IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH, *et al.*	)	
	)	
Plaintiffs,	)	
	)	CIVIL ACTION
v.	)	
	)	CASE NO. 1:14-cv-0284
DAVID LAKEY, M.D., *et al.*	)	
	)	
Defendants.	)	

DECLARATION OF JAMES ANDERSON, M.D.

JAMES ANDERSON, M.D., declares under penalty of perjury that the following statements are true and correct:

1. For 22 years I have been an Emergency Room Physician in the Commonwealth of Virginia. I received my M.D. from the University of Virginia, School of Medicine in 1978. I have been board certified in Family Practice since 1981 and board certified in Emergency Medicine since 1996 by the American Association of Physician Specialists. I have been certified in Advanced Trauma Life Support since 1992 and in Advanced Cardiac Life Support since 1984.

2. I am a Clinical Professor in the Department of Family Medicine & Population Health at Virginia Commonwealth University School of Medicine, having served on the clinical faculty since 1995. In 2002, I joined the U.S. Army Reserves. In 2005, I resigned from U.S. emergency rooms due to the time demands of my military responsibilities and have served in the emergency departments of the U.S. Army's Combat Support Hospitals (CSH) while deployed to Iraq in 2007 and 2009. In 2011, I served in the out-patient department at Craig Hospital at

Bagram Airfield, Afghanistan and held the rank of Colonel, USAR. I was discharged from the USAR in September 2012, when I turned 60 years old.

3. Over the last three decades, I have treated many patients who arrived at U.S. emergency rooms and U.S. military hospitals extremely sick including critical situations of hemorrhage and infection. I have also treated patients who have experienced serious complications from an abortion and required emergency room management. For a complete listing of my professional activities, please see my attached Curriculum Vitae. (Exhibit A)

4. I provide the following facts and opinions as an expert in family medicine and emergency medicine. I am familiar with abortion complications and their treatment and experienced with emergency medical services and transfers of care. The opinions I express here are based upon my years of experience in the fields of family medicine and emergency medicine, my teaching and clinical experience, my treatment of abortion complications, and my familiarity with the medical literature.

5. I provide these opinions in opposition to Plaintiffs' Motion for a Preliminary Injunction against enforcement of Texas House Bill 2, referred to herein as "the Act." I understand, among other provisions, that "a physician performing or inducing an abortion must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced and provides obstetrical or gynecological health care services . . ." Additionally, I understand that effective September 1, 2014, the Act requires licensed TOP clinics in Texas to meet the equivalent minimum standards adopted under [Texas Health & Safety Code] Section 243.010 for ambulatory surgical centers." Act, § 4 (codified at Tex. Health & Safety Code Ann. § 245.010(a)); 25 Tex. Admin. Code § 139.40. It is my opinion that these requirements are

reasonable and medically necessary for the health and safety of Texas patients who obtain abortions.

6. In my expert opinion, the above provisions of the Act are reasonable and medically necessary to protect the health and safety of Texas patients. Furthermore, it is my opinion that these regulations will most likely improve the quality of abortion care offered in abortion clinics and enhance postoperative management of serious complications. As I understand it, the purpose of the Act is not to limit abortions but to help ensure a higher standard of care for those who have complications of abortion. If a physician who does an elective procedure is not available for follow-up care, then the follow-up care of complications have a higher risk of being inappropriately delayed by the patient's isolation because of the inability to communicate with her doctor. The complications of abortion also have a higher probability of getting worse because of no or little communication between the abortion provider, emergency room physician and called-in subspecialists, usually an Ob-Gyn. These preventable and avoidable time delays in the context of serious abortion-related complications can have life-impacting and life-threatening consequences.

7. It is my understanding that as of 2004 Texas required abortions at 16 weeks LMP or greater to be performed in ambulatory surgical centers ("ASCs") (*See:* Texas Health & Safety Code § 171.004). At the time, allegations of clinic closures that would stay closed were rampant. Today there are six ASCs in Texas performing abortions, and more scheduled to open.[1] In 2011,

[1] Planned Parenthood is planning on building a $5 million ambulatory surgical center in San Antonio this year. See: Grimes A. "Planned Parenthood Announces Plan to Build New Surgery Center in Texas." RH Reality Check, April 3, 2014, available at: http://rhrealitycheck.org/article/2014/04/03/planned-parenthood-announces-plan-build-new-surgery-center-texas/ ; and the Texas Women's Reproductive Health Initiative plans on building three new licensed and accredited ambulatory surgical centers in Houston, Dallas and San Antonio in 2014 as well. Available at: http://TWRHI.org.

23% of all in-state abortions for Texas residents were performed in ASCs.[2] When abortion is performed at these facilities, I understand Texas previously required either that the physician performing the procedure must have admitting privileges or have a working arrangement with a physician who has admitting privileges at a local hospital (*See:* 25 Texas Admin. Code § 139.56). The Act replaces this regulation by eliminating the less safe option of transfer of care to another physician with admitting privileges, and extends the admitting privileges requirement to all physicians performing abortions in Texas. Currently, some 13 states require abortion providers to have some affiliation with a local hospital, 4 states require providers to have admitting privileges, and 10 states require providers to have either admitting privileges or an alternative arrangement, such as an agreement with another physician who has admitting privileges. Twenty-four states require abortion facilities to meet standards intended for ambulatory surgical centers.[3]

Abortion Safety: Concern for Credibility

8. While the majority of first trimester abortion complications can be handled as outpatients, the Act helps ensure a better standard of care for those who have serious enough complications as to need hospital care. This group of patients is the sickest and needs specialized care that is timely in an atmosphere of good communication. This is precisely what the Act does address and will help ensure.

9. Plaintiffs and their experts, Drs. Fine (Decl. ¶ 10) and Raymond (Decl. ¶ 9), all attest to the safety of surgical and medical abortion. However, in my opinion this is premature,

[2] Table 33: Selected Characteristics of Induced Terminations of Pregnancy Texas Residence. Texas Department of State Health Services, available at: http://www.dshs.state.tx.us/chs/vstat/vs11/t33.shtm.

[3] Guttmacher Institute. "Targeted regulation of abortion providers." State Policies in Brief. April 1, 2014. Available at: http://www.guttmacher.org/statecenter/spibs/spib_TRAP.pdf.

lacks foundation in the medical literature, and is false and misleading. Plaintiffs' assertions assume abortion mortality and morbidity data are complete, available, comparable and credible. This is not the case. There is sufficient research now to question both the physical and mental health benefits and safety of this procedure.[4] Because serious complications and death from abortion are seriously underreported, it is not reasonable to conclude, as Plaintiffs argue, that the health risks of abortion are miniscule, both compared to childbirth and other medical procedures, and accordingly, that there is no necessity of having abortion providers obtain staff and admitting privileges. These assertions are based upon faulty and incomplete data compilations and estimates, not actual or complete data. There is no mandatory federal reporting system of the incidence of U.S. abortions. Only 27 states require reporting (to varying degrees) of abortion complications.[5] While Texas does require the filing of abortion complications since 2012, statewide data only captures complications known to the physician reporter, including abortion providers. Furthermore, this aggregated data is not published and accessible to the public.

10. To indicate the incompleteness and inaccuracies of abortion related complications, I need only to attest to my experience as an Emergency Room physician for over twenty-five years. Never once did I report a complication of abortion to the State of Virginia even though in my career I have taken care of many patients who have suffered an abortion related complication. The State of Virginia neither requires the reporting of these complications nor do I know of any process in place where I could do it voluntarily other than to register a complaint about a violation of the standard of care.

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[4] Thorp, J. (2012). Public health impact of legal termination of pregnancy in the US: 40 years later. **Scientifica,** Article ID: 980812, 16pp. Available at: http://dx.doi.org/10.6064/2012/980812

[5] Guttmacher Institute. "Abortion reporting requirements." *State Policies in Brief*, April 1, 2014. Available at: http://www.guttmacher.org/statecenter/spibs/spib_ARR.pdf.

11. My experience is not an exception. My Emergency Room colleagues and other physicians I have spoken with have similar experiences. As an example, Chippenham Hospital in Richmond, Virginia, had over 92,000 Emergency Room visits in 2012. Chippenham Hospital's ER is the second busiest ER in the State of Virginia. I inquired of my former ER director, who has worked full-time in this ER since 1981, "how many abortion-related complications had he ever reported?" In thirty-two years he said he has never reported one such patient to the State of Virginia even though he also has taken care of many such patients. I asked another full-time ER physician the same question. He had practiced in Pennsylvania until moving to Virginia in 2006. He too had not reported a single patient who suffered an abortion-related complication to Pennsylvania or Virginia health departments, even though he had taken care of many such patients as well. Plaintiffs and their experts all allege the safety of abortion, yet they make no mention of incomplete data and the non-reporting of abortion complications that is prevalent. In my opinion, this is misleading and inaccurate.

