4/2/04 Judge Casey take 1 of national versus Ashcroft continuing direct of Dr. Westwho have Carol.
THE COURT: Good morning. Please be seated.
THE DEPUTY CLERK: Dr. Westhoff, you are still under oath.
THE WITNESS: Yes. Carolyn Westhoff, resumed.
DIRECT EXAMINATION

BY MR. HUT:
THE COURT: All right, Mr. Hut, you may inquire.
MS. GOWAN: Your Honor, this is Ms. Gowan.
THE COURT: Ms. Gowan, I'm sorry.
MS. GOWAN: May I just as a housekeeping matter, move the admission of the document that I read into the record, a portion of which I read into the record yesterday during Dr. Hammond's cross examination.
THE COURT: You can offer it.
MS. CHAITEN: Objection. This document was not designated as one of the defendant's exhibits pursuant to Rule 26 we object to its admission into evidence.
THE COURT: Overruled. It will be received.
MS. GOWAN: Thank you, your Honor.

THE DEPUTY CLERK: Excuse me, what's the document number?

MS. GOWAN: Excuse me, your Honor, just so the record is clear, this is Government Exhibit N, and the portion that I read into the record yesterday appears at Bates page stamped 1 NAF 001416. This exhibit is listed in the pretrial order provided to the Court.
THE COURT: It's in the pretrial order. Okay, thank you.
(Government's Exhibit N received in evidence)
THE COURT: Mr. Hut.
MR. HUT: Thank you, your Honor.
DIRECT EXAMINATION

BY MR. HUT:
Q. Dr. WEGS Wes, good morning.
A. Good morning.
Q. Yesterday we had concluded with a description by you of your method of performing vacuum aspiration in the first trimester, I would like now to move to the second trimester and ask you what type of abortion method is most commonly used after the first trimester?
THE COURT: Where and when?
Q. Let's take it nationwide currently.
A. Okay. In the United States?
MS. GOWAN: Objection, your Honor.

THE COURT: Can that be known?
THE WITNESS: Yes.
MR. HUT: Your Honor, Dr. Westhoff do you have a basis on your review of C D C statistics for knowing what abortion method is most frequently used in the United States?
A. Yes, Mr. Hut.
THE COURT: I think that's -- if that's what you are searching for I think that was a better way to approach it, Mr. H*ULT.
All right, go ahead.
Q. What is that, Dr. Westhoff?
A. The CDC reports that in the United States about 95 percent of all second trimester abortions are performed using D&E.
Q. What is your process or method, Dr. Westhoff, for performing D&E abortion?
A. Okay --
THE COURT: Excuse me Z. that mean dismemberment?
THE WITNESS: Dilation and extraction include a spectrum of approaches with varying possible degrees of a dismemberment and include the intact variation.
THE COURT: Does the report break it TKOURPB?
THE WITNESS: The report does not.
THE COURT: So in other words you don't know except that it comes within annum PWREL will a of D&E?
THE WITNESS: Yes, sir.

THE COURT: Okay.
THE WITNESS: Yes, your Honor.
BY MR. HUT:
Q. You stated, in your last answer to the Court, Dr. Westhoff, you referred to dilation and extraction, did you mean dilation and evacuation?
A. Yes.
Q. Could you now describe for us the way that you performed D&E?
A. As with of course any surgical procedure, a case will proceed individually based on both the particular circumstances and anatomy of the patient and each step of a indication will proceed according to what occurred in the preceding case.
So just as a general prologue I can describe a typical case for you but each case proceeds, will proceed a little differently one step at a time.
In our setting we take care of patients for D&E in the am before you will a Tory operating room. After the patient has had the induction of general anesthesia with an --
Q. Let me interrupt you Doctor. Why don't you take us a step back and describe the dilation portion of the process first?
A. Certainly.
For patients who are requesting a second trimester abortion and who have expressed a preference for D&E, we will first see the patient one or two days prior to the planned

operative procedure and at that time the patient will have routine type of history and physical examination, likely to have an additional sonogram to assess gestational age correctly and --

THE COURT: Excuse me, Doctor.

At that point or do you, sometime prior to that, do you have a discussion with the patient, when you are doing it permanently?

THE WITNESS: Yes.

THE COURT: And make a complete disclosure of the options available to them?

THE WITNESS: I will usually do a history and physical examination and sonogram in fact before the --

THE COURT: No, Doctor.

THE WITNESS: Before.

THE COURT: I'm trying to find out whether or not you discuss with her the options available and what is entailed in the procedures of the various options.

THE WITNESS: Yes, your Honor. I do discuss this.

What I wanted to say is that I want to assess the patient first because my assessment.

THE COURT: Okay.

THE WITNESS: May have an impact on what are the TPROEPT options for her.

So I do an assessment of the patient before I discuss

the options.

THE COURT: All right.

THE WITNESS: So that's the order in which I proceed.

And after I have done this preliminary assessment so that I can understand her physical condition, I understand the particularities of her pregnancy and it's what its complications may be and so on at that point we will in fact have a discussion of her alternatives which in fact includes the spectrum of continuing this pregnancy without interruption using an induction approach to interruption and using the D&E approach.

When patients come to me it is usually because they've been referred and they already have a preference for the D&E approach.

THE COURT: And when you discuss the D&E, do you discuss dismemberment?

THE WITNESS: I tell them that my responsibility is to remove the fetus and the other --

THE COURT: Doctor, that isn't my question.

Do you discuss dismemberment? Do you tell them about ripping or tearing a limb off the fetus?

THE WITNESS: I may very often discuss that I remove the fetus in pieces but that is not necessarily a uniform part of the discussion.

THE COURT: Well do you do it most of the time? I

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mean, do they really understand what are you doing when you tell them all these clinical terms?
THE WITNESS: I try to use everyday language and not use terms that are going to be confusing to the patient. We try to --
THE COURT: Do any of them ask you whether or not the fetus experiences pain when that limb is torn off?
THE WITNESS: I do have patient who ask about fetal pain during the procedure, yes.
THE COURT: And what do you tell them?
THE WITNESS: I, first of all, assess their feelings about this, but they of course even notwithstanding the abortion decision, would generally tell me they would like to avoid the fetus feeling pain.
I explain to them that in conjunction with our anesthesiologists that the medication that we give to our patients during the procedure will cross the placenta so the fetus will have some of the same medications that the mother has.
THE COURT: Some.
THE WITNESS: Yes, that's right.
THE COURT: What do you tell them, does the fetus feel pain or not when they ask?
THE WITNESS: What I tell them is that the subject of the fetal pain and whether a fetus can appreciate pain is a

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subject of some research and controversy and that I don't know to what extent the fetus can feel pain but that its --
THE COURT: Do you tell them it feels some pain STPHEUFRPBLGTS I do know that when we do, for instance an amniocentesis and put a needle through the abdomen into the amniotic cavity that the fetus withdraws so I certainly know based on my experience that the fetus with withdraw in response it a painful stimulus.
THE COURT: Going ba back to my question.
THE WITNESS: Yes, your.
THE COURT: Do you tell them that the fetus feels pain?
THE WITNESS: I tell them some of the things I just told you.
THE COURT: Don't you make it simple for them and say yeah, they feel it?
THE WITNESS: Well, your Honor, I think whether a fetus feels pain is subject to research and is uncertain and I share that with the patient.
I am not confident what the fetus feels with the anesthesia that we use and I don't want to shy away from the possibility the fetus feels pain but I do not believe it's fully determined what the fetus feels during this procedure.
THE COURT: Do you care?
THE WITNESS: Certainly.

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I think the while --
THE COURT: Next question, Mr. Hut.
BY MR. HUT:
Q. Let me follow up on the Court's question, Doctor.
You described the reaction or response that you discerned in the fetus when amnio SEPB TEUS EUS is delivered, do you discern a similar response when you performed the surgical extraction portion of a D&E in the fetus to stimuli?
A. No, we don't.
When we are doing the D&E and the mother and the fetus are receiving intraconvenient us annual SKWRAOES I cans and anesthetic agents, the fetus does not withdraw from the touching or grasping, so my interpretation of that different reaction is that the anesthesia is having an effect on the fetus.
Q. Let me now return to the question with which we started this morning, and that is to ask you from the process of assessment through dilation through the surgical component to describe your method with respect to D&E.
A. Yes.
After the assessment and the discussions that we were just alluding to, we proceed first with the use of osmotic dilators to soften and dilate the cervix. And we will decide for each patient how many dilators to use, again, depending on her personal anatomy, whether she has given birth before, how

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far PRG TPHAPBT she is and so on.
We in fact also have a separate discussion as part of the informed consent process of the use of the osmotic dilators. We insert osmotic dilators in exam room using local anesthesia so that that process is more tolerable for the patient and we may inS-RT dilators once or twice. We may see a patient on just one day prior to the operation or two days. If we see the patient for two days on the second day we will remove the first set of dilators and replace these with a new set of dilators in order to achieve greater dilation and, as I said, that decision is made primarily on the basis of gestational age and the woman's anatomy.
After we have allowed time for the dilation to proceed the woman is requested to appear after the hospital with an empty stomach so that we can induce general anesthesia for the D&E procedure. In and in some occasional cases we will also use some misoprostol for a few hours before the procedure to additionally soften the cervix.
In the operating room after the patient is asleep we will remove all of the dilators, assess the condition of the cervix and we will then rupture the amniotic membranes, allow amniotic fluid to drain and then we will insert either fingers or an instrument into the uterine cavity.
Before we can insert any instrument we do attach a tenaculum to the outside of the cervix in order to pull the

cervix down and stabilize the uterus as I described in the first trimester procedure.

But once the cervix is stabilized we will then insert finger or uterus -- finger or instrument into the uterine KAFB cavity to begin to pull down fetal parts.

In general, in our cases, we have a son O graphy unit in the room with us standing by but we decide on a case by case basis how much we want to use sonography during the case.

THE COURT: That's a on O gram.

THE WITNESS: Son O gram, ultrasound, yes, to take, to image the fetal portion, the fetal parts and position.

Q. Does that conclude the description, Doctor?

A. At this point we will begin the extraction of the fetus or the evacuation of the fetus. And we can do this with a combination of traction with instruments or digital traction until we remove the entire fetus from the uterus.

When we have removed the entire fetus, if it is in parts we do enumerate the parts to feel confident that all the fetus has been removed and then we will remove placenta and membranes using a combination of suction curettage and sharp curettage.

Q. You mention traction in your answer, Dr. Westhoff; what is traction?

A. Traction just means pulling.

Q. With respect to your earlier testimony that these

procedures all proceed variably, what are some of the factors that may vary among the D&E as performed for different patients?

A. There are differences both in -- well first of all in the maternal anatomy and every woman's cervix responds differently to the osmotic dilators so we don't know until we begin this part of the procedure how long the cervix is or how open the cervix is.

We, in every indication the placenta is going to be in a different position and in every case the fetus will be presenting in a different position.

In the middle trimester when we do these procedures the fetus may be head first but majority of the time is presenting in some other position.

At nine months 95 percent or more of the time when labor begins the fetus is head first. But in the mid try PHEFLTer because there is more space in the uterus the fetus can be in a much broader variety of positions and very roughly speaking about one third will be head first, one third will be feet first and one third will be in some more sidewayss kind of position at the beginning of the procedure. That position will affect, of course, what part of the fetus we are able to grasp as begin the case.

Q. How far, Dr. Westhoff, does the cervix dilate during a D&E, as you perform it?

A. There is really extraordinary variation and so some patients may only be one to two centimeters dilated, other women may be three to four cent meters dilated at the beginning of the case.

Women who are having a D&E because of miscarriage because may have a cervix that is already open to three or four cent meter without my using any laminaria to cause that dilation.

Q. Is getting too much dilation a concern for you in your D&E practice?

A. No, it is not.

Q. Why is that?

A. I have never had a cervix dilate in a way that was inappropriate for the case.

At nine moss of pregnancy during labor of course the cervix dilates on its own to about 10 cent meters in diameter overall. I have never ever seen someone respond to osmotic dilators to that degree, they're substantially less dilation but because the fetus is smaller less dilation is adequate to carry out the D&E.

Q. Can you state whether responding to osmotic dilators the cervix dilates quickly or gradually?

A. The cervix dilates gradually in response to osmotic dilators.

As I said over -- we could use them for as little as

six hours, for instance, in some cases late in the first trimester but generally we use in the second trimester we are using osmotic dilators anywhere from 24 to 48 hours before the case and so that degree of dilation of a couple cenimeters occurs over many hours. That's substantially slower than dilation that occurs during labor at term or during an induction abortion.

Q. Why doesn't maximizing the degree of dilation harm the woman's cervix in the D&E as you perform them?

A. Well the cervix is, of course, capable of dilating all the way to 10 cenimeters and that is -- that's the natural potential of cervical dilation and that is what is experience during childbirth and to our knowledge cervical dilation during childbirth is not harmful to the cervix.

What we do during a D&E is less dilation than childbirth tanned occurs much more slowly than childbirth.

Q. As between D&E and induction in the second trimester, which procedure typically has the most dilation associated with it?

A. Induction will have more dilation during the second trimester because the fetus in fact cannot be delivered in an induction until there is enough dilation in order to expel the fetal head and in an induction the fetal head is intact and so has larger diameters than it does with a D&E.

Q. Are you aware of the use of laminaria with certain second trimester abortions -- sorry, second trimester inductions,

currently?
A. Yes.
There are a number of people using induction abortion in the second trimester will do a combination kind of treatment where they may use OGS motic dilators prior to starting the induction and we know that that use of laminaria or other osmotic dilators during an induction abortion or prior to an induction abortion will shorten the time required for an induction abortion.
So it is an add junktive approach that enhances the induction.
Q. Dr. Westhoff, how much of the fetus can a physician remove with the first pass of instruments during a D&E?
A. Well --
MS. GOWAN: Objection, your Honor.
THE COURT: May I have the question, read, please?
(record read).
THE COURT: What's the objection?
MS. GOWAN: I don't think that Dr. Westhoff is qualified to respond to a question that asks generally about how much physicians can remove on the first pass of the instrument.
MR. HUT: I will rephrase the question, your Honor.
BY MR. HUT:
Q. In your D&E practice, Dr. Westhoff, how much of a fetus may

be removed by the physician with the first pass of instruments during a D&E?
THE COURT: Meaning herself.
Q. Herself or her service, to the extent she is familiar with it?
THE WITNESS: Myself, that's fine.
Many my own experience, my own personal experience there is a very wide range of possibility where SPHAOEUFPLSZ with the first pass of instruments in fact we do not succeed in removing any fetal parts so we can have an unsuccessful pass. And we can introduce instruments and remove the entire fetus at the first pass of the instruments and of course every possibility in between those two extremes have, which have all in fact occurred in my very own practice.
THE COURT: Does it vary with gestational age?
THE WITNESS: Yes, it does. But the correlation with gestational age is an imperfect one because both of the extremes that I described can occur early and late in the second trimester.
THE COURT: Have you ever perforated the uterus with one of these passes?
THE WITNESS: To my knowledge I haven't personally had --
THE COURT: That's all I'm asking.
THE WITNESS: Had a perforation. I can also tell you

the statistics for my service.
THE COURT: I'm just asking you, Doctor.
THE WITNESS: Okay.
THE COURT: We have more than enough statistics here.
Have you ever lacerated the cervix?
THE WITNESS: Yes. I have had patients experience cervical laceration under my care during D&E.
THE COURT: Yes.
BY MR. HUT:
Q. Have doctors performing D&E in your service under your supervision had uterine perforations during the course of D&Es they have performed, Doctor?
A. Yes.
As I was saying yesterday, I'm responsible for assessing all of our complications in order to make sure that we're taking good care of our patients and see what's going on.
In the last three years on our service we have had one cervical laceration and we have had three perforations of the uterus during D&E procedures.
THE COURT: Were these done by interns or residents?
THE WITNESS: They were done by other attending physicians or --
THE COURT: I didn't ask you that, Doctor. My questions are very simple.
THE WITNESS: No.

THE COURT: They were not done by residents.
THE WITNESS: They were not done by TPHERPBTZ or receipts dent.
THE COURT: Either win.
THE WITNESS: I know who was involved in each of these cases and it was not interns and residents.
BY MR. HUT:
Q. These perforations and lacerations occur in D&Es that were effected with dismemberment or more relative intact, Doctor?
A. Each of these cases I am referring to occurred during a dismemberment type of D&E.
We have had no lacerations or perforations on my service with the use of an intact variant of D&E.
Q. At what point during the D&E procedure as you do it, Dr. Westhoff, would it be decided the D&E would be proceeding by an intact or relatively intact extraction?
A. As I mentioned earlier, each step in our surgical care is really determined by the step that immediately precedes it.
My PREF convenience to minimize the passes of instruments into the uterine cavity and my corollary preference is to remove as much of the fetus in each pass as possible and the, sort of logical goal of that is if I can remove the fetus intact I will do so.
But we have to see each step of the way as we proceed if that's possible.

Sometimes I may remove a portion of the fetus first. Possibly I will remove a leg and then after I have removed that leg on the next pass I'm able to bring down the entire rest of the fetus.

So, each case may have a very individual kind of progression through the steps whether it's entirely intact, entirely in pieces or some combination between those two and that evolves as the case proceeds and depends on what is possible for me to do in the safest manner.

Q. With respect to the dilation process in a D&E as you described it earlier, does that process differ for an intact D&E or as between intact D&E and a dismemberment D&E?

A. No, it doesn't.

We approach dilation, as I said, based on the patient's anatomy, her obstetrical history and gestational age. We don't start out with a prior intent of doing something different.

For all of our cases I would like to do an intact evacuation if possible but everybody gets the same approach to the laminaria.

THE COURT: Going back if I could with you a moment, Doctor, to your discussion with patients who say all of them you try and do an intact procedure?

THE WITNESS: Yes, your Honor.

THE COURT: Do you tell the mother that when you do

that that you get to that stage that part of the body, that the fetus is outside her body you insert scissors in the base of the skull and insert them into the brain of the fetus?

THE WITNESS: I have not used those particular details but I do tell patients that my goal is to make the --

THE COURT: I'm not asking about goals, Doctor, I'm trying to find out what you really tell.

THE WITNESS: Okay.

THE COURT: The mother what you are going to do when you do this procedure.

THE WITNESS: Okay.

THE COURT: I want to know whether that woman knows that you are going to take a pair of scissors and insert them into the base of the skull of her baby, of her fetus. Do you tell her?

THE WITNESS: I do not usually tell patients specific details of the operative approach. I'm completely --

THE COURT: Do you tell her that you are going to then, ultimately, suck the brain out of the skull?

THE WITNESS: In all of our D&Es the head is collapsed or crushed and the brains are definitely out of the skull but those are --

THE COURT: Do you tell them that?

THE WITNESS: Those are details that would be distressing to my patients and would not -- information about

that is not directly relevant to their safety.
THE COURT: Don't -- whether it's relative to their safety or not don't you think it's since they're giving authorization to you to do this act that they should know precisely what you're going to do?
THE WITNESS: That's actually not the practice I have of discussing surgical cases with patients.
THE COURT: I didn't ask you that. I said don't you think they ought to know?
THE WITNESS: No, sir, I don't. That's not how I discuss C Sections with patients, it's in the ow I discuss hysterectomy mys and not how I discuss D&Es.
THE COURT: Next question.
BY MR. HUT:
Q. Do you tell a woman who is considering a D&E that the fetal arms, legs, extremities may be dismembered is in the course of a dismemberment variation D&E, Dr. Westhoff?
A. I tell patients that we will remove all of the fetus and the uterus and membrane, the placenta and membranes from the uterus as safely as possible and that that proceeds somewhat differently for all patients.
I then see if that elicits further questions from the patient and I address the questions according to her concerns.
Q. But following up on the Court's question, are you any more explicit with respect to the details of a D&E depending on

whether it's an intact D&E that may be performed or a dismemberment D&E?
A. I offer patients the same general information and because I don't know at the pre-operative visit how the surgery will actually play out when the time comes, I do give patients a general description and in fact tell them I don't have a crystal ball to predict exactly how their operation will proceed on the next day.
Q. During the midtrimester Dr. Westhoff, what is usually the largest part of the fetus?
A. The largest part is the skull itself and in particular we pay attention to the diameter across the skull.
Q. When any part of the fetus is too large to pass through the cervix during the course of a surgical abortion in the midtrimester, how do you remove the part in question?
A. For any fetal part that's too large to fit through the cervix we attempt to remove -- reduce the diameter of the fetal part by severing, crushing it or collapsing it.
Q. How often will it be necessary to collapse the fetal skull during D&E whether the D&E proceeds by a dismemberment or more relatively intact, Doctor?
A. For the vast majority of D&Es testimony be necessary it either crush or collapse the feel theal skull.
THE COURT: Do you tell the woman that? Do you use the word crush?

