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

Plaintiffs,

v. 03 Civ. 8695 (RCC)

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

Defendants.

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New York, N.Y.
March 31, 2004
9:40 a.m.

Before:

HON. RICHARD CONWAY CASEY

District Judge

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(Trial resumed)
THE COURT: All right, plaintiffs may call their next witness.
MR. HUT: Your Honor, plaintiffs call Dr. Timothy Johnson.
TIMOTHY JOHNSON,
called as a witness by the Plaintiff,
having been duly sworn, testified as follows:
DIRECT EXAMINATION
BY MR. HUT:
Q. Good morning, Dr. Johnson.
A. Good morning, Mr. Hut.
Q. Doctor, where are you currently employed?
A. I'm currently employed at the University of Michigan.
Q. Are you a physician, sir?
A. I am, yes.
Q. What positions do you hold at the University of Michigan?
A. I am professor and chair of the Department of Obstetrics and Gynecology. I'm a Bates Professor of the Diseases of Women and Children. I'm an Arthur Thurnau professor. I'm professor of Womens Studies. And I'm a research scientist in the Center for Human Growth and Development, all at University of Michigan.
Q. Would you briefly describe for us, Doctor, your responsibilities in these various positions?

A. My medical school responsibilities have to do with medical student education and training, postgraduate and subspecialty training and education.

My hospital responsibilities have to do with administering the department of obstetrics and gynecology, the inpatient services, subspecialty services and the various clinics and with recruitment, quality assurance issues of the faculty.

Q. Could you explain, briefly, your duties as Thurnau professor at the college?

A. Thurnau professor is a three-year appointment that's given for undergraduate teaching excellence, and I received that in recognition of undergraduate teaching in the women's studies department in the College of Literature, Science and the Arts and the expectation --

THE COURT: The college of what, Doctor?

THE WITNESS: I'm sorry. Literature, science and the arts.

THE COURT: Nothing to do with --

THE WITNESS: No, I have an appointment in the undergraduate college as well as the medical school.

Q. Doctor, can you explain briefly your responsibilities as research scientist at the Center for Human Growth and Development?

A. The Center for Human Growth and Development is a research

unit that's involved with various aspects of prenatal and early childhood development and growth. And as part of my research activities, I mentor and work with research scientists and post-doctoral students in that center.
Q. Do you have any research responsibilities in connection with the medical school, Doctor?
A. Yes. In addition to my own research program in fetal assessment, I am responsible for the research activities of the department.
Q. Dr. Johnson, are you a plaintiff in the action?
A. Yes, sir.
Q. Why did you bring it?
A. Well, I brought the action because of my interest in this topic.
I became involved in 1997 in litigation in Michigan, became more aware and more involved in the medical aspects of intact induced abortion procedures and have kept track of litigation statutes that have been passed since 1997 and have become involved with those.
Q. With respect to your involvement in the case you referred to in Michigan, what was your role there, Dr. Johnson?
A. Well, initially I was asked to serve as the Court's expert in Michigan suit.
Q. Who was the judge in the Michigan action?
A. Judge Gerald Rosen.

Q. And could you explain, briefly, the circumstances under which Judge Rosen asked you to serve as his Court-appointed expert?
A. Well, all I can say is that Judge Rosen decided that he wanted to have a medical expert assist him with the medical issues of that statute and asked me if I would be willing to serve in that capacity. And I agreed.
Q. Had you known Judge Rosen previously?
A. No, sir.
Q. Did you read his opinion in Evans v. Keller?
A. Yes, sir.
Q. Based on that reading, can you tell the Court here whether Judge Rosen relied on the testimony you gave in Evans v. Keller?
MS. GOWAN: Objection, your Honor.
THE COURT: Sustained. He can't tell what the Judge's mind was thinking. And the opinion speaks for itself.
Next question.
Q. Before you were appointed to serve as the Court-appointed expert in Evans v. Keller, Dr. Johnson, did you form any view on the opinion of intact variation D&E?
A. No, sir.
Q. Lets learn a little bit more about you, Doctor. From where did you obtain your medical degree?
A. I received my medical degree from the University of

Virginia in 1975.
Q. And in addition to your medical degree, sir, have you received any other medical training?
A. Yes. I completed four years of residency in obstetrics and gynecology from 1975 to 1979 at the University of Michigan. And then I did a two-year fellowship in maternal fetal medicine at the Johns Hopkins Hospital.
Q. We have had other witnesses refer to maternal fetal medicine but, briefly, can you explain for the Court what that discipline entails?
A. It's a subspecialty of obstetrics and gynecology that deals with high-risk and complicated pregnancies.
Q. What's a high-risk or complicated pregnancy?
A. Well, it would be a pregnancy complicated by either a maternal high-risk condition, maternal medical complication, maternal surgical complication, a pregnancy-related complication or a fetal complication such as a fetal abnormality, a fetal birth defect, genetic abnormality.
Q. Following your fellowship, what did you do?
A. I served four years in the United States Air Force. I served two years in Biloxi Mississippi at Keesler Air Force base, and then I served two years at Andrews Air Force base in Washington, D.C. where I also had an appointment at the Uniformed Services University of Health Sciences, which is the military medical school in Bethesda.

Q. Was your service in the Air Force in the medical corps of the Air Force?
A. Yes, I was in the Air Force medical corps.
Q. Were you honorably discharged from the Air Force, sir?
A. Yes, sir.
Q. What rank had you attained at the time of your discharge?
A. Major.
Q. Following your --
THE COURT: Where did you start at?
THE WITNESS: I started at second lieutenant.
THE COURT: When you went on active duty what did you have, what rank?
THE WITNESS: I was initially commissioned as second lieutenant when I went on active duty, in the medical corps I was captain.
THE COURT: So you just went up one rank in four years?
THE WITNESS: Yes, sir. That's in four years; yes, sir.
BY MR. HUT:
Q. What did you do after you left the service?
A. I was appointed to the faculty at Johns Hopkins Hospital and I was a member of the Division of Maternal Fetal Medicine and the Department of Gynecology and obstetrics at Johns Hopkins. I was there from 1985 to 1993.

I moved through the ranks, was appointed to be residency program director of the department. Eventually I became the director of the Division of Maternal Fetal Medicine and was promoted to Associate Professor of Obstetrics and Gynecology and Associate Professor of Pediatrics.
Q. Where did you go, Dr. Johnson, after Johns Hopkins?
A. In 1993 I took my career and appointment at Michigan and I have been there since then.
Q. Do you currently practice medicine, Doctor?
A. Yes, sir.
Q. For approximately how long have you practiced?
A. Since 1975.
Q. In what area or areas do you specialize in the practice of medicine?
A. I specialize in obstetrics and gynecology and in high-risk obstetrics.
Q. For how long have you specialized in those areas?
A. Well, I have, I have been active in maternal fetal medicine since I completed my fellowship in 1981 and during my training from '79 to '81.
Q. How did that specialization of obstetrics an gynecology, how long have you had that specialty?
A. I received and completed that training in 1979.
Q. Do you have any board certifications, Dr. Johnson?
A. Yes. I'm board certified in obstetrics and gynecology and

I am also certified by the subspecialty board of maternal fetal medicine.

And I am currently recertified and up to date in both of those certifications.

Q. Do you treat patients, Doctor?

A. Yes, sir.

Q. In what setting or settings do you do that?

A. Well, I treat patients both in an ambulatory setting, I see patients in an outpatient clinic at the university hospital and at one of our outlying health clinics. I also am involved in direct patient care on-call in the hospital.

Q. For what types of problems or conditions do you treat patients, Doctor?

A. Well, I see patients with a spectrum of routine obstetric and gynecologic problems.

I see pregnant patients, I see gynecologic patients for annual care, for typical-type gynecologic problems -- abnormal bleeding, other kinds of problems.

I also see high-risk patients, complicated patients that either come to me or are referred to me with pregnancy related complications.

When I am either working in the hospital on labor and delivery or covering the hospital as part of my faculty duties I would be responsible for patients in labor and delivery, patients in the obstetric inpatient unit, and also would be

responsible for patients who came into the emergency room with gynecologic emergencies. And I would go with those patients if they needed to to the operating room for surgery.
Q. Do you perform abortion procedures, Doctor?
A. I do; yes, sir.
Q. What types of abortion procedures do you do?
A. Currently I am involved, because of my call schedule, only in medical induction procedures.
Q. Do you have privileges to perform surgical procedures?
A. Yes, sir.
Q. And what about your call schedule involves you only in medical induction procedures?
A. Well, currently because of my administrative and daytime duties I take call usually on, on the evening or on weekends. I don't cover the operating rooms or the units during the daytime, which is the time that surgical procedures are carried out.

So, because of that the patients that I see are patients who are admitted for medical induction during my time on call.
Q. Prior to your current schedule and in the past, what types of abortions have you performed?
A. Both medical and surgical abortions, first and second trimester.
Q. And by medical abortions in the second trimester, can you

again tell the Court what you mean?
A. I am talking about abortion inductions that are induced using medications, using drugs to induce labor and to cause delivery.
Q. And by surgical procedures in the second trimester, what do you mean by that, sir?
A. Surgical procedures would be operative procedures to perform evaluation of the uterus, so, D&E procedures.
Q. Do you manage spontaneous abortions in the course of your practice?
A. Yes, sir.
Q. How do you do those procedures?
A. Those patients present to the emergency department -- generally occasionally to labor and delivery -- but to one of our acute triage units, and they're evaluated and then I would participate in their management.
Q. Have you had any training, Dr. Johnson, in abortion procedure?
A. Yes, sir.
Q. Could you describe it for the Court, please?
A. Well, as a resident and as a fellow I received didactic --
THE COURT: Can you tell us where it occurred and when it occurred?
THE WITNESS: Sure.
As a resident from 1975 to 1979 we had lectures,

directed readings and were involved in abortion procedures at University Hospital. Those were --

THE COURT: That was in Virginia?

THE WITNESS: No, that was at the University of Michigan.

THE COURT: University of Michigan.

THE WITNESS: When I was a resident between '75 and '79; so at that time most of those procedures were mid-trimester procedures because of the practice in the hospital. I had some experience at Planned Parenthood with first trimester procedures as a resident.

Subsequently, from 1979 to 1981, at Hopkins, I received further training. At the time, from 1979 to 1981, Hopkins had a large abortion research unit and the fellows, including myself, were responsible for managing the complications in that unit, managing the problems in that unit, doing any procedures that needed to be done in that unit at night when we were in-house managing those patients.

Since then I have continued reading the medical literature and attending conferences, attending quality assurance meetings, departmental meetings, and continued to be involved in the education and training of our residents who participate in abortion training in our institution.

Q. You made reference in that answer, Dr. Johnson, to the mid-trimester, I'm not sure we have heard that word, what is

the mid-trimester of pregnancy?
A. Considered generally from 12 to 24 weeks, but often in terms of the management we are talking more like 14, 15 weeks until 24 weeks.
Q. And the mid-trimester is synonymous with the second trimester, is that correct?
A. Correct, yes.
Q. Are you familiar with a variation of the D&E procedure known as the intact dilation and evacuation, or intact D&E?
A. Yes, sir.
Q. Have you observed performance of the intact variation of D&E?
A. Yes, sir.
Q. Where did that occur?
A. At affiliated -- at training sites that we have a relationship with at our institution.
Q. With respect to --
THE COURT: Where, specifically, Doctor?
THE WITNESS: Well, I'm afraid to identify that place because I'm concerned that my residents and my colleagues who are working there could be identified and targeted as -- if that were, became widely known.
MR. HUT: Your Honor, would it be possible at this point perhaps to approach and have the court reporter, if this would be satisfactory to Dr. Johnson, transcribe it only in the

presence of the Court and the government, rather than in the full courtroom?

THE COURT: Before we do that, let me understand your concern about the safety of your colleagues.

THE WITNESS: Yes, sir.

We have a very small community --

THE COURT: I didn't ask you --

THE WITNESS: I am afraid that my colleagues could be identified if it were known where they were doing their training in their abortions.

THE COURT: All right, I will take it at sidebar.

(Page 401 SEALED by order of the Court)

(In open court)
BY MR. HUT:
Q. Doctor, do have you teaching responsibilities?
A. Yes, sir.
Q. In what subject or subjects?
A. I am responsible for the educational program in obstetrics and gynecology at the medical school. I am responsible for the educational programs for our subspecialty training programs at the hospital and the medical school in reproductive endocrinology, maternal fetal medicine, gynecologic gynecology, and urogynecology.

I am also involved in teaching fourth year medical students in a variety of subjects, either maternal fetal medicine. I also teach a course on transnational and transcultural issues in women's health, global health.

At the undergraduate level I am responsible for teaching courses that are generally attended by junior and senior undergraduates. In the women's studies department I teach a class on women's reproductive health, I teach a class on men's health and I teach a class on transnational and transcultural issues on women's health on an intermittent basis. That is a grad level course.

THE COURT: You teach all of these courses now?

THE WITNESS: No. Right now I am only teaching women's reproductive health this semester, plus the medical

school courses. Men's health course I teach in the fall.
THE COURT: Those are undergraduate courses?
THE WITNESS: Yes, sir.
THE COURT: How many hours a week do you teach in the undergraduate school?
THE WITNESS: The classes are usually three hours a week and both of the classes I teach, the women's reproductive health class I teach with a professor from the nursing school, and the men's health class I teach with a professor from the psychiatry department. So, we co-teach those classes.
THE COURT: All right, go ahead, Mr. Hut. You may proceed.
BY MR. HUT:
Q. In your earlier answer, Doctor, before the colloquy with the Court, you made a reference to a discipline, if I heard you correctly, urogynecology; could you explain for the Court and for me what that is?
A. OB/GYN has four recognized subspecialties. Urogynecology is the commonly used term, it is also called female pelvic medicine and reconstructive surgery. And it is a relatively new subspecialty and it is focused on urinary tract problems, incontinence, pelvic floor prolapse and surgery --
THE COURT: Doctor, would you try and talk in layman's terms when you use technical language like that? I know you are not used to talking that way all the time but I am trying

to establish an intelligible record that could be understood by those other than in the medical profession.
THE WITNESS: Yes, sir.
THE COURT: Okay, I would appreciate your effort to do that.
Do you want to go back and describe what that first category was?
THE WITNESS: It's a subspecialty that deals with women who have trouble controlling their bladder, who leak urine, or who have problems with prolapse; where the vagina or uterus or rectum are prolapsing out and cause them pain or discomfort with urination, with bowel movements.
Q. Dr. Johnson, do you have responsibilities for the training of other physicians in obstetrics and gynecology?
A. Yes, sir. I have responsibility for the residency training program, which is a four-year program that trains 20 residents total, five residents a year.
I also have responsibility for the subspecialty training programs. Each of the four subspecialties I mentioned has up to one fellow a year and those are three year programs. So at any given time we might have as many as 12 subspecialty trainees.
We also have occasional trainees who spend a year or two doing advanced training and laparoscopic surgery, minimally invasive surgery, and we have regular exchanges with

post-graduates from abroad as well that rotate on our teaching services.
Q. Does your institution offer training in abortion procedures?
A. Yes, sir.
Q. What type of abortion procedures are taught or trained at your institution?
A. Well, we teach all of our residents the broad spectrum of both medical and surgical services in the first and second trimester.
The residents then actually participate in both first and second trimester procedures if, unless they -- unless they opt out. Our residents have an opportunity not to participate in training or provision of services that they morally or ethically don't feel comfortable with.
Q. And with respect to second trimester surgical and medical procedures, what are they as taught or trained?
A. Those would be either medical inductions or surgical procedures, second trimester.
Q. And the surgical procedures are what procedure?
A. Would be D&E procedures.
Q. Dr. Johnson, are you a member of any professional associations?
A. Yes. I'm a fellow of the American College of Obstetricians and Gynecologists. I'm a member of the Society for Maternal

Fetal Medicine. I'm an elected member of the Society for Gynecologic Investigation, which is the research society of my speciality. And --

THE COURT: What is the research part of your society?

THE WITNESS: The society for gynecologic investigation is the society that focuses on OB/GYN research.

Q. With respect to your memberships, in any of those organizations, have you served as member or chair of any committees of those associations?

A. Yes.

I have been chair of the International Committee of the American College, and then a chair of the International Committee of the American College of Obstetricians and Gynecologists, and I have served on Prologue and other educational task forces of the American College.

Q. What does Prologue stand for, Doctor?

A. Prologue is an educational brochure that the college produces that I was involved with on the production committee.

Q. Doctor, what is the Institute of Medicine?

A. The Institute of Medicine is an elected society of health professionals that is the health arm of the National Academy of Sciences.

Q. Is membership in the Institute of Medicine attained voluntarily or by election?

A. By election.

Q. Have you been elected a member?
A. Yes, sir.
Q. What year?
A. 2003.
Q. How many OB/GYNs currently serve as elected members of the Institute of Medicine?
A. I think, approximately 20.
Q. Dr. Johnson, do you serve on any government or governmental advisory committees?
A. Yes.

I am currently a member of the advisory committee on women's health research to the director of the National Institutes of Health.

Q. Have you served, sir, on the editorial board of any peer-reviewed journals?
A. Yes, sir.

I have been on the editorial board of the American Journal of Obstetrics and Gynecology, the Journal of Obstetrics and Gynecology, and I am currently associate editor and on the editorial board of the International Journal of Gynecology and Obstetrics.

Q. Are you currently, Dr. Johnson, an active peer reviewer?
A. Yes, sir.
Q. Have you authored any publications in the field of obstetrics, gynecology or medicine?

A. Yes, sir.
I have authored approximately a hundred peer-reviewed publications, 40 or 50 non-peer-reviewed publications, several book chapters and several books.
MR. HUT: Your Honor, may I approach the witness with an exhibit, which I have already supplied to the government in the form of actually two exhibits contained in notebooks, as we have proceeded in the past?
THE COURT: You may.
MR. HUT: Thank you.
Q. Dr. Johnson let me ask you to turn in the book I have supplied to you at the document Tab 106 marked Plaintiff's trial exhibit 106.
Do you see that, Dr. Johnson?
A. Yes, sir.
Q. What is Plaintiff's 106?
A. It is marked as my curriculum vitae.
Q. Do you recognize it as such?
A. Yes, sir.
Q. Is your curriculum vitae, as reflected in plaintiff's trial Exhibit 106, an accurate summary of your education and experience?
A. Yes, sir.
MR. HUT: Your Honor, plaintiff's move the admission of Plaintiff's trial exhibit 106.

MS. GOWAN: No objection, your Honor.
THE COURT: It will be received.
(Plaintiff's Exhibit 106 received in evidence)
Q. Dr. with respect to your service as a Court-appointed expert by Judge Rosen in Evans v. Kelly, did your views change as a result of any investigation or analysis you performed in your services as such an expert?
A. Well, I would say that I came to know more about the issues related to the so-called Michigan Partial-Birth Abortion Act and I came to understand better the medical issues having to do with that specific Act with respect to the definition and the various implications for women's health.
I would say during the course of that trial I did learn much more about the procedure than I had known before, before that experience.
THE COURT: When did you do that, Doctor? When did you get appointed by Judge Rosen?
THE WITNESS: That was in 1997.
THE COURT: Was that in a court proceeding involving a Michigan statute?
THE WITNESS: Yes, sir.
BY MR. HUT:
Q. Did you come to any professional conclusions, Doctor, as to the implications that that statute had for women's health?
MS. GOWAN: Objection, your Honor.

THE COURT: Sustained.
Q. In addition to your service as Court-appointed expert, Doctor, in Evans v. Kelly, have you offered expert testimony in any other court matters?
A. Yes, sir.
Q. In approximately how many other cases have you provided expert testimony?
THE COURT: What type of case are you talking about, cases challenging partial-birth abortion statutes in state or what are we talking about? Are we talking personal injury cases, malpractice cases? What is it you are asking?
MR. HUT: The question was intended to elicit any or all of those, your Honor. Let me rephrase it.
THE COURT: I just want to make sure that's what you are asking. I didn't know what the question was.
BY MR. HUT:
Q. Doctor, let's take those one by one. Have you served as an expert witness in any actions that have involved questions concerning abortion?
A. Yes, sir.
Q. What other case or cases have you served in, sir?
A. In a subsequent Michigan case which was Northland v. Granholm.
Q. Have you served as an expert in any case with respect to so-called parental consent issues in abortion?

A. Yes, sir. I was an expert in a Colorado case.
Q. Have you served as an expert witness in any malpractice actions as the Court inquired a moment ago?
A. Yes, sir.
Q. Approximately how many?
A. I have probably given trial testimony 10 or 12 times in malpractice cases.
MR. HUT: Your Honor, we offer Dr. Johnson as an expert in obstetrics and gynecology and in abortion procedures, pursuant to Rule 702 of the Federal Rules of Evidence.
THE COURT: Any objection?
MS. GOWAN: No, your Honor.
THE COURT: The Court will so recognize the doctor.
Q. Doctor, from the time you served as Court-appointed expert in Evans v. Kelly, has your opinion about the intact D&E changed?
A. Yes, sir.
Q. In what way?
A. Well, I would say that my understanding of the relative risks and benefits of the procedure, as well as my understanding of the applicability and the acceptance of the procedure in abortion practice, is changed.
Q. In your opinion, Doctor, has there been any evolution in the way D&E, of all variations, is performed?
MS. GOWAN: Object to the form of the question.

THE COURT: That would be? Please specify.
MS. GOWAN: Vague, your Honor.
THE COURT: May I have the question read? I don't know that that is false, but.
MR. HUT: I will rephrase it, your Honor.
THE COURT: It has a problem but I don't know that that is it, but go ahead, rephrase.
BY MR. HUT:
Q. Have you formed any opinion, Doctor, concerning whether D&E of all variations has changed over recent years?
MS. GOWAN: Objection. Lack of foundation.
THE COURT: I think you can get it. Try again, Mr. Hut. I don't know that you need a foundation for it, but.
Q. In your estimation, Doctor, has the practice of D&E changed over time, in recent years?
A. Yes, sir.
Q. In what way?
A. Well, I would say there are several things.
First of all, I would say that there has been an evolution in the way that D&E is managed with respect to preparing the cervix for the procedure. There have been advances since the '80s, both in the techniques used and also in how those techniques are applied.
With the introduction early on of laminaria and other techniques that allow the cervix to dilate using osmosis over a

relatively longer period of time than was initially done surgically, other types of osmotic dilators have been introduced, and techniques have also been developed using prostaglandins, specifically cytotec, in conjunction with laminaria, to prepare the cervix for the D&E procedures.

