THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

PLANNED PARENTHOOD OF WISCONSIN, INC.,
SUSAN PFLEGER, MD,
FREDRIK BROEKHUIZEN, MD, and
MILWAUKEE WOMEN'S MEDICAL SERVICES
d/b/a AFFILIATED MEDICAL SERVICES,

Plaintiffs,

v. Case No.: 13-CV-465

J.B. VAN HOLLEN,
ISMAEL OZANNE,
JAMES BARR,
MARY JO CAPODICE, DO,
GREG COLLINS
RODNEY ERICKSON, MD,
JUDE GENEREAUX,
SURESH K. MISRA, MD,
GENE MUSSER, MD,
KENNETH B. SIMONS, MD
TIMOTHY SWAN, MD,
SRIDHAR VASUDEVAN, MD,
SHELDON A. WASSERMAN, MD,
TIMOTHY W. WESTLAKE, MD,
RUSSELL YALE, MD, and
DAVE ROSS,

Defendants

DECLARATION OF DAVID C. MERRILL, M.D., Ph.D.

I, David C. Merrill, M.D., Ph.D., declare as follows:

1. I received my Ph.D. in Physiology in 1985 from the Medical College of Wisconsin. In 1987, I received my M.D. from the Medical College of Wisconsin. My residency training in Obstetrics and Gynecology took place at the University of California at San Francisco Department of Obstetrics, Gynecology and Reproductive Services and my fellowship in Maternal-Fetal Medicine was completed at the University of Iowa Hospitals and Clinics. I have been board certified in obstetrics and gynecology since 1994 and in maternal-fetal medicine since 1996.

2. Currently, I am the Medical Director of Maternal Fetal Medicine and the Physician Leader of the systemwide Women's Health Program at Aurora Health Care in Milwaukee. I am a Fellow of the American College of Obstetricians and Gynecologists as well as a member of the Society for Maternal-Fetal Medicine, American Institute of Ultrasound in Medicine, and the Society for Gynecologic Investigation. From 2005 – 2011, I was Professor and Chairman of the Department of Obstetrics and Gynecology at Wake Forest University School of Medicine in Winston-Salem, North Carolina.

3. I have published 57 articles in peer-reviewed journals, 88 abstracts discussing medical research and authored 6 book chapters. I have also been the principal investigator or co-investigator and recipient of 14 medical research grants.

4. For a complete listing of my professional background, experience, responsibilities, and publications, please see my Curriculum Vitae which is attached as Exhibit A.

5. I have reviewed Section 1 of 2013 Wisconsin Act 37 (Senate Bill 206) (the "Act"), the Plaintiffs' Complaint, and the Declarations of Plaintiffs' experts: Ms. Huyck and Drs. Christiansen, Laube & Broekhuizen. The opinions I express here are based on my education, training and experience, in addition to my familiarity with the medical literature, and all are based upon a reasonable degree of medical certainty.

Management of Abortion Complications and the Need for Staff Privileges

6. I agree with Plaintiffs' expert Dr. Laube that continuity of care and communication are key factors in providing optimal care for women who suffer complications of abortions. I disagree, however that requiring hospital privileges is "irrelevant" in terms of helping to ensure the continuity of care, communication, and providing optimal care. It has been my experience here in Wisconsin and the experience of many of my colleagues that abortion providers rarely if ever communicate to accepting providers about patients sent to hospitals with complications secondary to abortion. I have personally taken care of patients who have been admitted with complications following abortion procedures and can say that I do not ever remember being contacted by an abortion provider to give me information about the patient or the procedure which he/she performed. Furthermore, when attempting to contact the abortion clinic little information was provided.

7. In not communicating with emergency room physicians after serious abortion complications occur, abortion practitioners unnecessarily make a complex situation more complicated and less safe for their patients. Furthermore, emergency room physicians may or may not be an OB/GYN who is capable of managing such emergencies. Failure to communicate and provide for continuity of care on the part of a physician in my hospital would trigger an accountability review before hospital peers, and likely result in disciplinary action for patient abandonment and irresponsible care. No such accountability process exists for abortion practitioners due to the lack of hospital privileges.

8. In the Plaintiffs' Complaint ¶ 23 they allege: "In the rare instances where additional or after hours care is required, Plaintiffs' staff will refer the patient to a local

emergency room, as is also consistent with the standard of care." It is important to note that there is no discussion of a potential phone call from the patient's physician to the local emergency room or to the covering OB/GYN physician in after-hours cases.

