UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

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PLANNED PARENTHOOD OF WISCONSIN, Inc., et al.,

Plaintiffs, Case No. 13-CV-465-WMC

vs.

J.B. VAN HOLLEN, et al., Madison, Wisconsin
May 29, 2014
8:12 a.m

Defendants.

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STENOGRAPHIC TRANSCRIPT EXCERPT FROM COURT TRIAL
COURT'S COLLOQUY with DR. SERDAR BULUN, DR. JOHN THORP and DR. DOUGLAS LAUBE
HELD BEFORE CHIEF JUDGE WILLIAM M. CONLEY

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(Called to order.)

THE CLERK: Case No. 13-CV-465-WMC, *Planned Parenthood of Wisconsin, Incorporated, et al v. J.B. Van Hollen, et al.*, called for a third day of court trial. May we have the appearances, please?

MS. FLAXMAN: Yes. Good morning, Your Honor. Carrie Flaxman for Planned Parenthood of Wisconsin. I have Meg Holzer and Diana Salgado with me this morning.

MR. PINES: Lester Pines of Cullen, Weston,

Pines & Bach, LLP, for plaintiff Planned Parenthood of Wisconsin.

MS. PARADIS: Renee Paradis of the ACLU for Affiliated Medical Services. I have with me Jenny Lee and Larry Dupuis of the ACLU of Wisconsin.

THE COURT: For the defendants.

MS. LAZAR: Good morning, Your Honor. Assistant Attorneys General Maria Lazar, Clayton Kawski and Brian Keenan.

THE COURT: Very good. We are here for the third day of trial and we're beginning with a colloquy among experts: Dr. Laube designated by the plaintiff, Dr. Thorp designated by the defendant, Dr. Bulun designated as the neutral expert by the Court.

First, let me start with the most basics of all: do any of you know each other before today? Have you been introduced in any way? Dr. Laube.

DR. LAUBE: Yes, I have met Dr. Thorp casually and I believe about ten years ago we examined together for the American Board of OB/GYN oral examination.

THE COURT: All right. And hopefully that's your recollection as well, Dr. Thorp?

DR. THORP: Yes, sir.

THE COURT: Very good. And Dr. Bulun I think you at least know on paper and by reputation. I'm

confident we have three very qualified experts today and I appreciate your making yourselves available for this purpose. At this time I'm going to ask all of you to please stand, raise your right hand and be sworn by the clerk.

You don't need to show us your right hand, sir. Thank you. I take it on faith. You can hold it. Thank you, sir.

DR. SERDAR BULUN, DR. JOHN THORP and DR. DOUGLAS LAUBE, SWORN

THE COURT: Thank you.

MR. PINES: Could I ask that the witnesses move the microphones closer?

THE COURT: You can. Just hang on a minute. What we are attempting to do today is to have a practical discussion to see where we can reach consensus and, in those instances where we're not able to reach consensus, to try to determine as best we can the reasons for the lack of agreement.

I realize that particularly for the experts retained by counsel that you have played a role as an advocate for a position, although certainly one that you believe to be true, and I understand that you may view that as your role here. And I leave that to you, understanding that everyone is under oath and that this is testimony that I

am eliciting, albeit in discussion form.

And I would ask you to be as cooperative as you can more importantly for purposes of this morning to understand that I'm trying to arrive at the truth. And to the extent everyone can view this as a truth exercise, I would greatly appreciate it.

Do you have your clerk back? Why don't we pause for a moment.

DR. THORP: Yes, sir.

THE COURT: If you could explain to her if there is some way to move the camera angle, I would appreciate it.

THE CLERK: Okay. Where would you like --

THE COURT: I would just like him to be in the center of your shot. He's way off to our left. So if there is some way to make him the center of the shot, that would be greatly appreciated. That's close. If you could focus in a little. Why don't you leave it right there and we'll call this successful. That's too much. Go back out. That's perfect. Thank you, very much. I appreciate it.

We are on the record as we have this discussion. I would hope you would keep that in mind. We have a court reporter who is very talented but who's skills will be challenged by this arrangement. And so I would

appreciate it if you would speak generally when called upon, but certainly to raise your hand or let me know if you think you have something of substance that should be added to improve the discussion.

I would propose that we begin with the outline that Dr. Bulun prepared in response to the Court's questions, understanding that that's just the starting point. The first of those is on the subject of the safety of abortion procedures generally, understanding that there is a disagreement between Dr. Laube and Dr. Thorp as to the relative safety of abortion with respect to both practices -- other practices related to paternity as well as with respect to those practices having -- those surgeries or those procedures not involving pregnancy.

I thought I would start by asking simply, are we in agreement that abortion is a relatively safe procedure? And for that I'm going to start with Dr. Thorp. Would you at least agree that it's a relatively safe procedure?

DR. THORP: I would.

THE COURT: All right. There seems to be where the real disagreement lies over how safe and really over the limited data that's available. I see, Dr. Bulun, that you relied upon certain specific studies and you have had a chance I think to review Dr. Laube's and Dr. Thorp's studies or use of studies in this area which

mainly deal with census study and then studies from the -- and I'm going to get the name wrong -- Guttmacher, the Institute. GI is what it's referred to in most reports.

But do you know if the study that you're using, the Berg-Shulman study, is subject to the criticisms that Dr. Thorp described with respect to the census data and other data? In other words, do you think there's a risk of underreporting of complications and/or of events and, if so, why or why not? This is probably a good example of where a lawyer asks a lousy question.

DR. BULUN: Right.

THE COURT: If it's not a good question, let me know. But what I'm trying to --

DR. BULUN: It's a good question. So if one looks at the *PubMed* database that includes all the studies outside of also published studies, it's very customary in clinical medicine to see some differences between the studies with respect to safety of any procedure.

That's why when I was preparing my report I tried to adhere to major accepted textbooks. And most of the time the experts or authors who write the chapters in these textbooks, they try to cover all the major studies and also they use their common sense to give us some sense so

that that sort of helps us set the standard of care in that particular area.

So I do not recall all the details about the studies that are quoted on each side, but I would -- yeah.

THE COURT: Let me be more specific.

DR. BULUN: Yeah.

THE COURT: There seems to be two primary sources of data. And I guess I'll ask Dr. Thorp (sic) to confirm, when you were quoting your statistics for complications relative to number of procedures you relied I think on the CDC and the Guttmacher Institute's data as the best available data. If that's not fair, please correct me.

DR. LAUBE: That's fair.

THE COURT: All right. And Dr. Laube criticizes that reporting for --

DR. LAUBE: Excuse me, Your Honor. I'm Laube and he's Thorp.

THE COURT: I'm sorry. Dr. Thorp criticizes the CDC -- particularly the Guttmacher Institute because it is -- may have a bent in this area, and the CDC because the data reporting is not as robust or legally required as some better epidemiological studies.

And the question I come back to then is do you think that that's a fair criticism of the reliability of the

studies that you're relying on, do you know if they relied on those studies or if it's fair to say that they're being influenced by those studies and, really, as a science matter, as a medical science matter, are they as good as we have.

DR. BULUN: I think most of these studies are usually as good as we have. I mean, again you can probably pick any study and criticize them. I don't think there is any perfect study with respect to either the method and the biases and how the authors reached these conclusions.

THE COURT: All right.

DR. BULUN: Therefore, I think we can talk forever on these studies. I mean, there are, you know, sciences about how to discuss these studies. But in general, I think a study is a study and most of these studies are consistent with respect to the results and with respect to the results that give or take what I included in my report. I mean, that's --

THE COURT: Thank you.

DR. BULUN: Yeah.

THE COURT: Let me come to you then -- and I will get this right this time, Dr. Thorp -- and ask you, you make a statement in your report that "the CDC relies on state department data which is subject to considerable

underreporting by abortion providers due to the voluntary nature of the reporting." On what do you base that statement?

DR. THORP: On how the CDC describes their database.

THE COURT: Well, in particular the --

DR. THORP: There's no system --

THE COURT: -- in particular the underreporting. You say it underreports. How do you know that it underreports or overreports or, and if so, if it's in one direction or the other?

DR. THORP: Well, it's the basis for why these estimates are probably not accurate.

THE COURT: That's not what I'm asking. I want to be specific. What --

DR. THORP: I'm being specific and I need to be allowed to answer your question. And I'm southern and slow and it's just going to take me a while to get it out, if you could bear with me.

THE COURT: Fair enough.

DR. THORP: I'd like to try.

THE COURT: Yeah.

DR. THORP: If you -- we would all agree that a maternal death is a clearly-defined event: a pregnant woman that dies. It is a clear complication and a

clearly-defined event.

When you rely on voluntary self-reports from clinicians, and that occurs in a system where there are birth certificates and death certificates, you miss half the maternal deaths, a purely hard outcome, and you don't find them.

THE COURT: And from what you -- based on what?

DR. THORP: Let me finish. I'm not done.

THE COURT: I'm sorry, sir, but that's not how this is going to work because we only have two hours. I'm going to have to interrupt you. You base that on what? How do you know that half of the deaths are not reported? What are you relying on?

DR. THORP: Because if you link birth certificates to death certificates within the state of North Carolina, you double the number of maternal deaths that you discover. Half of them are not voluntarily reported. With termination of pregnancy there's no registration system, there's no complication system that records the data, and it's almost certainly underestimated.

THE COURT: All right.

DR. THORP: And I think all experts acknowledge that.

