetus was brought out.
Q. Have you ever heard the term "partial-birth abortion"?
A. Yes.
Q. What does "partial-birth abortion" mean to you, that term?
A. I think it is this procedure we are talking about in this case that I have just briefly described.
Q. So in your mind partial-birth abortion is the same as D&X?
A. Yes.
MS. GOWAN: Your Honor, pursuant to Federal Rule of Evidence 702, the government offers Dr. Clark as an expert in obstetrics and gynecology, maternal fetal medicine, and critical care obstetrics, with the knowledge, skill, experience, training, and education to testify and form an opinion about maternal health and abortion.
THE COURT: Any objection?
MS. PARKER: No objection.
THE COURT: The Court will so recognize the doctor.



Q. Doctor, have you been asked to render an expert opinion in this case concerning maternal health and D&X abortion?
A. Yes.
Q. Have you formed an expert opinion concerning maternal health and D&X abortion?
A. Yes.
Q. What is your opinion, in summary?
A. Twofold. Number one, under no circumstance is D&X abortion necessary to preserve the life or health of the mother. Corollary to that: Under no circumstance would the abolition of this procedure in any way jeopardize the life or health of any mother regardless of what medical condition she may have.
Number two, there are in fact grave concerns regarding the long-term safety of this procedure regarding the use of this procedure. To date, there are no publications even describing this procedure. There will be one coming out. And once that data is out and appropriately analyzed, the data from that procedure regarding rate of subsequent preterm birth is so incredibly disturbing that it makes -- I think it confirms what is suspected might result from this procedure in terms of long-term outcomes, and therefore it would be inappropriate to be used in the general sense.
MS. PARKER: Your Honor, I object to that last piece of the answer regarding Dr. Chasen's study and I ask that it be stricken from the record. This expert did not opine on the

Chasen study in his expert report. No supplemental expert report has been submitted, and we have not had an opportunity to depose this expert on this topic.

THE COURT: Is that Ms. Parker?

MS. PARKER: Yes.

THE COURT: Calm down. I can hear you.

Ms. Gowan?

MS. GOWAN: Your Honor, indeed, as I advised plaintiffs' counsel this morning, the government is not offering Dr. Clark's expert opinion as to any of the substance or the underlying methodology or in a way to critique Dr. Chasen's paper. Certainly Dr. Clark has looked at Dr. Chasen's paper. It is going to be out there in the medical literature. He will testify just in the way that he has read that and understands that there are certain facts or conclusions pressed in that paper and that he is applying those to his opinion. He is not being offered in any way to challenge that paper.

THE COURT: I will allow it.

Q. Doctor, does your opinion in this case in any way depend on the gestational age of the fetus?

A. No. You mean the two opinions I have just given you?

Q. Yes.

A. No, they do not. That would hold without respect to the gestational age of the fetus.

Q. Could you very briefly tell us why.



A. Sure. I can't imagine any medical condition -- I have tried hard to think of one, even a hypothetical one -- in which this D&X procedure might be helpful to me, as someone who spent my life caring for critically ill women, in which it might be helpful to me in preserving the life or health or well-being of the mother. I can't come up with one. I can't come up with one at 6 weeks, I can't come up with one at 18 weeks, I can't come up with one at 22 weeks. I can't come up with one at any gestational age.

Q. Does your opinion apply to those circumstances where the woman is experiencing a maternal medical complication that requires termination of her pregnancy?

A. Yes.

Q. Does your opinion apply to those circumstances where the woman is carrying a fetus with an anomaly that is incompatible with life?

A. Yes.

Q. Does your opinion apply generally to the issue of safety as it may relate to the procedure?

A. Yes.

Q. Are there available methods of abortion in the second trimester that may be used to safely terminate a pregnancy of a woman who is experiencing a maternal medical complication?

A. Yes.

Q. What are those methods?

A. Basically, one can induce labor with any one of those drugs we mentioned, or in the second trimester one can do this D&E, extraction dismemberment procedure. Those are available. In the vast majority of cases, either one is equally acceptable. There are certainly situations where the extraction may be somewhat preferable, and there are other cases where the medical induction may be somewhat preferable.
Q. When you say "extraction," are you referring to the D&E by dismemberment?
A. Yes.
Q. The procedure you described for the judge, the tearing of the fetus in parts?
A. Yes.
Q. I'm sorry. I didn't mean to interrupt. You were telling us that there may be certain circumstances where one may be contraindicated or the other may be preferable?
A. Absolutely. Not many, again, but there are some cases where one is preferable to the other. But there are no cases where the D&X, partial-birth abortion, is preferable to the D&E.
Q. Or the medical induction?
A. Right.
Q. If the D&E by dismemberment is contraindicated.
What is the physician's first goal when confronted with a pregnant woman who is ill?



A. To try to make her un-ill.
Q. What do you mean by that?
A. To try to treat her medical condition that is making her sick and get her better.
Q. So you try to stabilize the patient?
A. Stabilize and, if possible, improve and help cure, if that can be done to the patient.
Q. Do you do that for the purpose of assisting her in proceeding to term with her delivery, if possible?
A. Sure.
Q. Are you sometimes able to safely stabilize an ill patient through to live birth?
A. I think "sometimes" would be incorrect. Almost always would be correct, yes, the vast majority of situations no matter what the medical condition is. Yes, indeed, the mother can be treated medically, she can be treated surgically. Her condition can be stabilized. Again, I spend my days taking women with potentially serious conditions or serious conditions right up through the end of pregnancy and sending home healthy mother with healthy baby, yes.
Q. Is it fair to say that it would be rare that a termination would be required in order to preserve the health of an ill mother?
A. Very rare.
Q. Can you give us some idea based on your experience of how

often such circumstances might occur that a termination of a pregnancy would be required to preserve maternal health?
A. Sure, especially in the second trimester. Let me give you some numbers. About 30,000 deliveries occur each year in Utah, and my colleagues and I would see, I expect without exception, all of those mothers who might require termination for medical indication.

In addition, we would see a large number of such patients from the states of Nevada, Montana, Idaho, and Wyoming who would be referred into the University of Utah if they had a medical condition that required that sort of situation. So I suspect we are dealing with you might say a catchment area of 50, 60,000 patients a year.

We probably perform at all gestational ages now 2 or 3 a year, 2 or 3 terminations a year where the maternal medical condition warrants a termination. I suspect we would average zero to 1 a year where this would occur in the second trimester.
Q. Why would it be more rare in the second trimester?
A. For the following reasons, I think with the exception of one condition. I can think of occasionally a condition called preeclampsia which may suddenly blow up in the second trimester. This would be late second trimester. Still, that is very rare.

But most of these medical conditions, the very fact



that the woman is alive in the second trimester means that, by definition, she must have had access to really good healthcare throughout the first trimester or she would be dead by now. And if she had access to really good healthcare in the first trimester and the pregnancy was threatening her life, she would have terminated the pregnancy if she was going to already in the first trimester.

So the concept that a woman might have a really serious medical condition which is going to kill her and she suddenly drops out of the sky in the late second trimester needing a second trimester termination is simply one that is kind of a hypothetical construct that in truth doesn't happen, doesn't happen for the most part. Of course, there are exceptions to everything and occasionally it does happen. I gave you the idea of the frequency of that.
Q. What about where the medical condition isn't so severe that it might kill her but that the medical condition might jeopardize or negatively impact her health? Is that similarly rare or is that less rare, in your experience, in second trimester?
A. No, it is similarly rare, and I think for similar reasons. If a woman has a serious medical condition but now she is alive in reproductive age, she is going to have had for the most part access to mainstream American medicine and will have made that decision to terminate her pregnancy if it is going to affect

her health in the first trimester, when she can have a quick, easy, simple, safer D&C procedure.

The other reason, of course, is the woman has to make not only -- well, I think I have explained it.

Q. Doctor, is that why you don't have much experience performing abortions?

A. Yes, absolutely. The situation simply does not arise in the context of a medical indication. It is rare as hens' teeth. It is rare as hens' teeth for that to occur.

Q. Doctor, before we focus on specific conditions, can you just tell us very generally what types of maternal medical conditions might indicate that a termination would be necessary to preserve a woman's health.

A. Sure. I would say heart disease probably accounts for the vast majority of conditions where we find ourselves counseling the woman that if you carry this pregnancy further on you're going to die or you have a good chance of dying or your health being severely affected. So maternal heart disease is, I believe, the most common.

The next two would probably be cancer in pregnancy and hypertensive disease in pregnancy. Then rare cases of everything else probably would be less than 5 percent of the situations where medically indicated termination becomes an issue.

Those would be the major categories. Certainly there



are blood clotting disorders, bleeding disorders, pulmonary disorders, disorders of most of the organ systems of the body which might occasionally pose a risk to the mother's health.

Q. When you say occasionally for those types of disorders, can you give us any kind of rate of occurrence that you might see or have seen?

A. I have given you kind of the whole thing. I think less than 5 percent. And I want to make it clear here I am not speaking scientifically. I do not have data. This is just what seems to me when I give you these figures, so take these figures with a large grain of salt, please.

Q. When you say --

A. I think 90 percent of the cases where medical termination is necessary we are talking heart disease, 5 percent is cancer, hypertensive disease, and probably 5 percent is everything else under the sun combined. That is my thoughts as I sit here today but speaking without -- in answer to your question. But those numbers do need to be taken with a grain of salt, please.

Q. That is based on your experience working in critical care obstetrics, right?

A. Only my experience, yes.

Q. I want to focus first on cardiac conditions. Have you published any articles or books that deal with cardiac conditions in pregnancy?

A. Yes, both. That is articles, a number of peer-reviewed

articles, a number of review articles, and a number of book chapters.
Q. Are those listed on your curriculum vitae?
A. Yes, including this most recent thing with ACOG. When they wanted someone to write the summary for cardiac disease in pregnancy, they asked me to do so.
Q. If we turn very briefly, I would like to go through and identify some of the publications that you have had that relate to cardiac conditions in pregnancy. If you would turn to page 7, item number 13.
A. OK.
Q. Does that relate to cardiac conditions in pregnancy?
A. Yes.
Q. Can you read the title of that article, please.
A. "Obstetric Uses for the Pulmonary Artery Catheter."
Q. Does item number 14 relate to cardiac conditions in pregnancy?
A. Yes.
Q. Can you read the title of that item, please.
A. "Transient Ventricular Dysfunction Associated with Cesarean Section in a Patient with Hyperthyroidism."
Q. Could you look at item number 19. Does that relate to cardiac conditions in pregnancy?
A. Yes.
Q. Could you read the title, please.



A. "Experience with the Pulmonary Artery Catheter in Obstetrics and Gynecology."
Q. Could you refer to item number 21.
A. Yes. "Labor and Delivery in the Presence of Mitral Stenosis: Central Hemodynamic Observations."
Q. Does that relate to cardiac conditions in pregnancy?
A. Yes.
Q. Could you look at item number 26.
A. "Cardiac Arrest in Pregnancy: What to Do."
Q. Obviously, that relates to cardiac conditions in pregnancy?
A. Yes.
Q. Could you look at item number 44, please.
A. Yes.
Q. Does that relate to cardiac conditions in pregnancy?
A. Yes. "Structural Cardiac Disease in Pregnancy."
Q. Could you look at item number 86.
A. 86?
Q. Yes. Does that relate to cardiac disease in pregnancy?
A. Yes. It's called "Valvular Cardiac Disease in Pregnancy."
Q. Does item number 87 relate to cardiac disease in pregnancy?
A. Yes.
Q. Could you read the title, please?
A. "Cardiac Disease in Pregnancy."
Q. Item number 88?
A. Also titled, for a different journal, "Cardiac Disease in

Pregnancy."
Q. Are those two different articles, Doctor?
A. Hard to say. I suspect to a large extent they are very, very similar. Two journals asked me to write articles on the same topic in the same year, review articles. These weren't original research articles. I can't tell you they are exactly the same, but I bet you they are awful similar.
Q. How about item number 119, does that relate to cardiac conditions in pregnancy?
A. Yes. It is called "Cardiac Surgery During Pregnancy."
Q. Item number 127, does that relate to cardiac conditions in pregnancy?
A. Yes. It is called "Maternal Cardiac Arrest."
Q. Item number 144, does that relate to cardiac conditions in pregnancy?
A. Yes. It is called "Cardiac Disease." It is a textbook chapter.
Q. That was a chapter in the Critical Care Obstetrics textbook, third edition?
A. Yes.
Q. Did you write that chapter?
A. Yes.
Q. Would you refer to item number 150. Does that relate to cardiac conditions in pregnancy?
A. Yes. It is called "Cardiopulmonary Bypass."



Q. Was that another chapter in critical care obstetrics?
A. Yes.
Q. Did you write that chapter?
A. Yes. Well, no -- well, I wrote it. I'm the sole author on that. I thought I might have had co-authors, but it looks like I did not.
Q. Item number 154, does that relate to cardiac conditions in pregnancy?
A. It is called "Cardiac Disease in Pregnancy." That is a different textbook of maternal fetal medicine that I was asked to -- headed by Al Reese, who was the chairman at Yale at that point, either Yale or -- anyway.
Q. You wrote a chapter in the book?
A. I wrote a chapter for his textbook, wherever he was at that point, yes.
Q. I think item number 164, what is that?
A. That is called "Cardiac Disease in Pregnancy" for the 2000 edition of the ACOG's precis book. I explained what that was.
Q. So that is something that you wrote for the American College of Obstetrics and Gynecology that was included in the precis that they distributed to the membership?
A. Right. That is the 2000 edition. Then the one I am doing now will be I guess 2004 or 2005, whenever they finish it up.
Q. Doctor, why would like to do is direct your attention to some of the testimony that we have received in this case in

connection with cardiac conditions and pregnancy termination. Dr. Timothy Johnson, a plaintiff in this case, testified at page 438/lines 2 through 5 at trial as follows. This was concerning the issue of termination for cardiac conditions.

"I guess my response would be that in certain medical conditions, like heart conditions, the fluid shifts and the prolonged stress and pain of a medical induction would make a D&E procedure a preferable procedure in some patients."

Doctor, what kind of fluid shifts, if any, are there in pregnant patients with heart conditions?

A. The major fluid shifts occur after delivery. In the full-term patient you have a great big baby who has been to some extent blocking off the free return of blood from the lower extremities. That is why women get swollen legs, because they have increased pressure, increased pooling of blood in the lower extremities, and that gives rise to some of the edema that we commonly see in pregnancy.

When you deliver that baby, suddenly this partial obstruction to the return of blood to the heart is gone, and so once the baby is delivered, you get some fluid shift. It is called autotransfusion, where the heart now has to deal with a sudden increase in the amount of blood coming back to it.

Q. Would fluid shifts have anything to do with the selection of an abortion procedure in the second trimester?

A. No. Those fluid shifts are going to be minimal anyway in



the second trimester. Furthermore, it doesn't matter how you get the baby out; once the baby is out, the fluid shifts occur. So the fluid shifts would be completely irrelevant to the method of delivery.

Q. In your opinion, would any prolonged stress associated with medical induction in a cardiac patient make a D&E procedure preferable?

A. Yes, unless you gave the mother an epidural, epidural anesthesia during her labor. So I would say there would be some stress on a mother's heart if she were for some reason made to have a medical induction and wasn't given pain relief, yes. But if you give her an epidural, as we do -- that has actually been studied. The effects of epidural on fluid shifts, and so forth, has all been studied, and you can take care of it that way. So either labor induction with adequate pain relief or the extraction dismemberment procedure would be fine.

Q. So the giving of an epidural would satisfy Dr. Johnson's concern about pain associated with medical induction in these circumstances that he was describing, is that right?

A. Sure. It would more than satisfy that. Because Dr. Johnson has of course left out the other part of that, and that is the fact that any sort of surgical procedure which might result in, for example, perforation of the uterus or blood loss -- there are many heart conditions' where what is going to

kill the mother is sudden unexpected blood loss in a surgical complication.

As a general principle, we try to deliver women with heart disease vaginally even as opposed to by Cesarean section at term. For example, the most serious form of heart disease, pulmonary hypertension, the data is very clear that there is a dramatic increased risk of death when the mother is delivered surgically than when she is delivered medically.

Q. Dr. Westhoff testified at page --

THE COURT: Ms. Gowan, is this a convenient time for you or do you have a little bit more in this area, for our morning break?

MS. GOWAN: This would be a convenient time, your Honor. I have a little bit more on cardiac conditions. It would probably be too long before the break.

THE COURT: So take the break?

MS. GOWAN: Yes.

THE COURT: We will stand in recess.

(Recess)

THE COURT: Ms. Gowan, you may inquire.

Q. Dr. Clark, Dr. Westhoff testified at page 819/3 through 9 of the transcript: "I want to rely on the cardiologists who refer such patients to me. Because of the cardiac condition of these patients, these doctors will tell me whether it is second trimester or in fact for childbirth at term that prolonged



labor is dangerous to their patients because of the change in the dynamics of the blood supply. So they refer patients to me for a D&E."

Are there changes in the dynamics of blood supply in patients with cardiac conditions during the second trimester?

A. Sure.

Q. What does that mean, changes in dynamics of blood supply?

A. The only thing it could mean, the only true thing it could mean is that there is more blood, the woman has more blood in her body in the second trimester than she did when she was not pregnant. That would have nothing to do with termination, method of termination, delivery, nothing to do with nothing, actually. But, in truth, the woman does have more blood in the second trimester than in the first trimester or when she is not pregnant.

Q. So the fact of the existence of additional blood is not an indication for a particular abortion procedure in the second trimester, is that what you are saying?

A. That is exactly what I am saying.

Q. In your opinion, is prolonged labor dangerous to cardiac patients because of the increased blood supply that they may be experiencing in the second trimester of pregnancy?

A. No, not in the second trimester. I have said certainly there are changes, but those changes are not great by the second trimester. They have become significant by term, in

fact by 32 to 34 weeks is where they actually peak. But the hemodynamic changes are really much less in the second trimester. And I don't see how -- it is a true statement woman have more blood, but I see no way in which there is any -- that is some hand-waving there -- any relevance to the discussion of the method of termination.

Q. In your opinion, is labor induction abortion a safe method of termination for cardiac patients in the second trimester of pregnancy?

A. For most of them it is. As I mentioned, under most circumstances that is preferable. But in fact in many situations the D&E dismemberment procedure would also be safe. I would say 9 times out of 10 with a heart disease patient, either of those techniques would be equal preferable. I guess I can think of some situations in which one might be preferable slightly to the other, but in most cases either one would be just fine.

Q. What about D&X? Can you think of any circumstances in which D&X would be necessary to preserve the health of a cardiac patient?

A. Of course not. You don't even have to be a doctor to figure this out. Give me any changes in a mother, all the hormonal changes, all the blood supply changes, all the cardiac output changes, all the changes, the method by which you extract the baby -- either pull it apart piece by piece or pull



it out and suck its brains out and then pull it out -- does not affect the hormones of the mother, it doesn't affect the blood supply of the mother. It doesn't affect anything going on within the mother. That's smoke is what we are talking about.

