TWM 4/1/04 NAF v. Ashcroft.
SOUTHERN DISTRICT OF NEW YORK
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NATIONAL ABORTION FEDERATION,
MARK I. EVANS, M.D.,
CAROLINE WESTHOFF, MD, MSC;
CASSING HAMMOND, MD,
MARC HELLER, MD,
TIMOTHY R.B. JOHNSON, MD,
STEPHEN CHASEN, MD,
GERSON WEISS, MD,
on behalf of themselves and
their patients,

Plaintiffs,

v. 03 Civ. 8695 (RCC)

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

Defendants.



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New York, N.Y.
April 1, 2004
9:30 a.m.

Before:

HON. RICHARD CONWAY CASEY

District Judge

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(Trial resumed)
CASSING HAMMOND, resumed. K-PBLG TKPW-PL -FPLT KHRERBG KHRERBG TKR* -RBGS EULD HRAOEUBG TO RE PHEUPBD KWROU THAUR STEUL URPBD OEGT -FPLT [>

THE COURT: The Court good morning.

THE CLERK: I would like to remind you that you are still under oath.

MS. CHAITEN: Your Honor, might I inquire of the Court about the line of questioning that we deferred yesterday as a result of the government's objection?

THE COURT: Ms. Chaiten, I received a letter from the plaintiffs this morning when I came in, which I have reviewed. I just received the government's letter. I perused it very quickly. If you get to the end of your inquiry, I will stop and go in and prepare a ruling on it. But I really think I read it too quickly to rule on it at just this moment.

MS. CHAITEN: Thank you, your Honor.

THE COURT: If you are finished, I will go in. But seeing I have become both of your best pen pals, I don't know what a day would go without a little note from one of you.

MS. CHAITEN: Thank you for keeping us from being so lonely.

THE COURT: Yes, it is nice to know. It reassures me. You let me know when you get to a point where you are about finished. If we haven't taken a break and I haven't ruled on it, I will stop and look at the government's letter carefully and give you a ruling.
MS. CHAITEN: Thank you, your Honor. Then I will just move ahead.
THE COURT: If you would.
DIRECT EXAMINATION S-

BY MS. CHAITEN:
Q. Dr. Hammond, you may recall that yesterday you testified that sometimes an induction termination fails, is that correct?
A. Yes, it is.
Q. How does that happen?
A. In most cases, the patient, after having been given one of a variety of medicines to attempt to induce labor, simply fails to deliver the fetus or the placenta.
Q. Do you consider this to be a complication of induction?
A. Yes, it is.
Q. How often do these complications occur?
A. It varies somewhat based on the circumstances that the induction of labor is being performed. Certainly it is less common if the fetus has already died before the procedure. I am consulted probably, it is kind of hard to say an exact



amount, but at least once a month by a maternal fetal medicine service because of an induction that has failed and in the sense that the fetus is not delivered. There are some months where I am consulted more commonly and even get referrals from the community where they haven't worked. Probably about 15 to 30 percent of all cases of medical induction, depending on the agent, are complicated by failure to completely -- to result in complete delivery of the placenta.
Q. I believe you testified yesterday that when an induction fails in either of these ways, you essentially do a D&E in order to evacuate the contents of the uterus, is that correct?
A. That is correct.
Q. Doctor, if you were patient enough could you just wait for delivery of the placenta or fetal part rather than going in and instrumentally trying to remove the contents of the uterus?
MS. GOWAN: Objection to the form of the question.
THE COURT: Could I hear the question again, Mr. Reporter.
(Question read)
THE COURT: I will strike the word "patient." I don't know if that is appropriate. Eliminating that word, why don't you rephrase it.
MS. CHAITEN: I will, your Honor.
Q. Doctor, can you simply just wait for the placenta or other fetal parts to deliver, or is it necessary to go in and

instrumentally evacuate the uterus?
A. No, eventually you have to intervene. I think with respect to the fetus it is obvious that if the patient after a day or two days or three days HAEFPBT effected delivery, they are going to become impatient. And if medical circumstances haven't required you to PEURB you towards doing a D&E at that juncture. With respect to the placenta --
THE COURT: Wait a minute, Doctor. I don't think you have finished the question. Would it happen automatically if you didn't do it? And we are not talking about the patient beingism PEURBT. Would it happen?
THE WITNESS: Would the fetus deliver?
THE COURT: Yes.
THE WITNESS: In some cases we don't know. It probably would.
THE COURT: If we don't know, then you don't know, is that right? Is that your answer?
THE WITNESS: No. I think that it is a matter of at what risk to the patient, your Honor. Conditional I didn't ask that. Would it happen, or you just don't know?
THE WITNESS: I can't tell you when it would happen. It likely would eventually, but not without becoming complicated.
THE COURT: Do we know that for sure?
THE WITNESS: Yes, I think we do.



Q. WHALZ the risk of waiting to remove the fetal parts or the placenta be, Doctor?
A. Eventually, if you have a prolonged induction, the risk of the patient developing both infection and hemorrhage increases. That is why there is a point with respect to the induction of the fetus where a doctor eventually has to recognize that it is going on too long.
THE COURT: Do the costs go up with the amount of time hospital occupying pays?
THE WITNESS: Yes, sir, that would be true.
THE COURT: OK. And you are concerned about cost, like every hospital, I presume?
THE WITNESS: Well, with all due respect, I am not working for the hospital and I am not directly concerned about the cost. I am just concerned about the patient and what is best for her. To be very honest, your Honor, it really doesn't enter into our mind. I am not that concerned about how much the hospital is going to incur from this induction.
THE COURT: Do they ever remind you of how much your patients cost the hospital?
THE WITNESS: Not once in nine years at Northwestern have they come to me and complained about the length of induction for a patient or really any of my patients. I think the only time it has come up has been after frankly completely

unrelated surgeries when people are in the hospital, say, after a Cesarean or his TKREBG tome, we do a quality assurance kind of program where they look at the length of, say, post-op. If we were keeping people too long post-op or beyond the average for other doctors, then I would be called on the carpet. But never for an induction; that has never happened.

THE COURT: If you switched to a D&E right away, it wouldn't happen, would it?

THE WITNESS: I'm sorry, your Honor. Are you saying --

THE COURT: If the moment you don't have a delivery and you switch to a D&E, it doesn't happen, does it?

THE WITNESS: I'm sorry. If I switch --

THE COURT: The stay in the hospital is cut right there and then, isn't it?

THE WITNESS: That is true, your Honor.

THE COURT: Thank you. Next question.

BY MS. CHAITEN:

Q. Doctor, can you describe for me your concerns in terms of the patient's health about continuing to wait for delivery of the fetus and the placenta?

A. The placenta is a problem, because the longer it stays in after delivery, the greater the risk of both hemorrhage and infection. The standard when I initially went into practice was to wait no longer than approximately two hours. That has




been the standard based on some studies of saline and as a HRAEUGS abortions, which is where they in the second trimester injected a very concentrated salt solution into the uterus to cause the patient to deliver. What they had done was to basically wait after a patient has delivered and compare the risks of major complications over periods of time, comparing what happens in patients when the placenta comes out immediately at the time of fetal delivery, what happens at 2 hours, at 4 hours, at 6 hours, and so forth.

It had been clear that for patients who had immediately delivery of the placenta, about 4 percent would develop hemorrhages or infections or other PHAORPBL complications. If you waited beyond 2 hours, that risk went up to 8 percent. It remained had 4 percent at 2 hours.

So for much of obstetrics, particularly people who still adhere to this rule, a standard practice has been not to wait longer than approximately two hours after the baby has delivered for the placenta.

There is some nower data that actually came out when I was in residence, this was in the late eighties. They were actually using not saline and as a HRAEUGS abortions, by die la PROS teen, which is a prostaglandin analog. They did much the same thing, looking at time intervals after delivery and comparing major risks of complications.

What they found was that the risk of hemorrhage and

infection tended to rise after about a half hour after delivery. So as a result, we are a little bit more aggressive at my institution now than we were when I was a resident. If we are doing a medical induction termination and the placenta is still under by half hour, we move in the direction of delivering it. And we probably also do this simply because a lot of our induction termination patients have epidural anesthetic already on board, they are already comfortable, and it is also a good time for the patient to go ahead and effect delivery. [> check above<]
Q. Dr. Yesterday, when we finished at the end of the day we were in the process of talking about the safety advantages of an intact approach to D&E, and you had mentioned that there were general safety advantages. You had also mentioned that intact D&E might offer particular safety advantages for certain patients, is that correct?
A. That's correct.
Q. What types of patients does that apply to?
A. I think there are several types of patients it would apply to. People with certain bleeding disorders, people with choir am nights, people with certain types of heart disease can all benefit if I am able to do their procedures relatively intact than by dismemberment.
Q. Let's take those one at a time then. Why would annual intact D&E offer particular safety advantages for women with



bleeding disorders?
A. As we had talked about, a patient who has a bleeding disorder is at a greater risk of hemorrhage. During the course of a D&E, if I am able to perform the D&E relatively intact for reasons that I think I have already covered, there is less of a risk of perforation, less of a risk of cervical laceration, which would be complications that would be even more devastating to a patient who has a particular bleeding problem.
So to the extent I am less likely to run into those complications in these patients, it is safer for me to do the D&E as a tack as possible S-
I also think it is safer because of the control we have over the timing of the procedure. Keep in mind that -- I'll stop there. I really was thinking more of induction versus D&E, which we are not talking about. I'm sorry. Go ahead.
MS. CHAITEN: Your Honor, there seems to be some feedback or something coming from the microphone as the witness is speaking. We are hearing buzzing behind us and it is making it difficult to hear the witness.
THE COURT: Michael, could you ask the technician to come up. Do you want to take a 5-minute break here? Is it at your end, Ms. Chaiten? Chaiten chant I am hearing it behind me.
MS. GOWAN: I think the witness is too close to the

microphone.
MS. CHAITEN: Am' I too close to the microphone? Let's try that.
THE COURT: Back away a little bit. Try to put your hand between your mouth and the microphone. At least that is something somebody has told me. See if that works.
A. Can you hear me without hearing the reverb RAEUGS?
MS. CHAITEN: Yes. I am hearing you without the reverb RAEUGS.
A. I will stay back away from the microphone.
Q. Thank you. I hope I didn't interrupt you. Were you done with your answer as to why you think bleeding disorders offer a particular --
THE COURT: I think he said, I'll stop here.
Q. I didn't ask you, what do you mean when you are talking about bleeding disorders?
A. It could be one of a number of different disorders. There are PROBLS with the factors in the blood, clotting factors that people have. Sometimes they are born with these disorders, sometimes they acquire them. Also problems with blood platelets, which are another component of the blood that is important to cause the blood to be able to clot. People can be born with these problems or develop them, even develop them as a result of certain complications of pregnancy.
Q. Doctor, you also mentioned that patients with choir am



nights would be offered particular advantages by undergoing an intact approach to D&E, is that correct?
A. Yes, that's correct.
Q. Just remind us briefly what choir am nights is. I know we have defined it before, but there are a lot of medical terms here. Just for the benefit of the rest of us, can you briefly remind us what that is?
A. It is an infection of the fetal membranes and also the amniotic flute. We commonly, in case I lapse into this, will abbreviate it "chore yo -- for short.
Q. Why is it that a patient with choir am nights would benefit from an intact approach to D&E?
A. There are a couple of reasons. First of all, these are patients who are already at higher risk of uterine perforation. If the uterus is infected the wall doesn't have the usualature Gore, the reSKWREUDty that it would have if it were not infected. Because of the that, because of doing the procedure as I testified more intact decreases the likelihood of perforation, it is even more important in this kind of patient who is at higher risk.
There is another even more compelling reason, though. The more you manipulate the inside of the uterus when it is an infected environment, the more likely you are to seed the infection from the uterine lining into the blood and take a localized infection like chore yo and make the patient septic,

which I testified yesterday is a more disseminated infection and \vast\vatsly more dangerous to the patient.

So when I am doing a D&E on somebody who has chore yo, I am going to try to do the procedure with the minimum number of passes, the least intro uterine instrumentation that I can so that I don't make the patient sicker in the process of doing this.

Q. Does a patient who has choir am nights have to terminate the pregnancy?

A. The pregnancy must be delivered, yes.

Q. Why is that?

A. Because it is the only way that you are really going to eventually treat the infection. You must evacuate the uterus.

Q. Doctor, the last example that you gave us of situations where a patient would benefit from an intact approach to D&E because of a particular health condition was certain cardiac anomalies or problems. Can you explain what you mean by that.

A. Ee see patients with lots of different heart problems. But I think what I was thinking of originally are patients who have certain severe cardiomy pathies. It could also be patients who have severe valve lar Hart disease. The word cardioopthink is essentially a problem with the heart muscle. We see people who because of a variety of conditions, some that they are born with and others that they acquire, the heart loses its ability to pump as effectively as it should. So with each pump of the



heart, they fail to expel, to propel, an appropriate quantity of blood.

When you see in these patients is much like what you see in older patients who sometimes develop congestive heart failure, their heart has pump failure and doesn't work.

We can see similar problems in people who have problems with the heart valves, the texts between the different chambers of the heart. There are a large number of these different problems, but they can either be too constricted or they can be too loose. As a result, the heart can have problems filling or it can have trouble pumping.

That is what I mean by the heart problems that I am talking about.

Q. Can you describe what the particular safety advantage would be of an intact approach to D&E.

A. I think that these are patients in whom if you have a hemorrhage, they are at even greater risk of dying. These patients do not tolerate flute shifts well, and what might be a minor problem in any other patient rapidly becomes a major problem in these patients.

I like the control of D&E in general in these patients, because I am able to have them in the OR at a predictable time with not only STHAOERBLGTS but the cardiology \{^ivities}\{^ists}, and so forth, and I no, I exactly the 20-minute period of time when we are going to be SRABG AOUGT

the uterus. But in terms of doing the procedure intact, this is the last patient in the world that I want to have a uterine perforation or a bad cervical laceration on. I want the best degree of control that I can possibly get surgically. And, as I testified, I can get that degree of control with an intact procedure, at least the most intact procedure I can get at the time.
Q. What are the benefits of that control of an intact procedure?
A. The benefits of the control are that I am not reaching into the uterus and having to somewhat blindly go after disarticulated or dismembered parts. I can see and feel everything that I am doing, because it is closer to me. So I am never at as heightened a risk of perforating the uterus or las RAEUG the cervix.
Q. Doctor, you mentioned that you would have STHAOERBLGTS and cardiology its with you in the OR during the 20-minute or so period of the D&E. What would their role be?
A. They are actually responsible for administering the anesthetic agents but also monitoring the patient's vital signs and their response to everything I am doing. It is really a division of labor. If I am tied up doing the procedure, and this is true of most surgeries, I can't moment to moment also be monitoring the patient's blood pressure and her fluid volume status, and so forth. So both the STHAOERBLGTS and in the case



of a patient with a major heart disease a cardiologist can help me do those things so I can on sen trait on the surgery.
THE COURT: If you did an induction with a patient that had a heart problem, would you have a cardiologist there?
THE WITNESS: We would have consulted them. But there is no way of knowing if they would be there immediately at the time of the delivery, because we never quite know when the patient is going to deliver.
THE COURT: Once you knew there was going to be a delivery, would you call upon a cardiologist?
THE WITNESS: We would certainly be calling them and trying to get their advice by phone.
THE COURT: Or attendance, I assume, if you thought it was necessary, right?
THE WITNESS: We would certainly try. But it is far less predictable with an induction, because we don't know when the patient is going to actually deliver.
THE COURT: Once you know that is happening, can't you call? Isn't there a cardiology \{^ivity}\{^ist} on duty?
THE WITNESS: Yes, and we would call that person.
THE COURT: OK.
Q. Doctor, in situations of SEFRPB bleeding disorders, are there medications that can be given a patient during the time of the procedure that might assist you in alleviating the concerns you have resulting from this health condition?

A. Yes, there are. It is actually advantageous when you are doing a D&E, because depending on the bleeding disorder, we can often give the patient those medicines immediately before the procedure, when she is most at risk.

For example, if a patient has extremely low platelets, less than 10,000 particularly, we could commonly give the patient platelets immediately before the procedure, when she is most at risk of bleeding. Platelets, for whatever reason, that are donated to a patient don't have the normal life span of platelets that your body makes. So there is a window after you have given them when the patient will benefit from that infusion of platelets.

With a controlled D&E, I can give them immediately beforehand and know that it is going to be effective at the time I am operating.

There is also one of the more common clotting factor problems, you had asked about these, is something called von willow bran's disease S-. It is a problem with, I won't belabor this, but the factor 8 complex, which is also involved in hemophilia. It is much more common, it is much more common in women. We do see this. And there is a drug called DDADP, which they can actually give nasally immediately beforehand when we know exactly when the patient is going to deliver.

Q. Doctor, if the maternal health conditions you have just described, are any of these conditions that might arise after a



pregnancy has commenced?

A. Yes.

Q. Which ones?

A. THRPL bo sight I can penia, for example, which is low platelets, I'm sorry, and is a blood clotting problem, can actually arise as a result of the pregnancy. People who develop the help sin trom, a variety of variants of preE clampsia and toxemia will often develop PWHRAD PHRAEULGTS and Louis their blood's ability to clot. That is one example that can arise over the pregnancy.

KOEUR am nights by division arises after the preg TPHAEPBTS because it is an infection of pregnant material.

Q. Thank you, Doctor. I would like you now to turn to the black binder that is there in front of you. Do you have it there from yesterday?

A. Yes, I do.

Q. If you would turn to what has been marked Plaintiffs' Exhibit 679, and it should be at tab 69 in your binder. [> check above<]

A. Yes.

Q. What is that?

A. This is the PARBL birth abortion Act of 2003.

Q. Have you reviewed this act Act in its entirety?

A. Yes, I have.

Q. If you would, please, refer to section 2 of the Act

entitled "Findings." Do you see that on the TPEURBTS page?
A. Yes, I do.
Q. Then, if you would look under the findings to section 14(A), which is on page S3-4, do you have that in front of you?
A. Yes, I do.
Q. Doctor, would you please read that paragraph for us.
A. "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, aabruption, amniotic fluid embo bus, and trauma to the uterus as a result of converting the child to a footling breech presentation, 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 TORBGT 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 TKAEGTD."
Q. Thank you, Doctor. Do you see there in the first sentence the reference to partial-birth abortion?



A. Yes, I do.
Q. I would like for purposes of the next number of questions for you to assume that the procedure that we are talking about here is the intact approach to D&E, and assuming that what we are referring to is the intact approach to D&E, based on your experience, do you agree with the statement that an intact D&E "increases the woman's risk of suffering from cervical incompetence as a result of cervical dilation"?
A. No, not at all.
Q. Why not?
A. I don't think that there is really any data that substantiates the cervical incompetence is more common in these patients. In fact, there is some data that if you appropriately dilate the cervix in these patients, that they are not at a heightened Rick of having a subsequent obstetric bad outcome, let alone cervical incompetence.
Q. Doctor, do you do anything different when TKAOEULGT for an intact D&E than when you dilate for any other D&E?
A. Again, as I testified, I consider all D&E's part and parcel of the same procedure. The truth is we do nothing differently before our intact procedures, our relatively intact procedures, than for those that are done by dismemberment.
Q. You mean you do nothing different in TKAOEULGT for those, is that what you said?
A. That is correct. We have a protocol that is dependent upon

the patient's gestational age, and we do the same thing for all of those patients.
Q. Doctor, I would now like you to look at the sentence in that paragraph that you read -- not the sentence, but the phrase that refers to an increased risk of uterine rupture, and it goes on from there. Do you see where I am talking about?
A. Yes, I do.
Q. Again assuming that we are talking about an intact D&E, based on your experience, what, if any, opinion do you have about the statement that there is an increased risk of uterine rupture from an intact D&E?
A. I think that it is completely untrue. In fact, I think there is less of a risk of uterine rupture to the extent there is less of a risk of uterine perforation.
Q. Based on your experience, and again assuming that we are talking about intact D&E, what, if any, opinion do you have about the statement that there is an increased risk of abruption from intact D&E?
A. Abruption is separation of the placenta, and it is something that we do surgically during these cases. So there is really no difference in risk of abruption with these procedures.
Q. Again based on your experience, and assuming that we are talking about an intact D&E, what, if any, opinion do you have about the statement that there is an increased risk of amniotic



fluid embo bus from an intact D&E?
A. I know of absolutely no data regarding that. Frankly, I doubt it has ever been looked at, simply because the overall incidence of of amniotic fluid embolism is extremely low. Before any D&E, regardless of how intact T-TS it is, the first step that we take is to evacuate the amniotic fluid. The only exception is some of our PP ROM patients like we talked about yesterday where there is no amniotic fluid to begin with, where we occasionally omit that step. But we do that to decrease the risk of amniotic fluid empoliceman, and we do it in every procedure regardless of the degree of intactness that we anticipate.
Q. Doctor, do you believe that there is an increased trauma to the uterus from an intact D&E?
A. No. I think the risk of trauma is much less, if we are able to do the procedure more intact.
Q. Why is that?
A. As I testified, we are taking fewer passes into the uterus. The less I put an instrument into the uterus, the less likely it is that I am going to perforate the uterus F. I also have not dismembered the fetus as much, I do not have exposed bony SPEUBG useless that I can push through the uterus cause ago perforation or that I can pull out subsequently las RAEUG the cervix. So the more intact the less likely I am to traumatize the uterus.

Q. Doctor, for any of these complications that we have just talked about, uterine rupture, abruption, amniotic fluid embolus, or trauma to the uterus, are you aware of any peer reviewed studies that have ever determined that any of these complications increase in tan intact D&E?
A. No, I am not.
Q. Doctor, I would like you now to look at that same phrase a little farther down, where it says that there is an increased risk of trauma to the uterus as a result of converting the child to a footling breech position. Do you see that?
A. Yes, I do.
Q. It goes on from there to talk about a procedure which, according to a leading -B obstetrics textbook, there are only a few, if any, dot dot dot -- I'm sorry -- a few if any indications for dot dot dot other than delivery of a second twin.
Again assuming that we are talking about intact D&E, based on your experience, what, if any, opinion do you have about the statement that intact D&E causes 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 few, if any, indications for other than delivery of a second twin?
A. I think the statement is completely untrue. First of all, the PRER that they are talking about in the obstetric textbook




is doubtlessly internal podal I can version. So really what they are talking about are apples and oranges. An internal podal I can version is a procedure usually accomplished near term or at term, which we only now do to deliver an aftercoming twin. It involves reaching in, taking a term or near term baby that is coming out head first, grabbing the foot, converting it to a breech, and attempting to deliver it. And this is a risky procedure at term with these babies, because you can traumatize the full-term uterus and injure the mother, and you can also traumatize the baby in the process of doing it.
But we are not really concerned with that at 20 weeks' gestation, when the uterus is a very different organ. What we are doing is manipulating a much smaller, less traumatic fetus in the sense that it is not nearly as likely to injure the pregnant woman, inside a very, very different uterus.
So first of all they are talking about very different procedures.
In terms of the safety of manipulating that fetus, this is something that is common to every D&E, whether it is an intact D&E or not. At 20 weeks' gestation the likelihood that a baby is breech, which is buttocks first or head down or vertex or sideways, which is transverse, are all roughly equal. It is not like at term. So very common in any D&E, even if it is by dismemberment, we will reach in, we will convert a fetus that is initially transverse to breech or convert one that is

head-first to breech. We don't always know that we have done this, but it is a common part of every D&E.
D&E has been studied for 30 years and been shown to be a safe procedure. So clearly this manipulation isn't causing any harm to the patient, whether we to it intact, relatively intact, or by dismemberment.
Q. Doctor, do you have an understanding of what obstetrics textbook the Act is referring to when it says "according to a leading obstetrics textbook, there are very few, if any, indications for this procedure other than delivery of a second twin"?
A. I am not exactly certain. My assumption is Williams obstetrics, because it is one of the more commonly used textbooks. S- I think that if you look in either gabby text or Williams, you are going to find something decrying the use of internal podal I can version. But, again, that is not what we are doing at midtrimester. That is a completely different procedure that I think is being used completely out of context in this case.
MS. GOWAN: I move to strike the answer of the witness: Lack of personal knowledge.
THE COURT: Could I hear the question.
THE COURT: Read the question and SW- wer.
(RRD
THE COURT: What is your objection?



