UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

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PLANNED PARENTHOOD SOUTHWEST OHIO REGION, et al. : CIVIL NO. 1:19-CV-118

Plaintiffs, : Preliminary Injunction Hearing

-vs- : Day 1

DAVID YOST, et al. : 1:04 p.m.

: Wednesday, April 10, 2019

Defendants. : Cincinnati, Ohio

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TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE MICHAEL R. BARRETT, JUDGE

- - -

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PROCEEDINGS

(In open court at 1:04 p.m.)

THE COURT: How you doing, guys?

MR. FORSYTHE: Good afternoon.

MS. ELLSWORTH: Good afternoon, Your Honor.

THE COURT: Give me a second.

Okay. You guys ready to start?

MS. ELLSWORTH: We are, Your Honor.

MR. FORSYTHE: Yes.

THE COURT: Did we test drive the equipment and all that kind of stuff? We know what we're doing?

MS. ELLSWORTH: We did, Your Honor, although we have a live witness today only, so we don't need it.

THE COURT: Oh, that's right. Okay. All right.

Do you want to call the case?

COURTROOM DEPUTY: If you'd like me to.

THE COURT: Oh, no, if you want to, go ahead, call the case. Call the case.

COURTROOM DEPUTY: On the docket is District Court Case Number 1:19-CV-118, Planned Parenthood Southwest Ohio Region, et al. versus David Yost, et al.

And we're here this afternoon for a preliminary injunction hearing, Document Number 4.

THE COURT: Okay. Counsel introduce themselves for the record, please.

MS. ELLSWORTH: Your Honor, on behalf of the plaintiffs, Felisha Ellsworth from Wilmer Hale. With me is Allyson Slater, also from Wilmer Hale, and Jennifer Branch from Gerhardstein and Branch at the front table. We also have joining us today Melissa Cohen and Richard Muniz from Planned Parenthood Foundation of America at the back table and Sarah Schaumburg and Laura Bakst from Wilmer Hale joining us.

THE COURT: Okay.

MR. FORSYTHE: Good afternoon, Your Honor. My name is Dan Forsythe, and I'm here with Tiffany Carwile and Ann Yackshaw. We are all with the Ohio Attorney General's Office. Thank you.

THE COURT: Tiffany, you feeling better?

MS. CARWILE: Yes, Your Honor. Thank you.

THE COURT: All right. I think I told you guys on the phone yesterday that we do have a jury that's deliberating, and if they come back with a question, or perhaps a verdict, we're going to have to stand in recess. Fair enough?

MS. ELLSWORTH: Yes, Your Honor.

THE COURT: Okay. I think we ought to just get right to the evidence, don't you guys?

MS. ELLSWORTH: We agree.

THE COURT: Okay. Call your first witness, please.

MS. ELLSWORTH: We're calling Dr. Lisa Keder.

THE COURT: Okay. Ma'am, come forward and face

Miss Crum. She's going to administer the oath or affirmation.

COURTROOM DEPUTY: You do solemnly swear or affirm the testimony you're about to give in this cause now in hearing shall be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: I do.

COURTROOM DEPUTY: Thank you, ma'am. Please have a seat. Would you like some water?

THE WITNESS: Yes, please.

THE COURT: Okay. I know it's a weird setup because I'm behind you. Normally I would say to any witness don't worry about me, talk to the jury, but we don't have a jury. So position yourself any way that you think makes you comfortable, but when you're ready, would you please state your full name and spell it so that Julie can take it down?

THE WITNESS: Dr. Lisa Keder. My last name is spelled K-E-D-E-R, and Lisa, L-I-S-A.

THE COURT: Thank you.

Okay, counsel.

MS. ELLSWORTH: May I proceed, Your Honor?

LISA KEDER, M.D., M.P.H

DIRECT EXAMINATION

BY MS. ELLSWORTH:

Q. Dr. Keder, could you please describe for the Court your current occupation?

A. I'm a obstetrician/gynecologist.
Q. And where are you employed?
A. I'm currently employed at the Ohio State University in Wexner Medical Center in OSU College of Medicine.
Q. And what's your title there?
A. I'm a professor of obstetrics and gynecology, vice chair of the Department of OB/GYN.
Q. All right. Dr. Keder, are you here to offer a medical opinion to the Court in this case?
A. I am indeed.
Q. I'd like to ask you just to generally summarize the opinions you intend to offer, and we'll go into them in greater detail later after we've gone through your qualifications.
First, do you have an opinion on the safety and efficacy of the fetal demise procedures that have been proposed by the State in this case?
A. I do. My opinion with regard to the requirement for fetal demise procedures is that this will adversely affect women's access to safe abortion care in the state of Ohio, putting them at increased risk associated with those procedures.
Q. And, Dr. Keder, do you also have an opinion on the impact of Senate Bill 145 or S.B. 145 on practitioners and access to care in the state of Ohio?
A. Yes. The requirement for fetal demise, because it does introduce an additional procedure which does not have benefit

to the patient, I think might result in practitioners who do perform dilatation and evacuation procedures in the state of Ohio to no longer do so. That would adversely impact access to care for patients in Ohio.

Q. And, Dr. Keder, let's start with your educational background, please. If you could please just describe for the Court your educational history beginning with college.

A. I went to undergraduate school here in Ohio, and after finishing undergraduate school at Oberlin College, I actually worked for several years at the State Department of Health, Maternal and Child Health Bureau, following which I entered medical school at Ohio State University. Medical school, as you know, is four years, and then when I completed that, I did four additional years of training which is obstetrics and gynecology residency, I did that at the University of Pittsburgh. And then I did an additional two years of training as a fellowship in family planning at the University of Pittsburgh.

Q. And are you currently practicing, actively practicing in the field, the field of obstetrics and gynecology?

A. Yes, I am. I practice full-scope obstetrics and gynecology in the course of my work.

Q. Are you Board certified in the specialty of obstetrics and gynecology?

A. I am a Board -- I am Board certified.

Q. In what state are you Board certified?
A. Board certification is a national certification.
Q. Do you practice in the state of Ohio?
A. I practice exclusively in the state of Ohio.
Q. Are you a member, Dr. Keder, of any professional medical associations?
A. Yes, I am. So I currently am a member of the American College of OB/GYN and a Fellow of the American College of OB/GYN. I'm also a member of the Society for Family Planning, the American Medical Association, the Ohio State Medical Association.
Q. You stated that you are the -- you're currently involved with The Ohio State University as an obstetrician and gynecologist. Could you just briefly describe for the Court your duties in your current role at Ohio State?
A. So as I said, I directly practice obstetrics and gynecology. So a couple days a week I see patients in an outpatient setting, and then in the inpatient care world, I deliver babies and I perform surgeries at the Medical Center. So a large portion of what I do is direct clinical care.
Because I'm the division director for general obstetrics and gynecology, in that capacity, I have direct oversight responsibility for 22 other physicians and 12 advanced practice clinicians who provide obstetrics and gynecology services in terms of direct services.

But because I hold a faculty position as well, I do direct instruction of both medical students and residents in the course of my practice as well.

And then I conduct research and do administrative tasks as required in terms of my administrative leadership roles.

Q. Let's talk a little bit about your faculty role. How long have you held a faculty or teaching role in the field of obstetrics and gynecology?

A. So as a resident, we have a teaching role as an instructor, and so as a fellow and a resident, we have an instructor role. And then when I joined the University, I became an assistant professor, and then I've essentially worked my way -- self up the ranks to full professor.

Q. You stated that some of the teaching you do is with residents. Do you provide direct instruction to residents?

A. I do.

Q. Are there any standards that govern the training curriculum that residents go through?

A. So there is a national organization, the Council on Resident Education in Obstetrics and Gynecology, also known as CREOG, which has essentially standards that are set for what should be included in residency training.

Q. And do you follow those standards?

A. Yes.

Q. Have you received any awards or recognition for your

teaching or training?

A. So most recently, I was the faculty mentorship -- well, there's a organization at OSU called the Faculty Association for Mentoring and Education, and I was selected as the Mentor of the Year for the College of Medicine of last year. I also was inducted last year into the Ellison-Mazzaferri -- sorry, Mazzaferri-Ellison, I said it in the wrong direction, Master Clinician Society which is an inaugural society of just 16 physicians from the Medical Center who are recognized as what are called master clinicians. I've also been the recipient on multiple occasions in the past of teaching awards from the resident physicians within our program for excellence in teaching care. And I'm a member of the Alpha Omega Alpha Society which is the honorary society for medical education which I received in medical school.

Q. Do you have any involvement in the Board certification process in Ohio?

A. Yes. So as I said, Board certification is a national process. And so in our specialty, folks, when they finish their residency training, take a written examination in the last year of residency training, and that's followed generally two years later by an oral Board examination. And I'm an oral Board examiner. So on a national basis, I examine people who have completed residency as they're trying to obtain Board certification.

Q. And how long have you been doing that?
A. About seven years.
Q. Have you authored or co-authored any peer-reviewed articles, Dr. Keder?
A. Yes. So my particular interest in terms of academic research is in contraception and family planning, and so the -- primarily my research is focused on contraception. And I have authored a number of different peer-reviewed articles in that area.
Q. Other than the current positions that you've already listed for the Court, have you held any other roles at Wexner Medical Center?
A. So I currently and have for actually a number of years served on the credentialing committee for the Institution, and I currently chair the credentialing center for the Medical Center. I've participated in a lot of other committee duties as well in my role, so I sit on the operating room committee, I sit on the practitioner evaluation committee which evaluates concern with regard to practitioner either behavior or malpractice-related issues, and I have sat on the ethics committee for the Medical Center as well in the past.
Q. Have you ever, Dr. Keder, have you ever been affiliated with any Planned Parenthood affiliate in the state of Ohio?
A. Yes. So I currently work as a contract physician for Planned Parenthood of Central or Greater Ohio. And in the

past, I served as the medical director for Planned Parenthood of Great -- of Central Ohio.

Q. And is there a difference between Planned Parenthood of Central Ohio and Planned Parenthood of Greater Ohio?

A. Planned Parenthood of Central Ohio was the local affiliate in the Columbus area before it merged with some of the other affiliates within the state to create Planned Parenthood of Greater Ohio.

Q. When you were the director of Planned Parenthood of Central Ohio, can you just briefly describe some of your responsibilities?

A. So I was responsible for adapting the national protocols that Planned Parenthood uses in terms of clinical care to the local affiliates as well as supervising a group of advanced practice clinicians in direct patient care and also in providing direct patient care myself.

Q. And you testified that you still operate as a -- is it a contract physician for the Planned Parenthood of Greater Ohio?

A. That's correct. That's correct.

Q. How frequently are you called upon to provide medical care at Planned Parenthood of Greater Ohio in that role?

A. So I haven't been there in about six to nine months because I have not been needed. And before that, it was probably about on a monthly basis.

Q. And, Dr. Keder, are you familiar with the methods of

abortion that are available in the state of Ohio?
A. Yes.
Q. What abortion methods are available to women in Ohio?
A. Well, women in the first trimester can undergo either surgical or medical abortion. And in the second trimester, abortion can be performed by either induction of labor or performance of a surgical procedure called a dilatation and evacuation.
Q. And is that sometimes referred to as D&E?
A. Yes, it is.
Q. Are you familiar with Ohio state law regulating abortion services?
A. Yes.
Q. Can you explain how those laws have impacted the availability of abortion care in the state of Ohio?
A. Sure. So there are a number of different laws with regard to the provision of abortion in Ohio. So Ohio law requires that women wait 24 hours between the time that they are counseled about abortion and the procedure is actually performed. So that leads to women needing to make more than one visit to an abortion provider before the procedure can be performed or the medical abortion can be initiated.
The law also requires that patients receive specific information with regard to abortion before the procedure is performed, so there's a State-developed brochure that describes

fetal development that must be offered to a patient before an abortion can be performed.

The State also requires that patients be informed about whether there's a fetal heartbeat present, and that determination needs to be done by the physician who is intended to perform the procedure and must be provided in writing to the patient.

Those are a few of the examples of things that are required of -- of the -- for the practice of abortion.

Q. You mentioned a 24-hour waiting period. How many visits typically does a woman seeking a D&E abortion in the state of Ohio have to make?

A. So the first visit is a counseling visit in which the patient receives information, goes through informed consent, often an ultrasound is done to determine gestational age, and a number of the things that I just described are done in terms of the compliance with state law.

The patient then, if they are use -- if they require cervical dilation in advance of the procedure, they make a second visit at which time normally something called laminaria are placed into the cervix which initiates the dilation of the cervix. And then a third visit is required for the patient to actually have the surgical procedure done.

Q. So typically three visits for a patient in the state of Ohio?

A. At least three visits.
Q. In your experience, do women report to you or indicate that they find the repeated visits to clinics difficult?
A. I certainly have had patients under that circumstance who have difficulty getting to the clinic for a variety of different reasons. Patients do come from more rural areas in Ohio to Columbus, a more metropolitan area, in order to receive services, so sometimes it's a fair piece in terms of drive. They have to take time off from work and arrange for child care, be out of school, those kinds of things.
Q. And aside from the various things you've already mentioned, are there any legal limitations in Ohio that affect the type of procedure that you can perform as a provider?
A. There are restrictions on Medicaid -- excuse me, medical abortion in terms of complying with the way the FDA has approved the use of mifepristone for administration for medical abortion, and there are restrictions on gestational age with regard to how late in pregnancy an abortion can be performed.
Q. Dr. Keder, approximately, over the course of your career, approximately how many women have you provided obstetrical and gynecological care to in general?
A. Tens of thousands.
Q. And do you have any experience delivering babies in the state of Ohio?
A. Yes, I do.

Q. Approximately how many babies do you think you've delivered?
A. I am not one of those doctors who keeps a running total, but I'm certainly in the thousands.
Q. And what experience do you personally have in providing abortion services in the state of Ohio?
A. Likewise, I've been practicing here for over 20 years, and so I've performed thousands of abortions.
Q. Have you performed all of the techniques that you were describing earlier in terms of the methods of abortion available?
A. Yes, I have.
Q. Are the majority of abortions that you perform in Ohio done in outpatient facilities or in a hospital?
A. Majority are performed in outpatient facilities.
Q. Is there a particular gestational age up to which you perform abortions in Ohio in an outpatient setting?
A. In the outpatient setting, the Planned Parenthood clinic goes up to 19 weeks six days.
Q. And how is the gestational age measured by care providers like yourself?
A. Gestational age is generally calculated based on the last menstrual period, and it is usually confirmed with ultrasound.
Q. Do you perform any abortions in Ohio outside of at the Planned Parenthood clinic?

