NOS. 18-1323, 18-1460

IN THE
Supreme Court of the United States

JUNE MEDICAL SERVICES L.L.C., ET AL.,

Petitioner-Cross-Respondents,

v.

REBEKAH GEE, SECRETARY, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS,

Respondent-Cross-Petitioner.

On Writs of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF OF AMICI CURIAE LOUISIANA STATE LEGISLATORS IN SUPPORT OF RESPONDENT-CROSS-PETITIONER

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QUESTIONS PRESENTED

1. Whether the Court may resolve the issue of third-party standing even if it was not raised below.

2. Whether abortion providers have third-party standing to assert women's abortion rights when seeking to invalidate a regulation that protects women's health during abortion procedures.

3. Whether Act 620 protects the health of women who have an abortion.

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INTEREST OF AMICI CURIAE[1]

Amici consist of current, former, and incoming Louisiana state legislators who voted for or supported Act 620.

Amici have an interest in protecting women who seek an abortion. And they want to ensure that abortion providers cannot hijack women's rights and use them to overturn regulations that protect women's safety.

Additionally, amici have a specific interest in informing this Court why they enacted Act 620: to safeguard women who have an abortion. They also want to explain how the egregious practices of Louisiana abortion providers show that Act 620 helps protect those women.

A list of the amici legislators is included in this brief's appendix.

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[1] Pursuant to Supreme Court Rule 37(6), amici state that no one other than amici and their counsel authored this brief in whole or part or contributed money intended to fund the preparation or submission of this brief. Attorneys for Alliance Defending Freedom—the organization that represents amici—served as co-counsel for Respondent below, but none of its attorneys represents Respondent in this proceeding. All parties have consented to the filing of this brief in blanket consents on file.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

Petitioners want to use women's abortion rights to strike down a law that safeguards those same women during abortion procedures. It is akin to a car manufacturer that hijacks consumer rights to invalidate a regulation that makes cars safer. The Court should reject a third-party standing doctrine that forces this Court to decide important issues based on advocacy from plaintiffs whose interests conflict with those they purport to represent.

Before resolving that standing issue, this Court should clarify that the rules of third-party standing are rooted in Article III. While some cases refer to third-party standing as a prudential doctrine, this Court has recently called that into question while steadily shrinking prudential standing to the point of extinction. The time has come to affirm third-party standing's place within Article III. That conclusion is consistent with modern Article III principles, the policies underlying Article III, the broader trend toward eliminating prudential standing, and this Court's historical practice. Because Article III standing cannot be waived, this Court must address the third-party standing question, regardless of whether it was raised below.

Two rules of third-party standing control this case. First, litigants ordinarily may not raise the rights of third parties. Second, while there are exceptions to that rule, they do not apply when the litigant's interests conflict with the third party's. Such a conflict exists here; accordingly, Petitioners lack standing, and this case should be dismissed.

To demonstrate this conflict, this brief begins by discussing Act 620's purpose and effect. That statute was enacted to protect women who have an abortion procedure, and it directly furthers that purpose by (1) helping ensure the competence of doctors, and (2) promoting continuity of care and information exchange when medical complications arise.

The egregious practices pervading the Louisiana abortion industry illustrate the need for and usefulness of Act 620. Those practices include botched abortions by incompetent doctors, lack of screening for doctor competency, failures to stock emergency materials, a cavalier approach toward controlled substances, and countless other willful wrongs and inexcusable deficiencies that increase the danger to women who have abortions in Louisiana.

That misconduct also distinguishes this case from *Whole Woman's Health* v. *Hellerstedt*, 136 S. Ct. 2292 (2016) [hereinafter *WWH*]. While Texas could point to *no* woman who would have been helped by its law, Louisiana can. One such woman is Brenda J., whose story is discussed in detail below. She experienced heavy bleeding following her surgical abortion, but her doctor did not accompany her to the hospital or inform emergency personnel that she had an incomplete abortion. Since the hospital lacked this information and Brenda did not mention the abortion because she did not want to disclose it, she lay on a hospital bed for three days while a hole in her uterus became infected. Act 620 would have made a difference for Brenda.

With Act 620's purpose and effect in mind, it is easy to see that a conflict exists between Petitioners' and women's interests. One of the women's interests is in protecting their safety when having an abortion, and one of the doctors' interests—to eliminate a law that places a regulatory obligation on them—directly conflicts with that.

This conflict is central to resolving this case. It not only provides the pressing need for this Court to resolve the third-party standing question, it destroys any rightful claim to third-party standing. There is no third-party standing when "the interests of [the litigant] and [the third party] are not parallel" and "potentially in conflict." *Elk Grove Unified Sch. Dist.* v. *Newdow*, 542 U.S. 1, 15 (2004). Accordingly, Petitioners' claims should be dismissed and the Fifth Circuit's judgment affirmed, though on different grounds. Alternatively, the egregious practices of the Louisiana abortion industry distinguish this case from *WWH* and justify affirming the Fifth Circuit's ruling on the merits.

ARGUMENT

I. Act 620's purpose is to protect women who have an abortion procedure.

This Court's constitutional analysis considers "the purpose" of abortion regulations. *Planned Parenthood of Se. Pa.* v. *Casey*, 505 U.S. 833, 877 (1992) (plurality). One legitimate—even compelling—purpose is "to foster the health of a woman seeking an abortion." *Id.* at 878.

The legislative record confirms that Act 620 was enacted for that purpose. When discussing the bill on the House floor, the lead sponsor, Democratic Representative Katrina Jackson, said that "this is about the safety of women." Transcript of Legislative History at 35 (ECF No. 165-197) [hereinafter "Leg. Tr."]; see also *id.* at 38 (reiterating before a Senate committee that the bill "protect[s] the lives of women"); Dist. Ct. Op. ¶ 183 (cataloguing similar statements). After examining the legislative record, the district court agreed that "[a] purpose of the bill is to improve the health and safety of women undergoing an abortion." Dist. Ct. Op. ¶ 189(A).

The legislature heard testimony about the many abortion-related "health risks" that require "urgent medical attention," including "infection," "perforation of the uterine wall," "anesthesia-related complications," Leg. Tr. at 3 (ECF No. 165-197), "hemorrhage," and "retained fetal body parts," *id.* at 5. Testimony also recounted the stories of Louisiana women who experienced abortion complications and needed emergency medical help. *Id.* at 45.

The legislature focused on two ways that Act 620 would safeguard women. First, the Secretary of the Louisiana Department of Health and Hospitals testified—and other medical experts confirmed—that Act 620 "provides a more thorough evaluation mechanism of physician competency." *Id.* at 3; accord *id.* at 48; Dist. Ct. Op. ¶ 180. Second, the regulation would promote "continuity of care" and "optimize[ ] patient information transfer and complication management." Dist. Ct. Op. ¶ 180; see, *e.g.*, Leg. Tr. at 3, 48 (ECF No. 165-197).

Notably, Act 620 did *not* single out abortion providers for unique treatment; it sought to "achieve greater consistency in the overall regulation of outpatient surgical procedures." Dist. Ct. Op. ¶ 181. Existing Louisiana regulations required physicians at ambulatory surgical centers to be "member[s] in good standing on the medical staff of at least one hospital in the community" and to obtain "surgical privileges" there. La. Admin. Code tit. 48, § 4541(B). Act 620 extended similar requirements to abortion doctors. Dist. Ct. Op. ¶ 182 (cataloguing statements); see, *e.g.*, Leg. Tr. at 4 (ECF No. 165-197) ("[T]his is the standard that is currently in place for ambulatory surgical centers").

II. Louisiana abortion providers' egregious practices demonstrate that Act 620 protects women.

Petitioners deny that Act 620 protects women and insist that *WWH*'s analysis of Texas's statute controls. But Louisiana is not Texas, and this case is not *WWH*. There, as Petitioners recognize, the Court's analysis relied on "general medical evidence and studies." Pet'rs Br. 5. But here, the specific and egregious practices of Louisiana abortion providers amply support the legislature's conclusion that Act 620 will help protect women.

A. The legislature heard testimony about—and was concerned with—Louisiana abortion providers' egregious practices.

The legislature received testimony about "[t]he history of health and safety violations by Louisiana abortion clinics" and the "concerns" that history raises for "serious abortion-related complications."

Dist. Ct. Op. ¶ 180. For example, concerned citizen Deanna Candler provided handouts of her investigation "regarding the history of violations from the Delta Clinic," detailing "botched abortions, unsanitary conditions, [and] multiple state violations," including "protecting statutory rapists." Leg. Tr. at 10 (ECF No. 165-197); accord *id.* at 47 (Delta had "been cited for violations 18 times since 2006").

She also testified that these shoddy practices were not unique to Delta but endemic in the state. June Medical itself had "been cited 13 times since 2004, including for . . . reusing single-use equipment, allowing noncertified individuals to administer narcotics, failure to monitor patients' vital signs during abortions, and failing to meet reporting requirements [or] maintain a sterile environment." *Id.* at 47. Causeway Medical Clinic had also "been cited for violation 14 times since 2007, including for failure to determine viability of a child, not monitoring patients' vital signs during the abortion procedure, unsanitary conditions, expired medications, and failing to ensure parental consent for minor abortions." *Id.* at 46.

It did not end there. Bossier City Medical had "been cited for violations eight times since 2004, including for failing to obtain a controlled dangerous substances license . . . , for not monitoring patients' vital signs after being given narcotics, and for unsanitary conditions." *Id.* at 46–47. And Women's Health Care had "been cited for violations 12 times since 2004, including for failing to report abortions, as required by law, failure to ensure informed consent, missing and incorrect records, and failing to inspect equipment for safety. *Id.* at 47.

Public records corroborating this testimony paint a dreadful picture. Those documents, discussed below, are available on the Louisiana Attorney General's website (http://bit.ly/2P5sxoE), and a select portion is included in this brief's appendix. This Court may properly consider those materials. Most pertain not to adjudicative facts specific to the parties, but to legislative facts relevant to "legal reasoning and the lawmaking process." Advisory Committee Notes on Fed. R. Evid. 201. When courts consider legislative facts, they "may make an independent search for persuasive data," including a search through public records. *Ibid.* In addition, this Court may take judicial notice of the contents of public records produced by the state. Fed. R. Evid. 201(b), (d).

B. Louisiana abortion providers' egregious practices show that Act 620 helps ensure doctor competence.

1. Louisiana abortion facilities do nothing to confirm their doctors' competence. As the Fifth Circuit concluded, those facilities, "beyond ensuring that the provider has a current medical license, do not appear to undertake any review of a provider's competency." Pet. App. 35a–36a. "The clinics, unlike hospitals, do not even appear to perform criminal background checks." *Id.* at 36a.

Leroy Brinkley, the president of two of Louisiana's three existing abortion facilities (Delta and Women's Health), confirmed this. When asked how he determines whether a doctor is "capable," he testified: "I don't judge the license. If they have a license and the state gave the license, it's not for me to determine if they are capable." PRR 556 (App.

67a).[2] Moreover, conducting "a background check" is not within his "framework." *Ibid.*

The absence of physician screening is systemic throughout Louisiana abortion facilities. The state has issued Statements of Deficiency against multiple facilities for failing to adopt "a detailed credentialing process for physicians" or to investigate "possible restrictions" on their licenses or "evidence of prior malpractice claims/settlements." PRR 084; see also PRR 138, 1058.

Just like Delta and Women's Health, the medical director at June Medical "admits he neither performed background checks nor inquired into their previous training" before bringing in new doctors. Pet. App. 22a. This led to an ophthalmologist and radiologist performing abortions at June Medical! Trial Tr. Vol. 1 at 157–58 (ECF No. 190). In one instance, the state found no evidence that a "physician's application . . . was [even] reviewed by [that facility's] medical staff." PRR 906.

2. These facilities' failure to screen physicians endangers women by subjecting them to incompetent doctors. For example, Brinkley staffed Delta with Eileen O'Neill, whom he admitted "didn't follow acceptable medical care" and "did some things that were not up to medical standards." PRR 546. And he contracted with the infamous Kermit Gosnell to work at a facility in Delaware. PRR 448.

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[2] "PRR" refers to the bates-stamped page number on the public records available at the Louisiana Attorney General's website. And when an "App." cite is included in parentheses, that public record is part of this brief's appendix.

Brinkley also arranged for Dr. A. James Whitmore—a grossly negligent abortionist—to work at Delta. After performing a surgical abortion on a woman named D.C., Dr. Whitmore allowed her to bleed for three hours before getting help. PRR 2010 (App. 37a–38a). A coworker testified that Dr. Whitmore "would not let her call 911 because of possible media involvement." PRR 2010 (App. 37a). The coworker called anyway, and the emergency-room personnel discovered that D.C. had "a perforated uterus," that "the uterine artery was lacerated," and that "[i]t was necessary to perform a complete hysterectomy." *Ibid.* The Louisiana Board of Medical Examiners determined that Dr. Whitmore engaged in "unprofessional conduct," PRR 2008, 2010 (App. 34a, 38a), and that his "tardy recognition of the seriousness of the condition . . . endanger[ed] [D.C.'s] life," PRR 2010 (App. 38a). After years of enabling abortionists like Dr. Whitmore, Delta's track record deteriorated to the point that the National Abortion Federation stopped referring patients there. PRR 448.

Other Louisiana abortion facilities contracted with the incompetent Dr. David Lee Golden. He callously abandoned a woman named Audrey D. when she experienced excruciating pain following a surgical abortion. "He told her he had to go somewhere" but "did not return," so he had "the nurses give[ ] her some Tylenol" and instruct her to "go home and lie down." PRR 1979 (App. 9a). Dr. Golden suspected that "the fetal skull remained in the uterus," yet he "released her without performing an additional pelvic examination," PRR 1979 (App. 9a–10a), or telling her that "he suspected the abortion to be incomplete," PRR 1981 (App. 12a).

After Audrey left, "the pain got so bad" that she went straight to the hospital. PRR 1979 (App. 9a). The emergency-room physician "found a tear in the uterus," "a portion of the placenta protruding through it," and "a large hemotoma" containing "a fetal head." *Ibid.* Audrey then had "an emergency hysterectomy." *Ibid.* The Board of Medical Examiners determined that Dr. Golden "grossly mismanaged" Audrey's case, and that because of his "medical incompetency," Audrey was "deprived of [her] reproductive capacity." PRR 1981 (App. 12a).

These examples illustrate the high cost of Louisiana abortion facilities' medical incompetence and failure to screen doctors. Women's lives are endangered, and their ability to have children is ripped away. The costs are so great and the situation so dire that the legislature felt compelled to act.

3. Act 620 directly advances the state's interest in physician competence. As the state's expert Dr. Robert Marier testified, hospitals evaluate "a physician's training and experience" during the privileging process. Trial Tr. Vol. 4 at 20 (ECF No. 193). This means, as the district court found, that "a physician's competency is a factor in assessing an applicant for admitting privileges." Dist. Ct. Op. ¶ 94. Even Petitioners' expert conceded that admitting privileges are a "way" to "serve the function of providing an evaluation mechanism for physician competency." Trial Tr. Vol. 6 at 72 (ECF No. 195).

A law like Act 620 is especially necessary and effective in Louisiana, where abortion providers fail to screen for competence, exposing women to danger-

ous abortionists. Hospital review during the privileging process is that much more important and effective to shield women from bad doctors committing malpractice. Regardless what Texas showed in *WWH*, Louisiana surely faced a "significant health-related problem that the new law helped to cure." 136 S. Ct. at 2311.

Petitioners malign Act 620 because hospitals assessing privilege applications consider factors in addition to competence. But since one of the privileging factors *is* competence, Dist. Ct. Op. ¶ 94, requiring privileges helps prevent incompetent doctors from working at Louisiana abortion facilities.

The fact that some physicians will be denied privileges for reasons unrelated to competence does not mean Act 620 is ineffective, only that it has multiple goals and might not be perfectly tailored to all of them. Yet the *Casey* standard is not strict scrutiny, so narrow—let alone perfect—tailoring is not required.

C. Louisiana abortion providers' egregious practices show that Act 620 fosters continuity of care and information exchange.

Louisiana abortion providers have failed to maintain continuity of care or adequately transfer information when women experience serious complications. A prime example is another story involving Dr. Golden. During a surgical abortion on Brenda J., Dr. Golden "perforated the wall of the uterus and pushed the head of the fetus out" of the perforation. PRR 1976 (App. 4a).

Once finished, Dr. Golden suspected the abortion was incomplete but did not tell Brenda. *Ibid.* After keeping her "on the operating table for seven to eight hours, while she lost much of the blood in her body," PRR 1980 (App. 11a), he had someone take her to the hospital in a car (instead of an ambulance), PRR 1977 (App. 6a), and "told her to tell the admitting nurse that she had uncontrolled uterine bleeding," PRR 1976 (App. 4a).

Dr. Golden "did not accompany [Brenda] to the hospital," PRR 1980 (App. 12a), speak to the emergency-room physician, PRR 1977 (App. 5a), or inform the hospital that Brenda "had undergone an abortion, or that it might have been incomplete," PRR 1977 (App. 4a). "If he had accompanied [Brenda] to the hospital," the Board of Medical Examiners explained, Dr. Golden "would have given the reason for her admission," which would have benefited her greatly. PRR 1978 (App. 7a–8a). But without that information, the emergency-room physician waited three days before operating. PRR 1977 (App. 5a). When he did, he discovered "a fetal skull and an infected tear in the uterus" before removing the baby's leftover parts and performing a hysterectomy. *Ibid.*

Had Act 620 been in place, Dr. Golden (assuming he could have passed a hospital's competence screening and obtained admitting privileges) would have admitted Brenda to the hospital himself and ensured the staff was aware of the abortion that led to her condition. Instead, because Brenda did not want to disclose her abortion and thus did not mention it, she lay in a hospital bed bleeding for days, developed an

infection in her uterus tear, and tragically lost her ability to have children.

Brenda's story starkly illustrates the difference between this case and *WWH*. While Texas did not know of "a single instance in which the new requirement would have helped even one woman obtain better treatment," *WWH*, 136 S. Ct. at 2311, Brenda's tragedy shows the opposite here. The continuity of care and information exchange that Act 620 facilitates directly benefit real women like Brenda, helping keep them safe.

D. Louisiana abortion providers' egregious practices increase the risk of complications and hospitalization.

Additional facts specific to Louisiana increase the risks of complications and hospitalization for women who have an abortion in Louisiana, further distinguishing this case from *WWH*.