THE COURT: Let me just ask one more

straightforward time. And if you can't answer it, that's fine. On what do you base that? Was there a study done in North Carolina? Did you personally look at these reports? On what are you basing the 50% underreporting other than that's your impression? I assume that you're basing that on something specific.

DR. THORP: I can find you the data and provide it to the Court. It's a well-known fact that complications are underreported, particularly around pregnancy and particularly when complications are voluntarily reported by surgeons --

THE COURT: I'm willing --

DR. THORP: -- so I disagree with those numbers.

THE COURT: And I apologize because this is -- I know you're -- I have read your report. I did not see any reference in the report. There's no notation for that statement. And is there at least something in your -- in the summary of your report that you can point me to that makes this -- that you relied upon; in other words, anything in your *Facts or Data* section; or is it just your impression? Where does it come from; that's all I'm asking.

DR. THORP: It comes from the peer-reviewed literature and I can find it for you and provide it to you.

THE COURT: All right. Do you have your report in front of you?

DR. THORP: Yes, sir. It's not in my report --

THE COURT: All right. Let me then --

DR. THORP: -- that particular reference, but I can get it for you. And I imagine that the two other experts would agree with me that maternal deaths are underreported if they're not systematically searched for and done with vital records linkages. I don't think that's a radical concept to anybody who does what we do for a living.

THE COURT: Thank you. And that is what I was going to ask. And let me start with Dr. Laube. Are you in agreement that there's 50% underreporting of deaths? Let's leave complications -- other complications aside.

DR. LAUBE: Yeah. I agree that there are varied statistics from different states as to the reporting of maternal deaths and I think it probably is underreported to some extent.

THE COURT: Is it agreed -- is it a consensus that it's 50%?

DR. LAUBE: I don't -- there's no consensus that I'm aware of that it's 50% because each state has its own criteria for reporting what a maternal death is in the first place. Some states go as far as 30 days after a

pregnancy event. Some states go longer than that. And in some states, even a car accident for a pregnant women unrelated to her pregnancy is reported as a maternal death if it falls within that time frame. So there are a variety of reasons for the reporting variance among the states.

THE COURT: All right. And what about the other criticism that the CDC data doesn't capture other kinds of complications than death?

DR. LAUBE: Well, I think Dr. Bulun said it correctly that no study is perfect. And the CDC is as good as it gets as it sets standards for recording all of our public health statistics; not only in this country, but the CDC is called upon to do similar things in other countries at their request. So I think the CDC reports as well as it can be done.

THE COURT: What about reporting in Wisconsin, because we have some different rules, including legal requirements? Is there any reason to have more or less confidence in the data from Wisconsin?

DR. LAUBE: I think the data from Wisconsin we can be more confident in because of the way our limited number of clinics do report their statistics.

And I must add that the Guttmacher Institute in fact amplifies what the CDC can do very significantly because

they personally interview, by both questionnaire and by phone, each of the clinics in a teaching institution at least that is associated with abortion provisions. So if anything, I think Guttmacher assists in a positive way.

THE COURT: In terms of the depth of knowledge?

DR. LAUBE: In terms of the depth of knowledge and the number of procedures, the complications short of death, yes.

THE COURT: All right. Dr. Thorp, let me come back to you, first as to Wisconsin. Do you have reason to think that their data is as poor as in North Carolina, given the requirements of specific data reporting that exist in our state? Have you looked at that at all? Do you have any opinion?

DR. THORP: My opinion would be -- and while we were just talking, I Googled "underreporting of maternal deaths" -- there are thousands of articles that support that concept that just interviewing the surgeons is not, and the clinics, is not an adequate way to determine the number of complications.

THE COURT: Well, what is? What would be the accurate way to do it?

DR. THORP: To actually talk to the patients themselves and find out where they went, because many don't go with their complications to the termination

provider; they go elsewhere.

THE COURT: And has anyone --

DR. THORP: And the termination provider may not be aware of the complication.

THE COURT: And has anyone done that? Is there a study that you can point to that you think could confidently be relied upon to determine both number of deaths and complications?

DR. THORP: Well, I think if you go into Scandinavia where people have a unique identifier number and all health events are recorded around that number, you find much higher complication rates than you do in voluntary reporting systems such as exist in Wisconsin and the United States -- and in most of the United States.

THE COURT: And you --

DR. THORP: So I really think the numbers aren't good.

THE COURT: And you quote that at pages 5 and 6 of your report, is that right, the experience in other countries? I know there are two Canadian articles, but you also refer to a Denmark report?

DR. THORP: Yes, sir.

THE COURT: All right. And the numbers that you derive from that are different how?

DR. THORP: Well, because everybody in Denmark has a unique identifier. Their social security number is --

THE COURT: I'm sorry. No, no. That's not my question. What do you conclude from those studies as to what you believe to be the actual, let's start with, death rate?

DR. THORP: Well, I think the death rate is higher than the one in a hundred thousand so widely quoted in the comparing -- for termination of pregnancy in saying that termination is safer than pregnancy.

THE COURT: Dr. Thorp, I'm probably not asking it very well and I apologize. But from those studies, what do you think the rate is? That's what I'm asking.

DR. THORP: I think it's in the 10 to 20 range.

THE COURT: 10 to 20 out of a hundred thousand?

DR. THORP: A hundred thousand.

THE COURT: All right.

DR. THORP: And very comparable to pregnancy.

THE COURT: All right. And which of the studies gives it at a range of 10, which is I think you went from 2% to 10% as a possible range? What study reports a 10% range?

DR. THORP: I don't have them in front of me and we'd need to look at them to get down to specific

numbers. I made a guesstimate estimate at your request. I can find the articles and answer that question specifically.

THE COURT: I'm sorry. You made a --

DR. THORP: An estimate, sir.

THE COURT: I see you're saying today. I'm not talking about today. I mean in your report you adopted a 2 to 10 percent number. Where do you get the 10% at the high end?

DR. THORP: From the articles listed.

THE COURT: Which article indicated a 10% risk per hundred thousand or 10 per hundred thousand?

DR. THORP: I don't specifically recall which one. I'd have to pull them and look at them.

THE COURT: All right. But your reason for having more confidence in those reports is because it's a larger sample to sample all the entire population and more specific reporting; is that correct?

DR. THORP: Well, I would use the word *linkage*, that the termination is linked to subsequent hospital admissions and death certificates with -- by a unique identifying number, which is a more comprehensive way of looking at what happened than the voluntary reporting or even legally mandated reporting without mandated follow-up in Wisconsin, in North Carolina, in the United

States.

THE COURT: All right. Dr. Thorp (sic), the numbers we're using in the United States grossly understate what the real risks are. Based on these studies; although we're unclear specifically which ones, but based on studies from Danish countries, I gather; it's really -- it could be as high as 10%. Is that -- does that seem like at least a possibility based on what you know about the studies?

DR. LAUBE: It's a possibility, as anything is possible. But again I would reiterate the fact that between the two institutions doing the majority of this reporting that I think it's much more thorough and accurate than Dr. Thorp suggests.

So I don't think it's as high as our maternal mortality rate given viable pregnancies. I still maintain that it is a much safer procedure, both in my own experience of having been a provider as well as my teaching and review of the literature.

THE COURT: And when you say "much safer procedure," you mean than other --

DR. LAUBE: Than other pregnancy outcomes.

THE COURT: All right. In other words, either procedures or bringing a child to term or somewhere in between?

DR. LAUBE: Correct, any pregnancy outcome that will produce either a viable or nonviable fetus or viable baby.

THE COURT: All right. Dr. Bulun, I'm going to turn to you. Can you make some sense -- can you bring any consensus to this discussion in terms of what you think the science tells us about the risks; not just of mortality, but of complications; and those risks relative to other pregnancy outcomes?

DR. BULUN: Sure. First, as a general comment, I'm not sure if it would be useful to compare abortion to other outpatient procedures rather than pregnancy outcomes. I mean, that was my general opinion. Basically --

THE COURT: And I'll come back to that. I want to focus just for a moment and we'll go to that.

DR. BULUN: Okay.

THE COURT: This notion that we don't have any good data as to the relative safety of abortion -- and, Dr. Thorp, I'll come back to you, I'll give you a chance -- as to the relative safety of -- let's start with deaths -- of abortion procedures in this country versus in these Scandinavian reports, is there some reason to believe that there is underreporting and that we don't have good statistics to go by in terms of

relative risk of death?

DR. BULUN: I think the argument is that in Scandinavian countries the statistics are better because they have better health --

THE COURT: Reporting.

DR. BULUN: -- reporting. I think that notion has been around. I'm not sure if the underreporting in the U.S., on the other hand, would, like, increase the numbers of deaths tremendously. I mean, I cannot conceive that, but I guess anything is possible.

To be honest with you, I did not read the reports of these Swedish or Danish studies. I did not come to that. If you wish me to do so, I can do it during the lunch break and produce a more meaningful opinion.

THE COURT: All right. Dr. Thorp, you had wanted to say something more on this subject.

DR. THORP: Well, you just used in your question to Dr. Laube a death rate of 10 to 20 percent. The estimate I rendered was 10 to 20 per hundred thousand, which is dramatically different.

THE COURT: No, I'm sorry. If I did -- what you had said in your report was 2 to 10 or I think you actually used 2% to 10%. But I understand we're talking about 2 to 10 in a hundred thousand. And if I misspoke, I apologize. Was there something more you wanted to add

on this subject?

