TRANSCRIPT HIGHLIGHTS
National Abortion Federation, et. al. v. Ashcroft
U.S. District Court, Southern District of New York
The Honorable Richard Conway Casey, Judge

DAY TWO: Tuesday, March 30, 2004 (DAY ONE, opening statements only)
Excerpts from NAF's re-direct examination of Dr. Amos Grunebaum:

THE COURT. Doctor, you mentioned earlier today that you believe in full disclosure to your patients as to the procedures and the various possibilities that are available.

THE WITNESS. Yes, I do.

THE COURT. And that you spell out for the woman just what is entailed in a D&E that involves dismemberment, correct.

THE WITNESS. Yes, I do.

THE COURT. You also spell out that if you are doing an intact D&E or D&X or partial-birth abortion, whichever term is used, that that entailed a partial delivery, and then the procedure you described of inserting the scissors in the base of the skull and using a suction devise to remove the brain.

THE WITNESS. Yes, I do.
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THE COURT. And that some of them desire that because after the procedure if they want to see or hold the dead fetus, is that correct?

THE WITNESS. Yes.

THE COURT. I believe you mentioned also take pictures, is that correct?

THE WITNESS. Yes. That is part of our common policy -- it changed about ten years ago -- that we take pictures.

THE COURT. This is part of the grieving process?

THE WITNESS. Absolutely. We have been told by grieving counselors to take pictures of all dead fetuses and babies -- specifically babies, but also fetuses -- so there is a memory of the baby by the mother.

DAY THREE: Wednesday, March 31, 2004
Excerpts from NAF's direct examination of Dr. Timothy Johnson:

Q. Do you have an opinion, Dr. Johnson, as to which of the two D&E variations, the intact or the dismemberment variation, may best facilitate the extraction of the fetal skull during an abortion procedure?

A. I think that the intact procedure is actually developed in part to deal with the problem of the fetal skull. When one does a D&E, technically one of the challenges is to remove the fetal skull, partly because it is relatively large, partly because it is relatively calcified, and it is difficult to grasp on occasion. So one of the common technical challenges of a dismemberment D&E is what is called a free-floating head or a head that has become disattached and needs to be removed. This can lead to more passages of instruments through the cervix. And technically it is difficult to grasp the head; it is round, it slips out of the instruments that we generally use. Either those instruments or the head can be extruded outside the uterus and cause perforation.
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Q. Did you make any observation of the way the physician performing that intact D&E effected the incision into the skull?

A. In the situations that I have observed, they either -- actually, the procedures that I have observed, they all used a crushing instrument to deliver the head, and they did it under direct vision.

Q. Thank you, Doctor.

THE COURT: Can you explain to me what that means.

THE WITNESS: What they did was they delivered the fetus intact until the head was still trapped behind the cervix, and then they reached up and crushed the head in order to deliver it through the cervix.

THE COURT: What did they utilize to crush the head?

THE WITNESS: An instrument, a large pair of forceps that have a round, serrated edge at the end of it, so that they were able to bring them together and crush the head between the ends of the instrument.
THE COURT: Like the cracker they use to crack a lobster shell, serrated edge?

THE WITNESS: No.

THE COURT: Describe it for me.

THE WITNESS: It would be like the end of tongs that are combined that you use to pick up salad. So they would be articulated in the center and you could move one end, and there would be a branch at the center. The instruments are thick enough and heavy enough that you can actually grasp and crush with those instruments as if you were picking up salad or picking up anything with --

THE COURT: Except here you are crushing the head of a baby.

THE WITNESS: Correct.

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THE COURT: Was the body outside the woman's body to an extent?

THE WITNESS: Some of it. It can be or not. Some of it can be or -- it depends on where the cervix is. It depends on where the uterus is. It depends how long the baby is. It depends how long the mother's vagina is.

THE COURT: At some times that you observed it was?

THE WITNESS: Right. And sometimes during the procedure the cervix can actually be brought down so that -- the cervix and the uterus can be moved up and down relative to the opening of the vagina.

THE COURT: An affidavit I saw earlier said sometimes, I take it, the fetus is alive until they crush the skull?

THE WITNESS: That's correct, yes, sir.

THE COURT: In one affidavit I saw attached earlier in this proceeding, were the fingers of the baby opening and closing?

THE WITNESS: It would depend where the hands were and whether or not you could see them.

THE COURT: Were they in some instances?

THE WITNESS: Not that I remember. I don't think I have ever looked at the hands.

THE COURT: Were the feet moving?

THE WITNESS: Feet could be moving, yes.

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THE COURT: If you are all finished let me just ask you a couple questions, Dr. Johnson. I heard you talk a lot today about dismemberment D&E procedure, second trimester; does the fetus feel pain?

THE WITNESS: I guess I --

THE COURT: There are studies, I'm told, that says they do. Is that correct?

THE WITNESS: I don't know. I don't know of any -- I can't answer your question. I don't know of any scientific evidence one way or the other.

THE COURT: Have you heard that there are studies saying so?

THE WITNESS: I'm not aware of any.

THE COURT: You never heard of any?

THE WITNESS: I'm aware of fetal behavioral studies that have looked at fetal responses to noxious stimuli.

THE COURT: Does it ever cross your mind when you are doing a dismemberment?

THE WITNESS: I guess whenever I --

THE COURT: Simple question, Doctor. Does it cross your mind?

THE WITNESS: Does the fetus having pain cross your mind?

THE COURT: Yes.

THE WITNESS: No.

THE COURT: Never crossed your mind.

THE WITNESS: No.

THE COURT: When you have done D&Es or when you have done abortions, do you tell the woman various options that are available to her?

THE WITNESS: Yes, sir.

THE COURT: And do you explain what is involved like in D&E, the dismemberment variation? Do you tell her that?

THE WITNESS: We would describe the procedure, yes.

THE COURT: So you tell her the arms and legs are pulled off. I mean, that's what I want to know, do you tell her?

THE WITNESS: We tell her the baby, the fetus is dismembered as part of the procedure, yes.