Q. In your opinion, should D&X be performed on cardiac patients?

A. I guess the true answer is I don't know and neither does anyone else, because as it stands today there is no published data demonstrating just what happens and what the risks are to this D&X procedure.

Now, I understand that in a few weeks supposedly this one article will be published. But that is, I think, 120 women, 120 or 130 women, a relatively small number who underwent this procedure, and they looked at a limited number of complications.

Certainly for me, as someone who is concerned with the mother's health, to take a woman who is potentially critically ill with heart disease and subject her to a new procedure where, as it stands today, there is no published data telling what the complications are and there may be a tiny smattering of data at some point in the future, would frankly be irresponsible.

We have a procedure, D&E, in which there are a series of over 10,000 patients, where I can precisely know what the complications are and precisely inform the patient what the

complications and risks are and precisely inform myself so as to advise the patient. In some future day maybe we will know exactly what the risks are of this D&X in the same way that we know the risks are of D&E, and under those circumstances it may be that it would be an appropriate technique to use. It may be that it would be as safe to use. But currently I don't know, neither does anybody else.

Even that limited amount of data that is about to come out suggests that while in the small sample they couldn't discern any benefit or any change in risk, you look at the preterm birth rate that came after that, and it is downright shocking.

I think that is the limited information that is available today.

MS. PARKER: Your Honor, I once again object to the doctor's discussion of the Chasen study, his characterization of it, his criticisms of it, which was not in the doctor's expert report.

THE COURT: Thank you, Ms. Parker. Overruled. Next question.

Q. Doctor, previously in the declaration submitted in this case by Dr. Westhoff, she stated that women who develop peripartum cardiomyopathy are at a serious risk for cardiac failure and require an abortion because their pregnancy has compromised their health. Then at page 1009/lines 4 through 6


at trial she testified that she had a patient with this condition once but that she couldn't remember anything about the patient without resort to the medical records.

First of all, can you tell us, what is peripartum cardiomyopathy?

A. Yes, peripartum cardiomyopathy is a very specific condition, well defined by international criteria, which requires not only a certain type of heart failure but also requires that this come on in the last few weeks of pregnancy or in the first month or so post-partum. That is peripartum cardiomyopathy.

Q. Is that what "peripartum" means?

A. That is what peripartum is, around the time of delivery. So by definition, a woman could not develop peripartum cardiomyopathy in the second trimester of pregnancy. There are other forms of cardiomyopathy distinct from peripartum cardio-myopathy that any woman could have, including the pregnant woman. But any peripartum cardiomyopathy, that and second trimester termination can't come together by definition.

THE COURT: Ms. Gowan, whose testimony were you referring to?

MS. GOWAN: Dr. Westhoff's, your Honor.

THE COURT: I want to make sure I had that in mind. Thank you. You may proceed.

Q. Let's focus just briefly on cardiomyopathy generally. What

is that?
A. That is a condition in which, for unknown reasons, generally unknown reasons -- occasionally it is infectious but mostly unknown -- the heart muscle just basically turns to mush, and instead of pumping in a nice vigorous way, it doesn't pump very well at all. The heart muscle gets sick. That is cardiomyopathy. That occurs in people, and in fact unfortunately it particularly occurs in young people. In fact, we do run into it in women who coincidentally happen to be pregnant, yes, we do.
Q. Can you tell me at all in your experience what the rate of occurrence of cardiomyopathy might be in a woman in her second trimester of pregnancy?
A. No, I can't. We have treated -- I have personally treated three patients within the past year with cardiomyopathy in pregnancy. But the past couple of years before that I didn't treat any patients. It was a bad year under those circumstances. So it is uncommon, but I can't give you an accurate figure.
Q. In your opinion, if a woman is suffering from cardio-myopathy in her second trimester, would labor and delivery through the induction abortion method be contraindicated?
A. No. All three of these women were carried to full term.
Q. I see.
THE COURT: Your patients you are talking about?



THE WITNESS: Right.
A. Two of them ended up in the hospital for the last couple of months of their pregnancy. This was not an easy pregnancy. But ultimately they all went to term, they delivered vaginally, they took home healthy babies. They still have sick hearts, but we were able to, but treating the mother's heart with various pacemakers and drugs, able to carry her through so she could take home a healthy baby at the end of pregnancy.
But I want to make it clear that is not always the case. In fact, a serious cardiomyopathy is a perfectly fine, acceptable, wonderful reason to terminate the pregnancy. First or second trimester, that would be one of the reasons that you might terminate a pregnancy medically, yes.
THE COURT: Would that be to save her life?
THE WITNESS: That would be to save her life.
THE COURT: The heart condition is that serious?
THE WITNESS: Yes, that is true. Or the medical treatment to try to fix the heart condition just doesn't work and in fact she is going downhill despite it, yes.
Q. So that would be in a circumstance to advance maternal health, is that right?
A. Sure, exactly.
Q. In those circumstances where there would be a termination, would termination by medical induction abortion be appropriate?
A. Yes, it would. But, in fairness, the extraction procedure

would also be appropriate. This would be one of those situations where it wouldn't matter one way or the other.
Q. By "extraction," you mean the D&E by dismemberment procedure?
A. Yes.
Q. Doctor Hammond testified at trial at page 229/line 20 through 24 that, "There are certain circumstances where women have medical conditions where they are not supposed to go through labor. Some women have heart disease. Some women have lung disease. In those circumstances, to go through a long period of labor which can be associated sometimes with stress and pain, there are women who can't stand pain, so in those circumstances the D&E is advantageous to the induction and termination of pregnancy."
Doctor, can you give us an idea of the rate at which lung disease occurs as a medical complication in pregnancy?
A. Sure. It occurs quite commonly in the form of asthma. Roughly 34 percent of pregnant women have asthma. All other forms of lung disease are so small as to be essentially not worth considering. Young women just don't have lung disease.
Of course, there are exceptions, yes. We have a woman with cystic fibrosis. We have a woman with some rare sort of lung disease, sure. I've seen it. But for the most part, lung disease in pregnancy is asthma, and it occurs. 4 percent, is fairly significant.


Q. Have you written about asthma in pregnancy, Doctor?
A. Yes, I have.
Q. If you would take a look at page 12, item 110 on your curriculum vitae. Could you take a look at that.
A. Sure.
Q. Does that presentation relate to asthma in pregnancy?
A. Yes.
Q. Could you read that for us.
A. It says, "Asthma in Pregnancy. National Asthma Education Program Working Group on Asthma and Pregnancy, National Institutes of Health, National Heart Lung Blood Institute." This was the report of that NIH panel that I was asked to sit on, developing recommendations for managing asthma in pregnancy, which we then published in ACOG's journal Obstetrics and Gynecology.
Q. Would you turn to item number 121 on your curriculum vitae and read that to yourself.
A. OK.
Q. Is that an article that relates to asthma in pregnancy?
A. Yes.
Q. Could you read the title of that article for us and where it was published.
A. Yes. "Severe Acute Asthma: Contemporary OB-GYN."
Q. If you would take a look at item number 153, does that publication relate to asthma in pregnancy?

A. Yes.
Q. Could you read the title of that article for us.
A. Yes. "Out-patient Management of Asthma in Pregnancy." Those last, two, though, I had a co-author.
Q. OK?
A. It wasn't solely my work.
Q. Were both of those peer-reviewed articles?
A. No. The first one was peer-reviewed. The second was a review article. This third one is kind of halfway in between, actually. It is kind of a strange journal.
Q. What is the name of the journal in which the third one was published?
A. Clinics in Obstetrics and Gynecology. There is some element of peer review, but it is not nearly what that first article would have gone through.
Q. Dr. Westhoff testified at page 819/line 20 through page 820/line 20 that, "For patients with pulmonary disease, I'd prefer to do a D&E, because fundamentally the anesthesia care during the D&E can protect the rest of the body systems, including their lung, and also because some of the drugs that are used for induction, the prostaglandins, have a risk of causing bronchospasm, which would interfere with the patient's breathing and oxygenation."

Dr. Westhoff went on to explain in the transcript that bronchospasm is asthma. Is that your understanding as well,



Doctor, is bronchospasm asthma?
A. Well, I guess from a lay perspective that is not bad. There are other reasons for bronchospasm, but certainly one reason for bronchospasm is asthma, sure.
Q. Is there a prostaglandin that is contraindicated for use in medical induction abortion where a woman has asthma?
A. Sure.
Q. Are there other prostaglandins that are not contraindicated for use in termination for women who have asthma?
A. Yes. The F series prostaglandins, so the PGF2 alpha, which is an F prostaglandin, would be contraindicated in women with asthma. You just can't use it. The F prostaglandins cause bronchospasms. The breathing tubes clamp down and you get a bad asthma attack in the middle of things.

But the E series prostaglandins don't cause broncho anything, and we use them all the time in patients with asthma. As well as oxytocin, of course, which can be used, which has no effect either.

So he is correct, he is partially correct there. There is one method of medical induction or medical abortion in women with asthma which is contraindicated. The others are fine.

But, you see, the premise is wrong. Asthma is not a reason for medical termination of pregnancy. Generally, pregnancy has no effect on the outcome of asthma.

Q. Why do you say that?
A. A woman may have asthma and be pregnant, that is true. But terminating the pregnancy doesn't make her asthma any better. In fact, all of the medications that can be used to treat asthma are perfectly safe at all stages of pregnancy. So there is no reason to think a woman's asthma will get better or get worse whether she is pregnant or not. Asthma is not an indication for pregnancy termination, although the two may coexist.
Q. Let's assume that the woman is terminating the pregnancy for purely elective reasons but she happens to have asthma.
A. OK.
Q. In those circumstances, would labor induction abortion using a prostaglandin PGE2 or PGE1 in the second trimester be a safe method of abortion?
A. Absolutely, as long as they don't use PGF, yes.
Q. In your opinion, would D&E by dismemberment be a safe and accepted procedure for women wishing to terminate who may have asthma or other lung disease in the second trimester pregnancy?
A. Yes.
Q. I take it your opinion would be that D&X would never be necessary to preserve the health of a woman with lung disease or asthma seeking to terminate pregnancy in the second trimester?
A. No. Even if we accept all of the available and about to be



published data, which I am happy to accept in terms of the short-term safety, let's accept those, we are still completely blank in terms of any benefit of that procedure in a woman with asthma or any other conditions.
Q. Any other lung condition?
A. Lung condition or human condition.
Q. Dr. Hammond testified at page 691/line 20 through 692/line 2 that he believed that D&X offered advantages to women with bleeding disorders and low platelets. He referenced a patient whom he had treated with leukemia and low blood platelets. First of all, could you tell us what low blood platelets are.
A. Yes. The platelets are certain cells within our blood streams which help us clot if we get a cut. If the platelets are low, we don't clot as well. If there were a tear or a cut in our body, in our finger, in our head, anywhere, if there were a tear, then there would be more bleeding.
Q. Would that be so if there were a tear or cut in connection with the use of surgical instruments in performing an abortion in the second trimester of pregnancy?
A. Yes.
Q. In your opinion, should any kind of surgical abortion at 20 weeks or greater be used on a woman with, as Dr. Hammond gave as an example, leukemia with low blood platelets?
A. It would depend upon how low the blood platelets are. Luckily, we have got lots of extra platelets in our bodies.

Most of us have over 200,000 per cc. You don't really have an increased risk of surgical bleeding unless it is less than 30,000. So for most women with low platelets, due to anything, they could have either a dismemberment procedure or a medical induction and it would not matter.

But if, in fact, they had hardcore low platelets where the platelets are so low that bleeding would be a risk, then the last thing you want to do is any form of surgical procedure on these patients. We greatly prefer to deliver babies vaginally under all circumstances when the platelets are low as opposed to anything that would possibly tear, cut, poke a hole, and cause more bleeding.

So to say you need a surgical procedure to treat someone with low platelets, is probably the very worst example I have heard yet this morning in terms of somehow trying to justify this other procedure. Either the extraction or the D&X, anything that requires instrument manipulation of the uterus would be less preferable with low platelets. But in most cases it would probably be not a big deal either way.

Q. Doctor Hammond also testified at page 693/lines 12 through 16 that he preferred D&X for patients with HELLP syndrome. First of all, how do you spell HELLP syndrome?

A. It is an acronym. Capital H-E-L-L-P stands for hemolysis elevated liver function test, low platelets. It is a variant of severe toxemia which gets its own acronym for some very


obscure reasons.

Q. Have you written about patients with HELLP syndrome?

A. Yes.

Q. Take a look at your curriculum vitae. Would you look at item number 30.

A. OK.

Q. Does that item reflect your writing on HELLP syndrome?

A. Yes.

Q. Could you please read for us the title of that article.

A. "Antepartum Reversal of Hematologic Abnormalities Associated with HELLP Syndrome: A Report of Three Cases."

Q. I beg your pardon if I already asked this question. Does the LP at the end of HELLP stand for low platelets?

A. Yes.

Q. What would be, in your opinion, an appropriate, accepted, safe method of abortion in the second trimester for a woman with HELLP syndrome?

A. The same answer as with your prior question on leukemia. The low platelets are the key, whether due to HELLP syndrome or whether it is due to a blood dyscrasia, a blood disease like leukemia. If the platelets are low but not less than 30,000, then either your dismemberment procedure or your medical induction would be perfectly appropriate; it doesn't really matter. If the platelets are really low, less than 30,000, then the medical induction would be vastly preferable to any

form of surgical manipulation of the uterus.
Q. When asked to identify examples of medical conditions for which D&X would offer additional safety advantages, Dr. Frederiksen testified at page 1142/lines 3 through 5, "Acute fatty liver of pregnancy sepsis, where you have an unstable patient and significant infection within the uterus." First of all, what is acute fatty liver of pregnancy?
A. It is a very uncommon condition that causes the liver to fail, and it is because of pregnancy and it comes on only during pregnancy, virtually always third trimester of pregnancy. It has nothing to do with infection whatsoever. But in fact I guess somewhere in the world there may have been a patient who had both acute fatty liver and also for some completely separate reason happened to have an infection of the uterus. I suppose it could happen.
(Continued on next page)



BY MS. GOWAN:
Q. Have you ever seen that happen?
A. No, I have never seen it, I have never heard about it.
But two rare things could theoretically, at some point, occur together, yeah.
Q. Have you ever seen a patient with acute fatty liver pregnancy?
A. Yes, I have seen lots of patients with acute fatty liver pregnancy.
Q. How do you treat those patients?
A. We induce labor.
I have never seen one in the second trimester, that's why I am trying to -- I don't think acute -- acute fatty liver does not require third trimester for it's diagnosis like peripartum cardiomyopathy does. And I will bet somewhere there has been a case report of a second trimester acute fatty liver pregnancy but it is very rare.
Generally this occurs at-term or late in the third trimester. It's a rare condition to start with but most of them occur very late.
Q. When you say that you had patients with acute fatty liver pregnancy and you have induced them through labor, did you induce to live birth?
A. Sure, sure.
I don't recall I have ever had one prior to about 32

weeks' gestation so, yes, we induce them, they deliver a live baby.
That's right.
Q. If such a circumstance existed that there was a woman with acute fatty liver pregnancy that was adversely affecting her health during the second trimester of her pregnancy such that termination was indicated, in your opinion what would be the method of termination?
A. Well, it would depend upon one thing, and that is to what -- see, the liver makes other clotting factors other than platelets which are also important to help us clot our blood.
If the liver were not so badly affected that the clotting factors were low, then either method is fine. In that case.
Q. By dismemberment or medical induction?
A. Or medical induction.
Again, if it was hard core acute fatty liver and the liver was failing and the other clotting proteins made by the liver were in low supply because the liver was failing, then of course the dismemberment, any sort of surgical procedure would be relatively contraindicated and the medical induction would be vastly preferable.
Q. Can you envision a circumstance in which medical -- excuse me, termination would be indicated in a woman with fatty liver pregnancy?


A. Well, sure.
If somewhere in the universe there was a woman who got acute fatty liver at what, 23, 24 weeks -- say 23 weeks' gestation where we have, where the baby had no chance of survival -- I don't know that that's ever even been reported but I'm not sure of that, I mean somewhere it could have -- then termination might be a perfectly appropriate -- whenever you diagnose it you must deliver the baby, that's for sure.
And so, if there ever was a woman on our planet who had it at a time when D&X or D&E was, were potential options, then certainly the D&E would be appropriate to do, unless she really had it bad and had really -- and her clotting factors were affected, in which case that procedure would be contraindicated and you want to go medically.
Q. Let's focus on sepsis. Have you published any articles relating to sepsis in pregnant women? If you take a look at perhaps at item number 52 on your curriculum vitae?
A. Yes.
Q. Does that article relate to sepsis in pregnancy?
A. Yes. It's called septic shock during pregnancy.
Q. What is -- first of all what is septic shock, what is that?
A. When you say I have written, here is one where I had many co-authors.
Q. Okay.
A. What is septic shock? Septic shock is the worst form of

sepsis.

Sepsis, it means in a situation in which you have an infection somewhere, whether it's in the foot, the uterus, the lung, and now that infection is not just affecting that organ or that limb but actually the bacteria have spread and are now affecting the entire body.

So, septic shock is what happens before a person dies of infection. They have the infection, if untreated they go into septic shock, if untreated they die.

Q. What is uterine sepsis?

A. That simply means a situation where the infection began in the uterus and is now spread and affecting the entire body.

Q. Are you familiar with the term chorioamnionitis?

A. Yes.

Q. Is that the same as uterine sepsis or is that something different?

A. No, intrauterine infection in pregnancy and chorioamnionitis are identical.

Q. Okay.

Now, Dr. Hammond testified at page 589, 5 through 14, that, "A patient with chorioamnionitis would benefit from an intact approach to D&E." In other words D&X, partial-birth abortion.

Do you agree with him? Well, I guess I should say, in your opinion what method of abortion would be safe and



acceptable in cases where a woman has uterine sepsis or chorioamnionitis?

A. Well, this would be a similar situation. In most cases to my previous answers. No, most cases either would be acceptable.

Q. D&E by dismemberment or medical induction?

A. Or medical induction.

Now, there is a particular situation in general. The reason we know a woman has infection in her uterus, the most common presenting symptom is labor and contractions.

So, typically, these women are already laboring if they have infection in the uterus -- not always, but typically they are -- and so they are notoriously easy to put into labor since the infection in the uterus kind of starts that process anyway.

In the vast majority of cases we would deliver these women with medical induction if they had an infection in the uterus real early. And, if they had a really bad infection, that also can affect both the platelets and the other clotting factors.

Q. And so then you might not want to do a D&E dismemberment?

MS. PARKER: Objection, your Honor.

THE COURT: Just -- please.

Yes?

MS. PARKER: Leading.

THE COURT: Would you or wouldn't you, Doctor?

THE WITNESS: Then you would not wish to do any sort of surgical procedure such as the D&E by dismemberment.

But, having said all that, in the vast majority of cases in intrauterine infection either the D&E by dismemberment or medical induction, either of those would be acceptable, appropriate medical choices in the majority of cases.

