4/8/04 Judge Casey take 1 of NAF versus Ashcroft
THE COURT: Good morning. Please be seated.
I believe we are at that point where the government is going to read their designations portions of the transcript, is that correct?
MS. WOLSTEIN: Yes, your.
THE COURT: And who will be doing that?
MS. WOLSTEIN: Your Honor, it's Elizabeth Wolstein. I will be reading the questions to Dr. Creinin and Ms. Amy Goldman from our office will be reading the answers.
THE COURT: Wonderful.
Sound like you have a cold.
MS. WOLSTEIN: It is probably just morning, your Honor.
THE COURT: You women have a few days' break.
MS. GOWAN: Your Honor, before we commence reading may I address two mat STPHERZ.
THE COURT: Surely.
MS. GOWAN: I wanted to inform the Court first of all about the status of the government's subpoena that was served on New York Presbyterian Hospital on Sunday I've REUL 4th, 2004.
We told your Honor I believe on Tuesday that we expected to promptly move to enforce that subpoena before your Honor.

In light of the Court's views expressed at the time we stated that we intended to enforce the subpoena I called New York Presbyterian Hospital to see if it couldn't reach some sort of informal resolution of the matter and have the complications book produced. I was finally able to speak with counsel on the telephone last night.
I had told your Honor on Tuesday that Presbyterian had filed objections to the subpoena on Monday. One of those objections was Presbyterian's belief that the government subpoena had been served in violation or in contempt of the Second Circuit's order staying the initial subpoena served in December of 2003. I explored that matter with Presbyterian counsel last night. Certainly it is the government's view that the complications book is not covered by the December 2003 subpoena and that the service is --
THE COURT: You don't believe -- at least the Court didn't know it existed until a few days ago.
MS. GOWAN: Neither did the government, and I expressed that to counsel for Presbyterian, I was not able to dissuade them of their position and they suggested to us that any further effort to enforce the subpoena would be an additional violation of the Second Circuit's stay order.
Since that time we, the government, has been considering what would be the appropriate steps to take and one possibility that we are considering is attempting to reach an

understanding with Presbyterian Hospital that in the event the Second Circuit rules in the government's favor and affirms your Honor on April 20th, that Presbyterian would promptly produce the complications book at the same time that it produces the medical records sought by the December 2003 subpoena. That way any issues relating to the subpoena for the complications book would be, as it were, folded in to the matter that's currently on appeal and there would be no additional collateral litigation relating to that particular subpoena.

But, before the government would take that step we certainly would wish to have the record clear before your Honor on the Court's view of the relevance of the complication book to the matters being tried in this case at this juncture.

We think that the Court's views that were made at the hearing when Dr. Westhoff was on the stand were quite clear as to the relevance but if your Honor is so inclined we would respectfully request an additional ruling from the Court at this time as to the relevance of those TERLGZ to plaintiff's claims in this case and the government's defense of KOPBS TPHAOUGSality of the Partial-Birth Abortion Ban.

THE COURT: I think I made it quite clear that there is an abundance of testimony in the record that there are materials that would appear clearly relevant. There has been an enormous amount of testimony from Dr. Westhoff concerning various safety factors and she has acknowledged repeatedly that

complications are noted in that book and I think there is some question whether it is even a hospital record.

But that aside, I think it is without question relevant as to the claims of Dr. Westhoff as to various safety issues. No question in my mind.

MS. GOWAN: Thank you, your Honor.

THE COURT: So you can appendage whatever statement of mine on the record that this Court thinks it is relevant.

MS. GOWAN: Thank you, your Honor.

The other matter that I wanted to bring to the Court's attention was I advised Mr. Hut in writing last night that the government plans, as scheduled to call Dr. Lockwood to testify on Monday. The government will not be inducing any testimony from Dr. Lockwood concerning the Chasen study consistent with the Court's view, ruling I should say yesterday and therefore the government will not be supplementing Dr. Lockwood's expert disclosure in this case.

THE COURT: I think you misunderstood my ruling. I suggested you put it back so that you could supplement his expert opinion. It's up to you what you want to question him about. You try your case, I am not telling you but if you are going to ask Dr. Lockwood to opine on that study I think you should sup THREPLT and if that was going to happen then that you should try and, if you got the supplement to your opponents today that maybe if you could push it back a little bit in time

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to allow them the courtesy of digesting whatever it is he has to say but I'm not telling you -- or you have the option of putting him on and testifying about it and subject to recall.

MS. GOWAN: Your Honor, I understood you perfectly yesterday and the government has made a decision to elect not to adduce any testimony related to the Chasen study from Dr. Lockwood, to go ahead and present his testimony on Monday.

Thank you.

THE COURT: It's your case to try.

MS. WIGMORE: Your Honor, this is Ms. Wigmore, we have one brief housekeeping matter and I spoke with Ms. Gowan about this.

The plaintiffs do intend to put in the record, for a limited purpose, Plaintiff's Exhibit 1 which is the legislative history. There is a stipulation in the pretrial order about the types of materials that constitute the legislative history and we have provided to the government a set of binders that we believe includes all of that information.

Ms. Gowan has asked us for additional time to review that and make sure that she has no objections and she believes she needs time beyond the close of our case.

Ms. Gowan has assured us that to the extent we give they are that time and try to introduce it after our case-in-chief has been closed that she would have no objection to that and where he fine with that provided that your Honor

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agrees with that approach and that we won't be prejudiced in any way.

THE COURT: Well I assume the government is going to put the Congressional record in anyway but if that's what you agree upon I don't have any problems leaving your -- your case in general will rest but with this one piece of evidence I don't have any problem with counsel agreeing that it's being offered now and subject to the government's review as to any objection they may have.

But merely that your case has ended, I would not preclude it for that reason.

MS. WIGMORE: Thank you, your Honor.

THE COURT: No problem.

All right.

Now, Ms. Wolstein?

MS. WOLSTEIN: Thank you, your Honor.

THE COURT: It's all yours.

MS. WOLSTEIN: Thank you. Beginning on page 77, line 10:

"Q why would you not put laminaria in?

A. Because at any gestational age dilapan is a better dilator than laminaria, in my opinion.

"Q why, in your opinion is, is dilapan a better TKPHRAEUTor at any gestational age

"A it is a synthetic material that I can be assured

that I get the same dilation from every dilapan whereas from laminaria you can't always be sure. You need to place more laminaria than you need to place dilapan, so it makes it easier to achieve the dilation you need."

MS. WOLSTEIN: Page 82, line 5:

"Q 20 weeks, how much would you seek to dilate?

"A about two centimeters

"Q 21 weeks

"A about two centimeters

"Q 23 weeks and

"A about what cent PH-PBD an whatever I can get more than two centimeters I am glad to have base on the five to six dilapan that I place and that doesn't change through 24 weeks

"Q so from 22 to 24 weeks you seek to have the same amount of dilation?

"A approximately.

"Q in the 22 to 24 week time period are you generally using five to six dilapan?

"A yes.

"Q on occasion, do you use laminaria instead of dilapan for dilation purposes?

"A currently?

"Q currently.

"A no.

"Q have you in the past?

"A yes.

"Q when did you stop using laminaria?

"A when Hi dilapan available."

MS. WOLSTEIN: Page 85, line 12:

"Q let me ask this about laminaria. When you use or when you have used laminaria for purposes of a surgical abortion 18 weeks or later, how much laminaria did you use when there is a gestational age of 19 weeks?

"A as many as I could get in because laminaria are not as reliable as dilapan. So, we would mutual in as many as I could put in and judge the general number through the side if I feel it is sufficient. And there are different sizes of laminaria. They come in different sizes. It is not a simple question to answer."

MS. WOLSTEIN: Page 86, line 15:

"Q in 20 weeks two centimeters?

"A athat was my goal. Same goals

"Q the goals were the same when you were using the laminaria as they are with dilapan?

"A correct

"Q when you are pulling the parts of the fetus through the cervix, are you -- are you tugging at the parts? Are you twisting the parts? House do you pull the parts outside the woman's body?

"A I grab the part of the fetus that is in the lower

uterine segment, or if it is the vertex, if this is my first pass. I will try to get beyond the head on us us guidance and grab an exinterest TEU. Ideally a lower exTREU it to convert it breech. I will grab that part and pull through the cervix. There is no twisting motion inside of the uterus in response to your direct question, if that is what you intended to ask.

"Q is there a twisting at any point?

"A as the -- when I do the procedure, when I am pulling the fetus through the, the fetal part, very a grass of of, through the cervix as it is coming through the cervix. If it gets to a point where I am meeting resistance then I will begin to gently rotate minimally as it is working through the cervix but not twist. Again, just twisting minimally. And, no, you can't put this into words, but just twisting minimally.

"Q what is the purpose of twisting minimally?

"A to ease the part through the cervix because there is -- you are meeting resistance from the cervix so I don't want to yank very hard to tear the cervix. I want to allow the cervix, allow that part to work through the cervix and have the resistance from the lower uterine segment and the internal os, allow the fetus to break apart if it is going to do so.

As I stated earlier, my goal is to attempt to remove the fetus as intact as possible, to have as few parts for safety of the patient."

MS. WOLSTEIN: Page 90, line 1:

"Q if you have a fetus at 18 weeks and have you dilated to 1.75 centimeters, are you ever going to have -- would you ever have a situation where there wouldn't be any resistance

"A given those circumstances that you stated, that I would always get resistance if the cervix was only dilated that much and the feet is us was 18 weeks.

"Q and if you dilateed to that much to that amount, 1.75 centimeters and the fetus was 18 weeks, would you always have dismemberment then?

"A just short of the term always. I can never -- I can never guarantee never and I can always not guarantee always." Wolstein TPHAEUPBLG page 90, line 19:

"Q and if you have a 20 week fetus and you are at two cent PHAOERPTS dilation, in your experience, would you encounter resistance when you are removing the fetus?

"A almost always."

MS. WOLSTEIN: Page 92, line 5:

"Q when you are at 21 weeks and you have initially dilated to two centimeters you start pulling the fetus through the cervix. Is it your experience that you will encounter resistance?

"A same answer as before. Most commonly.

"Q at 22 weeks when you dilate the cervix a little bit more than two centimeters and you start to remove the

fetus, is it your experience that you encounter resistance in the cervix?
"A same answer before. Most commonly.
"Q at 23 weeks?
"A same.
"Q at 23 and 24 weeks, if you dilate to the amounts you previously set forth which would be between 2 and 2.25 approximately centimeters, is it your experience that you would encounter resistance in removing the fetus from the uteru uterus?"
Wolstein name there is an objection
"A in the 23rd week, yes. It is the same answer as before, but I don't do abortions at 24 weeks and beyond note note up at the beginning of that note note note note
"Q so, is the last time -- is the last point when you intend to do abortions, is it at 23 weeks and six days?
"A in the commonwealth of Pennsylvania that is my limit.
"Q if you always -- I guess I I am confused. If you are always trying to bring out the fetus as intact as possible, why wouldn't you dilate more at the earlier gestational ages?
"A because I have to balance the risks and the benefits of putting in more dilators for that individual patient. The more dilators I put in one setting the more uncomfortable it is for her, the harder it is for her to

tolerate the dilation, and the more the potential that she could go into labor from overdilation or induce labor
So since the goal is to put in dilators, have her be comfortable so she can have a normal day and then to come back the next day for the procedure, I have to find the balance between enough dilators to remove, to safely do a D&E procedure and not too many that I can make her uncomfortable or increase her chances of having problems while the dilators are in place."
MS. WOLSTEIN: Page 100, line 14:
"Q so, have you ever had a situation when you have been performing surgical abortion when the fetus was coming out intact and then the head was stuck at the internal cervical os?
"A so the question was I was pulling the body out and that came out with a problem, then I couldn't go any further because the head wouldn't come through easily?
"A yes.
"A yes.
"Q what did you do in that situation to deal with the head not coming out easily?
"A I have done different things in different situations.
"Q why don't you explain what some of those different things are.
"A well, I have continued to pull. Then the body,

the neck pulled off of the head, that is living the head inside. This is part of a D&E. Then I go in with my instrument again and get the head. I have used a scissor, PUFRBG KHERed the base of the skull, then stuck a suction canula into the opening and drained the brain tissue and had the head pop through.

"I have reached -- taken a second grasping instrument, put that inside the os, crushed the head and then pulled pulled it through

Those are the three things that pop into my head as the things I have done. It is possible there may be others. Those are the things that come to mind."

MS. WOLSTEIN: Page 103, line 24:

"Q was there anything -- were there any indications, based on the health of the mother, anything about the health of the morning that you think that in your medical opinion was the reason for why you ended up having a fetus intact all the way out to the head and then you needed to do something to detach the head, collapse the head?
head?"

MS. WOLSTEIN: There is an objection.

"A you are asking a very vague question. I can't answer.

"Q for the five circumstances that you were just describing, was there something unique about the woman having

the abortion that presented the situations to you?

"A no

"Q was there something unique about the fetus that presented those situations to you?

"A no."

MS. WOLSTEIN: Page 106, line 2:

"Q when you said one of the factors is how much dilation there is, how does the amount of dilation weigh into which one of the three mechanisms you were going to use?

"A if I am holding the body and the head is against the opening of the cervix and there is no room for me to manipulate to get an instrument into either crush the head or drain the brain tissue, then my only choice is just to pull and have it come apart. I would rather at that point not pull it apart because then I have to go back in and get the head without any traction on it.

So ideally, if it is possible at that point, if it is intact, all the way up to there, I would rather try and keep it as intact as possible alock the same lines as a D&E. But I have to use my judgment on based on how the cervix looks and whether I think I can get an entire forceps in around while I'm holding the head down against the cervix or if I can just get an instrument in to drain the brain tissue. I have to use my judgment."

MS. WOLSTEIN: Page 107, line 13:

"Q would you ever seek, if the head got stuck, to try to pull the head through with the rest of the fetus so it all came out intact without any collapsing of the skull?
"A if it was stuck I would not have been able to do that."
MS. WOLSTEIN: Page 108, line 4:
"Q Have you ever in your career had a situation when you were performing an abortion with a surgical abortion that you remove the entire fetus intact but you didn't need to do anything to collapse the skull or to collapse --
"A for clarification you are talking about a transvagina TPHAL --
"Q breech.
"A through the cervix procedure.
"Q yes
"A yes
"Q approximately how many times?
"A five to to 10
"Q and at about what gestational ages were those fees yous
"A between 16 and 24 weeks
"Q was there something unique about the situation such that the whole fetus, including the head, came out without having to collapse the head at all?
"A to the best of my recollection most of those

situations were women that were in pre-term labor that had opted to terminate rather than to continue through the pre-term labor, or were cases where there was a multiple pregnancy and the first fetus was removed and the following fetus would come out intact, or two.
two."
MS. WOLSTEIN: Page 110, line 9:
"Q if the woman was seeking an abortion -- if woman is seeking an abortion, would there be a concern at all with the fetus coming out intact without collapsing the head that the fetus could potentially survive and live?
"A it could depend on the gestational age. Can I take a two minute bathroom break?
"Q yes.
MS. WOLSTEIN: Resuming after the bathroom break.
"Q how would it depends on the gestational age
"A the closer between 24 weeks, between 23 and 24 weeks, that could potentially be possible."
MS. WOLSTEIN: Page 111, line 24:
"Q so, would you perform an intact D&E even if it were -- even if it were possible to bring out the entire fetus intact if the woman was seeking an abortion?
"A if she was seeking an abortion, yes, I would."
MS. WOLSTEIN: Page 114, line 3:
"Q in a situation that we were talking about before

where you have an intact fetus but the head got stuck, would you consider dilating the cervix more to deal with that situation instead of one of the three --

"A no.

"Q and why not?

"A you can't physically do that.

"Q why can't you physically do that?

"A because it is not possible.

"Q would it be possible to add, to give some misoprostol to dilate the cervix more?

"A I have -- no. It is not medically prudent or indicated.

It is not an appropriate thing to do for a patient having a D&E procedure."

MS. WOLSTEIN: Page 118, line 17:

"Q have you ever had a patient ask you when she is -- when she comes to you to have an abortion that the fetus be removed intact?

"A I cannot recall a patient specifically asking me that

"I do discuss that with my patients because there are other options to D&E. I go over those options."

MS. WOLSTEIN: Page 119, line 25:

"Q but you wouldn't do the intact D&E yourself?

"A no

"Q and why is that?

"A because I don't routinely do the multiple day dilation for an intact D&E.

"Q is it your understanding if you set out to do an intact D&E that you would do a multiple day dilation which is different from the way in which you do your D&E procedures?

"A correct. And because I don't have experience doing that, nor have I been trained in how to do that it would not be an appropriate thing for me to offer."

MS. WOLSTEIN: Page 121, line 15:

"Q what do you mean when you say dismemberment is safest for the woman or clarify?

"A because the lets -- because the procedure is done with enough, with less dilation than if she went through labor

"I don't offer an intact D&E so I can't make comparisons to that. If she is in my office in Pittsburgh and she wants to terminate her pregnancy, her options are to go elsewhere to get an intact D&E which because of insurance reasons most people would not choose to do.

"or even if they are paying in cash the cost of the travel object top of the procedure most people would choose not to go

"so in our -- in my office with the procedures that I am trained to do and experienced with and with the other providers in my -- in my area, I can offer a D&E or a labor

induction.
"Q and there is a little bit of confusion.
"when you refer people for an intact D&E, which sounds like something you don't do.
"A correct.
"not with the goal of doing one from the beginning.
"Q when you refer people for that but in your procedures, from what I understood your earlier testimony, was that you try to get the fetus out as intact as possible?
"A correct.
"Q I guess I'm a little confused. If you are not trying to do an intact D&E but you are trying to get it out as intact as possible, there seems to be a gap there.
"maybe you can clarify?
"A I am trying to remove it as intact as possible with the dilation that I have created with the intent that the fetus will mostly -- will most likely come out in pieces
Because every patient responds differently and every circumstance is different there are times when I have less dilation than I would like and I end up having to use smaller forceps and the procedure takes longer.
And there is potentially more risk of bony fragments because I end up with more pieces
There are times when I get more dilation and the fetus comes out more intact.

And there have been sometimes, as you asked me about, and I gave you numbers, that the feet us has come out almost completely intact.
So, it varies. And every circumstance is different
If somebody wants and TPHO*EUTD with those goals from the beginning I am not trained to understand the nuances of what happens during the multiple days of dilation, how to answer her questions if problems arise.
What the nuances are with that procedure, per se, compared to what I routinely do.
And although I could do it if I had to, I am sure the patient is in better hands if somebody who is in experienced in doing it which is the way -- which is the same way I would approach any patient of mine. Whether she is seeking an abortion or seeking some other gynecologic care there are people who have more experience in certain areas of gynecology that she is better served by those persons than me in those circumstances. KW-FRBLGTS
"Q is it your understanding then for an intact D&E that from the onset you set out to dilate the cervix more than the amounts that you set forth at 18 weeks, 19 weeks, 20, 21, 22?
"A that is my understanding. that is my understanding for all of those gestations.
MS. WOLSTEIN: Page 124, line 15:

"Q so, if you wanted, in a D&E procedure, if you wanted the fetus to come out intact more regularly, would it be correct to say one way to go about doing that would be to increase the level of dilation?
"A that would be correct.
"Q would there be other steps that could be taken to increase the likelihood of the fetus coming out intact?
"A because I am not trained in that procedure I don't know the answer to that.
"Q to the best of your ability to answer here today.
"A to the best of my ability, the logical thing seems to be to provide more dilation. There could be other things."
MS. WOLSTEIN: Page 126, line 9:
"Q if you would like to answer the answer, answer the question in steps
"A from the moment I puncture the skull to the moment the head is out, is that your question?
"A yes.
"Q 10 seconds. 15 seconds at most."
MS. WOLSTEIN: Page 127, line 9:
"Q and in instances when you take an instrument that collapses the skull, that crushes the skull, about how long does that take?
"same?

"A from the time I put the instruments in and begin to crush the skull until the time I remove the entire skull on the low end, about the same.
"sometimes when you crush the skull as it is coming through the head is still the biggest part. It may pull apart at that point. You may have to reach back in and pull out the remainder of the actual
It may take longer. It may take 30 to 45 seconds"
MS. WOLSTEIN: Page 128, line 11:
"Q as are you doing or after a surgical abortion is performed, talking about 18 weeks and later, do you indicate on a patient's medical record whether or not the fetus was removed intact? Would you make any kind of note of that?
"A no.
"Q would you note that you counted the fetal parts to make sure they are all there?
"A most of the time I don't note that because that is a typical part of the procedure, especially since it is done under ultrasound guidance sincere pretty standard you are seeing everything removed. You are counting the parts as you go along.
"I don't specifically write in the chart or make a comment in the dictation that all fetal parts were identified routinely. Unless I am dictating there was something particularly difficult with the procedure related to her

anatomy.
"an example would be a patient with lots of fibroids in the uterus where removal might be very difficult and prolonged. In that special circumstance I would likely, and I am speculating, make a special notation of it.
"otherwise, because it is a routine part of the procedure, to make sure that the uterus is empty and since ultrasound is used real-time to identify that the uterus has been emTEUD is not something I specifically note
"Q in instances when you have had to collapse the head for one of the three ways that we have gone over, would the method of collapsing the head be indicated in the patient's medical records for one of your patients?
"A I can't recollect for those patients if I dictated the note differently than I standardly do, so I can't answer your question with any accuracy.
"Q does it strike you as something you would think would be relevant to note on the patient's chart?
"A not at all.
"Q and why is that?
"A because I dictate that the fetus was removed in multiple passes of the instrument and the pathologist will make a notation of the pathology specimen. And from the standpoint of the procedure note, it doesn't really make a difference. It wouldn't matter if I did three passes of my forceps or four

passes of my forceps. I do whatever is necessary and would only dictate if it was something outside of the realm of normal being that it was more difficult.
"Q would you indicate if there were multiple passes with instruments?
"A I always do.
"Q and do you indicate how many passes with instruments?
"A no. I don't.
"Q so you would just say multiple passes of instruments, end of story
"A basically. Not those exact words. But basically
"Q and would you use, would you indicate multiple passes of instruments even if it was one instrument pulling, one instrument was used to pull the head?
"A it would be multiple passes. I would have to go back in and take out the placenta. It would always be multiple passes.
"Q would there be any way to look at a patient's medical chart and determine if she had had an abortion, a surgical abortion in which there was little to no dismemberment?
"A question yes.
"Q and how would you be age to answer that from looking at the chart

"A the pathology report
"Q and what would the pathology report --
"A it would describe the fetus that was sent to the pathology department."
MS. WOLSTEIN: Page 132, line 16:
"Q if there was an intact fetus but the head had been either collapsed or the contents sucked out, would the pathologist's notes indicate it was an intact fetus?
"A I am not a pathologist. I don't dictate the notes. But my guess would be yes."
MS. WOLSTEIN: Page 134, line 5:
"Q okay, we will take a specific example.
At 18 weeks you typically put in four. Have you ever had a situation when the woman's cervix did not dilate as much as you were expecting so you decided to had a fifth dilapan?
"A I can't be specific to 18 weeks but there are rare situations where I go to the operating room and we take the dilapan out and it is difficult to remove the dilapan because they are in an hourgrass shape because the cervix just did not let them dilate completely over that period of time
"and if I feel in my opinion that for that given patient given her gestational age that I really need more dilation to safely do the procedure, and I feel that I can't use rigid dilators to achieve that dilation safely again based on my experience and my opinion, then I have put in more

dilapan.
And we have taken her out of the operating room and brought her back the next day.
I can't remember the exact details of the gestational age or how many dilapan initially or medical circumstances surrounding it. But those situations have occurred. Rarely."
MS. WOLSTEIN: Page 135, line 16:
"Q would you ever do -- currently, do you ever do a D&E procedure 18 weeks or later anywhere else besides at the hospital?
"A I go to 18 and zero at Planned Parenthood. Planned Parenthood women's health services
"Q 18-is and later?
"A I only do those procedures at McGee women's hospital."
MS. WOLSTEIN: Page 135, line 24:
"Q what would you give the woman for purposes of her comfort level during a D&E procedure 18 and 1 -- 18-1 and later
"A for virtually all women they get intravenous sedation by an anesthesiologist and they also get local anesthesia in the cervix at the time of the procedure.
I have had some patients who have requested to have it done under local.
I do them under local under 18 weeks quite often.
And did them under local when I was in San Francisco.