1. To begin, Louisiana abortion facilities' extreme deficiencies increase the odds that complications will escalate and require hospitalization. Delta and its medical director neglected to maintain "a supply of emergency medications and medical equipment for stabilizing and/or treating medical and surgical complications," resulting in an "Immediate Jeopardy" situation. PRR 401, 405 (App. 85a, 90a–91a). This failure adversely affected a woman when Delta did not have "any IV fluids to administer to help stabilize" her as she experienced "a decrease in blood pressure, heavy bleeding and speaking incoherently." PRR 405–06 (App. 91a). She became "semiconscious . . . resulting in 911 being called." PRR 406–07 (App. 93a). The medical director had no explanation; he simply (yet

incorrectly) "assumed the [facility's] administrative staff ensured IV fluids were available for use." PRR 404 (App. 89a). When the woman arrived at the hospital, doctors performed another procedure because they suspected the abortion was incomplete. PRR 410 (App. 97a). The woman then underwent a hysterectomy and her fallopian tubes were removed due to "persistent postoperative hemorrhage." PRR 411 (App. 99a).

That is hardly the only time a Louisiana abortion facility lacked necessary emergency drugs or supplies. That same inspection of Delta revealed that its emergency cart did not include Midazolam like it should have—a deficiency the medical director admitted "he was aware" of—and the facility did not have a balloon on site to stop uterine bleeding. PRR 402–04 (App. 86a–89a). Also, an inspection of Causeway found no "reversal agent for Valium in the facility," PRR 063, or "tubing to connect the . . . mask to oxygen" should a complication occur, PRR 064.

2. Additionally, Louisiana abortion facilities' cavalier attitude toward anesthesia and controlled substances increases the risk of, and deepens the legislative concerns about, drug-related complications. Of particular concern, the state has cited three separate facilities—June Medical, Delta, and Causeway—for creating "Immediate Jeopardy" situations when they failed to monitor women who had been administered sedatives and other drugs. PRR 55–56, 171, 919-20. June Medical failed to ensure women's "level of consciousness" or monitor their "respiratory and cardiovascular status . . . during and after the administration of intravenous medications and . . .

gas agents." PRR 919. Delta neglected to monitor women "receiving conscious sedation regarding their cardiac status, respiratory status, and level of consciousness." PRR 171. And Causeway did not document "the continued cardiac and respiratory status of the patient" and "the consciousness level of the patient throughout the entire stay." PRR 55; see also PRR 019 (finding that Bossier failed to ensure women were "assessed after the administration of narcotic medications").

Compounding these concerns are many examples of the abortion facilities' drug-related negligence:

- June Medical did not ask women about their "past complications with anesthesia" before administering it. PRR 928.

- June Medical lacked policies to address "adverse reactions to the sedative medications and inhalation agents used." PRR 931.

- Multiple facilities stocked expired medications, including in their emergency kits. PRR 120–21, 193–94, 233–34, 403.

- Delta's doctors placed a pad of "*pre-signed* Promethazine prescriptions" on "the front desk in the main lobby of the clinic." PRR 205 (emphasis added).

- Delta and its doctors violated federal law and incurred a $337,000 fine by dispensing controlled substances without proper registration or record-keeping. *United States* v. *Clinical Leasing Serv., Inc.*, 759 F. Supp. 310 (E.D. La. 1990), *aff'd,* 925 F.2d 120 (5th Cir. 1991).

- A doctor at Women's Health was cited for ordering a "controlled dangerous substance" without a license. PRR 1097.

- Delta, Bossier, and Causeway failed to maintain records on the drugs they dispensed. PRR 015, 055–56, 171, 319, 336.

- And Dr. Kevin Work—an abortionist who worked at Delta, among other facilities—admitted that "controlled substances were prescribed to his patients and not documented." PRR 2031 (App. 27a).

3. Moreover, Louisiana abortion facilities' inadequacies in staffing, training, and oversight increase women's risks. Delta's medical director admitted that he does not have "adequate help": "he need[s] a nurse in the surgical room with him," but "the facility is not adequately staffed to allow" that. PRR 299–300. And Women's Health told the state that it did not have a registered nurse on staff. PRR 1038.

The facilities also allow unlicensed, unqualified staff to perform medical tasks. June Medical allowed its "operating room technician"—an unlicensed person who previously worked for "a portrait studio" and was trained by yet another unlicensed employee—to administer nitrous oxide and oxygen. PRR 917–18. Delta nurses repeatedly administered "drugs without a physician's order." PRR 302. And Dr. Work admitted that his staff was "not appropriately directed" or supervised—"allow[ing] non-licensed individuals, without ability and expertise, to . . . essentially practice medicine." PRR 2031 (App. 27a). He also admitted that his "signature was used on patient

treatment records . . . signifying that [he] had personally examined patients when he had not." *Ibid.*

Training for nurses and other staff has also been sorely lacking. Evidence of this deficiency at June Medical and Delta pervades the public record. PRR 315, 316–17, 902, 927 (June Medical's medical director "revealed he had not conducted in-services training with any staff personnel for approximately two years"). In particular, June Medical has been repeatedly cited for failing to train its nurses on compounding medications. PRR 946, 953. And worse yet, that facility was cited for failing to ensure its staff's competence in identifying retained fetal parts, even though its own policies say that such skills are "CRITICAL in ensuring the woman's health and the completeness of the procedure." PRR 957–59.

4. In addition, Louisiana abortion facilities have failed to comply with basic sanitary standards. It was "proven" during an investigation into Delta's Dr. Whitmore that "the instruments [Delta] used were rusty, cracked and unsterile." PRR 2009 (App. 36a). Delta also "use[d] single-use hoses and [tubes] on multiple patients," and the solution used to sterilize the instruments "was changed infrequently" and "often [had] pieces of tissue floating in [it]." *Ibid.*

Other facilities have had sterilization problems as well. To list just one example, the state found that Women's Health "performed abortions on 46 patients using surgical instruments that were not properly sterilized." PRR 1027. The health concerns that these severe sanitation deficiencies raise are chilling.

All these pervasive and extreme failings demonstrate that abortion is especially dangerous in Louisiana. That further supports the legislature's decision to pass Act 620.

E. Louisiana abortion providers' egregious practices undermine the veracity of Petitioners' statistics.

Louisiana abortion facilities' rampant reporting and documenting deficiencies justified legislators' reasonable doubts about the veracity of Petitioners' abortion-complication statistics. While some facilities have been cited for failing to notify the state about abortions performed, PRR 1030, more troubling is the failure to report medical complications. Women's Health's administrator admitted that the facility "does not keep track of patients that have had complications after the abortion," PRR 1028, including a woman treated for heavy bleeding that required "transfer to a hospital," PRR 1049–50 (App. 76a–77a). Nor did June Medical report when a woman experienced "excessive hemorrhaging" and an incomplete abortion. PRR 940–41 (App. 71a–73a).

The underreporting concerns are exacerbated by the facilities' brazen and self-serving efforts to hide complications and destroy records. As recounted above, a Delta employee testified that "Dr. Whitmore would not let her call 911" when a woman was bleeding excessively. PRR 2010 (App. 37a). The doctor was too concerned about "possible media involvement" to prioritize the woman's well-being. *Ibid.* The outright destruction of records is also alarming. For example, despite telling the state that Bossier would maintain its records after closing, PRR 039, the owner

shredded all documents just one month later, PRR 040–41. All this creates grave concerns that Louisiana abortion facilities' indiscretions are likely far worse than reported.

The cloud surrounding abortion reporting in Louisiana deepens the legislature's worries about the dangers of abortion in the state. This bolsters the legislature's concerns, further distinguishes *WWH*, and provides more support for affirming the Fifth Circuit's judgment.

III. Petitioners lack standing to raise the rights of the women they "represent."

Petitioners raise the abortion rights of women to challenge a law that protects those same women's safety. The state challenges Petitioners' standing on appeal. The Court should address that third-party standing question even if it was not raised below. And the Court should hold that Petitioners lack third-party standing because some of their interests conflict with the interests of the women they purportedly represent.

A. The third-party standing question is properly before this Court.

The third-party standing issue is properly before this Court for two reasons. First, third-party standing is best understood as an Article III issue to which waiver does not apply. Second, the specific circumstances of this case require this Court to decide the third-party standing issue even if waived below.

1. Third-party standing is an Article III issue.

While some cases have referred to third-party standing as an aspect of prudential standing, *e.g.*, *Kowalski* v. *Tesmer,* 543 U.S. 125, 128–129 (2004), this Court has already said that assumption should be reevaluated. Specifically, in *Lexmark International, Inc.* v. *Static Control Components, Inc.*, 572 U.S. 118, 127 n.3 (2014), a unanimous Court recognized that "limitations on third-party standing are hard[ ] to classify" and "that doctrine's proper place in the standing firmament" should be reassessed. In so doing, the *Lexmark* Court suggested that third-party standing is not prudential. It did so by discussing third-party standing alongside two other concepts—the "zone-of-interests test" and the prohibition on "generalized grievances"—that the Court "previously classified as . . . aspect[s] of 'prudential standing' but for which, upon closer inspection, [it] found that label inapt." *Ibid.* The Court should take the natural next step and clarify that third-party standing is an Article III issue.

a. Third-party standing fits squarely within modern Article III doctrine. Article III standing analysis is particularized: "the particular plaintiff" must demonstrate standing for each "*particular claim[ ]* asserted." *DaimlerChrysler Corp.* v. *Cuno*, 547 U.S. 332, 352 (2006); accord *Warth* v. *Seldin*, 422 U.S. 490, 500 (1975) (standing "turns on the nature and source of the claim asserted"). Questions of third-party standing arise when a particular plaintiff raises a particular claim belonging to others. Whether that

plaintiff may do so is an issue falling within this Article III rubric.

To illustrate, Petitioners do not satisfy Article III by showing they have standing to raise *some* claim. They must have standing to raise the claim they assert—that Act 620 violates women's rights. Because that claim rests on nonparties' rights, questions of third-party standing are inherent in the Article III requirement that litigants demonstrate standing for each of their claims.

b. Third-party standing implicates the core "policies embodied in [the] Article III" case-or-controversy requirement. *Valley Forge Christian Coll.* v. *Ams. United for Separation of Church & State, Inc.*, 454 U.S. 464, 472 (1982). In fact, this Court has already recognized that the default rule against third-party standing is "closely related to Art. III concerns." *Warth*, 422 U.S. at 500.

One key Article III policy is to ensure courts have a "concrete factual context conducive to a realistic appreciation of the consequences of judicial action"—that courts do not decide important questions with only "some, but not all, of the facts." *Valley Forge*, 454 U.S. at 472. The primary reasons for the general prohibition on third-party standing are similar: to "assure[ ] the court that the issues" will be "concrete and sharply presented," and to avoid adjudicating cases where a statute's "constitutional application might be cloudy." *Sec'y of State of Md.* v. *Joseph H. Munson Co.*, 467 U.S. 947, 955 (1984).

"The Art. III aspect of standing also reflects a due regard for the autonomy of those persons likely to be most directly affected by a judicial order." *Valley*

Forge, 454 U.S. at 473. The same goes for the rule against third-party standing, which respects that "the holders of th[e] rights" might "not wish to assert them" or might "be able to enjoy them regardless of whether the in-court litigant is successful." *Singleton* v. *Wulff*, 428 U.S. 106, 113–14 (1976) (plurality).

Relatedly, both Article III and third-party standing are concerned with whether the holder of the right has suffered a concrete injury. *Lujan* v. *Defs. of Wildlife*, 504 U.S. 555, 560 (1992) (Article III requires an "injury in fact"); *Singleton*, 428 U.S. at 114 (plurality) (expressing concern that the right-holder might already be "able to enjoy" the right and thus is not suffering an injury). That is a significant question here. No woman has alleged that Act 620 left her unable to obtain an abortion or will do so in the future. It is at odds with Article III's purposes to allow a party to litigate the interests of a third party whose injury remains so "conjectural" and "hypothetical." *Lujan*, 504 U.S. at 560.

c. Affirming third-party standing's place within Article III is consistent with the broader move to drastically diminish—if not eradicate—"prudential" standing as a separate category. In the 1980s, this Court recognized that at least three doctrines—the ban on generalized grievances, the zone-of-interests test, and the default rule against third-party standing—were aspects of prudential standing. *Allen* v. *Wright*, 468 U.S. 737, 751 (1984). But by the time *Lexmark* was decided in 2014, the Court had made clear that two of these three (the generalized-grievances ban and the zone-of-interests test) are not

within prudential standing and that the third one (third-party standing) is ripe for reconsideration.

Consider the parallels between the Article III ban on generalized grievances and the default rule against third-party standing. The generalized-grievances prohibition ensures that "there is a real need" to decide the legal issue, that the court has "precise facts," and that the court can properly "fashion remedies." *Lance* v. *Coffman*, 549 U.S. 437, 441 (2007) (per curiam). As discussed above, the general rule against third-party standing rests on similar concerns. Accordingly, this Court should hold that third-party standing, just like the generalized-grievances ban, is rooted in Article III.

This trend toward eliminating prudential standing is consistent with this Court's "recent reaffirmation" that "a federal court's obligation to hear and decide cases within its jurisdiction is virtually unflagging." *Lexmark*, 572 U.S. at 126 (cleaned up). Courts "have no more right to decline the exercise of jurisdiction which is given, than to usurp that which is not given. The one or the other would be treason to the constitution." *Cohens* v. *Virginia*, 19 U.S. 264, 404 (1821). But prudential standing says that regardless of what Article III requires, courts may exercise or withhold their jurisdiction based on what they think "prudence" dictates. That is contrary to a faithful application of the judiciary's duty.

Worse, perpetuating the notion that third-party standing is a matter of discretion threatens the judiciary's legitimacy. See Henry P. Monaghan, *Third Party Standing*, 84 Colum. L. Rev. 277, 278–81 (1984). Litigants' confidence in federal courts erodes

when they believe judges choose which cases they hear based on undefined rules lacking a clear source. Clarifying that the policies and principles underlying the rules of third-party standing are grounded in Article III will instill greater confidence that courts are acting justly rather than capriciously.

d. Finally, affirming third-party standing's place under Article III is consistent with this Court's historical practice. "For most of our Nation's history, plaintiffs could not challenge a statute by asserting someone else's constitutional rights." *WWH*, 136 S. Ct. at 2322 (Thomas, J., dissenting) (citing *Kowalski*, 543 U.S. at 135 (Thomas, J., concurring) (discussing case law)). Indeed, Article III's original understanding is that a lawsuit "should be brought in the name of the party whose legal right has been affected." *Tyler* v. *Judges of Court of Registration*, 179 U.S. 405, 407 (1900). It is past time to restore third-party standing to its original place under Article III.

2. This Court should resolve the third-party standing issue even if it was waived below.

Regardless of whether third-party standing is grounded in Article III, this Court should resolve the third-party standing question for two reasons: (1) waiver does not apply to third-party standing in a case like this, Cross Pet. 33–34 (citing cases from the D.C., Second, and Sixth Circuits), and (2) appellate courts have discretion to excuse waiver and resolve questions "for the first time on appeal" where justice requires, *Singleton*, 428 U.S. at 121 (plurality) (citing *Hormel* v. *Helvering*, 312 U.S. 552, 557 (1941)). Under either of these rationales, four reasons demonstrate

why this Court should decide the third-party standing issue.

First, this case presents an inherent conflict between some interests of Petitioner doctors and some interests of the women whose babies they abort. As explained, Act 620 helps protect women who have an abortion. Thus, women in Louisiana—people like D.C., Audrey, and Brenda—have compelling interests in protecting their health during abortions, ensuring their abortion doctors are competent, and fostering continuity of care and information exchange should complications result. In contrast, the doctors, among other interests they might have, ultimately want to void a law that places regulatory obligations on them.

Such an inherent conflict of interests requires this Court to address the standing issue even if waived below. *Valley Forge*, 454 U.S. at 473 (nonwaivable Article III rules "reflect[ ] a due regard for the autonomy of those persons likely to be most directly affected by a judicial order"). Courts must be vigilant to ensure that plaintiffs do not hijack others' rights, poorly represent those individuals, and undermine their interests through litigation. This judicial duty to third parties is especially important when health and safety are at stake. Waiver has no place here.

Second, the facts necessary to resolve the women's claims are not "concrete" and the issues not "sharply presented." *Joseph H. Munson Co.*, 467 U.S. at 955. The record discloses little about Act 620's impact on women seeking abortion in Louisiana because those women did not testify. And the evidence on Act 620's effect is unclear because the doctors failed to seek admitting privileges in good faith.

When the facts and issues are insufficiently concrete, as here, this Court cannot adequately perform its adjudicative function. *Valley Forge*, 454 U.S. at 472 (nonwaivable Article III rules ensure a "concrete factual context"). Deciding claims without "the information needed" results in "bad law." *WWH*, 136 S. Ct. at 2322–23 (Thomas, J., dissenting).

Third, the conflict of interests between the doctors and women leaves the Court without necessary facts and effective advocacy on remedies. Petitioners have asked to completely invalidate Act 620's requirements, vindicating the doctors' interests at the expense of women's health interests. But rather than striking down Act 620 completely, a narrower option that lessens the requirements on doctors while retaining the health protection for women might be available. *Lewis* v. *Casey*, 518 U.S. 343, 357 (1996) (Article III requires that the remedy "be limited to the inadequacy that produced the injury in fact"). Yet without women representing their own health interests, the Court lacks key facts and arguments on appropriate remedies. This, too, militates in favor of resolving the third-party standing issue. *Lance*, 549 U.S. at 441 (nonwaivable Article III rules exist so that "courts fashion remedies no broader than required") (cleaned up).

Fourth, whether doctors may invoke their patients' rights to invalidate regulations that protect those patients' health is a question of law. And courts regularly say that waiver does not apply or is excused when the issue raised is legal. *New Orleans Depot Servs., Inc.* v. *Dir., Office of Worker's Comp. Programs*, 718 F.3d 384, 387–88 (5th Cir. 2013) (en banc)

(pure question of law is "a well-settled discretionary exception to the waiver rule"); *United States* v. *Brunner*, 726 F.3d 299, 304 (2d Cir. 2013) (it is "particularly appropriate" to "consider waived arguments" when they present "question[s] of law").

For all these reasons, this Court should address the third-party standing issue.

B. Litigants lack third-party standing when their interests conflict with the third parties' interests.

1. "In the ordinary course, a litigant must assert his or her own legal rights and interests, and cannot rest a claim to relief on the legal rights or interests of third parties." *Powers* v. *Ohio,* 499 U.S. 400, 410 (1991); accord *Warth*, 422 U.S. at 500–01 (expressing a "reluctance to exert judicial power when the plaintiff's claim to relief rests on the legal rights of third parties").

