IN DISTRICT COURT, COUNTY OF CASS, STATE OF NORTH DAKOTA.

Josiah Flatt by and through His Natural Guardians Anita Flatt and James Flatt,	)	
Plaintiffs,	)	Civil No. 99-3761
vs.	)	
Sunita A. Kantak, M.D., MeritCare Medical Center and State of North Dakota,	)	
Defendants.	)	

TRANSCRIPT

OF

TRIAL

Taken at
Cass County Courthouse
Fargo, North Dakota
February 12, 2003

BEFORE THE HONORABLE CYNTHIA ROTHE-SEEGER - DISTRICT JUDGE -
-- AND A JURY --

VOLUME VII
(Pages 980-1211)

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(The trial herein was continued in open court, in the presence of the jury, at 8:59 a.m., Wednesday, February 12, 2003, as follows:)

THE COURT: Let the record show we are reconvened with all parties, counsel and all jurors present.

Members of the jury, the Court has again allowed an interruption in the plaintiff's case so that one of the defendant's witnesses can appear. And that person will be called at this time. So we're interrupting the plaintiff's case to allow a witness for a defense to appear. And this is a witness that was not able to be here at any other time.

The defense may proceed.

MS. VOGLEWEDE: Thank you, Your Honor. The defendants call Dr. Craig Shoemaker.

CRAIG T. SHOEMAKER, M.D.,

being first duly sworn, was examined and testified on his oath as follows:

DIRECT EXAMINATION

BY MS. VOGLEWEDE:

Q Would you state your name, please?
A Craig Thomas Shoemaker.
Q What is your occupation?
A I am a physician.
Q And what is your specialty?
A Pediatrics with subspecialty training in

neonatology.
Q What does the specialty of neonatology cover?
A The specialty of neonatology covers the care of premature and sick newborn infants.
Q Dr. Shoemaker, where do you practice currently?
A Currently in Sacramento, California.
Q And where is your position of employment?
A I am the Director of Special Care Nurseries at University of California, Davis Children's Hospital in Sacramento.
Q And do you also hold an academic position?
A Yes. I'm a clinical professor of pediatrics.
Q And with which educational facility?
A University of California, Davis.
Q How long have you been at the University of California, Davis?

A Two years and three months.
Q Did you practice medicine in Fargo previous to moving to California?
A I did.
Q How long were you in Fargo?
A 16-and-a-half years.
Q Starting in what year?
A 1984.
Q And what positions did you hold when you worked in

Fargo?
A I initially held the position of staff neonatologist. I subsequently became Assistant Medical Director of Children's Hospital and Vice Chair of Pediatrics. In 1991, I became Chair of Pediatrics and Medical Director of Children's Hospital. And with the merger of the hospital and clinic, I became managing physician partner of Pediatrics.
Q And what was it, Dr. Shoemaker, that took you to your current position in California?
A At a research meeting that I had been invited to as discussant, my mentor, a person that I had trained and I would speak of as a mentor, told me he was retiring and offered me his job.

Q Did you have previous ties to California?

A I did my residency training at Travis Air Force Base in California. I was a general pediatrician at Mather Air Force Base for three years, which is located in Sacramento, and subsequently did my neonatal fellowship, my postdoctoral training in neonatology at the University of California, Davis.

Q Do you still have family in the Fargo-Moorhead area?

A I do.

Q Doctor, I want to begin by asking you about your

connections to this particular case. First of all, are you familiar with a MeritCare booklet that is called "Should Your Infant Boy Be Circumcised?"

A I am.

Q And what was your role in the preparation of that booklet?

A As chair of the Department of Pediatrics, I brought forth as an agenda item the initiation of that booklet. And as chair, I drafted the first copy before corrections by the department -- corrections or additions by the Department of Pediatrics of that booklet.

Q Secondly, Doctor, were you a member of the American Academy of Pediatrics task force on circumcision which issued a policy statement on circumcision in 1999?

A I was.

Q And third, at my request, did your review the medical records of Josiah Flatt and Anita Flatt in this case to give me your opinion about whether Dr. Kantak met accepted standards of medical care?

A I did.

Q And what was your opinion?

A That the accepted standards of care were met.

Q Now, Doctor, would you tell the jury a little bit about where you did get your medical training and your specialty training for neonatology?

A My medical training was I got a B.S. in medicine from the University of South Dakota, which at that time was a two-year medical school. I transferred and graduated with an M.D. from the University of Minnesota. Was offered an Armed Forces health profession scholarship position at Travis Air Force Base for my residency in straight pediatrics. Subsequently did three years of general pediatrics at Mather Air Force Base, as I previously described, and was accepted at several programs in

neonatology, but elected to stay at the University of California, Davis Sacramento medical center for my neonatology training.

Q I believe you said, Doctor, that while you were in Fargo, you were medical director of the intensive care nursery?

A I don't believe I said that, but I did hold that position as well.

Q Okay. And were you director of neonatal services?

A I was.

Q And assistant medical director for the MeritCare Children's Hospital?

A Yes, I did mention that.

Q And chair of the Department of Pediatrics for a number of years?

A That's correct.

Q Did you do any consulting for other area hospitals?

A I did.

Q Which were they?

A United Hospital, which is now Altru Hospital in Grand Forks. St. Joseph's, which when I left North Dakota

was called Unimed. I don't know what -- if it's changed now. Trinity Medical Center in Minot, and St. Alexis Medical Center in Bismarck.

Q Did you hold any teaching positions while you were here in North Dakota?

A Yes. I started a teaching position as assistant professor of pediatrics, advanced associate professor of pediatrics. And at the time of my moving to Sacramento, I was a clinical professor of pediatrics at the UND School of Medicine.

Q Are you board certified?

A In pediatrics and subboard certified in neonatal perinatal medicine.

Q And where are you licensed to practice?

A North Dakota and California.

Q Doctor, are you a member of the American Academy of Pediatrics?

A I am.

Q Are you a fellow in that group?

A Yes.

Q And how big is that organization?

A It's about 450,000, I think, somewhere in that range.

Q Does it consist only of pediatricians?

A No. There are other subspecialties, pediatrics surgery. There are members that have interests in children's issues that are members of different sections of the American Academy of Pediatrics, such as transport medicine, military medicine. There are many different sections.

Q Does it consist only of United States physicians?

A No, it does not. It includes physicians in Canada and in Central America.

Q Have you held any positions either statewide or nationally with the American Academy of Pediatrics other than the position that you held on the task force on circumcision?

A Yes, I was chairman of the Committee on the Fetus and Newborn on the state level in North Dakota. I was also chairman of the Bioethics Committee for the State of North Dakota, I was the American Academy of Pediatrics North Dakota chapter's appointee on bioethics for the attorney general of the State of North Dakota while I was here.

I was -- had two 3-year terms at the -- on the

national Committee of the Fetus and Newborn. And am

currently on the executive advisory board for the District 9 of the California chapter for the perinatal section of the American Academy of Pediatrics.

Q Were you a delegate that represented an area larger than North Dakota?

A Yes. I represented District 6. My responsibility was Manitoba, Saskatchewan, North Dakota, South Dakota, Iowa, Illinois, Missouri, and Nebraska.

Q Let met ask you, Dr. Shoemaker, about your circumcision experience. Do you perform circumcisions?

A I do.

Q And for how long have you done that?

A Since 1976.

Q Could you give an estimate of how many circumcisions you've performed during your practice?

A Greater than 1,000 and less than 2,000.

Q Have all of those been on newborns?

A The vast majority. I have circumcised certainly less than 10 children -- male children under six months of age.

Q And other than those somewhere less than 10, they have all been on newborns?

A That's correct.

Q And can newborns in an intensive care nursery be

circumcised if their parents wish it to be done?

A They can be if they meet the criteria of physiologic stability and the criterion basically the American Academy sets forth in its last several statements.

Q Doctor, do you obtain informed consent for circumcisions?

A Always.

Q And approximately how many times have you done that?

A More than 1,000 and less than 2,000.

Q And are you familiar with the accepted practice among pediatricians in obtaining informed consent for circumcision?

A Locally or nationally or both?

Q Both.

A Both.

Q Do you teach others how to perform circumcisions?

A I do.

Q And in what circumstances and who do you teach?

A As a clinical professor of pediatrics, I teach pediatric residents, first-, second- and third-year residents, neonatology fellows, family practice residents whom I taught in North Dakota as well. And since my arrival in -- at the University of California, Davis, I have instructed several faculty members who were unfamiliar with

techniques in circumcision.

Q What device do you use, Dr. Shoemaker, when you perform circumcision?

A I exclusively use the Gomco clamp. G-o-m-c-o.

Q Why do you prefer the Gomco?

A I feel that it's easier to control during the procedure. It provides a better aesthetic effect and outcome and is -- the child is exposed to the procedure for a much briefer time than a procedure called the Plastibell, which is a string tied around a little plastic bell.

Q Doctor, had you ever done any special study or writing or research on circumcision before you were appointed to the task force on circumcision?

A Yes. I wrote an affidavit for the Supreme Court of the State of North Dakota in relation to a case in North Dakota.

Q And how about prior to that?

A Had I written anything?

Q Or did you have any special interest in circumcision?

A I had an interest that developed since my training in California during -- my training period was the 1979 statement on the -- from when the AAP came out, which essentially said there wasn't a good reason for circumcision. And I had kind of a historical, theological

and ethical interest, and did some readings on the historical reasons for circumcision and prospectus related to circumcision.

Q At what stage was that?

A That would have been during my final year of residency at Travis Air Force Base and during my years as a general pediatrician.

Q Okay. Doctor, is your level of experience now different from that of most general pediatricians in terms of the number of circumcisions that you do and your exposure to complications of circumcision?

A Yes. I would say it's quite a deal more extensive than the average general pediatrician.

Q Are you familiar with accepted standards of practice of general pediatricians regarding circumcision?

A I believe I am.

Q And with accepted practices concerning informed consent for circumcision?

A Yes.

Q And how are you familiar with that practice?

A I am familiar with what is recommended by the American Academy of Pediatrics, from consultations with my

colleagues in Canada and Mexico for this continent, and European colleagues in relation to what their counseling procedures are due to my national affiliations.

Q Doctor, is there only one accepted medical practice for discussing circumcision with parents?

A No, there are many.

Q Did you become aware of this lawsuit by Anita Flatt while you were still in Fargo at MeritCare?

A I did.

Q And are you -- were you a colleague of Dr. Kantak's?

A I was.

Q For how many years?

A From whenever Sunita came. I don't recall how long that was after I came. She came after I was there.

Q Did she ever talk to you about this lawsuit while you were here in Fargo?

A She did.

Q Were you chair of the department at that time?

A I was.

Q And did you find it surprising that she would come to talk with you?

A Not at all.

Q What did she tell you?
A To my recollection, she told me that she had been named in a suit regarding a child that she had circumcised and was distressed about that.
Q Did she describe the details of the case?

A She did not.
Q Were you aware as chair of the department of her general practices regarding talking to parents?
A From discussing it with nurses and other physicians who were my colleagues, I was generally aware of her practice.
Q And what was your understanding of her practice?
A My understanding was that it met the standard of care, and that her explanation regarding the risks and benefits of circumcision and anesthesia was quite extensive.
Q At a later date, Dr. Shoemaker, after you had left MeritCare, did I ask you to review the medical records in this case?
A You did.
Q And did I ask you to give me your opinion about whether Dr. Kantak's care met accepted standards?
A You did.

Q And did you do so?
A I did.
Q And what opinions did you reach?
A My opinion was, from reviewing the medical record, that the care that Dr. Kantak provided Josiah Flatt was well within the standard of care expected of general pediatricians who do circumcisions.
Q Do you still hold those opinions today?

A I do.
Q And do you hold them to a reasonable medical certainty?
A I do.
Q Doctor, how did you go about determining when you reviewed this information whether her care met accepted standards?
A I reviewed the medical record, I noted that the signature block on the newborn history and physical form had been filled out, that mother had been counseled. I did find a consent sheet that mother -- I assume it was mother, I had never met mother, I would not recognize her signature, but it was signed by mother, was on the chart. Then there was a subsequent note that the circumcision had been performed.
Q Doctor, have you since reviewed a number of other

materials in this case?

A Yes.

Q And have any of those materials changed your opinions?

A They have not.

Q Doctor, is it your opinion that Dr. Kantak did obtain informed consent for the circumcision that was done on Josiah Flatt?

A That is correct.

MR. BAER: Objection, leading.

THE COURT: Sustained. Would you restate it, please.

Q (Ms. Voglewede continuing) Doctor, what is your opinion regarding whether or not Dr. Kantak obtained informed consent for this procedure on this child?

A Based on the medical record and the signature block where it documents that informed consent was provided and it was signed by Dr. Kantak, it was my conclusion that she provided informed consent to mother.

Q And from the information that you have reviewed, what are your opinions regarding whether or not she properly performed the circumcision?

A To my knowledge, the circumcision was properly performed. I have seen pictures of the resultant circumcision, which appear to be a normal circumcised penis to me.

Q Doctor, did it -- did you reach any opinions or conclusions about whether anesthesia was used in the procedure?

A It was documented in the medical record that it was used.

Q And is a dorsal penile nerve block an acceptable technique of anesthesia for a circumcision?

A It is accepted and in some cases recommended as the ideal method of anesthesia.

Q Are you familiar, Doctor, with pain studies on pain related to circumcision?

A I am.

Q And do those studies show that dorsal penile nerve block is an effective technique to use for circumcision?

MR. BAER: Objection, leading.

THE COURT: Sustained. Please restate.

Q (Ms. Voglewede continuing) What do those studies show about the effectiveness of a dorsal penile nerve block for circumcision?

A The studies relating to pain of circumcision show that dorsal penile nerve block is one of several effective methods of alleviating pain or eliminating pain during circumcision.

Q Doctor, are you familiar with studies showing the use of sugar on pacifiers during circumcision?

A I am.

Q And what is the effect of using that?

A They do show a diminishing pain response in an infant who is provided a sugar-coated pacifier on which to suck during -- before and during a circumcision.

Q Is that an acceptable technique to use in addition to a dorsal penile nerve block for a circumcision?

A In addition, yes.

Q Doctor, one of the plaintiff's experts has

testified in this case about occurrences of pneumothorax or collapsed lung or gastric rupture from babies crying so hard during circumcisions. Are you aware of any such reports?

A I have never seen a case or reviewed a case report of such an occurrence.

Q Dr. Shoemaker, do you have an opinion on whether or not Josiah Flatt suffered any injury due to the

circumcision?

A I do not believe that Josiah Flatt was injured in any way due to the circumcision.

Q Do you hold that opinion to a reasonable medical certainty?

A I do.

Q And what is your opinion based on?

A My opinion is based on the fact that according to the subsequent medical records, his penis functions normally. The pictures I have seen, it appears to have good cosmesis, it looks normal. And there's been no evidence that I've seen that it functions abnormally.

Q Have the photos that you've seen included any recent photos?

A They included photos of a male child's genitalia, who was certainly in his toddler years. They weren't identified as Josiah Flatt, except that I received them from yourself and they were identified as being of Josiah Flatt.

Q And what's your understanding of the source of that photos?

A They were provided by --

MR. BAER: Objection, hearsay.

THE COURT: Overruled. Answer the question.

A My understanding is they were provided by the plaintiff's attorney.

Q (Ms. Voglewede continuing) Doctor, the jury has heard testimony about adhesions that were described by Dr. Sawchuk in a subsequent evaluation that he did of Josiah. In your opinion, do those adhesions constitute an injury?

A Adhesions are a quite common complication or result of the -- of a circumcision in that embryologically the squamous epithelium between the foreskin and glans penis persists. And if there is some residual, it's very common for some small adhesions to persist or even recur after a circumcision.

Q Do you know of any injury to Josiah's functioning in terms of urination?

A I do not.

Q Do you know of any impairment to his future function in terms of sexuality?

A I do not. I would not anticipate any.

Q Now, Doctor, let me turn your attention to the booklet that I asked you about earlier. Up until 1996, did

MeritCare have any written materials on circumcision to provide to parents?

A There was about a paragraph and a half, I believe, in the -- a booklet about infant care. I don't remember the name of that booklet.