In addition, I would say that the instruments have evolved, the type of forceps that are used for the procedure have been developed to more appropriately allow the grasping of the fetal tissue.

And, finally, I think many people now are using ultrasound guidance as part of their D&E procedures.

So, there have been a number of advances and changes over time in terms of the way people approached surgical D&E procedures.

Q. Do you understand the development of the use of osmotic dilators, such as laminaria, over a longer period of time? Is that a safe practice?

A. Yes. It's a practice that has relative safety benefits compared to manual surgical dilatation that was used previously.

THE COURT: Do you want to explain what that means, Doctor?

THE WITNESS: Sure.

In the 1970s when we were dilating the cervix we would do, use metal rods that would dilate the cervix relatively

quickly as we increased the size of the rods to get the cervix to dilate.

The laminaria are actually little sticks of seaweed that are placed in the cervix. They start off very small but they draw in water and, over a period of hours, they expand so that the cervix dilates more slowly and more evenly over a longer period of time than it would with the surgical dilators.

THE COURT: Are there risks involved in both?

THE WITNESS: Yes, sir.

THE COURT: Next question.

BY MR. HUT:

Q. In your opinion, have the changes that you earlier identified had an effect on the feasibility of the intact variation of D&E?

A. Yes, sir.

Q. What effect is that?

A. Well, first of all, the intact procedure requires that the cervix be both dilated and relatively unresistant to the fetal parts.

The laminaria, which can be used repetitively can, over a period of 12 hours or 24 hours, depending on how often they're used and how often they're replaced, dilate the cervix pretty significantly.

It's common practice, when we are using laminaria, to put a few laminaria in to allow them to dilate the cervix and

then for those laminaria to be removed and for another set of new laminaria in larger numbers to be placed in. And that can happen two times or three times or more over a period of time to dilate the cervix.

Cytotec, it has a different effect. It has an effect not only on dilating the cervix but has an effect on the consistency of the cervix so that the lower uterine segment is softened, the cervix shortens and the cervix is softer and less resistant.

So, both the combination of more dilated and softer makes intact D&E procedures more feasible.

Q. And has the combination of more dilation and softer affected the procedure's safety in your opinion, Dr. Johnson?

A. Yes.

Q. Have you observed the changes to which you just testified at your institution?

A. Yes, sir.

Q. And how would you describe the current thinking of your institution about the intact variation of D&E?

MS. GOWAN: Objection, your Honor.

THE COURT: Sustained.

Q. Have you had conversations with members of your faculty about potential safety advantages of D&E?

MS. GOWAN: Objection, your Honor.

THE COURT: I will allow that.

THE WITNESS: Yes. We talk about the safety advantages of virtually all the procedures that we do, including intact D&E.
Q. With approximately how many faculty members have you had such conversations concerning intact D&E?
A. With intact D&E?
Q. Yes.
A. Oh, I'd say five or six.
Q. How many faculty, Doctor, are involved in second trimester abortions -- 22 weeks?
A. I would say maybe eight or 10. Up to 22 weeks.
Q. Yes.
THE COURT: Do you really want to go in this direction? You are opening up to people who are not here and I suppose you aren't going to ask other people who disagree and I am going to allow Ms. Gowan to do that.
I thought he was here to testify as to his expertise, Mr. Hut. I don't know that you can reach out and grab a bunch of expert witnesses by doing the direction of examination that you are doing.
MR. HUT: I was going only in this brief direction, your Honor, and that has to do with his understanding of --
THE COURT: I know you want to direct it to the institution but I think you better stick with your expert.
MR. HUT: I shall.

THE COURT: As to his expertise, his talent otherwise, we have to explore the expertise of all the other groups and friends and fellows that he talks to and I don't think that's appropriate.
MR. HUT: I will follow Court's suggestion.
BY MR. HUT:
Q. Doctor, apart from the changes that you have described in surgical procedures in the second trimester, has induction procedure in the second trimester changed?
A. Yes, sir.
Q. In what way?
A. Well, both through the introduction of the laminaria and the osmotic dilators that I mentioned to dilate the cervix, and also there has been a transition since the 1980s with respect to the agents that are used for medical induction.
In the 1970s commonly we used saline. Subsequently we moved to urea.
THE COURT: This is what you used?
THE WITNESS: Correct, what I used.
THE COURT: Okay.
THE WITNESS: So, we used initially saline and then moved to safer agents -- urea, prostaglandins. We used intra-amniotic prostaglandins and urea, subsequently used vaginal prostaglandins, and now for medical inductions it is our general practice to use either vaginal or oral

prostaglandins in the form of misoprostol.
BY MR. HUT::
Q. Have those changes improved the safety and efficacy of induction, Doctor?
A. I believe so, yes.
Q. Do you, in the course of your academic responsibilities, have occasion to visit other universities as a visiting professor?
A. Yes, sir.
Q. Where have you visited?
A. Well, I visited Emory University, Indiana University, Cornell University, Johns Hopkins University, University of Nebraska, Northwestern University.
THE COURT: Over what period of time are you talking about?
THE WITNESS: Generally, as a visiting professor, I will be there for a day, sometimes two days, participating in educational activities.
MR. HUT: I think the Court had in mind over what span of years.
THE COURT: The last 20 years, the last two years? What are we talking about?
THE WITNESS: Usually visiting professor, maybe one, maybe two each year.
THE COURT: I think we ought to make this a reasonable

period of time, or at least identify if you are going to go into procedures that he has observed. I think it ought to be identified, the place and the time.
MR. HUT: I was not intending to do that, your Honor, but rather intending only to ask the question based on observations that you have made in recent years at universities that you have visited.
Q. Does a D&E procedure vary in the way it is performed one region to the other?
THE COURT: First of all, I think we ought to establish the fact, the mere fact he visited whether or not he observed procedures done, or he has just chitchatted in discussions.
MR. HUT: Let's establish that responsive to the Court's question, Dr. Johnson.
Have you had occasion, in your visits to universities in recent years, to observe procedures and to discuss with doctors who performed them, the way they do it?
THE COURT: How about last year, Doctor? We will try and get this hopefully at some point in time.
THE WITNESS: Last year I was at Northwestern University and was involved in case discussions, case conferences and I --
THE COURT: Did you observe any abortions while you were there?

THE WITNESS: I did not; no, sir.
BY MR. HUT:
Q. Doctor, do you have an opinion regarding the safety of the D&E procedure of all variations?
MS. GOWAN: Objection, your Honor.
THE COURT: Sustained.
Q. Do you have an opinion concerning the safety of the D&E procedure?
A. Yes.
Q. What is your opinion?
A. My opinion is that the D&E procedure is a safe procedure for termination of pregnancy.
Q. Do you have an opinion regarding the safety of induction procedures?
A. Yes. I think that's also a safe procedure.
Q. What are the bases for your opinions as to both?
MS. GOWAN: Objection, your Honor. Compound.
THE COURT: Compound?
MR. HUT: I will do it one by one, your Honor. I will rephrase.
THE COURT: What do you base it on, Doctor? I will ask the question.
THE WITNESS: I base that on my training, my experience, my reading of the literature, as well as our, as my clinical practice.

BY MR. HUT:
Q. Dr. Johnson, do you have an opinion as to how the safety of D&E compares to the safety of induction?
A. Yes. I think that D&E procedure compares favorably to medical induction, especially in the period from 16 to 20 weeks. It has relative safety benefits and other benefits.
Q. And at the 20 week period, what is your opinion as to the relative safety between the two procedures?
A. Well, I think all abortion procedures have greater risk at greater gestational age, so there is clearly a relationship between the gestational age and risk for both procedures.

I think that after 20 weeks the relative safety of D&E and medical procedures are more comparable than earlier. I think that the risk benefit ratio narrows between the two.
Q. And on what do you base that opinion, Dr. Johnson?
A. Well, my training, my experience, my understanding of the literature.

THE COURT: In other words, in my understanding no matter what procedure you use it's you go up in gestational age the risks increase, is that correct?

THE WITNESS: Yes, sir.

THE COURT: Next question.

Q. Prior to 20 weeks LMP, Dr. Johnson, why, in your opinion are D&Es generally safer than inductions?

THE COURT: I don't think the Doctor said that. I

think he testified they're both safe. Each had its own differences but both are safe.
Was that not your testimony?
THE WITNESS: No, I think I said that between 16 and 20 weeks there is a relative benefit for safety with respect to D&E.
BY MR. HUT:
Q. Why is that, Dr. Johnson?
A. Well, the D&E procedure is done, since its done surgically it happens over a fairly short period of time, there is less risk of bleeding, less risk of infection, compared to the medical induction procedure that extends over as many as 24 hours so there is, it's a more controlled environment. It's a shorter procedure and the major risks of both procedures of bleeding and infection, and there is a relative benefit for D&E in that time frame.
Q. Based on your knowledge of the field, Doctor, which are more common after 20 weeks, induction or D&E?
A. Nationally D&E procedures are more common.
THE COURT: How about in your practice?
THE WITNESS: In our practice -- in our practice I would say over the last several years medical inductions are more common.
THE COURT: When you say "our" you mean University of Michigan?

THE WITNESS: Yes, sir.
THE COURT: Does that encompass your geographical area, too, or just the University environment?
THE WITNESS: No, just the University environment.
I would say if you encompass the entire geographic region the practice is much more common for D&E.
THE COURT: But at the University the induction is more common?
THE WITNESS: I would say averaged over three years the induction because of the patient we are managing is more common; yes, sir.
BY MR. HUT:
Q. Dr. Johnson, have you had occasion to review patient records in response to the government's discovery in this action at your institution?
A. Yes, sir.
Q. Based on that review, Dr. Johnson, do you have an understanding of which of the procedures, if any, it is more common, say, over the last year, which is the time for which you reviewed documents?
MS. GOWAN: Objection.
THE COURT: Whoa, whoa, whoa, whoa. I think you better have a foundation for what records were reviewed first, otherwise we really don't know what we are getting.
MR. HUT: Can you answer the Court's question, Doctor?

THE WITNESS: Yes, sir.
In response to Court order I reviewed records from University Hospital, I reviewed records from 2002 -- 2001, 2002 and 2003.
THE COURT: Patients that you treated?
THE WITNESS: Patients that I treated.
THE COURT: Personally?
THE WITNESS: Personally, yes, sir.
THE COURT: Okay. And how many in number?
THE WITNESS: How many records did I review?
THE COURT: How many individual patients were involved in these records?
THE WITNESS: Well, actually what I did was for those three years I reviewed all the patients that I treated who had -- actually I queried the database to find out during those three years were there any patients that I treated who had a D&E procedure.
I also reviewed all the D&E procedures that were done during those three years to identify whether or not I had been responsible for those cases, and there were no cases that came up on either database.
THE COURT: Did you also ask to review records of inductions, procedures that you had done on patients?
THE WITNESS: Well, I asked to review records, all records for inductions and D&Es that I had done on patients

only for the year 2003.
THE COURT: But not inductions for 2001 and 2002?
THE WITNESS: That's correct. That wasn't something that was, that I was asked to do.
THE COURT: Is that because that's what the subpoena said or because somebody told you to do that?
THE WITNESS: No, the subpoena asked me to respond with all the patients who had had a consideration of a medical induction who subsequently had a D&E procedure and there were none of those because I could identify no D&E procedures that I had done in the last three years.
The second -- the second group of patients that I was asked to identify were those patients who had had a D&E procedure. I knew because of my practice that I had done no D&E procedures on, for abortion, for induction of abortion cases, but I also reviewed all of the spontaneous abortion cases for those three years to see whether or not I had either performed or supervised any D&E procedures on second trimester spontaneous abortions, and I had not.
THE COURT: Those are miscarriages?
THE WITNESS: Correct.
And then the third group of patients that I was asked to identify were any patients with hydrocephalous that I had treated by D&E, or otherwise, in 2003.
THE COURT: And there were none of those?

THE WITNESS: Well, that actually for 2003 I had to do a more extensive record review.

Because of the coding issues I reviewed all of the cases that I did in 2003 with a diagnosis of abortion or miscarriage. Identified in a separate database all the medical abortions and all the D&E procedures that were done at our hospital in order to identify whether or not I had been involved in any of those cases and whether or not any of those cases had associated hydrocephalous.

And I also reviewed all of our records from our prenatal diagnostic center and from our prenatal genetic center to identify all cases of hydrocephalous that might not have been on all the other databases.

So, I think I looked at all the places where patients with hydrocephalous undergoing pregnancy termination procedures could have been identified at our institution.

THE COURT: All right.

BY MR. HUT:

Q. Based on your query of the universe of records for all D&E procedures over the last year and your review of inductions in 2003, do you have a judgment about any trend at your institution with respect to the relative frequency of those procedures?

A. Well, I can --

THE COURT: The trend at the institution? I thought

these were just the Doctor's records. How can one tell a trend unless you took all of the records of the hospital?
MR. HUT: I believe in the Doctor's answer, as I understood it, your Honor, he had queried the database for all D&Es performed at the institution to make sure he surveyed the universe of those in which he had been involved.
Did I understand you rightly, Doctor?
THE WITNESS: That's correct.
THE COURT: All done at the hospital, not just yours?
THE WITNESS: Yes.
For 2003, in order to be sure, because occasionally what will happen is there will be a patient who is admitted with, for induction -- for medical induction, for example, and she will be admitted when I am on call. I will place the laminaria. I will place the cytotec. And she might be delivered on somebody else's watch. And since I was involved in that case I wanted to make sure that there were no cases where I was involved in the management of hydrocephalic, and there were none.
BY MR. HUT:
Q. Based on that review, Dr. Johnson, have you observed any trend at your institution concerning the relative frequency of the induction D&E procedure?
A. Well, I can tell you that based on that review I identified 24 D&E procedures that were done in 2003 at our institution and

22 medical inductions, which was actually surprising to me.
Q. Why is that?
A. It had been my impression and my opinion that medical abortion at our institution was the more prevalent procedure and when I have discussed this in the past with my colleagues, my impression and their impression had always been that we had about an 80/20 split medical induction versus surgical induction.

So I have to say that my review of last year's experience was interesting to me in that there was a fairly even balance between the two procedures.

There were more D&Es done at my institution, comparatively, than I had thought.

Q. Dr. Johnson, do you have an opinion why D&E is more generally common after 20 weeks, nationally and in your area, than induction if the two procedures are, as you testified, more or less equivalent in safety after the 20 week period?
A. Well, I think that it's a combination of access and availability.

Clinics that can provide surgical procedures are more common, they're easier for patients to get appointments at.

I think that there are certainly physician preferences in terms of performing D&E procedures because it allows them to do a surgical procedure in a shorter period of time. It allows them to do a procedure without admitting the patient to the

hospital, without needing a longer period of observation in the hospital.

And I think there is also a preference, many patients prefer a surgical procedure that's done compared to a prolonged induction procedure that might take 12 to 24 hours and might, in addition to taking longer, have pain over a longer period of time.

Q. Doctor, are there any circumstances in which medical inductions are relatively less preferable for certain women?

A. I think there are certainly conditions where medical inductions are -- I would say have increased risk, conditions where the uterus might be scarred because of previous incision, classical caesarian section where the incision is in the active segment in the active muscle of the uterus. Women who have had fibroids removed and women who have scars on their uterus. Women who have had multiple caesarean sections.

Those would be conditions where labor and contractions might increase the risks of uterine rupture and make people think about the risks associated with medical induction.

Q. Let's return to those in a minute, Doctor. Let me ask you this:

How does the labor that's involved in second trimester induction compare to the labor involved in at term in its duration, pain, and psychological effects?

THE COURT: I think that's quite a few questions. Do

you think we can break it down instead of the universe?
MR. HUT: I think so, your Honor. Yes.
BY MR. HUT:
Q. How does the labor in an induction during a second trimester abortion compare to the labor that a woman undergoes in term?
THE COURT: Can that be done?
THE WITNESS: Can the comparison be made?
THE COURT: I mean don't term labor -- the labor involved in delivery of a child varies enormously from woman to woman, patient to patient?
THE WITNESS: Well I think they certainly vary a lot. I would say that --
THE COURT: And so, when you add in another factor --
THE WITNESS: In terms of duration, if you were going to look at time periods, I mean average total labor for someone at term is in the range of 18 to 24 hours for a first pregnancy, for mid-trimester termination it would be about the same.
I would say that the drugs that are used and the contractions that are generated by the drugs are really quite different. The amount of uterine activity, the amount of force that's generated in the mid-trimester procedure is very different and significantly more than the type of force that's generated in spontaneous labor or when we tried to induce

spontaneous labor both because of the drugs that we use and because of the way the uterus contracts in the mid-trimester.

So the forces are different, the drugs are different. We give a much higher dose of drug for mid-trimester medical induction than we ever would at term because the uterus is not as responsive to the drugs and responsive uterine activity that might harm the fetus is not a consideration.

BY MR. HUT:

Q. Based on your experience, Doctor, are you able to make any comparison between the psychological effects on the woman as between labor during a second trimester induction abortion and labor term?

MS. GOWAN: Objection, your Honor.

THE COURT: Basis of the objection?

MS. GOWAN: Extremely broad question. And I also don't believe this witness is qualified to talk about psychological ramifications on unknown women.

THE COURT: Are you capable, based on your training, Doctor? Have you studied this? Or written on it?

THE WITNESS: No. And I guess I really don't have an opinion one way or the other about the relative psychological --

THE COURT: That answers that, next question.

MR. HUT: We will move on.

BY MR. HUT:

Q. How does a D&E procedure compare in terms of duration to medical induction during second trimester?
A. Well, a second trimester D&E procedure would take minutes compared to hours, so a surgical procedure would take maybe 20, 25 minutes, maybe an hour on the outside whereas a medical induction, depending on the patient's previous obstetric experience, might be anywhere eight to 10 hours to more than 24.
Q. Dr. Johnson, have you ever had a patient who did not want an induction for the reasons you've discussed?
A. Yes, sir.
Q. Can you estimate how often you have seen patients who have made clear to you that they do not want an induction?
A. I would say a couple times a year I have patients who are considering second trimester pregnancy termination who are not interested in having a medical procedure and desire a surgical procedure.
Q. Why are inductions more difficult to obtain than D&Es, Dr. Johnson?
A. Well they're generally done in a hospital facility, they require both hospital facilities and expertise and that expertise is often not available. They don't have the nursing support, they don't have the hospital beds, they don't have physicians who have the experience with the medical procedure.
So I guess the, it's mostly availability of hospital

beds.
Q. In the earlier testimony you described your judgment that inductions are less preferable for women with prior c-section. Did I understand that correctly?
A. Prior classical caesarian sections, yes.
Q. Thank you for the clarification. What is a prior classical caesarian section?
A. It is an incision in the active portion of the uterus.
Normally when we do a caesarean section we do a incision called bhindi cut and the cut in the uterus is a low incision very close to the bladder in a part of the uterus that doesn't contract actively.
Most caesarean sections are those so-called low transverse caesarean sections.
Occasionally either a maternal fetal condition causes us to do what's called a classical caesarean section where the incision is in the active, thicker part of the uterus. And since it is a contractual portion of the uterus, and since it doesn't heal as well as, the normal classical incisions carry increased risk with subsequent labors.
Q. Why is there -- let me withdraw that question and ask you this question first.
Are you familiar with data showing how many caesarean sections are performed each year in the United States?
A. Well, I can tell you that the average caesarean section

rate in the United States now is in the low 20s, somewhere between 20 and 25 percent at most institutions.

I can't tell you exactly what the most recent national rate is but the caesarean section rate in most institutions is somewhere between 20 and 25 percent.

Q. Is your institution's experience consistent with that?

A. Yes, sir.

Q. Why, for women with the scar that you have just described, is an induction less preferable? In your opinion?

A. The risk of rupture of that scar where the uterus actually breaks open during the induction, because of the drugs that we are giving to cause the uterus to contract, is an event that's both very risky in terms of bleeding and infection but also increases the, has a mortality risk for the woman as well.

Q. Why would rupture be a risk of induction for a woman with a prior classical c-section scar?

A. Because the drugs being given cause the uterus to contract and it's the contraction of the uterus in an area that's scarred and not -- and not, and at risk for rupture that it happens.

Q. And in your opinion, Dr. Johnson, what type of abortion procedure would be the most appropriate for a woman with a prior classical caesarean section scar?

THE COURT: Does is that vary depending on gestational period?

THE WITNESS: In terms of the rupture risk? Yes, sir.
THE COURT: Would you try and place that for us too?
THE WITNESS: Well, the incidence of rupture of classical scars would probably increase with gestational age and that risk is generally caught in the range of four to five percent for women with a classical scar. As I said earlier, any procedure, the risk of that procedure increases with advancing gestational age so there would be --
THE COURT: No matter which procedure you use?
THE WITNESS: No matter which procedure, correct.
THE COURT: You have that risk because of the prior surgery?
THE WITNESS: That's correct. So that with the medical induction, with medical induction there would be an increased risk because of the uterine contractions. But at any given gestationality there is any independent risk of that scar rupturing spontaneously or because of other procedure. So it could happen at time of a D&E as well but the biggest risk is associated with uterine contractions.
BY MR. HUT:
Q. Are uterine contractions associated with D&E?
A. No, sir.
Q. Would D&E present the same concerns -- let me withdraw that and ask this question.
With respect to the risk of uterine rupture from

contractions, which procedure would be the safer, D&E or induction?
A. With respect to excessive uterine force the D&E would be a safer procedure.
Q. In your opinion, what procedure would you recommend for a person seeking a second trimester abortion with a prior classical c-section scar?
A. I think that I would recommend a D&E.

I think both procedures are, as I have said earlier, both procedures can be safe and both procedures could be done but I think there would be a benefit, a risk benefit to a D&E procedure.
Q. Would, or for what reasons do women with multiple c-sections face risk in connection with the labor associated with a second trimester induction?
A. A similar reason.