There are some exceptions to this default rule. Most relevant here is the catchall exception that applies when (1) the litigant "has a 'close' relationship with the person who possesses the right" and (2) the third party faces a "hindrance" to protecting her own rights. *Kowalski*, 543 U.S. at 130. In *Singleton*, a plurality held that those factors were satisfied when two doctors raised women's abortion rights in a challenge to a state law that excluded elective abortions from Medicaid funding. 428 U.S. at 114–18.

But exceptions to the bar on third-party standing—both the general two-prong exception and that exception as applied to abortion doctors in *Singleton*—do not apply when there is a conflict

between the litigant's and the third party's interests. The Court established this in *Elk Grove*, 542 U.S. at 15. The plaintiff there was a father raising his daughter's asserted constitutional interest in objecting to hearing others recite the words "under God" in the Pledge of Allegiance at public school. *Id.* at 5. According to her mother, the daughter had "no objection either to reciting or hearing" the Pledge. *Id.* at 9.

The Court held that the father could not raise the daughter's rights. *Id.* at 15. The father's "standing derives entirely from his relationship with his daughter." *Ibid.* But "[i]n marked contrast to our case law on [third-party standing]," the Court said while citing *Singleton*, "the interests of this parent [the litigant] and this child [the third party] are not parallel and, indeed, are potentially in conflict." *Ibid.* *Elk Grove* reaffirmed that the rules on third-party standing—including *Singleton*'s analysis for abortion providers—are displaced when the litigant's and third party's interests conflict. Under those circumstances, the litigant cannot assert the third party's rights.[3]

2. This conflict-of-interest rule fits within the logic of existing third-party standing doctrine. The first prong of the catchall exception—the "close relation[ship]" between litigant and third party—contemplates "an *identity* of interests" between the

[3] Lower courts agree. "[C]onflicts of interests between the plaintiff and the third party . . . strongly counsel against third party standing," *In re Majestic Star Casino, LLC*, 716 F.3d 736, 763 (3d Cir. 2013); "there must be an identity of interests" between the litigant and the third party, *Lepelletier* v. *FDIC*, 164 F.3d 37, 44 (D.C. Cir. 1999); and the litigant and the third party must "have interests which are aligned," *Canfield Aviation, Inc.* v. *Nat'l Transp. Safety Bd.*, 854 F.2d 745, 748 (5th Cir. 1988).

two. *Lepelletier*, 164 F.3d at 44 (emphasis added). No such relationship exists when the litigant's and third party's interests diverge, as when a doctor seeks to invalidate a rule that helps keep her patients safe.

The conflict-of-interest rule also makes sense in other contexts. Courts would not allow an adoption agency to raise children's asserted right to a family placement in a case challenging agency-screening requirements for child safety. Nor could employers raise their employees' wage-and-hour rights to invalidate an OSHA regulation that limits dangerous tasks to a few hours per week.

3. As explained above, an unavoidable conflict of interests exists here. Petitioner doctors' interest in avoiding regulation conflicts with women's interests in protecting their health. Yet doctors are hijacking women's rights to overturn a regulation that helps keep them safe during abortion.

The conflicts between Louisiana abortion providers and the women whose babies they abort extend beyond this. Most notably, the state's abortion facilities have a long list of failures to represent the legal interests of women:

- Bossier did not report the rape of a 14-year-old to the authorities. PRR 027–28; accord Order at 7, *In re Gee*, No. 19-30953 (5th Cir. Nov. 27, 2019) [hereinafter *In re Gee* Order] (Elrod, J., concurring) ("According to Louisiana, in one incident, Doe 2 may have failed to report the forcible rape of a fourteen-year-old girl.").

- Delta has repeatedly neglected to report statutory rape. PRR 183, 210.

- Causeway did not ask questions necessary to assess whether women were raped or minors were statutorily raped. PRR 078–80.

- Delta and Causeway repeatedly failed to obtain signed parental consent for minors. PRR 116, 147, 213; see also *In re Gee* Order at 7 (Elrod, J., concurring) ("Louisiana proffers that Doe 2 may have knowingly performed an abortion on a minor without parental consent or judicial bypass.").

- June Medical paid to settle a lawsuit after it aborted the baby of a minor without parental consent. PRR 3337, 3471 (App. 46a–51a).

- June Medical and Women's Health have neglected to get signed informed consent. PRR 961–62, 1039–40.

- And Causeway violated state law by failing to document that any health risks justified late second-trimester abortions it performed. PRR 049–52.

As these examples illustrate, the legal conflicts between Louisiana abortion providers and their female patients are pervasive. Those providers' interests conflict with women's interests in this case.

4. Allowing Petitioner doctors to raise women's abortion interests would turn principles of third-party standing on their head. A conflicted litigant is not a fitting "proponent" for the third party's interest. See *Singleton*, 428 U.S. at 115 (plurality). Such a litigant

is an advocate who will distort the case and sacrifice the right-holder's interests.

Petitioner doctors' no-holds-barred approach to invaliding Act 620 illustrates this. If the doctors truly cared about ensuring abortion access, they would have diligently pursued admitting privileges instead of selectively and half-heartedly applying. Had they acted with diligence and good faith, the factual record would not be so incomplete, nor the legal analysis so "ill-defined and speculative." *Craig* v. *Boren*, 429 U.S. 190, 193 (1976).

And if the doctors cared about women's health and not just eradicating unwanted regulatory oversight, they would have sought a narrower remedy that keeps the law's health benefits intact instead of demanding Act 620's complete invalidation. Unlike Petitioners' self-interested arguments, that sort of advocacy would have represented the full panoply of women's interests in Act 620.

5. The unavoidable conflict that a safety regulation like Act 620 creates between abortion providers and women distinguishes this case from *Singleton*. The doctors there challenged a state law withholding Medicaid funding for elective abortions. That funding statute—unlike a safety regulation such as Act 620—created no conflict between abortion doctors and women. So even though the plurality allowed third-party standing there, the Court should not here. It is *Elk Grove*'s conflict-of-interest rule, not *Singleton*'s analysis, that controls this case.

Craig is also unlike this case. The plaintiff vendor there filed suit against a law prohibiting the sale of low-alcohol beer to men (but not women) ages 18

through 20. That vendor and its affected male customers had "an identity of interests" and no apparent conflicts. *Lepelletier*, 164 F.3d at 44. Because of that, the vendor "cogently" raised the legal issues and presented the legal arguments. *Craig*, 429 U.S. at 194. But as explained, the inherent conflict here has clouded both the factual record and the party advocacy, depriving the Court of "the information needed to resolve [the legal] issue." *WWH*, 136 S. Ct. at 2323 (Thomas, J., dissenting). *Craig* is inapposite.

In sum, this Court should apply *Elk Grove*'s conflict-of-interest rule and hold that Petitioners lack third-party standing to raise women's abortion rights when challenging a regulation that helps keep women safe when having an abortion.

CONCLUSION

For the foregoing reasons, the Court should hold that Petitioners lack third-party standing, dismiss the case, and affirm the Fifth Circuit's judgment, though on different grounds. Alternatively, the Court should affirm the Fifth Circuit's conclusion that Petitioners' claims fail on their merits.

Respectfully submitted,

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JANUARY 2020

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IN THE MATTER OF:
DAVID LEE GOLDEN, M.D.
(CERTIFICATE NO. 014260)

DECISION

94-A-001

This matter comes before the Louisiana State Board of Medical Examiners ("Board") on an Administrative Complaint, charging David Lee Golden, M.D. with the following violations of the Louisiana Medical Practice Act:

> First, David Lee Golden, M.D. is charged with violation of the terms and conditions of a Consent Order entered into between him and the Board dated February 21, 1991.
>
> Second, David Lee Golden, M.D. is charged with medical incompetency, in violation of R.S. 37:1285(A)(12), and continuing or recurring medical practice which fails to satisfy the prevailing and usually accepted standards of

medical practice in this state, in violation of R.S. 37:1285(A)(14). Both of these charges arise out of the treatment accorded two of his patients, Brenda J. and Audrey D.

The case was heard before a panel of the Board representing a quorum of its membership consisting of Drs. Mary Lou Applewhite, F.P. Bordelon, Jr., Ike Muslow, Elmo J. Laborde, Richard M. Nunnally and Bernard L. Kaplan.[1] Also present were Judge Frederick S. Ellis, Independent Counsel for the Board, presiding and L. Thomas Styron, Attorney at Law, representing the complainant. Dr. Golden, respondent was presented represented by Albert H. Hanemann, Jr., Attorney at Law.

FINDINGS OF FACTS

On the first charge, the record reveals that, by decision of November 10, 1987, Dr Golden was found in violation of the Medical Practice Act because of a federal felony conviction for Medicaid fraud, and his license suspended. Upon his release from incarceration, Dr. Golden and the Board entered into a Consent Order, dated February 21, 1991, which required, *inter alia*, that Dr. Golden obtain 50 Continuing Medical Education credits per year during the first three years of his probation, 1991, 1992, and 1993.

According to the Board's records, Dr. Golden submitted the necessary proof of compliance for 1991

[1] Keith C. Ferdinand. M.D., Vice-President, recused himself from the hearing, and, therefore, took no part in the hearing and its ruling.

and 1993, but failed to do so for 1992, despite numerous requests.

Robert Buras, the Board's probation officer, testified to his many attempts to secure proof of compliance for 1992 from Dr. Golden, and stated that such proof had never been received at the Board office prior to January 1, 1994, the date by which the probationary requirements were to be completed.

At the hearing of this matter, Dr. Golden produced proof that he had secured the necessary credits for 1992.

It would, therefore, appear that Dr. Golden had complied with the conditions of his probation, but that he failed to furnish proof thereof within the time required.

The Board finds Dr. Golden to be in violation of the conditions of his probation for failing to furnish timely the proof of his compliance therewith. However, since the fact of his compliance has been adequately demonstrated, the Board will impose no sanction other than to reprimand Dr. Golden for his cavalier disregard of the reporting requirements of his probation.

With respect to the second charge against Dr. Golden, the record reveals the following circumstances relative to Brenda J. She had gone to Crescent City Women's Clinic for an abortion and was referred to Dr. Golden because her pregnancy was in the second trimester. She consulted Dr. Golden at the West Bank Women's Clinic on March 16, 1993. At the time of the initial examination, Dr. Golden noted a cervical infection, but elected to proceed. The procedure was begun on the evening of March 17, 1993,

shortly after 6:30 p.m. During the procedure, Dr. Golden apparently perforated the wall of the uterus and pushed the head of the fetus out of the uterus. He suspected, but was not certain, that the abortion was incomplete. Brenda J. testified that Dr. Golden did not tell her that the abortion was incomplete.

When she awakened, Brenda J. was told that she had lost a lot of blood and would have to be admitted to a hospital. She testified that Dr. Golden told her to tell the admitting nurse that she had uncontrolled uterine bleeding. She was admitted to United Medical Center on the early morning of March 18, 1993. Although she was admitted by Dr. Golden, nowhere in the hospital records does it appear that Brenda J. had undergone an abortion, or that it might have been incomplete. Dr. Golden testified that he did not put the abortion in her history because she begged him not to. Over the next couple of days, Brenda J. received seven pints of blood.

On March 20, 1993, after hearing from a friend that Dr. Golden planned to take her back to the West Bank Women's Clinic to complete the procedure, she became frightened because she had thought that the abortion had been completed and had not been told otherwise by Dr. Golden. She sought advice from an attorney, who advised her to seek a second opinion. She then checked herself out of United Medical Center against medical advice, and went to the emergency room at Baptist Hospital, where she was seen by Thomas B. Ryan, M.D.

Dr. Ryan had the impression that Brenda J. had had an abortion, that it was uncertain that all of the tissue had been removed, and that she had received

blood and antibiotics at United Medical Center. He suspected a perforation of the uterus and ordered an ultrasound test, which showed the uterus to be empty and a six centimeter mass adjacent to the uterus. The radiologist suspected a blood clot and Brenda J. was treated conservatively for three days. When she failed to improve, Dr. Ryan operated.

The operation disclosed a fetal skull and an infected tear in the uterus. The fetal material was removed, and a supercervical hysterectomy was performed. Her recovery thereafter was uneventful. During the entire time that Brenda J. was in Baptist Hospital, Dr. Ryan never spoke to Dr. Golden, and made no attempt to obtain his records on Brenda J. until just before the operation. At that time he obtained releases from Brenda J. and began to try to get the records. The record reflects attempts as early as March 22, 1993, which continued through April 30, 1993, all without success. He was never able to obtain them, and still had not seen them at the time of this hearing. Dr. Ryan said he did not call Dr. Golden because he did not believe he would have a lot to offer. It did not occur to Dr. Ryan that Dr. Golden would have left the baby's head in without telling the patient.

In commenting on Dr. Golden's case of Brenda J., Dr. Ryan said:

> "A. I was shocked that an individual could be performing medicine such as this in New Orleans in 1993. I felt that his care of this patient was shockingly negligent. And the falsifications of records at United Medical Center, both on the admitting forms, the

progress notes, and even the discharge summary dictated a month after the patient left, nothing was mentioned of an incomplete abortion. I was flabbergasted at how incredible this case was. I was shocked that in several aspects of this case. Number one, that a patient who loses anywhere from a third to a half of her blood at a clinic is then allowed to be transported in a car to the hospital without being accompanied by the physician, or in an ambulance, which places the patient at terrible risk on the way to the hospital. She is then admitted to the hospital under a false diagnosis, so that people that are taking care of the patient there are not aware of what's going on, they think she's just having some hormonal dysfunctional uterine bleeding. When she gets there she's treated with medications which are inappropriate for dysfunctional uterine bleeding, but are appropriate for an incomplete infected abortion. When Dr. Golden writes progress notes, there's nothing, there's no physical exam as relates to the pelvis. This patient is being admitted for a GYN problem, there's nothing in the admission history and physical, there's nothing in the progress notes relating to a GYN exam, there's nothing in the discharge summary a month later. All of this is false information as relates to her admission and the admitting reasons to the hospital. And in his discharge summary he relates that he gave her three units of blood. She received seven units of blood, as near as I

> can tell, while she was at United Medical Center."

Dr. Golden, who was apparently unaware that he had perforated the uterus and pushed the fetal head, or caput, out of the uterus, was aware that Brenda J. had lost a lot of blood. He planned to build her up with blood and antibiotics at United Medical Center. He also prescribed a drug designed to bring the remaining fetal parts to the mouth of the uterus, where they could be easily removed, and was going to bring Brenda J. back to the West Bank Women's Clinic for that purpose. He was prevented from carrying out his intention by the departure of Brenda J. from United Medical Center against medical advice. Victor Brown, M.D., a board certified obstetrician and gynecologist, who testified as an expert for Dr. Golden, was of the opinion that the course of treatment planned by Dr. Golden was not unreasonable under the circumstances.

Dr. Golden testified that he performed three hundred to seven hundred abortions per month, and thousands every year. He felt that he was better qualified to judge the propriety of his treatment than were doctors who did not perform abortions. However, he did admit that he "missed" in Brenda J.'s case. He testified that he followed her to the United Medical Center in his car. He stated that he suspected there was some fetal product left in her body, but thought it would be ejected by the uterus.

We note, however, that there is no evidence in the record to indicate that Dr. Golden went to the hospital with Brenda J. If he had accompanied her to the hospital he would have given the reason for her

admission, rather than the patient. The nurses' notes do not record his presence. There were no hand-written orders by Dr. Golden on her admission.

Further, although Dr. Golden testified that Brenda J. needed bo be transfused immediately, no orders were written to type and cross match her blood until three hours after her admission. Her need for transfusion is evidenced by the fact that she received seven units of blood, plus albumin and plasma during her stay in the hospital.

Both Dr. Ryan, who testified as both a fact and as an expert witness, and Gerald Joseph, M.D., who testified as an expert witness, felt that Dr. Golden's treatment of Brenda J. was deficient in a number of respects. First, they felt that the procedure should have been done in a hospital setting because of Brenda J.'s cervical infection. Second, they felt that a procedure lasting seven or eight hours was too long and the loss of blood too high. Third, they felt that Dr. Golden should have accompanied Brenda J. to the hospital. Fourth, they were extremely concerned that the records at United Medical Center were falsified in that they did not disclose Brenda J.'s true condition, and that no gynecological examination was ever given her at the hospital. Fifth, they were concerned that Dr. Golden failed to inform Brenda J., when she was leaving United Medical Center against medical advice, that she still retained some of the fetal products.

Audrey D., the patient involved in the other case, was going into her third month of pregnancy when she saw Dr. Golden. She testified that the procedure was very painful. When it was complete, she was assisted

to the recovery room, where she remained for "a long time". While in the recovery room, she spoke to Dr. Golden twice on the telephone and was told he was stuck in traffic. Then she was taken back to the examining room, where she saw Dr. Golden. He told her he had to go somewhere, and to wait there, because he wanted to examine her before she left.

She testified that she continued to complain of pain, and was told that it was normal to have some cramping after an abortion. Her pain continued, and Dr. Golden did not return. Eventually, she talked to him on the phone, and he told her he would have the nurses giver her some Tylenol for the pain, and that she should go home and lie down.

She needed assistance in dressing and getting to the car. On her way home to Pascagoula, Mississippi, the pain got so bad that she asked her fiance, who was driving, to take her to a hospital. He took her to Ocean Springs Hospital, where she was seen by Richard A. Nicholls, M.D., who performed an emergency hysterectomy. He testified that he found a tear in the uterus, eight to 10 centimeters long, with a portion of the placenta protruding through it. Immediately adjacent to the uterus was a large hematoma, which contained a fetal head.

Dr. Golden testified that the procedure on Audrey D. was uneventful, but that he suspected that a part of the fetal skull remained in the uterus. An ultrasound examination revealed the uterus to be empty, but Dr. Golden still felt that not enough tissue had been removed. However, when the patient remained stable, with little bleeding, for two hours, he did not believe her to be critical. He testified that he asked

her to remain for an examination, but that the patient was anxious to leave so that her parents wouldn't find out she had had an abortion. Dr. Golden released her without performing an additional pelvic examination, which, he testified, was not necessary under the circumstances. Dr. Golden also admitted that he "missed" this case, as well. He also testified that he could not specifically recall this patient, and that he was testifying from the records.

The testimony of the personnel of Crescent City Women's Clinic, where the procedure on Audrey D. was performed, is not consistent with Audrey D.'s testimony. Sylvia Ann Cochran, the owner, testified that Audrey D. was able to get up and move around, answer the telephone, and go to the bathroom without assistance. When she left, Ms. Cochran testified that Audrey D. was able to dress herself and walk to the car without assistance.

