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

Plaintiffs,

v. 03 Civ. 8695 (RCC)

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

Defendants.

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New York, N.Y.
April 6, 2004
9:30 a.m.

Before:

HON. RICHARD CONWAY CASEY

District Judge

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(Trial resumed)
THE COURT: I have just one housekeeping matter. I thought I invited you last week, through my law clerk, that the Court would much appreciate hearing Dr. Carhart since he was a central part of what the Supreme Court focused on in Stenberg and so I, as we get into the second week I invite you, on the record, to call Dr. Carhart live, if you so choose. So, you have the invitation.
You may call your next witness. You wanted to call one out of order, as I remember from yesterday.
MR. HUT: That's correct, your Honor. Plaintiff's next witness is Dr. Rebecca Baergen, and Julie Sternberg for plaintiffs will inquire of the witness.
THE COURT: Very well, sir.
REBECCA BAERGEN,
called as a witness by the Plaintiffs,
having been duly sworn, testified as follows:
MS. STERNBERG: May I inquire, your Honor?
THE COURT: You may.
DIRECT EXAMINATION
BY MS. STERNBERG::
Q. Dr. Baergen, where are you employed?
A. I'm employ by the Joan and Sanford I. Weill Medical College and Graduate School of Cornell University.
Q. Is Cornell a short way of saying that?

A. Yes.
Q. Dr. Baergen, your microphone, you might want to swing it around. Thank you.
Are you a physician?
A. Yes.
Q. Do you have a speciality?
A. Yes.
Q. What is that speciality?
A. Pathology.
Q. How long have you practiced in that area?
A. Since 1987.
Q. Can you briefly define pathology, please?
A. Well, there is two components to pathology -- clinical pathology and anatomic pathology.
Clinical pathology is the analysis of bodily fluids, primarily blood, urine --
THE COURT: Doctor, would you slow down a little bit, please, and just back away from the microphone a tiny bit? If you get too close it distorts your voice.
THE WITNESS: Yes, sir.
THE COURT: And our reporters are wonderful but they can only take it at a human-level speed.
THE WITNESS: I will try, your Honor.
Analysis of bodily fluids which include blood, urine, cerebral spinal fluid and so on. And those tests are done, for

instance, blood counts and chemistries and so on.
Anatomic pathology is the study of tissues. So, when tissue is removed at surgery biopsies and resections of different abnormalities, that tissue is sent to pathology, we look at it and do a gross examination with the naked eye, describe and report on those abnormalities, then take portions of that tissue and submit it for microscopic examination.
Then, on the basis of the gross and microscopic examination, we render diagnoses on what is going on with the tissue, what pathologic processes and so on.
Q. Do you have any subspecialties?
A. Yes, I do.
Q. What are they?
A. Perinatal, placental and gynecologic pathology.
Q. What is perinatal pathology?
A. Perinatal pathology encompasses placental pathology and it is the study of abnormalities of the placenta and abnormalities of the fetus in a newborn infant.
Q. So, is placental pathology the study of the placenta alone?
A. Yes.
Q. What is gynecologic pathology?
A. That's the study of the pathologic processes involving the organs of the female reproductive track, the ovaries, tubes, uterus, and so on.
Q. Is the diagnosis of fetal anomalies part of perinatal

pathology?
A. Yes.
Q. What positions do you hold at Cornell?
A. I'm a professor of clinical pathology and laboratory medicine, and attending pathologist and chief of perinatal and pediatric pathology.
Q. How long have you been chief of perinatal and pediatric pathology?
A. Seven years.
Q. What are your responsibilities in that position?
A. Well, all the positions encompass the same responsibilities which include teaching of medical students and physicians that are in the pathology training program studying for a speciality in pathology.
It includes examination of patient care materials, specimens in the areas that I just described, and it involves administrative duties as well as research in those areas.
Q. What subjects do you teach as professor of clinical pathology and laboratory medicine?
A. I primarily teach in my areas of specialty which is perinatal pathology and gynecologic pathology.
Q. How long have you been on the faculty at Cornell?
A. Seven years.
Q. Dr. Baergen, are you a plaintiff in this case?
A. No.

Q. Do you plan to offer opinions as an expert?
A. Yes.
Q. On what general subject or subjects do you intend to offer an opinion?
A. My opinion is going to be on the advantages to having an intact specimen in the evaluation of fetal anomalies and fetal abnormalities.
Q. Before we get into your opinion, Dr. Baergen, let's talk more about your background. From where did you obtain your medical degree?
A. UCLA.
Q. What year?
A. 1983.
Q. Do you have any board certifications?
A. I'm board certified in clinical pathology and an anatomic pathology.
Q. Have you ever been performed an abortion procedure?
A. Yes.
Q. When was that?
A. I performed a few procedures when I was an intern back in, I think, 1983, '84.
Q. Have you performed any procedures in the last 20 years?
A. No.
Q. Do you currently perform abortion procedures?
A. No.

Q. Are you familiar with various abortion procedures?
A. Just, I just have a general familiarity but nothing specific.
Q. Dr. Baergen, you stated earlier that you have some teaching responsibilities, do you have any responsibility for training other physicians in addition to those teaching responsibilities?
A. Well, my teaching responsibilities include teaching the pathology residents in my area of speciality.
Q. Are you a member of any professional associations?
A. Yes. I'm a member of a number of associations.
Q. And in what field are those associations?
A. Most of those are in the field of pathology.
Q. Have you offered any publications?
A. Yes.
Q. On what subject?
A. Most of my publications are, again, on perinatal pathology and gynecologic pathology.
Q. Have you authored any books or book chapters?
A. One book chapter and one book.
MS. STERNBERG: Your Honor, may I approach the witness to show her an exhibit?
THE COURT: What is the chapter and what is the book?
THE WITNESS: The chapter is on placental pathology and products of conception, and it's in a two volume set of

general surgical pathology, so there is a chapter for each area of the body for the lung and the brain and so on. And so, I wrote the chapter on placental pathology.
The book is on placental pathology.
THE COURT: What is the title?
THE WITNESS: The book is in press and the title has not quite been determined.
THE COURT: So it hasn't been published yet.
THE WITNESS: It's in press. So, it's gone to the publisher and they're --
THE COURT: But it's not out there. In other words, it hasn't been actually published?
THE WITNESS: Correct.
THE COURT: Go ahead, Ms. Sternberg.
MS. STERNBERG: May I approach and show the witness an exhibit?
THE COURT: Of course you may.
BY MS. STERNBERG::
Q. Dr. Baergen, I put in front of you what's been marked Plaintiff's Exhibit 78, do you recognize this document?
A. Yes.
Q. What is it?
A. It's my curriculum vitae.
Q. Is this document an accurate summary of your education and experience?

A. Yes.
MS. STERNBERG: Your Honor, at this time I offer Plaintiff's Exhibit 78 into evidence.
THE COURT: Any objection?
MR. PANTOJA: No objection, your Honor.
THE COURT: It will be received.
(Plaintiff's Exhibit 78 received in evidence)
BY MS. STERNBERG:
Q. Dr. Baergen, aside from your work in this matter, have you offered expert testimony in other matters?
A. Yes.
Q. In what context?
A. I have served as an expert witness and testified in a number of malpractice suits -- malpractice suits.
Q. And what was the general subject matter of your testimony?
A. It related to placental and perinatal pathology and primarily with regard to causation of the adverse outcome.
Q. Did you testify in court in any of those cases?
A. Yes.
Q. In those cases in which you testified in court, did the Court recognize you as an expert in pathology?
A. Yes.
MS. STERNBERG: Your Honor, we tender Dr. Baergen as an expert in pathology and perinatal pathology pursuant to Federal Rule of Evidence 702.

MR. PANTOJA: No objection, your Honor.
THE COURT: The Doctor will be so recognized by the Court.
Doctor, may I ask you first, have you testified at any malpractice cases involving any of the doctors who are plaintiffs in this action?
THE WITNESS: Not that I'm aware of.
THE COURT: Do you know who all the plaintiffs are in this case?
THE WITNESS: Yes. I've read their names.
THE COURT: The cases did not involve the doctors in this case?
THE WITNESS: Not as far as I'm aware of.
THE COURT: All right.
Go ahead, Ms. Sternberg.
BY MS. STERNBERG:
Q. Dr. Baergen, are you receiving any compensation for your work in this matter?
A. No. Only reimbursement of expenses.
Q. Is the payment of your expenses contingent in any way on the outcome of this case?
A. No.
Q. You testified earlier that you are here to offer opinions on the advantages of an intact specimen for diagnosis of fetal anomalies or abnormalities; what is your opinion on that topic?

THE COURT: May I have that question, please?
(Record read)
THE COURT: Do you understand the question?
THE WITNESS: I believe so, sir.
THE COURT: You better. Go ahead.
THE WITNESS: I would say, in general, the more intact a specimen is the more likely you are able to diagnosis fetal anomalies. And the more anomalies and specific abnormalities that you can identify, the more likely you are to be able to make a diagnosis of what disease or disease process is affecting the fetus.
Q. Okay, let's break that down a little bit.
What do you mean by an intact specimen?
A. It is just generally what the words mean. An intact, completely intact specimen would be a specimen that's all in one piece that doesn't have any disruption; the skin is intact, it is not torn in any way.
Completely disrupted would mean that there are multiple pieces, the more disrupted the more pieces there are, the smaller they are, etc.
Q. And what makes up the specimen?
A. The specimen includes really the fetus, the fetal parts and the placenta, which is actually a fetal organ.
Q. What is a fetal anomaly?
A. An anomaly is just an abnormality of the fetus. Some

abnormality. It can be external or internal.
Q. What is fetal syndrome?
A. Well, a syndrome is usually considered to be a collection of specific abnormalities that are described multiple times. And so, since those certain set of, can be five or six or maybe even 10 different abnormalities when they occur together, this suggests, when it happens over and over again, it suggests that it is a particular disease process and thus would have the same cause or etiology.

That particular syndrome then could be further studied and determined, whether it's genetic syndrome and what type of inheritance it has and recurrence risk and so on.
Q. What method do pathologists use to diagnose fetal anomalies?
A. Well, the first method and probably the most important is the gross examination that I referred to earlier, which is evaluating the fetus and looking at each portion of the fetus and evaluating whether each of those parts are normal or abnormal to the naked eye.

The second part is the microscopic examination. After the gross examination is done particular sections are taken, pieces of tissue are submitted for microscopic examination, and additional information is obtained on microscopic examination.

Sometimes there is abnormalities visible grossly but not microscopically and sometimes they're visible

microscopically but not grossly. And those are the two main ones.

And then we often use --

THE COURT: Doctor, what do you mean by grossly?

THE WITNESS: Well, gross meaning to the naked eye. In other words, just looking at the specimen and examining the specimen without -- basically in contrast to looking under the microscope.
Q. You were discussing a third method?
A. Thank you.

The third is x-rays or radiographs, and this is useful in cases where there is abnormalities of the bone, bony abnormalities to further clarify what the specific abnormalities are.
Q. How do pathologists diagnose fetal syndromes?
A. Well, as I said before, a particular syndrome is a constellation of particular abnormalities. So, if you have enough of different abnormalities that would be recognizable as a syndrome, that's how you make the diagnosis.
Q. You have testified that there is an advantage in having an intact specimen for pathological examination, is that your opinion with respect to each of the methods of examination you have just discussed?
A. Yes.
Q. Why is having an intact specimen an advantage in a gross

examination?
A. Well, if -- you are looking for a particular exam -- I'm sorry, a particular abnormality in a particular part of the body. If you are looking at an abnormality that's in the chest and the chest is so disrupted that you can't recognize the different components, then you're not going to be able to identify that abnormality.
So, the most disrupted the specimen is the more likely you are to be able to diagnose gross abnormality.
Q. Is having an intact specimen an advantage in a microscopic examination?
A. In a microscopic examination -- first of all, in a disrupted specimen sometimes it's difficult to identify particular organs and you only take a small sampling of the tissue for microscopic examination.
So, sometimes if you can't identify particular organs with the naked eye, you can't submit sections of them so you may be missing that information. And if the organs themselves are disrupted, then that also limits certain abnormalities that you can see, the kind of tissue architecture seen under the microscope.
THE COURT: Does that vary with the age of the fetus?
THE WITNESS: I'm sorry. I don't quite understand, does what vary?
THE COURT: What are you saying, does it vary

depending upon how old the fetus is?
THE WITNESS: Well, I would say no, as far as the specimen being intact regardless of the age of the fetus, it will increase the chances of identifying abnormalities.
THE COURT: Doesn't make any difference if these organs haven't fully developed yet or not?
THE WITNESS: No, because if an organ is, there is organs that are not fully developed that are immature, they should be appropriate for that particular gestational age so there is a difference in what you look for and the normal features depending on the gestational age, but that's part of perinatal pathology, is knowing the difference between a kidney at 15 weeks and a kidney at 20 weeks. And so, by knowing what's normal you can tell what's abnormal.
So, for that in that way, it really doesn't make a difference what the age of the fetus is.
THE COURT: Can you still perform your work if the fetus is removed in pieces?
THE WITNESS: Well we always attempt to obtain --
THE COURT: Can it be done though?
THE WITNESS: I'm sorry?
THE COURT: Can it be done?
THE WITNESS: Not as successfully. Not as well.
THE COURT: Next question.
BY MS. STERNBERG::

Q. Why is having an intact specimen an advantage in an x-ray examination?
A. Well, if the bones are broken or disrupted, then you are going to lose the normal relationships and you are not going to be able to identify some of the bones. And if the joints are disarticulated or disconnected, then you won't be able to evaluate the joint.
So, depending, the more disrupted it is the less information that you are able to obtain.
Q. Do pathologists play any role in the testing that is used to diagnose fetal anomalies while the fetus is still in utero?
A. Well, the only involvement there is that specimens taken from fetal tissue, or fetal cells from amniocentesis and placental tissue from chorionic villus sampling --
THE COURT: What does all that mean?
THE WITNESS: Well, chorionic villi are components of the placenta, and "sampling" means you just take a sample of those villi.
So, it is done earlier in pregnancy than amniocentesis and I don't know the specifics of the exact procedure, but little fragments of the placenta are taken just like amniotic fluid is taken from amniocentesis. Those are both submitted to the cited genetics laboratory, which is usually in pathology, and those cells are then grown in culture and examined for chromosomal abnormalities.

MS. STERNBERG: May I inquire, your Honor?
THE COURT: Go right ahead.
Q. Is chorionic villi sampling also known as CVS?
A. Yes.
Q. Is it the case that the pathology of the analyzed specimens taken --
THE COURT: Both of you, please. The reporters have a very important job and if we don't get a transcript your time is wasted, Ms. Sternberg.
MS. STERNBERG: I understand and I agree. Thank you.
THE COURT: Thank you for agreeing. The Court appreciates it.
Q. Is it the case that pathologists analyze the specimens taken during amniocentesis and CVS in order to diagnose whether there are chromosomal anomalies?
A. Yes, that's generally done by pathologists.
Q. What fetal anomalies or syndromes can be diagnosed through amniocentesis?
A. Well, generally the only type of abnormalities that you can diagnose that way are chromosomal abnormalities, those in which there is an extra chromosome or a missing chromosome, which are really the minority of the different syndromes that you can have but those are generally the types of abnormalities you can diagnose with both amniocentesis and CVS.
Q. Is amniocentesis or CVS ever used to diagnose anything

other than chromosomal anomalies?
A. Well, since you have fetal genetic material in both cases, you can use that to do specific genetic testing if you want to look at a particular gene. You have to know specifically what disease you are looking for and there has to be enough molecular testing or genetic testing to be able to diagnose that.
So, say, for example, in the case of parents who carry genes for cystic fibrosis or Tay Sachs, tests for those specific things can be done on the tissue but you can't do screening for every known syndrome.
Q. Why is that?
A. First of all, we don't have that kind of testing for every syndrome and, secondly, it is just not practical because there is just so many different ones.
Q. Are there any downsides to CVS compared to amniocentesis?
A. Well, CVS takes tissue from the placenta and there is an entity called confined placental mosaicism, and what that means is there is a mosaicism that is confined to the placenta which means that there is a chromosomal abnormality that is in the placenta that's not in the baby, in the fetus, and sometimes there is an abnormality in the fetus that is not a chromosomal abnormality in the fetus that is not in the placenta. So, you can have false positives and false negatives because of that.
Q. Given the availability of amniocentesis and CVS, why is

pathological examination of the fetus ever necessary?
A. Well, in the cases of chromosomal abnormalities where you have a specific diagnosis by cytogenetic testing you don't need the pathology to confirm the diagnosis. But those are the minority of the syndromes and the minority of the cases.
For all the other cases, the only way that you can make the diagnosis unless, as I said before, you have a specific disease in mind, is to examine the fetus and look at all the different abnormalities and try to put it together into what syndrome it fits.
Q. Are you familiar with the use of ultrasound to diagnose fetal anomalies or syndrome while the fetus is still in utero?
A. Well, I am generally familiar with the procedure and certainly I am told by the obstetricians that particular anomalies were diagnosed by ultrasound and so on, but that really is in the field of obstetrics. And the specifics about what specific anomalies can be absolutely diagnosed and so on is really out of my area of expertise.
Q. Do you have any experience in assessing the accuracy of diagnoses of fetal anomalies or syndrome by ultrasound?
A. Well, what I can tell you is that usually when there is multiple anomalies, those are diagnosed most commonly by ultrasound and many times I am told by the obstetrician that the ultrasound examination revealed, and they'll list the different things that they saw in ultrasound, and sometimes it

will be something specific that they seem sure of and sometimes it will be a question of maybe this is there or not. And other times they'll say, well, there is an abnormality of the heart but they're not sure what it is.

And then when I examine the fetus sometimes I can confirm certain findings, sometimes I am unable to confirm or rule them out, but sometimes I find that their evaluation is not correct.

Q. So, why is pathological examination of the fetus ever necessary given the availability of ultrasound?

A. Because -- well, first of all, as I just got through saying, it's not always completely accurate.

And, secondly, it's an indirect method. It is an imaging method of the imaging the fetus in a certain plane and depends on a lot of exterior factors in the surrounding tissue, as well as the position of the fetus.

That's not going to ever be as good as direct examination by looking at the actual specimen and being able to see it in three dimensions and turn it every which way that you need to turn it and to take sections and look at it at it under the microscope.

Q. Can you give the Court some examples of fetal anomalies or syndromes where an intact specimen is particularly useful for pathological evaluation?

A. Well, congenital heart anomalies is one example. And all

congenital heart anomalies, in general, require, for diagnosis, that the heart, the great vessels coming to and from the heart and the lungs all be intact to be able to accurately diagnose them.

In certain specific abnormalities one example of total anomalous fetus return you have abnormal vessels that drain into the heart and sometimes those vessels come from under the diaphragm or the liver and therefore you need the heart, the lungs, the vessels, the diaphragm and the liver to be able to, all together, to be able to make that diagnosis.

Another example is the laterality syndrome.

THE COURT: Do you want to spell that, Doctor?

THE WITNESS: I'm not a very good speller but L-A-T-E-R-A-L-I-T-Y.

Most people have -- their organs are not symmetrical, in other words the left side of their body is not the same as the right, but in these syndromes the individuals have two, kind of two left sides of the body or two right sides.

So, for instance, if you have a left-sided syndrome you have the spleen on the left and so it would be duplicated so you have a spleen on the other side.

And also you get abnormalities of the heart. If you have a laterality of the heart that is right sided you have no spleen. And the only way you can make that diagnosis, for example, is to have an intact abdomen, etc., to be able to see

if the spleen is there.
Other things, specific syndromes like, that consist of a number of different anomalies like something called VATER, V-A-T-E-R, all capitalized, and that has, you know, heart defects, it has vertebral defects, it has real abnormality, tracheo-esophageal fistula and anal atresia. And if you don't have those things together you can't make the diagnosis.
Q. In your opinion, is it important to have an accurate diagnosis of fetal anomalies or syndromes?
A. Yes.
Q. Why?
A. Probably the most important aspect is trying to determine whether the syndrome is a sporadic problem or if it's inherited in some way, and this is important for the recurrence risk for the subsequent pregnancy and for people to know what kind of things are running in their families.
Usually what we do if we're able to make a diagnosis, we make the diagnosis of what the syndrome is and then genetic counselors will counsel the patient on what the recurrence risk is, based on previous experience with this particular syndrome.
Q. For a pathologist, what is the most important characteristic of a specimen for purposes of making an accurate diagnosis of a fetal anomaly or syndrome?
A. I would say having an intact specimen.
Q. What is the second most important characteristic of a

specimen for purposes of making an accurate diagnosis of fetal anomaly or syndrome?
A. I would say that the tissue is viable.
Q. What does that mean?
A. Meaning that the baby has not been dead in utero for a long period of time, which causes a number of postmortem changes that hinders examination.
Q. What period of time passes before those changes occur?
A. Well, very little changes occur within the first 12 hours or so. And then after that the changes are progressive such that when you get to 24 hours, there is significant degeneration and it is even worse at 48 hours and so on. And that's primarily because when the fetus dies in utero the fetus remains at body temperature, which is very high, and that causes an accelerated degeneration as opposed to if the baby had died outside and was basically sitting at room temperature.
Q. What is maceration?
A. Maceration is a change that occurs particularly in fetuses that have been retained in utero, and it's one of the postmortem changes I was referring to.
It is really kind of a softening of the tissue.
Q. And why is viability of the tissue important to your ability to diagnose fetal anomalies or syndromes?
A. Well, one of the things is that when you have maceration and there is what we call autolysis, a change that occurs

microscopically, then you lose a lot of detail and so there is a lot of information you are missing. And the more time has passed the more information that you are losing in the histologic details, the cells lose their -- you can't see their nuclei, you can't see the detail of the architecture of the organs.

The second thing is that when the external tissues that the skin and the, and actually the organs as well, they become softened, they become literally very mushy and they kind of disintegrate under touch. And when you try to separate the different tissues when you are trying to do the examination, they kind of fall apart and make examination very difficult.

Q. Did you say histologic before?

A. Yes.

Q. What is that?

A. That's just, that's a reference to looking under the microscope. In other words, the features that you see under the microscope is histologic features and the science of looking at tissues under the microscope is called histology. That's normal -- generally histology is used for normal tissue and pathology for abnormal tissue, but they're used somewhat interchangeably.

Q. What effect, if any, does the injection of a foreign substance into the amniotic fluid have on a pathological exam?

A. The only thing I --

MR. PANTOJA: Your Honor, objection. This is beyond the scope of her expert report.

THE COURT: Ms. Sternberg, show it to counsel.

MR. PANTOJA: On page 2 of her expert report, your Honor, she provides a statement of all opinions to be expressed and the basis and reasons therefore, and this is what it says: "Having an intact specimen is a decided advantage in the diagnosis of fetal anomaly when the specimen is disrupted as the case after D&E involving dismemberment can be very difficult to get information necessary to make a full and accurate diagnosis of fetal malformation and malformation syndromes."

