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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

THE DEFENDANTS' JOINT MOTION FOR PARTIAL SUMMARY JUDGMENT ON PLAINTIFFS' UNDUE BURDEN CLAIM

(Oral Argument Requested)

Pursuant to Fed. R. Civ. P. 56, the defendants move this court for partial summary judgment, dismissing with prejudice Count IV of the plaintiffs' Fourth Amended Complaint, which is based on the allegation that the Regulatory Act creates an undue burden on a woman's right to choose an abortion. This motion is supported by the accompanying memorandum in support and separate statement of facts relied upon pursuant to D. Ariz. R. 1.10(*l*)(1).

April 30, 2001.

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MEMORANDUM IN SUPPORT OF THE DEFENDANTS' JOINT MOTION FOR PARTIAL SUMMARY JUDGMENT ON PLAINTIFFS' UNDUE BURDEN CLAIM

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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.
Planned Parenthood	The Planned Parenthood Federation of America, a national association of local and state affiliates such as Planned Parenthood of Central and Northern Arizona and Planned Parenthood of Southern Arizona, which has promulgated clinical guidelines for the provision of abortion services that must be followed by local and state affiliates.
PPCNA	Planned Parenthood of Central and Northern Arizona, one of the largest abortion providers in Arizona, and the author of abortion "protocols," which are attached to the accompanying statement of facts as Ex. B.
The Regulatory Act	A.R.S. §§ 36-449 through -449.03, A.R.S. § 36-2301.02 and Title 9, Chapter 10, Article 15 of the 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.
Undue Burden DSOF	The defendants' joint Rule 1.10(*l*)(1) statement of undisputed facts in support of their partial motion for summary judgment on plaintiffs' undue burden claim.

Preliminary Statement

Undue burden claims similar to those made by the plaintiffs in this case have been summarily rejected by the courts as lacking merit. In both *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000), *cert. denied*, 121 S.Ct. 1188 (2001), and *Women's Medical Center of Northwest Houston v. Archer*, No. H-99-3639, slip op. (S.D. Tex. 1999)[1], the courts found, respectively, that South Carolina and Texas's comprehensive abortion clinic regulations did not impose an undue burden on a woman's right to decide to have an abortion, rejecting the same undue burden claims that are being made by the plaintiffs in this case.[2]

The clear purpose and effect of the Regulatory Act is to ensure that women have access to *safe* abortions. The U.S. Supreme Court has repeatedly recognized that maternal health is a legitimate state interest to support regulations regarding abortion. *See, e.g.*, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 875-76 (1992); *Roe v. Wade*, 410 U.S. 113, 150 (1973). Further, there is absolutely no evidence to support the plaintiffs' contention that the Regulatory Act was designed to "harass and harm" abortion providers or their patients. Rather, the Regulatory Act merely codifies standards promulgated by national abortion providers themselves–standards that even the plaintiffs acknowledge are appropriate. Therefore, the Regulatory Act does not impose any burden, much less an "undue burden," on the right of Arizona women to decide to have an abortion.

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[1] This case is also cited as *Women's Medical Center of Northwest Houston v. Bell*, 2001 WL 370053 (5th Cir. 2001) (referenced in defendants' joint motions for partial summary judgment on plaintiffs' vagueness and equal protection claims). However, for the purposes of this motion, the district court's opinion is cited and the correct caption is *Women's Medical Center of Northwest Houston v. Archer*. The district court's rejection of the plaintiffs' undue burden claims was not appealed.

[2] Moreover, the Regulatory Act does not, as the plaintiffs argue, violate their due process rights under 42 U.S.C. § 1983 for the simple reason that Section 1983 creates no substantive rights. Instead, it merely provides remedies for deprivation of rights established elsewhere. *Robins v. Harum*, 773 F.2d 1004, 1006 (9th Cir. 1985) (citing *Oklahoma City v. Tuttle*, 471 U.S. 808 (1985)).

Background

Purpose of the Regulatory Act

The Arizona Legislature adopted the Regulatory Act in response to specific abortion-related deaths and accidents that occurred in Arizona. [Undue Burden DSOF ¶¶ 1, 2] In connection with its consideration of the legislation regarding the regulation of abortion clinics, the Legislature heard testimony regarding the tragic, April 17, 1998, death of Lou Anne Herron from complications associated with an abortion. [*Id.* at ¶ 1] During her abortion, Ms. Herron's abortion provider, Dr. John Biskind, lacerated Ms. Herron's uterus. [*Id.*] Following the abortion and before Ms. Herron's condition was stabilized, Dr. Biskind left Ms. Herron in the care of medical assistants who were not properly trained. [*Id.*] As even the plaintiffs' own expert, Dr. David Grimes, recognized, Ms. Herron's death was "absolutely preventable," and was the result of substandard care. [*Id.*] This incident, as well as another abortion-related death in 1995 and the birth of a near term baby during an attempted abortion, provided the impetus for the State to examine the regulation of abortion clinics and to enact new rules governing such clinics and abortion procedures. [*Id.* at ¶ 2]

There is no dispute that the Regulatory Act was drafted and adopted with the intent to protect maternal health. [*Id.* at ¶ 5] As Bryan Howard, Chief Executive Officer of PPCNA, one of the largest abortion providers in Arizona, and a key participant in the legislative process, commented, the Regulatory Act was not designed to "drive [abortion] providers out of providing abortion service," rather it was intended to "provide both access and health." [*Id.*] Similarly, Dr. Damon Raphael, one of the plaintiffs in this case, also acknowledged that the primary intent of the Regulatory Act is to protect the health, welfare and safety of the public, and that the State has "the responsibility and the right to regulate in the interest of the health, welfare and safety of the public." [*Id.*]

Medical Risks of Abortion

Abortion is an invasive, surgical procedure that can lead to numerous and serious medical complications. Those complications include, among others, bleeding, infection, uterine perforation, blood clots, cervical tears, incomplete abortion, reactions to anesthesia, fertility problems, and emotional problems. As the case of Lou Anne Herron shows, an abortion can even lead to death. [*Id.* at ¶¶ 1, 6] Although complications may occur in connection with even a well-performed and supervised abortion, the possibility of the situation becoming an emergency increases if quality of care standards are not met. Incorrect or unperformed testing, unsterile conditions, uneducated staff, or lack of emergency procedures may all exacerbate the possibility and consequences of abortion complications.

The risks for second trimester abortions are even greater than those for first trimester abortions. The possibility of hemorrhage, in particular, increases with a late-term abortion. [*Id.* at ¶ 7] And, the treatment for complications in connection with a second trimester abortion are more radical, including hysterectomy, other reparative surgery, or blood transfusions. [*Id.*]

Because there are no uniform, state collection requirements for abortion data, the actual risk of medical complications in connection with abortion are impossible to accurately quantify. As the author of a leading abortion textbook writes, "[T]here are few surgical procedures given so little attention and so underrated in its potential hazard as abortion." Warren M. Hern, ABORTION PRACTICE 101 (1990).

National Standards

Recognizing that abortion is not without risks, some abortion providers comply with nationally-recognized standards for performing abortions. The Regulatory Act is, in large part, simply a codification of those standards, with which most of the plaintiffs already comply. In drafting the Regulatory Act, the Arizona Legislature and DHS relied on

standards promulgated and recommended by the National Abortion Federation ("NAF") and on a "Condensed Abortion Protocol" provided by Planned Parenthood of Central and Northern Arizona ("PPCNA"), which in turn is based on the national standards and guidelines of the Planned Parenthood Federation of America ("Planned Parenthood").[3] [Undue Burden DSOF ¶ 8] Each of these organizations is a proponent of abortion and access to abortion services.

Many physicians and abortion providers, including most of the plaintiffs, consider the NAF standards for abortion care to be an authoritative source of good medical practice for the provision of abortions. [*Id.* at ¶ 9] The "Condensed Abortion Protocol" also provides guidelines that help ensure quality care for abortion patients. The standards and guidelines set forth in the Protocol, as well as the Planned Parenthood national abortion standards from which they are derived, are a "source of helping everyone continuously look at quality improvement" in the provision of abortion. [*Id.*] It is not surprising, therefore, that the Protocol standards are also "generally NAF consistent."[4] [*Id.*]

Argument

The courts in *Greenville Women's Clinic* and *Women's Medical Center* have already heard and summarily rejected the exact undue burden claims that are being made by the plaintiffs in this case. Moreover, in February 2001, the U.S. Supreme Court, without dissent, refused to hear an appeal of the Fourth Circuit's decision in *Greenville Women's Clinic*, allowing the lower court determination that South Carolina's regulations did not "unduly burden" a woman's right to choose an abortion to stand. *Greenville Women's*

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[3] Copies of those standards are attached to the Undue Burden DSOF as Exs. A and B.

[4] Nor is it surprising that PPCNA was never a party to this lawsuit. Planned Parenthood of Southern Arizona, a Tucson are abortion provider and affiliate of Planned Parenthood that is also subject to Planned Parenthood's national abortion standards, was originally a plaintiff in this case, but later withdrew as a party.

Clinic, 121 S.Ct. 1188 (2001). As in those cases, the Regulatory Act is merely a codification of national standards for abortion practice, was designed to protect maternal health, and imposes no "undue burden" on a woman's right to decide to have an abortion.

I. THE "UNDUE BURDEN" STANDARD APPLIES TO A FACIAL CHALLENGE OF THE REGULATORY ACT.

The "abortion liberty," which the U.S. Supreme Court has held is protected by the Fourteenth Amendment, has been defined as the right of a woman herself– not her husband, her parent, her doctor or others– to make the decision to have an abortion. *Casey*, 505 U.S. at 877 (joint opinion of O'Connor, Kennedy and Souter, JJ.). Only when the state unduly burdens the ability of the woman *to make the abortion decision* does the power of the state reach into the heart of the liberty protected by the Due Process Clause. *Id.* at 874 (joint opinion of O'Connor, Kennedy and Souter, JJ.) (emphasis added). Accordingly, to the extent that state regulations interfere with the woman's status as the ultimate decision-maker or try to give the decision to someone other than the woman, the Supreme Court has invalidated them. *Id.* at 887-898 (majority opinion). Alternatively, state regulations that do not "reach into the heart" of the protected liberty do *not* violate the abortion decision right. *Id.* at 874 (joint opinion of O'Connor, Kennedy and Souter, JJ.).

Accordingly, regulations that are simply "designed to foster the health of a woman seeking an abortion" are valid as long as they do not constitute an "undue burden." *Id.* at 878. "Undue burden" is shorthand for "the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of an nonviable fetus." *Id.* at 877. Despite considerable debate among the circuits as to the proper standard of review for facial challenges, the Ninth Circuit applies the *Casey* "undue burden" standard to facial challenges to abortion regulations. *Planned Parenthood v. Lawall*, 180 F.3d 1022, 1025-27 (9th Cir. 1999); *see also Greenville Women's Clinic*, 222 F.3d at 164 (discussing disagreement among courts as to the proper standard to be applied to facial

challenges of abortion-related laws).

In order to prevail on their undue burden claim, the plaintiffs must therefore demonstrate that the Regulatory Act would present a "substantial obstacle" to a "large fraction" of women in Arizona who might seek an abortion at a clinic subject to the Regulatory Act. *Casey*, 505 U.S. at 895 (majority opinion); *see also Greenville Women's Clinic*, 222 F.3d at 165. Moreover, the constitutionality of an abortion regulation turns on an examination of the importance of the state's interest in the regulation and the severity of the burden that the regulation imposes on the woman's right to seek an abortion. *Barnes v. State of Mississippi*, 992 F.2d 1335, 1339 (5th Cir.), *cert. denied*, 510 U.S. 976 (1993). Thus, the type or extent of a burden imposed on the *abortion provider* is not the proper constitutional analysis. The fact that the Regulatory Act may inconvenience some abortion providers or result in an expenditure of time and money by these providers to bring their practices into compliance with the requirements of the Regulatory Act is not sufficient to constitute an "undue burden" on a woman's decision of whether or not to have an abortion.

The plaintiffs cannot make the necessary showing of a substantial obstacle to a large fraction of women in this case. The Regulatory Act does not in any way interfere with the woman's status as the ultimate decision-maker regarding whether or not to have an abortion. It does not delegate that decision-making authority to someone else. Nor does it restrict the ability of doctors to decide whether to perform an abortion, when to do so, or what procedure to use. In short, *nothing* in the Regulatory Act effects the core of the abortion liberty. Instead, the Act is simply fosters women's health without placing *any* obstacle, substantial or otherwise, in the paths of women seeking an abortion.

II. THE STATE HAS A LEGITIMATE INTEREST IN PROTECTING MATERNAL HEALTH.

In evaluating the constitutionality of abortion regulations, the Supreme Court has repeatedly affirmed that "the State has an important and legitimate interests . . . *in preserving and protecting the health of the [pregnant] woman*." *Casey*, 505 U.S. at 875-76 (emphasis

added); *see also Roe v. Wade*, 410 U.S. at 150 ("[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that ensure maximum safety for the patient"); *Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 428-29 (1983) ("a state has a legitimate concern with the health of women who undergo abortions").

Arizona's Regulatory Act implements that legitimate interest. Confronted with evidence of abortion-related deaths, the Arizona Legislature adopted the Regulatory Act, which was specifically designed to advance the health and safety of Arizona women seeking abortions. [Undue Burden DSOF ¶¶ 1-2, 5] Indeed, as most of the plaintiffs themselves recognize in the materials they provide to patients, abortion is an invasive surgical procedure that can lead to serious complications, particularly with second or third trimester abortions. [*Id.* at ¶¶ 6-7] As the Fourth Circuit recently noted in upholding South Carolina's comprehensive abortion clinic regulations–which are more detailed and onerous than are Arizona's–those regulations served a valid state interest and were "little more than a codification of national medical- and abortion-association recommendations designed to ensure the health and appropriate care of women seeking abortions." *Greenville Women's Clinic*, 222 F.3d at 159, 167-69. Similarly in Arizona, the Regulatory Act was designed to protect maternal health and incorporates nationally accepted standards for abortion care to achieve this aim.

III. THE REGULATORY ACT IMPOSES NO UNDUE BURDEN ON A WOMAN'S DECISION TO SEEK ABORTION.

In this case, the plaintiffs have presented no specific or direct evidence that the Regulatory Act will unduly burden a woman's right to choose to have an abortion in Arizona. Instead, the plaintiffs have rested solely on speculation as to the consequences of the Act and the unsupported assertions of the plaintiffs that they will have to increase their prices if the Regulatory Act is enforced. As was the case in *Greenville Women's Clinic*, the

record here does not allow this Court to determine with any certainty whether, under the *Casey* standard, a large fraction of Arizona women would encounter a substantial obstacle to their choice to seek an abortion. *See Greenville Women's Clinic*, 222 F.3d at 165. Thus, as did the court in *Greenville Women's Clinic*, this Court must uphold the Regulatory Act against plaintiffs' facial challenge.

A. The Regulatory Act Does Not "Strike" At Abortion Liberty.

The plaintiffs have pointed to nothing specific to support their claim that the Regulatory Act creates an undue burden on the right to an abortion. Instead, they appear to argue that *any* health and safety regulations, no matter how appropriate, create an impermissible burden.[5] However, as the Supreme Court noted, "[t]he fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Casey*, 505 U.S. at 874. In light of that holding, the Fourth Circuit noted:

> In maintaining the distinction between state regulations that trammel the woman's right to choose to have an abortion–those that impose an undue burden–and those that merely have an incidental effect on the woman's decision, *the Court has upheld, both before Casey and in Casey, various regulations, the costs and effects of which, while amounting to interference and intrusion, did not reach the core of the protected liberty.*

Greenville Women's Clinic, 222 F.3d at 167 (emphasis added).

Because the Regulatory Act does not "strike" at the "core of the protected liberty"–it does not interfere with a woman's right to chose on her own whether to have an abortion–the Regulatory Act is valid unless it creates a *prohibitive* financial burden on abortion providers (which would then, presumably, be passed on to women seeking abortion) or unless it would so severely diminish the number of abortion providers as to

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[5] It is ironic that plaintiffs appear to argue against *any* regulation of abortion procedures. One of the reasons that women fought to legalize abortion was to avoid unsafe and unregulated abortions. Thus, legalizing abortion necessarily contemplated some form of health regulations concerning the practice.

prohibitively curtail a woman's right to choose. *See id.* ("Only when the increased cost of abortion is prohibitive, *essentially depriving women of the choice to have an abortion*, has the Court invalidated regulations because they impose financial burdens.") (emphasis added). The plaintiffs can demonstrate neither of those conditions here.

B. Any Potential Cost Increase Under the Regulatory Act Will Be Incidental.

The plaintiffs cannot meet their burden of showing on the record that compliance with the Regulatory Act will force them to prohibitively increase the prices they charge to women seeking abortions. *See Casey*, 505 U.S. at 901; *Greenville Women's Clinic*, 222 F.3d at 167. In this case, the plaintiffs have not presented any specific or credible evidence regarding 1) whether they will be forced to actually increase their costs at all to abortion patients, and 2) if they do, what those costs would be. Not only have they not identified those costs, they have not even provided an *estimated range* of potential cost increases. Instead, they have relied solely on unsupported allegations. [Undue Burden DSOF ¶ 10]

Moreover, evidence in this case directly contradicts that assertion. Since this lawsuit was instituted in March 2000, each of the plaintiffs has ***decreased*** the price he or she charges for a first trimester abortion by $10 to $60. [*Id.* at ¶ 11] Those price roll-backs occurred in spite of the fact that many of the plaintiffs are already essentially complying with the provisions of the Regulatory Act. [*Id.*]

In light of the dearth of evidence (and even some contradictory evidence), this Court must reject plaintiffs' claims. As the district court recently held in connection with a challenge to Texas's abortion clinic regulations, "undetermined fee increases predicted by abortion providers, but not supported by specific credible estimates, when weighed against the regulations' health benefits, do not constitute an undue burden on women seeking abortions." *Women's Medical Center*, slip op. at 60-64 (because regulations were not designed to "strike" at the right to abortion, speculative cost increases to patients were not

enough to invalidate the regulations); *see also Webster v. Reproductive Health Svcs.*, 492 U.S. 490, 530 (1989) (O'Connor, J., concurring) (abortion regulation that would require only "marginal" cost increase, at best, was constitutional); *Planned Parenthood v. Ashcroft*, 462 U.S. 476, 490 (1983) (pathology report requirement was valid because any cost increase would be "small").

C. The Regulatory Act Will Not Affect Women's Access to Abortions.

Plaintiff Dr. Young's assertion that she will cease performing abortions or close her practice if the Regulatory Act is enforced will not affect a woman's right to choose an abortion in Arizona. As with all of the plaintiffs' contentions concerning the monetary impact of the Regulatory Act, Dr. Young has provided no evidence to support her assertion. Furthermore, the Regulatory Act is not rendered facially invalid even if Dr. Young, a Tucson abortion provider, chooses to close her medical practice, rather than comply with the Regulatory Act. *See Women's Medical Center*, slip op. at 64 (rejecting similar claim).