THE WITNESS: Your Honor, I do not.
THE COURT: I didn't think so.
Next question.
BY MR. HUT:
Q. Is that true of both dismemberment D&E and intact D&E, concerning the need to collapse the skull during D&E?
A. Yes, it is.
Q. Is there a difference, Dr. Westhoff, between the way a head, fetal head may be collapsed in a D&E by dismemberment and the way it may be collapsed during a D&E performed by the intact SRAEUR KWREUGS?
A. Yes. The approaches are different.
In the dismemberment D&E the fetal head will be up inside the uterus. It is necessary to insert our forceps, open them as wide as possible to try to capture the head within the opening of the forceps and then crush the head using external force applied against the head.
And at that point the contents of the skull will drain and the diameters will be reduced and we will be able to remove the skull through the cervix.
This is often difficult to do and may require multiple attempts which is one of the risks that concerns me.
With an intact D&E D&E, when we have put a hole into the base of the skull we can generally do that under direct visualization because the base of the skull is, thanks to

traction, held right in the cervical opening and so it is, in my experience and my opinion, less risky to put a hole in the base of the skull.
Because the contents of the skull are liquid the skull contents may often drain out spontaneously as soon as there is a hole in the skull. In some cases it is necessary to use succeeding. The bones of the skull are fairly soft and will just collapse inward at that point without any external application or force and then the diameters are reduced and it will be possible, using additional traction, to deliver the head through the cervix.
THE COURT: Doctor, when you are doing any of these crushing procedures, whether it be to an extremity or to the body, the skull, does the baby, does the fetus ever make any noise or cry?
THE WITNESS: It absolutely does not. And in our setting it does not move. It does not withdraw, it does not move. It has very limited tone to its body.
THE COURT: How about when you do the intact.
THE WITNESS: It does --
MR. HUT: Let me finish the question.
THE WITNESS: Yes, your Honor.
THE COURT: It is a breech presentation and and the extremity, the fetus is removed from the uterus up to the skull to do the hands ever move, the if I canners?

A. In my experience there is no spontaneous fetal motion. The fetus is limp.
THE COURT: You have never seen the feet move or the hands?
THE WITNESS: Not in my experience with a D&E.
THE COURT: Have you ever heard of them moving before you make the hole in the base of the skull.
THE WITNESS: Not in my experience on my service, sir.
THE COURT: Next question.
BY MR. HUT:
Q. Dr. Westhoff, are you able to see, ever, the base of the fetal skull when you are collapsing it in the course of a D&E proceeding by the dismemberment variation?
A. No. If I am collapsing the skull that is still inside the uterus in a dismemberment D&E I am not able to see the skull at all. That's when we often rely on sonography to help us locate the skull because it is high up -- it is usually high up in the uterine cavity so we need to use rather long forceps in order to grasp it and collapse it and bring it down to the cervix.
Q. Dr. Westhoff, when, in a pregnancy, can a D&E be performed?
A. We can did a D&E techniques throughout the second trimester.
Q. At what point in the second trimesterer are you able in some circumstances, to achieve or to use on regular basis, the intact variation of D&E?

A. The variation that we've been discussing in the last few minutes we may commonly use at 18 or 20 weeks or later in the second trimester.
Q. How often are you able to achieve intact delivery in a D&E?
A. At those gestational ages I would say very generally less than half of the time we effect an intact delivery.
Q. Does it ever happen in your experience, Dr. Westhoff, that prior to the 18 to 20 week period you just mentioned you are able to remove the fetus intact?
A. Yes, it does happen.
Q. In addition to D&E, Dr. Westhoff, what other options are available for abortions after the first trimester?
A. Induction is the main option that's selected and at least THRAOET KHREU hysterotomy, which is equivalent to a c-section or hysterectomy, would be techniques. But these are much greater risks of complication for the woman and so they are used extremely rarely.
Q. Based on your review of and familiarity with CDC statistics, Dr. Westhoff, what percentage of second trimester abortions are performed using the procedures you have just identified?
A. The best estimate is about 95 percent are D&E and about 5 percent are induction.
CDC also does report some perfect portion of cases as being done according to other techniques and we don't know

fully what is included in the other category.
But it appears that D&E and induction include most of them.
The CDC's categorization -- I'm sorry if this bores the Court, but only refers --
THE COURT: Why should you think that, ma'am?
THE WITNESS: Well you said something about statistics a minute ago not being so interesting.
THE COURT: The Court never told you that statistics bored it.
THE WITNESS: I'm sorry, your Honor.
THE COURT: So don't put words in my mouth, ma'am.
THE WITNESS: I'm sorry, your Honor.
That the CDC has for about 20 years now had a category of installation type of induction and may not, that may not include inductions that are currently being done using, for instance, administration of prostaglandin in the vagina rather than installation.
So, the statistics, the best we have in the United States, but not as perfectly informative as I might wish.
(continued on next page) TWM 4/2 take 2 NAF v. Ashcroft Caroline Westhoff on direct by Mr. Hut<]
Q. Does that mean that prostaglandin inductions in the second trimester would be performed less than 5 percent of the time?
MS. GOWAN: Objection.

THE COURT: What is the objection?
MS. GOWAN: Leading.
THE COURT: Sustained.
Q. Dr. Westhoff, do you have an opinion whether an abortion as performed in the United States today is a safe procedure based on your familiarity with statistics concerning complication rates?
A. Yes.
Q. What is your opinion?
A. Abortion is safer than continuing pregnancy to term and continuing childbirth, and it is also overall extremely safe.
Q. Without going into the relative safety of different methods of abortion at this point --
THE COURT: Before you go further, safer than childbirth?
THE WITNESS: Yes, your Honor.
THE COURT: Would you recommend abortions rather than childbirth then?
THE WITNESS: If a woman wants to have a baby, she should TKR*EUPBL definitely go the full nine months.
THE COURT: And take the risk?
THE WITNESS: And take the risk, yes, but --
THE COURT: Thank you, next question.
Q. Without delving into the relative safety of different melds of abortion, do you have an opinion on the impact of increased

gestational age of the relative safety of abortion?
A. Yes, sir. Abortion is safest in the early weeks of pregnancy and as the gestational age advances, the risks and complications increase as well.
Q. Dr. Westhoff, based on your experience as an obstetrician and TKPWOLGT, are you familiar with reasons why women terminate their pregnancies after the first trimester?
A. Yes, I am.
Q. In your practice what are circumstances you have seen that cause women to terminate pregnancies after the first trimester?
THE COURT: You can ask what women have told her. But obviously she can't testify what is in their mind and how they make the decision.
MR. HUT: Absolutely.
THE COURT: So the form of the question is objectionable.
Q. Subject to the Court's observation --
THE COURT: No. Just ask the questions, Mr. Hut.
Q. What have women told you as to reasons why they wish to terminate pregnancies after the first trimester?
MS. GOWAN: Objection: Hearsay.
THE COURT: I will allow it.
A. There are several categories of. One is personal problems such as relationship problems and social problems. A much larger group in our practice is women who HIV abnormalities in

the pregnancy itself. These may be chromosomal abnormalities that have been diagnosed or anatomical abnormalities of the fetus, and a smaller group are --
THE COURT: Could I stop you there. Do you make a note on your chart when that exists?
THE WITNESS: Yes, we do. We generally are in receipt of information from a referring physician with regard to test results, and so on.
THE COURT: But you perform the procedure. Do you note on your chart the reason for the abortion?
THE WITNESS: We usually do. I'm not sure that is true 100 percent of the time. But I think we usually do, sir.
THE COURT: Do you do it, personally?
THE WITNESS: Yes, I usually do.
THE COURT: Next question.
Q. Have you completed your answer as to the reasons women have told you why they seek to terminate pregnancy in the second trimester?
A. Just the last point is that a third cat TKPWOEURL of seeking abortion are problems with maternal health. That is a smaller category than the other two.
Q. With respect to problems with maternal health and chromosomal and anatomical anomalies with fetuses, do women who encounter these, are they mostly ending wanted or unwanted pregnancies, Dr. Westhoff, in your experience?

A. The majority of my patients across all reasons are in fact ending wanted pregnancies because of problems that have developed or been diagnosed.
THE COURT: Excuse me. If the abortion is done for maternal health reasons, do you note that on your charts?
THE WITNESS: Yes, we generally do.
THE COURT: You personally?
THE WITNESS: I personally generally do.
THE COURT: Next question.
Q. When in pregnancy, Dr. Westhoff, are fetal anomalies of the kind you described generally diagnosed?
A. For chromosomal abnormalities some women have early testing and may have a diagnosis of a chromosomal abnormality by the end of the first trimester. But most of the patients who I see have genetic abnormalities diagnosed by amniocentesis during the second trimester. That may be done anywhere between 16 and 20 weeks' gestation, and they will get the results of that test 2 to 3 weeks later. So that is when I see them with regard to genetic abnormalities.
For women who have anatomical abnormalities on a sonogram, such as an abnormal heart, for instance, that is most likely to be detected at or even after 20 weeks' gestation. So those patients tend to come to me towards the end of the second trimester.
THE COURT: Doctor, could I ask you, we have heard a

lot of about amniocentesis. Since you are very fond of statistics, or appear to be very aware of them, how frequently does amniocentesis occur in the pregnancy? How many fetuses have that problem?
THE WITNESS: Amniocentesis is a diagnostic test to remove fluid from the sac surrounding the fetus in order to do tests T. standards continue to evolve. The standard for most of my career has been to offer amniocentesis to all women age 35 or older because of the frequency of chromosomal abnormalities in that age group, as well as to women who have other problems in their personal history or family history. I don't know, however, the total number of amniocentesiss that are done in the United States each year. I don't have that information.
THE COURT: What is the condition where there is abnormal fluid in the head?
THE WITNESS: That is hydroselfous.
THE COURT: Can that be detected by the amniocentesis?
THE WITNESS: No. Hired selves is not a chromosomal abnormality. Hired selves will be likely diagnoseed with an anatomical study of the fetus using sonography at around 18 or 20 weeks.
THE COURT: Conditions that cause blindness in babies at birth, can that be detected prior to birth?
THE WITNESS: Not to my knowledge, your Honor.

THE COURT: So there are no, that you know of, abortions done because the mother can detect in advance that their baby will be born blind?
THE WITNESS: Not in my personal experience and not to my knowledge.
THE COURT: Go ahead, Mr. Hut.
Q. Dr. Westhoff, do you have an opinion regarding the safety of D&E?
A. Yes, I do.
Q. What is that opinion?
A. That D&E is a safe technique of abortion and is in most cases overall has less risk of maternal morbidity and mortality than continuing a pregnancy to term.
Q. What is the basis for your opinion, Doctor?
A. In part I base my opinion on data collected from the CDC with regard to maternal mortality, and for data regarding complications and morbidity from a variety of case series, as well as other government collected data on hospitalization rates.
Q. Do you have an opinion, Dr. Westhoff, regarding the safety of induction in the second trimester?
A. Yes, I do.
Q. What is that opinion?
A. Induction is generally a safe approach to abortion. The newer induction techniques appear to be safer than the

installation techniques that were used 20 years ago. But because induction is infrequent, there is somewhat less data available to assess its safety.
Q. Do you know what percentage of inductions in the second trimester are performed by the newer methods of induction as opposed to saline inSTEULGS?
A. I don't know, and I am not aware of any data source to help me with that.
Q. Dr. Westhoff, do you have an opinion as to how the safety of D&E compares to the safety of induction? [> installation should be instillation, above<]
A. Yes.
Q. What is your opinion, Doctor?
A. Both approaches are very safe. In the earlier part of the second trimester up to 16 weeks or so the uterus us less sensitive to the induction drugs, and so I think D&E is substantially safer because it is more likely to be successful in the earlier part of the second trimester. In the later part of the second trimester, in general, D&E and induction are similar. However, that depends on the resources available when taking care of the patient, because they are not going to be equal in all hands.
Q. With respect to the later part of the second trimester, do you have an opinion why D&E is the more common in that portion if, as you have testified, the procedures are, subject to your

testimony, approximately comparable in safety?
A. Yes. An induction abortion involves hospitalization for a period of several days during which a woman goes through essentially the experience of labor. This is painful and difficult for all women, and in particular is distressing. My patients find that would be very distressing when they are ending a wanted pregnancy, and they would prefer to have a D&E with less time in the hospital and the opportunity to under undergo the abortion itself in a very short period of time while they are asleep.
THE COURT: I don't think the witness can testify what the woman is thinking, Mr. Hut. I assume there is an objection, Ms. Gowan.
MS. GOWAN: Yes.
THE COURT: Sustained. Strike the answer. Ask it again, Mr. Hut. The witness can't testify what is going through multiple women's minds.
Q. Based on descriptions of the induction procedure that have been supplied to you by women who consulted your practice and opinions given to you by women who are --
THE COURT: That doesn't cure it. You have a crowd out there now.
Q. Dr. Westhoff, do you talk on a regular basis to women in your practice about the alternative of induction?
A. Yes.

Q. What do they tell you about their views W-FRPT induction?
MS. GOWAN: Objection.
THE COURT: Sustained.
Q. How do the contractions during induction during the second trimester, Dr. Westhoff, compare to those typically experienced at term during labor?
A. The uterine contractions during an induction abortion are similar to the contractions that women experience during childbirth where labor is also induced using similar med situations. I believe based on my experience that contractions that are induced with medication are more painful than contractions that occur spontaneously.
Q. How does the surgical portion --
THE COURT: How could you know that without feeling it yourself?
THE WITNESS: Your Honor, if it is appropriate, I have been through childbirth and have had an induction myself. But I have taken care of many, several thou, patients in childbirth. Based on my observation of spontaneous labor and induced later, I have a very definite opinion that induced labor is more painful for my patients.
THE COURT: Isn't pain something that can only be experienced by the person who is having it?
THE WITNESS: I agree that only the person who has the pain experiences it. I have an explicit responsibility

mandated by the joint commission to assess the level of pain and record the level of pain that my patients experience. So it is part of my job to assess, as an observer, the intensity and the quality of pain that my patients experience during all of my encounters with them.

THE COURT: So it is something subjective that you assess?

THE WITNESS: Yes, your Honor.

THE COURT: Next question.

Q. Is any portion of the curriculum for obstetricians and gynecologists either in medical ask school or residency devoted to pain management?

A. Pain management, yes, has become a priority based on the request of the joint commission that all doctors --

THE COURT: Which joint commission is this?

THE WITNESS: The joint commission for the accreditation of healthcare organizations, which periodically reviews all hospitals and SOERBGTd facilities for whether they meet national standards and can continue to be accredited to take care of patients.

Q. Dr. Westhoff, how long typically does the surgical portion of a D&E take from the commencement of the evacuation to the cessation of anesthesia in your practice?

A. There is of course a range. I don't have a practice of watching the clock during cases, but I would say that often in

the neighborhood of 20 minutes. But cases can be as short as 10 minutes and as long as an hour. If there are complications that require treatment, it can be much longer than an hour.

Q. With respect to the insertion of laminaria that you described that can occur one or two days prior, where is the woman typically after the laminaria are inserted and prior to surgery?

A. After a woman has laminaria she may return home or return to work.

Q. Do you have an opinion, Dr. Westhoff, whether inductions may be medically less preferable for some patients undergoing abortion?

A. Yes.

Q. For what types of complications might an induction abortion be medically less preferable?

A. There are several categories of patients where an induction may be more dangerous or likely to fail. First among women for instance where the uterus is inTPEBGTD they have a condition called chorioamnionitis. The cervix is often soft and easy to dilate but the uterus will not respond well to the medication, and prompt removal of the pregnancy by doing a D&E is safer in terms of the infection and quicker. So that is one example.

In looking at the maternal anatomy, in a woman who has had certain types of previous uterine surgery there is a risk with the contractions of induction that her uterus would

rupture. Therefore, while there is a range of opinion about exactly which surgeries are contraindications against induction, I think that doctors would agree that many uterine surgeries are contraindication to an induction because of the risk of uterine rupture -FPT those are two major examples.
Q. What is uterine rupture, Dr. Westhoff?
A. Uterine rupture simply means that the uterus rips open. The problem with that is that of course the woman can hemorrhage, the repair may require, will require, immediate emergency surgery, and if the uterus cannot be repaired adequately, it may be necessary to do a hysterectomy. So uterine rupture leads to the risk of permanent loss of child bearing capacity.
Q. What are some of the sources or origins of uterine scarring that may make an induction medically less preferable?
A. The most common type of uterine scarring is that from a previous Cesarean section. There are about 1 million Cesarean sections per year in the United States. If the Cesarean section is done high, if the incision is made high in the uterus, it is called a classical C-section, and I think most doctors would agree not to do an induction in that setting. If a woman has had multiple C-sections low in the uterus, I think that most doctors would agree an induction is more dangerous.
I think there is a wider range of opinion if a woman has had a single C-section, whether it is safe to do an

induction either in a future labor or at the time, for instance, of a possible abortion.
Q. Have you previously expressed opinion in writing on whether women or labor is appropriate for women following a single prior C-section?
A. I have some work that is relevant to that question, yes.
Q. What did you conclude in that regard?
A. Just briefly, that there has been a lot of concern that the rate of C-sections is a million per year, and one issue is whether we could allow all women after a C-section to labor and have a vaginal birth with the next pregnancy. So there has been a lot of work over 20 years now to assess the safety of that. I helped with a study a number of years ago to assess the risks of vaginal birth after C-section in a study that summarized the experience of about 11 or 12,000 women attempting vaginal birth after C-section.
For many of those women it is safe, but many of them require an additional C-section and they have a higher complication rate.
Q. Based on your experience, is there any evolution in medical viewpoint concerning the appropriateness of vaginal delivery following C-section?
MS. GOWAN: Objection.
THE COURT: May I have the question, please.
(Question read)

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THE COURT: Sustained. Rephrase it.
Q. Based on your review of literature, conversation with colleagues, and study in the field, has there been any evolution of point of view with respect to the appropriateness of labor following vaginal delivery?
A. Yes, there has been.
Q. What is that evolution, Doctor? S- S-
A. When I was in training in obstetrics at kings KOUPB any in the late 1970's, the rule that any woman with a previous C-section was not allowed to labor at all. There then began a trend over theeing next decade to permit labor and vaginal birth after C-section, although in general not to allow an induction after a C-section.
THE COURT: When you use the word "induction," do you mean induced birth?
THE WITNESS: Yes.
THE COURT: Or an induction abortion?
THE WITNESS: I was referring right then to any kind of induction, whether it is a future pregnancy at term to be induced or the possibility of an induction for an abortion. But induction at term for a birth would be far more prevalent.
Q. What is amy oh PHEBG tome, Dr. Westhoff, about which there has been some testimony from prior witnesses?
A. Amy oh met tome is an operation to remove benign growths from the uterus that are called fibroids or my OEPLS. S- there

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is concern that the weakened wall of the uterus after such surgery would contraindicate an induction in a future pregnancy because of the risk of uterine rupture. The magnitude of that risk will various according to how extensive themy PHEBG tomy was.
Q. Ismy oh PHEBG tomy a source of uterine scarring?
A. Yes, it is.
Q. Is induction relatively less preferable in your opinion for women who have uterine scarring from my PHEBG tome?
A. I would prefer to avoid inductions in women with uterine scarring.
Q. Dr. Westhoff, what is placenta previa?
A. That is a placenta in the position where it covers all or part of the cervical opening. Certainly the risks of placenta previa are hemorrhage as the cervix dilates. If the patient has a placenta previa and needs a second trimester abortion, I would prefer to use a D&E technique and not an induction, because of the greater risk of hemorrhage during induction.
Q. Do you see, Dr. West Westhoff, in the course of your practice, patients who experience cardiac disease during pregnancy?
A. Yes, we do.
Q. In your medical opinion, what type of abortion is the most appropriate for a woman with cardiac disease?
A. I want to rely on the cardiologists who refer such patients

to me. Because of the cardiac condition of the patients, these doctors will tell me that whether it is in the second trimester or in fact for childbirth at term, that prolonged labor is dangerous to their patients because of the change in the dynamics of the blood supply. So they refer patients to me for D&E.
Q. In the course of your practice, Dr. Westhoff, do you see patients refer to you with pulmonary disorders?
A. Yes, I do.
Q. Do you have an opinion concerning whether induction is medically preferable or not with respect to women with certain preliminary disorders?
A. For all of my patients with medical conditions, I try to make a decision in their best interest in conjunction with the specialist who is taking care of their primary problem. For patients with pulmonary disorders I prefer to do a D&E, because fundamentally the anesthesia care during the D&E can protect the rest of their body systems, including their lung. And also because some of the drugs that are used for induction, the PROS prostaglandins, have a risk of causing bronchospasm, which would interfere with the patient's breathing and oxygenation.
Q. Can you explain further what bronchospasm is.
A. I'm sorry. Bronchospasm is asthma. The air will not pass through the tubes in the lungs.
Q. Do you see any patients, Dr. Westhoff, who are referred to

you by other doctors with bleeding disorders?
A. Yes, I do see patients who have either primary bleeding disorders, so the patients who have abnormalities of clotting factors and abnormalities of their platelets because that is just a primary problem in their body, or because such a problem results as a side effect when they are being treated for some other condition. So I see patients with a wide range of clotting disorders in our practice.
Q. Can you state whether in your opinion induction is more or less medically appropriate for women with such bleeding disorders affecting clotting factors and platelets, Doctor?
A. In consultation with the medical doctors who are primarily taking care of these patients, our preference is to take care of them with D&E where during a brief time, as needed, we can replace any missing clotting factors during the short time that the procedure takes, and that minimizes the risk of hemorrhage in comparison to a more prolonged induction abortion.
Q. Are there certain types of fetal anomalies, Dr. Westhoff, that in your opinion make a medical induction less preferable?
MS. GOWAN: Objection, your Honor.
THE COURT: I think I heard THAERD question, but can you read
(Question read)
THE COURT: What is the objection?
MS. GOWAN: A fetal anomaly not a maternal condition,

so I believe the question is vague.
THE COURT: I will allow it.
A. Yes.
Q. What is your opinion in that respect, Dr. Westhoff? [> check above<]
A. Any large something of fetal anatomy will interfere with the progress of labor in flux and will therefore more likely result in a failed induction. So by and large in the presence of large abnormalities of the fetus, for instance, hydroselves, I would prefer to perform a D&E. A failed induction would mean that a patient would end up needing a D&E anyway. So rather than going through induction where there is a high risk of failure, I would prefer to start with a D&E.
Q. Is there a higher risk of failure with induction in connection with a fetal anomaly such as hydroselves?
A. The problem with hydroselves, in that case the fetus has a very large head so it is unlikely to be able to fit through the cervix. This depends of course --
THE COURT: Couldn't you just crush it then?
THE WITNESS: It would be an extra procedure to crush the head. And if you are going to do an induction, you don't actually have any access to the fetal head to crush it prior to the induction. So one would end up with putting the patient through labor and still needing to do a combined procedure.
THE COURT: Are there any studies done as to whether

it is more profitable for a physician to do a D&E rather than an induction? Is there anybody who has done a study on the profit margin?? Because it takes less time for the D&E, you can accomplish more of them in a shorter space of time, are they more profitable for the physician?
THE WITNESS: I think that I could probably lay out for you, if you would like, how we --
THE COURT: I asked you a simple question. Have there any studies been done that it is more profitable to do a D&E for a STPHUBGS as to the profit to the physician? S-
THE WITNESS: I think the amount of physician time has not been assessed in comparing these two procedures.
THE COURT: You have testified that they take normally less time. How about are they more profitable for the hospital?
THE WITNESS: Sir, if I may address the first point, the physician is not -- the induction takes a great deal more time for the patient. The physician is not necessarily directly involved during all of that time. So the amount of physician time that is involved in the two may not be so different, but I am unaware of any formal comparisons for that.
For the hospital, I don't know what the differences are in the billing on the part of the facility.
THE COURT: Has anybody ever made a study or comparison as you have heard it?