Just patients in Pittsburgh tend to be different than patients in San Francisco and don't have much request for that here.

When I do have the request for having it done under local, we still do the procedure in the operating room with an anesthesiologist on stand by if she needs some sedation

But then I will do the procedure just with the local an test yes and non steroidal analgesic in addition

Some patients in the operating room depending on their comfort level and their health status they are other health conditions they have sometimes in consultation with the anesthesiologist and we discuss it with the patient that it is in her best interest to have it done under general anesthesia or with a spinal anesthetic.

But those, again, are rare circumstances that need to be approached in an individual basis."

MS. WOLSTEIN: 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 exent

"A over what PAOEUPL tiered, of performing the abortions? All, ever

Q. Ever.

"A disAR tick 2002ed to some extent, 99 plus percent

"Q in abortions you performed at 21 weeks

"A aim answer all the way through to 23 and six sevenths weeks.

"Q it would be 99 --

"A plus percent.

"Q when you say disarticulate to some extent, what do you understand that to mean?

"A any part of the -- there is any part of the body has been removed from any part. Even if a foot is removed, it is disarticulated."

MS. WOLSTEIN: Page 149, line 11:

"Q when you pull, when us have a fetus that is intact, is there a risk in the procedure of uterine perforation?

"A yes. If you are using instruments in the uterus there is always that risk.

The same yes to always. Anything.

"Q is there a risk of cervical laceration when you pull out a fetus intact?

"A yes.

"Q and is there a risk of blood loss?

"A yes."

MS. WOLSTEIN: Page 156, line 6:

"Q have you ever -- sorry. Have you reviewed any peer reviewed published studies that supports your view regarding the safety of a D&E procedure in which the fetus is

removed intact?
"A not published at the current time. No.
"Q page 157, line 4:
"Q are there limitations to RETD RO specktive studies?
"A yes.
"Q what are those limitations?
"A it depends on the study question.
So there is different types of limitations based on the study question.
"Q in general, what are the limitations with respect to retrospecttive studies?
"A could you limit your question to this study?
"Q sure.
"A it is non -- the limitations are that the groups were not -- if you were doing a retrospecttive study with two groups, then the groups aren't randomized. It is always possible that there is bias in group assignment.
"meaning that potentially patients who would have a more favorable outcome received a specific type of procedure as compared to patients who didn't.
And there is a potential for it. It is something that needs to be evaluated as part of the study.
Other biases could include, in this case, the operators having bias and deciding that what procedure they're

going to do, meaning that if the outcomes are that two groups are similar in outcome, and it is only because the more dangerous proceduress were done one way and the -- or the more dangerous patients were handled one way and the less dangerous parents were handled another way.
"it could be that if the more dangerous patients had been handled with the other method then maybe the outcomes wouldn't have been the same. Those are the limitations of a retrospecttive study of this nature."
MS. WOLSTEIN: Page 160, line 3:
"Q other than the Chasen study, in the course of performing a D&E surgical abortion, have you ever lacerated a cervix?
"A yes. Clarification. You said a D&E or an intact D&E?
"Q during a D&E.
"A yes.
"Q approximately how many times?
"A I honestly could not answer that. It is going to be a few. Less than five.
"Q and had a were the circumstances surrounding those -- what were the circumstances surrounding the laceration?
"A I was doing a D&E procedure.
"Q and how did the laceration happen?

"A I was doing a D&E procedure and a laceration happened. It is part of the procedure.
"Q what was different about this procedure?
"A nothing was different. It is one of the things that can happen. I was pulling the fetal parts out of the uterus and a laceration occurred.
"Q in your view, was there any specific reason for the laceration to have occurred?
"A in these circumstances?
"Q yes.
"A as compared to other patients of mine? No."
MS. WOLSTEIN: Page 161, line 20:
"Q is it your view that it is safe err to remove a fetus intact as opposed to in parts?
"A that is a vague question. Safer implies relative to something else.
"Q is it safer to remove a fetus in parts versus intact?
"A it is still very vague.
"Q to the best of your ability to answer the question.
"A in my hands, with my skills and for my patients, it is safer for me to do a D&E than an intact D&E.
To have a procedure where my goal is to do a D&E than an inintact D&E.

And if the dilation happens to be adequate enough and the situation presents itself where I am performing what I could -- what I would routinely do for a D&E, then in those few circumstances I have done an intact D&E.
But in my hands it is safer to do a D&E than an intact D&E as far as from the outset what my goal is for a procedure.
"Q when you are referring to D&E as you just described, do you mean D&E entailing dismemberment of the fetus
"A yes. In my hands for my patients
In general."
MS. WOLSTEIN: Page 164, line 19:
"Q I am just trying to be clear. Have you ever had to crush the skull when the fetus has presented in a head first position in which the head was past the internal cervical os?
"A no."
MS. WOLSTEIN: Page 168, line 16:
"Q have you seen any documentation for the example you provided that having the pieces create specific risks for the mother?
"A again, this would be something where when you have individual circumstances of patients with disease processes that are not the routine you have to rely on your clinical experience, your understanding of physiology and your understanding of the case.
"I had plenty of cases I have seen, one of in the last

10 years. I have to use my judgment at that time.
"Q so, is your answer that, no, you haven't seen anything written about the concern for bony fragments in the example you were discussing?
"A any where I written discussion of D&E includes that discussion. That is textbook stuff at this point.
It is not even something that you need to prove in a paper or anything.
This is part of the procedure.
"Q but what I am asking is have you seen anything written?
"A I have given you the answer to the best of my ability
"Q have you seen any written reports about the concern about bony fragments 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 that time."
MS. WOLSTEIN: Page 169, line 23:
"Q in a D&E procedure, once you are beginning the extraction process, approximately how long does it take to complete the extraction part of the procedure?
"A can you be more specific? Is this an uncomplicated routine procedure?

"Q I guess answer in the best way that you can. If you need to provide details, that is fine.
"A for the average patient with no specific limitations, as far as adequate, inadequate, less than expected, more than expected dilation, for the average patient from the time that I start the extraction until the time that I get up from my seat?
"Q until the fetal parts are removed.
"A five minutes.
"Q and once in which there are complications? Approximately how long?
"A it would depend on the complication
"Q what is the HROFPBGest it has ever taken you to extract a fetus
"A where I was doing the entire case?
"Q where you were doing the extraction.
"A 15 to 20 minutes.
"Q approximately how long does it take to do the extraction when you have a fetus that is being removed intact?
"A from the time you grab with the forceps until the time the fetus is out in its enTAOEURTD?
"Q yes.
"A less than a minute."
MS. WOLSTEIN: Page 171, line 8:
"Q can you give me a rough estimate of how many

passes it takes to complete a D&E surgical abortion procedure?
"A no. I can't."
MS. WOLSTEIN: Page 176, line 15:
"Q do you think it is appropriate for Congress to legislate at all about the abortion procedures that physicians can and cannot do?
"A no."
MS. WOLSTEIN: Page 177, line.
:
"Q is one of the primary reasons you oppose it because you think, is it because on principal Congress should not be legislating on medical issues?
"A that is one of the reasons note note line 8 8 note note
MS. WOLSTEIN: Page 178, line 12:
"Q and what is your basis for believing it is preferable and enhances the safety of the procedure?
"A my -- the teaching I received in doing the procedure, as well as my vast experience in providing abortion care." OL WOL name page 180, line 17:
"Q for the surgical abortions that you perform from 18.1 weeks and later, 18-1 weeks and later, do most of your patients return for followup visits?
"A no.
"Q so because they don't return for followup visits

are you unable to make assessments about complications that they may have encountered later on?
"A no.
"Q you are not able to determine that?
"A no."
MS. WOLSTEIN: Page 182, line 5:
"Q so you would say -- would you say that you are virtually certain that if there is a complication that resulted from an abortion that you performed, a surgical abortion that you performed 18-1 weeks or later, that you would know about it?
"A yes.
"Q even though all your patients don't return to you for followup visit?
"A correct.
"Q page 188, line 22:
"Q so I guess I am not quite clear what your answer is.
Would I would you say a nonintact removal ask as safe as an intact removal in a D&E procedure?
"A I would prefer an intact removal from a risk standpoint if the circumstances lend themselves to that.
But I am perfectly comfortable and content with the risks when I am performing a D&E where it doesn't remain intact."

MS. WOLSTEIN: Page 190, line 12:
"Q what do you mean by special medical advantages?
"A given her medical circumstances, that when looking at the risks and the benefits of the different procedures, a procedure which is designed to remove the fetus intact could have a lower risk of complications or difference, a change in the ratio of risks to benefit. In which case it would be preferable for the woman to have the procedure designed to remove the fetus intact.
"Q where you have this example with women with the bleeding disorder or anti co-ago you HRAPBTs, is that the same as what we were talking about earlier?
"A yes
"Q and do you have any other examples?
"A at the current time, not off the top of my head."
MS. WOLSTEIN: Page 192, line 15:
"Q have you ever had a woman with a bleeding disorder as you have here in your examples in paragraph seven in which you performed a D&E and in which the fetus was removed intact?
"A no."
MS. WOLSTEIN: Page 194, line 15:
"Q have you ever -- have you ever brought the fetus out intact past the level of the navel and then performed dismemberment at all?
"A yes. We talked about it.

"where if it came out that far and even got stuck at the head and pulled off the body from the head it would be dismembered."
MS. WOLSTEIN: Page 198, line 15:
"Q in paragraph 12, when you use the term, when you use the term D&X, do you mean that term to be the way we have been using D&X, or TPHO*EUTD throughout today's discussion?
"A yes.
If you read on it says, 'also called intact D&E'. So, yes."
MS. WOLSTEIN: Page 199, line 8:
"Q are you aware of any data showing that D&X procedure is safe in all situations
"A no."
MS. WOLSTEIN: Page 203, line 14:
"Q have you ever watched anyone do an intact D&E?
"A yes.
"Q approximately when was that?
"A about a year ago.
"Q and only that one time? Or have there been other times?
"A that is the only time I can remember watching someone do an intact D&E." OL WOL name page 210, line 4:
"Q have you done any other literature searches to -- is there any other data to which you are referring to in

paragraph 18?
"A not that I am currently aware of. Although there may be other articles, if I were to do a more thorough search. Or an additional search, I should say."
MS. WOLSTEIN: Page 214, line 25:
"Q ever had any complications result because of an amniocentesis that you performed?
"A there are different times of amniocentesis.
"Q the ones that you performed?
"A I can't remember any. The ones I performed were different than the injections that would be done in this situation.
"I can't remember any complications from the ones I did which would have been at or near term."
MS. WOLSTEIN: Page 220, line 12:
"Q the second to last sentence states: 'there are few physicians in the country who have as much experience as I have in both clinical care and research.
"see that?
"A yes
"Q what is your basis for this statement?
"A there are very few -- that statement, to be correct, would be within family planning since -- I apologize for that error
"Q why would family plan being make a difference

"A there are very few physicians in this country that have as much experience in and clinical care as I have in the field of family planning.
"Q and then I guess, again, what is your basis for that statement?
"A there are relatively few specialists in family planning and contraceptive care that both provide clinical care and do research.
"if you do a med line search, my publications and my research and my funding far exceeds just about everybody. It is a community where we know each other.
"so, we know who the people are. I was recently promoted to professor, which required letters of support from peers to whom most learned people within family planning were included. I have seen their letters. They concur
"there are -- there is probably in other family planning research program in the country that has more funding than mine. Perhaps one other
"and based on the training we do the family planning fellowship programs of which there are 12 in the country that are available, that is what I base my opinion on."
MS. WOLSTEIN: Page 222, line 1:
"Q when you say family planning, what does family planning mean?
"A contra session and abortion. And early

pregnancy. Typically includes early pregnancy abnormals I miscarriages, those type of pregnancies
Most specifically contraception and abortion.
"Q abortion. When you say abortion, does that include high risk pregnancies and terminations in high risk pregnancies?
"A yes
"Q so, do you consider part of your area of specialities high risk pregnancies?
"A abortions in women with high risk pregnancies.
"Q and it is your opinion that you have as much or more experience than anyone in the country, both clinical care and research, with respect to pregnancy terminations in which there are high risk pregnancies?
"A in clinical care, yes. In research, not necessarily more than others. But in the field as a whole."
MS. WOLSTEIN: Page 223, line 1:
"Q what are some of the high risk pregnant skis that you had to deal with in the last year?
"A women with clotting disorders, blood clots in their legs, preeclampsia. Multiple sclerosis, strokes, cervical cancer, breast cancer, fibroid, large fibroid. Renal failure
"Q would you consider yourself more qualified to opine on high risk pregnancies than a maternal fetal medicine

specialist?
"A O you would have to define --
"Q who is board certified in maternal fetal medicine
"A you have to define what part of your care you would want me to qual myself for
"Q in handling high risk pregnancies
"A in what part of their care?
"Q in which they required termination of pregnanc.
"A yes.
"Q what is the Bates EUS for your opinion?
"A because I provide termination services and most of them do not."

MS. WOLSTEIN: Page 240, line note note page 240RBGS line 17.
"Q in your opinion, do you consider yourself to be an expert on fetal pain?
"A again, I would request clarification of what you consider expert to be in that situation.
"Q do you feel that you have the ability to opine at trial on fetal pain?
"A in the sense that irregular Larry take care of patients where this issue comes up and I have to be aware of the literature. And I interact on a virtually daily basis with patients where this issue comes you and I am expert in how you

discuss these issues with patients
"I am an expert in nursing what these issues are.
"I am not an expert this doing research on this especially since most people who understand this literature agree that a fetus does not feel pain then we would not be doing research object it.
Whereas people who are usually anti choice and want to prove that a fetus feels pain are the ones with those biases who do the research on it
So, that is the limitations. That is the breadth as well as limitations of my expertise."
MS. WOLSTEIN: Page 242.
(continued on next page) TWM 4/8 reading a deposition<] page 242 line 11.
"Q. Do you agree with the statement induction of labor is also indicated in some cases of pregnancy termination for fetal abnormalities?
"A. Yes."
Page 243/line 5.
"Q. Based on what is contained in the Goldberg and Creinin chapter, is it your opinion that misoprostol regimen is a safe option for women undergoing abortion in 13 to 31 week gestation range?
"A. 13 to 31? I will comment on abortion for 13 to 23 6/7.
"Q. OK?
"A. At this time, yes, it is a safe option."

Your Honor, that completes the government's counterdesignation.
THE COURT: Does that complete this witness? Chaiten TKHAEUPBT your Honor, there are a couple of PHRAEULGSs where counsel I think inadvertently failed to read the end of an answer F. I may read those into the record briefly.
THE COURT: I don't think it was inadvertence.
MS. CHAITEN: One of them was --
THE COURT: I know you made some objections on completeness and I made my ruling. You may read them at the end. But it wasn't inadvertent.
MS. CHAITEN: Your Honor, counsel and I discussed this prior to the reading of her testimony, she said she would read allful answers for completeness purposes in the course of their presentation. But I believe that they inadvertently failed to read in in a couple of places, so I would like to read those into the record.
THE COURT: You may.
MS. CHAITEN: Thank you.
Since these are just portions of answers, I will simply read them quickly. On page 120/line 13: "If a woman wants to see and hold her baby and does not want to go through labor, which I think would be a very reasonable way of going about that, then I can refer her to somebody who is experienced and trained rather than have me try and do something that I

don't know how to do or don't have experience with and haven't been taught to do."
Then the second one is on page 181/line 2. "I'm roughly able to, because of the few number of people, provide the services and the discomfort level of doctors in the community in handling anything related to these cases, if a patient has a complication, their doctor does not want to or even want to begin to try and deal with that complication. So I hear of it immediately. Then usually -- they usually either come back, the patient comes back to me or they talk to me even before going to their own doctor."
Thank you, your Honor.
THE COURT: That's it?
MS. CHAITEN: That's it.
THE COURT: That completes that witness. Mr. Hut, call your next witness.
MR. HUT: Plaintiffs call Dr. Stephen T. Chasen.

STEPHEN T. CHASEN,
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: First name Stephen, STEPHEN. Middle name Todd, TODD. Last name Chasen, CHASEN.
THE CLERK: Thank you. Please be seated.

DIRECT EXAMINATION S-

BY MR. HUT:
Q. Good morning, Dr. Chasen. Are you a physician?
A. Yes, I am.
Q. Are you a plaintiff in this lawsuit?
A. Yes, I am.
Q. Where are you currently employed, Dr. Chasen?
A. I am employed by the Weill Medical College of Cornell University, where I am a member of the full-time faculate.
Q. Do you have privileges, Dr. Chasen, at any hospital?
A. I have privileges to practice medicine at the New York Presbyterian Hospital and at flushing Hospital medical center in Queens.
Q. What position do you hold at Weill Medical College of Cornell University?
A. At the medical college I am an associate professor of obstetrics and gynecology.
Q. How about at New York Weill Cornell Medical Center?
A. At the medical center I am the director of high-risk obstetrics, I am the co-director of the obstetrics and gynecology residency, and I am the associate director of the maternal fetal medicine fellowship.
"Q. What are your responsibilities, Dr. Chasen, at Weill Medical College of Cornell University and at New York Weill

Cornell Medical Center?
A. As a member of the faculty at the medical college, my responsibilities include teaching medical students as well as residents in training and fellows in training, both die dact I can teaching and clinical teaching that occurs as part of patient care. My responsibilities at the medical KRERBGT as the director of high-risk obstetrics I supervise the high-risk obstetric clinic in providing antepartum care to women with high-risk pregnancies --

THE COURT: What does antepartum mean, professor?

THE WITNESS: Antepartum care is prenatal care. It is before birth.

THE COURT: Would you try and keep your responses in simple English.

THE WITNESS: Yes.

THE COURT: So that anyone could understand this transcript.

THE WITNESS: Yes. I'm sorry.

A. I am in charge of running the high-risk prenatal clinic, where we provide prenatal care towards patients who are high-risk. I also run the prenatal diagnosis unit at the medical college, where we provide ultrasound in a basic prenatal diagnosis with procedures like amniocentesis or chore KWROEUPBG SREULS sampling.

THE COURT: Does high risk have a meaning in

obstetrics, Doctor? Is that some word of art or is that the simple English usage? What does it mean to you? S- S- (w) to .

THE WITNESS: To me a high-risk situation in comparison to someone of regular risk or low risk implies that she would be at higher risk of one of any given range of complications in her pregnancy. It could relate to preexisting health problems that the mother may have. They may relate to health problems that could arise in the course of a pregnancy. They could arise in healthy women who themselves don't have medical problems but in whom a problem relating to fetal health may be identified at some point in pregnancy.

THE COURT: Is that the health of the baby or the fetus?

THE WITNESS: Yes.

Q. Dr. Chasen h do you have any responsibility for the residency program?
A. Yes. I am the co-director of the residency program. In the administrative capacity of that position, I play a large role in residency selection, I play a large role in die dact I can teaching and scheduling die dact I can lectures for the residents as well as the ones I give myself. I also participate in daily rounds in the hospital on labor and delivery in patients who are laboring, as well as pregnant women who need to be hospitalized who aren't in labor and they may be hospitalized for a variety of complications.

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Q. You made reference now a number of times to die dact I can teaching. Can you distinguish for the Court between die dact I can and clinical teaching?
A. Sure. In the clinical setting I am giving a lecture, usually a preprepared lecture, for instance with slides or handouts, not in the medical ward but in a conference room typically. When I talk about teaching in the course of clinical care, typically a resident or fellow will present a patient to me, and in deciding what the proper care, what is the proper care that we should provide to this patient, I will make relevant teaching points and perhaps expand that to related conditions. [> die dact I can was the first one<]
Q. Do you serve on any hospital committees, Dr. Chasen?
A. I do. I am a member of the quality assurance committee and I am a member of the patient safety committee.
Q. Can you describe briefly the functions of both the quality assurance committee and the obstetric patient safety committee.
A. The primary responsibility of the quality assurance committee is to review cases that are referred to us. These cases can be referred because of complications the patients may have had. They can also be referred to us because of complaints that patients or family members have made to patient services, and that triggers an automatic referral.
The patient safety committee is charged with identifying areas of concern and trying to head off potential

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problems. Developing protocols that will maximize patient safety and try to avoid complications.
Q. How frequently dot committees meet?
A. Both committees meet regularly, once a month. The quality assurance committee can also be called in on very short notice if there is a particular case that warrants immediate attention.
Q. As a plaintiff, why did you bring this lawsuit?
A. I participated as a plaintiff in this lawsuit because the partial-birth abortion Act would interfere with my ability to provide the best medical care I can for my patients.
Q. Let's some more a bit about your background. From when did you obtain your medical degree, Dr. Chasen?
A. My medical degree is from Jefferson Medical College in Philadelphia.
Q. In what year did you obtain it?
A. In 1992.
Q. Aside from your medical degree, Dr. Chasen, have you received any other medical training?
A. After I completed medical school, I did an internship and a residency in obstetrics and gynecology from 1992 through 1996 at the Thomas Jefferson University Hospital in Philadelphia. Following that, from July '96 to June of 1998, I did a maternal fetal medicine fellowship at what was then the New York Hospital and Cornell University Medical College.

THE COURT: Where did you get your undergraduate degree?
THE WITNESS: At Penn State.
Q. There has been some testimony in the record so far, but why don't you just tell the Court briefly what maternal fetal medicine is.
A. Maternal fetal medicine, it is a recognized subspecialty of obstetrics and gynecology. Before this was called maternal fetal medicine, many people referred to it and some still refer to it as high-risk obstetrics. Maternal fetal medicine, again, it comprises a variety of things in pregnancy. The maternal aspect of it relates to pregnant with him that may have medical problems that predate the pregnancy or they may have medical problems that are identified during the pregnancy, or obstetric complications that are pregnancy-related and which naturally are identified during the pregnancy.
The fetal aspect of it relates to prenatal diagnosis of fetal abnormalities, and it relates to assessment of fetal health typically after viability in identifying fetuses that might benefit from therapy or more commonly a timed delivery, fetuses that are better off outside of the uterus than within it. S-
THE COURT: Is this another word or another way to phrase "abortion"?
THE WITNESS: In what I was just referring to --

THE COURT: Yes, internal fetal medicine, is it just another name for those who provide abortion?
THE WITNESS: No. Most abortion providers are not maternal fetal medicine superb EURBLTS.
THE COURT: Is there a distinction between an abortion provider and an abortionist?
THE WITNESS: I think those terms refer to the same thing.
THE COURT: But maternal fetal medicine is broader?
THE WITNESS: Yes, and most maternal fetal medicine specialists are not abortion providers.
THE COURT: They are not? PW-PBLG no, not to my knowledge.
Q. What part of your practice as a maternal fetal medicine specialist, Dr. Chasen, involves bringing high-risk pregnancy to say term and delivery?
A. The vast majority of my clinical TPHAEFRS as a maternal fetal medicine specialist is towards achieve the goal of having healthy mothers deliver healthy babies and, if possible, at term. Preterm birth is the most common complication that I treat, however.
Q. Do you currently practice medicine TKRRBGS chains?
A. Yes, I do.
Q. For how long have you done so?
A. Since I graduated medical school in 1992.

Q. Please describe for the Court, to the extent you have not already, any specialties you have in the practice.
A. Do you mean in terms of board certification?
Q. Sure.
A. I have board certification from the American Board of Obstetrics and gynecology in general obstetrics and gynecology as well as in the subspecialty of maternal fetal medicine.
Q. When did you receive those board certifications?
A. I received my certification in general obstetrics and gynecology in 1999 and maternal fetal medicine 2001.
Q. In what setting or settings do you currently treat patients, Dr. Chasen?
A. I treat patients in the prenatal clinic, patients who are out-patients who come for scheduled appointments. I treat patients who are also out-patients who come for scheduled appointments to undergo ultrasound or other forms of prenatal diagnosis, women who come as out-patients for consultation. Some of these women may be planning a pregnancy and they wish to discuss potential complications and management. Or women who are already pregnant and may be encountering a complication and again we discuss management options and recommendations.
And I treat patients in the hospital, both who are in labor and delivery and patients who are hospitalized and pregnant but are hospitalized for other complications not related to delivery.

