

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA

PLANNED PARENTHOOD SOUTHEAST, INC.,
on behalf of its patients, physicians, and staff, *et al.*,

Plaintiffs,

v.

LUTHER STRANGE, in his official capacity as
Attorney General of the State of Alabama, *et al.*,

Defendants.

CIVIL ACTION

Case No. 2:13-CV-405-
MHT

**EXHIBITS TO PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION FOR
SUMMARY JUDGMENT AND RESPONSE TO DEFENDANTS' STATEMENT OF
UNDISPUTED FACTS, PART I**

COME NOW the Plaintiffs and file the following Exhibits to Plaintiffs' opposition to Defendants' motion for summary judgment and response to Defendants' statement of undisputed facts, contemporaneously filed herewith (Doc.119).

Amended Z. (Filed Under Seal Pursuant to the Protective Order)

KK. Deposition of June Ayers

LL. Deposition of John Thorp, M.D.

MM. Deposition of Staci Fox

NN. Deposition of Dr. Mary Roe

OO. Deposition of Dr. P1

PP. Deposition of Christopher Duggar, M.D.

QQ. Deposition of Gloria Gray

RR. Deposition of Dr. A

SS. Deposition of Dalton Johnson

TT. Deposition of Barbara Buchanan

UU. Deposition of Kiwana Brooks

Dated: January 16, 2014

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system and service will be perfected upon the following counsel of record on this day the 16th of January, 2014:

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Amended Exhibit Z
(Filed Under Seal Pursuant to
Protective Order)

Exhibit KK

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

PLANNED PARENTHOOD SOUTHEAST,
INC., et al.,

Plaintiffs,

Vs.

CIVIL ACTION NO.
2:13-CV-405-MHT

LUTHER STRANGE, in his official
capacity as Attorney General of the
State of Alabama, et al.,

Defendants.

* * * * *

DEPOSITION OF JUNE AYERS, taken pursuant
to stipulation and agreement before Haley A.
Phillips, Certified Court Reporter, ACCR # 151, and
Commissioner for the State of Alabama at Large, in
the Law Offices of ACLU Montgomery Office, 207
Montgomery Street, Montgomery, Alabama, on
Wednesday, September 25, 2013, commencing at
approximately 8:52 a.m.

* * * * *

1 settled so long ago I don't remember the
2 details. But it had to do with the person
3 who came in the office alleged that the
4 front desk receptionist told somebody that
5 she had come in.

6 Q. I see. So it was violating a
7 confidentiality agreement or something?

8 A. Well, before HIPPA.

9 Q. Got you. Got you.

10 Did you testify at all in that lawsuit?

11 A. No.

12 Q. Okay. Could you talk a little bit about
13 your education background?

14 A. Yes. I graduated from high school, went to
15 Auburn University Montgomery, got a
16 bachelor of science in psychology, and
17 then -- That was in '78 when I graduated.
18 I went back to school in '95 and graduated
19 in '98 with a B.S. in nursing.

20 Q. And what did you do before you got your
21 nursing degree?

22 A. In 1978 when I graduated, I started work at
23 the Reproductive Health Services.

1 A. That's a yes, yes.

2 Q. You're not talking about something that
3 you've done after getting your nursing
4 degree --

5 A. No.

6 Q. -- when you say experience?

7 What is a typical week like at the
8 clinic? So as your job as director, what's
9 your typical week like?

10 A. Each day that we're not actually doing
11 abortion procedures, we'll open up. We see
12 patients at the office for intake, and we
13 usually do that during the morning hours.
14 Afternoon hours are normally taken up with
15 doing whatever we need to do to set up for
16 the next day or set up for the surgical
17 day.

18 Q. And how many days a week do you perform
19 abortions at the clinic?

20 A. Normally one day a week.

21 Q. And when you say intake, what does that
22 entail?

23 A. Intake would be doing -- Obviously,

1 answering the phones and making
2 appointments. But, also, patients in
3 Alabama are required to meet a 24-hour
4 waiting period, so this would be patients
5 that would be coming in for their
6 counseling visit and preoperative visit
7 before the abortion.

8 Q. Okay. Do you -- Do you bring doctors in to
9 do the abortions always the same day of the
10 week or does it vary?

11 A. The day of the week varies depending on
12 their schedule.

13 Q. And so that's depending on when the doctor
14 is available?

15 A. We normally schedule in advance, so -- It's
16 a schedule between the doctor and myself
17 that we work out.

18 Q. What other services do you provide at the
19 clinic besides abortion?

20 A. We do pregnancy tests. We also do routine
21 OB-GYN exams, which means a Pap smear and
22 typically birth control.

23 Q. And birth -- What's encompassed in birth

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[REDACTED]

[REDACTED]

Okay. But besides the fill-in nurse,
all of your other employees live around
[REDACTED]

A. Yes, sir.

Q. Okay. Have you ever hired anyone for any
of these other roles that doesn't live
[REDACTED]
nurse?

A. I can't recall.

Q. Okay. What kind of abortions does your
clinic perform?

A. We perform surgical abortions.

Q. Okay. Could you describe to me what a
surgical abortion is?

A. Surgical abortion is one done by vacuum
aspiration.

Q. Okay. So does that -- Is that the same
thing as an aspiration method?

A. An aspiration method, yes.

Q. What does that mean exactly?

A. It's a suction-type D & C.

1 Q. Okay. Is that manual or machine based?

2 A. It's -- It can be either, but we do a
3 machine based.

4 Q. You only do machine based?

5 A. Yes.

6 Q. Why do you just perform aspiration-style
7 abortions?

8 A. Because that is what we do. We just do the
9 surgical abortions.

10 Q. Have you ever considered doing medication
11 abortions?

12 A. We've considered it, but we've opted not to
13 do it.

14 Q. Why not?

15 A. Just for various reasons. We've had
16 discussions with the physician and the
17 medical director, and it's just something
18 that we've opted -- elected not to do.

19 Q. Was it because of safety reasons?

20 A. I can't tell you what the absolute criteria
21 were that we just rejected it, but -- but
22 it had more to do with -- not with patient
23 safety or the safety of the method. It had

1 Q. Okay. Are you paid -- You're paid the four
2 hundred -- or \$550 up front?

3 A. No. They pay their first 100 when they
4 come for counseling, and the balance of the
5 450 is due when they have the abortion
6 itself.

7 Q. Do you take credit cards?

8 A. We do take credit cards, yes, sir.

9 Q. All right. Do you offer any discounts for
10 financial hardship?

11 A. We can refer to outside sources for funding
12 if the patient is having a financial
13 hardship.

14 Q. How often do you do that?

15 A. Probably 60 to 65 percent of our patients
16 get some economic hardship.

17 Q. Okay. And what -- When you say outside
18 sources for funding, what are those outside
19 sources?

20 A. We give them the numbers to various funds
21 that they might be able to tap into to help
22 them.

23 Q. And so what are the various funds?

1 A. Would be WRRAP and Make a Difference, and
2 the National Abortion Federation has a
3 fund.

4 Q. Okay. And I assume WRRAP is an acronym?

5 A. WRRAP is -- Yes. And I do not recall --
6 It's W-R-R-A-P, or it could be two Ps on
7 the end, but ...

8 Q. Okay. Do they -- Do they usually secure
9 funding?

10 A. In a lot of cases, they do. Most of them
11 will meet the criteria, which means they
12 make less than \$1300 a month. And we do
13 see patients that meet that criteria that
14 have anywhere from no children to ten
15 children.

16 Q. Is that number of current children
17 something that's factored into --

18 A. It's something that's factored into the
19 poverty level, yes.

20 Q. So these funding sources are based on the
21 poverty level?

22 A. My understanding, yes.

23 Q. Okay. So you said that you refer about 65

1 that you pay the doctor more for the
2 abortion that takes a longer period of
3 time?

4 A. Because it takes -- it takes a longer
5 period of time for him to actually do the
6 procedure, and so he gets paid an
7 additional amount.

8 Q. But you pay per procedure and not per
9 doctor time; is that right?

10 A. Correct.

11 Q. Okay. How long have you -- We've already
12 talked about how long you've charged the
13 same amount to the patients. But how long
14 have you kept the same fee structure with
15 the doctors?

16 A. As far back as I can recall.

17 Q. Okay. And when you increased the prices a
18 couple of years ago, did you also increase
19 how much you were paying doctors?

20 A. I don't recall that being part of the
21 discussion. I'm not sure. The doctors
22 that I have working for me at the present
23 time were not the same doctors that I had

1 not performed abortions for probably four
2 years.

3 Q. Okay. And what about Dr. H?

4 A. Dr. H was my medical director, I believe,
5 up until 2007 or 2008. And he passed away
6 in 2010. So -- And at the time, he was
7 working as medical director. He was not
8 doing abortion procedures at that time.

9 Q. But is that the same doctor that was the
10 original incorporator of --

11 A. That was -- Yes. He was my business
12 partner.

13 Q. Okay. What other roles did he have in the
14 clinic apart from being a business partner?

15 A. He was the -- pretty much the sole provider
16 of abortion services for many, many years.

17 Q. And why did he stop doing that?

18 A. He turned 80 and then 85 and decided to be
19 just a medical director. It became
20 physically taxing.

21 Q. So what does Dr. F currently do with
22 respect to your clinic?

23 A. Dr. F is my current medical director, and

1 Q. Have you ever paid him in any other way
2 besides a monthly fee?

3 A. I don't really understand the question. He
4 gets paid a monthly fee for seeing
5 patients.

6 Q. I guess I'm saying that's your current
7 compensation.

8 A. Right. And has been since --

9 Q. Is that --

10 A. -- we signed a contract with him, yes.

11 Q. Okay. When did you sign that contract with
12 him?

13 A. In -- I believe in August of 2006.

14 Q. And you say he also serves as a backup
15 physician; is that correct?

16 A. That's correct.

17 Q. What does he do in that role?

18 A. As -- When I have a patient that calls in
19 that warrants seeing a physician, then he's
20 the physician that I will refer to.

21 Q. Okay. What do you mean by warrants a
22 physician?

23 A. If I'm the person that answers

1 after-hours -- Well, I don't answer
2 after-hours phone calls. I'm the person
3 that answers -- If somebody calls in with a
4 problem, then I'm the person that they call
5 to answer to contact that patient. So when
6 I contact a patient and do an assessment
7 that would require physician intervention
8 or the patient to go to an emergency room
9 or if she were just to show up an at
10 emergency room without calling, which
11 sometimes happens, then he's the person
12 that I would call to see that patient.

13 Q. Do you use an answering service for
14 after-hours?

15 A. We do use an answering service.

16 Q. How does that work?

17 A. The patient calls our number. It's the
18 number to the office. And if they wish to
19 leave just a voice mail, they will press
20 two. If they wish to talk to the on-call,
21 it tells them to push nine. And then they
22 talk to the person -- a human being at the
23 answering service. They take a message,

1 his medical attention.

2 Q. So you get -- So you screen the calls
3 before you get --

4 A. I screen the calls, yes, and do a nursing
5 assessment.

6 Q. What are some of the factors that would
7 cause you to get the backup physician
8 involved?

9 A. If the patient were having heavy bleeding.
10 If the patient had a fever. If the patient
11 had clotting that -- that wasn't
12 manageable, severe cramps. It depends on
13 the patient, because they may not have
14 taken anything for it and just call and --
15 So you try to manage it first with the
16 medications that they're given to go home
17 with and the instructions.

18 But if in a particular amount of time
19 that patient is not comfortable or still
20 has problems with bleeding or clotting or
21 any sort of sign and symptom that would
22 indicate there was a complication -- And,
23 obviously, it's something that I have to

1 A. Most of these physicians work for me for
2 long periods of time. But yes, obviously,
3 we have networking. One of the reasons why
4 we're a member of the National Abortion
5 Federation would be just to bolster that
6 networking ability.

7 Q. Have you ever hired a doctor that wasn't
8 referred to you by some other clinic?

9 A. No.

10 Q. Okay. Have you ever advertised for doctors
11 to hire?

12 A. No.

13 Q. Have you ever done any recruiting of your
14 own at medical schools or conventions?

15 A. Not at medical schools or conventions, no.

16 Q. Have you ever done any other kind of
17 recruiting for doctors?

18 A. When Dr. D left, I went back and recruited
19 Dr. A. He -- Obviously, I've been doing
20 this for many years, and so I'm aware of --
21 Dr. A worked for me 20 years ago. So when
22 I was in need of a physician when Dr. D was
23 leaving, then I went to Dr. A, and he

1 last year. I'm not sure if it was '12 or
2 '11.

3 Q. Okay.

4 A. Okay. I mean, I'd -- I would have to
5 really -- I'd have to look back.

6 Q. But it was during the summer?

7 A. It was May, yeah.

8 Q. Okay. And Dr. A provides abortions for you
9 as well?

10 A. Yes.

11 Q. Does Dr. A do anything else at the clinic?

12 A. He does routine GYN exams, yes.

13 Q. Do you pay the doctors for routine GYN
14 services?

15 A. Yes.

16 Q. What's that pay scale?

17 A. To see a patient for -- Our Pap smears are

18 [REDACTED]

19 [REDACTED]

20 that patient.

21 Q. Do you know where A lives -- Dr. A lives?

22 A. It's listed on the form here. He -- Well,

23 [REDACTED]

1 he also maintains residence in his

2 [REDACTED] [REDACTED]
3 [REDACTED]

4 Q. So it's your understanding that he has a

5 [REDACTED]

6 [REDACTED]

7 [REDACTED]

8 A. Yes.

9 [REDACTED]

10 originally used him 20 years ago?

11 A. That's his homeland, so yes. Yes. I do
12 believe so.

13 Q. All right. How long do these doctors stay
14 when they come into town to work at your
15 clinic?

16 [REDACTED]

17 [REDACTED]

18 [REDACTED]

19 [REDACTED]

20 [REDACTED]

21 [REDACTED]

22 [REDACTED] [REDACTED]

23 [REDACTED] [REDACTED]

1 Q. Okay.

2 [REDACTED]

3 [REDACTED]

4 [REDACTED]

5 Q. Okay. Have you ever discussed with Dr. F
6 whether he would like to perform abortions
7 at the clinic?

8 A. He doesn't do abortions.

9 Q. So have you ever discussed it with him?

10 A. When we originally signed the contract, it
11 was this was just for backup services, not
12 for doing abortion procedures.

13 Q. Did he tell you why he didn't want to do
14 abortions?

15 A. It was hard enough to get him to sign a
16 contract to do backup services, much less
17 to provide any other services. And my
18 experience has been that he has suffered
19 from persecution, okay, by other physicians
20 in the hospital. I mean, he's told me of
21 incidents where other physicians in the
22 hospital have come and had negative things
23 to say about him being associated with our

1 clinic.

2 Q. So based on that, you assume he would not
3 want to do abortions?

4 A. Exactly.

5 Q. Okay. And so you haven't brought that up
6 with him?

7 A. I'm not going to say we probably haven't
8 talked -- I don't recall ever sitting down
9 and asking him if he wanted to do abortion
10 procedures. It just -- It was never part
11 of our agreement, and -- And I'm not aware
12 that he does abortions. I'm -- at all. I
13 mean, he does D & Cs in the hospital. And,
14 obviously, that's related to his practice.

15 But we didn't sit down and say, you
16 know -- He wasn't -- To my knowledge, he's
17 never performed abortion procedures in a
18 clinic setting. And so no, I didn't
19 approach him for that reason.

20 Q. Okay. How do you decide how many doctors
21 to have a relationship at a given time?

22 A. It's basically run by who my physicians
23 are. Obviously, when you have -- Even if

1 your backup physician but was not --

2 A. Sole.

3 Q. -- the medical director?

4 A. That's correct.

5 Q. Okay. Is it your preference to have a
6 primary abortion-providing physician and
7 then to have backups, or is that just the
8 way it's developed?

9 A. That is just the way it is developed.

10 Q. Okay. So you don't have a preference to
11 have a primary with backups versus some
12 other model?

13 A. Preferentially it would be nice to have
14 something like Tuscaloosa has where you
15 have a physician that's local, but that has
16 not been my experience in 35 years of doing
17 this.

18 Q. So you haven't had a local physician since,
19 I guess, Dr. H stopped doing --

20 No. I'm sorry. Yeah.

21 -- Dr. H. stopped doing abortions?

22 A. Never had a local physician that did
23 abortion procedures.

1 Q. Okay. So Dr. H was not a local physician
2 at the time when he was associated with the
3 clinic?

4 A. No.

5 Q. Okay. You say you would like to have the
6 kind of setup that they have in
7 Tuscaloosa. Why would that be your
8 preference?

9 A. It would be nice to have somebody that's
10 local to your area. It's just that with
11 what happened with Dr. F, you know -- We
12 still put up with picketing. We put up
13 with phone calls and threats and so forth.
14 And I'm not aware of any local physician
15 that has ever wanted to take that on.

16 Q. Right.

17 Have -- What local physicians have you
18 talked to about wanting to take that on?

19 A. In 2003 I sent out a letter to every OB-GYN
20 in the Montgomery area and did not get one
21 positive response just to being the backup
22 doctor, much less doing anything beyond.
23 And so if they won't associate with me in

1 providing backup services -- I've never had
2 anybody that I've heard of in my business
3 dealings with Reproductive Health Services
4 in this area that not only does abortion
5 procedures but would be willing to do it
6 with a local clinic.

7 MS. KOLBI-MOLINAS: If you're
8 reaching at a stopping point,
9 you might want to take a break
10 soon. But I don't know where
11 you are in your --

12 MR. BRASHER: Let's wait just a
13 little bit.

14 MS. KOLBI-MOLINAS: Yep. Yep.

15 MR. BRASHER: Then we'll have a
16 break in just a little bit.
17 Let's finish this list.

18 Q. You told me that you pay your medical
19 director slash backup physician monthly.
20 What do you pay him on a monthly basis?

21 A. For being the medical director and the

22

23 Q. And have you ever -- I think you might have

1 answered this already, but have you ever
2 discussed with him why he doesn't perform
3 abortions?

4 A. He has an OB-GYN practice here, and it's
5 been difficult enough with -- to be
6 associated with us as a backup in a backup
7 position and as a medical director. I'm
8 not aware that he has done clinical in a
9 clinic setting, okay, for first trimester
10 abortion procedures.

11 Q. Do you know -- Has he done first trimester
12 abortion procedures in his private
13 practice?

14 A. I don't think so. I've never heard of
15 him -- You know, I've never heard of any
16 doctor in Montgomery who does abortions in
17 their private practice. Not in this area.

18 Q. Have you discussed whether he does that
19 with him?

20 A. I don't -- I can't say we actually had a
21 conversation that said this is what he did
22 or did not do, but I'm not aware that that
23 is something that he's ever done.

1 Q. Okay. Have you discussed that with him?

2 A. No. Other than his work at the facility.

3 Not his privileges, no.

4 Q. Okay. Could you just explain to me why it
5 is you think that his privileges in

6 [REDACTED]

7 [REDACTED]

8 A. Because I -- When Dr. B initially worked

9 [REDACTED]

10 discussed with him when he took the job in

11 [REDACTED]

12 made whatever arrangements that they make

13 with their physicians that they hire.

14 Q. Okay. And I take it that you believe that

15 none of your current doctors can meet the

16 staff privileges requirement as it is in

17 the Women's Health and Safety Act?

18 A. That's my understanding, yes.

19 Q. Okay. Why do you believe that?

20 A. Because I've looked at the information that

21 was provided by the hospitals, and none of

22 my doctors would qualify for privileges

23 because they don't live in the Montgomery

1 area.

2 Q. So you mention the -- living in the area.
3 Is there any other criteria that you
4 believe your doctors wouldn't be able to
5 meet?

6 A. They must have a certain number of
7 admissions that -- My understanding is they
8 must have a certain number of admissions
9 each year and they are to see hospital
10 patients.

11 Q. To your knowledge, none of your current
12 doctors have applied for staff privileges
13 at a local hospital?

14 A. We haven't completed an application. I
15 have requested the application.

16 Q. All right. Do you know if any of your
17 current doctors have requested applications
18 on their own behalf to local hospitals?

19 A. (Witness shakes head.)

20 Q. Was that a no?

21 A. I'm not aware that they have requested an
22 application on their own behalf.

23 Q. Do you know for a fact that they have not

1 Q. Have you asked them to attempt to get staff
2 privileges?

3 A. They -- They knew that I was requesting an
4 application, yes.

5 Q. But you haven't asked them to attempt on
6 their own behalf to get staff privileges?

7 A. Because they don't live in the area.

8 Q. Right. So that's no, you haven't asked?

9 A. That is no.

10 Q. Okay. I take it you haven't offered them
11 any sort of financial incentive to get
12 staff privileges at a hospital?

13 A. It wouldn't make any difference how much
14 financial incentive I gave them. They
15 cannot obtain staff privileges at a local
16 hospital.

17 Q. And so that's the reason you haven't asked
18 them -- or you haven't provided any
19 financial incentive?

20 A. No. I really don't understand where you're
21 going with this. I -- No. I haven't
22 talked to them about financial anything
23 that has to do with them having privileges

1 I just handed you RHS-65 through RHS-81.

2 A. I'm familiar with it.

3 Q. Okay. Can you tell us what RHS-65 is, the
4 first document on top there?

5 A. The first document on top was a letter that
6 was sent out in 2003, and it was a joint
7 effort between Ms. Coleman and myself to
8 obtain a local physician with admitting
9 privileges to be our backup.

10 Q. What prompted you sending this letter?

11 A. New state regulations requiring that we
12 have a backup.

13 Q. And you say you sent it in 2003?

14 A. Yes. It was a joint effort between the two
15 facilities in Montgomery.

16 Q. Okay. What kind of responses did you get
17 to this letter?

18 A. You can see what was written up as far as
19 the responses.

20 Q. All right. So let's turn to that, then.
21 So RHS-68 Bates labeled is where -- looks
22 like we've got notes of responses here. So
23 nobody -- So the first three, no response;

1 is that right?

2 A. That's correct.

3 Q. And you sent this letter to OB-GYNs in the
4 local area?

5 A. To my -- At that time, to every OB-GYN that
6 we could find in the Montgomery area.

7 Q. Okay. How did you choose the doctors to
8 send it to?

9 A. There is a -- There was a state book that
10 we pulled from. It's a directory of
11 physicians that are licensed. And we
12 pulled from -- We pulled the names from
13 that book and in combination with the
14 telephone book as to who was advertising as
15 OB-GYNs or GYNs.

16 Q. Okay. So you didn't necessarily know the
17 doctors beforehand?

18 A. No.

19 Q. Okay.

20 A. Some of the doctors I'm familiar with, but
21 as far as knowing them, no.

22 Q. Okay. And I just note that on this letter
23 you don't offer any kind of compensation to

1 serve as an outside contracting physician;
2 is that right?

3 A. I don't see anything that says any -- that
4 we were offering compensation.

5 Q. Okay. Did you intend to offer compensation
6 to doctors to serve -- to meet this
7 requirement?

8 A. In order to have a contract with somebody
9 and to have somebody that would be on a --
10 in a retainer-type position, yes, we
11 expected to ...

12 Q. Okay. So most of these certified mail
13 slips, RH-68 through R -- let's see --
14 RH-80 or 81 -- most of them have no
15 response written next to them; is that
16 right?

17 A. The majority have no response.

18 Q. Did you write -- Is that your handwriting?
19 Did you write no response?

20 A. No. That would have been Laurasenia
21 Coleman.

22 COURT REPORTER: Who?

23 THE WITNESS: Laurasenia Coleman.

1 Q. And then look at RH-70. There's a Clayton
2 Schmidt, MD. What's the response next to
3 him?

4 A. It says, 8/17/03, negative response, see
5 note inside.

6 Q. Okay. Do you remember what his response
7 was?

8 A. That's been so far back.

9 Q. Okay. Would you look at RH-77? That is
10 also three certified mail slips; correct?

11 A. Yes.

12 Q. Okay. Next to the middle slip there,
13 Patricia Elliott, what does that say?

14 A. It says, verbal response, 7/16/03, will
15 consider, and then 8/11/03, negative
16 response.

17 Q. Okay. Do you recall what the verbal
18 response was?

19 A. I didn't -- This isn't my writing.

20 Q. Okay. So you didn't -- You don't recall
21 what the response was?

22 A. No. I'm -- If it was a neg -- If
23 Laurasenia put down it was a negative

1 response, it was a negative response.

2 Q. Okay. Why did you keep these documents?

3 A. For the same reason I send them out
4 certified.

5 Q. Okay. Were these documents sent out in
6 preparation for a lawsuit?

7 A. No.

8 Q. So you mentioned the contracting
9 requirement that made you send those
10 letters out or encouraged you to send those
11 letters out. Did you think you would be
12 able to comply with that?

13 A. At the present -- From these responses,
14 no. We were having a very difficult time
15 complying with that.

16 Q. All right. And did you tell people at the
17 time that you wouldn't be able to comply
18 with it?

19 A. I do believe we had correspondence with the
20 state that we didn't think we were going to
21 be able to comply with it.

22 Q. Okay. And did you hire a lawyer to file a
23 lawsuit over it?

1 A. Not at that time, no.

2 Q. Did you discuss filing a lawsuit about the
3 previous requirement with a lawyer?

4 A. (Witness shakes head.)

5 Q. No?

6 A. Not that -- I don't recall.

7 Q. Okay. Did you eventually comply with the
8 contracting requirement?

9 A. We eventually complied with the
10 requirement. This was to have a backup
11 physician --

12 Q. Uh-huh (positive response).

13 A. -- that had privileges. Yes

14 Q. So just the back -- We'll call it the
15 backup --

16 A. A verbal agreement with a local physician.

17 Q. So we'll call it the backup --

18 A. The backup, right.

19 Q. -- requirement.

20 Okay. How long did it take you to do
21 that?

22 A. I don't know. This was 2003. I want to
23 say probably we were -- I do believe we

1 were dealing with a time constraint also
2 and -- I don't know. I'll just say I don't
3 know. I don't remember.

4 Q. Well, you didn't get any responses from
5 your certified mail? We can say that?

6 A. No.

7 Q. So how did you eventually find someone to
8 comply with the requirements?

9 A. I don't remember. I just remember calling
10 somebody -- I called a local OB-GYN that I
11 knew personally.

12 Q. Okay. So you didn't -- you didn't get
13 responses to your form letter?

14 A. Didn't get any responses to the form
15 letter. Well, other than Ms. Elliott.

16 Q. Right.

17 A. Dr. Elliott.

18 Q. The way you eventually complied with it was
19 by calling a doctor that you personally --

20 A. That I personally knew.

21 Q. Okay. Have you sent any similar letters to
22 physicians about the new requirement?

23 A. In this leg -- In this piece of

1 legislation?

2 Q. Right.

3 A. No.

4 Q. Okay. Why haven't you done that?

5 A. Because it's been my experience in dealing,
6 even within 2003, that it is a very
7 difficult proposition for a local physician
8 to be associated with the clinic.

9 Q. And that's based on the non responses to
10 your letters?

11 A. To being just the backup, much less doing
12 abortion procedures and providing
13 privileges.

14 Q. And so just to clarify. With respect to
15 Dr. Elliott, who was the verbal response,
16 you don't know what the verbal response was
17 one way or the other?

18 A. I didn't talk to her, no.

19 Q. Okay. Have you contacted any abortion
20 doctors from out of state to encourage them
21 to move to Alabama?

22 A. No. I have perfectly competent physicians
23 working for me right now. There would be

1 Q. I mean, is that right?

2 A. I haven't talked to anyone about coming to
3 Alabama to live in Alabama. In my 35
4 years, there has never been anyone that has
5 come to Alabama to live in Montgomery to do
6 abortions.

7 Q. Okay. And so just to be clear, you have --
8 Unlike in 2003, you haven't contacted local
9 doctors about the new requirement?

10 A. I haven't contacted local physicians about
11 the new requirement.

12 Q. Okay. And you don't recall how long it
13 took you to comply with the 2003
14 requirement?

15 A. I don't remember. I do remember having --
16 Which is obviously not in here, but I
17 believe I recall a contact with the health
18 department that we weren't going to be able
19 to meet this requirement before the
20 deadline. And somebody finally agreed to
21 be our backup physician.

22 Q. What --

23 A. Not to do abortion procedures at our

1 office.

2 Q. Right. Just to meet the other requirement?

3 A. Exactly.

4 Q. Do you think -- Did it take several months
5 to find someone?

6 A. This was -- You're asking me to remember
7 something from ten years ago, but --

8 Q. I understand.

9 A. If this was July -- I don't know what the
10 time -- I just -- I'll be honest. I can't
11 recall what the time restraint was.

12 Q. Okay. Do you recall -- I've just handed
13 you a letter dated August 14, 2006. Do you
14 recall receiving this letter?

15 A. Yes, I do.

16 Q. Okay. What is attached to this letter?

17 A. An emergency order of license suspension.

18 Q. And do you know why your -- And so that's
19 suspending your license; is that correct?

20 A. Suspending the clinic license.

21 Q. The clinic's license. Right.

22 Do you recall why it was that your
23 license was suspended?

1 A. I believe it states in the document why it
2 was suspended.

3 Q. All right. Do you want to read paragraph
4 one of the document, then?

5 A. Paragraph one says, State Board of Health
6 rules for abortion or reproductive health
7 centers -- herein state rules -- require
8 that an abortion center have a physician
9 with admitting privileges at a local acute
10 care hospital or a contractual agreement
11 with a physician who has such admitting
12 privileges.

13 And it cites a code, the Alabama Code.
14 In accordance with state rule, such
15 physician is to provide or make
16 arrangements for continuing medical care
17 for patients who develop complications
18 medically related to an abortion performed
19 at the abortion center. RHS does not have
20 any such physician or contractual
21 agreement.

22 Q. Okay. And so that was the backup physician
23 requirement that we were discussing

1 earlier; is that right?

2 A. That's correct.

3 Q. So did you not have a backup physician
4 between 2003 and 2006?

5 A. I did have a backup physician.

6 Q. Okay. So what happened with respect to
7 this emergency order of suspension?

8 A. When the health department came in to do
9 their survey, I was -- they called my
10 backup physician. And he refused to do
11 any -- He refused to be associated with the
12 clinic anymore.

13 Q. Okay. So he quit?

14 A. He said he did not want to be called by the
15 health department.

16 Q. Okay. Did he explain why he was quitting?

17 A. He explained that he had not seen a patient
18 of ours for a year and would be no longer
19 doing abortion -- I mean, no longer be
20 doing backup services.

21 Q. We're talking about the backup physician,
22 not the abortion --

23 A. The backup physician, yes.

1 Q. Okay. Were you -- Were you paying him?

2 A. No.

3 Q. Okay. So he was operating as your backup
4 physician on a pro bono basis?

5 A. Yes.

6 Q. Okay. What eventually happened in this
7 license suspension action?

8 A. I was able to obtain a local backup
9 physician, which is F. And we had a
10 written contract. The health department
11 wanted a written contract, so we set up a
12 written agreement with Dr. F.

13 Q. Okay. So this is -- this is -- this is
14 what prompted you to get Dr. F on board?
15 Is that fair to say?

16 A. Actually, at the time of the survey was
17 prior to this suspension. I was working on
18 it. Yes.

19 Q. So it was when the survey when the current
20 doctor said that he didn't want to be
21 associated anymore?

22 A. Exactly.

23 Q. Okay. That makes sense.

1 A. The LPN told the doctor that the patient
2 was in the emergency room to be treated.
3 The physician told her I didn't do the
4 abortion. The LPN told Dr. 2 that she
5 would have her doctor call him. Dr. 2
6 asked for the name of the doctor who would
7 be calling and was told by the LPN I can't
8 tell you her name. The response from Dr. 2
9 was I guess I'm supposed to take a call
10 from an anonymous doctor. The LPN did
11 state that after the third phone call from
12 Dr. 2 she refused to talk to him again.

13 Q. Okay. Do you have any personal knowledge
14 of this incident?

15 A. I have personal knowledge in that the LPN
16 called me. I was en route to South
17 Carolina, so I talked on the telephone with
18 the LPN.

19 Q. During this in -- During this --

20 A. During this time.

21 Q. And what did you -- What was that
22 conversation like?

23 A. It was quite simple. She called me to let

1 me know that the patient had gone to
2 emergency room and that -- that the doctor
3 at the emergency room was asking to speak
4 to the attending.

5 Q. And what did you tell the LPN to do?

6 A. To tell him who the attending was.

7 Q. And so is the part that you don't disagree
8 with --

9 A. Is that -- And I've spoke with her -- with
10 my LPN and, you know -- I can't imagine her
11 not -- her telling him I'm not going to
12 tell you who the doctor is.

13 Q. So you think that she followed your
14 directions and did, in fact --

15 A. She --

16 Q. -- identify the doctor?

17 A. And identified the doctor, yes.

18 Q. But you don't know whether she did that or
19 not; you just directed her to do that?

20 A. No. I do know from talking with the doctor
21 afterwards that the attending called the
22 emergency room to speak with Dr. 2.

23 Q. Okay. But I guess I should say you don't

1 wasn't sure if Dr. Dugger was this
2 patient's physician. I wasn't talking to
3 Dr. 2.

4 Q. Okay.

5 (Off-the-Record discussion.)

6 (Brief recess was taken.)

7 MR. BRASHER: Let's go back on the
8 Record then.

9 Q. All right. You've mentioned a couple of
10 times that your clinic is subject to
11 protests. Could you describe those
12 protests?

13 A. On a weekly basis, on a -- Last week I
14 believe we were picketed every single day
15 of the week last week.

16 Q. And when you say picketed, what --

17 A. Picketed. We have people outside with --
18 who blow horns and place really graphic
19 signs all over the place. I believe he had
20 probably about eight signs this past week,
21 one of the individuals. Somebody else
22 brought another two or three signs when he
23 came. We have somebody that stands and

1 blows -- Periodically when he's out there,
2 he blows a big horn. The person who's the
3 most prevalent out there stands in front of
4 the building, which is maybe 25 feet before
5 you hit the front door, and screams at the
6 building incessantly for 30 minutes or
7 more.

8 Q. And that's on a regular occurrence?

9 A. That's a pretty regular occurrence, yeah.
10 Done on -- Every single week. I don't
11 think we've missed a week. It may not be
12 every single day. We did not have
13 picketers yesterday. We did not have --
14 Today is Wednesday; right? We did not have
15 picketers Monday. We didn't have picketers
16 Tuesday. But when I was there this
17 morning, we had picket.

18 Q. Okay. About how many people are out there
19 on a given basis?

20 A. Depends on the day.

21 Q. Okay.

22 A. We may have one person and six or eight
23 signs, and we may have up to eight or ten

1 people.

2 Q. Could you describe the kind of signs that
3 you're talking about?

4 A. Large graphic signs of -- you know, that
5 says an abortion is murder. You'll regret
6 your decision. Fetuses -- You know,
7 they're just really large graphic signs.

8 Q. So when you say graphic, you mean the
9 photos on the signs?

10 A. The photos on the signs are very graphic.

11 Q. And they have aborted fetuses or something
12 like that?

13 A. Right. Right.

14 Q. Okay. Has anyone -- Have you ever had an
15 experience where one of these protesters
16 has interfered with someone who is going to
17 get an abortion?

18 A. They try to every time the patient -- the
19 patient -- any patient or any guest of a
20 patient that's walking by them within --
21 literally within three feet of these
22 people. And so -- And they would love to
23 interfere if they could.

1 Q. Well, has anyone ever physically
2 interfered, I guess is what I would say?

3 A. Over the years, yeah.

4 Q. All right. About how many times has that
5 happened?

6 A. We've had at least two rescues. We've had
7 vandalism. I don't know how many times --
8 More than half a dozen times I've had to
9 call a locksmith because the locks were
10 superglued or wood putty or -- During the
11 rescues, we had to -- I think one time we
12 actually had to make -- I want to say we
13 had 69 arrests. It took two buses to get
14 them downtown.

15 Q. What is a --

16 A. A rescue.

17 Q. A rescue sounds interesting. What is a
18 rescue?

19 A. Rescue was back when they did -- when they
20 didn't have FACE legislation, which is the
21 legislation that says you can't blockade a
22 clinic. And so Operation Rescue was
23 very -- a very much larger organization and

1 they put together people in the area and
2 then people coming from outside also that
3 would involve themselves in a rescue, which
4 was to shut down the clinic.

5 Q. So they would physically block the
6 entranceway --

7 A. Yes.

8 Q. -- to the clinic?

9 A. That's true.

10 Q. And you said that after federal -- federal
11 legislation; is that right?

12 A. FACE legislation.

13 Q. FACE legislation.

14 A. That diminished.

15 Q. So that made that illegal to do?

16 A. It didn't make it illegal to do. It
17 just -- My -- My understanding of the law
18 is that it made it -- it didn't make it
19 illegal. It just made it punishable by --
20 I could -- We could prosecute them but not
21 in a -- It didn't make -- It didn't make
22 them criminals.

23 Q. Well, that's ... Since that legislation

1 was passed, you've said that that hasn't
2 happened?

3 A. I haven't had blockades. Now, if I don't
4 watch -- I haven't had blockades. But if I
5 don't watch what the picketers are doing
6 out front, if I don't keep tabs on them,
7 they will stop people coming into the
8 parking lot. They will physically stop a
9 car as they come into my parking area.

10 Q. Okay. And do you -- How frequently would
11 you report this activity to law
12 enforcement?

13 A. I go out and tell them to stop normally.

14 Q. So you don't report the activity to law
15 enforcement?

16 A. No. It's on camera.

17 Q. Have you ever --

18 A. But if they -- if they cease at that point,
19 then no, I don't pursue it. Have I ever --

20 Q. Right.

21 Reported to law enforcement.

22 A. Sure. Sure.

23 Q. Was that back when there were blockades at

1 the clinic?

2 A. No. Just recently -- I say recently. Two
3 summers ago I had two people who were
4 arrested for trespassing.

5 Q. What were they doing exactly?

6 A. They were literally coming onto the
7 property. Had been warned not to come onto
8 the property and were coming onto the
9 property.

10 Q. Okay. Do you have a sprinkler system that
11 tries to keep these --

12 A. I have --

13 Q. -- protesters off?

14 A. -- a sprinkler head to water the grass,
15 yes.

16 Q. It's not -- You don't use it to keep the
17 protesters off your property?

18 A. They are on the public sidewalk. The
19 sprinkler is just a little sprinkler that
20 just waters my grass out front.

21 Q. Okay. Do you ever turn it on when they
22 come onto the property?

23 A. It's set to come on.

1 Q. On a --

2 A. It's set to come on a -- It's set on a
3 schedule basis, yes.

4 Q. So it doesn't -- it doesn't turn on when
5 they come on the property?

6 A. It doesn't come on automatically when they
7 come on the property, no.

8 Q. Okay. Are you familiar with protests in
9 other parts of the country?

10 A. Other than what I've seen on the media. I
11 would not say personally I am, no.

12 Q. So you haven't -- you haven't discussed
13 abortion clinic protests with your peers in
14 other states?

15 A. With peers in this state.

16 Q. Oh, in this state.

17 A. Yeah, in this state.

18 Q. Are they -- Are all these protests about
19 the same from clinic to clinic?

20 A. I don't know what you mean by the same. Do
21 they have people with signs, yes. Do they
22 have people that scream and holler, yes.
23 Will they push the limits of whatever it is

1 that they're -- they can legally do, yes.
2 And then some.

3 Q. Uh-huh (positive response).

4 And that happens -- And I guess --
5 That's what I mean by about the same. So
6 that happens in your clinic, and to the
7 best of your knowledge, it happens in other
8 clinics as well?

9 A. In other clinics also.

10 Q. Okay. Have you ever been harassed yourself
11 by these protesters?

12 A. Yes.

13 Q. Okay. In what way?

14 A. I've been followed through the mall. And I
15 have had -- At -- Any clinic day when I
16 park, I'm accosted. Then they follow me
17 right up till I turn to come in the front
18 door.

19 Q. Okay. Let's talk about the mall
20 situation. What -- What exactly happened
21 with them following you?

22 A. I was shopping in the mall with my young
23 daughter, and they were literally behind me

1 making very, very nasty comments. And,
2 obviously, I moved away as fast as I could.

3 Q. What kind of comments did they make?

4 A. Just, you know, this person works for the
5 abortion clinic; do you know your mother
6 kills kids. You know, some pretty bad
7 stuff.

8 Q. Okay. Do they make comments when you go
9 into the abortion clinic?

10 A. Now? Yes, they do.

11 Q. Yes.

12 What kind of things are they saying?

13 A. Anything from, you know, God is on your
14 side and is praying for you to -- By the
15 time I get to the front door, it's I'm
16 going to burn in hell.

17 Q. So do they say that they're praying for
18 you?

19 A. They're saying I'm -- I try not to pay
20 attention to exactly his comments.

21 Q. Okay.

22 A. But it has something to do with prayer and
23 God and forgiveness.

1 Q. You say he. So is it a particular
2 protester that --

3 A. Actually, there's three or four of them
4 that -- that routinely will come up to me.

5 Q. Okay. What do you -- What do you say is
6 sort of the maximum number of protesters
7 you've had at your clinic?

8 A. The time of the arrest was well over
9 probably 150 people there.

10 Q. And when was that?

11 A. That was -- I don't recall what year.

12 Q. That was more than ten years ago?

13 A. Yeah, it was more than ten years ago.

14 Q. Was it more than 15 years ago?

15 A. I couldn't tell you what year it was. I
16 just can't recall what year it was.

17 Routinely we have two or three out on
18 every -- every day that we do abortions and
19 then other days during the week such as
20 today. We didn't do abortions today, but
21 we had -- This morning there were six of
22 them across the street.

23 Q. Okay. And there are some frequent ones

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[REDACTED] [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] [REDACTED]

Q. Okay. Got you.

And you told me earlier that you have a

[REDACTED]

A. Right.

Q. -- I think is right?

A. Right.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

A. No.

Q. Okay. [REDACTED]

[REDACTED]

1 A. He monitors for any -- We don't allow large
2 bags or cell phones in our building for
3 privacy reasons and security reasons. So
4 he's making sure that people don't bring
5 their cell phones in and out, making sure
6 that they're not carrying weapons. We've
7 posted it now so that people don't carry
8 sidearms. And so he's just making sure
9 that, you know, the people that are coming
10 in -- that somebody is with a guest and,
11 you know, where the guest is.

12 Occasionally, it may be that somebody
13 is parked in the wrong parking lot, so he
14 would have to do that. So just monitoring
15 ingress and egress to the clinic and the
16 people who are there.

17 Q. Have you ever sent him out to deal with the
18 protesters?

19 A. Normally I go out and warn them.

20 Q. Okay. Do you do anything for your personal
21 protection because of these protests?

22 [REDACTED]
23 [REDACTED]

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[REDACTED]

Q. When was that?

[REDACTED]

Q. When was that?

A. I don't know what year that was.

Q. Okay. Well, could you give -- give me a range?

A. In the '80s.

Q. In the '80s. Okay.

[REDACTED]

A. No.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Q. Okay. Is there anything else you do because of these protesters?

A. I don't know what you mean.

Q. Are there any other security precautions that you take because of these protesters?

[REDACTED]

[REDACTED]

[REDACTED]

1 We actually have training for the staff
2 members to be able to identify things
3 coming in the mail. We've had anthrax
4 letters and -- Fake anthrax letters sent,
5 but none -- It doesn't make any
6 difference. You handle them the same way
7 as if it was anthrax or not. We've had
8 that sent on at least three occasions, and
9 that has been since -- within the last ten
10 to 12 years.

11 Q. We. And so these were letters -- Just to
12 clar -- These were letters with, what, some
13 kind of white powder or something in them?

14 A. Yes. Yes.

15 Q. Did they have threats in the letters?

16 A. You know, I don't remember if there
17 actually was writing in the letter. It
18 was -- It was during the time when people
19 were sending out multiple anthrax letters.
20 It was sent to the post office. It was
21 during a very heightened national security
22 threat too. But they were obviously sent
23 to the clinic too.

1 Q. Uh-huh (positive response).

2 There's a -- There's another clinic
3 that receives just envelopes with no letter
4 in them on a regular basis. Do you receive
5 those?

6 A. We receive -- We receive those. We receive
7 them with Bible versus. I receive -- From
8 an organization that calls us
9 bottom-feeders. And we receive, you know,
10 postcards and information from them. I
11 can't say they're threats, but they're
12 obviously not intended as thank-you cards.

13 Q. How regularly do you think it is that you
14 receive letters like that?

15 A. I probably get something once a month.

16 Q. Once a month?

17 A. Yes.

18 Q. What do you do with them when you receive
19 them?

20 A. I try to put them in an envelope. I try to
21 show them to staff so that staff are aware
22 of what's coming in.

23 Q. You do show those?

1 A. Yes, I do. And I do training with staff,
2 and staff has training in taking a bomb
3 threat over the phone, taking -- We've had
4 a death threat. Physician H had a threat
5 against his life. That was reported to the
6 police and investigated.

7 And they -- My answering service was
8 very smart and asked him his name and his
9 telephone number, and he gave it. So those
10 are the kind of training things, that you
11 ask staff members not to panic and put down
12 the phone but just to say, okay, and who
13 are you and where are you calling from. We
14 have caller ID now, so ...

15 Q. Okay. So you do training with your staff
16 about that kind of stuff?

17 A. Yeah. Yeah.

18 Q. Okay. Let me ask you a question. We've
19 got this letter I have a few questions
20 about. Can you tell me what -- I've just
21 handed you a letter and the Bates label on
22 it is RHS-86. Can you describe what this
23 letter is?

1 A. It is a letter obviously from an
2 anti-somewhere. I normally try to keep the
3 envelopes with them. And, obviously -- So
4 that I have -- Not all of them -- Not all
5 of them have postage. And that's one of
6 the things you look for, is the type of
7 postage and where it came from. But this
8 is a letter that was sent to my office.

9 Q. Uh-huh (positive response).

10 So you do recall receiving this letter?

11 A. I do recall receiving this, yes. And I
12 would have put it in my stack of things
13 that I try to keep.

14 Q. Okay. Is this representative of the kind
15 of letters that you receive?

16 A. It's -- I can't say it's representative.
17 It is -- We've had several like these.
18 We've had various different kinds of
19 letters.

20 Q. Okay.

21 A. Sometimes it's as short as a little -- just
22 a little Bible verse. Sometimes it may be
23 a little tract, one of those little books

1 they send. You know, this is just one of
2 the myriad of type of communications they
3 send.

4 Q. Does this make you feel threatened?

5 A. Yeah.

6 Q. It does?

7 A. Yeah.

8 Q. Why?

9 A. Obviously, because it's somebody who is out
10 there that you don't -- who thinks enough
11 to send you letters. This one not in
12 particular, I would say. This is a song
13 verse. But some of them do. You know,
14 some of them are definitely more
15 threatening than others.

16 Q. Uh-huh (positive response).

17 A. This didn't make my day.

18 Q. Let me ask you about this. I'm handing you
19 another document that's Bates labeled RH-88
20 through RH -- I'm sorry -- RHS-88 through
21 RHS-89. And you can see this has been
22 redacted.

23 A. Redacted.

1 Q. But can you -- can you -- Otherwise, can
2 you identify what this -- the first page
3 is, the RHS-88?

4 A. The first page was -- is a wanted poster --
5 what we consider a wanted poster. It was
6 posted in -- at the physician's -- in the
7 physician's neighborhood on telephone poles
8 and handed out to his neighbors.

9 Q. All right. And when -- when was this
10 wanted poster posted?

11 A. It would have been in the '80s also.

12 Q. It would have been the '80s?

13 A. '80s.

14 Q. Okay.

15 A. Maybe early '90s.

16 Q. Okay. And --

17 A. I don't know the -- There's no date on the
18 letter, is there?

19 Q. Well, let me ask you. Is the letter that
20 came with this -- Are these related to one
21 another in some way?

22 A. The letter that is attached was the letter
23 from the physician to me.

1 Q. Oh, okay. So that's -- RHS-89 was a
2 letter --

3 A. Letter to me --

4 Q. -- to you?

5 A. -- from the doctor.

6 Q. Okay. And it says, I'm enclosing a copy of
7 a taped message off of his answering
8 machine. Is that right?

9 A. That's correct.

10 Q. Do you -- Do you recall what that message
11 said or --

12 A. It's been so long.

13 Q. Yeah.

14 So this was -- This letter would have
15 been sent to you in the late '80s or early
16 '90s?

17 A. Right.

18 Q. Okay. And it just -- Could you read down
19 here where it starts the voice of? Just
20 kind of read the first sentence there.

21 A. The voice of the person making the threats
22 on this tape sounds very much like the
23 voice of one of the most vocal of -- I

1 can't read the word.

2 Q. Yeah. Maybe the --

3 A. Harassers at the Montgomery clinic. He is
4 one of two people who followed me into a
5 restaurant in Montgomery, Alabama. His
6 name is --

7 Q. All right. You can stop there.

8 A. Okay.

9 Q. But he goes on to identify him by name and
10 address and phone number; is that right?

11 A. That's correct.

12 Q. Okay. And is this -- This is the same
13 doctor that has the wanted poster?

14 A. Yes, it's the same doctor.

15 Q. Okay. Where did he live when he received
16 these threats, to your knowledge?

17 A. He lived in Baltimore, Maryland.

18 Q. So he was threatened in Baltimore, Maryland
19 over his abortion activities in Alabama?

20 A. In Montgomery, Alabama. Yes, sir.

21 Q. Okay. And what did he do about these
22 threats, to the best of your knowledge?

23 A. Nothing.

1 Q. Nothing. So --

2 A. I don't remember any -- any redress that he
3 could do.

4 Q. Okay. So is this -- is this not the
5 incident where you said that it was
6 reported to the police?

7 A. No.

8 Q. Okay.

9 A. No. No. No.

10 Q. So the -- So the reports to the police that
11 you were talking about earlier -- the other
12 death threat, that was a different
13 incident?

14 A. It was a different incident. It was the
15 same doctor, but it was a different
16 incident all together.

17 Q. Same doctor?

18 A. Same doctor.

19 Q. Same time frame probably?

20 A. We had -- We worked together for 30 years.
21 So yeah. I mean, over the span of 30
22 years, there's been lots of harassment.

23 Q. Right.

1 And I think you already addressed this,
2 but the doctor was living in Maryland when
3 he received these threats?

4 A. These were posted in Maryland.

5 Q. Okay. So they were posted in Maryland.

6 A. In his neighborhood and on cars in his
7 neighborhood.

8 Q. Okay. I'm going to -- I'm going to move
9 just a few things. We labeled the -- the
10 statement of deficiencies that we discussed
11 earlier as Exhibit B. So we labeled that
12 as Exhibit B.

