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

Plaintiffs,

v. 03 Civ. 8695 (RCC)

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

Defendants.

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New York, N.Y.
March 30, 2004
10:00 a.m.

Before:

HON. RICHARD CONWAY CASEY
District Judge

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(Trial resumed)

THE COURT: Good morning. Please be seated.

Counsel, before we get started, I am informed that some papers have been served on the Court from an individual I believe whose name is Robert Finnegan, apparently on the face of it seeking to intervene. In any event, if he is in the courtroom, I direct that he serve copies of the papers on all parties. I will try and look at the papers later and see what course of action the Court will take.

Other than that, Mr. Hut, you may call your next witness.

MS. WIGMORE: Your Honor, this is Ms. Wigmore.

THE COURT: Excuse me. I didn't know who would be handling the next witness. Ms. Wigmore, please proceed.

MS. WIGMORE: Our next witness will be Dr. Amos Grunebaum.

AMOS GRUNEBAUM,

called as a witness by the plaintiffs,

having been duly sworn, testified as follows:

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

THE WITNESS: My full name is Amos Grunebaum.

THE CLERK: Please spell it.

THE WITNESS: A-M-O-S is my first name, and Grunebaum is my last name, G-R-U-N-E-B-A-U-M.

THE CLERK: Thank you. Please be seated.
MS. WIGMORE: Your Honor, we would propose to proceed in the same way we did yesterday, by providing exhibit binders to the witness, to the Court, and to opposing counsel at the beginning of the testimony. We will then offer exhibits in evidence as they come about in the course of the testimony. Is that acceptable?
THE COURT: I take it there is no objection again today from the government, is that correct, Ms. Gowan?
MS. GOWAN: Yes, your Honor.
THE COURT: We will proceed. That's fine. Will you hand my copy to one of the law clerks, please.
DIRECT EXAMINATION
BY MS. WIGMORE:
Q. Dr. Grunebaum, what is your occupation?
A. I'm an obstetrician and gynecologist and a specialist in maternal fetal medicine.
Q. Where are you currently employed?
A. I am currently employed by Weill Cornell Medical College in Manhattan.
Q. Is that affiliated with Cornell University?
A. That is correct.
Q. Is Weill Cornell Medical College affiliated with any hospital?
A. Yes, it is.

Q. Which hospital?
A. New York-Presbyterian Hospital.
Q. Do you practice at New York-Presbyterian Hospital?
A. Yes, I do.
Q. What are your responsibilities at New York-Presbyterian Hospital?
A. I am the director of clinical maternal fetal medicine.
Q. What is clinical maternal fetal medicine?
A. Maternal fetal medicine is a subspecialty of obstetrics and gynecology and deals mostly with high-risk pregnancies.
Q. What are your responsibilities as the director of clinical maternal fetal medicine at New York Presbyterian?
A. My responsibilities are to take care of patients in the clinic, on the labor delivery floor, and the operating rooms. I also have responsibilities of teaching other physicians, attendings, residents, and medical students.
Q. Do you have any administrative responsibilities?
A. Yes, I do.
Q. Could you describe those for us, please.
A. Yes. I develop policies within the department of obstetrics and gynecology, and I attend meetings, including patient care committee meetings and patient safety committee meetings, for example.
Q. What is the patient safety committee?
A. The patient safety committee of the department of

obstetrics and gynecology deals with issues surrounding safety in our specialty. What they do is they review and make sure that whatever we do in the department, on the floor, on the operating room, is safe.
Q. Are you a plaintiff in this case, Dr. Grunebaum?
A. No, I am not.
Q. Do you plan to offer expert opinions in this case?
A. Yes, I do.
Q. Before we get into your opinions, let's learn a little bit more about you. From where did you obtain your medical degree?
A. I graduated from the University of Cologne in Germany.
Q. In what year?
A. In 1975.
Q. Where were you born?
A. I was born in Haifa, Israel.
Q. Did you reside in Germany at some point?
A. Yes, I did.
Q. During what period of time?
A. From 1953 to 1977.
Q. When did you move to the United States?
A. In 1977.
Q. Have you lived in the United States since then?
A. Yes.
Q. Aside from your medical degree, did you receive any other medical training?

A. Yes, I did.
Q. Could you please describe that training for us.
A. Yes, I can. After I finished medical school, I did a one-year residency in anatomical pathology in Germany, which was followed by another year in an anesthesia residency, also in Germany. And in 1977 I came to New York, where I did another year of residency in anesthesia in Brooklyn.

From 1978 to 1982, I then did a four-year residency in obstetrics and gynecology, which was immediately followed by a two-year fellowship in maternal fetal medicine.
Q. What is anatomical pathology?
A. Anatomical pathology deals with the specialty of tissue and organs, examining tissue, examining organs, and also performing autopsies on people who died.
Q. You have used the phrase "obstetrics and gynecology." What does that refer to?
A. Obstetrics and gynecology is a specialty which deals overall with caring for women and specific diseases that are related to women, including gynecologic diseases, diseases of the uterus, of the vagina, of the fallopian tube, of the ovaries. And obstetrics is a specialty which deals with all issues surrounding pregnancy.
Q. Do you currently practice medicine?
A. Yes, I do.
Q. Do you have any specialties in that practice?

A. Yes.
Q. What are they?
A. It is obstetrics and gynecology as well as maternal fetal medicine.
Q. Have you obtained any board certifications?
A. Yes, I do.
Q. In what areas?
A. In obstetrics and gynecology first, and then a subspecialty board certification in maternal fetal medicine.
Q. Do your board certifications in those areas remain current?
A. Yes, they are.
Q. Do you currently treat patients?
A. Yes, I do.
Q. In what setting or settings do you treat patients?
A. I treat patients in our clinic, which is a suite where we receive private patients. I also see patients in clinics next to the hospital, where we see patients, where I see usually patients who are pregnant.
THE COURT: What do you mean by clinic patients?
THE WITNESS: Clinic patients as compared to private patients.
THE COURT: What does that mean?
THE WITNESS: We have a setting of private patients where I am the only doctor for that patient, whereas in the clinic there are several doctors assigned to the same patient.

Q. Do you see patients in the hospital setting?
A. Yes, I do. I see patients on the labor and delivery floors, I see patients on the antepartum and the post-partum floors, and I also see patients in the operating rooms.
Q. What does "antepartum" mean?
A. Antepartum is the period prior to delivery after pregnancy is diagnosed.
Q. What is post-partum?
A. Post-partum is the period after delivery.
Q. Approximately what percentage of your work involves caring for patients?
A. I would say about 80 percent of the time I purely take care of patients, and the remainder of the time I do administrative work.
Q. What types of patient care to you provide?
A. I provide mostly all care of obstetrics and all levels of obstetrics and gynecology. Women who are not pregnant, women who are trying to get pregnant, well women who are already pregnant, I provide prenatal care for those women. When those women have complications, they come to the hospital, I see them in the hospital. And then when they are in labor or they need surgery for pregnancy-related issues, I perform those surgeries. I also perform surgeries in the general operating rooms on women who are either not pregnant or who are in the early stages of pregnancy.

Q. What types of surgeries do you perform?
A. I perform cone biopsies, I perform D&C's, I perform hysterectomies, surgeries on the fallopian tubes and the ovaries. I perform abortions, I perform surgeries called cerclage, C-E-R-C-L-A-G-E, which is the operative closure of the cervix in early pregnancy. And I also perform Cesarean sections, for example.
Q. You used the term cone biopsy. What does that refer to?
A. The cone biopsy is the excision of part of the cervix in case it is diseased.
Q. You used the term "D&C." What does that refer to?
A. A D&C is a procedure which is also called dilatation and curettage, where the cervix is dilated and the contents of the uterus are being curetted out.
Q. You used the term "hysterectomy." What does that refer to?
A. The hysterectomy is the operative removal of the uterus.
Q. You mentioned, Doctor, that you have --
THE COURT: Just a moment. When you say in the D&C you remove the contents, what are the contents?
THE WITNESS: If a woman is not pregnant, the contents of the uterus is the lining of the uterus usually. Or if there is a polyp, you remove the polyp. If the woman is pregnant, the contents then become different; it is the fetus and the placenta and the amniotic fluid and also the lining of the uterus.

THE COURT: If she is not pregnant, what is it that you remove?
THE WITNESS: The lining of the uterus or any diseased portion inside the uterus.
Q. Does that include fibroids?
A. I do not do operative removal of fibroids, but they can clearly be done in a similar procedure, yes.
Q. Approximately how many abortions have you performed throughout your career?
A. I started with my medical school in 1968, and attended abortions throughout my medical school and after I finished medical school. So it's about 36 years that I have been doing them, probably about a thousand abortions just as a ballpark. But it is difficult to be very precise.
Q. Of the abortions that you perform in your current practice, approximately what percentage of those are abortions regarding wanted pregnancies?
A. The majority of the abortions that I perform in my practice over the last three years are wanted pregnancies, probably well over 95 percent.
Q. What types of abortions have you performed?
A. I have performed different kinds of abortions. We just described a dilatation and curettage, which is the form of abortion done in the first trimester. That procedure becomes more dangerous as pregnancy progresses, usually after 12 weeks.

At that time the options for abortions at that point are usually induction abortions or an abortion called D&E, dilatation and evacuation.
Q. What is an induction abortion?
A. An induction abortion is a type of abortion where labor is being induced, and after the woman has gone through a period of labor the cervix dilates and the fetus and the placenta are being expelled.
Q. Doctor, you have used the term "die-latation," "di-latation." What does that refer to?
A. "Dilatation" stands for opening. In the case of the cervix, it is the opening of the cervix by different means.
Q. Is that ever referred to as "dilation"?
A. Yes.
Q. You mentioned that you perform dilation and evacuation, or D&E's. What are those procedures?
A. A D&E is a form of abortion which is usually done in the second trimester of the pregnancy, which usually begins around 13 to 14 weeks of the pregnancy. In a D&E, as the first word refers, the cervix is being dilated. What we do now days is we dilate the cervix with small laminaria, we call them, small sticks about a couple of millimeters thick and probably an inch or so long, which we insert into the cervix and leave in the cervix overnight. And sometimes we repeat that procedure the next day.

Q. Are you familiar with the term "intact D&E"?
A. Yes, I am.
Q. What is an intact D&E?
A. As I explained before, D&E is a form of a termination of a pregnancy, an abortion, in the second trimester. The intact D&E is one version how to perform a D&E.
Q. How does that version proceed?
A. In an intact D&E the fetus is removed intact, as the word says. As compared to the other version of the D&E, where the fetus is removed in portions, and the medical term for that is "dismemberment".
Q. Dr. Grunebaum, have you performed intact D&E's?
A. Yes, I did.
Q. How did you learn to perform intact D&E's?
A. I saw my first intact D&E's shortly after I arrived at New York Hospital, I believe in the year 2001, when I first saw them. And I learned them in the year 2002.
Q. Is New York Hospital affiliated with New York-Presbyterian Hospital?
A. It is one hospital system, but there are two hospitals that have merged several years back. One is called Presbyterian, the other one is called New York Hospital.
Q. Is New York Hospital affiliated with any medical school?
A. Yes, it is.
Q. With what medical school?

A. Cornell.
Q. Did you receive training in the intact D&E procedure while you were working at Cornell?
A. Yes, I did.
Q. Approximately how many D&Es have you performed since joining the faculty at New York Presbyterian hospital?
A. I have performed or performed myself approximately 15 to 20 D&E's.
Q. 15 to 20 intact?
A. Intact D&E's, correct.
Q. How many D&E's of all types have you performed?
A. Approximately 100.
Q. Have you provided training to others in abortion?
A. Yes, I did.
Q. Who have you provided training to?
A. I have provided training to medical students, to obstetric and gynecology residents.
Q. What type of abortion training have you provided to those groups of people?
A. All the different kinds of abortions we just described, including D&C's in the first trimester of the pregnancy, D&E's in the second trimester of the pregnancy, and induction termination of pregnancies.
Q. Have you provided training on intact D&E?
A. Yes, I did.

Q. Where have you provided that training?
A. Also at Cornell.
Q. Doctor, you described for us an induction. Are there any different types of induction abortions?
A. Yes, there are.
Q. What are they?
A. There are historically some kinds of inductions and some that we do nowadays more often.
Q. What are the historical types?
A. The historical types were saline inductions, where we injected a high dose of saline into the uterus, the amniotic fluid, and then the woman went into labor shortly thereafter, usually within 24 hours. That is the main type of abortion I performed during my residency training and shortly thereafter.
Q. Do you currently perform saline induction abortions?
A. No, I do not.
Q. Why not?
A. Because I feel they are less safe to the patient.
Q. Are there other types of abortion?
A. Yes, there are.
Q. Of induction abortions, excuse me.
A. Yes. You can inject other forms of agents into the amniotic fluid. One of them I know of is called urea, but I have never done that. Urea, U-R-E-A. They are different chemicals.

Q. Are you familiar with a prostaglandin induction abortion?
A. Yes, I am.
Q. What is that?
A. A prostaglandin abortion, contrary to the saline abortion -- in the saline abortion you inject something into the uterus. With the prostaglandin abortion, you take suppositories which contain prostaglandin and insert them into the woman's vagina over a period of time, usually every four to six hours.
Q. What is prostaglandin?
A. Prostaglandin is a chemical which induces contractions.
Q. Are there different types of prostaglandins?
A. Yes, there are.
Q. Can you provide us with some examples, please.
A. There is prostaglandin E1 and E2. The other word for the first, E1, is Misoprostol. And the other one is Prostin E2.
Q. Could you currently perform prostaglandin abortions?
A. Yes, I do.
Q. Approximately how many prostaglandin abortions have you performed, Dr. Grunebaum?
A. That is difficult to say, because I have been doing those for several decades. But most likely I would say several hundred.
Q. Are you a member of any professional associations?
A. Yes, I am.

Q. Which ones?
A. I am a member of the American College of Obstetricians and Gynecologists, and the Society of Maternal Fetal Medicine.
Q. Have you authored any publications?
A. Yes, I did.
Q. On what subjects?
A. Usually on obstetrics, gynecology, and women's care issues.
Q. Have you authored any books?
A. Yes, I did.
Q. On what subject?
A. I authored, I co-authored actually a book Dr. Ruth's Pregnancy Guide for Couples.
THE COURT: What is that again?
THE WITNESS: Dr. Ruth's Pregnancy Guide for Couples.
Q. Dr. Ruth?
A. Yes.
Q. Is that Dr. Ruth Westheimer?
A. Correct, that is my co-author.
Q. What is the subject of that book?
A. The subject of the book is exactly what it says, a guide for couples who are trying to get pregnant and for couples who are pregnant.
THE COURT: She is the woman on television, isn't she?
THE WITNESS: Yes, she is on television, correct. She had a radio show and then she had a TV show.

THE COURT: A talk show?
THE WITNESS: Yes, in the early eighties.
Q. Dr. Grunebaum, if you could refer, please, to tab 94 in your exhibit binder. I want to ask you if you recognize Plaintiffs' Exhibit 94?
A. Yes, I do.
Q. What is it?
A. It is my curriculum vitae.
Q. That is your curriculum vitae?
A. Yes, it is.
Q. Is that an accurate summary of your education and experience?
A. Yes. There are only two changes there. It says that I am from '82 to now assistant professor of clinical OB-GYN at Columbia, and I was a professor at Columbia until I changed in the year 2001. Now I have a similar position at Cornell. And also I was recently appointed director of the patient safety committee at Cornell.
Q. With those changes, is that document an accurate summary of your experience?
A. It is a short version of it, yes, but it is generally accurate.
MS. WIGMORE: At this time, your Honor, we offer Plaintiff's Exhibit 94 in evidence.
THE COURT: Any objection?

MS. GOWAN: No, your Honor.
THE COURT: It will be received.
(Plaintiff's Exhibit 94 received in evidence)
Q. Dr. Grunebaum, what steps, if any, do you take to remain current on developments with your medical specialties?
A. There are several steps we usually take. We attend continuing medical education courses, which can have different forms. Some of those will be the grand rounds at Cornell, which are every week. Another one is our regular morbidity and mortality conference, which is also once a week. I also go to lectures which are given either in the hospitals or outside the hospital, and I go to conferences.
In addition to this, I read regularly several of our journals and educate myself with those. I read on the Internet. There are recently many different sites where you can educate yourself on the Internet.
Q. Doctor, you mentioned grand rounds. What are grand rounds?
A. Grand round is a weekly presentation by a professor who has been invited to give a talk.
Q. You also mentioned in your answer mortality and morbidity conferences. What are those?
A. Mortality and morbidity conferences are conferences where a case or several cases are being presented and discussed.
MS. WIGMORE: Your Honor, at this point we tender Dr. Grunebaum as an expert in obstetrics and gynecology, maternal

fetal medicine, and abortion practice and procedure pursuant to Federal Rule of Evidence 702.

THE COURT: Any objection?

MS. GOWAN: No, your Honor.

THE COURT: The Court will so recognize the doctor.

Q. Dr. Grunebaum, are you receiving any monetary compensation for your work in this matter?

A. No, I don't.

Q. Doctor, are you familiar with the term "gestational age" in the context of pregnancy?

A. Yes, I am.

Q. What is gestational age?

A. Gestational age counts the amount of time a pregnancy has progressed, and it is usually counted from the first day of the last menstrual period. Most people count it in weeks.

Q. Have you heard the abbreviation LMP?

A. Yes, I did.

Q. What does that refer to?

A. LMP stands for last menstrual period, and it is the first day when a woman had her last period. Usually she ovulates about an average 14 days afterwards, and that is when fertilization takes place.

Q. Are you familiar with the term "second trimester" in the context of pregnancy.

A. Yes.

Q. What does that refer to?
A. The pregnancy is usually divided in thirds or in trimesters. If you divide 40 by 3, you arrive at 13, 26, and then 26 and beyond to 40 weeks. 40 weeks is when the due date is.
Q. What is the second trimester?
A. The second trimester is usually the time after the 13th week until approximately the 26th week.
Q. Are you familiar with methods of abortion that are used in the second trimester of pregnancy?
A. Yes, I am.
Q. What are they?
A. They are usually dilatation and evacuation, short D&E, and induction termination abortions.
Q. Are there any other methods of abortion used in the second trimester?
A. Yes, but they are rarely, if ever, used. They would include taking out the uterus, which is total abdominal hysterectomy, or hysterotomy, which is similar to what we do with a Cesarean section, where we open up the mother's abdomen, we make an incision into the uterus, and remove, if it is done as a termination of the pregnancy, the fetus and the placenta.
Q. Doctor, you told us that the hysterectomy and hysterotomy methods of abortion are rarely, if ever, used in the second trimester. Why is that the case?

A. The complications of hysterectomy are big. The major complication, obviously, is a woman is infertile after you take out the uterus. You only revert to this procedure if all others have failed or if there is nothing else you can do. So that is a very dramatic way to terminate pregnancy.

A hysterotomy, on the other hand, you still preserve the uterus, but you make a big incision into the mother's abdomen and then an incision into her uterus. That is also a big procedure with its own complications, both at the time you perform it as well as it has implications for future pregnancies.

Q. What is the most common method of second trimester abortion?

A. It is called dilatation and evacuation, D&E.

Q. Do you have an opinion regarding the safety of D&E's?

A. Yes, I do.

Q. What is your opinion?

A. It is a safe procedure.

Q. You mentioned induction. Can you tell us how common inductions are as a method of second trimester abortion.

A. Inductions are another option of performing an abortion, a common option besides the D&E, but they are less common nowadays, since we have been trained in D&E's and more and more doctors are doing them. Clearly, doctors feel that when they do a D&E, it is more advantageous than the induction form of

termination of pregnancy.
Q. Could you describe for us, please, how an induction abortion typically proceeds.
A. Yes, I can. With a typical induction abortion where you use prostaglandins, the woman is admitted to the hospital, and in many hospitals she is usually located on the labor delivery floor. She can be somewhere else, but the labor delivery floor is deemed to be the safest by most hospitals to perform the induction procedure.

The woman is then in her bed and an IV is started. After she signs an informed consent, a suppository containing the prostaglandin agents is then inserted into the vagina and then reinserted with new ones over a certain time period until the abortion is completed.

What usually happens is the woman goes into labor, the cervix dilates over time with contractions, and then the fetus is being expelled. Then eventually the placenta either is expelled or the woman has to go to the operating room to remove the placenta.

Q. How long based on your experience does the labor portion of the induction typically last?
A. The labor portion of the induction typically lasts between 12 and 24 hours, but I have seen it last for several days.
Q. You mentioned one of the steps in the induction abortion is delivery of the placenta, is that correct?

A. That is correct.
Q. What is the placenta?
A. The placenta, another word for placenta is the afterbirth, and that is an organ, actually it is a very important organ -- most people sort of underestimate its importance -- which is where the fetus is attached to and which essentially exchanges nutrients between the fetus and the mother and is attached to the uterus. It also creates its own hormones to support the pregnancy.
Q. Doctor, have you ever performed an induction that required surgical removal of the placenta?
A. Yes.
Q. How frequently has that occurred in your practice?
A. I would say it happens probably one to two to three times in about ten inductions, in my own experience.
Q. Two to three times --
A. Between 10 and 30 percent of my inductions, yes.
Q. Do you have an opinion regarding the safety of induction procedures?
A. Induction procedures are considered safe. Nevertheless, there are certain circumstances where an induction procedure is considered contraindicated, and the word "contraindicated" means that you really should not use it in order to induce the abortion.
Q. Doctor, do you have an opinion as to whether D&E offers any

safety advantages over induction?
A. Yes: It does.
Q. What are those advantages?
A. Let me first start with contraindications for induction termination of pregnancy. The contraindications for induction termination of pregnancy include a prior scar in the uterus, specifically if the scar is from what we call a classical Cesarean section, is if a woman in a pregnancy has had a classical Cesarean section.