Q. Can you give the Court some idea of how many patients are currently under your care and perhaps distinguish between those under your direct care and those for which you have responsibility.
A. Patients under my direct care, the patients in the high-risk obstetric clinic, I believe at any point in time we are following between 50 and 75 patients in the prenatal clinic. I provide care to all women who come for ultrasound examinations, and we see more than 5,000 patients a year in my unit for ultrasound.
THE COURT: You don't do all of them yourself, do you? You personally, do you do 5,000?
THE WITNESS: No, no. We have 12 rooms and we have tech anythings who do the primary screening, and I and my colleagues review all the results. But no, I don't make contact with all of these women.
Q. Dr. Chasen, can you expand a bit on the range of obstetric care and counseling you provide to your patients S-
A. I provide care, counseling, to patients marks any patients who are not pregnant, patients who may have had a prior pregnancy that had some complications that they are very anxious to avoid in the next pregnancy; patients with medical conditions that could complicate a pregnancy. And again the best time to come up with a management plan is before they get pregnant. Women who are taking medications where there is a

question about toxicity to the developing baby and which I may recommend a change in medication regimen to avoid this.
I'm sorry. What was the question again?
Q. You may have completed the answer. I was inviting you to share with the Court a more general description or explanation of the range of obstetric and gynecological care that you provide?
A. The patients in the high-risk clinic who receive prenatal care coming for scheduled visits at which time we assess maternal health and fetal health as well as any problems related to the reason they are in a high-risk clinic. And I, again, provide care to women that are referred for having complications during pregnancy, hospitalized patients who are pregnant I provide direct care to, and I have some responsibilities in covering labor and delivery and actually doing or supervising deliveries, vaginal delivery and Cesarean births.
Q. In addition to ultrasound to which you made reference a moment ago, are you familiar with other methods or modes of diagnosis or assessments of fetal condition during pregnancy?
A. Yes. Ultrasound' is the most common way we assess fetal health. There are invasive tests that can be done to detect genetic conditions, something called chorionic SREULS samples or CMS done T-TD end of the first trimester, amniocentesis, that's done in the second STREUPL ter.

THE COURT: What is that, Doctor?
THE WITNESS: I'm sorry?
THE COURT: What is that? I am asking you to keep your medical terms in simple English language. Winning amniocentesis is a procedure whereby a needle under ultrasound guidance is placed through the maternal belly into the uterus and amniotic fluid, fluid in the amniotic sac is aspirated through this needle. Within this fluid are fetal cells and a variety of conditions can be tested for by assessing amniotic fluid.
Q. When is amniocentesis typically performed, Dr. Chasen?
A. The most common context is in the second trimester for genetic diagnosis, and then it is performed typically from 15 to 20 weeks, although there are circumstances when the need or the option for that procedure arises later in pregnancy.
Q. Once the sample is taken from the amniotic fluid, is there some time required for it to be analyzed in the laboratory?
A. Yes. The most common test that is performed is a genetic test looking at the number of chromosomes, and it is done to identify fetuses that have conditions such as down syndrome or Turner syndrome or other syndromes. S- that takes between one and two weeks, depending on the lab that the fluid is sent to.
Q. Do you perform surgery, Dr. Chasen?
A. Yes, I do.
Q. What types do you perform?

A. Surgical procedures, I perform Cesarean delivery, which is when a baby is delivered through an incision in the uterus and the maternal abdomen. I perform procedures in women who are pregnant, and these include something called a cervical sir KHRAPBLG, which is a stitch tied around the cervix this is done with the intent of preventing preterm birth. And in some women I also perform abortions.
Q. Approximately how many times in your career have you performed abortions?
A. This my career probably, including first and second trimester, I would estimate about 500.
Q. How does that divide as between first and second trimester?
A. I think the first trimester abortions, and most of these I did during my residency, were probably 50 percent of it, and the rest would be second trimester.
Q. Does the number you just supplied include surgical treatment or management of spontaneous abortion?
A. Yes, it does include that.
Q. Approximately how many abortions have you performed or supervised over the past year, Dr. Chasen?
A. About 50.
Q. How many of those were second trimester?
A. Over the last year all of them.
Q. What type of abortions have you performed?
A. I have performed abortions using suction curettage.

Typically, these are before 14 weeks of gestation. And I perform surgical abortion with dilation and evacuation in which the cervix, unless it is a woman that has a form of preterm labor miscarriage who spontaneously dilates her cervix, dilation and evacuation involves placing laminaria in the cervix and then evacuating the fetus and the placenta from the cervix one or two days later typically.
Q. Have you performed second trimester induction abortions, Doctor?
A. I have, yes.
Q. You testified about your abortion procedures performed over the past year. Currently, what type of abortion procedures are you performing?
A. Surgical abortions.
Q. Are those second trimester abortions?
A. Yes. Over the last year those are the only -- D&E is the only procedure I have done over the last year.
Q. Give us the range with respect to gestational age of the area in which and the time in which you performed second trimester surgical abortions S-
A. With the KEPGS of cases of fetal demise, which may exceed 24 weeks, and these are all from 13 weeks to 23 weeks and 6 days.
Q. When you say with the exception of fetal demise, do yo do you refer to situations in which there has been fetal demise prior

to the performance of any surgical procedure?
A. Yes. Spontaneous fetal demise or what some would call still birth.
Q. Did you have any training in abortion procedure or practice, Dr. Chasen?
A. Yes, I was.
Q. Can you describe that training for us, please.
A. During my residency, I was trained in techniques of first trimester abortion going up to about 12 weeks and using suction curettage, which is a form Aickin to vacuum aspiration. That was during my residency. I had very minimal exposure and just observation of second semester surgical abortion with D&E.
THE COURT: What year was that, Doctor?
THE WITNESS: My residency was between 1992 and 1996.
A. Starting in my fellowship when I came to the New York Hospital in 1996, I received training in performing something and evacuation, the form of surgical abortion in the second trimester S-
Q. Are you familiar with a variation of D&E procedure known as intact something and evacuation, or intact D&E?
A. Yes, I am.
Q. Have you heard that procedure referred to by any other name, Dr. Chasen?
A. I have. I have heard it referred to as, besides intact D&E, "intact dilation and extraction" or "intact D&X" or just

"D&X" and "partial-birth abortion."
Q. Is "partial-birth abortion" a medical term?
A. No, it is not.
THE COURT: Is this a convenient time to take our morning recess, Mr. Hut? Or do you have some line that you wish to continue for a short time?
MR. HUT: No. This will be a fine time, your Honor.
THE COURT: We take our recess.
(Recess)
THE COURT: Mr. Hut, you may inquire.
MR. HUT: Thank you, your Honor.
BY MR. HUT:
Q. Dr. Chasen, approximately how many D&E procedures have you performed during your career?
A. Between 200 and 300 by my estimation.
Q. Have you ever performed an intact D&E, Doctor?
A. Yes, I have.
Q. Approximately how many times?
A. I would estimate between 50 and 75.
Q. Do you perform intact D&E as a part of your regular practice, Dr. Chasen?
A. Part of my regular practice does include performing second trimester surgical abortion, and as a part of my regular practice I do that procedure in some cases.
Q. With respect to your teaching responsibilities at the

medical school and the medical center, what subject or subjects do you teach?
A. I teach really any and all aspects relating to obstetrics, including regular obstetrics, high-risk obstetrics, maternal fetal medicine, including prenatal diagnosis, including management of fetal anomalies, which in some cases includes abortion.
Q. Approximately how does your time divide between didactic teaching on the one hand and your other duties?
A. Purely didactic teaching probably accounts for between 10 and 20 percent. Teaching in the clinical setting I do more commonly on a daily basis.
Q. In the course of your clinical work, Dr. Chasen, do you have any responsibility for training other physicians?
A. Yes, I do.
Q. Could you describe that, please.
A. Sure. My responsibilities include training residents who are in training in obstetrics and gynecology and training people who have completed a residency and are doing a fellowship in the subspecialty of maternal fetal medicine I. teach medical students as well.
Q. Does your institution, Dr. Chasen, offer any training in abortion procedures?
A. Yes, it does.
Q. What types of abortion procedures are taught at your

institution?
A. Surgical abortion done in both the first and second trimester, as well as methods of medical abortion again in the first and in the second trimester.
Q. Is the intact D&E variation taught in your institution?
A. Yes, it is.
Q. To approximately how many medical students or residents?
A. All the residents have the opportunity to participate in D&E, including the intact variationrs, and in my residency program the majority of them do. So the majority do have exposure and do receive teaching of this.
THE COURT: Are they required to?
THE WITNESS: They are not required to, no.
Q. How many are in the residency program?
A. There are 25 residents at any given time.
Q. Are you a member, Dr. Chasen, of any professional associations?
A. I am a member of ACOG, the American College of Obstetrics and Gynecology, and a fellow of the society for maternal fetal medicine.
Q. Have you authored any publications TKRRBGS chains?
A. Yes, I have.
Q. On what general subjects?
A. Subjects pertaining to maternal fetal medicine, some papers relating to maternal complications in pregnancy, some papers

relating to renatal diagnosis of various conditions, and a couple of papers relating to abortion.
Q. How many papers have you authored that have been published in peer reviewed journals?
A. Between 25 and 30.
Q. What was the publication date, Dr. Chasen, of the most recent article that you authored or to which you contributed that has appeared in a peer reviewed journal?
A. March of 2004.
Q. In what journal did the article appear?
A. That was the American journal of obstetrics and gynecology.
Q. On a generalized level, without any technicalities, what was the subject of the article in the American Journal?
A. The subject of the article was relating to first trimester screening for Down syndrome and the impact that the screening has had on ways in which women make decisions about prenatal diagnosis.
Q. Do you yourself perform peer review for scholarly journals?
A. Yes, I do.
Q. Which ones, Dr. Chasen?
A. I have been a peer reviewer for the journal we just mentioned, the American journal of obstetrics and gynecology.
THE COURT: Is that published by ACOG?
THE WITNESS: No, it is not.
A. But I have been a peer reviewer for the journal that is

published by ACOG, which is called just obstetrics and gynecology. And I have been a peer reviewer for I believe the American journal of perinatology, the international journal of gynecology and obstetrics, the journal of maternal fetal medicine, and I think the journal of the -- the American journal of medical genetics, I believe.
Q. Dr. Chasen, have you received any honors or awards for teaching?
A. Yes, I have. Every year the graduating chief residents in obstetrics and gynecology give an award to the one faculty member for outstanding teaching, and I have received this award three times: In 1998, 2001, and 2003.
MR. HUT: Your Honor, may I approach with exhibits for the witness, please?
THE COURT: Surely.
Q. Dr. Chasen, please have a look at what has been marked Plaintiffs' Trial Exhibit 84, tab 84 in the book I just has handed to you. Do you recognize it?
A. Yes, I do.
Q. What is it?
A. This is a biographical sketch in the National Institutes of Health format. It is a curriculum vitae, or a CV.
Q. As of the date of its preparation is it an accurate summary of your education and experience?
A. Yes, it is.

MR. HUT: Your Honor, plaintiffs move into evidence Plaintiffs' Trial Exhibit 84.
MS. GOWAN: No objection, your Honor.
THE COURT: It will be received. [>
Q. Dr. Chasen, what, if any, steps do you take to remain current on developments within your medical specialties?
A. I on a monthly basis, which is the frequency of publications in those journals, I am aware of and I read the articles pertinent to maternal fetal medicine. I attend every year the annual society for maternal fetal medicine conference at which new and important research is presented. I read textbooks and newer editions of textbooks, ones that I contribute to and ones that I haven't.
MR. HUT: Your Honor, at this time plaintiffs offer Dr. Chasen as an expert in obstetrics and gynecology, in maternal fetal medicine, in abortion procedure and practice pursuant to Rule 702 of the Federal Rules of Evidence. Gowan TKPOUPB no objection, your Honor.
THE COURT: The Court will so recognize him.
Q. Dr. Chasen, in your opinion, what is the relationship between an intact D&E and a dismemberment D&E?
MS. GOWAN: Objection to the form of the question.
THE COURT: Could I have the question, please.
(Question read)
THE COURT: Sustained. Could you rephrase it, Mr.

Hut.
Q. What is the relationship, Doctor, if any, between intact D&E and the dismemberment form of D&E?
MS. GOWAN: Objection, your Honor.
THE COURT: I will allow it.
A. They are both dilation and evacuation procedures in which the cervix is in most cases deliberately dilated and the evacuation component is removal of the fetus and the placenta. They are both variations of D&E, one that involves dismemberment of the fetus with forceps and the other that accomplishes D&E primarily through breech extraction.
Q. Which is which?
A. The intact version of dilation and evacuation is the one that typically involves breech extraction.
Q. What is your goal or objective when you perform an intact D&E, Doctor?
A. My goal when I perform any D&E is to do it to minimize the risk of trauma to maternal tissues, including the uterus and the cervix. In any D&E I perform, my goal is to remove the fetus as intact as possible. So my goal in intact D&E is just that.
Q. Dr. Chasen, do you prepare a patient differently for one variation of D&E versus the other at the same gestational age?
A. No.
Q. Can you describe briefly for us, Doctor, how you perform

the D&E procedure in your practice.
A. The dilation portion of the procedure -- again, there are some patients who have spontaneous dilation who may have been in preterm labor in whom the dilation portion is not required. But absent that, the first step in the procedure, after obtaining informed consent and having a detailed discussion with the patient --
THE COURT: I would like you to stop there, Doctor. What do you mean by detailed information to the patient?
THE WITNESS: What I mean is discussing what the patient will experience and what will be done in the course of the procedure.
THE COURT: Do you tell a patient that they have options?
THE WITNESS: Yes, I do, options including continuing the pregnancy as well as the option for some patients of medical induction of labor.
THE COURT: Do you describe the D&E to them?
THE WITNESS: Yes, I do.
THE COURT: Do you describe the dismemberment to them?
THE WITNESS: I describe and all patients are aware that the dilation of the STEFRBGS is typically not enough to allow passage of the fetus intact. They are all aware that the procedure in almost all cases inherently involves some destruction of fetal tissue.

THE COURT: Do you tell them that in the process you tear limbs off their baby, the fetus? Do you tell them that?
THE WITNESS: Some patients I do.
THE COURT: But not all? Is that what you are saying, you don't tell them all?
THE WITNESS: These are patients most of whom I have been following for prenatal diagnosis --
THE COURT: I didn't ask you that, Doctor. I asked you a simple question: Do you tell them that the procedure entails your taking forceps and tearing a leg or an arm off the fetus and removing their baby in parts?
THE WITNESS: In general terms, in terms of using forceps in some cases and removing the fetus in parts, I do tell them that.
THE COURT: Do you tell them you actually -- you people I think like the word, what is it -- what do you use for technically to remove it?
THE WITNESS: I don't use the term "disarticulation" with patients.
THE COURT: You don't use that one? That was use add lot here in TKOURT. You don't use that?
THE WITNESS: No, I don't use that with patients. That probably wouldn't mean anything to them.
THE COURT: I wouldn't think so. Do you tell them that it physically tears off?

THE WITNESS: When I am describing the procedures with forceps?
THE COURT: Yes. Do you tell them straight out what you are doing? No should go arcoating, just you tear it off and remove it in pieces?
THE WITNESS: There is nothing I can do to make this procedure palatable for the patients. There is no should go arcoating.
THE COURT: I didn't ask you that, Doctor. I know it is not pleasant. I want to know whether or not these people know, have a fully-educated discussion with you what you are going to do.
THE WITNESS: We have a full and complete discussion about the fact that in most cases the fetus will not pass intact through the cervix and in many cases --
THE COURT: No, let's go back. I asked you a simple question. Do you tell them you are going to tear limbs off?
THE WITNESS: I don't have simple discussions with my patients. I have involved discussions. I can share with you what I tell my patients.
THE COURT: Go ahead. I am asking you, do you tell them you tear it off?
THE WITNESS: I initiate the discussion in general terms, and they always include the possibility that destructive procedures will be done to facilitate removal of the fetus.

THE COURT: Do you do it in nice should go arcoated words like that?
THE WITNESS: My patients are under no illusions and they don't regard that as should go arcoating andnd they are usually devastated-
THE COURT: How do you know, Doctor, do you see into their minds?
THE WITNESS: These are patients most of whom I have cultivated a relationship, and I can tell.
THE COURT: Oh, you can tell. Do you ever use the word you are going to tear the limb off?
THE WITNESS: Yes, I do, I use that terms sometimes.
THE COURT: You do?
THE WITNESS: Yes.
THE COURT: Sometimes?
THE WITNESS: Sometimes.
THE COURT: When you discuss an intact D&E, do you tell them that when the baby or fetus gets to the point where it is outside the mother up to, if it is a breech presentation, you are going to make an incision in the base of the skull?
THE WITNESS: At the time I am counseling a patient, I don't know what form of D&E I am going to use.
THE COURT: Well, when you are giving them all the options and you are describing this particular one, you tell me you do tell them.

THE WITNESS: That is not an option I give them. Their option is to have a D&E or to continue the pregnancy or to have a medical induction of labor. When I am telling them D&E, again, in general terms that some destruction of the fetus will be necessary and --
THE COURT: No, Doctor, let's get back. TKOUTS them that if it comes to that procedure, you will take a pair of scissors and insert them in the base of the skull?
THE WITNESS: I don't use those terms, but, again, they know that the brain has to be removed so allow --
THE COURT: You don't use those terms?
THE WITNESS: I don't talk about the specific instruments that I use to accomplish this.
THE COURT: Do you tell them that your going to suck the brain out of the skull?
THE WITNESS: I don't use the term "suck" but I say the brain has to be removed so that the skull will fit through the cervix without injuring them.
THE COURT: Do you ever discuss with them whether or not in the D&E, the dismemberment, when you tear limbs off, do they ask you, does it hurt?
THE WITNESS: Patients have asked about if --
THE COURT: What do you tell them?
THE WITNESS: I tell them that neither I nor anybody knows for sure whether it does.

THE COURT: But that it might?
THE WITNESS: I share with them some observations. I tell them I think to the extent that they receive a good degree of sedation or general anesthesia, that I am confident that the fetus also receives --
THE COURT: Some?
THE WITNESS: I share with them some observations that I make. I would be happy to share it with you.
THE COURT: Do you tell them there are some studies that suggest that fetuses do feel pain?
THE WITNESS: There are some authors of some studies who suggest that fetuses do feel pain. There aren't any studies that directly address the question.
THE COURT: Do you tell them that?
THE WITNESS: I tell them we don't know and we can't know for sure whether the fetus feels pain. But I tell them that I am confident based on my observations --
THE COURT: Having been a baby once?
THE WITNESS: I don't make reference to that.
THE COURT: Next question.
BY MR. HUT:
Q. Doctor, why, in your judgment, do you sometimes not use with your patients some of the language that Judge Casey used in his questions to you?
A. Almost all the patients I see have desired pregnancies,

planned or unplanned, they have been very happy to be pregnant, and at some point recently they have received some devastating news. Again, most of these patients uh I haven one of the physicians who participated in the process of prenatal diagnosis. Patients consult with gentists, with PAOED TRAT yes, I can SPERBLG it's w their families members, with their loved ones, and they make the decision that they think is right for them as TKEUFGT as it may be. When they come to me to talk about a D&E they are already in the grieving porosis. Many patients confide with me that what they are going to do violates every moral and religious belief they may have had to that point, but they are choosing to do that because they think it is the most appropriate thing for them to do.

THE COURT: Do you have women come to you who have no fetus with a fetal anomaly, no problem medically at all, who just want to terminate the pregnancy?

THE WITNESS: I don't see those patients as part of my practice.

THE COURT: You don't do those?

THE WITNESS: Those patients don't get referred to me as part of my practice as a maternal fetal medicine specialist.

THE COURT: Have you ever performed an abortion that was optional and had no medical necessity?

THE WITNESS: Yes.

THE COURT: Do you tell those women what is being done

in the terms we discussed a few moments ago, the dismemberment or the intact D&E, what the procedure entails?

THE WITNESS: All the abortions I did or almost all of them that were, as you described, occurred during my residency and I learned them at a Planned Parenthood clinic where the physician is not part or was not part of the detailed informed consent process. So I don't know specifically what those patients were told.

THE COURT: Have you performed any that were OPGal pregnancies in the second trimester since you have been at Cornell?

THE WITNESS: Since I have been a maternal fetal medicine specialist the only abortions in the second trimester I have performed on presumably normal fetuses were in mothers with medical conditions making continuation of the preg TPHAEPS dangerous for the mother.

THE COURT: Have you done any where neither the fetus nor the mother had a medical condition that required abortion?

THE WITNESS: In part of my training during my fellowship I did some of those cases, yes.

THE COURT: And did you do so to them what is involved in various types of abortion?

THE WITNESS: Those cases that I was doing as part of my training where patients of an attending physician who had put the laminaria in.

THE COURT: The question is simple, Dr. : Did you tell them or not?
THE WITNESS: These were patients under anesthesia at the time I walked in the room and I didn't have a discussion with them before the procedure.
THE COURT: I take it the answer is no, you didn't tell them?
THE WITNESS: The answer is no, I didn't tell them.
(Continued on next page) 4/8/04 Judge TA*EUSy take 3. Direct of Chasen by Hut.
BY MR. HUT:
BY MR. HUT:
Q. Dr. Chasen had you concluded your answer concerning the state of the patients based on your observations of them at the time they make a decision to terminate pregnancy in the second fry mester?
A. I hadn't finished manufacture what I was saying is that I have a relationship with some of these patients. I've been following them sometimes for days and sometimes for weeks. And I think I am -- I use my judgment as a physician and a human being as to what details to provide what patients. And I always ask patients if they want more details or if there is any information they want or if they have any questions that I haven't answered to their satisfaction.
And some patients insist on every detail I can provide them and very no problem doing that.

Q. Doctor, in earlier answer, again I think in response to a question put to you by his honor, you made reference to certain observations you have made concerning fetal response to stimuli and response to anesthesia; what were those observations?

A. In some cases prior to inserting lamb TPHAEUR why and performing the abortion procedure I will do a procedure to effect fetal death.
I will inject the fetus with potassium which will stop the heart. The most common way to do this is by injecting a fetal directly into the heart of the fetus under ultrasound guisance.
New these cases the mothers are no anesthetized and the fetuses don't receive any anesthesia by route of the mother.
And in every one of these cases, upon contact of the needle with the fetal chest, I see a withdrawal response of the fetus, recoiling that I can see on the ultrasound.
THE COURT: Are you trained in fetal pain?, as such?
THE WITNESS: No.
THE COURT: Next question.
A. I was --
Q. I think describing your practice in performing D&E, perhaps you want to continue that from perhaps from the outset.
A. Okay.

My practice in performing D&E?
Q. Yes.
Just describe for us if you can how you perform a D&E?
A. I perform a D&E, again in patients that don't have span containous serve call dilation following the detailed informed consent process the next step is to insert laminaria into the cervix which will accomplish dilation in advance of evacuation of the fetus and the placenta.
Depending on the SKWREGS TAEUGSal age and the fetal size I may put in the laminaria, may be done just one day prior to the procedure or they may be done both two days and one day prior to the procedure to achieve a greater degree of cervical dilation.
The day after the last insertion of laminaria the patients come to the operating room, they receive anesthesia, they are placed up in stirrups, the laminaria are removed, they receive sister I'll wash and sterile drapes are placed.
Once they're under anesthesia I do an examination and based on the dilation of the cervix, based on the proximity of the cervix to the opening of the vagina, based on the fetal position that I can determine by palpation or with ultrasound that I have there, I determine the, what I feel will be the most appropriate way to evacuate the fetus from the uterus.
Q. And what might those appropriate ways be?
A. The two ways to do D&E are with forceps. And had forceps

are involved in most cases disarticulation or dismemberment of the fetus will occur in the process of removing the fetus from the uterus although in some cases the fetus may come out intact using forceps or intact at least to the level of the head. But in some cases intact entirely.
If I make the determination that the cervical dilation and the proximity of the cervix to the vagina and the fetal position would enable me to do a breech extraction, then I will deliver the fetus like that and this will involve either manually, with my hands, bringing one or both of the legs through the cervix into the vagina, proceeding with a breech extraction P.
And in most cases the degree of cervical dilation will not accommodate passage of the fetal head through the cervix. And in this case my practice is to make an incision at the base of the skull with the scissors which I can do really under direct visualization, place a suction device within the skull, the brain tissue is aspirate and typically the head then delivers easily.
Q. And what do you do in the event that you are not able to --
THE COURT: Excuse me.
Does that mean because the skull collapsed.
THE WITNESS: Yes.
THE COURT: That it delivers easily.
THE WITNESS: Once the skull has collapsed.