13 (Defendant's Exhibit B was marked
14 for identification.)

15 MR. BRASHER: For the Record,
16 let's go ahead and take a
17 lunch break now.

18 (Brief lunch recess was taken.)

19 MR. BRASHER: Let's go on the
20 Record.

21 Q. I'm handing you RHS-15 through 26. Can you
22 describe what this is?

23 A. This is a monthly statistical form that I

1 Q. Are you aware that he had privileges at any
2 other hospitals?

3 A. I'm aware that he has -- I'm making the

4

5 that he has privileges at a hospital in

6

7 Q. Okay. You testified that in 2003 when you
8 were looking for a doctor to meet the
9 outside covering physician requirement that
10 you ended up finding one after talking to a
11 local physician; is that correct?

12 A. That's correct.

13 Q. Who -- Who was this local physician and
14 what were the circumstances?

15 MR. BRASHER: Objection.

16 Q. You can answer.

17 A. The cir -- The physician was my personal
18 OB-GYN. And -- And I had been refused by
19 every other physician that I had contacted
20 or had tried to contact in the Montgomery
21 area, and I went to him and pleaded for him
22 to continue to provide backup services --
23 he had done it previously -- to continue to

1 do so, so that we could maintain our
2 ability to be open as a facility and to
3 provide the backup for the patients.

4 Q. Okay. This morning when you left the
5 clinic to come here, how many protesters
6 were in front of the clinic?

7 A. When I left the clinic, there were six.

8 Q. And did you talk to your staff later today
9 about protesters?

10 A. At lunch I texted my staff and they said
11 there were approximately 100 people across
12 the street.

13 Q. And do you know why?

14 MR. BRASHER: Objection.

15 A. Because we had been targeted for the 40
16 days of antiabortion targeting. It's a
17 40-day ritual that they take around the
18 country, and they target specific clinics
19 for 40 days of vigil and prayer.

20 MS. KOLBI-MOLINAS: That's it.

21 * * * * *

22 FURTHER DEPONENT SAITH NOT

23 * * * * *

Exhibit LL

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

PLANNED PARENTHOOD SOUTHEAST,)
INC., on behalf of its)
patients, physicians, and)
staff, *et al.*,)
)
Plaintiffs,) CIVIL ACTION
)
v.) 2:13-cv-405-MHT
)
LUTHER STRANGE, in his)
official capacity as Attorney)
General of the State of)
Alabama, *et al.*,)
)
Defendants.)

DEPOSITION OF JOHN MERCER THORP, JR., M.D., M.H.S.

TUESDAY, NOVEMBER 19, 2013
WEDNESDAY, NOVEMBER 20, 2013

Conference Room
Law Offices of Patterson Harkavy, LLP
100 Europa Drive, Suite 250
Chapel Hill, North Carolina
1:30 p.m. and 2:00 p.m.

Volumes 1 and 2
Pages 1 through 208

A P P E A R A N C E S

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T A B L E O F C O N T E N T S

<u>WITNESS</u>	<u>DIRECT</u>	<u>CROSS</u>	<u>REDIRECT</u>
<u>JOHN MERCER THORP, JR.,</u> <u>M.D., M.H.S.</u>			
By Ms. Flaxman	5-199		205-206
By Mr. Parker		200-204	

EXHIBITS

<u>NUMBER</u>	<u>DESCRIPTION</u>	<u>MARKED</u>
1	<i>Planned Parenthood Southeast, Inc., et al. v. Strange, et al., Expert Report of John Thorp, Jr., M.D., M.H.S., 9/8/13</i>	9
2	<i>Planned Parenthood of Indiana and Kentucky, Inc. v. Commissioner, Indiana State Department of Health, et al., Declaration of John Thorp, Jr., M.D., M.H.S., in Opposition to Plaintiff's Motion for Preliminary Injunction, 9/26/13</i>	17
3	<i>Planned Parenthood of the Southeast, on behalf of its patients, physicians, and staff, et al. v. Bentley, et al., Rule 26(a)(2)(A) Expert Report of Paul M. Fine, M.D., 8/9/13</i>	124
4	Thorp, John M., Jr., "Public Health Impact of Legal Termination of Pregnancy in the US: 40 Years Later," <i>Scientifica</i> Volume 2012, Article ID 980812, 16 pages, accepted 10/15/12	129
5	Shannon, et al., "Infection after medical abortion: a review of the literature," <i>Contraception</i> 70 (2004) 183-190	137

T A B L E O F C O N T E N T S
(continued)

<u>NUMBER</u>	<u>DESCRIPTION</u>	<u>MARKED</u>
6	Rahangdale, Lisa, "Infectious Complications of Pregnancy Termination," <i>Clinical Obstetrics and Gynecology</i> . Volume 32, Number 2, 198-204	141
7	diagram drawn by witness	177

1 PROCEEDINGS 1:29 p.m.

2 (This deposition was taken pursuant to the Federal
3 Rules of Civil Procedure and the Local Rules of
4 the Middle District of Alabama.)

5 (Whereupon,

6 **JOHN M. THORP, JR., M.D., M.H.S.**

7 was called as a witness, duly sworn, and testified as
8 follows:)

9 DIRECT EXAMINATION 1:29 p.m.

10 By Ms. Flaxman:

11 Q Good afternoon, Dr. Thorp.

12 A Howdy.

13 Q I'm sorry?

14 A I said howdy.

15 Q Oh, howdy. I thought you said Allen. I thought,
16 "I don't remember seeing that on the record." How are you?

17 A I'm good. How are you?

18 Q Good, thanks. My name is Carrie Flaxman. I
19 represent the plaintiffs in this case. Could you state your
20 full name for the record?

21 A John Mercer Thorp, T-h-o-r-p, no e, Jr.

22 Q And Dr. Thorp, are you represented today by
23 counsel?

24 A I don't think so.

25 Q Mr. Parker is not representing you here today?

1 A I don't think I've hired Mr. Parker to represent
2 me. I think he represents the state of Alabama.

3 Mr. Parker: Can I interject here? It's my
4 understanding that the defendants in this case have retained
5 Dr. Thorp as an expert witness. I'm counsel for the
6 defendants and so will be here representing Dr. Thorp.

7 Ms. Flaxman: Okay.

8 By Ms. Flaxman:

9 Q Now, I know from your expert report that you have
10 been deposed before. Is that correct?

11 A Yes, ma'am.

12 Q So since you've been deposed before, I'll assume
13 you're familiar with most of the rules. I'm just going to go
14 over a few of them so we're clear. First of all, you'll need
15 to answer each question verbally and give a verbal answer.
16 Do you understand that?

17 A I'll try. Yes, ma'am.

18 Q And as Kay just mentioned, it's important that we
19 not speak over each other, so please, if you could wait until
20 I finish asking a question before you start to answer it. Do
21 you understand that?

22 A I'll do my best.

23 Q And if at any time you don't understand a
24 question, please ask me to clarify that question. And if you
25 answer the question, I will assume that you understood it.

1 Do you understand that?

2 A It may be a dangerous assumption, but yes, ma'am.

3 Q Thank you. If you need to take a break at any
4 time, let me know. The only thing I ask is that if there's a
5 question pending, that you answer that question before we
6 break. And I'll plan to take regular breaks as well.

7 A Sure.

8 The Reporter: Off the record. 1:31 p.m.

9 (Discussion off the record.)

10 The Reporter: On the record. 1:32 p.m.

11 By Ms. Flaxman:

12 Q And is there anything, Doctor, that might affect
13 your ability to give full and accurate testimony today?

14 A Not that I'm aware of.

15 Q Do you have any questions before we proceed?

16 A No, ma'am.

17 Q How did you come to be an expert witness in this
18 case?

19 A I don't recall.

20 Q Did somebody call you to ask if you were willing
21 to be a witness?

22 A Somebody usually calls or e-mails. I don't recall
23 the--I don't recall the specifics---

24 Q (interposing) Do you recall generally---

25 A ---in this case.

1 Q Do you recall generally how you might have come to
2 be involved?

3 A I don't recall generally or specifically.
4 Somebody usually contacts me.

5 Q And who might that have been?

6 A I don't recall.

7 Q Now, you have been a witness in other cases
8 involving admitting privileges requirements; correct?

9 A I think so.

10 Q And what states?

11 A It's hard for me to keep it all straight and what
12 specific parts of what laws apply to what states. I think
13 Texas. I don't know where else.

14 Q Mississippi?

15 A I think so.

16 Q Wisconsin?

17 A I think so.

18 Q And do you recall for any of those states who may
19 have contacted you about providing expert testimony?

20 A No, ma'am.

21 Q And have you also recently provided testimony in a
22 case in Indiana involving clinic regulations?

23 A Yes, ma'am.

24 Q And do you recall who contacted you about
25 participating in that case?

1 A No, ma'am.

2 Q And I understand that there may have been other
3 cases that you have testified as an expert relating to
4 abortion legislation; is that correct?

5 A Yes, ma'am.

6 Q And in any of those cases can you tell me who
7 contacted you to provide testimony in those cases?

8 A No, ma'am. I don't recall.

9 Q Do you recall who was the first attorney you spoke
10 with in the Alabama attorney general's office?

11 A I don't.

12 Q Was it Mr. Parker?

13 A I don't remember.

14 Q Was it Mr. Brasher?

15 A Don't remember.

16 Q Why don't we mark as Exhibit 1 your expert report?

17 (Exhibit 1 was marked for
18 identification.)

19 Ms. Flaxman: So we've marked as Exhibit 1
20 the Rule 26(a)(2)(B) expert report of John Thorp, Jr. M.D.,
21 M.H.S.

22 By Ms. Flaxman:

23 Q Do you recognize this document?

24 A Yes, ma'am.

25 Q And what is it?

1 A It's an expert report.

2 Q And is it one that you have submitted in this
3 case?

4 A I believe so. I haven't looked and read every
5 page, but I think it is.

6 Q Why don't you go look through it and confirm that
7 it is?

8 A I don't think I have time to read it, so I'm going
9 to assume that you're giving me my expert report.

10 Q And if you could look to page 34?

11 (Witness complies.)

12 A I'm there.

13 Q Is that your signature?

14 A I believe it is.

15 Q It is your signature?

16 A Well, I don't know what it is, but I believe that
17 it is. It looks like my signature.

18 Q Okay. So it looks like your signature?

19 A Yes, ma'am.

20 Q Any basis for thinking that it's not your
21 signature?

22 A No, but I don't know.

23 Q You don't recall signing this?

24 A I don't have an independent recollection of
25 signing it.

1 Q This was dated September 8th of this year, so it
2 was a little more than two months ago. But you don't recall
3 signing it?

4 A No, ma'am.

5 Q Do you recall signing other expert reports you've
6 submitted in the---

7 A (interposing) No, ma'am. I sign a bunch of stuff
8 every day.

9 Q Is this your electronic signature?

10 A I don't know. That's one of the reasons why I
11 don't know.

12 Q Why don't you take a look at it and--do you have
13 an electronic signature?

14 A I do.

15 Q Why don't you take a look at it again and let me
16 know?

17 A Well, how is looking at it going to tell me
18 whether a pen signed it or a computer signed it?

19 Q Why don't you just take a look at it, then?

20 (Witness peruses document.)

21 A I don't know.

22 Q Okay. If we could look at page 31 of your report,
23 sir?

24 (Witness complies.)

25 Q You have listed there cases in which during the

1 past four years you have testified as an expert at trial or
2 by deposition. And the first category you list are
3 constitutional cases in which you've provided testimony. Do
4 you see that?

5 A Yes, ma'am.

6 Q And by constitutional cases, you mean these are
7 the two cases in which--well, that relate to abortion that
8 you have provided testimony in in the last four years; is
9 that correct?

10 A I think it's fair to say that the only
11 constitutional issue that I've testified about would involve
12 termination of pregnancy, so yes, ma'am.

13 Q And the first case listed there is *Stuart v. Huff*
14 in district court here in North Carolina. Do you recall what
15 that case was about?

16 A Not by that caption I don't.

17 Q Well, what caption do you know it by?

18 A Well, if I don't know what it is, then I don't
19 know it by any caption.

20 Q So you're---

21 A (interposing) I don't know what *Stuart v. Huff*
22 means.

23 Q If I told you it was a case involving an ultra-
24 sound requirement in the state of North Carolina for
25 abortions, does that ring a bell?

1 A That rings a bell.

2 Q And what has your involvement been in that case?

3 A I think I was an expert retained by the state of
4 North Carolina.

5 Q And were you also involved in trying to intervene
6 in that case as a party?

7 A I don't know what intervening means.

8 Q Have you tried to participate as a party in that
9 case?

10 A I don't understand what you're asking me.

11 Q Now that I have--now that you recall what the case
12 is about, the ultrasound requirement in North Carolina, does
13 it refresh your memory as to how you came to be involved in
14 that case?

15 A It does not.

16 Q And the second case listed there is a case *Planned*
17 *Parenthood v. State of Alaska*?

18 A Yes, ma'am.

19 Q Do you recall what that case was about?

20 A It was a parental notification/parental consent
21 statute that the state of Alaska has that went to litigation.

22 Q And you provided testimony there by way of
23 deposition?

24 A I actually went to Alaska at some point in time,
25 in February. It was cold.

1 Q I'm sure it was in February.

2 A Real cold.

3 Q And do you---

4 A (interposing) And Alabama is warmer.

5 Q Do you--having seen this here and talking about
6 visiting Alaska in the cold, does that refresh your memory
7 about how you came to be involved in that case?

8 A It does not.

9 Q And then the next category of cases in which you
10 provided testimony are medical malpractice cases?

11 A Yes, ma'am.

12 Q Do you testify for plaintiff or defendant or both
13 in these cases?

14 A You haven't read my medical malpractice deposi-
15 tions because you would know that I don't like your wording
16 of the question.

17 Q Well, I've asked the question. It's your job here
18 to answer it, so---

19 A (interposing) Well, I'm going to answer it,
20 but---

21 Q (interposing) Okay. That's fine.

22 A ---that's part of my answer that--and I'd
23 appreciate your not interrupting me in the middle of an
24 answer. Could you ask the question again, please, ma'am?

25 Q When you have provided expert testimony in medical

1 malpractice cases, do you typically testify on behalf of the
2 plaintiff or the defendant?

3 A And I don't think I testify on behalf of either.

4 Q When you provide expert testimony in medical
5 malpractice cases, on which side of the case--whose side of
6 the case are you retained by?

7 A Retained by defense and retained by plaintiffs.

8 Q And so in the cases on this list, in some of them
9 you've been retained by the plaintiffs and in some of them
10 you've been retained by the defense; is that correct?

11 A Yes, ma'am.

12 Q Is there--are the majority plaintiff or defense?

13 A In what sort of testimony?

14 Q In the medical malpractice cases.

15 A But in what sort of testimony within the medical
16 malpractice cases because there seems to be a winnowing as
17 one gets closer and closer to trial, in my opinion.

18 Q So explain what you mean.

19 A That at least in my experience when I'm retained
20 by the plaintiff, it's more likely to end up in trial than
21 when I'm retained by the defense. So I don't know whether
22 you mean opinions, whether you mean deposition testimony, or
23 whether you mean trial testimony because I think the ratio
24 changes as the cases get settled---

25 Q (interposing) Okay. That's---

1 A ---or go away.

2 Q That's fair enough. How about in terms of just
3 your initial retention? What would you estimate the division
4 is?

5 A I would think two thirds by the defense and maybe
6 a third by the plaintiff.

7 Q And how are you generally contacted? Who
8 generally contacts you to provide that testimony?

9 A Usually an attorney.

10 Q And are these attorneys who you're previously
11 familiar with?

12 A Some I am and some I'm not.

13 Q And are any of those attorneys connected to people
14 who may have gotten you involved in the constitutional cases
15 in which you've provided testimony?

16 A It seems to be two different strains of lawyer.

17 Q It seems to be or you know it's two different
18 strains of lawyer?

19 A I don't know it is, but it seems to be that people
20 who do what y'all do--what I assume you do; I don't know what
21 you do--are different than the people who do tort actions.
22 It looks different to me.

23 Q So it's---

24 A (interposing) I don't see a lot of overlap
25 between the two.

1 Q So it's your recollection that they have not been
2 the same folks?

3 A To my recollection they have not been.

4 (Exhibit 2 was marked for
5 identification.)

6 Q Sir, I'm showing you what's been marked Exhibit
7 Number 2. It's a declaration of John Thorp, Jr. in
8 opposition to Plaintiff's motion for preliminary injunction
9 in a case in Indiana. Do you recognize this declaration?

10 A Yes, because I recall Tippecanoe County.

11 Q That's how you recall it?

12 A Yeah. Have you ever seen Tippecanoe County
13 before?

14 Q I have not.

15 A Neither have I.

16 Q Sir, can you turn to page 14?

17 A Sure. I can try to.

18 (Witness complies.)

19 Q Thank you.

20 A I'm there.

21 Q Great. Your signature there--is that your
22 signature?

23 A That's my long signature.

24 Q Okay. This is--because I was at--this is getting
25 back---

1 A (interposing) And this one (indicating) is my
2 short signature. And when I recently closed a mortgage,
3 which was a month ago, I did the short signature. My wife
4 had advised me to not do the short signature. And I had to
5 come back and the lady had to come back and I had to do the
6 long one.

7 Q So the signature in Exhibit 2 is your long
8 signature; correct?

9 A To my mind that's my full name, where the second
10 one is just Thorp.

11 Q And so then in Exhibit 1, that is what you call
12 your short signature?

13 A Yes, ma'am.

14 Q Both of them are your signatures; correct?

15 A Both of them are my signatures. And I prefer the
16 short signature. I think it's cooler, but---

17 Q And quicker to write?

18 A And quicker.

19 Q And as a doctor, you frequently sign things
20 quickly, I would imagine?

21 A I think so. But the mortgage underwriter did not
22 like the short signature.

23 Q To your knowledge have you ever been the subject
24 of a challenge to disqualify you from providing expert
25 testimony?

1 A Not that I'm aware of.

2 Q And so have you ever been disqualified from
3 providing expert testimony to your knowledge?

4 A Not that I'm aware of.

5 Q Going back to Exhibit 1, your report, could you
6 explain to me the process you went through to write your
7 report?

8 A I think I took other reports and the like--well,
9 let's take a step back. Do you mean how I actually produced
10 this document or the thinking processes that led to the
11 production of this document? How broadly do you want me to
12 go or not?

13 Q Go ahead. Tell me--well, not about the specifics
14 of the substance of it, but how you physically went about
15 drafting the report. I should back up and ask you, did you
16 draft your report?

17 A I think it was an iterative process in conjunction
18 with the attorneys and the state of Alabama.

19 Q And so you mentioned before that you thought that
20 you had used previous reports as well; is that correct?

21 A I think that lawyers tend to steal text from one
22 another, it looks like to me as a non-lawyer. And so I think
23 previous reports, structures, phrases get lifted and
24 wordsmithed into new reports is my guess.

25 Q But you were aware of the fact that the language

1 in your reports has been--and testimony has been similar from
2 case to case; correct?

3 A Well, I think the issues and what my testimony is
4 has been similar. And given that it's--I've sworn to tell
5 the truth, it better be similar.

6 Q How many hours did you spend, approximately,
7 preparing your report?

8 A I have no idea. I don't recall.

9 Q Do you keep records of the time that you bill?

10 A Yes, ma'am.

11 Q And so you don't recall today how long it took
12 you, but your records would speak to that?

13 A Yes, ma'am.

14 Q Did Defendants in this case place any limitations
15 on the amount of time that you could spend preparing your
16 report?

17 A Not that I recall.

18 Q So if you could take a look at Exhibit 1, your
19 report, does this document accurately set forth your opinions
20 with respect to the topics discussed in the report?

21 A I think it summarizes my opinions.

22 Q And have you changed any of those opinions since
23 signing it?

24 A I don't think so.

25 Q You have no reason to believe that you've changed

1 them?

2 A I have no reason to believe that I've changed
3 them.

4 Q Do you plan to do any further work to formulate or
5 revise these opinions?

6 A I haven't been asked to.

7 Q Have you made an effort to include in your report
8 all the relevant facts and data on which your opinions are
9 based?

10 A Well, again, a summary of the relevant facts and
11 opinions. It's not the whole universe of facts and opinions
12 that inform this topic, but I've tried to put it there for
13 you.

14 Q So the facts and opinions--the facts and data that
15 inform your opinion that are not in this report, what do you
16 mean by that?

17 A We;;. there's a whole universe of facts and
18 opinions. And you obviously can't in 30 pages put every fact
19 and opinion.

20 Q But you have done---

21 A (interposing) So this is a summary pertinent to
22 the legal question or the question about this law from my
23 vantage point that I've tried to put in there.

24 Q But you don't expect to rely on any additional
25 facts or data in connection with your opinion in this case,

1 do you?

2 A Well, I imagine there could be new facts and data
3 presented to me that could either change, modify, or bolster
4 my opinion.

5 Q At this point, though, you don't expect--you don't
6 anticipate having any additional facts or data?

7 A But the fact whether I anticipate it or not
8 doesn't mean that it's not there.

9 Q Right, but you don't anticipate it at this time;
10 correct?

11 A I don't understand--I anticipate that things
12 change. It's just a question of when.

13 Q But at this point if nothing changes, you don't
14 expect to introduce--offer opinions based on any additional
15 facts or data; correct?

16 A I don't have any new thing to give you this red
17 hot second, if that's what you're asking me.

18 Q Your hourly fee is \$385 per hour; is that correct?

19 A Yes, ma'am.

20 Q And is that the same fee that you charge in your
21 other cases in which you provide expert testimony?

22 A Are you talking about the constitutional,
23 so-called constitutional cases, or are you talking about the
24 medical---

25 Q (interposing) Let's start---

1 A ---malpractice cases?

2 Q Let's start with the constitutional cases.

3 A I think it varies from place to place and what
4 people are willing--able to pay. And having been a state
5 employee for 30 years, states try to be pretty cheap.

6 Q Have you been paid more than this per hour in a
7 constitutional case?

8 A I think so.

9 Q And have you been paid less than this per hour in
10 a constitutional case?

11 A I think so.

12 Q What do you do with the money that you make
13 testifying as an expert?

14 A Again, are we talking about constitutional cases
15 or are we talking about tort cases?

16 Q Is there a difference between how it's treated?

17 A There's a huge difference.

18 Q Okay. So start with constitutional cases.

19 A I spend the money, pay taxes on it and spend it,
20 or save it.

21 Q So the money is personal to you?

22 A Yes.

23 Q It goes into Dr. Thorp's bank account?

24 A Yes, ma'am.

25 Q And how about the malpractice cases?

1 A Dr. Thorp's joint bank account with his wife.

2 Q My mistake. And how about the malpractice cases?

3 A My employment contract with the University of
4 North Carolina, as does every faculty member's, stipulates in
5 an action against a physician, a claim of medical negligence,
6 that that money goes to the university and it's university
7 money. So the university bills and collects for the medical
8 malpractice cases.

9 Q And then what happens to that money once the
10 university has it?

11 A They take a hell of a lot of it and then they give
12 me some back, not in salary, but that I can apply to a
13 university approved expense.

14 Q And what types of expenses?

15 A I support a graduate student in the School of
16 Public Health. I bought a truck in Malawi for one of our
17 doctors to use who repairs fistula; if--you know, business
18 travel expenses and the like.

19 Q Why the difference in the treatment? You
20 mentioned that your contract with the university says that
21 cases involving negligence that that money goes to the
22 university.

23 A You'd have to ask my bosses, number one. But what
24 I understand is that, as you've probably figured out if
25 you've been here awhile, that this is a small town, and

1 you've got an 800 bed hospital, that if your doctors in your
2 hospital are out testifying against doctors in the state and
3 making money that that could impede referral of patients.
4 And so I think they just said, "Everything you do goes to the
5 university. You can't independently consult."

6 I think the university does not--I know the
7 university does not want to have an opinion on termination of
8 pregnancy. It wants to allow an array of different opinions
9 to exist. Thus this is seen as my personal work. And I'll
10 take vacation time for the deposition this afternoon, and if
11 you want to spend another night here, tomorrow afternoon.

12 Q And so aside from the malpractice cases, is the
13 way you've described the university handles your testimony in
14 abortion cases similar to how it would treat other areas in
15 which a doctor might be retained to provide testimony?

16 A I think so, but I don't--I don't really know.

17 Q But there's nothing in your contract with the
18 university that precludes you from providing your testimony
19 today; correct?

20 A Not that I'm aware of; I don't want to lose my job
21 because I spent an afternoon with you.

22 Q So your understanding is that you take vacation
23 time to provide your testimony?

24 A I take time off because this--because I will--if
25 the state of Alabama decides to pay me, I will get paid for

1 this over and above my university salary.

2 Q Are there other limits on your participation in
3 terms of use of university resources or---

4 A I have to fill out a form for external
5 professional activities for pay that says I won't use
6 university resources and the like.

7 Q And so that's something you comply with?

8 A I try to.

9 Q Is your compensation in this matter contingent in
10 any way on the outcome of this case?

11 A I hope not.

12 Q So the answer is no, as far as you're aware?

13 A Well, I don't know. I think me suing the state of
14 Alabama to get money I think they owe them in Alabama would
15 be a fool's errand.

16 Q So as far as you---

17 A (interposing) So I don't know if they're going to
18 cut me off or what they're going to do.

19 Q No one has told you that your--that your payment
20 in this case is contingent on success?

21 A No, ma'am.

22 Q If you could turn to page 35 of your expert
23 report, sir?

24 A Yes, ma'am.

25 Q It should be where your CV starts.

1 (Witness peruses document.)

2 Q Do I have that right?

3 A I think it's in the middle of my--well, maybe
4 that's page 35 of my CV.

5 (Witness peruses document.)

6 Q I'm sorry. 35--it should be the Appendix A.

7 A Yes, ma'am. I'm there.

8 Q Do you see that? As far as you know, was this CV
9 up to date as of the filing of your report?

10 A There will be a date on the last page of when it
11 last revised that we can look at, so August of 2013. So
12 you've got a month old one.

13 Q And so is this the most up to date version of your
14 CV?

15 A I don't know.

16 Q Do you update it every month?

17 A I don't know when my secretary updates it. I give
18 her stuff to put on it to update it.

19 Q And so when you ask for a CV, she'll give you a
20 copy and you don't know when it was most recently updated?

21 A Well, I know exactly when it was most recently
22 updated because I go look in the back (indicating).

23 Q Well, you know that this was updated in August,
24 but I'm talking about whether there's a more recent version.

25 A Well, if she updated it today, she'd say November

1 of 2013. I don't know whether there's a more recent copy or
2 not.

3 Q That was my question.

4 A Okay; sorry.

5 Q Sitting here today, you can't say whether there's
6 anything missing from this CV; is that correct?

7 A We can call the office and get you whatever
8 version she's giving out today.

9 Q Could you describe for me your medical education
10 and your training?

11 A I couldn't get in medical school at UNC, so I went
12 to the new medical school at East Carolina in Greenville,
13 North Carolina. I then came to UNC and did a residency and
14 fellowship and joined the faculty.

15 Q And so have you--are you a lifelong Chapel Hill
16 resident?

17 A I didn't grow up in Chapel Hill.

18 Q North Carolina?

19 A Rocky Mount, North Carolina, east of Raleigh, Nash
20 and Edgecombe counties.

21 Q And you have been at UNC for your entire
22 professional career?

23 A Yes, ma'am.

24 Q Where are you licensed to practice medicine?

25 A North Carolina.

1 Q You know, your CV says Malawi.

2 A And Malawi.

3 Q Your CV just says Malawi.

4 A Well, my CV is wrong then; North Carolina and
5 Malawi.

6 Q Why are you licensed in Malawi? It's on page 1 of
7 your CV.

8 A Because we started a fistula program and
9 ultimately a residency in Malawi for Malawians, the only
10 OB-GYN residency in that country. Our first residents were
11 enrolled on the 1st of November.

12 Q What's a---

13 A (interposing) And I have colleagues, three
14 colleagues there.

15 Q What is a---

16 A (interposing) We're also fortunate enough--I have
17 to dis the University of Alabama--recruited a couple named
18 Jeff and Elizabeth Stringer away from the University of
19 Alabama, who have an extensive women's health program in
20 Zambia, the adjacent country.

21 Q And so what's a fistula program?

22 A Do you want me to explain what a fistula is?

23 Q Yes, please.

24 A A fistula is a traumatic and permanent opening,
25 like a pierced ear, between bladder and vagina or rectum and

1 vagina or both that is a consequence of prolonged labor and
2 is a debilitating disease for a reproductive age woman.

3 And my colleague repairs fistula and we educate
4 and try to restore these young, mostly young--almost
5 everybody in Malawi is young--young women to become
6 productive members of society.

7 Q And so your colleague repairs the fistulas. Is
8 that a surgical procedure?

9 A It is a surgical procedure.

10 Q Is it one that you perform as well?

11 A I've assisted him, but I don't think there are--
12 these things are so big and so expensive I don't think
13 there's an American gynecologist who's not had international
14 experience, or urologist or general surgeon, who could even
15 begin to do it. It's fairly amazing.

16 Q And so which doctors would you say have the
17 expertise necessary to repair them?

18 A Because American women have access to cesarean
19 section in a safe and timely fashion, they don't develop
20 fistula to this extent. People will develop tiny, pinpoint
21 fistula posthysterectomy, postsurgery. Cancer can provoke
22 fistula. So somebody would need international experience.
23 And there are a handful of fistula surgeons and there are
24 thousands of African women with fistula.

25 Q And so---

1 A (interposing) We've got, you know, a big
2 business.

3 Q A lot of customers is what you're saying?

4 A We've got a lot of customers.

5 Q And what you're testifying is that doctors who are
6 best qualified to repair those fistulas are doctors who have
7 experience in doing such extensive fistula repair; correct?

8 A Well, true, but that's not to say that other
9 doctors can't assess, diagnose, and help rehabilitate.

10 Q But in terms of the actual surgery, the surgeons
11 who should be performing it are the doctors who have the
12 experience in doing such extensive repairs?

13 A That's usually what I look for when I'm looking
14 for a surgeon.

15 Q And are your--you mentioned that it's a colleague
16 who repairs the fistula. Does that colleague live in Malawi
17 full time?

18 A Yes, ma'am. He and his wife and children live in
19 Malawi full time. His name is Jeff Wilkinson.

20 Q And do all of the doctors who provide care there
21 also reside there full time?

22 A We found that to be the critical ingredient for
23 success, is to be willing to live there. A bunch of
24 Americans want to go and spend a week or two. That doesn't
25 really--the itinerant doctor doesn't work real well.

1 Q And when you have--when you have gone, how long
2 have you gone for?

3 A I've gone for a month. I went with the chancellor
4 of the university the first time. I'm not critical to
5 anything other than the development, the fund-raising, and
6 the like.

7 Q And do you see patients when you're there?

8 A I assist him in surgery and see patients with him.

9 Q And do---

10 A (interposing) He was our resident. I taught him
11 how to operate. He's far exceeded my abilities.

12 Q And so you don't see any patients on your own when
13 you're there?

14 A I see patients in my home. I see patients in
15 labor and delivery. There's a 18,000 delivery unit with one
16 little OR. I take care of patients there. I do some patient
17 care. I don't repair fistulas myself.

18 Q Do you deliver babies when you're there?

19 A I've delivered babies there.

20 Q And then what happens--because your testimony was
21 just that itinerant doctors don't work very well. If you've
22 delivered a baby in Malawi and there's a complication that
23 takes place with the mother after the delivery, what if you
24 had gone home?

25 A Well, usually we're responding to a complication

1 that arose during labor and delivery, a uterine rupture, an
2 emergency situation. And if there weren't a western person
3 there to help, that--you know, that might not get done at
4 all. But itinerant doctors can't change a culture. It's
5 people willing to live there. So I'm willing to help doctors
6 live there. That's my role.

7 Q Right, but I'm asking you about the deliveries
8 that you have been involved with. If one of those women
9 after you left had a complication, who would provide the care
10 to her?

11 A I guess it would depend on where she was and what
12 she was doing and what the complication was. And she might
13 not get any care at all.

14 Q But you would not be providing that care; correct?

15 A I can't go back 18 hours and respond to my
16 problem, if I created a problem or participated in care that
17 led to a problem.

18 Q And so she would be obtaining care either from
19 your colleagues who are in Malawi or from another physician;
20 is that correct?

21 A There are only four OB-GYNs in all of Malawi, so
22 she might not receive any care at all.

23 Q But if she did receive care, it would be from
24 another physician?

25 A True.

1 Q Where do you have hospital privileges?

2 A UNC Hospitals.

3 Q Is there more than one hospital?

4 A I don't know whether--it's one hospital.

5 Q Several locations? Is that why you hesitated?

6 A Yes.

7 Q But your privileges allow you to admit patients in
8 each of the hospitals, each of the locations?

9 A I don't know. I've never tried to admit anybody
10 at any of the other locations.

11 Q So which hospital will you admit patients?

12 A To the UNC Women's and Children's Hospital.

13 Q Just Women's and Children's?

14 A Yes, ma'am.

15 Q Have you ever held admitting privileges at any
16 other hospitals?

17 A I helped start the residency in Asheville at
18 Memorial Mission Hospital and flew out there every Wednesday,
19 staffed the high risk clinic, and I had privileges at
20 Memorial Mission. I also have worked at Wake Medical Center
21 in Raleigh when one of the MFM doctors had a stroke, and I
22 had admitting privileges for a brief period of time.

23 Q Is that called locus tenems (phonetic)?

24 A No, it was not locum tenens. Our faculty are in
25 Raleigh. I went to a different place. And I think at some

1 point in time I've had privileges at Durham Regional Hospital
2 when we did consulting work there. Currently the only place
3 I have privileges is at UNC Hospital.

4 Q So why don't you have privileges anymore at
5 Memorial Mission?

6 A Because we were successful and there's a free-
7 standing residency and ten attendings and they don't need me
8 anymore. I'm hoping the same thing is going to happen in
9 Lilongwe.

10 Q Did your privileges there lapse or were--did the
11 hospital revoke your privileges?

12 A I've never had my privileges revoked, so--I don't
13 know what lapse means.

14 Q Well, I assume privileges--you generally need to
15 renew them every certain period of time; correct?

16 A I guess so.

17 Q And do you think that that's what happened with
18 your privileges in--at Memorial Mission?

19 A Well, I think we probably mutually agreed that
20 there was no longer a role for UNC there and thus there was
21 no need for me to have privileges there.

22 Q And how about Durham Regional?

23 A Duke bought Durham Regional, and I don't want to
24 work for Duke.

25 Q Why is that?

1 A Well, if you have to ask the question---

2 Q (interposing) I'm not from town.

3 A ---you don't have a very good understanding.

4 Q I know something about the basketball. Was it
5 just the rivalry?

6 A Yeah, there's a rivalry.

7 Q Got that.

8 A Duke sucks.

9 Q Got it.

10 A S-u-c-k-s.

11 (Reporter nods affirmatively.)

12 She likes it too.

13 Ms. Flaxman: She agrees with it.

14 The Reporter: I was just agreeing with the
15 spelling. I have no opinion---

16 The Witness: (interposing) As do---

17 The Reporter: ---as to anything.

18 The Witness: As do most North Carolinians.

19 By Ms. Flaxman:

20 Q And so Durham Regional--did you let your
21 privileges there lapse?

22 A I don't think I let them lapse. I think they
23 ended. Lapse--lapse sounds like a deficit to me. It sounds
24 like a negative word. I just--we just quit going because the
25 Dukies were going.

1 Q So you didn't take steps to renew your privileges
2 when your---

3 A (interposing) I don't remember if I took steps to
4 not renew or whether I just called and said, "Drop me. I
5 don't need to come anymore." I can't remember.

6 Q And so what did you use your privileges at Durham
7 Regional for?

8 A We had an office there and we saw patients in
9 consult from private doctors at Durham Regional.

10 Q And so by office there--the "we" you mean the UNC
11 department?

12 A Yes, ma'am. But they don't credential a
13 department. They credential an individual.

14 Q So have you ever been denied staff privileges at
15 any hospital?

16 A Not that I'm aware of.

17 Q And when I say staff privileges and admitting
18 privileges, do you understand those to be the same thing?

19 A I think there are million different variations on
20 a theme. No, I think they could be, might not be. It would
21 vary hospital by hospital.

22 Q Well, how about for purposes of today's
23 depositions we'll use them interchangeably unless you think
24 that there's a difference. Is that okay?

25 A Well, if you ask me a specific question, I'm going

1 to get you to define a specific credential for today and any
2 other day.

3 Q Okay. If it matters to the answer, just let me
4 know and I'll define it.

5 A Yes, ma'am.

6 Q So you have said that you are an MFM; correct? So
7 what is MFM?

8 A I don't think I've said I'm an MFM. I think I
9 said I've done a fellowship in maternal-fetal medicine and
10 hold a subspecialty certification therein.

11 Q Okay, so what's maternal-fetal medicine?

12 A Sort of taking care of mothers and/or fetuses with
13 medical or surgical conditions that put them at increased
14 risk of death or disability.

15 Q So it's generally high risk pregnancies?

16 A That would be one way of looking at it.

17 Q Is this primarily your area of practice?

18 A Well, it's a subspecialty certificate, so it's sub
19 or underneath obstetrics and gynecology. So I think I'm
20 first an obstetrician and gynecologist as my profession. And
21 I have special training, expertise, and certification in
22 maternal-fetal medicine.

23 Q Are most of the patients you see pregnant women?

24 A It's variable.

25 Q Well, tell me then what kind of services you

1 provide.

2 A I practice as an obstetrician and gynecologist and
3 within that realm take care of people with, your phrase, high
4 risk pregnancies.

5 Q What gynecological care do you provide?

6 A I quit doing all but office based surgical
7 gynecology four or five years ago, I think--I'm bad with
8 time--because the rest of my life had gotten busy enough,
9 largely my research world, that something had to go. So I
10 see patients in the--GYN patients in the office, do GYN
11 procedures in the office, don't go to the GYN operating room,
12 and do the full range of obstetrics.

13 Q What types of gynecological procedures do you
14 perform in the office?

15 A Endometrial biopsy, vulvar biopsy, colposcopy,
16 cervical biopsy, IUD insertion/removal, completion of
17 spontaneous pregnancy loss, some GYN ultrasound.

18 Q When you say that you do these procedures in an
19 office setting, that's your everyday medical office?

20 A I'm not there every day, but--we have a bunch of
21 offices, so we do these things in multiple different offices.

22 Q But it's not an ASC or a hospital I guess is my
23 question. It's a medical office?

24 A Well, one of the offices is within the Women's
25 Hospital. It's the second floor--excuse me, the first

1 floor--of the Women's Hospital. The other offices are
2 freestanding. I don't know what you mean with the phrase
3 "ASC."

4 Q Ambulatory surgical center.

5 A It's not within an ambulatory surgical center.

6 Q Do you provide any sedation or anesthesia for
7 these procedures?

8 A Local anesthesia and conscious sedation on
9 occasion.

10 Q So when you said on occasion, you're referring to
11 conscious sedation?

12 A Uh-huh.

13 Q Local you provide more regularly?

14 A Yes, ma'am.

15 Q And what occasions might lead you to use conscious
16 sedation?

17 A Someone who could not tolerate something done
18 under local.

19 Q What would be an example of a patient who couldn't
20 tolerate something done under local?

21 A People have different pain tolerances and
22 different anxiety tolerances and different--different comfort
23 levels with different things. I go to sleep in a dental
24 chair to get my cavity filled. My wife requires--she wants
25 conscious sedation. I don't--we're getting the same thing

1 done. I think she experiences it differently than I do.

2 So I think that's the biggest variable, is that
3 individuality we all have regarding what hurts and what
4 doesn't and what scares the hell out of us and what doesn't.

5 Q Would you agree that using conscious sedation
6 increases the risks with those procedures to the patient?

7 A Yes, ma'am.

8 Q What are the risks to the patient from the
9 conscious sedation?

10 A Death would be the sort of biggest, but to have a
11 respiratory arrest, an aspiration event, to be overly
12 sedated, to be impaired on the way home and operate a vehicle
13 or something and be injured. It increases the risk.

14 Q And the risks that you just listed, to your
15 knowledge have any of those occurred to any of your patients
16 after a procedure?

17 A Not to my knowledge.

18 Q You mentioned respiratory arrest as a possible
19 complication. If you were doing one of these gynecological
20 procedures under conscious sedation and the patient
21 experienced respiratory arrest, what steps would you take?

22 A Which place would I be in---

23 Q (interposing) Let's say you're---

24 A ---a freestanding office or the office that's in
25 the hospital?

1 Q Let's say freestanding office.

2 A We would call 911 and get an ambulance. We
3 would--depending upon what we had done conscious sedation
4 with, would administer a reversal drug, would provide oxygen
5 and if need be CPR, and transport the patient to the
6 hospital.

7 Q To which hospital?

8 A There's only one hospital in my mind, a UNC
9 hospital.

10 Q Is there only one freestanding office setting in
11 which you provide gynecological procedures?

12 A There are multiple freestanding office settings.

13 Q In which you provide procedures?

14 A In which I provide procedures.

15 Q And is UNC hospital the closest hospital to all of
16 this?

17 A Yes.

18 Q And what steps would you take with the hospital?
19 Would you call ahead to the emergency room?

20 A Yes.

21 Q And then what would happen?

22 A What do you mean what would happen?

23 Q Well, the patient would be sent by ambulance;
24 correct?

25 A I assume it would depend on how the response to

1 the reversal drug went, but if not, yes, by ambulance.

2 Q And then she would be taken to the emergency room?

3 A Yes, ma'am.

4 Q And then what would happen after that, once the
5 patient arrived at the hospital?

6 A She would be seen by the emergency room
7 physicians, and I think I would go with her to the hospital.

8 Q And would you actually treat her at the hospital?

9 A I would be one of the people treating her.

10 Q And wouldn't the GYN on call also be called?

11 A It would--not necessarily, no, ma'am.

12 Q And why would that be?

13 A Because I'm a GYN and I'm here with my patient.

14 Q And what if you had other patients back in your
15 office and so you couldn't leave at the time?

16 A I would leave them.

17 Q You'd just leave your patients there?

18 A Yeah, they can wait. We don't do more than one
19 procedure at a time and we don't do that real often. So yes,
20 ma'am, I would leave.

21 Q Now, if for some reason you couldn't leave, the ER
22 doctor would have the resources of an on-call GYN; correct?

23 A Yes. One of my partners would be the attending of
24 the day or attending of the week and I would call him or her.
25 I can't imagine a hypothetical where I couldn't leave unless

1 I'd had a respiratory arrest trying to take care of a
2 respiratory arrest, but---

3 Q (interposing) But in that case---

4 A ---it's a hypothetical world, so you could kill me
5 as I was responding to the emergency.

6 Ms. Flaxman: Let the record reflect that the
7 witness came up with that hypothetical and not the attorney.

8 Q But in that case one of your partners would be on
9 call?

10 A We have a GYN attending of the day and a GYN
11 attending of the week, yes, ma'am, and we have multiple
12 residents. So I--if I could speak in your hypothetical, I
13 would alert that team and tell them what had happened, the
14 drugs administered, where I was in the procedure, whether the
15 procedure was completed or not, what this woman's wishes
16 were--if she's a Jehovah's Witness, you can't give her
17 blood, did she have a DNR. There are multiple things for me
18 to communicate to the receiving team.

19 Q But you could have that conversation over the
20 phone; right?

21 A I could have that conversation over the phone,
22 yes, ma'am.

23 Q And then those doctors would provide care at the
24 hospital?

25 A Those doctors would provide care in your

1 hypothetical, which I think is not going to happen.

2 Q Tell me how the call structure works at the
3 hospital. You mentioned there is a gynecologist--attending
4 gyn on call every day and then also for the week. Is that--
5 do they also cover obstetrics or is there a separate OB on
6 call?

7 A There is separate obstetric coverage and separate
8 subspecialty service coverage.

9 Q And so each division has their own call structure,
10 or schedule, I should say?

11 A Yes, ma'am.

12 Q And so when you mentioned the--or maybe perhaps I
13 mentioned OB--the gyn on call, who would that be, which
14 division?

15 A It's usually somebody in the generalist or women's
16 primary care division. Occasionally it's a subspecialty
17 gynecologist.

18 Q Now, do you take call?

19 A Yes, ma'am.

20 Q And what call do you take?

21 A I take in-house OB call and rarely do GYN call
22 because I don't--as I told you earlier, I don't go to the GYN
23 OR anymore.

24 Q And how often do you have in-house OB call?

25 A Two or three times a month.

1 Q And you said rarely GYN call. Could you estimate
2 how often that occurs?

3 A Less than five times a year.

4 Q What circumstances would lead you to take call?

5 A Holidays, meetings, things where a lot of people
6 are gone.

7 Q So schedules you're filling in when you can't get
8 coverage?

9 A Schedules that I'm filling in, and then I need a
10 surgical backup.

11 Q So you're talking about call for the women's---

12 A (interposing) For GYN, yes, ma'am.

13 Q So in your--in the call for your division, there's
14 also a surgical backup?

15 A I would personally need a surgical backup, some-
16 body to help me along those lines.

17 Q Because you don't typically provide gyn surgery in
18 the hospital; correct?

19 A I don't provide gyn surgery in the hospital.

20 Q So when you take gyn call, you also have a
21 surgical backup. Is that---

22 A (interposing) Yes, ma'am.

23 Q ---what you're saying? Okay.

24 A In the few events where I do that.

25 Q But that's not typical of the way call is

1 structured in your department?

2 A It's not typical of the way call is structured in
3 my department.

4 Q So is Women's Primary Healthcare--that's your
5 division; is that correct?

6 A That's the division I am the division director of.
7 I don't think it belongs to me.

8 Q That was my question, the one you're director of?

9 A Yes, ma'am.

10 Q Okay. And is that also the division that you are
11 a member of?

12 A I'm a member of three divisions, the MFM Division,
13 and the Global Women's Health Division.

14 Q So when you take OB call, you take it in
15 connection with MFM, the MFM department?

16 A I actually take it for both. I'm both the MFM and
17 the generalist.

18 Q Does the OB-GYN department have an ambulatory
19 surgical center?

20 A The hospital has an ambulatory surgical center.

21 Q And does the---

22 A (interposing) It has multiple ambulatory surgical
23 centers.

24 Q Do physicians in the OB-GYN department provide
25 procedures there?

1 A Yes, ma'am.

2 Q What types of procedures?

3 A It seems like every procedure in benign
4 gynecology. Nobody gets to spend the night in the hospital
5 anymore.

6 Q What do you mean by benign gynecology?

7 A Everything but cancer.

8 Q The traditional meaning of benign?

9 A The traditional meaning.

10 Q Okay. And is that being driven by insurance?

11 A I don't know what it's being driven by.

12 Q Do you ever provide procedures at the ASC?

13 A I haven't since I quit doing GYN surgery.

14 Q But you did before?

15 A Yes, ma'am.

16 Q Is this a freestanding ASC or is it close to the
17 hospital?

18 A It's freestanding and close to the hospital.

19 Q It's both freestanding and near the hospital?

20 A Yes, ma'am; both.

21 Q And is there, I assume, general anesthesia
22 provided?

23 A Yes, ma'am; general and regional anesthesia.

24 Q And the potential risks you listed of conscious
25 sedation, they would be the same and more so for general; is

1 that correct?

2 A Yes, ma'am.

3 Q And if there were some sort of complication that
4 required a transfer from that ASC, would the procedures be
5 the same as you described from your office?

6 A I think there would be more help in the surgery
7 center than there would be in one of our off-site offices,
8 but generally the same.

9 Q We've been going about an hour. Should we take a
10 short break?

11 A I'll do whatever you want to do.

12 Mr. Parker: I'm fine too. My phone just
13 ran out of battery, so I can't--I don't know what time it is.

14 Ms. Flaxman: Oh, it's about 2:30. Why don't
15 we take just a short break?

16 Mr. Parker: All right.

17 The Reporter: Off the record. 2:32 p.m.

18 (A brief recess was taken.)

19 The Reporter: On the record. 2:42 p.m.

20 By Ms. Flaxman:

21 Q Doctor, have you ever performed an abortion?

22 A No, ma'am.

23 Q And have you ever personally provided the
24 counseling as the abortion provider prior to a procedure?

25 A I don't understand the question.

1 Q Have you provided counseling to a patient about to
2 undergo an abortion?

3 A I've talked to people with an unintended or crisis
4 pregnancy about termination. Because I'm not going to
5 perform the procedure, I would not be the person to counsel
6 them directly about it. I think that's the duty of the
7 surgeon who's going to do the case.

8 Q So that counseling you were just referring to you
9 have never done; correct?

10 A I have never done.

11 Q And are you personally opposed to abortion?

12 A Yes, ma'am.

13 Q As far as you know, what are the potential
14 complications from abortion?

15 A Well, I think that there are short term
16 complications and long term complications. Do you want
17 either/or or both?

18 Q Why don't you start with short term complications?

19 A Sort of any other surgical procedure: bleeding,
20 infection, unintended organ damage. Unique to termination of
21 pregnancy would be the failure to terminate.

22 Then in terms of long term complications, I think
23 the strongest case can be made for subsequent preterm birth.
24 To my mind the mental health consequences are difficult to
25 ferret out between the things that lead somebody to make that

1 difficult decision versus the actual procedure itself, but
2 some suggestion of harm.

3 And then I'm not particularly convinced about the
4 abortion-breast cancer reputed link, although there might be
5 a loss of protection phenomenon that could occur and very
6 difficult to study or measure.

7 Q So just asking about the abortion-breast cancer
8 debate, you don't know if there's a link or not; correct?

9 A I think the epidemiologic studies are mixed with
10 different conclusions. I think it is a well-known fact that
11 an early term pregnancy and/or lactation are protective
12 against subsequent breast cancer. So I wonder and have
13 actually done some very simplistic modeling--and modeling is
14 probably too fancy of a word--to show that there could be a
15 loss of protection phenomenon that could occur, particularly
16 in young women.

17 Q So by---

18 A (interposing) Whether that truly exists or not I
19 don't know.

20 Q Because you haven't studied it?

21 A I haven't studied it and the U.S. would not be the
22 place to study it.

23 Q Now, the long term risks that you just listed.
24 Would you agree with me that the subject matter in this case,
25 admitting privileges, that those longer term complications

1 don't have any relevance to whether or not a provider might
2 have privileges; correct?

