TWM 4/16/04 test test test test test test TWM 4/16/04
NAF v. Ashcroft.
(Trial resumed)
THE COURT: Good morning. before we get started, I just received a copy of the stipulation. I don't know whether to address Ms. Gowan or Ms. Wolstein, between the governmentnd the New York Presbyterian Hospital, if that is the correct title, counsel obviously, somebody gets paid by the word. I think in my career I haven't seen a stipulation like this. Is the short of it that the complication book is included in the appeal?
MS. WOLSTEIN: Your Honor, Elizabeth Wolstein. Yes, that is the intent of that, that the complications --
THE COURT: It might have been so phrased. But that is the message that is to be conveyed to me and the Court of Appeals?
MS. WOLSTEIN: Yes, your Honor, that the complications binder will be treated like the other documents.
THE COURT: If and whereas and if and maybe, it breaks down to it is included?
MS. WOLSTEIN: Yes, your Honor.
THE COURT: Thank you.
As we broke off yesterday, Ms. Sternberg, I think you were at the plate.
MR. HUT: Actually, Ms. Sternberg is regrettably

delayed this morning, your Honor, so Ms. Parker will be conducting the lead.
THE COURT: Fine. I thought she addressed it yesterday.
MR. HUT: She did indeed.
THE COURT: Are you prepared to go ahead with that?
MR. HUT: We are, your Honor.
THE COURT: I take it someone will take the witness stand.
MS. PARKER: Yes, Ms. Liu will be doing that.
PAEPBLG 32/HRAOEUP 14.
"Q. Have you, did you meet with counsel for the national federation abortion prior to your deposition today to talk about your deposition?
"A. No.
"Q. Did you meet with counsel for Wilmer, Cutler & Pickering?
"A. No.
"Q. Counsel for planned painter hood?
"A. No.
"Q. Counsel for the Center for Reproductive Rights?
"A. No.
"Q. Did you talk with them?
"A. No."
Page 121/line 20.
Q. Have you had a chance to look at what has been marked as

Cain Deposition Exhibit 17, Dr. Cain?
"A. Yes.
"Q. Exhibit 17 is titled 'the Partial-Birth Abortion Ban Act of 1995' and it is subtitled 'medical assertions made in the debate on HR1333. On the left-hand side of the TKAOUPLT there are a number of quotations which appear to have been taken from the congressional debate on the Partial-Birth Abortion Ban Act of 1995 and on the right side is indicated who made the assertion. Down who created this document?
"A. It is my understanding that staff created this document S-S-
Q. Staff of ACOG?
"A. Uh-huh.
"Q. Did they create it specifically for the task force's deliberations?
"A. That is my understanding.
"Q. Let me just say in the middle of the document there are some other materials submitted by Dr. James McMahon. It's ACOG 0062 to 0068. I'm sorry. 0070. And then I believe there's another excerpt at 0075 to 0078. I'm going to ask you about the McMahon data separately, Doctor. I just want to focus on the quotations from the record attributed to certain individuals. Do you know specifically who prepared it?
"A. I think it was Kathy Bryant, but I don't know that for sure sure.

"Q. What role did the congressional quotation portions of this document play in the task force's deliberations?
"A. They again provided a broad range of issues that the task force could then identify and reflect on.
"Q. Any other role you can think of that this document played in the task force's deliberations?
A. That would be the primary role..
"Q. Was it considered as a source of medical information regarding intact D&X, the congressional quotation portion of this document?
"A. No. But it would have been considered as a part of the broad and vague description of the procedure that had to be addressed by the committee.
"Q. So specifically on the issue of terminology, this document --
"A. This was an example of the confusion.
"Q. And my question is, is it fair to say that the statements made in this document from the Congressional Record were considered by the task force specifically in connection with the issue of terminology? Is that a fair statement?
"A. That section on terminology, yes.
"Q. OK. And other than the section on terminology and other than the identification of issues, did you, did the task force, rely on or did the T-FBG force consider the information in this document and in what way did it consider it or for what reason

did it consider it?
"A. Identification of issues that needed to be addressed.
"Q. You don't know if the board saw this document, do you?
"A. I do not.
"Q. Do you know what is sores you have this was etc. etc.?
"A. I believe it was a congressional debate on HR1833."
MS. PARKER: That concludes the designations, your Honor.
THE COURT: Is there anything else in this transcript from the defendants?
MR. PANTOJA: That's it, your Honor.
MS. GOWAN: No, your Honor.
THE COURT: Ms. Gowan, or whoever is next, call your next witness.
MS. WOLSTEIN: Your Honor, Elizabeth Wolstein. The government calls Dr. Curtis Cook.

CURTIS COOK,
called as a witness by the defendant,
having been duly sworn, testified as follows:
THE CLERK: Please state and spell your full name slowly for the record.
THE WITNESS: Dr. Curtis Cook. Curtis is CURTIS. Cook, COOK.
THE CLERK: Thank you, Doctor. Please be seated.

THE COURT: Good morning, Doctor. All right, Ms. Wolstein, will you be conducting the exams?
MS. WOLSTEIN: Yes, your Honor.
THE COURT: You may proceed.
MS. WOLSTEIN: Thank you, your Honor.
DIRECT EXAMINATION S-

BY MS. WOLSTEIN:
Q. Good morning, Dr. Cook.
A. Good morning.
"Q. What do you do for a living?
A. I'm a maternal fetal medicine specialty? What is a maternal fetal medicine.
A. Maternal fetal medicine ace subspecialty of obstetrics and gynecology dealing with complicated pregnancies.
Q. Is that also referred to as a perinatologist?
A. Yes. It is referred to as perinatology or high-risk obstetrics. But the official title is maternal fetal medicine.
Q. Where do you practice medicine?
A. I'm based in Grand Rapids, Michigan, but we provide consult AEUF services for most of western and northern Michigan.
Q. Who are you employed by?
A. I'm employed by spectrum health, which is a large health system in West Michigan.
Q. Is that a hospital system?

A. It is a hospital system that entails multiple hospitals.
Q. Are you associated with a medical school?
A. I am. I have an academic appointment with Michigan State University College of human medicine, the department of obstetrics and gynecology.
Q. What is your post at Michigan State University?
A. I am an associate clinical professor in the department of obstetrics and gynecology.
Q. Does that mean that you teach medical students and residents?
A. Yes. Part of my responsibilities or the predominance of my responsibilities are the clinical teaching and training of medical students in what is called a third-year obstetrics clerkship and also some fourth year medical students doing elective rotations in complicated pregnancies.
Q. Where did you go to medical school?
A. Indiana University.
Q. When did you graduate?
A. 1989.
Q. What did you do after that?
A. I entered into my residency training program in obstetrics and gynecology.
Q. When was that?
A. In the summer of 1989.
Q. Where did you do your residency?

A. I did my residency at butter worth Hospital in Grand Rapids, Michigan, which is now part of the spectrum health system.
Q. How does a graduate of medical school become an OB-GYN?
A. You have to complete four years of training in an approved obstetrics and gynecology training program.
Q. Did you begin to specialize in any area during your residency?
A. Your specialty training usually starts after completion of your residency training program. So upon completion of my four years of res kensy I began my fellowship training in maternal fetal medicine.
Q. Where did you do your fellowship training?
A. At the University of Louisville in connect tuckky.
Q. What period was that?
A. From 1993 to 199 #-55.
Q. What did you do after your spell lowship?
A. I returned to Grand Rapids and started practicing maternal fetal medicine for at that time butter worth Hospital, which then subsequently became part of the spectrum health system [> 1995<]
Q. What course of instruction did you go through to become a maternal fetal medicine specialist?
A. During my years of training, it was a two-year training program. Currently it is a three-contrary training program.

During that time you learned to take care of all manners of medical complications of pregnancy, which would include maternal preexisting medical conditions, fetal conditions, and developing obstetrical complications during the course of the pregnancy. Generally, it also includes training in fetal medicine, fetal treatment, fetal surgical procedures, and also involves learning how to care for complicated pregnancies at all times during the course of the pregnancy. That would alsol include having to empty the uterus in all three trimesters of pregnancy and deal with complications related to that. Then there are other areas involved as far as your training and learning to perform clinical research or ways I can science research, courses in statistics, epidemiology, things of that nature.
Q. When you referred to fetal medicine, what is that?
A. Fetal medicine is any sort of therapy that is directed toward trying to improve the clinical outcome or address disease or pathology that is unique to the TPAETS. It may involve medical therapies, it may involve surgical therapies.
Q. The fetus is your SPAEURBT in that scenario?
A. That is correct, in that setting the fetus is our patient.
Q. In what settings do you teach your medical students and residents?
A. Most often it involves clinical instruction in both normal and abnormal or complicated obstetrics. We do formal lecturing

as well as on-the-floor clinical teaching and intraoperative teaching and intrapartum or during the delivery process teaching as well.
Q. Could you describe your practice in maternal fetal medicine.
A. We have a large volume practice that serves as the tertiary referral center for most of western and northern Michigan. Most of my time is spent in the clinical management of complicated pregnancies, but a portion is spent also in teaching, some in research, predominantly clinical research, and a small portion is also spent in administrative responsibilities.
Q. What do you mean by a tertiary referral center?
A. A tertiary referral center refers to those centers that are most equipped or adept at dealing with the most complicated medical conditions. So smaller hospitals with less subspecialized care or technological support would refer complicated medical conditions to those types of centers.
Q. Do you receive referrals from OB-GYNs of patients with complicated preg intenses?
A. Yes. Virtually every patient in our office is referred by another physician. The vast majorities of those from other obstetrician/gynecologists, but some are referred from other medical specialists as well.
Q. What kinds of maternal conditions and pregnancy do you

provide care for?
A. Again, because of the large volume of the practice and the large referral area, we see pretty much the entire spectrum of both medical and fetal complications. But they include, again, preexisting maternal medical conditions that involve one or more organ systems, may include malignancies, blunt or penetrating trauma in pregnancy, a whole host of maternal conditions. The fetal conditions are likewise varied and many in number but include genetic or chromosomal abnormalities, structural abnormalities in the fetus. We also deal with a number of obstetrical complications: Preterm labor, preeclampsia, multiple gestation, cervical incompetence and the list continues.
Q. How would you describe your patient population in terms of demographics?
A. Again, in our practice, because of the high-risk nature of the patients that we care for, approximately 50 percent of our patients are indigent or on government assistance. The other 50 percent are quite varied in socioeconomic background. We deal with patients from multiple ethnicities, multiple ages, and multiple levels of complication.
Q. Do you deliver babies?
A. We do.
Q. Do you perform medical procedures on living fetuses?
A. We do.

Q. Could you give us an example of the kinds of procedures you perform on living fetuses.
A. This may include medical treatments of the fetus for issues like irregular fetal heart rate patterns or development of fetal heart failure. It may include surgical procedures to reverse life-threatening fetal anemia or obstructions to normal fluid outflow from a fetus that may involve the need to drain certain fetal body cavities with fetal procedures, placement of certain diverting SHUPBTS into a fetus, things of that nature.
Q. Do you treat women for complications of abortion?
A. We do.
Q. Could you describe what your practice entails on that front.
A. On some occasions we will take care of a patient who had a complication from an attempt at a surgical abortion, most often in the second trimester. At that point they would be referred to our hospital, typically through our something department, and we would get involved thereafter. We also see patients that may develop certain infectious complications or bleeding complications from attempted abortion procedures. We also see patients that have had S- subsequent pregnancy complications that may have been related to the earlier abortion procedures and then we are caring for them with subsequent pregnancies.
Q. Does your practice involve pregnancy termination?
A. It does at times involve pregnancy termination.

Q. In what circumstances?
A. In a situation where there is some sort of conflict between the mother and the fetus, meaning that the mother's medical condition is worsening and not responding to therapies or continuation of pregnancy significantly threatens her life or health, then we would go ahead and proceed with the termination of pregnancy, which usually just requires separation of the fetus from the other, doesn't otherwise require destruction of the fetus. And many times we can delay that to the point at which the fetus has a chance of survival. Again, in the world of maternal fetal medicine, our optimal goal is to try to get the best outcome we can for both the mother and the fetus.
Q. What is the most common method of pregnancy termination you use in your practice today?
A. In our practice it would be predominantly medical induction of labor, typically using prostaglandins, occasionally using other therapies. That is predominantly because of the gestational ages at which some of these patients are referred and also secondary to the often preexisting medical complications in the mother and/or her unborn child.
Q. What are the gestational ages that are involved in your patient population?
A. In our practice, most that are related to a suspected fetal abnormality would be referred to our office typically sometime after the 16 to 18-week period since that is when most

significant ultrasound evaluation can be done, and also it is after the period of time that most other screening tests are done for fetal abnormalities.
For maternal medical conditions that are worsening with the pregnancy, that also typically occurs after 20 weeks' gestation, and most unique obstetrical complications, meaning a unique to pregnancy, such as preeclampsia, often also don't present until after 20 weeks' SKWRES TAEUGS by definition.
Q. Is it that the induction method is most suitable for those gestational ages? Is that why you use it frequently?
A. Yes. We feel it is the best procedure in those later gestational ages for multiple reasons. It may include the need to have an intact baby for evaluation in the case of suspected fetal abnormalities, and that means an intact central nervous system as well. It also allows us the ability to use the most natural or physiologic or least stressful method of delivery on a mother who may have a significant medical condition, and also allows us the ability to do certain types of critical care management, support, and monitoring of a mother in a hospital setting.
Q. You mean as opposed to an out-patient setting?
A. Correct.
Q. Have you performed pregnancy terminations by methods other than induction?
A. On rare occasions I have.

Q. In the second trimester?
A. In the TPEURDZ and the second trimester.
Q. What other methods have you used in the second trimester?
A. In the second trimester, we will on occasion have to empty the uterus by a dismemberment procedure such as a D&E, and in the first trimester we may have to do a termination of pregnancy for issues like a mo largesse TAEUGS using a suction curettage method S-
Q. Are most of your terminations on dead fetuses as opposed to living fetuses?
A. My experiences with second trimester termination of pregnancy by surgical techniques have been predominantly on babies that have already expired within 24 hours of the procedure. But my experiences with medical induction do sometimes involve the need to induce a pregnancy where the baby is still living at that time secondary to a worsening maternal condition.
Q. What is the term "viable" or "viability" refer to [> what does<]
A. Viability is generally understood as the gestational age at which a fetus is able to survive independent of the mother's womb, availing itself of the current medical technologies and support systems that we utilize every day in our neonatal intensive care units.
Q. What is the current gestational age of viability?

A. It does seem to continue to improve. In my career we have been able to reduce it backwards a week about every five years. But currently it is 23 weeks' gestation or about 400 grams fetal birth weight.
Q. In the post-viability period, in what circumstances have you performed terminations on life fetuses?
A. Most often in the situation where the mother's medical condition is worsening, and the typical patient would be somebody with severe preeclampsia or worsening hypertensive disease, but also frequently involves those patients that may have uterine infections, bleeding issues, or other threats to maternal health that are not responding to our therapies. Again, at that point our goal is to try to separate the placenta and the fetus from the mother. We don't need to destroy the fetus. We just need to deliver the fetus so the healing and recovery process can begin for the mother.
Q. You do that mostly by induction procedure?
A. Mostly by induction procedure. If we have a fetus who also is compromised by the medical condition, which does happen with some medical conditions, then we would generally proceed with a Cesarean delivery.
Q. In the previability period, in which circumstances have you performed abortions on live fetuses?
A. Generally, in similar scenarios that are more extreme and are not responding to our therapies but include generally

issues related to worsening hypertensive disease, potentially worsening of her preexisting medical diseases, or infection oftentimes as a result of early rupture of the membranes or early breaking of the water.
Q. Would you ever perform a D&E on a living fetus?
A. In a situation where the mother's medical condition was worsening and not responding to our therapies and significantly threatening her life offer health, when we are in that rare situation of there being a maternal and fetal conflict. At that point we always consider the mother's interests first, getting the best outcome for the fetus that we can, but never sacrificing the mother for a potential good fetal outcome. And if we felt that D&E was the best way to empty the uterus in that setting, then I would not be opposed to doing that.
Q. Have you performed and supervised D&E's on dead fetuses?
A. I have.
Q. At what gestational ages?
A. Usually somewhere in the range of 16 to 18 weeks, none beyond 20 weeks that I recall.
Q. Approximately how many times have you done that, performed or supervised D&E's on a dead fetus?
A. I myself have performed a small number. Somewhere on the order of 3 to 5, and have either supervised or assisted in approximately another 10 to 20, usually in the form of helping provide the ultrasound guidance to aid in the emptying of the

uterus.
Q. When you provide ultrasound guidance in that situation, are you able to observe the surgical part of the procedure?
A. We are.
Q. Are you personally able to do that?
A. I personally am able to observe what is going on, but I am not doing the dismemberment. I am up near the patient's abdomen doing the ultrasound.
Q. Doctor, what, if any, professional organizations do you belong to?
A. I belong to a number of organizations, but they include the American Medical Association, the American College of Obstetrics and Gynecology, the Society for Maternal Fetal Medicine, American institute of ultrasound and medicine, several others.
MS. WOLSTEIN: Your Honor, may I approach?
THE COURT: You may.
Q. Dr. Cook, I have handed you what has been marked for identification as Government Exhibit Z1. Do you recognize that?
A. I do.
Q. What is it?
A. This is a copy of my curriculum vitae that was updated in January of this year.
Q. If you turn to page 3, there is an entry that says "Health

intervention services." What is that?
A. That is a community health center in Grand Rapids that I started some number of years ago to treat patients that were falling between the cracks as far as medical insurance coverage. So typically it was a patient who was working in a job that had poor benefits for health coverage or college-age students no longer carrying medical coverage, or new immigrants to the country that sometimes are were registered and sometimes were not.
"Q. What was your role in that organization?
A. I founded the organization with another physician, and we purchased the building, started the clinic. Initially, I provided general medical care. Then I provided normal obstetrics care and delivery services. Currently I have relinquished all administrative responsibilities and just provide consul at itive care for complicated pregnancies there.
Q. Dr. Cook, does Exhibit Z1 accurately reflect your education, training, professional experience, and publications?
A. I believe that it does.
MS. WOLSTEIN: Your Honor, the government offers in evidence Government Exhibit Z1.
THE COURT: Any objection?
MS. WIGMORE: No objection, your Honor.
THE COURT: It will be received.
(Defendant's Exhibit Z1 received in evidence)

Q. Doctor, can you be a maternal fetal medicine specialist without knowing how to end a pregnancy early?
A. No. I believe that part of the training of taking care of complicated pregnancies is knowing how to deliver the pregnancy in all three trimesters, since it is necessary frequently to start the reversal of the medical conditions that are either unique to the pregnancy or exacerbated by the pregnancy.
Q. From your testimony, I take it you are familiar with the DEA method of abortion?
A. I am.
Q. What is the basis of your familiarity with D&E?
A. I performed D&E on nonliving fetuses. I have observed D&E being performed. I have read about D&E. I have seen literature about D&E. So I have a general familiarity with it.
Q. Could you describe a DEA procedure for us.
A. A classic D&E procedure involves some period of time of cervical preparation prior to the surgical dismemberment of the fetus. That preparation period is usually a day prior to the surgical procedure on the fetus. When the surgical procedure is performed on the fetus, it involves taking some sort of grasping instrument and grasping whatever portion of the fetus that you can grasp, pulling it down through the cervix, and then starting to dismember or disarticulate whatever portions of the baby that you can in order to effect complete EFRPT TEUG of the uterus.

Following that and the delivery of the placenta, there should be an accounting for all of the fetal parts so that you can confirm that there is no retained fetal parts or placenta following the delivery.
THE COURT: So the record is clear, Doctor, does "disarticulation" do you mean you tear off parts of the fetus?
THE WITNESS: Yes. It would be taking off an extremity like an arm or a leg, and the ahead and the chest are usually the other major portions.
THE COURT: All right. Next question.
Q. Doctor, in Dr. Chasen's study that is soon to be published, he states, "Using forceps, the fetal parts are grasped and the fetus and the placenta are disarticulated as they are removed." Would you agree with that description of the D&E?
A. I would.
Q. You stated that you are familiar with some of the medical literature on D&E?
A. I am.
Q. Would you agree with the following statement in Dr. Chasen's study: "All published reports of dilation and evacuation have described the use of grasping forceps to remove the fetus and the placenta"?
A. KWROEULD agree with that statement.
Q. In the medical literature on D&E that you are familiar with, is D&E described as a TKPHEPLT procedure?