THE COURT: Okay.
Go ahead PHRRBGS Hut.
BY MR. HUT:
Q. When are you not able to achieve a breech extraction and a relatively intact extraction, how do you evacuate the uterus in a D&E?
A. Again, in most cases this requires multiple insertion of forceps which will grasp parts of the fetus and in most but not all cases, involve dismemberment of the fetus and removal from the uterus in parts.
Q. And at what point in the process, just to be clear, do you decide which variation to perform?
A. At the -- after the PHOERPBLG is under -- after the lamb TPHAEUR is removed the mother is under anesthesia and I do an examination under anesthesia and again assess the degree of cervical dilation, the proximity of the cervix to the vagina and the position of the fetus by palpation or ultrasound.
I make a general determination.
Now, in some cases I don't think I can remove the fetus with breech extraction, however my first pass with forceps I may in fact bring a leg through the cervix into the vagina and not disarticulate or separate it from the body of the fetus.
THE COURT: Tear it off, right *R, Doctor?
THE WITNESS: I don't tear it off.

If that's the case then I can attempt to continue the case as a breech extraction.
Q. At what gestational age or ages are you typically able to achieve breech extraction relatively intact?
A. In general, but not exclusively, after about -- after 20 weeks. 20 weeks and zero days there is -- it's possible to do it.
At those gestational ages it is typically easier to achieve a higher degree of cervical dilation and the fetus is less likely to be dismembered or torn apart just by manual traction and doing a breech delivery.
But there have been cases of women who have had advanced degrees of cervical dilation prior to 20 weeks in which intact delivery is possible.
Q. When you perform a D&E, Dr. Chasen, where is the cervical os or opening? Relation to the vaginal opening?
A. It can vary widely between patients.
In women -- there are a couple factories.
Women that have been through labor before and delivered vaginally tend to have the muscles in the pelvis are stretched and these are the muscles that support the uterus and cervix and they can have a form of condition called prolapse which is basically when the cervix, which is usually 8 to 10 centimeters internal to the opening of the vagina but in some women with this condition, the cervix can be within a

centimeter or two, can can be, or visible entirely at the opening of the vagina.
Women who have the procedure under general anesthesia, the cervix is more likely to be lower because general anesthesia provides a great deal of relaxation to these muscles that support the uterus and the cervix.
So, it depends postally on obstetric history and it depends on what type of anesthesia is being used.
Q. And do those variables that turn on obstetric history dictate the same result in the case of a dismemberment D&E and intact D&E as to where the cervical opening is, vis-a-vis the vagina?
A. No.
In women, again, that have had one or more vaginal births before the cervix will more likely be close to the vaginal opening compared to women who haven't been through labor.
Q. And as between variations of D&E, does that affect where the cervical opening is, vis-a-vis the vagina TPHAPL opening?
A. No, it does not.
Q. Sand in those cases where the cervical opening is at the level of the vaginal opening, where is the fetus when you extract it from the uterus in relation to the woman's body?
A. This is in D&E with intact extraction or with --
Q. Either. As you are exTRABGTDing the fetus either intact or

in parts, in the case of the situations you described where the cervical opening is level with the vaginal opening, where is the fetus, either intact or in parts, as to the woman's body?
MS. GOWAN: Objection. Compound.
THE COURT: Sustained.
MR. HUT: I will try to rephrase it.
Q. In the circumstance you described where the cervical os is at the same level as the vaginal opening, when some or all of the fetus is extracted in a D&E procedure, where is the fetus or fetal parts in relation to the woman's body?
THE COURT: Could you read that question, again? I think you have now anot achieved your goal in rephrasing it, but. Read the question, please?
(record read).
THE COURT: Simplicity helps a lot, Mr. Hut. Why don't you try again.
MR. HUT: This concept is not as simple as I would like it, your Honor and I understand the question was complex. I will try to rephrase it one more file.
THE COURT: If you take it in pieces instead of trying to do it all. Sort of like would you give me the answer I would like the better one I ask you.
MR. HUT: It was not my intention to ask it that way, your Honor.
BY MR. HUT:

Q. In the case of where the cervical os is at the level of the vaginal opening, where is the fetus in relation to the woman's body when extracted from the uterus?
A. Parts of the fetus may be in the cervix in the uterus and parts of the fetus may be external to the vaginal opening.
Q. Dr. Chasen, do you have an opinion regarding the safety of D&E?
A. Yes, I do.
Q. What is that opinion?
A. My opinion is that it is the safest method of abortion in the second trimester.
Q. What are the bases or basis for your opinion, Doctor?
A. The basis for my opinion is my experience and my interpretation of statistics gathered by the center for disease control as well as other studies in the medical literature.
Q. Dr. Chasen, when you earlier described the counseling that you give to patients when they come to you with the possibility of terminating a pregnancy, do you discuss with them the option of induction abortion?
A. Yes, I do.
Q. In your experience, is induction a safe method of abortion?
A. It is a safe method for most patients.
Q. And in your experience in dealing with your patients, Dr. Chasen, which method of abortion is safer, induction or D&E?

A. D&E is safer.
Q. Based on your experience, which is the more common method of abortion through the second trimester, inductions or D&Es?
A. D&E.
Q. Based on your experience, Doctor, why do women choose D&E over induction?

A. Women choose D&E --
THE COURT: Is there any objection?
How can he testify as to why women do it? It is an operation of their mind.
MR. HUT: Based on any conversations he had with his patient.
THE COURT: He didn't say that.
If you want to ask about some conversation then point of view point of view pointless.
BY MR. HUT:
Q. Based on conversations you have had with patients and where they have expressed their preferences to you, why do they choose D&E over induction, Dr. Chasen?
A. Well, I share with my patients my impressions of the data regarding safety of the two procedures and the lower complication rates seen with D&E.
Probably what influences the patients even more is when I take them through the steps of either procedure, about

what they might experience.
THE COURT: I will sustain the objection.
MS. GOWAN: Thank you I was going to move to strike.
THE COURT: How can he testify in what probably convinces them?
Mr. Hut.
BY MR. HUT:
Q. Based on your experience, Dr. Chasen, is hospitalization required for D&E?
A. No.
Q. Is it required for induction?
A. Yes.
Q. Can you compare, based on your experience, the time required for induction as against the time required for D&E?
A. Well the time for D&E, from the beginning of the procedure where the laminaria are placed until the eSRABG is complete can be 24 to 48 hours bull for for a couple of hours the women are outpatiented and their at home or they're at work and they're not in the hospital.
The time for induction varies widely. It can be between several hours to several days, during all of which the patient is hospitalized.
Q. And what's --
THE COURT: So that takes hospital space, hospital personnel and your time when they're there in the hospital,

right?
THE WITNESS: It doesn't take my time.
THE COURT: Well it takes the staff, does it not? If they're in a bed in the hospital? And there are costs involved, correct STPHEUFRPBLGTS I can't speak with any authority about staffing issues or cost issues.
THE COURT: Well the last I knew there are staff personnel at hospitals, are there not?
THE WITNESS: There are. PAEURTS undergoing --
THE COURT: Everything from serving the meals to checking their blood pressure, right?
THE WITNESS: There are.
Patients who undergo D&E --
THE COURT: And I assume all those things cost money, right?
THE WITNESS: They do.
Although patients undergoing D&E have --
THE COURT: Next question.
BY MR. HUT:
Q. Are you aware of any evidence, Dr. Chasen, that you or anyone else at Weill Cornell has ever made a recommendation for abortion procedure to a patient based on costs?
A. I am not aware.
I have not.
Q. How about based on the requirement of staff commitments and

staff time?
A. I am not aware and I have not.
THE COURT: Do many patients follow your advice, Doctor?
A. I don't give patients advice, I give them counseling and they make the decision they think is appropriate for them.
THE COURT: And you don't urge them to do one or the other?
THE WITNESS: I don't urge them to terminate the pregnancy and I don't urge them to undergo D&E.
THE COURT: Next question.
Q. In your experience, Dr. Chasen, as between D&E and induction, which form of procedure involves the most psychological stress for your patients?
MS. GOWAN: Objection.
THE COURT: Sustained. I don't think the doctor has been qualified as an expert in psychiatry, so.
Next question.
Q. In your experience, Dr. Chasen, have you seen women for who inductions are con TRA indicated or relatively contraindicated?
A. Yes, I have.
Q. What types of patients have you treated that had contraindications or relative contraindications for induction, Dr. Chasen?
A. Women that have scars on their uterus -- whether that's

from having a prior c-section or having a procedure called a myomectomy when are where a benign time your is removed from the muscle of the uterus are particularly prone to have rupture of the uterus at the site of the scar which is weaker than normal, the normal muscle of uterus.
These women -- these women, the labor process, whether it is at term for a viable baby or whether it's a medical abortion, these women are at high risk of rupturing the uterus particularly if they have had a version of c-section with a vertical incision, often refers to as a classical incision.
But all women with any type of c-section even the common type are even at higher risk.
These women --
THE COURT: Do abortions leave any scarring, Doctor?
THE WITNESS: They don't leave any scarring in the PHUS of the uterus predisposing to rupture in a future pregnancy.
THE COURT: It doesn't.
THE WITNESS: It does not.
THE COURT: No matter when form that's used?
THE WITNESS: It does not.
THE COURT: Okay.
Next question.
Q. With respect to women who have had prior c-sections or myomectomies and thus, uterine scarring, why are inductions

contraindicated?
A. In this circumstance note note.
Q. In this circumstance?
A. The process of induction involves farm acloth KHREU inducing the muscle of the uterus to contract and often contract strongly.
Inducing muscle to contract that has a scar within it is a risk factor for rupture of the uterus.
In the process of D&E we do not use this type of stimulation to the muscle of the uterus and the risk of rupture at the scar is lower.
Q. If the uterus were to rupture in the event of an induction abortion, would that leave scarring, assumeing it were safely repaired?
A. Yes, it would.
Q. In your experience, Dr. Chasen, how KPHOFPB is a classical caesarean section?
A. As a percentage of all caesarean sections performed, it's relatively uncommon, probably comprising in my hospital, fewer than five percent of the cases are with a classical incision in the uterus, the type that is particularly prone to rupture in the future.
As an absolute number, we have 6,000 deliveries a year in my hospital, about one third of them are by c-section, so if there are 2,000 c-sections there may be between 50 and 100

women who undergo c-section with a classical incision.
Q. Is that each year?
A. That's each year.
Q. And approximately -- withdrawn.
With D&E present the same concern that uterine rupture for a woman with a classical c-section scar or scarring from myomectomy?
A. D&E would not expose the patient to that degree of risk.
Q. Why not, Dr. Chasen?
A. The risk relates to contractions in the muscle of the uterus and D&E is, involves mechanical -- involves dilation of the cervix through laminaria, not through inducing contractions in the uterus, removing the fetus through whichever technique of D&E does not involve expulsion with contractions of the uterus, thus it avoids the stimulation of the muscle of the uterus which is what precedes uterine rupture.
Q. Do you see patients, Dr. Chasen, with cardiac disease?
A. I do.
Q. When has the indication of cardiac disease manifested in the patients that you see and if it varies, please so state?
MS. GOWAN: Objection, your Honor. Broad.
THE COURT: Let me hear the question.
MR. HUT: I will rephrase it, your Honor.
Q. In the patients that you see with cardiac disease, can you share with the Court when the indications of that disease

manifest?
THE COURT: Could you read that question to me.
(record read).
MS. GOWAN: Same objection, your Honor.
THE COURT: I think it's unintelligible. Sustained.
Q. Describe the range of patients that you see, Doctor, with cardiac disease.
A. Patients with cardiac disease could have long-standing disease --
THE COURT: And short duration disease, is that correct?
THE WITNESS: That is correct.
There are patients that may have preexisting cardiac disease and may not have had SEUPL STOPL and may not have had it diagnosed through pregnant I but manifest through the physio logic changes in pregnancy.
And as the physio logic changes in PREG in answer become more announced with advancing gestation, there are some women that may not become symptomatic until the sec or third trimester of pregnancy.
Q. As between induction and D&E, Dr. Chasen, what abortion procedure would you recommend for women that you see with cardiac disease?
A. I would recommend that these women who are going to undergo abortion with cardiac disease have a D&E.

Q. Sand why is that?
THE COURT: Does it vary with degree with the seriousness of their heart condition?
THE WITNESS: Yes, it does.
THE COURT: I thought it might.
Q. Can you further amplify that answer, Dr. Chasen?
A. Women with -- my recommendation would become firmer with more, with increased severity of disease.
Q. That recommendation would be for what, Doctor?
A. For D&E.
Q. Dr. Chasen, are you aware of other complications of induction that you have not identified?
A. Yes, I am.
One complication is unsuccessful medical induction whereby women may have a prolonged -- there may be a prolonged attempt at induction of labor but some women will not expel the fetus in this process and then these women may have to undergo surgical abortion.
Q. What surgical abortion would be performed in this instance, Dr. Chasen?
A. Hopefully D&E would be available. If it's not then hysterotomy may be required.
Q. Is retained placenta a complication of induction, Dr. Chasen?
A. Yes, it is.

Q. In your experience, Dr. Chasen, are there ever cases in which, to your knowledge, the fetus dies during the course of an induction abortion?
A. Yes.
Q. How does that happen, in your experience?
A. In inducing labor the uterus contracts forcefully, in some cases very forceful contractions can force SPREUGS of the placenta depriving the fetus of oxygen.
In some cases, especially -- in some cases during medical induction the membranes rupture and the umbilical cord can get compressed or fall out of the cervix, again depriving the fetus of oxygen.
In either scenario the fetus would asphyxiate during the procedure.
Q. Based on your experience, Dr. Chasen, how long does the process of fetal death before I affixiation take from the onset of contractions and induction abortion?
A. It could take many minutes.
Q. What kind of anesthesia is used in the induction in your experience, Doctor?
A. Women typically receive the same types of anesthesia they would with term labor and that is epidural.
Q. How does that epidural compare to the anesthesia used in a D&E as you perform it?
A. In D&E, as I perform it, most patients have general

anesthesia or local anesthesia with very, very heavy degrees of sedation.
Women having induction with an epidural typically don't receive any sedatives.
Q. Dr. Chasen, do you have an opinion regarding the safety of intact D&E as compared to dismemberment D&E?
A. Yes, I do have an opinion.
Q. What is your opinion, Doctor?
A. My opinion is that in patients in whom I am able to do a D&E with intact extraction, that this procedure -- this variation of D&E offers safety advantages compared to dismemberment.
Q. Is the intact variation of D&E, to your understanding, Dr. Chasen, recognized in any medical texts?
A. Yes.
MS. GOWAN: Object to the form of the question. In what way?
MR. HUT: I'm happy to rephrase.
Q. Is inintact D&E identified as an available method of abortion in the second trimester in any medical texts of which you are aware, Doctor?
A. Yes.
Q. Which one or ones?
THE WITNESS: Williams' obstetrics.
Q. Do you use Williams' obstetrics in your practice?

A. Yes, I do. It's regarded as an authoritative text of obstetrics.
Q. Do you review it as well?
A. Yes.
Q. Does the will note note note note use it as Weill.
Q. Does the Williams TOEFPLT state whether the intact D&E is favored or unfavored in any way?
A. It does in the characterize it as that.
Q. Doctor, returning to your opinion concerning the safety of intact D&E, why can intact D&E be the safest way to perform a D&E?
A. Based on my experience, complications of D&E relate to insertion of instruments, typically forceps into the uterine cavity.

Insertion of forceps in the course of dismembering the fetus and removing it every time the forcep clasps around some tissue, even under ultrasound guidance I can't be certain that it's not grasping maternal tissue, the uterine wall.

So, use of forceps, and again these are used extensively in dismemberment, would increase the risk of uterine perforation.

In D&E using disarticulation or dismemberment, portions of the fetal skeleton are exposed and they may be sharp edges and removing these through the cervix may expose the cervix to trauma.

The intact extraction variation of D&E is typically, can be performed more quickly and, in my experience, with less blood loss.
Q. As between intact D&E and dismemberment D&E, which, if either, poses a greater risk of retained fetal tissue?
A. Using D&E with dismemberment poses a greater risk of retained fetal tissue.
Q. Can you describe, briefly for the Court, Doctor, what, if any, health risks may be associated with uterine perforation?
A. Uterine perforation can cause hemorrhage. It can certainly cause infection. If the perforation is not recognized and the forceps pass through the perforation then bowel or bladder can be injured and there is a risk of death.

THE COURT: Have you ever perforated the uterus doing a D&E?

THE WITNESS: Yes, I have.

THE COURT: Have you ever been sued for malpractice?

THE WITNESS: Yes, I have.

THE COURT: Next question.

BY MR. HUT:
Q. Were you sued for malpractice in connection with the uterine perforation for which you just testified?

THE WITNESS: In one case involving uterine perforation I was sued for malpractice.

Q. Did the quality assurance committee at the hospital in

question make any investigation or assessment of your conduct in connection with that perforation?
MS. GOWAN: Object to the form of the question. Leading.
THE COURT: I will allow it.
THE WITNESS: The quality assurance committee reviewed it and characterized it as a statistically occurring event with no deviation in medical care.
THE COURT: Did the plaintiff recover?
THE WITNESS: Yes.
THE COURT: Next question.
Have you been sued more than once for malpractice?
THE WITNESS: I was sued in that case and I was in a case when I was a resident, so that's twice.
THE COURT: Next question, Mr. Hut.
BY MR. HUT:
Q. What causes the presence of bony fetal parts about which you testified earlier?
A. Fetal dismemberment with forceps would cause exposure of bony fetal parts.
Q. Do bony fetal parts present any risk of cervical laceration, in your opinion?
A. In my opinion they do.
Q. What, if any health risks are associated with retained fetal tissue?

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A. Retained fetal tissue can interfere with the process known as involuntary HRAOUGS of the uterus where the uterus shrinks down to a non-pregnant size.
Failure of the uterus to do this because of retained tissue is a risk factor for hemorrhage. It's a risk factor for infection, both in the short-term.
In the long-TPERPL if retained fetal tissue, esspecially if it causes infection, could cause scarring of the uterine cavity which could be associated with future problems in fertility or obstetric complications.
Q. Why does intact D&E reduce the risk of retained fetal tissue, Dr. Chasen?
A. In delivering the fetus intact to the level of the head and then in suctioning out the brain tissue through a small incision at the base of the skull and then removing the fetus, I can clearly identify that all fetal tissue has been removed and that there is 100 percent no chance of any remaining fetal tissue.
Q. In your opinion, Dr. Chasen, can physicians or can a physician address the risk of retained fetal tissue by checking uterine contents with ultrasound following a completion of a surgical procedure?
THE COURT: Could you keep your voice up, Mr. Hut?
MR. HUT: Sorry, your Honor. I will restate the question.

THE COURT: You allow your voice to drop and nobody can hear you.
Q. In your opinion, Dr. Chasen, can a physician address the risk of retained fetal tissue by checking the uterine contents with ultrasound at the end of a procedure?
A. The physician can address it. And the physician certainly could identify any relatively large pieces of tissue that were missing.
But even if ultrasound, the physician could not exexclude the retention of very small fragments of bony or other tissue.
MR. HUT: Your Honor, I note it's 12:30. I'm happy to continue the examination or not at the Court's pleasure.
THE COURT: Fine. It's an appropriate time for lunch.
How much longer do you anticipate that you have?
MR. HUT: I would anticipate that I am about halfway through so perhaps another hour, 70 minutes. Something like that.
THE COURT: That long. Okay.
We will break for lunch at this time. We will resume at 2:00.
(luncheon recess) ' TWM 4/8.
AFTERNOON SESSION
2:00 p.m.
-Z STEPHEN T. CHASEN, resumed.

THE COURT: Good afternoon. Mr. Hut, you may inquire.
Direct examination (continued)
BY MR. HUT:
Q. Dr. Chasen, before the break you testified concerning a malpractice action filed against you with respect to a uterine rupture. From what variation of D&E did that rupture result?
A. That case was a D&E with forceps and fetal dismemberment.
Q. Have you ever perforated the uterus when using the intact variation of D&E?
A. No.
THE COURT: How about when you were a resident? You said you were sued for malpractice then, is that correct?
THE WITNESS: That's correct.
THE COURT: Did the plaintiff recover there?
THE WITNESS: I was dropped from the case. I believe the plaintiff settled with the attending physician.
THE COURT: So the case was settled?
THE WITNESS: Yes.
THE COURT: Next question.
Q. Was the claim dismissed against you before the case was settled?
A. Yes, it was.
Q. What procedure was involved in that matter?
A. That was a hysterectomy.
Q. Dr. Chasen, do you sometimes observe the process of

dismemberment D&E under ultrasound?
A. Yes, I do.
Q. When you do so and when you introduce forceps in a dismemberment D&E, does the fetus react?
A. No, not when I introduce and not when I grasp and not when I disarticulate or dismember.
Q. Dr. Chasen, in your experience, how is the fetal head extracted in a dismemberment D&E?
A. The fetal head is extracted by placing the forceps around it and crushing it.
Q. How readily is that -- how easy is that to accomplish?
A. In some cases it is relatively easily accomplished and in other cases it is very difficult.
THE COURT: Does it hurt the baby?
THE WITNESS: I don't know.
THE COURT: But you go ahead and do it anyway, is that right?
THE WITNESS: I am taking care of my patients, and in that process, yes, I go ahead and do it.
THE COURT: Does that mean you take care of your patient and the baby be damned, is that the approach you have?
THE WITNESS: These women who are having boringss at gestational ages they are legally entitled to it --
THE COURT: I didn't ask you that, Doctor. I asked you if you had any caring or concern for the fetus whose head

you were crushing.
THE WITNESS: No.
THE COURT: Thank you. Next question.
Q. How does the extraction of the fetal head compare in the intact variation of D&E?
A. In the intact variation of D&E the head, if it cannot -- if it cannot pass through the cervix, as is the case usually, then the head is decompressed by making an incision with a scissors at the base of the skull under direct visualization and then PHRAEUZing a vacuum device into the skull and the brain tissue is aoperated, and the skull collapses and the head fits through the cervix easily.
Q. How does that process compare to the collapsing in a dismemberment D&E in terms of the relative difficulty of the two producers?
A. Collapsing the head with the intact variation of D&E as I have just described is a much easier process than with forceps in the dismemberment variation.
Q. You mentioned direct visualization. What does that mean?
A. That means when the skull is obstructed at the level of the cervix, at that point I place a clamp on the front part of the cervix and, applying mild traction to this, it exposes the skin at the back of the fetal neck at the site through which I place the scissors. So I can in almost all cases actually visualize the spot through which I place the scissors.

THE COURT: Does that hurt the baby?
THE WITNESS: I don't know.
THE COURT: Do you care?
THE WITNESS: That's not my main concern during the procedure.
THE COURT: Do you care?
THE WITNESS: I don't consider it at the time I'm doing the procedure.
THE COURT: Then I take it your answer is you don't care, if you don't consider it.
THE WITNESS: I didn't say I don't consider it, but that is far from my prime concern.
THE COURT: You just said you don't consider it. I am quoting you, Doctor, back to you. You said you don't consider it, and I responded to that does that mean, then, you don't care. If you don't consider it, I don't see how you can care.
THE WITNESS: At the time I am doing the procedure, I am caring for the woman. I don't care.
THE COURT: Next question.
Q. How about prior to the procedure when you are consulting with them?
THE WITNESS: In my patients who express concern about whether the fetus will feel pain, yes, I do care.
Q. How long does it take to collapse the fetal skull the way you do it in an intact D&E?