MS. GOWAN: He said he didn't know, your Honor. He said "I assume."
THE COURT: Doctor, do you know-first of all, you throw in two texts. Do you know whether it is from one of those two texts for sure?
THE WITNESS: I don't know which exact text they were using, no, your Honor.
THE COURT: But you are more than willing to speculate that it is taken out of context and it is not appropriate, even though you don't know?
THE WITNESS: Yes, sir.
THE COURT: I will sustain the motion.
Q. Doctor, are you aware of whether in Williams on obstetrics-
THE COURT: Do you have the text there, Ms. Chaiten?
MS. CHAITEN: I do not have Williams here I. think Ms. Gowan may have it. TKPWOUPBL Gowan I do not.
MS. CHAITEN: We have it as an exhibit.
THE COURT: It seems like it isn't \worth\would there all this questioning speculation. If you want to show him the text, show it to him. Why should we all wonder? Client.
MS. CHAITEN: Your Honor, I'm not sure I need to do that.
THE COURT: If he doesn't know, he doesn't know. Why don't you move on. It seems to me we are all spinning our wheels about a text you are not showing him. And you don't

know that that is what is referred to in the statute. Until you establish that, it seems like a pointless exercise.
MS. CHAITEN: Thank you, your Honor.
Q. Doctor, are you aware of any obstetrics or gynecology textbook that decries the use of conversion to a breech position in a second trimester D&E procedure?
A. No.
Q. Doctor, turning back again to this paragraph that you read for us, assuming that we are talking about an intact D&E, based on your experience, what, if any, opinion do you have regarding the statement that intact D&E poses 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?
A. Again, I don't believe that statement is true.
Q. Why is that?
A. If anything, I think that this procedure exposes the patient to less of a likelihood of perforation or laceration.
Q. Why?
A. There seems to be a misunderstanding of what we are doing when we decompress the cal variousium, or the skull. Whenever I do this to deSKPRES the cal variousium, keep in mind my patients after 16 to 18 weeks are all under general anesthesia.
THE COURT: Excuse me. Is a cal variousium the skull?
THE WITNESS: I'm sorry, your Honor. Yes, it is the



skull or the head. I will try to say that from now on instead of cal variousium.
THE COURT: I don't mean to put words in your mouth. I just want to make sure I know what you are saying.
A. So when we do this procedure, I've got the patient asleep, I've got a device that I can hold on to the top of the cervix with. If I have done a procedure that is intact enough that we have delivered the fetus intact to the level of the head, where only the head remains woof the level of the internal opening of the cervix, I can actually see at this point the back of the neck of the fetus. So I can lift the cervix, look at the back operating table, and make an incision in the back of the fetal neck. That whole time I can see what I am doing. And in the very rare cases where I can't see what I am doing, I can usually put my finger, in fact always put my finger, on top of my scissors, which are against the back of the fetal neck, and I have complete control and feeling the entire time I do this. In those cases, feeling is just as good as seeing. I know exactly where the scissors are. They are not anywhere near the patient's cervix or uterus. It is a completely visible, completely palpable in the sense of feeling operation.
If you contrast that with a D&E that is by dismemberment -RGS the last part of the procedure usually involves trying to get the head or cal variousium out. What I

am having to do in one of those procedures is to try to feel with an instrument up inside the uterus with this skull that is bobbing at the end of my instrument, and I have to get around it. I don't have this control of that part. So I think doing the decompression procedure exposes the patient to less risk, not more, because it is a much more controlled, straightforward procedure.

THE COURT: Have you ever lacerated a uterus doing this?

THE WITNESS: No, never.

THE COURT: Or the-

THE WITNESS: I'm sorry?

THE COURT: Go ahead. Next question.

Q. Doctor Hammond, have you ever lacerated the uterus in the process of using a scissors to PAEUBG an incision in the back of the fetal neck in the course of conducting the intact approach to D&E?

A. I just want to be clear about the question last. I think the question of perforating the uterus and las RAEUG the cervix.

Q. Have you done either of those in the course of using a scissors otomake an incision in the back of the fetal neck?

A. Never, no.

Q. Dr. Hammond, do you always use scissors or other instruments to breech the fetal head or the fetal neck in the



course of doing an intact D&E of this kind -FRBGTS not always. It depends on the fetus. If you've got a fetus that is earlier in gestation, the skull, or cal variousium, it is SOFRT. It isn't as firmly formed. So in those cases you can often to this just with your finger, you can do this digitally. In some cases the scissors probably after 20 weeks I am more likely to use them. We actually have a number of instruments on the table that I can use, whatever seems like it is going to be most effective.

Q. Doctor, does it increase any risk to the patient to make an incision in the back of the fetal neck in the course of doing this sort of an intact D&E?

A. No, it does not.

Q. If you would now look at to section 2(2) of the findings, which should be back on the first page of the statute, where it says, "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 HRPBG-term health of women and in some circumstances their lives." Do you see what I am referring to, Doctor?

A. Yes, I do.

Q. Again assuming that we are talking about the intact

approach to D&E, based on your experience, what, if any, opinion do you have about the statement that intact D&E in fact poses serious risks to the long-term health of women and in some circumstances their lives?
A. That is untrue.
Q. Why do you believe that?
A. I think that doing these procedures as intact as possible is safer for patients and protects their health and their lives.
Q. Why is that?
A. As I have testified, I think there is much of a lower risk of perforating the uterus, of las RAEUG the cervix -FPLGT I think there is less likelihood of significant blood loss with the procedure. I have greater surgical control. It is just all in all safer to do these procedures as intact as possible.
Q. So for all of the reasons that you have been testifying over the last day or two, right?
A. That is correct.
Q. Doctor, can you now turn to paragraph 13 of the findings section. I'm sorry to be jumping around like this. It is on page S3-3.
A. I think I'm there.
Q. It says, "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 indicate that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care."
Doctor, again SAOUPG that we are talking about the intact approach to D&E, do you agree with the statement that intact D&E is never necessary to preserve the health of a woman?
A. No, I don't agree with that at the same time.
Q. Why not?
A. Because, again, as I have testified, I think that doing D&E's as intact as possible is the safest method of performing pregnancy, this will be the safest method for the patient.
Q. Do you agree with the statement that the intact approach to D&E poses serious risks to a woman's health?
MS. GOWAN: Objection: Asked and answered.
THE COURT: Sustained.
Q. Do you agree with the statement that the intact approach to D&E lies outside the standard of medical care?
A. Not at all.
Q. Why is that?
A. Because I think it is the standard of medical care. I think that since I have been doing this, a goal of D&E has been to accomplish that the procedure is intact as possible. What

we are seeing with the procedures we are describing is simply an evolution of these procedures. It has been the standard of care for at least the 15 years that I have been doing this.
Q. Doctor, would you now look to section 14(B) of the finding on page 013-4.
A. Yes, I see this.
Q. Would you read the last sentence for us, please; beginning "Indeed.?"
A. "Indeed, unlike other, more commonly used abortion procedures, there are currently no medical schools that provide instruction on abortions that include the instruction in partial-birth abortions and their curriculum."
Q. Summing that we are talking about the intact approach to D&E, do you agree that unlike other more commonly used abortion procedures, there are currently no medical schools that provide instruction on abortions that include the instruction an intact D&E in their KRUBG HRUPL?
A. That is clearly untrue. We have done it at Northwestern since I have been THRFPLT we have students who are involved in these procedures and know what we are doing, so are our residents and so are our fellows.
Q. Are you aware of any medical texts or other teaching materials that discuss intact D&E?
A. The one I am most familiar with is called a clinicians guide to medical and surgical abortion. It has a number of



different editors, but it is a book that we refer many of our residents and fell less to when they come on the family planning service and want an abortion resource.
Some newer editions, obstetrical texts, also refer to the current edition of Williams obstetrics, in fact, has a reference to in that case D&X.
THE COURT: When you say a reference, do they approve of it or disapprove it in the text?
THE WITNESS: I don't think that it was to approve or disapprove, but more to define the language, your Honor. I think there may have been a statement in Williams, but this is speculating on my part, that they say something like it may occasionally be necessary to protect a woman's health. That is my recollection of it.
MS. GOWAN: Objection: More to strike: Speculation. S-
THE COURT: Let me ask a question before I rule on your objection. You are the head of the department, and it is the most recognized text, and you don't know what it says?
THE WITNESS: I don't know everything that is in the new text. But I know that there is a reference to these procedures. Your Honor, I know they don't condemn --
THE COURT: Your motion is granted.
MS. CHAITEN: Your Honor, may I approach the witness with an exhibit?

THE COURT: You may.
Doctor, how many of these trials did you say you have testified in?
THE WITNESS: I testified in one other of these trials.
THE COURT: That being a challenge to a partial-birth abortion statute?
THE WITNESS: That is correct.
Q. Dr. Hammond, I have handed you a copy of what has been marked Plaintiffs' Exhibit 70. You have it in front of you. Can you please identify this.
A. Yes. This is a photocopy of a clin ig's guide to medical and surgical abortion.
Q. Is this a copy of the text you referred to a few minutes ago when you were answering my last question?
A. That is correct.
Q. Thank you.
THE COURT: Are you one of the editors?
THE WITNESS: No, I am not.
Q. Doctor, will you look at paragraph 14(F) of the findings. This appears on page S3-5, where it says a ban on the partial-birth abortion will therefore advance the health interests of pregnant women seeking to terminate pregnancy.?"
A. Yes, I see it.
Q. Do you see it? OK. Assume we are talking about intact



D&E, do you agree that a ban on intact D&E's will therefore advance the heating interests of pregnant women seeking to terminate pregnancy?
A. No, I don't.
Q. Why not?
A. Because I believe that a ban on this procedure will place patient at risk by removing from their possible option a procedure that is often the safest choice that they would have.
Q. Doctor, will you now look at paragraph 14(j) of the TPAOEUPBGDZ, where it says partial-birth abortion's also confuses the medical ethical and legal duty of physicians to promote life as the physician acts dwell 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."
Based on your experience and again assuming that we are talking about intact D&E, do you agree with that statement?
A. No, I do not.
Q. Why not?
A. Because the patient S- that I am taking care of in these procedures is the woman. I am actually acting on her behalf using the procedure that is safest under these circumstances to preserve had he ever heating and protect her life.
Q. Doctor, do you have an understanding --
THE COURT: Excuse me. You don't feel any obligation whatsoever to protect the life of the fetus?

THE WITNESS: We are seeing --
THE COURT: I am asking you something. Yes, your Honor.
THE WITNESS: With many of my patients, yes, particularly post-viability, your Honor.
THE COURT: You don't find any dual responsibility, your obligation is only to the woman?
THE WITNESS: In the circumstances in which I am doing terminations, that is correct.
MS. CHAITEN: May I continue?
THE COURT: You certainly may.
MS. CHAITEN: Thank you.
Q. Doctor, do you have an understanding of what a significant body of medical opinion would be?
A. I think I --
MS. GOWAN: Objection, your Honor.
THE COURT: What is the objection?
MS. GOWAN: I don't know how that question could possibly be answered. I don't know what that means, significant body of medical opinion I. think it is a vague question.
MS. CHAITEN: Your Honor, I am just asking for his understanding.
THE COURT: If we can't understand the term, what does it mean to us?



MS. CHAITEN: I have asked him to give his beginnings to us and then we can understand it.
THE COURT: I will sustain it.
Q. Doctor Hammond, is it possible to cause fetal demise before beginning to evacuate the uterus when performing a D&E?
A. Yes, it is.
Q. How would one do that?
A. Typically, people give some kind of either intraamniotic or intrafetal injection of a an agent to cause demise.
Q. Do you routinely inject either of these or any other drugs prior to performing a D&E in order to effect fetal demise?
A. No, I do not.
Q. Why not?
A. We do have first of all people at the institution who are trained to do so. So to literally answer your question, the reason I personally do not is that I am not trained to. And in those circumstances where a patient desires it, it would be other people who actually do the procedure.
We don't do so on a routine basis because there is no proven maternal benefit to doing this. And even though the risks are low, there are some risks that would be involved.
THE COURT: APS she said before this risk in every single procedure, correct?
THE WITNESS: That is correct, your Honor.
THE COURT: Next question.

Q. Would there be a benefit to your patient?
A. In giving one of these injections?
Q. Yes.
A. In most cases, no.
THE COURT: But you are not trained in this?
THE WITNESS: That is correct, your Honor. Yes.
THE COURT: Next question.
Q. Doctor Hammond, if you could, would you remove the fetus totally intact every time and bring about its demise after it had been fully delivered?
A. No, I would never do that.
Q. Have you ever in your career completely delivered a living fetus and then taken steps to effect demise after birth?
A. No.
Q. Has that always been your position?
A. Yes, it has.
Q. Doctor, have you ever completely delivered a living fetus when performing a D&E?
A. No, I have not.
Q. Have you ever done so in the context of an induction termination in the second trimester of pregnancy?
A. Yes. That is very common with induction terminations.
Q. What do you do under those circumstances when you have delivered a fetus that is alive in the course of an induction termination?



A. The very first thing we do is to assess the viability of the fetus. By that, we perform a very rapid assessment of whether we think this fetus is of the gestational age where resuscitation is appropriate. If there is any question of in our minds at apprentice, we have a full -- excuse me -- a 24-hour in-house knee oh natology \{^ivity}\{^ist} whom we contact who does an immediate assessment and then would perform whatever resus TAEUF measures are necessary on behalf of the baby -PLT.
Assuming, since we usually have very, very good data about gestational age and know that these are nonviable fetuses, assuming that that is not the case, we would then provide comfort and care to the baby. By that, we would place the baby under a radiant warmer to keep the baby warm. We might wrap the baby. Then depending on what the mother wishes to do, allow the mother to hold the baby at this point and simply way for nature to take its course.
Q. Doctor, we have talked about the safety of intact approach to D&E. Now let's turn to the scope of the Act. I would like you to again turn to Plaintiffs' Exhibit 69 in your binder, which is at tab 69. I direct your attention to section 1531 of the Act, which appears at page 013-6. Would you read the title of that section, please.
A. It says, "Partial-birth abortions prohibited."
Q. Now would you please read the first sentence under section

1531(A).
A. "Any physician who in or affecting interstate or foreign commerce knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under this title or imprisoned not more than 2 years or both."
Q. Thank you. Doctor, is partial-birth abortion a medical term?
A. No, it is not.
Q. Is there a commonly understood meaning of partial-birth abortion in the medical community?
A. No, there is not.
Q. Have you reviewed the entire Partial-Birth Abortion Ban Act of 2003, which is Exhibit 69?
A. Yes.
Q. After having read the Act, do you have a clear understanding of what conduct the Act prohibits?
A. No, I I don't.
Q. Why not?
A. There are a couple of reasons. First of all, some of the language that is used in the findings section of the Act is different or not included in the language of the ban. The other reason is that the language of the ban is vague or broad, and as a result I'm afraid that it could sweep in a lot of the procedures that I do in the second trimester of pregnancy.
MS. GOWAN: Move to strike the last portion of the



witness's answer: Calls for a legal conclusion.
THE COURT: No. I will allow it. That is what he thinks. I will allow it.
Q. Let's start with the first point that you made, Doctor. You stated that the definition of partial-birth abortion that is included in the acts banned is different in in many respects than what is discussed in the Act's findings, correct?
THE COURT: Now you are changing it to what it bans. If you ask him what he thinks, and he is not a lawyer --
MS. CHAITEN: Your Honor, I have moved on. I am simply going back to his prior testimony where he said that he believed that the --
THE COURT: He didn't say that. You changed it. Rephrase, please.
Q. Doctor, I am referring back to the first topic you raised as opposed to the second. The second one was your opinion that the ban is broad and vague. The first was that you, I believe, stated that the findings contained different information than the definition that is contained in the Act's ban. Am I understanding your testimony correctly?
A. You are.
Q. Can you explain what you mean by that.
A. There are several things that are discussed in the findings that aren't actually included in the ban itself. If you would like, I can identify some of those.

Q. That would be great.
A. If you go back to the beginning of the findings section -- again, this is section 2, findings -- let me look here and make sure I am referring to the right place.
THE COURT: Are you talking, Doctor, that some of these things you are talking about that are effects are not in the ban? Would you expect the effects to be in the ban? I know you are not a lawyer, but isn't it rather obvious?
THE WITNESS: No, I don't think I am talking about effects, your Honor.
THE COURT: You have been through all of those and you have noted those you agree with and disagree with, but I don't know that your statement makes any sense to me.
THE WITNESS: There is some language that is used to define or describe partial-birth abortion in the findings that doesn't appear in the ban at all. So I don't know if what is banned necessitates that I do those actions listed in the findings or not. They are different. They describe partial-birth abortion in different ways.
THE COURT: Ask the question, Ms. Chaiten.
Q. Doctor, can you explain how the findings describe partial-birth abortion in a different way than in the language of the ban?
MS. GOWAN: Your Honor, counsel is asking the witness to engage in statutory construction, which is not appropriate.



MS. CHAITEN: Your Honor, I am simply asking --
THE COURT: I think the witness is capable, if he can point to a line and say I don't think this is in the ban. But I don't think he is capable of saying what the statute does.
A. Do I go ahead and point to where there are some discrepancies?
THE COURT: I am not sure what you are seeking, Ms. Chaiten. I must say, you have me totally confused.
MS. CHAITEN: I am asking the Doctor to explain to us why he is confused by this statute. What he told us was that one of the reasons is that there is definitional language that is included in the findings section that does not then appear in the actual definition of partial-birth abortion. I have asked him to explain why it is he believes that.
THE COURT: Believes that? He can point to it. If it is not in the other section, it is not in the other section. If you think this exercise actually achieves something, try it.
MS. CHAITEN: Maybe he could very quickly point out what some of those facts are.
THE COURT: Do you think if you do it quicker, it is less of a problem?
Just point to the section, Ms. Chaiten. I don't know where you are going with it, but . . .?
A. Section 2, findings, the first paragraph, the statement "Or any part of the baby's trunk past the navel is outside of the

body of the mother and only the head remains STPHAOEUted womb." The wording "only the head remains inside the womb" isn't in the ban, it is only in this.
MS. GOWAN: The document speaks for itself, your Honor.
THE COURT: You are confused by that, Doctor?
THE WITNESS: I'm sorry?
THE COURT: Do you understand it?
THE WITNESS: I don't --
THE COURT: You don't understand that only the baby's head is inside the womb?
THE WITNESS: But it is not listed in the ban, your Honor. So I'm worried that the ban itself may actually sweep in procedures in which not only the head of the motor remains inside the womb --
THE COURT: The head of the mother?
THE WITNESS: I'm sorry. I misspoke. The head of the fetus. The findings are saying that to be a partial-birth abortion, since this isn't a medical term, involves procedures where only the head remains STPHRAOEUD the womb. But that language doesn't occur in the ban part of this Act. So someone in the TREFPS who has to worry if they are going to violate this law, I am wondering does it apply if only the head remains inside the womb or could it apply in less intact procedures where that may not be the case but I still have tripped up the



language that is in the ban itself.
THE COURT: Next question.
Q. Are there any other examples, Doctor?
A. Sure. The next line, for example, says, "for the purpose of performing an overt act" and then parenthetically "usually the puncturing of the back of child's skull and removing the baby's brains." There are references like this in the findings which don't occur in the ban itself. The ban doesn't talk about doing anything to decompress the cal variousium. So it leaves me wondering again is that a necessary act to constitute a partial-birth abortion or couldn't I be at risk with other procedures where I may not necessarily perform a compression of the cal variousium in this manner but still have swept in the language that is in the ban itself. They are different.
Q. Are there any other differences?
THE COURT: What are the ones you are afraid aren't covered?
THE WITNESS: In the case of the head inside the body of the mother or?
THE COURT: You tell me. You are pointing to a section. What is it you are afraid isn't covered?
THE WITNESS: It might be easier for me to answer the question if we go back to the ban. I can give you examples --
THE COURT: You are dealing with this section. Tell me what concerns you that you find unclear.