It is called "classical" because that is the first form of Cesarean section, which we started to do approximately 150 years ago. That is an incision in the uterus which is vertical in the top of the uterus. The reason why we cannot do an induction in those women is because a vertical uterine incision is more likely to rupture when a woman goes into labor. And if it ruptures, she can die, bleed out.

THE COURT: Hemorrhage.

A. Hemorrhage, exactly. So the woman can hemorrhage when the uterus ruptures, and she usually dies.

THE COURT: You can't stop the hemorrhage?

THE WITNESS: You have to do emergency operation. Most of the time you can save the woman. Still, until you get to do the emergency surgery, she can bleed a lot.

THE COURT: Most of the time you can save her?

THE WITNESS: You can save her, but the woman will end

up with a surgery. You have to open up the abdomen. She can be very sick, because what happens is when the scar opens up, the contents of the uterus, which is the fetus and the placenta, are spilled into the abdomen, and that can infect and lead to peritonitis. Sometimes I have seen women who had a ruptured uterus that ended up with a hysterectomy in order to save her life, and obviously she is infertile after that. So that is one of our most scariest moments in obstetrics.
Q. Doctor, you used the term "peritonitis." What is that?
A. Peritonitis, the peritoneum is the lining of the abdomen. All of the abdomen is lined with a very thin layer, including the bowels, including the stomach, including the uterus. When the uterus opens up, the peritoneum can become infected.
Q. Doctor, you mentioned a classical Cesarean scar as a contraindication for induction. Are there any other contraindications for induction?
A. Yes. The other form of Cesarean section is called a low segment transverse Cesarean section. Compared to the classical Cesarean section, the low segment Cesarean section is done in the lower portion of the uterus, and it is done in a horizontal fashion. That is how we usually do the vast majority of Cesarean sections. But there are some women who do have a classical one. So that is another contraindication for a woman to go into labor in future pregnancy. The risk of uterine rupture in a low segment transverse Cesarean section is lower

than in a classical one, but it is still present.
Q. Doctor, are there any other particular patient conditions for which D&E offers advantages over induction?
A. Yes. There are certain other circumstances. We talked about the uterine scar. The general gist is that a woman should not go into labor in a future pregnancy when she has a uterine scar. There are other conditions where labor per se can be dangerous to a woman.

For example, if the fetus is what we call a transverse lie, that means that the fetus has the head on one side and the feet on the other side, that can be dangerous to a woman if she goes into labor. Normally, the fetus is in one of two positions. Normally, the fetus is either with the head down or with the butt or the feet down. That it is called a breech presentation. The other presentation is called the vertex.

Then there is a third presentation, called a transverse lie. In a transverse lie, the spine of the fetus lies across the uterus. If a woman goes into labor, there is really no presenting part, like the head or the breech, which can dilate the cervix, and there is also increased risk that the uterus will rupture. Transverse fetal lie is a risk factor for uterine rupture.
Q. Can you perform a D&E in a situation involving a transverse lie?
A. Yes, absolutely.

Q. Does it present the same difficulties as it does in the induction. Does a transverse lie present the same difficulties?
A. Yes.
MS. GOWAN: Objection.
THE COURT: What is the objection?
MS. GOWAN: Leading, your Honor.
THE COURT: Ms. Wigmore, that happens to be true. Would you please try and avoid it and let the doctor do the testifying.
Q. Go ahead, doctor.
A. I lost the question.
THE COURT: Rephrase it.
Q. Can you tell us how the risk of performing an abortion in a case involving a transverse lie in an induction situation compared to the risk in a D&E situation?
A. The major difference is labor. The dangerous portion of the transverse lie is that the woman goes into labor. Her uterus contracts, and it is the contractions with the transverse lie that lead to the uterine rupture.
In a D&E, dilatation and evacuation, the fetus and the placenta are not expelled through labor. Specifically, they are not expelled through long-term labor, because the longer labor happens, the more dangerous it can become. The fetus and the placenta are removed through a surgical procedure, and that

is considered safer in those circumstances.
Q. Are there any other patient conditions for which D&E offers advantages over induction?
A. Absolutely. Another condition that I can think of is conjoined twins.
Q. What are conjoined twins?
A. Conjoined twins are twins -- well, I would say the common name for those in this country is Siamese twins. Those are twins that are stuck together, which failed to separate early on in pregnancy. When you have Siamese twins, you have two fetuses that are together, and you really cannot pass or it is very difficult to pass spontaneously conjoined twins through the vagina. You can't really deliver them through the vagina, through the cervix spontaneously after you go through labor.
Q. Why does D&E present an advantage in that circumstance?
A. We talked about two different forms of D&E. The dismemberment form of D&E provides that smaller portions of the fetuses can be removed, and that is making it much safer to perform the procedure.
Q. Doctor, are there any other conditions for which D&E offers advantages over induction?
A. Yes. There is an abnormal implantation of the placenta which is called placenta previa. A placenta previa -- normally, the placenta is attached to the top of the fundus, so when the fetus passes through the cervix, it doesn't really

pass by the placenta and there is nothing in the way between the fetus and the cervix. In a placenta previa, the placenta actually blocks the exit for the fetus. Then, for example, if you are at term, you need to do a Cesarean section to perform a delivery for a placenta previa.

In a termination of pregnancy, a woman, again, cannot go through labor hours and hours when she has placenta previa, because, as the cervix dilates specifically under the influence of contractions, the placenta detaches and the woman again can hemorrhage to death.

Q. Doctor, you used the word "fundus" in your previous answer. What is that?

A. Fundus is the top of the uterus. The uterus has essentially two portions. One is the lower portion, which is also called cervix, cervix uteri, that is the Latin word. Then the fundus, fundus uteri, which is the top portion of the uterus. That is the part which expands with pregnancy.

Q. Are there any other conditions for which D&E offers advantages over induction?

A. Yes. There are certain circumstances where women have medical conditions where they are not supposed to go through labor. Some women have heart disease. Some women have lung disease. In those circumstances, to go through a long period of labor which can be associated sometimes with stress and pain -- there are also woman who can't stand pain. So in those

circumstances the D&E is advantageous to the induction termination of pregnancy.
Q. You have given us a list of conditions. Are there any other conditions in which D&E offers advantages over induction?
A. I can tell you the general advantages of a D&E over induction. In a D&E you use instruments, which you don't really use in induction. Specifically, in an intact D&E you don't use instruments, whereas in an induction D&E you may end up in the operating room and removing the placenta.
Q. Are there any other general advantages of D&E over induction?
A. Yes.
Q. What are they?
A. A D&E is much shorter. The average D&E probably lasts much less than half an hour. It is done in the operating room under what we call controlled conditions. For a physician, controlled conditions means that somebody is with the woman all the time. Usually there are other doctors in the room, so any complications are treatable right away. It is done usually under general anesthesia so that pain is removed for the woman. And it is done usually as an out-patient procedure. An out-patient procedure means the patient comes to the hospital in the morning and goes home at noon or shortly thereafter.
Q. Doctor, let's take those one by one. You mentioned a shorter procedure. Why is that an advantage of D&E over

induction?
A. In general, the shorter procedure is safer than longer procedure. The hospital, as I explained to my patients, is not a place for any person to be for a long period of time, because there are a lot of what we call bag/box organisms, antibiotic-resistant organisms that grow in a hospital. So the longer you stay in a hospital, the more likely you are to become infected. So time from that point of view becomes important.

In an induction termination, the woman is on the delivery floor. Most, if not all, of my patients, I'd say most of my patients, have the termination of pregnancy done even though they really, really, really want to do have a baby. So for them to have to go to a hospital and be on the labor and delivery floor and to go through labor for a long period of time and then finally not end up with what they really wanted, they really wanted a healthy baby, can be extremely traumatic.

When I sit down with a couple and describe to them both procedures as options, if there are no contraindications to the induction termination of pregnancy, I would say nearly all patients prefer the D&E procedure over the induction.

Q. Doctor, do you have any opinion regarding the safety of intact D&E's?

A. The intact D&E is just one variation of the D&E per se. As we said before or as I said before, there is an intact and a dismemberment D&E. The intact D&E being one version of the

dismemberment, it is probably safer than the dismemberment D&E.
Q. When you say it is a variation, what do you mean?
A. If you compare what a D&E is about, let me simplify it as much as possible. In a D&E, which is usually done in the second trimester, before the 24th week, a woman is brought to my office. After I explain everything, after I describe everything, she is placed on the examination table in what we call a dorsal lithotomy position, where her legs are spread and exposed to me.

After we prepare the vagina, we use a speculum to open it up, and we place what we call laminaria in the cervix. The cervix then opens up over a time period, either one day or two days, very slowly. That procedure is the same in an intact or dismemberment D&E.
Q. Doctor, if I could interrupt for a moment, where is the woman located during the time in which the laminaria are dilating the cervix?
A. She is home. After I see her in my office, after I perform the procedure, she is being sent home.
Q. Then what happens?
A. Then she comes home, she is home. And if the pregnancy was usually less than 18 weeks, the next day she comes to the operating room for the final termination of the pregnancy. If her pregnancy is more advanced, the cervix needs to open up a little bit more, only because the fetus and the placenta and

the amniotic fluid, there is more of it present. So those woman with more advanced gestation ages, and also women sometimes in early ages, where the cervix has to open up -- for example, women with twins, the cervix needs to open up more -- so in those cases we on the second day have the woman come back to the office, remove the now widened laminaria, and put more laminaria into the cervix, so that after another 24 hours the cervix is dilated further and sufficiently for us to perform the procedure.

Those are the same in intact and dismemberment.

Q. Is there any difference in the way you prepare a cervix for a dismemberment D&E versus an intact D&E?

A. I bring every patient into the operating room with a plan to perform a dilatation and evacuation. I don't know ahead of time which variant of the D&E I am about to perform. I can't really plan for that consciously all the time.

Sometimes women tell me that they would like an intact fetus or there are medical reasons to have an intact fetus. In those cases, I will tell the woman that, yes, we can try to do an intact version of the D&E where the fetus is delivered fully intact in order to facilitate that diagnosis. But I cannot always plan it.

What I usually do is I bring the woman to the operating room, and at that moment, after I remove the laminaria I perform what I consider the safest possible method

of D&E.
Q. Could you tell us, Doctor, how a dismemberment D&E proceeds.
A. Yes. In a dismemberment D&E, again, the woman is brought to the operating room, general anesthesia is begun. I remove the laminaria from her cervix, and I look at the cervix and examine the cervix with my hands and my fingers, usually my index and my middle finger, and assess how wide the cervix is dilated. Again, the cervix is dilated at that point from the laminaria.

At that moment I put an instrument on the cervix and pull the cervix forward in order to straighten out the uterus. The uterus is not an organ usually that is straight. It is usually bent. That is called a flexed uterus. That is normal for most women. It can be flexed towards her back or it can be flexed towards the anterior portion of her abdomen. That is different from one woman to the other.

By pulling forward the cervix, I straighten it out. Straightening out the uterus decreases the risk of the most dangerous complication of the D&E. The most dangerous complication of a D&E is a perforation of the uterus, and we find that this may help them.

So everything we do, everything we do from this moment on after we straighten out the uterus is intended to decrease the risk of uterine perforation, to make it as safe as

possible.
Q. How does the dismemberment D&E proceed from the point you just described to us?
A. At that moment what I do with a dismemberment D&E, I rupture the membranes surrounding the fetus, and I use an instrument, a forceps, special instruments made for this procedure, which I place inside the uterus. At the same time, I have my other hand on the mother's abdomen to be sure I understand where the instrument is going to and to understand what I am doing.

I then try to find a part of the fetus that I can easily grasp, and then I pull on my forceps and pull that part out. Sometimes during that portion of the D&E I am able to pull forward either a foot or a leg or an arm of the fetus. If I pull at that moment forward the leg of the fetus, I try to deliver the fetus intact, because delivering a fetus intact has several advantages over delivering not intact.
Q. What are those advantages, Doctor?
A. The major advantage that you really don't have to use much instruments. Every time you place an instrument into the uterus, you increase the risk of perforating the uterus. It is always easier in most or in many medical procedures to remove something you want to remove in an intact way.

My medical students sometimes ask me, why do you want to remove something intact? What I usually explain to them is

to look at it from a totally different specialty. I think it is something that my medical students understand better, because they don't have the specialty yet. A dentist, for example. A dentist tries to remove a tooth complete. Once you break off the tooth, it is much more difficult to remove the root of the tooth.

Q. Are there any other advantages of intact D&E over dismemberment D&E besides the reduction of instrument usage?

A. The intact D&E, as I described before, if you deliver an intact fetus, you are able to send the fetus as a whole to a pathologic exam. As I mentioned before, most of the patients I deliver, I perform a D&E on, do have fetal malformations. Those fetal malformations are usually diagnosed on ultrasound, especially what we call the structural fetal malformation, where something is wrong with the fetal head or the abdomen or the chest. It could be many different things.

What we like to do is we would like to, first of all, compare what the fetus really looks like after the termination of pregnancy with what we saw on ultrasound to make sure that what we really see is what was on the ultrasound.

In addition to this, there are certain malformations of the fetus that we cannot see on ultrasound and which can be helpful after the termination of pregnancy to make additional, other correct diagnoses.

Q. Doctor, are you familiar with the term "fetal anomaly"?

A. Yes, I am.
Q. What does that refer to?
A. It is a general term of something that can go wrong with a fetus or with somebody. For example, fetal anomalies we have can be structural, which is something wrong with any organ or body or hand or arm, or it could be chromosomal. A chromosomal anomaly is something wrong with the chromosomes.
Q. Doctor, does intact D&E offer any advantages over D&E with respect to the diagnosis of fetal anomalies?
A. Yes, it does. It helps us frequently improve our diagnoses, and it also helps the couple, the woman and her husband, if she is married, to get counseled about future pregnancies. As I told you, most of these pregnancies, they desire the babies.

The number one question that I usually get from women, couples, who couple the see me, how likely is what happened now, is it going to happen again. That is a major, major question. Unfortunately, I counsel many couples who had termination of pregnancies or who had miscarriages where the fetus was not completely examined. In those circumstances, unfortunately, I am left with saying something is missing in evaluating what has happened.

When you perform the D&E as an intact D&E, you can always tell the woman, we got it completely, we will send to it a pathologist, who then can examine the fetus and provide

additional information.
Q. Doctor, do you recall mentioning ultrasound in an earlier answer?
A. Yes, I did.
Q. What is ultrasound?
A. Ultrasound is a diagnostic modality in obstetrics and gynecology which uses sound waves which then can create pictures to visualize as much as possible what is happening inside the uterus, in obstetrics, for example.
Q. Do you have experience using ultrasound?
A. Yes, I do.
Q. Can ultrasound be used to diagnose fetal anomalies?
A. Yes. They are used all the time to diagnose fetal anomalies.
Q. Based you know experience, does having an intact fetus offer any advantages over the use of ultrasound alone for purposes of diagnosing structure anomalies?
A. Absolutely.
Q. Why is that?
A. Because you have the complete intact fetus, you have arms, legs, and feet attached to the fetus, and that makes it much easier to see relationships between the different extremities and different portions of the body as compared to a dismemberment D&E.
Q. In terms of the use of ultrasound, can you see all of those

things on the ultrasound?
A. It is actually funny that you mention it. Most people believe that you can see everything on ultrasound. You can't. It is a myth that ultrasound can diagnose all fetal malformations. When you look at many different studies, you see a detection rate between 50, 80, 90 percent of all anomalies. So still a good percentage of anomalies are not seen on ultrasound. Unfortunately, sometimes when a baby is born at term, you detect an anomaly that wasn't seen on ultrasound and couldn't have been seen.
Q. Are you familiar with amniocentesis?
A. Yes, I am.
Q. What is amniocentesis?
A. The word "amniocentesis" is composed of two separate words, "amnio" and "centesis." Amnio, or amniotic, fluid is the fluid surrounding the fetus. Centesis means you make an incision or you insert a needle into something. So amniocentesis is inserting a needle into the amniotic sac, and usually it is done to remove fluid. It can be done for different purposes.
We talked about an induction termination of pregnancy where you inject fluid. That is also done in amniocentesis. But in this specific circumstance I suppose you are talking about an amniocentesis as a diagnostic procedure.
Q. Have you used amniocentesis for diagnostic purposes?
A. All the time.

Q. How many times have you performed amniocentesis?
A. Probably 3,000 over the last 20 years or so.
Q. When in the pregnancy is amniocentesis performed?
A. The earliest you usually can perform an amniocentesis is around 16 weeks, and that is because at that time there is enough amniotic fluid to diagnose whatever you want to diagnose. You take out approximately 10cc's of fluid at that time. So 16 weeks is the earliest. But you can perform amniocentesis at any time throughout the pregnancy until delivery.
THE COURT: After what?
THE WITNESS: Until delivery, until 40 weeks. Amniocentesis can be done any time.
Q. Any time after 16 weeks?
A. After 16 weeks, when there is enough amniotic fluid if you do it for diagnostic purposes.
Q. How long does it usually take between the time amniocentesis is performed and the time at which the patient receives the results?
A. It depends which results you are looking for. If you are doing amniocentesis for detection of chromosomal anomalies, the final results usually take about 10 to 14 days.
Q. Does amniocentesis present any potential risks to the woman undergoing the procedure?
A. Yes, they do.

Q. What are the risks?
A. Amniocentesis is considered an invasive procedure. Invasive procedure means you have to go through tissues or organs in order to arrive to where you want to go to. So potential risks of amniocentesis include injuries to any organs close to where the needle is inserted.

If amniocentesis done at 16 weeks, the organs close to are usually the bowel, the bladder, and sometimes even a blood vessel, because it is more or less a blind procedure in terms of blood vessels and you can rupture a blood vessel and the woman can bleed.

Q. Doctor, you mentioned earlier that you attend mortality and morbidity conferences. Do you recall that?
A. Yes.
Q. Have you at those conferences heard discussion of complications from amniocentesis?
A. Yes, I did.
Q. Can you describe what types of complications you have learned through those conferences.
A. The complications we usually tell our patients about and some of those I have seen is an infection can develop. Don't forget, you are using a needle. Even though you are using it in a very clean way, there is a chance that the needle will induce an infection. So infection is one major course.

If an infection happens, it can either affect the

pregnancy, leading to a miscarriage; the infection can lead to rupture of the fetal membranes, which is also usually a sequence of an infection, and that is an infection that happens inside the uterus.

Sometimes this infection inside the uterus can become worse. It can lead to infection of the uterus itself and the fallopian tubes, and that can lead to the woman becoming sterile, infertile, because infection of the uterus and fallopian tubes can lead to sterility.

Then, to make it even worse, sometimes it can lead to what we call peritonitis. We talked about the peritoneum. You have to go through the peritoneum in order to get to the uterus with a needle, and that can make a woman really sick. She can develop lung problems. She can develop a condition called DIC.

THE COURT: Keep your voice up, please, Doctor. You call it?

THE WITNESS: I'm sorry. DIC, disseminated intravascular coagulation is one of the most dangerous and most fearful conditions in pregnancy. That can happen after an infection has occurred. That can also lead to the mother dying.

Q. Doctor, can amniocentesis be used to diagnose structural fetal anomalies?

A. It is usually not used to make the diagnosis. But if you see a structural fetal anomaly, you would like to see if

anything else is going on. One way to find that out is by doing amniocentesis and examine the chromosomes. A lot of fetuses with chromosomal anomalies will also have structural anomalies, and that is usually the first thing we actually see before we make a diagnosis of chromosomal anomaly.
Q. In a case where amniocentesis indicates chromosomal abnormalities, does having an intact fetus have any value in terms of diagnosing an anomaly.
A. If it is a purely chromosomal abnormality with no other structural abnormality, in ultrasound it is helpful to know what else is going on. It is not as significant to an intact fetus with a purely chromosomal anomaly as it is in a fetus with no chromosomal anomaly. But it is helpful for us to look and see, gee, it wasn't just a chromosomal anomaly, there was something else also going on.
Q. Does amniocentesis diagnose a purely structural anomaly?
A. No.
Q. Doctor, have any of your patients ever asked that you perform a procedure resulting in an intact fetus?
A. Yes.
Q. What reasons have they given for that?
A. There are several reasons. One is a religious reason. There are some patients who, as I told you before, really, really, really wanted that pregnancy, and they have to make a decision to terminate the pregnancy for different reasons,

something went horribly, horribly wrong. They would like to have the fetus buried and arrange for a burial.

If you have an intact fetus, you can imagine that a burial of an intact fetus is much more accommodating to a couple and it decreases the grieving process. Many of our couples, the women are deeply upset about having a fetus like this. So for them anything I can do to decrease their pain when they have to undergo this procedure is helpful.

So yes, couples have asked me, if possible, can I perform it as an intact D&E. In some couples I was able to do it. In other couples, and I usually explain it to them, I say I will try to do it, but under the circumstances I will perform the safest possible way to complete the D&E. And sometimes an intact D&E is not the safest possible way.