A. When I'm doing it myself, it takes less than 30 seconds. If I am teaching a resident or a fellow, as in all things, it will take longer.
Q. Is there any risk of hitting the bowel in an intact D&E with the scissors you use to puncture the skull?
A. No.
MS. GOWAN: Objection: Leading.
THE COURT: Sustained. I take it back. I will allow it.
A. No, there is no chance of hitting the ball.
Q. In a dismemberment D&E, Dr. Chasen, is it possible to use entirety glycerin to help extract the fetal head from the uterus?
A. In some cases the fetal head may be lodged in a corner of the uterus where there may not be enough room to expand the forceps to safely fit around the fetal head. One option at that point could be to give a medication to the mother that could relax the muscle of the uterus and, though I have never administered this medication for that purpose, it could possibly enable the forceps to fit around the fetal head.
Q. Why don't you administer medicine for that purpose?
A. The cede TEUFS or general STHETics these women receive do relax the uterus, and I don't believe the additional uterine relaxation that entirety glycerin would provide would be significant, number one. Number two, this medication can

affect the cardiovascular system of the mother and make the pulse race and lower the blood pressure. And in giving a medication like this, that could relax the uterus. That relaxation could persist after the fetus is removed, and that would increase the risk of hemorrhage.
Q. Are certain of the fetal anomalies that you see, Dr. Chasen, incompatible with life?
A. Yes.
Q. Which?
A. An encephaly, some types of cardiac abnormalities, fetal cardiac abnormalities are incompatible with life. Certain sin TKROEUPLS liketriesmy 13 ortriesmy 18 if they involve severe cannediar anomalies are incompatible with life.
Q. What is an encephaly?
A. An encephaly is when the skull and the cerebral cortex, the front part of the brain, do not form.
Q. In your opinion, Dr. Chasen, does intact D&E offer safety advantages for women carrying fetuses with certain types of fetal anomalies?
A. Yes.
Q. Can you specify one or two such circumstances.
A. Sure. Probably the most common circumstance would be if the fetus has hydrocephalus, a condition where the head can be swollen considerably. In these cases the size of the head can make trying to apply a forcep around the head very difficult

and especially risky. The intact variation of D&E, the head can be brought easily to the level of the cervix, where an incision can be made and the brain tissue can easily -- and the fluid accumulated with hydrocephalus can easily be aspirated and the head can be brought down to a size that can easily pass through the cervix.
Q. Are there any other advantages, Doctor --
THE COURT: Excuse me. If the child has that condition, if the woman goes to term, does the child -- is the child born WALGT condition and that head swollen like that?
THE WITNESS: Yes.
THE COURT: Does the child usually die immediately thereafter?
THE WITNESS: It depends what is causing the hydrocephalus.
THE COURT: What is the normal condition? Does the child normally die? Do they all ultimately die shortly after birth?
THE WITNESS: No. There are certain forms of hydrocephalusthat are not lethal. Condition and can the condition then be treated?
THE WITNESS: If the women choose to continue the pregnancy, then for certain forms of hydrocephalus there is treatment.
THE COURT: Could the child then lead a normal life?

THE WITNESS: Again, it depends on what the underlying condition is. There is a form of isolated hydrocephalus where with aggressive surgical treatment there is a possibility of normal intelligence. The rates of mental retardation are much higher than in the general population.
THE COURT: Do a large number of these children, if they go to term, do they die shortly after birth?
THE WITNESS: Most cases of hydrocephalus that we diagnose in the fetus are associated with other abnormalities and not isolated. They are either Lee that will or a minimal chance of survival after birth.
THE COURT: So most of them would die on their own shortly after birth?
THE WITNESS: Many of them would.
THE COURT: OK. Next question.
Q. Are there any other advantages, Dr. Chasen, of intact D&E for abortions involving certain fetal anomalies?
A. Certain times, sometimes we will diagnose a fetal abnormality, and we see something abnormal but it doesn't tell us exactly what caused it or what the diagnosis is. We can tell by some of these anomalies that the prognosis may be very, very poor, and based on counseling by the appropriate specialist the patient may choose to terminate the pregnancy.
There are certain conditions that may have genetic components, and these women or these couples may be at

significant risk of recurrence in a future pregnancy. In these cases it can be very important for a skilled pathologist to look at the fetus or parts of the fetus after the abortion procedure to apply a diagnosis to the condition that we have detected in utero.
Using the intact variation of D&E, for abnormalities not involving the brain, all the tissue and the organs are preserved and they are not disrupted, and that maximizes the chance that a pathologist can identify such a syndrome if present.
Q. In such a case there are -- let me withdraw that and ask that question. Are there cases in which examination of the intact fetus offers advantage over amniocentesis for diagnosing fetal anomalies?
A. Most abnormal fetuses, if the mother has an amniocentesis, the amniocentesis will come back normal. Amniocentesis in general is used to diagnose chromosomal abnormalities, the most common of which is down syndrome. But that is a PHOEUPBT of fetal abnormalities that we can diagnose.
So, again, these are cases in which an amniocentesis would not provide diagnostic information.
Q. Are there any cases, Dr. Chasen, in which the examination of an intact fetus offers an advantage over ultrasound in diagnosing or assessing neatly anomalies? [> fetal<]
THE COURT: Can I hear that question?

(Question read)
THE COURT: KWROUPBL after the abortion?
MR. HUT: Yes, your Honor.
THE COURT: Isn't that where the field of a pathologist and not this doctor?
MR. HUT: I think this doctor has ample experience with patients with which he deals --
THE COURT: Is there an objection?
MS. GOWAN: No, your Honor.
THE COURT: Then go ahead and answer it.
A. Yes, there are such cases where a pathologist could examine the fetus and provide more information than we could have from ultrasound prior to abortion.
Q. Does the examination of an intact fetus offer any advantages over a fetus removed by dismemberment D&E in terms of diagnosing fetal anomalies?
A. In D&E using dismemberment, any or all parts of the fetus could be disrupted, perhaps beyond recognition. So the answer would be yes, the intact variation of D&E would offer an advantage.
THE COURT: Wouldn't it vary depending on how many parties and how much damage was done to the fetus, rather than just making an all-inclusive answer?
THE WITNESS: There are some cases with dismemberment D&E were the appropriate information can be ascertained by

looking at a dismembered fetus.
THE COURT: So it would depend case by case?
THE WITNESS: It would depend case by case, yes.
THE COURT: Next question.
Q. In the generality of cases that you see, are there advantages to intact D&E over D&E by dismemberment in terms of fetal diagnosis?
A. There are no cases in which a dismembered fetus would offer more information than aning intact fetus.
Q. Are the advantages to an intact fetus with respect to pathological testing that you have just described also common to inductions in your experience?
A. They may be, but not in all cases.
Q. What cases would they not be?
A. A small proportion of cases with induction don't in fact deliver through induction. Then again, these women have to have surgical abortion, hopefully by D&E if expertise is available. Again, this is D&E, dismemberment may be required in the D&E procedure.
The other case or the other reason is that in some cases of induction the fetus will die during the process of induction, and the duration between the time of fetal death and delivery can span many hours or even exceed one day, by which time the process of maceration, whereby the tissue in the organs can begin to decay, could have occurred, and that could

interfere with pathologic evaluation.
THE COURT: What is that, Doctor, pathologic evaluation, is that the term?
THE WITNESS: Autopsy or evaluation by a pathologist.
THE COURT: Thank you.
Q. Dr. Chasen, the way you perform intact D&E's, is there maceration involved with that procedure?
A. No, there isn't.
Q. Does intact D&E offer particular safety advantages for particular patients, Dr. Chasen?
A. Yes, it does. For women with certain medical conditions D&E would -- I'm sorry. Did you ask D&E with intact extraction or D&E in general?
Q. D&E with intact extraction.
A. Intact extraction variation of D&E minimizes the risk of uterine perforation and I believe minimizes the risk of hemorrhage, and can shorten the procedure time. Women who are having the procedure because of medical complications are least able to sustain the complications or to tolerate complications. So in these women D&E with intact extraction, in my opinion, would have specific advantages.
Q. You mentioned hemorrhage. What types of patients, TR chains, are at particular risk for hem ram?
A. Patients who may have decreased amount of clotting factors because of a metabolic condition or an inherited condition like

hem fellia could. Patients with cancer who have undergone chemotherapy which can prevent the body's ability to produce clotting factors also can be prone to hemorrhage. Women that may have ruptured the membranes and may have a significant likelihood of already having an infection in the uterus, that increases the risk of hemorrhage as well.
Q. Have you performed abortions for such patients either with shortage of colon I can TPAERBGTS -- either with a shortage of clotting factors or premature rupturing of membranes?
A. Yes, I have, as well as on chemotherapy.
Q. By what procedure or variation did you perform the abortions in those cases, if you recall?
A. I don't recall.
Q. Why, in your opinion, would intact D&E offer safety advantages for women who are at particular risk for hemorrhage?
A. In that the intact variation of D&E reduces the need to insert forceps, which can be associated with uterine rupture, and the insertion of forceps while removing the fetus could also disrupt the placenta prior to the fetus being removed and bleeding from the placental sack can be ongoing during the procedure, using the intact variation, which doesn't involve use of forceps to remove the fetus and which does not involve placental disruption prior to the removal of the fetus, hem rang would be less likely to occur. SP-P.
Q. In your experience, Dr. Chasen, does intact D&E offer

safety advantages over induction for women at risk for hemorrhage?
A. Yes, it does.
Q. Why is that?
A. In women at risk for hemorrhage, one common complication of medical induction is infection and another common complication is retained placenta. Oftentimes they coexist. Both are significant risk factors for hemorrhage.
THE COURT: Does infection ever occur in intact D&E's?
THE WITNESS: Almost never.
THE COURT: Does it ever occur?
THE WITNESS: Infection can occur in any surgical procedure, but I have never had a patient with --
THE COURT: Does hemorrhage bleeding occur in intact D&E?
THE WITNESS: Hemorrhage can occur in any procedure. I have never experienced it in doing a D&E with the intact extraction.
THE COURT: But it can occur?
THE WITNESS: It can occur in any surgical procedure.
THE COURT: That's all I asked, Doctor. Next question.
Q. Are there occasions, Dr. Chasen, that you have uncountered where a PHAEURBT needs an abortion urgently to protect her health?

A. Yes, there have been some situations.
Q. What are the situations that you have encountered, Doctor?
A. I have encountered women that have a dilated cervix in the second trimester or have ruptured membranes in the second trimester, and both of these conditions can be caused by an infection in the uterus or an infection can happen secondary to it. [> check the question<] continuing the reg TPHAEPBSs under these circumstances can lead to a bodywide infection called sepsis, which can be life-threatening. I have also taken care of women that have medical conditions. One specific to pregnancy is preeclampsia, which is a complication involving hypertension and deteriorating kidneys function. Although that typically happens close to term, rarely it can occur in the second trimester and continuing the pregnancy under these circumstances could be life-threatening to the women.
THE COURT: You could be said to be doing this to save their lives?
THE WITNESS: Yes, they could be. And there are also women with preexisting medical conditions, including heart disease, where because of the physiologic condition of pregnancy they may experience deterioration in their health and times relatively rapid deterioration of their health, and abortion is indicated as a life-saving procedure.
Q. Are these situations always life-threatening or are they sometimes health-threatening?

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A. They are not always life-threatening, but they certainly could be and they are certainly health-impairing.
THE COURT: And risk possibly to life?
THE WITNESS: Yes.
THE COURT: Next question.
Q. Would you do an intact D&E in cases a pregnancy termination is urgently needed?
A. Yes.
Q. Are there any advantages, in your opinion, that an intact D&E would offer in such circumstances over a dismemberment D&E?
A. Again, if this woman, if my patient needs to terminate the pregnancy urgently, then she is such a patient that would be most likely to suffer from an operative complication, and these operative complications in my opinion are more common with a dismemberment form of D&E.
Q. As between induction and intact D&E, what procedure would you recommend in circumstances where a patient needed pregnancy termination on an urgent basis?
A. I would recommend D&E.
Q. Why is that, Doctor?
A. Again, whereas normally for a D&E, especially after 20 weeks, I will do laminaria insertions for 48 hours, I can do multiple laminary insertions in a shorter time interval and I can generally accomplish the procedure from first laminary insertion to evacuation within a 24 hour window. A medical

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induction could take a few hours, but in many cases it could take considerably longer than 24 hours and I don't know at the outset of the procedure what will happen.
The other safety advantages that I have cited previously favoring D&E over induction certainly apply here.
Q. Dr. Chasen, when you set out to perform an abortion, can you assure that D&E that you perform will proceed intact?
A. No, are I can't.
Q. How then can you say that the procedure offers advantages?
A. In some cases, in the cases in which I am able to do it based on cervical dilatation, proximity of the cervix to the vaginal opening and fetal position, it offers safety advantages. These women are typically at a more advanced gestational age. If I could do it with intact extraction, then I could do it without introducing forceps into the uterine cavity, which increases the risk of trauma to the uterus, including rupture, and I can remove the fetus without exposing the maternal tissues to sharp edges of bony fragments and I believe I can minimize the risk of hemorrhage and shorten the procedure time.
Q. Dr. Chasen, in your opinion, is an intact D&E ever the only available procedure to terminate a second trimester pregnancy?
A. No.
Q. Does this affect your view of the safety advantages with intact D&E?

A. No, it does not.
Q. Why not?
A. In the cases in which I can do it, I have sufficient cervical dilation and the other factors I have mentioned, I am doing it because that is the way I can remove the fetus. In my medical judgment, that is the best way I can remove the fetus in minimizing the risk of complications that can harm the mother.

If I cannot use that procedure, then I will have to use forceps, which multiple insertion of forceps to remove a fetus that may be relatively large -- and, again, all the risks of complications that I have mentioned would apply. I think I could avoid these complications by using the intact extraction variation of D&E when it is feasible.
Q. Dr. Chasen, please turn in the notebook that I have supplied to you to tab 23A. Doctor, do you recognize Plaintiffs' Trial Exhibit 23A?
A. Yes, I do.
Q. What is it?
A. This is an article accepted for publication in the American Journal of Obstetrics and Gynecology. These are the proofs of that article, entitled "die dilation and evacuation at greater than the or equal to 20 weeks, comparison of operative techniques,"nd I am the primary author of the study.
Q. Please put that aside for the moment. You said it has been

accepted for publication. Do you know when it is scheduled for publication?
A. It is scheduled for publication in May of this year.
Q. I think you mentioned this before but remind us again. Is the American Journal of Obstetrics and Gynecology a peer owe viewed publication?
A. It is a peer-reviewed publication.
Q. What did you and your co-author set out to do in the study that is described in Plaintiffs' Trial Exhibit 23A?
A. Our objective was to describe a large series of patients who have had a D&E at 20 weeks or beyond and to look at the characteristics of patients and compare the outcomes based on which variation of D&E was used.
Q. Did the study as you performed it make such a comparison?
A. Yes, did.
Q. Whose idea was it, Dr. Chasen, to conduct the study reflected in Plaintiffs' Trial Exhibit 23A?
A. It was my idea.
Q. Why did you do it?
A. I did it because any time I take a study, any time I perform a study, including everything I have published prior to this, the objective is to answer a question. There are very few resolved issues in medicine, and there are very many questions, and sometimes there is no data address ago question and sometimes there is conflicting data. As a physician in

academic medicine, I think if you have data that can address one of these controversies, I think it behooves you to collect your data and publish it.
Q. Were there any preexisting published data addressing the comparisons that you and your co-authors made in the study?
A. Not that I am aware of.
Q. Dr. Chasen, what is the IRB?
A. IRB stands for institutional review board. It is a panel of both physicians and lay persons that exists at each institution that basically ensures that any research that is undertaken is ethical and protects the interests of patients.
Q. Did you need IRB approval to conduct the study?
A. I did.
Q. Did you request IRB approval?
A. I did request IRB approval.
Q. Did you obtain it?
A. Yes, I did.
Q. When did the study begin? Or when did you begin the study, I should say.
A. We obtained IRB approval I believe in March 2003 and the study began after that point.
Q. When did you complete the study?
A. We completed -- again, the study consisted of reviewing existing data from medical records. We completed our review in, I believe, July or August of 2003.

Q. Doctor chains, before the paper was accepted for publication by the American Journal of Obstetrics and Gynecology, did you send it to any other journals?
A. We initially submitted it to obstetrics and gynecology.
Q. What happened there S-
A. It was not accepted to publication there.
Q. Can you comment on the standing in --
THE COURT: Did they send you a letter rejecting it?
THE WITNESS: They sent me a letter informing me that it wasn't accepted for publication, yes.
THE COURT: Did they give you reasons?
THE WITNESS: No. They gave me comments from three peer reviewers. It wasn't apparent in reading the comments why --
THE COURT: I didn't ask your opinion. But they gave their reasons?
THE WITNESS: The letter from the editors didn't give specific reasons. They just referred to reviewers' comments collectively.
THE COURT: Just one other question, if you don't mind. In March of 2003 were you aware that there was once again a bill in Congress, which you I believe, I don't know what the the exhibit number is -- perhaps you will help me, Mr. Hut -- that resulted ultimately, became the partial-birth abortion bill of 2003.

MR. HUT: Plaintiffs' Exhibit 69.
THE COURT: Thank you, sir. 69. You knew that was pending, did you not?
THE WITNESS: Yes, your Honor, I did.
THE COURT: OK. Go ahead, Mr. Hut.
Q. Can you comment on the standing in your understanding etc. etc. intern journal of obstetrics and goggle in the obstetrics and gynecological field?
MS. GOWAN: Beings.
THE COURT: Sustained. Mr. Hut, real.
Q. What term, Dr. Chasen, did you use in the article for intact D&E? [> check the prior question<]
A. I used, after describing it as a variation of dilation and evacuation, subsequent to that, in what will be published it is referred to as "intact D&X." In earlier versions of the paper there was different terminology.
Q. How about for dismemberment D&E, what term does the article use for that variation?
A. The published form, what will be published, calls it "dilation and evacuation."
Q. What are your preferred terms for these variations?
A. The terms I use clinically, again, with patients or with my colleagues or residents or students, is "dilation and evacuation." I talk about dilation and evacuation with did disarticulation and dismemberment and dilation and evacuation

with intact extraction.
Q. How did you select the terms used in the article for the variations, that is, dilation and evacuation on the one hand and intact dilation and extraction on the other?
A. In the initial manuscript that was submitted to obstetrics and gynecology, I used the identical terms that I use in real life, dilation and evacuation with disarticulation, versus dilation and evacuation with intact extraction. Based on some of the feedback from the peer reviewers and the explicit suggestion of one, I in the next version incorporated the term "intact extraction" which has been used by the American College of OB-GYN.
THE COURT: Did you resubmit it to that publication?
THE WITNESS: No, your Honor.
THE COURT: Did you also a moment ago say it was also submitted to another publication that rejected it also? W-BLG no.
THE COURT: Just the one?
THE WITNESS: Just the one.
A. In the version that was then submitted to the American Journal of Obstetrics and Gynecology, I believe the terminology I used was "dilation" -- after describing both variations as variations of D&E, I then called it dilation and evacuation, referring to the STPHEPLT or disarticulation, and D&X, or dilation and extraction. So it was D&E and D&X. We submitted

that, and it came back tentatively accepted but requesting certain revisions.
In the third version that was resubmitted to the American Journal of Obstetrics and Gynecology, I added the word "intact" in front of "D&X" to create more avenue contrast for the reader. So dilation and evacuation is initially described as having two variations -RGS, and subsequently "dilation and evacuation" refers to disarticulation and "intact D&X" refers to dilation and evacuation with intact extraction.
Q. Doctor, you said earlier that the study involved looking at some records of patients who had had abortions. Who actually extracted the data from patient records?
A. The data was extracted -- the medical records were reviewed by primarily one of my residents.
THE COURT: Which record did he review or she review?
THE WITNESS: She reviewed the hospital medical records.
THE COURT: Which hospital?
THE WITNESS: New York Weill Cornell Medical Center records, as well as any out-patient records documenting follow-up. The other person helping beside the resident was a free medical student, an undergrad. [> premedical<]
THE COURT: A premedical student, not even a doctor, was given access to these records?
THE WITNESS: Under our supervision, yes.

Q. How many records did you yourself actually review in conducting the study?
A. I didn't primarily review any of the medical records. There were a few cases where n categorizing the procedure as D&E or D&X, the people doing the data extraction asked me to look at an operative report where in a couple of cases I had done the dictation and I could tell from the dictation exactly what I had done, whereas they may not. And in some other cases there was a transcription error where it was unintelligible to someone that didn't have expertise in these procedures.
THE COURT: Over what period of time were these records reviewed?
THE WITNESS: Your Honor, we had conducted in my department another study that was published in 2002, I believe, that didn't look at types of D&E that was performed but looked at a different question: Pregnancy outcomes in women following D&E in the second trimester. In this study, records of all women through the year-from 1996 to 2000 were reviewed. And we had this data already at the time that we started this current study.
THE COURT: Did you get permission of any of these women to use their records for these two papers?
THE WITNESS: We had permission from the institutional review board to review the records.
THE COURT: But not from the women?

THE WITNESS: No. We don't directly ask.
THE COURT: I didn't ask you that. I just asked you if you had permission.
THE WITNESS: No, we didn't.
THE COURT: Again, my original question: Over what period of time did your staff review these records?
THE WITNESS: For the purpose of the study, the review was, I believe, from March 2003 through August of 2003.
THE COURT: Next question.
Q. What was the period of time embraced by the procedures that were being compared in the study?
A. From 1996 through June of 2003.
Q. Doctor, you mentioned that you reviewed some operative reports to correct transcription errors and the other wise assist in making them intelligible. Approximately how many such reports did you review?
A. I think five at most.
Q. When you reviewed the operative reports to help determine which procedure was involved, did you know, were you privy to information about whether any complications had ensued?
A. No.
Q. Did you do any review of any documents to help clarify or categorize complications, Dr. Chasen?
A. The information contained in medical records was abstracted onto data sheets. In determining complications, I and one of

my co-authors looked at some of these data sheets in deciding whether something at a had been noted from the medical records should be categorized as a complication.
Q. When you made that categorization, you or your co-authors, were you aware at that time of what particular variation of D&E was involved?
A. We were not.
Q. How did you go about, Dr. Chase, comparing the relative safety of the two techniques under review?
A. We compared data comparing the two types of the baseline characteristics of pages: Ages, obstetric history, whether they had had a prior C-section, what the gestational age was, and the indication for the D&E. We compared complication rates for women having the two variations of D&E.
Q. Was this a prospective study or a retrospective study?
A. This was a retrospective study.
Q. What is that?
A. Retrospective study means that you are analyzing AOEFPBTSZ that have occurred already, that it doesn't involve any intervention in the care of these patients. You are merely recording events that have happened and then comparing them after the fact.
Q. What is a cohort study, Dr. Chasen?
A. A cohort study ace form of retrospective study, where your taking two or more groups of patients categorized by some

fashion, and comparing these two or more groups in terms of characteristics and outcomes.
Q. Was this a cohort study?
A. This was a cohort study, one cohort being women having D&E with disarticulation and the other being a group having D&E with intact extraction.
Q. In your opinion, Doctor chains, is a retrospective study of cohorts an appropriate way to conduct a medical study comparing the safety of surgical techniques?
A. Yes, it is. It is the most common way surgical techniques are compared.
Q. How, Dr. Chasen, did you distinguish between the two variations of D&E for purposes of the study?
A. The D&E with intact extraction was categorized as such if, in most cases in this cohort, if intact extraction occurred and the fetus was delivered intact above the level of the um byly cus, or the navel. There were also some cases that were categorized as intact in which the fetus was presenting head-first and the head was against the SEFBGS with advanced degrees of dilation and at the outset of the procedure an incision through the cull can be made, the brain could be aspirated, and then the fetus was delivered intact. These were cases where the fetus was able to be removed without disarticulation with forceps.
Q. How did you categorize the rest of the procedures?

A. If we weren't able to deliver the fetus without use of forceps, then they were categorized as disarticulation, because all these cases involved disarticulation or dismemberment or tearing.
Q. Dr. Chasen, what did you consider a complication for purposes of the study?
A. We sought out to define complications as objectively as possible. Where remedies or treatments for complications could be easily identified and objectively identified in these patients. Requirement for blood transfusion, requirement for suturing of a laceration, unplanned admission to the hospital, readmission to the hospital, perforation of the uterus, admission to the TPHEPSive care unit. These were all objective outcomes where it was easy to categorize objectively.
There were some cases and these were the cases where I or my co-authors adjudicated, where someone noted in an op report that there was heavy bleeding. If this was noted but this did not seem to require any treatment that we don't ordinarily provide, such as blood transfusion or admission to the hospital for observation, then we did not categorize that as a complication.
Q. Did the investigators' ability to categorize the complications introduce bias into the study?
A. I don't believe it did.
Q. Why not?

