IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

PLANNED PARENTHOOD SOUTHEAST, INC., et al., *Plaintiffs,* v. LUTHER STRANGE, in his official capacity as Attorney General of the State of Alabama, et al., *Defendants.*	)	CIVIL ACTION NO. 2:13-cv-405-MHT-TFM

DECLARATION OF JAMES C. ANDERSON, M.D.

I, James C. Anderson, M.D., declare pursuant to 28 U.S.C. § 1746 as follows:

1. My name is James C. Anderson, M.D. I have personal knowledge of the facts contained in this statement and they are true.

2. I have been retained by the Office of the Alabama Attorney General to render my opinions as to whether or not H.B. 57 is medically reasonable and necessary for the health and safety of women electing abortion.

3. I prepared a report in this case entitled "Rule 26(A)(2)(B) Expert Report of James C. Anderson, M.D.," dated September 8, 2013. That report disclosed the details of my engagement, my qualifications, my opinions in this case (and bases for those opinions), and all other items required by Rule 26; my curriculum vitae was attached thereto. A true and correct copy of that report is attached as Exhibit A.

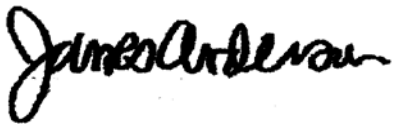
4. I declare, under penalty of perjury, that my September 8, 2013 report is true and correct.

5. In addition, I prepared a supplemental report dated November 22, 2013 entitled "Supplemental Report of James C. Anderson, M.D." in which I disclosed facts and information which support my opinions and that came to my attention after I prepared the report dated September 8, 2013. A true and correct copy of that report is attached as Exhibit B.

6. I declare, under penalty of perjury, that my November 22, 2013 supplemental report is true and correct.

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

Executed this 11th day of December, 2013.



James Anderson, M.D.

EXHIBIT A:

"Rule 26 (A)(2)(B) Expert Report of

James C. Anderson, M.D."

September 8, 2013

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
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RULE 26(A)(2)(B) EXPERT REPORT OF
JAMES C. ANDERSON, M.D.

I. Statement of Opinions and the Basis and Reasons for Them.

1. I have reviewed H.B. 57 (the "Act"), the Plaintiffs' Complaint, and the Declarations of Plaintiffs' experts: Ms. Fox & Ms. Ayers and Dr. Fine, as well as the Expert Report of Dr. Fine. The opinions I express here are based on my education, training and experience, in addition to my ongoing review and familiarity with the medical literature.

2. It is my understanding that Plaintiffs object to the provision of the Act which requires that all physicians associated with an abortion or reproductive health center (ARHC) hold hospital staff privileges in the same local area as the abortion facility as well as being permitted to perform D&C, laparotomy, hysterectomy, and other procedures reasonably necessary to treat abortion-related complications. In my expert opinion, this provision is reasonable and medically necessary to protect women's health in Alabama. Furthermore, it is my opinion that this regulation will most likely improve the quality of abortion care offered in ARHCs and enhance postoperative management of serious complications. The focus of Section 4(c) of the Act is to not to limit abortions but to help ensure a higher standard of care for those

who have complications of abortion. If a physician who does an elective procedure is not available for follow-up care, then the follow-up care has a higher risk of being inappropriately delayed by a patient's isolation and encumbered by no or little communication between the ARHC provider, emergency room physician and called-in subspecialists, usually an Ob-Gyn. These preventable and avoidable time delays in the context of serious abortion-related complications have life-impacting and life-threatening consequences.

3. H.B. 57 is consistent with the standard of care expected of ambulatory surgical care centers regulated by the Center for Medicare and Medicaid Services (CMS). CMS guidelines state that the ambulatory surgical center (ASC) must "ensure that all physicians performing surgery in the ASC have admitting privileges at a hospital that meets the requirements of paragraph (b)(2) of this section."[1] The (b)(2) requirement states that "This hospital must be local, Medicare participating hospital or a local, non-participating hospital that meets the requirements for payment for emergency services under section 482.2 of this chapter."[2] The admitting privileges requirement by the CMS for ASC physicians reflects the importance that the CMS places on the hospital credentialing process required to maintain physician quality and the importance of communication and continuity of care for patient safety and care.

Abortion Complications

4. Plaintiffs' expert, Dr. Fine, asserts in his Expert Report ¶9: "Almost all of the complications associated with medication abortions and surgical abortions through 14 weeks from the last menstrual period (LMP) (as I understand the Plaintiffs perform) can be

[1] *See*: CMS. *State Operations Manual, Appendix L-Guidance for Surveyors: Ambulatory Surgical Centers*, p. 46 (Rev.84., 06-07-13) available at: http://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/downloads/som107ap_l_ambulatory.pdf.
[2] *Ibid.*, p. 46.

appropriately and safely managed by monitoring and/or treating the patient in the abortion clinic." While the majority of these complications can be handled as outpatients, the Act helps ensure a better standard of care for those who have serious enough complications as to need hospital care. This group of patients is the sickest and need specialized care that is timely in an atmosphere of good communication. This is precisely what H.B. 57 Section 4(c) addresses and will help ensure.

5. In his Expert Report ¶6, Dr. Fine asserts that the risk of complications from abortion is low. I disagree with this conclusion. His assertion implies that federal and state data reporting the incidence of abortion complications is available, complete, comprehensive and credible. In fact, there is no mandatory federal reporting system, and many states do not require the reporting of this data as well, including Alabama. In the National Abortion Federation's textbook for abortion practitioners, even Plaintiffs' expert Dr. Stanley Henshaw acknowledges: "The abortion reporting systems of some countries and states in the United States include entries about complications, but these systems are generally considered to underreport infections and other problems that appear sometime after the procedure was performed. In the United States only about one-third of abortion patients return for follow-up care, so delayed complications are not always known to the abortion provider."[3] Another reason for underreporting is that women having abortion complications present to emergency rooms and are understandably reticent to acknowledge having had an abortion. I have had many patients request that I conceal the fact that they had an abortion as part of their medical history, both recent and even abortions from years prior.