Q. Are there cases in which intact D&E is the safest procedure?

A. Yes.

Q. Doctor, do you present the intact fetus to patients who request it?

A. It is the same as any baby dying. Couples want to hold the fetus after its death. In fact, it is part of our training as obstetricians and gynecologists to offer a couple to see a dead fetus or dead baby.

When I started my training, we used to hush a dead baby or fetus away from the couple, saying you don't want to

look at it. Then research has come out in the late seventies and early eighties that shows that if you can offer the dead fetus or baby to a couple, their bereavement process, their pain, is going to be less.
(Continued on next page)

BY MS. WIGMORE:
Q. Doctor, what is the condition of the fetus after the intact D&E?
A. After intact D&E, part of the intact D&E is to do what we call craniocentesis. And I'm sorry, I'm using a technical word here. The craniocentesis is a small incision we make in the back of a head and remove part of the brain.

Other than that an intact D&E the fetus is completely intact as compared to, for example, in an induction termination of pregnancy where the fetus looks totally different.
Q. How is the intact fetus presented to the parent?
A. Well, it's not routinely presented but there are some parents who want it.

What we usually do is we wrap it up very nicely, we put a hat on the fetus as we usually would do with any baby. And some parents want pictures to be taken.

And as they say, usually something -- this has, again, developed over the last two decades, what you see, as painful as it can be, what you see is rarely as bad as something you can imagine in your head.

So, couples who have not seen it or who didn't have a chance to see a fetus imagine a lot of things, some horrible things how the fetus looks like and they have nightmares where in some couples we have found that seeing the fetus after the procedure, it helps them in their bereavement process.

Q. Doctor, we were talking about the advantages of intact D&E over dismemberment D&E and you have told us about the introduction of reduction of instrument passes and the advantage of having intact fetus; are there any other advantages of intact D&E over dismemberment D&E?
A. Yes.
MS. GOWAN: Objection, your Honor. The counsel is characterizing the witness' testimony as well as leading.
THE COURT: Let me hear the question, please. Ms. Reporter.
(Record read)
THE COURT: It's a little bit long but I will allow it.
Do you understand the question, Doctor? Would you like it rephrased?
THE WITNESS: I agree with you it was long but I understand it.
THE COURT: Rephrase.
MS. WIGMORE: Thank you, your Honor.
THE COURT: You can break it down a little. It helps.
THE WITNESS: Thank you so much.
BY MS. WIGMORE:
Q. Doctor, are there any other advantages of intact D&E over D&E involving dismemberment?
A. Thank you.

Yes, there are advantages.
In dismemberment D&E what you do is you pull off different portions of the fetus and at that moment the fetus has already developed bones so you -- bones, the fetus has developed bones. So, those bones need to be pulled through the cervix to the outside. And there is a risk that those bones will break off in a very sharp fashion and that can increase the damage to the uterus and the cervix.
Q. Does the intact D&E offer any advantage over dismemberment D&E in that?
A. There is no sharp tissue, no sharp bones involved with an intact D&E; you don't break anything off, it's intact.
Q. Are there any other advantages of intact D&E over dismemberment D&E?
A. Yes. When you break off portions of the fetus you need to ensure that at the end of the procedure all portions have been removed from the uterus.
The reason why that is important is that if you leave anything behind it increases the risk of an infection. You want to ensure at the end of the procedure one of the most important things you do at the end of a, as a dismemberment D&E proceeds and that's actually the part which takes the longest, is to ensure that even the small portions are being removed.
So, you need to go in again and again and again with instruments to make sure that all of these portions are removed

to decrease the risk of infection and of potential risk of bleeding because retained fetal portions can lead to infection and can lead to bleeding. And, at its worse, they can lead to a woman's infertility.

So that actually, that portion of ensuring completeness with the dismemberment D&E takes up a good portion of the procedure.

And then, after you finish with that part you need to remove the placenta too.

Q. Doctor, in a dismemberment D&E can ultrasound be used to ensure that all fetal parts have been removed?

A. Absolutely.

But again, the use of ultrasound depends on the experience of the person performing the D&E. There are some physicians who are not as experienced as others and some feel that using an ultrasound might decrease the risk of portions to be left.

Now, what I have seen is I have seen despite using ultrasound you can, at the end of the procedure, have portions left over. And the reason for that is ultrasound can only visualize certain parts of the fetus, they cannot visualize every single part. For example, soft tissue portions cannot be usually visualized on ultrasound so if you leave that in large bones you can see it but not soft tissue.

Q. Doctor, are there any differences between intact D&E and

dismemberment D&E in terms of procedure time?
A. Yes.
With an intact D&E the procedure, in the operating room removing the fetus usually takes several minutes whereas with a dismemberment D&E, the removal of the fetus can take much longer.
Don't forget that you still have to remove the placenta in both cases, but that portion of the D&E where the fetus is being removed in intact D&E is usually shorter.
Q. And how, if at all, does that difference in procedure time inform your opinion concerning the relative safety of intact D&E and dismemberment D&E?
A. Given that everything else is similar, a shorter operative time is safer to a patient than a long operative time.
Q. Doctor, does intact D&E provide any advantage over dismemberment D&E for patients with certain medical conditions?
A. Again, as we said before, as I said before, the length of the operative time, the longer it takes to do the surgery the more stress there is on the body. Surgeries that can take hours, one to two hours, 45 minutes, are more stressful than surgeries that take 10, 15 minutes.
So, in certain individuals who do have medical conditions you really want to get in and out of the operating room in the safest possible time, that usually means a short time period.

You want to do the procedure safely and quickly and get out of there.
Q. What specific medical conditions are you talking to, Doctor?
A. There are many medical conditions. I'm sorry if my list is not complete.
For example, if a individual has an immuno compromise, they're more likely to develop an infection. If you can do the procedure to decrease the risk of an infection you will help them and improve their health. You will make sure that the risk of that happening to their health is less.
So, individuals with immuno compromise --
THE COURT: What is that, Doctor?
THE WITNESS: Thank you, I was going to --
You have an immune system and your immune system is actually a very important part of your daily life. You are exposed to quite a lot of bad stuff. I'm sorry, I can't use anything, I will use medical stuff, medical information.
You are exposed to bacteria that do, that you are exposed to every single day and our immune system is responsible for developing defense systems against this bacteria.
There are certain medical conditions where your immune system is depleted, and I will say the most typical one we all know about is patients who are on chemotherapy. Those patients

really should be kept away from bad bugs. And sometimes we do perform those procedures, a D&E, in the operating room on a woman who was just recently diagnosed with cancer.

Cancer is another immuno suppressive condition or people who receive chemotherapy which further suppress the immune.

In addition to this there is hepatic conditions, like Leukemia, will affect your immune system.

And then HIV, individuals who are infected with HIV.

Q. You described for us a number of immune conditions; does intact D&E offer advantages over D&E involving dismemberment for those conditions?

A. Well, again, are you decreasing your risk of complications. You are decreasing your chances that you pass the instruments into the uterus. You are decreasing your risk of perforating the uterus. You are reducing the time period that you are in the operating room so that if one of those complications occurred -- and they do occur occasionally -- you are more successful in treating it with a woman with a intact D&E and it is also less likely to happen.

Q. Dr. Grunebaum, are there any other conditions, patient conditions for which intact D&E offers advantages over dismemberment D&E?

A. Any medical condition where a individual is at risk to develop worsening of their condition, that, for example, would

include a patient with heart disease, with lung disease.
The longer somebody is in the operating room the more likely that -- asthma, for example, is one of the most common conditions.
Now, we can take care of those conditions in the operating room but we would rather not have them. So, our first goal is preventive. We would like to prevent that complication from happening in the first place.
Q. And why does intact D&E offer an advantage in those situations?
A. In those situations, again, if you have a complication you are more likely to -- you are less likely to have a complication when you do an intact D&E and you also are performing the procedure in a much shorter time period.
In addition to this most, many D&Es, at least my D&Es are done under general anesthesia.
General anesthesia involves many different steps to make sure that the anesthesia works. And as anesthesia is prolonged, more drugs are necessary to continue with anesthesia.
You would like to keep the general anesthesia at the shortest possible time period because especially in individuals with medical conditions, the longer the anesthesia the more complications there are.
We are pretty good today with anesthesia and I feel

very comfortable to be in an operating room with a patient with medical condition, but the less anesthesia I give the safer it is for the individual.
Q. And aside from the shorter procedure time and reduced anesthesia, does intact D&E offer any other advantages for compromised patients over dismemberment D&E?
MS. GOWAN: Objection. Asked and answered.
THE COURT: Sustained.
Q. Doctor, aside from what you have already told us about, are there any other advantages of intact D&E over dismemberment D&E?
MS. GOWAN: Objection, asked and answered.
THE COURT: I believe it has been, Ms. Wigmore.
Q. Doctor, are you familiar with the term fetocidal agent?
A. Yes.
Q. What is a fetocidal agent?
A. Here we have another one of our Latin words which will be easy to translate into English.
"Fetus" is very clear to everybody and "cidal" means to kill something.
Q. Can you give me some examples of fetocidal agents?
A. Yes. There is digoxin which can be used, and there is potassium chloride which can be used.
THE COURT: Keep your voice up, please?
THE WITNESS: Potassium chloride and digoxin.

THE COURT: Ms. Wigmore, is this a convenient time for us to take our morning break? Or do you have a few more questions on this subject?
MS. WIGMORE: I just have a few more on this subject, your Honor.
THE COURT: Go ahead.
MS. WIGMORE: Thank you.
Q. Is there chemical abbreviation for potassium chloride?
A. Yes, there is.
Q. What is it?
A. KCL. K for potassium, CL for chloride.
Q. Have you ever injected a fetocidal agent to affect fetal demise before performing a D&E?
A. No, I have not.
Q. Why haven't you?
A. I wasn't trained in that procedure.
Q. Why haven't you received training in that procedure?
A. Because --
THE COURT: Is there an objection?
How can the Doctor possibly tell, unless somebody told him, why he wasn't trained?
MS. GOWAN: Thank you, your Honor. The Government objects.
THE COURT: Sustained.
Q. Doctor, have you sought out training in the use of

fetocidal agents?
A. Well, the word training is a very general term.
You can get trained by reading a book, discussing it, you can get trained by attending lectures or you can get trained by actually performing a procedure.
But most doctors start their training, the actual training by not doing it but by hearing about it or reading about it.
So, while I have not done the procedure, I was trained on the procedure itself.
Q. Have you read about the procedure?
A. Yes, I have.
Q. Are there any risks associated with injecting a fetocidal agent into the woman?
A. Yes, there is.
Q. What are they?
A. Well, first of all you are injecting something. Any time you are injecting something that's potentially dangerous it can affect an individual.
In this specific circumstance you inject it to kill the fetus so it can also adversely affect the person, the person who is pregnant.
Q. Thank you, Doctor.
MS. WIGMORE: Your Honor, this would be a good time to take our morning break.

THE COURT: We will take our morning break.
(Recess)
THE COURT: Ms. Wigmore, you may continue.
MS. WIGMORE: Thank you, your Honor.
Q. Dr. Grunebaum, I believe you testified earlier that you were a member of the American College of Obstetricians and Gynecologists, is that correct?
A. That is correct.
Q. Is that organization also known as ACOG?
A. That's the abbreviation for it, yes.
Q. What is ACOG?
A. ACOG is the professional organization for obstetricians and gynecologists.
Q. For how long have you been a member of ACOG?
A. Probably for about 25 years or so.
Q. Has ACOG taken any public position regarding intact D&E?
A. Yes, they do.
Q. As a member of ACOG, are you familiar with ACOG's position regarding intact D&E?
A. Yes, I am.
Q. What is that position?
A. They consider it safe and they feel it should be offered to every woman.
Q. At this point could you please refer, Dr. Grunebaum, to Tab 5 in your exhibit binder?

A. Yes.
Q. Have you seen this document before?
A. Yes, I did.
Q. What is it?
A. It is the ACOG statement of policy as issued by the ACOG executive board and its abortion policy.
Q. As a member of ACOG, do you receive copies of ACOG policy?
A. Yes, I do.
MS. WIGMORE: Your Honor, at this point we offer in evidence Plaintiff's Exhibit 5 which was actually in conjunction with the Cain deposition yesterday as well.
THE COURT: Any objection?
MS. GOWAN: Yes, your Honor. And as you know, the parties have submitted briefing on the admissibility of this particular exhibit and this is not most certainly an appropriate witness through which to offer this into evidence.
MS. WIGMORE: We disagree with that, your Honor. This is a member of ACOG, he is familiar with their policies.
THE COURT: I don't know that I agree with you on that, but the only thing I can let it in for at the moment is that he is a member, as a member he received it. Beyond that I don't know that he is in a capacity to testify to ACOG's policy.
And I will try and rule on that for you this afternoon as far as the previous offer of that exhibit through the

deposition yesterday.
But let me ask you this, Ms. Gowan. There is also reference that -- well, I will just leave it at that.
But at this point in time I will allow it in, only for the purpose that the witness, as a member, he received it, for him to testify as to the policy, and on behalf of the organization under the foundation that's been laid, Ms. Wigmore. Otherwise I will deny it on that basis.
MS. WIGMORE: Your Honor, for clarification, will it be permissible to use the document as a vehicle to ask questions of the witness and to refer to specific language in the document at this point?
THE COURT: You can show a witness anything and ask him whether or not -- I don't know how you are going to use it, in what context, but you are not offering it in and this is not the witness to offer it into evidence, an officer or member of the board, etc. for ACOG.
It is something he has, you can ask him whether he believes it is correct or not correct or whatever but not on behalf of the organization.
MS. WIGMORE: Thank you, your Honor.
THE COURT: So, in other words, it's sustained except for that limited basis.
You don't even need the document to ask the question.
MS. WIGMORE: I understand.

THE COURT: You can ask him whether or not he believes something is correct or incorrect.
BY MS. WIGMORE::
Q. Dr. Grunebaum do you agree with the position ACOG has taken regarding intact D&E?
A. Yes, I do.
THE COURT: Now you just used that in a fashion that I told you no. Don't try it again.
MS. WIGMORE: I'm sorry, your Honor.
THE COURT: The question is stricken. You are saying ACOG and saying something as established fact, Ms. Wigmore, and I don't appreciate cute practice.
MS. WIGMORE: I apologize, your Honor.
BY MS. WIGMORE:
Q. Dr. Grunebaum, do you have an opinion as to whether intact D&E is a safe procedure that should be allowed?
MS. GOWAN: Objection. Asked and answered.
THE COURT: Sustained.
Q. Dr. Grunebaum, are you familiar with the phrase intact D&X?
A. Yes, I am.
Q. What is intact D&X?
A. Intact D&X is another word or description for an intact dilatation and extraction.
Q. And as a member of ACOG, can you tell us whether or not intact D&X is a term that has been used by ACOG?

MS. GOWAN: Objection, your Honor.
THE COURT: Sustained.
Q. Is there any difference in your opinion, Doctor, between the term intact D&X and the term intact D&E?
A. Not in my understanding.
Q. Dr. Grunebaum, when you perform an intact D&E, do you use instruments to convert the fetus to footling breech?
MS. GOWAN: Objection, leading.
THE COURT: I will allow it.
You can answer the question.
THE WITNESS: Usually not. But it's my understanding that some physicians do.
Q. Dr. Grunebaum, is intact D&E the only method available for performing abortions in any given circumstance?
A. Absolutely not.
Q. And given your opinion that is not the only method available, does that affect, in any way, your view as to the safety of intact D&E and whether it should be allowed?
A. No, it does not.
Q. Why not?
A. Because in medicine, you know, being a physician you learn about different procedures and you learn about different options. And each option or variation of an option under the different circumstances is the most appropriate one.
We have to decide, sometimes in a millisecond, which

procedure to do next.
So that because one procedure is not the only one and you sometimes have other choices, what you would like to do as a physician, and I hope as other medical personnel do, is that you can decide in a specific moment which is the most appropriate and safest under the condition.
Q. Can you give us an example of a situation in which a procedure that is not the only available option might be the safest?
A. Well, let me go out of my speciality.
As a man, something I'm going to be faced with soon is with the danger of prostate cancer. If I were to be diagnosed with prostate cancer I would have several options of treatment. This has recently received a lot of attention over the last couple of years when some famous New Yorkers were diagnosed with prostate cancer and their decision-making process of which options they had were explored.
When you have prostate cancer you can choose to do nothing -- believe it or not -- you can choose to have surgery done, and you can choose to be irradiated. Surgery is not the only way to treat prostate cancer.
THE COURT: They aren't options that you have to make instantaneously in the example you gave.
THE WITNESS: Right. You do have time to decide which option you do. That's correct.

THE COURT: A lot of times.
THE WITNESS: A lot of times that's right.
And in termination of pregnancy you sometimes, not as a physician but as a patient, you do have a lot of time to make those options.
When I sit down -- usually it is a couple -- but when I sit down with a woman who is about to have termination of pregnancy I explain to her all the different options exactly the way you just described.
THE COURT: You also, when you do that, Doctor, do you also describe those options such as the D&E with the dismemberment and that you take the parts of the fetus off?
THE WITNESS: Absolutely. It's part of my --
THE COURT: Oh.
THE WITNESS: Sorry for interrupting.
Go ahead.
THE COURT: Do you also describe the other option which you described which where the terms the D&X where the fetus is partially delivered and you place the scissors at the back of the skull of the child and insert those and then apply a suction device to suck the brain out?
Do you describe all of that to them --
THE WITNESS: Yes, I do.
THE COURT: -- in your practice?
THE WITNESS: In my practice I tell all. In fact, I

go a step further. I tell a patient that one very big complication of the procedure is that she can die. That's actually a much worse outcome than whatever you just described.

And I think it is important that as part of your disclosure there is informed consent given. That's part of the informed consent.

THE COURT: And you find this a vital factor?

THE WITNESS: Absolutely.

THE COURT: In your professional dealings with your patients?

THE WITNESS: Yeah. I mean, I am in charge of the patient's safety committee and the questions that you just brought up come up all the time. How much do you tell a patient about what you are about to be doing -- all the time on labor and delivery.

And we actually continuously develop new guidelines how much to tell somebody. And I think specifically -- specifically -- with a termination of pregnancy it is important that my patient gets all the options, not just the surgical options, not just the induction option, but also the option of not doing anything, not having a termination of pregnancy.

And I can tell you of patients who, who after I talk to them said, you know, we didn't know what was involved, let us think about it. They left my office and never came back. And think that's absolutely a valid choice. It's a choice that

a woman and whoever she makes her decision with should make under non-pressured circumstances.

THE COURT: Thank you, Doctor.

Ms. Wigmore.

BY MS. WIGMORE:

Q. Doctor, does informed consent, in your mind, require the doctor to disclose to the patient each and every detail of what will transpire during a surgical procedure?

A. Well, most doctors will not discuss each and every detail. You will not say how much stitches you put in, you will not say exactly where you make an incision.

But with a termination of pregnancy it is relatively simple. There are more or less 10 steps involved. More or less 10, couple of more, couple less, and it's straightforward to explain those procedures.

Q. What, if any role, does the physician's judgment play in determining what should be disclosed to the patient in terms of informed consent?

A. Well, it's the experience of the physician and the judgment.

When you look at me -- when I look at myself early on in my training my feeling was to tell a patient less. And as I have evolved with experience it is important to be able to decide how much and when to tell certain things.

Q. Do you agree that it's up to the individual physician to

determine how much detail to describe?
A. It's not only up to the individual physician and different physicians disclose certain things, what is even more important is how much a patient wants to know.

You cannot force any information onto a patient. You can give basic information but some patients ask questions and you tell them more, and some patients ask questions and you tell them slightly less. As long as you give them, overall, an idea of what is going on.

THE COURT: Do you have these standards of your ethics committee memorialized in writing?

THE WITNESS: No, I don't.

THE COURT: Do you publish them through your committee or group?

THE WITNESS: It is actually an interesting question because we have discussed it in our hospital and ethics is, especially in my speciality, is something that is fluctuant, it changes from week to week to week, so things do change over time.

THE COURT: But what good are they if you don't know the -- if you don't let the rest of those in your speciality know? Does it have any value if you just sit around and talk about it in a vacuum without disseminating your thoughts?

THE WITNESS: It is being disseminated. There are some basic ethical --

THE COURT: So you do put it in writing and disseminate it?
THE WITNESS: It is. When you say do you put it, I didn't.
THE COURT: I don't mean you personally.
THE WITNESS: I misunderstood you. It is being put in writing and there are ethical --
THE COURT: That's what I meant.
THE WITNESS: I'm sorry. I misunderstood you.
THE COURT: I mean the committee.
THE WITNESS: I apologize.
Yes.
BY MS. WIGMORE:
Q. Doctor, are you aware of any studies comparing the relative safety of intact D&E with dismemberment D&E?
A. Yes.
Q. What study or studies are you aware of?
A. Well, the studies that I know of is a study that was published a couple of years ago in one of the journals where they looked at long-term outcome of D&Es, and I believe most recently there is a study that is about to be published.
Q. What is that study?
MS. GOWAN: Objection, your Honor.
The government has a pending in limine motion in connection with the study that's about to be published by

Dr. Stephen Chasen and we would request that plaintiffs not be permitted to inquire of plaintiffs other witnesses concerning that study.

As your Honor knows, that involves the issue of medical records, it involves the issue that's currently pending before the Second Circuit.

THE COURT: I would defer questioning on that and the witness can be recalled for that area, but I think Ms. Gowan has a point.

MS. WIGMORE: Your Honor, may I be heard on that point?

