Janet Napolitano
Attorney General
Firm State Bar No. 14000

Kevin D. Ray (007485)
Lynne C. Adams (011367)
Timothy C. Miller (016664)
Assistant Attorneys General
1275 West Washington
Phoenix, Arizona 85007
(602) 542-1610

Attorneys for defendants Catherine Eden and Janet Napolitano

Nikolas T. Nikas (011025)
Denise M. Burke (admitted pro hac vice)
Stephen M. Crampton (admitted pro hac vice)
Brian Fahling (admitted pro hac vice)
Special Deputy Maricopa County Attorneys
c/o 16465 Henderson Pass, #1132
San Antonio, Texas 78232
(210) 494-7781

Attorneys for defendant Richard M. Romley

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Tucson Woman's Clinic, et. al., Plaintiffs, v. Catherine Eden, in her capacity as Director of the Arizona Department of Health Services, et. al., Defendants.	No. CIV 00-141 TUC RCC

DEFENDANTS' AMENDED JOINT RESPONSE TO PLAINTIFFS' AMENDED STATEMENT OF FACTS
and
DEFENDANTS' JOINT MOTION TO PRECLUDE AND MEMORANDUM IN SUPPORT

TABLE OF AUTHORITIES

Cases

Other Authorities

TABLE OF CONVENTIONS

A.A.C.	The Arizona Administrative Code
DHS	The Arizona Department of Health Services, the state agency that is responsible for overseeing the regulation and licensing of abortion clinics pursuant to the Regulatory Act.
NAF	The National Abortion Federation, a professional association of abortion providers that has adopted clinical policy guidelines related to abortion procedures, a copy of which is attached to the accompanying statement of facts as Ex. A.
PPCNA	Planned Parenthood of Central and Northern Arizona, one of the largest abortion providers in Arizona and the author of the Condensed Abortion Protocol which is attached to the accompanying statement of facts as Ex. B.
PPSA	Planned Parenthood of Southern Arizona, a Tucson abortion provider.
The Regulatory Act	A.R.S. §§ 36-449 through 36-449.03, A.R.S. § 36-2301.02 and Title 9, Chapter 10, Article 15 of Arizona Administrative Code, the statutes and regulations governing the licensing of abortion clinics in Arizona and ultrasound review requirements applicable to such clinics.
The State	The State of Arizona and its Legislature.

I. Defendants' Joint Response to Plaintiffs' Amended Statement of Facts.

Defendants respectfully submit the attached response to the plaintiffs' Amended Statement of Facts in Support of Plaintiffs' Motion for Summary Judgment (hereinafter, "statement of facts"). It is largely composed of irrelevant, inadmissible evidence and speculative, unsupported assertions and opinions. Indeed, plaintiffs' statement of facts is more akin to a numbered recitation of their legal argument in this case than to a statement of the specific facts that are material to their motion for summary judgment. Clearly, this type of evidence does not satisfy the burden the plaintiffs must meet to obtain summary judgment. Defendants dispute the vast majority of the statements and assertions made by the plaintiffs in their statement of facts and, in some instances, have provided evidence contrary to that proffered by the plaintiffs. Unless the defendants specifically indicate that a particular statement of fact is "not disputed," defendants dispute, in whole or in part, the statement, assertion, conclusion or opinion offered by the plaintiffs.

II. Motion To Preclude Consideration of Evidence and Memorandum of Law in Support.

Moreover, the defendants respectfully move this court to preclude the consideration of the following portions of the statement of facts pursuant to Fed. R. Civ. P. 56:

A. Irrelevant and Inadmissible Portions of Statement of Facts. Information offered to support a motion for summary judgment must be relevant and admissible at a trial on the merits. *United States v. Dibble*, 429 F.2d 598, 601-02 (9th Cir. 1970); Fed. R. Evid. 402 (only relevant evidence is admissible); Fed. R. Civ. P. 56(c) and (e); Ariz. Dist.

Ct. Rule 1.10(*l*). Courts will exclude from consideration any portion of a party's submissions that is not relevant to the matters at issue in the case. *United States v. Dibble*, 429 F.2d at 601-02. The following paragraphs of the plaintiffs' statement of facts should be precluded from consideration as irrelevant and, therefore, inadmissible:

1. **Paragraphs 51-53, 55 – 108, 136-137** and **141**: These paragraphs discuss surgical and medical procedures – other than abortion – and attempt to compare them to surgical abortions. This discussion is not relevant to any material issue in this case. This case concerns the provision of abortion services in Arizona and the State's regulation of those services. The a description of these other unrelated surgical and medical procedures, along with the attendant risks, complexity, scope and duration of these procedures, is not relevant to the resolution of these issues.

Plaintiffs are obviously proffering this evidence in an attempt to support their equal protection argument. However, as aptly demonstrated in the Defendants' Joint Motion for Partial Summary Judgment on Plaintiffs' Equal Protection Claim, the accompanying memorandum in support and other related pleadings, the plaintiffs' equal protection claims have been soundly rejected by the courts. As the United States Supreme Court and other lower courts have repeatedly recognized, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also*, *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000), *cert. denied*, 121 S.Ct. 1188 (2001) (citing to other U.S. Supreme Court decisions finding that the provision of abortions "significantly differs" from other medical and surgical procedures).

Specifically, plaintiffs' argument that it is unconstitutional to regulate the provision of abortion services while leaving other "comparable" surgical or medical procedures unregulated has been summarily and repeatedly rejected. Most recently, the Fourth Circuit Court of Appeals observed that

> [t]he rationality of distinguishing between abortion services and other medical services when regulating physicians or women's health care has been long acknowledged by Supreme Court precedent. Beginning with *Roe* itself, the Court recognized ... the special medical interest of the women seeking abortions ... The long stream of cases that followed *Roe* has only heightened an awareness that for purposes of regulation, abortion services are rationally distinct from other routine medical services

Greenville Women's Clinic v. Bryant, 222 F.3d at 173-74. *See also Women's Medical Center of Northwest Houston v. Archer*, No. H-99-3639, slip. op. at 81(S.D. Tex. 1999) ("the classification between physicians who perform abortions in their offices and physicians who perform other, comparable surgical procedures in their offices can be said to bear a rational relationship to a legitimate state end.") That "legitimate state end," as is the case with the Regulatory Act, is protecting the health and safety of women seeking abortions.

Simply, the State may regulate the provision of abortions while leaving other medical and surgical procedures unregulated. A discussion, description or comparison of other medical procedures is, therefore, not relevant. Thus, plaintiffs have no relevant legal or factual basis to support the admission of the evidence contained in paragraphs 51-53, 55-108, 136-137 and 141 and it should be precluded from consideration.

2. **Paragraph 114**: In this paragraph, plaintiffs assert that physicians who commit malpractice are practicing medicine outside established standards. While

arguably true, this has no bearing on any material issue in this case. The Regulatory Act does not deal with physician malpractice and does not apply to any action that could be taken by the Arizona Board of Medical Examiners ("BOMEX") to remedy or counter physician malpractice.

3. **Paragraph 119**: In this paragraph, plaintiffs assert that Lou Anne Herron's death could have been prevented if "life-saving actions already required by existing law" were taken. Whether or not this is true, it is irrelevant to any material issue in this case. It has no bearing on the appropriateness of the individual provisions of the Regulatory Act or of the Regulatory Act in its entirety.

4. **Paragraphs 125-128, 132, 147**: In these paragraphs, plaintiffs purport to offer information about ultrasounds and other diagnostic tests used in connection with gynecological and medical procedures other than abortion. This case concerns the provision of abortion services in Arizona and the State's regulation of those services. The use of ultrasounds and other diagnostic tests in medical procedures other than abortion is not relevant to the resolution of these issues. As previously stated, the State may regulate the provision of abortions –including what training abortion providers must have to perform ultrasounds and requiring an independent review of some ultrasound prints made in connect with an abortion - while leaving the use of diagnostic tests in other medical and surgical procedures unregulated.

5. **Paragraph 154**: This paragraph is a pure legal and/or factual argument, as opposed to an objective fact. As such, it is irrelevant.

6. **Paragraph 168**: In this paragraph, the plaintiffs assert that confidential medical information is "frequently" disclosed by people who have an obligation to maintain patient confidentiality. This allegation does not implicate the Arizona Department of Health Services ("DHS") in any breach of patient confidentiality. In fact, it does not identify the purported source for the alleged breaches of confidentiality. The Regulatory Act only implicates DHS's ability to maintain patient confidentiality. Breaches of confidentiality by any other person or entity are not relevant to any review of the appropriateness of the Regulatory Act or DHS's duty in administering it.

7. **Paragraph 182**: In this paragraph, plaintiffs assert that Dr. Sherrylyn Young has chosen not to maintain hospital admitting privileges and has never had to admit a patient to the hospital. This is irrelevant because Dr. Young no longer has standing to participate in this lawsuit. She closed her practice on June 1, 2001 and retired. Moreover, her personal decision not to maintain admitting privileges has no bearing on the appropriateness of A.A.C. R9-10-1506(B)(2), requiring that a physician in the abortion clinic have admitting privileges at a local hospital and be in the facility while abortions are being performed.

8. **Paragraph 185**: In this paragraph, plaintiffs assert that some physicians are self-trained or trained by other physicians in the use of ultrasounds. This assertion has no bearing on the medical appropriateness of the ultrasound training requirements in A.A.C. R9-10-1505(3) and is, therefore, irrelevant

9. **Paragraph 206**: In this paragraph, plaintiffs assert that Plaintiff Raphael believes his current staffing levels are appropriate and that he believes DHS's evaluation

of his staffing will differ from his own. The purported basis for this assertion is that he does not currently comply with the staffing requirements of the Regulatory Act. Whether Plaintiff Raphael believes his judgment is in accord with the Regulatory Act or DHS's enforcement of the requirements of the Regulatory Act is irrelevant. His personal belief has no bearing on the appropriateness of the staffing provisions of the Regulatory Act or DHS's method of enforcement.

B. Inadmissible Hearsay. Materials (including statements of fact) supporting summary judgment must not be hearsay. *Kim v. United States*, 121 F.3d 1269, 1276-77 (9th Cir. 1997). In **Paragraph 116**, plaintiffs attempt to introduce evidence about a comment allegedly made by the former Director of DHS concerning whether or not any regulation could have saved Lou Anne Herron, a women who died in 1998 as a result of substandard abortion-related care. The plaintiffs did not obtain this alleged comment directly from the former DHS Director. Instead, it came from the notes and recollection of another DHS employee who attended the meeting where the comment was allegedly made. As such, it is clearly hearsay and inadmissible. Moreover, it is also irrelevant.