DR. THORP: For deaths, or for deaths, and that denominator is a hundred thousand, which is dramatically different from a hundred.

THE COURT: All right. And the Canadian study, which seems to confirm a 1.2 to 1.6, you don't rely upon for what reason?

DR. THORP: I haven't said I didn't rely upon it. The Canadian study talks about 1.6 per hundred thousand. I just want you to get the denominator right when you summarize my testimony.

THE COURT: I'm not going to be summarizing your testimony. So you understand, this is simply a discussion. It will be transcribed verbatim. I won't misquote you because you will be quoted directly.

And more importantly, the attorneys are going to have an opportunity to ask you questions when this is done and to tease out any misstatements, if there were any. But I appreciate your being concerned that I may have been misled as to the statistics.

Let me come back then to this -- the next question that was posed to Dr. Bulun, which is this question of the relative complications, number of complications. I guess we'll skip over the second question and go to the third examples of outpatient procedures. This is on the

top of page 3.

Dr. Bulun has indicated what he viewed to be slightly more dangerous or more dangerous comparable and safer procedures. And, Dr. Thorp, you had your own views as to whether those comparisons were accurate which are set forth in your report.

I'm trying to think of the best way to proceed. Dr. Thorp -- or Dr. Laube, you had an opportunity to review Dr. Thorp's report, I'm thinking specifically at page 16, in which he criticizes some of these comparisons. Is there a way to reach any kind of consensus on this subject?

DR. LAUBE: That is, a consensus as to the comparison of abortion with these various procedures listed?

THE COURT: Yes.

DR. LAUBE: Well, I think again, given that these reports; that is, for colonoscopy, egg retrieval and other diagnostic studies like hysteroscopy; are reported as well as they can be reported, again given the fact that these are statistics reported by individual practitioners or groups of practitioners, it's very similar to the reporting done for abortion. So -- which is also done by either facilities or facilities in conjunction with their providers. So I think there is an

ability to come to consensus in comparing these procedures listed in Dr. Bulun's report with that of outpatient abortion.

THE COURT: And, Dr. Thorp, you don't agree?

DR. THORP: Would you refer to me exactly where -- what we are discussing right now? Can I get on that page?

THE COURT: Top of page 3, question 3: examples of other outpatient procedures, both gynecological and nongynecological, that are safer, comparable or more dangerous than abortion. I understood from your report that you don't believe these are -- can be accurately compared against the risk associated with abortion procedures.

DR. THORP: And what page of my report are you making that conclusion from?

THE COURT: I believe it's 16.

DR. THORP: So that's an expert rebuttal report?

THE COURT: No. Your rebuttal report is at page 2, paragraph 7 and 8.

DR. THORP: Paragraph 7 and 8 on the rebuttal report are what we discussed earlier and tried to reach consensus about. I haven't specifically read the neutral expert's -- these articles. I don't know what their follow up was like. I think surgery has risks and

complications and health systems need to be prepared. Physicians who are going to perform elective surgery need to have systems in place to take care of those complications.

THE COURT: And --

DR. THORP: And so in that sense, I think these things are comparable: the colonoscopy, oocyte retrieval, hysteroscopy --

THE COURT: Could you --

DR. THORP: -- and the thermoablation.

THE COURT: Could you at least agree that the data here is *apples to apples*; that is to say, whatever defects you may identify with respect to the risks associated with abortion procedures would be understated with respect to these other procedures as well; so that the Court could at least have confidence in the relative safety of abortion procedures against these procedures?

DR. THORP: That goes exactly against my first statement. I'm not sure it's *apples to apples*.

THE COURT: And why not?

DR. THORP: -- in terms of how -- because I don't know how the follow-up was done in each and every one of them.

THE COURT: Well, assume --

DR. THORP: One is -- the gastroenterology paper

is a prospective report of complications. The oocyte retrieval is a retrospective analysis. The third one is a review. So they are not *apples to apples* by any stretch of the imagination.

THE COURT: Would you at least --

DR. THORP: They're *apples to apples* to me in terms of their elective nature and that they're done in offices.

THE COURT: Would you at least agree that to the extent that the data is taken from the CDC reports for each, that's *apples to apples*? I didn't state it very well. If we're using the same CDC data for each of these procedures, would you at least agree that then we're talking *apples to apples*?

DR. THORP: To my knowledge, these are not CDC data. And the four articles on page 3 are the --

THE COURT: Right. Not my question. My question is if I'm trying to arrive at some sense of the relative safety of abortion procedures against other procedures, both pregnancy and nonpregnancy, would you agree that I can at least rely upon CDC data for each in determining the relative safety of the procedures?

DR. THORP: I don't understand your question.

THE COURT: Dr. Bulun, can you help? I'm probably not stating it very well. Do you understand

what I'm trying to ask?

DR. LAUBE: Yeah. I think we are limited by the number of studies. So what I tried to do is I basically went to the publicly-available database *PubMed* and put the search terms. For example, I mean, these are some of the procedures that came to my mind that could be comparable as outpatient procedures. And I put down the outpatient terms like *complication rates* and *colonoscopy* and I did the same thing for *abortions*. And these are what came up, to the best of my knowledge, so that's the data that we know of.

And again, I was in fact -- I was not that much familiar with the abortion literature. I was truly impressed how large the abortion studies were.

THE COURT: Large in the sense of population?

DR. BULUN: Large in the sense that the number of patients, what we call the number N. Like one study quotes like 170,000 cases. Of course -- and again, if the bias is -- if there's a bias, it can go either way. You can make all sorts of arguments. But the smaller the number, the less the reliability is.

And again, I mean, when I've done my sort of search, I was comparing *apples to apples* because that was what was available. And again, I think we can go on forever and criticize each study. And again, I mean, we do this

all the time in clinical medicine. But for the purpose of providing a common sense for the Court, I can say in good conscience that these are comparable studies. That's what we have.

THE COURT: And in terms of medical science, is there -- is there a consensus as to the relative safety of these procedures against abortion procedures?

DR. BULUN: I'm not sure if that has ever come up until now. And it is -- so I don't recall discussing this with any of my colleagues or anybody, so I don't have an opinion for that. I mean, until this question was posed, I hadn't thought about it that way. But when you asked me, I sort of came up with these.

THE COURT: All right. And did my -- is it possible to compare CDC data for other procedures against the CDC data that --

MS. FLAXMAN: Your Honor?

THE COURT: -- suggests 1 out of a hundred thousand or 1.2 out of a hundred thousand deaths with respect to abortion procedures?

DR. BULUN: I think so, yes.

THE COURT: I'm sorry. Was there a question?

MS. FLAXMAN: I was just mindful of your invitation to clarify.

THE COURT: Yes. Go ahead.

MS. FLAXMAN: I just wanted to clarify, and perhaps the doctors can confirm, that the CDC data relates to mortality --

THE COURT: Yes.

MS. FLAXMAN: -- and the complications are from these other studies.

THE COURT: Yes. Understood. Dr. Thorp, is there anything -- any other studies that you could point me to which would suggest that the risk of complications for these other outpatient procedures are not, on a relative basis, safer, comparable or dangerous -- more dangerous than abortion?

DR. THORP: In your desire for consensus, I will agree that the inaccurate estimates in the neutral expert's reports are equivalent to the inaccurate estimates for abortion. And if you're going to try to come up with a common sense, it's really not fair or accurate, but they came up with the same conclusions. They used different methods and I don't think they're necessarily comparable.

THE COURT: So what I'm hearing is there really is no good data as to the relative risk of deaths of any of these procedures that doctors can rely upon?

DR. THORP: I think these are estimates with inherent limitations.

THE COURT: Well, every estimate is. I keep thinking of Twain's line, "There's lies, damn lies and statistics." But you're working in an art, a science, both art and science, in which you have to make judgments every day based on the estimates, the best reporting.

And I'm trying to figure out if you just don't think any of these reports have any meaning and there's no way to make a relative assessment as to the risks of abortion to other gynecological procedures or nongynecological procedures, there just is no science out there that will permit me to make any judgment in that category; it's just all inaccurate.

DR. THORP: Well, what -- and I'm under oath, so Twain's quote gives me a chill when a federal judge says my testimony reminds him of lies, damn lies.

THE COURT: No, no, no, sir. If that's how you thought I intended it, it was not my intent. My intent was to say the statistics, as a general matter, can be manipulated. And I understand -- and that I think it was Twain's point, too, he wasn't -- if anything, it's suggesting that by not drawing any conclusion from statistics, we're probably better off because nothing is more misleading than trying to derive information from statistics.

But you're living in a medical science where you're

working off probabilities every day and yet you seem to be telling me that there is no data in this area that that can be relied upon; it's all inaccurate. And that's not particularly helpful and also doesn't seem to be consistent with how medical science proceeds every day. I mean, we may not be working on great data, but it works on the best data it has and draws conclusions, as you must in your practice.

DR. THORP: Well, I think we drew a conclusion as a group at the beginning that termination of pregnancy is relatively safe. The law in question doesn't say that it shouldn't be done as an outpatient; it says -- it tries to respond to how to respond to these complications, which I think we will argue about what the precise number is. I think the precise number is a relative -- is irrelevant to taking care of the person who has a complication.

THE COURT: Well, then let's --

DR. THORP: So in that sense, I'm willing to concede that they're comparable.