THE COURT: Sure.

MS. WIGMORE: This witness has already testified at his deposition, he has relied on this study, it is part of his expert opinion. Under the rules of evidence he is entitled to rely on evidence and describe it whether or not its admissible.

For those reasons I think it is appropriate that he be able to testify about the general nature of this study. It is part of the opinion.

THE COURT: Well you are putting --

Doctor, have you read this report of Dr. Chasen?

THE WITNESS: Yes, I did.

THE COURT: But it's not published.

THE WITNESS: It is accepted for publication. In our Speciality that comes as close to being published as you can in

fact.
Many papers that have been accepted for publication can be pre-publicized sometimes and it happens all the time that something that is really important people know about.
THE COURT: This witness is going to go over into the afternoon so I am going to restrict you at the moment but you can go ahead with the rest.
MS. WIGMORE: Sorry. I need clarification, your Honor. May I ask him about the study at all?
THE COURT: No, not now. He is going to continue into this afternoon. I will let you know whether or not I will allow questions about it after lunch.
MS. WIGMORE: One more point of clarification. I believe Ms. Gowan's motion does not address precluding all testimony generally about the article but rather precluding expert testimony of Dr. Stephen Chasen.
I will move on to another subject.
THE COURT: I'm not sure what you just said but go right ahead. Move on.
BY MS. WIGMORE:
Q. Dr. Grunebaum, could you please refer to Plaintiff's Exhibit 69 in your exhibit binder?
A. Yes.
Q. Do you see the word Section I, short title, on the first page of this exhibit?

A. Yes, I do.
Q. Will you please read the sentence under that heading?
A. This Act may be cited as (Partial-Birth Abortion Ban Act of 2003.)
Q. Dr. Grunebaum, have you read this Act in its entirety?
A. Yes, I did.
Q. Could you please refer to Section II of the Act? What is the heading of that section?
A. Findings.
Q. Have you reviewed this section of the Act?
A. Yes, I did.
Q. If you could refer, please to Section 14A of the findings, which appears on the fourth page of this Act?
A. I have it.
Q. I want to direct your attention to the following language at the beginning of the paragraph which I will just read for you and ask you to follow along:
"Partial-birth abortion poses serious risks to the health of a woman undergoing a procedure. Those risks include, among other things, an increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term."
Did I read that correctly?
A. Yes, you did.

Q. Are you familiar, Doctor, with cervical incompetence?
A. Yes, I am.
Q. What is it?
A. Cervical incompetence is a weakening of the cervix.
Q. Let's assume for a moment that the partial-birth abortion, the term used in this finding, is intact D&E. Based on that assumption, do you agree that an intact D&E increases the woman's risk of suffering from cervical incompetence?
A. From an intact D&E?
Q. Yes.
A. No.
Q. Why not?
A. There is no evidence for it whatsoever. And in addition to this, if you compare an intact D&E with a dismemberment D&E, it's very clear to everybody who understands the procedures that if at all any risks -- and there are no risks increased in a dismemberment D&E -- but even in a dismemberment D&E there is no evidence whatsoever from the procedure itself that there is increased risk of cervical incompetence, especially if it is done correctly by a trained person.
Q. Doctor, have you ever treated a woman with cervical incompetence?
A. All the time.
Q. Have you ever treated a woman with cervical incompetence who had no prior history of intact D&E?

A. All the time.
In fact, it happens more often than not in women who have never been pregnant before, so it's a condition whose origin more often than not we don't know about.
Q. Doctor, I want you just to assume for a moment that there were some evidence showing a risk of cervical incompetence from an intact D&E; if that were true would affecting fetal demise prior to the surgical removal of the fetus eliminate the risk of cervical incompetence?
A. I don't see how.
Q. Why not?
A. Because it has nothing to do with dilating or entering the cervix at that moment.
Q. Dr. Grunebaum, if you could refer back to section 14A of the Act, I want to follow on from where we left off.
Do you see the words increased risk of uterine rupture, abruption?
A. Yes.
Q. Embolus amniotic fluid?
A. Yes.
Q. What is uterine rupture?
A. Uterine rupture, as I mentioned before, is a hole in the uterus. The uterus is either opened up through artificial means or through labor.
Q. Do you agree that there is an increased risk of uterine

rupture from an intact D&E?
A. Well I have a problem with the word increased risk because I --
THE COURT: Could you say that again, Doctor?
THE WITNESS: I have a problem with the word increased risk in this specific circumstance because I don't know what it compares it with. Increased risk to what?
Q. Let's assume that increased risk refers to intact D&E in comparison to other methods of second trimester abortion.
MS. GOWAN: Objection. No foundation.
THE COURT: I think the doctor is capable of answering the question.
THE WITNESS: Well, as I testified before, in a induction termination of pregnancy with a scar on the uterus there is clearly, without any doubt, an increased risk of rupturing the uterus if the woman goes into labor.
So, if you compare the intact D&E with an induction D&E, specifically in a woman who has a prior classic incision, there is no doubt that the induction D&E has a much, much higher risk of rupture. In fact, it is so high that it's contraindicated.
The intact D&E in fact is the preferred method of terminating the pregnancy over the induction termination of pregnancy when there is a scar on the uterus.
THE COURT: How about when there is no scar?

THE WITNESS: When there is no scar, labor in and of by itself can also rupture the uterus but that is much, much lower risk.

And the risk in the dismemberment D&E is that you can rupture the uterus. There is no question about it. I testified to that previously. That's one of the risks in a dismemberment D&E.

In the intact D&E that risk is lessened because you do not use the instruments.

I testified that the time of uterine rupture happens in a dismemberment D&E when you introduce the instruments. It's the thing we are most frightened about and anything we can do to lessen the introduction of instruments, multiple passes of instruments will, by definition, decrease the risk of uterine rupture.

BY MS. WIGMORE:

Q. Dr. Grunebaum, what is abruption?

A. Abruption is the detachment of the placenta.

Q. Based on your experience, do you agree that there is an increased risk of abruption from an intact D&E?

A. I need to say ahead of time that, again, I have to compare it to increased to what? I'm assuming you are comparing it in future pregnancies, is there a risk, and I am just editorializing; in future pregnancies of having an abruption after you do an intact D&E, and I would say that's total and

absolute nonsense.
Q. Why is that?
A. Because an abruption, detachment of the placenta usually happens in the third trimester of the pregnancy, it happens when a woman still carries the fetus inside the uterus. And it usually happens -- one of the risk factors, if not the major risk factor -- is a woman having high blood pressure, hypertension, pre-eclampsia can lead to abruption of the placenta.

So, if I follow the steps here that if the intact D&E leads to the abruption it would also lead to hypertension in the next pregnancy and that's nonsense.

There is nothing that relates an intact D&E to an abruption specifically compared to a dismemberment D&E. It's much safer to do it specifically as it relates to the lining of the uterus.

Q. Doctor, what is amniotic fluid embolus?
A. Amniotic fluid embolus is one of the most dangerous life threatening conditions in pregnancy and if it happens it kills a good percentage of women. It happens. Fortunately, it is such a rare condition that most obstetricians have never seen it.

What happens is that the amniotic fluid is pushed into the blood vessels and in the uterus there are big blood vessels. And then it travels along the blood vessel into the

lung and it blocks the lungs and then the woman has difficulty breathing. It is similar to a pulmonary embolus.

In pulmonary embolus you have a blood clot and the pulmonary fluids, the blood clot blocks the lung.

Q. Doctor, do you agree there is increased risk of amniotic fluid embolus from intact D&E?

A. There is decreased risk --

Q. Why is that?

A. -- as compared to the induction termination of pregnancy.

In an induction termination of pregnancy it is logical. You give medication, you increase the pressure inside the uterus. It is like a balloon.

So, during an induction termination of pregnancy there are continuous contractions and as the balloon is being pressed, the amniotic sac, you increase the risk of that fluid being pressed into the blood vessel and creating a amniotic fluid embolus.

In a D&E, both dismemberment and intact D&E, you break the water immediately at the beginning of the procedure and most fluid is going to -- we know that with intact membranes the risk is higher than with ruptured membranes.

So, to say that the intact D&E has an increase of pulmonary fluid embolus is nonsense.

Q. Doctor, I would like to refer you back to Plaintiff's Exhibit 69, the Act, and to the next phrase in Section 14A

which reads:
"And the trauma to the uterus as a result of converting the child to a footling breech position, a procedure which, according to a leading obstetrics textbook 'there are very few, if any indications for' -- and then there is ellipses -- 'other than for delivery of a second twin."
Did I read that correctly?
A. Yes.
Q. First of all, what is converting the child to a footling breech position?
A. Converting a child to a footling breech position is when you turn the child around 180 degrees.
There are two positions -- three positions but two where the fetus is in longitudinal position as I explained earlier, it was either vertex or breech.
So, conversion to footling breech can be done from a vertex which is 180 degrees, or it can be done from a transverse line, which is 90 degrees.
Q. How often does that occur in the intact D&Es you perform?
A. I don't perform a conversion from vertex to breech in intact D&Es.
Q. Doctor, do you agree with the statement I just read regarding trauma to the uterus as a result of converting the child to a footling breech, a procedure which, according to a leading obstetrics textbook, there are very few, if any

indications for, other than for delivery of a second twin?
A. Yes.
Q. Do you agree with that statement?
A. No.
Q. Why not?
A. Because -- first of all, let me say that I do perform conversions from vertex to breech and vice versa fairly frequently, and I usually do it at the time of caesarean sections but I don't if indicated. So, I do perform those procedures.

In this specific instance the leading obstetrics textbook is Williams Obstetrics which is a text. The sentence mentioned here is taken more or less verbatim from that textbook. And the section --

THE COURT: Have you compared it, is it verbatim?

THE WITNESS: Yes.

THE COURT: It is verbatim. Not more or less, it is verbatim.

THE WITNESS: Well, actually you cannot -- there are three stars here in this sentence so in Williams those stars are missing.

MS. WIGMORE: There is an ellipses, your Honor, just for clarification.

THE COURT: All right.

BY MS. WIGMORE:

Q. Go ahead.
A. That section in Williams relates to doing a version in live fetuses where we are concerned about the health and well-being of the fetus.

For example, a mother goes into labor and we are about to deliver the baby. The textbook says we really shouldn't do it or should do only a few times because under those circumstances a caesarean section is more appropriate. It does not at all apply to an abortion procedure.

Q. Are there any differences in the risks of converting to a footling breech position in a live birth versus converting to a footling breech position in an intact D&E?

A. Absolutely.

In a live term gestation there are several things to consider. The first one is the well-being of the baby. We are very concerned that the baby is being delivered in the safest possible way.

In an abortion procedure we are not concerned about the well-being of the fetus but we are very concerned about the well-being of the mother. That's one reason why it's different.

The other reason it is different is that in an abortion procedure the fetus is much, much smaller, sometimes up to 10 times smaller than a term fetus so that damage that's possibly being done by a big baby is much larger than the small

one.
In addition to this, the uterus in a term pregnancy is much, much thinner than it is in a second trimester pregnancy so that also further increases the risk of uterine damage.
Q. Doctor, I want to refer your attention back to Section 14A of the Act and I want to refer you specifically to about seven lines from the bottom, do you see the word "lacerations?"
A. Where are you again? I'm sorry.
Q. The phrase is "a risk of lacerations," it is about --
A. 14A?
Q. Yes, 14A.
A. Yes, I see it.
Q. And I am going to read that phrase for you.
"A risk of lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull, while he or she is lodged in the birth canal and an action which would result in severe bleeding."
Did I read that correctly?
A. Yes.
Q. Do you agree that intact D&E involves blindly forcing a sharp instrument into the base of the unborn child's skull?
A. It includes forcing an instrument into the skull but more often than not that is either done with direct vision either with my eyes, I can see it happening, or with my hands, I can

feel where it goes into. That is different than a blind insertion with a dismemberment D&E where I go into the uterus and I feel nothing.

So, insertion of the instrument into the fetal skull, more often than not with my procedure, involves that I can see it, I can feel and I can see it.

Q. When you say more often than not you can see it, how is the fetus positioned?

A. Well, what you do during this procedure is you pull down the body of the fetus and the cervix is being pulled down and the vaginal walls are opened up by your assistant so you can actually see where you enter.

You never, if ever, enter the fetal skull without seeing where you are going to.

Q. Doctor, if you could refer back to the first page of the act I want to direct you to Section 2 of the findings.

Do you have that page?

A. Yes.

Q. And I want you to refer to the first sentence of paragraph 2 which reads:

"Rather than being an abortion procedure that is embraced by the medical community, particularly among physicians who routinely perform other abortion procedures, partial-birth abortion remains a disfavored procedure that is not only unnecessary to preserve the health of the mother but

in fact poses serious risks to the long-term health of the woman and in some circumstances their lives.

Assuming for the moment that the partial birth abortion referred to in that section is intact D&E, do you agree that intact D&E has not been embraced by the medical community and remains a disfavored procedure?

A. No.

Q. Why not?

A. Because it is a procedure which is embraced by my medical community which is the American College of OB/GYN. I am a member of the American College of OB/GYN. I work together with I don't know how many members right now, over 40,000, and we support that procedure.

So, to say it's not embraced is contrary to the reality.

THE COURT: Wait, Doctor. Have you circulated all 40,000 to see if they agree with you?

THE WITNESS: No, I did not circulate and I expect that not all 40,000 do embrace it.

THE COURT: So that might be an overstatement.

THE WITNESS: I'm sorry?

THE COURT: It might be an overstatement to say all 40,000 --

THE WITNESS: Yes.

THE COURT: -- agree with you, is that correct?

THE WITNESS: Yes.
THE COURT: Okay.
Next question, Ms. Wigmore.
BY MS. WIGMORE:
Q. Dr. Grunebaum, could you please refer to Section 13 of the findings which appears on the third page of the Act, and let me know when you have found that section?
A. Yes.
Q. Could you just take a moment -- let me just read that section for you so we have it on the record.
There exists a substantial -- there exist substantial record evidence upon which Congress has reached its conclusion that a ban on partial-birth abortion is not required to contain a health exception because the facts indicate that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health and lies outside the standard of medical care.
That's the first sentence of Section 13; do you agree with that sentence?
MS. GOWAN: Objection, your Honor. There is no foundation that this witness has any idea what's in the record evidence underlying the Partial-Birth Abortion Ban Act.
MS. WIGMORE: I will rephrase, your Honor.
Q. Dr. Grunebaum, do you agree that partial-birth abortion is never necessary to preserve the health of a woman?

A. No.
Q. Do you agree that intact D&E poses serious risks to a woman's health?
A. As compared to induction or other forms of termination of pregnancy? No.
Q. Do you agree that intact D&E lies outside the standard of medical care?
A. Absolutely not. If it's embraced by my professional organization how can it be outside the standard of medical care?
MS. GOWAN: Objection. Move to strike the part of the answer that refers to his professional --
THE COURT: Sustained.
THE WITNESS: It is not outside the standard of medical care.
BY MS. WIGMORE:
Q. And putting aside any statement about any medical organization, why do you believe that's the case?
A. Because it is being done at our hospital, it is being done at other hospitals around the country, and if something is outside the standard of medical care, believe me, very quickly those individual hospitals would forbid that procedure.
Q. Doctor, could you please refer to Section 14B of the findings which is on the next page?
A. Yes.

Q. And I want to direct your attention to the last sentence of that section which reads:

"Indeed, unlike other more commonly used abortion procedures there are currently no medical schools that provide instruction on abortions that include the instruction in partial-birth abortions in their curriculum.

Doctor, do you agree that there are currently no medical schools that provide instruction on intact D&E?

A. No.

(Continued on next page)

Q. Why not?
A. Because it is being taught at Cornell, and I know it's being taught at Columbia. I also know that other physicians in other places, and I have heard of them, do teach it at medical schools. But at the very least, there are at least those two medical schools in Manhattan who teach it on a routine basis to medical students and to residents.
MS. WIGMORE: Your Honor, I am at the end of a line of questioning. I don't know what your preference is for lunch, but I wanted to let you know that.
THE COURT: We will take our luncheon break. We were going to have to take it in five minutes anyway. We will take our luncheon recess at this time and reconvene at 2:00 p.m. Court will stand in recess.
(Luncheon recess)

AFTERNOON SESSION
2:15 p.m.
AMOS GRUNEBAUM, resumed.
THE COURT: Good afternoon. Before we continue with the testimony, there are a few housekeeping problems. There are a few open motions, I believe all by the government.
One we had this morning with regard to the inquiry of Dr. Grunebaum concerning Dr. Chasen's report. I have read the government's submissions and heard argument. Although I considered the result, unless something has changed in the Court of Appeals that I am not aware of, it results in a grossly unfair situation where the government cannot obtain records to inquire of witnesses.
On the other side, albeit the records are in the custody of third parties and are the records of the hospital, the government has given me no authority for precluding the testimony in this type situation where a third party has refused to turn them over, and in the case of the Seventh Circuit they have been upheld. We don't know about the Second Circuit. And the Court in Philadelphia has precluded records.
I am going to allow the plaintiffs to inquire as to the Chasen records, however with the caveat that I may order Dr. Grunebaum back to the stand if records are turned over and the government sees fit to inquire. I am going to not require the plaintiffs to defer Dr. Hammond any longer in that, for the

same reasons, the government has given me no reason to preclude his testimony, albeit in the Court's opinion the government should have the right to inquire as to the records underlying the doctor's clinical experience that I presume he is going to testify about.

With regard to the exhibits yesterday -- is Ms. Parker in the courtroom?

MS. PARKER: Yes, your Honor yes, your Honor.

THE COURT: I believe they are exhibits 5, 6, and 8, is that correct?

MS. PARKER: That's correct, your Honor.

THE COURT: I am going to refuse to admit them into evidence at this time. Although, I ask the government to consider, based on the foundation laid by the plaintiffs using, how many times have I said this, the ill-advised procedure to use deposition testimony, I don't think the foundation was laid.

However, I believe the government has listed the Congressional Record as their exhibit, and there has been some mention that these exhibits are part of the Congressional Record, which you are all free to remind me of. They will come in at that time in any event if that is the case. But based on the foundation laid yesterday, I will deny their offer into evidence based on the foundation laid in the deposition.

Ms. Wigmore, we can continue. Excuse me one minute.

Ms. Gowan, is there any news from the appellate world?
MS. GOWAN: No, your Honor, other than I believe the government's papers were either filed within the hour or will be shortly.
THE COURT: But there is no change as of this moment?
MS. GOWAN: That is correct.
THE COURT: And no other approaches have been taken that you need to tell me about at this point?
MS. GOWAN: No, your Honor. Thank you.
THE COURT: Ms. Wigmore, you may proceed.
MS. WIGMORE: Thank you.
DIRECT EXAMINATION (continued)
BY MS. WIGMORE:
Q. Dr. Grunebaum, are you aware of any studies comparing the relative safety of intact D&E with dismemberment D&E?
A. Yes, I am.
Q. Which study are you aware of?
A. There is a study about to be published with Dr. Chasen as the lead author, I believe.
Q. Could you please describe for us that study generally.
A. That study in general looked retrospectively at women who underwent dilatation and evacuation for termination of pregnancy. It then compared the dismemberment variant to the intact D&E variant.
Q. When you say the study looked retrospectively, what do you

mean?
A. Retrospectively is you identify people who undergo a certain procedure or who are under certain situations. Then you abstract information from those medical records and then you compare them with each other.
Q. In the course of your medical practice, have you relied on retrospective studies?
A. All the time.
Q. What were the results of Dr. Chasen's study regarding the comparison of intact D&E and dismemberment D&E?
A. I can give you the general gist. My understanding from the study is that both forms of D&E are safe.
Q. What, if any, impact does Dr. Chasen's study have on your opinion concerning the relative safety of intact D&E and D&E involving dismemberment?
A. It confirms what I said previously, that the intact D&E is as safe or even safer than the dismemberment D&E.
Q. Did Dr. Chasen's study conclude that there was any difference in complication rates for D&E versus intact D&E?
A. Not that I can recall.
Q. What is your basis for concluding that intact D&E offers safety advantages over dismemberment D&E?
A. The study shows that both dismemberment D&E and intact D&E have similar outcomes. But the groups that have been compared in that study are slightly different groups and they differ

mostly as to the gestational age of the pregnancies. The average gestation age of the patients in the intact D&E group were slightly more advanced.
THE COURT: Slightly more what?
A. More advanced in pregnancy. I believe they were 23 weeks on average as compared to 21 weeks in the dismemberment D&E.
Q. Do the risks of abortion change at all with the advancement of gestational age?
A. Absolutely. They increase as the gestational age advances. For example, an abortion done at 20 weeks is less risky than that done at 21 weeks, 22 weeks. The reason for that is as we explained before. The fetus is bigger, the placenta is bigger, and the uterus is more distended, so you would expect at a more advanced gestation age more complications.
Q. Doctor, could you please refer back to Plaintiffs' Exhibit 69, which is the Act.
A. I have it in front of me.
Q. I want to direct your attention to section 1531 of the Act, which appears on page S3-6.
A. I do have it in front of me.
Q. What is the title of section 1531?
A. "Partial-Birth Abortions Prohibited."
Q. Could you please read for us the first sentence under section 1531(a).
A. "Any physician who, in or affecting interstate or foreign

commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus, shall be fined under this title or imprisoned not more than 2 years or both. This subsection does not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from pregnancy itself."

Q. Thank you.

THE COURT: By what is the last phrase? Caused by what?