C. Declarant Lacks Personal Knowledge of Facts Asserted. Materials supporting summary judgment must be based on personal knowledge or be an expert opinion. . *Kim v. United States*, 121 F.3d 1269, 1276-77 (9th Cir. 1997). The following paragraphs of the plaintiffs' statement of facts should be precluded from consideration because the declarant lacks personal knowledge of the facts asserted. In **Paragraphs 103-104** and **106-108**, plaintiffs attempt to offer evidence that patients have died during surgical procedures other than abortion. While this is clearly not relevant, *see* 3-4, *supra*, the

plaintiffs have also failed to demonstrate that the declarants, Dr. Sherrylyn Young and Dr. Jeffrey Taffett, have personal knowledge of the facts asserted or have any factual basis or foundation for making the assertions.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
1. Plaintiffs are physicians and reproductive health care clinics that offer abortions, along with other medical services, in private physicians' offices or clinics ("physician practices").	1. The defendants do not dispute that the plaintiffs are licensed physicians who offer abortions in office and/or clinical settings. However, defendants state that the plaintiffs' offices and clinics qualify as "abortion clinics" under the Regulatory Act.
2. Plaintiff Dr. Damon S. Raphael is a board certified obstetrician and gynecologist, who is licensed to practice medicine in the state of Arizona and who has practiced medicine in the State since 1967.	2. Not disputed; however, the defendants state that the proper citation to the Declaration of Damon S. Raphael is paragraph 1 not paragraph 2.
3. Dr. Raphael currently provides a range of gynecological services at his physician practice, Plaintiff Tucson Woman's Clinic ("TWC").	3. Plaintiff Raphael and Plaintiff TWC currently provide patients with abortions and birth control. Plaintiff Raphael no longer provides regular, routine gynecologic services. Raphael dep. at 30-31.
4. These services include the performance of approximately 125 first trimester abortions by the suction currettage method.	4. In March 2000, Plaintiff Raphael reported performing approximately 125 first trimester abortions per month; however, in the late summer or early fall of 2000, he experienced a 50% decrease in the number of abortions he performed each month because of increased competition from another abortion provider. Raphael dep. at 39-40.
5. Plaintiff Dr. William Richardson is a board certified obstetrician and gynecologist, who is licensed to practice medicine in the state of Arizona and has practiced medicine for fifteen years.	5. Not disputed.
6. Dr. Richardson currently provides a range of gynecological services at his physician practice, Plaintiff Old Pueblo Family Planning ("OPFP").	6. Not disputed.
7. These services include approximately 50 first trimester abortions per month by the suction currettage method.	7. Not disputed.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
8. Other services that Dr. Richardson performs in his physician practice include: pregnancy testing; screening for sexually transmitted diseases; contraceptive planning; tubal ligations; and well-woman care.	8. Not disputed.
9. Plaintiff Dr. Sherrylyn Young is a physician licensed in Arizona who has completed a residency in Obstetrics and Gynecology and practiced obstetrics and gynecology for over sixteen years.	9. Not disputed. However, defendants assert that Dr. Sherrylyn Young has retired and closed her medical practice and thus no longer had standing in this lawsuit. To the end, the plaintiffs and defendants have stipulated to her dismissal as a plaintiff.
10. Until June, 2001, Dr. Young ~~currently~~ provided a range of gynecological services in her private medical office in Tucson.	10. Not disputed.
11. These services included approximately twenty first trimester abortions per month by the suction currettage method.	11. The number of first trimester abortions that Plaintiff Young provides each month is "very, very variable," but generally ranges from a low of 6 per month to a high of 20 or 25 per month. Young dep. at 21-22.
12. Other medical services that Dr. Young provides in her office include: diagnosis and treatment of cervical displasia; cervical cone biopsies; cryosurgery; dilation and currettage; hormonal replacement therapy; endometrial biopsis; contraceptive counseling and provision; and pregnancy testing.	12. Not disputed.
13. Plaintiff Dr. Robert Tamis is a board certified obstetrician and gynecologist, who is licensed to practice medicine in the state of Arizona and has practice medicine for over thirty-eight years.	13. Not disputed.
14. Dr. Tamis currently provides a range of gynecological services at his physician practice in Tucson.	14. Disputed, but irrelevant. Plaintiff Tamis maintains medical practices in Phoenix, not Tucson. Tamis dep. at 4-6.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
15. This includes approximately 200 abortions per month.	15. Defendants do not dispute that Plaintiff Tamis provides approximately 200 abortions per month; however, defendants state that this includes approximately 100 first trimester and 100 second trimester abortions each month. Tamis dep. at 152.
16. At his physician practice, Dr. Tamis performs abortion in the first trimester and second trimesters [sic] of pregnancy up to 19.5 weeks lmp using the suction currettage or dilation and evacuation (D&E) methods.	16. Not disputed.
17. Other services that Dr. Tamis provides in his physician practice include infertility screening and treatments.	17. Not disputed, but defendants state that Plaintiff Tamis provides infertility screening and treatment through Robert H. Tamis, M.D., P.C., a professional corporation that is incorporated and organized separately from SIMAT Corporation d/b/a Abortion Services of Phoenix, the corporation through which he provides abortion services. Tamis dep. at 6-7.
18. Prior to the enactment of the challenged regulatory scheme, Plaintiffs' physician practices were neither licensed nor regulated by the Arizona Department of Health Services ("DHS").	18. Defendants do not dispute that the plaintiffs and their practices were unlicensed and unregulated by DHS prior to the passage of the Regulatory Act.
19. The purpose of the regulatory scheme is to create an oversight mechanism to regulate abortion providers.	19. Disputed. The purpose of the Regulatory Act is to protect maternal health and to protect the health, welfare and safety of the public. Howard. dep. at 50-51; Raphael dep. at 118, 138.
20. All of the plaintiffs have been providing safe abortions within their existing facilities for many years.	20. Disputed, but not material.
21. Apart from the challenged regulatory scheme, the Plaintiffs' physician practices are already subject to a range of controlling standards.	21. Defendants do not dispute that plaintiffs' practices are subject to state and federal regulatory requirements and oversight.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
22. For example, some of the Plaintiffs' facilities are subject to the federal Clinical Laboratory Improvement Amendments of 1988 ("CLIA") standards, 42 U.S.C. § 263a, because they contain laboratories.	22. Not disputed.
23. Some of the Plaintiffs' facilities are also subject to the Occupational Safety and Health Act ("OSHA") regulations regarding their employees' safety.	23. Not disputed.
24. All of the Plaintiffs' medical facilities are subject to local building codes, including fire codes.	24. Not disputed.
25. Additionally, each of the Plaintiff physicians is licensed by the State of Arizona to practice medicine and is thereby subject to oversight, investigation and discipline by the Board of Medical Examiners.	25. Not disputed. However, defendants state that the well-publicized failure of the Arizona Board of Medical Examiners ("BOMEX") to oversee, investigate and discipline a substandard abortion provider, Dr. John I. Biskind, contributed to the 1998 death of Lou Anne Herron. BOMEX's failure also provided some impetus to enact and pass the Regulatory Act. Howard dep. at 57-58; Raphael dep. at 116.
26. Each of the Plaintiff physician practices is also subject to professional and ethical standards applicable to the practice of medicine and may be sued for malpractice for violation of those standards.	26. Not disputed.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
27. Abortions prior to 20 weeks lmp ("pre-20 week abortions") are safe procedures that can be safely performed in physician practices.	27. Disputed. While abortions prior to 20 weeks lmp can, under certain circumstances, be safely performed in physician practices, defendants state that "pre-20 week abortions" are associated with numerous and serious potential complications including bleeding, infection, uterine perforation, blood clots in the uterus, hemorrhage, cervical tears, incomplete abortions (retained tissue), failure to actually terminate the pregnancy, a reaction to anesthesia, possible problems with future fertility, emotional problems, free fluid in the abdomen, acute abdomen, missed ectopic pregnancies, cardiac arrest, sepsis, respiratory arrest, and death. Exhibit 2 to Deposition of Bryan Howard, "Fact Sheet About Early Abortion;" Raphael dep. at 53-54; Tamis dep. at 66.
28. The guidelines of the American College of Obstetricians and Gynecologists ("ACOG"), explicitly state that first trimester and earlier second trimester abortions may be performed in physicians' office [sic] and outpatient clinics.	28. Defendants do not dispute that the ACOG guidelines make this assertion.
29. First trimester abortions are typically performed using the suction currettage procedure.	29. Not disputed.
30. The suction currettage procedure generally involves the following steps: cleaning the genital area; opening the vagina with a speculum; applying local anesthesia at the cervix; grasping the cervix with a tenaculum to stabilize it; dilating the cervix by inserting thin metal rods of increasing diameter sizes or by giving the drug misoprostol; inserting a suction catheter (hollow plastic tube) into the uterus; and then applying suction to the end of the tube to withdraw the contents of the uterus.	30. Not disputed.
31. The suction currettage abortion procedure takes approximately 2 to 5 minutes	31. Not disputed.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
32. The suction currettage procedure has an excellent safety record.	32. Disputed. Defendants state that the actual number of women suffering abortion-related complications is impossible to accurately quantify because there are no uniform, state data collection laws for abortion. Grimes dep. at 32. Moreover, the Center for Disease Control has a voluntary reporting system and cannot guarantee that negative information is not being underreported. Grimes dep. at 32, 52, 127.
33. The mortality rate for the procedure is less than 1 in 100,000, much less than the mortality rate for childbirth.	33. Disputed. Defendants state that the actual number of women suffering abortion-related complications is impossible to accurately quantify because there are no uniform, state data collection laws for abortion. Grimes dep. at 32. Moreover, the Center for Disease Control has a voluntary reporting system and cannot guarantee that negative information is not being underreported. Grimes dep. at 32, 52, 127.
34. The rate of complications from the suction currettage procedure is also low.	34. Disputed. Defendants state that the actual number of women suffering abortion-related complications is impossible to accurately quantify because there are no uniform, state data collection laws for abortion. Grimes dep. at 32. Moreover, the Center for Disease Control has a voluntary reporting system and cannot guarantee that negative information is not being underreported. Grimes dep. at 32, 52, 127. For example, one Phoenix abortion provider, Dr. Joel Bettigole, estimates that 4 to 5% of first trimester abortion patients experience blood clots, requiring resuctioning. Bettigole dep. at 32.
35. The dilation and evacuation ["D&E"] procedure is the abortion method most commonly used in the second trimester of pregnancy.	35. Not disputed.
36. D&E requires greater dilation than suction currettage because larger instruments are used.	36. Defendants do not dispute that a dilation and evacuation abortion generally requires greater dilation.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
37. The physician achieves this greater dilation by inserting osmotic dilators, or laminaria, into the cervix and leaving them in place for a number of hours or overnight or by administering the drug misoprostol. Laminaria are small rods of seaweed that slowly expand as they absorb fluids, thereby gently and safely dilating the cervix. While the laminaria are in place, the patient is usually able to go about her ordinary business.	37. Defendants do not dispute that this is generally how the requisite dilation for a dilation and evacuation abortion is achieved.
38. Once the cervix is adequately dilated, the physician evacuates the uterus using a combination of suction and forceps. No incisions are made during a D&E, and general anesthesia need not be administered.	38. Defendants do not dispute that this is generally how the procedure is completed.
39. Up to sixteen weeks lmp, D&E is very similar to suction currettage, and suction rather than forceps are primarily used to evacuate the uterus.	39. Defendants do not dispute that this is how some physicians perform dilation and evacuation abortions prior to 16 weeks lmp.
40. The D&E procedure takes approximately 5-10 minutes.	40. Defendants do not dispute that some physicians perform a dilation and evacuation abortion in 5-10 minutes; however, defendants state that some physicians may take more or less time to perform the procedure.
41. Neither suction currettage nor D&E procedures necessitate the use of general anesthesia; Plaintiffs use local anesthesia and, in some cases, conscious sedation.	41. Defendants state that physicians performing these types of abortions may use a wide range of anesthesia and sedation, including general anesthesia in certain circumstances.
42. Once the physician completes the suction currettage or D&E procedure, the patient is usually taken to a recovery area, where she rests in a reclining chair or bed until ready for discharge.	42. Defendants do not dispute that this is how the plaintiffs conduct their practices; however, plaintiffs cannot speak for all physicians performing abortions in Arizona or for how they recover their patients after surgery.

