A CHOICE FOR WOMEN, et al.,

Plaintiffs,

vs.

ROBERT A. BUTTERWORTH, et al.,

Defendants.

Case 98-0774-Civ-DLG

MIAMI, *FLORIDA*
AUGUST 14, 1998

TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE DONALD L. GRAHAM,
UNITED STATES DISTRICT JUDGE

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THE COURT: Be seated please. Good morning ladies and gentlemen. We are now ready to continue.

MS. ANDERSON: Thank you, Your Honor.

Plaintiffs call Dr. Michael Benjamin to the stand.

DR. MICHAEL J. BENJAMIN, PLAINTIFFS' WITNESS, SWORN.

DIRECT EXAMINATION

BY MS. ANDERSON:

Q. Dr. Benjamin, could you, please, state your full name for the record?

A. Michael Benjamin.

Q. What is your profession?

A. I am a physician, specializing in obstetrics and gynecology.

Q. Are you licensed to practice medicine?

A. Yes.

Q. In what state?

A. State of Florida.

Q. Let me hand you what has been premarked as Plaintiff's Exhibit 6.

[Plaintiff Exhibit 6 marked for identification].

A. I have a problem with my eyes. I may not be able to read much of anything. I will try.

Q. Thank you.

Can you tell whether this appears to be a correct

copy of your current CV?
A. Yes. I can see this all right. It is a correct copy.
Q. Does it accurately state your medical school training and residency?
A. Yes, it does.
Q. It states professional societies in which you belong?
A. Yes.
Q. Are you currently board certified?
A. Yes.
Q. What specialty?
A. Obstetrics and gynecology.
Q. Could you briefly describe your current medical practice?
A. I provide a full range of obstetric and gynecological services, including obstetrical care, high risk obstetrical care, gynecological surgery, all of the usual gynecological procedures. Office gynecology, including contraceptive, family planning.

In addition to that, I provide a full range of abortion services through twenty-four weeks gestation and medical abortion with methotrexate.
Q. Do you currently deliver live babies as well?
A. Yes.
Q. Do you practice in a clinic setting, private practice or both?

A. I practice in both.
Q. Which clinic do you practice in?
A. Presidential Women's Clinic, West Palm Beach.
Q. Where is your private practice?
A. Tamarac, Florida.
Q. How long have you been performing abortion procedures?
A. Estimate, thirty years.
Q. Can you estimate, approximately, how many abortion procedures you have performed in the first trimester of pregnancy?
A. In excess of 10,000.
Q. How many in the second trimester?
A. In excess of 10,000.
Q. How early in the first trimester do you perform abortions?
A. As you early as I can confirm pregnancy on ultrasound, which is approximately four and a half menstrual weeks.

MS. ANDERSON: I ask the Court -- by the way, was there any objection to the introduction of Exhibit 6?

MS. BURGENER: No objection, Your Honor.

THE COURT: Received as marked.

[Plaintiff Exhibit 6 received in evidence].

MS. ANDERSON: We would like to have the Court recognize Dr. Benjamin as an expert in the area of obstetrics and gynecology, including abortion procedures.

MS. BURGENER: No objection.

THE COURT: Your request is granted.

MS. ANDERSON: Thank you, Your Honor.

BY MS. ANDERSON:

Q. Dr. Benjamin, in your experience, are abortions from maternal indications more prevalent in the second or first trimester?

A. Far more prevalent in the second trimester.

Q. Why is that?

A. The diagnose generally can't be made until the second trimester.

Q. In your experience, are abortions for fetal indication more prevalent in the first or second trimester?

A. Second.

Q. Why is that?

A. The procedure is not done until the diagnosis is made and the diagnosis cannot be defined until second trimester procedures are done.

Specifically, amniocenteses or high resolution ultrasonography. There was a nine week procedure, which is, occasionally would be the diagnosis in the first trimester that is seldom done.

Q. Most of the diagnoses are made in the second trimester?

A. Yes.

Q. Currently, what abortion procedures do you use in your

practice?
A. Essentially, I do two procedures and variations thereof.
Aspiration of suction curettage through approximately fourteen and a half weeks gestation, menstrual dates, and from that time through twenty-four weeks, which is the latest procedures I do, I use D&E or variations thereof.
Q. And do you also refer to suction curettage procedures as a D&A at times?
A. Yes. They are synonymous.
Q. What does D&A stand for?
A. Dilatation and aspiration.
Q. Yesterday other witnesses described procedures that they used when they use a suction curettage.
When you do that procedure, do you use a cannula?
A. Yes.
Q. Do you use something called a curette?
A. Yes.
Q. Is that the same as a cannula?
A. A cannula is a vacuum curette.
Q. When you perform a suction curettage procedure, what is your purpose in performing the procedure?
A. Terminating the pregnancy.
Q. How do you achieve termination of the pregnancy?

A. In the first trimester, using suction curettage, the cervix is opened or dilated. The suction instrument is introduced and at that point everyone's technique varies.

My technique is basically using it as a dissection tool to separate the contents of the uterus from the wall of the uterus, at which point the vacuum will draw the contents of the uterus through the instrument and downward through the tubing it's connected to.

Q. How do you get the cannula from outside the woman's body to the woman's uterus?

A. It's inserted through the vagina, through the cervix, into the uterus.

Q. And do you consider a fetus with a heartbeat to be a living fetus?

A. Yes.

Q. When you have performed the suction curettage procedure, has it ever occurred in your experience part of the living fetus is in the uterus and part in the vagina?

A. It undoubtedly is the case in infrequent amount of cases.

The fetus is very small. It's traveling at high speed through a suction instrument. You know, it goes from the uterus into the collecting system in the operating room, but you can't tell how and when it has come through, whether it has come through intact, whether it has come through in

part, at which point in the procedure life ceases based on my parameter of life.

My suspicion, most of the time the fetus dies sometime after its removed from the uterus?

Q. Why do you have that suspicion?

A. When we do examinations of tissues after they have been removed from the uterus, more often than not, up to, say, eleven or twelve weeks, the fetus comes through intact and if it comes through intact, the chances are that the actual demise occurs as a hypoxic death from the lack of oxygen.

Q. At the end of the procedure, are you able to determine whether the fetus came out intact or in pieces?

A. Yes.

Q. When you perform a suction curettage procedure, do you know if the fetus is living at the beginning of the procedure?

A. In my case, I do. I do routine ultrasound before a procedure, and I can visualize a heartbeat.

Q. Do you know if the fetus is dead at the end of the procedure?

A. It's always dead at the end of the procedure.

Q. Do you do the procedure in the exact same way each time you perform it?

A. My technique is the same, but the way it proceeds varies with an infinite variety.

Q. What are the reasons for some of that variation?
A. It's, basically, a blind procedure, so there is no control, no precise control of what is happening at the tip of the instrument.

It's difficult, if not impossible, to know what anatomic structure the tip of the curette is in contact with in terms of pregnancy tissues.

When you insert the curette, it may be against the placenta sac, fetal structures. It may be against lining membrane of the uterus.

The only thing you can ascertain is the instrument is safely within the cavity, but not what it is doing to fetal tissue at any given point in time.

Q. Is "partial birth abortion," to your knowledge, a medical term?
A. I don't believe it's a medical term.
Q. Is "vaginal delivery" a term used by obstetricians and gynecologists?
A. Yes.
Q. In the practice of obstetrics, is there other types of delivery other than vaginal delivery?
A. Vaginal delivery is juxtaposed to abdominal delivery, or cesarean section. It just means a baby coming out through the vagina.
Q. In your practice, in relationship to performance of

abortions, do you typically use the term "vaginal delivery" or "abdominal delivery" in the abortion practice?
A. No.
Q. If you were to apply those terms, "vaginal delivery" and "abdominal delivery," to abortion methods you are aware of, which ones would you consider to be vaginal deliveries and which ones abdominal deliveries?
A. The only ones I would consider abdominal would be hysterotomy and hysterectomy. The remainder of abortion procedures, one form or another --
Q. Would you consider the suction curettage procedure to be a vaginal delivery?
A. Yes.
Q. Is that true, even though the fetus is enclosed within the cannula during that procedure?
A. In the sense it passes through the vagina, yes.
Q. Do you have an understanding of what the term "partially vaginally delivered" means?
A. I think you could place a variety of meanings upon it. I have my interpretation, yes.
Q. Is that a term generally used by obstetricians in reference to live births, "partially vaginally delivered"?
A. I have never seen it.
Q. What would be your interpretation of "partially vaginally delivered"?

A. Some of the fetus coming through the entrance to the vagina, exiting the entrance to the vagina.
Q. And do you have an understanding as to how much of the fetus would need to exit the entrance to the vagina in order to be a partial vaginal delivery?
A. No, I don't.
Q. What would it mean to complete the delivery in the abortion context?
A. We don't use the term "delivery" in an abortion context, so I don't know what it would mean.
Q. When do you consider an abortion procedure to be completed?
A. When the uterus has been fully evacuated, there are no pregnancy contents, which would include the fetus, placenta, membranes within the uterus.
Q. You mentioned you also performed dilatation and evacuation procedures.
A. Yes.
Q. You mentioned you start using that, typically, at 14.5 gestational weeks.

Is that correct?

A. Yes.
Q. Why do you use that procedure at that gestational age, rather than using the suction curettage procedure?
A. The fetal structure has become too dense and compact to

pass through a reasonable size cannula at around that stage, and the procedure becomes difficult, if not impossible, much beyond sixteen weeks.

Q. And when you perform the dilatation and evacuation procedure, do you always perform it in the exact same manner?

A. No.

Like any surgery, I go by what the -- I go with the flow, I think is the best way to phrase it. Everything tends to vary a little bit in surgery.

Anyone who does everything the same way every time is falling into an inflexibility that is dangerous. You have to react to the situation at hand. The situation at hand will dictate that things be done slightly differently almost with each and every case.

Q. Typically, when you perform a dilatation and evacuation procedure, do you remove the feet in parts?

A. Typically, yes.

Q. And are there times when you remove it and it's not in pieces?

A. Yes.

Q. And at that point, is it intact?

A. Yes.

Q. How often, roughly, do you perform a dilatation and evacuation procedure and you remove a fetus and it's intact?

A. I would say it comes out intact in approximately five percent of the cases we do.
Q. Why does it sometimes come out in pieces and sometimes intact?
A. The fetus doesn't vary from stage to stage. What varies is the cervix, and when the cervix or neck of the uterus or neck of the woman is excessively dilated or soft there is minimal resistance.

That's really the ideal situation. You would like to get the fetus out with as few moves as possible. You grasp as much of the fetus as you can with the instrument that is used to extract it. With a soft cervix, it will tend to come out intact because the resistance of the cervix is what causes the dismemberment.
Q. When you perform the D&E procedure, do you insert any instrument into or onto the cervix?
A. Yes, the cervix is held in place.
Q. With a tenaculum? What is the tenaculum made out of?
A. Metal.
Q. Does the tenaculum affect the contents of the cervix in the context you are describing?
A. No.

Prior to all of this, I have inserted devices called dilapan or laminaria into the cervix. These soften, ripen and dilate the cervix, and the extent of that varies

from patient.
Q. What does dilapan do?
A. It is an osmotic dilator. It is something that absorbs moisture and in the process expands in the same way a sponge does.
When it expands inside the cervix, it stretches or dilates it over a span of twelve hours or so.
Q. When you have performed dilatation and evacuation procedures, has it ever happened the fetus was partially expelled after you removed the dilator, but before you have inserted the forceps into the women's uterus?
A. It is a frequent event.
Q. What do you do?
A. Depending on the extent it has been expelled, I may remove it from the vagina where it may be sitting. It may be protruding from the entrance of the vagina. It may be partially trapped inside the cervix.
I may have to do the remainder of the fetus as a D&E would be done. I may compress the head and extract it similar to what is done with the D&X.
Q. What is a D&X?
A. D&X is the same as intact D&E. It's a procedure which attempts to extract the fetus in a fashion similar to a breech delivery at term.
Q. Now -- do you perform D&X procedures?

A. Yes, I do.
Q. When I asked you about the procedures you performed, you didn't mention that one specifically.
Why was that?
A. It's a variety of D&E.
Q. At what gestational ages have you performed the variety of D&E that you call a D&X?
A. At twenty-four weeks, between the 23rd and 24th week, but I have done them, in effect, as early as seventeen weeks, eighteen weeks, when the fetus is accommodating, so to speak.
Q. Would you explain what the difference is between the D&X procedure and the other D&Es that you have performed?
A. The difference is the result more than the intent.
The intent of both procedures is using instruments to extract the fetus.
If the cervix is not well-dilated, the fetus tends to come out in fragments because the cervix will not allow larger portions to pass intact.
However, if the cervix is ripe enough, the fetus will tend to come out intact. If it will, I prefer it that way, because the less fragmentation, the less trauma to the cervix and uterus.
Q. I would like to show you what has been marked as Defendant's Exhibit 1, which is the ACOG statement of policy

on intact dilatation and extraction.

Have you seen this document before?

A. Yes, I have.

Q. In the middle of the page -- I don't know how your eyesight is doing.

A. I am making it.

Q. -- there are four points ACOG lists as being contained within what they define as the intact dilatation and extraction procedure.

When you do what you consider to be a D&X procedure, does that always involve deliberate dilatation of the cervix, usually over a sequence of days?

A. Yes.

Q. Does it also involve instrumental conversion of the fetus to a foot breech

A. No. It's not essential.

Q. What are the other variations on that in terms of the D&X you perform?

A. The conversion to a breech isn't done if it's already a breech, and frequently it is. I am not sure why ACOG lists that.

Q. When you perform what you consider to be a D&X, is the fetus always in a breech position or you convert it to a breech position?

A. Yes, but conversion isn't always necessary.

Q. You say the fetus often is already in a breech position. Approximately how often do you encounter that in that twenty-three to twenty-four gestational age?
A. Probably a third of the time. Something less than half.
Q. When you perform what you consider to be a D&X, do you always do a breech extraction of the body excepting the head?
A. That's my goal, but it may not work out that way.
Q. Have you done procedures you would consider to be D&X where that third step doesn't occur?
A. Yes.
Q. What are the variations?
A. Well, the attempt, the intent of the procedure is to do pretty much what is described here, but things don't always work the way you want them to work.

It is not a completely controllable situation, and with procedures that begin as a D&X, you may end up with something that looks very much like the earlier procedures with the fetus coming out in fragmentary form.

Q. Is there a particular point --
A. Or sometimes if things go real well, it's not necessary to evacuate the contents of the skull. It passes through without evacuation.
Q. In terms of the fourth step here, the partial

evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

Is that sometimes the case?

A. Usually the case.

Q. Why do you, when you do a D&X, perform that fourth step, partial evacuation of intracranial contents?

A. The head is the largest portion of the fetus. At that stage, it generally does not fit through the cervix. It is, generally, too wide for the amount of dilatation you have accomplished. It becomes much narrower if the cranial contents is evacuated.

Q. Is it your purpose when you evacuate the intracranial contents, is it the purpose of that procedure to cause fetal demise?

A. To accomplish evacuation of the fetus.

Q. When you do the D&X procedure, you say sometimes you actually start out, sometimes you start the procedure intending to do what you consider to be a D&X?

A. Yes.

Q. Why do you start the procedure with that idea in mind?

A. It's the least traumatic way of emptying the uterus at that stage.

You would like to have bones intact. They can lacerate, perforate, traumatize the uterus. The brain

contents is felt by some to be a source of a very serious complication called pulmonary embolus or amniotic fluid embolus with toxic and lethal results.

Any fetal tissue can be drawn up into maternal circulation through the lungs and cause a very serious and lethal complication.

Intact prevents trauma locally and dispersion of tissues into the maternal situation.

Q. At the twenty-three, twenty-four week gestational age, do you consider it to be safer to do an intact D&E?

A. It's always safer, but specifically at twenty-four weeks.

Q. Typically, at, say, the sixteen to twenty gestational week range, in most of the D&Es you perform, are you bringing out the fetus intact at that stage?