9. It has also been my experience that the abortion practitioner rarely escorts the patient to the hospital when emergency admission is needed. As was pointed out by Dr. Laube ¶ 21, severe complications can result from abortion procedures such as vascular and bowel injury. I agree that should these complications occur, they would be better handled by surgeons from other subspecialties. However, given that these severe complications are possible and do occur, it would seem illogical and even dangerous to the patient to not have her primary provider (the abortion practitioner) central in the coordination of her care upon admission to the hospital.

10. Although the abortion provider may not provide all of the care within the hospital, having admitting privileges would place him/her at the center of the patient's care, continuing an already developed physician-patient relationship established in the course of performing the abortion. If the goal truly is to provide excellent care to these already vulnerable patients in need, it is incomprehensible to me why there is such reluctance to provide this continuity of care to their patients.

11. In my opinion, most patients undergoing procedures such as abortion would assume that their abortion providers not only would have a medical license but also would have privileges in a hospital to manage the more common complications that can result. It is the duty of the abortion provider to inform his/her patient prior to performing the abortion that should a complication arise requiring hospitalization, that he/she will not and cannot be involved in her urgent care at the hospital due to the fact that the provider does not have admitting privileges at a hospital close to the abortion clinic. They should also be informed that in the event of a serious complication their emergent and ongoing care would be transferred to another provider, and that this transfer of care may result in a delay in treatment and possible worsening of their complication. It is unclear to me if any such disclosure is required in this state.

12. The benefit of having the abortion provider be the admitting physician if at all possible in the event of an acute complication is that he/she would be most familiar with the patient's history, physical exam and procedure performed. In addition, he/she should be most familiar with the woman's future reproductive desires. This becomes especially important in the face of acute bleeding or uterine rupture which may require hysterectomy. Delays in management of acute bleeding can make hysterectomy more likely and thus would make future childbearing impossible.

13. The risk of a woman experiencing a complication that requires hospitalization is estimated to be 0.3 to 0.5%, though these are rough estimates and based upon incomplete and unreliable data. As pointed out by Dr. Laube ¶ 22, patients many times present with complications to other facilities and thus the abortion clinic would not learn of the need for hospitalization. Therefore I believe that these estimates are not reliable and likely underestimate the need for hospitalization following an abortion. Even if these estimated percentages were reliable, this would equate to approximately 2-3 patient's per month in Wisconsin requiring hospitalization secondary to complications of abortion procedures.

14. Dr. Laube ¶ 19 alleges: "the provider often has little ability to control where the Emergency Medical Technicians (EMTs) take the patient." In my practice, whenever I have had to transfer a patient from an outpatient setting to a hospital, the EMT agreed to take the patient where I directed them to admit the patient. As stated above, in my experience, abortion providers rarely follow the patient and do not communicate with the hospital. It is not surprising then that they have a different interaction with the EMTs. If the abortion clinic merely calls and asks for urgent transport of the patient to a hospital, I agree that the EMT will take the patient to a hospital that the EMT determines to be most appropriate based upon the emergency.

15. Plaintiffs arguments on this issue are inconsistent. Dr. Laube ¶ 17 stated that it is a violation of the standard of care for the abortion provider to not communicate with hospital physicians in cases in which patients are transported or directed to be admitted to the hospital by staff from the abortion clinic. If this is such an important principal to ensure safe and optimal care for the women undergoing abortion, common sense would dictate that legislation to increase patient safety is reasonable and warranted if it increases the likelihood that the abortion provider will continue to be involved with the patient's emergency care should complications arise.

16. I understand that it is possible that the patient may return home and be living some distance from the abortion clinic at the time when complications arise. In this situation it still would be important for the abortion provider, not as an admitting physician, to communicate with the local physician. I would argue, however, that the majority of severe complications such as severe hemorrhage and uterine perforation occur immediately during or after the abortion procedure. This is the reason for the legislation requiring admitting privileges within 30 miles of the abortion clinic.

17. When complications arise and patients are admitted to the hospital, there is an inherent delay in getting treatment if there is minimal information from the abortion clinic. When patients are admitted they can be unstable from blood loss or infection. Fortunately many of these women are young and otherwise healthy and therefore mortality is rare. This legislation requiring admitting privileges provides a layer of safety for these women and helps to ensure that the continuity of care and coordination of care takes place for the 2-3 women per month who potentially will get admitted to the hospital in Wisconsin secondary to abortion complications.

