## PARTIAL-BIRTH ABORTION TRIAL UPDATE

## April 5, 2004

Information Compiled by: Secretariat for Pro-Life Activities, U.S. Conference of Catholic Bishops

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NEW YORK.

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

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

A. Yes.

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

A. Yes.

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

A. I may do that, yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. That's right.

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

A. That's right.

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

A. That's right.

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

A. That's right.

Excerpts from direct examination of Dr. Marilynn Fredriksen:

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

A. Yes.

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

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

THE COURT: Thousands, plural?

THE WITNESS: Thousands, plural.

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THE COURT: Have you ever perforated a uterus or done any of these things?

THE WITNESS: Yes.

THE COURT: Were you ever sued for malpractice?

THE WITNESS: Yes.

THE COURT: Involving an abortion?

THE WITNESS: Yes.

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

THE WITNESS: No.

THE COURT: Was there settlement?

THE WITNESS: No. We won.

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THE COURT: Doctor, do you make full disclosure to all your patients before you embark on a particular procedure?

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

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

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

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

THE WITNESS: Yes.

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

THE WITNESS: Yes.

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

THE WITNESS: I tell them that in the process.

THE COURT: Do you use "disarticulation"?

THE WITNESS: No.

THE COURT: What word do you use?

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

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

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

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

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

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

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

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

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

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

THE WITNESS: I tell them in simple, understandable words, depending upon the particular patient that I am dealing with.

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

THE WITNESS: Yes.

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

THE WITNESS: No.

THE COURT: You don't tell them that.

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

THE COURT: You do that sometimes?

THE WITNESS: Yes.

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

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

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

THE WITNESS: No.

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

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

THE COURT: The patient.

THE WITNESS: The patient?

THE COURT: The woman, the mother.

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

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

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

THE COURT: Ma'am, I didn't ask you that. Very simply I asked you whether or not do you tell the mother that one of the ways she may do this is that you will deliver the baby partially and then insert a pair of scissors in the base of the fetus' skull?

THE WITNESS: I have not done that.

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

THE WITNESS: I don't use suction.

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

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

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

THE WITNESS: No.

THE COURT: The mother?

THE WITNESS: No.

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

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

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

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

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

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

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

THE WITNESS: I'm sorry.

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

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

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

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

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

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

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

THE WITNESS: No.

THE COURT: Next question.

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

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

A. No, it is not.

Q. Why not?

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

Q. Dr. Frederiksen --

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

THE WITNESS: You compress the skull, yes.

THE COURT: You crush it, right?

THE WITNESS: Yes.

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

THE WITNESS: Yes.

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

A. Yes, I have.

~

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

A. You can't guarantee the process.

Q. Why not?

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

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

A. Yes.

Q. Can you describe that for us, please.

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

~

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

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

Q. In what context?

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

Excerpts from cross-examination of Dr. Marilynn Frederiksen:

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

A. No.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. I don't think so, no.

~

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

A. Yes.

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

A. That's correct.

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

A. No, it does not.

~

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

A. Correct.

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

A. Yes.

~

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Correct.

NEBRASKA.

DAY FIVE: Monday, April 5, 2004 (first day of Government's defense)
Excerpts from re-direct examination of Dr. Watson Bowes, Jr.:

Q. And, Doctor, what is your opinion concerning the medical necessity of partial-birth abortion procedures such as intact D&E with regard to preserving the health of the mother?

A. Well, I will restate what the American College of Obstetricians and Gynecologists said in their statement. They know of no instance where it's necessary to use this procedure to -- they could think of no specific instance when this procedure would be necessary to protect the health of the mother.

DAY SIX: Tuesday, April 6, 2004
Excerpts from direct examination of Dr. Kanwaljeet Anand:

Q. So, Doctor, do you have an opinion as to whether the partial-birth abortion procedure causes pain to the fetus?

A. If the fetus is beyond 20 weeks of gestation, I would assume that there will be pain caused to the fetus. And I believe it will be severe and excruciating pain caused to the fetus.

Q. What do you mean by severe and excruciating pain?

A. You see, the threshold for pain is very low. The fetus is very likely extremely sensitive to pain during the gestation of 20 to 30 weeks. And so the procedures associated with the partial-birth abortion that I just described would be likely to cause severe pain, right from the time the fetus is being manipulated and being handled to the time that the incision is made, and the brain or the contents, intracranial contents, are sucked out.

Excerpts from direct examination of Dr. Leroy Sprang:

Q. Okay. Doctor, if I could, I wanted to ask you, based on your training, experience as an OB/GYN, your knowledge of medical literature, do you have an opinion as to whether the intact D & X procedure presents significant risk to the woman?