THE COURT: You are going to remove parts of her baby.

THE WITNESS: Correct.

THE COURT: Are you ever asked, Does it hurt?

THE WITNESS: Are we ever asked by the patient?

THE COURT: Yes.

THE WITNESS: I don't ever remember being asked.

THE COURT: And although you have never done an intact D&E, do you know whether or not the incision of the scissors in the base of the skull of the baby, whether that hurts?

THE WITNESS: Well, I guess my response would be I think that the baby feels it but I'm not sure how pain registers on the brain at that gestational age. I'm not sure how a fetus at 20 weeks or 22 weeks processes and understands pain.

THE COURT: You have never done one of these procedures but did you ever ask what -- you say you know about it clinically, did you ever ask one of those who perform them whether it hurts the fetus?

THE WITNESS: No, sir.

THE COURT: When you describe the possibilities available to a woman do you describe in detail what the intact D&E or the partial birth abortion involves?

THE WITNESS: Since I don't do that procedure I wouldn't have described it.

THE COURT: Did you ever participate with another doctor describing it to a woman considering such an abortion?

THE WITNESS: Yes. And the description would be, I would think, descriptive of what was going to be, what was going to happen; the description.

THE COURT: Including sucking the brain out of the skull?

THE WITNESS: I don't think we would use those terms. I think we would probably use a term like decompression of the skull or reducing the contents of the skull.

THE COURT: Make it nice and palatable so that they wouldn't understand what it's all about?

THE WITNESS: No. I think we want them to understand what it's all about but it's -- I think it's -- I guess I would say that whenever we describe medical procedures we try to do it in a way that's not offensive or gruesome or overly graphic for patients.

THE COURT: Can they fully comprehend unless you do? Not all of these mothers are Rhodes scholars or highly educated, are they?

THE WITNESS: No, that's true. But I'm also not exactly sure what using terminology like sucking the brains out would --

THE COURT: That's what happens, doesn't it?

THE WITNESS: Well, in some situations that might happen. There are different ways that an after-coming head could be dealt with but that is one way of describing it.

THE COURT: Isn't that what actually happens? You do use a suction device, right?

THE WITNESS: Well, there are physicians who do that procedure who use a suction device to evacuate the intercranial contents; yes.

Excerpts from NAF's direct examination of Dr. Cassing Hammond:

THE COURT: Do they give full disclosure as to the various procedures available and what is entailed, such as the dismemberment, in some forms of D&E?

THE WITNESS: If they do not and then the patient is referred to me for D&E, we do tell the patient what's entailed in a D&E.

THE COURT: In simple, clear English?

THE WITNESS: I think so, your Honor, yes. Now, there are variations, depending on the patient's own kind of psychological situation that we clearly take into consideration, but we actually have a large number of patients who look at us and say, let me get this straight. What you will be doing is dismembering the fetus. And we say, yes, that's exactly what we are doing.

THE COURT: Do you tell them what happens when they do an intact D&E?

THE WITNESS: If the patient --

THE COURT: The brain is sucked out?

THE WITNESS: Well I don't -- as a point of fact, your Honor, I don't usually do the suction part. I do compress the calvarium and I do some other procedures. I don't actually do suction so I don't explain that part.

THE COURT: You don't explain that to them?

THE WITNESS: Well I explain the method.

THE COURT: You explain what a compression of the calvarium is?

THE WITNESS: Yes, sir; that I do explain.

THE COURT: That that's crushing the skull?

THE WITNESS: I explain that, yes.

DAY FOUR: Thursday, April 1, 2004.
Excerpts from direct examination of Dr. Cassing Hammond:

A. So when we do this procedure, I've got the patient asleep, I've got a device that I can hold on to the top of the cervix with…. So I can lift the cervix, look at the back of the neck, and then a scissors, which we have on our operating table, and make an incision in the back of the fetal neck. That whole time I can see what I am doing. And in the very rare cases where I can't see what I am doing, I can usually put my finger, in fact always put my finger, on top of my scissors, which are against the back of the fetal neck, and I have complete control and feeling the entire time I do this. In those cases, feeling is just as good as seeing. I know exactly where the scissors are. They are not anywhere near the patient's cervix or uterus. It is a completely visible, completely palpable in the sense of feeling operation. If you contrast that with a D&E that is by dismemberment -RGS the last part of the procedure usually involves trying to get the head or calvarium out. What I am having to do in one of those procedures is to try to feel with an instrument up inside the uterus with this skull that is bobbing at the end of my instrument, and I have to get around it

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Q. Dr. Hammond, do you always use scissors or other instruments to breech the fetal head or the fetal neck in the course of doing an intact D&E of this kind?

A. Not always. It depends on the fetus. If you've got a fetus that is earlier in gestation, the skull, or calvarium, it is soft. It isn't as firmly formed. So in those cases you can often do this just with your finger, you can do this digitally. In some cases the scissors probably after 20 weeks I am more likely to use them. We actually have a number of instruments on the table that I can use, whatever seems like it is going to be most effective.

~

THE COURT: Excuse me. You don't feel any obligation whatsoever to protect the life of the fetus?

THE WITNESS: We are seeing --

THE COURT: I am asking you something.

THE WITNESS: With many of my patients, yes, particularly post-viability, your Honor.

THE COURT: You don't find any dual responsibility, your obligation is only to the woman?

THE WITNESS: In the circumstances in which I am doing terminations, that is correct.

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Q. What do you do under those circumstances when you have delivered a fetus that is alive in the course of an induction termination?

A. The very first thing we do is to assess the viability of the fetus. By that, we perform a very rapid assessment of whether we think this fetus is of the gestational age where resuscitation is appropriate. If there is any question of in our minds at apprentice, we have a full -- excuse me -- a 24-hour in-house [neonatologist] whom we contact who does an immediate assessment and

then would perform whatever resuscitative measures are necessary on behalf of the baby -PLT. Assuming, since we usually have very, very good data about gestational age and know that these are nonviable fetuses, assuming that that is not the case, we would then provide comfort and care to the baby. By that, we would place the baby under a radiant warmer to keep the baby warm. We might wrap the baby. Then depending on what the mother wishes to do, allow the mother to hold the baby at this point and simply [wait] for nature to take its course.