Women who have had three or more caesarean sections of the low transverse type have an increased risk of uterine rupture and this similar, in that kind of a situation with multiple uterine scars the chance of a scar that had not healed well or had not healed -- or had not healed at all would increase their risk of uterine rupture if they were in labor or if they were given drugs to cause medical induction.
Q. In your medical opinion, Doctor, which, as between D&E and induction, would be the better choice for a woman undergoing

second trimester abortion with multiple prior c-sections?
A. I think probably a D&E procedure, especially in a woman who had three or more previous caesarean sections would have a safety benefit.
Q. What is myomectomy, Dr. Johnson?
A. Myomectomy is a procedure where a muscle tumor, a fibroid tumor is removed from the uterus and a scar similar to a classical caesarean section scar is the residual of the surgery.
Q. And which of the procedures of D&E and induction would you recommend for a woman having had a myomectomy and seeking a second trimester abortion?
A. D&E, for the same reasons that I would recommend it for a classical caesarean section, because of the similarity in the uterine scar.
Q. Are inductions relatively less preferable for women with cardiac ailments or certain ones, Doctor?
MS. GOWAN: Objection.
THE COURT: What's the basis of the objection?
MS. GOWAN: Your Honor, I don't know what the word preferable means. I believe it is vague.
THE COURT: Preferred to you mean, Mr. Hut, over another form of abortion procedure?
MR. HUT: Yes, your Honor.
BY MR. HUT:

Q. Do you recall the question, Doctor?
A. I guess my response would be that in certain medical conditions, like heart conditions, the fluid shifts and the prolonged stress and pain of a medical induction would make a D&E procedure a preferable procedure in some patients.
THE COURT: Are there some medical conditions that the induction would be preferable to the D&E?
THE WITNESS: Well, I guess in a situation where one needed to obtain an intact fetus in order to do a postmortem evaluation I would say yes. But in terms of is there any maternal medical condition where a medical induction would be preferred, I can't think of any pure maternal medical condition where it would be the preferred technique.
BY MR. HUT:
Q. Doctor, in prior testimony there has been reference to fetal anomalies; what is a fetal anomaly?
A. A fetal anomaly is any kind of a fetal defect, either a developmental defect, an abnormal heart, an abnormal kidney. It could be a biochemical defect or a genetic defect. Any kind of an abnormality of the fetus could be described as an anomaly.
Q. In your professional opinion, Doctor, are there indications relating to fetal anomalies for which you believe induction abortion is not preferred?
A. Yes, sir.

Q. What are -- what is that or what are those?
A. I would say that in situations where pathologic evaluation is, would be uninformative in situations where a definitive genetic diagnosis or a definitive biochemical diagnosis had already been made and was the basis for the decision to terminate the pregnancy, that a D&E procedure would generally be what was done in the United States.
Q. What is hydrocephalous, Dr. Johnson?
A. Hydrocephalous is a condition where there is excessive fluid in the ventricles of the brain leading to enlargement of the fetal cranium.
Q. In your opinion, Doctor, which of D&E or induction, would be the preferred procedure for a woman seeking an abortion in the second trimester pregnant with a hydrocephalic fetus?
A. It would depend. I think it would depend on two things.

First, it would depend on what the presumptive cause of the hydrocephalous was. If there was the possibility that the hydrocephalous was part of a complex series of anomalies and was a syndrome there might be a benefit to a pathologic evaluation.

On the other hand, if the hydrocephalous were severe, if the head were massively enlarged, then that would make vaginal delivery, medical induction relatively difficult in the absence of some kind of a procedure to destroy or reduce the size of the fetal skull.

So, with significant or severe or massive hydrocephalous I would say that some type of a destructive procedure would be beneficial and safer for the patient.
Q. Is D&E a destructive procedure, as you use the term?
A. Yes, sir.
Q. Are there, in addition to certain cardiac ailments that you described earlier and uterine scarring that you described earlier, any other indications relating to maternal health for which inductions may not be preferred that you have not yet described to the Court?
A. Well, I would say any underlying medical condition where either stress or labor, prolonged labor with the risks associated with either dehydration or excessive fluids would be relatively contraindicated.
So, for example, women who had underlying pulmonary disease who had asthma, women who had a medical condition where either prolonged labor or the fluid shifts associated with a medical abortion would be relatively contraindicated.
So, I mentioned, I think pulmonary disease, any underlying auto-immune disorder, any disease that predisposed the woman to infection, any disease that predisposed the woman to bleeding.
I would say there are a fairly broad spectrum of diseases across the organ systems that would require a person doing a medical induction to pay particular attention to the

maternal condition and might lead one to believe that a D&E might be a safer procedure.
Q. And why, with respect to women prone to infection, might a D&E be a better procedure?
A. Well, with medical induction there is a prolonged period of time, there is an increased risk of infection associated with multiple examinations with the prolonged labor and so that it would be relatively contraindicated.
The other -- you said patients at risk for infection?
Q. Yes.
A. Yes, that would be that.
Q. And when you say relatively contraindicated, can you explain to the Court what you mean by that, Doctor?
A. Well, what I mean is that given two procedures there would be a comparative advantage to the patient with respect to health risks, health outcomes to have one procedure compared to the other.
Q. Why, in your opinion, is a woman who may be prone to bleeding, why might such a woman and her doctor find a D&E preferable to induction?
A. Well, one of the -- there are several opportunities for bleeding in both conditions but one of the common technical problems associated with a medical induction is retained placenta after delivery of the fetus. And there can be a fair amount of bleeding that occurs at that time requiring surgical

removal of the placenta and that's happening in a, in a fairly uncontrolled situation.

So not only would there be relative benefit to the D&E, but also the D&E would be done in an operating room with a physician in attendance who could make sure that any bleeding problems or any bleeding tendencies were dealt with immediately, either medically or surgically. And that might be more difficult to do during the course of a medical induction.

Q. And when you referred, in your last answer, to circumstances happening in a fairly uncontrolled setting, which of the procedures were you describing by uncontrolled setting?

A. Well, a medical induction would be done in a hospital bed close to but not necessarily adjacent to an operating room.

There may -- it may take a while to get an operating crew ready, it may take a while for all the equipment to be brought together to a patient who has a bleeding complication associated for medical procedure. And, generally, all of those things are in the room for a D&E.

Q. In your opinion, is a medical induction a less controlled procedure? Is it a procedure that occurs in a less controlled setting?

A. I would say -- I mean, I think that it's a very safe procedure but in patients who are pushing the margins of health, patients who have marginal reserve in terms of bleeding, marginal reserves in terms of blood volume, patients

who are more medically compromised, the rapid availability of tools to manage complications are much more important in those patients than for a patient who didn't have those complications undergoing a medical induction.
Q. Are those tools more readily or rapidly available in a surgical procedure?
A. Yes, sir.
THE COURT: Is that true of all abortions that you are better off being in a hospital than in some clinic?
THE WITNESS: No, sir. I think that most D&E procedures are actually done in free-standing clinics.
THE COURT: I'm not saying -- that's where they're done. I'm saying are you better off, the patient, is better off being in a hospital, period?
THE WITNESS: I would say that I don't know of any data to support that.
THE COURT: Well, you mentioned a lot of the talented people available.
THE WITNESS: Right.
THE COURT: The facility.
THE WITNESS: Right.
THE COURT: The facility itself to deal with complication. It seems to me that all of that adds up that you are better off if you are in a hospital.
THE WITNESS: Well, I would say that --

THE COURT: Less risk.
THE WITNESS: Yes.
I mean, any time you are closer to the ability to have everything done for you, the better complications and other problems can be taken care of. Unfortunately, those hospitals aren't always available for people. But I would say availability of surgical services or resuscitative services certainly benefit people and they're generally more available in hospitals.
THE COURT: Thanks, Doctor.
BY MR. HUT:
Q. Dr. Johnson, have you seen any patient or patients for whom you have, you and the patient have determined induction was less preferable from a medical point of view?
A. From a medical point of view?
Q. Correct.
A. Over my career?
Q. Why don't we take it in the past three to five years.
A. I guess I can't remember a specific case in the last to five years where I have seen such a patient.
I guess I can't remember a specific case in the last three to five years where I have seen a particular patient that had a medical problem that would fit that category. It may have happened, I just can't remember one right now.
Q. Dr. Johnson, are there cases where inductions fail?

A. Yes.
Q. What happens in such a circumstance?
A. Well, there are two things that can happen. The purpose of the induction is to empty the uterus and when one does a medical induction, a fairly common event is for the fetus to be compelled and for the placenta to be retained. And in that situation the medical induction has to be completed surgically so that the removal of the placenta has to happen in the operating room, and people generally do that either if there is excessive bleeding or if there is, the placenta has not been expelled spontaneously after a certain number of hours. That's the most common cause for failure of the procedure.

In a small number of cases it is possible for the medical induction not to cause the cervix to dilate and not to cause the fetus to be expelled, but that's less common.
Q. Taken as a whole, the more common and the less common situations how often, in your judgment, do inductions fail?
A. I would say somewhere between 10 and 20 percent, depending on how you classify the failures and how you intervene to remove the placenta.
Q. You have used the word placenta now several times, I think we have had testimony about it, but for my benefit and perhaps for the Court's, can you remind me what a placenta is?
A. A placenta is an organ that attaches the fetus to the mother and through which gas exchange happens.

THE COURT: Between what happens?
THE WITNESS: Gas exchange. Gas and nutrition. Oxygen and nutrients passed from the mother through to the fetus through it.
BY MR. HUT:
Q. What does a doctor need to do when an induction fails?
A. A surgical procedure to complete it.
Q. Would the surgical procedure involve a D&E?
A. Well it would be a dilatation and removal of the placenta if it were just the placenta that needed to be removed, or D&E if there were more fetal tissue or other fetal tissue that needed to be removed.
MR. HUT: Your Honor, I'm about to move to a new line of questions, I wonder if this would be a good time for the morning break?
THE COURT: To take our morning break? Sure. That's fine. 10 minute recess. The Court will stand in recess.
(Recess)
THE COURT: Mr. Hut, you may inquire.
MR. HUT: Thank you, your Honor.
BY MR. HUT:
Q. Dr. Johnson, following up on a question put to you by the Court shortly before the break, do you know one way or the other whether most D&Es in the country are performed outside the hospital setting today?

A. Yes, sir; they are.
Q. Does that fact affect your view as to their overall safety?
A. No, sir.
Q. Dr. Johnson, what is uterine perforation?
A. Uterine perforation describes a condition where an instrument or an object goes through the uterine muscle.
Q. What, if any, health risks are associated with uterine perforation, in your judgment?
A. Well, the risks would be either bleeding or infection. Perforation site can lead to bleeding, the bleeding can be either intraperitoneal bleeding or intrauterine vaginal bleeding, infection.

Perforation can either introduce infection into the uterus or introduce infection outside the uterus into the peritoneal cavity.

Those would be the major complications of uterine perforation.
Q. As between the intact variation of D&E and the dismemberment variation, do you have an opinion which, if any, involve less risk of uterine perforation?
A. Yes.

It would be my opinion that the intact procedure would carry less risk.
Q. What causes the lesser risk in your opinion, Doctor?
A. Well, there are two potential items that can perforate the

uterus during a D&E procedure. One would be the instruments themselves and those instruments, with each passage into the uterus have a, have the potential to perforate the uterus so that an intact procedure would reduce the number of passes of the instruments and reduce the risk of perforation with the instruments.

In addition, the dismemberment procedure leads to fetal parts, bony parts, the head, various other body parts that can, themselves, cause perforation.

Long bones, sharp bones can actually perforate the uterus, can go all the way through the uterus either to the broad ligament, to the round ligament, or to the abdominal cavity during the course of the procedure.

So, in addition, as one attempts to get those uterine parts, extra passages with the instruments can lead to further risk. So, it's repetitive passages of the instruments to complete the procedure to retrieve parts that may be missing, and then finally those parts themselves that can move outside the uterus as part of the process.

(Continued on next page)

Q. Doctor, what is cervical laceration?
A. Cervical laceration describes a condition where the cervix is torn, basically torn or lacerated, generally during -- well, it could happen during a procedure, it could happen during labor. A mechanical force can cause the cervix to lacerate.
Q. What, if any, health risks are associated with cervical laceration, Doctor?
A. The immediate risk would be a bleeding risk. The cervix is a very vascular organ, and when there is a laceration there can be bleeding, significant bleeding, exsanguinating bleeding ultimately. There are long-term risks of incompetent cervix preterm delivery associated with cervical lacerations as well.
THE COURT: Doctor, let me ask you, in the abortions you have performed, have you ever perforated a uterus?
THE WITNESS: Not to my knowledge.
THE COURT: Have you ever lacerated a cervix?
THE WITNESS: Not to my knowledge.
THE COURT: Next question.
Q. As between the intact version of D&E and the dismemberment variation of D&E, Dr. Johnson, do you have an opinion which, if any, involves less risk of cervical laceration?
A. I think they would be fairly comparable with respect to cervical laceration. I think the risk of cervical laceration is reduced significantly by the laminaria and the cytotec that we talked about earlier. I would say that between the intact

procedure and the dismemberment procedure, I think the risk of cervical laceration would probably be about the same.
Q. What safety advantages, if any, Dr. Johnson, are associated with shorter operating time?
A. The benefits would be less bleeding, less infection.
Q. Is there any benefit conferred from less exposure or exposure of shorter duration to anesthesia?
A. Yes. Depending on the type of anesthesia, there would be benefits to that as well.
Q. Do you have an opinion as to which variation of D&E, the intact variation or the dismemberment variation, offers shorter operating time?
A. Given the clinical factors associated with the intact procedure, I think that clinical factors would favor shorter operating time for an intact procedure.
Q. Do you have an opinion, Dr. Johnson, as to which of the two D&E variations, the intact or the dismemberment variation, may best facilitate the extraction of the fetal skull during an abortion procedure?
A. I think that the intact procedure is actually developed in part to deal with the problem of the fetal skull. When one does a D&E, technically one of the challenges is to remove the fetal skull, partly because it is relatively large, partly because it is relatively calcified, and it is difficult to grasp on occasion.

So one of the common technical challenges of a dismemberment D&E is what is called a free-floating head or a head that has become disattached and needs to be removed. This can lead to more passages of instruments through the cervix. And technically it is difficult to grasp the head; it is round, it slips out of the instruments that we generally use. Either those instruments or the head can be extruded outside the uterus and cause perforation.

So at least one of the reasons I think that the intact procedure was developed was so that the fetal head would not be free-floating, would be attached to fetal parts that could be more easily grasped. It could be more easily removed and reduce the risks -- and enhance the ease with which the cranium can be removed.

Q. Can ultrasound guidance mitigate the problems associated with the evacuation of the head and dismemberment D&E as you have described it?

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

THE COURT: Can I have the question read, please?

MR. HUT: I will rephrase it, your Honor.

Q. Is ultrasound guidance useful in assisting a physician in evacuating the fetal head in a dismemberment D&E?

A. It might be. It might allow the physician to identify just exactly where the head is and allow him to grasp it more surely and more readily.

Q. Can ultrasound eliminate the problems you described a moment ago entirely?
A. No, sir.
Q. Based on the clinical factors that you described and with which you are familiar, do you have an opinion regarding the safety of the intact variation of D&E?
A. Based on those clinical factors, I would think that there are relative safety benefits to the intact procedure compared to the dismemberment procedure.
Q. Are you aware of any professional organization, Doctor, that shares your opinion on that?
A. That shares the opinion that the intact procedure might potentially be safer?
Q. Correct.
A. I believe that the American College of OB-GYN in its statements has made the statement that in certain clinical situations the intact procedure might be a preferred procedure, might have benefits.
THE COURT: Are you a member of any medical association that has a differing view?
THE WITNESS: No, sir.
Q. In your opinion, Dr. Johnson, is there a significant body of medical opinion that intact D&E can be safer for some women in some circumstances than the dismemberment D&E?
MS. GOWAN: Objection, your Honor.

THE COURT: May I have the question.
(Question read)
THE COURT: What does that mean?
MR. HUT: Your Honor, it means what the Supreme Court intended it to mean.
THE COURT: He is not a member of that court.
MR. HUT: Yes, sir. I am aware of that.
THE COURT: I think you have to break it down to him and define the terms, what you mean by it.
Q. Do you have an understanding, Dr. Johnson, of a significant body of medical opinion?
A. I guess for me that would be a significant number of practicing clinicians or practicing physicians.
Q. Based on that understanding, do you have an opinion whether there is a significant body of medical opinion that intact D&E can be safer for some women under some circumstances?
MS. GOWAN: Objection: Foundation.
THE COURT: I will allow it.
A. Yes. I think there are a substantial number of practicing OB-GYNs who believe that the intact D&E procedure has benefits compared to the traditional dismemberment procedure.
Q. In your opinion, Doctor Johnson, is intact D&E ever the only procedure available for a woman needing a second trimester abortion?
A. No, sir.

Q. Does that fact affect your view as to whether intact D&E should be available to physicians for use in second trimester abortions?
A. No, sir. I guess the fact that it is never the only option doesn't change my opinion that in certain situations it might be the most appropriate option in the hands of certain clinicians in certain clinical situations.
Q. Dr. Johnson, in your professional opinion, are there particular maternal health conditions where evacuation of an intact fetus in a D&E would have safety benefits?
A. Maternal conditions?
Q. Yes.
A. I think there are potential conditions where the relative clinical factors might reduce the risks to a mother with a bleeding abnormality or with infection or with other kinds of problems, yes.
Q. What type of patient might have a bleeding abnormality?
A. A patient with some type of defect in platelets or some type of defect in clotting or some type of deficiency in a clotting factor, for example.
Q. Why, in your judgment, would the intact variation of D&E offer safety advantages for women who may be at particular risk for hemorrhage?
A. Because it has the potential to reduce the risks of perforation, bleeding, and infection, all of which would be

poorly tolerated by those patients.
Q. Can you describe or explain to us, Dr. Johnson, what type of patients may be at particular risk for infection.
A. Either patients who have immune compromise or patients who have ongoing infections, patients, for example, who might have a urinary tract infection, who might have another type of lower genital tract infection would be at increased risk for infection at the time of an abortion procedure.
Q. Doctor, What is chorioamnionitis?
A. Chorioamnionitis is an infection of the amniotic fluid and the amniotic sac.
Q. Which variation of D&E, dismemberment or intact, would you recommend for someone with chorioamnionitis?
A. I think there would be benefits in that situation to an intact procedure.
Q. Why is that, sir?
A. Those patients have an entry of infection, and the termination of pregnancy would be indicated in that situation for the health of the mother. But the procedure, particularly an intact procedure, would reduce the risk of perforation, reduce the risk of dissemination of the amniotic fluid infection into the peritoneal cavity, so it would reduce the risk of peritonitis, would reduce the risk of spreading the infection outside the uterus because of the reduced risk of perforation.

Q. In your opinion, Dr. Johnson, for a woman with chorioamnionitis, would an intact D&E or an induction be more preferable?
A. I think a D&E procedure would be preferable in that situation.
Q. That would be the intact D&E?
MS. GOWAN: Objection: Leading.
THE COURT: Which type of D&E would be preferable, Doctor?
THE WITNESS: Any D&E procedure would be preferable to a medical induction, and I think that an intact D&E would be preferable in a patient with chorioamnionitis because of the reduced potential for perforation and dissemination of the infection.
Q. In your opinion, Dr. Johnson, does the intact version of D&E offer safety advantages for women who may be carrying fetuses with specific types of fetal abnormalities or anomalies?
A. Yes. I think in situations where pathological evaluation has the potential to inform a patient or a physician about medical conditions and recurrence risks, delivery of an intact fetus using intact D&E procedure would have a benefit.
Q. Why is that?
A. Because the intact specimen would allow a more complete pathologic evaluation, would allow a better gross anatomic

description of the fetus that would potentially lead to improved clinical diagnosis of the exact fetal condition.
Q. Other than post-procedure pathological examination, are there other ways to diagnose fetal anomalies?
A. Yes. They can be diagnosed through DNA testing, genetic testing. They can be diagnosed with biochemical testing, through either sampling of the amniotic fluid or biopsy of fetal tissue. They can be diagnosed using ultrasound. And they can be diagnosed using limited pathological evaluations as well.
Q. Are there any cases in which, in your opinion, the examination of an intact fetus pathologically and post-procedure offers advantage over some of the methods you have just described?
A. Yes, in situations where there are complex abnormalities, when there are multiorgan abnormalities, and the identification of those various anomalies and the classification of them into a diagnosis or a syndrome or a condition could be informative with respect to recurrence risk, with respect to familial inheritance, with respect to counseling the patient about how that fetal condition arose and what implications it had both for her health and the health of the future pregnancies.
Q. Had you finished your last answer, Dr. Johnson?
A. Yes, sir, I think so.
Q. Are there any fetal anomalies in your experience, Doctor,

that are difficult to diagnose by ultrasound?
A. I would say that there are fetal conditions and syndromes that are difficult to diagnose definitively using ultrasound, yes.
Q. Other than those that you have described thus far in your testimony, Dr. Johnson, are there any other advantages in terms of safety or health of the woman or her family for the intact variation of D&E?
A. We certainly have patients who have requested the opportunity to hold their fetuses, to grieve. An intact procedure would allow that opportunity for a patient who wanted to be able to look at the fetus and to be able to begin the grief process.
Q. Doctor, let me ask you to turn in the black notebook that I have placed on the table in front of you to Plaintiffs' 69. Dr. Johnson, what is Plaintiffs' Trial Exhibit 69?
A. It is the so-called -- it is the Partial-Birth Abortion Ban Act of 2003.
Q. Have you reviewed or read the Partial-Birth Abortion Ban Act of 2003 in its entirety?
A. Yes, sir.
Q. Please have a look on the first page of Plaintiffs' Trial Exhibit 69 at section 2. Do you see that, sir?
A. Yes, sir.
Q. What is the heading of that section?

