TWM April 5, 2004 NAF v. Ashcroft.
SOUTHERN DISTRICT OF NEW YORK
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NATIONAL ABORTION FEDERATION,
MARK I. EVANS, M.D.,
CAROLINE WESTHOFF, MD, MSC;
CASSING HAMMOND, MD,
MARC HELLER, MD,
TIMOTHY R.B. JOHNSON, MD,
STEPHEN CHASEN, MD,
GERSON WEISS, MD,
on behalf of themselves and
their patients,

Plaintiffs,

v. 03 Civ. 8695 (RCC)

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

Defendants.

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New York, N.Y.
April 5, 2004
9:00 a.m.

Before:

HON. RICHARD CONWAY CASEY

District Judge

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(Trial resumed)
CAROLJN WESTHOFF, resumed. Test test test
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
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(Trial resumed
CAROLYN WESTHOFF, resumed.
THE COURT: Good morning. Please be seated. Ms. Gowan, as I recall, Friday you were cross-examining the doctor. You may continue your inquiry.
MS. GOWAN: Thank you, your Honor.
CROSS-EXAMINATION S-

BY MS. GOWAN:
Q. Dr. Westhoff, you testified on Friday that you would have to check your Palm Pilot in order to determine whether you had conversations with anyone at New York Presbyterian Hospital about medical records prior to signing your verification to the government's interrogatories on December 28, 2003. Did you check your Palm Pilot for that over the weekend?
A. I did not. I was not aware I was instructed to do so.

Q. You testified that you recently had a conversation --
THE COURT: Just a minute, Ms. Gowan. Doctor, if you need an instruction, you are instructed. I would ask that you do it, if you have it with you, on the next break. When an inquiry is made and you say that you have to check it, I presume you will do that and report back.
THE WITNESS: Yes, sir.
THE COURT: Ms. Gowan.
Q. You also testified that you recently had a conversation with Mr. Into nan at New York Presbyterian Hospital about identification of medical records that would be responsive to the government's subpoena. You also told us that you have to check your diary to determine whether and when you had that conversation. Did you check on that?
A. No, I did not.
THE COURT: You are so instructed, Doctor.
THE WITNESS: Yes, your Honor.
Q. You testified on Friday that in addition to Dr. Chasen's paper, there have been some brief descriptions written by other practitioners of the intact D&E method and the results of their cases, correct?
A. Yes.
Q. You said that these papers had been available to colleagues, right?
A. I don't recall if I said that.

Q. You said that you had been shown some material for your own reading, correct?
A. Yes.
Q. On Friday I read to you the government's discovery requests that seek all documents that support your belief that intact D&E presents a decreased risk of has RAEUGS and damage to the woman and all documents supporting your belief that intact D&E is safer than alternative abortion methods, right?
A. Yes.
Q. , you testified on Friday, when I asked you why you hadn't produced those papers, you testified that there is material that you had at some time and that you are sure at the time of the discovery ask, in fact TPOUPBL was very explicit about being careful to comply with all requests as thoroughly as possible SP-P, 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. [> that was a quote?<]
Dr. Westhoff, I am going to place before you your document production to the government in this case. It is Bates stamped CW0001 through CW0548. Would you please take a look at those documents and one by one identify them for the record.
A. Yes.
A. There is a counsel of ***[STRIKE]***.

Q. Yes. There is a copy of my deposition by video conference for the case in Michigan from May 1997. [> TPOUPBL, above, should be counsel<] and there is a transcript of my deposition in the New Jersey case, July 1998. There is additional material from another day in July 1998 of deposition in New Jersey. And there is a copy of my declaration in the Michigan case. I am looking for a date. Dated March 1997.
Did I speak correctly? That was Michigan.
And there is a declaration for New Jersey dated December 1997, and a declaration for New Jersey dated August 1998, and there is material described as a telephone deposition in Michigan case, and the date on that is -- I'm not sure of the right date on that.t looks like it was filed -- I'm sorry. I can't even read the stamp on that. The date on that is May 1997. And here are the 2002 and 2003 statistics for the special GNY services at the Allen Pavilion, and there are several pages of information we give to patients including instructions for cervical dilators, frequently asked questions after an abortion procedure, both of those in English and Spanish, consent for dilator insertion in English and Spanish, and a surgical consent form in English and Spanish.
Q. You also provided some expert disclosure in this case, isn't that right?
A. I'm sorry. I'm not sure of the term.
Q. In connection with your designation as an expert in this

case, you provided some drafts of your expert report, isn't that right?
A. I'm not sure.
Q. Dr. Westhoff, did you bring with you today the complications book that you testified about on Friday?
A. No. I don't have it.
Q. Did you speak with anybody at Columbia University about the complications book?
A. I did not speak with anyone at Columbia University or elsewhere regarding the complications book.
Q. Did you speak with anybody at New York Presbyterian Hospital about the New York application complications book?
A. I did not.
Q. S- on Friday we were discussing your New Jersey and your Michigan declarations that you had submitted challenging the state partial-birth abortion laws. We were focusing on your use of the terms "breech extraction method of intact D&E," "intact dilation and evacuation," "dilation or extraction," "intact D&E," and the "intact variation of D&E," correct?
A. Yes.
Q. All of those terms apply to the same abortion procedure, correct?
A. Those all apply to variations of the same abortion procedure.
Q. That is the procedure that you witnessed back in 1997,

correct?
A. I actually don't recall what year I witnessed it, but yes.
Q. That was the procedure that you wanted to see how it was performed and you sought out a colleague who performed it and went and observed it, correct?
A. Yes.
Q. That procedure is used later in the second trimester, right?
A. Yes.
Q. In your declaration in the New Jersey case you called this a precise technique, right?
A. KWRAOBGT using those words ***[STRIKE]***.
A. I don't recollect using those words. Do you want me to look at the New Jersey information?
Q. Sure. If you take a look at paragraph 14 of your declaration in the New Jersey case, Government Exhibit C4. Why don't you read aloud for us the second sentence of that paragraph.
A. "Although I have not performed that precise technique, I have observed it, discussed it with colleagues, and reviewed their statements attesting to their experience with it."
Q. Would you please take a look, Dr. Westhoff, at paragraph --
MS. GOWAN: Excuse me just a moment, your Honor.
Q. -- paragraph 28 of your New Jersey declaration on page 11.
A. Yes.

Q. Could you read the first sentence of your declaration for us.
A. Yes. "Intact D&E using the breech extraction technique has not been the subject of comparative clinical trials."
Q. Since signing your declaration in the New Jersey case on December 12, 1997, there have not been any comparative clinical trials involving intact D&E, have there?
A. That's correct.
Q. In the next paragraph of your New Jersey declaration you state that you are again relying on the McMahon and Haskell testimony and writings in forming your opinions, correct?
A. Yes.
Q. That is the same material that you relied on in rendering your opinion in the Michigan case, right?
A. Yes.
Q. Dr. McMahon's data was self-reported, wasn't it?
A. Yes.
Q. You never separately analyzed that data, did you?
A. That's right.
Q. In fact, at the time that you signed this declaration, you recognized that Dr. McMahon himself considered his results ininconclusive, didn't you?
A. I don't recall.
THE COURT: May I have that question and answer SW-R read back.

(Record read)
Q. Dr. Westhoff, directing your attention to your testimony on the afternoon of May 1, 1997, in the Kelley case,-
THE COURT: Which state is the Kelley case? Is that Michigan?
MS. GOWAN: Yes, your Honor.
THE COURT: Thank you.
Q. Page 99/line 24 -- excuse me -- page 99/line 15:
"Q. The only writings you are familiar with are Dr. McMa man's 1995 presentation entitled 'intact D&E the first decade' and Dr. Haskell's 1992 presentation?
"A. I think that's right, just those two doctors, sir. And I think the technique deserves formal clinical comparative evaluation. That would be the best way to evaluate its risks and benefits for the future.
"Q. So any opinion that you have that this might be the most safe procedure is preliminary only, Doctor, is that correct?
"A. Yes, I think that's fair.
"Q. Do you have Dr. McMahon's 1995 report available there, Doctor?
"A. Let me look at what I have here. Yes, sir.
"Q. Would you turn to page 19, please.
"A. Yes, sir.
"Q. Do you see the third paragraph there?
"A. Yes, sir.

"Q. Do you see the second sentence in the third paragraph, Doctor?
"A. Begins 'however"?
"Q. That's right. Could you read it for us out loud.
"A. 'however, the evidence, although inconclusive, is beginning to suggest that this may be a safer approach, especially in the last half of pregnancy'.
"Q. After 10 years and 2,000 TPHUBGTd D&E's Dr. McMahon was saying that his conclusions were preliminary, was he not?
"A. I don't know Dr. McMahon, so I have no idea about -- is this Dr. McMahon? Yes. -- about his style or personality. But I think in the hands of a single surgeon, that that is an appropriate way to evaluate his data. And as an epidemiologist in particular, I'm totally in favor of using clinical trials with external monitoring as a way of assessing things.
"Q. The question was, though, Dr. McMahon still considered his evidence inconclusive?
"A. Yes. [> TPHUBGT is conduct<]"
Does that refresh your recollection, Dr. Westhoff, that Dr. McMahon himself considered his results inconclusive?
A. Yes, it does.
Q. This was the data that Dr. McMahon submitted to Congress in connection with Congress's hearings on partial-birth abortion, isn't that right?
A. Yes.

Q. As for Dr. Haskell, the only writing of his that you are aware of is the 1992 NAF presentation, correct?
A. Yes.
Q. Neither McMahon's paper nor Haskell's paper were submitted for peer review, were they?
A. That's right.
Q. You generally prefer to rely on data that is submitted for peer review, don't you?
A. Yes.
Q. In fact, when you perform studies, you routinely produce data and submit the data for peer review prior to publication, don't you?
A. Yes.
Q. At least as of 1997 you thought that the technique deserved formal clinical comparative evaluation, didn't you, Doctor?
A. Yes.
Q. You thought that that would be the best way to evaluate its risks and benefits for the future, right?
A. Yes.
Q. And you favor the use of clinical trials with external monitoring as a way to assess medical procedures, don't you?
A. Yes.
Q. In fact, TKWROU yourself perform clinical trials in the abortion context, don't you, Doctor?
A. I'm sorry. Could you repeat that?

THE COURT: Mr. Reporter, could you repeat the question.
(Question read)
A. Yes, I do.
Q. Right now you are offering first trimester abortion services at Columbia University in connection with a randomized trial designed to evaluate medical treatment for miscarriage, right?
A. That trial completed March 31st, yes.
Q. And you have conducted many other clinical trials, haven't you?
A. Yes.
Q. But you have never conducted any clinical trials for intact D&E, right?
A. That's correct.
Q. Now, Dr. Westhoff, in your Michigan declaration you did that intact D&E may result in less blood loss and trauma for some patients and may take less operating time, thus reducing anesthesia need, right?
A. Yes.
Q. You don't say it does; you opine only that it may have these kinds of benefits, right?
A. Yes.
Q. Your New Jersey declaration express it is same opinion, right?

A. That is probably what I said. I would have to actually look at the text to be sure.
Q. Why don't you take a look. Paragraph 32 of the New Jersey declaration, Government Exhibit C4.
A. Yes.
Q. You also discuss intact D&E in a chapter of the book that you co-authored in A Clinician's Guide to Medical and Surgical Abortion, Plaintiffs' Exhibit N, correct?
A. Yes.
Q. In that chapter you wrote again, "Only the intact D&E may prove to have advantages, including less bleeding and a reduced risk of major complications such as perforation," didn't you?
A. Yes.
THE COURT: Is there a date on that chapter or the book?
MS. GOWAN: There is no date on the book. I think Dr. Westhoff testified previously this was published in 1999, did you say.
A. The book was published in '99, and the course material was written slightly earlier.
Q. In this portion of your book chapter where you are referring to intact D&E, your citation I is to the McMahon paper and data, correct?
A. Yes, I believe so.
Q. There is not citation to any other authorities, is there?

A. That's right.
Q. You also said in the book that the outcomes of intact D&E have not been formally compared to other D&E procedures, didn't you?
A. That's right.
Q. That was true when you wrote it, correct?
A. Yes.
Q. And that is true today, except for the one scud that your co-plaintiff just did, right?
A. That's right.
Q. As for women who abort for fetal and medical indications, you state in the book only that intact D&E may be beneficial when such women wish to see and hold the fetus as part of the grieving process, right?
A. That's right.
Q. You don't say anything about maternal medical indications that would necessitate intact D&E, do you?
A. I did not.
Q. And you don't say anything about it being a preferable procedure because of a maternal condition, do you?
A. I did not.
Q. The distinction you were making here was termination of a wanted pregnancy as opposed to an unwanted pregnancy, isn't that right?
A. I'm sorry?

Q. The distinction that you were making about the benefit to a woman in wishing to see or hold the fetus as part of the grieving process was based on a wanted or an unwanted pregnancy, isn't that right?
A. I hadn't thought about it in terms of those distinctions.
Q. In your TRO declaration submitted in this case you affirmatively state that removing the fetus intact reduces blood loss, trauma, and operating time, don't you?
A. Do I have that in front of me or somewhere?
Q. I think so.
THE COURT: Is there an exhibit number?
Q. I will give you another copy. Government Exhibit 37A. I think it is Plaintiffs' 115 -- Plaintiffs' 125. It was 37A at your deposition.
THE COURT: The trial exhibit is 125?
MS. GOWAN: Yes, your Honor.
Q. If you look at paragraph 25 of your declaration, Dr. Westhoff?
A. Yes.
Q. You affirmatively state that it reduces blood loss, correct, trauma, and operating time?
A. For many patients, yes, what I stated.
Q. You took out the word "may" in your TRO declaration in this case, right?
A. Yes.