A. Usually not.

Q. Why not?

A. The amount of dilatation that we can achieve in the space of twenty-four hours is, generally, inadequate to remove the fetus intact, but sometimes done.

Q. And for the twenty-three to twenty-four week stage, do you dilate it for twenty-four hours?

A. No. I use serial dilatation, generally, over the space of forty-eight hours.

Q. Why don't you, at the sixteen to twenty week

gestational age do another day of dilatation to have a wider cervix?

A. It's really done based on a risk benefit calculation.

Most of us who do these procedures have the benefit to doing it in one stage. The mother doesn't have the procedure protracted. It does reduce cost. There is less time and less materials involved.

On the negative side, the D&E that is done other than intact has the hazards I mentioned previously of injury to the uterus and the cervix and fetal material entering the maternal circulation.

If it were an ideal world where maternal emotions were not a consideration and costs were not a consideration and my time was not a consideration, I would do them all as intact or D&X as a safer procedure.

Q. Does the risk posed by the fetus breaking into parts change over the gestational age?

A. Yes, I think it increases week-by-week.

Q. When you do -- strike that.

Do you sometimes, when you perform a D&E procedure, when you reach into the uterus, do you sometimes grasp the umbilical cord?

A. Frequently.

Q. When you grasp the umbilical cord, what do you do next?

A. I apply traction to it and disrupt it.

Q. Why do you do that?
A. If I don't, I will grab the umbilical cord again and again. It doesn't serve any useful purpose. You want to grasp fetal tissue not the umbilical cord.
Q. Does compressing the umbilical cord cause fetal demise?
A. Ultimately.
Q. How long does that take to cause fetal demise?
A. Probably eight minutes.
Q. When you perform D&E procedures, do you wait eight minutes? The times when you have grasped the umbilical cord, do you wait eight minutes before proceeding?
A. No.
Q. Why not?
A. From the time the procedure starts, a number of risks begin, including plug loss, including embolization of amniotic fluid or other tissues, and, more important than that, the uterus begins to contract once membranes are ruptured.

When membranes are ruptured the volume of the uterus is decreased, and the uterus' response is to contract or close down.

Closing down the uterus precludes inserting additional instruments and manipulating them with safety. It's much easier to work within the uterus before it's contracted.

If I waited eight minutes, frequently I would be dealing with a treacherous situation where there was no room to manipulate my instrument.

Q. When you start a D&E procedure, do you use suction at the start of the procedure?

A. No longer. I did at one time.

Q. And when you did use suction at the beginning of a procedure, what was the purpose of that?

A. To evacuate amniotic fluid.

Q. Why do you no longer do that?

A. I think it increases the risk of amniotic embolus. I think draining under normal pressure using a curette, without vacurette, without suction. I use it as a drain.

Q. How do you manage to drain the amniotic fluid using the vacurette without suction?

A. The pressure inside the uterus tends to be greater than outside. There is a natural tendency to flow.

I use it as a conduit to allow natural pressure to evacuate the fluid.

Q. What is a vacurette?

A. The suction instrument that is used in first trimester abortions.

Q. When you perform a D&E procedure, do you sometimes have the first part of the fetus you grasp be a leg?

A. Frequently.

Q. Typically, what do you then do with the leg?
A. I apply traction through the cervical canal.
Q. Does the leg sometimes disarticulate from the fetus?
A. Frequently.
Q. Does it always happen that way?
A. No.
Q. And when the leg does disarticulate from the fetus, at that point is the top of the leg where it connects to the trunk always located within the woman's uterus?
A. No.
Q. Where else is it located?
A. Well, when I have disarticulated, yes.
Q. Do you know if a disarticulated leg causes fetal demise?
A. It probably does ultimately, but not instantaneously.
Q. When you perform a D&E, do you know at what point fetal demise does occur?
A. Generally, not.
Q. Sometimes do you?
A. Yes.
Q. How so?
A. Well, a variety of indicators.

If I have extracted a chest wall, obviously, there is a demise. If I crushed a head with forceps, obviously, there is a demise. If a head is removed, obviously, there

is a demise.

There are some things that are clearly lethal.

Q. If you drain the intracranial contents of the fetus' head, does that cause demise?

A. Yes.

Q. When you perform a D&E, are you trying to achieve fetal demise at a particular point in the procedure?

A. No.

Q. If you are trying to perform an abortion procedure in the second trimester with a woman who has a fetus with a hydroencephalic head, what, typically, happens in that situation?

A. Hydroencephalic heads are much larger stage per stage than normal heads and they cannot be removed reasonably without evacuating the contents of the head.

Q. That would cause fetal demise?

A. Yes.

Q. Using ultrasound, can you tell ahead of time whether there is a hydroencephalic head?

A. Yes.

Q. If you see in an ultrasound there is a hydroencephalic head, could you, alternatively, perform a hysterotomy in order to evacuate the contents of the uterus?

A. Yes.

Q. Why don't you do that, or do you ever deliberately

choose a hysterotomy to evacuate a hydrocephalic fetus rather than a D&E?

A. I don't do that any longer.

Q. Why not?

A. It has greater morbidity and mortality than doing D&Es. That's well-established in the literature.

Q. Are you aware of other doctors in the Southern Florida or the Fort Lauderdale/Tamarac area who provide abortions up to twenty-four weeks, as late as twenty-three and twenty-four weeks?

A. I don't believe so.

Q. Do you see patients for abortion procedures only that are your own patients or the patients at the Presidential Women's Clinic?

A. No, I see many referrals, particularly for anomalous fetuses.

Q. Why is that?

A. It's generally known in the community I am a good source for surgical referral for that procedure.

Q. Have you done many of the procedures in which there is an anomalous fetus?

A. Yes.

Q. Once you start performing an abortion procedure, if you encounter an unexpected situation, are you able to safely stop performing the procedure?

A. There is a risk to stopping once you have begun.
Q. Typically, once you begin, do you continue or do you stop?
A. Typically, I continue until the uterus is evacuated.
Q. What are the most common risks from the D&E in which the fetus is removed in parts?
You mentioned already the risk of puncturing because of fetal bone matter, and you mentioned the risk of pulmonary embolism.
Are those the most common risks?
A. Well, no.
The most common risk is, number one, hemorrhage. That's true across the board for anything obstetrical.
Infection across the board is the second commonest risk. With a D&Es, injury to the uterus and surrounding organs is placed third. That's unique to the D&E procedure.
Q. The last one?
A. Yes.
Q. And how great is the risk of hemorrhage in performing a second trimester D&E procedure?
A. Hemorrhage requiring hospitalization, transfusion some sort of therapy is relatively uncommon. Less than one percent.
Q. What about the risk of infection from a second trimester D&E?

A. Clinically significant infection is less than one percent.
Q. What about the uterus, the problems you mentioned specific to the D&E procedure? How often do those occur?
A. They really vary dramatically depending upon institution. Experience is a major factor in that complication.

In inexperienced hands, it may be in the range of one in 100, 500. With experienced hands, it's a rare event.
Q. In your own practice, how common is it?
A. I have had about three in twenty-five years.
Q. Are you aware of risk associated induction procedures?
A. Yes.
Q. And in your understanding, how do the risks of induction procedures compare with risks of D&E procedures?

By "D&E," I am including the intact D&E procedure.

Which has greater -- first, let's take the D&E in which the fetus is removed in parts. How do the risks of that procedure compare to the risks of the induction procedures performed in the second trimester?
A. The studies that I am aware of indicate a greater risk with induction procedures than with D&E procedures.
Q. What about the risks of intact D&X procedures compared to induction procedures?
A. They are extremely low.

Q. Are you aware of any of statistical studies dealing with the risks associated with the intact D&E procedure?
A. I don't think anyone has done a study. I don't think there are enough numbers to do statistically significant study.

The feelings of safety are more informal communications between physicians who have done these procedures and, really --
Q. I'm sorry. What was the end of that?
A. Those of us who do them have not had significant problems with them.

I don't think you will find anything in the literature that confirms that, though.
Q. Approximately how many intact D&X procedures do you believe that you have performed or intact D&E procedures?
A. I have been doing them for intentional D&X procedures for about three years now. I would say I average one per week, so I guess that comes to one hundred fifty, maybe two hundred.
Q. Out of that number, how many situations have had in which the woman has had serious complications from the procedure?
A. I haven't had any.
Q. Have you ever been the target of anti-abortion activity?

MS. BURGENER: Again, I object on the basis of relevancy and cumulative.

MS. ANDERSON: I haven't asked this witness before.

THE COURT: Well, not this witness.

Can we get into this area quickly?

MS. ANDERSON: Absolutely.

THE COURT: Overruled.

BY MS. ANDERSON:

Q. Would you answer the question, "Yes" or "No"?

A. Yes.

Q. And if you could just very briefly explain the nature of the activity that you have experienced?

MS. BURGENER: Again, Your Honor, same objection as to relevancy and cumulative from the first witness, and, Your Honor, I believe it's relevant.

THE COURT: Overruled.

BY MS. ANDERSON:

Q. Well, briefly explain.

A. I have protesters in front of my office two or three times a week from the local Catholic church.

Q. Have you read the Florida Statute that is at issue in this case?

A. Yes.

Q. I am going to put in front of you a copy of the statute

that has been marked as an exhibit.
A. This is like the bottom line of the eye chart.
Q. This is smaller.
A. I can't see it.
Q. You have read the Florida Statute that bans partial birth abortions?
A. Yes, I have.
Q. And do you believe that this partial birth abortion ban, if allowed to go into effect, would prohibit some of the first trimester procedures that you perform?
A. Yes.
Q. And which procedures do you think it would prohibit?
A. I think it impacts on all the procedures in the first trimester.
Q. Why is that?
A. Because the definitions are unclear to me and what I do is very similar to what is described there in the statute.
Q. I will read it to you, since it's difficult for you to read it.

Do you, in the first trimester, perform termination of pregnancy procedures in which you partially vaginally deliver a fetus?
A. There is a point during the procedure in every procedure where the fetus is partially vaginally delivered.

If it comes from the inside and goes to the

outside, there is a point in transit where it's partially in and partially out.

Q. And do you perform, in the first trimester, termination of pregnancy procedures in which a living fetus is partially vaginally delivered?

A. I am sure I do.

Q. That's based on what you have already testified to?

A. It is inherent in the procedure, yes.

Q. Do you perform, in the first trimester, abortion procedures in which you kill a living fetus after it has been partially vaginally delivered?

A. I am sure this occurs with fair frequency.

Q. Do you perform procedures in which, after the fetus is killed, the abortion procedure is completed?

A. Yes.

Q. And in the second trimester, do you perform procedures that you believe would be banned by this act?

A. Yes.

Q. And which ones?

A. All the procedures that I do would be banned by this act.

Q. Does that include the D&E procedures in which you remove the fetus in parts?

A. I believe so.

Q. It would include the D&E procedures in which you would

perform what you call the intact D&E procedure?
A. Yes.
Q. Why do you believe those would be banned by the act?
A. They are identical to the description of termination that the act describes.
Q. In those situations also do you partially vaginally deliver a fetus?
A. Yes.
Q. Do you in those situations -- in every situation in which you do a D&E, do you partially vaginally deliver the fetus?
A. Yes.
Q. And in every situation in which you do a D&E, is the fetus still living after part of it has been moved from the uterus into the vagina?
A. Yes.
Q. And when you perform D&E procedure, is the fetus no longer living at the end of the procedure?
A. Almost always.
Q. And if the statute goes into effect, do you believe it might be used with reference to other abortion procedures? Besides the D&E procedures and suction curettage procedures, it might be applied to other types of procedures?
A. Yes, I am concerned it would be.
Q. Which other procedures?

A. Virtually any abortion procedure.
Q. Why is that?
A. Because the essence of all abortions is removing the fetus, and at one point it's partially in and partially out, and, ultimately, the fetus is dead at the end of the procedure, and the point at which death occurs and the mechanism by which it occurs is really difficult to define.

I don't know. I certainly could not argue that I didn't do exactly what was done as described in the law.
Q. Do you believe that hysterotomies would be banned by the act?
A. I am concerned charges could be made based on the act.
Q. Is a hysterotomy an abdominal procedure?
A. Yes.
Q. Why do you believe charges could be made with reference to hysterotomy?
A. From a functional standpoint, what you are doing is exactly the same. The only difference being the exit of the fetus. Otherwise, the procedure is done exactly the same way.

Up to and including evacuation of skull contents, a hysterotomy.
Q. Do you believe that --
A. I don't honestly think that charge would be sustained, but I am concerned, very concerned it would be raised in

this situation.
Q. Why do you think it would not be sustained?
A. Because of the technical difference between abdominal and vaginal delivery, but in obstetrics and gynecology "delivery" is "delivery," and the route is not that germane.
Q. Do you believe cesarean sections done prior to -- is there a type of abortion procedure which is comparable to a cesarean section?
A. Hysterotomy is very similar.
Q. Do you also believe hysterectomies would be banned by the act?
A. I think that charges could be made that it violated the act, yes.
Q. Is that a vaginal delivery?
A. No, it isn't.
Q. What --
A. Although vaginal hysterectomy is a vaginal delivery.
Q. Are most hysterectomies abdominal deliveries?
A. In a pregnant uterus, yes.
Q. In a pregnant uterus when a hysterectomy is performed, do you believe those would be successfully prosecuted if someone brought charges under this act?
A. Well, no, but I am concerned about misuse of the act as a putative measure.
Q. What do you understand the penalties could be under the

act?
A. I understand it's felonious. That means imprisonment and other fines associated with it.
Q. Is it your understanding it's only a criminal statute?
A. That's my understanding.
I know there are civil penalties. I am not clear on the difference between civil and criminal in that act.
Q. In terms of reading the act, let me -- are there techniques that a physician can use to ensure fetal demise?
A. Yes.
Q. We have already had testimony about various techniques, one of which is injection of digoxin
Do you believe there are risks associated with that?
A. There are established risks.
Q. Do you believe any maternal benefit derives from the injection of digoxin to ensure fetal demise?
A. No.
Q. With reference to other injections that could be potentially used to ensure fetal demise, do you believe such injections serve a benefit to the mother's health?
A. No, I don't.
Q. Well, is it your understanding there are risks with each of those procedures?
A. Yes, there are risks.

Q. Are you aware of laws in Florida which govern the performance of abortion if the fetus is viable?
A. Yes.
Q. Do you abide by those laws?
A. Yes, I do.
Q. Are you aware of laws in Florida which govern the performance of abortion during the third trimester?
A. I am not familiar with them, since I don't address that issue.
Q. Do you only perform procedures in the first and second trimester?
A. Yes.
Q. If the statute takes effect, in your opinion, what effect would that have on your practice?
A. Oh, I might cease to practice if that law take place.
Q. Why would that be?
A. One of the only things that keeps me going in practice, I feel I am doing something useful that others cannot do.

I am at a point in my career, if I am not being useful, I don't need to continue working.
Q. Do you feel if the act goes in effect, you would no longer be able to be useful in your practice?
A. I feel it would exclude D&Es, which is where my special expertise exists, and that's my raison d'être and first trimester abortions probably would be done under severe

chill, which I don't think I would want to deal with.
Q. Do you think there would be any harm to your patients if this statute goes into effect?
A. To be immodest, yes, I think there would be severe harm.
Q. Why is that?
A. My care would not be available to them.
Q. What effect --
A. It would drive them in a different direction which would be markedly more hazardous for their health and, perhaps, the terminations would not be available at all.
Q. In your opinion, if all doctors are required to perform abortions in one particular way, will that have an effect on maternal health?
A. Yes.
Q. What would that effect be?
A. If they are driven in the direction of inductions, inductions are a more hazardous, more expensive procedure, and between the two, either you are making it unaffordable or increasing morbidity to an otherwise safe procedure.
Q. Are there some women for whom inductions are not a feasible option?
A. Sometimes they just don't work.
Q. There are, there some women who have contraindications to the materials that are used in induction?