Moreover, even if Dr. Young ceases performing abortions or closes her practice, that result alone cannot create an "undue burden" on the right of Arizona women to choose abortion. There is no evidence that the Regulatory Act would cause any other abortion providers–much less a substantial number of providers–to cease practicing. Moreover, other providers in Arizona and, specifically in Tucson, would still be available to provide abortion services to any of Dr. Young's potential or existing patients. For example, plaintiff Dr. Raphael, whose practice is also located in Tucson, testified that he will comply with the Regulatory Act and remain in business. [Undue Burden DSOF ¶ 12] Moreover, plaintiff Dr. Richardson, another Tucson abortion provider, is not currently operating at full capacity and stated that he could absorb new patients. [*Id.*]

IV. In Enacting the Regulatory Act, The State Sought to Safeguard Women's Health, While Providing Access to Abortions.

The State had no improper motive or purpose in enacting the Regulatory Act. Rather,

the State sought to safeguard women's health, while providing access to abortions. In evaluating whether Texas's abortion clinic regulations imposed an "undue burden" on a woman's right to choose to have an abortion, the Texas court determined that "it is significant to note that the legislative history . . . shows that a diverse committee of medical experts and both abortion rights activists and anti-abortion activists was assembled to draft a set of regulations that would improve the safety of women without decreasing access." *Women's Medical Center*, slip op. at 58. The court also found that there was "no evidence of any intent or purpose to place obstacles in the path of women seeking abortions." *Id.* at 59.

Similarly, in drafting the Regulatory Act, there was a concerted effort by the Arizona Legislature to provide both access to abortions and protection of women's health. [Undue Burden DSOF ¶¶ 3-5] Moreover, during the legislative and rule writing processes, the Legislature and DHS consulted Arizona abortion providers, the NAF standards and the PPNCA protocols. [*Id.* at ¶¶ 3-4] DHS also visited several Arizona abortion clinics to learn more about their practices and procedures. [*Id.* at ¶ 4] There is simply no evidence that the State had an improper motive for enacting the Regulatory Act or that it sought to burden a woman's right to choose an abortion.

Conclusion

This court should grant the defendants' joint motion for partial summary judgment on undue burden grounds and dismiss plaintiffs' undue burden claim (Count IV) with prejudice.

April 30, 2001.

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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

Pursuant to Rule 1.10(*l*)(1), Local Rules of the District of Arizona, the defendants rely on the following facts in support of their joint motion for partial summary judgment on plaintiffs' undue burden claim (Count IV):

1. Lou Anne Herron died on April 17, 1998 in the A-Z Women's Center, a Phoenix abortion clinic, as the result of a lacerated uterus, an injury that occurred during an abortion. [EJA00000177-293 (Phoenix Police Department Report, dated July 15, 1998)] Although Ms. Herron's injury might not have resulted in death under different circumstances, the A-Z Women's Center was understaffed, and the staff that was on the premises during the abortion were improperly trained. [Grimes dep. at 91-97; EJA00005670-5879 (testimony of Dr. John I. Biskind in *State v. Biskind*, No. CR 99-00198 (Ariz. Superior Ct.), dated February 13, 2001)] Ms. Herron's care at the A-Z Women's Center was well beneath the standard of care for abortions and was "absolutely preventable." [Grimes dep. at 94, 96, 99]

2. This death and two other abortion-related incidents–the 1995 abortion death of a twenty-six year old woman who bled to death when her uterus was lacerated during an abortion and the 1998 birth of "Baby Phoenix" following an attempted abortion at 37 weeks gestation–were the impetus for the Arizona Legislature's decision to study and eventually regulate abortion clinics. [Bettigole dep. at 87; Davis dep. at 35, 62; EJA00000152-176 (1/18/96 interview transcript of Dr. John I. Biskind before the Arizona Board of Medical Examiners); EJA00000100 (*Near-Abortion Spurs Investigation of Valley Physician*, ARIZ. TRIB., July 11, 1998); Arizona State Senate Final Revised Fact Sheet, H.B. 2706, 44th Leg., 1st Reg. Sess. at 1 (Ariz. 1999) ("Events in 1998 at a Phoenix abortion clinic raised several questions about the responsibility of state agencies to ensure the public health and safety regarding abortion and other outpatient medical procedures."); Arizona House of Representatives Bill Summary, H.B. 2706, 44th Leg., 1st Reg. Sess. at 1 (Ariz. 1999) ("Events at a Phoenix abortion center raised questions as to how state agencies protect the public pertaining to abortion and various types of outpatient medical procedures.")]

3. In 1999, the Arizona Legislature convened a Joint Study Committee to study the potential regulation of abortion clinics and other outpatient treatment centers. [Davis dep. at 32] The Joint Study Committee was organized to hold public hearings, engage in fact finding, review abortion clinic regulations from other states, review the status of abortion services in Arizona, and make recommendations to the Legislature. [Howard dep. at 39-40] The Joint Study Committee received input from many existing Arizona abortion providers, including Planned Parenthood of Central and Northern Arizona ("PPCNA"), whose President and Chief Executive Office, Bryan Howard, met with legislators, staff members and DHS personnel to make certain that any regulation was "legitimate regulation oriented toward patient safety." [Howard dep. at 16-19]

4. During the administrative rule-making process, DHS held public hearings and solicited and received input and comment from abortion providers, including plaintiffs Raphael and Richardson and PPCNA. [Raphael dep. at 19-20; EJA00001677 (7/28/99 letter from Richardson to DHS); Howard dep. at 21; Conditt dep. at 15] In addition, DHS visited several Arizona abortion clinics to learn more about their practices and procedures. [Conditt dep. at 12] The rules adopted by DHS reflect some of the recommendations made during that process. [Raphael dep. at 34-35; Phillips dep. at 33, 35]

5. The Regulatory Act was drafted and adopted with the intent to protect maternal health; it was not designed to "drive [abortion] providers out of providing abortion service." [Howard dep. at 50-51; Raphael dep. at 118, 138 (acknowledging that the primary intent of the Regulatory Act is to protect the health, welfare and safety of the public, and that the State has "the responsibility and the right to regulate in the interest of the health, welfare and safety of the public")]

6. Potential complications from first trimester abortions include 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, fertility problems, emotional problems, free fluid in the abdomen, acute

abdomen, missed ectopic pregnancies, cardiac arrest, sepsis, respiratory arrest, and even death. [Ex. 2 to Howard dep. ("Fact Sheet About Early Abortion") (attached as Ex. C); Tamis dep. at 66]

7. The risks for second trimester abortions are greater than for first trimester abortions. The risk of hemorrhage, in particular, is greater, and the resultant complications may require a hysterectomy, other reparative surgery, or a blood transfusion. [Raphael dep. at 13-15, 54]

8. The Regulatory Act is simply a codification of national standards for abortion practice. In drafting the Regulatory Act, the Arizona Legislature and DHS relied on standards promulgated and recommended by the National Abortion Federation ("NAF") and on a "Condensed Abortion Protocol" provided by PPCNA, which is based on the national standards and guidelines of the Planned Parenthood Federation of America ("Planned Parenthood"), and consulted with Arizona abortion providers. (Copies of those standards are attached as Exs. A and B, respectively.) [Howard dep. at 18-19; Conditt dep. at 15]

9. The NAF standards for abortion care are considered to be an authoritative source of good medical practice for the provision of abortions. [Bettigole dep. at 11; Raphael dep. at 20-24; Richardson dep. at 39; Farnsworth dep. at 119] The Planned Parenthood standards and guidelines are "generally NAF consistent" and a "source of helping everyone continuously look at quality improvement" in the provision of abortion services. [Raphael dep. at 22; Richardson dep. at 105-07; Yrun dep. at 40]

10. None of the plaintiffs have determined the additional costs and time, if any, that compliance with 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. [Richardson's Resp. to State Defs.' First Set of Interrogs. 9, 15; Raphael's Resp. to State Defs.' First Set of Interrogs. 9, 15; Tamis's Resp. to State Defs.' First Set of Interrogs. 9, 15; Young's Resp. to State Defs.' First Set of Interrogs. 9, 15]

11. Since this lawsuit was instituted in March 2000, each of the plaintiffs has ***decreased*** the price he or she charges for a first trimester abortion by $10 to $60. [Raphael dep. at 111-13 (decreased fee from $310 to $290 or $295); Richardson dep. at 104 (decreased fee from $310 to $300); Tamis Decl. at ¶ 9 and Tamis Resp. to State Defs.' First Set of Interrogs. No. 14 (decreased fee from $340 to $280); Young Resp. to State Defs.' First Set of Interrogs. No. 14 and Young dep. at 104 (decreased price from $320 to $300)] Those price roll-backs occurred in spite of the fact that many of the plaintiffs already comply with all or many of the provisions of the Regulatory Act. [Richardson dep. at 33, 38, 84-85, 93-95, 100 (practice established in compliance with Regulatory Act); Raphael dep. at 65-107 (comply with many provisions of Act); Tamis dep. at 42-43, 63-65, 68, 95, 101-02 (same)]

12. Other abortion providers in Arizona and, specifically in Tucson, would be available to provide abortion services to any of plaintiff Young's potential or existing patients, should she choose to cease performing abortions instead of complying with the Regulatory Act. [Raphael dep. at 72-73, 85, 107; Richardson dep. at 97]

April 30, 2001.

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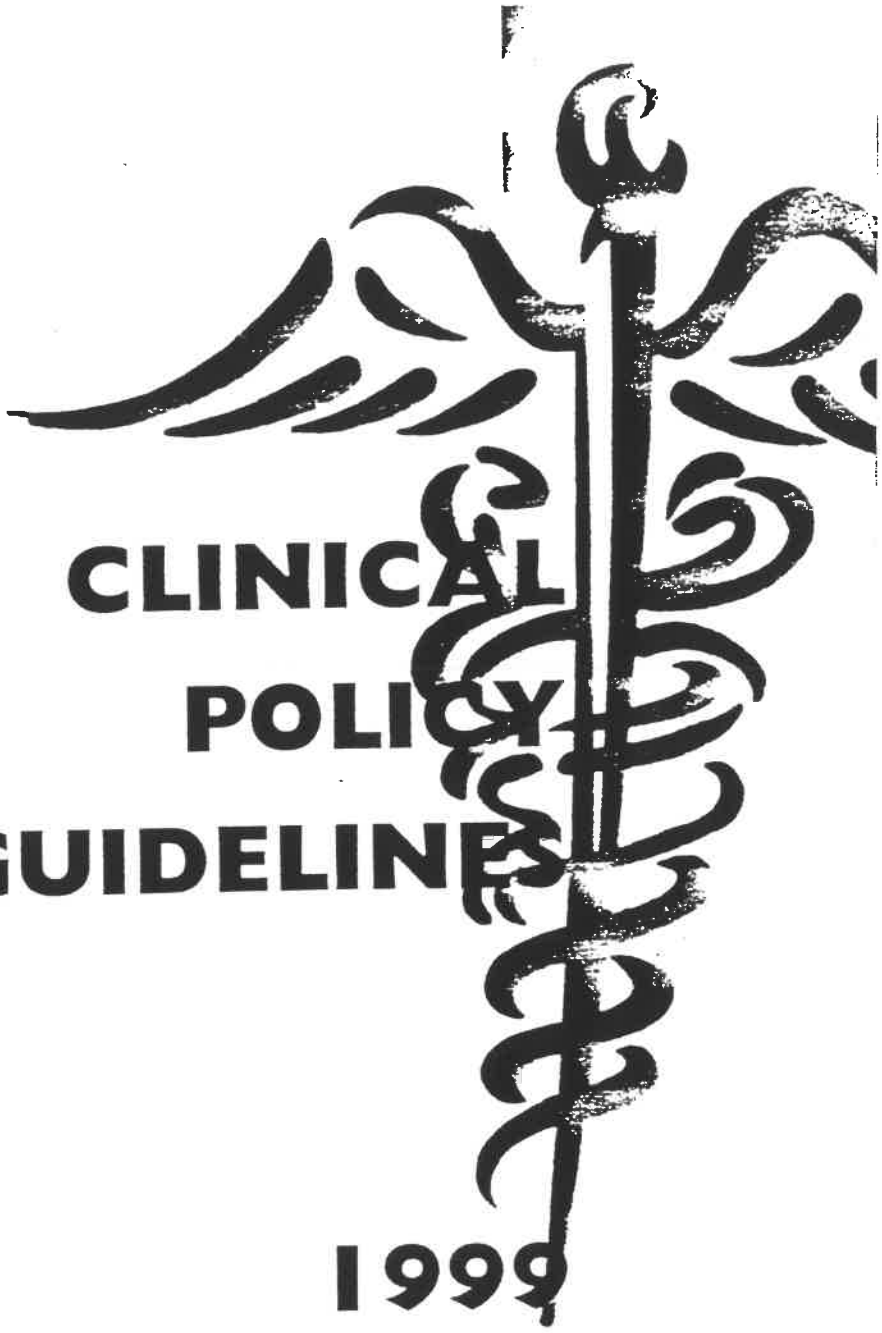
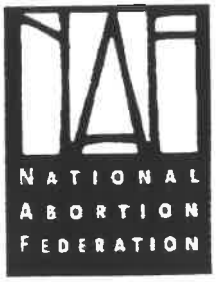
exhibit A



CLINICAL POLICY GUIDELINES 1999



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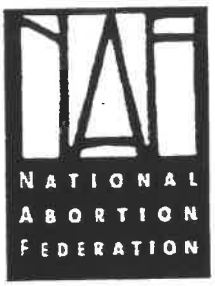

1999

National Abortion Federation

1999 CLINICAL POLICIES GUIDELINES

INTRODUCTION

The mission of the National Abortion Federation (NAF) is to promote and enhance the quality of abortion services. An important part of this mission is to assure that women receive high quality abortion care and that they have access to this care in a safe environment. NAF also educates providers in new techniques while setting and maintaining standards for abortion services.

Like its precursers, the 1999 edition of NAF's *Clinical Policy Guidelines* establishes clinical policy guidelines which are developed by consensus, based on rigorous review of the relevant medical literature and known patient outcomes. These guidelines provide a basis for ongoing quality assurance, help reduce unnecessary care and costs, help protect providers in malpractice suits, provide ongoing medical education and encourage research.

NAF's *Clinical Policies Guidelines,* first published in 1996 and revised annually, use the methodology described by David Eddy, MD, in *A Manual for Assessing Health Practices and Designing Practice Policies: The Explicit Approach.* Clinical policy guidelines are defined as a systematically developed series of statements which assist practitioners and patients in making decisions about appropriate health care. They represent an attempt to distill a large body of medical knowledge into a convenient and readily usable format.

When the outcomes of an intervention are known, practitioner choices are limited. But when the outcomes of an intervention are uncertain or variable, and/or when patients' preferences for those outcomes are uncertain or variable, practitioners must be given flexibility to tailor a policy to individual cases. This is addressed by having three types of practice policies according to their intended flexibility: standards, recommendations, and options.

1) **STANDARDS** are intended to be applied rigidly; they must be followed in virtually all cases; exceptions will be rare and difficult to justify.

2) **RECOMMENDATIONS** are steering in nature; they do not have the force of standards, but when not adhered to, there should be documented, rational clinical justification; they allow some latitude in clinical management.

3) **OPTIONS** are neutral with respect to a treatment choice; they merely note that different interventions are available and that different people make different choices; they may contribute to the educational process, and they require no justification.

NAF Clinical Policies Guidelines have listed references when appropriate and include discussions in more controversial areas. They are meant to be a living document, subject to periodic revision as better information becomes available.

References:

1. Eddy, DM. Clinical decision making: From theory to practice. Designing a practice policy: Standards, guidelines, and options. *JAMA*, 1990, *263*:3077.

2. Eddy, DM. *A Manual for Assessing Health Practices and Designing Practice Policies: The Explicit Approach.* Philadelphia: American College of Physicians, 1992.

3. Field, M & Lohr, K (Eds). *Guidelines for Clinical Practice: From Development to Use.* Washington, DC: National Academy Press, 1992.

4. Garnick, D, *et al.* Can practice guidelines reduce the number and costs of malpractice claims? *JAMA*, 1991, *266*:2856.

5. Hadorn, D, *et al.* An annotated algorithm approach to clinical guideline development. *JAMA*, 1992, *267*:3311.

6. Hayward, RS, *et al.* Users' guide to the medical literature VIII: How to use clinical practice guidelines; A. Are the recommendations valid? *JAMA*, 1995, *274*:570.

7. James, BC. Implementing Practice Guidelines through Clinical Quality Improvement. *Frontiers of Health Services Management*, 1993, *10*: 1.

8. Leape, LL. Practice guidelines and standards: An overview. *Qual. Rev. Bull.*, 1990, *161*:42.

9. Meeker, CI. A consensus-based approach to practice parameters. *Obstet.Gynecol.*, 1992, *79*:790.

10. Walker, RD, *et al.*, Medical Practice Guidelines. *West J. Med*, 1994, *161*: 39.

11. Woolf, SH. Practice Guidelines: A New Reality in Medicine. I. Recent Developments. *Arch Intern Med*, 1990, *150*: 1811.

12. Woolf, SH. Practice Guidelines: A New Reality in Medicine. II. Methods of Developing Guidelines. *Arch Intern Med*, 1992, *152*: 946.

13. Woolf, SH. Practice Guidelines: A New Reality in Medicine. III. Impact on Patient Care. *Arch Intern Med*, 1993, *153*: 2646.

WHO SHOULD PERFORM ABORTIONS

Policy Statement: Abortion is a safe procedure when performed by qualified practitioners.

Standard 1: Abortion must be performed by licensed physicians or licensed / certified / registered midlevel clinicians trained in the provision of abortion care, in accordance with state law.

Standard 2: All personnel performing abortions must receive training in the performance of abortions and in the prevention, recognition and management of complications.

Recommendation 0.1: When midlevel clinicians perform abortions, medical protocols should be in place that adhere to the midlevel provider scope of practice permitted by state law.

Recommendation 0.2: Appropriate referrals should be available for patients who cannot be cared for at your facility.

COUNSELING AND INFORMED CONSENT

Policy Statement: Obtaining informed consent and assessing that the decision to have an abortion is made freely by the patient are essential parts of the abortion process.

Standard 1: Accurate information must be provided regarding the risks and benefits of abortion.

Option 1.01: This information may be provided either on an individual basis or in group sessions.

Standard 2: There must be documentation that the patient affirms that she understands the procedure and its alternatives; the potential risks, benefits, and complications; that her decision is uncoerced; and that she is prepared to have an abortion.

Recommendation 0.1: There should be an opportunity for discussion of the patient's feelings about the abortion decision.

Standard 3: A woman must undergo the abortion as expeditiously as possible in accordance with good medical practice.

Standard 4: Information about birth control must be available to patients at the facility.

Standard 5: All reasonable precautions must be taken to ensure the patient's confidentiality.

Discussion: Informed consent and abortion counseling are two different processes.

The goal of informed consent is to assure that the woman's decision is voluntary and informed, and to obtain legal permission for an abortion.

