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 JOHN THORP, Jr., M.D., M.H.S.

I, John Thorp, Jr., M.D., M.H.S., declare as follows:

1. I received my M.D. degree from East Carolina University Medical School in 1983. My residency training took place at the University of North Carolina (Chapel Hill) School of Medicine in general obstetrics and gynecology (1983-1987). I also completed my fellowship in Maternal-Fetal Medicine at the University of North Carolina (Chapel Hill) School of Medicine in 1989. I received my Master's degree of Health Sciences in Clinical Leadership from Duke University School of Medicine in 2009.

2. Since 1991 I have been a board-certified obstetrician/gynecologist and since 1992 I have also had a certification in the sub-specialty of Maternal-Fetal medicine. I am a Fellow of the American Gynecological and Obstetrics Society and a member of the American College of Obstetricians and Gynecologists.

3. I am the Hugh McAllister Distinguished Professor of Obstetrics and Gynecology at the University of North Carolina (Chapel Hill) School of Medicine. I am also a Professor in the Department of Maternal and Child Health, School of Public Health at the University of North Carolina at Chapel Hill. In that role I teach both medical students and residents in Obstetrics and Gynecology. As part of my administrative duties, I have administrative oversight of the Family Planning Fellowship and Residency training programs at UNC. Members of my unit staff the abortion services at our academic health center.

4. I am also an Adjunct Professor in the Departments of Epidemiology at both the School of Public Health at the University of North Carolina and the School of Public Health and Tropical Medicine at Tulane University. I am the Deputy Director of the Center for Women's Health Research, Cecil G. Sheps Center for Health Services Research at both the University of North Carolina School of Medicine and School of Public Health (Department of Obstetrics and Gynecology and Department of Epidemiology, respectively).

5. I am also the Division Director of Women's Primary Healthcare, Program Director of the Women's Reproductive Health Research Scholars Program and Research Core Co-Director of the Women's Reproductive Health Research Scholars Program at the University of North Carolina.

6. In addition, I am a Fellow of the Carolina Population Center and the Director of the Biomedical Core of the Carolina Population Center of the University of North Carolina at Chapel Hill.

7. I have authored 18 book chapters and serve as a journal referee (reviewer) for 38 different medical journals, including *The New England Journal of Medicine, Mayo Clinic Proceedings, Obstetrics & Gynecology, The American Journal of Obstetrics and Gynecology, British Journal of Obstetrics and Gynecology, Lancet, Journal of Perinatal Medicine* and *Journal of the American Medical Association - Archives of General Psychiatry*.

8. I have published 282 peer-reviewed articles, 155 abstracts discussing medical research, and 36 non-peer reviewed articles.

9. I serve on the Editorial Board of the *Obstetrics and Gynecological Survey* and the *British Journal of Obstetrics and Gynecology*. I have been a principal investigator/researcher and recipient of research grants on 11 major medical research projects totaling millions of dollars.

10. For a complete listing of my professional background, experience, responsibilities, and publications, please see my Curriculum Vitae which is attached as Exhibit A. The opinions I express herein are my own and not those of the institutions with which I am affiliated. Throughout this declaration, I will refer to the termination of pregnancy as "TOP."

11. I have reviewed Plaintiff's Complaint, 2013 Wisconsin Act 37 (Senate Bill 206) (the "Act"), and the Declarations of Ms. Huyck and Drs. Laube, Christiansen, and Broeckhuizen. The opinions I express herein are based upon my medical education, training and experience, as well as my familiarity with the medical literature.

12. It is my understanding that Plaintiffs oppose only Section 1 of the Act, which requires every physician who provides abortions to have admitting privileges in a hospital within 30 miles of the location where the abortion is to be performed. In my medical opinion, the Act's requirement for hospital admitting privileges is protective of women's health and safety. It is a prudent and reasonable provision to advance women's reproductive healthcare with the likely effect of decreasing serious and life-threatening complications from TOP.

TOP Morbidity and Mortality & Comparisons to Childbirth

13. A key factor underlying the issues litigated here is that of TOP safety. The most common index used to show TOP safety, one used repeatedly in informed consent forms at TOP facilities, including Planned Parenthood of Wisconsin, is that of TOP mortality compared to childbirth. Not unexpectedly, Plaintiffs' expert Dr. Laube raises this issue first and foremost in his Declaration ¶¶ 8-11, and alleges: "Legal abortion is one of the safest medical procedures in the United States. The risk of death associated with childbirth is approximately 14 times higher than that associated with abortion, and every pregnancy-related complication is more common among women having live births than among those having abortions." Such an allegation is unfounded, and is lacking in scientific rigor and reality.