THE WITNESS: Let's start with the back of the baby's neck example. Let's say that I am doing a D&E, your Honor, and I extract the fetus all the way to the level of the navel. I have exposed part of the fetal trunk above the navel. Then I cut the umbilical cord. I am then able --
THE COURT: Has the baby been delivered into the uterus? Or have you just pulled parts out?
THE WITNESS: I'm sorry, your Honor, but the baby is being delivered from the uterus. You said the baby has been delivered into the uterus. I'm confused.
THE COURT: Was it past the cervix?
THE WITNESS: Certainly. If I have delivered, at that time if I have delivered the baby intact and have a part of the baby above the level of the navel beyond the cervix, I have now qualified, according to the ban section of this legislation, of having accomplished part of what is necessary for a partial-birth abortion. But in some cases I have cut the umbilical cord, have performed what I think is a overt AERT that will result in fetal TKPRAOEUZ, and then perform the res of the proceeds quite often wound having to perform a deKPHREGS procedure at the he feel of the cal RARPL ja. So it PEFLS me have I really done a partial-birth abortion under those circumstances? I haven't done anything that involves putting asy sore in the back of the baby's neck. I never suction out brains. I don't do that. Yet I have, if you look at the ban,



performed a procedure in which I delivered a part of the fetal trunk above the level of the fetal navel and have been perform an overt act which I know will result in the demise of the fetus. That is what the ban says an partial-birth abortions. It doesn't PHAEBGS the stuff about the babe's next, doesn't mention anything about the baby's head only remain inside the mother. It is not there.
THE COURT: So you have performed an act that results in the demise of the fetus, right?
THE WITNESS: In my example --
THE COURT: Isn't that clear to you?
THE WITNESS: Yes, it is clear that that act, cutting the um pill cal cord in the example that I just gave you, will eventually result in demise of the fetus and I think qualifies as a partial-birth abortion.
THE COURT: Next question.
Q. Doctor, you have just given us an example of how you think the language of the ban would apply. Were you referring to section 1531(D)(1)?
A. Yes, I was.
Q. Just so we are clear, why don't you read that section for us so that we have got the language of the ban out here.
A. Section 1 -- excuse me.
Q. 1531(B)(1)?
A. The term partial-birth abortion means an abortion in which

the person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or in the case of a breech presentation any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of PEFRPG an overt act that the person knows will kill the partially delivered living fetus and," and it goes on, "and performs the overt act other than completion of delivery that kills the partially delivered living fetus. AO*EUP ."
Q. Doctor, you testified that this language is so broad as to potentially encompass many of the second trimester abortion procedures you perform, is that correct?
A. Yes, it is.
MS. GOWAN: Objection: Leading.
THE COURT: I will allow it.
Q. Let's go back through the language and break it down so that you can explain why you have concerns. Beginning with the first line, "deliberately and intentionally vaginally delivers," does that cause you concern?
A. Yes, because every single procedure that I perform in any abortion, whether it is a medical induction abortion or whether it is a D&E, is deliberate and intentional and results in vaginal delivery. It doesn't distinguish anything for me.
Q. The ban refers to "living fetus." Does that term have



meaning for you?
A. It has meaning, but it can be more vague than might be apparent. We sometimes are concerned about the issue of viability. So there is living in the sense that there is a heartbeat or sign of life. But the more important issue with respect to when I perform an abortion -RBS since we don't do these post-24 weeks, post-viability, is the likelihood that the fetus can have sustained survival outside of the womb. That can be a little bit confusing. Do they mean simply sign of life or do they mean a viable fetus? There is no reference of it in this ban to viability.
Q. Do you understand "living fetus" to mean sign of life?
A. That is my interpretation of this, yes.
Q. In the earlier gestational age?
A. Yes.
Q. Doctor, do you understand the term head-first presentation?
A. Yes, I do.
Q. What is that?
A. It means that the fetus is presenting with the head nearest the person who is -- nearest the opening, nearest the SEFRBG.
Q. You have described already for us during your testimony what a breech presentation is, is that correct?
A. That is correct. It is where the bus tox is presenting nearest the cervix.
Q. Looking at the language outside the body of the mother, do

you understand what that means?
A. No. It is confusing.
Q. Why is that?
A. It sounds like it wouldn't be confusing, but I think if you are in an operating room and see what really -- or a delivery room for that matter, and see what the anatomy is like in reality, it is far less clear what constitutes outside of the body of the mother. One way to think about this is we have patients who have a significant amount of uterine discensus.
Q. Would you tell us what that is.
A. I was getting ready to define it. Which is just relaxation, where there is more give to the cervix. We have some who, once you get a speculum or a retractor into the vagina to do these procedures, you would be hard-pressed to tell whether, because the vagina is really continuous with the external space, what constitutes outside the woman's body. In some cases the cervix naturally is outside the have a SKWRAOEUPB once the person is relaxed and under a general aesthetic. So anything that is coming even outside the cervix is outside the body of the woman. In other cases, where the vagina is longer, outside the cervix might simply put the fetus within the vagina but nothing has come out beyond the vaginal entroy tus. And it changes during the course of the operation. We may have a fetus -- excuse me -- a cervix that begins significantly higher with respect to the vagina but as a result



of relaxation during the TKPRAEUGS, as we pull on the cervix, it STKPEPBDZ lower and lower, resulting in less of the vagina and a cervix that is closer to the entroy tus.
THE COURT: What is the entroy tus?
THE WITNESS: I'm sorry, your Honor. It is the apureature between the labia. So it is the opening of the labia to the outside.
Q. Would that be the entry to the vagina from the outside world, essentially?
A. Yes, I think you could say that.
Q. Doctor --
THE COURT: If it is beyond there, it is outside the woman, is it not? Do you have any problem with that? Do you know if it is there, it is outside the womb?
THE WITNESS: I have no trouble with that, your Honor.
THE COURT: I didn't think you would.
Q. Doctor, looking at partially delivered, is there a common meaning in the medical community of the term "partially delivered"?
A. No, there is not.
Q. Do you understand what is meant by "partially delivered"?
A. No.
Q. Why not?
A. Because there could be varying degrees of intactness and varying positions that constitute delivery. Partially deliver

what where? That is my problem.
Q. Doctor, you have testified that you are concerned that the language in section 1531(B)(1) could in fact sweep in many of the procedures that you perform in the second trimester of pregnancy to terminate pregnancy. What procedures are you referring to?
A. I think this could sweep in many of the second trimester surgical procedures I do. Frankly, I think they could even be interpreted in ways that could sweep in some medical abortions that we do, some medical induction of labor abortions.
Q. So you believe it would apply, when you refer to surgical procedures, are you talking about D&E?
A. Yes.
Q. And medical inductions?
A. That is correct.
THE COURT: Do you think that sweeps in dismemberment D&E?
THE WITNESS: I think it potentially could, your Honor.
Q. Doctor, why don't you explain for us how you think that could happen.
A. How it could sweep in which?
Q. Dismemberment D&E in response to the judge's question.
A. It might be easiest if I just take you through some of the language of the ban and describe what could happen easily



during one of my D&E's. There are several ways, your Honor, that this could happen, so bear with me.
First of all, every D&E that I do involves deliberate and intention vaginal delivery. I am always deliberately TKAOEULGT the cervix and I am eventually going to vaginally deliver the fetus.
Let's skip for purposes of my current example the head-first presentation and move on to "in the case of a breech presentation, any part of the fetal trunk past the navel is outside the body of the mother for the purpose of performing an overt act that the person knows will," and so forth. Let's say that I have a patient I have achieved adequate dilatation and I reach inside the uterus, have not controlled the lower extremity, but I grasp part of the fetal abdomen first. That can happen, and it has happened to me before with certain anomalies. So the very first thing that I take out of the vagina is the top of the abdo membership or part of the fetal thorax. Interthat case I have started a dismemberment D&E and I have delivered it outside of the body of the woman a part of the fetal trunk past the navel.
I then proceed to do the rest of my D&E by dismemberment. I know that that dismemberment itself is going to result in STKPHAOEUZ of the fetus, and therefore I think every act I take in the remainder of that dismemberment D&E could be interpreted to be an overt act that I know the fetus

isn't going to survive. In that kind of a scenario, I think that I could potentially trip this ban.
Q. Doctor, you mentioned that there were a number of examples of how that might happen. Can you give us just another one, how the ban's language could apply to a dismemberment D&E.
A. It might be easiest if I took you through an example in which we start with a fetus breech. Let's say that the fetus is presenting breech, and the first that I do is I grasp a lower extremity. I pull on the lower extremity until the fetus -- until I'm able to extract as much as possible before meeting resistance. I often meet resistance at the level of the fetal um bo lie cus, or the belly button, the navel. What I often do at that point is I do something to decompress, because you have now got the umbilical cord at the cervix, you are often pushing intraabdominal contents above the level of the cervix, and I need to do something unless the cervix is TKPWO*EUPBGT-excuse me, I misspoke -- because the fetus is going to tear. Because I try to do this as intact as possible, what I will often do at that point is to make an incision beneath the belly button, an incision in the fetal abdomen to permit decompression of the fetus. It inE creasing the likelihood that I might be able to do this intact.
Depending onto degree of intactness, whether I have delivered a part of the fetal trunk above the level of the navel beyond the cervix at this point, ignoring the ambiguity



in what constitutes out of the body of the mother, I know that the fetus can't survive that act of making an incision in the abdomen, and I think that I will have tripped the language of the ban in that circumstance also.
Furthermore, if preceding this I had dismembered part of the lower extremities of the fetus, let's say that to get to this point where I can pull the fetus out so that something is exposed beyond the level of the navel, let's say that I disarticulate the fetus completely at the pelvis, I think that I could be performing a disarticulated or dismemberment D&E and could till trip the language of the ban, because I have delivered the fetus such that I have exposed part of the fetus above the level of the navel and then performed the act, in addition dismemberment, that could be the overt act that the fetus isn't going to survive.
Q. Doctor, in that example, let's take that last example, have you deliberately and intentionally vaginally delivered a fetus?
A. I'm sorry?
Q. Have you intentionally and deliberately vaginally delivered the fetus?
A. Yes.
Q. Have you intentionally and deliberately delivered it as far as possible, including past the umbilical cord, past the navel?
A. In that example, yes, I have.
Q. Have you intentionally and deliberately taken steps that

you know will kill the fetus?
A. In that case, yes, I have.
THE COURT: But you have delivered it in parts, haven't you?
THE WITNESS: Yes, I have.
THE COURT: There lies the distinction, doesn't it, Doctor, from the language that you are so afraid of?
THE WITNESS: Yes, sir, that is one of the things I am afraid of.
THE COURT: But it is a difference: You have delivered it in parts?
THE WITNESS: In that case, yes,. That is why I am worried about this. I was giving an example of why a dismemberment D&E could trip the ban. And I would still have swept in the language of the ban while performing in essence a dismemberment D&E.
Q. Doctor, in any of the examples that you have just given us, have you taken the steps that you have taken for the purpose of delivering the fetus to a point past the umbilicus, or the navel, in order to perform an overt act that you know will kill the fetus?
A. No. The purpose in performing the procedure is to evacuate the uterus, to do the pregnancy termination. It is not for the express purpose of performing any of these specific acts or performing an act that will result in TPAOELT demise.



Q. Doctor, does the word "intact" appear anywhere in the language of section 1531(B)(1) that we have been talking about?
A. No, it does not.
Q. Doctor, you testified earlier to a situation you described as PP ROM or premature -- preterm premature rupture of membranes. Can you remind us again what that is?
A. That is where the bag of waters or the amniotic sac ruptures before the onset of labor, and in the case of true PP ROM, at a very premature time in pregnancy, with reference to our current discussion, we see this happening in the second trimester SP-P.
Q. How do you typically treat a patient who presents with PP ROM?
A. Logically, you have two choices: Either you do nothing and see if that patient can gradually progress until the fetus is viable in the sense of having a reasonable likelihood of sustained survival, and for the patient then to eventually SPOEUPB tainsly deliver, or you terminate the pregnancy.
Some patients, if they have ruptd the amniotic fluid -- excuse me -- the amniotic sac, will eventually develop choir am nights, chore yo, again, for short, which as we talked about is an infection inside the uterus. Then they would have to be delivered.
Q. What procedure would you counsel such a patient to undergo in order to terminate a pregnancy?

A. If she is before 24 weeks, I would counsel the patient to undergo a D&E.
Q. Do you have an opinion as to whether the definition of partial-birth abortion contained in the Act could cover treatment of such a patient?
A. Yes. I think it can.
Q. Why is that?
A. In many of these cases in which I am consulted, the fetus is still alive. So really the only thing different procedurally from anything that I have talked about today is the indication. These patients for most intents and purposes are experiencing a type of pregnancy loss, particularly with the earlier ruptures in the second trimester.
THE COURT: Does that mean a miscarriage, Doctor?
THE WITNESS: Yes, your Honor, it can.
A. So the prognosis for the pregnancy in those cases where the bag of waters ruptures very early in pregnancy, particularly if there is virtually no fluid remaining around the baby, is very, very grade. So in may of these patients decide to terminate. From that point forward it is the same as D&E in most cases.
Q. Did you ever do dilation of a woman who has PP ROM -FRPLTS it varies. Some of these patients have already achieved some degree of cervical dilatation, so obviously if they are already dilated enough, I occasionally don't have to do the step involving os mot I can dilators. If most cases we still have



to do this, and there is no problem doing so in a patient once the bag of waters has broken.
Q. In treating a woman with PP ROM, do you have to deliberately and intentionally reach in with your instruments in order to vaginally deliver the fetus?
A. Yes, I do.
Q. Do you have to take all of the other deliberate and intentional steps that you testified that you do in any D&E?
A. Yes, I do.
THE COURT: Ms. Chaiten, is this a convenient time to take our morning break?
MS. CHAITEN: That would be fine, your Honor. Maybe I can organize my notes a little and WRAB up.
THE COURT: Great. We will take our morning recess.
(Recess) 4 SHR*RB 1/04 Judge Casey take 2.
THE COURT: Ms. Chaiten, before you continue I will give you an evidentiary ruling on the open question on the area that was objected to yesterday.
That you have both submitted letter briefs on.
I have reviewed the parties' submissions related to Dr. Hammond's testimony on contraindications for medical induction in abortions. Having done so I conclude that pursuant to Rule 26A 2B Dr. Hammond's expert report does not adequately discuss the circumstances when an induction abortion is contraindicated.

Although this issue was raised during part of Dr. Hammond's deposition, this does not cure the deficiency in the report. See, for example, for sis could SRRS us Conway organizations, 1995 WestLaw 580197 at 2, Southern District of New York, October 3rd, 1995.

For these reasons, Dr. Hammond's testimony relating to contraindications for medical induction in abortions which appears on page 552, line 17 through page 561, line 11 is stricken and Dr. Hammond is precluded from offering further testimony on this subject.

All right, Ms. Chaiten, you may proceed.

MS. CHAITEN: Thank you, your Honor.

BY MS. CHAITEN:

Q. Doctor, I would like you to refer back again to Section 1531 B 1 of the Act that we have been discussing and take another look at it.

You received earlier that the word intact does not appear in the Act's TKPWEF TPHEUGS of partial-birth abortion, is that correct?

A. That is correct.

Q. Is that a concern for you?

A. Yes, it is.

Q. And why is that?

A. Well, as I think I mentioned earlier, I believe that many of even the dismemberment D&Es that I performed eventually fall



within the scope of the ban.

Q. The statute says partially vaginally deliver a living fetus; does that help you to understand better whether dismemberment procedures would be covered by the ban?

A. Well, no, it doesn't because it's possible, as I was testifying, to have started this delivery, have dismembered part of the fetus and yet the fetus could still have a sign of life such as a heartbeat, and I could then deliver the remaining part of the fetus above the level of the navel and I believe sweep into, and I believe in those circumstances could potentially have violated the ban.

Q. That situation, would you have partially delivered a living fetus -- I'm sorry -- partially vaginally delivered a living fetus?

A. Yes, I would.

Q. And would you have delivered it to a level past the emO PWO like us, or the Navyel?

A. Yes.

Q. And in doing so, would you then take steps that you know would kill the fetus?

A. Many of the steps that we take during the abortion, know that the fetus will not survive.

Q. And would --

THE COURT: The moment you dismember it it is going to plead to death isn't TEUFRPBLGTS but we don't know exactly when

demise is going to occur, your.
THE COURT: But start it.
THE WITNESS: Yes.
BY MS. CHAITEN:
Q. In taking those steps N. partially delivering the living feet to us a point past the emPWO like us, would your purpose be to enable yourself to take steps that you know will kill the fetus?
A. Well my purpose is to evacuate the uterus and complete the procedure. It's not specifically to do those portions of the procedure you described.
Q. Doctor, you mentioned that you were concerned that some of the induction termination procedures that you perform could come within the scope of this ban, is that correct?
A. That is correct.
Q. Can you explain how that could happen?
A. Well, I can certainly describe some scenarios which could potentially trip the ban.
Let's say that you had initiated an induction procedure. Keep in mind that an induction procedure is not a quote unquote natural event, it is a deliberate and intentional act with the prospect eventually of a vaginal delivery.
But let's say that the fetus starts to deliver but delivers such that the calvarium, the head is entrapped behind the cervix. That isn't a preposterous kind of assumption or



scenario because if you were inducing, let's say an infant with hydrocephalous or any kind of enlargement or disproportion of the head and the rest of the body, the head is the largest part and could get stuck at the cervix.
Now, what do you do under those circumstances? Well, this kind of sewn air yo could result in an obstetrician who really has had -- has tried in good faith not to violate what they might perceive this ban to be to now have to try to assist the patient in completing this process.
And what we usually would do is analogous to a D&E. It's one of the reasonsy the national TPWORGS federal kin HRAL policy gynecologicals are if you do a medical induction abortion are you supposeed to have the instruments for D&E on hand also in case you get stuck and have to finish the procedure surgically.
But let's say that the person doing the procedure didn't know how to, with the entrapped calvarium, with the entrapped head to reach up, perform a decompression procedure and complete the process as I have already described. Well, they might, in the process of trying to even just do a delivery, do an act which could be interpreted as the overt act.
Let's say they try to deliver a 20 week gestation where the neck is simply not as stable as what you might think with a full-term baby. We've had cases where people have -- we

being at TPHO*FRPBLGwestern, where people have attempted to do these deliveries and have eSRULsed, they basically torn a great deal of the neck if not tearing it off just trying to deliver the rest of the baby.

O.

And so in that case that person could have violated the Act because they know the fetus isn't going to survive that act.

Q. Doctor, in that example what would have to be done in order to then deliver the fetal head?

A. Well, you would have to do it instrumentally, just like we do for a D&E.

You need to reach in with one of the forceps that we use and do an act that would collapse the calvarium.

Now again because we have been talking about collapsing the head in many ways that doesn't always involve putting scissors in. And certainly, if it has been disarticulated we wouldn't do that. We would reach in with our forceps and take the head out.

Q. And in order to do that you would have to collapse the head?

A. Oh, you always have to collapse the head with the D&E procedures to get the head out.

Q. In every D&E?

A. That's correct.



Q. Doctor, in performing an intact D&E do you deliver the fetus to a certain point for the purpose of performing an Act that you know will kill the fetus?

A. No, I -- in any D&E, including intacts I deliver the fetus as intact as possible to get the operation over with.

Q. Doctor, in the induction example that you gave us where the head got stuck and you needed to proceed in the same way that you might with an intact D&E, are the steps that you take deliberate and intentional?

A. Yes, they R.

Q. And in that scenario do you deliberately and intentionally vaginally deliver the fetus?

A. Yes, I do.

Q. And what is the deliberate and intentional act that begins the delivery of the fetus into the vagina in an induction?

A. Giving the medicine that starts the delivery process.

Q. Do you deliberately and intentionally deliver the fetus to a point past the TPHAEFRBel?

A. In many cases, yes is because the uterus itself is going to start that process and affect that delivery and if it's incomplete we are going to have to help the delivery process continue.

Q. And WA would the overt act be in that scenario?

A. It would be in the note note could be in the scenario where you described where the fetus becomes stuck it could be any act

that can result in the demise as I extricate the baby, anything from disarticulating at the neck, to collapsing the calvarium and so forth.
Q. Do you deliberately and intentionally perform the overt act in this situation?
A. Every act that I do in most abortions is deliberate and intentional.
Q. Doctor, we talked a little bit ago about the P P Rom situation and your view that the Act could cover certain situations where you are treating patients who present with P P Rom, is that correct?
A. That is correct.
Q. In those situations, is the fetus still alive in a P P Rom situation when the patient first appears with ruptured membranes?
A. In the majority of cases there are cases where the fetus dies thereafter because of lack of fluid but in the majority of cases the fetus is -- in the majority of cases the fetus is still alive.
Q. And then the steps you would take would be akin to those of a D&E?
A. It is a D&E.
Q. Doctor, would you attempt to remove that fetus as intact as possible?
A. Absolutely, just as with any other D&E.



Q. Why?
A. Because I think it's safer for the patient.
Q. Doctor, you gave us an example earlier, I think in response to one of the Court's questions, about how even cutting the fetal umbilical cord could be an overt act under the statute, is that correct?
A. That is correct.
THE COURT: I don't think the Court phrased it that way.
MS. CHAITEN: I was referring to the Doctor's testimony, your Honor, not just that it was in response to one of the Court's questions.
THE COURT: I think he was already talking about that but I don't think it was phrased in the Court's question that so why don't you rephrase that.
BY MS. CHAITEN:
Q. You testified earlier about the possibility of cutting the umbilical cord as being an overt act that would bring you within the statute, is that correct?
A. It could be, yes.
Q. Let's just break that down a little bit so that we can understand that better.
Can you complain what it means for a delivery to be obstructed by the umbilical cord?
A. Well, in some cases I am able to reach in and grasp a lower

extremity. And as I have testified if I could do so and then start affecting delivery by grasping the other lower extremity and exERLT traction in tact as possible as removing the fetus I do so.

Let's say that I then am able to effect delivery to the level of the fetal Navyel. We quite commonly reach, have more obstruction at this point. Part of that, as I have testified, is because you are compressing other intra-abdominal contents above the level of the cervix as you run into it and one of the acts that I testified earlier I occasionally do, is to make an incision in the abdomen to release pressure to allow another outflow tract for those contents to continue this as an intact procedure.

But another reason why you reach obstruction at this point is because the umbilical cord itself takes up space. It's another thing that I will be pulling through the cervix at this level so another action that I will commonly take at this point is to cut the umbilical cord and I'm afraid that if I have delivered the fetus intact such that I have extracted it so that a part of the fetal trunk above the Navyel is below the level of the cervix and have now cut it -- have now cut the umbilical cord, that could be interpreted as the overt act because I know the fetus isn't going to eventually survive that act.

Q. Doctor, in that situation, is the, is an area of the fetus



above the Navyel outside the body the PHRORPBLG?

A. Can be, yes.

Q. And how is that?

A. Well because you've pulled beneath the level where the cord inserts the Navyel and are then cutting the umbilical cord. It could be really any part depending on how much I have been able to extract at that point in time.

Q. In this example have you vaginally delivered the fetus until any part past passed the --

THE COURT: Why don't you rephrase the question, Ms. Chaiten.

Q. Doctor, in the example you have given, have you vaginally delivered the fetus?

A. That is correct.

Q. And have you done so to the part where any part is past the Navyel out -- I'm sorry, let me state that again.

And have you done so so that any part past the Navyel is outside the body of the woman?

A. Yes, I have.

Q. What part is outside the body of the woman in your scenario?

A. Could be any part. I mean depending on how much of the fetus I have been able to pull down. It could be part of the abdomen above the Navyel, it could be part of the thorax above the naval. It could be everything except for the calvarium

above the neighbor be that I have been able to effect this and at the time I cut the umbilical cord.
Q. In this scenario the at time the cord obstructs delivery is the fetus alive?
A. Yes.
In most cases, again as I have testified it could be, in some scenarios that I have already done a disarticulation procedure and the fetus might have expired. But I don't always know if the fetus has died at this point.
Q. Doctor, what is the overt act in the scenario that you described?
A. Well, I think that cutting the umbilical cord could be the overt PWABGT Act because I know the fetus cannot survive transection of the umbilical cord.
Q. Doctor in the indication where the cord obstruct delivery, could you push the fetus back up into the uterus so that the um bill like us is not outside the body of the mother and then grasp the cord and cut it in order to avoid the effect of the ban?
A. No, that --
MS. GOWAN: Objection, leading.
THE COURT: I will allow it.
The answer yes or no.
THE WITNESS: No, I could not do that.
BY MS. CHAITEN:



Q. Why not?
A. It would be extraordinarily unsafe to the patient.
Q. Doctor in the scenario you described as cutting the cord is STKPWHROEURPBLT does KWUTing the court STKPWHRAOE did?
A. No, it does.
Q. What is the purpose in cutting the cord?
A. To give me more room to try to continue effects as intact a delivery as possible.
Q. Are all of the steps that you have taken in the scenario deliberate and intentional in?
A. Yes, they are.
Q. Your Honor, if I might just have one minute.
THE COURT: You may.
MS. CHAITEN: Your Honor, I have no more questions at this time. Thank you.
THE COURT: All right, Ms. Gowan, you may inquire.
CROSS-EXAMINATION

BY MS. GOWAN:
Q. Dr. Hammond, is it or is it not your testimony that you do not know what is meant by outside the body of the woman?
A. It is my testimony that I do not know what is meant by outside the body of the woman.
Q. Now you testified that various scenarios of conduct that you fear that you say make you fear prosecution under the Act;

did you work out those scenarios with counsel before coming to testify here today?
A. I had reviewed them previously with counsel. But, as I testified, I have been involved with this legislation before and have, over time, grown accustomed to thinking about some of this legislation.
Q. Did you work out those scenarios with counsel before coming here today to testify, Doctor?
A. I have talked to them about those scenarios, yes.
Q. Did you work them out with counsel?
MS. CHAITEN: Objection, your Honor. Asked and answered.
THE COURT: Overruled.
THE WITNESS: I discussed them and we reviewed them.
Q. And did you look at an outline of those scenarios prepared by your counsel in the case before coming here to testify?
A. Not an outline of those that was prepared by counsel. We have talked about those specific kinds of cases.
Q. Did you prepare or look at any question and answers describing scenarios that you have testified here today?
A. We've discussed these scenarios. I have not looked at prepared materials regarding these scenarios.
THE COURT: May I have that answer read back, please.
(record read).
THE COURT: Did you ever attend meeting with lawyers



and other OB/GYN doctors where you discussed the statute and planned testimony for challenges to such statutes?
THE WITNESS: I have not met with lawyers and other OB/GYNs. I have met with my attorneys to clarify scenarios that I run into that I think would violate the ban and which we have also gathered their opinion whether they thought it would violate the ban I.
THE COURT: Well have you met in groups though ever with other doctors and lawyers discussing, before the statute was passed, what legal attack or should we say legal/medical attack would be planned against the statute.
THE WITNESS: Not if with other doctors and lawyers discussing this, no.
THE COURT: But with lawyers?
THE WITNESS: But with lawyers to the extent that I have met with lawyers regarding this and also the Taft case. As I said discussing cases that I run into which I think would violate the ban.
THE COURT: Did you meet with professional groups before you did that or after?
THE WITNESS: No, I did not meet with professional groups in the sense of -- I'm sorry -RGS your Honor, I'm just trying to understand.
like ACOG?