Counseling is a discussion of the feelings and concerns expressed by the woman who finds herself in a crisis situation. There are many different personal styles of counseling, and no one style works best in all situations. Counseling is not therapy and, therefore, is not intended to extend over a long period of time. A referral to community services

should be available if that becomes necessary or the needs of the woman are outside the scope of training of the counselor. Counseling may include an exploration of the woman's feelings, help with decision making and contraceptive choices, values clarification, or referral to other professionals. Abortion counseling is also to prepare the woman for her procedure by reducing her level of anxiety. Counseling must not create a barrier to service and must be voluntary.

Confidentiality might become an issue when third-party payers are involved. It is helpful to obtain information on clinic registration forms on all authorized sources of reimbursement, along with a statement that listing a source of reimbursement constitutes authority from the patient to notify and/or bill that source. If a patient does not provide information about a potential reimbursement source, it may be a breech of confidentiality to notify and/or bill that source unless there is documentation that supplemental consent from the patient has been obtained.

References:

1. Baker, A. *Abortion and Options Counseling: A Comprehensive Reference.* Granite City, Illinois: The Hope Clinic for Women, 1995.

2. Beresford, T. *Short-Term Relationship Counseling.* Baltimore: Planned Parenthood of Maryland, 1988.

USE OF PERI-OPERATIVE ANTIBIOTICS

Policy Statement: Prevention and treatment of infection will reduce post-abortion morbidity.

Recommendation 0.1: All women should receive antibiotics at the time of surgical abortion.

Recommendation 0.2 Therapeutic doses of antibiotics should be considered for high risk patients.

Recommendation 0.3: For documented infections, CDC guidelines should be followed.[1]

Option 0.01: Antibiotics may be initiated at the time of insertion of osmotic dilators.

Option 0.02: Patients with non-cardiac prostheses may be given peri-operative antibiotics.[2]

Discussion: Our review of the literature supports universal antibiotic treatment of all women undergoing surgical abortion.

---

[1]Current treatment guidelines include:

Chlamydia -	Doxycycline	100 mg bid x 7d
	Azithromycin	1 gm stat
	Erythromycin	dosage based on preparation x 7d
	Ofloxacin	300 mg bid x 7d
Bacterial vaginosis -	Metronidazole	500 mg bid x 7d or 2 gm stat

[2]"It is the opinion of the American Academy of Oral Medicine that there is insufficient scientific evidence to support routine antibiotic prophylaxis for patients with prosthetic joints who are receiving dental care." Eskinazi, D & Rathbun, W. Is systematic antimicrobial prohylaxis justified in dental patients with prosthetic joints? *Oral Surg. Oral Med. Oral Pathol.*, 1988, *66*:43.

Studies of large series of patients in the past were inconclusive as to whether routine antibiotics were helpful in reducing post abortal infectious morbidity. Because of this controversy, previous NAF Clinical Policy Guidelines recommended that only high riskpatients be given perioperative antibiotics. High risk patients are defined as those at increased risk of Chlamydial cervicitis:

a. age under 21;
b. new or multiple sexual partners;
c. mucopurulent discharge;
d. presence of another STD;
e. previous history of pelvic inflammatory disease.

A recently published meta-analysis (see ref. 11) of randomized, controlled, clinical trials published between 1966 and 1994 indicates, however, that regardless of patient risk status, all patients would benefit from receiving antibiotics. Several antibiotic types and doses are effective.

References

1 Blackwell, AL. Health gains from screening for infection of the lower genital tract in women attending for termination of pregnancy. *Lancet,* 1993, *342:*206.

2. Darj, E, *et al.* The prophylactic effect of doxycycline on postoperative infection rate after first-trimester abortion. *Obstet. Gynecol.,* 1987, *70:*755.

3 Grimes, DA, *et al.* Prophylactic antibiotics for curettage abortion. *Am. J. Obstet. Gynecol.,* 1984, *150:*689.

4. Hakim-Elahi, E & Tovell, H. Complications of first-trimester abortion: A report of 170,000 cases. *Obstet. Gynecol.,* 1990, *76:*129.

5. Larsson, PG, *et al.* Incidence of pelvic inflammatory disease after first-trimester legal abortion in women with bacterial vaginosis after treatment with metronidazole: A double-blind randomized study. *Am. J. Obstet. Gynecol.* 1992, *166:*100.

6. Levallois, P & Rioux, J. Prophylactic antibiotics for suction curettage: Results of a clinical controlled trial. *Obstet. Gynecol.,* 1988, *158:*100.

7. McGregor, JA. Prophylactic antibiotics unjustified for unselected abortion patients. *Am. J. Obstet. Gynecol.*, 1985, *152:*722.

8. Moller, BR, *et al.* Pelvic infection after elective abortion associated with *Chlamydia trachomatis*. *Obstet. Gynecol.*, 1982, *59:*210.

9. Osser, S & Persson, K., Postabortal pelvic infection associated with *Chlamydia trachomatis* and the influence of humoral immunity. *Am. J. Obstet. Gynecol.*, 1984, *150:*699.

10. Qvigstad, E, *et al.* Pelvic inflammatory disease associated with *Chlamydia trachomatis* after therapeutic abortion: A prospective study. *Brit. J. Vener. Dis.*, 1983, *59:*189.

11. Sawaya, GF, *et al.* Antibiotics at the time of induced abortion: The case for universal prophylaxis based on a meta-analysis. *Obstet. Gynecol.*, 1996, *87:*884

12. Sawaya, GF & Grimes, DA. Preventing postabortal infection. *Contemp. Obstet. Gynecol.*, 1994, *15:*53.

PRE-OPERATIVE ENDOCARDITIS PROPHYLAXIS

Policy Statement: Endocarditis is a potential risk of surgical procedures.

Option 0.01: Patients with a prosthetic heart valve, previous bacterial endocarditis or surgically constructed pulmonary shunt may be given pre-operative prophylactic antibiotics.

Option 0.02: Patients with mitral valve prolapse *with a murmur* may be given oral antibiotics prior to the procedure.

Discussion: A review of endocarditis prophylaxis literature summarizes the indications for antibiotic prophylaxis as follows: "Prophylaxis against endocarditis, therefore, should be reserved for higher-risk procedures in patients with higher-risk cardiac disorders. Otherwise, prophylaxis should be considered either optional or unnecessary . . .. Prophylaxis is advised when *both* the underlying cardiac condition and the procedure seem to pose substantial risk [emphasis added]" (see ref. 2).

The American Heart Association specifically does not recommend prophylaxis in the absence of infection for the following procedures: urethral catheterization, dilation and curettage, uncomplicated vaginal delivery, abortion, insertion or removal of intrauterine device, sterilization procedures, and laparoscopy. The AHA does not define "absence of infection". Notwithstanding the AHA recommendations, it is reasonable medical practice to follow the advice of consultants and/or referring physicians, about prophylaxis.

"Because no adequate, controlled clinical trials of antibiotic regimens for the prevention of bacterial endocarditis in humans have been done, recommendations are based on *in vitro* studies, clinical experience, data from experimental animal models, and assessment of both the bacteria most likely to produce bacteremia from a given site and those most likely to result in endocarditis. The substantial morbidity and mortality in patients who have endocarditis and the paucity of controlled clinical studies emphasize the need for continuing research into the epidemiology, pathology, prevention, and therapy of endocarditis" (see ref. 1).

References:

1. Dajani, AS, *et al.* Prevention of bacterial endocarditis: Recommendations by the American Heart Association, *JAMA,* 1997, *277*:1794.

2. Durack, DT. Prevention of infective endocarditis. *New Eng. J. Med.,* 1995, *332*:38.

Rh TESTING AND Rh IMMUNE GLOBULIN ADMINISTRATION

Policy Statement: Rh alloimmunization is a significant health risk to Rh(-) women undergoing abortion.

Standard 1: Rh status must be documented in all women undergoing abortion.
- a. This documentation may be obtained by on-site testing or outside medical source.
- b. Du testing is not required.

Standard 2: Rh immune globulin administration must be offered to Rh(-) women and documented.

Standard 3: If Rh immune globulin is not administered in the facility, one of the following is required:
- a. informed waiver signed by a patient who refuses Rh immune globulin;
- b. documentation of other arrangements for administration.

References:

1. Baskett, TF. Prevention of Rh alloimmunization: A cost-benefit analysis. *Can. Med. Assoc. J.*, 1990, *142*:337.
2. Bowman, J. The prevention of Rh immunization. *Transfusion Med. Rev.*, 1988, *2*:129.
3. Chavez, GFP. Epidemiology of Rh hemolytic disease of the newborn in the United States. *JAMA*, 1991, *263*:3270.
4. Commentary: Immunoprophylaxis for Rhesus disease - Expensive but worth it?. *Brit. J. Obstet. Gynecol.*, 1991, *98*:509.
5. Gibble, JW. Maternal immunity to red cell antigens and fetal transfusion. *Cl. Lab. Med.*, 1992, *12*:553.
6. Roberts, H. The use of anti-D prophylaxis in the management of miscarriage in general practice. *Health Bull.*, 1991, *49*:245.

SONOGRAPHY

Policy Statement: Ultrasonography is a tool which has applications in abortion practice.

Standard 1: Verification of gestational age by ultrasonography is required prior to the termination of a pregnancy clinically estimated to be more than 14 weeks LMP.

Option 0.01: In the first trimester, use of ultrasonography can be of clinical value in verifying intra-uterine pregnancy and gestational age.

Option 0.02: In the first and second trimesters, intra-operative ultrasound can be of value to locate fetal parts and aid in their extraction, to verify an empty uterus, and to verify an intact uterus.

ANESTHESIA

Policy Statement: The use of anesthesia and/or analgesia can minimize pain and anxiety in abortion procedures but has certain risks in addition to its benefits.

DEFINITIONS:

1. Local Anesthesia - Elimination or reduction of sensation, especially pain, in one part of the body by topical application or local injection of a drug. In the context of abortion practice, this almost always signifies paracervical block.

2. Conscious Sedation - A minimally depressed level of consciousness that retains the patient's ability to maintain a patent airway independently and continuously, to be easily aroused, and to respond appropriately to physical stimuli and verbal commands.

3. Deep Sedation - A controlled state of depressed consciousness from which the patient is not easily aroused. This may be accompanied by a partial or complete loss of protective reflexes, including inability to maintain a patent airway independently and/or to respond purposefully to physical stimulation or verbal command. Deep sedation can result from sedative and analgesic administration intended to produce only conscious sedation.

4. General Anesthesia - A controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to maintain an airway independently and to respond purposefully to physical stimulation or verbal command.

PERSONNEL AND MONITORING

Standard 1: When conscious sedation, deep sedation, or general anesthesia are used, monitoring of the patient's level of consciousness must be documented.

Standard 2: When conscious sedation or local anesthesia is used, the practitioner responsible for the treatment of the patient and/or the administration of drugs for sedation must be appropriately trained.

Standard 3: When conscious sedation is used, a person other than the clinician, trained to monitor appropriate physiological parameters, must be present.

Recommendation 3.1: During conscious sedation the patient should be checked frequently for verbal responses.

Standard 4: The personnel administering conscious sedation must recognize that conscious sedation may lead to deep sedation with hypoventilation and be prepared to provide respiratory support.[3]

Standard 5: The supervising practitioner must be immediately available when conscious sedation is administered.

Standard 6: When conscious sedation is used, monitoring must be of a degree which can be expected to detect the respiratory, cardiovascular, or neurological effects of the drugs being used.

Option 6.01: Pulse oximetry may be used to enhance this monitoring.

Recommendation 0.1: During conscious sedation or local anesthesia, IV access should be maintained for patients in ASA III, IV, and V (see Attachment A, *page 21 of this document).*

Standard 7: The practitioner administering general anesthesia or deep sedation must be credentialed, and certified according to American Society of Anesthesiologists standards.

Standard 8: The practitioner administering general anesthesia or deep sedation must not be the practitioner performing the abortion.

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[3]See Clinical Policies Guidelines on Emergency Procedures.

Standard 9: For general anesthesia and deep sedation, the patient's oxygenation, ventilation, circulation and temperature must be continually evaluated as prescribed in the ASA Standards for Basic Intra-Operative Monitoring (see Attachment B, *pages 22-23 of this document).*

Recommendation 9.1: When deep sedation and/or general anesthesia are used, IV access should be maintained according to ASA guidelines.

Standard 10: The use of $N_20/0_2$ must follow guidelines for conscious sedation.

Standard 11: Equipment for the delivery of $N_20/0_2$ must:

a) provide a concentration of N_20 of no more than 50% inspired;
b) provide a maximum of 100% and minimum of 21% 0_2 conc.;
c) be outfitted with an 0_2 analyzer;
d) be checked and calibrated regularly.

Recommendation 11.1: N_20 concentrations in the work environment should be kept below the National Institute for Occupational Safety and Health (NIOSH) recommended limit.

Standard 12: When conscious sedation, deep sedation, or general anesthesia is used, there must be documentation that the patient has been warned of possible transient mental impairment.

FACILITIES AND EQUIPMENT: See Emergency Procedures guideline.

Discussion: ON THE USE OF ANESTHESIA IN GENERAL - All medications used in anesthesia have the potential for serious risk. This risk may be reduced to a minimum by adherence to established practice guidelines. Guidelines developed by other organizations concern themselves with anesthesia delivered primarily in hospital settings and to patients varying widely in age and general health. Abortion patients, however, are younger and rarely have significant health problems. Nonetheless, anesthesia complications are an increasing proportion of total abortion morbidity and mortality (see ref. 10).

The promulgation of guidelines for the delivery and monitoring of anesthesia care issued by organizations such as the American Society of Anesthesiologists (ASA), the American

Dental Society of Anesthesiologists (ADSA), American Society of Gastrointestinal Endoscopists and others have clarified many of the issues related to anesthesia care. Whether it be local anesthesia, intravenous sedation, or general inhalation analgesia/anesthesia, it is the degree of CNS depression rather than any type of modality *per se* that is the basis for establishment of NAF guidelines. Levels of sedation are not completely distinct, but merge one with the next - each level of deeper sedation requires an increased level of care and monitoring. These levels of sedation are defined elsewhere.

NAF guidelines specifically address the use of conventional anesthesia. It is recognized that patient comfort and reduced anxiety are not dependent only on pharmacologic measures, but are significantly affected by patient counseling and by a supportive staff. It is also recognized that there is a wide range of alternative modalities (such as acupuncture, yoga, hypnosis) that are helpful for many patients. The focus of NAF guidelines, however, is on the monitoring necessary for the safe and effective use of pharmacologic methods generally used in outpatient abortion facilities.

ON THE USE OF PULSE OXIMETRY - There have been no trials on young women undergoing outpatient abortion who only rarely have respiratory or hemodynamic compromise. Given the low risk of morbidity and mortality associated with this procedure it is unlikely that there will be studies large enough to assess pulse oximetry on the basis of outcomes. The major correlation with prolonged oxygen desaturation is advancing age and cardiovascular function deficits.

ON THE USE OF N_20 - Nitrous oxide has a long history of use for analgesia and sedation, as well as an excellent safety record in the hands of both anesthesiologists and nonanesthesiologists. Attention must be paid to the level of sedation provided and the clinician must be prepared to recognize and care for changes in these levels. Occupational exposure to N_20 has been associated with increased risks of neurologic impairment, spontaneous abortion, subfertility, and hepatic and renal disease. Although there is no OSHA standard for N_20, NIOSH recommends that airborne levels of N_20 be kept below 25 ppm (1995) through well-designed scavenger systems and other engineering controls, equipment maintenance, exposure monitoring, and safe work practices.

References:

1. ADAS Newsletters, 1988, 20:2, as reported in Rosenberg, MB, & Campbell, RL, Guidelines for intraoperative monitoring of dental patients undergoing conscious sedation, deep sedation, and general Anesthesia. *Oral. Surg. Oral Med. Oral Pathol.*, 1991, *71*:2.

2. Atrash, HK, *et al.* Legal abortion mortality and general anesthesia. *Am. J. Obstet. Gynecol.*, 1988, *158*:420.

3. Bailey, PL, *et al.* Frequent hypoxemia and apnea after sedation with midazolam and fentanyl. *Anesth.*, 1990, *73*:826.

4. Bell, GD, *et al.* Recommendations for standards of sedation and patient monitoring during gastrointestinal endoscopy. *Gut*, 1991, *32*:823.

5. Council on Scientific Affairs, American Medical Association. The use of pulse oximetry during conscious sedation. *JAMA*, 1993, *270*:1463.

6. Dodson, SR, *et al.*, Continuous oxygen saturation monitoring during cardiac catheterization in adults. *Chest*, 1988, *94*:28.

7. Eichhorn, JH, *et al.* Standards for patient monitoring during anesthesia at Harvard Medical School. *JAMA*, 1986, *256*:1017.

8. Holzman, RS, *et al.* Guidelines for sedation by non-anesthesiologists during diagnostic and therapeutic procedures. *J. Clin. Anesth.*, 1994, *6*:265.

9. Lavies, *NG, et al.* Arterial oxygen saturation during upper gastrointestinal endoscopy: Influence of sedation and operator experience. *Am. J. Gastroenterol.*, 1988, *83*:618.

10. Lawson, HW., *et al.* Abortion Mortality. United States, 1972 through 1987. *Am. J. Obstet. Gynecol.* 1994, *171*:1365.

11. Morlote, EB, *et al.* Hemodynamic monitoring and pulse oximetry during percutaneous gastrostomy and jejunostomy: Necessity or nuisance? *Surg. Endosc.*, 1991, *5*:130.

12. Raemer, DB, *et al.* Hypoxemia during ambulatory gynecologic surgery as evaluated by the pulse oximeter. *J. Clin. Monitoring*, 1987, *3*:244.

13. Singer, R & Thomas, PE. Pulse oximeter in the ambulatory anesthetic surgical facility. *Plast. Reconstr. Surg.*, 1988, *82*:111.

14. *Standards for Abortion Care.* Washington, DC: National Abortion Federation, 1986.

15. Standards for basic intra-operative monitoring. In: *ASA Standards, Guidelines and Statements.* Park Ridge, IL: American Society of Anesthesiologists, 1992.

ANESTHESIA: ATTACHMENT A:

American Society of Anesthesiologists

Physical Status Definition[4]

To avoid confusion as to the basis upon which the Department of Anesthesiology classifies physical status in operative patients, the following represents the official American Society of Anesthesiologists classification.

CLASSIFICATION OF PHYSICAL STATUS

P-1 - A normal health patient.
P-2 - A patient with mild systemic disease.
P-3 - A patient with severe systemic disease.
P-4 - A patient with severe systemic disease that is a constant threat to life.
P-5 - A moribund patient who is not expected to survive without the operation.
P-6 - A declared brain-dead patient whose organs are being removed for donor purposes.

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[4]ASA *Manual for Anesthesia Department Organization and Management.* 1997. Reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, Illinois 60068.