14. Implied in any discussion about the complication rates of TOP compared to childbirth is the presupposition that the data upon which they are based is accurate and complete. This is not insignificant as there are only two sources of data for TOP complications: the Centers for Disease Control[1] (CDC) and the Guttmacher Institute[2] (GI). Throughout its history, the latter has been affiliated with and/or funded by the largest TOP provider in the U.S., Planned

[1] The US Centers for Disease Control (CDC). Beginning in 1969, state health departments have voluntarily provided annual reports on TOP procedures and patients. These data are incomplete due to the wide variability in state requirements for reporting of TOP procedures, the voluntary nature of participation with some states choosing to not do so periodically, marked variation in the information each state obtains, and the lack of specific funding for TOP data accumulation. For instance, the sizable State of California has not reported in the past decade. Thus, any report on TOP epidemiology from the US is fraught with numerous assumptions and lack of any clear standardization. *See*: Cates, W., Grimes, D. & Schulz F. Abortion Surveillance at CDC. Creating Public Health Light Out of Political Heat. 19 *American Journal of Preventative Medicine* 2000, 12-17; Pazol, K., Creanga, A., & Zane, S. Trends In Use of Medical Abortion in the United States: Reanalysis of Surveillance Data from the Centers for Disease Control and Prevention, 2001-2008. 86(6) *Contraception* 2012, 746-751.; Pazol, K., Zane, S., Parker, W., et al., Abortion Surveillance in the United States, 2008. 60(15) *MMWR Surveillance Summaries* 2011, 1-41.; Pazol,K., Zane, S., Parker, W., et al., Abortion Surveillance-United States, 2007. 60(1) *Morbidity and Mortality Weekly Report* 2011, 1-39.; Pazol, K., Zane, S., Parker, W., et al. Erratum: Abortion Surveillance-United States, 2007. 60(10) *MMWR Surveillance Summaries* 2011, 315.

[2] GI obtains its estimated number of TOP procedures from its periodic surveys of all known US TOP providers. Reporting is voluntary and the surveys are done at irregular intervals up to five years apart. *See:* Jones, R. & Kooistra, K. Abortion Incidence and Access to Services in the United States, 2008. 43(1) *Perspectives on Sexual and Reproductive Health* 2011, 41-50.; Jones, R., Kost, K., Singh, S., Henshaw, S., & Finer, L. Trends in Abortion in the United States. 52(2) *Clinical Obstetrics and Gynecology* 2009, 119-129.

Parenthood Federation of America. GI has a clear TOP advocacy agenda that is evident to any reasonable reader reviewing their website. The CDC relies upon state health department data which is subject to considerable underreporting by TOP providers due to the voluntary nature of the reporting. Likewise, GI's reporting is based upon provider estimates and is subject to conflict of interest issues in reporting adverse TOP outcomes. In the U.S., only one-third to one-half of TOP patients return for follow-up care. *See:* Picker Institute, From the Patient's Perspective: Quality of Abortion Care, 1999 at 33, and Grossman, D. et al., Routine Follow-up Visits after First-Trimester Induced Abortion. *Obstetrics & Gynecology* 2004, 103: 738-745. Therefore, many complications, delayed or otherwise, are unlikely to be known to the TOP provider. There is no national mandatory registry or reporting of the incidence of elective TOPs or its complications. Numerous and complex methodological factors make a valid scientific assessment of TOP mortality and morbidity impossible: incomplete reporting, definitional incompatibilities of measures, voluntary data collection, investigator bias, reliance upon estimations, inaccurate and/or incomplete death certificate completion, incomparability with maternal mortality statistics, and failing to include other causes of death such as suicides. For these reasons, any meaningful comparison between the health risks of TOP and carrying a pregnancy to term is precluded at this time.

15. There are numerous reasons why any comparison of maternal deaths to abortion deaths is not epidemiologically valid or sound. Some of these I discuss at greater length in my 2012 article published in *Scientifica* entitled: Public Health Impact of Legal Termination of Pregnancy in the US: 40 Years Later.