Ellar Caroline Capps, who was a counselor at the clinic, also testified that Audrey D. was able to get up and move about without assistance. She added that, when her fiance was present in the recovery room, that Audrey D. would complain that she had severe cramping or that she was in a lot of pain, and when he was not in the room, she would act as though nothing was wrong with her.

The records at Crescent City Women's Clinic reveal that at 4:53 p.m., Audrey D. complained of severe cramps on the right side, and at 4:59 p.m., she complained of cramps. At 5:10 p.m., she left the clinic. There is no note of any examination by Dr. Golden.

In view of the testimony of Audrey D. that she was in continuous pain during her stay at the clinic, and

that she was unable to walk or dress without assistance; the clinic records, which record her complaints of pain; and the testimony of Dr. Nicholls as to her condition when he saw her in Ocean Springs, we find the testimony of the clinic personnel, that she was able to walk and dress herself without assistance, and only complained of pain in the presence of her fiance, to be unworthy of belief.

Both Dr. Golden and Dr. Victor Brown, who is board certified in obstetrics and gynecology, were of the opinion that Audrey D.'s symptoms were not so unusual as to to require any precautions other than monitoring. Dr. Brown testified that any fetal material left in the uterus would be expelled in time without ill effect.

Drs. Ryan and Joseph both were of the opinion that, considering Audrey D.'s complaints of pain, Dr. Golden's suspicion that he had left the fetal skull, and the ultrasound test showing the uterus to be empty, Dr. Golden should have suspected a perforation of the uterus, and should have conducted a pelvic examination before discharging the patient. Dr. Nicholls was of the same opinion.

Considering all of the above circumstances, and the opinions of the expert witnesses called by both complainant and respondent, the Board finds that Dr. Golden's treatment of these two patients is substandard in a number of respects.

With respect to Brenda J., we find that Dr. Golden should not have kept her on the operating table for seven to eight hours, while she lost much of the blood in her body. We find that, when he hospitalized her, he should not have falsified her records, regardless of

the reason. We further find that Dr. Golden did not accompany Brenda J. to the hospital, and that he was not present when she was admitted. We do not believe his testimony to the contrary. We find that his failure to order immediate transfusions was either negligent or below acceptable standards, in view of his testimony that Brenda J. needed immediate transfusions. We find that he should have advised Brenda J. that the abortion was incomplete. We find that it was impropitious of Dr. Golden to plan to complete the procedure in the clinic rather than in the hospital.

With respect to Audrey D., we find that Dr. Golden should have recognized the possibility of a tear in the uterus; particularly after the ultrasound test found the uterus to be empty, when he suspected that part of the caput was still unremoved; and when Audrey D. continued to complain of severe pain several hours after the procedure was completed. We find that Dr. Golden should have performed a pelvic examination before permitting the discharge of Audrey D. We find that Dr. Golden should have advised his patient of the fact that he suspected the abortion to be incomplete.

We find that Dr. Golden grossly mismanaged both of these cases, and that as a result, both patients have been deprived of their reproductive capacity. We find him guilty of medical incompetency in violation of R.S. 37:1285(A)(12); and of, continuing or recurring medical practice which fails to satisfy the prevailing and usually accepted standards of medical practice in this state, in violation of R.S. 37:1285(A)(14).

DECISION

IT IS THEREFORE ORDERED that he following sanctions be imposed:

First, that the license of David Lee Golden, M.D. as evidenced by Certificate Number 014260, to practice medicine in the state of Louisiana be and it is hereby suspended for a period of two years, beginning September 1, 1995.

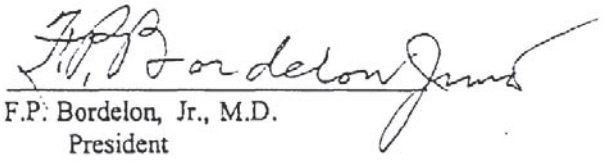
Second, that he pay a fine of $5,000.00, plus all costs of this proceeding.

Third, that his license be placed on probation for a period of 10 years, beginning when the suspension hereinabove imposed is completed.

Fourth, Dr. Golden shall obtain 50 credit hours per year of continuing medical education programs accredited by and qualifying for the Physicians Recognition Award of the American Medical Association, and he shall obtain such an award annually for the entire period of his suspension and probation. On or before January 1st of each year, Dr. Golden shall submit to the Board written certification of the CME programs completed by him during the preceding 12 months.

AT MARKSVILLE, LOUISIANA, this 25 day of August, 1995.

LOUISIANA STATE BOARD
OF MEDICAL EXAMINERS



F.P. Bordelon, Jr., M.D.
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IN THE MATTER OF:
DAVID LEE GOLDEN, M.D.
(CERTIFICATE NO. 014260)

DECISION

97-A-011

By Order of the Louisiana State Board of Medical Examiners ("Board"), in case No. 94-A-001, the license of David L. Golden, M.D., was suspended for a period of two years, beginning September 1, 1995. In the Administrative Complaint, which is the basis of this proceeding, Dr. Golden is charged with continuing to practice medicine throughout the month of September, 1995, after his license had been suspended as of September 1, 1995.

By way of history, we note that Dr. Golden's license was suspended on November 10, 1987, as the result of a conviction for Medicaid fraud. On February 21, 1991, when he was released from incarceration, he entered into a Consent Order with the Board, on

February 21, 1991, by virtue of which his license was reinstated on probation, subject to various terms and conditions.

Before the expiration of that probation period, Dr. Golden was charged by Administrative Complaint with medical incompetency and continuing medical practice which failed to satisfy the usually accepted standards of practice in this state. Following a full hearing, Dr. Golden was found guilty of both charges, and his license was suspended for a period of two years, beginning September 1, 1995.

Both Respondent and his counsel, Albert H. Hanemann, were properly notified of the above decision. On September 1, 1995, Respondent filed a petition for rehearing, which was denied by the Board on September 5, 1995. No further appeal was made on behalf of Dr. Golden, so that his suspension from practice became effective on September 1, 1995.

FINDINGS OF FACT

The Administrative Complaint before the Board was filed and accepted on July 23, 1997. A prehearing conference was held among Dr. Golden, counsel for Dr. Bobear, the Board's Investigating Officer, and Frederick S. Ellis, the Board's Independent Counsel, on August 15, 1997. At that conference, the hearing was set for October 24, 1997.

On September 19, 1997, Dr. Golden was advised that, because of the meeting of the Louisiana State Medical Society, the case could not be heard on October 24, 1997, but might be rescheduled for October 23, 1997. By letter of October 9, 1997, Dr. Golden agreed to the change in hearing date. In that letter, Dr. Golden also requested certain discovery.

By letter of October 21, 1997, Dr. Golden complained to L. Thomas Styron, counsel for the Complainant, that Mr. Styron had not responded to his discovery requests. Mr. Styron responded that he had sent to Dr. Golden copies of all evidence in his possession which he might use as exhibits.

On the morning of October 23, 1997, Mr. Styron and Dr. Golden participated in taking a telephone deposition of Janet Tompkin, which had been noticed on October 21, 1997. This deposition was tendered in evidence by Complainant at the hearing, over Dr. Golden's objection. The ruling on the offer was reserved.

The hearing went forward, witnesses were examined and a number of patient charts were introduced, apparently to prove that Dr. Golden had, indeed, practiced medicine after September 1, 1995. Dr. Golden objected to the admissibility of the records, based on the fact that they were not originals, and on certain breaks in the chain of custody thereof.

It appeared from the testimony that the records had been seized under a number of search warrants issued in connection with a New Orleans Police Department investigation. Subsequently, the Medicaid Fraud division of the State Attorney General's Office became involved and assumed custody of the documents. Copies of these were furnished to Complainant's counsel for use in the hearing. Neither the original seizing officers nor the original custodial officers testified.

Dr. Golden, under oath, denied that he had practiced any medicine on any patient after September 1, 1995. The records offered in evidence,

and the testimony of Janet Tompkin were suggestive to the contrary.

At the conclusion of the hearing, the hearing panel, consisting of Drs. Mary Lou Applewhite, Trenton L. James II and Elmo J. Laborde, was of the opinion that because Dr. Golden was not represented by counsel, and because much of the evidence offered by the Complainant was of doubtful admissibility, the case should remain open. The panel felt that there was evidence, available to either party, which could settle the matter with legal sufficiency.

The panel therefore ordered that the hearing remain open, and each party be given until December 7, 1997, to discover additional evidence, at which time the matter would once again be set for hearing. This deadline was later extended for an additional 30 days.

A status conference, properly noticed, was fixed for December 30, 1997, but Dr. Golden failed to appear. The status conference was reset for January 8, 1998, but Dr. Golden again did not appear. He did call in to say that he had received the notice, and that he was aware that a hearing date would be set. He gave an address to which documents to be introduced at the hearing could be sent.

The order issued after the status conference set the hearing for February 19, 1998, ordering that all documents which the Complainant intended to introduce at the hearing be immediately furnished to Respondent, and that any further documents and witness lists be furnished by each party to the other no later than February 10, 1998.

Complainant complied with the above order before February 10, 1998, and Dr. Golden furnished

his witness list, answers to interrogatories, and discovery requests on February 13, 1998. On February 16, 1998, he supplemented his witness list and made additional discovery requests. Dr. Golden further requested that the originals of all documents be made available for his inspection on February 18, 1998.

Despite the tardiness of his requests, all of the subpoenas requested by Dr. Golden were issued by the Board, and the originals of all documents were made available as requested. On the morning of February 18, 1998, Dr. Golden did not appear to inspect the documents. His wife, and a companion, did appear, and were given full access to the documents.

On the afternoon of February 18, 1998, a fax was received, purporting to be from Dr. Golden, requesting a continuance of the hearing set for the next morning.

When the hearing convened on the morning of February 19, 1998, Dr. Golden once again did not appear. His wife appeared, alleged that Dr. Golden was ill, and asked to be allowed to read into the record his letter asking for a continuance. She offered no medical certificate to prove illness on his part. She was allowed to read the letter into the record, after which she left immediately, before counsel for Complainant had given his opposition to the motion to continue.

After hearing the presentation of Complainant's counsel in opposition to the request for a continuance, the panel, again consisting of Drs. Mary Lou Applewhite, Trenton L. James II and Elmo J. Laborde, was of the opinion that the request should be denied. Dr.

Golden was fully apprised of the date of the hearing and furnished copies of all documents to be introduced by Complainant, well in advance of the hearing. All of his discovery and subpoena requests, although made untimely, were honored by the Board. He failed to appear for or participate in any of the status conferences. He failed to appear to make the inspection of the original records which he had requested. Finally, without any legal excuse, he failed to appear for the hearing. The panel felt that Dr. Golden's non-appearance was a willful and bad faith effort on his part to delay the proceedings. The panel therefore decided to proceed with the hearing.

At the second hearing, Janet Tompkin testified in person. She stated that she worked for Dr. Golden at the West Bank Clinic in Algiers from July 3, 1995, until September 29, 1995. Her duties included assisting Dr. Golden when he performed termination procedures, helping the patients, and operating certain equipment. She stated that, during September 1995, Dr. Golden was practicing medicine and performing abortions at the West Bank Clinic. She identified a number of records from the clinic from September 1995, which showed that Dr. Golden was authorized by the patient to perform the procedure. She testified that she was present when these procedures were performed by Dr. Golden. She also identified a number of charts from September 1995, which showed that Dr. Golden performed physical examinations. She identified Dr. Golden's signature on a number of records. She testified further that on September 28, 1995, Dr. Golden performed 11 abortions.

She did not learn that Dr. Golden's license had been suspended until September 29, 1995, at which time she resigned. The week after she left, Dr. Golden asked her to return to work to do the same job.

Finally, she testified about a patient, E.N., who came in on August 31, 1995, for an abortion. She heard Dr. Golden tell this patient that she was too many weeks pregnant, and that she would have to go to Houston. Later, she heard Dr. Golden say that she would have to pay him $3,000.00, and for her to return that night. On the next morning, E.N. was still in the clinic when Ms. Tompkin returned to work. E.N. said she had had a procedure. Ms. Tompkin helped her get dressed, and made an appointment for her to return on September 15, 1995. Ms. Tompkin further identified two prescription bottles as having been filled from prescriptions written by Dr. Golden on September 1, 1995.

Ramona Theresa Owen worked at the West Bank Clinic from April 28, 1995 until September 1, 1995, first as a laboratory technician and then as a medical assistant. She testified that she assisted Dr. Golden in the procedure performed on E.N., and that it was done between 5:00 and 6:00 AM. on September 1, 1995. This was Ms. Owen's last day on the job.

She stated that on September 30, 1995, Dr. Golden came to her home in Kentwood, LA, and told her he had a problem. His license had been suspended on September 1, 1995, and he knew it, but the real problem was E.N., who was trying to sue him. He asked Ms. Owen to tell anyone who asked her that she did not remember anything about E.N. He asked Ms.

Owen to come back to work, and said that he would buy her a car so she could commute.

He led her to believe that he was still practicing medicine, and that his lawyer would take care of the problem about the suspension of his license. Dr. Golden also said that he would say that he did not know about being suspended.

Later, she said that Dr. Golden's attorney called her and asked if anyone had gotten in touch with her. He asked her to let him know if anyone contacted her, and said that the best thing was for her not to remember.

Ms. Owen said that she agreed not to tell the truth, and, in fact, gave a statement to the police that she did not remember E. N. Later, when confronted with Ms. Tompkin, she decided to tell the truth, and gave them a truthful statement about E. N.

She testified that Dr. Golden had been good to her, and that is why she agreed initially to lie.

Randy Carr, a licensed pharmacist and the owner of a pharmacy adjacent to the West Bank Clinic, identified three prescriptions which he had filled, and which had been written by Dr. Golden on or after September 1, 1995.

Finally, we have the testimony of Officer Paulette Owens and Detective Glenn Taylor of the New Orleans Police Department, Investigator John Armand of the Attorney General's Medicaid Fraud Unit, and Charles Fleetwood, Investigator for the Board. They detailed the seizure and the chain of custody of the records introduced into evidence at the hearing. Without reiterating their testimony, we find

it sufficient to prove that the records introduced into evidence are the identical records seized from Dr. Golden's office, that they have been maintained in a secure location, and that they have not been tampered with.

In addition, Mr. Fleetwood testified that Dr. Golden had requested that he be permitted to inspect the original records on February 18, 1998. He further testified that he advised Dr. Golden, on the telephone, that the records would be available for inspection at the Board's office at 10:00 A.M. on February 18, 1998. At that time, Dr. Golden failed to appear, but his wife did come, and was given access to the records.

From the evidence presented at the hearing, the panel finds it clear that Dr. Golden did, indeed, practice medicine throughout the month of September, 1995. This is evidenced not only by the testimony of his employees, but by his own records. We find his denial, under oath, that he did not practice medicine after his suspension to be unworthy of belief. He has exhibited a cavalier disregard of the truth and of the high standards of conduct demanded of a physician.

CONCLUSION OF LAW

We therefore find Dr. Golden guilty as charged, and impose the following sanctions:

DECISION

1) The license of David Lee Golden, M.D. to practice medicine in the State of Louisiana, Certificate No. 014260, in hereby revoked and cancelled, effective this date.
2) Respondent shall pay a fine of $5,000.00 and all costs of this proceeding.

NEW ORLEANS, LOUISIANA, this 25th day of March, 1998.

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

Mary Lou Appplewhite, M.D.
Vice-President

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**BEFORE THE
LOUISIANA STATE BOARD
OF MEDICAL EXAMINERS**

IN THE MATTER OF: **KEVIN GOVAN WORK, M.D.** (*Certificate No.* MD.025394) *Respondent*	**No. 15-A-009**

INTERIM CONSENT ORDER

Kevin Govan Work, M. D. ("Dr. Work") is, and at all times pertinent hereto has been, a physician licensed to practice medicine in the State of Louisiana, but his license is currently on probation under a Consent Order executed on or about October 20, 2014 (the "2014 Consent Order"). At all times material to the facts and matters addressed herein, Dr. Work was engaged in the practice of obstetrics and gynecology at his clinics, the Canal Women's

Clinic ("Canal") and the Kenner Women's Clinic ("Kenner").

Dr. Work has been the subject of four prior investigations by the Louisiana State Board of Medical Examiners ("LSBME" or "Board"). In two of the investigations, one of which involved Dr. Work's business relationship with the owner of Midtown Medical Clinic ("Midtown"), the Board agreed to discontinue those investigations based on Dr. Work's representations that he would sever his business and financial relationship with the owner of Midtown. In another investigation, Matter No. 08-I-774, Dr. Work entered into a Consent Order with the Board. On January 11, 2011, Dr. Work's probation was terminated upon his demonstration to the Board that he had satisfied and fulfilled all the terms and conditions of the Consent Order.

The Board initiated a fourth investigation in November 2012 after receiving information that unlicensed or unqualified persons were allowed to administer medications to patients at Midtown. After Midtown's medical director, Dr. Varnishung, died on December 1, 2012, Dr. Work contacted the DOI to report that he would be returning to Midtown to attend to Dr. Varnishung's patients during a brief transition period in order to provide follow-up care and transfer those patients to his own clinic. The Board initiated an investigation and discovered that, during this interim period at Midtown, patients were not seen by Dr. Work or any other physician at Midtown, despite the fact that their medical records contained Dr. Work's digital signature. Dr. Work entered into a Consent Order with the Board in Matter No. 2013-I-014 and acknowledged that

Midtown staff were improperly using his name and electronic signature, and these staff were engaged in the practice of medicine while not under his supervision. This 2014 Consent Order, which is attached hereto, placed Dr. Work on probation for one year and, among other stipulations, provided that Dr. Work shall enter a practice monitoring program, protect his electronic signature, refrain from collaboration with and/or supervision of mid-level providers, and be present to direct activities of his medical personnel assuring that these activities were appropriate to their level of ability.

During the one-year period of probation, on or about June 16, 2015, the Board received information that a patient of Dr. Work's had not seen him for her prenatal visits, but had received her prenatal care from the staff at Canal. On or about June 23, 2015, the Board received a second complaint alleging that Dr. Work was allowing his staff members to do ultrasounds and provide the prenatal care in his clinic. Board staff conducted interviews and issued subpoenas for medical records. Reliable information was obtained by the Board that indicated that Dr. Work had allowed his unlicensed clinic personnel to evaluate his patients and provide prenatal care. Furthermore, the Board obtained information that he allowed the use of his signature for visit notes and prescriptions, and represented in the medical record and in his claims to Medicaid that he had seen the patients himself during visits when he had not.