A. The materials that are used are, all have contraindications in certain circumstances.
Q. Are you aware of any problem with maternal health of women receiving abortions in Florida which might be improved as a result of this ban, if it goes into effect?
A. No, I am not.
Q. And in your opinion, if enforcement of the partial birth abortion -- would the enforcement of the partial birth enforcement ban result in any benefit to women in Florida?
A. No.

MS. ANDERSON: I have no further questions.

THE COURT: Cross examination.

CROSS EXAMINATION

BY MS. BURGENER:

Q. Good morning, Dr. Benjamin.
A. Good morning.
Q. Dr. Benjamin, is the suction cannula a conduit between the uterus and a jar receptacle awaiting outside the body in a suction curettage procedure?
A. It is a portion of the conduit.
Q. The suction cannula is connected to a set of tubing, connected to a suction generator, connected to the waiting receptacle, is it not?
A. No.
Q. Are there other pieces and parts of that conduit system

besides the suction cannula, the tubing apparatus, the generator and the receptacle?

A. The cannula is attached to a tubing, which is attached to a receptacle, which is attached to a source of suction.

Q. And earlier you said during the suction curettage, it's a high speed travel through a suction apparatus.

Was that suction apparatus the suction conduit you just described, the cannula to the tubing to the receptacle connected to a suction source?

A. Yes.

Q. You indicated during the suction curettage there is usually a hypoxic demise to the fetus resulting from a loss of oxygen?

A. Yes.

Q. When the fetus is in the jar, they are not getting any oxygen, correct?

A. Yes.

Q. Is it fair to say that in most of the suction curettage procedures that you perform from the four and a half week mark to the fourteen and a half week mark, you get the transport of the intrauterine contents through that suction apparatus into the awaiting receptacle?

A. Yes, that's always true.

Q. It's always true?

A. Yes.

Q. Thank you.

Were you aware there were some physicians that perform the D&E procedure from week thirteen to week 16, using suction at the beginning to draw out some fetal tissues.

A. Yes, I did that in my early days of practice.

Q. And in those early days of practice when you performed the D&E weeks thirteen to sixteen to draw out some of that fetal tissue using the suction apparatus, did you end up with something in the jar receptacle at the end?

A. With something? Yes.

Q. And other than the suction curettage procedure, was the only other procedure that you used during the first trimester hysterectomy, if it was necessary?

A. I, personally, have not used any other procedure in the first trimester.

Q. Okay.

There are certain risks associated with the suction curettage procedure, correct?

A. Yes.

Q. And those include a wide range of things, including hemorrhage, infection, injury to internal organs, laceration of the cervix, perforation of the uterus, pulmonary embolus, shock, death, cardiac arrest, shock, bronchial asthma, et cetera.

A. Correct.
Q. Have you ever seen a definition as to what a D&E procedure is in the medical literature?
A. I am sure I have. I can't recall specifically.
Q. Is there a difference of opinion among OB/GYNs as to what constitutes a D&E?
A. Yes.
Q. Is it your understanding of a D&E that it's a forceps evacuation of the uterus following dilatation of the cervix?
A. Yes.
Q. And is there any procedure referred to in the medical literature to describe an aspiration procedure being used?
A. I imagine there is.
Q. And is the phrase, "D&E," a medical term that is described in the literature?
A. I believe so. I can't say with certainty. I am sure it's there somewhere.
Q. Are you using the expression, "D&E," as a synonym for suction curettage?
A. No.
Q. How are you differentiating the procedure known as D&E from suction curettage?
A. D&E generally refers to a procedure that is --
Q. I'm sorry. Wait a minute. I think I asked -- my question was how do you distinguish D&A from suction

curettage.
A. I don't. They are identical.
Q. I'm sorry. I misspoke.
Would it be fair to say that in the use of a D&E procedure that the fetus comes apart pretty easily up to about eighteen weeks.
A. Yes.
Q. Do you believe that there is no agreed-upon definition of "viability" amongst OB/GYNs?
A. Yes.
Q. What is your understanding as to what the South Florida community of OB/GYNs believes the period of viability to be?
A. I think, generally, the consensus falls around twenty-four weeks, based on the last menstrual period.
Q. Do you have an understanding as to the range of time that OB/GYNs believe that viability occurs?
A. Yes.
Q. Would that range run from about twenty-one weeks to twenty-eight weeks?
A. Yes.
Q. Earlier you said that in the D&E procedure the resistance of the cervix causes dismemberment.
Is the resistance of the cervix accomplished by attaching the tenaculum to the lip of the cervix?
A. No, it's not.

Q. How is that resistance of the cervix obtained?
A. The cervix is open to varying degrees and the amount of resistance is determined by how open the cervix is, as opposed to how large the fetus or fetal parts are.

If the opening is greater than the size of the fetus, there is minimal or no resistance. If it's smaller, the smaller it is, the greater the resistance.

Q. Performing the D&E procedure, would you agree it's better for the woman to try to avoid over-dilation of the cervix?
A. In some respects.

Over-dilation? Yes.

Q. Okay.
A. Yes.
Q. All right.

So, in other words, just to clarify for the record, when you are doing a D&E procedure, you don't want to over-dilate the cervix.

A. Correct.
Q. Do you know what a traditional D&E is?
A. I am not clear on what that means.
Q. Is "Intact D&E" a medical term in the medical literature?
A. Yes.
Q. Is it true that in '95 percent of the D&E procedures

performed in the second trimester that you are removing fetal parts rather than an intact fetus?

A. In my experience, yes.

Q. When I took your deposition on August 5th, 1998, you indicated that the week earlier you had performed a D&X procedure for a fetus at twenty-four weeks gestation.

Is that correct?

A. Yes.

Q. And in 1998 your estimate of performing D&X procedures was between twenty and thirty. Correct?

A. Yes.

Q. And today, here in court, you are estimating that you have done D&X procedures over a course of three years at about fifty a year coming up with a range of one hundred fifty to two hundred D&X procedures.

Is that right?

A. Yes.

Q. Now, is it fair to say that on direct examination you are stating for the record that you have intentionally performed intact D&X procedures in the State of Florida over the last three years in the amount of one hundred fifty to two hundred procedures?

A. Yes.

Q. Would you agree, doctor, if you are comparing the suction curettage procedure with the D&E procedure in which

you are removing fetal parts with the D&X procedure that you described on direct examination, that of those three, the safest procedure is suction curettage?
A. Yes.
Q. Is it true that about sixty percent of the abortions that you perform are performed in the first trimester, based on your medical practice?
A. My overall practice, including clinic, that's about right.
Q. The remaining forty percent of the abortions that you perform are performed in the second trimester, correct?
A. Yes.
Q. Doctor, you don't perform any induction procedures, do you?
A. Not for termination of pregnancy.
Q. And, doctor, for termination of pregnancy procedures from thirty-six weeks to forty-two weeks, you utilize the injection method, correct?
A. I'm sorry. Say that again.
Q. For termination of pregnancy procedures that you perform between thirty-six weeks and forty-two weeks for fetal anomalies or --
A. I don't perform procedures. I don't do terminations of pregnancy at that stage.
Q. You don't perform any termination of pregnancies beyond

twenty-four weeks?
A. Not for purposes of terminating fetal life, no.
Q. Do you perform terminations of pregnancies beyond twenty-four weeks for any purpose?
A. To the extent that a delivery is a termination of pregnancy, yes.
Q. You have never done any termination of pregnancy to result in a dead fetus, intentionally result in a dead fetus, after twenty-four weeks?
A. No.
Q. Are you familiar with the procedures utilized by physicians in the State of Florida to terminate pregnancies between the thirty-six week and forty-two week mark for purposes of fetal anomalies or the health or life of the mother?
A. Am I specifically, in general?
Q. Do you have any personal knowledge about that?
A. No, I don't.
Q. Doctor, besides your experience with D&X procedures that you have described in this courtroom today, are you aware of any other physicians in the State of Florida who perform D&X procedures?
A. Not personally, no.
Q. Doctor, do you believe that the one hundred fifty to two hundred intention D&X procedures that you have performed

in the State of Florida over the last three years would be a procedure that is banned by the Florida Statute banning partial birth abortions?

A. Yes.

Q. Did you begin doing intentional D&X procedures in the State of Florida back in 1995?

A. Approximately.

Q. And is it your testimony that in 1995 you intentionally performed fifty D&X procedures that you believe would be banned by the Florida Statute banning partial birth abortions?

A. No. I think we are confusing a couple of numbers.

I estimated that I have done one hundred fifty or two hundred D&X procedures, but some of those were not intentional.

Q. Without putting a number on it then, doctor, is it your testimony in 1995 you intentionally performed D&X procedures which would be banned by the enforcement of Florida Statute?

A. Yes.

Q. Well, is it your testimony that in 1996 you intentionally performed D&X procedures in the State of Florida that would be banned by Florida's act?

A. Yes.

Q. Is it your testimony that in 1997 you intentionally performed D&X procedures in the State of Florida that would

be banned by this act?
A. Yes.
Q. And in 1998 is it your testimony that you have intentionally performed D&X procedures which would be banned by this act?
A. Yes.
Q. When you gave your deposition, you believed the hysterotomy procedure would be banned by the act, correct?
A. Yes.
Q. And that was even though you do not consider a hysterotomy to be a vaginal delivery?
A. Yes.
Q. Doctor, can you point me to any language in the statute which says you would be criminally prosecuted for doing an abdominal delivery?
A. No, I can't, but I am concerned about how it might be interpreted by malicious individuals.

I don't think it would float, but I am concerned I could be assaulted on that basis.
Q. Doctor, do you believe delivering a baby at term with the intent of having a live, born fetus is a procedure that would be banned by the act?
A. No.
Q. Doctor, do you remember giving your deposition in this case on August 5th?

A. Yes, I do.
Q. Let me refer --
MS. BURGENER: This is, for counsel, at page 80, line 10.
BY MS. BURGENER:
Q. Do you recall being asked the following series of questions and you giving the following answers:
"Question: Are there any other procedures besides the hysterotomy, the D&E of fetal parts, the intact D&E or D&X and the D&A suction curettage procedure that you think are banned by this act?
"Answer: Yes.
"Question: What other procedures?
"Answer: Term vaginal delivery.
"Question: What do you mean by term vaginal delivery?
"Answer: Delivering a baby at term with the intent of having a live born fetus."
Do you recall giving that series of answers?
MS. ANDERSON: Your Honor, I would ask counsel continue reading.
THE COURT: I'm sorry. I can't hear you.
MS. ANDERSON: I would ask counsel continue reading so it's not taken out of context.
BY MS. BURGENER:

Q. "Question: And you think that is banned by the act?

"Answer: It can create a conflict with the act, yes.

"Question: How so?

"Answer: On occasion fetuses get stuck inadvertently. With breech delivery, in particular, there is something called an after-coming head, which is, basically, a head that is delivered last, and, in particular, premature labors which are inadvertently presented as breech deliveries, the head may become stuck and if the physician may inadvertently or unintentionally kill the fetus in the process of trying to deliver a live born. It has happened".

"Question: In a term vaginal delivery procedure, the intent of the physician is to try to bring about a live birth. Is that right?

"Answer: Yes."

Is it your testimony today that a live, that a term vaginal delivery of a live fetus is banned by this act?

A. If it comes out live, no.

Q. Pardon me?

A. If it comes out live, no. I can't guaranty that. That's where I have the problem.

Q. With regard to the termination of pregnancy procedures

you perform at the Presidential Women's Center, is it true about seventy-five percent of those terminations occur in the first trimester at the Presidential Women's Center?
A. Roughly.
Q. The remaining twenty-five percent at the Presidential Women's Second would be second trimester abortions?
A. Yes.
Q. At the Presidential Women's Center, for those seventy-five percent of termination of pregnancy procedures, the procedure utilized is suction curettage, correct?
A. Yes.
Q. With the second trimester terminations of pregnancy procedures which account for twenty-five percent of the clinic's practice, those are performed using D&E, correct?
A. After fourteen and a half weeks, yes.
Q. Is it fair to say with respect to the second trimester abortions at the Presidential Women's Center using the D&E process, approximately ninety-seven percent of those procedures involve the removal of fetal parts versus intact fetuses?
A. Yes.
Q. Likewise, the majority of D&Es performed between twelve and fourteen and a half weeks would also involve the removal of fetal parts versus an intact fetus, correct?
Q. If the D&X procedure proceeds as planned, the fetus is

removed intact followed by the suction of the skull contents, and there would be no suction to remove fetal parts, correct?

A. Yes.

Q. Doctor, do you believe that the full term vaginal delivery of a stillborn fetus could be prosecuted as a partial birth abortion?

A. If the fetus were alive at the onset of delivery, yes.

Q. When a physician sets about to deliver a baby and intends to bring about a live delivery versus extracting a dead fetus, do you think that that procedure would fall within the definition of an abortion or termination of pregnancy in the State of Florida?

A. I don't think so, no.

Q. Doctor, in the intentional D&X procedures that you have indicated that you have performed in the State of Florida over the last three years, did you at the commencement of those intentional D&X procedures sever the umbilical cord and wait a certain number of minutes for the fetus to suffer its demise in utero before you commenced the procedure?

A. Whenever possible, I will sever the cord early in the procedure, yes.

Q. Is it your testimony that during the last three years in the State of Florida there have been occasions when you did not sever the umbilical cord of the fetus and wait for

it to suffer its demise in utero before doing the D&X procedure?
A. Yes.
Q. And it is in those scenarios where you believe you performed a procedure intentionally that would be banned by the enforcement of Florida's statute?
A. Severing the cord doesn't cause instantaneous death.
I sever the cord whenever possible, but I am not monitoring the fetus. Therefore, I really don't know how often it dies before the delivery is accomplished and how often it doesn't.
Q. Why would you sever the umbilical cord of the fetus before intentionally beginning the D&X procedure?
A. Primarily, because it tends to be the first structure grasped. Because it's so prevalent in the uterine cavity, it gets in the way.
Secondary reason, it gives me a certain satisfaction to feel there is additional anesthesia provided to the fetus in the off chance it needs it.
Q. Doctor, do you believe the intact D&X procedures that you claim to have done over the last three years in the State of Florida would be considered a partial birth abortion under Florida Statute?
A. Yes.
Q. Doctor, did you give any statement to the Florida

Senate Health Care Services Committee about this act before it was enacted?

A. I spoke to the committee.

Q. Do you recall what you said to the Senate Health Care Committee about this proposed legislation?

A. In general. Not in specifics.

Q. Let me see if I can refresh your recollection, and since your eyes are bothering you today, I will just read it.

Do you recall stating to the Senate Health Care Services Committee on April 14th, 1997, "What I do on the occasions when I do intact D&E -- and it's not a partial birth abortion -- is to sever the umbilical cord as the first step in delivering the fetus, and I count eight minutes.

"After eight minutes, the fetus is dead. Hypoxia, the lack of oxygen for eight minutes in a fetus, is lethal. In four minutes, there is no cerebral function.

"Now, I have my philosophies about what a fetus is and what it can and can't feel, and, intellectually, I don't think they feel very much, but I am a human being and I have my emotional side, so just in case I am wrong, I can do this."

Do you recall making that statement to the Senate

Health Care Committee?
A. I don't recall the specifics, but I probably did.
Q. Did you at any time before indicate to the Senate Health Care Committee that you were performing procedures in the State of Florida that you believed were partial birth abortions in the sense that you were actually, intentionally performing intact D&X procedures?
A. I don't believe so.
Q. Dr. Benjamin, do you recall making the following statement to the Senate Health Care Committee: "The same thing --
MS. ANDERSON: Your Honor, could I ask what counsel is quoting from?
MS. BURGENER: The transcript of the Senate Health Care Committee, April 14th, 1997.
Ms. ANDERSON: Is that a sworn --
MS. BURGENER: We had it transcribed by a court reporter, yes.
MS. ANDERSON: Was the witness sworn at the time he was testifying?
BY MS. BURGENER:
Q. Do you recall whether you were sworn at the time, Dr. Benjamin?
A. I don't believe I was.
MS. ANDERSON: I assume the transcript would

indicate if he was sworn at the time.