A. So occasionally for medically indicated reasons, it needs to be done in a hospital setting.
Q. And do you personally perform those abortions in a hospital setting, if necessary?
A. Yes.
Q. Do the methods that are used or available to provide abortion services vary by gestational age?
A. Yes.
Q. What method is typically used to perform an abortion in Ohio after approximately 15 weeks gestational age?
A. So after 15 weeks of pregnancy, the procedure is generally referred to as a dilatation and evacuation.
Q. And that's also the D&E procedure; correct?
A. The D&E procedure.
Q. And approximately how many D&Es would you say you've performed in the state of Ohio?
A. Certainly hundreds, if not in the thousand range.
Q. Dr. Keder, you have two binders in front of you which are the joint exhibits the parties have agreed upon. If I could ask you --
MS. ELLSWORTH: And, Your Honor, you should have two copies of the binders as well.
THE COURT: I do.
Q. If I could ask you to look at tab 23 which is Joint Exhibit 23. It should be in the first binder.

A. 23?
Q. Yes.
THE COURT: It's your CV, Doc.
THE WITNESS: Yes. Found it. Thank you.
Q. Is that a copy of your CV?
A. Yes, it is.
Q. Is it an accurate summary of your educational and professional background?
A. Yes, it is.
MS. ELLSWORTH: Your Honor, I'd move to admit Joint Exhibit 23 into evidence.
THE COURT: That begs the question. If something's in the book, is it deemed admitted or do we have to individually move each exhibit as we go through?
MS. ELLSWORTH: Your Honor, from the plaintiffs' point of view, we'd be happy -- these are all agreed exhibits. We'd be happy to move them all in and avoid that. I don't know what the defendants' view is on that.
THE COURT: That's usually the purpose of a joint exhibit.
MR. FORSYTHE: Yes, we're fine with that understanding as well.
THE COURT: Okay. All right.
MS. ELLSWORTH: Then all the joint exhibits are admitted, so I don't have to admit that one.

Your Honor, at this point we would tender Dr. Keder as an expert witness pursuant to Rule 702 and specifically an expert in obstetrics and gynecology, including the provision of abortion care and second-trimester abortions in Ohio as well as resident training for obstetrics and gynecology and the training required to provide abortion care in Ohio.

THE COURT: Okay. That's all, of course, subject to cross-examination on qualifications and things like that, but I have no problem with her opinion based on what I've heard so far, but we'll see what happens.

MS. ELLSWORTH: Thank you, Your Honor.

Q. Dr. Keder, could you please describe for the Court your opinion on the general safety of abortion procedures?

A. So abortion is a very common medical procedure and a very safe overall medical procedure.

Q. When in the course of pregnancy do the majority of abortion procedures take place?

A. The majority of abortions are performed in the first trimester of pregnancy.

Q. And is that also true in the state of Ohio?

A. Yes.

Q. You referenced a few different types of abortion procedures earlier. In the first trimester, what are the types of abortion procedures available?

A. So the two types of abortion procedures that are done in

the first trimester are a D&C procedure, a surgical procedure which involves the cervix being dilated or opening -- opened, and then instrument being placed into the uterus which is a suction cannula which is like a small plastic piece of tubing. Suction is applied to that, and that removes the pregnancy from the uterus.

And the second method of first trimester abortion is the administration of medication, and that generally involves a combination of two medications, one called mifepristone and the second misoprostol, which are administered to the woman and result in spontaneous expulsion of the pregnancy as a result of those medications.

Q. When the pregnancy proceeds into the second trimester, are those methods of abortion still available to women?

A. So the first trimester of pregnancy is generally felt to end at about 13 weeks, and a suction D&C is still performed up to approximately 14 to 15 weeks depending on the individual practitioner's skill and expertise. Starting at about 15 to 16 weeks, it requires extraction of fetal tissue from the uterus which is a different procedure and then would be called a dilatation and evacuation.

Medical abortion in the way I described it is generally limited to the first trimester up to approximately nine weeks of pregnancy.

Q. Other than the D&E procedure, are there other types of

abortion available in the second trimester?
A. So the other alternative for abortion in the second trimester is induction of labor, and very rarely abortion could be done by what's called hysterotomy which essentially would be like a mini C-section type of procedure.
Q. Are induction of labor abortions available in an outpatient setting in the state of Ohio?
A. No, they're not.
Q. Why not?
A. Induction of labor generally takes somewhere between, well, as little as maybe eight hours but usually more on the order of 24 hours to induce labor and may take several days. It is associated with a relatively high risk of retained placenta which can require surgical intervention in the episode of where there might be heavy bleeding or the pregnancy does not completely pass. So in order for the medication to be administered and the patient to be adequately monitored, those procedures are typically done in an inpatient setting in a -- most often in a labor and delivery suite.
Q. In your experience, how common are induction abortions as compared with D&E abortions in the state of Ohio?
A. Induction abortion represents a really small percentage of second-trimester procedures.
Q. And why are induction abortions uncommon or such a small percentage, in your opinion?

A. Well, in my experience, women, when they're faced with the decision to terminate a second-trimester pregnancy, often find the thought of laboring to be very unpleasant, and so they often choose D&E over induction of labor based on personal considerations. And then access to hospitals that can provide that service is limited in the state as well.

Q. Are induction abortions typically more expensive than the D&E procedure, in your experience?

A. Exceedingly more expensive because of the hospital stay.

Q. Are there any risks associated with induction abortions?

A. Yes. So induction abortion is associated, as I said, as a potential for retained placenta, so in as many as 25 percent of patients may require surgical -- excuse me -- surgical procedure to remove the placenta, and increased risk of hemorrhage and infection in comparison to dilation and evacuation.

Q. Are the risks of induction abortions greater than the risks associated with the D&E procedure?

A. Yes, they are.

Q. Could you please, returning to the D&E procedure, could you please describe for the Court the first step or the first phase of the D&E abortion procedure?

A. So usually in the second trimester of pregnancy, a procedure is done the day before the actual surgery, and that procedure involves placing something called laminaria into the

cervix. Laminaria are compressed seaweed product which then absorbs water slowly and dilates the cervix over the 24 hours preceding the actual surgical procedure.

Q. And then what is the second phase or stage of the D&E procedure?

A. Then the second stage of the procedure is the actual surgical procedure in which the patient undergoes the surgery. The laminaria are removed. If the cervix needs to be further dilated, that's done so by using instruments in the operating room. And then the pregnancy is removed from the uterus using combination of suctions and instruments to remove the fetal and placental tissue.

Q. And that's referred to as the evacuation phase?

A. That's correct.

THE COURT: Would you guys let me interrupt for a second?

Julie, would you like everybody to slow down a little bit?

COURT REPORTER: That would be great.

THE COURT: Thank you. Okay.

MS. ELLSWORTH: Thank you, Your Honor. Sorry. We'll try and slow it down.

THE COURT: That's okay.

Q. Dr. Keder, how long does the second phase of the D&E procedure typically take?

A. The surgical procedure generally takes somewhere between 10 and 15 minutes to perform.
Q. Can a physician form -- excuse me, perform the first step of the D&E procedure, the dilation step, but not proceed to the second step?
A. It's not advisable to do so because once the cervix is dilated, the patient is at risk of ruptured membranes, infection. If she was to try to take the pregnancy on, the risk of pre-term delivery is also a concern.
Q. In your medical judgment, is it safe for a patient to have a dilation procedure and not proceed forward with the evacuation procedure?
A. It would raise the concern with regard to the things that I just mentioned, so it's not something that I would ever advise. There is occasionally patients who might change their mind and decide to do that, but it would not be medically advisable.
Q. And in your opinion, is the D&E procedure in particular a safe method of abortion?
A. Yes, it is.
Q. Let's turn, Dr. Keder, to your first opinion relating to the fetal demise procedures offered by the State.
Let me first ask, do you currently perform demise prior to a D&E in your practice in Ohio?
A. No, I don't.
Q. Why not?

A. The procedures that are used for fetal demise are, in my opinion, add an element of risk to the procedure which is not necessary for successful completion of the surgical procedure.
Q. Can I ask you, please, to look at Exhibit 35 which is in the second binder. JX 35. And do you have that in front of you?
A. I do.
Q. What is the -- what is JX 35?
A. This is a Practice Bulletin from the American College of Obstetrics and Gynecology entitled "Second-Trimester Abortion."
Q. First, can you please explain for the Court what is the American College of Obstetrics and Gynecology?
A. The American College of Obstetrics and Gynecology is our primary professional organization for obstetricians and gynecologists. It produces continuing medical education --
THE COURT: Slow down.
THE WITNESS: Sorry.
A. It produces continuing medical education programs. It produces Practice Bulletins. It issues committee opinions with regard to practice of obstetrics and gynecology.
Q. Is it sometimes referred to as ACOG?
A. It is always referred to as ACOG.
Q. Is ACOG an organization whose opinions and research you rely upon in the course of your work?
A. Yes, it is.

Q. Does this document, JX 35, address the question of fetal demise?
A. Yes, it does.
Q. And do you rely upon this document to support your opinions in this case?
A. I do.
Q. If you could turn, please, to the bottom of page three of JX 35. Do you see a section entitled "Effecting Fetal Demise"?
A. Yes.
Q. Can you please read slowly the first two sentences of that section?
A. "No evidence currently supports the use of induced fetal demise to increase the safety of second-trimester medical or surgical abortion. Techniques used to cause fetal demise include division of the umbilical cord, intra-amniotic or intrafetal digoxin injection, or fetal intracardiac potassium chloride injection."
Q. And did you rely upon this statement of ACOG in forming your opinions in this case?
A. Yes, I did.
Q. Do you understand that there are some doctors in Ohio that already attempt demise prior to performing a D&E procedure?
A. Yes, I have heard that's the case.
Q. And given your experience in the field, what is your understanding as to why certain doctors currently attempt

demise at certain gestational ages?
A. So on a even national level, I think that the process of especially digoxin injection really centered around people's concern with regard to the federal abortion ban that's called partial-birth abortion ban when physicians were concerned that if they did not create fetal demise prior to the procedure, that they might be in violation of that ban.
Q. Is it your understanding that any physician in the state of Ohio that attempts demise currently does so for reasons of medical necessity?
A. Not -- not to my knowledge, no.
Q. Your understanding is that it's the result of the legal strictures surrounding abortion?
A. That's correct.
Q. How does, based on your understanding of the field, how does the use of digoxin to attempt demise help some doctors ensure compliance with what's the so-called partial-birth abortion ban?
A. The partial-birth abortion ban precludes a certain procedure in which a live fetus is brought to certain anatomical landmarks and then the demise is initiated with surgical instrumentation. And so I think that physicians were concerned that if in the midst of a procedure they were faced with the situation where they felt like that was happening, that they could be, you know, prosecuted under the

partial-birth abortion ban. So if they initiated something that created fetal demise prior to the surgical intervention, they would be protected from being accused of that.

Q. Is it your understanding that the physicians that currently attempt demise in the state of Ohio ensure that demise has occurred before proceeding forward with any D&E procedure?

A. I honestly don't know about the physician necessarily in Ohio, but I know from looking at the literature with regard to digoxin injection that many places that do digoxin administration actually don't necessarily wait if it's ineffective in terms of causing demise to happen.

Q. And based on your review --

A. I'm sorry, don't necessarily wait if demise hasn't happened to go ahead with the surgical procedure.

Q. And your understanding and interpretation of the partial-birth abortion ban laws, which you're also subject to, is that demise is not required to be successful in order to comply with that law; is that correct?

A. That's correct.

Q. Is there a difference, in your understanding, of the Senate Bill 145 law that's at issue in this litigation?

A. Yes. My understanding is that it would require that demise occur prior to initiation of the surgical procedure and that you could not proceed with the surgical procedure if demise had not occurred, except in very limited situations in which it

might be a life-threatening situation to the patient.
Q. And so in your opinion, how is the use of demise procedures to comply with the partial-birth abortion ban law different than the mandate of S.B. 145, should it go into effect, to perform demise prior to a D&E procedure?
A. Well, the mandate requires that the practitioner create fetal demise prior to the surgical procedure, and it's exactly that, it's a mandate, and so it adds an additional procedure that does not hold benefit to the patient. And the partial-birth abortion ban has an intent clause in it which means -- is my understanding means that when you enter into the procedure, as long as your intent is not to perform this procedure but it's to perform a standard D&E, that you're not in violation of that ban.
Q. And, Dr. Keder, we'll talk about some of the demise methods proffered by the State in a moment, but before we do that, are you familiar with the declaration of Dr. Valley that was submitted by the State?
A. Yes.
Q. And you reviewed that in connection with your testimony today?
A. I did.
Q. Are you familiar with the studies that are cited by Dr. Valley and the State in that declaration and in their papers?

A. I did review those studies, yes.
Q. Have you reviewed the evidence that the State has offered suggesting the -- suggesting that demise may be prevalent in the United States, excuse me?
A. I did see that in his declaration.
Q. Do you agree with that statement?
A. I do not agree with that.
Q. And why not?
A. Because there have been survey studies that have showed that the majority of abortion providers who perform D&Es do not initiate demise prior to the surgical procedure.
Q. Let's look, please, Dr. Keder, at JX 37 which is behind tab 37 in your binder. What is this document, please?
A. This is an article from the journal Contraception entitled "Second-trimester surgical abortion practices in the United States."
Q. Is this an article that you reviewed and relied upon in connection with arriving at your opinion today?
A. It is.
Q. Do you find it to be a reliable article?
A. Yes.
Q. Is Contraception a journal that you're familiar with?
A. Contraception is a journal which is a peer-reviewed journal. It's the primary journal for contraceptive-related and abortion-related research that's in the U.S. press.

Q. If you would, Dr. Keder, if you could turn to what is numbered as page 98 of Exhibit 37. It's also numbered 37.4 on the bottom of the page.
A. Yes.
Q. Does this study provide some information about the prevalence of demise procedures in the United States?
A. Yes, it does.
Q. Could you please describe to the Court what this document indicates?
A. So under -- in this document on page 98 under the section that's 3.6, "Induction of fetal demise," the authors state: "In 2012, 74 percent of clinicians who reported performing D&Es at 18 weeks or greater did not routinely induce preoperative fetal demise."
Q. And is that consistent with your understanding based on your years of practice?
A. Yes, it is.
Q. How does the -- this study at JX 37 compare with some of the studies cited by Dr. Valley in support of his view of the prevalence of fetal demise methods?
A. So this study is a attempt to attain a national sample of abortion providers who perform D&E, and so it represents a much broader area, or excuse me, accumulation of data from around the country than the studies on which he relied.
Q. Does the gestational age factor into any of the studies on

the prevalence of demise that you reviewed or that Dr. Valley cites?

A. Yes. So the later in pregnancy, the more likely a practitioner would be to consider induction of fetal demise prior to the procedure. So in a -- procedures where a practitioner might be performing at 22 weeks or above, they're more likely to cause fetal demise to avoid the potential for extramural delivery of the live-born fetus.