A. It is.
Q. In your practice, at what gestational ages is D&E done?
A. D&E would be done in our practice in the gestational age range of approximately 14 to 18 weeks, but again is not frequently performed by us for a number of reasons. [> yes, I would agree, above<]
Q. Based on your understanding, can D&E typically be performed up to 20 weeks?
A. Yes. I believe that many practitioners will perform it up to 22 weeks. I don't believe it is performed often, if at all, beyond 22 weeks.
Q. Why isn't D&E done beyond 2 weeks?
A. For a number of reasons. One is the baby has a 30 to 40 40 percent STPEUFL at 23 weeks. Also, it is technically more difficult to remove the limbs or portion of a baby when you are at those advanced gestational ages, because the tissues are harder to disarticulate or tear apart. [> survival<] also, there means needs to be a greater amount of cervical dilation and potentially a greater amount of something at later gestational ages which would inKWRAES the risks of bleeding and infection [> manipulation<]
Q. You mentioned that fetal tissue is harder to tear apart at the higher gestational ages. What is the basis of your knowledge of fetal tissue?
A. My personal knowledge of fetal tissue comes from dealing

with fetuses throughout their life span in the predelivery setting, including doing procedures on babies in the second trimester and the third trimester. Also, we deliver babies frequently at those gestational ages. So we have a very clear understanding of how fragile that tissue is. We can even sometimes date a gestation of a pregnancy just by looking at the skin and how easy things like bruising occur, how transparent the skin is, things of that nature.
Q. Does the technique for the surgical part of a D&E differ when it is done on a dead versus a live fetus?
A. No. It is essentially the same procedure. If there has been some significant length of delay from the time that the baby was last living, then there may have been more degeneration or softening of the tissue and it may be easier to disarticulate or tear apart, but in its substance it is essentially the same procedure.
Q. Do you have an understanding of the D&X or intact D&E method of abortion?
A. I do.
Q. What is the basis for your understanding of the D&X method?
A. Initially, it came from reviewing detailed descriptions from two high-profile providers of the procedure, and then continued as I reviewed during the course of my years of involvement in this issue, submitted medical histories of women who had had the procedure, and testified about their

procedures. I also during the course of my years of being involved in this issue have had to view a videotape of one of the providers doing the procedure. And then my review of what little medical literature is available on this topic.
Q. Is there medical literature available on D&X?
A. There is very little information available. There are references to it in some more recent editions of textbooks on abortion procedures, and there are some very recent studies being done and some I understand soon to be published dealing with this issue.
Q. Are you referring to Dr. Chasen's studies?
A. In particular, that study I am referring to as far as the one soon to be published.
Q. You referred to two high-profile providers. Who were you talking about?
A. That time Dr. Haskell from Ohio and the late Dr. McMahon from California.
Q. Have you heard the D&X procedure and the intact D&E procedure referred to as partial-birth abortion?
A. I have. The term "partial-birth abortion" is used to describe essentially the same procedure that Dr. Haskell referred to as a D&X, that Dr. McMahon referred to as an intact D&E, and that the American College of Obstetrics and Gynecology refers to as an intact D&X procedure.
Q. Could you describe the D&X or partial-birth abortion

procedure?
A. The procedure involves cervical preparation and massive dilation of the cervix over at least a two-period preparatory phase, followed by a surgical procedure that involves breaking the bag of water, reaching inside the uterus, and converting the fetus to a feet-first breech position if it is not already in that position, then grasping that portion of the baby, dragging it down through the dilated cervix to the point of the after-coming head. Typically the after-coming head would then lodge at the cervix at that point. Then the practitioner would have the about a WEU in a position where the spine is up, make a puncture into the base of the skull with a scissor or some other hard-tipped aspirating devise, then suction out the intracranial contents or the brain matter, thereby causing collapse of the fetal skull. That would allow completion of the delivery. There would need to be delivery of the placenta afterwards as well.
Q. Similar to what you do in a D&E?
A. Correct.
Q. You mentioned a videotape by a professor of D&X. What were you referring to?
A. I was referring to a videotape that I understand Dr. Haskell had made of himself performing a partial-birth abortion procedure.
Q. You have seen that tape?

A. I did review it in the course of my trial testimony in federal court in the state of Missouri.
Q. Would you describe how the D&X done by Dr. Haskell proceeded on that video.
MS. WIGMORE: I object, your Honor. This is hearsay. This witness has not been qualified as an expert yet.
THE COURT: Do you wish to do the qualification, Ms. Wolstein, first?
MS. WOLSTEIN: I can do that. It is based on his own personal observation of the tape, and he is describing what he saw.
THE COURT: I think it is factual, too. I am going to allow it. Go ahead.
A. As I recall from viewing the tape, and it has been a number of years now, I don't recall seeing anything on the tape that involved the cervical preparatory phase, which again is usually done over two or three days in an out-patient setting. But I do recall the videotape showing him reaching inside the uterus, delivering the baby's body with the exception of the baby's head. You could see the baby's spine up, extremities down toward the floor. Then Dr. Haskell's hand is over the back of the baby's head and he is putting a scissor underneath his hand in the general area of the base of the skull or back of the neck. Then you see a suction as spraying device placed underneath his hand, presumably into the same defect. You can

then see a collapsing or a reducing of the size of the fetal head and then delivery of the baby thereafter.
Q. In what way is a D&X procedure different from a D&E procedure?
A. There are several areas where they deliver. One, the D&X procedure is designed for procedures at 20 weeks and beyond, whereas D&E procedures are done more commonly less than 20 weeks' gestation. A D&X procedure involves more cervical dilation, significantly more cervical dilation than that used for a D&E procedure. It involves more days of surgical preparation. It involves more extensive intrauterine manipulation if the baby needs to be convert to do a feet-first breech position. And it involves aspirating out or sucking out the fetal brain contents.
Q. Do you understand that there might be some variation in the precise procedures used in a partial-birth abortion or D&X procedure?
A. Yes. I understand that some practitioners use different methods of cervical preparation and that some practitioners use different methods of fetal skull compression.
Q. In your understanding, does TK*RBGS necessarily involve instrumental conversion of the fetus to a breech position?
MS. WIGMORE: Your Honor, I object. This witness is delivering expert testimony, and he has not yet been qualified. He does not do these procedures, so this could be nothing other

than expert testimony, which I would like the opportunity to challenge.
THE COURT: In TAOU course I will let you challenge. Overruled.
A. I'm sorry. Could I hear you repeat the question.
(Question read)
A. No, I don't believe it necessarily requires that. For instance, if the fetus is already presenting in a breech presentation, then there would be no need to convert the baby to a breech presentation.
Q. Have you ever personally performed a D&X?
A. I have not.
Q. Why in your practice have you performed so many more inductions than D&E procedures?
A. Again, there are several reasons. One is the later gestational age at which most fetal abnormalities are referred to maternal fetal medicine. The later gestational age for the development of most obstetrical and medical complications that would involve the need to terminate the pregnancy earlier, the desire to try to have as complete and intact a fetus as possible for pathologic evaluation, and the desire to try to deliver oftentimes compromised motors in a manner that would be the PHETS physiologic or the most natural process for entering the uterus with the least strain on a system that already may have limited reserve for certain types of complications.

Q. In your practice, if it was necessary to end a pregnancy before viability, would D&E ever be an option at some point in yes, sir TAEUGS?
A. Yes. If we felt that D&E was the best procedure and the patient was in that 14 to 18-week gestational age range, and we felt the maternal condition was not responding or improving to our treatments or therapies, then we would proceed with the D&E procedure.
Q. Do you refer women for D&E's in some circumstances?
A. I do.
Q. When and why?
A. In a situation where a fetus has an abnormality that is not otherwise threatening the maternal condition or is not known to be in lethal fetal anomaly, then we would refer them out to an out lying provider for their D&E procedure, if we felt pathology was not a necessary component for that patient's care.
Q. Does that include referring women for D&E's on living fetuses in some circumstances?
A. It does.
Q. Is that one reason why you were to understand the nature of the D&E procedure?
A. Yes, we do have to have familiarity with whatever procedures we are referring patients for. [> check the question<] in addition, if there was a complication arising

from that procedure, we may be the ones called upon to treat or care for that complication.
Q. We have been talking a lot about medical inductions. Could you describe a medical induction procedure for a second trimester termination.
A. Medical induction may or may not involve cervical preparation ahead of time, but at some point involves the use of medical agents to initiate uterine activity, and those agents typically are prostaglandins but may also include oxytocin or pe toe sin. And if the baby is previable at that point, then we may use different dosing intervals or dosing amounts. If the baby has reached the point of viability or 23 weeks, then we may alter certain medical treatments in order to optimize the fetal outcome as well as the maternal outcome S-
Q. Doctor, do you perform clinical research?
A. I do.
Q. What types of clinical studies have you performed?
A. I have participated in all types of clinical studies: Retrospective case controlled trials, randomized prospective clinical trials, cohort studies, things of that nature.
Q. Can you explain what each of those types of studies is.
A. A randomized clinical trial is a prospective study done where you enroll patients into typically one of two treatment arms that usually vary in only one aspect. Then you collect data to evaluate a previously established primary outcome.

Q. How about a cohort study?
A. A cohort study is typically following a population of patients in a forward or prospective fashion and then evaluating their outcomes thereafter, but doesn't involve randomization to various treatment arms.
Q. What is a case controlled study?
A. That is typically a retrospective study designed for outcomes that typically are either rare or there may be some ethical concerns with randomizing patients in a trial or there may be difficulty enrolling a patient in a trial. So we then try to control for whatever our study variable is by finding a similar control population to our study population that hopefully differs just in the area of the variable we are studying.
Q. What are your current clinical research interests?
A. Currently I am involved in multiple trials that all involve some aspect of preterm labor and preterm delivery and subsequent neonatal outcomes. I also have two studies that are approved and we are just starting to collect data on in the area of preeclampsia, one involving induction of labor issues in preeclampsia, one involving the genetics of preeclampsia.
Q. Doctor, do you keep up to date on the medical literature in the field of maternal fetal medicine?
A. I do my best, yes.
Q. Why is it important to do that, if it is?

A. On multiple levels it is important. One is just to make sure that our clinical management is contemporary. The second reason is because we do teach and train medical residents and students in the management of normal and abnormal pregnancies. Finally, it often helps guide some of our clinical research as far as helping us to ask an informed or good clinical question for subsequent study or evaluation.
MS. WOLSTEIN: Your Honor, pursuant to Federal Rule of Evidence 702, the government tenders Dr. Cook as an expert in obstetrics and gynecology with specialized expertise in maternal fetal medicine.
MS. WIGMORE: Your Honor, I do not object to that designation to the extent he is being treated as an expert in abortion procedures, however, I do. And to the extent the testimony touches on that, I would request an opportunity to voir dire the witness.
THE COURT: Fine. He will be so recognized by the Court. You can reserve your objection to the testimony as it comes up.
Q. Doctor, when did you first get involved in the partial-birth abortion issue?
A. As I can best recollect, it was in the fall of 1996.
Q. How did that come about?
A. It is not entirely clear to me all the details being, but as I recall', at the time it had to do with testimony in front

of Congress regarding specifically the issue of anesthesia and its use in this procedure and the assertion that the -- the false assertion that anesthesia caused the death of the fetus. At that time the president for the society of obstetrical anesthesia and others were giving testimony. In the course of that questioning they were asked other questions regarding the medical necessity of this procedure. Some of them did not feel comfortable addressing those issues and some of those questions were referred to me. From that point forward I got involved in various very different levels, basically answering questions regarding medical necessity and potential complications of this procedure.
Q. Did you eventually testify before Congress?
A. I did.
Q. When was the first time you did that?
A. As I recall, it was in March of '97.
Q. What is the PHACT organization, P-H-A-C-T?
A. As part of wanting to respond to a lot of the circulate medical misinformation, several physicians that deal with complicated pregnancies, most of which were academic physicians dealing either with complicated pregnancies or newborns or pediatric patients after complicated pregnancies, came together and wanted to formulate a systematic way to try to inform the public accurately about the medical truths regarding this procedure. So the PHACT organization was an ad hoc committee

basically to address the issue and only the issue of partial-birth abortion. It never commented on any other abortion techniques. It never dealt with any other ethical issues like stem cell research or anything of that nature. It dealt solely with this procedure. At one point we had over 400 physicians.
It basically doesn't have a function now that I feel we have successfully educated the public about details of this procedure, so I am not really certain when the last time was that we even created any sort of memo, teaching point, or press release about this procedure.
Q. When it was functioning, who generally were the members of PHACT?
A. Well, there were a half dozen or so founding members, and then the organization view to several hundred physicians. Again, as I understood them to be predominantly academic physicians dealing with pregnancies, complicated pregnancies, or pediatrics or pediatric subspecialists, and that group did include some people that were providing abortion procedures, many who were not providing abortion procedures, but all of whom had some background or superTAOES in pregnancy or complicated pregnancies.
Q. Did it include doctors who were supports of abortion rights?
A. It did.

Q. So PHACT was not a pro life political organization, I take it?
A. No. There was a number of physicians that were concerned about a lot of the information at the time circulate about this procedure. That included initially that the procedure was never performed, later that it was rarely performed, then something on the line that it was only performed in the most dire medical conditions of the mother or the fetus. Then it got around to the issue of anesthesia. That is what really concerned many of us, because we perform operative procedures all the time in pregnancy because of what we do and woe deliver anesthesia all the time in the course of pregnancy because of what we do. We were very concerned that patients would be hearing the wrong PHEPBG that this anesthesia, which is safely provided, could somehow threaten the health of their babies.
Then it got into other areas that needed clarification, like issues of fetal pain and things of that nature.
"Q. Those subjects you mentioned of what you called medical misinformation, were those subjects you addressed in your congressional testimony in 1997?
A. Yes, I addressed several of those issues at that time.
Q. One of the issues you mentioned was severe maternal and fetal anomalies. What made you think the information in public circulation was wrong?

A. At the time of the initial veto, President Clinton at that time surrounded himself with about five women that had the procedure and asserted that this procedure was only done in the most severe medical conditions, either maternal or fetal med medical conditions. In addition, a number of toes women had testified before Congress and revealed their medical histories and their supposed indication or need for this procedure. So that ahead up the basis of my understanding that that was the assertion and also the basis of my evaluation that that indeed was not the case.
In addition, I also reviewed what data was available from practitioners of this procedure, which at that time was predominantly very detailed data from Dr. McMahon. There has not been, to my knowledge, many other detailed records to review subsequent to that.
Q. How did you come to learn of the medical histories of the five women you referred to?
A. All of those women, as I recall, had testified in front of Congress or submitted testimony for evaluation, and those were the histories that I reviewed. In addition, when I actually gave testimony in front of Congress, some women that were also giving testimony at the same time described their medical historiesnd and that was also used for my evaluation.
(Continued on next page) 4/16/04 Judge Casey take 2 of NAF versus Ashcroft, direct of
male doctor on the stand, Curtis cook. By WOL Stein?

BY MS. WOLSTEIN:
THE COURT: Doctor, did the women who testify PWHR*D Congress make their medical records available?
THE WITNESS: No. At that time they just described their medical histories and I was asked by some members of Congress how I could comment without reviewing their actual medical records. And as I recall my response was that I would be happy to review the records if they wanted me to and it became clear they did not want me to do that, so I was only able to comment object the data available to me.
THE COURT: So when you say "they" you mean the women didn't want you or the Congress didn't want you to make the medical records available.
THE WITNESS: I'm sorry, your Honor, that wasn't clear.
The women made it clear they did not want to release their medical records for my review.
THE COURT: All right. Next question.
BY MS. WOLSTEIN:
Q. What were the indications that you learned of in those five women?
A. Well, again it's been a number of years, but as I recall, at least one if not two involved some issue related to hydrocephalous or increased fluid accumulation within the fetal brain.

There was at least one case of excessive amniotic fluid accumulation that I believe was a result of a specific fetal condition.
I believe there was also a woman with a certain genetic issue called trisomy which is an abnormal extra copy of a particular chromosome.
Things of that nature.
MS. WIGMORE: Your Honor I object and move to strike. Those records were not provided to us, the medical histories, they were not disclosed the details of them were not disclosed in the witness' report.
THE COURT: He didn't get the histories either.
MS. WIGMORE: He reviewed the histories and he is testifying about what was in the histories.
THE COURT: He said he did not getet medical records.
MS. WIGMORE: I I'm sorry he did, your Honor, he got his TREUZ and that is what the testimony is based on.
THE COURT: He was allowed to read the testimony of the women before Congress.
MS. WIGMORE: I don't believe that's correct, your Honor. I believe he received some medical history information that he is now testifying about and that was not turned over to AUZ as part of expert discovery.
THE COURT: To make it clear, Doctor, what did you receive,? What TKEU review.

THE WITNESS: What I reviewed was the testimony that the women gave before Congress where they described their medical histories. In addition, two women that had procedure were seated next to me during testimony and revealed their history that I heard first hand from them.
But all of that is in the Congressional record and all of that was listed in my expert report as a basis upon which I drew my conclusions.
THE COURT: Who made the objection for the plaintiff.
MS. WIGMORE: That was Ms. Wigmore, your Honor.
THE COURT: Ms. Wigmore, perhaps some more attention to the testimony will help.
Go ahead, Ms. Wolstein.
BY MS. WOLSTEIN: Thank you, your Honor.
Q. Doctor, was partial-birth abortion necessary for any of those conditions the women described in their Congressional testimony?
A. No.
Q. You also mentioned Doctor that you saw some of Dr. PH*BLGman's data?
A. Yes, I reviewed Dr. McMahon's data.
Q. And what did Dr. McMahon's data show?
A. The data I had from Dr. McMahon was that he submitted in Congressional testimony or sent to the Congressional committees at that time evaluating partial-birth abortion. And

Dr. McMahon was very detailed in listing what he called maternal indications and fetal indications for this procedure.
Q. What were some of his fetal indications?
A. Well as I recall, he used the term flawed to describe the indications that were fetal in origin and stated that about 50 percent of his cases were done on flawed fetuses.
My review of those indications reveal several very questionable diagnoses of things that we treat on a regular basis, many of which spontaneously resolve, most of which have no clinical implication for the fetus or the neonate, a few of which are easily correctable with minor surgical or medical therapies thereafter.
THE COURT: What is a neonate, Doctor?
THE WITNESS: A knee O Nate say term usually referred to a newborn child up until 28 days of life so it is usually referring to the baby in the first month of life.
THE COURT: Thank you.
Go ahead, Ms. Wolstein.
Q. So, Doctor, is what you are saying is that the anomalies were not severe ones or they were not lethal?
A. There were some that were severe and some that were lethal but I reviewed all the ones that he submitted and several were very minor indications, if any indication at all.
Q. And how about you mentioned the medical indications and Dr. McMahon's data, what did that data indicate to you?

A. I'm sorry, as medical do you mean maternal medical.
Q. I'm sorry maternal indications, thank you.
A. For maternal indications, as I recall, it was something in the order of 10 percent of his cases and it included also some very questionable diagnoses like a pediatric pelvis, a spouse that was abusing drugs, depression and other situations that we would treat differently than with an abortion procedure.
Q. What do you mean by questionable diagnoses in this context?
A. Well we would not consider many of those "indications" to be a justification for terminating a pregnancy for a medical condition. We would consider that an eelectrictive termination of pregnancy.
Q. Doctor, did you agree again to appear before Congress in 2002?
A. I did.
Q. Why did you agree to do that?
A. At that time there was another committee that was looking at some specific issues related to this proposed ban that did involve some new language and they also were asking me to comment again on issues I had commented on before, issues related to medical necessity and potential complications of the procedure.
Q. Why did you agree to serve as an expert on the government's behalf in the three cases challenging the current partial-birth abortion ban Act?