ANESTHESIA: ATTACHMENT B

American Society of Anesthesiologists

Standards for Basic Anesthetic Monitoring[5]

(Approved by House of Delegates October 21, 1986; last amended October 21, 1998, to become effective July 1, 1999)

These standards apply to all anesthesia care although, in emergency circumstances, appropriate life support measures take precedence. These standards may be exceeded at any time based on the judgement of the responsible anesthesiologist. They are intended to encourage quality patient care, but observing them cannot guarantee any specific patient outcome. They are subject to revision from time to time, as warranted by the evolution of technology and practice. They apply to all general anesthetics, regional anesthetics and monitored anesthesia care. This set of standards addresses only the issue of basic intra-operative monitoring, which is one component of anesthesia care. In certain rare or unusual circumstances, 1) some of these methods of monitoring may be clinically impractical, and 2) appropriate use of the described monitoring methods may fail to detect untoward clinical developments. Brief interruptions of continual† monitoring may be unavoidable. *Under extenuating circumstances, the responsible anesthesiologist may waive the requirements marked with an asterisk (*); it is rccommended that when this is done, it should be so stated (including the reasons) in a note in the patient's medical record.* These standards are not intended for application to the care of the obstetrical patient in labor or in the conduct of pain management.

†Note that "continual" is defined as "repeated regularly and frequently in steady rapid succession" whereas "continuous" means "prolonged without any interruption at any time."

STANDARD I: Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care.

OBJECTIVE: Because of the rapid changes in patient status during anesthesia, qualified anesthesia personnel shall be continuously present to monitor the patient and provide anesthesia care. In the event there is a direct known hazard, e.g., radiation, to the anesthesia personnel which might require intermittent remote observation of the patient, some provision for monitoring the patient must be made. In the event that an emergency requires the temporary absence of the person primarily responsible for the anesthetic, the best judgement of the anesthesiologist will be exercised in comparing the emergency with the anesthetized patient's condition and in the selection of the person left responsible for the anesthetic during the temporary absence.

STANDARD II: During all anesthetics, the patient's oxygenation, ventilation, circulation and temperature shall be continually evaluated.

OXYGENATION

OBJECTIVE: To ensure adequate oxygen concentration in the inspired gas and the blood during all anesthetics.

METHODS:

1) Inspired gas: During every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient breathing system shall be measured by an oxygen analyzer with a low oxygen concentration limit alarm in use.*

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2) Blood oxygenation: During all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed.* Adequate illumination and exposure of the patient is necessary to assess color.*

VENTILATION

OBJECTIVE: To ensure adequate ventilation of the patient during all anesthetics.

METHODS:

1) Every patient receiving general anesthesia shall have the adequacy of ventilation continually evaluated. Qualitative clinical signs such as chest excursion, observation of the reservoir breathing bag and auscultation of breath sounds are useful. Continual monitoring for the presence of expired carbon dioxide shall be performed unless invalidated by the nature of the patient, procedure or equipment. Quantitative monitoring of the volume of expired gas is strongly encouraged.*

2) When an endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by clinical assessment and by identification of carbon dioxide in the expired gas. Continual end-tidal carbon dioxide analysis, in use from the time of endotracheal tube/laryngeal mask placement, until extubation/removal or initiating transfer to a postoperative care location, shall be performed using a quantitative method such as capnography, capnometry or mass spectroscopy.*

3) When ventilation is controlled by a mechanical ventilator, there shall be in continuous use a device that is capable of detecting disconnection of components of the breathing system. The device must give an audible signal when its alarm threshold is exceeded.

4) During regional anesthesia and monitored anesthesia care, the adequacy of ventilation shall be evaluated, at least, by continual observation of qualitative clinical signs.

CIRCULATION

OBJECTIVE: To ensure the adequacy of the patient's circulatory function during all anesthetics.

METHODS:

1) Every patient receiving anesthesia shall have the electrocardiogram continuously displayed from the beginning of anesthesia until preparing to leave the anesthetizing location.*

2) Every patient receiving anesthesia shall have arterial blood pressure and heart rate determined and evaluated at least every five minutes.*

3) Every patient receiving general anesthesia shall have, in addition to the above, circulatory function continually evaluated by at least one of the following: palpation of a pulse, auscultation of heart sounds, monitoring of a tracing of intra-arterial pressure, ultrasound peripheral pulse monitoring, or pulse plethysmography or oximetry.

BODY TEMPERATURE

OBJECTIVE: To aid in the maintenance of appropriate body temperature during all anesthetics.

METHODS: Every patient receiving anesthesia shall have temperature monitored when clinically significant changes in body temperature are intended, anticipated or suspected.

FIRST TRIMESTER ABORTION PROCEDURE

Policy Statement: Abortion is one of the safest surgical procedures in the US today. The following guidelines enhance this safety.

PRE-OPERATIVE PROCEDURE

Standard 1: Pertinent medical history must be obtained and documented.

Standard 2: Confirmation of pregnancy must be documented.

Standard 3: Gestational age must be verified and documented by the operator.

Recommendation 0.1: HCT or HGB should be obtained in women with a history of significant anemia.[6]

Recommendation 0.2: Vital signs (e.g. blood pressure, pulse and temperature) and physical exam should be done as indicated by medical history and patient symptoms.

OPERATIVE PROCEDURE

Standard 4: All instruments entering the uterine cavity must be sterile.

Option 0.01: The vagina may be cleansed with a bacteriocidal agent.

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[6]By establishing a balance sheet of risks, costs and outcomes, it was discovered that a pre-operative HCT was of relatively questionable value statistically in preventing morbidity and mortality in a healthy woman in the first trimester with no history of anemia or major disease process.

Recommendation 0.4: Anesthesia should be used unless there are contraindications.[7]

Recommendation 0.5: The cervix should be dilated gently and gradually.

Option 0.51: Adequate dilation may be achieved by osmotic dilators.

Option 0.52: At very early gestational age, cervical dilation may be facilitated by delaying the procedure.

POST-OPERATIVE PROCEDURE

Standard 5: Completion of the procedure must be verified and documented by the operator.[8]

Standard 6: Rh immune globulin must be offered per Rh policy guidelines.[9]

Option 6.01: Rh immune globulin may be injected into the cervix for Rh(-) patients.

Standard 7: Clinical Policies Guidelines for Postoperative Care must be followed.

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[7]See Clinical Policies Guidelines on Anesthesia.

[8]See Clinical Policies Guidelines on Evaluation of Evacuated Uterine Contents.

[9]See Clinical Policies Guidelines on Rh Testing and Rh Immune Globulin Administration.

SECOND TRIMESTER ABORTION PROCEDURE BY D&E

Policy Statement: Second trimester[10] abortion by dilation and evacuation (D&E) is a safe outpatient surgical procedure when performed by appropriately trained clinicians in medical offices, freestanding clinics, and ambulatory surgery centers. As gestational age increases, complications and risks increase.

PRE-OPERATIVE PROCEDURE

Standard 1: Pertinent medical history must be obtained and documented.

Recommendation 0.1: A patient with prior C-sections should be evaluated for the presence of an anterior low-lying placenta.

Recommendation 0.2: Physical examination should be done as indicated by medical history and patient symptoms.

Standard 2: Gestational age must be verified by ultrasonography.[11]

Recommendation 0.3: A preoperative Hgb or Hct should be done.

OPERATIVE PROCEDURE

Standard 3: Appropriate dilation of the cervix must be obtained.

Recommendation 3.1: Dilation should be achieved gently and gradually.

Recommendation 3.2: Osmotic dilators should be used to facilitate adequate dilation.

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[10]For the purposes of these guidelines, second trimester begins at 15 weeks LMP. (Cunningham, FG, *et al. Williams' Obstetrics; 19th Ed.* East Norwalk, CT: Appleton and Lange, 1993; 249.).

[11]See Clinical Policies Guidelines on Sonography.

Standard 4: When osmotic dilators are used, a physician must be available for emergency care prior to the scheduled procedure.

Option 0.01: In second trimester abortions intra-amniotic or intra-fetal injection may be given.[12]

Recommendation: These injections, if utilized, should be given at the time of laminaria insertion.

Option 0.02: Fetal cranial decompression may facilitate evacuation of the uterus.

Standard 5: All instruments entering uterine cavity must be sterile.

Standard 6: Uterine forceps appropriate for second trimester abortion must be available.[13]

Recommendation 0.4: Anesthesia should be used unless there are contraindications.[14]

Recommendation 0.5: Oxytocics should be available to aid in control of uterine bleeding.

Recommendation 0.6: Vasopressin should be used in the paracervical block solution (see refs. 2,5,7).

Option 0.03: Intraoperative ultrasonography may be used to facilitate evacuation of the uterus.

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[12]Dig 0.5 - 1 mg. or KCl 0.5 cc of 10% solution to a maximum of 2 cc's (see refs. 1 and 2).

[13]Acceptable forceps include Bierer, Sopher, Hern, Pratt, Peterson, Van Lith.

[14]See Clinical Policies Guidelines on Anesthesia.

Option 0.04: IV access may be established prior to evacuation.

POST-OPERATIVE PROCEDURE

Standard 7: Completion of the procedure must be verified and documented by the operator.[15]

Standard 8: Clinical Policies Guidelines for Postoperative Care must be followed.

Option 0.05: Oral oxytocics may be prescribed.

Discussion: Second trimester procedures comprise approximately 10% of abortions in the United States today. The dilation and evacuation procedure requires special training, techniques, and equipment appropriate for gestational age. Dilation and evacuation is now the predominant second trimester procedure. Other, less frequently used procedures include amnioinfusion with hypertonic solutions (urea, saline) and prostaglandin inductions. Although hysterotomy may occasionally be used, it carries significant risks when compared to other methods and is discouraged (see ref. 6). The presence of fetal anomalies may require individualized procedures to permit thorough examination of an intact fetus for genetic causes.

References:

1. Berkowitz, RL, *et al.* First-trimester transabdominal multifetal pregnancy reduction: A report of two hundred completed cases. *Am. J. Obstet. Gynecol.*, 1993, *169*:17.

2. Dillon, TF. Vasopressin as a hemostatic in gynecology surgery. *Am. J. Obstet. Gynecol.*, 1989, *78*:1285.

3 Fletcher, JC, *et al.* Fetal intracardiac potassium chloride injection to avoid the hopeless resuscitation of an abnormal abortus: II. Ethical issues. *Obstet. Gynecol.*, 1992, *80*:310.

4. Grimes, DA & Schulz, KF. Morbidity and mortality from second-trimester abortions. *J. Reprod. Med.* 1985, *30*:505.

[15] See Clinical Policies Guidelines on Evaluation of Evacuated Uterine Contents.

COMPLICATIONS: BLEEDING

Policy Statement: One of the most serious complications of an abortion procedure is hemorrhage. Early recognition of the source of bleeding can reduce morbidity and mortality.

PRE-OPERATIVE BLEEDING

Recommendation 0.1: An ectopic pregnancy or spontaneous abortion should be considered.

PERI-OPERATIVE BLEEDING

Standard 1: When there is excessive bleeding, the surgeon must institute measures to identify the etiology of the bleeding and control it.

Recommendation 1.1: The surgeon should consider incomplete procedure, atony, fibroids, lacerations, perforations, placenta accreta, cervical or cornual pregnancy, coagulopathy.

Option 1.01: Ultrasound may be useful to determine whether the uterus is empty and to detect occult bleeding.

Option 1.02: When a cervical bleeding source is suspected, hemostasis may be achieved by compressing the cervix at the lateral fornices with ring forceps or placing a suture.

Option 1.03: When atony is suspected, uterine massage and uterotonics[16] may be useful.

Option 1.04: When coagulopathy is suspected, blood may be drawn for coagulation parameters.

Recommendation 0.2: When excessive bleeding continues, the following measures should be instituted:

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[16] methergine (intracervical or IM); oxytocin (intracervical, IM, or IV); prostaglandins (e.g. Prostin, intracervical or IM)

a) monitor and document blood pressure, pulse, clinical status;
b) uterotonics;
c) establish IV access;
d) initiate appropriate volume replacement;
e) prepare for transfer to a hospital facility if necessary.

Standard 2: The patient must be transferred to a hospital facility when the bleeding does not respond to therapeutic measures or when the patient is hemodynamically unstable.

DELAYED BLEEDING

Standard 3: When a patient reports excessive bleeding[17] after discharge from the abortion facility, she must be evaluated by that facility or an emergency contact service.

Discussion: Excessive bleeding in the peri-operative and in the post-operative period is almost always due to uterine atony, often complicated by incomplete emptying of the uterus. Therefore, the most important initial efforts should be directed at assuring complete evacuation of the uterus and at increasing uterine tone through uterotonics.

Problems arise when bleeding is ignored or its severity underestimated. Clinicians must always remember to do the simple things when confronted with a developing bleeding problem: continue assessment of the blood loss, measure and record blood pressure and pulse frequently, assure intravenous access.

As a preventive measure, many clinicians give uterotonics and vasoconstrictors pre-operatively. Common regimens include:

a) methergine 0.2 mg po 5-30 minutes pre-operatively. Many also use 4-8 units of oxytocin in the paracervical block (e.g. 10 units in 50 cc of lidocaine, using 20 cc of the lidocaine for the block, or 4 units total dose);

b) epinephrine in the paracervical block (20 cc of 1:200,000 in lidocaine, equivalent to 0.1 cc of 1:1,000);

[17] saturation of more than one pad per hour for more than 3 hours

c) 2-6 units of vasopressin in the paracervical block for its additional vasoconstrictive effects.

When bleeding continues after assurance of complete uterine emptying and when there are no visible cervical or vaginal lacerations, the clinician must consider other complications such as perforation, coagulopathy, or placenta accreta.

References:

1. Hakim-Elahi, E. & Tovell, H. Complications of first-trimester abortion: A report of 170,000 cases. *Obstet. Gynecol.*, 1990, *76*:129.

COMPLICATIONS: PERFORATION

Policy Statement: Uterine perforation is a complication of abortion that can lead to significant morbidity.

Standard 1: If, in the clinician's judgement, an instrument passes farther than expected, then uterine perforation must be considered.

Standard 2: If a perforation occurs, even if the patient is asymptomatic, close observation and follow-up must be done.

Option 2.01: Antibiotic coverage may be instituted.

Option 2.02: Uterotonics may be administered.

Option 2.03: The patient may be transferred to a hospital.

Option 2.04: If a perforation occurs and *the pregnancy has not been disrupted,* the completion of the procedure may occur immediately, after a delay, or by referral to another provider.

Recommendation 2.1: If a perforation occurs and *the pregnancy has been disrupted,* the abortion should be completed as soon as feasible.

Option 2.05: The uterine evacuation may be completed under direct ultrasound assistance.

Option 2.06: The abortion may be completed under laparoscopic visualization.

Option 2.07: Re-identification of the uterine cavity may be performed and the abortion completed.

Standard 3: The patient must be hospitalized for definitive care if :

a) intra-abdominal viscera are detected in the uterine cavity, cervix, vagina, suction tubing, or on tissue examination;
b) fetal parts are detected in the abdominal cavity;
c) expanding intra-abdominal hematoma is detected; or
d) hemodynamic instability is present.

3. Kaali, SG, *et al.* The frequency and management of uterine perforations during first-trimester abortions. *Am.J.Obstet.Gyn.*, 1989, *161*:406.

4. Lajinian, S, *et al.* Sonographic appearance of suspected iatrogenic uterine perforation. *J Reprod.Med.*, 1994, *39*:911.

5. Lauersen, NH & Birnbaum, S. Laparoscopy as a diagnostic and therapeutic technique in uterine perforations during first-trimester abortions. *Am.J Obstet.Gyn.*, 1973, *117*:522.

6. White, MK, *et al.* A case-control study of uterine perforations documented at laparoscopy. *Am.J.Obstet.Gyn.*, 1977, *129*:623.

POSTOPERATIVE CARE

Policy Statement: Most serious abortion complications are detectable in the immediate postoperative period. Appropriate and accessible follow-up care is essential to patients' wellbeing.

Standard 1: Completion of the abortion must be verified and documented.[18]

Standard 2: Rh immune globulin must be offered per Rh guidelines.[19]

Standard 3: All patients must be observed during the recovery period by a health care worker trained in postoperative care.

Standard 4: A clinician must remain in the facility until all patients are medically stable.[20]

Standard 5: The following criteria must be documented prior to discharge: the patient must be ambulatory with a stable blood pressure and pulse, and bleeding and pain must be controlled.

Standard 6: The patient must be given instructions outlining the signs and symptoms of postoperative complications.

Recommendation 6.1: Written instructions should be given to all patients.

Standard 7: The facility must provide an emergency contact service on a 24-hour basis and must assure physician referral if indicated.

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[18]See Clinical Policies Guidelines on Evaluation of Evacuated Uterine Contents.

[19]See Clinical Policies Guidelines on Rh Testing and Rh Immune Globulin Administration.

[20]Clinician is defined as a physician, nurse practitioner, physician assistant, or nurse midwife.

Option 0.01: A feedback form may be sent home with the patient to help gather medical, psychological and social information that may have affected her outcome.

EVALUATION OF EVACUATED UTERINE CONTENTS

Policy Statement: Complete removal and identification of products of conception help prevent complications of abortion.

Standard 1: Evacuated uterine contents must be examined before the woman leaves the facility.

Recommendation 1.1: In first trimester terminations, flotation of tissue with backlighting should be used to identify products of conception, including gestational sac.

Option 1.11: Pathological examination of evacuated uterine contents may be performed.

Standard 2: When insufficient tissue or incomplete products of conception are obtained, the patient must be reevaluated.

Recommendation 2.1: Follow-up pelvic ultrasound examination should be considered.

Recommendation 2.2: Resuctioning should be considered.

Standard 3: If insufficient tissue is present after adequate patient evaluation, a protocol to rule out ectopic pregnancy must be followed, and the patient must be informed of symptoms and dangers of ectopic pregnancy.

Recommendation 3.1: If the uterine cavity is determined to be empty, serial quantitative β-hCG or sensitive urine pregnancy test should be measured.[21]

Standard 4: The patient must not be released from follow-up care until the diagnosis of ectopic pregnancy has been excluded or an appropriate referral has been documented.

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[21] Sensitive urine pregnancy test is positive at 50 MIU of β-hCG.

Recommendation 4.1: A 48-hour post-procedure quantitative β-hCG test should be done. If there is a decrease of 50% or more, no further ectopic follow up is necessary.

Recommendation 4.2: If 48-hour post-procedure quantitative β-hCG testing shows no change, or a subnormal increase in value, referral for ectopic pregnancy evaluation and definitive treatment should be made and documented.

Standard 5: In second trimester abortions, placenta and all major fetal parts must be removed from the uterus.

Recommendation 5.1: If the above are not identified, the following should be considered: ultrasound evaluation, intravenous pitocin administration, repeat uterine exploration.

Recommendation 5.2: The clinician should continue care of the patient until completion of the abortion has been determined.

Option 0.01: Intraoperative ultrasound guidance may be used to facilitate uterine exploration.

FETAL TISSUE DISPOSAL

Policy Statement: The improper disposal of tissue can lead to spread of infectious disease, and can increase the risk of theft or misplacement of tissue. Because of the possible infectious nature of tissue removed during the abortion procedure, guidelines for proper fetal tissue disposal are established.