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

6. In Dr. Fine's Expert Report ¶¶4-7, he attests to the safety of abortion and the comparative risk of pregnancy. The Act's focus, however, is neither of these two issues. The Act provides a higher standard of care for the patient population that *does* experience dangerous complications of abortion. Even if post-abortion complications may be infrequent, in my opinion this does not justify physician unavailability, poor communication, and time delays to be the acceptable standard of care.

Advantages of the Hospital Staff Privileges Law

7. The Act is beneficial for two main reasons. First, the training and subsequent credentialing of doctors has been a time-proven method to ensure that those doing life-impacting surgical procedures are qualified to do so. Secondly, continuity of care and inter-physician communication have long been recognized as important components of good health care delivery. Even in Dr. Fine's Expert Report ¶10 he states: "the most important factor in ensuring a good outcome for the patient---as it is for any patient who is transferred to a hospital under any circumstances---is continuity of care. Continuity of care should involve direct communication between the abortion provider and the emergency room physician; this is standard medical practice and will ensure that the emergency room physician is aware of the extent of the complication, prior treatment and medication received." This is one of the very reasons that this Act is so important. Since hospital staff privileges have not been required, it is not unusual for abortion providers to simply refer their patients with serious complications to the ED, and then terminate the physician-patient relationship and any attendant responsibilities of care management. This facilitates providers who fly in and then leave after performing abortions. However, this is not consistent with the continuity of care standard that even Dr. Fine recognizes and says is "the most important factor in ensuring good outcome for the patient." To remove or

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

8. Dr. Fine repeatedly refers to patient transfer to the emergency room and then to different needed subspecialists (Expert Report ¶¶11-14). H.B. 57 helps safeguard these transfer-of-care situations by improving relationships accountability, and communication between the different physicians. Without hospital staff privileges, this area of peer-to-peer relationship and communication is diminished and presumption becomes the norm. It seems very inappropriate for a physician to do an elective procedure, receive cash payments and then just expect the emergency physician and hospital staff physicians to manage the post-abortion complications. The consultation and transfer process are often very necessary and appropriate but work best in the context of the peer-to-peer relationship that hospital privileging helps promote. Without implementation of the Act, the status quo is maintained and legalized abandonment is the standard, which is clearly not the optimum standard of care women need and deserve.

9. Dr. Fine also opines that EMT providers "will take the patient to the hospital that they determine the emergency warrants" (Expert Report ¶12). Without necessary qualifications to this opinion, I believe Dr. Fine mischaracterizes EMT practices. Even if he is right, his opinion does not undercut the rationale for the staff privileges requirement. Alabama Department of Public Health EMT protocols stress that the patient's preference (or the patient's family's preference) controls where the patient is transported. Only if these preferences are unknown would the EMT's exercise their own judgment. To use good medical judgment to prevent delayed care in this situation is consistent with the patient's need. This Act in no ways changes their decision-making process. Patient safety is top priority. In my experience, EMTs

make every effort to accommodate patient wishes and physician hospital preference to maintain continuity of care whenever possible. Timely interventions and continuity of care are both desirable but not always possible. Just because both of these are not always possible does not mean that we give up on the optimum possible standard of care. Hospital privileging helps maximize communication potential to minimize time-delays; it does not mandate that patients with post-abortion complications be transferred to one hospital over another.

10. In Dr. Fine's Expert Report ¶¶13-14 he asserts: "staff privileges are also irrelevant to providing optimal care in the event of a complication because, privileges notwithstanding, the physician who provides the abortion may not be the appropriate physician to manage the patient's care in the hospital." I do not agree with this statement. In fact, the Act facilitates physician-to-physician communication when a more highly trained specialist is needed. Staff privileges can actually improve this consultation process because the abortion provider is more likely to know who to consult and has the potential to assist the consultant in many different ways. Dr. Fine's statement illustrates the consultative process within the medical community. Every day physicians are consulting other physicians in patient care when they are out of the realm of their training or need advice. The more experience and familiarity a physician has with a consultant, the better the communication and subsequent outcome by minimizing communication errors and time delays.

11. In Dr. Fine's Expert Report ¶¶13-14 he argues that the Act is irrelevant to providing optimal care because: "In other circumstances, even an experienced ob-gyn might not have the relevant expertise to treat the patient. For example, in the very rare case of uterine perforation with a vascular or bowel injury, it is critical that the appropriate subspecialist treat the patient." Again, in answer to his statement, this Act in no way limits the consultation process

but improves it. In the case of uterine perforation, either with subsequent bleeding or infection, the consultation process needs to be as efficient as humanly possible. A time delay of 1 hour can mean the difference between life and death. Holding local hospital staff privileges is likely to minimize communication errors and time delays. If physicians live long distances from their outpatient abortion facilities, the communication errors and time delays are much more likely to happen. This is not the standard of care that is in the patient's best interest or in the State of Alabama's best interest.

12. Hospital credentialing protects patients. Requiring physicians associated with Alabama's abortion or reproductive health centers to have hospital privileges is consistent with the time-honored practice of requiring training and credentialing of physicians who are making decisions and doing procedures that have life-impacting consequences. If a physician cannot obtain privileges for the specific requested procedures at his or her local hospital, then in my medical opinion, the physician is not qualified to do the surgical procedures that have life-changing or life-threatening impact. Dr. Kermit Gosnell and Dr. Steven Brigham are two notorious examples of providers who did not hold hospital privileges and have injured many of their abortion patients.[4] When investigated, the underreporting of abortion-related complications is also very evident in their clinical practices.