3 A Well, if there--if there truly is mental health
4 consequences or harms, then privileges, being part of a
5 hospital staff, might have something--might be applicable to
6 this case. Certainly if the pathway that leads to preterm
7 birth is subsequent preterm birth, which I think the
8 strongest epidemiologic case can be made for--if it operates
9 via cervical damage or infection, hospital privileges could
10 have something to do with that.

11 Q Okay, but that would arise out of a short term
12 complication; correct?

13 A I think--well, I think if they're causal, then
14 they all arise out of the event that occurred. Whether the
15 path that leads to those outcomes can be interrupted early
16 and that harm avoided or reduced I don't think anybody knows.

17 Q Yeah, but in the case of the cervical damage you
18 just mentioned that you think could have an effect on preterm
19 birth, that's a complication that would occur in the
20 immediate term after an abortion; correct?

21 A Well, if it occurred at the time of the
22 abortion---

23 Q (interposing) Correct.

24 A ---whether it was--whether it could be recognized,
25 repaired, or mitigated and when I don't think anybody knows.

1 Q But what I'm saying is, is that when admitting
2 privileges might be relevant to an abortion would be in the
3 time frame immediately after the abortion when short term
4 complications would occur, if they do.

5 Mr. Parker: Object to the form.

6 A But if in the short term you can interrupt the
7 processes or mitigate or reduce the processes that lead to a
8 long term consequence, then admitting privileges might have
9 relevance.

10 Q How?

11 A How?

12 Q Yeah. Tell me how.

13 A Okay. Hypothetically, somebody undergoes a
14 termination of pregnancy, has a cervical laceration. She
15 maybe--people with cervical lacerations bleed longer or bleed
16 more heavily. Maybe that person goes to the emergency room
17 on day eight, day ten with a complaint of bleeding.

18 Maybe because of the doctor who performed her
19 surgery and because of the sensitive nature of that decision,
20 she doesn't disclose or there's not knowledge there. And
21 maybe that laceration, that damage, could be repaired at that
22 moment in time. So I think admitting privileges could have
23 something to do with long term consequences.

24 Q All right. But in that hypothetical you just
25 listed, where admitting privileges would be relevant, if at

1 all, would be in treating that short term complication?

2 Mr. Parker: Object to the form.

3 Q Correct?

4 A Well, I think that--I think--I think I've tried to
5 answer your question as best I can.

6 Q So just to clarify your answer, then---

7 A (interposing) Yes, ma'am.

8 Q ---what you're saying is that admitting
9 privileges--it's your opinion that admitting privileges would
10 be relevant because of the repair that would need to be done
11 eight to ten days after the procedure; correct?

12 Mr. Parker: Object to the form.

13 A I think that there would be a wide array of
14 different reasons why it might be relevant.

15 Q But in that specific example of a woman who had a
16 cervical laceration and went to the hospital eight to days
17 later with bleeding, privileges are relevant in your opinion
18 at that point to repair that short term complication?

19 Mr. Parker: Object to the form.

20 A I think in large part some--there would have to be
21 something--a condition that could be detected and something
22 that could be done to mitigate or reduce long term harm.

23 Q Right, but so---

24 A (interposing) I don't know that there is or there
25 isn't. So privileges, if there is, could have relevance.

1 Q Right. So privileges in your testimony have
2 relevance if there's a condition that can be detected or
3 diagnosed at that time; correct?

4 Mr. Parker: Object to the form.

5 A If there is a process that can be interrupted or
6 changed by some action of a clinician, then admitting
7 privileges could have relevance to long term harms.

8 Q Now, you mentioned the short term complications
9 being the usual surgical complications of bleeding and
10 infection, unintended organ damage, and then failure to
11 complete the termination. Are there any other surgical
12 complications that you're aware of?

13 A I guess it wouldn't be a surgical complication--it
14 would be a diagnostic complication--but an undiagnosed
15 ectopic pregnancy or undiagnosed heterotopic pregnancy.

16 Q And what about medication abortion? Are the
17 complications different from the ones you've already listed?

18 A I think the likelihood of each is different, but
19 they are the same.

20 Q Now, you've never performed an abortion. So if
21 you've never performed an abortion, how do you know that
22 these are the complications from an abortion?

23 A Well, one, I've emptied many uteruses with
24 pregnancy loss that was either incomplete or missed. Two,
25 I've taken care of abortion complications. Three, in my

1 residency training and on a very busy termination of
2 pregnancy service where instillation procedures were done, I
3 did not do the instillations, but--and I did not deliver the
4 babies or the fetuses, whichever word you would prefer me to
5 use, but I did get the placentas out and handle the
6 complications for hundreds of those. So I think short of
7 having performed a termination of pregnancy, I think I have a
8 lot of experience along those lines.

9 Q So going back to emptying many uteruses of
10 pregnancy loss, by that are you referring to D&C?

11 A Well, we do that the same way termination of
12 pregnancy providers empty a uterus. You can do it surgically
13 or you can do it medically.

14 Q And so you would agree that treatment of pregnancy
15 loss in the case of miscarriage is similar to procedures used
16 to complete abortion?

17 Mr. Parker: Object to the form.

18 A Similar, but not identical.

19 Q How are they not identical?

20 A Because a viable, ongoing--well, one, a termina-
21 tion of pregnancy results in the ending of a potential life,
22 where the other does not. Two, a viable pregnancy, ongoing
23 pregnancy, is continuing to expand the amount of cardiac
24 output going to the uterus, where a failed pregnancy or
25 pregnancy loss is not exerting that biologic effect on the

1 maternal vascular and cardiac systems. So I think those two
2 things are different.

3 Q And so the physiological difference for the
4 patient is perhaps additional blood? Is that what you mean
5 by the second?

6 A I think an additional propensity for blood loss,
7 yes, ma'am.

8 Q But the techniques used are the same; correct?

9 A The techniques used are the same.

10 Q And you've just testified that the complications
11 from the procedures are the same; correct?

12 A They are similar. And then I guess the other big
13 difference is one is elective. It doesn't have to be done.
14 The other is indicated.

15 Q But that doesn't change the complications that
16 might occur; correct?

17 A It changes the urgency and the--and I think there
18 is a difference, a big difference, between an elective
19 procedure and an urgent or an indicated procedure.

20 Q Well, the patients could be sicker, right, in the
21 procedures that you perform?

22 A They could be sicker, but they don't have a
23 choice. Usually they're--what they would have autonomously
24 chosen has been overridden by biology or nature or nature's
25 god.

1 Q Now, if you had--what are the complications of a
2 woman who's experiencing pregnancy loss? I'm sorry. What
3 are the symptoms of a woman experiencing pregnancy loss?

4 A They range from none to bleeding, pain.

5 Q And so they can be the same symptoms as a woman
6 who's experiencing symptoms after an abortion; correct?

7 A Well, the symptoms can be similar. Yes, ma'am, I
8 would agree the symptoms can be similar.

9 Q And is it your opinion, then, that the treatment
10 of those symptoms would be different?

11 A Well, the treatment is radically different.

12 Q Tell me how.

13 A The one woman wants to stay pregnant and the other
14 woman wants to not be pregnant. So there's completely
15 different goals in treatment.

16 Q How about in a patient experiencing pregnancy loss
17 where the pregnancy can't be saved?

18 A The fetus is dead.

19 Q Correct.

20 A Okay.

21 Q Tell me how the treatment of that patient would
22 differ from the treatment of a patient experiencing symptoms
23 after an abortion.

24 A Well, that person may have no symptoms or may have
25 extreme symptoms. And the person after a termination of

1 pregnancy may have--may do fine and have no symptoms or may
2 have symptoms. I don't see how you can compare post-
3 procedure to pre--I don't understand.

4 Q Well, you have two women who come--two women who
5 come into the hospital. One is complaining of bleeding after
6 an abortion and the other is bleeding because of a mis-
7 carriage. How does the treatment differ?

8 A Well, in the first instance you need to determine
9 whether the fetus is alive or dead, and that's a huge branch
10 point in the treatment. In the other, I guess you could have
11 a failed abortion where a fetus was still alive, so you'd
12 want to know whether the termination terminated the fetus's
13 life or not. But you're trying to handle a surgical
14 complication.

15 So in the one instance you're trying to handle a
16 complication of biology and the other you're trying to handle
17 a complication of an elective surgical procedure. So I
18 think--and they have different intents, different wishes,
19 different--I think they're a little--I think they're
20 different.

21 Q Well, I understand the causes might be different.
22 But in the case of two women who are bleeding--now, first of
23 all, I mean what's the first thing? You're going to do a
24 pregnancy test; right?

25 A Well, the first thing I'm going to do is take a

1 history.

2 Q Okay. And then what?

3 A Well, a history is important, so if we're going to
4 do a hypothetical, I'm going to take a history. You're going
5 to have to give me more than then what. You've given me two
6 facts, woman and bleeding.

7 Q Well, okay. So you have two women: a woman who's
8 bleeding from an abortion and she's complaining about
9 bleeding; right?

10 A Postabortion.

11 Q Postabortion.

12 A And when did she have the abortion?

13 Q Well, let's just say she had it the day before.

14 A Okay.

15 Q Okay?

16 A Surgical or medical?

17 Q Let's say it's medical.

18 A Done where?

19 Q You pick a provider.

20 A I get to pick.

21 Q Sure.

22 A In your hypothetical you're---

23 Q (interposing) Sure.

24 A ---allowing me to---

25 Q (interposing) Because I wanted to explore how it

1 may make a difference--any outpatient abortion provider. She
2 comes in. She's bleeding.

3 A Can I talk to the termination provider or review
4 his or her records or am I just dependent on what the patient
5 tells me?

6 Q Well, you tell me how it would make a difference
7 to the treatment of the patient.

8 A It would greatly expedite the treatment for me to
9 have communication with the person that provided the
10 termination of pregnancy.

11 Q How?

12 A How?

13 Q Yeah. Tell me what you would learn that you
14 couldn't learn from the patient. We're talking medication
15 abortion.

16 A I would learn the doctor's estimate of gestational
17 age, pertinent medical facts, and patients don't recall all
18 that.

19 Q But how that affect all of--knowing that, how
20 would that affect how you would treat that patient?

21 A Well, if she were RH negative, she might need more
22 Rhogam. If she were--I mean there--it would all depend on--
23 that history is important.

24 Q Well, give me specifics as how.

25 A Well, I just gave you one specific.

1 Q Okay, okay. You gave me Rhogam. But if she
2 was---

3 A (interposing) I don't think I have to give you
4 specifics within your hypothetical.

5 Q Well, I'm asking the questions here, sir. You do
6 need to answer my questions.

7 A That wasn't a question. I said I don't think I
8 have to provide you specifics---

9 Q (interposing) Can you give---

10 A ---within your hypothetical.

11 Q Can you give me specific examples?

12 A I gave you one and I can think of probably more,
13 but I've never really thought of it that way.

14 Q So think for a second about whether there are more
15 facts that you would need to know from a provider in deciding
16 what treatment to provide to that patient.

17 A Well, it would be helpful and appropriate in
18 medical care to build your care upon the foundation that was
19 constructed by another physician, who in the light of day
20 prior to an elective procedure elicited things: parity,
21 blood type, labs, gestational age, will or won't receive
22 blood products, allergies, how did you--did you do the
23 medical abortion where you observed the patient take the
24 medicine or did you do the one where you gave the medicine
25 and she did it at home.

1 Q But how do any of those specific questions you
2 would have affect the care that you provide to a patient?

3 A Well, they inform the branch points I go down---

4 Q (interposing) Okay, but so---

5 A ---in the care.

6 Q Tell me about--so if a patient is bleeding, what
7 are the possible branch points? What are the different
8 treatments that you might choose for a patient who's
9 bleeding?

10 A Well, is this a--this was a medical termination.

11 Q Sure.

12 A And did they do it the way the FDA says to do it
13 where the person takes the medicine in the facility or did
14 she take the medicine at home?

15 Q What are the--leaving that aside, leaving aside
16 the information that you--that you want to get---

17 A (interposing) Well, how can I leave aside the
18 information I want to get---

19 Q (interposing) I'm asking you--I'm asking you a
20 different questions, sir. I'm asking you what are the
21 possible different treatments that you have to choose from in
22 treating a patient who's experiencing bleeding after a
23 medication abortion?

24 A What are the possible different treatments? Well,
25 like what was her starting hematocrit.

1 Q Well, that's not a treatment. That's a--that's
2 a---

3 A (interposing) But that's going to--when I see her
4 hematocrit now, it will give me a much more accurate
5 estimation of her blood loss, does this require a trans-
6 fusion. You build upon--you build upon the care previously
7 rendered, particularly for something that was done
8 electively.

9 Q What if the elective---

10 A (interposing) And you're always a better--
11 something somebody chose to do, "We're going to do this
12 tomorrow at 3 o'clock," fill your tooth tomorrow at 3
13 o'clock. I could do it Friday. I could do it next Friday.
14 I could wait until after Christmas. I'm going to do this--
15 it's elective. I elected to do it.

16 Q No, I understand. I understand what elective
17 means. I'm just wondering how that affects what your
18 treatment is when you're treating a complication.

19 A Well, with elective things, people have the luxury
20 of having information. The health care providers usually
21 know a lot about the patient: her wishes, what baby is this,
22 what were her starting lab values, why was this way chosen
23 over that way, did somebody in your office observe her take
24 the medicine or did she take the medicine at home, on and on
25 and on.

1 So you build your care upon--upon that, upon that
2 foundation, as opposed to somebody who woke up in the middle
3 of the night, hasn't been to any doctor yet, and has bleeding
4 and a positive pregnancy test. They're two different--
5 they're two completely different scenarios.

6 Q Let me ask you, though--you mentioned about the
7 possible treatments that you might provide to a patient
8 experiencing these symptoms. You mentioned transfusion as
9 one.

10 A That's a commonly accepted treatment for bleeding.

11 Q And what are other--would emptying the uterus be
12 one?

13 A Well, it depends on what's in the uterus and it
14 depends on whether--what the person did with her medicine:
15 did she take it, has she not taken it. Some of that you'll
16 get from her. Some of that, it might have been observed.
17 Might you empty her uterus medically if it needs further
18 emptying? Was there a cervical laceration there? Was there
19 some cervical preparation done with laminaria, misoprostol?
20 So there's a lot of information that is of value, and why
21 should it be discarded?

22 Q Well, I'm not asking you that question. I'm
23 asking about as a provider---

24 A (interposing) You act like it's worthless, that I
25 see termination yesterday, bleeding, I'm going to do the same

1 thing to every person, and I'm not.

2 Q My question is just how those situations are
3 treated and whether they can be treated without having all
4 that information. And you talked about there being---

5 A (interposing) Well, they certainly can, but they
6 shouldn't be.

7 Q But they can be?

8 A They can be, but they shouldn't be. That's the
9 whole opinion of this case, I think.

10 Q Well, because doctors--they can be because doctors
11 are trained to assess these complications and provide needed
12 care; correct?

13 A Sure, but it would be better--it would be optimal
14 for that information to be communicated.

15 Q But they don't need to have it?

16 A They can save somebody's life without having it,
17 but can they increase the cost and increase the potential
18 harms without it? I think they can. And why wouldn't you
19 want the information transmitted? Why wouldn't I want that
20 information, if it's available?

21 Q Have you personally treated a complication from an
22 abortion?

23 A Yes, ma'am.

24 Q In what circumstances?

25 A Well, the--at that point in time they were called

1 therapeutic abortions or TAs. These instillation procedures,
2 there were a bunch of complications from them.

3 Q And is it just the instillation procedures?

4 A Well, that was--that was number one. And then in
5 the--in the emergency room when I was active in GYN call and
6 in our office people will show up after having had an
7 abortion with a complication or harm, so in multiple
8 scenarios. And it's always helpful to me to know what's
9 going on.

10 And there are termination of pregnancy providers
11 in town--and I saw you had something from Planned Parenthood
12 on your card, but Planned Parenthood right over there
13 (indicating), Charles--I can call him and he'll tell me
14 everything and I can take much better care of his patient.
15 And sometimes he'll even come to be with his patient. There
16 are other providers that come in and out of town, and I can't
17 communicate with them at all. And it's very--it makes it
18 difficult to be the person responding to a complication.

19 Q But the Planned Parenthood providers you do get
20 the information you---

21 A (interposing) From this Planned Parenthood across
22 the street (indicating). I don't have experience with other
23 Planned Parenthood providers. And maybe that's just a
24 function of him being a good doctor, not who he works for.

25 Q And so he has called the hospital?

1 A He would definitely call the hospital or call the
2 office, or if his patient came without him knowing and we
3 called, he would be responsive. If I called him up at 2
4 o'clock in the morning, he would be--he would say--or he'd
5 say, "I'll go to the office and get the records." He would--
6 he would respond. There are other providers in our community
7 who are not that responsive, not nearly that responsive.

8 Q So you mentioned instillation procedures during
9 your residency. I can probably do the math, but that was how
10 long ago?

11 A 30 years ago.

12 Q Because they aren't doing procedures that way now;
13 correct?

14 A I think they're doing some instillation abortions,
15 but not 1500 a year like they are now--like they were then.

16 Q Do you happen to know how late in pregnancy the
17 plaintiffs in this case provide abortions?

18 A Not specifically.

19 Q Now, you talked about--you said that you saw cases
20 in the emergency room, patients experiencing abortion
21 complications, when you were active in GYN call; is that
22 correct?

23 A Yes, ma'am.

24 Q So that's been at least--is it four years?

25 A Something like that.

1 Q So you haven't treated one of these complications
2 in at least four years?

3 A True, in the hospital setting. They've come to
4 our office. Most people don't know where to come when they
5 have a problem.

6 Q Tell me about the last specific complication you
7 recall.

8 A I don't have an independent recollection of the
9 last specific complication.

10 Q Well, describe a specific complication you recall.

11 A I don't recall a specific. I've seen bleeding,
12 infection, uterine perforation, cervical laceration post-
13 abortion in office and hospital settings.

14 Q Do you have a specific recollection of a
15 perforation that you've seen?

16 A No, ma'am.

17 Q Do you have a specific recollection of bleeding
18 that you've seen?

19 A No, ma'am.

20 Q How about infection?

21 A No, ma'am.

22 Q Now, you just--you mentioned a provider from the
23 local Planned Parenthood clinic. Can you recall at all
24 specifics of any complication that you've had interactions
25 with him about?

1 A On all these lines, people who do surgery have
2 complications.

3 Q But you don't recall any specifics of the
4 complications?

5 A Bleeding, infection, damage--unintentional
6 damage--to other organs.

7 Q But you can't recall any specific examples?

8 A I can't recall any specific.

9 Q And do--you say you see these patients in your
10 office. When was the last time you saw a patient in your
11 office?

12 A I would guess within the past year.

13 Q Six months ago?

14 A Well, my guess is within the past 12 months, so
15 it's a guess.

16 Q To your recollection do any of these patients
17 experiencing complications experience sepsis?

18 A How would you define sepsis?

19 Q How would you define sepsis?

20 A Blood culture positive bacteremia or---

21 Q (interposing) Is that the medical definition of
22 sepsis?

23 A It's one of the medical definitions.

24 Q Okay. Have you ever seen that in an abortion
25 patient?

1 A Yes, ma'am.

2 Q And give me the specifics of that.

3 A We've seen people on our termination service and
4 referred from other hospitals and providers, because we serve
5 the whole state of North Carolina, with abscesses, sepsis,
6 and infectious related death postabortion.

7 Q But again, you don't have any specific
8 recollection of an incident?

9 A No, ma'am. I don't write them down.

10 Q But you personally have treated these patients?

11 A Yes, ma'am.

12 Q Can you estimate how many patients total you have
13 treated?

14 A With sepsis?

15 Q Experiencing abortion complications generally.

16 A Including or excluding the residency experience
17 with the instillation procedures?

18 Q Let's exclude that.

19 A 100, 150.

20 Q And if you added the instillation experience
21 during your residency?

22 A I think it would at least double or triple.

23 Q How many abortions were taking place during your
24 residency?

25 A 1500 to 2,000 instillation abortions a year. And

1 then I don't know how many lower gestational age abortions.
2 At one point in time the instillation terminations out-
3 numbered the number of live births we were doing in labor and
4 delivery.

5 Q And what gestational age were you doing the
6 instillations above?

7 A Up until 24.

8 Q And where did you start?

9 A When did you start?

10 Q What gestational age would you start doing an
11 instillation?

12 A I never did the instillations. I think it was 18
13 to 24.

14 Q How many abortions does the UNC Hospital do now a
15 year?

16 A I don't specifically know. My guess is five to
17 ten a week, so maybe 500, 250 to 500.

18 Q Do you know Vincent Rue?

19 A Well, I've never met him. I've heard the name.

20 Q Have you spoken to him?

21 A On the phone, yes, ma'am.

22 Q Is he the connection between you and this case?

23 A I don't know.

24 Q So you don't recall him calling you and asking you
25 to participate in this case?

1 A I do not recall him calling me and asking me to
2 participate in this case.

3 Q Do you recall him e-mailing you to ask you to
4 participate in this case?

5 A I don't have a recollection of how I came--became
6 aware of this case or was asked to participate.

7 Q Is Vincent Rue your connection between you and any
8 of the other constitutional cases in which you've provided
9 testimony?

10 A Dr. Rue was often a consultant to attorney
11 generals--attorney generals' offices--on these cases. There
12 are other--it seems like there are other consultants that
13 help too.

14 Q And who are the other consultants?

15 A I can't recall anybody by name, but I meant that
16 to say he's not the exclusive consultant.

17 Q So it may have been another consultant who
18 contacted you about this case?

19 A Or it may have been the attorney general. I don't
20 remember.

21 Q Is Vincent Rue a medical doctor?

22 A I think he is a psychologist. He has a degree in
23 clinical psychology from the University of North Carolina.

24 Q Do you recall--you've spoken to him on the phone
25 you testified?

1 A Yes, ma'am. I don't think I've ever met him.

2 Q And do you recall what you spoke to him on the
3 phone about?

4 Mr. Parker: I'm going to object to that and
5 instruct you not to answer.

6 Ms. Flaxman: On what basis? He hasn't said
7 it had anything to do with this case.

8 Mr. Parker: Vince Rue has been noted as
9 he's engaged with the attorney general's office. He's an
10 agent of the attorney general for purposes of this case. So
11 you're essentially asking what is the attorney general's
12 office communicating with the witness about. And since this
13 witness is retained in this case to provide expert testimony,
14 I think that---

15 Ms. Flaxman: (interposing) Well, let me ask
16 him that and let me rephrase it, then.

17 By Ms. Flaxman:

18 Q Aside from this case, which you've testified you
19 don't recall how you got involved, did you have communica-
20 tions with Vincent Rue that did not relate to this litiga-
21 tion?

22 A Can--the objections make me nervous. Can you---

23 Q (interposing) He'll let you answer questions that
24 don't relate to the litigation. So I'm asking you if you've
25 had conversations with Mr. Rue that are unrelated to this

1 case.

2 A Other litigation.

3 Q Yeah, if that's what your conversations with him
4 have been about.

5 A Yes, ma'am.

6 Q Okay. So they've all been about litigation?

7 A He told me once that he went to graduate school
8 here and we identified that his graduate school classmate is
9 my son's father-in-law. He's a professor of psychology here.
10 That's the conversations that I remember.

11 Q Are you---

12 A (interposing) I also remember that Mr. Rue has a
13 son with Down syndrome that's like the Special Olympics in
14 Florida mile run winner or something.

15 Q Are you trained, sir, in epidemiology?

16 A What do you mean by trained?

17 Q Well, let's just back up for a second. What is
18 epidemiology?

19 A Study of causation.

20 Q And do you teach epidemiology?

21 A I lecture in epidemiology. I'm an adjunct
22 professor in the School of Public Health in epidemiology.
23 I'm a professor in maternal-child health with my specialty
24 being perinatal epidemiology.

25 Q And so what training or experience qualifies you

1 to hold those teaching positions?

2 A I have--the one embarrassing question you've asked
3 me. This is the first time I've personally felt discomfort,
4 but I have to mention a master's degree at Duke. And I fear
5 disinheritance of what meager inheritance I am due.

6 Q It can stay in this room, sir. So your---

7 A (interposing) No, it won't. It's on a damn
8 public record.

9 Q The master's listed on your CV is a master's in
10 what?

11 A Well, it's called clinical leadership, but it
12 included courses in epidemiology. I was a tenured professor
13 in the School of Public Health before I had the degree, so I
14 would describe myself as a clinical epidemiologist, an
15 untrained epidemiologist.

16 Q So your teaching that you were doing was based on
17 the experiences you have in treating patients; correct?

18 A Well, I think epidemiology is the basic science of
19 clinical medicine, that every clinician uses epidemiology to
20 one extent or another, and the--but I don't have formal
21 training. I wish I did.

22 Q Your next life?

23 A Maybe.

24 Q So based on that, do you believe you're qualified
25 to offer opinions on the quality and methodological soundness

1 of a particular epidemiological study?

2 A From a clinical epidemiologic perspective.

3 Q Can you turn to page 5 of your CV, which is
4 attached to Exhibit 1?

5 (Witness complies.)

6 Q Are you there?

7 A Yes, ma'am.

8 Q Under Memberships you list a number of
9 organizations?

10 A Yes, ma'am.

11 Q Are you a member of any organizations other than
12 the ones listed here?

13 (Witness peruses document.)

14 A Not that I know of.

15 Q Are you a member or otherwise affiliated with the
16 American Association of Pro-Life OB-GYNs?

17 A Yes, ma'am.

18 Q Describe that for me.

19 A Describe what for you?

20 Q Are you a member?

21 A Yes, ma'am.

22 Q Okay. And are you a member of the Christian
23 Medical and Dental Association?

24 A No, ma'am.

25 Q Are you affiliated with them or associated with

1 them in any way?

2 A Not that I'm aware of.

3 Q And how about the Catholic Medical Association?

4 A I know people in it, but I'm not formally
5 affiliated.

6 Q So you're not a member?

7 A I am not a member.

8 Q And so are you a member or otherwise affiliated
9 with the Bioethics Defense Fund?

10 A I'm friends with the two founders of the Bioethics
11 Defense Fund, Nik Nikas, N-i-k-a-s, N-i-k N-i-k-a-s, and
12 Dorinda Bordlee, B-o-r-d-l-e-e.

13 Q And do you recall submitting a brief with that
14 organization to the Supreme Court?

15 A I think that I have.

16 Q And what was that case about?

17 A I don't recall.

18 Q And do you recall submitting an amicus brief to
19 the U.S. Supreme Court with the American Association of
20 Pro-Life OB-GYNs and some other organizations in a case in
21 Oklahoma?

22 A I don't have an independent recollection, but I'm
23 not doubting that I did.

24 Q And if I told you it happened in the last year,
25 would that surprise you?

1 A Nothing about the lack of my memories would
2 surprise me at this point in time.

3 Q And so you mentioned--so you said you were a
4 member of the American Association of Pro-Life OB-GYNs, so
5 that should be on your CV membership list as well?

6 A Yeah. I don't know why it isn't, but I am.

7 Q And so are there any other organizations that you
8 can think of now that should be on here and aren't?

9 A I'm in the process--and I don't think there's been
10 a final ruling--of becoming a North American member of the
11 Royal College of Obstetrics and Gynecology. I hope that
12 comes to pass and my mentioning it doesn't---

13 Q Doesn't jinx it?

14 A Because I'd like to do that. I can't think of
15 anything else.

16 Q Well, let me ask you, you've been in your report
17 and here today referring not to abortions, but to termination
18 of pregnancy; is that correct?

19 A Yes, ma'am.

20 Q Why do you call it that instead of abortion?

21 A Because I think abortion is a confusing term and
22 is applied in clinical medicine to wanted pregnancies that
23 are lost or in the process of being lost and to elective
24 surgical procedures to end the pregnancy.

25 So Phil Steer, S-t-e-e-r, who is the editor

1 emeritus of the *British Journal of Obstetrics and Gynecology*,
2 to which I'm an editor, thinks that termination of pregnancy
3 is more precise language, more--a more accurate description
4 of what happens. So I try to consistently use TOP or
5 termination of pregnancy, although you've been fairly
6 relentless in not adopting that terminology and I've
7 slipped---

8 Q (interposing) Old habits die hard.

9 A And I've slipped on occasion into your--and I
10 don't want to be argumentative with you every time, just
11 selectively. But termination of pregnancy I think is more--
12 is a more accurate term. And if you were submitting a
13 manuscript to the *British Journal of Obstetrics and*
14 *Gynecology* about what I think you would describe as abortion,
15 we would insist that you use that nomenclature.

16 Q Does the editorial staff of the *British Journal*
17 have a position one way or another on abortion?

18 A I think there's a wide range of positions and
19 ideas and thoughts about the moral status of the embryo or
20 fetus vis-à-vis the autonomy rights of the mother.

21 Q Well, the editor that you mentioned who shares
22 your views about calling it a termination of pregnancy, does
23 he share your views about abortion as well?

24 A I don't think that he does.

25 Q And when you refer to TOP, you're, I think you

1 just said, trying to distinguish it from a spontaneous
2 abortion; is that correct?

3 A Yes, ma'am.

4 Q What about abortion or the term "abortion" other-
5 wise is ambiguous?

6 A It's nonspecific and applied across two different
7 scenarios---

8 Q (interposing) Okay.

9 A ---so it's confusing to patients. To people
10 outside of our field it is confusing. It can even be heart
11 wrenching to somebody who wanted to have a baby and had a
12 pregnancy loss and sees "abortion," even with the words
13 "spontaneous" or "incomplete" or "missed" on her checkout
14 sheet because it's become such a loaded term in North
15 American culture. And I don't think it's an accurate term.

16 Q So why don't you change the name of spontaneous
17 abortion then?

18 A Well, I would call it--we call--we would call that
19 a pregnancy loss and describe it by gestational age. We
20 would not use the phrase "abortion" for either--for either
21 side. We don't think it's an accurate term.

22 Q And by "we," who do you mean there?

23 A I'm talking about this--and I can send you Phil's
24 sort of two page reason, which we send to particularly
25 American authors who really get mad with us because we

1 question their nomenclature or their taxonomy. I don't think
2 it's an accurate taxonomy.

3 Q So you use termination of pregnancy versus
4 pregnancy loss---

5 A (interposing) Pregnancy loss.

6 Q ---to describe the two different---

7 A (interposing) Yes, ma'am.

8 Q ---scenarios? Are there other journals or other
9 publications that use that nomenclature?

10 A I don't know. Not everybody can be as good as we
11 are.

12 Q Do you believe your opposition to abortion affects
13 your ability to objectively evaluate abortion related issues?

14 A I don't understand the question.

15 Q Do you think your opposition to abortion affects
16 your ability to objectively judge regulation of abortion?

17 A I strive to be objective, as I hope you do too.
18 And I don't know what your world view is, but I have a guess.
19 And I will have to defer to the wisdom of a judge or a jury
20 to find out whether I'm objective or not.

21 I am who I am. I believe that a fetus or embryo
22 has a moral status. And in this crazy world where an entity
23 with a moral status occupies an autonomous woman that is--
24 obviously has a moral status, that that is a very troublesome
25 issue, troublesome event in the developed world in the 21st

1 century.

2 Q So you strive to be objective, but it's possible
3 that those views might affect the way you evaluate a regula-
4 tion; correct?

5 Mr. Parker: Object to the form.

6 A I do the best I can and can't claim to do it
7 perfectly, nor would I believe anyone else who said they were
8 unbiased about such a fundamental human event and condition.

9 Q Why don't we look back to Exhibit 1, your
10 report---

11 A (interposing) Yes, ma'am.

12 Q ---and turn to page--well, it's a paragraph 20
13 that begins on 11 and goes to page 12. If you could take a
14 look at that paragraph?

15 (Witness peruses document.)

16 A Okay.

17 Q Okay. I'm going to ask you first about the last
18 sentence in that paragraph. You state that "while the
19 magnitude of risk remains small, after 16 weeks, risks from
20 TOP may exceed the risks of carrying a pregnancy to term and
21 certainly do so by 20 weeks." Do you see that?

22 A Yes, ma'am.

23 Q So before 16 weeks, you would agree that the risk
24 of complication from an abortion is less than the risks of
25 carrying to term; correct?

1 A With the limits that the comparison is really
2 apples to oranges and not of--and not a fair comparison at
3 multiple different levels.

4 Q In terms of the medical risk of harm to the
5 patient, you would agree, would you not, that the risks from,
6 using your terminology, TOP---

7 A (interposing) Thank you.

8 Q ---are less than the risks of carrying to term
9 prior to 16 weeks?

10 A And the risk of what?

11 Q The risks--well, you tell me what this means
12 because the last sentence of your report here says that "the
13 magnitude of risk remains small, [but] after 16 weeks [the]
14 risks from TOP may exceed the risks of carrying a pregnancy
15 to term."

16 Now, isn't it the case that if you take--if you
17 look at that, that means that what you're saying is that the
18 risks from TOP do not exceed the risks of carrying to term
19 prior to 16 weeks?

20 A And I would go back to my original answer with the
21 caveats that the comparisons aren't fair.

22 Q Well, but you make the comparison here; right?

23 A I make a comparison in a sentence of a document
24 that, if I remember correctly--and I'd have to look to find
25 it--states why the comparisons of death or serious disability

1 from termination of pregnancy and carrying a pregnancy to
2 term at least in United States aren't comparable.

3 Q Because the data you think is incomplete; correct?

4 A Well, that's one reason. And it's not that I
5 think the data are incomplete. The data are incomplete.

6 Q So but looking again at this sentence--because you
7 have the caveat there---

8 A (interposing) And secondly--I'm sorry I'm slow.

9 Q I don't mean to interrupt you, sir.

10 A I don't feel interrupted. Pregnancy is a longer
11 period of time, a longer window. And morbidities and
12 mortalities--it goes out way beyond pregnancy for six or
13 seven weeks. So it's like a feature length film, where a
14 surgical procedure is like a snapshot. It's a one point in
15 time and a little bit thereafter, and then people don't
16 attribute--so it's--the comparisons I don't think are valid
17 or fair.

18 Q Okay. Well, let's add that caveat to the
19 sentence, going back to the last sentence of paragraph 20.

20 A I think I've added the caveat through the gist of
21 the whole--of the whole thing. It's hard to say that in a--
22 in every sentence.

23 Q Well, would you agree that based on the limited
24 and incomplete data available, before 16 weeks the risks of
25 carrying a pregnancy to term exceed the risks from a TOP?

1 A I would agree that that is conventional wisdom in
2 North American obstetrics, again with the caveats previously
3 described. I won't do it a third time unless you want me to.

4 Q So you agree that the magnitude of risks from
5 abortion are small; correct?

6 Mr. Parker: Object to the form.

7 A I would agree that the magnitude of risk asso-
8 ciated with abortion, and it depends upon gestational age,
9 range somewhere between 1 and 10 percent--I said 2 and 10
10 percent--complication rates. Whether that's small or large
11 is a value judgment that different people would interpret
12 different ways. So I'd rather give that range than I would
13 to say small, large or indifferent. Different people
14 perceive risk different ways.

15 Q Well, let's talk about that rate. Earlier in that
16 same paragraph, paragraph 20, you say, "Complication rates
17 range from 2 to 10 percent." Are you changing your opinion?
18 Did you just say 1 to 10?

19 A 2 to 10 suits me.

20 Q What is that estimate based on?

21 A It's based on medical literature from North
22 America and other developed countries.

23 Q Can you cite me to this literature?

24 A I wrote a review that's cited somewhere in here, a
25 *Scientifica* article, that lists tons and tons of that. I can

1 pull that article up if you want me to, and we can go through
2 the specific references or you can--I imagine one of your
3 colleagues has it in one of these big files somewhere.

4 Q Why don't you take a look at the articles that you
5 have listed starting at page 24 of your report and tell me
6 which of those articles have the complication rate ranging
7 from 1--or 2 to 10 percent?

8 (Witness peruses document.)

9 A I'm looking for the review.

10 (Witness peruses document.)

11 It would be the--on page 12, "Thorp, J.
12 *Scientifica*, 2012, op. cit." That would be a review
13 published a year ago.

14 Q And so---

15 A (interposing) And it would list all I could find
16 that would inform that decision for you.

17 Q So the estimate here of 2 to 10 percent, the
18 studies that support that rate are cited in the review in
19 *Scientifica*---

20 A (interposing) Yes.

21 Q ---that's cited at footnote 24?

22 A Yes, ma'am. And it says "op. cit.," so there must
23 be a full reference somewhere else. I don't know where. I
24 don't understand legal footnoting and referencing.

25 Q I don't understand medical footnoting and

1 referencing, so---

2 A (interposing) All right.

3 Q ---we can agree to be confused.

4 A All right.

5 Q Now, the sentence we just started about the 2 to
6 10 percent---

7 A Yes, ma'am.

8 Q ---you then end with saying "most complications
9 can be managed without major surgery." Do you agree with
10 that?

11 A Yes, ma'am.

12 Q And do you also agree that most complications can
13 be managed without treatment in a hospital?

14 Mr. Parker: Object to the form.

15 A I think many will require diagnosis and at least
16 the beginning of treatment in the hospital that can then be
17 completed at home.

18 Q But my question was most. Do you agree that most
19 complications can be managed without a visit to the hospital?

20 A I would probably use the word "many."

21 Q And what is that based on?

22 A My understanding of what it takes to assess and
23 manage one of these complications.

24 Q And why can't those complications be managed in an
25 outpatient setting?

1 A Well, oftentimes the outpatient setting is closed
2 when the complication presents itself. Two, there needs to
3 be laboratory and imaging work done that oftentimes is not
4 available in an outpatient setting. So people come to the
5 hospital, which is open 24/7 and has those modalities
6 available.

7 And so I would say "many" would be the word I
8 would use. I don't know whether it's greater or less than
9 50, but many need that. And probably the majority show up
10 there because a lot--most--there's not a termination of
11 pregnancy provider in our community that's available 24/7
12 postoperatively. Charles comes the closest.

13 Q But you don't know how many of those patients are
14 returning to the clinics for treatment; correct?

15 A No, ma'am, I do not.

16 Q And if those clinics are open, those clinics could
17 treat these patients; correct?

18 A It would depend on what the patient had wrong with
19 her, but could treat many of them, yes, ma'am.

20 Q And probably the majority of those could be
21 treated; correct?

22 A I don't know. I think it would depend on the
23 capacity of the clinic. You're using the word "treatment,"
24 and I'm looking at it as a diagnosis and treatment
25 phenomenon. So it would depend, even if they were open, on

1 their capacities and was there a physician present there or
2 not when they're open.

3 Q And by diagnosing--by lab and imaging, you mean do
4 they have an ultrasound machine; correct?

5 A Well, they can have an ultrasound machine. Do you
6 have somebody to work an ultrasound machine and interpret the
7 images? What lab tests do you have available? So labs,
8 imaging, and do you have somebody who can take a history and
9 do a physical exam, a knowledgeable physician, and many
10 don't.

11 Q But if you had the lab capability and ultrasound
12 capability with someone who can operate the ultrasound as
13 well as a practitioner that can treat---

14 A (interposing) And interpret it and a clinician
15 who can take a history and physical. Many--maybe the
16 majority can be treated in the--in that setting.

17 Ms. Flaxman: I'd like to go off the record
18 for a second.

19 The Reporter: Off the record. 3:51 p.m.

20 (A brief recess was taken.)

21 The Reporter: On the record. 4:03 p.m.

22 By Ms. Flaxman:

23 Q Doctor, I want to go back to something you
24 mentioned a little earlier today. You mentioned you had
25 privileges at one time at Memorial Mission---

1 A (interposing) Uh-huh.

2 Q ---Hospital, and that's in Asheville?

3 A Yes, ma'am, Buncombe County.

4 Q Baucom (phonetic) County, okay.

5 A No, Buncombe, B-u-n-c-o-m-b-e; right?

6 Q Buncombe?

7 A Yeah, Buncombe.

8 Q Okay. Got it. And how far is that from Chapel
9 Hill?

10 A 250 miles.

11 Q Do you drive that or do you fly?

12 A I told you I flew there every Wednesday on a
13 university airplane.

14 Q On a university airplane?

15 A The university operates eight airplanes. We're a
16 suburban-rural state.

17 Q You went there every Wednesday?

18 A Yes, ma'am, for 15 years.

19 Q What did you do when you were there?

20 A I helped the residents and attendings there
21 formulate plans on high risk patients. And I was a young
22 clinician used to a teaching hospital. Asheville is a
23 beautiful city and a very sophisticated medical community.

24 And we went to this lunch conference where I then
25 had to sell my plans to the people who were much older and

1 more experienced than me and were going to actually take care
2 of these patients because I was fly-by-day doctor. I wasn't
3 going to be there on Thursday. I could be there by phone,
4 but I couldn't be present.

5 Q And so when you said you couldn't be there on
6 Thursday, you meant they would be taking care of the patients
7 on Thursday.

8 A Uh-huh.

9 Q Correct?

10 A Yes, ma'am.

11 Q And so they didn't have--they didn't have the
12 necessary expertise in-house at that hospital?

13 A They didn't have a MFM specialist and they
14 desperately wanted to start a residency. And we were
15 ultimately able to recruit multiple MFM specialists to
16 Asheville, and there is a successful community residency.

17 Q And so when you were consulting with them, what
18 were you doing? Were you helping them care for patients or
19 helping them develop the residency?

20 A I was doing both.

21 Q And when you took care of patients, tell me what
22 kind of care you were providing.

23 A Well, it was clinical care, so it was nonsurgical,
24 making plans for--I remember it was the first pregnant person
25 they had ever taken care of with HIV. She was--she was--had

1 a low CD4 count, wasn't real sick yet.

2 This was pre AZ--that anybody knew that anti-
3 retrovirals could prevent mother to child transmission. But
4 I thought due to a beneficence obligation to the mother, she
5 should be provided with treatment. AZT was only
6 theoretically harmful to a baby. And so we decided to
7 initiate treatment with AZT, or that was my recommendation,
8 but they executed my recommendation. So I was purely a
9 consultant.

10 Q But you saw patients yourself; correct?

11 A Saw them with residents, attendings, midwives.
12 There were largely family medicine residents there. So I was
13 a consultant. And it's a residency now.

14 Q You just said they were largely family medicine
15 residents. Are they--now it would be GYN?

16 A No. There were--family medicine residents staffed
17 the high risk clinic. And there was usually an attending
18 there and there was a midwife, so we worked as a team.

19 Q And did you deliver babies when you were there?

20 A No, ma'am.

21 Q Who delivered?

22 A The family medicine residents, the midwives
23 supervised by the private doctors, who were attendings.

24 Q Were the---

25 A (interposing) And the guy who is the executive

1 director of the American College now, Dr. Lawrence, Hal
2 Lawrence, he was the--he was--I think that would be the thing
3 he'd be most proud of is getting that residency program
4 started in western North Carolina.

5 Q Was he--he was a member of the hospital staff?

6 A Yes, ma'am.

7 Q So the attendings were OB-GYNs?

8 A Yes, ma'am.

9 Q Did they ever call you on the phone to ask about
10 caring for one of the patients?

11 A Yes, ma'am.

12 Q Give me some examples.

13 A And I often called them on the phone to find out
14 what had happened and what was going on. We stayed in
15 communication from--during the time that I wasn't there.

16 Q And so they would call you and say--for example,
17 the patient with HIV, her---

18 A They would largely call me and say, "The
19 attending," who ultimately managed the patient, "thought it
20 was a stupid idea and doesn't want to do it, Thorp. Maybe
21 you ought to call him up and talk to him."

22 So it was very good for me to learn sort of the
23 art of clinical negotiation in a place where there was not a
24 hierarchy. I could only change behavior by influence. I
25 couldn't give an order to my resident, "Give her AZT" and

1 they'll do it.

2 Q If they had a concern about a patient, would they
3 call you to say, "What should we do with this patient?"

4 A Yes, ma'am.

5 Q And what would you do or how would you provide
6 help to them over the phone?

7 A Get the set of facts, share my experience and
8 knowledge, make a recommendation.

9 Q And then they would be able to take those
10 recommendations and treat the patient appropriately?

11 A Again, I had no authority to--I could make all the
12 recommendations I want to make, but they could do with them
13 what they will. And they took what they liked and left the
14 rest. So it was a--it was a good experience and it averted a
15 constitutional crisis in North Carolina.

16 Q What's that?

17 A The speaker of the house was from Asheville and he
18 introduced a bill in the state legislature, I think at Dr.
19 Lawrence's suggestion, that the University of North Carolina
20 have two residents in Asheville at all times, two OB-GYN
21 residents.

22 And my boss here--he actually once had--the board
23 had an--the American Board had an office in this--right up
24 there (indicating)--thought that if North Carolina munici-
25 palities could begin to assign his residents that he would

1 end up with no residents.

2 And so we went over and saw the speaker of the
3 house. His name was Liston Ramsey. We said, "Mr. Ramsey,
4 why do you want just two residents? Why don't you get a
5 residency?" He said, "Can you get me a residency?" And we
6 were like "Yeah." And we got him--we ultimately got him a
7 residency. I think it's been a good thing. I'm proud of it.

8 Q Let me just turn with the time we have left today
9 to the issue of staff or admitting privileges.

10 A Yes, ma'am.

11 Q You mention in paragraph 1 of your report, which
12 is Exhibit 1, on the first page that you had served on the
13 UNC Health System credentials committee?

14 A Yes, ma'am.

15 Q What is the--what are the responsibilities of that
16 committee?

17 A To review applications for privileges, to make
18 certain that the training and experiences of the applicant
19 are, one, true, and two, consistent with performance of the
20 privileges being requested, and to make a recommendation to
21 the chief of staff of the hospital whether those privileges
22 be granted, modified, or rejected.

23 Q Now, does UNC only grant privileges to faculty
24 members?

25 A UNC for years only granted privileges to faculty

1 members and I think in the late 1990s opened up privileges to
2 community physicians. The joke would be which community
3 physician would ever want to come to this big old university
4 teaching hospital not known for its efficiency.

5 Q As a---

6 A (interposing) Because I don't think we've been
7 inundated by people who say, "Oh, I'd love to practice there.
8 It's so much fun."

9 Q So when were you a member of this committee?

10 A I can't remember. I think that change occurred
11 when I--during my service therein.

12 Q So you're not on the committee any longer?

13 A No, ma'am.

14 Q Okay. And so has it been ten years or so since
15 you were on the committee?

16 A Well, the late '90s seems like a relative short
17 time ago to me.

18 Q But it was, and it was 15 or so years. Does that
19 sound--10, 15 years?

20 A 10 or 15.

21 Q Okay.

22 A I think.

23 Q Let me have you look at your CV at page 61. which
24 is Exhibit A to--or Attachment A to Exhibit 1.

25 (Witness complies.)

1 A Yes, ma'am.

2 Q You list a committee assignment there towards the
3 end of the page as a tenure committee. Is that something
4 different than we've talking about with the credentialing
5 committee?

6 A Yes, ma'am.

7 Q Okay.

8 A It's for faculty members to--with the up or out,
9 decision of tenure.

10 Q So the committee assignment of the credentialing
11 committee is not on your CV?

12 A It is not. And I don't put hospital based
13 committees. Some would say the CV is plenty damn long as it
14 is.

15 Q But isn't the tenure committee a hospital
16 committee?

17 A No, that's a university-wide committee. And that
18 would have a lot of weight in academic circles, that you were
19 on the campus-wide appointment to promotion with tenure
20 committee, the APT committee. You know, things in academics
21 are of such little importance to anybody else in the world,
22 but you have to take victories where you get them.

23 Q And so do you--on the credentialing committee, you
24 were then largely reviewing applicants who were already
25 faculty members?

1 A Well, largely people who were being hired as
2 faculty members, as fellows, as trainees, and then at some
3 point there was an opening to community physicians. When I
4 was there, we weren't inundated by community physicians who
5 wanted to be part of the monstrosity.

6 Q So what you're saying is that--would a faculty
7 appointment be conditional on getting privileges? Is that
8 how it worked?

9 A A faculty appointment would be conditional on
10 funding. And most clinicians fund themselves by practicing
11 clinically. And if you can't get credentialed, you can't
12 practice clinically. Thus you can't bill and collect. So---

13 Q (interposing) So it's part of---

14 A ---passing the D.C. bar and being a partner at the
15 firm would be two separate events that would be intersected.
16 You probably aren't going to be a partner in the firm if you
17 can't pass the bar.

18 Q So it's part of the process of hiring somebody---

19 A (interposing) Part of the process.

20 Q ---for a faculty appointment? So what factors
21 were considered in deciding whether to grant privileges?

22 A Well, one, were the credentials true or not. We
23 had a famous case of a guy who pretended to be a psychiatry
24 resident and had never been to medical school, won
25 psychiatric teaching awards, went all over the country,

1 published articles, a really good sociopath, ultimately
2 discovered, so are they true.

3 Are there problems, have--you know, your question
4 about me, that if I'd said I had my privileges revoked, you
5 would have been really happy. We'd still be here talking
6 about it; have you ever had your privileges revoked,
7 suspended, have you ever been convicted of something, run a
8 big perinatal substance abuse program. I mean now physicians
9 with DWIs or drug problems are huge issues for licensing and
10 credentialing.

11 And then do they--for certain procedures--if I'm
12 going to do--that are sort of on the cutting edge--if I'm
13 going to do robotic hysterectomy or robotic prostatectomy or
14 laparoscopic or whatever the techie thing is, what sort of--
15 did you go to a two day weekend course or do you actually
16 have training and experience.

17 Q So demonstrating proficiency in the areas---

18 A (interposing) Demonstrating proficiency. We
19 didn't watch the proficiency. You know, you have to produce
20 letters, things to say Dr. Parker has done 20 of X under my
21 supervision or as part of his residency or---

22 Q Was there a certain number of procedures you'd
23 want to see to determine whether someone was qualified to
24 perform that procedure? You just mentioned 20.

25 A They would make up arbitrary minimums. I'm not

1 sure there was an evidence basis for the minimal number.

2 Q But there were minimums that you would look to?

3 And who is the "they"?

4 A The department chair, who is the content expert,
5 the last content expert, sort of the chief content expert,
6 might set minimums of what needs to get done and what doesn't
7 need to get done. I'm not sure there is a real evidence
8 basis, if I've done 15 of something versus 20 of something
9 that I'm going to have more or fewer complications or
10 problems. It's---

11 Q You've mentioned---

12 A (interposing) It's a process.

13 Q You've mentioned you'd want to know if an
14 applicant had had privileges revoked. Would you also want to
15 know if privileges had been denied at a hospital?