Q. Your opinion isn't qualified anymore, right?
A. Right.
Q. You changed your opinion primarily based on your own experience in performing or supervising intact D&E's, isn't that right?
A. That's right.
Q. That is about 20 to 30 procedures, right, Doctor?
A. Yes, also based on the experience of my service as a whole.
Q. When you wrote the TRO declaration, you weren't relying on any data other than the McMahon data, were you?
A. I was relying on the data and the clinical experience of my group.
Q. You state in your declaration in this case that because of these safety advantages, ACOG states that intact D&E may be the best or most appropriate procedure in a particular circumstance, right? Paragraph 27.
A. Thank you. Yes.
Q. But ACOG's policy statement doesn't say anything about these claimed safety advantages, does it?
A. I I would have to refer back to the statement to refresh my memory whether they refer to that or not.
Q. I will get it for you. I am showing you what has been marked as Plaintiffs' Trial Exhibit 6, which is the ACOG statement of policy on intact dilation and extraction.
A. In the report I am referring to now in paragraph 27 I

reference the September 2000 statement. You just gave me the 1997 statement.
Q. All right. Plaintiffs' Exhibit 5, the 2002 statement.
A. Thank you.
A. This statement does not specify -- this ACOG statement does not specify safety advantages in the text.
Q. It doesn't say anything about the safety advantages that you mentioned in your declaration, does it?
A. That's right.
Q. And you don't know why ACOG says that intact D&E may be the best or most appropriate procedure in a particular circumstance, do you, Doctor?
A. That's right, I don't.
Q. What you wrote in your TRO declaration is your explanation of what you think would have led ACOG to make the statement, isn't that right?
A. Yes, that's right.
Q. You have never inTKPEPBLT undertaken any studies to quantify whether there is a risk of injury to the use of sharp instruments inside the uterus in a D&E, right?
A. I'm sorry. Can you repeat that.
THE COURT: Mr. reporter.
(Question read)
A. I have not personally carried out a study of that. [> independently<]

Q. And you have never taken any steps to quantify whether fewer passes with instruments have any effect at all on the safety of D&E by dismemberment, right?
A. Based on my clinical experience, there is reduced risk with fewer passes. Clinical SPWERPBS is in itself evidence, clinical evidence.
Q. Your main work as an epidemiologist is --
THE COURT: Excuse me. Could we have the question read again. I don't think it was answered.
(Record read)
THE COURT: I don't think your answer is responsive to the question, Doctor. Have you ever quantified? What is your answer, Doctor?
THE WITNESS: I'm just trying to think about phrasing it correctly, your Honor. In asking my --
THE COURT: Do you want the question read back, Doctor? It doesn't seem very complicated to me. Do you want I it read again?
THE WITNESS: No, thank you. In discussion with my colleague reviewing cases over the last several years, I asked everybody to help remember complications, and everybody reported zero complications of perforation or laceration in patients who had a D&E that was more or less intact. So zero ace type of quantification.
Q. That is about 60 procedures at Columbia, isn't that right?

A. That is probably correct. That is possibly correct.
Q. Your main work as an epidemiologist is conducting research, right?
A. Yes.
Q. I know you have testified you have performed randomized trials. You have also performed cohort studies and case controlled studies in your work, right?
A. Yes.
Q. In the field of epidemiology, intuition is not accepted as a valid method of proof or analysis, is it?
A. Intuition is not a method of analysis, I agree.
Q. You testified on Friday about Dr. Chasen's study. That was an observational study, right?
A. Yes.
Q. In an observational study, patients aren't assigned to treatment at random, are they?
A. That's correct.
Q. Each participant gets a procedure based on the physician's judgment, right?
A. Yes.
Q. In these circumstances you think it is reasonable to interpret the data conservatively, don't you?
A. Yes.
Q. As you understand the study, it shows that patients with intact D&E had no worse outcomes than patients with D&E by

dismemberment, right?
A. That's right.
Q. Dr. Chasen didn't have an equal number of participants in each group, did he?
A. That's right.
Q. He had 263 in his D&E by dismemberment group and 120 in his intact group, right?
A. That's right.
Q. Would you agree that in conducting a study where the goal is to assess the probability of accepting or rejecting a hypothesis, that there is a role for sampling error that you would preclude a meaningful analysis?
A. Yes.
Q. The larger the study is, the more power it has to evaluate the hypothesis using statistical tools, right?
A. Yes.
Q. If you have a study comparing two groups in an exact one-to-one match, you would have maximum amount of power for making a statistical comparison between the two groups, right?
A. Yes.
Q. If you had a study with 20 people in one group and one person in the other group, that study would have less power than a study with 10 people in each group for purposes of making a comparison, correct?
A. Yes.

Q. Such a study would be considered underpowered, right?
A. Can you repeat back the last bit?
Q. A study with 20 in one group and one person in the other group would be considered upped powered, right?
A. Yes.
Q. \if you were\if your Honor please doing a study relating to abortion and within your two groups you had different fetal gestational age, you might want to stratify the two groups by gestational age to see whether there are power consequences present bid the difference in gestational age, right? [> if you were doing<]
A. I don't-
THE COURT: Is there some reason why -- go ahead.
A. I don't understand the question.
THE COURT: Go ahead, Ms. Gowan.
Q. If you are doing a study in the abortion context and within your two groups, your two sample groups you had different fetal gestational ages, you might want to stratify those two groups according to fetal gestational age in order to determine whether there are power consequences presented by the differences in gestational age, wouldn't you?
MR. HUT: Objection: Vague and ambiguous, your Honor.
THE COURT: What is the objection?
MR. HUT: It is vague, it is ambiguous.
THE COURT: Overruled.

A. Stratification is certainly a useful analytic technique, but it is not used to E lus date anything about study power. So I would not extras TPAOEU for the purpose of evaluating power consequences [> would not stratify<]
Q. Directing your attention to page 31/line 16 of your deposition in this case:
"Q. What about \if you were\if your Honor please doing a study of abortion and in your group you had two populations and one had a different gestational age group than the other, what effect, if any, would that have on the value, the power of your study? Do you understand the question?
"A. Yes, and that's not a power issue.
"Q. Why isn't that a power issue?
"A. Based on what you just told me, that's not a power issue. That may be an issue where one would like to stratify the groups and then look at whether there are power consequences.
"Q. Why wouldn't it be a power issue?
"A. You would have to look at the exact numbers involved to see if there is a power issue.
"Q. So it may be?
"A. It may be, but not necessarily a power issue."
Were you asked those questions and did you give those answers at your deposition in this case?
A. Yes, that's correct.
Q. You testified on Friday that you are service performs about

250 -- performed about 250 D&E's in 2003, right?
A. Yes.
Q. It is about that same number for 2002, right?
A. I believe so.
Q. Is it about that same number for 2001, when you first set up your service?
A. I don't know.
Q. Do you have any idea how many D&E's were performed in 2001, when you first set up your service?
A. I am not sure. I think it was probably somewhat less than in 2002 and 2003.
Q. That 250 number is an approximation, not exact, isn't that right?
A. That's correct.
Q. Do you think it would be fair to say that overall in the three years your service has been existence that you have performed approximately 750 D&E's?
A. That is reasonable.
Q. That number is for all of the D&E's that you have performed, not just D&E's at 19 weeks or greater, correct?
A. That's right.
Q. In connection with performing your quality assurance, you calculate complex rates against your annual census number, right?
A. Yes.

Q. Your census number would be that 250 annual number, correct?
A. That's right.
Q. So your census number for the 3-year period, would it be fair to say, is around 750?
A. Right.
Q. For purposes of conducting your quality assurance, you you would expect to see complications possibly to occur at a rate of 1 or 2 or 3 percent, correct?
A. That's right.
Q. That is an acceptable range, isn't that right?
A. That's right.
Q. In calculating your complication rate, you look at the number of problems that you have and you relate them to your total number of cases to see if the percentage of cases with problems falls within the acceptable range, correct?
A. That's right.
Q. As a general matter, since its inception, your service has had a complication rate that fell within the accepted percentage, right?
A. That's right.
Q. You testified on Friday that you are aware of only one cervical laceration with D&E on your service in those tree three years, correct?
A. That's right.

Q. You testified that the laceration occurred in a case where there was a D&E by dismemberment, correct?
A. That's right.
Q. What was the gestational age in that case?
A. I don't recall.
Q. Would the complications book tell us that?
A. It very well may, but I am not sure.
Q. Would the medical record for the patient tell us that?
A. Yes.
Q. Let's take the most conservative approach, Dr. Westhoff. Let's assume that it was in the 19 to 20 weeks gestational age. It is fair to say that about 50 abortions are performed each year on your service on fetuses that are 19 weeks or greater, correct?
A. Yes.
Q. Of that 50, I understand that about 20 are by the intact D&E method, is that fair?
A. That might be correct, yes.
Q. So if we take three years times 50, fetuses aborted at 19 weeks or greater, we get 150 abortions at 19 weeks or greater, correct?
A. Yes.
Q. If we subtract from that number the 60 intact D&E's, we get 90 performed by D&E with dismemberment at 19 weeks or greater, correct?

A. Yes.
Q. 1 over 90, your problem, your complication, over your census will give us a complication rate of 1.11 percent, right?
A. Right.
Q. That is the worst-case scenario, the most conservative analysis possible, right?
A. Yes, that's --
Q. That is well within the accepted rate of complications at your university that you testified about, correct?
A. Yes.
Q. If we assume that the laceration occurred in a case with a gestational age at less than 19 weeks, the rate of complication would be even lower, wouldn't it?
A. That's right.
Q. Far lower, right?
A. That's right.
Q. In fact, it would be close to .14 percent, or 1 over 690 procedures, right?
A. About, that's right.
Q. You also testified on Friday that you are aware of 3 uterine perforations occurring on your service within the past 3 years with dismemberment by D&E, correct?
A. That's right.
Q. What was the gestational age in each of those cases?
A. I don't know.

Q. Would the complications book tell us?
A. It is very well possible that it would.
Q. Would the medical records for the 3 patients tell us?
A. Definitely should.
Q. Again, let's take the most conservative approach with those numbers. If we take 3 over our 90 D&E's performed by dismemberment at 19 weeks or greater, that would give us a complication rate of 3.3 percent, correct?
A. Yes.
Q. That is at the high end of your acceptable rate of complication, correct?
A. That's right.
Q. Once again, that is the most conservative analysis, isn't it, Doctor?
A. Yes.
Q. It would be a rate of complication that would be lower if it was applied to the total number of Dell procedures minus the 60 intact, correct?
A. That's right.
Q. We would come up with about a .4 percent if we ran those numbers, wouldn't we?
A. Sounds about right.
Q. Again, well within the accepted range at your university, isn't that right?
A. That's right.

Q. You testified that in your opinion D&E is preferable to induction abortion in several kinds of cases, correct?
A. Yes.
Q. You testified, for example, that for all of your patients with medical conditions, you try to make a decision in their best interest in conjunction with the specialist who is taking care of their primary problem for purposes of determining the appropriate method of abortion, cent?
A. That's right.
Q. You testified, for example, for patients with pulmonary disorders, you prefer to do a D&E because some of the drugs that are used for induction have a risk of causing a bronchospasm, right?
A. For instance, yes.
Q. And you told Judge Casey that for your patients with bleeding disorders who have abnormalities of their clotting factors, you prefer to perform D&E's so you can replace any missing clotting factors during the surgery and that that also minimizes the risk of memorandum RAPBLG in comparison to a more prolonged induction abortion, correct? [> cent should be correct<]
A. Yes.
Q. Dr. Westhoff, your GYN service at the Allen Pavilion doesn't offer induction abortion services, does it?
A. As I said, patients are referred to us for surgical

abortion.
Q. You don't offer induction abortion services on your service, do you?
A. No. Our MFM colleagues offer induction service and we cooperate.
Q. KWROUFR induction services is limited to out-patient D&E, isn't it?
A. Yes. [> your abortion service<]
Q. You don't have any in-patient component to your service at all, do you?
A. We have admitting privileges and we definitely take care of patients who may be in-patients in the hospital for medical reasons, and we can provide D&E services to patients who are in-patients.
Q. You don't provide any induction abortion in connection with your private practice either, do you, Doctor?
A. I do not.
Q. In the past you did provide second trimester medical abortion services, didn't you?
A. Yes, I did.
Q. In fact, as of 1997, 400 out of the 500 second trimester abortions that you performed were by medical induction, right?
A. That's right.
Q. You are the one who set up the GNY services at the Allen Pavilion, correct?

A. Yes.
Q. That was in January 2001, right?
A. Yes.
Q. You are responsible for running it, aren't you?
A. Yes.
Q. You are the director?
A. Yes.
Q. In addition to providing patient care and being in charge of quality assurance, you have managerial and administrative responsibilities on the service, right?
A. Yes.
Q. Your patient population at the GYN service is predominantly a Medicaid population, isn't that right?
A. Yes, that's correct.
Q. The abortion services that you perform on the GNY service are billed to the New York State Medicaid program under your provider name, correct?
A. Yes, and also the provider names of the other providers who work on the service, depending on who is involved in patient care for a particular patient.
Q. Those services are billed under code 59841, correct?
A. Yes.
Q. That is the code that is on your statistics sheet, isn't that right?
A. Yes.

Q. The New York State Medicaid program reimburses providers for D&E abortion using that same code, isn't that right?
A. I believe so.
Q. The amount that New York State pays for D&E abortion is more than the amount that New York State pays for labor induction abortion, including hospital admission, correct, Dr. Westhoff?
A. I don't know.
Q. Dr. Westhoff, have you ever seen the New York State Medicaid fee schedule?
A. I have certainly seen parts of the fee schedule. I have not read the entire fee schedule.
MS. GOWAN: May I approach, your Honor?
THE COURT: You certainly may.
Q. Dr. Westhoff, I am showing you the New York State MMIS provider medicated manual.
THE COURT: Does it have an exhibit number?
Q. Marked for identification as Government Exhibit Z9. I am directing your attention to the fee schedule for abortion. Do you see that, Doctor?
A. Yes, sir -- yes, ma'am. Sorry.
Q. Have you ever seen --
MR. HUT: Your Honor, just a moment. I object to the use of this exhibit. I am not sure what it is being offered for. It is not on the exhibit list. It is not being used to

refresh the witness's recollection.
THE COURT: Cross-examination.
MR. HUT: The government is purporting to have her read from it or use it to no apparent proper purpose.
THE COURT: I think it is apparent. Overruled.
Q. Dr. Westhoff, have you seen this portion of the fee schedule before?
A. I may have done so. KWRAOBGT, but I certainly might have [> I don't recollect<]
THE COURT: Let me get this straight. You are the head of the service, you primarily deal with these type of patients, and you have never looked at this?
THE WITNESS: I said I may have, your Honor, looked at this page of this 1997 revision of the fee schedule, but I don't recall looking at this document.
THE COURT: Go ahead. Next question.
Q. Do you see the procedure code 59841 listed on this fee schedule?
A. Yes, I do.
Q. What is the reimbursement amount?
MR. HUT: Just a moment. Objection, your Honor: Hearsay.
THE COURT: Overruled.
A. The 59841 reimbursement is $350.
Q. Do you see the CPT code for labor induction abortion with

prostaglandins with or without cervical dilation, for example, laminaria, including hospital admission?
A. Yes, 59855.
Q. Is the reimbursement rate for that service less than the reimbursement rate for abortion by D&E?
A. Yes.
MR. HUT: Objection: Hearsay.
THE COURT: Overruled.
A. Yes, it is.
THE COURT: Is this the same schedule that is in effect now, Doctor?
THE WITNESS: Your Honor, I don't know if this is the most current schedule.
THE COURT: These are your patients. This is how you get paid. You don't know? And you are the head of the service? Is that what you are telling me?
THE WITNESS: I don't know the most recent fee schedule, your Honor.
THE COURT: This schedule determines how you get paid, your service?
THE WITNESS: That's right.
THE COURT: And you don't know? Is that what you are telling me?
THE WITNESS: That's right. This may very well -- I have seen similar numbers in the past, but I'm not aware of the