Q Doctor, showing you Exhibit 58, is that the booklet that you're referring to?

A It is.

Q Information at pages 5 and 6?

A That's correct.

Q Was there a booklet specifically developed for circumcision at some point?

A There was.

Q Doctor, showing you Exhibit 105, is that the booklet that was developed at MeritCare regarding circumcision?

A Yes, it is.

Q When you -- would you describe for the jury, Doctor, how that booklet came about?

A Because of my personal interest and involvement in the previous case in North Dakota that I mentioned, I felt that the Department of Pediatrics should discuss the information we provided to parents regarding circumcision. And it was made an agenda item for the Department of Pediatrics. And the department decided that we should

develop such an informational booklet for parents.

And it was subsequently written, as I previously testified, by myself and first draft, and then adjusted, adapted several times before its initial printing, and then again after its initial printing because of interest and concerns that members of the Department of Pediatrics had.

Q Was it approved by the Department of Pediatrics?

A It was.

Q And when was it first printed?

A December of 1996, I believe.

Q And when was it implemented?

A December of 1996.

Q Was that booklet available for use for parents in March of 1997?

A Yes.

Q Doctor, how did that booklet, to your knowledge, compare with what other medical facilities were doing regarding written information on circumcision?

A To my knowledge, it was quite a bit more extensive than what the general pediatric practice provided to parents regarding circumcision, historical perspective, ethical implications, et cetera.

Q Doctor, how was that booklet to be used for the Family Birth Center?

A It was to be used both in the Family Birth Center

and the intensive care nursery to provide parents an initial idea of what circumcision was, and the controversy regarding whether or not an infant male should be circumcised, in order to establish a platform for which discussions could be made, and parents could ask questions that might arise from reading the booklet.

Q Was it intended to be self-sufficient to handle everything concerning informed consent?

A It was not.

Q Doctor, did that booklet that you initially drafted and that was approved by the department predate your involvement on the task force on circumcision?

A It did.

Q You began your work on the task force in what year?

A I believe we started in 1996. I don't remember the precise date of our first meeting.

Q Okay. And the work of the task force was completed in what year?

A The statement was published in 1999.

Q Did the task force in which you participated do a more exhaustive review of the research and literature than you had done previous to that when you were drafting the booklet?

A Quite a bit more extensive, yes.

Q Now, Doctor, there have been some criticisms made of the booklet by plaintiff's experts in this case. And I want to have you address a couple of these, if you would.

One of the criticisms is that the booklet used the lowest complication rate with regard to circumcisions and was therefore biased. Do you agree?

A I believe that there were three papers published in the journal of pediatrics from 1973 through 1989 which showed a complication rate of .19 percent, .2 percent and .2 percent. And we felt that since our complication rate at MeritCare was low, that that would be a reasonable complication rate to use in our booklet.

Q Another criticism, Doctor, is that you, the department, used the highest rate of reduction of urinary tract infections and that the booklet was therefore biased. Do you agree?

A I believe we used a 10 times increase in urinary tract infections. The literature --

Q Let me just interrupt you. A 10 times increase in which, circumcised or uncircumcised?

A In uncircumcised male infants, there was a tenfold risk over those children who were not circumcised. The literature, to my knowledge, varies between 7 percent and 14

percent, so actually we picked something that was slightly below the median. And the accepted standard -- well, not

really standard, but the accepted rate is approximately a tenfold increase. There are people on -- who are advocates of circumcision who will quote a much higher rate than that. And I don't think that those are accurate either.

Q Doctor, another criticism of the booklet is that it states that circumcision has been fairly common in Western culture, but that that statement is not actually true. Would you agree?

A I think that's an opinion based on your interpretation of Western culture. It is certainly common in the United States, it's fairly common in Australia. 50 percent of the men in Canada are circumcised. In nonWestern European nations or in Scandinavian nations, it's rare. In Asian nations, it's rare. And so there's a broad -- if we are going to look at the entire global village, it's going to make the numbers a lot different.

Q Another criticism, Doctor, is that overall there really is no difference in rates of cancer of the penis or cancer of the cervix in women based on circumcision status. Do you agree?

A I believe there's a documented difference. There

was a documented difference at this time. And over the past three years, there's been -- become an increasing amount of evidence that women who are sexual partners of men who are circumcised have a higher incidence of cervical cancer and

men have a higher incidence of cancer of the penis.

Q Doctor, another criticism is that there simply is no established medical benefit from circumcision so the booklet is in error in saying that there is. Do you agree?

A The task force on the 1999 task force statement, it says there are potential medical benefits from circumcision, and I agree with that statement.

Q And what is that statement based on?

A That statement is based on an extensive evidence-based review of English language literature, looking at controlled scientific studies with adequate power with which to make a conclusion about the question at hand.

Q Doctor, how was it that you came to be appointed as one of the members of the task force on circumcision?

A During my tenure -- my six-year tenure on the national Committee on Fetus and Newborn, it was known -- we often discussed things that were going on in our various districts.

It was known that I had participated in the case in North Dakota, I had written some small paragraphs for what is called the Guidelines of Perinatal Care on care of the uncircumcised and circumcised penis in the fourth edition.

And I was appointed by the chair of the Committee on Fetus and Newborn to represent our committee on that task

force because of my interest and knowledge regarding the topic.

Q You referred earlier, Doctor, to the fact that this was an evidence-based analysis of the research that the task force did?

A That was our attempt.

Q I am not going to ask you much about that, because the jury has heard Dr. Kaplan address that. But in the course of reviewing all of the English language literature dating back to -- I think you said about 1960?

A Yeah. I believe we looked at a couple articles even earlier than that but --

Q In the course of reviewing all of those studies, did the task force review some research that it considered not to have much medical validity?

A We reviewed a lot of literature that we thought

didn't have a lot of medical validity.

Q And did it review research that it found to be valued and reliable?

A It did.

Q Are most of the references that are cited at the end of the task force statement -- and I think there are 119 of them -- were those considered to be among the more reliable studies available to the task force?

A The vast majority were. There were a couple of

citations in there that were surveys that we normally would not have included, but they made a specific point or they were very recent and they were included to either establish a point or review a point on which evidence could be looked at further.

Q Doctor, again, because the jury's heard a lot about the task force and how it opera teed, I want to ask you to describe for the jury just what was the essence of the conclusion that the task force reached.

A The essence of the conclusion was that there were potential medical benefits from circumcision looking at the lifetime of a male, but the evidence was not strong enough to recommend that all male infants should be circumcised.

Q And how did the task force intend that its final report be used?

A As all task force statements, it is not a policy, it's a guideline for pediatricians, family practice doctors, people who take care of children on how they should consider information they should have available and recommendations about particular ways of practice.

Also, in the conclusion there were two statements that were extremely different from the three previous statements that the American Academy of Pediatrics had come out with. The second one was that although all male infants need not be circumcised, all parents of male children should

be counseled about the potential medical benefits and possible risks of circumcision; and that if circumcision was elected, that anesthesia should be used.

Q Okay. That differed from the previous statement, the 1989 task force statement?

A The last two statements that all parents should be counseled and that anesthesia should be used were different statements. The American Academy of Pediatrics has never recommended routine circumcision of all male infants.

Q Doctor, was it intended that pediatricians would convey to parents all of the information contained in the

17-page report from the task force?

MR. BAER: Objection, leading.

THE COURT: Overruled. Answer the question, please.

A It was not intended that all the information from the guideline -- the statement of the task force should be conveyed to parents. It was provided as information for individual practitioners to use.

Q Doctor, if the task force concluded that circumcision was not essential to the current well-being of the newborn, why didn't it just conclude "We're going to recommend that circumcisions not be done any more"?

A The task force had prolonged debate on several articles which showed that some of the benefits of the

circumcision were effective only if the child was circumcised in the newborn period, that they were not effective, for example, in eliminating penile carcinoma or penile dermatoses if they were done later on in life. And so looking at a lifetime of rather than -- pediatricians often focus on children, but if you look at a lifetime of any male, they're not children for very long, and some of the benefits may last well into the elder years.

Q Doctor, is circumcision a risky procedure?
A As a minor surgical procedure, I think it's a procedure which has little risk, but there is some risk.
Q And what risks are most common in circumcision?
A The most common risks are bleeding and infection.
Q And how common did the task force find that those two risks were?
A It was estimated at approximately two percent based on previous literature. Other studies had gone up to .6 percent. So it would be two in a thousand to six in a thousand.
Q Two percent or .2 percent?
A .2 percent.
Q And how serious did the task force find that infection or bleeding complications usually were?
A The vast majority of infections and bleedings were minor and able to be managed medically with no consequence.

It was infrequent that bleeding or infection was a significant complication.
Q Of risks other than bleeding and infection, how common did the task force find those risks were?
A I'm sorry, would you restate the question?
Q Of risks other than infection and bleeding, how

common did the task force find those risks were?

A Very rare.

Q And, Doctor, the jury has heard testimony from Dr. Kaplan that among the complications or risks described in the 1999 task force report, death was not included; is that correct?

A That's correct, in the 1999 statement.

Q Why was that not included?

A The -- I believe the last recorded death due to circumcision in the medical literature was approximately 1979. And that -- it was mentioned in the 1989 pediatric statement as a risk.

Q Dr. Shoemaker, showing you Exhibit 112, does that appear to be the previous task force statement on circumcision?

A It's reported that it's -- excuse me for being too close to the microphone. It is the 1989 report of the task force on circumcision, yes.

Q Would that report have been the report available

to pediatricians, such as Dr. Kantak, yourself, other members of the pediatric department, in March of 1997?

A Yes, it would be.

Q I would like to turn your attention, Doctor, to the section of the 1989 task force report called contraindications, complications, and informed consent. Do you see that?

A I do.

Q And, Doctor, what does the first paragraph of that section deal with?

A It deals with contraindications or, in more simple terms, when a circumcision should not be done, when it was not indicated.

Q For example, when would you not do a circumcision on an infant?

A In a male infant who had a penile abnormality, such as a hypospadias or an opening of the penile urethra in an abnormal position, if the child was not physiologically stable, was not feeding normally, couldn't maintain adequate temperature control, et cetera. Sometimes if metabolic disease would be present or infection would be present or there was evidence of a bleeding disorder. Those are some of the ones specifically mentioned.

Q Drawing your attention then, Doctor, to the second paragraph, let me just read that to you, Doctor. And I'll

have a couple of questions about that. It states, "The

exact incidence of postoperative complications is unknown, but large series indicate that the rate is low, approximately .2 percent to .6 percent. The most common complications are local infection and bleeding. Deaths attributable to newborn circumcision are rare; there were no deaths in 500,000 circumcisions in New York City or in 175,000 circumcisions in U.S. Army hospitals. A communication published in 1979 reported one death in the United States due to circumcision in 1973, and the authors' review of the literature during the previous 25 years documented two previous deaths due to this procedure."

Doctor, which specific complications were listed by that task force from circumcision?

A The specific complications are bleeding and infection.

Q And with regard to death --

A And death.

Q And with regard to death, what was the conclusion of that task force as to how common that occurred?

A Extraordinarily rare.

Q Doctor, have you heard of deaths occurring from circumcision?

A I did hear of one based on this report.

Q And when was that death?

A The death, as I'm reading the statement right now, appeared to have occurred in 1973, it was reported in 1979.

Q Okay. Was that when you learned about it?

A No, I learned about it -- I was not a pediatric resident at that time. And it was brought out during my residency that death was a rare but possible complication of circumcision.

Q And have you heard of any deaths from circumcision since that case report?

A I have not.

Q While I'm up, Doctor, let me show you Exhibit 119. Can you identify that, please?

A This is a copy of my curriculum vitae dated July of 2001.

Q And as of that date, is it accurate and complete?

A Yes, it should be. I think there are some typographical errors in it.

MS. VOGLEWEDE: We offer Exhibit 119.

MR. BAER: No objection.

THE COURT: Defendant's Exhibit 119 is received.

Q (Ms. Voglewede continuing) Dr. Shoemaker, are adhesions considered a complication of circumcision?

A Yes, they can be.

Q Is asymmetry a complication?

A Significant asymmetry can be a complication, yes.

Q Did you see either of those complications -- either of those complications in this case?

A Adhesions were described. I did not see them. And there was a slight asymmetry of the foreskin described. I did not see -- I did see videotapes of that asymmetry that was alleged by the parents in the newborn period. And then subsequently I saw what appeared to be a normal penis in a toddler.

Q Were adhesions or asymmetry described by either the 1989 task force or the 1999 task force as complications of circumcision?

A They were not.

Q Why is that?

A Because they're a fairly common occurrence with a normal circumcision.

Q Doctor, what benefits was the task force able to identify from circumcision that caused the task force to recommend that it be made available as an option to parents?

A Other than the religious and ethnic reasons for circumcision, the potential medical benefits that were recognized and documented in the 1999 statement were the elimination of penile cancer, decreased cervical cancer in sexual partners of circumcised men, elimination of the complications of having a foreskin; that is, infection of

the foreskin and subsequent structure of the foreskin, which might require subsequent surgery.

And, finally, there was some conflicting evidence that subsequently became stronger but was not stated in the 1999 statement regarding the transmission HIV or the AIDS virus and other sexually transmitted diseases.

Q What is the evidence on the effect of circumcision on HIV transmission or sexually transmitted diseases?

A At the time of this statement or at the time currently?

Q At the time of the task force's work.

A At the time of the task force's work, the literature that we had available was mostly African literature, where, of course, HIV is a major epidemic at this time. And it showed that there was a decreased incidence of transmission of HIV, both from male to female and female to male in men who were circumcised over men who were not circumcised.

Q Doctor, Mr. Baer asked Dr. Kaplan about an office brochure that Dr. Kaplan had concerning urinary tract infections in children, and asked him whether the brochure stated anywhere that circumcision was a treatment for urinary tract infections. Has it ever been suggested by the

AAP, American Academy of Pediatrics, that circumcision is a treatment --

A Not to my knowledge.

Q -- for urinary tract infections?

A Not to my knowledge.

Q Is it a treatment for urinary tract infections?

A Not in my opinion.

Q What did the task force conclude about the effect of circumcision on the occurrence of penile cancer?

A They concluded that although penile cancer in North America was extraordinarily rare, that it was virtually nonexistent in uncircumcised -- excuse me, if I may correct myself, in a circumcised male.

Q Doctor, do you recall Dr. Van Howe appearing before the task force to speak?

A I do.

Q And how did that come about?

A Dr. Van Howe was a known advocate of discontinuing the circumcision of male infants and had done personal literature review that was quite extensive. And he was invited to the task force to discuss his viewpoint and review of the literature so a fair opinion could be gleaned

from what research he had done, and the writings he had done regarding circumcision, and its risks, benefits and complications.

Q He has testified that he initiated contact with the task force and was then permitted to come and speak. Is that what you recall?

A That may be true; however, I have no personal knowledge of that. I was not chair of the task force.

Q Okay. Was his -- you did hear him speak?

A Yes, I did.

Q Was his interpretation of the scientific data and what it showed different from the conclusions reached by the task force?

A In my opinion, the task force felt that his interpretation of the literature was skewed in opposition to circumcision in that most of his articles, including several studies that he had done himself that he cited in support of his opinion, were anticircumcision or against the procedure of circumcision.

Q And did you review the data, the study, that he had done himself?

A Yes.

Q And was that consistent with other medical

research?

A The data -- we did not feel that it was controlled adequately from a scientific standpoint. He was the only observer, he defined what complications were, it wasn't -- there was no other observer other than he. And I believe he reached a complication rate that was 100 times what general pediatricians generally see.

Q Doctor, what are the alternatives to circumcision?

A I'm sorry, again?

Q What are the alternatives to circumcision?

A To not circumcision.

Q Doctor, what's the function of the foreskin?

A We're not clear on that entirely.

Q Do all body organs have a function?

A We assume that all body organs have a function. We may not know what all body tissue is functional for.

Q Are there any other organs or body parts for which we have not identified a function?

A The appendix comes immediately to mind.

Q Doctor, what did the task force conclude about the scientific evidence about the impact of circumcision on sexual function?