Excerpts from cross examination of Dr. Hammond:

Q. [Y]ou told the Judge that you explained to your patients what compressing the head means, correct?

A. Yes, we do.

Q. But in fact, you don't explain to every patient that there is a possibility that you might remove the fetus intact up to the point where the head is stuck in the internal cervical os
and you perform a procedure to compress the skull or puncture the skull, do you, Doctor?

A. Not to every patient, no.

Q. You only do it if the patient asks you, isn't that right, Doctor?

A. In some cases, yes.

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Q. And in fact, Dr. Hammond, no patient has ever asked you, has she?

A. I don't know. Somebody might have. I don't have an independent recollection at this point.

Q. Directing your attention to page 233, line 4 of your deposition in this case:

"Q has a patient ever asked that?

"A not to my knowledge, no."

~

Q. In fact, the closest you have ever come to having this kind of conversation with any of your patients is when they've come in and they've said to you, Doctor, is the procedure similar to what we've been hearing about in the media as being encompassed by the partial-birth abortion ban act of 2003 or a similar statute? Isn't that right, Doctor?

A. That is true.

~

A. So, if they choose to pursue this in any way or bring it up we will have this conversation with our patients.

THE COURT: With the technical language that you used here?

A. No. No. No. No. With patients I make the most, the best attempt I can not to use words

like calvarium and to replace it with skull and so forth, but we don't -- we don't sugar coat it too much, your Honor.

THE COURT: You use reduction rather than crushing the skull.

A. I will say crush, clamp and extract and I use those very words because those are what patients understand. We want them to know exactly what the procedure is going to entail and we actually try not to sugar coat this for them because they're the ones who are going to undergo the procedure.

THE COURT: But only if they ask.

THE WITNESS: No. Occasionally a patient clearly wants more information and if we sense that we try to give what's appropriate to the patient. Keep in mind, a lot of my patients are emotionally quite fragile so we don't have to bring up the terms -- we don't have to go into gory detail about everything that we are doing. But does that mean that we don't share with them, that this involves dismemberment or separation of parts of the fetus or taking the fetus apart? We do. And we use that term. We say we take the fetus apart. We say, it is coming out in pieces and we make sure that that's clear with the patients. And they understand it. And given the circumstances that they confront and their alternatives, the majority of them want us to do the procedure.

THE COURT: Do you tell them whether or not it hurts the baby?

THE WITNESS: We have that conversation quite a bit with patients, your Honor.

THE COURT: And what's your answer?

THE WITNESS: We say several things to the patient, your Honor. First of all, we tell the patient that it's controversial what exactly -- what the fetus experiences of pain at various gestational ages. We share with them the fact that even for normally developed fetuses people debate the beginning of sensation of the fetus. They debate at what gestational age the fetus is able to interpret pain as we think about it. We share with the patients that even though there are speculations about these things among normal fetuses, when you start dealing with the kind of circumstances that we confront where a baby may not have its forebrain or may not have its brain or may have [], which is in essence a completely disrupted and in some cases spinal cord, that there is no data that lead us to know what the baby feels.

THE COURT: How about when there is no anomaly instead of all these exceptions, how about when there is no anomaly.

THE WITNESS: We say that there is a possibility and one of the things that we are doing with most of these patients after 16 to 18 weeks is they're all under IV anesthesia, not just conscious sedation where it's some IV administered medications that likely don't reach the fetus in high concentrations but -- and not an inhalational anesthesia where it less would reach the fetus by IV deeply sedating anesthetic which may confer some pain control to the fetus. We also share with

them their alternatives and we share with them the fact that we really don't know what the fetus feels and some of the other things that they can do for pain. For example, frankly, your Honor, I think we sugar coat some of the other option and we share this with patients. They might ask, well can you give intracardiac or [] injections that we discussed or could you, could we do an induction termination and avoid this? But the honest truth is, how do we know that taking this huge instrument and poking it into the baby's heart and injecting a poison hurts any less than my rapidly cutting the umbilical cord or transecting the spinal cord with my scissors? Or how do we know that poisoning the environment that the baby is in with digoxin is any more painful or less painful than my doing a very rapid D&E. And if the baby delivers and is living in the sense of a medical induction, we're assuming because nature takes it course that it's not painful. But if the baby slowly tires and stops breathing and dies by asphyxiation it is reasonable to assume that even for a normally born fetus a normally formed fetus that this may also involve pain. So what we are really asking the patients that I see is, which do you think is going to hurt worse for your fetus?

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Q. You have seen a fetus born alive after induction abortion in the second trimester, haven't you?

A. I'm sorry, can I just -- you said after induction abortion in the second trimester? Am I correct?

Q. Yes. Doctor.

A. Yes, I have.

Q. And you have observed signs of life in the fetus, didn't you?

A. That is correct.

Q. You have seen spontaneous respiratory activity, right?

A. Yes.

Q. Heartbeat?

A. Yes.

Q. Spontaneous movements?

A. Yes.

Q. And you have seen these signs at 24 weeks, right?

A. That is correct.

Q. 23 weeks?

A. Yes.

Q. 22 weeks?

A. Yes.

~

Q. Doctor, don't you make an effort when you perform D&E by dismemberment to count the fetal parts after the procedure is over?

A. No. We look for sentinel parts. … But we don't count every single part that we've extracted after one of these procedures, no.

Q. Well you make an effort to count the four extremities and the head, don't you?

A. That we do, yes.

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Q. You could use a combination of your hand and your instrument; not really grasping but helping and assisting the delivery of the infant to the point its head gets stuck, right?