16 A Yes, ma'am.

17 Q And it would be a factor against that applicant if
18 they've had privileges denied; right?

19 A I guess it would depend on the reason.

20 Q But you'd want to know that reason; right?

21 A You'd want to know the reason. But I don't--I
22 think it would depend on the reason.

23 Q Were there criteria that the committee considered
24 that did not have anything to do with clinical skill or
25 competence of a provider?

1 A Not that I recall.

2 Q Personality?

3 A Well, usually we didn't know them, so we couldn't
4 dislike them. We hadn't had time to dislike them.

5 Q Have you ever had a report that someone was
6 difficult to get along with?

7 A Have I ever had a report that somebody was---

8 Q (interposing) No, no, no; in connection with the
9 credentialing committee. I'm just looking for--are there
10 examples of cases where decisions were made by factors other
11 than clinical?

12 A I don't recall.

13 Q Do you recall politics ever being involved at all,
14 certain---

15 A (interposing) Like are you a Democrat or
16 Republican?

17 Q No, no, no; more like institutional politics, some
18 doctors wanting an applicant and others not wanting an
19 applicant.

20 A Not at our level, no, ma'am.

21 Q But that could happen at another level?

22 A I don't know.

23 Q Well, what did you mean by not at our level?

24 A I meant that I never saw that happen at the level
25 of the credentials committee. Whether the chair and the

1 department wanted or didn't want somebody or liked or didn't
2 like somebody I don't know.

3 Q You don't know. It could happen. You just don't
4 know one way or another?

5 A I think it could happen. Anything that involves
6 humans is subject to imperfection and prejudice.

7 Q Do you have knowledge of how hospital
8 credentialing decisions are made at any other hospital?

9 A I think I do because I've helped an array of
10 learners seek and obtain an array of privileges all over the
11 United States and even some in Europe.

12 Q Who are these doctors?

13 A Residents; we have a fellowship program and
14 reproductive epidemiology fellows, faculty members moving to
15 other places, going to relocate, people who are out in
16 practice who are going to relocate. So you write letters.
17 You fill out forms. Sometimes you talk to credential
18 committees, the chair--or they usually have a person that
19 really does the work that you talk to.

20 Q So you have an understanding of other hospitals
21 from the perspective of assisting an applicant?

22 A Yes, ma'am.

23 Q You don't have any knowledge as a member of the---

24 A (interposing) The internal workings?

25 Q ---credentialing committee? Correct.

1 A No, ma'am.

2 Q And so you're not offering an opinion about how
3 privileges might be granted in Alabama; correct?

4 A I don't have any idea how privileges would be
5 granted in Alabama or not.

6 Q I want to ask you again on paragraph 1 of page
7 1---

8 A Yes, ma'am.

9 Q ---you mention you oversee and guide the
10 credentialing process, the last--or second to the last
11 sentence--for 12 OB-GYNs, three fellows, and three advanced
12 practice nurses. What do you mean by credentialing? Is that
13 just privileges or is that more than privileges?

14 A Privileges. I sort of flog them to get their
15 packets in line to get their--you know, all their stuff in
16 place. And I really, really want them to do it because they
17 can't bill and collect and earn anything--although they all
18 want me to pay them while they're waiting--you know, "We've
19 got to get you credentialed, licensed and credentialed."

20 Q You mentioned---

21 A (interposing) And it's not a lot of fun.

22 Q One of the headaches of leadership?

23 A Yeah.

24 Q You mentioned three advanced practice nurses. Are
25 they midwives, nurse practitioners?

1 A Nurse practitioners; one nurse midwife who retired
2 in September. So I don't know whether--I'm bad with time. I
3 don't know, so I just say advanced practice nurses.

4 Q But they have admitting privileges as well?

5 A Yes. North Carolina has a law that says advanced
6 practice nurses have to have a supervising physician, which
7 is a source of big contention and even constitutional
8 litigation in this state. But within that framework,
9 advanced practice nurses can admit people.

10 Q A few more minutes.

11 A Not many.

12 Q A few.

13 A Two.

14 (Reporter indicates time remaining.)

15 Q Four.

16 Q Let me just ask you. You had mentioned that as
17 part of your responsibilities--this is the bottom of page
18 29--you have administrative oversight of the Family Planning
19 Fellowship and Residency training program at UNC?

20 A Yes, ma'am. That changed in October and family
21 planning became a separate division. So Gretchen Stuart, Amy
22 Bryant; they have one fellow, Matt Zerden. David has
23 retired, so they spun off into their own division.

24 Q What was the reason for the spin-off?

25 A I think they had matured, and I don't mean as

1 individuals matured, but matured clinically, financially, and
2 as a discipline where they could subsist independently.

3 Q Did it have anything to do with your personal
4 views on abortion?

5 A Not that I'm aware of.

6 Q But that's possible?

7 A I guess anything is possible. I know I didn't
8 spin them off, nor did I resist them being spun off. I see
9 it as a--as a success. We hired Gretchen Stuart as a K Award
10 winner, as a BIRCWH, from UT Southwestern. She now has her
11 own division and directs it.

12 While I disagree philosophically with what a lot
13 of that division does, I see that as a success. And I admire
14 Gretchen and Amy as valued colleagues, friends--professional
15 friends. I don't know.

16 Q When you mentioned administrative oversight--at
17 the time when you had administrative oversight of that
18 program, what did that entail?

19 A Responsible for figuring out what they got paid,
20 where they got set, where they sat, if there were a problem,
21 a complication, a temper tantrum, a--whatever there was, I
22 was responsible for ferreting it--for ferreting it out. They
23 were good clinicians and they weren't ever a problem. So
24 when I say temper tantrum, I don't mean them specifically.
25 But if there had been, I would have.

1 Q Did you ever teach their residents?

2 A They don't have residents. They have fellows.

3 Q Did you ever teach their fellows?

4 A Yes, ma'am, and supervised their fellows
5 clinically in things that did not involve termination of
6 pregnancy.

7 Q And were you responsible at all for the curriculum
8 in that fellowship?

9 A No, ma'am.

10 Q That's it for today.

11 A You're very kind.

12 (The deposition was recessed at 4:30 p.m. to
13 reconvene at 2:00 p.m. Wednesday, November 20,
14 2013.)

1 F U R T H E R P R O C E E D I N G S 1:49 p.m.

2 (Whereupon,

3 **JOHN MERCER THORP, JR., M.D., M.H.S.**

4 the witness on the stand at the time of adjournment, resumed
5 the stand and testified further as follows:)

6 The Reporter: Doctor, I'm just going to
7 remind you quickly you're still under the oath I gave you
8 yesterday afternoon.

9 The Witness: Yes, ma'am. Thank you.

10 D I R E C T E X A M I N A T I O N 1:49 p.m.

11 _____ (resumed) _____

12 By Ms. Flaxman:

13 Q Good afternoon, Doctor. I appreciate you coming
14 back today.

15 A Yes, ma'am.

16 Q I want to ask you something I asked you yesterday,
17 which is just is there any reason today that you can think of
18 why you couldn't give fair and complete testimony?

19 A No, ma'am.

20 Q And I didn't ask you this yesterday, but I'd just
21 like to ask you to tell me what you did to prepare for
22 yesterday's and today's depositions.

23 A I read the report and somebody's rebuttal, Fine,
24 F-i-n-e. Is there a Fine in this case?

25 Q Yes.

1 A They're the two things I did.

2 Q Okay. So by the report, you mean your---

3 A (interposing) My report.

4 Q ---report, which is Exhibit 1?

5 A Yes, ma'am, Exhibit 1.

6 Q And you still couldn't confirm it was your
7 signature? You'd just looked at it.

8 A Well, I don't care about my signature.

9 Mr. Parker: Object to the form.

10 Q And so did you review anything else, any other
11 documents?

12 A None comes to memory.

13 Q And did you speak with counsel?

14 A I think I had a teleconference with counsel maybe
15 a week before.

16 Mr. Parker: I'll instruct you if she asks
17 any more questions about communications to be very circum-
18 spect.

19 Ms. Flaxman: I'm not going to ask anything
20 else.

21 By Ms. Flaxman:

22 Q All right. Let's take a look at Exhibit 1, your
23 report.

24 A Yes, ma'am.

25 Q If you could turn to paragraph 2 on page 2?

1 (Witness complies.)

2 A Got it.

3 Q Okay. Now, the last sentence of that paragraph
4 says, "The act is a prudent and reasonable provision to
5 advance women's reproductive health and increase the
6 likelihood that those women who may experience serious TOP
7 complications will receive optimal care." Did I read that
8 correctly?

9 A Yes, ma'am.

10 Q And is that your opinion in this case?

11 A I think so.

12 Q So tell me how the act increases the likelihood of
13 women experiencing serious complications receiving optimal
14 care.

15 A Well, my opinion would be that there will be
16 serious complications arise in some fraction of elective
17 terminations of pregnancy and that by having a formal
18 relationship, hospital staff privileges, the termination of
19 pregnancy provider can communicate better with the hospital
20 that will attend to those complications, could even treat
21 some of them him or herself and that there would be
22 improvements in the quality of care because of the linkage.

23 Q And you say--you use the phrase "increase the
24 likelihood." So it's your opinion that it increases the
25 likelihood, but it may not; is that correct?

1 A Well, I don't think it guarantees anything. I
2 think it improves the likelihood.

3 Q It doesn't guarantee it. It may improve it or it
4 may not?

5 A Well, I think if we were--for any single
6 individual it may or may not. For a population I think it
7 would over time.

8 Q And you just testified that privileges could allow
9 an abortion provider to treat some of the patients him or
10 herself?

11 A Some or all.

12 Q But you just used the word "some." Were there in
13 your mind some cases in which they wouldn't be the treating
14 physician?

15 A Well, if there were a perforation and a bowel
16 injury, unless the provider were a GYN oncologist or skilled
17 in bowel surgery, I think he or she would seek somebody else
18 to repair that--repair that bowel, as an example. So there--
19 depending upon knowledge, expertise, experience, there may or
20 may not be consultants involved in the care of women with
21 termination of pregnancy complications.

22 Q And so then in a case of a perforation with a
23 bowel injury, what specialist would be the best to do that
24 repair?

25 A Well, I think there are an array of different

1 specialists: a general surgeon, a trauma surgeon, a colo-
2 rectal surgeon, a GYN oncologist. And some gynecologists
3 have enough experience to do that. I personally would not--
4 personally did not when I did GYN surgery. There would be
5 other complications that would be within the scope of
6 practice of the termination provider.

7 Q If a treating physician was going to involve one
8 of these specialists in a patient's care, how would that
9 provider get that other specialist involved?

10 A Well, I think the most crucial element of that is
11 to step back and does somebody else need to be involved. And
12 I think the details known only to the termination provider of
13 the person's history, physical exam, and what happened
14 intraoperatively and postoperatively can inform do I think--
15 let's say I'm the termination provider--do I think there was
16 a perforation, yes or no, where was the perforation, what did
17 I see, what did I experience, what led me to believe that.

18 So one decision is do I need a consultant or do I
19 need further diagnostic work to include or exclude that, and
20 then if we get to the hypothetical I gave you, if there is a
21 bowel injury, then who best to repair it.

22 Q And then--I know you wouldn't be the provider, but
23 staying along your hypothetical of you being---

24 A (interposing) Yes, ma'am.

25 Q ---the provider and having a perf with a bowel

1 injury, at that point you pick up the phone and call one of
2 your colleagues? Is that how you get someone else involved?

3 A The phone would be one way. A lot of times we
4 have people in the hospital, specialists in the hospital, so
5 you might talk face to face. You might get them to look at
6 an imaging study or--an imaging study and presumed perf and
7 bowel perf would be probably the thing they would want to
8 see. So you could communicate with a colleague or peer.

9 Q And in the case of this example, this hypo-
10 theoretical, you would pass on to the specialist the history,
11 the physical exam, what happened pre and postoperatively and
12 the imaging. Is there anything else that---

13 A (interposing) There might---

14 Q ---you would need to share?

15 A Depending upon the complication, there might be
16 lab work that's important. There might be pieces of social
17 history that are important. There's a lot to communicate.

18 Q But you have those kinds of conversations with
19 colleagues all the time; correct?

20 A I try to.

21 Q And have you had conversations like that with
22 physicians who are not your colleagues?

23 A I don't understand the question.

24 Q Well, in other words, have you--let me be more
25 specific what I mean by colleagues. By colleagues I mean

1 doctors at UNC who are on staff with you. Have you had
2 conversations about a specific patient with doctors who are
3 not on your staff?

4 A About their acute care?

5 Q Well, sure, if you have.

6 A No, I don't think I have.

7 Q Have you--I know you're an MFM, so do doctors
8 sometimes---

9 A (interposing) I think I'm an obstetrician and
10 gynecologist with a subspecialty certificate in MFM.

11 Q Okay. Given your area of expertise, do physicians
12 who are not at UNC refer their patients to you?

13 A Yes.

14 Q And in the course of those referrals, have you had
15 conversations with those physicians explaining the back-
16 ground and history and the reason for the referral?

17 A Yes.

18 Q And you just said sometimes those are with
19 physicians who are not on staff with you; correct?

20 A Yes.

21 Q Have you ever had conversations like that with
22 physicians who you did not know personally?

23 A Yes.

24 Q So a physician knows you by reputation and refers
25 a patient with a high risk pregnancy to you for you to assume

1 care?

2 A Yes, ma'am.

3 Q So let me ask you, then, you had mentioned as one
4 of the reasons why the act could increase the likelihood of
5 optimal care is you said that a TOP provider could communi-
6 cate better with a hospital in the event of a complication.
7 Is that--does that summarize your previous testimony--

8 Mr. Parker: (interposing) Object to the
9 form.

10 Q ---correctly?

11 A I think it's a simplistic summation. It's
12 certainly in the spirit of what I said.

13 Q Well, let me ask you, how---

14 A (interposing) I don't mean to say your questions
15 are simplistic.

16 Q I'm not taking any offense whatsoever. But tell
17 me how in your opinion a TOP provider can communicate better
18 with the hospital if he or she has admitting privileges.

19 A How a TOP provider can communicate better?

20 Q Yes; well, how it is that having admitting
21 privileges would allow that provider to communicate better
22 with those taking care of the patient at the hospital.

23 A Well, it would allow the provider to take the
24 knowledge that he or she possesses into that health care
25 setting, get it into that hospital record, into that

1 electronic record, communicate with a colleague, somebody
2 that they probably know. So I think communications are
3 easier and smoother, even for me, with people that are within
4 the health system I work in rather than people who are out.

5 Q So the provider--the TOP provider could
6 communicate the knowledge that he or she possesses to the
7 treating physicians at the hospital; correct?

8 A I don't understand the question.

9 Q So in other words, if an abortion provider is
10 transferring a patient to a hospital with--we'll go back to
11 the hypothetical of a uterine perforation with a bowel
12 injury---

13 A (interposing) Okay.

14 Q ---or a suspected bowel injury.

15 A Yes, ma'am.

16 Q That providing physician could communicate the
17 history, the physical exam, what happened pre or post over
18 the telephone to the treating physicians at the hospital;
19 correct?

20 A Could; yes, ma'am.

21 Q And so if he or she did have that communication,
22 wouldn't then the hospital be able to treat that patient?

23 A Well, I think that's one facet of the communica-
24 tion and it's certainly better than not doing that but is not
25 as good as having--and the predominance of the electronic

1 medical record, to have those thoughts entered into the EMR,
2 to have the imaging studies, to have that communication. So
3 yes, it could occur by phone and sometimes does, and it
4 sometimes doesn't.

5 Q Do those conversations take place with patient
6 transfers to a hospital when those patients are experiencing
7 complications from other types of outpatient surgery?

8 A I don't understand the question.

9 Q Well, going back to yesterday, you had mentioned
10 that just about every kind of gynecological surgery now is
11 taking place in an outpatient setting or an ambulatory
12 surgical center.

13 A Yes, ma'am.

14 Q Well, let me go back and ask you, are there
15 freestanding ambulatory surgical centers in the Chapel Hill
16 area that are not affiliated with UNC?

17 A I don't know--I don't know whether Planned
18 Parenthood across the street considers itself--I don't
19 understand the ambulatory surgical center word. There was a
20 guy who has a surgicenter next to the post office. He just
21 sold it to UNC. It existed for years before he did that.

22 Q Did he do gynecological surgeries there?

23 A He largely did reversal of tubal ligation
24 surgeries there.

25 Q And as far as you know, were there any--did he

1 ever have to transfer to the hospital any of those patients?

2 A The couple of transfers over the years that I
3 remember, he came to the hospital with the patient and would
4 have very much liked to have had admitting privileges so that
5 he could have interfaced with the health care team that was
6 taking care of her is my impression.

7 Q But he didn't have privileges?

8 A He did not have privileges.

9 Q And you said it was your impression. Did he ever
10 tell you that he wished he had privileges?

11 A I--he's never told me in words. I've sensed
12 frustration where he couldn't go back, he couldn't be
13 involved. He--you know, he would have to be in the waiting
14 room and somebody would have to come and talk to him out
15 there. He felt like he had--I'm projecting, but it seemed to
16 me he felt like he was abandoning his patient and wanted to
17 be part of the care team.

18 Q But that wasn't anything he said to you. That was
19 just a sense you got?

20 A It's not what he said to me, no, ma'am.

21 Q And do you know if he ever applied for privileges?

22 A Oh, I think he did the ultimate in getting
23 privileges. He sold his surgicenter to them for about \$10
24 million.

25 Q So he cashed---

1 A (interposing) I think he got privileges---

2 Q (interposing) He cashed in and it doesn't matter?

3 A ---and got rich.

4 Q And so let me ask you---

5 A (interposing) Which I find to be good revenge.

6 Q Let me ask you, at times when he did have a
7 patient transferred, he would do the handoff, so to speak,
8 through a conversation with the treating doctors at the
9 hospital; correct?

10 A He would do the handoff through a conversation,
11 but I don't think that handoff was as good as it could have
12 been if he had had admitting privileges, or hospital staff
13 privileges that gave him access to the records system, the
14 lab system, a name badge so he could walk back and forth, all
15 that sort of stuff.

16 Q To the extent you remember, what were the outcomes
17 for the patients that he transferred?

18 A I think they had complications that required
19 subsequent surgery and were ultimately good outcomes.

20 Q So they ended up getting good treatment at your
21 hospital?

22 A They ended up getting treatment and good treat-
23 ment, but not the best treatment we could have provided.

24 Q Well, how do you think the treatment could have
25 been better?

1 A I think it would have been better if we could have
2 communicated with him. I think it would have been better if
3 he could have held his patient's hand, who he knew prior to
4 doing an elective surgical procedure on.

5 Q Well, but you just testified that he had
6 communications with you; correct?

7 A He had communications with us, but you'd have to
8 go out in the waiting room to talk to him. You couldn't--he
9 couldn't be part of the--part of the deal.

10 Q Well, but how would being part of the deal--how
11 would part of the deal have improved the care?

12 A Provide psychosocial support to the patient, be
13 present when the patient is being interviewed. When new
14 information presented the need for clarification of something
15 he'd communicated, he would have been present and we could
16 have talked to him.

17 Q But you can talk to him anyway; right? You can
18 pick up the phone or go out in the waiting room, if that's
19 where he is; correct?

20 A Yes, you could.

21 Q And he I take it--now, this may have predated
22 electronic medical records, but his records also wouldn't
23 automatically have been in the EMR system; correct?

24 A They would not have been. I think he was smart
25 enough to not use our EMR.

1 Q If you are having records from an outpatient
2 facility transferred to your hospital, is there a way that
3 they get entered into the EMR?

4 A They go to--I call it medical records purgatory,
5 but it's known as loose materials, where somebody ultimately
6 scans them in and they get loaded into the electronic medical
7 record. Loose materials doesn't work real well on nights and
8 weekends and holidays and things when it seems like
9 complications occur.

10 Q Do the loose materials stay with the patient
11 during that period of time?

12 A Well, if they stay with the patient--there are no
13 paper charts anymore, so who's going to look after them? I
14 mean I don't like electronic medical records, so--I think
15 it's sort of dumb. I would like to have a chart to look at
16 and somewhere to stick the notes from the referring doctor
17 and the prenatal record and the things that I need to look
18 back at. Oftentimes I can't get hold of them.

19 Q But if you are--if the patient is being referred
20 to you, you're the person who gets those records first;
21 correct?

22 A Maybe, maybe not.

23 Q And you could always contact that provider to get
24 that information; correct?

25 A If I know who that provider is and where they are

1 and they are available to me. And then they could be out of
2 town. The records could be locked up in their office. It
3 can be hard to get them when you need them.

4 Q That's not unique, though, to treating abortion
5 complications; correct?

6 A That's unique to all sorts of complications. I
7 mean that's common to all--forgive me for saying it's unique
8 to all--it's common to all sorts of complications.

9 Q Right, common across medicine and something that
10 medicine in general is trying to figure out how to manage;
11 right?

12 A Yes, ma'am.

13 Q So let me ask you about admitting privileges.
14 Admitting privileges don't actually require an outpatient
15 provider to actually be the one to provide care at the
16 hospital; correct?

17 A I think what comes under the rubric admitting
18 privileges varies from place to place in the little bit I
19 know about other places as to what it requires you to do or
20 not to do.

21 Q Okay. How about your hospital?

22 A So if we're talking about my hospital, can you ask
23 me again?

24 Q So at your hospital does having admitting
25 privileges require a doctor with privileges who performs a

1 procedure in an outpatient setting to be the doctor who
2 actually provides care to that patient in the hospital?

3 A No, ma'am.

4 Q I want to turn to page 20 of your report---

5 A (interposing) Yes, ma'am.

6 Q ---to paragraph 38. It begins at the bottom of
7 that page.

8 (Witness complies.)

9 Q Do you see there in the first sentence--are you
10 there now?

11 A Yes, I'm at page 20, paragraph 38.

12 Q Great. You say there in the first sentence--the
13 first sentence reads, "Termination of pregnancy is not a
14 benign medical procedure." What do you mean by it not being
15 a benign medical procedure?

16 A It's not without potential harms, or to say it
17 positively, there are potential harms that can arise.

18 Q And so what are other examples of--well, are there
19 examples of benign procedures?

20 A Completely harmless procedures?

21 Q If that's what you mean by benign.

22 A It's not what I mean by benign; procedures with
23 such minimal harm that there's no reason to prepare--to be
24 prepared to care for those harms. So a blood draw is
25 something the IRB considers to be of such minimal harm,

1 although there are harms, that you don't have to get informed
2 consent or do anything additional.

3 Q But you mentioned a number of procedures yesterday
4 that you will do in your office setting. Those procedures--
5 would you consider those to be benign or not benign?

6 A No. I would consider them to have harms
7 associated with them.

8 Q So similar to TOP, they would not be considered a
9 benign procedure?

10 A I think the set of harms of the things I listed
11 are in some ways different from TOP, but they all have a set
12 of harms. And I would not call them benign procedures.

13 (Exhibit 3 was marked for
14 identification.)

15 Q So you're taking a look at what we've marked as
16 Exhibit 3. It's the Rule 26(a)(2)(A) report of Paul Fine,
17 M.D. Have you seen this report before?

18 A I think I have.

19 Q If you could turn to page 2, paragraph 5 of this
20 report?

21 (Witness complies.)

22 Q Actually, before we do that, if we could look back
23 to page 6, paragraph 12 of your report?

24 (Witness complies.)

25 Q Now, in that paragraph you assert that the basis

1 for Dr. Fine's opinion about the hospitalization rate was
2 data that was approximately 38 years old?

3 A Yes, ma'am.

4 Q Is that correct?

5 A Old.

6 Q That's what I meant, 38 years old.

7 A Old.

8 Q So you were criticizing Dr. Fine---

9 A (interposing) It's old.

10 Q ---because he was relying on old data,
11 essentially?

12 A I think that was one of the critiques.

13 Q So let's take a look then--let's go back to
14 Exhibit 3, Dr. Fine's report, and take a look at paragraph 5
15 on page 2.

16 (Witness complies.)

17 A Okay.

18 Q And he cites in this paragraph some more recent
19 data.

20 A Well, I think he---

21 A (interposing) Do you see that?

22 A ---cites data from the past in a book published in
23 '99.

24 Q Well, that's--the second sentence in his paragraph
25 refers to the 1999 book; correct?

1 A Reference 2 is the only thing I see referenced in
2 paragraph 5, and reference 2 is the book.

3 Q Well, if you go, though, to the next sentence, the
4 sentence that says, "More recent data regarding first
5 trimester surgical abortion shows even lower complication
6 rates," do you see that?

7 (Witness peruses document.)

8 Q And that cites to a study that was published in
9 just this year, 2013. And then if you go to the next
10 sentence, it refers to a study of medication abortions that
11 were provided in 2009 and 2010 showing rates of treatment and
12 admissions. And that was also a study published this year.
13 So does that change your opinion about the basis for his
14 expert testimony?

15 A I disagree and believe he's underestimated the
16 risk of complications. And I think my testimony yesterday
17 provided my intellectual framework for that.

18 Q And so you think he's underestimating the
19 complication rate; correct?

20 A Well, the complication rate--I think he makes two
21 estimates, a complication rate and then the need for
22 additional--hospital based care would be the phrase he would
23 use.

24 Q And so--let me ask you this first. Are you no
25 longer--do you no longer criticize Dr. Fine for reliance on

1 old data?

2 A I would say, one, I'm critical for reliance on old
3 data, and two, I'm critical on reliance on two small series
4 done in research institutions.

5 Q Say that last part again.

6 A It looks like to me that his reference 3 and 4--
7 one was done in a special setting under a California legal
8 waiver. And I don't have the article in front of me. You
9 can produce it. I'm not acutely aware--I'm not aware of what
10 the N is, but it sounds like to me under special
11 circumstances. Aspiration abortion tends to be done--tends
12 to be a term of art that refers to lower gestational ages, so
13 I'm not sure it's generalizable.

14 And then number 4, I think that's the McGee
15 Women's Hospital research group that pioneered medical
16 termination of pregnancy in the United States. So I imagine
17 this is from their research setting and again with
18 gestational age restrictions.

19 So I think those two references, while they are
20 certainly contemporary, are a very limited look and not--and
21 not thorough, so old with the book chapter and then 3 and 4
22 not particularly generalizable.

23 Q Have you read the studies that are cited at 3 and
24 4?

25 A No, ma'am. I'd be happy to read them if you want

1 to show them to me. I'm projecting from their title and
2 could be wrong.

3 Q And in reference number 4, the reference to the
4 Cleland article, you mentioned gestational limits?

5 A Well, there are gestational--I don't know--again,
6 I don't have the article in front of me, but there are limits
7 on medical abortion, medical termination.

8 Q Right, because medical abortion is only offered to
9 a certain week in pregnancy; correct?

10 A Yes, ma'am.

11 Q But that factor wouldn't limit the usefulness of
12 the research in that study with respect to medical abortion;
13 correct?

14 A Well, it wouldn't limit--it would be generalizable
15 to medical abortion. But these are the world's leaders in
16 that technique. Is a medical abortion done in rural North
17 Carolina or Alabama the equivalent of one done at the McGee
18 Women's Hospital? I'm not sure that it is--or wherever these
19 were done. I'm presuming. I don't know.

20 Q And so you just mentioned that your framework
21 was--for evaluating complications was what we discussed
22 yesterday; correct?

23 A Yes, ma'am.

24 Q And that was your review article in *Scientifica*?

25 A I think I tried to find everything I could find to

1 inform this question in light of the limitations of U.S. data
2 and the like.

3 Ms. Flaxman: Okay. I'm going to mark
4 another article. This will be Exhibit 4.

5 (Exhibit 4 was marked for
6 identification.)

7 Q So is this the article that you were just talking
8 about, your review article in *Scientifica*?

9 A Yes, ma'am.

10 Q Now, you raised this yesterday when you were
11 speaking in support for the estimate in your report of a
12 complication rate of 2 to 10 percent?

13 A Yes, ma'am.

14 Q I've flagged here for myself page 4, section
15 heading "5. Short-Term Harms." Is that what you were
16 referring to?

17 (Witness peruses document.)

18 A Yes, ma'am, in part.

19 Q Was there anywhere else?

20 A I don't think so.

21 Q Okay. Now, I didn't see in this article the range
22 of 2 to 10 percent for abortion complications. How did you
23 arrive at that number?

24 Mr. Parker: Object to the form.

25 A Well, if you look at these references that I think

1 begin with 52, if I can get there, there are a series of
2 review articles which then take into account various
3 references in trying to meet the reference limitations of the
4 journal, over 300 references in this review. From those
5 primary sources is where I get the 2 to 10 percent range.

6 Q But is the 2 to 10 percent range in this article?

7 A I think if you aggregate up the bleeding, the
8 damage to bowel and bladder, and the infection, I think you
9 could get to 10. I'm at 6 just adding infection and
10 bleeding, and over 1 all the way.

11 Q What was that last part?

12 A And over 1 all the way.

13 Q So you get to 6 with infection and bleeding?

14 A With the two numbers I put in there.

15 Q Okay. Then how do you get from 6 to 10?

16 A Well, cervical trauma--and all of these reflect
17 ranges.

18 Q So the---

19 A (interposing) And all are dependent on
20 gestational age, as cited in the first paragraph in number 5
21 for short term harms.

22 Q And so the 2 to 10 percent figure in your expert
23 report is essentially adding up the purported complication
24 rates you have here; is that correct?

25 A Well, it's trying to make an educated or best

1 guess in the aggregate of the literature with all the
2 limitations inherent thereof.

3 Q Well, then why are you trying to make an educated
4 or best guess when there are other studies out there, such as
5 the studies that are in Dr. Fine's report, that are not based
6 on guesses, but are based on studies of patients?

7 A Well, my guesses are based on studies of patients.
8 I'm not making anything up. But I'm--and maybe guessing
9 isn't the best guess I can, but to make an approximation of
10 whatever the true complication rate is.

11 And I think I have been more comprehensive and
12 thorough herein--and I realize Dr. Fine was not writing an
13 article for a scientific audience, but have been more
14 comprehensive in this instance than to cite two limited and
15 nongeneralizable articles as my reference sources.

16 Q But you haven't read the articles that are cited
17 in Dr. Fine's report, correct, to know?

18 A I don't know whether I have or haven't. I don't
19 know have a recollection. I've got an iPad. I can pull them
20 up and we can read them if you want to.

21 Q No, that's all right.

22 A Okay.

23 Q We may get to there.

24 A They're discoverable.

25 Q Correct. We may get there. So your estimate of 2

1 to 10 is an aggregate of studies of different complication
2 rates rather than any one study that studies a large
3 population of women and gives you the total complication
4 rate?

5 A I don't think there's one definitive study, one
6 single source that reflects termination of pregnancy practice
7 in a large population like a U.S. state.

8 Q Let me ask you then about--you mentioned reference
9 number 52. Would you call them footnotes or reference
10 numbers?

11 A I would call them reference numbers, but---

12 Q (interposing) Well, we'll use your terminology.

13 A Okay.

14 Q So reference number 52 looks like an article
15 involving "Management of uterine perforations complicating
16 first-trimester termination of pregnancy." Now, it's
17 published in the *Israel Journal of Medical Sciences*. Is the
18 data in that article coming from Israel?

19 A I would assume so.

20 Q And so how do you extrapolate that article to, you
21 know, make a guess about complication rates in this country?

22 A Well, I don't think biology in Israel is different
23 than biology in the U.S., and I don't believe you think that
24 either.

25 Q No, but the numbers are far different; correct?

1 A What do you mean the numbers are far different?

2 Q Smaller population, fewer women obtaining
3 abortions.

4 A There are multiple differences, yes, ma'am.

5 Q And this was also--would you consider 1995 to be
6 old?

7 A I consider 1957 to be old.

8 Q Well, then 1970s and '80s to be old I gather too,
9 from what you were saying about Dr. Fine's testimony?

10 A Ma'am?

11 Q Huh?

12 A Ma'am? I didn't--I didn't--I was thinking about
13 1957.

14 Q When you criticized Dr. Fine's testimony as being
15 based on old data---

16 A (interposing) Coach Smith lost a national
17 championship in 1957 in triple overtime to North Carolina.

18 Q And do you remember that?

19 A He was on a Kansas team.

20 Q You don't remember that?

21 A I was in utero.

22 Q Okay, so you don't remember that either?

23 A Well, I have recollection of the horns blowing in
24 Rocky Mount.

25 Q So the---

1 A (interposing) Forgive me.

2 Q No, that's fine. The data that Dr. Fine--that you
3 criticized Dr. Fine for relying on was from the '70s and '80s
4 and you had said that that was old; correct?

5 A Well, I'm not--there's been a lot published since.

6 Q Okay, but you would consider then an article from
7 1995 to be something that you could rely on; is that right?

8 A Well, I'm not relying on it. It's one of 312
9 references.

10 Q Although with respect to complications, it's far
11 fewer than 312 references; right?

12 A There are probably at least 20, many of which are
13 reviews that include hundreds of articles.

14 Q Why don't we--let me ask about the second
15 paragraph under short-term harms. It's a discussion of--are
16 you there on page 4?

17 A Yes, ma'am.

18 Q It talks about bleeding or hemorrhage occurring in
19 up to 1 percent of TOPs in the first trimester and up to 2.5
20 percent in the second trimester. What is the source for that
21 statement because there's no reference there?

22 (Witness peruses document.)

23 A I think that 51 would be the reference that
24 applies to all three sentences that start the second
25 paragraph on page 4 in part 5.

1 Q Do you--are bleeding and hemorrhage the same thing
2 in your mind?

3 A Well, I define estimated blood loss greater than
4 500 ccs, so excessive bleeding would probably be a better
5 modifier to put there. But with defining it in the
6 parentheses, I thought I helped you out.

7 Q I just wanted to ask you whether the parentheses
8 also applies to the bleeding.

9 A Yes, ma'am.

10 Q Okay. So you don't mean bleeding in general
11 because that obviously happens in---

12 A (interposing) Yes, ma'am.

13 Q ---every procedure? So this is bleeding with
14 estimated blood loss of greater than 500 ccs; correct?

15 A Yes, ma'am, thus labeled a harm.

16 Q Let me ask you, your range of 2 to 10 percent for
17 abortion complications, is that for both first and second
18 trimester?

19 A Yes, ma'am.

20 Q And so you would say the risk of complications
21 from a first trimester abortion is 2 to 10 percent or would
22 you give a lower estimate?

23 A Probably less.

24 Q So what would your estimate be for first
25 trimesters?

1 A Well, I--we could--we could back it out. I give
2 you a hazard ratio by week in reference 50. So each
3 additional week, you would multiply whatever the background
4 rate was by 1.38. That's the hazard ratio. And you could
5 determine a week specific complication rate.

6 Q Now, I'm terrible with statistics or I wouldn't
7 have gone to law school. Can you do that sitting here and
8 give us an estimate of first trimesters?

9 A Well, then it would require me to aggregate all
10 the--from six to 12 weeks all the risks. The risk of harms
11 goes up as gestational age increases.

12 Q So how about a ballpark, then, on first trimester?

13 Mr. Parker: Object to the form.

14 A Well, you've been previously critical of me for
15 guessing. Now you're trying--are you going to ridicule me
16 again if I make a guess?

17 Q There's no ridicule here, sir.

18 A Not a bit?

19 Q Not a bit.

20 A I would guess 1 to 3.

21 Q Okay. Backing up a second, what's the audience
22 for *Scientifica*? I'm not familiar with this publication.

23 A What do you mean what's the audience?

24 Q Is it a medical---

25 A (interposing) Whomever will pick it up and read

1 it.

2 Q Is it a medical publication?

3 A It's a peer reviewed Index Medicus publication.

4 Q And so the audience is other physicians?

5 A Physicians, epidemiologists, biomedical

6 scientists, whoever wants to read it--lawyers.

7 Q Right now us sitting here?

8 A Law clerks--hell if I know who's read it.

9 Q All right. Back on page 4 again under short-term
10 harms--we're going back to page 4 under short-term harms. In
11 the third paragraph, the third sentence says, "Up to 3
12 percent of second trimester TOP procedures are complicated by
13 cervical trauma." Do you see that?

14 A Yes, ma'am.

15 Q And the reference is 56, an article by a Dr.
16 Shannon. I assume it's a doctor. Do you see that?

17 A Yes, ma'am.

18 Ms. Flaxman: I'm going to ask that we mark
19 as an exhibit that article.

20 (Exhibit 5 was marked for
21 identification.)

22 (Witness peruses document.)

23 Q Is that the article that you were referencing?

24 A It sure looks like it.

25 Q So if you could take a look and tell me where in

1 that article it talks about the cervical trauma in second
2 trimester TOP procedures?

3 (Witness peruses document.)

4 A I believe that it doesn't. And I fear, as much as
5 I hate to admit it, that in--and I believe there was a series
6 of reviews of which this was one--that I've left out a
7 reference. But I would have to go back to my original files
8 and look. So I think there is an absent reference for that
9 number or they are misnumbered.

10 Q Why don't you take a look and see?

11 A I can get limited by looking--I don't know whether
12 53 through 55 would--should be it, but it doesn't look like
13 it's 56. And the series of reviews are not reference 56, the
14 *Contraception*, but are the *Clinical Obstetrics and*
15 *Gynecology*, 57. There are a series of reviews on complica-
16 tions of pregnancy termination.

17 Q In reference 57?

18 A Yes, ma'am. Well, hers is infectious complica-
19 tions, but within that volume 52 of *Clinical Obstetrics and*
20 *Gynecology*, there are a series of reviews on harms of
21 pregnancy termination. And somehow I mislabeled or have done
22 something. But you are correct, and kudos to the person who
23 found the mistake. Yeah.

24 Q Okay. So Exhibit 5, which I should have said for
25 the record is an article by Caitlin Shannon and others

1 entitled "Infection after medical abortion: a review of the
2 literature," does not support the statement in the article
3 about risks of cervical injury; correct?

4 A It does not support the statement. And I think
5 there is an error in that paragraph that I'm responsible
6 for--not intentionally responsible for, but ultimately
7 responsible for.

8 Q Now, why don't we look at Exhibit 5 while we have
9 it? Have you reviewed this article before?

10 A I think I have, but I don't have an independent
11 recollection, but every article pulled that's in the review I
12 had in the file.

13 Q Now---

14 A (interposing) And quite a few more.

15 Q It does mention here that the frequency of
16 infection after medical abortion was very low. They said .92
17 percent. Do you see that?

18 A And they also said it varied among regimens.

19 Q Where are you referring to?

20 A The second half of that sentence where you give me
21 the very low .92 percent.

22 Q Let's look at page--let's see, it's 184, right at
23 the beginning section 3, which is Results. It says "Overall
24 frequency of diagnosed and/or treated infection...after
25 medical abortion treatment was less than 1 percent"?

1 A Yes, ma'am.

2 Q So that's lower than the rate of infection that
3 you cite in your article; correct?

4 A No, it's not.

5 Q Now, why is that?

6 A I said infection occurs after 1 to 5 percent of
7 surgical TOPs and is usually polymicrobial in nature. So I
8 haven't even commented on postmedical abortion.

9 Q So why did you not comment?

10 A Why did I not comment?

11 (Witness peruses document.)

12 Well, I think I did comment at the very end of
13 section 5, "When medical and surgical TOP procedures are
14 directly compared, more women in the medical...groups will
15 require surgical evacuation and experience more bleeding,
16 while surgical TOP has more traumatic complications."

17 Q Okay. But I'm talking about infection. You don't
18 mention infections from medical abortions except for
19 mentioning deaths. Do you see that? It's a little earlier
20 in the paragraph.

21 (Witness peruses document.)

22 A That I mention death? I think it's later in the
23 paragraph where I mention death.

24 Q Okay. Well, the only reference--well, let me ask
25 you. Isn't the only reference about infection related to

1 medical abortion in this paragraph about the fatal toxic
2 shock after medical TOP---

3 A (interposing) Yes, ma'am.

4 Q ---caused by *Clostridium*. Why would you have
5 included that reference without referring to an infection
6 rate for medication abortion from an article that you've
7 cited elsewhere?

8 A I don't know.

9 Q Would you agree with me that Exhibit--the article,
10 Exhibit 5, is a large scale study?

11 A Yes, ma'am, that comes up with a number awfully
12 close to 1 percent.

13 (Pause.)

14 Mr. Parker: Are you interested in a break?

15 The Witness: Are you interested in me taking
16 a break?

17 By Ms. Flaxman:

18 Q Let me just--I have one more set of questions
19 about this line and then we can take a break. Does that work
20 for you?

21 A Yes, ma'am.

22 (Exhibit 6 was marked for
23 identification.)

24 Q Okay. So now Exhibit 6 is an article by a Lisa
25 Rahangdale?

1 A Rahangdale.

2 Q Rahangdale. Do you know her?

3 A She works for us now.

4 Q Then you do know her?

5 A I do know her, saw her this morning.

6 Q And it's an article that she---

7 A (interposing) It took me awhile to learn how to
8 pronounce it.

9 Q I won't even try it again. I'll just call her the
10 doctor.

11 A Rahangdale.

12 Q Rahangdale.

13 A Yeah.

14 Q She wrote an article---

15 A (interposing) Grew up in Fayetteville.

16 Q Oh. She's local?

17 A Yes.

18 Q ---an article called Infectious Complications of
19 Pregnancy Termination. Have you read this article before?

20 A Yes, ma'am.

21 Q And that article is referenced at number 57; is---

22 A Yes, ma'am.

23 Q ---that correct? And so you cite this article
24 towards the end of page 4 for the infection rate of 1 to 5
25 percent of surgical TOPs. Do you see that?

1 A Yes, ma'am.

2 Q If you could find in the Exhibit 6 where she said
3 that in the article?

4 A Well, I think I extrapolated the first sentence on
5 page 199, "Approximately 0.1 to 4.7 percent...are affected by
6 uterine infection."

7 Q Okay. So you took .1 and made that 1; is that
8 correct?

9 A Well, I don't know.

10 Q Isn't that what you just testified?

11 Mr. Parker: Object to the form.

12 A Well, it's not what I just testified. I may have
13 taken the .7 in the second sentence and the 4.7 in the first
14 sentence and rounded up to 1 and 5.

15 Q Okay. So in both cases, though, whether it was
16 from the .1 or the .7 and the 4.7, you rounded up; is that
17 correct?

18 A That's what you tend to do with things over half.

19 Q Even in scientific research?

20 A Even in scientific research.

21 Q Let me ask you, though, about her reference of .1
22 to 4.7 percent. That's infections in surgical abortions
23 worldwide; correct?

24 A That's the statement she makes and refers back--
25 number 8 says "Infection after medical abortion: a review of

1 the literature."

2 Q And so on the face of it, though, this is a
3 statistic about worldwide infection and not limited to the
4 U.S.; correct?

5 A Yes, ma'am.

6 Q And with respect to that reference 57 about
7 surgical abortion infection, were there any other sources you
8 relied on?

9 A Well, I think to try to limit the number of
10 references, if you go back to Exhibit 5 and Shannon--who I
11 presume is a physician like you do, but I don't know

12 -- Table 1, there are 30 or 40 medical termination
13 infection rate articles, and it's continued, so there are
14 probably 60 in total listed for her to get her grand total of
15 46,000. Rather than put all 60 into the reference section,
16 I've cited back to these people, who have accumulated that
17 literature, that lump---

18 Q (interposing) Okay, but---

19 A ---as opposed to every individual piece.

20 Q You're relying both on the article and the
21 references in it?

22 A Yes, ma'am.

23 Q But nothing outside of either that article or the
24 references in it, I guess is my question.

25 A Well, I think for each and every complication

1 there are review articles in which I have done that in a
2 similar fashion, but for a different complication. You've
3 provided me sweetly, nicely, kindly with a example of what I
4 mean.

5 Q Okay. Why don't we take a break?

6 A Thank you.

7 The Reporter: Off the record. 2:54 p.m.

8 (A brief recess was taken.)

9 The Reporter: On the record. 3:06 p.m.

10 By Ms. Flaxman:

11 Q Okay. Doctor, if we could go back to Exhibit 1,
12 your report?

13 (Witness complies.)

14 A I'm there.

15 Q And directing you to page 14, paragraph 26.

16 (Witness complies.)

17 Q Are you there?

18 A Yes, ma'am.

19 Q Okay. In the first sentence you say:

20 "In my medical opinion, I believe most patients
21 would assume that their surgeon for an elective
22 procedure would have both current medical
23 licensure and staff privileges at an acute care
24 hospital that would allow for the diagnosis and
25 treatment of any unforeseen complications or harms

1 that could arise from their surgery."

2 Did I read that right?

3 A Yes, ma'am.

4 Q And is that still your opinion?

5 A Sure is.

6 Q What's your basis for that opinion?

7 A I haven't surveyed people, so there's not an
8 evidence basis; this is an experience basis, that if one is
9 going to undergo an elective surgical procedure that the
10 surgeon is credentialed and prepared to at least provide
11 acute care to the complications that might arise.

12 My wife is going to have elective sinus surgery
13 after the holidays. It's not really a fair analogy because
14 it's going to be in the UNC system and I know the person has
15 credentials. But if she were getting it done in Durham, I
16 would assume that if somebody were going to do whatever
17 they're going to do to her sinuses that if they perfed the
18 base of her skull and CSF was leaking that they could at
19 least begin to attend to that and get her into a system where
20 it could be fixed or addressed. I don't know how you fix it.

21 Q You wouldn't let her have surgery like that in
22 Durham, would you?

23 A Well, I wouldn't let her have surgery in the Duke
24 system, but my wife is very independent and she might tell me
25 to drop dead, that's where she was having it done. My

1 assumption would be that you--I think patients assume that
2 the complications or harms mentioned to them as part of
3 informed consent can be taken care of, at least
4 preliminarily, by the surgeon that's going to do the elective
5 procedure.

6 Q But you just said there were no surveys that you
7 did; right?

8 A No surveys that I've done and no surveys that I'm
9 aware of either way. It would be interesting to know what
10 people believe, I mean to actually formally assess what
11 people believe.

12 Q So have you asked patients about it?

13 A No.

14 Q And so you certainly haven't spoken to anyone in
15 Alabama about it; correct?

16 A I don't think so.

17 Q And so what you described to me as the experience
18 with your wife, it sounds to me like rather than your medical
19 opinion, that's based on kind of your experience of being a
20 patient, a consumer of medical resources, and not so much as
21 a physician?

22 Mr. Parker: Object to the form.

23 A Well, as a consumer and a provider.

24 Q But you haven't spoken to any patients you just
25 testified. And so what is the basis of---

1 A (interposing) Well, my---

2 Q ---your opinion as a provider--your opinion as a
3 provider if you haven't spoken to any patients?

4 A Well, my basis as a provider--when I say I haven't
5 spoken to patients, I haven't surveyed patients about to
6 undergo an elective surgical procedure about what do you
7 expect, what do you think would happen if you had a
8 complication.

9 I do know in the instances where I've cared for
10 people in the emergency department who had a complication and
11 found the termination of pregnancy office to be closed, or
12 didn't have a termination of pregnancy but had outpatient
13 gynecologic surgery and could not contact their surgeon and
14 felt abandoned, that there was an expectation there, that
15 that was part of the frustration in addition to having the
16 complication.

17 Q But you just told me you never spoke to patients
18 about whether they expected their providers to have
19 privileges.

20 A I've never prospectively spoken to patients. And
21 maybe I should have qualified the I have not spoken by the
22 prospectively spoken. That's retrospectively speaking after
23 the complication occurs. And I think I'm opining that people
24 have that expectation prospectively.

25 Q Did anyone ever tell you they had that expectation

1 prospectively?

2 A Never asked anybody.

3 Q It was just your assumption?

4 A It's my assumption and based on my retrospective
5 conversations with a limited number of patients, which I see
6 as different to my first answer.

7 Q But in those retrospective conversations did
8 anyone say they wished their provider had privileges?

9 A In the retrospective?

10 Q Yes.

11 A They said, "I wish my"--I don't think the average
12 person understands privileges--"I wish my doctor was here to
13 communicate and be involved in my care," you know, "They did
14 this to me this afternoon or yesterday afternoon. Why aren't
15 they part of the deal?" And I have heard that from both
16 patients and families.

17 Q When have you had those conversations?

18 A When somebody presents to our emergency department
19 after a complication from an elective procedure and are
20 frustrated by the absence of their surgeon.

21 Q No, I'm asking you for a specific. Can you give
22 me a specific example of when you've had this complication?

23 A After termination of pregnancy and I remember
24 somebody with an infection after a hysteroscopy would be the
25 two instances I have recollections of.

1 Q So turning to the example of the infection after
2 hysteroscopy, what's a hysteroscopy?

3 A It's sticking an endoscope in somebody's uterus to
4 look around and find a fibroid or polyp or lesion. It's
5 often done in outpatient settings.

6 Q Is that something you do in an outpatient setting?

7 A I don't do it, but others do.

8 Q And so in that case, what happened with that
9 patient?

10 A The harm of hysteroscopy is infection. The
11 patient had a postprocedure infection. She was frustrated
12 that on a Friday night she could not get in touch with the
13 office, anybody covering the office, and that her operative
14 records, her indications and all were not available to the
15 then treating team in the emergency room.

16 Q And so then what happened in the emergency room?

17 A What happened?

18 Q Well, they diagnosed the infection; correct?

19 A We took care of her in the emergency room, but her
20 care would have been facilitated by communication, and her
21 emotional and mental health would have been enhanced by the
22 person who operated on her being present.

23 Q Did anyone from the hospital try to get in touch
24 with her provider?

25 A Yes, ma'am. And the person was not available, not

1 there, and didn't have coverage and backup.

2 Q Did that provider have privileges in the hospital?

3 A No. I think communication would have been
4 enhanced if he or she had had privileges. And if she did
5 have privileges and was not available or did not have a
6 designee available, then we would have had some recourse to
7 talk to the chief of staff. So there would have been a
8 corrective action that might could have occurred.

9 I also base it--and I'm thinking about my basis--
10 on--Bill Droegemueller, *Droegemueller's Gynecology*, was my
11 chair and my mentor. And he insisted--and this isn't
12 privileging, but that you could not do something elective on
13 somebody and leave town, that if you were going to do an
14 elective surgical procedure, you had to be in town thereafter
15 for the expected length of hospital stay or then discharge
16 them out and out of the woods. So it was drilled into me by
17 him that if you electively do something on somebody, you need
18 to be available to attend to their problem.