Then it goes on to talk about the alleged benefits of intactness and it nowhere does it goes on to discuss what the effects are of the injection of chemicals into the amniotic sac.

MS. STERNBERG: Your Honor, I will withdraw the question.

THE COURT: All right.

MR. PANTOJA: Excuse me, your Honor. She also did not opine about the effects of fetal demise in utero with respect to the effect of that on the pathological examination after the termination of an abortion, and we ask your Honor to strike that testimony as well because that is clearly not in the report.

THE COURT: Okay.
MS. STERNBERG: Your Honor, all of this testimony was elicited at her deposition.
THE COURT: That isn't what counts, ma'am.
MR. PANTOJA: I think your Honor has --
THE COURT: Please, sir.
So, you knew that was not in the report but you sought to elicit it anyway, Ms. Sternberg?
MS. STERNBERG: Now, upon reading it I see that it is not in the report.
THE COURT: Motion is granted. And I would ask that you restrict your questions to the expert report.
MS. STERNBERG: Yes, your Honor.
Q. Dr. Baergen, you testified earlier that part of an intact specimen is the placenta?
THE COURT: Excuse me just a minute.
Counsel, you will have to get together with the reporter and make sure that portions that were testified to, since we have gone past that, which should be stricken. If you have a dispute I will rule on it but I grant the motion.
Go ahead, Ms. Sternberg. I'm sorry. Would you repeat the question?
MS. STERNBERG: Yes, your Honor.
Q. Dr. Baergen, you testified earlier that the placenta is part of the specimen when you referred to intact specimen, is

that correct?
A. Yes.
Q. Does an intact placenta aid in the diagnosis of fetal anomalies or syndromes?
MR. PANTOJA: Your Honor, once again, discussion of the placenta and how that aids in the pathological examination of the fetus is not mentioned at all in the expert report.
MS. STERNBERG: Your Honor, as Mr. Pantoja started to read to you earlier, the entire text of the expert report refers to intact specimen, and Dr. Baergen has just stated under oath that a specimen includes both the fetus and the placenta, which she says is part of the fetus.
THE COURT: I will allow it.
THE WITNESS: I'm sorry, could you repeat the question?
MS. STERNBERG: Yes.
Actually, Ms. Reporter, would you mind reading it back, if that's okay? If that's okay with your Honor.
THE COURT: Go right ahead.
(Record read)
THE WITNESS: Yes.
Q. Why?
A. Well, sometimes the problems with the fetus or the abnormalities in the fetus are caused by the placenta, and an example I can give you is a case in which a fetus was very

small and the limbs were extremely short and it was thought that the fetus had a form of skeletal dysplasia or dwarfism.
An examination of the long bones and the x-rays were not very helpful in trying to determine the cause but when the placenta was examined, one could see that there was abnormalities in the vessel supplying the placenta and that this was the cause of the abnormal growth of the baby and that this actually was due to an underlying maternal disorder. And it turned out that the mother had a coagulopathy and abnormalities in coagulation, that this was the cause of the placental abnormalities which caused the baby to have shortened limbs and to appear to have skeletal dysplasia when that was not the case.
THE COURT: Does that mean that the diagnosis prior to the abortion was an error and you were able to prove that through your investigation?
THE WITNESS: Actually this was a baby that was a recent fetal demise and was not an abortion specimen.
THE COURT: Does that happen, though, where there is the diagnosis that after the abortion you prove that the diagnosis is incorrect? Does that happen sometimes?
THE WITNESS: Well, sometimes there --
THE COURT: It is a simple question, Doctor; does it happen?
THE WITNESS: Well, not the way that you stated it.

THE COURT: Does it happen on occasion that a diagnosis is made on the fetus which, after the abortion, proves to be incorrect?
THE WITNESS: Not a diagnosis, no.
THE COURT: Well, what word would you use, Doctor?
THE WITNESS: Well, I'm sorry. I don't mean to be difficult, but diagnosis to me means the diagnosis of a syndrome and those kind of things are usually not given.
Sometimes the diagnosis of a specific anomaly is made and found to be incorrect. Yes, that happens.
THE COURT: And the abortion was performed for the belief that there was this anomaly, right?
THE WITNESS: Well, I don't have any information on why abortions are performed or whether --
THE COURT: You don't sit in on it but you know, I take it afterwards, that you were told that it was believed there was a fetal anomaly, is that correct?
THE WITNESS: I am told that there was a potential fetal anomaly but not why any particular procedure was performed.
THE COURT: Was it your belief that that's why the abortion was done?
THE WITNESS: In the cases when that happens, I don't have that knowledge.
THE COURT: But you have heard it?

THE WITNESS: Not in any particular --
THE COURT: It doesn't come in that context, is that what you are saying?
THE WITNESS: No, I haven't heard somebody say that about that case, about that particular case to me, that there was an anomaly that they thought was there and I said wasn't there and that they did the abortion for that purpose. I have never been -- had that.
THE COURT: You never asked that question?
THE WITNESS: No, I usually don't. That's kind of out of my area.
THE COURT: You have heard that it was believed that that condition existed, correct?
THE WITNESS: Yes.
THE COURT: And after your examination was proved it didn't exist, is that correct?
THE WITNESS: Correct.
THE COURT: Next question.
BY MS. STERNBERG:
Q. Has it happened, Dr. Baergen, that other conditions have existed, other than the conditions that were suggested by prior testing?
A. There are many cases in which the specific anomalies are listed and other anomalies that were not listed are found, and there are certain limitation to ultrasound examination so we

often find things that they were not aware of.
THE COURT: Are these anomalies that a person could live with if the baby was carried to term?
THE WITNESS: Which anomalies?
THE COURT: I don't know, Doctor, you are using them. You are giving me a hypothetical and you say sometimes they're found to have them that were not listed. I'm asking you whether or not -- anomaly is a very broad term, is it not?
THE WITNESS: That's why it is very difficult to answer.
I mean, in some cases usually it's not --
THE COURT: You can have an anomaly that's minor but it's not normal, right?
THE WITNESS: Right.
THE COURT: And you can live with it, right?
THE WITNESS: If it's a minor abnormality, yes.
THE COURT: Thank you, Doctor.
Next question.
BY MS. STERNBERG:
Q. In the example you were giving earlier, Dr. Baergen, about the evaluation of the placenta that explained the short limb issue with the fetus, what happened, if anything, in future pregnancies?
A. Well, she was treated with heparin for thrombophilia, or abnormal coagulation, and she had a normal baby in the

subsequent pregnancy.
Q. In your experience does an intact fetus correlate to an intact placenta?
A. In general, yes.
MS. STERNBERG: No further questions, your Honor.
THE COURT: Cross examination.
MR. PANTOJA: Your Honor, Joseph Pantoja for the government?
THE COURT: Go right ahead, sir. You may inquire.
CROSS EXAMINATION
BY MR. PANTOJA:
Q. Good morning, Dr. Baergen.
A. Good morning.
Q. You are not offering an opinion today with respect to the abortion procedure called intact dilation and evacuation, or intact D&E, correct?
A. Correct.
Q. In fact, you have no experience with intact D&E, right?
A. Well, I don't -- I will say that I don't really even know what it is so that's correct. I don't have any experience with it.
Q. You have never done one, right?
A. That's correct.
Q. You have never seen one performed, right?
A. I have been in the operating room during abortion

procedures when handling of tissue was required and they may or may not have been doing that procedure. I don't know because I wasn't really paying attention. But I might have seen one without really realizing it.
Q. The only thing you know about what the intact D&E procedure entails is what you have read in the statute at issue in this litigation, the Partial-Birth Abortion Ban Act of 2003, right?
A. Ms. Sternberg showed me the statute and I read it, if that's the one you are referring to.
And that is all I know about it.
Q. And you have no knowledge as to how the intact D&E procedure compares to the traditional D&E procedure, right?
A. Right.
Q. And it has been about 20 years since you have observed what actually goes on during an abortion of any kind, isn't that right?
A. Well, as I just told you, I have been in OR during abortion procedures and so I have observed them to some extent, but I have not been actively involved, only in a few cases, you know, 20 years ago.
Q. But in those cases in which you were in the operating room, you did not observe the procedure, you were not paying attention to the procedure being performed?
A. Right. I had other things to do.
Q. Doctor, in your view, completely intact fetuses are

preferable for the pathological work you perform, right?
A. Correct.
Q. When you say completely intact, you mean a pristine specimen, one where the skin is intact with no breaks, is that right?
A. That would be the definition of completely intact, yes.
Q. But you do not have an understanding as to what the word "intact" means when it is used in the phrase "intact D&E," correct?
A. I told you, I don't know what that procedure entails so, no, I don't know what that means.
Q. So you would agree then that your use of the term intact for pathological purposes is not necessarily the same as the use of the word intact in intact D&E?
A. It's not necessarily, yes.
Q. Doctor, when an aborted fetus is forwarded to you for pathological assessment, you routinely do not know what abortion procedure was used to terminate that pregnancy, correct?
A. That's correct. I don't know that nor do I know if it was spontaneously aborted either.
Q. And in your pathology work for fetal anomalies, less than 30 percent of the fetuses you receive were completely intact, right?
A. Yes.

Q. And you do not know what abortion procedure was used to terminate the pregnancies that resulted in those fetuses, correct?
A. Correct.
In most cases.
Q. And you don't know what abortion procedure was used in those cases where you received an intact placenta?
A. Yes, that's correct.
Q. And you don't know whether or not a traditional D&E may result in an intact placenta, correct?
A. Correct.
Q. And you are not aware of any studies or literature regarding the issue of the method of abortion and its impact on the ability to diagnose fetal anomalies, right?
A. Could you repeat the question?
Q. You are not aware of any --
THE COURT: Ms. Reporter, why don't you repeat it.
(Record read)
THE WITNESS: I'm not aware of anything specific on that issue.
BY MR. PANTOJA:
Q. Doctor, generally speaking, all parts of the fetus are important for every pathological examination, even though some parts of the fetus may be more important than others in the case of certain anomalies, correct?

A. Yes.
Q. An intact brain would assist you in diagnosis of certain fetal anomalies, right?
A. Anomalies in which there was an abnormality in the brain, yes.
Q. Such as Arnold-Chiai malformation?
A. Yes.
Q. And agenesis of corpus callosum?
A. Yes.
Q. And Dandy-Walker syndrome?
A. Yes.
Q. And Holoprosencephaly?
THE COURT: Slowly. Perhaps spell it for the reporter?
Q. H-O-L-O-P-R-O-S-E-N-C-E-P-H-A-L-Y.
A. Well, Holoprosencephaly is usually associated with marked abnormalities in the midface and so in that case the brain is not nearly as important as it is in the previous cases you mentioned.
Q. But it is important in that situation to some extent?
A. Some extent, yes.
Q. And cerebral ventriculomegaly?
A. Yes.
Q. And cisterna magna cyst?
A. Yes.

Q. And porencephalic cyst?
A. Yes.
Q. And for you to diagnose certain fetal anomalies it would assist you to have the intact brain in the cranium of the fetus, right?
A. In those cases where the brain abnormality is part of the syndrome which is certainly not the majority of cases.
(Continued next page)

Q. So your answer is yes?
A. I think so.
THE COURT: Not "I think." If you want the question read -- we don't have much of a transcript if you just think. You do or you don't.
THE WITNESS: I guess I have to have the question read back to me.
(Question read)
A. Yes.
Q. Doctor, if a suction catheter had been inserted into the base of the skull and had been used to evacuate the contents of skull prior your receiving the fetus, that would impair your ability to use the remaining fetus for diagnostic purposes, correct?
A. No.
Q. You testified at a deposition in this case on January 23, 2004, right, Doctor?
A. I don't remember the date, but yes.
Q. And you testified under oath?
A. Yes.
MR. PANTOJA: Your Honor, may I approach the witness?
THE COURT: Certainly.
Q. Doctor, I have handed you a copy of your deposition testimony in this case. Directing your attention to page 69/line 1:

"Q. If a suction catheter had been inserted into the opening of the cranium and had been used to evacuate the contents of skull prior to you receiving your specimen, is it safe to say that, therefore, it would make it more difficult to use the remaining fetus to diagnose fetal anomalies?
"A. Well, it would be more difficult to diagnose brain anomalies, because, again, the brain would not be intact."
Were you asked that question and did you give that answer at your deposition in this case?
A. Yes. Unfortunately, I guess I didn't really answer the question.
THE COURT: But your answer is yes, you were asked the question and you gave that answer on that date?
THE WITNESS: Yes. That's right.
THE COURT: Next question.
Q. Is it also true, Doctor, that an intact fetal face would be useful for diagnosing certain fetal anomalies?
A. Yes. Again, if the anomalies are involving the face, then you would want the face to be intact to diagnose those abnormalities.
Q. Isn't it true, their, that there are many fetal anomalies that have dysmorphic, or abnormal, features for which looking at the fetal the face would be useful in making a diagnosis?
A. Yes.
Q. Osteogenesis imperfecta is one anomaly where looking at the

fetal face would assist in diagnosis, correct?
A. You don't need the face to diagnose osteogenesis imperfecta, because that is a skeletal dysplasia, and actually x-rays and the evaluation of the limbs would be more important than the face.
THE COURT: Would it be helpful, though, Doctor?
THE WITNESS: It would be an additional finding that would be consistent with the diagnosis, but it would not be necessary at all.
Q. Directing your attention to page 46 of your deposition testimony, line 8:
"Q. Certainly I'm not asking you to give me all the anomalies with the syndromes off the top of your head. What I'm asking for is an example of an anomaly where looking at the fetal face would assist in diagnosing that syndrome or anomaly.
"A. Osteogenesis imperfecta."
Were you asked that question and did you give that answer at your deposition?
A. Yes.
Q. An encephaly is another one, right?
A. Another one?
Q. Another anomaly for which looking at the fetal face would assist in diagnosis?
A. Yes. It is not primarily made that way, but there are some facial abnormalities.

Q. Where the contents of the fetal skull have been evacuated, Doctor, that might have an impact upon the facial structure of the fetus, right?
A. It might.
Q. In order to diagnose encephalocele, you would prefer that the back of the head be intact, right?
A. Encephalocele, it is helpful to have the back of the neck and the back of the head intact for that diagnosis, yes.
Q. The spinal column starts right at the base of the skull, isn't that right?
A. Yes, the first vertebral process really articulates with the skull.
Q. And spina bifida is an example of a spinal column anomaly, right?
A. Yes.
Q. If you wanted to diagnose a spinal column anomaly such as spina bifida at the base of the skull, you would prefer to have that part of the fetus to be intact, right?
A. Usually, spina bifida is not at the base of the skull, so you don't necessarily need the head and the skull intact to be able to make that determination.
Q. But in those situations where a spinal anomaly is up at the top of the spinal column, at the base of the skull, you would prefer that that part of the fetus be intact, the back of the head and the base of the skull?

A. As I said, I would always prefer it be intact, so yes.
Q. It is true, isn't it, that fetuses aborted using the labor induction method of abortion are often completely intact?
A. Again, it is difficult for me to answer that question, because I don't always know. But generally speaking that is probably true.
Q. You do not know whether in an intact D&E the fetus has its skull crushed or punctured, do you?
A. When I receive a specimen, sometimes the skull is collapsed and sometimes there is an obvious incision in the back of the neck. That is all I can tell you, is what I receive. I can't tell you what they did or how they did it.
Q. My question, Dr. Baergen, is in an intact D&E, you don't know whether in an intact D&E the fetus has its skull crushed or punctured, do you?
A. Are you asking about the specimen?
Q. No.
A. I mean about the procedure?
Q. Yes. I am asking you whether you know whether an intact D&E entails the crushing or the puncturing of the fetal skull.
A. I don't know.
Q. You do not know whether in an intact D&E the cranial contents of the fetal skull are suctioned or otherwise removed, do you?
A. I don't know what is done in a particular procedure, no.

Q. Prior to your receiving a fetal specimen from a terminated pregnancy, the fetal specimen is supposed to be sent to a cytogenetics lab, right, Doctor?
A. No, not necessarily.
Q. The purpose of sending a fetal specimen to a cytogenetics lab is to conduct certain tests for pathological purposes, right?
A. To determine cytogenetic abnormalities.
THE COURT: What does that mean, Doctor?
THE WITNESS: Chromosomal anomalies, extra chromosomes, missing chromosomes, that sort of thing.
Q. At the cytogenetics lab a tissue sample is extracted from the fetal specimen in order to perform a chromosomal analysis, right?
A. It depends on which lab you are talking about, because the procedure is different. I can tell you the way we do it in our lab, if you like, but it isn't the same everywhere.
Q. In your cytogenetics lab, isn't it true that a sample of fetal tissue is removed for the purpose of chromosomal analysis?
A. If cytogenetics is requested, and it is not requested on every case nor is it necessary in every case, but in the cases in which it is requested, at my institution the whole specimen is sent to the cytogenetics laboratory, and they take a portion of fetal tissue to grow and then submit the specimen directly

to us in surgical pathology.
Q. Only a tissue sample, a few cells, is needed to conduct a chromosomal analysis, right?
A. No. You need more than a few cells, because a lot of the cells don't grow. So usually you need more than a few cells.
Q. But all you need is a tissue sample, you don't need the entire fetus, is that correct?
A. For cytogenetic analysis, no, you do not.
Q. Fetal tissue can also be subjected to a microscopic evaluation, right?
A. Yes. That is part of our examination of the fetus, microscopic examination.
Q. There are certain fetal anomalies that can be diagnosed by ultrasound, isn't that right?
A. I think I mentioned that before. There are a number of anomalies that are diagnosed by ultrasound, and sometimes they are correct and sometimes not, and sometimes they have a differential: They think there is an abnormality but they don't have a specific diagnosis.
Q. An encephaly can be diagnosed by ultrasound, isn't that right true?
A. I have seen that diagnosed by ultrasound. I don't have direct knowledge of how to do that, but I have been told that that diagnosis was made on ultrasound.
Q. And there are other fetal anomalies that can be diagnosed

by chorionic villus sampling based on a sample of fetal tissue, right?
A. Only chromosomal.
THE COURT: What does that mean?
THE WITNESS: Abnormalities in the chromosomes, extra or missing chromosomes.
Q. And there are fetal anomalies that can be diagnosed using an amniocentesis, right?
A. That is the same. You are also doing cytogenetics in that case and you are growing the cells, and that is primarily for the diagnosis of abnormalities in the chromosomes, missing or extra chromosomes.
Q. Down's syndrome is an example of a fetal anomaly that can be diagnosed using amniocentesis, right?
A. Yes.
Q. Abnormalities in chromosome number, those are all aneuploidies, is that right?
A. Yes.
Q. Examples of aneuploides include trisomy 13 and trisomy 18, right?
A. Yes.
Q. For the category of anomalies knows as aneuploides, a diagnosis can be made using chromosomal analysis, right?
A. Usually, yes.
Q. And by using amniocentesis, right?

A. Yes.
Q. And by using chorionic villus sampling?
A. Usually, yes.
THE COURT: What was your last phrase?
MR. PANTOJA: Chorionic villus sampling.
THE COURT: What is that, Doctor?
THE WITNESS: That is when you take a portion of the placental tissue early in gestation and grow it up. Since the placenta is really a fetal organ consisting of fetal tissue, then those fetal cells that are grown in culture, they are the same thing. And you look at the chromosomes to see if they are the correct number.
THE COURT: Thank you, Doctor.
Q. 5p- syndrome where the short arm of chromosome 5 is missing, that too can be diagnosed using chromosomal analysis, right?
A. Yes.
Q. For the fetal anomalies known as translocations, which involve abnormalities in the chromosome structure, they can be diagnosed using amniocentesis, right?
A. Some can. Not all of them. Some certainly can.
Q. They can also be diagnosed using chorionic villus sampling?
A. Yes. My answer is the same, because those two procedures both do the same thing. They obtain samples of cells and grow them in culture to look for chromosomal abnormalities.

Q. So it would be fair to say, wouldn't it, Doctor, that chromosomal analysis, chorionic villus sampling, amniocentesis, and ultrasound all permit the diagnosis of some fetal anomalies without the need for an intact fetus?
A. The only ones that you can actually I think make a diagnosis on is really the chromosomal abnormalities, which are a minority of the total syndromes. Usually ultrasound may be able to diagnose specific abnormalities, but usually not a whole syndrome.
Q. So your answer is yes?
A. Well, not exactly.
Q. Can you diagnose fetal anomalies using chromosomal analysis, chorionic villus sample, amniocentesis, and ultrasound without the need for an intact fetus?
A. Some chromosomal abnormalities and some fetal anomalies can be diagnosed using those methods.
Q. Doctor, at the point at which you become involved for a pathological assessment, the fetus is already dead, isn't that right?
A. Yes.
Q. Which means that the decision to terminate the fetus has already been made by the time the fetus is sent to you, isn't that right?
A. All I know is that I get the specimen. As you said, it is not alive at the time that I get it. Whether that was a

spontaneous death or there was a procedure done, I am not privy to that information.
Q. So it is true, isn't it, that you were not involved in the decision to terminate the fetuses you received for a pathological assessment?
A. If there was a termination, I am not involved in it, in a decision to terminate.
MR. PANTOJA: Thank you, Doctor. I have no further questions.
THE COURT: Any redirect, Ms. Sternberg?
MS. STERNBERG: Yes, your Honor. Just one moment, if I may.
REDIRECT EXAMINATION
BY MS. STERNBERG:
Q. Doctor Baergen, how many fetal anomalies exist overall?
A. Thousands and thousands.
Q. Mr. Pantoja asked you about certain anomalies that you can diagnose with amniocentesis or CVS, do you recall that?
A. Yes.
Q. Can you give the Court some estimation of what percentage of anomalies those are among all the anomalies that exist overall?
A. I couldn't give you an exact percentage, but most of the chromosomal anomalies actually lead to spontaneous abortions in the first trimester. Some of them do continue into the second

trimester. But of all the fetal anomalies and syndromes all put together, they certainly consist of a minority. I can't give you an exact number.
Q. Mr. Pantoja also asked you about a number of brain anomalies for which you said an intact brain would be helpful in diagnosis. Do you recall that testimony?
A. Yes.
Q. Can you give the Court some estimation of what percentage of anomalies overall those anomalies make up.
A. Again, if you take the anomalies where the brain is the only anomalous organ or is the major anomaly, those are certainly the minority of cases.
Q. When the fetus is disrupted, Dr. Baergen, are you more likely to find a disrupted placenta as well?
A. Yes.
Q. When the contents of the fetal skull have been evacuated, is the fetal face usually affected?
A. Not usually.
Q. Are there any disadvantages to fetal specimens that result from an induction abortion?
A. If there is an induction and the fetus dies in utero and is retained for a period of time, then that can lead to degenerative changes, autolytic change and maceration, that hamper interpretation.
MS. STERNBERG: Thank you. No further questions.