16. Two of the major issues confounding any valid comparison between maternal and TOP mortality are measurement and data quality. Because the data are so incomplete, the World Health Organization (WHO) has used multiple different methods to estimate maternal death. *See:* World Health Organization, *Maternal Mortality in 2005—Estimates Developed by WHO, UNICEF, UNFPA, and the World Bank*. Geneva, Switzerland: Department of Reproductive Health & Research, 2007. The estimative nature of the data and the use of differential definitions severely limit the conclusions drawn and the generalizability of any findings. Included in data quality is whether or not the data is complete, e.g., the ability to obtain the total number of TOPs in the U.S. or a particular state. As far back as 1998, a GI researcher concluded: "reporting of abortions is incomplete in most states." *See:* Henshaw, S. Abortion Incidence and Services in the United States, 1995-1996. *Family Planning Perspectives.* 1998, 30: 263. Even worse, in many states, TOP complications are not even required to be reported. In other states TOP complications are voluntarily reported or not reported at all due to provider conflict of interests resulting in the likelihood of significant underreporting. Given the inherent weaknesses of TOP mortality and morbidity data, it is inconceivable to me how TOP safety can be alleged with any reasonable degree of epidemiological certainty.

17. Existing research suggests the necessity of revisiting this issue. Two Canadian articles produced population based maternal mortality rates[3] (MMR) from a developed country in

[3] The maternal mortality rate (MMR) is the annual number of female deaths per 100,000 live births for a specified geographical area from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes). The MMR includes deaths during pregnancy, childbirth, or within 42 days of termination of

"healthy women." Though, neither controlled for age, their findings are illustrative here. One focused on excess risk associated with elective abdominal delivery and found an MMR of 1.2/100,000. *See: Wen, S. et al.* Comparison of Maternal Mortality and Morbidity between Trial of Labor and Elective Cesarean Section among Women with Previous Cesarean Delivery, *American Journal of Obstetrics & Gynecology,* 2004, 191: 1263-1269). The other focused on vaginal birth after caesarean section which is a higher risk condition due to uterine scarring and found a risk of 1.6/100,000. *See:* Liu, S et al. Maternal Mortality and Severe Morbidity Associated with Low-risk Planned Cesarean Delivery versus Planned Vaginal Delivery at Term. *Canadian Medical Association Journal,* 2007, 176, 455-460. One can safely speculate that this number would be lower in women with an unscarred uterus. Both of these MMRs are well within the 1-2/100,000 quoted for TOP in the US with all its limitations. In my epidemiological opinion and based upon a reasonable degree of medical certainty, it is false and misleading to assert that pregnancy is safer than TOP in low risk, healthy women. An additional factor that should be considered is age and maternal mortality. Younger women between the ages of 20 – 39 are generally healthier than older women and thus less likely to die from uncomplicated pregnancy and childbirth, which is a normal and natural process. In developing countries when direct obstetric deaths which are largely preventable are excluded, a "healthy pregnant woman effect" has been reported in which women currently or recently pregnant were up to five times less likely to die than women who had not been recently pregnant. *See*: Ronsmans, C. et al. Evidence for a "Healthy Pregnant Woman Effect" in Niakkar, Senegal. *International Journal of Epidemiology,* 2001, 30, 467-473.

18. Given the poor ascertainment and reporting of deaths after TOP in the US due to insufficient administrative oversight and subsequent inability to link TOP occurrence to death certificates (*See*: Reardon, D., Strathan, J. Thorp, J. & Shuping, M. Deaths Associated with Abortion Compared to Childbirth – A Review of New and Old Data and the Medical and Legal Implications. *Journal of Contemporary Health Law & Policy*, 2004, 20: 279-327), it is imprecise at best to compare TOP related to pregnancy related deaths and claim one is safer than the other. As mentioned earlier, pregnancy related deaths are systematically sought and investigated by state government sponsored commissions and the majority of states formally link birth certificates to death certificates. These efforts, which cannot currently be done for TOP, *double* the number of pregnancy related deaths discovered. Moreover, deaths after pregnancy cover an interval from conception to 42 days after delivery while TOP covers a much shorter window. An analogy would be comparing a full length film to a snapshot. For these reasons, comparing death rates and their derivative, safety claims, are inaccurate and imprecise. Such claims are not supported by adequate epidemiological methods and at this time, the comparative differences in the US cannot be quantified with precision.