current fee schedule.
Q. Doctor, based on the numbers that you have seen in the past, is it your understanding that D&E abortion is reimbursed by the State of New York at approximately $350 per procedure?
A. Yes, that is the right neighborhood.
Q. Based on your review of fee schedules in the past, is it your understanding that labor induction abortion by the PROS prostaglandin method is reimbursed at approximately $230?
A. Based on this schedule, yes, $230.
Q. And based on schedules that you have seen in the past, is that right?
A. I don't recall the induction amounts for schedules I have seen in the past.
(Continued on next page) 4/5/04 Judge Casey take 2 continuing cross of Dr. Westwho have
BY MS. GOWAN:
Q. Have you seen schedules in the past for induction abortion with intraamniotic injection using amniocentesis including hospital admission and visits? I see it here in front of me right now. I don't recall what I have looked at exactly in the past.
Q. But is it fair to say that you understand from your experience in the past that that is also reimPWURGSed at a lower rate than D&E?
A. I cording to the numbers that are listed in the schedule you gave me, the two induction abortions do have slightly lower

fee schedules than a D&E abortion.
THE COURT: Did you know that in '.
7? Or were you even there in '97?
A. I don't know if I knew it in '97, your Honor. I think I might not have known it in 1997.
THE COURT: Have you nonit since you headed up this service?
THE WITNESS: -*R I --
THE COURT: Doctor it is a simple question, you are the head of the service TKOFPLT you know it or not?
THE WITNESS: Not with any precision, your Honor.
THE COURT: Didn't ask you that.
THE WITNESS: No.
THE COURT: Next question.
MS. GOWAN: Dr. Westhoff, I would like to focus briefly on D&E by dismemberment. Would you agree that in performing D&E by dismemberment that the key in terms of cervical dilation is to dilate enough so that you can pass your instruments in and out of the woman's cervix?
A. That's certainly the minimal necessary dilation, yes.
Q. Would you agree that that's really the key?
A. One must also be able to open the instrument so it's not a matter of simply being able to pass them. And I would not describe that as the key.
Q. Directing your attention to page 173, line 9 of your

deposition in this case:
"Q how do you know what diameter to dilate to for a D&E by dismemberment or disarticulation at 18 weeks?
"A I need enough cervical dilation that I can pass my instruments in and out of the cervix. That's really the key. And in particular when I am removing the instruments through the cervix, since the instruments are going to be grasping some tissue there's got to be enough room for me to remove instruments that are grasping tissue. I think safety of all D&Es is enhanced by adequate cervical dilation. The less dilation there is the more difficult the case an the more passes we need with instruments. So how much dilation I want the answer to that often is more. It's not a certain number of centimeters. The other issue is the focus always seems to be on dilation but another issue is how long is the cervix. I cannot control or modify how long the cervix is."
Were you asked that question and did you give that answer at your deposition in this case?
A. Yes.
Q. Now, in the day that the woman comes in for placement of the laminaria, you measure the size of the fetus to help you decide the amount of cervical preparation that's necessary, right?
A. Yes.
Q. You do a son gram?

A. Yes.
Q. You take the bipa ryeetal diameter, the widest part of the fetal head and the femur length measurements, correct?
A. Yes.
Q. You put those measurements in the woman's medical chart, right?
A. Yes.
Q. And when you do the cervical preparation, you don't attempt to dilate to the widest part of the head, did you?
A. That's right.
Q. If you did that, and you had a head presenting fetus, the fetus would deliver, right?
A. Probably not because the laminaria would be in fact occupying the cervix.
THE COURT: Could I have that answer.
(record read).
Q. Dr. Westhoff, directing your attention to page 177, line 6?
A. Of which document?
Q. I'm going to read it to you, Doctor, page 177, line 6 of your deposition in this case:
"Q when you are doing the cervical preparation for the D&E by dismemberment at 18 weeks, do you make a conscious effort? I don't mean to put more than what they sound, but do you do anything to ensure that the dilation is not greater than the measurement you've taken of the widest part of the head?

"A we don't attempt to dilate to the widest part of the head. To my knowledge in essentially all D&Es the head will either be collapsed or crushed during the procedure.
"Q why don't you make an attempt to dilate to the widest part of the head?
"A that would require a great deal more time and effort to fully dilate the cervix. At this stage in pregnancy the cervix is not so soft and it does not necessarily respond to attempts to dilate so well.
"Q How much more time would it take to dilate to the widest part of the head?
"A well, I am not ever attempted to do that with laminaria or mechanical dilateors.
Basically the way that's down done is an induction because a vertex presentation, a head presentation presenting induction will deliver once the cervix has TKHRAEULTed to the largest diameter of the head
So the additional time and additional uterine effort required is exactly what is needed to get the cervix to that point and that is, in general, substantially more time and more uterine force than occurs with the assertion of laminaria."
Were you asked those questions and did you give those answers in your deposition in this case?
A. Yes, that sounds correct, although right now I have so many different exhibits in front of me I haven't been able, wasn't

able to put my hands on that one while you were reading but that sounded correct.
Q. Now you testified --
A. Without my actually referring to it in front of me.
Q. Now you testified on on Friday that too much dilation was never a concern for you, correct?
A. Yes. I may have said that. I don't recall exactly.
Q. And you mentioned that the fact that a woman TKHRAEUTS to 10 cent meters at term, right?
A. Yes.
Q. But that dilation occurs as a result of maternal hormones, correct?
A. Or as a result of induction.
Q. Even if the woman is given PE toesin to assist her in a delivery at term there is also going to be cervical dilation as a result of maternal hormones as the woman is getting ready to deliver her baby, right?
A. Yes.
Q. And that's a natural physiological response with the woman's body to the pregnancy, right?
A. Yes.
Q. An osmotic dilator, like laminaria, is an artificial dilator, correct?
A. Yes.
Q. And as I understand it, you've testified on Friday that you

have never seen a woman respond to an osmotic dilator with the dilation of 10 cent meters or the same was a woman at term, correct?
A. That's right.
Q. That's going to depend upon the amount of laminaria that you insert in the woman's cervix, isn't that is right?
A. The amount of dilation that we observe after use of laminaria depends both on the number of laminaria as you suggest and also on the individual woman's response to those laminaria.
Q. Aren't efficiently cervical dilation can lead to tearing of the cervix, can't it?
A. I have seen cervical tearing in response to medical dilation using mechanical dilateors.
Q. And do you use mechanical dilators, Dr. Westhoff?
A. Yes, sometimes.
Q. And are you aware that in performing D&E, mechanical dilators are sometimes used by others in the medical profession?
A. Yes.
Q. And the tearing of the cervix can lead to scarring, can't it?
A. Yes.
Q. And the scarring can lead to distoesa as in subsequent pregnancies, can't it? <!0>

A. It may.
Q. And there is evidence that scarring can lead to -- excuse me, that artificial cervical dilation can lead to an increase in cervical diameter, isn't there?
A. I'm sorry, can you repeat that.
THE COURT: Reporter?.
(record read).
THE WITNESS: Please say that one more time.
MS. GOWAN: Sure, sure. STKPWHRAO there is evidence that artificial cervical dilation can lead to an increase in cervical diameter, isn't there?
A. I'm not at all sure what evidence you might be referring to.
Q. Well, isn't there evidence that increases in cervical diameter can lead to problems for women in subsequent pregnancies?
A. There may just be a difference in terminology but I'm really not -- I don't understand what you are referring to.
Q. The use of mechanical dilators can lead to possible complications for women in later pregnancies, isn't that right?
A. I don't believe that that is known.
Q. I would like to turn now to the intact D&E procedure as you perform it at 20 weeks' gestational age.
As I understand it, you use the two-day cervical preparation for those patients, correct?

A. Yes; in general that's true.
Q. And in addition sometime on the second day you might, a couple of hours pre-operatively give a patient some misoprostol to additionally soften the cervix, right?
A. We sometimes do that.
Q. You don't ever do a three-day cervical preparation do you, doctor?
A. I have not.
Q. But you are aware that some physicians do, isn't that right?
A. Yes, I have heard that it is done.
Q. And you agree that the minimum size that the cervix must be dilateed to is relative to the duration of the pregnancy and the technique that's being used, right?
A. I agree that for D&E the dilation needs to be greater as the pregnancy progresses.
Q. Do you agree that it's also relative to the technique that's being used?
A. I don't know what you mean by that.
Q. Directing your attention to page 52, line 20 of your deposition in Planned Parenthood versus SRA* near yo on July 10th, 1998.
A. Hang on a second.
Q. Doctor, you don't have it there, I'm going to read it to you:

"Q is there a minimum size that the cervix has to be dilated for an abortion procedure?
"A it's not an absolute size. It's relative to the duration of the pregnancy and the type of the -- of technique that's being used."
Were you asked that question and did you give that answer at your deposition in the SRER TPHAEUR yo case?
A. Yes.
Q. Now is that uterine cramping or pain with the use of laminaria?
A. Yes, many patients have some KRAFRPZ.
Q. That's very common, isn't it?
A. Many patients have some KRAFRPZ.
Q. And women typically will use an analgesic to relieve that pain, right?
A. Yes.
Q. And is there vaginal bleeding with the use of laminaria?
A. Yes, there sometimes is.
Q. That's common too, isn't it?
A. Yes, it -- it occurs.
Q. Pardon me?
A. It definitely occurs.
Q. And it's not uncommon for women who receive laminaria to have ruptured membranes, is it?
A. In our KPER generals ruptured membranes do occur but it's

rare.
Q. And a woman may not be able to walk around or go to work during the cervical preparation period, right?
A. That's possible. But most of my patients do walk around and go to work while they use laminaria. It play be similar to the discomfort of their menstrual period.
Q. You would agree that some of them are not able to go to work or walk around, right, Doctor?
A. I agree that some cannot.
Q. Would you agree that it's primarily a convenience factor for the woman, not a health factor, to receive laminaria on an outpatient basis as opposed to being in the hospital having contractions from medication given in labor induction abortion?
A. Can you repeat that?
THE COURT: RORTDer would you repeat it.
(record read).
THE WITNESS: I think I would have to speculate as to how my patients interpret that. I think from a health point of view they are both acceptable.
Q. Directing your attention to page 107 ever 106, line 21 of your testimony before the honorable Gerald E. Rosen on March 1, 1997 in Evans v. Kelly.
A. If you could tell me the document before you tell me the page number I will find things more KWAOEUBGly.
Q. I will read it to you, Doctor. I'm talking about women who

have received the laminaria:
"Q so they may not be walking around going to work or whatever during that period of time, correct?
"A she might not be walking around going to work. It's entirely possible she won't be. I still think being out on her own is different than being admitted to a hospital having, you know, contractions from medication.
"
THE COURT: Is that a health factor or a convenience factor, Doctor?
"A I would consider that actually primarily a convenience factor and I can TEPL you hands down what choice I would make between those two circumstances but that is I would acknowledge that as primarily a convenience issue, but I don't think it's relevant to time the procedures necessarily in those ways.
I do think it is not comparable to count the hours of time spent in bed in a hospital versus time at home with laminaria, the quality of the time there is a little different."
Were you asked those questions and did you give those answers to Judge Rosen in Evans v. Kelly?
A. Yes.
Q. Now after you have done your two-day cervical preparation and you are in the operating room your patients will receive

general anesthesia, correct?
A. Yes.
Q. And you remove the laminaria and perform a digital assessment of the cervical dilation, right?
A. Yes.
Q. And as you testified before, sometimes you might use a mechanical dilator and enlarge the cervix there in the OR, is that right?
A. Yes.
Q. And there is risks to the use of mechanical dilators, right?
A. Yes.
Q. Physician could make a hole in the cervix and the uterus instead of opening it, right?
A. That's possible.
Q. Then assuming that you have sufficient dilation you will take two of your fingers, reach into the woman and attempt to grasp a fetal part and bring it down into the cervix, right?
A. Yes.
Q. And you like to grab the fetus' foot if you can, right?
A. Yes.
Q. And if you can you bring down the fetus' foot and then you break the amniotic sac with your forceps, right?
A. Yes.
Q. Then, because the fetus is wet you take a piece of gauze to

help improve your grasp and you bring one foot down and if possible sweep the second foot through the cervix, right?
A. Yes.
Q. Then with gentle traction on both of the feet you pull the fetus through the cervix, right?
A. Yes.
Q. And the fetus gradually emerges through the cervical canal, right?
A. Yes.
Q. And you keep extracting it with your hands until the fetus is lodged in the cervix and won't move further, right?
A. That is one possible scenario, yes.
Q. And that point might be at the thorax, right?
A. Yes.
Q. That's because, in your experience, the fetus' shoulder girdle will not pass through the cervix without additional maneuvering, right?
A. That is sometimes true.
Q. And when that happens you will orient the feet souse that its fact is facing up toward you, right?
A. Yes.
Q. And then you will P-S a finger up the back through the cervix and then to the side and back of the cervix, right?
A. I'm sorry, say that again?
Q. Well, you pass a finger up through the cervix to find the

fetus' arms, right?
A. Yes.
Q. And generally they're extending into the uterus at that point, aren't they?
A. Yes.
Q. And so you will move your finger along the shoulder to sweep the arm across the fetus' chest, right?
A. I may do that, yes.
Q. And by doing that you sweep the arm down and around and the arm comes through the cervix, right?
A. Yes.
Q. And then you repeat that maneuver on the opposite side of the fetus' body to sweep down the other arm, right?
A. Yes.
Q. And at that point the fetus' body is below the cervix and the next is in the cervix with the head still in the uterus, right?
A. Yes.
Q. And it's at that point that you take a scissors and insert it into the woman and place an incision in the base of the fetus' skull, right?
A. Yes.
Q. Now the contents of the fetus' skull, just like the contents of my skull and your skull is liquid, right?
A. That's right.

Q. And sometimes after you've made the incision the fetus' brain will drain out on its own, right?
A. That's right.
Q. Other times you must insert a suction tube to drain the skull, right?
A. That's right.
Q. And then the skull will collapse immediately after its liquid contents have been removed and the head will pass easily through the dilated cervix, right?
A. That's right.
Q. Have you ever performed a vaginal delivery of a live infant at term?
A. Yes.
Q. Do you cut the umbilical cord when you do?
A. Yes.
Q. Can you complete the delivery of the infant without cutting the cord?
A. In many cases, yes. In most cases, yes.
Q. In those circumstances in which you intervene to assist a woman experiencing miscarriage, do you cut the cord as well?
A. It depends on the stage of gestation, but yes.
Q. When you wrote your Michigan and New Jersey declarations you didn't include any discussion maternal health complications, did you?
Would you like me to ask it again, Doctor?