THE COURT: Any recross?
MR. PANTOJA: Just one moment, your Honor.
THE COURT: Surely.
RECROSS-EXAMINATION
BY MR. PANTOJA:
Q. Dr. Baergen, with respect to the fetuses that you received for pathological assessment, you don't know which of those fetuses had been terminated using the labor induction method, do you?
A. Generally, I am not told.
Q. When you receive a fetus in which the tissue has been macerated due to it having died for at least 24 hours, etc., you don't know what abortion procedure had been used to arrive at that fetus as well, do you?
MS. STERNBERG: Objection, your Honor.
THE COURT: What is the objection?
MS. STERNBERG: In his question he incorporated a fact that was not in evidence.
THE COURT: Overruled.
A. I'm sorry. Could you repeat the question.
(Question read)
A. I only know that the fetus has died in utero. I don't know what procedure has been used or not used.
Q. In fact, you don't even know if the fetus that you received was the result of an abortion, do you?

A. As I said, I don't know whether it was a spontaneous delivery, induction, abortion. I don't have any specific knowledge of that usually.
MR. PANTOJA: Thank you, Doctor. No further questions.
THE COURT: Thank you, Doctor. You may step down.
(Witness excused)
THE COURT: Mr. Hut, do you want to recall Dr. Frederiksen?
MR. HUT: Yes, your Honor, and again to be examined for the plaintiffs by Ms. Chaiten.
THE COURT: Very well.
MS. CHAITEN: Your Honor, Dr. Frederiksen has been waiting outside the courtroom, so somebody just went to get her.
THE COURT: Fine.
MARILYNN C. FREDERIKSEN, resumed
MS. CHAITEN: Your Honor, may I approach to make sure that the witness's binder remains at the witness stand?
THE COURT: Surely.
THE CLERK: The witness is on the stand already.
THE COURT: You may inquire.
MS. CHAITEN: Thank you, your Honor.
DIRECT EXAMINATION (continued)
BY MS. CHAITEN:

Q. Doctor Frederiksen, yesterday, when we were speaking, when you were testifying, you mentioned a patient with a prior uterine scar. What procedure would you want to do for a woman with a uterine scar?
A. A D&E or intact variation thereof.
Q. Doctor, is there ever a clinical reason that you would choose a dismemberment procedure for a particular patient as opposed to trying to remove the fetus as intact as possible?
A. No. The specific clinical situations are usually that an intact variation of a D&E is safer. There may be a rare case where you would have a conjoined twin where dismemberment wouldn't be necessary to deliver the fetus, but even in that situation you would want to deliver the fetus as intact as possible.
Q. Doctor, if the fetal head gets stuck in the cervix in a second trimester D&E, is it possible for the fetal body past the level of the navel to be outside the body of the woman?
A. Yes.
Q. How does that work?
A. There is a holder on the cervix, I usually use a ring forcep for this, and the traction on the uterus may deliver the cervix to the level of the entrance to the vagina. Moreover, you actually can have a particular patient with a prolapse of the uterus undergoing a procedure and her cervix can actually be outside of the body.

Q. Doctor, do you do anything different when dilating for an intact approach to D&E than for any other D&E?
A. No, I do not.
Q. Doctor, have you ever injured a patient in the process of using scissors to make an incision in the base of the fetal head during an intact D&E?
A. No, I have not.
Q. Are you aware of any other physicians who have?
A. No.
Q. Is it always necessary to make an incision at the base of the fetal head to facilitate delivery in an intact D&E?
A. No, it is not.
Q. Why not?
A. In certain circumstances it is easier to just use grasping forceps and deliver the head through the cervix.
Q. Dr. Frederiksen --
THE COURT: Excuse me. Grasping forceps, does that mean you crush the skull?
THE WITNESS: You compress the skull, yes.
THE COURT: You crush it, right?
THE WITNESS: Yes.
THE COURT: Yesterday you mentioned sometimes you use your finger, right, rather than using scissors?
THE WITNESS: No, that is not my testimony.
THE COURT: Isn't that what you said?

THE WITNESS: No, that is not. I said the scissors would be important to make an incision at the base of the skull, but I don't use suction. I use my finger to disrupt the contents of the cranial cavity, to thereby collapse the skull and allow delivery of the fetus.
THE COURT: So you use your finger to get the contents of the skull out rather than sucking the contents of the skull out, is that correct?
THE WITNESS: Yes.
THE COURT: Next question.
Q. Do you actually remove the contents of the skull, Doctor?
A. Not necessarily.
Q. Dr. Frederiksen, you testified yesterday about the general safety advantages of an intact to D&E. Do you have an opinion regarding whether an intact approach to D&E offers particular safety advantages for women with certain medical conditions?
A. I do.
Q. What is that opinion?
A. Women with certain medical conditions are sometimes better served by intact D&E than any other method of intact termination because the fetus comes out as intact as possible with less lacerations to the cervix and less chance of prolonged procedure, hemorrhage, or of tissue left within the uterus, thereby providing a nidus for infection.
Q. Can you give some examples of particular medical conditions

for which an intact D&E would offer additional safety advantages?
A. Acute fatty liver of pregnancy, sepsis, where you have an unstable patient and significant infection within the uterus. Those are two that come to mind.
Q. Let's talk first about sepsis. Why would an intact approach to D&E offer particular advantages for a woman at risk for sepsis?
A. A patient who is septic, and the particular circumstances is not only that there is chorioamnionitis, or an infection in the uterus, but there is infection in the uterus, she can be hemodynamically unstable or in shock with low blood pressure, high pulse, and potential of metabolic acidosis injuring the lungs.
THE COURT: Doctor, going back to hemo, what was the term?
THE WITNESS: Hemodynamic.
THE COURT: Do you want to define these terms? You get talking in very technical terms. We aren't going to understand it.
THE WITNESS: Hemodynamics is the function of the cardiovascular system that maintains pulse and blood pressure. In a patient in septic shock, you have very, very low blood pressure and a very high pulse. That lack of cardiac output decreases blood to the kidneys, to the lungs, and to other

maternal tissues. In that situation, you can have the development of metabolic acidosis.
THE COURT: What is that?
THE WITNESS: That is a change in pH.
THE COURT: What is that?
THE WITNESS: The acid/base balance. Is that sufficient?
THE COURT: What does that mean?
THE WITNESS: Acid/base is the amount of acid or base that is in the maternal bloodstream. It is usually kept in a very, very tight range physiologically. When you do not have adequate profusion of maternal tissues, the maternal tissues continue to make acid and waste products and they cannot be gotten rid of by the normal physiologic processes. Therefore, you get the development of more acids in the bloodstream.
With that, you can also develop what is called disseminated intravascular coagulation. That is a process by which you consume the clotting factors in the bloodstream as well as is the platelets. Platelets are small, subcellular elements of the clotting system which are usually the first mechanism by which the body stops blood loss in capillaries or in vessels.
In a situation with metabolic acidosis, you also have the development of disseminated intravascular coagulation, a consuming of the clotting mechanism. Therefore, the patient is

at increased risk for hemorrhage.
When you have a patient who is at increased risk for a hemorrhage, an intact D&E would be the optimal way to empty the uterus, because you would decrease the chances that the cervix would be lacerated during the process of delivery of the fetus. You also decrease the risk of hemorrhage, and hemorrhage in the second trimester is the highest cause of complications.
Q. Does it affect the procedure time, Doctor?
A. Procedure times for second trimester terminations with an intact or near intact delivery of the fetus are actually shorter.
Q. Than for a procedure with more dismemberment?
A. That's correct.
Q. Could you do an induction for such a patient who is at risk for sepsis?
A. An induction is possible, but, again, we are taking the patient through a riskier procedure and a longer procedure.
THE COURT: Longer for you, too, isn't it, Doctor?
THE WITNESS: Yes. But my focus is really on getting the patient delivered in a situation where she has the potential of multiorgan system failure and death.
THE COURT: But it is for a time of yours, which means less time for other patients, right?
THE WITNESS: If I have a patient in septic shock, I don't have the ability to take care of any other patient while

I am taking care of that patient.
THE COURT: But also, if you do this procedure rather than induction, it takes more of your time, therefore you can devote less time to other patients, correct?
THE WITNESS: Actually, an induction may not take as much time, because the induction process has actually begun and the whole length of time that the patient is undergoing induction I may be doing other things.
Q. Doctor, you said that if you have a patient in septic shock, you are not treating other patients. Is that regardless of what type of procedure you are using the terminate the pregnancy?
A. Yes.
Q. You also mentioned something called acute fatty liver of pregnancy, is that correct?
A. Yes.
Q. What is that?
A. Acute fatty liver of pregnancy is caused by the fetus having an inborn error of metabolism of long-change fatty acids. Long-chain fatty acids were the structural molecules by which many of our cell membranes and other fats are stored within the body. If the fetus cannot metabolize long-chain fatty acids, they can accumulate in the meantime and be then transferred to the maternal cardiovascular system for excretion. In acute fatty liver pregnancy, the biopsy of a

liver will show that there are lengths of fatty acids within the liver deposits and they are really coming from the fetus.
Q. Whose liver are you referring to?
A. I'm talking about the mother's, because that is the person who has acute fatty liver of pregnancy.
Q. So it is something that comes from the fetus that makes the pregnant woman ill?
A. Yes. The fetus and the placenta. Because the placenta has the same genetic endowment as the fetus, thereby it is the placenta that probably does not metabolize long-chain fatty acids in a normal fashion, giving increased levels of long-chain fatty acids to the mother, which she also cannot clear.
Q. What is the result of her inability to clear those long-chain fatty acids?
A. She develops hepatic failure or liver failure.
Q. Why would an intact approach to D&E offer particular advantages for a woman suffering from acute fatty liver of pregnancy?
A. These patients can be very sick. They can develop not only liver failure, but because of a liver failure they can develop renal failure or kidney failure. In that situation the liver is the principal place of production of all of the clotting factors that I mentioned earlier.
When the liver is not functioning, the patient then has less proteins within their bloodstream to clot blood. They

can also, again, consume platelets and be in a situation where they are in disseminating intravascular coagulation or with a very low platelet count, as well as low concentrations of the clotting proteins within the bloodstream.
Q. Could you do an induction for such a patient?
A. Yes. But, again, it is long. And the patients, because they are very, very sick, a longer procedure actually presents an increase risk for continued renal failure as well.
THE COURT: Have some women gone to full term with that condition?
THE WITNESS: Yes. It can develop over an acute period of time. It can be in the second trimester or in the third trimester. But there is really no therapy other than ending the pregnancy.
THE COURT: But some have gone to full term and delivered the baby?
THE WITNESS: Not after they develop acute fatty liver pregnancy. They are developing acute fatty liver pregnancy in the third trimester, and if they develop at that point, we can deliver the fetus in a safe manner and treat both mother and baby.
THE COURT: But it could be life threatening then, too, if it gets to that stage, correct?
THE WITNESS: Yes. It is a matter of when it presents.

THE COURT: Next question.
Q. Doctor, are any of the conditions you have mentioned ones that could lead to the need for termination on an emergency basis?
A. Yes.
Q. How would you achieve adequate dilation on an emergency basis in order to perform a D&E, including the intact variation?
A. We can use laminaria and misoprostol.
Q. But you wouldn't have the ability to do that over a 24-hour period, is that correct?
A. You can start an induction and have the patient develop acute deterioration. I have been in situations where particular patients have had an induction begun and it has taken 24 or 36 hours, and during that process they have developed -- I use a large term -- hemodynamic instability or septic shock. At that point we usually intervene to end the process as quickly as possible, because it is life-threatening to the mother.
Q. What if it is a situation where you are not attempting to convert from an induction, you have a patient who presents with a particular medical condition who needs to terminate the pregnancy on an emergency basis. How would you go about achieving adequate dilation?
A. It would depend upon the gestational age. In a hospital

situation we have the ability to add laminaria and treat the mother with vaginal misoprostol alternatively -- alternatingly, and achieve enough dilatation so that we can on a short period of time -- by short, I mean less than it would take to do an induction -- get the patient adequately dilated and allow for delivery of the fetus.
Q. Doctor, can one take steps to assure fetal demise prior to initiating a D&E in the second trimester of pregnancy?
A. Yes.
Q. How would one do that?
A. The mechanism by which you assure fetal demise is an intracardiac injection of either potassium chloride or digoxin. Potassium chloride is a naturally occurring salt that in high concentrations causes a cardiac arrest or cardiac arrhythmia and fetal death. Digoxin is a chronotropic and inotropic agent derived from foxglove.
THE COURT: What does that all mean, Doctor?
THE WITNESS: The drug?
THE COURT: Yes.
THE WITNESS: Digoxin is a drug which is derived from foxglove.
Q. What is foxglove?
A. Foxglove is a common plant. It is a biennial plant which has been used over a long period of time for the treatment of cardiac failure.

Q. Have you ever injected KCl or digoxin into the fetal heart before beginning a pregnancy termination in the second trimester?
A. Yes, I have.
Q. How do you determine which agent you will use, KCl or digoxin?
A. It is usually whatever is available.
Q. So you use them interchangeably?
A. When you are doing the intracardiac procedure, yes.
Q. Can a physician effect fetal demise by injecting KCl or digoxin anywhere other than in the fetal heart?
A. You can't guarantee the process.
Q. Why not?
A. I have been unable in certain cases to actually put a needle into the heart for technical reasons or because the mother is obese or the fetus is in a particularly difficult position to gain access to the heart. When you put these agents not in the heart or near the heart, you can't guarantee fetal death.
Q. Has it ever happened that you have attempted to inject a feticidal agent into the fetal heart but failed to do so and demise failed to occur?
A. Yes.
Q. Can you describe that for us, please.
A. It was a patient that had a particular body ambitus plus a

fetus which was very difficult to visualize ultrasonically, by ultrasound. Technically, we couldn't get the needle into the heart. We chose to put digoxin into the muscle mass of the fetus. The fetus still had a heartbeat the next day.
Q. Do you routinely inject KCl or digoxin into the fetal heart before a second trimester termination?
A. No, I do not.
Q. Do you ever?
A. When we are doing induction procedures, I do, because there is medical benefit. There is a body of information on the use of misoprostol, that misoprostol, used in the face of a dead fetus, actually facilitates delivery, and the induction interval from the beginning of the use of misoprostol until delivery of the fetus is shorter.
Q. What about in the context of D&E? Do you do intracardiac injections to effect fetal demise prior to D&E's?
A. No.
Q. Why not?
A. There is no medical benefit.
Q. Under what circumstances might you do an intracardiac injection to effect demise before a D&E?
A. If the patient requested it.
Q. Doctor, you have testified about a couple of situations where it would be difficult or impossible to achieve an intracardiac injection, such as an obese patient or positioning

of the fetus. Are there any other situations where it would be either difficult or impossible to achieve an intracardiac injection?
A. When you have loss of amniotic fluid, you don't have an interface between the fetus and the amniotic fluid, you can just be compressed with maternal tissue so that you may not be able to visualize where your needle is going.
Q. Are there maternal health conditions that increase the risk of performing an intracardiac injection?
A. Yes, there are.
Q. What are those?
A. Things that come to mind include infection in the uterus, where you do not a want to put a needle through the abdominal wall into the uterus and then withdraw it, because you increase the risk of infection in the tissues outside the uterus, such as the peritoneal cavity and subcutaneous tissue. Similarly --
Q. Can I interrupt for one second and ask you to tell us what the peritoneal cavity and the sub-- you will have to repeat that word.
A. I'm sorry. The peritoneal cavity is the cavity in which the bowel and the uterus and the ovaries sit within the abdomen. The subcutaneous tissue is the tissue below the skin and above the muscle. The layer that holds this together is called the fascia.
Q. You have said that you wouldn't want to attempt this sort

of injection into the maternal abdomen because it might seed the woman's abdominal cavity and the area below the skin, that is correct?
A. Yes.
Q. I interrupted you. Can you go on and explain the other risks of doing such an injection.
A. The other situation is that with a prior surgical incision into the abdomen, the patient may have scar tissue in the peritoneal cavity or bowel between the abdominal wall and the uterus. You certainly don't want to go through the bowel and then go into the uterus. Again, you are perforating other tissues and you are also increasing the chance of infection.
Q. Are there any other situations that would create a risk for attempting an intracardiac fetal injection?
A. If you had a bleeding disorder, such as disseminated intravascular coagulation or low platelet counts or leukemia, you wouldn't want to subject the mother to an additional procedure where you might get hemorrhage, especially in the subcutaneous tissue or in the peritoneal cavity, where you could get a lot of blood concealed from view and actually be causing a hemorrhage in the mother.
THE COURT: Ms. Chaiten, is this a convenient time to take our morning break?
MS. CHAITEN: That would be fine, your Honor.
THE COURT: The Court will stand in recess.

(Recess)
THE COURT: Ms. Chaiten, you may inquire.
MS. CHAITEN: Thank you, your Honor.
Q. Doctor, we were talking about intracardiac injections of KCl and digoxin prior to the break. Is there a risk of injecting the woman with the feticidal agent as you endeavor to inject the fetal heart?
A. If you actually have it within the fetus, there is no risk to the mother. However, if you inadvertently get into maternal circulation, there is a risk to her.
Q. What would that risk entail?
A. It would be cardiac arrhythmias or irregular heartbeat would be the most common.
Q. How did you learn to perform an intracardiac fetal injection?
A. It was an extension of my maternal fetal medicine training.
Q. In what context?
A. We initially started to do intracardiac injections of small fetuses in the end of the first trimester and the beginning of the second for the purpose of reducing multifetal pregnancies or multiple gestations, either with a twin gestation, where one twin is normal and the other is abnormal, or of a situation where we have too many fetuses within the uterus.
Q. To the best of your knowledge, is this a skill that is routinely taught to obstetricians and gynecologists?

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A. No, it is not.
Q. Doctor, you testified earlier, or yesterday I guess it was, that D&E practice has evolved since you were trained in this area in the mid 1970's, is that correct?
A. Yes.
(Continued on next page)

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BY MS. CHAITEN:
Q. Can you tell us what you were referring to when you stated that?
A. When I was a resident we did D&Es through 16 and a half weeks, and when I left my residency and was in practice we began to apply serial laminaria to achieve larger amounts of dilatation because laminaria were more readily available and we could thereby terminate fetuses in the second trimester to about 20 weeks.
And, with time, we actually went in further into 23 and five sevenths so that we changed the way we did the procedure so that we could make the procedure safe for the patient. And generally this had to do with multiple laminaria insertions for the mother prior to doing the procedure.
Moreover, with changes in instrumentation or availability of different instruments we were able to deliver more of the fetuses intact.
Q. Why is that important?
A. That decreases the risk to the mother and decreasing the number of passes of instruments into the uterus, and we can actually get the fetus intact for genetic purposes.
Q. Can you describe for us how this evolution to both doing D&Es later and more intact occurred within the medical community?
A. It was continuation or extension of procedure which I had

trained to do in my residency. And by talking to other physicians and by reading the literature we changed the procedure or adapted the procedure to our own particular surgical circumstances.

At one point we were using dilapan, which is a synthetic laminaria which achieves dilatation over about a four hour period. These are no longer available on the market. We used those at one period of time, then we substituted another process by which we achieved maximal cervical dilatation or the amount necessary to empty the contents of the uterus.

And we had also incorporated misoprostol, either oral or vaginally, at the suggestion of other physicians to help the cervix soften and dilate.

Q. So you have mentioned talking with other physicians, is this at meetings and conferences?

A. Yes.

Q. And then what do you do after you have gone to a meeting or in some other way discussed a procedure with another physician in terms of your attempt to apply it to your own practice?

A. You incorporate the suggestions of other physicians into your practice.

Q. Do you incorporate those suggestions exactly as they do it?

A. Sometimes. Sometimes not.

Sometimes you have a way of doing things that you can come up with, a variation of what they suggested that works

better in your hands.

Q. And then what happens?

A. You adapt a protocol to that particular change in the procedure.

Q. And then do you have any other discussions with other physicians?

A. You can. You then suggest things to other physicians.

Eventually you may have enough experience that you feel that your procedure is better and then you can do a study and publish it showing the changes and the safety and efficacy of that particular variation of procedure.

Q. Is this process by which D&E has evolved since the mid '70s consistent with your understanding of how surgical techniques, generally, evolve?

A. Yes, it is.

Q. Doctor, you testified earlier that you have been a member of the Northwestern University Institutional Review Board, or IRB, for 12 years, is that correct?

A. Yes.

Q. What are your responsibilities as a member of the IRB?

A. On a monthly basis I review protocols that are presented to the institutional review board for approval of a study of a particular, usually scientific hypothesis, and we look at the study protocol as to whether or not it can answer the question raised, whether it is ethical; and then the consent process and

the training and the conduct of that research by the particular investigators.
Q. In what circumstances is IRB approval required?
A. For any study involving human research.
Q. Is IRB approval required for changes in patient care by an individual physician?
A. If it's in the context of a study, yes.
Q. What if it is not in the context of a study?
A. Then it does not require institutional review board approval.
Q. Before a physician varies a surgical technique or approach, does the physician need IRB approval?
A. No.
Q. In your experience, have physicians sought IRB approval for new surgical techniques prior to performing them on patients?
A. Only in the context of a study.
Q. Dr. Frederiksen, you have got your black binder in front of you and if you would, please turn to Tab 69, which is Plaintiff's Exhibit 69. This is a copy of the Partial-Birth Abortion Ban Act of 2003.
Could you please turn to Section 14C under the findings that appears at page S-34? I would like to direct your attention to the first sentence.
Doctor, assuming that we are talking about an intact approach to D&E, do you agree that intact D&E has "never been

subject to even a minimal amount of the normal medical practice development"?
A. I disagree.
Q. Do you have an opinion as to whether a ban on intact D&E would affect the advancement of abortion practice?
A. Yes.
Q. What is that opinion?
A. It would stop the ability to explore the advantages of intact D&E to the patient.
Q. Now, would you please --
THE COURT: Could I have that answer read again, please?
(Record read)
BY MS. CHAITEN:
Q. Doctor, if you would now look at paragraph 14B on that same page, I direct your attention to the last sentence of that paragraph which reads:
"Indeed, unlike more commonly used abortion procedures there are currently no medical schools that provide instructions on abortions that include the instruction in" -- and again assuming we are talking about intact D&E -- "that include instruction in intact D&E in their curriculum."
Do you agree with this statement?
A. No, I do not.
Q. Why not?