19. The U.S. has no national health registry identifying and linking all individual healthcare interventions, diagnoses, hospitalizations, births, deaths and other vital statistics, unlike Scandinavian countries. Accordingly, epidemiological studies using these national data sets from abroad are methodologically superior to U.S. data. In a recently published study of 463,473 women using Danish linked birth and death registry records for an epoch of 25 years, when compared to women who delivered, women with TOP < 12 weeks gestation had higher

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pregnancy, irrespective of the duration and site of the pregnancy, for a specified year, and for a specified geographical area.

cumulative mortality rates from 180 days to 10 years later. See: Reardon, D. & Coleman, P. Short and Long Term Mortality Rates Associated with First Pregnancy Outcome: Population Register Based Study for Denmark 1980 – 2004. *Medical Science Monitor*, 2012, 18: PH71—Ph76. In a second study using the same national registries, the researchers again found increased risks of death for women electing abortion compared to childbirth. *See*: Coleman, P. Reardon, D. & Calhoun, B. Reproductive History Patterns and Long-term Mortality Rates: A Danish, Population-Based Record Linkage Study. *European Journal of Public Health* (September 5, 2012, Epub ahead of print). Record linkage studies of the population of Finland and of low income women in California have also reported higher death rates associated with abortion than childbirth. *See*: Gissler, M. et al. Pregnancy Associated Deaths in Finland 1987-1994: Definition Problems and Benefits of Record Linkage. 76 *A Acta Obstetricia et Gynecologica Scandinavica*. 1997, 76: 651-7; Reardon, D. et al. Deaths Associated with Pregnancy Outcome: A Record Linkage Study of Low Income Women. *Southern Medical Journal*, 2002, 95: 834-841.

Short & Long Term Risks of TOP

20. With the caveats identified above, and acknowledging the weaknesses of existing epidemiological research on TOP outcomes, risks from surgical abortion include bleeding, infection, and damage to bowel, bladder, or upper genital tract. Risks from medical abortion include failed abortion, incomplete abortion, bleeding, and infection. Medical termination is associated with a higher incidence of adverse events according to a record linkage Finnish study. *See:* Niinimaki, M. et al., Immediate Complications after Medical Compared with Surgical Terminations of Pregnancy. *Obstetrics & Gynecology* 2009, 114: 795-804. Heavier bleeding and more severe cramping are more common in medical abortion. Complication rates range from 2-10% and most complications can be managed without major surgery. While TOP complication rates tend to increase proportionately with gestational age, the magnitude of risk remains small. After 16 weeks, risks from TOP may exceed the risks of carrying a pregnancy to term and certainly do so by 20 weeks.

21. While there have been numerous claims that TOP has no long-term health consequences beyond the immediate complications identified above, these assertions are based upon the data limitations previously discussed, particularly lack of completeness and the sole use of observational data generated by self-report of TOP exposure. Methodologically sound research has, however, indicated significant associations between TOP and placenta previa, preterm birth, breast cancer, mental health problems, i.e., mood disorders, substance abuse and suicide. *See:* Thorp, J. *Scientifica*, 2012, op. cit.; Thorp, J. Hartman, K. & Shadigian, E. Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence. *Obstetrical & Gynecological Survey*, 2002, 58: 67-79.

The Importance of Hospital Admitting & Staff Privileges

22. Postoperative patient safety is another key factor in this litigation. One of the accepted means of safeguarding patient safety in the management of surgical complications is credentialing and privileging at a local hospital. The granting of admission and procedural privileges by a hospital's medical staff and executive board is an important process that determines which physicians may admit or perform procedures at a given inpatient healthcare

facility. According to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), this process is intended to assure patient safety by permitting only qualified physicians to provide such care. *See*: JCAHO, *Comprehensive Accreditation Manual for Hospitals: The Official Handbook* (CAMH), §§ MS 1.20 (2006). Being credentialed and privileged by a hospital is a necessarily lengthy and detailed process, but not an insurmountable one providing the applicant physician is a graduate from an accredited medical school and residency, is board eligible or certified, competently trained and experienced, has no history of violations of practice standards and holds state licensure in medicine. All competent physicians endure the "burdensome" nature of applying for hospital privileges for the safety and well-being of their patients.

23. Hospitals have a duty to protect their healthcare organization, their patients, and their reputation, and to avoid legal liability, exclusion from federal and state program participation, and/or loss of accreditation caused by association with incompetent and low-quality providers. As corporate health care providers, these organizations are themselves subject to surgical case reviews, mortality and morbidity review, adverse patient outcomes reporting, all of which may be negatively affected by unqualified providers. This is the practical and functional system of inpatient health care delivery that all physicians, including TOP providers, are subject to and accept.