A. I believe it does.

Q. Could you just briefly list kind of what those risks are?

A. My concerns with the procedure are several things that distinguish it from the traditional D & E. The fact that it -- more commonly for D & E, you can dilate the cervix over one day. There may be exceptions. But in general, more commonly one day. More commonly for a D & X, you're dilating it over two days.

Q. Does that present a risk?

A. Presents several problems. Laminaria are these little seaweed sticks that you're placing in the uterus, and they have to cover the entire length of the cervix. They have to be from the outside to the inside to make sure the entire cervix dilates evenly. Again, infectious disease is my area of expertise. … Bacteria have a better chance moving along the laminaria and getting inside the endocervical os and running a risk of infection, because they are in contact with the vagina, and up against the amniotic sack. That's the issue. … In the descriptions I have read on occasion, including Haskell, he says sometimes when you go back the second day, the bag breaks. But he still puts his

laminaria in, and still waits for the next day. Well, once the bag breaks and you have a foreign body sitting there and the bacteria are getting from the vagina to the uterus, that's a recipe for disaster. …

Q. You're talking about the risk of infection?

A. Correct, and trauma to the cervix. If you are dilating the cervix to a greater degree, some of it is mechanical. You mechanically dilate first before he puts the first laminaria in. I have been told by some -- the people, some or at least one of the people who does that, that they force as many laminaria in as possible on the second day because they want the greatest amount of dilatation as possible because that will make the delivery process easier. So it's not just slow dilation from laminaria taking in fluid, there is some mechanical aspects to it too. And that, I think, does more risk to the cervix. …

Q. What kind of risk to the cervix are you talking to?

A. You traumatize the cervix. And there is information on earlier ones, which even dilate mechanically now, dilate the cervix either from 10 millimeters to 11 millimeters, it increases the risk of an incompetent cervix later. The cervix not being able to maintain a pregnancy or maybe just weak enough you have more preterm deliveries. And preterm deliveries are the single greatest medical obstetrical problem in the United States today.

~

Q. Tell us what. I'm done with that. Doctor, have you ever performed an intact D & X procedure?

A. I have not.

Q. In your practice, have you ever seen the need for it?

A. I have not.

Q. Your practice involves high risk obstetrics; is that correct?

A. Full range including high risk obstetrics and, again, I'm now president of a group of like 27, 28 OB providers. So I have seen a great number of circumstances. With our issues, they do clearly present them to me and I have never seen that.

Q. Would that be true even of situations involving serious maternal health conditions?

A. I have never seen a situation where a D & X would be the safest, the best, or the only procedure to use to protect the health of the mother.

Q. And that would be even in emergency situations where the pregnancy needs to be terminated and very quickly?

A. I have never seen a situation where intact D & X would be required, or the best procedure to do. In reading all the other declarations and stuff, I haven't seen a single physician who provides it do that. The AMA committee that I sat on could -- and there were several different obstetricians and Counsel on Scientific Affairs. Nobody could come up with a situation where the intact D & X would be necessary to preserve the health of the mother. In ACOG, when they had their panel, could not come up with -- they couldn't come up with a single example where it would be, you know, the best, most appropriate alternative to save the health of the mother or to have a beneficial effect on the health of the mother.

CALIFORNIA.

DAY FOUR: Monday, April 5, 2004.
Excerpts from cross- examination of Dr. Fredrik Broekhuizen:

Q. Usually in examining the fetal parts you don't actually see the bones, do you? You usually see the limb and the actual bone is in the limb?

A. You can sometimes see bone. Sometimes you can see just the limb.

Q. But usually you just see the limb, and the actual bone is in the limb?

A. Actually, when disarticulation takes place in the joint one can certainly see the end of the bone on inspection.

Q. The end of the bone. But usually the rest of the bone is inside the limb?

A. There are situations where actually the bone is crushed in the middle of the limb. And under those circumstances one can see part of the bone.

~

Q. Doctor, you testified earlier that sometimes parents want an intact fetus for blessing or burial. Have you ever had the parent express that desire where you had compressed the head of the fetus to complete the delivery?

A. Yes.

Q. Was anything done in those instances, doctor, to improve the appearance of the fetus' head after decompression?

A. Yes.

Q. What was done?

A. The fetus was -- just like a newborn -- it was dressed and kind of had a little hat placed on it so that only the face was visible.

~

Q. You have seen the fetus' legs move before crushing the head, haven't you?

A. I have seen that before compressing/decompressing the head.

Q. And that is while the head is lodged in the internal os?

A. Correct.

Q. The rest of the body is outside the cervix?

A. Correct.

Excerpts from direct examination of Dr. Mitchell Creinin:

Q. If that happens and you remove the dilators and you find you have more than two, two and a half centimeters, is that a bad outcome?