A. We have been teaching intact or delivery of an intact fetus as possible at our medical school for the last several years.
THE COURT: How many, Doctor?
THE WITNESS: I really can't tell you. I don't remember.
THE COURT: You are teaching there, aren't you?
THE WITNESS: Yes, but I've taught there for over 20 years and I don't remember exactly when we got to the point where we were basically doing as intact a procedure as possible. That's been the general way we have made D&Es safer over this period of time.
When we incorporated it into teaching I can't tell you.
THE COURT: Can you give us an approximation, Doctor?
THE WITNESS: Probably over the last 10 years.
BY MS. CHAITEN:
Q. Doctor, do you have an opinion as to whether a ban on intact D&E would have an impact on abortion education?
A. It would essentially not allow certain aspects of abortion training to be trained, to be taught.
Q. Dr. Frederiksen, is intact D&E the only technique available to terminate pregnancy in the second trimester?
A. It is not necessarily the only technique but it is the safest.
MS. CHAITEN: Thank you, Doctor. I have no further

questions at this time.
THE COURT: Who will be conducting the cross?
MS. WOLSTEIN: Your Honor, it is Elizabeth Wolstein, I will be doing it.
THE COURT: All right, Ms. Wolstein. You may inquire.
MS. WOLSTEIN: Thank you, your Honor.
CROSS EXAMINATION
BY MS. WOLSTEIN:
Q. Doctor, a fetus is considered viable beginning at 24 weeks, isn't it?
A. In certain conditions. In the most common condition being a normal fetus, a fetus is viable at 24 weeks but there are conditions in which a fetus is never viable such as an anencephalic fetus, a thanatophoric dwarf or a campomelic dwarf.
MS. WOLSTEIN: Your Honor, I move to strike the remaining part, the portion of the answer that's not responsive.
THE COURT: Can I hear the question and the answer?
(Record read)
THE COURT: She gave more than you wanted, but.
MS. WOLSTEIN: Very well, your Honor.
THE COURT: She is going to fight it so just ask the questions, you will get what you want.
BY MS. WOLSTEIN:

Q. Doctor, a normal fetus is considered viable beginning at 24 weeks, correct?
A. Yes.
Q. And, in fact, when you are delivering a fetus at 24 weeks, you definitely have a neonatologist present, don't you?
A. Yes.
Q. And it's your practice to have a neonatologist present if you are delivering a 24 week fetus, isn't?
A. Yes.
Q. And the reason you have a neonatologist there is because at 24 weeks there is a chance the fetus will survive, correct?
A. Correct.
Q. And in fact there is data showing that at 24 weeks if the fetus is born there is a 50 percent chance that the baby will survive the delivery room, correct?
A. Yes.
Q. Doctor, you testified on direct examination that you perform abortions up to 23 and five sevenths weeks' gestation?
A. Yes.
Q. And by that you mean 23 weeks and five days?
A. Yes.
Q. So, Doctor, you perform abortions up to two days short of 24 weeks' gestation, correct?
A. Correct.
Q. And occasionally you use your induction protocol beyond 24

weeks' gestation, don't you?
A. Yes.
Q. Doctor, you are acquainted with Dr. Cassing Hammond?
A. Yes.
Q. He is your colleague at Northwestern?
A. He is a fellow physician.
Q. He is your colleague?
A. Yes.
Q. And he is a plaintiff in this case?
A. Yes.
Q. You are testifying here as an expert on Dr. Hammond's behalf?
A. Yes.
Q. And you are not receiving any compensation from plaintiffs for your work and your testimony in this case?
A. Correct.
Q. And there was a time when you were Dr. Hammond's boss at Northwestern, wasn't there?
A. Yes.
Q. He was your apprentice?
A. Technically not.
Q. Well, Doctor, Dr. Hammond testified at this trial that he was once your apprentice; was that testimony wrong?
A. Dr. Hammond was a fellow physician and, as such, provided second trimester terminations as an attending physician at

Northwestern --
THE COURT: Doctor, would you just answer the question?
Ms. Reporter, would you read the question?
(Record read)
THE COURT: It's a simple question.
THE WITNESS: No.
THE COURT: Stop fighting the questions, Doctor, just answer them. Your lawyer will get up and have another opportunity to question you.
THE WITNESS: No.
BY MS. WOLSTEIN:
Q. He was your apprentice when he moved to Northwestern after his residency, correct?
A. Yes.
Q. And that was when Dr. Hammond was beginning his career at Northwestern?
A. Yes.
Q. And while Dr. Hammond was your apprentice, he learned to increase the gestational age at which he performed abortions from 20 weeks up to 22 weeks, and then up to 24 weeks, correct?
A. Yes.
Q. And both you and Dr. Hammond were plaintiffs in the Hope Clinic case you mentioned in your direct testimony that challenged the State of Illinois partial-birth abortion

statute, right?
A. Yes.
Q. And the ACLU represented you in that case?
A. Yes.
Q. And you have also served as an expert for plaintiffs in two cases challenging the constitutionality of parental notification requirements in state abortion statutes, haven't you?
A. Yes.
Q. And those are state statutes that require doctors to notify parents before performing an abortion on a person under 18 years old, right?
A. Yes.
Q. And one of those was a challenge to Colorado's state law?
A. Yes.
Q. And the ACLU represented the plaintiffs in that case, correct?
A. Yes.
Q. And one was a challenge to Idaho's state law, correct?
A. Yes.
Q. And on November 19, 2003, shortly after the Partial-Birth Abortion Ban Act of 2003 was signed into law and after this lawsuit was filed, you were a speaker at a lunchtime discussion at the ACLU Chicago offices entitled "partial-birth abortion myth and reality," correct?

A. Yes.
Q. And that was about the federal partial-birth abortion statute that's being challenged in this lawsuit, right?
A. Yes.
Q. Now, that discussion was described publicly by the ACLU as a discussion that would address, "the fallacies perpetuated by anti-choice groups in this sophisticated attack of a right to choose and explain what the ACLU is doing to safeguard our most fundamental rights"?
A. I don't know.
Q. Another speaker at the ACLU Chicago was Ms. Chaiten, who conducted your examination today and yesterday?
A. Yes.
Q. And in its invitation to the lunchtime discussion, Doctor, the ACLU described you as having served as, "a critical medical expert in many of the ACLU's challenges to anti-choice legislation," correct?
A. Yes.
Q. And, Doctor, you currently serve on the board of directors of Physicians for Reproductive Choice and Health?
A. Yes.
Q. And Physicians for Reproductive Choice and Health describes itself as, "the voice of the pro-choice physician"?
A. Yes.
Q. And Dr. Carhart, the lead plaintiff in the case challenging

Partial-Birth Abortion Ban Act of 2003 that is now being tried in Nebraska, is also on the board of directors of Physicians for Reproductive Choice and Health, isn't he?
A. Yes.
Q. Doctor, you testified yesterday in your direct examination that induction abortions are safe procedures.
Do you remember that?
A. Yes.
Q. But you testified that you believe D&Es are safer than inductions, do you remember that?
A. Yes.
Q. And one of the bases for that opinion was a study you referred to yesterday that you did at Northwestern that was prompted by a paper by Chapman at the University of Alabama?
A. Yes.
Q. And your study looked at whether a prior caesarean delivery increases the risk of complication in second trimester pregnancy terminations, correct?
A. Correct.
Q. Now, that study has not been published, has it?
A. No.
Q. You published an abstract but not a paper, correct?
A. Correct.
Q. The paper you wrote based on that study was sent back to you for revision, right?

A. Correct.
Q. And you still have not published it, have you?
A. That's correct.
Q. And it's been five years since that abstract was published in 1999, hasn't it?
A. Yes.
Q. And the abstract is listed on your CV under publications, isn't it?
A. It's listed under abstracts.
Q. On your CV?
A. Yes.
Q. Now, your study has flaws that limit what you can say about it, doesn't it?
A. Yes.
Q. And, based on your study, you testified yesterday that you consider D&E safer than induction at 13 to 23 weeks' gestation.
Do you remember that?
A. Yes.
Q. Doctor, inductions are not done before 15 to 16 weeks, are they?
A. In certain cases actually a physician sometimes does attempt to induce pregnancies to be delivered by induction processes before 15 to 16 weeks.
Q. Well, Doctor, in your declaration in the Hope Clinic case from 1997, you wrote, "inductions generally are not done before

15 to 16 weeks' LMP," is that incorrect?
MS. CHAITEN: Objection, your Honor. Can we ask counsel to give us a cite where she is reading from when she is reading from extraneous documents?
THE COURT: Ms. Wolstein, would you be kind enough to show it to counsel?
MS. WOLSTEIN: Yes, your Honor.
THE COURT: You may proceed.
MS. WOLSTEIN: Thank you.
That was Government Exhibit U-1 for identification, and I am handing a copy to counsel and I have one for the witness, if the Doctor would like to see that.
THE COURT: I assume counsel has a copy of all the exhibits, do you not?
MS. CHAITEN: Your Honor, what I was asking for was a paragraph cite before she began to read.
THE COURT: I understand, ma'am, but you have a copy of the exhibit?
MS. CHAITEN: Yes, I do.
THE COURT: That's all I'm asking.
BY MS. WOLSTEIN:
Q. Doctor, was it incorrect when you wrote in your declaration at paragraph 26 in the Hope Clinic case that, "inductions generally are not done before 15 to 16 weeks' LMP"?
A. That is not incorrect.

Q. That's correct?
A. That's correct.
Q. And in the earlier part of the second trimester, inductions generally are less successful and may be difficult to perform, correct?
A. Yes.
Q. And that was in your Hope Clinic declaration also, wasn't it?
A. Yes.
Q. Now, in your study, your abstract, Doctor, the D&E group in your study had 561 patients and the induction group had 85 patients, correct?
A. Correct.
Q. So the D&E group had six and a half times more subjects than the induction group, correct?
A. Correct.
Q. And the induction group had inductions with medication that you would no longer use today, correct?
A. Yes.
Q. Now, you testified yesterday that you did the study, the study was partly prompted by the Chapman article from the University of Alabama?
A. Yes.
Q. And the Chapman article was based on a retrospective review of patient records who delivered at their hospital between 1980

and 1995, right?
A. I don't remember the years. I assume what you are saying is right.
Q. The authors selected the records for inclusion by searching medical records files with diagnostic group codes, right?
A. I assume so.
Q. And none of the inductions done in that study were done using misoprostol as the induction agent, were they?
A. You're asking me about something I don't know. I don't -- I can't remember.
Q. Now, you referred in your direct testimony yesterday when you were speaking about the relative safety of D&E versus induction, to a study that was published last week in the Journal of Obstetrics and Gynecology.
Do you remember that?
A. Yes.
Q. And you referred to that study as a basis for your opinion that D&E is safer than induction abortion; do you remember that?
A. Yes.
Q. And that is a study entitled, "Risk Factors for Legal Induced Abortion Related Mortality in the United States"?
A. Yes.
Q. And that is a descriptive epidemiological study of women dying of complications of abortion, correct?

A. It's descriptive, yes.
Q. And that study looked at mortality statistics across gestational ages, right?
A. Yes.
Q. And it concluded that the risk factor, "most strongly associated with mortality from legal abortion is gestational age"?
A. Yes.
Q. And the procedures used in the second trimester procedures that are discussed in that article were categorized by the authors as D&E installation or other, correct?
A. Yes.
Q. And installation is one of the induction methods available, correct?
A. Yes.
Q. And, in the study, installation involving prostaglandin or saline installation, correct?
A. Yes.
Q. Would you agree, Doctor, with the authors of this article, that saline and prostaglandin installation is a higher risk procedure that declined through the 1970s to approximately 3 percent in 1980?
A. Yes.
Q. And, Doctor, you don't use saline and prostaglandin installation when you do induction abortions, do you?

A. Currently I do not.
Q. Doctor, isn't it true that between 20 and 24 weeks the risks of D&E and medical induction are similar?
A. They may be, yes.
Q. Well, Doctor, your colleague, Dr. Hammond, testified at this trial that the risks of D&E and medical induction are similar between 20 and 24 weeks, is that testimony wrong?
A. No.
Q. And, Dr. Stubblefield, was he wrong when he wrote in his chapter, gynecological -- his chapter in the book gynecologic and obstetric and related surgery, his chapter on first and second trimester abortion that, "labor induction method and D&E are comparable in the later mid-trimester"?
MS. CHAITEN: Objection, lack of foundation.
THE COURT: What is foundation?
MS. CHAITEN: And hearsay. Sorry.
THE COURT: Overruled.
THE WITNESS: I'm unfamiliar with Dr. Stubblefield's statement and I don't know what textbook you are referring to.
THE COURT: Show the witness this textbook, if you wish.
MS. WOLSTEIN: Thank you, your Honor.
THE COURT: Are you familiar with Dr. Stubblefield's name?
THE WITNESS: Yes, yes.

THE COURT: Do you know who he is?
THE WITNESS: He trained me.
MS. WOLSTEIN:
Q. In fact, he was one of the plaintiff's experts in Stenberg v. Carhart in the Supreme Court?
A. I can't answer that question.
MS. WOLSTEIN: Your Honor, may I approach?
THE COURT: Go right ahead.
MS. WOLSTEIN: I am handing a copy to counsel as well.
Q. I have handed the witness and counsel a copy of Dr. Stubblefield's chapter on first and second trimester abortion in the textbook Gynecologic, Obstetric and Related Surgery, by Nichols and Clark Pearson from the year 2000.
Doctor, on page 1046 Dr. Stubblefield states that labor induction methods and D&E are comparable in the later midtrimester.
Do you disagree with that?
MS. CHAITEN: Your Honor, objection. Hearsay.
THE COURT: Overruled.
THE WITNESS: Excuse me, where is this statement, Ms. Wolstein? Could you show it to me?
Q. Page 1046.
A. What paragraph, please?
Q. Just a minute, I will tell you. Do you see where it says, choice of midtrimester procedure on the left column?

A. Yes.
Q. And the second sentence -- well, let me read the second and third sentence for completion.
Early in trimester D&E is the safest method. Labor induction methods and D&E are comparable in the later midtrimester and both are much safer an hysterotomy or hysterectomy for abortion.
Do you agree with that?
A. Yes.
Q. Doctor, you perform induction abortions, don't you?
A. Yes.
Q. And the inductions that you perform are safe, aren't they?
A. Yes.
Q. Your induction protocol is safe at 20 to 24 weeks' gestation, isn't it?
A. Yes.
Q. And, Doctor, you testified just earlier today in your direct examination that you don't routinely use an injection to bring about fetal demise before you do a second trimester abortion; do you remember that?
A. Yes.
Q. That wasn't accurate, was it?
A. I'm sorry, I lost you. I don't know where you are going. I don't understand the question.
Q. Your testimony that you don't routinely do an injection to

bring about fetal demise in a second trimester abortion was not accurate, was it?
A. I don't routinely do it.
Q. Well, Doctor, your protocol for performing induction abortions includes an intracardiac injection of potassium chloride the day before doing the induction, doesn't it?
A. Yes; but it doesn't include an intracardiac injection prior to a D&E.
Q. Well, you testified on your direct, Doctor, that you don't routinely do intracardiac injections before second trimester abortions.
A. I don't routinely do intracardiac injections before D&E procedures but I do with inductions.
Q. And you routinely do intracardiac injection with your induction protocol, right?
A. Routinely, yes.
Q. And these days you use potassium chloride rather than digoxin, right?
A. Yes.
Q. And the potassium chloride injection is an ultrasound guided procedure that assures the death of the fetus, right?
A. Yes.
Q. And a degree of risk associated with a potassium chloride injection is analogous to the degree of risk associated with amniocentesis? Would you agree with that?

A. You could make an analogy.
Q. And that's a risk of infection, right? That's the risks that we are talking about?
A. Given a set of circumstances where it's no difference there are medical things that I did include in my testimony where it would increase the risk to the mother, yes.
Q. And infection with amniocentesis happens in about one in one thousand procedures, right?
A. Yes.
Q. And that is approximately one tenth of one percent, right?
A. Yes.
Q. And if you get an infection with an injection in the pregnancy termination context, you would just go ahead with the termination to address the problem, right?
A. Yes.
Q. And that's what you were setting out to do anyway, wasn't it?
A. Yes.
Q. And the risk of digoxin injection is comparable to that of the potassium chloride injection, isn't it?
A. Yes.
Q. In fact, you used digoxin for years before switching to potassium chloride, didn't you?
A. Yes.
Q. And you switched to potassium chloride because it's easier

since you have it in stock at the hospital?
A. No, not at the hospital; in the office.
Q. In fact, you also use intracardiac potassium chloride or KCL injections to terminate pregnancies in the first trimester, don't you?
A. Yes.
Q. And you testified that, on your direct, that you used an injection before doing a D&E at 20 weeks or above if the patient requests it, right?
A. Yes.
Q. And, Doctor, you would not do something unsafe just because the patient asked for it, would you?
A. No.
Q. In fact, in the same chapter Dr. Stubblefield recommends that with all D&Es -- with all D&Es in a midtrimester he would suggest an ultrasound-guided fetal intracardiac injection of 1.5 milligram of digoxin and intracervical laminaria followed the next day by vaginal suppositories?
A. Could you point out where that is in the chapter?
Q. It's in that same paragraph a little further down.
A. What page?
THE COURT: Come up and show it to the witness.
MS. WOLSTEIN: Oh thank you, your Honor.
Q. And Dr. Stubblefield there says, for the surgeon faced with the occasional need to provide midtrimester abortion, I would

suggest ultrasound-guided fetal intracardiac injection of 1.5 milligrams of digoxin and intracervical laminaria followed the next day by vaginal suppositories of prostaglandin E2.
A. He is referring to an induction in that sentence.
Q. I don't think he is actually, Doctor. Why don't we go back.
"Several skilled surgeons offer D&E to 24 weeks. Indeed, the lowest reported rate of complications for any late abortion technique is that of Hearn or his combination method of laminaria, intraamniotic urea and D&E.
"For the surgeon faced with the occasional need to provide midtrimester abortion, I would suggest ultrasound-guided fetal intracardiac injection of 1.5 milligrams of digoxin and intracervical laminaria followed the next day by vaginal suppository of prostaglandin E2."
Did I read that correctly?
A. You read it correctly. I still think he is referring to induction because in the following sentence he talks about if the abortion is prolonged, before 24 hours he recommends alternative pharmacological mechanisms to get the fetus delivered.
And what he is referring to is a surgeon that is not doing routine D&Es. In other words, a person who has only the face of the occasional patient with ending a pregnancy in the midtrimester and this would be the way he would suggest

induction to terminate the pregnancy.
Q. Doctor, you testified in your direct testimony that you would not want to use KCL, potassium chloride or digoxin in the case of a woman with sepsis?
A. Yes.
Q. And you testified about sepsis in the context of an abortion started by induction, do you remember that?
A. Yes.
Q. And if sepsis ensued after the induction started, you could complete the abortion by doing a D&E, couldn't you?
A. Yes.
Q. And you testified about potassium chloride and digoxin where the patient is obese and so you cannot visualize the fetus?
A. Yes.
Q. So, it's hard to do an injection of KCL or digoxin in those circumstances, right?
A. Correct.
Q. In that case though you could still do an induction without KCL or digoxin, couldn't you?
A. Yes.
Q. Now, your induction protocol also uses, includes misoprostol, correct?
A. Yes.
Q. And you have used misoprostol and potassium chloride

injection as part of your induction protocol for the last 10 years, haven't you?
A. I don't know if misoprostol was really available to us 10 years ago, but over the past five to eight years we have switched from using E-2 suppositories to using misoprostol.
MS. WOLSTEIN: May I approach, your Honor?
THE COURT: You may.
MS. WOLSTEIN: I am providing the witness with a copy of her deposition transcript.
Q. Doctor, you gave a deposition in this case, didn't you?
A. Yes.
Q. And if you would look at page 102 of the deposition transcript I just handed you, which is your deposition in this case -- sorry, page 101 -- sorry, page 100. I apologize.
The question would be, were you asked the following questions and did you give the following answers:
"Q So, in 2004, what is your protocol for induction in the second trimester?
"A Normally I would like to do an intracardiac injection of potassium chloride the day prior to doing the induction, that is an ultra sound-guided procedure which we can do in an ultrasound suite where we assure the death of the fetus. Then you can use laminaria in pretreating the cervix and if you want to shorten the induction to delivery interval you can use actually serial laminaria similar to what we would

do for a D&E only admitting the patient when you intend to use misoprostol on a, I think it is an every six-hour basis that we now use to cause contractions of the uterus and expulsion of the fetus and placenta.
"Q And this protocol, as you have described it, when did you start using that protocol?
"A Misoprostol has been available to us over the last 10 years.
"Q Do you use misoprostol in every induction abortion you do?
"A Currently I would like to use misoprostol."
Were you asked those questions and did you give those answers?
A. I did.
Q. And you testified on your direct that there is evidence that using misoprostol with a dead fetus increases efficacy and it also decreases the time to fetal expulsion, correct?
A. Yes.
Q. In other words, potassium chloride plus misoprostol shortens the induction to abortion interval?
A. Yes.
Q. And you can shorten the induction to abortion interval even more if you pretreat the cervix with serial laminaria similar to what you do in a D&E, right?
A. Yes.

Q. Doctor, you testified on your direct about a case where you use an injection into a place in the fetus other than the heart and fetal demise took a long time.
Do you remember that?
A. Fetal -- I think my testimony was the fetus didn't actually die.
Q. Didn't actually die.
And so, from that you conclude that the injection is not always efficacious in bringing about the fetus' death, correct?
MS. CHAITEN: Objection. Misstates the testimony.
THE COURT: She's capable of responding. Overruled.
THE WITNESS: If you don't get it into the heart it doesn't always work.
Q. I take it, Doctor, you're not familiar with the Wright and Wattson study reported in the Clinician's Guide to Medical and Surgical Abortion, the NAF textbook that reports on a study of 5,000 D&E abortions at 19 weeks or more in which digoxin was injected without ultrasound into places other than the heart, in fact into the, inadvertently injected into the intramyometrial and systemic injection?
A. No, I'm not familiar with that study.
Q. So you're not familiar with that study of 5,000 cases in which, in all cases, fetal death was confirmed by ultrasonography in 30 minutes despite the failure to inject

into the heart, is that right?
A. I'm not familiar with that study.
Q. Doctor, when you do a D&E at 20 to 23 or 24 weeks, you attempt to achieve as much dilatation as possible, don't you?
A. Yes.
Q. At 20 to 23 weeks you used three to four sets of laminaria, right?
A. Correct.
Q. And using your protocol of three to four sets of laminaria, you can get a very widely dilated cervix, right?
A. Yes.
Q. You can get five to six centimeters dilatation before a D&E at 20 to 23 weeks, right?
A. Sometimes, yes.
Q. And at 20 to 23 weeks your placement of laminaria is completed within a 24 hour period, right?
A. Yes.
Q. Your protocol is to insert the first set of laminaria at 8:30 in the morning, right?
A. Yes.
Q. And at that point you are putting in as many sticks of laminaria as possible, right?
A. Yes.
Q. Then you add a second set of laminaria around noontime?
A. Yes.

Q. And that is approximately three and a half hours later, right?
A. Correct.
Q. Now, laminaria doesn't achieve its maximum dilatation in three and a half hours, does it?
A. No, it does not.
Q. In fact, laminaria takes about eight hours to maximally dilate, doesn't it?
A. Correct.
Q. And for the second laminaria insertion you also put in as many sticks as you can, right?
A. Yes.
Q. Then you add a third set of laminaria at the end of that same day, right?
A. Yes.
Q. That would be at 5:00 or 5:30 p.m.?
A. Yes.
Q. So that's approximately five or five and a half hours after the second set?
A. Yes.
Q. And for the third laminaria insertion you also put in as many sticks as you can, right? You can't put an upper limit on what the number on the high end might be, of sticks of laminaria that you put in, can you?
A. No.