A. "Findings."
Q. Have you reviewed that section of the Act?
A. Yes, sir.
Q. Dr. Johnson, please turn in Plaintiffs' Trial Exhibit 69 to page S3-4.
A. OK.
Q. Do you see paragraph 14(A) on page S3-4?
A. Yes.
Q. Let me read that section for you. "Partial-birth abortion poses serious risks to the health of a woman undergoing the 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; an increased risk of uterine rupture, abruption, amniotic fluid embolus, and 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 other than for delivery of a second twin'; and 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, an act which could result in severe bleeding, brings with it the threat of shock, and could ultimately result in maternal death."

Did I read that correctly, Doctor?
A. Yes, sir.
Q. Doctor, I would like you to assume that the abortion procedure being addressed in paragraph 14(A) of the findings is the intact variation of D&E. Based on your experience, do you agree with the statement that the intact variation of D&E "increases a woman's risk of suffering from cervical incompetence as a result of cervical dilation"?
A. No, sir.
Q. Why not?
A. I don't know of any evidence to suggest that that specific procedure increases a woman's risk of suffering from cervical incompetence compared to any other surgical D&E procedure.
THE COURT: Compared to what, Doctor?
THE WITNESS: Compared to any other D&E procedure. Compared to a dismemberment D&E.
THE COURT: Does that mean they all have a risk for that possibility?
THE WITNESS: There would be a very slight risk of cervical laceration and cervical incompetence with any surgical procedure, yes, sir.
THE COURT: You are not saying it is not true; it is just it is no more so than other procedures, abortion procedures?
THE WITNESS: Correct. I am saying that it is an

uncommon, it is not a common serious risk.
THE COURT: It is not common to any abortion procedure?
THE WITNESS: Correct.
THE COURT: So it is no more so with the partial-birth or intact D&E than it is for other procedures, is that your opinion?
THE WITNESS: That is my opinion, yes, sir.
Q. Based on your experience, Dr. Johnson, you agreed with the paragraph set out in paragraph 14(A) of the finding that there is, quote, an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus from the intact variation of D&E?
THE COURT: Could we take them one at a time?
MR. HUT: Sure.
Q. How about with respect to an increased risk of uterine rupture.
A. I assume this is comparing it with other surgical procedures, and I don't believe there is any evidence that there is an increased risk of uterine rupture with the intact procedure.
Q. How about compared to any medical procedure in the second trimester?
A. Probably less risk compared to a medical procedure.
Q. The next one is abruption.

A. No, no increased risk of that.
Q. How about amniotic fluid embolus?
A. No.
Q. How about trauma to the uterus?
MS. GOWAN: That is an incomplete statement. It is trauma to the uterus as a result of converting the child to a footling breech position.
THE COURT: With that amendment, Mr. Hut?
MR. HUT: That's fine.
THE COURT: Now, Doctor, can you answer it?
A. Actually, the statement goes on and compares it to a procedure that is commonly called internal podalic version and is described in obstetric textbooks. I guess I would say that --
THE COURT: Do you want to tell us what that is, so we all understand?
THE WITNESS: Sure.
THE COURT: Thanks.
THE WITNESS: Historically there was a description of a procedure where a fetus was turned from a head-first position to a breech position for delivery.
THE COURT: That being foot-first?
THE WITNESS: That being a foot-first, correct. In the early part of the last century, internal podalic version was a way that doctors managed difficult labors. So if a woman

was having problems at term in labor with a baby and it was coming head-first, they would often in their management go inside, turn the baby around, and pull it out by the feet. That is no longer a procedure that is done in medicine or obstetrics, with the exception occasionally of a second or aftercoming twin, where we will occasionally do a podalic version.

The comparison of that podalic version to a mid-trimester procedure like this is really not accurate. The fetus at term is much bigger, the uterus is much more distended, much more likely to rupture. There is much less amniotic fluid in a second trimester procedure where the fetus is manipulated into a footling, into a breech position for the procedure.

The mechanics, the amniotic fluid, the small size of the fetus, the relatively thickness of the uterus would all be very, very different than would exist in a term pregnancy with an internal podalic version. So that comparison is think is very problematic.

Q. What percentage of midtrimester terminations, Dr. Johnson, present in breech?

A. Generally, in the midtrimester up until certainly around 20, 24 weeks fetuses are about 50-50. It is only in the last trimester that they correctly line up head-first. So that at term fewer than 5 percent of fetuses are breech. But in the

midtrimester it is -- well, the not even 50-50, because they could be head-first, they could be feet-first, they could be transverse lie, they could be moving all around. It is really a pretty even mix of everything.
Q. With respect to those presenting feet-first, is there any need to do any manual or digital manipulation of the fetus to bring it into breech position?
A. No. It would come down that way spontaneously.
Q. Directing your attention, Dr. Johnson, to the last clause of paragraph 14(A), based on your experience, do you agree with the statement that the intact variation of D&E poses "a risk of lacerations and secondary hemorrhaging due to a 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"?
A. There is always a risk in anything we do in medicine, but I don't think that there is a serious risk of that kind of laceration or that kind of hemorrhaging, because the intact procedure is being done in a relatively controlled situation. Generally, the head is stabilized by the cervix. Generally, the physician can identify the cervix clearly and can affect placement of the instruments in a way that minimizes the risks of damage to the cervix.
Q. Based on your experience, Doctor, does a physician performing an intact variation of D&E visualize or is the physician able to palpate the fetal skull prior to effecting an

incision?
MS. GOWAN: Objection: Foundation.
THE COURT: I didn't understand that. Your objection is to foundation?
MS. GOWAN: Yes. I don't think there has been any testimony that this witness has any experience with other people performing the procedure. Counsel has just asked him basically what he --
THE COURT: Could you rephrase it, Mr. Hut, and ask the doctor if he has any problems.
Q. Dr. Johnson, did you earlier testify that you had observed the intact D&E being performed?
A. Yes.
THE COURT: Have you done it yourself?
THE WITNESS: No, sir.
Q. Based on procedure --
THE COURT: Just a minute. You have never done it?
THE WITNESS: Never done a procedure where the fetus was delivered intact through a D&E procedure, no, sir.
THE COURT: Then I don't think he is capable of answering that. He testified what he looked at and observed, but he has never done it. I will sustain the objection, unless you want to rephrase it.
MR. HUT: I would, your Honor.
Q. Based on what you have observed, Dr. Johnson, in the cases

where you have observed an intact D&E variation, is the doctor able to visualize or palpate the fetal skull prior to incision?
THE COURT: Sustained. He can't testify to what he visualized. You can ask him what he saw happened, but not what he visualized.
MR. HUT: I am not asking him what he visualized.
THE COURT: I know that. But he can't testify as to what another surgeon visualized. He can tell you what he saw.
Q. Did you make any observation of the way the physician performing that intact D&E effected the incision into the skull?
A. In the situations that I have observed, they either -- actually, the procedures that I have observed, they all used a crushing instrument to deliver the head, and they did it under direct vision.
Q. Thank you, Doctor.
THE COURT: Can you explain to me what that means.
THE WITNESS: What they did was they delivered the fetus intact until the head was still trapped behind the cervix, and then they reached up and crushed the head in order to deliver it through the cervix.
THE COURT: What did they utilize to crush the head?
THE WITNESS: An instrument, a large pair of forceps that have a round, serrated edge at the end of it, so that they were able to bring them together and crush the head between the

ends of the instrument.
THE COURT: Like the cracker they use to crack a lobster shell, serrated edge?
THE WITNESS: No.
THE COURT: Describe it for me.
THE WITNESS: It would be like the end of tongs that are combined that you use to pick up salad. So they would be articulated in the center and you could move one end, and there would be a branch at the center. The instruments are thick enough and heavy enough that you can actually grasp and crush with those instruments as if you were picking up salad or picking up anything with --
THE COURT: Except here you are crushing the head of a baby.
THE WITNESS: Correct.
THE COURT: You have watched this but you have never done it?
THE WITNESS: Correct.
THE COURT: Next question.
Q. Dr. Johnson, in the circumstance that you just described to his Honor, in what position was the fetus when the skull was compressed?
A. Breech.
Q. Was the head lodged at the cervical gloss?
A. Yes.

THE COURT: Was the body outside the woman's body to an extent?
THE WITNESS: Some of it. It can be or not. Some of it can be or -- it depends on where the cervix is. It depends on where the uterus is. It depends how long the baby is. It depends how long the mother's vagina is.
THE COURT: At some times that you observed it was?
THE WITNESS: Right. And sometimes during the procedure the cervix can actually be brought down so that -- the cervix and the uterus can be moved up and down relative to the opening of the vagina.
THE COURT: An affidavit I saw earlier said sometimes, I take it, the fetus is alive until they crush the skull?
THE WITNESS: That's correct, yes, sir.
THE COURT: In one affidavit I saw attached earlier in this proceeding, were the fingers of the baby opening and closing?
THE WITNESS: It would depend where the hands were and whether or not you could see them.
THE COURT: Were they in some instances?
THE WITNESS: Not that I remember. I don't think I have ever looked at the hands.
THE COURT: Were the feet moving?
THE WITNESS: Feet could be moving, yes.
THE COURT: Next question.

Q. With respect to the instrument that you described to his Honor a moment ago, Doctor, used to compress the fetal skull in the intact D&E variations that you observed, is the same or similar instrument used to compress the skull in a dismemberment D&E?
A. Yes. Basically, the same instruments are used for the two procedures. They are called Sopher. People use different kinds of forceps. The ones that we use for our D&E procedure are called Sophers, S-O-P-H-E-R.
Q. Dr. Johnson, please turn back to the first page of Plaintiffs' Trial Exhibit 69. Let me direct your attention to paragraph 2 of the findings. Do you see that, sir?
A. Yes, sir.
Q. This time could you read paragraph 2 for the Court, please.
A. "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 women and in some circumstances their lives. As a result, at least 27 states banned the procedure, as did the United States Congress, which voted to ban the procedure during the 104th, 105th, and 106th Congresses."
Q. Directing your attention to the first sentence that you

just read, Doctor, and let's assume again that the abortion procedure referred to here is the intact variation of D&E, is it your opinion that the intact variation D&E "in fact causes serious risks to the long-term health of women and in some circumstances their lives"?
A. No.
Q. Why not?
A. I guess I would say that any procedure has the potential to cause serious risks. But I don't think that the procedure as described here poses any more serious risks than any other medical or surgical midtrimester termination procedures.
THE COURT: Does that statement say more risk or just a risk?
THE WITNESS: It says imposes serious risks to the long-term health of women."
THE COURT: And your answer said more risk. In other words, you put it in the comparative.
THE WITNESS: Correct.
THE COURT: By itself it is not inaccurate, because you say all of these procedures have risk, correct?
THE WITNESS: Right. I would say that any medical procedure, with the exception of maybe drawing blood, but any medical procedure has the potential to have a serious complication.
THE COURT: So it would be fair to say that all

abortions, regardless of which procedure, have risks, correct?
THE WITNESS: That's correct, yes, sir.
THE COURT: OK. Next question.
Q. Dr. Johnson, is it your opinion that abortion as practiced in this country is safe?
A. Yes, sir.
Q. Is it your opinion that D&E by dismemberment is a safe procedure?
A. Yes, sir.
Q. Is it your opinion that induction in the second trimester is a generally safe procedure?
A. Yes, sir.
Q. Doctor Johnson, could you please turn to paragraph 13 of the findings which are located on page S3. Let me read a portion of that. "There exists 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 indicated 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 of the standard of medical care."
Again assuming that the paragraph is talking about the intact variation of D&E, do you agree with the statement that I just read?
MS. GOWAN: Objection, your Honor: Foundation. There

is nothing to show that this witness has surveyed the Congressional Record and is in any way qualified to opine on this statement.

THE COURT: Read the question, Mr. Reporter, please.

(Question read)

MR. HUT: Let me rephrase.

Q. Dr. Johnson, are you aware of any medical literature that indicates that intact D&E poses serious risks to a woman's health?

A. No, sir.

Q. Are you aware of any medical literature that indicates or suggests that an intact D&E lies outside the standard of medical care?

A. No, sir.

Q. Do you believe, in your professional opinion, that an intact D&E poses serious risks to a woman's health?

A. No, sir.

Q. Do you believe, in your medical opinion, that intact D&E lies outside the standard of medical care?

A. No, sir.

Q. Please turn, Dr. Johnson, to paragraph 14(F), which you will find on page S3-5. Let me read it for you. "A ban on the partial-birth abortion procedure will therefore advance the health interests of pregnant women seeking to terminate a pregnancy."

Assuming, Dr. Johnson, that the procedure referred to in that sentence is the intact variation of D&E, do you agree with the statement by Congress?
A. No, sir.
Q. Why not?
A. Because I think that there are potential situations where the intact procedure might have benefits in individual clinical situations for individual patients, and that it might be the preferred procedure in those situations to advance the health interests of the pregnant woman.
Q. Finally, Dr. Johnson, let me direct your attention to paragraph 14(J) on the same page. Let me ask, since this is the last of these, you to read the first sentence of paragraph 14(J).
A. "Partial-birth abortion also confuses the medical, legal, and ethical duties of physicians to preserve and promote life, as the physician acts directly against the physical life of a child whom he or she had just delivered all but the head out of the womb in order to end that life."
Q. Based on your experience and assuming again that the procedure referred to is the intact variation of D&E, do you agree with the statement you just read?
MS. GOWAN: Your Honor, once again, there is no foundation for that, that he has any experience performing the partial-birth abortion procedure.

THE COURT: Sustained.
Q. Based on your observations of intact D&E's, Dr. Johnson, and your experience in abortion procedures, is it your opinion that partial-birth abortion confuses the medical, legal, and ethical duties of physicians to preserve and promote life as the physician acts directly against the physical life of a child whom he or she had just delivered?
THE COURT: How could he possibly testify as to the operations of many unknown physicians, as to whether it confuses them or not? Next question. Sustained.
MR. HUT: As advertised, your Honor, I have no further questions of the witness.
THE COURT: I have 12:21. Do you want to do a bit of cross, Ms. Gowan?
MS. GOWAN: Yes, your Honor, that would be fine.
CROSS-EXAMINATION
BY MS. GOWAN:
Q. Dr. Johnson, you told us that you first became involved in partial-birth abortion law cases when you testified as a court-appointed expert for Judge Rosen in Evans v. Kelley. That was in Michigan in 1997, right?
A. Yes, ma'am.
Q. Then you also told the judge that you were an expert witness in another case, Evans v. Grantholm. You were also a plaintiff in that case, weren't you, Dr. Johnson?

A. Yes, ma'am.
Q. You were joined as a plaintiff in that case with Dr. Mark Evans, isn't that right?
A. I believe Dr. Evans was one of the other plaintiffs, yes.
Q. Evans v. Grantholm.
THE COURT: Could you keep your voice up, please, Doctor.
A. I remember Northland v. Grantholm. But I think Dr. Evans was one of the plaintiffs in that case.
Q. Dr. Evans was the lead plaintiff in Evans v. Kelley, the first case that you were involved in, isn't that right?
A. Yes, ma'am.
Q. Dr. Evans is one of your co-plaintiffs in this case, isn't that right?
A. Yes, ma'am.
Q. You know Dr. Caroline Westhoff, another of your co-plaintiffs in this case, very well, don't you, Doctor?
A. I don't know her very well, no. I know her professionally.
Q. You know her dating back to 1977, when she was at the University of Michigan doing her residency when you were in your post-doc training, isn't that right?
A. No. I think in 1977, when we met, she was a medical student and I was a resident in training.
Q. That was at the University of Michigan?
A. That's correct.

Q. So you have known her since that time, is that right?
A. I first met her when she was a medical student, and I have subsequently come to know her again.
Q. You have told Judge Casey that since 1997, when you were the court-appointed expert to Judge Rosen, that you have become more involved in the medical aspects of intact D&E, is that right?
A. I'm sorry?
Q. This morning you told Judge Casey that since 1997, when you were the court-appointed expert for Judge Rosen, you have become more involved in the medical aspects of intact D&E, right?
A. Correct.
Q. But you never performed it, right?
A. Correct.
Q. You never performed any research in connection with the procedure, right?
A. Correct.
Q. Never conducted any randomized trials, correct?
A. Correct.
Q. Cohort studies, you never did any of those, right?
A. That's right.
Q. Case studies? No?
A. I have not been involved in any research involved with the procedure.

Q. You testified that you had spoken at the University of Michigan with some of your colleagues about intact D&E, right?
A. Correct.
Q. They don't do intact DEA at the University of Michigan, do they?
MR. HUT: Objection: Vague and ambiguous, mischaracterizes the testimony.
THE COURT: Ask the question: Do they or don't they. Overruled. Just rephrase the question.
Q. Is intact D&E performed at the University of Michigan, Doctor?
A. I would say that it has been increasingly the intention of people to perform --
THE COURT: Doctor, is it performed there or not?
A. The specific procedure where it is completely done intact is not performed there.
Q. And it is not formally taught at Michigan either, is it, Doctor?
A. No. We do teach our residents, talk with our residents, and talk with our faculty about the intact modification of the procedure.
Q. It is not formally taught, is it?
A. At the University of Michigan?
Q. Yes.
A. No, it is formally taught at the University of Michigan.

Our residents are involved in and participate in the procedure.
THE COURT: But you said it is not done there. How could they participate?
THE WITNESS: They participate at one of our associated facilities.
THE COURT: In other words, you do it off-site?
THE WITNESS: Correct.
THE COURT: Does the university know that?
THE WITNESS: Yes.
Q. You told Judge Casey that you watched the performance of an intact D&E, right?
A. Correct.
Q. But you are not sure whether you actually saw it in person or whether you watched it on a video, isn't that right, Doctor?
A. No, that is not correct.
Q. Directing your attention to page 70/line 10 of your deposition in this case:
"Q. So when you say -- I asked you where you had witnessed the couple that you had mentioned to me, and I thought you said 'in my unit,' which prompted my question --
"A. Yes.
"Q. -- about whether they did them --
"A. Yes.
"Q. -- at the University of Michigan.
"A. We don't consciously do them at the University of Michigan.

Well, I've seen an intact D&E, but now I'm trying to think where I've seen it, and I can't remember whether I saw it in person, at another health center, or whether I saw it on a video at ACOG.
"Q. I see.
"A. Or at some other kind of meeting. It would not have been at our unit."
Were you asked those questions and did you give those answers at your deposition in this case?
A. Yes.
Q. Doctor, the last time you performed a D&E was about --
THE COURT: Excuse me. Could I interrupt you. You said in your answer you didn't consciously do this procedure at the University of Michigan. What does that mean, "consciously"? Were you unconscious?
THE WITNESS: No.
THE COURT: It confuses me.
THE WITNESS: What I mean by that is that the people who do our D&E procedures try to deliver the fetus as intact as possible with as few procedures as possible. So if, as they do the procedure, if they are able to deliver the fetus intact, that would be fine. The fewer number of passes to do a dismemberment D&E is always our goal. Because of the way we do the procedures in the past with the degree of cervical dilatation, generally it takes two or three passes to remove

all the tissue. But it would certainly --
THE COURT: You still don't do an intact D&E at the university?
THE WITNESS: Correct. We don't start off the procedure with the intention to necessarily deliver the fetus with a single pass.
THE COURT: And that is conscious and deliberate?
THE WITNESS: We are conscious and deliberate in trying to minimize --
THE COURT: But you don't start out to do that?
THE WITNESS: We consciously try to minimize the number of passes.
THE COURT: I am talking about the intact D&E.
THE WITNESS: Right.
THE COURT: You don't do that?
THE WITNESS: It has not been our practice, that's right.
THE COURT: We will break for lunch now and reconvene at 2 o'clock.
(Luncheon recess)

AFTERNOON SESSION
2:00 p.m.
TIMOTHY JOHNSON, resumed.
THE COURT: Before we get started, a little more housekeeping. I have received correspondence -- it is beginning to feel like I'm several people's pen pal. Believe me, I don't encourage it. Nonetheless, on the topic of Drs. Chasen and Westhoff, the Court is going to make the same ruling as we did with regard to Dr. Hammond.
We have heard from the Second Circuit, and in their wisdom they have declined to expedite a hearing earlier than April 20, I believe is the date. Therefore, I will not dissuade the plaintiff from calling those doctors. The caveat goes along, however, that should at some time toward the end of this proceeding the records become available, those doctors will be ordered back for the government to utilize records should they be made available to the government.
With that said, Ms. Gowan, you may continue your cross-examination.
CROSS-EXAMINATION (continued)
BY MS. GOWAN:
Q. Dr. Johnson, the last time that you performed a D&E was about four or five years ago, right?
A. That's correct, yes, ma'am.
Q. That was a D&E by dismemberment, right?

A. Yes, ma'am.
Q. The gestational age of the most recent D&E you performed was a fetus under 18 weeks, isn't that right?
A. Yes, ma'am.
Q. In all, you have performed less than 10 D&E's, right?
A. Correct.
MS. GOWAN: Your Honor, may I approach?
THE COURT: You may.
MS. GOWAN: I am going to show Dr. Johnson Government Exhibit A8.
Q. Dr. Johnson, I am showing you what has been marked as Government Exhibit A8. Dr. Johnson, will you take a moment to look at that. Do you recognize what it is?
A. It is a declaration of Dr. Mark Evans.
Q. Would you take a look at the last page, page 20. Is that not your declaration?
MR. HUT: The last page I have is 18 on the bottom and nothing on the top.
A. This is Dr. Evans' declaration that you gave me.
Q. That is a mistake. I see that. Thank you. Excuse me, Dr. Johnson. That's OK.
Dr. Johnson, did you submit a declaration in Evans v. Grandholm?
A. Yes, ma'am.
Q. Was that in or about February 10, 2000?

A. That sounds about right.
Q. I would like to read into the record an excerpt from your declaration submitted in that case. Turning to page 7, paragraph 13, going on to page 8, starting with the second full sentence, your declaration reads:
"A physician performing a D&E is also sometimes able to remove the fetus largely intact. In any D&E, for example, the physician may extract the fetal body intact feet first unless the cervix is obstructed by the aftercoming head, which may be too large to pass intact through the cervix. At that point, the physician uses some surgical procedure, such as collapsing the skull with forceps, to reduce the size of the head so that it can pass through the cervical os.
"As compared to disarticulating the fetus, removing it intact reduces the number of times the physician inserts sharp instruments into the uterus and may have advantages when an intact fetus is indicated for a pathological study to assess the extent, cause, and risk of occurrence of fetal anomalies."
At the time that you wrote that sentence in your declaration, you had never performed an intact D&E, correct?
A. That's correct.
Q. At the time that you wrote that sentence, in fact it had never happened to you in the handful of D&E's that you had performed that a woman was so dilated that the fetus came out largely intact, isn't that right, Doctor?