19 Q But that's not the rule that other physicians
20 follow; right?

21 A Oh, I think it's a rule that other physicians
22 should follow, that I want my physician to follow.

23 Q But it's not necessarily typical medical practice?

24 A I think by good surgeons and good doctors it is.
25 I don't think you do elective things on people and leave

1 town.

2 Q Well, but you can--you could leave town and have a
3 partner who's available to take any calls; right?

4 A That would be a second thing, but if you knew you
5 were going to leave town, if you weren't leaving town
6 emergently, I don't think you should do something elective.
7 If the guy doing my wife's sinus surgery on December 27th is
8 going to his mother-in-law's that evening, I'm going to be
9 pissed with him if she has a complication the next day. I
10 expect him to be in town.

11 Q But he would presumably after hours have someone
12 else covering for him; right?

13 A He could have somebody else covering, but I want
14 him to be in town and available.

15 Q Well, you might want him to, but that's---

16 A (interposing) I expect him to.

17 Q But that may not be the reality in medical
18 practice; right?

19 A I think it's the reality of good medical practice.

20 Q But there are plenty of good physicians who would
21 leave town as long as they had a partner providing for care
22 of patients after hours; right?

23 A I think that would be a shortcoming of a good
24 practitioner and I would be critical.

25 Q Now, some complications, though, wouldn't

1 necessarily arise the next day; right? They could arise a
2 week or two later in any kind of surgical procedure; right?

3 A Or years or two later.

4 Q No, we'll talk about the more short term. There
5 are those complications that might occur day of, day after,
6 and then there are those that could happen a week or two
7 later. A practitioner is not going to stay in town for weeks
8 after these procedures and you wouldn't expect them to;
9 right?

10 A I think the great bulk of the complications would
11 occur in the first 24 to 48 hours, and I expect people to
12 stay. If I'm going to do something elective--and what I do
13 elective are cerclages and cesarean sections.

14 And if somebody says, "Do my cesarean section this
15 morning" and I know I'm leaving town, I tell them, "I'm
16 leaving town. If you want me to get somebody who's going to
17 be in town to stay with you who's in town to see you, then we
18 should let them do it. If you accept the limitation of 'I've
19 got to do this tomorrow. This is something I'm obliged to do
20 and accept substitute coverage'"--but I want them to know I'm
21 not going to be there.

22 Q So you let your patients know, but it's not that
23 you haven't done it; is that what you're saying?

24 A If it becomes necessary to do, I inform the
25 patient. And some of them will say, "Let's do it a different

1 day. It's elective." And others will say, "No, if Dr.
2 So-and-So is here, I'm happy with that." I think there's an
3 expectation with elective procedures that there be continuity
4 of care, and I think that's a reasonable expectation.

5 Q What does the fact that it's an elective procedure
6 have to do with it?

7 A Because you schedule an elective procedure. It's
8 not that somebody comes in here and shoots me with a gun and
9 I have to go get trauma surgery with a belly full of diet
10 Coke. It's that I chose to get something done tomorrow or
11 Monday or Wednesday. It doesn't matter which day it was
12 done. It's elective.

13 Q And so are you saying, though, that patients don't
14 assume, in the case of nonelective procedure, that their
15 practitioner would have privileges?

16 A Well, I didn't say that they--we were talking
17 about continuity of care, of which privileges is a part. And
18 I think the trauma surgeon who would care for me if I was
19 shot or in a wreck today--I hope somebody would care for me--
20 I don't have an expectation that they're not going to their
21 mother-in-law's first thing in the morning. But for an
22 elective thing, I would want continuity of care.

23 Q So you're saying that for something that's not
24 elective, that's not critical?

25 Mr. Parker: Object to the form.

1 A Well, it would be nice, but it's impossible to
2 arrange.

3 Q Because in those cases patients need the care;
4 right?

5 A In those cases patients need the care and there's
6 no choice exercised in when the care occurs because I acutely
7 need the care or I will die or suffer a serious harm if I'm
8 not cared for now.

9 Q And so the physicians who are available to provide
10 care are going to be the best providers at that point; right?

11 A They're the only providers. I don't have another
12 choice. When I have a termination of pregnancy--not that I
13 will ever be pregnant, but when I have an elective surgical
14 procedure like termination of pregnancy, I choose when,
15 where, and who.

16 Q You mentioned a conversation you'd had with the
17 patient who had had---

18 A (interposing) A hysteroscopy.

19 Q ---a hysteroscopy.

20 The Witness: (addressing the Reporter)

21 H-y-s-t-e-r-o-c-o-p-y.

22 The Reporter: You left out an "s."

23 The Witness: Okay, thanks. She ain't bad.

24 Q And so with that patient, you said you'd had a
25 conversation with her where she said she wishes her doctor

1 were there; right? So she didn't mention privileges. Is
2 that what your testimony is?

3 A Well, she didn't mention privileges, but it would
4 be impossible for her doctor to be there at her bedside
5 without privileges. You can't care for somebody in an acute
6 care hospital at their bedside unless you're privileged. So
7 I think she was de facto asking, "I wish my doctor were here
8 and could be involved in my care," thus would need to be
9 privileged.

10 Q Okay. But she didn't use those words. Those were
11 your words, the privileged part of it?

12 A No. I don't think most patients have any under-
13 standing of privilege. I think they want their clinician to
14 be there who electively operated on them.

15 Q And the physician, though, could be there without
16 privileges; right? They just couldn't provide care?

17 A Well, they can't provide care and with HIPAA and
18 all the stuff that happens in hospitals now, it's difficult
19 for them to be even peripherally involved in the care other
20 than to relay part of the story. They're treated like a
21 visitor as opposed to a caregiver.

22 Q You mentioned before--when you were talking about
23 why patients would expect their providers to have privileges,
24 you mentioned that they would expect their provider to at
25 least--the quote was "begin to address the complication."

1 What did you mean by that?

2 A Well, exactly what I said is what I meant.

3 Q And so could--do you mean that they could begin to
4 address the complication at the time that it took place in
5 the outpatient center?

6 A Well, at the time it became manifested, at the
7 time it showed up, and be involved in their care to the
8 fullest extent possible. And I think in many instances
9 that's going to require privileges, if it involves
10 hospitalization. Some complications can be handled in the
11 office.

12 Q Right, which we talked about yesterday.

13 A Yeah.

14 Q But I guess, as we also just talked about earlier
15 today, in some cases the care that's required in treating the
16 complication would be better provided by another specialist.
17 And so the patient doesn't assume that their provider will be
18 the doctor providing care all the way through; right?

19 A I didn't say would provide all of the care. I
20 said start, initiate the care, and do to the fullest extent
21 he or she is capable.

22 Q Okay. And at some point if the---

23 A (interposing) So I don't expect a trauma surgeon
24 to do my autopsy. I want him to keep me from getting an
25 autopsy.

1 Q But short of that---

2 A (interposing) But if he fails, then another
3 discipline will become involved in the care, and I hope I
4 have a corpse and a soul, in the care of my corpse. But
5 there remains an adventure to find out whether that's true or
6 not.

7 Q Because there are specialists who might be the
8 better provider of care in some instances?

9 A Of specialty care, but the person who knows the
10 story best or should know the story best is the surgeon that
11 did the initial procedure. And so at least at the beginning,
12 if not the full care, he or she needs to be involved. I
13 think that's what Alabama is trying to make happen or
14 increase the likelihood of happening.

15 Q And so is it your opinion that most patients
16 believe that their general practice physicians have staff
17 privileges at a local hospital?

18 A Well, I think in a suburban-rural state like North
19 Carolina, most of them do.

20 Q Well, how do you know what patients in a suburban-
21 rural state like---

22 A Because I happen to live here.

23 Q Sorry; I thought you meant--I thought you were
24 saying Alabama.

25 A I said North Carolina.

1 Q You did, and that was my mistake.

2 A I didn't say anything about Alabama.

3 Q That was my mistake.

4 A And then my master's project at Duke, we looked at
5 end of life decision making and communication between ER
6 providers, primary care doctors, and hospitalists, urban
7 areas in North Carolina in like Durham and Chapel Hill
8 primary care doctors. Many of them don't have hospital
9 privileges. In rural and suburban settings, most of the
10 primary care doctors do. I think it is very, very
11 disappointing to people when their primary care doctors don't
12 show up and the hospitalist team takes care of them.

13 I also know from my master's degree at Duke that
14 the hospitalist team has a heck of a time figuring out what's
15 going on, what conversations have ensued, what the plans are.
16 And that's what we addressed was a communication gap, that
17 communication gap and its link to dissatisfaction, excess
18 expense, and in some instances poor outcomes.

19 Q And so going back, you were saying that patients
20 are disappointed when they find out that their provider
21 doesn't have privileges. Was that based on the two
22 conversations you mentioned before, the hysteroscopy patient
23 and the abortion patient?

24 A And in the master's degree at the Duke and the
25 people that we talked to. We looked at--Raleigh Community

1 Hospital was the site. People were disappointed when--
2 particularly older people; maybe they're not as smart as
3 younger people--when their doctor, who they had been seeing
4 or they had told their plans for what they wanted done at the
5 end of their lives, wasn't around. It was very frustrating
6 to the hospitalist because oftentimes they couldn't get the
7 information. So there's a big communication gap in these
8 handoffs.

9 Q Now, you were studying--you were studying this in
10 part because there is a trend toward use of hospitalists;
11 correct?

12 A Yes, but I'm not sure it's a good trend.

13 Q And you were looking at ways to improve a
14 communication gap; right?

15 A Yes, ma'am, I think so.

16 Q And that's something that's occurring in different
17 medical specialties; right?

18 A I think so.

19 Q One question I had--you were talking before about
20 a provider lacking privileges, not being able to participate
21 in the care of a patient. You mentioned HIPAA as one thing
22 that made it difficult for that provider to be involved in
23 the patient's care. Can't a patient waive that HIPAA barrier
24 and allow her physician to get information?

25 Mr. Parker: Object to the form. Objection.

1 A She can waive it, but in a busy emergency room
2 where a clinician is responding to a complication that may or
3 may not be acute, oftentimes the last thing on his or her
4 mind is a HIPAA waiver so I can go out in the waiting room
5 and talk to the treating physician, operating physician.

6 Q Right, but---

7 A (interposing) So yes, she can waive it. But it--
8 HIPAA limits a lot of conversations.

9 Q But if it were medically necessary, there are ways
10 to have those conversations; right?

11 A There are ways to have it, but I don't think that
12 most medical personnel appreciate HIPAA. And they're so
13 frightened by the legal implications that a lot of times they
14 just don't talk to anybody about anything because they don't
15 understand--I think it's had a disincentive to communication.

16 Q Right, but if it were medically necessary, a
17 physician would do that, would communicate or get a waiver if
18 it was necessary; right?

19 A Could.

20 Q Are there--you mentioned that there were primary
21 care providers who no longer have privileges in the urban
22 settings. Are there gynecologists who no longer do OB and
23 don't maintain privileges?

24 A I think most of them want to operate in a
25 hospital. In fact that's a major source of their livelihood,

1 so I'm not familiar with such--of such.

2 Q Will you turn to paragraph 24 in your report,
3 Exhibit 1, which is at page 13?

4 A Yes, ma'am.

5 (Witness complies.)

6 Q The last sentence in that paragraph says, "In
7 addition, the checks and balances"--sorry; it's the last two
8 sentences in that paragraph. "In addition, the checks and
9 balances for auditing patient outcome in the hospital setting
10 are less likely to be found in ARHCs." Actually, I'll just
11 read that one sentence. Did I get that right?

12 A Yes, ma'am.

13 Q What do you mean by that?

14 A I think that hospitals typically have more
15 resources and can dedicate more resources to quality
16 improvement. They see a larger number of patients, have more
17 data on practice patterns, and I think as a general rule tend
18 to do better quality improvement than do--than do free-
19 standing surgical centers.

20 Q And what's the basis for that opinion, that
21 hospitals do a better job of quality improvement than
22 freestanding surgical centers?

23 A Well, I don't think that's what I said. I think
24 they have more resources that they could dedicate to that. I
25 don't know of ambulatory surgery centers that have large

1 quality improvement programs, multiple quality improvement
2 staff like the hospitals that I've worked in and am familiar
3 with.

4 Q So you don't mean that auditing patient outcome
5 isn't occurring in outpatient settings; right?

6 A No, ma'am.

7 Q You just think---

8 A (interposing) And I imagine that there are
9 outlier outpatient settings that may do better than
10 hospitals, if they're really motivated. but to do quality
11 improvement audits cost money. And hospitals seem to be the
12 entities within the health system these days that have money
13 to spend and make money, plus I think there are portions of
14 the Affordable Care Act that require them to do such.

15 Q And I--the incentives of the malpractice system
16 are powerful as well; right?

17 A To do quality improvement?

18 Q To do quality improvement.

19 A I don't think that malpractice influences anybody
20 to do quality improvement because I think malpractice is a
21 fault based system. Quality improvement tends to be an error
22 preventability system. So I think the two often have a
23 negative influence on the other.

24 Q Do you have any basis for knowing what type of
25 auditing of patient outcome takes place in the abortion

1 clinics in Alabama?

2 A No, ma'am.

3 Q And do you know anything about what's required by
4 Alabama regulation for auditing in Alabama?

5 A I don't recall anything, ma'am.

6 Q So explain to me how privileges matters to the
7 subject of auditing patient outcome.

8 A I work in an ambulatory procedure center and I'm a
9 staff provider. And my complications are cared for in the
10 hospital, let's say postoperative reoperation. Then at least
11 there is an entity that has numerator data on how often that
12 occurs.

13 And if I am an outlier and have a particularly
14 large number, denominator data can be sought and one can see
15 whether I'm really an outlier or just a really busy person.
16 And if I am an outlier, if I have a high number of complica-
17 tion rates, hospital staffs tend to remediate people or
18 revoke their privileges.

19 Q But all of that could take place in an outpatient
20 setting; right?

21 A It all could take place, though the outpatient
22 setting, because it's not a receiver of all the complica-
23 tions, might not know about a complication, might be unaware
24 of a complication that presented to the hospital, was cared
25 for, and maybe the person didn't even say she'd had a

1 termination of pregnancy.

2 Q Well, then how would hospital privileges make a
3 difference to that?

4 A Well, it wouldn't make patients honest, but--and
5 so it wouldn't solve it in that sense. But you--you would be
6 able to identify people with high numbers and then get to try
7 to see what is their percentage.

8 If I do--I may have a 1 percent infection rate,
9 which is perfectly great, do 3,000 of whatevers and have 30
10 people that need treatment for infection and can go seek
11 denominator data. So I think it's part of a quality
12 improvement process.

13 Q But what about providers who primarily provide
14 care in an outpatient setting? How---

15 A (interposing) Well, I think that the problem is
16 that their complications, their serious complications, are
17 handled in an inpatient setting.

18 Q Well, but the hospital is auditing--the hospital
19 is auditing patient outcomes in the hospital; right?

20 A Well, it's auditing numerator data postop,
21 whatever.

22 Q And so I guess what I'm getting at is a hospital--
23 neither--in your testimony neither the hospital nor the
24 outpatient provider would necessarily have a full picture of
25 patient outcomes?

1 A Neither would have a full picture.

2 Q So I guess your testimony, you would want to have
3 auditing done in both locations; right?

4 A True.

5 Q Let's turn to paragraph 23 of your report,
6 starting on page 12.

7 (Witness complies.)

8 Q On the top of page 13, you talk about JCAHO. Is
9 that how you pronounce it?

10 A Yes, ma'am.

11 Q You talk about JCAHO---

12 A (interposing) I can tell you've dealt with them
13 before.

14 Q Occasionally--and what they have to say about
15 provider credentialing. And you say, "According to the Joint
16 Commission on Accreditation of Healthcare Organizations
17 (JCAHO), this process is intended to assure patient safety by
18 permitting only qualified physicians to provide such care."

19 What do you mean by such care?

20 A Well, I think it references "is an important"--the
21 preceding sentence, "an important"--"is an important process
22 that determines which physicians may admit or perform
23 procedures at a given inpatient healthcare facility." So it
24 sets minimal standards for me to claim that I can do
25 something and do it.

1 Q But by that you mean procedures that are provided
2 in the inpatient hospital setting; right?

3 A Yes, ma'am.

4 Q And so what about physicians who only provide care
5 in outpatient settings?

6 A What about them?

7 Q Well, what would hospital privileging say about
8 those physicians and their ability to provide care?

9 A I think it would depend on their training and
10 experience and past performance as to what they would be
11 allowed to do or not to do.

12 Q But the credentialing is for purposes of providing
13 procedures in the hospital setting; correct?

14 A Well, providing care in the hospital setting,
15 which is where the serious complications are headed from
16 termination of pregnancy.

17 Q But what about--again, how do physicians who
18 provide care only in outpatient settings demonstrate
19 competency in those procedures that they're providing in
20 those outpatient settings?

21 A Well, one, they would claim competency, and two,
22 they would provide evidence of competency.

23 Q What about--I know there are abortions that are
24 performed in your hospital, but what about in a case where a
25 hospital does not allow abortions to be performed? If an

1 abortion provider was seeking privileges at that hospital,
2 how would that abortion provider go about and obtain
3 privileges when the majority of his or her practice was
4 providing abortions?

5 Mr. Parker: Object to the--objection.

6 A Like any other person, apply for them.

7 Q But the procedure that they most often provide is
8 not one that's available in that hospital.

9 A I don't understand what you're asking. If they
10 wanted GYN surgery privileges to be able to perform a
11 hysterectomy, they would have to give evidence that they had
12 performed hysterectomies safety, efficiently, been trained,
13 and maintained their skill levels.

14 If they had never performed a hysterectomy, they
15 wouldn't merit privileges to perform a hysterectomy and would
16 either have to retain, retool, or not have GYN surgical
17 privileges. I voluntarily relinquished my GYN surgical
18 procedures. Thus I don't do that. I can't--I'm not
19 credentialed to do that.

20 Q Well, let's---

21 A (interposing) If I was going to go somewhere
22 where I wanted to do it, I would probably have to reprove to
23 a credentials committee that I was competent to do so,
24 probably by operating with somebody or doing some sort of
25 tutorial.

1 Q Well, then let's talk about an abortion provider
2 who's been primarily providing abortions and so has not done,
3 to cite your example, hysterectomies.

4 A Okay.

5 Q They would not be able to get privileges to
6 provide hysterectomies; right?

7 A But they could get privileges to care for
8 complications prior to those that needed surgical management.

9 Q But what would those privileges be for?

10 A History, physical, ordering lab tests, ordering
11 imaging. None of the internists on the medical staff I hope
12 don't have surgical privileges, so within the scope of what
13 they're capable of doing.

14 Q Right. But what if they're an OB-GYN? Does your
15 department give out GYN privileges just to do those things
16 that you listed?

17 A I have GYN procedures just to do those things that
18 I listed.

19 Q Do you have privileges to do other procedures?

20 A What do you mean?

21 Q In other words, you have privileges to do those
22 things. Do you have privileges to do other things as well as
23 a GYN?

24 A I don't have privileges to do GYN surgery outside
25 the office setting, but I could begin the care of somebody

1 who presented with a complication. I could take her history.
2 I could take her physical. I could order lab tests. I could
3 order diagnostic tests. I could interpret those tests. I
4 could involve consultants. I could go to the OR and see
5 whether what I thought was there was there. I can't do the
6 operation.

7 Q Right. At that point you transfer care to a
8 colleague to do the operation, if it were necessary?

9 A Yes, ma'am. But I could be involved in the
10 initial care and I think would be crucial to the initial care
11 if I were the person who had done the elective office
12 procedure.

13 Q Well, are you aware that the Alabama law at issue
14 here doesn't just require admitting privileges? It requires
15 the physician to have staff privileges to perform certain GYN
16 procedures. Are you aware of that?

17 A No, ma'am.

18 Q And so the law requires, in order to provide an
19 abortion, that a provider have privileges to provide
20 hysterectomy, laparotomy, and other--I think D&C and other
21 procedures that might reasonably be needed to treat an
22 abortion complication.

23 A doctor who only provided--who only provided
24 abortions or primarily provided abortions and has as a result
25 not done a hysterectomy in a long time would have difficulty

1 getting privileges to do a hysterectomy; correct?

2 A Yes, ma'am.

3 Mr. Parker: Object to the form.

4 A Or would have to go through a process to--if he or
5 she was otherwise trying to do so, to prove that he or she
6 was competent.

7 Q Because--and this is coming from JCAHO in part--
8 that hospitals want their providers who have privileges to
9 demonstrate competency to perform the specific procedures
10 that they have privileges to provide; right?

11 A I would never want to presume to speak for JCAHO,
12 but that's my understanding.

13 Q Okay. I wanted to ask you--well, let's turn to
14 page 14, paragraph 25.

15 (Witness complies.)

16 Q The first sentence there says, "When the TOP
17 provider is an ob-gyn and has staff privileges at a local
18 hospital, he or she is more likely to effectively manage
19 patient complications by providing continuity of care and
20 decrease the likelihood of medical errors." Is that correct,
21 what I read?

22 A You read really well.

23 Q My parents would be pleased to hear that the money
24 spent on my education was well spent. And so this opinion
25 assumes that the abortion patient would be seen at the

1 hospital where a provider would have privileges; correct?

2 A Yes, ma'am.

3 Q So what if the provider did not have privileges at
4 the closest hospital to the clinic?

5 A I don't understand the question.

6 Q So in other words, say--let's go back to the
7 hypothetical of a patient with the perforation and a
8 suspected bowel injury. If the provider had privileges at a
9 local hospital, but it wasn't the closest hospital---

10 A (interposing) The closest hospital to what?

11 Q To the clinic.

12 A Okay.

13 Q And so what would happen in terms of continuity of
14 care if the patient was transferred to the closest hospital,
15 which is not where the provider had privileges?

16 A So the termination of pregnancy place is here
17 (indicating). Hospital A is 5 miles away and Hospital B is
18 10 miles away.

19 The Reporter: Off the record.

20 (Discussion off the record.)

21 The Reporter: On the record.

22 By Ms. Flaxman:

23 Q So let's make this one 20 miles, B, if that's okay
24 with you?

25 A We'll make it 20.

1 Q 20 miles. What would happen in terms of providing
2 continuity of care if the patient went to Hospital A instead
3 of Hospital B where the patient has--I mean, I'm sorry, where
4 the provider would have privileges?

5 A Well, I think it depends on the acuity of the
6 situation. So suspected bowel perforation that occurred
7 during the procedure I would think could be assessed at
8 either hospital and that the difference in travel time would
9 not make any difference.

10 If somebody shows up, suspected perforation and
11 acute abdomen and peritonitis, I think the provider at the
12 termination of pregnancy center would want to go to the
13 hospital where he or she didn't have privileges and would--
14 because of the acuity of the situation would surrender--would
15 fold on the continuity of care phenomenon.

16 Q But how would the provider in that case ensure
17 that the patient received good care, have a conversation with
18 the hospital?

19 A He or she would need to do--have the conversation,
20 send the medical records, be available. It would be a
21 substitution of judgment. I'm sure when Reagan was shot on
22 the Blue Line, he was glad that George Washington was there
23 and that the Secret Service made a decision to not take him
24 to Walter Reed or the National Naval Medical Center, where I
25 think presidents historically get treated. He would have

1 probably been dead if they'd taken him to--so I don't think
2 this privileging--that the advantages of this communication
3 outweigh all other considerations. I think they're one of
4 many to take into account.

5 Q But in that case the patient would get taken care
6 of in Hospital A even though the providing physician didn't
7 have privileges at the hospital?

8 A I would hope so.

9 Q And what about--let's talk about complications
10 that may arise after discharge from an outpatient center.

11 A Yes, ma'am.

12 Q As I'm sure you're aware, many women who obtain
13 abortions travel some distance to an abortion provider. And
14 so those patients, if they experience complications after
15 discharge, will be away from the abortion clinic where they
16 obtained the abortion.

17 What hospital should an abortion provider send a
18 patient experiencing complications to after hours? Would it
19 be the one that's closest to her or would you say she should
20 come back into town to go the hospital where her provider had
21 privileges?

22 A Well, I think it's a judgment call, the same
23 judgments we talked about earlier.

24 Q And so you think if she needs to see somebody on
25 an urgent basis, you would advise her to go to the hospital

1 closest to her?

2 A Yes, ma'am.

3 Q And what would you---

4 A I think every doctor's office I call tells me
5 that.

6 Q So you've had experience with that?

7 A Well, "If you're experiencing a medical emergency,
8 hang up and dial 911." How many times do they say that?

9 Q Well, let me ask you this--I hate to---

10 A (interposing) I've tried to get it off of my
11 phone and they won't---

12 Q Liability.

13 A But what's the liability, that an idiot doesn't
14 know if you're having an acute--"Oh, I'm going to wait here
15 and die."

16 Q Let me ask you, in your practice do you see---

17 A (interposing) I can't get it off the phone in my
18 practice. It makes me so mad every time I hear it.

19 Q Changing the subject---

20 A (interposing) Urban legend.

21 Q ---only slightly, in your practice do you have
22 patients--let's talk about your high risk obstetrical

23 practice. Do you have patients who live closer to another
24 hospital than they live to yours?

25 A Many.

1 Q And have you ever advised a patient to seek care
2 at a hospital where you don't have privileges?

3 A I do it on the--I just told you I did it on the
4 phone all the time.

5 Q And so a patient calls. What's an example of a
6 time where you might advise a patient to go to a hospital?

7 A Somebody lives 90 minutes away. She thinks
8 she's--she doesn't know whether she's in labor or not. It
9 costs 50 bucks to drive to see me. Can she stop by the labor
10 and delivery in New Bern and get her cervix checked? Yeah.

11 Q And so what do you do in those cases?

12 A Call Labor and Delivery in New Bern, tell them the
13 situation, send--usually fax them her records and try to find
14 out what they think, try to communicate, try to save her a
15 trip.

16 Q And do they communicate back to you? Do they give
17 you a call if they need to find out more about the patient?

18 A They usually really want me to take care of the
19 patient, so yeah, they're very communicative.

20 Q So if--let's say they checked her cervix and she
21 was dilated and needed to go up to delivery. Then another
22 doctor at that hospital would do the delivery; right?

23 A Yeah. If she's complete and ready to push, they
24 shouldn't put her in the car and send her to Chapel Hill.

25 Q If it were me, I would have delivered in the car

1 on the way there, so I---

2 A Have you delivered in a car?

3 Q I have not, but it was close with my second.

4 A Which hospital in Washington?

5 Ms. Flaxman: Off the record. 4:00 p.m.

6 (Discussion off the record.)

7 The Reporter: On the record. 4:14 p.m.

8 (Exhibit 7 was marked for

9 identification.)

10 Ms. Flaxman: For the record, we have marked

11 as Exhibit 7 the diagram that Dr. Thorp graciously drew for

12 us of distances between hospitals and the abortion clinic.

13 And it was what he referred to in discussing where an

14 abortion patient would go if that patient was experiencing a

15 complication.

16 By Ms. Flaxman:

17 Q Dr. Thorp, if you would turn to page 21 of your

18 report?

19 (Witness complies.)

20 Q This is a continuation of paragraph 38 at the top

21 of the page. You express, the third full sentence, your

22 opinion that "Family practice physicians, despite their

23 commitment to providing reproductive health services, are

24 simply not adequately trained and experienced to perform

25 TOPs." Is that your opinion, sir?

1 A Yes, ma'am.

2 Q What is the basis for that statement?

3 A My experience in academic medicine and long-
4 standing participation and work with our family practice
5 residents.

6 Q Are you aware of any studies?

7 A No, ma'am.

8 Q Are you aware that there are family practice
9 physicians who provide abortions?

10 A Yes, ma'am.

11 Q Is your concern about family practice physicians
12 about training to perform the abortion procedure or lack of
13 training in providing care in the event of complications?

14 A Both.

15 Q Aren't D&Cs part of their training?

16 A Not necessarily.

17 Q If a family practice physician had training in
18 D&Cs, would that make them qualified to perform an abortion?

19 A I would answer half the equation.

20 Q So it would make them qualified to perform the
21 abortion; correct?

22 A Well, it would give them competency in
23 performance, but I think part of elective surgery is ability
24 to address or begin to address complications that experience
25 them.

1 Q Could a family practice physician acquire that
2 training and experience?

3 A I don't think it's a common part of family
4 medicine training or the family medicine training programs
5 that I'm aware of, but I imagine they could.

6 Q And you testified yesterday that family practice
7 doctors were delivering babies in Asheville; right?

8 A And in Chapel Hill.

9 Q Oh, okay. Are they in your--no, I guess they
10 wouldn't be in your department.

11 A They're in our labor and delivery, as are
12 midwives.

13 Q And are they trained to handle--both the family
14 practice doctors and the midwives, are they trained to handle
15 all the complications that might occur after a delivery?

16 A They are not.

17 Q And so what happens if one of their patients
18 experiences a complication after delivery?

19 A They work with us. They're trained to recognize
20 the complications and begin initial treatment.

21 Q And so if a family practice doctor were trained in
22 abortion and trained in recognizing the symptoms--recognizing
23 the complications and beginning initial treatment, in your
24 opinion they would be qualified to provide an abortion?

25 A Yes.

1 Q Let's turn to page 17, paragraph 32 of your
2 report.

3 (Witness complies.)

4 Q You mention in this paragraph that you reviewed
5 deficiency reports from the Alabama Department of Public
6 Health for abortion clinics in Alabama. Do you recall doing
7 so?

8 A Yes, ma'am.

9 Q Did you review those reports while you were
10 preparing your expert report in this case?

11 A Provided to me as part of the conversations that
12 led up to the expert report.

13 Q Do you recall how many deficiency reports you
14 reviewed?

15 A I don't have an independent recollection.

16 Q And do you remember which clinics you looked at?

17 A No, ma'am.

18 Q You cite here--the cite for that review is to
19 footnote 33 at the bottom of page 17?

20 A Yes, ma'am.

21 Q You said that those reports are available at
22 abortiondocs.org. Is that where you reviewed those
23 deficiency reports?

24 A They were provided to me by counsel I think in a--
25 as a scanned document or a paper document sent to me. I

1 don't know which.

2 Q Okay, so you didn't refer--you didn't--you just
3 cite there to abortiondocs.org, but you didn't review it on
4 that web site?

5 A I don't think I've gone to that web site.

6 Q Staying with that paragraph--well, the remainder
7 of that sentence--it says after reviewing those deficiency
8 reports "it is not difficult to understand the Legislature's
9 concerns and the basis for the Act's legislative findings."
10 Do you see that there?

11 A Yes, ma'am.

12 Q Number (2) under that, you cite to the legislative
13 finding that "At abortion or reproductive health centers,
14 patients are often treated in a manner inconsistent with a
15 traditional physician/patient relationship." Do you recall
16 reviewing any deficiency reports that bore on that finding?

17 A I do not.

18 Q And on the top of page 18, it's the third
19 legislative finding.

20 A Yes, ma'am.

21 Q Do you see that? It says, "Abortion or
22 reproductive health centers are not operated in the same
23 manner as ambulatory surgical treatment centers or physician
24 offices." Do you recall reviewing any deficiency reports
25 that related to that finding?

1 A I do not.

2 Q Do you recall if any of the deficiencies related
3 to a physician performing a procedure that he or she was not
4 qualified to perform?

5 A I don't recall.

6 Q And are you aware of any specific examples of
7 patients not receiving treatment for postabortion
8 complications in Alabama?

9 A No, ma'am.

10 Q Are you aware of the requirement in Alabama law
11 that abortion clinics have an agreement with a backup doctor
12 who has privileges?

13 A I think counsel has mentioned that to me.

14 Q And does that change your opinion about the
15 necessity of the providing physician?

16 A No, ma'am.

17 Q Why is that?

18 A Ask the question again.

19 Q Why--there's a requirement--the plaintiffs in this
20 case, all the abortion clinics in this case, have an agree-
21 ment with a backup doctor who has privileges at a local
22 hospital.

23 A Yes, ma'am.

24 Q That fact did not change your opinion about the
25 necessity of all physicians having admitting privileges?

1 A Does not.

2 Q Let's turn to paragraph 28, which is on page 15.

3 (Witness complies.)

4 A I'm there.

5 Q Okay. You talk at the end of that paragraph about
6 the provider of the abortion gaining that patient's
7 confidence prior to the TOP and being most familiar with her
8 future reproductive plans. And then you say, "Her future
9 plans are often crucial in decision making when treating a
10 serious complication." Is that your opinion?

11 A It is.

12 Q And what's the basis for it?

13 A My experience.

14 Q How would future reproductive plans be crucial in
15 decision making?

16 A Well, the most readily thought about example--I'll
17 answer with an example--would be if a hysterectomy were
18 entertained to treat a complication or thought to be one of
19 the options. The threshold to do that would be lower in
20 somebody who had multiple children and was considering
21 sterilization versus a woman that it was her first child.

22 I think in the midst of complications, hemorrhage,
23 infection, and the like, that thinking can--those thoughts
24 can become distorted. So the surgeon who talked to the
25 patient when she was in the light of day, not experiencing a

1 complication, and found out about sort of what her hopes and
2 plans were is best qualified, has information obtained
3 apriority that can inform that discussion.

4 Q So in that sentence you're referring to possible
5 hysterectomy as a treatment for a complication?

6 A No. I gave you an example of a hysterectomy. I
7 can probably think of another example.

8 Q Okay. Are there other examples?

9 A I think infection would be an example and how
10 aggressively one treated an infection or not.

11 Q How could knowing a woman wanted to have
12 additional children bear on treatment of an infection?

13 A I think I would treat it longer and more
14 aggressively to prevent any postinfection diminution of her
15 reproduction, so IV antibiotics longer in the hospital than
16 somebody whose family was, quote, complete, say at the end of
17 her reproductive life, who you might could prevent serious
18 sequelae with antibiotics by mouth, but wouldn't necessarily
19 maintain her fertility. So infection would have an
20 implication.

21 Transfusion would have an implication and its
22 impact on isoimmunization about what a person's future
23 reproductive plans were or weren't. So it would be a factor
24 to consider in multiple different complications of which I
25 chose hysterectomy as the first.

1 Q Are there any others you can think of now?

2 A No. I thought I did good coming up with three.

3 Q Two; right?

4 A I think I gave you three.

5 Q Hysterectomy, infection---

6 A (interposing) Hysterectomy, infection,
7 transfusion.

8 Q Okay. And then how would transfusion make a
9 difference?

10 A Transfusion carries with it a risk of isoimmuniza-
11 tion, of developing irregular antibodies that in a subsequent
12 pregnancy can cross the placenta and cause hemolytic disease
13 in the fetus. And so I think your threshold to transfuse
14 would be higher in somebody who had no children or who wanted
15 more children than it would be in somebody who said, "My
16 family is complete."

17 Q Now, all of this would only matter if the patient
18 were also unconscious; correct?

19 A No. I think it--I don't think it matters--I don't
20 think consciousness necessarily matters.

21 Q Well, if she's awake, you can ask her, "What are
22 your plans for future childbearing"; right?

23 A I think in the midst of a complication and
24 hospitalization, many of us say, "I'm never doing this again
25 because I'm hurting. I have a fever. I'm going to have to

1 undergo a second surgical procedure. I'm never going to get
2 pregnant again." So I would put more weight on what was said
3 in the time when there was not a complication. I think
4 complications influence people's short term thinking.

5 Q But ultimately---

6 A (interposing) Even conscious people.

7 Q But ultimately a conscious patient, if she wanted
8 you to choose the path that would you think potentially
9 endanger future childbearing, you would have to follow her
10 wishes; right?

11 A And I think you have a higher likelihood of regret
12 in following somebody's wishes, wishes that are made after a
13 complication has occurred as opposed to before a complication
14 occurs.

15 Q What I'm saying is even if--even if the doctor
16 providing care--you know, just as a way of an example, if
17 there was a serious complication after one of the outpatient
18 gynecological procedures you've performed and you were
19 treating that complication in the hospital and you reached
20 one of the decision points that you just mentioned in terms
21 of choosing care or not that might preserve future
22 childbearing, even if you knew from previous interactions
23 with that patient that she wanted to have more children, if
24 she said to you in the moment, "Do X. I don't want to do
25 this again," you would have to do X; right? And so the

1 knowledge that she wanted to have---

2 A (interposing) I don't think it would be binary.
3 And I think I would have the opportunity to say "Now, let's
4 go back and reflect on what your intentions were before you
5 had this bad thing happen to you, this complication. You
6 thought this. In the midst of this complication you're
7 saying that. That makes me fear that you're at increased
8 risk for regret for this decision. Should we rebalance it,
9 reconfigure it? Should we talk to your family? Do you want
10 to talk to"--you know, "Let's think about this further."

11 Q So it's about the reflection, the opportunity to
12 have that reflection?

13 A I think the opportunity to have that reflection is
14 really important.

15 Q Well, she could have---

16 A (interposing) And I think to have the knowledge
17 of the prior conversations made before the complication
18 occurs is really important.

19 Q She could have family that are anywhere, though;
20 right?

21 A Ask me that again, please.

22 Q So in other words---

23 A (interposing) "You might want to call your mom or
24 you might to call your rabbi. You might want to call your
25 best friend. You might want to"--"Let's really think about

1 that."

2 Q Right, but you can do all those things without
3 having had the previous conversation with them; right?

4 A But I need to have the knowledge of the previous
5 conversation.

6 Q Well, what if it's a, you know, 28-year-old woman
7 facing this choice? Wouldn't you encourage her to include
8 those folks in her decision anyway?

9 A I would encourage anybody to include those people.
10 I would insist that she get an outside opinion from somebody
11 she trusted about such a personal and important decision,
12 particularly if something irreversible were about to take
13 place.

14 Q Oh, I want to go back to one thing you said
15 yesterday. When you testified about the complications from
16 abortions that you had treated over the years, were those
17 complications all short term complications or were some of
18 them long term complications?

19 A I've treated multiple long term complications that
20 I believe were at least in part due to termination of
21 pregnancy.

22 Q So when you mentioned--I think you said around 100
23 or so complications that you had treated, leaving aside your
24 experience as a resident, were--how many of those were short
25 term versus long term?

1 A Well, if my memory serves me correct, you
2 specifically restricted the question to short term. Long
3 term I would say many, many more.

4 Q Okay. So you were referring at the time to short
5 term?

6 A Yes, ma'am.

7 Q Okay. Let's go to page 18, paragraph 34.

8 (Witness complies.)

9 Q You say in the middle of that paragraph that "In
10 the medical center where I practice at UNC, good inter-
11 physician communication is not the case except for those
12 physicians who are on our staff." Will physicians on staff
13 at the same hospital necessarily know each other?

14 A Not necessarily.

15 Q And so do you know all of the physicians at your
16 hospital?

17 A I don't think so.

18 Q So how is inter-physician communication better by
19 being on staff together?

20 A I think there's common culture, a common medical
21 record. There is a chain of command that one can go up if
22 somebody is not available or not responsive or you don't
23 think they're doing a good job. So I think there are
24 multiple aspects of staff privileges that enhance communica-
25 tion and ultimately patient care.

1 Q But you've testified before that physicians are
2 capable of effectively communicating pertinent medical
3 information concerning patients even to physicians they don't
4 know; correct?

5 A Sure. Yes, ma'am.

6 Q Do you have any knowledge, sir, of Plaintiffs in
7 this case's complication rates?

8 A No, ma'am.

9 Q Do you know if there have been ever--any of
10 Plaintiffs' patients have ever suffered harm because of lack
11 of communication or poor communication with a hospital?

12 A No, ma'am.

13 Q And are you aware of any specific instances of
14 patient abandonment by abortion providers in Alabama?

15 A No, ma'am.

16 Q To save time I won't refer you to a page of your
17 report unless you need me to, but you remark in your report
18 on the inadequacy of on-call coverage by OB-GYNs in suburban
19 and rural areas. Do you recall that or do you want me to
20 refer you to---

21 A (interposing) Refer me.

22 Q Page 15 (sic), paragraph 30.

23 (Witness peruses document.)

24 A So paragraph---

25 Q (interposing) So in the second--paragraph 30, the

1 second sentence, says, "In the suburban-rural mix of Alabama,
2 to assume the ready availability of an on-call ob-gyn is less
3 likely to be true, with the exception of Birmingham and
4 Mobile, than in urban metropolitan centers."

5 Are you aware that all the plaintiffs in this case
6 are in urban population centers of Birmingham, Mobile, and
7 Montgomery?

8 A All their patients aren't in those places.

9 Q Well, but the law doesn't require the providers to
10 have privileges at those hospitals; correct?

11 A It doesn't require people to have privileges at
12 those hospitals, but it does require them to have privileges
13 at a hospital that non-urgent complications could receive
14 care at, vis-à-vis Exhibit 7. If it's not urgent, I can
15 drive the 20 miles from small town to Birmingham as opposed
16 to go to the local hospital that may only have an emergency
17 department doctor and not OB-GYN backup.

18 Q But you've testified that you sometimes send
19 patients to their local hospital; correct?

20 A I send them to their local hospital if they have
21 somebody in my discipline. I don't send them to the Belhaven
22 emergency department for the moonlighting ED resident to
23 check their cervix. I send them to somewhere that has an
24 OB-GYN. This is--that's what I'm referring to here
25 (indicating).

1 Q So your opinion is not that there would be
2 insufficient OB-GYNs in Birmingham, Mobile, and Montgomery;
3 correct?

4 A I think there are too many there and too few out
5 in the countryside.

6 Q Is there a difference, though, for on-call
7 coverage of OBs, which is just what you were talking about
8 about your patients, versus GYNs?

9 A I think I'm talking about OBs and GYNs in this
10 instance. And there are emergency departments certainly in
11 North Carolina--I can name many of them--that don't have
12 OB-GYN physicians on staff and don't have the ability to do
13 anything more than triage a complication.

14 Q But they could triage a complication and they have
15 general surgeons available; correct?

16 A Some do and some don't. There are some small
17 places around here.

18 Q But you don't have any knowledge specifically of
19 Alabama hospitals?

20 A My bet is that there are places in Alabama that
21 don't, but I don't have specific knowledge. You're correct.

22 Q Let me point you to page 5 of your report, jumping
23 around.

24 A That's okay.

25 Q I appreciate that; page 5, paragraph 8.

1 (Witness complies.)

2 A Yes, ma'am.

3 Q Go actually to--well, on page 5 you talk about
4 underreporting by TOP providers.

5 A In the U.S.

6 Q In the U.S. Do you think there's underreporting
7 of total numbers or complications or both?

8 A Both.

9 Q And can you point to any evidence of the under-
10 reporting?

11 A Well, the reporting is voluntary and in some
12 incidents based on estimates and not actual counts. So I
13 guess rather than say underreporting or overreporting, I
14 would think inaccurate reporting would be a more precise
15 answer.

16 Q Is this different than other medical procedures?

17 A Well, the one that my friend David likes to
18 compare to, which is maternal mortality, abortion related
19 mortality, it's quite different because states have maternal
20 mortality commissions that systematically seek maternal
21 deaths, link birth certificates to death certificates, and
22 uncover numerous more maternal deaths that way than they do
23 through a voluntary system of reporting.

24 Q By your friend David, do you mean Dr. Grimes?

25 A Yes, ma'am. I think he would allow me to call him

1 my friend David.

2 Q I just wanted to clarify for the record.

3 A I thought he was such a proverbial figure in all
4 this that he could go by first name only.

5 Q But aside from maternal deaths, are there any
6 other medical procedures that you're aware of that rely on
7 anything other than self-reporting?

8 A Well, I think there are states that systemati-
9 cally--I think bypass surgery in the state of New York is the
10 famous one where there's a registry count. There are cancer
11 registries kept and certainly births and birth certificates.
12 There's mandatory reporting of live births over certain later
13 gestational age.

14 Q But your--the procedures for example that you
15 perform in an outpatient setting, if someone wanted to track
16 complications attendant to those procedures, they would need
17 to rely on self reporting; correct?

18 A Well, I think one of the great potentials of the
19 electronic medical record and the data warehouses that people
20 are setting up is that they ought to be able to do endo-
21 metrial biopsies in the Timberlyne office, if you could do
22 the SAS program and could get it out. And then you would
23 have a more systematic estimate than based on my memory.

24 Q Right, but right now, before we get to that point,
25 it would be based on self reporting?

1 A Our health system thinks it's sort of at that
2 point.

3 Q Five years ago when no one was at that point, it
4 was based on self reporting; right?

5 A Self reporting is a poor surrogate for knowing,
6 for a wide variety of reasons, many of which we've discussed
7 in this deposition.

8 Q And the electronic records presumably will allow
9 abortion providers to more effectively track complications;
10 correct?

11 A It would be one component that would increase--
12 that would help. But there are other problems inherent in
13 voluntary self reports. If a person has a complication of an
14 endometrial biopsy I did yesterday afternoon and they decide,
15 "To hell with Thorp and UNC; I'm going to the Duke emergency
16 room," till our two electronic medical records talk, we would
17 never--we would never know that.

18 Q And you wouldn't necessarily know either---

19 A (interposing) I wouldn't know.

20 Q ---from self reporting?

21 A I wouldn't know, so I can in good faith say, "Ms.
22 Jones had a complication-free endometrial biopsy," when she
23 had a serious complication.

24 Q So your concern about underreporting or inaccurate
25 reporting is not unique to abortion care?

1 A No, ma'am. I think the claims of safety with
2 abortion care based on such inaccurate reports are what make
3 it the outlier as opposed to the inaccurate data.

4 Q So do you think that any study that addresses the
5 complications of the medical procedure is methodologically
6 flawed when it relies on data voluntarily produced by a
7 health care provider?

8 A I think it's limited. Now, there are health
9 systems--and we can argue whether they're good or bad--in
10 Europe and Israel where there are unique identifiers, common
11 medical records, terminations of pregnancy are registered,
12 subsequent hospital admissions or expenditures, and there can
13 be linkage. And I think they would provide a truer picture
14 of what the numerator and the denominator are for complica-
15 tions.

16 Q But do you rely on complication rates in your own
17 practice that come out of studies that were created through
18 self reporting of complications?

19 A Well, that's why I cited such a huge range of 1 to
20 10 percent and am hesitant to rely on the two small studies
21 that--when you were trying to prove to me that Fine used
22 contemporary stuff and rebut my statement that he didn't.
23 That's why I think you can only do a range.

24 Q Let me ask you about---

25 A (interposing) There's inherent inaccuracy.

1 Q Let me ask you, though, about procedures, not
2 leaving--leaving abortion aside, procedures that you would do
3 yourself.

4 A Yes, ma'am.

5 Q Or even deliveries or, you know, high risk
6 conditions of pregnancy. Do you rely on studies that are
7 based on data that is voluntarily produced by health care
8 providers in assessing risk?

9 A When that's the best data available.

10 Q So you just mentioned that there can be under-
11 reporting or inaccurate reporting because some patients don't
12 return to their provider for follow-up care; right?

13 A That's one problem.

14 Q And so---

15 A (interposing) And some people don't report a
16 previous abortion or termination when they present for
17 follow-up care. And some people may--and all this is known
18 from maternal mortality--if I commit suicide on day number
19 two after a termination of pregnancy, nobody may know about
20 the termination of pregnancy I had.

21 In maternal mortality, the linking of birth
22 certificates and death certificates, people know that. There
23 are special autopsy forms to check off with pregnancy.
24 There's a real systematic effort. A large number of maternal
25 deaths aren't appreciated by the health system. I imagine

1 the same is true for termination of pregnancy, complications
2 and deaths.

3 Q Let me ask you a question, though, about the
4 example you just gave of an endometrial biopsy---

5 A Sure.

6 Q ---if that woman decided to go to Duke.

7 A Yeah.

8 Q So---

9 A (interposing) She's jumping from the frying pan
10 into the fire is all I can say. It's really going to get hot
11 now.

12 Q So isn't it possible you would learn about that
13 subsequent, that she would call you up and say, "I had to go
14 to Duke for this"?

15 A It may or may not. I think a lot of times
16 patients don't tell you. You know, the amazing thing to me
17 is how much patients love clinicians and how forgiving they
18 are and how much they don't want to disappoint their surgeon
19 by telling him about a complication.

20 Q Well, but if the complication--if she goes to a
21 hospital where you don't have privileges and you don't learn
22 about it, having admitting privileges is irrelevant to her
23 care in that instance; right?

24 A Well, she didn't have the benefit of being at a
25 place where I had admitting privileges. And ignorance is

1 bliss, so I continue to think I'm great.

2 Q So in footnote 13 of your report on page 7, you
3 talk about--you say, "Alabama ARHCs are only required to
4 maintain a facility postoperative call log and that any
5 adverse conditions be noted in the patient's medical record.
6 No reporting is required." Do you see that?

7 A Yes, ma'am.

8 Q Do you recall that? Do you recall learning that?

9 A No, ma'am. If it's not true, I'm certain you're
10 going to tell me.

11 Q Well, so are you aware of new reporting require-
12 ments that have been recently imposed on abortion facilities
13 in Alabama?

14 A No, ma'am.

15 Q Just give me--I think I'm almost done. Just give
16 me a couple of minutes just to collect my thoughts.

17 A Do you want us to wander out so you can talk to
18 the team?

19 Ms. Flaxman: And look at my notes. Let's go
20 off the record.

21 The Reporter: Off the record. 4:49 p.m.

22 (A brief recess was taken.)

23 The Reporter: On the record. 4:53 p.m.

24 Ms. Flaxman: I don't have any further
25 questions.

1 Mr. Parker: Oh, you don't?

2 Ms. Flaxman: I don't.

3 **CROSS - EXAMINATION** 4:53 p.m.

4 By Mr. Parker:

5 Q Dr. Thorp, I have a very few questions. A couple
6 quick ones relate to things that you just talked about in
7 this past hour. If you go to paragraph 34 of your report?

8 (Witness complies.)

9 A Yes, sir, I'm there.

10 Q I'm not there, so let me get to it. In your
11 conversation with Ms. Flaxman about this paragraph, I think
12 you said that you do not know all of the physicians whom you
13 serve on staff with at your hospital; is that correct?

14 A Yes, sir.

15 Q Do you think it is more likely that you would know
16 a physician who's on staff with you than a physician who is
17 not on staff with you?

18 Ms. Flaxman: Object to the form.

19 A I think it is.

20 Q Okay. The next paragraph is paragraph 32.

21 A Yes, sir.

22 Q In this paragraph in your discussion with Ms.
23 Flaxman earlier, you discussed reviewing deficiency reports
24 and your statement that certain deficiency reports led you to
25 understand the legislature's concerns in passing this act.