Q. The plaintiffs and their experts have testified generally about various auto-immune disorders and have expressed the opinion that D&X abortion might be preferable where such disorders are present.

For example, Dr. Hammond mentioned von Willebran's disease and identified it as a disease involving a problem with the factor 8 complex as in the case of hemophilia. Dr. Johnson referred generally to auto-immune disorders.

What's meant by that, auto-immune disorders?

A. Well, one thing that's not meant by that is von Willebran's disease, that is a congenital disease.

Auto-immune disorder is a situation in which a person develops antibodies that attack their own cells, like rheumatoid arthritis, Lupus, are common auto-immune disorders. And auto-immune disorders are bad things, no question about it.

Auto-immune disorders are -- the only auto-immune disorder which we -- well, auto-immune disorders themselves have nothing to do with pregnancy. That is to say, a woman may



have one, it's like cancer in pregnancy, she may have one and be pregnant but pregnancy neither helps nor hurts most women with auto-immune disorders.

And, in general, an auto-immune discord would not be a medical case for termination.

But, if a woman did have an auto-immune disorder and then wanted to electively terminate the pregnancy, in the vast majority -- I don't want to sound like a broken record but unless an -- auto-immune disorders can affect your platelets too.

So, same answer. Vast majority of auto-immune disorders, if a woman chose to he electively terminate, either one would be acceptable.

If the platelets were low medical induction would be preferable.

Q. I don't want to mischaracterize in any way Dr. Hammond's testimony and I understand you have explained now that von Willebran's disease is not an auto-immune disease, is hemophilia an auto-immune disease?

A. No.

Q. Okay.

A. Neither of those are. Those are inherited disorders of clotting where women have trouble bleeding.

Q. So, in and of itself, if you have von Willebran's disease, is that an indication for termination of pregnancy?

A. No, absolutely not. That's neither made worse nor made better by pregnancy, it just coexists. The woman's life will not be at an increased risk if she continues the pregnancy so it's irrelevant. But if she chooses to electively terminate, legally she can do so like any other woman.
Q. So, in those circumstances, would it be your opinion that D&E by dismemberment or medical induction abortion would be appropriate?
A. In the vast majority of cases, unless she's got it really bad and has a very bad bleeding tendency, in which case the medical route would be preferable.
THE COURT: When you say the medical, you mean medical induction?
THE WITNESS: Medical induction; yes, sir.
Q. And medical induction is the same as labor induction abortion?
A. Yes. Yes, that's what I'm talking about.
Q. What's placenta previa?
A. That is a condition in which the placenta has chosen to -- as the embryo comes from the fallopian tube after being fertilized tumbles into the uterine cavity, the placenta -- it happens to land real low right down by the cervix.
So, as the placenta grows the placenta covers the cervix. The cervix is where the baby has to get out of once it is ready to deliver. And, obviously, the baby cannot come out



vaginally under most circumstances or there would be, the placenta would tear and there would be a whole lot of bleeding.
And so, that -- it's a complication of pregnancy and women with placenta previa end up being delivered by caesarean section and then they generally don't have any problems at all.
Q. And when you say they're delivered by caesarean section, you are referring to live birth?
A. Sure. Sure.
Q. Have you written on placenta previa?
A. Yes.
Q. Will you take a look at item number 20 in your curriculum vitae? Would you take a look at that?
A. Yes.
Q. Is that an article that you have written related to placenta previa and pregnancy?
A. Yes.
Q. And what is that article?
A. It's called Placenta Previa Accreta and Prior Caesarian Section.
Q. Would you take a look at item number 172; does that relate to placenta previa?
A. Yes.
Q. And what is that?
A. It's a book chapter in the Maternal Fetal Text of Dr. Creasy and Resnick called Placenta Previa and Abruptio

Placenta.
Q. Have you received any awards in connection with your writing on placenta previa?
A. I think so. Yes.
Q. What awards have you received on your papers relating to placenta previa?
A. There were two awards. There was a district -- an American College of OB/GYN ACOG district award, prize paper award in 1984, and then there was the national ACOG research award called the Perdue Frederick Award, which I got for my work on placenta previa accreta in 1985.
Q. Now, Dr. Westhoff and others have testified in this that in cases of placenta previa they would prefer to perform a D&E abortion technique.

Now, they didn't specify which D&E abortion technique, by that I mean they didn't say D&E by dismemberment or D&X; but would you agree that in cases of placenta previa that D&E by dismemberment would be a safe and acceptable method of termination?
A. Well, keeping in mind that that's never and indication for termination but if a woman decided to electively terminate and at the time of termination was found to have a placenta previa, then they're exactly right. In fact, then an attempt at labor induction could cause all sorts of bleeding and you would then want to do a surgical procedure where you very quickly reach in



and pull out that placenta which is right there by the cervix, pull out the placenta so that the mother doesn't bleed to death.
Q. And so, a D&E by dismemberment would be appropriate in that circumstance?
A. Yes. That would be more appropriate than medical in this circumstance; yes.
Q. Why do you say placenta previa is not an indication for termination?
A. Well --
Q. A medical indication?
A. First of all because women, I mean the overwhelming majority of women with placenta previa carry normal pregnancy, they go to term, and then they get a c-section and they and their baby lives happily ever after and that's the end of the story.

It's even more so in this situation because, remember, the last thing you want to do is mess with the placenta in any way because you are going to cause bleeding.

And so, this would be, if a woman came in and said I want to terminate my pregnancy just 'cause I feel like it, and we say, whoa, you have a placenta previa at 20 weeks, this would be an additional risk of the pregnancy termination.

Because even the surgical procedure now requires you to go in and start poking around on the placenta.

Generally we, I have done that procedure when the baby is dead, the baby has died and she has got a placenta previa and you don't want to do a c-section if the baby is already dead and that's where you, you can inject some medicine to shrink up the blood supply to the uterus for a brief time and then quickly dilate the cervix and pull out the placenta and then you've got breathing time and the woman won't bleed to death.

So, it would never be an indication for termination. Of all the things you've mentioned this would be a relative contraindication, that is, there would be more risk to termination than to going to term and getting a c-section.

Nevertheless, it could be done safely and if a woman were to choose termination with a placenta previa in the second trimester, clearly the extraction procedure would be a safer way to go than the medical procedure.

Q. And, again, when you say the extraction procedure, are you referring to D&E by dismemberment?

A. Dismemberment, yes.

Q. Is dilation and evacuation, or D&E by dismemberment, sometimes also referred to as dilation and extraction?

A. Yes.

Q. Have you written about some of the medical issues relating to caesarean section?

A. Many.



Q. If you would take a look at item number 5 on your curriculum vitae, does that relate to caesarean section?

A. You are talking about prior caesarean section?

Q. Correct.

A. A prior uterine scar?

Q. Correct?

A. Yes. Yes.

Q. What is that?

A. Effect of indication for previous caesarian section on subsequent delivery outcome in patients undergoing trial of labor.

Q. Would you take a look at item number 7?

A. Yes.

Six or seven, they both have to do with --

Q. Why don't you tell us what both of those are.

A. Six is previous caesarean section, trial of labor in the macrosomic infant.

Seven is vaginal delivery after caesarean in women with unknown types of uterine scar.

Q. If you would take a look at number 10, does that relate to prior caesarian birth?

A. Yes. Prior caesarian birth, management conversation in the patient with acute puerperal -- that means around the time of delivery -- uterine inversion.

Q. And does that relate to around the time of the second

delivery?
A. Yes.
Q. So the --
A. They've had a scarred uterus and now they're pregnant again.
Q. Okay.
And would you take a look at number 20, does that relate to prior caesarian section and subsequent delivery?
A. Yes. Placenta previa accreta in prior caesarian connection.
Q. And item number 41, does that relate to subsequent birth after prior caesarian section?
A. That's the title, vaginal birth after caesarian.
Q. Now, what is meant by a classical caesarian section?
A. Most caesarian sections are performed by making a crosswise incision in the low part of the uterus.
A classical caesarian, on the other hand, is made when you make an up and down incision on the upper portion of the uterus.
Q. And the up and down incision, is that sometimes referred to as a vertical incision?
A. Yes.
Q. Okay.
A. In fact that's much more appropriate.
Q. I'm learning.



And you were talking previously about something in the lower portion of the uterus, is that a lower segment scarring?
A. Yes, or low transverse.
So, low transverse versus classical, or versus vertical incision, sure.
Q. What's a myomectomy?
A. That's a situation when a woman has a benign tumor in the uterus called a fibroid, and under certain circumstances those are removed surgically so you have to cut a hole in the uterus to do it and generally the myomectomies occur in that upper portion of the uterus.
So, a woman who has had a myomectomy in many situations is treated in the same way as if she had had a prior classical caesarian section.
Q. And will there, in some cases, be scarring associated with the prior treatment of myomectomy?
A. There will always be scarring either way.
Q. What is the percentage of caesarian sections performed in the United States that result in vertical scarring, approximately?
A. I suspect one or two percent, maybe less.
Q. And do women with vertical scarring from prior classical caesarian sections sometimes carry their fetuses to term?
A. Sure. Almost always.
Q. Is there some percentage, if you know, where women with a

prior classical caesarian may seek termination of pregnancy in the second trimester?
A. Well, sure. But again, that's kind of like the placenta previa issue. That's not a medical indication to do so. She's really not a danger of carrying the pregnancy, she needs to be delivered by c-section if she does because she can't labor.

But, a woman with a prior classical incision might electively choose to terminate the pregnancy.
Q. And do have you any idea what the rate of occurrence of that would be?
A. It would be real small.

If you have a very, a couple percent even have that incision; and then a small percentage of them will get pregnant again and a small percentage of them will get pregnant and choose to terminate; and a small percentage of them will get pregnant, choose to terminate but not terminate in the first trimester and, so, they would be a candidate for second trimester termination.

I'm sure it happens but not very often.
Q. We would be talking about a low number?
A. Sure.
Q. In your opinion what would be a safe and receivable method of abortion in cases where the woman had a prior vertical scar and sought an elective termination in the second trimester of a pregnancy?



A. Well, here is another indication where -- I can't prove this is true by data but I believe it to be true that in fact the extraction procedure would probably be safer than the, that is the dismemberment procedure than the medical induction.

We know that at full term when there is a lot of tension on that uterus it is not appropriate to induce labor, that's primarily because the uterus can rupture and the baby can be damaged or killed.

Now, in a woman who is purposely terminating early on and the baby doesn't matter also, there is less tension on the uterus. I can't prove to you that there is any greater risk with medical induction but it would be a reasonable thing to think there might be, and so I would say as a general principle I would feel more comfortable in such women if they chose to terminate or we had to do it medically if they had some other condition, doing the dismemberment extraction procedure rather than medical.
Q. Does the fact of a prior uterine scar present any risk in and of itself to using D&E by dismemberment in the second trimester?
A. No. I can't think of any data that would support the fact that D&E is any riskier in those women. In fact, I guarantee that there is no data to support the fact, the contention that a D&E or extraction or dismemberment procedure is any more hazardous in those women than in the general population of

women getting that procedure.
Q. Does that have to do, if you know, with the nature of how these scars heal?
A. Well, I suppose. I mean they're just, in a sense it's apples and oranges. The scar is healed and that scar may not be healed well enough to withstand 15 hours of intense contractions when distended to full-term size to force a baby through the vagina.

But there is not a whole lot of tension on that scar during the second trimester and I don't see any reason to think why since a -- any of these procedures you shouldn't be poking the uterus anyway, reaching inside the uterus and extracting the fetus. There is no reason to think that would be any more hazardous than if the woman didn't have a scar.

And again, the converse would be completely unsupported by data.
Q. So, assuming that the physician who is performing the D&E by dismemberment was not going to be malpracticed or was skilled in performing the procedure, there would be no danger in and of itself presented by the fact of the existence of the prior uterine scar?
A. Correct.

I mean, if the doctor pokes his instrument, rams it through the uterus either through that scarred tissue or through the soft normal tissue that surrounds it, that's bad.



If the doctor doesn't ram an instrument through the uterus then what percentage is scar and what percentage is the soft uterine tissue doesn't matter.
Q. I want to just sort of very quickly go through some medical conditions, throw them at you that the plaintiffs have mentioned during the course of the case, either in connection with their TRO affidavits or at their depositions or at trial.

Thrombo embolic disease --

THE COURT: Ms. Gowan, excuse me. If we are going to get into a series of questions, it is 12:30, is this a convenient place for you to break?

MS. GOWAN: Sure, your Honor.

THE COURT: We will take our luncheon recess and reconvene at 2:00.

(Luncheon recess)

(Continued on next page)

AFTERNOON SESSION

2:00 p.m.

STEVEN L. CLARK, resumed.

THE COURT: Good afternoon. Ms. Gowan, you may continue with your examination.

MS. GOWAN: Thank you, your Honor.

DIRECT EXAMINATION (continued)

BY MS. GOWAN:

Q. Doctor, we were about to start discussing some very serious medical conditions that have been mentioned by the plaintiffs during the course of the case that I wanted to ask you about. The first one was thromboembolic disease. What is thrombo-embolic disease?

A. Blood clots that either form in the leg and stay in the leg or pelvis or break off and go to the lung and can be lethal.

Q. Have you written about thromboembolic disease?

A. Yes.

Q. Could you take a look at item number 114 in your curriculum vitae. Is that an article that your name is on relating to thromboembolic disease?

A. Yes. It is called veinous thromboembolism.

Q. Have you ever seen patients in your practice with this condition?

A. Sure. As complications of pregnancy go, this is one of the more common ones.





Q. Have you had patients with this complication whom you have been able to stabilize their condition and you have taken them to delivery of a live infant?

A. Sure, the vast majority of women. They need blood thinners, but they give themselves blood thinners and go to full term. So, yes, generally. I have had one exception in my life. But as a general rule, this is not an indication for pregnancy termination, because it can be successfully treated during pregnancy.

Q. When you say you have had one exception in your life, what are you referring to?

A. This was a woman who had some -- there were some particular reasons why the medication wouldn't work for her, some unrelated reasons, the blood thinners. She had this clot in the early pregnancy, and it was a huge one. So in fact there wasn't a really good way to treat her, and continuing the pregnancy would have presented a fairly significant risk of a blood clot breaking off and going to the lungs. She chose to terminate with first trimester D&C.

That is the only case I have seen where termination was even considered. Generally, we make the diagnosis, we treat with blood thinners, healthy mother delivers healthy baby at term.

Q. Are you aware of any circumstance, a case or a study, in which there was a patient with thromboembolic disease who

proceeded to second trimester and then required a termination to advance her health for medical reasons relating to the disease?
A. No, I am not, but I am certain that it could happen.
THE COURT: Doctor, the patient you mentioned in that case where the termination was done, was that in a case where there was a threat to her life?
THE WITNESS: Yes. We could not treat it, and the pregnancy makes the blood clots worse. Since for other reasons we could not treat her with the medication, the pregnancy then posed a threat, ongoing threat, to her life. So she terminated the pregnancy.
THE COURT: Thank you.
Q. When you say it posed an ongoing threat to her life, what about to her health; and at what point do you make the distinction as between a threat to health and a threat to life, if you do, Doctor?
A. Generally, you don't, because there are very few conditions. I can think of certain maybe uncontrolled high blood pressure would be the exception. As a general rule, if the mother survives the pregnancy, she is going to do well. That is to say, a mother who goes through a pregnancy with an identifiable risk factor and survives it is not going to be really any worse off for having gone through the pregnancy.
Obviously, if she dies, she will be much worse off.



But in most of the cases we are dealing, the idea that a pregnancy would be detrimental to a mother's health but not be risky to her life is really something that is really an artificial construct here.
Cases of uncontrolled hypertension where the mother might have a stroke but not die, certainly that would be an example of an exception to what I just said. But for the most part, when we talk about and think about a pregnancy being risky to a mother, we are talking about a risk of her dying, not a risk of her having something that will give her long-term problems short of death. With some exceptions, of course.
Q. Are you talking about the risk of her dying right now?
A. Yes.
Q. Are you also talking about a risk of her dying potentially in two, three months if the medical condition, the problem, is not addressed today or next week by pregnancy termination?
A. No, I can't think of any condition where, having successfully completed a pregnancy, you are now going to be worse off for your future health than if you had terminated the pregnancy. I just don't think there is such a situation. It either would be lethal to the mother during pregnancy -- and you don't want to minimize that, it is a horrible sort of thing. But in fact if she survives the pregnancy, there really aren't conditions where having been pregnant now has a detrimental long-term effect on her health.

Q. Are you suggesting that by terminating the pregnancy you have advanced her health to the point where now her life is not in jeopardy?
A. Which patient?
Q. Any patient. We are talking about termination of pregnancy for medical necessity.
A. Right.
Q. For health reasons as opposed to just for saving a life today. Are you suggesting that a termination for a health reason today will necessarily preserve the woman's life after the termination? Or do you not make a distinction between the two?
A. I think I understand what you are saying. The answer is no. I think I am disagreeing in this sense. A woman is pregnant and the things that are going to happen to her during the rest of that pregnancy coupled with the disease she has may kill her. Now, she may have a medical indication for termination. If those things do not happen, though, once she delivers, she is going to be in the same condition she was in if she had never been pregnant, if she terminated, if she carried to term.

I am just not aware of conditions where the mother makes it through the pregnancy without any bad things having happened but now is somehow weakened chronically by virtue of having gone through the pregnancy.



As a general rule, real doctors in real hospitals are counseling real patients, and we talk about risk of life. That is, you might die from this pregnancy. We simply do not find ourselves counseling women: You are not going to die from this pregnancy but, boy, will you be sick for the rest of your life unless you terminate it. It is generally either death or they do fine. It is not to minimize that, but that is generally it.

People are making distinctions between health and life, and I am happy to talk about such distinctions, but in truth they are more theoretical.
Q. In the cases of thromboembolic disease, in your opinion would a safe and acceptable method of abortion be a medical induction abortion?
A. Yes. Now I am a broken record. Remember, we are back to the problems of blood clotting. If you are on a blood thinner, it is best not to have any surgical type of procedure where you might get a tear or a cut; it is better to deliver vaginally. This would be another situation, women who are on blood thinners.