12. The issue of incompleteness in abortion data has long been of concern, including the underreporting of incidence, morbidity and mortality.[6] In the National Abortion Federation's textbook for abortion practitioners, Guttmacher Institute's researcher, Dr. Stanley Henshaw, acknowledges: "The abortion reporting systems of some countries and states in the United States

[6] One study conducted at 3 Planned Parenthood clinics Massachusetts by Planned Parenthood researchers reported an overall complication rate of 4.0% among women who were followed-up post-procedure. This research made extra efforts to follow-up abortion patients: "Still, the loss to follow-up of one third of the study population may have resulted in underestimation of complication rates." (p. 411). Paul, M. et al. "Early surgical abortion: Efficacy and safety." *Obstetrics*, 2002, 187:407-411. Evidence of gross underreporting is acknowledged by Guttmacher Institute researchers as well in federal surveys where fewer than one half of estimated abortion were reported. "Inconsistencies in abortion reporting confirm that sensitive behaviors are often not reported, that the likelihood that they will be reported may vary considerably according to respondents' characteristics, and that researchers should exercise caution when using these data." (p. 195). Jones, R. & Kost, K. "Abortion in the United States. An analysis of the 2002 National Survey of Family Growth." *Studies in Family Planning*, 2007, 38:187-197. Other researchers report similar conclusions. Smith, L., Adler, N. & Tschann, J. "Underreporting sensitive behaviors: The case of young women's willingness to report abortion. *Health Psychology*, 1999, 18: 37-43.

include entries about complications, but these systems are generally considered to underreport infections and other problems that appear sometime after the procedure was performed. In the United States only about one-third of abortion patients return for follow-up care, so delayed complications are not always known to the abortion provider."[7] Another reason for underreporting is that patients having abortion complications present to emergency rooms and are understandably reticent to acknowledge having had an abortion. I have had many patients request that I conceal the fact that they had an abortion as part of their medical history, both recent and even abortions from years prior.

Advantages of the Hospital Staff Privileges Law

13. The Act is beneficial for two main reasons. First, the training and subsequent credentialing of doctors has been a time-proven method to ensure that those doing life-impacting surgical procedures are qualified to do so. Secondly, continuity of care and inter-physician communication have long been recognized as important components of good health care delivery. Continuity of care should involve direct communication between the abortion provider and the emergency room physician; this is standard medical practice and will ensure that the emergency room physician is aware of the extent of the complication, prior treatment and medication received. This is one of the very reasons that this Act is so important. Since admitting privileges have not been required, it is not unusual for abortion providers to simply refer their patients with serious complications to the ED, and then terminate the physician-patient relationship and any attendant responsibilities of care management. *See:* Fine Decl. ¶ 17. This facilitates providers who travel in and then leave after performing abortions. However, this is not

[7] Henshaw SK, "Unintended pregnancy and abortion: A public health perspective." In Paul M, et al. (Eds.). *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*. New York, NY: Churchill Livingstone, 1999, p. 20.

consistent with the continuity of care standard. To remove or undermine continuity of care, communication and timely medical interventions would be to undermine sound medical practice and the care patients might reasonably expect to receive by a competent physician.

14. When serious complications do arise from abortion, Dr. Fine suggests the patient just needs to arrive at a hospital and the emergency room physician will take care of her (Decl. ¶ 23). This is patient abandonment and illustrates the need for improving this substandard and non-patient-centered system of care. Responsible transfer of care requires effective communication and accountability. The Act helps safeguard these transfer-of-care situations by improving relationship accountability and communication between the referring abortion provider and the ER physician. Without hospital staff privileges, this area of peer-to-peer relationship and communication is diminished and presumption becomes the norm. It seems very inappropriate for a physician to do an elective procedure, receive cash payments and then just expect the emergency physician and hospital staff physicians to manage the post-abortion complications. The consultation and transfer process are often very necessary and appropriate but work best in the context of the peer-to-peer relationship that hospital privileging helps promote. Without implementation of the Act, the status quo is maintained and legalized abandonment is the standard, which is clearly not the optimum standard of care patients need and deserve.

15. When a woman with abortion complications presents at the emergency room, there are times when a more highly trained specialist is needed. Holding active hospital admitting privileges can actually improve this consultation process because the abortion provider is more likely to know who to consult and has the potential to assist the consultant in many different ways. This consultative process is commonplace within the medical community.

Physicians consult other physicians every day in patient care when they are out of the realm of their training or need advice. The more experience and familiarity a physician has with a consultant, the better the communication and subsequent outcome by minimizing communication errors and time delays.

16. A time delay of 1 hour can mean the difference between life and death when dealing with a serious post-abortion complication of hemorrhage or infection. Holding local hospital admitting privileges is likely to minimize communication errors and time delays. If physicians live long distances from their outpatient abortion facilities, the communication errors and time delays are much more likely to happen. This is not the standard of care that is in the patient's best interest.

17. Having hospital admitting privileges protects patients. Requiring physicians who perform abortions in Texas to have active admitting privileges is consistent with the time-honored practice of requiring training and credentialing of physicians who are making decisions and doing procedures that have life-impacting consequences. If a physician cannot obtain admitting privileges for the specific requested procedures at his or her local hospital, then in my medical opinion, the physician is not qualified to do the surgical procedures that have life-changing or life-threatening impact. Dr. Kermit Gosnell and Dr. Steven Brigham are two notorious examples of providers who did not hold hospital privileges and have injured many of their abortion patients. When investigated, the underreporting of abortion-related complications is also very evident in their clinical practices.

Hospital Staff Privileges: Maintaining Excellence in Patient Care

18. Obtaining admitting and staff hospital privileges is a careful and considered process. The most prominent entity overseeing these steps is the Joint Commission (TJC)

through its hospital accreditation process which is very thorough, precise and demanding. Its review process includes examining requirements for credentialing and continuing education of hospital staff, all under the umbrella of patient care and advocacy. In 2008 TJC added two significant standards into their hospital accreditation guidelines for physician competency-based privileging: the Ongoing Professional Practice Evaluation (OPPE) and the Focused Professional Practice Evaluation (FPPE). These required hospital accreditation criteria mandate focused and careful determination and review of physician competency.[8] Maximizing patient safety and health is the number one responsibility of the healthcare system. Requiring abortion providers to undergo peer review through the local hospital's credentialing process is a standard which is reasonable and appropriate given the gravity and uniqueness of the nature of abortion, and the potentially life-threatening complications that can result for the woman.

19. In my experience, hospital credentialing is generally a more rigorous screening and evaluation of a physician than obtaining state medical licensure. Both state licensing and hospital staff credentialing require proof of education, letters of recommendation, records of continuing medical education and questions about prior malpractice or disciplinary action from prior regulating agencies. Generally however, only hospital staff credentialing requires reporting the number of past procedures performed to verify the experience and training necessary for these specific procedures. Only by reviewing and evaluating this information is the hospital able to verify that the physician has sufficient training and experience to perform the requested procedures. Hospital staff privileges are dependent on this review; so is quality patient care. Since most, if not all hospitals require credential and licensing review every two years, this too helps maintain a quality medical staff and quality patient care. Renewing the medical license in

[8] Hunt JL. "Assessing physician competency: An update on The Joint Commission requirement for ongoing and focused professional practice evaluation." *Advanced Anatomy & Pathology*, 2012, 19:388-400.

most states, if not all, is only a matter of paying the set fee required by the particular state. In summary, the hospital credentialing process is protective of patient care but not restrictive or onerous for the physician.

20. While some hospitals may require a certain number of admissions per year in order for a physician to obtain admitting privileges, most have different categories of admitting privileges, i.e., courtesy and temporary, to accommodate those physicians who have infrequent admissions. For example, in the two local hospitals where I have had staff privileges since 1979, courtesy staff privileges meet the credentialing requirement of medical staff privileges but do not require a minimum number of admissions, nor the participation in staff-related administrative responsibilities.[9] It has been my experience that hospitals do try and accommodate physician staff privilege requests once the physician has demonstrated training/experience and clinical competency. In special circumstances hospitals have different medical staff classifications that allow for patient care without certain other staff requirements, i.e., committee assignments, minimum number of admissions, residence, or taking un-referred call.

