447rnat1

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
----------x

NATIONAL ABORTION FEDERATION,
MARK I. EVANS, M.D.,
CAROLINE WESTHOFF, MD, MSC;
CASSING HAMMOND, MD,
MARC HELLER, MD,
TIMOTHY R.B. JOHNSON, MD,
STEPHEN CHASEN, MD,
GERSON WEISS, MD,
on behalf of themselves and
their patients,

Plaintiffs,

v. 03 Civ. 8695 (RCC)

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

Defendants.
----------x

New York, N.Y.
April 7, 2004
9:45 a.m.

Before:

HON. RICHARD CONWAY CASEY

District Judge

APPEARANCES

AMERICAN CIVIL LIBERTIES UNION FOUNDATION
Attorneys for Plaintiffs
125 Broad Street, 18th floor
New York, New York 10004-2400
(212) 549-2600
BY: JULIE STERNBERG, ESQ.

APPEARANCES (continued)

THE ROGER BALDWIN FOUNDATION OF THE ACLU, INC.
Attorneys for Plaintiffs
180 N. Michigan Avenue, Suite 2300
Chicago, Illinois 60601
(312) 201-9740
BY: LORIE A. CHAITEN, ESQ.

WILMER CUTLER PICKERING LLP
Attorneys for Plaintiffs
2445 M Street, N.W.
Washington, D.C., 20037-14 20
(202) 663-6235
BY: A. STEPHEN HUT, JR.
AMY WIGMORE, ESQ.
KIMBERLY A. PARKER, ESQ.

SHEILA M. GOWAN, ESQ.
SEAN H. LANE, ESQ.
JOSEPH A. PANTOJA, ESQ.
ELIZABETH WOLSTEIN, ESQ.
Attorneys for Defendants
U.S. Department of Justice
86 Chambers Street, 3rd floor
New York, New York 10007
(212) 637-2800

447rnat1

(Trial resumed)

THE COURT: Good morning. I believe we were still reading deposition transcripts when we recessed yesterday. Is that correct?

MR. HUT: That is correct, your Honor.

THE COURT: Let us continue, I guess. Mr. Hut, was there any effort to subpoena these association witnesses to this trial or to request them?

MR. HUT: There was, your Honor. As far as I know, Mr. Baker is outside the subpoena power of the court.

THE COURT: Was there any request made of him?

MR. HUT: Yes, I believe there was, and he was unavailable.

THE COURT: You may proceed.

MR. HUT: I have now morphed into Helene Kraznoff's examination, counsel for plaintiffs in the California action. Ms. Liu will once again be reading the answers of Mr. Baker.

"Q. I'm Helene Kraznoff. I represent the plaintiffs in the Northern District of California. And the plaintiffs are the Planned Parenthood Association of America and the Planned Parenthood Golden Gate. The defendant in the case is the same as the case Ms. Wolstein works on. This is Mimi Liu, with the law firm of Wilmer, Cutler & Pickering, who represents the National Abortion Federation in the case pending in the Southern District of New York.

447rnat1 "Baker

"I'm going to show you two subpoenas on each those cases. Did you receive each of those subpoenas? We can mark them. We are up to 5. We will mark them as Plaintiffs' Trial Exhibits 73 and 64. The Northern District of California we will mark as Plaintiffs' Trial Exhibit 73, that one. And the Southern District of New York we will mark as Plaintiffs' Trial Exhibit 64.

"Are you appearing today in response to those subpoenas?

"A. Yes.

"Q. And that means you have been designated by APHA to testify about APHA's position on the Partial-Birth Abortion Act of 2003 and prior federal legislation that similarly purports to ban partial-birth abortion as well as the APHA, is that right?

"A. Yes.

"Q. You were designated by the organization as qualified to answer questions about those topics, right?

"A. Yes.

"Q. You told us a little bit about the APHA. I want to ask you a little more about it. You said it was a membership organization?

"A. Yes.

"Q. And how many members does it have?

"A. We like to advertise that we have roughly 50,000 members. Those 50,000 members, we count two different groups of people

447rnat1 "Baker

in arriving at that number. Of course, it changes constantly.

"We have people who are direct members of APHA who choose to pay dues directly to us. We have roughly 30,000 of those kinds of members. They are primarily individuals, although some people are part of what's called and agency membership for their agency, such as the Center for Disease Control has purchased an agency membership, and they can attend our conference and get the member rate and things like that. That's a very small fraction of that 30,000, plus 5 percent.

"We also have people who are members of our affiliates. There is -- in addition to the American Public Health Association, there is a public health association in every state. For instance, I worked in Maryland. There is a Maryland Public Health Association.

"Our bylaws and constitution, unlike some organizations, allow you to join our affiliates without being an APHA member. There is roughly 20,000 of those individuals. Again, that number is rough number. They share an interest in promoting and advancing public health. So, and since our affiliates are authorized, and I will use the phrase "chartered" -- that perhaps is not in the correct legal sense -- but let's say our constitution authorizes and charters the affiliates. They are officially recognized.

"Each affiliate is allowed to select a couple of individuals to sit on that council that I spoke about earlier

447rnat1 "Baker

that actually determines the overall direction and overall policy. So when we write a letter, we say that we represent more than 50,000 individuals both our direct members and our affiliate members.

"Q. Would it be fair to say those members are nationwide?

"A. Those members are not only nationwide, but a small portion of them are outside the United States, in either Canada or Mexico or in Europe or across the world.

"Q. And which public health occupations are represented by your organization?

"A. The short answer is all of them. That would be some of the larger areas. I think I mentioned physicians, nurses, health educators, social workers who work in public health and perhaps at a state or local level, the Health Department statisticians, people who teach at schools of public health or medical schools or at universities who have an interest or research interest or personal interest in public health.

"We have even lawyers as members. In fact, we have been working with a sister organization around the subspecialty of public health law and perhaps going and do some joint programs. There is a new organization that represent lawyers who do public health. Some of them are what are referred to as outreach workers. That might be a person from the community who is hired part time, perhaps doesn't have formal training, and encourage women in her community to, say, breast feed or

would encourage people to stop smoking.

"So we have everything from very highly educated professionals -- most of our members on average have two or more degrees, post-high school degrees -- to perhaps uneducated community members. But all work in or are interested in public health.

"Q. And those include MD's, or medical doctors?

"A. Yes.

"Q. Would that include obstetricians and gynecologists as well?

"A. All types of medical doctors, yes.

"Q. Is the APHA a for-profit organization?

"A. No, we are a nonprofit organization.

"Q. Is it a partisan organization?

"A. No, it's not partisan as the word is generally used.

"Q. I will rephrase it. Is it affiliated with a political party at all?

"A. No.

"Q. And if I say what is the leadership of APHA, what does that mean to you and how would you define it? I don't know if you designate. I don't know how to ask you what you consider to be the leadership structure of the organization.

"A. The primarily leadership is, I would characterize it as a representative organization that in each section selects a chair. Each affiliate selects a chair or a president. The association is the council that I talked about which itself is

a representative body.

"People selected by those sections, selected by affiliates, go with their council, like an assembly. They actually vote members onto a board. Likewise, as a council section has a representative on the board, whoever has been appointed to that education board, that chair is automatically on the board.

"There is an elected president by the council, and then of course the board hires an executive director and the executive director hires staff. When you talk about the leadership of an organization like that, depending on the context, I might think it means our executive director, who is my boss, who is day-to-day level runs themselves. Often it includes our elected representative or our council who ultimately makes policy and sets the direction of the association, kind of like a board of directors.

"Q. That is like a governing council?

"A. Yes.

"Q. There is also an executive board?

"A. Yes, there is an executive board also. The governing council meets once a year for several days at our annual meeting. The executive board meets in person or, in this day and age, by conference call, basically monthly.

"Q. And speaking to each of those, how many people are on these executive boards?

"A. The executive board is roughly 20, counting people who are elected, people who are elected for each year for a four-year term, for those people who are on there because of their official capacity, such as -- I gave the example a second ago. Our 26 or so sections have a council where they get together and discuss issues, where they have an interest of all sections.

"They select a chair, and that chair of that is called the council of sections. You know, it's actually whoever is in that chair seat each year is automatically on the board. Likewise, our affiliates, our council affiliates, whoever is their chair each year is automatically on the board. It does mean the board rotates a lot.

"Q. And currently are there medical doctors on the board? I think the question we were talking about the executive board was off the record, and my question was I think was, are any of the executive board members physicians?

"A. Currently the answer to that is yes."

Reading now from page 52/line 3.

"Q. And the governing council, how many people are on that?

"A. The governing council is roughly 200 people.

"Q. Does that include physicians?

"A. That includes lots of physicians. One of them is the medical care section. Certainly everyone who is a member of the medical care section is not a physician. That tends to be

the section that the physicians join. That tends to be people who are more involved in the clinical aspects of public health as opposed to epidemiology or policy resolver or statistics."

At page 55/line 2.

"Q. I want to talk a little bit again about Plaintiffs' Trial Exhibit 18. Dr. Benjamin I see here himself is a medical doctor, is that correct?

"A. Yes, he is.

"Q. And this document, was it prepared in the normal course of APHA's business?

"A. Yes.

"Q. And do you believe that the statements in it are representative of APHA's association at the time it was written?

"A. Yes, I do.

"Q. And is that still -- does that still reflect APHA's policy position?

"A. Yes.

"Q. But your understanding of it, the APHA had opposed prior versions of prior bills that had supported the ban on partial-birth abortion.

"A. We have written letters like this in the past on a variety of issues, not just partial-birth abortions.

"Q. So you think there had been previous letters on partial-birth abortion?

"A. Yes."

THE COURT: Excuse me, Mr. Hut. Who is doing the questioning again in this deposition at this moment?

MR. HUT: At this moment it is Helene Kraznoff, counsel for plaintiffs Planned Parenthood, Federation of American Planned Parenthood Golden Gate.

Now at page 58/line 5.

"Q. I'm sorry. I forgot when you were talking about, Plaintiffs' Trial Exhibit 18. Is it your understanding that that letter, the idea of writing that letter, originated at the APHA?

"A. In talking to Don Hopper and reviewing the email chain which you have seen, he actually says in there that we are considering writing to Congress, and he was asking perhaps some more organizations if they were planning to organize something as opposed to us doing something perhaps unilaterally.

"Q. And it wasn't solicited by an outside organization?

"A. That's my understanding, that we were planning to do that.

"Q. And is it also your understanding that the letter was drafted by the APHA?

"A. Yes.

"Q. And not by an outside organization?

"A. Yes.

"Q. OK. The APHA is not solely dedicated to dealing with abortion, is it?

"A. No. That's one of probably hundreds of public health issues we would be involved or have an interest in or our members would have a concern about.

"Q. And those often impact federal legislation, is that right?

"A. It might be fair to say that federal legislation could impact the provision of public health. That would be true of funding bills. Also, recently we've been one over a number of organizations supporting doubling the center for disease control budgets, which would improve public health in this country.

"Q. Let me state it another way. The APHA is routinely involved in taking positions on things that are happening in Congress?

"A. Yes. We often take positions on public health issues before the Congress".

That concludes, your Honor, the plaintiffs' designation in this deposition. Based on the testimony just read, however, I would request the Court reconsider its ruling on defendants' objection to our offer of Plaintiffs' Trial Exhibit 18. I think it is now qualified as a business record under 803(6).

THE COURT: My ruling stands. Next.

MR. PANTOJA: Your Honor, the government has a few counter designations.

THE COURT: By all means.

MR. PANTOJA: I will be doing the questioning. All of the counterdesignations of the government were part of the examination by Ms. Wolstein. And my colleague Ms. Wolstein will be the witness on the stand.

THE COURT: You are going to read her lines and she is going to read someone else's.

MR. PANTOJA: Yes.

THE COURT: Couldn't be better.

MR. PANTOJA: At page 10/line 8.

"Q. Who participated in preparing Baker Exhibit 1, which is plaintiffs Trial Exhibit 18.

"A. This letter was primarily prepared by our director of federal and congressional relations, Don Hopper. It was -- he did that in discussion with his boss, Kelly O'Brien, who is our assistant director for policy, and also in discussion with our executive director, Dr. George Benjamin.

"Q. And what did Mr. Hopper do in order to prepare this letter, Plaintiffs' Trial Exhibit 18?

"A. Are you asking what the process was he used to prepare the letter?

"Q. Yes.

"A. There was an issue before Congress at the time, and Mr. Hopper spent most time on Capitol Hill and in our office and talked to other organizations that we think may be of like minds on certain kinds of issues.

"During the course of discussions, phone calls, running into people, and so forth, he indicated to a colleague at another association that we were thinking, since this bill was before Congress and we had longstanding policy we thought was pertinent in this area, he indicated we were thinking of perhaps writing a letter, asked if they were thinking of writing a letter, or I think he used the phrase of what he called a letter drop, which is where --

"Well, and the answer to that was, yes, that they were thinking of perhaps organizing various organizations to submit material. And so we generated the letter and we forwarded it to them to actually forward to the Congress.

"Q. What is the organization you are referring to when you say he forwarded to them and he spoke with the other organization?

"A. I would actually have to look at the material I provided you to refresh my memory."

Page 12/line 14.

"Q. Why don't we mark -- well, never mind. Look through that and see if that refreshes your recollection.

"A. I believe the question was what was the other organization?

"Q. Yes.

"A. The other organization is Pro Choice America. Our director of governor relations colleague was Donna Crane.

"Q. What communications did Mr. Hopper have with Ms. Crane in writing about the writing of Plaintiffs' Trial Exhibit 18?

"A. Are you asking about the substance of the communication or are you asking with the methods of the communications?
"Q. I'm asking about the substance.
"A. OK. As I indicated earlier, this was -- the bill before the House of Representatives was of interest to us. There was an exchange back and forth whether that's of interest to them and whether or not if they were thinking of organizing perhaps what was referred to as a mail drop, a collection of letters. The answer back was yes, they were. So we -- our letter was prepared and was forwarded to them to be included.
"Q. What is a mail drop?
"A. My understanding of a mail drop is, instead of as many organizations as might be interested in a subject each writing to, say, the House of Representatives and distributing it to each member individually, an organization might say that they would take the lead and coordinate that activity. So they would coordinate all the material and put it together into a packet and deliver it into a packet as opposed to individual letters coming in and with all the other pieces of mail received on a given day.
"Q. Did Ms. Crane's organization do a mail drop in this matter?
"A. As far as we know."
Page 18/line 22.
"Q. In the course of preparing Plaintiffs' Trial Exhibit 18, did anyone at APHA communicate with any particular members of

APHA?
"A. I don't believe so."
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 we wrote the letter. His response was we have a longstanding policy on this issue, it's important to our members.
"Q. Did he say anything else in response to your question to him why APHA wrote the letter?
"A. Just the fact that the issue was timely in front of Congress."
Page 27/line 3.
"Q. OK. So let me -- if I understand, the basis for the statement in the letter in Plaintiffs' Trial Exhibit 18 are the two policies of APHA embodied in the 1981 policy statement and the 1989 statement that we have looked at as Plaintiffs' Trial Exhibit 19, personal knowledge of Mr. Hopper and Ms. O'Brien and Dr. Benjamin?"
An objection by counsel.

"A. Yes. That's what I believe to be the best I'm able to discern it."
Page 29/line 2.
"Q. I fear that I'm making this more complicated than this is. I'm trying to understand the basis for the statement in paragraph 3. From what I understand from your testimony, it's APHA's longstanding policy concerning abortion which are reflected partly in the 1981 statement and the 1989 statement, as well as a general knowledge of the people who participated in drafting the letter, is that correct?
"A. Yes.
"Q. Is there any other basis other than that where that statement in paragraph 3 of Plaintiffs' Trial Exhibit 18?
"A. No."
Page 34/line 21.
"Q. The policy. So what you are referring to is the 1981 statement and the 1989 statement, those went through the policy review process you described, correct?
"A. Yes."
Page 60/line 11.
"Q. It's fair to say, Mr. Baker, isn't it, that as a matter of policy, APHA opposes any legislative restriction on abortion?
"A. Yes."
That concludes the government's counterdesignations, your Honor.

THE COURT: Thank you. Ms. Wolstein, thank you. You can return to playing yourself.
Mr. Hut, call your next witness.
MR. HUT: Plaintiffs' next witness is Dr. Gerson Weiss, who will be examined by Ms. Parker.
THE COURT: Who is going to examine?
MR. HUT: Ms. Parker.
GERSON WEISS,
called as a witness by the plaintiffs,
having been duly sworn, testified as follows:
THE CLERK: Please state and spell your full name slowly for the record.
THE WITNESS: Gerson Weiss, G-E-R-S-O-N, W-E-I-S-S.
THE CLERK: Thank you. Please be seated.
DIRECT EXAMINATION
BY MS. PARKER:
Q. Good morning, Dr. Weiss.
A. Good morning.
Q. Dr. Weiss, where are you currently employed?
A. I'm employed by New Jersey Medical School in Newark, New Jersey.
Q. Are you a physician?
A. I am.
Q. Where are you licensed to practice medicine?
A. I am licensed to practice medicine in New Jersey and New

York State. I have licenses that I have relinquished in Pennsylvania and California.
Q. When you say "relinquished," what do you mean by that?
A. I had the licenses, but since I was unlikely to practice in those venues, I let them lapse.
Q. What position do you hold at New Jersey Medical School?
A. I am currently professor and chair of the department of obstetrics, gynecology, and women's health. I am also the chief of service of obstetrics and gynecology at University Hospital in Newark.
Q. Is University Hospital affiliated with New Jersey Medical School?
A. Yes, it is. It is affiliated and on the same campus.
Q. What are your responsibilities at New Jersey Medical School?
A. My responsibilities at New Jersey Medical School is broadly to run the academic department. This includes hiring of residents, faculty, to establish a research program, to teach medical students, residents, and teach fellows, to provide service to the community and healthcare for the local community in general, and subspecialty care for the northern part of the state in specific.
Q. How long have you been the chair of the department of obstetrics and gynecology?
A. I have been chair for 18 years.

Q. You said that at University Hospital you also hold a position?
A. That's correct.
Q. What position is that?
A. I am chief of service of obstetrics and gynecology.
Q. What are your responsibilities in that position?
A. My responsibilities there are generally to make sure that the care that is provided is competent and full. Along those lines, I am responsible for the establishment of care protocols, the evaluation of levels of care, establishing protocols to deal with the needs of the patients that we serve, provide protocols and supervision of care in operating rooms, clinics, out-patient surgery, in-patient care, out-patient clinics as well.
In addition, we train residents, we train post-residency fellows in subspecialties, and we teach obstetrics and gynecology to medical students. We also teach some parts of obstetrics and gynecology to nonphysicians, such as nurses and other healthcare providers, and physicians in other areas who need to learn the expertise of doing pelvic examinations, etc.
Q. How long have you been the chief of service at University Hospital?
A. Also 18 years.
Q. Dr. Weiss, are you a plaintiff in this action?

A. I am.
Q. Why did you bring this action?
A. I brought this action because it was my feeling that the passage and the enactment of this law would do a serious disservice to the patients that I am responsible for. It would eliminate some of the safest procedures to give them care, especially patients with medical illnesses who clearly would need a pregnancy termination later in pregnancy. It would hinder the practice of obstetrics and gynecology, because individuals that would be providing some care would be worried about providing the best possible procedures, because in doing so they may inadvertently come into a conflict with the requirements of the law.
Q. Dr. Weiss, before we get into your opinions, I want to ask you a little bit about your background. From where did you obtain your medical degree?
A. I obtained my medical degree from New York University in 1964.
Q. After you obtained your medical degree, did you receive any other medical training?
A. Yes, I did.
Q. Can you describe that training for us.
A. Certainly. I was a fellow in the department of medicine at Johns Hopkins University and an intern in internal medicine in Baltimore City Hospital 1964-65. Between 1965 and 1969 I was

resident and chief resident in obstetrics and gynecology at NYU-Bellevue Medical Center. Following that, I spent two years in the United States Army. When I completed my service in 1971, I was a research fellow in reproductive physiology at the University of Pittsburgh.
Q. When you were in the Army, were you practicing medicine?
A. I was. I was practicing my specialty of obstetrics and gynecology. My secondary military occupational status was surgery.
Q. Dr. Weiss, do you currently practice medicine?
A. I do.
Q. Do you have any medical specialties?
A. Yes.
Q. What?
A. My specialty is obstetrics and gynecology. I also have subspecialty certification in reproductive endocrinology and infertility.
Q. Can you explain what reproductive endocrinology is.
A. Yes. Reproductive endocrinology is that field, subspecialty, of obstetrics and gynecology that deals with hormonal abnormalities in women, diseases related to hormonal problems, such as abnormal puberty, abnormal bleeding, abnormal menopause, natural menopause, anomalous development of the reproductive tract, and infertility and all of its causes.
Q. For how long have you specialized in obstetrics and

gynecology?
A. I have specialized since I started my internship -- excuse me -- my first year of residency, which was in 1965.
Q. Do you have any board certifications?
A. Yes, I do. I was initially certified by the American Board of Obstetrics and Gynecology in 1971. I was certified as a subspecialist in reproductive endocrinology and fertility in 1975. In 1983 I had my first subspecialty in general obstetrics and gynecology. That was 1983. In 1993 I again volunteered for subspecialization certification and passed that.
Q. Those that you were just describing, those were recertifications?
A. The last two were recertifications. This was a voluntary process, because at the time I took my training, certification was life-long. Since then, certification is time-limited.
Q. Why is it that you haven't been recertified more recently?
A. I have as of 1993 been elected to the American Board of Obstetrics and Gynecology. I served as the president for the American Board of Obstetrics and Gynecology for four years, ending two years ago, and I am currently the chairman of the American Board of Obstetrics and Gynecology. It is the responsibility of the American Board of Obstetrics and Gynecology to do all the certification processes. It would certainly be a conflict of interest if I certified myself.

Q. Dr. Weiss, do you currently treat patients?
A. I do.
Q. In what settings do you treat patients?
A. I treat patients in an office setting in New Jersey, in Hasbruck Heights, in an office called University Reproductive Associates. I also take patients who are in-patient both in Hackensack University Medical Center and University Hospital in Newark. I sometimes see patients in consultation with Newark as well.
Q. What type of patients do you see?
A. By and large, I take care of patients with problems in gynecology. I am frequently referred to complex problems from other gynecologists, and I see a full range of reproductive endocrinology and infertility cases as well.
Q. Do you perform surgery?
A. I do.
Q. How often do you perform surgery?
A. Roughly 50 times a year.
Q. What types of surgeries do you perform?
A. I perform a fairly broad gamut of surgery in gynecology and in my subspecialty. These include office surgical procedures as well as hospitalized procedures, including reparative procedures, endoscopies, laparoscopies, hysteroscopies, vaginal and abdominal hysterectomies.
Q. You mentioned hysteroscopies. Can you explain what those

are.
A. A hysteroscopy is an operative procedure where the cervix is dilated and then the inside of the uterus is evaluated with a telescope put into the uterus through the cervix. In doing so, we can diagnose the presence of fibroids that are impinging on the cavity, occasionally observe a malignancy, observe polyps, adhesions, scars, and anomalies and things that interfere with fertility. They can frequently be corrected at the same time through instruments put into the scope.
Q. You also mentioned laparotomies. Can you explain what that is.
A. A laparotomy is an operation where the abdomen is opened. It is a generic term for any time the abdomen is opened. Specifically in gynecology, laparotomies, hysterectomies, abdominal hysterectomies, removal of cysts, tubal repair, tubal ligation, or removal of ovarian cysts and other things that need to be done through an open incision.
Q. Have you ever performed an abortion?
A. Yes.
Q. Approximately how many times in your career have you performed an abortion?
A. Approximately 1500 to 2,000.
Q. What types of abortions have you performed?
A. I have performed D&C abortions, including both sharp curettage and dilatation and suction. I performed D&E

procedures later on in pregnancy. I have performed an occasion hysterotomy. I have performed instillations. I think that completes it.
Q. Do you currently perform abortions?
A. I do.
Q. Dr. Weiss, how did you first learn to do abortions?
A. When I was a resident, abortions were not permitted and were illegal. When I was a chief resident in 1969 and the end of 1968, the law had softened somewhat in New York State and there was the ability to do abortions for women whose lives were endangered by the process.
Before that time, what we would see in my training at Bellevue Hospital were the referred complications of criminally induced abortions throughout the city. So every week, especially as a first-year resident, I would have to deal with completion of abortions of first and second trimester procedures, many times in women who had infected uteri and multiple problems. This is where I learned the techniques of finishing the abortion process, in dealing with the issues, in dealing with the complications and the trouble caused when procedures are not performed accurately and adequately.
When I was a chief resident, I had 12 individuals who, for medical or psychiatric reasons, were deemed by an independent committee of physicians and other members of the community that an abortion was appropriately required. These

women were in their second trimester. Because the process was a long one and even if they presented at 8 weeks, which would be usual -- because you could rarely in those days diagnose a pregnancy before 6 or 7 weeks -- they would have to go through a committee and they would be in their second trimester.