MS. BURGENER: I don't have the full transcript. I have the excerpt of his --

MS. ANDERSON: You don't know if it was sworn testimony?

MS. BURGENER: I --

THE COURT: Excuse me. If you ladies want to confer, you may.

Is there any objection on the floor?

MS. ANDERSON: Yes. I am objecting to her using this hearsay document until I find out --

THE COURT: Overruled.

If the witness acknowledges that he made a statement, whether it is sworn or not, would be a fact you would wanted to elicit.

MS. BURGENER: I am asking to refresh his recollection, because he was not clear on specifics.

THE COURT: Refreshing recollection involves showing him the document.

MS. BURGENER: He has a problem with his eyes.

THE COURT: You may proceed.

MS. BURGENER: I would have tried it.

During our conversation, he was putting the drops in his eyes.

THE, COURT: You may continue as you have.

MS. ANDERSON: Could I ask counsel provide a copy so we can check her reading of the document?

MS. BURGENER: Okay. Sure. Page 10, line 7.

BY MS. BURGENER:

Q. Let's start page 10, line 2.

Do you recall, Dr. Benjamin, Senator Jones stating to you, "As I understand the bill, the D&E procedure is still permitted. The D&X procedure is the one."

Then you responding, Dr. Benjamin is up: "Yes."

"Which is what makes hit ludicrous, Senator. The same thing, a D&E procedure, involves dismembering the fetus with forceps. Is this nicer than an intact D&E?

"By the way, I sever the cord in those, too."

Do you recall having that conversation with the Senator?

A. I can't say I can recall specifically, but it certainly sounds like me.

Q. Doctor, do you recall making a statement to the Senators on April 14th, 1997 in which you said, "I know that there are certain situations where the intact D&E is delivering the fetus intact, as opposed to dismembering it, which is what the so-called partial birth abortion is. I think this is peculiar to a

woman who has the need to bond with their loss, and I know it's a safer procedure than dismembering a fetus, which is infinitely more traumatic to the uterus and the cervix."

Do you recall making that statement to the Senators?

A. Again, I don't doubt I said it, but I don't specifically recall it.

Q. Dr. Benjamin, when you presented your views to the Senate Health Care Committee on April 14th, 1997, was it your understanding it was the intact D&E or intact D&X procedure which was the proposed subject of the partial birth abortion statute?

A. At that time I probably did, but that was my first contact with the proposed legislation.

I have had quite a time to think about it and view the wording of the statute since then. My opinion of that is changed.

Q. At no time before the Senate did you ever indicate a hysterotomy or hysterectomy or full term vaginal delivery or suction curettage or D&E involving dismembered fetal parts would be covered by a ban on partial birth abortions?

A. I don't think that subject was raised.

Q. Doctor, could you equate a suction curettage procedure to be the same thing as an intact --

A. No.
Q. Doctor do you agree a physician could commence a termination of pregnancy procedure with no intent of removing an intact fetus and something could happen where it results in an intact fetus being removed by accident?
A. It's common.
Q. When you performed the intentional D&X procedure a week before you gave your August 5th, 1998 deposition in this case, did you sever the umbilical cord and wait for the fetus to suffer its demise in utero before you did the procedure?
A. I can't recall.
Q. Doctor, do you have the equipment or instrumentation available in both your office and the Presidential Women's Center to do traction of the umbilical cord to ensure the demise before you do a D&X procedure?
A. Yes.
Q. Dr. Benjamin, are you okay?
A. Yes.
Q. Dr. Benjamin, can you tell me what the survival rates are for fetuses that are delivered at twenty to twenty-two weeks gestational age?
A. I would guess it is somewhere less than five percent. I really don't intimately study that area.
Q. Is it your testimony you don't have any personal

knowledge of what the survival rate of fetuses are at various gestational ages?
A. I have seen something.
Q. Is your answer the survival rate for the fetuses --
A. It's based on the most recent statistics I have seen, which are probably several years old.
Q. To your knowledge, you think the survival rate for the twenty to twenty-two week LMP fetus would be five percent?
A. Less than five percent.
Q. What about a twenty-two to twenty-four week LMP fetus? What would be the survival rate?
A. Somewhere in the range of five percent.
Q. Do you know what the survival rate would be for a fetus twenty-five to thirty weeks LMP?
A. Probably getting up into the fifty to seventy percent range. It increases dramatically as you get closer to twenty-eight weeks.
Q. What would you think the survival rate, or do you know what the survival rate would be for a fetus twenty-five to twenty-seven weeks LMP?
A. Probably fifty to sixty percent.
Q. In the vast majority of the suction curettage procedures, would fetal demise occur at the instant that the fetus enters the tip of the cannula within the uterus?
A. I don't think there is any basis for knowing with any

certainty. It's all speculative, since no one can observe or at least has observed it.

Q. Doctor, it's fair to say, isn't it, that the cannula tip is actually activated by the high speed suction apparatus?

A. High pressure suction, yes.

Q. It's a high pressure suction, like you are going to vacuum, actually, correct? It's a vacuuming suctioning instrument?

A. Negative pressure is attached.

Q. Is it similar -- you are actually drawing it in like a vacuum would?

A. Yes, aha.

Q. Doctor, would you agree the narrow diameter of the cannula would destroy the fetus as soon as it enters the tip of the cannula?

A. Not at all stages, no.

Q. In the vast majority of suction curettage procedures, isn't it fair to say the drawing of the fetus --

A. No.

Q. Let me finish my question.

-- the drawing of the fetus into the narrow tip of the cannula is going to result in its demise?

A. No.

Q. Doctor, do you believe that the intense suction of the

vacuum apparatus, combined with the narrow cannula, would cause fetal demise within the uterus?

A. Sometimes. Not by that mechanism, though.

It would be more blunt trauma by the tip of the instrument than the vacuum.

Q. You believe a fetus can sustain demise in utero because of the blunt force of the cannula?

A. I am sure it occurs that way from time to time.

Q. Now, doctor what is the range of minutes that it takes for a fetus to suffer its demise in the uterus after the severance of the umbilical cord?

A. Clinical death would be, roughly, eight minutes.

Q. Is it fair to say that the D&X procedure lasts approximately thirty minutes?

A. That would be on the long side.

Q. What is the range of time that it takes you to perform an intentional intact D&X procedure?

A. Average would be about ten minutes.

Q. Would that be ten minutes after waiting the eight minutes for the fetal demise?

A. No. I would estimate ten minutes from the time I begin surgery. The initial step would be inserting the speculum.

I would estimate ten minutes from that time. Thirty minutes is not realistic.

Q. It's your testimony, from the moment you insert the

tenaculum, before you cut the cord, to the time you complete the intact D&X procedure, it takes ten minutes?

A. Yes.

Q. In the intentional intact D&X procedures that you say you have performed in the State of Florida over the last three years, did the fetus suffer its demise before you aspirated the contents of the skull?

A. I can't say with certainty. I expect that that's frequently the case. That's after I partially vaginally delivered it.

Q. Do you have any personal knowledge or statistics as to the percentage of times in which the fetus suffered its demise in utero during the D&X procedures you performed?

A. No.

MS. BURGENER: Nothing further.

REDIRECT EXAMINATION

BY MS. ANDERSON:

Q. Dr. Benjamin, I have a few more questions: Do you remember whether or not you were sworn when you testified or when you gave the statement in front of the Senate Health Care Committee on April 14th?

A. I feel certain I wasn't.

Q. Do you remember this particular exchange taking place --

MS. ANDERSON: I am on page 2.

MS. BURGENER: Wait a minute.

BY MS. ANDERSON:

Q. "THE CHAIRMAN: Thank you, doctor.

Next we have Michael Benjamin. It's Dr. Benjamin, correct?

"DR. BENJAMIN: Yes, madam chairman, and members of the committee."

Does that sound familiar?

A. Not really.

Q. And at the time you testified and gave your oral statement in front of the Senate Health Care Committee, had you read the version of the bill that was in front of the Legislature?

A. I read a version of the bill. I am not sure what the stage of its development was at that time.

Q. When did you read a version of the bill?

A. The morning of my testimony.

Q. Is that while you were waiting to testify?

A. It was in my hotel prior to going over to the Senate.

Q. Was that the first time you had read the language of the bill?

A. Yes.

Q. At that point, at the time you gave a statement in front of the committee, had you read the bill on more than one occasion?

MS. BURGENER: Again, Your Honor, I would object to the leading nature of the question.

MS. ANDERSON: I will retract the question, Your Honor.

BY MS. ANDERSON:

Q. Dr, benjamin have you read the final enacted version of the partial birth abortion ban since the time you testified?

A. Yes.

Q. Have you read it more than once since you testified or gave a statement in front of the Health Care Committee?

A. Yes.

Q. And have you thought about what effect, since the time that the Legislature as a whole enacted the partial birth abortion ban, have you thought about what effect that ban would have on your practice?

A. Yes, I have.

Q. Dr. Benjamin, I want to refer to another portion of the transcript and ask you do you remember this exchange taking place --

MS. BURGENER: Page?

MS. ANDERSON: Page 12, line 5.

BY MS. ANDERSON:

Q. "SENATOR JONES: I just wanted to ask one question because the bill deals with D&X and not D&E. Why the emphasis on D&E?

"**DR. BENJAMIN:** I'm sorry. I don't understand.

"**SENATOR JONES:** You spoke at length about a procedure that is not being discussed here today.

"**DR. BENJAMIN:** I'm sorry that I didn't make myself clear. You were discussing that procedure today.

"A D&X or partial birth abortion is a variation of D&E. D&E means dilatation and extraction of the fetus. The variance, which is D&X or intact dilatation and extraction, involves extracting a fetus in one piece.

"In some fashion the fetus is going to be lost during the procedure."

Do you remember that exchange taking place?

A. Sounds familiar.

Q. "Dr. Benjamin, when you perform what you consider to be an intact D&E procedure" --

MS. ANDERSON: I have no further -- I do have a few other questions -- with reference to the suction --

MS. BURGENER: Counsel, where she left off on the last quote, she took it out of context. Can we have her go back and finish reading that portion she just read or do you want me to address it on recross?

MS. ANDERSON: I can read it.

BY MS. ANDERSON:

Q. "You stated the variance which is D&X or intact dilatation and extraction involves extracting the fetus in one piece. In some fashion, the fetus is going to be lost during the procedure.

"I do it by severing the umbilical cord."

MS. BURGENER: The last two lines, three lines on top.

BY MS. ANDERSON:

Q. "I think those who don't probably in their own conscience feels the fetus feels no pain. I am not sure, so I sever the cord. It is the same procedure, a variation on the theme.

"If you were to pass this law tomorrow, I could do everything I do right now, everything I see on the chart, as long as if the fetus were stillborn, as long as the act of draining the brain was done on a dead fetus. I sever the cord. This is something taught to me in London twenty years ago."

Dr. Benjamin, in reference to the ways in which you do what you consider to be the intact D&E procedure, do you currently wait until you are sure fetal demise has occurred from cutting the cord?

A. I am not monitoring the fetus, so I am making assumptions.

I know it takes me 10 minutes until I have

extracted the fetus. I am severing the cord thirty seconds into the procedure, and I am assuming at the point, where I evacuate the brain, the fetus is probably dead, or nearly so, but I am not monitoring and I can't monitor and I can't attest to that, nor would I want to be required to alter my procedure to ensure that.

Q. Every time --

A. I hope it's the case, is what the answer is.

Q. Every time you perform an intact D&E, do you manage to sever the cord?

A. At some point in the procedure.

Q. Do you always manage to sever the cord at the outset of the procedure?

A. No.

Q. Do you sometimes sever the cord later in the procedure?

MS. BURGENER: Your Honor, I object to leading.

THE COURT: Sustained.

MS. ANDERSON: Thank you, Your Honor.

BY MS. ANDERSON:

Q. Dr. Benjamin, would you agree -- well, what are the risks associated with doing, what are the most common risks associated with doing a suction curettage procedure?

A. Bleeding and infection.

Q. How common are the risks of bleeding with a suction curettage procedure?

A. General statistics are less than two percent.
Q. You mentioned in cross examination other risks. You acknowledged other risks associated with the suction curettage procedure.
How common are those risks?
A. They are rare.
Q. And you mentioned in cross examination that suction curettage is safer than the D&E procedure.
Is suction curettage -- is the D&E procedure used to terminate abortions during the first trimester of pregnancy?
A. I'm sorry. D&E?
Q. D&E.
A. Generally, no.
Q. Generally, what is the procedure used to terminate?
A. What is referred to as aspiration or suction curettage.
Q. Generally, is it safer to terminate a pregnancy during the first or second trimester?
MS. BURGENER: Your Honor, objection. Cumulative of direct examination.
THE COURT: Sustained.
MS. ANDERSON: Okay. Just a moment.
Thank you, Dr. Benjamin. No further questions.
THE COURT: Step down. You are excused.
THE WITNESS: Thank you.

[The witness was excused].

MS. ANDERSON: Sorry, Your Honor. Plaintiffs have no further witnesses. We would like to submit the declaration of Phillip Stublefield into evidence.

MS. BURGENER: I move to strike the declaration of Phillip Stublefield. None of the plaintiffs' witnesses testified about Dr. Stubblefield's affidavit in any way shape or norm. Nobody indicated they relied upon it.

He is not here, subject to cross examination. He was not produced for deposition, and I move the deposition be stricken in its entirety.

THE COURT: Response?

MS. ANDERSON: Your Honor, it's a sworn statement submitted in support of the motion.

THE COURT: But this is an evidentiary hearing and, obviously, we have rules of evidence which relate to admissible evidence. It would mean that it would not be appropriate to consider it.

MS. ANDERSON: Okay.

Thank you, Your Honor.

THE COURT: Are you resting your case?

MS. ANDERSON: Yes. Plaintiff rests, subject to rebuttal testimony, Your Honor.

MS. BURGENER: Since plaintiffs rest, Your Honor, defense moves for entry of an Order denying the plaintiffs'

motion for preliminary junction based upon the plaintiffs' failure to meet its prima facie case and to meet its burden of proof and persuasion under the law regarding the relief that is being sought in a sense of a motion for preliminary injunction.

We rely upon our memo opposing their motion for preliminary injunction to set forth the basis for that, and in furtherance of that, Your Honor, based upon the testimony that has been presented in this Court over the last day and a half regarding the medical evidence and the testimony from the plaintiffs' own experts concerning what procedures are not banned by this statute.

We believe that the plaintiffs have failed to meet their burden of proof and that a preliminary injunction should not be entered at this point in time.

They failed to show any undue burden on the right of a woman to choose to terminate her pregnancy. There are safe alternative procedures available.

The evidence has brought forward the particular procedure intended to be banned under this statute is something that is very rarely, if ever, used and there has only been one witness who talks about doing the procedure. He even admits he severs the umbilical cord to result in a dead fetus, and we have his statement, and he has not refuted that, that he indicated in April of 1997 that he

took steps to sever the umbilical cord to cause the demise, and he indicated in April of 1997 that if the Senate were to pass the law tomorrow, which would have been April 15th, 1997, Dr. Benjamin indicated he could do everything that he does right now.

What he does is he goes ahead and he severs the umbilical cord, and that's how he gets the dead fetus.

Under the statute, vaginally partially delivering a living fetus is what would be banned by this particular law. None of the plaintiffs have come forward to indicate that they performed the D&X procedure, other than Dr. Benjamin, and Dr. Benjamin's testimony, based upon the impeachment and cross examination, is insufficient to sustain the plaintiffs' heavy burden of establishing that this law is facially unconstitutional.

Your Honor, I would also like to rely upon the case law that we have cited in opposition to their memo and reserve further opportunity, should the event of further closing arguments be necessary.

We would ask the Court to deny the plaintiffs' motion for preliminary injunction at this juncture.

THE COURT: Response?

MS. ANDERSON: Thank you.

THE COURT: Briefly.