Standard 1: All surgically removed tissue must be considered biohazardous and be disposed of in accordance with applicable local, state, and federal regulations. A proper protocol for tissue disposal must be in place.

Recommendation 1.1: There should be medically adequate protection of personnel;

Recommendation 1.2: There should be proper handling and storage of tissue using either:
a. biohazard disposal service;
b. licensed pathology laboratory;
c. on-site disposal where permitted by regulations.

EMERGENCY PROCEDURES

Policy Statement: Optimal management of abortion emergencies reduces morbidity.

Standard 1: Functioning equipment and current medications must be available on site to handle medical emergencies and must include: an 0_2 delivery system, oral airways, uterotonics, and epinephrine.

Recommendation 1.1: Facilities should have a specified area for emergency equipment to include oxygen, medications, and supplies.

Recommendation 1.2: Protocols should be in place to ensure ongoing training of staff in the use of emergency equipment, the management of emergencies and the indications for emergency transport.

Recommendation 1.3: Medications should include IV crystalloids, and, in clinics using IV sedation, narcotic antagonists.

Standard 2: When abortion procedures are being performed, a current CPR-certified staff member must be available on-site for emergency care.

Recommendation 2.1: All medical staff should be current CPR-certified.

Option 0.1: The following supplies may be used:

Type of Emergency	Prevention, Treatment
1. Anaphylaxis	Corticosteroids, epinephrine
2. Allergic reactions	Diphenhydramine (Benadryl), epinephrine, albuterol inhalers
3. Respiratory arrest	Oxygen, suction, ambu bag, airways
4. Hemorrhage, shock	IV crystalloid (normal saline or Ringers Lactate), uterotonics
5. Cardiac arrest	CPR

6. Seizure	Diazepam (Valium), midazolam (Versed)
7. Respiratory depression	Pulse oximeter

Thirty-seven of the clinic representatives we interviewed believed that FACE had an effect on violent or disruptive incidents at their clinics, and 35 described that effect as reducing or deterring incidents. For example, one respondent said that violent demonstrators were given only a "slap on the wrist" before FACE, but FACE made them realize that consequences can be more severe. Another respondent whose clinic had been involved in a FACE prosecution credited FACE with ending what he described as a cycle in which some protestors endlessly engaged—blockading, being arrested, spending a few days in jail, and then blockading again. Five clinic respondents credited FACE with increasing support or awareness of local law enforcement. For example, one respondent explained that as a result of FACE, local authorities more seriously enforced clinic-related violations of the law.

Of the 36 U.S. Attorney office representatives surveyed, 21 believed that FACE had an effect on clinic violence or disruptions in their districts. In describing the effect of the act, 15 respondents said that FACE, or federal actions taken as a result of FACE, had reduced or deterred incidents. A representative from 1 U.S. Attorney office stated that his district's prosecutions of 12 individuals in 3 separate physical obstruction cases resulted in removing the violators from the streets and appeared to have deterred similar illegal conduct by others. In his view, FACE, in conjunction with state and local enforcement efforts, appeared to have reduced the number of illegal protestors to a core group of offenders who were unlikely to be easily deterred.

Twenty-three of the 36 U.S. Attorney office respondents believed that FACE enhanced local law enforcement's ability to protect clinics from violence, and 27 believed it enhanced federal law enforcement's ability to do the same.

Representatives of 27 U.S. Attorney offices cited strengths they saw in FACE. Eight respondents focused on the flexibility FACE provides or the additional federal tools it offers. These respondents cited federal restraining orders and injunctions and the law's flexibility that allows for bringing either civil or criminal causes of action. Seven respondents saw the act's strength in its establishment of federal authority. For example, one respondent explained that FACE allows for intervention in an area that was previously outside federal jurisdiction. To a lesser extent, respondents cited other strengths of FACE, including the additional attention it has brought to the issue of clinic incidents, its harsher penalties, and the communication it promotes among law enforcement agencies.

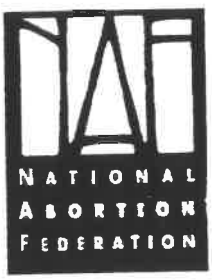
NATIONAL
ABORTION
FEDERATION

exhibit B

Planned Parenthood®
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In response to a request for information from the legislative staff, Planned Parenthood of Central and Northern Arizona is pleased to provide the following condensed protocol related to abortion services provided at our facilities for women who choose to exercise their right to have an abortion performed. These services are offered to ensure access to safe abortions to those patients who have been counseled on every phase of the abortion procedure and who are confident in their decision to terminate their pregnancy.

This condensed protocol covers many of the significant considerations related to the physical facilities, supplies, equipment and personnel involved in the procedure. This condensed protocol does not, however, cover other important considerations related to this procedure; including patient education & informed consent, patient selection - indications and contraindications, pre abortion procedures, post procedure management, quality assurance and management of high risk conditions & complications that are included in the complete Planned Parenthood of Central and Northern Arizona protocol.

Questions pertaining to the contents of this document may be directed to Beth Weber, Director of Medical Services of Planned Parenthood of Central and Northern Arizona at (602)263-4296.

SURGICAL SERVICES - ABORTION

I. PHYSICAL FACILITIES

Clinics providing abortion services will have:

1. adequate, private space specifically designated for interviewing, counseling and medical evaluation;
2. dressing rooms for staff and patients, and appropriate lavatory facilities;
3. facilities for pre-procedure hand washing;
4. private procedure rooms;
5. adequate lighting and ventilation for abortion procedures;
6. surgical or gynecologic examination table;
7. post-procedure recovery room, properly supervised, staffed and equipped;
8. emergency exit to accommodate a stretcher or gurney;
9. facilities for sterilization of instruments.

II. SUPPLIES AND EQUIPMENT

Supplies and equipment that must be immediately available for use or in an emergency kit include:

1. electrically safe vacuum aspiration equipment, suction tubing, and a supply of sterile plastic cannulas in various sizes;
2. conventional surgical instruments for cervical dilation and uterine curettage, in adequate supply to permit individual sterilized instruments for each patient;
3. equipment necessary for required laboratory testing;
4. a battery-operated light source for emergency back-up;
5. syringes and needles;
6. medications for sedation and analgesia and for local anesthesia;
7. antagonists for any narcotics or sedatives used;
8. parenteral dextrose and electrolyte solutions for emergency use;
9. pulse oximeter in the procedure room when a patient receives IV anesthesia or analgesia and available to the recovery room if patients have received IV anesthesia or analgesia;
10. medications for management of emergencies as designated by supervising physician;
11. oxygen, with connectors to nasal prongs or mask and resuscitative equipment;
12. stretcher or gurney;
13. ultrasound.

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All surgical equipment must be safe for the patient and for staff, must meet FDA standards, and will be checked annually to ensure safety and appropriate calibration.

III. PERSONNEL

The Medical Director will be the director of the abortion program. Physicians performing surgery will be licensed board certified/board eligible physicians who have demonstrated competence in the procedures involved and are acceptable to the Medical Director. Family Practice and OB/GYN residents may perform surgery under the direct supervision of the Medical Director or approved provider. A physician with admitting privileges at a local hospital must be available.

An RN, LPN, PA or Nurse Practitioner will be present during every clinic when abortions are performed to provide post-operative monitoring and care.

Surgical assistants and volunteers will receive training in counseling, patient advocacy and the specific responsibilities in the provision of this service.

IV. MEDICAL SCREENING AND EVALUATION

1. A medical history must be completed as required for comprehensive service patients. Special attention must be given to reported allergies to medications, antiseptic solutions, latex or past surgeries.

2. A physical examination including a bimanual exam estimating uterine size and palpation of the adnexa.

3. Laboratory testing shall consist of:
   A. urine or blood test for pregnancy;
   B. hematocrit;
   C. RH typing, unless reliable written documentation of blood type is available;
   D. other tests as indicated (saline suspension, serologic test for syphilis, etc.).

4. All patients will have an ultrasound evaluation. Staff will be trained in ultrasound for the determination of gestational age.

V. ABORTION PROCEDURE

1. Supportive personnel should be available to all patients throughout the abortion procedure.
2. Uterine evacuation must be done in a clean treatment room, using clean drapes, with adequate antisepsis of the vagina and with sterile instruments utilizing no-touch techniques.
3. Local anesthesia, analgesia and sedation may be used by physician order. All necessary equipment and personnel are maintained for safe administration thereof.
4. The manual-surgical-aspiration procedure will be the primary method used.
5. Patients undergoing mid-trimester abortion must have IV access established and maintained until the patient's condition is deemed to be stable in the recovery room.
6. Consciousness must be monitored throughout the procedure. Use of a pulse oximeter is required during all surgical procedures in which higher dose or combined drug narcotic analgesia or intravenous sedation is used. If low dose single drug IV analgesia is used and consciousness is not obtained, a trained person may monitor the patient's respirations, heart rate, and blood pressure. Blood pressure and heart rate must be evaluated and recorded on at least one occasion between the time that the abortion is completed and the patient is transferred to the recovery room.

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VI. RECOVERY ROOM

1. Immediate post-procedure care must consist of observation in a supervised recovery room for as long as the patient's condition warrants. Hospitalization without delay must be arranged if any complication beyond the management capability of affiliate staff occurs or is suspected.

   A licensed health professional who is trained in the management of the recovery area and is capable of providing basic CPR and related emergency care, must remain on the premises until all patients have been discharged.

   A physician must remain on the premises until all patients are stable, or until all patients have left the recovery room, whichever comes first. A physician must sign the discharge order and be readily accessible and available until the last patient has been discharged.

2. Prophylactic Methergine will be used as indicated.

3. RhO (D) immune globulin must be offered to Rh-negative unsensitized women within 72 hours, but preferably in the immediate operative period. If the woman refuses, a refusal form must be signed. FDA approved doses must be used as follows:
   - abortion through the end of 12 weeks LMP: 50 micrograms (Microgam) IM;
   - abortion at 13 weeks LMP or later: 300 micrograms (Rhogam) IM.

4. Written instructions with regard to coitus, signs of possible problems, contraceptive use, and general aftercare must be given to each woman. Each patient must have specific instructions regarding access to medical care for complications. When discharged, the woman should be accompanied by a friend or relative. A consumer feedback form shall be given.

5. Contraception must be discussed. Oral contraceptives or DMPA may be initiated on the day of the procedure.

6. Time in recovery
   - < 12 weeks = 30 minutes minimum
   - 13 - 16 weeks = 45 minutes minimum
   - 16 - 20 weeks = 60 minutes minimum

7. A call to the patient (when patient consents) will be made within 24 hours after surgery to access patients recovery.

VII. FOLLOW-UP VISIT

1. A post-procedure medical visit will be offered and scheduled for 3 weeks after the abortion. This visit will include a medical examination, including breast exam (when not performed as part of the pre-abortion medical screening visit); review of results of all laboratory tests; and offer of contraception. A low sensitivity urine pregnancy test will be obtained at the time of the follow-up visit in order to rule out continuing pregnancy or undiagnosed gestational trophoblastic disease. If a continuing pregnancy is suspected, the patient will be evaluated and a physician providing abortion services will be consulted

exhibit C

Planned Parenthood®
of Central and Northern Arizona

FACT SHEET ABOUT EARLY ABORTION

1. **WHAT IS IT:** A first trimester abortion is an aspiration procedure to end a pregnancy within 14 weeks of the first day of the last normal menstrual period. There are occasions when the physician may require an ultrasound examination prior to performing the procedure. This is done by passing over your abdomen a microphone-like instrument which measures the size of your uterus, or by using a vaginal probe. This helps to more accurately determine the age of the pregnancy and determine whether there are conditions that may cause complications. When done, there may be an extra charge for this service. The final decision as to whether the abortion may be performed in the clinic will depend on your medical history, the physical examination, laboratory tests, and will be made by the doctor.

2. **HOW IS IT DONE:** The standard method of first trimester abortion is vacuum aspiration (suction curettage):

    - A local anesthetic is usually injected into or around the cervix (the lower part of the uterus). In some cases a tranquilizing medication is administered by injection into a muscle or a vein. Usually, medications are given by mouth to reduce cramping.
    - The opening of the cervix is gradually stretched by a series of narrow rods (dilators), each a little wider than the one before. The largest dilator may be about as thick as your index finger. (Alternatively, the cervix can be stretched open over a period of several hours using osmotic cervical dilators that swell up by soaking up fluid from the cervix)..
    - A blunt-tipped tube (cannula) is inserted into the uterus. This tube is attached to a suction machine, which is then turned on. After the uterus has been emptied by gentle suction, a spoon-shaped instrument (curette) may be used to determine that the uterus has been emptied completely.

After this, you will spend as much time as needed in the facility under observation. When your condition is stable and you are ready to leave, you will receive the necessary prescriptions and follow-up instructions, including what you should do in the event of a complication.

You will be referred to one of our centers for an appointment for a check up, usually about 2 weeks after the abortion.

3. **COMPARISON OF RISKS:** As with any kind of procedure, complications can occur with early abortion. Early abortion by vacuum aspiration is, however, very safe. Fewer than 1 woman in 100 will have a serious complication, including, but not necessarily limited to:

    - **Blood Clots in the Uterus** - In about one in a hundred cases, blood clots may fill the uterus, leading to severe cramping. Usually the treatment is repeat uterine evacuation.
    - **Infection** - Infection is caused by germs from the vagina and cervix getting into the uterus. The likelihood of infection is less than 1 in 100 abortions. Such infections usually respond to antibiotics, but, in some cases, a repeat uterine evacuation or hospitalization is necessary. Rarely, surgery may also be required.

(continued on back)

Excerpts from Deposition of Joel Bettigole, M.D.
October 13, 2000

[11:09 - 11:16] Bettigole, Joel

Q. Now, Doctor, if someone is running an abortion clinic, is there any sort of publications or guidelines that are in existence that you think is authoritative or that you use yourself?

A. As a member of NAF, I agree to subscribe to their regulations, as far as on procedures and maintenance of an abortion facility, and those are th only ones that I recognize.

[87:01 - 87:25] Bettigole, Joel

Q. Doctor, can you tell me what you know about the case involving Louann Herron or Dr. Biskind?

A. Well, you know, obviously, I read the papers like everybody else did, and I knew the facility very well because I worked there years ago. And I knew Dr. Biskind – you know, casually I met him a couple of times.

And I knew the owner of the clinic very well. And I knew how the clinic was run. And I knew them, and I knew that they had one death previous to that, couple years before. And I was very saddened and very shocked at the death of Louann Herron, as well as the 37-week fetus, which they attempted to deliver, but I was not suprised.

Q. Why weren't you surprised?

A. Because I know the doctor involved was

and impaired physician, and I know the guy who owned the clinic didn't use high-quality personnel, and like -- you know, it happened to be an abortion clinic, but it could have been a plastic surgeon doing liposuction and doing the same thing could happen. It's just that -- as an aside, I mean, these whole regs, that cause these regs, that caused the legislature to do something.

Excerpts from Deposition of Vicki A. Conditt
October 19, 2000

[15:02 - 15:19] Conditt, Vicki

Q. That would be great. Thank you.
Did you attend the public hearing?
A. Yes, I did.
Q. On the revised rules?
A. Yes.
Q. Was anyone there?
A. We were there.
Q. Other than Department of Health employees, was anyone there? Did any member of the public --
A. Oh, member of the public?
Q. -- attend the hearing?
A. Two police officers were there.
Q. Serving as security guards or to give comment?
A. Serving as security guards. And that's it.
Q. Were you surprised that no member of the public appeared to give comment?
A. Somewhat surprised, considering this letter went to what I believe is thousands of licensed doctors.

Excerpts from Deposition of Victoria Davis
October 17, 2000

[32:07 - 32:14] Davis, Victoria

Q. Do you know who drafted those bills?
A. I know some of the people that worked on them. Richard Bark. Michael Bradley. As I understand, it was a committee effort, a consensus effort by committee members while the bills were introduced.
Q. When you say "committee members," do you mean the Joint Study Committee or a different committee?
A. The Joint Study Committee.

[35:07 - 35:24] Davis, Victoria

Q. Now you had mentioned that the Joint Study Committee, their purpose was to look into the current practice of regulating abortion clinics and other outpatient treatment centers?
A. Um hum, yes.
Q. And when you say their purpose was to look into it, were they -- besides just looking at it, were they trying to come to some conclusions?
A. I think that they wanted to know how outpatient treatment centers, which abortion clinics fall under that category, are regulated. Who has authority over it. And how they could prevent another tragedy from occurring like the Lou Ann Heron death.
Q. What conclusions did the committee come to on how to prevent another tragedy?
A. I would say that the conclusions were the draft legislation in 2647, giving us the authority to

24 regulate abortion clinics.

[62:16 - 62:25] Davis, Victoria

16 Q. Do you know what point he was making there?
17 A. Let's see. This would have been when the
18 bill was introduced, and he would have been giving a
19 preamble.
20 Q. Do you know the point he was trying to make
21 in that statement there?
22 A. He didn't want to have a recurrence of the
23 Lou Ann Heron incident. They wanted to empower DHS and
24 BOMEX to be able to regulate so there wouldn't be a
25 recurrence.

Excerpts from Deposition of Lynn S. Farnsworth, M.D.
October 18, 2000

[119:08 - 119:12] Farnsworth, Lynn

Q. Is it your understanding that the NAF guidelines attempt to articulate the standard of care for abortion practice?

A. I think they're attempting to articulate a good level of professional care for abortion practices, yes.

[91:09 - 97:05] Grimes, David

Q. And this police report details the discussions that detectives had with different staff of the A-Z Women's Clinic who were there on April 17th, 1998, when Lou Anne Herron had an abortion?

A. Correct.

Q. Okay. And based on what you have read, Doctor, is it accurate to say that Lou Anne Herron was at the clinic for about three hours before she died?

A. I would have to check to see what time she arrived at the clinic.

Q. If the police report says three hours, you wouldn't disagree with that?

A. Wouldn't quarrel with it, but I have not seen the medical records.

Q. Okay. And based on what you read, there was no registered nurse on site in the afternoon when Lou Anne Herron had her abortion, was there?

A. That is my understanding.

Q. The only staff that were there besides Dr. Biskind were medical assistants?

A. I don't know the training of all of them.

Q. That is what the police report would say, correct?

A. I have no other evidence.

Q. Now, Doctor, some of the discussions in this police report suggest that Dr. Biskind asked some of the

Herron's time in the recovery room, that one of the medical assistants went to tell Dr. Biskind that there might be a problem with Lou Anne Herron, and he was eating his lunch. Do you remember that discussion?

A. Yes.

Q. Okay. And do you remember that, according to this report, he responded angrily that he was eating his lunch and did not want to be bothered. Do you remember that?

A. I recall that.

Q. Would you say that that meets the standard of

care that a physician should provide in that situation?

A. No.

Q. Do you recall from this police report that the clinic administrator was not trained as a nurse or a medical assistant?

A. That is my understanding.

Q. And that after Dr. Biskind became upset, he told the medical assistant to go find the administrator and send the administrator in to check on Lou Anne Herron?