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THE WITNESS: I am not aware of that. The hospital has certainly not expressed a preference to me that they wish I would do one procedure or the other. I have never heard such a recommendation from the hospital.
THE COURT: So you don't know whether it is more profitable for a physician to do more D&E's because they occupy less of the doctor's time, whether it is more profitable?
THE WITNESS: As I told you, the D&E procedure itself may be 20 minutes or an hour in the operating room. But there is a lot of additional time spent with the patient in the preoperative care and post-op care, and that may be similar to the time that a physician spends taking care of a patient having an induction. I believe it would be possible to make those comparisons, but I'm unaware that anybody has ever done so.
THE COURT: All right. Next question.
Q. Approximately how often in your experience, Dr. Westhoff, do inductions fail?
A. For inductions, the entire induction can fail in terms of meaning that there is no expulsion of the fetus or perhaps the maternal condition deteriorates before enough time has elapsed. Those cases are fairly rare but are require immediate conversion to a D&E. For a large subset of inductions, anywhere from I would say 10 to 25 percent, the uterine contractions fail to expel the placenta and membranes;

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therefore, the patient still needs to have a D&C in order to remove that portion of the pregnancy.
THE COURT: A D&C?
THE WITNESS: A D KR*PBD C, yes, sir, to remove the placenta and membranes.
Q. When the induction fail in the sense that the fetus is not expelled from the uterus, what procedures are taken with respect to that condition?
A. In most cases, if there is some degree of uterine dilation, we would proceed to a D&E.
Q. Do you have an opinion, Dr. Westhoff, regarding the safety of the intact variation of D&E?
A. Yes, I do.
Q. What is your opinion, Doctor?
A. My opinion is that the intact variation is safer for the woman than the dismemberment variation of D&E.
Q. Why in your opinion is the intact variation safer than the dismemberment variation for the woman?
A. Because we minimize the number of passes of instruments into the uterus, we can reduce or possibly eliminate the risk of perforation of the uterus or laceration of the cervix that is directly due to the instrument itself. Also, because in TKPHEPLT D&E the fetus is removed in parts, there are bony fragments and it is possible for the bony fragments to cause perforation or laceration. With the intact variation, that

risk is decreased or eliminated.
Also, with the TKPHEPLT D&E there is a risk of small portions of the fetus remaining behind in the uterus, and that can lead to hemorrhage or infection of the uterus subsequent to the procedure. When the fetus is removed intact, that risk is reduced or eliminated.
Q. Dr. Westhoff, you made reference in your answer to the use of forceps in a TKPHEPLT D&E. I would like to show you an exhibit.
MR. HUT: Your Honor, may I approach at this time?
THE COURT: You may.
Q. Doctor, I have handed you Plaintiffs' Trial Exhibit 144.
MR. HUT: Your Honor, I have provided in advance of the trial this morning Plaintiffs' Trial Exhibit 144 for examination by government counsel.
Q. Dr. Westhoff, what is Plaintiffs' Exhibit 144. This is a surgical instrument referred to as vi are a forceps and comes from my operating [> BIERER forceps<]
Q. Are forceps like the beerer forceps that are Plaintiffs' Trial Exhibit 144 used by you during dismemberment D&E's?
A. Yes, these are.
Q. Can you describe the beerer forceps for the Court and in particular the KHRAFPG or grasping end of the beerer forceps, please.
A. Yes, sir. These are a stainless steel instrument, it is

about 11 inches long. At one end are finger holes to hold on to it. There is a hinge at about 7 or 8 inches along the shaft. Then at the tip of the hinge is -- the tips of the instrument are each about the size of my thumb and they are open, or fen straightd, they are smooth on the outside, and on the inside they are serrated in order to permit effective grasping.
Q. Since the external part of the KHRAFPG or grasping end of the forceps is smooth, how can those, if they do inflict uterine perforation, Dr. Westhoff?
A. There are several ways that these can cause perforation. First of all, during a D&E procedure the uterus is very soft. When we are reaching into the uterus seeking fetal parts, it is possible just to puncture the uterus directly with the tip of the forceps. Even though the tip of the forceps is smooth and rounded, it can easily penetrate the soft uterine wall during pregnancy.
Second, when we open the forceps to grasp fetal parts, it is actually possible to grasp the interior surface of the uterine wall and tear a piece of uterus from the rest of the uterus.
Q. Dr. Westhoff, in your experience as between the intact variation of D&E and the TKPHEPLT variation of D&E, which has the shorter operating time?
A. In our experience -- in my experience, my SPERPBL

experiencer intact D&E has a shorter operating time.
Q. Why is that the case, Doctor?
A. If I can remove the entire fetus intact, or close to intact, it is a fairly smooth sequence of events, and I do not have to repeatedly search within the uterine cavity for additional fetal parts. The search to grasp and remove each part separately may need to be repeatd as many as 10 to 20 times. That sequence of events usually culminating in the removal of the skull, is difficult and, because it is done blindly, must done with slow and careful approaches, and that takes more time.
Q. What safety advantages, if any, Dr. Westhoff, are associated with shorter procedure time?
A. For any surgical procedure there is just a general principle that shorter anesthesia time is safer for the patient. There are fluid shifts that can happen in the patient's body during the procedure and while under general anesthesia. So it is a safety benefit to limit the time.
In particular, during any surgery during pregnancy, there is always a risk of heavy bleeding and hemorrhage, and the more prolonged the procedure is, typically the greater the blood loss. Those are two STKAPBGS.
Q. Is there any safety advantage, Doctor, to shorter exposure to anesthesia?
A. In particular, for patients with medical abnormalities,

they will be less likely to experience complication and will recover more quickly if they have brief exposure to anesthesia.
MS. GOWAN: Your Honor, I would like to move to strike the testimony. It is beyond the scope of Dr. Westhoff's expert report in this case. I don't believe that she opined generally at all on the effects of anesthesia and the complications that might be associated with anesthesia.
THE COURT: Mark the exhibit and, Mr. Hut, if you think something contrary -- do you concede that or not?
MR. HUT: I am actually now paging, your Honor, through the expert report, which consists principally of --
THE COURT: I suggest you have one of your associates do that and you submit it to me on the break. If Ms. Gowan is correct, I will strike the testimony. If you believe she opined on this in the report, then have your associates mark it page and line.
MR. HUT: In general, your Honor, I do believe, I am confident, that she opined on general safety advantages of intact D&E and specified some. I do not know from memory whether she specified shorter exposure to anesthesia. I do know that it is --
THE COURT: If it is not there, I will strike it. Very simply, it is either there or it is not.
MR. HUT: My partner Ms. Wigmore has provided me a reference at paragraph 25.

THE COURT: I will look at it on the break.
MR. HUT: Of the declaration. Perhapss in Gowan would look at that as well during the break.
THE COURT: Fine. I will rule on it at the break. If you would go on to another area, please.
MR. HUT: Happy to.
Q. Dr. Westhoff, there was earlier testimony this morning about the way that the fetal skull is collapsed in the course of the TKPHEPLT D&E variation and the intact D&E version. As varying. As between those two, are there safety advantages incident to one of those, in your opinion?
A. Yes. I believe collapsing the skull in the intact procedure is safer for the patient.
Q. Dr. Westhoff, can you state whether there are any advantages to an intact D&E with respect to pathological examination post-procedure of fetal anomalies?
A. For patients who are --
THE COURT: Are you a pathologist, by the way, Doctor?
THE WITNESS: I am not a pathologist, sir.
THE COURT: I assume she did not opine on that in her expert report if she is not a pathologist.
MR. HUT: I believe she said, your Honor. Let me try to establish a foundation.
Q. Dr. Westhoff, have you talked to PALG on this \{^ivities}\{^ists} in connection with the D&E's that you

perform and learned about advantages to particular variations respecting pathological examinations?
THE COURT: That isn't going to cure it, Mr. Hut. Sustained. That's like me talking to aRod. I still can't hit 300.
MR. HUT: Would it were that easy, right, your Honor?
THE COURT: Would it be so easy.
Q. Dr. Westhoff, can you state whether in your opinion the intact variation of D&E facilitates a grieving by the woman or parents with respect to the D&E abortion?
A. Yes. We have taken care of several patients who have availed themselves of the opportunity to hold the fetus after a termination done by the intact D&E meld. Because it is the back of the skull that collapsed, since this is not disfiguring, and the face, for instance, is intact. Several of my patients have wished to hold the fetus after the procedure and have expressed gratitude that they were able to do so.
THE COURT: Would any of those patients that have expressed that desire to assist them in grieving, and certainly grieving is a serious thing, in any of those instances did you tell those mothers that what they authorized you to do was to make an incision at the base of the skull of their baby and suck its brain out?
THE WITNESS: Your Honor, I definitely --
THE COURT: It is a simple question, Doctor. Did you

in any of those cases?
THE WITNESS: I definitely in those cases discussed collapsing the skull. I definitely don't recall exactly what words I used to communicate it. But because we do not always achieve an intact D&E, for those patients we need to do have a detailed discussion that we might only a deliver a fetus in parts \that{,}\{,}that we would attempt to deliver it intact, that the skull would be collapsed, and so on. So we did discuss this ahead of time in those session. We also discussed whether the patient would in fact prefer, for instance, an induction in order to --
THE COURT: But did you tell them that you would be sucking the brain out of the same baby that they desired to hold, for the grieving process? Did you tell them that is what you did STPWH-
THE WITNESS: I definitely tell them I collapseted skull.
THE COURT: How about you can S-ing the brain out, did you tell them that before they wanted to hold that baby so they would know that is what they had authorized you to do?
THE WITNESS: They know that the head is empty. I do not use the term "sucking the brain out O*EU" with my patients. I don't think that helps the grieving process.
THE COURT: I didn't ask you that, Doctor.
Next question.

Q. Dr. Westhoff, you mentioned a moment ago that the face may remain even though the head is collapsed and the intracranial content suctioned out. Can you explain how that occurs?
A. Yes. The fetus has a tiny face and a relatively large head. The bones of the back of the skull are very soft. When we make an incision in the base of the skull, we don't disturb any of the skin covering the entire skull, we don't disturb the scalp. So the top and back of the head itself just collapses and looks a little wrinkly and collapsed, but the facial structures are not disturbed at all by that procedure.
Q. Do you or the hospital take any other steps to help facilitate the grieving process in circumstances where parents may indicate they desire it?
A. Yes, sir. We have clergy available to meet with our patients during their pre-opvisits or on the day of their surgery. We have social workers available. And we also have a variety of referrals available. We have arrangements to permit burial of the fetus if the patients want. And we have a protocol in place where the patients f they wish to, can identify a funeral home, and so forth.
Because the hospital also has small coffins present, both for still births or for fetuses after a termination, and in the case of our D&E patients we actually have little hats available so we could in fact cover the back of the head where the incision had been made. But we had a patient last year who

had an unfortunate abnormality of her pregnancy and aborted twins in the second trimester, and she was able to hold both of them and have clergy present and arrange for them to be buried.
Q. With respect to the subject of your testimony a moment ago, Dr. Westhoff, how long does it typically take, in your experience, to effect compression of the skull in an intact D&E?
A. It takes less than a minute.
Q. How long does it typically take in your experience, Doctor, to locate compress the skull in a TKPHEPLT D&E?
A. It takes several minutes. It is never less than a minute.
Q. Doctor, you referred in an earlier answer to the possibility or the counseling that you sometimes do or the offering that you sometimes do of an induction in cases where an intact fetus may be desired to facilitate the grieving process. Given that possibility, why then, in your opinion, did you do so the intact D&E variation offer advantages?
A. To some extent, the choices here are issues of patient preference. Even with my patients who, for instance, express a desire to hold the fetus, I make sure they know that I cannot offer them a certainty that I will deliver an intact fetus. They are aware of the probability it will be dismembered, but they really don't want to undergo labor and they would still rather undergo the D&E even though they know that the possibility of delivering an intact fetus is not certain. Did

I answer your question?
Q. Yes, Doctor.
THE COURT: Is this an appropriate time?
MR. HUT: I have about two more questions, or two more minutes, three more minutes, on this line. Then it would be a fine time, your Honor. But I'm happy to do whatever you want.
THE COURT: Go ahead, finish up this line.
Q. Dr. Westhoff, can you state whether in your opinion there are women with specific health conditions for which an intact D&E may offer safety or health advantages?
A. Yes.
Q. What are some conditions of maternal health for which an intact D&E may offer certain advantages, in your opinion, Doctor.
A. For those of my patients who arrive to be taken care of and already have serious medical conditions, and this includes heart disease, sickle cell TPHAOEPLia, organ transplant, and a variety of other conditions, for those patients whose physiologic status is marginal at the start of the procedure, any complication is more catastrophic in their case. They would really be not in a good position to undergo additional surgery to care for the possible complications. In those cases I believe those patients have the most to gain from an intact D&E, where I would have an opportunity to avoid complications that in their medical condition would be unusually risky for

them.
MR. HUT: This will be a fine time for the morning break, your Honor.
THE COURT: Fine. We will take our recess now.
(Recess) 4/2/04 Judge Casey continuing direct of Dr. Westhoff
THE COURT: Please, be seated.
Before we commence questioning I have reviewed the expert report and the transcript and I am going to allow the answer to stand as is, but I am going to preclude any more detailed inquiry along that line, as far as anesthesia, Mr. Hut.
I think as far as it goes I will allow it at this stage.
MR. HUT: Thank you, your Honor. I have no wish to pursue any further examination in all events but I appreciate the ruling.
THE COURT: All right.
BY MR. HUT:
Q. Dr. Westhoff, are you aware of any studies comparing the relevant safety of the intact variation of D&E with D&E involving dismemberment?
A. Yes, sir.
Q. What study or studies are you aware of, Doctor?
A. There is a study carried out by Dr. Chasen, who is another plaintiff in this case, which I believe has been accepted for

publication in the American journal of obstetrics and gynecology and is currently in press.
Q. Is the American journal of obstetrics and gynecology a peer HAOEUFR review journal?
A. Yes, it is.
Q. Have you read the article that is in press for publication in the American journal of obstetrics and gynecology by Dr. Chasen on the subject?
A. Yes. I have read the draft version of the article.
Q. Can you describe, in general, what the investigators, including Dr. Chasen, were seeking to do?
THE COURT: Do they say so in the report? Otherwise you are asking her to opine as to what was the operation of the mind of Dr. Chasen and if there were other authors. Investigators, I don't know who they are, but I'm not going to allow it if that's what are you asking.
BY MR. HUT:
Q. Was Dr. Chasen the lead investigator?
A. Yes.
Q. Based on what the text of the study or the article in press that you have read discloses, can you state what the investigators were seeking to do?
A. They were speaking to review their experience with D&Es over several years at a single institution in order to find out whether intact D&E cases had more complications than

dismemberment D&E cases.
Q. Based on your review of the study, how did Dr. Chasen and his co-investigators compare or go about comparing the relative safety of the two variations?
THE COURT: Before we go any further, what's this co-investigators business, are there more authors involved than Dr. Chase KHEUS? Who are the co-investigators.
MR. HUT: There are, your Honor. I have the study available. I can tell you the names of three others.
THE COURT: Well this is what I think you should bring out, as to who they are, what it's all involved, whose records did they study.
MR. HUT: Dr. Westhoff --
THE COURT: If you know.
BY MR. HUT:
Q. -- do you recall the names of any of the other investigators associated with Dr. Chasen in the study?
A. Yes. I don't know all of them. Do you quantity me to tell you the names of the ones I know.
Q. Yes, and their affiliations, to the extent you know those as well, Mrs. ?
A. Sure, Dr. Frank injury very in that case which is chairman of STWEUBGsened gynecology at the Cornell campus of the New York Presbyterian hospital is one of the authors; Dr. Bill rash Baum who is an attending physician there, Dr. SKWRA*UPB Kaufman

who did her training the Cornell campus of New York Presbyterian and who now is attending physician on my service at Presbyterian.
And I think there are one or two additional authors but I don't know those individuals <!0>
Q. Based on your review of the text of the study, can you explain what you believe Dr. Chasen and others, how they went about comparing the recommendtive safety of the two techniques?
THE COURT: Just a minute.
Is Dr. Chasen going to testify?
MR. HUT: He is, your Honor.
THE COURT: Then why would this witness be the appropriate one to ask how they went about it and what they did if she wasn't there and she didn't do it?
Don't you think Dr. Chasen might possibly be the one to ask.
MR. HUT: I think there is no question that Dr. Chasen has TPHUFP to offer on the subject. I thought Dr. Wes did as well but if it is the Court's preference we can go on.
THE COURT: If she didn't participate I don't think she qualifies.
MR. HUT: It is a study she reSTPAOEUFPLTD she reviewed.
MR. HUT: Of which I can make a proffer.
THE COURT: But if she didn't do it, it was like if I

read thyme Mag aSTKAOEPB today do you think I would be the appropriate witness to testify as to what thyme did in their investigation and their writing and what they did? I hardly think so.
Q. Perhaps I can simplify the question to this?
THE COURT: Especially since you are going to have Dr. Chasen. This is a waste of time asking her what it says. And what they did.
BY MR. HUT:
Q. Dr. Westhoff how, if at all, does the study performed by Dr. Chasen and its conclusions affect your view of the intact variation of D&E as compared to dismemberment variation?
A. The results of Dr. Chasen's study confirm my impression that intact D&E is a safe alternative for my patients and is less likely to result in serious complications than a dismemberment D&E.
So, his results from his patients conforms to my clinical experience.
Q. We will just leave it there until we are able to hear from Dr. Chasen.
Dr. Wes WERBGS for how long have you been a member of the American College of obstetricians and gynecologists?
A. I was a junior fellow from the late '70s through 1985 and I became a fellow in 1986 and have been a fellow since then.
Q. Has ACOG taken any public position as to the safety of

intact D&E that informs your view of the subject, Doctor?
A. Yes; ACOG has a position statement.
Q. As a member of ACOG are you familiar with that position?
A. Yes, I have read the position statement.
Q. And what position does ACOG take, Doctor?
A. ACOG has stated that there may be circumstances in which and patients for whom intact D&E did a safe and appropriate alternative.
Q. Do you recall the approximate year of the statement in which ACOG made the assertion you just described?
A. I believe the original statement was in 1997.
Q. Do you know, Doctor, whether ACOG has issued any subsequent statements regarding intact D&E since the 1997 policy statement?
A. I believe ACOG has two additional statements that address the issue in *RBG I think 2000 and 2002, and that affirm their original position.
Q. Dr. Westhoff, is D&E or is intact D&E -- excuse me -- in your opinion, the only aavailable method to terminate pregnancy in the second trimester?
A. It's not the only technique available.
Q. Does the fact that intact D&E may not be the only technique available to terminate a pregnancy in the second trimester affect your view that may be the safest procedure in some circumstances?

