STATE OF NORTH DAKOTA IN DISTRICT COURT

COUNTY OF TASS EAST CENTRAL JUDICIAL DISTRICT

JOSIAH FLATT, by and through natural)
guardians, ANITA FLATT and JAMES FLATT,)
and ANITA FLATT and JAMES FLATT,)
individually,)
Plaintiffs,)
-vs-) No. 99-3761
SUNITA A. KANTAK, M.D., MERITCARE)
MEDICAL CENTER,)
Defendants.)
_____)

DEPOSITION OF

CRAIG SHOEMAKER, M.D.

February 27, 2002

Taken before JENNIFER SCHUMACHER

Certified Shorthand Reporter

State of California

CSR License #9763

APPEARANCES:

FOR THE PLAINTIFF:

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BE IT REMEMBERED that on Wednesday, February 27, 2002, commencing at the hour of 12:49 p.m., at the offices of UCD MEDICAL CENTER, Sacramento, California, before me, JENNIFER SCHUMACHER, a Certified Shorthand Reporter, empowered to administer oaths and affirmations pursuant to Section 2093(b) of the Code of Civil Procedure, personally appeared

CRAIG SHOEMAKER, M.D.,

A witness in the within-entitled matter, called as a witness by the plaintiff, who, having been duly sworn by the Certified Shorthand Reporter to tell the truth, the whole truth, and nothing but the truth, testified as follows:

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EXAMINATION BY MR. BAER

Q. This is the time and date noted for the taking of the deposition of Dr. Craig Shoemaker for all purposes contemplated by the Rules of Civil Procedure.

Would you please identify yourself for the record and give us your address.

A. My name is Craig Thomas Shoemaker, S-h-o-e-m-a-k-e-r. Address is 4865 Dalewood, D-a-l-e-w-o-o-d, Drive, El Dorado Hills, California, 95762.

Q. And in the notice to take the deposition I asked

that you bring certain documents, and you have presented certain documents, and I've briefly reviewed them before going on the record. And I just wanted to for the record identify the contents of your file.

There's correspondence from Ms. Voglewede to you dated April 26th, 2001, correspondence dated March 26th, 2001 from Voglewede to you, correspondence from Voglewede to you dated April 18th, 2001, correspondence dated December 5th, 2001 from Voglewede to you, and a fax transmission from Voglewede to you dated August 31st, 2001 regarding an updated opinions by Cold and VanHow and Dr. Wang.

In addition to those documents which are located in the front sleeve of the three ring binder is one that's bound by a metal clasp dated March 26th, 2000 cover letter with additional affidavits of Dr. Cold and Dr. VanHow. The cover letter is from Jane Voglewede to you inquiring about Dr. VanHow and Dr. Cold and their status in the medical community.

In addition, you have a three ring binder, a black three ring binder that has been set up with separate divisions, and an index and table of contents. Was this supplied to you by the attorneys for the defendant?

A. It was.

Q. And it includes depositions of Dr. Kantak, Nurses Burgard, Thilmong, Larson, Engquist, and then depositions of Anita Flatt and James Flatt, and then five other documents which include the MeritCare booklet Should Your Infant Boy Be Circumcised, infant care section on pages five to six, MeritCare Family Birth Center Policy and Procedure on Circumcision, Dr. Kantak and MeritCare answers to interrogatories, and Dr. Kantak's curriculum vitae.

Do you know when those were supplied to you?

A. I don't remember the exact date.

Q. Going on, then, in the file you have a condensed copy of Dr. Wane's deposition, and then you have another fax copy of Dr. Eileen Wane's updated expert opinion testimony dated February 21st, 2002, a letter dated February 12th, 2002, looks like it's just a letter of conveyance of Dr. Wane's deposition to you from the attorneys for defendants.

Then you have in a pink, if I can call it that, covered binder or a two hole punched with different dividers what appears to be medical records of Anita and Josiah Flatt of E.R.M.C. clinic.

Are these the sum total of the medical records that you received and reviewed as a result of your preparation for this case?

A. They are.
Q. And were these assembled and supplied to you by the attorneys for the defendant?
A. They were.
Q. The next document is a letter dated January 16th, 2002 from Ms. Voglewede to you enclosing two depositions, one of Dr. Cold and the other one of Dr. VanHow. That completes the inventory of this black three ring binder and other loose documents. And you indicated you also had some other documents in your hand, and that was the AAP March 1999 policy statement on circumcision; is that correct?
A. That's correct.
Q. And the other document was a hard copy of the Should Your Baby Boy Be Circumcised and the Infant Care Booklet published by MeritCare?
A. That's correct.
Q. In addition, you did give me two articles, one was entitled "Neonatal circumcision: Risks and benefits" authored by you. It does not appear to have a date, although do you know when this was published?
A. It was published initially in early 2001, and it's updated yearly on the E Medicine textbook, which I think is listed in the first paragraph.
Q. October 6, 2000?

A. I wrote it -- initially I think it was published on January 1st when the E Medicine textbook came out.
Q. Now, the document identified as "Neonatal circumcision: Risks and benefits" is a document that you had published on the E Medicine journal?
A. Yes, that's correct. It's a textbook, actually.
Q. A textbook. Who publishes that textbook?
A. The company called UpToDate dot com.
Q. And just for the record, the last deposition exhibit we had marked yesterday was deposition Exhibit 18 of Dr. Kaplan. I'm going to mark this Exhibit 19 just for reference purposes.

(Plaintiff's Exhibit 19 was marked for identification.)

Q. MR. BAER: And is the E textbook, is that a peer review textbook?
A. No. It's what's becoming more common in medicine, compilation of opinions by authors. There are peer review text books in that regard in the Internet as well. But this is not a peer review. There are editors to the textbook which review it.
Q. Okay. And then the last document that I will mark with a sticker as Exhibit 19 --
MS. VOGLEWEDE: Try 20.
Q. MR. BAER: I'm sorry. Exhibit 20, is an

editorial comment that you handed to me just before starting the deposition, and it is entitled Editorial Comment with 21 references. It does not have a date. Do you know when that was --

A. It's listed in my CV. I think it was 1999. Is that in here someplace?

(Plaintiff's Exhibit 20 was marked for identification.)

THE WITNESS: Are you done with this, Mr. Baer?

Q. MR. BAER: Yes.

A. Yes, 1998.

Q. 1998, Yearbook on Neonatal and Perinatal Medicine?

A. Correct.

Q. Was it published?

A. Yes.

Q. Okay. Do you have children, Dr. Shoemaker?

A. I do.

Q. Three boys?

A. That's correct.

Q. Are they circumcised?

A. They are.

Q. Prior to coming here did you speak to Dr. Kaplan about this case?

A. I did not.

Q. Did you talk to anybody else on the circumcision task force about this case?
A. I did not.
Q. Did you talk at all with Dr. VanHow?
A. I did not.
Q. Dr. Wane?
A. I did not.
Q. Dr. Cold?
A. I did not.
Q. Did you talk to Dr. Kantak?
A. I did.
Q. When did you talk to Dr. Kantak?
A. I talked to Dr. Kantak, I don't recall the precise date, when she was notified that she was a defendant in this suit. That was before I had moved from Fargo. And I subsequently talked to her one or two other times about the case.
Q. Can you pin it down any closer than that, Dr. Shoemaker --
A. No.
Q. -- than one or two other times?
A. She sought me out for support and comment on her care, but I don't specifically remember dates.
Q. Okay. You said the first time would have been shortly after she was notified she was being sued?

A. That's correct.
Q. So that we can put some time frame on it. I don't have it right here today, but we can put some time frame on it. Were the other two times at critical junctures when she was being deposed or something like that? Do you recall any part of the conversation with Dr. Kantak?
A. I don't. They were all before I moved to California, so they would all be before December 2000.
Q. And this was on three different occasions?
A. I believe I can recall three total occasions.
Q. And did she come to seek you out on an individual basis at your office?
A. Yes.
Q. And your recollection of the conversation was that she was seeking out support?
A. Yes.
Q. For what she did?
A. I think she wanted me to review the medical -- initially she wanted me to review the medical records to see if there was anything I thought was unusual, out of line, and then she -- as you mentioned, it may have been around deposition time, and it was more for emotional support. She had never been sued before I don't believe.

Q. But you indicated that she wanted you to review what, her medical care, and what, her medical practice that she did?
A. That was my impression.
Q. So she would have described what she did to you?
A. I believe so, yes.
Q. On multiple occasions?
A. At least three.
Q. And she wanted to know whether or not if that was done that would meet the standard of care, at least as you understood the standard of care to be?
A. I don't remember that she ever used the word standard of care. I think she said do you see anything untoward in these, and she didn't use the word untoward, that's my word, in the care of the child.
Q. But what I'm asking, Dr. Shoemaker, is that she came to you and described what she did in the care of this patient and asked is there anything wrong with what I did or should I do more?
A. I believe it was generally that.
Q. So you have heard her side of the story at least three different times on those three occasions that she met with you?
A. I think so.
Q. And she described to you then all of the

disclosures that she would have made to Anita at the time there was a discussion about circumcision?

A. No, she did not describe in detail to me what she discussed.

Q. Okay. Well, what did she describe?

A. She described that she had been notified she was being sued about a child -- that she had been sued for a child she had circumcised in the neonewborn nursery, that she had counseled as we had recommended in our department meetings and wondered had she done anything wrong. I guess that's a satisfactory statement.

Q. You mentioned a concept there that I hadn't heard before, that in your departmental meetings you would instruct department members as to what they are supposed to describe for informed consent?

A. I would not instruct. We would discuss and arrive at a consensus about what we thought was an appropriate standard of care.

Q. As best you can right now, Dr. Shoemaker, why don't you just tell me what that instruction would be?

A. Well, beginning in the early '90s when I became involved, as you are aware, in circumcision issues, I brought it to the department as chair that having reviewed the literature that was currently available at MeritCare we probably needed a more extensive

explanation of circumcision so we could properly counsel parents. And we discussed what that might entail, how we could best accomplish it, what our individual opinions were as Board Certified pediatricians and proceeded from there.

Q. But what -- tell me what was the consensus that you as a collective body decided on would be the information necessary to meet whatever your collective consensus was to meet that information standard.

A. We decided that we should develop a written document that would describe the historical perspective, the procedure, risks and benefits, complications, social issues, and financial obligations. It was subsequently during meetings there was some correction -- or that's a wrong word. There was alteration of the document because of some statements made in the financial responsibilities, and so about a year after we published the first one for use we revised a paragraph in relation to financial obligations. And that was the written literature that we thought we should have, and then it was also -- and it was documented in our department notes that we should have a verbal conversation with the parents, and we should document that we had discussed analgesia and anesthesia regarding circumcision with each parent.

Q. So am I to conclude from your description just now, Doctor, that what has been marked as Exhibit 2, which is that Should Your Infant Boy Be Circumcised pamphlet that you referenced earlier, was that the written document that you came up with as a result of your discussion amongst your group members?

A. That is correct.

Q. And if you look at the publication date on the backside, which is on the front, it says it was initially published in 1996 and revised in January of 1997?

A. That's correct.

Q. Do you see that? What is the date in 1996, is it December?

A. 12/96.

Q. And as far as you know are those the dates that the document would have been first developed and then revised?

A. The dates -- the document would have been developed prior to that time. It was -- the department decided it was satisfactory to be published by 12/96 and distributed after that time.

Q. And the distribution then would have begun in December of 1996?

A. That's correct.

Q. When in December of 1996?
A. I don't know exactly the date.
Q. And then there was a revision of it in January of 1996?
A. Right.
Q. Or 1997? Sorry.
A. That's correct.
Q. Prior to that implementation of -- strike that.
Let's get back to the discussion you had. I'm still trying to understand from you, Dr. Shoemaker, what it is that you concluded in your department consultations would be necessary to give parents in order to inform them adequately enough to meet the informed consent standard.
A. There is no informed consent standard, actually.
Q. Okay. What did you conclude? Obviously you put together a booklet, right?
A. That's correct.
Q. Is there anything above and beyond the booklet that you as a department concluded would be necessary to give parents to meet the medical obligation of giving information so that the parent could make an informed decision about that procedure?
A. Not to give the parent anything but to discuss with the parent what was in the book and allow them the

opportunity to answer -- ask questions and have them answered in an unbiased fashion regarding the issue of infant male circumcision.

Q. Is it your position then that Exhibit No. 2, the pamphlet Should Your Infant Boy Be Circumcised is an adequate discussion of the risks and benefits to meet that informed consent standard?

A. Not in and of itself.

Q. You also used in your discussion just now a concept of department notes. What are department notes?

A. They are minutes from department meetings.

Q. Who keeps those?

A. They are kept by the secretary of the department of pediatrics.

Q. Who is that?

A. I don't know who it is right now.

Q. Who was it when you were there?

A. It was at that time -- I forgot her name. It could have been -- I don't remember whether it was Janet Dedrick who is currently the secretary of neonatology or an older lady who is now retired, and I don't remember her name. They would interchangeably sit in on pediatric and OB/GYN meetings to take notes as recorders. Marsha Gross. Sorry.

Q. That's okay. And the minutes from these

department meetings, were they kept at the department?
A. They were kept in my office.
Q. And where did you deliver those minutes after you left the clinic?
A. I left them in my office.
Q. So who took your position?
A. Dr. Ron Miller.
Q. Could you give me some sense of how voluminous these minutes would be say -- you used the term in the early 1990's you became actively involved in the circumcision issues and you started doing review. If you looked at the minutes from 1990 to the current when you left, December of 2000, how voluminous would they be?
A. Not terribly large. The items relating to circumcision would be relatively small I would think. They would be single paragraph as things were discussed in either new business, old business, standard agenda for Robert Schuler orders of meetings.
Q. How often would you hold these meetings?
A. Once a month.
Q. So there would be a maximum of 12 meetings for each of those ten years?
A. Yes, that's correct.
MR. BAER: I just want to make on the record a

request for those minutes.

MS. VOGLEWEDE: Your request will be considered.

MR. BAER: And I will follow that up.

Q. To your knowledge, Dr. Shoemaker, was there -- how many members of your pediatric group practiced in the children's hospital at MeritCare?

A. All of them.

Q. How many were there? What is the total number?

A. At my last recollection there was I think 21.

Q. Do you know what their mix was, males, females?

A. I think there was three females -- four females, 17 males.

Q. Were there any of the 17 males that did refuse to do circumcisions?

A. Not to my knowledge. There were people who did not do circumcision because that was not part of their practice. I'm not aware of anyone who refused to do circumcisions.

Q. Dr. Kantak indicated that there was a system in place where on a regular basis the physicians would take on call at the hospital on a weekly basis and that the person who was on call or doing rounds would do all the circumcisions. Were there any of the pediatricians who did not fit into that rotation so they would be put into that position of doing circumcisions?

A. No. But I will correct, if I may, my previous statement. I believe Dr. Litia Kreshnuska preferred not to do circumcisions and when she was on call someone else did that. That just popped into my head.

Q. Do you know if any of the 17 male members, were any of them intact, that is, have an uncircumcised penis if you know?

A. I'm trying to remember if I've seen any of my colleagues nude. The only -- no, none of the department of -- I do not know about any of the department of pediatrics members. I do know about the C.E.O. of MeritCare.

Q. And what do you know about the C.E.O. Roger --

A. He's intact. I'm sorry.

Q. How did that come up?

MS. VOGLEWEDE: I'm going to instruct him not to answer anything further about that.

Q. MR. BAER: Well, did you ever meet with Roger Gilbertson to talk to him about this case?

A. No.

Q. Did you talk to him about the Fishback case?

A. No.

Q. Did you talk to him about your sitting on the AAP committee studying circumcision?

A. I did.

Q. And is that the context in which it arose?
A. I don't remember.
Q. What is your title, Dr. Shoemaker? Are you a pediatrician, what title do you have professionally?
A. I am a --
MS. VOGLEWEDE: His title or his specialty?
Q. MR. BAER: Let's go title first.
A. My title at the University of California, Davis is clinical professor of pediatrics and medical director of the special care nurseries.
Q. Okay. And what is -- and broadly speaking are you a pediatrician?
A. I am a pediatrician.
Q. And then are there subspecialties under pediatrics that you have pursued?
A. Yes.
Q. And what are those subspecialties?
A. Neonatal perinatal medicine.
Q. How would you define a pediatrician? What words would you describe to a lay person what a pediatrician does?
A. A pediatrician is an individual who cares for children, and the definition of a child varies as to age, and who does medical care, well child care, including safety counseling, parent advice, counseling

of parents and children from infancy through adolescence.

Q. And your subspecialties, then, of pediatrics would be further confined from that broad category, I take it?

A. Yes, that's correct.

Q. And what of those subspecialties, what would you then do for a patient?

A. My subspecialty training in board certification is in the care of well and sick newborn infants from premature infants through early infancy and counseling of parents regarding those illnesses, as well as evaluation of in utero problems and counseling of parents regarding high risk pregnancies.