THE COURT: And so that abortion procedures are safer than other pregnancy outcomes?

DR. THORP: You've made it *safer*. I would say -- and I didn't say "as other pregnancy outcomes."

THE COURT: No, no, you didn't say that.

DR. THORP: I said it's safe --

THE COURT: I'm just trying to find out if there's any more consensus that can be reached. And perhaps your answer is no. I'm just trying to understand.

DR. THORP: Well, my answer pertained to No. 3 and the three elective outpatient procedures that the neutral expert, who's name I'm not pronouncing correctly --

THE COURT: *Bulun*. Have I got that right?

DR. THORP: *Bulun*. I apologize.

THE COURT: Dr. Bulun.

DR. THORP: *Bulun*. I apologize for calling him a *neutral expert* over and over again.

THE COURT: That's all right. At least you didn't call him *Dr. Laube*.

DR. THORP: I know who Dr. Laube is.

THE COURT: Apparently I don't.

DR. THORP: The three outpatient things, I would concede, are roughly comparable, if that's consensus.

THE COURT: And I don't think it is and I'm going to come back to Dr. Thorp (sic) -- I'm sorry, Dr. Laube. I did it again. Dr. Laube, is there some way to make better sense of this in terms of what the science tells us?

DR. LAUBE: Well, I think I'd step back and suggest that, as you alluded to, if we can't rely on these reports as they are for the various procedures -- colonoscopy, oocyte retrieval, thermoablation, hysteroscopy, et cetera -- if physicians could not rely on these reports, there would be absolutely no progress in medicine. People could not practice if one could not believe literature as it's reported through the peer review process.

And more to the point of this trial, the bigger question in my mind is why don't these procedures -- why aren't there laws regarding colonoscopy, hysteroscopy, et cetera, mandating admission privileges to hospitals. So the point is that when we're trying to discuss whether abortion is comparable to these in terms of complications, I think we have to put it into that context.

THE COURT: And, Dr. Bulun, it may be of significance, although I'm not certain, I haven't decided the level of significance in terms of the constitutional law question, but it may be significant the relative risk of abortion versus other procedures, both pregnancy procedures and nonpregnancy procedures.

Is there any consensus -- or does this discussion cause you to want to qualify the conclusions that you

reached based on the data that you originally looked at and the studies that you originally looked at in terms of relative risk?

DR. BULUN: Would you repeat the question?

THE COURT: Sure. It wasn't very well asked. In your conclusion that abortion procedures are relatively less risky than the others on the top of page 3 that you cite, does this discussion cause you to change your mind in that regard?

DR. BULUN: No, it didn't. I think again I try to give these examples -- *slightly less*, *equal* and *slightly more dangerous* -- with respect to the numbers that we looked at. But my general opinion is I think all these procedures; including if you, like, clump first and second-trimester abortions together; I mean clearly the first-trimester abortions are incredibly safe, like, if you can put that category aside.

But if you put them together, I think all of these procedures are very comparable. And it would be very difficult to make any determination which one would be, you know, safer or more dangerous because, as the experts -- other experts clearly pointed out, there are a lot of inaccuracies. But I think when you look at the data in gestalt, I think you can conclude that they are fairly very comparable procedures with respect to safety.

THE COURT: And, Dr. Thorp, would you agree -- it seemed like you were agreeing in your report and perhaps again I misunderstood -- would you agree that first-trimester surgical abortions are extremely safe or extraordinarily safe, as Dr. Bulun just said?

DR. THORP: I'm not sure that would be the --

THE COURT: Adjective?

DR. THORP: I guess isn't it an adverb, because *safe* is the adjective, *extraordinarily* or *extremely*?

THE COURT: Very good.

DR. THORP: I would say it's a relatively safe surgical procedure. The statement, the first line, "operative colonoscopy is comparable with a complication rate of 5% and a major event rate of 2%," my guess is that the termination of pregnancy things are about there. He says "slightly more dangerous," so he uses an adverb in front of it -- an adjective, and that's fine. I think it's comparable, but I don't think we know with precision.

THE COURT: All right. Why don't we move on to something that we will have greater consensus on, and that is -- hopefully we'll have greater consensus on -- and that is where complications typically present themselves, which is question 2 at the bottom of 1 and top of 2. Are we in general consensus as to where these

events are likely to take place?

And I guess I'll start with Dr. Bulun, if you have a sense, based on your research, as to where complications are likely to present.

DR. BULUN: With respect to, like --

THE COURT: First trimester, second trimester.

DR. BULUN: And is it the temporal relation when or --

THE COURT: Yes.

DR. BULUN: -- would that be in the office or would that be after the patient left the office?

THE COURT: If place is easier to answer, then temporal. But I think we are mainly talking about whether it's likely to present at the clinic where the abortion procedure is conducted or more or less likely to occur after the patient has left either to return to their home or some other place.

DR. BULUN: Right. First of all, if the procedure is a medical abortion, I think almost all the time the complications would present after the patient left the office. It would be in days or weeks after the procedure.

THE COURT: And, Dr. Thorp, you're in agreement with that, I assume?

DR. THORP: Yes, sir. Most of the medical

complications are out of the office. And then within the surgical terminations there's a group of immediate and a group of delayed complications.

THE COURT: Right. And as to the first-trimester presentations, as a general matter, without getting into the specifics, because I know your view is the more serious are likely to present at the clinic, but as a general matter, in the first-trimester surgical abortions, was there any consensus, Dr. Bulun, as to where those are likely to present?

DR. BULUN: I'm not sure if there's a consensus. But I'm not aware of any data that looked at when or where they would be presented --

THE COURT: All right.

DR. BULUN: -- so I really don't know.

THE COURT: Dr. Laube, any thoughts from your perspective?

DR. LAUBE: Well, I agree with the medical abortions, almost by definition they will occur outside the clinic because that's where the second medication is given.

With surgical abortions I don't think there is a consensus, although I can tell you that in my personal experience, the occurrences in the clinic, either as the procedure is being done or shortly thereafter, are much

less than the complications -- many fewer, I should say, than the complications that are perceived by patients after they have left and have left the facility and either gone -- and gone to their respective homes.

Most of these then, when one talks about where they're treated, they're either treated in the emergency room or in the doctor's -- or the provider's office, depending on when they're occurring, and can be dealt with that way without requiring hospitalization.

THE COURT: What about the opinion -- and, Dr. Thorp, I'll give you a chance to correct me if I misstate it -- with the opinion that the more serious of the complications are likely to present immediately at the clinic where the procedure is performed?

DR. LAUBE: I don't think there's consensus on that because the more serious complications that could occur with the procedure in the clinic are generally those that are surgical misadventures, which are very rare. The more serious complications that could occur outside the clinic would include those that have bleeding or those that have infection. So I don't think that there's a consensus that one could quantify one site or the other.

THE COURT: Dr. Thorp.

DR. THORP: I think it depends on the

complication. As Dr. Laube and Dr. Bulun I think both said, infection, almost my definition, is going to occur outside the clinic. Bleeding, retained products, perforation of the uterus can -- while retained products and perforation occur in the office, they all aren't necessarily recognized in the office and can be recognized as a delayed manifestation. A cervical laceration may or may not be recognized in the office. So it's a mix between what can be cared for at the event or at the operation and what will need care thereafter.

THE COURT: And do you have any opinion as to whether more serious complications are likely to present at the clinic or after?

DR. THORP: I don't know how I would determine what was more serious and what wasn't. An infection that threatened a women's future fertility I think most people would describe as serious. And how to compare it to a perforation in the office as -- I think people won't -- I won't mind elective surgery to not have a complication either in the office or outside the office.

THE COURT: All right. Before I switch to the fourth question, there was a procedure that's been discussed during the course of testimony that we didn't talk about, which was the LEEP procedure. I assume each of you is familiar with that procedure.

Dr. Bulun, do you know, off the top of your head or by general knowledge, how that would, that procedure, which I understand is generally done outpatient or at a clinic, compares to the abortion procedure in terms of relative complications and seriousness?

DR. BULUN: As any other surgical procedures, LEEP also started originally in the hospitals. And then as physicians figured that these could be done outpatient, I think now it's sort of moved to outpatient.

So when you really look at the studies for any of these procedures, that's also important to figure out some of them are -- some of the complications are reported as inpatient procedures and some are as outpatient procedures, so that's important to point out.

And I don't recall the numbers for LEEP, but I looked at it. I just did not include it in here. From what I could recall, that was a comparable procedure again, I mean. And again, I mean, there could be small bleeding and all the way into getting into the rectum, putting a hole into the rectum, and the patient may die. And all of these things happen in our practices. But if I have to guess, I think it would be comparable to any one of these procedures.

THE COURT: All right. And do either of the other experts disagree with that statement?

DR. LAUBE: I agree that it's comparable.

THE COURT: Yes, Dr. Thorp.

DR. THORP: I would think that LEEP is safer based on two principles, safer than termination: One, it does not invade a sterile body cavity. The cervix is colonized by bacteria, where inside the uterus is not. And two, LEEPs are typically not done as outpatients on pregnant women because of the excessive or the increase in blood flow that pregnancy does to the uterus.

So I think if accurate numbers existed, LEEP would be a safer outpatient procedure than a first-trimester and certainly a second-trimester termination of pregnancy.

THE COURT: And, Dr. Laube, this is a theme that comes up a number of times, this notion that blood flow is greater with a woman -- a pregnant woman. Do you agree with that, those qualifications that Dr. Thorp is making?