When you wrote your Michigan and New Jersey declarations you didn't include discussion about maternal health complications in those declarations, did you?
A. I don't recall whether I discussed maternal health in those declarations from 1997 and 1998.
Q. Well do you want to take a look? Are you looking at Government Exhibit C 3 and C 4, Doctor?
A. No, I'm looking at an unlabel declaration.
Now I need the question repeated now that I have reviewed those two. STKPWHRU didn't include discussions about maternal health complications in your New Jersey and your Michigan declarations, did you?
A. Briefly, in the Michigan declaration Exhibit C-3, paragraph 24, I described some maternal health conditions when induction might be contraindicated.
And similarly, in New Jersey Government Exhibit C-4 in paragraph 25 I also discussed maternal health conditions that are KOFRPB TRA indications to induction.
Q. That was in the context of being a contraindication for induction, is that right?
A. Yes, it was.
Q. Not in the context of complication that would necessitate an abortion, correct?
A. That's right.
Q. Now, are you familiar with the subspecialty, maternal fetal

medicine?
A. Yes.
Q. You don't have any expertise in maternal fetal medicine, do you?
A. I'm not a sub specialist in that area, no.
Q. Now, in paragraph 10 of your declaration in this case you identify a number of maternal medical conditions and you state that you have provided abortions for women with these medical conditions, correct?
A. I'm still looking for my declaration. I'm sure I've got it.
Q. I've got an extra TKOPy here.
Paragraph 10.
A. Okay, I'm looking at paragraph 10, yes.
Q. You identify a host of medical conditions and state that you have provided abortion for women with these medical conditions, correct?
A. Yes.
Q. For example, one of the conditions you reference is proliferative retinopathy, right?
A. Yes.
Q. That's a very rare condition, isn't is it?
A. Yes, it is.
Q. And had you a patient, one patient with that condition who was referred to you for an abortion, right?

A. That's right.
Q. But you don't know what the fetus' gestational age was, do you?
A. I don't recall.
Q. And you don't know what method of abortion you performed in that case, do you?
A. I don't recall.
Q. You don't know when that abortion took place, do you?
A. That's right.
Q. And aside from the fact of that condition, proliferative retinopathy, you can't tell Judge Casey anything about that patient, can you?
A. That's right.
Q. Would the patient's medical record help us get the answers to those questions, Doctor?
A. Yes.
As I told you during the deposition, that patient was certainly several years ago.
Q. You also, in paragraph 10, mention with per I partium cardio my opathy. That's a rare condition as well, isn't it?
A. Yes, it is.
Q. And you had one patient with that condition once, correct?
A. I have had at least one patient with that condition, yes.
Q. And you don't remember when that was either, do you?
A. No, I don't.

Q. You don't remember the gestational age of the fetus, right?
A. I don't.
Q. You don't remember the method of abortion, right?
A. I don't.
Q. Would the patient's medical chart answer those questions?
A. Yes.
Q. In paragraph 10 of your declaration in this case you also referred to providing abortions for women with H-RT disease, kidney disease, hypertension and pre he clam seea, right?
A. Yes.
Q. But you can't remember anything at all about the circumstances of these abortions other than you are confident that your service has provided second trimester abortions for women with these conditions, correct?
A. That's correct.
Q. We are only talking about 150 abortions, isn't that right, Doctor?
A. I'm sorry, where did that number come from?
Q. That's the number of abortions performed by your service at 19 or 20 weeks' gestational age, right?
A. That may be correct but paragraph 10 in my declaration is not referring only to abortions at 19 or 20 weeks.
Q. Well that's right; but you don't have a recollection about when these procedures were performed or anything about them, you are confident that such procedures were performed on women

with these maternal conditions and you think that those abortions were most likely performed by the intact D&E method, or at least some of those abortions were most likely performed by the intact D&E method, right?
A. Some of the -- paragraph 10 in my declaration refers to the total population of patients that we take care of and their medical conditions. I am confident that some of the women with those medical conditions were past 19 or 20 weeks and that some of them may have had a D&E with the intact D&E variation.
Q. Well, we are' only talking then about a maximum of 60 patients who have had intact D&E on your service, isn't that right?
A. That number may be about right.
Q. But yet you can't remember anything about the circumstances under which you provided abortions for women with heart disease, kidney disease, hypertension and pre eclamp seea, right?
A. What do you want me to remember about them?
Q. You can't remember anything about them, can you?
A. I don't have any information to offer about them, no.
Q. You can't be sure, without reference to the individual medical records, right, Doctor?
A. That's right.
Q. Dr. Westhoff, a version of your TRO declaration in this case is in the Congressional record, isn't it?

A. No.
Q. Doctor, isn't it true that a version of your declaration in this case appears in the legislative history for the Partial-Birth Abortion Act hearings on March 25, 2003, as the testimony of Ann R. Davis, M.D.?
A. Dr. Davis did testify in Congress and her testimony that you showed me does include some, a few sentences that are taken from my declaration, or that may be taken from my declaration. Are similar to my declaration.
Q. Well paragraph 10 that we have just been discussing of your declaration concerning maternal medical conditions appears, in significant part, in the record as Dr. Davis' testimony, isn't that right?
A. You showed it to me previously but I can't recollect sitting here without looking at it again.
Q. I'm showing you an expert from hearing PWRTD subcommittee of the constitution on the committee SKWRAOD issue rehouse of representatives 108th Congress first session on HR-760 March 25th, 2003.
If you take a look at page 191 it is the prepared statement of Ann R. Davis. If you take a look at page 192, third paragraph up from the bottom, would you read that, Doctor, to yourself?
A. Yes.
Q. Would you agree, would you not, that that portion of

Dr. Davis' testimony is very similar to paragraph 10 of the declaration that you submitted in this case as it relates to maternal medical conditions?
A. Yes.
Q. Dr. Davis is one of your colleagues at Columbia, isn't that right?
A. That's correct.
Q. And you don't have any explanation for how it is that a draft of your declaration appears in the legislative history of the act, do you?
MR. HUT: I object to the characterization. There has been no foundation that it is a draft of her declaration, your Honor.
THE COURT: Go ahead, Ms. Gowan, compare it them. Mr. Hut wants to challenge it.
MS. GOWAN: I will compare it, also I would like to ask this foundational question.
Q. Isn't it true, Dr. Westhoff, that in your expert disclosure in this case you submitted to the government a draft declaration with some lines drawn through it and that the words in that declaration were almost verbatim to what it was that was in Dr. Davis' testimony in Congress?
A. The declaration that I submited in this case went through several drafts that I worked on starting, I think late in 2002 already and Dr. Davis was working on her testimony around the

same time I was working on this declaration.
Q. Well, aside from the fact that you and Dr. Davis work in the same office and that it's possible that Dr. Davis might have looked at your declaration, you can't explain at all how it is that a draft of your declaration, in significant part, particularly as it relates to paragraph 10, wound up in the Congressional record, can you?
A. Yes.
MR. HUT: Objection, standing objection.
THE COURT: Overruled.
THE WITNESS: I have nothing to add.
THE COURT: That wasn't the question, ma'am. I don't think your answer is responsive rather to it.
THE WITNESS: Okay.
As I said, Dr. Davis and I worked together and that we were both working on these statements early in 2003. She prepared a statement that is similar in part to my declaration and that is the statement she presented to Congress and that's why her statement is in the Congressional record.
BY MS. GOWAN:
Q. Directing your attention to page 112, line 122 of your deposition in this case:
"Q do you have any idea how it is that the information that was submitted by Dr. Davis to Congress is almost identical to the information that was submitted by you

in this case?
"A well, several different things.
"first of all, this is pretty obvious information and I think there are lots of other documents pertaining to abortion that say exactly the same thing, not just my declaration or this statement. I definitely didn't specifically assist Dr. Davis in preparing for her testimony here but working in the same office over the years it's entirely possible anywhere along the lines she might have looked at my previous declaration. I really don't know who she was working with in preparation and presenting her statement here.
"Q do you know if she was working with anyone?
"A she might have been. I don't know."
Were you asked those questions and did you give those answer at your deposition in this case?
A. Yes.
Q. Now, Dr. Westhoff, you don't have any specialized knowledge on the subject of fetal pain, do you?
A. That's right.
Q. You haven't performed any research on the subject of fetal pain, have you?
A. That's right.
Q. You haven't published any articles on the subject, correct?
A. That's right.

Q. You don't have any scientific training on the subject of fetal pain, do you?
A. That's right.
Q. You're not an anesthesiologist, are you?
A. That's right.
Q. You don't have any special super STAOEZ in anesthesiology?
A. That's right.
Q. You're not an expert in anesthetic drugs, are you?
A. No, I'm not.
Q. Have been publicked any papers on anesthetic drugs, have you?
A. No.
Q. Now, you testified that anesthesia given to the mother will cross the placenta and in your view anecessary TE tease the feet us. Drugs are used at Columbia to answer TE ties the mother for D&E abortion?
A. I'm sorry.
Q. What drugs are used at, on your service to an necessary TE ties the mother for D&E abortion?
A. The exact choice of drugs is depend end *EPBT on the anesthesiologist and may vary, but among these include TPEPB TA TPHOL and propofol.
Q. And what <!0> dose of anesthesia of propofol, what dose of appropriate aTPHOL is ordinarily given to a woman who is aborting a fetus at 19 to 20 weeks on your service?

A. I'm sorry I can't tell you the dose of PROEF aTPHOL.
Q. What about for TPEPB TA TPHOL?
A. I can't tell you the dose.
MS. GOWAN: Your Honor, subject to possible production of the medical records from the New York Presbyterian Hospital and subject to the possible production of the complications both pursuant to the subpoena that the government served on New York Presbyterian Hospital yesterday afternoon, I have no further questions for this witness.
THE COURT: All right.
Mr. Hut?
REDIRECT EXAMINATION

BY MR. HUT:
Q. Dr. Westhoff, do you have in front of you the excerpt from the hearing before the committee on the SKWRAOD issue reof the HERPes that includes the testimony of Dr. Davis?
A. Yes, do I.
Q. Would you please turn to page 192, the page that Ms. Gowan referred you to during cross examination?
A. Yes.
Q. Directing your attention to the third paragraph from the bottom, which is the one that Ms. Gowan referred you to, could you please read that?
A. Read the paragraph?

Q. Yes, please.
A. Some women require abortions because their pregnancies compromise their health. In some instances the patient has a pre SAOEUFTing medical condition that is exacerbated by her pregnancy. For instance, women with certain kinds of heart disease are increased risk during pregnancy with the risk of maternal and fetal death as high as 50 percent. Women who develop per I part um cardio my open O think, a condition in which the heart muscle does not pump blood sufficient reare at sufficient risk of cardiac fail ire.
Women with conditions such as quid any and liver disease may experience SKAS base of those diseases as a result of the pregnancy.
Q. Please continue.
A. Some women who have cancer learn that they are pregnant. In these cases, although the pregnancy does not threaten the patient's life she may require treatment with chemotherapy or radiation which is inconsistent with carrying a pregnancy to term.
Q. Please read the next paragraph?
A. Even for women without preexisting medical problems dangerous conditions may develop during pregnancy. One such condition is pre emcamp pregnancy induced hypertension that can result in SKRAOEBal hemorrhage as KW-L liver dysfunction or failure, kidney failure, temporary or permanent visual

disturbances or visual loss and coma. In these situations PWRORGS may be indicated to preserve the patient's health or life.
Q. Thank you, Doctor.
Now, with respect to PROS TA glan dins that are used to induce induction abortions or labor to effectuate an induction abortion, are PROS TA glan dins artificial dilators?
A. Yes.
Q. There was some testimony elicited from you by Ms. Gowan on cross examination KERPBLG mechanical dilators, do you use mechanical dilators in most of the D&Es that you perform?
A. No, we don't.
Q. When you, do you use them ever in connection with the D&Es that you perform?
A. I use them mostly in conjunction with first trimester and occasionally I use them in the second trimester with a D&E.
Q. And with respect to the D&E second trimester, do you use a mechanical dilators any more pre KWEPBLTly when you perform the TKAO*E by dismemberment airiation than you do when you perform it by the intact variation?
A. I don't have any data about that.
Q. Please turn to the fee schedule for Medicaid reimbursement about which Ms. Gowan questioned you.
A. Yes.
Q. Help me out first to understand this. If you look at the

patient about which she was examining and go down to number 59856?
A. Yes.
THE COURT: What's the exhibit number again.
MR. HUT: It's Z-9, your Honor.
THE COURT: And page number?
MR. HUT: Page number I don't find. It's the last page of the exhibit.
THE WITNESS: I have page 7-384.
MR. HUT: Correct, thank you.
Q. Do you see the S*EP TREU for 59856?
A. Yes.
Q. Does that signify a dilation and curettage performed in connection with an induction abortion using a vaginal sup positives Tories?
A. Yes, it does.
Q. Is the performance of dilation and curettage in connection with such a procedure common or uncommon, Dr. Westhoff?
A. It's common. It can occur in up to 25 percent of inductions.
Q. And ask the price for induced abortion by one or more vaginal sup OS tores with dilation and curettage the same price as an induced abortion by dilation and evacuation?
A. Yes, it is.
Q. Dr. Westhoff, do profit considerations ever determine what

abortion procedure your patients receive or you recommend to them?
A. They do not.
THE COURT: How can she testify as to that?
MR. HUT: In her judgment.
THE COURT: You didn't say that.
MR. HUT: I said you, your Honor. Well I certainly meant to.
Q. With respect to the abortions that you perform, do profit considerations ever determine what abortion procedure your patients will receive?
A. No, never.
Q. And with respect to the abortion procedures received from doctors on your service, do profit considerations ever determine what abortion procedure patients will receive?
MS. GOWAN: Objection.
THE WITNESS: Never.
THE COURT: Sustained. Strike the answer. She can't testify to the operation of others.
BY MR. HUT:
Q. Based on your conversations with others, have you ever heard any --
THE COURT: You have to establish were there any.
BY MR. HUT:
Q. Have there been conversations that you have had with your

colleagues concerning abortion procedures provided?
A. Yes.
Q. Have you ever heard any of them allude to a profit considerations in connection with the procedures they provide?
MS. GOWAN: Objection.
THE COURT: Sustained.
Q. With respect to the abortions that you provide, Dr. Westhoff, have you ever determined what abortion procedure your patients will receive based on Medicaid reimbursement rates?
A. I'm sorry, can you repeat that?
Q. Yes, ma'am.
With respect to the abortion procedures that you provide your patients, have you ever determined what procedure a patient will receive based on the level of Medicaid reimbursement rates?
A. No, never.
Q. And with respect to your colleagues based on conversations that you have had with them and your familiarity with their practice, have you ever heard them say that reimburse the rates aTPORBGT what abortion procedures they provide?
MS. GOWAN: Objection.
THE COURT: Sustained.
Q. With respect to people at your hospital, have you ever heard anybody at your hospital indicate that the level of

reimbursement will affect the procedure that an abortion patient receives?
MS. GOWAN: Objection.
THE COURT: Overruled.
THE WITNESS: No.
Q. Do you have any evidence, Dr. Westhoff, that any abortion procedure performed in your service was done for reasons of maximizing profit?
A. No.
THE COURT: Doctor, are the doctors on your service compensated by the amount of revenue received by your service?
THE WITNESS: No, sir. Everyone receives straight salary.
Q. Dr. Westhoff, with respect to serve call laceration, is cervical laceration a concern that you have in connection with abortions you may perform even though they may be rare?
A. Yes.
Q. Why?
A. Cervical laceration leads to bleeding that requires repair. And if it is in an -- if the laceration is in an obscure location this can be surgically difficult and I wish to avoid any danger to my patients.
Q. With respect to uterine perforation, is uterine perforation a concern that you may have for your patients even though an abortion POERZ that you perform uterine perforation mate be

require?
A. Yes, it's a concern.
Q. Why?
A. Uterine perforation can be catastrophic requiring additional surgeries for the patients and damage to abdominal organs at the time of the perforation. So I wish to do everything possible to avoid such catastrophic complications for my patients.
Q. Dr. Westhoff, could you please turn to plaintiff's trial Exhibit 6, it is the 1997 ACOG policy, Doctor.
A. I'm sorry, I have a lot in front of me now. I have got number 6.
Q. You have it?
A. Yes.
Q. Would you please turn to the second page of plaintiff's trial Exhibit 6?
A. Yes.
Q. PWHRE beginning about half bay down the page do you see the sentence beginning, "an intact D&X, yes?
A. Why he.
Q. Intact D&X however could be the best or appropriate procedure in particular circumstance to save the life or preserve the health of a woman and only the doctor in consultation with the patient, based on the woman's particular circumstances, can make this decision."