A. That is correct.

Q. Sometimes you place an instrument in the uterus, grasp a lower extremity, deliver it into the vagina, take the instrument off, grasp the lower extremity with your right hand, feel with the fingers of your left hand beyond the external os to the opposing extremity, deliver that extremity to get a better grasp on the fetus and then continue the delivery, correct?

A. That is correct.

DAY FIVE: Friday, April 2, 2004.
Excerpts from direct examination of Dr. Carolyn Westhoff:

THE COURT: Doctor, that isn't my question. Do you discuss dismemberment? Do you tell them about ripping or tearing a limb off the fetus?

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

THE COURT: Well do you do it most of the time? I mean, do they really understand what are you doing when you tell them all these clinical terms?

THE WITNESS: I try to use everyday language and not use terms that are going to be confusing to the patient. We try to --

THE COURT: Do any of them ask you whether or not the fetus experiences pain when that limb

is torn off?

THE WITNESS: I do have patient who ask about fetal pain during the procedure, yes.

THE COURT: And what do you tell them?

THE WITNESS: I, first of all, assess their feelings about this, but they of course even notwithstanding the abortion decision, would generally tell me they would like to avoid the fetus feeling pain. I explain to them that in conjunction with our anesthesiologists that the medication that we give to our patients during the procedure will cross the placenta so the fetus will have some of the same medications that the mother has.

THE COURT: Some.

THE WITNESS: Yes, that's right.

THE COURT: What do you tell them, does the fetus feel pain or not when they ask?

THE WITNESS: What I tell them is that the subject of the fetal pain and whether a fetus can appreciate pain is a subject of some research and controversy and that I don't know to what extent the fetus can feel pain but that its --

THE COURT: Do you tell them it feels some pain?

THE WITNESS: I do know that when we do, for instance an amniocentesis and put a needle through the abdomen into the amniotic cavity that the fetus withdraws so I certainly know based on my experience that the fetus with withdraw in response it a painful stimulus.
~
THE COURT: Don't you make it simple for them and say yeah, they feel it?

THE WITNESS: … I am not confident what the fetus feels with the anesthesia that we use and I don't want to shy away from the possibility the fetus feels pain but I do not believe it's fully determined what the fetus feels during this procedure.

THE COURT: Do you care?

THE WITNESS: Certainly.
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THE COURT: Have you ever lacerated the cervix?

THE WITNESS: Yes. I have had patients experience cervical laceration under my care during D&E.
~
THE COURT: I want to know whether that woman knows that you are going to take a pair of scissors and insert them into the base of the skull of her baby, of her fetus. Do you tell her?

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

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

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

THE COURT: Do you tell them that?

THE WITNESS: Those are details that would be distressing to my patients and would not -- information about that is not directly relevant to their safety.

THE COURT: Don't -- whether it's relative to their safety or not don't you think it's since they're giving authorization to you to do this act that they should know precisely what you're going to do?

THE WITNESS: That's actually not the practice I have of discussing surgical cases with patients.

THE COURT: I didn't ask you that. I said don't you think they ought to know?

THE WITNESS: No, sir, I don't.

~

Q. Do you tell a woman who is considering a D&E that the fetal arms, legs, extremities may be dismembered is in the course of a dismemberment variation D&E, Dr. Westhoff?

A. I tell patients that we will remove all of the fetus and the uterus and membrane, the placenta and membranes from the uterus as safely as possible and that that proceeds somewhat differently for all patients.

~

Q. How often will it be necessary to collapse the fetal skull during D&E whether the D&E proceeds by a dismemberment or more relatively intact, Doctor?

A. For the vast majority of D&Es [] be necessary it either crush or collapse the fetal skull.

THE COURT: Do you tell the woman that? Do you use the word crush?

THE WITNESS: Your Honor, I do not.

THE COURT: I didn't think so.

~

Q. Is there a difference, Dr. Westhoff, between the way a head, fetal head may be collapsed in a D&E by dismemberment and the way it may be collapsed during a D&E performed by the intact [method]?

A. Yes. The approaches are different. In the dismemberment D&E the fetal head will be up inside the uterus. It is necessary to insert our forceps, open them as wide as possible to try to capture the head within the opening of the forceps and then crush the head using external force applied against the head. …With an intact D&E, when we have put a hole into the base of the skull we can generally do that under direct visualization because the base of the skull is, thanks to traction, held right in the cervical opening and so it is, in my experience and my opinion, less risky to put a hole in the base of the skull. Because the contents of the skull are liquid the skull contents may often drain out spontaneously as soon as there is a hole in the skull. In some cases it is necessary to use [suctioning]. …

THE COURT: Doctor, when you are doing any of these crushing procedures, whether it be to an extremity or to the body, the skull, does the baby, does the fetus ever make any noise or cry?

THE WITNESS: It absolutely does not. And in our setting it does not move. It does not withdraw, it does not move. It has very limited tone to its body.

~

A. Abortion is safer than continuing pregnancy to term and continuing childbirth, and it is also overall extremely safe.

Q. Without going into the relative safety of different methods of abortion at this point --

THE COURT: Before you go further, safer than childbirth?

THE WITNESS: Yes, your Honor.

THE COURT: Would you recommend abortions rather than childbirth then?

THE WITNESS: If a woman wants to have a baby, she should [] definitely go the full nine months.

~

Q. What have women told you as to reasons why they wish to terminate pregnancies after the first trimester?

A. There are several categories of. One is personal problems such as relationship problems and social problems. A much larger group in our practice is women who HIV abnormalities in the pregnancy itself. These may be chromosomal abnormalities that have been diagnosed or anatomical abnormalities of the fetus, and a smaller group are … problems with maternal health. That is a smaller category than the other two.

~

Q. How do the contractions during induction [abortion] during the second trimester, Dr. Westhoff, compare to those typically experienced at term during labor?

A. The uterine contractions during an induction abortion are similar to the contractions that women experience during childbirth where labor is also induced using similar med situations. I believe based on my experience that contractions that are induced with medication are more

painful than contractions that occur spontaneously.

THE COURT: How could you know that without feeling it yourself?