DR. LAUBE: Yes. It's basic physiologic fact that blood flow increases with pregnancy for sure, in all the reproductive organs; not only the reproductive organs, but the entire body.

THE COURT: Does that make you rethink your statement that you would expect LEEP to be relatively similar in terms of risk to abortion?

DR. LAUBE: No. I will stand by my opinion because, as Dr. Thorp pointed out, LEEP is rarely done in pregnancy. We've done them in pregnancy out of necessity, but it's not common. So again, it's very similar to the other outpatient procedures that were listed as far as its relative safety, although I don't have absolute numbers.

THE COURT: Dr. Bulun, can you make a sense of the two different views?

DR. BULUN: Again I don't recall any data, accurate data, from the literature regarding LEEP, so I do not --

THE COURT: And I think Dr. Thorp is conceding, as I think was Dr. Laube, there isn't -- he's saying there isn't accurate data.

DR. BULUN: Correct.

THE COURT: But that if he were required to express an opinion, a medical opinion, he would expect it would be safer than an abortion procedure.

DR. BULUN: I don't think it would be safer. I think it would be comparable, again because the numbers are fairly -- I mean, there, you know, there are some error margins, one thing about increased blood flow during pregnancy and as a physiologic concept that could be important.

And, you know, I think it may be studied or -- in the future. But at the end of the day I think what is reported as complications in these publications would be what we have. I mean, that might be a point of concern. But at the end of the day we would go with what is available for us as clinical data.

THE COURT: Dr. Thorp, you're raising your hand.

DR. THORP: Yeah. I'm raising my pencil. I would make one comment about blood flow in pregnancy, given that you said it was a recurring thing, is that it's a well-established fact that of all the blood that comes out of the heart, by the establishment of placentation about 10% of that goes to the uterus, where normally that number is about .1%.

So there's a massive, an exponential, rise in blood flow to the uterus that our very existence depends on, because it's going to grow, feed, and oxygenate a baby. And I think we can have consensus about that fact. About how it applies to complications, we may disagree.

THE COURT: Dr. Laube.

DR. LAUBE: There's just one other basic difference. I agree with Dr. Thorp about the changes in blood flow to the reproductive tract. But there is a basic difference in the mechanism of blood loss during either a LEEP or an abortion.

A LEEP, the danger in blood loss with a LEEP procedure is direct vascular bleeding from the tip of the cervix from the arteries that supply the cervix, whereas the control of blood after a suction abortion is by contraction of the uterus and the closing off of the venous sinuses. So mechanism of action is considerably different in the two procedures, thus making it I think really difficult to make a comparable -- a comparison.

THE COURT: And do you agree with that, Dr. Thorp?

DR. THORP: I'm the person that said we shouldn't compare, so I'm applauding Dr. Laube's conclusion.

THE COURT: All right. Fair enough. We haven't talked about second-trimester procedures, but it seems clear that there's a consensus that the risks increase as gestational age increases -- period increases. Is there reason to think presentation of complications will change in terms of timing in that -- in the second trimester?

DR. BULUN: Again I think the short answer is I do not know. If I would have to guess, you would be able to recognize more complications in the office with second-trimester abortions compared with first-trimester abortions, but this is just a guess. I'm not sure if there's any data to substantiate it.

THE COURT: All right. Dr. Laube.

DR. LAUBE: Yes. I agree with Dr. Bulun that I think, and in my own experience, it is more readily identifiable as a procedure as being done if, for no other reason that one can quantify, the products of conception that are removed more easily as the gestation moves farther along.

I also agree that it's with the literature in that the complication rate from second-trimester abortion, especially late second-trimester abortion, is significantly more than with first trimester.

THE COURT: And late being 20 weeks --

DR. LAUBE: I'm sorry?

THE COURT: -- 23 weeks?

DR. LAUBE: Yes, late meaning past 19 to 20 weeks, up to 22, and it depends obviously on the indication and the state laws.

THE COURT: All right. I can't tell if that's your pen/pencil hand, Dr. Thorp. Is there something you wanted to add or it sounds like there's general consensus on this subject.

DR. THORP: I'm at consensus.

THE COURT: Very good.

DR. THORP: I can't -- one thing I do want to say is Dr. Laube's testimony feeds in and out and I'm

only hearing part of it.

THE COURT: Yeah. He has moved his mike closer and hopefully that will improve.

DR. LAUBE: Is that better?

DR. THORP: Yes, sir. Thank you.

THE COURT: With that, then let me come to the -- let me make sure I get my numbering right.

MS. FLAXMAN: Your Honor, could I make a request of Dr. Thorp? I think he's looking for a binder we provided for cross-examination.

THE COURT: Had you asked him not to do that until cross; was that your concern?

MS. FLAXMAN: That would have been my intent. I didn't know it was going to be right in front of him right now.

THE COURT: I don't -- well, I'm not going to interfere with that at this point. If that was the intent, then it should have been arranged in advance. I don't know if you had specifically instructed that that's how it was to be treated. I'm asking you, had you --

MS. FLAXMAN: My paralegal arranged that. I can't speak to what the actual communications were.

THE COURT: All right. Dr. Thorp, the binder you have in front of you, did you understand you weren't to look at it until cross-examination began?

DR. THORP: It was plopped down here in front of me and I was told to look at it.

THE COURT: Very good. With that said, I want to go to the --

DR. THORP: And, sir, I might add, I was instructed to have a copy of the neutral report and the Eastern District Court will not let me have wireless Internet. And the lady was kind enough to print out the report for me, which has been very helpful in our coliloquy (verbatim).

THE COURT: I'm pleased to hear it. Let me then take you to the question of the value or the purpose, medical purpose, of hospital admitting privileges, which appears at the bottom of page 3. And I thought it might be good to start with some consensus as to what this means.

We've heard various testimony about having staff privileges, having courtesy privileges, having temporary admitting privileges, having refer and follow privileges. Is there any standardized set of terms, Dr. Bulun, as to what it means to have admitting privileges? Is there a way to reach -- is there a term we can use so we're all talking about the same thing? Does it vary by hospital?

DR. BULUN: It does vary by hospital. But again, there are basic principles that most hospitals

use. And there has been, like, recent efforts by the Joint Commission by introducing these methods such as FPPE, and such, that brought more probably standardization to this procedure.

But at the end of the day I think the way I see providing hospital admitting privileges is very specific for that hospital. I mean, basically by providing these privileges to a certain physician that hospital makes sure that their patient population is -- gets the best quality care they can that's coming to that hospital; that's one of the reasons. Another one is the hospital somehow regulates the number of physicians that can practice over there.

And again there are all sorts of different systems that different hospitals use. And it's a very very broad subject and I'm not sure if I'm doing justice by including only three or four examples here. I mean, as a department chair, I deal with it every day. I mean, it takes up almost, like, 5 to 10 percent of my time to provide hospital privileges.

THE COURT: On average, how long does it take to review an application for privileges in your hospital?

DR. BULUN: Probably the process takes about two to three months, one to three months, depending on how quick we can get through some of these procedures.

THE COURT: All right. And is the one-month situation, is that because the applicant is really good about responding or is it just that there's such a straightforward candidate that you're just able to breeze through the procedure? And if it's three months is it because of the applicant delay or because there's sufficient additional concerns that have to be addressed or both? Is there any way to generalize?

DR. BULUN: All of the above. Sometimes, I mean, we put some of the data on our website or we make it available, but it's not apparent to everybody. So, like, first of all the procedure is sort of like a black box for some of the physicians and not for the others.

For example, if a resident is graduating from the same program, this person -- this doctor can talk to other physicians and get more information; whereas somebody coming from outside, it might be more difficult, more challenging: who to call, where to start.

Like, in our case, I work at an academic medical center. And for a physician to have privileges, the physician has to have a faculty appointment at Northwestern University, for example. Once that is fulfilled, then the applicant is referred to the medical staff office of the hospital, which is the affiliated hospital, and in parallel works with another person at

the department who works on the faculty affairs and there's a lot of communication between these two individuals.

And somehow, like, the applicant fills out two different applications and eventually, you know, can move forward. And before the application -- before the applicant gets, like, fully privileged, they also have to go through a FPPE process which comes later. So, you know, I think it's a complex process. And it could be, like, more simple in a community hospital.

THE COURT: If there's testimony here that the process took approximately six months for an outside applicant working in a facility providing abortions, would that seem overly long to you?

DR. BULUN: Six months looks too long, yeah.

THE COURT: All right. And, Dr. Thorp, I'm going to go to you next on this question because in Dr. Bulun's report -- hopefully you've had a chance to look at it briefly -- he lists a number of other factors than qualifications, training, and competence to practice as considerations by a hospital in determining whether to give admitting privileges. Do you agree that there are other factors that are considered besides the qualifications, training, and competence of the physician?

DR. THORP: Well, I would say two big things that are looked at is past malpractice experience and past disciplinary actions.

THE COURT: All right.

DR. THORP: -- talking about other --

THE COURT: I'm going to tell you, those go into quality, in the Court's mind, even if they don't in yours. Let me be more specific. Do you agree that hospitals look to ensure a number of physicians and are less likely to add admitting privileges if they feel like their current number of admitted physicians meets their needs?

DR. THORP: I don't think they can -- I don't think in North Carolina they can reject somebody purely on that economic basis or argument.