A. Well, as I have described, I have been involved for a number of years in trying to clarify the medical truth about this procedure and I feel this is just sort of a completion of a process that I began many years ago not envisioning it would require this level of effort but my general nature is to try to complete that which I start.
Q. Doctor, do you have an opinion as to whether partial-birth abortion is ever medically necessary to promote the health interests of mothers facing high-risk or complicated pregnancy?
A. Yes.
MS. WIGMORE: Your Honor, I object. I think this gets into expertise in abortion and intact D&E and I don't believe this witness is appropriately qualified.
THE COURT: I will give you an opportunity to voir dire but I will allow an answer to the question.
THE WITNESS: Yes, very an opinion on that matter.
Q. What is your opinion?
A. My opinion is that it's never medically necessary and it potentially poses threats to the future health and fertility of women.
Q. What is the basis of that opinion?
A. It's based upon my extensive review of how the procedure is done, my immediate familiarity with aspects of the procedure that we perform and others clinical situations. It is based upon taking care of patients with complications related to

procedures similar to this.
It also is based upon my understanding of the medical literature and my more than 10 years of taking care of exclusively complicated pregnancies.
Q. Doctor, do you have an opinion as to whether partial-birth abortion is preferable to other second trimester methods of abortion?
MS. WIGMORE: Excuse me, your Honor.
THE COURT: Do you want to conduct your voir dire, go right ahead.
MS. WIGMORE: Okay.
At the Court's preference I can do it either at counsel table or at the podium.
THE COURT: Why don't you do it at the podium.
MS. WIGMORE: All right.
BY MS. WIGMORE:
Q. Dr. Kook, you testified that you have been practicing medicine for over 10 years, is that right?
A. I think I testified that I season *R had been providing care to complicated pregnancies exclusively for more than 10 years.
Q. And in that more than 10 years you personally performed between three and five D&Es, is that correct?
A. That's correct.
Q. And none of those D&Es involved an extraction of a fetus

that was living at the time the procedure was done, right?
A. All of those performed on babies that were living within 24 hours of the procedure but none that I'm aware of that were living at the time of the procedure.
Q. In those cases where you personally performed a D&E, you have never inserted laminaria to dilate the patient's cervix, have you?
A. I inserted laminaria many times for other situations of induction of labor but in the cases of those D&E procedures, I don't recall that I was the one that placed the laminaria.
Q. Is it true that you have never performed a D&E at 20 weeks or greater?
A. None that I can recall.
Q. As far as you know, you have never been present for a D&E that took place at 20 weeks or greater, isn't that right?
A. Very view of those are performed. And that is correct, yes, ma'am.
Q. You have been present at fewer than 20 D&Es total, is that right?
A. That is correct.
Q. And fewer than 10 of the D&Es at which you were present involved a fetus that was living at the time of the procedure, right?
A. That is correct.
Q. You do not consider yourself an expert in performing D&E at

20 to 24 weeks, do you?
A. I do not consider myself an expert performing late D&E procedures.
Q. And you believe you lack the skill to provide D&Es to your patients after 18 weeks' gestation, is that right?
A. No, that's not right.
Q. Doctor, did you give a deposition in the Missouri case?
A. I gave a deposition in the Missouri case, yes.
Q. And that deposition was given on February 18th, 2000, is that correct?
A. I don't recall the date but I accept that you do know the date.
Q. I am going to just read an excerpt from that deposition and ask you if you were asked these questions and gave these answers. And I'm reading from page 29, line 10:
A. It would be almost impossible for me to confirm that without looking at the deposition.
Q. I would be happy to provide you a copy.
MS. WIGMORE: May I approach the witness, your Honor?
THE COURT: You may.
Q. Dr. Cookie have handed you a rather large binder I apollize for its bulk but it contains prior testimony and I want to direct your attention to tab 5 which is the Missouri deposition.
Do you have that?

A. I'm getting there. Okay, I'm there.
Q. And if you turn, please, to page 29?
A. Would that be the small page 29 or the larger page 29?
Q. It's the page -- small page 29.
Do you have that page, Dr. Cook?
A. Yes, it's small print so I'm trying to get it all together here.
Q. See if you can follow along, I'm reading from line 10 on page 29:
"Q and how does that affect your decision between D&E removal and inducing labor
"A most D&E providers feel it takes a certainly level of experience and STKPER tease to perform a D&E beyond 16 weeks. It's a difficult procedure.
"Q and you feel that you don't do enough of them to have the skill to do it beyond 18 weeks?
"A that is correct."
Were you asked those questions and did you give those answers?
A. I did, in 2000.
Q. And have you done many D&Es after 18 weeks since 2000, Doctor?
A. Well I'm trying to recall when the last one was with the abdominal S*EUR KHRAPBLG but I have done them and I would do them if I needed to.

I think what I was attest to go here is that there are other people that have more experience that are readily available that I would say are the preferable people to do the procedure. But if the need arises I know how to do the technique and have done the technique.
Q. How many D&Es past 18 weeks' gestation have done since 2000, Dr. Cook?
A. I don't know. It is a small number but these are variations on techniques that we do all the time.
Q. Can you remember a single one since 2000?
A. I would -- well the one case that we've talked about extensively in deposition of the abdominal cerclage patient I would have to review when that patient was, specifically, but as I recall that was one of the latter ones I've had to P*ER form my STKPWHREFL you refer patients to other physicss for D&Es, is that your testimony earlier today?
A. I do.
Q. And in fact you can't recall anyone in your current office performing a D&E in recent years, is that correct STPH-FRPBLGT again, I think I clarified that that's correct because mostly the gestational ages we see these patients are later gestational ages.
Q. You yourself only perform an abortion if there is a lethal fetal condition that is causing deterioration of maternal condition, is that correct?

A. No, that's not correct.
Q. Could you refer, please, to the Nebraska transcript, which is Tab 2 in your binder? And this is the trial in Nebraska. I want to direct your attention to page 1333, and this is -- it's actually page 74 on the bottom but page 133 3 of the actual transcript.
A. Sortie, it was under seal here.
Q. Sorry.
A. Page 33 of the transcript.
Q. Page 74 on the bottom.
A. Okay, I'm at that page.
Q. And I want to direct your attention to line 4. There is a statement from the Court that I think will give you con text so I will start there and it says Mr. cop O lean joy just for your background I understood the doctor does not imself perform these procedures in the case of a fetal --
"mr. cop cop, anomaly, your Honor.
."
THE COURT: In the case of a fetal anomaly he will have one of his partners do it sand he may soup SRAOEUPZ the care but another personal will do it. If I misunderstand that I think it will be helpful to clarify it ."
Mr. cop cop. Dr. Cook
"A yes, my general practice is if the situation of the pregnancy is complicated solely by a lethal fetal anomaly

with no maternal medical complications related to that, then one of my partners will do the actual delivery process and I will do the before and after care or management of complications. If it's a lethal fetal condition where it is causing some sort of deterioration of maternal condition, then I will do the delivery."
Was that your testimony?
A. It was then and it is now.
THE COURT: All right, Ms. Wigmore, do you want to renew your motion? This is cross examination 26R7B89 yes, your Honor, a few more questions however if that's PROET.
THE WITNESS: Can I clarify, your Honor or -- my understanding of the question was is the only situation that I would do a termination of pregnancy in the situation of a fetal lethal anomaly with maternal medical conditions. My answer to that was no because I also perform terminations in situations without feet aanomalies where there are severe maternal medical conditions.
So, my statement in my deposition and my response to you are consistent with that management.
MS. WIGMORE: Thank you, Doctor. May I ask a few more questions, your Honor.
THE COURT: Yes but keep in mind it is voir dire and not cross.
BY MS. WIGMORE:

Q. Is it true, Dr. Cook, that you have never performed what you are referred to as a partial-birth abortion?
A. That is true.
Q. And you have never been physically present when such a procedure was performed, correct?
A. No. I have only observed it by videotape.
Q. And have you not spoken to anyone who performs partial-birth abortions about the technique use in the procedure, have you?
A. No. I have only reviewed their submitted testimonies.
Q. And did you testify previously in your deposition that your predominant source about how a partial-birth abortion is performed is the descriptions provided by Drs. Haskell and McMahon.
A. Yes, they have been the two most forth comeing about details of the procedure and then subsequent reviews, particularly for these trials, have enlightened me further about individuals' approaches to this procedure.
Q. And those additions about Mr. Haskell and McMahon are eight years or older at this point?
A. Well Dr. McMahon's last major presentation on this I believe was in 1995 that I had seen, but most of that was data that they had presented in the early 1990s which I don't understand to be substantialtively different than anything I have reviewed for these trials.

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Q. You have never treated a woman as far AUZ know, whose had a partial-birth abortion, is that right?
A. No. I have been contacted by an individual whose had the procedure done by Dr. McMahon in the past to query me about issues related to her subsequent complications but in my own practice, to my knowledge, I have not cared for a patient whose had this procedure done.
Q. You testified in the partial-birth abortion case in California earlier this week, correct?
A. I did.
Q. Isn't it true that the Court in that case refused to recognize you as an expert in the technique of intact D&E?
A. Would I have to defer to the attorneys for those details.
Q. You don't recall that part of the testimony?
A. I just answered questions, ma'am.
Q. Would it THOEP see the transcript? I don't want to spend too much time on this your Honor but I think this is a relevant detail?
THE COURT: It really isn't.
MS. WIGMORE: Okay. Well at this point I would then object to the witness' testimony on intact D&E and relative safety of abortion procedures based on his lack of experience.
THE COURT: Your objection is overruled. I think you take the position that unless it is abortion provider or abortionist who does the procedure nobody can be an expert on

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it and the Court disagree with you. It may have some effect on the weight but doesn't mean that the witness cannot be an expert and give opinion on it.
MR. HUT: Your Honor, Steven Hut may I approach.
THE COURT: Why.
MR. HUT: I would like to share an observation with the Court at the bench, if I may.
THE COURT: We only try this one at a time, Mr. Hut. It's not a tag team effort.
MR. HUT: This is not anything to do with the witness' testimony, your Honor.

MR. HUT: Your Honor, I am constrained to approach because the Court has used the term this week frequently abortionist. That term respectfully is dericive and derogatory. I know that you inquired of Dr. Chasen whether abortion provider and abortionist meant the same thing and said they do but they do in the same sense.
THE COURT: Please keep your voice done.
MR. HUT: Sure. They do in the same sense that ethnic slurs refer to ethnic members of the same groups and religious PHAEBZ of the same group.
THE COURT: Mr. Hut.
MR. HUT: Your Honor, that is my submission and I

wanted to make it clear to the Court.
THE COURT: I know you do Mr. Hut and you have done that.
Mr. Hut, I didn't know but I asked your own client the question because I had no idea and he responded just as you said, there is no difference.
MR. HUT: No he said they meant the same thing.
THE COURT: Exactly. That is no difference to me, the same thing.
MR. HUT: Respectfullyfully, your Honor.
THE COURT: Mr. Hut you may wish to for whatever reason make your objection.
MR. HUT: It is not an objection.
THE COURT: And you have made it.
MR. HUT: It is not an objection.
THE COURT: Your own client answered my question so that I could be sure that he who is a provider says there is no difference. I think taking your standard he knows.
MR. HUT: He knows that they mean the same thing, your Honor. That is exactly correct.
THE COURT: And he did say is it.
MR. HUT: He did say it.
THE COURT: You may not likeT Mr. Hut, you may not like it. But your client found no difference.
MR. HUT: In exactly the same way that I represented

to colt Court.
THE COURT: All right, that's how you feel and that's fine. You now have it on the record and.
MR. HUT: Thank you, your Honor.
THE COURT: And we will proceed.
MR. HUT: Thank you, your Honor.
THE COURT: But your own client made the statement and I would suggest perhaps he knows more than you do.
Thank you, Mr. Hut.
(Continued on next page)
(In open court)
THE COURT: All right, next question.
MS. WOLSTEIN: Thank you, your Honor. I'm sorry, could I have the last question before the voir dire read back and the answer?
THE COURT: Certainly.
.

BY MS. WOLSTEIN:
Q. To go back to that last question, Doctor, do you have an opinion as to whether partial-birth abortion is preferable to other second trimester methods of abortion?
A. Yes, I have an opinion on that issue.
Q. What is your opinion?
A. My opinion is that considered in total, I do not see where

partial-birth abortion provides any benefit or less risk than other well-established methods of abortion.
Q. What is the basis for that opinion?
A. Again, it's based upon my sense of review of how the note note note extensivive review of how the procedure is done.
Elements of the procedure that I perform in other clinical settings, my understanding of available literature and my dealing with complications of pregnancy related potentially to abortion procedures.
THE COURT: Ms. Wolstein, is this a convenient time to take our morning break?
MS. WOLSTEIN: Yes, your Honor. It is a fine time.
THE COURT: Okay, we will take a break.
At this time the Court will stand in brief recess.
T
(Recess)
THE COURT: Please, be seated.
Ms. Wolstein, you may inquire.
MS. GOWAN: Your Honor may we approach the bench for a brief side bar? This is Ms. Gowan.
THE COURT: It's becoming a habit, but of course.

MS. GOWAN: Your Honor, the government would like to address Mr. Hut's statement to the Court concerning the use of the word abortionist in these proceedings. I would like to

note the term abortionist appears 15 times in the Supreme Court's decision in Stenberg and it appears in 10 other Supreme Court cases including Roe vs. Wade. It also appears?
Webster's.
ninth new collegiate dictionary at page 45 where the term abortionist is defined as someone who induces abortions.
Also, the government would note that it is a term that is commonly used in the English language.
THE COURT: Well I appreciate all that information but I think it's adequate for Court's purposes that a plaintiff in this action said that and abortion provider and abortionist are the same, therefore the use by the Court was taken to mean that it was in no way a derogatory to those who perform it.
I think we have spent more than enough time on this subject.
Also, would you be kind enough, both sides to check, since this subject of adequacy THOEUF-the question of expert witnesses, which you verify the Court's impression that Dr. Johnsonner performed a D&X?
MS. GOWAN: Yes.
MR. HUT: That's absolutely true, your Honor.
THE COURT: And he does testify.
MS. GOWAN: Yes, your Honor.
THE COURT: And the question of weight, but not prohibiting from testifying as an expert.

Okay, let's continue.
(Continued on next page)
(In open court)
THE COURT: All right, now that he with have gotten to know each other, can we proceed with the interrogation please, Ms. Wolstein?
MS. WOLSTEIN: Yes, your Honor. Wolstein.
Q. Doctor, as a general matter, and we will get to specifics afterward, why do you believe that partial-birth abortion is never medically necessary to care for women with complicated or high risk pregnancies?
A. My belief is based upon the fact that there are many other alternative procedures available with demonstrated safety and that this procedure does not have demonstrated safety and indeed, in my opinion, poses potential risks that are both immediate and potentially delayed and can threaten the mom's health and future fertility.
Q. Have you ever experienced a clinical situation where the partial-birth abortion procedure was required?
A. No.
I have been presented many case scenarios over the several years that I have been discussing this issue and have never encountered or been presented with a single case that I believe warrants this technique.
Q. Can you think of a single medical condition in a pregnant

woman for which partial-birth abortion is medically necessary?
A. I cannot.
Q. Doctor, is it sometimes necessary to terminate a pregnancy for maternal health reasons?
A. Sometimes it is.
Q. And do you provide care to women who need to end their PREG TPHAEPBs for health reasons?
A. Do I.
Q. Is that a common situation that presents to you?
A. It is common that we have women with worsening conditions that makes it necessary for us to deliver her baby prematurely.
Most times we can delay that until post viability but there are some instances where we have to proceed pre viability to her induction of labor and delivery of her infant to facilitate her recovery of her health status.
Q. And what are some maternal conditions that require termination of pregnancy to preserve the mother's health?
A. Well there are a number that could arise. Certain types of complicated card in that case conditions, certain types of complicated hypertensive or high blood pressure or preeclampsia situation. Certain types of infectious situations where there is an infection in the uterus.
Things of that nature.
Q. Is infection in the uterus sometimes referred to as chorioamnionitis?

A. Yes. That would be the medical term for infection involving the lining of the uterus and the bag of water.
Q. Taking the condition of chorioamnionitis or uterine infection, why is it necessary to terminate a pregnancy prematurely when a woman has that condition?
A. Well there can be two primary reasons. One is that a localized infection in the uterus can potentially become a systemwide infection spread throughout the mother which could then threaten her life.

In addition, the fetus doesn't thrive inside an infected environment so it is generally in the best interest of both parties to proceed to delivery.
Q. And you said something just a few seconds ago I want to pick up on, but when you need to terminate a pregnancy because of a maternal condition, do you approach that situation differently depending on whether the fetus is pre or post viable?
A. Yes. We do make some slight adjustments in certain medications that we would use or certain cervical approachs that we may make depending upon the interest of the fetus at that time. The fetal interests become less significant if the fetus is pre viable and the pregnancy needs to be delivered.
Q. So for a fetus that you've determined has a chance to survive outside the mother, how do you proceed in the case of chorioamnionitis?

A. Well we would do continual fetal monitoring during the laboring process. We would still attempt to augment her labor or assist her labor because women that have an infection in the lining of the uterus generally are already contracting and may in fact already be in labor.

And then we would of course use pain relief med cases for the mother that would have the least risk for the fetus which most often would be the use of epidural anesthesia, or selected types of IV narcotics or intravenous narcotics.
Q. And what do you do differently for a fetus that is pre viable with chorioamnionitis?
A. In the pre viable setting we wouldn't necessarily be doing continuous fetal monitoring. We have a little bit more leeway in the amount and types of pain medications that we could use. Those are a few examples.
Q. Post viable, how would you end the pregnancy for a woman with chorioamnionitis?
A. Post viable we would SKWRPBLly recommend induction of labor.
Q. Why is that?
A. Again, most times the women are already laboring so we are actually just augmenting their labor rather than inducing their labor.

We also want to deliver her in an expeditious manner with minimal risk for uterine trauma and minimal risk for

allowing the infection to spread to other portions of the mother's system.
Q. Would you ever need to do a D&X in that situation?
A. No.
Q. Would it be preferable to do a surgical termination in that situation?
A. No. We would attempt to avoid surgical procedures, if possible, in that setting.
Q. Why is that?
A. Again, we want to try to utilize the most natural physiologic process that we can for completing the delivery.
We also want to reduce the possibility of allowing infection to have access to other portions of the mother's system including her bloodstream and her abdominal cavity.
Q. Now, the condition of severe preeclampsia, is it necessary to end a pregnancy for a woman who has that condition?
A. Well preeclampsia does come in multiple forms, but in the case of severe preeclampsia that's not responding to our therapies, then we frequently have to move toward premature delivery, which, in some instances, even includes moving toward delivery prior to the point of viability.
Q. And how would you end the pregnancy in that situation?
A. Generally in the pre viable situation we would attempt to proceed with the medical induction of labor.
In the post viability situation we would proceed

similarly, as long as we felt the baby could tolerate the labor process. STKPWHRU said as long as the baby could tolerate the labor process?
A. Correct.
Once we are in the post viable time frame we have to consider the fetal issues as well as the maternal issues. And in preeclampsia specifically, babies can be not thriving inside the uterus because of the nature of the disease and may not tolerate even minimal uterine activity.
That that situation we generally to proceed with a caesarean delivery.
Q. Would you ever need to do a D&X in that situation of severe pre- eclampsia?
A. No.
Q. Would D&X ever be preferable for a woman with pre-eclampsia to end her pregnancy?
A. No.
Q. Why not?
A. One is that there are other options available, but I'm also concerned about any sort of surgical procedure, especially a blind vaginal surgical procedure because these patients frequently have a tendency toward bleeding with low platelets and potentially other sort of clotting abnormalities that would not allow them to tolerate any sort of cervical or uterine trauma or perforation.

Q. Well, Doctor, we heard testimony from plaintiff Dr. Cassing Hammond that partial-birth abortion could offer safety advantages for women with bleeding disorders and specifically low blood platelets and clotting problems; do you adisagree with that?
A. Yes, I do. I deal with preeclampsia on an almost daily basis an we have never seen the need for that procedure in order to provide safe care for the mother and her unborn child.
Q. And does preeclampsia involve PWHROEDing disorders or problems?
A. Severe preeclampsia can lead to low platelet counts and platelet dysfunction such that they don't clot very well.
It can also lead to other types of clotting disorders.
Q. Would a surgical termination ever be preferable in a woman with bleeding disorders or low blood platelets or clotting problems?
A. Only in the situation of trying to obtain an optimal outcome for the fetus, as well as for the mother, then a controlled abdominal surgery under direct visualization may be utilized, but I would never utilize a vaginal surgery, portions of which would be done blindly.
Q. Meaning a D&E?
A. Including a D&E or a D&X in that situation.
Q. And what would be the problem with doing a D&E or a D&X in that situation?

A. Both include some element of a blind intrauterine procedure, both include the need for cervical dilation and risk for cervical laceration and trauma. Both of which can lead to the risk of perforation, laceration and other bleeding complications for which this type patient would have a limited reserve and a limited ability to tolerate.
Q. You earlier in your testimony mentioned that you fake care of women with heart conditions during their pregnancy?
A. That is correct.
Q. I take it that covers a broad range of conditions, the term heart conditions?
A. Yes. We see women with a number of heart conditions and have a number of women with heart conditions right now that are PREG TPHAEPBT as part of our practice.
Q. And in some of the those cases can you manage the pregnancy to delivery at term?
A. Most of those cases we can support the mother through her pregnancy and achieve late gestational ages with the pregnancy. But we do see patients with all levels of complexity.
Q. And if it's necessary to the mother's health to terminate the pregnancy in the case of a heart condition, would it be necessary to use a partial-birth abortion method?
A. No.
Q. Would there be other more preferable methods?
A. Yes.