Q. And in the state of Ohio, is there a gestational age beyond which abortions cannot be performed unless medically necessary?

A. Yes. That's 22 weeks.

Q. Do any of the studies that were cited by Dr. Valley in his declaration alter your view about the prevalence of demise among abortion providers?

A. No.

Q. Based on your knowledge and experience, do you believe that causing demise before the D&E procedure offers any medical benefits to the patient?

A. No, I do not.

Q. Does medical literature support the opinion that demise confers any medical benefits on patients?

A. No, it does not support demise.

Q. In your opinion, does requiring successful demise prior to a D&E procedure create medical risks for the patient?

A. In that it requires an additional procedure to be done

which has risks associated with it, it confers additional risk to the patient beyond just the surgical procedure itself.

Q. Let's turn, if we can, to the three demise procedures that have been offered by the State. But, first, let me just ask are you familiar with the three demise methods that are proffered here?

A. I have read about these three options, yes.

Q. Let's start with digoxin. Are you familiar with the demise method using the drug digoxin?

A. Yes.

Q. Can you explain to the Court what digoxin is, please?

A. Digoxin is a medication which has effect on cardiac function, and so with installation into the amniotic fluid or into the fetus itself, it interrupts conduction of the impulse to cause the heart to beat and stops the heart from beating.

Q. How is a demise procedure utilized in digoxin administered?

A. It's administered in as an injection, and so the injection can either be done transabdominally which is in taking a long needle and placing it through the woman's abdominal wall into the pregnancy and entering either just the fluid around the pregnancy or actually into the fetus and injecting the medication, or it can be done by a similar procedure but done transvaginally so that the medication or the needle is introduced through the cervix or the vaginal wall into the uterine cavity, but that's done -- but done through the vagina

rather than abdominally.
Q. Are those two procedures, whether it's intra-abdominally or intravaginally, are those difficult procedures to perform?
A. They would require skill and expertise, yes.
Q. How long does digoxin take to work, to effect demise?
A. So the one study that I could find that looked at that issue documented that at four hours after administration, it was unlikely to stop -- have stopped the heartbeat, but by 24 hours, the -- there was relatively good success in terms of that, that time frame. So it takes a number of hours, probably in the order of 20 to 24 hours.
Q. And when does a physician know that demise has in fact been effective if the physician is looking to perform a D&E procedure?
A. At the time of the procedure is actually scheduled to be performed typically.
I meant the surgical procedure is scheduled to be performed.
Q. You described the intra-abdominal injection of digoxin. Are there risks associated with that particular method of administration?
A. So, as I said, this involves taking a needle and placing it through the abdominal wall into the uterus, and so there's a risk of introducing infection into the uterus in that process. There's also a risk of creating a tear in the membranes that

surround the pregnancy resulting in ruptured -- rupturing of those membranes and leakage of amniotic fluid. There would be a risk that the patient might begin laboring as a result of either of those things as well.

Q. And what about the other method of administration, intravaginally, are there risks associated with that?

A. Likewise, that would also involve essentially the same risks.

The other risk that I didn't talk about is the potential for injury to vessels surrounding the uterus. So if a vessel was inadvertently punctured with the needle, there's a potential for bleeding as well.

Q. When digoxin is administered, does it have to be injected directly into the fetus?

A. It can be injected either into the fetus or into the amniotic fluid surrounding the fetus.

Q. Are injections into the amniotic fluid surrounding the fetus, are those difficult to administer as well?

A. In that one has to be skilled at doing essentially what's an amniocentesis in order to place the needle into the correct location.

Q. And based on your current role in training obstetric and gynecological doctors, excuse me, are medical providers trained in amniocentesis?

A. So amniocentesis is actually relatively infrequently

performed in this day and age because of the advances in terms of prenatal diagnostic testing, and so residents do not -- don't have a requirement to actually have performed amniocentesis during their residencies. They need to understand what the technique is, you know, what the relative indications and risks associated with it would be, but they don't -- they aren't actually trained to do it in residency in this day and age.

Q. Has that training changed or evolved over time?

A. It has just with the infrequency, but still even many years ago when I trained, it was still an infrequently performed procedure.

Q. Are there medical providers who are typically trained in amniocentesis even today?

A. So the majority of amniocenteses are done by maternal-fetal medicine specialists.

Q. And is there additional training required to be a maternal-fetal medicine specialist?

A. So after completing a obstetrics and gynecology training program, maternal-fetal medicine fellowships are a three years of additional training after residency.

Q. In your experience, do most abortion providers in Ohio have the maternal-fetal medicine credential?

A. No.

Q. And based on your knowledge and experience, how easy is it

to obtain a maternal-fetal medicine credential in Ohio?
A. Well, as I said, it would require three years of additional training, and so it requires a reapplication process to enter a fellowship.
Q. Do digoxin injections carry any medical risks to the patient?
A. So patients experience side effects from digoxin, the most common of which is nausea and vomiting. There would be a small risk if the patient had an underlying cardiac issue that it, if when absorbed into the circulation, could affect maternal cardiac function as well.
Q. Do digoxin injections carry any risks associated with earlier delivery or earlier onset of labor?
A. Yes. So there's the potential for early onset of labor once digoxin has been injected.
Q. And is that -- if labor occurs outside of a hospital or medical setting, does that have a term that's used in the literature?
A. It's commonly referred to as extramural delivery which means delivery outside of the healthcare setting.
Q. And based on your review of the medical literature and knowledge of the medical research, is extramural delivery -- the risk of extramural delivery increased by digoxin use?
A. By -- yes, it is.
Q. Are you aware of any scientific or medical research that

documents the risks of digoxin use?
A. So there are a number of published studies in the literature that have looked at digoxin use and the potential side effects and risks associated with it.
Q. And those are some of the studies that you've cited in your declaration; correct?
A. They are.
Q. As a sort of a general sort of overview matter, what does the medical research show about the risks of digoxin to patients?
A. So one study in particular with the author Dean showed that the risk of infection and the risk of extramural delivery were increased in patients who had undergone digoxin administration in comparison to those who had just had D&E procedures without digoxin administration.
Q. Are there other studies that have examined the risk of infection and hemorrhage and extramural delivery in connection with digoxin use?
A. Yes, there are.
Q. Are the risks to the patient of digoxin use uniform throughout all gestational ages?
A. So, I'm sorry, could you repeat the question?
Q. Sure. Are the risks to the patient of digoxin use, are they uniform, are they the same regardless of what gestational age the pregnancy may be?

A. Well, if we're looking at the outcome of creating fetal demise, it appears that that risk of that failing may increase with the increasing gestational age further into pregnancy.

Q. And I'll remind you just to try and slow down a little bit, Dr. Keder.

A. Thank you.

Q. Are there medical studies that have examined digoxin use at earlier gestational ages than 18 weeks?

A. So I could only find really one study in the literature that had documentation to 17 weeks of gestation, and beyond that, there really is no research that addresses digoxin administration at all.

Q. And the study that you reviewed that touched on 17-week gestations, did that provide any information about how digoxin might affect a 17-week pregnancy versus an 18-week pregnancy?

A. It really didn't because it really did not specify how many pregnancies were in that age range and it described the pregnancies by biparietal diameter which is a measure of fetal size rather than gestational age, so it made that particular study difficult to gain any understanding in that -- in that age of 17 weeks.

Q. Does the lack of data or study on digoxin use prior to 18 weeks create any concerns for you in your opinion?

A. It does. Because I think if we -- if the law requires that we administer digoxin prior to D&E below 18 weeks, it's really

an experimental procedure.
Q. And why do you have concerns about an experimental procedure being required?
A. Because we don't do experimental procedures without patient consent that they're undergoing an experimental procedure and it's not of proven benefit. So without understanding that it has benefit to the patient, it would put me as a physician in a difficult ethical quandary to be required to do something that I consider to be experimental without benefit.
Q. Are you familiar with Dr. Valley's opinions about the feasibility of digoxin injections throughout the second trimester?
A. Yes.
Q. What is your view of that opinion?
A. So he, I believe, in his declaration indicated there was no difference between a 15-week pregnancy and a 17-week pregnancy, and I just think that's wrong because with every week that a pregnancy advances in terms of gestational age, the pregnancy changes in terms of size, the uterus becomes larger, the amount of amniotic fluid changes in relationship to the fetus, and the fetus gets larger.
Q. Does Dr. Valley cite any evidence for the safety and efficacy of digoxin injections in the 15- to 17-week period?
A. No.
Q. Let's take a look at JX 5 which is in the first binder,

please, Dr. Keder. What is JX 5, please?
A. This is an article from the journal Contraception entitled "Effectiveness and safety of digoxin to induce fetal demise prior to second-trimester abortion."
Q. And this is an article where the lead author is a Michael Molaei; correct?
A. Correct.
Q. Is this the study that you were referring to that references 17-week pregnancy digoxin use?
A. Yes.
Q. And does the study provide any information that you would be comfortable relying on about use of digoxin at 17 weeks?
A. No, it does not.
Q. Can you please explain for the Court why the gestational age is important for understanding the risks that may attend the injection of digoxin?
A. Certainly. So, as I said, the pregnancy through development changes, obviously, in size over the course of gestation, and so what might be technically challenging at 20 weeks potentially to do an amniocentesis might become actually very difficult to do at 14 or 15 weeks of gestation. So the target in terms of introduction of a needle into the amniotic fluid around the pregnancy becomes more challenging the smaller the uterus is. And if injection into the fetus is the desired target for the digoxin introduction, then that becomes even

more challenging the smaller the fetus is.
Q. And are there differences in the efficacy of digoxin depending on whether it's injected intra-amniotically versus intrafetally?
A. Yes. So the literature seems to support that introduction, or, excuse me, installation of digoxin into the fetus itself is more effective in terms of causing fetal demise than is intra-amniotic injection.
Q. And might the dosing that a doctor needed to use or the amount of digoxin that a doctor needed to use increase if the only injection site that was available was intra-amniotic?
A. Yes. Potentially.
Q. And with greater amounts of digoxin, do the risks and side effects to the patient increase as well?
A. Yes.
Q. In your medical opinion, does gestational age impact the relative effectiveness of a digoxin injection if one is given?
A. Well, again, we don't have really any data less than 18 weeks to really rely upon, so I could not really offer an opinion about the effectiveness below 18 weeks of pregnancy.
Q. Are digoxin injections safe for the patient after 18 weeks, in your medical opinion?
A. I'm sorry, could you repeat the question?
Q. Sure. Is the use of digoxin after 18 weeks of gestation, is that safe for the patient, in your medical opinion?

A. Well, if it was necessary from the medical point of view, I would say it's safe from the point of view that it has a relatively low risk of complication. But in the situation in which it's not medically indicated, it would carry risks that I would not advise.

Q. In your medical practice, are you weighing risks and benefits in making medical decisions?

A. Every day.

Q. Can you describe for the Court some of the risks that are inherent in digoxin use at whatever the gestational age?

A. So the risks of digoxin would be the potential for digoxin toxicity to the mother. The side effects associated with that would include nausea and vomiting. The potential for cardiac effects, especially if the dosage was increased. The risk of digoxin introduction would include, as I previously stated, the risk of infection being introduced into the uterus, the risk of ruptured membranes, the risk of onset of labor outside of the hospital setting or an extramural delivery.

Q. You testified earlier that you are aware there are some providers who do use digoxin after 18 weeks to comply with the partial-birth abortion ban law; correct?

A. Correct.

Q. And are you aware that there are some Planned Parenthood affiliates in Ohio that use digoxin after 18 weeks?

A. I have heard that, yes.

Q. Why do you understand that to be?
A. Again, I think that the concern is with regard to the partial-birth abortion ban.
Q. In the medical literature that you reviewed relating to digoxin use, are there any references to the partial-birth abortion ban being an impetus for the use of digoxin?
A. Yes. In fact, in the majority of the literature that describes the use of digoxin, it appears this is the impetus for institution of digoxin institute -- use was with regard to the partial-birth abortion ban.
Q. Dr. Keder, if you could please look at tab 4 of your binder which is JX 4. What is the document at JX 4, please, Dr. Keder?
A. So this is a Clinical Guideline from the Society of Family Planning entitled "Induction of fetal demise before abortion."
Q. What is the Society of Family Planning?
A. It is a professional organization for physicians who are interested in family planning.
Q. If I could ask you, please, to look at page 470 of JX 4. In the section "Important questions to be answered," do you see that?
A. Yes.
Q. If you could look towards the bottom of the large paragraph beginning with, "If RCTs were to demonstrate," do you see that sentence? Third paragraph.

THE COURT: Hang on a second. Let me catch up to you. Where?

MS. ELLSWORTH: I'm sorry. It's the third paragraph under "Important questions to be answered."

A. Okay. And the sentence starting, "If RCTs"?

Q. Yes.

A. Okay.

MS. ELLSWORTH: Your Honor, do you see that?

THE COURT: Yes, I've got it.

MS. ELLSWORTH: Thank you.

Q. Dr. Keder, could you please read those sentences?

A. Sure. Starting with that one?

Q. Yes, please.

A. "If RCTs --" and can I inject that that means randomized controlled trials.

Q. Thank you.

A. The kind of gold standard medical study.

"If RCTs were to demonstrate that feticidal agents improved the safety of second-trimester D&E, large observational studies will be needed to quantify the risks of the intervention. These risks include extramural expulsions, infection, and possible changes in abortion safety. To justify the harm of the documented increase in spontaneous labor and extramural delivery, along with an increase in vomiting seen in the one blinded digoxin randomized controlled trial, in addition to any

more infrequent risks, a significant increase in D&E safety would seem to be warranted."

Q. And if you could just put that in nonmedical terms for me, at least, if not for the Court, what do you take from that to be the conclusion of the Society of Family Planning?

A. So I believe what they're trying to say there is that to justify using digoxin, one would have to observe a significant increase in safety of D&E to justify its usage.

Q. And do you agree that that would be required to justify the usage of digoxin?

A. Yes.

Q. Based on your experience and the medical literature, does digoxin increase the safety of the D&E procedure?

A. No, it does not.

Q. Does digoxin potentially have the opposite effect on the D&E procedure?

A. It has a potential to have the opposite effect to increase the risk of the procedure.

Q. Dr. Keder, aside from the risks that digoxin presents to the patient that you've already discussed, is it always even possible to provide digoxin in every case?

A. No. So there are a number of things that might preclude doing an injection into the uterus. So those would include significant maternal obesity. They would include uterine abnormalities such as large fibroids or previous surgical

procedures which might somehow scar the uterus into a position in which the cavity was inaccessible or that might create adhesions of bowel or something in front of the uterus that would preclude intra-amniotic injection through the abdominal wall.