21. Another significant reason supporting the need for the Act, paradoxically, concerns the quality of abortion providers. Because of the potential for significant financial gain in the context of a limited number of physicians willing to provide abortions, the potential for conflict of interests is very real. These conflicts warrant careful state scrutiny and regulation. In my opinion, hospital credentialing acts as another layer of protection for patient safety. The best scrutiny is the quality control process of assessing physician credentials, training, and competencies which is inherent in the hospital privileging process. With little to no

[9] A courtesy staff appointment generally refers to a physician who meets the qualifications for appointment to the medical staff but who admits patients to the hospital only occasionally or acts only as a consultant. Such a physician is typically ineligible to vote or otherwise participate in medical staff activities.

accountability, the best process for determining abortion physician quality and competency remains that of requiring active admitting privileges at a local hospital nearby where the procedure is performed. The limited number of abortion providers in no way justifies a system that allows for poor or substandard care to patients.

22. If a physician performing surgical procedures is providing care and is subsequently paid for it, it also makes sense that he or she should assume responsibility for the management of any complications. To allow the physician to do an elective procedure, as in the case of abortion, and then not to expect the physician to be involved in the management of complications, in my opinion, encourages patient abandonment. This is not the standard of care nor does it conform to patient expectations or desires.

The Act Conforms to Foundational Medical Principles

23. Requiring hospital admitting privileges of physicians who perform abortions is much more than a mere regulation. This Act supports medical principles that are related to better healthcare outcomes for patients who undergo an elective abortion because these principles are foundational and critical to all good healthcare delivery. They are: doctor-patient trust, communication, and continuity of care. These foundational principles undergird quality patient care and are presumed to exist throughout the healthcare system. Not only are these principles tied to better patient outcomes but, in my opinion, they are also what every patient would choose to have. I believe all patients should have the benefit of these foundational principles in their healthcare, particularly patients facing an undesired pregnancy.

24. These foundational principles are considered very important to the American Committee of Graduate Medical Education (ACGME) and to the Residency Review Committees (RRC) that oversee all graduate medical education, i.e., the residencies that train the future

physicians in different subspecialties. The ACGME and RRC's have developed a list of core-competencies that every Residency program across America must implement and measure in the training of each physician. These core competencies are professionalism, patient-care, interpersonal and professional communication skills, medical knowledge, practiced-based learning and system-based practices. These core competencies are considered to be essential to good healthcare delivery and good patient outcomes. In my opinion, the Act is consistent with the core competency priorities and focus of the ACGME and RRC's. Within these core competencies the development of doctor-patient trust, communication and continuity of care are taught, emphasized and regularly evaluated throughout the residency training. Each training physician is expected to become proficient with these aspects of the core competencies.

25. The training that emphasizes the importance of the doctor-patient relationship occurs throughout the residency training of physicians. This is so fundamental to a good healthcare system and good patient outcomes that this emphasis actually begins in the very first year of medical school. For over a decade, I have been involved in teaching a first-year course at the Virginia Commonwealth University Medical School entitled "Foundations of Clinical Medicine" (FCM). We spend the whole year on the doctor-patient relationship, effective communication, patient value and dignity, and medical thinking and processing. Lectures during the first year include titles such as "Students will describe professional, personal, and patient-focused benefits of an effective Dr/Pt relationship" and "Creating a Beneficial Doctor-Patient Relationship ("They're REALLY smart, but I don't think they're a very good doctor")."

26. At the very center of good healthcare delivery is the relationship between the doctor and the patient that involves trust. Trust is an investment into someone's character, their knowledge base and their technical skills. With trust there is always a vulnerability, sometimes

tremendous, which can be the doorway into healing, as in life-threatening elective heart surgery, or tremendous exploitation, as in charlatan medical practices. In a good healthcare system, the dynamic of trust is essential to guide and direct patient care for the good and benefit of the patient. Every patient desires and is entitled to trust in his/her doctor-patient relationship. This dynamic of 'trust' has been shown to be a "crucial element in the therapeutic alliance between patient and health care provider. It correlates directly with adherence to physician recommendations and patient satisfaction."[10]

27. The relationship of trust between physician and patient has long been recognized as critical to good care. It is basic in medical education that clinicians must build and sustain trustworthy relationships in order to hear and grasp patient concerns, elicit their requests, negotiate diagnostic and treatment strategies, teach them about their health or illness, check on adherence to treatment plans, and assess the outcomes of interventions. In my opinion, in the absence of the Act, if the state does not require a good credentialing process and follow-up responsibility, then the state is de-emphasizing and diminishing the fundamental value of the relationship between the abortion providing physician and the patient.

28. When focusing on the particular patient group involved here, it is reasonable to assume that many and perhaps most of these pregnant women are especially vulnerable given their circumstances. Many women with an undesired pregnancy may perceive their situation to be desperate and feel they are without the financial means to choose between alternate options. Many may feel pressured or coerced to abort or feel overwhelmed by fear and anxiety over the

[10] Petersen, L.A. "Racial differences in trust: Reaping what we have sown? *Medical Care,* 2002; 40:81; Thom, D.H. & Campbell, B. "Patient-physician trust: an exploratory study." *Journal of Family Practice,* 1997; 44:169.

future.[11] They often must trust a physician they do not know and hope that their trust is well-placed. It is in the best interests of these patients in particular to have a competent and peer-reviewed healthcare provider whose patient care is held accountable through hospital credentialing and privileging.

29. Physicians are generally held to a high standard of competency in almost every area of medicine through licensure, hospital credentialing and regulatory oversight which protects and strengthens the public's trust in the healthcare system and patient safety. Presently this high standard of competency is not consistently provided to this very vulnerable patient group, i.e., women with an undesired pregnancy. Because of the high standard of care mandated in other areas of elective surgical procedures, this foundational 'trust' in the healthcare system is more likely to make the pregnant women seeking an abortion more vulnerable to exploitation if they wrongly assume abortion-providing physicians are held to the same standards as other physicians. Specifically, patients seeking abortion may assume that: (a) their abortion provider's credentials have been thoroughly evaluated; (b) their abortion provider will be available if a complication develops; and (c) there will be good communication between physicians in the event of medical complications. Texas patients are likely to believe that these assumptions are part of elective abortion services because they are the norm in other areas in their state's healthcare system.

30. Texas has supported an education and proficiency standard-of-care expectation of physicians that has sustained a strong patient-doctor trust relationship. This correlates with good patient satisfaction and better patient outcomes in almost every area of medicine except in the

[11] Hall, M., Chappell, LC, Parnell, BL, Seed, PT & Bewley, S. Associations between intimate partner violence and termination of pregnancy: A systematic review and meta-analysis. *PLOS Medicine* Jan. 2014, 11(1): e1001581. Available at: http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001581.

care of women terminating their pregnancy. If the state continues to allow physicians performing abortions to avoid hospital credentialing and privileging and not be available for follow-up after elective surgical complications and not be required to communicate with other physicians in the transfer of care, then, in my opinion, the state is allowing this very vulnerable group of pregnant women to be exploited. Pregnant women will assume that the same standards of care will exist in elective abortions as in other outpatient surgical procedures. In this case, more likely than not, their trust is misplaced.

31. Communication skills and focus, another core competency, are intentionally taught in the medical education of a physician and are a foundational component that cannot be left to happenstance and vagueness. Poor and inconsistent communication is associated with medical errors and less than satisfactory outcomes. Evidence clearly links clinician-patient communication to patient satisfaction, adherence, and better health outcomes.[12] In the absence of communication and information flow, miscommunication occurs. Lack of communication can create situations where medical errors are more likely to occur which have the potential to cause severe injury or unexpected patient death. Medical errors, especially those caused by a failure to communicate, are a pervasive problem and an increasing concern today in healthcare organizations. According to The Joint Commission (TJC), if medical errors appeared on the National Center for Health Statistic's list of the top 10 causes of death in the United States, they would rank number 5, ahead of accidents, diabetes, and Alzheimer's disease, as well as AIDS, breast cancer, and gunshot wounds. More specifically, the TJC cites communication failures as the leading root cause for medication errors, delays in treatment, and wrong-site surgeries, as

[12] Eisenberg, J.M. "Sociologic influences on decision-making by clinicians." *Annals of Internal Medicine*, 1979; 90:957; Stewart, M., Brown, J.B., Boon, H., et al. "Evidence on patient-doctor communication." *Cancer Prevention & Control*, 1999; 3:25.

well as the second most frequently cited root cause for operative and postoperative events and fatal falls.[13] This Act helps ensure the availability of the physician who performs the abortion to admit and treat his/her patient in a medical emergency, not an ER physician unknown to the patient. If emergency room consultation is necessary elsewhere, the abortion provider has a duty to convey critical patient history, medication, and surgical information to the accepting physician.