A. Among the range of alternatives I usually think for most of my patients that intact D&E offers safety advantages, compared to those alternatives.
Q. Doctor, I would like you to now turn to Tab 69 in the notebook that is before you.
Do you have it?
A. Yes, I do.
Q. Have you ever seen plaintiff's trial Exhibit 69, which is at Tab 69 in the book before you, Dr. Westhoff?
A. Yes, I have. This is the partial-birth abortion ban.
Q. Let me direct your attention to Section 1531 of the Act which appears on page S-36.
A. Yes.
Q. Do you see that? I would like you to read, if you would, Dr. Westhoff -- well, let me first ask you to read the title of the Section.
A. This section is titled partial-birth abortions prohibited.
Q. Can you read the first sentence under Section 1531A?
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 two years or both."
Q. Doctor, with respect to the reference in the sentence you read to partial-birth abortion, is there a commonly understood meaning of partial-birth abortion in the medical community, so

far as you are aware?
A. Not in the medical community, no.
Q. I would like, if I can, Doctor --
THE COURT: TPHRUPB of them understand it?
THE WITNESS: It is not a medical term, sir.
THE COURT: I didn't say that, I asked you whether or not there are people in the medical community who understand it.
THE WITNESS: I don't think so but I cannot read their minds, of course.
BY MR. HUT:
Q. Let me direct your attention, Doctor, to Section 1531B 1 of Plaintiff's trial Exhibit 69 of the act which is set forth in Plaintiff's trial Exhibit 69. Please, read that section for us, beginning with the parenthetical containing the numeral 1?
A. "the term partial-birth abortion means an abortion in which the person performing the abortion, A, deliberately and intentionally vaginally delivers a living fetus until in the case of a head-fist presentation the entire fetal head is outside the body of the other; or in the case of breech PRPB TAEUGS, any part of the fetal trunk past the Navyel is outside the body of the mother for the purpose of performing an AO vertical act that the person knows will kill the partially delivered living fetus."
Shall I continue?

Q. Please do.
A. And B performed the overt act other than completion of delivery, that kills the partially delivered living fetus."
Q. Now, Doctor, if you would turn to the first page of Plaintiff's trial Exhibit 69, there you will find Section 2. PWHAS the title of Section 2 on the first page?
A. Findings.
Q. Please have a look at Section 2-is 1 of the findings, which appears on the same page; do you see the term partial-birth abortion in the second line of that section?
A. Yes.
Q. Could you please read for us the language that appears immediately after that phrase up to the dash mark that appears in the second line from the bottom of that paragraph 1?
A. Okay.
"an abortion in which a physician deliberately and intentionally vaginally delivers a living unborn child's body until either the entire babe KWREUP's head is outside the body of the mother or any part of the baby's trunk past the Navyel is outside the body of the mother and only the head remains in the woman, for the purpose of performing an overt act, marijuana usually the puncturing of the back of the Chile's skull and removing the baby's brains) that the person knows will kill the par shamly delivered infant, performs this act and then completes delivery of the dead infant."

Q. Now, could you refer back to the definition of the partial-birth abortion in Section 1531B 1, which you will find again on pages S-36 to S-37 and tell me whether the phrase "only the head remains inside womb" appears in the S*UBS W*EBGS section of B 1?
MS. GOWAN: Objection, the document speaks for itself.
THE COURT: Sustained.
Q. Dr. Westhoff, without enumerating them, have you perceived any differences between language that describes a certain abortion procedures in the findings of the statute and language that appears in the text of the ban in Section 1531B 1?
A. Yes. The ban is more general than the findings.
Q. Mindful of the Court's ruling I'm not going to take you through those difference but instead will ask you this, what imfact, if any between those differences between the text of the ban in Section 1531B 1 and the text in the findings have on your ability as a physician to determine what conduct is prohibited by the ban?
A. The language --
THE COURT: Doesn't your question presume a fact that hasn't been established?
MR. HUT: I said what difficulty if any, your Honor, what impact if any -- at least I certainly intended to.
THE COURT: All right.
Can you answer that question?

THE WITNESS: Reading the ban the language is more general and brief than in the findings. And it appears that it could apply to a broader range of D&Es that he perform including D&Es that involve dismemberment because it doesn't say anything about intact. And, therefore, it's really difficult for me it tell when I am actually doing a case exactly whether I would be violating the ban.
Q. Dr. Westhoff, does the term vaginally delivers, as used in the text of the ban, Section 1531B 1, have a commonly understood meaning in the medical community?
A. To vaginally deliver means to remove any tissue from the uterus out of the woman's body through the vagina. We can, for instance, refer to vaginally delivering a myoma of the uterus, we would vaginally deliver it if we remove it in that manner.
So, it is the removal of anything from the uterus out through the vagina.
Q. Do you have an understanding of the phrase living fetus, as that may be understood in the medical community?
A. Yes. And I think a living fetus would probably be most simply interpreted as one that has a heartbeat and that would be of course different from a viable fetus.
THE COURT: If you delivered a living fetus vaginally are you delivering a fetus with a heartbeat from the uterus to the vagina?
THE WITNESS: Yes.

THE COURT: You understand that?
THE WITNESS: If a fetus has a heartbeat I would consider it to be living.
THE COURT: And you understand then what that phrase means, correct?
THE WITNESS: I'm sorry, your Honor, I just got confused. Yes.
THE COURT: Oh, the answer is yes.
THE WITNESS: Yes.
THE COURT: Next question.
BY MR. HUT:
Q. Within the medical community is there a commonly understood meaning of the phrase "breech presentation," Dr. Westhoff?
A. Yes. Breech presentation means that either the feet or the buttocks of the fetus are facing the cervical canal.
Q. Within the medical community, Dr. Westhoff, is there a KPOFRPBly understood meaning of the phrase "completion of delivery" as used in the text that you read a moment ago?
A. Yes.
Completion of delivery would mean that all fetal parts, including placenta and membrane, have been removed from the uterus.
Q. Let me direct your attention to the phrase "any part of the fetal trunk past the Navyel is outside the body of the mother." Based on your experience as a physician and abortion provider,

do you have any understanding what that phrase means?
A. Well, the fetal trunk past the Navyel will include abdomen, abdominal organs, rib cage chest and back, or back.
Q. Turn to Section 1531B 1B, please, Dr. Westhoff on page S-37?
A. That's B at the top of S-37?
Q. Yes.
A. Okay.
Q. That states, "performs the overt act other than completion of delivery that kills the partially delivered living fetus."
Did I read that correctly, Doctor?
A. Yes.
Q. In your opinion, if part but not all of the fetus is outside the mother, is that fetus a partially delivered one?
A. Yes.
Q. Now, I would like you to focus your attention for the moment, Dr. Westhoff, on intact D&E asking you to direct your attention as I do so, to Section 1531B 1A of the act.
First, directing your attention to the phrase "vaginally delivers a living fetus," can you tell us whether or not intact D&E involves a vaginal delivery?
A. Yes, it does.
Q. When you perform an intact D&E, Dr. Westhoff, is the fetus living when you commence vaginal delivery?
A. Although I don't always check for it, I believe there is

usually a heartbeat and that the fetus is living.
Q. With respect to the phrase in Section 1531B 12 breech presentation, and I believe you may have testified it this previously, what percentage -- I with draw that comment. Let me start again, I withdraw the question.
What percentage, in your experience of intact D&Es involve a fetus in the breech presentation?
A. Well about one third of the time the fetus will already be in the breech presentation at the start of the case and as we progress through the case the position may change. So other fetuses may become breech presentation as the case develops.
Q. Dr. Westhoff, when you perform an intact D&E on a feet news breech presentation, do you vagina fallly deliver a living fetus until the point at which any part of the fetal trunk past the navel is outside the body?
A. Yes.
Q. Can you explain how that occurs, Dr. Westhoff?
A. With traction on the feet and legs. And right now we are talking about an entirely intact exSTRABGS, is that right?
Q. That's correct.
A. So, with traction on the feet and the legs the buttocks and abdomen will deliver out through the cervix and that's using traction usually with my hands and perhaps instruments.
Q. Directing your attention, Dr. Westhoff, to the phrase, "an overt act that the person knows will kill the partially

delivered fetus," in doing an intact D&E, do you perform an overt act after part of the fetal trunk past the navel is outside the woman's body?
A. Yes.
Q. Can you give us an example, Doctor, of the kind of overt act that you perform at that point or that you may perform?
A. Well one example would be cutting the umbilical cord and another example would be collapsing the skull, both of which I believe would be lethal.
Q. And at the time you either cut the umbilical cord or collapse the skull, is the fetus living?
A. Yes.
Q. And why do you perform the acts in question, either the cutting of the cord or the collapsing of the skull?
A. Because we need to do both of those things to continue the procedure.
THE COURT: And either act would kill the fetus, the cutting of the cord or the collapsing of the skull? Or does it take the combination?
THE WITNESS: No, no, I believe either of them would be lethal. I don't have any data about how soon the heartbeat would stop after either of those acts, but I believe either of them individually would definitely be lethal.
THE COURT: Kill the fetus.
THE WITNESS: Yes.

MR. HUT: Are either of those acts, acts that you know will kill the fetus correct, Dr. Westhoff.
A. Yes.
Q. Directing your attention again to 1531B 1A do you seize the phrase "deliberately and intentionally" at the beginning of the section?
A. Yes.
Q. With respect to the steps comprising an intact D&E that you just described, when you perform an intact D&E are any of the steps that you described performed deliberately and intentionally?
A. Yes. Every step of the procedure is done deliberately and intentionally, as is true with all surgical procedures. We proceed step by step in a deliberate and intentional manner.
Q. What is your purpose in performing an intact D&E?
A. To abort the pregnancy.
Q. Doctor, do you fear prosecution under this Act for the intact D&Es that you perform?
A. Yes, I do.
Q. Now I want to ask you some questions about the applicability of the act to dismemberment D&E.
Does vaginal delivery, Dr. Westhoff, occur in a dismemberment D&E?
A. Yes, it does.
Q. When you perform a D&E involving dismemberment, is the

fetus living when you KPHEPBSZ with the vaginal delivery?
A. Yes, it is.
Q. Based on your experience, Dr. Westhoff, in performing D&E involving dismemberment, has it ever occurred that you have vaginally delivered a living fetus until a point at which any part of the fetal trunk past the navel is outside the body of the mother?
A. Yes. In multiple scenarios.
Q. Could you provide an example of one of those multiple scenarios?
A. Every case proceeds individually but in a case I have taken care of I have brought down a leg and initially dismembered a leg so that the case had begun as a dismemberment case but on grasping the second leg was able to pull down the buttocks and trunk and so forth and continue the case with the fetus still having a heartbeat and until the trunk past the navel was out of the cervix.
Q. Can you explain how, in the example you have just given, that part of the fetus outside the woman's body -- excuse me, the part of the fetus past the navel is outside the woman's body?
A. Because using traction --
THE COURT: Can I -- stop right there.
Just tearing off TA one leg, that act itself would kill the fetus if nothing else happened, would it not? It

would bleed to death, wouldn't it?
THE WITNESS: It would not necessarily bleed to death. Arteries have a lot of elastic tissue in the walls of arteries so they contract when they are cut or opened and it may lead to a lethal act itself but not necessarily.
It may lead to the death.
THE COURT: More likely than not wouldn't it bleed to death?
THE WITNESS: It may lead to death but --
THE COURT: I'm not talking about the rare exception, I'm asking more likely than not wouldn't it just bleed to death?
THE WITNESS: Not within the length of time during which I'm carrying other parts of the procedure.
THE COURT: I didn't ask you that. I'm just asking you whether it would bleed to death. It would cause death?
THE WITNESS: If we stopped and did nothing else and waited it may be that the fetus would bleed to death. I can't give you probability around that though. I don't know how certain that is.
THE COURT: Next question.
BY MR. HUT:
Q. Directing your attention, Dr. Westhoff, to the phrase an overt act that the person knows will kill the partially delivered living fetus," in the example you just described

would you perform an overt act after part of the fetal trunk past the navel is outside the woman's body?
A. Yes.
As in the case we were discussing previously where the fetus was entirely intact, subsequent steps would include cutting the umbilical cord and collapsing the skull, either one of which would be more rapidly lethal.
Q. And why is it that you would perform such acts?
A. In order to continue the procedure and empty the uterus safely.
Q. And the the time that you would collapse the skull or cut the cord, is the fetus still living?
A. Yes. It would be likely is to still be living.
Q. And as with the last example, is the cutting of the cords or the collapsing of the skull an act that you know is lethal?
A. Yes.
Q. Are the steps that you have just described in performing the variation of dismemberment D&E discussed performed by you deliberately and intentionally?
A. Yes.
Q. What is your purpose in performing a D&E involving dismemberment such as the one you have just described?
A. It is to, as safely as possible, complete the abortion.
Q. Doctor, would you fear prosecution under the act for D&E by dismemberment and the way you just described it?

A. Yes, I would.
Q. Do you have any other examples or scenarios of the way D&E with dismemberment might proceed given its variability that would involve vaginal delivery of a living fetus until a point at which any part of the fetal trunk past the navel is outside the body of the woman?
A. Yes, certainly I can.
An example that I have in fact experienced myself taking care of the patient in the recent past involved not being able to start the procedure by bringing the feet down, using forceps and in fact first delivering part of the fetal back entirely separate from the patient.
So, that is a part of the fetal trunk above the navel that was delivered outside of the woman's body as a separate piece of the fetus.
We were then able to continue bringing the fetus down and bring the legs down and ultimately completed the abortion.
I don't remember in that case all the exact subsequent steps but we did bring out a piece of the trunk first while the fetus was still living.
So I fear that that particular sequence of events would also violate the ban.
Q. And in the sequence that you described, did you perform an overt act after the evacuation of the portion of the fetal trunk above the navel? And while that portion was outside the

body of the woman?
A. Yes.
And in that case as it evolved, we also cut the cord and collapsed the skull, both of which are lethal acts.
Q. Again, why did you perform those lethal acts in the situation you just described?
A. In order to continue emptyying the uterus and in order to continue the abortion.
Q. And at the time you performed the first of the cutting of the cord or the collapsing of the skull, was the fetus still living?
A. Yes.
Q. And at the time you performed either the first of cutting of the cord or collapsing of the skill, did you know that the, such act as performed, would be lethal?
A. Yes.
Q. Did you perform the acts in the abortion you just described deliberately and intentionally?
A. Yes.
Q. Now, in a dismemberment D&E do you deliver the fetus to a certain point for the purpose of performing an act that you know would kill a fetus?
A. I go step by step for the purpose of completing the entire abortion and I know that in the course of proceeding step by step I will perform a lethal act., but --

Q. Is that step by step process the same for an intact D&E, Dr. Westhoff?
A. Yes, it is.
Q. Now, Doctor, I would like to turn your attention or have you turn your attention to the applicability of the Act to the induction.
Does vaginal live re.
MS. GOWAN: Object to the form of the question.
THE COURT: What's your objection?
MR. HUT: I will rephrase it, your Honor.
Q. Does vaginal delivery occur, Dr. Westhoff, in an induction?
A. Yes; vaginal delivery occurs during an induction abortion.
Q. When you perform an induction abortion, is the fetus living when you commence the vaginal delivery?
A. Yes, it is.
Q. Based on your experience in performing an induction, has it ever occurred that you have vaginally delivered a living fetus until a point at which any part of the fetal trunk past the navel is outside the body of the mother?
A. Yes.
Q. Now, directing your attention to the phrase, "an overt act that the person knows will kill the partially delivered living fetus," does it ever occur in the course of an induction procedure that a physician must perform an overt act that he or she knows will kill the fetus?

A. Yes.
In an induction in the midtrimester it is very likely that the fetus will present in the breech position to start out with as I said earlier. And so, as the induction proceeds, the fetus may in fact deliver feet-first and typically the cervix will not yet be sufficiently dilated for the larger parts of the fetal body to pass readily through. It is common for there to be some tension on the cord which may be wrapped ash the body so a very common occurrence during an induction delivery of a breech would be to cut the cord along the way.
And in the case of a midtrimester abortion, that would be a lethal act.
Q. And when you would cut the cord in in the situation you just described, would there be a part of the fetal body past the navel -- excuse me, part of the fetal trunk past the navel, outside the body of the woman at the time that you performed the lethal act?
A. Yes, it would be.
Q. And at the time you performed the loathe note note loatheal act, would the fetus still be living?
A. Yes, it would be.
Q. And would the cutting of the cord as you just described it, an act that a physician knows will kill the fetus?
A. Yes.
Q. And the type of induction that you just described,

Dr. Westhoff, are steps taken deliberately and intentionally?
A. The overall plan of the induction is deliberate and intentional and if the fetus delivers to that position, any subsequent action by the physician is deliberate and intentional; yes.
Q. Dr. Westhoff, will you explain why it is that physicians have a role in treating upon stainous abortions?
A. Note note note note spontaneous abortions.
A. Spontaneous abortion or miscarriage can occur throughout gestation and many spontaneous abortions do not complete on their own. The patient requires physician assistance to complete the emptyying of the uterus and there is some portion of cases where women might complete the delivery entirely without intervention but I would say in the majority of miscarriages, of which there are about 800,000 per year in the United States, in at least 75 percent some medical intervention is required.
In particular, in the second trimester the cervix may be open and the patient may be bleeding or may have infection and this can only stop or be remedied through the completion of emptyying the uterus and so a physician must take some action to help the miscarriage be completed.
Q. And is the action of the physician may take in emptyying the uterus something that involves vaginal delivery?
A. Yes, it does.

Q. And when a physician may treat spontaneous abortion, may the fetus be still living when you commence with the vaginal delivery?
A. Yes, it may.
Q. Based on your experience, Dr. Westhoff, in managing spontaneous abortion, has it ever occurred that you have vaginally delivered a living fetus at the point at which any part of the featal trunk past the navel is outside the body of the mother?
A. Yes, I have.
Q. Directing your attention to the phrase "overt act the person knows will kill the partially delivered living fetus," does it ever occur in the course of treating a spontaneous abortion, that the physician must perform an overt act that she knows would kill the fetus?
A. Yes, it does.
Q. Can you provide us with an example?
A. Well there are two patients very recently taken care of, both of whom were miscarrying wanted pregnancies. In one case the cervix started to dilate and the patient was around 20 to 22 weeks, I don't remember the gestational age exactly but the cervix started to open and the amniotic membranes became infected so she had a condition called chorio amnio night EUS and that is dangerous to the woman she can become septic. Her entire body can become infected if all the infected tissue is

not removed from the uterus.
Because SHER cervix started to dilate she didn't need any laminaria treatment, TPREUPS -RGS but we took her to the OR for a D&E in order to complete the miscare rath.
In another recent patient the membranes ruptured prematurely and the fetus, while still alive, was not growing further and after three weeks it became clear that the ultimately the prognosis for the fetus was fatal, it was not going to be able to grow and survive this so we dilated the patient's cervix with laminaria and went to the O RBGSZ to perform a D&E.
So these were both miscarriages that did not complete on their own and we needed to take care of the patient to complete the miscarriage.
Q. In these or any other cases that you have seen, does it occur that there is a part of a navel -- excuse me -- a part of the fetal trunk past the navel that is outside the body of a woman at a time that the physician must perform an overt act that is lethal?
A. Yes.
THE COURT: Keep your voice up, Mr. Hut, please?
MR. HUT: Sure, your Honor.
Q. And in those situations or any other, what type of overt act might a physician have to perform?
A. Certainly it may be cutting the umbilical cord and also in

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these cases the collapse of the skull.
Q. And at the time of the collapse of the skull was the fetus in these cases still living?
A. Yes, it was.
Q. And why did you perform the collapsing of the skull in these cases or why do you perform collapsing of the skull and the cutting of the cord and any other treatment in the case of spontaneous abortion, Doctor?
A. In order to continue the procedure and accomplish the goal of emptyying the uterus, I need to proceed step by step and cannot complete it without carrying out those maneuvers.
Q. Is the collapsing of the skull or the cutting of the cord in such cases an act that the physician knows will kill the fetus?
A. Yes, it is.
Q. Are the steps taken by physicians in managing spontaneous abortion deliberate and intentional?
A. Yes, they are.
Q. What is the physician's purpose in managing a spontaneous abortion in the ways you have just described?
A. Overall the main purpose is to maximize the health and safety of the woman and it is necessary to empty the uterus to do so.
MR. HUT: Your Honor, I have reached the end of the line of examination and wonder since it is 25 past the hour