Plaintiffs' Statement of Facts	***Defendants' Joint Response***
43. After either a suction currettage procedure or pre-20 week D&E, the patient is generally ready for discharge within approximately ten minutes to forty-five minutes after surgery.	43. Defendants do not dispute that this is how the plaintiffs conduct their practices; however, plaintiffs cannot speak for all physicians performing abortions in Arizona or for how long these other physicians allow a patient to recover from surgery before discharge.
44. Like suction currettage, D&E has an excellent safety record.	44. Disputed. Defendants state that the actual number of women suffering abortion-related complications is impossible to accurately quantify because there are no uniform, state data collection laws for abortion. Grimes dep. at 32. Moreover, the Center for Disease Control has a voluntary reporting system and cannot guarantee that negative information is not being underreported. Grimes dep. at 32, 52, 127. Defendants further state that the risks for second trimester abortions are even greater than those for first trimester abortions and include hysterectomy, other surgery and blood transfusion. Raphael dep. at 13-15, 54.
45. Mortality rates for abortion increase with increasing gestational age.	45. Not disputed.
46. Nonetheless, D&E abortions up to 20 weeks lmp are still safer than continued pregnancy and childbirth.	46. Disputed. Defendants state that the actual number of women suffering abortion-related complications is impossible to accurately quantify because there are no uniform, state data collection laws for abortion. Grimes dep. at 32. Moreover, the Center for Disease Control has a voluntary reporting system and cannot guarantee that negative information is not being underreported. Grimes dep. at 32, 52, 127.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
47. Complications from D&E or suction currettage are not common, but can include excessive bleeding, infection, vasovagal shock, and uterine perforation.	47. Defendants dispute the assertion that complications from suction currettage and D&E abortions are not "common." Defendants state that the actual number of women suffering abortion-related complications is impossible to accurately quantify because there are no uniform, state data collection laws for abortion. Grimes dep. at 32. Moreover, the Center for Disease Control has a voluntary reporting system and cannot guarantee that negative information is not being underreported. Grimes dep. at 32, 52, 127. Defendants do not dispute that the listed complications are complications from suction currettage and D&E abortions. However, defendants note that "pre-20 week abortions" have numerous and serious complications including bleeding, infection, uterine perforation, blood clots in the uterus, hemorrhage, cervical tears, incomplete abortions (retained tissue), failure to actually terminate the pregnancy, a reaction to anesthesia, possible problems with future fertility, emotional problems, free fluid in the abdomen, acute abdomen, missed ectopic pregnancies, cardiac arrest, sepsis, respiratory arrest, and death. Exhibit 2 to Deposition of Bryan Howard, "Fact Sheet About Early Abortion;" Raphael dep. at 53-54; Tamis dep. at 66.
48. Abortion safety has dramatically improved since being legalized in the 1970s and continues to improve.	48. Disputed. Defendants state that the actual number of women suffering abortion-related complications is impossible to accurately quantify because there are no uniform, state data collection laws for abortion. Grimes dep. at 32. Moreover, the Center for Disease Control has a voluntary reporting system and cannot guarantee that negative information is not being underreported. Grimes dep. at 32, 52, 127.
49. Over the last twenty-seven years, more and more abortions have been performed in physician practices and other outpatient settings.	49. Not disputed.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
50. The impressive abortion safety record in the United States has benefited from, rather than been threatened by, the performance of abortion procedures in outpatient settings.	50. Defendants dispute the reliability of the abortion statistics underlying this claim and assert that this in an opinion of a witness and not a "fact." Defendants state that the actual number of women suffering abortion-related complications is impossible to accurately quantify because there are no uniform, state data collection laws for abortion. Grimes dep. at 32. Moreover, the Center for Disease Control has a voluntary reporting system and cannot guarantee that negative information is not being underreported. Grimes dep. at 32, 52, 127.
51. Many surgical procedures other than abortion are performed in physician practices in Arizona and elsewhere.	51. Not disputed, but irrelevant.
52. These include gynecological procedures performed by the Plaintiffs in their physician practices.	52. Not disputed, but irrelevant.
53. These also include general surgery, head and neck surgery, oral surgery and plastic surgery.	53. Not disputed, but irrelevant.
54. Physicians choose among the different settings for surgery (physician practices, ambulatory surgical centers, hospitals) primarily on the basis of the magnitude of the procedure to be performed.	54. Defendants do not dispute that many factors influence a decision as to where to perform a particular surgical procedure.
55. There are a number of benefits to performing minor surgical procedures in a physician practice rather than an ambulatory surgical center or hospital: (1) it is usually more convenient and less anxiety-producing for the patient; (2) it is much less expensive for the patient, who can avoid facility charges imposed in other settings; and (3) it is more efficient and cost effective for the physician.	55. Not disputed, but irrelevant.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
56. Many procedures performed in physician practices in Arizona and elsewhere are comparable to abortion prior to 20 weeks lmp in terms of the type of risks involved, the degree of invasiveness of the procedures, the type of instrumentation used, the duration of the surgery, and the patient's needs with respect to physical facility, policies and procedures, staffing, emergency transfer agreements, and physician competence.	56. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).
57. Hysteroscopy, which is performed in physician practices, involves the insertion of a tube containing a small camera through the cervix to permit visualization of the interior of the uterus.	57. Not disputed, but irrelevant. Defendants state that hysteroscopies are also performed in other settings such as outpatient treatment/surgical centers and hospitals. Farnsworth dep. at 34.
58. Hysteroscopy is comparable to pre-20 week abortions in terms of the type of risks involved, the degree of invasiveness of the procedures, the type of instrumentation used, the duration of the surgery, and the patient's needs with respect to physical facility, policies and procedures, staffing, emergency transfer agreements, and physician competence.	58. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).
59. Surgical treatment of miscarriage, which is performed in physician practices, involves essentially the same steps as a suction currettage abortion, except less dilation is usually needed.	59. Not disputed, but irrelevant. However, defendants state that surgical treatment of miscarriage is also performed in other settings such as outpatient treatment/surgical centers and hospitals. Farnsworth dep. at 15.
60. Surgical treatment of miscarriage is comparable to pre-20 week abortions in terms of the type of risks involved, the degree of invasiveness of the procedures, the type of instrumentation used, the duration of the surgery, and the patient's needs with respect to physical facility, policies and procedures, staffing, emergency transfer agreements, and physician competence.	60. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
61. Diagnostic dilation and currettage, which is performed in physician practices, involves essentially the same steps as a suction currettage abortion.	61. Not disputed, but irrelevant. However, defendants state that diagnostic dilation and currettage can be performed in other settings such as outpatient treatment/surgical centers and hospitals.
62. Diagnostic dilation and currettage is comparable to pre-20 week abortions in terms of the type of risks involved, the degree of invasiveness of the procedures, the type of instrumentation used, the duration of the surgery, and the patient's needs with respect to physical facility, policies and procedures, staffing, emergency transfer agreements, and physician competence.	62. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).
63. Endometrial biopsy, which is performed in physician practices, involves the removal of the uterine line by suction.	63. Not disputed, but irrelevant. However, defendants state that endometrial biopsies can be performed in other settings such as outpatient treatment/surgical centers and hospitals.
64. To perform the procedure, the physician stabilizes the cervix with a tenaculum, dilates the cervix if necessary, inserts a currette through the cervix into the uterine cavity, and suctions out the uterine lining using negative suction.	64. Not disputed, but irrelevant.
65. Endometrial biopsy is comparable to pre-20 week abortions in terms of the type of risks involved, the degree of invasiveness of the procedures, the type of instrumentation used, the duration of the surgery, and the patient's needs with respect to physical facility, policies and procedures, staffing, emergency transfer agreements, and physician competence.	65. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).
66. Cervical cone biopsy is also performed by some physicians in their physician practices.	66. Not disputed, but irrelevant. However, defendants note that cervical cone biopsies are also performed in other settings such as outpatient treatment centers and hospitals.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
67. In this procedure, after the patient has been given intravenous anesthesia and a local anesthetic, the physician surgically removes a central portion of the cervix using electrical loop excision.	67. Not disputed, but irrelevant.
68. This procedure is more complex than abortion in the sense that the physician must cut through tissue and the chance of post-operative bleeding is higher.	68. Irrelevant. Defendants do not dispute that, in a cervical cone biopsy, a physician must cut through tissue and there is a chance of post-operative bleeding associated with this procedure.
69. Finally, some physicians perform ovum retrieval in their physician practices.	69. Not disputed, but irrelevant. However, defendants note that ovum retrievals can be performed in other settings such as outpatient treatment centers and hospitals.
70. To perform ovum retrieval, the physician sedates the patient, and then using an ultrasound vaginal probe, guides a needle through the vaginal wall into the ovaries, making multiple punctures.	70. Not disputed, but irrelevant.
71. This procedure is of greater magnitude than pre-20 week abortions in that an instrument is inserted into the peritoneal cavity, creating risks of internal bleeding, and it last [sic] about an hour, therefore requiring more sedation.	71. Disputed and irrelevant. Defendants do not dispute that in ovum retrieval an instrument is inserted into the peritoneal cavity, that the procedure can take an hour and there is a risk of bleeding from the procedure. However, as the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
72. Sigmoidoscopy, which is performed in some physician practices, involves insertion of an instrument called a sigmoidscope into the rectum to permit visualization of the sigmoid colon.	72. Irrelevant. Defendants do not dispute that sigmoidoscopy involves the insertion of a sigmoidscope into the rectum. While these procedures is sometimes performed in physician practices, defendants state that sigmoidoscopies are also performed in other settings such as an outpatient surgical center. Moreover, the plaintiffs' own expert on this procedure, Dr. Robert Stephens, will not perform this or any surgical procedure in his office if any type of sedative is used. Stephens dep. at 17.
73. Sigmoidoscopy is comparable to pre-20 week abortions in terms of the type of risks involved, the degree of invasiveness of the procedures, the type of instrumentation used, the duration of the surgery, and the patient's needs with respect to physical facility, policies and procedures, staffing, emergency transfer agreements, and physician competence.	73. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).
74. Vasectomy, which is performed in some physician practices, involves making an incision into the scrotum, and then cutting and clipping the vas to achieve male sterilization.	74. Not disputed, but irrelevant. Defendants state that while this procedure is sometimes performed in physician practices, defendants state that these procedures are also performed in other settings such as an outpatient surgical center. Moreover, the plaintiffs' own expert on this surgical procedure, Dr. Robert Stephens, will not perform this or any surgical procedure in his office if any type of sedative is used. Stephens dep. at 17.
75. Vasectomy is comparable to pre-20 week abortions in terms of the type of risks involved, the degree of invasiveness of the procedures, the type of instrumentation used, the duration of the surgery, and the patient's needs with respect to physical facility, policies and procedures, staffing, emergency transfer agreements, and physician competence.	75. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
76. Some physicians drain neck and intraoral abscesses in their physician practices.	76. Not disputed, but irrelevant. However, defendants state that these procedures are sometimes performed in other settings such as outpatient surgical centers or hospitals. Defendants further state that the plaintiffs' own expert on this procedure, Dr. Jeffrey Taffett, sometimes performs this procedure in settings other than his office. Taffett dep. at 28.
77. In these procedures, the physician makes an incision deep into the tissue with a scalpel, dissects and debrides tissue, suctions out any pus, and then sutures the incision.	77. Not disputed, but irrelevant.
78. Draining neck and intraoral abscesses are comparable to, or of greater magnitude than, first trimester abortions in terms of risks, invasiveness, simplicity, and duration, and the patients' medical needs.	78. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures). Moreover, defendants state that the plaintiffs' citation to the Deposition of Dr. Lynn Farnsworth does not support this assertion. The specific lines (140:19-23) cited by the plaintiffs deal, generally, with the risks associated with changing a tracheotomy tube and do not compare abortion to draining intraoral abscesses.
79. Some physicians change tracheotomy tubes in their physician practices.	79. Irrelevant. Defendants do not dispute that some physicians change tracheotomy tubes in their offices. However, defendants state that these procedures are sometimes performed in other settings such as outpatient surgical centers or hospitals.
80. In this procedure, the physician must remove the existing tracheotomy tube and replace it with a new one, while maintaining the patient's airway.	80. Not disputed, but irrelevant.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
81. Changing a tracheotomy tube is comparable to, or of greater magnitude than, first trimester abortions in terms of risks, invasiveness, simplicity, and duration, and the patients' medical needs.	81. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).
82. Some physicians treat post-tonsilar bleeds and drain peri-tonsilar abscesses in their physician practices.	82. Not disputed, but irrelevant. However, defendants state that these procedures are sometimes performed in other settings such as outpatient surgical centers or hospitals. Defendants further state that the plaintiffs' own expert on this procedure, Dr. Jeffrey Taffett, sometimes performs this procedure in settings other than his office. Taffett dep. at 38-39.
83. To perform these procedures, the physician suctions blood from the tonsilar area, applies an anesthetic to the area, and then cauterizes the bleeding.	83. Not disputed, but irrelevant.
84. Treating post-tonsilar bleeds and draining peri-tonsilar abscesses are comparable to, or of greater magnitude than, first trimester abortions in terms of risks, invasiveness, simplicity, and duration, and the patients' medical needs.	84. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).
85. Some physicians perform nasal polypectomies in their physician practices.	85. Not disputed, but irrelevant. However, defendants state that these procedures are sometimes performed in other settings such as outpatient surgical centers or hospitals. Defendants further state that the plaintiffs' own expert on this procedure, Dr. Jeffrey Taffett, sometimes performs this procedure in settings other than his office. Taffett dep. at 39-40.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
86. To perform a nasal polypectomy, the physician injects anesthesia into the nose, surgically clips the polyps, and then packs the nose to control bleeding.	86. Not disputed, but irrelevant.
87. Nasal polypectomy is comparable to, or of greater magnitude than, first trimester abortions in terms of risks, invasiveness, simplicity, and duration, and the patients' medical needs.	87. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).
88. Some physicians perform minor ear surgeries in their physician practices.	88. Not disputed, but irrelevant. However, defendants state that these procedures are sometimes performed in other settings such as outpatient surgical centers or hospitals. Defendants further state that the plaintiffs' own expert on this procedure, Dr. Jeffrey Taffett, sometimes performs this procedure in settings other than his office. Taffett dep. at 41.
89. In minor ear surgery, the physician makes multiple incisions in the ear through an operating microscope.	89. Not disputed, but irrelevant.
90. Minor ear surgery is comparable to, or of greater magnitude than, first trimester abortions in terms of risks, invasiveness, simplicity, and duration, and the patients' medical needs.	90. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
91. Some physicians reduce nasal fractures in the physician offices.	91. Not disputed, but irrelevant. However, defendants state that these procedures are sometimes performed in other settings such as outpatient surgical centers or hospitals. Defendants further state that the plaintiffs' own expert on this procedure, Dr. Jeffrey Taffett, sometimes performs this procedure in settings other than his office. Taffett dep. at 42.
92. To reduce a nasal fracture, the physician injects both intra- and extra-nasal anesthesia, moves the nasal bones into the correct anatomical location, and then controls the bleeding.	92. Not disputed, but irrelevant.
93. Reducing a nasal fracture is comparable to, or of greater magnitude than, first trimester abortions in terms of risks, invasiveness, simplicity, and duration, and the patients' medical needs.	93. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).
94. Some physicians remove salivary stones in their physician practices.	94. Not disputed, but irrelevant. However, defendants state that these procedures are sometimes performed in other settings such as outpatient surgical centers or hospitals. Defendants further state that the plaintiffs' own expert on this procedure, Dr. Jeffrey Taffett, sometimes performs this procedure in settings other than his office. Taffett dep. at 94.
95. In this procedure, the physician injects anesthesia into the mouth, makes an incision into the floor of the mouth, opens the salivary duct, and then probes the duct until the stone is located and removed.	95. Not disputed, but irrelevant.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
96. Removing salivary stones is comparable to, or of greater magnitude than, first trimester abortions in terms of risks, invasiveness, simplicity, and duration, and the patients' medical needs.	96. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).
97. Some physicians perform palatal surgery in their physician practices.	97. Not disputed, but irrelevant. Defendants do not dispute that some physicians perform palatal surgery in their offices. However, defendants state that these procedures are sometimes performed in other settings such as outpatient surgical centers or hospitals. Defendants further state that the plaintiffs' own expert on this procedure, Dr. Jeffrey Taffett, sometimes performs this procedure in settings other than his office. Taffett dep. at 95.
98. To perform palatal surgery, the physician injects local anesthesia and then cuts out a portion of the palate (roof of the mouth) with a radio-frequency knife.	98. Not disputed, but irrelevant.
99. Palatal surgery is comparable to, or of greater magnitude than, first trimester abortions in terms of risks, invasiveness, simplicity, and duration, and the patients' medical needs.	99. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
100. The aforementioned procedures may, like pre-20 week abortions, result in some or all of the following complications: excessive bleeding, infection, vasovagal shock, and unintentional injury to organs.	100. Defendants state that this is only relevant to the extent that it concerns abortion-related complications. Defendants do not dispute that any of the procedures discussed in Statements of Fact 57-99 (above) may result in the enumerated complications, among others. However, defendants state that abortion has numerous complications including: bleeding, infection, uterine perforation, blood clots in the uterus, hemorrhage, cervical tears, incomplete abortions (retained tissue), failure to actually terminate the pregnancy, a reaction to anesthesia, possible problems with future fertility, emotional problems, free fluid in the abdomen, acute abdomen, missed ectopic pregnancies, cardiac arrest, sepsis, respiratory arrest, and death. Exhibit 2 to Deposition of Bryan Howard, "Fact Sheet About Early Abortion;" Raphael dep. at 53-54; Tamis dep. at 66.
101. The aforementioned procedures may, like abortion, also result in patient death in rare circumstances.	101. Defendants state that this is only relevant to the extent that it concerns abortion-related deaths. Defendants do not dispute the abortion and other surgical procedures can result in patient death. However, defendants state that the actual number of women suffering abortion-related complications, including death, is impossible to accurately quantify because there are no uniform, state data collection laws for abortion. Grimes dep. at 32. Moreover, the Center for Disease Control has a voluntary reporting system and cannot guarantee that negative information is not being underreported. Grimes dep. at 32, 52, 127.
102. For example, with respect to many surgical procedures, there are known serious complications that can occur and lead to patient death if not managed properly. These procedures include: the changing of tracheotomy tubes; the draining of neck abscesses; salivary stone removal; any procedure involving surgery and anesthesia within the mouth and throat; sigmoidoscopy; and hysteroscopy.	102. Not disputed, but irrelevant.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
103. More deaths occur in this country in connection with taking Viagra than they do in connection with abortion.	103. Disputed and irrelevant. Defendants state that the actual number of women suffering abortion-related complications, including death, is impossible to accurately quantify because there are no uniform, state data collection laws for abortion. Grimes dep. at 32. Moreover, the Center for Disease Control has a voluntary reporting system and cannot guarantee that negative information is not being underreported. Grimes dep. at 32, 52, 127. Further, Plaintiff Young was not able to provide any identifying information about the medical journal or other source for her assertion about Viagra. Young dep. at 134-35.
104. More deaths occur in this country in connection with liposuction than they do in connection with abortion.	104. Disputed and irrelevant. Defendants state that the actual number of women suffering abortion-related complications is impossible to accurately quantify because there are no uniform, state data collection laws for abortion. Grimes dep. at 32. Moreover, the Center for Disease Control has a voluntary reporting system and cannot guarantee that negative information is not being underreported. Grimes dep. at 32, 52, 127.
105. Patient deaths have occurred in Arizona in recent years in connection with procedures that are performed in physician practices.	105. Not disputed, but only relevant to the extent that it involves abortion-related deaths. Defendants state that there have been deaths associated with abortion complications in recent years in Arizona. *See generally* The Defendants' Rule 1.10(l)(1) Statement of Facts in Support of Their Joint Motion for Partial Summary Judgment on Plaintiffs' Undue Burden Claim, ¶ 1.
106. For example, a physician in Arizona recently had a patient die in connection with the draining of an intraoral abscess.	106. Disputed, but irrelevant. Defendants do not dispute that this is Dr. Jeffrey Taffett's proposed testimony. However, during his deposition, Dr. Taffett declined to disclose any specific information about this incident. Taffett dep. at 31-32.
107. A patient also recently died in Arizona during the changing of a tracheotomy tube.	107. Disputed, but irrelevant. Defendants do not dispute that this is Dr. Jeffrey Taffett's proposed testimony.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
108. Another patient died in Arizona recently when the patient's surgeon attempted to remove a skin flap and injured an artery.	108. Disputed, but irrelevant. Defendants do not dispute that this is Dr. Jeffrey Taffett's proposed testimony.
109. The State also recently experienced a patient death involving an abortion performed near twenty-four weeks lmp.	109. Disputed. Evidence indicates that Lou Anne Herron (who died as a result of abortion-related complications) was past twenty-four weeks gestation and that the abortion was performed in violation of Arizona law. EJA00000177-293 (Phoenix Police Department Report, dated July 15, 1998). Moreover, there has been, at least, one other abortion-related death in the State that occurred in 1995. EJA00000152-176 (1/18/96 interview transcript of Dr. John I. Biskind before the Arizona Board of Medical Examiners).
110. The physician who performed that abortion has surrendered his medical license to the state board of medical examiners and has been tried and convicted under the State's criminal laws.	110. Not disputed. However, the defendants state that this was not the first abortion-related death caused by this physician, Dr. John I. Biskind. *See* EJA00000152-176 (1/18/96 interview transcript of Dr. John I. Biskind before the Arizona Board of Medical Examiners) (review of 1995 incident in which a 26 year old woman bled to death after her uterus was lacerated).