THE COURT: All right. And do you know, is there a practice across the country that you're familiar with in that regard? Is it typically something that's considered or not considered?

DR. THORP: I think that there -- I don't -- I've never seen a hospital, never had a resident said, "We will not give you privileges because you -- you would be an economic threat or we've got enough cardiothoracic surgeons or enough GYN oncologists that you can't practice here."

THE COURT: All right. Dr. Laube, you've practiced in Wisconsin for most of your career. Is that consistent with your understanding?

DR. LAUBE: Yes. I have not seen that based on that sort of denial.

THE COURT: So, as a general matter, then admitting privileges are either given or not given based on the quality of the physician and no other factor?

DR. LAUBE: Yes, yes, and the fact that I think the expectation is that most of these credentialing procedures and privileges are granted with the expectation that there will be practice in that hospital, so in another sense it's an indirect economic incentive. But I'm not aware of a direct economic -- a denial based on economic incentive itself.

THE COURT: Some of the testimony has been that there might be qualifying considerations; for example, in one of the doctor's cases here that he was required to be board certified in a specific area, which he was not, and therefore that he was denied on that basis. That's his understanding.

DR. LAUBE: Board certification is a requirement in many hospitals, along with obviously licensure. And the board certification process has to occur in a candidate who has finished an accredited residency, so

accreditation comes into this as well.

A lot of places, particularly underserved places, communities that need physicians, will not have the board certification requirement. But many places where the competition, if you will, for physician placement is high, then the board certification process is a requirement. So that varies from place to place.

THE COURT: Are you familiar with situations where someone is denied because they're board certified but not in a specific area of practice?

DR. LAUBE: I personally am not aware of that, no.

THE COURT: All right. Dr. Bulun, can you add anything further to the discussion? In your experience are qualified physicians generally admitted to or given admission privileges without regard to other considerations?

DR. BULUN: I agree with both of the experts. I've never been aware of any hospital denying privileges based on economic principles or considerations. On the other hand, I have seen examples in which physicians with best academic credentials that match to that particular medical center's mission have been selected.

THE COURT: Have been selected?

DR. BULUN: Have been selected for both, you

know, directly or indirectly for privileging.

THE COURT: And I'm trying to make sense of that with your statement in your report. Now I'm at the bottom of page 3. "In general, the hospital is primarily interested in providing privileges for the procedures that are performed within the facilities." If that's their primary interest, that doesn't sound like necessarily the qualifications of the physician but rather the needs of the hospital.

DR. BULUN: For example, let's say the hospital needs general surgeons who would perform, say, any bowel surgery and things like that. I think the hospital will solicit and, you know, try to recruit physicians and provide privileges in that area. I think that's what I meant.

THE COURT: But let's say that they have -- I don't know, we'll use the example here -- they have, in their view, more than sufficient OB/GYN physicians. In your experience, they wouldn't deny some -- another OB/GYN, board-certified OB/GYN, to the -- to admitting privileges; that's what you're saying?

DR. BULUN: Right. For example, there are closed hospital systems. Like, unless you are employed by that hospital, then you are not going to get privileges in that hospital, right?

So let's just assume that the hospital has X number of dollars to hire ten physicians and they run out of this money and they don't -- they have a fiscal responsibility. They're not going to give any more privileges indirectly. That can happen.

THE COURT: What about in a nonclosed? Let me ask you this: How many, for each of you, how many have you worked in community hospital settings? Have any of you worked in a community hospital setting?

DR. BULUN: I do.

THE COURT: Dr. Thorp, you have?

DR. THORP: Yes, sir.

THE COURT: And --

DR. LAUBE: Yes, sir.

THE COURT: All right. So let's assume a community hospital, which I take it would generally not be a closed system -- is that fair?

DR. THORP: Yes, sir.

THE COURT: All right. -- in that setting you would anticipate that there wouldn't, if I'm understanding you all correctly, you'd anticipate that there wouldn't be any kind of quota or limit or cap on the number of individuals for whom privileges might be given.

DR. BULUN: That's correct.

DR. LAUBE: Correct.

DR. THORP: Yes, sir.

THE COURT: All right. Let me then come to something else that I -- perhaps we can agree on, and that is, in a *perfect world* it would be better to be given treatment by a physician who has admitting privileges in an outpatient setting than by a physician who does not. Does anyone disagree with that proposition?

DR. LAUBE: Would you repeat that, please?

THE COURT: Yeah. All things being equal, that it would be better to receive treatment in an outpatient setting from a physician who is certified or given admitting privileges than one who does not have them.

DR. LAUBE: No.

THE COURT: You don't agree with that. And why not?

DR. LAUBE: I don't think the fact that a physician has or does not have admitting privileges speaks to his or her qualifications as a provider of services necessarily. I think that usually that is the case because physicians, by and large, live in communities where, as we've just discussed --

THE COURT: You're just going to need to speak up a little bit.

DR. LAUBE: I'm sorry.

THE COURT: Dr. Thorp is apparently -- we're all hearing you, but Dr. Thorp is apparently not.

DR. LAUBE: Did you hear the first part, John?

DR. THORP: No, sir.

DR. LAUBE: All right. I said no, that I didn't think that admitting privileges, having them or not having them, necessarily spoke to the quality or the qualifications of the provider providing outpatient services.

THE COURT: It could be, however, an indication of it?

DR. LAUBE: It could be, but it's not necessarily so.

THE COURT: So the fact of admitting privileges is -- I guess I don't know why you wouldn't want your doctor to have it if you could.

DR. LAUBE: Well, I think it depends on the nature of the physician's practice. In general, I agree that I don't know why one wouldn't want admitting privileges because there are times in a physician's practice where he or she may want to have that for -- to complete adequate treatment of some condition, for instance.

On the other hand, admitting privileges in a

hospital for physicians who strictly have an outpatient practice is not necessary because it's not anticipated that any services will need to be provided in that facility.

THE COURT: So other than quality or an indication of the quality of the physician -- would everyone agree that admitting privileges is an indicator of the quality of the physician? Is there anyone who disagrees that that's at least an indication that the physician is a quality provider? Would anyone disagree with that proposition.

DR. LAUBE: No.

THE COURT: All right. Are there benefits to being treated by an admitted physician in an outpatient procedure that are not available if that physician has a transfer agreement with a local hospital other than this indicia of quality?

Dr. Bulun, I don't know if you're prepared to answer that, but I'll start with you.

DR. BULUN: Right. This is a complex question. I think, you know, it does make -- for example, I think it depends on the conditions for that particular procedure or services that are provided, I guess.

For example, let's say there are two physicians, they are both providing in vitro fertilization services.

And one has privileges at the nearby hospital and the other person doesn't and their offices are equal distant to the hospital. I would think that the one that has privileges may come with some advantages in that setting.

On the other hand, if the procedure that is provided is very sort of -- it's not a common procedure, just like IVF or abortion, and it's not uniformly privileged across the hospitals, I'm not sure. I mean, it would be very condition dependent.

So I think when you present a question as you did, I think the obvious answer is *yes* in the beginning. But when you, like, really think through some of the particular conditions, I have to think through it a little bit more. It may not be right all the time. I mean, probably 90% of the time it would be correct.

THE COURT: And just so we're clear, you're saying it would be correct that there would be an advantage to having admitting privileges?

DR. BULUN: Yes.

THE COURT: All right. And how do you distinguish that from having a transfer agreement with a hospital?

DR. BULUN: Transfer agreement in the sense --

THE COURT: That's a good point. We haven't really defined that.

DR. BULUN: Yeah.

THE COURT: But if there's an agreement with a local hospital that they will take transfers from this outpatient facility they have advance arrangements for the emergency room to accept; they have a procedure for at least phone discussion with the outpatient provider as to the, you know, hand-off; are there advantages to having admitting privileges over a transfer agreement in that setting?

DR. BULUN: I think in an ideal world both should exist, I guess. Both would be good. But the transfer agreement would be I think the most important one if I have to weigh in one or the other because having admitting privileges may or may not be advantageous to that patient. But if there's a well-established procedure for a transfer agreement, in my mind that would be the most important factor to ensure good quality of care.

DR. LAUBE: Mm-mm.

THE COURT: All right. Dr. Thorp.

DR. THORP: I think that medical staff privileges go beyond the transfer agreement in fulfilling what Dr. Bulun said in the first full paragraph on page 4, "Physician to physician communication is one of the most important requirements for optimal handling of a

complication arising from a procedure." And I have three reasons why I think medical staff privileges are important to that physician-to-physician communication he emphasizes:

One is the widespread use of electronic health records, much of which emanates from Wisconsin and you all have made a lot of money as a state.

Two, and I've not been a departmental chair, as Drs. Bulun and Laube have been, but in terms of staff discipline, if somebody doesn't come to Northwestern when their patient is admitted in labor or doesn't return calls from labor and delivery, Dr. Bulun has an ability to discipline him or her, to even revoke their privileges and their ability to function.

And three, staff privileges let that clinician participate in the culture of a hospital. They understand the things that are going on: we're remodeling four ORs today, or this week, and are only going to do essential surgeries; there's a problem in the blood bank; whatever. They participate in the culture and communication of a community and medical staff as opposed to just sending a patient to a *black box*, which to me is all a transfer agreement puts into place. Thank you.

THE COURT: In the case of a physician who's been required to get hospital privileges but is only

going to refer a single patient a year or two patients a year, would you agree that the third factor really doesn't have any role?