A The task force concluded that at the time of our writing there was no evidence that circumcising an infant changed in any way the sexual function of that person later in life. And we also reviewed some adult literature that indicated that there was no difference in at least the electrical sensations experienced by the glans penis during coitus from a circumcised or uncircumcised penis.

Q And in this case, Doctor, do you see any injury or harm to Josiah Flatt that occurred because of this circumcision?

A I see none.

MS. VOGLEWEDE: That's all I have, Doctor. Thank you.

THE COURT: Cross-examination, Mr. Baer.

CROSS-EXAMINATION

BY MR. BAER:

Q Dr. Shoemaker, good morning.

A Good morning.

Q I took your deposition about a year ago out at UC, Davis, correct?

A I believe it was about a year ago, yes.

Q You were under oath at that time?

A I was.

Q You testified truthfully?
A I did.
Q And you testified regarding facts of this case; is that correct?
A I did.
Q Did I ask you at that time whether or not you think known complications of circumcisions need to be disclosed to parents?
A You did.
Q And didn't you say that, yes, you think known complications ought to be disclosed?
A I did.
Q Now, Dr. Shoemaker, let's talk a little bit about

the known complications of circumcision, which you said need to be disclosed, correct?
A Correct.
Q You authored an editorial comment regarding circumcision sometime shortly after the Laumann article came out in April of 1997. Do you recall that?
A I do.
Q I want to give you a copy of your editorial comments so you can follow along, Dr. Shoemaker. Do you

recognize the editorial comments?

A I do.

Q And you indicated in the opening sentence, "A recent article presented by Laumann, et al, in JAMA manages to stack more kindling around the burning bush of circumcision." Did I read that correctly?

A You did.

Q And just so that we're clear, I think Dr. Kaplan mentioned this in his testimony that the article you're referring to is the article that was printed in the Journal of the American Medical Association entitled "Circumcision in the United States, Prevalence, Prophylactic Effects, and Sexual Practice" of April of 1997. Do you see that?

A Yes.

Q This was authored long before the committee reviewing circumcision reached their conclusions, wasn't it?

A It was.

Q And do you remember reviewing the Laumann article in which it said that the United States stands apart from the rest of the world for its high rates of neonatal circumcision?

A Yes.

Q You don't agree with that, though, I take it?

A Why not?

Q I thought you said that the entire Western world is circumcised. Doesn't your brochure say that? It's common in the Western culture?

A It is common in the Western culture, much more common than it is in Asia or in any other place. 50 percent is more common than 5 percent, Mr. Baer.

Q Oh, is that what you're saying?

A Yes.

Q Okay. And Western culture you're saying is only the United States? Is that what you're saying?

A No, I didn't mean to imply that, but that's where we live, that's where the brochure was written to inform parents.

Q Sure. But the brochure implies that Western culture, civilized world, basically circumcises, correct?

A It states that Western culture circumcises with a higher incidence than other cultures, yes.

Q Sure. And you would agree, also, wouldn't you, that the United States stands apart from the rest of the world in its rate of circumcision, correct?

A The incidence is higher than in most -- in all

other countries, to my knowledge.

Q You would also agree, would you not, with the article where it says --

A Which article are you referring to?

Q The Laumann article.

A Thank you.

Q -- where it says, "The AAP has counseled that parents be fully informed of the risks and benefits of the procedure before deciding to have their son circumcised." You would agree with that, wouldn't you?

A I would agree with that.

Q And you would agree with the statement that it says "fully informed," correct?

A Yes.

Q And do you recall reading in the Laumann article, Dr. Shoemaker, near the conclusion, where he says, "We have discovered that circumcision provides no discernible prophylactic benefit and may in fact increase the likelihood of STD contraction." Do you remember reading that?

A I remember reading that.

Q And you rejected it, I take it?

A I did. So did the rest of the committee, the task force.

Q Sure. The committee members that were appointed included you, correct?

A That's correct.

Q You're pro circumcision, correct?

A I would say I have no opinion about circumcision in general. I have an opinion about circumcision for my family, but not for yours.

Q Right. And you do it for your family?

A I do.

Q Do you do it for any religious reason?

A I have done it.

Q To your family members?

A Not for my family members, no.

Q Do you recall when I asked you about the makeup of the committee in your deposition, Dr. Shoemaker?

A Generally.

Q And didn't I ask you whether or not there were pro circumcision folks on the committee?

A You did.

Q And didn't you identify yourself as a pro circumcision person?

A For my own personal opinion, yes.

Q And didn't you also identify Kaplan as a pro

circumcision person?

A I think I probably did identify Dr. Kaplan as a pro circumcision person. I don't have my deposition in front of me to read it so --

Q I will get it for you so you can review it.

A Do you know what page you are referring to, Mr. Baer?

Q I do. Refer to page 140, if you would.

A Thank you.

Q Goes from 140 over to 141.

A Yes, fine. Thank you.

Q Didn't you identify yourself as pro circumcision in that exchange of question and answer, Dr. Shoemaker? Dr. Shoemaker, let me ask a question. I asked you how many people who sat on the committee were pro or anticircumcision.

"Answer: Most of them.

"Question: Anti, not in favor of circumcision?

"Answer: Yes.

"Question: Who were they?

"Answer. 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."

A That's correct.

Q "Dr. Kaplan I believe is pro," correct?

A Correct. And at no time, I should make clear, was the committee polled on what their stance on circumcision was. This was an opinion gained during the discussion. And it's my personal opinion.

Q You stated that under oath, correct?

A I did, yes.

Q And you profit from circumcisions, do you not? You get paid for doing them?

A I personally do not profit from doing circumcisions.

Q But your institution does?

A Yes. The institution I'm at right now doesn't.

Q Now, your editorial comment -- I want to get back to your editorial comment -- suggests that the male circumcision -- infant male circumcision is a very emotional, engendering topic. Would you agree with that?

A Absolutely.

Q And you equated the discussion about circumcision to issues concerning termination of life --

A I did.

Q -- correct? And you also indicate that -- by the way, there's no date on this editorial comment. Could you

identify more closely than the Laumann article having been published as to its date that you wrote it?

A I believe it was written for the 1998 Yearbook on Neonatal Perinatal Medicine, edited by Dr. Avory Fanaroff and Dr. Jeff Maisels. It's in my CV.

Q So about 1998, is that your best estimate?

A I believe that's correct. It could have been 1997, but I doubt it since the Laumann article was 1997.

Q Sure. Okay. Then you also identify the history of the AAP and the task forces on infant neonatal circumcision of the male infant, correct?

A I quoted the 1989 task force statement, yes.

Q Correct. And what you quote was "newborn circumcision has potential medical benefits and advantages as well as disadvantages and risks"; correct?

A That's correct.

Q That's not an endorsement of circumcision, is it?

A Absolutely not.

Q Then you also go on, Dr. Shoemaker, and say, "The Australian College of pediatrics stressed that 'in all cases the medical attendant should avoid exaggeration of either risks or benefits of the procedure.'" Do you see that?

A That's correct.

Q And you believe that that is also the standard here in America, that you should not give biased

information, correct?

A Yes.

Q Then you also identify that "Subsequently, several medical societies in the developed world have published statements concluding that routine circumcision of newborns should not be done, even though potential benefits were noted." Do you see that?

A Yes.

Q And the cites there are to the Canada statement, correct?

A Yes.

Q And the Australian statement, correct?

A That's correct.

Q Now, this is at a time when you are on the committee reviewing the literature for the AAP, correct?

A Correct.

Q And you're in the process then of determining what to do about it, correct?

A What we were going to say in the statement, yes.

Q Sure. And you would agree with Dr. Kaplan when he

testified and has written that physicians are really resistant to change? Would you agree with that?

A In general.

Q And in your editorial comment, you mention the Canadian statement, correct?

A Yes.

Q And that's the statement from 1996, correct?

A Yes.

Q And, obviously, you reviewed the Canadian statement before you wrote this editorial comment, correct?

A I did.

Q And the Canadian statement referred to their review of the AAP statements from 1971, 1975, and 1989, correct?

A That's correct.

Q They also reviewed statements from the committee of -- fetus and newborn committees, correct?

A Yes, I believe so.

Q And they also reviewed articles from the American colleges -- or College of Obstetrics and Gynecologists, correct?

A Yes.

Q And in their conclusion, did they not find that

neonatal circumcision should not be done?

A They said routine neonatal circumcision should not be done, I believe. I don't have the article in front of myself.

Q Well, would reference to it assist you?

A It would.

Q This is the 1996. And recommendation.

A Yes, that's exactly what I just said. Circumcision of newborns should not be routinely performed.

Q Okay. You put an emphasis on the word "routinely," Dr. Shoemaker.

A I did.

Q Are you making a distinction about medical institutions having preprinted forms, having a system set up to do circumcisions, and a distinction of doing it without any consent at all? Is that the distinction you're trying to draw?

A No. I think the two distinctions that are extraordinarily important to recognize -- and there's been a lot of confusion about that word "routine." Routine essentially means circumcising all male infants.

Q That's your take on it?

A I believe that's the task force's take on it, yes.
Q There's no definition of routine in the task force statement, is there, Dr. Shoemaker?
A No, there isn't.
Q And there's no definition of routine circumcision in any of the medical literature, is there?
A No. The word can be looked up in the dictionary.
Q And when you reviewed the Canadian statement, you reviewed the information where it said on decision-making processes and why parents make the decision, correct?

A I did.
Q And you read that they found that there's evidence that parents' decision making is based mainly on social rather than medical concerns, correct?
A I did read that.
Q You agree with that?
A In a large number of cases, yes.
Q In America as well, correct?
A Absolutely.
Q The strongest factor associated with the decision about whether to circumcise a male infant is whether his father was circumcised and concerns about the attitude of peers and the boy's self-concept as also -- are also

prominent influencing factors. Do you agree with that statement?

A I think that's a speculative statement, it's not been studied, but I think that's the opinion of many pediatricians.

Q Well, they give a cite here, Dr. Kaplan, to an article --

A Shoemaker. But that's okay.

Q I'm sorry. Dr. Shoemaker. Brown MS. "Circumcision Decision: Prominence of Social Concerns." Pediatrics, 1987. Are you familiar with that article?

A I'm not specifically familiar with that article.

I did discuss this article with several of the authors.

Q Then the last sentence here says, These concerns also need to be discussed during physician counseling of parents, further information that addresses these concerns is required.

A That's what the Canadian statement says.

Q And in your mind, the members -- or our neighbors to the north are also a Western culture, correct?

A Yes.

Q They have a civilized society?

A Yes.

Q And they have a fairly developed medical system, correct?

A I would say so.

Q And the Canadians did a review of their literature and they found the incident rate of complications to be anywhere from .2 percent to 2 percent, correct?

A I don't remember that specifically. I remember the number .2.

Q Well, do you see that?

A Yes.

Q Is it .2 to 2 percent?

A That's what the article states.

Q And that in terms that you have been using on direct examination would mean between two out of a thousand

and 20 out of a thousand, correct?

A Correct.

Q You further referenced the Australian study; is that correct?

A Yes.

Q And the Australian study is from the Australian College of Pediatrics; is that correct?

A Yes, I believe that's correct.

MS. VOGLEWEDE: Your Honor, I'm going to object to this line of questioning on the grounds of lack of relevance.

MR. BAER: Your Honor, he relied on these statements to formulate the opinion of a 1999 statement and formulate his opinions here today. I believe that they are very relevant as to what he rejected from these other societies.

THE COURT: Can you be more specific, Ms. Voglewede? Are you saying because they're not within the United States that they're not relevant?

MS. VOGLEWEDE: That's correct.

THE COURT: Mr. Baer, you have talked about Canada, now you are going to Australia.

MR. BAER: These are both that he mentioned that he has used.

THE COURT: Just listen, please. Do you have

other -- are there other countries --

MR. BAER: No. These are just the ones that he mentioned.

THE COURT: I'm going to overruling the objection. Go ahead, Mr. Baer.

Q (Mr. Baer continuing) You also reference in your editorial comment the statement of the Australian College of Pediatrics, correct?

A Correct.

Q And that is from May 27, 1996, correct?

A I believe so. I'm looking for it. Yes, that's correct.

Q And this was long before you even were appointed to the committee to study newborn circumcision, correct?

A Well, I wouldn't say it was long before, but it was before, yes.

Q Okay. And in fact this document came to your attention when you were reviewing the literature; isn't that correct?

A That's correct.

Q And doesn't the Australian College of Pediatrics touch on the issue of HIV and STD transmission, Dr. Shoemaker?

A It does.

Q Do you have it in front of you?

A No.

Q Okay. I'll show it to you, if you want to read along. Does the Australian College of Pediatrics say that,

However, studies claiming these benefits do have methodological problems -- I'm sorry, I will start out -- it has also been claimed that there is a reduction in the risk of sexually transmitted diseases, especially HIV, and of cancer of the cervix in partners of circumcised males. However, studies claiming these benefits do not have method -- or do have medical -- methodological problems which could influence findings, and these problems will be difficult to overcome. Therefore, at the present time it would be wrong either to claim that there is a definite health benefit or to deny that they exist.

Did I read that correctly?

A You did.

Q And doesn't the statement also provide that in the view of the Australasian Association of Pediatric Surgeons that routine infant circumcision should not be performed until the age of six months, correct?

A I don't remember the exact date, but I remember the surgeons wanted to delay it until later.

Q And that is for pain control, correct?

A I believe that was one of the items they mentioned. The other item was -- I think that this -- so

they could -- so someone with more experience would do it.

Q And doesn't it also say that neonatal male circumcision has no medical indication, it is a traumatic procedure performed without anesthesia to remove a normal and healthy prepuce? Do you see that?

A That is the statement of the Australian College of Pediatrics Surgeons in 1997.

Q 1996?

A '-6. Sorry. '-6? You're correct. '96.

Q Now, in your editorial comment, Dr. Shoemaker, you also reference, do you not, the AAP statement on -- or the AAP Committee on Bioethics statement on informed consent, correct?

A I do make reference to it, yes.

Q You cite it with approval, do you not?

A I don't under -- with approval?

Q Well, you cited it for the proposition that the AAP Committee on Bioethics has maintained that parental permission generally represents the best interests of the child. Do you see that?

A Yes.

Q And you would agree, would you not, that the AAP statement on informed consent gives a general guideline of the elements of informed consent, correct?

A It does.

Q And you would agree that that guideline would have applied to medical doctors practicing in Fargo, North Dakota, in March of 1997, correct?

A In general. It does not mention circumcision specifically in this statement of bioethics.

Q Okay. We have a copy that has been marked as an exhibit. I want you to follow along with me. Exhibit 31.

Now, you had mentioned in your direct examination that you were a member of the Committee on Bioethics; is that correct?

A For the State of North Dakota, yes.

Q And that is -- basically the national committee authored the statement identified as Exhibit 31, correct?

A That's correct.

Q And on page 2 of the statement, where it talks about ethics and informed consent, it basically gives the elements from a medical standpoint of what informed consent entails, correct?

A That's correct.

Q And I want to go over those in some detail and see whether or not that is -- is accurate in your mind, at least as an expert.

A In relevance to this case?

Q Yes.

A That was published in 9-6 of 2000, more than one

year after the statement from the task force was published.

Q Dr. Shoemaker, what is the date up here?

A That's 1995. This date down here is 2000.

Q The publication date is February of 1995, correct?

A That's correct. I was in error.

Q Okay. So in February 1995, you already had your arms around the AAP statement for the bioethics committee on what it meant to have informed consent correct?

A Yes.

Q And this would have applied to pediatricians practicing in Fargo, North Dakota; is that correct?

MS. VOGLEWEDE: Objection, Your Honor. This is an issue which the Court has previously advised it will instruct the jury on as far as a statement of law in informed consent. I will object to the questions as not relevant.

MR. BAER: Your Honor, we're not asking anything about law. We're asking about the medical standard for informed consent only.

THE COURT: May I see the exhibit, please?

The Court, ladies and gentlemen of the jury, is going to give you a cautionary instruction before I allow questioning on this particular issue.

The law in North Dakota establishes what must be

given by a physician to obtain informed consent. The law will be given to you by myself at the end of the case. That sets forth what the elements are. And when you decide the case, you need to apply the facts that you find to the law that I give you.