32. Others corroborate the critical nature of physician communication. According to Moorman: "Analysis of sentinel events reported to the JCAHO [now TJC] over the last decade reveals failure of communication as the most frequent problem, cited in most of the events."[14] The Institute for Healthcare Communication asserts very clearly that good communication is critical to patient safety: "An estimated one-third of adverse events are attributed to human error and system errors. Research conducted during the 10 year period of 1995-2005 has demonstrated that ineffective team communication is the root cause for nearly 66 percent of all medical errors during that period. This means that when health care team members do not communicate effectively, patient care often suffers."[15] Hospital admitting privileges will help improve the communication between physicians in the case of post-abortion complications and help reduce poor outcomes attributable to communication errors.

33. When an abortion provider is absent in the management of his/her patient's serious complications and simply relies upon the ER physician to manage the patient's crisis, this

[13] O'Daniel, M. & Rosenstein, A.H. "Professional communication and team collaboration," Ch. 33, in Hughes, R.G. (Ed.) *Patient Safety and Quality*. Rockville, MD: Agency for Healthcare Research and Quality, 2008.

[14] Moorman, D.W. "Communication, teams and medical mistakes." *Annals of Surgery*, 2007, 245, 173-175.

[15] Institute for Healthcare Communication. Impact of Communication in Healthcare. 2011. Available at: http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/.

is substandard care and is the opposite of effective communication and quality patient care. According to Cohn good physician consultation is critical: "Effective communication is the foundation underlying the art of medical consultation; the manner in which the question or information is phrased can influence the consultant's response. The 'routine' consult request, for example, will generate a different response than the request for specific advice on the management of preoperative congestive heart failure. . . Given the high frequency of misunderstanding between consultants and referring physicians, direct communication is important and likely will prevent misinterpretation."[16] Hospital admitting privileges help maintain a higher standard of accountability in the consultation process that improves communication between physicians and consultants and thus improves patient outcomes.

34. Continuity of care pertains to physician availability, reliability and perseverance rather than abandonment. Continuity of care involves knowing particulars about patients that influence future medical decisions, such as allergies, past medical-surgical procedures and chronic disease states and the responsibility to convey this important information accurately and sufficiently for others to continue care. The Act ensures greater accountability for the physician performing the abortion to be involved in post-abortion complications rather than being unavailable after the procedure which is the case when abortion providers come in from out of town and leave the same day of the abortion. The unavailability of abortion physicians not only makes continuity of care nearly impossible, it also undermines trust rather than builds it, and is inconsistent with the assumptions and expectations of vulnerable patients undergoing this elective procedure.

[16] Cohn, S.L. & Macpherson, D.S. "Overview of the principles of medical consultation and perioperative medicine. *UpToDate*. June 28, 2013.

35. The conveyance of patient medical information about patients treated in different medical facilities handicaps patient care and increases the risk of adverse outcomes. According to Bourgeois and Olson:

> "Healthcare providers require timely access to patients' health information to deliver effective and safe medical treatment. However, they frequently do not have access to complete medical information, particularly for patients who have been treated at other health care facilities. Therefore, providers often rely on fragmented and incomplete medical information to make complex management decisions. Treating patients without complete information poses an important challenge to patient safety, increasing the likelihood of medical errors, adverse events, duplication of laboratory tests and procedures, and increased health care costs."[17]

Hospital admitting privileges create better connectedness between outpatient offices and hospitals. This connectedness helps build better information sharing (such as compatible electronic medical record systems) and in turn improves the transfer of medical information and its completeness.

36. Future physicians are taught that every patient is entitled to the inherent respect and dignity that the ACGME and RRC's core competencies help ensure. These core competencies are not considered an option. They must be mastered before the training physician can advance into the completion of his or her residency. Trust, communication, and continuity of care are foundational constants that a good health care system is built upon and this Act helps ensure.

[17] Bourgeois, F.C., Olson, K.L. & Mandl, K.D. "Patients treated at multiple acute health care facilities: Quantifying information fragmentation." *JAMA Internal Medicine*, 2010, 170: 1989-1995.

37. It is inconsistent with good medical care to allow a certain group of physicians, i.e., abortion providers, to simply rely on other physicians to manage the complications associated with their surgical procedures without any sense of responsibility or continuity. If informed beforehand, the unavailability of the surgeon after completion of the procedure is clearly a standard of care that almost every patient would universally reject when choosing a physician and a treatment plan that required a surgical intervention, including an abortion. This Act is consistent with the foundational principals of continuity of care, communication and doctor-patient trust that are inherent in any good treatment plan, including abortion procedures. The Act helps ensure the high quality of care experienced in other areas of medical care that all patients are entitled too. The unavailability of abortion providers after hours is an unacceptable standard of care and only tolerated in the practice of abortion. The Act improves the standard of care for patients who experience complications of an abortion procedure by enhancing physician availability, which enhances communication, continuity of care and supports the doctor-patient relationship.

38. In the ambulatory care center that I utilize for my referrals, admitting privileges to the local hospitals nearby is a mandatory requirement for job employment for the physicians. Patient abandonment because of physician unavailability is not considered an acceptable standard of care. Physicians who do procedures need to be available if complications arise to help orchestrate the patient care and/or the consultative process that would be most beneficial for the patient and their family. Even the gastroenterologists, who I use in my referrals, who do routine outpatient colonoscopies require their physician staff to have hospital privileges in case a complication from that procedure should arise. Again, physician availability is a major

component in the medical realm of communication, doctor-patient trust and continuity of care and the management of complications.

Continuity of Care in Practice

39. There are three major components of continuity of care: *informational continuity*, i.e., formally recorded information is complemented by tacit knowledge of patient preferences, values, and context that is usually held in the memory of clinicians with whom the patient has an established relationship; *management continuity*, i.e., shared management plans or care protocols, and explicit responsibility for follow-up and coordination, provide a sense of predictability and security in future care for both patients and providers; and *relationship continuity*, i.e., built on accumulated knowledge of patient preferences and circumstances that is rarely recorded in formal records and interpersonal trust based on experience of past care and positive expectations of future competence and care.[18] While the current focus on increasing access makes it more difficult for patients to see the same doctor, the relationship between doctor and patient is central to good care. Neither information nor management continuity directly substitutes for relationship continuity.[19] There is good evidence to support the assertion that patients are more satisfied when they see the same doctor.[20]

40. Another major benefit of requiring abortion providers to have local hospital admitting privileges is this maintains continuity of care that ensures better care and minimizes time delays for treatment of critical conditions. Every patient desires and expects to receive care

[18] Guthrie, B., Saultz, JW, Freeman, GK. Continuity of care matters. *British Medical Journal* 6 Sept. 2008, 337:548-549. Available at: http://www.commed.vcu.edu/IntroPH/Primary_Care/2008/Continuity.pdf.

[19] Ibid.

[20] Ibid., citing Saultz, JW, Albedaiwi, W. Interpersonal continuity of care and patient satisfaction: A critical review. *Annals of Family Medicine* 2004; 2:445-451.

from a physician that they know and trust. This explains why a patient will delay care as long as possible rather than deal with a new physician with whom they have not established a relationship of trust. Likewise, this explains why patients drive distances to be treated by a physician who is known to them and trusted, or whose reputation and qualifications for quality care are well known and respected.

41. Physician-to-physician communication is a very important part of staff privileges. There is a different level of communication between physicians who are on staff together and know each other compared to the communication between physicians who do not know each other and are in different geographic locations. When not on staff together, there will not be the same level of communication and relationship between the physicians such that transfer of care is more likely to be encumbered by time delays, poor communication and inaccurate details.[21] Optimal care implies effective communication within any physician team taking care of the patient. There is not a patient in our nation that wants physicians to be non-communicative with their other physicians about their care, especially when dealing with life-threatening issues.

42. Dr. Fine minimizes continuity of care and indicates a simple telephone call is sufficient (Decl. ¶ 17). I disagree. When my patients require hospitalization and the care of a specialist, this does not mean I am not involved. I am very much involved with communicating with the consultant and discussing treatment options. My involvement is very necessary for timely implementation of treatment as well as communicating the specific areas of my concern. Likewise, an abortion provider has an equivalent responsibility in the management of his/her

[21] The Emergency Department is a prime environment for miscommunication or insufficient communication. See generally: Kessler CS, et al. "A prospective, randomized, controlled study demonstrating a novel, effective model of transfer of care between physicians: The 5 Cs of Consultation." *Academic Emergency Medicine*, 2012, 19:969-974; Talbot R & Bleetman A. "Retention of information by emergency department staff at ambulance handover: Do standard approaches work?" *Emergency Medicine Journal*, 2007, 24:539-542.

patients' complications. Time delays and miscommunication work against continuity of care. The overall management and responsibility of the patient rests squarely on the shoulders of the abortion provider. To support or continue a system where this is not the case only promotes a greater likelihood of fragmented and poor care.