Q. In your experience treating patients in Ohio, Dr. Keder, is obesity common among patients in Ohio?

A. About 33 percent of Ohioans are obese.

Q. And in your experience, are uterine malformations like fibroids, et cetera, are those common in the state of Ohio?

A. Fibroids are very common.

Q. And on what do you base that knowledge?

A. My own personal experience caring for women in Ohio over the last 20-plus years.

Q. If digoxin is able to be administered, is it always effective in causing demise?

A. It is not.

Q. What's your understanding of the failure rate of digoxin?

A. The failure rate of digoxin has a pretty wide reported incidence in the medical literature, but in the order of about 8 percent or so, 8 to 10 percent.

Q. To your knowledge, is there any way to know in advance whether a digoxin procedure is going to fail for a particular patient?

A. No.

Q. Based on your knowledge and experience, when would a doctor know that in fact digoxin had failed to effect demise?
A. So it would require ultrasound evaluation which is typically done on the same day as the surgical procedure would have been scheduled.
Q. And under your understanding of Senate Bill 145, if digoxin had been administered but failed to effect demise, would the provider be able to continue with the D&E procedure?
A. No.
Q. And based on your medical knowledge, if digoxin fails, would the provider be able to attempt a second injection of digoxin?
A. That could be entertained as an option. I think it would carry, again, additional risk to the patient of doing so.
Q. Are you aware of any doctors in Ohio or anywhere who currently use a second digoxin injection in the event the first one fails?
A. I'm not aware of that, no.
Q. Are you aware of any medical studies on the risks or safety of a second digoxin injection?
A. I am not.
Q. If in the event that digoxin did fail to effect demise, what are the choices that a provider would be left with if S.B. 145 goes into law?
A. Well, one option would be, as we just talked about, a

second injection, but there's, you know, the safety of that is undocumented.

A second one would be to resort to some other procedure that would cause demise to happen, but, again, would additionally carry risk to the patient.

Third option would be to not perform the procedure, but usually digoxin is administered the same time as laminaria, so the cervix has already been dilated at the time that you would discover that the procedure had been ineffective in causing fetal demise.

And then, you know, the only other option would be to complete the surgery, but you would be, you know, as a physician, at risk of having -- of, you know, violating the law.

Q. And what are the types of risks that would be presented to a patient in the event digoxin failed to cause demise and the surgery could not be completed under S.B. 145?

A. So there would be the ongoing risk of infection developing after intra-amniotic injection. And then if laminaria had been placed and had to be removed, there would be the risk of the patient developing ruptured membranes with infection or pre-term delivery as a result of the cervix having been dilated.

Q. And in your medical judgment, would it be safe for the patient to stop the procedure at that point in time?

A. Certainly it would not be advisable medically.
Q. In your medical opinion, would a failed demise attempt using digoxin, for example, put the patient in a situation where she was at serious risk of substantial and irreversible impairment of a major bodily function?
A. No.
Q. Why not?
A. Well, that terminology, to me as a physician, means that the patient's likely going to die if I don't intervene immediately.
Q. And is that a position that you think a failed demise procedure would place a patient in?
A. No. Although the failed demise procedure, as I said, has risks, I don't think it meets the standard that you just quoted in terms of immediate bodily harm.
Q. And that standard I quoted is what you understand to be the, quote, medical exception to the statute?
A. Correct.
Q. Dr. Keder, based on everything you've looked at and everything you've said today, what is your opinion on mandating the use of digoxin to successfully cause demise prior to a D&E?
A. So I think that this puts physicians in a difficult position in that we want to provide the best care that we can for patients, and it requires that we do a medically unindicated procedure to a patient which would put her at

increased risk of having complications associated with the procedure.

Q. And in your medical judgment, is the -- a mandating the use of digoxin to successfully cause demise something that's in the best interests of patients in the state of Ohio?

A. No, it's not.

Q. And in your role as a physician and a provider of abortion services in the state of Ohio, what would the effect of a state-mandated use of digoxin be on your own practice?

A. So in my own case, I would have to consider no longer performing this procedure. I think it's a difficult position because on the one hand, I'd like to assure access to needed services for patients, but on the other hand, I do not want to put patients at increased risk by doing procedures which are medically unnecessary.

Q. Dr. Keder, you're familiar -- are you familiar with the form of or the demise procedure that's described as umbilical cord transection?

A. Yes.

Q. Is that a procedure that you use when providing abortion services?

A. Not routinely, no.

Q. Is it sometimes referred to as UCT?

A. Yes.

Q. Could you please describe the procedure known as UCT?

A. So umbilical cord transection is a description of grasping the umbilical cord and interrupting the blood flow from the -- of the placenta to the fetus in the course of doing the procedure prior to any other extraction of fetal tissue from the uterus.

Q. And based on your medical knowledge, how long after a successful umbilical cord transection would demise occur?

A. In the one reported study in the literature, up to 11 minutes.

Q. And what would the condition of the patient be while a physician waited for demise to occur for potentially up to 11 minutes?

A. So I think it's really important to understand kind of what the patient would be undergoing in the circumstance. So this would be a patient that we actually have on the operating room table, legs in stirrups. We've removed laminaria. We've ruptured membranes. And then we're reaching into the uterine cavity and attempting to locate the umbilical cord and interrupting the umbilical cord and then waiting with ultrasound visualization to see if we can detect when the fetal heartbeat stops.

Q. And would the patient be at risk for any complications during that waiting period?

A. So a typical abortion procedure, as I previously said, takes about 10 to 15 minutes to perform in the second

trimester, so this could potentially double the amount of time that's required to complete the surgery. The longer a patient is under anesthesia, the more risk there is. The longer it takes for us to complete a procedure, the greater the risk of infection potentially is. It also requires reaching into the uterine cavity to find an umbilical cord which might require that we reach multiple times into the uterine cavity or more times into the uterine cavity than we typically would which might increase the risk of injury to the cervix or the uterus. And there's the potential if the patient starts bleeding while we're waiting for fetal demise to occur, that she could have an increased blood loss associated with the procedure.

Q. Are there any medical benefits to the patient from a UCT procedure?

A. No.

Q. Is the umbilical cord transection always technically feasible?

A. Not in my experience.

Q. And when would it become impossible?

A. Well, once ruptured membranes has occurred during the course of the abortion procedure, the fluid around the fetus is gone, and that makes direct visualization of structures within the uterus more difficult ultrasonographically. So it would be difficult to guide the instruments in the uterus to accurately detect where the umbilical cord was located, and so that would

make the procedure technically maybe difficult to do.

There also, the smaller the fetus and the umbilical cord are, the less likely one would be able to successfully identify what the cord is versus what is fetal tissue.

Q. In cases where the cord is difficult to locate, what would the doctor be doing in order to attempt to locate it to perform an umbilical cord transection?

A. I'm sorry, could you repeat the question?

Q. Sure. In a case where the cord is difficult to locate, what would a doctor be doing to attempt to locate the cord, what activities would the doctor be doing?

A. I would imagine that the doctor would have an assistant who would be using an ultrasound to try to identify structures within the uterus and the doctor would have an instrument inside the uterus attempting to see if they could locate the cord by trying to grasp it or using a suction device to try to pull the umbilical cord through the cervix so it could be visually identified.

Q. And you mentioned earlier that one of the risks associated with the UCT procedure was the potential for multiple passes through the cervix; is that right?

A. Correct.

Q. Why does that create a risk?

A. Because every time we introduce an instrument into the uterine cavity, we're placing it through the vagina which is

not a sterile environment, so there's increased risk of introducing infection. We're placing instruments through the uterus -- excuse me, through the cervix which can traumatize the cervix, and the potential also for uterine perforation exists as well.

Q. In your practice and medical opinion, is it advisable to make more passes through the cervix or uterine cavity than necessary?

A. No. In fact, when I teach these techniques to my trainees, I try to encourage them to use the minimal number of times as possible, again, to decrease the risk of infection or trauma.

Q. You mentioned also that it can be difficult to locate the umbilical cord and potentially to discern it from other fetal tissue; is that right?

A. That's correct.

Q. How likely is it that a physician attempting to perform umbilical cord transection would grasp other tissue?

A. I think it's highly likely that that would be possible.

Q. And would grasping other fetal tissue while attempting to perform a transection create any concerns in your mind?

A. Yes, it would because it would violate this Act if they did that.

Q. Are there any differences in the feasibility of performing a transection at earlier gestational ages versus later?

A. Well, as I said, there is very minimal literature on this

subject, but from a theoretic point of view with my medical knowledge and experience doing procedures in all of these different gestational ages, the smaller the fetus is and the smaller the -- the smaller the umbilical cord is, and so earlier in pregnancy, I'd say 15 or 16 weeks, I think it might be very difficult to identify the umbilical cord.

Q. Is it possible to know in advance of beginning an attempted UCT procedure if it will be feasible in a given patient?

A. No, I don't think it is.

Q. You've mentioned, Dr. Keder, that you don't typically perform the UCT procedure; is that right?

A. That's correct.

Q. Have you attempted to perform it in the past?

A. I have.

Q. Were you successful?

A. In one out of two times when I tried to do so.

Q. So you have a 50 percent success rate?

A. Correct.

Q. In your medical opinion, if a doctor experiences, like you did, an unsuccessful umbilical cord transection for a particular patient, what choice is that doctor faced with under S.B. 145 if it goes into effect?

A. Well, again, I think the physician would have to resort to some other technique potentially or to stop the procedure.

Q. And what would the risk to the patient be of stopping the

procedure while an umbilical cord -- after a failed umbilical cord transection?

A. Well, we just talked about all the risks associated with not completing the procedure after digoxin, but in this case now you have definitely ruptured membranes, you've introduced instruments into the uterine cavity, so the risk would be even greater potentially for hemorrhage and infection for this patient.

Q. Would it be, in your medical opinion, safe for the patient to not see the procedure through at that point in time?

A. No, it would not be safe for the patient.

Q. Would, in your medical opinion, would the patient meet the criterion set out by the Bill for medical necessity?

A. Again, I think the way medical necessity is outlined in this Act, that the patient would essentially have to be dying in order for me to feel like my intervention was warranted.

Q. You mentioned that the umbilical cord transection procedure has not been the subject of a lot of medical analysis. Is there any research or study on the safety and efficacy of UCT that you're aware of?

A. So there's one published study that I'm aware of.

Q. And is that a study referenced by the State by a Dr. Tocce?

A. Yes.

Q. All right. If you could look, please, at tab 14 of your binder which should have JX 14 behind it.

A. Yes.
Q. And what is the title of this study, please?
A. The title of the study is "Umbilical cord transection to induce fetal demise prior to second-trimester D&E abortion."
Q. Have you reviewed this study in connection with arriving at your opinion?
A. I have.
Q. What did the evidence show in the study that is JX 14?
A. So this was a study that was done in one institution, and they were able to demonstrate that they were able to achieve uterine cord transection under most circumstances.
Q. Does this study change your opinion about the availability of cord transection as a safe, available, and effective avenue of effecting fetal demise?
A. No.
Q. Why not?
A. Well, again, it was a study, first of all, that was done in one institution, so it's not been replicated elsewhere. And, secondarily, the time to causing asystole or a lack of heart rate in the fetus was up to 11 minutes in this study, and that's a substantial amount of time, in my opinion, as it about doubles the time of the surgical procedure.

In addition, there was a limited number of cases in gestations that we talked about in terms of like 15 or 16 weeks.

Q. Why is the fact that the study only looked at one provider or one clinic relevant?
A. So normally, you know, in medical work when we introduce a new technique, we like to be able to see that it can be replicated in other settings before it can be generalized to general -- to practice. So in this case, you know, this is just one practitioner, and, you know, perhaps this person had especially, you know, good techniques or expert techniques in terms of ultrasound guidance for doing this. But, again, one study under one practitioner is not generalizable in medical practice.
Q. And the study at JX 14 is from 2013; correct?
A. That's correct.
Q. And you haven't been able to find any other medical study or analysis on the feasibility of UCT?
A. I have not.
Q. In your opinion, is there any medical benefit to the patient at all of performing the UCT procedure?
A. No.
Q. And in your opinion, if you could please just summarize for the Court what the risks are of the UCT procedure to patients.
A. So the risks of this procedure would include the risk of prolonging the procedure, which would potentially increase the risk of infection and hemorrhage associated with the surgery. And if it was -- if it failed to be able to cause fetal demise,

then there would be substantial risk of complication associated with an incomplete abortion.

Q. Dr. Keder, let's move on to the third method of demise posited by the State which is the potassium chloride injection.

First, let me just ask, are you familiar with potassium chloride or KCl injections as a method of demise?

A. Yes.

Q. And you don't conduct KCl injections --

A. I do not.

Q. -- for demise yourself; correct?

A. Correct.

Q. Can you please describe for the Court on what you base your understanding of KCl injections?

A. Potassium chloride is injected directly into the fetal heart to cause cardiac arrest in the fetus.

Q. Is it effective as a demise method, meaning does it cause fetal demise?

A. Yes.

Q. Is there a particular type of training that's necessary to perform a KCl injection?

A. Yes. So, again, the majority of these procedures are performed by maternal-fetal medicine specialists who have additional training and expertise in ultrasound and also in performing procedures that involve fetal therapy or cannulation of the umbilical cord and other things that are invasive

procedures that are done with the fetus.
Q. And what are the types of techniques specifically that a practitioner would have to utilize in order to effectively inject the KCl?
A. So it would require an expertise, first of all, in amniocentesis, but then, secondarily, in ultrasound to identify the fetal heart, and extra skill in terms of directing the injection into the fetal heart itself.
Q. Would you describe the KCl injection as a technically difficult procedure?
A. Yes, I would.
Q. Other than the maternal-fetal medicine credential, is there other training that's available to perform KCl injections?
A. Not that I'm aware of.
Q. Do most abortion providers in Ohio have training in maternal-fetal medicine?
A. No.
Q. Do most abortion providers in Ohio have some other training that would allow them to successfully perform a KCl injection?
A. Not to my knowledge.
Q. Do you know of any practitioners in Ohio who use KCl injections?
A. Not on a regular basis, no.
Q. Based on your medical knowledge, is KCl available as a demise option to patients in Ohio?

A. No.
Q. Are there risks to the patient associated with an injection of KCl?
A. So potassium chloride, if injected into maternal circulation, can result in cardiac arrest.
Q. And with proper training, is KCl always successfully administered, meaning does it always inject into the correct target?
A. No. So I think in the one case in the literature that's been reported with regard to maternal cardiac arrest, the concern was that in fact the injection had not occurred into the fetus and had -- some of it had gone directly into maternal circulation.
Q. And do you agree with Dr. Valley's statement that abortion providers in Ohio can currently provide KCl injections or be easily trained to do so?
A. No, I do not agree with that.
Q. Can you please explain the basis for your disagreement?
A. So, again, this is a technically difficult procedure. We -- as a general OB/GYN, I have not been trained to do intrafetal injections. The fetus, depending on the gestational age, you know, the heart may be actually a very small target. And I think these procedures would be only done in locations in which there was immediate options in terms of maternal resuscitation because of the risk of cardiac arrest.