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whether it might be an appropriate time to break for lunch.
THE COURT: What are you H*UPBG retoday?
MR. HUT: No, sir, I'm happy to go on if your Honor wishes. Or at least no more hungry today than on any other today.
THE COURT: You must know the menu is a little better today than I am aware of yet.
All right, we will take our luncheon recess and we will reconvene.
But, just before we break, Mr. Hut, being Friday I am trying to get a handle, as best you can tell, are you on schedule as far as your case?
MR. HUT: As best I can tell, yes we are, your Honor.
There are questions as to decisions that we need to make with certain witnesses. I have supplied the government and did so yesterday with a list of witnesses that we would be expecting to present through Thursday. I think thereafter whether there remains any time is something just and what we do with it is something we will need to assess.
But the answer to your Honor's question is yes, we are on time.
THE COURT: Because it may come as a shocker or blow to you, but if we are falling behind I am trying to try and stay with schedule and I will, if you think you are falling behind I would like to keep to it. Sadly enough I do have

other cases and so I have to keep all of this in PHOEUPBD in my schedule.
So, if we are falling behind we will add some time on to our workday whether we start a little early or we sit a little bit later.
So, I wish you would keep me abreast of that.
Also, I would like to mention at this time there is a, one open question which is the deposition of some Department of Justice people. The government has submitted a brief. The plaintiff has submitted a letter but I wish just simply pretty much objecting that time is late but that seems to have been violated more than once in this case. But I afford you the opportunity, if you wish, to submit, by tomorrow, anything that you might wish to put in and I will rule on that by Monday.
But, in any event, I would appreciate -- and this goes to both sides as we get into the defense note note the defense's case, the government's case, to keep me abreast of your SKED AOULG STKPWRAOERPBLGS scheduling and should there be a problem we will cure it.
MR. HUT: For the plaintiffs we are fine on time now.
Indeed, your Honor, since we are talking about housekeeping, I don't know how long Ms. Gowan has or plans to have on cross examination with Dr. Westhoff this afternoon. I would estimate that I have probably no more than another 20 to 30 minutes and I wondered whether if there were cross

examination that didn't take us quite to the end of the day, whether the Court might consider adjournment of that time.
The other thing, on our list for today, if you wanted to sit further, would be to have the depositions read of the Rule 30B 6 representatives of the American medical Womens' session and American public health association, but we would be happy to defer those and we think we can fit them in probably better next week.
THE COURT: As long as you feel you are on time but I think it's important, at least for the Court to try and stay on SKED you'll, and I would appreciate it personally if you would let me know and we can cure it by setting an extra hour or starting a little bit early or something of that nature, or even cutting out lunch, Mr. Hut.
MR. HUT: That places everything in a different light Judge, Casey.
THE COURT: I tell you it wouldn't hurt me one bit if I missed one.
MR. HUT: Many people tell me the same thing, your Honor. No, we are well on time.
THE COURT: Just, if you keep it in mind, if you see a problem, try and alert me to it so we can try and take care of it, okay?
MR. HUT: Yes, sir.
THE COURT: The Court will stand in recess until 2:00:

(luncheon recess).
(continued on next page) TWM 4/2/04.
AFTERNOON SESSION
2:00 p.m.
CAROLYN WESTHOFF, resumed.
THE COURT: Mr. Hut, you may inquire.
MR. HUT: Thank you, your Honor. Gowan TKPWOUFPB excuse me, Mr. Hut. Your Honor, this is Ms. Gowan. May I race raise a very brief matter?
THE COURT: Yes.
MS. GOWAN: I understand your Honor is permitting plaintiffs to file a more formal opposition to the government's motion in limine in connection with the 30(b)(6) testimony of Mr. Moss KHEL la and the testimony of Mr. Kim. Will the government be permitted to a short reply to that in limine motion or not?
THE COURT: I think I know what the law is on it. Tell you what. Limit it to two pages. How is that? Gowan that is fine.
THE COURT: I think I know what the law is on the subject and I can evaluate what each of you puts in. But if you think you will, and God forbid we break up this pen pal relationship, two pages.
MS. GOWAN: Would you like that when, your Honor?
THE COURT: You would probably be advised to send it

to me over the weekend. I assume you want a ruling on this fairly quickly. So try and have it by if not Monday morning, sometime on Monday.
MS. GOWAN: Gowan yes, your Honor. Thank you.
MR. HUT: Your Honor, for the plaintiffs, I was not clear whether the Court was inviting a submission earlier. I am now fairly clear that the Court is not. I think we are prepared to have you rule on the basis of the submissions to date.
MS. GOWAN: If that is so, we would as well.
THE COURT: Good stuff. I think you are starting to read me. I think it is probably adequate. But so that my law clerks wouldn't think that I didn't give each of you every possible opportunity, the record will reflect I gave it to you, and in your wisdom you made this choice.
MR. HUT: Is there occasion TPOUGS, your Honor, we would be glad to do this, if it would be for the convenience of the Court and the Court's clerks to submit the depositions, testimony, and exhibits that are in question?
THE COURT: Sure.
MR. HUT: Thank you. In any event, that is fine. Mr. Hut. TKWOUPB Gowan excuse me, your Honor. I'm sorry. Ms. Gowan again. Just to note that while we would have no objection to plaintiffs submitting is the deposition designations, the government has not yet prepared any

counterdesignations. Oh, excuse me. We did. Excuse me, your Honor.
THE COURT: I know how you feel sometimes, Ms. Gowan.
MS. GOWAN: Foot in TPHAOEU mouth.
THE COURT: That's all right. I'm never quite sure that my clerks tell me that I have gone through the right door. I think that should take care of it. I will review it and try and deal with it with the alacrity of a lep ard or maybe something short of that.
With the real season about the start, Mr. Hut, you're at the plate.
MR. HUT: And isn't.
Let me continue some housekeeping. On behalf of plaintiffs we move for the admission of redacted Plaintiffs' Trial Exhibit 70, a copy of the redacted form which we have supplied the government, and Plaintiffs' Trial Exhibit 144, which is the demonstrative forceps about which Dr. Westhoff testified before the lunch break.
THE COURT: Could I examine those, please? I never asked to see them after you were through with the witness.
MR. HUT: May the witness hand them up to you, your Honor?
THE COURT: Sure.
THE WITNESS: Careful. They are sharp inside.
THE COURT: Before I injure myself, I will hand them

back.
MR. HUT: Keep them there, Dr. Westhoff, and we will supply them to the KO*URPL deputy following this afternoon's sess
I take it there is no objection.
MS. GOWAN: No.
THE COURT: They will be received then. S- S-

DIRECT EXAMINATION S-

Q. Dr. Westhoff, by way of follow-up to one or two matters that were the subject of testimony by you this morning, with respect to intact D&E, do you deliver the fetal trunk above the navel to a particular point for the purpose of performing an act that you know will kill the fetus?
A. No. I carry out each step in order to complete the abortion as a whole. But not for the purpose of -- not for the specific purpose of a lethal act.
THE COURT: You are not doing it to deliver the fetus, are you, live? Each is a step leading to the killing of the fetus, right?
THE WITNESS: Yes, ultimately the fetus --
THE COURT: You start out with a predetermination you are going to kill the fetus, right?
THE WITNESS: Yes, that is true.

THE COURT: OK. Next question.
Q. Dr. Westhoff, at the start of an intact D&E, can the physician take any step that in and of itself eventually will cause fetal death?
THE COURT: Can I have that question again?
(Question read)
A. For instance, on some level, as soon as we rupture the membranes, ultimate if time passed that might lead to fetal death. But in the short run, if the very first step was the delivery of the placenta, if the position of the placental loud delivery of the placenta prior to delivery of the fetus, the placenta of course supplies the blood supply to the fetus, so the fetus would bleed to death before delivery of any fetal part, if I were to take that as the first step. In some cases the placenta does deliver first.
THE COURT: Is the short answer to the question yes?
THE WITNESS: Yes, your Honor.
THE COURT: Dr. Westhoff, with respect to your testimony earlier today about the evolution of medical thing on the question of vaginal delivery after C-section, what is, in your understanding, the current thinking of the profession based on reading and conversations that you have had?
MS. GOWAN: TEUBT form of the question.
THE COURT: Sustained.
Q. Dr. Westhoff, have you read the literature that reflects

current medical thinking about vaginal delivery after C-section?
A. Yes, sir. KPWOUPB Gowan I object to the form of the question.
THE COURT: If we are going to draw this out, what have you read, Doctor?
THE WITNESS: That the great urgency to avoid repeat C-sections has come at some cost in maternal risk, and that nowadays it is again more preferred to avoid labor, and particularly to avoid induction after --
THE COURT: Maybe we are having trouble communicating, Doctor. My question is: What have you read?
THE WITNESS: I am not going to be able to recollect the TPHAEUPLGS or authors of specific articles.
THE COURT: If you can't remember it, then I am not going to allow the testimony, and I will strike it, that is to say what the current literature says. Next question.
MR. HUT: Can I inquire of Dr. Westhoff, your Honor, whether she can recall generically the kinds of literature in the field that she has read?
THE COURT: I think she has answered she doesn't remember, and I don't think I am going to let you lead her.
Q. Dr. Westhoff, as a member of the American medical women's association, are you aware of any statement by that organization that supports your view concerning the safety

advantages of intact D&E?
A. The organization AMWA S- did produce a statement that I have seen that supports the view that intact D&E has safety advantages for patients.
Q. As a member of the American Public Health Association, Dr. Westhoff, are you aware of any position taken by that organization that supports your view concerning the safety of intact D&E?
A. Yes. I have also read a statement of the APHA which supports the safety of the potential use of the intact D&E procedure for its benefits for women's health.
MR. HUT: Your Honor, with respect to the earlier line of examination concerning current thinking of vaginal delivery after C-section, may I make an offer? The only reason I ask to do so is because there has been earlier testimony by the doctor that was, I believe, incomplete. I am happy to approach and do it at sidebar if your Honor wishes.
THE COURT: What is it you are trying to proffer, Mr. Hut?
MR. HUT: Do you want me to address that subject from the podium?
THE COURT: Come on up to the sidebar. It is good exercise.
(At the sidebar)
MR. HUT: Your Honor, prior to the lunch break Dr.

Westhoff was permitted to give some testimony concerning evolution in the thinking in the profession about vaginal birth after C-section. What she said was, and I am paraphrasing now, that there was a time in the seventies and early eighties when it was thought that vaginal delivery was ill-advised. Then there was a shift in the thinking a point when it was thought that vaginal delivery should be sought to be accomplished whenever possible. She would say, if I were permitted to ask the question that your Honor sustained the objection to, she would say that the thinking in her estimation has shifted back. Indeed the essence of the testimony she would give is think is what she responded to your Honor's question.
THE COURT: In answer to your question.
THE COURT: You asked her what have you read.
THE COURT: That was after you couched it in those terms.
MR. HUT: Exactly. I know why I asked.
MR. HUT: I am not making an assertion. She I think misunderstood your question.
THE COURT: We are not going to play that game. We are not going to speculate what she understood.
MR. HUT: You subsequently asked her just to tell you what she had read.
THE COURT: Because you were asking what her reading in the profession was.

MR. HUT: That is the substance of what she is going to say.
THE COURT: I am not going to allow it. She couldn't remember what she had read. That is where it stands.
MR. HUT: All right. Thank you, your Honor.
(Continued on next page)

(In open court)
BY MR. HUT:
Q. Dr. Westhoff, do you have an opinion concerning the suggestion made by certain of defendants' experts that a physician can easily get around a ban by causing fetal demise before the physician starts to evacuate the uterus?
MS. GOWAN: Objection, your Honor.
THE COURT: Sustained.
Q. Dr. Westhoff, are you aware of any suggestion made that a physician can get around the ban by causing fetal demise prior to the beginning of the SRABGulation?
MS. GOWAN: Objection.
THE COURT: Read the question to me, please.
(Question read)
THE COURT: I think you can ask the question if you rephrase it.
Q. Dr. Westhoff, do you have any opinion concerning the advisability of effecting fetal demise prior to the evacuation

of the uterus at the start of a D&E?
MS. GOWAN: Your Honor --
THE COURT: I don't think you -- read the question again, please.
(Question read)
MS. GOWAN: Your Honor, Dr. Westhoff gives no such opinions in her expert disclosure in this case.
THE COURT: That is another reason, if that be so. Do you contest that, Mr. Hut?
MR. HUT: I would have to actually go back to --
THE COURT: Why don't you have one of your associates review the expert opinion as presented to the defendants and you move on to another question.
MR. HUT: I shall.
Q. Let me ask a question on the basis of the doctor's own experience. Dr. Westhoff, do you effect fetal demise prior to commencing surgical evacuation of the uterus in a D&E?
THE COURT: When?
MR. HUT: Hut in any T*E.
THE COURT: In any one?
Q. The question is, in any D&E do you usually or typically effect fetal demise as a normal course activity prior to SRABGuateing the uterus?
MS. GOWAN: I object to the form of the question.
THE COURT: It seems a bit confusing to me, Mr. Hut.

I suppose if you do a D&E as we discussed at some length this morning and you tear a limb off, sooner or later, I don't know the time spread, but I know there was some variation as to what part you dismembered and tore off, you are going to have a dead fetus.

MR. HUT: That is not where I am trying to go with the question, your Honor. Let me try it again.

Q. Dr. Westhoff, do you make it a practice either to effect fetal demise by using potassium chloride, as we have heard about, or injecting injock sin into the amniotic sac prior to the time that you effect a surgical evacuation of the uterus?

THE COURT: Wasn't that a lot simpler? You may answer that question, Doctor.

A. No, Mr. Hut, I usually do not do so. S-

Q. Why not?

A. [> TKEUPBLG Exxon?<] the main reason that it is an additional procedure that does not offer any benefit to the woman that I am taking care of. The procedure itself is not trivial, it can be difficult to accomplish, can fail, and has some risks. Those are the main reasons I do not use this procedure.

THE COURT: As you said this morning, there is some dispute as to fetal pain. If you had done that, there wouldn't be any pain, would there? To the fetus I'm talking about.

THE WITNESS: I don't think we know whether

intracardiac injection would cause fetal pain, your Honor.

THE COURT: But there wouldn't be any as far as the dismemberment if you had, or as far as that goes, the incision to the back of the skull, if you did that before you started?

THE WITNESS: That's correct.

THE COURT: If the baby is dead, it is not going to feel any pain, is it?

THE WITNESS: No.' We don't know if the intracardiac injection causes pain, however.

THE COURT: So there might be still some there?

THE WITNESS: That's right.

Q. Is potassium chloride a toxin to the fetal system?

A. Yes, it is.

THE COURT: I take it, then, the question of the infliction of pain to the fetus is not on the top of your list of concerns when doing your work?

THE WITNESS: While I wish to avoid fetal pain, I have no desire to inflict fetal pain t top of my list is the safety of the woman who is undergoing the procedure.

THE COURT: In fact, do you consider fetal pain at all?

THE WITNESS: Yes, your Honor. As I previously stated, I think one of the benefits of using general anesthesia with my patients, since I don't know if there is fetal pain, is that the general anesthesia crosses the placenta and does

circulate in the fetal circulation and may have a physiologic effect in the fetus, and I think that is a benefit.
THE DEFENDANT: That is the limit of your concern? OK. Next question.
Q. Dr. Westhoff, do you have any opinion concerning whether the effectuation of fetal demise at the outset would cause a D&E to be more or less difficult?
MS. GOWAN: Objection, your Honor. This goes to the scope of Dr. Westhoff's expert report in this case. We previously objected on the grounds that no such opinions were offered in the report.
MR. HUT: I will rephrase it, your Honor. That's correct.
Q. Dr. Westhoff, in your experience on the occasions when you have effectuated fetal demise, is it your belief that that makes the ensuing D&E more or less easy to accomplish?
A. In cases where I am taking care of a patient who has received KCl, for instance, so the fetus is already dead at the beginning of the procedure, or where we are doing the procedure after spontaneous fetal demise, the fetal tissue softens rapidly and that makes evacuation of the uterus more difficult, because it usually requires many more passes, and in my experience there is a greater risk of retained tissue in the uterus, which in turn leads to increased risk of infection for the woman and potential need for additional procedures.

THE COURT: Have you ever left tissue behind that could cause infection to the woman?
THE WITNESS: Yes, sir, I have.
THE COURT: Next question.
MS. GOWAN: Your Honor, I would like to move to strike this testimony. I think it unfairly prejudices the government, not having been put on notice in Dr. Westhoff's expert report that she was going to opine on this subject. Certainly the government did not inquire upon this at her deposition. Counsel is now attempting to use Dr. Westhoff as a fact witness to elicit the same type of testimony.
THE COURT: Were you referring to my question of the witness?
MS. GOWAN: No, your Honor. Mr. Hut's question.
THE COURT: It is not in the report? Is that what you are saying?
MS. GOWAN: Yes.
THE COURT: Mr. Hut, do you want to point it out if it is there?
MR. HUT: No, your Honor. But I do want to point out that Dr. Westhoff is now testifying as PH- Gowan says, as a fact with the with respect to her practice. She is a plaintiff in the action. She has brought the action because she believes that the Act will have potentially very, very serious consequences for the kind of medicine she practices. She is

listed as a fact witness --
THE COURT: She has testified Ms. Gowan at some length this morning as to her personal practice.
MS. GOWAN: Most certainly, your Honor, and we believe that she is entitled to do that. However, what is going on in the government's view right now is an attempt to recast expert opinion about the nature of fetal tissue after the injection of potassium chloride as fact testimony.
THE COURT: Is there any mention of that in the expert report?
MS. GOWAN: No, your Honor.
MR. HUT: I believe that it is proper fact testimony, your Honor. This is a central issue in the case. She has views based on her personal experience.
THE COURT: Have you used it in the last three years in effectuating the demise?
THE WITNESS: Yes, your Honor.
THE COURT: In what sort of procedure have you done it?
THE WITNESS: Most recently I used it the same week the PBA ban was signed into law and we did not yet know if there would be a restraining order. So in taking care of my patients that week I used intracardiac KCl injections to make sure that I would not in fact violate the ban -- would not be at risk of violating the ban. So that experience is just a few

months ago.
THE COURT: Was the procedure carried out without mishap?
THE WITNESS: I felt the procedure was more difficult --
THE COURT: I didn't ask you that. Was theremy mishap?
THE WITNESS: A particular patient I am remembering had retained tissue and had two additional D&C's subsequent to the day of the procedure in order to remove --
THE COURT: Did you remove it?
THE WITNESS: We subsequently removed it.
THE COURT: No further injury to the patient, and so you got it all out?
THE WITNESS: The patient had an infection. She had to be admitted on another day. She is fine now.
THE COURT: You got it cured and she is fine now?
THE WITNESS: She is fine now.
THE COURT: Have you had infections where there has been no tissue left behind in patients?
THE WITNESS: Yes, we sometimes have infections.
THE COURT: Have you also had infections where you have had an intact D&E? I mean infections in your patients. Has it occurred?
THE WITNESS: I have had infections in all sorts of

patients. Are you asking just about the specific subgroup with intact D&E?
THE COURT: Yes. I will take one at a time. I'm am piecemeal type of guy. HAGS it ever happened? Simple question.
THE WITNESS: Yes, I have taken care of many patients and many of them have had infections.
THE COURT: I didn't ask you that. I just said did it ever happen?
THE WITNESS: Yes.
THE COURT: It is so much simpler when you do a little piece at a time.
Ms. Gowan, I think I am going to allow it, within limits though, Mr. Hut. I'm not sure where it really goes, achieves anything for you.
MR. HUT: I just have one more question and that is by way of follow-up to your Honor's question. It was not clear to me respectfully whether Dr. Westhoff remembers infections in that subgroup of D&E patients who received a procedure that resulted in an intact or relatively in fact fetus.
THE COURT: I think she does. We are not going to rehit that, Mr. Hut. We don't play that game. Move op. Next question.
BY MR. HUT:
Q. Doctor, please turn again to Plaintiffs' Trial Exhibit 69,

Partial-Birth Abortion Ban Act of 2003. Turn to section 1531, which I think you will find on page S3-6. The second sentence of section 1531 subsection (A) states, "This subsection does not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." Did I read that sentence correctly, Doctor?
A. Yes, sir? In light of this exception, would you have concern about providing a banned procedure to a patient with the kind of life-endangering condition enumerated? [> that was a question<]
A. Yes, I would.
Q. Why is that, Doctor?
A. A woman can have a very serious or deteriorating health problem, but it is a matter of judgment as to exactly if and when her life is in danger. So if I were to judge that her life is in danger, that would, I think, be something that would be subject to other interpretations by other physicians and would also therefore leave me at risk of prosecution to proceed.
Q. Doctor, with respect to testimony from you in the morning, why is it that the Chasen study confirms your view respecting the safety of intact D&E?

A. There are two reasons Dr. Chasen's results confirm my view. One is that among the complications that he reports on in his study about 5 percent of patients in the intact group and 5 percent of the patients in the dismemberment group experienced complications. But in fact on reading the details, all of the serious complications he reported, the most serious complications, were in the dismemberment group and that those actually are entirely analogous to the complications that we have observed in our own patient practice at Presbyterian.

Second, his overall conclusion is that the complication rates are the same in the two groups. But in his study the patients who underwent an intact D&E had a gestational age that was about two weeks greater than the gestational age of patients undergoing dismemberment D&E. Since we do know based on other existing data that the risk of complications increases with advancing gestational age, I would expect to see more complications in the subgroup that had a more advanced gestational age. The fact that they had the same overall rate of complications is, I think, something that favors intact D&E as being a safer technique.

I think that supports --

THE COURT: Does that mean you disagree with Dr. Chasen's report?

THE WITNESS: I think Dr. Chasen --

THE COURT: Do you disagree, ma'am?

THE WITNESS: I agree with his results. I think his conclusions are too conservative.

THE COURT: So it is like a legal opinion, you agree in part and disagree in part?

THE WITNESS: Yes, your Honor.

THE COURT: We have a Court of Appeals that does that a lot. OK, for whatever it is worth, Mr. Hut, it's all yours.

MR. HUT: One more question on this line.

Q. Dr. Westhoff, you mentioned a moment ago that your own results concerning complications observed at New York Presbyterian were analogous. In which group, those who received D&E by dismemberment or those who received D&E intact, do you see the major complications?