1 Do you remember that discussion?

2 A Yes, sir.

3 Q Even if deficiency reports--even if you do not
4 recall information in deficiency reports pertaining to the
5 specific findings you quote here, is it still your opinion
6 that you understand why the--understand the legislature's
7 concerns in passing the act?

8 A Yes, sir.

9 Q In other words, there are other sources that would
10 allow you to sympathize with the legislature's concerns?

11 Ms. Flaxman: Object to the form.

12 Q Is that correct?

13 A Yes, sir.

14 Q Yesterday afternoon Ms. Flaxman asked you a series
15 of questions in which she compared some situation involving a
16 complication with the treatment of--a complication coming
17 from an abortion center performed by a doctor without
18 privileges. I believe she was attempting to elicit
19 information from you about why having staff privileges--why
20 an abortion doctor having staff privileges would improve the
21 quality of care given to a patient. Do you remember that
22 conversation?

23 Ms. Flaxman: Object to the form.

24 A I think that's been the source of conversations
25 yesterday and today.

1 Q Okay. Maybe I'm not being specific enough. I'm
2 trying to ask you to recall for example when you talked about
3 the situation where--if there are any differences in
4 treatment between pregnancy loss and a termination of
5 pregnancy. Do you recall that from yesterday afternoon?

6 A Vaguely.

7 Q Okay. If--let's just assume that treatment for
8 those two situations would be identical, regardless of
9 whether the doctor transferring the patient had privileges at
10 a local hospital. Is it possible that the--in a situation
11 where the doctor has staff privileges it could speed up the
12 treatment even if the treatment of the two complications
13 would be the same?

14 A I believe that could be the case.

15 Q So in other words, one benefit in addition to any
16 other benefits you've mentioned in this deposition in the
17 staff privileges requirement is that it could speed up
18 treatment of a patient in certain circumstances; right?

19 Ms. Flaxman: Object to the form.

20 A Agreed.

21 Q In your opinion is the time it takes to treat a
22 patient ever important to the outcome of that patient's
23 situation?

24 A Yes, sir, and I think I discussed that in the
25 conversations around Exhibit 7.

1 Q Okay. Let's also look briefly at your report,
2 paragraph 43. And this is not something that you discussed
3 with Ms. Flaxman, I don't think, but can you read that
4 paragraph briefly and---

5 Ms. Flaxman: (interposing) Well, does this
6 relate to testimony he's already given?

7 Mr. Parker: I can't remember if it does,
8 but--well, I'm pretty sure it does not.

9 Ms Flaxman: Well, then wouldn't it be
10 beyond the scope of the deposition?

11 Mr. Parker: I don't think that I have to--
12 in this situation have to limit my questions. Do you have
13 any authority for that?

14 Ms. Flaxman: Go ahead.

15 Mr. Parker: Okay.

16 By Mr. Parker:

17 Q Are you a member of the American College of
18 Obstetricians and Gynecologists?

19 A Yes, sir.

20 Q Are you familiar with any statements published by
21 the college in the field of abortions or terminations of
22 pregnancy?

23 A Yes, sir.

24 Q How would you characterize in general the
25 statements that the college publishes on that topic?

1 A I think the college has had a longstanding bias,
2 preference, for there being no restrictions to termination of
3 pregnancy beyond those outlined in *Roe v. Wade* and *Doe v.*
4 *Bolton*.

5 Q Are you familiar with the statement published by
6 the college specifically addressing the topic of admitting
7 privileges for TOP providers?

8 A I think they have been opposed to any so-called
9 legislative limits or restrictions on termination of
10 pregnancy practice.

11 Q Do you think any statement published by the
12 college on the issue of admitting privileges would fairly be
13 described as reflecting a consensus within the community--the
14 medical community on that issue?

15 Ms. Flaxman: Object to the form.

16 A As I know consensus, it would mean that everybody
17 was in agreement or generally in agreement. And there--and I
18 don't know how many, but there are a significant number of
19 members of the college who would disagree with the college's
20 positions on termination of pregnancy.

21 Q Do you have any way of estimating the degree of
22 difference in opinion on that issue?

23 A I do not.

24 Mr. Parker: Okay. That's all I have.

25 Ms. Flaxman: Just one or two follow-ups.

1 REDIRECT EXAMINATION 5:03 p.m.

2 By Ms. Flaxman:

3 Q What is ACOG, Doctor?

4 A The American--did they change the name from
5 College to Congress, I think?

6 Q Okay. And what---

7 A (interposing) The American Congress of Obstetrics
8 and Gynecology?

9 Q And do you consider them the leading organization
10 of OB-GYNs in this country?

11 A No, ma'am.

12 Q Do other OB-GYNs consider them to be the leading
13 organization?

14 A I think they're the advocacy group for OB-GYNs in
15 this country would be how I would describe them.

16 Q And do you yourself consider yourself a member of
17 that organization?

18 A I think I am a member unless you know something
19 about my dues that I'm unaware of.

20 Q No, but you are a member of ACOG?

21 A Am a member.

22 Q And there are many, many of their positions and
23 statements with which you agree; correct?

24 A I have a wide variety of responses to their
25 statements. Some I agree; some I disagree.

1 Ms. Flaxman: I don't have anything further.
2 I just wanted to preserve our objections to that last line of
3 questions. And that's it.

4 (The deposition was closed at 5:03 p.m.)

STATE OF NORTH CAROLINA

COUNTY OF WAKE

C E R T I F I C A T E

I, Kay K. Rohde, Notary Public-Reporter, do hereby certify that **John Mercer Thorp, Jr., M.D., M.H.S.** was duly sworn or affirmed by me prior to the taking of the foregoing deposition, that said deposition was taken by me and transcribed under my direction, that the foregoing pages 5 through 206 constitute a true and correct transcript of the testimony of the witness and the statements of counsel, and that the witness reserved the right to review his testimony.

I do further certify that I am not counsel for or in the employment of either of the parties to this action, nor am I interested in the results of this action.

I do further certify that the stipulations contained herein were entered into by counsel in my presence.

In witness whereof, I have hereunto set my hand, this 7th day of December, 2013.

/s/ Kay K. Rohde

Kay K. Rohde, CVR-CM
Notary No. 19971050205

S I G N A T U R E

I have read the foregoing pages 5 through 205, which contain a correct transcript of the answers made by me to the questions herein recorded. My signature is subject to corrections on the attached errata sheet, if any.

(Signature of John Mercer Thorp, Jr., M.D., M.H.S.)

State of _____
County of _____

I certify that the following person personally appeared before me this day and I have personal knowledge of the identity of the principal or have seen satisfactory evidence of the principal's identity in the form of a _____ or a credible witness has sworn to the identity of the principal, acknowledging to me that he or she voluntarily signed the foregoing document for the purpose stated herein and in the capacity indicated: _____.

(Name of Principal)

Date _____

(Official signature of Notary)

(Official Seal)

_____, Notary Public
(Notary's printed or typed name)

My commission expires _____.

I, Kay K. Rohde, the officer before whom the foregoing deposition was taken on 11/19/13 and 11/20/13, certify that the foregoing transcript was delivered to the witness either directly or through the witness' attorney or through the attorney retaining the witness on _____ and that as of this date I have not received the executed signature page.

Therefore, more than 30 days having elapsed since receipt of the transcript by the witness, the sealed original transcript was filed with attorney for Plaintiffs on _____ by means of US Priority Mail, in accordance with Rule 30(e) of the Federal Rules of Civil Procedure.

Date

Kay K. Rohde, CVR-CM
Court Reporter

Exhibit MM

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

PLANNED PARENTHOOD SOUTHEAST,
INC., et al.,

Plaintiffs,

Vs.

CIVIL ACTION NO.
2:13-CV-405-MHT

LUTHER STRANGE, in his official
capacity as Attorney General of the
State of Alabama, et al.,

Defendants.

* * * * *

DEPOSITION OF STACI FOX, taken pursuant
to stipulation and agreement before Haley A.
Phillips, Certified Court Reporter, ACCR # 151, and
Commissioner for the State of Alabama at Large, in
the Law Offices of ACLU Montgomery Office, 207
Montgomery Street, Montgomery, Alabama, on
Thursday, September 26, 2013, commencing at
approximately 8:33 a.m.

* * * * *

1 A. The rhetoric of the letter. And we
2 routinely receive some more letters at the
3 office, so the rhetoric of the letter was
4 clearly anti-choice.

5 Q. Did they say they were praying for you?

6 A. I couldn't remember.

7 Q. Did they offer you assistance in finding a
8 new job?

9 A. Not in the letters but protesters have.

10 Q. Okay. Do you -- Do you know if any other
11 staff that you had personal knowledge of
12 from talking to them ever had anyone follow
13 them home from a clinic?

14 A. When I was in Florida?

15 Q. Yeah.

16 A. No.

17 Q. What about -- Did you ever hear of any
18 other staff members at any of the clinics
19 that you're familiar with receive harassing
20 abortion-related phone calls at home?

21 A. In Florida?

22 Q. In Florida.

23 A. No.

1 Q. And my questions right now --

2 A. Okay.

3 Q. -- pertain to Florida, the four clinics
4 that -- based on your personal knowledge --

5 A. Sure. Sure.

6 Q. -- like, from 2007 to 2013.

7 Was there ever any violence directed
8 specifically at doctors?

9 MS. FLAXMAN: Object to the form.

10 You can still answer.

11 A. During my tenure?

12 Q. Yeah. I'm sorry. So from 2007 to 2013
13 when you were familiar with -- while
14 working at any of the four clinics in the
15 what is now called the, I think, Planned
16 Parenthood North Florida service area, did
17 you ever -- were you ever aware of any
18 doctors experiencing physical injury or
19 serious threats of physical injury?

20 A. No, not our doctors. But our clinics were
21 targeted with fake anthrax letters and
22 multiple letters that were mailed to the
23 clinics as well as harassing phone calls.

1 Our clinic -- health centers were
2 vandalized multiple times and after I
3 became CEO, vandalized again. And I was,
4 you know, a target on anti-choice blogs in
5 the state of Florida.

6 Q. When you say vandalized, what are you
7 talking about, like spray paint on the side
8 of the building?

9 A. Spray paint and broken into.

10 Q. Was anything ever taken from the building?

11 A. Not that we could tell.

12 Q. Okay. Was anyone ever present at the
13 clinic -- the building when the acts of
14 vandalism occurred?

15 A. No.

16 Q. Okay. Let's change gears and talk about
17 Georgia now.

18 A. Okay.

19 Q. I understand you're now at Georgia -- in
20 Georgia; correct?

21 A. Right.

22 Q. It's not -- You haven't been too long
23 there; right?

1 A. Correct.

2 Q. So far in your experience, is the climate
3 of harassment and sort of anti-choice
4 activism, as you would call it, similar in
5 Georgia to your experience in Florida?

6 MS. FLAXMAN: Object to the form.

7 Go ahead.

8 A. It's similar but heightened.

9 Q. Okay. What do you mean by that?

10 A. I would say that the protest activity is
11 more vigilant. There are larger number --

12 Q. Just more --

13 A. -- of protesters.

14 Q. There's more people?

15 A. More people.

16 Q. Do they -- Do they -- So you said there are
17 more people. Is there anything else that
18 leads you to your conclusion that it's
19 heightened?

20 A. Well, also, just the interaction with the
21 staff and anecdotal stories I've heard from
22 staff prior to my arrival.

23 Q. Are there -- Are there -- Are you saying

1 there are any incidences of physical
2 violence at these protests in Georgia?

3 A. Not physical violence, no. But I know
4 increased harassment of, you know, staff
5 and providers.

6 Q. Okay. Does that mean increased
7 communications between anti-choice
8 protesters and staff members?

9 A. Correct.

10 Q. Okay. Who was the CEO of Planned
11 Parenthood Southeast before you were hired?

12 A. Kay Scott.

13 Q. Kay Scott.

14 How long had she been head of Planned
15 Parenthood Southeast?

16 A. I'm not sure of the history. I don't think
17 I could give you the history of dates,
18 because they are a product of merger. I
19 know she has been with Planned Parenthood
20 for 32 years.

21 Q. Wow.

22 Was she -- Was she in a CEO position
23 for more than five years?

1 A. Yes.

2 Q. Okay. Do you know why she left?

3 A. She retired.

4 Q. Okay. Was that entirely her free choice?

5 A. Yes.

6 Q. Okay. Is the -- Is your headquarters in
7 Atlanta?

8 A. Yes.

9 Q. Okay. Is that headquarters strictly
10 headquarters, or is it also connected with
11 a what I'll call clinic or health center?

12 A. There's a health center co-located with us
13 at our administrator site.

14 Q. Okay. Where is that again? I know you
15 mentioned that earlier, but I just --

16 A. 75 Piedmont Avenue, Atlanta.

17 Q. Is that -- Can you just -- I'm a little bit
18 familiar with Atlanta. Can you just -- Is
19 that, like, downtown or ...

20 A. Right downtown.

21 Q. Okay. Earlier I asked you to compare -- We
22 were talking about the comparison between
23 Georgia and Florida in terms of the

1 pro-life or anti-choice protesters. You
2 said there were more people and they talked
3 to patients more frequently; is that right?

4 A. Correct. They're more harassing of
5 patients. We hire off-duty police
6 officers. They maintain a daily blog of
7 their activity, including comings and
8 goings of staff and I know prior to my
9 arrival had been, you know, targeting
10 providers.

11 Q. What do you mean targeting providers?

12 A. In other words, a provider in our history
13 who worked for us and other providers who
14 felt such harassment that she moved her
15 family out of the area.

16 Q. When was that?

17 A. I couldn't tell you.

18 Q. Was it more than five years ago?

19 A. I don't know.

20 Q. More than three years ago?

21 A. I don't know.

22 Q. More than two years ago?

23 A. I don't know.

1 understand that question?

2 A. Are you asking me to rank Alabama, Florida
3 and then the other states we provide at
4 Planned Parenthood Southeast?

5 Q. The ones that you have experience --
6 personal experience in, which I take to be
7 Alabama, Georgia and Florida.

8 A. And we also cover Mississippi but do not
9 provide abortion care in Mississippi.

10 Q. Okay. I want to talk about Mississippi in
11 a second. But my question is for you to
12 rank Alabama, Georgia and Florida based on
13 your experience in terms of the severity of
14 what you might call harassment against
15 abortion providers.

16 A. I would rank Alabama first, Florida second
17 and Georgia third.

18 Q. Okay. I thought a second ago you testified
19 that Georgia had a heightened level of
20 harassment than Florida.

21 A. When I said Georgia, I meant Planned
22 Parenthood Southeast, so my experience at
23 Planned Parenthood Southeast versus my

1 experience at Planned Parenthood of
2 Florida.

3 Q. All right. What facts support your
4 conclusion that Alabama ranks highest of
5 those three states?

6 A. The -- The need for response to the
7 protesters that we have at our clinic. In
8 Florida, we didn't have a need to hire
9 off-duty police officers to protect our
10 staff and patients. In Florida, I didn't
11 need to have providers rent cars or be
12 concerned about their arrival at clinics.

13 Q. Okay. Is it your understanding that --
14 Have you ever heard of any state that does
15 not have any abortion protests?

16 A. Not specifically.

17 Q. Okay. Is it fair to say that abortion
18 protests happen in every state of the
19 country?

20 MS. FLAXMAN: Object to the form.

21 A. I couldn't say that that happens in all 50
22 states, no.

23 Q. Do you ever talk to colleagues in other

1 A. There may be others, but those are the
2 specific. In Florida, there are five
3 Planned Parenthood affiliates and there are
4 multiple affiliates in Texas and multiple
5 affiliates in Tennessee.

6 Q. Okay. And have you talked to anybody in
7 the northeast about abortion protests?

8 A. Not that I could specifically remember.

9 Q. Any in the Midwest?

10 A. Not that I can specifically remember.

11 Q. Any on the west coast?

12 A. Not conversations I can specifically
13 remember.

14 Q. All right. What is it about -- You said
15 that Alabama protesters require, you know,
16 more security efforts like -- Well,
17 actually, can you remind me what additional
18 security efforts that you employ in
19 Alabama -- that Planned Parenthood
20 Southeast employs in Alabama to deal with
21 Alabama protesters?

22 A. Specifically at our Birmingham site during
23 the 40 Days of Life protest -- that

1 happened twice a year. We hire off-duty
2 police officers.

3 Q. Are there any other additional measures you
4 take in Birmingham?

5 A. Well, at both sites we have security
6 cameras, you know, and security protocols
7 at all of our sites.

8 Q. Are security cameras and those security
9 protocols and the off-duty police
10 officer -- are those unique to an Alabama
11 location?

12 A. For Planned Parenthood Southeast?

13 Q. Uh-huh (positive response).

14 A. The police officer is unique to the
15 Birmingham site. But protocols and cameras
16 are common at --

17 Q. At all --

18 A. -- at our health centers.

19 Q. All Planned Parenthood health centers?

20 A. At all Planned Parenthood Southeast you're
21 asking me?

22 Q. Yes.

23 A. Yes.

1 you know, I hear stories of women flying in
2 for service.

3 Q. Okay. You said a second ago between 45 and
4 55 percent of the patients are coming from
5 the local area. Can you -- Can you tell
6 me -- Can you break that down and give me a
7 specific breakdown for Birmingham and for
8 Mobile?

9 And let me clarify. Do you know what
10 percentage of patients at the Birmingham
11 clinic are from the local area?

12 A. I couldn't recall specifically which
13 percentage was associated with which
14 clinic. I know the range.

15 Q. Okay. Have you ever studied or reviewed
16 information concerning the extent to which
17 patients coming to Planned Parenthood
18 clinics are considered in poverty?

19 A. Yes.

20 Q. Okay. What's your understanding about the
21 percentage of patients who are in poverty
22 that appear at the Birmingham clinic? Have
23 you ever seen information on that?

1 A. I couldn't give you specific numbers
2 related to a clinic --

3 Q. Could you give me --

4 A. -- in my recollection.

5 Q. Could you give my an estimate with respect
6 to each clinic?

7 A. I don't feel like I would -- I don't feel
8 like I could give you a number, an estimate
9 that I could recall.

10 Q. Could you give me an estimate with respect
11 to the clinics combined in the state -- in
12 Ala -- I mean, Planned Parenthood in
13 Alabama?

14 A. I'm hesitant to give a number, only because
15 I don't feel like I can remember an exact
16 number.

17 Q. Can you -- I mean, just broad ballpark, is
18 it higher than 75 percent you think?

19 A. I mean, I would say at least 75 percent.
20 We provide financial assistance to a good
21 deal of our patients and that financial
22 assistance is based on their -- a number of
23 factors, including their income. So I

1 would say at least 75 percent.

2 Q. Do you think it's possible it could be as
3 high as 90 percent?

4 A. It could be.

5 Q. I think -- I think one of the
6 administrators testified this week that it
7 was 90 percent. Is that -- Is that
8 plausible to you at least?

9 A. Absolutely. Based on the amount of
10 financial assistance that we give.

11 Q. So based -- based on that, if we -- if we
12 presumed that between 75 and 90 percent of
13 patients are in poverty and we also take
14 that and compare it to the range, 45 to 55
15 percent, of patients who are coming to one
16 of the clinics from outside the local area,
17 is it fair to say that a substantial
18 portion are both people who come from
19 outside the local area are patients who are
20 in poverty?

21 MS. FLAXMAN: Object to the form.

22 A. I just want to be clear. You're asking me
23 that -- asking me to confirm a statement

1 that a majority of patients that are coming
2 from outside the local area of the clinics
3 are women who are living in poverty?

4 Q. Uh-huh (positive response).

5 A. I would say that, you know, many of our
6 patients are. So yes, I'm sure that many
7 women coming from outside the area are
8 living in poverty.

9 Q. When you say many, do you think it's the
10 majority?

11 A. If majority is over 50 percent, yes.

12 Q. Okay. Are you familiar with some of the
13 obstacles women in poverty face in --
14 especially those women who are coming from
15 outside the local area, are you familiar
16 with the obstacles they face in getting to
17 the clinic?

18 A. Absolutely.

19 Q. Can you -- Can you give me an example of
20 two or three?

21 A. Availability and cost of child care to the
22 possibility of taking off work, the cost of
23 transportation.

1 Q. And I want you to look at the bottom of the
2 page. Do you see where it says PPSE and
3 then a number?

4 A. Uh-huh (positive response).

5 Q. Okay. We're going to go to PPSE232.

6 A. Okay.

7 Q. Do you see your name on that page anywhere?

8 A. Yes.

9 Q. Okay. Why do you -- Can you explain why
10 you see your name on the page?

11 A. I see my name as a recipient of the e-mail
12 at the top of the page.

13 Q. Okay. Can you look at the body of that
14 e-mail and tell me if you recognize it, and
15 if so, can you tell me what it -- what it's
16 about?

17 A. Sure. This was an e-mail about a
18 connection made at a conference by our --
19 one of your national staff members,
20 Dr. Vanessa Cullins, who's the vice
21 president of external medical affairs,
22 looking at a follow up to a conversation
23 from a meeting at a conference about

1 potential physician recruitment in Alabama.

2 Q. Okay.

3 A. As well as some general information about,
4 you know, Planned Parenthood and our
5 provision of services.

6 Q. Do you know -- This was in April of this
7 year?

8 A. Yes.

9 Q. Can you tell me what happened with respect
10 to that -- that prospective doctor?

11 A. Uh-huh (positive response). Well, this
12 wasn't a prospective doctor. It was a
13 prospector connection to doctors who might
14 have other connections. And we provided a
15 sort of job posting type document for them
16 to share with connections that they had.

17 Q. Did the leads go anywhere?

18 A. No.

19 Q. Okay. Let's go to PPSE230.

20 A. Okay.

21 Q. Do you see your name on this page?

22 A. Yes.

23 Q. Why do you see your name on that page?

1 A. As a recipient of the e-mail and addressed
2 to me in the body of the e-mail.

3 Q. Who's sending you the e-mail?

4 A. Our vice president of public policy, Nikema
5 Williams.

6 Q. Okay. And what's this e-mail about?

7 A. About a potential physician in Mobile,
8 Alabama.

9 Q. And can you summarize the content of the
10 e-mail?

11 A. Sure. So this e-mail to me was a follow up
12 to a conversation or reminder about a
13 conversation that had happened some time
14 ago with a local Mobile physician as a
15 potential provider of abortion care in
16 Mobile.

17 Q. As an outside backup physician or as a full
18 provider?

19 A. A full provider.

20 Q. Okay. What happened -- Did this doctor
21 ever become a provider at the Mobile
22 clinic?

23 A. No. No.

1 Q. Why not? Do you know why not?

2 A. The provider told our staff member that he
3 was not comfortable providing abortion
4 care -- direct abortion care.

5 Q. Did he give a reason why he wasn't
6 comfortable?

7 A. Religious objections.

8 Q. Okay. If you can look at 228 -- PPSA228.
9 Do you see your name on this page?

10 A. Yes.

11 Q. Okay. Can you tell me why and summarize
12 the content of the e-mail?

13 A. Sure. So I see myself as a recipient of
14 this e-mail. The content of the e-mail
15 were about some contacts that had been made
16 at some conferences that PPFA staff had
17 attend -- had attended with lists of nurse
18 practitioners and physicians in our service
19 area for Planned Parenthood Southeast.

20 Q. Okay. Did this lead to any new hires at
21 Planned Parenthood Southeast?

22 A. No. We sent a cultivation contact, just a
23 letter about our services, to these

1 providers, but there was no one on the list
2 who was -- had the credentials in order to
3 provide direct abortion care out of this
4 list.

5 Q. If you can look at 229. I want to read --
6 First of all, do you see your name on this
7 page?

8 A. Yes.

9 Q. Okay. In what context is it on this page?

10 A. As a recipient.

11 Q. And who is sending you the e-mail?

12 A. Looks like Mollie Williams, who -- I
13 couldn't quote you her direct title -- but
14 as the director of the Southern Access
15 Project for Planned Parenthood Federation
16 of America.

17 Q. Okay. She writes -- I'm going to read
18 this. It says, last week -- Hi, Staci.
19 Last week we briefly discussed that the SAP
20 budget includes funds for incentives to
21 help recruit, entertain providers. Does
22 SAP stand for Southern Access Project?

23 A. Yes.

1 Q. That's a program of PPFA?

2 A. Yes.

3 Q. What's your understanding about the
4 incentive funds that she's talking about?
5 Can you tell me about those?

6 A. Sure. My understanding of that -- these
7 incentive funds were really around
8 recruiting and retaining nurse
9 practitioners to provide family planning
10 services. And we were just talking about,
11 you know, how those funds might be used to
12 help with the recruitment of those nurse
13 practitioners for a particular service.

14 Q. Could those funds be used to recruit
15 doctors?

16 A. I don't believe so, but I don't -- I don't
17 believe so from my understanding of those
18 funds.

19 Q. Do you have any idea --

20 A. They're donor-restricted funds.

21 Q. Okay. Thank you.

22 The e-mails we've looked at appear to
23 be over this past spring and summer; is

1 to grow the practice, but there were no
2 benchmarks shared.

3 Q. Okay. When you have taken these steps to
4 expand services, have you done so without
5 any assurances that it will lead to staff
6 privileges for Dr. Roe?

7 A. Yes.

8 Q. Are there other reasons to expand these
9 services besides the possibility Dr. Roe
10 will get services -- I mean, besides the
11 possibility Dr. Roe will get privileges?

12 A. Yes.

13 Q. Have -- Did you ever contact any faculty
14 members who have privileges at UAB or USA
15 about providing clinic -- providing
16 abortions at either one of the Planned
17 Parenthood clinics in Alabama?

18 A. Yes.

19 Q. Can you tell me about those -- that attempt
20 to contact them?

21 [REDACTED]
22 [REDACTED]
23 [REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Q. If -- That doctor is a she; right?

A. Yes.

Q. If that doctor started to work with Planned Parenthood, do you have any knowledge about what consequences she might face?

A. I was not told about a conversation that included direct consequences.

Q. Okay. So it's possible that she would not have any jeopardy with -- her privileges at UAB would not be jeopardized by working with Planned Parenthood?

A. I would speculate to say that that would not be the case given the fact that it was an unwritten but spoken condition of her

1 experience in providing care to women and
2 our ability to provide care in our clinics
3 and the ability for women to seek the care
4 that they need if complications should
5 arise in any hospital.

6 Q. And turning to the issue of applying for
7 staff privileges. Did you ask Dr. Roe to
8 apply for privileges?

9 A. Yes, I did.

10 Q. And what is your understanding of why she
11 did not apply?

12 A. My understanding is that she did not apply
13 because of the concern of the denial of
14 privileges and that impact on her medical
15 license record, so to speak, and that her
16 ability to continue to practice medicine or
17 seek privileges elsewhere, you know, the
18 impact on her career and livelihood.

19 Q. And then turning you back to this morning.
20 I think it was maybe the first thing you
21 talked about was about harassment that you
22 and your providers face. You talked about
23 harassment and protest at the health

1 center, and you talked about some
2 harassment you've experienced at home
3 through letters. What is the effect of
4 that harassment and the protests on you?

5 A. Well, I would say on both myself and the
6 staff and providers that I interact with
7 that the protests may seem regular to the
8 outside world but that the connection of
9 those protests to what they could mean
10 around violence, both in our clinics and to
11 people, including death and murder to
12 providers that it is impossible to detach
13 that -- that protest activity from the
14 possible implication of what that is tied
15 to.

16 So, you know, being for the staff and
17 for the providers being targeted at home
18 means someone knows where you live, which
19 means -- And we've seen, you know, a
20 physician gunned down in his own home, you
21 know, with his family. Whether that is a
22 one-time instance or not, the fear is still
23 there. And so it's really impossible to

1 separate the fear of that, being around
2 that protest activity all day long. And so
3 it creates an extra level of vigilance and
4 stress. And certainly in my experience, it
5 has impacted our ability to hire staff and
6 hire providers because of the fear as
7 connected with that harassment.

8 MS. FLAXMAN: No further
9 questions.

10 MR. PARKER: I think I want to ask
11 just one or two more follow-up
12 questions.

13 **EXAMINATION**

14 **BY MR. PARKER:**

15 Q. You said you asked Dr. Roe to apply for
16 privileges; correct?

17 A. Yes.

18 Q. Did you ever ask her to speak to hospitals
19 about how to -- how to interpret their
20 requirements in such a way that might make
21 it possible for her to obtain privileges?

22 A. No.

23 Q. Okay. And then -- Do you have any idea

1 when the last abortion-related death
2 like abortion clinic murder occurred in the
3 United States?

4 A. I believe it's in the late 2000s. But as
5 recently as last year, a clinic in
6 Pensacola, Florida was a victim of arson.
7 And, you know, I have colleagues -- CEO
8 colleagues who are being targeted in their
9 homes in their communities and their
10 churches and physicians who are being
11 protested in their homes and communities
12 that I could tell you are happening today.

13 Q. Do you know anything about -- Have you ever
14 studied trends -- undertaken a systematic
15 study of trends in levels of
16 abortion-related harassment?

17 A. I haven't personally, no.

18 Q. Have you ever read anything about trends
19 connected to abortion-related harassment?

20 A. Just that -- My understanding is that, you
21 know, the -- that there is a trend that the
22 violence that happens at clinics doesn't --
23 majority of the time doesn't happen when

1 staff and clients are on premise at the
2 clinic. I read about that, but no other
3 scientific, you know, research related to
4 trends.

5 Q. So your knowledge of -- When you express
6 concerns, the effects the harassment has on
7 you, that's based more on anecdotal
8 evidence that you may have heard about or
9 read about in the news or conversations
10 with colleagues; is that right?

11 A. Well, I think it's based on my experience
12 and the experience of the staff that I've
13 interacted with for years, not just
14 anecdotal information. I mean, the
15 emotional pieces is real and not anecdotal.

16 Q. Yeah. But I'm talking about -- You know,
17 you mentioned the prospect of murder
18 really.

19 A. Uh-huh (positive response).

20 Q. But I think you testified earlier that you
21 have never been physically assaulted;
22 correct?

23 A. Correct.

Exhibit NN

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

PLANNED PARENTHOOD SOUTHEAST,
INC., et al.,

Plaintiffs,

Vs.

CIVIL ACTION NO.
2:13-CV-405-MHT

LUTHER STRANGE, in his official
capacity as Attorney General
of the State of Alabama, et al.,

Defendants.

* * * * *

DEPOSITION OF DR. MARY ROE, taken pursuant to
stipulation and agreement before Pamela A. Wilbanks,
Registered Professional Reporter, ACCR #391, and
Commissioner for the State of Alabama at Large, in the
offices of the ACLU, Bell Building, Suite 910, 207
Montgomery Street, Montgomery, Alabama, on Monday,
September 23, 2013, commencing at approximately
8:50 a.m.

* * * * *

1 Q. So when you were a professor, you didn't publish
2 a lot I gather.

3 A. No. I was mostly teaching medical students and
4 residents.

5 ■ [REDACTED]

6 ■ [REDACTED] [REDACTED]

7 ■ [REDACTED]

8 [REDACTED]

9 ■ [REDACTED] [REDACTED]

10 Q. Okay. And you're licensed in Alabama, I know;
11 is that correct?

12 A. Correct.

13 Q. What other states are you licensed in?

14 A. I'm licensed in the state of Georgia.

15 Q. So just Alabama and Georgia?

16 A. Correct.

17 Q. Okay. Have you ever been subject to any
18 disciplinary action for your licenses or
19 anything like that?

20 A. No, I have not.

21 Q. Okay. So apart from abortions, what do you do
22 in your private practice?

23 ■ [REDACTED]

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[REDACTED]

work in a private practice as well.

Q. What kind of procedures, I guess, do you do in your private practice?

A. As an obstetrician/gynecologist, I provide the gamut of surgical care for a gynecological patient, and I do deliveries.

Q. Let's talk a little bit about -- What abortion clinics do you work at?

A. I work for Planned Parenthood.

Q. So just Planned Parenthood?

A. Correct.

Q. All right. And in what states?

A. In the state of Georgia and the state of Alabama.

Q. Okay. Where are those clinics located specifically?

A. I work with a clinic in Augusta. I also work with a clinic downtown where I provide colposcopic procedures, and I work in the clinic in Birmingham and occasionally the clinic in Mobile.

Q. Okay. Could you -- You just used the term

1 Q. Let's talk a little bit about complications.
2 What kind of complications can arise from an
3 abortion?

4 A. I'm sorry. Can you repeat your question?

5 Q. What kind of complications can arise from an
6 abortion?

7 A. It depends.

8 Q. Okay. What are the types of complications that
9 one could get?

10 A. Bleeding, infection, surgical complications.

11 Q. What do you mean by surgical complications?

12 A. Laceration of the cervix, bruising of the
13 vagina, bruising of the vulva, perforation of
14 the uterus.

15 Q. And do you agree with me that some complications
16 can happen without any doctor error?

17 A. I'm not sure I understand.

18 Q. Okay. Even if the doctor performs the abortion
19 properly, there can be complications?

20 A. Yes.

21 Q. Right. And then there could also be
22 complications because the doctor didn't perform
23 the operation properly.

1 A. Yes.

2 Q. Is that right?

3 So the kind of complications that you just
4 explained are complications that can happen even
5 if the doctor is well-qualified and performs
6 properly?

7 A. Yes.

8 Q. Are there any other kind of complications that
9 you know of that would arise from an abortion
10 procedure?

11 A. Again, it depends on the method of the abortion.

12 Q. Okay. Well, how does it depend on the method of
13 the abortion?

14 A. If it's a medical abortion, the patient may have
15 an allergic reaction to the medication.

16 Q. What kind of reactions might they have?

17 A. An allergic reaction.

18 Q. What does that mean? Allergic reaction.

19 A. They may develop a rash, shortness of breath,
20 redness.

21 Q. So it would be something specific about that
22 patient that would cause them to react to that
23 medication?

1 A. Yes.

2 Q. I see.

3 So are there any other complications that
4 you would advise a patient about before they had
5 the abortion procedure?

6 A. No.

7 Q. Okay. What about an incomplete abortion?

8 A. I'm sorry. What was the question?

9 Q. Correct me if I'm wrong, but I understand that
10 sometimes pieces of the fetus can be left inside
11 the womb; is that correct?

12 A. Rarely. Yes.

13 Q. That rarely happens.

14 Why do you say that rarely happens?

15 A. We try to confirm that the procedure is
16 complete.

17 Q. Okay. How do you go about confirming the
18 procedure is complete?

19 A. We will perform an ultrasound at the end of the
20 procedure.

21 Q. Okay. I take it that ultrasound is intended to
22 show you whether there's something still in the
23 womb?

1 A. Yes.

2 Q. What would -- What kind of complications arise
3 from an incomplete abortion?

4 A. Bleeding.

5 Q. Okay. What would you advise a patient to do if
6 they called you and said that they had bleeding
7 after visiting an abortion clinic?

8 A. We try to evaluate how much bleeding they are
9 having. We try to make sure to evaluate
10 whether -- how they are feeling, whether the
11 bleeding is having a physical effect on the
12 patient. And then we advise the patient
13 according to the way they answer the question.

14 Q. When you say "we," who do you mean by "we"?

15 A. Both myself and the nurse on call.

16 Q. Okay. So you don't actually -- You told me
17 before that you come in for the day and then go
18 back to Atlanta. So you don't actually stay at
19 the clinic to take calls like that; is that
20 correct?

21 A. No, I do not.

22 Q. Okay. Is there some mechanism that you would
23 take calls even though you were in Atlanta?

1 A. Yes.

2 Q. Okay. How does that -- How would that work?

3 A. The answering service and the nurse have my
4 phone number, and my phone number -- and my
5 phone is on 24/7.

6 Q. So someone would call into the clinic and get
7 the nurse, and then the nurse would forward it
8 to you? Is that what you're saying?

9 A. Yes.

10 Q. Has that ever happened?

11 A. Yes.

12 Q. Okay. How often does that happen?

13 A. A handful of times a month.

14 Q. Okay. So what was the most recent time that
15 that happened I guess I should say?

16 A. Last week.

17 Q. What was that about?

18 A. I'm sorry?

19 Q. What happened last week?

20 A. A patient called the after-hours answering
21 service and was complaining of bleeding. The
22 nurse assessed her, and the nurse called me.
23 And I asked the nurse to have the patient go to

1 the nearest emergency room.

2 Q. Is that the same thing that would happen if it
3 were an Atlanta-based patient?

4 A. Yes.

5 Q. What emergency room would they go to if they
6 were the Atlanta-based patient?

7 A. I don't know. I have no control over that.

8 Q. Okay. Would you ever meet them at the emergency
9 room?

10 A. I'm not sure I understand what you mean.

11 Q. In Atlanta, if you were to advise a patient to
12 go to the emergency room, do you meet them at
13 the emergency room?

14 A. No, I do not.

15 Q. Do you talk to any doctors at the emergency
16 room?

17 A. The emergency room physician will call me.

18 Q. Where would he get your number?

19 A. Through the answering service.

20 Q. Is that -- To the best of your understanding, is
21 that the same thing that happens when you're in
22 Alabama?

23 A. Yes.

1 MS. FLAXMAN: Object to the form.

2 Q. You can answer.

3 A. I'm not sure I understand the question.

4 Q. Is it standard medical practice for a doctor not
5 to make contact with an ER physician when they
6 advise a patient to go to the ER?

7 MS. FLAXMAN: Object to the form.

8 A. I'm not sure how to answer your question.

9 Q. It's a yes-or-no question.

10 A. It's not a yes-or-no question. It depends on
11 the patient's medical condition. It depends on
12 the patient's resources. It depends on the
13 acuity of the condition of the patient. So it's
14 a medical evaluation and a medical call. If the
15 call -- the medical evaluation warrants a call,
16 then the call needs to be made regardless. If
17 the evaluation doesn't warrant the call, then I
18 will refer the patient, and the emergency room
19 physician will take care of the patient.

20 Q. So you're saying that whether you would call the
21 emergency room physician and discuss the patient
22 depends on how serious the complications were?

23 A. Yes.

1 provider in Mobile escapes me right now.

2 [REDACTED]

3 A. Once a month. Unless there's a situation that
4 requires him to be called.

5 Q. What would be a situation where he was required
6 to be called?

7 A. A patient care issue as well as administrative
8 issues.

9 Q. All right. You would never -- I think we've
10 already established this. If you received a
11 call from the after-hours hotline, you would

12 [REDACTED]

13 A. Generally, if I receive a call after -- from the
14 after-hours hotline and it's an acute patient,
15 my first duty is to the patient and is to get
16 them to the person who can see them the
17 quickest, so that's what I do.

18 Q. So you tell them to go to the emergency room?

19 A. Uh-huh (positive response).

20 Q. Right. Would you follow up with any call to

21 [REDACTED]

22 A. Depending on the condition of the patient, yes.

23 Q. Okay. And what kind of circumstances would you

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[REDACTED]

patient-care situation?

A. If we have a patient with an ectopic pregnancy that required surgery. If we have a complication from an abortion procedure that required for the patient to be admitted in the hospital and have a major procedure.

Q. What's an ectopic pregnancy?

A. It's a pregnancy that is implanted outside of the cavity of the uterus.

Q. And would that be something that you would diagnose at the clinic?

A. Sometimes we do.

Q. Okay. What other situations would arise from -- Scratch that.

What about an ectopic pregnancy would lead

[REDACTED]

A. If it's an ectopic pregnancy that requires that the patient undergo a surgical procedure, then I would call him to let him know.

Q. All right. And you can't recall the person for

[REDACTED]

A. I honestly don't remember his name right now.

1 Q. I take it that you do not talk to him as

2

3 A. I'm not in Mobile as frequently.

4 Q. Do you perform any abortions in Mobile?

5 A. Maybe once every other month.

6 Q. And how does the quantity of abortions that you
7 perform in Alabama compare to the quantity that
8 you perform in Georgia?

9 A. It varies from month to month.

10 Q. Do you perform more in Georgia than Alabama or
11 fewer?

12 A. I would say slightly fewer.

13 Q. Slightly fewer?

14 A. Uh-huh (positive response).

15 Q. Do you keep the same type of schedule with the
16 Georgia clinics as you do with the Alabama
17 clinics?

18 A. Yes.

19 Q. So you show up kind of one day, perform whatever
20 procedures, and then go back home?

21 A. Yes.

22 Q. Okay. And that was Augusta and Atlanta clinics
23 that you worked in in Georgia?

1 Q. How long did you do that?

2 A. About three-and-a-half years.

3 Q. Has anyone ever offered you an incentive package
4 or compensation to get you to reside in a
5 particular place?

6 MS. FLAXMAN: Objection to the form.

7 A. I'm not sure I understand.

8 Q. Has any employer ever tried to recruit you to a
9 particular location?

10 A. No.

11 Q. Just give me a range or an estimate. About how
12 much money do you make in a year?

13 A. It depends.

14 Q. Just give me a range or estimate.

15 A. In private practice, anywhere from 190 to 225.

16 In academic and nonprofit practice, 150 to 190.

17 Q. And you're talking about all sources of income?

18 A. Correct.

19 Q. If someone were to offer to pay you double that
20 to live in Birmingham, would you do that?

21 MS. FLAXMAN: Objection to the form.

22 A. No.

23 Q. Why not? You can be honest.

1 A. Because money is not the only consideration.
2 Quality of life, and I have a family that I also
3 have to consider.

4 Q. So your husband works in Atlanta, and he would
5 have to leave his job?

6 A. My husband actually works in Birmingham.

7 Q. Oh, really?

8 A. Yes.

9 Q. What does he do in Birmingham?

10 A. He's a deejay.

11 Q. So it actually might be easier for you to live
12 in Birmingham.

13 A. Don't tell my husband that.

14 Q. That's an affirmative response.

15 When you say quality of life, what do you
16 mean by quality of life?

17 A. I have two children. The education that they
18 are receiving right now is not something that I
19 would be able to get in Birmingham. The -- If I
20 may be candid, I'm an African-American woman,
21 and one of the first things that I dealt with
22 when I moved to Birmingham from New York was
23 having patients say that they didn't want me to

1 take care of them because I was black. That
2 thus far has not happened in Atlanta.

3 Q. Has that ever happened at the Planned Parenthood
4 clinic?

5 A. No.

6 Q. So you're talking about your private practice
7 when you were in Birmingham?

8 A. Yes.

9 Q. Do you intend to provide any expert testimony in
10 this case?

11 A. Yes.

12 Q. Okay. Have you looked over the report that your
13 lawyer has provided to us?

14 A. No.

15 Q. Okay. Is it your opinion that abortion is one
16 of the safest medical procedures you can get?

17 A. Yes.

18 Q. Okay. What is that opinion based on?

19 A. Personal experience as well as medical -- the
20 medical evidence in the literature.

21 Q. Okay. So when you say literature, what do you
22 mean by literature? Can you tell me?

23 A. I'm not sure I understand.

1 Q. What is continuity of care?

2 A. It's ensuring that the patient evaluation at
3 that particular point in time is transferred
4 from one provider to the next provider, from one
5 point of care to the next point of care.

6 Q. Okay. Do you believe that the procedures that
7 you've described during this deposition are
8 describing adequate continuity of care?

9 A. Yes.

10 Q. Okay. And the procedures I'm talking about are
11 the late-night phone call, the referral to the
12 emergency room, that kind of stuff.

13 A. Yes.

14 MS. FLAXMAN: Objection to the form.

15 Q. You say here that it's not necessary that the
16 physician who performed the abortion have staff
17 privileges.

18 Do you agree with that?

19 A. Yes.

20 Q. Would it be helpful if the physician had staff
21 privileges?

22 A. No.

23 Q. It wouldn't be helpful?

1 A. No.

2 Q. How would it not be helpful?

3 A. It depends on the circumstances.

4 Q. Well, let me give you a hypothetical.

5 Let's say that one of your Atlanta-area
6 patients had a complication, and you told them
7 to go to the emergency room and they went to

8 [REDACTED] [REDACTED]
9 an easier time treating those complications if

10 [REDACTED]

11 A. No.

12 Q. Why not?

13 A. Because once the patient is evaluated and the
14 patient goes to the emergency room, the
15 emergency room physician takes over the care of
16 the patient. And they'll re-evaluate the
17 patient and make the medical calls, medical
18 management.

19 Q. So you would just turn it over to the emergency
20 room physician at that point?

21 A. Yes.

22 Q. Do you know any emergency room physicians at

23 [REDACTED]

1 Q. So your licenses are in good standing in Alabama
2 and Georgia?

3 A. Yes.

4 Q. When did you get that Georgia license?

5 A. I'm sorry?

6 Q. When did you get the license for Georgia?

7 A. In 2006.

8 Q. All right. Have you ever been harassed over
9 providing abortions?

10 A. Yes.

11 Q. Can you explain that?

12 A. Heckled. I've been heckled. I've been -- I've
13 had -- been stalked, I guess, for lack of a
14 better word, around the perimeter of the house
15 center.

16 Q. So your experience with harassment over
17 abortions has been at the abortion clinic?

18 A. Yes.

19 Q. Has anybody ever followed you home to your
20 knowledge?

21 A. Hopefully not.

22 Q. All right. So that's a "no."

23 Do you take any security precautions because

1 Q. Just to be clear, there are protests and
2 picketing around the Georgia clinics?

3 A. Yes.

4 Q. And there are protests and picketing around the
5 Alabama clinics as well?

6 A. Yes.

7 Q. Have you ever been confronted by anybody about
8 your abortion activities?

9 A. I'm sorry. By whom?

10 Q. Has anyone ever face-to-face confronted you and
11 harassed you that way?

12 A. Other than the protestors, yes. Other than
13 protestors, no. I'm sorry.

14 Q. So just the protestors at the clinics?

15 A. Yes.

16 Q. Okay. When you say you were heckled, what do
17 you mean by heckled?

18 A. Depending on the number of protestors and
19 depending on the time of the year, you might
20 arrive and they start screaming stuff at you
21 and -- I'm going to hell I've been told. I'm
22 killing my people. That kind of stuff.

23 Q. Okay. And when you say stalked, you seem to be

1 referring to a specific incident. What were you
2 referring to?

3 A. They will hide behind the bushes and pop out and
4 start taking pictures of you or pictures of your
5 license plate and stuff like that.

6 Q. And so that wasn't a specific incident? That
7 just happens from time to time?

8 A. No. That was one specific person --

9 Q. Oh, one specific --

10 A. -- who will do it.

11 Q. Okay. One specific person you say?

12 A. Yes.

13 Q. Are the protests in the Georgia clinics
14 meaningfully different from the protests in the
15 Alabama clinics?

16 A. No.

17 Q. It's about the same?

18 A. Yes.

19 Q. Okay. And they were protesting there when you
20 lived in Alabama I take it?

21 A. Yes.

22 Q. So you worked there and lived in Alabama, and
23 the protests were going on?

1 abortions?

2 A. No.

3 Q. Under what circumstance might you see a patient
4 with an ectopic pregnancy?

5 A. Ectopic pregnancy is a possible complication of
6 being pregnant.

7 Q. So any patient you might treat could have an
8 ectopic pregnancy?

9 A. Yes.

10 Q. Mr. Brasher asked you a number of questions
11 about sending patients to an emergency room if
12 you received a call from a patient after she had
13 been discharged from the health center. If you
14 have to refer a patient to an emergency room, do
15 you know which emergency room that patient is
16 going to visit?

17 A. No, I don't.

18 Q. Why not?

19 A. Because the patients that we care for usually
20 will come from out of state or from two, three
21 hours away from the clinic. So they could be
22 anywhere in the state.

23 Q. And if you had a patient -- if you had a patient

1 in Birmingham and you knew that patient was from
2 Birmingham, would you know where that patient
3 was going to go?

4 A. No, I would not.

5 Q. And so when you talked about continuity of care
6 in connection with those patients, what do you
7 mean?

8 A. When we refer the patient to the emergency room,
9 we will follow up with the patient within 24 to
10 48 hours to find out, number one, how they are
11 doing and, number two, what care they received
12 in the emergency room.

13 Q. Mr. Brasher asked you about the various expert
14 opinions that you intend to provide in this
15 lawsuit. Are these expert opinions based only
16 on the medical literature?

17 A. No. They are also based on my experience in
18 providing abortion care.

19 Q. And how long have you been providing abortions?

20 A. Since I finished my residency in 2002.

21 Q. When Mr. Brasher was asking you about comparable
22 procedures to abortions in terms of risks, you
23 mentioned -- I'm going to get those wrong --

Exhibit OO

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

PLANNED PARENTHOOD SOUTHEAST,
INC., et al.,

Plaintiffs,

Vs.

CIVIL ACTION NO.
2:13-CV-405-MHT

LUTHER STRANGE, in his official
capacity as Attorney General
of the State of Alabama, et al.,

Defendants.

* * * * *

DEPOSITION OF DR. P1, PHYSICIAN, taken pursuant
to stipulation and agreement before Pamela A. Wilbanks,
Registered Professional Reporter, ACCR #391, and
Commissioner for the State of Alabama at Large, in the
offices of the ACLU, Bell Building, Suite 910, 207
Montgomery Street, Montgomery, Alabama, on Monday,
September 23, 2013, commencing at approximately
12:25 p.m.

* * * * *

1 Q. Okay. So in sort of the training, they are
2 lumped together? Does that make sense?

3 A. It's part of our training core curriculum.

4 Q. Okay.

5 A. Yes.

6 Q. And then you can develop a specialty in that
7 after you --

8 A. If you want to include that in your practice,
9 yes.

10 Q. Okay. Have you ever -- So have you ever lived
11 anywhere else besides Georgia?

12 A. Rochester, New York.

13 Q. Just in Rochester, New York.

14 A. And Columbus, Georgia.

15 Q. Right. Columbus.

16 What was the hospital that you worked at in
17 Columbus?

18 A. It was Columbus Regional at the time. Yes.

19 Q. Okay. Have you ever had an employer offer you
20 financial or some kind of other incentive to
21 move to a different location?

22 A. Not particularly. No. Not that I can recall.

23 Q. All right. And so I assume Planned Parenthood

1 has never offered you any financial incentive to
2 move your residence to another location?

3 A. No.

4 Q. About how much money -- you can just give me an
5 average or estimate -- do you make in a given
6 year?

7 A. Since it's contract work, it varies from year to
8 year. 200,000.

9 Q. That would be from all your sources?

10 A. Correct.

11 Q. If someone were to offer you, let's say, twice
12 that much to move your residence, would you
13 consider moving your residence?