A. No. … I want -- I judge the number of Dilapan based on making sure I get the minimum amount without putting in so many that I make her uncomfortable or get more dilation than I absolutely need, which I have found at times can cause patients to go into labor or deliver.

~

Q. What do you do to evacuate the contents of the uterus?

A.. . . If it is head first, it's very, very, very difficult to try and grasp the head as the very first thing. So, with every D&E, the way I have been taught, the way I have always done it, the way I have always taught it is to try and grab a lower limb to convert the position to breech and then proceed with the evacuation. If it's already breech, or if it's transverse, that's easier to grab a lower extremity. After grabbing the lower extremity, I am going to pull the pregnancy or pull whatever part I have grasped through the open cervix until there is resistance from the lower uterine segment and the internal os. My goal is to try and remove the fetus as intact as possible. The fewer passes, the safer it is for the woman. So, as I pull down, the uterus is going to tell me how far I can go just by the resistance I get. So when I meet resistance, I will continue to pull, and it's the pressure of the fetus against the lower uterine segment that actually results in dismemberment of the fetus. And where that is going to happen on the fetus will vary from patient to patient.

~

Q. So, moving along, once you've located and grasped the lower extremities and turn the fetus if you need to, what do you do next?

A. Pull with the instrument that I am using to remove the fetus with the attempt to remove the fetus in as few passes as possible. So until I meet resistance from the lower uterine segment, I will continue to pull.

Q. Why --

A. And once I meet resistance, I will then, while holding on to the fetus -- minimal rotation, but just kind of try and ease those parts through the cervix to allow whatever's meeting resistance to try and slowly get through the cervix. The fetus will either continue to come or will begin to break apart. It will break apart wherever or whatever it is. It may be in the middle of the leg, it may be at the abdomen, it may be at the chest, just depending on the dilation and the size of the fetus, et cetera, just on that individual case.

~

Q. Does it ever happen that in grasping the fetus you're able to remove the fetus intact or relatively intact all the way up to the calvarium?

A. Yes, on occasion.

Q. If that happens, would you do anything differently to complete the procedure?

A. If the fetus is intact up to the calvarium, there's two things I could do. One would be to continue to pull, and usually it comes apart at the level of the neck, or I can insert, what I would I have done is insert scissors through that part of the head under direct visualization, inserted the 11-millimeter cannula that I used before and drain the brain tissue and then the head comes through the opening.

DAY FIVE: Tuesday, April 6, 2004
Excerpts from Government's cross-examination of Dr. Mitchell Creinin:

Q. Now, you have encountered situations in which you are performing a D&E and the fetus is removed intact except that the head of the fetus gets stuck at the internal cervical os, correct?

A. Correct.

Q. When that has happened you have preceeded with the D&E procedure in one of three ways, correct?

A. If you can tell me the three ways I would be happy to.

Q. One method would be to pull on the baby so that the head breaks off from the rest of the body; is that right?

A. Yes.

Q. And then, you will go inside the uterus with the forceps and remove the head?

A. Correct.

Q. The next method is that you would use scissors to puncture the base of the skull?

A. Correct.

Q. And the, you will stick a suction cannula into the opening and drain the brain tissue, and then you will have the head come out.

A. Did you say "Drain the brain tissue"?

Q. Then, you will drain the brain tissue?

A. Yes.

~

Q. And the third method is that you take a crushing instrument, put that instrument inside the cervical os, crush the baby's head, and pull the head through the cervix, correct?

A. That would be the third possible, although physically that would virtually never be the case. It would be one of the first two. Those are my three options, but it would be one of the first two that I could realistically do.

~

Q. Doctor, if a woman's cervix was so dilated the fetus could be delivered in intact it would not be necessary to collapse the skull because the fetus could pass through the cervix, right?

A. Correct.

Q. But you would not allow the fetus to pass intact if the fetus were at or about 24 weeks in gestation, correct?

A. Correct.

Q. Because if the fetus were close to 24 weeks, and you were performing a transvaginal surgical abortion you would be concerned about delivering the fetus entirely intact because that might result in a live baby that may survive, correct?

A. You said I was performing an abortion, so since the objective of the abortion is to not have a live fetus, then that would be correct.

Q. In your opinion, if you were performing a surgical abortion at 23 or 24 weeks and the cervix was so dilated that the head could pass without compression, you would do whatever you needed to do in order to make sure that the live baby was not delivered, wouldn't you?

A. Whatever I needed, meaning whatever surgical procedures I needed to do as part of the procedure? Yes. Then, the answer would be: Yes.