MS. ANDERSON: We would like to rely on our

motion in support of the, or memorandum in support of the motion for preliminary injunction, and also our response to the defendants' opposition.

Moreover, we would like to point out there has not been testimony that establishes only one procedure is banned by this act. All of plaintiffs' witnesses have provided expert testimony. All of them have provided their interpretations of what this act would ban. All of them have provided the basis for those interpretations.

The variety of interpretations supports plaintiffs' position, this act is unconstitutionally vague and doesn't put doctors on sufficient notice as to exactly what procedures it does prohibit.

Moreover, the language of the act itself shows this act is unconstitutional. The act fails to contain a health exception, as required by the Supreme Court, in the *Casey* decision.

The act is not limited to post-viability abortions. Therefore, to the extent it restricts performance of any abortion procedures, it is not valid.

There is no basis for -- this act does not satisfy either an interest in maternal health or an interest in potential life.

There has been no evidence to support such interests being promoted. In fact, the evidence has known

they are not promoted. Maternal health is not promoted by requiring doctors perform one procedure over another to try to ensure fetal demise.

The evidence shows doctors cannot control how they can best and most safely and sufficiently perform the procedure. They need flexibility to deal with a variety of situations that present themselves.

At the outset of the procedure they need to be concerned about exactly what will present itself because if they do it in one way, it may subject them to criminal prosecution. Yet, if done in another way, it would not -- that would not let them feel comfortable providing abortion procedures to the extent they discontinue providing any procedure in an attempt to avoid prosecution. Obviously, it would be an undue burden on women seeking abortions.

We have presented testimony the most common and safest abortion techniques used, namely suction curettage and D&E, could be reasonably interpreted as falling within the language of the act.

Moreover, when those procedures are performed, a physician may unexpectedly encounter situations when the physician takes actions intentionally to continue the process and terminate the pregnancy and the physician performing those particular situations, which may not have been foreseen, they may end up performing situations in

contravention of the act.

I think in light of controlling Supreme Court precedents, as well as the evidence today, the defendants' motion should most certainly be denied. We have met the burden of showing all four factors, Judge.

THE COURT: The defendants' motion is denied. You may now continue with the defense case.

MS. BURGENER: Your Honor, are we going to have a morning break at all?

THE COURT: All right. We will break at this time.

How long do you expect your case in chief will take, counsel?

MS. BURGENER: Well, Your Honor, I am going to try to expedite the direct examination on both of our witnesses. We have two witnesses for the defense and I will try to move as swiftly as I can. I expect, probably, like forty minutes on direct for each.

MS. ANDERSON: Your Honor, we anticipate the cross examination of Dr. Di Giacomo will be maybe fifteen minutes, approximately. However, we anticipate the cross examination of Dr. Aultman will be at least an hour.

THE COURT: We may not finish today, counsel. We'll have to see how we do. I doubt that we will finish today, so we'll have to think about making alternative

arrangements.

MS. BURGENER: Your Honor, what I'm going to do is Dr. Aultman is not from South Florida. She is from the Jacksonville area. I will put her on first. In case we need to bring somebody back, Dr. Di Giacomo is from Hollywood.

MS. ANDERSON: If I could request I be allowed sufficient time to cross examine Dr. Aultman, so, if necessary, if we are not finished with our cross examination, she would have to come back, based on their estimate.

THE COURT: We'll have enough time to finish at least one of the witnesses.

MS. BURGENER: Is our break just, like, five minutes?

THE COURT: Let's break for ten minutes.

[There was a short recess].

THE COURT: Be seated.

Please call your witness.

MS. BURGENER: To move things along, what the defense has done, with the stipulation of the plaintiff, we are going to withdraw Dr. Kathi Aultman as an expert and call as our only witness and expert in this case, Dr. Wayne Di Giacomo. That way we will finish today, hopefully.

THE COURT: I don't want to rush you, counsel.

If there are witnesses you want to present, I don't want you to withdraw because of time.

MS. BURGENER: I understand that.

We are trying to move forward and expedite things because it's an important issue, and it's an important statute. You know, we want to be able to conclude and get it to the Court for consideration.

THE COURT: All right.

As long as you understand, and I would make arrangements for you to return, perhaps, next week or very soon. We can still talk about this. I am not going to limit you to one witness, if you decide at some point in time during the lunchbreak that you want to present additional --

MS. BURGENER: Maybe I should clarify. I thought the way the hearing was noticed today, we are concluding at 1:00.

Is that not correct?

THE COURT: I can give you a little more time. We could probably remain in session until I do have a 2:00, but I could fudge a bit and move it to, maybe, 2:15 or 2:20. We could take a short lunchbreak, maybe forty-five minutes.

MS. BURGENER: Let me confer with my co-counsel and the expert witness for a second, Your Honor.

THE COURT: All right.

Counsel, if it helps, we could remain in session until 1:00, break for thirty to forty-five minutes and remain in session until about 2:20.

MS. BURGENER: Your Honor, we would just like to proceed with Dr. Di Giacomo. We believe he will be able to give the opinion testimony we need to present on record and avoid any cumulative testimony.

I would call Dr. Wayne Di Giacomo.

THE COURT: Please come forward.

DR. WAYNE P. DI GIACOMO, DEFENDANTS' WITNESS, SWORN.

DIRECT EXAMINATION

BY MS. BURGENER:

Q. Please state your name for the record, spelling your last name.

A. Dr. Wayne Di Giacomo, D, as in Dante, i-G-i-a-c-o-m-o.

Q. Dr. Di Giacomo, what is your occupation?

A. Obstetrician and gynecologist.

Q. How long have you been licensed to practice in the State of Florida?

A. Over twenty years.

Q. Are you board certified?

A. Yes.

Q. Where is your practice currently?

A. Hollywood, Florida.

Q. Can you give the Court a brief summary of your educational and -- I'm sorry. Could you tilt the microphone a little toward you?
A. I did my undergraduate studies at the University of Miami. I did my medical school studies at the University of Rome in Italy. Obstetric and gynecological specialization at Jackson Memorial Hospital, University of Miami.
Q. Can you give the Court a summary of your medical work experience?
A. I cover the entire field of women's reproductive health, obstetrics and gynecology, the other incidental things that include this field.
Q. Can you indicate for the Court what number of years you have been in private practice?
A. Over twenty.
Q. Let me refer you to what has been marked as Defendants' Exhibit 2. I would like to have you identify that document.
[Defense Exhibit 2 marked for identification].
A. That's my resumé.
Q. Is that a current resumé?
A. Yes, ma'am.
Q. Does that resumé accurately reflect your experience --
A. Yes.
Q. -- in the field?
MS. BURGENER: I would like to move this

curriculum vitae marked as Defendants' Exhibit 2 into evidence.

MS. ANDERSON: No objection, Your Honor.

THE COURT: Received as marked.

[Defense Exhibit 2 received in evidence].

BY MS. BURGENER:

Q. Dr. Di Giacomo, are you a member of my associations?

A. Well, I have several leadership positions which include the Board of Directors for Healthy Start.

I am on the advisory board for the Miami Dade School of Midwifery. I was on the Advisory Committee for the Chief of Health Services Tallahassee, Florida, the medical director of Better Babies of Broward.

Q. Dr. Di Giacomo. Let me ask you to slow down a little bit. I understand your referring to your CV. The court reporter, however, is human and needs to keep up.

A. I apologize.

Q. Doctor, are you board certified?

A. Yes.

Q. What are you board certified in?

A. Obstetrics and gynecology.

Q. Are you a member of the American College of Obstetrics and Gynecology?

A. Yes, I am a life fellow.

Q. Is that known ACOG?

A. Yes.
Q. Do you do any consulting work at all for the State of Florida?
A. Yes.
Q. Would you, please, describe for the Court the type OF consulting work you do for the State of Florida?
A. I am on -- I have been a credential consultant for the State of Florida for review for the ACOG, A, B, C for health care reform for the Department of Regulation physicians in discipline.
Q. When you say "physicians in discipline," what are you referring to?
A. Licensing.
Q. Is that under the Florida Board of Medicines?
A. I believe so.
Q. Do you review any cases for medical malpractice purposes?
A. Yes.
Q. Can you please describe to the Court the types of cases that you review?
A. I review a vast majority of cases from obstetrics to gynecology to termination, just a vast number.
Q. How long have you been performing consulting services for the State of Florida?
A. I have, probably, about three years. I would have to

refresh the original contract date. Maybe four years.
Q. Are you under contract with the state to perform expert review of medical files for professionalism standards?
A. Yes.
Q. Doctor, have you performed termination of pregnancy procedures?
A. Yes.
Q. What types of termination of pregnancy procedures have you performed?
A. I have performed suction curettage, suction evacuation, instillation procedures.
Q. During what phase of your practice or training did you do termination of pregnancies?
A. I continue to do terminations of pregnancies, but there is one requirement, and that's the fetus has to be dead.
Q. When was the last time you did a termination of pregnancy?
A. On a live fetus -- termination of pregnancy? Yesterday at 6:00.
Q. You were in court yesterday.
A. After court.
Q. When was the last time you performed the live birth of a child?
A. Last night at 11:30.
Q. Do you affiliate with any other providers in the State

of Florida with regard to termination of pregnancy procedures?

A. Would you describe affiliation? I am not sure what you mean by that.

Q. Do you have any type of referral practice or coverage arrangements with any other providers that happen to provide termination of pregnancy procedures?

A. I provide full services obstetrics and gynecology.

When an individual presents with that option, it is her choice. When she does choose, I give her the option, abortion, adoption, maintaining the pregnancy.

I counsel her on the risk versus benefits of each of those procedures, which are laid out in policy formats.

Q. Do you actually do the terminations of pregnancy procedures?

A. For stillborns. I will not for live fetuses.

Q. When was the last time the patient presented to you with a scenario that might trigger her option to choose to terminate the pregnancy?

A. Last Wednesday.

Q. And what were the particular circumstances involved in that scenario?

A. This was a young lady who was -- without mentioning her name -- she's a thirty year old white female. First pregnancy.

She has a pregnancy from an individual she doesn't know that much about. Additionally, she have been on several psychotropic drugs and medications for psychiatric reasons. Some are contraindicated in pregnancy. Some not.

I advised she can continue the pregnancy; I will need to change her drugs to those in a class B status of pregnancy, or if she desires she can be referred to a termination, and there is many termination clinics she can attend.

Q. Do you hold any privileges at any South Florida hospitals?

A. I hold privileges in six hospitals.

Q. What kinds of hospitals?

A. Well, Columbia Northwest Regional, Broward General Medical Center, which is a tertiary facility. Hollywood Medical Center, Memorial Health Care Systems, Columbia Aventura, and Mt. Sinai.

Q. What counties in the State of Florida do those hospital privileges extend to?

A. Broward and Dade.

Q. Is your current practice located in Broward County or Dade County?

A. Broward County.

Q. Are you in sole practice at this time?

A. Yes.

Q. Prior to going into private practice, can you, please, summarize for the Court your prior medical work experience?
A. I was in college, routine college education. I obtained my Bachelor of Science in chemistry, minor in languages.

I went on to medical school as a general practitioner. After medical school, I was achieved and applied to and accepted at the Jackson Memorial Hospital residency program, which included a one-year internship in OB/GYN, two other years, second year being associate chief resident, the final year being chief resident in charge of the department.

Q. Did you also serve as any type of medical executive director for the department of corrections?
A. Yes. Specifically, women's services, the women's health facility, the maximum security prison.
Q. Can you describe for the Court the types of medical practice that you were involved in through that facility?
A. I was mainly a consultant at that facility. I was the director. Mainly it was -- excuse me -- executive administrative position.

I would make the decisions as to where to send the client. We had several in-house physicians and paraprofessionals performing those services. They would consult with me. If I decided these individuals needed to

go outside the prison system for consultation, I would approve that.

Q. In addition to your own clinical experience, have you taken any steps to keep abreast of the developments in the State of Florida with regard to termination of pregnancy procedures?

A. I am constantly on the Internet.

Q. Can you describe for the Court the type of materials that have been available and are available to you that you have reviewed in connection with termination of pregnancies?

A. A multitude of databases. The North Broward Hospital District, the South Broward Hospital, Tallahassee, District 10, ACOG and the AMA and *Medline*.

Q. The American college of OB/GYNs?

A. Yes, sir.

Q. Does ACOG have its own database within the Internet?

A. Yes.

MS. BURGENER: Your Honor, at this time I would like to offer Dr. Di Giacomo as an expert in the field of obstetrics and gynecology, including termination of pregnancy procedures.

THE COURT: Any objection?

MS. ANDERSON: We object -- we have concerns about the level of his expertise as to abortions, but we are willing to ask our questions on cross and let it go to

the weight that Your Honor would place on his testimony.

THE COURT: All right.

The witness' testimony will be received as that of an expert.

You may continue.

BY MS. BURGENER:

Q. Doctor, let me direct your attention to the Florida Statute that is in front of you. I think it's marked as Exhibit 3.

A. Yes, Exhibit 3.

Q. Have you reviewed that legislation?

A. On a multitude of occasions.

Q. Let me direct your attention to page 6 of that particular bill, that law. Chapter 390.0111 would be line 26, subsection 7 on page 6.

A. Yes.

Q. What is your understanding in the State of Florida as to what is considered third trimester under the law?

A. Under the law -- I would have to research the law, but under medical terminology, the third trimester is carried out at the 28th week of pregnancy.

Q. With regard to the statutory definitions, page 6, beginning line 26, what is the definition that is given in the statute concerning third trimester?

A. Well, third trimester means the weeks of pregnancy

after the fourth, after the 24th week of pregnancy.
Q. And, likewise, directing your attention to page 3 of the bill, sub-section 4, under chapter 390.0111, sub-section 4, standard of medical care to be used during viability.
A. Yes.
Q. Are you aware of the standard of medical care that OB/GYNs in South Florida would utilize during the period when a fetus is viable?
A. We are required -- not required -- but it's a commitment just as attorneys are to the Bar, to our board and hospitals.
Q. And when a physician does a termination during the period of viability, what particular interests under this particular statute are they supposed to be considering during that phase?
A. Specifically, the delivery of a live born infant through the vaginal canal.
Q. When there is a termination of pregnancy procedure, as addressed in the particular statute, is there any weight or consideration given to the life and health of the mother at that stage?
A. Yes.
Q. When there is any conflict between the fetus and the mother with respect to health or life, in whose favor does the treatment go?

A. The mother.
Q. When you evaluate, for malpractice purposes, termination of pregnancy procedures, do you take into consideration that standard of care that is required of the OB/GYN?
A. Yes.
Q. Doctor, let me direct your attention page 2 of the statute, line 1, on the termination in the third trimester, sub-part A.
A. Shall I read it.
Q. No, not out loud.
With regard to that particular statute, is there a standard in the State of Florida with regard to under what circumstances a physician should proceed with the termination of pregnancy in the third trimester using due care?
A. Yes.
Q. What particular scenarios should they go forward with a third trimester abortion?
A. Two physicians certify in writing to the fact, to a reasonable degree of medical probability, the termination of pregnancy is necessary to save the life or preserve the health of the pregnant woman, or the physician certifies in writing to the medical necessity or the legitimate emergency medical procedures for termination of pregnancy in the third

trimester, and another physician is not available for consultation. No termination of pregnancy shall be performed at any time except by a physician as defined in Florida Statues.

Q. Thank you, doctor.

Now, with regard to the § (b), viability, and the standard of care that is to be used in viability at which the mother's health and life is considered, is that same consideration to be utilized in the third trimester?

A. No. The mother's health is always of primary concern.

Q. So, when it's the third trimester, if a situation arises where the life or health of the mother is at risk, the termination can be performed at that point?

A. Yes.

Q. Doctor, what is your understanding as to when viability occurs?

A. Viability is a legal definition. I would have to research the statute, but, generally speaking, I believe it's the presence of a cardiac heart rate and EEG studies, electroencephalogram studies.

Q. Based upon your practice, can you tell the Court at what gestational age in terms of weeks, LPN, a fetus would fall within the range of viability?