If they did choose to terminate, women who are on blood thinners would be best to do it medically rather than surgically, although with some certain complex procedures you could do it surgically safely. But it would take a whole bunch of placing other things called vena cava filters, and so forth, that might be necessary if you are going to do it with blood

thinners.
Q. There has been mention generally of kidney disease, kidney related conditions, as being an indication for abortion for medical reasons. Does pregnancy make kidney disease worse in any way?
A. No. That is one that really doesn't apply at all. A woman can have bad toxemia and part of that toxemia can be kidney disease, and yes, continuing the pregnancy may pose a risk to her, true. But a woman who starts out with some sort of kidney disease is not going to be --
I couldn't think of a single exception to this, where having kidney disease makes a pregnancy more risky to the mother's life, aside from the toxemia considerations. As a general principle, kidney function improves dramatically during pregnancy in all women.
Q. Why is that?
A. Part of it has to do with increased blood flow to the kidneys so they filter, the kidneys can filter easier. I have no idea and neither does anyone else. It just does. When you measure kidney function during pregnancy, it generally improves, both in normal women and in women with kidney disease. Not always.
What I am saying is being pregnant with kidney disease or being not pregnant with kidney disease really has no effect on the kidney disease except for the kind associated with



toxemia. So as a rule, kidney disease is not something that would be a medical indication for termination.
Q. Have you carried women to term who have suffered from kidney disease?
A. Sure. Every form from mild to severe to kidney transplant.
Q. In cases of toxemia occurring with kidney disease, what is the rate of occurrence of that, if you can quantify it?
A. Actually, in women who have kidney disease, which isn't many women, they do have a higher risk of toxemia. I don't know a number, but it is not as -- if you start off with a population of kidney disease, a quarter to a third of them are going to get toxemia.
Q. That would be indication for termination of a pregnancy, if I understand what you are saying, is that right?
A. If it were severe enough, yes.
Q. In those cases, what method of abortion in the second trimester would be safe and acceptable?
A. Generally, either the dismemberment procedure or the medical procedure. Usually, you could do either.
THE COURT: Again, when you say "medical," that means induction?
THE WITNESS: Yes, sir.
THE COURT: Thank you.
Q. Why do some physicians refer to it as "medical abortion" and others refer to it as "labor induction abortion," do you

know?
A. No.
THE COURT: That makes me feel better. Thank you, Doctor. Go ahead, Ms. Gowan.
Q. We have also heard a lot in this case about hypertension and preeclampsia. Are those two associated with each other?
A. Yes.
Q. How are they related?
A. The major abnormality in most women with preeclampsia is hypertension, high blood pressure. That is a disease which is unique to pregnancy. By definition, it does not occur with a living fetus prior to 20 weeks of gestation. So it has to occur after 20 weeks. And the risk of it occurring increases with gestational age.
The vast majority of toxemia occur near term, most of the rest occur later in the third trimester. I can think of a couple in my life that have occurred between 20 and 23 weeks, when fetal viability would not be an issue.
Q. You just said "toxemia." Did you mean "preeclampsia"?
A. Same thing. Those are two synonymous terms.
Q. I see. I'm sorry I cut you off.
A. So occasionally we might see a woman with toxemia, preeclampsia, which is so bad that we need to end it in order to avoid a bad thing happening to mother. The range of when we might be talking about these procedures, these termination



procedures: Very rare, but it surely could occur. Under those circumstances, unless they had the low platelet version we talked about this morning, either dismemberment or induction would be appropriate procedures.
Q. Have you written, Doctor, articles about preeclampsia?
A. Yes.
Q. If you take a look at --
A. Many.
Q. -- item number 22 on your curriculum vitae. Does that article relate to your study of preeclampsia?
A. Yes.
Q. What is that article called?
A. "Preeclampsia, Eclampsia, Hemodynamic and Neurologic Correlations."
Q. What is eclampsia?
A. That is when a woman has toxemia or preeclampsia and also has seizures, then we say you have eclampsia.
Q. Is that something that would occur in the second trimester period we are talking about, the 20- to 24-week period?
A. That would be even rarer than preeclampsia, in the pre-24-week period, but it surely could occur.
Q. In those cases, if it did occur, would that be an indication for termination of the pregnancy?
A. Definitely. If eclampsia occurred, yes.
Q. What method of abortion would you want to use in that case?

A. Same story. Unless she also has bad platelets with this disease, either is acceptable. If she does have bad platelets, medical would be preferable.
Q. There has also been some talk generally in the case about cancer, and I know we spoke about leukemia earlier today. As a general matter, in your opinion, is the fact that a woman is suffering from cancer an indication, medical indication, for termination of pregnancy?
A. No.
Q. Why do you say that?
A. Put it this way. Pregnancy doesn't make cancer better and pregnancy doesn't make cancer worse. Pregnancy and cancer may coexist. As a general principle, one does not interfere with the other.

But there certainly are times when being pregnant may interfere with therapy for cancer. That is to say, a patient might need a surgical procedure for her cancer, but you've got this big uterus blocking the surgical approach, so you've got to empty the uterus before you can operate on the cancer. There are other times when the patient might require radiation therapy for the cancer, but that radiation therapy will kill the baby, so she might terminate before the radiation therapy.

There are other situations -- surprisingly, most chemotherapeutic agents don't hurt the baby. But there are some chemotherapeutic agents which reliably do kill the baby.


If a woman needs that sort of agent to help her in her chemotherapy during her pregnancy, that might be another situation where she might choose to terminate, which even if she doesn't the baby will die due to the chemo. So there are certainly some times when cancer will require or certainly justify a medically indicated termination of pregnancy.
Q. When you talk about certain kinds of chemotherapy that might be lethal, lethal to the fetus, is that right?
A. Yes.
Q. When that is the only kind of chemotherapy that the woman could use, is that right?
A. That sometimes happens, yes.
Q. How often does that happen?
A. Very rarely. Cancer in young people is, fortunately, uncommon. Most forms of cancer don't require therapy that would be harmful to the fetus. Frankly, I can't give you a realistic number. Surely less than 1 in 1,000. But there are cases where pregnancy and cancer coexist and termination is in the best interests of the health of the mother, absolutely.
Q. In those cases, depending on circumstances, would either medical abortion or D&E by dismemberment be appropriate?
A. I can't think of any circumstance in which one would be preferable to another. There probably are, if I thought hard enough, but in general either one would be appropriate.
Q. Very briefly, we saw early on, I think in some of the TRO

declarations in this case, an issue with organ transplants.
A. Yes.
Q. Is the fact that the woman has had an organ transplant ever something that would be an indication for a termination of a pregnancy for maternal health reasons?
A. No, it wouldn't be. The best way to put this is pregnancy does not help a woman with organ transplantation, it doesn't hurt her. It doesn't make it any more likely that her organs will be rejected or that she will have complications of that organ transplantation. Those are separate issues. I can't think of any type of organ transplantation in which pregnancy termination would improve the long-term function of that woman.

Probably the only exception is if you had a kidney transplant, you might get toxemia, and then we go back to everything I just said about toxemia. But it would be the fault of the toxemia, not the fault of the organ transplant.

We carry women all the time with kidney transplants, pancreas transplants, heart-lung transplants, plain old heart transplants. They can terminate if they want, but it has nothing to do with their medical condition.
Q. When you say "we carry women all the time," are you talking about carrying women to term and delivery of a live infant?
A. Sure.
Q. Have you ever in your practice had a termination in a case where there has been organ transplant?





A. Not that I have performed. I have heard of them. But these are situations where the mother does not want -- I mean, these are elective terminations, not terminations because if she continues the pregnancy it will make her organs sicker or have anything to do with the transplantation.
Q. In those cases would it be true that the accepted, studied, safe methods of abortion -- D&E by dismemberment and medical induction abortion -- that are available in the second trimester could be used by that woman?
A. Either one, yes, because these are elective procedures to start with.
Q. Proliferative retinopathy, what is that?
A. This is a condition that occurs in individuals with diabetes in which the blood vessels on the retina react because of the diabetes, undergo certain changes which can lead to visual impairment, ultimately could lead to blindness. In most pregnant women it doesn't matter. A pregnant woman with diabetes is not an issue.

But there are a number of case reports of women with preexisting retinopathy, they then become pregnant, and for some reason the pregnancy seems to set up just a rip-roaring progression of that retinopathy, which would require treatment, either laser photocoagulation -- which is fine. You can do that in pregnancy and then the patient is fine. You can also certainly terminate the pregnancy, and that may halt that rapid

progression of retinopathy.
Q. Why wouldn't the photocoagulation be done in circumstances where a woman had the preexisting retinopathy and it advanced to the proliferative retinopathy with pregnancy?
A. Have no idea. Maybe she doesn't want to undergo photo-coagulation. I have never seen or heard of it happening that way, of needing to terminate because of that. But we have been in the range of theoretical things that could sometime happen to some woman somewhere for most of my testimony here, and this is another one.

This is a condition which is worsened by pregnancy. In fact, this is an exception to what I said before, where in fact it won't lead to death but could lead to permanent disability.
Q. That would be loss of eyesight?
A. Loss of eyesight. Hence, a situation which, as I said in deposition, would be an acceptable -- which, for whatever reason she wanted to keep the baby and undergo a photo-coagulation, it would be acceptable medically for a termination.
Q. There would be nothing about that condition that would dictate the method of termination in the second trimester, is that right?
A. No. Any method that is available could be used.
Q. We have gone over quite a few maternal conditions today,



and I am sure that we could spend a long time going through additional ones. I think it might be appropriate to get down to the bottom line and ask you: Can you envision any circumstance at all in which the D&X procedure would be necessary to preserve the health of a woman who was terminating her pregnancy for purposes of, because of, a maternal medical complication or health reason?
A. No. I have read all of the plaintiffs' experts' reports. The fact is that 99 percent of the substance of those reports don't address the issue. That is, they talk about how certain medical conditions are indications for abortion. True, true. And they talk about how sometimes D&E, the dismemberment procedure, is preferable to medical induction of abortion. True. No argument. That is 99 percent of what they are saying and that is all absolutely fine. But it doesn't address the issue I have been asked to address.

There still remains neither any convincing -- reading all those reports, nothing came to mind which is known to have -- in which the outcome is improved, in which there is any data to suggest the outcome is improved by the D&X procedure as opposed to some other method of pregnancy termination.

So having read all that and agreeing with 99 percent of what they say, it doesn't change the issue one bit that there simply still remains no condition, no maternal medical condition for which D&X would be necessary to preserve the life

or health of the mother. There are always equally if not more safe alternatives that do not involve D&X.
Q. I would like to turn very briefly to the issue of fetal anomalies. The fact that a woman is carrying a fetus with an anomaly, does that require termination of the pregnancy in order to advance the health interests of the mother?
A. No.
Q. Why do you say that, Doctor?
A. Because most anomalies are certainly bad things but it doesn't place the mother's health at risk. We have different issues here, and that is the fetal health. I think a very neglected, severe hydrocephalus might be the only case I can think of where there would be a fetal anomaly which, if not terminated, could result in the need for a more extensive type of C-section at term which could adversely affect the woman's future reproduction. Hence, this would be a fetal abnormality in which termination might ultimately have some positive impact upon the mother's future health.

Maybe conjoined twins would be another example. But for the most part, fetal anomalies have nothing to do with maternal health. That is a different issue altogether.
Q. Let's for a moment take those two, hydrocephalus and conjoined twins. Fetuses that are hydrocephalic, are they sometimes delivered to live birth?
A. Usually they are. Usually they are. We are talking a


small portion of hydrocephalic babies whose heads are so big, if allowed to go to term, that in fact the only way to get that baby out is to really do a very extensive incision on the uterus, which then puts her into that vertical incision classical Cesarean situation where she must have all her other babies by C-section. That could impact things, so she may choose to terminate early.
Q. When you are talking about a small number, Doctor, can you put a figure on that for us at all, or is that not possible?
A. To say less than 1 in 1,000 pregnancies is a vast over-exaggeration. I think less than 1 in 10,000 pregnancies still is a vast overexaggeration. This is the sort of thing where I can think of a couple of occasions in my life, in my career, my patients, my partners' patients, where we have seen a head blowing up before our eyes in the second trimester and we have counseled the woman, look, this baby has no prognosis anyway because it is just all water in there, and going to term is going to mean we have to do the big incision on the uterus; you may want to consider terminating now before the head gets so big. Very rare.
Q. Aside from termination by Cesarean section -- would that also be called a hysterotomy?
A. They call it hysterotomy if it is done before the fetus is 24 weeks' gestation or 23 weeks. If there is no intention to save the life of the baby, the C-section is called hysterotomy.

If there is an intention to save the life of the baby, they call it C-section. It may be the very same operation.
Q. Is there any way to deliver the fetus where the intended purpose is to abort the hydrocephalic fetus aside from the performance of a hysterotomy?
A. Well, sure. In most cases, remember, even a small fetal head which is rapidly expanding and you know what it is going to look like in 4 months is still way smaller than a normal fetal head. So a medical induction is just fine. In other cases, the dismemberment deal, procedure, would be acceptable.

If there is some concern about the size of the head, you could do what is called a cephalocentesis. You are not suctioning out the brain, but what you are simply doing is placing a needle into the large fluid-filled spaces and taking off that abnormal fluid and then allowing the baby to be delivered.

Any of those would generally be appropriate.
Q. If you did the cephalocentesis procedure to draw some fluid from the brain, could you then do the medical induction abortion procedure?
A. Or the D&E, sure.
Q. By dismemberment?
A. Sure, either one.
Q. How quickly does fluid accumulate, reaccumulate I should say, in the head after performance of the cephalocentesis to



drain fluid out?
A. It is extremely variable, but I think if you did that probably within the next couple of weeks you would be back to where you were to start with.
Q. So it wouldn't reaccumulate with an hour?
A. Oh, no.
Q. Or two?
A. No, no. Not even within a day or two. There would be some fluid within a day or two, but it would not be anything significant. In most cases, for weeks.
Q. If there was some fluid that accumulated within a couple of days, would that interfere in any way with the safe performance of a medical induction abortion or a D&E by dismemberment two or three days later?
A. No. If what you are saying is if there is some reason to object to cephalocentesis, again, don't give me the story that it is going to accumulate so darned fast you couldn't do a medical induction of a labor. That's nonsense.
Q. That was my question, because we have heard something along those lines, and I do want to make sure I get the facts straight on that.

You also mentioned conjoined twins. Have you ever had any circumstances where you have encountered conjoined twins?
A. Sure.
Q. Is that rare?

A. Yes. 1 in 10,000 or less, I think.
Q. How many times have you encountered that situation in your practice?
A. It seems like my partners or I, maybe 3 times in my life.
Q. Have you delivered to live birth?
A. Sure.
Q. Or has that been abortion?
A. Yes. I think those, if I recall, have been live birth. The mothers always wanted to go for the babies. We took the baby along and delivered by C-section.
Q. Is the fact, the existence, of conjoined twins an indication for abortion to preserve maternal health?
A. Yes, I think you could stretch things to make a case that that might be the case. If you have conjoined twins, there are certain cases where, for example, they both share one heart and the heart is abnormal, it is not going to be good enough for either of them. So this is lethal.
Q. But that doesn't have anything to do with the mother?
A. But if it were allowed to get bigger and bigger, sometimes the C-sections that are necessary to deliver conjoined twins have to be the big classical major incisions, which means you would always have to have C-sections with other babies. So it could impact her health.
So I would disagree. Conjoined twins could in fact impact the mother's health in that she might need C-sections


for her other babies. We are not talking serious. She is not going to die from carrying the conjoined twins. But it could have a health impact, and accordingly she might choose to terminate rather than undergo a C-section.
Q. What would be an appropriate method, a safe, accepted method of termination for a woman carrying conjoined twins in the second trimester of her pregnancy?
A. I can't give you one answer on that. It depends how they are hooked together. There may be time when it could be done vaginally. But here would be one example where, as a general principle, the dismemberment procedure would probably be generally preferable to medical induction in most cases of conjoined twins.
Q. Again, I think we could probably go through various other fetal anomalies, the trisomies-- which trisomy is Down syndrome?
A. 21.
Q. Is Down's, the fact that a fetus has trisomy 21, is that an indication for abortion to preserve maternal health?
A. No.
Q. Would you say that abortion in the context of trisomy 21 would be elective?
A. Yes.
Q. As a general matter, and without going through additional --

A. It would be elective in that it doesn't risk the mother's health. On the other hand, I do think it is very different than just I've got a normal baby but I don't feel like being pregnant so let's terminate the thing. I think that would be a very different situation with Down syndrome.

So I don't want to put any moral judgments on. When I say elective, it is a very difficult decision for any parent with a Down syndrome, what to do. Having never been in that situation as a parent myself, I would not want to tell a woman with Down syndrome that this is in the same camp as I'm just sick of being pregnant sort of thing. But neither could I tell her that it is risky to her health. I think that may be an in-between category, somewhere in between elective and indicated.

Q. Would this be a circumstance in which you would believe that a woman's right to choose is very important?

A. Sure. If I were king of the world, I would not touch Down syndrome. If I were making all the rules, I certainly would not say you should or should not abort Down syndrome. That is an individual decision. I would really, if you want, personally be opposed to any sort of politicians stepping in to make that decision for a mother with Down syndrome, if you want my two cents worth on it.

Q. I would like your two cents worth on method of abortion.

A. Irrelevant. Any method there is.



Q. Medical induction abortion?

A. Yes.

Q. D&C?

A. Right.

Q. Can you think of any fetal anomaly that may exist in a fetus at the second trimester, in the 20 to 24 weeks' gestational age range, where termination of the fetus would not be appropriate through either D&E by dismemberment or medical induction abortion?

A. No. Although, again, I would have to say there would be one situation. If there were a huge, huge head, I think either of those should probably be preceded by the cerebral spinal fluid decompression before either of those procedures was done. But given that decompression of the cerebral spinal fluid, either would be appropriate.

Q. You are talking about the hydrocephalus situation?

A. Yes, in the case of hydrocephalus, where it may already be too big to fit through, so one would simply drain the abnormal fluid off and then deliver the baby.

Q. We have been talking about maternal medical complications and fetal anomalies in terms of the medical necessity of the D&X abortion procedure. I would like to talk a little bit about your view as to whether the D&X procedure presents safety advantages such that there would be a medical necessity for its performance.

Dr. Clark, are the risks associated with D&X known?
A. Not very well.
Q. What do you mean by that?
A. In fact, officially, no, they are absolutely unknown. I understand this first paper that is going to be published will be the first peer-reviewed publication of risks, which in a very small group of women suggests that the short-term risks, at least in 120 patients, were not statistically different regardless of whether dismemberment or this D&X procedure were used but have a threefold increased risk of premature birth along with a plausible biologic explanation for why that might occur, namely, twice the dilatation which companies this procedure. That trend is very worrisome but not proven.
MS. PARKER: Objection, your Honor.
A. And that is all we can say about the procedure today.
THE COURT: Overruled.
MS. PARKER: Your Honor, can I state my objection for the record?
THE COURT: Ma'am, you stated it more than once. Do you think a third time will help? Go right ahead if you wish. By the way, I'm blind, not deaf. Go right ahead.
MS. PARKER: Your Honor, my objection is that this study was not discussed in the witness's expert report and we did not have notice that the witness would be making substantive characterizations about the results of the study.