MS. GOWAN: Objection. I don't think there has been any testimony about results, for results of any examination of procedures at Columbia.

THE COURT: Let me hear the question.

MR. HUT: Let me rephrase it. I am only referring to the doctor's testimony that Dr. Chasen's observations of serious complications in the dismemberment group were analogous to Dr. Westhoff's own observations in patients that her service treats.

Q. My question to Dr. Westhoff is, in which group of patients whom you treat do you see the greater number of major complications?

A. As I testified this morning, we review all of our complications on a routine basis, and all of our major complications in the last three years, including perforation and laceration, were observed in patients who had a dismemberment D&E. And none of those serious complications occurred among patients who underwent an intact D&E.
THE COURT: You say you review this. Do you keep records of it so that you and those in your group can review this together?
THE WITNESS: Yes. We write a one-page report on every kind of complication that we see among all the patients on our service. We bind those together in a notebook. I review with them.
THE COURT: Was that requested by the government?
THE WITNESS: THO.
THE COURT: And did you produce isn't it.
THE WITNESS: No, sir, no one asked me for that.
THE COURT: I don't know whether it did or it didn't, but I would ask that you check, because I didn't hear anything about a document like at a, a book with complications.
THE WITNESS: It is a looseleaf binder where we put all of our complication reports.
THE COURT: It is amazing what you find in looseleaf binders.
THE WITNESS: I try to keep track of this one so that

I don't get too surprised.
THE COURT: Next question, if any.
BY MR. HUT:
Q. Dr. Westhoff, please refer to section 2 of the Act called "Findings" again, Plaintiffs' Trial Exhibit 69. Turn to page S3-4, please.
A. Yes.
Q. Let me read a portion of section 14(A) of the findings. "Partial-birth abortion poses serious risks to the health of a woman undergoing a procedure. Those risks include, among other things, an increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation making it difficult or impossible for a woman to successfully carry a subsequent TREG TPHAEPBS to term."
THE COURT: Keep your voice up, Mr. Hut.
MR. HUT: Yes, your Honor.
THE COURT: Thank you.
Q. "an increased risk of uterine rupture, abruption, emPWOEUT being fluid emblues and trauma to the uterus as a result of converting the child to a footling breech position, a procedure which, according to a leading obstetrics textbook, 'there are very few, if any, indications for, other than delivery of a second twin, and a risk of lacerations, secondary ham RAPBLGing due to the doctor blindly TPORGS \{^s}\{^ings} a sharp instrument into the base of the unborn child's skull why he or

she is lodged in the birth canal, an act which could result in severe bleeding, brings with it the threat of shock, and could ultimately result in maternal death."
Did I read that correctly?
A. Yes, sir.
Q. Let's assume for this question and subsequent questions that the procedure being discussed in this paragraph 14(A) is intact D&E. Based on your experience, Doctor, do you agree with the statement that intact D&E "increases a woman's risk of suffering from cervical incompetence, a result of cervical dilation"?
A. I do not agree with that statement.
Q. Why not, Dr. Westhoff?
A. I don't agree with it mainly on the basis of the fact that dilation occurs very gradually for women who undergo this procedure, and that the amount of dilation they experience is far less than the dilation that occurs at the time of childbirth. I also know of no evidence to support the statement.
Q. Based on your experience, Dr. Westhoff, do you agree with the statement that there is an increased risk of uterine rupture?
A. No, I don't agree with that statement.
Q. How about with the statement that there is an increased risk of abruption?

A. I don't agree with that statement.
Q. How about the statement that there is an increased risk of amniotic fluid embolus?
A. I don't agree with that statement.
Q. Are you aware of any literature that demonstrates increased risk of any of these complications with intact D&E?
A. I have seen no literature that describes any of these increased risks.
Q. Are you aware of any increased risk of trauma to the uterus as a result of converting the child to a footling breech position, Dr. Westhoff?
A. I am not aware of any increased risk to the uterus from the version procedure during a D&E.
Q. Why not?
(RRD)
Q. Why do you not agree with the statement of Congress?
THE COURT: How if how she is not aware, I don't know if she could explain that. Do you want to rephrase it?
MR. HUT: Surely. [>check this<]
Q. You state that you are unaware of any basis for thinking that there would be any risk of trauma to the uterus as a result of conversion to a footling breech. Why do you think that there is an absence of any evidence suggesting any risk?
A. I haven't in my personal practice had any patients with a complication from that source, and that includes the practice

of my group and my colleagues who are part of my group. And I have not seen any reports of such adverse kind of events in the medical literature.
Q. Does version or conversion to a footling breech occur in all intact D&E's, Dr. Westhoff?
A. No, it does not.
Q. Why is that?
A. In many cases the fetus is already in a breech position at the beginning of theeing procedure [> version, not conversion, in that answer EURGS didn't understand<] can version or conversion occur in a STKPHEFPLT D&E if a fetal foot is grasped something.
A. Yes, it didn't.
Q. Is version or conversion more dangerous in other contexts than it is in your estimation in an abortion procedure [> check above<]
A. In a version procedure done at term, at 9 months, the larger size of the fetus can make version more difficult and -- and that's all.
Q. Based on your experience, Dr. Westhoff, do you agree with the statement by Congress that intact D&E poses "a risk of lacerations and secondary hemorrhaging due to the doctor PWHREUPBLGD force ago sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal"?

A. I do not agree with that.
Q. Why not?
A. First of all, it is not a -- the incision in the base of the skull is not a blind procedure, so that is inaccurate. But we have carried that out many times and have never experienced a problem of damage to the maternal tissue or hemorrhage during that part of the procedure. And I have not heard of any of my colleagues experiencing that problem.
Q. Doctor, I would like now to make or I want to ask you to make two assumptions. First, assume an intact D&E procedure in which, contrary to your view of safety, the physician has acted to cause fetal demise prior to cervical evacuation. Second, assume, contrary to what you have just testified to, that any or all of cervical incompetence, amniotic fluid embolus, PRUPGS, trauma to the uterus, or laceration or secondary ham RAEPBLGing or in fact risks of intact D&E, would these risks have been reduced in any way in your opinion by the step of causing initial fetal demise?
MS. GOWAN: I object to the form of the question.
THE COURT: It is a pip. Do you want to repeat it, Mr. Reporter.
THE COURT: Read the question back.
(Question read)
THE COURT: Sustained.
Q. Let me try to simplify it. Assume that a physician has

acted to cause fetal demise. Assume further that, contrary to what you have testified to, all of the risks or any of them numerated by Congress in section 14(A) of the findings, were true. Does the act of causing fetal demise at the outset reduce or eliminate any of those risks?
THE COURT: Are you talking about fetal demise prior to the procedure starting?
MR. HUT: Yes, your Honor, through the injection of TKPWEUPBLG Exxon to the am no, ital sack or --
THE COURT: That S-S what you said. You just said prior to --
Q. Sorry W. that qualification, Dr. Westhoff, are you able to answer the question? [> check the judge<]
A. If any of those risks were present, I do not believe that causing fetal demise prior to the beginning of the procedure would reduce any of the risks [> TPAOEPLT<] [> fetal<]
Q. Dr. Westhoff, let me direct you to section 2 of the findings. Let me read the first sentence of that paragraph. "Rather than being an abortion procedure that is embraced by the medical community, particularly among physicians who routinely perform other abortion procedures" --
THE COURT: Routinely do what?
Q. "perform other abortion procedures, partial-birth abortion remains a disfavored procedure that is not only unnecessary to preserve the health of the mother but in fact poses serious

risks to the long-term health of WEFPL and in some circumstances their lives."
Are you with me, Dr. Westhoff?
A. Yes, I found it.
Q. Did I read it correctly?
A. Yes, you did.
Q. Again, let's assume for purposes of the next question that the procedure referred to here in this finding by Congress is intact D&E. Based on your experience, Doctor, do you agree with 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. No, I do not agree.
Q. Why not, Dr. Westhoff?
A. I don't have any -- there is no biological plausibility based on my knowledge and experience that there are long-term health risks for women. Similarly, based on my knowledge and biological plausibility, that there is RAEUFBG to their lives.
Q. Dr. West off, please turn to section 13 of the findings which appears on page S3-3.
A. Yes.
Q. Let me read the first -- rather the second sentence of that paragraph. "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." Did I read that correctly?
A. Yes.
Q. Again, I ask you to assume that what the paragraph is talking about is intact D&E. On that assumption, do you agree with the statement by Congress in this finding that intact D&E 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?
MS. GOWAN: I object to the question. Counsel has not read the entire sentence of that paragraph, which reads as follows: "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." There is no foundation that this witness has reviewed the Congressional Record in this case.
MR. HUT: That is exactly right, your Honor. That is why I didn't ask her about the Congressional Record. This replicates the exchange that took place during the testimony of Dr. Johnson. At that time I did read that question, and Ms. Gowan objected to it. I thought, on consideration further, that that objection was well-founded and I asked permission to rephrase and I believe your Honorr said at that time you

better, and so I did, and the question proceeded as I have just asked it.
THE COURT: You aren't going to cause me to reverse myself are you, Ms. Gowan?
MS. GOWAN: No, not on that. I don't think he phrased the question? Just that way.
THE COURT: I was going to do it on other grounds, but not on that basis. We aren't going to revisit that. But I do think it would be nice if you broke it into parts.
MR. HUT: Hut I would be happy to do that, your Honor.
Q. Do you agree with the statement in the sentence just read that partial-birth abortion, rather, intact D&E, "is TPHEFRS necessary" --
THE COURT: You won't get sick if you say the words. It is sort of like you have to have your mouth washed out if you say the words. I realize you slipped, but . . .
Q. Do you agree with that portion of Congress's findings, Dr. Westhoff?
A. No.
Q. Why not?
A. I believe that an intact D&E is in fact beneficial to preserve the health of the woman and that it does not pose serious health risks, and that it lies inside the stash standard of care.
Q. Do you discuss with your colleagues their views about the

safety of intact D&E?
A. Yes.
Q. Do you discuss with other providers outside your institution who perform D&E their views as to the safety of intact D&E?
A. Yes.
Q. Do you discuss with other obstetricians and gynecologists who may not perform intact D&E their view of intact D&E and its safety?
A. Yes.
Q. Based on those discussions that you have had within your profession, do you believe that there is widespread agreement that D&E may in some circumstances be safer for some women than its alternatives?
MS. GOWAN: Objection.
THE COURT: Sustained.
Q. Dr. Westhoff, please look at paragraph 14(B) of the findings which appear on page S3-4. Are you there?
A. Yes.
Q. Let me read the last sentence of that paragraph. "Indeed, unlike other, more commonly used abortion procedures, there are currently no medical schools that provide instruction on abortions that include the instruction in partial-birth abortions in their curriculum." Did I read that correctly?
A. Yes.

Q. Do you agree with that statement?
A. No, I do not agree.
Q. Why not?
A. I provide instruction in this technique at Columbia University, and I know colleagues at other medical schools who also provide this instruction.
Q. What other medical schools?
A. The Albert Einstein College of Medicine, NYU, Cornell, and certainly Northwestern, and University of California San Francisco.
Q. At the time the Partial-Birth Abortion Ban Act of 2003 was enacted in November 2003, were you teaching intact at Columbia?
A. Yes.
Q. To your knowledge, were intact D&E's being taught at the other institutions you mentioned?
A. Yes.
Q. Next please look at paragraph 14(F). That appears on the next page, S3-5. [> teaching intact D&E at Columbia<] that finding is but a single sentence. Let me read it to you. "a ban on the partial-birth abortion procedure will therefore advance the health interests of pregnant women seeking to terminate a pregnancy." Did I read that correctly?
A. Yes.
Q. Assuming that the procedure referred to in that sentence were intact D&E, do you agree with the statement?

A. No. I disagree.
Q. Why not? Or why do you disagree?
A. In my experience and opinion based on my experience, intact D&E decreases risks to the patient during a D&E procedure, and I think decreasing risks does in fact advance the health interests of the woman.
Q. Please turn to section 14(J) which appears on the same page. Let me ask you, Dr. Westhoff, to read the first sentence of the findings set forth in paragraph 14 SKWRPBGTS.
A. "Partial-birth abortion also confuses the medical, legal, and ethical duties of physicians to preserve and promote life as the physician acts directly against the physical life of a child whom he or she had just delivered all but the head out of the womb in order to end that life."
Q. Based on your experience, Dr. Westhoff, in performing intact D&E, and assuming again that that is the procedure that is being discussed, do you agree with the statement that you just read?
A. No, I don't.
(Continued on next page) 4/2/04 Judge K*EUSy take 5 continuing direct of Dr. Westhoff.
BY MR. HUT:
Q. Why not?
A. In all of the abortion procedures that I carry out, we clarify that the goal. Procedure is to terminate the pregnancy, that the fetus will TPHOBT alive at the end of the

procedure, and that this is done at the request of the patient and explicitly with the consent of the patient.
So for all abortion procedures overall, regardless of technique, we in fact seek to clarify these legal, ethical and medical issues prior to beginning any procedure. And the intact D&E D&E is not different from the rest of abortion practice in that regard.
THE COURT: But you do so, as you testified this morning while not describing all the gory details to the woman who is consenting and authorizing you to do it, correct?
THE WITNESS: Correct, your Honor.
THE COURT: Thank you.
Next question.
BY MR. HUT:
Q. Finally, directing your attention to paragraph 14C of the findings, Dr. Westhoff, the first sentence states, ," a prominent medical association has concluded that partial-birth abortion is not an accepted medical practice, that it has never been subject to even a minimal amount of the normal medical practice developed, and that the relative advantages and disadvantages of the procedure in specific circumstances remain unknown?
THE COURT: Keep your voice up, please.
Q. Remain unknown and that there is no consensus among obstetricians about its use."

Did I read that clearly?
A. Yes.
Q. Once again let me ask you to assume that the procedure being discussed is intact D&E; let me ask you whether you agree that a prominent medical association -- or let me ask you if you agree first with the proposition that intact D&E is not an accepted medical practice?
A. I do not agree with that proposition.
Q. Do you agree with the proposition that it has never been subject to even a minimal amount of the normal medical practice development?
A. I do not agree.
Q. Do you agree with the proposition that the relative advantages and disadvantages of the procedure in specific circumstances remain unknown?
A. I do not agree.
THE COURT: Until Dr. Chasen's paper there has been nothing written, correct?
THE WITNESS: I think that medical -- my medical practice itself is the evidence I need to use.
THE COURT: I didn't ask you that, Doctor. I asked you simply, until Dr. Chasen's paper nothing has been written; correct?
THE WITNESS: No, your Honor. There have --
THE COURT: What are the other papers that have been

written then?
THE WITNESS: There have been some brief descriptions in the past by other practitioners of the method and the results in their cases.
THE COURT: That were published in peer journals?
THE WITNESS: I don't think they've been published in per review journals, no, but they have been available to colleaguess.
Q. Is there any paper that HRZ been written subject to review if a peer reveal journal that finds intact D&E to be in any way less safe that dismemberment D&E or another alternative?
A. No, there -- no.
MR. HUT: I have no further questions of the witness -RGS your Honor.
THE COURT: Just one question so I don't forget to ask you.
You say there are written communications concerning partial-birth abortion or intact D&E, whatever you want to call it, amongst colleagues; do you save them?
Do you keep a file?
THE WITNESS: I have files, sir, yes.
THE COURT: So you have files on this subject, were knees subpoenaed by the government?
THE WITNESS: I think there are some paper --
THE COURT: I don't know, I'm asking you were they

subpoenaed by the government.
THE WITNESS: I don't know. My files were not subpoenaed but I have been shown some material that I have seen before, in my own reading.
THE COURT: All right.
Ms. Gowan.
MS. GOWAN: Yes, your Honor.
CROSS-EXAMINATION

BY MS. GOWAN:
Q. If you will just give me a moment, your Honor.
THE COURT: Surely.
CROSS-EXAMINATION

BY MS. GOWAN:
Q. Dr. Westhoff, have you ever seen the government's discovery requests?
A. Yes.
Q. Did you read interrogatory number 10, the government's first set of interrogatories and requests for documents to Plaintiff Carolyn Westhoff, which was provided to your counsel on November 21st, 2003, and which reads as follows:
"identify all documents and/or data that supports your belief as stated in paragraph 26 of your declaration in this case, that the risk of laceration and of damage from blind

insertion of instruments is decreased, not increased, by removing the fetus intact."
Did you read that?
A. I'm sure I did, yes.
Q. Did you read government interrogatory number 11, identify all documents and/or data that supports your belief as stated in paragraph 26 of your declaration in this case that, "all in all, I believe intact procedures are safer than the alternatives."
Did you read that?
A. Yes, I did.
Q. Did you read document request number 1, "all documents identified in response to any interrogatory set forth herein.?"
A. I'm sorry, repeat the last thing you asked me?
Q. Did you read document request number 1, "all documents identified in response to any interrogatory set forth herein?"
A. Yes, I read that.
Q. Did you read document request number 11, "all written materials prepared by you concerning the abortion method intac intact D&E, also known as intact dilation and extraction, or D&X, as stated in paragraph 39 of the complaint.?"
A. Yes. I know I read all of them.
Q. Why didn't you produce those portions of the complication binder that you've testified to concerning intact D&E to the government in response to these requests?

MR. HUT: Objection. May I approach, your Honor?
THE COURT: No, I'm going to allow the question.
MR. HUT: Well it's objection.
THE COURT: If it gets into I talked with lawyers.
MR. HUT: No, it is not privilege it's that Ms. Gowan has read the document requests incompletely. Think there is an essential component that's left out, I want the Court to be aware of it and I don't want to signal the witness.
THE COURT: All right.

MR. HUT: Your Honor, the government's document.
THE COURT: Keep your voice down.
MR. HUT: The government's document requests consistent with the terms of Rule 34 of the Federal Rules of Civil Procedure required the witness to produce those documents in her possession, custody or control.
To my knowledge document that Ms. Gowan is intimating may be responsive to those requests are not, as you know, within the witness' possession, custody or control but are in fact within the possession, custody or control of the hospital.
THE COURT: Oh no.
MR. HUT: For instance such as the University. Oh yes indeed, your Honor.
THE COURT: I'm sorry. That may be true of the patient records, that is not the way she described those

complication binders that she and other doctors.
MR. HUT: I believe those were not in her possession custody and control and that Ms. But but has it establish that.
THE COURT: I'm sure she is going there and I am sure she talked about correspondence that I just finished asking about and that is not things that, it would seem, are contained or protected perhaps by H*EP a. These aren't necessarily part of a patient's record, these are things the doctors are keeping in her particular segment.
MR. HUT: These are hospital records, I think the government will, if it inquires, establish that and I think in fairness it needs to do so before pursuing this line.
THE COURT: I am sure she is going to pursue it further but it's a different kettle I think. I didn't want to O TPEBDZ barny there in that it's a cat and not a dog. I have to be SEBStive to my comments.
MS. GOWAN: I'm a cat fan, Judge.
THE COURT: Sorry about HR* oh dear, sore rewill that, somebody has it fall in these things.
MR. HUT: Will I'm not I'm at dog fan.
MS. GOWAN: I would like to add your Honor Dr. Westhoff produced statistics from Columbia University in response to the government's request and she also produced consent forms.
So it appears --

THE COURT: I have already ruled. You are liable to sink yourself if you keep going. When you got it in hand, take it and go.

Go ahead.

(Continued on next page)

(In open court)

BY MS. GOWAN:

Q. Why didn't you produce those portions of the complication binder that you have testified about in response to the government's discovery requests?

MR. HUT: My objection, for the reasons noted, your Honor.

THE COURT: Yes. Of course.

Go right ahead Ms. Gowan, we have just noted the objection and I have overruled it.

THE WITNESS: There are two reasons that are both true at the same time and I think the one that has become relevant over time is the reports in the binder I was referring to are, they're not mine, they're the hospital's and they're located on the hospital unit at the Allen Pavilion so I don't actually have them to produce for you.

But also another issue, just thinking about those pieces of paper, in fact even if I had those pieces of paper -- I guess what I have is an absence of complication reports on the patients with the intact D&E and I guess I wouldn't have --

I don't know how I would produce to you something that is absent because it's just there are no such pieces of paper for these particular patients.

BY MS. GOWAN:

Q. Why didn't you identify the book in response to the interrogatories and assert, as you did, with the medical records, that they were not in your custody and control?

A. It really -- it actually didn't occur to me to bring up the existence of this binder that isn't mine. It didn't occur to me to tell you about it. I mean it--I certainly looked at my files and in the notebooks that we do keep in my office to provide, for instance our summary statistics and so on, and but it's bother sort of the negative quality of the information that there were no reports relevant to these particular cases but also the fact that it's in a different building a couple miles away and doesn't belong to me. I didn't think of that as something that I could produce.

Q. When did you last look at that binder?

A. I don't honestly recall. If I take care of a complication I produce a report and give it to the head nurse to put it in the binder but I don't have any recollection of the last date and when I did that.