A. I recall he argued with the administrator.

Q. He argued with her. That is correct. But do you recall one of the medical assistants testifying to the police or giving evidence to the police that the administrator was told by Dr. Biskind to take care of Lou Anne Herron?

A. I don't recall.

Q. Okay. If that was the case, and the administrator had no medical training at all, would that

meet the standard of care?

A. I think it would be reasonable for an administrator to take a look at a patient in jeopardy, yes.

Q. Okay. Not while the physician was eating his sandwich?

A. Separately, together. I think it is -- would not be unreasonable, especially if a transfer is being contemplated. The administrative staff will oftentimes handle that.

Q. Okay. But there is nothing at this point in the police report that would suggest that anything was -- anyone was discussing transfer. In fact, she stayed there for approximately three hours, correct?

A. That is my understanding.

Q. Is it important that medical assistants and other staff be properly trained?

A. Certainly.

Q. Do you recall in this police report that the medical assistants became more and more agitated because there was more and more blood under Lou Anne Herron's legs? Do you recall that?

A. Yes, I do.

Q. Do you recall, in fact, that one of the medical assistants described it as a puddle of blood?

A. Yes.

Q. And do you recall that -- as you just testified, you recall reading that Lou Anne Herron and -- excuse me, that the administrator and Dr. Biskind were arguing about whether there should have been an RN

available in the afternoon. Do you recall that?

A. That was the claim, right.

Q. Do you recall that at some point during the three hours, Dr. Biskind -- while Lou Anne Herron was still bleeding, he just simply left the facility?

A. He left at one point. I know he did see, reportedly, the patient and worked on her IV. So he did see her at least once in the recovery room by report.

Q. I don't want to go into the details with you. I am not sure that is correct, but that is what you recall?

A. Teresa Jensen's testimony or report was that he tended to her in the recovery room.

Q. He walked in, correct?

A. And worked on her IV. So he was clearly aware of her situation.

Q. And then he left, correct?

A. That is my understanding.

Q. Okay. Would leaving in a situation where a patient was bleeding heavily be the standard of care?

A. No. It is inexcusable.

Q. Do you recall this same Teresa that you were just talking about say that she was never given any policy or procedure manuals to study nor given any training before she worked in the recovery room?

A. I recall that.

Q. And would that meet the standard of care, not

receiving training like that?

A. Well, training is one thing. Policy and procedure manuals are something separate. Training is important. I am not sure manuals are.

[99:4 - 99:9] Grimes, David

Q. Dr. Graham also stated that Lou Anne Herron should not have died and would have survived with a minimal amount of care and treatment from Dr. Biskind. Do you agree with that?

A. I am not sure "minimal" is the term I would use. But absolutely, this death was preventable.

Excerpts from Deposition of Bryan S. Howard
October 18, 2000

[17:21 - 19:04] Howard, Bryan

Q. And could you tell me, Mr. Howard, when was the first time -- well, let me ask you, were you involved at all in the legislative process that led to the statute and the rules?

A. Yes, I was.

Q. And can you describe for me how you were involved

in that process?

A. I was pretty heavily involved. I met with legislators, I met with the speaker of the house, I met with the speaker's staff, I met with senate staff, I met with staff from the Department of Health Services to provide input about the -- to attempt to get to a place where the outcome was legitimate regulation oriented toward patient safety as opposed to a political product that would restrict access to abortion.

Q. And the legislature invited input from Planned Parenthood of Central and Northern Arizona?

A. Yes.

Q. Do you know if the legislature invited input from those who opposed abortion?

A. I know from the statements of people like the Speaker, Mr. Groscost, and his staff, I just -- Richard Bark, more than one occasion they made the comment, well, we've just finished meeting with right to life, and so they stated that they did.

Q. And you have no reason to doubt that what they said was true?

A. I took them at their, you know, word.

Q. So, PPCNA, you said that you spoke with a number of people in the legislature, and did you provide any kind of written documents to the legislature for their consideration?

A. At the start of the process -- the answer is yes.

At the start of the process, we provided a summary of some of our standards, Planned Parenthood of Central and Northern Arizona standards, and I think we provided written comment after that.

[19:08 - 19:22] Howard, Bryan

Q. BY MR. NIKAS: Mr. Howard, let me show you what's been marked as Exhibit 1 to your deposition. Is that the document you were talking about that you provided to the legislature?

A. Bearing in mind that this is going on two years ago, I think this is the first thing that we submitted, yes.

Q. And these are entitled "Condensed Abortion protocols"?

A. That's correct.

Q. Was this document prepared especially for the legislature or is this a document that you had before the legislature asked you to prepare it?

A. This is something that we would have compiled from our internal protocol specifically related to the work of the joint task force that had been convened.

[21:16 - 22:13] Howard, Bryan

Q. Now, I believe you said that you -- you spoke with different people in the joint task force and different

legislators. Did you also have input when the regulations were being formed?

A. We had less input.

Q. Okay.

A. I testified, and I believe I submitted one set of comments in writing, but that process was more closed than was the legislative one.

Q. Okay. If you know, is it fair to say that when

this statute was passed, the clinic regulations statute itself was passed, whether it was a bipartisan effort?

A. There were -- there was both Republican and Democratic support for this.

Q. And as far as you know, there was both abortion rights and antiabortion support for this?

A. I really can't speak for the antichoice organizations. I know by what Jeff Groscost and Richard Bark said, that they were given an opportunity to provide input. I don't know if they in the end were satisfied with what was produced.

Q. But PPCNA provided input?

A. We provided input.

[39:13 - 40:08] Howard, Bryan

Q. When was the task force set up, do you know?

A. It was sometime -- I want to say it was in August or so of 1998. It was sometime during the summer of 1998.

Q. And do you know who headed the task force?

A. I want to say that it was -- you know, I actually -- I can't remember. I want to say Jeff Groscost chaired it on the house side, and I can't remember who chaired

it. There are co-chairs. One was a house member, one was a senate member, and if I remember correctly, I can't say that I did.

Q. Do you remember how the task force did their work?

A. There were a total of three, maybe, public hearings that were fact-finding hearings. I think the only one that I

may have attended was -- it may be the only one that I attended, I think the last one in which their findings, which was an overview of some abortion clinic regulation from other parts of the country, review of exactly who were and how many abortion providers there were in the state, and recommendations that the legislature adopt licensure, create a licensing plan or program for abortion clinics was proposed, and that was the report that was adopted.

[50:14 - 51:20] Howard, Bryan

Q. And your impression is, you were working on this bill, and that people were trying to enact legislation that would improve women's health in this area?

A. That was a primary piece. I mean, you know, Jeff Groscost is very clear that his inclusion, that the products of conception piece was his brain child, and the reason he wanted it there was a deterrent from providers providing postviability abortions which had nothing to do with maternal health. That was our intent, and I think that was -- a good piece of the work was around maternal health.

Q. And you, in your participation in this bill, were -- well, let me -- when you were in Chicago, did the

Chicago affiliate ever become engaged in lawsuits against

challenging abortion statutes in Illinois?

A. I'm sure that we did. I couldn't name them today, but...

Q. And in 1997, when you came to Phoenix, was your affiliate involved in litigation challenging abortion statutes?

A. Yes. We were challenging an earlier version of parental consent.

Q. Now, your participation in this legislative process, was good faith effort on your part to develop a bill that would work; right?

A. Yes.

Q. You were trying to develop a bill that would improve health for women; right?

A. Correct.

Q. And that could be applied by --

A. That could simultaneously protect women's health and safety while not imposing regulations of a sort which would drive providers out of providing abortion services. We were trying to provide both access and health.

Excerpts from Deposition of Kathleen Phillips
October 19, 2000

[33:02 - 33:17] Phillips, Kathleen

Q. Can you take a look at 1508-I-1?
A. Uh-huh.
Q. Okay. And what was the change made there by the new rules?
A. It just states that "if the patient care staff is unable to speak with the patient, for any reason, the attempt to contact the patient is documented in the patient's medical record."
Q. And why was this change made?
A. Actually, we responded to comment that was made previously, and we wanted to be able to facilitate it, the fact that if a patient is unreachable, that they just need to document that they attempted to make that contact.
Q. When you talk about comments submitted earlier, that was comments submitted to the original set of rules?
A. Right.

[34:16 - 35:08] Phillips, Kathleen

Q. Okay. Can you look finally -- not finally, sorry, at Section 1514?
A. C?
Q. C, regarding door widths?
A. Uh-huh.
Q. The minimum of 36 inches was taken out; is that correct?
A. Correct.
Q. Why was that done?

A. Because all we needed to do was to make sure that -- to make sure that the exit can accommodate the stretcher or gurney. It was overly prescriptive.

Q. And what played -- what made the team go back and rethink this section?

A. Again, it was in response to a comment that we received, and I'm trying to remember who made the comment.

Q. Does the name Dr. Tamis sound familiar?

A. It was Dr. Tamis's assistant.

[13:20 - 15:05] Raphael, Damon

Q. Doctor, are you aware of any other cases that come to mind involving injuries during or immediately after an abortion procedure?

A. Yes.

Q. Could you give me an overview of what that would be?

A. There was one individual who was in practice in Tucson some years ago, who since left, who had had a high rate of uterine perforations requiring surgical repair. There was a clinic --

Q. Do you recall that individual's name? I'm sorry to interrupt.

A. His last name was Bush. I don't remember his first name.

Q. Continue on. I'm sorry.

A. It was in my close association with members of the Department of Obstetrics and Gynecology, they had approached me and asked me if I knew anything about the situation, because they had in several instances had to deal with the complications.

There was a clinic, I don't remember the name, which was run by a -- like the A to Z Clinic, which was run by out-of-state investors, or an investigator from Cleveland, which hired University of Arizona residents to do procedures. And in the course of an abortion one of the residents at the

University of Arizona underestimated the size of the duration of the pregnancy and ended up with a severe injury to the uterus, which required surgical repair. In the course of the surgical repair the resident, who I understand scrubbed, and the doctor who was

called to perform the surgery tied off a ureter, which is a serious injury, and the woman ended up with a hysterectomy and had to subsequently have a reimplantation of the ureter in the bladder. And as a result of that injury, that clinic was closed.

[19:08 - 24:13] Raphael, Damon

Q. Doctor, let me go ahead and show you Deposition Exhibit 1. Could you tell me what that is?

A. It says, re proposed rules for abortion clinics, it comes from -- it says that's from me, that's who it's from.

Q. And that's a letter dated the 29th of July 1999?

A. That's correct.

Q. And that's a letter that you submitted to the Department of Health Services?

A. That's correct.

Q. Why did you submit that letter, Doctor?

A. We submitted this as an answer to a request from the Arizona Department of Health Services to assist them in rulemaking, as I recall. The nature of the original information that we received was a statement of an intention to promulgate rules, and

that statement also asked for input from us, and so that's -- we responded.

Q. That was basically how you were providing input to DHS?

A. That's my recollection.

Q. Do you recall if you've reviewed any outside documentation or guidelines in preparing that letter?

A. I was familiar with the rules that are promulgated by the National Abortion Federation, which is the recognized organization which does this in the abortion field. We are a NAF-approved clinic, we meet the rules and regulations, which most knowledgeable people agree are proper for our type of clinic.

Q. So you looked at the NAF guidelines or standards?

A. Yeah.

Q. Do you recall specifically which ones you looked at?

A. No.

Q. Did you consult with anyone other than your attorneys in preparing that draft?

A. I did not.

Q. Okay. As you mentioned, Doctor, you speak

of the NAF guidelines in this letter.

A. That's correct.

Q. Did you actually compare the existing NAF guidelines to the state administrative rules?

A. I did not, but my office manager did.
Q. Okay.
A. It's her job to make sure that we adhere to the rules and regulations that governs the type of practice that we have, that we do that to the letter.
Q. And there were no other standards that you had looked at?
A. No.
Q. Okay. So you consider the NAF standards to be authoritative?
A. I do.
Q. Are you aware of the standards that ACOF puts out?
A. No, I'm not.
Q. And, obviously, from your time at Planned Parenthood you were aware of the Planned Parenthood standards?
A. Yes, I am.
Q. How is -- you say the Planned Parenthood and the NAF standards compare?
A. The Planned Parenthood clinics are

generally NAF consistent because they want to be NAF approved and they have to be NAF approved individually. On the other hand, Planned Parenthood rules and regulations are a mire of paperwork, and they are designed to protect Planned Parenthood from legal action, essentially. They are overly restrictive and, in my opinion severely bind the hands of physicians who are trying to take care of patients. There's a conflict between the physicians

within Planned Parenthood and their ability to practice medicine, but on the other hand, Planned Parenthood does a very good job at what they do, and the American public would be severely damaged if Planned Parenthood was unable to do what they do. They serve a very necessary purpose, but the rules and regulations -- there are too many, and they are too complicated and often conflicting.

Q. So I guess from what you said, if I asked you what you consider authoritative in your practice, it would be the NAF guidelines?

A. That's correct.

Q. Now, when you are looking at the NAF guidelines do you see those as an absolute standard or a minimum standard to meet, how do you classify those?

A. Well, they are not absolute. The standards must change to meet the nature of the technology. For instance, we're about to embark on the use of mifepristone and how you handle that type of a patient will be different from how you handle the patients who came for surgical termination. It's a whole different technology. So it has to be a living, breathing, changing system, and that's what NAF does. NAF collects scientific information, it does -- it is involved in education and supervision and criticism.

Q. So when you apply these or look at these standards for your practice, do you consider the NAF standards the minimums that you want to meet?

A. That's correct.
Q. And do you generally follow them in your practice, the NAF standards?
A. I do.
Q. Now, Doctor, I would like to specifically refer you to the first page of your letter, and specifically the third paragraph, last sentence in which you state, we have always endeavored to meet or exceed the current standards of care.
A. Where is that in?
Q. I'm sorry. The last sentence of the third

paragraph.
A. Okay, yeah.
Q. Okay. Is that generally true about how you run your practice?
A. That's true.
Q. Now, when you say the current standards of care, what specifically are you referring to?
A. I'm referring to the National Abortion Federation standards.
Q. So in your practice you like to not only meet those standards but exceed those standards?
A. Very careful. I make sure not to bite off more than I can chew.

[34:08 - 35:12] Raphael, Damon

Q. Okay. So did you notice in the final draft of the rules as compared to this first draft that we're talking about, was DHS responsive to any of the concerns that you had?

A. Few.
Q. Okay. Were changes actually made in some cases?
A. Some, correct.
Q. Now, there was also a letter submitted by a Patricia Stoll from your clinic. Who is she?
A. She's my daughter and my office manager.
Q. Okay. And do you recall that she submitted a letter in October to the Department of Health Services?
A. Yes.
Q. Did she do this at your direction?
A. Yes.
Q. Did you review the letter that she

submitted?
A. I did.
Q. So she was speaking on behalf of TWC?
A. That's correct.
Q. And do you recall in that letter whether or not she commended DHS for being responsive to your concerns?
A. I believe she did.
Q. Okay. And that TWC felt that some of the burdens that were contained in the initial draft had been removed in the final draft?
A. Yes.

[53:18 - 54:] Raphael, Damon

Q. Could you tell me what the common complications are or possible complications for a

first-trimester abortion?

A. For first trimester?

Q. Uh-huh.

A. Bleeding and infection.

Q. Okay.

A. Rarely injury.

54

Q. How about for a second trimester?

A. The same complications, with the risk of hemorrhage much greater, and if the injuries occur they are much more serious.

[65:16 - 107:17] Raphael, Damon

Q. Now, Doctor, if you could go ahead and look at Exhibit 2, deposition exhibit, which are the rules themselves, right there.

A. This thing?

Q. Uh-huh. Now, I know you have been through the rules before, but I'd like to take you through them and talk with you about them, if you would, please.

If you go ahead, Doctor, look at the first section, 1501, which lists out several definitions.

66

A. Where would I find that?

Q. One more page. I believe one more page. Five, six maybe.

MS. JONES: One more.

BY MS. BURKE:

Q. One more. There you go.

A. Okay.

Q. Section 1501 dealing with definitions. Doctor, if you could at this time go ahead and review that list again and tell me which definitions you feel are problematic or not medically acceptable.

A. Okay.

Q. And take however much time that you need.

A. Well, first of all, the definition of abortion, that's not the correct definition of abortion.

But does this mean -- this is ambiguous. Does this mean that we're supposed to assume that the definition of abortion is for the -- in terms of the application of this set of rules and regulations? It's certainly not the proper medical definition of abortion.

Q. Okay. What is your understanding of the proper medical definition of abortion?

A. Abortion means the termination of

pregnancy, either spontaneously or intentionally. When a person has a miscarriage, that's an abortion, it's a spontaneous abortion.

Q. Abortions can obviously be done by surgical means.

A. That's correct. And they can be done by chemical means.

Q. Okay.

A. Abortion clinic. Well, this is a definition for the purpose of the law, so it's an arbitrary definition. But for the purpose of the law

rules and regulations, did not proceed with due diligence. They are not experts in this area and they've not consulted with the proper individuals and, therefore, don't use the right terminology.

I think, in my opinion, this is the key problem with this set of rules and regulations, that the individuals who are charged to develop these regulations did not go to the proper -- did not go to experts to decide how these rules should be implemented, these directions of the legislation should be implemented by them.

Q. Doctor, are you aware of who the legislature did or did not talk with?

A. I don't know, but I can guess.

Q. Okay. Go ahead. And with number 16?

A. 16 is accurate, 17 is accurate. 18 refers to a regulation which is not before me, so I can't comment.

19 through 21 appear to me to be adequate.

Number 22, licensee seems to fall within the province of the police power of the state.

23 through 25 seem to be okay.

25 through 32 are, on the surface, acceptable where they don't refer to a regulation. Where they do refer to a regulation I can't comment, since I don't have the regulations before me.

And number 33, the patient care staff is arbitrarily -- or leaves out a medical assistant. A physician assistant is a specific title, medical

assistant is another title. Now, did they leave that out on purpose or by accident? I don't know.

But I don't understand the definition of surgical assistant in 42.

Q. Let me make sure I understand. Do you have any difficulties with 34 through 41?

A. Only those that refer specifically to regulations where I don't have the regulations to refer to.

Q. Okay.

A. But I have no objection there. They all make sense.

Q. You said you didn't understand the definition in 42, surgical assistant.

A. No. The standard definition of a surgical assistant is a physician who assists another physician at surgery. Now, this is out of context and I don't know what they are referring to.

An individual who is not licensed as a physician, a physician's assistant, a nurse practitioner, or a nurse who performs duties directed by a physician, physician's assistant, nurse practitioner. To me it doesn't make any sense, but if I saw the way they intended to use it I might have some understanding of it.

43, viable fetus. This is -- fetal viability is subject to interpretation, but I don't have the regulation and I don't -- in my own practice I don't deal with pregnancies near viability by anybody's definition.

Q. At any time during your practice, Doctor, either before you stopped doing second-trimester abortions at TWC or at Planned Parenthood where you continued to do second-trimester abortions, did you ever have an instance where a fetus survived the abortion?

A. Never.

44 appears okay.