Using the skills that I had developed as a junior resident dealing with the many hundreds of abortions that were in various stages of completion, I trained myself to perform these abortions, because no one had done them beforehand and there was no one that could teach the procedure. The skills are not that much different from the skills I already had. So I learned really in a way being self-taught at that time.

Q. What were some of the consequences of the illegal induced abortions that you described?

MR. LANE: Objection, your Honor.

THE COURT: What, pray tell, has this got to do with this case?

MS. PARKER: Your Honor, may I?

THE COURT: Yes.

MS. PARKER: He is just describing the way he learned abortions and some of the consequences.

THE COURT: I think you are going far beyond that.

MS. PARKER: I will move on, your Honor.

THE COURT: Sustained.

Q. Dr. Weiss, approximately how many D&E procedures have you

performed throughout your career?

A. I would estimate 20 percent of the total, so that would be somewhere around 3 to 500.

Q. In conjunction with your work at the hospital and the medical school, do you supervise other physicians' abortion practices?

A. Yes. I am required to do quality control for all procedures in the hospital. There was a period of time when the abortion service, for varying reasons, was actually not part of the obstetrics and gynecology department. But even at that time I was responsible for the oversight of the procedures, the quality assurance, and the evaluation of the procedures by morbidity and mortality conferences.

I now see that residents are trained in these procedures and evaluate the process. Specifically, we have generic screens, such as readmission to the hospital for removal of structures not planned for, readmission within a month after procedure, that trigger what is called the morbidity mortality conference, which is an evaluation of the problem, why it occurred, what could be done to prevent it from occurring again.

We have now established, I have hired someone to establish, an abortion service. She has received a national grant from the Ryan Foundation for I guess it is $450,000 the first year to set up training programs to teach individuals all

aspects of contraception and abortion. This is to teach residents as well as medical students and other --

THE COURT: What foundation is this?

THE WITNESS: The Ryan Foundation.

THE COURT: How do you spell that?

THE WITNESS: R-Y-A-N. It is named after Kenneth Ryan, who was the chairman of obstetrics and gynecology at Harvard Medical School for many years and the chairman of I believe it was President Nixon's ethics committee.

Q. Dr. Weiss, how many D&E procedures have you supervised your career?

A. It would have to be thousands.

Q. Are you familiar with a variation of the D&E procedure sometimes known as intact D&E?

A. Yes.

Q. Have you ever delivered a fetus intact in a D&E procedure that you have performed?

A. Yes.

Q. Do you have any responsibility for training other physicians?

A. Yes. Part of my job as the chairman of the medical school department is to see that we train other physicians in the subspecialty. We specifically through this grant are required as a department, as recipients of this, to train individuals as well.

Q. Are you a member of any professional associations?

A. Yes, I am.

Q. What are those?

A. I am a member of the American College of Obstetrics and Gynecology. I served in many capacities, including some elected capacities when I was in New York State, and I chaired for several years the gynecologic practice committee, which is the committee that deals with gynecologic practice, including abortion practice. I am a member of the New York Gynecological Society and the New York Obstetrical Society. I have been president of both these organizations.

I am a member of the American Society of Reproductive Medicine. I am a member of the Council of University Chairs in Obstetrics and Gynecology, and I am the immediate past president of that organization. I am a member of the Endocrine Society. I am a member of the Society for Gynecologic Investigation and currently am its president-elect. I am a member of the Society for the Study of Reproduction, SSR.

There may be one or two others.

Q. What is the Society for Gynecologic Investigation?

A. The Society for Gynecologic Investigation is an international society founded in this country that is responsible for research. That is the society involved in the basic and clinical research in reproductive medicine and all its aspects. Its role is to function as a clearinghouse for

information.

It has an annual meeting in which probably a thousand scientists present their work and discuss their work and protocols with other members. It also has an educational component as well, with symposia throughout for this annual meeting. It also has other, smaller, subspecialty meetings that will be meeting internationally.

Q. Have you authored any publications?

A. Yes, I have.

Q. Approximately how many publications?

A. Roughly 250.

Q. Have any of those publications been peer-reviewed?

A. Most of them.

MS. PARKER: Your Honor, may I approach the witness to hand him a binder of exhibits?

THE COURT: Surely.

Q. Dr. Weiss, please turn to tab 124 in that binder.

A. Yes.

Q. That document has been marked as Plaintiffs' Exhibit 124. Do you recognize the document?

A. I do.

Q. What is it?

A. It is my curriculum vitae.

Q. Is this document an accurate summary of your education and experience?

A. It is reasonably accurate. I may have neglected to add a publication or an abstract, but it is pretty much accurate.

MS. PARKER: Your Honor, at this time plaintiffs move to offer Exhibit 124 into evidence.

THE COURT: Any objection?

MR. LANE: No objection, your Honor.

THE COURT: It will be received.

(Plaintiff's Exhibit 124 received in evidence)

Q. Dr. Weiss, what, if any, steps do you take to remain current on developments with the field of obstetrics and gynecology?

A. As I run a department, we run an educational system. Among the things we do is we have a two-year revolving lecture series of 100 lectures to keep everyone current on aspects of obstetrics and gynecology. In addition, we have weekly conferences, case reviews, grand rounds where we have outside speakers, journal clubs where we look at articles in the literature and dissect them in terms of their quality and appropriateness for changing practice.

In addition, I subscribe to and read a fairly sizable number of journals in medicine and my specialty, both general and specific areas. I discuss items with my colleagues. And since I am active in national and international spheres, I will frequently meet with other physicians and discuss what is new in the field.

Q. Aside from your work on this matter, have you offered expert testimony in any other matters?
A. I have.
Q. Have any of those matters involved challenges to bans on partial-birth abortion?
A. Yes.
Q. What case or cases was that?
A. That was the New Jersey case I guess in 1998.
Q. Were you also a plaintiff in that case?
A. I was.
Q. Have you been a plaintiff in any other challenges to state laws?
A. I have.
Q. What were those laws?
A. There were editions, I recall. One was the parental notification law in New Jersey, and the other was the law that limited welfare payments to individuals who became pregnant when they were on welfare. The issue there was if a woman became pregnant, even by rape, and elected to have the child, she would not receive additional welfare information to support her.
Q. Has a court ever failed to qualify you as an expert in any case?
A. No.
MS. PARKER: Your Honor, we tender Dr. Weiss as an

expert in obstetrics and gynecology and abortion practice and procedures pursuant to Federal Rule of Evidence 702.
THE COURT: Any objection?
MR. LANE: No objection, your Honor.
THE COURT: The doctor will be so recognized.
Q. Dr. Weiss, you testified earlier that you are familiar with a variation of D&E sometimes called intact D&E, is that correct?
A. That's correct.
Q. Do you have an opinion regarding the safety of removing the fetus intact in a D&E procedure?
A. Yes, I do.
Q. What is that opinion?
A. My opinion is that removing the fetus intact is a safer procedure than disarticulating or breaking the fetus into parts before removing it.
Q. Why is that?
A. When you do a termination procedure, the first step is to dilate the cervix and the second step is to remove the uterine contents. This is done initially by suction and then by putting instruments into the uterus to grasp the fetus and take out whatever parts one can take out.
If one were doing a disarticulation procedure and not taking the fetus out intact, there would be multiple attempts at taking a rigid instrument out of the uterus, putting it back

into the uterus, moving around and closing it, and each one of these acts, which may be done 15 or 20 or more times, attends to the risk of perforating the uterus. The more you enter and leave the uterus, the greater the chance of inducing infection.
THE COURT: Have you ever perforated the uterus performing this procedure?
THE WITNESS: I have perforated the uterus --
THE COURT: Performing this procedure?
THE WITNESS: I'm not sure what you mean, sir. Do you mean by performing an abortion procedure --
THE COURT: Yes, a D&E, where you are dismembering, tearing the fetus apart.
THE WITNESS: I don't start off a procedure saying I'm going to do a --
THE COURT: I didn't ask you that, Doctor. It's a simple question. In doing that procedure, have you perforated the uterus?
THE WITNESS: No.
THE COURT: See how simple that was? Have you ever been sued for malpractice, Doctor?
THE WITNESS: Yes.
THE COURT: Did any of those involve your specialty?
THE WITNESS: Yes.
THE COURT: Next question.
Q. Doctor, you were describing why it is that you thought that

removing the fetus intact in a D&E procedure was safer. Did you have more to add on that?
A. Yes. When the fetus comes out intact, there is minimal manipulation inside the uterus, hence minimal chance of producing damage. You see the entire fetus. If you were dismembering the fetus, what you would have to do is take the parts, leave them aside, and then try to reconstruct the fetus from what you have done.
You can reconstruct in a general sense. You can find limbs, maybe trunk, maybe head. But there is the possibility that small parts or pieces of soft tissue would be left inside the uterus, and that could serve as a nidus of infection, and that can serve as a problem in the future in which retained products would produce pain in the future, abnormal periods, or even, by functioning as a foreign body in the uterus, functioning as an intrauterine contraceptive device and therefore interfering with conception.
None of this will happen when you are doing an intact D&E. When you are doing an intact D&E, the entire procedure is under visual control. What you need to do is deflate the head, but you have much control over that and it is right in front of you at the time.
The time of procedure is decreased. It is clear, a vast medical literature suggests, that the complication of infection is highest the longer the procedure. During an

abortion procedure there is bleeding until the procedure is completed. A briefer procedure results in less blood loss and less risk, again, of infection and leaving material behind.
Q. Are there any risks that relate to how the fetal parts come out?
A. If you remove the fetal parts -- the fetus intact, you have full control of this issue. If on the other hand you disarticulate, break the fetus apart --
THE COURT: Disarticulate is you tear off a piece, isn't that what that means?
THE WITNESS: Yes.
THE COURT: Why don't you use those words, Doctor, so the transcript will reflect vocabulary that any person could understand.
THE WITNESS: Certainly.
A. When the fetus is broken apart, the long bones especially that are broken may have sharp edges. These sharp edges may effect laceration of the walls of the uterus and produce bleeding that way. The sharp edges can also embed and sometimes stick into the wall of the uterus, occasionally even breaking off in the wall of the uterus and remaining there for long periods of time, producing complications well into the future.
Q. Taking those one by one, you discussed the risks of putting instruments in the uterus. Why would removing a fetus intact

reduce that risk?
A. You don't see where the end of your instrument is, because it is inside the body. When you put an instrument in, you are grasping without seeing what you are grasping. Each time it is possible that you could grasp the wall of the uterus. Or if the geometry changes because the uterus contracts, it is possible that you could put the instrument through the wall of the uterus. This type of perforation would not happen if you don't have to go through that process.
Q. How common is uterine perforation among experienced providers of D&E?
A. Essentially every provider has had uterine perforation. Different providers have vastly different levels. Let me first describe the difference in perforation, because that will help you understand.
As you dilate the uterus, some people frequently will sound it, use a very thin, blunt device. If you were to perforate with a sound, you would never know it, because it would be similar to sticking a needle in the uterus, and it wouldn't have very much adverse effect.
On the other hand, a tear in the uterus that is three inches long and would produce horrendous bleeding is also called the same name, "perforation." Everyone has experienced this. Occasionally it will happen and you will not know about it and you will learn about it years later when there is an

operation and you see that there was a rent in the uterus and that was be the reason for it. Sometimes there is a shock, bleeding, or evidence of other problems that would lead you to this information.

There was a practitioner in New Jersey who was in my department when I got there who was performing late terminations by D&E and had in the month before I got there three very serious perforations.

Q. Given that perforations --

THE COURT: Did you stop him from performing under your guidance?

THE WITNESS: Yes, sir, I did. I took action to not only stop him from performing abortions, I stopped abortion procedures beyond 18 weeks because there was no one that could do it competently, and took action that resulted in his losing his medical license.

THE COURT: Doctor, when you perform an abortion, do you make complete, full disclosure to the patient?

THE WITNESS: I try to.

THE COURT: Do you explain to them the options available?

THE WITNESS: Well, I --

THE COURT: In simple, clear language?

THE WITNESS: I explain it in language appropriate to the individual I am speaking to.

THE COURT: I didn't ask you that. Simple and clear language that anyone, any layman, could understand.

THE WITNESS: Yes.

THE COURT: Do you explain to them that if you do a D&E, you're going to tear their fetus apart and remove it in pieces?

THE WITNESS: I explain that --

THE COURT: Do you tell them that? It is a simple question.

THE WITNESS: Do I use those words? No.

THE COURT: Do you use similar questions that are just as clear?

THE WITNESS: Yes.

THE COURT: Not "disarticulation"?

THE WITNESS: Yes.

THE COURT: You tell them you are to remove pieces, pull them off?

THE WITNESS: Remove pieces, yes. I say it may come out intact or in pieces. I do not say "pull them off."

THE COURT: So you don't make it clear that you are pulling them off. That is what you are performing, is it not?

THE WITNESS: I make it clear that the fetus may be removed in pieces.

THE COURT: Do you discuss with them fetal pain?

THE WITNESS: No.

THE COURT: Do you, when you tell them the various procedures available, say that in an intact D&E, if you choose to call it, or partial-birth abortion, that you take a pair of scissors and make an incision in the base of the skull?
THE WITNESS: I say that we take the fluid and material out of the skull.
THE COURT: No, Doctor. The question is simple. Don't turn it around. Just do you tell them that if you do that procedure you're going to take a pair of scissors and make an incision at the base of their baby's skull?
THE WITNESS: I do not use that language.
THE COURT: Do you discuss with them whether or not this inflicts pain on the fetus or the baby?
THE WITNESS: No, I do not.
THE COURT: Do you tell them that you are going to use a suction device and suck the brain out of the baby?
THE WITNESS: Yes.
THE COURT: You use simple words and tell them that?
THE WITNESS: Yes.
THE COURT: Next question.
BY MS. PARKER:
Q. Dr. Weiss, you were explaining before that uterine perforation, although every provider I think you said has had one, is not very common, is that correct?
A. That is correct.

Q. Given that it is not common, are you concerned about it in performing D&E's?
A. Of course. If you were not concerned about it, it is likely it would happen more frequently. If you didn't keep it foremost in your mind, if it happens and you miss the diagnosis, especially if after perforation you damage the other abdominal contents, such as the bowel, you may after a day or two or three have a patient with generalized peritonitis who would be at risk of death. It is a very serious complication which can lose the life of an individual.
Q. Dr. Weiss, have you ever perforated a uterus in any abortion procedure you have performed?
A. Yes, I have.
Q. Would using ultrasound eliminate the risk of uterine perforation in a D&E?
A. It would not.
Q. Why is that?
A. It would be difficult for an individual to use ultrasound at the same time that they are doing the procedure, so they would have to depend on someone to help them. That requires communication and it requires immediacy.
What would happen likely is you would be looking for not a perforation, but you are coming close to the wall of the uterus. As the input, clearly you want to come close to the wall of the uterus, because the placenta is attached to the

wall of the uterus. It might help better to diagnose the problem if it occurred. I think I see your instrument outside the uterus, but I don't think it would be very helpful as a preventive in most cases.
Q. Are instruments ever used in a D&E to remove the placenta?
A. Yes.
Q. How does the use of instruments to remove the placenta in a D&E compare with the use of instruments to remove the placenta in an induction abortion?
A. It would be the same if you needed to remove the placenta in that roughly one-third of induction procedures you then have to do an operative procedure. The difference would be that if you did it during the D&E, it would be fairly rapid and have a decreased risk of infection.

If, on the other hand, you did it at the time of induction, membranes may have now been ruptured for a day or two. You are probably 6 or 12 or 18 hours after the delivery of the fetus. If the placenta is still intact and you have not been able to remove it, you would be increasing the risk of infection, because the risk of infection occurs whenever the membranes are ruptured. When that happens, the clock is ticking, the intrauterine contents do not protect themselves from infection, and that rate increases at a greater rate the longer the membranes are ruptured.
Q. You mentioned that in a dismemberment procedure there is a

risk to removing the fetal parts. Can you explain how an intact procedure would reduce those risks.
A. With an intact procedure, there would be no sharp parts, so there would be nothing to embed in the uterine wall or tear the cervix. In an intact procedure, you would not have the multiple insertions of equipment that would produce the potential of uterine rupture and/or uterine damage or the increased risk of infection as one did this procedure multiple times.

THE COURT: But both do occur in intact D&E's, do they not, from time to time?

THE WITNESS: At a lesser incidence --

THE COURT: But they do occur?

THE WITNESS: No, not all of them, sir. You would not leave fragments in the uterus.

THE COURT: I didn't say that. They do occur occasionally?

THE WITNESS: Excuse me. What do you mean by "they"? Which they?

THE COURT: Perforation of the uterus.

THE WITNESS: Perforation can occur.

THE COURT: And does infection occur?

THE WITNESS: It can occur.

THE COURT: That's all I asked, Doctor.

Next question.

Q. Doctor, when you remove the fetus in a procedure involving dismemberment, are the fetus's bones covered by soft tissue?
A. Excuse me? When you?
Q. Remove the fetus in a dismemberment procedure, are the pieces of the fetus covered by soft tissue?
A. Frequently much of the bone is covered. It is quite likely that the ends of the bone in the area that is broken are uncovered and sharp.
Q. Doctor, you mentioned another advantage of removing the fetus intact was that there would not be retained fetal tissue. Can you explain why that would be the case.
A. Specifically because the fetus is intact. There is no parts of the fetus that you are leaving behind. You see it intact, you know it is intact. If you tear the fetus into pieces, some pieces may remain inside the uterus.
Q. Is there a concern about pieces remaining inside?
A. There is certainly concern there can be. The focus of infection, a foreign body left inside anywhere in the body becomes an area that is likely to be infected. Specifically, attached to the wall of the uterus, it can become a polyp later, producing chronic pain, producing chronic bleeding, and producing difficulty in getting pregnant. Occasionally, if a sharp piece perforated into the uterine wall, it may even years later break through or cause additional problems. This does not occur if the fetus is intact.

Q. Can you eliminate the risks of retained fetal tissue in a D&E involving dismemberment by counting the fetal parts at the end of the procedure?
A. No, you can't. You can count roughly. You can count there is a limb here, I can see feet and hands, I can see skull fragments, I can see trunk. But when you see little pieces, if there are small pieces left behind that are torn off, you can't fully reconstruct and you cannot fully count the small pieces.
Another way of looking at that is if you have a long bone that is broken into six parts, you are only going to say I see long bone parts. You will not be able to reconstruct to a point of that accuracy.
Q. Can you eliminate the risk of retained fetal parts by checking the uterus with ultrasound at the end of the procedure?
A. You cannot. Sometimes the retained fragments are not bony. Sometimes they are collagenous and you will not see them. The material left inside the uterus after a procedure -- tissue fragments, blood clots, and fragments of the lining of the wall of the uterus that has been removed -- produces a variety of confusing echoes on ultrasound, and a small piece of tissue or occasionally a small piece of bone would not be detected.
Q. You also testified that removing the fetus intact leads to a shorter procedure. Why is that the case?
A. The fetus, if you have it out intact, is removed in one

motion, it is removed quickly. You don't have to go back multiple times to remove several small fragments persistently. In addition, you don't have to go through the process of reconstruction, all of which takes time. Consequently, it is a shorter procedure, and shorter procedures lose less blood and decrease the risk of infection.
Q. Dr. Weiss, does removing the fetus intact in a D&E offer any safety advantages for women with specific medical conditions?
A. Yes, it does.
Q. What might those be?
A. If a woman is at specific risk of infection, for instance, if she has an immune deficiency, a faster procedure would decrease that risk and be to her benefit. If she has a coagulation problem or a problem preventing her from clotting, or if in fact she needs to be on medications that will decrease clotting, a faster procedure will save her much blood loss that otherwise she would lose.
If a woman had a condition such as severe asthma or a severe cardiac problem such that anesthesia would be a problem and you would want to have as fast and as brief a procedure as possible, an intact procedure would be an advantage to that woman.
MR. LANE: Your Honor, if I may, during the course of that answer I checked the expert report of Dr. Gerson Weiss,

and there is no mention of specific maternal health conditions and whether this procedure would be an advantage. I therefore move to strike the answer and the question. I am certainly happy to provide the Court and counsel with a copy of Dr. Weiss's expert report.
THE COURT: Is that correct, Ms. Parker?
MS. PARKER: No, it is not correct, your Honor. May I read a piece of the expert report?
THE COURT: Sure.
MS. PARKER: The expert report says on page 2, "For these kinds of reasons, intact removal of the fetus is particularly preferable for women with certain conditions, such as women at increased risk of hemorrhage or infection."
MR. LANE: Your Honor, I stand corrected. I apologize.
THE COURT: Fine. It is always good to have the ability to do that. It is refreshing. Overruled.
Q. Dr. Weiss, would a D&E involving intact delivery offer any advantages over a D&E involving dismemberment for a woman with any kind of uterine scar?
A. The answer is yes. A woman with a uterine scar from surgery, let's say, that removed multiple fibroids may have very thin areas in the uterus which, with multiple insertions of equipment, potentially produce problems such as perforation. An intact removal is more straightforward, simple, and

definitive.
If a woman had a Cesarean section scar, likewise, if it were a vertical scar, you would be at risk of having a thin area in the uterus and having it perforated. And more perforation is likely with multiple insertions of equipment.
(Continued on next page)

BY MS. PARKER:
Q. Dr. Weiss, can you think of any maternal condition that would require the use of the intact D&E variation?
A. I don't -- require is a difficult word.
You would want to do a complete, a procedure such as that for conditions where you would want to shorten the procedure or decrease physiological stress to the mother. The problem is that you can't always do an intact D&E, you can't always, even if that's what you would like to do as you would like to in most cases for the advantages of that procedure, you can't always do it for technical reasons.
So, you can't really say that it is required.
Q. Does the fact that you --
THE COURT: What are the technical reasons, Doctor?
THE WITNESS: You may -- again, the uterine contents are not visible to you so you may not be able to bring the fetus down in a longitudinal position that would allow a more rapid delivery.
If, for instance, you grasped and grasped the trunk and brought the trunk down, you would never get the fetus out by its geometry which is transverse to the opening of the cervix, you would never get the fetus out intact and you would have to dismember.
Q. So when you said technical, you mean the way the fetus presents?