THE COURT: Yes.
THE WITNESS: No, I have not.
THE COURT: Go ahead, Ms. Gowan; next question.
BY MS. GOWAN:
Q. Were your lawyers in the Taft case the same lawyers as in this case?
A. No, they were not.
Q. Were your lawyers in the other case the same lawyers as in this case, that would be in the Hope clinic case?
A. It was also the ACLU N Hope clinic ways can case.
Q. And are you at count boot our *T it A C L?
A. No I have con PWAOUTed to the bald bald bald foundation, yes.
Q. And you are a member of the freedom council of the contributing group to the bald bald bald foundation of the ACLU of Illinois, aren't you?
A. That is correct.
Q. You are listed in their 2002 to 2003 annual report as have contributed somewhere between $1200 and $2499, isn't that right?
A. That is correct.
Q. How much did you contribute in the year 2002 to 2003?
A. I don't recall offhand. It would be somewhere within the range that you have described but I don't remember the exact figure.



Q. Did you contribute for the year 2001 to 2002?
A. I don't believe that we contributed that much.
Again I don't -- in fact I'm sure we didn't contribute that much in that year. I don't remember the exact amount we contributed but I believe that we did contribute to ACLU that year.
Q. When was the first year that you contributed to the Roger bald bald foundation of the A R L U of little R* Illinois?
A. I simply don't recall.
THE COURT: Could I just interrupt?
When you say we is this some group.
THE WITNESS: No, my partner and I because we have given jointly to the ACLU and that is what I am saying when I say we.
THE COURT: Who is my partner.
THE WITNESS: Do I give the name or --
THE COURT: It's your partner, isn't KRFRPBLGT your Honor, this is not a professional partner, does he need to give his name?
THE COURT: Oh I thought it was a Doctor.
A. No, no, no, this is my domestic partner.
THE COURT: Oh, all right. Fine. I thought you were talking about another Doctor.
THE WITNESS: No, I didn't want to enter that name in the testimony unless --

THE COURT: No, no, no. I misunderstood. I misunderstood..
Q. How much have you contributed to the ACLU roll bald bald bald foundation?
A. I can't tell you total aggregate amount. I can tell you just to give you in broad terms that I doubt I have ever given more cumulatively than $3,000.
The last year that you had mentioned was the largest that we had ever donated.
Q. Now, you told the Judge this morning that you had only testified in one other partial-birth abortion case, that was the women's medical professional corporation versus Taft case, is that right?
A. That is correct.
Q. Now, you prepared an expert report in that case as well, didn't you?
A. Yes, I did.
Q. Were you a plaintiff in that case?
A. No, I was not.
Q. But you were plaintiff in the hope clinic versus Ryan case, correct?
A. That is correct.
Q. And that was a indication challenging the partial-birth abortion law of the state of Illinois, right?
A. That is correct.



Q. And you appeared in that case as an expert as well as being a plaintiff, right?
A. Yes, that is correct.
Q. And one of your co-plaintiffs in that case was Dr. Frederikson, right?
A. Yes, that is correct.
Q. And Dr. Frederikson is one of your expert witnesses in this case, isn't that right?
A. That is correct.
Q. Now there wasn't a trial in that case, was there?
A. No, there was not.
Q. If there had been you would have testified at that trial, isn't that right?
A. I believe so.
Q. Now, you also testified on direct that you refer residents and fellows to the book, a clinician's guide to medical and surgical abortion, correct?
A. That is correct.
Q. And that's a textbook developed by the plaintiff in this case, National Abortion Federation, isn't that right?
A. That is correct.
Q. And the lead editor in that book is Dr. More even Paul, right?
A. That is correct.
Q. And Dr. PA*U is testifying as an expert witness in the

challenge to the Partial-Birth Abortion Ban Act of TWAO*E that is pending right now in San Francisco, California, isn't that right?
A. That is correct.
Q. And you have sought, as a plaintiff in this case, to bring before Judge Casey, some deposition testimony of Dr. Paul in that case, correct?
A. I'm uncertain. My attorneys may have done so. I don't know if we have sought to bring her deposition forward tore not.
Q. Yesterday, in response to Judge Casey's questions you were testifying about what you tell your patients when you give them informed consent, right?
A. Yes.
Q. And you told the Judge that you explained to your patients what happens during the course of an intact D&E, didn't you?
A. Yes, we do.
Q. And you told the Judge that you explained to your patients what compressing the head means, correct?
A. Yes, we do.
Q. But in fact, you don't explain to every patient that there is a possibility that you might remove the fetus intact up to the point where the head is stuck in the internal cervical os and you perform a procedure to compress the skull or puncture the skull, do you, Doctor?



A. Not to every patient, no.
Q. You only do it if the patient asks you, isn't that right, Doctor?
A. In some cases, yes.
Q. Directing your attention to page 232, line 4 of the deposition that you gave in this case:
"Q do you tell patients of the possibility that you may be removing the fetus intact up to the point where the head is stuck in the internal cervical os and then you perform a procedure to puncture the skull and ask for STRAS letter ate the consents
"A as I just stated there are some patients who need more information than others. Most patients don't want to know specifics of the procedure, just as most patients who come in for a hysterectomy don't want to know the names of the class or the procedure I used to eye late the out REURP feel are or what I will go if we
Or what I will do if we have a ureter that's located close to the uterus. Just as most patients don't want to know the exact method that I use to crush or coagulate the uterine tube if we are doing a tubal ligation
So, in answer to your question, do I say this to every patient? No. But, if there was a patient who came in with specific questions and said, well, what do you do if you're dilated enough and you extract to this or that point, we would

share that information with the patient."
Were you asked those questions and did you give those answers at your deposition in this case?
A. Yes, I did.
Q. And in fact, Dr. Hammond, no patient has ever asked you, has she?
A. I don't know. Somebody might have. I don't have an independent recollection at this point.
Q. Directing your attention to page 233, line 4 of your deposition in this case:
"Q has a patient ever asked that?
"A not to my knowledge, no."
The closest --
THE COURT: Wait, let's finish the question.
Was he asked the question and degive the answer?
MS. GOWAN: Doctor?
THE COURT: Did you?
A. Am I.
THE COURT: Is that.
THE WITNESS: That's, if you are reading from my deposition then yes, that was my testimony.
BY MS. GOWAN:
Q. In fact, the closest you have ever come to having this kind of conversation with any of your patients is when they've come in and they've said to you, Doctor, is the procedure similar to



what we've been hearing about in the media as being epcompassed by the partial-birth abortion ban act of 2003 or a similar statute?; isn't that right, Doctor?
A. That is true.
Q. And your answer to THAEPL is, I'm not sure. There are a lot of problems with the legislation but that you will do whatever is necessary encompassed by the D&E to effect the procedure safely.
Isn't that right, Doctor?
A. That is correct.
Q. Now, my --
THE COURT: That's what you tell patients?
THE WITNESS: Well the question was what I tell patients if they ask is this --
THE COURT: I heard the whole question and that is your response you give them?
THE WITNESS: EUFRPLGTS it's part of my response and they will occasionally ask me, well, what exactly are you doing?
Do you -- how intact do you extract.
And we will have a relatively graphic conversation, your Honor, with those patients and we will tell them exactly the kind of things that I spoke about earlier this morning on the direct examination.
So, if they choose to per sue this in any way or bring

it up we will have this conversation with our patients.
THE COURT: With the technical language that you used here?
A. No. No. No. No. With patients I make the most, the best attempt I can not to use words like calvarium and to replace it with skull and so forth, but we don't -- we don't sugar coat it too much, your Honor.
THE COURT: You use reduction rather than crushing the skull.
A. I will say crush, clamp and extract and I use those very words because those are what patients understand. We want them to know exactly what the procedure is going to entail and we actually try not to sugar coat this for them because they're the ones who are going to undergo the procedure.
THE COURT: But only if they ask.
THE WITNESS: No.
Occasionally a patient clearly wants more information and if we sense that we try to give what's appropriate to the patient.
Keep in mind, a lot of my patients are emotionally quite fragile so we don't have to bring up the terms -- we don't have to go into gory detail about everything that we are doing. But does that mean that we don't share with them, that this involves dismemberment or separation of parts of the fetus or taking the fetus apart? We do. And we use that term. We



say we take the fetus apart. We say, it is coming out in pieces and we make sure that that's clear with the patients. And they understand it.
And given the circumstances that they confront and their alternatives, the majority of them want us to do the procedure.
THE COURT: Do you tell them whether or not it hurts the baby?
THE WITNESS: We have that conversation quite a bit with patients, your Honor.
THE COURT: And what's your answer?
THE WITNESS: We say several things to the patient, your Honor.
First of all, we tell the patient that it's controversial what exactly -- what the fetus experiences of pain at various gestational ages.
We share with them the fact that even for normally developed fetuses people debate the beginning of sensation of the fetus. They debate at what gestational age the fetus is able to interpret pain as we think about it.
We share with the patients that even though there are speculations about these things among normal fetuses, when you start dealing with the kind of circumstances that we confront where a baby may not have its forebrain or may not have its brain or may have a man New England O mile aseal, which is in

essence a completely disrupted and in some cases spinal cord, that there is no data it lead us to know what the baby feels.

THE COURT: How about when there is no anomaly instead of all these exceptions, how about when there is no anomaly.

THE WITNESS: We say that there is a possibility and one of the things that we are doing with most of these patients after 16 to 18 weeks is they're all under IV anesthesia, not just conscious sedation where it's some IV administered medications that likely don't reach the fetus in high concentrations but -- and not an inhalational anesthesia where it less would reach the fetus by I V deeply sedating anesthetic which may confer some pain control to the fetus.

We also share with them their alternatives and we share with them the fact that we really don't know what the fetus feels and some of the other things that they can do for pain.

For example, frankly, your Honor, I think we sugar coat some of the other option and we share this with patients.

They might ask, well can you give intracardiac or intraam knee OT, death or KCL which are the feet O sideal injections that we discussed or could you, could we do an induction termination and avoid this?

But the honest truth is, how do we know that taking this huge instrument and poking it into the baby's heart and injecting a poison hurts any less than my rapidly cutting the



umbilical cord or transecting the spinal cord with my scissors? Or how do we know that poisoning the environment that the baby is in with digoxin is any more painful or less painful than my doing a very rapid D&E.

And if the baby deliers and is living in the sense of a medical induction, we're assuming because nature takes it course that it's not painful.

But if the baby slowly tires and stops breathing and dies by aSTPEUBGiation it is reasonable to assume that even for a normally born fetus a normally formed fetus that this may also involve pain.

So what we are really asking the patients that I see is, which do you think is going to hurt worse for your fetus? And if there is some competing internal benefit for doing the D&E, is the speculation about the amount of pain enough to force you to say take a different risk of one of those procedures.

And we do have this conversation with our patients. My fellows and I a few months ago pulled some articles on it and reviewed it. My family planning fellows because it's a question that patients come in and ask us occasionally.

THE COURT: Occasion I.

THE WITNESS: That's yes.

THE COURT: Very often?

THE WITNESS: It's hard to give you a percentage.

Frankly a lot of the initial counseling is done by my fellows. I would wager, gosh, I don't want to mislead you, I just -- I can't tell you an exact percentage. At least, let's say 20 or 30 percent of the time.

THE COURT: Ms. Gowan.

BY MS. GOWAN:

Q. You don't consider yourself an expert on fetal pain do you, Doctor?

A. No, I do not.

Q. You are not an anesthesiologist are you?

A. No, I'm not.

Q. What's the dose -- what's the dose of appropriate O follow you give patients who are undergoing D&E abortion?

A. I don't give it my anesthesiologist does and I don't know the dose.

Q. You don't know the dose your patient gets, is that right?

A. That is correct.

Q. How quickly does appropriate appropriate cross the plas even it da Doctor do have you any idea?

A. I can tell.

Q. What's the blood pressure of your patients at the time they're getting the dose of appropriate appropriate?

A. It varies, actually.

Q. What is it?

A. Well it varies because I have patients who are referred to



me who are severely I'mer tense I have SABD I have others who run relatively low blood pressures so we run the gamut.

Q. Give me a range, Doctor?

A. Well, to give you kind of a general range we have people who are anywhere from 80 systolic over 50 to 60 die as tollic all the way up to 220 over 110. So we have a large range of blood PRURZ and like I said the anesthesiologist is responsible entirely for its administration.

Q. What's the dose of appropriate appropriate give to a patient who is undergoing intact D&E, Doctor?

A. I would -- I think they give the same dose to all of our -- the same appropriate dose to our patients and don't change the dose based on whether we are performing the D&E any differently because like I said a D&E is pretty much a D&E to me.

Q. Do you have any understanding at all how appropriate appropriate works in connection with maternal circulation?

A. In connection with, do you mean reaching the fetus? Is that what you are asking me?

Q. Yes.

A. No, I do not.

Q. Now 98 percent of the terminations that you provide for women with maternal health condition ORZ fetal issues are based on referrals that you receive from other physicss, contradict?

A. That is correct.

Q. And these patients have already been counseled by a number

of other physicians before they come to see you, right?
A. That is correct.
Q. And these physicians could be maternal fetal specialists andgenet I civilities, right?
A. That is correct.
Q. You're not maternal fetal medicine, are you Doctor?
A. No, I'm not.
Q. You're general STREUBLGs and gynecology, right?
A. That is correct.
performing the abortion procedure, correct?
A. That is correct.
Q. And you're not the physician who actually makes the recommendation for termination, are you?
A. In many circumstances, no. We counsel regarding method of termination but not usually regarding termination itself.
Q. Well the initial counseling on the method of abortion is done by the referring service, isn't that right?
A. They may or they may not, it varies somewhat.
Q. Directing your attention to page 33, line 4 of your deposition in this case:
"Q who does the initial counseling on the type of method of abortion with the patients who are referred to you?
"A typically the referring service.
"Q do you participate at all in those initial

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counseling services?
"A in the majority of cases, no. However, if it's a patient who is referred either from my own practice in the sense of division of general obstetrics and gynecology or what is more common given the nature of these patients, our division of maternal of fetal medicine I might be involved and have frequently been asked to come and speak with these patients. I am most likely to be consulted with the patient is an inpatient and already admitted to the hospital.
"Q oh, and inpatient, I see."
Were you asked those questions, did you give those answers at your deposition in this case
MS. CHAITEN: Objection, your Honor. She read a statement from a question and didn't give what the answer was.
MS. GOWAN: Well the follow up question was, are you maternal fetal medicine and the answer was no, I'm general obstetrics, gynecology.
THE COURT: All right.
THE WITNESS: Yes, that was my testimony.
BY MS. GOWAN:
Q. And it's rare, isn't it, that you make a different recommendation concerning the method of termination selected by the woman and her referring physician?
A. That is true.
Q. Now, during the 20 to 24 gestational age range at least 95

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percent of the terminations that you perform are by D&E,

correct?
A. That is correct.
Q. And the remainder are by medical induction abortion, right?
A. That is correct.
Q. And you mainly use mice O PROS toll for induction abortion?
A. That is correct.
Q. And you give the PHAOES PHAOES through vaginal sup OS tores pouredly until the woman delivers, is that right?
A. That is correct.
Q. In 90 percent of the cases where the fetus is dead prior to the start of the procedure the induction abortion interval with PHAOES PHAOES will 12 to 24 hours, correct?
A. That is correct.
Q. And in cases where the fetus is alive at the outset of the procedure, the lower limit of the induction abortion interval will be within 12 to 24 hours with the upper limitless predictable isn't that right, Doctor?
A. That is correct.
Q. You have seen a fetus born alive after induction abortion in the second trimester, haven't you?
A. I'm sorry, can I just -- you said after induction abortion in the second trimester? Am I correct?
Q. Yes. Doctor.
A. Yes, I have.



Q. And you have observed signs of life in the fetus, didn't you?
A. That is correct.
Q. You have seen spontaneous respiratory activity, right?
A. Yes.
Q. HAR beat?
A. Yes.
Q. Spontaneous movements?
A. Yes.
Q. And you have seen these signs at 24 weeks, right?
A. That is correct.
Q. 23 weeks?
A. Yes.
Q. 22 weeks?
A. Yes.
Q. The word "disarticulation" in connection with D&E means the tearing of the fetus' body as you understand it, correct?
A. That is correct.
Q. And that tearing occurs more easily at 20 do 24 weeks, correct?
MS. CHAITEN: Objection, your Honor.
THE COURT: More easily than what?
BY MS. GOWAN:
Q. Than no.
MS. CHAITEN: Objection, your Honor. I'm still



confused by the question.

BY MS. GOWAN:
Q. Doctor, the nature of the tissue of the fetus at 20 weeks is is that it will tear more easily than not, isn't that right?
A. Are you asking does it tear more easily than earlier in pregnancy or --
Q. No, than later?
MS. CHAITEN: Objection.
THE COURT: Than later than 24 weeks?
MS. GOWAN: Yes.
THE COURT: Oh, all right.
THE WITNESS: Can I just hear the question again because I am confused.
THE COURT: Ms. Reporter do you want to read the question, please?

(record read)
THE WITNESS: The fetal tissue tears more easily in gestation than later in gestation.
BY MS. GOWAN:
Q. What about at 20 weeks, does the tissue of the fetus tear more easily at 20 weeks than at 24 weeks?
A. That is correct.
Q. And then the D&E by dismemberment you routinely count all



the fetal parts after the procedure is over, right?
A. We don't count all of the fetal parts, no.
Q. Doctor, don't you make an effort when you perform D&E by dismemberment to count the fetal parts after the procedure is over?
A. No. We look for sentinel parts. We look for certain things as well as the total amount to get an idea in conjunction with the feeling that we have based on the uterine feel to tell whether we have performed a complete evacuation. one of these procedures, no.
Q. Well you make an effort to count the four extremities and the head, don't you?
A. That we do, yes.
THE COURT: What are sent I knell parts?
THE WITNESS: I am usually speaking with sent I knell parts about four extremities and calvarium. I'm not trying to be eHRAOUSive but some of our fetuses don't have these so we are basically trying to look and make sure that we have accounted for the majority of the fetus looking for major parts. But we don't count every single thing that we have extracted.
BY MS. GOWAN:
Q. You don't put the TPHEURB in information in your operative note because it is assumed that if have you completed a D&E you



have counted the extremities and the head, isn't that right?
A. That is correct.

Q. But if you haven't been able to retrieve all of the four extremities or what appears to be all of the fetal head, you will often put in your operative note the fact that you did an ultra sound after the procedure to confirm that you took that extra measure to confirm evacuation, right?
A. That is correct.
Q. Now, at 20 to 24 weeks you typically place between two to three sets of laminaria prior to D&E, correct?
A. That is correct.
Q. And for a late second trimester abortion you will place up to 15 laminaria and you have seen cases where there have been 20 sticks of laminaria in place, right?
A. That is correct.
Q. And you place that laminaria typically 24 hours before the procedure starts, right?
A. That is correct.
Q. And laminaria can hurt, can't it?
A. Can hurt in the sense of cause pain as they are inserted?
Q. Yes.
A. Yes, they can.
Q. And you warn your patients to expect uterine cramping from the laminaria, don't you?
A. Yes, we do.



Q. Sometimes you use miss O PROS toll in a patient who has a tight cervix during the placement of a third set of laminaria the morning of the woman's procedure, right?
A. That is correct.
Q. And that's to facilitate the extraction, isn't that right?
A. It's -- well in the sense that it's to further help prepare the cervix which will facilitate extraction, it is to facilitate extraction.
Q. Now you think it would be desirable to dilate a woman's cervix to the point where you could simply reach inside her and take the fetus outside of her body and lay it on a bed, don't you, Doctor?
A. Yes, I would like to do this as intact as possible.
Q. You would like to do exactly what I described, isn't that right, Doctor?
A. Please repeat the question.
Could I hear it again just to make sure that I'm answering correctly?
THE COURT: Read the question, please, Ms. Reporter.

THE WITNESS: Yes.
BY MS. GOWAN:
Q. But you don't do that because in most cases you do not achieve a cervical dilation you would need to do that, isn't that right?



A. That is correct.
Q. And in your opinion to achieve such dilation would be

unnecessary to effect a safe D&E, isn't that right, Doctor?
A. That is correct.
Q. Now, you have reached inside a woman and pulled a dead fetus out of her uterus up to the point where the head becomes stuck in the internal cervical os, right?
A. That is correct.
Q. And in those circumstances you have reached into the woman with an extraction forceps, reached in above her cervix and grasp -PD the fetus' head and by compression exTRABGTD it, right?
A. That is correct.
Q. You have also had the occasion, when performing a D&E at 20 to 24 weeks, to reach inside a woman her instruments and pull out a live fetus up to the point where the fetus' head gets stuck in the internal cervical os, correct?
A. That is correct.
Q. And when you do that that's not an accident, is it?
A. If you're -- I want to make sure I understand.
As I testified, every action I do is deliberate and intentional so it's not an accident that I have achieved the extraction to that point. It's not predictable either because I never know aprayer or reif I am going to be able to achieve that intact a delivery.