14 MS. FLAXMAN: Objection to form.

15 Q. You can answer it.

16 A. The question is --

17 MS. FLAXMAN: You can answer.

18 A. -- if they asked me to move?

19 Q. Let me just restate that.

20 If someone were to offer you \$400,000 as a
21 salary if you were to move to Alabama, would you
22 consider that?

23 MS. FLAXMAN: Same objection.

1 A. It would depend on the work and also what's
2 available in terms of work for my husband.

3 [REDACTED] [REDACTED]
4 [REDACTED]

5 also doing research out of one of the clinics in
6 Atlanta, work I really enjoy. So I would have
7 to be able to -- It's not just a dollar figure.

8 Q. Right. What does your husband do in Atlanta?

9 A. He's a financial planner.

10 [REDACTED]
11 [REDACTED]

12 [REDACTED]

13 Q. And what kind of research are you doing?

14 A. I do research with an organization known as
15 Gynuity out of New York.

16 COURT REPORTER: What was that?

17 THE WITNESS: Gynuity, G-Y-N-U-I-T-Y.

18 A. And we primarily do reproductive health
19 research.

20 Q. Can you be more specific about reproductive
21 health research?

22 A. The most recent study I financed was using
23 antibiotics in women who are coming in for g-y-n

1 go to one of the community centers.

2 Q. Describe to me sort of your schedule during the
3 week.

4 [REDACTED]
5 [REDACTED]
6 [REDACTED]
7 [REDACTED]
8 [REDACTED]
9 [REDACTED]

10 Q. When you go -- I assume the only reason you go
11 to Virginia is to work for Planned Parenthood.

12 A. Yes.

13 Q. When you go to either Virginia or Alabama, how
14 does that work? How does your travel work?

15 A. What do you mean?

16 Q. Do you drive in for the day, the same day, or do
17 you stay at a hotel?

18 [REDACTED]
19 [REDACTED]
20 [REDACTED]
21 [REDACTED]
22 [REDACTED]
23 [REDACTED]

1 A. Yes.

2 Q. Okay. And how did you get those?

3 [REDACTED]

4 [REDACTED]

5 it's a separate process. You have to fill out
6 the hospital's application and be credentialed
7 to them.

8 Q. And why did you have to apply?

9 A. Why did I have to apply?

10 Q. Right.

11 A. To be able to admit patients and see patients in
12 the hospital.

13 [REDACTED]

14 A. The teaching hospitals do, yes.

15 Q. Okay. It's not some -- That's part of your
16 teaching responsibilities?

17 A. Correct.

18 Q. Okay. Have you had any staff privileges at any

19 [REDACTED]

20 A. Highland Hospital in Rochester, New York.

21 Q. How did you get those?

22 A. When I was in fellowship.

23 Q. What is a laparotomy? if I'm pronouncing that

1 word right.

2 A. A laparotomy?

3 Q. Yeah.

4 A. A surgical procedure.

5 Q. Do you perform those?

6 A. I do not.

7 Q. Are you qualified to perform those?

8 A. No, I'm not. It's a surgical skill that we
9 don't acquire.

10 Q. And I assume the same thing for a hysterectomy?

11 A. Correct.

12 Q. So whatever kinds of privileges you have at
13 
14 procedures?

15 A. Correct.

16 Q. Do you think you could get similar staff
17 privileges at a hospital in Alabama?

18 A. Similar to what I have in Atlanta?

19 MS. FLAXMAN: Objection to the form.

20 Q. Yes. You can answer.

21 A. Could I get privileges based on ...

22 Q. Just similar to what you've had in Atlanta or
23 Rochester.

1 Q. Okay.

2 A. Yes.

3 Q. So, then, it's your understanding that he
4 actually performed that abortion in that
5 particular circumstance?

6 A. Yes.

7 Q. Okay. Are there any other circumstances where
8 you've used him to treat a patient or brought
9 him in on a patient?

10 A. Not that I can recall.

11 Q. And I assume the only time you would talk to him
12 would be in that situation where you needed him
13 for some kind of patient care?

14 A. Correct.

15 Q. Okay. What's been your experience with sort of
16 the protests and whatnot outside abortion
17 clinics?

18 A. What's been my experience --

19 Q. Yeah.

20 A. -- specifically?

21 Q. Well, I mean, what do you think about the
22 protests?

23 A. I don't like it.

1 Q. Right. I mean, you see them in Alabama, I
2 assume.

3 A. Pretty much everywhere.

4 Q. Pretty much everywhere.

5 And so in the Georgia clinics you work at
6 you see them?

7 A. Yes.

8 Q. And I assume in Virginia as well?

9 A. Yes.

10 Q. Are they worse in a particular state?

11 A. In what way?

12 Q. Are they about the same everywhere?

13 A. Some places have more numbers. There are more
14 people on the sidewalks. Some people have fewer
15 numbers, more signs.

16 Q. But you wouldn't say that the abortion clinic in
17 Mobile has any sort of different protest
18 atmosphere than Virginia or Georgia?

19 A. Mobile has more numbers in terms of volume than
20 I see in Georgia.

21 Q. What about Virginia?

22 A. I think they outnumber Virginia.

23 Q. Have you ever -- Do you feel harassed or

1 anything like that when you go to work in
2 abortion clinics?

3 A. I do.

4 Q. Okay. Could you just explain that to me, why
5 you feel that way?

6 A. Name-calling.

7 Q. Okay.

8 A. Unpleasant terminology, yeah.

9 Q. What -- So they yell at you, I guess, as you're
10 going in the clinic?

11 A. Yes.

12 Q. Okay. I won't ask you about that.

13 Have you ever felt in danger by any of the
14 protests around the clinics?

15 A. Yes.

16 Q. When did you feel in danger?

17 A. When I hear people calling me a murderer, when
18 they are standing at the back door, when they
19 are jumping out behind the dumpster.

20 Q. So just in general. I mean --

21 A. It feels threatening, yes.

22 Q. -- no particular situation you can think of?

23 A. What I just named actually happened. Those

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[REDACTED]

where you work about abortion?

A. None that I know about.

Q. So there have been no protestors that have

[REDACTED]

[REDACTED]

A. None that I'm aware of.

[REDACTED]

[REDACTED]

A. No.

Q. So these are just things that happen around the clinic?

A. Yes.

Q. And they happen in every state that you work

Exhibit PP

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

PLANNED PARENTHOOD SOUTHEAST,
INC., et al.,

Plaintiffs,

Vs.

CIVIL ACTION NO.
2:13-CV-405-MHT

LUTHER STRANGE, in his official
capacity as Attorney General of the
State of Alabama, et al.,

Defendants.

* * * * *

DEPOSITION OF CHRISTOPHER DUGGAR, M.D.,

taken pursuant to stipulation and agreement before
Haley A. Phillips, Certified Court Reporter,
ACCR # 151, and Commissioner for the State of
Alabama at Large, in the Law Offices of Attorney
General's Office, 501 Washington Avenue,
Montgomery, Alabama, on Friday, October 18, 2013,
commencing at approximately 12:48 p.m.

* * * * *

1 the office?

2 A. No, ma'am.

3 Q. No?

4 A. Other -- Other than medicine. We may give
5 them some medicine like SYDATEC.

6 Q. Uh-huh (positive response). Okay.

7 So if they come in in the process of
8 a -- of a miscarriage, they might get
9 SYDATEC?

10 A. Yes, ma'am.

11 Q. And so at the hospital, what do you do,
12 what sort of procedures?

13 A. How long do we have?

14 Q. As long as you want.

15 A. So we obviously perform obstetrical care.

16 Q. Right.

17 A. So we do antepartum care. We do vaginal
18 and C-section type deliveries.

19 Q. Uh-huh (positive response).

20 A. For GYN, I generally do laparoscopy. We do
21 a lot of hysterectomies, both laparoscopic
22 and open. We would do suction D & Cs or
23 just D & Cs in general. We do endometrial

1 to you with -- she's been diagnosed with a
2 fetal anomaly and wants a termination, what
3 do you do?

4 A. So in that case, we will oftentimes refer
5 them to UAB to be evaluated and taken care
6 of.

7 Q. I see.

8 And have you -- What about if a woman
9 came or one of your patients came and it
10 was a situation of rape? Where would
11 you -- And what if she wanted an abortion?
12 Would you refer her somewhere?

13 A. We would -- We would give her information
14 about the local clinics. We have a lot of
15 patients that also go to Tuscaloosa.

16 Q. I see. Because they go later.

17 And so the local clinics -- You will
18 refer patients to Reproductive Health
19 Services?

20 A. Yes, ma'am. At the point of telling them
21 that there are local clinics.

22 Q. Uh-huh (positive response).

23 When a patient is seeing you or your

1 routinely take care of other physicians'
2 patients. This was actually a very rare
3 situation where I would have done that.

4 Q. So you're saying -- So in -- When you're on
5 call at the hospital, you either take care
6 of your own patients or your -- or your
7 practice patients --

8 A. Yes, ma'am.

9 Q. -- patients of your practice --

10 A. Yes, ma'am.

11 Q. -- or people who are considered to be
12 unattached?

13 A. People who are having problems who are
14 unattached. But I would say that I can
15 count on my finger the number of times I've
16 taken care of a post-surgical patient from
17 another physician. This being maybe one of
18 them.

19 Q. Would this be the only complication from an
20 abortion that you can recall treating at
21 the hospital?

22 A. We actually -- A few months after this, six
23 to 12 months later, had another patient

1 Q. So offices -- So, for example, offices can
2 provide plastic surgery or use general
3 anesthesia in their offices and they're not
4 required to have admitting privileges.
5 Were you aware of that?

6 MR. BRASHER: I'm going to object
7 to that.

8 Q. Were you aware?

9 A. No, ma'am.

10 Q. And do you think that every doctor that
11 works at an outpatient facility could meet
12 the criteria for a -- for getting
13 privileges?

14 A. I do, actually.

15 Q. Even though the minimum procedure amount?

16 A. Again, we -- I know, again, just speaking
17 for Jackson Hospital they have different
18 levels of membership privileges at the
19 hospital. And they've gone to extreme
20 measures to try to account for physicians
21 that may or may not meet minimum criteria.

22 Q. Uh-huh (positive response).

23 And do you know about Baptist?

1 A. I don't know anything about Baptist.

2 Q. And are you aware now of the -- of the rule
3 that applies to abortion clinics where they
4 have to have a covering physician?

5 A. It's my understanding that that is the
6 current situation.

7 Q. And do you know who the covering physician
8 is for Reproductive Health Services?

9 A. I do not.

10 Q. Do you know -- Do you understand what the
11 role is of that covering physician for the
12 clinics?

13 A. It's my understanding that that physician
14 is responsible for complications or other
15 issues that come up outside of clinic --
16 clinic hours.

17 Q. And how would it be different or rather --
18 Scratch that.

19 We saw -- You saw earlier the
20 requirements of the law that's the subject
21 of this litigation. Is it correct to say
22 that that requirement is that every doctor
23 that works at the clinic has admitting

Exhibit QQ

Gloria Gray

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1 IN THE UNITED STATES DISTRICT COURT FOR THE
2 MIDDLE DISTRICT OF ALABAMA
3 NORTHERN DIVISION
4 CIVIL ACTION NUMBER
5 2:13-cv-405-MHT

7 PLANNED PARENTHOOD SOUTHEAST,
8 INC., et al.,
9 PLAINTIFFS,

COPY

10 VS.

11 LUTHER STRANGE, in his official
12 capacity as Attorney General of the
13 State of Alabama, et al.,
14 DEFENDANTS.

16 DEPOSITION OF:
17 GLORIA GRAY
18 MONDAY, OCTOBER 21, 2013

20 S T I P U L A T I O N

21 IT IS STIPULATED AND AGREED, by and between
22 the parties through their respective counsel,
23 that the deposition of GLORIA GRAY may be taken

Gloria Gray

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1 aspect of it. I do anything the doctor doesn't
2 want to do.

3 Q. So all paperwork --

4 A. Correct.

5 Q. -- and staff supervision, and sort of the
6 odds and ends, I suppose?

7 A. That's correct.

8 Q. Who else besides yourself works at the
9 clinic, and what do they each do?

10 A. I have one physician. Do you need names?

11 Q. If you'd like. We understand that this is
12 a sensitive sort of subject, so if there's
13 anybody that you would prefer just to give a job
14 description and what they do and how long they've
15 been there, you know, just keep the name silent,
16 that's fine.

17 A. I have no problems giving my physician's
18 name. I don't know how the other staff feels
19 about it, so I'll just limit that. The
20 physician's name is Louis T. Payne, and he has
21 been at the clinic since August of 1993, and he
22 is the medical director and the on-staff
23 physician. I have two RNs. One has been with me

Gloria Gray

22

1 for them at all in the ER; this is designed to
2 sort of help improve the situation, help it run
3 more smoothly?

4 MR. MARSHALL: Objection to the form.

5 A. Well, you're asking me questions that I am
6 totally removed from, because I don't know what
7 happens once the patient gets to the ER.

8 Q. One last question before I move on from
9 that. Do you recall any specific examples of Dr.
10 Payne calling in for a patient to the ER, and can
11 you tell me about that at all, prior to them
12 leaving the clinic? I know that's sort of where
13 your involvement ends.

14 A. Yes.

15 Q. Would you tell me a little bit about the
16 situation?

17 A. We had a perforation of a patient and he
18 was preparing that patient for surgery, so he
19 called. There again, he gave them the
20 instructions on how he wanted the patient to be
21 cared for, what tests he wanted performed prior
22 to him taking her to surgery. If we are sending
23 a patient to the hospital and it's not a patient

Gloria Gray

24

1 I am having to take some of my much-needed space
2 to put in a back-door exit, because you cannot
3 exit through my recovery room. So I do not see
4 how that has anything to do with the patient
5 safety.

6 Q. Well, focusing in more on the staff
7 privileges requirement, what's your understanding
8 of those particular provisions in the act?

9 A. It's my understanding that the new law will
10 require that all the doctors have to have
11 admitting privileges at a local hospital.

12 Q. In your own words, how would you define
13 "admitting privileges"?

14 A. Where they can admit a patient and be able
15 to follow that patient's complications, whether
16 it's surgery, excessive bleeding, whatever it is.
17 That patient would have to -- excuse me, let me
18 back up. The doctor would have to be able to
19 follow that patient, as Dr. Payne currently does.

20 Q. And admitting privileges, do you mean it's
21 the same thing as staff privileges; they're
22 interchangeable?

23 A. In my opinion, they're one and the same. I

Gloria Gray

1 don't know how the hospital looks at it.

2 Q. Does Dr. Payne have staff privileges
3 locally?

4 A. He does.

5 Q. Where does he have them?

6 A. He has them at Druid City Regional
7 Hospital.

8 Q. Anywhere else?

9 A. No. The only other hospital in Tuscaloosa
10 is the Northport part of Druid City.

11 Q. Do you know how Dr. Payne obtained his
12 staff privileges?

13 A. Dr. Payne has had his privileges since he
14 came to Tuscaloosa, which, I believe, was in
15 1969.

16 Q. So, no, you don't really know very much
17 about that?

18 A. No, I don't.

19 Q. Why would you say that Dr. Payne has staff
20 privileges? This is not a trick question. Just
21 why would you say that he has them at the local
22 hospital?

23 A. I'm sure when he first obtained his

Gloria Gray

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1 hospital privileges, he also was doing OB in his
2 practice; so he was there to deliver babies, and
3 he has maintained those privileges ever since.
4 And a patient that requires any type of surgery,
5 hysterectomy, it can be something totally
6 unrelated to abortion, he does those at the
7 hospital.

8 Q. So it's partially concerned with his work
9 at the clinic and partially not, would you say?
10 Or is all of his work done at the clinic now?

11 A. All of his work now is done at the clinic.
12 Initially it was not, but he moved his entire
13 practice there probably nine years ago.

14 Q. So just to confirm that answer, the reason
15 he has staff privileges now is because of his
16 continuing work at the clinic?

17 A. Yes.

18 Q. Would you agree that the doctors who are
19 granted staff privileges at DCH, to your
20 knowledge, are well-qualified in their fields?

21 A. Yes.

22 Q. As a general matter, just thinking about
23 the realm of all possible doctor-patient

Gloria Gray

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1 Q. Let's start with generally speaking, not
2 limited to the abortion field.

3 A. If I was a patient, I would want to go to a
4 doctor that had the privileges of following me
5 all the way through with whatever my problem was.
6 If I needed surgery, I would want him to be able
7 to have that done in a hospital.

8 Q. And what about in an abortion-specific
9 context? Is it still preferable?

10 A. In my opinion, yes.

11 Q. So to sort of take that just a step
12 further, if your daughter wanted to have an
13 abortion, would you prefer that the doctor
14 performing the abortion be locally based and have
15 staff privileges?

16 A. Yes. And I'm answering that as a mother.

17 Q. Does that change in your official capacity
18 as a clinic administrator?

19 A. As a clinic administrator, knowing the way
20 that the clinics are set up now, they are
21 required to have a backup doctor so if there is a
22 complication, they can contact that backup doctor
23 and the doctor can meet the patient at the

Gloria Gray**29**

1 hospital. The only disadvantage to that would be
2 that the patient had not gained any type of
3 rapport with the patient; but as a clinic
4 administrator, I would know that the physician
5 that's going to meet her there is going to be
6 respectful of her, nonjudgmental in her decision,
7 and will not be a pro-life doctor who is not
8 going to provide her the type of care that I
9 would want her to have.

10 Q. And just to clarify a hundred percent, this
11 backup doctor would have staff privileges at the
12 local hospital, correct?

13 A. Yes.

14 Q. Has WAWC ever used an outside physician? I
15 know that you have Dr. Payne on staff, but if he
16 were on vacation?

17 A. Dr. Payne and I are both workaholics. Our
18 vacations are limited to two or three days at the
19 beach. We've never taken an extended vacation,
20 say, a two-week vacation since we opened the
21 clinic. We do have a backup physician who has
22 agreed to see our patients if there is a problem,
23 and he's out of town. However, if he is out of

Gloria Gray

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1 come to your clinic. Where do they come from?

2 A. Everywhere.

3 Q. Do they come from Mississippi?

4 A. We see patients from Mississippi, we see
5 patients from Georgia, Louisiana. The majority
6 of our patients are from Alabama, but
7 Mississippi, Georgia, Louisiana, and Florida are
8 the main.

9 Q. And of your patients that are from Alabama,
10 are most of them from, like, Tuscaloosa and
11 surrounding area, or are they from further away?

12 A. We probably only see about 25 percent of
13 our patients from Tuscaloosa. We see a lot from
14 Jefferson County until New Women, All Women has
15 opened back up, and then that dropped.

16 Q. So the number of patients that come from
17 Jefferson County, presumably just Birmingham and
18 the surrounding areas, is dependent on which
19 clinics are open in the city at the time?

20 A. Yes.

21 Q. So 25 percent of your patients are from
22 Tuscaloosa, and you've said that on occasion some
23 of them are from Birmingham. Where else would

Gloria Gray**60**

1 over another, nor does it signal disrespect or
2 lack of concern for patients. In fact, quite the
3 opposite. It is the reality of what clinics here
4 in Alabama and in many areas of the country must
5 do today in order to ensure that women have
6 access to high quality, compassionate care."

7 Q. So if employing doctors from outside the
8 community isn't part of the business model, then
9 why do you choose to advertise the fact that you
10 have a local doctor on staff on your website as
11 part of your means to attract patients?

12 A. I think that it is a draw to moms, such as
13 I was referring to earlier, that does not
14 understand how the clinics operate. But being a
15 provider and knowing that the current laws do
16 require that each clinic have a backup doctor,
17 that ensures that the patient is being cared for
18 by someone who is offering them the same respect
19 as the physician who is performing the procedure.
20 I would not want a patient to be sent to the
21 emergency room to be seen at the mercy of an
22 emergency room doctor, because she may get a
23 pro-life doctor who will not provide her that

Gloria Gray**61**

1 respect and care; to where the clinics have a
2 backup doctor, they know the doctor they're
3 dealing with and they know that that doctor is
4 going to take care of their patient in the same
5 way as they would if it was the physician doing
6 the procedure. It's just that the physicians
7 that perform the procedures, in most cases, do
8 not live within the city and cannot obtain
9 hospital privileges. I think it's a big plus if
10 we could all have hospital privileges for the
11 doctors performing the procedures; but even with
12 this law, the antis were pushing for this law,
13 stating that it was in the safety of the women to
14 have a doctor with hospital privileges, yet some
15 of the doctors have attempted to get these
16 hospital privileges and in some cases have been
17 successful, and now these same antis are
18 protesting the hospitals for allowing the doctors
19 to have hospital privileges.

20 Q. To your knowledge, has that had any effect
21 on the hospital's decision?

22 A. Not at this time, no.

23 Q. You've said that for a mother going into

Gloria Gray

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1 harassment and things like that. Would it be
2 fair to say that abortion clinics are subject to
3 protests all over the United States?

4 A. Yes.

5 Q. In Georgia?

6 A. Yes.

7 Q. Mississippi?

8 A. Yes.

9 Q. Florida?

10 A. Yes.

11 Q. Massachusetts?

12 A. I don't know about Massachusetts.

13 Q. Would you be surprised to learn that it did
14 happen in Massachusetts?

15 A. No.

16 Q. Would it be fair to say that the protests
17 that occur happen largely at the clinic rather
18 than at the homes of individuals that work there
19 or elsewhere?

20 A. I think that depends on the region.

21 Q. How so?

22 A. How aggressive your protesters are.

23 Personally we have not experienced that here, but

Gloria Gray**64**

1 I have heard and read of some other situations
2 where they've gone to great -- "they" being the
3 antis, I don't refer to them as pro-lifers
4 because they don't seem to care what happens once
5 the child is born. The antis have taken great
6 measurement to harass, intimidate the staff at
7 clinics. I know one director in North Carolina
8 where they contacted her and told her that her
9 daughter was involved in a car accident and was
10 in the hospital, and she was just frantic, and
11 her daughter was in school. So I think that is
12 just determined by the area, you know, where
13 they're protesting.

14 Q. For your clinic specifically, has your
15 clinic ever been the target of any anti-abortion
16 protests?

17 A. Oh, yes.

18 Q. How frequently?

19 A. Right now we are experiencing it daily
20 because of the 40 Days of Life. And since the
21 health department decided to post the number of
22 procedures done at each individual clinic, we
23 have seen an increase in protesters because they

Gloria Gray

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1 realized we do the majority of the abortions in
2 the state of Alabama.

3 Q. Outside of the 40 Days for Life, can you
4 tell me a little bit about what the protests are
5 generally like?

6 A. Our facility is located in an office
7 complex of free-standing buildings, and it's all
8 private property, so they are required to stand
9 out on the road. They're not allowed in the
10 parking lot. So they hold up signs, they yell at
11 the staff, they yell at the patients. We receive
12 harassing letters through the mail, telephone,
13 and then we've had several incidents that have
14 occurred after-hours, thank goodness.

15 Q. What kind of incidents?

16 A. I guess the first incident was in 1997,
17 just four years after we opened. We had a fire
18 that was determined to be arson, and it destroyed
19 everything in the clinic, and our damages
20 exceeded \$400,000. We had to completely gut the
21 building in order to get the smoke smell out. We
22 lost everything in the clinic. And what occurred
23 in that situation was someone built a homemade

Gloria Gray**66**

1 ladder, brought it in at night, climbed on top of
2 the roof, and put a flare down through our
3 air-conditioning unit, and we were never able to
4 determine who did that. At that time I did not
5 have security cameras. But after I rebuilt, I
6 did include security cameras. So we had one
7 incident where they shot out the window in the
8 back portion of the building, and we feel like
9 that was just a test run to see if it was fake
10 cameras and if our alarm system truly worked. No
11 one was ever caught on that. And then we had a
12 gentleman who decided to drive his car into the
13 front of the building after-hours.

14 Q. When did that happen?

15 A. That was probably four or five years ago.

16 Q. And when did the gunshot happen?

17 A. That's probably been seven or eight years
18 ago. The most recent was the guy driving his
19 car.

20 Q. And they all happened after-hours?

21 A. Yes, thank goodness.

22 Q. Did they ever catch the guy with the car?

23 A. The guy with the car?

Gloria Gray

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1 Q. Yes.

2 A. Yes. Do you want to hear that story?

3 Q. Of course. It sounds interesting.

4 A. He ran his vehicle into the front of the

5 building. When the alarms went off, I think it

6 frightened him because I don't think he realized

7 that it would set off an alarm. So he backed out

8 and was going out of the parking lot, and it tore

9 his bumper off. The police contacted me, I met

10 them at the clinic; and while the officer was

11 investigating that, he got a call that they were

12 chasing someone who was driving erratically and

13 was missing their bumper. They took the bumper

14 and matched whatever on the car, the vehicle

15 number, and determined that it was the person who

16 had run into the clinic. They chased him to

17 Moundville, the next little city over, contacted

18 Moundville police of the chase, and Moundville

19 put out strips to blow out his tires. His tires

20 blew out, he pulled over, and the cops told him

21 to get out of the vehicle. He rolled the windows

22 up, locked his doors, so the cops surrounded his

23 vehicle. He reached in the backseat; and when he

Gloria Gray

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1 reached in the backseat for whatever, they shot
2 him. So he spent, I think, a couple months in
3 the hospital because it went through his lung;
4 and to my knowledge, he is still in prison.

5 Q. That was a good story.

6 A. He was on drugs, too, I might add.

7 Q. So, so far what you've talked about are
8 protests occurring at the clinic. Has anyone
9 ever been followed home from the clinic or even
10 followed to a different location other than their
11 home?

12 A. Not to my knowledge.

13 Q. Have any protests occurred at any location
14 other than the clinic that you knew were targeted
15 at your clinic?

16 A. Yes. They targeted a temporary agency
17 service that I used one time for staff. They
18 targeted that agency for providing services.
19 Right now what they're doing is they are looking
20 at anyone who provides supplies, services to the
21 clinic, and writing them letters asking them not
22 to do business with us.

23 Q. I actually want to turn back to your

Gloria Gray

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1 others have been harassed at their homes?

2 A. Dr. Payne, they did not picket his home,
3 but they did send out fliers to all of his
4 neighbors, letting them know that he was
5 performing abortions and asking them to shame
6 him.

7 Q. Has that happened to any of your other
8 staff members or yourself?

9 A. No. They stand out there and they holler
10 and they yell at us. I have been threatened by
11 one of them, but not to my home.

12 Q. Well, was it a physical threat?

13 A. Yes.

14 Q. What did he say that he was going to do, or
15 she?

16 A. It was one of the Catholic protesters who
17 told me -- this is going to be an ugly word --
18 that he would knock me on the fucking ground; I
19 was in his space, and if I did not get out of his
20 space, he would knock me on the fucking ground.

21 Q. He said that you were in his space while
22 you were at the clinic?

23 A. Yes, while I was outside.

Gloria Gray

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1 Mississippi. In Mississippi, he had a live birth
2 and he killed it. And when he told the story to
3 us, I was just in awe, and the first thing I said
4 was, "That's murder," and he said, "Thank you,
5 Ms. Pro-Life." So I continued to work with the
6 medical board to take this doctor's license away.
7 While I was working with them, Dr. Payne
8 contacted him and asked if he needed any help
9 with performing abortions. Dr. Payne's partners
10 had become concerned about protesting their
11 offices and decided that they did not want him to
12 do abortions at his private practice anymore,
13 because he was just a partner. So he had
14 contacted Thomas Tucker in Birmingham, and Thomas
15 Tucker called me and asked me if I knew Dr.
16 Payne, and I told him "Yes." Dr. Payne had a
17 very good reputation in Tuscaloosa. I did not
18 want to see him get mixed up with this doctor,
19 who I knew was going down, and he was actually
20 going to buy into this doctor's practice. So I
21 contacted Dr. Payne and told him that he was
22 going to have to trust me, that I could not tell
23 him what was going on, but he did not need to go

Gloria Gray**78**

1 into this agreement with this doctor; that I had
2 been giving some thought to opening a clinic in
3 Tuscaloosa, and he agreed and trusted me. So
4 after the medical board felt like my work was
5 done with this doctor, I quit and proceeded to
6 open a clinic in Tuscaloosa because I saw the
7 need there, and I saw the need for a reputable
8 clinic that provided quality of care to patients
9 that they deserved. So that's how I got into
10 opening the Tuscaloosa clinic. And Dr. Payne
11 worked just as the physician for a couple years,
12 and then he decided that it would be -- he was
13 working at his private practice half-a-day and
14 working at the clinic a half-a-day, and we
15 discussed it and decided it would be more
16 beneficial to him to combine the two, and so he
17 moved all of his practice to the clinic.

18 Q. That's how the clinic opened. Now what
19 about selling the clinic when you retire? Have
20 you talked to anyone about doing that yet, or
21 been approached?

22 A. I have an RN that I am grooming to take
23 over as the administrator of the clinic. I'm not

1 it in person?

2 A. Probably one to two percent, and that's
3 usually patients that are coming from
4 out-of-state.

5 Q. One to two percent do registered mail?

6 A. Right. And the reason for that is because
7 of the delay. We have to wait until we get the
8 green card back signed by the patient before we
9 can make their appointment.

10 Q. About your pay structure, you said earlier
11 that you pay the doctor by procedure; is that
12 correct?

13 A. That's correct.

14 Q. How much does he get paid per procedure,
15 and does that vary by the complexity of the
16 procedure?

17 [REDACTED]

18 [REDACTED]

19 [REDACTED]

20 [REDACTED]

21 [REDACTED]

22 [REDACTED]

23 Q. Do you have a range, a pay range for them?

Gloria Gray

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1 [REDACTED]

2 [REDACTED]

3 Q. And sometimes you --

4 A. Oh, let me back up on that. I'm sorry.

5 [REDACTED]

6 [REDACTED]

7 [REDACTED]

8 [REDACTED]

9 A. Yes.

10 [REDACTED]

11 [REDACTED]

12 A. Yes.

13 Q. Is that sort of an ad hoc decision that you
14 make?

15 A. Yes.

16 Q. Do you take into account any particular
17 factors in deciding, or is it just a gut feeling?

18 A. As to which ones we don't charge?

19 Q. Right.

20 A. It just depends on the situation. Rape
21 victims, we may not charge for them if we can tie
22 back the police report to the date -- number of
23 weeks of pregnancy. If someone has children at

Exhibit RR

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Page 1

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

3
4 PLANNED PARENTHOOD
SOUTHEAST, INC., et al.,

5
Plaintiffs,

6
vs. CIVIL ACTION NO.
7 2:13-CV-405-MHT-TFM

8 ROBERT BENTLEY, in his official
capacity as Governor the State
9 of Alabama; LUTHER STRANGE, in
his official capacity of Attorney
10 General of the State of Alabama, et al.,
11 Defendants.

12
13
14 * * * * *

15
16 DEPOSITION OF [REDACTED], M.D., taken
17 on behalf of the Defendants, pursuant to the
18 stipulations set forth herein, before Wendy L.
19 Kendrick, Certified Court Reporter and Notary
20 Public, at the offices of ALABAMA CIVIL LIBERTIES
21 UNION OFFICE, commencing at approximately 2:00 p.m.,
22 Thursday, September 26th, 2013.

23

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1 [REDACTED]

2 too.

3 Q Let me first start by -- Where exactly in

4 [REDACTED]

5 [REDACTED]

6 Q And am I correct that you are originally

7 [REDACTED]

8 A Yes.

9 Q How long have you been in the states?

10 A Total?

11 Q Yeah. How many years have you been in

12 the states?

13 A I -- I came to the states at the age of

14 [REDACTED]

15 Q We'll do that math later.

16 A Okay.

17 Q Did you come from -- for college?

18 A Yes. I came for college, medical school,

19 residency.

20 Q Okay. And so you also said that you have

21 a residence here in the United States?

22 A Yes.

23 Q Where is that residence?

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1 Q Okay. Your mama lived in the United
2 States?

3 A Yes.

4 Q About how much of the year do you spend

5

6 A Now, I've got to do some calculation.

7 Q Sure.

8 A Let's take this year for example.

9 Q That's perfect. So, in 2013 you want to
10 say?

11 A Uh-huh (positive response).

12 Q About how much time in 2013 have you

13

14 A I spent four months.

15 Q I heard you counting months off. Was it
16 a -- was it a long -- Was it a continuous
17 four months that you spent there?

18 A No. It was a continuous three months
19 that I spent here because of health
20 issues.

21 Q Okay. So you spent three months here
22 continuously?

23 A Yes, for health issues this time.

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1 Q And so what about -- Is that about the
2 same for 2012?

3 A I've got to go back to 2012.

4 Q Okay.

5 [REDACTED]
6 months here.

7 Q And when you say "eight months in
8 [REDACTED]
9 continuously for eight months?

10 A No. Break them up.

11 Q Okay.

12 A For when I come back and forth, yes.

13 Q So, did you do two months there, one
14 month here?

15 A Yes, something like that.

16 Q Okay. So you didn't go back every week,
17 back and forth?

18 A No. I can't afford that.

19 [REDACTED]
20 to United States?

21 A About \$5,000.

22 Q Why do you maintain the residence in
23 [REDACTED]

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1 A My wife lives there. She works there.

2

3 A Volunteer work.

4 Q Is that medical based volunteer work?

5 A Medical based. I am also trying to farm.

6 Q So, when you say you're "trying to farm,"
7 do you have a bunch of acres that --

8 A Yes. That I'm trying to get a nice farm.

9

10 A We don't say acres. We say hectares.

11 Q Hectares. I can look that up later. How
12 many hectares do you own?

13 A I don't know. It is family -- family --
14 family owned.

15 Q Is it more than 100?

16 A No. 100 hectares?

17 Q So, it's less than 100 hectares?

18 A Maybe five or something.

19

20

21 A No.

22

23

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1 the Reporter.)

2 BY MR. BRASHER:

3 Q So, you said you practiced in Huntsville.
4 And by "practice," you mean you performed
5 abortions in Huntsville?

6 A Yes.

7 Q What clinic did you work at in
8 Huntsville?

9 A Alabama Women's Health.

10 Q Okay. And how long have you been
11 associated with them?

12 A Since 2004.

13 Q What other clinics have you worked at in
14 Alabama?

15 A I worked with June here in Montgomery.

16 Q Okay. What other clinics?

17 A That's it.

18 Q Have you ever worked for Planned
19 Parenthood?

20 A Yes.

21 Q Okay. When did start working for Planned
22 Parenthood in Alabama?

23 A When did I start?

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1 Q Uh-huh (positive response).
2 A In 1990. It's when I was living in
3 [REDACTED]
4 Q Okay. Did you stop working for Planned
5 Parenthood when you --
6 A Yes.
7 [REDACTED]
8 A Yes.
9 Q Okay. When did you start again working
10 for them?
11 A Back in 2000 -- maybe 2006.
12 Q And do you currently work for Planned
13 Parenthood?
14 A No.
15 Q When did you stop?
16 A Maybe 2010.
17 Q So, you are giving me an approximate --
18 A Approximate, yes.
19 Q All right. Where do you work in United
20 States --
21 A That's it.
22 Q -- outside the state of Alabama?
23 A That's it.

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1 Q -- and then you -- That was a yes?

2 A Yes.

3 Q And then you semi-retired at some point;
4 is that right?

5 [REDACTED]

6 [REDACTED]

7 [REDACTED] [REDACTED]

8 still did abortions. I still came back
9 to do abortions in Alabama 2004 until --
10 until now. Put it that way.

11 Q Okay. So, what led you to start doing
12 abortions in Alabama in 2004?

13 A Because I was needed in Huntsville, and
14 Planned Parenthood also needed -- needed
15 me to cover for them.

16 Q So, was it the Huntsville clinic that
17 initially brought you back to Alabama to
18 do abortions?

19 A I can't say which one because I was still
20 doing Planned Parenthood when I left.
21 But I think it was the Huntsville clinic
22 that brought me back.

23 Q So, you have been performing abortions in

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1 Alabama continuously since 2004?

2 A Yes.

3 Q And -- and just so I'm clear, you were
4 also performing abortions in Alabama
5 before 2004?

6 A When I had a full practice, yes, in

7

8 Q But that was part of your practice in

9

10 A Also when I was -- I was doing abortions
11 then with Planned Parenthood.

12 Q So, you were performing abortions pre-
13 2004, both with Planned Parenthood and as
14 part of your private practice?

15 A Yes.

16 Q And pre-2004, were you also performing
17 abortions with June Ayers' clinic in
18 Montgomery?

19 A When we met, yes. Whenever we met, I
20 just covered for her maybe three or four
21 times in those years, just sporadically
22 when she needed coverage.

23 Q How did you meet the folks that run the

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1 clinic in Huntsville?

2 A How?

3 Q Yes.

4 A They called me. They needed help. I
5 think the doctor who owned the clinic
6 then died.

7 Q Okay.

8 A The OB/GYN doctor died, and they wanted
9 to continue to keep the place opened.
10 So...

11 Q Do you know if they were referred to you
12 by someone?

13 A I don't know.

14 Q Okay. Right now --

15 MR. BRASHER: Strike that.

16 Q The way you perform abortions right now,
17 do clinic administrators approach you
18 about coming to their clinic, or do you
19 approach them about coming to their
20 clinic?

21 A If they need help, if they need coverage,
22 they approach.

23 Q Okay. So, they would -- they would reach

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1 MR. BRASHER: Strike that.

2 Q Did you have privileges when you lived in

3

4 A Yes. Because I was doing a full-time
5 practice where I needed a hospital.

6 Q And I take it you currently do not have
7 privileges at any hospitals?

8 A Because I don't do full-time practice
9 anymore.

10 Q So, you don't have privileges in any
11 hospitals?

12 A No. I don't have any privileges in any
13 hospitals because I don't do full-time
14 OB/GYN practice.

15 Q Okay. When you had privileges in

16

17 those privileges?

18 A We applied. And you have to meet certain
19 requirements.

20 Q And you filed those applications
21 yourself?

22 A In this year -- I think, if I recollect,

23

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1 experience and how many you've done and
2 -- and that's written in there, you mark
3 it and you say you want to continue to do
4 it. And at that time, we used to do
5 abortions in the hospital.

6 Q So, you provided that on the forms --

7 A Yes.

8 Q -- when you submitted those for
9 application of privileges?

10 A Yes.

11 Q Did anyone ever talk to you from the
12 hospital about the fact that you
13 performed abortions?

14 A No.

15 Q Okay. Did anybody ever put any pressure
16 on you when you were privileged at the
17 hospital to stop performing abortions?

18 A No.

19 Q So, I take it then you had no
20 conversations with anyone in the hospital
21 about performing abortions?

22 A Performing abortions wasn't a bad thing
23 then.

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1 Q Okay. What is your experience with
2 harassment or threats at the abortion
3 clinics?

4 A Specifically which abortion clinic are
5 you talking about?

6 Q Well, let's start with the clinic here in
7 Montgomery.

8 A Harassment? My harassment?

9 Q Uh-huh (positive response).

10 A Probably when I come in, they call my
11 name. They say I will rot in Hell. They
12 show me pictures and they try to take
13 pictures. And I'm not sure whether it's
14 pictures they're taking or if there's
15 something else they're bringing out of
16 their purse. And so that's basically it.
17 They take pictures of the place.

18 [REDACTED]

19 [REDACTED]

20 [REDACTED]

21 Q Are the protestors outside the clinic any

22 [REDACTED]

23 A What do you mean?

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1

2

A I don't think they know it, so, no. I

3

don't know. I don't think so.

4

Q You said they tried to take your picture.

5

Do you know if they have managed to take

6

a picture of you?

7

8

9

10

11

A Oh, yes. It said all kinds of things

12

too.

13

Q Were there any protests when you

14

performed abortions at the hospital in

15

16

A No.

17

Q And when you were working at abortion

18

clinics during the 90's, were there

19

protests then as well?

20

A Where? In --

21

Q At the clinics.

22

A At the clinics? I don't remember in the

23

90's. I think all this came up in -- in

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1 going to a different mode.

2 Q Could you say that -- Did you say "mode"?

3 A You -- you -- There are more things you
4 would do to be able to do greater than 12
5 weeks than under 12 weeks. It takes
6 longer.

7 Q And you say that Huntsville has the same
8 kind of structure?

9 A Uh-huh (positive response). Yes.

10 Q Does Planned Parenthood have the same
11 kind of structure too?

12 A I don't remember if I did Planned
13 Parenthood over 12 weeks or not. I don't
14 remember.

15 Q Okay.

16 A But I know the under 12 weeks is about
17 the same.

18 Q Okay.

19 [REDACTED]
20 patient.

21 [REDACTED]
22 Huntsville clinic as well as Montgomery?

23 A Yes.

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1 Q So, it's the same -- You get paid the
2 same at the Huntsville clinic as you do
3 in Montgomery?

4 A Yes.

5 Q Have you ever tried to negotiate a rate?

6 A I tried.

7 Q What --

8 A With Montgomery -- I mean, with Planned

9 [REDACTED]
10 until 2010. And I just -- Well, I didn't
11 -- But I didn't -- I didn't -- I didn't
12 really try to negotiate because I was
13 doing God's work.

14 Q So, it's your recollection that Planned

15 [REDACTED]

16 A Yes.

17 Q Do you know if Ms. Ayers in Montgomery
18 has had the same rate structure for a
19 long time?

20 A I don't know. I don't know.

21 Q You have never tried to negotiate an
22 increase from Ms. Ayers?

23 A No.

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1 Q What about the Huntsville clinic?

2 A No.

3 Q And just to be clear, why is it that you
4 haven't tried to negotiate for a better
5 rate?

6 A I'm doing a job that is required and half
7 of the people who go to those clinics
8 don't have that kind of money anyway.
9 They don't have insurance, so little they
10 can pay. Sometimes the clinic takes a
11 loss, but we're doing the job we need to
12 do.

13 Q Did you make more or less money for
14 abortions when you were in private
15 practice than you do in the clinic?

16 A For abortions?

17 Q Yes.

18 A I didn't have as many abortions while I
19 was doing my private practice because it
20 wasn't an abortion clinic.

21 Q Well, I guess for each abortion procedure
22 that you did, did you charge more than

23

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1 [REDACTED]
2 [REDACTED]
3 [REDACTED]
4 [REDACTED]
5 [REDACTED]
6 [REDACTED]
7 [REDACTED]
8 [REDACTED]
9 [REDACTED]
10 [REDACTED]

11 Q Okay. So you're saying a million
12 dollars?

13 A Oh, yes, I will come.

14 Q You would definitely come --

15 A I'll definitely come. Even my wife would
16 make sure I come.

17 Q Anything less than that --

18 A No way.

19 Q -- would encourage you to come to
20 Alabama?

21 A No way.

22 Q Okay. And is that because you enjoy

23 [REDACTED]

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1 A One, yes. Two, I've given 35 years of my
2 life to full-time medicine. So, for me
3 
4 come back and do full-time work.
5 Delivering babies full time, I don't
6 think I want to do that anymore. I'm
7 tired. But for a million dollars I will
8 wake up.

9 Q Do you have any role with Planned
10 Parenthood or June Ayers' clinic in
11 recruiting doctors to work at the
12 clinics?

13 A No.

14 Q Have you ever referred any doctors to
15 work at the clinics?

16 A No.

17 Q Have you ever discussed with any other
18 doctors them working at the clinics?

19 A No.

20 Q Have you heard of courtesy privileges at
21 hospitals.

22 A Yes.

23 Q Could you tell me what a courtesy

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1 CROSS-EXAMINATION

2 BY MS. FREDIN:

3 Q I just want to ask you a couple of
4 questions to clarify a few things.

5 I believe you said that you pay
6 entirely for your flight, the cost of

7

8 A Yes.

9 Q Was that always the case during the time
10 you were working in Alabama?

11 A No.

12 Q So, when was it different?

13 A Well, when I was working only in

14

15 in 2008, was splitting the cost of it
16 then. But by 2010, when -- By the time
17 2010 came around and June -- things
18 started going down, you know, so I -- I
19 -- Huntsville couldn't help any longer,
20 so I did it by myself. Now that June was
21 added to the clinic that I cover. So --

22 Q So --

23 A Yeah. They don't -- I pay for it now.

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1 Q So, since 2010, you have paid entirely --
2 A Yes.
3 Q -- but between 2008 and 2010 you split --
4 A Split it, yes.
5 Q If a person has a fever, is that
6 indicative of an infection?
7 A Yes.
8 Q And the infection could be a complication
9 of an abortion?
10 MR. BRASHER: Objection.
11 A It's going to be a complication -- uh-huh
12 (positive response). Yes. It's going to
13 be a complication of an abortion.
14 Q But you could have --
15 A But not -- not limited to an abortion.
16 Q But you don't -- a fever doesn't exist
17 absent an infection?
18 A Say that again.
19 Q Does a fever exist absent an infection?
20 A Does a fever exist in absence of
21 infection?
22 Q Yes.
23 A Rarely.

Exhibit SS

Dalton Johnson

1

1 IN THE UNITED STATES DISTRICT COURT FOR THE
2 MIDDLE DISTRICT OF ALABAMA
3 NORTHERN DIVISION
4 CIVIL ACTION NUMBER
5 2:13-cv-405-MHT

6
7 PLANNED PARENTHOOD SOUTHEAST,
8 INC., et al.,
9 PLAINTIFFS,

COPY

10 VS.

11 LUTHER STRANGE, in his official
12 capacity as Attorney General of the
13 State of Alabama, et al.,
14 DEFENDANTS.

15
16 DEPOSITION OF:

17 DALTON JOHNSON

18 MONDAY, OCTOBER 21, 2013

19

20 S T I P U L A T I O N

21 IT IS STIPULATED AND AGREED, by and between
22 the parties through their respective counsel,
23 that the deposition of DALTON JOHNSON may be

Dalton Johnson

13

1 Q. Was there another founder of the clinic?

2 A. Dr. Carl Palmer.

3 Q. And how did you connect with Mr. Palmer?

4 A. Dr. Palmer was friends with the Gibsons,
5 who were my employers. I befriended them,
6 befriended him over a time period. He knew I had
7 medical experience. Actually, I sat out, in
8 between coming to A&M from DePauw, for a year to
9 make sure that medicine was what I wanted to do,
10 and worked -- I did a year internship in a family
11 practice office, and then he also knew I had, you
12 know, business and administrative experience
13 working with the Gibsons.

14 Q. So was it Dr. Palmer's idea to start the
15 clinic?

16 A. Yes. He was a private OB-GYN in town who
17 did terminations for his private patients; and as
18 his children, his last child was graduating high
19 school, he wanted to open up the clinic. I did
20 the legwork and he did the financing, and we
21 became partners, 51/49.

22 Q. 51/49?

23 A. Yes.

Dalton Johnson

14

1 Q. Who is the 51?

2 A. Dr. Palmer was.

3 Q. And you say that he decided to start this
4 clinic when his children had graduated from high
5 school?

6 A. Right.

7 Q. What's the reasoning behind that?

8 A. He used to work at, I think, the first
9 clinic in Huntsville. This is kind of before I
10 got to Huntsville, what I can remember. He
11 worked there, and there were some issues with
12 violence towards him and his family. They threw
13 a brick through his window at his residence, and
14 so he stopped working there. So he wanted to
15 wait for his children to get out of the area
16 before he moved forward with the clinic, because
17 he believed that the services needed to be
18 available to the community.

19 Q. I believe I saw that he has passed away?

20 A. Yes. He passed away Father's Day 2004.

21 Q. So are you now the sole shareholder?

22 A. That's correct.

23 Q. How did that come about?

Dalton Johnson

22

1 procedure has been completed.

2 Q. So do you do a final ultrasound for all
3 patients who have had a medical abortion?

4 A. Yes.

5 Q. You said that the patients have the option
6 of using a private physician?

7 A. Some of the patients come -- with the
8 surgical procedures, some of the patients are
9 coming from more than 100 miles away, so with the
10 two appointments, a lot of times it's more
11 convenient for them to go to their private
12 physician where we can actually fax over the
13 procedure notes and a copy of their pathology
14 report, and they can go to their private
15 physician.

16 Q. About what percentage do you think use the
17 private physician versus use the clinic physician
18 for the follow-up appointment?

19 A. Well, with the medical procedures, we like
20 all of our patients to come back, to return to us
21 for their final ultrasound; although, you know,
22 you can call and document it in the chart and
23 send out a letter if they don't come. I would

Dalton Johnson

23

1 say maybe about 20 to 25 percent don't return. A
2 lot of times it's due to the distance that
3 they're traveling. As far as with the surgical
4 procedures, I would say we have about 50 percent
5 compliance.

6 Q. And when you say "compliance," you mean
7 just someone that has a follow-up appointment?

8 A. With us or going to their private
9 physician.

10 Q. Do you have an estimate of how many women
11 go to the private physician as opposed to come
12 back to the clinic?

13 A. I would probably say -- I don't know. I
14 would probably say about 25 percent, I guess.

15 Q. So you think it's probably about
16 half-and-half?

17 A. Yes, about half-and-half.

18 Q. Do you allow patients to leave the clinic
19 unaccompanied after they've had their procedure,
20 a surgical abortion?

21 A. No. We make sure that they have drivers.

22 Q. Why is that?

23 A. Because we give IV sedation here.

Dalton Johnson

30

1 nurse practitioner, and made the contact. And at
2 that time, he was residing in California.

3 Q. But it's your understanding right now he
4 resides in Nigeria; is that right?

5 A. That's correct, Lagos.

6 Q. You said that after Dr. Palmer passed away,
7 you had difficulty finding a physician?

8 A. Sent out letters to every OB-GYN practice
9 in the Madison County area explaining the
10 situation; that I was looking at physicians, if
11 not to perform the procedure itself but to be
12 emergency backup coverage. No physicians
13 replied, other than I knew that Dr. [REDACTED] at the
14 funeral told me if I needed anything to let him
15 know, and that's how I was able to provide the
16 clinic coverage, was with Dr. [REDACTED]

17 Q. So does Dr. [REDACTED] perform abortions at the
18 clinic?

19 A. Yes. Originally the plan was that he was
20 not going to do abortions at the clinic, he was
21 just going to be emergency coverage and serve as
22 the medical director, and Dr. [REDACTED] was going to
23 be the main one performing the procedures. But

1 did the procedure, Dr. [REDACTED] might do the
2 follow-up.

3 Q. So it's one of these three doctors?

4 A. That's correct.

5 Q. And it's not necessarily the one who did
6 the procedure?

7 A. Exactly.

8 [REDACTED]
9 else besides work at your clinic?