The medical information and committee findings and statements that have been referred to in this case do not necessarily follow what the law is. They may be different in some -- in some way, they may have different language, they may have different particulars. So I want to be sure that you understand that the medical standards or statements are just that, medical standards or statements. You in this case, when you decide it, will have to follow the law. And I will give that to you at the end.

So, Mr. Baer, you may continue.

Q (Mr. Baer continuing) Dr. Shoemaker, I don't mean to ask you any questions regarding law, I want to talk about your specialty; and, that is, medical practice. Okay?

A I understand.

Q And you as a medical practitioner must understand what it means to get informed consent, correct?

A Correct.

Q And that's why you're here to testify is, because you understand what it means to get informed consent?

A I believe so.

Q From a medical doctor's standpoint; is that

correct?

A Correct.

Q You indicated that the 1995 statement, which is before you marked as Exhibit 31, is an outline of what a medical doctor would need to do to obtain informed consent, correct?

A It's a guideline or suggestion from the Committee on Bioethics on what might be included in obtaining informed consent, yes.

Q If you would bear with me then, under the ethics and informed consent, No. 1, it says, "Provision of information." And it says, "The patients should have explanations, in understandable language, of the nature of the ailment or condition." Do you see that?

A I do.

Q And as it relates to this case, Dr. Shoemaker, what would be the ailment that Josiah Flatt was suffering from on March 6, 1997?

A He had no ailment.

Q So whatever intervention was not designed to treat therapeutically any condition, correct?

A No, it was designed as a potential medical benefit.

Q And in order for you as a medical doctor to describe the condition, you must describe to the parent what

that organ does, correct?

A Not necessarily, not if it's not known.

Q Well, let's take an absurd example. If a -- if you said, you know, I want to cut your hand off --

A That's an absurd example.

Q Right. Or if you want to take out an appendix, you would have to know before you, as a medical doctor, would be able to give a patient information about what condition the child finds himself in, you need to know what the purpose is of the organ you're suggesting ought to be taken off?

A Particularly in relation to your description of an appendix. We don't know what the appendix does in relation to a specific activity of the bowel, and it's often taken out incidentally by surgeons, so I would disagree with you on that point.

Q Is it taken out prophylactically in infants?
A Not in infants, no.
Q Is it taken out prophylactically, to your knowledge, at any time?
A If incidental -- if surgery is being done on the abdomen for another reason, it is often taken out.
Q I'm asking you whether or not the standard of practice would allow the prophylactic removal of an appendix?

A Yes, it would.
Q Usually on consenting adults, correct?
A Or children.
Q Now --
A Including neoates, by the way.
Q You indicated that there was no -- or that you didn't know what the purpose was of the foreskin, correct?
A I don't know what all the purpose of the foreskin is.
Q And you're a neonatologist; is that correct?
A That's correct.
Q Have you read Taylor's article?
A I have.
Q Taylor's work?

A Yes.
Q Dr. Cold's work?
A Yes.
Q Describing the Meissner's corpuscles?
A Correct.
Q The Langerhans cells?
A Correct.
Q The gliding -- the function to it?
A Those are mucosal membrane functions, yes.
Q You -- the immunological functions?
A That's very unclear.

Q But you've read those, correct?
A I have, yes.
Q And as a neonatologist, you probably would rely on a pathologist to describe the cellular structure of the foreskin, correct?
A I would.
Q And it would not be uncommon for a pediatrician to perhaps rely on another discipline to describe what the function is of an organ that you don't know anything about, correct?
A I wouldn't say that -- as a general pediatrician,

that's correct. I would not characterize myself as knowing nothing about the foreskin.

Q Oh. Then you do know a lot about it?

A I know some things about it.

THE COURT: We need to take a break, so I'm going to stop at this point. Jurors, remember my admonition. We're going to recess until 10 minutes to 11:00. Jurors, you are excused. Court is in recess.

(Recessed at 10:29 a.m. until 10:49 a.m., the same day, at which time the following proceedings were continued in open court, in the presence of the jury:)

THE COURT: Mr. Baer.

Q (Mr. Baer continuing) Dr. Shoemaker, before we broke, we were talking about the elements of informed

consent from a medical doctor's standpoint. And we got to the first one, and that was describing the nature of the ailment or the condition. And it's my understanding that as it relates to Josiah Flatt on March 6, 1997, it would have been normal newborn infant, correct?

A That's correct.

Q The second element of the informed -- of the informed consent from a medical doctor's standpoint is a discussion with the parent of the nature of proposed

diagnostic steps and/or treatment or treatments. Do you see that?

A Yes.

Q And as it applies to circumcision, that would obligate the doctor, would it not, to describe what treatments that medical doctor was going to provide for Josiah Flatt, correct?

A Potential treatments, yes.

Q It doesn't say potential treatments, does it?

A No. But in relation to circumcision, that's what we're talking about.

Q It says proposed diagnostic steps and/or treatments, correct?

A Correct.

Q Diagnostic steps. What would you have to do to diagnosis a condition that you're potentially treating?

A There is nothing you can do to do that.

Q Okay. So in order to have an foreskin that is ready -- that is diagnosed as ready to be removed, it has to be a normal one, correct?

A Yes.

Q Then, the -- it's actually the same of that. And

it says, the probability of the success of the diagnosis and treatments. The probability of success, correct?

A Correct.

Q When you're talking about probability, that implies one out of a thousand, three out of a million, one out of 10 million, correct?

A Correct.

Q Then the next element is the existence and nature of the risks involved. Do you see that?

A Yes.

Q And it doesn't say major risks, does it?

A No.

Q It doesn't say minor risks, does it?

A No.

Q It says risks, correct?

A Correct.

Q And the statement earlier said that parents need to be fully informed, correct?

A Yes.

Q And the risks that are identified with circumcision would be, for instance, those risks identified by Dr. George Kaplan in his treatise of 1983, correct?

A Those might be some.

Q Okay. And you actually cited in your -- in your editorial comment -- but we'll get to that in a moment -- but you have an obligation as an medical doctor to describe the risks, correct?

A Correct.

Q And it says the risks -- or the existence, potential benefits, and risks of recommended alternative treatments?

A Correct.

Q And you indicated the alternative treatment is to leave it alone, correct?

A That's correct.

Q Now, that's not quite true, is it? because you can have circumcision of varying degrees, can't you?

A Would you define varying degrees?

Q Sure. More or less foreskin taken off. Correct?

A It would still be a circumcision.

Q Right. But a circumcision of just the preputial opening would be much different than circumcision all the way down to the corona --

A Absolutely.

Q -- would you agree?

A It would still be a circumcision.

Q Correct. But the one is much more severe than the other, correct?

A I would not necessarily characterize it as severe, but would cause a different cosmetic appearance.

Q That's right, because you don't think there is any value to the foreskin?

A I did not ever say that, Mr. Baer.

Q Okay. The last element of the ethics of informed consent as it applies to medical doctors is that you have to describe the potential benefits --

A That's correct.

Q -- of the procedure? And those you described as it relates to circumcision as decrease UTI's, eliminate cancer risks, correct?

A Virtually.

Q Now it's virtually eliminate?

A There are still some kinds of squamous dysplasia that can occur, but severe invasive carcinoma is virtually eliminated.

Q And then the third one you said is do away with that thing so you never have any infection in it and the -- the rest of your life?

A I didn't characterize it as that way. I said, it

does prevent -- if one does not have a foreskin, one cannot get an infected foreskin, not -- one cannot develop a stricture of an infected foreskin.

Q Sure. Just like if you don't have a finger, you'll never have an ingrown fingernail on that finger, correct?

A That's correct.

Q Okay.

A And if you don't have a brown nevus on the front of your arm, you'll never have cancer in it either.

Q Okay. Now, on page 2 of your editorial note, if you just follow along with me, Dr. Shoemaker, you indicate, right after footnote 11, you say, The surgical risks of circumcision are certainly real but extremely rare. There's no cite to that sentence. But then you go on to say, There is a reasonable body of literature which suggests that surgery after infancy is more painful and carries a higher risk than when the procedure is done in the newborn period. Do you see that?

A Yes.

Q And you cite your friend, Dr. George W. Kaplan, in his 1983 article on that proposition, correct?

A George Kaplan is an acquaintance of mine, he's not a friend.

Q Okay. Now, did you review Dr. George Kaplan's

article of 1983 before you attributed that as a source for the statement there's a reasonable body of literature that suggests surgery after infancy is more painful?

A I would assume that I would have done so.

Q I have his article here, and I've gone through it fairly closely, and I find no reference to the increased incidence of or body of evidence -- literature which would suggest that surgery after infancy is more painful than in infancy.

A You want me to read the whole article right now?

Q Well, do you know whether that is even talked about in George Kaplan's article, Dr. Shoemaker?

A If I referenced it, I would assume that I referenced it correctly. I don't specifically find such a statement.

Q You did rely on Dr. George Kaplan's article, however, for the AAP statement, correct?

A Yes. And I think I can clarify the further statement. I think the --

Q It's referencing the risks; correct?

A It's -- it's referencing the surgical risks, yes.

Q Okay.

A That's correct.

Q And you say in your editorial comment, do you not, Dr. Shoemaker, that surgical risks of circumcision are

certainly real but extremely rare? Do you see that?

A Yes.

Q Let's assume you meant to cite George Kaplan's article for that proposition.

A Yes. That's -- I believe that's what my intent was.

Q You would agree, would you not, with Dr. Kaplan in his article when he says that there are definite indications for circumcisions, but none of these are present in the newborn, correct?

A That's correct.

Q And when he describes complications, Dr. Kaplan talks about complications, and he talks about a -- complications, the exact incidence is unknown. And then he cites a study about one series shows a 9.5 percent repeated circumcisions.

A If that's what it says, I will take your word for it. You're reading the article.

Q Is 9.5 percent a high? Is it extremely rare?

A It's very high, in my opinion.

Q Okay.

A In my experience, it's very high. Is that what

your question was? Or are you just saying, is 9.5 percent a high number?

Q Doctor, you referenced this article, the 199- --

1983 George Kaplan article as authority for your proposition that surgical risks are extremely rare.

A For neonatal circumcision.

Q Okay. Bleeding. Dr. Kaplan found reported incidence of bleeding anywhere from .1 percent to 35 percent. Is that extremely rare?

A Is it significant bleeding or is it just bleeding?

Q Is that extremely rare? He defines it as a complication, Doctor.

A Yes. So does the American Academy of Pediatrics defines bleeding as a complication.

Q Okay.

A Bleeding requiring anything other than brief pressure or -- is a complication, but it doesn't require further intervention. And in my experience, that number is probably fairly close.

Q And are you familiar with the risks involving removal of insufficient amount of tissue creating phimosis in the future?

A I am familiar with that as a complication.

Q And you would say that's extremely rare?
A In my experience, it is.
Q You would also agree, would you not, Dr. Shoemaker, that concealed penis, which is basically the opposite of removing too little, removing too much is a

complication, correct?
A Well, concealed penis can also occur from removing too little as well because the foreskin, particularly if the child has a large fat pad or something like that, but it is a complication, yes. It's also very rare.
Q Concealed penis, you say that that's very rare?
A In my experience.
Q All right. The next one he talks about is the skin bridge, skin bridge as a complication of circumcision. Do you agree with that, Dr. Kaplan -- Dr. Shoemaker?
A I do. I have seen one in my career.
Q Okay. Infections. Dr. Kaplan identifies infections occurring after circumcisions as -- identifies the rates to be .4 percent to as high as 10 percent.
A In various studies that -- those are fairly accurate.
Q That's not extremely rare, is it?

A The infections that can be taken care of --

Q Is it extremely rare?

A It is rare at the lower end of the range.

Q All right. Okay. But you still --

A Again, in 25 years, I have never seen a serious infection. That's my personal experience.

Q Okay. All right. But you still decide that you should tell parents about infections, correct?

A Absolutely.

Q Because there is this extremely rare chance that they might have an infection, correct?

A And it would cause prolonged hospitalization or necessity for further treatment.

Q But you wouldn't tell them about a skin bridge even though that's also extremely rare, correct?

A Generally not. I would generally include it personally under a broader category as sometimes there are adhesions or remnants of tissue that need to be looked at in the future. That's my personal approach to counseling.

Q Another one of the risks that Dr. Kaplan described in his 1983 article that you cited with approval in your commentary was urinary retention. Do you agree with that as a risk?

A I agree with that as a risk.
Q Do you -- yes or no. Do you?
A Can I clarify that? It was a much higher risk.
Q Ms. Voglewede will clarify it when she gets an opportunity, Doctor.
A It is a risk with certain types of circumcision, and almost a nonexistent risk with other types of circumcision.
Q You would agree, would you not, Dr. Shoemaker, that meatitis is a serious risk of circumcision, correct?

A It's not a serious risk, it's a risk.
Q Dr. Kaplan reports the incidence of meatitis to be between 8 and 31 percent. Would those be high percentages, Dr. Shoemaker?
A In my experience as a general pediatrician, they are extraordinarily high.
Q And you would not doubt Dr. Kaplan's expertise in this area, would you?
A He is a urologist. Difficult cases are referred to him because they are difficult cases that general pediatricians normally do not see. I would expect him to see a high incidence.

Q Precisely. And you rely on urologists to describe for you as a pediatrician what risks should be disclosed, correct?

A No. I rely on the American Academy of Pediatrics, the American Academy of Pediatrics task force, and review of the literature.

Q All right. And Kaplan is part of the literature, correct?

A Absolutely.

Q All right. And, in fact, the AAP 1999 statement cites the 1983 and 1995 Kaplan work with authority under risks, correct?

A Yes.

Q Another risk described by Dr. Kaplan in his book is chordee, correct?

A Dr. Kaplan describes --

Q Does he describe that?

A He describes the risk of chordee as a complication of circumcision. I don't agree with that.

Q He's the surgeon, is he not?

A Yes. And I'm the person who refers to the surgeon. Chordee is a congenital malformation of the ventral surface of the penis, which causes a stricture of

fibrous tissue. It is not a complication of circumcision. It might be an indication for not circumcising a child.

Q You would disagree with his statement then that this chordee usually is produced by a dense scar on the ventrum of the penis and a Z-plasty often suffices for its resolution? Do you disagree with that statement?

A I -- I -- it could occur. I have never seen it.

Q All right. How about inclusion cysts, Dr. Shoemaker? Would you agree that inclusion cysts are risks of circumcisions?

A Inclusion cysts are part of the natural progression of separation of the foreskin from the squamous epithelium of the glans penis and could be there whether the child was circumcised or not circumcised.

Q So you would disagree with Dr. Kaplan when he says

inclusion cysts and circumcision line have been reported. These presumably are produced by the rolling of the epidermis at the time of circumcision or perhaps --

A If you're talking about the epidermal border, yes, they would be created by the circumcision.

Q All right. How about lymphedema, penile lymphedema?

A I --
Q Would you agree that that is a risk?
A I know that Dr. Kaplan describes it. Again, I have never seen it.
Q Fistulas. Urethral cutaneous fistulas. Would you agree that that is a complication of circumcision?
A I have read about them, yes.
Q Dr. Kaplan cites five different articles on that issue. Are you aware of that?
A No.
Q And the fistulas are typically caused by crushing of the urethra by use of the clamp; is that correct?
A They think -- that's a speculation on your part. There's several different ways that fistulas could be caused.
Q Well, I'll just read what Dr. George Kaplan wrote in his 1983 article, Dr. Shoemaker. Presumably, these fistulas occur either because the urethra is actually pulled

into and crushed by the circumcision clamp or because the urethra is actually incised either with a knife or as a suture placed for hemostasis.
A Yes, that's much more accurate. That probably is the way they would occur.

Q Okay. Would you also agree, Dr. Shoemaker, that necrosis is a known risk of circumcision?

A It would be an expected risk with a Plastibell circumcision.

Q Would you agree that there have been reports where the entire glans penis has been necrosed following circumcision?

A There is one report to my knowledge.

Q Would you agree that hypospadias and epispadias are risks or complications of circumcision?