Q. Did you review that binder in connection with your preparation for your testimony at trial here today?

A. No, I didn't.

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THE COURT: Where is that binder physically kept?
THE WITNESS: It's at the Allen Pavilion, which is about 220th Street and it's in the, at the head nurse's office on three field west.
THE COURT: And you and your colleagues in your section file reports and put them in there when you have such a problem?
THE WITNESS: Whenever we identify a complication I ask all of the doctors to fill out a form and put it in the binder.
THE COURT: And you are free to go in and review it as the head of the department, I assume you are free to go in and review it any time you want, correct?
THE WITNESS: Correct.
THE COURT: Maintained in your section.
THE WITNESS: Correct. And I do --
THE COURT: Next question, Ms. Gowan.
BY MS. GOWAN:
Q. And do you review it periodically?
A. Yes, I do; to make sure that the reports are complete and to have our fellows actually complete a summary.
Q. And do you review it in connection with your quality assurance work that you testified about yesterday?
A. Yes.
Q. Now why didn't you produce the other documents that you

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testified about moments ago, the papers or possibly correspondence that have you in your file, relating to intact D&E?
A. There is material that I have had at some time and I'm sure at the time of the discovery request in fact counsel was very explicit about being careful to, you know, comply with all the requests as thoroughly as possible and that I did provide everything in my possession at the time.
And I certainly hadn't done anything to avoid providing the material. I provided whatever I had at the time.
MS. GOWAN: Your Honor, the government moves to strike Dr. Westhoff's testimony concerning the comparison of complications between intact D&E and D&E by dismemberment based on the experience of service at Columbia for, number one, failing to identify the existence of a complication book to the government in discovery so that it could, the government could independently make a determination whether or not it needed to include that in its subpoena to New York Presbyterian hospital; and for the further reason that Dr. Westhoff did not, herself, take steps to determine whether she could provide it to the government consistent with her employment at Columbia University.
THE COURT: I am going to reserve decision on your motion but I am going to order Dr. Westhoff to produce this complications manual and also files she has previously

described as correspond dense and communications in a vague description about the subject back and forth between members of the medical profession which she maintains a file on.

MR. HUT: Your Honor --

THE COURT: I don't think that's protected by the patient records that were previously sought which I ordered produced and which are now subject of an appeal. I don't know that H*EUPa attaches to any of these at all and I will order, as of, it should have been produced I think for decision as to whether or not there was any pro text at the time of demand for discovery. However, I will give you opportunity to comply with my order or I will consider Ms. Gowan's motion.

MR. HUT: Your Honor, respectfully may I be heard?

THE COURT: Of course.

MR. HUT: And I don't know whether you want to take this up at side bar, but these are not Dr. Westhoff's documents to produce, they belong, as she testified to, the hospital.

THE COURT: Oh I think you could probably do that but I think she has access to them and I don't know that they do apply. If you want to file some paper saying so, but I don't know that they would be protected anyway.

MR. HUT: I'm not arguing the protection, your Honor, I don't know. I don't know with the reach of helpa what I am saying is he is doesn't own, maintain or control them or possess them.

THE COURT: She main tapes or keeps them and her staff keeps them THRFPLT I don't know who they belong to.

MR. HUT: I believe you have testimony forty cents witness that they belonged to the hospital.

THE COURT: After you came to side bar and talked a little too laud she picked up on it quit. I she said that she kept records and they sound very much like her records.

MR. HUT: Your Honor, if I spoke too loudly TPOERB give me it was certainly not my intention to do that that is why I came to the side bar, sir.

THE COURT: I know but it doesn't always cure things, it moves you closer to the witness. I have been doing this for a long time, Mr. Hut, and so we will see what happens but at the moment I am ordering it. You can file some application if you want but none theless a subpoena can be issued to the hospital as well is this a problem.

But, as I told counsel early on before, Mr. Hut, I have a feeling all litigation ought to be on a level playing field and I feel there is a deliberate course of action, I don't know whether it was done some time ago in conjunction request H*EPa or what, but it seems like people have gathered all the records in the medical profession and put them behind a wall, whether it be individual's personal medical records and I can understand that, and that's why I went to great lengths before I ordered them produced to make sure that they were

redacted so that the privacy of any individual could not be impacted by this production.

But you full well knew what was going on in this litigation and what was there and I really don't much care about this KAOUTSy approach of a shell game of moving records here, there and 'shells.

And I would suggest to the government that they issue a subpoena immediately. That I don't know that there is any protection for these records and I think a certain amount of candor in this litigation probably would have been helpful to say well, there are some records, you know, if you give me a subpoena to the hospital, they will be responded to and hopefully complied with.

MR. HUT: Two points, your, if I may.

THE COURT: You may. Of course you may.

MR. HUT: First, we were at pains, respectfully, to identify to the government before the government issued its discovery requests the concern that we had about the amenability of production of these documents because they were in the possession, custody or control of the hospital.

So with all respect, your Honor, I believe we have at every stage, assiduously told the government what we have, what might be responsive.

With respect it these --

THE COURT: Did you also tell them that you could find

them in another drawer.

MR. HUT: With respect to these particular documents, Dr. Westhoff's testimony is that it did not occur to her and I think for perfectly understandable reasons, that these were responsive because it was the absence of any data that suggested complications that informed the determination she's made about the absence of complications. That's a very difficult --

THE COURT: Why do you have a folder if there is nothing in it? I don't think that flies, Mr. Hut. They keep a binder for the very reason so that she and her staff can report these things and she has just completed saying that she directs the nurse to do these things so there is something there. It isn't an absence.

MR. HUT: It is an absence, your Honor, with respect, of documents that indicate complications for intact D&Es. They're not there.

THE COURT: I think only when they're examined can we know that.

MR. HUT: But that is why, your Honor, respectfully, it may have been the case that the full universe of such complication reports were not identified to the government, because it is the absence of such data in Dr. Westhoff's judgment, she is the only person familiar with them, that may turn out to be probative.

Lastly your Honor, and respectfully, would you either inquire of the witness whether she heard me at side bar or permit me to conduct voir dire because I don't think she did.
THE COURT: If she would KPWH- STPHRAO whether she heard me at side bar as the Court suggested may have been the case or permit me to conduct voir dire on the subject?
THE COURT: You will be allowed to do redirect and we will finish it then. I am not going to prolong this any longer. If you wish to ask on redirect you are more than happy to.
I think this is probably an appropriate time, after we have all gotten exercise, to have our afternoon recess.
I will direct counsel not to talk to the witness, however concerning this subject during the break.
(recess).
THE COURT: Please, be seated. Ms. Gowan, you may inquire.
MR. HUT: Your Honor, before that commences, this is Mr. Hut. I wonder whether responding to the observation of the Court earlier it might be possible to go longer this afternoon if there is any possibility of concluding the cross examination of this witness. I spoke to Ms. Gowan she is uncertain whether that is feasible. She indicated she had approximately two more hours she thought, that would require obviously going back the 5:00 adjournment hour. We would request that if at all

possible.
THE COURT: I would love to accommodate you but I don't think I can today. If I had known a little bit earlier perhaps I could have but I don't think I can today. I apologize and I'm sorry. If you give me some advance warning I will be happy any time to try and accommodate you but I don't believe I can do it today.
MR. HUT: I understand, your Honor. Thank you.
THE COURT: Okay, in the future if you see it coming, just give me some warning but as you have seen, I have had other engagements booked other days and such and occasionally I go home and have dinner, but I just can't do it tonight, okay?
I apologize, I would love to help you out.
Ms. Gowan.
MS. GOWAN: Your Honor, at the break I placed two exhibits, Government's Exhibits on the witness stand for Dr. Westhoff, Government Exhibit T-7 and Government Exhibit Z-8.
BY MS. GOWAN:
Q. Dr. Westhoff, first, would you please take a look at Government Exhibit T-7 and tell me if you recognize that document?
A. Yes. This document is the responses to the interrogatories.
Q. Is it your responses to the government's first set of

interrogatories and requests for document?
A. Yes, my responses.
Q. And would you please turn to the last page of this document and what is the last page of this document?
A. The last page is my signed verification. Good and what is the date of your signature?
A. December 28th.
Q. 2003?
A. 2003, yes.
Q. And do you recognize Government Exhibit Z-8?
A. Yes. These are the objections to the interrogatories.
Q. And have you seen this document before?
A. Yes, I saw it at the time we prepared it.
Q. And would you turn to the last page of this document?
A. Yes.
Q. And what is the date on that page?
A. December 17th, 2003.
Q. And who has signed this document?
A. That's signed by TA*L could the camp.
Q. And who is Ms. Camp?
A. Ms. Camp is one of my attorneys.
MS. GOWAN: Your Honor, the government moves the admission of Government Exhibit T-7 under federal rule of evidence 801D 2A and the government moves the admission of Z-8 under federal rule of evidence 801D 2B.

MR. HUT: No objection.
THE COURT: They'll be received then.
(Government's Exhibits T-7 and Z-8 received in evidence)
BY MS. GOWAN:
Q. Dr. Westhoff, let's turn for a moment to Government Exhibit T-7.
A. Yes.
Q. And if you look, for a moment on the first page, will you please read for us interrogatory number 1?
A. Yes.
Identify the patient medical record numbers for at least 50 of the D&Es that are procedures after 19 or 20 weeks by your service in the last year as stated in paragraph 7 of your declaration.
Q. Let's turn to Government Exhibit Z-8.
Excuse me PWRRBGS we do that, could you please read your answer to interrogatory number 1 as it appears on Government Exhibit T-7?
A. Dr. Westhoff incorporates her objections in responses to interrogatory number 1 set forth in Westhoff objections.
Q. Now let's turn to Government Exhibit Z-8, which is your objections to the government's discovery requests, and if you turn to page 3 you will see the response, the objection to interrogatory number 1, correct?

A. Yes.
Q. Now, in that response an objection, you are objecting because the patient medical records numbers belong to the New York Presbyterian/columbia Presbyterian medical center (columbia Presbyterian); correct?
A. Yes.
Q. Now, there is no such entity called Columbia Presbyterian, is there?
A. I don't know what you mean.
MR. HUT: Objection, your Honor.
THE COURT: Yes.
MR. HUT: Columbia Presbyterian is a defined term referring to the New York Presbyterian-Columbia medical center as set forth in the response.
BY MS. GOWAN:
Q. Dr. Doctor my question is who rereferring to here?
THE COURT: I will allow the question.
THE WITNESS: Okay.
The New York Presbyterian hospital is a hospital with several campuses and the campus where I work is colloquially referred to as Columbia Presbyterian.
Q. Okay, and by calling, in the objections here by denominateing that as Columbia Presbyterian, are you referring to the New York Presbyterian hospital? Or are you referring to Columbia University? Or are you referring to both?

A. No, I'm referring to New York Presbyterian hospital.
Q. Now, did you contact the New York Presbyterian hospital prior to December 28, 2003, when you signed the verification to your responses to the discovery requests?
A. Yes.
Q. And did you contact them about your, the medical records for your patients?
A. I had general conversations with relevant administrative staff at New York Presbyterian and I believe counsel had direct conversation with them about obtaining records.
Q. Who did you have a conversation with?
A. I had, around the time this case began, I had conversations with an attorney named Brian TPHAO*PB an and also a Mr. com pano.
Q. And what did you say to Mr. noon an?
MR. HUT: Objection, your Honor, it's privileged for reasons set forth yesterday in the testimony of Dr. Hammond.
THE COURT: I think I ruled against you yesterday.
Overruled.
THE WITNESS: Mr. noon an was just new, relatively new to his position at New York Presbyterian at around the time this case began and I wanted to introduce myself to him because I thought that this might, this issue, prior to the interrogatories that none theless areas around the case might be of interest and I should meet this new person and indicate

my plan for us to collaborate together, as necessary, in this case.
BY MS. GOWAN:
Q. What kind of collaboration did you anticipate having with New York Presbyterian Hospital?
A. I didn't have any specific collaboration planned but since the case is, concerns patients I take care of there, it appeared that we would probably need to have conversations and I wanted to meet a new person.
Q. Did you discuss with Mr. noonan, when you first spoke with him, the issue of medical records possibly being at play in this litigation?
A. I don't recall discussing that. And we met -- I would have to actually check my diary to find the date we met, but I believe that preceded the issuing of the interrogatories.
But I want to be clear to you that I did contact hospital's counsel and spoke with them at the time the case began.
Q. And what was the name of the other attorney that you spoke with?
A. Mr. com pano, and I believe Mr. noonan RORGS to him.
THE COURT: Keep your voice up, please.
A. Mr. com pano. I don't remember his first name.
Q. When did you speak with Mr. com pano?
A. Actually on the same day.

Q. Did you discuss the issue of medical records with Mr. com pano?
A. I don't believe so.
Q. Did you ever contact anyone at New York Presbyterian Hospital prior to signing your verification in this case on December 28, 2003, about medical records?
A. I do know for sure that counsel contacted the hospital to discuss obtaining the records and I don't remember right now if after the interrogatories I had separate conversations with people about obtaining the records.
I unfortunately had to check my palm pilot at the door and so checking dates on those conversations is something I can't do.
Q. Can you recall any conversation that you have had with anyone at New York Presbyterian Hospital about the issue of producing medical records in response to the government's discovery requests?
A. Yes.
More recently I had another conversation with Mr. no Mr. noonan but I think it was after these responses, but in which I wished to tell him some ideas I had about how to figure out which records might be applicable, so that if the hospital were willing to produce the records it would be manageable to figure out which records would be appropriate.
Q. When did you have that conversation?

A. Again, I don't have the date of -- I don't have the date. It was definitely after these responses and it was before trial began and -- but I can't tell you the exact date I spoke to him.
Q. Was it within the last two weeks?
A. I think it was probably more than two weeks ago but I'm in not sure. If I referred to my diary I probably would be able to figure out what date it was.
Q. When, to your knowledge, did your counsel first speak with anyone at New York Presbyterian Hospital about the identification and production of medical records?
A. I would have to guess it was December. I know it was shortly after we received the interrogatories and discussed how to respond to the interrogatories but I don't know what date that conversation occurred.
Q. Did your counsel report to you what Presbyterian Hospital had said about the production of medical records?
A. My general recollection is that counsel told me that the hospital said the medical record numbers are their property and that I wouldn't be able to have access to them. But I'm probably not getting the language quite right on that conversation.
But that simply that I wasn't going to be able to proceed to identify the cases that responded to the particular interrogatories by using hospital medical records.

MR. HUT: For the record, your Honor, I just want to renew the objection to request to disclose privilege information.
I understand you previously ruled.
THE COURT: Your objection will continue. You don't need to do it each time.
BY MS. GOWAN:
Q. Did your counsel tell you whether New York Presbyterian Hospital had said that it would not permit you to have access to the medical records?
A. I believe that's correct.
Q. Do you know how many times your counsel spoke with New York Presbyterian Hospital on this issue?
A. I have an impression there were many conversations but I have no idea what the number might have been.
Q. Did you -- withdrawn.
Now, the government was advised by your counsel on March 26th, 2004, that you have obtained permission from Columbia University to use Columbia University's billing records to create a list of second trimester abortions from your service. The government was advised by your counsel that the billing records are maintained by an outside service that had made significant errors in the record keeping.
Do you know what it was that you first obtained permission to look at Columbia's billing records for purposes

of creating a list of second trimester abortions to assist you in responding to the government's discovery request?
A. I don't have any -- I can't possibly come up with a date for you. I have been trying to think of other ways that I could possibly generate information in order to be responsive when I was in the situation of not having access to the records and so that was, I had the idea that perhaps the billing records would be useful but I can't give you any dates for when Hi that idea or exactly how I pursued it.
Q. What was that, in the last week that you had that idea?
A. No, no. It was certainly more than a month ago. Certainly more than a month ago.
Q. When did you learn that Columbia was going to give you access to information in their billing records to assist you in identifying patient medical record numbers that were responsive to the government's requests?
A. I don't have any idea of what date I became aware that it was okay to proceed in that way. There were conversations with a lot of people to try to find a way to proceed that would be acceptable.
Q. Well do you remember if it was this month?
A. No. I do think it was more TH-PB a month ago but I'm not -- I'm really not sure of a date. It was not in the last couple weeks.
Q. Do you know when it was that you were given permission to

access the billing records?
A. I don't know when it was that I had permission.
Q. Have you looked at the billing records?
A. Yes. I've gotten a printout of billing records.
Q. And when did you first do that?
A. I don't remember exactly when I got the billing records but it was more than -- PH-R than a couple weeks ago, certainly.
Q. Who gave you permission?
A. It's not always clear to me who gives me permission but I had discussed this issue with general counsel for the University and was told in those conversations it was certainly okay for me to look at billing records.
Q. Now, counsel's letter to the government on March 26, as I said a moment ago, referenced the billing records are kept by an outside service; isn't it true that Columbia University's department of OB/GYN has its own billing department?
A. There has been a transition between outside billing and internal billing that's been taking place over the last couple years and so the billing records exist in more than one place.
I was concerned with the interrogatory that covered patient records for three years and how we would possibly figure out who are the relevant patients to respond to that interrogatory so that required going to the outside billing service in order to try to create a list.
Q. Are the services that you performed at the Allen Pavilion

billed under your name?
A. They're billed by the University and I believe they're billed in my name or in the name of a range of different doctors who provide these services.
Q. Are your services billed under your name, Dr. Westhoff?
A. Yes.
Q. Isn't it true that billers from the Columbia University department of OB/GYN come up to the Allen Pavilion to gather information from the medical records in order to prepare bills for your services?
A. I actually don't know what the billers do.
We fill out billing forms when we take care of patients and to my knowledge the billers use the billing forms. I don't know what else they need to use.
Q. And those billing forms identify the patient's name, right?
A. Yes, they do.
Q. The patient's medical record number, right?
A. Yes.
Q. The service that was performed, right?
A. Yes.
Q. The date of the service?
A. Yes.
Q. And do you sign those forms?
A. Yes, I do.
Q. And are those forms kept at Columbia University, the

department of OB/GYN, to your knowledge?
A. I have no idea what happens to the forms after I'm finished with them.
Q. To your knowledge does Columbia University department of OB/GYN have a database that shows the medical record numbers and the patient names and the type of services that you have performed for patients at the Allen Pavilion?
A. Can you ask me that again?
THE COURT: Ms. Reporter would you read the question. Would you be so kind?
(record read).
THE WITNESS: To my knowledge the medical record number is not included in that database. There is a separate identification number that's used in that database. But I'm not -- I'm certainly not completely knowledgeable about the database.
BY MS. GOWAN:
Q. The government learned on March 24th, 2004 from counsel for New York Presbyterian Hospital this a list of 286 names that you had identified had been sent to Presbyterian Hospital; where did you get the list of the 286 names?
A. That was -- that was from the billing department. That list of names did not contain medical record numbers but it did contain names and the procedure code for D&E and some billing information.

Q. And when did you create that list?
A. I don't -- I did not create that list. People in the billing office created that list but I don't recall when they created it.
Q. Was the list created at your request?
A. Yes.
Q. Do you have any idea at all when that list was created, Dr. Westhoff?
A. It was definitely created in 2004 and during the time I was exploring ways to respond to the interrogatories. But I do not recall either when I requested the list or when I received the list.
Q. Do you know why it was that the list was not sent to New York Presbyterian Hospital until March 24th, 2004?
A. No, I can't explain.
Q. Do you have a copy of that list?
A. It's possible that my secretary has a copy of that list and I could ask her if she does. I don't know if she does. I don't have a copy of that list in my own files.
(continued on next page) TWM 4/2/04 Westhoff on cross by Gowan<]
Q. On March 29, 2004, the government was also advised by New York Presbyterian Hospital that they had received a second list of 28 medical record numbers which they had been told was prepared by you based on memory in the records of Columbia University. When did you prepare that list of 28 names?

A. I believe I prepared that list just last week.
Q. What did you do to prepare that list from your memory?
A. It was somewhat more my secretary's memory. After discussions with Columbia's general counsel, I asked if I could review records from faculty practice to see if that would help me identify any patients responsive to the interrogatories. While those records don't actually contain information about the D&C per se, my secretary was able to help me recognize some names of patients who had been D&E's and therefore we were able to use that as a source for medical record numbers of patients that were responsive to the interrogatories. As I testified yesterday, my tame in faculate practice is about 10 percent of my time. The patients from that source represent add small percentage of all the patients we take care of for D&E's. But I thought it was at least something that I was able to provide, although it is a small portion.
Q. Prior to the time that you submitted your verified response to the government's interrogatories on December 28, 2003, had you made any effort to review the faculty practice plan medical records for your patients to determine whether there was information in those records that was responsive to the government's discovery requests?
A. No, I had not.
Q. Why not?
A. There were such a small number of patients there, and I had

been thinking -- I had been trying hard to think of all the ways that we could come up with a comprehensive list that would in fact be more completely responsive to the discovery request. It turned out that basically none of the ideas I had to identify patients more comprehensively were acceptable in terms of looking at hospital lists, and so on. So it was a late realization that I might be able to turn to this source. I then discussed that with university counsel, who found that acceptable.

At about 15 file folders of charts that we went through last week and were able to find these that are relevant.

MS. GOWAN: May I approach the witness, your Honor?

THE COURT: You may.

Q. Dr. Westhoff, I am showing you what was previously marked as your deposition as Government Exhibit 35A. Do you recognize that document?

A. Yes.

Q. What is it?

A. These are some summary statistics from the TPW* YN services at the Allen Pavilion for 2002 and 2003.

Q. That is your services tGYN services?

A. Those are my services.

Q. Did you produce this document to the government in discovery?

A. Yes, I did.

Q. What does code 59841C and E stand for?

A. That is the procedure code for second trimester surgical abortion.

Q. Does this document show the number of services of surgical abortion provided by your service in 2002 and 2003 on a monthly basis?