Predicated upon the information outlined above, the DOI determined that reasonable cause existed for recommending that a formal Administrative Complaint be filed against Dr. Work, charging him with

violations of the Louisiana Medical Practice Act ("the Act"'). Pursuant to La. Rev. Stat. §37:1285 A, the Board initiated action against the license of Dr. Work as a result of: (11) "Making or submitting false, deceptive, or unfounded claims, reports, or opinions to any patient, insurance company or indemnity association, company, individual, or governmental authority for the purpose of obtaining anything of economic value;" (13) "Unprofessional conduct;" (18) "Knowingly performing any act which, in any way, assists an unlicensed person to practice medicine, or having professional connection with or lending one's name to an illegal practitioner;" and (30) "Violation of any rules and regulations of the board."

Dr. Work hereby acknowledges and admits that, after reviewing patient medical records and other records from Canal and Kenner for this period: (1) Dr. Work's signature was used on patient treatment records, including medical records signifying that Dr. Work had personally examined patients when he had not; (2) patient care activities in Dr. Work's clinics were not appropriately directed, which allowed non-licensed individuals, without ability and expertise, to provide prenatal care and essentially practice medicine; (3) Dr. Work failed to comply with the 2014 Consent Order by not contracting with a Board-approved practice monitor within the time allowed; and (4) controlled substances were prescribed to his patients and not documented, resulting in a failure to maintain accurate medical records.

As evidenced by his subscription to this Order, Dr. Work acknowledges the substantial accuracy of the foregoing information and that such acknowledgment, and the reported information, could provide the

Investigating Officer with probable cause to pursue formal administrative proceedings against him for violation of the Act, La. Rev. Stat. §§37:1285(A)(11) (13) (18) and (30), respectively and, further, that proof of such information upon administrative evidentiary hearing could establish grounds under the Act for the suspension, revocation or imposition of such other terms, conditions or restrictions on his license to practice medicine in the state of Louisiana as the Board might deem appropriate.

Recognizing his right to have administrative adjudication of such charges, at which time he would be entitled to be represented by legal counsel, to call witnesses, and to present evidence on his own behalf in defense or in mitigation of the charges made and to a decision thereon by the Board based upon written findings of fact and conclusions of law pursuant to La. Rev. Stat. §§49:955-965, Dr. Work, nonetheless, hereby waives his right to notice of charges, formal adjudication, and written decision and pursuant to La. Rev. Stat. §49:955(D) consents to entry of the Order set forth hereinafter. Moreover, by his subscription hereto, Dr. Work also waives any right to which he may be entitled pursuant to the Louisiana Administrative Procedure Act, La. Rev. Stat. §§49:951, et seq. or which otherwise may be afforded to him by law to contest his agreement to or the force and effect of this document in any court or other forum or body relating to the matters referred to herein. By his subscription hereto, Dr. Work also hereby authorizes the Investigating Officer designated by the Board with respect hereto to present this Consent Order to the Board for its consideration and to fully disclose to and discuss with the Board the

nature and results of the investigation and he waives any objection to such disclosures under La. Rev. Stat. §49:960. Furthermore, Dr. Work expressly acknowledges that the disclosure of information to the Board by the Investigating Officer shall be without prejudice to the Investigating Officer's authority to pursue an Administrative Complaint against him or to the Board's capacity to adjudicate such Complaint should the Board decline to approve this Consent Order.

Based upon the information provided, the Board has concluded that the public interest would be properly protected and served by allowing Dr. Work to maintain his license subject to appropriate specified terms and conditions. In consideration of this finding, accordingly, and on the recommendation of the Investigating Officer, the Board has concluded that its responsibility to insure the health, safety, and welfare of the citizens of this state, pursuant to La. Rev. Stat. §37:1261, will be effectively served by entry of the Order set forth hereinafter by consent. Accordingly, in consideration of the foregoing, and pursuant to the authority vested in the Board by La. Rev. Stat. §37:1285 and La. Rev. Stat. §49:955(D);

IT IS ORDERED that Kevin Govan Work, M.D., Certificate No. MD. 0295394, currently on Probation, **IS HEREBY REMOVED FROM PROBATION AND REINSTATED TO AN UNRESTRICTED STATUS. DR. WORK AGREES AND SHALL NOT PRACTICE MEDICINE IN ANY CAPACITY** and **SHALL NOT RETURN TO PRACTICE FOR A MINIMUM PERIOD OF ONE (1) YEAR FROM THE DATE OF THIS CONSENT ORDER**, and until the Board issues an Order allowing him to

return to practice based upon demonstration that he has satisfied the following terms and conditions:

(1) Passage of Written Examination for Basic Certification in Obstetrics and Gynecology. Dr. Work shall take and pass the written examination required to achieve, in part, board certification in Basic Obstetrics and Gynecology.

(1.1) If complete Board certification is not obtained within three (3) years of the date of this Consent Order, Dr. Work agrees to surrender his medical license.

(2) Payment of Fines, Costs, and Fees. Dr. Work shall reimburse the Board Five Thousand and no/100 ($5,000.00) Dollars for costs and fees expended in this matter.

(3) Continuing Medical Education. During this time period where Dr. Work is not practicing medicine in any capacity, he shall fulfill all continuing medical education requirements.

(4) Personal Appearance before the Board. After the one-year term imposed herein is completed, and after Dr. Work has satisfied the requirements of paragraphs (1), (2), and (3) above, he shall request a personal appearance before the Board to demonstrate his compliance with the above-listed requirements and to request his ability to return to practice. Upon the Board's satisfaction that the requirements of paragraphs (1), (2), and (3) are satisfied, the Board shall issue an order authorizing Dr. Work's return to

practice, provided that such practice is in an institutional setting or other such setting that has been approved by the Board.

(5) Cooperation with Board's Compliance Officer. Dr. Work shall immediately notify the Board's Compliance Officer of any change in his current home and professional addresses and telephone numbers and he shall direct all matters required pursuant to this Consent Order to the attention of the Compliance Officer, with whom he shall cooperate on all matters and inquiries pertaining to his compliance with the terms, conditions, and restrictions of this Order.

(6) Effect of Violation/Sanction. By his subscription hereto, Dr. Work acknowledges that his receipt of written notification that the Board has received apparently reliable information which indicates his failure to comply with the requirements set forth by this Order in any respect shall, without the need for formal hearing or for providing him with any right to which he may otherwise be entitled pursuant to the Louisiana Administrative Procedure Act, La. Rev. Stat. §§49:951 et seq., or which otherwise may be afforded to him by law, constitute his irrevocable consent to the immediate suspension of his license to practice medicine in this state pending a hearing before the Board and the conclusion of the administrative proceedings by issuance of a final decision following administrative

adjudication of such charges; provided, however, that after the receipt of the written notification of suspension as provided for by this paragraph, on written motion to the Board filed by Dr. Work within seven (7) days of his receipt of the written notification, Dr. Work may request a preliminary hearing regarding the suspension order, which hearing shall be conducted according to the following procedures by a single member of the Board designated for this purpose. Upon such motion by Dr. Work requesting a hearing, the designated Board member shall schedule a hearing within ten (10) days of the motion by Dr. Work. Said hearing shall be conducted on written submissions by the parties filed five (5) days before the telephonic hearing, and a telephonic hearing conducted by the designated Board member who shall, based on the written submissions and the telephonic hearing, issue a decision either sustaining or vacating the suspension order pending the issuance of a final order by the Board at the conclusion of the administrative proceedings.

(7) **Effective Date.** This Consent Order shall be effective as of March 1, 2016.

IT IS FURTHER ORDERED that any violation or failure of strict compliance with any of the terms, conditions, or restrictions set forth by this Order by Dr. Work shall be deemed adequate and sufficient cause, upon proof of such violation or failure, for such other action against Dr. Work's license to practice medicine in the state of Louisiana as the Board may

deem appropriate, as if such violations were enumerated among the causes provided in La. Rev. Stat. §37:1285.

IT IS FURTHER ORDERED that this Consent Order shall be, and shall be deemed to be, a public record.

Signed in New Orleans, Louisiana, and effective on this 15th day of Feb., 2016.

LOUISIANA STATE BOARD OF
MEDICAL EXAMINERS

BY: _____

J. Michael Burdine, Jr., M.D.
President

Acknowledgement and Consent
Follows on Next Page

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

630 Camp Street, New Orleans, LA 70130
General Correspondence Address: Post Office Box 30250, New Orleans, LA 70190-0250
www.lsbme.org

Telephone (504) 568-6820
FAX (504) 568-8893
Writer's Direct Dial

Ext. _____

BEFORE THE LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

NUMBER: 00-A-021

IN THE MATTER OF:

A. JAMES WHITMORE, III, M.D.
(CERTIFICATE NO. 05734R)

****

OPINION AND RULING

This matter comes before the Board pursuant to an Administrative Complaint charging A. James Whitmore, III, M. D. with a number of violations of the Medical Practice Act.

First, he is charged with violation of R. S. 37:1285A(13) for unprofessional conduct.

Second the is charged with violation of R. S. 37:1285A(14) for continuing or recurring medical practice which fails to satisfy the prevailing and usually accepted standards of medical practice in this state.

Third, he is charged with violation of R. S. 37:1285A(15) for immoral conduct in exercising the privileges provided for by license or permit issued under this part.

Fourth, he is charged with violation of R. S. 37:1285A(17) for abandonment of a patient.

Fifth, he is charged with violation of R. S. 37:1285A(30) for violation of any rules and regulations of the Board, or any provisions of this the Medical Practice Act.

The case was heard before a panel consisting of Drs. Laborde, LeBlanc, Amusa, and James, President. Dr. Bourgeois, who was scheduled to sit on the case, was recused because of a possible conflict of interest.

At the hearing, Dr. Whitmore appeared without counsel. His former counsel had withdrawn from the case, and no new counsel had enrolled on his behalf. When asked if he was represented, Dr. Whitmore advised the Board that he was represented by counsel, but that she had other business on the day of the hearing which precluded her attendance. He stated that he had retained this counsel about a month prior to the hearing. Counsel for Complainant advised the Board that she had received a telephone call from someone purporting to represent Respondent, and had returned the call on several occasions,

without success, and had left messages. There was no further contact with the attorney.

In view of the fact that Respondent had adequate notice of the hearing, and his purported attorney made no attempt to enroll as such or to return the calls of Complainant counsel, the Board determined it was appropriate to continue with the hearing as scheduled.

The charges against Dr. Whitmore arise out of certain events which took place at the Delta Women's Clinic in Baton Rouge, Louisiana. Respondent would come to the Clinic two days per week, and perform terminations of pregnancies, on an average of 20 to 30 procedures per day.

It is alleged that these procedures were performed under unsanitary conditions. Specifically, it was alleged, and proven that the instruments used were rusty, cracked and unsterile. He would use single-use hoses and cannulas on multiple patients. The Cidex solution in which these, and other instruments were sterilized, was changed infrequently, and there was often pieces of tissue floating in the solution. The person who worked on sterilization of the instruments testified that Dr. Whitmore was aware of these deficiencies, because she told him about them, but that nothing was done.

Dr. Whitmore testified that he thought it was all right to re-use single use instruments, so long as they were sterilized between uses. He did not appear to be disturbed by the other deficiencies in sterile conditions noted above.

Dr. Whitmore admitted that he signed report forms required by the Louisiana Department of

Health and Hospitals before they were filled out, and that they were filled out by others. The law, R. S. 40:1299.35.10, specifically requires that these forms be completed by the attending physician. Dr. Whitmore said that he thought that was the way they did it at the Delta Women's Clinic, and he went along with it.

It was also testified, by personnel of the Delta Women's Clinic, that Dr. Whitmore was rude to his patients, would not answer their questions, and would not tolerate patients who were uncooperative, in his opinion.

The Administrative Complaint also alleges substandard practice relative to Respondent's treatment of D. C., on whom he performed a second trimester abortion. The procedure was completed at 5:10 o'clock P.M., and the patient taken to the recovery room, where she continued to have moderate bleeding. Dr. Whitmore was advised at 6:00 o'clock P.M., and, over the next two hours, tried various drugs and uterine massage to stem the bleeding. His treatment was unsuccessful, and, at 8:00 o'clock P.M., an ambulance was summoned. One employee of the Clinic testified that Dr. Whitmore would not let her call 911 because of possible media involvement, and that she then summoned the ambulance herself, without authorization from Respondent. Dr. Whitmore denied this. The EMTs in the ambulance found D. C. to be in such bad condition, apparently due to loss of blood, that they took her to the emergency room at the nearest hospital. There it was discovered that the patient had a perforated uterus, and that the uterine artery was lacerated. It was necessary to perform a complete hysterectomy.

This is the second time Dr. Whitmore has come to the Board's attention. On May 21, 1992, he entered into a Consent Order, by virtue of which his license was suspended for one year, the suspension stayed, and he was placed on probation for a period of three years, with requirements for proctoring of his obstetrical practice, and other conditions. The basis for the consent order was the Board's concerns relative to Dr. Whitmore's competence.

After hearing the evidence in this case, we find that Dr. Whitmore's disregard of proper sanitary procedures, his rude and callous treatment of his patients, his refusal to answer their questions, and his tardy recognition of the seriousness of the condition of patient D. C., thereby endangering her life, render him guilty of the first two charges against him, which are detailed above. We do not find that the record supports a finding of guilty in the other charges, and we find him not guilty of those.

Once again, we find ourselves with grave reservations as to Dr. Whitmore's professional competency. We therefore impose the following sanctions:

The license of Dr. A. James Whitmore, III, to practice medicine in the State of Louisiana, No. 05734R, is hereby placed on immediate probation for an indefinite period, subject to the general terms and conditions of probation heretofore adopted by the Board, and subject to the following special conditions:

First, Dr. Whitmore shall, within six months, submit himself to Colorado Personalized Education for Physicians for testing, to determine whether he is competent to practice medicine.

Second, Dr. Whitmore's practice shall be subject to proctoring by a physician satisfactory to the Board until such time as he is able to gain admittance to the program at Colorado Personalized Education for Physicians, above referred to. Dr. Whitmore shall immediately submit a list of three physicians to the Board, from which the Board will select a proctor, if they or any of them are satisfactory.

On completion of the evaluation hereinabove required, and the receipt of the report thereof by the Board, Respondent shall appear in person before the Board, at which time the Board may impose such additional sanctions as it may deem appropriate, including, but not limited to, revocation, suspension, reprimand, further training, additional Continuing Medical Education, the imposition of a fine, and costs, and any other sanction the it may deem appropriate.

In the event Respondent does not submit himself for evaluation as ordered above, within six months, his license to practice medicine in Louisiana shall be suspended, without further proceedings, until such time as the evaluation shall be complete.

AT BATON ROUGE, LOUISIANA, THIS 22 DAY OF JANUARY, 2002.

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

Elmo J Laborde M.D.

BY: ELMO J. LABORDE, M.D., PRESIDENT

BEFORE THE LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

In the Matter of Ifeanyi Okpalobi, M.D. (CERTIFICATE NO. 03923R) Respondent.	CONSENT ORDER DOCKET NO. 93-I-051-X

Ifeanyi Okpalobi, M.D. ("Dr. Okpalobi"), is, as of the date hereof, a physician licensed to practice medicine in the State of Louisiana and principally engaged in the practice of Obstetrics and Gynecology in the Parish of Orleans, New Orleans, Louisiana, where he has continuously maintained a practice since the year 1977. Predicated upon apparently reliable information, the Board undertook an investigation of Dr. Okpalobi's malpractice complaints, and Hospital privilege applications, and Obstetrical and Gynecological patient care, spanning the years 1986 through 1998. The results of such investigation indicate that Dr. Okpalobi may have misrepresented to the Board and area Hospitals the occurrence, status and results of malpractice complaints filed against him by failing to report same as he was legally required to do, constituting deceptive and unprofessional conduct and may have demonstrated professional and/or medical incompetency in his inability to provide timely and appropriate care to his patients, including but not limited to risk assessment, pre-natal and post-natal management, determination of uterine size and gestational age and testing and evaluation related to pregnancy termination.

* * * * *

IT IS FURTHER ORDERED that this Consent Order shall be, and shall be deemed to be, a public record.

Signed in New Orleans, Louisiana, and effective on this 24th day of March, 1999.

LOUISIANA STATE BOARD
OF MEDICAL EXAMINERS

BY: _____
Mary Lou Applewhite, M.D.
President

ACKNOWLEDGMENT
AND CONSENT

I, IFEANYI OKPALOBI, M.D., HEREBY ACKNOWLEDGE, APPROVE, ACCEPT AND CONSENT to entry of the above and foregoing Order, this 8th day of March, 1999.

_____
Ifeanyi Okpalobi, M.D.

_____
WITNESS

Louisiana State Board of Medical Examiners

Mailing Address: P.O. Box 30250, New Orleans, LA 70190-0250
Physical Address: 630 Camp Street, New Orleans, LA 70130
Phone: (504) 568-6820
Fax: (504) 568-5754
Web site: http://www.lsbme.louisiana.gov

Telephone: 568-6820
Fax 568-5754

IN THE MATTER OF:

IFEANYI CHARLES OKPALOBI, M.D.
(*Certificate No. 03923R),*

Respondent

10-I-033

CONSENT ORDER

The Director of Investigation ("DOI") of the Board initiated another investigation of Dr. Ifeanyi Charles Okpalobi, M.D. in August of 2009 after the Department of Health and Hospitals ("DHH") conducted an unannounced licensing survey of an abortion clinic owned and directed by Dr. Okpalobi. Findings of this survey as well as subsequent DHH surveys established that Dr. Okpalobi repeatedly failed to meet Abortion Facility Licensing Standards and demonstrated continued conduct that is indicative of

a practice which fails to satisfy the prevailing and usually accepted standards of medical practice. The DOI's own investigation and analysis of the DHH's findings has confirmed to her satisfaction that just cause exists for recommending that a formal Administrative Complaint be filed charging Dr. Okpalobi with violations of the Louisiana Medical Practice Act, La. Rev. Stat.§ 37:1285A(13)[1] and (14).[2]

* * * * *

IT IS FURTHER ORDERED that this Consent Order shall be, and shall be deemed to be, a public record and it shall be effective the date it is approved and accepted by the Board as shown by the signature of its representative.

---

[1] Pursuant to La. Rev. Stat. §37:1285(A)13, the Board may suspend, revoke, or impose probation or other restrictions on the license of an individual licensed to practice medicine in the state of Louisiana as a result of "unprofessional conduct".