A Generally, they're identified by a circumcision, that the -- they would be in the same category as fistulas as you previously referred to, but hypospadias and epispadias are felt to be congenital abnormalities that already exist, and would be identified only by removal of the foreskin.

Q Dr. Kaplan describes the risks iatrogenic in nature, where he says both hypospadias and epispadias have inadvertently been produced during circumcision by splitting the glans penis at the time of dorsal or ventral split

preparatory to actual excision of the prepuce.

A That would be -- following along in your

descriptions of fistulas, it would be a continuum of that kind of an injury, yes.

Q But it is a risk?

A It could be a risk, yes. It is a risk.

Q He describes complications of Plastibell, correct?

A Correct.

Q You would agree that is a risk of circumcision, correct?

A A Plastibell is a risk of circumcision? Plastibell is a mechanism for doing a circumcision.

Q And that has its own risks associated with it separate and distinct from a Gomco clamp?

A Yes, that is my belief.

Q Dr. Kaplan also describes in his 1983 work impotence as a risk of circumcision. Would you agree with Dr. Kaplan that that is a risk?

A I have read literature as a member of the task force where it was described as a risk. As a pediatrician, it would be very hard for me to comment on that from personal experience.

Q Sure. But as a pediatrician, you described for the members of the jury this morning that you're looking at a lifetime of -- a child's lifetime, not just pediatrician,

when you're making this decision about circumcision, correct?

A That's correct. And that's why --

Q And if impotence is a potential risk, you would want to describe that, wouldn't you?

A It's very rare. I wouldn't describe it to parents.

Q Dr. Kaplan also identifies a risk, the psychosocial issue. Would you agree that's a risk?

A The way that it's described in that article, I believe, is that if a male comes who has no penile problems and expresses a wish to be circumcised, that one needs to consider the psychological state of that patient. Is that what you're referring to in that article?

Q Would you agree that the psychosocial issues are a risk of circumcision, Dr. Kaplan?

A Shoemaker. But, yeah, I would agree with that.

Q Okay. Then one of the last broad categories of risks are anesthetic complications?

A Yes.

Q And those carry with them risks all of their own, correct?

A They can.

Q And under infection, there are infections and then there are infections, correct?

A Well, there are minor infections and there are serious infections, yes.

Q Right. And the infections that Dr. Kaplan lists here include infections that have morbidity that causes major skin loss. Would you agree with that?

A That is a rare possibility, yes.

Q Necrotizing fascitis. Would you agree with that?

A That's very rare.

Q Staphylococcal scalded skin syndrome?

A Yes, that's very rare.

Q Fournier's gangrene?

A I'm not familiar with that term, but gangrene is a very, very rare complication.

Q Generalized sepsis?

A That's also very rare.

Q Meningitis?

A Extraordinarily rare.

Q And Dr. Kaplan goes on to say that some of these complications have resulted in severe, permanent disability or death?

A Yes, that's correct.

Q And death would be a complication?

A It is mentioned in the MeritCare pamphlet and in the AAP statement as a possible risk of circumcision, yes.

Q In the informed consent, Exhibit 31, which is

before you, Dr. Shoemaker, you would agree, would you not, with the statement, at least as it applies to medical doctors, contained on page 3 of 8, under the heading of "Problems With the Concept of 'Consent' By Proxy" -- by the way, the difference between proxy consent and informed consent is that true informed consent comes from the patient themselves, correct?

A That's correct.

Q And as it relates to an infant, a medical doctor must obtain proxy consent, correct?

A Which is considered to be informed consent in the best interests of the child.

Q Sure. Okay. And you would agree, would you not, with the statement that a provider of pediatric care has ethical duties to the child patients to render competent medical care based on what the patient needs, not what somebody else expresses. Would you agree with that statement?

A I would relate to that in emergency and in potential medical treatment as well.

Q Would you agree with that statement, that your duty is to the child patient, not to what the wishes are of the guardian?

MS. VOGLEWEDE: Objection, Your Honor, on the grounds of lack of relevance, and under Rule 403, as is --

it is an unnecessary waste of time.

THE COURT: Sustained.

Q (Mr. Baer continuing) You would agree, would you not, that any decision that you make for in your provision of information so that the parent can make a decision, you and the parent must be looking out for the best interests of the child?

MS. VOGLEWEDE: Same objection.

MR. BAER: Your Honor --

THE COURT: I ruled, Mr. Baer. We have been over this.

Q (Mr. Baer continuing) As a medical doctor, your duty runs to who?

MS. VOGLEWEDE: Same objection.

THE COURT: Sustained.

Q (Mr. Baer continuing) Going back to your editorial comment, Dr. Shoemaker, in your editorial comment, page 2, you describe that current scientific evidence cannot support a recommendation for routine neonatal circumcision of all normal male infants nor does it justify a total ban on the elective, prophylactic surgical procedure. Do you

see that?

A Yes, that's correct.

Q And this was written what? about a year and a half before the policy statement was issued?

A Yes.

Q And you also indicate there that the -- in cases where there are potential benefits and risks exist, it would seem prudent to offer all parents of male infants accurate and unbiased information about circumcision, correct?

A That's correct.

Q And you still believe that to be the case to -- the obligation of you is to provide accurate and unbiased information to the parent?

A Yes.

Q And you conclude that you have to provide accurate and unbiased information in order that they may decide what is in the best choice for the potential lifelong health of the child, correct?

A Their child.

Q Right. And in order to make a decision about the lifelong health of a child, wouldn't that parent want to know that death is a potential risk?

A They might.

Q Wouldn't they want to know that penile cancer is only something that afflicts elderly gentlemen?

A I would assume so.

Q Wouldn't they want to know that the risk is there of impotence?

A I know of no cases documented where neonatal

circumcision has resulted in impotence in an adult male. I personally don't. I'm not aware of any.

Q And you conclude in your editorial comment, Dr. Shoemaker, with a statement saying that by discussing realistic, unbiased information with new and prospective parents, we might actually provide the service we propose to achieve, the real informed decision about lifelong maintenance of good health. Did I read that correctly?

A Yes.

Q By saying that you might even achieve what you're attempting to -- or strive for, does that suggest that you have not met it?

A I think in some cases we have not met it as a medical society, yes. Certainly, that's been the case in the past.

Q In fact, weren't you interviewed by Mark Jenkins

for an article entitled "Separated At Birth" for Men's Health in July, August of 1998?

A Yes, I was.

Q And you were quoted in that article, correct?

A Yes. I don't remember the quotation. I'm sure you'll be glad to read it to me.

Q Let me show it to you. Page 2 of 12.

A Yes, I found it.

Q Did you say, "That's typical according to" -- or

put it into context. "'I never questioned it,' said Kyle Joseph, the father of a circumcised boy. 'The doctor took him away, performed the operation and brought him back. That's just the way it was done. I was circumcised; he was circumcised. I don't even remember signing a consent form.'

"That's typical, according to Craig Shoemaker, M.D., a North Dakota pediatrician and member of the American Academy of Pediatrics task force on circumcision. 'Many doctors do not adequately counsel parents regarding circumcision. What the risks are, what the potential benefits are, how much it costs. Performing a circumcision without such counseling is inappropriate. Some people would call it criminal assault.'"

Did I read that correctly?

A Yes. There's a doctor in Toronto that actually wrote an article that called it criminal assault. It's also exactly why MeritCare developed a pamphlet so that pediatricians had a consensus on what we would tell parents about the risks and potential medical benefits to avoid that.

Q Dr. Shoemaker, I understood you to say on examination from Ms. Voglewede this morning that you developed that brochure in 1996?

A That's correct.

Q So it wasn't because of this that you made that --

put together that brochure?

A This was a work in progress, Mr. Baer. I started researching this in about 1976.

Q Okay. And look to page 10 of 12 of that article, if you would. There's another quote from Dr. Shoemaker. The last paragraph. It says, "The AAP is expected to publish its new position on circumcision sometime this year. 'This is just my opinion,' says task force member Dr. Shoemaker, 'but I think the Academy is going to say there's not enough medical evidence to recommend routine circumcision but that there's also not enough evidence to

say that it shouldn't be done at all.' If this happen, the position paper will again be subject to interpretation and it will be of little guidance."

Did I read it correctly?

MS. VOGLEWEDE: Counsel added a section not part of the quotation.

A Yes, the last sentence is not mine.

Q (Mr. Baer continuing) Okay. I'm sorry.

A You want me to read what I said? I said, "But I think the Academy is going to say there's not enough medical evidence to recommend routine circumcision but there's also not enough evidence to say it shouldn't be done at all." End of quote.

Q I apologize. I didn't mean to read beyond your

quote. This article was published before you completed your final review of the 1999 statement, correct?

A That's correct. And since that article was embargoed until its publication, I would not be entitled to say what the consensus opinion of the members would be, only my personal opinion.

Q Now, Dr. Kaplan testified to this jury on Monday that he really didn't know what the function of a foreskin

was. You testified this morning that you also were not sure what the function of an foreskin was, correct?

A Not entirely, that's correct.

Q You know some of the functions, though, correct?

A You referred previously in your examination of me that there are immune functions related to Langerhans cells, Meissner's corpuscles. There is some innervation of foreskin, as there is in other skin coverings of the human body. There is certainly contradictory evidence about what the immune function of the foreskin might be.

Q Did I ask you in your deposition -- turn to page 74, Dr. Shoemaker.

A I was -- just to clarify, I was laughing because it's wet.

Q I was a little sneaky.

A Okay. I'm on page 74.

Q 74, line 21. Did I ask you a question: "The

foreskin is designed by nature to protect the penis, does it not?" "Answer: I am not God."

Was that your response?

A That's exactly my response.

Q Okay.

"Question: You don't know what it's designed to

do?

"Answer: 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 keratinized epithelium on it. What it was designed to do, I don't know. It is there."

A I believe that's what I just said a minute ago.

Q My question is: "On anatomically whole baby boys, it is there, right?"

A That is correct.

Q "Answer: That is correct."

Is that still your testimony?

A Yes.

Q Now, in your writings for the UpToDate journal, you did some writings for that journal, did you not?

A Yes.

Q And that was an on-line medical journal; is that correct?

A Yes, that's a web-based journal.

Q That's not peer reviewed, is it?

A No.

Q You just submitted an article on circumcision; is that correct?

A I submitted an expanded version of the pamphlet from MeritCare with more references, which although not peer reviewed, were reviewed by three different editors prior to publication, and is updated on a regular basis with my approval based on new literature that's available.

Q So it's not peer reviewed?

A No.

Q And in that article, you talk about sexual satisfaction, do you not?

A I believe I did, yes.

Q And in sexual satisfaction -- the topic of sexual satisfaction, Dr. Shoemaker, you say the prepuce contains specialized sensory mucosa that is removed during circumcision, correct?

A Yes.

Q And you cite for that proposition Taylor's article, correct?

A You know, I don't remember without having it in front of me, but I would -- if it's there, I probably do. Yes.

Q And John Taylor is a pathologist from Winnipeg,

Canada, correct?

A Yes.

Q And he was essentially the first person to have studied the foreskin in any anatomic detail. Would you agree with that?

A He's the first publications that I read.

Q Sure. And his publications -- or his publication was from approximately 1996, correct?

A I think he had some earlier publications as well.

Q Sure. And as a member of the committee, you even reviewed this article, didn't you?

A Yes.

Q And the article was "Specialized Mucosa of the Penis and Its Loss to Circumcision," correct?

A Yes.

Q And did you remember reading the conclusion that Taylor formed, that the amount of tissue lost estimated in the present study is more than most parents envisage from preoperative counseling. Circumcision also ablates junctional mucosa that appears to be an important component of the overall sensory mechanism of the human penis. Do you remember reading that?

A Yes. That was Dr. Taylor's opinion, yes.

Q And those opinions have been replicated, have they

not?

A Would you clarify that question, please.

Q His findings of his 1996 work were duplicated by an independent examiner, correct?

A You mean that when the foreskin is removed, what's in the foreskin is removed? Yes, that's been replicated.

Q No, that there's sensory mechanisms in the human penis --

A Yes, there are --

Q -- that is removed?

A -- there are -- in the foreskin that are removed. The sensory mechanisms in the glans penis remain.

Q And you would agree with the results of their research, indicating that 51 percent of the length of the mean adult penile shaft or more, that nearly half the penis is removed in a typical circumcision?

A I would not agree with that.

Q You're not an anatomist, are you?

A I was trained in anatomy.

Q Do you specialize in it?

A No.

Q Those are the results of Dr. Taylor, are they not?

A Yes. And it may be from his observations.

Q You just reject that?

A I have never seen 51 percent of the skin of a

penis removed in my entire career.

Q Okay. Dr. Taylor also identifies in his article that the prepuce provides a large and important platform for several nerves and nerve endings. The innvervation of the outer skin of the prepuce is impressive. Its sensitivity to light touch and pain are similar to that of the skin of the penis as a whole. The glans by contrast is insensitive to light touch, heat, cold, and, as far as the authors are aware, to pinprick. La Gros Clark noted that the glans penis is one of the few areas of the body that enjoys nothing beyond primitive sensory modalities.

Remember his findings on that?

A Yes. That is while the foreskin is intact.

Q And you would agree with that, correct?

A While the foreskin is intact.

Q He cites here to articles from as far back as 1989 and Winkelmann from the Mayo Clinic in 1957, correct?

A He does cite so.

Q I take it, you disagree with Dr. Taylor and his findings about the function of the foreskin, correct?

A In what way?

Q Or do you agree with it?

A You mean in what way?

Q That the foreskin is highly innervated.

25 A Yes. So are --

1 Q You agree with that?
2 A -- the fingers. Yes. And the tongue.
3 Q You would agree that the foreskin is -- has the
4 type of nerve cells like in the fingertips, very light
5 touch, sensitive nerve cells?
6 A Yes.
7 Q And you would agree that the foreskin is heat
8 sensitive?
9 A Yes.
10 Q That's because of the dartos muscle?
11 A It's because it's normal human epidermis.
12 Q Now, what you were saying is that you have never
13 heard of the 51 percent of the foreskin being removed,
14 correct?
15 A No, I didn't say I never heard of it. I said I
16 had never seen it.
17 Q You've never seen it. Do you see the drawing in
18 front of you that's been introduced as Exhibit 56, Dr.
19 Shoemaker?
20 A Yes, I do.
21 Q Do you see that?
22 A Mm-hmm.

Q Now, understanding this is not to scale, Dr. Shoemaker, but it's a schematic of the anatomy, correct?

A Correct.

Q And if you look at the schematic, the dotted line that is identified on here reaches from the -- what's known as the preputial orifice to the corona, correct?

A That's correct on the drawing that you have.

Q And that is what is removed, correct?

A Not necessarily.

Q It depends on the operator, correct?

A Absolutely. I don't teach to do it that way.

Q I believe the testimony will be that Dr. Kantak goes to the corona and cuts -- frees up the adhesions all the way to the corona.

A Most of us try to free up the adhesions to the base of the corona but not the -- don't remove that -- the degree of foreskin that you have written there. I do not know what Dr. Kantak does or did.

Q You've never seen her do one, correct?

A I have not.

Q Okay. And if you look at the glans penis in this whole photo, what you're removing is actually an inner layer

of skin that folds back on itself and comes back on the outer layer, correct?

A You're disrupting a layer of what's called squamous epithelium between those -- the prepuce and the glans.

Q So if allowed to develop naturally, you're taking

off inside skin, like the inside of the lip, and outside skin, which is epidermis?

A If it's allowed to develop naturally, it degenerates and leaves a space there. That's why the foreskin -- that's why the foreskin in an uncircumcised male becomes mobile later on in life.

Q Sure. There's no space there, really, it's free. But when it's retracted, there's no space there, is there?

A Well, there's a space there when the tissue goes away; otherwise, you couldn't retract the foreskin, just like you can't retract the foreskin of a normal newborn.

Q So the removal of this, the distance from the tip of the penis to the back, if you wanted to equate the length of skin that would be removed, it would double it, correct? Take that distance and double it, correct, because you have the inside and the outside, correct?

A On your premise, that would be correct, yes.