THE WITNESS: "caused by or arising from the pregnancy itself."

THE COURT: Thank you.

Q. Doctor, is "partial-birth abortion" a medical term?

A. No, it is not.

Q. Is there a commonly understood meaning of "partial-birth abortion" in the medical community?

A. No, there isn't.

Q. If you could please turn your attention to section 1531(b)(1). Could you please read that section for us, sections 1531(b)(1)(A) and (B).

A. "As used in this section, the term 'partial-birth abortion' means an abortion in which the person performing the abortion (a) deliberately and intentionally vaginally delivers a living

fetus until in the case of a head-first presentation the entire fetal head is out of the body of the mother, or in the case of breech presentation any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus and (b) performs the overt act other than completion of delivery that kills the partially delivered living fetus."

Q. Thank you, Doctor. You can stop there for the moment. Does the term "vaginally delivers" have a commonly understood meaning in the medical community?

A. Yes, it does.

Q. What does that term mean?

A. A vaginal delivery is the passage of a fetus through the cervix into the vagina and then outside of the woman's body.

Q. Does the term "vaginally delivers" cover an instance in which only part of the fetus is delivered?

A. Yes, it does.

Q. Does the phrase "living fetus" have a commonly understood meaning in the medical community?

A. Yes, it does.

Q. What does that phrase mean?

A. Usually, it means that there is a fetal heart beat and/or fetal movements or the fetus is breathing, breathing movements.

Q. Are you familiar with the term "viable" in the context of a

fetus?
A. Yes, I am.
Q. In the medical profession, is there any distinction between the meaning of the term "living" and the meaning of the term "viable"?
A. Unfortunately, sometimes the word "viable" is misunderstood as meaning the same thing as "living." However, in the medical context the word "viable" means that the fetus has a reasonable chance to survive outside the uterus.
Q. Within the medical community, is there a commonly understood meaning of the phrase "breech presentation"?
A. Yes, there is.
Q. What does that phrase mean?
A. A breech presentation is when the fetus presents to the vagina or the cervix either with one or two feet or the butt.
Q. Dr. Grunebaum, in the definition you just read for us, do you see the phrase "any part of the fetal trunk past the navel"?
A. That is correct.
Q. Based on your experience as a physician, do you have an understanding of what that phrase means?
A. It is not very clear. I assume, I think, it is anything other than the head or the legs or the feet. But my problem is that I don't know what "past the navel" means, because the word "navel" in this context is not a medical term. The fetus does

not have a navel.
Q. Do you have an understanding of what "past the navel" means?
A. No, I don't. Because depending on from where you look, if I look from myself down, it could be part of my behind; or if somebody looks from my feet up, it could be part of my chest. So it is not clear what "past the navel" means.
Q. Doctor, I would like to focus your attention for a few moments on the intact D&E. We have discussed the medical meaning of a number of terms in the definition of "partial-birth abortion." Do you have an opinion as to whether that definition encompasses intact D&E?
A. Yes: It does.
MS. GOWAN: Objection to the form of the question.
THE COURT: Let me hear it again.
(Question read)
A. Yes, it does, for the following reason. In an intact --
THE COURT: Doctor, I didn't rule on it yet.
THE WITNESS: I'm sorry. I apologize.
THE COURT: Rephrase the question, please.
Q. Doctor, do you have an opinion as to whether the definition of "partial-birth abortion" you just read encompasses intact D&E?
MS. GOWAN: Objection: Calls for a legal conclusion.
THE COURT: Sustained.

Q. Doctor, I direct your attention to the phrase "vaginally delivers a living fetus." Can you tell us whether or not intact D&E involves vaginal delivery?
A. Yes, it does.
Q. When you perform an intact D&E, is the fetus living when you commence with a vaginal delivery?
A. It usually is.
Q. In your experience, what percentage of intact D&E's involve a fetus in a breech presentation?
A. In my case, the vast majority.
Q. When you perform an intact D&E on a fetus in a breech presentation, do you vaginally deliver a fetus at which any part of the trunk past the navel is outside the body of the mother?
MS. GOWAN: Objection to the form of the question.
THE COURT: Let me hear it.
(Question read)
MS. GOWAN: And leading, your Honor.
THE COURT: No. I will allow it.
A. Yes, I do.
Q. Can you please explain how that occurs.
THE COURT: Ms. Gowan, the question is yes or no. It is not leading. In any event, go ahead. Next question.
Q. Could you explain, please, how that occurs, Dr. Grunebaum.
A. In an intact D&E, the legs or the feet of the fetus are

pulled forward through the cervix until the head lodges in the cervix, so at that moment you have delivered most parts of the fetus except the fetal head.
Q. Dr. Grunebaum, does an intact D&E involve an overt act that you know will kill the fetus?
A. The whole abortion involves that, so with all abortions they involve it. That is the idea of an abortion, to kill the fetus.
Q. Dr. Grunebaum, in an intact D&E do you typically compress the skull?
A. Typically, yes.
Q. Is that an act that you know will kill the fetus?
A. Not necessarily. It is the whole procedure. As you pull the fetus down, it will kill a previable fetus. I know the fetus will not survive outside the uterus at that moment. So there are several things that may potentially kill the fetus, but one of them could be the compression of the skull.
Q. Have you ever performed an intact D&E during which you have compressed the umbilical cord while the fetus was still living?
A. Not intentionally. But then the umbilical cord is being compressed as you pull the fetus down.
Q. Is the compression of the umbilical cord an act that will kill the fetus?
A. Not necessarily. Not all the time. It could be an act, but not necessarily.

Q. At what point in the procedure would you perform the act of cutting the umbilical cord?
A. After I have compressed the fetal skull and delivered the body.
Q. At that point is any portion of the fetus outside the mother's body?
A. Yes, nearly all of the fetus is outside the mother's body at that point.
Q. When you perform an intact D&E, are any of the steps you take that you have described for us deliberate and intentional?
A. Yes.
Q. Which ones?
A. All of them, I hope.
Q. Doctor, assuming the acts and their effects, do you have any fear of prosecution should you perform an intact D&E?
A. That is why I am here today, to explain my fears of being prosecuted and ending up in prison. I have been a doctor now for, what, 30 years, and I have never been really threatened by law with going to prison by doing a procedure that I consider safe for my patients.
Q. Dr. Grunebaum, I want to focus your attention now on D&E's involving dismemberment. Do you have any fear of prosecution under the Act if you were to perform a D&E involving dismemberment?
A. Yes, I have.

Q. Why is that the case?
A. Because in a dismemberment procedure, more or less the same as is described under what this Act calls a partial-birth abortion, and I can only read again, "The term 'partial-birth abortion' means an abortion in which a person deliberately performing the abortion deliberately and intentionally vaginally delivers a living fetus." That is what I do in a partial-birth abortion, in a dismemberment D&E also.
Q. In a dismemberment D&E do you ever deliver a portion of the fetal trunk past the navel outside the woman's body?
A. It definitely can happen. I don't do it all the time, but it is definitely part of the possibility of doing a dismemberment D&E.
Q. Can you give us an example of when that might occur.
A. At the moment when I have removed the laminaria and I have ruptured the membranes, let's suppose the fetus is in vertex presentation and I decided to do a dismemberment D&E.
Q. If I could stop you there. Could you tell us what vertex presentation is.
A. Vertex presentation is with the head down. As I explained before, I prefer to do the intact D&E when the fetus is in breech presentation. So in a vertex presentation I usually initiate the procedure by inserting an instrument into the vagina through the cervix and remove portions of the fetus. At that moment the fetus is alive, and at that moment, as I pull

out portions of the fetus, I deliver part of the fetus.
Q. Is it ever the case that you deliver a portion of the fetus past the navel outside the woman's body in a dismemberment D&E?
A. Yes.
Q. Could you provide an example of how that might occur.
A. I may deliver initially a leg or an arm of the fetus. Both of them are past the navel, depending on where you look.
Q. After you had delivered that portion, is the fetus still living?
A. It could be.
Q. If you have dismembered a leg, can the fetus still be living?
A. Absolutely.
Q. And after you have done that, what would the next step be in the procedure?
A. The next step would be to remove other portions of the fetus or to deliver the remainder of the fetus. At that moment I can either deliver additional portions of the fetus or, if with the next step I get a portion of the fetus that is still more or less intact even though I am doing a dismemberment D&E, I potentially could deliver the fetus intact with whichever portion I have removed before.
Q. Let's take those situations one by one. In the case where you continue to deliver the fetus by continued dismemberment, is that an act that would kill the fetus?

A. Eventually it will, yes.
Q. Let's take the other example you gave, where you may deliver the fetus intact. What happens next?
A. It depends how I deliver it intact. Let's say the fetus at that moment has turned from a vertex to a breech -- it can happen -- and at that moment I have already delivered part of the fetus. I can then deliver the fetus with the instrument and then sometimes proceed similar to the intact D&E where the head is lodged in the uterus. And I then have to perform a craniocentesis to decrease --
THE COURT: What is that?
THE WITNESS: A craniocentesis is a procedure whereby you make an incision in the back of the fetal head and you then remove portions of the fetal contents of the skull to reduce the size of the skull.
THE COURT: Is that where with a suction device you suck the brains out?
THE WITNESS: You can either do it with the suction device or do it without.
THE COURT: How do you do that?
THE WITNESS: If you make an incision, sometimes the brain tissue comes out without suctioning it, because it is soft tissue and then the skull collapses. The idea is to make the skull collapse, because it is a very wide portion of the skull.

THE COURT: Does it do it on its own or do you have to do something to crush it and compress it?
THE WITNESS: That is a good question actually. Sometimes you have to crush it. But sometimes, for example, in a medical condition called hydrocephalus -- hydrocephalus is a medical condition and it is a frequent condition for doing termination of pregnancy -- all you need to do is make a small incision in the back of the skull anywhere, whichever is easiest accessible. Then the water inside the skull will come rushing out without suction and the skull collapses. The idea is to decrease the size of the skull so that you can deliver the remainder of the fetus.
THE COURT: Sometimes it does it on its own and sometimes you have to crush it?
THE WITNESS: Absolutely.
Q. Doctor, I just want to make sure I understand the example you have given us. Is the first step that you remove a portion of the of fetus outside the body of the mother?
A. Yes, it is.
Q. Then what is the next step after that piece has been removed?
A. Then, with the dismemberment D&E, I remove remainders of the fetus piece by piece.
Q. Is that an act you know will kill the fetus?
A. Absolutely.

Q. In the other example you gave us, you have removed a portion of the fetus, is that correct?
A. Correct.
Q. Then do you deliver the rest of the fetus up to the head?
A. Yes, I do.
Q. At that point is the fetus still living?
A. It could still be living, that is certainly possible, because just removing an arm or a leg does not at that moment necessarily kill the fetus.
Q. At that point do you compress the skull?
A. I may have to compress the skull if it is easily accessible. I will be lucky from a safety point of view to be able to offer this to the patient, because if I cannot safely compress the skull at that moment, I would have to use additional instruments to crush the skull. And every time I enter with those additional instruments into the uterus, I increase the risk to the mother.
Q. Can compressing the skull kill the fetus?
A. Yes.
Q. Doctor, I want to turn your attention now to the induction abortion. Do you have any fear of prosecution under the Act if you perform an induction abortion?
A. Absolutely.
Q. Why is that the case?
A. Again, I deliberately and intentionally vaginally deliver a

living fetus in some instances. With an induction abortion, sometimes it can take 12 hours, sometimes it can take 8 hours. But at the time the fetus has been expelled, there is still a possibility that the fetus is living. The induction abortion does not always kill the fetus.
Q. Doctor, in an induction abortion, do you remove the fetus; do you vaginally deliver the fetus to a point at which a portion of the fetal trunk past the navel is outside the woman's body?
MS. GOWAN: Objection: Leading.
THE COURT: No, I will allow it.
A. Yes. Same, similar to a dismemberment or intact D&E. As the fetus passes by through the cervix, it can be intact or not.
Q. What do you do after that?
A. What I usually do is I guide with my hands to the fetus and I try to remove the remainder of the fetus from the cervix. If it is stuck at that moment in the cervix, if the cervix is less dilated than the head and the head is stuck, that can be very dangerous to the woman, because the uterus contracts in an induction termination of pregnancy and can rupture much more easily because it is trying to expel the fetal head.
Q. Have you uncountered circumstances in an induction where the head lodges in the cervix?
A. Absolutely.

Q. What do you do in those circumstances?
A. I have several options. I can wait longer and wait for the delivery to be complete, and sometimes it takes hours. Or at that moment if I feel there is too much hemorrhage, for example, because the procedure has already begun, I may have to take the patient to the operating room and then decompress the skull at that moment.
Q. Is decompressing the skull an act that can kill the fetus?
A. If the fetus was still alive at that point, absolutely.
Q. Are there any cases in which the fetus is still living when you have vaginally delivered it up to the point where the head is lodged in the cervix?
A. It is absolutely possible. You perform the induction termination of pregnancy to deliver the fetus, not necessarily to kill it prior to delivery.
Q. Doctor, you mentioned another option of waiting to see if the fetus will be delivered in its entirety, is that right?
A. Yes.
Q. Are there any risks associated with that approach?
A. Yes.
Q. What are they?
A. What happens is at that moment the fetus eventually will be delivered through contraction activity of the uterus. If the head, which is larger than the diameter of the cervix, is continuously pushed through the cervix, the cervix can get

injured, and that can be a very dangerous situation.
Q. Doctor, are you familiar with the term "Duhrssen's incision"?
A. I am familiar with it, yes.
Q. What is a Duhrssen's incision?
A. A Duhrrsen's incision is an incision that was developed a long time back by I believe a German physician who performed the incision in order to decrease the pressure on the fetus's head and facilitate a vaginal delivery when the head is lodged in the cervix.
Q. Is that a method that you would recommend for freeing the fetal head?
A. Let's say one thing: I've never done it. Because I was told and I read it everywhere that when you do an incision into the cervix, it can be threatening, life threatening to the mother. It can go up beyond the cervix into the uterus, and when that happens severe hemorrhage can happen. I have never done it, and I haven't heard of any physician who has done it.
Q. Dr. Grunebaum, you have described steps in an induction. Are any of those steps taken deliberately and intentionally?
A. I hope so. Yes, they are.
Q. Which ones?
A. Inserting prostaglandin suppositories is done deliberately and intentionally. Or if you do it by saline, but they don't do that anymore, they do it deliberately and intentionally.

But that you do on a regular basis, sure.
Q. In the case where you vaginally deliver the fetus up past the navel, is that deliberate and intentional?
A. Yes, it is.
Q. In the case of an induction where the head becomes lodged and you compress it, is that a deliberate and intentional step?
A. Yes, it is.
Q. Doctor, you described for us earlier an example of a dismemberment D&E where you removed a portion of the leg. Do you recall that example?
A. Yes, I do.
Q. Are any of the steps that you take in that procedure deliberate and intentional?
A. Yes, they are.
Q. Which ones?
A. All of them.
Q. Doctor, are you familiar with the term "spontaneous abortion"?
A. Yes. The other word for spontaneous abortion is also a "miscarriage."
Q. What is a miscarriage?
A. A miscarriage is when a woman loses her pregnancy without any act of intervention by anyone.
Q. Do physicians have any role in treating miscarriages?
A. That is one of our major jobs, treating women who have a

miscarriage.
Q. Doctor, do you have any fear of prosecution under the Act associated with your treatment of miscarriages?
A. Yes, I do.
Q. Why is that the case?
A. Because, again, in a miscarriage I deliberately and intentionally potentially vaginally deliver a living infant. What happens in a miscarriage, specifically in the second trimester, a woman can present to the emergency room or to wherever she has been examined with the cervix already opened. We talked before about an incompetent cervix. Typically, in an incompetent cervix the cervix is opened. As part of the miscarriage, the fetus can be partially expelled through that cervix. Again, the feet and head can get stuck spontaneously.
Q. In the case of treating a miscarriage, is it ever the case that the fetus is living when you commence with a vaginal delivery?
A. Absolutely.
Q. In the treatment of a miscarriage, is it ever the case that you vaginally deliver the living fetus until the point at which part of the fetal trunk past the navel is outside the body of the mother?
A. This can happen, sure.
Q. Does it ever happen in the treatment of a miscarriage that the head becomes lodged in the cervix?

A. It happens many times.
Q. What do you do in those circumstances?
A. Again, I can wait until the rest of the fetus is spontaneously delivered. But it can also happen that the fetal head is stuck so much in the cervix that I have to then move on and decompress the fetal head. Because if it is stuck in the cervix at that moment, and the mother can, for example, hemorrhage, I can't allow that to go on for too long of a time.
Q. In those circumstances, is decompressing the fetal head an act that can kill the fetus?
A. Yes.
Q. Are any of the steps you just described in managing a spontaneous abortion or miscarriage deliberate and intentional?
A. The steps to deliver the fetus, yes.
Q. Are there any other steps that are deliberate and intentional?
A. Up to the point when the woman comes to the emergency room, nothing happens really deliberate or intentionally. But from the time she is admitted, yes.
Q. Doctor, based on your experience as an abortion provider, what impact, if any, will the ban on partial-birth abortions have on physicians who provide abortions?
MS. GOWAN: Objection.
THE COURT: What is your objection?
MS. GOWAN: I don't know how this witness can possibly

testify to the impact that it is going to have on all physicians.
THE COURT: May I have the question read back.
(Question read)
THE COURT: Sustained.
Q. Dr. Grunebaum, based on your experience as an abortion provider, what impact, if any, will the ban on partial-birth abortions have on your practice?
A. It already had impact. I'm afraid to provide a late, second trimester abortion, because I'm afraid that on a day-by-day basis I may get prosecuted, because whatever I do might fall under this ban.
Q. Doctor, based on your experience in treating patients, what impact, if any, will the ban on partial-birth abortions have on women seeking abortions?
MS. GOWAN: Objection, your Honor.
THE COURT: Sustained.
Q. Dr. Grunebaum, what impact, if any, will the ban on partial- birth abortions have on your patients?
MS. GOWAN: Objection, your Honor.
THE COURT: Sustained. How can he testify unless you are talking about a particular person and what they have told him? You are asking him to testify about the operation of some unspecified woman's mind. It can't be done. Next question.
Q. Dr. Grunebaum, you described for us a case involving the

treatment of a spontaneous miscarriage. Have you encountered any patients who have come in for that type of treatment?
A. Yes.
Q. You described for us an example involving --
THE COURT: Excuse me. I thought the very word "spontaneous," they don't come for treatment, do they? Something has already happened to them. Am I incorrect? Doctor, perhaps you could tell me. I don't think people come looking for spontaneous abortions, do they?
THE WITNESS: They come to see me --
THE COURT: Because it has already happened.
THE WITNESS: No.
THE COURT: Or at least the process has started.
THE WITNESS: Yes. But the process does not involve necessarily the passage of the fetus from inside the uterus to the outside. You can --
THE COURT: But the process of having a spontaneous abortion has commenced already when they come to see you, correct?
THE WITNESS: Yes. But there are different ways it can commence.
THE COURT: Yes, I understand that. But it is not something that you come in and perform on them?
THE WITNESS: The initial phase, no, correct.
THE COURT: Next question.

Q. Doctor, in terms of the patients whom you have seen were having spontaneous abortions, do any of them come in when the fetus is still living?
A. Yes.
Q. Have you ever had to perform any medical procedures to manage that process?
A. Yes.
Q. Doctor, do women come to you seeking D&E abortions?
A. Yes.
MS. WIGMORE: Thank you. I have no further questions at this time.
THE COURT: Ms. Gowan, are you going to conduct the cross-examination?
MS. GOWAN: Yes, your Honor.
THE COURT: You may inquire.
CROSS-EXAMINATION
BY MS. GOWAN:
Q. Dr. Grunebaum, you have a website where you offer medical advice, right?
A. Yes, I have.
Q. That is called OBGY.net, right?
A. How do you spell that, please?
Q. OBGY.net?
A. No.
Q. What is it called?

A. I work for a company called --
THE COURT: Keep your voice up, Doctor.
A. I work for a company called WebMD, and the website is WebMD.com.
Q. If I were to put in the key OBGY.net, would I not find you listed, Dr. Grunebaum?
A. I wouldn't know. But I do not have a website with that name.
Q. But are you listed on a website?
A. Called?
Q. OBGY.net.
A. I don't know. I don't know what you are talking about.
THE COURT: Is it your testimony you have never heard that you are listed there?
THE WITNESS: No.
MS. GOWAN: May I approach, your Honor?
THE COURT: You may.
MS. WIGMORE: May I see a copy, please?
MS. GOWAN: I don't have a copy. I will show it to you.
Q. Mr. Grunebaum, I am showing you a printout from the OBGYN.net website.
A. OK.
Q. Would you take a look at that, please.
A. Yes.

Q. Does your name appear on that printout?
A. It does.
Q. How is it that your name appears on that printout?
A. I don't know.
Q. If you take a look, there is a copy of your curriculum vitae attached to that printout. Do you see that?
A. Yes, I do.
Q. There is a line on the top that shows that you are curriculum vitae is published on OBGY.net, is that right?
A. Yes.
MS. WIGMORE: Objection, your Honor. At this point I don't have a copy of this exhibit. There is also a hearsay issue to the extent she is reading from the document.
THE COURT: Do you want to come up and look over his shoulder? Or what do you want?
MS. WIGMORE: I would like a copy of the document.
THE COURT: Well, you are going to get that. Obviously, I wish it was available. But if you have some problem, come up and stand next to the doctor.
MS. WIGMORE: Thank you, your Honor.
THE COURT: Where you can talk to him, of course.
A. Actually, the spelling is incorrect. It is OBGYN.net.
Q. Oh. Does that refresh your recollection now as to your bio being posted on a website?
A. I believe it is my bio, but I don't know who posted it.