DR. THORP: I think it has a crucial role in knowing what is going on at the hospital.

THE COURT: How would they know if they're not -- how would they know that if they're never there?

DR. THORP: Well, physician medical staff, and I know it's true at my hospital and I assume at Northwestern and the University of Wisconsin, communicate important things about the hospital, the community: We're having a Middle East respiratory virus outbreak and things that are important to that medical staff to know what's going on within that hospital.

So I don't think you have to go to the hospital and admit a patient to know that, I think you have to be privy to the communications of the medical staff, and I think that's important to physician-to-physician communication.

THE COURT: All right. Dr. Laube.

DR. LAUBE: I would say that transfer agreements are extremely important, and particularly for the provider who is only practicing in outpatient procedures, because the transfer agreement provides the communication to a person or persons, other providers, who may in fact

and often are more capable of dealing with the complication than the provider, him or herself, the initial provider.

So, for instance, if a person is practicing only outpatient gynecology and hasn't been to the operating room in the past year and has a complication with hysteroscopy or LEEP, or whatever the other procedures are, or an abortion, and needs to refer a patient to a hospital for admission for further treatment, I think it would be better to have a more capable physician with more experience in doing whatever it is that's needs to be done rather than the provider, the initial provider.

THE COURT: I think what Dr. Thorp was referring to was Epic Systems, but I'm not going to go any further down that road. But what about the benefits of information transfer that may come with admitting privileges?

DR. LAUBE: Well, I think the transfer agreements that represent those facilities, at least in this state, are very explicit, very well detailed and have a certain well-vetted protocol to them so that I think the communication either via that protocol or via the phone is perfectly adequate to deal with the types of rare complications that we're discussing within the context of this situation. So I think a complete

electronic medical record is really a lot of fluff in most of these cases.

THE COURT: And the peer review, the follow-up, the opportunity for discipline of a botched procedure?

DR. LAUBE: I think if a provider were chronically -- had had a number of complications that represented a pattern of poor practice and poor behavior that there would be other mechanisms to deal with that person, particularly through state board actions, so that he or she --

MS. PARADIS: Your Honor, don't I think Dr. Thorp can hear.

DR. LAUBE: I'm sorry.

THE COURT: I understand. Doctor, we're doing the best we can.

DR. LAUBE: It's echoing in here, so I assumed it was loud enough. I said, John, since there are other mechanisms for discipline for providers who do not have hospital privileges through state medical boards for chronic poor practice.

THE COURT: Would you agree that's one benefit you wouldn't get if the physician wasn't admitted or didn't have admitting privileges; in other words, that peer review is one benefit, but it's not --

DR. LAUBE: Yes, yes.

THE COURT: And this notion of participation in hospital culture, do you value that?

DR. LAUBE: Not for a person who's never there.

THE COURT: All right. I'll come back to you, Dr. Bulun. Your initial statement was you thought the transfer agreement was the most important feature. Do the comments made by the other experts change your view as to the relative benefit of a transfer agreement over admitting privileges?

DR. BULUN: My view did not change. I agree that definitely having privileges is not going to hurt. But the single most important action that provides -- saves lives or that provides optimal care for a patient is for the doctor who has conducted the abortion to pick up the phone and speak to the surgeon or the ER doctor who's going to handle the complication.

Sometimes when you look at the electronic records you might miss lab values or you might misinterpret them. So the best information is for these two individuals to speak on the phone, especially, you know, for acute situations.

THE COURT: Dr. Thorp.

DR. THORP: Well, and the transfer agreement only works for the complications that are recognized during the procedure. The later complications, they're

recognized after the person is discharged from the termination facility: the infections, the bleeding, the undiagnosed ectopic, the retained products. The transfer agreement does not help that in any way, shape or form because the person is going to go to the health care facility and not be transferred.

So that crucial phone call that Dr. Bulun identifies, I know I agree with and I'm confident Dr. Laube agrees with, doesn't occur with late complications, only under a transfer agreement.

THE COURT: Assuming that the patient went to the same hospital, which isn't -- isn't the case in at least some of these facilities. Yes, please respond.

DR. THORP: I think usually when you have elective surgery, and my wife just had her fractured humorous repaired two weeks ago, if we had had a delayed complication, we would have gone to the health care. And it was done on an outpatient basis in her case. We would have -- we knew where her clinician had admitting privileges and we would have gone to that emergency room if at all possible rather than a separate one.

So I think that if patients knew that my doctor who operated on me this morning has admitting privileges at Waukegan General that that's where she will try to get to to get her care provided.

THE COURT: Let me follow up on that point. From the comments you've made this morning, what I'm hearing is that no matter what the outpatient procedure, you should -- the doctor should have admitting privileges at a hospital.

DR. THORP: I would agree with that.

THE COURT: All right. Is there any reason why it's more or less necessary for an abortion procedure than for others?

DR. THORP: Not that I'm aware of.

THE COURT: All right. Anyone want to add to the general discussion on that subject?

DR. LAUBE: Just briefly. The only -- I agree with Dr. Thorp that transfer agreements are primarily important for immediate complications. However, the admitting privileges requirement to be within 30 miles does not make any sense for the delayed complications because the woman in Tomahawk who had an abortion in Appleton isn't going to drive back to Appleton; she's going to go to the small hospital in Tomahawk for her initial evaluation. So the hospital to which a patient will present is oftentimes not the hospital to which the physician was required to have privileges.

THE COURT: And, Dr. Thorp, for your benefit, that would be Charlotte versus Durham. You'd agree --

I'd assume you agree that you would probably go to the, particularly for a serious complication, you'd probably direct your patient to the closest hospital or the closest ER that you had confidence in rather than tell them to drive a hundred miles or more back to the hospital where you had admitting privileges.

DR. THORP: It would be a function of time, but I think -- and distance. So there are certainly, as the Charlotte-to-Durham or Tommyhawk*(ph)*-to-Appleton argument, there would be people who wouldn't go back to the hospital where the clinician had admitting privileges --

THE COURT: Sure.

DR. THORP: -- but many would.

THE COURT: Sure. I'm tempted to ask you all about midwives. But I think that's just going to open a whole other set of problems, so I'm not going to go there.

DR. LAUBE: You better not go there.

THE COURT: I think instead what I'll do is try to focus on the admitting privileges within 30 miles, although I think we pretty much covered this issue. Dr. Bulun describes it as an arbitrary distance.

And I don't want to put words in your mouth, Dr. Bulun, but that to the extent there's a major benefit

to admitting privileges, it's that it ensures or it's an indication of the quality of the physician. But would you agree having admitting privileges within some reasonable distance, whatever that might be, the procedure is an advantage?

DR. BULUN: Yes, yes. I mean, I don't know what that distance would be. And, for example, I think here it would be different in a rural area. But in a large city, for example, there are so many hospitals, it would be meaningless to put a, you know, a distance like a number of miles. Whereas here I'm not that familiar with the geography and so I think to me it didn't make sense when I first looked at it. But it may or may not. I mean, but the answer to your question is *yes*, it might provide some benefit.

THE COURT: All right. Dr. Laube, I take it from your earlier comments that you don't think it's particularly important that the physician have admitting privileges, a physician performing an outpatient procedure have admitting privileges in a hospital relatively close?

DR. LAUBE: No.

THE COURT: For the reasons you've already indicated?

DR. LAUBE: Correct.

THE COURT: And, Dr. Thorp, you clearly view that differently?

DR. THORP: Yes, sir.

THE COURT: And I don't think we need to spend more time on why. Would you all agree that abortion providers are under pressure through harassment, publicity, business pressures that other doctors do not face? Is there anyone who disagrees with that statement?

DR. LAUBE: No.

DR. BULUN: No.

DR. THORP: I would say that anybody who takes a strong stand on either side of this issue risks ostracism, protests, death threats, et cetera. So it's not just the providers of terminations, but those of us who believe that embryos and fetuses have a moral right to existence and are willing to stand up for that belief.

THE COURT: And so you've experienced those pressures because of the public positions you've taken?

DR. THORP: Yes, sir.

THE COURT: All right. Have you experienced pressure on your -- in a professional manner you've experienced ostracism as a professional matter?

DR. THORP: Yes, sir.

THE COURT: Does everyone agree that because of the pressures, there is a declining number of providers

willing to perform abortions in your profession? Does anyone disagree with that statement?

DR. LAUBE: No.

DR. BULUN: No.

THE COURT: Yes, Doctor.

DR. THORP: I would disagree that -- I would agree that there are a declining number of providers. I'm not sure that it's the pressures. I would like to think that our society is progressing in its recognition of what constitutes human life. So I would see the reason for the decline as different than what you stated.

THE COURT: I've heard some fairly compelling testimony from physicians performing this to suggest that they're losing additional physicians and having difficulty recruiting physicians not because of a change in their view of the morality of abortion procedures, but rather because the level of harassment and other pressures are such that it's not worth it or they can't tolerate it. And you disagree with that statement?

DR. THORP: I disagree with that opinion and I don't think they know that. I think that's speculation on their part, just like what I said was speculation on my part.

THE COURT: Dr. Laube, speculation?

DR. LAUBE: No, it's not speculation; it's data.

And I have -- I can cite a specific example in this state within the last ten months of just what you're referring to.

THE COURT: Dr. Bulun, do you view that as an opinion or do you think that's an accurate statement of the status of those people providing abortions now?