Q. And then you give vaginal misoprostol the next morning three hours before surgery, right?
A. Correct.
Q. So, Doctor, you don't dilate the cervix over a sequence of days before doing an intact D&E, do you?
A. No.
Q. You dilate the cervix over 24 hour period, right?
A. Correct.
Q. And you achieve up to five to six centimeters dilatation over a 24 hour period, don't you?
A. Yes.
Q. Now, in a vaginal delivery of the baby at term, the cervix dilates to about 10 centimeters, right?
A. Correct.
Q. And, Doctor, you mentioned dilapan or dilapan on your direct testimony, do you remember that?
A. Yes.
Q. And you used to use dilapan as the dilating agent, didn't you?
A. Yes.
Q. You routinely used dilapan as the dilating agent, right?
A. Yes.
Q. And dilapan is a synthetic osmotic dilator rod, correct?
A. Yes.
Q. And the advantages to dilapan was that you got maximum

dilatation of the dilator in four hours, right?
A. Correct.
Q. And you liked using dilapan because you could get maximum dilatation in four hours, right?
A. Correct.
Q. But, with laminaria on the other hand, because it's a natural product, you don't always get maximum dilatation within a set number of hours, do you?
A. Correct.
Q. Dilapan was taken off the market as a result of F.D.A. action, wasn't it?
A. I don't -- I don't know the exact mechanism by which it was taken off the market, whether it was F.D.A. or whether it was the company.
Q. Either it was the F.D.A. or it was a voluntary recall by the company, right?
A. Some -- something along that way.
Q. And it is no longer on the market in the United States, is it?
A. Correct.
Q. Now, dilapan was prone to fragmentation, wasn't it?
A. It hadn't been my experience that it was, but other people did report that it fragmented.
Q. Well, would you agree with the statement in the clinician's guide to medical and surgical abortion, the NAF textbook from

Chapter 10, page 128, that, "dilapan devices provide superior dilating power but sometimes fragment on attempted removal"?
A. I would agree with that.
Q. And retention in the patient of a fragmented piece of dilapan could create a risk of infection, couldn't it?
A. Yes.
Q. Now, once the dilatation of the cervix is completed, the next step in doing a D&E is to begin to evacuate the contents of the uterus, right?
A. Yes.
Q. And when you begin the evacuation of the uterus depends on when you get an OR slot, right?
A. Correct.
Q. So, whether it's 24 hours after the first insertion or a few hours after that depends largely on when you get that golden slot in the operating room, right?
MS. CHAITEN: Objection, your Honor.
THE COURT: Oh, that's minor. I will overrule it.
THE WITNESS: The statement --
THE COURT: You are objecting, I take it to the golden slot?
MS. CHAITEN: No. I was objecting because I found the question confusing and ambiguous.
THE COURT: If that's your reason then you are definitely overruled.

THE WITNESS: Could you repeat the question?
THE COURT: I think you have already answered it. Would you read the question and answer, if there is an answer?
(Record read)
THE COURT: Go ahead.
THE WITNESS: Do I answer now?
THE COURT: Yes.
THE WITNESS: The context of how we prepare the cervix really relates to the length of time prior to surgery.
BY MS. WOLSTEIN:
Q. But when you begin the surgical portion of the procedure depends on when you have a slot in the operating room, right?
A. Correct.
Q. In fact, even if you don't get maximum expansion of the laminaria at your allotted time you still have to operate, don't you?
A. That's correct.
Q. And you still have to do that surgery because you don't have control of the operating room and you have to empty the contents of the uterus when you are scheduled to do that, right?
A. Correct.
Q. In fact, if you didn't have to worry about operating room availability you would want to achieve more dilatation than you do under your current protocol so as to bring the fetus out

entirely intact, right?
A. If it were possible, yes.
Q. Now, Doctor, you testified that you do not use forcible dilatation in a second trimester abortion procedure yesterday, do you remember that?
A. Yes.
Q. And by forcible dilatation you meant dilatation with metal dilators?
A. Yes.
Q. You testified that forcible dilatation can cause uterine perforation, right?
A. Yes.
Q. And it can also cause cervical damage?
A. Yes.
Q. So, Dr. Westhoff's protocol of occasionally inserting metal mechanical dilators before a D&E procedure, you do not think that's a good practice, do you?
A. I don't do that.
THE COURT: Would you answer the question, Doctor? Your answer was not responsive.
Would you read the question, please, Ms. Reporter and would you answer the question?
(Record read)
THE WITNESS: No, I don't use forcible dilatation the second trimester.

THE COURT: Is your answer that you don't think it's a good procedure?
THE WITNESS: No.
THE COURT: All right, that's what the question is.
BY MS. WOLSTEIN:
Q. Doctor, if a complication occurred in connection with a D&E performed at Northwestern Memorial Hospital, would that complication be noted on the patient's medical record?
A. Yes.
Q. And that would be true for both dismemberment D&E and intact D&E, right?
A. Yes.
Q. And if a complication occurred in connection with an induction abortion performed at Northwestern Memorial Hospital, the complication would be noted on the patient's medical record, wouldn't it?
A. Yes.
Q. And, Doctor, uterine preparation and cervical laceration can be complications of second trimester surgical abortion, right?
A. Yes.
Q. And blood loss can be a complication of second trimester induction abortion and surgical abortion, correct?
A. Yes.
THE COURT: Ms. Wolstein, is this a convenient time

for us to take our luncheon break?
MS. WOLSTEIN: Yes, your Honor, it is a convenient time.
THE COURT: We will recess until 2:00.
(Luncheon recess)
(Continued on next page)

AFTERNOON SESSION
2:15 p.m.
MARILYNN C. FREDERIKSEN, resumed.
THE COURT: Good afternoon.
THE COURT: Ms. Wolstein, I believe you were cross-examining. You may inquire.
MR. HUT: Your Honor, if I may inquire with one or two procedural matters that I believe both the government and we believe will require a ruling from the Court shortly. The first relates to what we believe to be an effort by the government to belatedly supplement expert reports.
THE COURT: Belatedly what?
MR. HUT: Supplement expert disclosures. Yesterday after trial we were served with two documents purporting to be supplemental expert reports, one for defendant's Dr. Sprang, the other for defendant's Dr. Bowes. Both purport to comment upon the study to which the Court has heard reference by Dr. Chasen.
The relevant chronology, your Honor, is this. In January plaintiffs advised defendants about the Chasen study, and then on January 29th, following the negotiation of a protective order with respect to the copyright interests of the respective publisher, we supplied it to the government. That was January 29th.
The depositions of Dr. Sprang and Bowes took place

February 11th and February 19th respectively, or approximately 14 days and 21 days after the closure of the Chasen study. There was no indication at the time of the depositions, no supplementation of the expert disclosures to indicate that there would be any opinion rendered by either of these men with respect to the Chasen report.

THE COURT: Till now.

MR. HUT: Till now, until yesterday, yesterday after court. Then, on February 27th, that was the date, the Court will recall, by which pretrial disclosures needed to be made, including any supplements to the expert disclosures, and nothing was made then.

We believe that at this stage, without having had the opportunity to depose these witnesses about the opinions that they formed, we would be very, very substantially prejudiced by any testimony, and we would ask the Court to preclude it.

THE COURT: Ms. Gowan, do you want to respond?

MS. GOWAN: Yes, your Honor. Dr. Chasen's paper and the underlying materials for it have been cloaked in confidentiality by the plaintiffs in the case. It became apparent to the government recently that that cloak of confidentiality had to do with the relationship that Dr. Chasen had with his publisher, not because there was anything relating to patient information or that was otherwise subject to the confidentiality orders in this case.

We learned very recently before trial that apparently Dr. Chasen has resolved those issues with his publisher and no longer does he seek to have made confidential substantial portions of his deposition testimony relating to the study itself as well as some of the underlying data.

We had not previously produced to our experts, except for Dr. Lockwood, the information relating to the study. I notified counsel I think it was mid to late March that we were in fact sending it to some of our experts, of course subject to the confidentiality order, for them to look at. Counsel objected to my doing that and suggested somehow our experts would be able to address this study in their report.

Apparently, Dr. Chasen is going to San Francisco to testify. In connection with that, the issue of Dr. Sprang and Dr. Bowes, two government witnesses, their review of the materials and their wish to comment on the study, just as Dr. Westhoff commented on the study yesterday here before your Honor, was expressed to the Court. What Judge Hamilton worked out with the parties there is that Dr. Bowes and Dr. Sprang would just supplement their expert reports to put the plaintiffs in that case, as well as presumably Dr. Chasen, on notice of the views that they had of his study.

That process, that supplementation --

THE COURT: Let me stop you there.

Mr. Hut, were you aware of that?

MR. HUT: The --

THE COURT: Mr. Hut, a simple, direct, succinct, and truthful answer.

MR. HUT: The direction by Judge Hamilton?

THE COURT: Yes.

MR. HUT: Absolutely, your Honor.

THE COURT: I am very surprised at you, sir, that you didn't mention that in your presentation to me. In fact, I'm shocked.

You may continue, Ms. Gowan.

If you ever pull that again in this courtroom -- what do the ladies call it? -- it will be a bad hair day for you. Complete candor, complete, is the rule that this courtroom is run by. One more cute trick . . .

Ms. Gowan, go ahead.

MS. GOWAN: Late Sunday night I received by fax I believe it was Dr. Sprang's supplemental, though it could have been Dr. Bowes', and I brought a copy to court with me yesterday and I gave it to Mr. Hut. I had not received, by the time I came to court yesterday, the other report, if it is Dr. Bowes' or Dr. Sprang's, the second one.

We told counsel yesterday about it, that we were expecting it, that we had not received it, and that we would give it to him as soon as we did. Yesterday afternoon, after we left the courthouse, we received a copy by fax, and my

co-counsel sent that over to Mr. Hut for his review.

Certainly it is not the government's view that supplementation of the expert reports in this case would be necessary, given that they are not opining on a different subject matter than they did in their expert reports, they are merely addressing the published paper, the to-be-published paper of Dr. Chasen, just as Dr. Frederiksen brought to the attention of the Court yesterday a recently published paper. Although, it is true the government certainly has been on notice of Dr. Chasen's paper for some time.

We would certainly, your Honor, request that our experts be permitted to address Dr. Chasen's paper if they so wish in their direct testimony in this case, just as Dr. Chasen, now that he has removed his confidentiality issues with his publisher, I expect will be testifying fully about his study in his examination.

THE COURT: We will give you the opportunity to submit overnight a report, but I will limit it to three pages.

MR. HUT: May I be heard briefly in response?

THE COURT: You may.

MR. HUT: I want to first apologize to the Court. There was no, absolutely no, intention on my part not to disclose to you, your Honor, anything that I thought was pertinent.

THE COURT: You didn't think that was pertinent, sir?

MR. HUT: No, sir, I did not.
THE COURT: The very same question presented hearing a challenge to this statute in San Francisco and the same question presented to another judge, you didn't think it was pertinent?
MR. HUT: No, sir.
THE COURT: Then, Mr. Hut, I suspect you had better rethink things, because I assure you it is.
MR. HUT: I will do so, your Honor.
THE COURT: If ever again there is something else on the same issue presented to another court that you don't divulge, I will take a real dim view of it.
MR. HUT: The Court ought to be advised, in that case, of two things. First of all, the prologue to what Ms. Gowan had to say about the confidentiality with respect to the copyright issues and Dr. Chasen's relationship with his publisher, which we will address in the overnight submission, had nothing to do with whether the government could, upon one of their experts or two signing that protective order, disclosing it to those experts.
The second point I want to raise and apprise your Honor with respect to the San Francisco proceedings is that I understand that depositions have been permitted of those experts, the government's experts, in that case.
MS. GOWAN: I don't understand that that is so, Mr.

Hut. I believe that the supplemental reports are in lieu of depositions.
MR. HUT: I am advised otherwise, that if the plaintiffs wanted to in that case, they could take depositions. That is my understanding.
THE COURT: Find out about that question. It was going to be my next question to you, Ms. Gowan: Did the court permit the reopening of the depositions?
MS. GOWAN: As I said, your Honor, my understanding was it did not, that it was that the supplemental reports were in lieu of that, that that was something that was on the table.
THE COURT: Fine. Just inform me of that. I will not deny either side anything.
MS. GOWAN: I will find out the facts and inform you of that.
THE COURT: It would be wise to let me know full disclosure of whatever has happened there so that nothing will be prejudiced. This is to be limited. I wouldn't waste an awful lot of time, Mr. Hut, on the copyright laws in your submission.
MR. HUT: I was just explaining for the Court's benefit --
THE COURT: I understand the reason it has been offered, but I would not address that for my purposes at length.

MR. HUT: Yes, sir, and we will not do so.
The second procedural matter that I want to raise with your Honor has to do with the plaintiffs' wish to offer the depositions of Dr. Lauren Paul and Dr. Mitchell Creinin. The Court may recall that there have been submissions on this. We have sort of laid out why, the basis for our view that they are available within the meaning of the rules of evidence and the rules of civil procedure, what their credentials are, the relative and noncumulative testimony that they would have.
Therefore, we would very much like to be in a position to do that possibly tomorrow afternoon if the testimony of our next witness, Dr. Weiss, concludes early, so we might have a full court day. The government has not yet made counter-designations pending the ruling with respect to the government's motion to preclude, as I understand it.
THE COURT: You have Dr. Weiss for tomorrow morning. Will Dr. Chasen be back from California? You are still calling him. He is the plaintiff.
MR. HUT: Absolutely. I don't believe he has yet gone. I may be mistaken about that. I believe he is in New York. He is going to be back on Thursday, or we would like to, I should say, present him on Thursday morning. I am quite certain he is with patients tomorrow and was unable to be here tomorrow.
THE COURT: That raises a question for me in

scheduling the next couple of days. Are we currently, in your judgment, on schedule?
MR. HUT: I believe so, yes, your Honor.
THE COURT: I will give you a ruling first thing in the morning on the depositions, although it seems to me, judging from what is happening here in court, it seems we are getting somewhat cumulative. Maybe there is something new. I will review it again and give you a ruling first thing in the morning.
MR. HUT: Thank you, your Honor.
THE COURT: All right.
MS. GOWAN: Your Honor, Ms. Gowan.
THE COURT: I recognize your views after this much time.
MS. GOWAN: Thank you, your Honor. While we are bringing matters to your attention, I guess it would be appropriate to let you know that we have received an objection to the subpoena that we served on New York Presbyterian Hospital seeking the complication book. We served that subpoena Sunday afternoon and we attached to it the portions from the trial transcript on Friday where Dr. Westhoff described the book and its location. We received yesterday by fax objections to the subpoena, and we anticipate that we will shortly be moving to enforce that subpoena before your Honor.
THE COURT: I thought on the witness alone I had

ordered it, given the urgency of the time and what-have-you. In any event, I would not waste any time.

MS. GOWAN: Your Honor, you did order the witness to produce it.

THE COURT: I ordered the witness to produce it. If you check the transcript, I believe I did. It appeared to me it was within her control and it should be produced. Just on the question of HIPAA, I think it ought to be produced anyway, with the appropriate security taken for the rights of privacy of the patients.

MS. GOWAN: And we did make that clear to Presbyterian.

THE COURT: I hope you communicated that to the hospital. The same extreme caution as was taken before to secure the privacy of the patients we will again adhere to.

MS. GOWAN: Would your Honor like me to read my letter to Presbyterian? It is very brief.

THE COURT: Surely.

MS. GOWAN: "Dear Mr. Frank," counsel for the hospital at Phillips Nizer, "Transmitted herewith is a subpoena to the New York Presbyterian Hospital seeking the immediate production of a 'complications book' or 'looseleaf binder' that Dr. Westhoff testified about late Friday afternoon at trial in the above-referenced case.

"The relevant portions of Dr. Westhoff's trial

testimony concerning the book/binder are attached to the subpoena. You will note from the transcript that Judge Casey has ordered Dr. Westhoff to produce the book/binder to the government. See transcript at page 912/lines 18 through page 914/lines 9.

"While Dr. Westhoff testified that she and her colleagues created the book/binder, the government is serving this subpoena on New York Presbyterian Hospital in the event that New York Presbyterian Hospital may be the owner of the book/binder. According to Dr. Westhoff, the book/binder may be found in the 'head nurse's office, 3 Field West,' at the Allen Pavilion in New York City. See transcript at 909/lines 21 through 24.

"It is unclear from Dr. Westhoff's testimony whether the book/binder contains confidential patient identifying information. If so, the government agrees in advance that any such patient identifying information may be redacted and that the book/binder will be treated in accord with the agreed protective order in this case. An executed copy of the agreed protective order was previously provided to you by the government under cover of letter dated March 22, 2004. Please advise me immediately if you are not authorized to accept service of the subpoena on behalf of NYPH.

"Very truly yours, Sheila Gowan.

"cc: A. Stephen Hut, Esq. by facsimile with

enclosures."
THE COURT: Fine. You are going to then try and enforce that subpoena now?
MS. GOWAN: That's right, your Honor.
THE COURT: All right. Go right ahead and seek to do it. I have no comprehension why there is such resistance from doctors maintaining as they argue as to the appropriateness, the safety, etc., of these procedures, why the records, in this case that book, should not be opened for examination. To not have it turned over to the government continues not in a fashion of a level playing field and I don't think was what was envisioned as to how we should administer trials of this nature or any trials in this court.
I would hope that the hospital would rethink their position. I would also urge any of the plaintiffs, if they have any records that are personal to them, that they don't wait until, shall we say, by accident or whatever means they are uncovered or stumbled upon; that they produce them, as well they should know through their counsel that our system believes in full discovery and disclosure, and concealing facts or things in this context in our courts, in federal court, is not something that is encouraged, just as the Court has expressed a strong feeling that lawyers should be open and completely candid in their statements to the Court.
CROSS-EXAMINATION (continued)

BY MS. WOLSTEIN:
Q. Dr. Frederiksen, you testified yesterday on direct examination that in your opinion intact D&E is "always safer than other abortion procedures." Do you remember that?
A. Yes.
Q. One of the reasons you mentioned for that was because intact D&E involves fewer passes of instruments into the uterus, right?
A. Yes.
Q. By that did you mean fewer passes of instruments than a classical D&E, as you used that term yesterday in your testimony?
A. Yes.
Q. By "classical D&E," as you used that term yesterday, you meant D&E by dismemberment, right?
A. Correct.
Q. Intact D&E doesn't involve fewer passes of instruments than induction abortion, does it?
A. There are no instruments used with induction.
Q. Doctor, you do not count the number of instrument passes you typically use when you perform a dismemberment D&E, do you?
A. No, I do not.
Q. You do not keep track of how many instrument passes you use when you perform a dismemberment D&E, right?
A. No, I don't.

Q. There are a number of instrument passes common to both dismemberment D&E and intact D&E, right?
A. Yes.
Q. Those common passes include injection of the pericervical block?
A. Yes.
Q. And aspiration of the amniotic fluid?
A. Yes.
Q. And grasping the fetus with forceps?
A. Yes.
Q. And using suction to deliver the placenta?
A. Yes.
Q. And suction curette at the end?
A. Yes.
Q. And delivery of oxytocic agents to cause uterine contractions at the end also?
A. I give that through intravenous line. I don't put it into the uterus.
Q. That is common to both intact and dismemberment D&E, right?
A. Yes.
Q. You are not offering any data in this case to support your opinion that intact D&E always involves fewer instrument passes than dismemberment D&E, are you?
A. Objective data, no. Experience data, yes.
Q. You are just offering your testimony, right?

A. My experience.
Q. As you describe it in your testimony?
A. Yes.
Q. You testified yesterday that the medical literature doesn't do any specific study on intact D&E's versus classical D&E's and that there hasn't been any study in the area, right?
A. Correct.
Q. Doctor, the use of ultrasound with a D&E reduces the number of instrument passes necessary to empty the contents of the uterus, doesn't it?
A. Not necessarily.
Q. Well, Doctor, ultrasound serves essentially as another set of eyes guiding the doctor to where the fetal parts are, doesn't it?
A. It does.
Q. And ultrasound lets you know exactly where the fetal parts are, right?
A. Yes.
Q. Doctor, directing you to your deposition in this case, which is in a binder on the witness stand still, page 193/line 11, were you asked the following question and did you give the following answer:
"Q. How does ultrasound guidance help reduce the risk of injury from bony parts in a D&E?
"A. It is not necessarily that it reduces the risk from bony

parts, but it reduces the overall risk in that it reduces the number of times you have to put instruments within the uterus to get the fetus delivered and get the contents of the uterus emptied and complete the procedure."
Were you asked that question and did you give that answer?
A. Yes.
Q. Now, Doctor, to grasp the fetal parts and bring them through the cervix in a dismemberment D&E, you used an elbow forceps, right?
A. No.
Q. You used a Hern forceps or a Sopher forceps or both, right?
A. Either one, yes, whichever we need to do the procedure.
Q. The inside of the forceps has ridges that interlock, right?
A. Yes.
Q. Those ridges, or protuberances, are what do the grasping during a D&E, right?
A. Yes.
Q. Doctor, there is nothing sharp about those ridges or protuberances, is there?
A. No.
Q. The grasping portion of the forceps is not sharp?
A. No.
Q. You can run your finger over the grasping portion of the forcep without hurting yourself, right?