A. Again, because these complications were objective and verifiable. There was nothing subjective about whether or not uterus was perforated, about whether or not sutures were used to repair laceration, about whether or not a patient received a blood transfusion, got him into the hospital, got them into the intensive care unit. So I don't think there was a potential for bias here.
Q. Did the investigators attempt to categorize types of variation introduce any bias?
MS. GOWAN: I object to the form of the question. I don't know what that means by types of variation.
THE COURT: Sustained.
Q. Let me rephrase. Did the investigators' ability to assign different case to say one group or another introduce any bias into the study?
A. No, it didn't.
"Q. Why not?
A. We had objective criteria in the categorization of these cases and in reviewing operative reports as well as the pathology reports which described the condition of the fetal specimen. It was obvious which cat TKWOEUR of D&E.
THE COURT: Was the criteria written down and memorialized?
THE WITNESS: No. Not before the review.
Q. Were the criteria described in the study?

A. They are described in the study.
Q. Doctor, how many patients were included in the study?
A. There were 383 patients within the duration that we looked at who had DEA in our hospital at or beyond 20 weeks' gestation.
Q. How many of those had had intact variation of D&E at or beyond 20 weeks of gestation?
A. 120.
Q. How many of those had D&E with dismemberment at or beyond 20 weeks of gestation?
A. 263.
Q. How many patients with subsequent pregnancies were included in the study?
A. There were 262.
Q. In your opinion, Dr. Chasen, was the methodology and the data you used appropriate to draw E liable conclusions about the respective safety of the two techniques of D&E?
A. Yes, I do believe that.
Q. In particular, do you think the number of cases studied was sufficient?
A. Yes, I do.
Q. Why is that?
A. In looking at the medical literature published before this especially from single institutions, a series of 383 of these cases constitutes a very large series. To our knowledge, there

is no prior data looking at techniques, including the intact extraction. In the midst of controversy about this procedure and in the absence of any prior published data, I think this is an important study. And I think, given the size, the data and our conclusions are reliable.
Q. Doctor, what were your results regarding the comparative complication rates of intact D&E and D&E with dismemberment?
A. Out of the 383 patients, 19 patients had complications, and it was 5 percent overall and it was 5 percent in each group, in the D&E with intact extraction and the D&E with disarticulation.
Looking at the two groups and nothing else, the complication rates were identical.
Q. What does a complication rate of 5 percent overall and within the two groups reveal about both these abortion variations?
A. That as we performed them in our hospital, they are safe, especially given that the majority of complications we would consider minor.
Q. What kind of complications did you observe in your study?
A. I think a majority of the complications were genital tract lacerations, mostly cervical lacerations, super-B efficiently class RAEUGSs where the clamp was put on the cervix that required sutures. There was at least one patient that had severe nausea from presumably anesthesia that required an

unplanned admission to the hospital. There were one or two patients who went home and then had to come back to the hospital for bleeding who were found to have retained tissue and had to undergo suction curettage procedure subsequent to that.
There were three complications that we considered major, because three patients required admission to the intensive care unit. One of these patients had a uterine perforation and required hysterectomy as well as blood transfusion. Another patient had an amniotic fluid embolus and she required admission to the intensive care unit and transfusion of blood and blood products. The third of these patients had a bodywide infection called sepsis and a pulmonary embolus, which is when the blood clot lodges in the blood vessels in the lung, both of which are life-threatening conditions, and she was admitted to the intensive care unit as well.
Q. Just briefly, what is amniotic fluid embolus?
A. Amniotic fluid embolus is when a portion of amniotic fluid leaves the uterine cavity and enters the circulation, the blood vessels of the mother. This can induce what we thinks is like a severe allergic reaction throughout the body, particularly in the blood vessels in the lungs. This could cause essentially a collapse of blood pressure. The most common outcome of amniotic fluid embolus is death.

Q. Did any of what you described as these three major complications occur in the group of patients who had had intact D&E?
A. None of these complications happened in those patients.
Q. Did you find that the difference between the two groups in terms of the major complications was at a level of statistical significance?
A. It was not.
Q. Were there any differences, Dr. Chasen, in the demographics of the studies to cohorts?
A. There were differences.
Q. What were those?
A. I think the most significant difference is that the median gestational ages, the women who had D&E with intact extraction were closer to 23 and 24 weeks as a whole group, and the women that had D&E with disarticulation or dismemberment were more likely to be closer to 20 and 21 weeks. So as a whole the women with the intact extraction variation, that group were of more advanced gestation, with bigger fetuses and more placental tissue. That was one difference.
Q. Let me interrupt you. Why, in your judgment, is that difference in demographics a significant one?
A. It is significant because the rate of complications, and indeed the rate of maternal death, related to abortion in studies clearly demonstrates an increased risk with advancing

gestational age. Complication rates are also higher with advancing gestational age. So the fact that women who had D&E with intact extraction were sass whole at more advanced gestation suggests that they were at higher risk for complications, they were at higher risk for complications.
Q. Dr. Chasen, were there any differences in the intraoperative variables as between the intact D&E cohort and the cohort for D&E about dismemberment?
A. We did not observe a difference in operative times or in estimated blood loss between the two groups.
Q. How about with respect to laminaria use -RPBGTS there were more women in the D&E with intact extraction who were undergoing this procedure because they had dilated their cervix prematurely and were terminating because they were at high risk of miscarrying prior to viability or shortly thereafter, and after counseling they chose to terminate.
These women who had advanced degrees of cervical dilation already did not require laminaria for cervical dilation before evacuation, and in that advanced degrees of dilation facile at it intact extraction, there were more of these women proportionally speaking in the intact extraction group compared to the disarticulation group.
Q. Dr. Chasen, did your study find a difference in the obstetric outcomes of subsequent pregnancies between the intact D&E cohort and the D&E with disarticulation cohort?

A. There were no significant differences between the two groups.
Q. What were the results?
A. I believe there were -- there were four patients who in the subsequent pregnancy or hospital delivered prematurely which is more than three weeks from the anticipated due date. Two of these patients were in each group. It was 2 out of 45, which is between 4 and 5 percent in the disarticulation group 2 out of 17, which is 11 or 12 percent, in the intact extraction group. SP-P that was not a statistically significant difference.
Q. With respect to subsequent pregnancy outcomes, what is the import of the results that you discerned?
A. The two women who delivered prematurely following D&E with intact extraction were both women that had undergone abortion because they had ruptured membranes or had considerable dilation of their cervix as the indication for undergoing an abortion procedure. These women, based on their obstetric history, were at very high risk of premature delivery, and they did deliver prematurely following pregnancy, one at 32 weeks and one at 35 weeks. In light of their risk factors, these were considered very successful pregnancies.
It is important that in the 15 patients who underwent D&E and intact extraction who were not doing this procedure because they had ruptured membranes or had cervical dilation,

in other words, who would not have had an obstetric risk factor for premature delivery following pregnancy, all 15 of these patients subsequently delivered at term. So in this group of patients it did not seem that D&E with intact extraction was associated -- was not associated with subsequent preterm birth at all.
Q. Dr. Chasen, is the number of subsequent pregnancies that you followed, which I think you earlier testified was 62, a sufficient one in your judgment on which to base a conclusion?
A. The conclusion that we made in the paper that the results appear comparable, I think that is a reliable conclusion based on the numbers. Any time you are doing a retrospective or a prospective study, it is always better to have -- the higher the subjects you have in any study, the more likely you are to discern a difference, if there is one. If there is a difference of small magnitude, to discern a difference at a high degree of the statistical confidence, you need many patients. We acknowledge that we lack that in this study. However, given that there is no data published at all addressing this question and that in women who wouldn't be considered at high risk for delivery in a subsequent pregnancy, we didn't see subsequent preterm birth in the intact extraction group i think we were comfortable making the conclusions that we did.
Q. Dr. Chasen, what was the conclusion in your study as to the

relative safety of the two variations of D&E analyzed?
A. Our main conclusion was based on the data, based on the fact that the complication rates were essentially -- were identical. They were both 5 percent. Or one was 4.9 percent and one was 5 better than the. That in our institution, women undergoing D&E at these gestational ages, there was no difference -- the complication rates between women undergoing the two procedures was comparable.
Q. Do you still adhere to that conclusion?
A. I adhere to the conclusion that both variations are safe and that there is a low complication rate, especially of major complications for both procedures. However, given that I would consider the women who had D&E with intact extraction to be at higher risk for complications in that they were at more advanced gestational ages, with larger fetuses, with more placental volume, and more of these women had ruptured membranes or cervical dilation, which can be associated with a preexisting infection, which can be associated with emhemorrhage, for instance, that this was a higher risk group for complications. The fact that we aachieved the same level, the same rate of complications in these two groups, who I don't think I would consider at equal risk of complications -- and in fact we did not see any severe complications in the patients with intact extraction -- in my opinion, we could take it a step further and say this is IBT consistent with our belief

that D&E with intact extraction has safety advantages.
THE COURT: Is that statement included in your report that you just made?
THE WITNESS: In the study --
THE COURT: Or did your report stop with they were equal?
THE WITNESS: Explicitly they stopped with they were equal.
THE COURT: So this is yours that you are adding on but it is not in your report?
THE WITNESS: It is in the study that we believe we prevented adverse outcomes in that we were able to implement our medical judgment as to the right type of evacuation procedure and that we believe we prevented complications in women in whom intact extraction was feasible. That is in the paper.
Q. Dr. Chasen, are there other factors reported in the paper apart from the same complication rate for different gestational ages that support the conclusion you just articulated?
A. I'm sorry. Could you repeat the question?
Q. Sure. You just indicated that you thought that the same complication rate for cohorts with different gestational ages suggested possible advantages to intact D&E.
THE COURT: Stop whispering, Mr. Hut. Speak up.
Q. I wondered whether there were other results in the study

that support that conclusion to which you just testified.
A. Again, other than complication rates, in terms of achieving similar procedure times and similar blood loss, again, that indicates that if you have equal results in those intraoperative factors but you have one group -- generally procedure times in my experience relate to gestational age and how much fetal and placental tissue needs to be removed, how long it takes for the uterus to contract down and stop bleeding can depend on the size of the uterus at the outset of the procedure, and advanced gestational age of the uterus is bigger. Again, with equal operative times and equal blood loss, that suggests to me that there are safety advantages to D&E with intact extraction.
MR. HUT: Your Honor, plaintiffs offer in evidence Plaintiffs' Trial Exhibit 23A, which is a copy of the chains study.
THE COURT: Any objection?
MS. GOWAN: Your Honor, we did object to it on hearsay groups, I believe. Yes, your Honor, we object to that on hearsay. TAS unpublished article. It is a statement by a party in the case.
THE COURT: For whatever that is worth, I will let it in.
(Plaintiff's Exhibit
S- S- received in evidence)

THE COURT: Are any of your co-authors other plaintiffs or expert witnesses in the three cases going on at the present time?
THE WITNESS: No, they are not.
Q. Dr. Chasen, before the lunch break I asked you whether you prepared patients differently depending on whether you ultimately achieved intact extraction versus D&E by dismemberment. Could you tell us whether the dilation that you apply is in all cases the same irrespective what outcome you achieve.
A. The dilation we seek to achieve is a maximum dilation that we can. Not only with higher levels of cervical dilation enable us in some cases to use the intact extraction variation of D&E, it will also make a D&E requiring dismemberment or disarticulation easier, in my view.
Q. Dr. Chasen, are you familiar with the various options for causing fetal demise before beginning the surgical evacuation of the uterus in a D&E?
A. Yes, I am.
Q. What are?
A. There are chemicals or drugs such as potassium chloride or something called digoxin that can be injected directly into the fetal circulation, either directly into the fetal heart or in some cases into the umbilical cord, both under ultrasound guidance, that can effect fetal demise.

Digoxin can also be injected into the amniotic space, and in most cases that will effect fetal demise.
Q. Dr. Chasen, do you reTAOEPBL use either KCl or digoxin to effect fetal demise before starting to evacuate the uterus in a D&E?
A. No, I don't.
Q. Why not?
A. Some of my patients, there would be a benefit, there may be a benefit from fetal autopsy, from having a placental pathologist look at the fetus or the fetal parts in terms of effecting a diagnosis. If fetal death is effected before the procedure happens, then this process of maceration and decay will likely have TKURD to a considerable degree prior to the evacuation, and that could interfere with pathology.
The main reason why I don't do it is that it is a procedure that can cause discomfort to the patient, it can have some rare complications, it can be difficult to accomplish in certain circumstances. So in most cases I don't do it.
Q. Do you ever?
A. I do in certain cases.
Q. Which ones?
A. Some patients request it. Some patients ask is there anything that can be done before the procedure so that the fetus is dead prior to the evacuation. I comply about such request. Very few patients have made this request to me,

however.
If I am doing a case after 23 weeks of gestation and between 23 and zero and 23 and 6/7 weeks of gestation, and there is not a lethal fetal abnormality that we have identified or a fetal abnormality that is likely to be lethal, I discu discuss this with my patients, I discuss with my patients that insertion of laminaria very rarely can cause women to go into labor. These are women that, because they are choosing to undergo abortion, do not want to experience a live birth, and I let them know that there is a small possibility but a possibility that they will go into labor, but laminaria insertion and that they could deliver a live baby, and that one way to preclude that if we are successful is to induce fetal death prior to that.
(Continued on next page) 4/8/04 Judge Casey take 5 continuing direct of Chase Chase
BY MR. HUT:
Q. Based on your experience with KCL, how easy is it to acom HREURB a KCL insection?
A. In the easegy cases it is easy and in the hard cases it can be impossible.
Q. Are there any women who you have seen for whom it, an injection cannot be done?
A. Yes, there are.
Q. Can you identify some of those, Doctor?
A. There are some women, they may be obese, they may have --

the uterus may be distort I had by large TPOEUB ROEUD tumors shall the denine tumors that are not uncommon, especially as women get holder, where the fetal heart or the fetal umbilical cord or the amniotic cavity may be not anywhere near close proximity to the surface of the maternal abdomen and the far KHER away you get the deeper the penetration that the needle is required to achieve, the more difficult these procedures can be.

There are some types of fetal abnormalities that can be associated with no production of amniotic fluid and any ultrasound guided procedure relies on fluid to surround the fetus to be able to see it,. The sound waves required to see something on ultrasound need a contrast from liquid to solid and you need amniotic fluid to see what you are doing.

In cases where there is a fetal anomaly and there is no am knee OLTic fluid, it is very, very difficult to visualize either the fetal heart or the umbilical cord. This could also be present in women who that have ruptured TH-R maim brains and there is no amniotic fluid for thaten.

These are technical cases that in some cases I haven't been able to overcome.

There are also some women who are extrily afraid of need and WEUPBLD not hold still for a procedure in which a needle is placed through their abdomen. They can't do it.

Q. Is it possible for a physician to cut the umbilical cord

and thereby effect fetal demise prior to surgical extraction?

A. In some cases that may be possible.

Q. Do you routinely do this?

A. I do not.

Q. Why not?

A. In performing -- when I perform D&E, and that's either with intact extraction or with disarticulation my objective is to remove the fetus, intact or not, in the shortest amount of time that it can be done. Every time, for instance a forcep is introduced into the uterine cavity the potential of perforating the uterus and I would much prefer that every time I am introducing a forcep into the uterus cavity and placing this woman at risk that it should be with the objective of removing the fetus. That's why she is having the procedure.

In that trying to grasp the you will bill call cord before doing this would be an extraneous step tanned would suppose the patient to risk I don't do it.

Q. How long does it take, Doctor, in your experience, for the fetus to die after the umbilical cord has been cut?

A. It's not instantaneous.

Q. What effect, if any, can that delay have on the woman?

A. In waiting -- if you're asking if we would wait until we could confirm a fetal demise that the heart wasn't beating in this woman who is already being subject to risks of anesthesia and in which prolonged operative times could increase the risk

of bleeding an infection, then that could have an adverse effect on the patient.
THE COURT: Despite all of those reasons, Doctor, can you finally give an answer at how long does it take?
THE WITNESS: I don't know exactly how long it fakes.
THE COURT: Could you give us an approximation?
THE WITNESS: During most D&Es I perform I'm not watching the fetal heartbeat while I am doing it.
THE COURT: I didn't ask you that, Doctor.
Do you know how long it would take approximately for the fetus to die if the umbilical cord is cut?
THE WITNESS: I would -- I -- I think it would take several minutes, at least.
THE COURT: Under 10?
THE WITNESS: I don't know.
THE COURT: Under five?
THE WITNESS: I don't know.
THE COURT: Any other questions, Mr. Hut?
BY MR. HUT:
Q. One final question actually, your Honor, you anticipated my almost conclusion.
Dr. Chasen, turn if you would, please to plaintiff's trial Exhibit 69.
And that exhibit your Honor will recall from earlier is the Act.

Turn please Dr. Chasen to page S-34 and to paragraph 14B of the Congressional findings.
The last sentence there reads: Indeed, unlike other more commonly used abortion procedures there are currently no medical schools that provide instructions on abortions that include the instruction of partial-birth abortions in their curriculum.
Did I read that correctly, Doctor?
A. Yes, you do.
Q. Assuming that the abortions in question referred to in this finding were the intact variation of D&E, do you believe that there is any basis for the statement by Congress in paragraph 14B?
A. There is no factual basis for this statement.
THE COURT: Well in your school it's voluntary, right?
THE WITNESS: It is voluntary, yes.
THE COURT: Next question.
MR. HUT: I have no further questions of the witness.
THE COURT: All right, it is almost time to take our break.
One thing I forgot to ask you, Doctor.
What was the amount of the recovery in the malpractice suit that was brought against you?
THE WITNESS: I don't know.
THE COURT: You don't know?

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THE WITNESS: I don't know. It was in the malpractice suit I think --
THE COURT: Were you there?
THE WITNESS: It didn't go to trial.
THE COURT: Was it settled?
THE WITNESS: It was settled.
THE COURT: You said it was a verdict for the plaintiff. You don't know.
THE WITNESS: It wasn't a verdict, it was a settlement.
THE COURT: And you don't know.
THE WITNESS: I was awe full-time employee of the hospital and the hospital --
THE COURT: Doctor it is a simple question do you know the amount of recovery.
THE WITNESS: I don't know.
THE COURT: Were you ever told.
THE WITNESS: I don't recall being told the specific amount.
THE COURT: Was the hospital a defendant too?
THE WITNESS: Yes.
THE COURT: And you do not add at the head of that service, co-head of the service you don't know -- what year was that?
THE WITNESS: The complication occurred in 1999, I

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there I the settlement occurred one or O years later. I was not the head or the co-head of the service. I wasn't in my current position.
THE COURT: But you were on the staff of the hospital and the hospital was a defendant?
THE WITNESS: Yes.
THE COURT: And you have no recollection.
THE WITNESS: No. The only recollection I have is is that the lawyer said it was an economic decision and it was in the a large settlement.
THE COURT: Did you include this one in your study in this case, in your study.
A. This was prior to 20 weeks' gestation and it was not at the hospital I am currently at,.
So, for both reasons it would not have met inclusion criteria.
THE COURT: We will take our afternoon recess.
(recess).
THE COURT: Please,be seated.
THE COURT: Ms. Gowan will you be conducting the cross examination.
MS. GOWAN: Yes, your Honor.
THE COURT: You may inquire SRAO.
Q. Doctor you testified some moments ago that you may use potassium chloride to kill the fetus, correct?

A. Correct.
Q. The policy at Cornell is not to perform an abortion on a living foot us at 24 weeks or beyond except where the fetus is an even cephalic, correct?
A. That's correct.
Q. And the practice at Cornell is to inject a living fetus with KCL in all abortions that occur at 24 weeks where there has not been a prior spontaneous fetal death, right?
A. That's my practice.
Q. That's the practice at Cornell, right?
A. The practice at Cornell at this gestational age prior to medical induction of labor but it is actually my practice. I don't know that there is a policy pertaining to D&E.
Q. It is the policy of the department, correct?
A. I don't know if there is a policy for D&E. I think there is for medical induction.
Q. Directing your attention to page 102, line 15 of your deposition in this case:
"Q why is a chemical agent used for all terminations that are going to be occurring at 24 weeks where there has not been a spontaneous demise?
"A the policy of my department is that termination of a living fetus at 24 weeks or beyond is not done with the exception of an even receiveally
"Q what's the agents used?

"A potassium chloride."
Were you asked those questions, did you give those answers at your deposition in this case
A. Yes, I did.
Q. Now, in your study population you had 39 abortions at 24 weeks, correct?
A. Yes.
Q. And 22 of those abortions at 24 weeks were done by D&E by dismemberment, correct?
A. Correct.
Q. And 17 of those were by the intact extraction method, right?
A. Correct.
Q. And the underlying data for your study shows that KC SHRRBGSZ injected to ensure demise in 33 out of the total of 39 procedures at 24 weeks, correct?
A. I don't think the June lying data has anything in there about KCL.
Q. Well, Doctor, isn't it true that in your underlying data there is a column for demise and there is a column for gestational age?
A. That's correct.
Q. And isn't it true that for the gestational age of 24 weeks that you had, in your underlying data, associated a zero with -- excuse me -- a one with spontaneous fetal demise an the

zero will account for injection of fet I sideal agent?
A. That's not correct.
There are some cases where a fetal diagnosis was made, structural abnormality or abnormal chromosomes, and the patient elected not to terminate but the fetus spontaneously died after that.
Those cases were categorized they had two category -- they had two dying niece EUS for which we had categories and those cases that were both the spontaneous demise and a structural abnormality that had the diagnosis of which had preceded fetal demise or a chromosomal abnormality which had preceded fetal demise were not characterized as fetal demise.
Q. So that wasn't a one in the demise column is that what you are saying?
A. We categorized -- we put patient in only one category.
Q. Is that right, that was not a one in the demise category? Or you don't know?
A. No, that's right.
Q. It was not a one in the demise category.
How many were there at 24 weeks in that category?
A. I don't recall.
Q. Well, isn't it fair that it's approximately then, Doctor, 33 out of the total of 39 procedures that KCL was used at in 24 weeks? Isn't that fair to say that?
A. It's not fair to say that given that an encephally is an

exception that the procedure could be done at 24 weeks.
Q. Did you have an an encephfall lick in your study population at 24 weeks?
A. I believe we had several.
Q. But, in any event, fetal demise was assureed in all cases where the fetus had not spontaneously demised, died, prior to the commencement of the abortion, isn't that right?
A. At 24 weeks or beyond, that's correct.
Q. At 24 weeks.
There is no policy for the use of KCL at 23 weeks, is that right?
A. In patients undergoing surgical abortion, I don't believe there is.
Q. But you discuss it with your patients, don't you?
A. Yes, I do.
Q. And you tell the woman that rarely at 23 weeks a fetus can survive exouter RO. And you tell her that unless it is a clearly lethal fetal abnormality, inserting the laminaria could result in a spontaneous labor prior to the time she presents to the operating room for the procedure and this could result in the birth of a living fetus, right?
A. That's what I tell my patients.
Q. And you tell her that to prevent this from happening you can inject KCL directly into the fetal heart or the umbilical cord, right?

A. I tell her we can attempt that and be successful in most cases.
Q. And you tell her that will stop the fetal heart resulting in death, right?
A. In most cases.
Q. And you tell her it involves the discomfort of having a needle pass through her abdomen, correct?
A. Yes the. It involves that.
Q. You tell her that it can be a brief procedure, five to 10 minutes or sometimes longer for technical reasons, correct?
A. Correct.
Q. And you tell her that any time there is a needle introduced into the uterus, that that can precipitate an infection, although it's rare, right?
A. Correct.
Q. And have you done KCL injections several dozen times, right, Doctor?
A. Correct.
Q. Now, you prepared an signed a declaration in 1998 for a case captioned National Abortion Federation versus Reno identifying the Court of jurisdiction as the northern district of Illinois Eastern division, correct?
A. Correct.
Q. And no such case was ever brought, isn't that right?
A. That's correct.