Q. Is that known as perinatology?

A. Perinatology is an obstetric subspecialty that deals with the medical management and counsel of mothers in relation to high risk pregnancies.

Q. Once a baby is born as a pediatrician that baby is capable of being a patient, right?

A. That's correct.

Q. And as a pediatrician you would consider a newborn, a full term newborn child to be -- if he or she is under your care to be your patient?

A. That's correct.

Q. And in order to do any procedure on a patient you first must obtain consent; is that correct?
A. That is correct.
Q. And the infant cannot give consent; is that correct?
A. That is correct.
Q. So you have to obtain proxy consent, typically it's a parent?
A. A surrogate consent, that's correct.
Q. And in order to do that, to get the surrogate consent, you would need to provide enough information to the surrogate to adequately inform that individual about the risks and benefits of a procedure before going forward with the procedure?
A. I believe so, yes.
Q. And you'd have to give unbiased information?
A. That's correct.
Q. In understandable language?
A. That's correct.
Q. And it is the physician who has that obligation, that cannot be delegated to a nurse or an LPN?
A. That is my personal opinion. That is not always how it's done.
Q. I want to show you what has been marked as Exhibit 12. I'll represent to you that that is an

exhibit that was discussed yesterday with Dr. Kaplan, and it is the AAP Policy Statement on Informed Consent, Parental Permission, and Asset in Pediatric Practice number RE9510. I believe it's from 1995.

A. You're correct, 1995.

Q. Are you familiar with that statement?

A. I am.

Q. And would you agree that the AAP's statement is a general statement as to the standard of care of -- required to obtain informed consent before doing surgical operations or other interventions on minors?

A. The Academy of Pediatrics does not establish standard of care. The Academy of Pediatrics writes policy statements, statements of clinical guidelines. So this is a suggestion of policy, but it doesn't necessarily represent the standard of care.

Q. What represents the standard of care, Dr. Shoemaker?

A. The standard of care is represented by individual communities in relation to what they feel must be performed in relation to providing an adequate amount of unbiased information.

Q. And the individual community in Fargo may be much different than the individual community from here at U.C. Davis?

A. That's very true.
Q. Or in San Diego?
A. That's true.
Q. So if somebody was not familiar with the individual community up in Fargo, North Dakota they may not be able to give helpful information on the standard of care in Fargo?
MS. VOGLEWEDE: I'll object on the grounds that that asks for a legal determination, not a medical one. You can answer.
THE WITNESS: I think in relation to commonly performed procedures standard of care could be met by a person describing a procedure but without being in the community for -- since that's something that is almost never done, someone comes into a community and does a procedure without being involved in the community, it would be very difficult to answer. It's kind of speculative.
Q. MR. BAER: Dr. Kaplan has never practiced at Fargo, North Dakota?
A. That is correct, to my knowledge.
Q. Well, he told us yesterday under oath that he never practiced in Fargo, North Dakota. By your statement just now Dr. Kaplan would not have any firsthand knowledge of what the standard of care would

be for performing a circumcision in Fargo, North Dakota, would he?

MS. VOGLEWEDE: Same objection that it goes to a legal issue not a medical one as to what the standard of care is.

THE WITNESS: I think in general as a pediatric urologic surgeon he would have a general concept of what should be mentioned in standard of care, but he would not be familiar with what was done normally in Fargo, North Dakota.

Q. MR. BAER: And in your mind, Dr. Shoemaker, the standard of care is what is done in Fargo, North Dakota by the community of people who practice there?

A. In regards to the fact that they have access as do we all to national information about what policies, what organizations they belong to to develop that procedure, I would say that was true.

Q. And one of those things that you tap into is the AAP statement on informed consent; isn't that right?

A. That would be correct.

Q. I take it, Dr. Shoemaker, that you do not believe or agree that there is an objective standard of care, it's subjective dependent upon the community within which you practice?

MS. VOGLEWEDE: I'll object on grounds that it

goes to a legal question, not a medical one. Secondly, it mischaracterizes his previous testimony.

THE WITNESS: Is your question is there an absolute standard of care?

Q. MR. BAER: No. If you didn't understand the question, I'll rephrase it.

A. Please rephrase it.

Q. Okay. I take it, Dr. Shoemaker, that you do not believe there is an objective standard of care but that the standard of care is subjective dependent upon which community you practice?

A. There are certain parts of standard of care which would be objective and recognized in general. There are other parts which would be subjective.

Q. Okay. Tell me which ones would be objective and which ones subjective.

A. Subjective in my opinion would particularly be whether or not the procedure was paid for. If a parent was required to pay prior to the procedure being done, the insurance company was not going to pay for that. A subjective standard would be that one of religious belief, symbolic procedure. I think those are subjective. Cosmetic as well would be subjective.

Q. Have you read the informed consent statement by the AAP?

A. I have sometime ago.
Q. Do you agree with that statement generally?
A. I think the statement gives good guidelines for discussion with parents regarding how a discussion should go in relation to obtaining informed consent or informed permission.
Q. Would you agree with the statement in the policy statement that suggests informed consent has limited direct application in pediatrics?
A. I don't know where that statement is in context. Do you know where it is?
Q. Yeah, I do. I thought I did. Page 2 of Exhibit 12, the first full paragraph.
A. Would you restate the question then, please?
Q. Do you agree with the statement that informed consent has limited direct application in pediatrics?
A. In context to the remainder of the statements, the remainder of that paragraph that say that only patients who have appropriate decisional capacity to provide informed consent, that is correct.
Q. So if you have a child who cannot give consent because of their immaturity, the doctrine of informed consent really doesn't apply to your patient, does it?
A. It does apply indirectly because parents --
Q. But only to the proxy?

MS. VOGLEWEDE: Let him finish.

THE WITNESS: Because the parents have been recognized legally as being able to provide informed consent, or as this document says informed permission, for elective procedures for their children.

Q. MR. BAER: Would you agree with the concept that informed consent assumes that the person who is consenting is giving that consent?

A. Generally, yes.

Q. And there is a distinction to be made about an informed consent of a patient capable of giving that consent and a proxy consent where the patient is not able to give that consent?

A. That is correct.

Q. Even in the situation where you have a proxy consent, however, your patient is the infant?

A. Generally pediatricians consider parents to be part of the maternal infant diade. So mother is part of their patient responsibility as well. But the patient with whom you are treating generally is the child, yes.

Q. Would you also agree with the observation by the AAP policy statement identified in Exhibit 12 that there was a time where there was a concept that doctor knows best and whatever the doctor thinks should be done was done without giving adequate information to patients to

make those decisions?

A. Over the past several hundred to thousand years that has been the feeling in several cultures, yes.

Q. Including the American culture?

A. That is correct.

Q. And the 1995 statement by the AAP suggested that that is outdated thinking, we now have to think of it as being a more partnership and that the patient had a right to refuse recommended treatments suggested by the physician?

A. As you commented before, in relation to that statement that would directly say if the patient has the appropriate decisional capacity, yes. If the patient does not have appropriate decisional capacity, they cannot be expected to comment on informed consent.

Q. Exactly. But if the patient does not have sufficient capacity, then you have to go through the legal mechanism to determine who can give substitute capacity?

A. And legally the parents are able to give that.

Q. You know that?

A. I do know that.

Q. Okay. You would also agree that the right to choose treatment or no treatment is for the patient to decide?

A. If a patient has the ability to make that decision.

Q. And of course, an infant doesn't have that ability, right?

A. They do not.

Q. And so you look to a parent to obtain that permission?

A. Yes.

Q. And is it not true that you would not be able to do a procedure on your patient, that infant, unless you concluded it was in the best interests of that child to do the procedure?

A. Or if it was a life saving procedure.

Q. Right, life saving or in the best interests?

A. Yes.

Q. If it was life saving, you wouldn't even perhaps need the parent's consent?

A. That is correct.

Q. And would you also agree that as a medical doctor treating an infant you have a duty to respect the autonomy of that infant?

A. To the point where the infant can understand autonomy. I mean there's a concept of self. Children really don't have a concept of themselves as beings until sometime between age two and three, so their

ability to have a concept, it doesn't exist.
Q. From the child's standpoint. But from a human standpoint a baby is born, that's a separate living, breathing, thinking, albeit rudimentary being, isn't it?
A. To a certain extent, yes.
Q. That child is endowed with all the rights and privileges of a human being, right?
A. Most people would agree with that.
Q. And as a medical doctor treating an infant like that you have a duty to respect that person, right?
A. That's correct.
Q. Looking under the provision on informed consent under the broad heading of Ethics and Informed Consent, would you agree with the elements of informed consent, basically four elements with the first one being the most broad having a number of subcategories, the first element of informed consent is the provision of information to the patient and explanation and in understandable language of, A, the nature of the ailment or condition, B, the proposed diagnostic steps, treatment, success, failure rates, C, the existence of risks, D, the potential benefits, and E, the risks of recommended alternatives?
A. In relation to the remainder of the paragraph under item number 3 where it says "Assessment of the

capacity of the patient or surrogate to make the necessary decisions," I would agree with that.

Q. I'm getting to that, but I just wanted to know on item number one, you would agree that those are elements of the first element of informed consent is the provision of information to patient and explanation in understandable language of those different aspects?

A. That's correct.

Q. And then the second broad category is assessment of the patient's understanding, and as it relates to an infant boy who has just been born, you wouldn't have much understanding by that patient, right?

A. I would agree with that.

Q. And similarly under number three you have to assess the capacity of the patient or surrogate to understand, right?

A. That's correct.

Q. And then four, assurance that the patient has the choice to refuse without coercion?

A. Or the surrogate, yes.

Q. Now, if we apply that standard of informed consent with those elements under the provision number one, what would you describe the baby boy's condition to be?

A. Which baby boy?

Q. The baby boy who was just born that the parents want to circumcise, what would you describe the condition to be?
A. You're asking me to speculate on a patient?
Q. Yep.
A. With a healthy term male child who is physiologically stable?
Q. Yes.
A. I then, therefore, described him.
Q. Yep.
A. Do you want further explanation?
Q. What is the ailment or condition that he would be treating?
A. I just said there's a healthy male child who is in stable physiologic condition.
Q. So you wouldn't be surgically intervening to treat anything?
A. I think in relation to certain lesions, certain duplications of digits, certain things that were asked for cosmetic procedure to be removed, there might be an indication in a healthy child to do a surgical procedure, yes.
Q. Let me just back up to take out of this equation all of those extra digits, skin tags, and those other issues. Let's just say there are none of the

abnormalities or genetic problems with a child, the only thing is he's got a foreskin.

What would you describe to a parent to describe the nature of the ailment or condition that the patient is suffering from?

A. I would say that the child is normal.

Q. And then how would you describe the proposed diagnostic steps, treatment and the success or failure of those?

A. I would describe if -- we are discussing circumcision, one would assume.

Q. Yes.

A. If one was to describe circumcision, there are, as the Academy of Pediatrics notes in their 1997 statement, potential medical benefits that are not essential to the child's current well-being but that may help in the child's long term health that might be a reason to consider removing some of the foreskin.

Q. Okay. You said some of the foreskin.

A. Uh-huh, yes, I did say some of the foreskin.

Q. And why do you say some of the foreskin?

A. Because it is generally felt that the foreskin which anatomically extends quite a way along the shaft of the penis should not be entirely removed.

Q. Are there any studies that have looked at the

amount of foreskin that is removed that you are aware of?

A. There are at least a couple.

Q. Can you refer me to those?

A. Not off the top of my head. They are in the voluminous work that we reviewed for the Academy statement.

Q. Now, the AAP statement talks about proxy consent and problems with the consent by proxy, and I just want to know whether you agree with the statement that the -- as a medical doctor having an infant as a patient that you have a legal and ethical duty to your child patient to render competent medical care based on what the patient needs, not what someone else expresses?

A. That is --

Q. Do you agree with that statement?

A. That is quoted from the paper. I would generally agree with that.

Q. And so in order to do a circumcision as a medical doctor you conclude that the patient needs the circumcision?

A. I do not conclude that in any case ever.

Q. But isn't it your legal and ethical duty to the child patient to render competent medical care based on what the patient needs?

A. And the patient's needs are described by the parents after they have been adequately counseled regarding the procedure.

Q. Not what someone else expresses, are you saying in this case patient is mom or dad?

A. The patient as a surrogate decider is under the concept of reasonable, it is reasonable to assume that the parents will make a reasonable decision for their child. That is well established.

Q. Why do you need a law that bans female genital mutilation then?

A. I think that's irrelevant. They are not even the same procedure.

Q. Why do you need a law -- if the patient is going to make a decision always in the best interests of the child, why would you need a law banning that?

A. There are religious elements in third world countries that believe female genital mutilation is a procedure. In the developed countries of the world we do not feel that that procedure is appropriate, and so a law and a statement by the Academy of Pediatrics has been developed to say that we do not feel as a group that this is an appropriate procedure. It is mutilation. It is not a medical therapy.

Q. Is Europe a developed country?

A. I would say it is.
Q. Is Australia a developed country?
A. Yes.
Q. Is Canada a developed country?
A. Yes.
Q. Is Britain a developed country?
A. Yes.
Q. Europe doesn't practice routine infant circumcision, does it?
A. The United States doesn't practice routine infant circumcision to my knowledge either.
Q. It doesn't?
A. The world routine means to do on everyone. The American Academy of Pediatrics has never recommended routine circumcision.
Q. What is the percentage of people or baby boys that are circumcised?
A. In this country?
Q. Yes.
A. Depends on which part of the country you're in. But I think the average in this country probably right now is about 70 percent.
Q. How about Fargo Moorehead?
A. It's more like 95 percent.
Q. And those are just rough estimates; is that

right?
A. Yes, they are rough because I haven't done a study on it.
Q. Well, there are no studies out there that are accurate and reliable, are there?
A. There have been survey studies, sample studies done by public health in California or whatever that asked the circumcision rate. There are studies that have done surveys about men knowing their own circumcision status.
Q. In your AAP statement don't you conclude that the studies are insufficient to conclude what the rate is in America?
A. Oh, absolutely, it changes every day.
Q. Getting back to the decision on the proxy consent, if I understand your position correctly, Dr. Shoemaker, you would say that as a medical doctor carrying out your ethical duty to the patient and that ethical duty is that you do only what that patient needs that you can determine what that patient needs by the whim of a parent?
MS. VOGLEWEDE: I'll object to that as mischaracterization of his testimony.
THE WITNESS: It is not the whim of the parent. It is an informed decision that is made after counseling

the parent in an unbiased manner regarding the potential medical benefits and the risks of the procedure of circumcision.

Q. MR. BAER: Well, let's put another factor into this equation. What if you have mom and dad sitting there, they listen to all of your descriptions about the risks and benefits of circumcision, they say I don't care what you say, Doctor, I want my child to look like me, do it. Do you then continue and do the circumcision?

A. I'm not sure what your question actually is. If I have consented the parents?

Q. If you have given information to the parents, the parents say I don't care what you say, Doctor, I'm not listening to you, just do it, do you do the circumcision?

A. To answer your question, I never do a circumcision without informing the parents regarding the risks and benefits. To directly answer what you said to me, if a parent said I don't want to listen to you, just do the circumcision. I would say, I'm sorry, I can't do that until I've adequately informed you. Does that answer your question?

Q. So then adequately -- you give them the rest of the information, they say I don't care, just do it, do

you do it?
A. Then I have informed them and I would do the procedure, yes.
Q. Would you agree that under that circumstance, that scenario, that it would be a whim of the parent?
A. I think they would have heard the explanation of informed consent and made a decision. On what their decision was based is not for me to decide.
Q. What is the purpose of informed consent, Dr. Shoemaker?
A. It is to provide adequate, unbiased information about the risks and benefits of the procedure.
Q. But it's not in a vacuum, is it? That adequate, unbiased information is supposed to be absorbed by an individual to take and weigh the risks and benefits and whether or not the procedure should be done, right?
A. I believe that's correct, yes.
Q. Would you agree that the pediatrician's duty and responsibility is to the patient not the parent?
A. Yes, in most circumstances.
Q. Why do you qualify that?
A. I think there are situations where parental interest and infants interest can come into conflict, but they are mostly life threatening instances.
Q. Where the parent might not consent to a procedure

and you think it has to be for saving the child?
A. Or on the contrary where a parent wishes a procedure done which would not be in the best interests of a child.
Q. Give me an example of that.
A. A baby who has a lethal chromosomal abnormality and parents want to have extensive surgical procedures done. There are multiple kinds of problems.
Q. Do you do the surgeries then?
A. I think there is a fairly good ethical standard made in this country that a physician if they feel morally or ethically opposed to doing a procedure does not have to do the procedure.
Q. The subsection of the policy statement, Exhibit 12, on parental permission and shared responsibility talks about the situation where you have a parent making a decision for an infant child who can't make the decision on their own, that you still need all of the elements of informed consent that had previously been described. Do you see that?
A. Yes.
Q. And that would be those four elements that we talked about with sub parts, right?
A. Correct.
Q. And that usually after given all that information

a parent will make the decision on the best interests of the child standard, and you would agree that that is the standard that you need to follow?