THE COURT: Sounds repetitious to me. Overruled.
Q. We have heard the claim in this case that D&X is safer than D&E by dismemberment because there are less passes with instruments in the uterus, through the cervix into the uterus. What is your view, your opinion, on whether the issue of less passes with instruments has any role at all in assessing the safety as between intact D&X and D&E by dismemberment?
A. Three things. First of all, when we talk about D&X being potentially safer, it is very difficult to believe anything could be safer, because of course proponents of this procedure have for two decades now put forth D&E as the absolute end of the story in terms of safety.
11,000 patients delivered with D&E, aborted with D&E, negligible risks involved. Up until this, that was this incredibly safe procedure that had an almost negligible risks of complications. Now of course it has become -- now it is a very dangerous procedure with all these problems. But if you look at the data which does exist for the dismemberment D&E, it is very difficult to imagine that there could be any procedure which is safer than that.
The previous position of proponents of D&E was exactly correct. It is in fact a documented, incredibly safe procedure in huge numbers of patients.
The second thing is that while on a theoretical basis, yes, less passes, doesn't it make some sense that less passes

might cause you less problems or less jaggedy bones from broken bones might make it safer, I guess in some sense it makes sense. But if I drive in and out of my driveway a hundred times, if I do it properly, that really doesn't increase the risk that I am going to hit the side of the garage.

The same situation. If you do it right and do it carefully, there is no reason to think that passes should be hazardous. Once again, look at the D&E data in 11,000 patients who underwent this extraction dismemberment procedure. It would appear that all of the passes, however many passes you need to do this in 11,000 patients, was not associated with an increase risk of problems.

Theoretically, could that be safer because of less passes? Theoretically, it could be. But actually, as I said in deposition, theoretically dilating the cervix further could be an increased risk of subsequent preterm birth. And what do you know, when I finally saw the data after I said that is what I suspect it is going to show, it is there, a threefold higher risk of subsequent preterm birth. So it is very hazardous to say something is safer based on some sort of theory.

Finally, I think this current data, we now have data to say is it safer. Is it safer? This paper that is going to be published compares those two procedures and shows no difference in outcome. So you start off with 11,000-plus patients, incredibly safe procedure. You now have a study



comparing the two which shows no improvement in outcome with this procedure. How you could say yes, it is safer, when there is volumes of data suggesting -- all the data there that suggest it is not? This is not believable to me.

For those reasons, I don't find that for me as a scientist to be a credible argument to say this is a safer procedure, when the only published data on it shows no differences in outcome.

MS. PARKER: Your Honor, may I have a standing objection to reference to the Chase study?

THE COURT: Yes, ma'am, you may.

Q. Is a sort of theoretical advantage in any way similar to what some people have characterized as an intuitive advantage to the procedure? Are they sort of the same things?

A. Sure.

Q. Have there been examples in medicine where something theoretically seems safer or medical science's intuition was that it would be safer and people went ahead and used the treatment, and it turned out in the end not to be so?

A. Medicine is full of that. There were theoretical reasons -- in 1970 the C-section rate was 5 percent. This year it will be 25 percent. Much of that increase has been based upon a really good theoretical assumption that if certain heart rate patterns identify on the fetal monitor at term, if that baby is quickly delivered by C-section it will prevent cerebral

palsy.

Literally millions of women have been sectioned over that time, undergone a major abdominal operation on that really good theory. It has been a total bust. We are realizing that now. The rate of cerebral palsy hasn't done anything over the years. One instance where theory has turned out not to be so.

We used to treat threatened miscarriage with DES, a form of synthetic estrogen. Very good theoretical reasons why additions of estrogens should support that pregnancy. As it turns out, it didn't. But what it did do is cause vaginal cancer in women once they get into their twenties and also cause other sorts of reproductive problems in these women who were exposed to DES as fetuses.

We could go on and on. I am not claiming -- I suspect that there will -- when we have cases, if there ever were cases of millions of extraction -- excuse me -- D&X's, I don't suspect that in skilled hands there would be more short-term complications than the D&E procedure. I suspect it will turn out to be exactly the same in terms of short-term safety.

This preterm birth thing I think is dynamite waiting to go as soon as it is published. People are going to jump on this and require informed consent once this preterm birth rate is out there.

I am not claiming that this would be like DES or like fetal monitoring, but what I am saying is there are many



examples of something that seems intuitively obvious that turns out to be just the opposite. Until and unless, when you have got a very safe procedure that works, until you have some real good data suggesting that a new, different procedure is better, you ought not take the chance with women's health based on theory.

THE COURT: Doctor -- excuse me. I didn't mean to interrupt you. Go right ahead.

THE WITNESS: I'm finished, sir.

THE COURT: I want to make sure I understand what you just said. Are you saying that once this report, being the Chasen report, is out, the profession is going to be demanding that part of informed consent is that you warn a patient that this procedure could threaten her with premature births in future pregnancies?

THE WITNESS: I wouldn't say it that strongly, your Honor, because obviously I would be speculating to say what the profession is going to say. But I know that the letters to the editor are going to come, assuming it is published in that form, are going to look at this and say this is politically motivated, how can you possibly publish something that has shown no benefit and a threefold risk of preterm birth without having the final sentence being, therefore, we ought to be very cautious about doing this procedure until this has been sorted out.

I think certainly, if I were counseling such a patient, I would hate to find myself in the situation of having done this procedure on a woman who subsequently gave birth prematurely and be asked, Doctor, did you inform her that the only available data on the planet today showed a threefold increased risk of preterm birth compared to the safe alternative form procedure? Did you inform her of that? I wouldn't want to be in that position.

THE COURT: You personally would feel it would be your ethical obligation to warn her?

THE WITNESS: Yes, because that is what the data shows, and I am assuming that data is exactly correct. If a woman wondered what are the risks or potential risks of that procedure, I would feel obligated to tell her the complete, whole truth about what risks there are. Whether others will or will not, I can't speak to that.

THE COURT: But you would?

THE WITNESS: I surely would. I surely would.

Q. Does the fact of what you learned from your survey of the medical literature or other data, does that inform the advice that you give to your patients as a general matter when you are giving informed consent?

A. Of course it does. Whatever literature is available, you don't have to give every detail, but I think certainly have to give the gist of that. And when there is peer-reviewed data



available on this D&X procedure, it will of course be incumbent upon doctors performing it to accurately portray the results of that procedure to the woman and contrast it with the alternative and the proven complications of the alternative. That is the basis of informed consent.

Q. Is preterm birth a big problem or a small problem?

A. If 1,000 obstetricians and 1,000 pediatricians came into this room and were asked the question, what is the number one problem in obstetrics and pediatrics, 1,000 of 1,000 would say prematurity. Prematurity accounts for more morbidity and mortality, that is, long-term sickness and death, than any other single condition in all of obstetrics and all of pediatrics. To say it is a big thing is a huge understatement. Premature birth is a huge, huge problem.

Q. We have also heard, Doctor, that D&X may have safety advantages over induction abortion and D&E by dismemberment because there are fewer bony parts that are left in the uterus.

A. Right.

Q. Do you have a view as to the risk presented by bony parts vis-a-vis no bony parts left in the uterus?

A. I don't have a view. We've got data. Look at the Peterson article, 11,000 D&E's, and see what the risks were of all this stuff together. They have a nice table. Pick a complication. You will see what the risk of that was. In fact, the complications are so low that this procedure absolutely

correctly was touted for 20 years as an incredibly safe procedure with negligible risk of serious complications in skilled hands, and rightly so.
Q. You are talking about D&E?
A. I am talking about the D&E. People say, well, now suddenly the jagged parts are a big problem. Show me the data. Show me the data. The old data doesn't suggest they were much of a problem. The new data comparing, this is Chasen's study, comparing the two doesn't show any improvement in outcome between the two procedures. Before you claim this is a safer procedure, I want to see some data, and the data that exists suggest it is not so.
Q. I want to very briefly go back to the fetal anomaly issue and ask you very briefly about the diagnostic pathology and the assessment of genetic, chromosomal abnormalities --
A. Yes.
Q. -- for purposes of genetic counseling or counseling women for future pregnancies.
A. Right.
Q. In your opinion, would D&X be necessary for purposes of diagnostic pathology?
A. It could be done for purposes of diagnostic pathology. It would not be the only acceptable way to proceed. What you are saying is there are some conditions where we know the baby has a real big problem by ultrasound but we don't know exactly what


that is until we do an autopsy of the baby. Doing that autopsy may allow us to pin a name on the syndrome, and with that name then goes a known recurrence risk that might be helpful to the parents in planning future pregnancies.

In fact, if you dismember the baby, you may be losing important data which will not allow you to put a name on the syndrome, hence will deprive the parents of information that might help them in planning future pregnancies. That is an absolutely true concept and I have actually even seen it a couple of times in the many, many patients that I have dealt with.

Under those circumstances, the best thing would be medical induction, because then the baby is delivered completely intact and you can examine the brain, all of the body, to try to put a name on that syndrome. Sucking out the brain removes the possibility of doing autopsy on the brain or any sorts of examinations, and may hinder your ability to place a name on that in the same way that pulling apart all the limbs would be. So this would be a situation where medical induction would be the best thing.

Now, what about a woman who had a rare birth defect and it was so rare that we needed to have an autopsy and she did want to terminate even though we couldn't tell her exactly what she had, and she also had a previous C-section and that previous C-section was a classical section, so she couldn't

have a medical induction? I'm sure somewhere on earth such a person will be found at some point. For that woman, if you couldn't do the medical induction but you were going to terminate the pregnancy, you would have to, say, do potassium injection into the baby. Then you could do your, for example, D&X procedure. But it wouldn't really be a D&X procedure.
Q. What would a potassium injection do?
A. That would kill the baby. Then this would not be a D&X procedure, at least as defined in my humble way as I read the -- my understanding is there is no proposed law which would prohibit how a dead baby is delivered.
Q. Are there risks to the injection of potassium chloride?
A. With skilled hands, no, no. It would require amniocentesis. But the risks of amniocentesis are primarily of causing premature labor or complications with the baby. Obviously, the woman doing this is not concerned about complications with the baby.
Q. When you say premature delivery, that is the risk. The intention here would be to abort, so therefore you are saying there is no --
A. Right.
Q. Premature delivery doesn't cause any danger?
A. Right. Even for that theoretical patient we are talking about, where medical induction would not be appropriate, D&X as described would not be the only safe alternative for

terminating that pregnancy.
MS. GOWAN: Thank you, Doctor. I have no further questions.
THE COURT: You may cross-examine.
MS. PARKER: Thank you, your Honor.
CROSS-EXAMINATION
CROSS-EXAMINATION
BY MS. PARKER:
Q. Good afternoon, Dr. Clark.
A. Good afternoon.
Q. My name is Kimberly Parker. We met at your deposition.
A. Yes.
Q. Dr. Clark, you have never written any article about abortion procedures, have you?
A. Correct.
Q. You have never written any article about abortion techniques, have you?
A. Correct.
Q. You have never conducted any studies of any method of abortion, is that right?
A. Correct.
Q. You have never participated in any studies of any method of abortion?
A. Correct.
(Continued on next page)

BY MS. PARKER:
Q. You performed only approximately a dozen first trimester abortions on live fetuses in your career, is that right?
A. Yes.
Q. You haven't done many labor induction abortions, have you, either?
A. Correct.
Q. In fact, you've done under 20 labor induction abortions in your entire career --
A. Yes.
Q. -- is that right?
You've performed only a handful of D&Es on live fetuses?
A. Yes.
Q. You've performed at most a dozen D&Es over the course of your career on live fetuses?
A. Yes.
Q. The last D&E you performed on a live fetus was one or two years ago, is that right?
A. Yes.
Q. You've performed D&Es on live fetuses only up to a gestational age of 20 weeks, is that right?
A. Yes.
Q. One of the reasons for that is because you lack experience in doing D&Es after 20 weeks?



A. Yes.
Q. You testified on direct examination about the procedure referred to as D&X?
A. Yes.
Q. You've never performed a D&X, have you?
A. Correct.
Q. You have never seen one performed, have you?
A. Correct.
Q. You haven't had any conversations with anyone who performs D&X, have you?
A. That's where I don't know because I've talked with Mark Evans. In fact, I even talked with Marilyn Frederikson now that you bring it up.
So, if they do D&Xs then sure enough I've talked to someone but I can't --
Q. You haven't talked to anyone when performs D&X about the technique, is that right?
A. About the technique, exactly. Exactly correct.
Q. Dr. Clark, you consider yourself only moderately skilled in the provision of abortion, isn't that right?
A. Yes.
Q. You wouldn't consider yourself as expert in performing abortions as those who do it all the time, isn't that right?
A. By definition.
Q. You're ethically opposed to elective abortion, correct?

A. Correct.
Q. You're morally opposed to elective abortion?
A. Correct.
Q. Dr. Clark, you've testified extensively as an expert witness in medical cases, is that right?
A. Yes.
Q. In fact, you've given deposition or trial testimony more than 160 times in the last four years, is that right?
A. Boy, that seems like a lot for four years but certainly extend that -- extend that back a few years and that wouldn't be -- I don't know. If you've got one of these searches that says that's how many it was then I certainly believe you.

It has been a lot. The more I write and publish the more it seems that lawyers want my opinion, as well as doctors.

So if you've got a count I believe your count but it's been a whole lot until I stopped doing that a couple years ago, stopped taking cases as a potential expert. Throughout the '80s I reviewed and testified in many malpractice cases; yes, indeed.

Q. You provided expert disclosures in this case, didn't you?
A. Yes, I did.
Q. Part of those disclosures was listing the cases in which you testified or gave a deposition in the last four years, is that right?
A. I think so, yeah. I think so.



Q. Okay. You get paid for the testimony that you give in these medical cases, is that right?
A. Not for this case, but in medical malpractice cases I charge for my time, yes.
Q. And you charge $400 an hour for that time?
A. Yes.
Q. So, assuming that I'm right that in fact you've given a deposition or provided testimony 160 times in the past four years, assuming you spent five hours on each of those occasions preparing, that would be about $300,000 in income from testimony in medical cases, is that right?
A. Over the past -- well, I -- if you've done the math correctly you certainly do have the correct beginnings.

THE COURT: Is there some relevance here, Ms. Parker?

MS. PARKER: Your Honor, the relevance is discussing the doctor's extensive experience providing testimony in cases.

THE COURT: What he has been paid as expert witness in malpractice cases, you find some relevance to this case?

MS. PARKER: I do, your Honor.

THE COURT: I'm not shocked but I don't agree with you, but we'll see how far you go with it. At some point I assure you it does not have a whole lot of relevance.

Go ahead.

BY MS. PARKER:
Q. Dr. Clark, in none of the cases in which you've testified

as an expert did you testify about abortion method or techniques, is that right?
A. I believe that's right.
Q. You've been barred from testifying in three of the cases in which you were retained as an expert?
A. Yes, because I would not provide my wife's income tax information on our joint income tax returns and the judge in those cases said everybody's got to give their income tax returns. So, I said well, if that's the case I'm out of your case.

And I would do it tomorrow a hundred times again. That's exactly right.
Q. Okay.

In one of those cases the Court held that you destroyed or failed to produce evidence.

THE COURT: Excuse me, did you know this from deposition, ma'am?

MS. PARKER: I did.

THE COURT: And you think it's relevant?

MS. PARKER: I do.

THE COURT: Well, it isn't. That's the end of that line.

BY MS. PARKER:
Q. In one of the cases in which you testified, did the court hold that you destroyed or failed to produce evidence?



A. I think, in all -- I think probably in all three because I, the Court was right, I failed to produce my income tax -- my wife's and my joint income tax return so I'm -- I suspect it was all three of those cases because that would be a true finding. I in fact failed to provide my income tax returns and any other personal information about my wife and myself so I think that all three but I'm sure in one.
Q. In one did the Court hold that you destroyed or failed to produce evidence?
A. I'm saying I'll bet -- I'll bet all three that that was the finding because -- I mean the "destroy" wouldn't be true but the "or failed to produce" is absolutely true in spades.
Q. Dr. Clark, you would agree, wouldn't you, that there are some maternal health conditions that could, under some circumstances, be indications for termination of pregnancy, right?
A. Of course.
Q. You think that certain types of heart disease could be an indication for termination of pregnancy?
A. Yes.
Q. You think certain kinds of hypertensive disease could be indication for termination of pregnancy?
A. Yes.
Q. How about malignant maternal cancer where the chemotherapeutic agents or continuing pregnancy would interfere

with appropriate therapy; that's a case where you think indication for termination, correct?
A. Exactly.
Q. Those are some of the examples, correct?
A. Yes.
Q. There are other ones?
A. Yes, there are.
Q. You would agree that D&E is a safe procedure, correct?
A. Yes.
Q. In fact, you think it's an incredibly safe procedure, is that right?
A. Well, I guess that's not the complete story. I do but it's not because I think of it. It's because the D&E data documents it to be so, yes.
Q. Right. You agree that the safety of D&E is well documented?
A. Absolutely.
Q. You think it is incredibly well documented?
A. Yes.
Q. In fact, working on this case has shown you that D&E is even safer than you thought, is that right?
A. Yes. Yes.
Q. That's an opinion of yours that changed from working on this case, correct?
A. I don't think it changed but it was enhanced. I knew it


was safe but until I reviewed the D&E literature I didn't realize how incredibly safe it was, so.
Q. You weren't aware before this case of how incredibly safe D&E was, right?
A. Sure. You might say I knew it was really, really safe but now I know it's really, really, really safe. Absolutely.
Q. You think that a D&E, in most cases, is preferable to an induction abortion before 18 weeks, correct?
A. Barring any medical complications that would make me choose one or the other, I would say most women would choose that, yes, and hence it would be preferable.
Q. Well, putting aside what women would choose, you currently probably would not recommend a D&E before 18 weeks, is that right?
A. That's different than the question you just asked.
I do not recommend medical induction before 18 weeks.
Q. Sorry, induction.
A. Right, that was the question you meant to ask. Yes.
Q. You wouldn't recommend induction before 18 weeks. Exactly.
A. Right. All things being equal, if a woman asked my opinion, exactly.
Q. If a woman asked your opinion, you wouldn't recommend an induction before 18 weeks?
A. You've got it right.
Q. Is that right?

A. Yes.
Q. And that's because an induction is usually much more difficult prior to 18 weeks, is that right?
A. Much more difficult for the mother.
Easier for the doctor, difficult for the mother and so I would, that's why I would not recommend it, because I would say her, how it is for her is more important than how it is for me.
Q. D&Es would always take substantially less time than a medical induction at the same gestational age, correct?
A. True. True.
Q. A D&E usually takes less than an hour, is that right?
A. True.
Q. And an induction can take up to 36 or 48 hours, is that right?
A. Not very often but occasionally it surely may. And it's always going to be longer than an hour, guaranteed.
Q. So the time difference between a D&E and an induction is the difference between within an hour and up to 48 hours; that's the difference, right?
A. That's fair.
Q. Labor induction abortions can be prolonged, right?
A. Yes.
Q. And induction is often uncomfortable, correct?
A. Until the epidural is in, yes.



Q. And it's a psychologically draining experience, is that right?
A. I believe it is from my observation of women undergoing it, yes.
Q. And for that reason you think D&E is preferable, isn't that right, for some women?
A. It's preferable for some women, sure.
Q. You've testified that you haven't performed D&E abortions after 20 weeks, right?
A. Yes.
Q. But you refer patients to your colleagues who perform D&Es at greater gestational ages than you do, right?
A. Usually my colleague, yes.
One of us, because that's so rare, one person has tried to get most experience in the medical provision of those things and so there is one individual who is kind of the designated 20 weeker performer.
Q. And you refer your patients for abortion to that colleague after 20 weeks?
A. Yes, I do.
Q. Doctor, it's your opinion that D&E may be safer at some gestational ages than medical induction when an incision has been made in the uterine fundus prior to the pregnancy, correct?
A. Yes. That's what I told Ms. Gowan, sure.