Q. What is your opinion on using KCl prior to the D&E procedure to cause demise in Ohio?
A. I think it's really unfeasible that we would be able to train abortion providers to do this procedure without additional significant investment and training.
Q. We talked, Dr. Keder, about three -- the three methods of demise posited by the State. In your opinion, do any of these three methods confer medical benefits to women seeking D&E abortions in Ohio?
A. No.
Q. Do these three methods of demise create risks for women seeking D&E abortions in Ohio?
A. Yes, they do.
Q. And can you please summarize those risks?
A. So the risk is of an added procedure in addition to the surgical D&E procedure itself. So the risk of these procedures would include a risk of introducing infection or causing infection to develop in the uterus, the risk of creating ruptured membranes which increases the risk of infection, a risk of intramural delivery.
In the case of the umbilical cord transection, a delay in completion of the operative procedure which, again, would increase the risk of infection and potentially hemorrhage and anesthetic time which all have risk to the woman.
Q. Dr. Keder, let's move, if we could, to the testimony or

declaration presented by Dr. Valley about patients' preference for fetal demise. Are you familiar with that testimony?

A. Yes.

Q. Let's take a look, please, at tab 3 of your exhibit binder which is JX 3, and can you please describe for the Court what JX 3 is?

A. This is a study that is entitled, "Digoxin to Facilitate Late Second-Trimester Abortion: A Randomized, Masked, Placebo-Controlled Trial."

Q. And is this -- the lead author on this a Jackson?

A. Yes.

Q. Is this a study relied upon by Dr. Valley in support of his suggestion that patients prefer demise?

A. Yes, it is.

Q. Have you reviewed it?

A. I have.

Q. Are there any limitations to this study that you identified in your review of it?

A. Yes. So with regard to the issue of patient preference in particular, I do not agree with his assessment of the results of the study.

So this is a study in which women were enrolled and had to agree to either injection of digoxin or a placebo substance prior to their procedure. So the patients who were enrolled in the study had agreed to undergo a procedure which, you know,

would have been digoxin or placebo and, therefore, was a kind of self-selected group of women who were willing to do that before they were surveyed about their reactions to the procedure itself.

Q. And why does the universe of women who were surveyed for purposes of this study, those characteristics, why does that affect your view of the conclusions that can be drawn from it?

A. Because they were already willing to undergo the procedure before they were asked about its acceptability to them.

Q. Does this Jackson study impact your view about whether patients in fact do prefer a fetal demise procedure prior to D&E?

A. No, it doesn't. And, in fact, my own personal experience in having counseled many women in these circumstances before second-trimester abortion is that it's actually quite rare for them to express an opinion about this subject in advance of the procedure.

Q. Dr. Keder, let's look, if you could, at JX 9 which is at tab 9 of your exhibit binder. Can you please describe what JX 9 is for the Court?

A. So, again, this is an article from the journal of Contraception entitled, "Transvaginal administration of intra-amniotic digoxin prior to dilatation and evacuation."

Q. The lead author on this is Gariepy; correct?

A. It is.

Q. Does this study provide some information about patients' preference for fetal demise?
A. Yes, it does.
Q. What information is that?
A. So in this study, they approached women about undergoing transvaginal administration of intra -- or intra-amniotic digoxin, and so there was -- they were enrolling women in the study to look at this approach. And in the study, they approached 108 women, and 81 percent of those women declined to participate. In other words, they did not want to undergo digoxin administration.
Q. And what conclusion do you draw from that?
A. My conclusion in that situation is these are women who are being approached about -- are having an abortion procedure and they're being asked about whether they want to undergo this type of procedure or not, and the vast majority of those women when presented with that scenario chose actually not to undergo digoxin procedure or create fetal demise prior to their abortion.
Q. Dr. Valley also suggests that physicians or staff at hospitals or clinics have a preference for fetal demise. Do you recall that from his declaration?
A. Yes, I do.
Q. Is that consistent with your experience and understanding?
A. No, it's not.

Q. We talked already a little bit about Senate Bill 145, and let me just ask for the record have you reviewed the text of that Bill?
A. Yes, I have.
Q. Have you reviewed the provision of Senate Bill 145 prohibiting what the Bill describes as dismemberment abortions, quote?
A. Yes.
Q. Is that a medical term?
A. No, it's not.
Q. Do you have an understanding of what procedures are covered by the Act, even though it does not use a medical term you're familiar with?
A. So I believe it refers to what we refer to as dilatation and evacuation or dilation and evacuation.
Q. And what do you understand the effect of Senate Bill 145 to be on D&E procedures in Ohio?
A. My understanding is that it would preclude doing D&E procedures unless a patient underwent a procedure to create -- cause fetal demise prior to the actual surgical procedure.
Q. Does Senate Bill 145 require that the demise be effective or successful before a D&E can legally be performed?
A. Yes, that's my understanding.
Q. And are the fetal demise procedures that we've been discussing today, are those a separate medical procedure from

the D&E procedure?
A. Yes, they are.
Q. Do you have an opinion as how -- as to how a requirement to effect fetal demise would impact abortion care in Ohio?
A. So I think the immediate effect would be that it would decrease the availability of abortion in Ohio because there would be practitioners who are not trained or knowledgable in how to do these procedures. I think it's also possible that practitioners may choose not to do these procedures and therefore not provide abortion in the second trimester in the state.
Q. And as an abortion provider yourself, do you have an opinion as to how the requirement to effect fetal demise would impact abortion providers in their attempts to operate within the confines of the law?
A. Would you repeat the question?
Q. Sure. Do you have an opinion as to how S.B. 145 would impact individual abortion providers who are attempting to comply with it?
A. Well, I think, as I said previously, it puts us in a bit of an ethnical quandary because I think physicians who perform abortions feel like that's an important part of full scope of reproductive health care for women and feel it's in women's best interests from a medical point of view to have access to safe abortion. And so they will either be required to perform

a procedure which is medically unindicated and in itself problematic from an ethical point of view or to no longer provide the procedure which they think is important for women.

Q. And do you have an opinion on how S.B. 145 may affect patient care, patient medical care, in the state of Ohio?

A. Well, again, I think it would decrease the availability of second-trimester abortion and so might require that women travel to other states in order to have these procedures done, and it would increase the burden to women in terms of that travel as we've talked about. These are usually, at least in Ohio, require three visits for this type of service, and for a patient to travel out of state in order to have this type of procedure done would add significant burden to women.

MS. ELLSWORTH: Your Honor, may I just have a moment to consult?

THE COURT: Yes, of course.

(Pause in proceedings.)

MS. ELLSWORTH: I don't have any further questions. Thank you, Dr. Keder.

Thank you, Your Honor.

THE COURT: Thank you.

Cross-examine?

MR. FORSYTHE: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. FORSYTHE:

Q. Dr. Keder, my name is Dan Forsythe. I'm with the Ohio Attorney General's Office. I have some questions for you today.

Based on your earlier testimony, I believe it's correct that since March 21st, 2019, just a couple weeks ago, you have not performed any D&E abortions?

A. I'm sorry, could you repeat the question?

Q. Yes. Since March 21st of 2019, just a couple weeks ago, have you performed any D&E abortions?

A. No, I have not.

Q. To your knowledge, since March 21st, 2019, has Planned Parenthood of Greater Ohio performed any D&E abortions?

A. I cannot answer that question.

Q. To your knowledge, has Planned Parenthood of Greater Ohio complied with the currently enforceable provisions of Revised Code 2919.15?

A. As far as I know.

Q. And going forward, with any D&E abortions that you provide, will you be complying with the currently enforceable provisions of Revised Code 2919.15?

A. This is the Act we're talking about?

Q. Yes. This is what has become the Senate Bill 145 which was passed.

A. So I do not intend to perform abortions which would require one of these procedures at this point in time.

Q. Okay. So how the law is in effect and also part of it is enjoined, going forward in its currently enforceable way, you -- I guess we are to take that you will be doing D&E abortion procedures on fetuses that are gestational age prior to 18 weeks --

A. Correct.

Q. -- LMP?

After this law was passed at the end of December and prior to when it was supposed to take effect in March of 2019, did you do anything to prepare yourself to comply with it?

A. Educating myself with regard to what the law required --

Q. Okay.

A. -- in terms of the text of the law so that I would fully understand what it meant for practice.

Q. Okay. Did you do anything to review ways to perform fetal demise yourself?

A. Only in the context of preparing for this by reviewing of the medical literature.

Q. Okay. I want to ask you a little bit about your involvement with Planned Parenthood. Now, you've been involved with Planned Parenthood of Greater Ohio or maybe by other names since 1998; correct?

A. Correct.

Q. And you were medical director for that organization from 1999 until 2010?

A. Correct.
Q. You have performed abortions at Planned Parenthood of Greater Ohio, which may have been known as something previously, since 1998?
A. Correct.
Q. When you are performing abortions at Planned Parenthood of Greater Ohio and as you've done in the past, are you required to follow Planned Parenthood's own policies?
A. Yes.
Q. Are you currently involved with Planned Parenthood of Greater Ohio to assist them in implementing any of their own policies?
A. In that I serve as a contract physician, they inform me of their changes in medical standards and guidelines.
Q. Do you assist them in coming up with ways to comply with State regulations of abortion?
A. I'm not really sure what you're asking me.
Q. Well, for example, Senate Bill 149, did you work with anyone at Planned Parenthood of Greater Ohio to come up with ways that if that was to be enforced, that Planned Parenthood of Greater Ohio could comply with it?
A. I discussed with them that I was not planning to conduct procedures that would require fetal demise.
Q. Is Planned Parenthood of Greater Ohio compensating you for your testimony today?

A. No, they are not.
Q. Are they providing any mileage or out-of-pocket costs?
A. Not that I'm aware of.
Q. And according to your CV which is marked Joint Exhibit 23, it also states that you have been a member of Planned Parenthood Federation of North America in the past; is that correct?
A. I've served on the Planned Parenthood National Medical Committee which is an advisory board to the national organization.
Q. I notice in your first declaration which has been marked as Joint Exhibit 22, you cite to the Guttmacher Institute for some of your statistics regarding abortion; is that correct?
A. Correct.
Q. And the Guttmacher Institute is affiliated with Planned Parenthood, is it -- isn't it?
A. Yes.
Q. You testified a little bit on direct examination about induction abortion; correct?
A. Yes.
Q. Is that something you have performed for patients?
A. Yes.
Q. And I understand that you said induction abortion would not be your first choice; that there were risks and complications involved with that, but you would agree that induction abortion

is a alternative, second-trimester alternative to D&E?
A. We talked about that previously, yes.
Q. And also on direct examination you talked about if a woman would want a D&E second-trimester abortion in Ohio right now, that's a three-day procedure which includes a day for the consent; correct?
A. It's a three-visit procedure.
Q. Okay. Better way of putting it, thank you.
When you personally perform D&E second-trimester abortions, do you use an ultrasound?
A. When I perform second-trimester abortions, yes, I typically use an ultrasound.
Q. If you could turn to Joint Exhibit 22 in the first volume binder in front of you. On Exhibit 22, I want to direct your attention to page 7 and paragraph 21, and I'm going to read the very last sentence which begins "Usually," and it will go on to page 8. Are you there?
A. Yes.
Q. Okay. Let me read here. "Usually, because the cervical opening is narrower than the fetal parts, some disarticulation or separation of fetal tissues occurs as the physician withdraws the instrument through the cervix."
Did I read that correctly?
A. Yes, you did.
Q. What do you mean that some disarticulation or separation of

fetal tissues occurs?
A. If the fetus is not removed intact from the uterus.
Q. Okay. And so another way of saying that is the fetus is being ripped apart which could be limb by limb?
A. That's not the way I would describe it.
Q. Okay. Is the description of the fetus being ripped apart limb by limb, is that an accurate description?
A. Parts of the fetus would be removed through the uterus as I described with instrumentation. Whether it would involve removal of limbs or grasping the trunk of the fetus and extracting it would depend on the procedure itself.
Q. Okay. So another way to put it maybe would be the fetus is being ripped apart part by part; is that accurate?
A. Some parts of the fetus would be removed. The fetus would not necessarily be removed intact from the uterus.
Q. Okay. And continuing on in that same paragraph 21, we're on page eight one -- page 8, I'm sorry, let me read this: "As a final step, suction may be used to ensure that the uterus is completely evacuated. The entire D&E process takes approximately ten minutes."
Did I read that correctly?
A. Yes.
Q. Okay. So what is the suction evacuating?
A. The suction may be evacuating the placenta, the amniotic fluid, or portions of the fetus.

Q. Okay. So the suction could be evacuating still parts of the fetus?
A. (Nodding.)
Q. Is that correct?
A. That's correct.
Q. I want to ask you some questions about fetal demise. You testified that you have done a umbilical cord transection or two; correct?
A. Correct.
Q. Have you performed any other type of fetal demise?
A. No.
Are you specifically asking me about potassium chloride or digoxin injection, is that what you mean?
Q. Yes.
A. Yes, I have not done either of those procedures myself.
Q. If you could turn to exhibit Joint Exhibit 4 in the binder in front of you. You were asked about this document during your direct examination. It's a medical article from the Society of Family Planning, their Clinical Guidelines. And, first, you are a member of the Society of Family Planning; correct?
A. That's correct.
Q. And you cited to this and you discussed it in cross -- I'm sorry, on direct examination, in part because you believe that the harms of fetal demise before abortion would outweigh its

benefits; is that correct?

A. Correct.

Q. This was published in a journal called Contraception, and you would agree that that's a reliable authority?

A. Yes.

Q. I want to ask you to turn to page 469 in Exhibit 4. At page 469, and I want to direct your attention to the second column that says "Conclusions and recommendations." And under "Level B," the first bullet point, I'm going to read this. Please read along. "Intrafetal injections require less digoxin than intra-amniotic injections to achieve -- to achieve demise effectively. Intrafetal injection of at least one milligram digoxin is required to ensure fetal demise consistently."

Did I read that correctly?

A. Yes.

Q. The next bullet, "Although technically challenging and thus requiring skilled technicians, intracardiac KCI injections are a generally safe and effective method to induce fetal demise, although rare complications could occur."

Did I read that correctly?

A. It's KCl, not KCI.

Q. Thank you. Thank you. So I read that correctly besides my incorrect way of saying KCl?

A. Correct.

Q. Thank you.

The third bullet point under "Level B," I'm going to read this, "A one milligram intra-amniotic digoxin dose has been established as generally safe by pharmacokinetic trial and by observational studies, although this cannot exclude the possibility of more rare complications."