A. Yes, in regards to the entire statement that mentions a pluralistic society and acceptable child rearing and welfare and religious beliefs, et cetera.

Q. So there are certain circumstances where parents try to make decisions that in your opinion are not in the best interests of the child, and that's why you need child neglect laws and assault laws, FGM, those kinds of things?

A. I answered that previous, yes, in the same way.

Q. How do you as a physician determine what is in the best interests of a child? Instead of doing this in the abstract, how would -- I guess we have to do it in the abstract to some extent because you weren't there.

How would a physician determine what is in the best interests of Josiah Flatt as he is sitting in that bassinet, intact, a healthy baby boy?

A. By their knowledge of pediatrics, by their knowledge of medical literature, by their knowledge of -- by their training in pediatrics, that's how one would determine what was in the best interests of the child.

Q. Okay. So how can -- if a parent wanted to cut

off part of the earlobe, would a doctor do that?
A. I think not.
Q. Why not?
A. It wouldn't be in the best interests of the child. What if the parent wanted to pierce the ear?
Q. Do you pierce ears, Doctor?
A. I don't.
Q. Would you as a medical doctor pierce an ear?
A. I would.
Q. If a patient requested?
A. It's quite culturally common in some parts of our society.
Q. I'm asking you, would you pierce an ear of a patient if mom says, Doctor, I want this ear pierced?
A. I would prefer that I would do it after I did an informed consent rather than have it be done in a dime store.
Q. Have you ever done that for a patient?
A. I never have. Most the parents -- my experience is after informed consent most the parents don't have me do it, or all parents that I've talked to haven't had me do it.
Q. So we're talking about how a doctor would determine what is in the best interests of that healthy baby boy, and you said by the knowledge you have,

experience and training, the medical literature. And would there be any basis upon which the doctor could say it's in this child's best interest to be circumcised?

A. I believe so.

Q. Even if it was a healthy baby boy?

A. Absolutely.

Q. Based on the 1999 Academy statement?

A. No, based on my personal medical experience, my review of the medical literature, the 1999 American Academy statement, 1995 American Academy of Pediatrics, my training and my personal experience having worked in intercity emergency rooms, V.A. hospitals, migrant health clinics, and in pediatrics I think circumcision is an issue that is relative not only to an infant but to an entire life. And I think that's why it's important to counsel parents regarding that.

Q. Are you circumcised?

A. I am.

Q. Do you think it's proper for a medical doctor to circumcise a child just because a parent wants that child to look like their dad?

A. A male child, if the parents have been appropriately counseled, I believe that is an adequate, an appropriate societal or personal decision.

Q. But by your description right now I would

characterize you as being procircumcision.
A. I believe that I would want my family members circumcised. But I have no personal feeling about what you should do with your family.
Q. But if somebody came in and they were your patient, they said what would you recommend, Doctor, you would recommend circumcision?
A. That's an easy question for me to answer because I have told parents for over 20 years I don't give my personal opinion. I will give you the medical facts, and then you must make the decision.
Q. And the medical facts were as you described them in Exhibit 2 as best you could?
A. In a language that most parents can understand. One must understand I wrote the statement, at least initially before it was revised by the department, we had to lower the quality of the language down somewhat.
Q. Okay. Under the statement, keeping on with the informed consent statement of the AAP, there is a subheading talking about practical applications. It gives several examples of when you would get informed permission, and it mentions immunizations, invasive diagnostic testing, long term anticonvulsant therapy. Do you see that?
A. I'm looking. I'm trying to find it. Yes.

Q. It doesn't mention circumcision in there, does it?

A. It does not.

Q. Unless you -- I am done with this one. I'll just go to a different exhibit now, Doctor.

Showing you what's been marked as Kaplan Exhibit 8 and Kantak Exhibit A, that is an AMA standard I believe identified as E-8.08 Informed Consent. I believe the date is 1981. Are you familiar with that document?

A. Yes, I am.

Q. And does that provide a standard for informed consent at least as the AMA described it?

A. It doesn't. It, again, applies a guideline for informed consent, but the standard of care is not written anywhere.

Q. That is the --

A. This is the AMA's opinion.

Q. What you're qualifying is that the standard of care is based on the locality?

A. Right, correct.

Q. And in Exhibit 8 do you see the language that talks about informed consent is a basic social policy? It's about halfway through.

A. I'm just looking for it exactly. Yes.

Q. And then it says for which there are exceptions, certain exceptions are permitted. Do you see that?
A. Yes.
Q. And the first exception is where you have an unconscious patient or a patient incapable of giving consent and harm is imminent?
A. That's correct.
Q. Now, the second exception doesn't really apply to the circumcision issue, does it? You would never have the second exception apply where disclosure of the risks would cause psychological problems to the patient?
A. Perhaps to the parents in that regard.
Q. But the parents aren't being circumcised, are they?
A. No, but they are the surrogates that are responsible, and I have indeed known parents that have developed psychological distress when hearing the risks and the benefits of the circumcision for their infant male child.
Q. Read the second one.
A. When risk-disclosure poses such a serious psychological threat of detriment to the patient as to the medically -- as to be -- there's a cross out -- it must be medically -- contraindicated.
Q. You've never seen that where it's been so

stressful that it's medically contraindicated, have you?
A. I think probably twice where mother has become so distressed I wouldn't even consider the circumcision.
Q. But the first exception requires that there be a patient who is incapable of giving consent or unconscious and harm is imminent. Would you agree with that?
A. That's correct.
Q. And in the situation with circumcision the patient cannot give consent, true?
A. That's correct.
Q. Harm is not imminent, though, if you just left that foreskin alone, is it?
A. It depends on your definition of imminent.
Q. Well, how do you define imminent?
A. In relation to an infant it is two years, the first decade of life, second decade of life. Pediatricians, as I said before, must consider a lifetime when they counsel about a procedure. And an immunization, certainly an immunization for hepatitis in Fargo Moorehead, there's no imminent danger of developing hepatitis B in Fargo Moorehead for an infant.
Q. What is imminent, that's what I'm asking?
A. I think it's a relative statement.
Q. As it's used in the AMA statement, Exhibit No. 8,

you don't know what imminent means?
A. I think the AMA which deals primarily with adult patients, this would refer to in close temporal proximity to the procedure.
Q. Immediate?
A. Hours, days.
Q. Do you agree with the informed consent statement of the AMA identified as Exhibit 8?
A. I don't.
Q. Why not?
A. Because, again, as I mentioned previously, the AMA tends to deal primarily with the adult patients, and the AMA and American Academy of Pediatrics have frequently disagreed on statements.
Q. Okay. Showing you Exhibit 13 I'll present to you that is the AMA statement on neonatal circumcision identified as H-60.945. Do you see that?
A. Yes, I do.
Q. And that was issued, I believe, shortly after the AAP statement was released in March of 1999.
A. It gives a date of 1999 in the statement, but I don't see a date on there, but one would assume, though, it would have to be after 1999.
Q. Doesn't it actually just quote your findings from the AAP statement?

A. Yes, it does.
Q. So it would have to have been just after 1999?
A. I would assume that.
Q. And what I'm wondering about, Dr. Shoemaker, is that the opening sentence of this policy statement talks about encouraging training programs for pediatricians, obstetrics, family practitioners on the use of local pain control?
A. That's correct.
Q. This is 1999?
A. That's correct.
Q. Are you saying that pediatricians, obstetrics and family practitioners weren't aware of pain control for circumcisions before 1999?
A. Many weren't in relation to pediatrics.
Q. So they were performing circumcisions without any anesthesia at all?
A. That's correct.
Q. In fact, there are still some practitioners in MeritCare who don't use anesthesia, aren't there?
A. I do not know that.
Q. Did you have it as a policy of your group that you all used anesthesia?
A. Over the 17 years I was at MeritCare during the time that the research that you may be alluding to was

being done, more was being done, the policy changed from one of not using anesthesia to using some anesthesia to the recommendation of the department as I remember it to that anesthesia, it went right along with the Academy statement, that if circumcision was to be done, all male infants should be provided anesthetic analgesia.

Q. When did that policy change to the best of your recollection, Dr. Shoemaker?

A. '96 or '97.

Q. Prior to that children, baby boys, were not anesthetized on a routine basis?

A. Commonly.

Q. They were not?

A. Yes.

Q. Now, I want to touch a little bit on the concept of the standard of care, and I know you've talked earlier about it being a locality, and then Ms. Voglewede says it's a legal concept. Do you understand what is meant when I say standard of care?

A. Not entirely.

Q. Well, what do you understand standard of care to be?

A. My opinion of what standard of care is based on what is accepted medical practice in this country in relation to safety, necessity, potential medical benefit

and community interest and beliefs that establishes the standard of care.

Q. You used the concept of community and national. Are you saying that there is a national standard or is it a community standard?

A. I think previously we discussed the fact that there are some -- this is some degree of objective things that would be agreed on in the entire country, and there are other things that are subjective. So I think that it will be a mixture of that.

Q. Would you agree, Dr. Shoemaker, that medical standard of care, whatever it might be, could be modified by legislation?

A. Absolutely.

Q. For instance, the FGM, the ban on female genital mutilation may have had the affect of modifying standard of care, right?

A. May have.

Q. If anyone was performing clitoridectomies or those procedures?

A. That's exactly my reservation. If anybody was, that probably changed it. I don't know if the procedure was being performed by anyone in this country.

Q. Okay. Why did the AAP feel compelled to put out a statement then disavowing female genital mutilation?

A. I think I answered that earlier in that there are a number of -- not a number, a small number of countries where female genital mutilation was practiced, and as people from those areas of the world came to this country there were non medical practitioners as I reviewed that literature who were doing female -- or mutilating female genitalia on the basis of a religious belief that was somewhat societal based -- as I understood it, that required legislation or a statement that says that, no, this is not something -- we don't believe religion goes this far.

Q. Those same cultures that you referred to that practiced female genital mutilation also circumcise their boys in a ritual sort of setting, do they not?

A. Most of those cultures are Abrahamic religions, and I would expect them to. I don't know of any specific associated literature that states that. That's an assumption I would make.

Q. And the methods use to mutilate the boys are sometimes just as brutal as the girls?

A. Well, the word mutilate is entirely yours. The surgical procedure that is done is not even anatomically similar. The same tissue is not even involved. Embryologically the tissues come from entirely different places.

Q. What about in a Type I female genital mutilation?
A. Are you referring to the similar --
Q. The soony where all you do is remove the clitoral hood, you remove the female foreskin.
A. The clitoral hood involves the clitoris itself and is a -- and generally the Type I involving suturing of the labia over that specific area and is really not relevant to male circumcision in my opinion.
Q. Exhibit 9 is the female genital mutilation policy statement of the AAP and it gives a breakdown of the different types of female genital mutilation, Type I through IV. If you want to refer to Type I, it just says that the procedures are often very benign, and it's very hard to even recognize whether or not there has been a Type I mutilation in situations where there's simply the removal of the clitoral hood. Do you see that?
A. Yes.
Q. Does that refresh your recollection as to what Type I FGM is?
A. Maybe. It also says in the same statement when this procedure is performed in infant or young girls a portion of or all of the clitoris and surrounding tissues may be removed. So we're talking about a fairly broad spectrum, even in relation to what may occur.

Q. But the type of tissue that's removed in the most benign of the FGM procedures, the soony procedure, is just the removal of the clitoral hood.

A. In exactly the situation that you mentioned, if the portion of the clitoral hood was removed without injury at all to the clitoris, which would be extraordinarily difficult in a female infant, that would be a similar anatomic procedure to a male circumcision.

Q. But they do these in infants, they do them when they are grown, don't they?

A. That's my -- I think 3 is where they start.

Q. 3 to 11 to 13?

A. Yeah.

Q. So they would be more pronounced at 3 or 11 or 13 to be able to remove that clitoral hood with greater ease?

A. In my knowledge of female adolescent infants and adolescent anatomy that would be correct. It's also pertinent, I think, that those young children and adolescents usually don't get informed consent for that procedure.

Q. Nor do the boys in that society, do they?

A. I don't believe so.

Q. So the way the culture treats the girls is bad, but the way they treat the boys, we'll live with that?

MS. VOGLEWEDE: I'm going to object to lack of foundation and lack of relevance.

Q. MR. BAER: Go ahead. Answer it if you can, Doctor.

MS. VOGLEWEDE: If you know.

THE WITNESS: In a Biblical perspective I would say Abrahamic religions believe exactly that.

Q. MR. BAER: On page 3 of Exhibit 9 on the bottom paragraph it talks about some of the physical burdens on FGM, and what I want to refer to you -- and we can take a break as soon as I'm done with this comment.

What I want to refer you to, Dr. Shoemaker, is the statement that talks about the procedures violate the principal of nonmaleficence, commitment to avoid doing harm. I want you to focus on the principal of nonmaleficence, commitment to avoid doing harm.

Do you agree that that is a principal that is held by the medical community as one of its bedrocks?

A. Yes, I do.

Q. And it applies not only in FGM but in overarching all of your treatment decisions?

A. Yes.

(Discussion off the record.)

Q. MR. BAER: To your knowledge was there a time when circumcision was performed to prevent masturbation

in young boys?
A. Not only -- to my exact certainty.
Q. How long did that thread hold true in the medical community?
MS. VOGLEWEDE: I'm going to object on grounds of lack of relevance to this case. Go ahead.
Q. MR. BAER: Go ahead.
A. It was during late Victorian era, early into the last century, perhaps later into the last century, and in some cases even up into the middle of the century.
Q. In America?
A. In America.
Q. And are you aware of any circumcisions or clitoridectomies being performed on women to stop masturbation?
A. I am not personally aware of it, but I have read that it did occur.
Q. Do you know when the last one was performed in North Dakota?
A. I do not.
Q. You indicated that you would agree with the concept that standard of care can be modified by legislation, right?
A. Yes.
Q. To your knowledge is there a law in the state of

North Dakota that deals with informed consent?

MS. VOGLEWEDE: I'm going to object. This is beyond the scope of his testimony as a fact witness and a medical expert in this case and deals with legal issues, not medical ones.

THE WITNESS: Do I answer or not?

MS. VOGLEWEDE: Answer, if you know.

THE WITNESS: I'm not aware of.

Q. MR. BAER: I want to show you what's been marked as Exhibit 11 Kantak and Kaplan West's North Dakota Code 23-12-13. I believe it's dated 1995.

Have you ever seen that before?

A. I have not.

Q. I'll give you a moment to review it if you would like to, Doctor.

A. All right. Thank you.

Q. And I just want to identify for you the way I understand it is set up. It's a statute that talks about authority for medical doctors to do procedures on incapacitated or minor children, incapacitated individuals or minor children, right?

A. That's my impression.

Q. And the first section talks about the order of priority which you follow in order to obtain proxy consent?

MS. VOGLEWEDE: I'm going to object to any questions which asks for his interpretation of a North Dakota law that he's just now seeing. Well, I mean you already have, but I'm going to object to any of these questions that asks for some type of legal interpretation. It's inappropriate.

THE WITNESS: And I answer now or not?

MR. BAER: Yes. Go ahead.

MS. VOGLEWEDE: What was the question? Was there a question?

MR. BAER: Yeah, there was a question.

THE WITNESS: Would you repeat it now, please.

Q. MR. BAER: Sure. The first subsection talks about informed consent and then it gives a hierarchy of the individuals who are authorized to give consent in the case of an incapacitated adult or a minor. Do you see that?

A. Yeah, I do.

Q. The second section talks about a physician's duty that if they are going to be performing a procedure on an incapacitated person or a minor they must first in good faith try to locate one of the authorized individuals, correct?

A. Correct.

Q. And then the third section talks about before any

person authorized to provide informed consent pursuant to this section exercises that authority the person determining -- I'm sorry -- the person must first determine in good faith that the patient if not incapacitated would consent to the proposed health care. Do you see that?

A. Yep, and the subsequent line says if such determination cannot be made, the decision to consent to the proposed health care may be made only after determining that the proposed health care is in the patient's best interests.

Q. All right. Then let's talk about that as it relates to circumcision. So you have -- before you give -- do a procedure you as a medical doctor, the state law would be obligated first to determine in good faith that the patient if not incapacitated would consent to the proposed procedure?