Q. Like what?
A. Well if it's in the first trimester we would recommend doing a suction and curettage or a suction aspiration or emptying of the uterus.
If it's in the more common situation that we would see of the later gestational ages, then we would recommend a medical induction of labor.
Q. Why would you recommend induction in that case?
A. For a number of reasons.
One is that we would be only moving toward a pre viable delivery if the patient's medical situation was so tenuous that she couldn't tolerate labor well. In that setting we would want to avoid anything that would cause uterine stimulation or uterine contractions, so we would want to proceed typically with a more controlled approach rather than an uncontrolled causing of potential trauma to the cervix so that most controlled approach would be to proceed with a medical induction under epidural anesthesia with critical care support present.
If we thought her situation was so severe she couldn't tolerate any uterine activity then we would generally recommend proceeding with a caesarian delivery and often times if a patient is that ill we will have discussed with them doing permanent sterilization at the same time, which would mean tying the tubes at the time of that caesarian delivery.

Q. Why would that be appropriate or necessary?
A. Well the types of cardiac conditions that I am referring to are those that generally aren't going to improve significantly in the next few years just because she's delivered of this pregnancy. Any future pregnancy would equally threaten her health and so it would be in her interest to not have any future pregnancy if it is that rare patient with that level of complex heart disease.
Q. We heard testimony from Dr. Hammond about cardio myopathy and valve you HRAR heart disease; are you familiar with those conditions?
A. I am.
Q. What is cardio myopathy?
A. Arrested could my open O think is a term generally used to describe a heart that is poorly functioning in the area of contract EULT or poor function as a pump.
Q. What is valve you HRAR heart disease?
A. Valve you HRAR heart disease means that in some of the critical communication areas between the chambers of the heart there is some problem with the valve. It can either be too leaky or it can be too narrowed.
Q. And is it necessary to terminate a pregnancy for a woman who has either of those conditions?
A. Well, we see patients with those conditions frequently and I have patients in my practice right now with those conditions.

Most of them can be supported easily throughout the course of their pregnancy, but there are levels of severity with all of those diseases.

So, for instance, someone with a cardio myopathy who is then evaluated with a heart ultrasound and found to have minimal cardiac function or heart pumping capability may be an indication for termination of pregnancy.

Or someone with a very critical, severe narrowing ing, specifically of the a or theic valve, what we call a or theic stenosis, if it is severe enough may also warrant termination of pregnancy.

Q. And in either of those cases of severe cardio my opathy or severe valve you HRAR heart disease that warranted pregnancy termination, would D&X ever be necessary?

A. No.

Q. Would it ever be preferable?

A. No.

Q. Why not?

A. Well in issues related to severe cardiac disease, the increased workload on the heart related to the pregnancy starts in the first trimester and starts to peak by 20 weeks' gestation.

So, if you want to do a procedure to spare the mother's health, you would want to do that in the first trimester preferably with a suction D&C procedure.

If the patient has continued the pregnancy and she's beyond 20 weeks and has just continued to worsen during the course of her pregnancy, then she would require a very controlled delivery process trying to use a variation of normal labor with critical care monitoring, potentially central line placement to evaluate her fluid status and fluid shifts very carefully. And again, we would want to avoid any untoward abnormalities like perforations or lacerations if at all possible.

Q. Now, Doctor, we have heard a lot of testimony about induction being less preferable in the case of women with prior uterine scars and we have heard about a scar from a prior classical c-section; where in the uterus is that scar?

A. Typically it would be on the top portion or the anterior surface of the uterus generally involving the majority of that surface, although there are also what we call low vertical inSR*EUGS cisions that just involve the lower portion of the anterior surface.

Q. What is the worry about doing an induction where there has been a classical c-section scar?

A. Whenever there has been a scar in the uterus it's an area of potential weakness. Most times that area of weakness tolerates future labors well without complication.

But in the sitting of a vertical or classical scar on the uterus it may increase the risk for that scar giving way up

to five to 10 percent of the pregnancies.
Q. In and your opinion is all induction contraindicated where the woman has a classical caesarian section scar?
A. No.
The rupture rate that I referred to of five to 10 percent is generally used for labors at term. In the mid-trimester when the uterus is thicker and doesn't require as much thinninggen TEU TP-S felt that the risk is probably less than that. Soy would recommend using caution in that patient, avoiding certain types of medications and having the capability to proceed to a corrective surgery if a rupture is indeed encountered.
Q. You would avoid using misoprostol in that scenario?
A. Yes.
There is a particular type of prostaglandin, misoprostol, that appears to pose a greater risk for uterine rupture, so I would avoid that prostaglandin in particular.
Q. Doctor, have you heard the term spontaneous abortion?
A. I have.
Q. What does it mean?
A. Spontaneous abortion is defined as a pregnancy loss that occurs without outside intervention prior to 20 weeks' gestation.
Q. Can you ever have a spontaneous abortion with a living fetus?

A. No. The definition of spontaneous abortion would be that the fetus is no longer living at that time. It may still be retained within the uterus and not expelled yet, but it, by definition, no longer has cardiac or heart motion.
Q. Doctor, do you have an opinion about the relative safety of D&Xs compared to other second trimester abortion methods?
A. I do.
Q. What is your opinion?
A. My opinion is that in total I am concerned that the D&X procedure doesn't offer any significant benefits and may indeed involve greater risk than other existing procedures.
Q. What are the aspects of the D&X procedure that concern you?
A. Well, there are both short-term or immediate and long-term or delayed concerns that I have with the procedure.
But my immediate concerns are the need for significant overdilation of the cervix that can increase the risk for laceration, bleeding and infection.
I am also concerned about the additional intrauterine manipulation that's required to convert a baby to a breach position in a limited uterine environment, meaning a uterus that's big enough for just one child.
I am also concerned about delayed complications as well, which would include the potential increased risk for cervical weakness in pre-term delivery with subsequent pregnancies.

Q. What is your basis for being concerned about longer term problems or risks?
A. Well, there has been proposed for some time that the more dilation involved in the cervix the greater the concern for subsequent increased rate of pregnancy lost with future pregnancies.
There also is an increasing body of evidence that shows that people that have even a minimal amount of cervical dilation as that, as in that required for a first trimester pregnancy loss have -- or pregnancy termination -- I'm sorry. Have a greater risk for preterm delivery or pregnancy loss with subsequent pregnancies.
So I'm concerned if we see that even from first trimester procedures we would see it with even a greater extent with those that require more cervical manipulation and those done at later gestational ages.
Q. And what kind of evidence are you referring to?
A. Well, for the first trimester pregnancy losses I did include an article in my expert report from, I believe the British journal of obstetrics and gynecology looking at the issue of increased risks for preterm delivery with people that had predominantly first trimester procedures.
And then in addition, I have also reviewed a pending article for publication that has limited numbers and limited power but shows a disturbing trend toward increased risk or

preterm deliveries specifically as a result of the D&X procedure.
MS. WIGMORE: Your Honor I object and move to strike the testimony about the pending publication.
This witness did not address it in his expert report. In his deposition he was asked about it and said that he had not read it and had not been told about it.
And moreover he did not provide a supplemental report as did the other doctors, at least one of the other doctors who testified about it here today or in this proceeding. Woman WOL name your Honor, Dr. Cook is not offering an opinion on the validity of the study or or is not critiquing the study, it is something that supports his opinion on the procedure that's at issue and that's about to become part of the mid call literature.
MS. WIGMORE: Your Honor, he was expressly asked about it, he did not disclose it. He said he had no read it. He did provide provide a supplementation to his expert disclosures and on those grounds I ask that his testimony be stricken.
THE COURT: He said he had eye concern about it before the report and now I am going to allow it. Overruled.
MS. WOLSTEIN:
Q. Doctor are you acquire that the plaintiff doctors in this case and their experts are claiming that D&X is safer than D&E because an intact extraction involves fewer instrument passes

and fewer passes of sharp fetal fragments?
A. I am aware of that assertion.
Q. What is your view on whether the claimed fewer instrument passes and fewer passes of sharp fetal fragments offer safety advantages?
A. Well, on the surface it would make sense that the less manipulation involved in the uterus the less the risk for complication. However, just passing an instrument isn't necessarily equivalent to having to reach inside the uterus and convert a baby or turn a baby to a breech presentation, which I would offer is a greater amount of intrauterine manipulation.
And again that doesn't take into account my concerns about the delayed complications and the cervical dilation issues. But intuitively you could say it would make sense to presume less passes could mean less complications of that narrow area of complication.
(continued on next page) TWM take 3 April 16<]
Q. Is there anything wrong with relying on intuition to draw these two safety conclusions?
A. Intuition or understanding of related medical issues is critical in the evaluation of new surgical techniques, meaning that it informs us of what potential complications may arise and should lead us to study those specific issues in order to then demonstrate the safety of a new procedure. You cannot intuitively assume the safety of a procedure without such

testing and then accept it as safe. So institution can inform how to further study something by presuming risk, but you cannot as safe in an untested situation based on your intuition alone.
Q. To the potential intuitive safety advantages of fewer instruments and fewer sharp fragments tell us anything about the overall safety of partial-birth abortion? [> do<]
A. No. It addresses just one particular area and one particular part of the procedure.
MS. WOLSTEIN: May I have a moment, your Honor?
THE COURT: You certainly may.
MS. WOLSTEIN: Thank you, your Honor.
Q. Doctor, I was asking you earlier about a lot of different maternal conditions and you were explaining. Rather than go over every maternal condition that we have heard about in the case, let me ask you generally, is there any maternal condition in the mother that you think necessitates doing a partial-birth abortion to preserve the health of the mother?
A. No, I know of no such condition. Again, I have been considering this issue for a number of years, I have talked to many individuals about this issue and have taken care of SHRAOUFL complicated pregnancies for more than a decade, and I have yet to find a single plausible scenario where this procedure would be recommended or the best procedure to proceed with.

Q. Thinking of all the maternal conditions you know about and have been presented with and can imagine from your practice and your knowledge, can you think of a maternal condition in which partial-birth abortion would be preferable to help in preserving the health of the mother?
A. No, I know of no such scenarios where it would be preferable over other well-established existing techniques. And, again, I have been presented with many scenarios.
Q. Turning to fetal anomalies or abnormalities, of all the fetal abnormalities you know of or you can think, is there a single fetal anomaly for which you think partial-birth abortion is necessary to preserve the health of the mother?
A. No, I know of no such situation where that would be required or even recommended.
Q. Or even recommended anticipated my next question. Is there any conceivable fetal anomaly that you can think of for which partial-birth abortion would be a preferable method for terminating a pregnancy to preserve the health of the mother?
A. No, I can think of no such condition.
Q. Is there any combination of maternal conditions and fetal anomalies for which partial-birth abortion is necessary or preferable to preserving the health of a pregnant woman?
A. No. Again, I have been asked this question many times in many ways over the years and the examples get to be a bit more bizarre each time. But I can think of no such situation where

that would be required.
Q. Doctor, what is the induction to abortion interval refer to [> what does<]
A. That refers to the length of time from initiating a medical induction of labor until delivery of the fetus.
Q. In your experience and your knowledge, what is the average induction-to-abortion interval. The average interval is approximately 12 hours, it may be shorter with newer types of medications with newer dosing intervals and dosing strengths.
S- S-
Q. Where do you come up with that 12-hour figure?
A. It is an active area of research, continuing to try to find the optimal KWEUPBGS of medications for medical inductions with the least amount of complications. So it is an area where there is quite a bit of literature out there. There are also many textbooks that you can refer to that will tabulate such data in a table form, and you can refer to any of those types of standard textbooks for that information. But it does seem to be continuing to improve to becoming a shorter and shorter interval.
Q. Is that partly due to the use of misoprostol?
A. Misoprostol has been an advance in that area, and other types of cervical preparation even prior to induction.
Q. Have you heard the term "failed induction"?
A. Yes.

Q. What does that refer to?
A. I understand that to refer to generally the situation where delivery has not occurred despite the use of some sort of medical regimen to attempt to induce labor.
Q. If you still have a failed induction after 24 hours so the fetus hasn't delivered, what would you do?
A. We do get asked about that situation, not infrequently, and generally I evaluate what the practitioner has been using for a medical regimen and will make additional recommendations. Most commonly it is the addition of an F series prostaglandin, which in my experience has been very successful at progressing to delivery typically within 6 hours of initiation after other failed techniques.
Q. One of the things that the plaintiffs are asserting in a case is a problem with induction is retained placenta [> in the case<] what is your view on whether retained placenta is a problem with induction?
A. It is a known side effect, if you will, of medical induction, occurring something on the order of 5 to 10 percent of the time, when the baby will be expelled but the placenta is not immediately forthcoming. In that situation we would also recommend trying different medical approaches first, such as an injection intramuscularly of a prostaglandin. Then, if there was still no delivery of the placenta, we would do a curettage or surgical removal of the placenta similar to that which is

used in a D&E procedure.
Q. If you have retained placenta after an induction, you would do just what you are doing with a D&E anyway, is that what you are saying?
A. Hopefully, it would deliver spontaneously and we would allow up to two hours before we would surgically remove it if the patient was stable. And during that two-hour period we would generally be using other medications. But in that situation if we still had no placental delivery or the mother was having more bleeding concerns, then we would proceed to a surgical removal of the placenta that is very similar to that which is done in a D&E procedure.
MS. WOLSTEIN: Thank you, Doctor. I have no further questions.
THE COURT: It is 12:208 2*8, so I think we will take our luncheon recess two minutes early. We will reconvene at 2 o'clock.
(Luncheon recess) TWM take 3A.
AFTERNOON SESSION
2:00 p.m.
CURTIS COOK, resumed.
THE COURT: Good afternoon. Ms. Wigmore, you may inquire.
CROSS-EXAMINATION S-

BY MS. WIGMORE:
Q. Good afternoon, Dr. Cook.
A. Good afternoon.
Q. You testified on direct that you perform induction abortions, correct?
A. That's correct.
Q. It is true, isn't it, that in only some of those induction abortions that you perform is the fetus live at the beginning of the procedure?
A. Yes, in only some of those situations is the fetus live.
Q. In that type of procedure where the fetus is alive at the beginning and you perform an induction only comes up once every few months in your practice, is that fair -FRPLTS I'm not sure that is correct, nor am I sure I understand the question.
THE COURT: Then ask that it be rephrased if you don't understand it. Would you rephrase it, please, Ms. Wigmore.
MS. WIGMORE: Sure, your Honor.
Q. Is it true that in your practice you perform procedures where the fetus is alive at the beginning of the procedure and you do an induction?
A. Correct.
Q. Is it true that that type of procedure is a procedure that you perform only once every few months in your practice?
A. It depends. Are we talking about before viability or are we talking about before and after viability?

Q. Viability aside, I am just asking whether the fetus is actually living before the procedure commences?
A. Then the answer is no. We do inductions on living fetuses almost weekly, if not more often.
Q. Doctor, could you refer, please, to your deposition in this case, which can be found at tab 3 of the testimony binder provided you earlier. I direct your attention to page 258 of that deposition., specifically to line 21 on that page. Do you have that?
A. Not yet.
Q. I am going to read that for you and ask you to follow along, starting on line 21.
"Q. OK. Now is it still the case that in your practice you do approximately 3 or fewer induction abortions per year where the fetus is alive at the beginning of the induction?"
Mr. Cappolino: Objection.
"The witness: I'm not sure it's that small, but it's not a large number. I just did one this week end but it probably comes ums once every few months."
Were you asked that question and did you give that answer?
A. I was asked that question in the setting of previability as I recall the question, and indeed that is the correct response.
Q. Is it true that you have not written any articles about the relative safety of different types of abortion procedures?

A. No, I have not written articles about the safety of abortion procedures.
Q. And you have not performed any clinical studies or research relating specifically to any method of abortion, have you?
A. Not to a method of abortion. I do research in other areas.
Q. In fact, abortion is not your primary research focus, is it?
A. That's correct, it is not my primary research focus.
Q. You have never peer-reviewed an article method *FR regarding a method of abortion, have you?
A. No. you are usually asked to peer review your areas of primary research.
Q. You testified on direct that the partial-birth abortion procedure is a blind procedure, is that right?
A. No. I think I testified that there are elements of the procedure that are done in a blind fashion.
Q. You are referring to what you called the blind use of instruments, is that right?
A. I would have to refer back to the exact language, but I can tell you which portions of the procedure I consider to be blind.
Q. What is that?
A. That would be when you are reaching up inside of the uterus to try to convert a baby to a feet-first breech position.
Q. It is true, isn't it, that you never actually observed a

live procedure that you would call partial-birth abortion?
A. The procedure that I observed by videotape, the fetus was alive when they were doing the procedure.
Q. Perhaps my question wasn't clear. You have never actually been present when a partial-birth abortion was performed, is that right?
A. That is correct.
Q. You told us you watched the video that was a video prepared by Dr. Haskell, is that right?
A. I understood it to be a video that he had prepared. He was the person doing the procedure in the video.
Q. You first watched that video when you were testifying in Missouri, is that right?
A. That is correct.
Q. It is true, isn't it, that the video did not provide you with an optimal view to make an assessment of the procedure, right?
A. That is not true.
Q. Could you refer, please, to page 235 of the NAF deposition transcript which is at tab 3 of your binder.
A. Which page again, please?
Q. Tab 3, page 235.
A. 235?
Q. Yes. I want to call your attention to line 1.
"Q. And when you watched the video of Dr. Haskell performing

this procedure, what portion of the fetal head or neck was punctured with an instrument?
"A. Well, the visualization of the tape, as I recall, was not optimal. It wasn't like there was a SAOPLD-in on just the baby and the peroh ne um, so it is not an optimal situation THO man aassessment. But it appeared to be somewhere this the back of baby's head. The baby was fine up and it was underneath the operator's hand.
Q. Were you asked that question and can you give that answer in your deposition, TKRRT?
MS. WOLSTEIN: Objection.
THE COURT: Where do you find that inconsistent with the testimony?
MS. WIGMORE: I understand, your Honor. It says the visualization was not optimal.
THE COURT: But it had other words in there limiting it.
Q. Was the visualization optimal in the tape that you observed, Doctor?
A. The answer I gave is in response to the question "What portion of the fetal head or neck was punctured." That portion anatomy makes up an entire area of a very few centimeters. My response was that you cannot make a distinction between the base of the skull or the back of the neck when the operator's hand is over that area based upon the videotape I reviewed. It

was quite clear what was going on in the videotape, which was easily identified as a partial-birth abortion as described by Dr. Haskell.
Q. Is it true, Doctor, that for teaching purposes in medicine you prefer actually being present to using videotapes?
A. No. We use a variety of methods for teaching, and videotape is one of the methods that we utilize in training programs and other training programs.
Q. Is it true that you find videotape teaching inferior to actually being present at the procedure?
A. No, I don't believe that I would agree with that.
Q. Can you please refer to your Missouri trial transcript, which is at tab 4 of your binder. I direct your attention to page 74. I am reading from line 16.
"Q. In teaching medical students, which do you find to be a better aid for teaching a medical procedure, a videotape of the procedure or drawings?
"A. Well, we use surgical textbooks to teach surgical techniques, but we find those inferior to videotape teaching, which we find inferior to actually being present doing the procedure."
Were you asked that question and did you give that answer?
A. Yes. That is the answer in response to how we teach medical students. We teach medical residents in a different

manner.
Q. The Haskell videotape that you observed did not show the process of inserting and removing laminaria, did it?
A. It did not.
Q. And there was no internal podalic version in the procedure you observed on the Haskell video, was there?
A. I cannot comment on that. There was visualization of the operator reaching their hand into the uterus, again a blind procedure as I had talked about previously. So without ultrasound guidance or visualization of the uterus, I could not know exactly what was going on inside the uterus.
Q. So you didn't see an internal podalic version in that procedure, is that right?
A. I did not see inside the uterus.
Q. So is it true that you have never actually observed an internal podalic version in the context of a partial-birth abortion?
A. That is correct, I have not observed a partial-birth abortion other than the videotape.
Q. You testified earlier that when you are colleagues perform D&E's that you provide ultrasound assistance on occasion, is that correct?
A. Yes, mostly in the years prior to the newer prostaglandins, where there was a greater incidence of a failed induction.
Q. When you do that, you are present at the maternal abdomen,

correct?
A. That is correct.
Q. From the maternal abdomen, you can't see what is happening in the woman's cervix, can you?
A. We can see what is happening at the level of the peroh knee um in the vaginal opening.
Q. Can you see the cervix?
A. No. I am not looking inside the woman's cervix at that point.
Q. Are you a member of right to life?
A. I am not.
Q. Are you a member of American Association of Pro life obstetricians and gynecologists?
A. Yes. That is a special interest group in the American College of Obstetrics and Gynecology.
Q. You testified on direct examination about a group called PHACT, PHACT, correct?
A. Correct.
Q. PHACT was founded in the summer of 1996, correct?
A. I believe that's correct.
Q. It was formed specifically to address partial-birth abortion, right?
A. It was formed only to address partial-birth abortion.
Q. In fact, supported legislation banning partial-birth abortion, isn't that right?