[4] Dr. Gosnell is serving a life sentence in jail after being convicted on three counts of first-degree murder, and other charges including involuntary manslaughter, infanticide, performing abortions past the legal limit in Pennsylvania, conspiracy and running a corrupt organization. *See:* http://usnews.nbcnews.com/_news/2013/05/14/18255789-abortion-doctor-kermit-gosnell-spared-death-sentence?lite. Dr. Brigham has had multiple practice violations including gross negligence from multiple state licensing boards and health departments throughout his career and currently has no license to practice in any state though he continues to operate abortion clinics through his American Women's Services. *See*: http://www.americanwomensservices.com/ and also http://www.nytimes.com/2013/07/11/us/marylands-path-to-an-accord-in-abortion-fight.html?pagewanted=all&_r=0

Hospital Staff Privileges: Maintaining Excellence in Patient Care

13. On page 13 ¶50 Plaintiffs argue in their Complaint: "The staff privileges requirement makes Plaintiffs' clinic licenses contingent on their physicians' obtaining staff privileges at local hospitals, and thereby unconstitutionally delegates standardless and unreviewable licensing authority to private parties." This allegation is erroneous. In fact, the accreditation of hospitals and their operations, procedures and policies is exactly opposite of this statement. As an example, The Joint Commission's (TJC) hospital accreditation process is very thorough, precise and demanding. Its review process includes examining requirements for credentialing and continuing education of hospital staff, all under the umbrella of patient care and advocacy. In 2008 TJC added two significant standards into their hospital accreditation guidelines for physician competency-based privileging: the Ongoing Professional Practice Evaluation (OPPE) and the Focused Professional Practice Evaluation (FPPE). Hardly "standardless and unreviewable," these required hospital accreditation criteria mandate focused and careful determination and review of physician competency.[5] Maximizing patient safety and health is the number one responsibility of the health-care system. Requiring abortion providers to undergo peer review through the local hospital's credentialing process is a standard which is reasonable and appropriate given the gravity and uniqueness of the nature of abortion, and the potentially life-threatening complications that can result for the woman.

14. In my experience, hospital credentialing is generally a more rigorous screening and evaluation of a physician than obtaining state medical licensure. Both state licensing and hospital staff credentialing require proof of education, letters of recommendation, records of continuing medical education and questions about prior malpractice or disciplinary action from

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

prior regulating agencies. Generally however, only hospital staff credentialing requires reporting the number of past procedures performed to verify the experience and training necessary for these specific procedures. Only by reviewing and evaluating this information is the hospital able to verify that the physician has sufficient training and experience to perform the requested procedures. Hospital staff privileges are dependent on this review; so is quality patient care. Since most, if not all hospitals require credential and licensing review every two years, this too helps maintain a quality medical staff and quality patient care. Renewing the medical license in most states, if not all, is only a matter of paying the set fee required by the particular state. In summary, the hospital credentialing process is protective of patient care but not restrictive or onerous for the physician.

15. Hospital staff credentialing protects patients. Requiring physicians associated with Alabama's abortion or reproductive health centers to have hospital staff privileges is consistent with the time-honored practice of requiring training and credentialing of physicians who are making decisions and doing procedures that have life-impacting consequences. If a physician cannot obtain privileges for the specific requested procedures at his or her local hospital, then in my medical opinion, the physician is not qualified to do the surgical procedures that have life-changing or life-threatening impact.

16. In Dr. Fine's Expert report he states ¶20: "HB 57 is also completely out of step with the realities of hospital credentialing. For example, many hospitals require that physicians with privileges admit a certain number of patients each year." I do not agree with the accuracy of this statement. In the two local hospitals where I have had staff privileges since 1979, courtesy staff privileges meet the credentialing requirement of medical staff privileges but do not require a minimum number of admissions, nor the participation in staff-related administrative

responsibilities.[6] It has been my experience that hospitals do try and accommodate physician staff privilege requests once they have demonstrated training/experience and clinical competency. In special circumstances hospitals have different medical staff classifications that allow for patient care without certain other staff requirements, i.e., committee assignments, minimum number of admissions, residence, or taking unreferred call.

17. Another significant reason supporting the need for the Act, paradoxically, concerns the quality of abortion providers. Because of the potential for significant financial gain in the context of a limited number of physicians willing to provide abortions, the potential for conflict of interests is very real. This conflict of interests warrants careful state scrutiny and regulation. Hospital credentialing acts as another layer of protection for patient safety. The best scrutiny is the quality control process of assessing physician credentials, training, and competencies which is inherent in the hospital privileging process. With little to no accountability, the best process for determining physician quality and competency remains that of requiring staff privileges at a local hospital nearby where the surgery is performed. The Act helps ensure quality physicians provide abortion services and therefore better patient care and outcomes, rather than, as Dr. Fine states in his Expert Report ¶27 that the Act is "increasing the obstacles and correspondingly diminishing the number of providers." The limited number of abortion providers in no way justifies a system that allows for poor or substandard care to women.

18. If a physician performing surgical procedures is providing care and is subsequently paid for it, it also makes sense that he or she should assume responsibility for the

[6] A courtesy appointment on a hospital's medical staff is defined by the Alabama Hospital Association: "Physicians and other licensed individuals who meet qualifications for appointment to the medical staff but who admit patients to the hospital only occasionally or act only as consultants and who are ineligible to participate in medical staff activities." Available at: http://www.alaha.org/resources_terms.aspx?id=1143).

management of any complications. To allow the physician to do an elective procedure, as in the case of abortion here, and then not to expect the physician to manage complications encourages patient abandonment. This is not the standard of care nor does it conform to patient expectations or desires.

Continuity of Care

19. Another major benefit of requiring ARHC doctors to have local hospital staff privileges is this maintains continuity of care that ensures better care and minimizes time delays for treatment of critical conditions. Every patient desires and expects to receive care from a physician that they know and trust. This explains why a patient will delay care as long as possible rather than deal with a new physician with whom they have not established a relationship of trust. Likewise, this explains why patients drive distances to be treated by a physician known to them and trusted.

20. Physician-to-physician communication is a very important part of staff privileges. There is a different level of communication between physicians who are on staff together and know each other in comparison with the communication between physicians who do not know each other and are in different geographic locations. When not on staff together, there will not be the same level of communication and relationship between the physicians such that transfer of care is more likely to be encumbered by time delays, poor communication and inaccurate details.[7] Optimal care implies effective communication within any physician team taking care of

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

the patient. There is not a patient in our nation that wants physicians to be non-communicative with their other physicians about their care, especially when dealing with life-threatening issues.