Q. And one step you would take to avoid delivery of a live baby would to be to deliver or hold the fetus' head on the internal side of the cervical os in order to collapse the skull; is that right?

A. Yes, because the objective of my procedure is to perform an abortion.

Q. And that would ensure that you did not deliver a live baby?

A. Correct.

Excerpts from Planned Parenthood's re-direct examination of Dr. Creinin:

The witness: There have been situations, most commonly if there is a multiple pregnancy and the first one is removed by D&E, and then the second one because the cervix is very pliable at that point will come out completely intact.

The Court: Have you had that experience?

The Witness: Yes. In all of those situations, though regardless of whether the fetus comes out completely intact, intact up to the head, and I do a procedure on the base of the skull, or I did - or it comes out completely at the level of the head, and I disarticulate it, all of those have at times gone intact or relatively intact to the level of the umbilicus or greater and would violate the law.

Excerpts from Planned Parenthood's direct examination of Dr. Carolyn Westhoff:

Q. And in what way does it - looking at the reduction in the risk of injuring the woman with the sharp, boney fragments, if you can explain in a little more detail how that happens?

A. Well, I need to explain that by contrasting it to a D&E that involves disarticulating the fetus. When the fetus is disarticulated, the skin and soft tissue covering the bones is disrupted, so sharp fragments of bone are exposed. And in the process of exposing them, grasping them, and removing them from the uterus there is the possibility that those boney fragments can lacerate at any level of the uterus and the cervix itself during extraction.

~

Q. Can the boney parts perforate the uterus in addition to lacerating it?

A. Yes, they can.

Q. Have you ever observed uterine perforation or laceration or cervical laceration as a result of instrument passes in a D&E with disarticulation?

A. Yes.

Q. Have you ever observed that happening as a result of sharp fetal parts?

A. Yes, I have.

~

Q. Is there an advantage to intact D&E in terms of not having retained tissue in the uterus after the procedure?

A. Yes, there is.

Q. What is the - what is that - can you explain that advantage in a little more detail?

A. Yes. When the fetus is removed in parts we attempt to account for all the parts on the operating table at the completion of the case. But it is entirely possible that small fragments of soft tissue can remain inside the uterus that we can't be sure of. And even with, for instance, the sonographic scan, we may not be able to detect those, and that can lead to subsequent infection or hemorrhage on the part of the patient. We have, in fact, on our service had a case with a small fragment of retained skull leading to those very difficulties and requiring a second procedure subsequently to relieve those symptoms.

~

A. … In contrast, when I am retrieving a fetal skull that is floating fee in the uterine cavity, I must

pass instruments in an attempt to grasp it inside the uterus. And that is a blind use of instruments, which has more potential for perforation.

~

Q. And Dr. Westhoff, in your opinion, does the intact variant of D&E in any way facilitate the grieving process of women that are ending their pregnancy, that was a wanted pregnancy but they are ending it due to an anomaly or a maternal health condition?

A. Yes, it does. In a particular case in the last year, as an example, a patient who was aborting twins due to complications during the pregnancy absolutely did not want to go through labor and didn't want to go through an induction, but expressed the desire to hold these babies after the procedure. We were able to deliver both of them intact and present them to the woman to hold with clergy and her family present. And she was very grateful for that opportunity.

~

Q. Dr. Westhoff, do you fear prosecution under this act for the D&E's that you do where the fetus is disarticulated in the course of the evacuation?

A. Yes, I do. The ban itself, the language here does not specify that the fetus must be intact. And there are cases such as we discussed partly a moment ago in which I may first remove a foot or a leg, and then -- so I partly dismember the fetus, but then proceed to bring down the breech. And I believe that would again fulfill the conditions stated in part a of the ban. There are also cases in which perhaps the first part of the fetus I remove might be part of the back or the ribcage, which are, in fact, part of the fetal trunk past the navel and it appears then for me to continue to carry out the D&E would violate the ban as it is stated here.

~

Q. And once you start the procedure with instruments, do you complete it with instruments? Or might you bring out a presenting part with an instrument, and then switch to your fingers?

A. Yes. Each procedure proceeds very individually, and so each step of the procedure will depend really on just what happened in the one step before it. And for each step of the procedure I want to do what is going to be safest at that moment. So, yes, in fact, I have had cases where I may bring down and extract a leg with an instrument and disarticulate that leg, but because the position of the fetus comes down in the uterus during that maneuver, I may then be able to bring down the next leg with my fingers. And, in fact, the rest of the fetus will follow. So, similarly, I could start with my fingers and then in addition need to use instruments. So the combination of maneuvers I use are determined one at a time on an individual basis to minimize the total number of passes and maximize patient safety at each step of the way.