Q. Please turn to plaintiff's trial Exhibit 5.
A. Yes.
Q. What is that?
A. That is ACOG's statement of policy titled abortion policy.
Q. And do you remember the year of the issuance of plaintiff's trial Exhibit Number 5?
A. This was most recently issued and reaffirmed in September 2000.
Q. Could you please turn to the third page of plaintiff's trial Exhibit 5?
A. Yes.
Q. Directing your attention to the second column, do you see there the sentence "an intact D&X, however? The second column?
A. Yes.
Q. Could you read that sentence, STPHREZ?
MS. GOWAN: Your Honor, Plaintiff's Exhibit 5 and Exhibit 6 are not in evidence. Certainly we have no objection to counsel asking the witness to read these and eliciting any response to any question that he may wish but your Honor has already ruled that these are not in evidence.
MR. HUT: But the door has been opened, your Honor, because they used both documents to refresh the witness' recollection and therefore under Rule 613 of the Federal Rules of Evidence --
THE COURT: Mr. Hut, didn't you hear Ms. Gowan? She

said she pointed it out but she wasn't objecting to your asking the question.
MR. HUT: I am seek to go have these sentences admitted into evidence, your Honor.
MS. GOWAN: Objection, hearsay.
THE COURT: If that's what you are doing, then denied.
MR. HUT: Your Honor, as I know you know, Rule 613 of the federal rule states that when pay writeing is used to refresh memory, an adverse SPAERT entitled to have you are the WRAOel produced to cross examine the witness and to PWAOUS in evidence those portions which relate to the testimony of the witness.
THE COURT: I am familiar with the rule. They may already be in in the Congressional record as well.
MS. GOWAN: Your Honor, it is also it's prior statement of the witness. The ACOG policy statement is not a statement of Dr. Westhoff's.
THE COURT: I am aware of that. The ruling stands.
MR. HUT: The Rule does not relate to prior statement of the witness, your Honor, but I will move on.
In any event, Dr. Westhoff, could you read that sentence?
MS. GOWAN: Objection, your Honor, it reading out loud.
THE COURT: Just RAOE it to your sex, Doctor then go

ahead and ask a question.
MR. HUT: Well there is no -- if your Honor will not let the witness read it out loud then I will move on.
THE COURT: You are having her testify. Just have her read it and ask a question if that's what you want.
MR. HUT: I think we will move on, your Honor, if I may.
THE COURT: All right.
BY MR. HUT:
Q. Doctor, are you aware of any time after ACOG's promulgation of the 1997 policy statement when ACOG explained the reasons behind its statement in the policy statement that an intact D&E may have safety advantages?
A. I'm not aware of acooing explaining their statement.
Q. Have you ever read the opinion in Stenberg v. Carhart, Dr. Westhoff?
THE COURT: You aren't going to try and get it in through her having read the opinion, are you?
MR. HUT: I was going to --
THE COURT: I wouldn't try.
MR. HUT: All right. Because the --
THE COURT: She is not from ACOG, she is not an attorney, as far as I know, and that isn't going to put the opinion in the, the Stenberg opinion in through her, Mr. Hut.
Next question.

MR. HUT: Your Honor, forgive me. Ms. Wigmore reminds me that I may have referred, when I was reading the rule of evidence a moment ago to Rule 613, where as I was referring to Rule 613 but I was reading you Rule 612. The Court probably knew.
THE COURT: It's quite all right, it doesn't chaining any ruling. None theless I think I am familiar with it. We will take our morning recess at this time.
(recess) TWM take 3 Westhoff on cross<]
THE COURT: Mr. Hut, you may inquire.
REDIRECT EXAMINATION

BY MR. HUT:
Q. Dr. Westhoff, with respect to your testimony on randomized trials, do you believe that doctors must wait before he employ a safe variation on an existing surgical procedure until a randomized trial has been conducted?
MS. GOWAN: I object to the form of the question.
THE COURT: What is the objection?
MS. GOWAN: Assumes a fact not in evidence. Conditional let me hear the question, please. [> before they employ<]
THE COURT: Safe variation?
MS. GOWAN: Yes, your Honor, that is the objection.
THE COURT: Sustained.

MR. HUT: I believe there is ample testimony, but I will rephrase it.
THE COURT: I don't know which one you are referring to, Mr. Hut.
Q. With respect to your testimony on randomized trials, do you believe that doctors must wait to employ a variation of an existing surgical procedure until a randomized trial has been conducted?
A. No.
Q. Doctor, Ms. Gowan asked you a number of questions concerning your declarations prepared for the New Jersey case and for the Evans v. Kelley case in Michigan and with respect to the Clinician's Guide in which you wrote in substance that the intact variation of D&E may have safety advantages. At the time you wrote those materials, were you in fact performing the intact variation of D&E?
A. No, I was not.
Q. Since then, and before you executed your declaration in support of the TRO in this case, have you begun to perform the intact variation of D&E?
A. Yes.
Q. What, if anything, led to the evolution of your opinion from the May language you used to the language that you used in your declaration?
A. My own clinical experience using this approach led to the

change in my language.
Q. Finally, Dr. Westhoff, did you on Friday afternoon overhear any part of anything that I said at sidebar with his Honor and Ms. Gowan and the court reporter?
A. No, I did not.
MR. HUT: I have no more questions of the witness, your Honor.
THE COURT: Ms. Gowan, any recross?
MS. GOWAN: Yes, very briefly, your Honor.
REDIRECT EXAMINATION

BY MS. GOWAN:
Q. Dr. Westhoff, would you please read aloud paragraph 10 of your declaration in this case.
A. Hang on. I picked up the wrong declaration. Can you give me the number?
Q. It is a plaintiffs' exhibit.
A. I know it's here.
THE COURT: Perhaps you would show it to the witness, Ms. Gowan.
MS. GOWAN: Yes, your Honor.
THE WITNESS: I'm sorry, your Honor. I have quite a stack here at this point.
THE COURT: I am well aware that you have quite a bit there.

Q. It is on page 5, Doctor.
A. Paragraph 10?
Q. Correct.
A. You want me to read it out loud?
Q. Please.
A. "Other patients require abortions because their pregnancies compromise their health. In some instances the medical condition is preexisting and exacerbate bid the practicing TPHAEPBS. For example, women with certain kinds of Hart disease are at increased risk during pregnancy with the risk of fetal or maternal death as high as 20 or 30 percent. Women who develop presomething card myopathy an condition PH- which the heart does not: Women can once such as RAOEPBal and deliver TKAOEZ risk having the pregnancy make those conditions wore of the or women with kidney K-FRG kins, for KAFRPL, this can amend a risk of death or loss of kidney function and a lifetime of dialalize if they continue with meg TPRAEPBS. With with developing severe preeclampsia or E clampsia, a condition that is characterized by simultaneous convulsions and comma, among other life threatening effects, an that can be cured ohm by terminating the pregnancy. During pregnancy women with preexisting diabetes also risk acceleration of conditions such as something RET no pathy meaning that she did Luke his eye light, TPHEF ro if a think, kid TPHAOEU failure, and pregnancy can because dangerous conditions, including preeclampsia and

hyperemsis in which the patient's vomiting is so excessive as to proceed extreme weight loss detried TRAOEUGS and az doze from staffer SRAEUGS. We see women with all of these medical conditions and others as well.
Q. Dr. Westhoff, at the break did you check your Palm Pilot to determine whether you had conversations with anyone at New York Presbyterian Hospital about medical records prior to signing the interrogatory verification on STKERL 28, 2003 -FRPLTS yes, I did.
Q. What did you find, if anything [> determine<]
A. I did a search for Mr. Into man nan, and the other meani meeting I have recorded with into nan occurred January 30, 2004. I don't routinely record telephone conversations in my PAULT pilot, so I don't have records of any of those. But I know I had a telephone conversation with Mr. Into nan on March 19th because I know I was traveling that day and I was telling him how to get me by beeper if I could be of any assistance, he should Kel me even though I was going to be out of town. So that was March 19th. But otherwise I don't have records of telephone calls and I only have the one meeting recorded as an appointment.
Q. You told us on Friday about your conversation with Mr. Into nan initially when you became -- because you told us that you wanted the people at New York Presbyterian to know that you were going to be a plaintiff in this case or that you were a

plaintiff in this case, correct?
A. That's right.
Q. You didn't say anything to us on Friday about discussing medical records at that time, is that right?
A. That's right.
Q. Was that the January 30, 2004 conversation?
A. I don't remember.
Q. Do you have any recollection at all when you spoke with Mr. Into nan on January 30th about discussing medical records?
A. I don't.
Q. Do you have a recollection about discussing medical records with Mr. Into nan on March 19th?
A. We didn't discuss records per se. I was just letting him know I was available if he would want to talk to me or needed my help for anything, to make sure that he had my beeper number, since I was going to be out of town.
Q. What was your conversation about on March 19th?
A. Just what I told you.
Q. You called Mr. Into nan up to give him your beeper number?
A. Yes. It was my understanding that the Court was actively deciding what was going to happen in terms of the medical record numbers, and I wanted to make sure if Mr. Into nan needed anything in that regard that he could get ahold of me because I wasn't going to be in my office or available.
Q. I see. What did Mr. Into nan say to you?

A. He said he would call me if he needed me.
Q. Did he ever do that?
A. He did not call me.
Q. Does your Palm Pilot reflect that you had any other conversations, meetings, telephone calls with anyone at New York Presbyterian Hospital relating to the issues in this case and medical records?
A. No.
MS. GOWAN: Thank you.
THE COURT: Is that all, Ms. Gowan?
MS. GOWAN: Yes, your Honor. Thank you.
THE COURT: Doctor, let me ask you a couple of questions. With regard to the schedule of fees to -- is it Medicare?
THE WITNESS: Medicaid, sir.
THE COURT: Medicated. That is New York State or is that the federal government?
THE WITNESS: That is New York State.
THE COURT: Your service, you are the head of it, right?
THE WITNESS: That's right.
THE COURT: Does your service bill the state independently of the hospital.
A. The hospital bills for the hospital part of the services. The department of obstetrics and gynecology does billing for

professional KPOEPT of services.
THE COURT: Who does that?
THE WITNESS: The department of obstetrics and gynecology, which is part of Columbia University.
THE COURT: They bill the professional services?
THE WITNESS: Yes, sir.
THE COURT: You submit to them your billing?
THE WITNESS: Yes, sir.
THE COURT: Do you in turn pay out the the doctors' salary that you mentioned before from the income from what the state pays you as head of the service.
A. I am responsible for a portion of various doctors' salaries, and I use all the different sources of income in our division to pay those portions of the doctors' salaries.
THE COURT: As head of the service, is what is left over yours?
THE WITNESS: I am responsible for both the income and the debts of my division, yes.
THE COURT: Do you run at a loss?
THE WITNESS: I wish I were a better accountant in order to give you a clear --
THE COURT: Does your service make money?
THE WITNESS: I don't know that the clinical part of the service has money left over after we pay our expenses.
THE COURT: Do you make money? You are able to pay

all the salaries, right?
THE WITNESS: Yes.
THE COURT: Do you pay yourself a salary or do you get whatever is left over? How are you compensated?
THE WITNESS: I do pay a salary. My salary comes from other sources besides these funds.
THE COURT: Where does your salary come from?
THE WITNESS: I have responsibilities for the family planning clinic. I run a number of grants. So portions of my salary come as investigators on these grants.
THE COURT: So you have multiple sources of income yourself?
THE WITNESS: Right.
THE COURT: But does the service break even? Does it make money, does it lose money?
THE WITNESS: I think it breaks even.
THE COURT: I am sure you know. You are the head, right?
THE WITNESS: Yes, sir.
THE COURT: Do you break even?
THE WITNESS: We find enough funds to pay for the doctors' time.
THE COURT: Do you ever meet with the state vis-a-vis the schedule of fees for the various services?
THE WITNESS: No, I have never done so.

THE COURT: Thank you, Doctor. You may step down.
(Witness excused)
THE COURT: Mr. Hut, you may call your next witness.
MR. HUT: Thank you, your Honor. Plaintiffs call Dr. Marilynn Fredriksen, who will be examined for plaintiffs by Ms. Chaiten.

MARILYNN FRE DRIKSEN,
called as a witness by the plaintiffs,
having been duly sworn, testified as follows:
THE CLERK: Please state and spell your full name slowly for the record.
THE WITNESS: Marilynn, MARILYNN, Fredriksen, Fredriksen is FRE DERIKSEN S-.
DIRECT EXAMINATION S-

BY MS. WIGMORE:
Q. Dr. Fredriksen, would you please introduce you feel to the Court.
A. I am Marilynn C. Fredriksen.
Q. Where are you currently employed?
A. Northwestern perinatal associates.
Q. Is that a medical practice?
A. Yes, it is.
Q. What type of a practice is it?