A. The purpose of the group was just to provide medical information. Is that the question?
Q. Did the group opposite -- did the group support legislation banning partial-birth abortion beings Doctor?
A. I believe it did. But the position papers were just about the specifics of the medical procedure.
Q. PHACT did not commission or fund any studies assessing the safety of the so-called partial-birth abortion procedure, did it?
A. No. It asked several academic physicians in dealing with complicated pregnancies to review the available medical evidence and render their best opinion about the specifics of the procedure.
Q. But there were no studies, right?
A. We did not perform any studies.
Q. You personal have not participated in any clinical studies relating to partial-birth abortion, have you?
A. I can't see why I would.
Q. You have testified in other lawsuits in support of partial-birth abortion bans, haven't you?
A. I have.
Q. You testified last week in the case in Nebraska, correct?
A. That is correct.
Q. You testified a few days ago in California, is that right?
A. That is correct.

Q. You testified in Missouri regarding a state law partial-birth abortion ban, correct?
A. Correct.
Q. You also testified in the Evans v. Kelley case in Michigan, didn't you?
A. That is correct.
Q. And you have submitted declarations in a few other cases, is that right?
A. I believe that is the case, yes.
Q. Is it true that you will be paid $500 per day by the government for your testimony in this case?
A. That is my understanding.
Q. You are also being paid $250 per day for any other work you perform on this case, is that correct?
A. I haven't been paid anything yet, and I have worked on this for a number of months, but they assure me they will.
Q. You are receiving similar reimbursement, or you hope to, in your other cases, the Nebraska case and the California case, correct?
A. Yes, I am always hopeful.
Q. You told us earlier that you testified twice before Congress regarding partial-birth abortion, correct?
A. That is correct.
Q. Isn't it true that you had a role in drafting the Partial-Birth Abortion Ban Act of 2003?

A. I was asked to give input, yes.
Q. You gave input on how the procedure could be defined, is that right?
A. That was part of the input, yes.
Q. Isn't it true that you suggested a definition that would limit the procedures covered to those performed after 20 weeks' gestational age?
A. That was one of the suggestions, yes.
Q. The reason for that suggestion was so that there would be no potential for misinterpretation that other surgical procedures such as D&E were covered, correct?
A. No, that was not necessarily the motivation for that suggestion.
Q. Are you saying that had no role in your suggestion?
A. No. I am saying I offered that because that was how the procedure was defined. Both Haskell and McMahon discussed it being used predominantly as a 20 weeks and later gestation procedure, so it seemed reasonable to include it. And at the time I had been spending a lot of time trying to address what I felt were disingenuous arguments being offered that it would somehow include miscarriages and first trimester spontaneous abortions. So I thought the easiest way to just practically dismiss that is to put a gestational age limit on it.
Q. Your suggestion was not followed, was it, Doctor?
A. I made many suggestions. Some became incorporated, some

did not. That was one that did not.
Q. You testified on your direct examination that you performed fetal surgery, correct?
A. That is correct.
Q. Some of the surgeries you perform on fetuses are invasive procedures, correct?
A. That is correct.
Q. Do you perform transfusions on fetusts, correct?
A. Correct.
Q. You also perform shunting procedures on STPAOETSs, is that right?
A. That we do much less often now, but I have in the past.
Q. In performing those procedures, you don't directly anes they advertise the fetus, do you?
A. That is not correct.
Q. Do you directly nes they advertise the fetus in all cases?
A. No. We do several things for the fetus. If we are going to do a procedure where we need to imPHOEBLZ the fetus, then we directly paralyze the fetus. If we are doing something just for an invasive procedure, then we deliver medications, both sedation and narcotics, through the mother in order to nes they size the fetus condition does it depend on the gestational age at all.
THE WITNESS: The doses we use are gestational age-dependent. For instance, when I give a paralyzing agent, I

give it based upon the estimated weight and gestational age, because there is a very nar owe therapeutic window for a fetus getting drug medication.
Q. But it is true that sometimes you medicate the mother with the intent that some of the medication will transfer across the placenta to the fetus, is that true?
A. That is true. If we were going to do an extensive procedure on the fetus, then we would treat the fetus directly. But most of the things we are doing are transfusions into the umbilical cord or else we are doing a sampling of a fluid cavity which would involve a 22-gauge needle, which is a smaller needle than you would have your blood drawn with in a laboratory and a smaller needle than you would have your IV started in your arm. In those situations we do not even nes they size the mother's skin.
Q. But there are some cases where you give anesthesia to the mother with the intent that it will reach the fetus, is that right?
A. The reason for giving medication is predominantly for maternal reasons. But a secondary benefit would be that the fetus would experience some of that medication exposure as well.
Q. Now, Doctor, you told us earlier that you have on occasion performed an abortion when the fetus was living before the procedure started, correct?

A. Correct.
Q. You have done that in cases where the fetus was not yet viable, correct?
A. Correct.
Q. In those situations the primary concern of the physician is finding the safest and most expeditious manner to separate the mother from the fetus and the placenta, right?
A. Correct.
Q. You said that you have never experienced a clinical situation in which the partial-birth abortion procedure has ever been necessary, right?
A. That is correct.
Q. You have told us that you don't perform D&E's after 20 weeks, correct?
A. No. I stated that I haven't done them, I didn't say that I wouldn't do them.
Q. If a patient comes to you and chooses to have a D&E after 20 weeks, would you refer that patient to another physician?
A. It would depend upon her clinical stability. If it was a patient where we felt that D&E was the safest and most expeditious manner to deliver her and she was otherwise unstable, then I would do the procedure myself.
Q. And in some cases you would refer the patient to another doctor, correct?
A. Yes. In a situation that there is no maternal concerns,

medical concerns, meaning predominantly in the case of an abnormal fetus, then we typically would refer that patient out, unless we needed specific pathology information.
Q. You told us, Doctor, that you practice in Grand Rapids, Michigan, is that right?
A. That is where we are based, yes.
Q. Is it fair to say that the population of Grand Rapids is roughly 200,000 people or so?
A. I don't know what the population of the city limits are. The city and out lying area is over a million, and our referral area goes as far north as the boundary of Michigan and the upper peninsula, as far west as lake Michigan, as far as east as mid state, as far south as Indiana. How many millions of people that entails, I'm not certain.
Q. Would you agree that Grand Rapids with is a smaller city than New York City?
A. I think I can grand you that, yes.
Q. By many of millions of people, isn't that right?
A. I don't know what the population is in New York. But I no, I that our referral area involves several million peoples.
Q. And it is true that TKPWRAPBDZ rapids is a STPHAERL city than Chicago, STPHAEUT?
A. TKPWRAPBDZ ran I said as a city is SPHAEURL than Chicago, yes.
Q. One of the things that you relied upon in forming your

opinion that partial-birth abortion is never required was a query you conducted of some of your colleagues, correct?
A. That was a portion of my opinion, yes.
Q. You PHREPBGSd that inure your expert report, don't you, Doctor?
A. I believe that I did, but I can review it to confirm.
Q. You talked to more than a dozen physicians in preparing your SPET report, didn't you?
A. I talked to them in preparation for all of my many times I have testified on this issue. I didn't necessarily requery a number of people just for the purpose of this expert report.
Q. So the questioneree that you mentioned in your expert report, when did you conduct that?
A. That has been done over a number of years since I have been testifying about this issue.
Q. You talked to more than a dozen physicians, correct?
A. Correct.
Q. To your knowledge, none of those physicians was an intact D&E provider, right?
A. That is correct.
THE COURT: What is an impact D&E, Doctor?
MS. WIGMORE: I said intact, Doctor.
THE COURT: Intact, oh.
Q. That is another word for partial-birth abortion in your view, is that right?

A. Yes. I understood that you were asking me do I know providers that do partial-birth abortions and have I K-D them about their experience.
Q. They were not part of your survey, correct?
A. They were not part of my informal survey, no.
Q. You said informal survey. You didn't do any kind of random sampling in the survey, did you?
A. Surveys are never random SAFRPLGS. But I never made a formal survey of any groups of patients or physicians.
Q. Among the physicians you talked to were three physicians from grand rapid, is that right?
A. They were some of the number, yes.
Q. You also talked to two from the University of Cincinnati, correct?
A. Two that are currently at the University of Cincinnati but weren't necessarily there when I first discussed the issue with them.
Q. You also talked to four individuals from the Louisville Kentucky yea, correct?
A. Yes, some of which may still be there, some of which may not.
Q. You talked to a couple of physicians from North Carolina, is that right?
A. If you are talking about Dr. Bowes and Dr. THORP, they are currently still associated with North Carolina.

Q. You mentioned Dr. Bowes. Dr. Watson Bowes, is that who you are referring to?
A. I am assuming, when you say North Carolina, those would be two of the individuals I would have talked to about this. Another is Dr. Mike McMahon, who is not Dr. Jim McMahon in California. But he is no longer currently living, unTPORBLT.
Q. So Dr. Watson Bowes was one of the people that you talked to in undertaking this query of other physicians about partial-birth abortion, right?
A. Yes. There are a number of people we would talk to and say have you ever seen a situation where you can imagine having to do a procedure like this, and universally the response was no, I can't think of a situation. In fact, when I was initially involved in this situation, many people approached me and said, why are you doing this? This doesn't happen, does it? Where is this happening? Questioning along those lines. That is what oftentimes led to our conversations.
Q. By universally, are you referring to --
THE COURT: Excuse me you one minute. When you say this doesn't happen, you mean partial-birth abortion?
THE WITNESS: Yes. When this first started coming to light, many physicians that I know in academic medicine and maternal fetal medicine couldn't imagine that somebody was doing this. So they were under the impression that it wasn't occurring. So they would ask me questions like, who's doing

this, where is this happening, why are they doing it? That is what oftentimes led to these questions.
THE COURT: Next question.
Q. By "universal I," are you talking about the more than dozen people you talked to?
A. Yes, that is what I am referring to, the people that I actually spoke with.
Q. Watson Bowes, he is another individual who is designated as a government expert in this case, correct?
A. I am not aware of all the people that were designated as experts in this case.
Q. You don't know if he was?
A. I know they has given testimony in other trials. I don't know if he gave testimony in this trial or not.
Q. Do you know if he gave testimony in California?
A. I believe that he did. I know that he did in Nebraska, I believe. But I was not present for any of the court proceedings in any of those trials except for the days that I gave testimony. I haven't reviewed any transcripts. Unfortunately, I have a quite busy life outside of this case, so I haven't kept as KHROE a track as I am sure you have.
Q. Dr. Cook, in performing your query, did you talk to any physicians from Columbia?
A. I don't believe that I did.
Q. Did you talk to any physicians from Cornell?

A. I don't believe that I did.
Q. You claim that partial-birth abortion is never medically necessary to preserve the health of the woman, is that correct?
A. That is correct.
Q. When you say a procedure is medically unnecessary, you don't mean that it is by definition unsafe, do you?
A. Sometimes I do.
Q. But not always, isn't that right?
A. No. When I say medically unnecessary i mean that it either doesn't add anything to our ability to care for complicated pregnancies: Either it doesn't make the procedure easier to do, doesn't make it less risky to do, doesn't make it more convenient or cheaper to do. If it doesn't meet at least one of those criteria, then I consider it unnecessary.
Q. It is true, isn't it, that a procedure could be safe but not medically necessary?
A. Yes, I believe that you could have a procedure that is redundant or doesn't add anything new and could still be potentially safe. But if it adds nothing further, then it would be unnecessary.
Q. It is your view, isn't it, that in and of itself lack of medical necessity doesn't indicate that a procedure should be band?
A. No, it doesn't need to be band just because it is redundant if a procedure is redundant. My concerns about the banning of

this procedure include not just the complication risk and not just the inhumane treatment of the fetus, but the fact that it doesn't serve any purpose and, more important, may cause harm. So that is why I have always summarized that opinion as never medically necessary.
Q. Doctor, isn't it true that reasonable physicians can disagree about whether a given treatment is medically necessary?
A. Yes.
MS. WOLSTEIN: Objection.
THE COURT: What is the objection?
MS. WOLSTEIN: Reasonable physicians. I am not sure what we are talking about.
THE COURT: Why don't you rephrase the question.
Q. Doctor, isn't it true that physicians can disagree about whether a given treatment is medically necessary?
A. Yes. When I have responded to your initial question, I think I answered both reasonable and unreasonable physicians can disagree. But yes, physicians can disagree.
Q. You also said that is why some patients seek second opinions, didn't you?
A. I did say that before, yes.
Q. You have performed D&E, as you told us, a few times, is that right?
A. That is correct.

Q. And you can't say that a D&E is ever the only option available in a given scenario, can you?
A. I am not sure I can say it is ever the only option available.
Q. It is true, isn't it, that there are some circumstances in which D&E may be the best option?
A. Yes, that is possible.
Q. Your most common method of abortion in your practice is induction, right?
A. That is correct.
Q. But you would agree, wouldn't you, that there may be circumstances in which D&E would be the preferred method for termination?
A. That is possible, yes.
Q. Is it true that one of the reasons you prefer induction over D&E is your view that induction can be done had in a controlled and monitored fashion?
A. There are many reasons I prefer induction in our patient population.
Q. Is that one of them, Doctor?
A. That may be one of them, yes, especially in a mother with a severe preexisting medical condition.
Q. Isn't it true, though, that D&E could also be done in a controlled and monitored fashion?
A. If a D&E was performed in the same scenario, the same

hospital setting, with the same critical care support people at a gestational age at which D&E is safely performed or could be safely performed, then yes, it is possible it could be performed in a monitored situation.
Q. You testified earlier today that labor in an induction procedure lasts 12 hours or less on average, is that correct?
A. Yes. I stated that by the current methods used for induction of labor, 12 hours or less is generally considered the average labor to induction interval.
Q. Doctor, I believe you have a copy of your expert report in the testimony binder in the front pact. I believe it is on the right-hand side in the pocket folder.
A. Yes, I have it.
Q. I want to call your attention to page 14 of that report, the second paragraph, last sentence. Didn't you say in your expert report that the average induction can be completed, including the time for preparation for the procedure, in 12 to 24 hours?
A. Yes, that is including not just the mean average but the two standard deviations, which means liberal they are delivered within 12, two standard deviations being 24 hours. So 12 to 24 hours I was trying to give the impression of what 95 percent of the deliveries are going to be included within. I also was trying to include in that cervical preparation, which may be done the night before.

Q. So an induction can take at least up to 24 hours, is that right?
A. The mean gestational -- the meantime from initiation of induction to delivery is 12 hours or less. If you ask me to include what would be the two standard deviations beyond, the the outer limit thereof, which would include 95 percent of the population, that would go to 24 hours.
Q. So there are some inductions that take 24 hours, is that right?
A. There are some that may take 24 hours and there are some that may take less than 12.
Q. Is it true that the process of labor can cause the fetus to die within the uterus during an induction?
A. That is possible, yes.
Q. That can happen as a result of contractions, can't it?
A. Sometimes it is not always clear why exactly that happens. It can happen because of a cord compression. It can happen because of a placental separation. Or it can happen because of contractions in a low-fluid environment. There are a number of reasons why it can happen.
Q. Doctor, you have testified that inif he can is more common for surgical abortions than for inductions, is that right?
A. I am not sure that is what my testimony was. I believe we were talking about certain types of complications that we could attempt to avoid in a situation of a medical induction versus a

surgical procedure.
Q. Do you believe there is any increased risk of infection in a D&E versus an induction?
A. I believe that the more dilated the cervix is, the greater the risk for infection.
Q. Is it true that D&E's are typically TPHEFRPLD an operating room setting?
A. You would have to define what you mean by operating room setting. Most of the ones that I am aware of take place in an off site clinic with no access to anesthesia, main operating Suite, critical care units, blood banking, or even antibiotics by intravenous administration.
Q. How many clinics that perform D&E's have you visited Doctor?
A. I am referring specifically to the clinic that I refer patients to in addition to descriptions of the settings that Dr. McMahon was operating in. Specifically, those were the ones that we initial reviewed their data.
Q. Are surgical procedures typically performed under sterile conditions?
A. Some surgical procedures are done in sterile situations, in some what we call clean situations, depending upon what portion of the body you are operating on.
Q. Induction abortions are typically performed in the labor ward, is that right?

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A. Inductions are typically performed in the labor ward, where we have on-site anesthesia and critical care equipment and critical care support people.
Q. Do you agree that placenta previa is a situation where you would potentially need to avoid labor?
A. Yes, that would be a situation where labor would not be optimal.
Q. The incidence of placenta previa can be as high as 5 percent in midtrimester pregnancies, correct?
A. That can be correct. However, that also includes those previas that are just partial in nature and just cover a portion of the cervix.
Q. Is it your view that a prior classical Cesarean section scar, which you discussed this morning, is not an absolute contraindication to an induction abortion?
A. Yes, it is not an absolute contraindication. It is a relative contraindication.
Q. You agree that the prior classical Cesarean scar increases the risk of uterine rupture, don't you?
A. It does carry auate run rupture rate as hey as 5 to 10 percent, yes.
Q. So that means if a woman has such a scar and undergoes labor, she has a 5 to 10 percent of her uterus rupturing, is that right?
A. Yes. If that would happen, then we have the operating

Suite on the labor and delivery unit, the anesthesia support people are there. It requires basically a variant of a Cesarean delivery. Rarely requires hysterectomy, usually just requires oversewing of the defect in the AOUPB rin wall.
Q. You just sew it back up?
A. Yes, just like a Cesarean incision.
Q. Isn't it true that you have been sued for malpractice?
A. I have.
Q. Were you sued for malpractice in a case related to uterine rupture, Doctor?
A. In a case relating to uterine rupture I was a fact witness, I was not a defendant.
Q. Is it correct that you have seen more than one case ofuate run rupture in your experience as a physician?
A. That is correct.
Q. How many?
A. How many uterine ruptures?
Q. Yes.
A. That becomes difficult, because there is a uterine dehisence where you have just separation of the scar in the uterus, and that is a common finding even at time of a repeat Cesarean in an unlabored situation. So if you strictly define uterine rupture to mean, as an editor of a journal would define it, that you have not only a disruption in the uterine muscle but extrusion of some fetal part or placenta through that

defect, then that is a much less common finding. But yes, I have seen several cases of that.
Q. Uterine rupture can be fatal, can't it.
A. Yes, it can be. I have never seen a case of that, but it certainly could be.
Q. Did you testify as an expert witness in a case involving a woman who suffered a fatal uterine rupture?
A. I don't believe I testified in a case of a fatal uterine rupture, no.
Q. You are familiar with retained placenta, aren't you?
A. I am.
Q. That occurs in at least 10 percent of induction abortions, is that right?
A. No, I would not say that is correct. It may occur in 5 to 10 percent. I am not sure that it is more than that. And it seems to be less than that with the newer use of prostaglandins, specifically misoprostol.
Q. Sometimes in an induction abortion it takes up to two hours for the placenta to deliver on its own, is that correct?
A. Yes, it can take up to two hours. That is the vast minority of cases, in my experience.
Q. Sometimes you need to use instruments to remove the retained placenta, correct?
A. Again, in the minority of cases, when they have failed our other medical managements, then we would remove the placenta

just like we would in a D&E procedure.
Q. Is it true that on two or three occasions you have been involved in an abortion where an attempt at induction failed and the procedure was convert to do a D&E?
A. Yes. Those are cases predom inability where I was the University of Louisville where other physicians had been attempting to induce the labor in the era before we had the newer prostaglandins that we use now, and I was asked to assist with their surgical procedure to empty the uterus thereafter. Most of those times involved me providing the ultras ultrasoundguidance for the procedure.
Q. You are aware of cases in which the fetus was partially expelled during the induction but the induction could not be completed without instruments, correct?
A. I am not sure that is correct. I have been asked to assist or else I have experienced myself a situation where you are doing an induction and the baby is delivered with the exception of the after-coming head, and I have been asked to assist in completion of the deliveries thereafter. The cases where I have had to use forceps on after-coming head have been cases where they have been post-viable and were trying to extract the about apy in a rapid fashion because of the compression on the umbilical cord.
Q. Do you agree that in some instances the fetus's head can get stuck in the cervix during an induction abortion?