MS. VOGLEWEDE: I'm going to have a standing objection to these questions asking for a legal interpretation.

Q. MR. BAER: Isn't that what it says?

A. In regards to the patient being able to make such a decision, make such an interpretation.

Q. But Doctor, you would never have that if you even had this apply because the patient is incapacitated.

A. Also, the third item that you just mentioned, it says the appointed guardian or the custodian of the parent.

Q. The patient is not the custodian, is it, the patient is laying there.

A. The patient is incapacitated if they are a child intellectually.

Q. That's precisely what it is. It says that before consent can be given you must determine in good faith that the patient if not incapacitated would consent to the health care. How would you determine if a baby boy would consent to being circumcised?

A. One would reasonably assume that most children, and I'm going to say most and not all, would follow what their parents believed. Certainly we're both aware that not all children follow what their parents believe, but most children do.

Q. So you would say that whatever the parent wanted would be a determination that the patient would have wanted the same thing?

A. In relation to the discussion that we continue to have regarding circumcision I believe that to be true, yes.

Q. And you also believe it to be true that even if that doesn't apply to the situation it would be in the

best interests of the child to have that child circumcised anyway?

A. Once the parents had consented after having been informed in a nonbiased -- same statement I've made previously.

Q. And if the statute conflicts with MeritCare policy you would agree that the statute controls?

MS. VOGLEWEDE: Object on grounds that it calls for a legal conclusion, legal interpretation.

THE WITNESS: One -- because it's legal doesn't always make it right and vice versa. So I would say in general statutory law is meant for the benefit of society. It is sometimes wrong.

Q. MR. BAER: Showing you what has been marked as Exhibit 1, and that is the AAP statement. You have seen that statement before, Dr. Shoemaker?

A. I certainly have.

Q. You sat on the committee?

A. I did.

Q. The committee was composed of yourself, Dr. Kaplan, Dr. Lannon, Dr. Bailey, Dr. Fleischman, Dr. Swanson and Dr. Coustan, right?

A. That's correct.

Q. Do you know whether any of the members, say the male members of the committee were intact?

A. I do not know that, no. I assume intact relates to circumcision.
Q. Do you understand that term, that they have not been circumcised?
A. Yes. That's the way you are using it, yes.
Q. Yes. Do you know how you were chosen to sit on the task force?
A. Appointed by the chairman of the American Academy of Pediatrics committee on the fetus and newborn.
Q. Do you know why you were chosen, what criteria was used to determine who should sit on the committee?
A. I don't specifically know exactly why the chairman chose me. I had had some experience in writing the sections in guidelines for perinatal care regarding care of the uncircumcised penis and care of the penis, and when the committee, the task force was being formed, I had experience in review of the literature that was moderately extensive in relation to the Fishback versus North Dakota case.
Q. To your knowledge were there any members of the task force who did not perform circumcisions?
A. Had never or did not routinely?
Q. Did not routinely do it?
A. Dr. Lannon did not routinely do circumcisions, Dr. -- what is the anesthesiologist's name? Anderson --

no, Dr. Bailey did not perform circumcisions, Dr. Coustan was ill a lot, and he communicated with written literature, and I don't know whether he did. And I don't know whether Dr. Fleischman did because I never spoke to him about it.

Q. How about Kaplan?

A. Kaplan did.

Q. And you?

A. I do.

Q. Swanson?

A. Yes.

Q. What is the state of the literature, Dr. Shoemaker, describing what it is like to be an adult with a foreskin versus being an adult without a foreskin?

A. It's widely varied, as you're probably aware. There is evidence that circumcised male infants are more prone to some problems and less prone to other problems. There is evidence that -- there's a lot of not very scientific literature that discusses psychological issues, sensation issues, hygiene issues.

Q. Maybe I asked a bad question. But what I'm trying to get at, Dr. Shoemaker, is that you know folks in our generation born in the '50s would by and large be circumcised, so how does our generation get an objective

view of what it's like to have a foreskin?
A. I think since we are fairly much of a global village now we have the experience of a lot of other countries, we have opinions, and we have discussion among colleagues who are not in the United States, if that's an answer to your question.
Q. And the view of the literature that you did suggested that more circumcisions take place in America for non religious reasons than any other civilized country in the world?
A. That is correct.
Q. And that was one of the factors that drew your attention to why does this continue here in America, right?
A. That's correct.
Q. Because you looked at the Academy of Pediatrics in Australia, whatever their name is, and they recommended against it, right?
A. They recommended against routine circumcision, as did the Canadian Pediatrics Society, as did -- I forgot the exact name
Q. The U.K.?
A. Yeah.
Q. And those are civilized societies, aren't they?
A. Oh, yes.

Q. And you even in the task force report reference those and say, you know, these medical societies have published statements that do not recommend routine circumcision of male newborns, right?

A. That's correct.

Q. So what you were trying to do in this committee is to study why it persists in America because Europe is civilized, Australia is civilized, Canada is civilized, why are we so more pronounced in the rates in circumcision than other developed countries?

A. I don't think the task force was formed for that reason to ask why we were different. I think the task force was formed -- this is my opinion -- as a task force member to determine if there was scientific evidence to justify routine circumcision.

Q. And you do observe at least in the opening paragraphs of the statement that until the last half century there has been limited scientific evidence to support or repudiate the routine practice of circumcision?

A. Yes. I wrote that sentence.

Q. You believe there was a practice of routine circumcision?

A. Absolutely.

Q. And there still is?

A. In some parts of the country.
Q. One of those parts would be Fargo, North Dakota?
A. Absolutely not.
Q. It's not routine?
A. Absolutely not.
Q. Where is it routine?
A. I know some cities in the southeast in the rural south where some practitioners don't obtain informed consent.
Q. Are you saying establishing routine from an absolute number, or are you saying it's not routine if you give informed consent?
A. I'm saying it's not routine if you give informed consent.
Q. Okay.
A. And that's what the statement says.
Q. Where does it say that?
A. It says in the case of circumcision in which there are potential benefits and risks yet the procedure is not essential to child's well-being, parents should decide or should determine what is in the best interests of the child to make an informed consent. Parents of all male infants -- all male infants should be given accurate and unbiased information and be provided the opportunity to discuss this decision.

Q. The question was whether or not -- maybe I misunderstood your statement, that the statement, the AAP policy statement, Exhibit 1, says that routine circumcision means circumcision done without informed consent?

A. That is the dictionary definition. The dictionary definition of routine is something that's done without discussing it.

Q. All right. If that's the dictionary definition, without discussion, routine is without discussion?

A. Done routinely over and over again without thought.

Q. So if something is done 95 percent of the time the same way that would not be considered routine?

A. Again, I think we're getting into a semantic discussion here about what the word routine means, which is a big, I think, difficulty with the statement and the statements all over the country, in the other parts of the world. No one recommends routine circumcision. The American Academy of Pediatrics has never recommended a routine circumcision.

Q. Getting back to the question I was trying to ask before, how can a group of task force members make a determination of what is lost by having a foreskin amputated by way of sexual pleasure, fulfillment of the

human being, being a whole person, how can we as circumcised individuals make that determination?

A. I don't think we can make that for individuals. We can do statistical analyses, we can evaluate scientific data, we can look at studies as Masters and Johnson did about appropriate perception and light touch during coitus that say there isn't any difference. That's scientific data. Knowing whether a human being has been emotionally traumatized when they realize that their foreskin is gone is a decision that an individual -- I mean that's a psychological issue that is only individual. It is not based on populations.

Q. Not only did the early medical literature describe the circumcision as being a cure for masturbation, it was attributed to curing a whole host of other maladies, wasn't it?

A. It was.

Q. Club foot?

A. I don't remember specifically club foot. I remember tuberculosis.

Q. Scoliosis?

A. A lot of things that were scientifically invalid.

Q. Was that at a time where there was this concept, there was a nerve base concept of disease?

A. You know, I don't know what the concepts were in

1900 or 1880. I have no idea.

Q. Have you looked at the literature to determine what the rate of circumcision was before the medicalization of childbirth?

MS. VOGLEWEDE: Object on grounds of lack of relevance.

THE WITNESS: I have not. I don't specifically recall any literature, but -- I don't specifically recall any literature.

Q. MR. BAER: I notice that the AAP statement didn't go into a lot of history of the history of circumcision?

A. No, I wrote that, and they took it all out.

Q. Who took it out?

A. The committee decided by consensus it wasn't necessary.

Q. So you were also in consent with that?

A. No, but --

Q. So it wasn't consensus?

A. A consensus is not a unanimity. It's not 100 percent of the people. A consensus is a consensus.

Q. And from review of -- the statement basically says that you reviewed the English language literature from 1960 to present?

A. That's what the committee based most of its stuff on. We reviewed several German articles. We talked to

the German Pediatric Society, French and Chinese literature, but we mainly reviewed --

Q. It doesn't say you reviewed French.

A. The committee did not, the process of the committee was a step-by-step process where each member brought information to the committee, and then the committee got rid of some of it.

Q. But the statement is based on English language literature from 1960 to present?

A. There is no referenced article in there that is not an English language reference.

Q. And you would not expect there to be a lot of literature on the topic of routine circumcision in a country where you didn't practice it, would you?

A. I wouldn't expect it, no.

Q. Now, if you'd turn to Exhibit 1 the subsection on sexual practice, sensation, and circumcision status.

A. Yes.

Q. That seems to describe what we talked a little bit about earlier, and you referenced the Masters and Johnson survey about the sensitivity of a penis that has not been circumcised versus a circumcised penis.

A. It references that, and yes, I did reference. You asked two questions there.

Q. The whole section on sexual practice, sensation,

and circumcision status is three sentences long, isn't it?

A. That's quite correct.

Q. The only study talking about the sensitivity of a circumcised versus non circumcised is a 1966 Masters and Johnson study, right?

A. That's correct.

Q. Does your statement describe how the penis loses sensation as a result of being circumcised?

A. There is no good scientific evidence in relation to the literature that we reviewed on the task force that the penis loses sensation. There is certainly neurologic tissue that is taken, but to say that the sensation is lost, certainly there are surveys that imply that sensation is different but not lost. So I would disagree with your question in that regard.

Q. Well, does the statement, the information statement describe how the penis loses sensation?

A. I think I just answered that.

MS. VOGLEWEDE: He just answered that question.

Q. MR. BAER: Is it yes or no? Does it describe how the penis loses sensation?

A. There is no statement there that says that the penis loses sensation.

Q. Okay. Thank you. And the reason is because you

don't think there's medical literature to support that?
A. I'm not personally stating that that was the consensus opinion of the committee task force.
Q. Does it mention at all the loss of Meissner's corpuscles?
A. It was reviewed. It does not mention it.
Q. Does it mention the loss of erogenous nerves from the foreskin?
A. It does not. I think I mentioned that a couple of statements ago.
Q. Does it mention the loss of lubrication?
A. It does not.
Q. Does it mention that the loss of lubrication leads to drier sex?
A. It does not.
Q. Does it in any way describe the benefits of the mucosal membranes in sexual activity?
A. It does not, nor does it describe some of the problems that might be associated with some of those same immunologic functions.
Q. The foreskin is designed by nature to protect the penis, does it not?
A. I am not God.
Q. You don't know what it's designed to do?
A. I don't know that anyone knows what the foreskin

is designed to do. It is a piece of anatomical tissue to protect the glans penis. It has nervous endings, it has immunologic function and squamous epithelium and cortonized epithelium on it. What it was designed to do, I don't know. It is there.

Q. On anatomically whole baby boys it is there, right?

A. That is correct.

Q. Doesn't the foreskin in infancy protect the glans penis from feces, urine, those sort of things?

A. Actually, there's some literature that would indicate that if feces gets under the foreskin that fimbriated E coli are actually attracted and held against the glans penis and meatus and may contribute to urinary tract infections. So the evidence is -- the scientific literature is on both sides of that issue.

Q. We'll get into the UTI discussion in a moment, Dr. Shoemaker, but bear with me for a moment. Isn't it true that the foreskin that is removed during the circumcision procedure is adherent to the glans penis in most instances?

A. Exactly what I was going to say, in most instances is at least partially adhered.

Q. And it is adhered by a membrane that sometimes doesn't totally separate from the foreskin and the

glands until the child may be even up into the eight, nine, ten years old?

A. Actually, it's not a membrane, it's squamous epithelium that breaks down in pockets and usually has occurred by age three, but in less than five percent of kids it doesn't occur until early adolescence, so your statement was generally correct.

Q. What is squamous epithelium?

A. It's epidermal cells, skin cells. A membrane is more a fibrous tissue.

Q. But it is cell tissue?

A. Absolutely.

Q. Living tissue?

A. Yes.

Q. Blood vessels? Is it enervated?

A. No, the squamous epithelium between the foreskin and the glans penis doesn't have any direct enervation. The tissue immediately adjacent to it would be.

Q. You can't remove the squamous epithelium without causing some trauma to skin cells?

A. You have to disrupt the squamous epithelium to free up the other parts of the foreskin, yes.

Q. But by doing that you injure, shall we say, the foreskin. You've got a frown on your face, Doctor.

A. I'm trying to think whether one injures the

foreskin, one disrupts the squamous epithelium. But I wouldn't say one injures the foreskin. If one injured the foreskin, to take your analogy, could you use that skin to, as has been done in medical literature, to use as a transplant, and one couldn't do that if the skin was injured. Are you following me there?

Q. No, I'm not.

A. Sorry. It has been done.

MS. VOGLEWEDE: Zenas, is this a good place for a break? We've been going for two hours.

MR. BAER: Sure.

(Break.)

Q. MR. BAER: Back on the record. Before we broke, Doctor, we were talking about the injury that was caused to the foreskin or the glans penis when you break that squamous epithelium, and you indicated that, no, there was no injury because you could use that skin as a transplant. Did I understand you correctly?

A. Yeah, I thought about the question for a while, and to explain further, if you were to merely -- which is a procedure called a dorsal slit, where the tissue is crushed and that squamous epithelium is sliced, the foreskin remains intact but still open, and it just stays there as foreskin with a little bigger opening. That's a procedure that's done in some European

countries.

And so to say that the foreskin is injured, I don't know that I would agree with that. The squamous epithelium is disrupted between the glans penis and the foreskin, but the foreskin itself I don't think is injured.

Q. Well, would you agree with Dr. Kaplan in his article Complications of Circumcision, that is the August 1993 edition and cited in the work that you developed in the AAP statement, that talks about the phenomenon of premature retraction of the foreskin causing repeated injuries to the foreskin and also the glans?

A. Absolutely. If the tissue -- if the foreskin is disrupted -- I'm using the word disrupted a couple different times. If the foreskin is stretched and torn, then it's going to cause scar tissue, but it's merely separated from the penis, it's not injured in and of itself. The tissue itself has to be torn or cut or something.

Q. So you think there's a distinction to be drawn of the practice that Dr. Kaplan criticized --

A. Oh, absolutely.

Q. -- of retraction --

MS. VOGLEWEDE: Wait until he finishes.

Q. MR. BAER: -- retraction versus the separation by a mosquito forceps?
A. Yes, absolutely.
Q. In one case you do have injury and the other case you don't have injury, is that your position?
A. To the foreskin?
Q. Yes.
A. Yes.
Q. Would you agree that the foreskin is like a transition zone from internal organ to external?
A. I'm not sure that I would agree with that. It certainly covers the glans penis, which when it is removed, when the foreskin is removed, the glans penis becomes exposed to outside stimuli and it becomes -- the skin of the glans penis becomes thicker. But to say that you were exteriorizing an internal organ, I don't think I would go that far.
Q. Have you read literature that equates the foreskin to tissue like the eyelids or the lips or the anus where it's a transition between -- the mucosal membranes are apparent in the lips and the eyes and the anus, are they not?
A. I have read that literature. I do not agree with it.
Q. Why not?

A. I don't agree with it.
Q. You don't think there's mucosal membranes in the foreskin?
A. There are mucosal membranes after the squamous epithelium breaks down. Until then the glans penis is continuous with the internal surface of the foreskin. The eyelid is not continuous with the eye at any time, so I think it's a different analogy.
Q. Okay. Are you familiar with the various types of circumcision clamps, the Gomco clamp, the Plastibell, and the Mogen clamp?
A. Yes.
Q. I want to say the Davis clamp. Do you use all three?
A. No. I use Gomco clamps.
Q. Why?
A. I like the appearance afterwards. The Plastibell I was exposed to in the military. I found it very unaesthetic. I found that mothers had difficulty dealing with the tissue as it essentially dried up and fell off, and the Mogen clamp is a device which I think predisposes people to go too fast on the procedure and doesn't give it as good a cosmetic result.
Q. The AAP statement talks about the methods of circumcision. I just want to spend a little bit of time

on the discussion that is contained in that statement. And it talks about common elements of any circumcision, and there's -- it's like six different common elements. The first one is -- the goal is to eliminate a certain -- you first have to estimate the amount of skin to be removed, right?