21. Plaintiffs' expert, Dr. Fine, in his Expert Report ¶13 argues "the physician who provides the abortion may not be the appropriate physician to manage the patient's care in the hospital." Many times my patients require a specialist but this does not mean I am not involved. I am very much involved with communicating with the consultant and discussing the treatment options. My involvement is very necessary for timely implementation of treatment as well as communicating the specific areas of my concern. Dr. Fine seems to be saying that the patient just needs to arrive at the hospital and "the healthcare system" will take care of her. Unmentioned however, is the inevitability of time delays and miscommunication of information in the patients' care. The overall management and responsibility of the patient rests squarely on the ethical shoulders of the abortion provider. To support or continue a system where this is not the case, only promotes a greater likelihood of fragmented and poor care.

22. As stated earlier, I have worked in local Emergency Rooms across Virginia for over twenty-five years. Plaintiffs argue that there already is good continuity of care for women with post-abortion complications without the need to establish this requirement of hospital privileges. See: Plaintiffs' Complaint ¶27; Fox Declaration ¶15; Ayers Declaration ¶14, Dr. Fine's Declaration ¶15. Dr. Fine, in his Expert Report ¶10 indicates "Continuity of care should involve direct communication between the abortion provider and the emergency room physician . . ." What should happen and what does happen are two different worlds. While communication is a critical component of health care, it remains a major contributing factor in medical errors. According to The Joint Commission, Hospital Emergency Departments are the source of just over one-half of all reported sentinel event cases of patient death or permanent injury due to

delays in treatment with breakdown in communication being cited in 84% of cases, most often with or between physicians (67 percent).[8] These delays and lack of communication are likely to only be exacerbated by physician unavailability, particularly so when a provider is not local and flies in to perform abortions and then flies out afterwards.

23. Furthermore, after examining Alabama health department data regarding abortion providers, the Alabama Legislature reported in their findings of fact: "That the percentage of abortion or reproductive health centers that have been subject to adverse licensure action vastly exceeds the percentage of facilities in any other category that have similarly been subject to adverse license actions. This alarming level of regulatory non-compliance among abortion and reproductive health centers in Alabama puts abortion patients at unreasonable risk." It is my understanding that these legislative findings form the foundation for this Act.

Management of Serious Abortion Complications

24. I have worked in the Emergency Department for 25 years. When women came to the ER with complications related to an abortion, never once did I receive a phone call initiated by the provider conveying information about the abortion, the young woman's condition or potential complications. I always had to evaluate the situation, come to my own conclusions and initiate what I thought was appropriate treatment. This definitely created some time delays that were not in the patient's best interest. I have called many abortion clinic physicians but never once did the provider come to the Emergency Room to assume care. I have always had to call a staff Ob-Gyn. This then creates another time-delay since the staff physician is taking care of his/her own patients but now must change his/her schedule to assume the care of someone else's

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

patient. These delays can have life-threatening implications when dealing with hemorrhage or infection.

25. Section 4(c) of the Act promotes the State of Alabama's compelling interest in the health and safety of those who experience abortion complications. Even though serious complications are not the routine experience, this does not justify allowing a lower standard of care for patients receiving abortions. Requiring hospital privileges will improve physician review and accountability as well as improve continuity of care that will minimize time-delays when dealing with infection or hemorrhaging.

26. In his Declaration ¶13, Dr. Fine alleges: "Surgical abortion is also comparable to non-gynecological outpatient surgical procedures in terms of risk, invasiveness, instrumentation and duration. For example, the abortion procedures that the plaintiffs perform are comparable in these respects to vasectomy. Physicians can and do safely perform such procedures without hospital staff privileges." In reference to the well-known abortion complication of uterine perforation, Dr. Fine opines ¶19: "in the very rare case of uterine perforation with a vascular or bowel injury, it is critical that a patient be treated by the appropriate subspecialist." This statement contradicts and thus disqualifies his earlier statement that an abortion and vasectomy carry the same risks and potential consequences, and therefore, hospital staff privileges are unnecessary. A vasectomy is performed outside of the abdominal cavity whereas the abortion procedure carries the very real risk of violating the abdominal cavity. These are totally different procedures in term of purpose, risks and consequences. In over thirty years of practice, I have never seen life-threatening hemorrhage or infection as a consequence of vasectomy.

27. Post-abortion complications are serious and can be life-threatening. The two most common of the serious and life threatening complications of an abortion are infection and

profuse post-abortion bleeding. Time delays, as little as one hour (as explained later in this declaration), with these two conditions can mean the difference between life and death. Good communication and relationship between physicians is critical with either of these conditions. Dr. Fine acknowledges that he relies upon his colleagues to manage abortion complications and that they rely upon him for evaluation. *See*: Fine Declaration ¶19. It is this very relationship realm between physicians that this law addresses and helps remediate. When abortion providers have no relationship with local hospital physicians, it is inevitable that poor communication and inaccurate information will impact patient care. Ensuring communication between physicians and health-care facilities has been a major focus in the last decade as a way to reduce patient errors and improve patient outcome. The Act is consistent with this focus.

28. Infection can be the result of bacterial spread from retained fetal parts, uterine perforation, colon perforation or poor uterine contraction and persistent bleeding post-abortion. As in many areas of emergency care, time has been proven to be of critical importance. The amounts of bacteria that invade the blood stream or contaminate normally sterile compartments make the time until initiation of antibiotic treatment the top priority. Uterine perforation or colon perforation can cause an infection which grows and spreads very quickly because so many bacteria are introduced into the abdominal cavity and blood stream. Sepsis is a clinical syndrome that complicates severe infection. It is theorized that the infection sets in motion a massive inflammatory response, "an uncontrolled release of pro-inflammatory mediators that initiate a chain of events that lead to widespread tissue injury. This response can lead to multiple organ dysfunction syndrome (MODS) which is the cause of the high mortality associated with sepsis."[9]

[9] Neviere, R. "Sepsis and the systemic inflammatory response syndrome: Definitions, epidemiology, and prognosis" *UpToDate*, 2012, p. 1.