A. Yes, that is possible.
Q. Is it your view that in that situation, if it is a nonviable fetus, the first preference would be to simply wait?
A. Yes. If it is a baby where there are no fetal interests so there is no need for immediate delivery because of compression of the cord, then I would suggest, when asked, that you immediately just wait, because the baby has the ability to survive if it is still living at that point for only a few minutes with complete cord compression. Oftentimes with spontaneous loss of life of the fetus and continued contractions, the remainder of the head will deliver spontaneously, generally within an hour.
Q. Is it your view that if you wait for the fetus to die, that the skull bones might collapse spontaneously?
A. Yes. One of the findings in obstetrics called a SPALDing's sign is a sign of overlapping sutures, which means overlapping bone fragments. That happens after a baby has no longer been living.
Q. One of the things you might do if the fetal head gets stuck in the cervix is to wait for the fetus's skull to collapse by itself?
A. No, I am not waiting for the cull to collapse. I am waiting for the baby to deliver spontaneously between the contractions the mother is having and the baby no longer living? That can take several minutes, can't it, Doctor.

A. Yes. If we felt there was a situation where a mother was unstable, then we make different steps. But in a stable mother we would just wait initially in order to minimize the invasiveness necessary to the mother.
Q. It is fair to say, isn't it, that the patients you treat are typically women in medically compromised situations?
A. No. My practice is pretty evenly divided between women that have preexisting medical conditions, pregnancies where there are fetal abnormalities, and pregnancies that develop obstetrical complications later in the course of the pregnancy.
Q. Didn't you say earlier, Doctor, that you would only be involved in performing the abortion if the mother was medically compromised?
A. Well, if you are talking about a pre-viable TWAEUGS, yes, I would only be doing it in a situation where the mother had some medical KPROPLGS. In a post-viable situation we are doing it regularly in a situation that we feel the pregnancy would be better served to be ended from either a fetal indication or a maternal indication.
Q. Let's focus on the pre-viable situation where you have begun an induction but the fetus's head gets stuck in the cervix. You have told us that one thing you will do is wait for several minutes to see if it works out, is that right?
A. I would say we wait for several minutes for the uterine contractions to continue and the baby to pass. It is not a

completely passive approach. It is allowing a natural process to ensue or continue.
Q. Have you referred to it as benign neglect, Doctor?
A. It is benign neglect on my part, meaning I am not doing anything to the mom directly that could potentially harm her. It doesn't mean that she is not doing something or that her uterus isn't TKOEUPB \{^}ing in\{^ning}.
Q. Doctor, do you tell the woman before the procedure that this is how you are going to proceed if the fetus's head gets stuck?
A. We do discuss with the patient, depending upon if it is pre-viable or post-viable, how we are going to manage the delivery if there is any problem with the after-coming head.
Q. Let's focus on pre-viable again. Do you tell the mother before the procedure that it is possible that while she is lying there in her medically compromised state, the fetus might get stuck in her cervix? Do you tell her that?
A. I'm not sure we tell her like that. We tell her that there is a possibility if she does not completely deliver the baby or the placenta, that we might have to do some additional procedures to help continue that process.
Q. Do you tell her that one of those procedures is to wait?
A. No. I generally tell her that it may include doing other surgical procedures, like suction removal of the placenta. She already understands that she is going to be contracting,

because we have an extensive discussion about what it means to have a medical induction. So I generally don't feel the need to say that she is going to have contractions and potentially more contractions.
Q. Do you tell her that one of the options she has is to have an intact D&E?
A. No, we do not.
Q. Is it true that another thing you might do if the fetal head gets stuck in the cervix is to provide nitroglycerin to the woman?
A. Depending upon the clinical situation, that is one of the many options we have.
Q. But nitroglycerin can cause a woman's blood pressure to drop, isn't that right?
A. That is why you have to be a physician to administer it. But we don't give it in a situation where a woman has low blood pressure concerns. Most people tolerate nitroglycerin very well even those with the complications we take care of.
Q. But you can't give it to every patient, can you, Doctor?
A. No, you cannot give it to every patient, particularly in our practice.
Q. Are you familiar with Williams obstetrics?
A. I am.
Q. You agree, don't you, that Williams Obstetrics is a reliable source of information in the field of obstetrics?

A. Having written book chapters in the past, there are frequently editorial errors in textbooks, so I do consider it a source. But I cannot necessarily attest to the reliability of all portions of the textbook because of human error issues.
Q. Have you ever testified under oath, Doctor, that Williams obstetrics is considered to be a reliable source of information in the field of obstetrics?
A. I usually try to qualify when asked that it is a source, and the reliability may be subject to human error because of the way textbooks are created. If I --
Q. Are you --
A. I'm sorry.
THE COURT: Please let him finish.
Q. I'm sorry. I thought you were finished. Please continue.
A. If I don't give that longer definition of what I mean by a reliable source, then I may, yes, agree to just it's a reliable source.
Q. Are you aware that Williams obstetrics states that the efficacy of nitroglycerin for fetal head entrapment has not been substantiated?
A. No, I am not aware of that.
Q. Another option that you would consider when the fetal head is trapped in the cervix would be to cut the cervix, is that right?
A. Yes. But going back to Williams obstetrics, we do use

nitroglycerin in that setting as described in other research trials in other clinical series. So this is a modality that we did not come up with on our own and is evidently used in lots of places besides our location. But I would be happy to review the Williams obstetrics reference to try to put it into clinical context, if that is desired by counsel.

Now you can put the other question.

THE COURT: Would you like to show it to the witness?

MS. WIGMORE: Perhaps his own counsel will give him the opportunity to do that, your Honor.

THE COURT: You are using it. I thought maybe you would like to have the witness complain.

MS. WIGMORE: If you would like me to, I would be happy to.

THE COURT: I didn't say that. I thought perhaps you might wish to.

MS. WIGMORE: Let's do that. May I approach, your Honor?

THE COURT: You may.

Q. Doctor, I have handed you what is the cover page and an excerpt from Williams obstetrics, and I want to direct your attention to page 525. Do you see the heading "Entrapment of the after-coming head"?

THE COURT: What is the date on this volume of the text?

MS. WIGMORE: 21st edition --

THE WITNESS: 2001.

MS. WIGMORE: The 2001. Thank you, Dr. Cook.

(Continued on next page) 4/16/04 Judge Casey take 2 cross examination of cook by Wigmore.

BY MS. WIGMORE:

Q. Do you have the section I referred you to, Doctor?

A. I do.

Q. Let me refer you to the second paragraph of that section. If you could just read that, please?

A. The second paragraph?

Q. Yes.

A. Some advocate the use of intravenous night RO glycerin in doses of 50 to 100 micrograms to effect rapid uterine relaxation. Its use has been reported to be of benefit for intrapartum external version of a second twin replacement of uterine inversion and removal of a retained PHRAGS TA.

And then there are several references of how it relaxes the uterus and allows you to do those procedures.

It then says. Its use for a trapped aftercoming fetal head with breech delivery has been suggested by Meyer and weeks, and then there is a reference, by robe inand associates, and then there is a reference.

And then it says, night RO glycerin, however, directly relaxes smooth muscle which constitutes only 15 percent of the

cervix. Then they give a reference for their 15 percent of the cervix. It goes its efficacy for fetal head entrapment has not been substantiated.
Q. Thank you, doctor?
A. Would you like interpretation of that what THAOEPBZ?
Q. KUBG proceed that on re?
THE COURT: If you want to finish your answer, Doctor, go right ahead.
THE WITNESS: What it means is there is reasonable clinical evidence as cited by other studies to suggest how it's effective in relaxing the uterus and allowing delivery to occur in other situations where we need to maintain an open cervix such as removing a placenta or replaceing what we call uterine inversion where the uterus falls out through the cervix and you have to keep the cervix relaxed and open so you can push the
uterus back up inside and through the cervix.
What it states is its suggestion, for those reasons, have also been made by at least two sets of investigators for relaxation of the fetal head with a breech delivery.
They then make their point that they think there is a limited amount of smooth muscle in the cervix and they list a single reference.
Then they say its efI can a is I has not been substance SHAEULTed which SKWEPBLly means they have not been

prove in a clinical trial or any randomized settling but there certainly is extensive medical support for at least considering its use.
Q. Doctor, is it fair to say that you make use of medical procedures whose effectiveness has not been substantiated in clinical trials?
A. Well its efficacy has not been substantiated. I don't see anything about its safety -BLG questioned.
Q. Now you were talking about another method you might use when the fetal head is stuck in the cervix, and that is KWUTing the cervix, is that right?
A. Yes. This same reference refers to TK*UR son incisions in that same context, I believe just the paragraph above, it goes, if on occasion in small preterm fetuses the incompletely dilated cervix will not allow delivery of the aftercoming head, then with gentle traction on the fetal body the cervix or at times the back of the baby's head can be manually slipped over and then they talk about a maneuver, I Brock maneuver may be tried.
It goes if these action maze not be successful then TK*URson incisions can be made knit cervix.
And then after that they discuss the KPWRUS of night RO glycerin.
Q. Dr. Cook, isn't it true that the TK*UR son incision that the trauma to the mother may be appreciable?

A. No, that's not true.
Q. May I approach the witness, your Honor?
THE COURT: You may.
Q. What I have handed you Doctor is yet another excerpt from the 21st edition of Williams obstetrics and I would like to call your attention to page 513 and specifically to the first full paragraph on the reasoned column and and in that paragraph I want to direct your attention to the -- actually let's just read aparagraph.
Q. Could you read that paragraph that I just referred you to, Doctor?
A. Beginning with the phrase with a preterm fetus?
Q. Yes. And if you could just read up to the word 27 weeks when you get there.
A. Okay.
"with a preterm fetus, the disparity between the size of the head, meaning the fetal head, and buttocks is even greater than with a larger fetus. At times, the buttocks and lower extremities of a preterm fetus will pass through the cervix and be delivered and yet the cervix will not dilate adequately for the head to escape without trauma.
And they give a reference.
Then they said: "in this SAEURBG stance, TK*UR SO*PBZ incisions of the cervix may be attempted.
Then it says, even so -- meaning despite those

incisions -- trauma to the fetus and mother may be appreciable and fetal hypoxia may prove harmful. Then they give a reference -- I'm sorry, then they end that sentence.
Then it says Robertson and colleagues observed no significant difference in the incidence of head entrapment by mode of delivery for breech infants at 28 do 36 or 24 to 27 weeks.
Q. Thank you, Doctor?
A. So there is nothing in that paragraph about TK*UR son incisions causing appreciable trauma.
Q. Excuse me, Doctor, but if you could refer back to the sentence beginning in this circumstance?
A. You're simply misreading the aparagraph, it goes --
Q. Doctor?
THE COURT: Let please let the witness finish don't argue where him.
THE WITNESS: It is a simple misreading of the paragraph.
It says in this circumstance, TK*UR son incisions of the cervix may be attempted.
Then it goes, even so, meaning so, despite that effort ebb, trauma to the fetus and mother may be aappreciatable and fetal hypoxia may prove harmful. This is all in relation to the trapped aftercoming head. That by no means is making a comment on did you remember son's incisions.

It is saying even if you do those incisions trauma to the fetus and mother may be appreciable.
If it wasn't saying that then how is a TK*UR son incision causing trauma to a fetus.
Q. Thank you, Doctor.
Now, it's true, isn't it that these discussions of TK*UR son's incisions in Williams obstetrics are referring to live births? WOL KWOL name objection.
THE WITNESS: My understanding is the --
THE COURT: Just a minute, what is the objection.
MS. WOLSTEIN: She has several pages here, if we can read enough to have him determine that then that's feign.
MS. WIGMORE: Your Honor, the witness seems adept at interpreting.
THE COURT: Please, ladies.
Read the whole section, Doctor, then we went have this dispute.
THE WITNESS: Well what I was going to say is.
MR. HUT: I.
MS. WIGMORE: I will withdraw the question.
THE COURT: Let him finish it, you started it. You can't pick and choose, Ms. Wigmore.
MS. WIGMORE: I'm hammy to have him answer, your Honor.
THE COURT: I'm sure you.

A. In the section I was asked to review it is only preferenced as preterm fetus it doesn't say if the fetus is alive or not alive.
BY MS. WIGMORE:
Q. Let's talk about a TK*UR sons incision and what it is. It is true that this is an incision in the cervix, correct?
A. It is a surgical incision in the lower portion of the cervix.
Q. And it can involve one to three incisions in the woman's cervix, right?
A. It can.
In my clinical situations that I have encountered I have never TPOUS it necessary to do more than one and it is very rare that we have to use it at all.
Q. You said before that you make from one to three incisions?
A. I was describing how the procedure it done.
Q. Now, an incision in a TK*UR son's incision can be up to two centimeters in length, is that right?
A. Generally it just involves the very lower portion of the cervix and that's generally a son O meter incision, could be more depending on how much relaxation you need.
Q. And you cut all the way through the completely effaced cervix, don't you?
A. Well that's -- that is not exactly correct in that the completely effaced cervix means just the lower portion of the

cervix.
Had a cervix is eface it had means when it is thinned out completely WH-FPLT a cervix then returns to its normal usual uneffaced position, then it is not the full length of the cervix, it's just the lower portion of the cervix.
Q. And you usually use scissors to cut the cervix, don't you, doctor?
A. Y, we usually use scissors that so that we don't risk trauma to the baby's head when making the incision.
Q. Well I'm talking to you about an abortion, Doctor. In that situation there is no risk of trauma to the baby's head, is there?
A. I'm talking about preterm deliveries of babies where their heads are stuck and some of those situations we are decidedly trying to preserve the fetus as well.
Q. Which is a reason you might want to did a TK*UR son's incision, right?
A. No. A TK*UR sons incision is in order to complete the delivery.
The manner in which I do a TK*UR son's incision may have to take into consideration the fetus.
Q. And, the TK*UR sons incision can be made with scissors, do you disagree with that?
A. No, I do not.
Q. And do you tell the woman before you perform an induction

abortion that you may end up slicing into her cervix with scissors?
A. No. We tell a woman when we are having to do a procedure like that what the procedure entails and what we are going to do.
In some something that occurs so rarely we don't usually discuss that in all induction as head of time.
If the issue comes up, which it does rarely, at that point we discuss that a TK*UR son incision may be required and what that means.
Q. When you say when it comes up, do you mean as she is lying there way fetus stuck in her cervix, that's what you tell her?
THE FOREPERSON: That's the situation that's exactly when we tell her.
A did you remember son's incision is nor more an extensive incision that we make with a normal epeas KWROLTy which we also don't normally discuss unless we are in a situation where we have to do abepeas KWROT my because most times with rible to STKPA.
Q. So you don't tell the woman before the induction that you might cut her cervix, right?
A. Generally, no.
Q. And do you always tell her at the time at which you are going to start doing it during the induction? Do you tell her before you do?

A. Yes, we do.
Q. And you tell her you are going to cut one to two cents meters into her SER EUFPL?
A. I say we are going to make a small incision are around the baby's head where the SER sheriff is make Holding the baby's helped you to allow completion of the deliver.
Q. Do you use the word incision?
A. I use the word cut or incision or whatever we generally what say what we are talking about that. We say make an incision with scissors.
Q. And do you tell her that another option at that point would be an intact D&E?
A. I do not.

It generally wouldn't be well received by my patients in that setting to say we are going to suck out the baby's brains.
Q. Well, how do you know whether it's well testified if you tell her you are going to slice up her cervix, Doctor. Because we generally had extensive discussions prior to this about her desire to maintain pregnancy or her concerns for her baby. Part of that process, which is an extensive process flew our office, is having them meet with a perinatal social worker and aggrieving a briefment person which is mandatory for those types of patients.

In that process they are told that there will be every

effort made to be able to deliver an intact baby to them and, if possible, to deliver a live born baby to them even if the baby won't survive, so they can optimize their ability to bond and hold their baby and if we sucked out the babe it's's brains and collapsed their skull and the face of the baby, I don't think that would be well received after we promised then the opportunity to be abled to bond with their child.
Q. Doctor, have you ever seen a fetus that was subject to an intact D&E?
A. I have seen children whose skull bones are collapsed many times.
Q. Thank you, but my question was, have you ever seen a fetus that was subject to an intact D&E?
A. Fortunately I have not.
Q. And it's a fact that before you perform an induction you do not tell the woman that you might cut her cervix, is that right?
A. We discuss with them all of the portions of the induction that are critical elements to performing the induction.

We also discuss with her those which are the most common complications that they may encounter.

We don't generally discuss with them every possible complication that's possibly conceivable, especially those in which they are very rare in occurrence and especially those that can be treated with variations of the normal delivery

process.
In a normal delivery process the cervix often times experience a small laceration to allow delivery of the baby's head and it's basically a SREURiation on what frequently occurs as a result of many normal deliveries.
Q. In cases where labor is in addition visable, would you recommend a hister rot O my over an intact D&E?
A. I would have to know the specific cases you are referring to, but if it's a situation where labor is intolerable because of a severe medical condition, then I would strongly recommend consideration for a controlled surgical procedure over doing something as untested and dangerous as an intact D&E procedure, particularly in a patient who already has medical compromise.
Q. Is it your view that a his rot my is safer than D&E between 22 and 24 weeks?
A. If you are asking me in the situation of a patient with a complex medical condition that does not allow her to undergo a child labor, then I am testifying here that a hysterotomy or caesarian delivery and controlled abdominal surgery is a safer procedure for her than an unproven, untested potentially dangerous procedure like D&X.
Q. Let's just talk about D&E, Doctor.
In a 22 to 24 week abortion which you view hister rot my as a safer approach than D&E?
A. I made no such statement.

MS. WOLSTEIN: Objection.
Q. You don't ma UFRPBLGTS I don't believe I made the statement that hysterotomy between 22 and 24 in universally applied situations taking all comers is a safer procedure than D&E. P-
If you would like to call TPAOEU to a sub population then I would be happy to answer that.
Q. Okay, let's take a woman with placenta previa.
A. Okay.
Q. In that situation, would you recommend hysterotomy over D&E?
A. Absolutely, without question.
Q. Isn't it true that the mortality rates for hysterotomy are much higher than those for D&E?
A. That is not a blankly true statement. You have to look at comparing similar case scenarios.
If you used hysterotomy as your primary source of abortion in otherwise healthy mothers and healthy babies then you would have a higher complication risk are hysterotomy.
If you applied hysterotomy to the situation where vaginal delivery is contraindicated, meaning absolutely contraindicated like placenta previa, then there would be no question in any reasonable physician's mind that I know of that hysterotomy would be safer.
Q. So if the physician disagreed with that he would be unreasonable, Doctor?

A. He would be in contra distinction to everything I have ever seen published or written on the subject of dealing with a placenta previa and effectively emptying the uterus.

It is considered something that is taught at the most basic levels of medical education that a placenta previa, complete placenta previa is a contraindication to vaginal delivery. And in fact is considered a contraindication to even doing a vaginal exam. And in fact is taught as a contraindication to even putting a speculum into a woman's vagina.

Q. Doctor, hysterotomy is a more complicated procedure than D&E after 18 weeks, isn't it?

A. I'm not sure what you mean by complicated.

Q. Have you ever said that hysterotomy is more complicated than D&E after 18 weeks?

A. Well, again I would be happy to review where I stated that and put it into context, but your context lacks the background for me to answer that.

Q. You have described hysterotomy as a last resort option for abortion, haven't you?

THE COURT: Do you have that statement?

MS. WIGMORE: Sure. Just trying to speed thing along your Honor but I would be happy to pre provide it.

Referring to your Missouri deposition, pages 42, Tab 5. And I'm starting at line 5

"Q after and note note note note and after 18 weeks how do you compare hysterotomy to D&E? Do you think it's more complicated?

"A it's difficult to say for certain. I think they're both complicated procedures at that gestational age but probably a hysterotomy is the more complicated procedure."

Were you asked that question and did you give that answer?

A. I was asked the question, as I understood it, in the context of all comers, not subsets of otherwise clinically medically compromised mothers in the setting of a healthy mother and a healthy baby then I say that that statement is very accurate.

Q. And hysterotomy is a last resort option for abortion, isn't it?

A. I think I've stated here that it would never be your first choice in a healthy baby and a healthy mother.

Unfortunately those aren't the patients that I care for and often times in our situations, particularly with a situation like a placenta previa or even more so of placenta accreta, hysterotomy is not only the preferred option, it is the only option.