10 A. Dr. [REDACTED] has a private practice in
11 Huntsville; however, he's doing GYN only. He

12 [REDACTED]

13 [REDACTED]

14 [REDACTED]

15 [REDACTED]

16 [REDACTED]

17 [REDACTED]

18 [REDACTED]

19 [REDACTED]

20 [REDACTED]

21 [REDACTED]

22 [REDACTED]

23 [REDACTED]

1 [REDACTED]

2 [REDACTED]

3 [REDACTED]

4 [REDACTED]

5 [REDACTED]

6 [REDACTED]

7 [REDACTED]

8 [REDACTED]

9 [REDACTED]

10 [REDACTED]

11 [REDACTED]

12 [REDACTED]

13 [REDACTED]

14 [REDACTED]

15 [REDACTED]

16 [REDACTED]

17 [REDACTED]

18 [REDACTED]

19 [REDACTED]

20 [REDACTED]

21 Q. Just a few questions before we take a break

22 for lunch. You said the difficulty with

23 privileges at Huntsville. What's your

1 understanding about that difficulty?

2 A. The understanding that we've had is that
3 they're concerned about her having two practices
4 in different areas; although, the practice -- she
5 has coverage when she's away. She's already
6 arranged coverage for her Huntsville practice
7 when she's away on Mondays and Tuesdays, but
8 there's been issues with -- you know, I guess
9 they don't like the agreement or arrangement.
10 I'm really not sure. They have not given her
11 anything in writing, I do know that. But we
12 applied for privileges -- she applied for
13 privileges in February at both hospitals, started
14 with the privileges process, and she received
15 privileges at Crestwood first and hasn't
16 received --

17 Q. But it's your understanding that the
18 problem she's having with Huntsville is that they
19 
20 at the same time?

21 A. Yes. In addition to that, it's probably
22 due to harassment from the protesters. They have
23 done a letter-writing campaign. They protested

1 Crestwood Hospital this past weekend because

2 [REDACTED]

3 Q. Let's just be clear. Do you know that
4 Huntsville Hospital is delaying her privileges
5 because of protesters?

6 A. She's a board certified OB-GYN with
7 coverage, you know, available 24 hours a day.
8 Like I said, they have not given her anything in
9 writing for the reason being.

10 Q. But earlier you mentioned that it was
11 [REDACTED]

12 A. Right. Right.

13 Q. So you do know or she's told you --
14 actually, how do you know that the practice in
15 [REDACTED]
16 Huntsville?

17 A. From, I guess, what she has told me; from,
18 you know, me being in contact with her, seeing --
19 you know, we know the board meeting is coming up
20 and getting kicked down the road.

21 (Whereupon, at this time a lunch break was
22 taken.)

23 Q. Just to recap, you said you had three

1 A. Uh-huh.

2 Q. Is that right?

3 A. That's correct.

4 Q. And the patient called and said, "I'm
5 having" --

6 A. No. The patient came in to the clinic to
7 have a re-suction done, and we had to admit her
8 for observation, because she was doing a little
9 bit more bleeding than we like, and so we
10 contacted Dr. [REDACTED] to let him know that she was
11 being transported to the hospital.

12 Q. Who saw her when she came to the clinic?

13 [REDACTED]

14 Q. Did Dr. [REDACTED] see her at the hospital?

15 [REDACTED]
16 the hospital. She just wanted to let Dr. [REDACTED]
17 know. They're always communicating between them
18 to kind of let them know what's going on.

19 Q. What happened with that patient?

20 A. They never really could find out. It was
21 one of those freak things. They observed her and
22 everything else, then she went home the next day.
23 I know Dr. Robinson, you know, had a detailed

1 talk with the radiologist, and it was just one of
2 those things, they never could figure it out.

3 Q. Have you had a patient that needed to be
4 transferred to the emergency room during a
5 procedure?

6 A. Not during. Normally it's -- we've had
7 patients, yes, during -- during the procedure?

8 Let's see. Out of those seven complications -- I
9 would say during or shortly after, maybe three or
10 four times.

11 Q. Let me just ask this a different way. What
12 are the seven complications that you're talking
13 about, if you can recall?

14 A. We've had one hysterectomy from an IV drug
15 user, one bowel perforation. We've had two that
16 could not tolerate the procedure under the
17 sedation level that we were giving, so Dr. ██████████
18 decided to take them to the OR to continue the
19 procedure, so that's four.

20 Q. Could not tolerate, what do you mean when
21 you say that?

22 A. A lot of times it's just unbelievable the
23 number of people that are recreational drug

Dalton Johnson

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1 A. Yes, sir.

2 Q. Have you had any communications with
3 anybody from Crestwood about those protesters?

4 A. Not recently. Back about two years ago, I
5 believe, roughly, the CEO of the hospital called
6 me and just let me know kind of what was going
7 on; that the hospital was, you know, coming under
8 fire for having Dr. [REDACTED] on staff at the
9 hospital, just kind of a courtesy call. He
10 wanted to know if I was aware of it.

11 Q. So that was two years ago, you said?

12 A. Two or three, yes.

13 Q. So have there been protesters at Crestwood
14 for two or three years now?

15 A. On and off. When they found out that

16 [REDACTED]
17 then that's when it started back up again.

18 Q. And has anyone from Crestwood ever
19 threatened to revoke privileges based on those
20 protesters?

21 A. Not that I'm aware of.

22 Q. I'm just going to hand you this document
23 and see if you recognize this. This is a

Dalton Johnson

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1 statement from Crestwood Medical Center about the
2 recent protesters. I just don't know whether
3 you've seen this statement.

4 A. Yes. I think this is something they put
5 out on a website or e-mail. It looks familiar.

6 (Whereupon, Defendants' Exhibit Number
7 3 was marked for identification, a copy of which
8 is attached to the original of the transcript.)

9 Q. Well, let's mark it as Exhibit 3. Could
10 you read the second-to-last paragraph down there?

11 A. "We respect the rights and personal choices
12 of the physicians who practice medicine at our
13 hospital. We would not remove a physician from
14 our medical staff because of the way he or she
15 votes, or the church they may attend, or the way
16 they spend their time outside the hospital. We
17 do not intend to - nor can we legally - revoke
18 the medical staff privileges of any trained,
19 licensed, lawful and duly credentialed physician
20 for issues that have no bearing on his or her
21 work or practice at the hospital."

22 Q. So reading that, it's your understanding
23 that they're talking about your physicians there?

1 A. That's correct.

2 Q. When they say that they cannot legally
3 revoke the medical staff privileges, do you know
4 what they mean when they say that?

5 A. That they can't legally terminate their
6 privileges just because they believe in a woman's
7 right to choose and are willing to exercise their
8 right to access of choice.

9 Q. I may have asked this already, but have you
10 discussed with Crestwood anything about these
11 more recent protests?

12 A. No. I haven't had any contact with them.

13 Q. And you haven't called them to talk to them
14 about it?

15 A. No, huh-uh.

16 Q. I take it that you're not particularly
17 worried about the recent protests at Crestwood?

18 A. Oh, I'm worried. I mean, I just hate that
19 it's happening to them, but I just try to keep as
20 low profile as possible. I think me calling over
21 there talking with them is not going to do any
22 good.

23 Q. You said that you had a call about two or

1 A. Dr. [REDACTED] has been on staff there for
2 probably 15, 20 years now.

3 Q. So his privileges have come up and been
4 reviewed several times?

5 A. That's correct.

6 (Whereupon, at this time, a short break was
7 taken.)

8 Q. We just talked about some of the protests
9 at Crestwood Hospital. Have there also been
10 protests at your clinic itself?

11 A. Yes, sir.

12 Q. What are those like?

13 A. I think we got the worst ones in the state.
14 We have anywhere between five to, on their big
15 rallies, 150 people out there. Literally it
16 shuts the street down in front of the clinic on
17 their large rally days. They get a permit for
18 that.

19 Q. They get a permit to shut the street down?

20 A. In front, yes.

21 Q. Could you just describe the layout of the
22 protests versus your clinic?

23 A. My building, looking at the front, they'll

1 be in front of here (witness indicating). The
2 patients drive down the drive, parking is in the
3 rear, and then they'll be across the street.

4 Q. So looking at the picture of the building
5 on the website, you couldn't see where the
6 protesters are in that picture?

7 A. If there was protesters here?

8 Q. Right.

9 A. The protesters have to be right in front.
10 They have a permit in front of the building, and
11 then across the street. Our pro-choice group
12 that just started a year ago, it will be a year
13 ago at the end of this month, they have a permit
14 on the right side of the clinic and down at the
15 end of the block.

16 Q. I saw on, I think it was the news, that you
17 had been involved in starting a pro-choice
18 organization.

19 A. The pro-choice organization kind of just
20 found me. Some ladies in the community saw what
21 was going on and wanted to know if they could
22 help escort the patients in, because I have
23 limited parking in the back so the patients have

1 to park on side streets, like on a public
2 right-of-way, then a doctor down the street is
3 nice enough to let us use her parking lot on
4 clinic days. But the patients still have to walk
5 through the protesters, so the pro-choice people
6 assist the young ladies getting in the clinic.

7 Q. About how many pro-choice people have been
8 coming out there?

9 A. I want to say it's probably about 25 in
10 their group, maybe; but on an average day,
11 they'll have about ten out there, because they do
12 different days.

13 Q. Do they only come out there on clinic days?

14 A. On clinic days or when there's protesters
15 out there. Normally on the 40 Days of Life,
16 they're out there every day.

17 Q. This has come up previously in this
18 litigation. There's a thing called 40 Days of
19 Life where there are a lot more protesters than
20 usual; is that right?

21 A. Yes. They're there from 6:00 in the
22 morning until 6:00 at night, seven days a week,
23 to protest the clinic.

1 Q. And there's more than usual protesters that
2 come out?

3 A. No. There's normally two to three, because
4 they stagger, because they have to be out there
5 all day from 6:00 in the morning until 6:00 at
6 night, so they'll have two or three to come out.
7 They're always in pairs, and then they might do a
8 shift from 6:00 to 8:00, and then have another
9 set come in from 8:00 to 10:00. It goes all the
10 way from 6:00 in the morning until 6:00 at night,
11 and they'll do it during Lent, and they'll do it
12 again in the fall.

13 Q. Just correct me if I'm wrong. What's
14 different about 40 Days of Life is that they're
15 always there; is that right?

16 A. Always there, that's correct.

17 Q. Whereas usually they're just there
18 sometimes?

19 A. On clinic days. When I get there, they
20 normally have a little silent thing in the
21 morning, and then they'll leave as soon as I get
22 there. I normally like to be the first one in
23 the facility and the last one to leave.

1 Q. Dr. [REDACTED] told me that there was some
2 particularly loud person who was there?

3 A. Dr. James Henderson, who is their leader.

4 Q. Do you know what Dr. [REDACTED] meant by -- it
5 sounds like you know what he meant by being
6 particularly loud.

7 A. He gets on a blow horn. He's been out
8 there at our clinic for twelve years. Before
9 that, he was at the clinic on Longwood. And this
10 is this guy's mission in life, is to --

11 Q. You called him a doctor. Do you know --

12 A. No, he's not a doctor. I mean Reverend
13 Henderson.

14 Q. Reverend?

15 A. Yes, reverend.

16 Q. So he's a pastor of some kind?

17 A. No. Come to find out, he doesn't have a
18 church. I guess he's just like a street
19 preacher. I always assumed that he had a church,
20 but the pro-choice people told me that they
21 researched it and he does not have a church. I
22 always assumed that he did.

23 Q. So he introduced himself to you as

1 reverend? Is that why you refer to him as
2 "reverend"?

3 A. Yes. He wears the collar and has a big
4 crucifix on and all that, and I just assumed
5 that's what he was.

6 Q. Has anyone ever followed you home from the
7 clinic?

8 A. No, that I'm aware of.

9 Q. Do you receive harassing letters at the
10 clinic?

11 A. Yes.

12 Q. What kinds of letters?

13 A. Everything from, you know, the nasty kind,
14 which is okay. Then there always used to be this
15 guy, Donald Kantz, that used to send me letters
16 that were folded with nothing in them, empty.
17 And that kind of used to -- you know, I almost
18 like the more harassing kind better than -- that
19 would kind of give me pause.

20 Q. Because it seemed like he was just a crazy
21 person?

22 A. Yes. It was just empty. I'm like, "What
23 does he mean by that?" You know, it would just

Dalton Johnson**78**

1 be folded. I normally keep all my other
2 correspondence, and the FBI normally comes by for
3 a courtesy call about once a year. I let them
4 look at the correspondence and sometimes they'll
5 take them.

6 Q. So I take it you don't pass those letters
7 on to employees?

8 A. No, huh-uh.

9 Q. You don't pass them on to the doctors
10 either?

11 A. No.

12 Q. What kind of security precautions do you
13 take at the clinic itself?

14 A. For about the past six or seven years, I've
15 employed off-duty Huntsville police officers to
16 be there on clinic days; however, I'm just
17 about -- three or four months ago, I discontinued
18 doing that because we have the pro-choice people
19 that are there. They do a really good job of
20 keeping, you know, videotaping the protesters
21 when they break the laws or whatever, you know,
22 having videotape evidence going down there. So
23 they've been doing a really good job of that.

Dalton Johnson

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1 And also it was extremely expensive, because I
2 was having to pay \$25 an hour, so my security
3 costs would be anywhere between, you know,
4 \$1,000, \$1,500 a month paying officers.

5 Q. Did you have one officer at a time?

6 A. Yes, one officer at a time on clinic day.
7 They normally kind of do like a rotating deal
8 where they would come in on clinic days. You
9 might not have the same officer. It was kind of
10 whoever was available. It was like a pool of
11 four officers, I would say, that would come in
12 and do it.

13 Q. Did you have a hard time getting those
14 officers?

15 A. No. A family friend of mine is an off-duty
16 police officer kind of part-time, and he was able
17 to arrange a detail for me.

18 Q. So you went through a friend to kind of
19 arrange that situation?

20 A. Yes, to kind of let me know who I need to
21 contact, and then he put me in contact that I've
22 had, you know, and they would set up four guys
23 that would come in and go. They would normally

Dalton Johnson**80**

1 sit right here in front in a car to keep an eye
2 and make sure the women didn't have any problems
3 getting in, although they would still get the
4 harassment and the yelling and all that. There
5 was nothing they could really do, which I
6 understood that; whereas, the pro-choice people
7 do more escorting making sure the women get in
8 okay. Also, they have the ability to take the
9 video evidence to the people that have issued --
10 the City issued the permit and say, "Hey, they're
11 out of" -- "They're not following their permit
12 rules and guidelines," where I'm in the clinic,
13 so I can't do it, you know.

14 Q. So the permit rules would probably be
15 something like they're not allowed to touch any
16 of the women that are coming in?

17 A. Right. They're not supposed to touch,
18 impede access, all that.

19 Q. But you said that they could occasionally
20 get a permit to shut down the street in front of
21 your clinic?

22 A. Yes. They have -- I think about once a
23 quarter, they have a big rally on Saturday

Dalton Johnson**81**

1 mornings, and they actually will get a permit to
2 march down Madison Street, because we're in the
3 downtown area. They normally stand in front of
4 Parker Griffith's office, who is a congressman.
5 They are, you know, all on that side. So they
6 actually get a permit, I'd say, once a quarter to
7 do the extremely large rallies, where they'll
8 march from the park, I'm assuming, and then come
9 down and have these big rallies.

10 Q. So they're not closing down the street to
11 block access to your clinic?

12 A. No. They're closing down the street,
13 almost like a parade route thing.

14 Q. Do you take any security precautions at
15 home?

16 A. I have an alarm with cameras. I always
17 carry a firearm on me at all times. My daughter,
18 she goes underneath her mother's name and not my
19 last name.

20 Q. So you're saying your daughter uses your
21 wife's maiden name?

22 A. Her mother's maiden name, her mother's name
23 and not my last name, just so they can't make the

1 connection.

2 Q. Have you ever been personally threatened by
3 any of these protesters?

4 A. I understand all of them, the normal thing,
5 the verbal assaults and all that. That's what
6 Dr. [REDACTED] was referring to.

7 Q. What kinds of stuff do they say?

8 A. "You're going to go to hell," "What if
9 somebody kills you," you know, all that type of
10 rhetoric.

11 Q. How many hospitals are there in Huntsville?

12 A. There's two, there's Huntsville and
13 Crestwood. But Huntsville is the big one, that's
14 the major trauma one. And that's actually the
15 closest hospital to me, that's two blocks away.

16 Q. Is there some reason why Dr. [REDACTED] hasn't
17 applied to Huntsville for privileges?

18 A. Dr. [REDACTED] originally had privileges at
19 Huntsville, although he never went back and got
20 board certified because he had been practicing
21 for so long. And just like Dr. Palmer was
22 grandfathered in. He had been practicing in
23 Huntsville longer than Dr. [REDACTED] was, so

1 Dr. Palmer was grandfathered in at Huntsville.

2 Q. So you're saying that Dr. [REDACTED] hasn't
3 applied because Huntsville requires board
4 certification?

5 A. Board certification.

6 Q. And Dr. [REDACTED] doesn't have board
7 certification?

8 A. That's correct. He's board eligible but
9 not board certified.

10 Q. And he hasn't tried to get board certified,
11 to your knowledge?

12 A. No. He's at the end of his career, I
13 believe, and so he's not going to go back and do
14 that.

15 (Whereupon, at this time, a short break was
16 taken.)

17 Q. You said earlier that Huntsville was
18 probably the worst place in the state for
19 protesters. Is there something specific that led
20 you to say that?

21 A. Because it's the number of protesters that
22 I have. And just with James Henderson, it seems
23 like he's the most vocal in organizing, I guess

Dalton Johnson**84**

1 the head organizer for the state anti-abortion
2 protesters. And just talking with the other
3 clinic administrators, you know, "How many do you
4 have?" And also with the way my building is set
5 up where, you know, we're not like in an office
6 complex or something like that. You have to, you
7 know, be exposed to the patients.

8 Q. Because a patient would have to walk
9 through a public area to get to the clinic?

10 A. Right. Exactly.

11 Q. Have you ever confronted the protesters?

12 A. You know, early on I did. Sometimes you'll
13 say something back to them, but that just feeds
14 into it. Every now and then -- you know, I
15 haven't done it in years; but, you know, I park
16 right in front, that's my parking space, and, you
17 know, they'll catch you on a bad morning. But
18 I've learned not to do that, that just feeds into
19 them.

20 MR. BRASHER: I think I'm ready to pass
21 the witness.

22 MR. MARSHALL: I just have one question.

23

1 EXAMINATION BY MR. MARSHALL:

2 Q. Mr. Johnson, I believe you were asked
3 whether you have ever been followed home in your
4 car?

5 A. Uh-huh.

6 Q. I believe your response was not that you
7 know of?

8 A. Uh-huh.

9 Q. Do you take any precautions in your
10 driving?

11 A. I live out in Madison, so I have to get on
12 the highway; so when I'm coming out of downtown,
13 I normally drive at a pretty high rate of speed
14 getting on the highway to make sure that nobody
15 is following me. However, I know that with
16 Google and everything else that's available, you
17 know, it's all public information, and that they
18 would be able to pretty much probably find out
19 where I lived. That's the reason why I said I've
20 always told people that if I ever did decide to
21 settle down and get married and was to have kids,
22 which you know how things happen, I would want to
23 be in a gated community just for their safety.

Dalton Johnson

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1 But luckily, my child's mother and my daughter
2 live in Birmingham, I live in Huntsville, so
3 there's that separation.

4 MR. MARSHALL: No other questions. We'll
5 reserve signature.

6 (Whereupon, at this time, the deposition
7 was concluded at 2:05 p.m.)

8 FURTHER DEPONENT SAITH NOT.

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Exhibit TT

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

PLANNED PARENTHOOD SOUTHEAST,
INC., et al.,

Plaintiffs,

Vs.

CIVIL ACTION NO.
2:13-CV-405-MHT

LUTHER STRANGE, in his official
capacity as Attorney General of the
State of Alabama, et al.,

Defendants.

* * * * *

DEPOSITION OF BARBARA BUCHANAN, taken
pursuant to stipulation and agreement before
Haley A. Phillips, Certified Court Reporter,
ACCR # 151, and Commissioner for the State of
Alabama at Large, in the Law Offices of ACLU
Montgomery Office, 207 Montgomery Street,
Montgomery, Alabama, on Tuesday, September 24,
2013, commencing at approximately 9:09 a.m.

* * * * *

1 two years. One of them one month. One of
2 them I don't know.

3 Q. Okay. Where do they live?

4 A. In the Birmingham metro area.

5 Q. Okay. So that could be, like, Birmingham
6 plus, like, Adamsville or some -- some
7 areas -- suburbs of Birmingham?

8 A. Yes.

9 Q. You also mentioned you have one nurse
10 practitioner?

11 A. Yes.

12 Q. Is that a he or a she?

13 A. She.

14 Q. How long has she been with the clinic?

15 A. I don't know.

16 Q. Longer than three years?

17 A. I don't know.

18 Q. Longer than one year?

19 A. I don't know.

20 Q. Okay. Do you know where she lives?

21 A. Yes.

22 Q. Can you tell me?

23 A. Atlanta.

1 Q. And she also coordinates with the clinics
2 based on their schedule needs?

3 A. Correct.

4 Q. Have you ever heard of any abortion doctor
5 telling Ms. Bess or anyone -- or you or
6 anyone else at Planned Parenthood Southeast
7 that he or she will not perform abortions
8 in Alabama because of protests?

9 A. Say that one again. I'm sorry.

10 Q. Sure. Have you ever heard of any abortion
11 doctor telling Ms. Bess or you or anyone
12 else at Planned Parenthood Southeast that
13 he or she will not come to your clinic or
14 to Ala -- come to your clinic to perform
15 abortions because of protests?

16 A. Yes.

17 Q. How many doctors is that?

18 A. One followed through with that and one
19 threatened.

20 Q. Those are the only ones that you've ever
21 heard of expressing concern over protests?

22 A. That's not what you asked me.

23 Q. I'm sorry. Those are the only -- only

1 doctors you've ever heard about either
2 refusing to perform abortions in Alabama or
3 threatening to perform abortions in
4 Alabama --

5 A. Correct.

6 Q. -- due to protests?

7 A. Yes.

8 Q. No others?

9 A. (Witness nods head.)

10 Q. I'm sorry?

11 A. Yes.

12 Q. Okay. Who is your medical director?

13 A. Dr. Roe.

14 Is it Dr. Roe?

15 Q. What does the medical director do?

16 A. I haven't seen her job description.

17 Q. Can you just give me an idea of what --
18 What's different between a medical doctor
19 from any other doctor who performs
20 abortions at your clinic?

21 A. The medical director oversees all our
22 medical services, including family
23 planning -- all medical services. And she

1 candidates? Let me rephrase.

2 When you were appointed administrator
3 the second time --

4 A. Uh-huh (positive response).

5 Q. -- a month and a half ago --

6 A. Uh-huh (positive response).

7 Q. -- did -- who informed you that you would
8 be --

9 A. The CEO.

10 Q. Staci Fox?

11 A. Yes.

12 Q. Did Ms. Fox tell you any reasons why she
13 was hiring you as administrator?

14 A. She didn't tell me reasons why.

15 Q. Okay. To your knowledge, was Shamika
16 Davis' departure as administrator in any
17 way related to this lawsuit?

18 A. Not to my knowledge.

19 Q. Okay. To your knowledge, was your hiring
20 as administrator in any way related to this
21 lawsuit?

22 A. No.

23 Q. Okay. I want to -- We sort of left off

1 before the break talking about recruiting
2 doctors, your attempts to recruit doctors.
3 You said that you tried to recruit over
4 five physicians to come to your clinic; is
5 that right?

6 A. Not exactly.

7 Q. Okay. Can you tell me exactly what --

8 A. You asked me did I try to recruit
9 physicians that had local admitting
10 privileges, and I said over five.

11 Q. Okay. What did you do to recruit those --
12 to try to recruit those physicians?

13 A. I met them or called them, spoke with them,
14 talked about it.

15 Q. Can you be more precise on the number?
16 When you say over five, does that mean,
17 like, six or does that mean, like, 25?

18 A. Closer to six.

19 Q. Does that -- I mean, is it more than seven?

20 A. I'm sure of six.

21 Q. How many are you unsure of?

22 A. Probably five more.

23 Q. Okay. Why are you unsure about those?

1 A. When I approached the physician, I did not
2 always know their admitting privilege
3 status.

4 Q. Okay. So how many total doctors did you
5 contact seeking to -- seeking to -- seeking
6 to recruit doctors for purposes of
7 complying with the Women's Health and
8 Safety Act?

9 MS. FLAXMAN: Objection to form.

10 A. I have not recruited physicians since the
11 Health and Safety Act was passed.

12 Q. Oh. When did -- When did you -- You
13 recru -- The recruitment efforts that
14 you're talking about occurred before the
15 Women's Health and Safety Act was passed?

16 A. Correct.

17 Q. When did that occur?

18 A. Between 2006 and 2013.

19 Q. When in 2013?

20 A. In 2013 in the spring, I spoke with two
21 physicians about the possibility of
22 providing abortion care for us at Planned
23 Parenthood Southeast. And they both have

1 admitting privileges.

2 Q. But that was before the Women's Health and
3 Safety Act was passed?

4 A. Yes.

5 (Defendant's Exhibit 2 was marked
6 for identification.)

7 Q. Okay. I want to show you a document that
8 we'll mark as Defendant's Exhibit 2. There
9 are three -- In Defendant's Exhibit 2,
10 there are three what appear to be letters
11 from hospitals. And in a second I want you
12 to, you know, scan them and see if you
13 recognize them. These are -- These are
14 documents that were provided by your
15 lawyers in response to our request for any
16 communications your clinic had with
17 hospitals concerning staff privileges.
18 These, I believe, were given to us.

19 A. Okay.

20 Q. Can you look at these -- maybe not read
21 every word, but just scan these and see if
22 they seem familiar to you?

23 A. Okay. I have never seen this.

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] [REDACTED]

A. I don't know. I started working for
Planned Parenthood in 2006, so I don't
know.

Q. Let's go to the next page, which is the
fourth page of Exhibit 3, I believe. It

[REDACTED]

[REDACTED]

[REDACTED] [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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10 [REDACTED]

11 [REDACTED] [REDACTED]

12 [REDACTED]

13 [REDACTED]

14 [REDACTED]

15 [REDACTED]

16 [REDACTED]

17 [REDACTED]

18 [REDACTED]

19 [REDACTED]

20 Q. All right. I want to talk about

21 complications -- if any complications arise

22 during an abortion. And the first question

23 on this topic is if a patient of your

1 near -- at clinics in San Francisco?

2 A. I don't recall.

3 Q. You mentioned that there have been protests
4 at your clinic. Can you tell me what they
5 are like?

6 A. Yes. Tomorrow and for the next 40 days a
7 group called 40 Days For Life will hold a
8 vigil outside of my clinic. They will
9 stand on the sidewalk on the same side of
10 the road as my clinic. They will -- And
11 I'm speak -- I can speak from past
12 experience, so I won't say they will. I'm
13 going to say that have.

14 Arrive at 7 a.m. and leave at 7 p.m.
15 And there are anywhere from two to 20
16 protestors at any given time. They place
17 signs like real estate signs. They'll put
18 anywhere from five to ten signs along the
19 road in front of my clinic in the grass, or
20 in the dirt. They carry signs. They speak
21 to me personally. They use my name,
22 including my nickname.

23 Q. You mean Babs?

1 A. Uh-huh (positive response). Yes.

2 They -- They attempt to stop cars of
3 patients as they enter the property. They
4 encourage the driver to roll down their
5 window and accept written information. As
6 people get out of their cars and walk --
7 make their way through the parking lot to
8 the clinic, the protestors speak to them,
9 photograph them. They photograph their
10 license plates.

11 They tell them that they will buy them
12 diapers. They tell them what wonderful
13 parents they will be and what a blessing a
14 baby is. They tell them that they will
15 take them to Her Choice where they can have
16 a free ultrasound. They tell them -- I'm
17 not going to finish that sentence. They on
18 occasion have called the police to report
19 child abuse and forced -- report that a
20 woman is being coerced into having an
21 abortion. They do this completely without
22 knowledge of why the patient is there.

23 They tell the patients that -- or they

1 tell the people coming in that they need to
2 make sure and go take their -- their
3 partner, or whoever they're with, to a real
4 doctor. They tell them that -- They tell
5 young women that they're going to have a
6 higher risk of breast cancer.

7 And when it's not 40 Days For Life,
8 they are there sporadically one or two days
9 a week, and they engage in the same type of
10 activity.

11 Q. Is it fewer people when it's not 40 Days
12 For Life?

13 A. Yes. The groups are generally from two to
14 seven people.

15 Q. Two to seven people when it's not 40 Days
16 For Life?

17 A. When it's not 40 Days For Life.

18 Q. How many people when it is 40 Days For
19 Life?

20 A. Anywhere from two to 20, 25.

21 Q. You said they speak to you?

22 A. Yes.

23 Q. What do they say to you?

1 A. Harassing phone calls. I need to ask her a
2 question.

3 Q. Are you --

4 MS. FLAXMAN: Do these relate at
5 all to your employment of
6 Planned Parenthood?

7 THE WITNESS: No.

8 MS. FLAXMAN: You didn't ask her
9 whether they were limited to
10 abortion protests.

11 Q. Oh, I'm sorry.

12 THE WITNESS: Thank you.

13 MR. PARKER: Thank you.

14 Q. Have you ever received a harassing phone
15 call from an abortion protestor at your
16 home?

17 A. No.

18 Q. Thank you.

19 Have -- To your knowledge, have any
20 doctors that performed abortions at your
21 clinic ever been followed away from the
22 clinic by an abortion protestor?

23 A. Yes.

1 Q. How often?

2 A. Not often.

3 Q. How many times?

4 A. Twice.

5 Q. Can you -- Can you explain those to me?

6 A. Dr. P5 was followed and Dr. P3 was
7 followed.

8 Q. What do you mean by followed?

9 A. On leaving the clinic, they were followed
10 in a car by one of the -- one or more of
11 the protestors.

12 Q. Is this, like, a couple blocks, or what --
13 Do you know anything about what -- how that
14 incident -- those incidents played out?

15 A. On both occasions, the physicians drove
16 around long enough to lose the protestor.

17 Q. Would you describe the -- all these
18 protests -- 40 Days of Life -- 40 Days For
19 Life and the protests that occur outside
20 that 40-day period as largely peaceful?

21 MS. FLAXMAN: Objection to form.

22 A. Largely but not always.

23 Q. How much money does it cost to bring -- Do

Exhibit UU

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

PLANNED PARENTHOOD SOUTHEAST,
INC., et al.,

Plaintiffs,

Vs.

CIVIL ACTION NO.
2:13-CV-405-MHT

LUTHER STRANGE, in his official
capacity as Attorney General of the
State of Alabama, et al.,

Defendants.

* * * * *

DEPOSITION OF KIWANA BROOKS, taken pursuant
to stipulation and agreement before Haley A.
Phillips, Certified Court Reporter, ACCR # 151, and
Commissioner for the State of Alabama at Large, in
the Law Offices of ACLU Montgomery Office, 207
Montgomery Street, Montgomery, Alabama, on Tuesday,
September 24, 2013, commencing at approximately
1:48 p.m.

* * * * *

1 Q. When -- When was that?

2 A. It ended maybe a month ago.

3 Q. And how long -- When did you start
4 supervising the Birmingham location?

5 A. Roughly in 2010.

6 Q. Okay. When did you start supervising the
7 Hattiesburg location?

8 A. Oh. 2011.

9 Q. And your -- And 2011 to present -- 2011 to
10 present you've been supervising
11 Hattiesburg?

12 A. That's correct.

13 Q. When did you start super -- Do you
14 supervise the Mobile clinic?

15 A. I do.

16 Q. When did you start supervising that clinic?

17 A. 2008.

18 Q. And you currently supervise Mobile. So
19 2008 to present you supervised Mobile?

20 A. That's correct.

21 Q. So at one time, you were supervising three
22 clinics; is that correct?

23 A. That's correct. Well, regional director of

1 A. I don't recall.

2 Q. Okay. Did you -- Were you trying to -- Why
3 did you look at your competitors' prices?

4 [REDACTED]
5 [REDACTED] [REDACTED]
6 [REDACTED]
7 [REDACTED]
8 [REDACTED]

9 Q. Does it make -- Did you -- Did the team
10 want to try to price your abortions less --
11 like, less than the Pensacola perhaps to
12 increase --

13 A. We would --

14 Q. -- traffic?

15 A. I honestly believe in the care that we give
16 our patients. I want every patient if they
17 have to go through an abortion to come to
18 Planned Parenthood. Yeah.

19 Q. Okay. Do you know if as a result of that
20 price change you did decrease your price to
21 underneath the price charged by Pensacola?

22 [REDACTED]
23 [REDACTED]

1 not on this list who should be on it in
2 order to make for a complete list of all
3 the doctors that have worked at the Mobile
4 clinic in the last three years?

5 A. No.

6 Q. Okay. And just to summarize again, can you
7 tell me which of the doctors currently work
8 in Mobile clinic -- the Mobile clinic?

9 A. Mary Roe and Dr. P1 and indirectly Dr. P10.

10 Q. Okay. For Dr. Roe, what does -- What does
11 Dr. Roe do at your clinic?

12 A. She performs abortions at our centers, and
13 she also is our medical director.

14 Q. For the Mobile clinic?

15 A. Yes.

16 Q. Okay. Is she also the medical director at
17 Birmingham?

18 A. Yes.

19 Q. Okay. How often does Dr. Roe come to the
20 Mobile clinic?

21 A. It varies.

22 Q. Okay. What does it vary on?

23 A. Like at -- Rephrase that. I mean, repeat

1 that.

2 Q. What does her schedule vary on? What
3 factors determine when she comes to Mobile?

4 A. Mostly her availability.

5 Q. Okay. On average, how often does she come
6 per month for the past year?

7 A. Usually, once a month.

8 Q. When she comes to the clinic, does she --
9 to the Mobile clinic, does she stay
10 overnight anywhere?

11 A. No.

12 Q. When did you first speak with Dr. Roe?

13 A. I don't recall the exact date, but it was
14 within maybe the first month of when she
15 started.

16 Q. Do you remember when that was?

17 A. I don't remember the exact --

18 Q. Do you remember if -- Were you
19 administrator at the time?

20 A. Yes.

21 Q. Do you -- Do you play a role in hiring --
22 Yeah. Do you play any roles in hiring
23 doctors --

1 come to your clinic? Who schedules that?

2 A. Our medical director.

3 Q. So Mary Roe?

4 A. Yes, Mary Roe.

5 Q. Do you ever talk to Mary Roe about
6 scheduling doctors?

7 A. She'll come -- Well, after the schedule is
8 made, she'll confirm that we do have enough
9 staff to handle the days that are
10 available.

11 Q. So she tells you here's what procedure days
12 we're going to have this year. Is it done
13 on a yearly basis?

14 A. It's done on a monthly basis.

15 Q. Monthly basis.

16 And remind me again how many per month,
17 usually.

18 A. If we're looking at one per week, it's an
19 average of four or five depending on the
20 month.

21 Q. Okay. Has Dr. Roe ever told you that
22 Planned Parenthood Mobile would have to not
23 schedule a procedure day due to abortion

1 protests?

2 A. No, not that I can recall.

3 Q. Have you ever heard of a doctor,
4 specifically in connection with the Planned
5 Parenthood of Mobile, that did not want to
6 come because of abortion protests?

7 A. We've had a physician in the past that
8 decided not to come anymore because of
9 protesters.

10 Q. Okay. Do you know what -- Is there a
11 specific incident that led to that doctor's
12 decision?

13 A. To my knowledge, it had something to do
14 with the protesters just having a lot of
15 personal information.

16 Q. Okay. So just the fact that they had the
17 information -- personal information about
18 this doctor --

19 A. Uh-huh (positive response).

20 Q. -- was what led to her concern and led her
21 not to come to perform abortions at Mobile
22 anymore?

23 A. Yes. Well, it wasn't the Mobile center.

1 It was the Birmingham center.

2 Q. Okay. What about the Mobile center? Have
3 you ever heard of any doctors --

4 A. Well, I'll rephrase that. Because she
5 worked for both, so I guess it would have
6 been both. But she did more services for
7 Birmingham.

8 Q. Is that doctor on this list?

9 A. Yes.

10 Q. Which doctor is that?

11 A. It's Dr. P3.

12 Q. Okay. Did -- To your knowledge, did anyone
13 ever act violently in respect to Dr. P3?

14 MS. FLAXMAN: Objection to form.

15 A. It would really define -- You're going to
16 have to define what you mean by violently.

17 Q. Was Dr. P3 ever assaulted -- physically
18 assaulted?

19 A. No, not -- not to my knowledge.

20 Q. Okay. Was Dr. P3 ever, like, personally
21 confronted in a harassing manner?

22 A. All of our physicians are confronted in a
23 harassing manner.

1 Q. Okay. Let's -- Let's talk more about
2 Dr. P10. I think you said a second ago
3 that Dr. P10 is an outside covering
4 physician.

5 A. That is correct.

6 Q. What does that mean to be an outside
7 covering physician?

8 A. It means that if anything were to happen
9 with any of our patients and they needed to
10 seek services at a hospital that he would
11 be the person that would be able to admit

12

13 Q. Okay. Is Dr. P10 your only outside
14 covering physician right now?

15 A. Yes.

16 Q. Okay. Have you had others?

17 A. Since I've been employed with PFFC, no.
18 And we were speaking with respect to the
19 Mobile center.

20 Q. Correct.

21 A. Yeah.

22 Q. Correct.

23 How often do you talk -- do you

1 essentially -- Scratch that.

2 It's your understanding that Dr. P10 is
3 paid nothing in compensation for his
4 willingness to cover as your outside
5 covering physician?

6 A. Meaning that as far as Planned Parenthood
7 Southeast? No, we -- They -- We do not
8 compensate Dr. P10 for his services.

9 Q. Okay. Does Dr. P10 ever come to the
10 clinic?

11 A. No. He's never had any reason to.

12 Q. Okay. In the times that you've been at the
13 Mobile clinic, how many times has he
14 been -- has he ever been called upon to
15 provide services to a patient?

16 A. To my knowledge, twice.

17 Q. Do you remember when those were --
18 incidents were?

19 A. Roughly one in 2009. The second case, I
20 don't recall.

21 Q. The 2009 incident, do you remember -- can
22 you tell me what happened there?

23 A. Yes. There was an incident in the clinic

1 where -- where, I believe, that it may have
2 been a perforated uterus --

3 And, again, I'm only speculating. I
4 think that's what the diagnosis was.

5 -- where we had to call him so that he
6 could see her at the hospital.

7 Q. Okay. When you say you're speculating,
8 you're -- you're answering based on the
9 best of your memory?

10 A. That's correct. I'm sorry. To the best of
11 my memory.

12 Q. And what did Dr. P10 do at the hospital
13 with that patient?

14 A. To the best of my knowledge, I think that
15 he performed -- No. What did he do? I
16 don't remember. But he treated the patient
17 successfully.

18 Q. Why was he -- Why was he called? First of
19 all, who called Dr. P10?

20 A. It was either Dr. P5 or myself.

21 Q. Okay. Why do you say it might be Dr. P5?

22 A. Because I would have initiated the call and
23 given him a breakdown of the information,

1 your hands. But did Dr. P5 give you any
2 indication as to why you should call
3 Dr. P10?

4 A. Dr. P5 told me to get Dr. P10 on the
5 phone. So it's been -- It's been so long
6 ago. But I'm sure -- He gave me
7 instructions to call Dr. P10 and, again, I
8 got him on the phone for Dr. P5.

9 Q. Did Dr. P5 use Dr. P10's name, or did he --
10 Dr. P5 say something more generic like can
11 you get our doctor -- our outside covering
12 physician on the line?

13 A. I don't recall.

14 Q. Okay. Have you ever talked to Dr. P10
15 about abortions in general?

16 A. Yes, I have.

17 Q. Okay. Has he ever discussed -- Well, first
18 of all, I think you said -- Do you know if
19 he's ever performed abortions?

20 A. I wouldn't know.

21 Q. Okay. Have you ever talked about him --
22 talked to him about whether he was willing
23 to perform abortions?

1 A. I have.

2 Q. And what did he say?

3 A. He was not interested.

4 Q. Okay. Did he give a reason why?

5 A. He felt like with the political climate
6 there that that wouldn't be in his best
7 interest.

8 Q. Even though he is already associated with
9 Planned Parenthood Mobile?

10 A. That is correct. And I have to say he's
11 not publicly -- publicly associated with
12 us.

13 Q. Did he ever indicate that his staff
14 privileges might be put in jeopardy if he
15 was willing to perform abortions at your
16 clinic?

17 A. From the conversation, I could -- I could
18 assume that's what he was telling me. So
19 yes, kind of hinted around as if -- And
20 this is a conversation, like, he would be
21 blackballed pretty much. So it was not in
22 his best interest to perform abortions for
23 us or to be publicly associated with us.

1 Q. Did he use the term "blackball", or is that
2 your term?

3 A. I don't remember. I don't remember.

4 Q. Okay. Did he talk about being blackballed,
5 to use that term, at the hospital or was it
6 more in the community generally?

7 A. If he said it, then I think from the
8 conversation it would have been from the
9 hospital, or his partners.

10 Q. I don't understand why you say if he said
11 it. I mean --

12 A. Well, you asked me whether or not -- was
13 that my term or his term, and I told you I
14 couldn't recall.

15 Q. Okay.

16 A. So --

17 Q. Is there anything that you -- you can --
18 you can remember that gives you a basis for
19 thinking that he would -- that he would be
20 unwelcome at the hospital?

21 A. Repeat that.

22 Q. Is there anything from your conversation
23 with him that he said that you can remember

1 that would give you a basis for thinking
2 that he would be unwelcome at a hospital if
3 he began performing abortions at Planned
4 Parenthood Mobile?

5 A. From -- I don't remember what his exact
6 statement was, but I can gather that he
7 would have some problems in general at the
8 hospital he was working for if he performed
9 abortions at our center.

10 Q. Did he specify the problems, like --

11 A. He didn't specify the problem.

12 Q. Okay. I think we have talked about the
13 Women's Health and Safety Act. Are you
14 familiar with that law? Have you heard of
15 that law before?

16 A. Not by that name.

17 Q. Okay. You're familiar with a requirement
18 of Alabama law that requires doctors
19 performing abortions at abortion clinics to
20 have staff privileges; right?

21 A. Yes.

22 Q. What do you call the law that that
23 requirement is in?

1 A. Beyond my pay grade, so no.

2 Q. Okay. Do you -- Before we leave that. Are
3 you aware of any efforts by anyone at
4 Planned Parenthood Southeast to recruit new
5 doctors that are not currently associated
6 with the Mobile clinic to come to the
7 Mobile clinic that could get -- that could
8 get staff privileges?

9 A. I'm not aware.

10 Q. Okay. Have you ever talked to anybody
11 about that possibility?

12 A. I haven't.

13 Q. Okay. Let's look at this.

14 (Off-the-Record discussion.)

15 A. I take that back.

16 Q. Let's -- Do you have something to clarify?

17 A. Yes. We -- There's one doctor -- I'm
18 sorry. And his name isn't on here. But he
19 does have admitting privileges, and I did
20 ask and he said no. And the only reason at
21 that time that I asked was because he was
22 actually our backup for our family planning
23 nurse practitioners.

1 Q. Uh-huh (positive response).

2 What do you mean by backup to family
3 planning?

4 A. We have to have -- When nurse practitioners
5 practice, you have to have a doctor who
6 have -- well, who they're in collaboration
7 with, and then for that collaborator, you
8 can have somebody that's going to cover
9 her.

10 Q. Did that doctor explain -- Is it a he or
11 she?

12 A. He.

13 Q. Did he say why he would not provide
14 abortion services?

15 A. He said that he was Catholic.

16 (Defendant's Exhibit 6 was marked
17 for identification.)

18 Q. Okay. Let's move on to Defendant's Exhibit
19 6. The page -- The exhibit that I just
20 gave you contains, like, three pages.

21 A. Uh-huh (positive response).

22 Q. But the top entry is an e-mail from -- It
23 appears to be from you to several other

1 to you?

2 A. Yes.

3 Q. Okay. I would ask you to estimate. Do you
4 know how many that is?

5 A. I wouldn't.

6 Q. Yeah.

7 A. Or if they exist. Yeah.

8 Q. Let's -- If it's okay, let's just power
9 through.

10 A. Uh-huh (positive response).

11 Q. Okay. Have you ever heard about any legal
12 claims brought against the Mobile clinic
13 due to -- in connection with allegations of
14 improper care at -- during an abortion at
15 your clinic?

16 A. No. Again, above my pay grade.

17 Q. Have you ever -- Are there ever protests at
18 your clinic --

19 A. Yes.

20 Q. -- abortion protests at your clinic?

21 How often do those happen?

22 A. Daily.

23 Q. Every single day?

1 A. Maybe they don't do it on Sundays.

2 Q. Okay. Are you open on Sundays?

3 A. We are not open on Sunday.

4 Q. So every day that you're open, there is an
5 abortion protest there?

6 A. That is correct.

7 Q. How many people are at the abortion
8 protest?

9 A. It varies.

10 Q. From what to what?

11 A. There have been just one, and I've seen as
12 many as -- as many as 15 to 20.

13 Q. Have you ever heard of something called 40
14 Days of Life -- or 40 Days For Life?

15 A. Yes.

16 Q. Does that start tomorrow?

17 A. What's today?

18 MS. HOWELL: 24th.

19 A. Yes.

20 Q. Is that -- Does that last for 40 days?

21 A. Yes.

22 Q. Does the protests during 40 days of that
23 event -- are they in any way different from

1 the ones that you have every day during
2 other times?

3 A. I would say yes.

4 Q. In what ways?

5 A. During that time, you know, we have some
6 that tend to be more aggressive.

7 Q. Can you just tell me -- start out telling
8 me the basic protests on every day -- not
9 during the 40 Days For Life. Can you tell
10 me what the protests are like?

11 A. Every day it's usually maybe from -- It
12 varies from one to three. And they tend to
13 follow our patients around the building.
14 They tend to try to catch them on their way
15 out to try to give them material and to
16 tell them that, again, whatever they
17 believe. They will follow us around the
18 building to take pictures.

19 Q. When you say they follow you around the
20 building --

21 A. Uh-huh (positive response).

22 Q. -- do they come onto your property?

23 A. They don't. But there's another property

1 adjacent to ours, and they can walk along
2 their side of the fence, so that she's --
3 he or she is able to see us the whole time
4 when they walk along the fence.

5 Q. Okay. I interrupted you. Can you keep
6 describing a typical protest?

7 A. I've had -- Like, even when we come out,
8 they're -- You know, they're there when we
9 come out. I've had one to -- I thought she
10 was following me home. She was behind me,
11 so I had to, you know, circle around the
12 corners to lose her. I'm trying to think
13 of -- You know, as far as the physicians,
14 they tend to say, you know, really bad
15 things.

16 Q. What are some examples of really bad
17 things?

18 A. Calling them killers, leader of genocide.
19 Things of that nature.

20 Q. Have they ever talked to you?

21 A. They have.

22 Q. What do they say to you?

23 A. That they can find me another job. Do I

1 understand that I'm committing genocide.

2 I've had one to verbally attack me.

3 Q. What do you mean by that?

4 A. Meaning that -- I forgot exactly what he

5 said, because it was so many years ago.

6 But I felt that he violated my rights by

7 directly, you know, protesting against me.

8 Q. Was his voice raised?

9 A. It was.

10 Q. Did he use obscenities?

11 A. He did.

12 Q. Was he on the clinic property when he did
13 that?

14 A. He was not.

15 Q. How far away was he from you?

16 A. He was on our sidewalk.

17 Q. How far away was that from you?

18 A. I have no idea.

19 Q. Like 30 feet away?

20 A. No. It's been closer than that. From the
21 backside, maybe as close as maybe six or
22 seven feet. Yeah.

23 Q. Would you say that in general the protests

1 are violent?

2 MS. FLAXMAN: Objection to form.

3 A. It just depends on what you -- I feel like
4 if ...

5 Q. Have you -- Have you ever witnessed
6 physical violence in connection with
7 abortion protests at your clinic?

8 A. No.

9 Q. Let's see. Have -- You said that one time
10 someone -- you believe someone followed you
11 away from the clinic.

12 A. Yes.

13 Q. Are there any other incidences of that?

14 A. Not with me.

15 Q. Have you ever heard of instances of other
16 staff members from your clinic?

17 A. Being follow.

18 Q. Being -- I'm sorry. Being followed.

19 A. No. But just being, what I would call,
20 stalked, yeah. Meaning that if they go
21 from one side of the building to the next,
22 they follow them.

23 Q. Okay. But as far as you're aware as to

1 other staff members and as to you apart
2 from that one instance you told me about,
3 the protesters do not follow any of the
4 staff members away from the building?

5 A. There's only one other incident that I can
6 recall. And it was with Dr. -- It was with
7 P5. They followed him to the interstate.

8 Q. Okay. That was a doctor?

9 A. Yes.

10 Q. Have you ever received harassing letters at
11 the clinic?

12 A. I -- Yes.

13 Q. Okay. Have -- Harassing letters at the
14 clinic -- Have you ever received harassing
15 letters at the clinic that state
16 antiabortion views?

17 A. Yes.

18 Q. How many do you receive of those on a given
19 week?

20 A. I would -- I don't think that it's weekly.
21 If I had to say per year, that would be
22 maybe eight to ten per year.

23 Q. Okay. Have you ever received harassing

1 Alabama. Do you feel like you're qualified
2 to talk about that?

3 A. I do.

4 Q. Why do you feel qualified to talk about
5 that?

6 A. My experience.

7 Q. Okay. Have you ever taken these -- any
8 kind of systematic studies regarding any
9 statistical studies of the burdens faced by
10 low-income women in obtaining abortions in
11 Alabama?

12 A. No.

13 Q. Have you ever received education? Like,
14 have you ever taken any classes in social
15 science research?

16 A. No.

17 Q. What percentage -- Roughly, if you had to
18 guess, what percentage of abortion patients
19 at your clinic are in poverty?

20 A. I would have to say about 90 percent.

21 Q. The -- Do those -- Do those patients -- You
22 said that you would be testifying based on
23 your experience. Do you mean -- Do you