Q. You would agree that D&E beyond 20 weeks would be preferable to induction where a woman has a prior classical incision, right?
A. I've told you I believe it to be true. I can't prove it but I believe it to be true, yes.
Q. That's your opinion --
A. Yes.
Q. -- although you don't have any data to support that opinion?
A. It is my opinion, yes.
Q. But it's your opinion anyway?
A. It is.
THE COURT: He said that three times.
Q. Doctor, in the late second trimester you would have a bias for D&E for a woman with a prior uterine incision, although you can't prove that it would be safer, right?
A. No. I have said it four times, yes.
Q. Okay, great.
That would be because D&E reduces the risk of uterine rupture, right, in that situation?
A. I think.
Q. You think it reduces the risk of uterine rupture in that situation?
A. I think.
Q. From a time standpoint you think a D&E might be preferable



to induction in a case of severe pre-eclampsia at 20 to 23 weeks, right?
A. It could be, barring problems with blood clotting that we talked about before.
Q. But that's an example, barring problems with blood clotting where a D&E would be preferable from a time standpoint, is that right?
A. Sure.
Q. There are cases in which a quick surgical delivery would be preferable to a medical induction, correct?
A. Correct.
Q. One example is a case where you can't control the patient's blood pressure, right?
A. That's really the situation we just talked about. That would be the preeclampsia woman.
Q. And that's a case where you might want to do a D&E, correct?
A. Yes, sure.
Q. You would agree, Doctor, that induction of labor for abortion does not always succeed in completely emptying the uterus, correct?
A. Yes.
Q. And if an induction procedure fails to empty the uterus, you have to perform an instrument procedure to empty the uterus?

A. Yes.
Q. Retained placenta is a complication of induction, is that right?
A. And of D&E.
Either way, once the baby is out the placenta is not, and either way you then have to go get the placenta with instruments.
Q. And would you describe that as a complication in the case of an induction, is that right?
A. Sure.
Q. It's occasionally necessary to use curettage to remove the retained placenta in an induction, correct?
A. Sure.
Q. You would agree that when you use an instrument to remove the placenta, there is a risk of an infection, is that right?
A. Yes.
Q. And when you use instruments to remove the placenta, there is a risk of perforation, is that right?
A. Yes. Yes.
Q. Perforation would be the primary risk of that instrument procedure?
A. I suppose ultimately -- I suppose ultimately that's true. I mean in good hands both of them should be very infrequent but I will go with that.
Q. Perforation is a potential risk of D&E, correct?



A. Any time you put an instrument in the placenta, in the uterus, yes.
Q. In fact, you discuss perforation as a potential risk when you provide informed consent to your patients for D&Es, is that right?
A. Sure, sure.
Q. Cervical laceration is a potential risk of D&E, correct?
A. Or anything else that dilates the cervix mechanically, yes.
Q. And when you provide informed consent to your patients when you do a D&E, you tell them about the risk of laceration, correct?
A. Yes. Yes.
Q. Infection is also a risk of D&E, is that right?
A. Yes.
Q. And bleeding is a risk of D&E, is that right?
A. True.
Q. And you mentioned these as well when you provide informed consent to your patients for D&E, correct?
A. I'm not sure that I mentioned the bleeding, to be honest with you, because there is always going to be some bleeding.
So, I can't honestly tell you that I say bleeding every time. I believe that's understood but I probably should in fact. That would certainly be more complete. I think you're right there.
MS. PARKER: Your Honor, I'm at a stopping point if

you wanted to take the break.

THE COURT: That's fine, we will take our afternoon break.

This Court will stand in recess, briefly.

(Recess)

THE COURT: Counsel, you may inquire.

MS. PARKER: Thank you.

Q. Dr. Clark, you would agree, wouldn't you, that a woman who has experienced a preterm delivery is at a higher risk for preterm delivery in a subsequent pregnancy, correct?

A. True.

Q. You think that D&X requires more dilation than D&E involving dismemberment, is that right?

A. Yes. That's what the Chasen paper shows, twice the dilation.

Q. You don't know whether doctors currently performing D&X prepare the cervix any differently for D&X than D&E involving dismemberment, do you?

A. No. We only know that they get an average of four centimeters' dilation before the procedure as opposed to two centimeters.

Q. And you don't they use the same number of laminaria for the D&X than for D&E involving dismemberment, do you?

A. I don't know what they do to get twice the dilatation.

Q. You don't know whether they use the same cervical ripening



agents?

A. Correct.

Q. In performing D&Es you use laminaria, correct?

A. Correct.

Q. And in the D&Es that you've performed, you generally use two sequences of laminaria prior to evacuating the uterus, correct?

A. Correct.

Q. With each laminaria sequence you put in as many laminaria as you can in an atraumatic way, correct?

A. Correct.

Q. You would agree that laminaria is a more gentle form of dilation than mechanical dilators?

A. Correct.

Q. You would agree that in contrast to mechanical dilators, laminaria does not cause increased pregnancy loss, correct?

A. That is generally felt to be true but with this new data showing three times the pregnancy loss, if indeed that extra mechanical dilatation was achieved through the use of laminaria, one would certainly have to ask the question about whether that needs to be re-evaluated.

But for standard, proven, studied techniques of pregnancy termination, the use of laminaria does not increase the risk of pregnancy loss.

Q. You are not aware of any study that suggests that laminaria

increases pregnancy loss other than the one you just mentioned, is that right?
A. When controlled for the reasons they're giving the laminaria; that's correct.
Q. Sometimes in a D&E you've used mechanical dilators in addition to laminaria, is that right?
A. Yes.
Q. It's your opinion, Dr. Clark, that there are times of when examination of an intact fetus may assist in the diagnosis of a fetal syndrome, right?
A. Yes.
Q. You would agree that there are cases in which examination of the intact fetus might help you put a name on a syndrome, is that right?
A. As I explained earlier, yes.
Q. Under those circumstances, one choice for termination would be medical induction, correct?
A. Still true, yes.
Q. Another choice would be doing a D&X, correct?
A. That would certainly be physically possible.
Q. And another choice would be killing the fetus and then doing a D&X, correct?
A. Also physically possible, yes.
Q. As between doing a D&X or killing the fetus first and then doing a D&X, you think those two options would be equally safe


medically, correct?
A. Yes.
Q. And you think they would be equally appropriate, is that right?
A. Well, equally safe for the mother you are talking about?
Q. I am.
A. Yes. And the answer to the next question would be yes.
Start over again, excuse me?
THE COURT: Would you like the question read, Doctor?
THE WITNESS: I would. Both those questions, if you would ask those two questions again.
THE COURT: Would you read the question again, please, Ms. Reporter?
(Record read)
THE COURT: Counsel, try and slow down a little bit. Go ahead, Doctor.
THE WITNESS: No, those -- those are the correct answers to those questions.
BY MS. PARKER:
Q. So you think those two options would be equally appropriate, correct?
A. In terms of maternal safety, yes; either killing the baby and then D&X or just plain old D&X. I can't see how that would make a difference to the mother.
Q. In circumstances like those you testified about earlier

where there is a prior incision, classical incision, if a woman needed an intact D&E you think a D&X would be safe, is that right?
A. The limited data suggests it's safe in the short-term. The limited data suggests it may pose significant hazards to future pregnancies in the long-term in terms of preterm birth.
Q. You think that the short-term data suggests that they would be equally safe, right?
A. Yes.
The only data we have is Chasen, and he showed no difference in any short-term outcome with D&E versus D&X, so I would have to say as best we can tell in the short-term, yes. In terms of long-term, perhaps not.
Q. Doctor, it's not your practice to induce fetal demise before evacuating the uterus in an abortion procedure, is it?
A. To induce fetal demise?
THE COURT: Would you like the question read?
THE WITNESS: I'm not sure I understand.
THE COURT: Would you read the question, please, Ms. Reporter?
(Record read)
A. When you say induce fetal demise you mean cause fetal demise?
Q. Right. Sorry.
A. Okay, I got inductions mixed. Okay.





Q. I apologize.
A. Right.
Q. You have never done that, you have never taken steps to cause fetal demise before an abortion procedure, correct?
A. I can't think of the time I have.
Q. You have never administered digoxin as a method of causing fetal demise in an abortion procedure, have you?
A. True.
Q. You have never administered potassium chloride or KCL as a method of effecting fetal demise?
A. True.
Q. You have never considered injection of KCL desirable for purposes of causing fetal demise in an abortion procedure, have you?
A. True.
Q. You have never compressed the umbilical cord on purpose as a way to cause fetal demise in an abortion, have you?
A. That's for sure.
Q. After the cord is clamped it may take 10 to 15 minutes for the fetus to die, correct?
A. Yes.
Q. And a fetus dies from lack of oxygen in that circumstance, correct?
A. Yes.
Q. If you inject KCL to cause fetal demise, that wouldn't do

anything about your concerns that you have expressed about preterm labor in subsequent pregnancy, would it?
A. Well, if you inject that and then did a D&X procedure, that would not, there would be no reason that would alter preterm birth risks for D&X, true.
Q. Doctor, you have read the findings of fact that are included in the Partial-Birth Abortion Ban Act of 2003, correct?
A. I don't know.
I mean, I have read that Act I guess but is the findings of fact something different than that or? Is that just the Act, is that what you are saying?
Q. Yes.
A. I have read the Act.
MS. PARKER: May I approach the witness, your Honor?
THE COURT: You may.
Q. This is Plaintiff's Exhibit 69.
A. I have read this, yes.
Q. Doctor, I would like to turn your attention to section 14A of the findings, which is on page 3.4 of Plaintiff's Exhibit 69.
A. Yes.
Q. Will you take a look at that?
A. Yes.
Q. You disagree with much of section 14A of the findings of



the Act, isn't that right?
A. Yes.
Q. Section 14A talks about the risks of partial-birth abortion to women who undergo it, correct?
A. Yes.
Q. But you don't think that anyone could say that those are the risks of the procedure, do you?
A. Would you -- let me go through them again here.
THE COURT: Would you like to have that read, is it? Do you want the question again?
THE WITNESS: No, I've got the question, I just want to read these risks to see if I agree in each case with your premise here.
Q. Of course.
A. Well, there is really only one of these which there is now some data to support, and that would be the risk of subsequent preterm birth, makes it difficult to carry a subsequent pregnancy to term.
The Chasen study gives evidence at least suggesting that that may in fact be true but these other things, in fact there is no evidence that would support that there is an increased risk of rupture, abruption, amniotic fluid embolism or trauma, and so I would disagree that one could make those statements there being no evidence that they are true.
THE COURT: You are not saying they're false, you are

just saying that there is no evidence that you know of to say to prove they're true.

THE WITNESS: Correct. So I would disagree with the statement that says these things are risks.

THE COURT: Uh-huh.

THE WITNESS: I would disagree with that. I don't know if they're risks or not except the one, and that appears to be a risk.

BY MS. PARKER:

Q. Putting aside that one, you don't think anyone could say that those are risks of the procedure, do you?

THE COURT: He just said that.

THE WITNESS: Correct.

Q. Doctor, you testified earlier that there is no evidence that D&X a safer procedure than D&E, correct?

A. Yes.

Q. But you also have said, haven't you, that any conclusion that D&X is more dangerous than D&E represents pure speculation, is that right?

A. It did before I read the Chasen article.

The Chasen article gives us evidence for the first time to what I told you I would fear would happen in deposition. Remember even before I read the article I said the thing I would be worried about is increased risk of preterm birth with the additional dilatation but it would be



speculation to say whether that occurs.

The Chasen data suggests that that's exactly what they, what they, what may be the case, exactly what was seen, three times greater risk of preterm birth.

So at this point it was true then, but with the addition of that new data it was possibly no longer quite speculation.

Q. Putting aside the Chasen study, it was your position that saying that D&X is more dangerous than D&E represents pure speculation, correct?

A. Absolutely true.

Q. Putting aside the Chasen study, it's your position that any conclusion that D&X is more dangerous than D&E has no place in scientific discussion, is that right?

A. True.

Q. Dr. Clark, you don't have any opinion as to whether any particular abortion method is preferable over any other from the perspective of the fetus, do you?

A. Yes, but I think the answer is no.

Q. Yes, you have an opinion and the answer is no, none is preferable to the fetus?

A. Yes. I don't -- there is no way I can prove it but I suspect if you are going to kill a baby tearing it apart limb from limb or sucking its brains out is ultimately quite irrelevant or even compressing the umbilical cord to asphyxiate

it is probably irrelevant in the long-term.
That would be my -- so I suspect there would not be any preference from the fetal standpoint.
THE COURT: Do you believe there is fetal pain?
THE WITNESS: Sure. If there is pain once --
THE COURT: Then you might have a difference to the fetus in that case, would it not?
THE WITNESS: It might, but I --
THE COURT: If they could fee pain tearing the limbs off in a D&E or sucking the brain out in a D&X?
THE WITNESS: It might, your Honor.
I mean I -- whether I would rather have my, something, a hole poked in my brain and sucked out or pulled apart at the limb, I don't know if I can say.
THE COURT: When it is over it doesn't make any difference.
THE WITNESS: They both sound pretty brutal so I, as far as I know the fetus, it doesn't have any long-term differences to the fetus, how it's killed.
BY MS. PARKER:
Q. Doctor, you would agree that within the realm of safe procedures it is important for physicians to have some flexibility in how they perform procedures to account for their particular skills, correct?
A. Yes.



Q. You would also agree that it's important for physicians to have flexibility to account for their particular level of experience, is that right?
A. Within reason.
Q. You would agree that as a rule physicians should have some flexibility in how they perform a procedure, correct?
A. Some flexibility, yes.
Q. You would agree that physicians should have some flexibility to account for unanticipated events in the course of a procedure, right?
A. True.
Q. Doctor, you have testified that the Chasen study that you looked at has not been published, correct?
A. Yes.
Q. The government provided that study to you, is that right?
A. Yes.
Q. When did they provide it to you?
A. After I talked about it in deposition.
Q. You hadn't seen it before they supplied it to you, had you?
A. Correct.
MS. PARKER: Your Honor, may I approach the witness?
THE COURT: You may.
Q. Dr. Clark, I'm showing you Plaintiff's Exhibit 23A; have you seen it before?
A. Yes.

Q. What is it?
A. This is the Chasen article that we've been discussing.
Q. Is that the version that you've seen before?
THE COURT: Is there more than one version, ma'am?
MS. PARKER: There are galley proofs and there is a version that is not in the form of a galley proof.
THE WITNESS: I believe I have not seen this form before. I believe I've seen the non-galley proof version.
MS. PARKER: Okay.
THE COURT: Are the contents the same?
MS. PARKER: Yes, they are.
Q. Dr. Clark, you expressed the view that the data relating to subsequent pregnancy outcomes in this study was downright shocking to you, is that right?
A. Yes.
Q. Let's take a look at this study. Can you turn to page 3, please?
A. Yes.
Q. The bottom of the first column, the last sentence that starts with the word "spontaneous," can you read that sentence, please?
THE COURT: To himself?
MS. PARKER: No, aloud, please.
THE WITNESS: This is the first column bottom, "spontaneous"?



Q. Yes.
A. Spontaneous preterm birth occurred in 2 of 17, 11.8 percent pregnancy in the intact D&X grouped compared with 2 of 45, 4.4 percent in the dilatation and evacuation group.
Q. And then is there something at the end of that sentence?
A. Yes. Then it says P equals .30.
Q. Doctor, P equals .30 signifies the P value of the difference in outcomes between the intact group and the dismemberment group, correct?
A. Yes.
Q. And the P value is the measurement by which statistical significance is determined, is that right?
A. Using the method they used in this case, yes. There are other ways to do it too.
Q. And a P value of .30 is not a statistically significant difference, is it?
A. Correct.
Q. In fact, it means that there is a 30 percent chance that the different outcomes occurred by chance, is that right?
A. Fairly close. Statistically speaking you are on a little bit shaky ground.
Q. You wouldn't agree that it means that there is a 30 percent chance that these outcomes occur by chance?
A. I wouldn't quite phrase it like that but I will accept it. That is, there is a good chance that it occurred by chance.

THE COURT: How would you phrase it, Doctor?

THE WITNESS: Well, I would say that if the P value is less than .05 then there is absolutely no question. Usually we don't accept something as absolute scientific truth unless the chances are less than five percent.

In this particular case it's just stretching it a little bit to say 30 percent chance, but you're roughly correct.

Q. I'm roughly correct, right?

A. You're roughly correct, right.

And then which means, of course, that if there is a -- if that is true there is a 70 percent chance that in fact this is a real difference, had this been less than .05. Remember what I said is this is very concerning, is cause for -- I'm alarmed by it -- is cause for inclusion in informed consent and if this weren't given a political free ride, would be enough to make the conclusion be we ought to be very, very careful about this.

If this had been less than .05 we wouldn't be here because this procedure would have been forever banned if the numbers had been bigger and shown a statistically significant increase in this.

Then, even the political arm of ACOG could not have overruled this worrisome thing.

So, you're right, it could be wrong, that's why it's



only a -- it's only a worry is -- probably is correct. As you've said, 70 percent chance, there is a chance this could be random and that's why I said it's only worrisome rather than it's downright criminal to perform this procedure which would be the case if it were definitely proof that there was a three times risk of preterm birth.

Q. Dr. Clark, a P value of .30 is not a statistically significant difference, is it?

A. That's right.

Q. Okay, let's go to the next sentence. Can you read that sentence?

A. Both spontaneous preterm births in the intact D&X group occurred in women at high risk for prematurity. One woman who underwent intact D&X caused by PPROM at 20 weeks' gestation and subsequently delivered at 32 weeks, and the other underwent intact D&X at 23 weeks' gestation because of cervical incompetence with advanced cervical dilatation and subsequently delivered at 35 weeks.

Q. Doctor, PPROM means premature rupture of the membranes, is that right?

A. Yes.

Q. Doctor it is true, is it not that each of the women in the intact group were at a high risk for preterm birth in subsequent pregnancy regardless of undergoing the D&X procedure, is that right?

A. They were an increased risk for that, yes.
Q. Correct, they were at increased risk regardless of the D&X procedure, is that correct?
A. Right, and --
Q. In fact one of them --
THE COURT: You don't need to shout, counsel.
Q. One of them underwent the intact D&E procedure at 23 weeks as a result of experiencing PPROM, is that right?
A. Yes, that's true.
Q. And prior PPROM is in fact a risk factor for preterm birth, is that right?
A. Sure.
Q. And the second woman underwent intact D&X at 23 weeks because of cervical incompetence, correct?
A. Yeah.
Q. And prior cervical incompetence is in fact a risk factor for subsequent preterm birth, right?
A. Yeah.
Q. So, in fact, in each subsequent pregnancy each of these two women succeeded in carrying their pregnancies beyond 23 weeks, is that right?
A. Right.
Q. And they did that even though they both were at higher risk for subsequent preterm birth regardless of the abortion procedure that they had, is that right?