Did I read that correctly?

A. Yes.

Q. And turning to page 470, these would be bullet points under "Level C," the first bullet point says, "Inducing fetal demise before induction termination avoids signs of live birth that have been beneficial -- that may have beneficial emotional, ethical and legal consequences."

Did I read that correctly?

A. Yes.

Q. And then going to the third bullet point, "Inducing demise may lead to fetal maceration and cervical priming."

Did I read that correctly?

A. Yes.

Q. I also want to ask you about another medical journal article. It will be found at tab 21 in the first volume. Okay. And this is also from the Contraception journal. This is titled, "A qualitative study of digoxin injection before dilatation and evacuation," and the lead author is Blair McNamara; is that correct?

A. Yes.

Q. Okay. And this was -- you cited to this in your declaration in this matter; correct?
A. Yes.
Q. I want to direct your attention to page 516 of Exhibit 21, the first column, under the third section titled "Results." And I want to direct your attention to I believe the last sentence of this paragraph that begins, "Despite these negative experiences." Are you there?
A. Yes.
Q. Okay. I'm going to read it. "Despite these negative experiences, most participants (number 14, 70 percent) suggested that the digoxin injection was better than they had expected, and most (number 15, 75 percent) claimed that they would choose to receive the medication again, even if it were not routine."
Did I read that correctly?
A. Yes.
Q. And then I'd like to turn to the next page, page 517, second column, under Section 3.3, "Reassurance." Are you there?
A. Yes.
Q. The first sentence reads: "Despite the negative experiences and confusion discussed above, many participants (number 12, 60 percent) expressed feeling reassurance about some aspect of their abortion experience due to the digoxin

injection."

Did I read that correctly?

A. Yes.

Q. Let's turn to in the second binder Joint Exhibit 35, please. Okay. And you were asked about this Exhibit Joint 35 on direct examination; correct?

A. Correct.

Q. Okay. And this is a Practice Bulletin from ACOG about second-trimester abortion from June, 2013; correct?

A. Correct.

Q. I want to ask you to turn to page three of this document, second column, under the title "Effecting Fetal Demise," and I think you were asked about the first two sentences about this paragraph. I want to go to the third sentence beginning with "Some providers." Do you see that?

A. Yes.

Q. Okay. And I'm going to read along here. "Some providers of second-trimester surgical abortion use these methods to ensure fetal demise before the procedure or because they believe it facilitates D&E by causing maceration."

Did I read that correctly?

A. Yes.

Q. And if you go down a couple more sentences after some statistics there, there's a sentence that says, "However, another study." Are you there?

A. Yes.
Q. Let me read there. "However, another study reporting on a large case series cited at 37 found a much lower rate of complications, including spontaneous abortion (.3 percent)," and some additional statistics on that, "and infection (.04 percent)."
Did I read that correctly?
A. Yes.
Q. And there's some other numbers in there, I think, relating to the study.
Okay. Do you know Dr. Haskell?
A. I have met Dr. Haskell before, yes.
Q. Are you aware that he's been performing or he has or had performed digoxin injections for a number of years?
A. No, I've not ever spoken with him about his direct practices.
Q. Well, then maybe you do or do not know, but were you aware that he is not an OB/GYN, he's not Board certified in that, nor is he Board certified in maternal-fetal medicine? Were you aware of that?
A. No.
Q. And at least for more recently in his practice, he was not Board certified in any profession. Were you aware of that?
A. No.
Q. Do you have any concerns about Dr. Haskell lacking any

skill in doing digoxin procedures?
A. I really do not know about Dr. Haskell's qualifications.
Q. Okay. Would you be willing to have Dr. Haskell train you in performing a digoxin injection?
A. I, as I said, really don't know anything about Dr. Haskell's qualifications in this realm.
Q. Okay. So you don't know anything about Dr. Haskell's skills, training, or competency in digoxin training?
A. I do not.
Q. And I think you also mentioned on direct examination that you were aware of other Planned Parenthood affiliates providing digoxin injections, and let me ask you specifically were you aware that Planned Parenthood Southwest Ohio Region provides digoxin injections under certain scenarios?
A. I do not know in detail about the practices at Southwest Ohio. I only became aware in the preparation for this discussion that there are places in Ohio that are doing digoxin administration.
Q. And would you be willing to have anyone at Planned Parenthood Southwest Ohio train you on the use of digoxin injections?
A. Again, I'm unfamiliar with the practices of those physicians, so I don't think I could speak to that.
Q. You spent part of your direct examination testimony talking about the different risks and complications of digoxin;

correct?
A. Correct.
Q. Would you agree that any medical procedure that has complications can still be safe and effective?
A. So medical procedures, you know, in and of themselves all have risks associated with them, some more risky than others.
Q. Based on your past experience and your current experience, do you ever follow the NAF, any sort of policies from the National Abortion Federation?
A. I am not a member of the National Abortion Federation. I don't have access to their standards and guidelines.
Q. Okay. But you do for anything that you do at Planned Parenthood of Greater Ohio, you would follow Planned Parenthood policies; correct?
A. Yes.
Q. I want to ask you to turn to Joint Exhibit 17 in the first volume.
A. I'm sorry, did you say 18?
Q. Let's go to 17, please, Joint Exhibit 17. This is a packet of policies revised May of 20 -- 2007 through June of 2010. And on the bottom it states "PPFA Manual of Medical Standards and Guidelines, Planned Parenthood Federation of America." Did I read that correctly at the bottom?
A. Correct. Yes.
Q. Is this the type of policy that you would be familiar with

from your time at Planned Parenthood of Greater Ohio?
A. So the medical standards and guidelines are generally updated every six months to a year in my experience at Planned Parenthood Federation of America. These appear to date to 2007. So, yes, they would have been in place at some point when I was working for the agency.
Q. All right. I'm just going to skip through some of this. I want to ask you some questions about -- there's Bates numbers on the bottom, PPFA dash. I want you to turn to 0017.
THE COURT: Are we in the same exhibit?
MR. FORSYTHE: Yes. We're still on Joint Exhibit --
THE COURT: 17?
MR. FORSYTHE: -- 17.
THE COURT: What page are we going to?
MR. FORSYTHE: It's Bates stamped PPFA-0017.
THE COURT: My book's not Bates stamped, I don't think.
MR. FORSYTHE: Maybe some of the copies didn't --
THE COURT: Does it have a page number?
MR. FORSYTHE: Well, it's numbered 1. It appears -- this is like a lot of different excerpts.
THE COURT: I see what you're saying. Give me a second. Give me the month and the year.
MR. FORSYTHE: It's May, 2007.
THE COURT: Okay.

MR. FORSYTHE: I believe it's six pages in, and it's page numbered 1 after a page 13.

THE COURT: Okay. I got it.

Do you have that, Doc? Top left it says, "Use of Digoxin as a Fetocidal Agent."

Q. Doctor, do you think you're on the same page as we are?

A. No, I'm not sure that I'm on the same page as you.

THE COURT: It's about four pages in into the book, double-sided pages.

A. Okay. Maybe here.

THE COURT: Got it?

A. "Use of Digoxin as a Fetocidal Agent"?

THE COURT: Yes, there you go.

Q. I've also placed it on the screen which I understand, Doctor, is actually behind you but may not be totally convenient for you.

THE COURT: If you've got --

A. Yeah, I think I have that page in front of me now.

Q. All right. Let me read under Roman Numeral One under "General Information. Digoxin may be used to cause fetal demise before later second-trimester abortions."

Did I read that correctly?

A. Yes.

Q. Under Roman Numeral Two, "Indications for Use. Digoxin must be given for all pregnancy terminations at 20 weeks or

over. Number Two, Digoxin must be given for all pregnancy terminations at 18 weeks and over if cervical preparation consists of," and it lists some additional reasons why to do that.

Did I read that part correctly?

A. Yes.

Q. And then going down the page before Number Three, there is an unnumbered paragraph. Let me read that. "If the client refuses digoxin or it is contraindicated, the client may either be referred out of the affiliate for care or the program director must be consulted."

Did I read that correctly?

A. Yes.

Q. And then down to Number Three, still under Roman Numeral Two, "Digoxin use before 18 weeks can only be used with written approval from PPFA Medical Affairs."

Did I read that correctly?

A. Yes.

Q. Were you aware that this was Planned Parenthood Federation of America's policy in 2007?

A. So in 2007 at our local affiliate, we were not doing abortions in this gestational age range, as I recall, so this would not have been part of the medical standards and guidelines that we would have adopted to our local agency.

Q. I want to ask you to turn to the next page in Exhibit 17.

And the top of the page says "Risks" -- Roman Numeral Five, "Risks and Side Effects." Do you see that?

A. Yes.

Q. And I want to direct your attention to the end of the page where it says, "FYI - Commonly asked questions about digoxin. Is it safe?" Do you see that?

A. Yes.

Q. And there is a reference to a medical journal article Drey, D-R-E-Y, et al., year 2000. And the conclusion there says, "One milligram intra-amniotic digoxin is safe before late second-trimester D&E abortion."

Did I read that correctly?

A. Yes.

Q. Doctor, when did Planned Parenthood of Greater Ohio start to do later-term abortions, 18 weeks or later?

A. To be honest with you, I can't tell you that off the top of my head. I think it might be in the range of 2012ish, but I really --

Q. Thank you.

A. I think it was after I stopped being the medical director for the agency.

Q. If you can turn to the next page in Exhibit 17, this page is numbered 4 on the bottom. We're still in May of 2007. The question on this page, the first bullet -- or, I'm sorry, bolded question says, "Does digoxin make the procedure easier?

If so, for whom?" And it cites to a journal article by Jackson, et al., 2001; is that correct?

A. Correct.

Q. And under "Conclusion," it says, "Digoxin was not found to increase efficacy but most later second-trimester D&E patients prefer its use. Anecdotal reports from experienced providers claim use of feticidal agents make the procedure easier for the clinician and that it is low risk for the woman. Fetal demise softens fetal tissue and may make for easier removal of the fetus."

Did I read that correctly?

A. Yes.

Q. Okay. If you can skip a couple pages, and this looks to be an informed consent sheet. Again, it's dated May 20 -- 2007. Page on the bottom, it's page 1 again. But at the top it says, "affiliate name, address, and telephone number. Client Information for Informed Consent, Using Digoxin in Abortion."

Did I read that part correctly?

A. Yes.

Q. Is it your understanding that this would be a document -- is this a document that would be given or just basically the information contained here would be provided to a client or patient?

A. This looks like a document that would be provided to the patient because it says, "Client Information for Informed

Consent."

Q. Okay. I want to look at the first paragraph under the box that begins with "Digoxin is a common heart medicine." Do you see that?

A. Yes.

Q. The last sentence in that first paragraph, let me read this. "Some clinicians also believe that using digoxin makes it easier to do the abortion."

Did I read that correctly?

A. Yes.

Q. And then in the next paragraph, second sentence begins, "And in one study, more than eight -- 90 percent of women who had digoxin preferred knowing that fetal death occurred before the abortion surgery began."

Did I read that correctly?

A. I'm sorry, where are you?

Q. Part of that second paragraph, the one that begins, "Studies have shown."

A. Okay. Yes, I see it now.

Q. I'll just read that whole paragraph. That might be a little easier.

A. Yes, I think that refers back to the Jackson article that we already discussed.

Q. Okay. And then the third paragraph under the box says, "Digoxin is given through a thin needle. The needle goes

through your abdomen and into the fluid surrounding the fetus or into the fetus itself. It can take from several minutes to 24 hours for digoxin to work. You will have the abortion after the digoxin has had a chance to work."

Did I read that correctly?

A. Yes.

Q. And is what I read, is that an accurate description of what the digoxin procedure would be?

A. Digoxin procedure would involve taking a long needle and placing it through either the vagina or the abdominal wall into the amniotic fluid and/or the -- or the fetus and injecting the medication.

Q. Okay. I want to keep looking to the bottom of the page under "Risks and Side Effects." First, it says, "Failure to cause fetal death." Can you see that?

A. Yes.

Q. Let me read that. "An injection of digoxin will not cause fetal death in about eight to ten of every 100 cases. The clinician may give you another dose of medication if this happens. It is likely that you will still be able to have the abortion completed on the scheduled day."

Did I read that correctly?

A. Yes.

Q. Let's turn to the next page, please. On the top of the page says, "Gastrointestinal Problems." And under those --

after the bullet points, after four bullet points, there's a paragraph that begins, "Digoxin is commonly used." Do you see that?

A. Yes.

Q. All right. Let me read that. "Digoxin is commonly used before abortion to cause fetal demise. It is not approved by the Food and Drug Administration (FDA) for this specific purpose. However, there are no published reports of serious problems from using digoxin before abortion."

Did I read that correctly?

A. Yes.

Q. And then under the box is another -- it's a small title of "Benefits." Do you see that?

A. Yes.

Q. All right. And the first bullet talks about it decreases the risk of clinicians violating the federal abortion ban, and you discussed that a little bit during direct examination; correct?

A. Yes, I did.

Q. And if we continue on the benefits, it reads: "It decreases the risk of a live birth. Some women are helped by knowing that the fetus died before the procedure. In some experts' opinion, it may make the procedure easier to do."

Did I read that correctly?

A. Yes.

Q. All right. You can set that aside.

Is it your testimony and opinion now that you're trying to distance yourself from the prior policies that Planned Parenthood had?

A. I'm sorry, I'm not sure I understand what you're asking.

Q. Well, in your rebuttal declaration which is Joint Exhibit 26, it appeared from my reading that you're trying to distance from Planned Parenthood of Greater Ohio these prior Planned Parenthood policies.

A. Well, as I said, these are policies that are dated in 2007. So medical understanding and knowledge advances, fortunately, over time. We're now 12 years later. Practices have changed. Understandings have changed. Additions have been made to the literature in the meantime. So I don't think it's fair to say I'm distancing myself. I think I'm trying to reflect what a current understanding -- my current understanding of the medical literature is. And as I pointed out, at the time that these were published, we were not in fact performing these procedures at the affiliate at the time.

I'm not trying to distance myself. I'm trying to reflect what's accurate knowledge today as opposed to this which was printed in 2007.

Q. Okay. I want to talk now about potassium chloride injections. And I would ask you to direct your attention to Exhibit 16 in the Joint Exhibit binder. This is a case report

article titled "Maternal cardiac arrest associated with attempted fetal injection of potassium chloride." Lead author is Coke; is that correct?

A. Yes. I have it in front of me.

Q. Okay. And you also cited to this in your declaration as well; isn't that correct?

A. Yes, I believe I did.

Q. I want to ask you to turn to page 288 of this exhibit which is the second page, second column, and the final paragraph in the second column begins, "The placenta and umbilical cord." Can you see that?