A. The way the fetus presents or the way you grasp the fetus.
Q. Does the fact that you can't think of a circumstance that would require intact D&E affect your opinion on the safety of it?
A. Not at all.
Q. Why not?
A. Because if you can't have it done for all of the reasons I have mentioned it would be a much safer procedure. Ergo with less risk of blood loss, less risk of damage to the uterus, less risk of infection -- in all situations it would be preferable if it could occur.
Q. Doctor, you testified that in your own practice you have delivered the fetus intact in a D&E procedure, is that correct?
A. That's correct.
Q. Now, up to what week of gestation do you perform D&Es?
A. 18 weeks.
Q. Are you aware of a definition of intact D&X that's been set forth by the American College of Obstetricians and Gynecologists?
A. Yes, I am.
Q. Is the ACOG definition that you are aware of a four-part definition?
A. Yes.
Q. Is it a definition that says: One, deliberate dilation of the cervix usually over a sequence of days; two, instrumental

conversion of the fetus to a footling breech; three, breech extraction of the body excepting the head, and; four, partial evacuation of the intercranial consents of a living fetus to effect delivery of a dead but otherwise intact fetus?
A. Yes.
Q. That's the definition you are aware of?
A. Yes.
Q. Do you perform intact D&X procedures as described by ACOG?
A. I do not.
Q. Why is that?
A. I do not because that would usually be done beyond 18 weeks and I do not perform procedures beyond 18 weeks.
Q. I would like to read you another definition of intact D&E, this is a definition from Plaintiffs' complaint:
"Intact D&E, which is also known as intact dilation and extraction or D&X is one variation of the D&E procedure, generally used after 19 weeks' LMP that is intended to maximize the chances of an intact or relatively intact delivery and thereby minimize risk to the woman."
Are you familiar with that definition?
A. Yes.
Q. Do you perform intact D&E as described in that definition?
A. I do not.
Q. What is different about your practice in that definition?
A. I only perform procedures up to 18 weeks.

THE COURT: Why is that, Doctor?
THE WITNESS: Well, I have only been trained and had experience in doing them in 18 weeks. These are relatively or quite rare procedures, so my feeling is that if I'm going to do them without an experience behind me, I would not want to do it rarely and would prefer to refer the patient to someone with greater expertise who has a greater learning curve with it because they have done more procedures.
THE COURT: How long have you done the intact D&Es up to 18 weeks?
THE WITNESS: I have done them since 1973.
THE COURT: When you talk to a patient, as we were talking about earlier in full disclosure, what words do you use when you say you do tell them that? You don't tell them that the incision at the base of the skull but you do tell them about the removal of the brain; what words do you use? Intercranial?
THE WITNESS: No.
THE COURT: Such as counsel just used, the intercranial contents? What do you use, Doctor?
THE WITNESS: The term I use is puncture. I think most people understand the term puncture.
THE COURT: And what do you say? How do you describe the removal, the sucking of the brain out of the skull?
THE WITNESS: Suck out the contents of the skull.

THE COURT: And you use those words?
THE WITNESS: Yes.
THE COURT: And they authorize you to do it?
THE WITNESS: Yes.
THE COURT: Next question.
BY MS. PARKER:
Q. Dr. Weiss, you testified earlier that you only performed procedures up to 18 weeks, is that right?
A. That's correct.
Q. And you also testified that you have brought a fetus out intact in some of the D&E procedures that you have performed, is that right?
A. That's correct.
Q. Is your ability to bring the fetus out intact affected by the fetal tissue at that gestational age that you perform D&Es?
A. The earlier the pregnancy the more fragile the fetus. So, grasping a fetus early on is more likely to tear it and less likely to allow you to bring it out whole.
If the fetus were older its condition would be tougher enough that it could take, you could move it into an appropriate position easier.
Q. And you also testified that you have, when you were speaking with the Judge, that you have used suction to remove the brain of the fetus, is that right?
A. Yes.

Q. Is there another way that you have removed the head in the D&E procedures that you have performed?
A. Yes.
Q. What is that?
A. You can in a, before 18 weeks, sometimes grab the head with one instrument, with a grasping instrument in one hand and use a grasping instrument in the other hand to grab the rest of the head. Usually with a twist you can deflate the head enough to bring it through.
So, it's a crush --
THE COURT: Do you crush the head?
THE WITNESS: Yes, it could be a crushing; yes, early on.
Q. Dr. Weiss, in your hospital do women ever first appear for a medical examination when they are already in their second trimester of pregnancy?
A. We serve an inner-city population. 20 percent of our patients appear for delivery without any ante-partum care.
The majority of our pregnant women do not appear until the second trimester.
Q. They do not appear, you mean for care?
A. For care at all, until the second trimester of pregnancy. So, it's not unusual for women to appear at any time late, including for the first time in labor.
Q. In labor when they're about to have a baby?

A. When they're about to have a baby.
Q. Dr. Weiss, are you aware of diagnostic tools available in the first trimester for diagnosing fetal anomalies?
A. I am.
Q. In your hospital, in light of these new tools, are fetal anomalies ever first diagnosed after the woman is already in her second trimester?
A. Yes.
Q. Why is that the case?
A. Two general reasons. One is because the woman may not present herself for care until that time. That's likely the most common reason.
There are also other problems and anomalies that may not be diagnosed except in the second trimester. The techniques occasionally will show risk or call -- the blood tests will give you relative risks and explain the patient that needs further evaluation, and frequently that evaluation will be in the second trimester. Hence, a patient who might be diagnosed to have a condition such as trisomy-18, a uniformly fatal anomaly due to an extra chromosome, you rarely have that information before well into the second trimester.
Q. Are you familiar with chorionic villa sampling or CVS?
A. I am.
Q. What is it?
A. Chorionic villa sampling is a biopsy of the chorion, which

is a fetal membrane, to allow one to get tissue to evaluate the number of chromosomes in it. This will allow you to detect and diagnose chromosomal anomalies which may produce problems and suggest nonviable fetuses, etc.
Q. When is CVS performed, when in pregnancy?
A. CVS is best performed early -- late in the first trimester at around 9 weeks.
Q. Do you perform CVS at University Hospital in Newark?
A. We do not.
Q. Dr. Weiss, have you ever had a patient for whom induction posed more risk than D&E?
A. Yes.
Q. Can you explain that circumstance?
A. Certainly.

The last procedure I did was at roughly 18 weeks, and a woman in heart failure with severe valvular and cardiac disease who was really quite close to death, and the objective was to decrease her stress and to eliminate, to make her unpregnant to avoid the physiologic risk of a pregnancy as fast as possible. We were able to do this in 20 minutes.

Had she gone through an induction procedure it is quite likely, according to our cardiologist, that that stress would have killed her -- it would be the stress of labor.

THE COURT: You did that to save her life?

THE WITNESS: That's correct.

Q. Dr. Weiss, please refer, in your binder of exhibits, to Plaintiff's Exhibit 69.
A. Yes.
Q. Do you recognize this document?
A. I do.
Q. What is it?
A. This is the so-called Partial-Birth Abortion Ban Act of 2003.
Q. Have you reviewed the act?
A. I have.
Q. Have you reviewed it in its entirety?
A. I have.
Q. Please turn to page 3-4, section 14A, of the findings of the Act.
A. Yes.
Q. Would you please read the first sentence of that paragraph?
A. "Partial-birth abortion poses serious risk to the health of a woman undergoing the procedure."
Q. Dr. Weiss, assuming that that sentence is referring to the intact D&E procedure, do you agree with that statement?
A. I do not.
Q. Why not?
A. Well, all medical procedures produce risk.

You need to look at the risk of a pregnancy termination in comparison to the other methods available at

that time. In fact, an intact D&E poses less risk than any other method.
THE COURT: If they all pose risks then it is not inaccurate, is it? It is just what you make it relative to, to other procedures it is different, isn't that correct?
THE WITNESS: I think not in this context, sir, because the context is specifically banning one procedure and not others suggesting this is worse. In fact the opposite is true.
THE COURT: Do the words say it is worse?
THE WITNESS: No.
THE COURT: So it doesn't. This is your interpretation?
THE WITNESS: That's correct.
THE COURT: Okay.
BY MS. PARKER:
Q. Looking at the next sentence which reads: "Those risks include, among other things, an increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term."
Do you see that sentence?
A. I do.
Q. Assuming again that the sentence is referring to intact D&E, do you agree with that statement?

A. I do not.
Q. Why not?
A. There is no evidence whatsoever specifically that this procedure increases the risk of cervical incompetence.
There are multiple known causes of cervical incompetence, they include tearing of the cervix or ripping of the cervix frequently at the time of a term delivery. They occur in some women because they have abnormalities in the enzymes that cause softening of the collagen and elastic fibers which maintain the integrity of the cervix. Or because they have abnormal levels of the inhibitors of these processes.
Cervical incompetence has some control hormonally, and the hormones progesterone and estrogen, oxytocin and, to a greater extent, prostaglandins and the hormone relaxin, are all involved in this mechanism of cervical softening and incompetence.
This appears to be due to specific hormonal problems rather than procedures. The issue of cervical incompetence has, among other things, other associations. Cervical incompetence is more likely in a multiple pregnancy and it may be more likely in a multiple pregnancy and in pregnancies induced by in vitro fertilization because there is a release of hormones as relaxin that are released in higher level under these circumstances.
So, there are many known causes. Likely there many

unknown causes as well. This procedure is not one of them.
Q. Doctor, can you take a look at the next clause of that sentence, the one that says, "An increased risk of uterine rupture, abruption, amniotic fluid embolus and trauma to the uterus as a result of converting the child to a footling breech position, a position which, according to a leading obstetrics textbook, there are very few if any indications for other than delivery of a second twin."
Taking the first part of that, based on your experience, Dr. Weiss, do you agree that there is an increased risk of uterine rupture from a D&E involving intact delivery?
A. No.
Q. Why not?
A. Well, "increased" I believe, is a comparative term.
If you are doing a procedure that has less manipulation, you are likely to have a decreased rather than increased risk of rupture. Uterine rupture is a very rare event, likely more rare in this procedure.
Q. Again, looking at that same sentence and assuming it refers to intact D&E, do you agree that there is an increased risk of abruption from intact D&E?
A. This is not clear.
Abruption is the separation of the placenta before delivery. If this occurs during pregnancy where the placenta separates or partially separates there are two problems.

Problem number one is the placenta will not function and the fetus will become asphyxiated because it doesn't get blood. Problem number two is there is bleeding in this separated placenta causing blood loss and the increased risk of hemorrhage in the woman as she has consumed her clotting factors.
You will be separating the pregnancy in all abortion procedures as you will in a normal delivery. It's not an abruption at that point, it's a separation of the placenta.
So, in this context, this makes no sense.
Q. What if it were referring to abruption and subsequent pregnancies, do you think that there is an increased risk of abruption in subsequent pregnancies?
A. There is no evidence or data or literature on this point.
Q. Do you agree that there is an increased risk of amniotic fluid embolus from a D&E involving intact delivery?
A. No, there is not.
Q. Why not?
A. An amniotic fluid embolus is a very rare condition which results in seizure, abnormality in blood clotting, hemorrhage and shut down of many important organs in the body. It is usually fatal.
It is related most commonly to two things -- one is an association with pre-eclampsia or the specific hypertensive disease of pregnancy where women have abnormal high blood

pressure in their pregnancy. That usually occurs after 24 weeks of pregnancy so it clearly would not be appropriate to deal with here.
The second reason for -- second association of amniotic fluid embolus is a hectic or abrupt delivery. A woman who dilates her cervix from two centimeters to delivery in 10 or 15 minutes and abruptly, rapidly delivers the fetus and then has this complication, clearly that's irrelevant to this and doesn't apply.
There is no literature on this, there is no data, and it makes no sense to make this statement.
Q. Doctor, do you agree that there is an increased risk of trauma to the uterus from a D&E involving intact delivery?
A. I do not, for the reasons we have discussed.
Q. What are those reasons?
A. The reasons are a decrease in putting instruments into the uterus, less manipulation in the uterus in an alternative procedure of tearing the fetus.
Q. Doctor, looking at the last sentence in that paragraph, do you agree with the statement, again assuming it relates to intact D&E, that intact D&E poses, "a risk of lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal."
Do you agree with that statement?

A. No. This makes no sense whatsoever.
Q. Why not?
A. Because this statement says -- let me find it. Blindly forcing the sharp instrument. There is nothing blind about it.
Visualize in your mind this. The cervix has to be dilated enough to allow the entire trunk of the fetus to pass through it. The neck of the fetus is much smaller than the shoulders and the trunk but a larger thing, the shoulders and the trunk have passed through. So, not only is the neck through but a portion of the skull which is vividly, you know, exactly where it is and you see it, it's above the neck --
THE COURT: Do you always see it, Doctor?
THE WITNESS: Almost always, yes.
THE COURT: Not always then.
THE WITNESS: I can't think of anything that I always --
THE COURT: You do it by feel, don't you?
THE WITNESS: You always feel it. It's right there where your finger is.
THE COURT: If you feel it you can't see it.
THE WITNESS: Usually you see it.
So, when it's right there you can usually, under direct vision, insert a sharp instrument into the skull or, at worst, by feel, not blindly, because you know exactly where it is and you feel it with your finger.

MS. PARKER: Your Honor, I'm at the end of a line of questioning, do you want to take the break now?
THE COURT: Sure.
MS. PARKER: Okay.
THE COURT: Fine. The Court will take a recess.
(Recess)
THE COURT: Ms. Parker, you may inquire.
MR. HUT: Your Honor, before the resumption of the direct and with the assent of the government, I rise simply to share with the Court some possible scenarios on timing today with respect to the plaintiff's evidence.
That is, I think Ms. Parker's contemplation that the direct of the doctor currently on the stand will not last past the lunch hour. Depending then on the duration --
THE COURT: The direct is going to last up until lunch?
MR. HUT: It may not. It will not last longer.
Depending then on the length of Mr. Lane's cross examination, and then if the Court is prepared to rule later in the day on the admissibility of the offered designated depositions of Drs. Paul and Creinin.
THE COURT: I am still awaiting some challenged lines.
MR. HUT: We may or may not have proof that would take the balance of the day. Our next witness, Dr. Chasen, is not available until first thing in the morning.

THE COURT: I thought that was my understanding yesterday but I think, if I'm not mistaken, I asked one of my law clerks or the deputy, I guess Mr. Brantley, to speak with the government and I am informed that I should have their objections to questions -- well, I hesitate to say momentarily, but soon. And if that happens we will take care of it. If it is not of great number then I assume we can handle it on the lunch hour and you would be free to take as long as is necessary.
But I am not surprised that you may come up a bit short, in other words, is that what you are saying because Dr. Chasen won't be until tomorrow?
MR. HUT: That's exactly, right, your Honor.
THE COURT: Is he your last witness?
MR. HUT: It is our present contemplation, in all likelihood, that he is.
THE COURT: Okay. Well, my invitation to Dr. Carhart stands, I won't pull it back. I am a person in that fashion.
MR. HUT: Let me address that.
We have, I think three times, conveyed the Court's interest in hearing Dr. Carhart, to counsel for Dr. Carhart and have been told that he is not available. He is expected to be present at the Nebraska trial through its duration and then has a backlog of patients.
On the basis of what the Court placed on the record

yesterday morning we have again relayed to Dr. Carhart the Court's interest in having him testify, through counsel, and we are awaiting final word.
THE COURT: All right. The invitation is there. He can choose to do whatever he wants to do.
MS. GOWAN: Your Honor, if I might just give an update on the objections. I know I did tell Mr. Brantley this morning that I believed I would have them for the Court at the break and I also told Mr. Cinoti last night that I would have them first thing.
THE COURT: Did you lie or falsify, Ms. Gowan?
MS. GOWAN: I was not under oath, your Honor.
THE COURT: Your testament wasn't quite on the numbers, huh?
MS. GOWAN: The problem is there are not a lot.
THE COURT: Can you have them for me at lunch?
MS. GOWAN: Yes. There are not a lot of objections, the problem is counter designations, and one witness has been concluded and Ms. Wolstein is hard at work now finishing up with the second witness and she tells us we will have them for you at noon.
THE COURT: If you give me the objections we can try and run through it and it won't hold you people up. So, if you can?
MS. GOWAN: We will send the paralegal now to get the

objections from them.
THE COURT: That would be helpful.
MS. GOWAN: Thank you.
THE COURT: All right. You may continue Ms. Parker, we are still in your hands.
MS. PARKER: Thank you, your Honor.
BY MS. PARKER:
Q. Dr. Weiss, in performing D&Es, do you take any steps to kill the fetus before beginning evacuation of the uterus?
A. No, I do not.
Q. Why not?
A. Because any step to kill the fetus would be an additional procedure and all procedures have increased risks to the mother. They will extend the time of the procedure, they will require additional punctures into the mother. Each one of which may produce bleeding or damages to a vessel or damage to the uterus.
MR. LANE: Your Honor, Mr. Lane.
There was no mention of, in Dr. Weiss' report, of feticidal techniques. At the risk of my somewhat earlier somewhat embarrassing gaff I did make a point of double-checking.
THE COURT: Ms. Parker, do you want to concede this?
MS. PARKER: I concede it is not in the expert report, your Honor, but I am asking him about the fact of his practice

and how he performs abortions procedures and he is a plaintiff in this action listed as a fact witness. I'm not asking for his expert opinion.
MR. LANE: Your Honor, if I may respond, I believe what the doctor just testified to was the risks of such feticidal techniques.
THE COURT: May I have the question and answer, please?
(Record read)
THE COURT: I'm going to allow it.
MR. LANE: Thank you.
BY MS. PARKER:
Q. Dr. Weiss, do you generally, in your abortion practice when you are performing a D&E, cut the umbilical cord before evacuating the fetus from the uterus?
A. I do not.
Q. Why not?
A. The umbilical cord is frequently not available. To spend separate time to look for it would be impractical, somewhat difficult to do and, again, delay the procedure.
I wouldn't see the benefit of it.
Q. Dr. Weiss, I would like now to direct your attention to section, to Plaintiff's Exhibit 69. Again, that's in your binder.
A. Yes.

Q. Specifically section 1531(b)(1) of the Act, which is page 3-6?
A. Yes.
Q. Are you there?
A. Yes.
Q. Could you please read that section of the Act for us, starting at one?
A. "The term partial birth abortion means an abortion in which the person performing the abortion, (A), deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation the entire fetal head is outside the body of the mother, or in the case of breech presentation any part of the fetal trunk past the navel is outside the body of the mother for the purpose of performing an overt act that the person knows will kill the partially-delivered living fetus."
Shall I continue?
Q. And read B as well, please.
A. "And, (B), performs the overt act other than completion of delivery that kills the partially delivered fetus and; (2), the term physician" --
Q. Okay that's fine. Thanks, Doctor.
Dr. Weiss, based on your understanding of the terms in the Act that you just read, do you have a fear of prosecution under the Act for performing a D&E involving dismemberment?

A. Yes, I do.
Q. Why do you have that fear?
A. Because situations will occur in which in performing a procedure that may even start as a dismemberment you may come into difficulty with the Act. Let me give you an example.

Let's say that one is started and is likely to do a dismemberment and possibly grasps a structure and it turns out to be a fetal arm so the arm is removed, put down, and then you grasp again at which point you may grasp the feet or both feet and they deliver to the trunk.

At that point you have come into conflict with this law because you will then do something that will cause the death of the fetus and, finally, delivery of the fetus, meeting every requirement of the Act to do what is called a partial-birth abortion, hence, an illegal procedure.

THE COURT: Do you think as you started describing what you might do, do you think tearing the arm off is part of the delivery?

THE WITNESS: I'm not sure I understand the question.

THE COURT: You said that you reach in, you get one structure, I think.

THE WITNESS: Yes.

THE COURT: You wouldn't want to say arm -- but then you amended it and said arm -- and you remove the arm. And then you said you move on to a leg.

Do you think taking that arm off was part of a delivery?

THE WITNESS: Well --

THE COURT: Would you call that a delivery? Simple question.

THE WITNESS: Yes, it would be delivery of the arm.

THE COURT: You really think that's what's intended by the statute?

THE WITNESS: No. It was the second thing that would fall foul.

I may have, in a inadvertent procedure first grasped an arm because that's what was there and in the second step -- that would not have killed the fetus. The second step would have been to bring the legs out to the trunk.

THE COURT: You really think those words confuse you, you really think that's what's intended by the statute?

THE WITNESS: I believe it is stated clearly because --

THE COURT: All right, Doctor.

Next question, Ms. Parker.

Q. Dr. Weiss, in your sample was the fetus in a breech position or some other position?
A. When the feet were delivered the fetus was a footling breech.
Q. And in that example that you just gave, did you deliver a

living fetus?
A. Yes.
Q. And did you deliver it vaginally?
A. Yes.
(Continued on next page)

Q. In the example you just gave, did you vaginally deliver the living fetus until a part of the fetal trunk passed the navel, is outside the body of the woman?
A. Yes.
Q. What was the part of the fetal trunk past the navel in your example?
A. That would be most of the trunk of the fetus. What would happen is that --
THE COURT: But with one arm missing, right?
THE WITNESS: In that case, yes. It didn't have to be.
THE COURT: OK. That is the example you gave. Ms. Parker asked you about the example you gave.
THE WITNESS: Yes. One of many. The next example could be without the arm being removed.
A. When you are doing the procedure, part of the procedure is to grasp the cervix and bring it down as close to the opening of the vagina as possible. Frequently, the opening of the cervix is brought down to the opening of the vagina.
More frequently, it is brought down within a centimeter, two-fifths of an inch, to the opening of the vagina. Under those circumstances, if this were a 16-week fetus, the trunk from the navel down would be out of the woman's body, and the remainder of the upper part of the trunk would remain inside.

Q. What is it that you are using to bring the cervix down in your description?
A. You are using a grasping instrument called a tenaculum. Usually they have several opposing teeth which grasp the cervix and allow you to hold it without tearing.
Q. In the example you just gave, I think you said that there were several things you might do that would be an act that would kill the fetus. What might those things be?
A. One thing would be to simply pull the fetus out. Having done that, it is likely that the fetal head would remain inside, and in pulling it would have separated the head from the body, and that would have resulted in the fetal death and later delivery. Another possibility is that you would grasp the head under those circumstances and either crush it or hold it and then puncture it to deliver the head. In either case, you have done an overt act after delivering the fetus to the trunk.
Q. In the example you gave where you delivered the fetus up to the head, is any part of the trunk past the navel outside the woman's body?
A. Yes, certainly.
Q. What part?
A. Depending on the anatomy of the woman, most of the cervix is dilated, so it is usually a good part of the fetus, probably from the navel down in the situation when the vagina and the

cervix are in the same plane or close to the same vertical plane.
Q. In that example is any part of the trunk above the navel outside?
A. It is possible that, depending on the situation, a part of the fetus above the navel would be outside. It depends only on the geometry of the cervix and how far the cervix is brought down.
Q. In the example you gave where the head separates, is that an act that you know will kill the fetus?
A. It is.
Q. Is that an act that completes the delivery of the fetus.
A. No, it is not.
Q. Why not?
A. Because you would then have to remove the head.
Q. You would have to go back --
A. You would have to go back, grasp the head, and remove it.
Q. Dr. Weiss, what is your purpose, in the example you just gave, in delivering a fetus up to the head after removing an arm? What is your purpose in doing that?
A. Your purpose in doing the procedure is overall to terminate the pregnancy, to make the woman no longer pregnant. You want to do this in as atraumatic a way as possible to the mother. Hence, in removing the fetus longitudinally, one has atraumatically removed most of the fetus. This is safer for

the mother but would come into conflict with the Act.
Q. Are any of the steps that you take in the example that you just gave deliberate?
A. Every step you take is deliberate. It may not even be predictable, but it is a deliberate move. Putting an instrument into the cervix, into the uterus, and grasping is a deliberate act. Not a very precise act, because you can't see what you are doing, but certainly deliberate.
Q. Are any of the steps that you take --
THE COURT: It is not your intent, though, is it?
THE WITNESS: My intent is to deliver the fetus by as safe a method as possible. If I were able to do it in an intact way, I would. The problem is you can't in the second trimester before 18 weeks.
Q. You can't ever do it?
A. You can't predictably do it.
Q. In your example, are any of the steps that you take intentional?
A. Every step is intentional.
THE COURT: But if you intended not to deliver the entire fetus, then it is accidental, isn't it?
THE WITNESS: The act of delivery is intentional. Since you can't see what you are doing, whatever you grasp is accidental. If you grasp the lower pole of the fetus, then you have intentionally -- and that would be what you would like --

delivered the entire fetus intact to the trunk. This could happen at 16 weeks, this could potentially happen earlier.
MS. PARKER: Your Honor, I have no further questions at this time.
THE COURT: Mr. Lane, you may cross-examine.
MR. LANE: Yes, your Honor. Thank you. Your Honor, if I may just have a moment to arrange my materials for cross?
THE COURT: Of course.
MR. LANE: Thank you, your Honor.
CROSS-EXAMINATION
BY MR. LANE:
Q. Good morning, Dr. Weiss.
A. Good morning.
Q. You were on the board of directors of Planned Parenthood of Essex County from 1992 through 1997, is that right?
A. That is correct.
Q. You are still a member of Planned Parenthood?
A. I don't know if I am a member.
Q. Would it surprise you to learn that your CV lists you as a member of Planned Parenthood?
A. No. I am not sure what the dates are. I would be continuing a member if I sent them a check this year, and I don't recall doing so.
Q. As soon as the law on abortion changed in 1971, you were part of a group that established a Planned Parenthood-sponsored

abortion facility in Pittsburgh, is that correct?
A. That is correct.
Q. And you have provided testimony --
THE COURT: What year was that?
MR. LANE: Excuse me, your Honor?
THE COURT: What year was that?
MR. LANE: 1971, your Honor.
THE WITNESS: Excuse me, sir. I misspoke. On recollection, it was after the law was changed, and that was January 22, 1973. So I believe it was 1973.
THE COURT: A date that sticks in your mind, is it, Doctor?
THE WITNESS: Vividly.
Q. Doctor, you have provided testimony at trial on behalf of Planned Parenthood, is that correct?
A. Yes.
Q. That case is the Planned Parenthood of Central New Jersey v. Verniero case?
A. Yes.
Q. That was an action in federal district court in New Jersey that went to trial in 1998?
A. Yes.
Q. That action was a challenge to the New Jersey state law regarding partial-birth abortion?
A. Yes.