24. Serious complications can only be evaluated in full service hospitals and often occur after regular business hours. Given the frequency of short-term complications from TOP (2-10%), follow-up medical care is often needed on an urgent basis to treat infection, bleeding, or organ damage. If recognized and attended to promptly, long-term sequelae can be minimized. Often, TOP procedures are performed in freestanding clinics during weekday hours and complications are managed in urgent care centers or emergency departments after hours or on weekends. Thus, it is important that the ob-gyn inducing the TOP have admitting and staff privileges at a local hospital to reasonably meet the health care needs of his or her patients.

25. When the TOP provider is an ob-gyn and has admitting and treating privileges at a local hospital, he or she is more likely to effectively manage patient complications by providing continuity of care and decrease the likelihood of medical errors. In particular, medication errors resulting from either incomplete medication history taken at admission or from inadequate communication between community and hospital caregivers are one of the leading causes of patient harm in hospitals. This failure to communicate a patient's medication history often results in incorrect drug treatment, and subsequent adverse drug events and potentially life-threatening situations for patients. *See*: Van Sluisveld N. et al., Medication Reconciliation at Hospital Admission and Discharge: Insufficient Knowledge, Unclear Task Reallocation and Lack of Collaboration as Major Barriers to Medication Safety. 12 *BMC Heath Services Research* 2012, 170. Then too, with the stigma and shame associated with induced abortion, many women may be reluctant to even disclose a TOP in accessing emergency medical care which can place them at increased risk.

26. In my medical opinion, I believe most patients would assume that their surgeon for an elective procedure would have both current medical licensure and admitting privileges at an acute care hospital that would allow for the diagnosis and treatment of any unforeseen

complications or harms that could arise from her surgery. Not having these safeguards in place violates the patient's legitimate expectations of safety. The Act conforms to this reasonable patient expectancy of professional competency in their medical provider and the protection of their health and safety.

27. Because the termination of pregnancy is unique in medicine and because it involves the purposeful and irrevocable ending of the life of the ob-gyn's second patient, i.e., the fetus, standards of care should be higher, not lower given the potential life-changing nature of this medical intervention. In the absence of empirical validation of TOP's safety as delineated above, and given the considerable conflicts of interests of TOP providers, it is logical and reasonable to emplace more protections and increased safeguards rather than less. Additionally, women considering TOP are vulnerable and often have not told family members and friends about their decision. Thus, they may be deprived of the social and physical support that other non-TOP patients benefit from when a complication arises after elective surgery. For these reasons and others, the Act protects the best interests and safety of the patients.

28. Furthermore, in my medical opinion, it is reasonable to require the TOP provider to have admitting privileges because the operating surgeon is most familiar with the patient's history, physical exam, and surgical procedure. Thus, he/she is best positioned with that knowledge necessary to diagnose and correct complications that arise. Moreover, he/she has gained that patient's confidence prior to the TOP, and is most familiar with her future reproductive plans. Her future plans are often crucial in decision making when treating a complication.

29. Another reason to require TOP providers at abortion clinics to have admitting and staff privileges at a local hospital pertains to specialty physician coverage. Nationally, 73% of emergency departments report *inadequate* on-call coverage by specialist physicians, including obstetricians/gynecologists who are particularly difficult to secure. *See*: O'Malley, A., Draper, D. & Felland, L. Hospital Emergency On-Call Coverage: Is There a Doctor in the House? *Issue Brief No. 115 Center for Studying Health System Change* 2007 (available: http://www.hschange.com/content/956/956.pdf).

30. Plaintiffs' expert, Dr. Laube in his Declaration ¶ 26, opined that the Act "is at odds" with the emergent practice of using hospitalist/laborist obstetricians. I am unaware of any reliable evidence suggesting patient care improves and patient satisfaction increases when women's reproductive health care or TOP complications are managed by these practitioners who have no prior relationship with their patients and potentially no information on the patient's TOP. In fact, in one study when physicians without admitting privileges had their patients emergently hospitalized and treated by a hospitalist, approximately half of those patients were admitted with at least one medication error. *See*: Unroe, K. T., et al., Inpatient Medication Reconciliation at Admission and Discharge: A Retrospective Cohort Study of Age and Other Risk Factors for Medication Discrepancies. *American Journal of Geriatric Pharmacotherapy*, 2010, 8:115–126.