A. Correct.
Q. When the forceps is closed, there are no ridges or teeth on the outside of the forceps, correct?
A. Correct.
Q. When the forceps is closed and the ridges on the inside articulate, the outside of the instrument is smooth, right?
A. Yes.
Q. Doctor, you would never use a scissors to grasp for and extract fetal parts, would you?
A. No.
Q. In an intact D&E you use a scissors to puncture the fetus's skull at the base of the neck, correct?
A. Yes.
Q. You would agree, Doctor, wouldn't you, that a scissors is potentially more dangerous to the woman than a forceps if a mistake is made, right?
A. Yes.
Q. A scissors is more dangerous than a forceps because a scissors is a sharper instrument than a forceps, right?
A. Yes.
Q. In fact, Doctor, in your opinion, forceps do not pose a risk of cervical laceration, do they?
A. I don't think so, no.
Q. The risk of perforation in a D&E really comes from forcible dilatation, as you explained earlier, not from the use of a

forceps, right?
A. No, actually it is any instrument that can go through the wall of the uterus. Forcible dilatation is the most common cause of uterine perforation.
THE COURT: Did you include that in your expert opinion submitted in this case?
THE WITNESS: I don't remember.
MS. WOLSTEIN: Your Honor, I don't think it was in the expert report.
THE COURT: I will check it, but I didn't think so.
MS. CHAITEN: Your Honor, the expert report includes a number of statements about the risks of --
THE COURT: Please. She is under cross-examination. It is inappropriate to do what you just started to do. I asked a question, she answered it. Ms. Wolstein is conducting cross-examination. There is no coaching, Ms. Chaiten. I thought I had admonished you for that.
Q. Again, by forcible dilatation of the cervix, you mean a gradual process by which you use metal dilators to introduce them into the uterus and essentially force them through the uterus, right?
A. Force them into the cavity of the uterus.
Q. You testified yesterday in your direct examination that uterine perforation is much more common with forcible dilatation of the cervix than by using forceps to grab tissue,

right?
A. Yes.
Q. Forcible dilatation can cause bleeding at the internal os?
A. Yes.
Q. And bleeding at the internal os requires you to stop the procedure, doesn't it?
A. No.
Q. Doctor, directing you to page 80 of your deposition in this case, line 11, were you asked the following question and did you give the following answer:
"Q. Why do you want to avoid forcible dilatation?
"A. Because with forcible dilatation there is an increased incidence of perforation of the uterus, and you can also cause bleeding at the internal os, which requires procedures to stop."
Were you asked that question and did you give that answer, Doctor?
A. Yes.
Q. In fact, the chance that perforation will occur as a result of forceps going through a thinned-out area of the uterus is pretty rare, isn't it, Doctor?
A. It is rare.
Q. It is pretty rare, isn't it?
A. I have experienced it, but it is pretty rare.
Q. In response to the Court's question yesterday, you

testified that the risk of uterine perforation occurring as a result of instrument passes is a low-risk occurrence, didn't you?
A. Could you repeat the question, please.
THE COURT: Mr. Reporter.
(Question read)
A. Yes.
Q. Doctor, inductions have an even lower rate of uterine perforation than D&E, don't they?
A. Yes.
Q. Doctor, you also testified yesterday on direct examination that you believe intact D&E is safer than dismemberment D&E because it involves fewer bony fragments passing through the cervix and thus reduces the risk of cervical laceration, right?
A. Correct.
Q. The basis for that opinion is your experience, right?
A. Correct.
Q. You are not offering any data to support your opinion that intact D&E is safer than dismemberment D&E because it involves fewer bony fragments passing through the cervix and thus reduces the risk of cervical laceration, right?
A. There is no data on that particular aspect. It is only indirect with the incidence of hemorrhage.
Q. You testified earlier that you note in the patient record when a cervical laceration occurs, right?

A. Yes.
Q. And in the patient's medical record you note the type of abortion procedure being performed, don't you?
A. Yes.
Q. So if you wanted to offer data based on your experience, you could offer data from the medical records of your patients, right?
A. Yes and no.
Q. Doctor, there are no studies that address the risk of injury from bony parts in connection with a D&E, are there?
A. I'm not familiar with that.
Q. Because there aren't any, are there?
A. I said I'm not familiar with any.
Q. In fact, Doctor, in any given case where you have a cervical laceration, you won't necessarily know what caused the laceration, will you?
A. You may not know that you have actually lacerated the cervix or nicked an artery, and it is only with continued care of the patient that that becomes the problem or becomes obvious. You may initially have a higher blood loss at the time of surgery. And hemorrhage still is the leading complication with second trimester terminations.
Q. During the procedure you won't know what caused cervical laceration, right?
A. You may not know, no.

Q. In fact, it would only be your best guess that the laceration was caused by a bony fragment, right?
A. Correct.
Q. As you testified, damage to the cervix could also be caused by forcible dilatation with metal dilators, right?
A. Yes.
Q. In fact, Doctor, you have never seen any data assessing the risk of laceration of the cervix in connection with an intact D&E, right?
A. Correct.
Q. And you have never seen any data assessing the risk of nicking an artery in connection with an intact D&E, right?
A. That's correct.
Q. Those risks, namely, nicking an artery and blood loss, are also present with an intact D&E, right?
A. Yes.
Q. Doctor, is the amount of blood loss that occurs in an induction abortion performed at Northwestern Memorial Hospital noted on the patient's medical record?
A. Yes.
Q. Is the amount of blood loss occurring in a second trimester surgical abortion performed at Northwestern Memorial Hospital noted on the patient's medical record?
A. Yes.
Q. If the doctor performing the abortion considers the amount

of blood loss by the patient to be a complication of the procedure, would the amount be noted in the patient's medical record?
A. Yes.
Q. Doctor, if you considered the amount of blood a patient loses during a second trimester surgical abortion to be a complication of the procedure, you would note the amount of blood loss on the patient's medical record, wouldn't you?
A. It is part of the operative note, yes.
Q. You have to write it down?
A. Yes.
Q. Doctor, yesterday you testified on direct that in your opinion there is less blood loss overall with an intact D&E than with a dismemberment D&E, right?
A. Yes.
Q. But, Doctor, you have never seen any data assessing the amount of blood loss in connection with an intact D&E, right?
A. No. It is all my experience.
Q. You have never seen any data assessing the need for a blood transfusion in connection with an intact D&E, have you?
A. No.
Q. You are not aware of any published data comparing blood loss in an intact versus a dismemberment D&E, right?
A. No.
Q. You are not offering any data in this case as to the amount

of blood loss you have observed in cases of intact D&E versus dismemberment D&E, right?
A. No, I have not.
Q. In fact, Doctor, blood loss in itself is considered a minor complication of abortion according to CDC criteria, isn't it?
A. No, that is incorrect.
Q. One complication of abortion that the CDC defines as a minor complication is a blood loss of 500 milliliters or more, right?
A. They estimate blood loss. In the paper I mentioned yesterday, the leading complication for second trimester terminations is hemorrhage.
Q. Hemorrhage requiring transfusion is a major complication, right?
A. Yes.
Q. But blood loss of 500 milliliters or more is a minor complication, according to the CDC, right?
A. Well, more than 500cc's is more than we actually lose. Most D&E's are intact D&E's.
Q. Doctor, do you know whether a total blood loss of 500 milliliters or more is one of the criteria that the CDC considers a minor complication or not?
A. I don't know the exact definition, but it seems to be counterintuitive that they would include a greater-than sign, when the greater-than sign would also include blood loss of

1,000 or 2,000 or 3,000 cc, to be minor.
Q. Doctor, you testified yesterday on direct examination that intact D&E can reduce the risk of fetal parts remaining in the uterus, right?
A. Correct.
Q. In fact, Doctor, making sure that the uterus is completely evacuated is part of doing an intact D&E and a dismemberment D&E, isn't it?
A. Correct.
Q. You do that by assessing fetal parts, right?
A. Correct.
Q. And by ultrasound?
A. Not necessarily. I don't always use ultrasound.
Q. Not always. But you can, is that right?
A. You can, yes.
Q. By doing a suction curette as a last step of the procedure?
A. Correct.
Q. And by assessing the uterus to see whether it contracts, right?
A. Correct.
Q. Doctor, you would not discharge a patient from your care after a second trimester abortion without making sure that you have completely emptied the uterus, would you?
A. It is within the standard of care to basically make your best assessment that the uterus is empty. Unfortunately, the

procedures are not always perfect and we can leave tissue, even after a term delivery, within the uterus inadvertently.
Q. Is that a no?
A. No. I won't say that, because in the sense what you are saying to me is that I have to guarantee that the uterus is empty, and I can't guarantee that the uterus is empty after a term delivery.
Q. Doctor, you would not discharge a patient from your care after a second trimester abortion without making your best effort to ensure that you have completely evacuated the uterus, would you?
A. No, I would not.
Q. Doctor, at Northwestern Memorial Hospital, is the start time of an abortion procedure noted in a patient's medical record?
A. It is.
Q. Is the time the procedure ends noted in a patient's medical record?
A. It is.
Q. If you look at those two times, the start time and the end time, from that can you determine the total amount of the procedure time?
A. Yes.
Q. Now, Doctor, you are not offering any data to support your opinion that intact D&E involves a shorter procedure time than

dismemberment D&E, right?
A. No objective data.
Q. But if a doctor who performs D&E abortions, both dismemberment and intact, at Northwestern Memorial Hospital wanted to offer data on procedure time, he or she could find that data in the patient medical records, right?
A. Yes.
Q. Doctor, you offered the opinion in your expert report that one advantage to intact D&E is that you get an intact fetus or pathologic assessment, right?
A. Yes.
Q. In fact, with an intact D&E you don't actually get a fully intact fetus, do you?
A. That's correct.
Q. A fetus aborted by intact D&E has no brain contents, does it?
A. No, it does not.
Q. To get a truly intact fetus from an abortion, you would have to do an induction, wouldn't you?
A. Correct.
Q. To get a fetus with a brain and an intact body, you would have to do an induction, right?
A. Yes.
Q. You cannot confirm a diagnosis of any intracranial defect with an intact D&E, right?

A. That is correct.
Q. That means you cannot confirm a brain defect with an intact D&E, right?
A. Yes.
Q. A defect of the brain cannot be confirmed by any means other than an induction abortion, isn't that so?
A. Yes.
Q. So you cannot confirm a diagnosis of hydrocephalus with a fetus in which the brain contents have been suctioned by a D&E, correct?
A. That's correct.
Q. If you are dealing with a hydrocephalic fetus where you need a diagnosis, it is best to do an induction, right?
A. Yes.
Q. Doctor, you use the term "intact dilatation and evacuation" synonymously with "intact dilatation and extraction," don't you?
A. Could you repeat the question, please.
THE COURT: Mr. Reporter.
(Question read)
A. Yes.
Q. You have also referred to intact D&E as a "breech extraction variant of D&E," right?
A. Yes.
Q. An intact D&E can also be referred to as "dilation and

extraction" or "D&X," right?
A. Yes.
Q. D&X was developed for late second trimester abortions, wasn't it?
A. Yes.
Q. D&X is especially suited to late second trimester abortions?
A. Yes.
Q. One reason D&X is especially suited to late second trimester abortions is because dismemberment of the fetus becomes more difficult beyond 22 or 23 weeks gestation, right?
A. Yes.
Q. Fetal tissue becomes more difficult to break apart somewhere between 22 and 23 weeks?
A. Yes.
Q. In fact, you yourself usually do the D&X procedure beyond 20 weeks, right?
A. Yes.
Q. When you do the surgical portion of the D&E procedure, you place a Grave's speculum in the vagina?
A. Yes.
Q. Then the cervix is prepped with Betadine and lidocaine is infused in the anterior lip of the cervix?
A. Yes.
Q. Then the cervix is grasped either with one tenaculum or two

tenaculums or with a ring forceps?
A. Yes.
Q. Then a pericervical block is placed with 5cc's of lidocaine infused?
A. That is only the beginning of the cervical block. Yes.
Q. Then you pass a large later, number 35 Pratt, to ascertain the dilatation of the cervix and to assess whether there is any resistance?
A. Sometimes, sometimes not, yes.
Q. With most patients, in the second trimester there will be no resistance, correct?
A. Correct.
Q. Then a number 12 cannula is placed on a suction hose, which is placed on a suction machine, and the cannula is placed within the uterus?
A. Correct.
Q. With that, the amniotic fluid is evacuated, right?
A. Correct.
Q. You testified in your direct testimony that it is at that point, namely, when you empty the amniotic fluid, that the cord usually comes down and you can sever it, right?
A. Correct.
Q. Further suction with the machine will bring either the placenta, the umbilical cord, or the fetal parts close to the cervix, right?

A. Correct.
Q. Then, beyond 14 weeks instruments will need to be used to evacuate large fetal parts, including the head?
A. Correct.
Q. To do that, you grasp the fetal parts and bring them through the cervix, right?
A. Yes.
Q. After the placenta is delivered, oxytocin is infused to help with uterine contractions, and you curette the uterus to make sure there are no remaining products of conception, right?
A. Correct.
Q. At the conclusion of the procedure, you examine the products of conception to ascertain that they have all been evacuated?
A. Correct.
Q. When you do a D&X or intact D&E, you either compress the fetal head with forceps or you make an incision into the back of the neck, into the skull, with a scissors, and then you cause disruption of the fetal brain?
A. Yes.
Q. So D&X involves either puncturing the skull with scissors or collapsing the head with forceps, correct?
A. Yes.
Q. When you have done a D&X, you have used both the method of compressing the head with forceps and making an incision into

the back of the skull and reducing the head with a scissors, right?
A. Yes.
Q. To disrupt the fetal brain, you use your finger, and that compresses the contents of the head and allows it to pass through the cervix?
A. Yes.
Q. When you do a D&X in breech presentation, you grasp the fetal foot, and with careful manipulation of the fetus you deliver the fetus to the trunk, right?
A. Yes.
Q. Then you essentially do a breech delivery, where you are left with the fetal head inside the cervix, right?
A. Yes.
Q. Then you either compress the head or you enter the skull with scissors and disrupt the fetal brain, correct?
A. Correct.
Q. In your view, Doctor, D&X does not necessarily involve converting the fetus to a breech presentation, does it?
A. Correct.
Q. If the fetus is in head-first presentation and if you take certain other steps, you still could be doing a D&X, right?
A. Correct.
Q. You have done the D&X when the fetus was in head-first presentation without converting it to a breech, right?

A. Yes.
Q. In fact, usually you do not convert the fetus to a breech position when you do a D&X, right?
A. Correct.
Q. That is because the conversion to a breech presentation involves discomfort to the woman and you don't have enough anesthesia available to cover that?
A. Correct.
Q. Doctor, if you are performing a second trimester abortion at Northwestern Memorial Hospital for a maternal health condition, would the maternal health condition be noted on the patient's medical record?
A. Yes.
Q. If you are doing a second trimester termination at Northwestern Memorial Hospital for a fetal indication, would the fetal indication be noted in the patient's medical record?
A. Yes.
Q. Now, Doctor, you testified on your direct testimony about a condition called acute fatty liver pregnancy. Do you remember that?
A. Yes.
Q. D&E is not contraindicated for that condition, is it?
A. No.
Q. Whether a D&E or a D&X is done is a preference, right?
A. Yes.

Q. Now, Doctor, we have heard testimony by Dr. Hammond and others about a condition called chorioamnionitis. Are you familiar with that condition?
A. Yes, I am.
(Continued on next page)

BY MS. CHAITEN:
Q. What is it?
A. It's an infection of the chorionic and the amniotic membrane that surrounds the fetus.
Q. And, in your opinion, pregnancy termination is medically necessary for that condition, right?
A. It is.
Q. And if chorioamnionitis though, no particular method of termination is indicated, is it?
A. No.
Q. You could do an induction or a D&E, right?
A. Yes.
Q. And are you familiar with the condition known as severe pre-eclampsia?
A. Yes.
Q. What is that?
A. It is a hypertensive abnormality of pregnancy characterized by high blood pressure, abnormal liver enzymes, protein in the urine, and it can extend to low platelet counts as well.
Q. And, in your opinion, pregnancy termination is medically indicated in the case of severe pre-eclampsia, right?
A. It is.
Q. But no particular method is indicated, right?
A. No.
Q. The abortion could be done by whichever route the patient

or the doctor chooses, right?
A. Correct.
Q. Are you familiar with a condition known as pulmonary hypertension?
A. Yes.
Q. What is that?
A. In the pulmonary vasculature the pressures are normally low and in pulmonary hypertension, for whatever reasons, there are higher pressures changing the dynamics of blood flow from the right side of the heart in through the lungs.
Q. And, in your opinion, is pregnancy termination medically indicated for a woman with pulmonary hypertension?
A. It may be, yes.
Q. And if it is in a particular case you could do either a D&E or a D&X, right?
A. Correct.
Q. And you mentioned on your direct testimony renal disease, do you remember that?
A. Yes.
Q. Now, renal disease can sometimes be managed successfully to term, isn't that so?
A. That's correct.
Q. But if a woman decided to have an abortion in the case of renal disease, you could do either an induction or a D&E, right?

A. Correct.
Q. Doctor, a D&E on a woman with a prior caesarean section would not be contraindicated, would it?
A. A D&E?
Q. Right.
A. No, it would not be contraindicated.
Q. Doctor, in developing your expert opinions in this case, you did not read any articles or books, did you?
A. I did review some literature, yes.
Q. Doctor, in preparing your expert report in this case you did not read any articles, did you?
A. Oh, for my expert testimony? I don't think I reviewed anything for my expert report, no.
Q. And in preparing your expert report, you did not read any books, right?
A. Correct.
Q. And you did not look at any specific medical literature, right?
A. Correct.
Q. But you did look at your declaration in the Hope Clinic case, right?
A. Yes.
Q. Now, Doctor, you testified on direct that when a new surgical technique or techniques evolve, you may talk with other physicians about it. Do you remember that?

A. Yes.
Q. And you learn about their techniques and they learn about your techniques?
A. Yes.
Q. And you said that you may adapt your protocol to what you learned from other doctors?
A. Yes.
Q. And eventually maybe a study will be done on the new technique?
A. Yes.
Q. Doctor, have you talked to your colleague, Dr. Hammond, about D&X or intact D&E over the years?
A. We may have mentioned it in passing. I don't remember any specific conversations.
Q. You haven't discussed your techniques for intact D&E?
A. No.
Q. Have you discussed what have been the benefits over traditional D&E with Dr. Hammond?
A. The majority of what we discussed is cervical preparation for the second trimester D&E.
Q. Now, Doctor, in your 1997 declaration in the Hope Clinic case challenging Illinois' partial-birth abortion statute you wrote that, "intact D&E has not been the subject of comparative clinical trials."
Do you remember that?

A. Yes.
Q. And that's still true today, isn't it, Doctor?
A. To my knowledge, yes.
Q. And you also wrote, in 1997 in your Hope Clinic declaration that, "there are no data comparing intact D&E with other procedures."
Do you remember that?
A. Yes.
Q. And that's also still true today, Doctor, isn't it?
A. Yes.
Q. And you testified earlier today that the IRB at Northwestern Memorial Hospital only needs to give its approval for research on human subjects in the context of a study.
Do you remember that?
A. It's actually the Institutional Review Board of Northwestern University, and it only gives its approval when it has a study protocol presented to it.
Q. And no studies on intact D&E have been provided to the IRB at Northwestern University coming out of the work that you and Dr. Hammond do there, have they?
A. Not that I know of.
Q. So, when you and Dr. Hammond perform intact D&E at Northwestern, you don't need to inform the IRB of that, do you?
A. Would you repeat the question?
Q. When you and Dr. Hammond perform intact D&E at Northwestern

Memorial Hospital, you don't need to inform the IRB of that, do you?
A. That's correct.
MS. WOLSTEIN: No further questions, your Honor.
THE COURT: Redirect?
MS. CHAITEN: Yes, briefly, your Honor. May I have just one minute?
THE COURT: You may.
REDIRECT EXAMINATION
BY MS. CHAITEN:
Q. Dr. Frederiksen, do different doctors have different protocol for abortion procedures?
A. Yes, they do.
Q. Can a procedure vary in terms of safety depending on factors like physician's skill and experience?
A. Yes.
Q. Doctor, on cross you testified to a number of -- or testified about a number of medical conditions where you said that you could do either a D&E or a D&X. When you referred to D&X, were you referring to the intact D&E variation?
A. Yes.
Q. And do you have an opinion as to whether one of those approaches would be safer than the other?
A. The D&E can very readily go into a -- the intact variation. When you deliver fetal parts you can very easily deliver the

whole fetus.
In all cases the more intact procedure decreases the overall risk.
Q. Doctor, when you perform a D&E where you have had to dismember the fetus, does the assessment of whether the uterus is empty at the end of the procedure take longer than it does where the fetus comes out intact?
A. Yes, it does.
Q. On cross you answered affirmatively to a question as to whether a D&E or a -- I'm sorry -- whether a physician performs a D&E or an intact variation of D&E is done is the physician's preference; what did you mean by that?
A. Could you repeat the question?
Q. I'm sorry. I didn't state that very well. Sorry about that.
On cross you answered a question as to whether a D&E or a D&X is done at the physician's preference. What did you mean by that? That it is your preference as to whether you do a D&E or a D&X?
A. Well, you can start to do a D&E where you -- but the intent is not to dismember, the intent is actually to empty the uterus as quickly as possible so that as you deliver the fetus you can deliver the whole fetus and it is essentially an intact variation.
Q. Dr. Frederiksen, early in your cross examination you

testified there were circumstances under which your induction protocol would be used after 24 weeks.
Do you recall that?
A. In my deposition?
Q. No, this was in cross-examination this afternoon.
A. Yes.
Q. Under what circumstances would you perform an induction after 24 weeks' gestation?
A. A lethal anomaly in the fetus.
Q. Any others?
A. The only time I do an abortion beyond 24 weeks is with a lethal fetal anomaly.
Q. And do you sometimes use induction to deliver a baby at or near term?
A. An induction procedure, yes.
We induce labor at any portion of the latter portion of the second trimester or in the third trimester.
Q. Doctor, you testified that one of the risks of KCL is that you might inject a toxic substance into the pregnant woman. Does that risk exist in connection with amniocentesis?
A. Amniocentesis is a procedure by which we are extracting fluid from the amniotic cavity.
When we are putting potassium chloride into the fetus we are actually injecting a toxic substance in high concentration into the fetus. If you don't know exactly where

it is it can accidentally get into the maternal circulation.
That type of injection into the amniotic cavity occurred with saline and with prostaglandins when we were doing more installation abortion techniques in the -- a while ago.
Q. So, when you do an amniocentesis though, you're not at risk for injecting the pregnant woman with the toxic substance?
A. No.
Q. Dr. Frederiksen, are there some maternal health conditions where you would be unwilling to perform an intracardiac injection even if a patient requested it?
A. Yes.
Q. And what would those -- and some examples of those situations be?
A. Well, if there was going to be a risk to the mother, such as if there was overlying bowel from prior surgical procedures, if there was a bleeding abnormality in the mother, if there was intrauterine infection such as chorioamnionitis, or if there was a chance that the mother who had an increased incidence of sepsis and the uterus was infected, by putting another needle into the uterus you could inadvertently seed maternal tissues.
Q. Doctor, you were asked a number of questions about amniocentesis on cross, I am just going back to amniocentesis for a minute.
Would you do an amniocentesis on a woman who was suffering from sepsis?