Q. One of the counsel in that case was Talcott Campbell of the ACLU, correct?
A. Yes.
Q. She in fact is the individual who signed the complaint that was filed on your behalf in this case before Judge Casey?
A. Yes.
Q. Dr. Westhoff testified in the Verniero case as well, is that correct?
A. I believe so.
Q. And she is a plaintiff with you in this case?
A. Yes.
Q. You have known her for close to a decade?
A. Yes.
Q. Doctor, there are three subspecialties for obstetrics and gynecology that are boarded and approved, isn't that correct?
A. That is correct.
Q. You have a specialty in one of those, which is reproductive endocrinology?
A. That is correct. That is a subspecialty. I am a specialist in obstetrics and gynecology. In addition, subspecializing in reproductive endocrinology and infertility.
Q. In your field, the referrals you get include women who suffer from hormonal problems and some who are infertile?
A. Those are some of the issues, yes.
Q. The most common surgical procedures that you conduct are

endoscopic procedures to remove fibroids, polyps, and other problems that are hindrances to producing pregnancy?
A. Endoscopic procedures are one of the more common procedures that I do.
Q. You currently do not do obstetrics yourself, do you?
A. That is correct.
Q. And you don't have the subspecialty of maternal fetal medicine, is that right?
A. That is correct.
Q. The field of maternal fetal medicine covers high-risk obstetrics?
A. That is correct.
Q. For questions of high-risk obstetrics, you certainly would defer to a competent doctor who has a subspecialty in that particular field, would you?
A. I may or may not, depending on the doctor and depending on the question.
Q. You believe there are certain health conditions that may require termination of a pregnancy?
A. Yes.
Q. You mentioned some of these, including cardiac conditions and malignancy that can't be treated until a pregnancy is concluded?
A. Yes.
Q. In your view, this also includes severe psychiatric

problems where it is the impression of the psychiatrist that this needs to be done, that is, an abortion procedure?
A. In that area I would defer to the judgment of the psychiatrist.
Q. In any event, you can't think of a circumstance that would require an intact DEA, can you?
A. The decision is to terminate the procedure -- the pregnancy. The method, if there is a condition such as severe asthma or cardiac disease that would be optimal, would be an intact D&E.
Q. Let me ask you this question, Doctor. I understand your testimony that it is your belief that intact D&E is generally safer. Putting that aside, there are no particular maternal conditions that require the use of that procedure, are there?
A. Beyond the fact that safer is better.
Q. Beyond the fact that as a general matter you believe the procedure to be safer?
A. As a general matter, I know the procedure is safer by virtue of the reasons I have given already.
Q. But you can't think of a circumstance where it would be required to do an intact D&X for a maternal health condition?
A. That's correct.
Q. In your answers to interrogatories in this case, you stated that you performed or supervised approximately 1,000 D&E's in the past 5 years, isn't that right?

A. Yes.
Q. But in fact in the last 5 years you personally performed no more than one abortion per year?
A. That's correct.
Q. This number includes both D&E's and suction curettage procedures?
A. They were mostly midtrimester.
Q. Of the abortions that you supervised over the last year, there were not very many procedures where you were actually in the room when the procedure was performed?
A. Yes.
Q. Doctor, I think you told us about a D&E that you most recently performed at 18 weeks, is that correct?
A. That's correct.
Q. But you testified in the Verniero case that you considered yourself competent to perform early second trimester D&E's up until only about 14 or 15 weeks, isn't that right?
A. I don't recall.
MR. LANE: Your Honor, if I may approach?
THE COURT: Of course.
Q. Doctor, I am handing you what is your deposition transcript from the Verniero proceedings. In fact, as you may or may not know, there are Bates numbers at the bottom of that document GW with some numbers, and that indicates that you produced this document to the government in discovery, isn't that right?

A. Yes.
Q. I would ask you to look at page 53 of your deposition, starting at line 22.
"Q. Do you consider that you still have the competence to perform a second trimester abortion?
"A. I still have the competence to perform an early second trimester abortion.
"Q. And would that be the D&E method?
"A. Yes.
"Q. What do you mean by early second trimester?
"A. Depending on the situation, size, etc., of 14, 15 weeks."
Did you give those answers to those questions in your deposition in the Verniero case?
A. Yes, I did.
Q. In fact, Doctor, you gave exactly that same time range as to your competency to perform D&E's when you testified at trial in the Verniero case, didn't you?
A. I don't recall.
MR. LANE: Your Honor, may I approach?
THE COURT: Yes, of course.
Q. Doctor, you have been handed what is the hearing transcript volume 1 of the Planned Parenthood of Central New Jersey v. Peter G. Verniero case, testimony that took place on September 9, 1998. That is your testimony. I would ask you to look at the trial transcript 1.117, starting at line --

Your Honor, can I have one moment?
THE COURT: Of course.
A. I'm on 117.
Q. Starting at line 13, Doctor.
A. Yes.
Q. "Q. Do you consider yourself still competent to perform a suction curettage abortion after the first trimester?
"A. Yes.
"Q. What about a D&E?
"A. I would now perform D&E's until about 15 weeks."
Did you give those answers to those questions while at a hearing in the Verniero case in New Jersey in 1998?
A. Yes, I did.
Q. In fact, you have not gotten any specific training in that particular abortion since you testified in the Verniero case in 1998, have you?
A. That's correct. I don't believe I said anywhere that I was incompetent to perform procedures beyond that.
Q. Doctor, if you could just answer my question.
THE COURT: Doctor, don't argue with the lawyer. Just answer the question.
THE WITNESS: Yes, sir.
THE COURT: You have your lawyer to ask you questions later, if they so choose.
Q. But it is true that you said in the Verniero case at trial

that you would now perform D&E's until about 15 weeks, is that correct?
A. Yes.
Q. And you haven't gotten any specific training in methods of abortion in the last ten years?
A. Yes.
Q. Doctor, you offered some opinions this morning about the relative safety of the induction method of abortion, isn't that right?
A. That's correct.
Q. You have never performed an induction abortion?
A. That's correct, but I have supervised many.
Q. You personal have never performed an induction abortion?
THE COURT: You have never done one, is that correct?
THE WITNESS: That's correct.
THE COURT: Next question.
Q. Staying with the question of labor induction for a moment, Doctor, you would agree that there are instances during the 18- to 24-week gestation period where a labor induction method would be more advantageous to use than the D&E method?
A. I don't believe so. There may be, but that would only be when labor is already in progress. In other words, if the cervix were already dilated, it would be completion of an act already present. That would be a stimulation more than an induction, but it would fall in a classification under

induction.
Q. Doctor, let me ask the question again, and please give me a yes or no answer. Are there instances where the labor induction method would be more advantageous to use than the D&E method of abortion in the 18- to 24-week window?
A. Yes.
Q. These would include instances where there was a damaged uterus where you would not want to do a mechanical or surgical procedure, right?
A. No. That is a misstatement. That is not accurate. I did say it; I was wrong.
Q. Doctor, when you said you did state that, I am assuming you understand that you stated that at your deposition in this case.
A. Yes.
Q. That was inaccurate?
A. That is correct.
Q. Doctor, you would agree that the labor induction method is not a surgical procedure successfully completed?
A. What do you mean by successfully completed? A third of the time --
Q. Do you understand what I mean by a successful completion of a labor induction abortion, Doctor?
A. I understand what a successful completion of an induction is. The abortion completion, are you talking about the entire

process or the induction?
Q. Where you have a fetus that you are able to terminate using the labor induction procedure, that procedure is not a surgical procedure, correct?
A. Yes. But the procedure is not over.
Q. If you could just answer my question, Doctor.
THE COURT: Doctor, please don't fight with the lawyer. Just answer.
THE WITNESS: Excuse me, your Honor. He is asking a question that can't be answered, because it is in the middle of the process.
THE COURT: Just answer the question.
A. Repeat the question, please.
Q. Doctor, let me make this a little easier for you.
MR. LANE: Your Honor, if I may approach?
THE COURT: You may.
Q. Doctor, I have handed you what is your deposition in this case, and I would ask you to look at page 124, starting at line 21.
"Q. Are there any advantages -- well, let me back up. Is the labor induction method a surgical procedure?
"A. The labor induction starts off as not being a surgical procedure. Many times, as we have discussed, it ends up being a surgical procedure, as one has to deal with the retained placenta.

"Q. If it's completed successfully without a retained placenta or a major complication, is it a surgical procedure?
"A. No."
Were you asked those questions and did you give those answers in your deposition in this case?
A. Yes.
Q. D&E is a surgical procedure, right, Doctor?
A. That is correct.
Q. As a surgical procedure, it has its own risks?
A. Every medical procedure has a risk.
Q. By virtue of being a surgical procedure, a surgical procedure brings with it certain risks, isn't that right?
A. Surgical risks, yes.
Q. These include damage to the uterus from the use of instruments, right?
A. Yes.
THE COURT: Keep your voice up, Doctor, would you please?
THE WITNESS: Yes.
Q. Going back to the question of induction, you would agree that the induction method of abortion has improved over the last decade or so, wouldn't you, Doctor?
A. Yes.
Q. The agents used for induction have improved and the methods for administration are better, isn't that right?

A. Yes.
Q. Doctor, in your view, you don't set out to do a specific abortion procedure, but instead set out to make a woman unpregnant, isn't that right?
A. That's correct.
Q. The word "unpregnant" is your term, right, Doctor?
A. That's correct.
Q. That is a term you used here this morning as well as in your deposition?
A. Yes.
Q. That is not a medical term, is it, Doctor?
A. No. It is a term in English.
THE COURT: It is a what term?
THE WITNESS: A term in English.
Q. Let me ask you about a few other terms. "Vaginal delivery" is a term used in the medical profession, is it not?
A. Yes.
Q. It is a fairly common term among obstetricians and gynecologists?
A. Yes.
Q. "Living fetus" is also a term used with some frequency in the medical literature?
A. Yes.
Q. You have an understanding of the word "partial" and what that means, don't you?

A. Yes.
Q. And the word "partial" is sometimes used in the medical literature?
A. It is a word in English, not a medical term.
Q. Well, let me make this simple. You have used the term "partial" in the medical literature yourself, haven't you?
A. I may have used it. I use language as I write English. It doesn't make the term a medical term.
Q. Again, let me try to make this easier. You are one of the authors of a chapter in Danforth's Obstetrics, right?
A. Yes.
Q. That would be chapter 33?
A. I don't recall.
Q. A chapter in the book?
A. I have written for Danforth's book.
Q. In the chapter that you wrote for Danforth's book, you used the word "partial" when referring to partial androgenization, isn't that right?
A. What was that last word?
Q. Androgenization.
A. I would have to see what you are saying. I'm not clear what that is. I guess I used the word "the," too. I wouldn't consider it medical terminology.
Q. If I can refer you back to your testimony at the hearing in the Verniero case, page 1.145.

A. This is the small piece?
Q. No, it is actually I think the largest of the group, and it is not in the bound volume.
A. OK. What page?
Q. 1 period 145.
A. Yes.
Q. Starting at line 17.
"Q. Is it fair to say you yourself have used the term 'partial' in medical literature?
"A. That I have used the term 'partial' in medical literature?
"Q. Yes.
"A. I'm afraid I can't answer that question.
"Q. Are you one of the authors of a chapter in Danforth's Obstetrics, aren't you?
"A. Yes.
"Q. Would that be chapter 33?
"A. I don't recall.
"Q. Showing you what we will mark as Exhibit D15A, I ask you if this refreshes your recollection whether you authored chapter 33 of Danforth's Obstetrics.
"A. I am.
"Q. Chapter 33 appears on pages 611 to 619?
"A. If you say so.
"Q. Do you want to verify that?
"A. I'm sure it does."

There is a colloquy with the court and counsel.
Moving down to line 18.
"Q. The question is, Doctor, does Exhibit D15 at page 618 refresh your recollection whether you yourself have used the word 'partial' in your medical literature?
"A. I have written the word 'partial.' This refers to partial androgenization. 'Partial' is a modifying word which sometimes makes sense and sometimes doesn't. It is in the context of its use."
Did you give those answers to those questions?
A. I did.
Q. Doctor, again getting back to terminology, you have never referred to "vacuum aspiration" or "suction curettage" as a birth, have you?
A. I don't recall.
Q. If I could ask you to keep that same document out and look at page 1.147, starting at line 19.
A. I don't have page 1.147. I have two pages 1.146, then it goes to 1.148.
MR. LANE: Your Honor, I am happy to provide my copy to the witness.
THE COURT: All right, Mr. Lane, then do that.
Q. Doctor, could you look at the testimony on that page.
A. Yes.
Q. Does it refresh your recollection that you have never

referred to vacuum aspiration or suction curettage as a birth? Starting at line 19, Doctor.
A. I said, "I never referred to it as a birth. I am not sure it was necessarily appropriate or inappropriate. I think I would have to mull it over and look up the definition. It is not common to use that as a term referring to abortion."
Q. Doctor, my question for you is: You have never referred to vacuum aspiration or suction curettage as a birth, is that correct?
A. I don't recall. This is in 1998. We are in 2004.
THE COURT: Doctor, just answer the question.
A. I don't recall.
Q. Doctor, at the time you testified in the Verniero case in 1998, you had never referred to it as a birth, had you?
A. That's correct.
Q. And you can't recall any instances where you have made such a reference sitting here today, can you?
A. That's correct.
Q. In fact, you have never heard the term "birth" used to refer to a D&E procedure either, have you?
A. I can't recall.
Q. Doctor, if you could look at page 1.148, which I believe you do have, starting at line 4.
"Q. And is it common use to refer to a D&E as a birth?
"A. No."

Is that correct, Doctor?
A. That's correct.
Q. Did you give that testimony in the Verniero case?
A. That's correct.
Q. Doctor, getting back to your views on abortion procedures, in your mind there is no distinct separation between suction curettage and D&E procedures, because they both start out exactly the same way, is that right?
A. That's correct.
Q. You don't set out to do a specific abortion procedure, in your view, but instead set out to make the woman unpregnant?
A. Yes.
MR. LANE: If I may approach, your Honor?
THE COURT: You may.
Q. Doctor, I am handing you what has been marked as Government Exhibit B in this case. Again I refer to the Bates numbers at the bottom, starting with the letter GW. These are documents that you produced as a plaintiff to the government in this case, isn't that correct?
A. Yes.
Q. I would like you to refer to document GW000232 and 233. That document is from University Hospital, isn't that right?
A. That's correct.
Q. That is the hospital where you work?
A. That is correct.

Q. This document is entitled "Consent for Surgical, Diagnostic, and Other Procedures," correct?
A. That is correct.
Q. Under the number 1 it says "Operation or Procedure. I hereby authorize and consent to the performance of the following operation or procedure," and then there are many lines left -- three lines left to be filled in for a particular procedure, isn't that right?
A. That's correct.
Q. On this form the procedure that has been typed and filled in is suction curettage for termination of pregnancy, right?
A. That is what is written.
Q. These consent forms are sought from a patient before a procedure is performed?
A. Consent is. These are not.
THE COURT: What was that answer?
THE WITNESS: Consent forms are. These forms are not.
Q. This consent form is a form that you approved in your capacity as chief of the service at your hospital and chairman of the department of obstetrics and gynecology, isn't that right, Doctor?
A. That's correct.
Q. This consent form identifies a particular procedure: Suction curettage for termination of pregnancy?
A. That's correct. But it was never used with a patient.

Q. Why do you say it was never used with a patient, Doctor?
A. I asked what forms were available and got this package. As I clearly stated in my testimony, I never use these forms. I write in, in consultation with the patient, what the issues are.

When I looked at all of those forms, I saw them together as being inconsistent one to the other, and when I gave my deposition said that it will not be used.

When I got back to the office, it turns out that in fact they never had been used, they were in preparation. To this day I, as well as the rest of the staff, use a blank form and fill out the procedure that they plan to do in discussion with the patient.

Q. Doctor, that doesn't change the fact that, as the person in charge of the hospital, you approved this form, right?
A. I approved the forms, but they haven't been used.
Q. Again, my question is you approved the form and the form identifies a particular pregnancy termination procedure on it?
A. Yes. I stated I review the forms and said they were inappropriate. They have never been used for that reason.
Q. But, Doctor, you approved them, isn't that right?
A. At one point.
Q. Yes, at some point before this litigation this became an issue, you approved these forms as the person in your hospital with the responsibility for setting the standards at your

institution?
A. Yes. I'm not the final approval, though. It is not clear whether the institution approved them. In any event, they were withdrawn.
Q. Doctor, I understand from your deposition you are in charge of your institution's guidelines for abortions, isn't that right?
A. I am in charge. But all forms go to a forms committee. After I approve them, I think I explained that they have to then go through an approval and ultimately go through the executive committee of the medical board.
Q. Doctor, once again, my question is: You are in charge of your institution's guidelines for abortion, correct?
A. Yes.
Q. In fact, you told us earlier this morning that you prohibited the use of D&E's after 18 weeks at your institution because of a certain circumstance that arose, isn't that right?
A. That is correct.
Q. That was your call to make?
A. That's correct.
Q. And you made it?
A. That's correct.
Q. Doctor, I would like to refer you to another document in the same package, 228 through 229.
A. I have it.

Q. That is another consent for surgical diagnostic and other procedures?
A. Again, this was never used.
Q. Doctor, that wasn't my question. If you could just listen to my question and try to answer my question. This is a consent for surgical diagnostic and other procedures, isn't that right?
A. Yes.
Q. This is yet another form that you approved in your capacity as chairman of the department?
A. Yes.
Q. Under "Operation or Procedure" it mentions dilation and extraction for termination of pregnancy?
A. Yes.
Q. Moving on to page 230, this is a third consent for surgical diagnostic and other procedures.
A. Yes.
Q. That is another form that you approved?
A. Yes.
Q. That identifies under "Operation or Procedure" laminaria insertion?
A. Yes.
Q. Doctor, this morning I believe you gave us some scenarios as to how a first trimester abortion procedure could violate the Act, in your view.

MS. PARKER: Objection, your Honor: Mischaracterizes the testimony.
THE COURT: Overruled.
A. Sorry. What was the question?
(Question read)
A. I don't believe I did.
Q. Doctor, let me make this simple. In your view, there are certain trimester abortion procedures that can violate the Act, isn't that right?
A. I believe it is possible that a late first trimester procedure might violate the Act.
Q. One of those instances, in your view, would occur in a 10-week pregnancy when laminaria is used to dilate the cervix and then a doctor grasps the cervix and pulls it down to the opening of the vagina, takes the laminaria out, and right behind it comes the fetus up to the head, isn't that correct?
A. Yes.
Q. You have never seen this happen, have you?
A. No.
Q. In your view, you also think it would violate the Act if you were using a suction cannula and a fetal leg got caught inside the suction device, isn't that correct?
A. That's correct.
Q. Could you describe again for the Court what a suction cannula device is.

A. A suction cannula device is a hollow tube, blunted at one end so that it will not have a sharp part to irritate the wall of the uterus. It usually has a valve in it to relieve pressure. It is attached to tubing which is attached to a suction pump. When the suction pump is turned on, suction is applied through the tip of the tubing. If you need to decrease the suction, you flip the valve or push the valve with your thumb, and the suction will be released.
Q. Thank you, Doctor. But when you insert the vacuum cannula, it goes inside the uterus to evacuate fetal tissue, isn't that right?
A. That is correct.
Q. That is why you need to dilate the cervix in the first place, to be able to get the suction cannula inside the uterus?
A. Yes.
Q. So the tip of the suction cannula is inside the woman's body?
A. That is correct.
Q. Notwithstanding all of this, you believe that this circumstance might violate the Act?
A. Shall I explain why?
Q. No. Just a yes or no answer would be fine, Doctor.
A. Yes.
Q. Thank you. In fact, you would agree that in a first trimester vacuum aspiration the suction is almost invariably

sufficient to evacuate the uterus?
MS. PARKER: Objection, your Honor. All of this is beyond the scope of the direct examination.
THE COURT: Ma'am, could I help you -- no. It is cross-examination. Overruled. You might check the rules of evidence before your next objection.
Go ahead. Next question.
Q. If you suction out a live fetus at an early gestational age, such as the first trimester, it will expire very rapidly on its own?
A. Yes.
Q. That is because it is not viable?
A. Yes, and it is separated. That is partially the reason.
Q. You can't point to any medical literature that refers to the suctioning out of uterine contents as delivery, and you don't recall seeing that terminology used, do you?
A. That's correct.
Q. I would like to ask you a few questions about your view that the Act may cover D&E procedures. I am going to use the term "traditional D&E" to mean dismemberment D&E in case I lapse into that term, Doctor.
When you do a traditional D&E abortion and you reach in with the forceps and grab something in the uterus, you usually remove the forceps closed at that point, is that correct?

A. Yes. But I can't answer that question, because the determination of whether you did a traditional D&E is a retrospective determination.
THE COURT: Doctor, why don't you just restrict your answers to the questions asked.
THE WITNESS: It can't be answered as stated, your Honor.
THE COURT: Then you say that.
A. It can't be answered as stated.
Q. I am happy to rephrase it, Doctor. When you reach in with a forceps to grasp something in the uterus, you usually remove the forceps closed at that point?
A. Yes.
Q. When the instrument is closed, there is more pressure on it by virtue of closing it?
A. More pressure on what?
Q. Than leaving the instrument open if there is something that has been grasped by the forceps. By virtue of closing the forceps, pressure would be applied, isn't that correct?
A. That's correct.
Q. As a result, if you grasp the fetus and close the instrument, you are likely to crush what you have grasped?
A. You may or may not, depending on how tight you grasp it and how rough you are with the equipment.
Q. Doctor, I would like to refer you again to the Verniero

trial transcript at 1.158, starting at line 16.
"Q. Is it fair to say, then, in most instances in the early second trimester, when you close the instrument, that it has a crushing event on the fetus?
"A. If you grasp the fetus and you close the instrument, you are likely to crush what you have grasped."
Did you give that answer to that question in the Verniero trial?
A. Yes.
THE COURT: Mr. Lane, is this a convenient time, or would you like to ask a few more questions in this particular line?
MR. LANE: Certainly, your Honor, this is a convenient time.
THE COURT: Court will recess until 2 o'clock.
(Luncheon recess)

A F T E R N O O N S E S S I O N

2:33 p.m.