A. We are becoming very technologically advanced. Some have provided at twenty. From twenty-two to twenty-four

weeks, I believe the statistics are, survival rates.
Q. You were here to hear the testimony of Dr. Benjamin?
A. Yes.
Q. Do you disagree with his testimony that the survival rate is only five percent for the weeks, gestation, twenty-two to twenty-four?
A. Not in the current literature. That's old.
Q. What is the current survival rate recognized in the current literature for gestational ages twenty-two to twenty-four weeks?
A. In addition, with neonatal statistics at various hospitals, in the area between twenty-two and twenty-four weeks. I can't give the exact number, but it's around twenty-four percent.

And increasing thereafter.

Q. Doctor, referring you to the statute on page 3, subsection 5(a), beginning on line 25, what is your understanding of the phrase "knowingly perform" in the sentence, "No physician shall knowingly perform a partial birth abortion"?
A. Of the intent.
Q. Doctor, in reviewing this particular statute, did you look at the definition of partial birth abortion as found on page 6, chapter 390.0111, subsection 5?
A. Yes.

Q. Did you read through that definition and come to any understanding as to what types of procedures, termination of pregnancy procedures in the State of Florida would be banned by that act?
A. A D&X procedure, which is outlined by ACOG policy and protocol, which means termination of pregnancy in which the physician performing the pregnancy partially vaginally delivers a living fetus before causing fetal demise and completing the delivery.
Q. Doctor, let me direct your attention to Defendants' Exhibit 1, which is in evidence. It's the ACOG policy statement.
Can you identify that document for me?
A. This is the ACOG statement of policy issued by the American College of Obstetrics and Gynecology Executive Board.
Q. And does that statement of policy contain a description of what an intact D&X procedure is?
A. Yes, it does.
Q. Doctor, in your review of the medical literature and the Internet databases in the particular subject area of termination of pregnancies, have you come across the term "Intact D&X"?
A. Yes.
Q. Well, is there a description of intact D&X in the

materials that you have reviewed?
A. Yes.
Q. And, in fact, isn't there a description of the intact D&X within ACOG's own statement of policy?
A. Yes.
Q. Doctor, in your review of the literature and the Internet databases concerning terminations of pregnancy, have you come across any description of partial birth abortions?
A. Yes.
Q. And in what types of materials have you found references to partial birth abortions?
A. Multiple. *Medline*, newspapers, American College of OB/GYN, *Journal of Health and Reproductive Law*, numerous.
Q. Do you have any idea how long the phrase "partial birth abortion" has been within this medical database, medical literature field?
A. I would have to research that, but I am sure probably the last several years.
Q. Now, doctor, you were here when the plaintiffs' expert, Dr. deProsse, testified. Is that correct?
A. Yes.
Q. You heard the opinion that Dr. deProsse rendered in this courtroom. Is that correct?
A. Yes.

Q. Doctor, can you tell me whether a first trimester suction curettage procedure would be banned by the enforcement of Florida Statute?
A. No.
Q. Why not, doctor?
A. In one hundred percent of the time, almost, but nothing is one hundred percent, the fetus is usually in demise when suction is performed.

Also, it passes through a cannula which passes into a receptacle apparatus. The destruction of the fetus usually happens upon application of the suction.
Q. Let me refer you to Plaintiffs' Exhibit 2, which should be in front of you, a diagram of the woman's pelvic anatomy.

Do you have that?
A. Yes.
Q. Can you, just holding that up, describe for the Court, just by pointing to it with your finger, how the suction apparatus is lodged and connected to the uterus of the woman?
A. A weighted speculum is placed in the posterior vaginal vault. The anterior as a result is retracted. The anterior surface is grasped. Follow that by aggressive dilatation occurs.

A suction cannula is placed, which forms suction, which is connected directly outside the body to a receiving

canister.
Q. Is the suction apparatus you described in the form of a conduit from the uterus to the awaiting receptacle?
A. Yes.
Q. Can you, please, describe to the Court what the actual suction mechanism is that is enacted to evacuate the intrauterine contents?
A. It's a vacuum apparatus with negative pressure.
Q. Can you describe to the Court what the cannula is?
A. Plastic tubing. Variations in size flare from six millimeters to fourteen or sixteen millimeters.
Q. What is it about the suction curettage procedure that you believe makes it not a partial birth abortion as defined in the act?
A. Ninety-nine percent of the time the fetus is going to fit through that suction tubing, especially if it's twelve weeks using a twelve millimeter catheter.
May I have some water?
Q. Yes, doctor.
Are there a variety of sizes of suction cannulas to be used in the suction curettage process?
A. Yes.
Q. Now, did you also hear Dr. deProsse's testimony regarding a certain scenario of the suction curettage procedure in which he described the effect of an enlarged

after-coming head being entrapped?
A. That usually doesn't happen in the first trimester.
Q. With regard to the scenario that Dr. deProsse described with an entrapped after-coming head, would that type of scenario be something that is an intended consequence for a physician who does a suction curettage procedure?
A. No. That would be a complication of the procedure, not an intent.
Q. If a physician performing a suction curettage procedure unexpectedly encounters an entrapped enlarged head somewhere on the other side of the suction cannula, would that be a scenario that would be banned by the enforcement of Florida Statute?
A. No, that would be a complication, and handled appropriately.
Q. Doctor, is a second trimester D&E procedure in which a large bore cannula is utilized to evacuate the fetal parts and intrauterine contents into a waiting receptacle, is that a procedure banned by the Florida Statute?
A. No.
Q. Why not?
A. Once again, it's a similar reason. It passes to the receptacle from the intrauterine contents. By the time that happens, after you suck out the amniotic fluid and placenta, nine times out of ten the fetus is going to be dead and

delivered as such.
Q. Now, doctor, did you hear the plaintiffs' expert, Dr. deProsse, give testimony in this courtroom yesterday in which he described the scenario where a physician performing a D&E unexpectedly encountered an entrapped after-coming head?
A. Yes.
Q. Would that particular scenario be something that would be banned by the act?
A. No. Again, it's a complication.
Q. Doctor, is a second trimester D&E procedure where the physician is able to successfully disarticulate the fetal limbs and torso in order to remove disjointed fetal parts, is that a procedure that would be banned by the act?
A. No.
Q. Doctor, why wouldn't the extraction of disjoined fetal parts be banned by the law that bans partial birth abortion?
A. Because the actual disarticulation was part of the fetal demise ascribed by Dr. Benjamin.
Q. Is there any language in the definition of partial birth abortion on page 6 of the statute which indicates that a physician would be criminally liable for delivering fetal parts?
A. No.
Q. What is your understanding of the phrase "living

fetus"?
A. "Living fetus" would be a fetus that is viable.
Q. Would a living fetus have a heartbeat?
A. Yes.
Q. Would a living fetus refer to a fetus that has a heartbeat even before viability?
A. That's really subjective. "Living," to me, would mean compatible with life versus living. Yes, it is functioning. It has its own innate control.
Q. Doctor, would an induction procedure be a procedure that would be banned by the enactment of Florida's Statute?
A. No.
Q. Can you explain to the Court why an induction procedure would not be a procedure that would be banned?
A. Firstly, there was no intent. Secondly, an induction procedure, you instill normal saline when the gestation is greater than eighteen weeks.

Also, you can mix normal saline with prostaglandin, which in nine times out of ten, almost one hundred percent of the time the fetus comes out in demised state.
Q. When you performed induction procedures, did you have materials available at that time to cause fetal demise?
A. Yes.
Q. Are there additional procedures that are available

today to do induction procedures?
A. Yes.
Q. Have you reviewed the literature and the computer databases to ascertain the existence of these induction procedures that are available today?
A. Yes.
Q. Is it fair to say that the level of toxicity in fetal demise is quite high in those inductions procedures?
A. You are pickling an infant with normal salines. With digoxin, you are causing immediate cardiac arrest, with digoxins and potassium.
Q. You heard Dr. Pendergraft describe his use of amino injections yes?
Are you familiar with the procedures he described for the second trimester?
A. Yes.
Q. Is it fair to say there is a high level of fetal demise in those procedures using methodologies Dr. Pendergraft referred to?
A. Ninety-three percent die. Seven percent remain viable, according to ACOG's statement, with the ones using the prostaglandin alone. The prostaglandin, in normal situations, is almost one hundred percent.
Q. Did you hear Dr. Pendergraft's testimony about methotrexate up to the first eight weeks LMP?

A. It's an experimental thing, but, yes.
Q. Is such a procedure up to eight weeks with methotrexate a procedure that would be banned by Florida Statute?
A. No.
Q. Why not?
A. Methotrexate would kill the fetus. It's a chemical toxin.
Q. And when you say it's experimental, why do you say that?
A. Methotrexate, it now is a neuro drug. We mainly use the drug to treat trophoblastic disease of pregnancy, which is a form of cancer. If it kills the cancer, it will kill the live fetus.

The experimental studies today, according to the recent literature, show it's used for atropic pregnancy, to save hospital time and improve patient outcome.
Q. Doctor, did you hear Dr. deProsse's testimony in which he described one scenario, using the induction or instillation procedures in which a physician unexpectedly encounters an entrapped after-coming head?
A. Yes.
Q. Would that procedure, that particular scenario as described by Dr. Pendergraft -- by Dr. deProsse -- be a procedure banned by Florida Statute?
A. No, that would be a complication.

Q. Now, doctor, if you used the word "complication," what do you mean by that?
A. An unexpected event of a specific procedure that you would have to deal with.
Q. Is that complication something that would be intended by the physician at the outset of the procedure?
A. No.
Q. Doctor, you said you performed live births, correct?
A. Yes.
Q. When you commence the live birth process, do you intend to bring about a live, fully delivered child?
A. Yes.
Q. Are there some times scenarios in which, unexpectedly, the child comes out still born?
A. In today's technology, probably not. We use internal electronic fetal monitoring.

Also, there several Florida Statues which govern out of hospital births, which require fetal monitoring. If there is a problem, there is an immediate problem, the woman is taken to a tertiary or secondary center where the infant is delivered by cesarean situation.

Q. If the doctor set about to a full term delivery of a live child and something went awry and it was a stillborn child, would that procedure be a procedure banned by Florida's act?

A. No.
Q. Doctor, would a hysterotomy be a procedure banned by Florida's act?
A. No.
Q. Why not?
A. Hysterotomy, there is no passage of the fetus through the vagina.
Q. Would the process of a hysterectomy be something banned by Florida Statute?
A. No.
Q. Why not?
A. You are killing the fetus in utero.
Q. Did you hear Dr. Benjamin's testimony concerning his practice of severing the umbilical cord?
A. Yes.
Q. What is your experience with how long it takes to have fetal demise following the severance of the umbilical cord?
A. Usually four to eight minutes.
Q. Now, doctor, how long does it take to do an intact D&X procedure?
A. Approximately thirty minutes. Intact D&X procedure?
Q. Intact D&X procedure?
A. Is that -- well, first --
Q. As defined by ACOG.
A. As defined by ACOG?

Q. Yes.
A. Several days.
Q. Now, the ACOG procedure talks about the dilatation over a period of several days, correct?
A. Correct.
Q. Assuming that the woman spent the one or two, or maybe three days, to do the dilatation, once she presented for the actual second, third and fourth steps of the procedure as defined in the ACOG statement, how long would it take to do those last three steps?
A. It would take anywhere from fifteen to over an hour, and sometimes it will not work at all, and there are other things you would have to perform.
Q. Doctor, in your experience doing consulting work for the State of Florida and reviewing cases for medical malpractice and rendering your opinions in the obstetric and gynecological, obstetrics and gynecology field that you have, have you ever come across any information that physicians within the State of Florida intentionally perform D&X procedures ascribed by the ACOG statement of policy?
A. D&X procedures are performed in accordance with the ACOG Guidelines as illustrated. I am not sure I understand the question.
Q. My question to you was do you have any information, having worked in the field and having served in your

capacity as a consultant for the State of Florida, have you come across any first-land information that any physician in the State of Florida actually intentionally performs D&X procedures as described in the ACOG bulletin?

A. Dr. Benjamin.

Q. Is that just based upon his testimony here in the courtroom this morning?

A. Yes.

Q. Dr. Di Giacomo, looking at Dr. Benjamin's scenario, if Dr. Benjamin severed the umbilical cord of the fetus which resulted in its fetal demise in utero before doing the D&X procedure, would his subsequent performance of the D&X procedure be something that would be banned by Florida Statute on a dead fetus?

A. No.

Q. Why not?

A. It's a dead fetus.

Q. Doctor, do you have any understanding as to when D&X procedures are performed?

A. D&X procedures are performed in the late second trimester.

Q. Can you give an idea to the Court as to what weeks LMP that would be?

A. Generally, twenty weeks in gestation on.

Q. Anything over twenty weeks?

A. Twenty, twenty-one, yes.
Q. Now, doctor, if a physician finds himself presented with the entrapped after-coming, enlarged head, would the presence of that head lodged in the mother pose a danger to the life of the mother?
A. Yes.
Q. Tell the Court what, if anything, could be done at that point to dislodge the entrapped head from the mother?
A. Depends on the circumstance, but the simple thing is hanging Pitressin would work.

In a live fetus, that also does occur in a term of pregnancy if you deliver a live breech presentation and you get an entrapped head. There are several maneuvers and a multitude of drugs to use, the debilitation of the cervix.
Q. Doctor, would there be alternative procedures available besides the D&X procedure to terminate a pregnancy?
A. Yes.
Q. Can you tell the Court what those alternatives are?
A. Suction curettage, prostaglandin F2 Alpha, E2, and the various prostaglandin families, saline abortions, urea.
Q. The latter ones you described, are those part of the induction procedures?
A. Induction instillation, yes.
Q. Doctor, in the vast majority of the suction curettage procedures, does the force of the suction cannula cause the

demise of the fetus?
A. I would say most likely so, yes.
Q. Can you just describe to the Court what kind of impact or force of the cannula is used at that suction curettage process?
A. Similar statistics, it's like taking a hand and vacuuming it into the hose in a car wash.
Q. Is there any particular reason why a physician would use a certain size suction cannula in the suction curettage procedure in the first trimester and the second trimester?
A. Yes.
Q. What is that?
A. The cannulas are measured in millimeters. Generally, each millimeter is the week's gestation. Ten millimeter cannula is ten weeks' gestation.
Q. Can you describe for the Court what the difference in size is for the fetus at the various gestational ages?
A. I have a slide rule. I would have to look at that. I couldn't tell you.
Q. Do you have it with you?
A. Oh, yes.
Q. What is that device that you have? What is that device that you have, doctor?
A. This is a slide rule. It is that we use in our practice for obstetrics and gynecology.

Q. You have two of them?
A. They are different. They are two different companies. They are plus or minus the same, yes.
Q. Now, doctor, when you say there are two different companies that make those spin dials, are these based upon some type of studies?
A. Yes. They give -- it has one number, but there is a range, like five to ten. For space utilization, they only put one number on it.
Q. Do you utilize that routinely in your practice?
A. Daily.
Q. Please describe then for the Court, what we are doing with weights on that?
A. This particular --
Q. Or size.
A. This particular wheel, each one has a different thing.
This particular wheel describes the weeks gestation, the biparietal diameter, the femoral length, the weight, the weight in pounds and grams, and the length.
Q. When a physician commences a suction curettage procedure, they can approximate the gestational size or weight of the fetus, give or take?
A. Yes.
Q. Now, given that information, when a physician selects the size of cannula, what are they trying to accomplish with

the choice of size?
A. They are trying to accomplish that the size of the cannula is pretty much equal to the size of the fetal contents to be evacuated.
Q. Is that to accommodate a swift and complete successful evacuation from the uterus to the awaiting receptacle?
A. Yes.
Q. Does the same principle apply in the early second trimester D&E procedures where large bore cannulas are utilized?
A. Yes.
Q. Please, briefly indicate for the Court then what that typical size would be for a large bore cannula in that second trimester at weeks gestational age thirteen to sixteen.
A. Thirteen weeks, the weight would be approximately fourteen grams, the biparietal lamina millimeters-wise is twenty-two, and you would use a fourteen to sixteen catheter, which pretty much, after the high powered suction, would suck it into the tube.
Q. Doctor, do you equate the suction of the intrauterine contents through this tubing into a jar as the same thing as a vaginal delivery as referenced in the statute?
A. No.
Q. Why not?