[2] Pursuant to La. Rev. Stat. §37:1285(A)14, the Board may suspend, revoke, or impose probation or other restrictions on the license of an individual licensed to practice medicine in the state of Louisiana as a result of "continuing or recurring medical practice which fails to satisfy the prevailing and usually accepted standards of medical practice in this state".

Signed in New Orleans, Louisiana, and effective on this 21 day of May, 2012.

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

By: _____

MELVIN G. BOURGEOIS, M.D.
President

ACKNOWLEDGMENT AND CONSENT

STATE OF Louisiana

COUNTY/PARISH OF Orleans

I, IFEANYI CHARLES OKPALOBI, M.D. hereby acknowledge, approve, accept and consent to entry of the above and foregoing Order, this ____ day of _____, 2012.

_____

IFEANYI CHARLES OKPALOBI, M.D.

WITNESSES:

_____
Signature

Kaci L. Lennix
Printed Name

124 S. Clark St.
Address

New Orleans, LA 70119
City, State, Zip Code

_____
Signature

Joseph Bowling
Printed Name

124 S. Clark St.
Address

New Orleans, LA 70119
City, State, Zip Code

Sworn to and subscribed before me at New Orleans ~~LA~~ LA, this 9 day of May, 2012, in the presence of the two stated witnesses.

Notary Public (Signature & Seal)

David J. Foshee (5729
Printed Name/Notary Number (or Stamp)

CIVIL SUIT NO. 448715

DIVISION "B"

JOHN MURPHY, INDIVIDUALLY AND ON BEHALF OF HIS MINOR CHILD, E.M.	1ST JUDICIAL DISTRICT COURT
	PARISH OF CADDO
VERSUS	
HOPE MEDICAL GROUP FOR WOMEN AND DR. JOHN DOE	STATE OF LOUISIANA

149-50-15-16

FILED
MAR 17 2000
GREG SHYNE
DEPUTY CLERK OF COURT

PETITION

The petition of John Murphy, a person of the full age of majority and a resident of and domiciled in Rapides Parish, Louisiana, on behalf of his minor daughter, E.M., represents:

1.

Made defendants herein are:

a. Hope Medical Group for Women, which may be served at its physical address through its administrator, Ms. Robin Rothick, 210 Kings Hwy., Shreveport, LA 71104; and

b. Dr. John Doe, a person of the full age of majority and a resident of and domiciled in the State of Louisiana, who was employed by and/or owned an interest in Hope Medical Group for Women on or about 20 March 1999.

2.

On 17 March 1999, petitioner's minor daughter, E.M., appeared at the Hope Medical Group for Women requesting an abortion. E.M., used her sister's driver's license as proof of identity. The license photo did not closely resemble E.M., and her height and weight obviously did not match those identified for her sister. E.M. was then examined by a physician for the Hope Medical Group for Women (identity of physician is currently unknown), without further inquiry as to her age, and an abortion was scheduled for and subsequently performed on 20 March 1999.

3.

The abortion was performed on E.M. without her informed consent and without the consent of her parents, and thus constituted a battery and abuse of E.M.

4.

As a result of the unlawful abortion performed, E.M. suffered severe and debilitating injuries, including:

a. Past, present and future mental anguish; and

b. Medical expenses.

WHEREFORE, John Murphy, individually and on behalf of his minor daughter, E.M., prays that after

due proceedings have been had, there be judgment in his favor against Hope Medical Group for Women and Dr. John Doe as prayed for above and for all costs of these proceedings, including expert witness fees.

PRAYS FURTHER for all general and equitable relief as may be appropriate in these premises.

Respectfully submitted,

FAIRCLOTH & DAVIDSON, L.L.C.

By: _____

Jimmy R. Faircloth, Jr. #20645
P.O. Box 12730
Alexandria, LA 71315-2730
(318) 442-9533

ATTORNEYS FOR PLAINTIFFS, JOHN MURPHY, INDIVIDUALLY AND ON BEHALF OF HIS MINOR CHILD, E.M.

PLEASE SERVE:

Hope Medical Group
Ms. Robin Rothick, Administrator
210 Kings Hwy.
Shreveport, LA 71104

ERIN MURPHY	:	NUMBER 448, 715-B
VERSUS	:	FIRST JUDICIAL DISTRICT COURT
HOPE MEDICAL GROUP FOR WOMEN	:	CADDO PARISH, LOUISIANA

MOTION AND ORDER TO DISMISS

NOW INTO COURT, through undersigned counsel, come plaintiffs, John Murphy and Erin Murphy, and defendant, Magnolia Medical Services, Inc., who, with respect, represent:

1.

Plaintiffs' demands arising out of the captioned litigation have been settled in full by amicable agreement between the parties, and Plaintiffs have received the proceeds of said settlement.

2.

Part of the consideration of said settlement was the agreement by Plaintiffs to cause the dismissal, with full prejudice, of this case.

THE PARTIES FURTHER PRAY that this suit be dismissed, with prejudice and for all orders and decrees necessary and proper herein and for full, general and equitable relief.

Respectfully submitted,

FAIRCLOTH, DAVIDSON, VILAR & ELLIOTT, L.L.C.

By: _____

Jimmy R. Faircloth, Jr.
P.O. Box 12730
Alexandria, LA 71315-2730
(318) 442-9533

WIENER, WEISS & MADISON, P.C.

By: _____

John S. Hodge, #18951
333 Texas, Suite 2350
P.O. Box 21990
Shreveport, LA 71120-1990
(318) 226-9100

ERIN MURPHY	:	NUMBER 448, 715-B
VERSUS	:	FIRST JUDICIAL DISTRICT COURT
HOPE MEDICAL GROUP FOR WOMEN	:	CADDO PARISH, LOUISIANA

ORDER

THE FOREGOING MOTION CONSIDERED;

IT IS ORDERED that this case be, and it is hereby, dismissed, with prejudice.

Shreveport, Louisiana, this 19th day of November, 2003.

DISTRICT JUDGE

DIV. D. ROBINSON

SHERRIE HARRIS	NUMBER: 106371
VERSUS	26TH JUDICIAL DISTRICT COURT
DR. JOHN P. EPLING, JR., ABC INSURANCE COMPANY, and BOSSIER CITY MEDICAL SUITE, INC.	BOSSIER PARISH, LOUISIANA
ASSIGNMENT:	SECTION "____"

PETITION FOR DAMAGES

The petition of plaintiff, SHERRIE HARRIS, who is domiciled in Webster Parish, Louisiana, through undersigned counsel, respectfully represents:

1.

The following are made defendants herein:

a. DR. JOHN P. EPLING, JR., a person of the full age of majority domiciled and residing in Caddo Parish, Louisiana, who may be served at his office, 2303 Line Avenue, Shreveport, Louisiana.

b. ABC INSURANCE COMPANIES, which may be one or more insurance companies doing

business in Louisiana, the identities of which are currently unknown to Plaintiff.

c. BOSSIER CITY MEDICAL SUITE, INC., a business operating in Bossier City, Bossier Parish, Louisiana, which may be served through their registered agent for service of process, CT Corporation System, 8550 United Plaza Blvd., Baton Rouge, LA 70809.

2.

This is an action for recovery of damages for injury pursuant to Louisiana law including, but not limited to La. C.C. Art. 2315, La. R.S. 9:2800.12, and/or the Medical Malpractice Act, as applicable.

3.

The acts and omissions, wrongful conduct, and medical malpractice complained of herein and resulting damages were continuous over the period of time alleged below herein.

4.

The continuous acts and omissions, wrongful conduct, and medical malpractice complained of herein occurred for the most part if not all in Bossier Parish, Louisiana and continuous resulting damages were sustained in Bossier, Caddo, and Webster Parishes.

5.

Defendant, DR. JOHN P. EPLING, JR., at all times pertinent hereto, was a qualified health care provider under the provisions of the Louisiana Medical Malpractice Act.

6.

Defendant, BOSSIER CITY MEDICAL SUITE, at all times pertinent hereto, was a qualified health care provider under the provisions of the Louisiana Medical Malpractice Act.

7.

On May 17, 2000, Plaintiff, SHERRIE HARRIS, went to BOSSIER CITY MEDICAL SUITE, INC. to have an abortion performed. At that time, DR. JOHN P. EPLING, JR. attempted to perform an abortion, but the procedure was stopped when it was discovered that DR. JOHN P. EPLING, JR. had caused the perforation of MS. HARRIS' uterine wall and caused contusions of her intestines. This caused her severe, prolonged pain at the time.

8.

After some time, when MS. HARRIS did not recover, she was advised by someone at BOSSIER CITY MEDICAL SUITE, INC. to go to Louisiana State University Medical Center for emergency treatment and she was driven there by staff member of BOSSIER CITY MEDICAL SUITE, INC.

9.

Upon arrival at LSU Medical Center, MS. HARRIS was examined and underwent an exploratory laparotomy. The procedure required anesthesia, an incision, exploration of the pelvis and abdomen, causing blood loss and suturing. MS. HARRIS remained in the hospital until May 21, 2000 and was released then only because she had no one to take care of her small children and she needed to get home.

10.

MS. HARRIS had to have a foley catheter installed, intravenous therapy, medications, anesthetic, intubation and other medical procedures and tests that she would not have had to undergo if her uterus had not been perforated.

11.

During MS. HARRIS' hospital stay at LSU Medical Center, she suffered with pain, nausea, vomiting, cramping, and other problems. Ultimately, MS. HARRIS underwent an abortion at a later time which obviously had to be performed at a more advanced stage of pregnancy resulting in a second period of recovery.

12.

The above were some of the immediate physical damages MS. HARRIS suffered as a result of the failed abortion and perforation of her uterus and contusion of her bowel. After being released from the hospital, she continued to suffer with pain, could not pick up her youngest child or hold him in her lap. She became fearful and her state of mind was confused. She became afraid of dying. For quite some time she could not do her housework or cook meals for her family.

13.

Additionally, SHERRIE HARRIS' damages include the scarring and disfigurement at the site of the incision for the exploratory laparotomy which had to be performed as a result of the perforation of her uterus during the said abortion procedure. Plaintiff alleges on information and belief that the exploratory

laparotomy will predispose her to future intestinal adhesions, which can require future surgery.

14.

MS. HARRIS has incurred hospital, doctor, medical, and drug expenses as a result of the acts and omissions sued upon herein.

15.

The acts, omissions, fault, and deviation from the proper standard of care of DR. JOHN P. EPLING, JR. consists of the following non-exclusive particulars:

a. Failure to maintain proper control of the instrument used in attempting to perform the abortion on Ms. Harris.

b. Failure to properly perform the abortion.

c. Negligent insertion/application of abortion equipment.

d. Using the instrument in such a manner as to cause the perforation of Plaintiff's uterus and cause contusions to her intestines.

e. Any other acts, omissions fault, or want of care which might be disclosed through discovery or at the trial of this matter, or otherwise.

16.

At the time of the injuries sued upon herein, DR. JOHN P. EPLING, JR. was employed by and acting in the course and scope of his employment with BOSSIER CITY MEDICAL SUITE, INC. As a result, the negligence, fault, and want of care of DR. JOHN

P. EPLING, JR. are imputed to BOSSIER CITY MEDICAL SUITE, INC.

17.

The procedure was performed on the premises of and under the name of BOSSIER CITY MEDICAL SUITE, INC. which offered the service and held itself out as a party responsible for the procedure. As a result, BOSSIER CITY MEDICAL SUITE, INC. should be found liable in solido with DR. JOHN P. EPLING, JR. for the injuries and damages sustained herein.

18.

The negligence, fault, and want of care of BOSSIER CITY MEDICAL SUITE, INC. include but are not limited to the following:

a. Failing to assure that safe procedures and safeguards were followed.

b. Failing to ascertain and assure that DR. JOHN P. EPLING, JR. was capable of performing the procedure in a safe manner.

19.

As a result of the acts and omissions sued upon herein, SHERRIE HARRIS, has suffered the following itemized damages:

a. Past and future physical pain and suffering.

b. Past and future mental pain and anguish.

c. Past and future physical disability.

d. Loss of enjoyment of life.

e. Curtailment of activities.

f. Scarring and disfigurement.

g. Predisposition to intestinal adhesions and in turn to additional surgeries to correct them.

h. Expenses for past medical, hospital, doctor, therapy, and pharmacy bills.

20.

Plaintiff will be required at the trial on the merits to call medical experts and other expert witnesses to establish the standard of care and breach thereof and the nature and extent of Plaintiff's damages. Plaintiff desires and is entitled to have these expenses of such experts taxed as additional costs of Court.

WHEREFORE PLAINTIFF PRAYS:

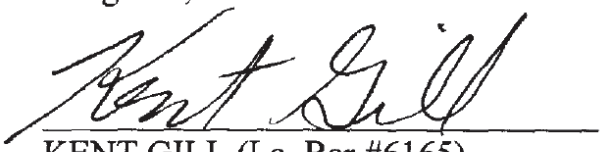
a. That the defendants, ABC INSURANCE COMPANY, DR. JOHN P. EPLING, JR., and BOSSIER CITY MEDICAL SUITE, INC. be served with a copy of this petition as indicated on the first page hereof and cited to appear and answer it according to law.

b. That after all legal delays and due proceedings, there be judgment in favor of Plaintiff and against the defendants, ABC INSURANCE COMPANY, DR. JOHN P. EPLING, JR., and BOSSIER CITY MEDICAL SUITE jointly in an amount reasonable in the premises, together with legal interest thereon from the date of judicial demand until paid, together with all costs of these proceedings including the costs for all expert witnesses of any description.

c. For all orders and decrees necessary in the premises and for all other and further general and equitable relief.

Respectfully submitted,

THE COOK LAW FIRM, APLC
4070 Highway 80 E
Haughton, La 71037



KENT GILL (La. Bar #6165)
3833 Gilbert Drive
Shreveport, La 71104
(318) 861-5937

Attorney for Plaintiff

PLEASE SERVE DEFENDANTS AS INDICATED ON THE FIRST PAGE OF THE FOREGOING PETITION.

SHERRIE HARRIS	NUMBER:
VERSUS	26TH JUDICIAL DISTRICT COURT
DR. JOHN P. EPLING, JR., ABC INSURANCE COMPANY, and BOSSIER CITY MEDICAL SUITE, INC.	BOSSIER PARISH, LOUISIANA

VERIFICATION

STATE OF LOUISIANA

PARISH OF Caddo

BEFORE ME, the undersigned authority, personally came and appeared, SHERRIE HARRIS, who after being duly sworn did depose and say that she is the Plaintiff in the foregoing petition, that she has read it in its entirety, and that all allegations of fact contained therein are true and correct to the best of her knowledge, information, and belief, and that she desires judgment as prayed for therein.

Sherrie Harris

SWORN TO AND SUBSCRIBED before me on this 04 day of May, 2001.

Kent Gill

NOTARY PUBLIC

SHERRIE HARRIS	*	**NUMBER 106,371**
VERSUS	*	**26TH JUDICIAL DISTRICT COURT**
DR. JOHN P. EPLING, JR., ABC INSURANCE COMPANY and BOSSIER MEDICAL SUITE, INC.	*	**BOSSIER PARISH, LOUISIANA**

MOTION AND ORDER TO DISMISS

NOW INTO COURT, through undersigned counsel, comes plaintiff, SHERRIE HARRIS, and defendant, DR. JOHN P. EPLING, JR., and upon suggesting to the Court that the above-entitled matter has been settled in full as to this defendant and that Movers desire to dismiss same with prejudice:

IT IS ORDERED, ADJUDGED AND DECREED that the claims of SHERRIE HARRIS against defendant DR. JOHN P. EPLING, JR. in the above captioned matter be, and they hereby are, **DISMISSED, WITH PREJUDICE**, costs of court incurred by plaintiff in the prosecution of this claim against this defendant only to be paid by defendant.

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that the claims of SHERRIE HARRIS against BOSSIER CITY MEDICAL SUITE, INC. in the above captioned matter be, and they hereby are, reserved unto her.

THUS DONE AND SIGNED in the city of Benton, Bossier Parish, Louisiana, this 30 day of August, 2002.

DISTRICT COURT JUDGE

PREPARED BY:

PETTIETTE, ARMAND, DUNKELMAN,
WOODLEY, BYRD & CROMWELL, L.L.P.

BY: _____
Joseph S. Woodley #19228
509 Market St., Suite 200
Post Office Box 1786
Shreveport, Louisiana 71166
(318) 221-1800
(318) 226-0390
ATTORNEYS FOR DEFENDANT

APPROVED AS TO FORM AND CONTENT:

By: Kent Gill
Kent Gill #6165
~~214 Suzanne Drive~~ 3833 Gilbert Dr.
Shreveport, Louisiana ~~71115~~ 71104
(318) 861-5937
ATTORNEY FOR PLAINTIFF

FILED
AUG 30 2002
Loran M. Charles

SHERRIE HARRIS	**No. 106,371**
versus	**26TH JUDICIAL DISTRICT COURT**
DR. JOHN P. EPLING, JR., ABC INSURANCE COMPANY and BOSSIER CITY MEDICAL SUITE, INC.	**BOSSIER PARISH, LOUISIANA**

MOTION AND ORDER TO DISMISS

NOW INTO COURT, through undersigned counsel, come plaintiff, **SHERRIE HARRIS**, and defendant **BOSSIER CITY MEDICAL SUITE, INC.**, and upon suggesting to the Court that the above-entitled matter has been settled in full as to all defendants and that Movers desire to dismiss same with prejudice:

IT IS ORDERED, ADJUDGED AND DECREED that the claims of **SHERRIE HARRIS** against the defendant **BOSSIER CITY MEDICAL SUITE, INC.**, and all defendants in the above captioned matter be, and they hereby are, **DISMISSED, WITH PREJUDICE**, costs of court incurred by each party to be paid by each party respectively.

THUS DONE AND SIGNED in the City of Benton, Bossier Parish, Louisiana, on this the 8th day of January, 2003.

District Judge

Prepared By:

Walker, Tooke & Lyons, L.L.P.
1700 Irving Place
Shreveport, LA 71101
318/221-8644

By: _____
Laurie W. Lyons, #09328
Attorneys for Defendant, Bossier City Medical Suite, Inc.

FILED
JAN 8 2003
DEPUTY CLERK
26TH JUDICIAL DISTRICT COURT
BOSSIER PARISH, LOUISIANA

Approved as to Form and Content:

The Cook Law Firm
3833 Gilbert Drive
Shreveport, LA 71104
318/861-5937

By: _____
Kent Gill, #6165
Attorney for Plaintiff, Sherrie Harris

I hereby certify that this document has been mailed or hand delivered to all parties or counsel of record on this the 8th day of Jan, 2003.