Q. Was it an accident when you have done that, was it?
A. Well it's not predictable so in that sense it is an accident that I have been able to. It's still a deliberate and intentional act that I want to have occur so it's something I have been attempting to do.
Q. And you will do so if you can, right, Doctor?
A. Yes, that is correct.
Q. And you do that at least three times a month in your practice, don't you?
A. That is correct.
Q. Now, after you have done your cervical preparation and you are in the operating room and you have assessed the degree of dilation of the woman, the next step is for you to put a suction curette into the uterus and suction out as much of the amniotic fluid as possible, right?
A. That's correct.
Q. And in the majority of the cases the umbilical cord will come out with the aspiration of the amniotic fluid, right?
A. That does happen in many cases, yes.
Q. In the majority of cases, doesn't it?
A. In a large number I may have at some point said majority of cases in my testimony. It happens frequently.
Q. And you cut the cord with a scissors at that point, don't you?
A. Usually, yes.



Q. And cutting the cord causes the fetal death, correct?
A. Eventually, yes.

Q. Now you would agree, wouldn't you, Doctor, that there is simply nothing inherent to the surgical instruments used in D&E that increases the likelihood of perforation of the uterus?
A. That is correct.
Q. In and your view is that any STRAOUFPLT that the Doctor puts inside the uterus, in theory, carries with it some probability that it could perforate the uterus, scrape the cervix and cause maternal trauma, right?
A. That is correct.
Q. And would you agree, wouldn't you, Doctor, that laceration of the uterus with forceps is a very uncommon outcome of D&E?
A. I'm sorry, did you say laceration of the cervix or of uterus? I want to make sewer I am anxiousing correctly.
Q. Uterus.
A. Laceration of the uterus? I'm sorry we think of uterine perforation and cervical laceration, which is what I am getting confuse sod I want to know if are you talking about perforation of the uterus or laceration of the cervix TPAOEUFPLT what's the difference between a perforation and a laceration.
THE WITNESS: Well perforation to me just implies that there is a hole through the uterus and HRASZ ration is a cut.
It's very hard to get a laceration outside of when you are doing other kinds of surgery. If you are doing this



operation most lacerations would be perforations.
BY MS. GOWAN:
Q. It's very uncommon, isn't it, to PEFR rate the uterus in connection with D&E?
A. Yes, that is correct.
Q. And the forceps that you insert into the woman are smooth on the outside, aren't they, Doctor?
A. That is correct.
Q. And there isn't any scientific data to support your theory that more passes of instruments increase maternal risk, is there, Doctor?
A. No.
Q. And you don't even keep track of the number of passes that you make with instruments in any given procedure in the woman's medical record, do you?
A. That is correct, we do not.
Q. You couldn't even tell me how many passes with instruments fetus from a woman's uterus up to the point where the fetal head was stuck in the internal cervical os, could you, Doctor?
A. No, I could not.
Q. Its entirely possible that you could use more than one instrument pass to bring a live intact fetus out of the woman's uterus up to the point where its head gets stuck in the cervical os, correct?



A. That is correct.
Q. You could grasp a presenting part then realize that you have the fetus in an intact position. You could let go,

regrasp higher on the fetus, right?
A. That is correct.
Q. You could grasp the presenting part, realize that you have a potential intact extraction, that you are not using the best instrument, take it out, use another instrument, right?
A. We typically would not do that.
Once you have control of a presenting part you leave the instrument on, retaining traction so you don't lose control of it and then would regrasp with the other instrument while it is completely visualized.
Q. Or you could make a decision that it would be better to use your hand, right?
A. That's correct.
Q. You could use a combination of your hand and your instrument; not really grasping but helping and assisting the delivery of the infant to the point its head gets stuck, right?
A. That is correct.
Q. Sometimes you place an instrument in the uterus, grasp a lower extremity, deliver it into the vagina, take the instrument off, grasp the lower extremity with your right hand, feel with the fingers of your left hand beyond the external os to the opposing extremity, deliver that extremity to get a



better grasp on the fetus and then continue the delivery, correct?
A. That is correct.
Q. And when you do this it's not unlike procedures that you do during term deliveries to the extent that you perform a breech delivery or other procedure where this is necessary on an infant, isn't that right, Doctor?
A. Yes, that's correct.
Q. And when you do this you also have another Doctor in the room who is pressing on the woman's abdomen or giving fundal pressure to help effect delivery, right, Doctor?
A. Are you talking about term deliveries or are you talking about the D&E procedures?
Q. Talking about the D&E procedure?
A. I sometimes do that, that is correct.
Q. And then you give traction and try to rotate the fetus so that the stomach is face down and the back is facing up to give you greater control and eventually lead you to the um bill I cuss, correct, Doctor?
A. The -- we do those maneuvers but to eventually allow us to extract further but that in general the KWRFD rotating the fetus an getting greater control is correct, yes.
Q. That helps you then grasp the fetus with one finger on the other side of the fetal neck, right?
A. That is correct.



Q. And then your assistant will grasp the tenaculum that's on the lower lip of the cervix and exert gentle traction to raise the interior lip of the cervix so you can put an instrument

into the cervix around the fetal head to compress it and then deliver the fetus, right?
A. No there was one error.
The assistant is holding a tenaculum that's on the anterior not the posterior of the cervix.
So usually the assistant is holding that, lifting up on this,.
The remainder of what you described is correct.
Q. And the fact that they're holding on to the anterior lip of the cervix is what permits you to insert the forceps in to compress the head and then deliver the fetus, right?
A. It gives me better visualization. I could do it without the assistant if I needed to. And sometimes we do it by feel not relying on what we are seeing.
Q. And when you compress the skull you are trying to reduce its size so that it can fit through the cervix, right?
A. That is correct.
Q. You are trying to remove the skull in pieces so that the liquid brain will empty from the cranium, right?
A. No. We are trying to remove the skull in one felled swoop with these procedures.
We are trying to make a hole in the posterior surface



of the calvarium so that it can gradually decompress and we can take the fetus out intact, that's part of the point of these procedures.
It is relatively rare we take the skulls out in pieces but we are much more likely to do so with a addition articulated or dismembered D&E than the circumstances you are describing.
Q. Has it, in the circumstances that we have just been discussing, occurred sometimes that the head has been broken into pieces?
A. Oh, I'm sure it's happened at some point.
Q. Some of those fragments could cause lacerations, correct?
A. That's a possibility.
Q. Now, if you compared the risks associated with the puncturing of the fetal skull with the risks associated with another pass of instruments, your opinion is that neither one poses a significant maternal risk, isn't it?
A. I think the risk with each is very low; that's correct.
Q. It's merely that you wish to have the control. You wish to have the ability to make a decision in those individual cases which of the two you need since neither constitutes a significant maternal risk, right, Doctor?
A. No, I want to have the control because.
MS. CHAITEN: Objection.
THE COURT: Wait a second, there is an objection.



MS. CHAITEN: Objection. I'm not sure what she is referring to when she says which of the two.
BY MS. GOWAN:

Q. Another pass or puncture of the fetal skull.
THE WITNESS: I'm sorry, can I just rehear the question?
THE COURT: Ms. Reporter would you repeat the question?
MS. CHAITEN: Your Honor I object still I if I think the question is quit con few.
THE COURT: Overrule.
A. No I wish to be ache to make decision about what is lower risk to the patient. Because Bowes are though that's not the same as being equal.
THE COURT: All right, is this a convenient time to break for lunch?
MS. GOWAN: Yes, your Honor.
THE COURT: Before we do, one question, Doctor.
Have you ever been sued for malpractice involving an abortion you performed?
THE WITNESS: No, not involving an abortion, no, sir.
THE COURT: Have you ever been sued for malpractice?
THE WITNESS: Yes, with respect to an obstetrical case I was sued but not with regard to an abortion procedure.
THE COURT: I didn't catch the record.



THE WITNESS: I'm sorry I said with respect to an obstetrical case a shoulder disassociate case in which a baby was stuck during normal childbirth that esilently resulted in a lawsuit but I have never been sued with respect to one of my abortion procedures.
THE COURT: All right, thank you.
We will take our recess now and reconvene at 2:00.
(luncheon recess) TWM 4/1/4.
AFTERNOON SESSION
2:00 p.m.
CASSING HAMMOND, resumed.

THE COURT: Good afternoon.
CROSS-EXAMINATION S-

BY MS. GOWAN:
Q. Before the break, Doctor, we were talking about the comparison between the risk associated with puncturing the fetal skull and the risk associated with another pass of the instrument. I understand that it is your opinion that neither one of those poises a significant maternal risk, right?
A. That is correct.
Q. Is it fair to say that you want to be the decision-maker, you want to be the one to have the ability to decide whether you should make another pass with an instrument in connection



with performing D&E or whether you should be able to puncture the fetus's skull?
A. I want to do what is safest for my patient.

Q. Is that a yes or a no, Doctor?
A. I think it is a yes.
THE COURT: There isn't any question, is there? Let's not pussyfoot.
Q. Counsel asked you to assume, in connection with your review of Congress's finding on cervical incompetence, she asked you to assume that the finding related to intact D&E, and you testified that there was data that would support that in fact there was no evidence of cervical incompetence in connection with intact D&E. What data were you referring to?
A. I was referring to the article by Schneider, et al., from the mid nineties, Schneider and Caspi, I think, CASPI, are two of the authors, that has looked at the dilatation of the internal os, or opening of the cervix, after second trimester and first trimester abortions, and has also looked at obstetrical outcome after second trimester abortions.
Q. That article and the data underlying that article does not deal specifically with intact D&E, does it?
A. It deals with D&E. It is correct they don't specify intact
Q. And you are not aware of any specific data that does break out or address the safety of instrumental or digital fetal



conversion in connection with the performance of intact D&E, right?
A. I believe that is a part of every D&E, so I believe that it is covered by any studies of D&E.
Q. You are not aware of any that specifically breaks it out, as you have assumed -- you assumed in your response to counsel's question the fact of intact D&E. So I am merely asking you to assume intact D&E and whether there is any specific data that breaks that out in connection with addressing safety of instrumental or digital fetal conversion.
A. I know of no data that specifically breaks out instrumental conversion with respect to intact D&E.
Q. Occasionally when you perform D&E you convert a fetus to the breech position, don't you?
A. When I perform a D&E, that's correct, yes.
Q. You have testified that you think intact D&E offers advantages because less passes with instruments present fewer chances of perforation of the uterus, less procedure time, and less blood loss, right?
A. That is correct.
Q. In your opinion, uterine perforation is so uncommon that it cannot even be used as an end point for a study, isn't that right?
A. I believe it can be used as an in point for a study, but it would be difficult because you have so many case to say chief



statistical power, that it would be a very lengthy and difficult study to perform. [> in point I guess is correct<] [> end point is correct<]
THE COURT: While we are waiting, Doctor, why don't

you define an end point study.
THE WITNESS: The end point would be a criteria or SRAEURBL that represents outcome. So in evaluating D&E, examples of end points could be reiterated uterine perforation, could be rate of hemorrhage typically is defined by the number of patients who require blood transfusion. The number of patients who have clinically significant infactions which they might define based on a temperature that a patient develops, and so forth. S-
Q. Isn't it true, though, Doctor, that in studies of D&E that have been done, uterine perforation is usually not used as an end point, because it is so uncommon?
A. That is correct.
Q. When you refer to ***[STRIKE]***.
Q. It is also your opinion, is it not, that secondary outcome variables such as blood loss or operating room time, aren't meaningful in any way to operators themselves?
A. I am hard-pressed to say that blood loss is not meaningful to operators. It may not be as significant in some studies as an end point as, say, the rate of uterine perforation. But I think it is important to people who do the operations.



Q. When you refer to blood loss, you are referring to blood lost when the placenta is removed, correct?
A. It is at any point during the course of the procedure if we are discussing D&E.
Q. That is from the placenta being removed after the fetus has been extracted or the placenta coming off during the course of the procedure, isn't that right?
A. That is usually responsible for the majority of blood loss.
Q. It is not bleeding cautioned by lacerations or tears made by instruments, right?
A. It could be. If there is a tear that has occurred during the course of the procedure, that is part of the blood loss of the procedure.
Q. Wouldn't you agree that it would be rare that there would be blood loss from a laceration or a tear?
A. No.
Q. Directly your attention to page 223/line 7 of your deposition in this case:
"Q. What you mentioned here is not bleeding caused by laceration or tears, is that right?
"A. It is possible that a laceration or tear could cause bleeding during the procedure also. It is rare that that happens, but it is a conceivable risk."
Were you asked that question and did you give that answer at your deposition in this case?



A. Yes, I did.
Q. Would you agree that excessive bleeding during or after surgical abortion occurs in less than 1 percent of the cases?
A. KWROEULD.

Q. As a risk factor of infection, antibiotics are given prove HRABGT KAEL in connection with all D&E at Northwestern in first trimester and second trimester abortion, right?
A. That is correct.
Q. Wouldn't you agree that if at Northwestern antibiotics are taken prophylactically, that the risk of infection to a woman is 1 percent or less in connection with surgical D&E?
A. Yes, I agree that it is likely less than 1 percent in our patients who take the antibiotics.
Q. That would be regardless of the number of instrument passes, correct?
A. Yes.
Q. In the majority of induction labor abortions, the physician attempts to have the placenta delivered spontaneously, much as you would after a term delivery of a KHRAOEULD without instrumental delivery, correct?
A. That is correct.
Q. I know you testified previously about the two-hour interval between the delivery and induction abortion and the expelling of the placenta that is often provided. You are aware that today some medical institutions wait two hours for delivery of



the placenta after the fetus is expelled in an induction abortion?
A. Yes, there are some places where that occurs.
Q. One of those, are you aware, is where your coplaintiff Dr. Johnson practices, at the University of Michigan?
A. I was not aware that that was the case at the University of Michigan. But it may well be so.
Q. Whether there is spontaneous delivery of the placenta also varies with the induction agent that is used, isn't that right?
A. I believe that is the case.
Q. I think you mentioned earlier today dine oh PROS tone?
A. That is correct.
Q. S- most of the available data on the time frame relates to die no PROS tone or toe sun, is that correct?
A. That's correct.
Q. That is dated from the 1980s, STPHAEUT?
A. The seventies as well as the eighties, that is correct.
Q. There isn't much data yet with regard misoprostol in induction abortion, is there?
A. With regard to retained placenta?
Q. Correct.
A. No, there is not.
Q. In a D&E by disarticulation and in an intact D&E, there is always surgical instrumental removal of the placenta, is th correct?
A. That is correct.



Q. You would agree, wouldn't you, Doctor, that there isn't any data substantiating that D&E is safer than abortion by medical induction at 20 to 24 weeks?
A. I agree that the risks are similar between 20 and 24 weeks.

There is some data suggesting a slight preference of D&E, but there is also data suggesting a slight preference for medical induction. So it is unclear between 20 and 24 weeks, particularly or every practitioner, which is the safer method of terminating pregnancies [> for every?<]
Q. You assume in your hands, meaning in your practice, that D&E between 20 and 24 weeks is only at least as safe as
A. I assume that it is at least as safe and probably safer.
Q. Directing your attention to page 196/line 19 of your deposition in this case. We are talking about comparing D&E and labor induction.
"Q. When you say we must assume, are you saying you, Dr. Hammond, assumes or are you saying that the medical profession at large assumes that and it's written somewhere?
"A. I am saying that we, the medical profession, and particularly those of us who practice in institutions that have competent trained providers of second trimester abortion have to assume that in skilled hands this procedure is at least as safe.
"Q. And you certainly assume that, right?

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"A. About myself or about --
"Q. Yes, yes.
"A. I assume that D&E between 20 and 24 weeks in my hands is at least as safe as inducing labor."
Were you asked those questions and did you give those answers at your deposition in this case?
A. Yes, I did.
Q. You testified today about various maternal conditions in which you believe that intact D&E would offer advantages. You talked about bleeding disorders and low blood platelets, correct?
A. That is correct.
Q. When you were testifying about that, did you have in mind the woman with the leukemia and the low blood platelets that you had referenced in your declaration in this case?
A. It could be a number of patients. That would be one example of a patient for whom this might apply. I can't say that I was saying it with reference to any one particular case.
Q. With respect to that particular case which you previously put forward in this case, you don't remember at all whether this patient had a D&E abortion in which the fetus was extracted intact up to the neck with the head remaining lodged in the internal cervical os, do you?
A. No. We don't report the degree of intactness, so no, I do not remember. I don't.
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Q. You don't have a recollection of it at all, right?
A. No.
Q. You also testified today about health syndrome, preeclampsia, and where that might be a condition where it would be important to be able to offer a woman intact D&E. Were you thinking then, too, about the woman with he will'

syndrome that you put forward in your TRO declaration in this case?
A. In terms of? I'm sorry. Could I hear the question again? Are you asking with respect to bleeding disorders, was I thinking of that TAS a patient in whom because of the risk of bleeding?
Q. You were testifying generally today about preeclampsia in women with help syndrome S-. And previously in this case you had put forward a specific example about a woman with help syndrome and preeclampsia. So my question to you was today, when you were testifying generally, did you have in mind that particular case that you had previously put forward in this litigation?
A. Did I have in mind this case with respect to the need to do an intact procedure?
Q. Yes.
A. Or a D&E in general? I just don't understandure what you are asking.
Q. Yes. You were talking about the need to do an intact



procedure, weren't you? Or were you just talking generally this morning?
A. I talked about it so much, I don't know which context you are referring to. If you are asking with respect to the advisability of doing a D&E as intact as possible in a patient who has help syndrome, yes, I believe that it is advisable to do it as intact as possible.
Q. Doctor, that is not my question. This morning you were speaking very generally about conditions in which you thought that it would be important to offer a woman intact D&E. One of those conditions was help syndrome and preeclampsia. Previously in this case you have put forward evidence about a specific patient that you have treated with those exact conditions. My question to you was simply today, when you were speaking generally and telling the judge about this condition, did you have that patient in mind?
A. No. She would by one of many patients that I might have in mind who I have done D&E's for who had preeclampsia or any number of its variants. But she could be one of those patients.
Q. With respect to that particular patient, you don't have any recollection whatsoever as to whether you performed the intact D&E procedure, correct?
A. I do not recall the degree of intactness of of that procedure, that is correct.



Q. You don't routinely note in the patient's medical chart whether you have performed an intact extraction, do you?
A. That is correct.
Q. And you don't necessarily track at your institution or in your practice who has intact extractions, isn't that right, Doctor?

A. That is correct.
Q. You also testified today generally that it would be important to do an intact D&E in cases where there was a woman with valve ular heart disease. When you were testifying generally about that today, were you thinking about the specific condition the patient that you put in issue in this case in your declaration [> valve lar<]
A. I don't recall a specific patient that I put at issue in my declaration with valve lar heart disease. I think I was thinking generally about patients either with valve lar heart disease or who have cardiomy oh pathies.
Q. You have only PEFRPD one or two abortions in cases where there was a woman when had val ular heart disease, isn't that right, Doctor?
A. Val ular heart disease specifically and distinct from ard yo myopathy, yes, that is true.
Q. And you don't have any recollection at all if you have ever performed D&E by extraction of the fetus intact up to the point where the he did is lodged in the internal receive cal os when



val ular heart disease was the maternal condition at issue in those one or two abortions that you performed, isn't that right?
A. That is correct.
Q. You also testified this morning about chorioamnionitis, performing abortions for patients with KOEURPLTS, and that it was important in your view to offer these patients the intact extraction. Were you referring, when he were speaking generally there, to the patients that you put at issue previously in this litigation through your deposition?
A. I was again speaking generally to the number of patients that I have treatmentd with KPOEURPLTS and not to a specific case S- S-
Q. You don't have any specific recollection to have ever performed D&E by extraction of the fetus intact up to the point where the head is lodged in internal cervical os where the condition KOEURPLTS was present in a woman, do you, Doctor?
A. I'm sure at some point, given the volume that I have, but I can't specifically remember one specific case.
Q. Correct. You don't recall at all, do you?
A. Well, as I said, I don't remember one specific case with the exact degree of intactness that you describe.
Q. You also testified today about premature rupture of membranes and why you believe that intact D&E would be better in those circumstances. But similarly, you don't have any



recollection of having performed an abortion in the 20-week to 24-week gestational age for a woman with premature rupt of membranes in which you extracted the fetus intact up to the point where the fetus's head is lodged on the other side of the internal cervical os, do you, Doctor?
A. Again, as I mentioned, I am sure that this has happened,

but I can't recall one particular case.
Q. Where did you first asked Northwestern university for access to your patient medical records in order to respond to the government's discovery in this case?
A. It was almost immediately after I received the, and forgive me if I use incorrect terms, the STKOEUFR ask discovery request. After I received it, I told my attorneys the problem that I had, which is that I do not have any records myself. They are all owned by the hospital. Then the hospital as well as the university became involved.
Q. Did you speak with anybody at Northwestern yourself?
A. I spoke with the attorney for the faculty foundation. Again, if I seem confused, keep in mind Northwestern applies to three STKEUBGT entities: A university, a hospital, and a faculty foundation. So I am wanting to make sure that I am clear.
Q. Who did you speak with?
A. I spoke to the general counsel of the faculty foundation that I had received this and this litigation was on going,



because I thought at this point she should know.
Q. What was her name?
A. Her name is deny crew sus.
Q. What did you say to her?
MS. CHAITEN: Excuse me, your Honor. I need to object reason privilege grounds. His communications with his attorney for the employer on this subject are privileged communications and I have been asked by the Northwestern medical faculty foundation to protect that PREUFG on its behalf. S- S-
THE COURT: What privilege does he have with that attorney?
MS. CHAITEN: Your Honor, they had attorney-client communications in connection with the issue RAOEGT to the records, his communications with regard to the Northwestern medical faculty foundation's attorney, his his employer's attorney on an issue relating to his employer.
THE COURT: Are you suggesting that there is a privilege vis-a-vis this witness and that lawyer?
MS. CHAITEN: What I am suggesting is that I have been asked by the Northwestern medical faculty foundation's attorney to assert their privilege in connection with those communications.
THE COURT: I can see the attorney and the foundation, fine. Delight to do hear it. But how does that control this witness and his conversations?



MS. CHAITEN: He is their employee, your Honor, and she is counsel --
THE COURT: Overruled.
A. Could I hear the question again.
Q. What did you say to her?
A. I told her that we had received this discovery request

specifically to Ms. PRAOU sis S-. I was concerned because the request included requests for information about our students and our residents. I had concerns about revealing information about them that they might consider confidential and really didn't know if this was something that I had the authority to turn over, particularly since both the residents and the students are, for lack of a better term -- and again this may not be the right legal term -- affiliates or subordinates of the university in this case.
Q. Are you saying that the requests for medical records sought information relating to residents and students? Winning the discovery request included things other than just medical records. So that is why I contacted deny PRAOU sis because she is the attorney, she is the general counsel of my employer and also the person who is going to represent the university in this kind of a situation. So I let her know that this was ongoing and I was concerned.
Q. What discussion did you have with her about access to the medical records for purposes of responding to the government's



discovery?
A. To be honest, at this point it was clear that the biggest issue with regard to medical records would be a hospital issue, a Northwestern Memorial Hospital issue. I didn't really know who to get involved TPHRLS has been this issue. Deny PRAOU sis is the attorney for the faculty foundation. I don't remember if she contacted the hospital or if my attorneys contacted the hospital S- S- or how the hospital at that point became involved. But the hospital later is --
THE COURT: When you say your attorneys, who are your attorneys?
THE WITNESS: I'm sorry. The attorneys for the ACLU in this case is what I was referring to as my attorneys on this case.
Q. Did you ever contact anyone at the hospital yourself about access to the medical records?
A. I eventually spoke with an attorney from the hospital. I do not recall her name off the top of my head, although I can get that information for the Court-who was involved with the hospital legal department in sorting this issue out.
Q. Do you know when your attorneys from the ACLU spoke with the hospital about your accessing the records in order to respond to the government's discovery?
A. I think it was sometime in late December, is my recollection. I don't recall the specific date.