31. Practitioners in any surgical specialty know that increasing the delay in recognizing and treating a surgical complication increases the damage that can happen to a

patient. Long delays in diagnosis and treatment can indeed convert a minor complication into a major complication or death. This is true as well in TOP related complications. TOP providers having admitting privileges at a hospital local to the abortion mitigates this risk and acts as an important safeguard to protect women's health.

Obstetrician/Gynecologists as TOP Physicians

32. Termination of pregnancy is not a benign medical procedure. In some cases, serious complications, even life-threatening ones, arise and necessitate optimal and evidence-based treatment. Because obstetrician/gynecologists are best trained to perform termination of pregnancy, they are also the physicians who are best prepared to safely treat and manage TOP complications. Obstetrician/gynecologists handle all of the serious complications arising from surgical terminations.

33. An obstetrician/gynecologist focuses on the health of women before, during, and after childbearing years, diagnosing and treating conditions of the reproductive system and associated disorders. It is for this reason that the vast majority of TOP providers are obstetrician/gynecologists. *See*: O'Connell, K. et al., First Trimester Surgical Abortion Practices: A Survey of National Abortion Federation Members. 79 *Contraception* 2009, 387; O'Connell, K. et al., Second Trimester Surgical Abortion Practices: A Survey of National Abortion Federation Members. 78 *Contraception* 2008, 494.

34. Termination of pregnancy is an elective medical or surgical procedure that requires not just the technical ability to complete but clinical judgment in the assessment of the patient, the choice of technique, the setting where the termination is accomplished, and the recognition and management of complications. Failure to exercise clinical judgment, despite technical expertise, can endanger the life and health of the patient seeking termination of pregnancy.

35. The initial assessment of a patient must include a history and physical exam and appropriate diagnostic tests to confirm that a pregnancy exists, determine that it is intrauterine (not ectopic), and estimate gestational age. Contraindications to various methods of termination of pregnancy or recognition of conditions that should alter the physician's approach must be sought for and recognized. These would include congenital abnormalities, common neoplastic conditions such as leiomyomata, multifetal gestations, and placentation problems such as placenta previa or accreta. Underlying maternal medical problems must be excluded or if present, recognized and managed.

36. After the assessment is completed and the termination of pregnancy begun, acute complications that are inherent to all such procedures must be recognized and emergent care provided to prevent permanent disability or death. These complications would include failure to complete the termination with retention of part or all of the pregnancy, perforation of the uterus with or without damage to intra-abdominal organs such as bowel or bladder, and acute blood loss. Delays in recognition or initial management of termination of pregnancy complications can

threaten a patient's life and render her incapable of having children in the future. Obstetrician-gynecologists are those clinicians with the best preparation/education to address these multiple issues and safely perform TOP procedures and manage their complications.

37. Plaintiffs' experts Teresa Huyck in her Declaration ¶ 11 and Dr. Broekhuizen in his Declaration ¶ 9 both assert that all of Planned Parenthood's physicians are either board certified ob/gyns or family medicine and that most have hospital admitting privileges. This is a clear acknowledgement of both the importance of employing ob/gyns in TOP care, and the necessity of having admitting privileges for continuity of care and patient safety. Privileged surgery is one that is generally recognized by the certifying board as falling within the scope of training, practice and competency of the physician providing the care. If TOP providers who are family medicine physicians are unable to obtain local admitting privileges to manage TOP complications and those procedures are best done by ob/gyns by virtue of their training and competency, then patient safety rightly remains foremost and TOP clinics must adapt their hiring policies accordingly.

Miscellaneous

38. Plaintiffs' expert Dr. Christiansen alleges in his Declaration ¶ 14 that in the last eight years, they transferred on average two patients per year to the hospital, with at least half of those being treated in the emergency room and released without being admitted for impatient care. In the U.S., only one-third to one-half of TOP patients return for follow-up care (*See:* Picker Institute, From the Patient's Perspective: Quality of Abortion Care, 1999 at 33, and Grossman, D. et al., Routine Follow-up Visits after First-Trimester Induced Abortion. *Obstetrics & Gynecology* 2004, 103: 738-745), so complications, delayed or otherwise, are unlikely to be known to the TOP provider or administrator, and thus remain unreported.