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
111. Arizona is not experiencing any public health problems with the provision of legal abortions, nor was it experiencing one when the regulatory scheme was promulgated.	111. Disputed. Defendants state that there was evidence of public health problems related to abortion in 1999 when the Regulatory Act was passed. First, Lou Anne Herron bled to death after her uterus was lacerated and she was left in the care of inexperienced medical technicians in a Phoenix abortion clinic. EJA00000177-293 (Phoenix Police Department Report, dated July 15, 1998). Moreover, there has been, at least, one other abortion- related death in the State that occurred in 1995. EJA00000152-176 (1/18/96 interview transcript of Dr. John I. Biskind before the Arizona Board of Medical Examiners). Defendants also state that, in 1998, there was a botched abortion that resulted in the birth of a near-term baby girl. *See Near-Abortion Spurs Investigation of Valley Physician*, ARIZ. TRIB., July 11, 1998. Finally, defendants state that the extent of abortion-related complications and incidents in Arizona are impossible to quantify because there are no uniform, state data collection laws for abortion. Grimes dep. at 32. Moreover, the Center for Disease Control has a voluntary reporting system and cannot guarantee that negative information is not being underreported. Grimes dep. at 32, 52, 127.
112. The recent abortion death in Arizona and the resulting administrative and criminal actions taken by the State indicate that Arizona was experiencing a problem with the competence of an individual physician and that the State already had authority to address that problem.	112. Disputed. Defendants state that the public health issues concerning abortion in Arizona extend beyond the incompetence of one physician. In support of this assertion and by way of example, defendants state that Plaintiff Tamis has personally hospitalized two patients since 1990 for abortion-related complications; one of his abortion patients died from a blood clot following an abortion; and, in February 2001, a patient of Plaintiff Tamis had to undergo a hysterectomy following abortion-related complications. *See* Tamis Resp. to State Defs.' First Set of Interrogs. No. 11; *Woman Hospitalized After Having Abortion*, THE ARIZ. REPUBLIC, February 6, 2001.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
113. Neither the challenged regulatory scheme nor any set of similar regulations can prevent the commission of malpractice by physicians.	113. Disputed. This is an opinion and not an established "fact." Conversely, defendants' expert will testify that the provisions of the Regulatory Act are necessary and are "helpful in the application of medicine." Farnsworth dep. at 96. Further, he will testify that the Regulatory Act establishes minimum, reasonable standards that will help ensure access to safe abortions and will improve the health and lower the risks (including the risks of complications associated with malpractice) of women seeking abortions. Declaration of Lynn S. Farnsworth, M.D., ¶ 1.
114. Physicians who commit malpractice, by definition, are practicing medicine outside of the standards and norms that govern them.	114. Not disputed, but irrelevant. Defendants do not dispute that this is Dr. David Grimes' proposed testimony.
115. There is no reason to believe that adding an additional set of requirements upon those physicians would bring them into compliance.	115. Disputed. This is an opinion and not an established "fact." Conversely, defendants' expert will testify that the provisions of the Regulatory Act are necessary and are "helpful in the application of medicine." Farnsworth Dep. at 96. Further, he will testify that the Regulatory Act establishes minimum, reasonable standards that will help ensure access to safe abortions and will improve the health and lower the risks (including the risks of complications associated with malpractice) of women seeking abortions. Declaration of Lynn S. Farnsworth, M.D., ¶ 1.
116. Indeed, during the promulgation of the regulatory scheme, the director of DHS stated that Dr. Biskind's patient died as a result of bad medical judgment and that all the regulations in the world could not take care of that problem.	116. Irrelevant and inadmissible.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
117. Furthermore, nothing in the challenged regulatory scheme would have prevented the abortion death that recently occurred in Arizona.	117. Disputed. This is an opinion and not an established "fact." Conversely, defendants' expert will testify that application and enforcement of the Regulatory Act could have prevented the death of Lou Anne Herron. Declaration of Lynn S. Farnsworth, M.D., ¶ 26; Farnsworth dep. at 89-100.
118. That death could have been prevented had the physician in question remained in the facility and provided appropriate care to his patient when she was in the recovery room, or had the clinic administrator in the facility encouraged, rather than obstructed, the medical assistants from calling an ambulance.	118. Undisputed. However, defendants state that this does not lessen the appropriateness of the Regulatory Act. Importantly, among other provision ensuring and protecting the health of an abortion patient, the Regulatory Act specifically requires a physician with admitting privileges to remain in the abortion clinic until every patient is stable and ready to leave the recovery room. A.A.C. R9-10-1506(B)(2).
119. But those life-saving courses of action were already required by existing law, as has been evidence by the physician's surrender of his medical license and the criminal convictions of both the physician and the clinic administrator.	119. Not disputed, but irrelevant. Whether or not existing law, professional ethics or other standards require a physician to provide safe and appropriate care to his or her patients does not lessen the appropriateness of the Regulatory Act.
120. There is no reason to believe that an additional layer of regulations would have made the physician or clinic administrator provide the degree of care that was already required of them.	120. Disputed. This is an opinion and not an established "fact." Conversely, defendants' expert will testify that application and enforcement of the Regulatory Act could have prevented the death of Lou Anne Herron, Declaration of Lynn S. Farnsworth, M.D., ¶ 26; Farnsworth dep. at 89-100; that the provisions of the Regulatory Act are necessary and are "helpful in the application of medicine," Farnsworth dep. at 96; and that the Regulatory Act establishes minimum, reasonable standards that will help ensure access to safe abortions and will improve the health and lower the risks (including the risks of complications associated with malpractice or malfeasance) of women seeking abortions. Declaration of Lynn S. Farnsworth, M.D., ¶ 1.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
121. Ultrasound is commonly used to ascertain gestational age in connection with abortions.	121. Not disputed.
122. The purpose of ascertaining gestational age in connection with an abortion is to permit the physician to know what to expect in terms of the procedure so that he or she can determine whether the procedure is one that the physician is capable, willing, and prepared to perform.	122. Defendants do not dispute that this is one of the purposes for ascertaining gestational age in connection with an abortion.
123. By permitting the physician to gain this knowledge, performance of an ultrasound increases the safety of the procedure.	123. Defendants do not dispute that the safety of an abortion can be enhanced by the proper performance and reading of an ultrasound.
124. If a pregnancy appears to be advanced well into the second trimester, performance of ultrasound also permits the physician to ensure that the pregnancy has not reached viability, which can occur around twenty-four weeks lmp or later.	124. Defendants do not dispute that an ultrasound can be used to determine if the pregnancy has reached viability. Defendants state that viability may occur prior to 24 weeks lmp. Grimes dep. at 100 (a 24 week lmp pregnancy "approaches or passes the point of viability").
125. Ultrasound is commonly used in connection with gynecological procedures other than abortion, such as checking for ectopic pregnancies, ovarian cysts, and multiple pregnancies.	125. Not disputed, but irrelevant.
126. The purpose of using ultrasound in these contexts is to ascertain whether the patient is experiencing conditions that may be health or life-threatening.	126. Irrelevant. Defendants do not dispute that this is one purpose of using an ultrasound in these enumerated procedures.
127. By permitting the physician to gain this knowledge, performance of the ultrasound increases the physician's ability to safeguard the patient's life and health.	127. Not disputed, but irrelevant.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
128. Other diagnostic tests are used throughout the practice of medicine. For example, mammograms are performed to check for breast lumps that might be cancerous; C.A.T. scans are performed to check for abnormal growths in the brain; and sigmoidoscopies are performed to check for rectal cancer.	128. Not disputed, but irrelevant.
129. Errors can be, and sometimes are, made in the performance of ultrasounds and other diagnostic tests, posing risks to the patient.	129. Defendants state that this is only relevant to the extent that it involves ultrasounds or diagnostic tests performed in conjunction with an abortion.
130. In addition, ultrasounds and other diagnostic tests all have ranges of error quite apart from human error.	130. Defendants state that this is only relevant to the extent that it involves ultrasounds or diagnostic tests performed in conjunction with an abortion.
131. For example, the estimation of gestational age made by an ultrasound machine has a range of error of ten days at some points in pregnancy.	131. Defendants state that different ultrasound machines use different internal "scales" to calculate gestational age and that, between the different scales, there may be a difference in the estimate of as much as 7 to 10 days. Bettigole 2d dep. at 14. Moreover, the "scales" tend to be more accurate after approximately 8 and 1/2 weeks lmp. Raphael 2d dep. at 16.
132. Similarly, mammograms give false positives approximately 80-90% of the time and false negatives 10-20% of the time.	132. Disputed, but irrelevant.
133. Ultrasound machines calculate the gestational age of the pregnancy by taking measurements from calipers placed on relevant points on the screen and then converting those measurements on the basis of measurement charts stored within the machine.	133. Defendants state that the person taking the ultrasound takes the measurements by placing the calipers on the screen and the ultrasound then uses these measurements to calculate gestational age. Bettigole 2d dep. at 13.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
134. There are a variety of charts that ultrasounds [sic] machines can utilize in estimating gestational age; and these different charts can produce variations of one to one and one half weeks in the machine's gestational age estimate.	134. Defendants state that different ultrasound machines use different internal "scales" to calculate gestational age and that, between the different scales, there may be a difference in the estimate of as much as 7 to 10 days. Bettigole 2d dep. at 14. Moreover, the "scales" tend to be more accurate after approximately 8 and 1/2 weeks lmp. Raphael 2d dep. at 16.
135. Ultrasounds performed in conjunction with pre-20 week abortions and the other ultrasounds and diagnostic tests just discussed are comparable in their importance to patient health and their potential for error.	135. Defendants state that this is only relevant to the extent that it involves ultrasounds or diagnostic tests performed in conjunction with an abortion.
136. The challenged regulatory scheme imposes a number of costs and burdens exclusively on regular providers of abortion services, and not on comparable medical procedures.	136. Disputed, but irrelevant. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures). Moreover, the State regulates many types of medical providers and facilities. *See generally* Memorandum in Support of The Defendants' Joint Motion For Partial Summary Judgment on Plaintiffs' Equal Protection Claim, at 7-9.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
137. Physician practices in which procedures comparable to abortion are performed are not licensed by the State, and some, if not all of those practices, could not meet the requirements of the regulatory scheme.	137. Disputed, but irrelevant. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures). Moreover, the State regulates many types of medical providers and facilities. *See generally* Memorandum in Support of The Defendants' Joint Motion For Partial Summary Judgment on Plaintiffs' Equal Protection Claim, at 7-9.
138. The scheme thereby places abortion providers in a status below other physicians and stigmatizes and marginalizes the practice of abortion.	138. Disputed. This is a baseless opinion and not an established "fact." Conversely, defendants state that Dr. Lynn Farnsworth will testify that the Regulatory Act will not stigmatize or negatively effect public perception regarding abortion providers. Declaration of Lynn S. Farnsworth, M.D., ¶ 26a.
139. It also conveys an underlying punitive message to physicians that the continued provision of abortions will itself trigger investigations and harassment.	139. Disputed. This is a baseless opinion and not an established "fact."