A. It specialized in obstetrics and gynecology. I'm an something obstetrician in prenatal diagnosis and provides pregnancy terminations as well.
Q. Can you give us a general description of the medical services you provide at Northwestern perinatal associates?
A. General obstetrics and gynecology care of a high risk pregnant woman, prenatal diagnosis, and pregnancy terminations, both medical inductions and D&E's and the intact version of D&E.
Q. Where is your practice located, Dr. Fredriksen?
A. Chicago, Illinois.
Q. How long have you operated this practice?
A. Two and a half years.
Q. Are you a physician?
A. Yes, I am.
Q. Did you practice medicine prior to opening your own practice two and a half years ago?
A. Yes, I did.
Q. Where did you practice?
A. My practice was incorporated into the Northwestern Medical Faculty Foundation, which is the full-time practice of Northwestern University medical school.
Q. Can you describe briefly your practice as a part of the Northwestern Medical Faculty Foundation.
A. I provide care similar to what I do now I. also supervised

residents and faculty and was a member of the full-time obstetrics and gynecology department of Northwestern University.
Q. Did your responsibilities as a part of the Northwestern Medical Faculty Foundation include treating patients?
A. Yes, they did.
Q. Are you currently affiliated with any medical schools or universities?
A. Yes, I am.
Q. Which?
A. I am still a clinical associate professor of obstetrics and gynecology at Northwestern University medical school in Chicago, Illinois.
Q. How long have you taught at Northwestern?
A. Since 1981.
Q. Can you describe your responsibilities as an associate professor of clinical obstetrics and gynecology at Northwestern.
A. Currently I provide patient care at Northwestern Memorial Hospital, and in that respect I also work with residents, other faculty members. I also provide educational opportunities for medical students and residents, I give lectures in the second year of medical school, in the third year of medical school relating to pathology in pregnancy, contraception, abortion, and antenatal care of the pregnant patient. I am also involved

with resident teaching and education in the care of obstetrics and gynecological patients. I am also a member of the institutional review board for the university.
Q. When you were a full-time member of the faculty, did your responsibilities in connection with abortion training, for example, differ in any way?
A. At the time that I was a member of the full-time faculty, I also ran the abortion services and supervised the resident education in abortion for the university.
Q. You mentioned that you are a part of the institutional review board for Northwestern university. Is that sometimes referred to as the IRE?
A. Yes.
Q. What is that?
A. All institutions that are engaged in human subjects research are required by law to have panels of experts judge whether the conduct and whether or not the proposed studies are ethical and are under the -- fall within the realm of good human research or ethical studies to be done. We are also involved in the consent process and developing consent process for those studies.
Q. How long have you been a member of the Northwestern University institutional review board?
A. Twelve years.
Q. Are the IRB's responsibilities and authority limited to

obstetrics and gynecology?
A. Oh, no. They are the full gamut of human research, whether they are doing psychological, psychiatric, cancer studies, transplant studies, surgical studies, studies looking at records.
Q. Dr. Fredriksen, where did you earn your medical degree?
A. Boston University medical school.
Q. What year was that?
A. 1974.
Q. Have you received any formal medical training since that time?
A. Yes, I have.
Q. Can you describe that for us, please.
A. I had two years of pediatric residency at the University of Maryland Hospital, and then I received three years of obstetrics and gynecology training at Boston Hospital for Women at Harvard University. I did a fellowship in maternal fetal medicine at Northwestern University, and I also have completed a fellowship in clinical pharmacology at Northwestern University. I have also received training in academic leadership fromal gay any University.
Q. Dr. Fredriksen, was your training at Harvard University a residency program?
A. Yes.
Q. That was your obstetrics and gynecology residency?

A. Yes.
Q. How long have you practiced medicine?
A. Since I graduated from medical school in 197 4.
Q. Do you have any specialties?
A. I am specialized in obstetrics and gynecology, maternal field medicine, and clinical pharmacology.
Q. Do you have any board certifications?
A. Yes, I do.
Q. What are those?
A. Obstetrics and gynecology, had aternal field medicine, and clinical pharmacology.
Q. When did you become board certified in each of those areas?
A. Obstetrics and gynecology was 1982. Maternal fetal medicine was 1983, and clinical pharmacology was 1991 [> maternal fetal medicine<]
Q. Do you recertify?
A. Yes. I have voluntarily E certified. My original certificates are not time-limited, so I do not have to. I have chosen, because I was a board examiner, to recertify on a yearly basis.
Q. You mentioned that you were a board examiner. What is that?
A. The board examination process for obstetrics and gynecology includes an oral examination of candidates. I served as a board examiner for two years, in '97 and '98.

Q. Doctor, turning your attention again to your private practice, you mentioned that you have a focus in your practice on high-risk pregnancies. Do you assist women in carrying pregnancies KPHREURBTd by maternal health conditions to term?
A. Yes, I do.
Q. Do you assist women in carrying pregnancies complicated by fetal anomalies to term?
A. Yes.
Q. Do you perform any surgeries?
A. Yes, I do.
Q. What surgeries do you perform?
A. Cesarean sections, hysterectomies, in the full range of obstetrical and gynecological services. I also do D&E's and the intact variation.
Q. You mentioned that you do D&E's and the intact variation, and earlier you mentioned that you provided abortion service. Can you describe to me the scope of your abortion practice.
A. I provide abortion services from approximately 4 or 5 weeks of gestation through 23 and 5/7 weeks of gestation.
THE COURT: 23 what?
THE WITNESS: And 5/7.
Q. What procedures do you perform?
A. [> five- sevenths<]
A. I do first tremster tell TKAEUGS and something or suction curettage. I provide section trimester terminations by

laminaria and dilatation evacuation as well as the intact variation. I also do induction medical abortions in the second trimester, and I provide medical abortion medications for the induction of early first trimester terminations S-
Q. Approximately how many abortions have you performed in your career?
A. Thousands.
Q. Currently, how many do you perform per year?
A. Approximately 100 to 125 per year.
Q. Do you have specific training in abortion practice?
A. Yes, I do.
Q. Can you describe that, please.
A. During my residency, there was an abortion service at the Boston Hospital for women, and all residents rotated through that. We received training in dilatation and evacuation as well as borings induction in the second trimester.
Q. Have you had any additional abortion training since your residency?
A. Formal training, not per se. It is a matter of evolution of the existing procedures and extension of their services beyond what it was during my residency.
Q. How does that evolution occur?
A. It is a process by which we communicate with other physicians or have availability of better equipment or better pharmacological means to attempt different techniques as we

provide abortion services.
Q. You mentioned that you perform a procedure known as dilation and evacuation, or D&E, is that correct?
A. Yes.
Q. Approximately how many D&E procedures have you performed throughout your career?
A. I really don't know, but probably thousands.
THE COURT: Thousands, plumber?
THE WITNESS: Thousands, plural. [> plural, not plumber<]
Q. You also mentioned a variation of D&E known as intact dilation and evacuation or intact D&E, is that correct?
A. Yes.
Q. Briefly explain what that term means as you understand it.
A. It is a procedure which you use serial laminaria in the cervix over a period of time, after which there is adequate dilatation to allow extraction of the fetus relatively intact.
Q. Can you also assure that the fetus will be removed intact?
A. No, I can't.
Q. Why is that?
A. During the process of doing those techniques, you pay encounter resistance to the cervix or somewhat -- the fetal tissues are relatively fragile and you can't guarantee getting the fetus out totally intact.
Q. Do you ever perform a D&E using the intact approach?

A. Yes.
Q. Do you do those as part of your regular practice?
A. Since my training in the seventies i have gradually changed the protocol under which I operate and have found that when I can get the fetus out relatively intact, I can ensure that there is no retained fetal tissue within the uterus, decreasing the risk of infection. The procedures are generally shorter, and the blood loss and the anesthesia time is less for the woman, so that it is a safer procedure.
Q. Approximately how many times have you performed an intact D&E?
A. I don't know.
Q. Why can't you tell us?
A. I have no mechanism. I don't keep track of it.
Q. You testified that your teaching responsibilities at Northwestern medical school include abortion training, is that correct?
A. Yes.
Q. What types of abortion procedures are taught at Northwestern?
A. Medical terminations, medical induction of pregnancy in second trimester, dilatation and evacuation in the intact variation.
Q. Dr. Fredriksen, are you a member of any professional associations?

A. Yes, I am.
Q. What are some of those?
A. The American College of obstetricians and gynecologyists, the American Society for Clinical pharmacology and they are putics. I'm a member of NAF. I'm a member of different -- I can't think of any other ones.
Q. The society for maternal fetal medicine?
A. Yes.
Q. And a number of other associations that appear on your CV, is that correct?
A. Yes.
Q. Have you authored any publications?
A. Yes, I have.
Q. How many?
A. Approximately 50.
Q. On what subjects?
A. My focus has been in drug use and pregnancy, but there are many -- there are general obstetrics and gynecology topics on my CV as ectopic pregnancy treatments as well as abortion papers.
MS. WIGM .
MS. CHAITEN: Your Honor, may I approach the witness with an exhibit binder?
THE COURT: You may.
Q. Dr. Fredriksen, I note that you have a lot of exhibits

around you left over from the prior witness. Are those in your way at all? Do we need to move those?
A. No, that's fine.
THE COURT: Why don't you come up and make the place tidy, and then you won't confuse anyone.
MS. CHAITEN: Thank you.
Q. Dr. Fredriksen, can you please open your binder to tab 92, which is Plaintiffs' Exhibit 92. Do you recognize this document?
A. This is a copy of my curriculum vitae.
Q. Is it an accurate summary of your education and experience?
A. It is.
Q. Dr. Fredriksen, do you take steps to remain current in developments within your area of expertise?
A. Yes. I attend meetings on a regular basis. I also participate in continuing medical education activities, and I have been recertified recently.
MS. CHAITEN: Your Honor, I would like to move the admission of Plaintiffs' Exhibit 92 into evidence.
THE COURT: Any objection?
MS. GOWAN: No objection, your Honor.
THE COURT: It will be received.
(Plaintiff's Exhibit 92 received in evidence)
Q. Dr. Fredriksen, what areas do you consider yourself to be an expert [> in what<]

A. I consider myself to be an expert in the care of the general obstetrics and gynecology patient. Specifically, the obstetrical patient and the high-risk patient. I also consider myself an expert in drugs and pregnancy. I also consider myself an expert in abortion practice.
Q. Do you intend to offer opinions to the Court today?
A. Yes.
Q. On what subject or subjects do you intend to offer opinions in this case?
A. I intend to offer opinions about general safety of abortion practice and the safety of the D&E and the intact variation thereof.
Q. Do you intend to offer opinions relating to the safety of , the relative safety of any other abortion procedures?
A. The induction method as well.
Q. Do you consider yourself to be qualified to offer opinions in those areas?
A. Yes, I do.
Q. Aside from your work in this matter, have you offered expert testimony in any other matters?
A. Yes, I have.
Q. In approximately how many other cases have you offered expert testimony?
A. I have been involved in legal cases approximately four or five per year. They may not always have involved formal

deposition or trial testimony, over a period of over 20 years SP-P.
Q. Have you ever been qualified to provide expert testimony in court?
A. Yes.
Q. In what area or areas have you offered expert testimony?
A. High-risk care and abortion practice.
Q. Have you ever offered expert testimony on other obstetrical issues?
A. The majority of the obstetrical cases are involving care of patients at term, but they also may relate to any medical condition under the broad area of obstetrics.
MS. CHAITEN: Your Honor, we tender Dr. Fredriksen as an expert in obstetrics and gynecology, abortion practice and maternal fetal medicine pursuant to Federal Rule of Evidence 702.
MS. GOWAN: No objection, your Honor.
THE COURT: The Court will so recognize. Doctor, could I just ask you, you say you testified in cases involving abortion as an expert witness, is that correct?
THE WITNESS: Yes.
THE COURT: Have you testified in any cases in which the case was challenging a partial-birth abortion statute in any particular state?
THE WITNESS: I provided a document in the Hope Clinic

case against the State of Illinois partial-birth abortion statute. K-PL against the what?
THE WITNESS: The State of Illinois.
THE COURT: The Illinois statute?
THE WITNESS: Yes.
THE COURT: Did you testify in that case?
THE WITNESS: No, I did not.
THE COURT: So you weren't recd as an expert in that case in any area, because you didn't testify, right?
THE WITNESS: I did not testify.
THE COURT: Did you testify in any other litigation challenging a partial-birth abortion statute?
THE WITNESS: No.
THE COURT: So this would be your first time?
THE WITNESS: Yes.
THE COURT: All right. Next question.
BY MS. CHAITEN:
Q. Dr. Fredriksen, are you receiving any compensation for your work in this matter?
A. t I am compensated for my travel expenses.
Q. Is the payment of your expenses conting intent any way on the outcome of this case?
A. It is not.
Q. Doctor, you testified that you intend to offer your opinion on the safety of certain abortion procedures, is that correct?

A. Yes.
Q. Does that include second trimester D&E, including the intact variation about which you have spoken?
A. Yes.
Q. What is your opinion as to the safety of second trimester D&E?
A. D&E has been shown to be the safest way to terminate a pregnancy in midtrimester. It has evolved over time, but it has become more safe. And in a publication that came out just last week in obstetrics and gynecology S-, it has been shown to be 2.5 times safer than induction terminations in the midtrimester.
Q. When you say "midtrimester," what are you referring to?
A. It is generally referred to as 13 to 28 weeks, although we don't go beyond 24 weeks in the termination of pregnancies.
Q. Dr. Fredriksen, on what do you base your opinion about the safety of D&E in the midtrimester, aside from the publication you have just mentioned?
A. There are other publications. There was a whole ser AOS of them by David Grimes talking about the safety of the D&E. They generally supported the safety to about 20 weeks. Beyond that, it is really an individual basis of the individual operator.
We did a study at Northwestern that was promptd by a paper in the American journal of obstetrics and gynecology by Chapman that showed that there was about a 2.3 times higher

risk of uterine rupture and hemorrhage with patients who had had a prior Cesarean section undergoing second trimester pregnancy termination by induction. All of their patients were induced.

It has not been our experience at Northwestern that we felt that those patients were at any higher risk, nor did we experience any increase in hemorrhage from patients who had had a prior Cesarean section. So we opened a study under IRB guidance that looked at a 5-year period of time, which we looked at our experience. Our definition was 13 to 24 weeks of gestation, and we compared not only inductions but D&E's. D&E's were not part of the Chapman paper.

We showed that there was no increased risk to a patient that had a Cesarean section. But the most striking difference between our data showed that the induction method was significantly more risky for a patient and that D&E was significantly more safer, and that did include patients to 24 weeks.

Q. Dr. Fredriksen, is your opinion regarding the safety of second trimester D&E procedures include an approach that would be the intact approach to D&E? [> does your<]

A. Yes.

Q. Do you have an opinion as to whether intact D&E is ever safer than other abortion procedures?

A. An intact D&E is always safer because the fetus comes out

relatively intact, involving less passes of the instruments into the uterus. It also has no ability to leave fetal parts within the uterus. There are less bony parts or bony fragments which can lacerate or cut the cervix as they are delivered from the uterus. And there is less blood loss overall.

Because the procedure is with the intact delivery of the fetus, the placenta usually delivers intact as well.

Q. What do you base that opinion on?

A. My experience and the -- well, the majority of it is my experience.

Q. Do you also base it on the medical literature that you have been referring to?

A. The medical literature doesn't do a specific study on intact D&E's versus classical D&E's, and there hasn't been any study in that area. But imembedded in the D&E data over the last 10, 15 years there are more and more operators that have moved from doing a strictly dismemberment procedure to an intact variation. So it is embedded in that. And we have shown that D&E has become much more safer as time has gone by.

THE COURT: Doctor, what is an operator?

THE WITNESS: The person doing the procedure.

THE COURT: You don't call them a doctor?

THE WITNESS: Yes, you can call them a physician.