Q. Did your attorneys tell you what the hospital said?
MS. CHAITEN: Objection, your Honor.
THE COURT: Sounds like a stage whisper from stage left.
MS. CHAITEN: Sorry about that. I tripped on my chair.

THE COURT: I don't think it was the chair \that{.}\{.}that reminds me of my mother's church whisper.
What is your objection?
MS. CHAITEN: Privilege, your Honor. Dr. Hammond's communications with his counsel in this case are privileged communications.
THE COURT: All right. I think that is valid.
MS. GOWAN: May I respond, your Honor?
THE COURT: Yes.
MS. GOWAN: The fact that a communication took place is not privileged. A yes or no answer could be made to that question without impinging on the privilege.
THE COURT: I thought your question asked what did they tell you. You just asked him whether they told him?
MS. GOWAN: That was my first question. My next question would be what did they say. I don't think what Northwestern said to the ACLU is privileged, number one. Then, to the extent that what Northwestern said is communicated to Dr. Hammond through his lawyers does not cloak the



communication between Northwestern and the acinclude privilege.
THE COURT: I that is probably a valid point. It is not any advice that you all gave him. If it is a statement made by the hospital that was then relayed to you, I think you can state it.
MS. CHAITEN: Your Honor, the communications between Dr. Hammond and plaintiffs' counsel in this case, to the extent that they reported communications with Northwestern Memorial Hospital, were in the context of advising him in terms of his --
THE COURT: You are trying to KAFPB me now. That isn't going to fly. Go ahead, answer the question.
A. Could I hear the question again.
Q. Did your lawyers at the ACLU tell you what Northwestern had said about your access to the medical records?
A. About what? Northwestern Memorial Hospital had said?
Q. Yes. [> about what Northwestern<]
A. I apologize, but I need to think about this, because I don't remember all of the specific things that are occurring at at that time. [> that were<]
THE COURT: It is not very complicated, Doctor. Do you remember?
A. I'm not certain I remember exactly. I remember that my attorneys had said that the hospital was then involved and that I would -- they told me, my attorneys again being the ACLU in



this case, had told me that there would be --
MS. CHAITEN: Objection, your Honor. I really have to ask the Court allow this witness not to testify about communications between him and counsel. I understand that the Court has ruled in connection with a factual report about the specific things that were --

THE COURT: Stop telegraphing him. I warned your side about this through Mr. Hut two days ago. You pull it again and I'll take appropriate steps.

You may testify as to what they told you Northwestern Hospital told you.

But don't pull that again.

A. I was told that there was a member of the legal department who I could contact subsequently about the records issue, and that was the attorney who I alluded to earlier whose name I simply don't recollect at this point, who I think from that point forward was dealing with the issue for the hospital.

Q. Did you ever contact that attorney?

A. I spoke with that attorney. As I recall, initially there was confusion about where this should would lead. One of the big issues was HIPAA, for example, and how we could respond to this discovery request while respecting the confidentiality of patients at Northwestern Memorial Hospital. They did not know where this would lead. Eventually, the records were made available so that I could prepare to respond to this discovery



request.

Q. Did you have conversations with Mr. Gal land S-

A. There was a meeting where he was present and deny PRAOU sis was present. I do not remember other people who were present at that meeting. There was actually an administrator from our department also so that in part I could explain what was going on with this legislation, and so forth.

Q. Did you participate in the decision-making about what was going to happen with regard to access to the medical records?

A. Not really. My involvement with this process was to be prepared to respond in an appropriate manner. Once it had been decided what legally I could do. SP-P.

Q. Why did you discuss the legislation at the meeting about what to do with access to the medical records for purposes of responding to the discovery?

A. At this point in time some members of my department weren't aware that I was a plaintiff in this matter. We discussed it to the extent that I explained that this was a challenge to the partial-birth abortion Act of 2003. We did not go into detail regarding the legislation but explained why I was concerned and that I had taken this action. That's my answer.

Q. Did there come a time when you were provided access to your patient medical records?

A. Yes, there was.

Q. When was that?



A. It was also in late December and early January.

Q. How did you go about determining what records to look at?

A. We had been served with a discovery request, and I didn't know exactly at first how the hospital codes this information. Again, one of my biggest concerns was I didn't know how the hospital -- whether they would code first trimester abortion

and second trimester abortion separately. I didn't know whether there would be other medical diagnoses which they could easily bring forth, or whether they would simply have to pull every pregnancy termination that I had done let's say over the past six years, since there were several years discovered in the discovery request.

Eventually, I was told through I believe, and I'm not certain of this but I think it was the hospital attorney, that there was a person within the department of medical records at the hospital who would be, so to speak, my point person on this issue, and that I was to let her know the type of records that I was looking for, and she would pull any records that looked like they might fit under that rubric.

Q. What did you tell her you were looking for?

A. I told herl I shared with them the kinds of records that you had looked for in the discovery request. As I recall, they ended up pulling the vast majority of D&E's that I had done for, and I may have my dates incorrect, but I think a lot of the procedures you were looking for was 2001 to 2003. It could



have been 2000. That they pulled a PHAOPBLGT of all of my procedures in the first and second trimester during those years. So what I had to do was to go back through and identify any of the charts that might correspond with the discovery request.

Q. How many charts in all did you review?

A. I'm not certain of an exact number. I would guesstimate approximately 400 charts.

Q. How many charts did you find that were responsive to the government's discovery requests?

A. Again, I don't know what the exact number was, but it was approximately 40 charts, I would say.

Q. To which requests were those records responsive?

A. Again, I can't tell you the exact requests. However, there were KW-TS for information regarding patients who had had D&E's for specific indications during a certain calendar year at certain gestational ages. What I tried to do was to go through and glean which charts corresponded with those diagnoses.

Q. Did you see any chart that was responsive to government request number 6, identify the patient medical record number for those abortions that you have performed or supervised within the year 2003 because the patient was, quote, suffering from severe ohly go hydromy nas closed quote as stated at paragraph 5 of your declaration in this case?

A. As I recall, I did find some charts relevant to that. I



don't know how many. And the other problem I had in responding to the request was distinguishing. We may not have somebody, for example, where the express reason for the chart was ohly go high TKRAPL any os, and yet we may have had a patient with PPROM who had no fluid around the baby which in essence is ohly go high TKRAEUZ, so there is THO some overlap here. If I

thought the charts would apply, basically what I did was to note those so that eventually, as the issue got sorted out, the hospital could respond to the subpoena.
Q. Did you find any document in response to interrogatory number 7, identify the patient medical record number for the abortion that you performed or supervised for the patient who had leukemia as stated in paragraph 6 of your declaration in this case?
A. Actually, this is one that the hospital still had not been able to find. They were looking for it and had not been able to encounter this at the time that we started to receive other rulings in Chicago.
Q. Did you find the record responsive to government request number 8, identify the patient medical record number for the abortion that you performed or supervised for the patient who had, quote, renal failure and help syndrome closed quote as stated in paragraph 6 of your declaration in this case?
A. That had not yet been identified.
Q. Did you find the patient medical records in response to



item number 9 for the abortions that you performed or supervised within the year 2003 for patient who were 16 or more weeks LMP who had, quote, breast cancer and chose an abortion because continued pregnancy might worsen their prognosis and delay appropriate treatment of cancer, closed quote, and stated in paragraph 6 for of your declaration in this case?
A. I really don't recall how many charts we received in each of those categories. I did this in late December and early January. My recollection is that our breast cancer patients who were in the specific years that you had requested had been earlier in gestation than you had requested. But I simply don't remember this, because, to be honest, I did this as rapidly as possible so that we would have the records to the repond.
Q. Would your answer be the same if I read the remaining government requests seeking particular medical records?
MS. CHAITEN: Objection, your Honor. It just groups a number of them together. How can the witness answer?
THE COURT: All right. We will do them one by one, Ms. Chaiten, if that is what you want. Fine.
Q. Government request number 10, identify the patient medical record number for the boringss that you performed or supervised within the year 2003 for patients who are 16 or more weeks LMP who had, quote, severe cardiac conditions, continued pregnancy would put them at risk of further heart fail u and even death,



closed quote, as stated in paragraph 6 of your declaration in this case?
A. I simply don't remember how many or what we had in that category at this point.
THE COURT: Did you find any, Doctor?
THE WITNESS: Your Honor, I found 40 --

THE COURT: Did you find them or not?
THE WITNESS: I don't remember for that category, honestly, your Honor. We found responses in the majority of the categories that people asked for.
THE COURT: This is only three months ago.
THE WITNESS: But I really don't remember.
THE WITNESS: I really don't remember. And it was confusing, because some of the requests, as she is noting, were actually relatively narrow gestational age ranges. So I had actually included some charts, if they asked for 20 weeks, that were like 19 weeks so that you could get a representative sample of what we are doing. But I really don't --
THE COURT: You were trying to respond to the requests, were you not?
THE WITNESS: Yes, I was.
THE COURT: So one would think you would have a recollection of who were you found responses to the specific requests.



THE WITNESS: There are some I remember. For example, with respect to PPROM and chorioamnionitis. PPROM overlapping with ohly go high TKRAPL any os. I remember that we have a large number of charts in those categories.
I also remember that we had a variety of fetal anomalies such as otoSOEPLal trisomeees. I don't remember if that was one of the specific requests. I believe it was. But I can't remember specifically about cardiac issues that you noted.
THE COURT: Go ahead, Ms. Gowan.
MS. GOWAN: Excuse me, your Honor I. lots my page. One second.
Q. You mentioned that you found some records relating to chorioamnionitis, which was the subject of request number 11: Identify the patient medical records for the abortions that you performed or supervised within the year 2003 for patients who are 16 or more weeks who have chorioamnionitis as stated in paragraph 6 of your declaration in this case. Did you find records responsive to that request?
A. Yes, as I recall I did.
Q. How many?
A. I don't recall the number.
Q. Did any of those records reflect that the abortion had been performed by the intact D&E version?
A. No. We don't note the degree of intactness in our records.



Q. Did any of those records reflect that the woman had experienced a complication as a result of the abortion that had been performed?
A. Not to my recollection, no.
Q. Did you identify any records in response to discovery request number 12: Identify the patient medical record number for the abortions that you performed or supervised within the

past two years for patients who are 16 or more weeks LMP who had, quote, life-threatening rejection of transplanted vital organs such as liver, closed quote, as stated in paragraph 6 of your declaration in this case?
A. I don't recall off the top of my head if we had it with the discovery request. I have had a case similar since then. I just don't remember. If we did, we did not have a large number of charts in that specific area.
Q. Did you have a record in response to request number 13: Identify the patient medical record numbers for the abortions that you performed or supervised within the past two years for patients who are 16 or more weeks LMP who had, quote, severe neurological disease, including brain tumors, closed quote, as stated in paragraph 6 of your declaration in this case?
A. Yes, we did find cases.
Q. How many?
A. I can't recall exactly. I think there were two, but I may be mistaken.



Q. Did either of those two records show that the intact D&E procedure had been performed?
A. Again, they would not have, because we don't track the
Q. Did either of those records show whether the woman had experienced a complication as a result of the performance of the procedure?
A. Not that I recall.
Q. Government Exhibit number 14: Identify the patient medical record number for the abortions that you performed or supervised within the past two years for patients who are 16 or more weeks LMP who had, quote, severe complications from diabetes, closed quote, as stated in paragraph 6 of your declaration in this case?
A. Yes, we did find our records that were germane to that request.
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BY MS. GOWAN:
Q. How many?
A. I can't recall the number.
Q. And did any of those records show that the abortion had been performed was an intact D&E?
A. Again, we don't track the degree of intactness so that would not have been demonstrated by the records.
Q. Did any of those records show whether the woman had



experienced complication as a result of the abortion?
A. Not to my recollection at this time.
Q. Government request number 15, identify the patient medical record numbers for the abortions that you performed or supervised within the past two years for patients who were 16 or more works LMP who had "SRAOEB row vascular disease' as stateed in paragraph 6 of your declaration in this case?
A. Yes, we did find records in that category.

Q. How many?
A. I don't recall the exact number.
Q. Did any of those records reflect whether the abortion had been performed by the intact D&E method?
A. No, we don't track the agreeing of intactness.
Q. Did any of those row TPHREBGTS whether the woman had expressed a complication as a result of the abortion?
A. Not that I recall at this time.
Q. Government request number 16, identify the patient medical record numbers for the abortions that you performed or supervised within the past two months for patients who are 16 or more works LMP and who experienced 'pregnancy loss or in layterms, miscarriage' and were fetal demise has already occurred as stateed in paragraph 7 of your declaration in this case?
A. Yes, we encountered, those. There are actually indicate a few of those.



Q. Do you remember how many there were?
A. I couldn't tell you exactly.
Q. And did any of those records show whether the intact D&E procedure had been performed?
A. Again, we don't know the degree of intactness and I don't recall that having been recorded.
Q. Did any of those records show whether the woman had experienced a complication as a result of the abortion?
A. Not that I recall.
Q. Did you uncover any records responsive to Government Exhibit 5, identify the patient medical record number for those abortions that you have performed or supervised within the year 2003 because the fetus had "an aself-ally and other severe neural tube defects" as stateed in paragraph 5 of your declaration in this case?
A. Yes, I did identify charts in that category.
Q. How many?
A. I can't recall the exact number. At least five or more. I was actually surprised by the number that were responsive.
Q. And did any of those records show whether the abortion had been performed by the intact D&E method?
A. Again, we do not note the degree of intactness so those charts, to my recollection, did not record that.
Q. Government Exhibit number 4, identify the patient medical record number for the abortion services that you have performed



or supervised within the year D&E "where if the pregnancy continued, the fetus would die before onset of labor or within the first year of life because of trisome O 134 or trisome I 18 <!0>" as stateed in paragraph 5 of your declaration in this case?
A. Yes, we identify charts in that category.
Q. How many?
A. I don't recall the exact number.

Q. Around again, is it true that there were no records identifying whether the intact D&E procedure had been performed?
A. Yes, that is correct.
Q. Did any of those records identify whether the woman had experienced the complication as a result of the performance of the procedure?
A. Not that I recall.
Q. Government Exhibit number 2, identify the patient medical record number for the abortion services that you have performed or supervised within the year 2003 for women who are 19 to 20 weeks LMP and who "must end pregnancies in order to preserve their health" as stated in paragraph 4 of your declaration in this case?
A. I simply do not recall if we had a chart in that category.
Q. Government request number three, identify the patient medical record number for the abortion services that you have



performed or supervised within the year 2003 for women who are 19 or 20 weeks LMP and when are "experiencing pregnancy loss, which in layterms is sometimes called miscarrying" as stated in paragraph 4 of your declaration in this case?
A. Again, this is an area where there was overlap so I would have included in this response the patients who had P P Rom because that is a type of pregnancy loss or considered by so many people so yes, we did have patience who fit in this category.
Q. Do you remember how many records?
A. I can't tell you the exact numbers of records, to.
Q. Those records did or did not reflect PWHR the intact D&E procedure had been performed?
A. That is correct, they did not.
Q. They did not.
Doctor, did you review any of these records prior to your deposition in this case on February 18, 2004?
A. Well, as I testified I reviewed all of these records very briefly simply to see whether they were responsive to the request and I had done all of them by mid-January or so. So, yes, all of them would have been reviewed before the time of the deposition.
Q. Did your review of those medical records inform, in any way, the answers that you gave to the questions that the government posed to you at your deposition in this case?



A. No, it did not.
Q. Did your review of those records inform, in any way, the answers that you have given to counsel's direct questioning of you today or my cross-examination of you today?
A. No, it did not.
Q. How about yesterday?
A. No, it did not.
Q. Do you have any copies of those records?

A. No, I have no copies of those records.
Q. Did you approach any of your patients and ask for WAEUFRPBZ or consent to release the records?
A. No, I did not.
Q. Did you approach any of your patients to discuss the issue of access to your records?
A. No, I did not.
Q. Did you ask any of your patients to ask Northwestern to give you permission to review their records?
A. No, TKEU not.
Q. The government receive aid letter from George Gowan, counsel for Northwestern University in which it was reported that you were unable to review records for a period because you were working on an expert report that you were required to produce for this litigation.
MS. CHAITEN: Objection, your Honor. I believe that misstates the letter but we don't have copies of it, counsel



hasn't made them available.
letter how do you know what it says, ma'am?
MS. CHAITEN: I saw the letter at some point in one of counsel's filings.
THE COURT: Why didn't you state it that way?
MS. GOWAN: Ms. Chaiten is a C C on the letter as is Ms. TA*L can a, camp, Ms. TKAFB TKAFB TKAFB, TRAOES lick to and Nancy maldon add O esquire.
THE COURT: Is that true.
MS. CHAITEN: I am a C C on the letter.
THE COURT: Is that true.
MS. CHAITEN: Yes, it's true.
THE COURT: Then why don't you say that up front?
MS. CHAITEN: My objection is that I think she's misstated the letter, your Honor.
THE COURT: Go back and look at the letter. And if it's not so, Ms. Chaiten, we are going to have a few words.
MS. CHAITEN: Your Honor, would you like me to read the appropriate sentence?
THE COURT: Just if counsel has misstated it then point out the misstatement to counsel.
MS. CHAITEN: Counsel stated that he was unable to review records because he was preparing an expert report and that is not what the letter says.



Would you like me to read the appropriate part?
THE COURT: Counsel, is that correct?
MS. GOWAN: Well, no, your Honor, I don't think that that's correct. And I am happy to read it for your Honor.
THE COURT: All right, read the whole.
MS. GOWAN: After I spoke to you I spoke with Lorie Chaiten, counsel for Dr. Hammond. She says that Dr. Hammond will cooperate with our plan. She did inform me of three time constraints which he will have to deal with.

First, beginning December 26, 2003 and continuing until January 2nd, 2004, he has 'night float' duty in which he will be working nights, all night, in the hospital covering for his own and other obstetricians patients.

Despite this arduous schedule Ms. Chaiten says that he may be able to find some time during those nights to engage in the extensive review of medical charts that will be necessary in order to identify the patients in question and thereby pin down the charts that we will be copying.

Second, he will be working on a expert report during this period which he is required to produce for the litigation.

Third, Dr. Hammond will be out of town from January 9th through January 17th, 2004, and during that period he will be unable to work on this project.

Subject to those time constraints she says that Dr. Hammond will do his best to work with NMH so that we can



momentize the time needed to produce any records that are ordered to produce."

THE COURT: You may proceed, Ms. Gowan.

BY MS. GOWAN:

Q. Dr. Hammond, were you working on an expert --

THE COURT: By the way, your objection is overruled and I would be more careful in the future.

Q. Dr. Hammond, were you working on an expert report during this period which you were required to produce for this litigation?

A. I may have been. I don't recall if it was the exact period of time. I just remember that we were doing the expert report sometime at approximately this time.

Q. Dr. Hammond, it's report the government received in this case was your TRO declaration with a cover sheet onT were you preparing some other expert report during this period to submit to the government?

A. I'm sorry, could you repeat the question?

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

(record read ((.

THE WITNESS: I'm sorry I'm trying to follow the question and make sure I answer this correctly.

My predominant concern at that point with my night float duty and also the fact that I was leaving the country and I do not recall, other than the fact that I submitted an expert



report in this case at some point approximately at that time exactly when we were preparing it.

MS. GOWAN: May I approach, your Honor?

THE COURT: You may.

BY MS. GOWAN:

Q. Dr. Hammond, I am going to show you the expert report that you produced to the government in this case; would you please take a look at it?

A. Sure.

Q. Do you recognize that?
A. Yes, I do.
Q. What is it?
A. This is my expert report for this case.
Q. What is the first page of that?
A. The majority of the first page is referring to my declarations. So for my expert report, because I had already stated in my declaration most of what I would also state as an expert, we simply referenced that report.
Q. What is the remainder of that document after the first page?
A. It is a signature page with my signature and the date January 8, 2004.
Q. And then what is attached is your TRO declaration in this case attached?
A. Let me go through this.

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I've got my CV, then I have the, my declaration. Then I have another copy of my CV, that's all I have up here, Ms. Gowan.
Q. What is the date of your declaration?
A. Let me look back. 11/4/2003.
Q. Is that the TRO declaration which you submitted in this case?
A. You know I may be -- I'm sorry, I don't quite understand the word TRO declaration.
Q. Well, Doctor, you're a plaintiff in this case and in connection with the filing of the temporary restraining order in the complaint enjoining the Act, did you not submit a declaration in support of the application for the temporary restraining order?
A. Yes. And I believe that this declaration is a copy of the declaration have I have also submitted opposing this legislation.
Q. And that is your expert report in this case, is that right, Doctor?
A. That is correct.
Q. And is that the cover sheet, is that what you were preparing it's referenced in this letter from Mr. Gowan to the government?
A. The cover sheet, are you talking about the first two pages where it begins, expert report for Cassing Hammond?

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Q. Yes.
A. That may be what they were talking about, yes.
Q. Could you just read for us the headings on that cover sheet?
A. It says, expert report for Cassing Hammond regarding National Abortion Federation etal versus Ashcroft and goes on.
Q. What's the next heading?
A. Statement of opinions and bases thereof.
Q. What does that say?

A. See my declaration submited in this case.
Q. What's the next heading?
A. Data and other information considered.
Q. What does that say?
A. It says see my declaration submitted in this case.
A. Exhibits. See me declaration submitted in this case.
And the updated curriculum SROE TAEU attached to this report.
Q. Are there any more headings?
A. It says qualifications, publications, compensation. And then the last heading is listing of other cases in which I have given testimony in the past four years.
Q. Dr. Hammond, are you aware that plaintiff National Abortion Federation has made this statement:
"anti-choice groups have formed and organization



called FACT parens physicss add hock coalition for truth), to assert that the intact D&E procedure is never medically necessary or appropriate. Former surgeon general C. *EFB receipt Coop is part of this organization and has written Open Eds in support of the legislation. Dr. Coop is known to be anti-choice.
"moror, neither he nor TPHEURPBLG of the fact Doctors have reviewed the medical charts of patients who have undergone intact D&E procedures and therefore these doctors cannot determine what medical options were most appropriate for these patients.
Despite the attention that a public figure like Dr. Coop may garner, it is important to remember that no major medical organization S-PLTS this legislation."
Are you aware of that statement?
A. I wasn't aware that they had made that statement, no.
Q. Is today the first you have heard of that statement?
A. To my recollection, yes.
Q. Do you agree with that statement?
A. It's a lengthy statement, I would like to look at it again before I say one way or the other.
Q. Well, do you agree with National Abortion Federation's criticism that the fact doctors and Dr. Coop's opinion is somehow defective because they have not reviewed the medical charts of patients who have undergone intact D&E procedures and



therefore they cannot determine what medical options were most appropriate for the patients?
A. I'm sorry, could I hear the question just read back to me?
MS. GOWAN: Due agree with that.
THE COURT: Yes, would you read it again?