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
140. It is neither medically appropriate nor good public health policy to treat abortions differently than comparable procedures in purported health regulations.	140. Disputed. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures). Defendants state that Dr. Lynn Farnsworth will testify that it is good public health policy to establish regulations that address public health concerns without unduly burdening health care providers. Declaration of Lynn S. Farnsworth, M.D., ¶ 28. Finally, defendants state that the citation to the Deposition of Dr. Lynn Farnsworth has been incorrectly paraphrased and taken out of context. In lines 139:22-141:19, Dr. Farnsworth was asked to assume there had been deaths from other specified medical procedures and asked if, taking the plaintiffs' counsel assumptions as true, it would be appropriate to regulate abortion but "no other outpatient surgical procedure." Dr. Farnsworth responded that "[I]f people are dying in the State of Arizona because of those procedures, they ought to be regulated." Dr. Farnsworth never said that it would only be appropriate to regulate abortion if it were experiencing unique complications not experienced with other surgical procedures.
141. The adoption of uniform health standards is equally appropriate for other surgical procedures as it is for abortion.	141. Disputed and irrelevant. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
142. Singling out abortion from comparable procedures for the imposition of unnecessary health regulations stigmatizes and burdens the practice of abortion, discouraging physicians from becoming abortion providers.	142. Disputed. This is a baseless opinion and not an established "fact." As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures). Further, defendants state that Dr. Lynn Farnsworth will testify that the Regulatory Act will not stigmatize or negatively effect public perception regarding abortion providers. Declaration of Lynn S. Farnsworth, M.D., ¶ 26a.
143. The small number of abortion providers in this country already hinders access to abortion services.	143. Disputed. This is an opinion and not an established "fact."
144. This lack of access threatens women's health by causing some pregnant women to delay obtaining desired abortions until later in pregnancy, when the risks of abortion are greater.	144. Disputed. This is an opinion and not an established "fact." Conversely, Dr. Lynn Farnsworth will testify that the Regulatory Act will have no impact on women's access to *safe* abortion in Arizona. Farnsworth dep. at 101-04. Defendants, however, do not dispute that the risks of abortion increase later in the pregnancy.
145. In addition, from a medical and public health standpoint, there is also no justification for singling out for regulation only those physicians who *regularly* perform abortions.	145. Disputed. Defendants state the citation to the deposition of Dr. Lynn Farnsworth is incorrectly paraphrased. In lines 149:3-9, Dr. Farnsworth states that he is not aware of any medical evidence as to why the Regulatory Act applies to abortion providers who do five or more first trimester abortions in any month. He did not say there was no "basis" for such regulation as alleged by the plaintiffs.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
146. Physician experience and skill impact the safety of abortion procedures, as they do with other surgical procedures. Thus, as a general rule, patients of physicians who provide abortions on a regular basis are less likely to experience complications than are patients of physicians who very rarely perform abortions.	146. Disputed. Defendants do not dispute that physician experience and skill is one factor contributing to the safety of abortions. However, defendants state that experienced providers are not immune from serious complications. In support of this assertion and by way of example, defendants state that Plaintiff Tamis, who has practiced medicine for more than 38 years, has personally hospitalized two patients since 1990 for abortion-related complications; one of his abortion patients died from a blood clot following an abortion and, in February 2001, a patient of Plaintiff Tamis had to undergo a hysterectomy following abortion-related complications. *See* Tamis Resp. to State Defs.' First Set of Interrogs. No. 11; *Woman Hospitalized After Having Abortion*, THE ARIZ. REPUBLIC, February 6, 2001 (copy attached).
147. Furthermore, there is no medical reason for the State to treat ultrasound performed in connection with abortion differently from ultrasound performed in other contexts or other comparable diagnostic procedures in terms of monitoring and regulation.	147. Disputed and irrelevant. As the United States Supreme Court and other courts have repeatedly noted, "abortion is a unique act." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 852 (1992); *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173-74 (4th Cir. 2000) (citing other U.S. Supreme Court decisions finding that abortion services "significantly differ" from other medical or surgical procedures).