The mortality rate associated with sepsis ranges from 20-50%.[10] The medical literature affirms the importance of early treatment: "early institution of adequate antibiotic therapy was associated with a 50% reduction in the mortality rate."[11] The medical literature emphasizes the necessity of early intervention in sepsis: "poor outcomes are associated with delays in initiating antimicrobial therapy, even short delays (e.g., one hour)."[12] A retrospective analysis of 2,731 patients with septic shock demonstrates that the time to initiation of appropriate antimicrobial therapy was the strongest predictor of mortality.[13] With this clear emphasis on early treatment to reduce the morbidity and mortality associated with sepsis and severe infection, it is in the woman's best interest to reduce delays in treatment so that medical intervention is not postponed. If the ARHC physician has local hospital privileges, this will reduce potential delays in the initiation of treatment for infection or hemorrhage. As affirmed by the medical literature, as well as my own clinical experience, even short time delays can have life-threatening implications.

29. Post-abortion bleeding, another complication of abortion, can be life-threatening and is hard to recognize in its early stage. Prolonged bleeding can result in the under-perfusion of vital organs, including brain, heart and kidneys, which can have implications up to, and including death. It is very difficult for a woman to be able to distinguish between "normal and acceptable" post-abortion bleeding and dangerous bleeding. Symptoms of early volume loss are minimal because people have such good compensatory circulatory mechanisms to shunt blood from non-essential organs to essential core organs. If bleeding is heavy, a patient can deteriorate in over one hour's time from a fragile but recoverable situation to one of grave or irreversible prognosis. Not all post-abortion bleeding is visible (intra-abdominal bleeding from a uterine vein tear or a

[10] Neviere, R. ibid, p. 4.
[11] Neviere, R., ibid. p. 5.
[12] Schmidt, G. "Management of Severe Sepsis and Septic Shock in Adults." *UptoDate*, 2012, p. 7.
[13] Schmidt, G., ibid, p. 8.

colon puncture involving an artery or vein), but even in the cases in which it is visible (vaginal bleeding from poor uterine contractions, retained fetal parts or infection), a woman cannot accurately recognize what a dangerous amount of bleeding is in order to respond appropriately. Even experienced emergency medical technicians and surgeons often have difficulty accurately predicting the amount of blood loss when viewing the scene or situation. The availability of her operating physician is of utmost importance in the management of her complication(s). The actual degree of blood loss can only be determined by the patient's symptoms, vital signs, organ function and lab values. If a woman knows her physician does not practice at a local hospital, then she is faced at that moment with having to change physicians and possibly have to wait in a crowded Emergency Room to see a doctor she has never met. Both are a hurdle that most patients try to avoid. If the ARHC physician met her at the ER, then a quicker evaluation and lab monitoring is possible and therefore an earlier intervention takes place. If she knows her physician does not practice at the hospital, she will likely put off going to the hospital as long as possible.

30. From both my medical experience and my continuing review of the medical literature, early intervention is paramount in order to reduce morbidity and mortality from massive blood loss.[14] Initiating treatment as fast as possible is of top priority. A drop in blood pressure and increased heart rate are the most common signs of hypo-perfusion but critical hypo-perfusion can also occur in the absence of hypotension as the compensatory circulatory mechanisms try to prevent collapse. The medical literature strongly emphasizes the need for early intervention: "Initial management of the patient with hemorrhagic shock is focused on restoring intravascular volume, maintaining adequate oxygen delivery, and limiting ongoing

[14] Schmidt, G., ibid, p. 10.

blood loss."[15] Additionally, rapid volume repletion is indicated in patients with severe hypovolemia or hypovolemic shock. "Delayed therapy can lead to ischemic injury and eventually to irreversible shock and multi-organ system failure."[16] Early correction of this volume deficit is essential in hypovolemic shock to prevent the decline in tissue perfusion from becoming irreversible.[17]

Ensuring High Standards for Patient Safety

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

32. A tragic example of the need for hospital credentialing and staff privileges is that of Dr. Nicola Riley. She remains licensed to practice medicine in Utah, but not in Wyoming (she voluntarily surrendered her license because of threatened board revocation) and Maryland (her license was permanently revoked). Along with Dr. Steven Brigham mentioned earlier in this report, she would transit in from Utah, perform late-term abortions in Elkton, Maryland, and then return to Utah where she also practices and resides. Though licensed in Maryland at the time, she held no hospital staff privileges there. While being supervised by Dr. Brigham, Dr. Riley performed a late-term abortion on an 18 year old woman and ruptured her uterus and perforated

[15] Colwell, C. "Initial Evaluation and Management of Shock in Adult Trauma." *UptoDate*, 2012, pp. 1-2.
[16] Rose, B. "Treatment of Severe Hypovolemia or Hypovolemic Shock in Adults." *UptoDate*, 2012, p. 1.
[17] Rose, B., ibid, p. 1.

her bowel. Dr. Riley's license to practice medicine in Maryland was irretrievably revoked for failing to have an emergency plan for complications at the Elkton abortion clinic, failing to call for emergency help for at least an hour and a half after perforating her patient's bowel during the procedure, and for transporting her critically injured patient to a nearby hospital in the back seat of a car, thereby compromising the life and safety of her patient. The Board found Dr. Riley's decision and complication management was "not only flawed, life-threatening and unprofessional, but showed poor clinical judgment" (p. 11). The Maryland State Board of Physician's expert, Dr. Coles, testified that Dr. Riley's patient could have suffered internal hemorrhage and bled into the abdominal cavity with her going into shock or cardiac arrest at any time after her critical injuries were sustained prior to her arriving at the ER. Furthermore, Dr. Coles testified and the Board agreed that Dr. Riley's decision was faulty and unprofessional because it involved lifting up a consciously sedated and slumped-over patient in order to move her from the operating table to a wheelchair, from a wheelchair to the car, and from the car onto another wheelchair before arrival at the Union Hospital ER. The patient's bowel, usually in a sterile compartment in the abdominal cavity, was protruding into her unsterile vagina. Dr. Coles opined that lifting her up, putting her in a seated position and moving her around in this manner risked further prolapse of bowel into that area and causing injury to a longer length of bowel. The patient should have been transported lying down on a stretcher in an ambulance to ensure CPR could have been performed if needed, and allow smooth entry into the ER. And finally, a one hour and forty-five minute delay in transporting a patient after discovering a serious complication was also cited as a breach of professional standards.[18]

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

33. Dr. Riley is not alone. The existence of other substandard abortion providers has been discovered. The most comprehensive and detailed listing of these providers I have found is a 2013 report compiled by the Susan B. Anthony List, a pro-life organization.[19] I have also searched pro-choice websites and was only able to find one other website that mentioned "substandard providers." That site was the National Abortion Federation which identified just two providers: Dr. Hermit Gosnell and Dr. Steven Brigham.[20] *See:* http://www.googlesyndicatedsearch.com/u/NAF?q=substandard+providers&sa=Search.