A. Yes.

Q. All right. Let me read: "The placenta and umbilical cord are easily visualized by Doppler-flow sonography. However, in a deviation from routine practice, the ultrasound machine used in this case was not capable of visualizing Doppler-flow of the placenta, nor was it capable of magnification. It had no zoom feature."

Did I read that correctly?

A. Yes.

Q. And this article, Exhibit 16, came out of the University of Maryland Medical Center. So it appears that the researchers at that time were reviewing cases that were using actually an older ultrasound machine that they, you know, could have in 2004. Is that your reading of that?

A. It sounds like they were using an ultrasound that didn't have all of the capability that they were used to using, I would say.
Q. Okay. And certainly advances -- I'm sorry.
A. If this was a maternal-fetal medicine practice, they -- there are various grades of ultrasound machine. If this was a maternal-fetal medicine practice, they typically would have very sophisticated ultrasound machinery because they're, you know, focused on doing prenatal diagnosis of fetal abnormalities which requires, you know, very high-caliber machines -- equipment.
Q. Okay. But for some reason, they didn't use that type of ultrasound on the case of the maternal cardiac arrest; correct?
A. That's what it says, that they did not.
Q. Okay. And obviously advances in ultrasound technology since 2004, you could get an even higher quality today than you could in 2004; correct?
A. That's possible, yes.
Q. Do you know plaintiffs' expert Dr. Steven Ralston?
A. No, I do not.
Q. Would you agree with him, he said this in his declaration and he's expected to testify on Friday, that in order to perform intracardiac KCl injections, you'd have to have very good ultrasound skills and you have to have very good skills for needle procedures; would you agree with that?

A. Yes.
Q. And you believe that for an abortion provider to properly perform a KCl injection, they would need an advanced ultrasound imaging equipment; is that correct?
A. Yes.
Q. And certainly Planned Parenthood would have those type of ultrasounds?
A. No.
Q. So Planned Parenthood does not have the most advanced ultrasound imaging equipment?
A. They have imaging equipment, but it's usually not of the same caliber that a maternal-fetal medicine practice would employ.
Q. Would you be willing to hire plaintiffs' expert Dr. Ralston to come to Ohio and train you or other abortion providers in how to perform a KCl injection?
A. I don't know Dr. Ralston. I don't think I could speak to that.
Q. All right. Let's talk about your ability to learn the procedure. How many KCl injections do you think you would have to observe in order to be able to perform one?
A. That's very hard to answer because I've never seen the procedure performed before. And not doing it myself, I think that question would be better addressed to someone who actually does the procedure and is trained to do it.

Q. Okay. I'm going to move on to umbilical cord transections. And you testified you do not do this routinely but you have done it once or twice?
A. Yes.
Q. Let's look at Exhibit 14 in the first volume book. This is an article you were asked upon -- asked about on direct examination. It's from the journal Contraception. It's titled "Umbilical cord transection to induce fetal demise prior to second-trimester D&E abortion." Lead author is Kristina Tocce; is that correct?
A. Correct.
Q. Do you know Dr. Tocce?
A. I may have met her before, but, no, I don't -- I don't think I would know her by sight.
Q. And okay. You testified -- strike that.
I believe on direct examination you testified that one of the reasons that they had 100 percent success rates of doing umbilical cord transection was that they probably had really good ultrasound? Did you say something like that?
A. I don't remember that I said that. I think what I said was that perhaps they had advanced ultrasound skills. I wasn't referring specifically to the equipment as so much as the expertise of the individual.
Q. And do you believe that ultrasound is necessary in order to do umbilical cord transection?

A. I think to be able to do it reliably and accurately that -- at least in the situation in which I might be at risk of causing a felony offense, I would want to have -- be able to do it with ultrasound to try to ensure that it was successful. But even at that, I'm not sure that I could a hundred percent guarantee I'd be able to do it accurately even with excellent ultrasound equipment.

Q. I want to ask you to turn to page 713 of Joint Exhibit 14. First column, under Part 2, "Materials and methods," the second paragraph that begins, "Since the passage of the PBA ban," halfway through that, I want to begin where it says, "Although the time needed to complete UCT is not recorded." Do you see that?

A. Yes.

Q. All right. Let me continue reading. "Although the time needed to complete UCT is not recorded, this is usually accomplished quickly and without ultrasound guidance; the use of ultrasound guidance and/or forceps to extract the cord is rarely needed. If ultrasound and forceps are needed, the cord is grasped in the area of the placenta and efficiently extracted."

Did I read that correctly?

A. Yes.

Q. Turning to the next page, page 714, under Part 4, "Discussion," do you see that?

A. Yes.
Q. All right. Let me read the beginning of that paragraph. "In this analysis, inducing fetal demise by amniotomy and UCT immediately prior to D&E was found to be effective and safe. All attempts resulted in fetal asystole within 11 minutes; 95 percent within seven minutes."
Did I read that correctly?
A. Yes.
Q. And earlier you testified that the study talked about being able to cause fetal demise within 11 minutes; correct?
A. Yes.
Q. Okay. But, in fact, 95 percent of their cases completed fetal demise within seven minutes; correct?
A. That's what they report, yes. I believe I said it took up to 11 minutes.
Q. I believe that is accurate, yes.
You were asked a little bit about if there -- on direct examination if there is an attempt at fetal demise and there is a failure, for example, digoxin injection or potassium chloride injection and then you come back and as far as everyone can tell, there is no fetal demise, and so the question is what do you do next. And you talked about how the patient would already be dilated and depending on, you know, what sort of fetal demise had been done first, if the D&E procedure is then not completed, she is at a higher risk for infection; correct?

A. Right.
Q. She would also be at a higher risk for hemorrhage or extramural delivery; correct?
A. (Nodding.)
Q. Is that true?
A. Yes.
Q. At that point would she also be at a higher risk for harm to her reproductive system?
A. If she developed a complication, yes.
Q. I want to ask you about fetal pain. Do you believe there is ever a time when a fetus, during any point in its gestational age, that it can feel pain?
A. I am not an expert in fetal pain and fetal development.
Q. So you don't have an opinion one way or the other?
A. I don't feel qualified to answer the question.
MR. FORSYTHE: Your Honor, may I have a moment?
THE COURT: Sure.
(Pause in proceedings.)
Q. You were asked some questions on direct examination about patients and provider preference, so I'm going to ask you some questions about that. Specifically in your rebuttal declaration which is Exhibit 26, you wrote that no one you have ever worked with providing abortions ever experienced mental distress. And I can direct you to it's paragraphs 10 and 11 in Exhibit 26, and that would be page five.

Have you been able to review paragraph 10 of your rebuttal declaration?
A. Yes.
Q. Okay. Is it really your testimony that no one that you have ever worked with in providing abortions ever experienced mental distress?
A. That's not what I -- I don't believe that's really what I said. I said, "I have not observed physicians or staff experience mental distress as a result of providing D&E procedures without demise."
So I certainly have had colleagues who have had stress and, you know, related to their work, but not specifically that I know of related to abortion without fetal demise.
Q. So it's your testimony that no one you have ever worked with in the providing abortions have ever felt mental distress regarding providing D&E abortion procedures?
A. I've never seen anyone with a mental health disorder that I would attribute to that.
Q. Okay. And what about yourself?
A. I have not had any mental health disorders.
Q. Have you ever had one of those moments like Steve McQueen in the movie Bullitt at the end of the movie when he's looking at himself in the mirror?
A. I've never seen the movie, so I don't know what your reference is.

MR. FORSYTHE: Judge, I might need some help here.
THE COURT: You mean you've never seen the car chase?
MR. FORSYTHE: Thank you. Thank you.
THE COURT: Come on.
THE WITNESS: Sorry.
MR. FORSYTHE: I'm glad I'm not the only one.
A. I'm a very busy person, but I've never seen the movie.
Q. Well, okay. That was one of my dad's favorite movies. It's from the 1960s and known for --
THE COURT: I think I just got aged a little bit there.
Q. It's known for its iconic car chasing through the streets of San Francisco. But he plays a detective. He's got a tough job. And at the end of the movie, he comes home, he's washing his face in the mirror. He stands up and he catches himself in the mirror, and it's one of those looks of how long do I need to keep doing this. Have you ever had one of those moments?
MS. ELLSWORTH: Your Honor, I'm going to object on this. This seems unnecessary, particularly for an expert witness. She can certainly answer the question, but it doesn't seem particularly helpful to me.
THE COURT: I'll let her.
If you can answer the question as phrased, you can try to answer the question.
A. Okay. So now I've forgotten. It's have I ever had a

moment when I looked in the mirror? I --

Q. And had one of those thoughts of how long do I need to keep doing this for?

A. Doing what?

Q. Working for abortion practice?

A. No. I've always felt that it was in women's best interests to have access to safe abortion care.

Q. Okay. Let me ask you about a newer movie. There's a movie out right now called Unplanned. Have you seen that movie?

A. No, I have not.

Q. Okay. Are you familiar with the movie?

A. I'm not.

Q. Okay. It's based on a true story about a clinic director for a Planned Parenthood clinic who ended up leaving. And there is a scene in there that has to do with staff mental distress, I would say. So I wanted to describe it and see if you've ever seen that sort of experience at your clinic or in your experience?

MS. ELLSWORTH: Object on foundation grounds.

THE COURT: We'll go through it. It's okay.

Q. It's basically a hypothetical that was reenacted in a recent movie. But the clinic director is asked to help on an abortion, and it does appear to be a D&C suction abortion at 13 weeks. And she says the baby just, you know, it just, you know, moved away from the catheter, and the abortion provider

says, "That's very common." And she later describes what she saw was the fetus twisting and fighting for its life before being suctioned out by viewing the ultrasound. She runs in the bathroom. She's crying and very upset. Have you ever witnessed that experience of yourself or somebody else that you have worked with in providing abortions?

A. I have not.

Q. At some point in this matter I may take your discovery deposition, and do you think between now and then you might be able to watch the movie Unplanned so I can ask you some additional questions about it?

A. No. I don't -- I don't know the movie. I --

Q. Thank you, Dr. Keder. That's all the questions that I have.

THE COURT: Let's take a ten-minute break, guys. We'll be back.

Doctor, you can step down. Just don't discuss your testimony with anybody. Okay?

THE WITNESS: Okay. Thank you.

THE COURT: Great.

(Recess in proceedings from 3:24 p.m. to 3:38 p.m.)

AFTER RECESS

THE COURT: Give me a second here. I'm trying to readjust.

Are you guys ready to start?

MS. ELLSWORTH: Yes, Your Honor. If I could just inquire of one question on the scheduling matter we were discussing.

THE COURT: Okay.

MS. ELLSWORTH: So we're finishing earlier than I think we anticipated. But we could get Dr. Haskell on but probably not off. So our preference is still to wait till Friday, if that's okay with you all.

MS. CARWILE: I did not bring my Haskell documents anyway. So --

MS. ELLSWORTH: Okay. So we'll, after this witness, Your Honor, we'll rest for today, then, if that's all right with you.

THE COURT: All right. Doctor, I have a couple of questions for you. Can we start where we were just a minute ago, Exhibit 14, do you have that handy?

Okay. So on the last full page, I just gotta make sure I'm on target with this. So on the last full page, it's number 715. Do you have that handy?

THE WITNESS: Yes.

THE COURT: Okay. So in the left-hand column there, that discussion about the Jackson survey is what you were talking about, right, about the patients' predilection for the involvement; that sort of summarizes your position on that?

THE WITNESS: Correct. So those were patients who

were willing to accept the digoxin as an entry into that study.

THE COURT: Let's go back to the previous page, then. So this article is setting up the difference between the UCT and the digoxin; right?

THE WITNESS: Correct.

THE COURT: But do you agree with the -- do you agree or disagree with -- and you might take a moment to read it -- with some of the discussion about the effectiveness and the risks involved? Because they've got some figures in there. They've got some failure rates in there and they talk about some other issues. And I'm just kind of wondering since you were asked about this on cross, and I'm wondering if you could read that paragraph and tell me if you -- well, read -- if you could just read that discussion because it could be helpful at some point to tell me how you feel about what's contained in there.

THE WITNESS: (Witness complied.)

THE COURT: And I'm concerned mostly about the part about the effectiveness of digoxin, et cetera, et cetera.

THE WITNESS: So it comments on the effective of digoxin as dependent on both injection location and dose, and I would agree with that. And that failure rates of 6.6 to 13 percent have been reported. And actually, in some studies up to 20 percent, depending on the dosage, but those studies mostly used doses that were quite low.

And I don't remember a study in which multiple injections were used. And there is one study that looks at the timing, and that looked sequentially up to four hours and then jumped to like later; and they found that most fetuses still had cardiac activity four hours post-injection, but in that study demise had typically occurred by 24 hours after injection.

THE COURT: Okay. But this, this article, is setting up UCT, I think, to be safer than digoxin, right, or not?

THE WITNESS: I think they're exploring it as an alternative to digoxin, and that's why they -- they're -- they've put this out there. But as I said earlier, it's only one study. It's really the only reported trial in which this procedure has been used.

THE COURT: Is there a study on the complications, risk of infection and all that, that are I don't know if I want to use the word "standard," but just a routine D&E, I mean, as you said, all medical procedures have some risks. And I'm trying to understand in the vac -- albeit in a vacuum here, the risks that you're talking about compared to the normal risks. Is that how it -- how would you understand that?

THE WITNESS: Yes. So there are studies that look at the risk of D&E and that just describe D&E, and I don't think we have any of those in the binders.

Do we have the Dean study?

There's one study that looks at one place's experience using digoxin and not using digoxin.

THE COURT: No, no, no. I'm talking -- yes. I mean, a regular D&E, I'm assuming complications occur at different times; right?

THE WITNESS: Yes. Correct.

THE COURT: So what is the failure rate or complication rate on that procedure?

THE WITNESS: Yeah. So there essentially really isn't a failure rate associated with the procedure.

THE COURT: Okay. Not failure rate, complication rate.

THE WITNESS: Yeah. So the complication rate, the infection rate is generally considered to be less than 1 percent.

THE COURT: Okay. All right. And on this, in this paragraph they talk about there may be I think they say successive needs for the digoxin injections, and you were asked, I think, on direct about some of your concerns with the statute. If the statute didn't require successful fetal demise but only attempt at it, would you be okay with that?

THE WITNESS: No.

THE COURT: Why not?

THE WITNESS: Because it still introduces a procedure that carries risk to the individual woman without benefit to

her from a medical point of view.

THE COURT: You said that you did the cord transections when medically indicated. What were the medical indications in the cases you did?