Q Well, let's talk about another premise without this -- without this drawing up here. If you have a routine infant male circumcision and you're only cutting off, say, one centimeter of the foreskin from the tip to the corona, you're actually cutting off two centimeters of mobile skin?

A I disagree with that. You're cutting off one centimeter.

Q But it has an inner layer and outer layer,

correct?

A It has a bottom squamous epithelium layer and a top epidermal area, yes.

Q And if allowed to grow to a functional age, you could double the length, correct?

A Possibly.

Q Now, what I understood you to say is that by removing that foreskin, there was no injury, correct?

A There was no injury to Josiah Flatt.

Q Okay. Was there injury to that foreskin?

A Any time --

Q Dr. Shoemaker --

A You want to let me finish my question before you ask another one?

Q Was there injury to the foreskin?

A There was injury -- there was no injury to Josiah Flatt. Whenever you make a surgical -- whenever you do a surgical procedure, there is tissue that is disrupted that needs to heal. That can be termed an injury. There was no permanent harm or injury done to Josiah Flatt based upon his circumcision. If I cut myself, that's an injury. It heals up.

Q Dr. Shoemaker, let me approach it from a different way. Anita and Jim Flatt named Josiah Flatt at 3:41 a.m. on March 6, 1997. Josiah Flatt on March 6, 1997 at 3:41 a.m.

had a foreskin. Would you agree with that?

A I would have to review the records, but I would assume that that's correct.

Q All right. And he continued to have his foreskin until sometime on March 7, 1997, correct?

A I believe it was the morning sometime, yes.

Q And then that foreskin was taken from him, would you agree?

A It was surgically removed.

Q Sure. And what you're saying is that that is not injury?

A I am saying exactly that.

Q Tell me, Dr. Shoemaker, would it be an injury if Dr. Kantak had removed the tip of a finger of Josiah Flatt?

A Inadvertently or on purpose?

Q On purpose. Would it have been an injury?

A It would have been a permanent injury that would have decreased the function of that finger, yes.

Q Okay. Similarly, if Dr. Kantak had removed an earlobe, there would have been an injury, permanent, correct?

A A cosmetic change in the appearance of the -- of anybody, yes.

Q Sure. And by removing the foreskin, that decreased the function of the penis as a whole penis, didn't it?

A Not necessarily.

Q Well, you no longer have the foreskin do you, Dr. Shoemaker?

A No. And you no longer have the risk of having it infected, getting a stricture or getting cancer of it either.

Q But isn't that the choice that the parent needs to make?

A Absolutely. She signed the consent.

Q Then, Dr. Kaplan -- or, Dr. Shoemaker -- maybe it's just because you're from California also and it's warm down there?

A I actually still feel like this is home when I came in the other day. It's funny.

Q In your UpToDate article, Dr. Shoemaker, you continue on, and you say that some authors feel that the end of the penis thus becomes less sensitive when the foreskin is removed and sexual sensation may be decreased.

A Yes.

Q You wrote that?

A I think there's a sentence following that as well.

Q Sure. However, most circumcised males do not describe psychological trauma.

A Yes. And there's -- there's more.

Q Or decreased sexual function or desire as a result of the procedure?

A Yes.

Q Now, I want to get into that a little bit, Dr. Kaplan. Bite my tongue. Dr. Shoemaker. Would you agree that it would be very difficult to find a group of adult males who were circumcised as infants describing

psychological effects resulting from the infant circumcision? Wouldn't you agree?

A No, I wouldn't. I have two documented letters from organizations in San Francisco from my trial on the task force of exactly that kind of documentation.

Q I understand. But the reliability of those --

A Was certainly in question.

Q -- in question?

A Yes.

Q I mean, people can say it, but the reliability is very difficult to prove from a medical standpoint, correct?

A Absolutely.

Q It's almost impossible from a medical standpoint, isn't it?

A Or a psychological standpoint, right.

Q And so you're dealing with an issue of the potential psychological harm, which you acknowledge could be there, correct?

A It could be there.

Q And there is absolutely no way we can get a scientific study of that because it is fraught with subjectivity, correct?

A We cannot tell from what a neonate knows to what he knows as an adult. We can, however, tell what an adult who is circumcised as an adult subsequently feels after a circumcision.

Q You're aware of the work of Dr. Cold, are you not?

A I am.

Q And he did some work on the prepuce, the embryology development and basically the -- following up on Dr. Taylor's study, correct?

A Yes, I read his article in some detail.

Q In what --

A In some detail.

Q Okay. And did you have any problem with his conclusions, Dr. Shoemaker?

A I didn't have any problems with his pathological conclusions. I had problems with his comments regarding what those might entail, in that, you know, it was prejudicial against circumcision rather than just being a descriptive pathological dissertation.

Q Well, let's just keep it on the pathological end then, Dr. Shoemaker. And would you agree that surgical

amputation of the prepuce removes many of the fine touch corpuscular receptors from the penis and clitoris? Would

you agree with that?

A We're not talking about clitori, to my knowledge. We're talking about penises.

Q Okay. Well, from the penis. Would you agree with that?

A It removes the foreskin in which those corpuscular bodies and nerve endings are present. There are still remaining nerve endings in the glans penis itself.

Q Sure. Would you also agree with Dr. Cold when he says that most of the penile dartos muscle is removed?

A From an anatomic standpoint, yes.

Q Would you also agree that the male prepuce contains the vast majority of the penile dartos muscle that cannot be regenerated after circumcision?

A Yes. But the dartos muscle is a muscle that allows the foreskin to slide. It's not an innervating tissue. I'm not sure what you're implying by that.

Q No. The innervation is on the dermis, correct?

A Yes, that's correct.

Q Would you agree, Dr. Shoemaker, that as a result of a circumcision, the child permanently loses his foreskin --

A Yes.

Q -- correct?

A Well, permanently -- permanently indicates, as you mentioned yourself, that there are very rare described cases where the foreskin does grow back. You mentioned -- yeah, you mentioned that a little while ago. Requiring further circumcision.

Q I mentioned that?

A I believe you did.

Q I have never read a study like that, Dr. Shoemaker.

A That's what I thought I heard you say a little while ago.

Q Would you also agree that circumcision removes the ridged band, as described by Dr. Taylor?

A If the amount of tissue that you proposed on your graphic before is removed, yes, it would.

Q Would you also agree that it removes all of the Meissner's corpuscles that are in that tissue?

A Of the tissue that is removed, it would, of course, remove the Meissner's corpuscles in that tissue. There may be remaining Meissner's corpuscles in the remaining tissue.

Q Sure. Would you agree that from time to time, depending on the circumciser, the frenulum is involved with remove- -- and is removed?

A The dorsal frenulum?

Q Yes.

A Yes. It's disrupted, certainly.

Q How about the ventral frenulum?

A The ventral frenulum is generally thought not to be disrupted because of the nerve vascular bundle in there. At least by myself.

Q Certainly. But that sometimes is involved in circumcision?

A It can be, and is one of the causes of bleeding.

Q And the circumcision also removes the dartos fascia, does it not?

A It if removes the muscle, the fascia lies on top of the muscle, it would have to remove the fascia as well.

Q And the fascia is the temperature sensitive part of that muscle that retracts when it's cold and relaxes when it's hot?

A No. It's actually a reactive tissue that reacts to the nervous stimulation. It's a fibrous covering of a muscle.

Q So you would disagree with Dr. Cold that says -- who says that the dartos muscle and the fascia are heat sensitive?

A No. They respond to nervous impulses they receive, but the muscle retracts and expands due to the

nervous impulses, not to the action of the muscle in and of itself. If you left the dartos muscle and denervated it, it wouldn't work.

Q Would you agree that it is heat and light -- or heat and cold sensitive?

A As long as the nervous system remains intact, yes.

Q Would you agree that removing the foreskin removes the immunological defense system of the soft mucosa?

A It may to some benefit.

Q Does it remove the immunologic defense system of the soft mucosa?

A No. It may -- it may -- actually, removing it may cause some benefit in that it attracts -- and this is where the conflicting evidence regarding the immunologic function of the foreskin arises -- is that it has been demonstrated in at least a couple of studies that those cells attract E.coli and bind them and may be one of the indications that urinary tract infection in uncircumcised little boys is higher. That's the speculation done by other authors, not by me.

Q I will ask you again, Dr. Shoemaker, does removal of the foreskin remove the immunological defense system of the soft mucosa?

MS. VOGLEWEDE: Objection, repetitious, asked and answered.

MR. BAER: He didn't answer it, Your Honor.

THE COURT: He answered in his own way. The objection is sustained. Let's move on.

Q (Mr. Baer continuing) Would you agree that removal of the foreskin removes several feet of blood vessels?

A To the characterization that they are microscopic and wind in and out of the tissue, they probably do remove several feet. With a centimeter of tissue, there's probably more than several feet of microscopic blood vessels in it.

Q And those microscopic blood vessels would develop and mature, correct, with age?

A As any other microscopic blood vessels in your epidermis would develop.

Q Sure. I mean, you have microscopic blood vessels in your finger, don't you?

A Yes.

Q In your eyelid?

A You have microscopic blood vessels throughout your body. That's why we grow.

Q So when you say that you would lose microscopic blood vessels, that's no judgment as to what the value is of those microscopic blood vessels, is it?

A No, it's a statement that they would be lost.

Q Correct. And it is still your position, Dr.

Shoemaker, that no injury results as a result of circumcision?

A No permanent injury results.

Q Is there a permanent scar, Dr. Shoemaker?

A Yes, there is.

Q And a permanent scar identifies the loss of some living tissue, correct?

A It identifies a site of previous injury that is healed.

Q Sure. Now, these are some cartoon drawings that were introduced, Exhibit 55. Have you seen these before, Dr. Shoemaker?

A I have not seen these specific drawings, no.

Q Can you recognize what is being depicted there, Dr. Shoemaker?

A It appears that there's --

Q Just do you recognize what it depicts?

A Yes, I do.

Q Okay. And on the bottom -- I'll give you a chance to look at -- I have an extra copy that you can refer to.

A I can see it okay.

Q Can you see it okay?

A Yeah.

Q It's kind of hard to read on that screen, but there you go. It's my understanding that in this instance

Dr. Kantak used a Gomco clamp to perform the circumcision of Josiah Flatt. Is that your understanding?

A Yes, it is.

Q And, by the way, you didn't teach Dr. Kantak how to do a procedure, did you?

A No.

Q She came to the facility already trained on how to perform circumcisions, correct?

A That's my impression.

Q And you have never observed her do a circumcision, correct?

A I don't remember doing so.

Q And you have never listened to her give her talk to expectant parents on circumcision, have you?

A I have not.

Q Now, Exhibit 55, on the top line, it's kind of a low-tech type of Gomco clamp with a Gomco bell that --

A I was going to comment on that.

Q Yes. It's perhaps the drawings from the patent application? This was patented in 1935, wasn't it?

A You know, I don't honestly know, but it looks -- it's a very archaic-looking device.

Q Right. And -- but the Gomco clamp has been around since 1935, essentially, hasn't it?

A Yes.

Q Hasn't changed at all in its -- basically its functional appearance?

A Well, it's changed in its appearance. It hasn't changed in its functional usage.

Q Thank you. And the way the Gomco clamp works is the principle of a simple lever and a screw, correct?

A Yes, to imbricate the tissue layers. That means pressed together.

Q And the Gomco bell is drawn up against a steel plate and then pressure is put on by the use of this screw?

A The principle of the lever, yes.

Q To lever it up like that? Basically to jack it up, correct?

A It pulls -- the current Gomco is actually a bell on a stem. And it pulls the bell up through the opening that you describe here, so the bottom of the bell, which is flanged out, meets the bottom of the circumcision device, and is tightened to make sure that the hemostasis and tissue imbrication is correct.

Q And I read somewhere that the amount of force that could be applied using the Gomco clamp with a screw mechanism and the lever is between 8,000 and 40,000 foot pounds. Do you remember reading that in your literature?

A No. It's an interesting analogy, but it -- but how much is applied is limited by when it hits the base of

the -- the flat portion of the device here, and the upward force is enough to push those layers together.

Q Dr. Shoemaker, wouldn't it be limited by the amount of force you push --

A On the lever.

Q -- on the screw?

A Right. Archimedes says, I can move the world if you gave me a lever long enough. Right.

Q If you tightened it real tight, there is going to be more force, correct?

A You can only tighten it so tight. I mean, you can only turn it to its limit. You can't increase the tightness past the point where the bell is pulled up proximate to the bottom portion of the piece. So, yes, you can tighten it to a certain degree and tighten no farther.

THE COURT: We have to take a break. Members of the jury, I want to advise you that we're changing the schedule slightly. We're going to reconvene at 1:00 o'clock today rather than at 1:30, and we're going to go to 5:00 o'clock rather than 4:30. So keep that in mind. So you're coming back into court at 1:00 and you'll be here until 5:00. Remember my admonition.

Jurors, you are excused. Court is in recess.

(Recessed at 12:00 p.m. until 12:59 p.m., the same day, at which time the following proceedings were continued

in open court, in the presence of the jury:)

THE COURT: Let the record show we are reconvened with all parties, counsel, jurors. Mr. Baer, you may continue.

MR. BAER: Thank you.

Q (Mr. Baer continuing) Dr. Shoemaker, when we broke for lunch, you were just describing the Gomco clamp and the lever mechanism that is used. And I think what you

were saying is that once you tighten it, you can't tighten any more, correct? Is that what you were saying?

A Yes. Once you tighten it to its limit, you can incur no further force.

Q Would that be like tightening a bolt? You can only tighten it so far, then you can't tighten any more?

A Correct.

Q Unless you strip it off, correct?

A Or you break it off, right.

Q You could actually do that with a Gomco clamp? You could draw the bell through the base, right?

A Not in a -- no, you couldn't do that. No. 1, you couldn't do it physically. It's a stainless steel piece of equipment. No. 2, the base of the -- on your drawing -- can I point to his drawing, Your Honor, so everybody can see?

Q You have it --

THE COURT: Do you want to -- would you like to

get down?

THE WITNESS: That's what I was asking.

THE COURT: Yes, go ahead.

THE WITNESS: So if you -- everybody can hear me, I assume, because I talk pretty loud. If you take this

part, it -- it stops on top of that plate when you screw it all the way down. So you can't screw that piece of stainless steel through the bottom plate. It only pulls it up to -- to do that.

So in order to pull the Gomco bell, unless it was inadequately made -- and that has been -- that has happened -- then it would be too small, this opening. The flange is bigger than the opening. So you could not pull that through this stainless steel plate and pull the bell through the top.

Q (Mr. Baer continuing) Would the actual Gomco be of assistance to you to describe that to the jury?

MS. VOGLEWEDE: Your Honor, I'm going to object to this line of questioning as not relevant to any of the issues in dispute in this case. And under Rule 403, it is a needless waste of time.

THE COURT: Sustained.

Q (Mr. Baer continuing) Doctor, when you're applying this force to -- I assume it is foreskin tissue, the stuff that is highly innervated, that is between the

base and that bell, correct?

MS. VOGLEWEDE: Same objection, Your Honor.

THE COURT: Sustained.

MR. BAER: Your Honor, it goes to the injury of pain.

THE COURT: We have been over this. I've ruled.

Q (Mr. Baer continuing) Dr. Shoemaker, do you have that booklet in front of you that you were describing this morning?

A The MeritCare booklet? This one?

Q Yes. I understood you to say in direct testimony that you're the one who basically set the ball in motion to develop that book? Is that what you testified?

A Yes, I think so.

Q My notes say that as chair, you brought forth the idea as an agenda item and then you started drafting it, correct?

A After I got consent from the department and, you know, approval it would be a good idea from the department.

Q That was the MeritCare Clinic, correct?

A At that time, yes.

Q And so it would have been -- you would have been the chair of that clinic department that decided you should be doing something more for circumcision, correct?

A Doing something more in -- regarding providing

parents information regarding circumcision.

Q Okay. And you recall when I took your deposition a year ago, Dr. Shoemaker? You recall that?

A I recall the deposition, yes.

Q Right. And I asked you about how the booklet came about, and you said you had minutes of meetings and stuff like that?

A Yes.

Q And you indicated at that time that whatever the history was would be in the minutes, correct?