(record read)
THE WITNESS: Again, I made -- it's a complicated phrasing that I am hearing. I'm not certain --
THE COURT: Would you like it read again.

THE WITNESS: A apologize, your Honor, if I could hear it read one more time it would help.
THE COURT: Go ahead Ms. Reporter.

THE WITNESS: Really no I cannot agree with that statement. I am not certain that Dr. Coop would have needed, based on what's been read to me, to review the charts to be able to make that accessionment.
MS. GOWAN: I don't have any further questions, your Honor. Thank you.
THE COURT: Any redirect? KHAEUT.
MS. CHAITEN: Your Honor I will have brief redirect would you like to do it now or after the break.
THE COURT: If it's brief, go right ahead.
REDIRECT EXAMINATION



BY MS. CHAITEN:
Q. Dr. Hammond, you've answered a series of questions on cross regarding medical records that you reviewed in connection with discovery in this case; my question for you is, in preparing the declaration that you submitted in this action, did you review any medical records in order to prepare that?
A. Not in preparing the declaration, no.
Q. And did you review any medical records in reaching the opinions that you testified to here today and yesterday?
A. No. This is not the sum review of medical records.
Q. And have you reviewed any medical records to reach the opinions that you have asserted throughout this litigation?
A. No.
Q. Doctor, when Northwestern Memorial Hospital made medical records available to you to review for purposes of identifying responsive documents, did you take it upon yourself to review those as soon as you received them?
A. Yes, I did.
Q. And did you review all medical records that were made available to you?
A. Yes, I did.
MS. CHAITEN: Your Honor, if I might just have one minute.
THE COURT: Sure.



MS. CHAITEN: Your Honor -- excuse me. Doctor. Doctor is what I am looking for.
You testified a number of times that you don't record the degree of intactness in your medical charts after you conducted a D&E regardless of the variation; can you tell us why you don't record the degree of intactness?
A. Because it really doesn't help us. We record those things necessary to document the procedure or that might really help us with patient management if there is a problem in the future.
The key thing that I need to document is whether I

think the procedure is complete or not and the degree of intactness documenting it doesn't help me in that regard.
Q. And why is it that you can't remember the degree of intactness as it relates to any specific or to a number of specific procedures?
A. Well, it's something that we really don't keep track of and we have this continuum of degrees of intactness.
It is also just hard to remember the cases.
I mean over the course of nine years I see lots of patients who have chorio, P P Rom and many of the things that you have indicated and am constantly doing these procedures with varying degrees of intactness.
So, trying to remember, yes, there was this patient and we were able to deliver to just this point, or just above this point, or just below this point is.



THE COURT: But these records weren't over nine years were they, Doctor?
THE WITNESS: Some were over --
THE COURT: Just three years you told us before.
THE WITNESS: That is correct, the majority of the records were over three years. There were requests for other years but the majority were over approximately three years.
BY MS. CHAITEN:
Q. One last question. How many D&Es do you perform in a year?
A. Approximately -- do I about 300 pregnancy terminations in a year and a large portion of those, because of our referral population, are in the second TREU mester.
MS. CHAITEN: Thank you. I have no further questions at this time.
MS. GOWAN: Your Honor, if I may two questions?
THE COURT: Sure, I was going to say do you want it take a break or okay, two questions. Go right ahead.
BY MS. GOWAN:
Q. Dr. Preparing the declaration that you sib mitted in this case, isn't it true that you drew on the clinical experience that have you had at northwestern *URT?
A. That is true.
Q. And isn't it true, Doctor, in preparing the declaration that you submitted in this case that you drew on specific patient care that you have rendered at Northwestern University



hospital?
A. If what you mean is that I drew upon specific cases and that kind of aggregate experience of specific cases in the past, then that's true.
Q. Isn't it true, Doctor, in your declaration in this case, that you referred to specific patients that you have treated at Northwestern University hospital?
A. That might be true. I would want to look back and I could tell you if I have referred to specific patients.
I think typically I was referring to general

categories of patients rather than specific patients.
MS. GOWAN: Thank you, your Honor.
THE COURT: All right, Doctor, you may step down.
THE WITNESS: Thank you, your Honor.
THE COURT: We will take our afternoon recess at this time.
(recess)

THE COURT: Just for your information, I have a criminal conference at 5:00 so we will recess about five minutes of.
Would plaintiffs like to call their next witness?
MR. HUT: Yes, your Honor.
THE COURT: Just before we do that, Ms. Gowan, that last document you read are from, is that? STPHEFDZ.



MS. GOWAN: No, it's not but it's part of the admission, your Honor.
THE COURT: It's what.
MS. GOWAN: A party admission.
THE COURT: All right.
So it will be offered at some later time?
MS. GOWAN: Judge, were you referring to the NAF statement or the letter.
THE COURT: Yes, the NAF statement about C *EFB receipt Coop and all that have.
MS. GOWAN: Yes, I'm happy to move it at some later time as a party admission or we can offer it now as a party admission.
THE COURT: All right, well I just want to make sure that it's mentioned in the record but I don't want to lose track of it. Does it have an exhibit number or anything like that?
MS. GOWAN: Your Honor, we shall mark it right now.
THE COURT: Just so the record is clear. I think you have a neater and tidier record if we have exhibit numbers so we can refer back to it in testimony. And I didn't recall your mentioning an exhibit number and if it doesn't have one I think it would be better if you don't mind, if you would mark it now and offer it.
MS. GOWAN: Your Honor, it does have an exhibit number



and at the conclusion of the day we will give you that so the record is clear.
THE COURT: If you would. Okay, I'm sorry Mr. Hut, you may proceed., or whoever is going to call the next witness.
MR. HUT: It is I, your Honor, and at this time plaintiffs call Dr. Carolyn Westhoff.

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

THE WITNESS: Carolyn, C A R O L N Y, Westhoff, W E S T H O F F.
THE DEPUTY CLERK: Thank you. Please be seated.
DIRECT EXAMINATION

BY MR. HUT:
MR. HUT: May I inqueer, your Honor.
THE COURT: You may.
BY MR. HUT:
Q. Dr. Westhoff where are you currently employed?
A. I'm employed at Columbia University.
Q. What position or positions do you hold there, Dr. Westhoff?
A. I'm professor of obstetrics and gynecology in the college of medicine and I'm professor of epdeem KWROLgy and of pop HREUGS and family health in the school of public health.



Q. Is the college of medicine currently called or was it once called the college of physicians and surgeons?
A. Yes, it is.
Q. What are your responsibilities as professor of obstetrics and gynecology in the college of medicine include?
A. I provide a range of teaching to medical students, residents and post doctoral fellows.
I also carry out research in the area of reproductive health as part of my role as professor.
Q. And with respect to the professorship of epdeem KWROLgy that you hold at the school of public health, can you explain for us what epdeem KWROLgy is?
A. Epidemiology is the study of the distribution of diseases in populations so who gets what in different populations.
Q. And what do your responsibilities as professor of epidemiology at the school of public health include, Dr. Westhoff?
A. As professor of epidemiology, predominantly I am supervising graduate students who are studying this subject for either masters of public health or Ph.D degrees.
Q. In connection with your professorships at the college of medicine and the school of public health, what portion of your time, approximately, is spent on formal teaching?
A. Most of the teaching that I do is probably one on one supervision of students carrying out research. I also lecture



in the medical school and provide small group teaching to medical students as well as some one on one clinical precept orship to medical students.
I'm sure that at least one day -- all of those activities take up at least one day per week and probably a little bit more.
Q. Are you a physician, Dr. Westhoff?
A. Yes, I'm a physician.
Q. Are you affiliated with any hospital, Doctor?
A. Yes, I'm an attending physician at the New York president

TKEU tearian hospital.
Q. And had a position or positions do you hold at the hospital?
A. That -- along with being an attending physician I'm the medical director of our family planning clinics which are part of the ambulatory care network and also director of special TKPWAO*EUPB services at at Allen paville KWRPB.
THE COURT: At PWHAT.
THE WITNESS: The Allen pavilion which is part of the New York Presbyterian.
Q. What are your responsibilities, Dr. Westhoff as attending physician at New York Presbyterian?
A. I provide direct patient care and I also provide supervision of other physicians, of nurse practitioners, supervision of medical students and residents. And for the two



services where I have administrative responsibility as well I am responsible for generally determining the scope of our practice and assessing the quality of the care that we give and reporting to other members of the hospital about those issues.
Q. In assessing the quality of the care that you give, does that involve you in internal quality assurance activities?
A. Yes, it does.
Q. Can you describe your duties generally with respect to internal quality assurance?
A. Well, for both of the hospital services we routinely collect information about the total number of patients that we see with some subdivision with relation to patient types and we keep track of problems and complications experienced by the patients and we review these on a regular basis to identify any pat THAERPBZ may require remedy to identify opportunities for improvement and to assess whether our rates of complexions or problems are, fall within an acceptable range.
THE COURT: Excuse me, is this at New York hospital?
THE WITNESS: New York Presbyterian, sir.
THE COURT: Well I know they're merged now.
THE WITNESS: That's right.
THE COURT: But which, physically, are you at 60 whatever Street?, east side or are you at Washington heights.
A. I'm located at the Washington heights campus, sir.
THE COURT: Okay.



BY MR. HUT:
Q. What are your responsibilities, Dr. Westhoff, as director of special TKPWAO*EUPB services at the Allen pavilion?
A. The special GYN services is the clinic in which we see patients seeking tubal ligation as well as those seeking care for miscarriages and induced abortions and I'm responsible for determining the scope of practice for supervising all the physicians who work on the service and for carrying out quality assurance activities as well as interacting with hospital administration about all relevant issues.

Q. And briefly, Dr. Westhoff, with respect to your responsibilities as medical director of the family planning clinic, can you describe those for us?
A. Similarly I'm responsible for determining the scope of services that we offer for assessing the quality of the care that we offer, particularly for evaluating all of the clinical staff in the clinic and providing their reviews and for interacting with members of hospital administration with regard to all of these issues.
Q. Do you currently practice medicine, Dr. Westhoff?
A. Yes, I do.
Q. Do you have a private patient practice?
A. I am part of the faculty practice of the department of obstetrics and gynecology.
THE COURT: So is the answer to that no, you don't



have a private practice?
THE WITNESS: I think the faculty practice is a type of private practice, so yes.
Q. Approximately how much time do you spend attending to the private faculty practice?
A. That is one half day a week of my time.
Q. Dr. Westhoff, are you a plaintiff in this case?
THE COURT: Let me just Mr. Hut, I am terribly confused by what you say.
THE WITNESS: Sorry.
THE COURT: You say first of all in answer to whether you have a private practice that you have a faculty, is that right?
THE WITNESS: Faculty practice.
THE COURT: What does that mean? You do this a half day a week?
THE WITNESS: Yes. Most --
THE COURT: What does that mean?
THE WITNESS: Most of the mens of the department of obstetrics and gynecology belong to the faculty practice so part of the distinction may be the business relationship which is the that the practice is owned by the department and the university and I'm paid a salary by the department, patients -- patient fees are collected by the department and so that might be a little bit different than what most people think of in



terms of a private practice.
I don't have my own office that --
THE COURT: Well that's what -- you don't have your own office outside the hospital and your own collection of patients.
THE WITNESS: Right.
THE COURT: These are all patients referred to you as a member of the faculty.
THE WITNESS: Right. And I think many of the patients who come to me would identify me as their doctor, they don't

identify the department as their doctor, they do identify me as their doctor.
THE COURT: Do they walk in off the street?
THE WITNESS: No. This tiny practice that I have does not have a walk-in component. Patients --
THE COURT: Where do the patients come from?
THE WITNESS: They are often referred by my other colleagues. They may find my name listing in the directory as provided by their insurance companies. They may be referred by friends and previous patients.
THE COURT: But in any event, whatever this practice is it's a half day a week?
THE WITNESS: Yes, it's a half day a week I.
THE COURT: All right, Mr. Hut.
BY MR. HUT:



Q. Dr. Westhoff, are you a plaintiff in this action?
A. Yes, I am.
Q. Why did you bring the action, Dr. Westhoff?
A. The reason I brought the action is that I think the federal abortion ban will interfere with my ability to take the best possible care of my patients and also leaves me some trepidation about being prosecuted for providing care to my patient.
Q. Lets devil a bit into your background Dr. Westhoff.
From where did you obtain your medical degree?
A. University of Michigan in Ann Arbor.
Q. What year was that, Doctor?
A. 1977.
Q. Aside from your medical degree, have you received any other medical training?
A. I was, after medical school I was an intern in internal medicine at the Henry Ford hospital in Detroit, Michigan.
TKPOLG that I was a resident in obstetrics and gynecology at the Kings County hospital in Brooklyn.
Following completion of my residency I studied epidemiology at the London school of hygiene and tropical medicine.
Following that I was a post-doctoral fellow at O*FPL Ford University doing research in epidemiology.
Q. How long have you practiced medicine, Dr. Westhoff?



A. It's almost 27 years since I graduated from medical school and so I've practiced medicine all that time except for the years that I was in England doing epidemiology which was a nonclinical time.
Q. Do you have any specialitys in your medical practice?
A. My practice is mainly focused on the area of family planning to, and while that is -- so that's a narrow scope of my practice and I think you could call that a speciality.
Q. Are you board certified, Dr. Westhoff?
A. Yes, I am.

Q. As what?
A. I was board certified as obstetrician gynecologist originally there 1986 and recertified in 1996.
THE COURT: Do you do it every year?
THE WITNESS: Every 10 years.
THE COURT: You do don't do it every year?
THE WITNESS: The American Board of OB/GYN requires recertification every 10 years.
THE COURT: We have had a doctor who does it every year, that's why I wondered, you do it every 10 years., all right.
THE WITNESS: Yes.
THE COURT: I mean there is an opportunity, as I understood the testimony from another doctor, you can answer, I think she said 120 out of 180 questions and do it on an annual



basis., is that correct?
THE WITNESS: I'm not sure.
THE COURT: In any event you do it every 10 years?
THE WITNESS: Yes.
BY MR. HUT:
Q. Dr. Westhoff, taking together your roles as attending physician at New York Presbyterian as director of special GYN services at the Allen paville KWRPB and as medical director of the family planning clinic and your one half day a week private practice, approximately how many patients are currently under your care?
THE COURT: Could you define that? Well go ahead and get an answer and I with like it defined if you would Mr. Hut. I don't know what you mean by under your care.
Q. Given your broad supervisory responsibilities what patient population are we talking about in your various roles?
A. The family planning clinic of which I am medical director, we provide care in about 20,000 patient visits per year. Now obviously I don't see most of those patients myself but I do see several hundred of them myself and I do have supervisory responsibility for all of that care.
Special GYN services, we're seeing about, between 2,000 and 3,000 visits perer and I have responsibility for that.
In my private practice it's a much smaller number.



THE COURT: I assume it is. I take it most of yours is supervisory, administrative and supervisory. You certainly don't see 20,000 patients a year, do you?
THE WITNESS: No, sir. I spend about two days a week providing direct patient care myself and I have responsibility, however, for the care that's given in those clinics for all five days a week.
THE COURT: As I say, administrative and supervisory, correct?
THE WITNESS: Yes.

BY MR. HUT:
Q. The court anticipated my next question?
THE COURT: I just want to hear these numbers.
Q. I was going to make that clear, your Honor which is to ask?
THE COURT: I will let you have free reign.
MR. HUT: No, no.
THE COURT: For a moment.
MR. HUT: Your Honor, please --
THE COURT: I just get confused when I hear these large numbers.
MR. HUT: I am happy to be held on a close tether by the Court but I would now like to ask you Dr. Westhoff for the Court, to tell us how many of the patients that you have described do you personally interact with first in the special GYN unit?



A. In the special GYN services I probably see myself POERPBLly about 500 patience per year good and how about at the family planning clinic?
A. In family planning clinic also at least between 500 and 1,000 patients per year.
Q. In connection with your small private practice?
A. Perhaps slightly less than 500 patients per year.
Q. Can you give us an idea with respect to each of those what types of patients you see?
A. Sure.
Q. For the family planning clinic it's a full range of benign gynecological problems in, that one would see in reproductive age women, so it includes well-woman care, pregnancy diagnosis and family planning services as well as treatment of sexually transmitted diseases and menstrual irregularities, that spectrum.
Special GYN services, as I mentioned, is abortion, miscarriage and tubal ligation predominantly.
And in my private practice it is focused on miscarriage and abortion care and also some women who need contraceptive consultation.
Q. And do you, yourself, perform abortions, Dr. Westhoff?
A. Yes, I do.
Q. For about how long have you been doing so?
A. I started performing abortions during my residency training



at Kings County Hospital and there have been over all these years changes in the scope of practice so I started providing abortion in the late 1970s and continued to do so today but there have been a few, several years in between where I was not providing abortion care because my energies were focused elsewhere.
But for most of the time since 197878 since 1978 can you give the Court an approximation of how many abortion procedures you've performed?
A. I'm sure it's more than several thousand and I would need

to think year by year what I was doing to try to add up., but.
Q. I think we probably don't need?
A. Okay.
Q. I don't think we need that unless the OURT would line to inquire.
Do you currently perform abortion procedures?
A. Yes, I KUFRPBTly do provide abortion procedure.
Q. Is that at the specially it wases atalen paville onyes at special TKPWAO*EUPB services and in perfect private practice.
Q. Approximately how many abortion procedures are performed at the special TKPWAO*EUPB services unit each year?
A. The unit, overall, provides abortion care for about 2,000 patients per year.
Q. And you don't do all of those?
A. I do not do all of those.



Q. What type of abortion procedures are performed at special G Y N services?
A. We provide, in the first trimester both surgical abortion, vacuum aspiration abortions and also medical abortion use miff we provide surgical abortion, D&E.
Q. And in the past, Dr. Westhoff, what other abortion procedures, if any, have you performed?
A. In past years I also performed second trimester induction abortion and particularly used the saline installation method, although I have in the past done other kinds of induction abortions as well but that's not currently part of my practice.
Q. Have you in the past, Dr. Westhoff, performed HEUFT rot mys?
A. I have on a few occasions performed HEUFT rot my for abortion.
Q. How many induction procedures have you performed over your career, Dr. Westhoff?
A. It certainly has been several hundred. I don't know the exact number.
Q. Are you familiar with the use of prostaglandins to induce preterm uterine contractions?
A. Yes, I am.
Q. Have you authored any publications or instructional materials concerning that use?



A. Yes.
On behalf of the American College of OB/GYN I helped prepare a teaching tape for doctors to learn about method of emptying the uterus with using prostaglandins.
Q. Do you remain current, Dr. Westhoff, on literature in the field regarding induction procedure?
A. I try to remain familiar with the literature.
Q. At about what gestational age, Dr. Westhoff, does your service perform suction curettage procedures?
A. We perform suction curettage starting from the, whatever early gestational age a woman might present seeking such a

treatment. We don't have a lower limit as long as we can make a diagnosis of pregnancy, and we continue using the suction curettage technique through the first three months of pregnancy.

So, certainly up to 12 or 13 weeks.

And there are some patients where suction curettage is successful even early in the second trimester.

Q. At about what gestational age does the special GYN service perform medical abortions?

A. We perform medical abortions just through nine weeks, until nine weeks after the last menstrual period.

Q. You made reference in an earlier answer, I think to the use of me have O PREUS tone in the medical abortions that you do?

A. Yes.



Q. Does that go by another name?

A. Me have O PREUS ton is formerly known as R U 486.

Q. At what what gestational age does your service perform D&E, doctor?

A. We perform D&E throughout the second trimester from the beginning of the second trimester about 14 weeks gestation through 23 weeks and six days gestation.

Q. Does the service perform the variation of D&E known as intact D&E?

A. Yes, we do.

Q. At about what gestational age do you begin to do that?

A. In general we use that approach in the later part of the second trimester, perhaps starting around 18 or 19 weeks but there are -- it's not an exact threshold. Each case is different.

Q. How many D&E procedures, approximately, of any variation, does your service perform each year?

A. In 2003 our service performed about 250 D&Es.

Q. You said 250?

A. I think so.

Q. And approximately how many of those involve or involved, in 2003, if you know, intact D&E?

A. We haven't had the practice of keeping any kind of sense us where we distinguish what kind of D&E we did so I don't have any sort of statistics to support that number, but my general



recollection is that it would be at least 50 of the D&Es last year would have been intact D&Es.

THE COURT: Is there any time when you did keep such a record at your institution as to what type of D&E was done at the institution?

THE WITNESS: No, your Honor, we have not kept records with that kind of breakdown.

Q. Can you explain for the Court the basis for your judgment not to keep those sorts of breakdowns?

A. Well all of these cases are variation on D&E. The main fact for us is that we did perform a D&E and I think a lot of

documentation sometimes is driven by requirements to match the coding that exists, the procedure coding, diagnosis coding and so on, and there exists no special coding for different variations on D&E, they're all coded the same.
Q. In addition to the procedures, the D&E procedures that you personally performed, what is the basis for your general recollection that the order of number of D&Es that you do each year is about 50, or that did you in 2003, perhaps?
A. One reason I have for giving that number is just the way our week is structured we perform our D&Es on Fridays, which means we do cervical preparation with laminaria on Wednesdays and Thursdays. I have assigned myself to see patients on Wednesday on this service so that that means I'm likely to see most of these patients when they have, when they begin their



cervical preparation, they begin getting ready for the D&E.
And so that just gives me a sense of who the patients are going to be and it gives me a sense that probably every week we have at least one such patient.
In addition I just discuss with all of my colleagues who share the coverage of the operating room on Friday what they're impression is about doing these cases.
Q. Of the types of abortion procedures performed at the personal GYN service, which do you currently perform, Doctor?
A. I perform all of the -- some -- I take care of some cases for all of the types of treatments that we offer, although I don't currently perform tubal ligations.
Q. And with respect to those treatments can you give the Court an idea of how many are involved, say with respect to suction curettage, for example?
A. Sure.
In the year 2003 I probably performed, personally, about 500 suction curettage, some give or take a hundred, and I probably personally performed or personally supervised in the operating room about 50 D&E cases.
THE COURT: You supervised or you performed?
THE WITNESS: Well, since we're a teaching institution we often will have more than one doctor in the operating room at the same time and so sometimes I'm right there working with another doctor but I might not be the main person who actually



has my hands on the patient.
THE COURT: How many times do you have your hands on the patient in that setting in that procedure?
THE WITNESS: I haven't thought about distinguishing that previously so I just need to think about my answer and.
THE COURT: Well I would think you know what you did last year, I mean roughly, I'm not asking you for an exact count.
THE WITNESS: No. Because an important part of my role in taking care of patients is also to teach other doctors I want the doctors working with me to provide as much of the

direct hands on care as they are competent to do and often my role is there to help or guide them rather than to carry out the case alone and so I would --

THE COURT: Would it be fair to say then that you supervised them all but you do the hands on?

THE WITNESS: In the majority -- yes. And I mean I will be there with my gloves on so-to-speak, but in the majority of cases it will be the other doctors I'm working with who are actually doing more than I am.

(continued on next page) TWM 4/1 take 5 Caroline Westhoff on direct<]

THE COURT: You are primarily the supervisor then, is that correct, fair to say?

THE WITNESS: Yes, that is fair, your Honor.

BY MR. HUT:

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Q. Approximately, how many D&E procedures, Dr. Westhoff, have you performed throughout your career?