A. No.
Q. Why not?
A. Because you would be putting a needle into an infected area and then withdrawing it through the maternal tissues.
Q. And what would your concerns about that be?
A. Again, infecting maternal tissues.
MS. CHAITEN: I have no more questions at this time.
THE COURT: I suppose, Ms. Wolstein, do you have some recross?
MS. WOLSTEIN: No, your Honor. Nothing further.
THE COURT: All right, Doctor. You may step down.
Why don't we take our afternoon recess then at this time.
(Recess)
THE COURT: Please, be seated. Just one or two things before we continue with testimony.
With regard to the deposition testimony of the two doctors, I would ask that you get copies of the transcripts to my chambers this afternoon along with, from the government, any objections or counter-designations. But that we need the transcripts to review it and try to be prepared to make any rulings, if we need make any, by tomorrow.
With regard to the question of whatever Judge Hamilton is doing on the west coast with regard to Dr. Bowes and Dr. Sprang, that I would hope that you are coordinating

whatever you are doing if in fact they have been re-opened. And do not quote me that I am suggesting, because I haven't thought this through yet, I am in no way suggesting they should be reopened but if they were, I would hope that they would be in court and that these doctors would be inconvenienced as little as possible and that it would be done just once.
But, since I have counter-interpretations of what Judge Hamilton did I don't know whether it's happening or not. Can you tell me, are those two doctors testifying on the west coat today?
MR. LANE: Your Honor, Sean Lane for the government.
We understand Dr. Bowes has testified in one of the other cases, I don't want to misstate which case it is, but I know he has testified in one of the other cases, Nebraska or San Francisco already.
I'm not sure about Dr. Sprang.
THE COURT: Okay.
MR. LANE: And your Honor, if I may also take this opportunity; your Honor had mentioned the depositions of Drs. Paul and Creinin.
THE COURT: Yes.
MR. LANE: In light of the government's pending motion, we have not yet provided the Court with counter-designations or objections and we will endeavor to do so as quickly as we can.

THE COURT: Well I believe we, I had my clerk check, I believe we have the plaintiff's designations and I haven't ruled on it yet but I will, but I thought I would do it all at once should I allow the depositions to go in. I would like to see what the testimony is and whether there is anything objectionable.
MR. LANE: Certainly, your Honor. The reason for me mentioning this is just because we want to provide that to the Court but we don't have that readily available and we will prepare that this afternoon, early this evening and get it to your Honor's chambers as soon as possible.
THE COURT: I don't believe the intention was to offer until, at the earliest, until sometime tomorrow afternoon.
MR. LANE: Thank you, your Honor.
THE COURT: That will give us a little time to try and review it.
MR. LANE: Certainly, your Honor. And that would be our intent, to get that to you as soon as possible.
THE COURT: All right. Plaintiffs can call their next witness.
MS. WIGMORE: Your Honor, this Ms. Wigmore and at this time we would like to read the deposition of Ms. Meghan Kissell, who is a 30(b)6 witness for the American Medical Women's Association.
THE COURT: All right. How many pages -- you are

going to use one of your staff?
MS. WIGMORE: Yes. The part of Ms. Kissel will be played by Ms. Mimi Liu.
I do have a copy of the transcript and exhibits referenced in it for your clerk, your Honor, if you would like me to provide that.
I have provided a copy of the exhibits to the government.
THE COURT: If you would.
How many pages of this are you intending to offer?
MS. WIGMORE: I do not have the precise page count in front of me but my colleague, Mr. Hut, can count those up off the pretrial designations.
THE COURT: Are there objections from the government to any of this?
MR. PANTOJA: Yes, your Honor. They were included with the pretrial order in this case.
MS. WIGMORE: Objections have been ruled and will be received in order on those?
MR. PANTOJA: Yes, on April 2nd.
THE COURT: So I don't have anything new coming?
MS. WIGMORE: That's correct, your Honor.
MR. PANTOJA: That's correct, your Honor.
MS. WIGMORE: We believe it is about 30 pages. Subject to the ruling, some of those pages may have been

excluded but something in that range, your Honor.
THE COURT: I hope you are all assessing this for the benefit of future trials you may have in your career as to its value to proceed in this fashion.
Go right ahead.
MS. WIGMORE: Just for the record, the deposition transcript is dated January 30th, 2004.
THE COURT: Very well.
MS. WIGMORE: I will be reading the questions that were asked by Mr. Pantoja of the government, and later in the transcript I will be switching roles to Ms. Novak and then Ms. Liu.
THE COURT: Did anybody sit down and assess the impact you have of such testimony being, answering questions, proposed questions by different parties?
MS. WIGMORE: Your Honor, we would be happy to have different attorneys play the roles of the other.
THE COURT: No, think about it, how you might pose a question, how a witness might react to it, all of which is lost in a cold transcript, even with the human factor added in in the reading of the question and answer.
MS. WIGMORE: Understood, your Honor.
THE COURT: I hope you would reassess the value, the value of such procedure.
Go right ahead.

MS. WIGMORE: Thank you.
"Q If you could please state your name and business address for the record?
"A Sure. My name is Meghan Kissell. The business address is American Medical Women's Association, 701 North Fairfax Street, Suite 400, Alexandria, Virginia, 22314
"Q I would like to show you what has been previously marked as Government Exhibit 29-D" -- and just for the record, your Honor, that is trial Exhibit 32 -- "are you familiar with that document?
"A Yes, I am.
"Q Can you just tell me what it is?
"A This is the subpoena in a civil case that AMWA received on -- I'm sorry, I thought it had the date on it. The subpoena that AMWA received on January 8th, 2004, in the case of NAF versus John Ashcroft.
"Q Are you testifying here today pursuant to that subpoena?
"A Yes, I am."
MR. PANTOJA: Excuse me, counsel.
Your Honor, may I propose since we have different pages and line numbers, if you could just designate specifically which page and line number you are at?
MS. WIGMORE: Surely, I will definitely do that.
Now, beginning page 8, line 12:

"Q Can you tell me who you are employed by?
"A I work for the American Medical Womens' Medical Association.
"Q What is your position and title?
"A I'm the director for communications and advocacy.
"Q Can you briefly tell me what your duties are as the director of communications and advocacy is?
"A Sure. My responsibilities include overseeing government affairs actions that the organization takes, facilitating communication with our physician members, overseeing communications of the organization which include website, newsletter and e-mail communication with our members.
"Q How long have you been a director of communications and advocacy for AMWA?
"A Been the director since October of 2001 and I have been with the organization since June of 2000."
MS. WIGMORE: Now moving to page 10, line 16:
"Q And, can you just briefly tell me what AMWA is?
"A Sure. The association is an organization of 10,000 medical professionals which include women physicians, residents and medical students dedicated to advancing women in medicine and improving women's health.
"The organization focuses on professional development for their members as well as education in women's health and advocacy on women's health topics."

MS. WIGMORE: Now moving to page 12, line 22:
"Q If you could, please refer to Government Exhibit 31-D, page AMWA-3." For the record, trial Exhibit 17.
" Can you explain to me what that document is?
"A This document is AMWA's position on abortion statement.
"Q If you thumb through pages AMWA-3 through AMWA-6, I believe on AMWA-5 there is another document there. Is that also a position statement?
"A Yes. AMWA-5 is a position statement on abortion and access to comprehensive reproductive health services.
"Q Can you tell me what a position statement is as far as AMWA is concerned?
"A Sure.
The position statements of AMWA put forward the positions of the organizations that have been reviewed and approved by both our members and our board of directors. These are formal positions that the association has taken on various women's health issues.
MS. WIGMORE: Now moving to page 14, line 4:
"Q AMWA issues position statements from time to time?
"A Yes, we do.
"Q How is it decided, on what matters AMWA issues position statements?

"A Position statements are developed at either the request of the president or member of our leadership. The matter is then referred to the appropriate committee, either the advocacy committee and women's health committee.
"These committees then choose a writing team of experts in the area that's been determined. The team then develops the paper. It is reviewed by the appropriate committees, the paper then goes to the board of directors. If the board of directors approves the paper, the paper is then brought to the meeting of the members where the membership of the association has an opportunity to accept or reject the proposed statement.
"Q If you see AMWA-4 in Government Exhibit 31-D" -- and for the record that is trial Exhibit 17 -- "and AMWA-6, there is a reference to adoption by something called the house of delegates; can you tell me what that is?
"A The house of delegates was renamed the meeting of the members by bylaws changed in 2002 so that -- it is the same. It's a formal body of the association where the general membership has an opportunity to vote on bylaws changes and policy statements.
"So, when I am referring to the meeting of the members, that is the current term; whereas the house of delegates was the appropriate term at the time these two papers were formalized.

"Q Can I refer to the body as the house of delegates?
"A Yes.
"Q Or meeting of the members interchangeably?
"A Yes.
"Q With respect to the house of delegates, I'm assuming that it is composed of a body of delegates. If not, if you can just explain to me what the membership is of the house of delegates?
"A Sure. That's a distinction between the house of delegates and the meeting of the members. The house of delegates was made up of delegates from each state whereas the meeting of the members now is a general voting of membership without delegates.
"Q When you say members from each state, are you referring to doctors or something else, politicians? What are you referring to?
"A No. Our association memberships are only physicians, residents and medical students. Those are the only members who are allowed to vote so delegates would have either been physicians, residents or medical students.
"The branch presidents from around the country would -- a branch rep and regional gover would sign off on a particular delegate. So, there was a formal process of who the delegates were at the meeting. A delegate would not just be

any physician who chose to come. A delegate would have been approved by a branch president or a regional gover.
"Q And then how would the voting process work?
"A The voting process for the house of delegates?
"Q Yes, the house of delegates.
"A an issue would be put forward. We follow Robert's Rules of Order for voting. There would be an opportunity for discussion, statements for and against a particular position regarding what the matter at hand was and then a hand vote, hand count vote would be taken.
"Q And then was there a minimum number of votes required to undertake any action like super majority vote? What was required to act?
"A The house of delegates had a minimum number of members that needed to obtain a quorum for a meeting and that minimum is 100 members or 100 delegates when we did house of delegates.
"For approval of position statements a simple majority was appropriate for approval.
"Q For?
"A For approval of a position statement.
"Q When you say that a quorum was 100 for the house of delegates, when that was the body 100 out of how many total delegates at that time?
"A At which time are you referring to? I don't know

what number of delegates we would have in a given year.
"Q Let's refer to the position statements that are at AMWA-3 and 4 and AMWA-5 and 6."
"A I don't know how many delegates we would have, what the maximum number of delegates we will have had in those years so I'm not sure.
"Q Do you have an approximate understanding of how large the body is?
"A The delegates were made up based on how many branches we had in any particular year and that was a determination of how many delegates we could have. Without knowing how many branches we had in the years that these statements were approved I don't know how many delegates were possible.
"Q Was there a certain number of delegates per state that the AMWA either tried to have or did have?
"A It depended on the number of members in those states in those years and I don't have those numbers with me.
"Q So it wasn't a fixed number per state, it depended on -- if a state happened to have more numbers in that state you would have more delegates?
"A Correct.
"Q At the time that AMWA had the house of delegates, what was the role of the board of directors in connection with the issuance of a position statement?

"A A position statement would need to first be approved by the board of directors before going on the agenda for the house of delegates or meeting of the members, so that would need to happen in a meeting be prior, in a board meeting prior to the meeting of the house of delegates.
"Q And how would an issue get to the board of directors for a consideration for advancing to the house of delegates?
"A If a committee was working on a position statement, the committee chair would bring it to the attention of the president or another member of the board of directors. A position statement would need to go to the board three months prior to a board meeting in order for it to be put on the agenda for a vote.
"Q And can you just again tell me the names of the committees that would propose a position statement to the board of directors?
"A Sure. The two committees that might be involved in proposing a position statement would be the government affairs committee, which is now referred to as the advocacy committee or the women's health committee, which is the committee in charge of these two papers.
"Q Now, between these two committees, the government affairs committee now known as the advocacy committee and the women's health committee, would one or both be expected to

propose a position statement in the area of abortion procedures?
"A The women's health committee oversaw the writing of the abortion statements papers.
"Q Just using the topic of abortion, between those two the government affairs committee now known as the advocacy committee and the women's health committee, would it have only been the women's health committee would have proposed a position statement on abortion?
"A In this case, that's correct. The committees have overlapping membership so the women's health committee has taken the lead on both of these papers."
MS. WIGMORE: I'm now moving to page 22, line 13:
"Q Once the board of directors has approved the proposal of a position statement to the house of delegates -- am I describing that accurately -- would it propose it or would it basically direct the house of delegates to act on or issue a position statement?
"A The board of directors would first approve the statement and if the board of directors approved the statement, the statement will be put on the agenda for the house of delegates or meeting of the members to vote on. The board cannot dictate an approval of a paper.
"Q Who, at AMWA, which body would have final say as to whether AMWA would in fact issue a position statement?

"A The final say is with the membership, with the house of delegates or the meeting of the members.
"Q Once AMWA has decided to issue the position statement, either by the house of delegates or a meeting of the members, how would AMWA go about formulating the position statement?
"A It's a little bit backwards. The statement would already have been created by the time final approval is given. The statement is not approved in concept, the statement is approved in totality, is a statement would have been prepared by the committees reviewed, gone to the board.
"The board would review a prepared statement, and I'm referencing AMWA-3 and 4 of the example in front of us. The board would either approve or reject the prepared statement. If they approved it would go then -- it would then go to the meeting of the members or house of delegates for final approval and acceptance by the association.
"Q When you say at that, the position statement is already drafted by the time it goes to the board of directors, the board of directors then approves it and forwards the position statement as it is to the house of delegates or the meeting of the members. Is there any further revision to the position statement that can take place during that process? Or will the house of delegates or the meeting of the members take it or leave it as it is?

"A There are changes. There can be changes within the document from the time that is originally drafted and the time it is formalized by the meeting of the members. However, those changes happen at the committee level and at the board level.
"Once the board approves the paper, no more changes can be made to the paper. So, the paper statement is then sent as a complete document to the house of delegates. If there are questions about the content of the document, the house of delegates or meeting of the members will send the paper back to the appropriate committee for further revision before approval.
"Q So once a position statement reaches the front steps of the house of delegates or meeting of the members, that is a form in which it was and when the board of directors approved it?
"A That's correct.
"Q During the process undertaken by the house of delegates to decide whether to in fact issue a position statement that is before it, what is that process? Does it, for example, hire consultants? Does it convene another committee in itself it undertake that process?
"A By the time the house of delegates is looking at a paper, the paper would start with either a committee suggestion of either we need a committee on this issue or requesting a committee to assign a term to write a paper on a

certain issue.
"So, a committee has been working on the development of the paper surrounding a certain issue and those committee members, in many times, are at the house of delegates and can speak to the paper.
"So, by the time of house of delegates or the meeting of the delegates convenes, there has been a lot of input from the physician membership.
"Q I guess my question is, once the position statement is handed to the house of delegates or the meeting of the members, is there any further analysis of the statement or is it put to vote right away, without any further analysis or input, if you will?
"A There is further input. As I said, the association follows Robert's Rules of Order at the meeting which the members of the house of delegates or the meeting of the members have had an opportunity, prior to the meeting to review the paper.
"So, there is an opportunity in the meeting for statements for and against a particular paper before the paper is voted on so there is an opportunity for discussion before a paper would be proved."
MS. WIGMORE: Now moving on to page 30, line 9:
"Q So you have position statements. You mentioned the participation in amicae brief; any other example of

official AMWA action that you can think of, or have we exhausted that?
"A I want to know if you consider the letter to a member of Congress an official action of the association.
"Q Yes
"A Then yes.
"Q I would like to show you what's been marked as Government Exhibit 32-D" -- and for the record that is trial Exhibit 15 -- "are you familiar with that document?
"A Yes, I am.
"Q Can you tell me what it is?
"A This letter is a letter from our president, Lynn Epstein, to Congressman Gerald Nadler, in opposition to HR-760.
"Q HR-760 is what ultimately became the Partial-Birth Abortion Ban Act of 2002-2003?
"A That's correct.
"Q Do you know who prepared this document?
"A I prepared this document.
"Q And when you say you prepared it, can you be a little more specific in what you mean by that?
"A The process for preparing a letter to Congress is to see if the organization has taken a position on this bill before. If the organization has taken a position on this bill, if the bill is consistent with our currently stated policies.
"The letter was prepared again. This letter was

extremely similar to a letter that we sent for the Partial-Birth Abortion Ban Act of 2002, so a letter was prepared. It was signed. The president and the executive director were notified and advised that we were taking this action."

MS. WIGMORE: Moving now to page 33, line 10:

"Q Did anybody else have a role at AMWA in drafting this document, that is Government Exhibit 32-D."

MS. WIGMORE: Which is trial Exhibit 15.

"A This letter is almost identical to a letter that was issued previously, which I believe you have as another government exhibit where the association would have written the original letter for the Partial-Birth Abortion Ban Act of 2002 based on our position papers that we have reviewed, and also the amicus brief that we signed on the Stenberg Carhart case.

"So, based upon the positions of the organization and our position in the court case that we have taken, and the fact that we have had a previously written letter on an almost identical bill, we just needed, in order to go forward with this document, we just needed to notify the executive director and the president at the time.

"We were without a government affairs chair at the time, otherwise that position would have been notified as well."

(Continued on next page)

Moving ahead now to page 39/line 14.

"Q. If you could, look at the second paragraph of Trial Exhibit 15, the March 25, 2003 letter. If you see that second sentence, it starts with, 'As such, we recognize this legislation as an attempt to ban a procedure that in some circumstances is the safest and most appropriate alternative available to save the life and health of the woman.' Do you see that statement?

"A. Yes, I do.

"Q. What procedure is the letter referring to at that point?

"A. AMWA's position was that this bill was a broadly based bill but did not define a specific procedure and was referring to abortion procedures in general. We have not outlined a particular medical procedure in the bill in our letter.

"Q. Just going back to the statement itself, though, it says here, quote-unquote, this legislation is an attempt to ban a procedure that in some circumstances is the safest and most appropriate alternative available. Were you referring to a specific procedure when you made that statement?

"A. The statement, which is the same statement we have written in a previous document, was written based on not one narrowly defined procedure.

"Q. Can you tell me what was meant here in the use of the word 'procedure' in the March 25, 2003 letter? Let's look at the phrase 'a procedure that in some circumstances is the safest

and most appropriate alternative available.' Did you have something in mind there when you wrote that statement? And if so, can you please tell me what it was.
"A. The letter might have been more appropriate to say attempt to ban procedures as a plural, because AMWA was not referring to a specific document. The ban references late-term procedures of which the association feels that doctors, physicians, should have the option of choosing the most appropriate procedure for a woman at the time she chooses to terminate pregnancy."
Your Honor, at this time we would offer in evidence the Plaintiffs' Trial Exhibit 15 which was referenced in the deposition. It is Government Exhibit 32.
THE COURT: Any objection?
MR. PANTOJA: Your Honor, we object to the admission of document into evidence: Foundation, exception to the hearsay rule has not been established, nor the residual hearsay rule. Also, some of these documents are part of the legislative history in this case, and to that extent they are only to be used to inform whether Congress acted reasonably with the record that was before it. We would object to the admission of this document.
THE COURT: Is it in the Congressional Record?
MR. PANTOJA: We are referring to Plaintiffs' Exhibit 15?

MS. WIGMORE: Yes.
MR. PANTOJA: Yes.
THE COURT: It will be received.
(Plaintiff's Exhibit 15 received in evidence)
MS. WIGMORE: Moving on now to page 54/line 6.
"Q. If you could turn to Government Exhibit 33D, which is Trial Exhibit 16, which is the July 18, 2002 letter. Are you familiar with that document?
"A. Yes, I am.
"Q. And do you know who prepared this letter?
"A. I would have prepared in it consultation with another employee at the association. I'm trying to recall exactly who was working on it.
"Q. Do you remember the title held by that employee?
A. I'm taking a moment to recall the dates. I'm trying to think of when somebody left to make sure I'm giving you an accurate response here. Lorie, do you remember what year Eileen left? I want to clarify my statement. With the letter dated July 18, 2002, I would have put together the letter based on previous statements of the organization.
"Q. Do you know which statements you are referring to specifically?
"A. The organization has opposed similar bans in the past on the federal level. The document opposing previous bans would have been reviewed by then the government affairs chair, the

executive director, and the women's health committee, and the chairs of the advocacy committee, since a letter to Congress would have been an advocacy action. The letter also references AMWA's involvement in an amicus brief in Stenberg v. Carhart."

Turning ahead now to page 72/line 8.

"Q. Now, did you consult with anyone at AMWA prior to including that statement in this letter which is the July 18, 2002 letter, Government Exhibit 33D, which is Trial Exhibit 16?

"A. At the time this letter was written, our current president would have seen the letter prior to it going out, prior to it being sent."

Your Honor, at this point plaintiffs offer in evidence Plaintiffs' Trial Exhibit 16, which was Government Exhibit 33D at the AMWA deposition.

MR. PANTOJA: Your Honor, if I may. This document, just like the previous document, in this deposition transcript there has been no foundation with respect to what is necessary for the business records exception and hearsay rule. There has been no testimony with respect to the recordkeeping system of AMWA, whether this has been kept in the ordinary course of business in that recordkeeping system, how that document was retrieved from whatever recordkeeping system AMWA might have had even if it has one.

For the same reasons as with respect to the documents that were sought to be admitted in connection with the ACOG

exhibits, there is no proper foundation established in this deposition transcript for an admission pursuant to the exception to the hearsay rule.

THE COURT: On the business record objection, sustained.

MR. PANTOJA: Would that be with respect to this letter and the Plaintiffs' Trial Exhibit 15?

THE COURT: No. You didn't do it then.

MS. WIGMORE: Your Honor, with respect to Plaintiffs' Exhibit 16, just for clarification, it is part of the legislative history.

THE COURT: We will get to that.

MS. WIGMORE: I need to step back, I apologize, to page 43/line 11. I missed one excerpt, so I will read that at this point.

"Q. In that second sentence of the second paragraph of the March 25, 2003 letter, when you refer to an attempt to ban a procedure, are you referring to dilation and extraction?

"A. The organizational position as stated later in the letter states that we feel that the definition in the bill is too imprecise and doesn't include the correct medical terminology. So the organizational -- the position as stated and as previously stated in other documents of the organization would not articulate a particular procedure at this point, but late term procedures should be left -- the particular procedure

chosen by a physician should be left in the hands of the physician and not the government.
"Q. Is it fair to say, then, that the reference to procedure in this statement by AMWA is not a reference to a specific procedure?
"A. I do understand what answer you're looking for.
"Q. Quite frankly, the question is a yes or no answer, and you can have an opportunity to explain your answer. What I'm asking is a very straightforward question. The reference to procedure in this paragraph which was drafted by you, was the use of that term meant by AMWA to refer to a specific procedure?
"A. The procedure mentioned -- the procedure reference goes back to other documents that are not in evidence in regard to a court case that the association has been involved in. The association, when this letter was originally drafted, did not choose -- the organization position was to choose not to articulate a single procedure.
"Q. So is the answer no, it is not a reference to a specific procedure?
"A. It's not in reference to a single procedure, no."
Moving ahead now to page 84/line 5. At this point I'm reading a question from Ms. Novak.
"Q. My questions that I'm going to be asking are on behalf of all three plaintiffs' attorneys here. I would just like to

mark this as an exhibit. This is Planned Parenthood v. Ashcroft, a notice of deposition to AMWA. If we could mark this as an exhibit please.
"Ms. Kissell, you are looking at Exhibit No. 1, which is Trial Exhibit 72. Do you recognize that document?
"A. No.
"Q. Do you see what it asks of, if you can read in who it asks to appear here, into the record?
"A. Yes. This asks that the -- the Planned Parenthood will take the deposition upon oral examination for the witness for the American Medical Association.
"Q. And does it say it's pursuant to 30(b)(6) of the Federal Rules of Civil Procedure?
"A. Yes, it does.
"Q. And are you that person that AMWA has designated to appear for such a deposition?
"A. That is correct.
"Q. I would also like you to take a look at Government Exhibit 29D and 30D, which are Trial Exhibits 32 and 33. Do you see in those exhibits that they ask for a person to testify about letters dated July 15, 2003, and another letter dated March 25, 2003, where AMWA recognized house 760 and house 4965 respectively 'as an attempt to ban a procedure that in some circumstances is the safest and most appropriate alternative available to save the life and the health of a woman'?