43. As stated earlier, I have worked in local Emergency Rooms across Virginia for over twenty-five years. Plaintiffs argue that there already are emergency protocols in place and good continuity of care for patients with post-abortion complications without the need to establish this requirement of admitting privileges. When a post-abortion patient arrives at the hospital for treatment of complications and was not transported by ambulance from the abortion facility, it is unlikely that her medical records are available to the emergency room physician. After-hours communications and long-distance providers make conveyance of this information even less likely, much less promptly. What should happen and what does happen are very often two different worlds. "Communication" is mentioned only once by Plaintiffs' experts, Dr. Fine (Decl. ¶ 17) and Dr. Raymond (Decl. ¶ 40), with the latter quoting the National Abortion Federation: "it encourages member clinics to 'consider developing a transfer agreement with a hospital outlining the means of communication and transport and the protocol for emergent transfer of care.'" While communication is a critical component of healthcare, it remains a major contributing factor in medical errors. According to The Joint Commission, Hospital Emergency Departments are the source of just over one-half of all reported sentinel event cases of patient death or permanent injury due to delays in treatment with breakdown in communication being cited in 84% of cases, most often with or between physicians (67 percent).[22] These delays and

[22] The Joint Commission. "Delays in Treatment." *Sentinel Event Alert*, June 17, 2002. Available at: http://www.jointcommission.org/assets/1/18/SEA_26.pdf.

lack of communication are likely to only be exacerbated by physician unavailability, particularly so when a provider is not local and flies in to perform abortions and then flies out afterwards.

Management of Serious Abortion Complications

44. When patients came to the ER with complications related to an abortion, never once did I receive a phone call initiated by the provider conveying information about the abortion, the young woman's condition or potential complications. I have also inquired of my ER physician colleagues as to how many times they were ever called by the physician who performed the abortion when they are taking care of an abortion-related complication. With over 60 years of combined service in the ER, the answer was unequivocal: "not once."

45. Since I have never received a phone call from the physician who did the abortion, when taking care of patients suffering from a complication of abortion, I have always had to begin the evaluation without the benefit of the information from the abortion provider, then come to my own conclusions and initiate what I thought was appropriate treatment. This definitely created some time delays that were not in the patient's best interest. I have called many abortion clinic physicians but never once did the provider come to the Emergency Room to assume care. I have always had to call a staff Ob-Gyn. This then creates another time-delay since the staff physician is taking care of his/her own patients but now must change his/her schedule to assume the care of someone else's patient. These delays can have life-threatening implications when dealing with hemorrhage or infection.[23]

[23] A tragic example is that of 24 year old Tonya Reaves. Planned Parenthood of Illinois settled a wrongful death suit brought against it by the family of Ms. Reaves . Ms. Reaves had an abortion at 16 weeks at PPI's Chicago Loop office, began hemorrhaging, yet EMTs were not called for over 5 hours. At the hospital she subsequently had another dilation and evacuation procedure and died from uncontrollable hemorrhaging 12 hours after her abortion. See: *CBS News*. Documents shed light on woman's death after abortion. July 24, 2012. Available at: http://chicago.cbslocal.com/2012/07/24/documents-shed-light-on-womans-death-after-abortion/ ; and http://chicago.cbslocal.com/2012/08/27/mother-of-woman-who-died-after-abortion-sues-planned-parenthood-hospital/.

46. Even if serious complications are not the routine experience following abortion, this does not justify allowing a lower standard of care for patients receiving abortions. Requiring admitting privileges will improve physician review and accountability as well as improve continuity of care that will minimize time-delays when dealing with infection or hemorrhaging.

47. Post-abortion complications can be serious and life-threatening. The two most common of the serious and life threatening complications of an abortion are infection and profuse post-abortion bleeding. Time delays, as little as one hour (as explained later in this declaration), with these two conditions can mean the difference between life and death. Good communication and relationship between physicians is critical with either of these conditions. It is this very relationship realm between physicians that this law addresses and helps remediate. When abortion providers have no relationship with local hospital physicians, it is inevitable that poor communication and inaccurate information will impact patient care. Ensuring communication between physicians and healthcare facilities has been a major focus in the last decade as a way to reduce patient errors and improve patient outcome. The Act is consistent with this focus.

48. Post-abortion infection can be the result of bacterial spread from retained fetal parts, uterine perforation, colon perforation or poor uterine contraction and persistent bleeding post-abortion. As in many areas of emergency care, time has been proven to be of critical importance. The amounts of bacteria that invade the blood stream or contaminate normally sterile compartments make the time until initiation of antibiotic treatment the top priority. Uterine perforation or colon perforation can cause an infection which grows and spreads very quickly because so many bacteria are introduced into the abdominal cavity and blood stream. Sepsis is a clinical syndrome that complicates severe infection. It is theorized that the infection

sets in motion a massive inflammatory response, "an uncontrolled release of pro-inflammatory mediators that initiate a chain of events that lead to widespread tissue injury. This response can lead to multiple organ dysfunction syndrome (MODS) which is the cause of the high mortality associated with sepsis."[24] The mortality rate associated with sepsis ranges from 20-50%.[25] The medical literature affirms the importance of early treatment: "early institution of adequate antibiotic therapy was associated with a 50% reduction in the mortality rate."[26] The medical literature emphasizes the necessity of early intervention in sepsis: "poor outcomes are associated with delays in initiating antimicrobial therapy, even short delays (e.g., one hour)."[27] A retrospective analysis of 2,731 patients with septic shock demonstrates that the time to initiation of appropriate antimicrobial therapy was the strongest predictor of mortality.[28] With this clear emphasis on early treatment to reduce the morbidity and mortality associated with sepsis and severe infection, it is in the woman's best interest to reduce delays in treatment so that medical intervention is not postponed. If the abortion provider has local hospital admitting privileges, this will reduce potential delays in the initiation of treatment for infection or hemorrhage. As affirmed by the medical literature, as well as my own clinical experience, even short time delays can have life-threatening implications.

49. Post-abortion bleeding, another complication of abortion, can be life-threatening and is hard to recognize in its early stage. Prolonged bleeding can result in the under-perfusion of

[24] Neviere, R. "Sepsis and the systemic inflammatory response syndrome: Definitions, epidemiology, and prognosis" *UpToDate,* 11/14/2013, p. 1.

[25] Neviere, R. ibid, p. 4.

[26] Neviere, R., ibid. p. 5.

[27] Schmidt, G. "Management of severe sepsis and septic shock in adults." *UptoDate*, 2014, p. 7.

[28] Schmidt, G., ibid, p. 8.

vital organs, including brain, heart and kidneys, which can have implications up to, and including death. It is very difficult for a woman to be able to distinguish between "normal and acceptable" post-abortion bleeding and dangerous bleeding. Symptoms of early volume loss are minimal because people have such good compensatory circulatory mechanisms to shunt blood from non-essential organs to essential core organs. If bleeding is heavy, a patient can deteriorate in over one hour's time from a fragile but recoverable situation to one of grave or irreversible prognosis. Not all post-abortion bleeding is visible (intra-abdominal bleeding from a uterine vein tear or a colon puncture involving an artery or vein), but even in the cases in which it is visible (vaginal bleeding from poor uterine contractions, retained fetal parts or infection), a woman cannot accurately recognize what a dangerous amount of bleeding is in order to respond appropriately. Even experienced emergency medical technicians and surgeons often have difficulty accurately predicting the amount of blood loss when viewing the scene or situation. The availability of her operating physician is of utmost importance in the management of her complication(s). The actual degree of blood loss can only be determined by the patient's symptoms, vital signs, organ function and lab values. If a woman knows her physician does not practice at a local hospital, then she is faced at that moment with having to change physicians and possibly have to wait in a crowded Emergency Room to see a doctor she has never met. Both are a hurdle that most patients try to avoid. If the abortion provider met her at the ER, then a quicker evaluation and lab monitoring is possible and therefore an earlier intervention takes place. If she knows her physician does not practice at the hospital, she will likely put off going to the hospital as long as possible.

50. From both my medical experience and my continuing review of the medical literature, early intervention is paramount in order to reduce morbidity and mortality from

massive blood loss.[29] Initiating treatment as fast as possible is of top priority. A drop in blood pressure and increased heart rate are the most common signs of hypo-perfusion but critical hypo-perfusion can also occur in the absence of hypotension as the compensatory circulatory mechanisms try to prevent collapse. The medical literature strongly emphasizes the need for early intervention: "Initial management of the patient with hemorrhagic shock is focused on restoring intravascular volume, maintaining adequate oxygen delivery, and limiting ongoing blood loss."[30] Additionally, rapid volume repletion is indicated in patients with severe hypovolemia or hypovolemic shock. "Delayed therapy can lead to ischemic injury and eventually to irreversible shock and multi-organ system failure."[31] Early correction of this volume deficit is essential in hypovolemic shock to prevent the decline in tissue perfusion from becoming irreversible.[32]

Ensuring High Standards for Patient Safety

51. Recent media attention has focused on examples of egregious and substandard abortion care by both abortion providers and clinics. Of course these cases do not suggest that all abortion providers are deficient and/or dangerous. They do, however, identify problems that improved state surveillance and regulation would help remedy. Some abortion providers and clinics may do quality control on their own. However, others have not been held to the quality standards of hospitals and their medical staffs. One way to eliminate this identified deficiency in oversight is to mandate hospital credentialing and privileging for abortion practitioners.