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
148. The challenged regulatory scheme will increase the monetary costs of abortions by, for example, causing abortion providers to spend considerable time documenting their policies and procedures, and by requiring abortion providers to use licensed practical nurses, rather than medical assistants supervised by physicians, to monitor patient recovery, make follow up calls to patients, and remain in the facility until all patients are discharged.	148. Disputed. Defendants state that, since the filing of this lawsuit and with full knowledge of the requirements of the Regulatory Act, each of the plaintiffs has *decreased* the price he or she charges for a first trimester abortion. *See generally* The Defendants' Rule 1.10(l)(1) Statement of Facts in Support of Their Joint Motion for Partial Summary Judgment on Plaintiffs' Undue Burden Claim, ¶ 11. Further, defendants state that, as the plaintiffs are aware, abortion providers can seek assistance from the Arizona Department of Health Services and the National Abortion Federation in drafting written policies and procedures for their practices. *See* Richardson dep. at 32; Raphael dep. at 36; Young dep. at 34-35; Blair dep. at 91, 100, 106. Finally, the Regulatory Act allows a medical assistant supervised by a physician to monitor patient recovery. *See* A.A.C. R9-10-1506(B)(3).
149. These costs will inevitably be passed on to patients in some way.	149. Disputed. Defendants state that none of the plaintiffs in this case has determine what additional costs, if any, the Regulatory Act might impose on their individual practices, whether or not they would pass those costs onto their patients, and in what manner and amount those costs would be charged to patients. *See generally* The Defendants' Rule 1.10(l)(1) Statement of Facts in Support of Their Joint Motion for Partial Summary Judgment on Plaintiffs' Undue Burden Claim, ¶ 10. Moreover, plaintiffs' expert, Dr. David Grimes, stated, during his deposition, that he is not aware of any increase in the cost of abortion associated with compliance with OSHA, CLIA or any other regulation of abortion providers. Grimes dep. at 220.
150. Raising the cost of abortions causes some pregnant women to delay obtaining abortions until later in pregnancy.	150. Disputed. This is an opinion and not an established "fact." Conversely, Dr. Lynn Farnsworth will testify that the Regulatory Act will have no impact on women's access to *safe* abortion in Arizona. Farnsworth dep. at 101-04.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
151. Confidentiality is critical to all medical patients, and is especially important to women undergoing abortion.	151. Defendants do not dispute that confidentiality is important in the provision of all medical services.
152. Abortion patients expect that their privacy will be maintained by those who provide them medical care.	152. Defendants do not dispute that abortion patients expect privacy just as any other patient would.
153. The challenged regulatory scheme allow DHS inspectors to review and copy unredacted patient medical records in an "abortion clinic" without the patient's consent.	153. Defendants state that, for the purposes of an administrative inspection of an abortion clinic for compliance with the Regulatory Act and for the purposes of specific complaint investigations, authorized DHS personnel may review and copy patient records. A.R.S. §§ 36-424(B), (D), 36-425(A); A.A.C. R9-10-1503(B)(4).
154. This provision appears to expose all of the medical records at an abortion provider's office – regardless of whether those records are of patients undergoing abortions or other gynecological care – to disclosure to the State.	154. Disputed and irrelevant. The plain language of this "statement of fact" belies the fact that it is not a "fact," but an assertion or argument by plaintiffs' counsel and/or Plaintiff Young.
155. Copies of patient records made by health inspectors will be brought back to DHS's Office of Medical Facilities ("OMF"), where they are kept in unlocked file drawers or employee's desks.	155. Defendants state that plaintiffs have neglected to fully describe the manner in which patient records will be maintained by DHS. Defendants state that copies of patient records in the possession of DHS employees are not kept in public files and are not available for public inspection. *See* The Defendants' Rule 1.10(l)(1) Statement of Facts in Support of Their Joint Motion for Partial Summary Judgment on Plaintiffs' Informational Privacy Claim, ¶ 2-3; Blair dep. at 53-55. Further, the area in which OMF stores copies of patient records is controlled. Blair dep. at 54-55.
156. All employees of OMF, including support staff, have access to the patient medical records maintained there.	156. Disputed. Defendants state that only those OMF employees who need access to particular patient records in the course of official DHS business are given access to those records. *See* The Defendants' Rule 1.10(l)(1) Statement of Facts in Support of Their Joint Motion for Partial Summary Judgment on Plaintiffs' Informational Privacy Claim, ¶ 2; Blair dep. at 53-55.

Plaintiffs' Statement of Facts	Defendants' Joint Response
157. This may significantly threaten patient confidentiality.	157. Disputed. Defendants state that DHS trains its staff on the necessity of patient confidentiality and how to maintain that confidentiality. Blair dep. at 39; Phillips dep. at 59-61. Moreover, DHS has never had a problem protecting patient confidentiality and neither the plaintiffs nor any other witness in this case could point to a single instance in which DHS has breached patient confidentiality. *See generally* The Defendants' Rule 1.10(l)(1) Statement of Facts in Support of Their Joint Motion for Partial Summary Judgment on Plaintiffs' Informational Privacy Claim, ¶ 4.
158. If DHS is permitted this unfettered access to medical records, abortion patients are likely to withhold important information that their physicians need to know to ensure the safety of their care.	158. Disputed. This is an opinion and not an established "fact." By its own terms, the Regulatory Act does not grant DHS inspectors or other DHS employees unfettered access to abortion clinics. *See generally* Memorandum in Support of The Defendants' Joint Motion for Partial Summary Judgment on Plaintiffs' Information Privacy Claim, at 6-7.
159. The regulatory scheme also permits DHS inspectors to enter abortion providers' offices and patient areas when patients are present.	159. Defendants state that DHS inspectors normally go to the facility during business hours. Defendants further state the initial licensure inspections are scheduled in advance with the facility. However, relicensure inspections and complaint investigations are unannounced in order to allow the DHS inspector to determine how the facility operates in a routine manner without an opportunity to change anything or deviate from how they normally provide care. Blair dep. at 31-33, 38. Finally, by statute, DHS inspectors are required to notify a licensee being inspected of their presence in the facility and their authority to inspect. Phillips dep. at 62.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
160. The inspectors can make unannounced inspections for relicensure or to respond to complaints.	160. Defendants state that relicensure inspections and complaint investigations are unannounced in order to allow the DHS inspector to determine how the facility operates in a routine manner without an opportunity to change anything or deviate from how they normally provide care. Blair dep. at 31-33, 38. Finally, by statute, DHS inspectors are required to notify a licensee being inspected of their presence in the facility and their authority to inspect. Phillips dep. at 62.
161. This threatens patient confidentiality by creating the risk that such inspectors will be able to recognize or ascertain the identity of patients in the facility.	161. Disputed. Defendants state that DHS trains its staff on the necessity of patient confidentiality and how to maintain that confidentiality. Blair dep. at 39; Phillips dep. at 59-61. Moreover, DHS has never had a problem protecting patient confidentiality and neither the plaintiffs nor any other witness in this case could point to a single instance in which DHS has breached patient confidentiality. *See generally* The Defendants' Rule 1.10(l)(1) Statement of Facts in Support of Their Joint Motion for Partial Summary Judgment on Plaintiffs' Informational Privacy Claim, ¶ 4.
162. Any person can make a complaint and thereby trigger an inspection, regardless of whether the person has first hand knowledge of the violations alleged.	162. Disputed. Defendants state that a complaint to DHS triggers a "complaint investigation," not an "inspection." Defendants further state that, before DHS can investigate, the complaint must allege a violation of the administrative rules and be specific enough to be investigated. Blair dep. at 36-37, 47. Finally, a complaint investigation may simply involve an inspector calling the facility for information rather than visiting the facility. Blair dep. at 34.
163. Such complaints can also be made anonymously.	163. Not disputed. However, defendants state that DHS always maintains the confidentiality of any complainant. Blair dep. at 34, 45.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
164. The concerns, delays and anxiety that will be caused to patients by unannounced inspections will have a negative effect on those patients' health.	164. Disputed.
165. In addition, the regulatory scheme requires abortion providers to submit post-12 week abortion patient's ultrasound prints to an agent of DHS for review. Such prints will reveal not only the identity of the patient, but the gestational age of the pregnancy that was terminated and, by the print's very submission, the fact that the woman underwent an abortion.	165. Defendants do not dispute that ultrasounds associated with abortions done after 12 weeks gestation will be reviewed by a firm employing board certified radiologists; however, DHS is considering implementing a coding system to "ensure anonymity of both the patient and the abortion provider." Conditt 2d dep. at 62, 95-96; Exhibit 8 to Conditt 2d dep.
166. The contract entered into by DHS and its current contractor, Apex Radiology ("Apex"), for this purpose does not limit Apex's employees' access to the ultrasound prints; does not provide any mechanism for ensuring employees do not reveal patient information; does not indicate where Apex will maintain the records for the first two years; or how or if Apex will dispose of the records.	166. Defendants state that the details of the arrangement with Apex for ultrasound reviews have not been finalized. Details that remain to be worked out between DHS and Apex include the maintenance and disposal of ultrasound prints. Conditt 2d dep. at 62-70. Defendants further state that Arizona law prohibits DHS and its contractor, Apex, from disclosing any personally identifiable patient information. A.R.S. § 36-2301.02(G).
167. The requirement that abortion providers post their "abortion clinic" license in a conspicuous place in their office also intrudes on patient privacy by indicating to patients that some of the women present are there to undergo abortions.	167. Disputed. Defendants state that Plaintiffs Raphael, Richardson and Tamis advertise that they provide abortion services. Raphael dep. at 38-39; Richardson dep. at 67-68; Tamis dep. at 25. Defendants further state that it is common for abortion providers to advertise that they provide abortions in newspapers, in the Yellow Pages and on the Internet, s*ee, e.g.*, Bettigole dep. at 99-103; and that it is often common knowledge within a community who provides abortion services. *See, e.g.*, Tamis dep. at 25.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
168. Although the regulatory scheme purports to require DHS officials and their agents to maintain confidentiality of patient information, the fact is that confidential medical information is frequently "leaked" or discussed by people who have a legal obligation not to disclose it.	168. Disputed, but irrelevant. Defendants further state that DHS trains its staff on the necessity of patient confidentiality and how to maintain that confidentiality. Blair dep. at 39; Phillips dep. at 59-61. Moreover, DHS has never had a problem protecting patient confidentiality and neither the plaintiffs nor any other witness in this case could point to a single instance in which DHS has breached patient confidentiality. *See generally* The Defendants' Rule 1.10(l)(1) Statement of Facts in Support of Their Joint Motion for Partial Summary Judgment on Plaintiffs' Informational Privacy Claim, ¶ 4.
169. Threatening the confidentiality of abortion patients may also cause some pregnant women to delay, or even forego, obtaining desired abortions at the expense of their health, or to seek clandestine illegal abortions.	169. Disputed. This is an opinion and not an established "fact."
170. As a result, the challenged regulatory scheme may indirectly injure or even kill women.	170. Disputed. Defendants state that this is an opinion, not an established "fact." Conversely, defendants' expert will testify that application and enforcement of the Regulatory Act could have prevented the death of Lou Anne Herron. Declaration of Lynn S. Farnsworth, M.D., ¶ 26; Farnsworth dep. at 89-100.
171. Physicians, including Plaintiffs, have an expectation of privacy in their medical offices and records.	171. Defendants state the abortion providers, like the plaintiffs, have a diminished expectation of privacy in their offices and clinics. *See generally* Memorandum in Support of The Defendants' Joint Motion for Partial Summary Judgment on Plaintiffs' Fourth Amendment Claim, at 1-3.
172. The challenged regulatory scheme will usurp abortion providers' ability to exercise medical judgment by dictating such matters: when the physician may bring patients in for follow-up visits; who among the physician's staff may perform particular tasks; and what equipment the physician must maintain in the facility.	172. Disputed. Defendants state that nothing in the Regulatory Act prevents a physician from exercising his or her medical judgment in treating patients. *See, e.g.*, Declaration of Lynn S. Farnsworth, M.D., ¶ 19.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
173. The staffing of a physician practice is ordinarily determined by the physician on the basis of his or her medical judgment.	173. Defendants do not dispute that medical judgment is one factor in determining staffing needs for an abortion clinic.
174. In a physician practice that provides abortions, staffing needs vary depending on the gestational age at which the abortions are provided and the nature of the overall practice.	174. Defendants do not dispute that the gestational age at which abortions are provided and the nature of the overall practice are two factors that some physicians use in staffing their abortion clinics. However, they are not the only important considerations.
175. The regulatory scheme does not take these different needs into account, but instead imposes standardized staffing requirements that are largely unnecessary, particularly in a practice that provides only first trimester abortions.	175. Disputed. Defendants state that the Regulatory Act prescribes "minimum, reasonable standards generally applicable to abortion providers" in Arizona and that abortion providers are free to exceed those minimum standards. Declaration of Lynn S. Farnsworth, M.D., ¶ 1. Further, the defendants state that the requirements of the Regulatory Act are based on standards promulgated by abortion-rights organizations such as the National Abortion Federation and the Planned Parenthood Federation of America. Declaration of Lynn S. Farnsworth, M.D., ¶ 20-23.
176. The regulatory scheme also requires physicians to offer their abortion patients a follow-up visit at least three weeks after an abortion procedure, despite the fact that abortion providers generally believe that follow-up should be sooner.	176. Disputed. Defendants state that nothing in the Regulatory Act prevents an abortion provider from seeing an abortion patient "anytime there is a problem" or at anytime within three weeks of the abortion. Grimes dep. at 254; Farnsworth dep. at 123. Defendants further state that the citation to Dr. Lynn Farnsworth's deposition has been taken out of context. In his deposition, Dr. Farnsworth stated that nothing in the Regulatory Act precludes a physician from seeing a patient earlier than three weeks after the abortion, but that *if* the Act had stated that "[you] may not provide" a postoperative visit until after three weeks, that would take away the physician's judgment.
177. Many abortion providers believe that calling their abortion patients one day after their procedures is medically inappropriate and annoying to the patients, and that if required, this task could be appropriately performed by unlicensed medical assistants.	177. Disputed. Defendants state that the Regulatory Act requires a physician to get the patient's permission before calling the patient. A.A.C. R9-10-1508(I)(1).