34. One pro-choice website even acknowledges: "So each woman who is thinking about abortion is on her own. And they [women who obtain abortions] may not report substandard care to health authorities because they don't want to jeopardize their own confidentiality. Or they may not even realize that they deserve better." *See:* *http://www.abortioncarenetwork.org/news/secrecy-and-stigma-the-roots-of-substandard-abortion-care*. Indeed women with unwanted pregnancies deserve much better, and in my opinion, they deserve to have providers who are trustworthy caregivers and who are competent,

[19] *SBA Fact Sheet: Abortion Industry Negligence Nationwide.* Available at: http://www.sba-list.org/sites/default/files/content/shared/08.08.13_updated_version_abortion_clinic_violations_fact_sheet.pdf.

[20] Patient safety can be all too easily compromised by physician financial conflict of interests. Dr. Steven Brigham's American Women's Services multi-state abortion businesses are illustrative of the need for hospital staff credentialing and privileging. Under "Employment" on their website, the job specification for physician in 12 clinics identifies: "Lucrative opportunity for Physician with progressive pro-choice women's centers. No on-call responsibility. Any specialty will be considered. All MDs/ODs welcome (including GPs, FMGs and residents). No experience necessary, we will train. Flexible Schedules to accommodate your needs. Great opportunity for MDs in private practice who wish to supplement their incomes, or for doctors seeking a Full-time lucrative opportunity. . . Board eligibility not required." Only two requirements are necessary: "Must have an active license to practice medicine. Must be pro-choice and respectful of women." *See:* http://www.americanwomensservices.com/employment/index.php. For more information regarding Dr. Brigham and his financial ties with both American Women's Services and Associates in Ob/Gyn Care, whose four Maryland clinics were recently suspended by the State for serious and immediate danger to patients, see: http://mobile.nytimes.com/2013/07/11/us/marylands-path-to-an-accord-in-abortion-fight.html?from=health.

peer-reviewed and evaluated by hospital medical staff. This is reasonable and protective of patient safety.

35. The Abortion Care Network cautions abortion consumers: "The quality of care can vary widely among all medical facilities and since many women do not talk about their abortion experiences, it is often difficult to know what to look for when choosing a clinic." *See:* http://www.abortioncarenetwork.org/considering-abortion/choosing-a-quality-clinic. Alabama's experience with the New Woman All Women abortion clinic is an example of this disparity in abortion services and substandard practices, affirming the need for both state regulation and surveillance, as well as consumer education. The Alabama Department of Public Health recently sought a court order to close this clinic having previously issued a 76 page deficiency report that cited multiple violations including:

- Clinic staff was not properly trained to provide safe quality patient care.
- Failure to have policy and procedures related to medication errors and the administration of medications. This resulted in the hospitalization of three abortion patients on January 21, 2012, with one patient placed in ICU.
- There was no documentation that the two abortion providers employed by owner Diane Derzis were even qualified to perform abortions.
- Abortion providers made illegible notations on patient charts that made determining critical information about patient care impossible. In several cases, the abortion provider's notes about patient care and/or condition were completely false.
- Lack of documentation of medications administered.
- Inaccurate preparation and administration drugs resulting in overdoses or inadequate pain management.
- Use of equipment with inspection dates from 2007 or no inspection date at all.
- Failure of on-call nurse to return patient calls, document correct dates on reports, or notify the physician of patient problems.[21]

[21] *See:* http://abortiondocs.org/wp-content/uploads/2012/04/NEW-WOMAN-ALL-WOMEN-20120301l.pdf *and* http://www.sba-list.org/sites/default/files/content/shared/08.08.13_updated_version_abortion_clinic_violations_fact_sheet.pdf

36. In 2000, the Institute of Medicine released "To Err Is Human." The premise of this report is that "the problem in medical errors is not bad people in health care—it is that good people are working in bad systems that need to be made safer. Poor communication, unclear lines of authority of physicians, nurses, and other care providers all contribute to medical errors." With the adoption of H.B. 57, Alabama is improving an inadequate system which essentially allows ARHC physicians to abandon their patients when critically ill after a procedure they performed, as well as continue a system that accepts poor communication as the norm. By not requiring hospital staff privileges for an ARHC physician, the State of Alabama would be in effect contradicting itself by asserting: "The physician who performs an abortion procedure is responsible for ensuring that all patients receive adequate follow-up care."[22] In practice, however, the State is saying the physician has no responsibility for his patient's care when there are critical complications. This essentially points to patient abandonment and constitutes very poor, substandard and fragmented medical care. Abandonment in any other circumstance is considered negligent and cause for malpractice.

37. Currently Alabama Administrative Code 420-5-1.03(6)(b) only requires that an ARHC "have a valid written contract with an outside covering physician." In my opinion, this is insufficient and substandard. Transfer of care many times is necessary but if it is the norm, then it is often just fragmented care. This is not the best quality care as it violates "continuity of care" which is the optimum standard. Under this lower standard, the ARHC physician does not go to the hospital nor is there a mandated specific mechanism for communicating with other doctors/emergency facilities that is time-sensitive and needed for a good transfer of care. Inter-physician communication is critical to good care so relieving the abortion doctor from this

[22] See: Ala. Admin. Code r. 420-5-1.03 (6)(b).

responsibility is inconsistent with the State of Alabama's responsibility to protect its citizens from harmful or substandard medical care.

38. In Dr. Fine's Expert Report ¶¶17-19 he states: "H.B. 57 is completely at odds with the reality of contemporary medical practice, including the trend of dividing ambulatory and hospital care. The model of the community physician who provides all of his or her patient's care –whether inpatient or outpatient—is out of date and no longer the norm." I disagree with Dr. Fine. While the mode of delivery of medical services can vary, the physician's ethical duty to his/her patient remains. Ethical standards affirm the operating physician especially with elective surgery has the duty of care for his/her patient's outcome, and that duty, if at all possible, should not be transferred to anyone else. Thus, in my opinion, Dr. Fine's argument is unpersuasive.