THE WITNESS: So those were patient preference. So they happened to be in patients who had -- I don't recall the exact circumstances for the patients, but they were patients that expressed to me a desire or a concern in counseling with regard to the actual procedure of the D&E resulting in destruction of the fetus or non-intact extraction and expressed a concern about that. And so when I explored that with them, I tried to counsel the patient about what we know about fetal pain, specifically referencing the JAMA article about that.

But when asked if there was something that I could do to create demise, I discussed the options with the patients, and these two patients I can recall in particular who asked me to attempt cord transection in process of the actual surgical procedure, in one, I was able to do that; in the other one, I was unsuccessfully -- was not able to interrupt the cord because the patient started having heavy bleeding in the midst of the procedure, and I needed -- I felt like I needed to expedite it in order to complete the procedure safely.

THE COURT: And where does patient preference come into this? I mean, you described before the earlier conversation, the 24-hour waiting period, things like that.

THE WITNESS: Um-hmm.

THE COURT: If a patient wanted to have a procedure but wanted to have digoxin or one of the other things used, are they able to do that or what happens?

THE WITNESS: So I think obviously we always need to respect patient preference in medical concerns. I think with -- we need to make sure patients understand kind of relative risks and benefits.

In my experience, I know this seems a little odd on the face of it, but I think that patients sometimes when they have a situation where they feel like they need this procedure, they want things kind of over and done with as quickly as possible and that's my experience in terms of why patients often don't choose induction abortion.

But beyond that, I think that also -- and I think if you parse out this literature in a little bit more detail, one of the things that comes out in it is sometimes people -- women feel uncomfortable making the decision to do something that's a separate procedure that causes fetal demise, almost as if it's more in their hands that way than if the physician is responsible for that process happening. I don't know if that makes any sense or not, but there's a certain I think --

THE COURT: Well, I'm just -- I mean, I'm just wondering if in fact the Jackson study -- okay, understanding what this article is and what you think the shortcomings are,

but if people -- if a large number of women have a preference to have the fetal demise occur first, what happens? You're talking about it being, you know, a tricky maneuver and things like that. I mean, can they get that procedure if they want it or how does it work?

THE WITNESS: So I think the Planned Parenthood affiliate here does not offer it routinely. In the hospital setting with a medically indicated procedure we could probably manage to do it because we have the equipment and the medication stocked in the hospital setting. I don't think -- I think if a patient fully understands kind of the relative risks and benefits, that we would respect her choice in making that decision if she wanted that done.

THE COURT: Okay. You were asked a lot of questions about Exhibit 17. That was the May, '07 discussion.

THE WITNESS: The Planned Parenthood guidelines.

THE COURT: Planned Parenthood, yes. I think you indicated that you thought those were outdated. Is there an updated version of that that --

THE WITNESS: Yeah. As I said, they're updated at least every year. So I don't currently have a copy of it with us in terms of this year's standards and guidelines.

THE COURT: I mean, if there was a current -- if there were a 2017, '18, or 2019 discussion like that, do you think it would be markedly different in terms of --

THE WITNESS: I think it's different, yes.
THE COURT: Okay.
MS. ELLSWORTH: Anything else, Your Honor?
THE COURT: I might have more later, but go ahead.
MS. ELLSWORTH: All right.

REDIRECT EXAMINATION

BY MS. ELLSWORTH:

Q. Let's pick up where His Honor left off, Dr. Keder. Why don't you, if you could, look at JX 17 which is the Planned Parenthood guidelines. Now, you testified on cross-examination these are from 2007; correct?

A. Correct.

Q. So we know they're not in effect now?

A. Correct.

Q. Do the current Planned Parenthood guidelines that are in effect at least in the Greater Ohio affiliate that you occasionally provide services at, do they provide -- require any digoxin use?

A. No, they don't.

Q. Do they require any sort of fetal demise?

A. No.

Q. You testified in response to I believe it was on direct examination but also in response to questions from Mr. Forsythe about the partial-birth abortion ban being a part of why digoxin had been used by some practices. Do you recall that

testimony?
A. Yes.
Q. Do you have an understanding of the evolution of digoxin use over time in the 10 or 15 years since that federal and state ban went into place?
A. Yeah. I think that the majority of the literature and the studies even that we've looked at for this case was in response to the partial-birth abortion law. So I think the concern that practitioners had about the implications about how that would affect practice led to the research, kind of a flurry of research done on this subject matter. And then as people have better understood that if it's clearly delineated what the intent is in terms of the abortion procedure, that there is less concern about prosecution from the point of view of the partial-birth abortion ban, and so digoxin has really fallen back out of practice, so to speak. And I think especially with the study that demonstrated that it didn't seem to have any effect in terms of improving the safety of the D&E procedure, that people found that as good evidence that the practice or that that was some evidence that it actually was not a good idea to do it.
Q. And if you turn your attention to what is -- you were -- one of the pages of JX 17 you were looking at with Mr. Forsythe, unfortunately the page numbering will be a challenge for us again, but I think it's about five pages in.

It has a page 3 on the bottom. And it's the section that has the box describing the Jackson article, if that helps.

A. Yes.

Q. So Mr. Forsythe had you read some of these excerpts from these two pieces of literature, the Jackson and the Drey literature; correct?

A. Correct.

Q. Those are from 2000 and 2001; is that right?

A. That's right.

Q. Has the medical research and literature evolved like the Planned Parenthood guidelines have evolved over the years?

A. Yes.

Q. All right. And what direction has it evolved in terms of the efficacy or safety of digoxin?

A. So, again, the research has looked now at whether the injection of digoxin improves the safety of the procedure, and that has not been demonstrated. And then there is a kind of a more nuanced evaluation of patients' reactions or desire for fetal demise procedures as well.

Q. You were talking also with His Honor about this question of when patient preference comes into account. Do you recall those questions?

A. Yes.

Q. Under Senate Bill 145, does a patient's preference not to have a demise procedure, can that be respected?

A. No.
Q. Why not?
A. Because it requires fetal demise occur before the D&E procedure.
Q. The Court was asking you about the general D&E complication rate, and could you just remind me again what that -- sort of the general across-the-board --
A. So it's a very safe procedure. It has very low complication rates.
Q. Is the complication rate for a D&E procedure lower than the complication rate for carrying a pregnancy to term?
A. So generally, carrying a pregnancy to term has a higher risk of mortality than does the D&E procedure.
Q. Is the complication rate of the D&E procedure, absent any fetal demise efforts, lower than the complication rate if you add these additional procedures on top?
A. I'm sorry, could you repeat?
THE COURT: Yes.
Q. Yes, that's a tough question. I got myself -- I got carried away. Let's try it this way. You identified various complications that might arise from digoxin or UCT or KCl; correct?
A. Correct.
Q. Would those complication rates be on top of whatever the rate is for just a general D&E?

A. Yes.
Q. So would they increase the complication rate?
A. It would increase the complication rate because it's a separate procedure that has its own inherent risks associated with it.
Q. Is the D&E procedure safer with these fetal demise procedures or without them?
A. No, there's no evidence that it's safer with the fetal demise procedure. So despite the expert opinion that was expressed in this document, that's not been demonstrated in the medical literature.

THE COURT: Felicia, can I ask a question?

Is there a number for what the generally accepted risk of any procedure would be? Like, you know, is there for any surgery, is there a 5 percent risk of infection? Is there some standardized number that doctors consider?

THE WITNESS: In terms of --

THE COURT: Maybe that's a stupid question. I'm just trying to figure out, you know, I don't want to be comparing apples to oranges. I have to sort of get this whole thing figured out in my head about the risk and all that stuff.

So, I mean, the numbers we're talking about, does that -- is that a risk that's not, in your mind, not prudent to take or not medically necessary to take? I mean, you know, so am I making sense at all? Are you confused?

THE WITNESS: So, I mean, I think there are -- there are published literature with regard to different surgical procedures, and, you know, risks associated with different surgical procedures. This D&C and abortion in general has a very low risk associated with it.

THE COURT: Okay.

THE WITNESS: And, you know, the risks associated with digoxin administration, you know, are just added to it on top of that I guess is what I would say. So there's risks to both, but when you require an additional procedure, what I'm saying is that adds additional risk, if that makes sense.

BY MS. ELLSWORTH:

Q. Dr. Keder, are there any sort of common procedures that have a risk rate that you're aware of that you could provide to the Court, right, we think of a hip transplant as having an X risk rate, something like that that's in your head, just to try and assist us with some grounding here?

A. Yes, I guess the most common other procedure I perform is a Cesarean section, and so a Cesarean section has risks associated with it; that generally the risk of infection is felt to be somewhere in the order, depending upon the patient's circumstances prior to the C-section, in the order of 1 to 2 percent. Risk of hemorrhage is well below that. Those are the kind of two major risks associated with that procedure.

Q. And how do you compare that risk versus the risk that is

inherent in a D&E procedure?

A. It's a D&E has lower risk associated with it.

MS. ELLSWORTH: I don't know if that's helpful but --

Q. Dr. Keder, you were asked some questions by Mr. Forsythe about what Planned Parenthood of Greater Ohio might be doing today to implement various state laws. Do you recall that?

A. Yes.

Q. You don't have any management role with Planned Parenthood today, do you?

A. I do not.

Q. So you don't have any involvement in setting forth procedures or policies they might follow?

A. That's correct.

Q. You're only -- can you describe again what it means to be a contract physician?

A. It means that I work there when they have need of me as a clinician, not as an administrator.

Q. Do you follow whatever procedures they may have seen fit to implement at that point in time?

A. So I would follow the guidelines that they establish.

Q. One point of clarification or correction I just wanted to make to your testimony. You asked whether you were being compensated in any way for your testimony today?

A. Yes.

Q. And you said you were not. That's right?

A. Correct.
Q. Is your hotel room being compensated by Planned Parenthood?
A. I think my husband paid for that this morning so --
Q. Was it offered to you to have your --
A. It was offered to, yes.
Q. Just wanted to be sure we were being accurate here.
You were asked some questions about the ACOG Practice Bulletin which is JX 35 by Mr. Forsythe. Could you take a look at that, please?
A. Which tab is it?
Q. 35.
THE COURT: It's in the other book, I think.
Q. And in particular on page three of JX 35, Mr. Forsythe asked you about some studies that are referenced. Do you recall that?
A. Yes.
Q. Just stepping back, can you describe for the Court what an ACOG Practice Bulletin is, what it attempts to do?
A. Sure. These are bulletins that are put out on a variety of different clinical care areas of practice, and they generally look at all of the literature on that particular subject and come to recommendations based on a thorough examination of the literature on that particular topic to try to help clinicians sort through that data and make suggestions for practice recommendations based on that.

Q. And in particular, in this JX 35, if you look beginning on page nine, there's a list of references; correct?
A. Correct.
Q. And it goes on for several pages?
A. Yes.
Q. Up to 106; right?
A. Um-hmm. Correct.
Q. So are those 106 different studies that were synthesized by ACOG?
A. That's correct.
Q. And what did ACOG conclude after conducting its review and synthesis of that medical literature?
A. They concluded that D&E didn't -- induction of fetal demise prior to D&E did not improve its safety.
Q. I don't have any further follow-up questions.
Thank you, Dr. Keder.
THE COURT: Do you?
MR. FORSYTHE: Yes, Your Honor.

RECROSS EXAMINATION

BY MR. FORSYTHE:
Q. The risks of a D&E abortion, that would include infection, hemorrhage, bleeding, extramural delivery; is that correct?
A. Yes.
Q. Are there any other complications, common complications from D&E?

A. You said infection?
Q. Hemorrhage, bleeding, and extramural delivery. Anything else?
A. So none of those are common, but the other potential complications would be cervical lacerations, uterine perforation, incomplete procedure.
Q. And what's the general rate of complication for those?
A. Depends on which one we're talking about, but they're all considered to be less than 1 percent.
Q. And is that an acceptable rate in order to perform the procedure?
A. Yes.
Q. That's all the questions that I have. Thank you, Dr. Keder.

MS. ELLSWORTH: One more?

THE COURT: Yes, sure, but then he gets another shot.

MS. ELLSWORTH: That's fine.

FURTHER REDIRECT EXAMINATION

BY MS. ELLSWORTH:
Q. Dr. Keder, when a patient comes to you when you -- before you perform a D&E, do you inform them of the potential risks of the procedure?
A. Yes.
Q. And then they make an informed choice about whether to proceed with it; correct?

A. Correct.

MS. ELLSWORTH: That's all.

THE COURT: Okay. Anything?

MR. FORSYTHE: Nothing further, Your Honor.

THE COURT: Jade, do you want to talk to me at all or are we okay?

MS. SMARDA: I'm fine.

THE COURT: Okay.

All right. Ma'am, you can step down. Okay.

THE WITNESS: Thank you.

MS. ELLSWORTH: Well, I think since we don't have any further witnesses today, Your Honor, unless the State has something --

THE COURT: Okay. You guys have had conversations with yourselves, with Crum, and some with me. Okay. So somebody just give me the game plan of where we are now. So what happens tomorrow?

MS. ELLSWORTH: As I understand it, the plan for tomorrow is we're beginning first thing in the morning with Dr. Valley who's the State's expert. I think it remains --

THE COURT: What time do you guys want to start?

MS. ELLSWORTH: Nine?

MR. FORSYTHE: 9 o'clock is good for us, yes.

THE COURT: Okay. Is that video or live?

MR. FORSYTHE: We're planning for it to be live. He

is coming from Minnesota, which is -- I guess they're getting some winter storms right now.

THE COURT: Okay.

MR. FORSYTHE: So we're as a backup going to try to have him by video, but hopefully he'll be live.

THE COURT: Okay.

MS. ELLSWORTH: And after Dr. Valley finishes, we'll have Dr. Liner.

THE COURT: Okay.

MS. ELLSWORTH: She'll be live.

THE COURT: Okay.

MS. ELLSWORTH: And then we are planning on Friday morning, with Your Honor's agreement, to begin at 8:30 --

THE COURT: Okay.

MS. ELLSWORTH: -- with Dr. Rivlin and then -- who will be live, and then to have Dr. Haskell who will be by video, and in the afternoon Dr. Ralston who will also be by video.

THE COURT: That's what you guys understand as well?

MR. FORSYTHE: Yes.

THE COURT: Okay. We'll see what happens.

So we'll start at 9 o'clock tomorrow and we'll start at 8:30 on Friday. Is that all right with you, Barb?

COURTROOM DEPUTY: Yes.

THE COURT: Does that work for you, Jade?

MS. SMARDA: Yes.

THE COURT: All right. Thanks, guys.

MS. ELLSWORTH: Thank you very much.

MR. FORSYTHE: Thank you, Your Honor.

(Proceedings adjourned at 4:03 p.m.)

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C E R T I F I C A T E

I certify that the foregoing is a correct transcript from the record of the proceedings in the above-entitled matter.

s/Julie A. Wolfer
Julie A. Wolfer, RDR, CRR
Official Reporter

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