THE WITNESS: Your Honor, if it is appropriate, I have been through childbirth and have had an induction myself. But I have taken care of many, several thousand, patients in childbirth. Based on my observation of spontaneous labor and induced later, I have a very definite opinion that induced labor is more painful for my patients.

~

Q. Dr. Westhoff, can you state whether in your opinion the intact variation of D&E facilitates a grieving by the woman or parents with respect to the D&E abortion?

A. Yes. We have taken care of several patients who have availed themselves of the opportunity to hold the fetus after a termination done by the intact D&E meld. Because it is the back of the skull that collapsed, since this is not disfiguring, and the face, for instance, is intact. Several of my patients have wished to hold the fetus after the procedure and have expressed gratitude that they were able to do so.

THE COURT: Would any of those patients that have expressed that desire to assist them in grieving, and certainly grieving is a serious thing, in any of those instances did you tell those mothers that what they authorized you to do was to make an incision at the base of the skull of their baby and suck its brain out?

THE WITNESS: Your Honor, I definitely --

THE COURT: It is a simple question, Doctor. Did you in any of those cases?

THE WITNESS: I definitely in those cases discussed collapsing the skull. I definitely don't recall exactly what words I used to communicate it.…

THE COURT: But did you tell them that you would be sucking the brain out of the same baby that they desired to hold, for the grieving process? Did you tell them that is what you did…

THE WITNESS: I definitely tell them I collapsed skull.

THE COURT: How about [sucking] the brain out, did you tell them that before they wanted to hold that baby so they would know that is what they had authorized you to do?

THE WITNESS: They know that the head is empty. I do not use the term "sucking the brain out" with my patients. I don't think that helps the grieving process.

~

Q. Dr. Westhoff, you mentioned a moment ago that the face may remain even though the head is collapsed and the intracranial content suctioned out. Can you explain how that occurs?

A. Yes. The fetus has a tiny face and a relatively large head. The bones of the back of the skull are very soft. When we make an incision in the base of the skull, we don't disturb any of the skin

covering the entire skull, we don't disturb the scalp. So the top and back of the head itself just collapses and looks a little wrinkly and collapsed, but the facial structures are not disturbed at all by that procedure.

Q. Do you or the hospital take any other steps to help facilitate the grieving process in circumstances where parents may indicate they desire it?

A. Yes, sir. We have clergy available to meet with our patients during their pre-op visits or on the day of their surgery. We have social workers available. And we also have a variety of referrals available. We have arrangements to permit burial of the fetus if the patients want…. Because the hospital also has small coffins present, both for stillbirths or for fetuses after a termination, and in the case of our D&E patients we actually have little hats available so we could in fact cover the back of the head where the incision had been made.

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Q. When you perform an intact D&E, Dr. Westhoff, is the fetus living when you commence vaginal delivery?

A. Although I don't always check for it, I believe there is usually a heartbeat and that the fetus is living.

~

Q. And at the time you either cut the umbilical cord or collapse the skull, is the fetus living?

A. Yes.

~

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

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

Q. Why not?

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

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

THE WITNESS: I don't think we know whether intracardiac injection would cause fetal pain, your Honor.

~

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

THE WITNESS: While I wish to avoid fetal pain, I have no desire to inflict fetal pain… top of

my list is the safety of the woman who is undergoing the procedure.

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

THE WITNESS: Yes, your Honor. As I previously stated, I think one of the benefits of using general anesthesia with my patients, since I don't know if there is fetal pain, is that the general anesthesia crosses the placenta and does circulate in the fetal circulation and may have a physiologic effect in the fetus, and I think that is a benefit.

THE COURT: That is the limit of your concern? OK. Next question.

DAY SIX: Monday, April 5, 2004
Excerpts from cross- examination of Dr. Carolyn Westhoff:

Q. Then assuming that you have sufficient dilation you will take two of your fingers, reach into the woman and attempt to grasp a fetal part and bring it down into the cervix, right?

A. Yes.

Q. And you like to grab the fetus' foot if you can, right?

A. Yes.

Q. And if you can you bring down the fetus' foot and then you break the amniotic sac with your forceps, right?

A. Yes.

Q. Then, because the fetus is wet you take a piece of gauze to help improve your grasp and you bring one foot down and if possible sweep the second foot through the cervix, right?

A. Yes.

Q. Then with gentle traction on both of the feet you pull the fetus through the cervix, right?

A. Yes.
~
Q. Well, you pass a finger up through the cervix to find the fetus' arms, right?

A. Yes.

Q. And generally they're extending into the uterus at that point, aren't they?

A. Yes.

Q. And so you will move your finger along the shoulder to sweep the arm across the fetus' chest,

right?

A. I may do that, yes.

Q. And by doing that you sweep the arm down and around and the arm comes through the cervix, right?

A. Yes.

Q. And then you repeat that maneuver on the opposite side of the fetus' body to sweep down the other arm, right?

A. Yes.

Q. And at that point the fetus' body is below the cervix and the neck is in the cervix with the head still in the uterus, right?

A. Yes.

Q. And it's at that point that you take a scissors and insert it into the woman and place an incision in the base of the fetus' skull, right?

A. Yes.

Q. Now the contents of the fetus' skull, just like the contents of my skull and your skull is liquid, right?

A. That's right.

Q. And sometimes after you've made the incision the fetus' brain will drain out on its own, right?

A. That's right.

Q. Other times you must insert a suction tube to drain the skull, right?

A. That's right.

Q. And then the skull will collapse immediately after its liquid contents have been removed and the head will pass easily through the dilated cervix, right?

A. That's right.

Excerpts from direct examination of Dr. Marilynn Fredriksen:

Q. You mentioned that you perform a procedure known as dilation and evacuation, or D&E, is that correct?

A. Yes.

Q. Approximately how many D&E procedures have you performed throughout your career?

A. I really don't know, but probably thousands.

THE COURT: Thousands, plural?

THE WITNESS: Thousands, plural.
~
THE COURT: Have you ever perforated a uterus or done any of these things?