A. Exactly.
Q. The first woman was able to deliver her subsequent pregnancy at 32 weeks, correct?
A. Yeah.
Q. The second was able to deliver her pregnancy at 30 weeks, is that correct?
A. Right.
Q. And the authors of this study don't purport to conclude that intact D&E causes improved outcomes for women, do they?
A. No, they definitely don't. They show absolutely no benefit to women undergoing this procedure. Like the ACOG task force who could find no benefit to it either. You're right.
MS. PARKER: Your Honor, I move to strike the reference to ACOG as nonresponsive to my question.
THE COURT: Disagree. It will remain. Overruled.
Q. Dr. Clark, the numbers of preterm birth in subsequent pregnancy in this study are too small to really reach any conclusions, isn't that right?
A. Any conclusions other than the one that you've correctly reached already that there is a 30 percent chance this occurred by chance and a 70 percent chance that it in fact is a true, meaningful, increased risk other than that, one can reach no conclusions.
Q. This study identifies no increased risk for preterm birth in subsequent pregnancy in the two women who underwent

dismemberment procedures and experienced subsequent preterm birth, is that right?
A. No, you said something in there wrong.
Q. Which was?
A. No increased risk in two women. You can't have a risk in a specific -- that's just -- part A doesn't go with part B, you need to ask that in a different manner.
Q. I will rephrase.
Doctor, the two women that we are talking about here, both of these women that we are talking about here already had a risk of preterm birth prior to undergoing any abortion procedure, is that right?
A. Right.
MS. PARKER: Your Honor, I have no further questions at this time.
THE COURT: Any redirect?
MS. GOWAN: No, your Honor.
THE COURT: Doctor, you may step down.
THE WITNESS: Thank you.
THE COURT: Ms. Gowan, are we going back to the transcript?
MS. GOWAN: Yes, your Honor.
THE COURT: All right. Do we have all of our participants?
MS. GOWAN: Yes, we do.



THE COURT: At the ready?
MR. PANTOJA: Your Honor, Joseph Pantoja for the government.
THE COURT: Yes, sir. I think for the record, since we broke and took a witness, that you better introduce what we are getting into. Do you have your assistant here to answer the questions?
MR. PANTOJA: Yes, my colleague Michael James is here today.
THE COURT: Mr. James, fine.
Just indicate on the record what it is that you're reading and so that it can be understood in the transcripts.
MR. PANTOJA: Yes, your Honor. Certainly.
Page 135, line 7:
"Q Let's go back to Cain deposition Exhibit 18 for a moment. Do you know what, for now Dr. Cain, all I want to do is establish that this was reviewed by the task force, this memo from Kathy Bryant. Is that correct?
"A Correct.
"Q And the attached document from district 2, ACOG district 2 was also reviewed by the task force?
"A Correct.
"Q That's all I want to do with that one for now, for right now.
"And then on Cain deposition Exhibit 19 the first two

pages appear to be the same ACOG district 2 question and answer on third trimester abortion procedures, and the only thing I want to establish at this point is whether the task force had before it Dr. Frigoletto's letter of July 3rd, '96, ACOG 007, and the letter to Penny Murphy at ACOG 005 and 006 that appears to be in response to Dr. Frigoletto's letter.

"That was before the task force?

"A That is correct."

MR. PANTOJA: Page 137, line 10:

"Q Dr. Cain, I have shown you what's been marked as Cain Deposition Exhibit 20 which is ACOG 006 to 0093. It's a memorandum dated October 3rd, 1996 to the task force on third trimester abortion from Elsa P. Brown, additional background material. 'Attached is additional background material requested by Dr. Frigoletto'.

Was this material placed before the task force in its deliberation in October 1996?

"A Yes.

"Q Whose handwriting is on the first page, ACOG 0087?

"A I don't know.

"Q The same question for the next page, do you know whose handwriting that is?

"A No.

"Q There is also handwriting on 0089, do you


recognize that handwriting?

"A No.

"Q All right. What roles did these materials play in the task force's deliberations?

"A They were background material, again for the same identification of issues. Additionally, the vital statistics reports from the CDC would be considered information, background information, and the information from the Allen Guttmacher Institute.

"Q If you look back at Plaintiff's Trial Exhibit 6 which is in that statement on instant dilatation and extraction, the last paragraph on page 1 which references CDC, do you see that Center for Disease Control?

"A Uh-huh.

"Q Is that paragraph which refers to statistical information based on the statistical information provided by the materials at Cain Exhibit 20?

"A No. I think there was -- there were other publications from the CDC, that's 1994 and this is what, 1991?

"Q Just so I understand, with respect to the Guttmacher Institute material, what use was made of these statistics in drafting the statement?

"A It would be background material about general distribution of abortions and the place that this particular procedure might play within the discipline of obstetrics.

44F5NAT5 "Cain -

"Q The same question for the CDC data which starts on ACOG 0090, did this particular statistical report, was this particular statistical report reflected in the background statement or did you rely on some other statistics?

"A we relied on the statistics available from the CDC for 1994.

"Q Right. And this particular document played what role?

"A It would be background material to look at the place of the procedure."

MR. PANTOJA: Page 142, line 12:

"Q Did the task force write a written report to the board?

"A The task force wrote the draft statement.

"Q And that's it?

"A That's my understanding, yes.

"Q There were no other --

"A The report would have come from the chair of the committee or the president of the college.

"Q If you look on page ACOG 0097 where it says 'item 4.1, report of the president continued, task force on third trimester abortion,' and there is one paragraph there, is that the report to the board on the -- task force on third trimester abortion?

"A That's Dr. Frigoletto's report and the task force



44F5NAT5 "Cain -

would have sent the statement on intact dilatation and extraction through the president and the head of the -- and the chair of the committee.

"Q What I am trying to establish, Doctor, to the extent you know, is other than the single one-page statement of the task force and this one paragraph on ACOG 0097, is there any other report that was written by the task force to the board?

"A Not to my knowledge.

"Q Okay, Doctor.

"On the issue of documents a little bit further, you mentioned that there was a side table at the conference in October of 1996, the meeting of the task force. To the best of your recollection, what was on this side table?

"A I don't remember the exact textbooks but they would have been the general textbooks in obstetrics and gynecology, at the time.

"Q Do you recall how many texts were there?

"A No, I don't.

"Q They're textbooks on obstetrics and gynecology?

"A Right.

"Q Do you recall anything else about the textbooks?

"A Other than the fact that they were picked because they included abortion as part of the material covered.

"Q Was reference made to information in the

textbooks during the task force discussions?
"A Yes.
"Q Do you recall what references were made to the textbooks?
"A I believe if there was any question about a particular procedure or how it had been described in the literature previously, we might have referred to it.
"Q Do you recall the dates-- I know this is a very specific question but let me try it anyway, do you recall the dates of the particular books, the publication dates of the particular books that were available at the time?
"A No. But my guess would be they'd be the most current prior to that date.
"Q But you don't recall what dates those were?
"A Nuh-uh.
"Q And you don't recall the names of the textbooks?
"A Not specifically for sure.
"Q Do you recall any authors?
"A I can recall authors of common textbooks but whether or not they were the ones there, I can't truly say."
(Continued on next page)





"Q. What else was on the side table?
"A. That was primarily it. There might have been published text. There might have been anything else published by the CDC.
"Q. Were there any other in journals --
"A. Separate articles?
"Q. Let me just finish. I appreciate your anticipating my questions and you usually do so very well. But for the sake of the record, let me finish stating it.
"Were there any separate articles from obstetrical journals discussing abortion procedure or procedure on the side table?
"A. Not to my recollection."
Page 146/line 12.
"Q. Did members of the task force receive any written materials from other fellows of ACOG? Did they receive them during their deliberations on intact dilatation and extraction?
"A. Not to my knowledge.
"Q. Did the task force receive any written materials from members of the public on the issue of intact dilatation and extraction that were considered by the task force during its deliberations other than to the extent these materials that we have just reviewed are from the public?
"A. No.
"Q. Did members of the task force write materials themselves

for consideration by other members of the task force on specific issues? And I would like to exclude from that draft language for the moment. What I am talking about is did the members of the task force write up any kind of memos or statements for the task force to consider on the issues that were before them?
"A. No.
"Q. Prior to the meeting in October 1996, did members of the task force exchange written communications, to your knowledge, concerning the topics that you were going to be meeting on?
"A. Not to my knowledge, other than what is reflected in here with Dr. Frigoletto sending materials."
Page 149/line 22.
"Q. Did the task force receive any information orally in the form of interviews or conversations other than among themselves from doctors, organizations?
"A. No.
"Q. You didn't take any testimony, I take it?
"A. No.
"Q. Did members of the task force have discussions with others who were not on the task force and then reported back in those conversations?"
Comment by counsel.
"During the weekend that you were visiting, did any members of the task force go off and have a conversation on the





phone or in person with some organization or person who was not -- that was not on the task force, and then report back on the substance of that conversation?
"A. Not to my knowledge.
"Q. Prior to the task force convening and drafting this statement, do you know if members of the task force had conversations with individuals or organizations that were not on the task force and then subsequently reported to the task force the substance of those conversations?"
Comment of counsel.
"Give it a shot.
"A. Well, I know that Dr. Frigoletto had conversations with district 2 regarding their statement. I don't remember any other pertinent conversations.
"Q. Just so the record is clear, and just to tighten the question a little bit, specifically with reference to the task force's upcoming deliberations on intact dilatation and extraction, do you know if members of the task force engaged in conversations with individuals or organizations for purposes of preparing for that?
"A. Not to my knowledge."
Page 152/line 6.
"Q. In the course of the deliberations, were task force members asked to contact other physicians and get their views on particular issues?

"A. No.
"Q. And they did not do so?
"A. That is correct.
"Q. There were a number of people listed in the congressional testimony. This is Cain Deposition Exhibit 17. To your knowledge, either during the meeting or before, did members of the task force contact individuals who provided testimony to Congress to obtain their views on the intact dilatation and extraction procedure?
"A. Specifically for that purpose, no.
"Q. I'm going to run through a couple of the names. I'd like you to tell me if members of the task force, either before or during their meeting, consulted with these individuals to get their views on intact dilatation and extraction. If your answer is no, you can just say 'no' after I give the name. OK?
Dr. Cortland Robinson?
"A. Not to my knowledge.
"Q. Watson Bowes?
"A. Not to my knowledge.
"Q. Lawrence Berg?
"A. Not to my knowledge.
"Q. Nancy Rohmer?
"A. Not to my knowledge.
"Q. Pamela Smith?
"A. Not to my knowledge.





"Q. Curtis Cook?
"A. Not to my knowledge.
"Q. Joseph D. Cook?
"A. Not to my knowledge.
"Q. Allen Rosenfield?
"A. Not to my knowledge.
"Q. Drew Elaine Carlson?
"A. Not to my knowledge.
"Q. Robert White?
"A. Not to my knowledge.
"Q. Joseph Schreiber?
"A. Not to my knowledge.
"Q. None of those individuals, to your knowledge, was contacted by the task force, is that correct?
"A. As far as I know and I remember.
"Q. Did the task force contact Dr. Warren Hern in Colorado?
"A. Not to my knowledge.
"Q. Dr. Tiller in Kansas?
"A. Not to my knowledge.
"Q. Did the task force contact Dr. Darney in San Francisco?
"A. Not to my knowledge.
"Q. Did the task force contact Dr. Haskell?
"A. Not to my knowledge.
"Q. Do you know if Dr. McMahon was still living at the time the task force met in 1996?

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"A. I don't know.
"Q. Neither do I. I take it if he was living, no one tried to contact him, is that fair to say?
"A. Well, especially if we didn't know if he was living or dead."
THE COURT: Off the record.
(Discussion off the record)
THE COURT: You may proceed.
"Q. Did ACOG seek to arrange for anyone to testify before Congress orally on intact dilatation and extraction prior to the time that the task force met?"
Comments by counsel.
"Did ACOG send a representative to testify before Congress on intact dilatation and extraction prior to the time that the task force met?
"A. I don't know, although I would imagine they would be responsive to a request from Congress.
"Q. Do you know of anyone who did testify before Congress prior to the time the task force met who was testifying on behalf of ACOG?"
Original answer:
"A. I will have to assume there was someone."
Errata answer:
"A. No, I don't know.
"Q. Do you know if Mr. Hale testified before Congress?



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"A. I personally don't."
Page 158/line 6.
"Q. I want to talk a little bit about your meeting in October 1996. I've asked the reporter to mark what appears to be the agenda of that meeting. Is that in fact what Cain Deposition Exhibit 24 is?
"A. Yes.
"Q. Actually, Doctor, if you look back at Exhibit 21, Cain Exhibit 21, the very last page of Cain Deposition 21, which is Bates stamped ACOG 0100 -- pardon me, the last page of 22, the individuals listed, Dr. Gibbons, yourself, Dr. Tattell, Dr. Reilly, Dr. Frigoletto, were they the only ones who made it to the October conference?
"A. That is correct.
"Q. Miss Bryant was present?
"A. That is correct.
"Q. Do you remember anything about Dr. Gibbons' introduction?
"A. No.
"Q. What role did Dr. Gibbons playing during the meeting as chairman?
"A. He made sure that we stayed on the agenda. He made sure that everybody's examples and expertise were heard and that there was a full discussion of every aspect.
"Q. When it says 'review of materials' on the agenda, what materials did you review?

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"A. As I remember it, it was merely a listing of the things that we had been sent and what was on the side.
"Q. Where it says 'develop a fact sheet,' item 4, what does that refer to?
"A. That refers to the work of the committee discussing the issues that they saw and the text that ultimately resulted in the statement.
"Q. Just to be clear, Doctor, Cain Deposition Exhibit 7 was the draft statement prepared by the task force?
"A. Uh-huh.
"Q. Is that what is being referred to here as the fact sheet?
"A. Yes.
"Q. In other words, I'm not going to pull them out, but there were other fact sheets that ACOG subsequently did on this subject?
"A. That is correct.
"Q. But they are not the fact sheets being referred to in this agenda as what was developed at that conference, is that correct?
"A. That is correct.
"Q. OK. The topic 'terminology,' what was discussed with respect to the issue of terminology?"
Original answer:
"A. As I indicated, in the materials the partial-birth abortion terminology was not considered a part of the medical lexicon.



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None of us could identify a clear procedure that did not leap over into normal obstetrical procedures. We reviewed how these terms were used and various descriptions and how the committee saw it as a separate procedure by sequencing events."
Errata answer:
"A. As I indicated, in the materials the partial-birth abortion terminology was not considered a part of the medical lexicon. There was no clear definition of the term 'partial-birth abortion.' One of the goals of the task force was to identify a specific definition that did not encompass other obstetrical procedures. Another goal was to identify an appropriate name for the procedure."
Page 160/line 20.
"Q. Would you take a look at Cain Deposition Exhibit 18, Doctor. Here it is, Doctor.
"A. Thank you.
"Q. This is the memo from Kathy Bryant to Dr. Frigoletto. If you look at the third paragraph on that page, Ms. Bryant is referring to the ACOG district 2 document.
"A. Uh-huh.
"Q. And I'm not going to read the entire paragraph into the record, but she says in this paragraph that, she says, 'We need to decide what is the most appropriate term for the procedure, the term "intact dilatation and extraction" or "intact D&E" (not universally used). This term has been used by Dr.

McMahon. A letter written by Dr. Zinsberg on behalf of ACOG to an Ohio legislator states that the exact term is 'dilatation and extraction.' Dr. Haskell and other organizations such as NARAL refer to it as D&X."

"Do you see that statement?

"A. Uh-huh.

"Q. First of all, did the task force consider the fact identified by Miss Bryant that there were several terms for the intact D&E/D&X procedure?

"A. That was apparent from the multiple publications we had on the table.

"Q. So let me restate the question a little better. Did the task force recognize there were multiple terms to describe the procedure that ACOG came to call intact D&X?

"A. That is correct?

"Q. Did the task force agree with what Ms. Bryant has said here, that they needed to decide on one term?

"A. The task force felt that much of the confusion regarding partial-birth abortion came from the fact that there were no clearly delineated common usage of procedures linked to that description, and the college took the position, being a professional organization, to define that.

"Q. As a result of that state of affairs, the college decided to propose a term, is that correct?

"A. To link a term and a set of procedures.





"Q. On ACOG 007, Ms. Bryant writes, 'Before deciding on a term, we could collect and review all data and other relevant information published on the procedure before we begin officially using the term in any publications.' Do you know if that literature search described by Miss Bryant was undertaken?

"A. I don't know relative to this.

"Q. And in the parenthetical she says, 'A literature search was conducted last summer, found no reference to intact D&E or intact D&X.' Any reason to doubt the truth of that assertion?

"A. No.

"Q. Did she report that to the task force?

"A. This material would have been available to the task force.

"Q. Is it fair to say that through this memo Miss Bryant reported the fact that the literature search conducted last summer, which we believe is 1996, found no reference to intact D&E or D&X? Is it fair to say that she reported that fact to the task force through this memo?

"A. It would be fair to say the memo was available to the task force.

"Q. Let's step back and look at the description of the procedure itself. This is in Cain Deposition Exhibit 7. This is Plaintiffs' Trial Exhibit 5 which includes it."

Excuse me. I will restate the question at page 164/line 1.

"Q. Let's step back and look at the description of the

procedure itself. This is in Exhibit 7.
"A. This is Plaintiffs' Trial Exhibit 5, which includes it.
"Q. All right. I'm going to work on Exhibit 3, Doctor, but I think it's the same.
"A. Go ahead.
"Q. My question is really, Plaintiffs' Trial Exhibit 6 describes a definition of intact D&X that ACOG developed as containing all of the following four elements, and it lists those elements: 'deliberate dilatation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.' And the statement says, 'Because these elements are a part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D&X.'
"Now, first question. Did the task force come up with this formulation that I've just read?
"A. Yes.
"Q. And did the task force conclude that it was necessary that all four elements must be present in sequence or the procedure is not an intact D&X?
"A. Yes.
"Q. Why would -- and maybe you're misunderstanding me, so I





just want to ask you this question so I understand what the task force has done here. Why would a procedure not be an intact D&X if the fetus was already in a breech position?
"A. The committee at that time was concerned that a procedure was being described that included instrumental conversion of the fetus to a footling breech, and, because that was a significant part of the description, felt that it should be included in that way.
"Q. If all of the other elements were present except the fetus was not converted to a footling breech by means of instrumentation, would you say that the procedure performed was not an intact D&X?
"A. By the description of this statement, then, yes, it would not be an intact D&X.
"Q. In other words, under ACOG's definition, if the fetus was already in a breech position but all the other elements were the same, it would not fall into the definition of an intact D&X?"
Comment by counsel.
"Has this definition changed since 1997 some?
"A. This is still in the college policies.
"Q. OK. Do you need my last question? Could you read back my last question."
The last question was read back by the reporter.
"A. Not according to this definition."