39. Plaintiffs' expert, Dr. Laube, also alleged in his Declaration ¶ 25 that the American College of Obstetricians & Gynecologists (ACOG) opposes state mandated admitting privileges for TOP providers. Instead, Laube contends that ACOG's *Guidelines for Women's Health Care Manual* and the National Abortion Federation's (NAF) *Clinical Policy Guidelines* are an adequate substitute. I disagree. These guidelines attempt to remove responsibility from the TOP provider and merely exhort TOP clinics to develop vague plans for emergent transfer of care to others. An additional factor should not be minimized. ACOG has a long history of supporting a woman's right to terminate her pregnancy. For example, in 1993 it stated: "The College continues to affirm the legal right of a woman to obtain an abortion prior to fetal viability" (approved by the Executive Board in January 1993 and reaffirmed in July 2011). ACOG's opposition to any statutory regulation of TOP practice is well known; given their long standing advocacy of unrestricted TOP, their opinion on this issue is neither authoritative nor persuasive. The opinions of Planned Parenthood and the National Abortion Federation are even less informative, given their obvious biases and conflicts of interest.

40. Most of the declarations of Plaintiffs' experts assert that because of the Act's required admitting privileges, some abortion clinics will have to close for failure to obtain these privileges and that the consequences will be dire for women. Among the alleged adverse outcomes for Wisconsin women are: they will be forced to self-abort, suffer significant delay,

have to travel great distances and otherwise be unable to terminate their pregnancies, suffer significant and irreversible harm, etc., I am unaware of any credible evidence supporting these assertions. If abortion clinics cannot meet licensure requirements or physicians are unable to obtain admitting privileges, in my medical opinion, women would be safer and better served driving greater distances to ensure their terminations are performed by licensed facilities with credentialed and privileged providers than seeking terminations at more convenient but substandard ones. The Act's admitting privilege requirement helps to ensure quality providers and protect patient safety.

41. With the exception of Dr. Christiansen, none of the Plaintiff abortion providers identify their policies and procedures for managing serious TOP complications, other than making a telephone call to the emergency room physician. *See* Broekhuizen Declaration ¶ 14 and Laube Declaration ¶ 17. The assumption is clear that the communication lines are open and reliably in place between the TOP provider and the emergency room physician or on-call ob-gyn. This has not been my experience. In an attempt to further diminish the inherent responsibilities the operating physician has to his/her patient, Plaintiff Planned Parenthood Wisconsin acknowledges the use of nurses, not TOP physicians, to assess and manage the patient's TOP complications by phone, including referring a patient to the nearest emergency room when a "more acute concern" is present. *See* Broekhuizen Declaration ¶¶ 15-16. This is substandard care. The TOP physician best knows his/her patient's history, physical examination results, and the details of the operation that are critical to the emergency room physician. It is his/her duty to communicate this information, and no one else's.

42. Plaintiffs' expert, Dr. Christiansen argues in his Declaration ¶ 29 that women coming to his TOP clinic after a diagnosis of severe or lethal fetal anomaly will be deprived of the ability to have an abortion and will be cruelly forced to suffer through the demise of a wanted pregnancy over a period of weeks or months. This is untrue. These patients always have the option of obtaining an abortion in a hospital setting.

43. The Act is also medically necessary to prevent itinerant surgeons from being allowed to abandon their patients if complications arise and emergent follow-up intervention is necessary. Itinerant surgery was expressly proscribed by the American College of Surgeons at the turn of the last century and remains so today in their *Fellowship Pledge* & *Statements of Principles* believing that the surgeon has a moral, ethical and legal obligation to give patients upon whom he/she has operated his personal attention, and to attend his patients postoperatively (*Available at:* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/about-ethics-group/ethics-resource-center/educational-resources/federation-repository-ethics-documents-online/american-college-surgeons.page; *See also:* McCullough, L., Jones, J. & Brody, B. (eds.), *Surgical Ethics*, Oxford, UK: Oxford University Press, 1998). The Inspector General of the U.S. Department of Health & Human Services in 1989 concluded "There is a higher-than-average risk of poor quality care in itinerant surgery" (*Available at:* http://oig.hhs.gov/oei/reports/oai-07-88-00850.pdf). Wisconsin women expect and deserve to receive responsible medical services which conform to accepted standards of care in medicine, not substandard care offered by unethical itinerant surgeons who fly in and out and leave their surgical complications to hospital providers unknown to the patient. Patient safety and quality of care are inextricably linked, and neither should be compromised.

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

s/John Thorp, Jr., M.D., M.H.S.
John Thorp, Jr., M.D., M.H.S.

Dated: July 13, 2013