Q. Is that your curriculum vitae attached to it?
A. That is part of it, yes
Q. And is that your photograph there?
THE COURT: Part of it? Is there something missing?
THE WITNESS: Yes. It is an old curriculum vitae. It is an old one.
THE COURT: It is an old one, but as far as it goes, it is correct?
THE WITNESS: I believe so.
THE COURT: OK. Next question.
Q. Doctor, take a look at your curriculum vitae. It identifies you as having a faculty appointment as an associate professor of clinical obstetrics and gynecology at Columbia University?
A. Yes.
Q. That is a printout from the website today, isn't that, Doctor?
MS. WIGMORE: I object: Foundation.
THE COURT: What is the foundation? She is asking a question, ma'am. Please.
A. It is a printout from today, correct. The printout is correct. But also I must say I am not married anymore. It says I am married, and I'm not. I have not been married for many years now. Just because it is a printout from today doesn't mean I am still married.

Q. And you haven't been a professor at Columbia University for several years, have you, doctor?
A. No. I haven't been married, correct.
Q. That is just like the curriculum vitae which you submitted to the government with your expert disclosure in this case, isn't it, Doctor?
A. It is not the same, no.
Q. Doctor, didn't you submit a curriculum vitae to the government in this case with your expert disclosure identifying you as being a professor of OB-GYN at Columbia University?
A. No. That is not what my CV says.
THE COURT: It isn't the question, Doctor. The question is, did you submit it to the government a curriculum vitae that said that?
THE WITNESS: That I was a professor at Columbia, no.
Q. Doctor, showing you what was marked as Government Exhibit 24A at your deposition in this case, it is an expert report of Dr. Grunebaum with your curriculum vitae attached.
A. And it says here assistant professor. That is different than a professor. They are different levels of being a professor. You can be assistant professor, you can be an assistant professor of OB-GYN, you can be an associate professor, you can be an associate professor of clinical OB-GYN, you can be an associate professor of OB-GYN, you can be a clinical associate professor. So all of those things are

different.
Q. At the time that you submitted that to the government in this case, you were not an assistant professor of OB-GYN at Columbia University, were you?
MS. WIGMORE: Objection, your Honor. I ask that the witness be examined from behind the podium.
THE COURT: All right. Fine. We know it is up here. Ms. Gowan, please, except when you have to come up with an exhibit, stand by the podium. Counsel is correct on that.
MS. GOWAN: Yes, your Honor.
A. At the time that I was examined by you, I was a clinical professor of clinical OB-GYN at Cornell, correct. And proud of it because it is --
THE COURT: Please, doctor. Don't argue with counsel. Just answer the question.
THE WITNESS: I apologize.
Q. You were not an assistant professor of clinical OB-GYN at Columbia University, were you?
A. Anymore, correct.
Q. That's correct. And your curriculum vitae says 1987 to now, isn't that right, Doctor?
A. That is correct.
Q. Of the 16 peer-reviewed articles that you have published, only three of those have been within the last ten years, isn't that right, Doctor?

A. Absolutely.
Q. None of those articles relates to abortion, do they?
A. That's correct.
Q. You are not engaged in any research projects at this time, are you?
A. No.
Q. But you found time over the past few years to appear on news programs, isn't that right?
A. That's true.
Q. And you have participated in a nationwide television, radio, and bookstore publicity campaign as Dr. Ruth Westheimer's co-author of Pregnancy Guide for Couples, right?
A. Yes.
Q. And you even appeared Marisa Tomei's obstetrician in Ron Howard's movie The Paper, right?
A. Yes, I did.
Q. The plaintiff Steve Chasen is a colleague of yours at Cornell, isn't that right?
A. That is correct.
Q. He was the person who approached you about becoming an expert witness in this case, isn't that right?
A. That's correct.
Q. You told us just a few moments ago that you are in fear of prosecution for performing D&E abortions because of the Act, you are afraid that you might go to prison, right?

A. That's correct.
Q. That was a fear that first came to you or that you first realized after you had agreed to be an expert in this case, isn't that right, Doctor?
A. After I first read the Act, correct.
Q. That was after someone explained to you, after you had been approached to be an expert in this case, what the law meant, isn't that right, Doctor?
A. That's correct.
Q. Is it fair to say that the number of abortion services that you provide to your private patients is a small percentage of your private practice?
A. Yes, it is.
Q. About less than 5 percent?
A. Correct.
Q. Prior to going to New York-Cornell, you were at St. Luke's, right?
A. Correct.
Q. You only performed first trimester abortions on an irregular basis at St. Luke's, didn't you?
A. No.
Q. Directing your attention to page 19/line 25 of your deposition taken in this case:
"Q. What about" --
MS. WIGMORE: Objection, your Honor. I do not have

the transcript.
THE COURT: Wait. Wait until the transcript is before everyone, please, Ms. Gowan.
MS. GOWAN: Would you like me to provide the witness a copy?
THE COURT: It is not necessary, unless you wish to. But counsel must have an opportunity to see where you are reading from.
MS. GOWAN: Are you ready, counsel?
MS. WIGMORE: Yes. May we have the line number, please?
MS. GOWAN: Page 19/line 25.
"Q. What about when you were at St. Luke's? Did you do any abortions at St. Luke's?
"A. On a very, very irregular basis."
A. Your question was first trimester abortion. This question is about abortions per se. So you did not --
Q. Doctor --
A. Your question was different. Sorry.
Q. "Q. Doctor, what type of services did you provide at St. Luke's?
"A. I did first trimester abortions on my own private patients if they desired and they wanted it to be done at St. Luke's-Roosevelt."
Were you asked those questions and did you give those

answers at your deposition?
A. Yes, I did, but there is no work "irregularly" associated with that question and answer.
Q. You also perform abortions using the labor induction method, correct?
A. Yes, I do.
Q. And within the last six months or so you performed a labor induction abortion for a woman carrying a fetus with abnormal chromosomes, isn't that right?
A. That is correct.
Q. As best you can recall, the gestational age of the fetus was between 16 and 20 weeks, wasn't it?
A. Correct.
Q. The selection of that method was based on patient choice, wasn't it?
A. That is correct.
Q. It was a perfectly safe choice in your view, wasn't it?
A. Yes, it was.
Q. You wouldn't have done it otherwise, would you ever, Doctor?
A. I gave the patient several options, and she chose to do the induction method. I would have done the D&E if that is what she had chosen.
Q. You testified this morning that D&E is as safe or safer than induction, right?

A. Correct.
Q. You can't identify any specific study in the literature that supports your belief that D&E is safer than induction, can you, Doctor?
A. It is based on my experience.
THE COURT: Could I hear your answer, Doctor?
THE WITNESS: It is based on my experience over about 20 years.
Q. You can't identify any specific study in the medical literature that supports your view, can you, Doctor?
A. There are a lot of studies that show that D&E's are safe, correct.
Q. You cannot identify any specific study in the literature that supports your belief that D&E is safer than induction, can you, Doctor?
A. I don't recall any.
Q. You testified that inductions have complications, like increased bleeding, retained placental tissue, that require D&E and that some patients develop infections. You can give patients undergoing labor induction abortion antibiotics prophylactically to ward off the possibility of infection, isn't that right, Doctor?
A. Yes.
Q. And you do that yourself sometimes in the case of a diagnosis of infection at the time of the abortion, don't you,

Doctor?
A. Yes, I do.
Q. Sometimes even prior to the induction, isn't that right, Doctor?
A. As a prophylactic measure, yes.
Q. You are suggesting that induction abortions should never be used because there is a risk of ruptured membranes and infection, aren't you, Doctor?
A. I don't recall having said that.
Q. Ah. So you are not suggesting that, is that right?
A. I'm not suggesting what?
Q. That induction abortions should not be used because there is a risk of ruptured membranes and infection.
A. I'm not suggesting that it should not be used unless there are certain contraindications.
Q. OK. Now, you expressed the view that D&E abortion, without distinguishing between D&E by dismemberment and intact D&E, is preferable over saline or prostaglandin induction abortion, right?
A. Yes.
Q. You don't do saline abortion anymore, do you?
A. Correct.
Q. Nobody does, do they?
A. I don't know what others do, but I don't do it anymore. I have not seen anybody doing it recently.

Q. And it is not your view that D&E is always preferable over induction abortion by oxytocin, isn't it?
A. Where does oxytocin come from.
Q. Isn't oxytocin sometime used in induction labor abortion, Doctor?
A. Not in my practice.
Q. You don't have any view, then, on whether D&E would be preferable over induction abortion by oxytocin, do you?
A. My experience has been that using oxytocin is not successful in an early second trimester abortion procedure.
Q. Is it your view or not, Doctor, that D&E would be preferable over induction abortion by oxytocin?
A. Yes, it is my view.
Q. It is your view. And that that would be only in circumstances in which the cervix wasn't sufficiently dilated, is that right?
A. I don't really use oxytocin induction abortions, so I don't know where this comes from.
Q. And you have no opinion as to whether D&E would be preferable to misoprostol-induced abortions, isn't that right?
A. Yes, I do.
Q. Directing your attention to page 136/line 15 of your deposition transcript in this case:
"Q. What about the use of prostol? Do you think that D&E is preferable to induced abortion through the use of misoprostol?

"A. I have no experience with misoprostol-induced abortions."
Were you asked those questions and did you give that answer at your deposition in this case?
A. Yes, I did.
THE COURT: Would you be please be kind enough to explain what misoprostol is.
THE WITNESS: Absolutely. Misoprostol is a kind of prostaglandin which, when given, can soften the cervix and induce labor and lead to a termination, to an abortion. However, misoprostol can also be used together with a D&E. So yes, I have used misoprostol together with preparing the cervix for the D&E, but it by itself did not lead to the abortion; it is just part of preparing the cervix for the abortion.
Q. You perform D&E by dismemberment between 14 to 23 weeks gestational age, isn't that right?
A. Correct.
Q. You sometimes use ultrasound guidance in connection with performing the procedure, right?
A. Correct.
Q. You usually perform ultrasound at the end of the completed procedure to make sure that you have removed all the fetal tissue, isn't that right?
A. That's partially correct.
Q. That is good medical practice, right?
A. It is partially correct. May I explain?

THE COURT: Doctor, just answer the questions. Counsel who called you will have an opportunity to question you further if they decide it is necessary.
THE WITNESS: Thank you, your Honor.
Q. You testified that cervical preparation is the same for D&E by dismemberment as it is for intact D&E when you perform it, correct?
A. Correct.
Q. The amounts of the preparation depends on the gestational age of the fetus, doesn't it?
A. Correct.
Q. On the first day of the preparation, on average, you insert about 5 or 6 laminaria sticks in a woman's cervix if she can tolerate that, right?
A. Correct.
Q. If it is not too painful, right?
A. Correct.
Q. As the cervix dilates, the laminaria expands, right?
A. Correct.
Q. Then when you remove the laminaria sticks the next day, you put all those sticks together and you measure them across the top, so you know the degree of dilation that you have achieved, right?
A. No.
Q. No?

A. No.
Q. Directing your attention to page 70/line 12 of your deposition in this case:
"Q. What degree of dilation is achieved with the insertion of 5 or 6 laminaria at 18 weeks?
"A. It is impossible to know. I only know the degree of dilation when I bring the mother in the next day of the operating room. I remove the laminaria. I can put all of them together and I can measure them across. Or what's even more important is that I do an examination with my finger, with my hand, to observe the dilation of the cervix."
A. Exactly. I measure the cervical dilatation with the finger, not by measuring the laminaria.
Q. Excuse me, Doctor. "Sometimes when the laminaria while there in the cervix, dilation can be more when you find after you remove them. So it is impossible to know.
"Q. Do you do that, do you put them all together and measure them across?
"A. I do, yes."
Were you asked those questions and did you give those answers at your deposition?
A. Yes, I did.
Q. If the fetus is 20 weeks or more, you do a two-day cervical preparation, right?
A. Usually.

Q. On the second day of the cervical preparation, you take out the 5 or 6 sticks that you put in the first day and you may insert up to 20 more sticks on the second day, correct?
A. Correct.
Q. But sometimes the laminaria doesn't dilate the cervix sufficiently to perform the abortion, isn't that right?
A. On the next day.
Q. Correct.
A. Yes.
Q. When that happens, you use metal dilators in the operating room to increase the degree of dilation, don't you, Doctor?
A. I personally have never had to do it, but I know that some doctors do.
Q. Directing your attention to page 76/line 13 of your deposition in this case:
"Q. Have you used metal dilators on occasion to further dilate the cervix once you are in the operating room?
"A. Yes, I did.
"Q. And what kind of metal dilators did you use?
"A. They're usually called Hagar, called Hagar dilators. But there could be different dilators, depending on what the -- on the operative set."
Were you asked those questions and did you give those answers at your deposition in this case?
A. Yes, I did.

Q. The use of a metal dilator presents a risk of injury to the cervix, correct?
A. The inappropriate use, yes.
THE COURT: Pardon me, Doctor? Could I have the answer read back.
(Answer read)
THE COURT: Could you keep your voice up, Doctor. You have a habit of dropping your voice.
THE WITNESS: Usually people have the opposite, but I'm sorry. I promise to speak up of the.
THE COURT: I understand.
THE WITNESS: If it is too much now, please let me know.
THE COURT: It is just fine.
Q. You can tear the cervix, correct?
A. I can tear the cervix with any instruments, correct.
Q. You can tear the cervix with the metal dilator that you use to increase dilation, correct?
A. If you don't do it correctly, you can do that, correct.
Q. Then you record the degree of dilation in your operative note, isn't that right?
A. That is correct.
Q. And you try to dilate to 2 to 3 centimeters at 20 weeks, correct?
A. That is correct.

Q. That is because in a D&E by dismemberment, 2 to 3 centimeters will be sufficient to insert your instruments, isn't that right?
A. For both D&E's, that is correct, not just the dismemberment.
Q. When you perform the D&E by dismemberment procedure, you dismember the fetus by pulling on the fetal parts with a special forceps, right?
A. Correct.
Q. Or you can use a rotating motion to disarticulate the portion of the fetus that you grasp with your forceps, right?
A. That is another method, correct.
THE COURT: What does that mean, Doctor?
THE WITNESS: I beg your pardon?
THE COURT: What does that mean, what counsel just asked you?
THE WITNESS: What you usually do is you take the forceps, you grasp part of the fetus, and you can either pull it down directly or, after you grasp the portion of the fetus, you can do a rotating motion, either clockwise or counterclockwise, to pull off the portion of the fetus.
THE COURT: Does that pull it away from the body?
THE WITNESS: At the same time that you do the rotating motion, you pull it away.
THE COURT: That pulls it, dismembers it from the body

of the fetus?
THE WITNESS: Correct. It makes it easier sometimes.
THE COURT: On whom?
Q. It tears sometimes, right, Doctor?
A. Yes.
Q. You agree that the idea of D&E by dismemberment is to disarticulate the fetus, correct?
A. The idea of is to terminate the pregnancy.
Q. And with a dismemberment D&E you terminate the pregnancy by dismembering the fetus?
THE COURT: Ms. Gowan, I have asked everyone to use as simple terms as possible for the record. I am just a country lawyer. "Disarticulate" may be something you use every day, and the doctor understands, But I wish you would cooperate in the attempt to try and make this record as clear as possible.
MS. GOWAN: Yes, your Honor, I will. Thank you.
THE COURT: I don't mean to interrupt. But if you would try as well, not just the technical witnesses.
(Continued on next page)

BY MS. GOWAN:
Q. I would like to focus now on the intact D&E procedure. You have also called that procedure complete intact D&E dilation and evacuation, right?
A. Correct.
Q. And you have heard it called dilation and complete evacuation, right?
A. I have heard many different words, yes.
Q. And complete intact D&E, you have heard it called that?
A. I have heard that too.
Q. And as you understand it, intact D&E, which we will call it for the purposes of the examination, is an abortion where there is no real removal of body parts, is that right?
A. The whole fetus is removed intact so, yes, you remove all body parts intact.
Q. It's an abortion where the entire intact fetus, head to toe, is removed from the woman's body, right?
A. Correct.
Q. Now, the first time that you saw this procedure, this abortion procedure performed, was in New York Cornell at some point in early 2002, isn't that right?
A. That is correct.
Q. Possibly by Dr. Chasen, right?
A. Probably.
Q. And you scrubbed-in to the operating room to observe the

abortion of a fetus at 20 weeks, right?
A. I don't know exactly what gestational age it was but it was probably between 20 and 23 weeks.
Q. And you understood from the physicians in the operating room that the fetus was in a breech position and that they would be able to remove it intact from the woman's body, right?
A. I understood at that time when it was happening, yes.
Q. Yes.
And that's different than the D&E by dismemberment procedure that we were talking about a moment ago, right?
A. That's step is different. Everything else up to that step is the same.
Q. And you had never seen that before, had you? You had never seen an intact fetus removed from the body of a woman before, right?
A. It happens all the time when I do a normal delivery.
Q. In an abortion, doctor; you had never seen an abortion before that day in which an intact fetus was removed from the body of the woman, isn't that right?
A. Under those circumstances, correct. I have seen spontaneous abortions where it happens but I have not seen D&Es done as intact version, correct.
Q. And you have never seen that even though at the time you had been practicing medicine, including performing abortions, for at least 20 years, right?

A. Correct.
Q. And you thought that what you had witnessed, the complete removal of a fetus from the woman's body, was a miracle, didn't you, Doctor?
A. Correct.
Q. And you said, wow, this is fantastic; right?
A. Correct.
Q. And you understood at the time that the doctor was specifically trying to remove the fetus intact from the woman, right?
A. At the time it was done and the time we do it we are trying to do what's in the safest interest of the mother. And if that at that moment required the intact removal of the fetus, absolutely.
Q. And you understood at that time that the doctor was specifically trying to remove the fetus intact from the woman, didn't you?
A. That's what the intact D&E is about.
Q. And you understood that that wasn't the first time that that doctor had performed an abortion that particular way, right?
A. I suspect that's true.
Q. You don't have any recollection at all about why that abortion was performed, do you?
A. The abortions I have watched at that time were mostly done

for fetal malformations. And I know Dr. Chasen and I don't know the specifics, but he gets usually referrals when there is a malformed fetus.
Q. Doctor, I'm asking you about the the very first time that you saw this procedure performed at Cornell in early 2002, the very first time you saw it. Recollecting back to that day, you have no recollection about why the abortion was performed, do you?
A. Yes; for fetal malformation.
Q. Directing your attention to page 91 of your deposition transcript to this case, line 17:
"Q When was it that you first saw this?
"A I believe it, it must be 2002, sometime early on.
"Q Do you remember why the termination was being performed?
"A No.
"Q Do you know whether there was a fetal anomaly?
"A Usually there was when I observed them when I did them, yes.
"Q Well, I'm asking about the first time you saw this. If you don't have a specific recollection just tell me that, but I don't want you to tell me what usually there was. Do you have a recollection whether at the time that you first saw this procedure performed the fetus was suffering from anomaly?

"A No.
"Q No, you don't remember?
"A No, I don't remember."
Were you asked those questions and did you give those answers at your deposition in this case?
A. Yes.
Q. And you don't know whether there was a maternal medical complication for the woman who was aborted that day either, do you?
A. Correct.
Q. And the fetus wasn't dead before the doctor reached in the woman and pulled it out, was it?
A. Correct; that's part of a D&E.
Q. At the time you didn't know how the fetus died when this procedure was performed, did you?
A. At which moment?
Q. Pardon me?
A. At which point didn't I know when the fetus died?
Q. The day you first saw it, at that time you didn't know how the fetus died, did you?
A. When I first saw the patient the fetus wasn't dead yet.
Q. I understand that. But you didn't know at the time how the death of the fetus was going to be affected during the course of the procedure, did you?
A. Prior to the procedure or after the procedure?