A. Correct.

Q. The second is the dilation of the preputial orifice; is that right?

A. Yes.

Q. And you do that by use of a mosquito forceps?

A. It's done in various ways. One can do that, one can free up the tissue by disrupting the squamous epithelium that we were talking about before and then clamp.

Q. How would you disrupt it?

A. I disrupt it with a blunt probe that I sweep between the foreskin and the glans penis.

Q. You push it into the opening of the foreskin and then you sweep this blunt probe to tear the squamous epithelium?

A. Yes.

Q. And is the preputial -- am I saying that right?

A. You can say it that way. That is the hole in the opening of the foreskin.

MS. VOGLEWEDE: You need to wait until he's finished before you start, and you need to do likewise.

Q. MR. BAER: The dilation of the preputial orifice means that you have to make it larger, right?

A. That's correct.

Q. And the statement says that you have to visualize the glans to see if it's normal. Do you see that in the statement?

A. Yes.

Q. Why would you want to see if the glans is normal?

A. If there's a penile opening of the urethra in a different spot than where it's supposed to open on the end of the glans penis, generally you want to leave the foreskin there because it can be used in subsequent repair.

Q. So the first step is to dilate, you stretch out the opening of the foreskin?

A. In that description, yes.

Q. And the next step is bluntly freeing the foreskin from the glans penis?

A. Yes.

Q. That's what you described as being the use of the a blunt instrument to tear the squamous epithelium?

A. Yes.

Q. What is the instrument called that you use?

A. A blunt probe.
Q. That's all that it's called?
A. I don't know that it has a specific other name.
Q. And then the next step is the placement of the device on the penis, right?
A. Yes, with the qualification that, in parenthesis, at times a dorsal slit is necessary to do so.
Q. And a dorsal slit is a situation where you take a clamp that locks and just clamp it on the foreskin and leave it for a period of time and then cut it; is that right?
A. That is correct.
Q. How long do you leave the clamp on before you cut?
A. Seconds personally.
Q. And then you put the device on the glans penis, tighten the clamp, wait until hemostasis is achieved, right?
A. Well, it's a little simplified in my opinion in that, yes, those steps are all involved, but when the bell is inserted, it's inserted only to the level of the foreskin that you want to remove, and you have to establish that before you pull the clamp tight or you get a result which you may not want to get. And -- what else was I going to add? And then the clamp is

tightened.

Q. How do you determine how much you want to take?

A. You estimate the size of the glans and you can generally do that by palpation, by feeling the glans penis, and then take what's generally recommended in most pediatric training program, and what I personally teach is to take only down to about half, to two-thirds from the tip of the glans penis.

Q. And you personally teach how to do circumcisions, don't you?

A. I do.

Q. And then the final step is the amputation of the foreskin, which is a common element that we're talking about, about how the circumcisions are done?

A. That's correct.

Q. And amputation is performed by using a knife?

A. A scalpel.

Q. To cut the foreskin?

A. Yes.

Q. What do you do with the foreskin?

A. It's disregarded.

Q. Is it ever sold in the secondary market?

A. Not to my knowledge.

Q. Are you aware of literature to talk about foreskins being used to grow artificial skin for

purposes of burn victims?
A. I've heard about those. I've never read them. I don't know where I've heard about them.
Q. It's a company here in California that does it.
A. It may be some literature that was provided to me by somebody here in California. I've heard about it, but I have not read it.
Q. Are you involved in the disposal of the tissue?
A. No.
Q. Who does that?
A. It's sent -- it's generally placed on the sterile tray and sent to central supply where it's disposed of.
Q. Do you know how it's disposed?
A. I do not.
Q. Would you agree that as Dr. Kaplan stated yesterday that the circumcision is a surgical procedure?
A. I do agree with that.
Q. Now, under the subheading of complications of circumcision you have identified the complications and the rate of complications, and it's actually a few sentences on the complications of circumcision, and most of the articles cited are by a Dr. Kaplan, aren't they?
A. I would have to check on that.
Q. It's actually half the articles cited.
A. The first two aren't.

Q. Well, 32 is.
A. Oh, 32, Kaplan is in on that one, 33 and 34 aren't, 35 is, and it cites 35 again. So it jumps around.
Q. There is four articles cited, two of the articles were written by Kaplan, right?
A. That's correct.
Q. Did he write this section?
A. I don't remember.
Q. And in the section it talks about the complication rate of being anywhere from .02 percent to 0.6 percent?
A. That's -- you misstated. It's .2 percent. You said .02 percent. It's .2 percent to .6 percent.
Q. Would you agree that that is a medically significant number?
A. It's fairly insignificant I would say.
Q. It's insignificant?
A. Yes.
Q. So if there was that risk of complication you don't think you'd have to tell a patient about that?
A. Oh, no, I would tell them about that.
Q. Well, why don't you think it's medically significant? What I'm asking you about medical significance, is there a level which you say the risk is

so small I don't have to tell the parent about it?
A. No, I don't. I think known complications should be discussed.
Q. So even though the rate is .2 percent to .6 percent, whatever those complications are that are reported, should be discussed with the parents?
A. In most cases -- I mean, there are rare complications that would occur that one might not discuss. There are extraordinarily severe complications that are extraordinarily rare that one would discuss. I think you understand what I'm saying there.
Q. Okay. Does the section on complications of a circumcision procedure address at all the potential for sex reassignment as a result of a botched circumcision?
A. I don't believe it does.
Q. And you're familiar with several cases on that point, aren't you?
A. At least a couple.
Q. John Joan John?
A. I'm not familiar with that particular terminology, but I am familiar with a couple cases.
Q. Do you know why it wasn't included in this complications of circumcision?
A. I don't know. I don't remember.
Q. Would you agree that there is perhaps a tendency

to underreport complications in circumcision procedures?
A. I think that depends on who is describing what a complication is. Bob VanHow and I would disagree what a complication is, for example.
Q. Let's just take it maybe from a different approach and see if we can get at it in a different way. As a surgeon if you're doing a surgical procedure in the operating theater you have a certain requirement for dictating operative notes that contain certain predetermined elements, right?
A. Uh-huh, that's correct.
Q. And you have to have a start time, a finish time, right?
A. That's correct.
Q. You have to describe any complications, right?
A. That's correct, in major surgical procedures. You're describing major surgical procedures.
Q. Where does the guideline talk about just major surgical procedures?
A. It doesn't.
Q. And under those circumstances if you had that surgical report you'd be much more likely to have a report of this case or that case, right?
A. That's correct.
Q. In circumcision I understand you don't follow

those rules for surgery, do you?
A. No.
Q. And so the chance of underreporting is greater, isn't it?
A. Why I'm not -- I wouldn't agree with that. If you had a complication and you are an ethical physician, you would report that there was prolonged bleeding, there was a need for another stitch and a note should be made about that.
Q. Have you observed bleeding while you do circumcisions?
A. Absolutely.
Q. Would it be unusual for somebody to go through their career and not see bleeding?
A. I think it would be very unusual.
Q. The only article cited under the complications of circumcision procedure that were not written by Dr. Kaplan were the articles on -- by W.F. Gee, G-e-e, and W.L. Harkavy, H-a-r-k-a-v-y.
Do you know what those articles talk about as you sit here today, Dr. Shoemaker?
A. Well, I have some remembrance as I read the titles of the articles, the Gee article, G-e-e, talked about complications between Gomcos and Plastibells, and the Harkavy article from 1987 included ethics and a lot

of the things that were discussed in the previous pediatric statements.

Q. Most of the information, if you will, contained in the complications of the circumcision procedure are from Kaplan's work, are they not?

A. I would say that's true.

Q. And one of those cited articles is Exhibit 14. Isn't that the article that is identified as footnote number 35?

A. Yes.

Q. And yesterday Dr. Kaplan told us that article with the lead author of S.D. Niku, N-i-k-u, was just an update of the 1983 article. Are you aware of that?

A. I am not.

Q. So the pediatric statement, the AAP statement as it came out at least with respect to complications of circumcision procedure was a summary of Dr. Kaplan -- Dr. Kaplan's article?

A. Yes, but Dr. Kaplan's article was also a review article. It reviews multiple -- the urologic -- the clinics of North America as published by this publisher are a compendium of review articles. They are not a study. They review a specific topic, so this is not just Kaplan's work, it is Kaplan's writing a review of lots of work.

Q. Okay. Now, the next section I want to address is dealing with circumcision after the newborn period. Do you give any statistics of how many times adult males seek the services of urologists to perform a circumcision after the newborn period?

A. I don't think we did in this article.

Q. Would you agree with Dr. Kaplan who says in Exhibit 14, his 1983 work that under the psychosocial issues where he suggests that if a person who is asymptomatic comes to have a circumcision completed you should look for psychiatric reasons, and perhaps to paraphrase what I understand it to mean, that he might be psychotic?

MS. VOGLEWEDE: Object. Lack of foundation.

THE WITNESS: I don't think that's what this statement says.

Q. MR. BAER: What does it say? Read it.

A. It says circumcision in the adult may precipitate or be a part of psychotic delusional behavior. One way to detect such psychiatric problems preoperating is by carefully scrutinizing the motives leading the unasymptomatic adult to seek circumcision.

So this is under multiple topics. It's one heading that says psychosocial issues. So yes, if someone who has no problems with their penis comes in

and says I want to be circumcised, I think this suggests that one might scrutinize their reasons for wanting to be circumcised.

Q. And what did the literature show as the incident of people having an intact penis coming to your office or a urologist to have it removed after 18 years of age?

A. There's Australian literature that says it's up to 18 percent.

Q. Where is it in this?

A. It's not in this article.

Q. Where is it in the AAP?

A. It's not in there.

Q. It's not in it?

A. I think it's referenced on the article on UpToDate that I gave you because someone asked me the question, and I couldn't answer it, and I had to look hard for it. That's a high number I believe, though.

Q. You wouldn't rely on that statement, would you?

A. No. It's published, but I would think it's lower than that.

Q. How about in America?

A. About 10 percent I think.

Q. And what do you base that?

A. There's some literature that indicates that balanitis, posthitis occurs and requires circumcision,

and that as that occurs sometimes when you get scarring with sexually transmitted disease. I think Lannon's article on the survey, again, that's survey data, it's not hard science.

Q. Perhaps I asked a bad question. My question is not how often do people come in with problems that are medically treated by circumcision, but how often do people come in that are asymptomatic and request a circumcision?

A. I would agree with you you asked a bad question. I don't think that's very common at all.

Q. Even in Australia?

A. Even in Australia.

Q. Okay. So can you conclude from that that those individuals who are allowed to have their foreskin to an adult age do not particularly want to part with it?

A. Unless they have problems.

Q. Right. Showing you Exhibit 17, have you seen the letter by Sir James Spence from 1950 printed in The Lancet I think in 1960?

A. It's entertaining.

Q. Do you agree with it?

A. I agree that a small preputial opening at seven months will become larger, yes, as someone reaches into adolescence and adulthood, yes, I agree with that.

Q. Do you agree with the statement where he says that the anatomists have never studied the form and evolution of the preputial orifice, they do not understand that nature does not intend it to be stretched and retracted in the Temples of the Welfare Centers or ritually removed in the precincts of the operating theaters?

A. No, I don't agree with that. I think it's part of the sarcasm in British society. If you read The Lancet regularly letters are in there like that all the time. It's a good letter, though.

Q. Dr. Kaplan cited it as approval for his 1977 article. Are you aware of it?

A. I wasn't aware of it.

Q. What do you estimate the American population to be today who is circumcised? What do your findings show?

A. On a percentage basis I believe it's around 60 percent, but I would have to look that up. That's just a recollection.

Q. I mean, in rough terms, if that is correct, you'd have 40 percent of people who were not circumcised or intact, right?

A. If my assumption is correct.

Q. Yeah. And if all of these things that are

supposed to be cured by circumcision were in fact true, wouldn't you expect to see more of this 40 percent coming to have that procedure done?

A. I have personally seen several people coming to have it done.

Q. There are those people who have it done but then you have to ask what the motivation is, right?

A. Well, not necessarily. I know a significant number of males out of childhood with -- out of infancy that have required circumcision. I personally know of more than a dozen, some of whom were friends of mine who required circumcision for a medical reason.

Q. I understand the medical reason aspect, and I'm not denying that there are certain medical reasons for doing a circumcision.

A. We must be talking across purposes. You're again asking about people requesting it for cosmetic reason?

Q. Yes, yes.

A. Yes, I would think then -- restate your question, please.

MS. VOGLEWEDE: I'm going to object to the form of the question because it started with the premise of medical prevention of medical problems, or as you said, cure.

Q. MR. BAER: The prophylactic removal of a foreskin

to prevent medical problems, right? That's what you're doing, isn't it?

A. In the newborn.

Q. Yeah, but if there's 40 percent of those kids are not circumcised they come of age, and then they say, what the hell, I want to have this prophylactic protection, I want to get circumcised, how many of those kids do you see coming to you?

A. I don't see any children coming to me. You see adults, the adult urologists have people seeing them, and I don't know what those numbers are.

Q. Did you review -- did the literature described any instances of asymptomatic adult males seeking to have circumcision performed for the prophylactic effect?

A. Not that I remember.

Q. Is the absence of that significant from a medical standpoint?

A. Do I consider that in context of society there is evidence in the literature the fact that some of the benefits of the -- the prophylactic benefits of circumcision are only good, if you will, if it's done in infancy. If it is done later on in life, it doesn't offer protection. So you would have to counsel that maybe the prophylactics that maybe lifestyle counseling would be better in those circumstances.

Q. Turn to the heading of Analgesia.
A. Are we back at the Academy statement?
Q. Yes, Exhibit No. 1. And the opening sentence in that paragraph talks about there is considerable evidence that newborns who are circumcised without analgesia experience pain and physiologic stress.
A. Physiologic stress, yes.
Q. Is there any doubt that they do?
A. Not in my opinion.
Q. Was there any doubt by the committee?
A. No, I don't think so.
Q. Why do you say there's considerable evidence that they do show that? Why don't you just say they do experience pain?
A. In science we always say there's a statistical evidence, there's a considerable amount of evidence. I have certainly circumcised infants that gave no evidence that they were in pain without analgesia. Not many, but a couple. But to say absolute, say it's absolutely everybody experiencing a considerable amount of pain is something just that medicine doesn't do. That's why it says it.
Q. In doing a circumcision procedure why do you need restraints?
A. Because if you don't restrain the child their

knees generally get in the way because babies don't lay still.

Q. And do you typically use the olympic restraint?

A. Only for the knees. I swaddle the upper extremities.

Q. But the olympic restraint has four Velcro straps to hold the child spread eagle, right?

A. That's correct.

Q. What is the significance of elevated blood pressure in the child of circumcision?

A. One would assume from the literature, and it's -- what I believe is it's a physiologic response to stress.

Q. What is the significance of the elevated pulse?

A. The same.

Q. How about the elevated cortisol levels?

A. The same.

Q. What about high pitched crying?

A. That's a relative term. Infants cry when they are hungry, when they are in pain, and there are some developmental people who believe that you can tell the quality of cry. Certainly most mothers by two or three months of age can tell the difference between a pain cry and a hungry cry, but a high pitched cry is in this regard indicating stress.

Q. How about breath holding?

A. It's very uncommon, but it does occur.
Q. How about total body rigidity?
A. That does occur. Those are stress responses.
Q. Stress responses?
A. Yes.
Q. How about vomiting, what is the significance of vomiting?
A. In my opinion child fed too soon close to the procedure.
Q. Why would a child vomit when a procedure is being done?
A. Stress.
Q. How about passing out?
A. Stress.
Q. How about respiratory or cardiac arrest?
A. I've never seen it. It's described.
Q. Have you read about it? What would cause that?
A. A very unusual pain or stressed response perhaps in a child that had abnormal -- another abnormality.
Q. How about gastric rupture?
A. I don't think I've even read about that one.
Q. What causes gastric rupture?
A. One might assume -- well, lots of things cause gastric rupture. What would cause it in relation to a circumcision I can only speculate on since I haven't

seen that particular article described. I would only be guessing.

Q. Okay. That's fair enough. How about decreased ability to breast feed?

A. Actually, I don't agree with that one.

Q. So you disagree with that literature?

A. Yes. My experience is in fact very commonly after I do a circumcision I put the child immediately to breast as a comfort, and they don't -- in my experience they don't have any problem at all.