Q. Do you use volunteers at all in your practice, Doctor?

A. No.

Q. Have you ever?

A. No.

Q. When you were at Planned Parenthood did they use volunteers?

A. They used volunteers.

Q. Now let's speak specifically to 1502, which is a general provision requiring licensure.

I believe you've already stated your objections to being licensed by the state. Is there

anything you would like to add that you find objectionable to being licensed?

A. I can't think of anything right now, but it doesn't mean that I might not think of something later.

On the other hand, if I was required to apply for licensure, I would. I object to it, but I would meet the letter of the law. I've never performed an illegal abortion. I have no intention of doing it.

A. Not insofar as -- except where it refers to a regulation. I don't have the regulation to refer to.

Q. Okay.

A. Amount and type of training to be required

for an individual to provide counseling. There's no such regulation or requirement.

And does this mean that the state is going to impose one arbitrarily? And where is the input going to come for what sort of qualification a counselor should have?

My counselor is a social worker. Is that adequate to the legislators or the people who are empowered to promulgate regulations? It's ambiguous, and as such it's not a good statement.

Q. And that's C2, Doctor?

A. Correct. Verification of the competency of the physician performing an abortion. I don't know what the regulation says or will say.

I personally have no problem with the state having the police power to say -- to require a physician to be competent to perform abortions, I agree with that. So if the state would come and say, you have to be a trained obstetrician-gynecologist; if not, you should have so many years of residency or supervised practice or so on, I would have no problem with that.

Q. That's C3, correct?

A. Right.

Q. Okay.

A. Four okay, five is proper, six is proper, seven through nine are proper.

Q. Okay. Let me stop you there, Doctor, and ask you some specific questions about what's covered in this section of the regulation as it applies to your current practice at TWC.

A. Correct.

Q. Is there someone in your office who ensures that you comply with all federal, state and local laws?

A. Yes.

Q. And who is that?

A. My office manager.

Q. Okay. And who actually adopts the policies and procedures that you follow in your clinic?

A. I adopt them. I'm responsible, I sign off on them.

Q. Okay. And I believe you indicated earlier that you have an evacuation map posted in each room of your facility?

A. Yes.

Q. Is there any other -- anything else that you post in your waiting room for your patients?

A. I don't go out there. I don't know what they have right now.

Q. Okay.

A. It's various information. I don't know.

Q. Do they have stuff such as written pamphlets and brochures available?

A. Yes.
Q. You're not sure?
A. I don't know what's out there.
Q. As far as the written policies and procedures that are required by subsection C of this regulation that you just went through, can you tell me which ones your clinic currently has policies and procedures in place?
A. We have one. Three is irrelevant, because I'm the only physician there, and I'm licensed and certified and -- board certified and I teach it. I'm a professor at the University, so on, so forth. The University has periodically rotated residents through my facility to watch me and see how I do it for the purpose of education.

We have four, we have five, we have six, we have seven, we have eight and nine. We have policies for all of those.

Q. Okay. Doctor, if you could go ahead and review 1504.
A. 1504 did you say?

Q. Yes. It would be the next section.
A. Okay.
Q. And, again, let me know any specific provisions you feel are problematic or do not meet medical standards.
A. I have no problem with any of it.
Q. No problem with any of the provisions in 1504?
A. No. They are fully within the police power

of the state.

Q. Okay. Doctor, you mentioned earlier when we were talking about some incidents that occurred in your clinic over 12 years ago, I believe --

A. Uh-huh.

Q. -- can you tell me how those emergencies were managed, or what you did in response to those emergencies -- or, excuse me, incidents? Were any reports made on those incidents, that you recall?

A. I don't remember. They are a matter of public record. The patient was admitted to the hospital.

Q. But you don't recall whether a specific incident report was prepared?

A. I don't remember.

Q. But you don't feel it's unreasonable to

require an investigation of an incident at the clinic?

A. No. Since that time we've become -- we're NAF members, we keep records of things like this, and so on.

Q. Okay. And it wouldn't be unreasonable to require a written report of some type?

A. No, I think it would be proper.

Q. Doctor, if you would please review 1504 and, again, let me know anything that you have -- think is problematic -- 1505, I'm sorry -- problematic or does not meet medical standards.

A. I think that three is the counseling again, the definition of what is adequate counseling can

Q. You also indicated earlier --
A. I don't think it's appropriate for children to be working in this type of a situation. They can better spend their time someplace else learning to be grownups.
Q. Okay. You mentioned earlier that you

performed ultrasounds. I would assume that none of the medical assistants --
A. I'm the only one in the office who uses the ultrasound machine.
Q. Okay. Doctor, if we could go ahead and move on to 1506, again, letting me know anything that you consider problematic or not in conformance with medical standards.
A. Sure. That there is a sufficient number -- now this is arbitrary, because sufficient has a different meaning to different people.

The problem that you run into is, number one, you never know the percentage of scheduled patients that are going to show up. There are days you have a full schedule and two people show up, for whatever the reason, competition, people are stopped at the border by the Mexican police, whatever. And there are days when our staff gets sick, so people have to do double duty and we end up working later because of it and so on.

We can't just close a place down because we're short a patient. We have to make do like people do in all businesses. Running an abortion clinic is similar to running a police station or fire

department or so on. Sometimes people get sick,

people are down. If you have a football team, you know, you have two linemen injured, the substitutes have to go in or whatever. Football's one of the few sports where you can't go out there with not enough players. But sometimes we have to go out there with not enough players and just work hard.

But if an organization is properly run and it has good people and the individuals who are responsible are committed to the quality of patient care as opposed to seeing how many people you can push through the door in a given amount of time, then you're going to carry through in the difficult times with a good safety record; and I have. So in that respect I can speak for myself.

Does the state have a compelling interest to define -- to make a definition of sufficient? I can't answer that, but all I can say is that the definition should be flexible to meet the exigencies of the situation.

Q. Okay. We're specifically talking about A, correct?

A. Correct.

Q. And, Doctor, let me just follow up with one question. You believe that there should be room in this regulation for the doctor to exercise his or her

judgment as to their staffing requirements?

A. Correct.

Q. If you would go ahead, Doctor.

A. I have no problem with the rest of 1506.
Q. Okay. Would that include the subparts under A1, 2 and 3?
A. Of 4A -- oh.
Q. A, You mentioned a concern about the first sentence of A.
A. Sufficient, that was the only -- that was the problem.
Q. Okay.
A. Definition of sufficient. As far as documenting when people are where and maintaining records, I have no problem.
Q. Okay. So other than that first sentence of A, you don't have any problem with the rest of 1506?
A. Yes.
Q. Let me ask you some questions. In determining the staffing requirements that you currently have at TWC, how did you determine, you know, that you needed two medical assistants, your office manager, and two part-time assistants, how did you make that?
A. I didn't determine that. My office manager

determines that on the basis of the work load and the efficiency with which we do our job so that we don't have any safety problems and we can go home in time for supper.
Q. Do you have any sort of formal organizational chart of any type?
A. We don't have, you know, a box with myself at the top. I mean, we have a handful of people, but

the policy manual states who is in charge of who.

Q. You have a policy manual that delegates everybody's responsibilities and who reports to who?

A. That's right. The office manager is the boss, and she tells me where to go.

Q. Do you currently maintain a written schedule of who worked when in your clinic?

A. Now we do.

Q. Did you do this in preparation for complying with these regulations?

A. Correct. Put in a time clock, everybody has to document that they are here at this time, we save it.

Q. Are you normally in your facility until all of the patients are discharged?

A. I don't leave until the last patient is gone.

Q. All right. Doctor, if you could go ahead and move on to 1507, again, letting me know if you disagree with or don't think you should have to comply with any of the provisions, or they don't meet standard medical practice.

A. I have no -- well, let's start again.

To state: To be treated with consideration, respect and full recognition of the patient's dignity and individuality, this is true of proper medical interaction with the patient in any circumstance. To require that it specifically be enforced and so on in only abortion doctors' offices, it's really insulting. The physicians who perform

abortions are physicians like anybody else. They went to the same schools, they have the same ethics and so on.

Q. Okay.

A. I have problems with number two. I think this was addressed in one of the supplements.

To refuse treatment or withdraw consent at any time. There is a point of no return in surgical procedures where you can't stop. And sometimes you are almost done with a procedure, the patient says stop, you can't stop or you're going to have a hemorrhage and so on. So, again, no patient should

be forced to have a procedure they don't want, but once it's almost done you have to -- you can't safely stop it sometimes.

Q. Okay. You said you think it may have been dealt with in a subsequent --

A. I recall it being mentioned in another -- somebody might -- I don't recall, but it was in one of the documents I read in the last few days.

Q. Okay.

A. And I have no problems with the rest of 1507.

Q. Okay. In your practice at TWC right now are the patients informed of this type of information?

A. I offer the patient -- they can have a copy of the ultrasound if they want. Mine is a policy of full disclosure. If I see that a patient has twins, I tell her so she has the opportunity to not go

through with the abortion, so she wants to have twins, so on and so forth. I don't want patients to have abortions who don't want to have abortions. I show them the ultrasound if they want to see it, I give them a copy, and I have no reason -- no personal inclination to hide things from patients.

Q. Okay. So the information contained in four

you currently provide to your patients?

A. That's correct.

Q. All right. Moving on to 1508, Doctor, again letting me know if anything is inappropriate or does not meet acceptable medical standards.

A. We comply with and agree with the rest of 1508, except for a routine telephone call to a patient. I think it creates all sorts of privacy problems.

Q. Okay. So you don't currently do that --

A. No.

Q. -- in I1?

A. No. Patients have instructions on what to do, and we don't generally call people because of the wrong people answering the phone.

Q. Okay.

A. Disturbs their privacy.

Q. Okay. Have you ever had, to your knowledge, a patient ask you to give them a call?

A. No, but I do occasionally. I tell -- well, I don't generally; occasionally I do. If I have a patient who has some bleeding problem, I'm worried they may not call me, I'll call them back. But they

Q. Medical, meaning you use a drug or chemical of some type?

A. Correct.

Q. A suction curettage abortion, how long does that normally take to complete?

A. Two to three minutes.

Q. Two to three minutes?

A. Not including the anesthetic, the analgesic, the actual surgical procedure takes two to three minutes.

Q. And what sort of medication do you normally give a patient for a suction curettage?

A. Intravenous Valium and Demerol --

Q. Do you do it by --

A. -- and Lidocaine, local anesthesia.

Q. As a paracervical block?

A. Correct.

Q. Do you give the medication in a shot or through an IV?

A. By direct push slowly.

Q. Do you ever use an IV?

A. Only in an emergency.

Q. What sort of situations might that be?

A. People who come in who are bleeding.

Q. What sort of instrumentation do you use during the suction curettage?

A. First I -- the usual procedure is insert a vaginal speculum, cleanse the vagina with Betadine, a povidone-iodine solution, that's the generic for Betadine -- and inject the -- I use between 15 and 18

mls of one percent lidocaine for a paracervical block. I inject anteriorly into the cervix, grasp the cervix anteriorly with a single-tube tenaculum, then I usually inject the remainder of the medication in three places bilaterally, paracervical areas, drawing back with each injection to make sure I'm not in the blood vessel.

Then while I'm doing all this I'm talking to the patient, I'm talking to the patient while I administer the medication, asking her where she's from, what she does, where she went to school, what kind of work she does, I ask her about her family, and so on. I give her the injections, I ask her what she does for fun, ask her her kids' names, all these things to take her mind off what's going on, giving my medicines a chance to take effect. Then I dilate the cervix with graduated metal dilators and use the appropriate suction tip to suction the inside of the

uterus.

Then I check the interior with a sharp metal curette to make sure there's no tissue left in the corners of the uterus. I usually resuction with a second suction curette that's one to two sizes below the first, and I remove the instruments, I check for bleeding from where I held the cervix to see if there's any tenaculum laceration, and treat that, if necessary; and tell the patient the procedure is over. All during the time I'm talking to the patient for the patient's psychological well-being, number one, and to make sure that the

patient's not oversedated.

Q. Okay.

A. Patients who are more likely to be oversedated are women of Asian descent. Occasionally we have to use some Narcan, but it's not often, maybe once a month. Excuse me.

Q. No, go ahead.

A. I do not intentionally put patients to sleep. I use conscious sedation. Patients do fall asleep, but I'm not trying to give people general anesthesia. I use a dose that is almost invariably safe. I never had a serious reaction. I've never had to take a patient to the hospital, and I'm very

confident and I've had very, very few allergic reactions. Valium and Demerol are drugs that have a very, very low allergic potential.

And this is what I do, and I've been fortunate that I have never had any serious complications, thank goodness.

Q. Now, the instrumentation that you just mentioned to me, you use a suction -- new suction tip with each insertion, correct?

A. Uh-huh.

Q. As far as other instrumentation that you described, how many complete sets of that do you maintain in your clinic?

A. I think it's about nine or ten, but I'm really not sure. We may have added to it. My office manager would know that.

Q. All right.

A. But there was a time a few years ago where we occasionally had to wait to reorder clave instruments, but it hasn't been ordered in the last year or two when we were very busy, so we've probably added some since.

Q. How do you sterilize the instruments?

A. The metal instruments are autoclaved with OK strips in there to make sure that the autoclave

reached the proper temperature and pressure.

Q. The medical assistants take care of this for you?

A. Correct. Plus when I open the set, the OK strip is in there, I can see whether or not when I look at the set to make sure the wrapper hasn't been punctured, and the plastic tubes are immersed in glutaraldehyde. It's a bactericidal solution for chemical sterilization.

Q. How often?

A. It's done after every use.

Q. Okay. What vital signs are you monitoring of the patients during the procedure?

A. We have one of those things you stick in your -- pulse ox.

Q. Pulse ox?

A. Yeah. The most important thing is not the pulse ox. The most important thing is I'm talking to the patient, so I know that, obviously, if a patient is speaking rationally to me they are not oversedated.

Q. Okay. Now, when does a patient recover, in

the procedure room or is there a separate room?

A. They are walked to the recovery room. We have a specific recovery room with the lights a

95

little dimmer, the tables are soft so they can -- there are blankets and pillows and some refreshments, and things like that.

Q. And the medical --

A. Also, if the patient can walk they are obviously not oversedated. Occasionally a patient can't walk. Some Asian patients -- I usually cut the dose, the Demerol dose by one-third, from 75 milligrams to 50 milligrams, for an Asian patient, one who actually comes from Asia, and even then occasionally they may be oversedated. But the ordinary garden-variety American girl is a more expensive date.

Q. And the medical assistants are responsible for monitoring in the recovery room, Doctor?

A. Correct.

Q. And what specifically do they monitor in the recovery room, what are they looking for?

A. I believe respiration, pulses, pulse and blood pressure, as well as state of consciousness.

Q. Okay. Are they required to chart their observations?

A. Yes.

Q. And when it comes time -- how long would you say, on average, a patient spends in the recovery

96

room?

A. Minimum of ten minutes.
Q. Is that a minimum you've established?
A. That's generally recognized.
Q. Once a decision is made to discharge the patient, who makes that determination?
A. The medical assistant does, unless there's a problem.
Q. Is there a --
A. If there's a problem they will ask me, the patient is vomiting, should we give some atropine; or if the patient seems to be dizzy and still having difficulty dealing with the sedation, we'll give an injection of Narcan.
Q. Is there a discharge order that's actually signed, or any notation in the chart made at the time of discharge?
A. They do, yes.
Q. Do you sign a discharge order?
A. No, I don't sign a discharged order.
Q. Okay.
MS. JONES: Are you about to move on to a new section?
MS. BURKE: Yeah. Why don't we take a break.

(Recess.)
BY MS. BURKE:
Q. Doctor, before we took a break I believe we finished with section 1508. If you could go ahead and look at section 1509, and again tell me if there is anything that you don't think is appropriate or

not medically acceptable.

A. At present we comply with all of section A and all of section B, except for the doctor signing the discharge order.

Q. That's B1, correct?

A. Correct. I don't feel that's necessary. I'm ultimately responsible for it. If something would go wrong, which it never has, I'm the one they would hang. So I delegate the responsibility to people who have been trained and whom I trust.

Q. Okay. The medical assistants, what -- if you know, what criteria are they using to determine when a patient's ready for discharge?

A. They should be specified in the policy manual, if the patient is alert, the patient can stand, is steady, the patient's vital signs are within normal limits.

Q. And you currently provide the written information detailed in B2 to the patient at

discharge?

A. Yes, we do.

Q. All right. Doctor, again, with section 1510, if you can indicate if anything is inappropriate in your view or not within medical standards.

A. The reference to a regulation, I don't know what that regulation is. To my knowledge we comply with all regulations on medications.

Q. Okay. That's in number one?

A. Yes.

Q. Okay. What regulations do you actually comply with in terms of medication, state and federal regulations?

A. Any applicable. We comply with everything in 1510.

Q. Let me ask you a few specific questions.

Who makes an order for medication for a patient?

A. I do.

Q. Okay.

A. I administer the intravenous medications, and no ancillary medications are administered unless I specifically tell the medical assistant to do it.

Q. Okay. Where do you actually store the

medications in your facility?

A. We have a refrigerator for drugs that have to be refrigerated, we have a lock box area in a -- a lock box in a locked closet for narcotics.

Q. Okay. And other nonnarcotic types of medications, where are those stored?

A. We have samples, we have a sample closet, which is ordinarily kept locked except when we are using it, and most of the other medicines are kept in the same closet as the lock box for the narcotics, and that closet is in the laboratory.

Q. Okay. Who has access to it?

A. The clinic director, my manager, and one of the designated medical assistants. I don't have access to it. I'm serious, I don't.

Q. Okay. Let me make sure --

A. I don't have the key to it.
Q. Your daughter functions as office manager/clinic director?
A. Correct.
Q. Okay. All right. Doctor, if we could move on to 1511. Again, if you could tell me anything you feel is inappropriate or not within medical standards.
A. Again, there are references to regulations,

I can only assume that we comply with it. I hope we do. I know I want to comply with those regulations. I presume we do. We certainly have satisfied CLIA's requirements. We currently comply with all of four and five. I'm concerned about this section 4B, for review no later than two hours from the time the department requests the medical record.

I mean, the records are there, but the implication is that for abortion clinics you got to be ready for somebody to come in at a moment's notice and you should be worried about it. We're no different than any other medical facility. I don't know if such a regulation applies to other medical facilities, but we have our records, we have all our records on site.

Q. Okay. That's A, 4B, correct?
A. Correct.
Q. All right. So, otherwise, you comply with what is in --
A. That's correct.
Q. -- A?

A. And we comply with everything else, to my knowledge, in 1511.

Q. Okay. That would be section B that you just reviewed?

A. Right, and C.

Q. B and C. Okay. Let me ask you a couple of specific questions.

You said that you maintain the records on site in your office?

A. Yes.

Q. How are they maintained, in file cabinets or --

A. Current records are in a locked file cabinet, and we have -- I still have some patient charts from my regular practice, and we have been providing them to the patients that transfer, of records. We have a large attic up above where we store records, all the rest of my regular practice records and old ones and abortion records as well. I still have not destroyed any old records of any of my practice dating back to 1967.