A. It had not happened to me, that's correct.
Q. This statement in the declaration that you submitted in the Michigan case was just based on things that you had heard from others, isn't that right, Doctor?
A. Based on things that I had heard, things that I had spoken about, my clinical impressions, yes, ma'am.
Q. When you say your clinical impressions, Doctor, it wasn't based on any actual clinical experience, because this hadn't happened to you, isn't that right?
A. It is correct that it had not happened to me. But my clinical impression is derived from more than just my own personal clinical experiences. It is derived from my interactions with colleagues, my discussions at national meetings, my reading the literature, my previous experience. Those kinds of things inform my clinical opinions.
Q. Was there anything written in the literature as of 2000 about intact D&E that informed your statement in your declaration submitted in the Michigan case?
MR. HUT: Objection, your Honor. The paragraph is about dismemberment D&E.
THE COURT: Let me hear the question.
(Question read)
THE COURT: The question is about the literature. He may answer the question.
MR. HUT: Excuse me. May I be heard?

THE COURT: Yes.
MR. HUT: The subject of the paragraph --
THE COURT: I know what the paragraph is about. But the question asks him about the literature, and he is capable of answering it yes or no. Then from there you can go back and address the paragraph. I know what the paragraph is about.
Go ahead, answer the question, Doctor. Do you need it read again?
THE WITNESS: No, sir.
A. There was no published literature that I was aware of in 2000.
Q. In most of the pregnancies that you have terminated, you used medical induction abortion because you wanted an intact fetus for genetic evaluation, isn't that right?
A. At our institution, that has been our bias, yes.
THE COURT: That's done what?
THE WITNESS: At our institution, that has been our bias, yes.
THE COURT: Your bias?
THE WITNESS: Correct.
THE COURT: OK.
Q. It is the practice, in fact, at Michigan that virtually all terminations are done for genetic or developmental reasons, isn't that right?
A. Yes. Virtually all the pregnancy terminations that we do

are for an underlying pathologic indication, usually in the fetus.
Q. That would be in 99 percent of the abortions performed at Michigan, is that right?
A. If you are talking about second trimester procedures, I would probably say at least 95 percent.
Q. You would agree that the majority of fetal anomalies have an adverse effect on the health of the fetus as opposed to the health of the woman, right?
A. Correct.
Q. In your view, there are only a few fetal anomalies that could have an adverse effect on the health of the woman, right?
A. There are a number of fetal anomalies that can have an adverse effect on the mother, yes.
Q. A few number, isn't that right, Doctor?
A. A few, yes.
Q. You are expecting in the future to see a decrease in the number of mid to late second trimester abortions thanks to some newer diagnostic screen tools that permit diagnoses of Down's syndrome at an earlier gestational age, isn't that right?
A. Possibly, yes.
Q. Over the past year at Michigan, as you have been planning to implement these new diagnostic techniques and have expanded your prenatal diagnostic services, you have seen earlier diagnoses which have resulted in a lower gestational age for

abortion at your institution, isn't that right?
A. I would say across the board that is probably correct.
Q. Since virtually all terminations at the University of Michigan are for genetic reasons, medical induction is used to enable an intact fetus for genetic evaluation, right?
A. I think I said earlier that we have a substantial number of procedures at least that were done last year where the indication was a genetic abnormality where the D&E procedure was performed. But when there are anatomic defects, when there are developmental defects, where we feel that a pathologic evaluation would be informative, then we favor a medical technique.
Q. You would certainly agree, wouldn't you, Doctor, that in doing the second trimester abortion for fetal anomalies, both medical abortion and D&E by dismemberment are options that are available to you, isn't that right?
A. I would agree that those are available options, yes.
Q. The other 1 percent or so of abortions that are performed at Michigan are as a result of maternal medical conditions or as purely an elective procedure done in conjunction with some other procedure, like a woman coming in and having her tubes tied, isn't that right?
A. I would say for the most part. We occasionally do elective terminations in some circumstances, but not very often.
Q. Of those abortions that you do perform for maternal

complications, most of them are done at earlier gestational ages, isn't that right?
A. It would depend. They are done, I would say, pretty much across the spectrum. I would have to look to tell you and quote you exactly.
THE COURT: You don't know the answer to that as head of the department?
THE WITNESS: I don't know at what gestational age the various procedures are done. We see a fair number of patients who present early from our clinic with medical complications that we would terminate early. But we also have a percentage of patients that refer to us late in the second trimester from other hospitals where the diagnosis and the referral has been delayed. So I don't know the breakdown on those numbers.
Q. Doctor, let me direct your attention to page 80/line 18 of the deposition that you gave in this case.
THE COURT: What is the date of the deposition, please, Ms. Gowan?
MS. GOWAN: Monday, February 23, 2004.
THE COURT: Thank you.
Q. "Q. Now, you mentioned briefly, and I'd like to ask you about it, there is some small number of abortions that are done for maternal indications?
"A. Mm.
"Q. Now, that's separate and apart from those electives that

are done in connection with another procedure?
"A. Correct.
"Q. Like a BTL, right?
"A. Correct.
"Q. OK. And what kinds of maternal indications can you describe for me that let's say within the past year there have been terminations performed at your institution?
"A. Well, we don't do very many, because we're able to handle most maternal complications. If you give me the last couple of years, I may be able to talk about the kinds of conditions that we see most commonly. I would say maternal cardiac disease, maternal renal disease, women with end stage renal failure, and women with autoimmune diseases like lupus that are unstable would, in my experience, probably be the most common indications that we would have, because those conditions would be those where the mother's life would be at significant risk if the pregnancy were allowed to continue. Let me just say that generally those procedures would tend to be done early.
"Q. And when would that be?
"A. Well, I think in most situations they would be first trimester cases."
Doctor, does that refresh your recollection as to whether most of the abortions performed at Michigan for maternal complications are done at earlier gestational ages?
A. Again, I can't give you an exact breakdown. I wouldn't

disagree with the statement that most of them are probably done in the first trimester. I think that is probably correct.
Q. As a maternal fetal specialist, you sometimes manage women through to viability of the fetus and delivery of an infant when they have maternal medical complications, don't you, Doctor?
A. Yes, ma'am.
Q. You cannot remember any second trimester abortion that was performed at your institution over the past several years because of a maternal medical condition, can you, Doctor?
A. Actually, we had a case of a patient who had significant cardiovascular disease, vascular disease, that I believe had a midtrimester termination sometime in the last year.
Q. Directing your attention to page 82/line 17 of your deposition in this case:
"Q. Can you recollect any termination from the last several years, going over in your mind in answering my question, for a maternal condition that was in the second trimester?
"A. I can't remember, no."
Were you asked that question and did you give that answer at your deposition in this case?
A. Yes.
Q. In your view, the number of medical conditions where a woman's life is significantly threatened by pregnancy are probably fewer than there were 20 or 25 years ago because of

improved medical management, right?
A. Yes, I would agree with that.
Q. You would also agree, would you not, that there are only a few conditions where a pregnancy can adversely affect the long-term health of the woman?
A. I think I would agree with that statement generally.
Q. You can't think of a situation involving a maternal health complication where an intact D&E would be the only procedure that could be performed, can you, Doctor?
A. I think I stated earlier that I don't believe there is ever a condition where an intact D&E would be the only procedure that would be available or an option to perform.
Q. It is fair to say, isn't it, Doctor, that you don't think there is any maternal complication that would either require an intact D&E or make an intact D&E the only procedure that could be performed?
A. I'm sorry. I don't understand how that question was different than the previous question. Could I hear it back, please.
(Question read)
A. I think that is what I just said. I would agree with that statement.
Q. You testified this morning about misoprostol.
A. Right.
Q. Misoprostol changes the kind of resistance that the cervix

gives and tends to bring down fetal parts into the lower uterine cavity, isn't that right?
A. Yes.
Q. It also results in increased pliability of the cervix because it is a softening agent, right?
A. Yes, that's correct.
Q. Would you agree that the combined use of laminaria and misoprostol increases the possibility of doing an intact D&E procedure?
A. I would say it would increase the possibility, yes.
Q. That is because if the cervix is not well dilated with laminaria, if the lower uterine segment is not softened with misoprostol such that the presenting parts of the fetus -- the feet, the legs -- remain higher in the uterus, the physician is more likely to dismember fetal parts because of the resistance encountered as the physician removes the fetus, isn't that right?
A. I would say there are two components. There is a resistance component that allows the cervix to be more plastic and allows the fetal tissue to come through the cervix. I also think that the position in the lower uterine segment facilitates the delivery of an intact specimen.
Q. That's right. And if the misoprostol and the laminaria were not used in combination, then you would not have the circumstance that you just described, and the procedure would

probably go forward as a dismemberment D&E, right?
A. I guess the preparation of the cervix for the procedure in the absence of those two drugs would probably make it more difficult to do an intact procedure and would lead to a higher chance of doing a dismemberment procedure.
Q. In your opinion, the use of more laminaria and misoprostol increases the likelihood of a fairly rapid delivery of an intact fetus, right?
A. I would agree with that, yes.
Q. It is your understanding, isn't it, Dr. Johnson, that physicians who are attempting to perform intact D&E will use more laminaria per insertion in the woman and are using two and sometimes three insertions prior to the surgical procedure?
A. With respect to intact procedures or with respect to all surgical procedures?
Q. Intact procedures.
A. I think physicians are using more laminaria and cytotec in combination for virtually all the procedures they do, both intact and dismemberment and medical, because of the advantage that I spoke of earlier.
Q. Would you agree, Doctor, that a physician could avoid the degree of dilation that would result in a fetus coming out intact if the physician did not use misoprostol in combination with laminaria?
A. I think they would decrease the chances of an intact

delivery. But the reason that physicians are using more laminaria and more cytotec is to prevent rapid dilatation of the cervix and to decrease the risk of damage to the cervix during the procedure.

The reason we are using more laminaria and cytotec is actually to decrease cervical complications, and that is the reason it is being used more liberally. So I don't know why a physician would avoid using those drugs when a physician feels that they are benefiting the patient and making for a safer, less risky procedure.

Q. You have heard the term "classic D&E," right?

A. Classic D&E, yes.

Q. In your mind that term is anonymous with D&E by dismemberment, isn't it?

A. I would use those terms interchangeably.

Q. You can't think of any situation where abortion by D&E dismemberment would be contraindicated after 20 weeks, can you?

A. Not absolutely contraindicated, no.

Q. You can't think of any situation after 20 weeks where surgical termination wouldn't be a clinical option. Let me go back a minute. You just said in answer to my question, absolutely contraindicated. What did you mean by that?

A. That the procedure could not be done under the circumstances.

Q. So it can be done, there is no contraindication, after 20

weeks for the performance of D&E by dismemberment, is that right?
A. I can't think of a situation where that particular procedure could not potentially be done. There might be a situation where another procedure might be better, but I can't think of a particular situation that that procedure would be absolutely contraindicated.
Q. It is your view, isn't it, that the D&E by dismemberment and medical induction have comparable advantages for abortion during the 16 to 20 week gestation age range?
A. I think they are comparable advantages. I think there are some relative benefits for the D&E procedure, but I think they are both relatively safe procedures and are widely considered to be safe, yes.
Q. And have comparable advantages, right?
A. And have comparable advantages? Well, they have different advantages. The medical abortion procedure would have the advantage of an intact fetus. The D&E procedure would have other advantages. I think one could compare the advantages. It would depending on the clinical situation. One might use those relative advantages to pick or choose what one did.
Q. But after 20 weeks, when the risks for both are higher, in your opinion the relative comparative advantages of D&E by dismemberment may not be as high as those of medical induction abortion, right?

A. I think I said earlier that the comparative risks increase after 20 weeks, and the comparative benefits probably depend on the clinical situation.
Q. In your view, there have been advances since the 1980s in the medical abortion technique, right?
A. Yes.
Q. That is what we spoke about this morning, the use of misoprostol and vaginal agents that have clinical profiles suggesting there might be shorter abortion initiation time for medical induction abortion and that suggest that there might be some improved profile characteristics, correct?
A. I think that's correct, yes.
Q. In your view, some of these improvements may translate into increased safety for a medical abortion and less risks associated with the procedure, right?
A. I think there is the potential for that, yes.
Q. You testified this morning about contraindications for a medical induction abortion. There are two types of contraindications, right?
A. We generally talk about relative contraindications and absolute contraindications.
Q. In your view, you think medicine has pretty much gotten away from the idea of absolute contraindications, isn't that right?
A. Yes. I think I would be uncomfortable saying that never

was a procedure possible. So I would be uncomfortable with an "always" or a "never" in a clinical situation.
Q. You also testified this morning about the circumstances when a patient has had a prior C-section, especially a classical C-section on the vertical insertion or a patient with multiple C-sections, correct?
A. Right. We talked about that this morning.
Q. In these circumstances, in order to determine whether the abortion should be by medical induction, you would want to look at the risk/benefit ratio to the woman, wouldn't you?
A. Yes. I think you would look at the relative risk, you would look at the benefits. You would discuss the options and the risks with the patient and make a decision there.
Q. You would want to look at the type of incision, the type of surgery, the number of prior surgeries, and there might be situations where medical induction abortion could be safely performed, isn't that right?
MR. HUT: Objection: Compound.
THE COURT: Overruled.
A. Can I hear the question again, please.
(Question read)
THE COURT: I am going to change my ruling, Ms. Gowan. Break it down.
Q. In making that assessment, that risk/benefit assessment, you would want to look at what the type of incision was, isn't

that right?
A. That would be one of the things you would consider if you were dealing with a previous surgical scar, yes.
Q. You would want to look at how many prior C-sections there had been, right?
A. Those would be informative historical factors yes.
Q. After taking that information into account, there might be situations where a medical induction abortion could be safely performed, isn't that right?
A. I think there are certain situations where a medical abortion could be selected and where it could be performed relatively safely, yes.
Q. You are aware of references in the literature that medical induction is safe for women with prior low transverse C-sections, right?
A. Yes.
Q. In cases of a classical C-section incision, you might find some benefit to doing a surgical D&E by dismemberment under ultrasound guidance, where you can watch the incision, right?
A. That might be an interesting clinical modification to make in those situations.
Q. You have taken a woman with a prior classical C-section to term and delivery through a trial of labor, haven't you, Doctor?
A. Yes.

Q. When you testified this morning about the C-section rate being at 20 to 25 percent, you were talking about all C-sections, isn't that right?
A. Correct.
Q. That wasn't 20 to 25 percent with a classical C-section, correct?
A. No. That was all Cesarean section rates, repeats and primaries. So that is the total Cesarean section rate for an institution.
Q. This morning you also described a situation involving a myomectomy. Isn't it true, Doctor, that medical abortion is sometimes used for patients with a myomectomy?
A. It can be, yes.
Q. You reviewed your patient medical records in connection with discovery in this case recently, isn't that right?
A. I reviewed some of my patients' medical history and medical records, yes.
Q. You reviewed the records that were responsive to the government's discovery request, didn't you, Doctor?
A. Yes, I did. But I didn't review all of my patients' medical records, just those that were --
Q. And you made a diligent review for records that were responsive to the government's discovery request, right?
A. Yes.
Q. And you made a thorough review, right?

A. I made a thorough review in an attempt to answer the discovery questions, yes.
Q. You couldn't find a single medical record where, for abortions that you performed or supervised within the past three years, the induction method of abortion was considered but rejected because the method was contraindicated, isn't that right, Doctor?
A. I think what I answered this morning was that I have not done personally any D&E's in the last several years, so it would have been impossible for me to find any cases where medical abortion had been considered where I then did a procedure, since I haven't done the procedure in the last three years.
Q. Doctor, you have done medical induction abortions in the past three years, haven't you?
A. The records that I was asked to identify were records of patients who had had consideration made for a medical abortion where it was felt to be contraindicated and then who subsequently had a D&E procedure where I was the surgeon. And since I did not do any D&E's, it would have been impossible for me to find any cases where patients fit that category.
Q. That's right. So doesn't that mean that all of the procedures that you performed in the past three years were by medical induction abortion and the procedure was not contraindicated?

A. That's correct, yes.
Q. Is it fair to say, in your opinion, that there are some different steps taken by doctors to effectuate an intact removal as opposed to steps taken in D&E by dismemberment?
A. I think that there are specific steps that could be taken to maximize the potential for an intact procedure.
Q. Two of those we have already spoken about, and that is the increased use of laminaria and the use of misoprostol, right?
A. Right. I think we also spoke about the use of ultrasound as another potential.
Q. The ultrasound itself doesn't do anything to effectuate the intact removal; it just assists the physician in viewing the operating area, isn't that right?
A. That would be correct, yes.
Q. You are not aware of any significant data that has been published that would show that intact D&E is necessarily a safer procedure than D&E by dismemberment, correct?
A. That is correct. I am not aware of any data that has been published reporting on D&E.
Q. You haven't seen anything written that connects the advances with laminaria and misoprostol with the performance of intact D&E in a way to suggest that there might be advantages to intact D&E, have you?
A. Have I seen anything written about that?
Q. That connects the two.

A. No. That is the kind of connection that clinicians make in their practice. Since there have been no reports about intact procedures, I would be hard-pressed to find any articles that talked about the relationships between advances in surgical technique and intact procedures.
Q. When you testified before Judge Rosen in 1997, you didn't have an opinion on the safety of intact D&E relative to D&E by dismemberment, did you?
A. That's correct.
Q. I understand that you testified this morning that intact D&E has safety advantages over D&E. But isn't it a fact, Doctor, that your view is that it may have some safety advantages, not that it does?
A. I guess my opinion is that there are clinical factors to suggest that there would be advantages that I described this morning comparing the intact procedure to the dismemberment procedure.
Q. When you say would be, are you saying may be?
A. I would say that with a reasonable degree of clinical certainty, there probably are differences.
Q. Directing your attention to page 148/line 6 of your deposition testimony in this case. By way of background, I am referring to your testimony before Judge Rosen in 1997.
"Q. You were asked, 'Doctor, do you have an opinion on the safety of intact D&E procedure relative to conventional D&E?

'A. Not really.' And you were asked some sort of more narrow questions. Is it still true today that you do not really have an opinion on the safety of intact D&E relative to conventional D&E's or have you changed your view.
"A. Yes. Let me take a look at what was going on before," reviewing the testimony. Then you go on and you say, "I guess in response to your question I would say that my opinion has changed since 1997.
"Q. OK.
"A. That I think that the discussions that I'm beginning to hear about the intact D&E procedure suggest to me that there may be some safety advantages to the procedure. In 1997 I really didn't have an opinion. In 2004 it's my opinion that there may be some safety benefits, but that's based on clinical experience, discussions with colleagues, information that I discovered that I've read this weekend, and changes in practice" -- excuse me. I'm missing one page, and I want to be sure to read the rest of your answer -- "and changes in practice that I'm seeing as people are talking about the increase in ability to successfully perform an intact D&E procedure using the ancillary techniques that we've already talked about.
"Q. When you say the clinical conditions, what were you referring to just now?
"A. I wasn't listening to myself, so -- I suspect that I was

talking about cytotec, laminaria, ultrasound guidance. I think I was talking about clinical technique, clinical adjuncts."

Were you asked those questions and did you give those answers at your deposition in this case?

A. As you were reading that, were there some areas that you skipped over? I don't have the text in front of me. If you read the text, then I assume that reflects what I said.

Q. The only area that I skipped over was just my handing you at the deposition. As you recall, I was handing you my highlighted portion of the testimony so that you could be sure to see it when I was asking the questions.

A. I'm sorry. I wasn't quite sure what the ellipses were. The question is does that reflect my testimony that day?

Q. Were you asked those questions and did you give those answers at your deposition in this case?

A. I assume so.

THE COURT: Do you have a doubt?

THE WITNESS: No. I don't have the deposition here in front of me. No, I'm sure that reflects the deposition. I didn't read it. If you read all that was written down there, then I'm sure that reflects the record.

Q. In 1997 you also told Judge Rosen that you weren't sure whether you could conceive of a situation where intact D&E might be the best medical procedure, correct?

A. I think that's correct, yes.

Q. Your view has changed since that testimony, but only insofar as there might be a situation where a woman with a fetal anomaly does not want to have an induction abortion, she wants to have a quick surgical procedure, and says if I can have a pathological evaluation of the fetus, I would like it; isn't that right, Doctor?
A. I don't think that is the only reason. That would be one potential advantage. But I think we already spoke about the advantages of fewer passes, lower risk of perforation, and so on.
Q. Directing your attention to page 151/line 17 of your deposition in this case, where I am asking you about your prior testimony to Judge Rosen. Beginning on line 17:
"Q. Sitting here today, can you identify a situation where the use of intact D&E might necessarily be the best medical procedure, or does your answer to that question remain the same?
"A. I think my opinion has changed on this since 1997. I think that the situation we talked about earlier, a patient with a fetal anomaly where a postmortem evaluation might be informative, who does not want to have a medical procedure but prefers to have a surgical procedure, an intact D&E might be the best medical procedure in that particular situation for that particular patient.'
"Q. Well, when you say the patient doesn't want to have a

medical abortion, what do you mean?
"A. That the patient --
"Q. That they have --
"A. -- says I don't.
"Q. -- a choice?
"A. Yeah, that the patient says I don't want to be in labor, I don't want to have an induction, I want to have a quick surgical procedure, and I want it done today.
"Q. OK.
"A. But if I can have a pathological evaluation, I'd like it.
"Q. OK, fine."
Were you asked those questions and did you give those answers at your deposition in this case?
MR. HUT: Your Honor, I object at this point. That is a transcript in which there is a lot of back and forth between what was said in 1997, what was being said at the deposition, and now we are being asked what was said here today. I wish that Ms. Gowan would show Dr. Johnson a copy of the transcript so that it can be intelligently followed by the witness.
THE COURT: Overruled, Mr. Hut. And, by the way, don't use that technique again.
MS. GOWAN: Yes, your Honor.
THE COURT: I'm not talking to you. I'm talking to Mr. Hut. In this court this is known as telegraphing to the witness, Mr. Hut. Don't do that ever again in this courtroom.