A. Vagina, normal vaginal delivery -- I'm sorry. Can you repeat that?
Q. Do you he equate the suctioning mechanism of the cannula through the tubing of the intrauterine into the conduit into a jar to be the same thing as a vaginal delivery?
A. No.
Q. Why not?
A. It passes through a closed system.
Q. Is that similar to a bypass?
A. Yes.
Q. Doctor, can you tell me what the risks are that are associated with the intact D&X procedure and as identified in the ACOG statement of policy?
I am talking about the risks that you are aware of, based upon the definition of the intact D&X?
A. I am not sure I understand your question.
Q. Please describe for the Court the risks of a woman undergoing an intact D&X procedure, the medical risks.
A. The medical risks are, of medical D&X, are hemorrhage, perforation of the uterus, infection and bleeding.
Q. Is there any danger associated with the use of the insertion of the blunt scissors into the fetus?
A. Yes.
Q. What are the risks that are associated with that?

A. It's a blind procedure done under feel. You can puncture the wrong thing.
Q. What are some of the consequences to the mother's health?
A. Puncturing the wrong thing can mean anything from puncturing bladder, bowel, to the vaginal wall, causing peritonitis, the cervix, the uterus.
Q. Is the D&E procedure involving removal of fetal parts something that is done usually in earlier gestational ages than the intact D&X procedure?
A. Yes.
Q. Is the quality of risks higher for the later termination procedures done at greater gestational ages?
A. Yes.
Q. Doctor, do you find anything confusing about the definition of the partial birth abortion in Florida's Statute?
A. No.
Q. Do you believe that the language of the Florida Statute banning partial birth abortions would prevent physicians in the State of Florida from performing all abortion procedures?
A. No.
Q. Do you recall the testimony from the plaintiffs and their expert concerning the hydroencephalic child, the

fetus?
A. Yes.
Q. Have you ever encountered hydroencephalic fetus?
A. Yes.
Q. Are there any scenarios in which the hydroencephalic fetus can be removed from the mother without crushing the skull?
A. Yes.
Q. What are those procedures?
A. Cesarean section.
Q. Is there any procedure to draw off the excess fluid without removing the other intracranial contents?
A. Yes.

MS. ANDERSON: Objection. Leading, Your Honor.

THE COURT: Overruled.

BY MS. BURGENER:

Q. Doctor, do you have an opinion as to whether or not the enactment of Florida's Statute would cause harm to women in the State of Florida?
A. No.
Q. What is your opinion?
A. That the enactment would cause harm.
Q. My question to you was do you have an opinion whether enactment of this law would cause harm to women?
A. No, it will not cause harm to women.

Q. First I was going to ask you if you had an opinion, and what was it?
A. No. My opinion is it would not cause harm to women.
Q. Why do you believe the enactment would not cause harm to women?
A. For those seeking a termination of pregnancy, there is a multitude of other methods available.
MS. BURGENER: One moment, Your Honor.
BY MS. BURGENER:
Q. Doctor, can you just demonstrate for the Court when you are talking about the size of the fetus in terms of fingers, you know, like in terms of inches, I suppose, how big is that fetus when it's under twelve weeks?
A. The size of the head, under 12 weeks, it's less than twenty-two millimeters.
Q. What does twenty-two millimeters equate to? Are we talking something like the size of a baseball or much smaller?
A. Standard measurements, very small.
Q. What about the thirteen to sixteen week size?
A. Thirteen weeks is twenty-five millimeters, twenty-nine millimeters.
Q. Again, does that equate to a very large piece of paper you are talking about of the fetus at that gestation?
A. No.

MS. BURGENER: Thank you.

No further questions.

THE COURT: It is 1:00 p.m. How long would you like to break for lunch?

MS. ANDERSON: Your Honor, when we gave an estimate of fifteen minutes, that was the assumption he would come second.

I estimate it would be half hour for the cross. I wanted to alert you to that.

MS. BURGENER: Your Honor, first, I know that counsel and I had talked before about whether or not we wanted to rely upon our written memos in brief in lieu of an oral closing.

MS. ANDERSON: That would be fine with us.

MS. BURGENER: That would be fine with us.

That way we could spend the time doing the cross examination. The Court would have the full evidentiary record and the written memos.

THE COURT: How long would you like to break for lunch?

MS. ANDERSON: Your Honor, it really is up to you. Anything. A half-hour would be sufficient from our standpoint. Longer is fine also.

I want to be sure I have enough time for the cross. I know you have something else coming up.

THE COURT: We will be in recess for 30 minutes.

[There was a recess for the noon hour].

THE COURT: Have the witness return please.

CROSS EXAMINATION

BY MS. ANDERSON:

Q. Good afternoon, Dr. Di Giacomo.

A. Good afternoon.

Q. Dr. Di Giacomo, when was the last time you performed an abortion?

A. Thursday night.

Q. An abortion, meaning to cause the termination of pregnancy, not producing a live fetus with the intent not to produce a live fetus?

A. Many years ago.

Q. How many years ago?

A. During residency.

Q. When did you complete your residency?

A. 1981.

Q. So, since 1981 to present, you have not performed an abortion in order to terminate a pregnancy and not have a result of a live birth?

A. I can't answer "Yes "or No" without clarification.

Q. Okay. Why don't you go ahead and clarify?

A. I perform abortions defined as evacuation of contents of the uterine cavity. It does not define whether it's live

or not.

The last abortion I have performed was Thursday evening at 6:00.

Q. Dr. Di Giacomo, do you still have the Florida Statute in front of you?

A. Yes, I do.

Q. Referring you to page 6 of that statute. Do you see the definition of "abortion" starting at line 7?

A. Page 6, line 7? On line 7. Yes.

Q. And do you understand that under Florida law "abortion" means the termination of human pregnancy with an intention other than to produce a live birth or remove a live fetus?

A. This is defined by this statute.

Q. Under that definition, the last time you performed an abortion would be during your residency, correct?

A. Yes.

Q. During your residency, you performed approximately how many abortions?

A. Fifty to one hundred.

Q. And the abortion techniques you used were, I believe, suction curettage, suction evacuation and instillation.

Is that correct?

A. That's correct.

Q. Suction curettage, you have heard that term used in this courtroom yesterday and today, correct?

A. Yes.
Q. The description of that process, is that the same as the suction curettage procedure, essentially, that you performed back in your residency?
A. Yes.
Q. The suction evacuation, what procedure was that?
A. I'm sorry?
Q. You say you also performed suction evacuation to terminate.
A. Dilatation and evacuation.
Q. You performed dilatation and evacuation?
A. In residency.
Q. How many dilatation and evacuation procedures did you perform?
A. I would have to check my records.
Q. Did you perform dilatation and evacuation procedures during the second trimester?
A. Yes.
Q. Any of the first trimester?
A. First trimester suction dilatation and curettage.
Q. Is that the same as the procedure Dr. Pendergraft described?
A. They can be used interchangeably.
Q. Were the majority of the abortions you performed during your residency during the first trimester of pregnancy?

A. Yes.
Q. You also mentioned you performed instillation procedures.
A. Yes.
Q. Is that the same as the induction procedures that are done currently, or is that different?
A. Yes.
Q. What was the instillation you performed during your residency?
A. Prostaglandin, normal saline and urea.
Q. Has the procedure by which inductions are performed in order to achieve an abortion as defined by Florida law the same now as they were in the early 1980s?
A. Please repeat.
Q. Are the induction procedures that are used now to perform abortions identical to those that were used in the early 1980s?
A. Technology is always changing. Nothing is identical.
Q. So, in fact, generally, abortion methods have continued to evolve over time, correct?
A. Yes.
Q. In your current practice, isn't it correct you choose not to perform any abortions as defined by Florida Statute?
A. Yes.
Q. And during -- in your practice, isn't it true that you

have not referred any of your patients for abortions?
A. No.
Q. No, that's not true?
A. Repeat -- I have referred.
Q. You have referred patients for abortions in your current practice?
A. Yes.
Q. Dr. Di Giacomo, do you remember being deposed in this action on August 5th?
A. Yes.
Q. Do you remember the following exchange --

MS. BURGENER: Page.

MS. ANDERSON: 7, line 2.

BY MS. ANDERSON:

Q. "Question: Okay. Have you ever have had occasion in your practice over the past twenty years to refer any of your patients for an abortion?

"Answer: No. If they want an abortion, I -- they don't come to my office so, no.

"Question: So, in the twenty years that you have been practicing, you have not had a circumstance where a woman's pregnancy threatened her life or health so that you needed to find someone to deal with her situation other than yourself?

"Answer: No."

Do you remember that testimony?

A. Can I answer with clarification?

Q. Certainly.

A. Yes, I remember that testimony. The case I described happened recently, after that deposition.

Q. Thereafter, the one you mentioned earlier?

A. Yes.

Q. In your twenty years of practice, you have that one occasion to refer a woman to an abortion?

A. No, I have referred them, but I have not personally done them.

Referring them -- my, my initial patient interview consists of the following: I interview the patient. I find out her emotional concerns, reasons. I counsel the patient, give her various options available to her and according to Florida Statute, which consists of normal spontaneous vaginal delivery, abortion or adoption.

I counsel the woman for, probably, about an hour. I send her to one of my nursing staff, who counsels --

THE COURT: Excuse me, doctor. Slow down just a bit. We are having a little difficulty keeping up with you.

BY MS. ANDERSON:

Q. Thank you, doctor.

Have any articles that you authored been

published in the field of obstetrics and gynecology?
A. No.
Q. I take it you have not had any publications relating to abortion procedures, correct?
A. No.
Q. Did you know saline is now a highly disfavored method of performing abortions?
A. Yes.
Q. Now, you testified earlier with reference to the ACOG definition of the a D&X procedure. Do you still have the ACOG statement of policy in front of you?
A. Yes.
Q. Referring you to the, to the middle of the first page of that document. It gives four steps that ACOG says fall within the definition of an intact D&X.
A. Yes.
Q. Is it your understanding the procedure specified in that ACOG statement is the, is -- let me restate that.

Is it your understanding the Florida Statute banning partial birth abortions bans this procedure as described by ACOG?
A. Yes.
Q. To your knowledge, does -- in your opinion, does the Florida Statute ban any other abortion procedure?
A. A D&X can be accomplished, is allowed to be performed

as illustrated in the ACOG statement of policy, so it's not banned unless it meets these requirements.

Q. I want to be sure I understand your testimony.

The Florida partial birth abortion statute, in your opinion, would, if it goes into effect, ban the performance of abortion procedures in which the four steps laid out by ACOG --

A. No, no. I apologize if I said that.

Q. What do you believe it does ban?

A. The ACOG statement, policy, speaks for itself.

Q. I'm sorry. Let me restate the question.

I am asking you about your opinion as to what procedure is banned by the Florida Statute.

A. Delivery of a live fetus from the vaginal canal.

Q. Do you believe the description of the four steps laid out in the ACOG statements, the four steps ACOG defines as being an intact D&X, do you believe that procedure is banned by the Florida Statute?

A. No.

Q. Do you believe that a procedure in which a physician removes an intact fetus and its head becomes, the physician is trying -- let me rephrase that.

When a physician is performing a D&E procedure and the physician is bringing the fetus down from the uterus into the vagina, and as the physician continues to

bring the fetus down, the fetus's head gets stuck so the physician is not able to pull the intact fetus all the way out of the uterus, in your opinion, is such a procedure banned by the act?

A. That was a pretty wordy question. If you could cut it down?

Q. Yes.

Let me refer you back to your testimony on direct. You mentioned when an after-coming or an enlarged head becomes stuck in the cervix in a D&E procedure, if the physician then has to take some steps to remove the fetus, to decompress the head in order to remove the fetus, you would consider that a complication?

A. Correct.

Q. In that instance, you would not think that was banned by the act?

A. Correct.

Q. The same is true with an induction procedure. If the physician is performing an induction procedure, a fetus is partially vaginally delivered, but still alive, and the head becomes stuck, and the physician has to either drain the skull contents or compress the skull in order to get the fetus out the rest of the way, that would be a complication, correct?

A. Correct.

Q. It's your understanding that would not be banned by the act?
A. Correct.
Q. In a suction curettage situation in which the physician is not able to remove -- in which the head of the fetus becomes stuck in the cervix and the physician is then, has to -- let me rephrase that.

In a suction curettage procedure in which the physician trying to remove the fetus from the uterine cavity finds that the head does not readily come out through the suction, then the physician has to do something to the head in order to affect the removal, that would be a complication?
A. In most of the cases the head is destroyed on entrance to the cannula.
Q. In the situations in which it is not, and the physician has to take steps in order to remove, additional steps to remove the head from the uterine cavity, that would not come under the ban because that was not, the physician was not intending for the head to get stuck?
A. Correct.
Q. It's your understanding that it's those situations in which the physician is intending for the head to become stuck and then takes action as a result is banned by the statute?

A. Yes.
Q. On direct examination -- you currently do not perform any -- let me ask you again.
On direct examination you were asked about the law relating to third trimester abortion procedures in the State of Florida.
Is that a law that you need to be familiar with with your current practice?
A. Yes.
Q. With reference to the term "partial birth abortion," on direct examination you testified you have seen discussion of that term through your research on Medline?
A. I didn't say Medline. I said on the Internet.
Q. Was it medical publications you saw through your search on the Internet that referred to partial birth abortion?
A. Yes.
Q. And you mentioned that in the last several years you have seen some publications that appeared on the Internet that relate to partial birth abortion, correct?
A. Yes.
Q. Are you aware in 1995 the Congress considered legislation to ban what was termed partial birth abortion?
A. I would have to research. I don't recall.
Q. Prior to -- do you remember when you first heard about legislation that was attempting to ban what were termed

partial birth abortions?
A. I don't recall.
Q. Several years ago?
A. I do not recall.
Q. Do you recall whether you ever saw any reference to partial birth abortion in any medical literature prior to when Congress first considered banning partial birth abortions?
A. That data is available. If you pull it up on the Internet, it gives you the time these articles were written.
I haven't paid attention. At this point, until I review my reference as to what time --
Q. You are not sure what the date of the articles were, sitting here now?
A. Off the top of my head, no.
Q. Thank you.
If I understand your testimony, you do not consider a suction curettage abortion procedure to be, to cause a vaginal delivery of the fetus, correct?
A. Correct.
Q. Do you consider a D&E to cause a vaginal delivery of the fetus?
A. No.
Q. And do you consider an induction to cause a vaginal delivery of the fetus?

A. Yes.
Q. Would you agree that some of the time when a D&E procedure is performed, the fetus comes out intact?
A. Yes.
Q. You would agree some of the time when a D&E procedure is performed the head becomes stuck in the cervix?
A. Yes.
Q. You would agree some of the time when an induction procedure is performed the head becomes stuck in the cervix?
A. Yes.
Q. And you would agree some of the time when a D&E procedure is performed a limb of the fetus could be in the vagina while other parts of the fetus is still in the uterus and the fetus is still living at that point?
A. Yes.
Q. And is it your belief in the D&E procedure, the disarticulation of limbs causes fetal demise?
A. Yes.
Q. Do you have an understanding of how quickly that fetal demise results?
A. Almost instantaneously. If someone took a blow to the head, it would cause a fetal demise.
If someone were to grasp the calvarium with forceps, it would cause demise.
Q. You think fetal demise would occur as rapidly if you

disarticulate a leg as if you give a blow to the head?
A. No.
Q. It would occur more quickly with the head?
A. Yes.
Q. If you disarticulate a limb it would occur not as quickly than draining the head?
A. I believe draining the head is probably quicker.
On the other hand, disarticulating the fetal limb would cause internal hemorrhage. And the fetus would die.
Q. You would agree induction procedures used, today such as the prostaglandin, though they often cause fetal demise of the fetus while it is still in the vagina, they do not -- I'm sorry -- while it's still in the uterus, they do not always cause fetal demise while the fetus was still in the uterus?
A. Run that by me.
Q. Induction procedures using prostaglandin, fetal demise does not always occur while the fetus is still in the uterus?
A. Ninety-three of the cases, it does.
Q. In another seven percent of the cases, fetal demise could occur when the fetus is still part in the vagina?
A. Yes.
Q. You mentioned on direct your estimate of how long it takes to perform a D&X procedure.