Q. Okay. Now, you said current records. How do you define current records, year old, two years old, that you store in a locked cabinet?

A. I don't know how far back they go.

Q. Who has access to those locked file cabinets?

A. Our social worker/interviewer and anyone else who is designated to have access by the clinic

manager.

Q. Okay. Do you have any computerized records?

A. I do have patients in my regular practice from -- I'm a computer nerd, and I had computerized medical records before anyone else in Tucson. I have medical records of my private GYN patients up until maybe 1992 when I stopped doing it. We keep no computerized records or any other kind of records of patients for abortions, involving the abortion practice, for their own privacy sake. We do have computerized billing records of the financial part of the practice from my private GYN practice.

Q. Okay.

A. There is still some accounts receivable in there, but they are almost done.

Q. Okay. Again, Doctor, if you could review 1512 and tell me if there's anything you feel is inappropriate or not within medical standards.

A. Again, I do not object to what's in 1512, except to say that they are redundant, that they are required by CLIA and the -- but probably unnecessary. But on their face I don't object to them.

Q. And you're obviously --

A. We are in compliance with all this stuff

because we're CLIA compliant.

Q. Doctor, if you could review 1513 and tell me if there's anything in there that you find inappropriate or not within medical standards.

A. We comply with everything in 1513.

Q. Let me ask you a couple of questions related to that, Doctor.

Do you maintain log books, to your knowledge, dealing with the calibration and testing of the equipment in your office?

A. To my knowledge we do.

Q. And do you happen to know where those are maintained?

A. I don't know, but my clinic manager could tell you.

Q. But you do maintain the logs?

A. We do.

Q. Okay. Doctor, finally, if you could look at 1514 for me and tell me if anything in there is inappropriate or not within acceptable medical standards.

A. We comply with everything in here. There is ambiguity involving 1B, a place for a patient to dress. Does that mean that there has to be a designated place to dress which is separate from an

ordinary bathroom, et cetera, et cetera?

We have bathrooms for patients to do that, or in recovery, but we don't have a special designated dressing room where we send patients to dress or undress.

Q. Okay.

A. Other than that, we comply with all of this.

Q. All right. Do you believe, Doctor, that these regulations taken as a whole would increase the

cost for you to perform abortions?

A. Yes, I do.

Q. Why is that?

A. The one that was of the most concern is the one requiring actual nurses to -- one or two nurses in an office in order to perform procedures.

First of all, nurses are an expensive luxury, and sometimes you can't get nurses, no matter how much you're willing to pay. There's a terrific nursing shortage now.

I could foresee a time when one or two people would become sick and we would have to turn people away because we couldn't comply with state regulations because we didn't have one or two nurses on site. And in two-day procedures -- and I perform

overnight procedures in all patients between 12 and 14 weeks and in all nulliparous patients, patients who haven't had children, from 11 weeks to 14 weeks.

These patients already have an ongoing situation that have to be terminated. Now what I am going to do if I show up and my nurse is sick? Does that mean I have to break the law in order to complete the procedure?

Well, Doctor, you could take her to a hospital. This patient can't afford to go to a hospital, hospitals are expensive. You can't use a bathroom in a hospital without it costing a thousand dollars.

I mean, we provide our services as a benefit to the public to keep them out of hospitals,

because they can't afford to go to hospitals. We provide low-cost, safe services. I haven't had to hospitalize a patient in over ten years.

But I do it all myself. Sometimes it's difficult, but I manage to keep my patients out of hospitals and keep them healthy. And regulations, because of their specificity or ambiguity that may lead to increased personnel costs, are worrisome, especially as I'm about to leave practice. I can't afford at this stage of life to leave owing people

money. I've got to get out, make a clean getaway. I've got to get out of Dodge without having to sacrifice my pension.

So the nursing thing is one expense, and then if there are any modifications that have to be done to our facility -- I have a pretty nice facility, I'm happy with it. One of the rooms could be a little bit larger, but if there were size constraints, things like this that would require capital expenditures, it would create real problems economically for myself in particular, in the sense I'm at this stage of practice.

Q. Okay. Do you recall seeing anywhere in the regulation where they specified the size of any room in your facility?

A. No, I don't, but, you know, we haven't seen -- the final draft hasn't been written. I'm saying this for educational purposes, so they shouldn't write those kind of regulations.

Q. Okay. Is there any provision -- I know

you've told me that these provisions you came into compliance with in expectation of having to meet these provisions. Is there any provision in there you feel that you absolutely could not comply with?

A. As I said before, I would comply with any

regulation that the state -- I mean, the law is the law. The state, through its police power, has the responsibility and the right to regulate in the interest of the health, welfare and safety of the public.

So the state is a cop, and it has the right to be a cop, but it's got to be a good cop. It's got to do it the right way, in a nonprejudicial way which doesn't harm people, but in a manner which is consistent with the spirit of the law. And if regulations are that way, I have no specific objection to them.

On the other hand, if the regulations produce undue hardship and are designed to adversely affect and denigrate my area of practice, either for myself now or for the people who come after me, I think it is a bad thing.

[111:14 - 113:02] Raphael, Damon

Q. Now, we talked briefly a few minutes ago that you believe that these regulations could increase the cost of the abortions that you provide. Have you done anything to -- or spoken with your accountant in terms of determining just how much that's going to be?

A. Well, my office manager has been hard at it trying to figure out what to do, especially now that we've been pressured with new competition and a sudden disappearance of up to half of our business at a time when new regulations are likely to come into force. I can remember when we were under the same

circumstances over five years ago and before my income was supplemented by Planned Parenthood, where at times my office overhead went up to 80 percent because the volume of patients -- of abortion patients was so low and my malpractice insurance was higher in those days. So those -- that's what we have to face now.

As a matter of fact, we've had to, just this past week, reduce some of our abortion fees to be more competitive. And so that means, unless we increase the number of patients that we have, that the percentage of our -- the percentage of expense versus the total amount we take in is going to be greater, it's going to climb higher, up to the 80 percent range again. It's a high-expense business.

Q. So your office manager is the one that's been working on this issue for you?

A. Correct. And we discuss it and try and figure out how we can work our way out of it.

Q. Now, you mentioned you recently had to reduce your abortion fee.

A. Correct.

Q. How much are you currently charging for an

25 abortion?

1 A. I believe we went down from $310 to either
2 295 or 290.

[118:11 - 118:16] Raphael, Damon

11 Q. What do you think the intent of this
12 statute is then?
13 A. The primary intent of the statute, on its
14 face, is to protect the health, welfare and safety of
15 the public, which is fully within the police power of
16 the state.

[137:21 - 138:07] Raphael, Damon

21 Q. Okay. And my last question then is,
22 besides the fact that these rules don't apply to any
23 other physicians except for those performing
24 abortions, what is your major complaint or objection
25 with these rules?

1 A. That is my major objection.
2 Q. That's it?
3 A. The state has the right to regulate for the
4 health and welfare and safety, but it has to do it in
5 a nondiscriminatory manner. They have to treat every
6 doctor in a similar, fair manner, preserve the
7 privacy of the patients.

Excerpts from Deposition of William Richardson, M.D.
October 20, 2000

[33:02 - 33:25] Richardson, William

Q. You are familiar with CLEA?
A. Yes.
Q. What laboratory services does your office provide?
A. We provide hematocrit screening, Rh blood typing, wet mount, and stool for occult blood.
Q. All right. Do you believe that these laboratory guidelines -- having these laboratory guidelines is good medical practice?
A. That's not a yes or no question. The laboratory guidelines in part were formulated to adhere to CLEA regulations, but they were also formulated with the knowledge that so-called abortion clinic regulations would be coming, and it was partly in response to that as well.
Q. Do you perform all the laboratory procedures in your office?
A. Personally?
Q. Yes.
A. No.
Q. Do you expect the people who are performing laboratory procedures in your office to follow these guidelines?
A. Yes.

Q. In your view does the surgical and medical abortion policies and procedures for Old Pueblo Family Planning comply with the regulations the Health Department has passed?

A. Yes.

Q. Okay. Now in addition there's a document numbered 698 to 739. And it reads at the top, "Table of Contents," but in handwriting up at the top right-hand corner it says, "NAF 2000 Guidelines"?

A. Yes.

Q. Are you familiar with this document?

A. Yes.

Q. And are these National Abortion Federation 2000 documents?

A. Yes.

Q. And do you consider the National Abortion

Federation an authoritative source for good medical practices in this field?

A I consider the National Abortion Federation the source in this field.

Q And are your policies and procedures for Old Pueblo Family Planning designed to comply with NAF Guidelines?

A Yes.

Q. Then I guess we're to R9-10-1508, Abortion Procedures. Again, I understand your umbrella objection to this. Are there any procedures in R9-10-1508 that are inconsistent with your policies and procedures that you've adopted for your clinic?

A. Since my policies and procedures were adopted with the regulations in mind, I'm hoping not.

Q. Okay. And we have them here if you want to look at them?

A. No. So is that your question for this section?

Q. Yes. Are there any provisions in this section that are inconsistent with the policies and procedures for your office?

A. No.

Q. Let's go to R9-10-1509 then. It's entitled, "Patient Transfer and Discharge." Are there any requirements in here that are inconsistent with your policies and procedures for your practice?

A. Again, my policies and procedures in this area were adopted with these regulations in mind, so no.

Q. So these are things that you can do and do do?

A. These are things that I do.

Q. Going to page -- or to Section R9-10-1514, Physical Facilities, on Page 27. Does your private medical office comply with these requirements?

A. At somewhat increased overhead, yes.

Q. Okay. So you already do comply with these requirements now?

A. Right, in anticipation of these regulations I complied. For instance, I probably wouldn't have knocked a door out and had it expanded to 36 inches.

Q. All right. So that did cost you some money?

A. Oh, yeah, among other things.

Q. Okay. Do you recall how much it cost you

to expand the door to 36 inches?

A. No, he just sent me a general bill.

Q. Okay.

A. He probably did itemize it.

Q. Was it a general bill for construction services or remodeling services?

A. When I moved in my building, I had it gutted and completely remodeled.

Q. I see.

A. And in that remodeling I explained to him what the regulations were. He added onto the price accordingly.

Q. So the gutting and remodeling in addition

to complying with these regs was to comply with your own requirements for what you wanted that facility to be like?

A. Part of the gutting and remodeling was for that purpose. Some of it was also to comply with the regulations.

Q. Is your private -- was your private medical office formerly a residence?

A. I think it was a gastroenterologist's office before.

Q. Okay. So it was formerly a medical office?

A. Yes.

Q. But --

A. From the '70s.

Q. So you felt that there were changes that needed to be made?

A. Yes.

[97:18 - 97:23] Richardson, William

Q. Is your business presently operating at its highest capacity?

A. No.

Q. So if you -- if more patients were available, you could accommodate those patients?

A. Yes.

[100:03 - 100:21] Richardson, William

Q. Now we've talked several times here that a lot of what you did in setting up your practice was in anticipation of the regulations that are the subject of this lawsuit, correct?

A. Yes.

Q. Other than preparing the specific policy guidelines and looking at how the physical setup of your office was, was there anything else that you did in anticipation of these regulations relative to your practice?

A. In every aspect of the, you know, formulation and execution of my practice the regulations were one of the, you know, screens through which I viewed it. Not the only, but one of them.

Q. And the other screen would be maybe the NAF Guidelines or what else?

A. The first was whether or not it makes sense medically, and then secondarily, to adhere to NAF and the regulations in CLEA and OSHA.

[104:15 - 104:23] Richardson, William

Q. Then I just wanted to go over a few items from previous submissions you've reviewed in the case where issues might have changed. I think we covered the first one, that what you charge for first -- what do you charge for a first trimester abortion?

A. $300.

Q. And at some point in time did you charge anything more than that?

A. I charged $310.

[105:24 - 107:06] Richardson, William

Q. Were you attempting to set up a private office practice that -- let me go back one step. Do

you believe that Planned Parenthood, the two affiliates, provide quality medical services in delivering surgical abortions?

A. Yes.

Q. And certainly your mission is to provide quality health services for women, and that would include --

A. In a different setting, yes.

Q. Right. Now were you trying to establish guidelines that allowed your clinic or your private medical practice to deliver surgical abortion procedures in a safe and high quality manner as Planned Parenthood or even higher?

A. Your question is when I formulated my policies and procedures, was I trying to provide medical care in a way that was equal to or greater than in terms of the quality of Planned Parenthood?

Q. Yes.

A. There were several audiences that my policies and procedures were directed toward. I think that the provision of quality medical services at my office probably could have taken place without such an extensive list of policies and procedures. And so I would say that the writing down and codifying of all of these things is something that I did largely to

comply with the regulations.

When I was a medical director of Planned Parenthood, I felt that the policies and procedures were appropriate for that setting. But if what you're

asking -- they're not necessarily appropriate to a private office.

Excerpts from Deposition of Robert H. Tamis, M.D.
October 13, 2000

[42:05 - 43:15] Tamis, Robert

Q. Okay Doctor. Let me ask you a question. You performed pregnancy -- you perform abortions in you Abortion Services of Phoenix facility, correct?

A. That's correct.

Q. If a woman comes in for an abortion, how do you determine whether she's pregnant?

A. How do we determine she's pregnant?

Q. Correct.

A. Well, it depends upon which I do first. I could be doing a physical exam first, I could do urine pregnancy test, I could be doing a blood pregnancy test, and I could be doing an ultrasound.

Q. And after one of those methods, and you determine woman is pregnant, do you make a determination of how far along into the pregnancy she is?

A. Yes, I do.

Q. What method do you use, Doctor?

A. Ultrasound.

Q. And do you believe ultrasound will give

you an accurate determination of how far in the pregnancy she is?

A. Give me a reasonably accurate time. I will backtrack that we determine the length of pregnancy by ultrasound and, on occasions, with blood

pregnancy testing.

Q. And of the different methods you just mentioned to me, what do you believe is the most accurate method for determining the gestational age of the –

A. Serial ultrasounds.

Q. How many ultrasounds would you do to determine that?

A. Would require to be really accurate, two ultrasounds approximately two weeks apart.

[63:14 - 65:04] Tamis, Robert

Q. Tell me how you perform the first-trimester abortion.

A. Carefully.

Q. Can you describe each step, please?

A. I put a speculum into the vagina, I grab the cervix with a -- to grab the cervix with a Jacobs tenaculum, dilate the cervix with cervical dilators, attach -- place a suction tip into the uterus commensurate with the pregnancy, evacuate pregnancy with suction, curette out the inside of the uterus with a sharp curette, replace the suction curette to double-check any loose tissue.

And might repeat that process more than once, depending upon how empty I feel I have -- how well I have emptied the uterus.

When I feel that I am done, the vaginal instruments are removed, the patient is taken out of stirrups, she is -- our operating table is our

stretcher. So that the operating table is reconstructed into a stretcher, and then she's wheeled from the operating room into the recovery room.

The intravenous line is removed at that time, since the patient -- the purpose of it is only to medicate the patient, and she is now in the recovery room.

During the time of surgery, she is monitored with a pulse oximeter. We medicate our patients with intravenous Sublimaze and Versed. That's very short-acting. Usually within five minutes in the recovery room, the patient is awake. If they are a drug addict, they are awake immediately.

They are observed in the recovery room for approximately 20 to 45 minutes. Their blood pressure is taken. They are watched in terms of bleeding. They are assisted off the stretcher, go to

the bathroom, get dressed; and then depending upon whether their ride is available, they are either allowed to go home or they sit in a post recovery room waiting for their ride to arrive.

[66:10 - 66:24] Tamis, Robert

Q. And what type of complications can occur in performance of a first-trimester abortion?

A. Do you want to talk about the common ones, or are we going to talk about every single complication that can occur in this world?

Q. I'd like to know, unless it is 10,000 or something, something unreasonable. I'd like to know what complications could occur.

A. The common ones would be bleeding, drug reaction to the IV, uterine perforation. I suppose those are the things you can talk about.

Q. Those are the common ones. Are there any others that can occur?

A. Oh yes. You can have death; cardiac arrest, respiratory arrest.

[68:12 - 68:23] Tamis, Robert

Q. someone attending that patient in the recovery room?

A. Yes.

Q. Who would that be?

A. Most of the time it's an LPN.

Q. Is there always someone with the recovering patients?

A. There is always someone with the recovering patients.

Q. And does the person with the recovering patients monitor their vital signs in any way?

A. Yes

[95:01 - 95:15] Tamis, Robert

No. 3.a. is a problem because it says, "A urine or blood test to determine pregnancy if an ultrasound examination is not done."

I am not sure why that is, because if I

do an ultrasound, which in our facility we do an ultrasound on every single patient, first and second trimester.

Q. Every single patient?

A. Every single patient.

Q. And I believe you testified because you believe that's the most accurate --

A. That's right.

Q. -- method of determining where you are in the pregnancy

A. That is correct.

[101:06 - 102:12] Tamis, Robert

No. 2, "Intravenous access is established and maintained." I don't know, again, why it's necessary. In our hands, 99.9 percent of the patients do get intravenous medication. So we do have intravenous access.

But we do have some patients who do not want to use intravenous medication. They only want the paracervical block, and on those patients, there is no need for an intravenous line.

Q. Doctor, let me ask you about that. Let me also say for the record, Doctor, I can't speak either way for your reputation one way or the other, but I wanted to make clear in my question I am not trying to cast any aspersions on your practice. Whether you have a good reputation or not is something I can't speak to.

But let me ask you, Doctor, I believe that in response to one of your questions, one of my

questions, you said that you use intravenous access on most of your abortion patients.

Was I incorrect in understanding your answer?

A. Yes, as I said, we use probably on probably 99.9 percent of our patients. But you have a requirement that is not necessary, and there are other practices that do not use intravenous method of medicating patients. And you are requiring them to do something that is really not necessary.

Q. But in your practice it is, 99.9 percent?

A. That is correct, okay?

Excerpts from Deposition of Sherrlyn Young

October 10, 2000

[104:14 - 104:25] Young, Sherrylyn

Q Okay. How much do you charge for an abortion?
A Three hundred dollars.
Q Three hundred dollars?
A Yes.
Q In the last ten years, how often would you say your charge or your fee for an abortion has increased?
A It actually -- I have never charged less than 290, and I have never charged more than 320. So it just kind of varies.
Q Okay. Does the charge -- does the fee vary currently, or do you charge $300?
A I charge $300, right now.

Excerpts from Deposition of Virginia Yrun
October 10, 2000

[39:14 - 40:04] Yrun, Virginia

Q. Right. The Planned Parenthood Federation of America has standard policies and procedures for the provision of abortion services that they provide to all of their affiliates, isn't that correct?

A. Planned Parenthood Federation of America has standards and guidelines for medical services and all its affiliates.

Q. Right. And the reason for that is that Planned Parenthood Federation of America, as well as PPSA, are concerned about, you know, the provision of quality medical services and improving women's health; right?

A. The standards and guidelines -- I mean, I'm not a physician, so what I'm aware of is that the standards and guidelines are a source of helping everyone continuously look at quality improvement.