THE WITNESS: Yes.

THE COURT: Were you ever sued for malpractice?

THE WITNESS: Yes.

THE COURT: Involving an abortion?

THE WITNESS: Yes.
~
THE COURT: Just one…did in the malpractice suit against you, Doctor, did the plaintiff recover?

THE WITNESS: No.

THE COURT: Was there settlement?

THE WITNESS: No. We won.
~
THE COURT: Doctor, do you make full disclosure to all your patients before you embark on a particular procedure?

THE WITNESS: I educate them in the process of an informed consent as to the risks of pregnancy termination and the relative difference of risks of the different procedures.

THE COURT: Well, when you tell them about pain and such that you were talking about before, do you also tell them about that you do the D&E, it involves dismemberment? Do you tell them that you tear the limbs off the fetus?

THE WITNESS: I don't use that term, as I say it.

THE COURT: Do you use simple English words so they know what you are doing --

THE WITNESS: Yes.

THE COURT: -- and what they're authorizing?

THE WITNESS: Yes.

THE COURT: Well, how do you tell them that you are going to take the limb off?

THE WITNESS: I tell them that in the process.

THE COURT: Do you use "disarticulation"?

THE WITNESS: No.

THE COURT: What word do you use?

THE WITNESS: I tell them that in the process of the termination we will attempt to get the fetus out as intact as possible but that is not a guarantee and sometimes a fetus comes out in parts.

THE COURT: Do you discuss with them whether or not there is any fetal pain?

THE WITNESS: I think that's a concern. My approach has been to say that the cord usually comes down and severing of the cord means that the fetus sanguinates.

THE COURT: Do you think that a normal woman patient understands those words?

THE WITNESS: Well, bleed to death is the analogy on more lay terms.

THE COURT: Well, do you use sanguinate or do you say bleed to death?

THE WITNESS: I use the term that the fetus loses all of its blood when the cord is severed.

THE COURT: Do you tell them whether or not the fetus experiences pain?

THE WITNESS: Since I don't know that I do say that most of the time the fetus may not experience anything. Because once the cord has been severed there is no blood supply to the central nervous system and therefore the fetus, for all intrinsic, purposes dies. Whether or not that is analogous to the end of the presence or absence of a fetal heartbeat I don't know, but there is no fetus that has central nervous system activity once they have lost all oxygenation.

THE COURT: Do you use all of those words, "oxygenation," and things like that? Or do you tell them in simple words?

THE WITNESS: I tell them in simple, understandable words, depending upon the particular

patient that I am dealing with.

THE COURT: Oh, depending on the patient the words vary?

THE WITNESS: Yes.

THE COURT: And when you do an intact D&E do you tell them that you are going to insert scissors in the base of the skull?

THE WITNESS: No.

THE COURT: You don't tell them that.

THE WITNESS: No, because I don't always do that, number one.

THE COURT: You do that sometimes?

THE WITNESS: Yes.

THE COURT: When you do, do you tell them?

THE WITNESS: Not ahead of time because I can't predict who I'm going to do that with and who I can't do that with.

THE COURT: Do you tell them you may be doing that?

THE WITNESS: No.

THE COURT: Do you tell them whether or not it hurts?

THE WITNESS: Who am I -- what am I --

THE COURT: The patient.

THE WITNESS: The patient?

THE COURT: The woman, the mother.

THE WITNESS: It doesn't hurt her, no.

THE COURT: Do you tell whether or not it will hurt the fetus?

THE WITNESS: The intent of an [abortion is] that the fetus will die during the process of uterine evacuation.

THE COURT: Ma'am, I didn't ask you that. Very simply I asked you whether or not do you tell

the mother that one of the ways she may do this is that you will deliver the baby partially and then insert a pair of scissors in the base of the fetus' skull?

THE WITNESS: I have not done that.

THE COURT: Do you ever tell them that after that is done you are going to suction or suck the brain out of the skull?

THE WITNESS: I don't use suction.

THE COURT: Then how do you remove the brain from the skull?

THE WITNESS: I use my finger to disrupt the central nervous system, thereby the skull collapses and I can easily deliver the remainder of the fetus through the cervix.

THE COURT: Do you tell them that you are going to collapse the skull?

THE WITNESS: No.

THE COURT: The mother?

THE WITNESS: No.

THE COURT: Do you tell them whether or not that hurts the fetus?

THE WITNESS: I have never talked to a fetus about whether or not they experience pain.

THE COURT: I didn't say that, Doctor. Do you tell the mother whether or not it hurts the fetus?

THE WITNESS: In a discussion of pain for the fetus it usually comes up in the context of how the fetus will die. I make an analogy between what we as human beings fear the most -- a long protracted painful death.

THE COURT: Doctor, I didn't ask you --

THE WITNESS: Excuse me, that's what I tell my patients.

THE COURT: But I'm asking you the question.

THE WITNESS: I'm sorry.

THE COURT: And I'm asking you whether or not you tell them that.

THE WITNESS: I feel that fetus dies quickly and it's over quickly. And I think from a standpoint of a human being our desire is that we have a quick death rather than a long protracted death --

THE COURT: That's very interesting, Doctor but it's not what I asked you. I asked you whether or not you tell them the fetus feels pain.

THE WITNESS: I don't believe the fetus does feel pain at the gestational ages that we do, but I have no evidence to say one way or the other so I can't answer that question.

THE COURT: Have you ever read any studies about fetal pain?

THE WITNESS: Fetal pain is best explored in the premature context of delivering premature babies beyond 24 or up to 28, at 28, 30 weeks. In those studies it's much, much further in gestation than where I am dealing with the fetus.

THE COURT: Are you aware of any studies done on fetal pain in a shorter gestational period?

THE WITNESS: No.

THE COURT: Next question.