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
178. Preventing physicians from exercising their medical judgment in the best interest of their patients hinders physicians' ability to serve the health needs of their patients.	178. Disputed. Defendants state that nothing in the Regulatory Act prevents a physician from exercising his or her medical judgment in treating patients. *See, e.g.*, Declaration of Lynn S. Farnsworth, M.D., ¶ 19.
179. The scheme will also take abortion providers away from their time providing patient care by requiring them to create policies and procedures and to respond to DHS requests for medical records and impromptu visits by DHS inspectors.	179. Disputed. Defendants state that, as the plaintiffs are aware, abortion providers can seek assistance from the Arizona Department of Health Services and the National Abortion Federation in drafting written policies and procedures for their practices. *See* Richardson dep. at 32; Raphael dep. at 36; Young dep. at 34-35; Blair dep. at 91, 100, 106. Defendants further state that the initial licensure inspections are scheduled in advance with the facility. However, relicensure inspections and complaint investigations are unannounced in order to allow the DHS inspector to determine how the facility operates in a routine manner without an opportunity to change anything or deviate from how they normally provide care. Blair dep. at 31-33, 38.
180. By requiring that abortion providers have admitting privileges at a hospital in the state, the scheme prevents some physicians who are willing and competent to perform abortions from doing so.	180. Disputed. Defendants state that the Regulatory Act does not require every physician performing abortions to have admitting privileges. Rather, the Regulatory Act simply requires that *a* physician with admitting privileges is in the abortion clinic until each abortion patient is stable and ready to leave the recovery room. A.A.C. R9-10-1506(B)(2). Defendants further state that the following citations are improperly relied on by the plaintiffs because the cited declaration paragraph or deposition excerpt does not mention or discuss physicians having to forego performing abortions because they do not have admitting privileges: Howard ¶ 16; Howard dep. 53:20-54:21, 61:4-17; Richardson dep. 22:20-23:21.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
181. Maintaining admitting privileges is often expensive and time-consuming, and may therefore be an unnecessary and costly burden for a physician who rarely, if ever, admits patients.	181. Disputed. Defendants state that Plaintiffs Raphael, Richardson and Tamis all currently maintain admitting privileges at one or more hospitals in Arizona. Raphael dep. at 8; Richardson dep. at 11-13, 15-17, 19-20; Tamis dep. at 84.
182. Thus, for example, Plaintiff Dr. Young has chosen not to maintain admitting privileges at any hospital, and she has never admitted a patient to the hospital in her sixteen years of providing office-based gynecological services, including abortions.	182. Irrelevant. Plaintiff Young's choice not to maintain admitting privileges has no bearing on the medical appropriateness of the admitting privilege requirement in A.A.C. R9-10-1506(B)(2).
183. The admitting privileges requirement was not included in the regulatory scheme to ensure that abortion patients have access to hospitals in emergencies, but, rather, to give hospitals authority to decrease the pool of physicians who can provide abortions.	183. Disputed. Defendants state that the plaintiffs' reliance on the deposition of Bryan Howard for this proposition is in error. In lines 57:19-58:11 of his deposition, Mr. Howard does not state that the admitting privileges requirement was included in the Regulatory Act to decrease the pool of physicians who can provide abortions. Rather, he states that the provision was included, in part, because BOMEX was viewed as being weak in its oversight of physicians.
184. The regulatory scheme also hinders competent physicians from performing abortions because it prevents a physician who has completed a hands-on course in performing ultrasounds under the supervision of a qualified physician, but has not completed a course in ultrasound from a manufacturer or distributor of ultrasound equipment and did not perform ultrasound as part of the physician's medical training, from performing ultrasounds, or training their staff to perform ultrasounds, in connection with abortion.	184. Disputed. Defendants state that the requirements of the Regulatory Act pertaining to ultrasound, A.A.C. R9-10-1505(3), will not hinder competent physicians from performing abortions and that assertion has no bearing on the medical appropriateness of the ultrasound training requirements.
185. Many physicians, including some of the Plaintiffs, have been trained in ultrasound by other physicians or have taught themselves to perform ultrasound yet did not perform ultrasound in their medical training and have not taken a course from an ultrasound manufacturer or distributor.	185. Irrelevant. This assertion has no bearing on the medical appropriateness of the ultrasound training requirements in A.A.C. R9-10-1505(3).

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
186. The small number of abortion providers in this country already hinders access to abortion services.	186. Disputed. This is an opinion and not an established "fact."
187. This lack of access threatens women's health by causing some pregnant women to delay obtaining abortions until later in pregnancy, when the risks of abortion are greater.	187. Disputed. Defendants, however, do not dispute that the risks of abortion increase later in the pregnancy.
188. The regulatory scheme will not improve the safety of abortions in Arizona, and no scientific evidence or public health guidelines support these burdensome regulations. To the contrary, the requirements of the regulatory scheme imposes are likely to have a negative impact on the quality of abortion care in Arizona.	188. Disputed. Defendants state that the provisions of the Regulatory Act are not "burdensome." Rather, defendants state that the requirements of the Regulatory Act are based on standards promulgated by abortion-rights organizations such as the National Abortion Federation and the Planned Parenthood Federation of America. Declaration of Lynn S. Farnsworth, M.D., ¶ 20-23. Finally, defendants state that the requirements of the Regulatory Act will improve the quality of abortion patient care in Arizona. Declaration of Lynn S. Farnsworth, M.D., ¶ 26.
189. For example, requiring that licensed practical nurses monitor the recovery of abortion patients after local anesthesia, make follow-up calls to patients, and remain in the abortion facility until all patients have been discharged will not make abortion in Arizona any safer because properly supervised medical assistants, who are less expensive and more readily available, can satisfactorily perform those tasks.	189. Disputed. Defendants state that the requirements of the Regulatory Act will improve the quality of abortion patient care in Arizona. Declaration of Lynn S. Farnsworth, M.D., ¶ 26. Defendants further state that the Regulatory Act allows "surgical assistants" to monitor a patient's recovery, if a physician is in the abortion clinic. *See* A.A.C. R9-10-1506(B)(3).

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
190. Likewise, giving the state untrammeled access to patient records and abortion facilities will not make abortions in Arizona any safer because the state already has sufficient access to records and health facilities by means of seeking permission of the patient and provider or obtaining a search warrant.	190. Disputed. By its own terms, the Regulatory Act does not grant DHS inspectors or other DHS employees unfettered access to abortion clinics. *See generally* Memorandum in Support of The Defendants' Joint Motion for Partial Summary Judgment on Plaintiffs' Information Privacy Claim, at 6-7. Defendants further state that, in compliance with statutory authority, none of DHS's licensing and regulatory programs (for any type of health care facility) require search warrants before conducting an inspection or reviewing patient records. Phillips dep. at 59-60.
191. Dictating how abortion providers set up and operate their practices will not make abortions in Arizona safer because physicians can make many different, appropriate choices about the staffing mix, equipment and procedures for their practice.	191. Defendants state that the Regulatory Act prescribes "minimum, reasonable standards generally applicable to abortion providers" in Arizona. and that abortion providers are free to exceed those minimum standards. Declaration of Lynn S. Farnsworth, M.D., ¶ 1. Moreover, defendants state that nothing in the Regulatory Act prevents a physician from exercising his or her medical judgment in treating patients. *See, e.g.*, Declaration of Lynn S. Farnsworth, M.D., ¶ 19.
192. Additionally, requiring written procedures in physicians practices will not make abortions in Arizona safer because many such practices can be appropriately operated with informal, unwritten policies.	192. Disputed. Defendants state that the requirements of the Regulatory Act, including requiring written policies and procedures, will improve the quality of abortion patient care in Arizona. Declaration of Lynn S. Farnsworth, M.D., ¶ 26.
193. Furthermore, proposed national standards for abortion care exist, such as the clinical policy guidelines of the National Abortion Federation.	193. Not disputed. Defendants further state that the requirements of the Regulatory Act are based, in part, on standards promulgated by abortion-rights organizations such as the National Abortion Federation and the Planned Parenthood Federation of America. Declaration of Lynn S. Farnsworth, M.D., ¶ 20-23.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
194. Arizona's regulatory scheme is inconsistent with those standards.	194. Disputed. Defendants state that the requirements of the Regulatory Act are based, in part, on standards promulgated by abortion-rights organizations such as the National Abortion Federation and the Planned Parenthood Federation of America and are consistent with those standards. Declaration of Lynn S. Farnsworth, M.D., ¶ 20-23.
195. Requiring that abortion providers have admitting privileges at a hospital in the state will also not make abortions safer because abortion providers who do not have hospital privileges can and often do make arrangements with other physicians to admit their patients in the event of an emergency, and because hospitals must admit and stabilize emergency patients regardless of whether their own physician is with them.	195. Disputed. Defendants state that the requirements of the Regulatory Act, including requiring admitting privileges, will improve the quality of abortion patient care in Arizona. Declaration of Lynn S. Farnsworth, M.D., ¶ 26. Defendants further state that, by way of example, Plaintiff Young who does not have admitting privileges, also does not have a transfer agreement or other arrangement with another physician to admit her abortion patients, if needed. Young dep. at 25.
196. Requiring that ultrasound operators obtain certification will also not make abortions safer because those operators can receive training of equal or better quality on the job.	196. Disputed. Defendants state that the requirements of the Regulatory Act, including requiring ultrasound certification, will improve the quality of abortion patient care in Arizona. Declaration of Lynn S. Farnsworth, M.D., ¶ 26.
197. Requiring that only physicians interpret ultrasound results will not make abortions safer because trained nurses are competent to perform that task.	197. Disputed. Defendants state that the requirements of the Regulatory Act, including that physicians interpret ultrasound results prior to performing an abortion, will improve the quality of abortion patient care in Arizona. Declaration of Lynn S. Farnsworth, M.D., ¶ 26. Defendants further state that Plaintiff Raphael interprets every ultrasound in his practice, as do other abortion providers. Raphael 2d dep. at 21; Bettigole 2d dep. at 15 ("nothing" is done in his practice with him first interpreting the ultrasound).