Deputy Clerk

IN THE COURT OF COMMON PLEAS
FIRST JUDICIAL DISTRICT OF PENNSYLVANIA
CRIMINAL TRIAL DIVISION

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IN RE:	:	MISC. NO. 000-9901-2010
COUNTY INVESTIGATING GRAND JURY XXIII	:	C-17

– – –

November 4, 2010

1515 Arch Street, Suite 18013

Philadelphia, Pennsylvania

– – –

TESTIMONY OF LEROY BRINKLEY

– – –

PRESENT:

JOANNE PESCATORE, ESQUIRE
CHRISTINE WESCHLER, ESQUIRE
SUZANNE WILCOX, ESQUIRE
District Attorney's Office

NINO TINARI, ESQUIRE
Attorney for the Witness

* * * * * *

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Dover and Wilmington were not making enough to pay expenses.

Q. Are the arrangements in Louisiana the same, where the clinic provides the space, basically, and the doctors are independent contractors?

A. Yes, and hospitals almost have the same arrangements I do.

Q. So all the clinics you worked at in your --

A. That's the standard arrangement. The doctors, lawyers, dentists, all of the professional, certified people. The doctors who work for hospitals are --

Q. How do you decide what doctors are going work in your facilities?

A. I don't decide . The doctors --

Q. How about --

A. -- decide that. Those that are concerned about women's health that want to do it, do it.

Q. Do they knock on your door, or do you do screening? How do you --

A. Some knock, some –

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Q. -- do that?

A. -- don't. We try to seek doctors. Because of the anti-abortion people, it's hard to find people to help women.

Q. How do you hire people to be an independent contractor?

A. How do I hire them? Usually, if people are looking to do the work, they've committed to doing it. If they show that interest and have their license and they seem capable, then we accept it.

BY MS. PESCATORE:

Q. Whose idea is it if they were capable?

A. I don't judge the license. If they have a license and the state gave the license, it's not for me to determine if they are capable.

Q. Do you do a background check if they are sued, if there's a problem, or --

A. That's not within my framework. If the State of Pennsylvania gave a physician a license, they have deemed them qualified to perform. It's not up to me. I didn't say --

BY MS. WESCHLER:

Q. You have to make sure that your facility

* * * * *

Excerpts from Statement of Deficiencies for Hope Medical Group for Women dated May 27, 2011 (Blank "Plan of Correction" columns have been omitted to improve readability) [Original found at PRR – 00938–941]

Health Standards Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/CLIA IDENTIFICATION NUMBER: **BO0004728**
(X2) MULTIPLE CONSTRUCTION A. Building: _____ B. Wing: _____	(X3) DATE SURVEY COMPLETED R **05/27/2011**
NAME OF PROVIDER OR SUPPLIER **HOPE MEDICAL GROUP FOR WOMEN**	STREET ADDRESS, CITY, STATE, ZIP CODE **210 KINGS HIGHWAY SHREVEPORT, LA 71104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
{S4409}	Continued From page 3 policy.

{S4415}	PATIENT RECORDS AND REPORTS This Rule is not met as evidenced by: §4415. Patient Records and Reports A. Retention of Patient Records 1. An abortion facility shall establish and maintain a medical record on each patient. The facility shall maintain the record to assure that the care and services provided to each patient is completely and accurately documented, and that records are readily available and systematically organized to facilitate the compilation and retrieval of information. Safeguards shall be established to maintain confidentiality and protection from fire, water, or other sources of damage. B. Content of Medical Record 1. The following minimum data shall be kept on all patients: a. identification data; b. date of procedure; c. medical and social history; d. physical examination; e. chief complaint or diagnosis; f. clinical laboratory reports (when appropriate); g. pathology report (when appropriate); h. physicians orders;
{S4415}	Continued From page 4 i. radiological report (when appropriate);

	j. consultation reports (when appropriate); k. medical and surgical treatment; l. progress notes, discharge notes, and summary; m. nurses' records of care given, including medication administration records; n. authorizations, consents or releases; o. operative report; p. anesthesia report, including post-anesthesia report; and q. special procedures reports. 2. Signatures. Clinical entries shall be signed by the physician as appropriate, i.e., attending physician, consulting physician, anesthesiologist, pathologist, etc. Nursing notes and observations shall be signed by the nurse. 3. Nurses' Notes. All pertinent observations, treatments and medications given shall be entered in the nurses' notes. All other notes relative to specific instructions from the physician shall be recorded. 4. Completion of the medical record shall be the responsibility of the attending physician. C. Nothing in this §4415 is intended to preclude the use of automated or centralized computer systems or any other techniques for the storing of

	medical records, provided the regulations stated herein are met. Based upon record review and interview, the facility failed to ensure medical records, to include the Vital Records Registry, were accurate and complete as evidenced by: 1) failure to complete the registry form "REPORT OF INDUCED
{S4415}	Continued From page 5 TERMINATION OF PREGNANCY" for 1 of 12 sampled patients who had complications from the abortion procedure (F1), and 2) failure to follow Louisiana Revised Statute 40:64 related to documenting the physician's full name who performed the abortion for 12 of 12 sampled patients (F1-F12). Findings: Review of Louisiana Revised Statute 40:64 revealed in part, "The state registrar shall prescribe forms for the collection of information and statistics with respect to abortions. Such forms shall require, but not limited to, the following information...(3) The full name and address of the physician or physicians performing the abortion, (6) Medical procedure employed to procure the abortion, and (9) Other significant conditions of the fetus and mother. Review of patient #F1's medical record revealed during the post abortion procedure recovery period, the patient exhibited excessive bleeding. Review of

	physician SF2's notes revealed "12/02/10 - 2005 (8:05 PM) (approximately 2 1/2 hours post procedure). Was contacted by nurse at 1850 (8:50 PM) noting excessive hemorrhaging despite Methergine. 600 mcg was given rectally at 1905 (7:05 PM). Pt (patient) continued heavier than normal bleeding. At 1945 (7:45 PM) exam revealed uterus still slightly boggy and heavier than normal bleeding. Re-aspirated with 12 mm curette at 1955 (7:55 PM) revealed small fragments of retained placenta and membranes. 10 units Pitocin added by me to 500cc NS (normal saline) and infused to patient. Bleeding has decreased to minimal levels now...". The patient was monitored post procedure, discharged from the clinic and re-evaluated by physician SF2 the morning of 12/-3/10.
{S4415}	Continued From page 6 Further review of patient #F1's medical record revealed the Office of Public Health, Vital Records Registry form PHS 16-AB titled "REPORT OF INDUCED TERMINATION OF PREGNANCY" and dated 12/02/10, revealed for the portion of the form titled "Termination Procedure, Complications, Reason for Termination, Post Abortion Procedure", 9b (Additional Procedures Used For This Termination), 9c. (Complication of Pregnancy Termination), 9d.(Reason for Pregnancy Termination), and 9e.(Type of

	Procedure done after abortion) were all left blank. Interview with the Clinic Manager SF1 on 05/27/11 at 2:30 PM, revealed when questioned about 9b through 9e being incomplete, SF1 stated "it was just missed". Further review of the forms titled "REPORT OF INDUCED TERMINATION OF PREGNANCY" revealed for 12 of the 12 sampled patients (F1-F12), the full name of the physician performing the abortion failed to be identified on the form.
S4421	PHARMACEUTICAL SERVICES This Rule is not met as evidenced by: 4421. Pharmaceutical Services. C. The facility shall provide facilities for proper storage, safeguarding and distribution of drugs. Based upon observations and staff interviews, the facility failed to ensure drugs were properly stored and safeguarded as evidenced by: 1) failure to store Nubain 10 milligram injectables, Valium 10 milligrams pills and Methergine 0.2 milligram pills in a secure locked area prior to distributing the

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Excerpts from Statement of Deficiencies for Women's Health Care Center dated September 2, 2015 (Blank "Plan of Correction" columns have been omitted to improve readability) [Original found at PRR – 01048–1053]

Health Standards Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/CLIA IDENTIFICATION NUMBER: **BO0004641**
(X2) MULTIPLE CONSTRUCTION A. Building: _____ B. Wing: _____	(X3) DATE SURVEY COMPLETED C **09/02/2015**
NAME OF PROVIDER OR SUPPLIER **WOMENS HEALTH CARE CENTER INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2701 GENERAL PERSHING STREET NEW ORLEANS, LA 70115**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
S 163	Continued From page 4

S 163	4425-C - 1-a-o Patient Med. Records/Reporting Requirements C. Contents of Patient Medical Record 1. The following minimum data shall be kept on all patients: a. identification data; b. date of procedure; c. medical and social history; d. anesthesia and surgical history; e. physical examination notes; f. chief complaint or diagnosis; g. clinical laboratory reports; h. pathology reports; i. individualized physician's orders; j. radiological/ultrasound reports; k. consultation reports (when appropriate); l. medical and surgical treatment; m. progress notes, discharge notes, and discharge summary; n. nurses' notes, including, but not limited to, all pertinent observations, treatments, and medications dispensed and/or administered; o. medication administration records, including, but not limited to, the date, time, medication, dose, and route; This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure the minimum data required was kept on all patients in the medical record. This would include, but not be limited to,

	physical examination notes, chief complaint or diagnosis,
S 163	Continued From page 5
	medical (and surgical) treatment, progress notes, nurses' notes, all pertinent observations, and treatments. This deficient practice was evidenced by no documentation of a patient's return to the clinic with a complication, or the assessment and treatment of the patient for 1 of 1 (#1) medical records reviewed for complications requiring transfer to a hospital. Findings:
	Review of the medical record of Patient #1, provided by S1ADM in response to a request for a list of patients with complications, infections, and/or requiring transfer to a hospital, revealed there was no documentation after 2/5/15, the date of her non-surgical procedure. A follow-up visit appointment was documented as scheduled for 3/3/15.
	In an interview 9/1/15 at 12:10 p.m. S1ADM reported that Patient #1 had a non-surgical procedure at the clinic 2/5/15. The administrator reported Patient #1 called the clinic 2/9/15 and asked to come to the clinic with a complaint of vaginal bleeding. S1ADM reported Patient #1 had called S12MD from a hospital parking lot and was advised to go into the Emergency Room

	to be assessed. The administrator reported the patient then called the clinic from home and wanted to come to the clinic to be seen by the physician. S1ADM reported the patient told staff she did not have a ride so S6Staff, being the only staff member with a car, was sent to pick the patient up and transport her back to the clinic. When S6Staff returned to the clinic with Patient #1, the staff determined she was bleeding too heavily to wait for the physician to come in. S1ADM reported the patient refused to go to the hospital ER in an ambulance, but agreed to go in
S 163	Continued From page 6 S6Staff's vehicle. Patient #1 was transported to a local hospital where she was seen and admitted to the hospital for treatment. S1ADM verified there was no documentation of any communication, complaint, assessment, or treatment of Patient #1. In an interview 9/2/15 at 10:01 a.m. S12MD reported that she did remember Patient #1. The physician reported she had spoken to the patient on the phone that morning (the patient was seen at the clinic post procedure). She reported Patient #1 told her she was bleeding heavily and was in the parking lot of a local hospital. S12MD reported she advised the patient to go into the ER

	where the patient was located. S12MD reviewed Patient #1's medical record and verified there was no documentation, by herself or clinic staff, in the patient's record noting the patient had called her, the clinic, had been at the clinic, or needed further care at the hospital.
S 169	4425 - E-F Patient Med Records/Reporting Requirements E. Other Reports. The outpatient abortion facility shall maintain a daily patient roster of all patients receiving a surgical or chemically induced abortion. Patients may be identified corresponding to the patient's medical record. This daily patient roster shall be retained for a period of three years F. Reporting Requirements 1. The outpatient abortion facility shall maintain documentation to support that the outpatient abortion facility is compliant with all reporting requirements, including, but not limited to, the induced termination of pregnancy (ITOP)
S 169	Continued From page 7 form and other documentation as required by federal, state, and local statutes, laws, ordinances, and department rules and regulations. 2. The outpatient abortion facility shall report in accordance with all

	applicable state laws for the reporting of crimes against a child that include but are not limited to: a. rape; b. sexual battery; c. incest; and d. carnal knowledge of a juvenile This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure all reporting requirements were met, as required by state statutes as evidenced by a induced termination of pregnancy on 2/5/15 being reported 8/14/15 (5 months beyond the required registration date) and incorrect documentation that there was no complication. Findings: Review of LA RS 40:1299.35.10 Reports, revealed, in part "...B. An individual complication report for any post-abortion care performed upon a woman shall be completed by the physician providing such post-abortion care. The report shall include: (1) the date of the abortion. (2) The name and address of the facility where the abortion was performed or induced. (3) The nature of the abortion complication diagnosed or treated. (4) The name and address of the facility where the post-abortion care was performed. C. All abortion reports shall be signed by the attending physician and submitted

	to the Department of Health and Hospitals within thirty days after the date of the abortion. All
S 169	Continued From page 8
	complication reports shall be signed by the physician providing the post abortion care and submitted to the Department of Health and Hospitals within thirty days after the date of the completion of the post-abortion care. Review of the medical record of Patient #1, provided by S1ADM in response to a request for a list of patients with complications, infections, and/or requiring transfer to a hospital, revealed there was no documentation after 2/5/15, the date of her non-surgical procedure. A follow-up visit appointment was documented as scheduled for 3/3/15. Further review revealed a ITOP report of Patient #1's termination of pregnancy on 2/5/15, with a date registered /reported of 8/14/15. The complication of Termination of Pregnancy was documented as "none". In an interview 9/1/15 at 12:10 p.m. S1ADM reported that Patient #1 had a non-surgical procedure at the clinic 2/5/15. The administrator reported Patient #1 called the clinic 2/9/15 and asked to come to the clinic with a complaint of vaginal bleeding. S1ADM reported Patient #1 had called S12MD

	from a hospital parking lot and was advised to go into the Emergency Room to be assessed. The administrator reported the patient then called the clinic from home and wanted to come to the clinic to be seen by the physician. S1ADM reported the patient told staff she did not have a ride so S6Staff, being the only staff member with a car, was sent to pick the patient up and transport her back to the clinic. When S6Staff returned to the clinic with Patient #1, the staff determined she was bleeding too heavily to wait for the physician to come in. S1ADM reported the patient refused to go to the hospital ER in an ambulance, but agreed to go in
S 169	Continued From page 9 S6Staff's vehicle. Patient #1 was transported to a local hospital where she was seen and admitted to the hospital for treatment. S1ADM verified there was no documentation of any communication, complaint, assessment, or treatment of Patient #1. In an interview 9/2/15 at 10:01 a.m. S12MD reported that she did remember Patient #1. The physician reported she had spoken to the patient on the phone that morning (the patient was seen at the clinic post procedure). She reported Patient #1 told her she was bleeding heavily and was in the parking lot of a

	local hospital. S12MD reported she advised the patient to go into the ER where the patient was located. S12MD reviewed Patient #1's medical record and verified there was no documentation, by herself or clinic staff, in the patient's record noting the patient had called her, the clinic, had been at the clinic, or needed further care at the hospital.
S 241	4447 A Infection Control A. The outpatient abortion facility shall develop, implement, enforce, monitor, and annually review its written infection control program. The purpose of this program shall seek to minimize infections and communicable diseases through prevention, investigation, and reporting of infections. This program shall include all contracted services This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop, implement, enforce, monitor, and annually review its written infection

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Excerpts from Statement of Deficiencies for Delta Clinic of Baton Rouge dated March 29, 2019 (Blank "Plan of Correction" columns have been omitted to improve readability) [Original found at PRR – 00400–415]

Health Standards Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/CLIA IDENTIFICATION NUMBER: **BO0004642**
(X2) MULTIPLE CONSTRUCTION A. Building: _____ B. Wing: _____	(X3) DATE SURVEY COMPLETED C **03/29/2019**
NAME OF PROVIDER OR SUPPLIER **DELTA CLINIC OF BATON ROUGE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **756 COLONIAL DRIVE BATON ROUGE, LA 70806**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
S 000	Initial Comments Complaint survey #LA0051232

	Abbreviations: BP - blood pressure bpm - beats per minute cc - milliliter cm - centimeter D&C - Dilation and Curettage D&E - Dilation and Evacuation DON - Director of Nursing ga - gauge gm/dL - grams per deciliter H/H - Hemoglobin and Hematocrit Hct - Hematocrit Hgb - Hemoglobin IJ - Immediate Jeopardy IM - intramuscular inj - injection IV - intravenous LPN - Licensed Practical Nurse mcg - micrograms MD - Medical Doctor mg - milligram mil/uL - millions per microliter ml - milliliters NS - normal saline OAF- Outpatient Abortion Facility P&P - Policy & Procedure po - per os/by mouth POC - Products of Conception POR - Plan Of Removal PR - per rectum PRBC - Packed Red Blood Cells RBC - Red Blood Cells s/p - status post SP02 - oxygen saturation

	u - unit V/S - Vital Signs yo -year old
S 137	4423 C - c -f - i-iv Staffing Requirements, Qualifications (i). identifying emergency medical equipment and medications that will be used to provide for basic life support until emergency medical services arrive and assume care; (ii). identifying and ensuring that a supply of emergency drugs for stabilizing and/or treating medical and surgical complications are maintained on the licensed premises; (iii). identifying and ensuring that each patient, before an abortion is performed or induced, is given by the physician performing or inducing the abortion, a telephone number of the hospital nearest to the home of the pregnant woman at which an emergency arising from the abortion would be treated; and This Rule is not met as evidenced by: Based on observations, review of records, and staff interviews, the Medical Director failed in the responsibility of identifying and ensuring that a supply of emergency medications and medical equipment for stabilizing and/or treating medical and surgical complications was maintained on the licensed premises. This failed practice affected 1 (Patient