DAY SEVEN: Tuesday, April 6, 2004.
Excerpts from direct examination of Dr. Marilynn Frederiksen:

Q. Is it always necessary to make an incision at the base of the fetal head to facilitate delivery in an intact D&E?

A. No, it is not.

Q. Why not?

A. In certain circumstances it is easier to just use grasping forceps and deliver the head through the cervix.

Q. Dr. Frederiksen --

THE COURT: Excuse me. Grasping forceps, does that mean you crush the skull?

THE WITNESS: You compress the skull, yes.

THE COURT: You crush it, right?

THE WITNESS: Yes.
~
THE COURT: So you use your finger to get the contents of the skull out rather than sucking the contents of the skull out, is that correct?

THE WITNESS: Yes.

~

Q. Have you ever injected KCl or digoxin into the fetal heart before beginning a pregnancy termination in the second trimester?

A. Yes, I have.

~

Q. Can a physician affect fetal demise by injecting KCl or digoxin anywhere other than in the fetal heart?

A. You can't guarantee the process.

Q. Why not?

A. I have been unable in certain cases to actually put a needle into the heart for technical reasons or because the mother is obese or the fetus is in a particularly difficult position to gain access to the heart. When you put these agents not in the heart or near the heart, you can't guarantee fetal death.

Q. Has it ever happened that you have attempted to inject a feticidal agent into the fetal heart but failed to do so and demise failed to occur?

A. Yes.

Q. Can you describe that for us, please.

A. …Technically, we couldn't get the needle into the heart. We chose to put digoxin into the muscle mass of the fetus. The fetus still had a heartbeat the next day.

~

Q. How did you learn to perform an intracardiac fetal injection?

A. It was an extension of my maternal fetal medicine training.

Q. In what context?

A. We initially started to do intracardiac injections of small fetuses in the end of the first trimester and the beginning of the second for the purpose of reducing multifetal pregnancies or multiple gestations, either with a twin gestation, where one twin is normal and the other is abnormal, or of a situation where we have too many fetuses within the uterus.

Excerpts from cross-examination of Dr. Marilynn Frederiksen:

Q. Doctor, you would never use a scissors to grasp for and extract fetal parts, would you?

A. No.

Q. In an intact D&E you use a scissors to puncture the fetus's skull at the base of the neck, correct?

A. Yes.

Q. You would agree, Doctor, wouldn't you, that a scissors is potentially more dangerous to the woman than a forceps if a mistake is made, right?

A. Yes.

Q. A scissors is more dangerous than a forceps because a scissors is a sharper instrument than a forceps, right?

A. Yes.

Q. In fact, Doctor, in your opinion, forceps do not pose a risk of cervical laceration, do they?

A. I don't think so, no.

~

Q. Doctor, you offered the opinion in your expert report that one advantage to intact D&E is that you get an intact fetus or pathologic assessment, right?

A. Yes.

Q. In fact, with an intact D&E you don't actually get a fully intact fetus, do you?

A. That's correct.

Q. A fetus aborted by intact D&E has no brain contents, does it?

A. No, it does not.

~

Q. At the conclusion of the procedure, you examine the products of conception to ascertain that they have all been evacuated?

A. Correct.

Q. When you do a D&X or intact D&E, you either compress the fetal head with forceps or you make an incision into the back of the neck, into the skull, with a scissors, and then you cause disruption of the fetal brain?

A. Yes.

~

Q. To disrupt the fetal brain, you use your finger, and that compresses the contents of the head and allows it to pass through the cervix?

A. Yes.

Q. When you do a D&X in breech presentation, you grasp the fetal foot, and with careful manipulation of the fetus you deliver the fetus to the trunk, right?

A. Yes.

Q. Then you essentially do a breech delivery, where you are left with the fetal head inside the cervix, right?

A. Yes.

Q. Then you either compress the head or you enter the skull with scissors and disrupt the fetal brain, correct?

A. Correct.

DAY EIGHT: Wednesday, April 7, 2004
Excerpts from direct examination of Dr. Gerson Weiss:

THE COURT: Do you, when you tell them the various procedures available, say that in an intact D&E, if you choose to call it, or partial-birth abortion, that you take a pair of scissors and make an incision in the base of the skull?

THE WITNESS: I say that we take the fluid and material out of the skull.

THE COURT: No, Doctor. The question is simple. Don't turn it around. Just do you tell them that if you do that procedure you're going to take a pair of scissors and make an incision at the base of their baby's skull?

THE WITNESS: I do not use that language.

THE COURT: Do you discuss with them whether or not this inflicts pain on the fetus or the baby?

THE WITNESS: No, I do not.

THE COURT: Do you tell them that you are going to use a suction device and suck the brain out of the baby?

THE WITNESS: Yes.

THE COURT: You use simple words and tell them that?

THE WITNESS: Yes.

THE COURT: Next question.

~

Q. Doctor, when you remove the fetus in a procedure involving dismemberment, are the fetus's bones covered by soft tissue?

A. Excuse me? When you?

Q. Remove the fetus in a dismemberment procedure, are the pieces of the fetus covered by soft tissue?

A. Frequently much of the bone is covered. It is quite likely that the ends of the bone in the area that is broken are uncovered and sharp.

~

Q. Can you eliminate the risks of retained fetal tissue in a D&E involving dismemberment by counting the fetal parts at the end of the procedure?

A. No, you can't. You can count roughly. You can count there is a limb here, I can see feet and hands, I can see skull fragments, I can see trunk. But when you see little pieces, if there are small pieces left behind that are torn off, you can't fully reconstruct and you cannot fully count the small pieces. Another way of looking at that is if you have a long bone that is broken into six parts, you are only going to say I see long bone parts. You will not be able to reconstruct to a point of that accuracy.

~

Q. Is your ability to bring the fetus out intact affected by the fetal tissue at that gestational age that you perform D&Es?

A. The earlier the pregnancy the more fragile the fetus. So, grasping a fetus early on is more likely to tear it and less likely to allow you to bring it out whole. If the fetus were older its condition would be tougher enough that it could take, you could move it into an appropriate position easier.