39. The transfer of care of a patient increases the chance of time delays and miscommunication, both of which are detrimental for the patient's health and well-being. In my medical opinion, women seeking abortions deserve better not less care. The improved regulations set forth in the Act can and should make this possible.

II. Facts or Data Considered in Forming My Opinions.

My opinions expressed herein are based upon my 35 years of medical experience, including over 25 years as an emergency room physician. Medical articles and media reports I have considered are provided below, and while informative, are not the sole basis of my opinions. In addition, my opinions are based upon my ongoing review of the medical literature encompassing sources too numerous to list here in full. My opinions are not based solely upon one study or subset of studies, but rather upon the integration of my training, clinical experience, and related medical literature.

Ala. Admin. Code r. 420-5-1.03 (6)(b).

Alabama Department of Public Health, "Statement of Deficiencies and Plan of Correction for New Woman All Women Health Center." March 1, 2012. Available at: http://abortiondocs.org/wp-content/uploads/2012/04/NEW-WOMAN-ALL-WOMEN-201203011.pdf

Alabama Hospital Association. Definition of "Medical Staff, Courtesy." *Terminology: General Terms.* Accessed September 8, 2013. Available at: http://www.alaha.org/resources_terms.aspx?id=1143).

American Women's Services website, accessed September 8, 2013. Available at: http://www.americanwomensservices.com/

Bratu B, "Abortion doctor Kermit Gosnell spared death sentence." U.S. News on NBCnews.com, May 14, 2013. Available at: http://usnews.nbcnews.com/_news/2013/05/14/18255789-abortion-doctor-kermit-gosnell-spared-death-sentence?lite.

Center for Medicare & Medicaid Services. *State Operations Manual, Appendix L-Guidance for Surveyors: Ambulatory Surgical Centers*, p. 46 (Rev.84., June 7, 2013). Available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_l_ambulatory.pdf.

Colwell, C. "Initial Evaluation and Management of Shock in Adult Trauma." *UptoDate*, 2012.

Eckholm E. "Maryland's path to an accord in abortion fight." *New York Times*, July 10, 2013. Available at: http://www.nytimes.com/2013/07/11/us/marylands-path-to-an-accord-in-abortion-fight.html?pagewanted=all&_r=0

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

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

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

Kessler CS, et al. "A prospective, randomized, controlled study demonstrating a novel, effective model of transfer of care between physicians: The 5 Cs of Consultation." *Academic Emergency Medicine*, 2012, 19:969-974.

Maryland State Board of Physicians, "Final Decision and Order of the Maryland State Board of Physicians in the matter of Nicola I. Riley, M.D." May 6, 2013. Available at: http://www.mbp.state.md.us/BPQAPP/orders/D7121305.063.pdf

Neviere, R. "Sepsis and the systemic inflammatory response syndrome: Definitions, epidemiology, and prognosis" *UpToDate,* 2012.

Rose, B. "Treatment of Severe Hypovolemia or Hypovolemic Shock in Adults." *UptoDate*, 2012.

Schmidt, G. "Management of Severe Sepsis and Septic Shock in Adults." *UptoDate*, 2012.

Susan B. Anthony List, *SBA Fact Sheet: Abortion Industry Negligence Nationwide*. Available at: http://www.sba-list.org/sites/default/files/content/shared/08.08.13_updated_version_abortion_clinic_violations_fact_sheet.pdf.

Talbot R & Bleetman A. "Retention of information by emergency department staff at ambulance handover: Do standard approaches work?" *Emergency Medicine Journal*, 2007, 24:539-542.

III. Exhibits to be Used to Summarize or Support My Opinions.

None.

IV. Qualifications, Including a List of All Publications Authored in the Last Ten Years.

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

2. I am a Clinical Professor in the Department of Family Medicine & Population Health at Virginia Commonwealth University School of Medicine. In 2002, I joined the U.S. Army Reserves. In 2005, I resigned from U.S. emergency rooms due to the time demands of my military responsibilities and have served in the emergency departments of the U.S. Army's

Combat Support Hospitals (CSH) while deployed to Iraq in 2007 and 2009. In 2011, I served in the out-patient department at Craig Hospital at Bagram Airfield, Afghanistan. I hold the rank of Colonel, USAR.

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

V. List of All Cases in Which, During the Past Four Years, I Have Testified As An Expert At Trial or By Deposition.

Expert Witness for Defendants. *Planned Parenthood of the Great Northwest et al., v State of Alaska.* Case No. Civ. 3AN-10-12279 CI, Anchorage, Alaska.

VI. Statement of Compensation.

My consultation fees are $300 per hour and $3,500 will be charged per day for time spent testifying either in deposition or at trial. My understanding is that all travel related expenses are also paid for by the State of Alabama.

James Anderson, M.D.

Dated: September 8, 2013

APPENDIX A:

Curriculum Vitae of

James C. Anderson, M.D.

Curriculum Vitae

March 27, 2013

1. Personal Information:

1.1 **James Corr Anderson, M.D.**
1.2 9/23/52 Newport News, Virginia
1.3 United States Citizen
1.4 Married: 38 years to Doris K. Anderson

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

1.5 Home: 2911 Fincastle Court
Midlothian, Virginia 23113
(804) 320-3527

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

2. Licensure:

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

3. Education:

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

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

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

4. Military Service Record:

US Army Reserves: Rank of Col.-
February 2002 – September 2012
Medical Director of Emergency Medical Training of U.S. Army Reserves in Pennsylvania, West Virginia, New Jersey, Maryland and Virginia. Surgeon's Office, 9th Battalion, 80th Division.
(Five Active Duty deployments for 3 months each in Texas during 2003, Germany in 2005, Iraq in 2007, Iraq 2008, Afghanistan 2011)

5. Postdoctoral Training or Special Work Experiences:

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

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

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

6. Academic Appointments:

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

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

7. **Membership in Professional Societies:**

Richmond Academy of Medicine, 1995 - present
Medical Society of Virginia, 1995 - present
American Medical Association, 1995 to present
Christian Medical and Dental Society, 1991 - present
American Academy of Family Physicians, 1998-present
Virginia Academy of Family Physicians, 1998-present

8. **Membership in Community Organizations:**

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

9. **Awards:**

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

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

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

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

EXHIBIT B:

"Supplemental Report of

James C. Anderson, M.D."