A. Yes. These numbers were provided to me by hospital staff. As we have discussed previously, I don't have any assurances that they are correct or complete, but it is the best information I have about the number of services we provided.

Q. Your second prepared this summary, is that right?

A. Yes.

Q. The numbers that are on the summary were tabulated by nurses on your unit based on a patient log, right?

A. Yes.

Q. Does that patient log identify the names of patients?

A. Yes, it does.

Q. Does that patient log identify the date of service?

A. Yes, it does.

Q. Does the log identify the type of service rendered?

A. Yes, to some degree.

Q. Does it identify the provider of the service?

A. Yes.

Q. Did you review the patient log to assist you in responding

to the government's discovery requests in this case?
A. I did not, because the patient log is the property of the hospital, and I was advised I was not allowed to make a list from that log.
Q. Who told you that?
A. I don't remember.
Q. When were you told that?
A. I think back in December.
Q. Where is the log kept?
A. The log is kept at the hospital.
Q. Have you had access to the log on a regular basis since this litigation has started?
A. I never write in the log, but I know where it is kept, yes.
Q. Have you had occasion to look at it since this litigation has started?
A. I don't know that I have.
Q. Have you ever asked any of your patients whether they would consent to release of redacted medical records in this litigation?
A. I have had several patients tell me they do not want me to release their records, but I have not systematically tried to contact patients and gather that information.
Q. When did you have those conversations?
A. In the last few months.
Q. How did it come about that those conversations took place?

A. Those conversations were initiated by the patients.
Q. How many patients initiated such conversations?
A. Several of them did, but I'd say fewer than ten.
Q. Were the conversations about the contents, the use of the records in this litigation?
A. Yes.
Q. Did you tell the patients that the government had agreed voluntarily to enter into a confidentiality order to be signed by this Court regarding those records?
A. Could you read that back?
(Question read)
A. No, I didn't make that statement to my patients.
Q. Did you tell your patients that in the event the medical records were provided to the government, that all patient identifying information would be redacted from the records?
A. I didn't use those words, but I did tell any patients with whom I had this discussion that, yes, identifiers would be removed if records were released.
Q. What were the words you used?
A. Probably the words I just used. I don't remember my exact words in those discussions.
Q. You are an NAF member?
A. Yes.
Q. Had you had occasion to review Government Exhibit N prior to -- let me back up. First of all, were you in the courtroom

yesterday when we were asking Dr. Hammond about the NAF resource guide on legislative efforts to ban certain late-term abortion procedures, any excerpt relating to NAF's statement about fact and medical records?
A. I was in the courtroom, yes.
Q. Prior to yesterday had you been aware of this particular document?
A. No, I think not. S-
Q. I am going to read for you that portion of Government Exhibit N that we read to Dr. Hammond yesterday when you were in the courtroom. "Antichoice groups have formed an organization called TPA*BGT, physicians ad hoc coalition for truth, to assert that the intact D&E procedure is never medically necessary or appropriate. Former surgeon general C. effort coop is part of this organization and has written upeds in support of this legislation. Dr. Coop is known to be antichoice. Moreover, neither he nor any of the TPA*BGT 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 supports this legislation."
Do you agree with NAF's statement that I have just read to you?

A. That was a long statement. Do I agree with it in its entirety? Do you mean do I agree with each and every element of that statement?
Q. Do you agree that Dr. Coop's opinion [> Koop<], FACT's opinion, that the procedure is never medically necessary or appropriate, is somehow defective because they have not reviewed medical charts of patients who have undergone the procedure as is claimed by NAF?
A. No.
Q. Did you have a discussion between yesterday and today with anyone from NAF about this particular statement?
A. We didn't discuss the statement.
THE COURT: Did you have discussions with people from NAF, though?
TH
THE WITNESS: Yes.
THE COURT: To whom did you speak?
THE WITNESS: The executive director of NAF, who is here in the courtroom. We have chatted yesterday at the end of the day about --
THE COURT: Who is that?
THE WITNESS: That is vickysy pour at a. But we did not discuss the statement. We discussed other things. S-
THE COURT: Did you talk with anyone else from the organization?

THE WITNESS: No, I didn't.
THE COURT: You may inquire, Ms. Gowan.
Q. Did you talk to Dr. Hammond about it?
A. No, we didn't talk about it.
Q. You testified this afternoon that in your opinion injection of KCl and TKEUPBLG Exxon to cause fetal demise prior to abortion is not safe, is that right?
MR. HUT: Objection: Mischaracterizes the testimony. [> digoxin<]
THE COURT: If she disagrees with it, she can say so.
A. I testified that it doesn't have any benefit to the woman I am taking care of and that it does have some risks.
Q. Do you disagree with the National Abortion Federation 2003 clinical policy guidelines that suggest -- that state as an option in second trim ter abortions intraamniotic or intrafetal injection may be given?
A. I agree it is an option.
Q. You have a longstanding interest in abortion care and know people who are on the ackivist side of abortion issues, right?
A. Yes.
Q. You have been a member of the board of directors of Planned Parenthood of New York City since 1994, right?
A. Yes.
Q. Before that, beginning in 1991, you were a member of the Planned Parenthood medical advisory chi, right?

A. Yes.
Q. You are on the advisory committee of the national abortion rights and action league foundation, right?
A. Yes.
Q. The national abortion rights and action league is knowns NARAL, right?
A. Yes.
Q. As far as you know, NARAL is involved in advocacy work regarding abortion access, right?
A. Yes.
Q. Can you identify on your curriculum vitae your consultive work with the ACLU reproductive rights project from 1997 to present, right [> and you<]
A. Yes.
Q. This is the third lawsuit that you have been involved with concerning partial-birth abortion laws, right?
A. Yes.
Q. The first case was Evans v. Kelley, is that right?
A. That's right.
Q. Where was that case brought?
A. That case was in Michigan.
Q. Was that in 1997?
A. I believe that's correct.
Q. Was your co-plaintiff in this case Mark Evans one of the lead plaintiffs in that case?

A. I believe so, yes.
Q. He was the Evans in Evans v. Kelley, right?
A. Yes.
Q. Was your co-plaintiff in this case Dr. Timothy Johnson also involved in that case?
A. Yes, he was.
Q. Were you an expert witness on behalf of the plaintiffs in that case?
A. Yes.
Q. You were not a plaintiff, were you?
A. I was not a plaintiff.
Q. Did you submit a sworn declaration to the court in that case?
A. Yes.
Q. Was that in connection with plaintiffs' application for a TRO enjoining the Michigan partial-birth abortion law?
A. I don't know if it was in conjunction with an application for a TRO.
MS. GOWAN: May I approach, your Honor?
THE COURT: You may.
Q. Dr. Westhoff, I am showing you what has been mark as Government Exhibit C3.
A. Yes.
Q. Would you take a moment and look at that.
A. Yes.

Q. Do you recognize it?
A. Yes. That is my declaration in the case in Michigan.
Q. If you would turn to the last page, is that your signature?
A. Yes, it is.
Q. What is the date of your declaration?
A. March 18, 1997.
Q. As of March 18, 1997, you had never performed an intact D&E, right?
A. That's right.
Q. But you understood it was a specific procedure, didn't you?
A. I understood it was a variation of the D&E technique.
Q. In paragraph 13 of your declaration you state in the second sentence, "Although I have not performed the procedure, I have observed it, discussed it with colleagues, and reviewed the testimony of my colleagues attesting to their use of the procedure.?"
A. Yes.
MR. HUT: Objection, your Honor. In the interests of completeness under Federal Rule 106, Federal Rule of Evidence, I ask that Ms. Gowan read the first sentence, which places the -- that is my objection.
MS. GOWAN: Certainly I will read that, your Honor. The first sentence is, "for procedures later in the second trimester, some physicians use a variant of D&E knowns intact D&E or dilation and extraction (D&X)."

Q. By "procedure," in the second sentence of your declaration, you meant SP-P intact D&E, dilation and extraction, D&X, right?
A. Yes.
Q. At some point before signing the declaration you went to watch the procedure performed, isn't that right?
A. Yes.
Q. You had heard about it in the news, right?
A. That's true.
Q. You wanted to become informed about the technical aspects of the procedure, right?
A. Yes.
Q. So you asked around to find someone who was familiar with the technique, right?
THE COURT: I didn't hear an answer, ma'am.
A. Yes. I am thinking about the locution that I asked around.
Q. You asked your colleagues, correct?
A. Yes.
Q. I didn't mean that you asked around town. You asked your colleagues if they were aware of someone who was familiar with the technique so that you could go and observe it, right?
A. Yes. I identified a colleague who performed the technique and was willing to have me come observe it.
Q. You went to watch that physician perform it on four or five patients, right?
A. Yes.

Q. In forming your opinion as set forth in this declaration that you submitted in the Michigan case, you relied on a paper -- well, I should say you relied on a letter that a Doctor McMahon had sent to Congress when Congress was holding hearings on partial-birth abortion in a paper that Dr. McMahon presented at a National Abortion Federation conference, right?
A. Yes.
Q. Who is Dr. McMahon?
A. He was a physician who provided abortion care and described the use of this technique. I don't have a personal relationship with Dr. McMahon, so I can't tell you more about him.
Q. In preparing and forming your opinion in the Michigan case, did you also rely on a paper that Dr. Haskell presented at a NAF meeting?
A. I'm looking at item 13 in my declaration here in 1997, where I said I relied on testimony of Dr. Haskell in a case in Ohio. I can't remember right now in 2004 exactly what I was looking at, so I would rely on my statement here in 1997 that the material of Dr. Haskell I reviewed was his testimony.
Q. Directing your attention to your deposition taken in Evans v. Kelley on May 1, 1997 at page CW0452, line 14, where you were being questioned by counsel for the State of Michigan. "Q. Do you have any publications, printed material, from Dr. Haske

Haskell?
"A. Yes.
"Q. OK. Could you just identify it for me, please.
"A. I have an article that I think was a presentation at NAF in 1992 titled 'dilation and extraction for late second trimester abortions.'"
Does that refresh your recollection as to whether you relied on Dr. Haskell's paper in forming your opinions in the Michigan case?
MR. HUT: Objection: Improper impeachment. And at the outset of the reading of the question and answer I had not been supplied by counsel a copy. Conditional do you want to look at it? Go right ahead.
MS. GOWAN: This was a document that plaintiffs produced to the government. They have a copy of this.
THE COURT: Is that correct, Mr. Hut?
MR. HUT: Surely. We produced about 75,000 pages of documents, your Honor. We don't have them all in the courtroom.
THE COURT: I think it is hardly one you can complain about that they haven't given you a copy. You seemed a little bit upset about that. The fact that you choose not to bring it to court, but since it is one of your documents, I don't think it is legitimate that you should be distressed about it. But I will say if you wish to go back and look at it, go right ahead

and do so.
MR. HUT: Thank you, Ms. Gowan has supplied it to me. This is testimony at page what?
MS. GOWAN: It is your Bates counsel.
MR. HUT: CW452 and it is lines 14 to 23? Can. A. May I ask the date of that?
THE COURT: Of course you can. Ms. Gowan, tell tus date of it. Gowan gone I identified it, Doctor WH-RBGS I started to read. It is May 1, 1997.
THE COURT: I thought so. All right.
MR. HUT: I think it is improper impeachment, your Honor. I object.
THE COURT: Overruled. Go ahead.
Q. Does that refresh your recollection, Doctor, as to whether you relied on Dr. Haskell's paper in forming your opinion in the Michigan case?
A. Even with hearing about the testimony and also having the declaration in front of me, I can't tell you exactly when I read each of those, if I read them and if there was any reason I cited relying on one in the declaration and cited reRAOEUG on the other at the time of testimony. If I said I read both of them, I'm confident that I did read both of them in 1997 or earlier, but I don't know why I referred to different documents in the declaration and testimony.
Q. In your Michigan declaration at page 11, paragraph 31, you

referred to a standard D&E. By "standard D&E" you mean D&E by dismemberment or disarticulation, right?
A. That's what I meant in that sentence, yes.
Q. That is also known as a conventional D&E, right?
A. People might refer to it as a conventional D&E. I think that is possible.
Q. As you have testified earlier, in a D&E by dismemberment you use forceps to grasp the fetal part and, through a combination of traction and twisting, you disconnect that part from the rest of the fetus's body, right?
A. Yes.
Q. That is different from an intact D&E, where the fetus is removed intact up to the shoulders and the skull is collapsed, right?
A. Yes.
Q. As of 1997 you understood that physicians performed intact D&E as a planned technique after 20 weeks, didn't you, Dr. Westhoff?
A. I don't understand what you meant.
Q. You understood that it was a planned technique, didn't you?
A. I still don't understand exactly how to answer that. I don't know what you are asking, so I don't know how to answer it.
Q. Well-
A. All surgery is planned except for emergency surgery. This

is not emergency surgery. In that sense, it is planned.
Q. As opposed to inadvertent procedure?
A. I think that usually an intact D&E is performed with deliberation and intent, yes. It can occur inadvertently, but I think usually it is deliberate.
Q. If you would turn to paragraph 4 of your Michigan declaration. The second sentence of paragraph 4 of your declaration reads as follows: "I have also observed intact dilation and evacuations (intact D&E's) and reviewed testimony of at least two physicians who use this variation of D&E."
In paragraph 13 of this same declaration you refer, as we mentioned earlier, to dilation and extraction and D&X. Is dilation and extraction the same as intact dilation and evacuation?
A. I think "intact dilation and evacuation is the same as intact dilation and extraction [> no quote<]. But for either one of those terms, one can either use the modifier "intact" or not. But I don't think either one of the terms D&E or D&X implies intact, to me, unless the modifier "intact" is used to describe it or precede it.
Q. Is intact D&E the same as D&X?
A. I think in paragraph 13 I refer to D&X as abbreviation for dilation and extraction. I think it is still in second trimester abortion cases we dilate and we extract. If it is intact, it is probably more informative to use the modifier

"intact."
Q. When you went to observe the procedure, did you see a D&X performed?
A. What is the usefulness of the shorthand?
Q. Doctor, did you see a D&X performed?
A. I saw D&E procedures in which the fetus was removed intact. I don't necessarily think verbally that has a one-to-one correspondence with the term D&X. I think D&X is a shorthand that may be used to describe this procedure.
Q. When you went to see the procedure, did you see an intact dilation and evacuation performed?
A. Yes.
Q. When you went to see the procedure, did you see a dilation and extraction performed?
A. Yes.
Q. When you went to see the procedure, did you see an intact D&E performed?
MR. HUT: Objection: Asked and answered.
THE COURT: Overruled.
A. Yes.
Q. In your expert report that you submitted in this case, your TRO declaration, you refer in paragraph 24 to the intact D&E variation.
A. I don't have a copy of my declaration.
Q. Would you like one?

A. Yes, please.
Q. I will show you what was marked as Plaintiffs' Exhibit 1235.
A. Thank you.
Q. Is that your expert report in this case?
A. Yes. Thank you.
Q. If you would turn to paragraph 24, which is on page 11.
A. Yes.
Q. Do you see the reference there to intact D&E variation?
A. Yes.
THE COURT: Is this exhibit in evidence?
MS. GOWAN: No, your Honor.
Q. You don't know where that term comes from, do you?
A. For me, it is a useful descriptive term for the procedure, but I don't know where it comes TPWR in the sense of who might have used it before or elsewhere, no.
Q. You don't know whether you first heard it from someone else or if it is just a way that you came up with to talk about in the declaration, right?
A. That's right.
Q. You think you might have come up inTKPEPBLT with that term without hearing it from anyone else, right?
A. It is possible that I used it and it is definitely possible I heard other people using the same term before.
Q. You just don't know, do you?

A. That's right.
Q. When you went back in 1997 to observe the procedure, did you see an intact D&E variation?
A. Yes, I would describe it that way.
Q. In your mindl, is intact D&E variation the same as intact dilation and evacuation?
A. They are both reasonable ways to describe the procedure we have been discussing, yes.
Q. Is it the same as dilation and extraction?
A. It is not the same in the sense that the words aren't exactly the same, but they are all different ways --
THE COURT: But the procedure is the same, doctor? Are we playing semantics here?
THE WITNESS: Well, your Honor, it sounds to me like we are playing semantics.
THE COURT: It seems pretty simple. You keep saying they are the same but then you hesitate. Is it the same or isn't it? Very simple.
THE WITNESS: There are a variety of terms used to describe this procedure.
THE COURT: But it is all the same procedure, is that what you are saying?
THE WITNESS: The procedure itself has a lot of individual variations, but there is a core procedure that we are thinking about.

Q. So it is the same as D&X, too?
A. When people use the term D&X, they may be describing the same procedure that I am talking about when I talk about the intact variation of D&E.
Q. It is the same as intact D&E?
A. Yes.
Q. At page 8, paragraph 22 of your Michigan declaration, you opine that induction abortions are safe procedures and have some advantages over D&E, right?
A. Yes.
Q. In particular, the advantages that you saw were that induction abortion does not require the use of sharp instruments inside a woman and the induction abortion has a lower rate of uterine perforation, correct?
A. Yes.
Q. You also thought as an advantage that induction abortion would be indicated when an intact fetus is required for an autopsy to study a fetal anomaly, right?
A. As I said, it may be indicated in that setting, yes.
Q. The second case that you were involved in was in New Jersey, right?
A. Yes.
Q. What was the name of that case?
A. I would have to refer to it for the name of the case.
MS. GOWAN: May I approach, your Honor?

THE COURT: You may.
Q. I am showing you what has been marked as Government Exhibit C had 46789?
A. Thank you.
Q. Take a moment and look at that. Do you recognize that?
A. Yes. That is my declaration in the case of Planned Parenthood of central New Jersey v. Peter SRERPBia ro.
Q. Is that your signature on the last page?
A. Yes.
Q. What is the date of that?
A. December 12, 1997.
Q. Was one of your co-plaintiffs in this case Dr. Gerson Weiss a plaintiff in that case?
A. I was an expert. I don't think I was a plaintiff in that case. And I think Dr. Weiss was a plaintiff in that case.
Q. That is the declaration that you submitted in that case in support of a TRO enjoining the New Jersey partial-birth abortion law?
A. Yes.
Q. Would you please turn to page 3, paragraph 4.
A. Yes.
Q. Would you please read for us [> VERNIERO<] the second sentence in that paragraph.
A. It says, "I have also SPWAOEUFD the breech extraction method of intact D&E and reviewed testimony of at least two

TPWEU situations who used this variant of D&E."
Q. Would you agree that the only difference about the text of paragraph 4 in your New Jersey declaration and the text at paragraph 4 in your Michigan declaration is, I should say are the words "breech extraction method of intact D&E"?
A. Yes.
Q. In your Michigan declaration you called what you had witnessed the intact dilation and evacuation intact D&E. Is the breech extraction method of intact D&E the same as intact dilation and evacuation?
A. In practice, not all intact D&E's will occur with a breech extraction, but many of them do. The breech extraction variant is a common method for intact D&E.
Q. As opposed to a vertex presentation, is that right, Dr. Westhoff?
A. Yes, that's correct.
Q. So as you used the term in your New Jersey declaration, is it the same as intact dilation and evacuation of a fetus in the breech presentation?
A. Could you read that question back? (k) Mr. Reporter, read the question back.
(Question read)
A. Yes.
THE COURT: Ms. Gowan, it is 5 o'clock, a little after. Is this a convenient time or do you have a few more

questions on this subject before we break?
MS. GOWAN: Just a couple of more quick questions, your Honor, if I may.
THE COURT: They can even be slow.
MS. GOWAN: Thank you, your Honor.
Q. Is the breech extraction method of intact D&E the same as dilation or extraction of a fetus in the breech position?
A. Yes, I think that describes it, those are similar descriptions.
Q. Is breech extraction method of intact D&E the same as D&X in the breech position?
A. I think those are similar descriptions.
Q. Is breech extraction method of intact D&E the same as an intact variation of D&E of a fetus in the breech position?
A. Yes, I think those are similar descriptions.
MS. GOWAN: Your Honor, I think this would be a good time to stop.
MR. HUT: Your Honor, may I inquire with respect to one brief housekeeping matter?
THE COURT: Surely.
MR. HUT: Because Dr. Westhoff has gone a little longer than I at least anticipated, I wonder whether there would be any possibility of beginning earlier on Monday. We may encounter a logjam with our witnesses on Monday and Tuesday.

THE COURT: I was just going to say that I received a request that we break on Monday for those who wish to celebrate or observe Passover. So what I was going to suggest is that we try and start about 9 o'clock. But we will go through until 1 o'clock and we will break then and that would enable any who wish to be in Washington or wherever they may be going by sundown. So that would be my plan for Monday.
MR. HUT: Thank you, your Honor. I appreciate the Court's cooperation, on both ends.
THE COURT: We are trying to do what we can. We will do whatever needs to be done. That will give you four solid hours of testimony.
MR. HUT: Thank you, your Honor.
THE COURT: Well, we will take a morning break. But roughly speaking we will have four hours of testimony.
I hope you all have a fine weekend.
(Adjourned to 9:00 a.m., April 5, 2004)