Q. And you also testified that you have, when you were speaking with the Judge, that you have used suction to remove the brain of the fetus, is that right?

A. Yes.

Q. Is there another way that you have removed the head in the D&E procedures that you have performed?

A. Yes.

Q. What is that?

A. You can in a, before 18 weeks, sometimes grab the head with one instrument, with a grasping instrument in one hand and use a grasping instrument in the other hand to grab the rest of the head. Usually with a twist you can deflate the head enough to bring it through. So, it's a crush --

THE COURT: Do you crush the head?

THE WITNESS: Yes, it could be a crushing; yes, early on.

~

Q. Why not?

A. Because this statement says -- let me find it. Blindly forcing the sharp instrument. There is nothing blind about it. Visualize in your mind this. The cervix has to be dilated enough to allow the entire trunk of the fetus to pass through it. The neck of the fetus is much smaller than the shoulders and the trunk but a larger thing, the shoulders and the trunk have passed through. So, not only is the neck through but a portion of the skull which is vividly, you know, exactly where it is and you see it, it's above the neck --

THE COURT: Do you always see it, Doctor?

THE WITNESS: Almost always, yes.

THE COURT: Not always then.

THE WITNESS: I can't think of anything that I always --

THE COURT: You do it by feel, don't you?

THE WITNESS: You always feel it. It's right there where your finger is.

THE COURT: If you feel it you can't see it.

THE WITNESS: Usually you see it. So, when it's right there you can usually, under direct vision, insert a sharp instrument into the skull or, at worst, by feel, not blindly, because you know exactly where it is and you feel it with your finger.

~

Q. What is it that you are using to bring the cervix down in your description?

A. You are using a grasping instrument called a tenaculum. Usually they have several opposing teeth which grasp the cervix and allow you to hold it without tearing.

Q. In the example you just gave, I think you said that there were several things you might do that would be an act that would kill the fetus. What might those things be?

A. One thing would be to simply pull the fetus out. Having done that, it is likely that the fetal head would remain inside, and in pulling it would have separated the head from the body, and that would have resulted in the fetal death and later delivery. Another possibility is that you would grasp the head under those circumstances and either crush it or hold it and then puncture it to deliver the head. In either case, you have done an overt act after delivering the fetus to the trunk.

Q. In the example you gave where you delivered the fetus up to the head, is any part of the trunk past the navel outside the woman's body?

A. Yes, certainly.

Q. What part?

A. Depending on the anatomy of the woman, most of the cervix is dilated, so it is usually a good part of the fetus, probably from the navel down in the situation when the vagina and the cervix are in the same plane or close to the same vertical plane.

Q. In that example is any part of the trunk above the navel outside?

A. It is possible that, depending on the situation, a part of the fetus above the navel would be outside. It depends only on the geometry of the cervix and how far the cervix is brought down.

Q. In the example you gave where the head separates, is that an act that you know will kill the fetus?

A. It is.

Q. Is that an act that completes the delivery of the fetus.

A. No, it is not.

Q. Why not?

A. Because you would then have to remove the head.

Q. You would have to go back --

A. You would have to go back, grasp the head, and remove it.

Q. Dr. Weiss, what is your purpose, in the example you just gave, in delivering a fetus up to the head after removing an arm? What is your purpose in doing that?

A. Your purpose in doing the procedure is overall to terminate the pregnancy, to make the woman no longer pregnant…

Excerpts from cross-examination of Dr. Weiss:

Q. You were on the board of directors of Planned Parenthood of Essex County from 1992 through 1997, is that right?

A. That is correct.

Q. You are still a member of Planned Parenthood?

A. I don't know if I am a member.

Q. Would it surprise you to learn that your CV lists you as a member of Planned Parenthood?

A. No. I am not sure what the dates are. I would be continuing a member if I sent them a check this year, and I don't recall doing so.

Q. As soon as the law on abortion changed in 1971, you were part of a group that established a Planned Parenthood-sponsored abortion facility in Pittsburgh, is that correct?

A. That is correct.

Q. And you have provided testimony --

THE COURT: What year was that?

MR. LANE: Excuse me, your Honor?

THE COURT: What year was that?

MR. LANE: 1971, your Honor.

THE WITNESS: Excuse me, sir. I misspoke. On recollection, it was after the law was changed, and that was January 22, 1973. So I believe it was 1973.

THE COURT: A date that sticks in your mind, is it, Doctor?

THE WITNESS: Vividly.

~

Q. Doctor, in your view, you don't set out to do a specific abortion procedure, but instead set out to make a woman unpregnant, isn't that right?

A. That's correct.

Q. The word "unpregnant" is your term, right, Doctor?

A. That's correct.

Q. That is a term you used here this morning as well as in your deposition?

A. Yes.

Q. That is not a medical term, is it, Doctor?

A. No. It is a term in English.

THE COURT: It is a what term?

THE WITNESS: A term in English.

DAY SEVEN: Thursday, April 8, 2004.
Excerpts from direct examination of Dr. Stephen T. Chasen:

THE COURT: Yes. Do you tell them straight out what you are doing? No sugar coating, 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 sugar coating.

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 sugar-coated words like that?

THE WITNESS: My patients are under no illusions and they don't regard that as sugar-coating and 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: 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. [Do you tell] 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 you're 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.

~

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 [laminaria] 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 guidance. New these cases the mothers are not 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.

~

Q. Yes. Just describe for us if you can how you perform a D&E?

A. …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. ....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.

~

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. Based on your experience, Dr. Chasen, how long does the process of fetal death [by] asphyxiation take from the onset of contractions and induction abortion?

A. It could take many minutes.

~

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 [abortions] 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.

~

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.

~

Q. Which ones [referring to earlier question about use of KCl or digoxin to effect fetal demise before starting to evacuate the uterus in a D&E]?

A. 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, by 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.

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.

Excerpts from cross-examination of Dr. Chasen:

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.

Q. If 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…Doctor?

A. There have been a few occasions, yes.

Q. Then you remove the fetus with the towel, you put 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 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.