52. A tragic example of the need for hospital credentialing and admitting privileges is that of Dr. Nicola Riley. She remains licensed to practice medicine in Utah, but not in Wyoming

[29] Schmidt, G., ibid, p. 10.
[30] Colwell, C. "Initial Evaluation and Management of Shock in Adult Trauma." *UptoDate*, 1/29/2014, pp. 1-2.
[31] Mandel & Pavlesky. "Treatment of Severe Hypovolemia or Hypovolemic Shock in Adults." *UptoDate*, 2013, p. 1.
[32] Mandel, J., ibid, p. 1.

(she voluntarily surrendered her license because of threatened board revocation) and Maryland (her license was permanently revoked). Along with Dr. Steven Brigham mentioned earlier in this declaration, she would transit in from Utah, perform late-term abortions in Elkton, Maryland, and then return to Utah where she also practices and resides. Though licensed in Maryland at the time, she held no admitting privileges there. While being supervised by Dr. Brigham, Dr. Riley performed a late-term abortion on an 18 year old woman and ruptured her uterus and perforated her bowel. Dr. Riley's license to practice medicine in Maryland was irretrievably revoked for failing to have an emergency plan for complications at the Elkton abortion clinic, failing to call for emergency help for at least an hour and a half after perforating her patient's bowel during the procedure, and for transporting her critically injured patient to a nearby hospital in the back seat of a car, thereby compromising the life and safety of her patient. The Board found Dr. Riley's decision and complication management was "not only flawed, life-threatening and unprofessional, but showed poor clinical judgment" (p. 11). The Maryland State Board of Physician's expert, Dr. Coles, testified that Dr. Riley's patient could have suffered internal hemorrhage and bled into the abdominal cavity with her going into shock or cardiac arrest at any time after her critical injuries were sustained prior to her arriving at the ER. Furthermore, Dr. Coles testified and the Board agreed that Dr. Riley's decision was faulty and unprofessional because it involved lifting up a consciously sedated and slumped-over patient in order to move her from the operating table to a wheelchair, from a wheelchair to the car, and from the car onto another wheelchair before arrival at the Union Hospital ER. The patient's bowel, usually in a sterile compartment in the abdominal cavity, was protruding into her unsterile vagina. Dr. Coles opined that lifting her up, putting her in a seated position and moving her around in this manner risked further prolapse of bowel into that area and causing injury to a

longer length of bowel. The patient should have been transported lying down on a stretcher in an ambulance to ensure CPR could have been performed if needed, and allow smooth entry into the ER. And finally, a one hour and forty-five minute delay in transporting a patient after discovering a serious complication was also cited as a breach of professional standards.[33]

53. It is my opinion that the higher scrutiny that hospital credentialing and privileging processes provides would far better protect abortion patients if they experience complications rather than unknowingly relying upon physicians whose abortion practice may be substandard and negligent and who have no hospital privileges.

54. Dr. Riley is not alone. Other abortion providers have been investigated, shut down, and sometimes convicted for providing substandard care to their patients. The most comprehensive and detailed listing of these providers I have found is a 2013 report compiled by the Susan B. Anthony List, a pro-life organization.[34] I have expanded that list and it is attached as **Exhibit B**. I have also searched pro-choice websites and was only able to find one other website that mentioned "substandard providers." That site was the National Abortion Federation which identified just two providers: Dr. Hermit Gosnell and Dr. Steven Brigham.[35]

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[33] Final Decision and Order of the Maryland State Board of Physicians in the matter of Nicola I. Riley, M.D. Available at: http://www.mbp.state.md.us/BPQAPP/orders/D7121305.063.pdf

[34] Susan B. Anthony List. *Fact Sheet: Abortion Industry Negligence Nationwide*. Available at: http://www.sba-list.org/sites/default/files/content/shared/09.11.13_updated_fact_sheet.pdf.

[35] Patient safety can be all too easily compromised by physician financial conflict of interests. Dr. Steven Brigham's American Women's Services multi-state abortion businesses are illustrative of the need for hospital staff credentialing and privileging. Under "Employment" on their website, the job specification for clinic physician identifies: "Lucrative opportunity for Physician with progressive pro-choice women's centers. No on-call responsibility. Any specialty will be considered. All MDs/ODs welcome (including GPs, FMGs and residents). No experience necessary, we will train. Flexible Schedules to accommodate your needs. Great opportunity for MDs in private practice who wish to supplement their incomes, or for doctors seeking a Full-time lucrative opportunity. . . Board eligibility not required." Only two requirements are necessary: "Must have an active license to practice medicine. Must be pro-choice and respectful of women." *See:* http://www.americanwomensservices.com/employment/display_position.php?pos_id=2. For more information regarding Dr. Brigham and his financial ties with both American Women's Services and Associates in Ob/Gyn Care,

55. One pro-choice website even acknowledges: "So each woman who is thinking about abortion is on her own. And they [patients who obtain abortions] may not report substandard care to health authorities because they don't want to jeopardize their own confidentiality. Or they may not even realize that they deserve better." *See:* http://www.abortioncarenetwork.org/news/secrecy-and-stigma-the-roots-of-substandard-abortion-care. Indeed women with unwanted pregnancies deserve much better, and in my opinion, they deserve to have providers who are trustworthy caregivers and who are competent, peer-reviewed and evaluated by hospital medical staff. This is reasonable and protective of patient safety. Furthermore, the Abortion Care Network cautions abortion consumers: "The quality of care can vary widely among all medical facilities and since many women do not talk about their abortion experiences, it is often difficult to know what to look for when choosing a clinic." *See:* http://www.abortioncarenetwork.org/considering-abortion/choosing-a-quality-clinic.

56. In 2000, the Institute of Medicine released "To Err Is Human." [36] The premise of this report is that "the problem in medical errors is not bad people in health care—it is that good people are working in bad systems that need to be made safer. Poor communication, unclear lines of authority of physicians, nurses, and other care providers all contribute to medical errors." With the adoption of the Act, Texas is improving an inadequate system which essentially allows abortion providers to abandon their patients when critically ill after a procedure they performed, as well as continue a system that accepts poor communication as the norm. In effect, by not

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whose four Maryland clinics were recently suspended by the State for serious and immediate danger to patients, see: http://mobile.nytimes.com/2013/07/11/us/marylands-path-to-an-accord-in-abortion-fight.html?from=health.

[36] National Research Council – Institute of Medicine. *To Err Is Human: Building a Safer Health System.* Washington, D.C.: The National Academies Press, 2000. Available at: http://www.nap.edu/catalog.php?record_id-9729.

requiring admitting privileges for an abortion provider, Texas is essentially affirming that the physician who performs an abortion procedure is not responsible for ensuring that his or her patients receive adequate follow-up care when there are critical complications. This constitutes patient abandonment and very poor, substandard and fragmented medical care. Abandonment in any other circumstance is considered negligent and cause for malpractice.

57. Transfer of care many times is necessary, but if it is the norm, then it is often just fragmented care. This is not the best quality care as it violates "continuity of care" which is the optimum standard. Under this lower standard, the abortion provider does not go to the hospital nor is there a mandated specific mechanism for communicating with other doctors/emergency facilities that is time-sensitive and needed for a good transfer of care. Inter-physician communication is critical to good care so relieving the abortion doctor from this responsibility is inconsistent with the State of Texas' responsibility to protect its citizens from harmful or substandard medical care. The transfer of care of a patient increases the chance of time delays and miscommunication, both of which are detrimental for the patient's health and well-being. In my medical opinion, patients seeking abortions deserve better not less care. The improved regulations set forth in the Act can and should make this possible.

Other Incongruities

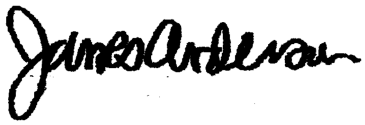
58. Plaintiffs' expert Dr. Fine argues in his Declaration ¶ 19 that requiring an abortion provider to have hospital privileges within 30 miles of the abortion clinic would have no bearing as to where an EMT would transport a patient with abortion complications. From my twenty-two years in the second busiest emergency room in the state of Virginia, it was always the case that the EMT's would do their best to accommodate the desires of the patients and medical doctors. If the patient was in extreme distress, it is true that the closest ER was the logical choice

but otherwise, they would transfer the patient where continuity of care was best for that patient. The patient's medical doctors and medical records were the deciding factor as to where they would transport stable patients.