THE COURT: But you choose "operator"? Are they all physicians?

THE WITNESS: Yes.
Q. Do you use the term "operator" when you are referring to somebody who is doing an operation?
A. Yes.
Q. Or in other contexts?
A. No. Just in terms of doing operations, a person is operating.
Q. So it would be the physician doing an operation?
A. Correct.
Q. Thank you. Dr. Fredriksen, you have testified that you have performed the intact variation of D&E, is that correct?
A. Yes.
Q. Why do you use that approach?
A. Because overall it is safer for the pregnant patient.
Q. You have mentioned a number of reasons why you believe that it is safe, and I would like to break that down and take then one by one and ask you some more questions about them. First, you mentioned that there are fewer passes with instruments. Why is this a safety advantage?
A. When you are passing instruments into the uterus, you always have the ability to inadvertently go through the wall of the uterus and perforate the uterus and deliver something that you don't intend to deliver. That could include maternal tissues.
Q. Is that something of concern to you?

A. Uterine perforation is a medical emergency. A bowel injury or an injury to maternal tissues is also an emergency, mandating exploration of the maternal abdomen to repair damage.
Q. When you refer to a bowel injury, is that something that can result from a uterine perforation?
A. Yes.
THE COURT: Have you ever perforated a uterus or done any of these things?
THE WITNESS: Yes.
THE COURT: Were you ever sued for malpractice?
THE WITNESS: Yes.
THE COURT: Involving an abortion?
THE WITNESS: Yes.
Q. Have you ever perforated the uterus using the intact approach to D&E?
A. No.
Q. Doctor, how is it that you are --
THE COURT: Just one SEFPBLGTD did in the malpractice suit against you, Doctor, did the plaintiff recover?
THE WITNESS: No.
THE COURT: Was there settlement?
THE WITNESS: No. We won.
MS. CHAITEN: May I inquire, your Honor?
THE COURT: Sure.
MS. CHAITEN: Thank you.

Q. Dr. Fredriksen, how is it that uterine perforation during a D&E in the second trimester?
A. Perforation is much more common with forcible dilatation of the uterus, but it can be an inadvertently happened when you are using forceps to grab tissue. There can be irregularities in the uterine wall which make you think there are fetal parts there and there are not. There can be irregularities in the thickness of the uterine wall, including with a scarred uterus. Or you can very easily go through the scar, the prior scar, or have the scar open, and you then have a chance of delivering anything from the maternal abdomen.
Q. Doctor, you mentioned that uterine perforation is more common with forcible dilatation of the uterus. What is forcible dilatation of the uterus?
A. Forcible dilatation of the cervix is a gradual process by which you use metal dilators to introduce them into the uterus and essentially force them through the uterus. That can cause damage to the cervix.
Q. Do you use forcible dilatation in any second trimester intact -- I'm sorry. Let me rephrase.
Do you ever use forcible dilatation in a second trimester D&E procedure?
A. I do not.
Q. Doctor, is there a high risk of uterine perforation from repeated instrumentation of the uterus during a second

trimester D&E?
A. The more passes that you do, there is a chance for passing those instruments through the uterus.
Q. But is it a significant risk of that happening? Is there a high risk of that happening?
A. In the second trimester, because we use cervical dilators, cervical dilatation by laminaria or misoprostol, it is less frequent than with a first trimester termination. But it still can occur.
THE COURT: Does that translate that it is a low risk, Doctor?
THE WITNESS: It is low risk in occurrence, yes.
THE COURT: Thank you.
Q. Then why are you concerned about it?
A. Because it is a medical emergency and places the patient at the necessity of doing a subsequent abdominal operation to explore damage.
THE COURT: That is if it happens?
THE WITNESS: Correct.
THE COURT: But it is a low risk event. Next question.
Q. Doctor, you also testified that intact D&E can reduce the risk of cervical laceration. Why is that?
A. Cervical laceration can actually nick an internal branch of the cervical artery as well as lacerate the endocervical canal

and cause bleeding. The leading cause for this is bony pieces -- pieces of bony parts of the fetus which can be very sharp, and when you pull them through the cervix can lacerate the cervix and cause hemorrhage.
Q. What causes the presence of sharp bony parts in the first place?
A. The dismemberment process that is necessary to empty the uterus.
Q. Are these fragments present in an intact evacuation?
A. No, they are not.
Q. Why not?
A. Because the fetus is delivered almost or virtually intact, and thereby you don't have those bony fragments.
Q. Dr. Fredriksen, is there a high risk of cervical laceration or uterine perforation from bony fragments during a D&E?
A. If you end up having a situation where you end up having multiple fetal parts, there is always a risk of cervical laceration.
Q. Is that why you try to control for this risk?
A. We decrease that risk by doing an intact or near intact procedure.
Q. Doctor, you mentioned in the case of uterine perforation as well as in the case of cervical laceration that it could require an additional procedure, is that correct?
A. Yes.

Q. Would the additional procedure that is required be riskier than a second trimester D&E?
A. Absolutely.
Q. Why is that?
A. When you open the abdomen, you are increasing the risk of infection, something infection, and you don't know what you are going to encounter. It can be a bowel injury, it can be bowel spillage. It can be just a uterine perforation or it can be involving damage to the ovaries and tubes as well. So it depends upon what the extent of the damage is. S-
You also can get hemorrhage or delayed hemorrhage from perforations, and the hemorrhage can be into a space behind the abdominal cavity which can accommodate quite large amount of blood without being notice STKPWHRD Doctor, you mentioned opening the maternal abdomen. Is that part of the subsequent procedures that are necessitated by cervical laceration or uterine perforation?
A. Yes.
Q. You testified that intact D&E can also produce the risk that fetal tissue or parts can remain behind in the uterus. How is it that fetal tissue or parts can remain behind doing an D&E?
A. If you do a D&E where the fetus doesn't come out intact, you are making an assumption or you make your best clinical estimation that the uterus is entirely empty. Unfortunately,

we are not very good at that, and we can leave other fragments of the fetus in the uterus or fragments of the placenta in the uterus, and there can be an knights for infection and there can be the cause of a post-abortal hemorrhage.
Q. Used the word aknights. What is that?
A. Like a focus.
Q. So it would be a location of, a point of infection?
A. Yes.
Q. S- what is post-abortal hemorrhage?
A. Post-abortal hemorrhage is hemorrhage which occurs overt abortion has occurred. It can be episodic or you can get a hemorrhage and then find no evidence for the bleeding by examining the patient. That is characteristic of a cervical artery laceration of the internal os or the internal os of the cervix, where bony fragments can lacerate that branch of the cervical artery.
Or they can be caused by the uterus failing to contract or maintain a contraction after the delivery of the fetus and the the majority of the pregnancy. That is called uterine at knee S-, and that may necessitate reexploration of the uterus. It can also or use of medications S-
Q. Why are you concerned about the uterus failing to contract? What purpose does that serve?
A. The physiological changes of pregnancy increase the cardiac output proportion that goes to the uterus during pregnancy.

That is maintained in the post-part um stage. So an obstetrical post partum memorandum RAPBLG or a post-abortal hemorrhage --
THE COURT: Doctor, can you slow down a little bit? The reporter has to get it all.
THE WITNESS: Yes.
A. I don't know where HEUFS.
Q. I had asked you about why you were concerned about the uterus being able to contract after an abortion procedure.
A. During pregnancy a higher proportion of the cardiac output is directed to the uterus, and that is maintained in the post-pregnancy termination period, whether that be at 24 weeks or 22 weeks or 17 weeks. It takes approximately 12 weeks after pregnancy termination for the card cardiovascular changes to go back to normal. During that period of time, if the uterus failed to contract, there is no -- the contraction of the uterus stops the arterials from bleeding into the cavity of the uterus. At knee, or failure of the uterus to contract, increases the amount of blood flow which can then commaulate in the uterus and then be passed vaginally. So obstetrical hemorrhages post-abortion or post-delivery can be very heavy.
Q. So failure of the uterus to contract impedes stopping of the bleeding? Is that sort of a basic way to say that?
A. Yes.
Q. You talked about some of the complications from having

retained fetal tissue or parts in the uterus. Can those complications affect future reproductive health?
A. When you develop an infection in the uterus, you can develop something called asher man's syndrome. It is usually associated with multiple occuriat TAPBLG of the endome TRAOEL tissue and it is also usually thought to be associated with infection. So yes, you can develop a condition in itch when uh KWROEPBT don't have menstrual periods because the clini lining of the uterus has been damaged.

There can also intrauterine STPHAOEBG KWRAOEU. That is a big term. It is basically internal scar tissue which go from one side of the uterus to another side of the uterus, and therefore impede implantation and development of the subsequent pregnancy.

You can also get infection that is so se SRAOEFR that you can get PWHROSage of your tubes [> blockage of your tubes<]
Q. Why is it that the intact D&E retains the risk of retaining fetal tissue or parts?
A. Ensuring that the fetus delivered intact or virtually intact decreases the chances that there can be amounts of tissue in the uterus that are left. It also usually, when you do an intact D&E [> check above<], you usually get the placenta out as more of a dischord organ rather than in bits and pieces S-
Q. Doctor, I apologize if I maybe didn't hear you, but when I

asked you why it is that fetal tissue or parts -- let me start over. I apologize.

When I asked you why intact D&E reduces the risk of fetal tissue and parts remaining in the uterus, I think you said that intact D&E reduces the risk of fetal tissue or parts remaining in the uterus. I would like you to explain why that is.
A. Because the fetus comes out intact or virtually intact, there are no fetal pieces of tissue left within the uterus. As such, when you deliver the fetus intact or virtually intact, the placenta can come out also virtually intact, thereby ensuring that the uterus contracts and there is no retained products of conception within the uterus, which is the leading cause of infection in the post-abortal period.
Q. Dr. Fredriksen, can you assure that all fetal tissue and parts have been removed by scanning with ultrasound following the procedure?
A. You can if you don't think that you haven't completed the procedure. Ultrasound is usually available to scan the patient. But then if you don't have an intact fetus or you are questioning whether the uterus is really empty or not, if you actually have left, you have to go back and continue the procedure.
Q. Does that lengthen the procedure?
A. Yes.

Q. Can you always visualize remaining tissue with an ultrasound?
A. No, because you lose the contrast of the amniotic fluid as you empty the uterus, and fetal parts are the same density sometimes as blood clots. Therefore, you may not be able to see them.
Q. You testified earlier that intact D&E offers the advantage of a shorter operating time. Why do you believe that is the case?
A. My experience, the tame necessary to complete emptying the uterus has actually gone down. That is an experience that I have had over the last 20 years.
Q. To what do you attribute that?
A. Experience would be number one. The fact that we know that the uterus is empty, we don't have to go looking for extra parts at the end of the procedure.
Q. So you are referring to the in the course of the an intact interpret the procedure time has gone down?
A. Intact D&E is a variation of D&E. Therefore, as we have gotten the fetus out more intact, the total time necessary to ensure that the uterus contracts and is empty has gone down.
(Continued on next page) S- 4/5/04 Judge Casey take 4 direct by KHAEUTen of female doctor
BY MS. CHAITEN:
Q. What safety advantages, if any, are associated with shorter operating time?

A. Less blood loss, less anesthetic time, less pain to the pregnant patient.
Q. Anything else?
A. I think overall your risk of infection goes down with time because you are just exposing the uterus and to less trauma.
Q. Doctor, you receivederly testified earlier that you do second trimester pregnancy terminations through induction procedure, is that correct? EFRPLTS.
Q. Do you have an opinion as to the general safety of the induction procedures to terminate second trimester pregnancies?
A. Induction procedures are safe. The paper that came out this week shows that they are more risky overall than D&Es in the intact variation.
Q. Has that been your experience as well?
A. Definitely.
Q. Dr. Frederikson, what about the induction procedure, as compared to D&E, makes you believe that D&E is safer?
A. About the procedure per se? I guess I base my decision on my, the relative safety of a D&E versus an induction really on the basis that there has been a long history that inductions in this country have been riskier and induction haves gone down as a percent of midtrimester terminations. The safety for women for terminating pregnancy in the midtrimester actually has gone up as evidenced by best evidence is the paper that just came out where that's one of the points that the authors make that

as D&E has gotten safer that induction procedures have not been used and their relative safety is less than a D&E.
Q. Why do you believe induction is riskier?
A. It's taking a patient in the midtrimester whose uterus is not really ready for labor and attempting to put the uterus and cervix into HRAEURB and deliver the fetus.
The whole process takes a long time because the cervix is not ready to dilate and the uterus is really not ready to contract.
The pharmacological mechanisms by which we have done this over a period of time have been prostaglandins instilled into the amniotic fluid, prostaglandins that are injected and we used to use sup OS tores of prostaglandin in the vagina. We now use another form of prostaglandins in the vagina that seems to be the safest way that we can do this but the whole period of time that takes a patient to go from a cervix which is long and closeed to shortened and dilated can be nine, 14, 24, 36, 48 hours. It's an open-ended period of time. It also associates the uterus and the contents of the uterus to anything that's in the vagina and we know that infections originate from vaginal flour are a that ascend into the uterus increasing the risk of infection.
There is also a risk of hemorrhage at the time or during the process. It's a long painful procedure for the patients. Its essentially analogous to labor and there really

is not anything that they're going to deliver other than a fetus which they are choosing to terminate.
Q. How does that compare to a D&E?
A. The D&E procedure begins with dilating the cervix with laminaria which are seaweed twigs placed in the cervix which absorb water from the mother's body then gradually begin the process of softening the uterus and dilating the os or the opening of the cervix to the gradually over a process of time.
We also use misoprostol orally or vaginally to facilitate this process, that's lower dose medications than what we use for induction of a midtrimester termination.
And then we bring the patient to the operating room and can empty the uterus under a controlled period of time and thereby have a controlled handling of the placenta and ensuring that the uterus is empty we can also decrease the total time the patient needs to be away from her family and other children or a job and there is less pain for her because she doesn't go through labor. Pain has become a major issue with respect to how we handle midtrimester terminations and now we are actually giving patients epidural anesthetics for the conduct of midtrimester pregnancy terminations.
THE COURT: Doctor, do you make full disclosure to all your patients before you embark on a particular procedure?
THE WITNESS: I educate them in the process of an informed consent as to the risks of pregnancy termination and

the relative difference of risks of the different procedures.
THE COURT: Well when you tell them about pain and such that you were talking about before do you also tell them about that you do the D&E, it involves dismemberment, do you tell them that you tear the limbs off the fetus.
THE WITNESS: I don't use that term, say say it.
THE COURT: Do you use simple English words so they know what you are doing.
THE WITNESS: Yes.
THE COURT: And what they're authorizing?
THE WITNESS: Yes.
THE COURT: Well how do you tell them that you are going to take the limb off? Inch I tell them that in the process.
THE COURT: Do you use disarticulation.
THE WITNESS: No.
THE COURT: What word do you use?
THE WITNESS: I tell them that in the process of the termination we will attempt to get the fetus out as intact as possible but that is not a guarantee and I sometimes a fetus comes out in parts.
THE COURT: Do you discuss with them whether or not there is any fetal pain?
THE WITNESS: I think that's a concern.
My approach has been to say that the cord usually

comes down and severing of the cord means that the fetus asang question nature.
THE COURT: Do you they that I normal woman patient understands that words.
THE WITNESS: Well bleed to TK-PBLG is the analogy on more lay terms.
THE COURT: Well do you use asang we nature or do you say bleed to death?
THE WITNESS: I use the term that the fetus loses all of its blood when the cord is severed.
THE COURT: Do you tell them whether or not the fetus experiences pain?
THE WITNESS: Since I don't know that I do say that most of the time the fetus may not experience anything because once the cord has been severed there is no blood supply to the central nervous system and therefore the fetus for all intrinsic purposes dies. Whether or not that is analogous to the end of the presence or absence of a fetal heartbeat I don't know but there is no fetus that has central nervous system activity once they have lost all oxygenation.
THE COURT: Do you use all of those words, oxygenation and things like that or do you tell them in simple words?
THE WITNESS: I tell them in simple understandable words. Depending upon the particular patient that I am dealing with.