THE COURT: Before we get started, just a couple of housekeeping matters.

I have read the letters from the plaintiff and from the government concerning the testimony of Doctors -- and forgive me if I mispronounce their names, it's Dr. Bowes, is that correct?

MS. GOWAN: Yes, your Honor.

THE COURT: And Dr. Sprang.

MS. GOWAN: Yes.

THE COURT: Well, let me simplify it. They're going to testify and they're going to testify about whatever their comments may or may not be with regard to the Chasen report.

I think it's important that we have a full and complete hearing. There is an awful lot of who struck John on both sides of the letters. And much of this -- and the urgency might have been avoided, and I am still quite concerned that the plaintiff was less than candid in its outrage yesterday, knowing full well it had been dealt with in other courts.

Thus, they will testify, they will be allowed to testify concerning Dr. Chasen's report. I would suggest to plaintiffs, if they haven't done so, and I can't believe they haven't -- to order, immediately, their transcripts of their testimony. Have they both testified in California by now?

Does anyone know?

MS. GOWAN: Your Honor, Dr. Sprang has testified in Nebraska. I don't know if he has yet testified in California.

THE COURT: Well, they're testifying this week. The defense case is on there, correct?

MS. GOWAN: That's correct; and the defense case will conclude in Nebraska on Friday.

THE COURT: Is Dr. Bowes testifying in other venues?

MS. GOWAN: Yes, he has.

THE COURT: Well, I would order his transcript. I believe that with all this disclosure that I am not going to overly burden these doctors. It seems that their trial transcript plus their supplemental reports to their expert reports should be adequate. However, I will hear any application if after -- after reviewing their transcripts. And I would hope they would not be called by the government immediately. But those transcripts, I assume, are available on a daily basis and they ought to be either electronically or, at the very least, Federal Expressed and reviewed.

I will hear any argument if something additional needs to be covered by way of any deposition, but I'm not going to order that at this stage. And I will ask if any application is made after review of both the supplemental and the trial testimony in the two cases in the west. I will hear some offer from the plaintiff if they want to reopen the deposition but it

better be with strong reason and not just as an abusive tactic. But that is where it stands at the moment and I would place your orders immediately if you haven't already done so.
Now, the doctors, Ms. Gowan, who has read the report from Yale, what is that doctor's name?
MS. GOWAN: Your Honor, Dr. Lockwood.
THE COURT: Is he going to opine on the Chasen report?
MS. GOWAN: Yes, I believe he will offer some comments on the Chasen report.
THE COURT: Well, I would suggest that you -- have you submitted a supplemental to his expert report then?
MS. GOWAN: No, I have not.
He saw the report the day before his deposition --
THE COURT: I understand that.
Mr. Hut, I take great issue. This whole matter has upset me because I tell you, your letter is a little less than straightforward also. As you can tell I am still very, very annoyed.
You cite to me as to the Court's ruling on expert reports but you fail to say that those are experts who are, at the time, testifying on the stand and the objections are made at the moment. You don't play that, do you, in your letter?
MR. HUT: I'm not understanding the Court's question, your Honor.
MS. GOWAN: It's addressed to me.

THE COURT: If you have a problem with that, I will do it slowly.
Your letter objection in this subject cites to the Court its rulings when there has been objections to plaintiff's expert testifying outside their expert report, but you fail to mention in your letter that that is a scenario where the expert is on the stand and the objection is made at the moment they are testifying, a totally different -- totally different situation than what we have here. We are anticipating experts testifying about something in the future. You don't mention that, do you, Mr. Hut?
MR. HUT: Your Honor --
THE COURT: Completeness seems to be a problem.
MR. HUT: With respect, I don't see the difference. I think that --
THE COURT: If you don't, sir, then I have no hope for you.
MR. HUT: And I assumed, frankly, in all candor, that the Court also knew that the rulings with respect to those who had testified were with experts on the stand and that these were with experts whose reports were disclosed in advance.
THE COURT: You have those witnesses coming in the future that you are objecting to now. The objections by the government was when your witnesses -- your witnesses were testifying live at the moment, and you don't see that

distinction?
MR. HUT: Because we have been unable to --
THE COURT: You have a major problem, Mr. Hut.
MR. HUT: Forgive me, your Honor.
THE COURT: In any event, that's the ruling. You should submit a supplemental also on the doctor from Yale then, Ms. Gowan.
MS. GOWAN: Yes.
THE COURT: And he will be allowed to testify.
And I would suggest to the plaintiffs they do as they wish, of course. But if they want to get the trial testimony they should and then, after reviewing all of that, the supplemental report and the trial testimony of these witnesses I will entertain, should there be any request.
As I understand it the lawyers in Omaha, after hearing from the witnesses, decided not to have any depositions. And the lawyers perhaps who approached this a different way in California decided that they would not seek depositions but went ahead and, with the supplemental reports, are prepared to go ahead with the testimony of these witnesses and that's how we will deal with it.
All right?
MR. HUT: Your Honor, may I be heard on one additional matter on this subject? Dr. Lockwood, as I understand it, who Ms. Gowan just addressed, is not testifying in California.

Dr. Lockwood is testifying, I am advised, in Nebraska on Friday. His transcript will not be available Saturday, so --
THE COURT: They don't have daily transcript?
MR. HUT: It will not be available until Saturday. Forgive me.
THE COURT: Then get it. I take it these will not be your first witnesses. I'm directing you not to have them be your first witnesses, Ms. Gowan.
MS. GOWAN: Your Honor, Dr. Lockwood is scheduled to testify as the first witness on Monday.
THE COURT: I would change that schedule now so that the transcript can be available. I asked the plaintiffs to change their schedule and I'm going to have to ask you to do this. I didn't -- the Court wasn't consulted when you decided to have supplementals and bring these things up. I assume you would rather have him here once --
MS. GOWAN: That's correct.
THE COURT: -- and not inconvenience him by having him testify to part, then leave the stand and come back.
MS. GOWAN: That's correct.
THE COURT: So I would make some adjustments. A little organization might have helped but sobeit.
I believe, Mr. Lane, you were in the middle of your cross-examination?
MR. LANE: Yes. Thank you, your Honor.

CROSS EXAMINATION
BY MR. LANE:
Q. Good afternoon, Dr. Weiss.
A. Good afternoon.
Q. I just wanted to clarify one point from this morning referring to the consent forms that are in Government Exhibit B; these are the consent forms that set consent for specific abortions procedures that you approved, correct?
A. Yes.
Q. And you did so, even though you believe, you never set out to do a specific abortion procedure, right?
A. I'm not sure what you are asking me.
Q. I had understood your testimony this morning that you never set out to do a particular abortion procedure, so when someone makes the distinction between you're setting out to do a D&E or a suction curettage, that distinction is not meaningful to you as you set out to do the procedure, is that right?
A. Yes; but that's not related to these.
Q. Well, am I correct in your understanding that you don't set out to do a particular abortion procedure?
A. I try to do a simple a procedure as possible and that way I do determine something. If suction would not be adequate I would do extraction.
Q. I will take that as a yes, Doctor, that you don't set out to do a particular abortion procedure?

A. In some context of early procedure, clearly I know that in an advance second trimester procedure I will have to do an extraction.
Q. My reason for bringing this up is you had said that you were deposed on this subject where these consent forms were brought to your attention and after that you went back to your institution, correct?
A. That's correct.
Q. And you made some changes, is that correct?
A. I didn't make any changes. I said this in discussion with the staff, we all agreed that this would probably be not appropriate to use the preprinted forms.
Q. And you came up with new forms?
A. We have the form as it sits without the typing.
Q. So then what do you put into the part of the form that says procedure?
A. What is written, by hand, at discussion with the patient. It may be transvaginal abortion, it may be transvaginal abortion by suction, it may be transvaginal abortion by whatever the discussion led it to be.
There has got to be concordance between what is written and what the patient understands. It is always easier to do that with a blank sheet of paper than fitting your discussion into something that's preprinted.
In --

Q. My question for you would be in a second trimester procedure if you don't set out to do a particular abortion procedure at the outset, what would you put in that section?
A. Under what circumstances?
Q. After your discussion with a patient.
A. That would depend on the discussion.
I don't want to be obtuse, but if you give me an example I will be glad to tell you what I write.
Q. Well, Doctor, if you do not know in, say, the early second trimester you don't set out to do a particular abortion procedure and so that distinction between D&E and suction curettage is not meaningful to you, what do you put in the form when you are going to do one of those procedures in the early second trimester?
A. In the early second trimester it may simply say transvaginal pregnancy termination by cervical dilatation or by suction, or by suction and evacuation, whatever I think is most likely after discussing with the patient. It's important that the patient knows what I am doing. I don't need a preprinted form for that.
Q. Doctor, as of 1998 you didn't think intact D&E was a recognized medical term, did you?
A. That's correct.
Q. And here my understanding, and you let me know if this is correct, for a D&E what you try to do is maximize the chances

of an intact or relatively intact delivery when do you it?
A. One hopes to get the fetus out intact. There is frequently no technology to do it.
Q. Doctor, I don't mean to interrupt you but I'm going to. If you can answer that question yes or no I would appreciate it.
For you, for a D&E, is it safe to say that you try to maximize the chances of an intact or relatively intact delivery?
A. Yes.
Q. And in fact you're one of the plaintiffs in this case and there was a complaint filed on your behalf, correct?
A. Yes.
MR. LANE: Your Honor, if I may approach?
THE COURT: You may.
Q. And you have been handed what is the supplemental complaint for a declaratory and injunctive relief in this case; do you recognize that document?
A. Yes, I do.
Q. I would ask you to turn to page 39. I'm sorry, page 13, paragraph 39. I apologize, Dr. Weiss. And that paragraph has a description of the intact D&E procedures provided by plaintiffs, correct?
A. That is correct.
Q. And you're one of the plaintiffs in this case?
A. That is correct.

Q. And it says, "Intact D&E, which is also known as intact dilation and extraction, or D&X, is one variation of the D&E procedure generally used after 19 weeks' LMP that is intended to maximize the chances of an intact or relatively intact delivery and thereby to minimize risk to the woman."
Did I read that correctly?
A. You did.
Q. And other than the part of that paragraph that deals with 'generally after 19 weeks' LMP,' you would agree that that definition is the same definition you just agreed with as to what you attempt to do in a D&E, correct? That is, that you intend to maximize the chances of an intact or relatively intact delivery, correct?
A. Yes.
Q. So it meets your definition that you just gave me of what you try to do in a D&E.
A. Yes.
Q. But when I asked you at your deposition whether you had ever performed an intact D&E as defined by the complaint, you had said that you never performed such a procedure, isn't that right?
A. You would have to show me what I said.
Q. Dr. Weiss, I would ask you to look at your deposition in this case and if you have a few things up there, if you can't find it I'm happy to help you out.

THE COURT: Why don't you come right up, Mr. Lane. It will short circuit things if you assist the witness and show it to him.
MR. LANE: Thank you, your Honor.
Q. And I would ask you to look at page 183, Dr. Weiss. I am going to read a section to you and ask you if this refreshes your recollection, starting at line 6:
"Q I just wanted to confirm that's your interrogatory response that you performed or supervised no abortions in the past five years using the intact D&E variation of D&E, as stated in paragraph 39 of the complaint.
"A Yes.
"Q And I want to ask you, using that same definition of intact D&E contained in paragraph 39 of the complaint, have you ever performed an abortion that fit that description of intact D&E?
"A No."
Does that refresh your recollection?
A. I see it here. I don't recall it but I believe it.
Q. So, am I to understand your testimony correctly that you attempt to do exactly what is defined in paragraph 39 of the complaint but when asked at your deposition you said you don't perform such procedures?
A. There are several differences between what you said and what's here.

For instance, this says after 19 weeks and I accepted that and I don't do procedures after 19 weeks.
Q. Isn't it correct, Doctor, that what it says is generally used after 19 weeks' LMP?
A. Yes.
Q. And isn't it correct that you did not at all explain that in your deposition answer that I just read back to you?
A. That's correct.
Q. In fact, Doctor, as of 1998 you didn't know whether you had ever delivered a live, intact fetus during a D&E abortion, did you?
A. No.
Q. Is what I just said correct?
A. I never knew whether I delivered a -- repeat the question. I'm sorry.
Q. Certainly. I'm happy to.
THE COURT: Madam reporter, read the question, please.
(Record read)
A. The question is before 1998 did I ever deliver a fetus that was living when I delivered it.
I'm sure I have.
Q. A live, intact fetus was the question, Doctor.
A. Oh, yes.
Q. So, before 1998 you thought that you had delivered a live, intact fetus during a D&E abortion?

A. Yes. I can specifically recall several specific instances.
Q. Doctor, I ask you to look at your trial testimony in the Verniero case which is the largest stack of papers in front of you.
A. Okay.
Q. And I would ask you to turn to page 1.178, starting at line 20:
"Q You can remove a live, intact fetus during a D&E abortion?
"A Potentially you can, yes, early enough.
"Q Has that ever happened to you?
"A I don't know. I don't check for that if it's early enough.
"It's like a suction procedure, if you suck out the fetus intact, when you suck it out it's probably alive. Being only a few weeks old it will expire very rapidly."
Have I correctly read your testimony in the Verniero case, Doctor?
A. You did.
Q. So you testified in the Verniero case that you didn't know whether you ever removed a live, intact fetus during a D&E abortion?
A. I said it; that's correct.
Q. And your testimony is different here today then?
A. My testimony is compatible, it is not different. Here it

was not, no. That would mean that if I can recall something I can recall it. I didn't say I didn't, I said I didn't know on the stand, I couldn't think of an instance.
Also, since then, six years have transpired.
Q. Doctor, the Verniero case that you testified in occurred on September 9th of 1998, correct?
A. Yes.
Q. And you were deposed in this case on January 28th, 2004, correct?
A. Yes.
Q. And that's a period of a little more than five years, correct?
A. Yes.
Q. And in this case you've told us that over the last five years that you have performed approximately one abortion a year, correct?
A. Yes.
Q. And that includes not only D&E but also suction curettage, correct?
A. I believe they were mostly D&Es.
Q. But you have only performed five procedures in the past five years, correct?
A. That's correct.
Q. As of 1998 you have encountered circumstances in a second trimester abortion where you removed, through the cervical os,

the head of the fetus before removing any of the limbs, correct?
A. Yes.
Q. And in those circumstances the head, upon removal, was detached from the body, correct?
A. Yes.
Q. And as of 1998 in the second trimester D&E abortion, you had removed the torso of the fetus' body before removing the limbs through the cervical os, correct?
A. Yes.
Q. And in those circumstances, the torso of the fetus was detached from the head when removed, correct?
A. Yes.
Q. Doctor, you would agree that research is an important part of medicine, would you?
A. Yes.
Q. And, in fact, you're president-elect of the Society of Gynecologic Investigation, is that right?
A. That's correct.
Q. And that society is the research society in the field of clinical gynecology and obstetrics?
A. Yes.
Q. And it promotes research in the field?
A. Yes.
Q. And you told us this morning that part of your

responsibilities at New Jersey Medical School included setting up a research department, correct?
A. That is correct.
Q. And you also mentioned that there was a journal club to look at articles to determine the appropriateness of changing your practices based on the information contained in the articles?
A. Yes.
Q. Doctor, for intact D&E you would agree, wouldn't you, that there are no published studies evaluating the potential risks or benefits of intact D&E as compared with other abortion procedures?
A. That is clearly correct.
Q. And you don't believe that such a study exists because you don't think anyone has done a substantive series on that topic?
A. That is correct.
Q. And a substantive series, in your mind, is one large enough to be able to define, in a statistically significant way, occurrences and compare those occurrences to other possible procedures?
A. That is correct.
Q. So, there is no published study evaluating intact D&E as compared to other abortion procedures regarding the risk of laceration, correct?
A. To my knowledge.

Q. And there is no published study regarding intact D&E as compared with other abortion procedures regarding the risk of perforation, correct?
A. To my knowledge.
Q. And that's also true for the risk of infection, isn't it, Doctor?
A. Yes.
Q. And it's also true for whether the procedure increases or decreases procedure time, correct?
A. I believe so; as with other abortion procedures that are late and many other factors in medicine. Most of the things one does in medicine does not require a published study.
May I give an example?
Q. No, Doctor. Your lawyers are here and may ask you some questions on redirect.
But suffice it to say, your answer is that there is no such published study on the increase or decrease in procedure time, correct?
A. Yes.
Q. And as of 1998 you had never seen any study to show that the risk of uterine perforation is lower for procedures that use fewer passes with forceps, correct?
A. That's correct. That would be logic.
Q. Well, in fact you testified this morning, didn't you, that perforation is an uncommon complication, correct?

A. That is correct.
Q. And that you, yourself, had never perforated a uterus doing a D&E, correct?
A. Yes.
Q. In fact, Doctor, uterine perforation and cervical laceration are complications of second trimester surgical abortions, in general?
A. Yes.
Q. And that's also true for blood loss, correct?
A. Yes. Some more than others depending on the length of the procedure.
Q. One of the reasons that you mentioned that intact D&E, in your opinion, had a safety advantage involved fewer passes with instruments into the uterus, correct?
A. Yes.
Q. And by that you were not referring to fewer passes of instruments as compared with an induction abortion, correct?
A. Yes.
Q. In fact, there are a number of instrument passes that are common to both dismemberment D&E and intact D&E, correct?
A. I'm not sure what you are asking me there.
Q. Well, let me give you an example.
When I am talking about common passes it is true in both dismemberment D&E and intact D&E that you would have an instrument pass for aspiration of amniotic fluid, correct?

A. You would -- what do you mean by pass? You would put into the uterus, is that what you mean?
Q. Yes.
A. You would put in an instrument to remove the amniotic fluid.
Q. And that would also be true for both procedures, that you would have an instrument pass as we have just defined it, to grasp the fetus with forceps?
A. Yes.
Q. And you would also have a pass in both procedures to suction the delivery of the placenta?
A. Yes. To remove the fetus, though, the number of passes would be different.
Q. Well, my question is about passes, that would be in common with both procedures, Doctor --
A. In frequency? Or just the fact that you grasp in both cases?
Q. Yes.
A. Yes, in both cases you do both.
Q. For placenta?
A. And for the fetus.
Q. And you are not offering any published studies in this case to support your opinion that intact D&E involves fewer instrument passes than dismemberment D&E?
A. That's correct. I am relying, however, on my experience in

doing procedures, and the more intact the fetus the fewer passes I did. This is also true with the observations of my staff.
Q. Doctor, if I can, if you can just answer my questions I would appreciate it. Your lawyer will get an opportunity to conduct your redirect.
Doctor, are you aware that in an intact D&E a doctor may use scissors to puncture the fetus' skull at the base of the neck?
A. Yes.
Q. And you would agree, Doctor, wouldn't you, that a scissors is potentially more dangerous to a woman than a forceps if a mistake is made, isn't it?
A. That's an unnatural comparison. You need to talk about where it is.
A scissors under the direct vision is clearly not more dangerous than a forceps blindly put in the uterus. Certainly that would make no sense. If you are seeing what you are doing you are better off in performing the procedure.
Q. Well, Doctor, let me ask you: You only use blunt instruments for suction curettage, correct?
A. Yes.
Q. And you only use blunt instruments for suction curettage because a sharp instrument would be more dangerous and you can do the job with a blunt instrument, correct?

A. Yes.
Q. And you would agree that a scissors is a sharper instrument than a forceps, wouldn't you?
A. A scissors closed is not a sharper instrument. Usually the edge of the scissors is blunt, not pointy. It doesn't have to be.
Q. Doctor, in conducting procedure with the scissors, would you expect the scissors to remain closed during the entire time during the procedure?
A. No.
Q. Doctor, you testified on direct that intact D&E can reduce the risk of fetal parts remaining in the uterus in your opinion, correct?
A. This is clear. I think it's not an opinion, I think it's an obvious fact.
Q. And, Doctor, you do your best to ensure that the uterus is completely evacuated when are you doing a dismemberment D&E, correct?
A. Yes.
Q. And you do that by assessing the fetal parts?
A. Yes.
Q. And you do that by doing a suction curette as the last step in the procedure?
A. Yes.
Q. And you certainly wouldn't discharge a patient from your

care after second trimester D&E without attempting to have completely emptied the uterus, correct?
A. That's correct.
Q. And you testified this morning you were asked about whether ultrasound would remove the risk of preferation?
A. Perforation.
Q. Perforation. Excuse me, Doctor.
And you opined that retained fetal parts produce a variety of confusing echoes on ultrasound, correct?
A. Yes. There is a literature on this.
Q. But, in fact, you have never used ultrasound during an abortion procedure, have you?
A. I may have used it on one procedure. It's not my common practice.
THE COURT: How many years ago was that, Doctor?
THE WITNESS: Probably a year or two: Maybe --
THE COURT: You only do one a year.
THE WITNESS: Now, yes.
THE COURT: So it was a year or two, you can't remember?
THE WITNESS: That's correct, sir.
THE COURT: And you are not sure whether you did or you didn't, is that correct?
THE WITNESS: I believe -- I did it in a procedure, I'm not sure exactly whether the procedure was evacuation of a

living or a dead fetus. It was intrauterine. It is an abortion in any event.
THE COURT: And you only do one a year.
THE WITNESS: I do a lot of things, your Honor. My day is full.
THE COURT: Next question.
Oh, I bet it is. I bet it is.
BY MR. LANE:
Q. Doctor, you understand that the intact D&E procedure can include conversion of the fetus within the uterus to a footling breech?
A. That is the definition by ACOG, yes. That's not in some other definitions. But that's the requirement of the ACOG definition and it's --
Q. And would you agree that any situation involving an intrauterine manipulation in a pregnant uterus poses a risk of infection, wouldn't you?
A. Yes.
Q. And the risk of infection from intrauterine manipulation in a pregnant uterus holds true even if it is performed manually than if it were being performed with instruments?
A. I think you have a risk whenever you put something in the uterus.
Q. And when there is a manual intrauterine manipulation there is a risk of perforation, correct?

A. Yes.
Q. And there is also a risk of trauma to maternal tissue?
A. With all intrauterine procedures the answer would be yes.
Q. And, Doctor, when you perform an abortion you would like to use the minimum amount of dilation necessary to do the job, correct?
A. That's correct.
Q. And, you think that that's in the best interest of your patient?
A. That is correct.
Q. And, for an intact D&E you would agree that you don't think it would ever require less dilation than a dismemberment D&E?
A. That's correct.
Q. And you would also agree that it may require more dilation depending upon the individual physician performing it?
A. I would never have dealt with it with more. My objective is always to try to get as much as possible out and I dilate not for one or the other. It's not a plan.
Q. Well, Doctor, my question is about the intact procedure and you don't perform the intact D&E procedure, correct?
A. As defined by ACOG, no.
Q. Also as defined in your complaint, apparently.
A. As defined by the Act, yes.
Q. Let me try this again.
Your complaint has a definition for intact D&E,

correct? An that's contained in paragraph 39?
A. Yes, yes.
Q. And, according to that definition, you don't do an intact D&E?
A. That's correct.
Q. So, I'm not asking you about your personal experience with intact D&E because apparently you don't have it. What I am asking you is your opinion as to whether that procedure may require more dilation depending on the individual physician performing it.
A. I don't think I can speak for other physicians.
MR. LANE: No further questions, your Honor.
THE COURT: Any redirect?
MS. PARKER: Yes, your Honor. Just a little bit.
REDIRECT EXAMINATION
BY MS. PARKER:
Q. I am just organizing my notes for one second.
Doctor, when Mr. Lane was asking you a question about situations that require a study in medicine, you wanted to give an example. What was that example that you wanted to give?
A. Yes.
The British Medical Journal recently had a study to make and raise the points of when it is important to have data and when it isn't. Their study was a question of gravitational challenge.