DR. BULUN: I think it's a strong opinion. And, I mean -- take that back. I didn't mean to say "strong opinion." I think I would believe that there is a strong connection. I mean, if you see people being killed for apparently linked to abortion, that would scare people off. I mean, that's understandable. Is there any positive science that would link one to the other? I don't know. It's a very highly-charged social issue.

THE COURT: Well, and that's what I guess I'm trying to get at. It looks like where we could agree is that the numbers of abortions are declining in this country. Is everyone in agreement that that's the case?

DR. LAUBE: Yes.

DR. THORP: Yes.

DR. BULUN: Yes.

THE COURT: And it appears, I think everyone could agree, that the number of locations where one can go to obtain an abortion are declining as well, right; everyone agrees?

DR. LAUBE: Correct.

DR. BULUN: Yes.

DR. THORP: Yes.

THE COURT: Where the disagreement apparently lies is why that's occurring. And, Dr. Thorp, I think there's certainly data to support the suggestion that there may be less women seeking out abortions, for whatever reason.

But is there -- is there any consensus in medical science as to the reasons for the concentration of locations for abortions being provided, the concentration of abortions being provided by a smaller number of physicians? And relatedly, is there any data to suggest that illegal abortions are increasing in this country? And I'll start with Dr. Bulun on this subject.

DR. BULUN: I'm not aware of such data. I don't know.

THE COURT: Dr. Thorp.

DR. THORP: I know of no upsurge in illegal abortion.

THE COURT: What about the reasons for the decline, any data that suggests the reasons?

DR. THORP: I don't think there's been a systematic study of clinician attitudes by a so-called *neutral party* that would explore all the various reasons.

THE COURT: Dr. Laube.

DR. LAUBE: I agree that there is no documentation of an increase in illegal abortion. There are, however, qualitative data suggesting the reasons for which there's a declining number of abortion providers. I can cite at least one example of Lori Freedman's studies from the University of California-San Francisco, and in fact a paper that I co-authored a few years ago, suggesting a decline in the number of abortion providers and various reasons for that, co-authored by Dr. Steinauer and Dr. Darney.

So there are data and I have personal experience in all my time since *Roe* in being interested in this issue and being a provider myself and having counselled residents leaving our program over the past 17, 13 -- 30-some years. Many want to go to facilities or to communities where they could, if allowed to, practice abortion, either through local Planned Parenthood clinics or through private clinics, and have been denied that ability because of physician pressures, hospital system pressures, social pressures, et cetera.

And so as I said earlier, unrelated to this case at all, I can cite two examples in another city in this state where this has just happened.

THE COURT: Dr. Bulun, any experience that

you've had with people you've trained who have indicated an interest in performing abortion but have given other reasons -- or given reasons for not doing so other than not wanting to do the abortion?

DR. BULUN: No. I haven't had any direct experience with the subject.

THE COURT: All right. And Dr. Thorp.

DR. THORP: Since Doug was going to talk from personal experience, I can talk from mine. And I've been a resident since -- started a residency in 1983 in a program that was on the very forefront of the -- of legalization of termination of pregnancy in the United States. And I've seen a profound change in the conscience activity of our incoming house officers and medical students and an embrace by a newer generation that a fetus or embryo has ethical rights over and in addition to his or her mother.

So I've seen it from a different perspective. And I think that has something to do with the decline in the number of people willing to provide this elective procedure.

THE COURT: All right. I believe those are the subject matters that I had hoped to cover this morning, but I'm not precluding others that any of the experts feel would be productive to discuss. And I guess I'll

start with the experts for both sides if there's something more you think needs to be amplified either because we can reach consensus or because it may help define where the disagreements are.

Dr. Thorp, understanding that you will be given an opportunity through your counsel and through cross-examination to further delve into these issues, anything more that you think would be productive for us to discuss in this colloquy?

DR. THORP: I think No. 8: "What are the health risks, if any, associated with decreasing access to abortion." And Dr. Bulun notes a significant increase in the number of illegal abortions and ultimately deaths.

I am co-author on a paper from Chile. The first author is Ellard, E-L-L-A-R-D; Coch, C-O-C-H. Chile made abortion or termination of pregnancy illegal in the early 1990s, and rather than see the predicted uptick in maternal deaths saw a continued decline in maternal deaths in Chile after access was severely restricted. And so I'm not sure that that's a true assumption.

When we analyzed what was the biggest predictor of diminishing maternal mortality, it was education of women. And the better educated and empowered women were, the risk of maternal death declined.

Secondly, we have work from Mexico where state by

state there are different restrictions on abortion, some of which outlaw them completely, and there's no correlation with maternal death. So I reject the assumption in No. 8 that the Wisconsin law will decrease access to abortion and that decreased access will result in death or harm.

THE COURT: Well --

DR. THORP: And that would be the only additional thing that I would have to say, sir.

THE COURT: All right. I want to make sure I understand. So your assumption is that if there was decreased access, there wouldn't be any increase in the number of illegal abortions?

DR. THORP: Well, there wouldn't be any access -- there wouldn't be any increase in harm or maternal deaths.

THE COURT: That's not what I asked. Do you have reason to think that there wouldn't be an increase in the number of illegal abortions if its access is decreased?

DR. THORP: Well, I think the more restrictive you make a law, the more likely there are to be violations of the law.

THE COURT: And are you --

DR. THORP: So I agree with your statement.

THE COURT: And are you of the opinion that illegal abortions are going to be as safe, at least in number of deaths, as legal abortions?

DR. THORP: I can tell you that in Chile they did the national experiment. And much more restrictive than this little admission/privilege law would ever be, the exact opposite was seen, Your Honor.

THE COURT: So there were less deaths once it was illegal to perform abortions?

DR. THORP: Yes, sir. The death rate continued to plummet.

THE COURT: And I guess it begs the question, isn't that because they probably -- no one was reporting any deaths related to abortion since it was illegal? Consistent with your general assumption that it's underreported, isn't it really going to be underreported when it's illegal?

DR. THORP: Even if you factored in a 50% underreporting rate, death rates fell. So, no, I don't think that's true. So I reject the final premise that a law like this is going to harm Wisconsin women.

THE COURT: Well, I want to be clear. I'm not talking about the law here. I'm talking about a decreased access to legal abortion would eventually cause more illegal abortion and illegal abortions tend to be

substantially less safe than legal abortions. You disagree with that proposition as well?

DR. THORP: Well, our data disagree with that proposition.

THE COURT: "Our data" being data from Chile?

DR. THORP: Chile, it's published, and plus the Public Library of Science.

THE COURT: All right.

DR. THORP: It's a peer-reviewed journal.

THE COURT: Understood. Dr. Laube.

DR. LAUBE: I can assure you that if it were illegal, there would be a hundred-percent underreporting and not 50% and that the information -- first of all, I'd have to say that there are many abortions going on in Chile and most of which are occurring in Santiago. And we know this from communications by our colleagues who are members of our professional college.

Secondly, I agree with Dr. Thorp that education and empowerment are important, which includes the use of contraception which has a tremendous surge in many Latin American countries.

Thirdly, I can tell you that the world's experience for unsafe abortion contributes approximately 12 to 15 percent of worldwide maternal mortality. And if we can rely on our experience and go back to our experience here

prior to *Roe*, that was this country's experience as well. So we had a tremendous problem before it was legalized and we will have tremendous problems if it is made illegal or if access is denied significantly.

THE COURT: Dr. Bulun, I'll let you have the last word as a neutral expert.

DR. BULUN: And again, I think it would be an unacceptable experiment to, you know, decrease abortion and see if people would die or have, you know, less at this day of age. I think I make my conclusions based on past experience, like, when legal abortion was not available, illegal abortions were still performed, and this caused harm. And again, I mean, should we do new experiments to see if this is correct or not? I don't think so. It's not acceptable. It's not ethical.

I still have the view that if we restrict legal abortion, I don't think abortion will stop and people will resort to illegal abortions. And I think it's reasonable to assume that there will be a higher incidence of septic abortions and other complications. So should we do an experiment for this? I don't think so.

THE COURT: All right. Thank you all for your time. It is 10:15. What I would propose is that we take our break now and then reconvene. And the question is we

have Dr. Bulun on the -- I'm sorry, Dr. Thorp on the line -- I do that again -- Dr. Thorp on the line. Is the preference to proceed with him since he's is on the line and then Dr. Laube; is that the process?

MS. LAZAR: Yes, Your Honor.

THE COURT: All right. Dr. Thorp, we're going to take a break for 15 minutes, so a little bit after 10:30 we will reconvene for your testimony. And I would ask if you could be back about that time. Maybe we will just keep the line open rather than risk any further issues.

DR. THORP: Yes, sir.

THE COURT: And we are then recess. We will reconvene at a little after 10:30 and I will see you all then. And you are free to move about the courtroom. Thank you.

(Recess at 10:17 a.m. until 10:35 a.m.)

(Trial proceedings continued.)

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I, CHERYL A. SEEMAN, Certified Realtime and Merit Reporter, in and for the State of Wisconsin, certify that the foregoing is a true and accurate record of the proceedings held on the 31st day of May, 2014, before the Honorable William M. Conley, Chief Judge of the Western District of Wisconsin, in my presence and reduced to writing in accordance with my stenographic notes made at said time and place.

Dated this 30th day of May, 2014.

/s/

Cheryl A. Seeman, RMR, CRR
Federal Court Reporter