November 22, 2013

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

PLANNED PARENTHOOD SOUTHEAST, INC., et al., *Plaintiffs,* v. LUTHER STRANGE, in his official capacity as Attorney General of the State of Alabama, et al., *Defendants.*	)	CIVIL ACTION NO. 2:13-cv-405-MHT-TFM

SUPPLEMENTAL REPORT OF
JAMES C. ANDERSON, M.D.

I. Statement of Opinions and the Basis and Reasons for Them.

1. I have previously submitted a report in this case entitled: "Expert Report of James C. Anderson, M.D." ("Anderson Report"). My qualifications and particulars regarding my participation in this case were disclosed at that time. My Curriculum Vitae was attached to the Anderson Report as Exhibit A.

2. I submit this supplemental report on the basis of new information that has come to my attention after September 28, 2013, when the Anderson Report was submitted.

3. It may be necessary for me to revise or supplement this report based upon material subsequently presented, and I reserve the right to do so. I may also present demonstrative evidence at trial, and I reserve the right to do so.

4. Recent evidence confirms the opinion I previously expressed in the Anderson Report ¶ 16: "It has been my experience that hospitals do try and accommodate physician staff privilege requests once they have demonstrated training/experience and clinical competency."

5. A law similar to Alabama's H.B. 57 which requires physician abortion providers to hold hospital staff privileges was recently implemented in Texas. That law, H.B. 2, requires among other provisions: "A physician performing or inducing an abortion must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced." Planned Parenthood and other abortion providers filed suit against the State of Texas and this litigation is captioned: *Planned Parenthood of Greater Texas v. Abbott*, Case No. 1:13-cv-862. In this matter, I have submitted a Declaration in support of the Defendants, Texas Attorney General Gregory Abbott and others.

6. It is my understanding that the Texas law went into effect October 29, 2013. Yesterday I received an email that informed counsel for the Office of the Texas Attorney General that one of the physicians employed by Plaintiff Planned Parenthood of Greater Texas has secured admitting privileges at a local hospital in compliance with Texas' law and intends to start performing abortions again. This email is attached as Exhibit A. In my opinion, if this physician was able to obtain admitting privileges at a local hospital, it is likely others will be able to do so as well. If H.B. 57 is implemented, I believe the same would be true in Alabama.

7. Additionally, I have recently become aware of a publication of the National Abortion Federation (NAF). NAF is the largest association of abortion providers in the U.S. According to their website: "NAF Provider Members care for more than half of the women who choose abortion each year in the United States and Canada. . . NAF sets the standards for abortion care in the U.S. and Canada." Available at: http://www.prochoice.org/membership/process.html. In 2000, NAF produced a women's guide for finding quality abortion providers entitled: "*Having an Abortion? Your Guide to Good Care.*"

Under the section "Finding a Doctor & Facility" are the following recommendations for selecting a TOP provider:

> "Make sure the person performing the abortion has these qualifications: She or he should be a physician who is licensed by the state. In a few states, other medical professionals may perform abortions legally. *In the case of emergency, the doctor should be able to admit patients to a nearby hospital (no more than 20 minutes away).*" [emphasis added]

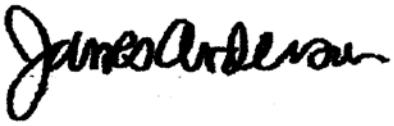
8. This NAF guide for women seeking quality abortion care corroborates that abortion providers, and their national advocacy association, have long known and respected the importance of "good care" and what standard of demonstrated physician competency is most likely to protect the patient's health and safety and ensure quality reproductive healthcare services. Most particularly, in this patient guide, NAF directly instructs abortion-seeking women that in medical emergencies resulting from an abortion, the consumer is directed to "[m]ake sure" the physician performing the abortion has local hospital admitting privileges. This admission confirms the opinions I have previously submitted in the Anderson Report and acknowledges the critical importance of abortion providers holding the highest standard of physician competency for patient safety, i.e., local hospital staff privileges.

II. Facts or Data Considered in Forming My Opinions.

In addition to the sources set forth in the Anderson Report, the facts or data informing my opinion include the following:

- Electronic mail from H.T. Krasnoff to A. D'Andrea regarding *Planned Parenthood v. Abbott,* November 21, 2013.

- National Abortion Federation (2000). *"Having an Abortion? Your Guide to Good Care."* Available at: http://web.archive.org/web/20000918203719/http://prochoice.org/pregnant/goodcare.htm



James Anderson, M.D.

Dated: November 22, 2013

EXHIBIT A:

Electronic Mail

From:

Ms. Helene T. Krasnoff

Assistant Director, Public Policy Litigation & Law

Planned Parenthood Federation of America

To:

Mr. Arthur D'Andrea

Assistant Solicitor General

Office of the Texas Attorney General

Dated:

November 21, 2013

From: Krasnoff, Helene [mailto:helene.krasnoff@ppfa.org]
Sent: Thursday, November 21, 2013 1:11 PM
To: D'Andrea, Arthur
Cc: Janet Crepps; Mitchell, Jonathan; Lionberger, Philip; Oldham, Andy; Murphy, Michael P.; Klusmann, Beth; Elizabeth von Kreisler; Brigitte Amiri
Subject: Planned Parenthood v. Abbott

Counsel:

I am writing to notify you that a physician employed by Plaintiff-Appellee Planned Parenthood of Greater Texas Surgical Health Services (PPGT) has obtained active admitting privileges, effective November 18, 2013, at a hospital within 30 miles of PPGT's Austin facility. Therefore, PPGT will soon be providing abortions again at that facility. Please contact me if you have any questions about this matter.

--

Helene T. Krasnoff

Assistant Director, Public Policy Litigation & Law

Planned Parenthood Federation of America

202/973-4890

helene.krasnoff@ppfa.org