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
198. Requiring that a physician monitor a patient's vital signs during an abortion procedure will not make abortion safer because physicians can simply talk to the patient during the procedure to ascertain her condition.	198. Disputed. Defendants state that the requirements of the Regulatory Act, including monitoring vital signs, will improve the quality of abortion patient care in Arizona. Declaration of Lynn S. Farnsworth, M.D., ¶ 26.
199. As a general principle, increasing the cost (both monetary and otherwise) of medical care without creating corresponding benefits to patient safety threatens public health and is not good medical practice.	199. Disputed. Defendants state that the requirements of the Regulatory Act will improve the quality of abortion patient care in Arizona. Declaration of Lynn S. Farnsworth, M.D., ¶ 26. Defendants state that, since the filing of this lawsuit and with full knowledge of the requirements of the Regulatory Act, each of the plaintiffs has *decreased* the price he or she charges for a first trimester abortion. *See generally* The Defendants' Rule 1.10(l)(1) Statement of Facts in Support of Their Joint Motion for Partial Summary Judgment on Plaintiffs' Undue Burden Claim, ¶ 11.
200. Because the regulatory scheme will hinder access to abortion, but will not improve the safety of abortion procedures, it threatens the health of women seeking abortions in Arizona.	200. Disputed. Defendants state that the requirements of the Regulatory Act will improve the quality of abortion patient care in Arizona. Declaration of Lynn S. Farnsworth, M.D., ¶ 26. Defendants further state that the Regulatory Act will not hinder women's access to abortion services. *See generally* Memorandum in Support of The Defendants' Joint Motion for Partial Summary Judgment on Plaintiffs' Undue Burden Claim, at 10-11.
201. The condensed protocols of Planned Parenthood of Central and Northern Arizona, on which the regulatory scheme was allegedly based in part, are tailored only to the special circumstances of Planned Parenthood affiliates, not to the provision of abortion in physician practices.	201. Disputed. Defendants state that the requirements of the Regulatory Act are based, in part, on standards promulgated by abortion-rights organizations such as the National Abortion Federation and the Planned Parenthood Federation of America and are consistent with those standards. Declaration of Lynn S. Farnsworth, M.D., ¶ 20-23. Defendants further state that the Planned Parenthood protocols articulate an outstanding level of care for abortion patients. Farnsworth dep. at 119.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
202. Moreover, those protocols are not even required of Planned Parenthood affiliates in every instance; to the contrary, those affiliates can obtain waivers from particular requirements if they propose a different, medically sound method for providing care.	202. Defendants do not dispute that some Planned Parenthood affiliates seek waivers from certain requirements of the protocols. Defendants further that state that, while waivers are available, the standards (embodied in the protocols) are minimum standards with which every affiliate must comply and that local affiliates are permitted to incorporate local standards, as long as the minimum standards of care embodied in the protocols are met. Howard dep. at 8-11. Finally, the availability of waivers also does not diminish the medical appropriateness of the standards delineated in the Planned Parenthood protocols or the comparable standards in the Regulatory Act.
203. The regulatory scheme includes numerous, ambiguous or standardless requirements, with which some of the Plaintiffs do not know how to comply.	203. Disputed.
204. For example, the scheme requires sufficient numbers of patient care staff and employees to ensure the health of the patient's needs, but these terms appear to the Plaintiffs to be open to multiple interpretations.	204. Defendants state that, if a certain provision or administrative rule in the Regulatory Act requires the exercise of professional judgment, such as have sufficient staffing to ensure patient health, DHS inspectors will defer to that exercise of discretion, as long as the minimum standards are being met and the facility complies with acceptable standards of care. Blair dep. at 69, 85-86. Further, if the Regulatory Act is not specific on how the rule is to be met, DHS will expect the clinic's written policies and procedures to specify how the requirement is being met in that particular facility and, in turn, the facility to comply with its own policies and guidelines. Blair dep. at 103-04.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
205. This assessment will be made by the individual OMF inspector on the basis of his or her interpretation of what is sufficient in the situation.	205. Defendants state that, if a certain provision or administrative rule in the Regulatory Act requires the exercise of professional judgment, such as have sufficient staffing to ensure patient health, DHS inspectors will defer to that exercise of discretion, as long as the minimum standards are being met and the facility complies with acceptable standards of care. Blair dep. at 69, 85-86. Further, if the Regulatory Act is not specific on how the rule is to be met, DHS will expect the clinic's written policies and procedures to specify how the requirement is being met in that particular facility and, in turn, the facility to comply with its own policies and guidelines. Blair dep. at 103-04.
206. Because Dr. Raphael believes that his current staffing is appropriate and the scheme requires him to change certain aspects of that staffing, he already believes that his judgment about such matters will not be the same as DHS's.	206. Irrelevant.
207. Gestational age may be characterized in 2 different ways. It can be described as a number of weeks from either the woman's last menstrual period ("lmp") or from an estimate of the date of conception, which occurs two weeks later.	207. Defendants do not dispute that these are two methods of estimating gestational age; however, they are not "inconsistent" or "vague."
208. By using both of these different methods of characterizing gestational age in defining that term, the regulatory scheme leaves abortion providers without notice as to whether ultrasounds must be performed between 12 and 13.9 weeks lmp.	208. Disputed. Allowing two methods of calculating gestational age is not "vague" and does not impermissibly prohibit any conduct.
209. Although the regulatory scheme does not define "significant inaccuracies" in gestational age estimations, DHS plans to automatically forward all records of such inaccuracies from its contractors to the Board of Medical Examiners.	209. Defendants state that currently there is only one contractor, Apex, that will be reviewing ultrasound prints for DHS. Defendants further state that the details of the arrangement between DHS and Apex for ultrasound reviews have not been finalized, including the handling of prints with "significant inaccuracies" in the gestational age estimate. Conditt 2d dep. at 62-70.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
210. The regulatory scheme's definition of an "emergency" is also ambiguous.	210. Disputed.
211. DHS inspectors will have discretion to determine that term's meaning on a case-by-case basis.	211. Defendants state that DHS inspectors will not "peer review" a physician's judgment. Blair dep. at 63, 74. Defendants further state that if a certain provision or administrative rule in the Regulatory Act requires the exercise of professional judgment, such as what constitutes an "emergency," DHS inspectors will defer to that exercise of discretion, as long as the minimum standards are being met and the facility complies with acceptable standards of care. Blair dep. at 69, 85-86. Further, if the Regulatory Act is not specific on how the rule is to be met, DHS will expect the clinic's written policies and procedures to specify how the requirement is being met in that particular facility and, in turn, the facility to comply with its own policies and guidelines. Blair dep. at 103-04.
212. Although the regulatory scheme requires a variety of written policies and procedures, it does not specify criteria for determining whether specific policies and procedures are satisfactory; instead DHS inspectors will have discretion to determine the sufficiency of such policies and procedures on a case by case basis.	212. Defendants state that DHS inspectors will not "peer review" a physician's judgment. Blair dep. at 63, 74. Defendants further state that if a certain provision or administrative rule in the Regulatory Act requires the exercise of professional judgment, such as drafting appropriate policies and procedures, DHS inspectors will defer to that exercise of discretion, as long as the minimum standards are being met and the facility complies with acceptable standards of care. Blair dep. at 69, 85-86. Further, if the Regulatory Act is not specific on how the rule is to be met, DHS will expect the clinic's written policies and procedures to specify how the requirement is being met in that particular facility and, in turn, the facility to comply with its own policies and guidelines. Blair dep. at 103-04.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
213. The scheme's definition of counseling could mean any number of things and individuals are likely to differ in their interpretations of the term.	213. Defendants state that DHS inspectors will not "peer review" a physician's judgment. Blair dep. at 63, 74. Defendants further state that if a certain provision or administrative rule in the Regulatory Act requires the exercise of professional judgment, such as what constitutes "counseling," DHS inspectors will defer to that exercise of discretion, as long as the minimum standards are being met and the facility complies with acceptable standards of care. Blair dep. at 69, 85-86. Further, if the Regulatory Act is not specific on how the rule is to be met, DHS will expect the clinic's written policies and procedures to specify how the requirement is being met in that particular facility and, in turn, the facility to comply with its own policies and guidelines. Blair dep. at 103-04.
214. The scheme also requires "sufficient" lighting and ventilation, without specifying how sufficiency will be accessed. This determination will be left to the discretion of the individual DHS inspector.	214. Defendants state that if a certain provision or administrative rule in the Regulatory Act requires the exercise of professional judgment, such as what constitutes "sufficient lighting and ventilation," DHS inspectors will defer to that exercise of discretion, as long as the minimum standards are being met and the facility complies with acceptable standards of care. Blair dep. at 69, 85-86. Further, if the Regulatory Act is not specific on how the rule is to be met, DHS will expect the clinic's written policies and procedures to specify how the requirement is being met in that particular facility and, in turn, the facility to comply with its own policies and guidelines. Blair dep. at 103-04.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
215. The scheme also requires that a facility maintain "sufficient" equipment and supplies, but provides no criteria for accessing compliance. This determination will be left to the discretion of the individual DHS inspector.	215. Defendants state that if a certain provision or administrative rule in the Regulatory Act requires the exercise of professional judgment, such as what constitutes "sufficient equipment and supplies," DHS inspectors will defer to that exercise of discretion, as long as the minimum standards are being met and the facility complies with acceptable standards of care. Blair dep. at 69, 85-86. Further, if the Regulatory Act is not specific on how the rule is to be met, DHS will expect the clinic's written policies and procedures to specify how the requirement is being met in that particular facility and, in turn, the facility to comply with its own policies and guidelines. Blair dep. at 103-04.
216. The regulatory scheme is ambiguous as to whether an unlicensed individual can monitor post-abortion recovery if a physician is elsewhere in the facility.	216. Disputed. Defendants state that the Regulatory Act allows a medical assistant supervised by a physician to monitor patient recovery. *See* A.A.C. R9-10-1506(B)(3).
217. The regulatory scheme requires physicians to file an incident report with DHS with respect to any "serious injury" to the patient, but the definition of that term is a subjective one open to multiple interpretations.	217. Defendants state that if a certain provision or administrative rule in the Regulatory Act requires the exercise of professional judgment, such as what constitutes "serious injury to a patient," DHS inspectors will defer to that exercise of discretion, as long as the minimum standards are being met and the facility complies with acceptable standards of care. Blair dep. at 69, 85-86. Further, if the Regulatory Act is not specific on how the rule is to be met, DHS will expect the clinic's written policies and procedures to specify how the requirement is being met in that particular facility and, in turn, the facility to comply with its own policies and guidelines. Blair dep. at 103-04.
218. The regulatory scheme fails to indicate how physicians are to comply with the requirement that they maintain patient records in the "abortion clinic" for six months after patient discharge when those physicians close their medical practices.	218. Defendants state that, as a practical matter, once a facility closes, it ceases to be regulated by DHS and is no longer subject to the terms and requirements of the Regulatory Act. Blair dep. at 81-84.

Plaintiffs' Statement of Facts	*Defendants' Joint Response*
219. There are many different types of drugs and equipment that can support cardiac function, and it is unclear which of these will satisfy the regulatory scheme's requirements.	219. Defendants state that the DHS inspector will defer to the abortion clinic's medical director in determining which drugs are necessary to comply with A.A.C. R9-10-1513(b) and A.A.C. R9-10-1513(c). Blair dep. at 87-88.
220. Finally, while the scheme requires that rooms or areas be provided for various purposes, it does not indicate whether those rooms or areas may be used to satisfy multiple purposes.	220. Defendants state that if a certain provision or administrative rule in the Regulatory Act requires the exercise of professional judgment, such as whether areas may be used for multiple purposes, DHS inspectors will defer to that exercise of discretion, as long as the minimum standards are being met and the facility complies with acceptable standards of care. Blair dep. at 69, 85-86. Further, if the Regulatory Act is not specific on how the rule is to be met, DHS will expect the clinic's written policies and procedures to specify how the requirement is being met in that particular facility and, in turn, the facility to comply with its own policies and guidelines. Blair dep. at 103-04.

Dated: June 29, 2001

Janet Napolitano
Attorney General

By Lynne C. Adams
Kevin D. Ray
Lynne C. Adams
Timothy C. Miller
Assistant Attorneys General
1275 W. Washington Street
Phoenix, AZ 85007
(602) 542-1610

Richard M. Romley
Maricopa County Attorney

By Denise M Burke
Nikolas T. Nikas
Denise M. Burke
Brian Fahling
Steven M. Crampton
Special Deputy Maricopa County Attorneys
c/o 16465 Henderson Pass #1132
San Antonio, TX 78232
(210) 494-7781

Copy mailed on June 29, 2001 to:

Ms. Bonnie Scott Jones
Ms. Brigitte Amiri
The Center for Reproductive Law and Policy
120 Wall Street, 14th Floor
New York, NY 10005
Attorneys for Plaintiffs

Elva Martinez