They noted, (1), that people falling from great heights and have not gotten hurt, on occasion. They noted, (2), that people using parachutes have been injured.

They stated that in fact what the world needs is a study to determine whether it's appropriate when you are falling out of an airplane to use a parachute or not, and suggested that the only way to answer this question was to do a randomized controlled study but suggested that the volunteers be those individuals who require a study for everything that's patently obvious.

The reason I am using this example is that it ought to be obvious that the longer -- and there is a literature -- that the longer your procedure in general for most operations, for all operations that have been studied, the greater the chance of infection.

It's clear that the longer the procedure in which there is persistent bleeding the longer the blood loss. If the study -- if the situation isn't very common there will never be a study.

There are rare diseases where there will never be a randomized perspective double-blind controlled study because there is not enough individuals and there will be individuals when you can never get that answer.

The way medicine functions is to use not only studies but a basic understanding of physiology, the history in terms

of such obvious things as the more you put an instrument in the more likely you are to damage than the less, and the longer the procedure the more you are likely to have infection. And it is clearly logic.

Decisions aren't all based on randomized perspective double-blind studies, the gold standards, or there would be almost no therapy for anything because most treatments do not have those as their background. They would be desirable, you get the best information but we frequently don't have it.

THE COURT: Does that mean that since there is no studies on these risks you also testified they are so rare they're meaningless too; does your joke apply to that too?

THE WITNESS: No, it doesn't, your Honor. It's not a joke first of all, it is in fact a written publication in the British Medical Journal. And what I think it's saying --

THE COURT: The British have a sense of humor.

THE WITNESS: They do have a sense of humor, indeed.

What they were saying is that sometimes you can use logic and sometimes you can base it on what you know. And while there hasn't been a study, it is clear that falling out of an airplane you would probably be better off with a parachute.

And it's equally clear that the longer your procedure takes the more blood you are going to lose if there is continuous bleeding during the procedure.

BY MS. PARKER:
Q. Doctor, do you need a study to show that fewer instrument passes reduces the risk of uterine perforation?
A. No, you don't need a study for that. That should be patently obvious to everyone that thinks about what is going on and can conceptualize it.
Q. You testified also on cross-examination that there are risks to the intact D&E procedure as defined by ACOG; is that correct?
A. Yes.
Q. How do the risks of the procedure as defined by ACOG compare to the risks of other abortion procedures used in the second trimester?
THE COURT: Could I have that question read, please?
(Record read)
THE COURT: The question doesn't even say what procedure.
MS. PARKER: Sorry, your Honor. I thought I said the intact D&E procedure as defined by ACOG.
THE COURT: I just had the reporter read the question.
THE WITNESS: Compared to --
THE COURT: Please, Doctor. Don't do the questioning too. You do quite enough testifying.
Would you rephrase the question.
MS. PARKER: I will rephrase it, your Honor. I

apologize.
Q. Dr. Weiss, how do the risks of the intact D&E procedure, as defined by ACOG, compare to the risks of a dismemberment D&E?
A. The risks of the intact procedure are less. They're less because it's a faster procedure with potentially less blood loss because it's faster with less risk of recurrent instrumentation and with less likelihood of leaving retained fragments.
Whatever one does when one pulls a fetus apart, one can never be sure that you haven't left pieces behind, some of which are stuck in the wall of the uterus and you would be unable to get them out.
Q. Doctor, in an induction procedure might the physician have to use an instrument inside the woman's body?
A. This is a very common occurrence.
Roughly a third of inductions which may take several days to complete in that you have delivered the fetus, roughly a third will then go on to not be able, even after several hours of medication, to deliver the placenta as one.
So one has to then, in this one third of the inductions, go into the uterus and, using instruments, remove the placenta. However, there is a difference between doing it under those circumstances and doing it during a D&E procedure.
A D&E procedure starts off sterile until the membranes are ruptured and then is briefly completed. Once amniotic

fluid membranes are ruptured, there is an opening to the outside and to the vagina for infection to ascend into the uterus, and it does so rapidly.

So, most of those times the membranes have been ruptured for two days. There is clear medical evidence that infection increases from the time that membranes rupture and become serious after 12 to 24 hours. So you would be putting instruments in an infected uterus, would further increase the risk.

Q. Doctor, on cross-examination you testified that you don't refer to suction curettage procedures as a birth, is that right?

A. Yes.

Q. And you also testified that you don't refer to D&E procedure, abortion procedures as a birth, is that right?

A. Yes.

Q. Do you refer to intact D&E procedures as a birth?

A. No.

Q. You also testified that you don't currently do obstetrics in your practice?

A. I do not do obstetrics in my practice but I supervise an obstetrical service and set their parameters and guidelines and evaluate their cases and difficulties.

Q. Have you ever done obstetrics in your practice?

A. I have done obstetrics in my practice.

THE COURT: How long ago?

THE WITNESS: 20 years, sir.

THE COURT: You have been concentrating in other areas since then?

THE WITNESS: That is correct. I have been concentrating --

THE COURT: I didn't ask you that, sir.

BY MS. PARKER:

Q. Doctor, outside of the abortions that you performed, do you ever have occasion to use ultrasound for any of the other procedures that you do?

A. Yes, I do.

Q. What procedures are those?

A. I use ultrasound in many situations. I use ultrasound to determine ovulations when we are doing ovulation induction or in vitro fertilization. I use ultrasound to identify the follicles that in fact contain the eggs to aspirate them using ultrasound guidance.

I use ultrasound to determine the thickness of a woman's endometrium. I use ultrasound to define the presence of uterine fibroids such as endometrioma, ovarian cysts, and tumors and anomalies of a uterus.

I will use ultrasound on occasion to evaluate abnormal bleedings to see if there are retained product of pregnancy in the uterus.

I will use ultrasound to diagnose an early pregnancy. I will use ultrasound to evaluate the development of the fetus through the first trimester. And I will utilize ultrasound to evaluate the occurrence of an ectopic or tubal pregnancy.
Q. Dr. Weiss, Mr. Lane showed you a hospital consent form with the term "dilation and extraction" typed on it. Do you recall that?
A. Yes, I recall that.
Q. Are you familiar with the term dilation and evacuation?
A. Yes.
Q. In your understanding, the way you use the terms in your practice, how does the term "dilation and evacuation" compare with the term dilation and extraction?
A. I use them synonymously.
Q. Doctor, you testified that you sometimes crush a part of the fetus with your instrument in a D&E, is that correct?
A. That is correct.
Q. Does whether the fetal part can be crushed depend on the gestational age of the fetus?
A. Yes, it does.
Q. Why is that?
A. Because over time, as the fetus develops, its limbs become bigger, the bones become stronger, and there is more bulk and body to the tissue. The fetus, in other words, is less friable, meaningless able to be broken up or fractured.

Q. Doctor, you testified that in 1998 you had the competence to perform D&Es up to 14 or 15 weeks.
A. Yes.
Q. But you also testified that you had recently performed a D&E at 18 weeks.
A. That is correct.
Q. Why did you feel it was okay for you to do that procedure?
A. There is not much difference between the 16 and an 18 week, technically.
I had done 18 weeks before. The occurrence recently is 15 or 16. So preceding the deposition in 1998 that was in reality what I had done. It did not preclude my doing it up to 18 weeks where I felt comfortable.
Q. Thank you.
THE COURT: Do you tell the patient that before you did it, that you hadn't done one?
THE WITNESS: No, sir, I didn't.
MS. PARKER: I have no further questions.
THE COURT: Any recross?
(Continued on next page)

MR. LANE: Three brief questions, your Honor.

RECROSS-EXAMINATION

BY MR. LANE:

Q. Dr. Weiss, you would agree that D&E has been studied and articles have been published about it in peer-reviewed journals, correct?

A. There have been articles published, yes.

Q. You would agree that the labor induction abortion method has been studied and there are articles about it in peer-reviewed journals, correct?

A. There are articles, yes.

Q. You would also agree that D&E by dismemberment is a very safe procedure?

A. That's correct.

MR. LANE: No further questions, your Honor.

THE COURT: You may step down, Doctor.

(Witness excused)

We will take our afternoon recess at this time.

(Recess)

THE COURT: Mr. Hut, call your next witness.

MR. HUT: Your Honor, we will now proceed with reading depositions. This will be the deposition of Maureen Paul.

Before we commence, your Honor, let me raise one or two scheduling or housekeeping matters. With respect to the reading of the depositions consistent with the Court's rulings

on Dr. Paul and Dr. Creinin, as communicated to chambers, we are willing to submit the identified designations on paper. I gather that the Court wishes them to be read, and we are happy to do the reading.

THE COURT: That's correct.

MR. HUT: In that event, it may be that we will not get to Dr. Creinin this afternoon. We are going to begin with Dr. Paul. In that event, I would hope that we could, I take it the Court has no problem, commence first thing with Dr. Chasen in the morning.

THE COURT: I don't care about the order. It makes no difference to me.

MR. HUT: Finally, I don't know what, frankly, the length of either the direct or cross-examination of Dr. Chasen will take, and I know this is on the eve of a holiday, so I recognize that this may be impractical or impossible. I wonder whether there is any possibility of going a little longer, if necessary, tomorrow.

THE COURT: To finish your case? Yes, I will consider that. In order to wrap up your case, sure. Let's see how it goes.

MR. HUT: Thank you, your Honor.

THE COURT: I would be happy to consider doing whatever is necessary. As I understand it, we have Dr. Chasen and perhaps another transcript. Is that what is possible for

tomorrow?

MR. HUT: That is correct, your Honor. Another transcript being the transcript of Dr. Creinin if we don't get there this afternoon.

THE COURT: Yes. That's what I thought you meant. If we don't get in it today, we could go a little later tomorrow, if necessary, in hopes of wrapping up plaintiffs' side of the case. That would be fine.

MR. HUT: Thank you. Finally, with respect to Dr. Carhart, we made a further inquiry of his counsel over lunch, and he will not be able to appear here we were advised.

THE COURT: The invitation was there. So be it. That is his choice.

MR. HUT: This is the deposition of Maureen Paul, MD, MPH, taken by the government through Mark Quinhoven, a lawyer with the Department of Justice, on Monday, March 1, 2004, in San Francisco. Reading from page 13/line 4.

"Q. Can you recall what specific literature" --

THE COURT: Who is going to be answering?

MR. HUT: Excuse me, your Honor. This will be Mimi Liu, one of our colleagues.

THE COURT: All right. I just wanted to know who was going to be doing the answers. Go right ahead.

MR. HUT: "Q. Can you recall what specific literature you may have reviewed for today's deposition?

A. Literature concerning the safety of abortion, some literature involving cervical incompetence. I believe that's it.

"Q. With respect to the literature about the safety of abortion, can you -- do you recall which specific studies you may have reviewed?

"A. I reviewed studies by the CDC looking at the mortality of abortion, and I looked at studies from the 1970s, also conducted by the Centers for Disease Control, CDC, about abortion complication rates. That's what I recall.

"Q. Did you review any of the expert reports submitted by the government in this case?

"A. Yes, the seven that I referred to.

"Q. Let's mark this as Plaintiffs' Trial Exhibit 115. Dr. Paul, I'm showing you what's been marked as Plaintiffs' Trial Exhibit 115. Are you familiar with this document?

"A. Yes, I am.

"Q. Is that the expert report that you submitted in this case?

"A. Yes, it is.

Q. A copy of your curriculum vitae is attached to the expert report?

A. That's right.

"Q. And mark this as Paul -- excuse me -- Plaintiffs' Trial Exhibit 116. Now, if you could turn to Plaintiffs' Trial Exhibit 116, are you familiar with that document?

447rnat5 "Paul

"A. Yes, I am.
"Q. And is that the rebuttal expert report that you submitted in this case?
"A. No, it's not.
"Q. Can you tell me what it is?
"A. It says Ph.D at the top, and mine said MPH.
Q. Ah. Can you turn to the third page of this document. Is that your signature?
"A. Yes, it is ".
Reading at page 17/line 24.
"Q. With the exception of the change of MPH to Ph.D, is that the text of the document which you recall signing?
"A. Yes, it is.
"Q. Does your declaration and your expert report and your rebuttal expert report constitute the testimony which you intend to give at trial in this case?
"A. Yes, it does."
Reading from page 20/line 5.
"Q. While you were at the University of Washington, did you receive training in abortion methods?
"A. Yes.
"Q. If you recall, can you tell me which specific methods you received instruction in.
"A. We did some D&E abortions, vacuum aspiration abortions. And I don't recall if we did any instillation procedures. We

447rnat5 "Paul

did do other methods of induction abortion.
"Q. Was this in class or in clinical training?
"A. In clinical training.
"Q. Did you perform any abortions or participate in the performance of any abortions while you were at the University of Washington?
"A. I don't recall. I believe I did under the supervision of the faculty."
Reading from page 21/line 22.
"Q. While you were a resident at Tufts during that period, did you receive any training in abortion methods?
"A. Yes.
"Q. Do you remember if it was in class or in clinical training?
"A. Clinical training.
"Q. Do you recall the specific methods of abortion?
"A. Vacuum aspiration abortions, D&E abortions, and induction abortions.
"Q. And did you also while you were at Tufts participate in or perform any abortions?
"A. Yes, under the supervision of the faculty.
"Q. And if you recall, do you recall what types or what methods of abortion you used?
"A. Vacuum aspiration abortion, D&E abortion, and induction abortion.
"Q. Were these abortions for both first and second trimester

abortions?
"A. Yes.
"Q. And did you use a specific method for first trimester abortions as opposed to second trimester abortions?
"A. Vacuum aspiration for first trimester abortions, D&E or induction for second trimester abortions."
At page 23/line 16.
"Q. Did you teach abortion methods while you were an assistant professor at Tufts?
"A. Yes.
"Q. I apologize if I'm asking you to repeat yourself, but, again, do you remember which specific methods you taught?
"A. Vacuum aspiration abortion, D&E abortion, and induction abortion.
"Q. And was this in class or clinical training?
"A. Clinical training.
"Q. And you mentioned you also had a practice. Was that practice with the Tufts New England Medical Center?
A. It was situated at Tufts New England Medical Center, yes.
"Q. And in the course of that practice, did you perform any abortions?
"A. Yes, I did.
"Q. If you recall, what methods of abortion did you use?
A. Vacuum aspiration abortion, D&E abortion, and induction abortion."

Reading from page 31/line 11.
"Q. And then from 1993 to 2002, were you an associate professor at the same institution?
"A. That's correct."
On page 32/line 5.
"Q. During this time did you teach students, either in class or in a clinical setting, about abortion methods and techniques?
"A. Yes, I did.
"Q. And the same question: Do you recall which techniques or methods you taught?
"A. For medical students, I taught about different methods of abortion didactically.
"Q. What do you mean "didactically"?
"A. Through lectures.
"Q. What were those procedures?
"A. I taught about vacuum aspiration, D&E abortion. I don't recall if I talked about induction abortion.
"Q. And were your teaching responsibilities any different with respect to the residents?
"A. Yes. It involved clinical hands-on experience and supervision.
"Q. And what abortion methods were you -- did you teach the residents while at the university of Massachusetts?
"A. Vacuum aspiration abortion and induction abortion."
Reading from page 35/line 18.

447rnat5 "Paul

"Q. Am I correct that while you were on the faculty at the University of Massachusetts, you also served as the medical director of preterm health services in Brookline, Massachusetts?
"A. Yes."
Page 36/line 5.
"Q. And did the preterm health services -- let me ask you first, was that a clinic?
"A. Yes, it was.
Q. And did that clinic perform or provide abortion services?
"A. Yes.
"Q. And did it provide abortion services for first and second trimester abortions?
"A. Yes."
Reading from page 41/line 7.
"Q. And finally, coming to your current position as chief medical officer for Planned Parenthood Golden Gate, when did you take that position?
"A. In July of 2002.
"Q. And briefly describe your responsibilities in that position.
"A. Pretty much the same: To oversee the quality of the medical services, to develop protocols that were in accordance with Planned Parenthood Federation of America's standards and guidelines, to approve physicians who want to work there, to

447rnat5 "Paul

supervise mid-level clinicians who are carrying out gynecologic services, to provide clinical services, and to monitor the quality of care in various ways.
"Q. And I take it Planned Parenthood Golden Gate provides abortion services?
"A. That's right."
From page 42/line 24.
"Q. And do you teach abortion methods to the residents at UC San Francisco?
"A. I don't teach the residents at UCSF. I teach residents from various residency programs throughout northern California. So I do the teaching at Planned Parenthood Golden Gate clinics.
"Q. You instruct residents in abortion methods at Planned Parenthood Golden Gate?
"A. Yes."
At page 49/line 13.
"Q. Can you tell me what fields you are board certified in?
"A. I'm board certified in obstetrics and gynecology and occupational and environmental medicine."
Reading from page 55/line 3.
"Q. How about dilation and evacuation procedure; can you estimate how many of those you performed over your career?
"A. Estimate: 2,000.
"Q. Have all those been in the second trimester?
"A. Yes."

Reading from page 57/line 6.
"Q. Would you describe the D&E procedure that you performed.
"A. There is different variants of D&E.
"Q. Well, let's start with: Is there a common type of D&E or a typical D&E that's ordinarily performed?
"A. There's different variations in which the fetus may be extracted.
"Q. First off, how many possible variations are there?
"A. It's a very hard question to answer, because it's not very specific. There's many things that may vary: The kind of pain medication you give a person, the amount of dilation you achieve, the way that the fetus is extracted, the instruments that you might choose. So I'm not sure how specific you want me to be.
"Q. Can you go through the steps of how you achieve that level of dilation."
This is at page 60/line 5, your Honor.
"A. By inserting laminaria, placing the laminaria snugly in the cervix without forcing, and basically you put as many laminaria in as the cervix will comfortably accommodate. My goal is to achieve had as much dilation as possible."
Page 65/line 19.
"Q. Is it fair to say that disarticulation or dismemberment is the predominant characteristic of a D&E procedure?
"A. No.

"Q. Why not?
"A. Because a D&E can proceed in various ways, and it can proceed so that the fetus is disarticulated or it may proceed in such a way that the fetus is extracted intact.
"Q. In your experience, can you give me a rough estimate of how many D&E procedures proceed by way of disarticulation or dismemberment?
"A. In my practice?
"Q. In your practice. Again, I'm limiting it to Planned Parenthood Golden Gate.
"A. Approximately 9 out of 10."
We are on page 72/line 14.
"Q. Dr. Paul, I'm showing you what's been marked as Paul Exhibit 6, the first page of which is a copy of the cover of A Clinician's Guide to Medical and Surgical Abortion, and then the following pages are pages 123 to 138, which consist of chapter 10. Are you familiar with the cover page and the following pages of Paul Exhibit 6?
"A. Yes."
Page 73/line 1.
"Q. Let me ask you just a few questions about this textbook. How did you come to be involved in editing this textbook?
"A. When I was on the board of the National Abortion Federation, I served on the medical education committee, and we decided that it was time for a new textbook on abortion. There

hadn't been a textbook on abortion written for 16 years, a comprehensive textbook, and so we decided, as a committee, that we would proceed with trying to get one written and published. And I volunteered to be the editor in chief.
"Q. Dr. Paul," this is on page 75/line 14, "turning your attention to page 136 of Paul Exhibit 6, is there a section entitled 'Intact Dilation and Evacuation'? Is that correct?
"A. That's right.
"Q. And does the following text accurately describe an intact dilation and evacuation procedure?
"A. I would say it describes some scenarios, yes. There's a lot of information in here, so I find the question a little bit general. But it does describe some of the ways that intact dilation and evacuation is achieved.
"Q. Have you also heard the term 'dilation and extraction" or "D&X" for this procedure?
"A. Yes, I have.
"Q. Have you ever heard the term 'partial-birth abortion' used for this procedure?
"A. I don't recognize that as a medical term, but I have heard the term."
On page 77/line 11.
"Q. In your view, is an intact D&E only used in cases of advanced compromised pregnancies?
"A. No.

"Q. What would be some of the other circumstances in which a physician might use an intact D&E?
"A. I perform an intact D&E whenever I can, whenever cervical dilation is sufficient for me to extract the fetus intact, because I believe it's safer than a D&E which requires several instrument passes.
"Q. Let me follow up with some questions on that. You have performed some intact D&E procedures?
"A. Yes, I have.
"Q. Can you give me an idea of how many you performed over the duration of your career.
"A. 1 in 10 to 1 in 20 D&E procedures that I do are intact D&E's. So if I've done 2,000 D&E's, a couple hundred."
Reading from page 78/line 22.
"Q. In the case of a dismemberment or disarticulation D&E, is dilation ever accomplished using multiple serial osmotic dilators over two days or more?
"A. Ever? Sure.
"Q. Could you just give me some examples of when that would occur."
Reading from page 91/line 10.
"Q. Can you go through the process of the intact D&E's that you say you've performed.
"A. Describe generally?
"Q. Describe generally.

447rnat5 "Paul

"A. How I do them?
"Q. Yeah, exactly.
"A. I insert the speculum. I don't know until I'm presented with the cervix whether in fact I'm going to be able to do an intact procedure. I -- sometimes there will be a fetal foot that will be presenting at the cervical os, which is the opening. Sometimes when I put my forceps in and begin to extract the fetus, generally the foot or feet, right, I will notice that there's enough dilation to extract the fetus right down to the neck.
"Generally what happens is that the calvarium, the skull, will get lodged in the internal os because there's insufficient dilation for the whole fetus to deliver. So I have to do some kind of maneuver to reduce the size of the skull in order to bring the fetus through intact. Generally, I do that with a forceps, just by nipping at the skull until it collapses. Then I'm able to bring the whole fetus out."
Reading from line 19 on page 92.
"Q. At what point during the procedure did you have an idea that it might become an intact delivery?
"A. Sometimes I can see that the cervix is quite widely dilated and that it's likely. Sometimes it's not until I actually extracted the fetus to the neck."
Reading from page 96/line 8.
"Q. Have you ever performed an intact D&E procedure of a fetus

447rnat5 "Paul

in the vertex position?
"A. Not that I recall. I -- gosh, I think I'm going to take that back. Because I define intact D&E as just the -- the fetus comes out intact. So I would have to say yes.
"Q. Can you tell me when that may have been, if you can recall?
"A. I think throughout my career occasionally, when the fetus would present vertex, I was able to extract the whole fetus intact."
At page 97/line 23.
"Q. You've mention that had in doing a D&E procedure it's preferable to have the fetus delivered as intact as possible. Can you tell me why that is.
"A. I believe it's safer because there's fewer instrument passes and because I know that I've extracted the whole fetus, and so the risk of having retained fetal parts or retained tissue is virtually eliminated.
"Q. Why does the lessening of instrument passes make the procedure safer, in your view?
"A. Because the forceps can perforate the uterus or cause a cervical laceration.
"Q. In performing disarticulation or dismemberment D&E's, have you ever had a situation in which there has been a perforation by the forceps?
"A. Yes.
"Q. How many times?