Q. Have you referred to it as a last resort?

A. I may have referred to it as an option that is not our first option and it is an option that is used based upon the

clinical situation in the setting of placenta previa it is not the last resort, it is the first option.
Q. Hysterotomy is, it involves abdominal surgery, doesn't it, Doctor?
A. Yes. Hysterotomy is basically a caesarian delivery.
Q. But in distinction from a SO*EUS at full term the uterus is in a different condition in a midtrimester hysterotomy, isn't it?
A. I rarely perform a caesarean delivery at term because of what I do.
Most of the caesareans we do are performed prematurely.
Q. And I am focusing your attention for the moment on a midtrimester abortion by hysterotomy. Would you agree that if a hysterotomy is performed at midtrimester the uterus would be in a different condition than it would be at a full-term?
A. It would be in the same condition of most of the uteruses that I operate on. Most of the deliveries that we have to do caesarean deliveries done are done on premature babies, meaning that the uterus is thicker walled, less thinned out, frequently does not allow a low transversion PWAUPZ, the low he segment is not thinned out enough.
So HEUFT rot Mt. Is almost very similar if not almost the same as many of the caesarean delievery that I and many other maternal fetal medicine people have to perform.

Q. My question though Doctor was taking a full term caesarian section, taking the uterus at that stage versus the uterus at the stage of a midtrimester hysterotomy, you would agree that there are differences, wouldn't you?
A. The differences are minor and not substantive.
Q. Well it's true, isn't it, that with a hysterotomy at midtrimester you would most likely have to perform a vertical incision, right?
A. That is correct.
Q. And would you agree that a vertical incision has implications for the woman's ability to have vaginal deliveries in the future, wouldn't you?
A. As does a low transverse, that's why I said it doesn't differ substantively. It is still an incision in the anterior wall of the uterus, it still involves delivery of a baby through the anterior wall of the uterus, it still involves an abdominal incision on the PHORBLG. Still involves the same risk for bleeding an infection. Still involves the same recovery risk.
Q. You don't think there is any difference in risk in a subsequent labor for a vertical incision versus a tranverse incision?
A. I don't believe I ever stated that. I said I --
Q. I'm asking you now do you think there is a difference?
A. There is a difference in what would be a subsequent risk

for uterine rupture in a low transverse incision versus say vertical incision, yes.
Q. And it's true, isn't it that the vertical incision has a much high he risk of uterine invicinities than the transSHER in?
A. Less than 10 percent but it is higher than that for a low transverse incision.
Q. Now you claim that partial-birth abortion involves the use of an excessive number of laminaria, is that right?
A. Laminaria or dilators. I can't remember what I've stated.
Q. But you told us that you've never been present at a partial-birth abortion, right?
A. That is correct. That is based upon the testimonies that I reviewed of people who describe their procedures in great detail.
Q. That's Dr. Haas KET and Dr. McMahon?
A. That is correct.
Q. And those are from 1992 and 1995?
A. I'm not certain of the dates of the two but I'm sure that's about when it was, early to mid-'the 0s.
Q. When you watched the Haskell video, that video didn't address the preparation of the cervix, did it?
A. At least the portion that I reviewed, I don't believe that it did.
Q. You are not aware of any studies, are you, assessing

whether the use of osmotic dilators in the second trimester abortion increases the risk of cervical incompetence in subsequent pregnancies?
A. Actually this has been suggested for decades as a concern and there are some smaller data sets that do suggest that those people that have second trimester terminations with greater amount of cervical TKHRAEUBGS are at higher risk for preterm delivery. That's even been attested to by people who are well known researchers in the area of abortion.
Q. Doctor, are you aware of any study of the impact of osmotic dilators in second trimester abortions?
A. I believe that they exist, yes.
Q. Could you refer, please, to tab 2, your testimony from the Nebraska trial? Page 1442?
A. I'm sorry which tab is that?
Q. Tab 2.
A. And the page number one more time?
Q. 1442 and let me get you the number, there are numbers on the bottom, I will get that for you as well. It goes from page 172 to 173 on the bottom.
And I want to direct your attention to line 18:
"Q I don't remember what question it was in response to, is that your belief that there is no study of the impact of osmotic dilators in second trimester abortions, Doctor?
"A I don't know that there is any study specifically

looking at the issue of osmotic dilators. There are studies looking at the issue of having had a procedure or not having had a procedure, having had multiple procedures and having had later procedures."

Were you asked that question and did you give that answer, Doctor?

MS. WOLSTEIN: Objection.

THE COURT: What's the objection?

MS. WOLSTEIN: I don't think it's proper impreachment, it's not.

MS. WIGMORE: It's totally inconsistent with what he said, your Honor, he said there is no --

THE COURT: Please. I will allow the answer to the question.

THE WITNESS: I don't know if I can state that the studies that I'm aware of specifically limit the subject population to only those dilated by osmotic dilators. I was trying to be very precise in that response. I understood your question to imply the idea of the cervical dilation and overdilation as was the preference to the questions.

If you are asking me not looking at the issue of dilation but only looking at how they dilated, there may be studies about that, there may not be. I cannot directly give you a study where I know that every subject was dilated only by osmotic dilators.

I know that that is still the commonly used method so I would say there probably do exist studies that have looked at the issue of having second trimester terminations in increased risk for later poor pregnancy outcomes, meaning preterm delivery, where either osmotic dilators were used completely, solely or at least predominantly.

But I don't don't know that was ever the subject matter only of any study that I reviewed, meaning osmotic dilator ORZ being the subject matter.

I was looking more at the issue of cervical dilation and overdilation being my area of concern.

Q. Thank you, Doctor.

Isn't true that other things being equal, you would need more cervical dilation to perform an induction abortion than you would need to perform what you would call a partial-birth abortion?

A. Well, again, the issue is not just how much dilation you eventually achieve, it's also how you get to that amount of dilation.

If that dilation occurs as a result of normal uterine activity, then you achieve more dilation when you deliver a normal baby at term than you do with any of these procedures.

However, that's not my concern.

My concern is doing something artificially to the SER SR*EUFPL SREUFPL that requires five to six centimeters of

dilation more than I have known people to use for a regular D&E procedure, certainly more than is used for a first trimester pregnancy termination procedure.

It is that issue that concerns me and there is data to support that that is a reasonable concern.

MS. WIGMORE: Your Honor, I would request that the witness be instructed to answer the questions put to him.

This was done with witnesses for our side, he did not answer my question. He has been giving speeches I know you don't want me to interrupt him but there has to be some level of control here and I ask that he be so instructed.

THE COURT: Ma'am, overruled. And your analysis is not accurate. You've asked and you got your answer you just, whenever you don't like the answer you decide it's not responsive to you.

MS. WIGMORE: Well I respectfully disagree, your Honor.

THE COURT: Next question.

BY MS. WIGMORE:

Q. Well let me just ask this question because I don't believe I got an answer, sir.

Isn't it true that all things being equal, you would need more cervical dilation to perform an induction abortion than a partial-birth abortion? Yes or no?

A. No.

Q. In a partial-birth abortion there is a step of reducing the size of the fetal head, right?

A. Correct.

Q. And that's not typically done in an induction, is it?

A. Correct.

Q. And it's your opinion that induction involves dilation of the cervix through a natural and physiological process, is that right?

A. That is correct. It uses uterine contractions to cause cervical change.

Q. But isn't it true, Doctor, that you typically use prostaglandins to help dilate the cervix for an induction?

A. No. We use PROZ prostaglandin to induce uterine contractions which then subsequently dilate the cervix.

Q. So the prostaglandins initiate the process whereby the contractions occur, is that correct?

A. That is correct.

Q. And the uterus doesn't simply contract on its own before the prostaglandins are at it, is that right?

A. Generally, no.

Q. And that's why it's called an induction, right?

A. You are catching on.

Q. Thank you, sir.

Now external chemical agents are used as part of the induction process, correct?

A. External chemical agents?
Q. Yes.
A. I'm not sure what you mean by that terminology.
Q. The prostaglandins, are they chemical agents?
A. I guess we consider them pharmaceutical agents.
Q. They don't come from the mother, they come perfect a farm soot KWAL company, right?
A. Yes. They're exogenous agents ORLG agents outside the mother.
Q. Isn't it true that you have never personally cared for a patient with cervical incompetence that you believed was directly caused by a partial-birth abortion?
A. I have not provided direct care to such a patient. I have been contacted by such a patient.
Q. You have seen numerous patients with cervical incompetence, haven't you?
A. I have.
Q. And it's true, isn't it, that there is no way of knowing for sure what is the cause of cervical incompetence?
A. No, that is not true.
Q. For women who experienced cervical incompetence after mid-trimester abortions, is there any way of knowing what the cause of the cervical incompetence was for sure?
A. Well if I'm understanding your question, there are known risk factors for cervical incompetence. Part of our treatment

of a patient with a history of possible cervical incompetence is to see if we can elicit a his rethat would be consistent with that.

The reason that is is important is because it has to do with how we treat her with subsequent pregnancy. Not everyone who deliers prematurely had cervical incompetence. Some had premature onset of labor.

So, if we place a stitch in a cervix and a patient only had preterm labor, it won't be beneficial.

So it's apparent that we -- or it's imperative that we find out why I patient had a pregnancy loss and to the best we can throughout if it seems STKPWHREUFRPBLGTS figure out if it seems to be related to known risk factors. Pregnancy terminations are known risk factors.

If we had a patient who had a history of prior pregnancy loss that had been preceded by pregnancy terminations, typically two or more first trimester procedures or one or more second trimester procedures, we would be much more likely to want to place a cervical cerclage in that patient to prevent preterm delivery with subsequent pregnancy.
Q. Would you agree, Doctor, that if a patient had premature rupture of membranes in one pregnancy that patient would be at a greater risk to have premature delivery in a subsequent pregnancy?
A. Generally that's the case, however it depends why they had

premature ruptured membranes.
We have patients frequently who they're -- who experience early ruptured membranes because they had vaginal bleeding from something called a sub chorionic hematoma, or a blood clot underneath the bag of water. That's felt not to be a recurring risk factor.
We have people that have water that breaks prematurely because of external abdominal trauma, like in a car accident. That hopefully is also a non-recurring risk factor.
But if we KW-PB identify the risk factor, that population probably had a a higher risk with subsequent populations.
Q. Is it true that you have seen cases of cervical incompetence where you cannot identify a preexisting risk factor?
A. That is true.
Q. Now, in forming your opinion you cited two articles in your expert report examining the risks of cervical incompetence, is that correct?
A. That's not correct.
Q. You did not list two articles in your report about cervical incompetence?
A. I listed three articles and I listed those articles in support of the whole expert report. I don't remember stipulating that I felt these articles were in support of

cervical incompetence alone.
Q. Now, one of the articles that you cite in your report is an article by ah due, did I pro PHOUPBS that correctly?
THE COURT: Do you accept that, ma'am? Are you misreading what the report says.
MS. WIGMORE: I think there was a misenergyings I wasn't suggesting there were only two.
THE COURT: Sure sounded like it to me.
MS. WIGMORE: There are three articles cited in your report --
THE COURT: And you also limited it to the ones subject. I hope you wouldn't mislead.
MS. WIGMORE: I don't believe I was.
THE COURT: Sure SHOUPBDed like it.
A. It the third article in your report, Doctor, does that relate specifically to the risks of cervical incompetence from abortions?
And let me give you a precise cite?
A. I don't recall which order I listsed articles.
THE COURT: Show him the roar and ask him.
MS. WIGMORE: I'm doing that, your Honor.
If you will look at the report, it is page 15?
A. I have it.
Q. Page SA, beginning at number 5 there are three articles listed, the first is an article by Henryet, correct?

A. Yes beings number article number 5.
Q. Yes?
A. The first SARL by Henry AET.
Q. And the second is ah due how do you pronounce that?
A. That's my understanding STKPWH-FPLT.
Q. And then the third article is by KHA*EUPB?
A. KH*EZ.
Q. That article, my understanding at HROEFT but correct me if I am wrong, that SARL doesn't address the specific issue of cervical incompetence caused by or allegedly caused by abortion, am I wrong about that, Doctor?
A. You are not WROBG wrong about that but none of the articles were supporting cervical incompetence, they were supposed to support increased risk for preterm delivery with subsequent pregnancy.
Q. And is it true that with respect to that issue you relied on articles five and six in forming your opinion?
A. Well what I did was list articles that I thought were supportive and also consistent with that testimony.
Q. Let's talk about the article by A*U due.
Isn't it true that that article does not stand for the proposition that you originally thought it did?
A. Yes, that is true.
Q. The ah due article defines midtrimester abortions to include any delivery before 24 weeks of pregnancy, correct?

A. Yes. The article includes a smaller number of induced abortions than I had originally KWRRD since they kept using terminology mid-term or mid-trimester abortion to include also spontaneous losses.
So, in the further review of that article, it doesn't shed a lot more light on THEURB but it certainly doesn't contraindicate anything in the expert report.
Q. Now it's true that only seven of the 141 women in the adew study had induced abortions of any kind, is that right?
A. Yes. I believe I stated it was a very small number and essentially was not informative for the purposes of this report.
Q. And those abortions were D&C abortions, correct?
A. That is my understanding, yes.
Q. So that article doesn't tell us anything about the relationship between partial-birth abortion and subsequent problems in pregnancy, right?
A. Yes. I believe I have stated now several times I consider it now noninformative but not contradictory to anything I have stated in the report.
Q. Let's talk about the --
THE COURT: Is this a convenient file, Ms. Wigmore, to take our afternoon break?
MS. WIGMORE: Certainly, your Honor.
(recess).

THE COURT: You may inquire, counsel.
MS. WIGMORE: Thank you, your Honor.
Dr. KWAOBG, we were talking before the break about some of the articles referenced in your expert report. You mentioned that the Henry AET STUT KWREUDZ was another one you relied on in forming your opinions, is that correct?
A. That is correct.
Q. And that article, isn't it true that the data set that formed the basis for that study included predominantly first trimester pregnancy terminations?
A. Yes.
Q. Are you familiar with mechanical dilation?
A. Yes.
Q. Is mechanical dilation used in the first try most STPHER?
A. Yes.
Q. Are you familiar with a study by Robb inKalish and others entitled impact of midtrimester dilation and evacuation on subsequent pregnancy outcome?
A. I believe I have seen it, yes.
Q. You were shown that article during your testimony in Nebraska, is that right?
A. I don't recall. I may have been.
Q. And the objective that study was to eSRAPL indicate obstetric follow up from second trimester D&E procedures, correct?

A. I wouldn't be able to answer very accurately without seeing the article in front of me as you ask me questions if that's possible.
MS. WIGMORE: Your Honor, may I approach.
THE COURT: Show the witness the article.
THE WITNESS: Thank you.
Q. Dr. Cook I have marked -- I have handed but what's been marked Plaintiff's Exhibit 55, have you seen this document before?
A. I believe that very, yes.
Q. Is this the Kalish study we were just speaking about about?
A. Yes.
Q. And if you could refer, please, to the reasoned column on the first page, second paragraph, that paragraph reads. P few studies have specifically addressed future obstetric outcomes after midtrimester abortions by D&E. The objective of the current study is to evaluate obstetric followup from second trimester D&E procedures performed at the New York Weill-Cornell medical center.
Does that refresh your memory about what this study addressed, Doctor?
A. Yes.
Q. Doesn't this study conclude that there was a significant negative correlation between pre-operative cervical dilation and spontaneous preterm birth?

A. No, I don't recall that being the primary objective of the study.
I understood the objective of the study was to see what the risk factor was for subsequent pregnancy loss.
Q. Was that a finding that the authors made, Doctor?
A. Can you refer me to where you are talking in this article?
Q. Certainly. If you could refer to what's marked as page 884, I believe it's the third page of the article in the first column, second paragraph, would you just read that paragraph for us, please?
A. Starting gestational age?
Q. Yes.
A. Gestational age at D&E and pre-operative cervical were significantly correlated.
Patients at more advanced gestational ages at the time of D&E had greater dilation achieved pre-operatively there was significant negative correlation between pre-operative cervical dilation and spontaneous pre TPERPL birth. In patients who had subsequent preterm delivery there was a trend toward less pre-operative cervical dilation compared with patients delivered after 37 weeks.
Q. Thank you, Doctor.
And did the authors of this study also find that second trimester D&E at later gestational ages appears to be associated with a low are risk of preterm birth and subsequent

pregnancies compared with D&E per TP-RPLD at earlier gestational ages?
THE COURT: May I have that questioned read again, please?
(record read).
THE WITNESS: No, I don't believe it has established that with this article.
Q. Can I refer you, Doctor, to the same page we were just looking at, 884, and to the right hand column, second full paragraph beginning, "an unexpected," could you read that sentence for us, please?
A. Sure.
"an unexpected finding was that second trimester D&E at later gestational ages appears to be associated with a lower risk of preterm birth in subsequent pregnancy compared with D&E performed at earlier gestational ages."
Q. Thank you.
Dr. Cock, in the induction abortion procedures you have performed, have you ever used digoxin or KCL to induce fetal demise?
A. Very not.
Q. And you have always considered that unnecessary, haven't you?
A. Yes, I have considered that unnecessary.
MS. WIGMORE: Thank you, I have no further questions

at this time.
THE COURT: Counsel, any redirect?
MS. WOLSTEIN: No, your Honor.
THE COURT: Pardon?
MS. WOLSTEIN: No redirect, your Honor.
THE COURT: No redirect.
All right, Doctor, you may step down.
THE WITNESS: Thank you.
THE COURT: Ms. Gowan, do you have any other witnesses?
MS. GOWAN: No, your Honor. At this time we would like to move into evidence certain of the exhibits that the government has marked in this case.
THE COURT: All right.
MS. GOWAN: Your Honor, almost all of these exhibits, the admissibility has been agreed to by the other side side but there are a few that has not.
What I would like to do is just go through the exhibits in order and then as we have reached the ones that have been objected to we will state our basis for an admission and I will note the objection by counsel.
The government moves the admission of Exhibit E 2, which is a document entitled the role of receive no centesis in modern obstetrics, Stephen Chasen is an author of the article. Plaintiffs have objected to the admissibility on the ground of

relevance.
The government submits that the article sin deed relevant, it deals with hydrocephalous and the importance of cephalo centesis which is a proper procedure to drain fluid from the head, head RO cephalous certainly has been much discussed here at trial, as has receiveal although centesis?
THE COURT: Do the plaintiffs wish to argue this or just note their objection and move on.
MR. HUT: We will note our objection, your Honor, and note that there is much in the article if the government wants to proffer certain portions of it that's fine, but to admit the whole thing goes beyond what is fairly relevant.
THE COURT: I think being a non-jury situation I don't have a problem with that.
It will be received.
(Government's Exhibit
MS. GOWAN: The government moves the admission of Exhibit J-8, which is a clinical training curriculum in abortion practice copyrighted by the national abortion federation 1995.
Plaintiffs object to this on the grounds of hearsay and relevance.
The government asserts that this is an admission pursuant to Rule 801 D 2A and B by plaintiff National Abortion Federation.

THE COURT: Mr. Hut?
MR. HUT: We have the same relevance objection, your Honor. It is also hearsay. The fact that it was copyrighted by NAF is without probative value. The authors are people who are not NAF.
MS. GOWAN: If I just may add.
THE COURT: It will be received.
(Government's Exhibit
MS. GOWAN: What I would like to do is just read, very briefly, a few facts that appear in Government Exhibit J-8 in evidence.
THE COURT: Very well.
MS. GOWAN: On page 73 under the section D&E procedure, item B, "many clinicians believe that late D&E (greater than 20 weeks) is more easily and safely performed by inducing fetal demise one or two days before the procedure. This may be done with ultrasound guided injection of intrafetal digoxin or potassium chloride."
Reading from page 85 of Government Exhibit in evidence J-8 the page is titled management of abortion complications, Second 1RBGS immediate complications less than 24 hours from beginning of abortion. A, bleeding. 2 -- that's item 2, incidence: 0.3-1 percent.
Reading from page 91 of Government Exhibit J-8 in evidence under the section delayed complications (24 hours to

four weeks) A2. "retained products of conception A, incidence equal 0.5 to 1 percent."
The government moves the admission of.
MR. HUT: Excuse me, your Honor. Had we known, had we known that which specific exhibits were going to be offered over objection we would have reviewed the specific exhibits in advance of today's trial session in order to designate possibly specific components that need to be read into the record in the interest of completeness pursuant to Rule 106. We did not have the opportunity, I would like to reserve that right.
THE COURT: Whoa, whoa, whoa. WRAEUPLT.
You knew these were marked as exhibits, were going to be offered by the government. You noted your objection. Presumably some place you note you had your objections.
MR. HUT: We have noted our objections, your Honor.
THE COURT: We aren't doing this a second time, so.
MR. HUT: The question is completeness, your Honor . We did not -- there are 273 exhibits marked by the government. They're not all going to be offered here and I don't think it is incumbent on the plaintiffs to have reviewed all 273.
THE COURT: You don't?
MR. HUT: I do not, to be prepared to designate.
THE COURT: Well I don't know where you tried your cases before but if they're listed as exhibits I sure as heck would have looked at the exhibits.