MS. VOGLEWEDE: Objection, Your Honor, this was ruled on by the Court prior to trial and excluded.

MR. BAER: May we approach, Your Honor?

THE COURT: Yes.

(Discussion at the bench, out of the hearing of the jury and the court reporter.)

THE COURT: Jurors, I am going to excuse you at this time. Please go into your jury room with the bailiffs.

(Continued in open court, out of the presence of the jury:)

THE COURT: Please be seated.

The jury has been excused.

Mr. Baer.

MR. BAER: Thank you, Your Honor. I have begun an area of inquiry into the drafting of the brochure, which was

testified to on direct examination by Dr. Shoemaker. And I believe his testimony, at least according to my notes, indicated that he was the one who began the process in motion to draft the booklet, "Should Your Infant Child Be Circumcised?" that he was involved in the meetings with the department, that he reviewed it with his department, that they shared the brochure.

And then he indicated that the brochure was developed out of his personal interest, that it was discussed at the Department of Pediatrics, it was made an agenda item, the department decided to develop the information. Shoemaker wrote the initial draft, it was adjusted several times, and then it went to print in December, 1996. And his testimony was that it was implemented in December, 1996.

And I believe also his testimony on direct examination was that it was generally available in both the ICU -- or ICN, intensive care nursery, and on the general nursery room floor by March of 1997.

The Court made some pretrial rulings on the admissibility of exhibits. And I don't intend to offer these as exhibits, Your Honor. I believe the Court ruled that the minutes would be excluded as exhibits. That's -- the only thing that was requested by the defendant in their motion was to exclude the minutes. And in the Court -- the

Court's ruling basically excluded these documents as exhibits except for one where there was a discussion about lidocaine.

The purpose of inquiry into the development of this brochure is to impeach this witness. Much of their case, Your Honor, rests on the existence of that one brochure. The minutes of the meeting begin in April of 1996, and it's the MeritCare Hospital Department of Pediatrics.

This is in proffered Exhibit 20-A, where the minutes of the meeting indicate the need for circumcision policy statement was noted, action, the FBC, which is Family Birth Center, Joint Practice Council will be asked to develop a statement regarding the risks and benefits of circumcision. This statement will then be brought to the Department of Pediatrics for final discussion and approval.

And in the subsequent minutes, there does not appear to be any subsequent return of those proposed statement of risks and benefits to the Department of Pediatrics, MeritCare Hospital.

The next minutes that are disclosed were from 1997, where it indicates from November 19, 1997 -- and it just indicates circumcision task force met in New Orleans. There are no minutes indicating that this booklet came back

to the Department of Pediatrics, MeritCare Hospital for final approval.

The other minutes proffered, Exhibit 18, are the minutes of the Maternal Newborn Joint Practice Council, beginning December 5, 1996, indicating Shoemaker had been selected to participate in the national committee task force on circumcision. January 14, 1997, there's a discussion about American Academy of Family Practice revising the circumcision statement. But there's nothing in here suggesting that the directive from the MeritCare Hospital Department of Pediatrics was in fact carried out.

There are minutes as well from the Department of Pediatrics, the clinic. And there -- there are discussions about the development of the brochure. And those minutes do indicate that in November -- they say, Dr. Shoemaker has sent a letter in to be written in lay terms for patient use.

Then the December 18th minutes, under old business, it says, circumcision brochure is ready to go to print, 1,500 copies will be printed and distributed. It is -- it has been written in low reading level.

There is nothing to indicate in any of these that it ever was completed or a final review ever adopted by

these committee meetings. And since it is so critical that -- on the publication date and the availability date none of the nurses remember and were relying on just that one footer date on the back side of this publication without

anything else to be able to determine whether or not that was an accurate date.

So we would request leeway in examining this witness as to the development of the brochure and the lack of any minutes in the meetings suggesting that it was finally adopted.

Thank you.

THE COURT: Ms. Voglewede.

MS. VOGLEWEDE: Your Honor, this is an issue that was briefed by both parties, argued by both parties, decided by the Court on a pretrial basis. And the evidence was excluded. If Mr. Baer's argument is that he doesn't plan to introduce the minutes as exhibits but should be entitled to freely examine the witness about the contents of the minutes, the Court's ruling is meaningless.

The Court has excluded that evidence as cumulative because the -- we have the booklet itself. I don't know whether Mr. Baer is now claiming that MeritCare never has published such a booklet and never did implement it. We

have it here. I don't know of any evidence to dispute that. The Court ruled that it was cumulative because we have the booklet here and it has the publication date.

I think it's unfair to the defendants, unfair to the Court to take up additional time on the issue that has already been decided.

MR. BAER: Your Honor, I didn't open the door to this issue on whether or not that booklet was developed. It was the defense, out of turn, taking this witness and developing the time line for the development of this brochure.

THE COURT: The hospital meeting minutes have previously been considered as part of a pretrial motion. And the Court ruled that they would be excluded except for one portion which addressed buffered lidocaine.

The Court at this point in time sees no change and no reason to change that order. That order stands. If you want to ask Dr. Shoemaker about his recollections, you can. If there are objections to it being cumulative, I'll rule on the objections as it comes. But your request to question about the minutes or to have them used to question Dr. Shoemaker, that request is denied. And you've preserved

that for the record.

Anything else?

MR. BAER: One other issue. On the issue of injury, Judge, I am -- I am not sure how to proceed if I can't examine an expert witness about whether or not use of these instruments would cause pain or injury. It is my burden to prove pain, it is my burden to prove injury. That is an element of damages. And the Court has apparently limited my ability to ask this witness about whether or not

that the use of the Gomco clamp causes pain.

And I think it is very prejudicial to the plaintiff's case if I can't describe what caused the pain, Judge. I don't know how else to do it unless -- pain is one of the things I have to prove by the -- on the damages. And so I'm just -- I'm asking to have the Court at least look at that issue again and determine whether or not I can get into the issue of pain. Thank you.

THE COURT: Ms. Voglewede.

MS. VOGLEWEDE: Dr. Shoemaker answered a number of questions this morning on cross-examination from Mr. Baer about whether he believed there was an injury in this case. He has addressed that issue extensively. My objection was to going into the details of this procedure, the details of

the clamp.

The Court has already restricted that because it goes to some purported claim apparently that the procedure was done wrong, when that's not an issue in this case. If he wants to ask Dr. Shoemaker about whether a circumcision causes pain, he can do that. But he was going into the detailed descriptions of the equipment. And at this stage in the trial and given the Court's pretrial rulings, that again is a needless waste of time on collateral issues.

THE COURT: The objection was sustained previously. And I'm agreeing with defense counsel that to

put up the exhibit with the clamp and to go into detail with how it is used is cumulative. And it's outside of what we need to be doing here today. If you want to inquire of Dr. Shoemaker about circumcision and does it cause pain, you can certainly do that. Does that clarify it for you?

MR. BAER: I think so.

THE COURT: Okay. Anything else?

MR. BAER: No.

THE COURT: Okay. Could we have the jury back, please?

(Continued in open court, in the presence of the

jury:)

THE COURT: Please be seated.

Mr. Baer, please continue.

Q (Mr. Baer continuing) Dr. Shoemaker, you indicated that you were the one who developed this brochure, correct?

A Initiated it, yes.

Q You said it was from the clinic side, correct?

A Well, Mr. Baer, I was --

Q Didn't you say that?

A I said it was from the Department of Pediatrics.

Q All right. And there is a Department of Pediatrics from the hospital, correct?

A They're pretty much one in the same.

Q The three different minutes -- three different meetings are typically held, correct?

A At one time three different meetings were held.

Q And that was at the time when these policies were developed, correct?

A Yes. And I was chair of all three of those committees.

Q Sure. You knew what one was doing, they all knew what you were doing, correct?

A Pretty much, yes.

Q And I understood you to say that you developed this because you got into a case involving the Supreme Court of North Dakota?

A No, I didn't say that. I said it was a case in North Dakota. In my deposition, I may have said Supreme Court.

Q My notes here indicate that you wrote an affidavit for the Supreme Court in North Dakota.

A I did do that.

Q You did?

A Yes.

Q It was not for the Supreme Court, was it? Is this a copy of the affidavit? I'm sorry.

A I believe it to be so. Is it something different?

Q Doesn't it say the United States District Court

for the District of North Dakota, Southwestern Division?

A It does say that.

Q So that's what you're talking about?

A Yes, that's the affidavit.

Q It is not the Supreme Court, is it?

A Not to my knowledge. I thought the case was

brought to the Supreme Court.

Q Then in direct examination, Dr. Shoemaker, you responded to Ms. Voglewede about your background and your experience in doing circumcisions and obtaining informed consents. You indicated that you had done more than 1,000 and less than 2,000?

A I believe that's correct, yes.

Q And you still, as part of your job and teaching duties, do circumcisions on an annual basis regularly?

A That's correct.

Q A couple hundred a year?

A No, much less than that now.

Q Now, did you file an affidavit in this case in April of 2000, Mr. Shoemaker?

A I prefer doctor, but I don't --

Q Dr. Shoemaker.

A -- I don't remember filing a specific affidavit.

Q April 5, 2000. Is that your signature?

A It is.

Q And that was in the case of Josiah Flatt versus Sunita Kantak; is that correct?

A Yes.

Q And on No. 6, doesn't it say, I estimate that I

have performed more than 2,000 circumcisions in my practice?

A It does say that.

Q You did this as an affidavit, under oath, correct?

A Yeah. I did it as an estimate.

Q Sure. Now your estimate is somewhat different as you come into court today?

A I will gladly change my estimate to 2,000. I have been in practice for 25 years and often did three or four circumcisions a day. There's no way I can possibly estimate accurately how many I have done.

Q Well, you were willing to put it in an affidavit form and file it with the Court, correct?

A I estimated it based on my time as a general pediatrician, my time in the Air Force, my time as instructor, and an estimate of how many I would have done per day per week over 25 years.

Q But today you came into court and you said it's more than a thousand but less than 2,000, correct?

MS. VOGLEWEDE: Objection, repetitious.

THE COURT: Sustained.

A Yes, it could be --

THE COURT: I'm sorry.

THE WITNESS: I'm sorry.

THE COURT: When I sustain, that means you don't answer.

THE WITNESS: Right.

THE COURT: Go ahead, Mr. Baer.

Q (Mr. Baer continuing) You talked in direct examination, Dr. Shoemaker, about sucrose studies. Do you recall that?

A Yes.

Q And the sucrose studies just identified decreased crying, correct?

A Yes.

Q That was not anything to do with pain? What they just said is that it decreased crying in infants?

A I believe in Dr. Taddio's study she did some physiologic measurements as well in relation to heart rate and other things.

Q Now, Dr. Shoemaker, as a member of the AAP committee that discussed and reviewed the literature on the issue of circumcision, is it accurate that you were appointed to that committee in late 1996?

A To the best of my recollection.

Q As a member of the committee, you reviewed a number of articles, correct?

A Correct.

Q And the committee came up with a recommendation or an evaluation of the scientific basis for the literature, correct?

A Evidence-based, yeah, evaluation of the medical literature.

Q And there is no section in this statement that describes the function of the foreskin, is there?

A There is not.

Q So as a group of medical doctors, you reviewed all the medical literature and, yet, did not describe what it was and the function of what you were removing?

A We did not describe it in the paper. It was discussed and decided not to be included.

Q Sure. Because United States of America stands so far and above the rest of the world in circumcisions, correct?

A I wouldn't characterize it as that. I would characterize it as that was our evaluation of the literature and what needed to be in the statement.

Q And what was it about the state of the literature that suggested to you that there was no need for putting in the function of the foreskin?

A Embryologically, as I mentioned before, the description was written and left out. There was conflicting

data on what the function of the foreskin was, both immunologically and from a sensory standpoint, so it was felt not to be necessary to be put in the statement.

Q The American Cancer Society has written something on circumcision as a cure for cancer, haven't they?

A There have been several people who -- from the American Cancer Society who individually have written things. And there has been a statement by the American Cancer Society in the past that I'm not extraordinarily familiar with.

Q I will show you a February 16, 1996, letter from the national vice president of the American Cancer Society and vice president of the Epidemiology and Surveillance Research of the American Cancer Society. Doesn't the letter suggest that there is a distancing between the Cancer Society and those who would argue removal of the foreskin for treatment of cancer?

MS. VOGLEWEDE: May I see a copy, counsel?

A Yes. The statement says that portraying routine circumcision as the only means of preventing penile cancer is -- distracts the public, it says, from the task of avoiding the behaviors proven to contribute to penile and cervical cancer, particularly cigarette smoking, unprotected sexual relations with multiple partners.

Q Doesn't it also say that the research claiming a

relationship between circumcision and penile cancer is inconclusive?

A It does say that.

Q Doesn't it also say that penile cancer is an extremely rare condition, affecting one in 200,000 men in the United States?

A Yes. I believe I stated earlier in my testimony this morning it's an extremely rare condition.

Q Your AAP statement says one in 100,000, doesn't it?

A You know, I don't remember that exactly. There are different levels of what is described as -- from erythroplasia as a form of simple cancer to more complex cancers, so it certainly would be confusing in relationship to what was being described as cancer.

Q Doesn't it also indicate that the research suggesting a pattern in the circumcision status of partners of women with cervical cancer is methodologically flawed, outdated, and has not been taken seriously in the medical community for decades? Does it say that?

A It does say that, which has subsequently been proven to be incorrect.

Q According to you?
A According to the New England Journal of Medicine, sir.

Q Now, it's interesting that you bring up the New England Journal of Medicine, Dr. Shoemaker. There was a time when the New England Journal of Medicine was touting a whole host of cures or diseases that could be cured by removal of the foreskin, correct?
A The New England Journal of Medicine is one of the oldest medical journals in this country, if not the oldest medical journal in the country. And I would assume that at some time in its prolonged history, it has advocated or published articles that were 50, 60, 70 or 100 years later proven to be incorrect.
Q Did everything from gout, correct? Didn't they?
A I am not familiar with the very early articles in the New England Journal regarding circumcision.
Q But I mean, you researched the issue on what diseases were allegedly cured by circumcision, haven't you?
A I know of several that are -- have unscientific -- have been proven to be not true.
Q Clubfoot?
A I have not read about that one.

Q How about epilepsy?

A Epilepsy was at one time considered with masturbation to be able to be cured by circumcision.

Q And that proved to be untrue, correct?

A This was a textbook from 1876.

Q Isn't that when childbirth started to be taken over by medical doctors?

MS. VOGLEWEDE: Objection, lack of relevancy.

THE COURT: Sustained.

Q (Mr. Baer continuing) Now, in your 1999 statement, under complications of circumcision, Dr. Kaplan testified here on Monday that he basically wrote that, and it was a summary of his work from 1983 and 1995. Would you agree with that?

A We all wrote several sections. We were assigned to write sections for the document, and we brought them back together and ripped them apart.

Q So is that a yes, Dr. Kaplan did write this section?

A He wrote the initial draft of that section.

Q Right. And he indicated that it was a summary of his risks that he found and wrote about in '83 and '95,

correct?

MS. VOGLEWEDE: Object, lack of foundation.

THE COURT: Sustained.

Q (Mr. Baer continuing) Not only did your committee write -- write the statement on circumcision in 1999, but you got to respond to criticism of the statement in a public way with basically a reply, correct?

A The committee did so. That letter was written by

the chair of the committee and distributed to the other -- excuse me, the task force, was written by the chair of the task force and distributed to us for comment, and then published in Pediatrics.

Q All right. It has all your names on it, doesn't it?

A Yes.

Q And doesn't the response indicate that in the process of informed consent in all pediatric cases should include a complete explanation of the benefits and risks of any procedure? Do you want to read it?

A The benefits and risks of procedures should be explained as a matter of routine for any procedure.

Q Doesn't it say "complete"?

A It does say "complete," yes.

Q And that was the position of you as a committee? You signed the letter, correct?

A That was the consensus of the committee, yes.

Q Okay. Sure. Now, in your deposition, Dr. Shoemaker, I asked you some questions about obtaining informed consent. And the issue came up about how you make decisions on what to recommend or how you make those decisions. And I believe you testified that in order to do it, you have to look out for the interests of your patient.