	#1) of 3 (Patients #1, #2, and #3) sampled patients and had the potential of affecting 3 of 3 (Patients #1 - #3) sampled patients who had a surgical abortion procedure at the OAF. Findings: On 3/18/19 at 1 :35 PM, S5Adm and S6Board
S 137	Continued From page 2 Member verified that Patient #1 underwent a surgical abortion procedure on 3/15/2019 and experienced heavy blood loss at the time. The two staff continued and said the OAF failed to have available the necessary IV fluids to help stabilize the Patient at the time, 911 was called, and the Patient was transported out by ambulance to an acute care hospital for treatment. During interview with S5Adm on 3/28/2019 at 11:05 AM, S5Adm presented a POR, done in response to another cited deficiency, which included the Policy and Procedure Managing Hemorrhage. The Interventions section of this Policy and Procedure documented medications and other supplies to be used in such procedures and documented interventions to be performed by Administrative, Nursing, and Physician staff. The Physician intervention for hemorrhage secondary to Uterine Atony and/or retained tissue/products of

	conception included in-part: Tamponade with sterile gauze and __ Balloon. When questioned about the use and availability of the __ Balloon as was documented on the Policy and Procedure, S5Adm affirmed that the OAF had no __ Balloon on site or available for use by a physician if needed. S5Adm said the OAF would have to order one. On 3/28/19 at 12:20 PM, S5Adm presented two additional forms which were explained to be the list of emergency medications and supplies that the Medical Director approved to be kept on site. S5Adm explained that the form labeled as List of Emergency Equipment was the list of equipment the Medical Director approved to be kept on site. This form included a Crash KIT (crash cart). The next form labeled as STAT KIT ACLS was explained as the Medical Director's inventory list
S 137	Continued From page 3 of emergency medications and supplies which were kept in the STAT KIT (crash cart). On 3/28/2019 at 12:27 PM, a comparison of the OAF's STAT KIT (crash cart) inventory with the STAT KIT ACLS (inventory list of emergency medications to be kept in the cart) was performed with S4LPN. S4LPN verified that the inventory list included two vials of

	Midazolam (Versed) 2mg injection and two vials of Adenosine 3mg/4 ml. S4LPN verified that the STAT KIT (crash cart) had no Midazolam (Versed) available and only one vial of Adenosine which was expired as of 02/2019. An interview and review of the OAF's presented Policy and Procedures and associated list of emergency medications and emergency supplies was conducted with S3MD/Medical Director on 3/29/2019 at 11:10 AM. S3MD affirmed that he was involved with the OAF's POR and Policy and Procedures. S3MD acknowledged that the OAF's lists of emergency medications and supplies were approved and said that they were the responsibility of the administrative staff to maintain. When asked about the potential use of a __ Balloon for an intervention in a patient who experienced hemorrhaging secondary to uterine atony and/or retained tissue/products of conception as was documented on the OAF's Policy and Procedure Managing Hemorrhage, S3MD said that he would not use a __ Balloon. S3MD was asked about the inventory list containing the OAF's emergency medications, the lack of Midazolam (Versed) and only one of two vials of Adenosine, which was expired, present on the crash cart. S3MD replied that he would not use Adenosine. S3MD

	said the Adenosine would be for the 911 response personnel to use. S3MD said the medications should be checked and
S 137	Continued From page 4
	should not have been expired. S3MD said he was aware that the Midazolam (Versed) was on back-order and was not aware of another medication to use in place of the Midazolam (Versed). S3MD was asked about the OAF's supply of IV fluids for stabilizing and/or treating medical and surgical complications should such complications present. S3MD said in the case of Patient #1, he assumed the OAF's administrative staff ensured IV fluids were available for use. S3MD acknowledged that the OAF's lists of emergency medications and supplies were approved and said that they were the responsibility of the administrative staff to maintain.
S 205	4435 A-B Intra-operative Procedures
	A. The outpatient abortion facility shall ensure that emergency medical equipment and supplies as required by the governing body, medical director and medical staff are available for intra-operative care and shall include, but are not limited to: 1. surgical or gynecologic table; 2. surgical instrumentation; 3. emergency drugs for stabilizing and/or treating medical and surgical

	complications as approved by the medical director; 4. oxygen; 5. intravenous fluids; and 6. sterile dressing supplies. B. The outpatient abortion facility shall ensure that the medical equipment required for an abortion shall be maintained and immediately available to the physician in the procedure and/or post-anesthesia recovery area to provide emergency medical care and treatment.
S 205	Continued From page 5 This Rule is not met as evidenced by: Based on interviews and record reviews, the outpatient abortion facility failed to ensure that emergency medical equipment and supplies were available for intra-operative and/or post-op care. This is evidenced by failure of the facility to have emergency intravenous fluids available for 1 (#1) of 3 (#1, #2, #3) patients sampled having surgical abortion procedures. Patient #1 experienced excessive bleeding and a decreased blood pressure and had to be transferred to a local hospital without having been given IV fluids by the OAF to help stabilize her condition. This deficient practice resulted in an Immediate Jeopardy situation. Findings:

	An Immediate Jeopardy situation was found to exist and notification was made to S1DirOperations on 3/15/19 at 4:40 p.m. The immediate crisis was that patients undergoing surgical abortions did not have necessary IV fluids to help stabilize them in the event of complications during procedures or post-operatively. On 3/15/19 Patient #1 was admitted for a surgical abortion. She had a history of five previous Cesarean Sections (C-Section) and one miscarriage with heavy bleeding post operatively. During the surgical abortion procedure Patient #1 began to have a decrease in blood pressure, heavy bleeding and speaking incoherently. The OAF did not have any IV fluids to administer to help stabilize Patient #1. When the OAF checked to see if they had any fluids they realized there were no fluids available. The OAF had no system in place to replace/restock IV
S 205	Continued From page 6 fluids that were used and/or to check to ensure IV fluids were available prior to the start of a surgical abortion procedure in the event of a complication. Patient #3 was currently having a surgical abortion procedure and Patient #2's surgical abortion procedure was to follow after Patient #3's was completed.

	Review of Patient #1's OAF medical record revealed she had arrived at the facility on 3/15/19 for a surgical abortion procedure. Further review revealed she had previously had 5 Cesarean Sections and 1 miscarriage. Review of Patient #1's OAF Operative Notes revealed the surgical abortion procedure began at 12:18 p.m. and ended at 1:02 p.m. Documentation revealed after Patient #1's placenta was extracted she began to have heavy supra-cervical bleeding. Patient #1's blood loss during the procedure was documented as 250cc-350cc. Patient #1's blood pressure was documented as 148/90 with a pulse of 92 bpm at the beginning of the procedure at 12:19 p.m. Patient #1's blood pressure upon transfer to a local hospital at 2:15 p.m. was documented as 100/70 with a pulse of 104 bpm. S3MD documented that, "Patient #1's affect was not to my satisfaction and I felt she needed fluids or blood." S3MD also documented Emergency Medical Services (local ambulance) had been called. There was no documentation that IV fluids had been administered. Review of Patient #1's OAF Recovery Room record revealed at 1:06 p.m. her blood pressure was documented as being 90/55. Further review revealed in the nurse's notes Patient #1 was documented

	as being semiconscious with a moderate amount of blood loss resulting in 911
S 205	Continued From page 7
	being called by S2DON.
	In an interview on 3/15/19 at 4:17 p.m. with S1DirOperations, she said there had been an ambulance at the facility earlier in the day. She said Patient #1 had lost a heavy blood volume after her procedure. S1DirOperations said S3MD had been concerned over Patient #1's blood volume loss. She also said Patient #1 had a history of heavy bleeding after a previous miscarriage. She said Patient #1 also had 5 previous cesarean sections.
	In an interview on 3/15/19 at 4:20 p.m. with S2DON, she said Patient #1 had been transferred out to a local hospital at about 2:15 p.m. to receive IV fluids and possibly blood. She said Patient #1 had a significant blood loss during her procedure. When asked if they give blood at the OAF she said no. When asked if they give fluids at the OAF, she said normally they did but they did not realize they had ran out of IV fluids until Patient #1 needed them. She said they typically have 3 bags of 1 Liter Normal Saline in the crash cart but there was none when she checked. She said there was no current process for restocking the fluids when they were used. S2DON said Patient #1's blood pressure had dropped

	to 78/56 at one point and her pressure was 100/70 when she was transferred to a hospital. In an interview on 3/15/19 at 4:30 p.m. with S1DirOperations, she said Patient #3 was currently in the middle of a surgical abortion procedure and Patient #2 was to have a surgical abortion procedure after Patient #3. When asked the process for checking the crash cart for fluids she replied it was checked regularly but she was not sure how often.
S 205	Continued From page 8 In an interview on 3/15/19 at 4:35 p.m. with S2DON, she said the crash cart was checked for expiration dates monthly, but she did not know what the system was for replacing the normal saline bags of IV fluids when some had been used. A copy of the facility's policy for replacing emergency fluids was requested 3 times but none was provided. As of 3/15/19 at 5:45 p.m. the IJ remained in place. S1DirOperations was instructed and acknowledged that the OAF was not to perform any surgical abortion procedures until the IJ had been removed. An onsite revisit was conducted on 03/18/2019 at 1:35 p.m. S5Adm and S6Board Member presented the first

	POR dated 03/15/2019 which included in-part: the OAF will keep an adequate amount of IV fluids and necessary IV start kits on hand. ..the nurse on duty will check the stock of IV fluids during first work day of the week to ensure that proper amounts of IV fluids are readily available on site. S5Adm verified that the POR did not address what was an adequate amount of IV fluids or supplies to be kept on site and did not include input from any nursing or medical staff. A second POR was presented on 3/18/2019 at 2:20 p. m. This POR indicated in-part: that the OAF would keep a minimum of 3-1000 ml of 0.9% Sodium Chloride and 3-500 ml of 0.9% Sodium Chloride and all necessary IV start kits. S5Adm verified that the second POR did not include any input from any nursing or medical staff, did not address the quantity of IV start kits to have on site, or show any method of how the
S205	Continued From page 9 OAF determined the minimum amount of IV fluids to maintain on site. As of 3/18/19 at 3:00 p.m. the IJ remained in place. S5Adm verified that the OAF was instructed not to perform any surgical abortion procedures until the IJ had been removed.

	Review of the transporting ambulance run report dated 03/15/2019, revealed the following in-part: Patient #1's name: Primary Impression: Vaginal Hemorrhage Secondary Impression: Hypotension Chief Complaint: Weakness Signs & Symptoms: Genitourinary – Abnormal uterine and vaginal bleeding Cardiovascular-Hypotension. Generalized Symptoms - Weakness. On scene: 14:11:03 At Patient: 14:12:16 14:13: Assessment- Physician reports that he was performing a D&E procedure on the patient and was able to extract the fetus but could not stop the vaginal bleeding and called 911 V/S monitored on scene. Pt is found hypotensive. Pt was moved over to stretcher. IV was established on scene. Pt was administered NS in route. BP increased in route. 14:16: Patient alert, blood pressure 88/59, pulse 109, respirations 16, SP02 97% room air. 14:17: 16 ga, right antecubital, Normal Saline (0.9% NaCl), total fluid 300 ml, pt. response improved. Review of Patient #1's Hospital Records revealed in-part: Arrival 3/15/19 at 14:54 Arrival Mode: Ambulance

	Chief Complaint= Bleeding
S 205	Continued From page 10
	Hospital Report: Due to likely incomplete abortion and persistent moderate vaginal bleeding, I called ___ resident, to consult ____ OBGYN service for possible surgery ... Signed by MD 3/15/19 at 15:37
	History and Physical in-part: GYN Faculty I saw and evaluated Patient in (the Hospital). Impression: 28 yo s/p attempted dilation and evacuation of 15 weeks pregnancy with continued vaginal bleeding, guarded condition. Plan: 1. s/p D&E - continued vaginal bleeding, approximately 300 cc + 800 after the procedure. Given 400 mcg Cytotec PO + 800 mcg PR given at the OAF, with continued bleeding. Tachycardia to 120's, + (positive) orthostatics, H/H 7/24. Patient symptomatic. Counseled about options, will proceed to OR for suction D&C for suspected retained POC. Signed 3/15/19 at 16:46 by MD.
	Operative Report: Date of Procedure March 15, 2019 Preoperative Diagnosis: retained POC status-post dilation and evacuation for elective abortion.

	Operation: Exam under anesthesia, Suction dilation and curettage, ultra-sound guided. Specimen: Products of Conception. Drains: Foley catheter, uterine tamponade balloon containing 50 cc of saline. Estimated Blood Loss: 400 cc. Complications: Bleeding, Methergine 0.2 mg IM given intraoperatively along with one unit of packed red blood cells. Operative Progress Note: Procedure: Signed by supervising MD on 3/15/2019 at 19:19 I was present and scrubbed for exam under
S 205	Continued From page 11 anesthesia and suction D&C. Cervix examined and without lacerations, approximately 1-2 cm dilated. Active bleeding was noted from os, suction and sharp curettage was done multiple times. US performed intra-operatively which helped to confirm intact uterus and homogenous appearing endometrial stripe. Methergine 0.2 mg IM given intra-operatively, along with 1 u PRBCs. Bleeding improved, but due to continued minimal bleeding from os, balloon placed in uterus with 50 ml saline and urinary catheter inserted into bladder. Operative Report: Surgery: 03/16/2019

	Preoperative Diagnosis: Persistent hemorrhage following D&E and status - post D&C for retained POC, cesarean section times five, suspicion for placenta accrete (accreta). Operation: Total abdominal hysterectomy and bilateral salpingectomy. Anesthesia: General endotracheal Estimated blood loss: 500 ccs. Specimens: Uterus, cervix and bilateral fallopian tubes. Indications: in part- Despite medical management as well as the tamponade balloon, the patient had persistent hemorrhage so it was decided at this time that the patient would undergo a hysterectomy and bilateral salpingectomy for persistent postoperative hemorrhage with suspicion for placenta accrete (accreta) due to the patient's history of five cesarean sections in the past. Hospital Laboratory Services Report: Patient #1's lab values were as follow: in-part: 3/15/2019 at 15:54: RBC = 2.90 with Reference at 4.2 to 5.40 mil/uL
S 205	Continued From page 12 Hgb = 7.3 with Reference at 12.0 - 16.0 gm/dL Hct = 23.8 with Reference at 37.0 - 47.0%

	Notes: in-part = Normocytic anemia consistent with blood loss/hemolysis. The hospital record indicated that the patient received a total of 4 units of blood as of 3/17/2019. The documented units of blood was administered as follows: 1. 3/15/19 at 17:36 2. 3/15/19 at 19:39 3. 3/17/19 at 12:40 4. 3/17/19 at 15:42 As of 3/18/2019 at 5:00 PM, Patient #1 remained an in-patient at the area Hospital. On 03/29/2019, an onsite survey was conducted at the OAF. At 3:30 p.m. S1DirOperations, S2DON, and S5Adm were notified of the accepted POR for the IJ situation. The surveyor confirmed that the OAF completed the following to remove the immediate jeopardy. The OAF, with involvement from S2DON and S3MD/Medical Director, developed a plan in-part as follows to ensure that: -The requisite number of IV fluids and IV start kits were available to nursing, determined on a daily basis by the number of patients scheduled for surgical procedures. -Designated staff were to fulfill the daily task of reconciliation of patients scheduled for surgical procedures and availability of IV fluids and IV start kits

	in accordance with the on-site work schedule of the DON. -Train all necessary staff for response to emergencies requiring IV resuscitation. -The development of the P&P; Pharmaceutical
S 205	Continued From page 13 Services Audit And Ordering - IV Start Kit And IV Fluids for auditing and maintaining the necessary amounts of emergency supplies to be available in the OAF. -Identified specific labeled containers in specific locations where IV fluids and IV start kits were to be maintained. -Trained staff and had staff view the location of the specific containers where IV fluids and IV start kits were located. -Developed daily and monthly check lists for designated nursing staff to check the quantities of IV fluids and IV start kits in the 3 designated storage areas. -A determination that the OAF shall maintain on site: 25 sets of IV fluids Sodium Chloride, 10 sets of IV fluids Dextrose, and 10 sets of IV fluids Lactated Ringers shall be on site daily and the same amount shall be kept in reserve. Maintenance of this inventory shall be the responsibility of the DON and has been reviewed and approved by the Medical Director. DON or clinic Administrator will be responsible for replenishing any used quantities using

	the same day or next day supplies ordering per protocol.
S 259	4451 H Pharmaceutical Services H. The outpatient abortion facility shall order and maintain a supply of emergency drugs for stabilizing and/or treating medical and surgical complications on the licensed premises as authorized by the medical director.
S 259	Continued From page 14 This Rule is not met as evidenced by: Based on observations, review of records, and staff interviews, the OAF failed to order and maintain a supply of emergency drugs for stabilizing and/or treating medical and surgical complications on the licensed premises as authorized by the medical director. This deficient practice had the potential to affect 3 (Patients #1 - #3) of 3 (Patients #1 - #3) sampled patients who underwent a surgical abortion procedure at the OAF. Findings: During an interview on 3/28/19 at 12:20 PM, S5Adm presented a form which was explained to be the list of emergency medications and supplies that the Medical Director approved to be kept on site. S5Adm explained that the form labeled as STAT KIT ACLS was the Medical Director's inventory list of emergency

	medications and supplies which were kept in the STAT KIT (crash cart). On 3/28/2019 at 12:27 PM, a comparison of the OAF's STAT KIT (crash cart) inventory with the STAT KIT ACLS (inventory list of emergency medications to be kept in the cart) was performed with S4LPN. S4LPN verified that the inventory list included two vials of Adenosine 3mg/4 ml. S4LPN verified that the STAT KIT (crash cart) had only one vial of Adenosine which was expired as of 02/2019. An interview and review of the OAF's list of emergency medications and emergency supplies was conducted with S3MD/Medical Director on 3/29/2019 at 11:10 AM. S3MD acknowledged that the OAF's lists of emergency medications and supplies were approved and said that they were
S 259	Continued From page 15 the responsibility of the administrative staff to maintain. S3MD was asked about the STAT KIT ACLS (inventory list) containing the OAF's emergency medications and about only one of two vials of Adenosine, which was expired, present on the crash cart. S3MD replied that he would not use Adenosine. S3MD said the Adenosine would be for the 911 response personnel to use. S3MD said the medications should have been checked and should not have been expired.

List of Amici Curiae
(* denotes former lawmaker)

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Senator Conrad Appel*

Senator Taylor F. Barras, Speaker*

Senator Regina Ashford Barrow

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Senator Norbèrt N. "Norby" Chabert*

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Senator Gerald Long*

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Senator John Milkovich*

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Senator Dan W. Morrish*

Senator-elect J. Rogers Pope (current Representative)

Senator Mike Walsworth*

Senator Mack "Bodi" White

Louisiana House of Representatives

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Representative Tony Bacala

Representative Larry Bagley

Representative Stuart J. Bishop

Representative-elect Rhonda Butler

Representative-elect R. Dewith Carrier

Representative Charles R. "Bubba" Chaney

Representative Jean-Paul Coussan

Representative Raymond J. Crews

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Representative Paula Davis

Representative Phillip R. DeVillier

Representative-elect Michael Echols

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Representative Polly Thomas

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Representative Lenar Whitney (current Republican National Committeewoman)*

Representative Mark Wright

Representative Jerome "Zee" Zeringue