Q. You prepared and signed that declaration in 1998 in anticipation of bringing a lawsuit challenging an earlier version of the Partial-Birth Abortion Ban Act of 2003, right?
A. Correct.
Q. That was a version of the act that was never signed into law, correct?
A. Correct.
Q. And you were going to be a plaintiff in that case, right?
A. Yes.
Q. And the ACLU was going to be your lawyer, right?
A. Yes.
Q. When you first got in contact with the ACLU in connection with challenging partial-birth abortion laws in 1998, correct? Note note no when note note?
A. 1998 or 1999.
Q. And did you ask your colleague, Amos Grunebaum, if you would be interested in being an expert witness on your behalf in this case?
A. In 1998?
Q. In this case presently.
A. No, I did not.
Q. Did you ask Dr. Skupski whom you are written articles with, if Dr. SK*UP can I would be interested in being an expert on behalf you you in this case?
A. No, I did not.

Q. Were you involved in a indication in Colorado in 1999 challenging the Colorado parental notification Act?
A. No, I was not.
Q. You told the Judge that none of the coauthors on your study are testifying at any of the three pending cases challenging the Partial-Birth Abortion Ban Act of TWAO*E, right?
A. Rye.
Q. Are you aware that one of your coauthorss is a consulting expert witness in this case?
A. No.
Q. Now you mentioned that you received IRB or institutional review board approval for your study.
A. Yes.
Q. Now you asked for the IRB approval so that you could look at medical records, right?
A. That's right.
Q. And you told the Judge that you reviewed medical records, right?
A. I reviewed very few medical records, but.
Q. You reviewed some.
A. Okay.
Q. You said something about the medical records belonging to New York Weill Cornell medical center, right?
A. Yes.
Q. In fact, the medical records are in the custody and control

of the New York Presbyterian Hospital, isn't that right?
A. I believe I said the New York Weill Cornell medical center, which is the hospital.
Q. It's the New York Presbyterian Hospital that has custody and control of those records, right?
A. The New York Weill colonel medical center is part of the New York Presbyterian Hospital.
Q. And the New York Presbyterian Hospital is the same hospital that has custody and control of the medical records that the government is seeking from you in discovery in this case, isn't that right, Doctor?
A. That is correct.
Q. Now you decided to undertake your study in the spring of 2003, right?
A. Correct.
Q. And you performed a retrospecttive study because that was the easiest type of study to do, correct?
A. That was the appropriate study to do, yes.
Q. And almost all the data already existed, right?
A. That's right.
Q. And that was the data that had been compiled for the KA*EULish study, correct?
A. The data compiled for the KHR*EURB study only went up to May 2000.
Q. Right; so you had to get some additional data but you had

already compiled a broad array of data in connection with the KHR*EURB study, correct?
A. The last date of data collection was nearly three years prior to when we started this study, the current STEUD study.
Q. You had a database from the KHR*EURB study at your finger tips going back to early 2001, right?
A. Going back to May 2000.
Q. And you relied on that data, there was about 600 charts that you relied on in connection with this study, correct?
A. That's correct.
Q. And you only reviewed a couple hundred new charts for June -- excuse me, from 2000 to June 2003 in connection with your study, right?
A. Correct.
Q. You could have used the data from the KHR*EURB study to perform a like study to the current study a couple years ago, couldn't you?
A. That would have been considerably fewer cases there.
Q. Now, your study does not include all patients who had surgical abortion at Cornell during the period under your review, isn't that right?
A. That is correct.
Q. It only included cases where a physician performed both D&E by dismemberment and intact extraction, right?
A. Where a physician was capable of performing those two

procedures, yes.
Q. And there were other physicians at Cornell who performed only D&E by dismemberment, right?
A. Right.
Q. And those cases were not included in your study, correct?
A. That's correct.
Q. The physicians, there were the work of three physicians were included in your study, correct?
A. My study, it was the -- there were only two attending, two physicians who.
Q. Just two?
A. Who were the attending surgeons.
Q. One of them, at the request of your counsel, I will call Dr. Y, and the other one was you, correct?
A. Correct.
Q. And the majority, dare I say the vast majority of the cases were performed by Dr. Y, correct?
A. Please define vast majority.
Q. Well, how many cases did you perform that were encompassed in the study, Doctor?
A. I believe somewhere between one fourth and one third.
Q. So, two thirds --
A. If that KOPBS Tuesday --?
Q. Or three quarter were performed by Dr. Y, correct?
A. If that constitutes a vast majority, then yes.

Q. Now, out of the total 383 cases that were included in the study, about half to two thirds of those cases were from the old data, the KHREURB data, right?
A. That's right.
Q. And all of those cases Dr. Y had been the attending on, correct?
A. He had been the attending. I had performed many of these cases while I was training.
Q. You performed a handful of those cases right, Doctor?
A. I don't know what the definition of a handful is, but I performed more than what I would consider a handful.
I performed, I think the majority of his indications from 1996 to 1998 but he was the attending physician of record.
Q. Now, Dr. Y came to Cornell in or about 1996, right?
A. Yes.
Q. And it was about that time that there was a significant increase in volume of patients at Cornell that were undergoing D&E, correct?
A. That's correct.
Q. And Dr. Y is highly skilled at performing D&E, isn't that right?
A. Yes, he is.
Q. And would you agree that he is also highly skilled at performing intact D&E?
A. Yes, I would agree.

Q. In fact, you learned the intact D&E procedure from Dr. Y, isn't that right?
A. That is right.
Q. And as I said before, he was the attending for all of the 600 D&Es that were the subject of the KHR*EURB study, correct?
A. Yes.
Q. And in all, you have only done between 50 and 75 intact procedures, correct?
A. Corrects.
Q. That's on the order of about 12 intact procedures each year at 20 weeks or greater, right, Doctor?
A. That's correct.
Q. And about 150 to 200 D&Es by dismemberment, correct?
A. Correct.
Q. As far as you know Dr. Y was at Albert Einstein in the Bronx prior to coming to Cornell, correct?
A. He was, yes.
Q. Now, you selected 120 cases for your intact extraction group in the study, right?
A. 120 cases met inclusion criteria.
Q. And in order to determine what would meet the inclusion criteria, what would go in each of the two groups, you looked at information in the medical records, right?
A. Information in the medical records was looked at. Most of it not by me.

Q. Someone looked at the information in the medical records, right?
A. That's right.
Q. And the information was found in one of two places, either the operative report or the pathology report describing the condition of the fetal specimen, right?
A. That's right.
Q. Now, you testified earlier today that if the fetus was intact past the umbilicus, it was included in the intact group, right?
A. That's right.
Q. But in some cases the medical records showed that cervical dilation was sufficient to pass the fetus' lower extremities but between the passage of the pelvis in the upper part of the back or the arms the fetus had disarticulated, correct?
A. Correct.
Q. And those cases were put in your intact group even so, correct?
A. They didn't involve forcep and disarticulation with forceps so we included them with the intact; yes.
Q. But you don't know for certain, do you, Doctor, whether the arms or the upper part of the back had been dismembered prior to bringing down the lower extremities in the pelvis, do you?
A. I don't imagine how they would have been dismembered before bringing down the lower extremities and pelvis.

Q. Well, isn't it possible that the physician, could have with the forceps, reached up and dismembered an arm and then removed the arm and then brought down the fetus' legs into the breech for delivery?
A. We would not have categorized that as an intact extraction if disarticulation with forceps had preceded it.
Q. But how would you know that that is how the upper part of the back or arms had been disarticulated or not?
A. Well if the operative report most likely would have reflected it and if not then the pathological report would have.
Q. But you didn't look at very many records did you, Doctor?
A. Me personally? I did not.
Q. Now, you completed collecting your data in August of 2003 and you finished your manuscript in late August, early September 2003, right?
A. That's right.
Q. And as you told the Judge, you sent it to the journal of obstetrics and gynecology and that was in either late August or early September, right?
A. I sent it to obstetrics and gynecology.
Q. That was the ACOG journal, is that right?
A. Yes.
Q. And you heard back from them in October of 2003 rejecting your paper and you told the Judge that you had received some

criticism from some of the reviewers at obstetrics and gynecology, right?
A. I received feedback, some positive, some not.
Q. And some of the not so positive feedback related to the terminology that you used to describe the procedure, right?
A. That's right.
Q. And you were faulted for your use of the term dilation and extraction with disarticulation to describe the non-intact procedure, right?
A. That -- that was an issue from one of the reviewers.
Q. And it was pointed out to you that the procedures that were at issue in this study were more appropriately called dilation and evacuation and D&X, dilation and extraction, also called D&E, correct?
A. In the opinion of that reviewer.
Q. And you were also criticized for the conclusion in the abstract portion of your first draft, right?
A. I believe so, yes.
Q. And that conclusion was, "dilation and evacuation with intact extraction is as safe as dilation and extraction with disarticulation after 20 weeks' gestation."
Right?
A. Correct.
Q. It was found that that conclusion was too conclusive, correct?

A. By one of the reviewers.
Q. That's right?
A. -- in his or her opinion.
Q. And the criticism was that you had not proved that it was safe, only that you had found in your retrospecttive review, that there were no obvious differences between the two procedures, correct?
A. Again, one person's opinion but that's what the reviewer said.
Q. Well that criticism caused you to change your conclusion in your next draft, didn't it, Doctor?
A. Yes, it did.
Q. You changed it to, "outcomes appear similar between patients undergoing dilation and evacuation and dilation and extraction after 20 weeks' gestation."
Correct?
A. It wasn't in response to that reviewer.
Q. The changed language is what appears in your paper in press, correct?
A. The language is different than the original version but not in responsive to the reviewer from obstetrics and gynecology.
Q. Its outcomes appear similar, not is as safe.
Correct?
A. The outcomes assessed in the paper as it will be published relate both to complications during a D&E as well as to

outcomes in subsequent PREG TPHAEPBs.
Using just the term "safety" doesn't encompass both and the language was changed because I wanted to change it to encompass both.
Q. You change the conclusion in your concluding paragraph of your first draft, didn't you, Doctor?
A. Yes.
Q. There you had stated, "our data affirmed that D&E, after 20 weeks' gestation with intact extraction when performed by experienced physicians, is as safe as D&E with disarticulation."
Correct?
A. Correct.
Q. And you changed that in your next TKRAF to, "our data affirmed that abortion after 20 weeks' gestation with intact D&X appears to have similar complication rates as dilation and evacuation when performed by experienced physicians."
Correct?
A. Correct.
Q. And you cannot state that one technique is superior to the other, can you, Doctor?
A. Not based solely on the data in a retrospecttive study with certainly TEU.
Q. Not based solely on the data in your retrospecttive study, correct, Doctor?

A. I cannot prove it or state it with certainly TEU.
Q. You were also criticized for your conclusion that, "subsequent obstetric outcomes are similar between the two groups."
Correct?
A. Correct.
Q. And that related to your finding about preterm birth, KRBGT?
A. Spontaneous preterm birth.
Q. And because you are only able to follow up on 62 pregnancies of your group out of 363 patients, the reviewers identify a potential weakness to your conclusion on that score, correct, Doctor?
A. Correct.
Q. Now, you could have contacted the remaining 321 women to determine the absolute number of subsequent pregnancies that occurred, couldn't you?
A. We could have, but we had no guarantee of obtaining reliable data that way. That --
Q. Well you could have asked them for permission to study the medical records to assist you in performing your study, isn't that right?
A. We could have. But, again, I don't think that would have led to uniformly reliable data.
Q. Now, the spontaneous preterm birth occurred in your study

in women who had undergone D&X at almost twice the rate of D&E by dismemberment, correct?
A. There was no statistical difference in the rate.
Q. Almost twice the rate, isn't that right, Doctor?
A. Yes. But that was not statistically different.
Q. Well, wouldn't you agree that the quality of your conclusion may be affected by the number of patients that you were able to subsequently follow who had pregnancies and delivered at Cornell?
A. No, I wouldn't agree.
Q. Directing your attention to page 39, line 20 in your deposition in this case:
"Q how about the quality of your conclusion? Does that depend, in any way, on the number of patients that you were able to subsequently follow at your institution?
"A it might.
"Q in what way?
"A as we addressed the conclusion we did not assess pregnancies that were cared for outside of our hospital.
"Q and why does that affect the quality of your conclusion, Doctor?
"A can you read back the last question as to the quality of the conclusion, my response to that question.
Where upon the question and answer were read back to you

"A and read back the current question now.
Where upon the current question was read back to you.
"A answer it might affect the quality of the conclusion if, as we acknowledge in paragraph 2, it could introduce bias.
"Q what do you mean by that?
"A hypothetically the patients who underwent D&E at our hospital and delivered elsewhere may have had a higher or lower rate of spontaneous preterm birth.
"Q and why, as stated in your report, do you think the significant bias would be unlikely?
"A we believe a significant bias would be unlikely.
"Q why?
"A we did not determine where patients would delivered.
"Q but KPWR would a significant bias be unlikely?
"A we didn't epvision a scenario where a significant bias would be unlikely
"Q but what's the basis for that statement in the study?
"A it's in the comments section, it's our opinion.
"Q what what is the basis for your opinion?
"A our lack of ability to envision such a scenario.
"Q and why couldn't you envision such a scenario?
"A we did not.

"Q why?
"A I don't have anything to add."
Were you asked those questions, did you give those answers at your deposition in this case?
MR. HUT: Objection, your Honor. I believe that Ms. Gowan P-S read the last word at line 21 on page 41. In the copy that I have before me it is likely and I believe you said unlikely.
MS. GOWAN: Oh. That's correct.
Q. Were you asked those questions did you give those answers at your deposition, Doctor?
A. Yes.
Q. Now, after having your paper returned you sent it to the American journal of obstetrics and gynecology in October of 2003, right?
A. That's correct.
Q. And that paper was tentatively accepted for publication in December of 2003, right?
A. Right.
Q. And you again had some reviewer comments, right?
A. Right.
Q. And one of those comments related to the fact that the very serious complications that you told Judge Casey about occurred only in the non-intact group, right?
A. Right.

Q. Those were the amniotic fluid emPWOlism, the severe sepsis and the perforation at the site of the prior Caesarian section, right?
A. That's right.
Q. And the reviewer wondered whether those complications in fact could have been avoided if the intact procedure had been used, correct?
A. That's correct.
Q. But the answer to that question is no, isn't that right, Doctor?
A. That's in the -- that is in the, what will be published version of the manuscript. The answer is no.
Q. And the reasoned the answer is no is because would you have done the intact procedure if it had been feasible for those patients. And since you didn't do it for those patients that meant you couldn't do it, right?
A. As we have readily acknowledged in the paper; yes.
Q. Therefore, the complications could not have been avoided by doing a different procedure?
A. In those patients.
Q. And you fixed it in -- I should say you made a statement in the paper to be in press that, "because our approach is to perform intact dilation and extraction when possible, based on cervical dilation and fetal position, it is unlikely that intact dilation and extraction could have been performed in

these patients undergoing dilation and evacuation who experienced severe complications."
Right?
A. Right.
Q. Is it fair to say, Doctor, that in your study the default went to the non-intact procedure?
A. That's vague. What do you mean?
THE COURT: Could I have that answer? You swallow your words, Doctor.
THE WITNESS: I'm sorry.
THE COURT: Could I have the answer read, please.
(record read).
Q. Do you understand the question?
A. No.
Q. If you couldn't do the intact procedure you did the non-intact procedure?
A. If we couldn't do the procedure that in our judgment would be the safest then we would -- when we weren't technically age to do the intact extraction then the disarticulation was done.
Q. When you weren't technically able to do intact D&E you did D&E by dismemberment, right?
A. That's right.
Q. Therefore, Doctor, isn't it fair to say that you could neverality PWAOUT a difference in complication to one procedure or the other because you could not have done both procedures on

the same woman?
A. We didn't attribute complications to one procedure or the other.
Q. And wouldn't you agree, Doctor, that a randomized trial would have given the reader a better understanding of what the true comparison rate between the two procedures is?
A. Ideally if such a study could be done.
Q. In response to a suction by one reviewer that you should mention the fact that legal challenges to the constitutionality of the Act were underway, you stated that, "while your paper may be relevant to the political controversy," you didn't think it was appropriate to acknowledge the controversy in the paper, correct?
A. That's correct.
Q. Did you mention to the journal that you were a plaintiff in one of those legal challenges?
A. No, I didn't.
Q. Now, you prepared several drafts of the paper, correct?
A. Correct.
Q. And in the drafts you changed the name for the procedures being studied, correct?
A. That's correct.
Q. In the first draft you called them dilation and evacuation with disarticulation and dilation and evacuation with intact extraction, right?

A. Correct.
Q. And in the second draft you called them dilation and eSRABG situation and dilation and extraction, correct?
A. That's correct.
Q. And in the third draft you called them dilation and evacuation and intact dilation and extraction, correct?
A. That's correct.
Q. And you understand that dilation and evacuation is one technique and that intact dilation and extraction is another technique, right?
A. No, I do not acknowledge that they're separate techniques. They're separate procedures.
Q. Directing your attention to page.
5, line 2 of your deposition in this case:
"Q why did you use the word 'technique' in your paper?
"A the title of the paper refers to dilation and evacuation at 20 or greater weeks, therefore every procedure described in here is a dilation and evacuation.
"Q Doctor, why did you use both techniques on page five, first paragraph of your study?
"A for the purpose of the study, to differentiate between the two techniques of dilation and evacuation.
"Q and what are those two techniques?
"A dilation and evacuation with disarticulation and

dilation and evacuation with intact extraction. Note note 9 up there STKPWHRAOEURPBLGTS note note
"Q why didn't you say that in your paper? Why distribute you describe it that way in this paragraph
"A the first draft of the paper described it exactly that way. And then based on some feedback from reviewers it was suggested to use the term intact D&X for dilation and extraction so that the reader could create more of a contrast.
"but based on the title of the paper and based on my feeling, these are all dilation evacuation and there is the disarticulation technique and the intact dilation and extraction technique."
Were you asked those questions, did you give those answers at your deposition in this case?
A. Yes, I did.
Q. Now, you testified earlier today about the complications in the gestational age groups in your study and you talked about a higher risk group of complications being in the intact group and that being associated with the higher gestational age, is that right?

A. That's right.
Q. And you base that because you took a median average on the 20 weeks to 27 weeks gestational age that were in your study, correct?

MR. HUT: Objection, your Honor. Vague and ambiguous.
THE COURT: May I have the question, please?
(record read).
THE COURT: Overruled.
THE WITNESS: We THAOBG a median ats not an average. They're not interchangeable terms.
Q. So you got a median for D&E by dismemberment of 21 weeks and you got a median for D&X of 23 weeks, right?
A. That's correct.
Q. And so, based on that, you have a higher median in the intact group and then you, when you were testifying earlier today, were drawing some conclusions about that.
But if you stratified the group and if you take a look at the gestational age groups individually, in fact the intact D&X group is not at a higher gestational age than the other except for at 23 weeks, correct?
A. Apples and or ranges.
(continued on next page) TWM take 6 Dr. Chasen on cross by Ms. Gowan<]
Q. Yes or no, Doctor?
A. If you are talking about which procedure at each individual gestational age would comprise the majority of procedures, you are right that only at 23 weeks where the intact extraction variation of D&E exceed 50 percent of the total. That is different than saying that the median gestational age of the D&E with intact extraction was at a higher gestational age than

the D&E with dismemberment. Two totally different things.
Q. You have a D&E with dismemberment at 27 weeks, right?
A. Yes.
Q. You don't have an intact D&E at 27 weeks, do you?
A. There was only one case at T-P weeks, I believe, and it was with dismemberment.
Q. You have a D&E with dismemberment at 26 weeks, right?
A. Yes.
Q. You don't have an intact D&E at 26 weeks, do you?
A. I just detailed fewer than 1 percent of the cases.
THE COURT: Their Doctor, just answer the question.
A. Yes.
Q. You have 2 each of a D&E and a D&X at 25 weeks, right?
A. Correct.
Q. You have at 24 weeks 22 D&E and 17 D&X, right?
A. Correct.
Q. It isn't until you get to 23 weeks that you have more D&X than D&E's, you have 40 D&X and 34 D&E's, right?
A. What do you mean until you get to 23 weeks?
Q. That is the only gestational age where you have PH-R D&X in the group than you do D&E, right?
A. That's right.
Q. At 22 weeks you have 35 D&E by dismemberment, 28 D&X, right?
A. Correct.

Q. And at 21 weeks you have 72 D&E by dismemberment and 23 D&X, right?
A. Correct.
Q. At 20 weeks you have 96 D&E's and 10 D&X, right?
A. That's right.
Q. At 20 weeks or greater in most patients you insert the lamb Maria on two executive days, right?
A. That's right.
Q. Then the day following the second laminaria insertion you take the patient to the OR where under general anesthesia, you remove the laminaria, examine the patient, and decide which operative approach D&E by dismemberment or D&X to take, correct? SP-P?
A. You said general anesthesia. Many patients did not get general anesthesia [> do not<]
Q. Aside from that, everything else that I just said is exactly what you are operative approach is, correct?
A. That's correct.
Q. You make your decision about which technique, which procedure to perform based on the amount of cervical dilation, the depth of the vagina, the fetus's gestational age, the size of the uterus, the fetus's position, and the reason for the abortion, right?
A. The primary factors are the cervical dilation, the vaginal depth, the fetal position. Those are primarily what I use.