"A. That's correct.
"Q. And have you been designated by AMWA to be that person today?
"A. Yes, I have.
"Q. And are you qualified to answer questions about those topics.
"A. Yes, I am.
"Q. In that case, my questions toward you will be directed towards your testimony as a representative of AMWA in the capacity of a 30(b)(6) representative. I believe you testified earlier that the membership of AMWA is made up of physicians and residents and medical students. Is that correct?
"A. That's correct.
"Q. Are some of those members obstetrician-gynecologists?
"A. Yes.
"Q. Are some of those obstetrician-gynecologists abortion providers?
"A. Yes.
"Q. And I have a similar question about the committees that you referenced earlier. Are the members of those committees physicians, medical students, and residents?
"A. Yes.
"Q. And are some of those members on the committee of obstetrician-gynecologists?
"A. Yes.

"Q. And are some of those obstetrician-gynecologists abortion providers?
"A. Yes. But to be clear, it would change from year to year depending on who is on the committee.
"Q. And the same for the house of delegates. Are the house of delegates made up of physicians, residents, and medical students?
"A. Yes. For the house of delegates and for the meeting of the members? G.
"Q. Yes.
"A. The body is made up of physicians, residents, and medical students.
"Q. And did the house of delegates for the meeting of members, were some of those physicians and residents and medical students obstetrician-gynecologists?
"A. Yes.
"Q. And are some of them abortion providers?
"A. Yes.
"Q. And then is the board of directors made up of physicians?
"A. Yes.
"Q. And are some of those physicians obstetricians and gynecologists?
"A. Yes.
"Q. And is the president of AMWA a physician?
"A. The current president, oh, yes.

"Q. The questions that I just asked you about, the current membership at any time, has it been different that the members of the membership, the committee, the board, the house, the president, have they ever not been physicians, medical students, or residents?
"A. No.
"Q. The position statements that you were asked about that were produced, Government Exhibit 31D, which is Trial Exhibit 17, 0003 and 0005 -- I'm sorry if I misstate. Did you say that they were drafted by the women?
A. The women's health committee.
"Q. And that committee, as you stated, is made up of physicians, is that correct?
"A. That's correct.
"Q. And does that committee, are some of the physicians obstetricians and gynecologists?
"A. Yes.
"Q. And do you know if at the time that those position statements were drafted, members of that committee or some members were obstetricians and gynecologists?
"A. That's correct.
"Q. Are obstetrician-gynecologists always members of the women's health committee?
"A. Yes.
"Q. First I'm going to ask you a few questions about Government

Exhibit 32D, which is Trial Exhibit 15, and 33D, which is Trial Exhibit 16. Trial Exhibit 15 is the March 25, 2003, letter to Representative Nadler. Was that letter reviewed, approved, and signed by the president of AMWA at the time?
"A. I'm just trying to make sure I give you a complete answer here.
"Q. Prior to the sending of this letter, Trial Exhibit 15, was this letter reviewed by the president?
"A. The president was notified that the letter was written.
"Q. And was this letter prepared in the normal course of business?
"A. Yes.
"Q. And Trial Exhibit 16, the July 18, 2002, letter to the House of Representatives, was this letter prepared in the normal course of business?
"A. Yes, it was.
"Q. Both of these letters, Trial Exhibits 15 and 16, did they go through the formal approval process that you testified about earlier?
"A. Yes.
"Q. In these letters, Trial Exhibits 15 and 16, I believe you testified, correct me if I'm wrong, but they're both based on previous and current policy statements of the organization, is that correct?
"A. That is correct.

Q. And are those policy statements still in existence today?
A. Yes, they are.
Q. Are they the current policy of AMWA?
A. Yes, they are.
"Q. I'm sorry. I just want to clarify. Trial Exhibits 15 and 16 are both based on position statements of AMWA, is that correct?
"A. That's correct.
"Q. And are those statements that they were based on, are they current today?
"A. Yes.
"Q. Those position statements?
"A. Yes.
"Q. And they are the current position statements of AMWA, is that correct?
"A. They are the current position statements.
"Q. Earlier you had testified about discussions, a participation that you had with other reproductive or groups concerning reproductive rights matters. I just want to clarify for the record, because there was some confusion. Were those groups that you discussed some of the issues contained in the letters, were they acting on behalf of AMWA at any point? You can answer the question.
"A. They were not acting on behalf of the organization.
"Q. And these discussions are -- you had with other groups

about reproductive rights matters, are they ongoing?
"A. Yes.
"Q. And do these discussions help you formulate some of the positions that result in what types of materials you write for AMWA?
"A. The positions of the association are made up from the membership, the physician membership of the organization. That's the only way that the organization formally adopts a position.
"Q. I believe you testified that you drafted these letters, is that correct?
"A. That is correct.
"Q. And that the basis for these letters were the position statements of AMWA, is that correct?
"A. Yes, that's correct."
Moving ahead now to page 94/line 14. This is a question by Ms. Liu.
"Q. If you could, just take another look at Exhibits 15 and 16."
THE COURT: First of all, we had the government's lawyer, then we had Ms. Novak, who is --
MS. WIGMORE: She is a lawyer from Planned Parenthood, I believe. Center for Reproductive Rights in the Carhart case in Nebraska. Ms. Liu is from our team, a lawyer in the Knapp case.

THE COURT: All right.
MS. WIGMORE: By Ms. Liu.
"Q. If you could, just take another look at Trial Exhibit 15 and 16. Trial Exhibit 15, second sentence in the paragraph states, 'We recognize in legislation an attempt to ban a procedure that in some circumstances is the safest and most appropriate alternative available to save the life and the health of a woman,' is that correct?
"A. That's correct.
"Q. Is that AMWA's current position?
"A. That is AMWA's current position.
"Q. You said that this letter was -- you previously testified that this letter was authorized by the president of AMWA, is that correct?
"A. That's correct.
"Q. And is the president of AMWA at the time this letter was -- was the president of AMWA -- was the president who signed this letter a medical doctor?
"A. Yes, she's a medical doctor.
"Q. And was the person who signed the 2002 letter also the president of AMWA? Is she a past president of AMWA?
"A. The president who signed the 2002 letter was the current president when the letter was written.
"Q. And is that person also a medical doctor?
"A. Yes, she is."

THE COURT: Is there some purpose in reading these repetitious questions, other than repetition? Go ahead.
MS. WIGMORE: I am now on page 105/line 3.
"Q. Would it be fair to say that the women who make up the women's health committee have expertise in women's health?
"A. Yes.
"Q. Just getting back to Trial Exhibit 15 for just one second, the sentence 2 in paragraph 2, you testified that reflects AMWA's current position, correct?"
THE COURT: That must be at least the fourth time.
MS. WIGMORE: I'm sorry. That one should be stricken. I should not have read that question, your Honor. I apologize.
MR. PANTOJA: Counsel, I believe that is the conclusion.
MS. WIGMORE: Yes, that is the conclusion. Thank you.
THE COURT: Thank you.
MR. PANTOJA: Your Honor, the government has some counterdesignations.
THE COURT: I can't wait.
MR. PANTOJA: The witness portion will be done by Sean Lane. For the government, I will be reading the questions.
THE COURT: Mr. Lane is going to play who?
MR. LANE: Meghan Kissell, your Honor.
MR. PANTOJA: Examination by Joseph Pantoja for the government, on page 13/line 21.

"Q. Has AMWA issued a position statement on the Partial-Birth Abortion Ban Act of 2003?
"A. We have not issued a formal statement on that particular bill.
"Q. Has AMWA issued a position statement on any one of the acts underlying bills HR760 or S3?
"A. No, we have not."
Turning to page 21/line 3.
"Q. With respect to the Partial-Birth Abortion Ban Act of 2003, did the government affairs committee propose a position statement with respect to that Act?
"A. No, the government affairs committee did not.
"Q. And with respect to the Partial-Birth Abortion Ban Act of 2003, did the women's health committee propose position with respect to that Act?
"A. Not to that Act.
"Q. And I guess the same question for the advocacy committee, the latter manifestation of the government affairs committee. Did the advocacy committee ever propose a position statement with respect to the Partial-Birth Abortion Ban Act of 2003?
"A. No, they did not."
Page 22/line 6.
"Q. With respect to the Partial-Birth Abortion Ban Act of 2002 and the Partial-Birth Abortion Ban Act of 2003, were there any other committees at AMWA who proposed a position statement with

respect to either of those acts?
"A. We had no committees that proposed a position statement on either of those two acts."
Page 28/line 10.
"Q. Have any AMWA members submitted a resolution with respect to the Partial-Birth Abortion Ban Act of 2003?
"A. No, we did not receive resolutions on that Act."
Page 29/line 13.
"Q. Aside from the resolutions, is there any other mechanism by which a member can propose official action by AMWA? And by "official action" I mean a position statement for some other action by AMWA.
"A. There are other ways. There are other official actions of the association in addition to the position papers and resolutions. The position papers and resolutions, there's only one formal process. There's no other ways other than the ones I've described in order to create a position statement or a resolution. The organization has also taken positions on amicus briefs in court cases, and that is a different process."
Page 34/line 6.
"Q. Did anyone assist you in the preparation of this document which is Plaintiffs' Trial Exhibit 15?
"A. No. This letter is almost identical to a letter we wrote in the past, so I prepared the letter.
"Q. Did anyone advise you on the drafting of this document?

"A. No. This document looks identical to a letter from the prior year.
"Q. In the course of preparing this document, the March 25, 2003 letter that is Plaintiffs' Trial Exhibit 15, did anyone at AMWA in terms of the membership, did they have any input as to the content of this letter?
"A. With reference to the specific letter, the specific letter is identical to a previously written document, so it did not require further review, because the positions of the organization had not changed.
"Q. The decision to prepare this letter, who made that decision?
"A. I acted as in my role as the director of communications and advocacy to prepare the letter, since it was consistent with previously written statement by the association.
"Q. Was there a decision by the board of directors at AMWA directing you to prepare this letter?
"A. With regard to this specific letter, no.
"Q. Which is the March 25, 2003 letter, Plaintiffs' Trial Exhibit 15, the answer is no?
"A. No.
"Q. What role did the house of delegates have your deciding to draft this letter?
"A. The house of delegates did not play a role in preparing this particular letter. The house of delegates doesn't play a

role in the specific letters that the organization writes in opposition to -- in opposition or support of particular legislation."
Page 38/line 22.
"Q. The March 25, 2003, letter that is Plaintiffs' Trial Exhibit 15 --
"A. If you're asking if we showed the content of the letter to an outside organization before sending it over to a member of Congress, no, we did not.
"Q. Did you receive any input from outside AMWA with respect to the content of that letter?
"A. With regard to the content of our letter, no, we did not."
Page 50/line 11.
"Q. Just to clarify your prior testimony and to sum this up in light of the struggle we just had in trying to clarify the question, and then we will move on, if you could just itemize for me the written materials that you referred to, if any, in drafting the document that is Plaintiffs' Trial Exhibit 15, the March 25, 2003 letter.
"A. The written materials that I would have referred to in drafting Plaintiffs' Trial Exhibit 15 would have been -- were included in Government Exhibit 33D, which is the July 18, 2002 letter. That's the primary document I relied on in drafting it. The language remained consistent from one letter to another, and my knowledge of the medical review that was being

conducted on our reproductive health papers."
Page 51/line 20.
"Q. Can you clarify what position statement were you referring to that was in the works.
"A. The previous documents that have been entered into that are in front of us. AMWA's position paper on abortion, AMWA's position paper on abortion and access to comprehensive reproductive health services are very similar papers. They go in different directions. The organization has been undergoing a review to consolidate the papers.
The staff person who's responsible for working with our physicians on reviewing it to make sure that the papers were still medically accurate, I share an office with. So I had verbal communication that this was what the papers were, that the papers were not veering from AMWA's previously stated positions based on the current medical information that was available at the time. The written documentation that I relied on in writing the 2003 letter is the July 18, 2002 letter."
Page 56/line 21.
"Q. So prior to finalizing the letter, did anyone else assist you in preparing this document which is the July 18, 2002 letter, Plaintiffs' Trial Exhibit 16?
"A. No. This letter is consistent with previously written statements. It sets --
"Q. I'm sorry?

"A. There wasn't any additional staff members who would have seen the letter. The president of the organization would have seen the letter prior to it being signed."
Page 72/line 8.
"Q. Now, did you consult with anyone at AMWA prior to including that statement in this letter, which is the July 18, 2002 letter, Plaintiffs' Trial Exhibit 16?
"A. At the time this letter was written, our current president would have seen the letter prior to it going out, prior to it being sent.
"Q. And aside from the president seeing the letter prior to it going out, did you consult with anyone at AMWA prior to including that statement in the letter?
"A. I don't recall anyone else that would have been involved in this."
Page 92/line 23.
"Q. And these discussions you had with other groups about reproductive rights matters, are they ongoing?"
Counsel's objection.
"A. Yes.
"Q. And do these discussions help you formulate some of the positions that result in what types of materials you write for AMWA?"
Counsel's objection.
"A. The positions of the association are made up from the

membership, the physical membership of the organization. That's the only way that the organization formally adopts the position."

That is the conclusion of our designations, your Honor.

THE COURT: Thank you. Is there another witness, Mr. Hut, this afternoon?

MR. HUT: Yes. One further witness again to come in through deposition testimony to be read, your Honor. I believe a bit briefer than the last one. This is the deposition testimony taken of Alan Baker pursuant to a Rule 30(b)(6) deposition notice to the American Public Health Association, taken on January 21, 2004, at the offices of the Justice Department in Washington, D.C. In a gender role reversal, your Honor, I will read the examination by Ms. Wolstein, and my colleague Ms. Liu will read the answers of the deponent Mr. Baker. If I may, your Honor, may I approach with some exhibit binders for the witness for the government and for the Court's law clerk?

THE COURT: Very well.

MR. HUT: Beginning at page 7/line 15.

"Q. Could you please state your name for the record.

"A. My name is Alan Baker.

"Q. What is your address?

"A. My work address is 200I Street Northwest, Washington, D.C.

at the American Public Health Association."

Mr. Page 8/line 21.

"Q. What is your position at APHA?

"A. I'm the chief of staff.

"Q. What are your duties and responsibilities in that capacity?

"A. They are somewhat evolving. It's a new position that didn't previously exist. But I serve the executive director. I coordinate issues for him, follow up on issues, work on projects that he assigns me. So I'm currently working on finalizing a strategic plan developing membership plan.

"We are working on some development activities to raise funds. We are waiting for a report. I'm on a committee that is supposed to hire a vendor to do an IT strategic plan. So my responsibilities are mainly the administrative and managerial and cross into a variety of areas at APHA.

"Q. How long have you been at APHA?

"A. Only October 27, 2003. As I said, it's a new position."

From line 23 on the same page.

"Q. You can take a look at Baker 1, which I shall hereinafter refer to as Plaintiffs' Trial Exhibit 18. Have you seen that document before?

"A. Whether I believe that was a document that was attached to your subpoena?

"Q. Do you recognize what is Plaintiffs' Trial Exhibit 18?

"A. Yes.

"Q. What is it?
"A. It's a letter from our executive director on behalf of our association to the House of Representatives."
On page 16/line 19.
"Q. Did Dr. Benjamin read the final letter before his signature was affixed to it?
"A. He was aware of what was in the letter and approved it going forward."
Reading from page 21/line 3.
"Q. If you could look back at Plaintiffs' Trial Exhibit 18, there is a sentence in the third paragraph of the letter that refers to APHA opposing the bill because it 'fails to include an adequate health exception language in instances where certain procedures may be determined by a physician to be the best or most appropriate to preserve the health of the women.' Do you see that?
"A. Yes, ma'am.
"Q. What is the basis for that statement by APHA?
"A. As part of the original subpoena for documents, we provided two formally approved policies at APHA which have actually not been shown to me in the material you have given me yet today. One was from 1981 and one was from 1989. Obviously, reproductive health and a woman's right to choose are longstanding areas of concern to a group such as the American Women's Health Association going back to at least 1981.

"While those two policies are somewhat different and seem to be precipitated by different extents, to APHA they both share some common elements. One is that the woman's right to choose should be somewhat close to absolute. That alone, based on the longstanding officially adopted policy, would be reason for us to perhaps write to Congress if a bill impacting a woman's right to choose was to be introduced.
"One of those policies also suggests that public health workers actually have a duty to speak up on issues like that. That again would be reason for us to take advantage of the ability to write to Congress on the issue of concern to our members. There is some suggestion in those policies that, and I don't have a phraseology in front of me or memorized, that by constitutional amendment or by statute shouldn't limit which medical procedures might be available.
"I believe all that is the basis for this letter and for the statements in it.
"Q. Is there any other basis for the sentence in the third paragraph of Plaintiffs' Trial Exhibit 18?
"A. Again, the basis for this letter is very clearly the fact that we have longstanding, preexisting, formally approved and adopted policies. The choice language in the letter undoubtedly was impacted by the actual nuance of the bill in front of Congress."
Reading from page 23/line 14.

"Q. Other than what you have already testified to, was there any other basis for the sentence in the third paragraph of Plaintiffs' Trial Exhibit 18?
"A. No, not that we have been able to determine in hindsight, but going back and asking.
"Q. Well, who did you ask?
"A. Let me try to perhaps provide a clearer answer. I asked Mr. Hopper why he wrote the letter. His response was we have longstanding policy on this issue, it's important to our members."
Reading from page 24/line 8.
"Q. Again, documents produced by APHA, we have Bates stamped them APHA 1 through 6. Take your time and look at Plaintiffs' Trial Exhibit 19 marked at the deposition Baker Exhibit 4. I don't remember if I said this. I will represent to you that all of these documents were provided by APHA to my office in response to subpoena. Do you recognize pages what's been stamped as APHA 3, 4, 5, and 6?
"A. Yes, I do.
"Q. What are they?
"A. Those are the longstanding APHA policies to which I referred a moment ago."
From page 27/line 24.
"Q. Thank you. Does the statement -- well, does Plaintiffs' Trial Exhibit 18 reflect a policy position of APHA?

"A. You mean the statement, the sentence you referred to my attention previously as opposed to the tally of the letter?
"Q. I'm starting with the whole letter. Does it reflect a statement of APHA as an organization?
"A. Yes.
"Q. OK. And so what is in the letter, Plaintiffs' Trial Exhibit 18, it's fair to say is a policy statement adopted by APHA?
"A. It's the communication of existing APHA policy to some extent shaped by the current issue in front of Congress. I say current: Current at that time."
Reading from page 30/line 10.
"Q. There is a committee that is involved, an APHA committee that develops policy positions, is that right?
"A. Would you like me to explain policy development process?
"Q. Sure.
"A. APHA is a membership association, so therefore our membership, through various governance structures, determines what both our policy is, what we should work on, which, you know, the fact we are in book publication and things like that.
"Our policies are member-initiated. We actually have a yearly cycle where we actually call, advise our members to our various publications, and post it on our website, that they may initiate a policy if there is an area where we don't have policy. Our sections tend to be organized based on how people

work. Public health nursing is one section. Health administrators is another section. Epidemiology is a third section.

Members will have an area they feel strongly about. They will get together typically within their section or cross-sections or however they choose to, and they will, either as a committee or individual, will prepare a draft policy. And then it goes through a policy review process of the policy in various back and forth and rewrites and some editing as you might anticipate in the development of the policy.

"It then goes to a group called the action board, which is appointed by our board. We have an executive board which people are on because they are either elected to it or because they have an official capacity in the association that automatically puts them on the executive board. The action board appointed by the executive board will work with the policy, will send it out and make sure all the other sections and all the other groupings of members have a chance to see it.

"Then, when we get to our annual meeting, which we have every year, our conference each year, we call it the annual meeting, there is actually a policy review committee that's held during one day of the meeting. Every proposed policy that has come up during that yearly cycle, and this year in San Francisco we had 25 or 30 of them, is reviewed and argued out and wordsmithed and changed possibly or unchanged,

but, you know, as a result of discussion. Then the policy review committee, when they have it as good as they think they can have it with a deadline facing them, take it to our council.

"Our council is an ultimate governing body. It's made up with representatives from our affiliates from each state and its representatives from -- in total it's roughly 200 people who are themselves members and are fulfilling their role as the section or affiliate or so forth. Likewise, the past presidents of association are members of the council.

"All policies then go at the annual meeting to the council with a recommendation. Some of the policies are discussed in some detail at the annual meeting. There can be amendments from the floor. Wording can be changed and other noncontroversial policies may be on a consent agenda, which is, as you may think, a grouping of policies where they are voting yea or nay or can be removed by sort of a voice vote.

"Policies are voted on by a voice vote. If it's too close to tell, the speakers of the council, who are selected by the council, who is assisted by a parliamentarian, can call for a show of hands. If they need be, they can count hands.

"So the reason I explain this is I think you can see we have a rather formal policy process. Our members represent the people who have either interest or work in the field of public health, as I mentioned earlier. It could be doctors,

medical researchers, epidemiologists, nurses, educators, statisticians.

"If they develop policies, it's not unusual, as you see in these two policies, for there to be footnotes. Sometimes the footnotes are from scientific literature, perhaps our own, the American Journal of Public Health, which is peer-reviewed, the most respected public health journal in the world, you know. So policies often have a basis in science,

"And the members who have taken a lead in initiating them or have chosen to work on them, since you are not forced to work on a policy that another group is not working, have a sincere interest in it and often much expertise."

Your Honor, plaintiffs now move in evidence Plaintiffs' Trial Exhibit 18.

MR. PANTOJA: We object again on the basis of hearsay. There is no testimony in this deposition transcript that it was the regular course of APHA's business to create this document, nor was there anything certainly that the document was kept in the regular course of business, and absolutely nothing of course with respect to the recordkeeping system that APHA had, if it even had such a recordkeeping system. Therefore, we object to the introduction of this document into evidence on the basis of hearsay.

THE COURT: Sustained.

MR. HUT: Your Honor, it is approximately two minutes

to the hour. I would guess I'm a little bit more than halfway through this. Do you want me to continue?

THE COURT: This is an appropriate time if you think you have that much time, fine, we will break for the day and reconvene tomorrow morning at 9:30. Court will stand in recess.

(Adjourned to 9:30 a.m., April 7, 2004)

INDEX OF EXAMINATION

PLAINTIFF EXHIBITS