MS. VOGLEWEDE: Your Honor, I'm going to object to

this as improper use of references to depositions for impeachment purposes.

MR. BAER: I will give him a cite, Judge.

THE COURT: Go ahead.

MR. BAER: Refer to page 43, 44.

THE COURT: Ms. Voglewede.

MS. VOGLEWEDE: He can use the deposition to impeach this witness's trial testimony. He is not using that process.

THE COURT: Sustained.

Q (Mr. Baer continuing) Dr. Shoemaker --

A Yes. I would -- and before I answer the further

question, I would like to say, you intimated that I would make a recommendation to parents. And I do not make recommendations to parents. I explain to them the risks and benefits.

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

A I would explain -- as the American Academy of Pediatrics statement says, from 1999, I would explain to them the potential medical benefits and risks, including bleeding and infection, some of which may be life threatening, and go over any questions the parents might have, and let them make the decision as the surrogate

decision-makers and the people responsible for that child's best interests.

Q Have you ever asked -- or have you ever been asked to pierce ears of infants?

MS. VOGLEWEDE: Objection, lack of relevance.

THE COURT: Sustained.

Q (Mr. Baer continuing) Now, Dr. Kaplan -- Dr. Shoemaker, the pamphlet that you have before you, the should my infant child be circumcised, I understood you to say in and of itself would not be sufficient to meet informed

consent, correct?

A Yes, that is my impression, and I think the impression of my colleagues as well.

Q Same way with the "Infant Care" book? That would not be sufficient to meet informed consent, would it?

A That is my opinion.

Q The two together would not meet informed consent, correct?

A That is also my opinion.

Q And you indicated on direct testimony that, in your opinion, the standard of care was met in this case, correct?

A I did so indicate.

Q And in order to do that, you have to make certain assumptions, do you not?

A I make conclusions based upon the medical record.

Q Do you have to make assumptions, Dr. Shoemaker?

A I have to make assumptions based on the medical record.

Q Well, okay. Let's go into those assumptions, Doctor. One of those assumptions, I take it, is that when Dr. Kantak signed off on the new baby admit exam, page 3 of

Exhibit 6, the key assumption is that she actually did what the note says, correct?

A That's correct.

Q Absent that assumption, the document in front of you in and of itself does not meet the standard, does it?

A As you pointed out to me, if it's not written, it's not done. If it is written, it is done. I assume -- my assumption is it was done, based on the medical record.

Q Okay. And page 3 of Exhibit 6 is the basis upon which you believe Dr. Kantak gave sufficient information for informed consent, correct?

A Yes.

Q I understood you earlier to say that you had never heard her talk, correct?

A No.

Q You had never sat in on when she was giving a talk, correct?

A Not to my recollection.

Q You had never talked to nurses about what her talk was like?

A Yes, I had.

Q Before this happened?

A No.

Q After?

A I might correct that. I had never asked nurses about what Dr. Kantak's impression -- or presentation was like. But it was a fairly well-known phenomenon that Dr. Kantak's presentation regarding risks and benefits of circumcision was quite detailed.

Q Did it --

A That's hearsay.

Q Right. You testified that the standard was met because you assume that Dr. Kantak carried out risks of local anesthesia and circumcision discussed, procedure described, parent expresses understanding?

A Yes, that's correct.

Q Now, not only do you have to assume that she carried out what it says in the record, Dr. Shoemaker, you also have to assume a whole host of discussion, correct?

A I have to assume that she followed the guidelines that we laid down in the Department of Pediatrics so we would be relatively consistent in counseling parents and on to which the Department of Pediatrics had agreed that we

would counsel parents.

Q And that's contained in this should your infant

child be circumcised?

A Some of it.

Q So what you're saying is that if she used this as a guideline, you're assuming that that would be sufficient?

A Absolutely not. I would -- I -- informed consent can be obtained without any literature at all, just by discussion. That was to give parents a basis for opening discussion if they had no knowledge at all. It was also written at a sixth grade level so we could get everybody to pretty much understand it.

Q Aren't you also assuming that it was given to Ms. Flatt?

A Yes. It was the policy of the Department of Pediatrics to give it to every mother or parent group in the normal newborn nursery and in the intensive care nursery.

Q What's the publication date on that brochure, Dr. Shoemaker?

A 12-96.

Q What's the revision date on it, Dr. Shoemaker?

A 1-97.

Q Okay. You don't know when it got into production or into distribution, do you, from your own knowledge?

A From my own knowledge, I was using it in December

of 1996 in the intensive care nursery.

Q In the ICN?

A And as department chair, I had mandated that it be distributed and was approved by the Department of Pediatrics from a personal call to the Department of Family Practice I made -- informed them that it was available and to be used for MeritCare patients in the Family Birth Center.

Q You don't know if it was distributed?

A I did not distribute it myself.

Q Right. Who printed it?

A I assume the MeritCare printing place.

Q Did you follow it through to make sure it was printed?

A No, I did not.

Q Don't you also have to assume, Dr. Shoemaker, that Anita Flatt is mistaken in what she recalls Sunita Kantak telling her?

A I have never spoken to Mrs. Flatt. I don't know what her impressions are. I have read her deposition.

Q Don't you have to assume that she is mistaken?

A She is mistaken or disremembering.

Q That's your assumption, correct?

A I would have to make that assumption.

Q Sure. And if that assumption is incorrect, your opinions may change, correct?

A As I said before, informed consent can be adequately obtained without any of this literature if it's discussed. And I have to assume that it was discussed because it's in the medical record as being discussed.

Q You read Ms. Flatt's deposition?

A Yes.

Q And what she said was discussed was a little brief discussion about lidocaine. If you assume that that is all the discussion that took place between Dr. Kantak and Anita Flatt, that would not meet the standard, would it?

A That calls for me to speculate on something I can't speculate on.

Q Oh, you can't speculate?

A I speculate that she remembers something that somebody might have told her, and she might have forgotten, and they might not have told her something. I mean, it's a circular argument.

Q Let me ask you, Dr. Shoemaker, isn't your assumption that Dr. Kantak carried out her speech speculation?

A It's documented in the medical record.

Q What risks are described in the medical records that were described?

A It says that the risks and benefits of circumcision and anesthesia were described.

Q What risks are described?

A I was not there. I do not know.

Q So you assume adequate risks were described, right?

A I make that assumption based on the decision of the Department of Pediatrics at that time what we were all going to discuss.

Q You speculate that's what happened, correct?

A I assume that.

Q Okay. And those risks would be bleeding and infection, correct? That's all you would do, correct?

A Those were the only ones that were specifically mentioned in the American Academy of Pediatrics 1999 statement. It was my impression from talking to the nurses that Dr. Kantak's normal description was more extensive than that. And my description is extraordinarily long.

Q Now, before testifying today, did you have an opportunity to review a videotape?

A I did.

MS. VOGLEWEDE: Your Honor, I will object to this as repetitious. It has already been shown to the jury.

THE COURT: Mr. Baer.

MR. BAER: Your Honor, I want to go to the -- just

the segment on the penis at the end. That's all I want to show. And describe what the foreskin would cover if it were

still there.

MS. VOGLEWEDE: Objection, repetitious. The witness has stated that he has seen the video. Mr. Baer can inquire about his opinions.

THE COURT: Sustained.

Q (Mr. Baer continuing) Now, I understood you to say, Dr. Shoemaker, on direct examination, that adhesions were indeed a complication of circumcision, correct?

A Yes, I did say that. They're generally minor.

Q Okay. And you said that they were fairly common, correct?

A Yes. Some people would not describe them as complications, they'd just describe them as the result of a normal circumcision.

Q Sure. And you also indicated that asymmetry was fairly common, correct?

A Very common.

Q And if asymmetry is very common in circumcisions, don't you have an obligation to tell the parent that is one of the risks?

A Asymmetry is very common in the uncircumcised

penis.

Q So when Dr. Welle diagnosed asymmetry, what did it mean, Dr. Shoemaker?

A I have no idea what it meant.

MS. VOGLEWEDE: Objection, lack of foundation.

THE COURT: Sustained.

Q (Mr. Baer continuing) Dr. Shoemaker, you did review the record, did you not?

A I did.

Q And you're not denying that one of your cohorts at that time in the medical community diagnosed asymmetry, are you?

A Are you referring to Dr. Sawchuk's notes or Dr. Welle's note or whom?

Q Dr. Welle first.

MS. VOGLEWEDE: Objection, lack of foundation. I don't believe Dr. Welle ever saw this patient.

Q (Mr. Baer continuing) I'm sorry, Dr. Mastel.

A I never saw a note by Dr. Welle -- Dr. Mastel -- Dr. Mastel's note, is that to which you're referring?

Q Did Dr. Mastel diagnosis asymmetric circumcision?

A Dr. Mastel I believe -- and I don't have the

medical record in front of me.

Q Yeah, you do, page 19.

A That's this --

Q Of the clinic records. You have to go to the back more, Doctor.

A You said 19, right?

Q Go to the back. It's the clinic records. You're

in the hospital records.

A Thank you. On a preprinted form signed by Dr. Mastel, it says, under genitalia, circ asymmetric.

Q Would that be a diagnosis?

A It would be an observation.

Q Okay. Not a diagnosis?

A Diagnosis, observation, it's --

Q Same thing?

A -- it's in the chart. Yes.

Q Okay. Dr. Mastel at least on May 7, 1997, observed asymmetry, correct?

A He so describes.

Q You have no reason to doubt his observations, do you?

A No.

Q Dr. Sawchuk then evaluates him on August 2 or

August 1. We don't know which one it was. Page 24, Doctor. Doesn't he find on physical examination adhesions, correct?

A He describes some asymmetry of the skin around the distal shaft, and a minor amount of redundant skin on the shaft, but not protruding over the penis.

Q Doesn't he --

A I'm still looking.

Q There were adhesions, more on the left side at the corona than on the right?

A Yes, that's the sentence prior to that. There were adhesions more on the left side at the corona than on the right resulting in some asymmetry of the skin around the distal shaft, right. That's a very common finding post circumcision in little boys.

Q Very common?

A Very common.

Q Why wouldn't you inform parents that that's a common risk associated with circumcision?

A I do inform them of that.

Q Why didn't Ms. Kantak -- or Dr. Kantak inform the parent?

A I do not know that she did not.

Q Okay.
A It used to be common practice to lyse those.
Q Dr. Sawchuk did lyse it?
A Mm-hmm.
Q Is that what you're talking about, the common practice?
A Yes.
Q And he indicated there was two choices for the parent, either lyse it in the office or wait later and do it under anesthesia. Did you see that?
A I am looking for the anesthesia. Yes. Or we could do an anesthetic later -- yes, an anesthetic later on

down the road once he gets older. Generally, those kinds of -- I did not see Josiah Flatt at this point. I don't know what the adhesions were like. But, generally, those will resolve as they are remnants of that epithelial layer that we talked about before or with the child's first significant erection will break off themselves.
Q Dr. Sawchuk was your colleague at that time, correct?
A That's correct.
Q And he diagnosed two alternatives, either lyse it in the clinic on August 1st or 2nd, or wait and do it under

anesthesia, correct?

A That was his opinion, yes.

Q At the time this occurred, Dr. Kantak was your colleague, correct?

A That's correct.

Q And you have visited with her about this case on about three occasions before you left the clinic, correct?

A Yes.

Q And you talked about the case?

A Not in great deal.

Q And you talked to nurses about the case?

A I don't remember talking to any nurses about this case other than people associated with MeritCare administration, who might be nursing personnel.

Q Now, this morning Ms. Voglewede asked you about Dr. Van Howe and his presentation to the committee?

A That's correct.

Q And you remembered that he made a presentation to the committee, correct?

A Yes. An extensive one.

Q Extensively researched?

A He had multiple references. I don't remember how

many. There was a lot.

Q Would you recognize a document? An objective assessment of neonatal circumcision?

A This looks like the title page. And it has the same format as the document that I still have in my files, so I would make the assumption that it's a similar copy, anyway.

Q All right. And you indicated that the committee did not adopt the recommendations made by Dr. Van Howe, correct?

A That's correct.

Q And his recommendations were that --

A There be a moratorium --

Q -- you put a moratorium--

A -- on circumcision.

Q -- on it, correct?

A Correct.

Q And didn't he ask the committee to -- until the full extent of the harm is known, prudence demands a moratorium on the surgery?

A He did ask that.

Q And what his point was is that until you know what it is you're cutting off, you should stop doing it?

A That was Dr. Van Howe's opinion.

Q Right. You would agree that the presentation contained a number of different citations which -- a number of which you perhaps used in the committee report, correct?

A We certainly reviewed some of them that he had used in his document preparation, yes.

Q How many did he have? About 334?

A I'm sure there was something like that. 333. Yeah, 334, that's what he lists.

Q Would you say it was a fairly exhaustive research of the literature as it relates to circumcision?

A If somewhat skewed, yes.

Q And his conclusion was that you should put a moratorium on it instead of continued cutting until you know what you're cutting?

A Yes. He also admitted there were potential medical benefits to circumcision.

Q Right. What he says is that -- if you remember the silicone breast implants, once harm was documented, the

manufacturer removed the product from the market until the harm could be adequately assessed. And he is referring to Taddio's study of the permanency of pain and the change of

pain response in infants, correct?

A In breast implants?

Q No. As a basis for terminating circumcisions.

A That was one of his arguments. His argument was also, when questioned directly, does circumcision prevent some urinary tract infections, his response was, yes, definitely.

Q I don't think anybody doubts that. But even you, as a committee, you, as an individual who was pro circumcision, would not be able to say that it is justifiable to do it just to treat a urinary tract infection, correct?

A You do not treat urinary tract infections by circumcision. You prophylax against getting them by doing the circumcision. And to answer your question directly, I would not counsel anyone that they should have a circumcision. It is not necessary to circumcise all male infants.

Q And the treatment regimen for urinary tract infection is antibiotics, correct?

A It depends on how severe it is. Or if there's any preexisting renal abnormality. In fact, one of the

indications where one might counsel parents to have their

child circumcised, if there was a preexisting renal abnormality, that an infection might cause permanent renal damage.

MR. BAER: Nothing further.

THE COURT: Ms. Voglewede.

REDIRECT EXAMINATION

BY MS. VOGLEWEDE:

Q Dr. Shoemaker, if you would turn to the clinic records for Josiah Flatt, close to the page that Mr. Baer referred you to for Dr. Mastel's visit, which is at page 19.

A Yes.

Q And if you would turn then to page 22.

A Yes.

Q Does that appear to be a four-month checkup visit with Dr. Mastel?

A It does.

Q And what does he note under genitalia?

A Normal.

Q If you would turn then to page 26, does that appear to be the six-month checkup visit with Dr. Mastel?

A It does.

Q And what does it say under genitalia?

A Normal.

Q And if you then turn to page 30, does that appear

to be the nine-month checkup of Josiah Flatt with Dr. Mastel?

A It does.

Q And what does it say under genitalia?

A Normal.

Q Dr. Shoemaker, do you believe that Josiah Flatt has an injury from his circumcision, either functionally or cosmetically?

A In no way do I believe that Josiah Flatt has an injury functionally, cosmetically or in any other fashion.

MS. VOGLEWEDE: That's all I have. Thank you.

THE COURT: Mr. Baer.

RECROSS-EXAMINATION

BY MR. BAER:

Q You do not believe it's an injury even though the foreskin has been permanently removed, correct?

A Correct.

MR. BAER: Nothing further.

THE COURT: Ms. Voglewede.

MS. VOGLEWEDE: Nothing further.

THE COURT: You may step down.

MR. BAER: We would continue with Sherry Stoa. I am assuming you're ready.

THE COURT: Yes. Yes.

MS. VOGLEWEDE: Your Honor, we tried to estimate

based on what Mr. Baer planned on his remaining exam. We do have Ms. Stoa on the way and she should be here shortly.

THE COURT: Mr. Baer, would you like to take a break at this point then?

MR. BAER: Yes.

THE COURT: Members of the jury, we're going to take a 15-minute recess so we'll be in recess until about 22 minutes after 2:00. Court is in recess.

(Recessed at 2:06 p.m.)

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