Q. Your decision is made at the beginning of the procedure, before you start the procedure, correct?
A. The first part of any procedure is an examination under anesthesia. That is the beginning of the procedure.
Q. You make a judgment in the operating room if you are able to do an intact extraction, and if you are, you proceed with an intact extraction, cent?
A. That's correct.
Q. You use the intact extraction procedure because you are able to, correct, Doctor?
A. Yes.
Q. This morning, when you were describing how you performed D&E, you used the term "breech extraction." Breech extraction involves the delivery of the fetus with the feet initially and the rest of the body to follow, right?
A. That's right.
Q. Sometimes the breech extraction involves the use of an instrument, correct?
A. In some cases.
Q. You would insert a forceps into the uterus, right?
A. In some cases.
Q. In the cases when you don't use instruments, you deliver the fetus with your hands, right?
A. That's in most cases, yes.
Q. In your definition of an intact extraction is when the

fetus is delivered intact [> your definition<] in the breech presentation to the level of the um byly cus or higher with the head being well applied to the cervix decompressed with suction, followed by intact delivery of the entire fetus, correct?
A. An intact extraction does not have to follow, does not have to involve decompression of the head. It does in most cases.
Q. Yes. Sometimes you can tuck the fetus's chin down to its chest and pull the head out of the cervix without decompression, right?
A. That's right.
Q. You would agree, Doctor, wouldn't you, that at 20 weeks' gestational age the fetus is more likely to disarticulate with traction than to deliver intact?
A. I would agree.
Q. Traction is used in D&E by dismemberment, correct?
A. Traction with forceps is used.
Q. When it is feasible for you to perform the intact procedure, you generally start with the delivery of one leg of the fetus, correct?
A. Correct.
Q. You gently pull on the one leg with your hands, and when it is almost out, the other leg is swept out, correct?
A. Yes.
Q. You wrap a small sterile towel around the fetus, because it

is slippery, and after the legs are out you pull on the sacrum, or the lower portion of the spine, to continue to remove the fetus, right?
A. Right.
Q. When the fetus is out to the level of the breech, you place another, larger towel around the first small towel, right ?
A. Right.
Q. You gently pull downward on the sacrum until the shoulder blades appear, right?
A. Right.
Q. Then, with your hand on the fetus's back, holding it with the towel, you twist in a clockwise or counterclockwise motion to rotate the shoulder, right?
A. Right.
Q. The shoulder in front or the arm in front is swept out with your fingers, and then you rotate the other side of the fetus to sweep out the other arm, right?
A. Right.
Q. Then the fetus is at a point where only the head remains in the cervix, correct?
A. That's correct.
Q. That is when you make the decision based on the gestational age and the amount of cervical dilation, whether the head will fit out intact, whether you can tuck the head of the fetus to its chest, or whether you have to decompress the skull to

remove the fetus's head, right?
A. It is based on the size of the fetal head and the cervical dilation. I don't directly consider the gestational age. [> check the question<]
Q. If you you are able to deliver the head by flexing the chin against the fetal chest -- and you have been able to do this several times, RAOEUPLT, Doctor?
A. There have been a few occasions, yes.
Q. Then you remove the fetus with the towel, you not it on the table, and you turn back to the woman to deal with the placenta, right?
A. That's right.
Q. If you can't do that, you know you are going to have to crush the head, and so you take a clamp and you grasp the cervix to elevate it, and then your assistant there in the operating room will pull down on the fetus's legs or back, gently lowering the fetus's head toward the opening of the vagina, right?
A. Right.
Q. That is when you put two fingers at the back of the fetus's neck at the base of the skull where you can feel the base of the skull, and then you puncture the skull with the scissors, right?
A. I usually can see it as well as feel it. But yes.
Q. At that point you see some brain tissue come out, and you

are 100 percent certain that you are in the brain, so you open the scissors to expand the hole, remove the scissors, and put the suction device in the skull, right?
A. Correct.
Q. You turn on the suction, and typically the fetus comes right out with the suction device still in its skull, right?
A. Right.
Q. You would agree, wouldn't you, that the maneuvers that you perform are very similar to an assisted breech delivery after viability?
A. With the exception of the decompression of the skull, yes.
Q. Your paper included in the intact group some cases where the fetus was delivered in the vertex presentation, right?
A. Yes.
Q. That's a head-first delivery, isn't it?
A. Yes, it is.
Q. In those cases an incision with scissors is first made in the fetus's head, suction is placed in the skull, and then the fetus is delivered, correct?
A. Correct.
Q. The the incision with the scissors is made while the fetus's head is still in the uterus but flush against the internal cervical os, right?
A. Yes.
Q. Then the suction curette is placed in the head to drain

the' brain, correct?
A. Correct.
Q. Similarly, you typically find that with the suction curette still in the head, the fetus will descend through the cervix and easily come out of the woman's body, right?
A. Yes.
Q. You testified this morning in response to counsel's questions that in your opinion intact D&E is the safest way to perform an abortion as compared to dismemberment D&E, right?
A. When I can technically accomplish -- if I can do either, that the intact variation is safer.
Q. Your study doesn't support that conclusion, does it, Doctor?
A. I think my study does support that conclusion.
Q. You testified that in your opinion the intact D&E has safety advantages over D&E by dismemberment because the procedure is quicker, right?
A. Yes.
Q. Your study doesn't support that conclusion either, does it?
A. I don't think my data are inconsistent with that conclusion.
Q. Procedure time was the same, wasn't it?
A. It was the same, but in those cases with intact extraction', that group, based on appropriate statistical tests with which the' reviewers and editors agreed, were at higher

gestational ages as a whole than women who had D&E with disarticulation.
Q. You testified that the intact D&E has safety advantages over D&E by dismemberment because there is less blood loss with the procedure, correct?
A. Correct.
Q. And your study doesn't support that conclusion either, does it; the blood loss is the same?
A. When it is the same in two cohorts, one of when I say is in my opinion at considerably higher risk of hemorrhage, then it STKUZ support that advantage of safety advantage of D&E with intact extraction.
Q. 80 percent of the blood loss that occurs after the placenta has been delivered, which is after the fetus has been removed from the woman, correct?
A. Correct.
Q. That is not blood loss from perforations or lacerations, is it?
A. It's not. [> check the question<]
Q. Wouldn't you agree that you would expect that if there was a benefit to less passes with instruments, you would have less procedure time or less blood loss with intact D&E?
A. Yes.
Q. Your study doesn't show that you do, does it?
A. Again, the cohort in which we used the intact extraction

and achieved the same blood loss in the same operative time would be expected based on advanced gestational age to have increased operative time and increased blood loss. So, again i think those safety advantages are not inconsistent with the data in the study.
Q. You don't make that claim in your study, do you?
A. I don't make that claim in the study, no.
Q. In any event, Doctor, when you give the consents to your patients, you tell them that D&E carries a small risk of hemorrhage, isn't that right?
A. That's right.
Q. Approximately 1 percent, correct?
A. Correct.
Q. You also tell them that it carries a small risk of perforation, correct?
A. Correct.
Q. What is that percent, Doctor?
A. I believe it is less than 1 percent.
Q. A very small risk of uterine perforation, correct?
A. Correct.
Q. You also tell your patients that, like every surgical procedure, there is a small risk of infection, correct?
A. Correct.
Q. That is at about 5 percent, right?
A. Correct.

Q. You prescribe antibiotics prophylactically on the first day of the laminaria insertion for all surgical abortions to be continued through the day of the operation, correct, Doctor?
A. Correct.
Q. You testified this morning that D&E is safer than induction. What gestational age were you referring to?
A. I was referring to the second trimester, 14 through 23 weeks.
Q. What is the data that you are relying on in forming that opinion?
A. I am relying on my own experience and I am relying on, I believe, studies that I have read comparing the two techniques.
Q. What studies?
A. With the Autry study and CDC data looking at mortality rates have shown lower rates with D&E compared to medical induction in the second trimester.
Q. What rates did it show?
A. The rates were very, very small, not more than a few per hundred thousand. But I believe the rates were lower with D&E compared with medical induction.
Q. You don't disagree with the fact that medical induction abortion is safe, do you, Doctor?
A. No, I don't.
Q. You don't disagree with the fact that D&E by dismemberment is safe either, do you, Doctor?

A. No, I don't.
Q. Would you agree that your study shows that the intact extraction procedure is rarely used in cases of a maternal medical problem?
A. I would agree.
Q. That is because in the D&X group, Table 2, you have a small percentage of abortions for what you have categorized as "other," 10.8 percent in "other," right?
A. Correct.
Q. "Other" includes rape, incest, maternal medical problem, and purely elective abortion, correct?
A. Correct.
Q. So the maternal indications for the performance of the procedure in your study was some percentage point below 10 pointer 8 percent, correct?
A. That's correct. [> 10.8 percent<]
Q. While a woman may be experiencing a severe medical condition that requires termination of her pregnancy, the fact that she has the medical condition does not affect your selection of the surgical technique for the abortion, does it, Doctor?
A. No. I use the same criteria.
Q. In your mind, it all boils down to whether the intact extraction procedure is technically feasible to perform on that woman, correct?

A. That's my pro, practice, yes.
Q. You have had three women, for example, with cases of preeclampsia that presented in the second trimester, correct?
A. Correct.
Q. And at least two of those cases the fetuses were beyond to weeks, right?
A. That I can recall, yes.
Q. You remember that in one of those cases it was feasible to perform an intact extraction, and so you did, correct?
A. Correct.
Q. You have performed, as you testified earlier, abortions for women with cancer. It was two women exactly, wasn't it?
A. That I can recall.
Q. Right. One had brain cancer and one had breast cancer, right?
A. Correct.
Q. But you can't recall the procedure used there or the gestational age, aside from the fact that it was about a year ago, right?
A. I believe it was more than a year ago, but I don't remember the gestational age or the variation of D&E.
Q. But you are confident that if it were feasible, you would have performed the intact D&X procedure, and if it wasn't, you would have performed the D&E by dismemberment procedure, correct?

A. Consistent with my practice, yes.
Q. You testified that you believe that an intact extraction procedure had advantages in cases where a path OPBLG cal assessment of the fetal anomaly might be desirable, correct?
A. Correct.
Q. The labor induction abortion would also result in intact specimen -- intact fetus for purposes of pathological assessment, right?
A. Only if the labor induction was successful.
Q. Labor induction is often successful, isn't it, Doctor?
A. In most cases but not all.
Q. In those cases, most of those cases, when it is successful, that will result in a completely intact fetus for purposes of pathological assessment, right?
A. Completely intact but in many cases macerated.
Q. Are you familiar with the literature concerning genetic diagnoses in D&E by dismemberment?
A. I'm familiar with the study, yes.
Q. Which study are you familiar with?
A. The study from Chicago, I believe.
Q. Dr. Shulman's work?
A. That's the one.
Q. It is actually more than one study on the point, isn't it?
A. Probably, yes his view certainly is that D&E by dismemberment is completely appropriate for purposes of

conducting genetic analysis and assessment for fetuses with anomalies, isn't it.
A. Genetic assessment relies on tissue. It doesn't rely on any portion or portions of the fetus being intact.
Q. So you would disagree with Dr. Shulman's views?
A. Genetic diagnosis in many cases does not rely on -- it relies on tissue and cells that can be obtained from amniotic fluid or can be obtained from a small portion of fetal tissue. In those cases having an intact or a dismembered fetus wouldn't make a difference, if it is a genetic test.
Q. Is that the same as a chromosomal test? Is that what you are referring to?
A. Yes. A chromosomal or a test involving DNA or a gene.
Q. That can be diagnosed from amniocentesis, correct?
A. Or any small portion of fetal tissue, yes.
Q. But you have had situations where you believed that you were able to -- would be able to receive a good evaluation of organs or structures because the fetus was removed but you didn't choose to do the intact procedure, correct?
A. I have done the intact procedure whenever I technically could.
Q. When you could. Even if it might have been desirable to have an intact fetus but you couldn't do it, you went head and did D&E by dismemberment, correct?
A. That's correct.

Q. So you don't purposefully set out to do an intact procedure to get additional pathological assessment, do you?
A. No, I don't.
Q. You make your decision based on what the conditions are at the time you start the surgery?
A. Prior to the surgery, the patients have been counseled about the possibility and the options for having an intact fetus, but the decision about which technique of D&E is made at the time of the surgery.
Q. Do I read your study correctly to support the conclusion that chromosomal abnormalities are more likely to be diagnosed early in pregnancy and that abortion for such abnormalities will occur at earlier gestational age, where D&E by dismemberment is used?
A. Yes, you do.
Q. That is in Table 2, right?
A. Yes.
Q. We see an overrepresentation, a disarticulation group, when the abortion indication is abnormal fetal ter a type, correct?
A. Correct S-
Q. You testified this afternoon about hydrocephalus, hydroselfic fetus. You would agree, wouldn't you, that if a physician performed a procedure to drain the fluid off the brain of a hydroselfic fetus, correct?
A. If a physician could. Very often it reaccumulates quickly.

Q. The procedure is called receive lo centesis, isn't it?
A. Yes, it is.
Q. You could repeat it, couldn't you S-
A. One could.
Q. You wouldn't have to crush the head that way, would you?
A. You might not have to.
Q. Indeed, the use of receive lo centesis to drain fluid from the brain of a hydroselfic fetus is an appropriate technique to use in order to facilitate vaginal delivery, right?
A. Only in the case of an abortion or a lethal form of hydrocephalus.
Q. Correct. And that can safely be accomplished through the use of medical induction abortion, right?
A. That's correct.
MS. GOWAN: I don't have any further questions. Thank you, your Honor. Oh, excuse me. I apologize. I do have some more questions.
Q. Doctor chains, on December 23, 2003, you served verified responses to the government's discovery requests in this case. Those requests had previously been provided to your counsel in or about November 21, 2003, with an effective date of service I believe it is December 5 or 3, 2003. Can you tell me what steps, if any, you took prior to signing your verified response on December 23rd to obtain access to the medical records for your patients at New York Presbyterian Hospital?

A. Yes. I think in the first week of December I believe I contacted the head counsel of New York Presbyterian Hospital, John cam pa no, and made him aware of this request and asked whether I was authorized to obtain the information that would be responsive.
Q. What did he say?
A. His initial response was he was discussing it with an attorney subordinate named Michael colston and not to do anything until they told me it was OK.
Q. Did you hear from them again?
A. I believe the next conversation I had was with Mike colston probably several weeks later, and he apprised me that the hospital was contesting this or not authorizing me to go to medical records and access patient records, that the hospital was contesting this.
Q. Did he say why?
A. I believe he said something about concerns for privacy.
Q. What, if anything, did you do after he told you that?
A. I complied with his instructions to not obtain any patient information that wasn't directly related to their care.
Q. What was his instruction exactly?
A. I don't remember the exact words, but the emphasis was not to do anything to comply with these requests if it involved obtaining hospital records that were not related to patient care.

Q. On March 26, 2004, the government was informed by your counsel that Cornell University has some of your records but has denied to you review, at least as of that date. What kind of records does Cornell University have relating to your patients?
A. Almost all of my patients have had care in our prenatal diagnosis unit, they have had ultrasounds, they may have had invasive procedures, and they may have had consultations with me. Those records are there for the patients that have undergone D&E. As out-patients, not the patients that are in-patients, a documentation of conversations relating to informed consent and the laminaria emplacement.
Q. When did you first contact someone at Cornell University about access to the records relating to your patient care?
A. I believe I made the Weill Cornell counsel, James Kahn, aware of this sometime in March.
Q. Why did you wait until March to contact Cornell University about records that might have been responsive to the government's subpoena served in 2003?
A. The government was asking for a comprehensive list of medical record numbers. None of my records have patient medical record numbers, and it is certainly not comprehensive. And the way to do that from my perspective would have been to go through the hospital medical records, and I was not authorized to collect that information.

Q. What made you think at some point in March 2004 that you should contact Cornell?
A. Again, to be responsive to the government request in full would have required access to medical records through the hospital. I was not authorized to do that. The records that I have or that are in custody of the medical college, who is my employer, would not be responsive at all to some of the interrogatories, wouldn't have medical record numbers in response to the first interrogatory, I believe. And in order to get medical record numbers based on patient names, I would have had to access hospital records, and I wasn't authorized to do that.
Q. Have you looked at all at any of the records at Cornell University?
A. When the hospital -- I'm sorry -- my college counsel informed me that the hospital was contemplating how to respond to a subpoena and that they may need to get a list of medical records quickly, yet they weren't authorizing me to go through medical records which could be comprehensive, he suggested or he asked me if there was a way that I could get some list of patients to something to the hospital so that at their discretion they could perhaps begin putting the records aside or a process of redaction. In response to that I said, well, some of the patient names, not medical record numbers, but names would be in billing records under the custody of the

medical college, my employer, and that I also, from my memory, could generate a list that, again, wouldn't be anywhere near comprehensive, but I could remember a number of names.
Q. Is this process you are describing that has taken place recently in March?
A. I believe I compiled a list of PHAEUPLS from my memory on Friday, March 26th, and I was authorized by James Kahn Monday morning, March 29th, to obtain those billing records that had the names of some patients.
Q. Did you do that?
A. I did that.
Q. We understand from plaintiffs' counsel on April 7, 2004, that counselor has permitted you to look at the billing records. I think that is what you were you telling us, is that right?
A. That's right.
Q. What have you looked at?
A. On the billing records, the patients have a name, they have a billing code that is not a medical record number, they have a procedure code. They may have information about the patient's insurance company and about the account balances and things like that.
Q. Do you have any idea which of the government's discovery requests that information is responsive to or do you have no way of telling from the billing records?

A. Again, I think the government was asking for medical record numbers, so the billing records would not respond to those in that they don't contain medical record numbers.

MS. GOWAN: Thank you.

THE COURT: Are you finished, Ms. Gowan?

MS. GOWAN: Yes, your Honor. Thank you.

THE COURT: Any redirect?

MR. HUT: Brief redirect, your Honor.

REDIRECT EXAMINATION

BY MR. HUT:

Q. Dr. Chasen, if the risk of uterine perforation is small, why do you want to minimize it?

A. It is not small to the patient in whom it occurs, I guess is the short answer. Over all, the risk is very low, but I believe even minimizing, even if there is a miniscule difference in the risk based on variation of D&E, I would still want to use the one that in my best medical judgment would absolutely minimize it.

Q. How about with respect to the risk of infection, if that is small, why do you want to minimize that one?

A. For the same reason I would want to minimize the risk of perforation. Again, I would want to use my medical judgment as to which procedure would minimize that risk.

Q. Is the fetus larger on average at 23 gestational weeks than

it is at 21 gestational weeks?

A. Yes, considerably larger.

Q. Approximately how much?

A. By estimated weight, probably about 50 percent larger.

Q. What does that difference mean, if anything, with respect to the safety and potential complications of a procedure at 23 weeks versus 21 weeks?

A. Again, a larger fetus through a cervix that in most cases is not dilated as large -- to a caliber that would accommodate the largest fetal part, which is the head, that would increase the challenge in removing the fetus while avoiding trauma to maternal tissue.

Q. With respect to your answer to Ms. Gowan that the gestational age variability -- let me withdraw that and start again.

With respect to your answer that for each gestational week there were various spreads of procedures done intact and procedures done by dismemberment, and your answer that those were apples and oranges, what did you mean by that?

A. In the whole cohort of 383 patients undergoing D&E at 20 weeks and beyond, the intact extraction variation of D&E was used in 120 cases, roughly about 30 percent. At 20 and 21 weeks, certainly at 20 and 21 weeks, the rate of intact extraction at those SKWRES TKAEUGSal ages was casually lower than 20 percent. Starting at 22 and 23 weeks and 24 weeks it

was considerably higher than 30 percent [> 30, not 20<] to imply or to state with statistical, near statistical certainty that the gestational age distribution in the cohort that underwent intact extraction is at an increased gestational age then compared to the group that had D&E with dismemberment is not the same to say that it constituted a majority of cases at higher gestational ages. That is the apple and the orange, the majority versus the increasing proportion, the trend towards increasing proportion that we saw as gestational age advanced.

Those proportions and the statement comparing the gestational ages in the two groups where in the paper in the original version it underwent peer review at two medical journals by six different peer reviewers and by two editorial boards, and none of them objected to that statement the, because it was obvious.

Q. When you say median, could you define that for us, please.

THE COURT: Is there an objection? All right. I don't know how he can testify as to why there was no objection.

MS. GOWAN: Could I hear the -- thank you, your Honor. I was looking something up in the doctor's deposition transcript. I apologize. Could I hear the answer back, Mr. Court reporter.

(Record read) Gowan KPWOUPB because it is obvious.

THE COURT: He has no way of knowing the operation of the mind of various reviewers.

MS. GOWAN: Thank you, your Honor.

THE COURT: It is stricken.

MR. HUT: So the motion to strike it is obvious?

THE COURT: It is stricken.

Q. Is a study's methodology and statistical analysis examined as part of the American journal of obstetrics and gynecologists peer review process?

A. Yes, it is.

Q. In your last answer, the one previous, you used the word "median." Could you tell us what median means, please.

A. The median is the 50th percentile. In other words, half are above that and half are below that. That is the median. So saying that the median gestational age in the cohort undergoing D&E with intact extraction was 23 weeks is to state that half the patients were at 23 weeks or beyond and half were at 23 weeks or below compared to the median of 21 weeks with D&E with dismemberment, where again half would be at 21 weeks and below and half would be at 21 weeks or above.

Q. Ms. Gowan asked you a number of questions and she read you some excerpts from peer review comments from the obstetrics and gynecology journal. Do you recall that?

A. Yes.

Q. Did you receive comments from peer reviewers for that journal that were different in tenor from the comments that Ms. Gowan read to you?

A. Yes, I did.
MS. GOWAN: Objection.
THE COURT: What is the objection?
MS. GOWAN: Objection as to form, your Honor. .
"different in tenor."
THE COURT: I will sustain it. But he can ask where there others and we can go through them.
Q. Were there comments that were different in substance from the ones that she read to you?
A. Absolutely, yes.
Q. Were you advised by one of the peer reviewers that the manuscript was very important and should be published?
A. I think the words were "violately important," but yes, one of the peer reviewers said that.
Q. Did a second peer reviewer say that the paper warrants publication with major revision as stated?
A. Yes.
THE COURT: Did it still get rejected?
THE WITNESS: It did.
Q. Dr. Chasen, Ms. Gowan asked you about the Kalish study.
THE COURT: Just one thing. On the peer review, did you participate and sit in while they were doing it is this.
THE WITNESS: No, no. It is done by --
THE COURT: So you don't really know what they did, do you.

THE WITNESS: The manuscripts are emailed to several different places and --
THE COURT: You didn't participate in it, did you, Doctor?
THE WITNESS: The peer reviewers are anonymous to me.
THE COURT: You didn't participate. If they are anonymous, you have no way of knowing what they did in performing their review, isn't that correct?
THE WITNESS: I assume they read the paper.
THE COURT: Don't assume anything. I asked you if you know.
THE WITNESS: All I know is the comments that they submitted to the journal.
THE COURT: That's all you knew. The answer to my question is you have no idea what they did?
THE WITNESS: That is the correct answer, your Honor, yes.
THE COURT: Next question.
Q. Dr. Chasen, there was some colloquy between you and Ms. Gowan about the Kalish study. Do you recall that?
A. Yes.
Q. At a level of generality, what does the Kalish study conclude?
MS. GOWAN: Objection.
THE COURT: I have no idea what a level of generality

is. Try it again.
MR. HUT: I will. I just at this hour did not want a long answer on the Kalish study. So let me ask the question again.
Q. What was the substance of the conclusions of the Kalish study?
A. The conclusions of the Kalish study, of which I am a co-author, are twofold. Number one, that the rate of spontaneous preterm birth in women in a pregnancy following D&E at gestational ages of 14 to 24 weeks is low and not higher than one would expect from the background rate of the general population. The other conclusion is --
THE COURT: Excuse me. Is this Kalish study in evidence?
MS. GOWAN: No, your Honor, it is not.
THE COURT: The witness can't testify to it. Next question.
MR. HUT: Testimony about it was elicited on cross-examination, your Honor.
THE COURT: But you are asking him now what it said.
MR. HUT: He was a co-author.
THE COURT: What does that mean? Nothing. What it means -- the questions on cross were whether or not it could have been used, but not into its contents. We are not going into the contents.

Q. Dr. Chasen, I noted that the transcript shortly after -- let me withdraw that and begin again. Shortly before the break I think for lunch you were asked about a settlement involved in the case in which I think you testified there had been uterine rupture. Do you recall that?
A. Yes.
Q. The transcript as I read it made reference to, quote, in a large settlement, unquote, referring to that case. Is that what you said?
A. A large settlement?
Q. That's what it said.
A. I know the settlement not to be large. That wasn't my intent if I said that.
THE COURT: Doctor, I asked, and you said you had no idea what the amount was. Did you not say that?
THE WITNESS: I didn't know the precise amount, but --
THE COURT: Did you not say that you didn't know what it was?
THE WITNESS: I didn't know numerically the amount. But it was categorized as "small."
THE COURT: I don't think those were your words at the time. Didn't you say it was settled for economic reasons?
THE WITNESS: The economic reasons stated were that it would cost more to defend in court if the case proceeded than it would to settle, implying to me that it was a relatively

small.
THE COURT: That is what you drew from it. That does not necessarily translate that it was small.
Next question.
MR. HUT: Your Honor, on the basis of the cross-examination, plaintiffs offer Plaintiffs' Trial Exhibit 55, which is the study by Kalish, et al., titled "Impact of mid trem stir dilation and evacuation on subsequent pregnancy outcome."
MS. GOWAN: Your Honor, the government objects. The cross-examination was restricted to the underlying data.
THE COURT: Sustained.
MS. GOWAN: Thank you, your Honor.
THE COURT: Is that it, Mr. Hut?
MR. HUT: Yes, it is, your Honor. Thank you.
THE COURT: Any recross?
MS. GOWAN: Very briefly, your Honor.
RECROSS-EXAMINATION

BY MS. GOWAN:
Q. Dr. Chasen, you did not submit any of your underlying data to the peer review group for review, did you?
A. It was available upon request. They did not request it.
THE COURT: Can you did you submit it? That was the question. Yes or no.

THE WITNESS: It is not done unless it is requested, so --
THE COURT: Doctor, I didn't ask you to explain. That is what you have a lawyer for.
THE WITNESS: There is an explanation. But the answer, your Honor, is no, I did not submit it.
MS. GOWAN: Thank you, your Honor.
THE COURT: All right, Doctor, you may step down.
THE WITNESS: Thank you.
(Witness excused)
THE COURT: Does the plaintiff rest?
MR. HUT: Yes, subject to, of course, your Honor, the plaintiffs' right to call one or more rebuttal witnesses if appropriate following presentation of the government's evidence.
THE COURT: Was that reserved in your pretrial order?
MR. HUT: Yes, your Honor.
THE COURT: It was? Are they designated as well?
MR. HUT: They are, your Honor.
THE COURT: Very well. If there is nothing else, the court will stand in recess until Monday morning at 9:30.
(Adjourned to 9:30 a.m., April 12, 2004)