447rnat5 "Paul

"A. In my entire career, two, I believe.
"Q. And do you recall anything about the circumstances of those cases?
"A. The one I recall most vividly is when we needed to do a hysterotomy because of it.
"Q. Going back to some of your testimony earlier, is it fair to say, when you begin a D&E procedure, you do not know whether the fetus will be delivered intact or not?
"A. That's fair, yes."
At page 99/line 8.
"Q. Is it fair to say that your judgment that it is safer is based on an intuitive assessment?
"A. Yes, and my own experience.
"Q. In your view, are there any risks to performing an intact D&E procedure?
"A. There's risks, albeit small, to any D&E procedure.
"Q. Are there any risks that would be unique to an intact D&E procedure?
"A. No, I don't believe so."
Line 21 of the same page.
"Q. If you accomplish an intact D&E procedure, would that be something that would be listed on the medical chart?
"A. No."
At page 101/line 9.
"Q. I want to go back to what I believe is Paul Exhibit 6,

447rnat5 "Paul

which is chapter 10 of your text. If you could turn to page 125, the second column, the second-to-last paragraph says, 'Grieving is important for the parents of an anomalous fetus, and seeing and holding the fetus are important components of healing.'"
I should emphasize, your Honor, that the quotation in the text begins at the word "grieving." Continuing:
"'Their needs may be better met if intact fetus, intact D&E procedure, although reconstruction in a swaddling blanket after nonintact D&E is possible in some cases.'"
At page 102/line 3.
"Do you agree with both sentences?
"A. Generally, yes. It's of course different for different patients."
At page 105/line 7.
"Q. If I could turn your attention to Paul Exhibit 2, which is the declaration that you've submitted in this case, and I'll direct your attention to page 5, paragraph 13. The first sentence of that paragraph reads, 'Central to safe medical practice in the context of abortion ('or any other medical matter') is the ability of the physician to exercise appropriate medical judgment in planning a medical procedure and responding to unplanned events in the course of the procedure.' Can you tell me what you mean by 'appropriate medical judgment.'

447rnat5 "Paul

"A. Yes. I just mean that you cannot predict in many areas of medicine exactly what you'll be faced with when caring for a patient. It's important that you're able to exercise your medical judgment to carry out the procedure in the safest way possible."

On page 106/line 1.

"Q. When a physician exercises his or her judgment, what kinds of factors do they consider?

"A. You may consider patient preference. Certainly you would consider safety. You may consider what's the most expeditious way of accomplishing something. Those would be the main things.

"Q. And one of the factors you mentioned was safety. How does a physician determine whether a particular procedure is safe?

"A. I think from a combination of knowledge that's gathered from the medical literature and clinical experience.

"Q. And is it typical that in gaining that information through clinical experience, that information ultimately will be subject to some kind of study or review?

"A. I would not say that that's typical. I think there's many, many things that are done in medicine that are not subject to study.

"Q. Within the field of abortion outside the context of intact D&E, can you give me some examples of procedures that are not studied?

447rnat5 "Paul

"A. There's many variations that can occur, even in the course of an abortion, that have not been studied, particularly, for instance, comparison of different pain medicines that could be given ahead of time, the use of one type of forcep versus another, so choice of instruments, any kind of really refinement in degrees of dilation. I mean, there are several examples of, you know, just minor variants and techniques that are not subject to study.

Page 109/line 2.

"Q. I'm turning your attention to the second sentence. I will read that. It says, 'The Act thus denies physicians the necessary discretion to provide medical care with the safety and health of their patients as their foremost concern.' In your experience, was there ever a situation in which an intact D&E was necessary to preserve the life or health of the mother?

"A. I think in terms of preserving health, it's really synonymous to say that you're using the safest method possible. And so, yes, in my experience, when I perform an intact D&E, I do think that it is preserving the health of the mother, because I believe it to be the safest way to proceed at that time.

"Q. And is it also fair to say, though, based on your earlier testimony, that you do not know, when you begin a D&E procedure, whether it will result in an intact D&E?

"A. That's right."

447rnat5 "Paul

At page 111/line 6.

"Q. Turning to paragraph 21, the last sentence reads, 'In my experience, a disproportionate number of women who have abortions in the second trimester do so because of maternal health reasons or fetal anomalies or are pregnant as a result of rape or incest.' Do you have a rough estimate -- when you say 'a disproportionate number,' are you talking about 50 percent or 75 percent or are you able to quantify it in any way?

"A. What I mean by this sentence is that compared to first trimester abortions --

"Q. I understand.

"A. -- a disproportionate number of women having second trimester abortions will do so because of those reasons.

"Q. If you could turn your attention to page 9, paragraph 26, which discusses the lack of health exception of the Partial-Birth Abortion Ban Act, mid-way through that paragraph the sentence reads, 'There are other instances as well where continued pregnancy might seriously compromise a woman's health, perhaps permanently, but where her life might not be immediately at risk.' Can you give me some of those or examples of those instances where continued pregnancy might compromise a woman's health but not put her life immediately at risk?

"A. Infection.

447rnat5 "Paul

"Q. What kind of --

"A. Cardiac.

"Q. I'm sorry?

"A. Some cardiac conditions. Diabetes I already mentioned in there.

"Q. What kind of -- any specific kind of infection?

"A. Pelvic infection.

"Q. And with respect to the cardiac conditions, is there any specific cardiac condition you are referring to?

"A. Valvular heart disease. There are a number of cardiac conditions that can be taxed by pregnancy."

At page 114/line 22.

"Q. At the bottom of the page, section 1531 subsection (a), the sentence reads, 'This subsection does not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical conditioning caused by or arising from pregnancy itself.' Is that the subsection of the law that you were referring to in paragraph 27?

"A. Yes.

"Q. And in the first sentence you say that under a possible reading of the law the exception would never apply. And my question is that by modifying the word 'reading' with the word 'possible,' does that mean that there are other possible

447rnat5 "Paul

readings or interpretations of the law?
"A. What it means is that the law is ambiguously written, in my opinion, and especially the word 'necessary.' Who deems what's necessary? The point I'm making in this paragraph is as long as there are other procedures available, like even hysterotomy, then one might argue that it's never necessary to do the procedure as described in the law. But it's not acceptable to me. What I go on to say is that hysterotomy is never an acceptable alternative because it's not nearly as safe as other methods.
"Q. Is it possible that there may be a different reading of the law that would allow the decision whether to perform this procedure to save the life of a mother, that that decision can be based on the physician's own judgment?
"A. You're going to have to repeat that.
"Q. Let me repeat it. Is it possible that another possible reading of the law is that the determination of whether this, an intact D&E, can be used to save the life of the mother is left to the discretion of the physician?
"A. It definitely does not say anything about the discretion of the physician in the law. I would say that's one of the problems I have with it."
Reading at page 120/line 7.
"Q. Let me ask you, in your practice, now I'm talking both at Planned Parenthood Golden Gate and during your career, are you

447rnat5 "Paul

aware of situations in which an intact D&E was necessary to preserve the health of the mother?
"A. In the sense that the health of the mother is linked to the safety of the procedure, I have performed intact D&E's because I felt it was the safest way to proceed and, therefore, that affected the health of the mother.
"Q. Is there any specific maternal condition for which you think an intact D&E is safer than a dismemberment D&E or an induction procedure?
"A. There are conditions that I could -- that I would think would apply even if I haven't done them particularly in my practice.
"Q. And what would those be?
"A. One is pelvic infection.
"Q. When we spoke earlier, I think you had said pelvic infection, cardiac conditions, diabetes. Those are the conditions you're talking about?
"A. Those are examples of some of the conditions I'm talking about where this procedure of an intact D&E may be safer than other alternatives."
At page 124/line 1.
"Q. Turning your attention to paragraph 60 on page 18, it reads, 'When beginning a D&E or induction procedure, the physicians cannot know or predict if it will proceed in a manner that violates the Act.' Dr. Paul, is that consistent

with your experience in performing intact D&E procedures?
"A. Yes."
At page 126/line 21.
"Q. If you can recall, did the Autry study compare labor induction with the more recent methods of induction to dismemberment or disarticulation D&E only, or did it also compare the newer methods of labor induction to intact D&E?
"A. It didn't make the distinction. Because intact D&E is a variant of D&E, it may have included some cases of intact. I don't know. It didn't address that in the article.
"Q. In the last paragraph of your rebuttal expert report, you note that 'In addition to painful labor contractions, many women experience nausea, vomiting, diarrhea, and fever from the vaginal prostaglandins used for the induction.' Is nausea or vomiting or diarrhea, is that a complication of induction or would that be a side effect of induction?
"A. It's a side effect.
"Q. And can you explain the difference between a complication and a side effect for me.
"A. Some of it is probably just historical in how things got categorized. But nausea, vomiting, diarrhea are adverse effects from the medication. They're not complications that result from the procedure itself. There's usually standard complications that are looked at in regard to abortion, things like hemorrhage, infection. This is clearly different. These

are side effects of the agent used to induce.
"Q. And are those side effects common to the use of prostaglandins in labor induction?
"A. Yes."
Reading from page 133/line 1.
"Q. Is an amniocentesis a difficult procedure to perform?
"A. It can be."
At page 137/line 10.
"Q. I'm sorry. I misspoke. It's Paul Exhibit 3. If I could turn your attention to page 4, paragraph 19. The first sentence reads, 'The absence of controlled studies involving D&E's in which the fetus is removed intact or largely intact does not cast doubt on the safety of such abortions.' Do you agree with that statement categorically?
"A. Categorically. I generally agree with that statement, that's right.
"Q. When you say generally agree with that statement, what do you mean by that?
"A. That there are good studies that show the safety of D&E abortion, and it's my opinion that intact D&E is a variant of D&E abortion in that in fact many of the studies that were probably done in the past included cases of intact. I don't think it's necessarily true that those studies had to have mentioned intact as a separate entity, because I regard it, and I think many physicians regard it, as just a variant. So I do,

I do believe that there probably has been more research than is credited on the technique.
"And I think in the -- if you look at evidence-based medicine, that one of the tenets of evidence-based medicine is that if there are no studies, no evidence that actually proves that a specific procedure is superior to another procedure, then it's at the discretion of the physician to use whatever option he or she believes is safest and best to use in those circumstances. And in my experience, intact D&E is safer.
"Q. Does the absence of controlled studies involving intact D&E give you any pause whatsoever?
"A. Not in my clinical practice, no."
Your Honor, that concludes the reading of the plaintiffs' designated portions of the Dr. Paul deposition. I would like at this time to move the admission into evidence of Plaintiffs' Trial Exhibit 116, which is the curriculum vitae for Maureen E. Paul, MD, MPH.
THE COURT: Any objection?
MS. WOLSTEIN: No, your Honor, no objection.
THE COURT: It will be received.
(Plaintiff's Exhibit 116 received in evidence)
MR. HUT: At the break, shortly before the break, your law clerk asked us to identify any objections we had to counterdesignations by the defendant. We have no objections.
THE COURT: All right. If the government wants to go

ahead, read the counterdesignation.
MS. WOLSTEIN: Thank you, your Honor. This is Elizabeth Wolstein. I will be reading the questions that were asked by Mr. Quinhoven, and Ms. Amy Goldman will be reading the answers. She is a paralegal in our office.
THE COURT: Fine. Go right ahead.
MS. WOLSTEIN: Your Honor, I have omitted a couple of counterdesignations that appear on our list. I can either inform Mr. Hut at the outset or just skip them.
THE COURT: You are not compelled to offer anything. I have already ruled on his, he has read it. Go ahead and read what you want.
MS. WOLSTEIN: Starting at page 18/line 8.
"Q. Do you intend to give testimony about any other matters that are not set forth in any of those three documents?
"A. No, I don't."
Page 57/line 25.
"Q. Is there a standard protocol of any form for D&E's at Planned Parenthood Golden Gate?
"A. We have a protocol for second trimester abortions, yes.
"Q. And what is that protocol?
"A. It has various components. Everything ranging from preoperative evaluation and preparation of the patient, to the procedure, to postoperative care."
Page 60/line 19.

447rnat5 "Paul

"Q. Do you ever try to exceed dilation beyond or in excess of, slightly exceeding the diameter of the cannula?
"A. My goal is to get as much dilation as possible with one laminaria insertion generally, and I'm happy if it exceeds the 16-millimeter diameter, because, in my experience, the procedure is easier the greater the dilation you have."
Page 66/line 1011.
"Q. Can you tell me in that tenth case what happens that's different from disarticulation or dismemberment during the D&E procedure.
"A. What's different is that the dilation is adequate to allow extraction of the fetus intact."
Page 66/line 21.
"Q. Dr. Paul, in a D&E procedure in which disarticulation or dismemberment occurs, how does the disarticulation or dismemberment, how does that take place?
"A. It takes place by extracting a fetal part, which generally causes counterpressure at the internal os of the cervix, at which point the piece will disarticulate."
Page 67/line 11.
"Q. Do you change your procedure during different gestational ages? And let me just say during, say, weeks 14 to 16 weeks. Is there a difference between how you would perform a D&E during 14 and 16 weeks and, say, between 16 and 18 weeks?
"A. The terminology of D&E gets a little confusing, because

447rnat5 "Paul

some people refer to a D&E for any second trimester procedure in which the fetus is extracted. And I tend to use vacuum aspiration without forceps at gestational ages of 14 and 15 weeks. Sometimes I have to use forceps, but I'm more likely to be able to accomplish the abortion without the use of forceps. At 16 weeks and up I must invariably use forceps."
Page 68/line 1.
"Q. And is there any difference between how you use the forceps at, say, 16 weeks' gestational age versus 18 weeks' gestational age?
"A. It's not really dependent on gestation. I may use a different instrument. I may use the -- as I said earlier, I may be more likely to use a Bierer forceps in the later gestations over the earlier gestations over a Sopher forcep in the earlier gestations."
Page 69/line 5.
"Q. And in using laminaria, how many sticks would you commonly use or is it fairly dependent on the circumstances of each woman's case?
"A. I like to use the most number of laminaria that the cervix will accommodate with a snug fit.
"Q. Is there any typical amount of laminaria that you use?
"A. I have minimum criteria that I like to use. I generally use -- large is my reference point. Large laminaria is my reference point. So at 17 weeks and up I like to have at least

447rnat5 "Paul

3, and at 18 weeks I like to have at least 4 laminaria inserted. For early gestations, like 15, 16 weeks, two large laminaria might suffice. But that's a minimum criteria I want to emphasize. My practice is to insert as many as will comfortably go into the cervix."

Page 69/line 24.

"Q. What's the most number that you've ever used, say, at 17 weeks gestational age, if you can recall?

"A. I don't recall exactly. I believe 7 or 8.

"Q. Same question at 18 weeks' gestational age: Would it also be 7 or 8?

"A. 7 or 8.

"Q. How long does dilation usually take when you're doing a dismemberment or disarticulation D&E procedure?

"A. It depends on the gestational age and the dilating agents used.

"Q. Let's start with using laminaria.

"A. Laminaria. You receive optimal dilation at greater than the 6 hours, so we generally use laminaria for overnight dilation."

Page 74/line 12.

"Q. And how did you go about selecting contributors for the various chapters?

"A. Brainstorming with the committee, brainstorming with each other, being aware of the medical literature and who had

447rnat5 "Paul

written it, who were recognized experts. We also wanted to involve as many NAF members as possible, because it was a NAF textbook."

Page 76/line 14.

"Q. Is 'intact D&E' or 'D&X' a medical term?

"A. I have seen it in medical writings and textbooks.

"Q. In your mind, is there any differentiation between an intact D&E and a D&X procedure?

"A. I use them synonymously."

Page 81/line 22.

"Q. And turning to the next paragraph, it talks about a presentation by Dr. McMahon of a 13-year personal series of 1,362 intact D&E cases. Have you personally reviewed any of Dr. McMahon's data?

"A. I've read the presentation and heard the presentation that he gave at NAF.

"Q. To your knowledge, was that presentation ever subjected to peer review?

"A. No.

"Q. Was it ever presented as part of a prospective randomized study?

"A. I'm not sure I understand that question.

"Q. Was the data that he reported part of a prospective randomized study?

"A. No.

447rnat5 "Paul

"Q. Was it a retrospective case or cohort study?
"A. It was a case series.
"Q. And describe -- explain to me the difference between case series and a cohort study.
"A. There was no comparison group."
Page 83/line 2. This is a rereading of the record.
"Q. Are you aware of any prospective randomized trials that compare the safety of the procedure utilized and described here that was utilized by Dr. McMahon as compared to a disarticulation or dismemberment D&E?
"A. No, I'm not."
Page 84/line 19.
"Q. I'm looking at the next paragraph and the carryover sentence from page 136 to 137 that says, 'Dilation was sufficient to enable most complex presentations to be converted digitally or with conversion forceps to vertex or breech presentation. In your experience performing disarticulation or dismemberment D&E's, have you ever achieved the level of dilation that's described in that sentence?
"A. Well, I don't convert the fetus, so I'm not sure exactly what you -- what you mean by -- you know, in my practice what the level of dilation would be."
Page 87/line 2.
"Q. Are you familiar with the data that Dr. Haskell is reporting? Have you personally reviewed the data?

447rnat5 "Paul

"A. No."
Page 91/line 1.
"Q. In your experience, is there a particular week of gestational age at which the fetal tissue becomes more difficult to break apart when doing a disarticulation or dismemberment D&E?
"A. In my experience, it's more difficult at 18 weeks than it is at 16 weeks. In general, I think it's harder as the gestation advances."
Page 92/line 25.
"Q. And when you talked about when the head gets, I guess, I don't know if the word is 'stuck,' but when the head is stuck in the cervical os, do you ever use additional dilation to try to remove the head?
"A. No.
"Q. Is there any reason why?
"A. Well, you really can't use additional dilation once you have the fetus in the cervical canal.
Q. Are you aware of any other physicians who use additional dilation when a head gets stuck in the cervical canal?
"A. At that time, no.
"Q. In your view, does the intact D&E procedure ordinarily involve a breech presentation?
"A. In my practice, I do the intacts with breech presentations."

447rnat5 "Paul

Page 95/line 6.
"Q. Doctor Paul, we were talking before about the intact D&E procedure as performed by Dr. McMahon and the procedure performed by Dr. Haskell and the procedure defined by ACOG. And I think you said that you had never performed any one of those procedures. Is that right?
"A. I think I said I'd like to talk about -- if I'm going to talk about specific procedures, I'd like to have the descriptions in front of me.
"Q. OK.
"A. But I did say that in terms of the description that was in the textbook, that I had not performed that specific procedure.
"Q. OK. Thank you. Do you know anyone at Planned Parenthood Golden Gate who has performed the procedure as described in chapter 10 of the textbook?
A. No.
"Q. How about when you were at the University of Massachusetts; were you familiar with anyone who performed the procedure as described in the textbook?
"A. No.
"Q. And when you were at the University of Massachusetts, did you ever perform the procedure as described in the textbook?
"A. Specific procedure described in the textbook, no."
Page 97/line 7.
"Q. Let me withdraw that and let me ask you, which techniques

447rnat5 "Paul

or procedures do you use to cause fetal demise in a vertex presentation?
"A. Collapsing the skull.
"Q. Is that with the forceps?
"A. Yes."
Page 99/line 1.
"Q. In terms of lessening the number of instrument passes in a D&E procedure, are you aware of any peer-reviewed studies that have discussed whether an intact D&E is safer than a dismemberment or disarticulation D&E?
"A. There are no comparison studies that I'm aware of, no."
Page 100/line 3.
"Q. Do you list on medical charts the type of dilation that you use in either an intact D&E or a dismemberment D&E?
"A. Yes.
"Q. Did the medical charts reveal how much dilation was achieved prior to the beginning of the procedure?
"A. No."
Page 102/line 6.
"Q. Can you tell me what your experience has been in terms of the need of a woman or a parent or parents to hold the fetus after an abortion procedure?
"A. After an abortion procedure for an anomalous fetus, which -- I would say this. First of all, most of the abortions that I have done for anomalous fetuses have been induction

abortions, because they occurred at the university. They were hospital-based. And we don't do a lot for anomalous fetuses at Planned Parenthood Golden Gate in the out-patient setting.
"I distinctly remember at the university that we would encourage -- the social workers would actually encourage the parents of wanted pregnancies who had fetuses with serious malformations that, where they chose termination, to hold the fetus afterwards. So I have very vivid memories of the fetus being swaddled and presented to the parents as a component of their healing.
"Q. And were those, to your recollection, all after induction procedures or were there some D&E procedures as well?
"A. At the University of Massachusetts we didn't do D&E procedures.
"Q. So they were all induction procedures?
"A. Yes."
Page 103/line 14.
"Q. The next sentence reads, "Traditionally, labor induction abortion has offered the advantage of intact fetal salvage for documentation of suspected genetic and structural abnormalities.' Do you agree with that sentence?
"A. Yes. That's an advantage of induction."
Page 108/line 21.
"Q. Are you opposed in principle to legislative bodies regulating which medical procedures a physician can or cannot

use?
"A. In general, I feel that it's not the place of legislative bodies to regulate the practice of medicine in terms of to that degree."
Page 113/line 13. I'm sorry. I just noticed a mistake in our designations. It should be 113/line 13 through 18 rather than 13 through 16.
MR. HUT: We have no objection to that, your Honor.
MS. WOLSTEIN: I apologize for that.
THE COURT: There being no objection, go right ahead.
MS. WOLSTEIN: Page 113/line 13.
"Q. Are you aware of any studies comparing intact D&E with either dismemberment or disarticulation D&E?
"A. No.
"Q. Or induction in terms of safety?
"A. No."
Page 121/line 7.
"Q. And I know I may have asked you this before, and if I have I apologize. Have you ever had experience with a woman facing one of those conditions in which you used an intact D&E?
"A. No."
Page 130/line 19.
"Q. To your knowledge, have injections of digoxin to ensure fetal demise been proven to be safe for the mother?
"A. There are articles that testified to its -- to the safety.

There's also -- I know I was speaking to Dr. Drey, and she told me that there is a case of a serious maternal complication from digoxin. I can't remember. It was recent, and I can't remember exactly the nature of the case, but --
"Q. Let me --
"A. So anecdotal cases of complications. But generally in the series that I've read about, it's generally safe."
Page 132/line 5.
"Q. Is an injection of potassium chloride similar to an amniocentesis?
"A. An intraamniotic injection, yes, is similar to an amniocentesis, yes."
Page 139/line 16.
"Q. If there is an existing alternative procedure available, is there a greater requirement that the variant of that procedure be subjected at some time to a controlled study to determine whether it is safe?
"A. I think it's optimal to have comparison studies, but I don't believe that it's unethical to use procedures before those controlled studies are done."
Page 140/line 15.
"Q. You also testified that optimally a new procedure would be subjected to controlled studies, is that correct?
"A. Ideally, yes. I would never argue against evidence-based practice.

"Q. Let me ask you a couple of quick questions. Is the concept of evidence-based medicine controversial in the medical field?
"A. I don't believe so.
"Q. Has it come to be accepted over the period of the last, say, 10, 15, 20 years?
"A. I think it's accepted, increasingly accepted, yes.
"Q. To your knowledge, in the field of surgical procedures, has the evidence-based medicine approach increasingly become adopted as well?
"A. I think in all specialties and areas of medicine it's increasingly adopted."
Your Honor, we have no further designations.
THE COURT: Fine. Mr. Hut, do you want to start reading the transcript of the other doctor?
MR. HUT: I think it probably makes sense to, your Honor, given the possible constraints on time. That will be handled by Ms. Chaiten.
(Continued on next page)

4475nat6

THE COURT: We have already had rulings on the government's objections, correct?

MS. CHAITEN: We have had rulings on the government's objections but --

THE COURT: But not as to the counter-designation, correct?

MS. CHAITEN: Yes. And, your Honor, this afternoon, sitting in the courtroom, I wrote out the couple of objections we have to the counter-designations and can provide them to the Court and to the government at this time and we can deal with them, I guess, as they come up if the Court wishes or perhaps --

THE COURT: I don't know if we will get to that.

MS. CHAITEN: We may not get to them today, so.

THE COURT: Let's see how far we get and then we will worry about that problem.

MS. CHAITEN: I think since they're handwritten I am going to give both copies to the government and compare them to make sure they don't have any problems with my submitting to the Court.

Is that okay, your Honor?

THE COURT: Sure, sure. Why don't we get on with what we have and we will worry about how far -- how many are there?

MS. CHAITEN: Only a couple. There is a couple completeness objections, that's all.