Q. When you were there.
A. I pretty much knew how the fetus died. It died by doing a craniocentesis and removing part of the brain and collapsing the skull. That's usually how those fetuses die.
THE COURT: Not usually, Doctor, that day. Listen to the question and answer the question.
THE WITNESS: This was -- can I answer, your Honor?
THE COURT: Answer the question you're asked.
Q. Doctor, directing your attention to page 95 of your deposition transcript in this case, line 8:
"Q Was the fetus dead before the doctor reached in and pulled the entire fetus out?
"A I don't believe.
"Q How did the fetus die?
"A I don't know.
"Q You don't have a recollection?
"A At that moment I didn't know. I eventually learned how fetuses die but at that moment I didn't."
Were you asked those questions and did you give those answers at your deposition in this case?
A. Yes, I did.
Q. You eventually learned how the fetus dies during the course of the procedure, did you not, Doctor?
A. Yes, I did.
Q. And what you learned was that the fetus dies when the

doctor sucks out the fetuses brains, right?
A. When you do that procedure and you insert a canula into the brain; correct.
THE COURT: Insert a what, Doctor?
THE WITNESS: You insert a canula.
A canula is a hollow tube that is inserted and when suction is applied, you can suction something through.
THE COURT: So, it's a suction device.
THE WITNESS: Suction device or a vacuum, in a sense.
THE COURT: Go ahead, Ms. Gowan.
BY MS. GOWAN:
Q. Sucking out the brains, right?
A. Correct.
Q. That's when the fetus dies?
A. Yes.
THE COURT: Ms. Gowan, is this a convenient time to take our afternoon break?
MS. GOWAN: Yes, your Honor.
THE COURT: If you have a few more questions on this or if it's a convenient breaking point, if it's convenient.
MS. GOWAN: It is convenient, your Honor.
THE COURT: Okay, take our afternoon recess.
(Recess)
THE COURT: Ms. Gowan, you may inquire.
BY MS. GOWAN:

Q. Dr. Grunebaum, I understand that you have performed about 10 or 15 intact D&Es, right?
A. I think I testified 15 to 20 but in that range about.
Q. Directing your attention to your deposition testimony in this case, page 47, line 21:
"Q Of the percentage that were intact D&Es, how many of those did you actually perform yourself?
"A I would say between 10 and 15."
Were you asked that question and did you give that answer at your deposition in this case?
A. Yes, I did.
Q. Now, Doctor, you make the decision about whether you are going to perform an intact D&E when you are in the operating room, right?
A. As compared to the dismemberment D&E, correct.
Q. And you look to see if the cervical dilation is sufficient enough for you to put your fingers in the woman's cervix?
A. That's one of the criteria, correct.
Q. And if it is it's at that moment that you choose either to do an intact D&E or a D&E by dismemberment, right?
A. Well there are several other things that, besides the dilatation of the cervix and that is the presentation of the fetus.
Q. Correct, and if it's in the right presentation and the cervical dilation is sufficient, that's when you choose to

perform the intact D&E as opposed to the D&E by dismemberment, right?
A. Right. It's actually not performed, it's attempted because sometimes I'm attempting to do an intact D&E and I can't do it and then I continue with a dismemberment D&E.
Q. But you make your choice, correct?
A. Yes.
Q. And then you put your left hand on the woman's body at the point where her uterus is so you know what the right direction is to enter her with your fingers, right?
A. Correct.
Q. Then you enter her with your fingers of your right hand, right?
A. Correct.
Q. And you feel for the fetus' feet or legs, don't you, Doctor?
A. Correct.
Q. And then you grab them with your fingers?
A. Correct.
Q. You clamp the legs or the feet between your fingers, right?
A. Sometimes I do, sometimes I don't have to.
Q. When you grab them or clamp the feet you then ease them through the cervix, right, Doctor?
A. Correct.
Q. And then when they come, when the fetus' feet or legs come

a bit more through the cervix you use your thumb, index and middle finger to slowly pull both the feet through the cervix, right?
A. Correct.
Q. Now, the woman's under general anesthesia, right?
A. Usually, correct.
Q. And you do that because there is more relaxation and you can manipulate the woman's uterus and vagina more easily during the procedure, right?
A. Wrong.
Q. Directing your attention to page 117 of your deposition, line 18:
"Q Why do you use general anesthesia?
"A Because I feel that the procedure can be done easier if the pain threshold for the mother is much better, the patient tolerates the procedure well.
"Q Why do you think that the procedure can be done more easily under general anesthesia?
"A There is more relaxation and I can manipulate the uterus and her vagina much easily without the patient moving."
Were you asked those questions, did you give those answers at your deposition?
A. Absolutely. Absolutely.
Q. Now, as you use your thumb and index and middle finger to slowly pull both of the feet of the fetus through the cervix,

you are doing this in a very gentle way, isn't that right, Doctor?
A. Correct.
Q. And once you can see the fetus, you have drawn it through sufficiently so that you can see it, you don't have to put your right hand into the woman's uterus any more, do you?
A. Correct.
Q. And you're free to use your left hand as well, you don't need it on top of the woman's abdomen, right?
A. Correct.
Q. So at that point sometimes you use an instrument to hold the fetus' feet in place, right?
A. I don't, but I do it with my hands.
Q. With your left hand, right?
A. Right or left hand, correct.
Q. And then you ease the rest of the fetus' body further throughs the cervix.
A. At that point it is called breech extraction. This is a medical procedure which we have been doing for centuries, actually.

So all you need to say is a breech extraction, complete breech extraction. That's the name of that procedure which has been done for centuries.
Q. Well, Doctor --
A. Nothing unusual about it.

Q. There are parts, there are maneuvers, there are steps that comprise a breech extraction, isn't that right?
A. Absolutely.
Q. And that's what we are talking about, isn't it?
A. Absolutely; talking about a complete breech extraction.
Q. And we are describing the specific steps that you use, that you yourself use when you are performing a complete breech extraction?
A. Which many other people use too, not just me.
Q. And we were talking about the fact that once you're able to see the fetus that you have sufficiently drawn it through the cervix, then you make an effort, you ease the rest of the fetus' body through the cervix, don't you, Doctor?
A. Correct.
Q. And at that moment you are able to deliver the whole body, the legs, the trunk and the arms, right?
A. Correct.
Q. And the only part of the fetus left is the head, which is usually stuck in the uterus in the internal cervical os?
A. Behind the the internal cervical os.
Q. And what is the internal cervical os?
A. It's part of the cervix, there is an external os and internal os.
THE COURT: What is the word os?
THE WITNESS: Os, O-S, mouth. It stands for mouth.

And the cervix is like an inverted bottle with a short neck and if you -- if I may say so, the neck of the bottle is the cervix and the rest of the body of the bottle is the uterus, the body of the uterus.

So, the internal os, if you invert a bottle, is at the juncture between the cervix and the body of the uterus.

BY MS. GOWAN:

Q. And at the point at which we are describing, the fetus' head is stuck at the point of the internal cervical os?

A. Correct.

Q. And the body of the fetus, the rest of the body of the fetus is outside the cervix, right?

A. Correct.

Q. But sometimes the body of the fetus is still in the vagina, not completely out of the body of the woman, right?

A. Sometimes it could happen, yes.

Q. And when that happens that could interfere with your ability to see the place where you need to insert the scissors, isn't that right?

A. It could be.

Q. So sometimes what you need to do is pull the cervix down a bit more with your instruments, right?

A. Maybe.

Q. Once you pull the cervix down more parts of the fetus are outside of the body of the woman, right?

A. Correct.
Q. And the instrument that you use to pull the cervix down is called a tenaculum, right?
A. It depends what instrument you use.
Some people use a tenaculum, other people use sponge forceps. I personally don't lake a tenaculum because it is very sharp and increases risk. But it really depends on the individual physician.
Q. That's right, some physicians do use a tenaculum to your knowledge, correct?
A. Yes.
Q. And there is a risk of cervical laceration with the use of a tenaculum, isn't there, Doctor?
A. There is actual risk with the whole procedure, not just the tenaculum. The whole procedure is a risky procedure.
Q. Now, Doctor, you don't have any specific recollection as to whether any one of the 10 or 15 intact D&E abortions that you have performed were on a woman who had a medical complication that required termination of her pregnancy, do you?
A. Correct.
Q. Similarly, you have no specific recollection whether in any of those 10 or 15 cases the fetus had an anomaly, isn't that right, Doctor?
A. I only did those cases that were indicated.
Q. You don't have any specific recollection in one of those 10

or 15 cases that the fetus had an anomaly, isn't that right, Doctor?
A. The vast majority were done for anomalies.
THE COURT: Doctor, could you keep your voice up? I didn't hear your answer.
Ms. Reporter, could you repeat it?
THE WITNESS: The vast majority were done for anomalies.
I do recall patients specifically if they don't have an anomaly. I don't recall a specific patient with no indication.
BY MS. GOWAN:
Q. You don't recall whether one of those 10 to 15 was a fetus with an anomaly, is that right?
A. I don't recall whether one of those was a patient with no indication.
Q. And you don't recall what the indication was for any one of those patients either, do you, Doctor?
A. I can tell you what the usual indications are. If you want me to tell you I can.
Q. No, Doctor. Specifically the 10 or 15 intact D&Es you have performed, you don't have a recollection, do you?
A. Not specifically on a specific day for a specific patient, no. I would have to go back and look at my records.
THE COURT: Would your records reflect the anomaly?

THE WITNESS: All records always reflect an anomaly, absolutely.
THE COURT: Okay, thank you.
Next question.
THE WITNESS: Not necessarily all anomalies, but they reflect the reason for the termination of pregnancy, sure.
BY MS. GOWAN:
Q. Now, you testified earlier this morning that labor induction abortion is contraindicated for a woman with a classical uterine incision, right?
A. Correct.
Q. Now, you didn't mention this specific condition in your expert report that you disclosed to the government in this case, did you?
A. I don't recall.
(Continued on next page)

Q. Do you still have your expert report in front of you there, Doctor?
A. I don't think so.
Q. Doctor, showing you again what was marked as Government Exhibit 24A, which was the expert --
MS. WIGMORE: May I see it, counsel?
MS. GOWAN: It is the expert report.
MS. WIGMORE: I would like to see it before you give it to him, please.
MS. GOWAN: Do you not have a copy of your witness's expert report, counsel? I don't know that I have an extra copy.
MS. WIGMORE: I would like to see that what he is being handed is in fact that expert report. I have my own copy.
THE COURT: All right, Ms. Gowan, show it to Ms. Wigmore. Are you questioning that that is the report?
MS. GOWAN: Yes. Is this the report, Ms. Wigmore?
Q. Doctor, would you take a moment to look at that and see if that refreshes your recollection --
A. That's my report. It is my report, yes.
Q. Does that refresh your recollection as to whether you disclosed in that report the circumstances of a woman who has had a medical condition of a prior classical C-section?
A. In which context shall I look for that?

Q. Did you mention it, Doctor?
THE COURT: Do we have a date on this report?
MS. GOWAN: Your Honor --
A. I did not describe in my expert report induction termination of pregnancy at all, so there is no reason for me to mention the prior classical Cesarean section.
MS. GOWAN: Your Honor, January 13, 2004.
THE COURT: Thank you.
Q. This particular condition, a woman with the circumstances of a prior classical C-section, was something that you offered unbidden at your deposition in this case, right?
A. I offered? I beg your pardon?
Q. Unbidden.
A. I don't know that word.
Q. That you offered voluntarily without being questioned upon it, right?
A. Offered when?
Q. During your deposition in this case.
A. I don't know what you are talking about. I'm sorry. I don't understand your question.
Q. You didn't disclose it in your expert report in this case, and --
A. As I said, I didn't mention induction termination of pregnancy.
Q. Right. You didn't mention induction at all.

A. Correct.
Q. You mentioned some medical complications, but you didn't mention this particular medical complication, did you?
A. I don't think I mentioned absolute contraindications to inductions of terminations of pregnancy. I don't think I went into that.
Q. Doctor, you would agree, wouldn't you, that you can safely perform a D&E by dismemberment in cases where there is a prior classical C-section scar?
A. Correct.
Q. And you haven't seen anything in the literature comparing the risks in cases of prior classical C-section as between intact D&E and D&E by dismemberment, have you?
A. Correct.
Q. This morning you talked generally about lung and heart diseases and various conditions, medical conditions, where you opined that an intact D&E would be preferable over a labor induction abortion, isn't that right?
A. That is correct.
Q. You have never performed an abortion for a woman with lung cancer, have you, Doctor?
A. Lung cancer would not be among the cancers you would usually see in women who are pregnant.
Q. And you have never performed an abortion on a woman with lung cancer, have you?

A. I don't recall.
Q. Directing your attention to page 172/line 1 of your deposition in this case:
"Q. Have you ever provided an abortion to a woman with lung cancer?
"A. No."
Were you asked that question and did you give that answer at your deposition in this case?
A. Yes. Yes, I did, and I confirm it here.
Q. And you have never performed an abortion on a woman with a collapsed lung either, have you?
A. No.
Q. You mentioned cancer this morning. You have never performed an abortion on a woman with various cancers, have you?
A. I don't recall. But I have taken care of women with various cancers.
Q. Page 172/line 10:
"Q. And what about various metastases?
"A. No."
Were you asked that question and did you give that answer in your deposition in this case?
A. There is a difference between cancer and metastasis. One is a metastasis, which is the spread of cancer, and the other one is just cancer per se.

Q. You have never provided an abortion to a woman with a pulmonary embolus, have you?
A. No.
Q. And you would agree, wouldn't you, Doctor, that it is rare that pregnancies are terminated because a woman is experiencing a serious medical condition?
A. Fortunately, it is rare, correct.
Q. In those cases where you have provided abortion to women who are carrying fetal anomalies, you weren't the physician who made the initial diagnosis of the anomaly, were you?
A. Usually not, correct.
Q. The patient was referred to you for the abortion, right?
A. Not necessarily. She could have also found me through other means. Referral from other physicians is just one means of patients coming to me.
Q. In all of these cases relating to fetal anomaly, the identification of the abnormality was the reason for the abortion, right?
A. No.
Q. Directing your attention to page 179/line 16 of your deposition, where you were being questioned on terminations in cases of abnormalities:
"Q. I was just trying to follow what you just told us a few minutes ago. So you would do the sonogram, which would then lead you to the amniocentesis, which would then lead you to the

termination decision?
"A. With or without chromosomal abnormality."
Were you asked that question and did you give that answer at your deposition?
MS. WIGMORE: I object, your Honor: Improper impeachment.
A. I don't know how --
THE COURT: Wait. Whoa. There is an objection. Wait. What is improper, ma'am?
MS. WIGMORE: The question and answer that was just read were unrelated to the question and answer the witness was just asked. It is not proper impeachment.
THE COURT: Overruled.
Q. The advice that you give to a woman about the method of the abortion depends on the type of the fetal malformation, doesn't it?
A. It plays a role, yes.
Q. Your advice depends on the time at which the diagnosis of the fetal malformation is made, right?
A. No. It depends on the gestation age at which I first see the patient. The diagnosis could have been made a month or two ago. When I first see the patient, that is when I decide on the type of abortion procedure.
Q. Isn't it true that in cases where the fetus has a chromosomal abnormality, the abortion is usually going to be

done before 20 weeks because you can detect those abnormalities at earlier gestational ages?
A. The decision to do the abortion is made by the woman who is pregnant. I do not make the decision. Nor is a decision made because there is a fetal anomaly. The woman who chooses to have an abortion makes solely the decision based on her own experience. One of those reasons could be that there is a fetal anomaly.
THE COURT: Keep your voice up, Doctor. A few of those reasons are what?
A. One of the reasons to perform an abortion is because there is a fetal anomaly. A fetal anomaly is not the reason to do the abortion. The reason to do the abortion is because the woman chooses to have the abortion done.
Q. Doctor, isn't it true that the identification of the malformation is usually the predicate for the D&E abortions that you perform?
A. It is the initiator of the woman considering to have an abortion done, that is correct. But the decision to do the abortion per se is for the woman to make.
Q. The policy at New York-Cornell is to send all aborted tissue for pathological assessment, whether additional testing is required or not, isn't that right?
A. A pathologic exam is additional testing. So yes, you send it for additional testing to pathology.

Q. Doctor, whether you want additional testing or not, the policy at Cornell is that all fetal tissue goes to pathology, isn't that right?
A. That is correct.
Q. If you don't make a specific request for an analysis, you don't have any understanding as to what the pathology department does with the fetus, right?
A. I have a pretty good understanding of what they do.
Q. Pardon me?
A. I have a pretty good understanding of what they do. I have done those exams myself.
Q. Directing your attention to page 181/line 6 of your deposition in this case:
"Q. Before we get to that, if you don't request a specific analysis, do you have an understanding of what the pathology department does with the tissue it receives?
"A. I don't specifically know what they do. You would have to ask a pathologist that question."
Were you asked that question and did you give that answer at your deposition in this case?
A. Yes, I did give that answer.
Q. Sometimes you do make the specific requests asking for your diagnoses to be confirmed, right?
A. Correct.
Q. Other times you ask for evaluation because you feel that

you need more information about the diagnosis that was made from the ultrasound or amniocentesis, right?
A. Correct.
Q. Sometimes you send the fetus for an autopsy, don't you?
A. That really depends on the mother's wishes. In order to do an autopsy, the woman who was pregnant who has the abortion needs to sign a specific consent. I discuss with her prior to performing the procedure whether an autopsy should be done or not.
Q. It is your understanding that you can get a good pathologic assessment from fetal parts by doing an autopsy of a fetus aborted by D&E dismemberment, isn't that right, Doctor?
A. You sometimes can. It depends really on the circumstances. So it is an individual kind of thing.
Q. Of all of the D&E's by dismemberment that you have performed, you can only think of one example where you did not believe that you were able to give appropriate genetic counseling to your patient because the fetus wasn't intact, isn't that right, Doctor?
A. I don't specifically recall.
Q. Directing your attention to page 187/line 4 of your deposition in this case:
"Q. Can you give me some examples of when you thought you were not able to give the appropriate genetic counseling to your patients because the fetus had not been aborted through the use

of the intact D&E procedure?
"A. This is one example where you don't see amniotic fluid, and the one that sticks in my mind most."
Were you asked that question and did you give that answer at your deposition in this case?
A. Yes, if you say so.
Q. Aside from --
THE COURT: Wait. Doctor --
A. Yes, I did.
Q. Aside from your maternal fetal training in genetics, you don't have any special expertise in genetics, do you?
A. It is part of my OB-GYN residency training, which began in '78, and I get continuously trained on genetic issues throughout my career.
Q. Other than being part of your maternal fetal training, you don't have any special expertise in genetics, do you?
A. That's pretty good enough, right? Two years of maternal fetal medicine fellowship is what people usually do.
Q. Doctor, are you aware of the literature reporting on the use of D&E by dismemberment for purposes of pathological assessment?
A. Not specifically.
Q. You testified this morning about various advantages that you believed intact D&E had over D&E by dismemberment. You talked about less procedure time, and you opined that intact

D&E is safer than D&E by dismemberment because it takes less time to perform the procedure, isn't that right?
A. Correct.
Q. Your opinion is based on the cases that you have performed, right?
A. Not only.
Q. Or watched, right?
A. Not solely.
Q. Directing your attention to page 138/line 8 of your deposition in this case:
"Q. Let's focus on the operative time which I think you delineate more specifically in paragraph 12 of your report. What's the basis of your statement that intact D&E takes significantly less time than D&E by dismemberment?
"A. It's the observation of cases I've seen and cases I've done."
Were you asked that question and did you give that answer at your deposition in this case?
A. I did.
Q. You can't tell us how much faster, can you?
A. I can tell you about my experience.
Q. You can't give us time, you can't quantify the time, can you?
A. What do you mean by I can't give you? I can count minutes.
Q. You can't tell us if it is 10 minutes faster, 20 minutes

faster, can you?
A. I can tell you what it takes me on average to do an intact D&E, and I can tell you what it takes me on average to do a dismemberment D&E. And I can tell you the time specifically as it relates to removal of the fetus. Because after the fetus has been removed, there is still additional operative time involved.
Q. Directing your attention to page 138/line 15 of your deposition, where you were asked about the time that you have observed in the cases that you have seen and done:
"Q. And what have you noticed?
"A. I've noticed that if you can do a D&E safely as an intact D&E, the procedure to deliver the fetus is faster than it is with a dismemberment D&E.
"Q. How much faster?
"A. Significantly faster.
"Q. What does that mean?
"A. Maybe twice as fast, half as fast.
"Q. Give me some minutes, some time. 10 minutes, 20 minutes?
"A. Difficult to say. I can't pinpoint it down. Because it's difficult to do with intact D&E, then it will be more difficult to do when it's normal D&E."
Were you asked those questions and did you give those answers at your deposition in this case?
A. Yes, I did.

Q. You have never quantified the time difference, have you?
A. That is actually a normal thing in medicine. We don't quantify a lot of things we do.
THE COURT: Doctor, just answer the question.
A. No.
Q. And you have never studied it, either, have you?
A. No, I did not.
Q. Aside from telling us that you have seen some intact D&E's where the fetus was delivered in a couple of minutes, 2, 3, or 4 minutes, and that you have rarely seen a dismemberment D&E in less than 5 minutes, you can't really give us any specifics, can you, Doctor?
A. You can't say better. It is exactly what I agree with.
Q. In your view, Doctor, part of the reason that the D&E dismemberment procedure takes longer is because after you have removed the fetal parts, you put them on a separate table and count them and assemble them, isn't that right?
A. That adds to the operative time.
Q. But that process has nothing to do with inserting instruments in a woman, does it?
A. That process does have something to do, because if you don't assemble all the parts as you think they should be there, you have to add more instruments into the uterus and remove more parts. So it is probably the most crucial aspect of the dismemberment D&E, which decides how many more times you have

to insert instruments into the uterus.
Q. But you are not inserting instruments while you are counting up the fetal parts, are you?
A. No. But it decides how much more times I have to do it, correct.
Q. And it takes time to count up the fetal parts, right?
A. It takes time, yes, it does.
Q. That adds to the procedure time, right?
A. Absolutely.
Q. In your opinion, intact D&E is safer because it decreases the amount of anesthesia that a woman is exposed to, is that right?
A. Yes.
Q. That opinion is based on your opinion relating to procedure time, right?
A. Correct.
Q. None of your patients who have had D&E by dismemberment have ever had a complication from anesthesia, isn't that right, Doctor?
A. Yes.
Q. So it would be fair to say in your view, as far as anesthesia is concerned, that intact D&E presents a hypothetical benefit, right, Doctor?
A. And I'm glad for my patients that at this point it's hypothetical, because that is what medicine is about. Just

because you don't have a complication doesn't mean that you cannot have one.
Q. You have never measured this hypothetical benefit in any way, have you, doctor?
A. No, I did not.
Q. And you are not aware of any studies measuring it either, are you?
A. There are studies that show that less anesthesia is safer for patients, sure.
Q. But not in comparing intact D&E and D&E by dismemberment, right, Doctor?
A. I don't know about those studies.
THE COURT: Do you know, do any exist?
THE WITNESS: On general anesthesia? Absolutely.
THE COURT: No. In the context of the question that was posed to you.
THE WITNESS: I don't know, your Honor. I don't know.
THE COURT: You don't know of any?
THE WITNESS: I don't know of any.
THE COURT: OK. Next question.
Q. You told us that in your view intact D&E decreases the potential amount of blood loss by the woman as opposed to D&E by dismemberment, right?
A. Correct.
Q. In your view, that is because with intact D&E there is less

use of instruments, thus less chance of injuring the uterus and causing blood loss, right?
A. That's one of the reasons.
Q. But you have never quantified in any way the amount of blood loss as between your patients who had intact D&E and your patients who have D&E by dismemberment, right?
A. Correct.
Q. You never recorded that anywhere, right?
A. I believe we do record blood loss. But fortunately in my patients blood loss or hemorrhage was never excessive to be concerned about it.
Q. You would agree, wouldn't you, Doctor, that there is a risk to the woman from the scissors that puncture the back of the fetus's skull?
A. A potential risk, correct.
Q. You would agree that there isn't any risk of injury to the cervix or uterus from instruments with induction abortion, right?
A. No. I said before that in some induction abortions women do end up in the operating room where you do have to insert instruments: If, for example, the fetus or the placenta are retained.
Q. But the risk from instruments does not normally present in cases of induction abortions, does it, Doctor?
A. Not at the time when the fetus is being expelled.