THE COURT: Oh depending on the patient the words vary.
THE WITNESS: Yes.
THE COURT: And when you do an intact D&E do you tell them that you are going to insert scissors in the base of the skull.
THE WITNESS: No.
THE COURT: You don't tell them that.
THE WITNESS: No, because I don't always do that, number one.
THE COURT: You do that sometimes?
THE WITNESS: Yes.
THE COURT: When you do do you tell them?
THE WITNESS: Not ahead of time because I can't predict who I'm going to do that with and what I can't do that with.
THE COURT: Do you tell them you may be doing that STPHEUFRPBLGTS no.
THE COURT: Do you tell them whether or not it hurts?
THE WITNESS: Who am I what I am --
THE COURT: The patient.
THE WITNESS: The patient?
THE COURT: The woman, the mother.
THE WITNESS: It doesn't hurt her, no.
THE COURT: Do you tell whether or not it will hurt

the fetus.
THE WITNESS: The intent of an PW-RGS that the fetus will die during the process of uterine evacuation.
THE COURT: Ma'am, I didn't ask you that. Very simply I asked you whether or not do you tell the mother that one of the ways she may do this is that you will deliver the baby partially and then insert a pair of scissors in the base of the fetus' skull?
THE WITNESS: I have not done that.
THE COURT: Do you ever tell them that after that is done you are going to suction or suck the brain out of the skull?
THE WITNESS: I don't use suction.
THE COURT: Then how do you remove the brain from the skull?
THE WITNESS: I use my finner to disrupt the central nervous system thereby the skull collapses and I can easily deliver the remainder of the fetus through the cervix.
THE COURT: Do you tell them that you are going to collapse the skull?
THE WITNESS: No.
THE COURT: The mother?
THE WITNESS: No.
THE COURT: Do you tell them whether or not that hurts the fetus?

THE WITNESS: I have never talked to a fetus about whether or not they experience pain.
THE COURT: I didn't say that, Doctor. Do you tell the mother whether or not it hurts the fetus?
THE WITNESS: In a discussion of pain for the fetus it usually comes up in the context of how the fetus will die. I make an analogy between what we as human beings fear the most-HAEUF a long protracted painful death.
THE COURT: Doctor I didn't you.
THE WITNESS: Excuse me that's what I tell my patients.
THE COURT: But I'm asking you the question.
THE WITNESS: I'm sorry.
THE COURT: And I'm asking you whether or not you tell them that.
THE WITNESS: I feel that fetus dies quickly and it's over quickly and I think from a standpoint of a human being our desire is that we have a quick death rather than a long protracted death.
THE COURT: That's very interesting, Doctor but it's not what I asked you.
I asked you whether or not you tell them the fetus feels pain.
THE WITNESS: I don't believe the fetus does feel pain at the gestational ages that we do but I have no evidence to

say one way or the other so I can't answer that question.
THE COURT: Have you ever read any studies about fetal pain?
THE WITNESS: Fetal pain is best explored in the premature context of delivering premature babies beyond 24 or up to 28, at 28, 30 weeks.? Those studies it's much, much further in gestation than where I am dealing with the fetus.
THE COURT: Are you aware of any studies done on fetal pain in a shorter gestational period?
THE WITNESS: No.
THE COURT: Next question.
BY MS. CHAITEN:
Q. Dr. Frederikson, you mentioned that you attempt to cut the umbilical cord relatively early in a D&E procedure, is that correct?
A. Yes.
Q. Can you always do that early?
A. No, I can't. It's been my experience over time that when we empty the amniotic fluid the cord usually comes down and we can sever that and that's one way we can attempt to decrease any perceived fetal pain.
Q. When you say usually, how often is that?
A. I can usually get the cord done about 70 percent of the time.
Q. So in the 30 percent of the time when the cord doesn't come

down, do you search for the cord so that you can cut it early?
A. No, I can't do that.
Q. Why not?
A. It is a long fruit *S operation and it doesn't -- the goal here is to empty the uterus in a timely fashion thereby decreasing pain and suffering of a mother.
Q. Do you know when --
THE COURT: The mother is an necessary TE advertised isn't she.
A. I don't any procedure under conscious said TAEUGS with paracervical TPHROFL in the SER AEUFPBLD giving medications usually TPEPB TA nil and SRER set to provide pain relief and amnesia.
THE COURT: So she's an TPHEZ TE TAOEUSed.
THE WITNESS: She is but the amount of drug varies between the patients and she is not under a general anesthesia.
THE COURT: Next question.
BY MS. CHAITEN:
Q. Doctor, do you know after you cut the cord how long it takes for the heart to stop beating?
A. No, I do not.
Q. Getting back to your testimony about inductions, induction terminations in the second trimester of pregnancy, are there risks associated with the use of misoprostol or another prostaglandin in order to produce the termination?

A. Prostaglandins have been associated with cardiac aridge me KWRAOs and sudden death. They are not totally safe.
Q. You also mention controlled handling of the placenta, do you recall that testimony?
Do you recall that testimony?
A. That was with respect to D&E.
Q. Right, I'm sorry, yes; in the context of D&E you talked about controlled handling of the placenta; does that differ from an induction?
A. The main problem with an induction is not only the length of labor and getting the fetus delivered, it also has to do with the fact that the placenta does not always separate and that separation can be a long process and it can also be associated with EUP creased blood loss.
Because of that it is often necessary to take a patient to the operating room and empty her uterus to get the retained placenta from the second trimester induction procedure.
Q. Do you consider the failure of the placenta to deliver during a second trimester induction PRER a complication?
A. Yes.
Q. Why is that?
A. Because it entails another procedure O to end the whole pregnancy termination process.
Q. Doctor, does an induction termination always work?

A. No, it does not --
Q. I'm sorry, to expel the fetus?
A. No, it does not.
Q. What happens in that situation?
A. Often times there is enough cervical dilatation and softening that we can go ahead with the TKEUL aTEUGS and evacuation.
If you do not have access to an operator that has skills with D&E and you have a failed induction the only other option would be a hysterotomy.
Q. What is a hysterotomy?
A. Hister OT AO my is abdominal incision through the abdominal wall into the uterus and into the uterus for purposes of emptying the ewe Russ.
Q. So you cut open the maternal abdomen?
A. Yes, and the uterus. And the incision on the uterus is usually a vertical incision and that would mandate all future pregnancies be delivered by caesarean sections because in the mid TRAOT I have you can't do lower segment transverse insession or lower segment vertical incision because you don't have a lower SEG the, you only have the contractal portion of the uterus so you are putting an incision analogous to classical caesarean section on the uterus and there by we would not want that patient to labor in subsequent pregnancies.
Q. So in subsequent pregnancys that woman would have to have a

c-section?
A. Yes.
Q. And could that woman undergo a subsequent induction termination in the second trimester of pregnancy?
A. She could undergo subsequent induction of pregnancy but she incurs about a 2.3 higher risk of a uterine rupture or hemorrhage based on Chapman's article from the University of Alabama.
Q. Doctor, you mentioned a number of other concerns relating to induction and I would like to go back and ask you some questions about those. You talked about blood loss, is blood HROES a complication of induction?
A. It can be.
Q. And why is that?
A. It can be associated with labor, you can loose blood during the course of labor, you can have an aTPWRUPGS or an infringe -- and the longer the process or the longer it takes to dilate the cervix and deliver the fetus you have a higher risk of blood loss.
You also have a higher risk of blood loss with a placenta that is either recontained or fails to separate entirely where you have continued leading into the cavity of the uterus before delivery of the placenta allowing for the uterus to then contract and stop the process of bleeding.
Q. Doctor, in your experience how did the blood loss in an

induction termination in the second trimester compare to a D&E in the second trimester?
A. A D&E, because KWREULGS a more detined procedure, usually has less blood loss.
Q. You also mentioned a minute ago uterine rupture as a complication of inTKURBGS why is that?
A. Uterine rupture is a complication for second trimester terminations largely due to the fact that scars in the uterus are, can be in the contractal portion of the uterus and they can open during the process of induction.
The induction THAGTS we use that can be concentrated ox I toes inwhich can be a higher trance indication than we useality term and also PROS PROS, and PROS PROSes also have been associated with uterine rupture.
Q. And how does that compare with a D&E in the second trimester?
A. A D&E in the second trimester is not usually associated with uterine rupture and is actually safer for a woman who has undergone a Caesarian section or any classical incision on her uterus or even a myomectomy.
Q. Doctor, I'm going to, can I ask you to not speak to closely into the microphone because we are getting feed become and we have learned that it's because our witnesses put their mouths too close to the microphone, thank you.
You mentioned a my O mectomy what is a myomectomy?

A. A myomectomy is an operative procedure by which uterine fibroids are excised or taken off the uterus and in the process they can actually go into the cavity of the uterus because fibroids can actually reside in the wall of the uterus and extend all the way into the cavity.
Q. Doctor, you mentioned infection earlier, is infection a complication of induction?
A. Infection is a complication of any pregnancy termination.
Q. How does your concern about infection in an induction compare to a second trimester D&E?
A. Well with an induction you don't ever know whether the placenta has been delivered intact or not. Even though we can look at the placenta and say it's intact we don't know that. We also, because of the process of labor, the process by which the cervix opens and exposes the uterus to contents of the vaginal area increases the risk for organisms to ascend into the cervix and into the uterus during the process of labor. Labor, in itself increases the risk of infection.
Q. Doctor, other than your belief that D&E is safer or can avoid complications of induction, are there any other reasons you would choose not to use an induction termination approach for certain women?
A. There are certain object stet TREU call conditions which mandate that a patient be terminated or pregnancy terminated in a different fashion other than induction.

In other words, if a patient has a placenta PRAOEFBa, she cannot be laboreded. A patient who has had prior uterine scars on the upper portion of the uterus also should not be exposed to PROS PROSes and labor because they have a higher risk of uterine rupture during the course of labor.
Q. Why is it that a patient with placenta PRAOEFBa cannot be labored?
A. Because the placenta PRAOEFBa, the position of the placenta includes the opening of the cervix into the uterus and as that process of labor occurs, there can be profound maternal hemorrhage.
Q. Did you say profound maternal hemorrhage?
A. Yes.
Q. I'm sorry, I just didn't hear.
THE COURT: Is this a convenient time for you to break break.
MS. CHAITEN: That would be fine, your Honor.
THE COURT: All right, because it is just about 1:00.
Before we recess however I will give you a ruling on the questioning of the use of the depositions of the government witnesses that have previously been discussed.
The Court is prepared to rule on defendant's motion to preclude the deposition testimony of William month shell will a and Juan Kim from the Department of Justice.
Both depositions will be precluded.

Mr. Mo shell will a's testimony regarding the KHREUPL, Clinton administration view on the constitutionality of prior drafts of the act has little, if any, probative value. It is for the Court to determine whether the Act as passed is unconstitutional.
Mr. Mo shell will a's deposition testimony is precluded under Federal Rule of evidence 403 because it's probative value is substantially outweighed by considerations of undue delay and waste of time.
Mr. Kim's testimony concerning the lack of enforcement action by the Department of Justice also adds nothing to the Court's determination whether the Act is unconstitutional. Establishing that the Department of Justice has yet to formalize its views on what procedure the Act prescribes will not tend it prove or disprove that the Act's language is unconstitutionally vague.
Mr. Kim's testimony is therefore precluded under Federal Rule of evidence 402.
All right, that completes the Court's ruling on that motion. We will reconvene tomorrow morning at 9:30 and those of you who will be celebrating passover I wish you a very pleasant evening.
The Court will stand in recess.
MR. HUT: Your Honor, may I make one quick inquiry with respect to the Court's RAOUG?

THE COURT: Yes.
MR. HUT: We, the plaintiffs, would like to make a proffer with respect to the testimony that the Court has ruled precluded. I don't know whether we have, -- we have provided the testimony to the Court, the Court may deem that we have made an appropriate proffer and that's fine with us. If not, I would like some guidance as to how you would like us to proceed. We will proceed in any way the Court thinks is most expeditious and economical.
THE COURT: You submitted the deposition, I assume that's what you are offering but I am more than happy to hear whatever you would like to say.
MR. HUT: No. Given the Court's sum sun that that is what we would proffer that is indeed what we would proffer and we are content to leave the record where it is.
THE COURT: I'm in the sure what it is you are saying, Mr. Hut. First you say that perhaps you would like to make a proffer. Go aright ahead.
MR. HUT: I think we have.
Just to be clear, hour proffer is that both witnesses would testify in accordance with the testimony that we have designated by page and line.
THE COURT: As what, sir?
MR. HUT: That in accordance with the testimony that we have designated in the pretrial order.

THE COURT: The portions of the deposition that you have designated. Is there something additional in those transcripts that you are now suggesting you want to offer? Or just what you designated?
MR. HUT: Just what we have designated an the accompanying SKEUBGS, your Honor.
THE COURT: That's what I was ruling on. If you wish to make further argument of course you may.
MR. HUT: No, sir.
THE COURT: Okay. See you at 9:30 tomorrow morning. Thank you very much.
(adjourned to April 6, 2004 -- I have.
MR. HUT: Excuse me, your Honor, I'm sorry, there is one more housekeeping matter that my colleagues have just reminded me about and that is with respect to the next witness that will follow Dr. Frederikson, that is Dr. Bear Rebecca Baergen, she is constrained in terms of time and we would like it take her out of order and present the testimony of Dr. Baergen first thing tomorrow morning.
THE COURT: I don't see any reason why we can't accommodate her.
MR. HUT: Thank you, your Honor.
THE COURT: Okay, fine.
Thank you.
(adjourned to April 6, 2004 --

THE COURT: I assume this witness' deposition has been taken of this witness, is that correct?
MS. GOWAN: Yes, your Honor.
THE COURT: All right, well then we will take her out of order. That's fine.
(adjourned to April 6/2004 at 9:30 a.m.)