Have you ever performed a D&X procedure?
A. No.
Q. Have you ever witnessed the performance of a D&X procedure?
A. Yes.
Q. Who did you see perform a D&X procedure?
A. In residency for fetal demise of a hydroencephalic infant.
Q. In the early 1980s?
A. Yes.
Q. Have you ever at any time, other time, witnessed the performance of a D&X procedure?
A. No.
Q. So, is your estimate of how long it takes to complete a D&X procedure based on your personal experience witnessing the procedure?
A. No. Medical literature.
Q. What literature have you read that told you exactly how long the procedure takes?
A. ACOG protocols.
Q. What ACOG protocols did you read that state how long procedure takes?
A. Technical bulletins.
Q. What technical bulletins?
A. 109.

Q. Excuse me?
A. 109. I believe that's the number.
Q. And to the best of your recollection, that actually states how long the procedure takes?
A. Approximately.
Q. And you mentioned that to your knowledge the only doctor, the only doctor you are aware of in Florida who performs the intact D&E procedure is Dr. Benjamin. That was based on his testimony in court?
A. Based on his testimony.
Q. Do you go to National Abortion Federation meetings?
A. No.
Q. Do you regularly meet with doctors who perform abortions to discuss exactly what procedures they are performing?
A. No.
Q. On direct you mentioned alternatives to the D&E procedure are suction curettage and the use of prostaglandin, saline or urea, those three, last three being induction procedures, correct?
A. Correct.
Q. And, to your knowledge, how late in a pregnancy can suction curettage be sufficient to terminate the pregnancy?
A. Well, less than thirteen weeks.
Q. How late into pregnancy, how far into pregnancy can

induction be used to terminate the pregnancy?
A. Usually, probably, around any time if you use intracardiac digoxin.
Q. If you don't, how late can induction procedures serve to terminate a pregnancy?
A. You can always.
Q. Induction can be used not only the second-trimester but the third?
A. Yes.
Q. Can induction be used in the first trimester?
A. No.
Q. You mentioned -- you referred to your circular slide rule for a reference tool in order to mention fetal weight of a particular gestational age.
Do all fetuses weigh the same at a particular gestational age.
A. Within a plus or minus deviation.
Q. Is there variation -- does every fetus have the exact same shape at a particular gestational age? Are all fetus shaped the same?
A. All fetuses differ within standard deviation.
Q. Do all fetuses lie within the cavity in the exact same way?
A. No.
Q. You had mentioned risks associated with the intact D&E

procedure. Hemorrhage, perforation of the uterus, infection and bleeding.

What is your basis for believing that?

A. ACOG publications.

Q. Have you seen peer review studies that analyze the risks associated with intact D&E procedure?

A. Yes.

Q. What were -- who conducted those studies?

A. American College of OB/GYN.

Q. Referring you to the ACOG statement, do you have that in front of you?

A. Yes.

Q. Is that one of the ACOG publications that you relied upon for your understanding of the intact D&X or D&E procedure?

A. Yes.

Q. Referring you to the first paragraph of that statement where it says:

"The debate regarding legislation to prohibit a method of abortion such as the legislation banning 'partial birth abortion' and 'brain sucking abortions' has prompted questions regarding those procedures.

"It is difficult to respond to those questions because the descriptions are vague and do not delineate a specific procedure recognized in medical literature."

Do you agree with that second statement by ACOG. Do you hold the same opinion?

A. Yes.

Q. And the next sentence reads:

"Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques."

Do you agree with that statement by ACOG?

A. Yes.

Q. Referring you to the second page of that statement, meaning the document, the first sentence states "Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother," and the next sentence states "Intact D&X is one of the methods available in some of those situations."

Do you agree with that statement?

A. Yes.

Q. Then it goes on to state a select panel convened by ACOG could identify no circumstances under which this procedure as defined above would be the only option to save the life or preserve the health of a woman. An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor in consultation with the patient, based upon the woman's particular circumstances

can make this decision."

Do you hold the same opinion as that expressed by ACOG in that last sentence?

A. Yes.

Q. It goes on to state "The potential exists that legislation prohibiting specific medical practices such as intact D&X may outlaw techniques critical to the lives and health of American women."

Do you hold that same opinion?

A. Yes.

Q. Finally: "The intervention of legislative bodies into medical decision-making is inappropriate, ill-advised and dangerous."

Do you hold that same opinion?

A. It is not reality, but, yes, I hold that opinion.

Q. Referring you back to the statute, the definition of partial birth abortion, page 6, starting at line 18, do you see any mention of "intact" within that definition?

A. No.

Q. And do you see anything in this definition that limits the application of this ban to procedures done in the third trimester?

A. No.

Q. Do you see anything in the definition of partial birth abortion which limits it to abortions performed after

viability of the fetus?
A. No.
Q. An do you see anything in this definition that relates to the gestational age of the fetus at all?
A. No.
Q. Referring you to the exception to the application, page 3, starting with line 30, continuing to page 4, line 3.
If you could read that to yourself, please?
A. (Complied).
Q. Having read that, do you see anything in that exception that permits a physician to use a banned partial birth abortion in the interest of the woman's health?
A. Yes.
Q. Do you see anything in that language that allows a physician to perform a banned, otherwise banned partial birth abortion if the health risk is not life threatening?
A. Yes.
Q. What in there causes you to think there is a health exception not restricted to it being a life-threatening situation?
A. Do you want me to read it.
Q. Certainly.
A. Life-threatening and life-endangered, it depends upon. Life-endangered by physical disorders or injury, is what it states. It doesn't say life-threatening.

Q. Do you interpret live-endangered, any condition that would impose health risk to the mother?
A. Yes.
Q. Any type of health risk would automatically be life-threatening?
A. Could be.
Q. Would that include risks to the woman's mental health? Would that many automatically be life-endangering?
A. Yes.
Q. Would you agree there is no medical benefit to the pregnant woman from requiring, in the course of the abortion, the fetus be caused to die while it's still within the uterus, as opposed to while part is in the vagina?
A. Please repeat.
Q. You would agree, wouldn't you, that there is no medical benefit to the pregnant woman for requiring during an abortion the fetal demise be induced prior to any part of the fetus being in the vagina?
A. Emotional, which is defined as medical.
Q. Other than emotional, do you see any medical benefit for a woman for requiring that?
A. Safety.
Q. Why do you see it as a safety issue to cause the fetal demise to occur while the fetus is still in the uterus, rather than part of it in the vagina?

A. According to recent literature, the safety factor and death of fetus ratio is five to one hundred thousand, ten to one hundred thousand. Later on in hysterotomy is sixty to one hundred.
Q. The later you go in gestational age, there is greater risk, correct?
A. Yes.
Q. Your opinion is it's better to cause death of the fetus in utero than while part of it is in the vagina is based on the fact that there is increased --
A. You are mumbling. I'm sorry.
Q. It's your belief there is a medical benefit to the woman of causing fetal demise while the fetus is still in utero, rather than while part is in the vagina, because abortions are safer if they are performed earlier?
A. Yes.
Q. It's your opinion, isn't it, physicians should not be subject to -- it's your opinion, it is preferable for a physician not to fear criminal prosecution for performing abortions?
A. Yes.
Q. Would you agree if the -- in your opinion, if the Legislature chooses to restrict medical practices, they should try to be as specific as possible in their restrictions so the physicians will be able to comply with

their restrictions?
A. Yes.
Q. Are you being paid today for your time in connection with this case by the Florida Agency for Healthcare and Administration?
A. I am not sure where the funds come from, but somewhere in the State of Florida.
Q. Would you agree there are risks associated with causing fetal demise by the injection of digoxin?
A. What type of risk, maternal or fetal?
Q. Maternal.
A. Very minimal.
Q. Would you agree there are risks to the mother resulting from the injection of potassium chloride?
A. Minimal.
Q. Do you agree injecting potassium chloride requires additional steps beyond the steps typically taken in a D&E?
A. Yes.
Q. Would you agree the injection of digoxin requires additional steps beyond which are typically taken in a D&E?
A. Yes.
Q. Do you believe that for a procedure to fall within the ban of the Florida Statute, it would be necessary for the physician to insert scissors into the fetal head?
A. No.

Q. Do you believe for a procedure to fall within the definition of partial birth abortion in the Florida Statute, one necessary step would be for the physician to drain the intracranial contents of the fetus' head?
A. If the fetus is still alive, and if the physician inserts a needle into the intracranial contents, it's a violation of the act.
Q. Would it be able to violate the act without draining the contents of a fetal head?
A. If you deliberately killed the fetus in the vaginal canal, yes.
Q. Let me try again: I understand that you believe the statute would apply only in a case where there is a living fetus and if a step was taken to kill the fetus.
A. Correct.
Q. I am trying to find out what are the steps that could fall within the ban, what killing steps could fall within the ban, in your opinion?
A. Delivery of a live infant through the vaginal canal thereby subsequently killing the fetus by intracranial injection or sucking out the brain.
Q. The ban only applies if killing is achieved by intracranial injection or sucking the contents of the brain?
A. No. When you have a live fetus, killing the fetus, regardless of the method you use.

Q. Any method to kill a live fetus that has been partially vaginally delivered, that procedure would fall within the ban, in your opinion?
A. Yes.
Q. I take it that was only if the procedure was taken with necessary -- let me strike that.
To the extent that -- your understanding of the wording of the ban, is it necessary the fetus be intact at the time the step that killed the fetus is taken?
A. It's not stated in this statute.
Q. So, is it your opinion it would be required?
A. No.
THE COURT: Counsel --
MS. ANDERSON: Very little left.
THE COURT: You have been conducting your cross examination for about forty-two minutes.
MS. ANDERSON: I have about three more minutes.
MS. BURGENER: Your Honor, I have a few minutes of redirect.
BY MS. ANDERSON:
Q. Dr. Di Giacomo, are you aware that the AMA has stated that "To minimize uterine or cervical perforation, either from instruments used during the D&E or through piercing by fetal parts, some physicians use a form of D&E that has been referred to in the popular

context as intact dilatation and extraction"?

A. You would have to show me the literature.

MS. BURGENER: May I see it, please?

MS. ANDERSON: (Handing.)

THE WITNESS: Thank you.

MS. BURGENER: What page are you referring to?

MS. ANDERSON: Page 8.

BY MS. ANDERSON:

Q. I am showing you what has been marked as Plaintiffs' Exhibit -- I believe it's 8.

A. 7.

[Plaintiff Exhibit 7 marked for identification].

MS. BURGENER: Your Honor, I object to this document coming in as evidence because we don't have it authenticated.

THE COURT: It hasn't been offered.

I am not sure what you are seeking to use it for. Maybe it's to refresh recollection.

Proceed, please.

BY MS. ANDERSON:

Q. Dr. Di Giacomo, have you ever seen this document before?

A. No.

Q. Are you familiar with am AMA publications -- well, as part of your search for literature relating to partial birth

abortion bans, did you find any AMA publications?
A. I really didn't classify the organization etiology.
Q. Do you remember if you saw any publications by the AMA as part of that search?
A. I do not recall.
Q. Let me ask you, would you agree that hysterectomy is a more, there are more complications associated with hysterectomy than with D&E?
A. Yes.
Q. And you would agree there are more complications associated with hysterotomy than with D&E?
A. Yes.
Q. And you would agree there are more complications from hysterectomies and hysterotomies than there are for suction curettage procedures?
A. Yes.

MS. ANDERSON: I have no further questions.

Thank you, Your Honor.

Thank you, Dr. Di Giacomo.

REDIRECT EXAMINATION

BY MS. BURGENER:

Q. Dr. Di Giacomo, on cross examination you were asked a few questions about the ACOG statement of policy marked as Defendants' Exhibit 1 in evidence.

Can you refer to that please?

A. (Complied.)
Q. With regard to the description of the intact D&X procedure identified in Defendants' Exhibit 1, do you have an opinion as to whether or not a physician who knowingly and intentionally goes forward with performing that procedure violates Florida Statute?
A. Yes.
Q. Does he violate Florida Statute?
A. I'm sorry. I didn't understand the question.
Q. Does a physician who knowingly and intentionally performs an intact D&X ascribed in the ACOG policy statement violate Florida's statute banning the partial birth abortions?
A. Yes.
Q. And were you present at the other witnesses' testimony earlier yesterday and today about the differences of opinions of what actually constitutes a D&X procedure?
A. Yes.
Q. Would you agree OB/GYNs that are members of ACOG amongst themselves disagree as to what the specific elements of the D&X procedure are?
A. Yes.
Q. Is it your position the phrase "partial birth abortion" could encompass variations of a D&X procedure that might differ from the ACOG definition?

A. Yes.
Q. And, likewise, are there alternative safe procedures available to a woman to terminate her pregnancy in the interest of her health or life besides the intact D&X procedure described in the ACOG bulletin?
A. Yes.
Q. And, doctor, based upon your experience in the field of obstetrics and gynecology, is it possible for a physician who intends to do an intact D&X on a woman to take steps such as severing the umbilical cord to assure the demise of the fetus in the utero?
A. No, it would not violate the ban.
Q. Is it possible for them to do that?
A. Yes.

MS. BURGENER: Thank you, Your Honor.

Thank you, Dr. Di Giacomo. Thank you, Your Honor.

THE COURT: You may step down, sir. You are excused.

[The witness was excused].

THE COURT: Thank you very much for your presentations, counsel. I appreciate your preparation and efforts. You both represented your clients very well.

I would like for the parties to submit written closing arguments, summarizing the testimony presented that

you think may be of assistance.

How much time would you request?

MS. ANDERSON: Your Honor, I really would like to be able to have a transcript. I think that would be most useful. Recitation of the evidence would be most accurate and helpful to Your Honor.

It would be dependent on the court reporter's ability to provide us with the transcript, and once we have the transcript --

THE COURT: Is that really necessary? Usually counsel have to present closing arguments with no transcript at the conclusion of any proceeding.

MS. ANDERSON: We could do without a transcript. I thought it would be more helpful.

MS. BURGENER: To that extent, I would agree with the plaintiffs' counsel. Since it deals with such a technical matter, we might be able to cite to page and line specifically to Your Honor.

THE COURT: The transcript can be provided in two weeks. Thereafter, how much time would you like to present the written closing arguments?

MR. GROSS: Does Your Honor have a preference as to page length?

THE COURT: Let's agree on a length. What are you requesting?

MS. ANDERSON: I am checking the two weeks because of my scheduled vacation.

MS. BURGENER: I know if we could get it -- I am going into a couple of trials beginning September 14th. I would have to have it done before then anyway. Maybe not.

The day after the Labor Day weekend. That's all I would ask.

MS. ANDERSON: September 11th.

MS. BURGENER: That would give bus about seven days.

THE COURT: The transcript may be available a little earlier than two weeks, but September 11th for closing arguments to be submitted in writing.

The Restraining Order will remain in effect until such time as the Court resolves the issues relative to the injunction.

MS. BURGENER: Thank you, Your Honor.

MS. ANDERSON: Do we want to agree on page length at this time?

MS. BURGENER: Ten pages?

MS. ANDERSON: Twenty pages.

MS. BURGENER: Ten pages written closing.

THE COURT: Fifteen pages.

MS. BURGENER: Sounds good.

THE COURT: Thank you very much.

Have a good afternoon.

C E R T I F I C A T E

I hereby certify that the foregoing is an accurate transcription of proceedings in the above-entitled matter.

8/25/98
DATE

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