Q. How about a disturbance of a maternal infant bond?

A. I don't think that occurs either.

Q. You disagree with those articles?

A. I disagree.

Q. You are aware of those articles?

A. I am aware of them.

Q. But you don't subscribe to them?

A. I don't.

Q. Those physiological responses that we just went through a list are not disclosed in this report, are they?

A. Well, it says there is evidence of physiologic response to pain and stress, yes.

Q. But it doesn't --

A. It doesn't list them, no.
Q. Talking about analgesia, I don't want to talk about the major categories but in the subheading of Others you list in the Academy report sucrose on a pacifier under the heading of analgesia. Is sucrose noted for its analgesia qualities, Dr. Shoemaker?
A. No, but it does initiate the secretion of endorphins, and I didn't believe this one either until I read it.
Q. Is it designed by an anesthesiologist as an anesthesia?
A. It is not.
Q. Do you perform any procedures on children using sucrose as the analgesia?
A. Not alone. I actually used Dextrose on a pacifier as part of the analgesia anesthetic for all my circumcisions.
Q. And this anesthesia only works on infants, right?
A. Absolutely, absolutely.
Q. Because the infant can't say anything, right?
A. Well, the sucrose, the release of natural endorphins occurs with chocolate in adults, occurs with other kinds of sugars in adults and to a certain extent does offer an analgesic effect. But an analgesic effect that an adult would tolerate a minor surgical procedure

probably would not be accepted by an adult, and indeed, as I mentioned in my previous testimony, I would not rely upon it alone for an infant either.

Q. Why do you mention it in the article that sucrose has analgesia?

A. Because there was data on that, and it was a couple of articles that looked at the testing of sucrose as opposed to just a pacifier without water -- I mean without sugaring to correct myself.

Q. In your experience in doing circumcision on neonates when they are strapped down in the circumstraint, do they protest?

A. Yes.

Q. How?

A. Cry.

Q. How else?

A. They draw their legs up.

Q. They try to?

A. Yes.

Q. And then all of these other things, vomiting, passing out, those are also types of protest that the body is doing to the procedure?

A. Yes, their response to pain.

Q. Do you having that in mind believe that the infant wants that done to him?

A. I don't have any way of knowing that. I have had children when I counsel them as young as four request no anesthesia to sew up incisions before.

Q. I'm just going back to that question, Dr. Shoemaker, if you concede that all of those indicia would be indicia of the child saying -- protesting, can you not conclude that the child doesn't want it done?

A. The child doesn't want to have an immunization done either one would assume.

Q. From its own rudimentary development this infant is in the only way possible trying to tell those people entrusted with its care I don't want this done.

A. I would disagree and say the child is expressing pain. The child cries when it's born. Does it not want to be born?

Q. Well, I think there's some psychological literature on that that they probably want to stay in the womb, you're right. Come out to this big bad world.

Getting then to the major topic of this AAP statement on circumcision which takes up most of the copy space, at least -- maybe not most, but it is by far the largest section. It's the section on UTI, which promulgated the most discussion I take it with most the committee members, right?

A. Absolutely.

Q. And it was driven by a procircumcision lobby composed of Wiswell, Schoen and Moses and an anticircumcision lobby --

A. It was certainly the focal point of their arguments to see, it was driven by one or the other, does one agree with the scientific data, were the studies adequate, does it justify, does the weight of the scientific evidence justify -- that's where the discussion went.

Q. And if I read the conclusions or the analysis correctly, and I want you to make sure that I'm not misstating this, but in the discussion where you talk about the rates and the increased risks suggested from the literature, the statement says one can estimate that 7 to 14 of a thousand uncircumcised male infants will develop an UTI within the first year of life compared to one or two of a thousand circumcised male infants; is that correct?

A. That's correct.

Q. Is it correct, then, to think of this in terms of number that you have to circumcise 990 baby boys to stop one urinary tract infection?

A. No, I think it's more like a hundred to stop one.

Q. Okay. So it's a hundred circumcisions you have to do to prevent one urinary tract infection?

A. Yeah, it's a factor of ten.
Q. Okay. And you would agree, would you not, that the incident of urinary tract infection in girls is much higher than that?
A. Yes.
Q. What is it, about five percent?
A. It's -- four percent, between four and five percent.
Q. So that would be a multiple of, what, about 20 times higher?
A. Yes.
Q. And is there any suggestion that girls should be somehow altered to stop those urinary tract infections?
A. There is no way to do that.
Q. Why?
A. Because the anatomy of the female genitalia predisposes itself to exposure to coliform organisms from stool.
Q. Your literature also suggested that the research reports were suspect.
A. In some cases.
Q. And all of the literature seemed to be deficient because it did not take into account confounding factors.
A. There were different confounding factors -- there

are always confounding factors when you look at a research study. They are different in relation to how the urine was obtained.

Q. Collection methods?

A. Exactly.

Q. Breast feeding?

A. Yes.

Q. Inclusion of premies in a study?

A. In one study.

Q. Those are all confounding factors that may skew the results?

A. They are.

Q. And you even found that the data was biased, didn't you?

A. In a couple of cases that was correct.

Q. You found that Dr. Wiswell's data was inflated?

A. Some people believed that.

Q. Well, the statement says it, doesn't it?

A. Well, the statement implies it, yes. It implies that it may be possible.

Q. Wouldn't another confounding factor be the retraction of the foreskin by either practitioners or parents under instruction by the physician?

A. Yes, it certainly could be.

Q. And that to your knowledge was never isolated in

these research studies?
A. Not to my knowledge.
Q. The next broad category of the statement is the cancer of the penis, and you would agree, would you not, that the condition of cancer of the penis is almost entirely limited to a very elderly population?
A. That is correct.
Q. And there is a very low incidence of cancer in the penis; isn't that true?
A. That is correct.
Q. What is the incident?
A. It's .9 to 1 per 100,000 males in the United States. It's very rare.
Q. And didn't the research also show that removal of the foreskin as an adult did not seem to affect the incident of cancer?
A. Yes, I commented on that previously.
Q. And so that's why you suggested the cancer connection is only if you do it as an infant?
A. The literature suggests that, yes.
Q. Well, the literature is very skimpy, isn't it, Dr. Shoemaker?
A. It is skimpy, but that's what the literature suggests.
Q. I understand that. But there's literature that

is scientifically significant and literature that is without significance, wouldn't you agree?

A. I would agree with that; however, I would agree that the literature in that report had a large enough power to be worthwhile of note.

Q. Was that a Wiswell study?

A. No.

Q. What were there, six reported cases in all of the American literature?

A. In the American literature, in the Chinese literature, there was an English paper reporting incidents in Chinese men had a very large number of incidents.

Q. But that isn't cited here, is it?

A. No.

Q. Would you agree that if you remove the foreskin prophylactically as an infant that you remove any possibility that any disease process will affect that removed tissue?

A. If I understand your question correctly, if you remove the tissue, it cannot become diseased, that is correct.

Q. Right. And sometimes the cancer of the penis is in the foreskin, isn't it?

A. One type of cancer is in the foreskin, yes.

Q. So if you remove the foreskin, you'll never have cancer on that foreskin, will you?
A. That's quite right.
Q. You'll never have an infection on there, will you?
A. That's correct.
Q. You'll never have balanitis?
A. Balanitis is an irritation of the foreskin, and depending on how much of the foreskin is taken off, unless you take off 100 percent, which is not recommended by anyone, you can still get balanitis.
Q. And if you'd look at the category of ethical issues in this statement, again, you talk about the ethical duty of the practitioner is to attempt to secure what is in the child's best interest and well-being, right?
A. Yes.
Q. And a few moments ago we were describing how the child protests through screams, through body rigidity, through breathing, through arching the back or the legs. Looking at those criteria, can you sit here and say that you are carrying out your ethical duty to doing what is in the child's best interests by circumcising an infant prophylactically?
A. Mr. Baer, I have a 16 year old child with

cerebral palsy. He's had four major surgical procedures. He had his spine opened up, legs cut and derotated, his quadriceps were transferred, and his ankles were fused. He was in cast for months and in pain the entire time, and that was in his best interests. So yes.

Q. So your answer is yes?

A. Yes.

Q. You think that it is because you believe circumcision is beneficial?

A. Yes.

Q. The statement also identifies that parents should be able to take into account cultural, religious and ethnic conditions to make that decision. Do you see that?

A. Yes.

Q. Are there any limits to that?

A. I think there are limits, and one of them is the female genital mutilation act which you mentioned before.

Q. And why do you single that out as not allowing the parents to be able to consider the culture, religious or ethnic traditions in allowing male circumcision to take those factors into consideration?

A. This is only my opinion. But since the act of

female genital mutilation or female circumcision, I think is erroneously referred to, is mentioned neither in the Bible or in the Koran that it was somebody's interpretation, so if you look at both the English or the Western Bible or the Koran the procedure is mentioned for male children that is the Abrahamic covenant. So in that regard as a symbolic religious ritual I think it's justified.

Q. But Dr. Shoemaker, you would agree, would you not, that the procedure that's described in the Koran or the Bible is not the procedure where there's a prophylactic removal of the entire foreskin?

A. I don't think the American Academy of Pediatrics recommended prophylactic removal of the entire foreskin either.

Q. What do they recommend?

A. They recommend some of the foreskin. They don't recommend any routine circumcision, and they don't actually comment on how much of the foreskin should be taken off. The general accepted principal is one should never take off all the foreskin.

Q. Do you agree that the AAP statement that we've been discussing for the last few minutes indicates that circumcision is not recommended by the Academy?

A. No, I do not agree with that at all.

Q. What is your take on the statement?
A. My take on the statement is that routine circumcision, that is circumcision of male infants without counseling of the parents regarding the risks and benefits, is not indicated. And interestingly enough, if you'll read the second sentence in the summary, which is different than all the previous statements -- it's not the second sentence, it's the third sentence -- to make an informed choice parents of all male infants should be given accurate and unbiased information and be provided the opportunity to discuss this decision.

That specifically goes back to one of your points that says when you mentioned what if the parents say I want it done anyway, and what if the parent says I don't want it done, I counsel those parents as well because of this statement.

Q. It says parents, doesn't it?
A. It says parents.
Q. Usually mom and dad?
A. We always like to have concurrence from both parents. It's very infrequently that both parents are available for counsel.
Q. What do you do if they don't agree?
A. I don't do the circumcision.

Q. And this statement as you suggested says parents of all male infants?
A. Right.
Q. Are you saying that the standard of practice is not to have both parents?
A. Yes, it's not. The standard of practice is to assume that the parents agree.
Q. Now, in response to the AAP statement Wiswell, Schoen and Moses wrote an article to the AAP which was published, right?
A. Yes, it was.
Q. And the editors of the AAP gave you an opportunity as a group, as a committee, a task force to respond, right?
A. Yes.
Q. Showing you Exhibit 16, that is a copy of the response, is it not?
A. Yes.
Q. And wasn't the criticism leveled against you as a task force by Schoen, Wiswell and Moses that you did not come out with a recommendation recommending routine circumcision of all newborns?
A. That is correct.
Q. They don't say anything about doing it without informed consent, do they?

A. Did Wiswell and Schoen, no.
Q. They weren't at all talking about criticizing you for saying, you know, that you didn't want us to do it without telling the parents, did they?
A. No.
Q. And you concluded in your response that -- in the third paragraph --
A. Of the whole statement?
Q. Yes, third paragraph. Actually, it's in the paragraph before that. You said that the task force did recommend making all parents aware of the potential benefits and risks of circumcision and leaving it to the family to decide whether circumcision is in the best interests of the child, right?
A. That is the statement, yes.
Q. So what the committee did is punt on the issue, we're not going to make a decision, we'll leave it to the parents?
MS. VOGLEWEDE: Object to the form of the question. Go ahead.
THE WITNESS: Actually, what the committee did was what I read to you a moment ago was say that because there are potential medical benefits all parents of male children should be counseled, not that they should avoid it, which is done by a lot of practitioners. Are you

done with that one?

Q. MR. BAER: Yes. Now, you've had an opportunity to review the medical records of Josiah Flatt; is that right?

A. Yes, I have.

Q. What diagnosis was made of Josiah Flatt before he was subjected to the circumcision?

A. Normal male infant.

Q. There was no indication for surgery, was there?

A. There was no indication for major surgery, no.

Q. There was no indication for any surgery, was there?

A. If the counseling of all parents of male children was done regarding the potential medical benefits of circumcision, it would be the parents' right to choose to have the child circumcised.

Q. Was Jim Flatt counseled?

A. I do not know.

Q. There was no immediate need to do a circumcision, was there, from a health standpoint?

A. No.

Q. No harm to wait until the child turns 18?

A. No.

Q. Was there any complaint raised about the child's Josiah's penis by the father?

A. Not to my knowledge.
Q. Did the records reflect any complaint raised by the mother?
A. Not to my knowledge.
Q. What were the physical findings suggesting a necessity for surgery?
A. There were no physical findings suggesting a need for surgery.
Q. Is there a history and physical that documents the need for surgery?
A. There is not a history and physical that documents an abnormality that requires surgery.
Q. And that's what would be required by JCHO following their standards, right?
MS. VOGLEWEDE: Object. Lack of foundation.
THE WITNESS: The circumcision is an elective procedure based on potential medical benefit.
Q. MR. BAER: Do you know of an exception to the JCHO standards that allows the exception of circumcision done in a hospital setting?
A. I do not.
Q. And the JCHO standards is a governmental agency that sets standards for certain operations of hospitals, surgical suites, and so forth, right?
A. That's correct, it makes no comment about

circumcision.
Q. Well, it doesn't list each and every surgical procedure, does it?
A. No.
Q. It just says surgery, doesn't it?
A. Right.
Q. And there's certain criteria that need to be followed if you're doing surgery?
A. For major surgery.
Q. Oh, how do you define major surgery?
A. Well, surgery that requires general anesthesia in an operating room. There are strict criteria how a room is set up, how many people are available, how many team members are there. If you have to cut off a mole, there are no criteria other than you have to maintain a sterile environment and that policies and procedures should be developed and maintained and reviewed regularly.
Q. Are you familiar with the concept of severity of illness, intensity of care? Does that mean anything to you?
A. Yes.
Q. What does it mean to you?
A. It means that there are certain levels of illness and certain levels of care required to treat illness.

Q. So the more ill the more aggressive you have to treat a patient?
A. Sometimes.
Q. With that as a context, what was the severity of Josiah's illness?
A. He was a normal, healthy male infant.
Q. And what was the intensity of the care?
A. It was normal pediatric care.
Q. And that normal pediatric care was the amputation of his foreskin?
A. It includes amputation of the foreskin, it includes administered hepatitis B vaccine, it includes putting a probe in his ear to test his hearing, yes, all of those things.
Q. What was the chief complaint treated by the circumcision?
A. There was none.
Q. Was the circumcision medically justified?
A. The parents requested it.
Q. Was it medically justified?
A. Yes.
Q. Because the parents requested it?
A. And there is potential medical benefit from the procedure, yes.
Q. Was the circumcision treatment for any illness?

MS. VOGLEWEDE: Objection. Repetitious. Asked and answered.

THE WITNESS: It was not for an illness, it was to prevent potential illness.

Q. MR. BAER: What are the alternative means of treating those potential illnesses?

A. Depends on what the illness might be. We can talk about that for another hour.

Q. For a UTI the typical one is antibiotics, right?

A. Right. However, the complication of urinary track infection in a male infant may be life threatening. In an infant that has hydronephrosis that is a medical indication to be circumcised to avoid a urinary track infection.

Q. I don't think anybody says if there's a medical necessity it shouldn't be done, Doctor.

A. Right.

Q. What are the alternatives to circumcise a child?

A. In relation to preventing X disease?

Q. Yeah, what are the alternatives?

MS. VOGLEWEDE: I'll object to the form of the question. It's overbroad and vague, and I don't understand it.

THE WITNESS: I don't either. It's a procedure that is either done or not done.

Q. MR. BAER: Isn't the alternative to leave it alone?
A. Well, that is, yes, the only alternative.
Q. That's what I thought. I was wondering why you had some problem with that.
A. You were asking alternatives to a procedure that is either done or not done. Well, there are no alternatives. You either do it or you don't do it.
Q. So the alternative to circumcision is to leave it alone, right?
A. Yes.
Q. Leave it as God, the creator, whoever it is that is the higher power intended those children to be?
A. That is an alternative, yes.
Q. What are the elements of an operative report?
A. Usually if you're talking about an operative report from the operating room there's an indication of the day, the procedure that was done, what the procedure is, the day and time the procedure was performed, the indications for the procedure, the anesthesia used in the procedure, a description of the procedure itself, a description of the estimated blood loss, a signature that's timed and dated.
Q. Time of beginning and time of end, right?
A. Yes.