And if you looked at them sufficiently to object to them then you must have had a reason.
MR. HUT: We do have reasons and we have stated the reasons, your Honor. We did not counter designate completeness portion you but we women do it since they are going to be admitted ewill could it on our rebuttal case.
THE COURT: We will see if there is a rebuttal case. You will TE tell me what it is that you wish to offer and we will see if it qualifies as rebut we will decide that.
I hope you let me know soon if you desire to do such a thing.
MR. HUT: We reserved the right last Friday, your Honor.
THE COURT: I know you reserved it, Mr. Hut.
MR. HUT: We are certainly going to let you know this afternoon as soon as Ms. Gowan finishes there are housekeeping matters the plaintiffs wish to take up. I think the government does as well.
THE COURT: Fine.
MS. GOWAN: The government moves moves the admission of Government Exhibit K-4, National Abortion Federation clinical policy guidelines for 1997. No objection interposed by plaintiffs.
MR. HUT: No objection asserted here.
MS. GOWAN: Your Honor, should I move O on, is it

received.
THE COURT: Yes, it is received. There is no objection, it is received. If you want to hear the words, yes, it is received.
(Government's
Exhibit
MS. GOWAN: Government Exhibit K-National Abortion Federation clin cam policy guidelines 1998 no objection pretrial order.
MR. HUT: No objection.
THE COURT: Received.
(Government's Exhibit
MS. GOWAN: Government moves admission of clinical policy guidelines for NAF 1999 Government Exhibit K-6 no objection in the retrial order.
THE COURT: It will be received.
MS. GOWAN: Government moves admission of NAF clinical policy TKPWHRAOEUPBZ 2000, Government Exhibit K-7, no objection in the pretrial order.
THE COURT: It will be received.
(Government's Exhibit
BY MS
MS. GOWAN: Government moves the admission of Avenue clinical policy TKPWHRAOEUPBZ 2001 Exhibit K-8 no objection in the pretrial order.

THE COURT: It will be received.
MS. GOWAN: Government PHOFRBZ the admission of NAF clinical policy guidelines 2002 Government Exhibit 11, no objection in the pretrial order.
MR. HUT: I'm sorry, what number?
MS. GOWAN: L.
MR. HUT: You said 11, L.
MS. GOWAN: Government Exhibit L.
THE COURT: It will be received.
(Government's Exhibit
MS. GOWAN: Government move the admission of National Abortion Federation 2003 clinical policy guidelines, Government Exhibit L-1. No objection in the pretrial order.
THE COURT: It will be received. Government Exhibit Government Exhibit.
MS. GOWAN: I would like to very briefly road R* read a few items into the record from Government Exhibit L-1 in evidence.
THE COURT: Go right ahead.
THE COURT: How many exhibits are you putting in this afternoon, offering in evidence?
MS. GOWAN: I think your Honor I just have a couple more.
THE COURT: Fine. I just wanted to have a general idea.

MS. GOWAN: Reading from page 3 little I, National Abortion Federation 2003 clinical policy guidelines introduction. "like its pre cursors the 2003 edition of NAF's clinical policy guidelines establishes clinical policy guidelines which are developed by consensus based on rigorous review of the relevant medical literature and known patient outcomes.
These guidelines are intended to provide a bases for ongoing quality assurance, help reduce unnecessary care and costs, help protect providers in malpractice suits, provide ongoing medical education and encouraged research."
Referring to --
MR. HUT: Excuse me, your Honor. If Ms. Gowan is moving on here there is a portion that I would like to read from the same page as a matter of completeness under Rule 106.
THE COURT: Go right ahead.
MR. HUT: Thank you. There are at the bottom of the page the following definitions enumerated 1. Standards are intended to be applied rigidly. They must be followed in virtually all cases. Exceptions will be rare and difficult to justify.
2. Recommendations are steering in nature. They do not have the force of the standards but when not adhered to there should be documented rational clinical justification. They allow some latitude in kin call management.

3. Options are neutral with respect to treatment choice. They nearly note the different interventions are available and different people make different choices. They may contribute to the educational process and they require no justification.

MS. GOWAN: Page 15 which is entitled second trimester abortion by D&E, page 16, which is the second trimester abortion by D&E section.

"option. 0.02. "in second trimester abortions intraamniotic or intrafetal injection may be given." footnote nine "digoxin 0.5-2 MG, see reference one, KCL 0.5 CCs of 10 percent solution to a maximum of 2 CCs. See reference four or hypersome O HRAR ewe RAOEa. See reference six."

Page 19, the title is second trimester abortion by medical induction. "policy statement. Medical induction is a safe and effective method for termination of pregnancies beyond the first trimester. Footnot. For the purposes of these TKPWHRAEUPBs second trimester begins at 15 weeks' LMP with citation."

Reading back to the text. In appropriate clinical settings by trained clinicians as gestational ages increase, complication and risks increase.."

Reading from page 21, which is still.

MR. HUT: Your Honor, may I in the interest of completeness, read some portions in from that page?

THE COURT: Go right ahead.

MR. HUT: Option 0.01. A patient with low lying placenta confirmed by sonogram and prior uterine scarring may be evaluated for placenta previa. See reference 3. Standard, 3. Patient comfort level during the abortion procedure must be considered.

MS. GOWAN: Note for the record that that does not complete in any way -- withdrawn.

THE COURT: If you want to complete something go right ahead. The exhibit is in evidence.

MS. GOWAN: That's fine, your Honor.

THE COURT: Go right ahead. I will hear from it later anyway but go ahead if you want to complete it in this oral presentation.

MS. GOWAN: I shall move on, your Honor, thank you.

THE COURT: No, seriously. I mean, go ahead. It's Friday afternoon I am amenable to such things. That Grown you heard before was Barney and not myself.

MS. GOWAN: Page 20, option 0.02. "in second trimester abortions intraam flee OTic or intrafetal injection may be given" footnote 13. Intraamniotic digoxin 0.5 to 2.0 M G see reference 1, intraamniotic hyper so molar urea, see 7 or fetal intracardiac KCL 0.05 C Cs of 10 percent solution to a maximum of 2 C Cs. See reference 5, are safe, effective regimens.

In addition to achiefing fetal demise feticidal agent induce softening of fetal core tickle bones and decrease induction to abortion intervals if administered 12 to 24 hours prior to delivery. See reference 2.

MR. HUT: Your Honor, from the same page, standard 10, a licensed clinician capable of performing a timely curettage must be available until post abortion discharge.

And then there is reference 14, the incidence of retained placenta with midtrimester induction abortion has been reported in 10 to 40 percent of all cases. See reference 2.

MS. GOWAN: The government moves the admission of P-6, National Abortion Federation fact sheet on the safety of abortion. Plaintiffs have objected on relevance grounds. Certainly your Honor the safety of abortion procedures has been much at issue in this case. This particular document has a section detailing complications from legal abortion and putting forth rates for infection and perforation and bleeding, all of which have been subjects at this trial.

THE COURT: Mr. Hut, do you know this objection?

MS. GOWAN: Relevance.

THE COURT: It will be received.

MR. HUT: We are going to withdraw the objection in any event anyway.

THE COURT: Oh you were. I would say it would be a tough one to argue but, in any event, go aheads.

It will be received.

(Government's Exhibit

MS. GOWAN: Thank you, your Honor. I would like to read briefly from the section on complications from legal abortion, which appears on page 1.

THE COURT: Go had a head.

MS. GOWAN: Although rare, possible complications from a surgical abortion procedure include blood clots accumulating in the uterus requiring another suctioning procedure which occur in less than one percent of cases. Infections, most of which are easily identified and treated if the woman carefully observes followup instructions which occur in less than three percent of cases. A tear in the cervix which may be repaired with stitches which occurs in less than 1 percent of cases. Perforation, a puncture or tear of the wall of the uterus and or other organs which may heal itself or may require surgical repair or rarely hysterotomy which occurs in less than one half of one percent cases.

(continued on next page) Take 5.

In missed abortion which does not end the pregnancy and requires the abortion to be repeated, which occurs less than of 1 percent of cases.

Incomplete abortion, in which tissue from the pregnancy remains in the uterus and requires the abortion to be repeated, which occurs in less than 1 percent of cases;

Excessive bleeding caused by failure of the uterus to contract and which may require a blood transfusion, which occurs in less than 1 percent of the cases." SP-P.
MR. HUT: From the same page, your Honor, if I may.
THE COURT: Yes.
MR. HUT: In the first column, "Generally, the earlier the abortion, the less complicated and safer it is."
MS. GOWAN: My colleague corrects me. When I was reading about the complications with the need to perforation, I said hysterotomy. The word in the text is "hysterectomy."
THE COURT: All right. Would you correct that in the record, Mr. Reporter, please. If that is what it says. Reporter reporter yes, your Honor.
THE COURT: So it appears in the correct spot and not any many sentences later.
MS. GOWAN: Just to complete Mr. Hut's statement, on page 2 the text reads, "After 16 weeks the different methods carry about the same complication rates."
MR. HUT: No, I did not read that. I was reading from the first page. But now in the interests of KHRAOEGS the previous sentence there reads, "Between 13 and 16 weeks the dilation and evacuation D&E procedure is significantly safer and more effective than other second trimester abortion methods."
MS. GOWAN: Your Honor, we had marked as exhibits the

CD room of the Congressional Record that we had previously submitted to the Court. We had also marked as exhibits the specific portions of the legislative history that we had identified on our Rule 26(a)(1) disclosures previously in this case. Mr. Hut, as he mentioned, has prepared for the Court some binders of the legislative history, and we are still in the process of looking at that, and Mr. Hut and I are in the process of confirming our stipulation for the submission of the records. With the Court's permission, I would like to defer until Monday.
THE COURT: Sure. Go ahead.
MS. GOWAN: T-B only thing I wanted to bring to the Court's attention was that we had, as your Honor will recall, played an excerpt from Government Exhibit E, which is a tape, and we had played the Haskell presentation for the Court two days ago. I had discussed with plaintiffs' counsel that we would supplies that tape and create a new Government Exhibit E, which just reflects the portions of the tape that were played not Court, which mainly is the introductory statement.
THE COURT: Do you want to substitute that, just the part that was played for the Court? Gowan that is exactly right. I did give Mr. Brantley that suppliesd tape I believe it was yesterday.
THE COURT: Fine. I assume you afforded the plaintiffs the opportunity to hear it.

MS. GOWAN: I did. I provided them with a copy of the tape as well.
MR. HUT: We have no objection, your Honor, provided that the record reflects what is the true and I hope noncontroversial fact that Exhibit E is an excerpt from a tape originally offered called "Second trimester techniques D&E 14 to 19 weeks, 20 weeks and beyond, NAF 2 September 13-14, 1992, Dallas,, Texas," which constitutes a set of presentations made at the National Abortion Federation's risk management conference on those dates and which includes presentations by a number of other individuals and other discussions among attendees.
THE COURT: I didn't hear any offer of that previously.
MR. HUT: Indeed, your Honor, that was the basis in significant part for our objection that this was hearsay, that this was neither --
THE COURT: No, no. I ruled on that part of it, if that is what you are talking about.
MR. HUT: I understand you did, your Honor. We are not offering this. I just want the record to reflect this so that should it ever be necessary to challenge the ruling on hearsay, the full context of the tape that your Honor initially ruled admissible is clear.
THE COURT: Thank you, Mr. Hut.

MS. GOWAN: Your Honor, I neglected to move the admission of Government Exhibit L8, which is the National Abortion Federation principles of abortion care curriculum for physicians, assistants, and advanced practice nurses. Again, this is a copyrighted document by NAF [> physicians' assistants?<] and the document reflects that the training modules that make up the document were adapted from NAF's clinical training curriculum abortion practice, which is Government Exhibit J8 in evidence. Plaintiffs had objected to the admission of this document on hearsay and relevance grounds.
MR. HUT: We withdraw the hearsay objection, your Honor, because this is a NAF document consistent with the Court's rulings, but we think there are significant parts of this that are not relevant to any claim or defense in this action.
THE COURT: I think the Court can deal with it. I will receive it in evide
(Plaintiff's Exhibit something received in evidence)
MS. GOWAN: As we mentioned a couple of days, your Honor, we will be appearing in the United States Court of Appeals for the Second Circuit on Tuesday for argument on New York Presbyterian's stay application and mandamus petition. In light of that, we would respectfully request that the government not be required to rest at this time and that the

record of these proceedings remain open.
THE COURT: Do you have a witness for Monday?
MS. GOWAN: No, we do not, your Honor. We have no further witnesses to call.
THE COURT: I thought Dr. Bowes was coming Monday. I misunderstood.
MS. GOWAN: Your Honor, we are not calling Dr. Bowes to testify on our case. I understand that the plaintiffs may seek to introduce some of his deposition testimony on Monday.
MR. HUT: That is correct, your Honor. We do so pursuant to what I understand is agreement with the identified designated portions.
THE COURT: This would be as rebuttal?
MR. HUT: Precisely so, your Honor, yes. And in part because when we initially -- it is completely appropriate rebuttal because it refutes --
THE COURT: I will determine that.
MR. HUT: Well, that is my proffer.
THE COURT: If you will lend me a few prerogatives in this courtroom. You will offer it as rebuttal.
MR. HUT: That is our intention. What I was going to also state, however, your Honor, is that the Court may recall that we also designated it as a portion of our case in chief. The government then moved to preclude it along with the designated deposition testimony of Drs. Sprang, I believe, and

Dr. Cook. We said in response -- excuse me, and Dr. Lockwood. We said in response, based on the government's assurance that these witnesses were going to testify, that it would be sufficient for us to cross-examine and we need not proffer the deposition testimony. On that basis the Court ruled by memorandum or order endorsed that at this time the defendant's motion to preclude would be denied as moot based on our acceptance of the government's assurances.
THE COURT: I remember that.
MR. HUT: Now we don't have the witness, and we would like to offer it in rebuttal.
THE COURT: You made some mention earlier that you might have some rebuttal case. Is this it?
MR. HUT: No. There is perhaps one and perhaps two additional portions. I earlier today -- earlier, we had advised the government that we might call Dr. Jackson in rebuttal, designated as a witness. Earlier today, bearsd on where I thought we stood, I advised Mr. Lane and Ms. Gowan that we did not think we would be calling Dr. Jackson. We now in all candor, your Honor, want to evaluate some of the material in the exhibits that Ms. Gowan has introduced in evidence today to determine finally whether we would wish in fact to call Dr. Jackson. I would not anticipate that the testimony would be long, but we do want to reserve that option to ourselves now.
THE COURT: I want to know a proffer of whether or not

she qualifies. Is this a lady?
MR. HUT: It is.
THE COURT: Whether or not she qualifies as rebuttal, legitimate rebuttal. So I would expect, should you decide to call her, you will submit to me by Monday morning a proffer of what she is being offered for.
MR. HUT: Very well.
THE COURT: I will be happy to reserve on that and we will go from there.
MR. HUT: I should add one other potential witness is Dr. Ho well, also designated in the pretrial order. We will likewise make a similar proffer with respect to Dr. Ho well should we elect to want to call him by way of rebuttal.
THE COURT: That sounds fine. Half have it to me first thing Monday morning, 9: 30 Monday morning.
MR. HUT: Yes, your Honor.
THE COURT: I think unfortunately we had no control of this, but our friends across the street will rule on that. Is your appearance Tuesday morning?
MS. GOWAN: 10 o'clock, your Honor.
THE COURT: I don't know what else to do except why don't we tentatively set to reconvene at 2 o'clock on Tuesday afternoon, and we will see what we know at that time and face whatever the situation is. There is no way any of us can forecast what that is going to be, and I will deal with

whatever problems arise depending on what our friends across the street decide.
MR. HUT: Your Honor, we had hoped that if the proffer were satisfactory to the Court, to present our rebuttal witnesses on Monday. That was our plan.
MS. GOWAN: We don't have any objection to that.
THE COURT: All right. Then we have to have some time to review what you have. As far as you know, this will be a transcript and possibly two live witnesses?
MR. HUT: Yes, both with testimony that I anticipate, if we present at all, would be very short.
THE COURT: With cross-examination, you would believe that -- I realize it is a guesstimate -- you think we would finish Monday afternoon?
MR. HUT: Absolutely. I would anticipate each shorter than an hour with cross-examination.
THE COURT: Then why don't you submit this Monday morning and I will need some time to review it. Why don't we plan on reconvening at 2 o'clock Monday afternoon, if you think we can do that in that time.
MR. HUT: I think we can, your Honor.
THE COURT: Why don't we plan on that. Get me the materials, the proffers, and your decision whether you want to call them. You may decide against it. We will see what happens.

MR. HUT: Sure.
THE COURT: Is there anything else?
MR. HUT: There are two other matters, your Honor, that plaintiffs have. It is implicit in your Honor's deferral of proceedings following the rebuttal case to Tuesday afternoon, am I correct in thinking that at that time you will identify the Court's preferences with respect to the timing of the closing arguments?
THE COURT: Yes. I just have no idea what the Court of Appeals is going to say. But yes, when I know what the Court of Appeals says, then I will schedule. If, for instance, they say no, I would anticipate we would try and have closing arguments later in the week. You can indicate to me, if you would like, maybe you want to think about it over the weekend, and send that to me Monday morning, too: (a) how much time you think you would need. I assume by now you realize that I think economy of words is important, not to deny you full opportunity to explore your arguments but repetition has absolutely no weight with me at all. I will give you the opportunity to think about how much time you want and whether you would like a day. If they denied records and we went ahead, I would not think we would want to delay more than a day to have the closing arguments.
MR. HUT: I my in that event, your Honor, without anticipating anything, beg the Court's indulgence and ask for a

deferral until Thursday. But I certainly would understand if the Court wanted to have it sooner.
There is one last item.
THE COURT: I am always in every case encourage people, you are much more effective when you do a punchy closing argument than going on forever.
MR. HUT: One last matter, your Honor, and that is sometime last week I think it was government counsel raised the question with plaintiffs of perhaps some additional time following the conclusion of closing arguments for submission of proposed findings and conclusions. We are also interested in that possibility. So I rise to raise with the Court the question.
THE COURT: I would be amenable to that. Do you want a couple of weeks?
MR. HUT: We had thought to request 30 days.
THE COURT: How much time are you thinking? Then I will tell you whether you are interthe ballpark or not.
MR. HUT: Both government counsel and I thought to ask *R at least ask the Court for 30 days.
THE COURT: Is that under the old philosophy ask for 30, you will get 15?
MR. HUT: I hope not, your Honor. We are very much hoping for 30.
THE COURT: Tell you what. I will give you that

answer Monday, too. I am liable to become Solomones being over the weekend. It all depends on whether the red skins trade up and steal our draft pick from the Oakland raiders. If they do that, you aren't going to get squat, Mr. Hut, I tell you that right now, not didly. S-

MR. HUT: Your Honor, I am a born and bred fan of the New York Giants -FRPLTS I attended every home game.

THE COURT: A recent convert.

MR. HUT: No, not a convert. I am a born and bred giant fan. I attended every home TKPWA*EUPL game I confess from the age of 8 to age of 17, including, I'm not happy to say, the Sunday following the Kennedy assassination.

THE COURT: Not all of your youth was misspent them [> strike all that<] I will give you an answer on that Monday. I certainly will give you some time. You are both on the same page and think you would like 30?

MR. HUT: Indeed.

MS. GOWAN: That's right, your Honor.

THE COURT: I don't want to kill you with it. It is a lot of material. It isn't an easy task. Believe me i am not unappreciative of the task you have with the record you have. I will give you that answer Monday W. that PH-PLD in mind we will see what you deliver to me. I will try to do that quickly. If I think it is appropriate, we will go ahead Monday afternoon. Then we are in the and of our friends across the

street, and we will reconvene, as I mentioned earlier, we will still plan to be together on Tuesday afternoon, and we will decide our schedule then, depending on what we know then.

Anything else, good people?

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

THE COURT: Have a wonderful weekend. Thank you very much.

(Adjourned to 2:p.m., April 19, 2004)