59. Dr. Fine alleges in his Decl. ¶ 23: "Moreover, it is my experience that many of those women who visit ERs after an abortion do so because of concerns they are having about their symptoms in cases where the ER visit is not actually medically necessary." I disagree. Many times, in many medical circumstances, medical treatment takes on the form of reassurance and instructions after a thorough evaluation. Again, I have evaluated and treated many young patients with bleeding, pain and fever after an abortion. Medical evaluation and assessment were always necessary to determine who needed inpatient treatment or who could be safely discharged to home. Fear and anxiety are very real and cloud judgment so in even the most minor presentations, evaluation and instructions and reassurance were very much needed. The abortion doctor who was paid for this elective procedure should also be available to provide this significant follow-up care.

60. In my opinion, Plaintiffs' arguments in opposition to the admitting privilege requirement are specious. In Texas, a number of abortion providers do indeed hold admitting privileges at local hospitals, including Plaintiffs' expert, Dr. Fine. It is illogical and unreasonable to argue against the value of hospital privileging in abortion services on the one hand, while acknowledging that most Texas abortion facilities already comply with the Act. If these providers and facilities can meet the requirements of the law, it is reasonable to assume others can as well. The abortion clinics in El Paso and McAllen may be able to hire new physicians eligible for local hospital privileging. If not, as is true in other areas of medical specialization, Texas patients will travel to those facilities nearest them to address their

healthcare needs despite inconvenience and increased costs. If a reduction in the number of abortion facilities results in more travel but safer procedures for patients, it is a reasonable and prudent trade-off of convenience for healthcare quality and risk reduction. Plaintiffs argue that many patients cannot afford to pay for longer distance travel, but I believe that the poverty situation of these patients does not warrant providing them with substandard care. Abortion patients in poverty deserve the same standard of healthcare as those who are wealthier in our society.



Dated: April 11, 2014

James Anderson, M.D.

APPENDIX A:

Curriculum Vitae of

James Anderson, M.D.

Curriculum Vitae

March 27, 2013

1. Personal Information:

1.1 **James Corr Anderson, M.D.**
1.2 United States Citizen
1.3 Married: 38 years to Doris K. Anderson

4 Children:	Elizabeth Anderson Smith	age 36
	James Luke Anderson	age 34
	Emily Ruth Anderson	age 28
	Mary Katherine Anderson	age 26

1.4 Office: 2500 Pocoshock Place
Richmond, Virginia 23235
(804) 276-9305

2. Licensure:

2.1 0101 030737 Virginia
2.2 Board Certification in Family Practice: 1981
Re-certified 1987, 1993, 1999, 2006
2.3 Board Certification in Emergency Medicine: 1996, 2008 (by American Association of Physician Specialists)

3. Education:

Chesterfield Family Practice Residency Program
Richmond, Virginia (1978-1981)
Residency Training in Family Practice

University of Virginia
Charlottesville, Virginia (1974-1978)
M.D. 1978

University of Virginia
Charlottesville, Virginia (1970-1974)
B.S. 1974

4. Military Service Record:

US Army Reserves: Rank of Col.-
February 2002 – September 2012

Medical Director of Emergency Medical Training of U.S. Army Reserves in Pennsylvania, West Virginia, New Jersey, Maryland and Virginia. Surgeon's Office, 9th Battalion, 80th Division.
(Five Active Duty deployments for 3 months each in Texas during 2003, Germany in 2005, Iraq in 2007, Iraq 2008, Afghanistan 2011)

5. Postdoctoral Training or Special Work Experiences:

Associate Director
Chesterfield Family Practice Center, P.C.
Richmond, Virginia
October 1995 to present

Southeastern Emergency Physicians P.A.
Emergency Medicine Johnston-Willis Hospital and Chippenham Medical Center
Richmond, Virginia
Full time: 1985 to 1995, part-time 1995-2005 (resigned from ER after 3 years in with US Army Reserves)

House Physician-Emergencies within Hospital
Johnston-Willis Hospital
Richmond, Virginia
1981 to 1985

6. Academic Appointments:

Clinical Professor
Department of Family Medicine & Population Health
School of Medicine
Virginia Commonwealth University
2010 - present

Associate Clinical Professor
Department of Family Medicine & Population Health
School of Medicine
Virginia Commonwealth University
1996 - 2010

7. Membership in Professional Societies:

Richmond Academy of Medicine, 1995 - present
Medical Society of Virginia, 1995 - present
American Medical Association, 1995 to present

Christian Medical and Dental Society, 1991 - present
American Academy of Family Physicians, 1998-present
Virginia Academy of Family Physicians, 1998-present

8. Membership in Community Organizations:

Elder, Grace Covenant Church, 1984 to 1996
Chairman and School Board Member of Dove Christian School, Inc. 1981-1989
Chairman, Virginia Physicians for the Unborn Child, Inc. 1983-1988
Chairman, Family Policy Council, Inc. 1988 to present
Executive Board, Richmond Christian Medical & Dental Society, 1991 to present
Chairman of Greater Richmond Roever Crusade, 1993-1995, 2003
Co-Chairman of Abstinence Promotion, 1995-1996, 1999-2000
Appointed by Governor Allen to "Virginia Neurologic Birth Defect Fund" Board 1995 to 1999
Chairman of "One Way to Play - Drug-Free" Promotion, 1997-1998
Executive Board, March for Jesus, 1996-2000
Missions Service:
6 short-term Mission trips to: Philippines in 1981
Mexico in 1984
Mexico in 1986
Hungary in 1987
Nicaragua in 2010
Thailand in 2011
Chairman of U-Turn, Peak Performance Academy, 1998-2000
Executive Board of U-Turn, Peak Performance Academy, 1998-present
Chairman, 'Jesus Day' Board, 2000-2005
Chairman, Abstinence – Now Until Marriage, 2000 Campaign

9. Awards:

Outstanding Educator Award in Emergency Medicine by Family Practice Interns 1992, 1993, 1994, 1995, 1996, 1998 (In 1998, as a full time staff member at Chesterfield Family Practice, I withdrew from consideration for this award)

Alpha Omega Alpha Clinical Volunteer Faculty Award in 2008 by VCU-MCV graduating medical students in the AOA Society

Outstanding Teacher Award for Best Teacher in the M3 Family Medicine Clerkship 2008-2009 by VCU Medical Center, VCU School of Medicine.

High Evaluation Award for the 2009-2010 academic year in M3 Family Medicine Clerkship

EXHIBIT B:

Examples of Substandard &

Unregulated Abortion Practice in the U.S.

Examples of Substandard & Unregulated Abortion Practice

- Dr. Kermit Gosnell in Pennsylvania[37]
- Dr. Soleiman Soli in Pennsylvania[38]
- The Beacon Women's Center in Alabama[39]
- Drs. Feliciano Rios[40] and Andrew Rutland in California[41]
- Dr. Albert Dworkin in Delaware[42]
- Dr. Randall Whitney[43] and Dr. James Pendergraft[44] in Florida
- Dr. Ann Kristin Neuhaus in Kansas[45]
- The Gentilly Medical Clinic for Women[46] and the Hope Medical Group for Women[47] in Louisiana

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[37] *See*, *Los Angeles Times* Editorial: "The Kermit Gosnell Verdict." "Gosnell, a 72-year-old doctor who was neither an obstetrician nor a gynecologist (having failed to complete a residency in those specialties, according to a grand jury report), ran what has been described by authorities as a filthy, bloodstained, poorly equipped abortion clinic with the help of unqualified staff. Multiple complaints had been lodged at the Pennsylvania Department of Health against the clinic, which ministered mostly to poor women. On Monday, Gosnell was convicted of first-degree murder for killing three babies in botched abortions; he cut their spinal cords after they were born alive. He also was found guilty of involuntary manslaughter in the 2009 death of a woman who died undergoing an abortion, and of nearly two dozen violations of the Pennsylvania law that bans abortion after the 24th week of gestation." Available at: http://articles.latimes.com/2013/may/15/opinion/la-ed-abortion-gosnell-philadelphia-20130515

[38] *See*, e.g., M. Scolforo, *2 abortion clinics closed after reports* (Mar. 10, 2011), available at http://www.washingtontimes.com/news/2011/mar/10/2-abortion-clinics-closed-after-reports/.