Abortion Providers' Ability to Obtain Admitting Privileges

18. The idea that there is a clear divide between inpatient and outpatient care in contemporary medical practice in this country is false. This is true in some areas in internal medicine and pediatrics but certainly not in obstetrics and gynecology. I would argue that the majority of physicians performing outpatient surgical procedures most likely would have admitting privileges.

19. I agree that in modern medicine, consultants are many times obtained to treat various medical complications of admitted patients. This does not, however, negate the importance of the primary caregiver, who in this case would be the abortion provider, from being involved with and coordinating the care upon his/her patient being admitted to the hospital.

20. Plaintiffs argue that most if not all hospitals require all physicians with privileges to admit a certain minimum number of patient's in a year. In my medical opinion, this statement is false and lacks foundation. I personally have privileges at 4 hospitals in which I have not admitted a single patient over the past 2-1/2 years. My privileges are still active and there has been no question of my status at these hospitals. I maintain these privileges due to the fact that I may rarely need to admit a patient at one of these hospitals or may be asked to perform an inpatient consultation. Nor am I familiar with any privileging standard that requires geographical residence near the hospital, contrary to what Plaintiffs assert. I live in Milwaukee County yet have privileges in Green Bay, Kenosha, and Oconomowoc.

21. Although there may at times be a delay in obtaining hospital privileges for any number of reasons, the process can be facilitated if all documents are submitted in a timely way. In addition it is possible to obtain emergency or courtesy staff privileges if needed which can be transitioned later to full active privileges via the normal privileging process.

22. I would also disagree with Plaintiffs' allegation that it would be difficult for abortion providers to obtain privileges even at Catholic hospitals. They may not be able to obtain privileges to perform abortions in some hospitals, but all hospitals would provide privileges to care for complications which were secondary to abortion procedures.

23. It should be noted that Plaintiff Dr. Pfleger had privileges at Aurora Sinai Medical Center in Milwaukee as recently as the end of 2011. To allege that it would be a hardship or that she would have difficulty in reinstituting her privileges at Aurora Sinai Medical Center which is very close to the Milwaukee-Jackson Health Center is simply not true.

Miscellaneous

24. When an obstetrician or family physician delivers a baby and there are complications post-delivery, the patient would be readmitted (if needs be) by the OB/GYN (or group) who delivered her. They would then obtain consults as needed from infectious disease, general surgery, etc., to manage the complication. When a pregnancy ends secondary to abortion (as opposed to natural delivery) there is no logical rationale why this process should be treated any differently. In both instances a pregnant patient is being cared for, the pregnancy ends, and a complication arises postpartum. For natural childbirth, it is the expectation that she will still be cared for by her primary caregiver (whether OB/GYN, family practice, or even midwife) if a postpartum complication occurs. For abortion providers, a totally different standard is now in place that makes no medical sense. I understand that term deliveries occur in the hospital whereas abortions largely occur in an outpatient setting, but optimal management of serious postpartum complications is the same regardless if it is a natural delivery or an abortion.

25. The pregnant woman who has undergone an abortion is especially emotionally vulnerable. In my medical opinion, the continuity of care if postpartum complications arise is even more important for her. Since she has made this difficult decision in collaboration with her abortion caregiver, I think it would be vitally important for that connection/relationship to be maintained in the postpartum period if at all possible, especially if complications arise.

26. It is incomprehensible how Plaintiff abortion providers can claim that they will be financially hurt by the Act. If they obtain hospital privileges they can still perform abortions, and, they could *also* bill for in-hospital services rendered should patients be seen by them at a local hospital.

27. It is my medical opinion that the Act is not only reasonable and appropriate, but is a vitally important measure to increase patient safety and protect women's reproductive health. Women deserve the best medical care, not what is easiest or most convenient for the physicians providing the care. In my medical opinion, a competent and well trained abortion provider would have no difficulty in obtaining hospital privileges. To me, a lack of willingness to obtain such privileges demonstrates a lack of interest or commitment to providing comprehensive care to women seeking abortion services.

I declare under penalty of perjury that the foregoing is true and correct.

s/David C. Merrill, M.D., Ph.D.
David C. Merrill, M.D., Ph.D.

Dated: July 13, 2013