Q. Why do you require that in an operative report, why is it required?
A. The JCHO requirement, it times how long someone is under anesthesia, and it describes the procedure. It's good medical practice.
Q. Isn't it also a significant peer review tool that can be used?
A. It can be, yeah.
Q. For instance, if somebody takes an hour to do a circumcision, something might be wrong, right?
A. Yes.
Q. Or if somebody takes an hour that takes a procedure -- that normally would take ten minutes, you've got to question what happened in there, right?
A. That would be what we call now in business medicine a sentinel event, yes.
Q. And without those benchmarks you can never tell in reviewing a circumcision report whether there were sentinel events?
A. It depends on if there are complications reported, complications which we discussed previously, and it also depends on observation of practitioners by a nursing staff.
Q. Showing you Exhibit 3, have you seen that before?
A. Yes.

Q. Is that the operative report for Josiah Flatt?
A. Yes, for his circumcision.
Q. Does it meet the JCHO standards for operative reports for surgery?
A. Not for a major surgical procedure. This is, however, not a major surgical procedure.
Q. I guess it depends who you ask.
A. It does.
Q. If you ask Josiah when he's 18 whether they can cut the rest of it off, they would probably say, yeah, it is major, right?
MS. VOGLEWEDE: I'll object to that.
MR. BAER: I'll withdraw that.
Q. Would you agree, Dr. Shoemaker, that performing unnecessary surgery and billing for it is fraud?
A. I would agree with that.
Q. Would you also or have you heard of the term if it's not document, it wasn't done?
A. Yes.
Q. In what context have you heard that?
A. Oh, I've heard that several times in depositions, in testimony, in teaching my house officers.
Q. You use it to teach your --
A. Absolutely.
Q. -- students, that unless it's document, it hasn't

been done?
A. Yes, I do.
Q. It's same for nursing staff, right?
A. Yes.
Q. And that's why it's critical to keep accurate medical records and document everything you do?
A. Yes.
Q. I think we talked about Should Your Baby Boy Be Circumcised, but I want to make sure I have your answer correctly. Would you agree with Dr. Kaplan that that is not sufficient to meet the informed consent standard?
A. In and of itself, I would agree with that.
Q. And there's no place on there for a signature of the parents, is there?
A. There is not.
Q. And you don't know whether Anita got that, do you?
A. I do not know that.
Q. You don't know what Anita Kantak -- I'm sorry -- Dr. Kantak told Anita, do you?
A. I was not present when anything was said to Mrs. Flatt by Dr. Kantak.
Q. So you don't know what was said?
A. I don't.
Q. You don't know whether or not Anita received the

other booklet that you had, the infant care booklet, do you?

A. I do not know that she received it. It was policy that everyone received it.

Q. In the description of your opinions as disclosed to me it is indicated that you will testify about your participation in the APA task force. I assume it's a misprint. It is AAP?

A. It's there all the way through that statement. I just found it this morning.

Q. And it's the AAP, correct?

A. Correct.

Q. And the second sentence on that says it is your opinion that the care Dr. Kantak provided to Josiah Flatt in 1997 was consistent with the -- correction -- AAP recommendations?

A. Yes.

Q. You're making that opinion based on assumptions, are you not?

A. I am.

Q. And those assumptions would include that Dr. Kantak described the risks and benefits as she did in her deposition, right?

A. Yes.

Q. The assumption is further -- or is that the only

assumption you need to make?
A. No, the assumption that -- restate your question for me, the whole question.
Q. What I'm asking is in order to make the conclusion that Dr. Kantak met the standard of care as stated in the AAP statement you're making assumptions, right?
A. Based on medical record.
Q. Are you making assumptions?
A. Yes.
Q. Is one of those assumptions that Dr. Kantak accurately testified -- let me clarify that -- that Dr. Kantak's deposition testimony about what she said to Anita Flatt actually took place?
A. Yes, that's documented in the record.
Q. Is that an assumption you're making?
MS. VOGLEWEDE: I'm going to object. It's argumentative. He's answering your question and describing what he based that opinion on.
Q. MR. BAER: Is that your assumption?
A. Yes.
Q. If you assume that to be true, Dr. Shoemaker, would that be sufficient to meet the standard of care, if all you had was that, would that be sufficient to meet the standard of care?

MS. VOGLEWEDE: Was what?

THE WITNESS: My assumption?

MR. BAER: Yes.

MS. VOGLEWEDE: Which assumption? I'm not clear on this question.

MR. BAER: All right. Let's back up and try it again. You've just got him primed too well, Jane. Dr. Shoemaker, I want to focus --

MS. VOGLEWEDE: Zenas, to try to save time, are you asking about the assumption concerning the deposition testimony of Dr. Kantak? I just want to make sure I'm not losing where you're headed.

MR. BAER: Asking about the assumptions he's made. He said he's made assumptions, right.

MS. VOGLEWEDE: I just want to understand in the context of this question what assumption you're referring to.

Q. MR. BAER: I'm going to start over again and go again.

A. Okay. Because I'm not clear on it either.

Q. Okay. Dr. Shoemaker, in order to make this statement that Dr. Kantak provided to Josiah Flatt in 1997, care that was consistent with the AAP recommendations, in order to make that statement, you have to make some assumptions, do you not?

A. I do.
Q. And one of those assumptions is that Sunita Kantak actually told Anita Flatt the benefits and risks as she described them in her deposition, right?
A. Yes.
Q. If you only had that assumption, would that be sufficient to meet the standard of care?
A. I don't think that's relevant because the chart documents that it was explained, the risks and benefits were explained, the literature was provided, and Ms. Flatt subsequently signed the consent implicitly saying that she agreed. So it's more than assumption, it was documented in the record, it was described, the literature was provided, and Mrs. Flatt signed the consented.
Q. Okay. Then let's back at it from another direction then, Dr. Shoemaker.
A. Okay.
Q. If you didn't have Dr. Kantak's testimony and she said I don't remember a thing and all you had was the medical records saying I described those benefits, would that be enough?
A. Knowing Sunita Kantak, it would be for me.
Q. What if you didn't know Sunita Kantak?
A. I couldn't make any assumptions then.

Q. Why, because it's just a signature, isn't it?
A. It is a signature. It's a legal medical record.
Q. It's on page 3 of Josiah's records where it has a preprinted form and her signature beside it, right?
A. That's correct.
Q. Read it into the record.
A. "Risks of local anesthesia and circumcision discussed, procedure described, parent expresses understanding," and it's signed by Dr. Sunita Kantak and dated 3/6/97.
Q. And so your position is, Dr. Shoemaker, that even if you didn't have Dr. Kantak's deposition testimony having this record alone would be sufficient to meet the standard of care?
A. Yes.
Q. Dr. Kantak was your partner, wasn't she, at the practice?
A. She was.
Q. How long was she your partner?
A. Six or seven years I think. I don't remember exactly.
Q. Were you her supervisor?
A. I was the chief of the department.
Q. Does that mean you were a supervisor?
A. We had a very collegial -- I was responsible for

managing the department. I was responsible for discipline, I was responsible for quality assurance, so in some regards, yes, I was her supervisor. But I was not her instructor, mentor, or didn't monitor her practice. I might have been from the financial aspect.

Q. You also indicate in your opinion that you drafted, Exhibit No. 2, which is Should Your Baby Boy Be Circumcised, and that you were going to talk about how it was implemented. Why don't you tell me how you know about that?

A. We reviewed that before. I wrote this as I was involved in the -- began to be involved in the circumcision issue, and this was written prior to the time I was even associated with MeritCare, and then it was periodically updated.

And since I was knowledgeable about the fact that the circumcision debate was increasing, I thought we should be more proactive in regards to the information that we provided parents. This is something I had always done, even in the historical stuff. And so I wrote this, presented it to the department at meetings, it was discussed, it was handed out, it was rediscussed, some things were changed, it was rediscussed. It was voted on to be accepted and sent to the printer, and then it was by policy by departmental mandate, if you

will, supposed to be given to all parents of male children.

Q. How is that -- where is that policy?

A. It's in the --

Q. Family Birth Center, is that a possibility?

A. It's in the minutes of the pediatric department.

Q. Okay. From what month would we get those minutes?

A. I don't remember. It would be prior to December 1996, probably Octoberish.

Q. So how does it go from a practical standpoint, if you have a meeting and you pass a resolution or a motion to instruct that this pamphlet be given to parents of all male infants, how is that carried out?

A. It would be -- since the meeting, the pediatric department minutes would also be conveyed through the pediatric joint practice council, which is a collaborative meeting between the normal newborn nursery and the intensive care nursery.

Q. Is that the pediatric council --

A. The pediatric joint practice council of which I was also chair, the managing nurse for the normal newborn nursery would have it communicated that the pediatricians wanted this booklet given to all parents.

Q. Okay. Were you involved in those steps?

A. Yes.
Q. Between the council and then from the council --
A. I was chair of both of those things. I'm sorry. I'll let you finish.
Q. How about to the managing nurse, were you involved in that?
A. Yes.
Q. In what way?
A. She was at the meeting. She was at the joint practice meeting. She and I jointly -- I manage the medical practice, she managed the nursing issues.
Q. Okay. And was this a nursing issue or a medical practice issue?
A. Both.
Q. So you instructed the nurse to take care of this aspect of it?
A. On behalf of the department the pediatrician would say this is what we want done, and it would be generally handed out by the nurses in the normal newborn nursery. In the intensive care nurseries generally the -- or it was not uncommon for some pediatricians to walk around with one and hand it to parents after they did the normal newborn examination, and very commonly in the normal newborn nursery the nurses would carry stacks of stuff behind the doctor as they went around to make

rounds and would hand them stuff.

Q. Would you do rounds?

A. Periodically in the normal newborn nursery I would help out if we were short.

Q. I'm still wondering if you went to the committee, the pediatric committee, is that what you called it?

A. This was first presented to the department of pediatrics, all the pediatricians, because we wanted to make sure we had a consensus what was said, that we felt it was not significantly biased, that we covered all of the things that we wanted to have covered. Once we approved it, it went to the joint practice council, not committee, and then it would be communicated that we wanted this done in both the intensive care nursery and normal newborn nursery.

Q. After the council said we wanted it done, who takes care of it from an administrative standpoint to get it copied or put into a format to be published? Who takes care of that aspect of it?

A. Generally that would be in the nurse manager's portfolio in what she did.

Q. Do you know anything about what they did in implementing this?

A. No. I know it was available December of 1996 because I was using it.

Q. Did you ever accompany Dr. Kantak on rounds?
A. I did not.
Q. So you have never heard first hand of what her routine would be, if we can use that word, in describing the risks or benefits?
A. No, I have not.
Q. If you assume, Dr. Shoemaker, that -- and I know you probably won't assume -- assume that Anita Flatt is telling the truth and there was no information given to her, was the standard of care met?
A. It's a speculative assumption. I mean if --
MS. VOGLEWEDE: You mean no verbal, no written, or oral information?
Q. MR. BAER: Yes.
A. Why would a person of her intelligence, an attorney I believe, sign a consent if she had not been consented? You leave me in a situation that I having dealt with attorneys for quite a while I just don't see as possible.
Q. Have you ever had a baby?
A. Yes.
Q. You?
A. Oh, me, no.
Q. Going back to the question again now -- you diverted me for a moment, but I'll get back to it. If

you assume that Anita -- or that the facts are that Anita did not receive any oral or written information about the risks or benefits of a circumcision, was the standard of care met?

MS. VOGLEWEDE: Objection. Repetitious. Asked and answered.

THE WITNESS: Do I say something now?

Q. MR. BAER: Yes, you can answer.

A. Okay. Since the consent was signed, and it was documented that -- by somebody else that consent was given, and even if Ms. Flatt does not remember that she was counseled, it was still documented that she was.

Q. I still don't think that answered the question, Doctor, and I'll try it one more time. If you can't answer it, let me know.

A. I can't answer it. I just can't.

Q. Why?

A. Well, because it's speculative to the point of saying Ms. Flatt is lying, Dr. Kantak is lying, it's saying --

Q. And you can't believe that either of those are true?

A. Yeah, I can't.

Q. Okay.

A. I mean, it just -- it's something I don't

comprehend I guess.

Q. You also indicate in your opinion that in your opinion Josiah Flatt did not suffer any injury.

A. That's my opinion.

Q. How do you define injury?

A. Permanent harm.

Q. Isn't the amputation of erogenous tissue permanent?

A. Yes.

Q. Isn't it harm?

A. Hasn't bothered me.

Q. Isn't that what this whole thing is about?

A. What?

Q. I'm circumcised, it hasn't bothered me, what the hell?

A. No, it's not.

Q. So you don't think there's any harm in the permanent amputation of erogenous tissue?

A. In the relation to the fact that there are potential medical benefits to that procedure, no. I believe the benefits out weigh the risks and the potential that you're referring to.

Q. I was asking you about injury, whether or not Josiah Flatt suffered any injury.

MS. VOGLEWEDE: He hasn't asked a question yet.

THE WITNESS: I know.

Q. MR. BAER: And you described briefly how you use the Gomco clamp, that first you cut the foreskin and that is actually cutting off living tissue where blood appears from time to time, right?

A. Yes.

Q. Isn't that an injury?

A. Yes.

Q. And when you take the Gomco clamp and put the bell in it and insert it against the metal base and screw it down to make hemostasis, doesn't that crush the vascular system in the foreskin?

A. Yes. This is an anesthetized penis.

Q. It wasn't -- it was a dorsal penal block, wasn't it?

A. As I remember the records, yes, that is correct.

Q. It wasn't an anesthetized penis, correct?

A. Generally anesthetized most the foreskin and the glans penis.

Q. Most, but not all?

A. In my experience the anesthesia is fairly complete.

Q. But when you crush the vascular system with this clamping system that's injury, isn't it?

A. Yes.

Q. So it's inaccurate to say Josiah did not suffer injury?
A. In the relation -- in relationship to the fact that his tissue was removed, any surgical procedure, minor, major causes injury.
Q. Let me just make sure I understand or I caught that. You said any surgery causes injury?
A. Yes.
Q. Circumcision also generates money for the practice, doesn't it?
A. It does.
Q. Exhibit 15 is a billing chart. Can you identify on Exhibit 15 what the charge would have been for circumcision?
A. I don't think this is the right code.
Q. What do you think is the proper code?
A. Since I've moved to California we no longer use the code. I'm trying to remember the code for circumcision. It might have been 56660. These are care codes. There is no charge for circumcision in there. I don't think these are the right codes. I would have to look at the coding book because I've forgotten that now. But these appear to be daily care codes, and I don't see a circumcision code in there that I recognize. That's not to say it's not there.

MR. BAER: For the record, I would like to request the billing for the circumcision. I was at least given this in response to that request earlier, and I'd like to have the circumcision billing in this case.

THE WITNESS: These are daily care code charges. Sorry.

MR. BAER: And this is the only billing that I know that I've received on Josiah Flatt.

THE WITNESS: Just to be clear, again, I don't remember those codes anymore. I don't do it anymore.

Q. MR. BAER: Showing you what has been marked as Exhibit 7, Dr. Shoemaker, have you seen the model informed consent form identified as Exhibit 7?

A. No.

Q. Do you know of any informed consent form that would adequately meet the standard of care as described by the AAP statement?

A. Preprinted standard of care -- informed consent?

Q. Yes.

A. Any written statement without discussion does not meet the standard of care.

Q. Okay. Fair enough. Do you know of any written statement that would meet the standard of care, or you just said no written statement would meet it, right?

A. Not without discussion.
Q. Well, I mean, if you have the statement in the medical records that says risks of local anesthesia and circumcision discussed, procedure described, patient expresses understanding, and a signature line there, would that be sufficient?
A. That meets the standard of care.
Q. That does?
A. Yes. This meets the standard of care --
Q. You're saying this, you're talking about Exhibit 2?
A. Yeah.
Q. Meets the standard of care?
A. No, no, I started to say something, and I stopped what I was saying. Are we still on this one?
Q. Look at the model informed consent. Take a moment to review it.
Do you think it would be useful for parents to read that before deciding whether to circumcise their child?
A. Absolutely not.
Q. Why?
A. It's prejudiced biased about circumcision.
Q. How can you tell it's biased?
A. It's written by Nocirc. It also lists 28

complications -- no, sorry, 31 complications and says presumed but unproven benefits it lists five, and then it says their potential are conjectured benefits which have not been proved to actually exist. I think that's a misstatement of fact.

Q. Okay.

A. I think they do indeed exist.

Q. Anything else?

A. No.

Q. Now, you said it's biased. Isn't the AAP report that we're discussing this afternoon also biased?

A. I don't believe so.

Q. Well, how many people who sat on that committee were pro or anticircumcision?

A. Most of them.

Q. Anti, not in favor of circumcision?

A. Yes.

Q. Who were they?

A. The women, where's my list? Dr. Lannon, the chair was anticircumcision, Carol Lannon, Ann Bailey, Jack Swanson, I don't know Dr. Coustan's stance, as I said, he was the guy that communicated by letters. I would -- because of my personal beliefs I would define myself and my personal family as pro. Dr. Kaplan I believe is pro. Dr. Fleischman I wouldn't comment on.