Page 167/line 9.
"Q. OK. Miss Bryant comments on page 0048, and I believe she is commenting with respect to the subject of intact dilatation and extraction in the district 2 document. And she says, 'The paragraph is vague with regard to identifying the part of the procedure that actually terminates the fetus.'
"A. Where are we again?
"Q. I'm on page 48.
"A. I have that, the fourth one down.
"Q. It says, 'Second."
"A. Oh.
"Q. 'Second, the paragraph is vague with regard to identifying the part of the procedure that actually terminates the fetus. The description of the needle being used to drain cerebral fluid so that the head can be delivered leaves the impression that a living fetus is being delivered. The description also alludes to the procedure being done on fetuses that die in utero. Again, the overall tone leaves a false impression that no termination takes place. I do not think we can be vague about this.'
"My question, Doctor, is did the task force agree with Miss Bryant's evaluation of the description of the procedure of intact dilatation and extraction described in the district 2 document?
"A. The task force described the procedure and includes





Plaintiffs' Trial Exhibit 5, which is partial evacuation of the intracranial contents of the living fetus.
"Q. Is the description in the ACOG district 2 document which says that --
"A. What page are we on?
"Q. 0050. Under 'Intact dilatation and extraction,' about the middle of the paragraph, it says, 'Since the cervix is often incompletely open, it may be impossible to deliver the head. Therefore, a needle or other surgical instrument can be introduced to drain cerebral fluids (clinically this is similar to a spinal tap) which makes it possible to deliver the head through the cervix without damage to the mother.'
"In the task force's study of the D&X procedure, is that a correct description of that element of the procedure, specifically, the element of draining of the head?"
Comments by counsel.
"A. Yes.
"Q. I read you the portion of the paper that I wanted you to focus on specifically referring to 'a needle or other surgical instrument can be introduced to drain cerebral fluids (clinically this is similar to a spinal tap) which makes it possible to deliver the head through the cervix without damage to the mother.'
"A. OK. Give me your question again.
"Q. The question is, did the task force find that this is an

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accurate description of the element of the intact D&X procedure that involves reducing the size of the head and collapsing the cranium?

"A. The committee would have brought to the table significant expertise and case examples. So this might be one circumstance. But the committee ultimately said the intracranial contents, so that could mean more than cerebral spinal fluid."

Page 170/line 22.

"Q. Miss Bryant also says in her letter on the same page, 0048, the first full paragraph, 'With regard to -- with regard to the paragraph about intact D&E' -- again, these referring to the district 2 statement -- 'I have several concerns. Overall, I'm concerned that the statements are presented as absolute fact without any reference to documentation. At a minimum, we would have to gather all published materials about this procedure before we should make any such statements.'

"Did the task force agree with Ms. Bryant's assessment in that -- that I just read to you?

"A. The task force had significant expertise in the members of the task force, who were quite able to document their experience with the procedure as well as the information on hand.

"Q. Let me break it up. Did the task force agree that the district 2 statement was presented as absolute fact without any



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references or documentation?

"A. We would not have discussed this specifically in order to answer that.

"Q. Did the task force gather all published materials about this procedure?

"A. The task force had it in the materials we had. I believe at the time they tried to gather anything that would include references to the procedure. It is possible in the world there was published material that we did not find or receive.

"Q. Is it your understanding that through ACOG's staff an effort was made to gather all published material about the intact D&X procedure?

"A. Yes, with the material that was published in books.

"Q. And the result of that effort to gather all published material on intact D&X was material that we discussed today that was before the committee?

"A. And the books on the side table.

"Q. And the books on the side table?

"A. Uh-huh?

"Q. And that was as of October 1996, correct.

"A. Right. But remember, the intent of the materials for the task force was to identify the issues. The expertise that was being relied on was the individuals on the task force.

"Q. Let me just wrap this up by asking two questions. Did the task force intend to gather all published material on intact

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D&E? And let me make that the first question. Did the task force intend to gather all published material on intact D&E?
"A. I don't believe there was a stated intent to do that.
"Q. Did the task force gather all published materials on intact D&E at the time of its deliberations?
"A. I don't think that's knowable.
"Q. What did the task force think at the time? Did it think it had gathered all published materials on intact D&E?
"A. I believe the task force believed that we had a range of different descriptions of D&E and relevant material that would apply to the procedure.
"Q. Did you think you had all relevant material that would apply to an evaluation of the procedure?
"A. Yes".

Page 174/line 22.

"Q. Did the task force find that the intact D&X procedure was performed in the second trimester?
"A. That is correct.
"Q. Doctor --
"A. Primarily in the second trimester.
"Q. That it was performed primarily in the second trimester?
"A. Uh-huh.
"Q. Dr. Haskell's paper at Cain Deposition Exhibit 13 is titled 'Dilatation and Extraction for Late Second Trimester Abortion.' That's ACOG 0032 in Exhibit 13. My question is, was there any



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doubt in the task force's mind that intact D&X was not just a third trimester procedure?
"A. State that again.
"Q. Let me ask it differently and a little more clearly, because I think I confused you with my question.
"A. OK.
"Q. I think I'll use Miss Bryant's memo. It's on page 1 of the memo, ACOG 0047. Page 1 of Miss Bryant's memo, middle of that first full paragraph.
"A. 'The document contains important information.'
"Q. I was actually looking at the paragraph beginning, 'First, an overall concern that the title and the information presented in the document address only third trimester abortions.' She's referring to the district 2 document. Further down she says, 'Further, the procedure is often performed in the second trimester. Both Drs. McMahon and Haskell have written and/or have been quoted that they performed this procedure in the second trimester. Dr. Haskell was quoted that he performed the procedure in the 18- to 25-week range. Dr. McMahon wrote that he performed the procedure beyond 18 weeks.'
"Was this information considered by the task force in connection with considering the stage of gestation issue on the agenda?
"A. Just like it considered all of the literature presented to it and also the expertise of the individuals and their

experience with procedures similar to this.
"Q. And the task force understood, did it not, that this procedure was performed beginning at 18 weeks, the intact D&X procedure?"
Original answer:
"A. That it could be performed starting at 18 weeks."
Revised answer:
"A. That it could be performed starting at 16 weeks.
"Q. Did it have an understanding that it was being performed starting at 18 weeks?"
Original answer:
"A. If it was possible, yes."
Errata answer:
"A. The task force understood that intact D&X was one method of performing an abortion after 16 weeks.
"Q. What did the task force discuss with respect to safety?
"A. Numerous examples were raised by the members of the task force regarding different procedures in specific cases and issues of safety. For example, in gynecology the most pertinent example would be triploidy, which is a form of cancer of the placenta often diagnosed in the second trimester with severe preeclampsia.
"In that case the least amount of instrumentation possible of the uterine wall is desirable. So it is much safer for the woman to have an intact D&X to remove the molar





pregnancy. So multiple examples were used to explore issues of safety at the time and in comparison to other procedures.
"Q. Does the statement in Cain Deposition Exhibit 7, the draft proposed statement, does this statement reflect the conclusions of the task force with respect to intact dilatation and extraction?
"A. Yes.
"Q. OK. Did the task force identify any study which discussed the relative safety of intact D&X versus another method of abortion?
"A. No, not as we had described it for purposes of our debate.
Q. Did the task force identify any study on the relative safety of abortion procedures in general which it relied on in reaching its conclusions about this procedure?
"A. The CDC data, the ongoing data documents, the safety.
"Q. Of? In what way?
"A. D&E second trimester abortions.
"Q. OK. And you mentioned the CDC data. What was it about the CDC data which informed the task force's view with respect to the safety of intact D&X?
"A. The overall safety in the second trimester.
"Q. Of D&E?
"A. D&E, because D&X was not separately coded.
"Q. Was the task force aware that Dr. Grimes had written an article in the 1980s regarding the relative safety of abortion

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procedures?
"A. I'm sure that members of the task force would have been aware, since it probably was quoted also in the textbooks available.
"Q. Did the task force specifically consider Dr. Grimes' study with respect to the relative safety of abortion procedures?"
Original answer:
"A. Not as a separate study, but as a part of the literature that supports the safety."
Errata answer:
"A. I don't remember.
"Q. Well, what I'm asking you is, can you say that wherever it was as a separate study referenced in a textbook, the task force specifically considered the data found by Dr. Grimes in his study 'The Relative Safety of Abortion Procedures'?
"A. I can say that it's likely."
Page 187/line 19.
"Q. Let me reformulate that one. Did the task force discuss any findings made by Dr. Haskell with respect to the safety of the intact D&X procedure?
"A. We would have discussed the article. As I stated before, as a part of the background materials.
"Q. Did the task force rely in any way on Dr. Haskell's articles in reaching the conclusion with respect to the safety of the intact D&X?



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"A. No.
"Q. Did the task force rely on the materials of Dr. McMahon submitted to Congress which were before you in reaching any conclusions with respect to the safety of intact D&X?
"A. No.
"Q. What does the reference to data on frequency refer to in the agenda? This is Cain Deposition Exhibit 24.
"A. As I remember it, there were contradictory statements in the materials about how frequent this procedure was and the fact that we simply did not know, since there was no standard definition.
"Q. Did the task force reach any determinations as to the frequency of the intact D&X procedure?
"A. No, although members of the task force could indicate cases of which they were aware.
"Q. In which the procedure was utilized?
"A. That's correct.
"Q. Did the submissions of Dr. Haskell inform your conclusions as to the frequency of intact D&X?
"A. It informed it in a background manner. We only have his report.
"Q. What about Dr. McMahon? Did his submissions inform the conclusions, inform the views of the task force with respect to the frequency of intact D&X?
"A. No, because it's one physician's comments.

"Q. And what's wrong with that?
"A. It was important to the committee to have experts in the area and to identify whether we knew or not the actual frequency.
"Q. The select panel concluded, according to your draft, that 'A select panel convened by ACOG concluded it could identify no circumstances under which this procedure, intact D&X as defined above, would be the only option to save the life or preserve the health of the woman.' Was that the conclusion of the select panel?
A. That it was the only option?
"Q. Well, if you want to look at Cain Deposition Exhibit 7, I'll go a little above that. 'Terminating a pregnancy is indicated in some circumstances to save the life or preserve the health of the mother.' This was, obviously, the conclusion of the select panel, is that correct?
"A. That is correct. And we could identify numerous circumstances in which this might be the best procedure for that. Rare, but still numerous.
"Q. Where does it say in this statement that this would be the best procedure to do that? Would you agree with me it doesn't say in this statement that it might be the best procedure in some circumstances?
"A. Right. Dr. Frigoletto and I discussed that actually on Saturday, because the amended final statement, which includes


the executive committee statement, does include a sentence between the sentence you read and 'Notwithstanding this conclusion': 'ACOG strongly believes that decisions about medical treatment must be made by the doctor in consultation with the patient.' And both of us agreed that it was clearly the sense of the committee. We just thought it spoke for itself and that we were glad that the executive board had put that phrase in.
"Q. I want to ask you about that in a second. But I just want to confirm that the sentence that 'A select panel could identify no circumstances under which this procedure would be the only option to save the life or preserve the health of the woman,' was that the conclusion of the select panel as reflected in this document?
"A. Correct.
"Q. Now let's talk about the added sentence. This is in the final statement. And you could look at Plaintiffs' Trial Exhibit No. 6 if you'd like to have it in front of you.
"A. I have Plaintiffs' Trial Exhibit 5.
"Q. It's the same thing, the final statement approved by the board. A sentence is added, 'An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman.' And to complete the sentence, 'and only the doctor, in consultation with the patient, based upon the woman's

particular circumstances, can make this decision.' Who added that sentence?
"A. The executive board edited the sentence.
"Q. Were you a part of the deliberations on that?
"A. No, I was not.
"Q. Was this additional sentence presented to the task force for its consideration?
"A. No, although it is very much in the sense of a discussion of the task force.
"Q. Do you have any knowledge of the deliberations that resulted in the addition of this sentence?
"A. I have information from Dr. Frigoletto about his recollections and also from Dr. Hale.
"Q. And was it Dr. Frigoletto that proposed adding the sentence?
"A. I don't believe that Dr. Frigoletto -- I know that Dr. Frigoletto could not remember who proposed the sentence.
"Q. Have you -- other than Dr. Frigoletto, you said you discussed how this sentence came to be added with Dr. Frigoletto?
"A. That's correct.
"Q. And did you discuss it with Dr. Hale?
"A. Not specifically with Dr. Hale, but I'm aware of his memory.
"Q. Was there any debate at the task force over this sentence?


"A. I don't remember this sentence coming up.
"Q. Was anyone -- do you know if anyone in particular was an advocate for adding this sentence?"
Original answer:
"A. Well, I would think Dr. Frigoletto would be an advocate."
Errata answer:
"A. I don't remember the sentence coming up at the task force meeting.
"Q. Do you know if he was an advocate at the board for adding the sentence?
"A. I don't know.
"Q. Do you know if Dr. Hale was an advocate at the board for adding this sentence?
"A. I don't know. This is a statement that was added by the entire executive board.
"Q. Do you know if Dr. Gibbons was an advocate for adding this sentence?
"A. I don't know if he was an advocate at the time of the executive board. It is very much in keeping with the sense and the discussion of the task force.
"Q. Then why isn't it in the draft of the task force?
"A. As I said, when Dr. Frigoletto and I discussed that, we came to the same conclusion, that we -- because we had talked about it so much, to us the 'Notwithstanding this conclusion, the decisions about a medical treatment based upon the woman's

particular circumstances' covered that. It is a matter of phrasing. To us, we were already there. We assume in medicine that our choices are made for the life and the health of our patients.
"Q. Why did the select panel find that there were no circumstances -- why was the select panel unable to identify circumstances under which the intact D&X procedure was the only option to save the life or preserve the health of a woman?
"A. Because there are multiple procedures available. It was simply a factual statement. There are other things that are available. They may not be the best for that individual patient.
"Q. Are you aware of any analysis or study -- let's strike that and say: Are you aware of any study which supports the conclusion that intact D&X may be the best or most appropriate procedure in certain circumstances?
"A. I'm not aware of a study. I'm well aware of multiple circumstances that an expert panel could identify at the time of the task force where it was clearly the best choice, including in my field, where the other options led to a higher likelihood of death or recurrence of disease.
"Q. I'm going to ask you about that in a minute, but I just want to document a couple of facts first, if I can. To your knowledge, are there any studies documenting the statement in the final statement that the intact D&X procedure may be the


best and most appropriate procedure in some circumstances?
"A. And how do you define studies?
"Q. Well, how are studies typically defined in the field of obstetrics and gynecology?
"A. They can be anything from case reports to prospective randomized controlled trials.
"Q. Are there any case reports that you are aware of documenting that intact D&X may be the best or most appropriate procedure in certain circumstances?
"A. I consider the case reports brought to the table as significant.
"Q. By -- you mean the case reports of Dr. Haskell and McMahon?
"A. No. By members of the task force.
"Q. Oh, I see. Did any of the members of the task force publish any case study with respect to the safety of intact D&X?
"A. Not with regard to the safety of intact D&X.
"Q. Did they publish any studies, case studies or otherwise, with respect to why it's the most appropriate procedure or may be the most appropriate procedure in certain circumstances?
"A. Not particularly.
"Q. As far as you know, there have been no prospective studies demonstrating that intact D&X may be the best or most appropriate procedure in certain circumstances, are there?
Let's back up. At the time of the task force report.

"A. Not to my knowledge. But a randomized controlled prospective trial would not be ethical in some of these circumstances.
"Q. I want to back up and ask you a little bit about the task force members. Of the ones that were unable to attend the meeting in October, did they participate in any way in the crafting of this document?
"A. I believe that the document was sent to all the members for comment before it was forwarded to the board. And it was Dr. Frigoletto's memory, as I understand it.
"Q. I asked you this morning whether you had understood whether Dr. G had any experience in performing abortion terminations, and I believe you said you didn't know, is that correct?
"A. That is correct.
"Q. Who among this panel --
"A. Although I'm aware that he in general was in opposition to abortion.
"Q. Who on this panel performed intact D&X's at the time of the study in 1996, at the time of the statement in 1996?
"A. Who performed procedures that would fall within this newly defined criteria? It would have been Dr. Frigoletto would have overseen it, Dr. R -- I need to look at the list.
"Q. Dr. D?
"A. Dr. D probably. I don't know for sure.
"Q. Dr. J?


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

actually performed that procedure?
"A. Yes.
"Q. And those are the five doctors we just identified: Dr. R, Frigoletto, Dr. N, Dr. D, and Dr. B?
"A. Uh-huh."
Comments by counsel.
"Q. In Dr. N's case, she only oversaw them?
"A. That would be my understanding, or my memory.
"Q. Did any of these doctors say how many they had participated in or overseen, how many intact D&X's as identified by ACOG that they had participated in or overseen?
"A. No.
"Q. Do you have any indication of the numbers?
"A. We discussed specific cases.
"Q. How many specific cases did you discuss? Just numbers?
"A. I would just guess, given the variation of diagnoses and the fact that most people saw referral cases that we talked about, at a minimum 25 to 30 different types of cases.
"Q. All right. Do you know approximately how many cases Dr. Frigoletto had performed or overseen of intact D&X?
"A. No.
"Q. No idea? Of the 25, no idea how many were his?
"A. No.
"Q. Dr. R, of the 25, do you have any idea how many intact D&X's he performed or oversaw?



"A. She."
THE COURT: Counsel, it is 5 o'clock. How much more do you have to go?
MR. PANTOJA: Your Honor, I actually have 10 seconds left.
THE COURT: Right by the clock. All right, go right ahead, finish it up.
MR. PANTOJA: I will repeat the question.
"Q. Dr. R, of the 25, do you have any idea how many intact D&X's he performed or oversaw?
"A. She.
"Q. She, I'm sorry.
"A. No.
"Q. Dr. N, any idea of the 25 that she performed or oversaw?
"A. She was not present at the task force.
"Q. Did the task force obtain information from her on her experiences on intact D&X?
"A. In regard to reviewing the data or reviewing the statement?
"Q. No. Did they get any information from her on her experience in intact D&X cases?
"A. No.
"Q. Dr. D was present. Any idea of the number of intact D&X cases of the 25 that she was involved with?
"A. No."
Your Honor, that concludes the government's reading in

of the designations of the ACOG transcript.

THE COURT: Fine. We will recess until 9:30 tomorrow morning.

MS. STERNBERG: Your Honor, this is Ms. Sternberg for the plaintiffs. We have very few cross-designations. We can read them in the morning, if that is what you prefer.

THE COURT: That would be fine. I knew there were some.

MS. STERNBERG: It is not many.

THE COURT: You want to wrap that up in the morning?

MS. STERNBERG: Sure.

THE COURT: We will do it then. See you at 9:30. Have a nice evening. Court will stand in recess.

(Adjourned to 9:30 a.m., April 16, 2004)



INDEX OF EXAMINATION



GOVERNMENT EXHIBITS