MR. HUT: I apologize, your Honor. It was not my intention.
THE COURT: You may proceed, Ms. Gowan.
Q. Were you asked those questions and did you give those answers at your deposition in this case, Doctor?
A. Those were my answers to those questions, yes.
Q. You are not sure, are you, whether intact D&E adds substantially to the safety of D&E?
A. It is my belief that it does.
(Continued on next page)

BY MS. GOWAN:
Q. Directing your attention to page 206, line 1 of your deposition in this case:
"Q Does intact D&E, in your view, add substantially to the safety of D&E?
"A I'm not sure. I think it has the potential to add marginally. Where it adds substantially I don't know."
Were you asked that question and did you give that answer in your deposition in this case?
A. I believe so. Yes.
Q. Now, we spoke this morning about the risk of conversion to a footling breech. Now, as you understand it, with performing intact D&E some physicians bring the fetus to a double footling breech presentation either with instruments or their fingers, correct?
A. That's correct, yes.
Q. And would you agree, would you not, Doctor, that that maneuver presents a potential risk of perforation?
A. Well, I think there is a potential risk. I think it is a very, very low risk in a midtrimester procedure.
Q. You would agree it presents potential risk, correct?
A. It presents a potential risk, yes.
Q. And we were, you were talking this morning about the idea that there was less risk with the intact D&E procedure because there are less passes with instruments and less bony parts and

you talked about uterine perforation.
Now, wouldn't you agree that uterine perforation is an uncommon complication of second trimester surgical abortion?
A. Well, uterine perforation is a serious complication of one of the more serious complications. I would -- I guess I would say that midtrimester surgical, we have said earlier that it's a relatively safe procedure so all complications are relatively uncommon for second trimester procedures. Uterine perforation is one of the more common of those uncommon complications.
Q. It varies from the low range of .5 per thousand to a high of two to three per thousand, isn't that right?
A. I think that ballpark range is probably about right.
Q. And that's available data relating to D&E from 16 to 20 weeks, isn't that right?
A. I think those numbers would obviously increase with advancing gestational age but those are the generally quoted numbers for perforation between 16 and 20 weeks.
Q. But you have never seen any data that you would consider reliable for perforation after 20 weeks, right?
A. I don't know of any data that I would consider reliable.
Q. Now, you testified this morning that you disagreed with Congress' finding about the risk of cervical incompetence?
A. Correct.
Q. Now, in 1997 you testified about potential risks of cervical dilation including incompetent cervix or preterm

labor, and you expressed the view at that time that you couldn't really tell whether there might be a risk from the dilation of the cervix in intact D&E, isn't that right?
A. In 1997 when we were using different techniques that was my opinion; yes.
Q. But you're not aware of any published studies relating to the risk of cervical competence associated or not associated with intact D&E, are you?
A. I'm not aware of any data to suggest that there is an increased risk of cervical incompetence associated with second trimester D&E procedures.
Q. It's not studied, is it, Doctor?
A. Well, that's the whole point. Congress made a finding there was an increased incidence of cervical incompetence and it's not been studied so I don't know what the basis for their finding is since there is no data that I know of to support that finding.
Q. But intact D&E has never been studied, has it, Doctor?
A. Well, I think that there are ongoing studies that I know about with respect to intact D&E. To my knowledge there are no published studies with respect to intact D&E.
Q. The only study that you're aware of, isn't it true, Doctor, is the study that was prepared by the plaintiff, one of your co-plaintiffs in this case, Dr. Chasen?
A. That's correct. That's the only study I'm aware of.

MS. GOWAN: No further questions. Thank you.
THE COURT: Mr. Hut, do you have any redirect?
MR. HUT: I believe I have only one or two questions, your Honor.
REDIRECT EXAMINATION
BY MR. HUT:
Q. Dr. Johnson, please return to Government Exhibit A-4.
A. I don't have it anymore. Is that the Evans deposition?
Q. No, sir.
A. I'm sorry.
Q. That is your declaration in the Evans v. Granholm case. Do you no longer have that?
A. I never got it. I got the wrong deposition and then Ms. Gowan didn't give me the other deposition.
MR. HUT: Your Honor, may I approach?
THE COURT: You may.
BY MR. HUT:
Q. You did not have a copy of Government Exhibit A-4 before you when you answered questions about paragraph 13 of your declaration in Evans v. Granholm?
A. That's correct.
Q. Turning your attention, please, to paragraph 13, Dr. Johnson.
A. Yes.
Q. Does paragraph 13 address the disarticulation or

dismemberment variation of D&E?
A. It describes the dismemberment disarticulation variant.
MR. HUT: Thank you.
No further questions, your Honor.
THE COURT: Ms. Gowan?
MS. GOWAN: Nothing, your Honor.
THE COURT: If you are all finished let me just ask you a couple questions, Dr. Johnson.
I heard you talk a lot today about dismemberment D&E procedure, second trimester; does the fetus feel pain?
THE WITNESS: I guess I --
THE COURT: There are studies, I'm told, that says they do. Is that correct?
THE WITNESS: I don't know. I don't know of any -- I can't answer your question. I don't know of any scientific evidence one way or the other.
THE COURT: Have you heard that there are studies saying so?
THE WITNESS: I'm not aware of any.
THE COURT: You never heard of any?
THE WITNESS: I'm aware of fetal behavioral studies that have looked at fetal responses to noxious stimuli.
THE COURT: Does it ever cross your mind when you are doing a dismemberment?
THE WITNESS: I guess whenever I --

THE COURT: Simple question, Doctor. Does it cross your mind?
THE WITNESS: Does the fetus having pain cross your mind?
THE COURT: Yes.
THE WITNESS: No.
THE COURT: Never crossed your mind.
THE WITNESS: No.
THE COURT: When you have done D&Es or when you have done abortions, do you tell the woman various options that are available to her?
THE WITNESS: Yes, sir.
THE COURT: And do you explain what is involved like in D&E, the dismemberment variation? Do you tell her that?
THE WITNESS: We would describe the procedure, yes.
THE COURT: So you tell her the arms and legs are pulled off. I mean, that's what I want to know, do you tell her?
THE WITNESS: We tell her the baby, the fetus is dismembered as part of the procedure, yes.
THE COURT: You are going to remove parts of her baby.
THE WITNESS: Correct.
THE COURT: Are you ever asked, Does it hurt?
THE WITNESS: Are we ever asked by the patient?
THE COURT: Yes.

THE WITNESS: I don't ever remember being asked.
THE COURT: And although you have never done an intact D&E, do you know whether or not the incision of the scissors in the base of the skull of the baby, whether that hurts?
THE WITNESS: Well, I guess my response would be I think that the baby feels it but I'm not sure how pain registers on the brain at that gestational age. I'm not sure how a fetus at 20 weeks or 22 weeks processes and understands pain.
THE COURT: You have never done one of these procedures but did you ever ask what -- you say you know about it clinically, did you ever ask one of those who perform them whether it hurts the fetus?
THE WITNESS: No, sir.
THE COURT: When you describe the possibilities available to a woman do you describe in detail what the intact D&E or the partial birth abortion involves?
THE WITNESS: Since I don't do that procedure I wouldn't have described it.
THE COURT: Did you ever participate with another doctor describing it to a woman considering such an abortion?
THE WITNESS: Yes. And the description would be, I would think, descriptive of what was going to be, what was going to happen; the description.
THE COURT: Including sucking the brain out of the

skull?
THE WITNESS: I don't think we would use those terms. I think we would probably use a term like decompression of the skull or reducing the contents of the skull.
THE COURT: Make it nice and palatable so that they wouldn't understand what it's all about?
THE WITNESS: No. I think we want them to understand what it's all about but it's -- I think it's -- I guess I would say that whenever we describe medical procedures we try to do it in a way that's not offensive or gruesome or overly graphic for patients.
THE COURT: Can they fully comprehend unless you do? Not all of these mothers are Rhodes scholars or highly educated, are they?
THE WITNESS: No, that's true. But I'm also not exactly sure what using terminology like sucking the brains out would --
THE COURT: That's what happens, doesn't it?
THE WITNESS: Well, in some situations that might happen. There are different ways that an after-coming head could be dealt with but that is one way of describing it.
THE COURT: Isn't that what actually happens? You do use a suction device, right?
THE WITNESS: Well, there are physicians who do that procedure who use a suction device to evacuate the intercranial

contents; yes.
THE COURT: It is so much nicer to say evacuate but now you told me also, which I am trying to comprehend, that some women prefer this procedure so that it helps in the grieving process -- that they can hold this fetus that they have, just a short while prior to this, ordered the physician to kill this baby by this procedure?
THE WITNESS: Well, I was talking in the context of our, in our, of our institution where most of these pregnancies are desired pregnancies with multiple anomalies where the mother has decided to terminate a desired pregnancy with a heart defect or an abnormal brain or abnormal kidneys.
THE COURT: But they've also, since you say full disclosure, they've also authorized you to kill this fetus by the procedure described by you, at least two of them, dismemberment.
THE WITNESS: Or medical induction; that's right, sir. Yes.
THE COURT: Thanks, Doctor, very much. You may step down.
THE WITNESS: Thank you, your Honor.
THE COURT: Mr. Hut, you may call your next witness.
MR. HUT: Your Honor, the next witness is Dr. Cassing Hammond and my colleague Lorie Chaiten will conduct the examination of Dr. Chasen.

THE COURT: The lawyer's name is Chaiten?
MR. HUT: Correct, your Honor.
MS. CHAITEN: Good afternoon, your Honor.
THE COURT: Good afternoon.
CASSING HAMMOND,
called as a witness by the Plaintiff,
having been duly sworn, testified as follows:
DIRECT EXAMINATION
BY MS. CHAITEN:
Q. Dr. Hammond, please introduce yourself.
A. My name is Dr. Cassing Hammond.
Q. Dr. Hammond, where are you currently employed?
A. I'm currently employed by the Northwestern Medical Faculty Foundation at Northwestern University Medical School.
Q. Can you please describe briefly what the Northwestern Medical Faculty Foundation is?
A. The Northwestern Medical Faculty Foundation is a multi-speciality organization that comprises all the full-time teaching faculty of Northwestern University Medical School.
THE COURT: Doctor, would you please just slow down a little bit? Our reporters are world class but they're only human.
THE WITNESS: I'm sorry, your Honor.
THE COURT: Just slow down. It would be helpful.
BY MS. CHAITEN:

Q. Are you a physician?
A. Yes, I am.
Q. What positions do you hold?
A. I am currently an assistant professor of obstetrics and gynecology at Northwestern and I wear a variety of different clinical and administrative hats.

I am a member of the division of general obstetrics and gynecology. I am also the gynecologic consultant for the rehabilitation institute of Chicago. I am the gynecologic consultant for the Comprehensive Women's AIDS Center at Northwestern Memorial Hospital.

I am also the director of the program and fellowship in family planning at Northwestern University.

From an administrative standpoint and educational standpoint I am medical director at Prentice Ambulatory Care.

I am also is director of our third-year clerkship in OB/GYN at Northwestern University Medical, and assistant director of the Division of Undergraduate Education for our department.

Q. Dr. Hammond, I'm going to ask you to briefly describe your responsibilities associated with each of these positions but first I would like to ask you a couple of questions for clarification.

You mentioned the word Prentice a number of times, what is Prentice?

A. Prentice Womens Hospital is a part of Northwestern Memorial hospital. It is actually our free-standing women's hospital so it's part of the same corporation as Northwestern Memorial, but is a separate structure.
Q. You also mentioned the Rehabilitation Institute of Chicago; what is that?
A. The Rehab Institute of Chicago is a free-standing rehabilitation hospital. It actually stands immediately adjacent to Prentice. It is also a separate corporate entity from Northwestern Memorial Hospital but it has very close ties to the Northwestern University Medical School system.
Q. Thank you, Dr. Hammond.
Let's start with that one. You mentioned that you are the gynecologic consultant for the Rehabilitation Institute of Chicago; what responsibilities does that entail?
A. These are clinical responsibilities. I see patients each month in the women's center at the rehab institute so, essentially, I am providing obstetric and gynecologic care to women with severe disabling conditions.
Q. Doctor, do you assist those women in carrying healthy pregnancies to term?
A. Yes, I do.
Q. You also mentioned that you are gynecologic consultant to Northwestern Memorial's comprehensive AIDS center; can you please describe what responsibilities that entails?

A. One day each week the comprehensive AIDS center becomes a womens center where we have both two infectious disease doctors, a high-risk obstetrician and myself, I perform all the gynecologic care that day in that center.
Q. Those are for patients who are suffering from HIV and AIDS?
A. That is correct.
Q. Doctor, you also mentioned the Northwestern program in family planning; can you describe your responsibilities in connection with this program?
A. I supervise the performance of pregnancy terminations from very early in gestation through 24 weeks that are referred to at Northwestern, us at Northwestern's family planning center.

I also supervise fellowship, a two-year advanced training program where people are receiving training in these procedures and also in family planning and contraceptive research, generally.
Q. And that's a fellowship program for physicians?
A. That is correct.
Q. Doctor, what responsibilities are involved in your role as the Director of Prentice Ambulatory Care surgery?
A. This is predominantly an administrative function.

Prentice Ambulatory Care, or PAC as we call it, is a clinic that serves predominantly a low-income population. We have a general OB/GYN clinic as part of it, we have a high-risk OB clinic, and several other smaller clinics. And I'm the

person who is consulted regarding medical policy issues, particularly those that kind of fall between cracks within each of the clinics.
Q. And then you also mentioned that you are the director of the clerkship program at Prentice Women's Hospital; what is that program and what are your responsibilities?
A. Every 12 weeks -- excuse me, every six weeks at Prentice we have 12 students who rotate through our hospital as part of their third-year clerkship, which is where medical students receive the majority of their basic OB/GYN training.
I am responsible for all the students who rotate, specifically at Prentice Women's Hospital, which is the largest site for OB training in our system.
As assistant director of the undergrad education division I also assist our director in managing all three of those sites.
Q. And finally, Dr. Hammond, you mentioned that you're an assistant professor in the Department of Obstetrics and Gynecology at Northwestern University; what responsibilities are involved in that position?
A. That's my academic title.
I was originally hired as an instructor and was then promoted to assistant professor several years, and it really indicates my teaching responsibilities within the department.
Q. And does that involve teaching of medical students and

residents and fellows?
A. That is correct.
Q. Doctor, why are you here today?
A. I'm here as a plaintiff challenging assertions in the Partial-Birth Abortion Act of 2003.
I am also here as an expert in obstetric, gynecologic and abortion practices.
Q. Why did you bring this action?
A. I brought this action because I disagree with assertions in the Partial-Birth Abortion Act of 2003. I'm especially concerned that the legislation is vague and could sweep in a large number of the procedures I do, and I'm concerned that the assertions the Act makes regarding safety are also not true.
Q. On what subject or subjects do you intend to offer opinions in this case?
A. I intend to offer opinions regarding both why I believe that this legislation is vague and also why I believe that the safety assertions are untrue.
Q. Do you consider yourself qualified to offer opinions in those areas?
A. Yes, I do.
Q. Doctor, before we get to those opinions, let's go back and discuss your experience and background a bit more.
Where did you earn your medical degree?
A. I earned my medical degree through the six year B.A.M.D.

program at the University of Missouri in Kansas City.
Q. In what year was that?
A. That was in 1988.
Q. Have you received any other formal medical training?
A. Yes, I have.
I performed my residency in obstetrics and gynecology at the University of Rochester in Rochester, New York and completed that training in 1992.
Q. Is obstetrics and gynecology your speciality?
A. Yes, it is.
Q. Do you have any board certifications?
A. Yes. I am boarded by the American Board of Obstetrics and Gynecology.
Q. And when did you become board certified in that area?
A. I completed the boarding process in 1994.
Q. And do you annually recertified?
A. Yes, I do.
Q. Is that compulsory or voluntary?
A. No, it's voluntary.
Q. Dr. Hammond, do you currently treat patients?
THE COURT: Excuse me, could I interrupt?
Would you mind explain what boarding is that you do voluntarily?
THE WITNESS: Certainly, your Honor.
Many of the boarding agencies for various specialities

have started to require recertification as opposed to what they previously did where somebody was boarded and then set for life.

You have the option currently, in OB/GYN, to retake a written examination, I believe every eight years; or every year to retake a series of questions based on articles that the American Board of OB/GYNy selects.

So, each year on a voluntary basis I choose to recertify by reading approximately 30 articles and answering 120 out of 180 questions that they provide.

THE COURT: Thank you, Doctor.

Good ahead, Ms. Chaiten.

BY MS. CHAITEN:

Q. Doctor, I'm not sure whether you answered my last question so I will repeat it just in case I missed the answer.

Do you currently treat patients?

A. Yes, I do.

Q. And what types of patients do you see?

A. I see a large number of different types of patients.

Approximately 60 percent of my time is simply as a member of the division of general obstetrics and gynecology in our faculty-based practice and there I do what you would expect any private OB/GYN to do. I deliver babies and so forth.

I also see patients, as I have indicated, at the rehabilitation institute of Chicago, I see patients in the AIDS

center providing their gyne care. And then I also see patients who are referred to us for also first and second trimester pregnancy termination.
Q. Doctor, do you perform surgeries?
A. Yes, I do.
Q. What types of surgeries do you perform?
A. Again, the majority of surgeries can would be germane to general OB/GYN so, to name a few, caesarean sections, operative vaginal deliveries like forceps deliveries, tubal ligations, gynecologic procedures such as hysterectomy, myomectomy, and so forth.

I also provide, as I have indicated, pregnancy terminations through 24 weeks' gestation.
Q. Doctor, I would like to just ask you to describe what a couple of those procedures you mentioned are.

You mentioned myomectomies, what is a myomectomy?
A. A myomectomy literally means removal of myomas. And myomas, which are more commonly known by the words fibroid tumors of the uterus, are the most common benign, i.e., cancerous tumor of the uterus.
Q. What is a hysterectomy?
A. Hysterectomy is removal of the uterus.
Q. Doctor, you also testified that you deliver babies; about how many babies do you deliver each year?
A. I delivered approximately 100 babies last year.

Q. And you have testified that you perform abortions; how long have you been performing abortions?
A. I began providing pregnancy terminations in the first year of my residency. I have continued since that time, so approximately 15 years.
Q. And what types of abortions have you performed over the course of your career?
A. I have provided both medical abortions and also surgical abortions.
Q. Can you describe for me what you mean by medical and surgical abortions, please?
A. Well, medical abortion involves giving some kind of medication or drug to induce abortion. So, in the first trimester of pregnancy you are inducing something akin to a miscarriage.

In the second trimester of pregnancy you are, in essence, inducing labor to cause a patient to deliver.

For surgical abortions, typically in the first trimester this involves suction curettage where we vacuum the uterine lining.

In the second trimester pregnancy it involves a performance of the procedure dilation and evacuation, commonly abbreviated D&E.
Q. Doctor, do you currently perform each of these types of abortions?

A. Yes, I do.
Q. And approximately how many abortions have you performed in your career?
A. I have performed at least approximately 3,000 abortions since beginning my residency and probably a thousand or more D&Es.
Q. How frequently do you currently perform abortions?
A. I am currently scheduled to perform abortions each Tuesday and also each Friday; they are referred to the family planning service.

We often have to add extra procedures in because of the nature of our practice, so we will occasionally add them in that have to be done sooner and other times of the week, or even the weekend.
Q. What type of abortions are you currently providing in your practice?
A. Really all types I have been trained to do, so both medical and surgical abortions in the first as well as the second trimester.
Q. So that would include the procedures you have described for us a few minutes ago, the suction curettage and the medical abortion in the first trimester, and the dilation and evacuation and labor induction procedure in the second trimester; is that correct?
A. That is correct.

Q. Doctor, what gestational ages do you perform abortions?
A. We currently provide abortions from very early in gestation, really as early as the pregnancy is diagnosed. So, approximately five weeks until 24 weeks.
Q. Do you have formal training in providing abortion care?
A. Yes, I do.
Q. Can you describe that for us?
A. Well, I received training when I was a resident in obstetrics and gynecology.

When I was at the University of Rochester obtaining training abortion training was optional but was routinely provided to residents, and I chose to learn how to do this. So, I was trained in my residency program to provide surgical abortion through approximately 20 weeks' gestation.

THE COURT: Ms. Chaiten, is this a convenient time to take our afternoon break? Or do you have a little bit more you would like to do on this?

MS. CHAITEN: Your Honor, if I might just ask one follow up question and then it would be a fine time to take a break.

THE COURT: Of course. Go ride ahead.

BY MS. CHAITEN::

Q. Have you received any additional training in abortion care?
A. Yes, I have.

After I finished residency I continued to provide

abortion care, but when I moved to Northwestern University had really only been trained through approximately 20 weeks' gestation.

At that point my boss was Dr. Marilyn Frederikson, she needed something to be able to assist with these procedures because there is a lack of people out there who are actually trained to do them.

And she -- in essence I was an apprentice to her as I gradually advanced the gestational age at which I was comfortable to 22 weeks. And then, after approximately 2001, gradually advanced my comfort level, had advanced my comfort level to 24 weeks.

MS. CHAITEN: Your Honor, this would be a fine time to take a break.

THE COURT: Fine. The Court will stand in recess.

(Recess)

THE COURT: Before we continue I thought I would just tell all of you that having experienced two days of listening to this testimony, I would tell you in advance that when the hearing or trial was concluded I still want summations but I'm going to require written submissions on findings of fact and conclusions of law, which I am going to -- at the time, I won't set a date of course -- but it will be at the moment 10 days after the conclusion of the hearing, all right?

Ms. Chaiten, you may inquire.