He was the bioethics representative. And I don't know what his opinion was. But ethicists are good at that.

Q. But would you agree that all medical literature comes with some sort of a bias towards it?

A. Most. We attempt to keep it out I think if you're fair.

Q. But it's difficult to do that, isn't it?

A. It is.

Q. What would the normal charge for a circumcision be as you recall it in MeritCare?

A. As I remember when I started it was about $75, and when I left it was about $125. Right now in California it's $220.

Q. And that's the cost of physician's charge?

A. Yeah, that's the physician's charge.

Q. And is there a separate charge for like set up tray and things like that?

A. No, it's included in the room cost. At MeritCare it was included in the room cost. I don't know about here.

Q. Do you know how much -- or was the room cost the same whether it was circumcised baby or a noncircumcised?

A. It was the same cost.

Q. I guess with 95 percent you're not spreading it

over too much.
A. No, the cost of the tray really isn't significant.
Q. Showing you what has been marked as Exhibit No. 5, that is the signed consent of Anita Flatt, you would not consider that to be an informed consent form, would you?
A. It's the standard informed consent form for surgical procedures at MeritCare, yes, I would.
Q. You believe that that gives sufficient information about the risks and benefits of the procedure?
A. Not of the procedure in and of itself. It lists the procedure.
Q. What does it say?
A. It lists circumcision, and there's a line for that, and then it says several things, do you consent to the anesthesia and pictures, and I generally read this aloud to people. I don't know what Dr. Kantak's practice was. It's witnessed, it's signed by -- assuming it was Ms. Flatt's signature, and I assume it's Ruth Larson's signature because I don't know either one.
Q. The time was 7:20 in the evening?
A. Uh-huh.
Q. Dr. Kantak wasn't there at that time, was she?

A. She may have been. I don't know.
Q. She said she wasn't.
A. Quite possible.
Q. Are you aware that the practice was that LPNs took these around to expectant mothers or mothers who just delivered?
A. I was aware in the normal newborn nursery after a parent had been consented that they would be taken. It wasn't the practice in the intensive care nursery, but it was the practice in the normal newborn nursery.
Q. Since you sent me the indication of what your opinions were going to be in September of 2001, have you formed any other opinions that are not stated in the disclosures?
A. Can I read the disclosure again really quick?
Q. Uh-huh.
A. In relation to the almost the last -- second to the last sentence that says it is his opinion that Josiah Flatt did not suffer any injuries from his circumcision, I had the opportunity to view a video cassette tape, I believe was the -- I assume was done by the parents where I saw the penis, very short amount of a minute or so of videotape, that I didn't think that the circumcision looked significantly unusual.
Q. So you would contest Dr. Surcheck's finding of

a -- I forget, but it was sort of an asymmetric --
A. I didn't have a chance to examine the child. Asymmetry in the foreskin within the first couple months to years after life is very common in circumcisions, so it looked like a fine, an adequate circumcision to me from what I could see on the videotape. And like I said, I didn't examine the child.
Q. I'm just looking at Dr. Kaplan's notes that I got yesterday, his review of the chart. He said on May 7th, 1997 there was an entry that there was circ asymmetrical. Do you remember reviewing that?
A. Yes, I think Dr. Surcheck said that.
Q. Do you disagree?
A. I didn't examine the baby. I didn't see a significant asymmetry on the videotape.
Q. Do you contest that Dr. Surcheck diagnosed circ asymmetry in May of 1997?
MS. VOGLEWEDE: Objection. Argumentative. It's a different question than what you asked him before, did he disagree, and he was explaining his answer.
THE WITNESS: Dr. Surcheck saw what Dr. Surcheck documented.
Q. MR. BAER: And are you disputing what he documented?
A. No.

MS. VOGLEWEDE: Objection. Repetitious.

Q. MR. BAER: In August of 1997 the records show that Dr. Surcheck, I believe, broke up the adhesion on the left to treat asymmetry. Did you remember reading that?

A. No.

Q. Surcheck observed an erection and noted that most of the redundant skin is stretched out. Do you remember reading that?

A. No.

MS. VOGLEWEDE: Are you reading from Dr. Kaplan's notes or Surcheck's report?

MR. BAER: I told you and the reporter that it was Dr. Kaplan's notes. I'm assuming Dr. Kaplan transcribed it accurately.

Q. Exhibit 6, do you know when those birthing policy and procedures were implemented?

A. Well, it says in 1993, and it was revised in 1993, and in 1987. So at least in 1993.

Q. Were you involved in the development of those?

A. I was not.

Q. Were you involved at all in the implementation of those?

A. No, I wasn't.

Q. Have you seen it before?

A. I don't believe so.
Q. Exhibit 19 is your E book. Is there a site that I could access on the Web to download it conveniently?
A. UpToDate dot com, but I think you have to be a member. I think you have to --
Q. And what key word, or how do you access it?
A. Just WWW -- just a regular URL address, WWW.UpToDate.com, just the way it's done right there on the first paragraph, first word.
Q. And then your editorial comment, can that be accessed digitally at all, Exhibit 20?
A. I don't think so. It should be in any medical library.
Q. We couldn't find it in the MeritCare library.
A. The journal of --
Q. I'll take a look for it.
A. It's published by Saunders. It's all over the place.
Q. Thank you. I have nothing further.
A. Okay.

MS. VOGLEWEDE: Just one or two questions.

EXAMINATION BY MS. VOGLEWEDE

Q. You were asked a number of questions by Mr. Baer about injury and whether Josiah Flatt suffered any injury. Let me ask it just a little differently.

In your opinion was Josiah Flatt harmed or damaged in any way by the care that Dr. Kantak provided?

A. I do not believe so.

Q. And when you said that any kind of surgery causes injury, what did you mean by that?

A. It causes tissue damage that needs to heal.

Q. For example, if you place an IV in a baby --

A. That's an injury.

Q. Meaning tissue damage?

A. Yes, tissue damage. You make an incision and sew it up, that's an injury.

Q. And by that do you mean that there was any harm or damage to this child?

A. No, I did not mean or -- mean to imply that.

MS. VOGLEWEDE: That's all I have.

MR. BAER: That brings up a whole universe of questions, Dr. Shoemaker.

EXAMINATION BY MR. BAER

Q. As I understood your answers to the leading questions that your counsel asked was that there was injury to Josiah Flatt but you didn't mean that injury to imply that Josiah was harmed or damaged.

A. That's correct.

Q. How do you define harm?

A. I would define harm as -- in the context that I'm

thinking of it as something that is lasting, and I think that's the context that you're thinking of it as well.

Q. And isn't the permanent amputation lasting?

A. It is lasting.

Q. Right, so there's harm?

A. In the regard that one implies harm as a negative persistent injury damage, no, I don't think that it was. It heals. If you have a tooth pulled, it causes injury, but it heals, and it doesn't cause harm because it's not lasting. Am I being unclear?

Q. What isn't lasting about the permanent amputation of highly enervated tissue that covers otherwise an internal organ?

MS. VOGLEWEDE: I'll object to the form of the question.

THE WITNESS: You're stating your opinion now.

MR. BAER: Would you read back the question?

(The question was read back by the reporter.)

THE WITNESS: The organ is not internal, it's external. It's a piece -- it's tissue that covers an external sexual organ, and once it's removed it still functions normally.

Q. MR. BAER: Okay. You took a little piece of my question and disputed the premise of that question. Read that question back without that focus of the

internal organ.

(The question was read back by the reporter.)

MR. BAER: Just take off "otherwise internal organ."

MS. VOGLEWEDE: Objection. This is the third time it's been asked and answered.

THE WITNESS: The tissue heals. After the removal of the tissue, it heals and the resulting organ functions normally. So I don't believe there is permanent harm.

Q. MR. BAER: The resulting organ functions normally, that's only true if you consider a circumcised penis a normal penis, isn't it?

A. I would say, yes, that's true.

Q. So if you have a child who is in its natural state that's normal functioning of a penis, isn't it, without any alteration?

A. A child with a circumcision is also in a normal state. He's had a piece of tissue removed.

Q. What if you remove a finger, doesn't that heal?

A. Yes, and most people with a removed finger function normally.

Q. But there's permanent harm, isn't there?

A. One would have to describe that for oneself.

Q. What if you remove an earlobe, would that be

lasting --

A. One, again, would have to describe that for oneself.

Q. So the way you used he wasn't harmed is subjective to the person who has had it done to them?

A. Oh, yes, absolutely.

Q. And that's all you're implying to say is that he wasn't injured because he hasn't raised an objection saying he was injured?

A. His penis to my knowledge functions normally.

Q. Absent the foreskin, right?

A. At least part of it.

Q. What's the normal functioning of a penis with a foreskin, Dr. Shoemaker? What does the foreskin do?

A. It covers the glans penis, it has some nerve tissue in it, and it has some cells that respond to bacteria in it.

Q. If allowed to grow to a normal size or an adult size, what is the dimensions that this foreskin which is removed fairly routinely? What dimensions would it grow to?

A. It depends on the operator. Sometimes a good deal of foreskin grows back.

Q. What are the ranges depending on the operator?

A. Depending on the operator, the glans of the penis

can be entirely exposed to only the area immediately around the urethra can be exposed.

Q. So are we talking a range between 5 square inches and 20 square inches?

A. Square inches is -- I don't want to go there.

Q. Well, square centimeters.

A. Yeah, you could be talking an area from a square centimeter to, oh, 20 square centimeters probably. I don't know what the volume of the adult male glans penis is, as a matter of fact, or the outside dimensions.

MS. VOGLEWEDE: Then don't speculate.

THE WITNESS: All right. I won't speculate.

Q. MR. BAER: You've never seen any literature on that, on approximating the amount of tissue that is removed as a result of infant circumcision?

A. Nothing controlled.

Q. Have you read anything that's junk science in your mind?

A. Yeah, Bob Howe stuff.

Q. How much was that?

A. How much was what?

Q. What was the size of the --

A. I don't remember the exact size. I don't remember the exact numbers that he quoted.

Q. Why do you say Bob Howe stuff was junk?

A. Because he was the only observer. There was no control other than himself.

Q. In what -- which one are you talking about?

A. He was talking about complications of circumcision, he observed a rate of complications of circumcision which was almost ten times what everybody else observes.

Q. Was that the only one that you had a criticism about?

A. That's the only one I remember.

Q. How about anything of Dr. Wane, did you read anything about Dr. Wane?

A. I read Dr. Wane's deposition.

Q. And what did you conclude from that?

A. It was quite obvious she wasn't aware of the neonatal pain data.

Q. What is that data?

A. Specifically you asked about sucrose and the pacifier. She equated it to an adult. I mean, she's an adult surgeon. The fact that she thought she might be able to get circumcision privileges at a hospital when she was an ophthalmologist I thought was not very reasonable. She obviously is opposed to the procedure, but -- and her accent really seemed to me to be of an informed consent rather than the procedure itself,

although she was obviously not in favor of it.

Q. Earlier you said that the informed consent model that is marked as an exhibit, Exhibit 7, you said that it's biased and you said that it's written by Nocirc.

How do you know it's written by Nocirc?

A. It says TTP. It may not be written by Nocirc, but it was provided from their Web site.

Q. You don't think Nocirc could provide unbiased data?

A. Absolutely not.

Q. They can't provide access to unbiased data?

A. Yes.

Q. If it came off the Web site, it could just be access to it.

A. Whoever wrote this is biased.

Q. Exhibit 7?

A. I'm sorry, Exhibit 7. Wherever it came from, it's biased.

Q. And you would also say the same thing that the document you wrote, Exhibit 2, is biased, right?

A. I attempted to keep bias out of it, but it certainly could be criticized, I think, because it doesn't list every single complication, and it was criticized by my own colleagues because of the financial things that I put in there. To my knowledge, it's more

informational than anything I've ever seen for written literature that's handed out in the hospital.

Q. Getting back to what started us on this journey, injury and your response to Ms. Voglewede on the question that you -- when you responded that there was injury to Josiah you said you didn't mean it in the sense of harmed or damaged. Now, we talked about harmed, we talked about what you thought you meant by harmed. I want to know how that distinguishes itself from damaged, that Josiah isn't damaged as a result of the circumcision.

A. Well, I think I expressed my opinion before is that his penis continues to function normally, so therefore, there is no permanent damage or harm, and there was injury because any time you cut tissue there is an injury.

Q. How can you say that the penis functions normally when you've removed perhaps 20 or 30 percent of the skin covering the penis?

A. My review of the literature would lead me or has lead me to believe that the sensation between a circumcised and an uncircumcised penis is different, but essentially the same, that sexual function is normal, and that there are potential medical benefits to circumcision which justify it being done. In that case

I believe Josiah was provided a service at the request of his mother.

Q. That didn't answer the question, but I'll try it again.

A. Okay.

Q. Are you familiar with the gliding function that the foreskin serves on an intact penis?

A. Yes.

Q. That gliding function is no longer there, is it, after circumcision?

A. If all of the foreskin is removed, all of the gliding function would be removed. If part of the foreskin is removed, some of the gliding function would remain.

Q. But it isn't the natural state, is it?

A. No.

Q. So it isn't in -- the penis does not function naturally, it is altered?

A. You're confusing naturally with normally in my opinion.

Q. Do you have a problem with that?

A. Yeah.

Q. Why?

A. Because I think normal function may not be -- you can function normally and not have -- you function

normally without an appendix, you function normally without your molars. Those are all natural things. But they may not be -- their removal doesn't leave you abnormal. And in this country if you define normality as the majority of the population, being uncircumcised would make you abnormal.

Q. Is that the way you define normality?

A. No.

Q. How do you define it?

A. I define normality as on a functional basis.

Q. You mentioned the literature on sensation. The AAP statement, the only literature mentioned is the 1966 Masters and Johnson survey.

A. To my knowledge that's the only literature that's available.

Q. Do you know what the protocol was for that study?

A. The protocol was to place needle sensory probes beneath the ventral and dorsal surface of the glans penis and measure the electrical responses during coitus.

Q. So it measured electrical responses?

A. Right.

Q. That's all?

A. That's all.

Q. It didn't measure pleasure, did it?

A. No, it could not do so.
Q. Right. And you'd never be able to do that, would you?
A. No.
Q. And so there isn't any literature that would be able to describe what we are missing as a circumcised society?
A. There's only opinion.
Q. Right.
A. There is no scientific literature, you're right.
Q. I want to go back, just one thing that you said that is really troubling to me is a range of tissue loss from 1 centimeter to 20 square centimeters. I'm wondering, is that pure off the wall stuff, or do you have any basis to believe that there is that range of 1 to 20 square centimeters that is removed?
A. From my personal experience during -- with adult males in emergency rooms in V.A. hospitals, I would say the range is quite broad. Those numbers are purely speculative.
Q. Okay.
A. But the range is from having only the tip of the penis exposed to the entire glans exposed, whatever that surface area would be, I don't know what that is.
Q. And it's not just one layer, it's two layers of

skin, isn't it?
A. It's the inside layer and the exterior layer. The exterior is skin like other skin. The interior at some point has a different composition.
Q. The mucosal membranes?
A. Sure.
Q. Why do they call them mucosal membranes?
A. Usually there's mucus glands in the tissue.
Q. That would provide some lubrication for sexual activity?
A. Masturbatory activity, any sliding of the function, yes.
Q. And that would be lost in the circumcision?
A. To whatever degree those mucus glands were removed, yes.
Q. Most all routine circumcisions performed remove those mucus glands, don't they?
A. I can't really comment on that because I don't know of studies that measure if you take one-third of the way down -- I don't know of any distance that says the mucus -- I know of circumcised people that still have mucus function in their foreskin, I know of people who don't, and I don't know of any literature that supported how much foreskin. Certainly if you remove all the foreskin, it's gone. But how much in between, I

don't know.

Q. There are no standards in the medical practice of how much to remove, is there?

A. There are not.

Q. It's just by guess, by golly?

A. I think it's a little more thoughtful than that, but there are no standards.

Q. Would you agree with Dr. Kaplan who wrote unfortunately circumcision is usually done by untrained, unskilled individuals causing problems that the urologists have to address later on?

A. As a urologist Dr. Kaplan has a certain degree of prejudice because he does see problems. I would agree that there are people who have inadequate training in circumcision who do them.

Q. Even current medical grads?

A. I would say so.

Q. Thank you. That's all I have.

MS. VOGLEWEDE: He will read and sign.

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(Deposition concluded at 5:14 p.m.)

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I hereby declare under penalty of perjury that I have read and corrected the foregoing in all particulars desired, and it is a true and correct transcription of my testimony given on the date indicated herein.

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CRAIG SHOEMAKER, M.D.

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DATE

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