Q. Directing your attention to page 155/line 23 of your deposition transcript:
"Q. I understand you're comparing intact D&E versus D&E by dismemberment in that paragraph, and so I'm saying what about the comparison with induction method of abortion?
"A. Induction method of abortion, you do not normally use instruments, so that risk is not present with induction."
Were you asked that question and did you give that answer at your deposition in this case?
A. Yes, I did.
Q. You can't compare the amount of blood loss between intact D&E and prostaglandin induction abortion, can you?
A. It is difficult.
Q. You claim that another known complication of D&E by dismemberment is that fetal parts may be left behind in the uterus, right?
A. Correct.
Q. That is one of the reasons why you opine that intact D&E has advantages?
A. Correct.
Q. You don't know if that complication is specifically reported in the medical literature, do you?
A. I have seen it many times myself.
Q. Aside from your observation, you don't know whether that complication has been reported in the medical literature, do

you?
A. I'm sure it is reported.
Q. But you don't know specifically, do you?
A. Yes. I recall certain papers many years ago, and I have seen a lot of patients myself.
Q. Directing your attention to page 157/line 13 of your deposition in this case, where you were being questioned about fetal parts left in the uterus:
"Q. Do you know if it's reported in the literature?
"A. I don't specifically know, but I have seen that."
Were you asked that question and did you give that answer at your deposition in this case?
A. Yes, I did.
Q. This morning you were asked questions about feticidal agents that might be used to ensure fetal demise. Is potassium chloride a feticidal agent?
A. Yes, it is.
Q. Is that sometimes called KCl?
A. Yes. That is the chemical name for potassium chloride.
Q. You told the judge this morning that you were trained in the use of feticidal agents to cause fetal death, right?
MS. WIGMORE: Objection, your Honor: Mischaracterization.
THE COURT: In what way?
MS. WIGMORE: Mischaracterization of the witness's

testimony.
THE COURT: I repeat: In what way is it mischaracterizing?
MS. WIGMORE: If you want me to approach the bench? I just don't want to influence the witness's testimony. But I believe he said quite the opposite.
THE COURT: Overruled.
Q. Doctor, are you trained in the use of KCl?
A. I have never used it myself, never saw anybody doing it.
Q. Directing your attention to page 128 of your deposition at line 17, where you were being asked whether you had been trained to use feticidal agents, you were specifically asked about training, at line 17, of injection with KCl.
MS. WIGMORE: I have an objection, your Honor, at this point. There was an errata sheet that was provided that changes this testimony. I want to make sure that is reflected in the testimony here.
MS. GOWAN: Do you have that?
MS. WIGMORE: Yes, I do.
THE COURT: All right.
Q. Doctor, what is NaCl?
A. Sodium chloride.
Q. Is that a feticidal agent?
A. Yes.
Q. So you have received training in sodium chloride for use as

a feticidal agent, is that right?
A. That is a saline injection, and it is a different method than potassium chloride. I testified earlier that I have done those abortions before.
Q. I see. And you have used that agent to ensure fetal demise, is that right?
A. Fetal demise is part of that, but it is a different method. It is a completely different method than potassium chloride. One is an injection in the amniotic fluid. That is sodium chloride. Potassium chloride is an injection into the fetus itself.
Q. You also testified this morning about the use of amniocentesis. You testified about all sorts of serious complications that might occur to the woman from the use of amniocentesis. I think you mentioned complications with the bowel and others. Would you agree, Doctor, that in fact the risk to the woman from the use of amniocentesis is negligible?
A. It is 1 in 200. If you consider that to be negligible, that is your interpretation.
Q. Less than half a percent, right, Doctor?
A. Correct.
Q. Now, you have testified that you disagreed with Congress's finding that intact D&E may pose a risk of cervical incompetence. That is because you are not aware of any credible research that supports that view, is that right,

Doctor?
A. Congress used the word "partial-birth abortion." They don't use the word "intact D&E."
Q. Doctor, we are talking about cervical incompetence.
A. Yes.
Q. I understand you disagree with that finding, is that right?
A. Congress uses the word "partial-birth abortion" when they talk about risks of cervical incompetence.
Q. Well, let's --
A. Don't they? That's what it says there.
Q. Let's talk about intact D&E.
A. OK.
Q. Do you think that intact D&E might pose a risk of cervical incompetence?
A. No. Why should it? How should that be?
Q. You are not aware of any credible research that supports that view, are you, Doctor?
A. Yes, I am.
Q. Directing your attention to page 194/line 12 of your deposition in this case:
"Q. Are you aware of any credible research that supports the conclusion that satisfactorily done intact D&E would not result in cervical incompetence?
"A. I'm not aware of that, I said that."
Were you asked that question and did you give that

answer at your deposition in this case?
A. Yes, I did.
Q. Doesn't your opinion on this point, Doctor, simply boil down to the fact that in the absence of a positive finding of cervical incompetence, you believe that that is the same as a negative finding of cervical incompetence?
A. To me that sounds like common sense. You cannot say something is happening when nobody ever found that it did.
Q. So if something isn't studied, there must not be anything wrong with it, is that right?
A. That's not what I said, and you are mischaracterizing what I said. What I said is you cannot claim something can happen when nobody ever found it. Nobody ever found cervical incompetence to be increased with an intact D&E, so you shouldn't claim it.
Q. And you can't claim that it won't happen similarly?
A. Actually Congress claimed it. I am not claiming it. I am just repeating what Congress had said. Congress said that partial-birth abortions, and you say -- did you say it is the same as intact D&E? I am confused. Congress says partial-birth abortion increases the risk of cervical incompetence. Now you are telling me that they mean by that an intact D&E, isn't that correct?
Q. You testified that you disagreed with Congress's finding on that point. If your testimony is just because you do not know

what partial-birth abortion is, I don't know what the basis of your opinion is.
A. I didn't say I disagreed with Congress' finding. What I said was you said doesn't intact D&E increase the risk of cervical incompetence, and I said no. There is no proof of that anywhere.
Q. Doctor, in the expert report that you provided to the government in this case, you referred specifically to paragraph 14(a) of the Act, and you said, "It says that an intact D&E 'increases the woman's risk of suffering from cervical incompetence.' In my opinion, this is not true if the dilation is done properly." Then you go on.
A. That's correct.
Q. You are not aware of any credible evidence that supports your view that the procedure does not cause cervical incompetence, isn't that right, Doctor?
A. I'm confused. I am not sure -- I am not claiming it does --
THE COURT: Ask the question again, Ms. Gowan, or rephrase it.
Q. There isn't any credible research at all about intact D&E, is there, Doctor?
A. I don't know what you mean by credible research.
Q. There isn't any research, any studies published, there is no randomized trials, there is no case reports, there is no

cohort studies, there is nothing, is there, Doctor?
A. There are some retrospective observations.
Q. That is Dr. Chasen's study, is that what you are referring to?
A. That's right, correct.
Q. What is the other?
A. The other ones are that if there would be an increased risk in, for example, cervical incompetence, I'm sure our college would say that's a risk. And when I look at risks for cervical incompetence, a D&E is not part of those risks.
Q. Can you identify for me a single other published study or a single published study that deals with intact D&E?
A. No.
Q. Congress also made a finding about amniotic fluid embolus. Isn't it true in fact, Doctor, that you don't necessarily disagree with Congress's finding that intact D&E presents a risk of amniotic fluid embolus?
A. Any pregnancy, any pregnancy intervention, and any procedure can lead to amniotic fluid embolism.
THE COURT: Keep your voice up, please.
A. Any procedure you do enough, and even if you don't do a procedure, can lead to an amniotic fluid embolism.
Q. You told Judge Casey this morning that your opinion is that there is a decreased risk of amniotic fluid embolism with intact D&E, isn't that right?

A. That is right.
Q. But isn't it true, Doctor, that you don't necessarily disagree with Congress's finding that there is a risk of amniotic fluid embolus with intact D&E?
A. Congress does not say that an increased risk with intact D&E. They used the word "partial-birth abortion."
Q. Directing your attention to page 200/line 7 of your deposition in this case:
"Q. What about Congress's finding of an increase of amniotic fluid embolus? What is that, first of all?
"A. It's amniotic fluid embolus is when amniotic fluid enters the maternal blood circulation, usually a vein, and then moves along from the uterus up into the body of the woman, and then through the liver into the heart, and then from the heart into the lung.
"Q. And do you have an opinion on this finding of Congress?
"A. Again, what I don't understand is that if there's an increased risk of amniotic fluid embolus with a D&E, it doesn't specifically apply to an intact D&E; it would apply to all D&E, because the procedures are not significantly different. So it's not just intact.
"Q. It would be both?
"A. If at all."
Were you asked those questions and did you give those answers at your deposition in this case?

A. Yes. And I stand by them, correct.
THE COURT: What did you say, Doctor?
THE WITNESS: I stand by those. I did say that.
Q. You also spoke this morning about the internal podalic conversion. I understand that you have never had to do an internal podalic conversion when you have performed an intact D&E, is that right?
A. That's correct.
Q. But you have watched others do it, haven't you?
A. Maybe I did, but I don't know the specifics.
MS. GOWAN: If you would give me one moment, your Honor.
THE COURT: Go right ahead.
Q. Directing your attention to page 201/line 17 of your deposition in this case, which was taken on February 2, 2004:
"Q. Have you observed someone do the conversion?
"A. Yes, I did.
"Q. And how is that done, by hand or by instrument?
"A. It's done -- the ones I've seen?
"Q. Yes?
"A. Was done by hands."
Does that refresh your recollection, Dr. Grunebaum, as to whether you have observed others perform the internal podalic conversion?
A. Your initial question was if I have seen them during an

abortion procedure. But now your question was a more general question. A internal podalic version can be done at any time during the pregnancy, not just during abortion. So are you referring to abortions or term or to a Cesarean section?
Q. Yes, abortions. Have you observed others perform --
A. I have never done them during abortion. I have done them at the time of Cesarean section, and I have observed others do both.
Q. You have observed others do the internal podalic conversion during the course of an abortion, is that right?
A. I may have. Probably I did.
Q. You testified this morning that you disagree with Congress's finding that conversion to a footling breech presents a risk to the mother. But isn't it a fact, Doctor, that you would agree that at 23 weeks even if you do the conversion carefully and gently, there is a slightly increased risk of perforating the uterus when performing this manipulation?
A. Can you show me in Congress a finding where they talk about internal podalic version?
Q. Doctor, this morning you were asked, in connection with finding 14(a), about the use of an internal podalic conversion.
A. I don't see it in the --
THE COURT: Doctor, wait until the question is posed to you.

THE WITNESS: I apologize.
Q. And you understand, don't you, that the Act refers to the performance of abortions?
A. In the definition of "partial-birth abortion" there is no mention of internal podalic version. That is not part of the definition.
Q. You understand, don't you, Doctor, that some physicians, when performing intact D&E, in fact do an internal podalic conversion?
A. Yes, I am aware of that.
Q. Don't you agree that in those cases, that at 23 weeks there is a slightly increased risk of perforating the uterus when performing this maneuver?
A. Yes, I agree.
Q. You would also agree, wouldn't you, Doctor, that at 20 weeks there is a slightly increased risk of perforating the uterus when performing this maneuver?
A. I agree.
Q. You would agree, wouldn't you, that if you are going to do such a conversion, you would want the maternal membranes to be intact?
A. I can't comment on this, because I don't do those podalic versions. So I leave this up to the physician to decide. But in general it is preferable to have the membranes intact, yes.
Q. Directing your attention to page 204/line 3 of your

deposition in this case:
"Q. How much room is there in the uterus at 20 weeks?
"A. Good question, actually. It depends if the water has broken, if the membranes have ruptured or not. If water is broken and membranes have ruptured, there is less space, because the uterus clamps down. So if you do an inversion, you want the membranes to be intact."
Were you asked that question and did you give that answer at your deposition in this case?
A. Yes, I did.
Q. That is because if the membranes are ruptured, it makes it almost impossible to do the conversion, correct, Doctor?
A. It makes it very difficult, correct.
Q. You would agree, wouldn't you, that the physician must gently and slowly insert his or her hands or the instrument into the woman in order to effect the conversion without rupturing the membranes?
A. That is the preferred way to do it, yes.
Q. You would agree, wouldn't you, Doctor, that in order to safely perform the internal podalic conversion as part of the intact D&E, a degree of medical skill is clearly important?
A. That is important for anything we do in medicine. The more your skills, the less complications there usually are.
Q. You agree with Congress's finding that the use of the sharp instrument, the scissors, to puncture the fetus's skull

presents a risk of laceration and secondary hemorrhaging, don't you?
A. I agree that puncturing the skull increases the risk of complication. I am not so sure where it says what you just said in the congressional findings. Does it mention that anywhere as being part of an abortion procedure? Maybe it does, but I couldn't find it. That is a different version of a partial-birth abortion. It doesn't say that. Puncturing the skull is part of a partial-birth abortion as Congress defines it.
Q. Directing your attention to page 205/line 24 of your deposition in this case, paragraph 21, we were talking about your expert report.
"Q. I know we touched on this before. I just have a couple of questions. You refer to Congress's findings that D&X poses a risk of laceration and secondary hemorrhage due to the doctor blindly forcing a sharp instrument in the base of the unborn child's skull while he or she is lodged in the birth canal. Now, you make the statement that this is similar -- excuse me -- that this is true for most gynecological procedures. What do you mean when you said this is true for most gynecologic procedures?
"A. The sentence the risk of lacerations and secondary hemorrhaging, a risk of lacerations and secondary hemorrhaging, is true for most gynecological procedures."

MS. WIGMORE: Your Honor, I want to object at this point. Ms. Gowan read two questions, the first of which elicited an objection and then was rephrased. So I object and move to strike the reading of the first question.
MS. GOWAN: I merely read it for context, your Honor, to show --
THE COURT: That's all right. Move on. Overruled.
Q. "Q. And that's because instruments are involved?
"A. Or surgery is involved or hands are involved or anything else is involved, correct, not just instruments.
"Q. So you are agreeing with Congress's finding that intact D&E poses a risk of lacerations and secondary hemorrhaging?
"A. Yes, I agree with that."
Were you asked those questions and did you give those answers at your deposition in this case?
A. Yes, I did give those answers.
THE COURT: Doctor, what is secondary hemorrhaging?
THE WITNESS: I apologize, your Honor. I didn't hear the word "secondary hemorrhaging." I don't think I --
THE COURT: Do you know what the term is?
THE WITNESS: No, I don't.
THE COURT: Do you recognize it?
THE WITNESS: No, I don't.
THE COURT: You have never heard it?
THE WITNESS: Not -- maybe I should hear the context

in which it is used.
THE COURT: Doctor, you have been answering questions that contain it.
THE WITNESS: I did? When did I say secondary hemorrhage?
THE COURT: The question contained it, Doctor, and you answered. What did you understand by "secondary hemorrhaging"?
THE WITNESS: I don't understand that term. I'm sorry.
THE COURT: But you answered the question anyway.
THE WITNESS: Yes, I did.
Q. Now, you testified this morning about your work on the patient's safety committee at New York-Cornell, right?
A. That is correct.
Q. Your work on that committee deals with reviewing and establishing guidelines relating to OB-GYN care, correct?
A. Correct.
Q. Those guidelines are called protocols, aren't they?
A. They are.
Q. You have been personally involved in developing protocols for practice at New York-Cornell, right?
A. Correct.
Q. You participated in establishing a protocol for the use of Pitocin for pregnant women whose labor is being induced for live birth, right?

A. Correct.
Q. That protocol deals with how physicians should use Pitocin medication and the kinds of precautions that should be taken in connection with the use of that drug for induction for live birth, correct?
A. Correct.
Q. But you haven't worked on establishing any protocols for abortion, have you?
A. No, I have not worked on those.
Q. And you don't know if there are any protocols for abortion at New York-Cornell, do you?
A. No, I don't.
Q. And you have never asked, have you, doctor?
A. I have not specifically asked.
MS. GOWAN: No further questions.
MS. WIGMORE: Your Honor, I have just a few.
THE COURT: All right.
REDIRECT EXAMINATION
BY MS. WIGMORE:
Q. Dr. Grunebaum, do you recall answering in response to one of Ms. Gowan's questions that intact D&E procedure is a risky procedure?
A. I don't specifically recall it.
Q. How does the risk of intact D&E compare to the risk of dismemberment D&E?

A. It's lower.
Q. How does the risk of intact D&E compare to the risk of induction?
A. It is lower.
Q. Do you recall Ms. Gowan asking you about the time in which you count the fetal parts during a dismemberment D&E?
A. Yes.
Q. While you are counting the fetal parts, is the patient under anesthesia?
A. Yes.
Q. While you are counting the fetal parts, is the cervix of the patient dilated?
A. Yes.
Q. Doctor, do you recall Ms. Gowan asking you questions about your deposition questions and answers relating to the risk of lacerations and secondary hemorrhaging?
A. The word "secondary hemorrhaging" now comes to mind, yes.
Q. In terms of the risk of secondary hemorrhaging and lacerations, how does that risk for an intact D&E compare to that risk for a D&E involving dismemberment?
A. It's probably lower with an intact D&E. The risk of lacerations and hemorrhage.
Q. Why is that?
A. Because you have less instruments that you use, there is less of a chance of retaining placenta, and there is less of a

chance to have parts of the fetus being dismembered go through the cervix.
MS. WIGMORE: Thank you. I have no further questions.
THE COURT: Any further cross?
MS. GOWAN: No, your Honor.
THE COURT: Doctor, you mentioned earlier today that you believe in full disclosure to your patients as to the procedures and the various possibilities that are available.
THE WITNESS: Yes, I do.
THE COURT: And that you spell out for the woman just what is entailed in a D&E that involves dismemberment, correct.
THE WITNESS: Yes, I do.
THE COURT: You also spell out that if you are doing an intact D&E or D&X or partial-birth abortion, whichever term is used, that that entailed a partial delivery, and then the procedure you described of inserting the scissors in the base of the skull and using a suction devise to remove the brain.
THE WITNESS: Yes, I do.
THE COURT: You spell that out to the potential mother, correct?
THE WITNESS: Yes, I do.
THE COURT: Then you also described that some women choose to have the intact D&C -- or D&E after you have described that?
THE WITNESS: Yes.

THE COURT: And that --
THE WITNESS: May I interrupt, your Honor they do. I'm sorry. Yes.
THE COURT: And it is on an individual basis, not every one, but some do?
THE WITNESS: Many do. Many do.
THE COURT: And that some of them desire that because after the procedure if they want to see or hold the dead fetus, is that correct?
THE WITNESS: Yes. For example, in --
THE COURT: Is that correct, Doctor?
THE WITNESS: Yes.
THE COURT: I believe you mentioned also take pictures, is that correct?
THE WITNESS: Yes. That is part of our common policy -- it changed about ten years ago -- that we take pictures.
THE COURT: This is part of the grieving process?
THE WITNESS: Absolutely. We have been told by grieving counselors to take pictures of all dead fetuses and babies -- specifically babies, but also fetuses -- so there is a memory of the baby by the mother.
THE COURT: You say that as part of this grieving process, the mother or potential mother --
THE WITNESS: Yes.

THE COURT: -- requests this, even though after full disclosure from you about the fetus, that they ordered you to go ahead and suck the brain out of that child, is that correct?

THE WITNESS: And perform the abortion, correct.

THE COURT: Yes. No further questions. You may step down.

(Witness excused)

THE COURT: It is almost 5 o'clock. 4:55. I take it at this point in time there is not much point in putting on another witness. We will recess for the day and reconvene at 9:30 tomorrow morning. Court will stand in recess.

(Adjourned to 9:30 a.m., March 31, 2004)

INDEX OF EXAMINATION

PLAINTIFF EXHIBITS