[39] For a copy of the Alabama Department of Health's February 2010 report on the clinic's "numerous and serious violations," see Alabama Department of Health, *Statement of Deficiencies and Plan of Correction* (Feb. 1, 2010), available at http://wsfa.images.worldnow.com/images/incoming/linkedwebdocs/13113.pdf.

[40] *See* S. Ertelt, *Abortion Practitioner in California Operates Despite Repeated Legal Troubles* (Jan. 1, 2009), available at http://www.lifenews.com/2009/01/01/state-5544/.

[41] *See* C. Perkes, *Abortion Doctor Gives Up License Over Death* (Jan. 25, 2011), available at http://www.ocregister.com/articles/ rutland-285561-death-license.html.

[42] *See* S. Ertelt, *Hearing: Delaware Abortionist Helped Kermit Gosnell Avoid Law* (Mar. 16, 2011), available at http://www.lifenews.com/2011/03/16/hearing-delaware-abortionist-helped-kermit-gosnell-avoid-law/.

[43] *See* J. Stanek, *Late-Term Abortionist Randall Whitney Arrested for Slapping Patient* (Jun 7, 2010), available at http://www.opposingviews.com/i/late-term-abortionist-randall-whitney-arrested-for-slapping-patient.

[44] *See* S. Ertelt, *Abortion Practitioner James Pendergraft Loses Florida License a Fourth Time* (Jan. 1, 2009), available at http:// www.lifenews.com/2009/01/01/state-5339/.

[45] *See, e.g.*, J. Hanna, *Doctor Defends Abortion Referrals* (Sept. 17, 2011), available at http://www.kansas.com/2011/09/17/2020433/doctor-defends-abortion-referrals.html.

[46] *See* S. Ertelt, *Abortion Business in Louisiana Loses License for Poor Health, Safety Standards* (Jan. 20, 2010), available at http://www.lifenews.com/2010/01/20/state-4743/.

[47] *See* P. J. Smith, *Louisiana Abortion Clinic Shut Down for Ignoring "Most Basic" Medical Practices* (Sept. 7, 2011), available at http://www.lifesitenews.com/news/archive/ldn/2010/sep/10090707.

- Dr. Romeo Ferrer[48], George Sheppard[49], and Nicola Riley[50] in Maryland
- Dr. Steven Brigham[51] in Maryland, New Jersey, and Pennsylvania
- Dr. Rapin Osathanondh[52] in Massachusetts
- Dr. Alberto Hodari[53] in Michigan
- Drs. Salomon Epstein[54] and Robert Hosty[55] in New York
- Southwestern Women's Options[56] in New Mexico
- Drs. Robert E. Hanson Jr., Margaret Kini, Douglas Karpen,[57] Pedro J. Kowalyszyn, Sherwood C. Lynn Jr., Alan Molson, Robert L. Prince, H. Brook Randal, Franz Theard, and William W. West Jr.[58] in Texas
- Whole Woman's Health[59] in Texas
- Dr. Malachy DeHenre in Mississippi[60]

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[48] *See* S. Ertelt, *Pro-Lifers Want Maryland Practitioner Disciplined, Killed Woman in Botched Abortion* (June 1, 2010), available at http://www.lifenews.com/2010/06/01/state-5145/.
[49] *See* S. Ertelt, *Troubled Abortion Biz Sees Two Practitioners Lose Medical Licenses* (Sept. 3, 2010), available at http://www.lifenews.com/2010/09/03/state-5416/.
[50] *Id.*
[51] *See, e.g., N.J. targets abortion doctor Steven Brigham's license* (Sept. 9, 2010), available at http://www.lehighvalleylive.com/phillipsburg/index.ssf/2010/09/nj_targets_abortion_doctor_ste.html, and Press, E. *A Botched Operation*, The New Yorker (Feb. 2, 2014), available at: http://www.newyorker.com/reporting/2014/02/03/140203fa_fact_press.
[52] *See Doctor gets 6 months in abortion patient death* (Sept. 14, 2010), available at: http://www.msnbc.msn.com/id/39177186/ ns/us_news-crime_and_courts/t/doctor-gets-months-abortion-patient-death/.
[53] *See, e.g.*, Office of the Attorney General, *Schuette Files Suit to Close Unlicensed Abortion Clinic* (Mar. 29, 2011), available at http://www.michigan.gov/ag/0,1607,7-164--253426--,00.html.
[54] *See* S. Ertelt, *Practitioner Denies He Botched Legal Abortion That Killed Hispanic Woman* (Mar. 1, 2010), available at http://www.lifenews.com/2010/03/01/state-4858/.
[55] Hosty, who ran the A-1 Women's Center abortion clinic in Queens, New York, had his license revoked after causing the death of Alexandra Nunez, a 37-year old single mother of four. Revocation Order can be found at http://operationrescue.org/pdfs/Hosty%20revocation.pdf.
[56] See J. Kryn, *New 911 Call from New Mexico Abortion Clinic Exposes Pattern of Emergencies* (Oct. 20, 2011), available at http://www.lifesitenews.com/news/new-911-call-from-new-mexico-abortion-clinic-exposes-pattern-of-emergencies.
[57] See Operation Rescue, *Another Gosnell: Report Shows Texas Abortion Doc Kills Babies Born Alive, available at:* http://www.lifenews.com/2013/05/15/another-gosnell-report-shows-texas-abortion-doc-kills-babies-born-alive/.
[58] *See* S. Ertelt, *Tenth Texas Abortion Practitioner Under State Investigation* (Aug. 24, 2011), available at http://www.lifenews.com/2011/08/24/tenth-texas-abortion-practitioner-under-state-investigation/.
[59] *Id.*
[60] After Dr. Malachy DeHenre lost his medical license indefinitely following the death of one of his patients and three malpractice actions against him, New Woman All Women in Jackson closed. DeHenre was convicted of

- New Woman All Women[61] in Alabama
- Dr. Tommy Tucker[62] in Alabama and Mississippi
- Mi Yong Kim[63] in New York and Virginia
- Dr. Leroy Carhart[64] in Maryland
- Dr. Nicola Riley[65] in Maryland

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manslaughter in 2008 in his second trial in Jones County and was sentenced to 20 years in prison. See Associated Press State & Local Wire, July 2, 2010.

[61] New Woman All Women (NWAW) abortion clinic has had numerous health and safety deficiencies identified by the Alabama Department of Public Health. See Alabama Department of Public Health, Statement of Deficiencies and Plan of Correction available at http://abortiondocs.org/wp-content/uploads/2012/04/NEW-WOMAN-ALL-WOMEN-201203011.pdf. Diane Derzis, clinic owner of NWAW and Jackson Women's Health Organization and who is also a Plaintiff in this action, was ordered to not have any further affiliation with NWAW by the Alabama Department of Public Health. Consent Order available at http://abortiondocs.org/wp-content/uploads/2012/04/New-Woman-Consent-Order.pdf

[62] Dr. Tommy Tucker lost his license after he refused to help one of his abortion patients who was bleeding to death, leaving her with an untrained employee at his abortion clinic in Alabama. *See http://clinicquotes.com/former-clinic-worker-joy-davis/*

[63] *See Troubled Virginia abortion clinic puts bleeding botched abortion patient in hospital* available at http://www.lifesitenews.com/news/troubled-virginia-abortion-clinic-puts-bleeding-botched-abortion-patient-in/. Kim, who continues to own/operate Nova Women's Healthcare in Virginia, voluntarily surrendered her New York medical license in 2000 and by consent order, and permanently surrendered her Virginia medical license in 2007 after repeated serious violations. Consent Order can be seen at http://abortiondocs.org/wp-content/uploads/2012/04/Kim-VA-License-Surrender05182007.pdf

[64] Dr. Carhart was under investigation for the death of Jennifer Morbelli, a 29 year-old school teacher who underwent a late-term abortion. According to news reports, Carhart left town shortly after completing the abortion and was not reachable when Morbelli needed emergency care. *See* S. Cohen, *Coroner: Woman bled to death after late-term abortion* (Feb. 21, 2013), available at http://www.usatoday.com/story/news/nation/2013/02/21/woman-late-term-abortion-bled-to-death/1935799/l . The Maryland Montgomery County Police Department closed an investigation into this death without filing criminal charges against Carhart. Morbelli's death certificate confirmed she died from complications due to a 33-week abortion. Available at: http://www.breitbart.com/Big-Government/2013/05/16/No-Criminal-Charges-Brought-Against-Abortionist-LeRoy-Carhart-In-Maryland

[65] Dr. Nicola Riley had her medical license permanently revoked in Maryland after failing to call for emergency help for a critically injured abortion patient and transporting her to the hospital in the backseat of a rental car. *See http://abortiondocs.org/wp-content/uploads/2013/05/Nicola-Riley-MD-Permanent-Revocation-May-6-2013.pdf*