MS. CHAITEN: Thank you, your Honor.
BY MS. CHAITEN::
Q. Dr. Hammond, you testified earlier that you performed procedures called D&E, is that correct?
A. That is correct.
Q. Approximately how many D&E procedures have you performed throughout your career?
A. At least a thousand.
Q. Can you just describe what is involved in a D&E?
A. Well, a D&E is really a two-day procedure, or at least a two-part procedure.
The first part of a D&E involves dilating the cervix. And after the first trimester you usually can't do that adequately or safely simply by rigidly dilating the cervix with a blunt instrument as we do in the first trimester.
So, what we usually do, once you've hit about 12 weeks' gestation is we use something called osmotic dilators. There are several different types of osmotic dilators but we use them according to a protocol that we have that's gestational-age dependent and put them in the day before the --
THE COURT: Slow down a little bit Doctor, please?
THE WITNESS: I'm sorry.
We put them in typically the day before the procedure and then the next day, once the cervix has been opened by the dilators, we then proceed with the second part of the procedure

which is the uterine evacuation.
That part consists of reaching inside of the uterus with one of a variety of instruments and removing the pregnancy, both the fetus as well as the placenta.
BY MS. CHAITEN:
Q. Doctor, have you ever heard of an approach to D&E called intact D&E?
A. I have heard of intact D&E and have used the term.
In all honesty, we use the term more with respect to this type of legislation than we typically use it clinically.
THE COURT: Do you know what it means though? In this matter in which the term is used?
THE WITNESS: With some ambiguity, your Honor, because we try to do every D&E intact and there are variations and degrees of intactness with D&E. And I hear the term used but don't always know if every procedure that I'm doing qualifies as an intact D&E or not.
Q. Doctor, in the context of your practice, what do you consider an intact approach to D&E?
A. Well, again, every D&E that I do has as part of its goal trying to remove the pregnancy as intact and as expeditiously as possible. So, I can't really designate one specific degree of intactness that always constitutes an intact procedure.
Clearly, if I perform something such as a breech extraction procedure and have been able to accomplish a large

part of the procedure intact, that seems like an intact procedure to me.
Q. Doctor, you mentioned a breech extraction procedure; can you just describe briefly what is a breech extraction procedure?
A. A breech extraction refers to reaching into the uterus and if the fetus is presenting in a breech or buttocks-first presentation, grasping a lower extremity, then grasping the other lower extremity and gradually delivering the fetus -- in this particular scenario, to the level of the fetal head or calvarium.
Q. Thank you, Doctor.
Doctor, is it your view then that an intact D&E is a separate procedure from other kinds of D&Es?
A. No.
MS. GOWAN: Objection, leading.
THE COURT: Sustained.
Q. Doctor, have you ever heard the intact D&E approach -- I'm sorry, let me restate that.
Have you ever heard the intact approach to D&E referred to by any other names?
A. Some people have characterized intact D&E as dilatation and extraction, or D&X.
Q. Doctor, you described a minute ago a breech extraction; are there approaches to D&E where the fetus is removed to a lesser,

less intact than the approach that you just described that you would also consider an intact approach to D&E?
MS. GOWAN: Objection. Vague, leading.
THE COURT: May I hear the question please, Ms. Reporter?
(Record read)
THE COURT: Rephrase Ms. Chaiten. It sounded leading.
Q. I will move on, that's fine.
Doctor, in the context of your practice, approximately how many times have you performed an intact approach to D&E?
A. That's really hard for me to say because, again, we are dealing with this continuum of procedures where you're really looking at how intact constitutes an intact D&E. And, to be honest, we don't really think much about how intact we are doing it at the time. It's not something that we record or that we note or keep track of.
Now, I can tell you that in those procedures that I do between 20 and 24 weeks' gestation I am probably, in about half of all of those cases, able to extract a part of the fetal torso intact to the level of the fetal navel or above.
Q. Does that depend on fetal presentation?
A. Yes.
Typically the fetus, for me to be able to do so, would have to eventually be in the breech position. It might not start out in breech position but I would have to control a

lower extremity to eventually proceed in that fashion.
Q. Doctor, you testified earlier that you have teaching responsibilities at Northwestern University; can you please describe those in more detail?
A. I teach medical students, residents and fellows, each appropriate to their level of training.

So, medical students at the first or second year occasionally observe us. Medical students at the third or fourth year level continue observing and occasionally will do minor forms of assistance in the operating room.

Residents are a completely different matter. People who are in residency training are training in this case to become obstetricians and gynecologists and they actually do procedures with us, though always under my supervision.

So, between the beginning of residency, which is internship and the end of residency, or even the end of fellowship, I supervise and assist residents as they help me perform these procedures.
Q. Doctor, you mentioned the family planning fellowship program earlier, can you describe any teaching responsibilities you have in connection with that program?
A. My teaching responsibilities are predominantly to the residents and fellows when they rotate on the family planning service.

We have a fourth-year resident at any one point in

time who works with us on the service learning to perform first, and complicated second, trimester procedures.

We also have two fellows in the program, a first-year and a second-year fellow who are also learning to do these procedures whom I also supervise.

Q. Doctor, what types of abortion procedures are taught at your institution?

A. Well, really all of the abortion procedures that I have described. So, first trimester medical and surgical, and second trimester medical and surgical abortions as well.

Q. So, Doctor, when D&E is taught at your institution, does that include the approach to D&E that is an intact approach to D&E?

A. Well, we teach D&E. And to the extent that every D&E involves an attempt to remove the fetus as intact as possible, yes, we teach intact D&E. But I really have trouble with this notion that intact D&E constitutes the separate and distinct procedure.

It's really part and parcel of D&E in general and we teach that so we teach all degrees of intactness.

Q. Are you a member of any professional associations?

A. Yes, I am.

I am a member of the American College of Obstetricians and Gynecologists. I'm a member of the Association of Professors of Gynecology and Obstetrics. I'm a member of the

Central Association of Obstetrics And gynecology. I am a member of the National Abortion Federation. I am a member of Physicians for Reproductive Choice and Health.
Q. You mentioned that you are a member of the American College of Obstetricians and Gynecologists; what is that organization?
A. It is the largest professional organization of obstetricians and gynecologists in the United States.
Q. Do you hold any particular titles within that organization?
A. I'm a fellow of the American College of OB/GYN.
Q. Doctor, have you authored any publications?
A. I have authored two chapters on women with disabilities.
I presented a number of poster presentations and abstracts at national meetings.
Q. Are there any other issues besides women with disabilities on which you have written or spoken?
A. HIV in women, particularly HIV as pertains to both reproductive choice and abortion.
MS. CHAITEN: Your Honor, if I might approach the witness to hand him a binder of exhibits as we have been proceeding previously?
THE COURT: Go right ahead.
MS. CHAITEN: Thank you.
Q. Dr. Hammond, if you would please look at what's been marked Plaintiff's Exhibit number 98, it should be at Tab 98 in the binder that I just handed you.

A. Yes, I see it.
Q. What is this document?
A. This is my CV or curriculum vitae.
Q. Is this an accurate summary of your education and experience?
A. Yes, it is.
MS. CHAITEN: Your Honor, at this time I would like to offer Exhibit 98 into evidence.
THE COURT: Any objection?
MS. GOWAN: No, your Honor.
THE COURT: Received.
(Plaintiff's Exhibit 98 received in evidence)
MS. CHAITEN: Thank you, your Honor.
Q. Doctor, what if any actions do you take to maintain current on your developments within your medical specialities?
A. Well, I read common journals within my specialities such as the American Journal of OB/GYNe and American Obstetrics and Gynecology.
I attend regular grand rounds in our department, a weekly presentation our department requires that we attend.
I attend national meetings on issues that are germane to my work such as pregnancy termination, such as medical education, as well as some other more general types of OB/GYN meetings. And I also confer with colleagues.
Q. Aside from your work in connection with this matter, have

you offered expert testimony in any other matters?
A. Yes, I have.
Q. Approximately how many other cases have you provided expert testimony?
A. I believe there have been three other cases.
Q. And have you testified live at trial in each of those cases?
A. No. I testified live at trial in two of those cases.
Q. And in the third one did you offer your testimony in some other form?
A. It was in written format.
Q. Maybe an affidavit?
A. Yeah, it was an affidavit or declaration. Yes.
Q. Have you ever been qualified to provided expert testimony in Court?
A. Yes, I have.
Q. And in what areas, Doctor?
A. Related to obstetrics, gynecology and also abortion practice.
MS. CHAITEN: Your Honor, we tender Dr. Hammond as an expert in obstetrics and gynecology and abortion practice pursuant to Federal Rule of Evidence 702.
THE COURT: Any objection?
MS. GOWAN: Your Honor, the government has no objection. I would just like to make a caveat.

Before the break counsel elicited testimony that Dr. Hammond was going to offer opinions on vagueness and then she asked if he was qualified to offer opinions on the subjects that she had elicited. Most certainly we would object to any qualification of Dr. Hammond as an expert on vagueness as it relates to the statute.

THE COURT: Well, perhaps that was used loosely. I don't think you really are offering him as an expert on vagueness, are you, Ms. Chaiten?

MS. CHAITEN: No, your Honor. We are not.

THE COURT: He can testify what he understands.

Can you just, I take it generally then as offered you have no objection, is that correct?

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

THE COURT: Okay.

MS. CHAITEN: Thank you, your Honor.

THE COURT: The Court will acknowledge it.

Can you inquire, the witness testified he testified in three cases, I'm not sure what type of cases he testified in.

MS. CHAITEN: Certainly, your Honor.

Q. Doctor, can you please tell us what type of cases those three cases were?

A. One of them was a case involving similar legislation in the state of Illinois. I believe that was known as the Hope Clinic case.

There was another case also involving similar legislation in Ohio that was, the Taft case in Ohio.

And the third case was medical malpractice case in which I was an expert witness for one of the defendants, and that was in Chicago.

THE COURT: Excuse me, the last case?

THE WITNESS: The last case was a medical malpractice case in which I was an expert for one of the defendants.

THE COURT: And I believe in the Ohio case did you testify for the plaintiffs?

THE WITNESS: Yes, I did, your Honor.

THE COURT: And that was challenging the Ohio statute on partial-birth abortion?

THE WITNESS: That is correct.

THE COURT: And that's the same case that the Sixth Circuit, I believe, just upheld the statute?

THE WITNESS: That is correct.

THE COURT: And the other was the Illinois challenge?

THE WITNESS: That is correct.

THE COURT: Okay.

You may inquire.

MS. CHAITEN: Thank you, your Honor.

BY MS. CHAITEN:

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

A. Only my expenses.
Q. And is the payment of your expenses contingent in any way on the outcome of this case?
A. No, it is not.
THE COURT: Do you get to ride home no matter what happens?
THE WITNESS: Yes, your Honor.
THE COURT: Okay.
MS. CHAITEN: Do I?
Q. Dr. Hammond, earlier you said you were here to give your opinion on, among other things, the safety of D&E. Is that correct?
A. That is correct.
Q. And what is that opinion?
A. I think the D&E is a very safe procedure when performed to terminate pregnancy in the second trimester, and likely the safest method of termination of pregnancy in the second trimester through approximately 20 weeks' gestation.
Q. Doctor, do you have an opinion regarding the safety of second trimester induction termination procedures?
A. I think that induction of labor terminations are also very safe procedures.
Q. What are the bases for your opinions?
A. Well, the bases for my opinion that D&E is safe relates to nearly 30 years of data that D&E has repetitively been shown to

be a very safe procedure, particularly when compared to a variety of different methods of inducing labor.

I also now have nearly 15 years of experience to corroborate the fact that, in skilled hands, D&E is a very safe procedure not only through 20 weeks' gestation but also through 24 weeks' gestation.

Q. Do you have an opinion as to how the safety of D&E compares to the safety of induction?

A. I think through approximately 20 weeks' gestation D&E is likely the safer method of pregnancy termination. I think once you hit approximately 20 weeks' gestation the data breaks down a little bit and it's harder to tease out which method is safer, particularly if you start looking at more recent medications, such as misoprostol, that are used to induce those terminations.

I think that both methods between 20 and 24 weeks are a very safe method of terminating pregnancy.

Q. And what is your experience in connection with your practice between 20 and 24 weeks?

A. Well, I think in my practice at 20 to 24 weeks D&E is likely safer. We have considerable skill within the institution doing D&E, significant experience with this method, and a patient population that generally likes some of the advantages of D&E.

Q. Doctor, why, in your opinion, are D&Es generally safer than

inductions, at least through 20 weeks' gestation?
A. I think that the principal problem with induction of labor involves the so-called induction abortion interval.

The fact is, when you start an induction of labor you don't know how long it's going to take from the time that you start giving a medicine to induce labor until the abortion is complete, that is, until the patient delivers either the fetus or the placenta, or both fetus and placenta. And that's what really ends up complicating a large number of induction terminations.

We just don't know when you start this procedure that the patient will deliver within six hours, 12 hours, or in some cases we have patients who attempt induction and still haven't delivered in 24, 48 or 72 hours.

Now, to get back to your question how that implicates or how that involves safety, the longer you induce somebody the longer that they gradually accumulate the risk of certain complications, particularly infection and hemorrhage.

So, a lot of the risks of induction eventually come back to the unpredictable and often long period of time that people are waiting to deliver without doing so.

Q. Doctor, based on your experience which are more common after 20 weeks, inductions or D&Es?

A. D&Es are more common generally and particularly at our institution.

Q. Do you have an opinion as to why that is the case even after 20 weeks?
A. Well, I think one key reason is that most people in our speciality realize that D&E is generally safer way of terminating pregnancies and there may be some hesitancy or uncertainty between 20 and 24 weeks. But their general knowledge of this often will lead them to consult with us at a tertiary care center and ask for opinions.

I think that specifically at our institution other than our experience with the common knowledge among obstetricians that it's safe, it boils down to a personal preference of a lot of patients.

When you really sit down with a patient and you try to explain the two options that she has, a lot of patients really recoil at the thought of an induction. Now, keep in mind that neither of these procedures are particularly aesthetic or good to think about but I'm typically dealing, in fact in almost all the cases at 20 to 24 weeks that you mentioned, I am dealing with women who are coming in to me because they're sick or because they have a really bad fetal anomaly that's prompting them to terminate the pregnancy.

So, these are people who feel like they're experiencing like a pregnancy loss. And when you look at a patient like that and say, well, now that you are already upset about this, we may need to expose you to a procedure where you

could sit on the labor floor contracting and uncomfortable for six hours, 12 hours, or a day or two or three days and we don't know exactly when that's going to end. And that uncertainty, for a lot of people, is a big psychological burden.

THE COURT: Is that the way you present it to them, Doctor?

THE WITNESS: No. We try to be as equitable as possible as we present this to people. And frankly, your Honor, sometimes by the time they get to me they have already been counseled by our maternal fetal medicine doctors or someone else in the community.

THE COURT: Do they give full disclosure as to the various procedures available and what is entailed, such as the dismemberment, in some forms of D&E?

THE WITNESS: If they do not and then the patient is referred to me for D&E, we do tell the patient what's entailed in a D&E.

THE COURT: In simple, clear English?

THE WITNESS: I think so, your Honor, yes.

Now, there are variations, depending on the patient's own kind of psychological situation that we clearly take into consideration, but we actually have a large number of patients who look at us and say, let me get this straight. What you will be doing is dismembering the fetus. And we say, yes, that's exactly what we are doing.

THE COURT: Do you tell them what happens when they do an intact D&E?
THE WITNESS: If the patient --
THE COURT: The brain is sucked out?
THE WITNESS: Well I don't -- as a point of fact, your Honor, I don't usually do the suction part. I do compress the calvarium and I do some other procedures. I don't actually do suction so I don't explain that part.
THE COURT: You don't explain that to them?
THE WITNESS: Well I explain the method.
THE COURT: You explain what a compression of the calvarium is?
THE WITNESS: Yes, sir; that I do explain.
THE COURT: That that's crushing the skull?
THE WITNESS: I explain that, yes.
THE COURT: By the way, is cost a factor when a patient asks you, because the D&E is quicker is it less expensive to the hospital and the patient?
THE WITNESS: I don't know how that factors for either the patient or the hospital. It's not a factor in our discussion at all.
THE COURT: You don't know if it's less expensive?
THE WITNESS: Well, I don't know because it would really depend on a variety of factors for the induction termination. How long it takes in particular because if it --

THE COURT: If the patient is there for, as you say, 48 or 72 hours, that's going to cost more, isn't it?
THE WITNESS: You're right, that those would be very expensive procedures for the hospital.
THE COURT: And I assume then for the patient?
THE WITNESS: I don't know. I don't know what part of that costs --
THE COURT: Unless it is a charity patient it will cost the patient more, will it not?
THE WITNESS: I honestly don't know the answer to that, your Honor.
THE COURT: You have been at that hospital how many years?
THE WITNESS: I have been at Northwestern for nine years.
THE COURT: And you don't know?
THE WITNESS: I don't know the relative cost to the patient of induction termination.
THE COURT: You don't know if it's more expensive if they're there for a matter of hours or they're there three days.
THE WITNESS: I know if they're there for three days it is more expensive than if they are there for a few hours.
THE COURT: Okay. Next question, Ms. Chaiten.
MS. CHAITEN: Thank you, your Honor.

BY MS. CHAITEN::
Q. Doctor, let's go back to what you just testified to and break it down a little bit.

You mentioned that there was uncertainty in the length of the procedure in the case of an induction termination and you have described this to some extent, but can you explain briefly what you mean by that?

A. The uncertainty is when the patient will eventually deliver the fetus and the placenta.

We start the medicine and we don't know when that's eventually going to cause her to deliver.

Q. And you also mentioned the possibility of a failed induction; can you explain what you mean by that and how that plays into this testimony?

A. Yes.

Q. Induction of labor doesn't always work. By that you will have patients who simply don't deliver in response to this medicine and there is a point where, particularly given the patient's clinical circumstances, in other words how sick she is, that the person taking care of her has to draw a line and figure out when enough is enough and you need to convert the procedure to a D&E.

We actually get patients referred in from the community who have sometimes been induced for a number of days who have become infected in that process and frankly come in

relatively sicker to us than they otherwise would have been if we had had them sooner.

(Continued on next page)

Q. Doctor, you also mentioned the psychological burden on a patient who is undergoing an induction termination procedure. Can you briefly explain what you mean by that.
A. It is the burden of, first of all, not knowing when she is going to deliver, the burden of being on the labor floor and waiting and not knowing, and then also the burden of delivering the fetus.
THE COURT: When you say the labor floor, they are in a bed, aren't they?
THE WITNESS: That's correct.
THE COURT: They aren't on the floor.
THE WITNESS: I'm sorry. We commonly refer to our labor ward --
THE COURT: That is what I thought. But I sounded rather grim.
Q. Doctor, you have referred a number of times to the fact that an induction termination is performed on the labor floor. Why is that induction termination is performed on the labor floor or where labor occurs?
A. Because the patient needs to be monitored throughout that process, so they need to have appropriate nursing personnel on hand regularly checking in on them, particularly depending upon the induction agent that is the medication that is being used. We also don't know when they are going to deliver, so we wouldn't want them in another part of the hospital where we

might not be able to make it to the delivery as easily.
Q. Doctor, what happens if they don't deliver, if it is what you called a failed induction? Do you deal with that on the labor floor?
A. If it is a failed induction, our other alternative is to do a D&E. That could either be accomplished on our labor floor where we have the same operating rooms or we perform Cesarean sections, or we also have other operating rooms in other parts of the building, Prentiss, as well as the main hospital where we can do those.
Q. So in order to do that, the patient is taken to the operating room?
A. That is correct.
Q. Thank you. Dr. Hammond, you have now listed a number of reasons why you think that D&E is more common even after 20 weeks. Have you ever observed a patient who did not want an induction termination for the reasons that you have identified?
A. We see patients quite often who have that characteristic. We have a large number of patients who say that they do not want to have an induction after they have been counseled and are sent to our service. We also now have patients who come in to us specifically requesting that we do these procedures as intact as possible so that they can have the benefits of both.
In other words, there are some women who want the control of the D&E and the predictability of the D&E, but they

would still like to be able to hold the fetus afterwards. So we now have patients coming to see if we can specifically do these as intact as possible.
Q. What do you tell those patients?
A. I tell them that we can't guarantee, that the general approach to the D&E is the same for pretty much all gestational ages and I simply don't know a priori whether or not I am going to be able to extract the fetus intact or not. But I tell them that we will do our best, as we always do, to do that.
Q. Doctor, do you ever have a patient for whom an induction termination, in your view, might not be the most appropriate medical approach?
THE COURT: At a particular point of gestation or just open-ended?
MS. CHAITEN: During the period when he can do an induction termination, which is in the second trimester.
A. Yes, I do have patients in whom medical induction is either not a wise decision or that it is contraindicated.
Q. Can you tell me what you mean by the term "contraindicated."
A. Not indicated. In other words, we see absolute and relative contraindications. An absolute contraindication would be a reason you absolutely cannot do this procedure in the way you suggest. A relative, and that is the most applicable to D&E's, a relative contraindication would be a reason that the

risk/benefit ratio is tilted towards one procedure versus another.
Q. You mentioned that relative contraindications are most applicable to D&E's. Is there ever an absolute contra-indication for a labor induction?
A. There are very few, but one example would be a complete placenta previa.
Q. Before you proceed, I wanted to ask you to please explain to us what is a complete placenta previa.
A. A complete placenta previa is where the placenta or the afterbirth is completely covering the opening to the womb or the cervix. In that circumstance, the only way that the fetus can come out of the womb, out of the uterus, would be to deliver through the placenta. So not only can't you induce that to happen, but were you somehow able to do so, the patient would be bleeding very, very heavily in the process.
Q. Why is that, that the patient would be bleeding very heavily?
A. Because as the placenta separates from the wall of the uterus and is disrupted, there is a maternal hemorrhage where the placenta has been connected to the wall of the uterus.
Q. Doctor, what type of pregnancy termination procedure would you want to perform for a patient who has complete placenta previa?
A. If you think of it logically, you have only two logical

options and realistically only one safe option. Logically, the baby in some cases with a placenta previa where there is a need to terminate, would need to come out either abdominally or it would need to come out vaginally through something like a D&E.