THE COURT: Could we have this clarified that we are talking about supervising or actually PERPLG them hands-on, if you could break that out.

Q. If you could distinguish that for the Court and answer my question, please do so.

A. Until we started this service three years ago at the Allen Pavilion, I was performing only a small number of D&E's. We didn't have a service at our hospital. Since we started the service, it is more cases, and I would say in the -- again, looking back just at 2003, I was probably in the operating room helping take care of patients about 50 patients having D&E's. But, as I said a moment ago, that is a mixture of hands-on and supervisory care, which is the nature of a teaching service.

Q. If you extend that back beyond 2003, going back to the time you first began to perform D&E, can you give us an approximation of the number of times you performed D&E?

A. Our service was a little less busy in 2001 and 2002, so I think the numbers were a little less in those years. And prior to 2001 the numbers would have been much smaller, because we didn't actually have a whole service of our own.

Q. Does the number of D&E that you indicated you performed or supervised in 2003 include the intact variation?

A. Yes, it does.

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Q. Have you ever heard, Dr. Westhoff, of intact D&E referred to by any other name?

A. Yes.

Q. What name or name have you heard?

A. There have been a variety of descriptions that I think are all attempting to describe the same variations on the D&E procedure that include D&X or intact D&X or dilation and extraction. Those would be some of the alternative names.

THE COURT: Have you also hurt "partial-birth abortion"?

THE WITNESS: I don't consider partial-birth abortion

a medical description.
THE COURT: I didn't ask you what you consider. I asked you if you have heard of it.
THE WITNESS: I heard of it. Conditional good. Next question.
Q. Dr. Westhoff, during the course of your practice and your effort to assess the complication rate experienced at the service, do you make evaluations and reevaluations of the safety of the abortion procedures you provide there?
A. Yes, we do.
Q. Is your experience in epidemiology come to bear on making those evaluations and reevaluations? [> does your<]
A. I think my training and experience in epidemiology definitely informs my thinking and practice about assessing



complications.
THE COURT: About assessing what?
THE WITNESS: Complications.
A. What I want to do, whether in our clinic or whether in the service at the Allen Pavilion is to try to enumerate all the complications that we have identified and then relate those to the total number of cases that were done so that we can describe them, for instance, in terms of percentages. Then we can also compare that to other sources of complication rates to see whether our rates fall into the same range.
Q. When you made that assessment, do your rates fall into the same range?
A. Yes. I think our complication rates are comparable to other clinics as well as published estimates.
Q. Does Columbia University offer any training in abortion procedures?
A. Yes, we do.
Q. What type of abortion procedures are taught at Columbia?
A. We teach both medical and surgical abortion in the first trimester. We also teach D&E in the second trimester. And because there are other doctors currently who carry out inductions in the second trimester, I am not sure about what teaching is done with regard to that procedure.
Q. Is the intact variation of D&E procedure taught at



Columbia?
A. Yes, it is.
THE COURT: How long have you been teaching that?
THE WITNESS: I have had a fellowship program in family planning for about 5 or 6 years now; so we have been teaching this throughout that time.
THE COURT: Five or six years?
THE WITNESS: Yes, sir.
THE COURT: But just in that family planning unit?
THE WITNESS: Because several years ago we had a smaller volume of cases locally, I also encouraged the young doctors who come to train with me to go and work in some other

practice settings in order to get more experience.
THE COURT: That wasn't part of Columbia presspy derian, was it.
THE WITNESS: Right.
THE COURT: That was in other settings?
THE WITNESS: I have sent some TKORBGS to other settings. Now that we have sufficient volume of cases for our teaching, all the teaching happens locally at column Columbia Presbyterian.
Q. Are you a member, TR Westhoff, of any professional associations?
A. Yes, sir.
Q. Which ones?



A. I am a fellow of the American College of OB-GYN. I am a member of the association of reproductive health professionals, a member of the American Public Health Association. I forget. And a number of other professional organizations.
MR. HUT: With the Court's indulgence I will try to help him.
Q. Are you a member of the American medical women's association?
A. Yes, I am.
Q. Are you a member of the National Abortion Federation?
A. Yes, I am.
Q. Are you a member of any committees within these professional associations?
A. Yes, I am.
Q. Could you describe your committee memberships.
A. For the association of reproductive health professionals and the American medical women's association, I am a member of the board of directors, so through that have involvement with a SRORT of organizational functions. At the American medical women's association I am also the chair of the advisory committee for reproductive health initiative, which is the largest educational program of the American medical women's association.
Q. Have you authored any publications, Dr. Westhoff?
A. Yes, I have.



Q. On what subjects?
A. I do clinical research on contraSEPTive development, contraSEPTive evaluation, contraSEPTive effectiveness and safety. So I would say the majority of the articles I have written cover those areas. I am also interested in cancer epidemiology, particularly risks of oh variousian cancer and oh variousian cancers in young women and have published in those areas. I have also published a number of articles with regard to the safety and efficacy of PHEF PREUS tone or early medical abortion in the first trimester.
There are a number of other areas I have written in, but I would say that is the focus of my publication.

THE COURT: Where have you been published, Doctor?
THE WITNESS: In a wide range of medical journals. Recently on emergency contraception in the New England Journal of Medicine. In obstetrics and TKW-LG, in Journal of the American Medical Association, in the American SKWROUFRPBL obstetrics and gynecology, in contraception, in fertility and sterility.
Q. Are the journals that you just mentioned in response to the Court's question, Dr. Westhoff, peer reviewed journals?
A. Yes, they are.
Q. Do you also number amongst your publications other works in other peer reviewed journals?
A. Yes.



Q. Are you the author of any books or chapters of books, Dr. Westhoff?
A. I am the author of several chapters.
Q. Did you author a chapter in a clinician's guide to medical and surgical abortion?
A. Yes. I am KO*E author on that chapter titled procedure selection in the clin ig's guide.
THE COURT: Who is your co-author?
THE WITNESS: The other author of that chapter was Charlotte E lig son.
Q. Do you rely on a clinician's guide in your practice, Dr. Westhoff?
A. Yes. We use the clinician's guide for medical student, resident, and fellow education.
Q. Do other of your colleagues at the special GYN service also rely and own a clinician's guide?
A. I know that several of my immediate colleagues have that text on their bookshelves. I can't tell you exactly how they use it though.
Q. To your knowledge, is a clinician's guide a text frequently relied on by persons in the field of abortion practice?
A. To my knowledge, yes, it is.
MR. HUT: May I approach, your Honor?
THE COURT: You may. I don't know how she knows the answer to the last question, but nobody objected.



Q. Would you turn, Dr. Westhoff, to the tab marked 70, which is Plaintiffs' Trial Exhibit 70.
A. Yes.
Q. Do you recognize Plaintiffs' Trial Exhibit 70?
A. Yes. This shows the face page of the clinician's guide that we were just discussing.
Q. Behind the face page does it appear this the full text of the clinician's guide is replicated?
A. This looks like it could be the full text.
Q. Does your chapter in the clinician's guide refer to intact D&E as a variation of D&E, Dr. Westhoff?
A. Let me refer to the page that mentions that so I can answer

that correctly.
THE COURT: Do we have a date on this exhibit?
THE WITNESS: I think this book was published in 1999.

-B yes.
THE COURT: Is each chapter that date or are these chapters updated at different times?
THE WITNESS: This has been published just once, all at the same time, in 1999.
Q. Let me try to assist you, Dr. Westhoff, and ask you to direct your attention to page 68 of Plaintiffs' Trial Exhibit 70.



A. Thank you. Now, I'm sorry, could I have the question back, please.
MR. HUT: I can do it, if that is all right with the Court. The doctor wantted question back and I can give it as readily as the court reporter.
THE COURT: All right.
Q. The question is does the clin ig's guide and your chapter relate to refer to intact D&E as a variation of D&E?
A. Yes, it does.
Q. Do you recall what additional thing or things [> check the question<] the clinician's guide says about the intact variation of D&E?
MS. GOWAN: Objection, your Honor.
THE COURT: What is the objection?
MS. GOWAN: He is asking the witness, I think, to basically read into the record information that is not in evidence.
THE COURT: Sustained.
MR. HUT: That was not my intention.
THE COURT: I don't know what it was, but that is what you asked.
Q. Dr. Westhoff, please do not refer to the guide responding
MR. HUT: Is that all right, your Honor? May I now ask whether she knows the content of the text?



THE COURT: She is an author. Was she not?
MR. HUT: She was, but it was some years ago.
THE COURT: Come, come, Mr. Hut. I would hope she would know that.
Q. Do you know, Doctor, what the chapter states about the intact D&E variation of D&E?
A. In our chapter --
THE COURT: Sustained. Try again. This is self-serving. She wrote it. There is another way of asking the question rather than this way, which is grossly improper.
MR. HUT: Plaintiffs move Plaintiffs' Trial Exhibit 70 in evidence.
MS. GOWAN: Your Honor, the government objects. This

book is a compendium that is produced by plaintiff natio National Abortion Federation. It has multiple chapters that have been bound together in a compendium. Counsel so far has only referred to one particular chapter. In order to get this chapter and indeed this book into evidence, counsel must publish the reliability of it. I assume the basis that he is seeking is learned treatises. Is that right? He has not met the test for that.

THE COURT: I don't know that he has to establish all the things you say. I think if he wishes, he can offer the chapter that the witness authored. It doesn't speak to its authenticity, its truthfulness, its value. It is just



something she wrote, other than a self-serving statement that other clinicians rely on it, which is meaningless, because I don't know how you could establish that. Did they all call her up and tell her that? What are you offering it no? That she wrote it?

MR. HUT: That she wrote it and that is what it states.

MS. GOWAN: That is for the truth of the matter asserted, your Honor, and it is hearsay.

THE COURT: I will allow you to put the chapter in for whatever it is worth. It is up to you and Mr. Hut to establish whether it is worth anything.

(Plaintiff's Exhibit 70 received in evidence)

THE COURT: I would ask you to redact the rest of it and just present tomorrow a redacted version of the one chapter that she authored. And for no other proof is it being accepted other than the fact that she wrote it.

MR. HUT: We will be happy to proceed on that basis, your Honor.

Q. With the Court's permission, I would now like to ask you, Dr. Westhoff, whether you -- I will withdraw that question and move on.

Are you a peer reviewer for any journals, there Westhoff?



A. Yes, I am, for several journals.

Q. Which are some of the journals for which you are a peer reviewer?

A. I think all of the journals I just also had mentioned, such as obstetrics and gynecology, American journal of obstetrics and gynecology, jam a, New England journal, and a variety of others. I think if we need to, we could refer to my CV for the list.

Q. We are going to get there a moment, Doctor. You have anticipated me.

THE COURT: We are all ahead of you today, Mr. Hut. That's my afternoon chuckle. Go right ahead.

MR. HUT: I will do my best, your Honor, to catch up

over the evening recess.
THE COURT: Thanks very much. And excuse me. Just some days, you know.
Q. Doctor, is the journal called obstetrics and gynecology, who publishes that?
A. Technically, I believe the publisher is Elsevier, but it is the official journal of the American College of Obstetrics and gynecology.
Q. Do you sit on any governmental advisory committees or panels at any level?
A. Yes, I do.
Q. Which?



A. I have just finished five years as a member of the United States preventive services task force. I have sat on study section or initial review groups for the National Institutes of Health, and an adviser to the national institute of child health and human development for program planning.
I sit on the data safety and monitoring boards for several NIH-sponsored studies, including the prostate, colon, and OEFry cancer STKRAOEPBG clinical trial. And I'm sure there are a few others that don't come to mind just at the moment.
Q. Have you served, Dr. Westhoff, as a guest lecturer or visiting professor at any AO*UFRTS?
A. Yes, I have.
Q. Which ones?
A. I have been a visiting professor at Washington State University College of pharmacy. I have been visiting professor at University of Michigan at the department of obstetrics and gynecology, and a visiting professor at Brown University's department of obstetrics and gynecology.
Q. I think we have now reached an opportunity for Hut's first catch-up opportunity, your Honor.
Q. Let me ask you, Dr. Westhoff, to turn to tab 126.
THE COURT: Could I interrupt just one second? I couldn't resist.
Do you serve, are you an officer, do you serve on the board of ACOG?



THE WITNESS: No, sir, I am not on the board of ACOG.
THE COURT: Have you ever?
THE WITNESS: I have not been on the board of ACOG. I am a member of some district committees of ACOG, serving at their pleasure if I can be helpful. But I have no national office for ACOG. Conditional or on the board?
THE WITNESS: And I am not on the board.
Q. Have you turned to Plaintiffs' Trial Exhibit 126, Dr. Westhoff?
A. Yes.
Q. What is it?
A. That is my resume as of last December.
Q. Is this as of last December an accurate summary of your

education and experience?
A. Yes, it is.
Q. Are there any significant additions or updates of which the Court should be aware?
A. There are always a number of additional publications, but nothing important. I'm sorry.
MR. HUT: Plaintiffs offer, your Honor, Trial Exhibit 126 in evidence.
MS. GOWAN: No objection, your Honor.
THE COURT: It will be received.
(Plaintiff's Exhibit 126 received in evidence)
Q. What, if any, steps, Dr. Westhoff, do you take to remain



current on developments within your medical specialty?
A. I subscribe to medical journals that I review on a regular basis. I attend regular meetings such as the two-hour weekly grand rounds in my department. I talk with colleagues in my department about new developments and about clinical care. And I attend a variety of national meetings.
Q. Doctor, have you offered expert testimony in any other court cases?
A. Yes.
Q. In approximately how many other such cases have you proceeded expert testimony?
A. With regard to challenges to state abortion bans, I participated in the Michigan case and the New Jersey case.
Q. Did those bans and cases involve bans on so-called partial-birth abortion?
A. Yes.
Q. Have you served as an expert in connection with any case concerning nor plant?
A. Yes.
THE COURT: Concerning what STPH-RPB.
MR. HUT: Nor plant.
A. Yes, I did. I provided some expert testimony regarding nor plant.
Q. Where was that case venued or located, if you recall S-
A. It certainly took place in a courthouse reel nearby here,



but I'm not exactly sure from your point of view what the venue was.
Q. How about the state?
A. I think it was probably -- I'm sure it was state court, but . . .
Q. In New York?
A. No New York, yes, very nearby, within blocks.
MR. HUT: Your Honor, we offer Dr. Westhoff as an expert in obstetrics and gynecology, in abortion procedures and practice, and in epidemiology pursuant to Rule 702 of the Federal Rules of Evidence.
MS. GOWAN: No objection, your Honor.
THE COURT: In epidemiology? Is that going to be

relevant?
MR. HUT: I think yes, it may be, at a future point in the testimony, sir.
THE COURT: If there is no objection by the government, the Court will so recognize the witness.
Q. Dr. Westhoff, are you receiving any compensation for your work in this matter?
Q. Before we progress to your opinions with respect to factual matters in this case, Doctor, I would like to ask you a few background questions about abortion practice generally. Are you familiar with the phrase "fetal viability"?



A. Yes.
Q. What does that refer to?
A. That is a condition in which the fetus would be capable of sustained life outside the uterus.
Q. When does fetal viability occur, in your opinion, Doctor?
A. Fetal viability with opportunity for excellent neonatal intensive care, a substantial number of fetuses will be viable after 24 weeks of gestation.
Q. In keeping with New York law, Dr. Westhoff, what is the latest gestational age at which you have performed an abortion?
A. We do abortions just through 23 weeks gestation. We will not do an abortion if the pregnancy has reached 24 weeks gestation.
Q. Do you take any measures to ensure that the --
THE COURT: You say we. Is this Columbia -- I mean New York press?
THE WITNESS: New York press, yes, sir.
THE COURT: Go ahead.
Q. Do you take any measures, Doctor, do ensure that the fetus is not viable before you perform an abortion?
A. Yes, we do.
Q. What are those measures?
A. We do S- an assessment based on patient's history, any physical examination or sonographic examination prior to the patient coming to us, as well as physical examination and use



of stenography at the time we first see the patient.
THE COURT: Use of what, ma'am?
THE WITNESS: Sonography.
THE COURT: What is is that?
THE WITNESS: Using ultrasound, using sound waves to take fetal measurements. We use a combination of all of the data from those sources to come up with our best estimate of gestational age, and we do not proceed with an abortion if the pregnancy has achieved 24 weeks [> sonography, not stenography<]
Q. Are you familiar, Doctor Westhoff, with the percentage of abortions as those are distributed through the three trimsters of pregnancy?
A. Yes, I am.

Q. What is your source of information for such percentages?
A. For national data, I rely primarily on statistics that have been collated by the Center for Disease Control.
Q. Are the statistics collated by the cents for disease control published on a regular basis?
A. Yes. They are published both in reports from the CDC directly and in journal articles that result from the data.
Q. Do you regularly review those statistics, Doctor?
A. Yes, I do.
Q. Based on that regular review, do you have an opinion concerning the reliability of the CDC statistics?



A. They are the best data available in the United States and do an excellent job of representing the STKPWREUBGS of abortion care in the United States.
Q. On the basis of your regular review of those CDC statistics, could you tell us the percentage of abortions performed in each trimester of pregnancy?
A. Yes, sir. In about 90 percent of all abortions are performed in the first three months of pregnancy [> no in<] and about 10 percent of abortions are performed in the second trimester of pregnancy. The number of states that permit third trimester abortions is very small, so to my knowledge the number of third trimester abortions that occur is vanishingly small and is not separately reported. The vast majority of states explicitly have forbidden abortion in the third trimester. So second trimester abortions are about 10 percent, 10 or 11 percent of the total. And in the second trimester it is about 1 percent of abortionts that occur after 20 weeks je gestation.
THE COURT: How many states allow third trimester abortions?
THE WITNESS: Your Honor, I don't know for suring, do you want me to --
THE COURT: I just asked if you knew. That's all.
THE WITNESS: There are at least two that I am aware of that permit some third trimester abortion or that don't have

their own state statute forbidding it. I believe there are several others, but I don't know which they are.
THE COURT: What are the two you know?
THE WITNESS: I believe Kansas does not forbid third trimester abortion. And I believe in Georgia that under certain circumstances, and I don't know what the constraints are, that third trimester abortions are not forbidden within certain constraints of state law. In most states they are explicitly forbidden at the state level.
THE COURT: Thank you.
Q. Doctor, could you turn in the binder, please, to Plaintiffs' Exhibit 28.
A. Yes. Got it.
Q. Do you recognize it?
A. Yes. This is the recent abortion surveillance statistics from the CDC which were published in morbidity/mortality weekly report.
Q. Are the statistics that are set out in Plaintiffs' Trial Exhibit 28 the most recent CDC stat STUBGS available, to your knowledge?
A. Yes. These cover year 2000, and the publication date of this report is listed here as November 28, 2003.
Q. Could you please turn to page 16 of Exhibit 28.
A. Yes.
Q. Directing your attention to the data set forth on page 16,



aretles the basis of the testimony that you just gave regarding the percentage of abortions performed in each trimester?
A. Yes. This page contains a table detailing various characteristics of abortions in the United States, and one of the categories that is presented here is how many weeks of gestation divided into percents. And yes, this is a basis for the distribution I described a couple of minutes ago.
Q. For what years do the CDC summaries provide abortion statistics of the kind you just described?
A. This particular report actually summarizes data from 1973 all the way through 20 and presents data separately for each year.
Q. Doctor, directing your attention to the pages in Plaintiffs' Trial Exhibit 28, beginning at page 14, do these tables set out information about percentage of abortions distributed across trimsters for the years 1973 to 1999?
A. Yes, they do.
Q. Based on your review of those tables, are the statistics from 1973 to 1999 showing the percentage of abortions performed in the first trimester from 13 to 20 weeks LMP and after 20 weeks LMP generally statistics with the statistics you described a moment ago in your testimony?
THE COURT: Mr. Hut, is this exhibit in evidence?
MR. HUT: Skis excuse me, your Honor?
THE COURT: Is this exhibit that the witness is

reading from, is it in evidence?
MR. HUT: It is not in evidence. I would move it in evidence at this point.
THE COURT: In the old days, that is what we used to do, put exhibits in evidence first and then have witnesses testify from them.
Any objection?
MS. GOWAN: No, your Honor.
THE COURT: It will be recei
(Plaintiff's Exhibit 126 received in evidence)
Q. Dr. Westhoff, what type of abortion is most common in the first trimester of pregnancy?
A. Vacuum aspiration is the most, or suction curettage, alternatively known as suction curettage is the most common type of abortion in the first trimester.
Q. Very briefly, what does suction curettage or vacuum aspiration involve?
A. Very briefly, suction curettage proceeds in a manner where a patient is positioned on a procedure table as for a gynecologic examination, and after the appropriate preparation, use ofant SEPTics, use of analgesics or STHAETics as appropriate in each case, the cervix is grasped with a te knack HRUPL to stabilize it. At that point the cervix is then usually stretched open with mechanical dilators to an appropriate diameter, and a sterile plastic tube called a KUPBL



la or suction KUPBL la is then inserted through the cervix into the uterus, and that will be attached to either tubing to an elec suction machine or to a spring permitting a manual SOURT of vacuum, and then the contents of the uterus are then aspirated through the tube.
Q. You made a reference in your last answer, Dr. Westhoff, to something called a te knack HRUPL. Can you explain what that is.
A. Yes. Sorry. A te knack HRUPL is a grasping instrument, so it has in the handle little holes to place the fingers, and it has a little clasp to open or close it. There are several different kinds of te knack HRUPLS, but they are maybe about 10 or 12 inches long, and at the opposite end from the handle there is a pair or two or three pairs of small grasping teeth, and those are used to grasp the cervix or the entrance to the uterus, and then the te knack HRUPL is closed.
Q. For what purpose does the physician use a te TPHAPL HRUPL to bring down the cervix as you described it?
A. The uterus is not held in place by any bony structures in the woman's body. It is attached to ligaments but is lying sort of loose inside the pelvic cavity. In order to proceed safely when inserting any instruments into the uterus, it is best to stabilize the uterus and hold it steady. So the te knack HRUPL is used to put traction on all the ligaments. That straightens out the canal of the uterus and holds it steady so

the uterus will not move back and forth when instruments are inserted.
Q. As you perform surgical abortions in the second trimester, do you also use a ten column for that procedure?
A. Yes, we do, yes.
Q. When in pregnancy can suction curettage or vacuum aspiration be used as an abortion method?
A. We will use suction curettage from the earliest time that a pregnancy is diagnosed throughout the first trimester, and sometimes early in the second trimester a large- bore suction cannula will be adequate to also permit completion of the abortion using vacuum aspiration. But as we enter the second trimester, we often need to switch to D&E techniques.
Q. Does each and every suction curettage procedure, Dr. Westhoff, proceed precisely in the manner that you have just described?
A. No. There is a general set of steps, but in fact every patient is a little bit different and every single case proceeds individually, with variations that depend on the patient's individual anatomy and depend on the gestational age of the pregnancy as well.
MR. HUT: Your Honor, we have come to a place that may be convenient to break off here. I note it is approximately 5 minutes to the hour.
THE COURT: I appreciate that, yes. We do have a 5



o'clock conference.
We will reconvene at 9:30 tomorrow morning. Good people, have a nice evening. Court will stand in recess.
(Adjourned to 9:30 a.m., April 2, 2004)