4475nat6

I also would ask that I be permitted to provide a copy of the transcript, or the pages of the transcript that have been designated, to the Court's law clerk.

THE COURT: Sure.

MS. CHAITEN: And the two other little points.

Actually, there some pages of the transcript that have been designated confidential. It appears that those pages are designated as confidential because the document that was in front of the witness is a confidential document. So, unless there is any objection and with the Court's permission, what I will do is simply read those portions that are designations and refer to the document as "exhibit" and that way, hopefully, avoid any concerns about confidentiality.

MS. WOLSTEIN: That's fine, your Honor.

THE COURT: No objection from the government. All right.

MS. CHAITEN: The final little housekeeping point is we actually designated a couple of rebuttal designations. And in light of the counter-designations of the government we do want to submit them.

So I will, for efficiency's sake as long as it is okay with the Court and there is no objection, I will simply read them when I read our initial decision anyways.

THE COURT: Unless there is objection from the government I have no way of knowing, but if there is no

4475nat6

objection from the government -- but are they going to have time to look at your rebuttal?

MS. WOLSTEIN: I'm not sure we have seen them.

MS. CHAITEN: They're in the pretrial order. They were done with the initial designations. They're the last two on the list and they say rebuttal.

MS. WOLSTEIN: Okay, fine.

THE COURT: No problem then?

MS. WOLSTEIN: That's fine, your Honor.

THE COURT: Okay.

MS. CHAITEN: So I will be reading for Ms. Kaya Clark, who is a government lawyer; and my colleague, Ms. Liu, will be reading for the witness.

THE COURT: Very well.

MS. CHAITEN: Beginning on page 6, line 5:

"Q For the record, Dr. Creinin, please state your full name.

"A Mitchell D. Creinin. C-R-E-I-N-I-N."

MS. CHAITEN: This deposition is actually the deposition of Mitchell D. Creinin and it occurred on February 27th, 2004. I am not quickly finding where it happened on the transcript. Perhaps we can provide that later.

Again, page 6, line 5:

"Q For the record, Dr. Creinin, please state your full name.

4475nat6 "Creinin -

"A Mitchell D. Creinin. C-R-E-I-N-I-N".

MS. CHAITEN: Page 27, line 21:

"Q Dr. Creinin, are you a board certified OB/GYN?

"A Yes.

"Q Currently?

"A Yes.

"Q Are you board certified in maternal fetal medicine?

"A No.

"Q Do have you any specialities?

"A Yes.

"Q Do you have any board certified specialties?

"A No.

"Q When you said yes, that you have specialities, what were you referring to?

"A A speciality is within obstetrics and gynecology, that I am a specialist in family planning contraception."

MS. CHAITEN: Turning to page 33, line 16:

"Q I will talk to you about the number of abortions you have performed. How many abortions, approximately, do you perform on an annual basis?

"A I would ask for clarification.

"Q Any abortion.

"A Any abortion. 500. It will vary from year to year. Roughly start with 500. It could be 400, it could be

800, depending on the year.
"Q In the last year, roughly how many abortions did you provide?
"A Roughly 500. I would stress roughly."
MS. CHAITEN: Then proceeding to line 11:
"Q How many abortions, roughly in the last year, did you perform in the first 14 weeks' gestation age?
"A 400. 350 to 400, purely a guess.
"Q I guess would that leave roughly 100 to 150 in the last year that you have done 15 weeks and beyond?
"A Correct.
"Q In the last year, approximately how many D&E abortions have you done in the 18 to 24 week time frame?
"A About a hundred.
"Q Would you estimate that between 15 and 18 weeks you did about 50?
"A Correct.
"Q In the last year, approximately how many D&E abortions did you do between 18 and 20 weeks?
"A 40 to 50.
"Q Roughly how many between 20 to 22 weeks?
"A Very roughly 30 to 35.
"Q In the last year roughly how many between 20 to 24 weeks?
"A You can do the math. If you want to hand me the

numbers I would be happy to look at them and add them for you. You are getting to the point where I am losing track of the numbers in my head.
"Q I will understand if these don't add up.
"A Whatever is left over is my answer.
"Q You said between 18 to 24 you had roughly 100, is that correct? So, 40 to 50 between 18 to 20 weeks, is that about 45 right there? And then 30 to 35 for the next -- we will just say 35. So we are at 80, so approximately 20 -- between 20 to 24, does that sound right?
"A Between 22 and 24?
"Q Yes, in the last year.
"A It may be slightly higher, 20 to 30 but, again, this is all a lot of guessing and estimating."
MS. CHAITEN: Proceeding now to page 58, line 22.
And, your Honor, this is the portion that has been designated as confidential and again, I will simply replace any reference to the actual exhibit with the word "exhibit."
"Q On the exhibit that I gave you, if you turn to the bottom, PPFA 490 this is, for the record, Exhibit 5. If you read down in the paragraph that begins 'Midtrimester abortion is more complex than abortion performed earlier in pregnancy.' See that paragraph?
"A On which page?
"Q PPFA 491.

"A Okay.
"Q If you read down it says, 'Midtrimester abortion is more complex than abortion performed earlier in pregnancy.'
"See that paragraph?
"A Yes.
"Q Then the third paragraph in that sentence states, 'However, compared with the other methods available, after 16th week of pregnancy injection of saline or prostaglandins inside the uterus) there is less risk with D&E of bleeding, infection and incomplete abortion.'
"See that?
"A Yes.
"Q Do you think D&E at seven weeks is safer than any other procedure?
"A Yes.
"Q What about compared to labor induction with misoprostol?
"A Can you be more specific with your question?
"Q I guess I'm wondering what your basis is for believing or for your opinion to be that after 16 weeks of pregnancy that D&E is safer than any other procedure including induction labor?
"A You want to know the basis of my opinion? The medical literature.
"Just about, if you look at any paper, if you look at

the bulk of the medical literature that is available that reports on either it is easy to see that D&E is safer than labor induction.
"Q And would that be at any gestational age?
"A Any gestational age."
MS. CHAITEN: Moving to page 115, line 10.
"Q You sort of seem to allude to this; is there some risk if, when the head got stuck, to wait a period of time before collapsing it?
"A Yes. The uterus is bleeding this entire time. You want to completely empty the uterus so it can contract down once it is empty and stop bleeding. It is not bleeding torrentially, but if I waited half an hour the woman would lose a significant amount of blood, or potentially could lose a significant amount of blood.
"Again, these are all hypotheticals.
"Q If the head got stuck, would it be possible to wait for the woman to have a contraction and expel the fetus? Would that be a possibility?
"A No.
"Q Why not?
"A For the same reasons.
"Q I'm not sure, is that because of the waiting or the bleeding? What do you mean when you say for the same reasons?

4475nat6 "Creinin -

"A Both. Same answer I had to the previous one. You are asking things that medically are inappropriate. There is no way to answer. It is so medically incorrect and inappropriate I can't even fathom an answer as a physician."

MS. CHAITEN: Turning to page 117, line 21:

"Q How long, once the head gets stuck there, how long can you wait before there starts to be danger for the woman?

"A I can't answer that question. Any medically appropriate person wouldn't wait. So, there are no studies or no experiences with somebody waiting to see how long it would take for the woman to get in danger. It is medically an unfathomable concept.

"Just like if somebody was in labor and the lower part of the body wouldn't come out in a head-first presentation. You wouldn't say, let's wait and see how long we can go before she starts to hemorrhage. Or, let's wait and see how long we can go before the newborn gets in trouble. Nobody would fathom that.

"You would do your best to get the fetus or newborn out as quickly as possible because you know the longer you wait the more likely complications occur.

"So, there is no reasonable way to answer that question."

MS. CHAITEN: Turning to page 119, line 13:

4475nat6 "Creinin -

"Q In the context of discussing abortion with a woman and in the context of discussing a surgical abortion with a woman, does anything about an intact fetus ever come up in the discussion that you have with her?

"A Yes.

"Q What is that?

"A That if she -- it arises in nonelective cases where I discuss with her for her needs, for her grieving, if she wants to see and hold her baby. Then she can have a labor induction or I can refer her for an intact D&E."

MS. CHAITEN: Turning to page 143, line 3:

"Q In abortions you have performed at 20 weeks, approximately what percentage of those cases was the fetus disarticulated to some extent?

"A Over what time period, of performing the abortions? All? Ever?

"Q Ever.

"A Disarticulated to some percent, 99 plus percent."

MS. CHAITEN: You know what? I read the wrong part starting at 143, line 3. I accidentally read the counter-designations. I apologize.

Line 143, line 21:

"Q Do you regard scissors in a surgical abortion procedure as a potentially more dangerous instrument than a forceps if a mistake is made?

"A Not even close, no. Excuse me. No.
"Q What is the reason for that?
"A You would have to define the way in which they are used, but in my definition when I gave the answer -- do you mean the way the scissors are used for an intact D&E versus forceps to do a D&Es?
"Actually, when you said 'forceps' I was thinking obstetrics forceps, so can you rephrase the question and let me answer and make it clear and I will ask for clarification?
"Q Do you regard scissors as a potentially more dangerous instrument than the forceps, the kind of forceps you would use in a D&E procedure if a mistake is made when performing a surgical abortion?
"A It is vague. What kinds of mistakes?
"Q To the extent you can answer this, do you use scissors as a more dangerous instrument than forceps in performing surgical abortion procedure?
"A Well, the limitation that the scissors are used only when doing an intact D&E to puncture the base of the skull.
"Q Would the scissors be used for anything else?
"A Not that I'm aware of.
"Q So, let's limit scissors to puncturing the head.
"A No. Because it is something that is done under direct vision with the scissors. You can see where it is going

as opposed to forceps, which you put them in the uterus and you have ultrasound guidance most of the time, but it is till a 2-D view of something that is really 3-D so you are using ultrasound to the best of your ability.
"I can't say the forceps are definitely more dangerous but I would definitely not say that the scissors are more dangerous.
"Did I make that last statement clear?
"Q You think forceps aren't necessarily more dangerous than scissors, that is one point.
"A And scissors -- the question is are scissors more dangerous. By my answer I am not implying forceps are more dangerous than scissors but I do not feel that scissors are more dangerous than forceps."
MS. CHAITEN: Page 146, line 10:
"Q Are forceps more dangerous than scissors?
"A I will answer. I can't clearly answer because there is no -- it would just -- it would be my opinion and in my opinion, given the fact that because they are used for different things, you can't really directly compare.
"Because the way forceps are used as part of the procedure, inherently they are used during a more dangerous part of the procedure. So, by definition, their use would be more dangerous but as an instrument they are not necessarily -- neither one is more dangerous, it is what you do with them.

"What you are doing is inherently more dangerous than that process you do with the forceps is more dangerous.
"Q In what way are forceps dangerous in the surgical abortion procedure?
"A During their use, like any surgical instrument, a complication can occur, just like with the use of any medication a complication can occur. So, when the forceps are being used, the uterus can be perforated and the cervix can be torn during those portions of the procedure.
"Q How could the uterus be perforated with the forceps?
"A If the instrument is pushed through the uterus.
"Q And how could the forceps do damage to the cervix?
"A When the -- it is not the forceps itself, it is the process of removing the tissue. It is during the use of the forceps. The cervix can tear while the tissue is being removed. Although that occurs, very rarely it can happen."
MS. CHAITEN: Turning to page 155, line 2:
"Q Is it your view that when you do a D&E procedure in which the fetus is intact, is that procedure safe for the woman?
"A Yes.
"Q And what do you base -- on what do you base that view?

"A Based on my general experience doing D&Es, the medical literature on D&E, the general philosophy behind how to perform D&E procedures and the relative risks between D&E and labor inductions.
"Q Have you seen any studies specifically on a D&E surgical procedure in which the fetus is removed intact?
"A Yes.
"Q What studies would those be?
"A Article by Chasen.
"Q Anything else?
"A You said studies. Can you define what you mean by 'studies'?
"Q Have you read any articles?
"A Articles? Any reports? Any written reports?
"Q Yes.
"A The original work by Jim McMahon and also studies and reports of other types of abortion procedures used by George Tiller in Kansas and Warren Hearn in Boulder, Colorado; to understand how their procedures are done and the statistics.
"And then understanding how D&Es are done in order to be able to make a judgment."
MS. CHAITEN: Turning to page 165, line 24:
"Q Are there any maternal health conditions which you believe indicate a need to remove the fetus intact through a surgical abortion procedure other than hysterotomy or

4475nat6 "Creinin -

hysterectomy?

"A Yes.

"Q What would those maternal health conditions be?

"A If a woman had a current pulmonary embolus and was required anti-coagulation at the current time, I would want to do the procedure intact.

"Q Why is that?

"A Because her active anti-coagulation, I would not want to have bony fragments traipsing through the lower uterine segment in the cervical canal. And because it was a recent pulmonary embolus it is not safe, or an active pulmonary embolus, one that just occurred in the prior few days or even weeks. I would not want to stop anti coagulations because that would put her at risk of dying right then and there.

"Q You would not want to stop her coagulation because?

"A Because she has a clot in her lungs. If I stop it she could die. Her need for anti-coagulation is very high.

"In cases, as opposed to a patient where it would be safe to stop the anti-coagulation for a few hours, this would be a case where you would not want to stop it at all.

"Q When you mention the risk of bony fragments, why would that be a risk?

"A If I am disarticulating the fetus as part of a D&E, when you pull the fetus apart into fragments, into pieces,

4475nat6 "Creinin -

there is bony fragments.

"Q Why would that be a particular concern with the example that you provided?

"A She is anti-coagulated, so if there is scrapes, are small tears in the lower uterine segment, which the body would normally be able to stop bleeding on its own without any problems and likely routinely occurs to some extent during the normal D&E -- because she is anti-coagulated she could continue to bleed and hemorrhage.

"Q And what does it mean to be anti-coagulated?

"A To be on blood thinners so your blood won't clot.

"Q Have you seen any written documentation about this risk of bony fragments or is this just based on your own clinical experience?

"A It is part of a D&E procedure.

"Q I'm sorry, about the risks of having bony fragments in this example?

"A That is part of a D&E procedure. It is, when you pull a fetus apart as part of a D&E, there are bony fragments. That is it. Period. There is nothing more to say, say, see or question.

"Q But the fact that, quote, in your words, 'bony fragments could create a risk to the mother,' have you seen any documentation that this is a specific risk to the mother?

"A That is one of the ways in which complications

can occur. You are asking from a medical standpoint, you are asking the obvious. You are asking a question that answers itself."

MS. CHAITEN: Turning to page 169, line 16:

"Q Have you seen any written reports about the concern about bony fragment in a woman with a condition that you described?

"A No. But I have also taken care of patients in the last year that I have never seen any written reports for that you need to use your best judgment at the time."

MS. CHAITEN: Turning to page 177, line 12:

"Q The exhibit that has been identified as Plaintiff's trial Exhibit 86, your expert report, if you would turn to page 6, please. The first sentence states:

"When performing dilation and evacuation, D&E abortion, extracting the fetus from the uterus so it remains as intact as possible is preferable and enhances the safety of the procedure."

"Is that correct?

"A Yes.

"Q What do you mean by this statement?

"A That when the goal, when the procedure is started as a dilation and evacuation procedure, that the fewer pieces, the better. And if it is intact that would provide the least risk.

"Q What do you mean it would provide the least risk?

"A Of complications to the woman who is having the procedure.

"Q And what complications do you have in mind?

"A Cervical tears, perforations, infection, hemorrhage.

"Q And what?

"A Need for additional surgery."

MS. CHAITEN: Page 179, line 7:

"Q And have you seen fewer complications when a fetus is removed intact than when it is dismembered?

"A In the estimated 50 or so where it has come out intact for me, and the three where I have done an intact D&E, I have had no complications from that removal.

"So, if the question is have I seen fewer compared to my other procedures, I have had zero compared to any. So, the answer would be yes."

MS. CHAITEN: Page 187, line 24:

"Q In the last sentence it states, 'In my opinion there is no respect in which intact removal of the fetus during a D&E is less safe than non-intact removal.'

"Is that correct?

"A Yes

"Q Is it your opinion that non-intact removal is as safe as intact removal?

"A During a D&E?
"Q Yes.
"A When the goal of the procedure is to do a D&E, if the fetus comes out intact that would be preferable.
"In my opinion it is likely safer if we were to have thousands and thousands of women to assess that since the goal of a D&E is not necessarily to remove the fetus intact as opposed to the goal of an intact D&E. The experience to be able to prove that would be unattainable
"But, in my opinion, when my goal is to do a D&E, if the circumstances are right and the fetus is coming out intact, I would not purposely dismember it to improve the risk outcome."
MS. CHAITEN: Page 189, line 15:
"Q In your opinion, generally speaking, is a non-intact removal as safe as an intact removal?
"A Generally in my hands, yes. But if I have two patients side by side and one was coming out intact and one was coming out non-intact, most likely I would prefer the one intact."
MS. CHAITEN: Page 203, line 1:
"Q If you turn to paragraph 16, if you look at the first sentence it states, 'It is my opinion that intact removal is safe and in some cases preferable.'
"A Yes.

"Q I am wondering if other people expressed to you that they share your opinion that intact removal is safe and in some cases preferable.
"A Yes.
"Q Approximately how many people?
"A 10.
"In the past year was your question?
"Q Sure.
"A 10 in the past year."
MS. CHAITEN: Turning to page 207, line 24:
"Q Turning to paragraph 18, you have a statement in here, second sentence, 'There is data showing that such an injection does not make the procedure easier or safer.' I think you are referring to before an injection of any chemical agents to cause intrauterine fetal demise prior to performing a D&E abortion.
"What is the basis for this statement?
"A The Jackson study.
"Q Did you help prepare the Jackson -- did you help work on the Jackson article?
"A No."
MS. CHAITEN: Turning to page 2 --
THE COURT: How many more pages do we have?
MS. CHAITEN: I have about six pages, your Honor.
THE COURT: Pages or lines?

4475nat6 "Creinin -

MS. CHAITEN: Page -- it's portions of six pages, actually, not six full pages.

THE COURT: All right, we will try and complete those.

MS. CHAITEN: Okay. Turning to page 210, line 11:

"Q And in paragraph 18, when you refer to potential complications in the last sentence, what potential complications are you referring to?

"A Putting a needle in the woman's abdomen I could hit a vessel, a maternal vessel. I could cause rupture of membranes which could increase risk of infection from her procedure since she will have a prolonged rupture of membranes. And if there is no benefit to doing so, as far as the procedure, that I get risks without benefit."

MS. CHAITEN: Page 210, line 24:

"Q With the puncturing of a vessel in the woman, I think that is one of the risks you articulated, is that correct?

"A Correct.

"Q Why would that present a risk to the mother?

"A If I put a needle in one of her large blood vessels, especially if she is pregnant, like vessels that feed the uterus, and that vessel then is leaking blood into her abdomen, she would basically bleed inside her belly and lose blood inside her abdomen.

"Probably after a couple liters of blood in the belly

4475nat6 "Creinin -

she might become symptomatic and quickly approach death for an unnecessary procedure.

"Q Is it your opinion that an injection of digoxin carries a risk of death by virtue of puncturing a vessel in the mother?

"A It potentially carries that risk.

"So, if I decide I'm going to incur that risk, that I should have a benefit that outweighs that risk. So, although the risk is small, very, very small, I don't have any benefit that balances out. So that benefit, that risk becomes all I have.

"Everything is a risk/benefit comparison, not just a risk or just a benefit."

MS. CHAITEN: Page 212, line 21:

"Q When you discuss the other risk, the rupture of membranes, I think you articulated with respect to the digoxin injection, is that correct?

"A Yes.

"Q With respect to that risk, can you just explain -- can you explain further how this poses a risk to the mother?

"A The amniotic membranes are a barrier between the intrauterine environment and the vagina. There are bacteria that normally live in the vagina. If the membranes are ruptured and amniotic fluid is leaking out, that barrier is

broken. The amniotic fluid also provides some anti-infective properties.
"The longer the membranes are ruptured the more time there is for the bacteria to enter the uterus and cause an infection inside the uterus. Putting a needle through the membranes includes a risk of rupture of the membranes. The longer those membranes are ruptured the more the risk increases, that infection will occur.
"So, since procedures at this point in pregnancy would require, if this was the procedure being done, an injection, dilators is being placed, then waiting 24 hours. If ruptured membranes occur at the time of injection you are still waiting the 24 hours to do the procedure and the risk of infection would be greater than if she had been waiting that 24 hours for the procedure with membranes intact.
"Q With rupture of membranes, what could that ultimately lead to? Could that ultimately lead to death for the mother?
"A Theoretically, but very unlikely.
"Q What is more likely to be the result to the mother?
"A Infection in her uterus that would require antibiotics.
"If you have a small percentage of people who have resistant infection, could get complications with the

antibiotics, could lead to infections in the bowel. Prolonged diarrhea, dehydration, prolonged hospital stays. Could have prolonged hospitalization for treatment of the intrauterine infection. Treatment of infections, albeit right, can lead to sterility."
MS. CHAITEN: Turning to page 235, line 12:
Your Honor, at this point we are on the two rebuttal designations that I mentioned earlier and these will be our last two designations that we will be reading. Line 12:
"Q Turning to paragraph three of your rebuttal report, what do you tell your patients about fetal pain when a woman undergoes abortion?
"A For patients that ask me about fetal pain I explain exactly what is printed on my expert report rebuttal.
"Q I guess in your own words if a woman said to you 'Is my fetus going to feel pain if I undergo the surgical abortion,' what is it you would explain to her?
"A I explain to her a fetus can't feel pain in the way we as conscious human being adults understand and feel pain.
"I explain there are studies for people who have attempted to investigate whether fetuses feel pain, and the best studies show that fetuses can't understand pain until 26 weeks. There are studies that look at autonomic reflexes like if I were to hit your knee and your leg would kick, but that

those are present early but that is not a level of consciousness.

"If the patient requires further explanation I also explain, ask them if, for example, if the patient had general surgery, did she feel pain during the surgery because she wasn't conscious and that it requires consciousness

"If you also understand the data -- I don't say this to her literally -- if you understand the data as put together in a compilation by the Royal College of OB/GYN, the pathways aren't present until 26 weeks.

"That is the best data that is available. The best understanding we have."

MS. CHAITEN: Page 238, line 7:

"Q Is it your opinion that a fetus does in fact feel some pain before 26 weeks, although different from the kind of pain human beings experience?

"A No.

"Q Is it your opinion that a fetus feels something before 26 weeks in a surgical abortion?

"A I have no way of answering that question because there is no way I can truly understand -- actually, I should take that back. It is my opinion it doesn't, no.

"Do you want my opinion? No, it doesn't."

MS. CHAITEN: Your Honor, at this point I would ask that the Court receive the Plaintiff's Exhibit 87, which is the

curriculum vitae of Dr. Creinin, into evidence.

MS. WOLSTEIN: No objection, your Honor.

THE COURT: It will be received.

(Plaintiff's Exhibit 87 received in evidence)

THE COURT: I think we will recess at this time. Would you please give the exhibit to my law clerk? I would like to see that curriculum vitae.

We will reconvene tomorrow morning at 9:30.

And the objections to the counter-designations will be given to one of my clerks, is that correct?

MS. WOLSTEIN: Your Honor, we have compared the two copies and we see that they're exactly the same.

THE COURT: Okay. So you give that to my clerk so we can review it and be ready for the morning.

MS. CHAITEN: Yes, your Honor.

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

(Adjourned to April 8, 2004, at 9:30 a.m.)

INDEX OF EXAMINATION

Examination of:	Page
GERSON WEISS	
Direct By Ms. Parker: . . .	1305
Cross By Mr. Lane:	1365
Cross By Mr. Lane:	1398
Redirect By Ms. Parker: . . .	1417
Recross By Mr. Lane:	1426

PLAINTIFF EXHIBITS

Exhibit No.	Received
124	1319
116	1452
87	1491