From a realistic medical standpoint, taking the baby out abdominally is not a valid option. In terms of what I mean abdominally, I am talking about something akin to a C-section, but at the gestational ages that you are talking about a C-section isn't really the same as doing what would in essence be a hysterotomy.

A uterus is a thicker, more vascular organ. You would be cutting through a segment of the uterus that not only bleeds more but is more prone to rupture in subsequent pregnancies, placing the patient's reproductive future at risk. So almost everyone agrees that terminating a pregnancy by hysterotomy is not wise and is medically unsound except in very, very rare circumstances.

So this kind of patient, a patient with a complete placenta previa who for whatever other reason needs to terminate a pregnancy, should undergo a dilation and evacuation.

Q. Dr. Hammond, can a woman with placenta previa carry her pregnancy to term?

A. Absolutely. The majority of placenta previas can be carried to term. What I was trying to indicate is if you had a

patient who for some reason needed to terminate the pregnancy and also had a coexistent complete placenta previa, under those circumstances D&E would be the best method of termination.

MS. GOWAN: Your Honor, I move to strike as nonresponsive to the question.

THE COURT: Could I please hear the question and answer.

(Record read)

THE COURT: Overruled.

Q. Dr. Hammond, you testified a little bit ago to the term "relative contraindications." Can you remind us again what is a relative contraindication.

A. It is a reason that kind of changes the risk/benefit ratio. By that, you wouldn't absolutely consider avoiding to do a procedure or intervention under those circumstances, but there might be something about the patient's medical history or the current clinical situation that certainly makes one a much, much better option than the other.

Q. Are there relative contraindications for second trimester induction termination?

A. Yes, there are.

Q. Could you provide some examples of those?

A. There are several. I think probably the best example is a prior uterine incision such as would be obtained from a myomectomy, which is removal of fibroids from the uterus, or

from a classical Cesarean section. But there are others, such as chorioamnionitis, bleeding disorders in the patient, certain kinds of heart anomalies, and so forth, that the patient has, heart disease, that I think could certainly make D&E a much better option than labor induction.
Q. Doctor, let's start with the chorioamnionitis example. Could you tell us, what is chorioamnionitis?
A. Chorioamnionitis is an infection of the amniotic fluid and the fetal membranes.
Q. Is this a serious condition?
A. It can be. It certainly justifies delivery to evacuate the uterus because the patient, the mother, is at significant risk.
Q. Why is chorioamnionitis is a relative contraindication for second trimester induction termination?
A. There are several reasons. First of all, it is not an absolute contraindication. I wouldn't fault somebody who induces labor, because the number one priority is you have to evacuate the uterus for the patient's well-being in those circumstances.
However, I think that D&E is a better choice for at least a couple of reasons. First of all, you have to contend with the unpredictable induction abortion interval that I just mentioned. A patient who is already starting infected, if she is allowed to remain infected and undelivered to one day, two days, three days, is only going to become sicker and sicker

during that process.
She also mounts other risk factors during that process. She is already infected, but her risk of hemorrhage is eventually greater because the infected uterus doesn't squeeze like it is supposed to after it has delivered. It is the squeezing of the uterus around the blood vessels that flow through its walls that stops it from bleeding. So a patient who is infected and has a prolonged induction is more at risk for a hemorrhage, which we already know is a greater risk with medical induction abortion than it is with D&E.
There is also another reason, which has to do procedurally. Anything that you can do that decreases the -- I'm going to end it there. I think I have adequately addressed it.
Q. Doctor, you mention that a woman could become sicker and sicker and sicker. How does that happen, aside from the increased risk of hemorrhage?
A. The patient can also become septic. By that, the infection that at first is localized to the uterus can disseminate through her bloodstream. She develops what we call sepsis, particularly gram negative sepsis, referring to the most likely bacteria involved. And that can be life threatening. It is in many cases.
Q. Doctor, how is the infection spread?
A. It is spread in a variety of ways. The bacteria enter the

bloodstream usually at the level of the wall of the uterus and are picked up in this manner. A lot of whether or not it is spread has to do with the inoculum, the dose of bacteria, for lack of a better way of putting it, that are eventually introduced into the bloodstream. They are also picked up as the uterus is contracting and squeezing. So the longer the induction, the greater the dose of bacteria and the greater the chance for the uterus to spread them into the patient's bloodstream.

Q. Why is that bad?

A. Because the patient can get very, very ill, and you can take what was at first a localized infection to the uterus and now generate a disseminated, life-threatening uterus to the woman.

Q. Doctor, what procedure would you think most advisable for a patient with chorioamnionitis?

A. A D&E.

Q. Can you perform a D&E safely for a patient in an emergency situation where, for example, you don't have the 24 hours to dilate the cervix that you testified to earlier?

A. Absolutely. In some circumstances, patients will have already achieved enough dilatation that you can go ahead and perform the D&E. In other cases, however, if I have some benefit that requires that I accomplish the D&E more expeditiously, I can abbreviate the preparation time somewhat.

To explain this perhaps a little bit further, laminaria, which are the most common dilator that we put in the cervix to open it, take about eight hours to maximally dilate. However, they achieve really good dilatation by four hours. So I know that I can often cut down on the time frame somewhat, particularly if I have a patient whose cervix is particularly predisposed to having this done.
Q. Do you ever have to terminate for chorioamnionitis on an emergency basis?
A. Yes.
Q. Does that happen frequently?
A. Yes, it does.
Q. Why is that?
A. One of the more common reasons that I am consulted at our institution is because of preterm premature rupture of membranes, which is where the amniotic sac or the bag of waters breaks sometime during the second trimester. Again, this really is what a lot of lay people might think of under more general rubric of pregnancy loss, because the prognosis for many of these pregnancies is very bad, particularly if it is earlier in gestation than the second trimester. Once that bag of waters has broken, they have lost the barrier to infection, and a lot of germs that typically reside in the vagina can ascend and affect the fetus in the fetal membranes.
Q. You mentioned premature rupture of membranes. Is there an

acronym that is commonly used for that term?
A. We commonly refer to that is PPROM or PROM.
Q. So if you say PPROM or PROM during the course of pregnancy, you are talking about a situation where the amniotic sac has ruptured prematurely?
A. That is correct.
Q. Doctor, is it possible to manage the pregnancy to term if a patient is suffering from chorioamnionitis?
A. No. If a patient has chorio -- and I apologize, we commonly don't said the whole word, we abbreviate it "chorio" for I think obvious reasons. The treatment of chorio is to deliver -- keep in mind that there are patients who develop chorio at term. So we do have patients who will be in normal labor at full term who develop chorio, and we are simply getting those patients delivered. But at very early gestational ages you cannot manage those pregnancies expectantly once you have that diagnosis.
Q. And managing expectantly means expecting to manage the pregnancy to term?
A. Either attempt -- yes, that is correct. But I would make it clear you cannot do nothing and you also cannot simply treat those patients with antibiotics. You have to evacuate the uterus under those circumstances.
Q. Dr. Hammond, you also said that bleeding disorders can be relative contraindications for second trimester induction

termination. Can you tell me what do you mean by "bleeding disorders."
A. There are any number of either congenital or existing from birth bleeding disorders or acquired bleeding disorders that patients can get. Some of the common examples people might have heard of would be hemophilia. There are a variety of different types. There are disorders of other clotting factors that we see. There are disorders of platelets that we run into where people lose their blood's typical ability to clot.
Q. Why would such disorders be a relative contraindication for second trimester induction terminations?
MS. GOWAN: Your Honor, I understand that Dr. Hammond is a plaintiff in this case, but he is also an expert, and counsel has qualified him as an expert to testify. Dr. Hammond's affidavit, TRO affidavit, in this case was submitted to the government as his expert report. Nowhere in that affidavit does he discuss contraindications for medical induction abortion. It is beyond the scope of the expert disclosure that Dr. Hammond has provided to the government in the case.
I would like to read, if I may, your Honor --
THE COURT: No, no. Is that correct, Ms. Chaiten? Is it correct?
MS. CHAITEN: He speaks about the advisability of D&E over induction termination because for some patients it is more

advisable not to do an induction termination.
THE COURT: I would suggest you move on to another area. I will take the expert report and look at it overnight and let you know.
MS. CHAITEN: Your Honor, there is much testimony from this witness about the advisability of different second trimester abortion procedures. Perhaps he might not have used the actual term "relative contraindication," but there is a great deal of testimony from him previously in the case on this subject.
THE COURT: I guess we will find out when I read his report.
MS. CHAITEN: Thank you, your Honor.
BY MS. CHAITEN:
Q. Doctor, you testified earlier that most women prefer D&E over induction for medical as well as personal reasons where a skilled D&E provider is available, is that correct?
A. That is correct.
Q. You have also told us your view that D&E is a safe procedure, is that correct?
A. That is correct.
Q. You also testified earlier that when you perform D&E you always try to remove the fetus as intact as possible, is that correct?
MS. GOWAN: Objection: Leading.

MS. CHAITEN: Your Honor, I am simply trying to facilitate the testimony, since we have jumped ahead.
THE COURT: I will allow it just to set the stage for it. But beyond that, please don't do any leading.
MS. CHAITEN: Thank you, your Honor.
Q. Did you testify earlier that you always try to remove the fetus intact as possible?
A. Yes, I do.
Q. Is that approach to D&E that we talked about earlier what some people refer to as intact D&E?
A. Can be, yes.
Q. For ease of reference here, can we refer to the intact approach to D&E as "intact D&E"?
A. Yes, we can.
Q. Do you have an opinion regarding the safety of intact D&E?
A. I think it is a very safe procedure.
Q. Do you have an opinion as to the comparative safety of intact D&E to other second trimester abortion termination procedures?
A. I think D&E's generally are very safe procedures. But I think the more intact you can do a D&E, the safer it is for the patient. So I think intact D&E's are really the safest type, the safest variation, the safest evolution of D&E's.
Q. Why is it that you believe that intact D&E is the safest way to perform a D&E?

A. There are several reasons that I think it is safer to proceed with a D&E as intact as possible. One reason is simply that it involves fewer passes of instruments. The less that I pass an instrument into the uterus, logically, the less chance I have to perforate the uterus, which is simply to poke a hole in the uterine lining with either my instruments or one of the parts of the fetus.

THE COURT: Have you ever punctured a uterus?

THE WITNESS: Yes, I have.

Q. Doctor, can you continue to explain why you believe that --

THE COURT: Just one second. In what type of procedure did you do?

THE WITNESS: In first as well as second trimester abortions.

THE COURT: What type of abortion? What procedure?

THE WITNESS: Using both suction curettage in the first trimester and D&E in the second trimester.

THE COURT: Is that a dismemberment D&E?

THE WITNESS: Yes. I have had, like most providers, relatively few perforations.

THE COURT: I am asking about when you did have the perforation.

THE WITNESS: Yes. They have been with dismemberment D&E's.

THE COURT: Were you sued for malpractice?

THE WITNESS: No.
THE COURT: Did the patient know you perforated the uterus?
THE WITNESS: Absolutely. We always share that with the patient.
THE COURT: Go ahead. Next question.
Q. Dr. Hammond, I believe you were talking about the reasons why it is your opinion that the intact approach to D&E is the safest way to perform a D&E. I think you mentioned the decrease in the number of passes of instruments into the uterus. Would you continue with your answer, please.
A. Like I was saying, there are many other reasons that I think that it is safer to use the intact procedures. Another reason is simply that there is less of a chance to lacerate or to make a cut in the cervix. If you are doing this relatively intact, you have fewer bony parts of the fetus that are exposed that can cut into the cervix as you remove them from the patient. So the more intact the fetus, the less chance there is for those to cut the cervix and injure the patient.
Another reason is simply the degree of surgical control that we have. With very intact procedures, when I have control over the fetus external to the cervix, I can see a large portion of the procedure that I am doing. I am not having to blindly grope inside the uterus like I am with a more disarticulated or dismembered D&E, and therefore have a

drastically lower likelihood of perforating the uterus and injuring the cervix, because it is all exposed.

I also, particularly if this has proceeded intact to the level of the fetal head, have complete control of the head. One of the hardest parts of a D&E is if the head has been dismembered and you have to, because it is usually the last thing you have to extract, if you have to try to again grope blindly inside of the uterus, it is entirely based on your experience with the instruments and it is not something that you have the degree of surgical control over at that time. So I think surgical control is another issue.

I also think that there is less likelihood of retained products, retained material if we are doing one of these as an intact or relatively intact procedure. One of the problems with a more disarticulated D&E is you have to have some way of accounting for what you have removed from the uterus. All of us, after doing these for a while, get a gestational age-appropriate concept of what is an appropriate amount of fetal as well as placental material. But clearly, if I have watched the intact fetus delivery, I know, without having to do anything further, that I have removed the fetus intact and haven't left something behind.

I also think that this is safer in the case of some fetal anomalies. I also think that the intact D&E decreases our time in the OR. I don't mean that from a matter of

convenience. It is simply the fact that one of the kind of standards in surgery is the less time that the patient is exposed to the procedure, the less duration of anesthetic she is receiving, the less likelihood her complications. If I can do this intact rather than having to constantly reach in and remove more and more parts, I can accomplish the D&E faster.
Q. Doctor, let's talk about your testimony that intact D&E reduces the risk of uterine perforation because of fewer passes with instruments. Can you explain how uterine perforation would occur.
A. It can occur in one of two ways: Either because the instrument goes through the wall of the uterus or because a fetal part that has been disarticulated, particularly a sharp fetal part, is pushed by the instrument or something else inside the uterus through the wall of the uterus.
Q. What, if any, health risks are associated with uterine perforation?
A. It varies. Uterine perforations are actually more common with D&E and with first trimester abortion than many people realize. We know that from studies where they have done simultaneous first trimester abortions and tubal ligations so that they were looking into the abdomen while they were doing it.
We know that most small perforations probably cause no harm, but certain perforations cause more harm than others. If

it is a large perforation at the top of the uterus, the patient can bleed from it. But usually we can fix the uterus without any long-term sequelae, long-term problems.

On the other hand, a similar size perforation on the side of the uterus, which is where the blood supply for the uterus comes in, the uterine artery cones from the side wall of the pelvis, if you poke a hole or perforate the side of the uterus, the patient can have catastrophic hemorrhage quite rapidly, because she is bleeding from very large blood vessels.

Q. Doctor, are the risks associated with uterine perforation serious?

A. Again, there is a wide range of uterine perforations. In most cases, no, but they can be. It can vary from simply needing extra observation in the hospital to some patients requiring surgery to repair the uterus. And in other cases the only way we can control the hemorrhage is by performing a hysterectomy, which is obviously serious, because at that point the patient has lost her reproductive capacity.

Q. Why does intact D&E reduce the risk of uterine perforation?

A. Again, there are several reasons. First of all, I am just not reaching into the uterus as frequently. Secondly, when I am reaching in, I am not having to rely solely on feel. I have greater control of the fetus, often operating almost directly in front of me external to the cervix. So I am not reaching into the uterus as frequently, I don't have dismembered fetal

parts in the uterus that can poke through the uterus, and I have far better surgical control throughout the procedure.
Q. Doctor, you also testified that one of the advantages of an intact D&E is reducing the risk of cervical laceration or uterine perforation due to the fact that the presence of sharp bony fetal parts is reduced. First of all, can you tell us, what is cervical laceration?
A. It is a cut or a tear in the cervix, a scrape in the cervix.
Q. What causes the presence of sharp bony parts in the first place?
A. Disarticulation or dismemberment of the fetus.
THE COURT: Have you ever lacerated a cervix?
THE WITNESS: I am sure at some point that I have, your Honor. I don't specifically recall a circumstance right now.
Q. Doctor, why is the presence of sharp bony fetal parts associated with laceration and perforation?
A. In terms of perforation, obviously if you have a sharp object that is inside of the uterus and you are reaching in somewhat blindly into the uterus to grasp that sharp object, you can either directly push that object through the uterine wall or indirectly do so as whatever other parts jostle that object inside the uterus.
In terms of cervical laceration, if you have exposed

bony fragments and you are extracting them through this ring-like structure, which is what the cervix is, they can scrape against the cervix as you remove them and lacerate the cervix.
Q. Why does intact D&E reduce this risk?
A. If you are doing the procedure intact, again, you don't expose those bony fragments, the fetus remains intact. It is more akin in many degrees of intactness to a standard delivery.
Q. Another advantage that you mentioned earlier was the reduction of retained fetal tissue or parts. What does that mean?
A. Retained parts just means that we leave something behind. It can be either the placenta or it can be part of the fetus. As I was indicating earlier, one of the things we do at the end of the procedure is to make a mental note as to whether we think that we have extracted everything that might have been inside.

In some of the cases that I have seen, that is not nearly as easy as it would seem. I have seen patients referred in because they have fetal anomalies. So I have cases where the baby doesn't have much of its head or may be lacking extremities or any of the other landmarks that we commonly use to tell us whether we have extracted everything that we need to extract.

So if I have done this intact and have an intact fetus in front of me, then I know that I have done at least an intact

extraction of the fetus and have nothing else that I need to look for.
Q. Why is it important to make sure that you have removed all the fetal tissue and parts from the uterus?
A. With respect to both the fetus and the placenta, if you leave tissue inside of the uterus, the patient is at an increased risk for coming back with either an infection or a hemorrhage. Most of the time the patient will simply pass the tissue and will be fine, but many patients don't, and we eventually have to evacuate that material under less than optimal circumstances.
Q. Why does intact D&E reduce the risk of retained fetal tissue or parts?
A. As I had just indicated, because we have seen the fetus delivered. We now at that point that there is nothing that we have dismembered or disarticulated that could be remaining behind inside of the uterus. It is all at that point present and accounted for.
Q. How would you go about making sure that you have removed all of the fetal tissue and parts in a situation where you have disarticulated the fetus, or dismembered it?
A. There are several things that we do. Probably the most important is the operator's experience in assessing the feel that the uterus has afterwards. The last part of a D&E typically involves vacuuming the uterus after we have finished

the extraction. There is a characteristic feel that the uterus has when vacuuming that allows to us tell that it is empty.

Apart from that, though, we have to rely on what we can see that we have actually removed. So we look for certain sentinel things, certain sentinel parts to indicate whether we have removed the fetus or not. We look, for example, for extremities in the calvarium of the head to make sure that all of this has been taken outside of the mother at this point. Occasionally we will also use ultrasound as an adjunct in some circumstances to help us out.

Q. Can you fully address the risk of retained fetal tissue and parts with the use of ultrasound?

A. No. I chose the word "adjunct" specifically because I don't think that ultrasound is really a definitive tool to tell that the uterus is completely evacuated. It can be helpful particularly with some of the anomalies that I see, because, like I said, we don't always have the sentinel parts, the fetus does not have them, for us to look for. That makes it a little bit tricky in some of the circumstances. So looking at the uterus and also making sure that it appears empty can help us out.

The critical thing is really the experience of the operator knowing that the uterus gives him that feel, knowing that there is really an appropriate amount of mass, of material, that you have removed at the gestational age.

Q. Doctor, if you were to use an ultrasound in order to determine whether all fetal tissue and parts have been removed from the uterus, what is the patient doing while you are examining the uterus with an ultrasound?
A. At that point, the patient is still in the OR and asleep, because we use general anesthesia on our patients after approximately 16 to 18 weeks. At that point we do not want her awakened after she has already taken the risk of the general anesthetic and the intubation only to find that there are more things that we need to be removing from inside of the uterus.
before we reverse the anesthetic and take her to the recovery room, we have to account for those parts. So she would still be asleep, still -- I was going to say in the dorsal lithotomy position and caught myself -- still basically in stirrups and basically in the position essentially of a pelvic exam while we finish this.
Q. Would reliance on ultrasound to determine whether fetal tissue and parts had all been removed lengthen the procedure?
A. It could lengthen the procedure, particularly if we were to rely on it routinely or need to rely on it routinely, especially in cases of anomalies.
Q. Doctor, you testified earlier a little bit about this and to the fact that intact D&E offers advantages because it offers the potential for shorter operating time. Can you describe why that is the case.

A. Again, I believe that the shorter operating time is not just a matter of convenience for the operating staff or the patient. It is the fact that the morbidity of any procedure, the risks in general, correlate with the duration of the operative procedure, particularly the duration under which the patient receives a general anesthetic. So anything that I can do to facilitate the procedure expeditiously and yet still retain the degree of safety that we need is in the patient's best interest. And that is actually true of most surgical procedures, not even in just obstetrics and gynecology but throughout surgery.

With regard to an intact procedure, it is usually a quicker procedure, because we aren't having to spend the time we would ordinarily take grasping within the uterus for parts of the fetus that have been disarticulated as we have been doing this procedure. Again, if we can control the lower extremity and do something like a breech extraction as I have described, I can often deliver the fetus, if not intact to the level of the calvarium, at least partially so, and obviate the need for a lot of other steps that we have to take in a more dismembered D&E.

Q. What safety advantages, if any, are associated with shorter operating time?

A. As I indicated, there is a decreased exposure to the general anesthetic, which anesthesiologists tell me is safer.

There is also a decreased risk of bleeding, because you simply aren't exposing the patient to the same prolonged procedure when the placenta may already have been initially disrupted and the patient starts bleeding throughout the course of the D&E. I'm in, I'm out, the patient is no longer bleeding, her uterus is well contracted by that squeeze-down, stopping itself from bleeding, and it's over.

THE COURT: Ms. Chaiten, I am going to recess a couple of minutes early today. I have to conduct a sentence in a couple of minutes. We will break at this time and reconvene at 9:30 in the morning.

Also, Ms. Gowan, would you send us, please, one paragraph of where you think it is in the expert report that there is no mention. Ms. Chaiten can respond and direct to us a portion of that report where you this is not included.

MS. CHAITEN: Your Honor, would you like that in writing this evening?

THE COURT: It would help so we could look. We will give you a ruling in the morning.

MS. CHAITEN: I can provide you with the pages of the paragraph of the declaration and the pages of the deposition at this time, if that would be useful.

THE COURT: You can give that to my law clerk, and Ms. Gowan can do the same.

MS. CHAITEN: Thank you.

THE COURT: That's fine. Have a lovely evening. We will see you at 9:30.

(Adjourned to 9:30 a.m., April 1, 2004)

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PLAINTIFF EXHIBITS