IN THE IOWA DISTRICT COURT FOR POLK COUNTY

PLANNED PARENTHOOD OF THE HEARTLAND, INC., EMMA GOLDMAN CLINIC, and JILL MEADOWS, M.D., Petitioners, v. KIM REYNOLDS ex rel. STATE OF IOWA and IOWA BOARD OF MEDICINE, Respondents.	Equity Case No. _____ AFFIDAVIT OF JILL MEADOWS, M.D. IN SUPPORT OF PETITIONERS' MOTION FOR TEMPORARY INJUNCTIVE RELIEF

1. I am the Medical Director of Planned Parenthood of the Heartland (PPH). My duties and responsibilities include providing reproductive health care to patients of PPH, including abortion services. I am a board-certified Obstetrician/Gynecologist (obgyn). Prior to this position, I was an Associate Professor in the Department of Obstetrics and Gynecology at the University of Iowa. Currently, I am an adjunct clinical faculty member and continue to train medical students and residents from the University of Iowa and other institutions. In addition, I have given academic presentations on medical abortion to family medicine and gynecology physicians. My CV is attached hereto as Exhibit A.

2. I submit this affidavit in support of Petitioners' Motion for a Temporary Injunction to enjoin enforcement of Section 4 of Senate File 359 ("the Act") to be codified at Iowa Code § 146C.2 (2018), based on my own personal knowledge. I understand that the Act bans abortion as soon as embryonic or fetal cardiac tones are detected, which occurs as early as six weeks of pregnancy (and sometimes earlier), measured from the last menstrual period

("lmp"). The Act will make it virtually impossible, if not impossible, to access abortion in Iowa. I anticipate that patients who can scrape together the resources will travel out of state for medical care, and many others who cannot do so will be forced to carry an unwanted pregnancy to term.

I. PPH and Its Services

3. PPH provides a full range of reproductive health care services at eight health centers in Iowa, including well-women exams, cancer screenings, STI testing and treatment, a range of birth control options including long-acting reversible contraception or LARC, transgender healthcare, and medication and surgical abortion. Medication abortion is the use of a combination of the drugs mifepristone and misoprostol taken by mouth to safely and effectively end an early pregnancy without surgery, in a process similar to an induced miscarriage. It is available in the first 10 weeks of pregnancy, as measured from the first day of the last menstrual period (lmp). Surgical abortion is the use of suction and/or additional instruments to end a pregnancy. In Iowa, we provide surgical and medication abortion at two health centers, in Des Moines and Iowa City. We currently provide abortion through 20.6 weeks lmp, which complies with the 20 week *post-fertilization* statutory limit in Iowa and is a minimum of several weeks before any fetus would be viable.

4. Three of our other health centers provide medication, but not surgical, abortion: in Ames, Cedar Falls and Council Bluffs. We recently had to close three other health centers that were providing medication abortion after the legislature barred abortion providers from participating in certain publicly-funded non-abortion family planning programs.

5. In 2017, we provided over 2300 abortions in Iowa.

6. Most patients are at least six weeks lmp into their pregnancy by the time they contact us seeking an abortion. Many people do not even know they are pregnant before this very

early point. (The lmp method of dating a pregnancy counts from the last menstrual period, which occurs weeks before implantation. Thus, by the time a woman misses her period and has reason to suspect she is pregnant, she is almost always more than four weeks pregnant as calculated by lmp, and in many cases already at or near six weeks of pregnancy lmp.) Even for those few patients who realize they may be pregnant sooner than that, it can often take them weeks to confirm the pregnancy, decide to terminate, research their options, contact us, find a time when they can travel to us and we can see them, and put together the financial resources they need to travel to us and obtain treatment.

7. In a typical pregnancy, embryonic or fetal cardiac tones are detectable (by transvaginal ultrasound) as early as six weeks into a pregnancy. For patients who are five to six weeks pregnant lmp, we sometimes are able to see the gestational sac but unable to detect any embryonic cardiac tones. When there is an empty intrauterine gestational sac visualized on ultrasound or an embryo visualized without fetal heart activity detected, based on ultrasonographic criteria, the ultrasound may be 1) consistent with very early pregnancy 2) suspicious for miscarriage or 3) diagnostic of miscarriage. Miscarriage is common at this stage of pregnancy, occurring in about 15–20% of recognized pregnancies.

8. In the case of sonographic findings suspicious for miscarriage, we give patients the options of 1) being referred to their preferred obgyn for further evaluation; 2) rescheduling so that we can do another ultrasound at least one week later to re-evaluate or 3) proceeding with a termination procedure, either medical or surgical. Patients make that decision based on personal circumstances. Some people strongly prefer to reschedule because, if miscarriage is confirmed, their insurance will cover their medical costs. This is a particularly important consideration for our many lower-income patients, who otherwise may have to choose between paying for a

procedure and paying basic living expenses.

9. In 2017, of over 2300 abortions we provided, only 45 (approximately 2%) occurred before six weeks lmp.

II. The Act's Effects

10. If allowed to take effect, the Act would gravely harm my patients.

11. The Act would prevent virtually all, if not all, of our patients from obtaining an abortion in Iowa.

12. In addition to the medical and practical impediments I have just described to patients' obtaining an abortion before six weeks, Iowa also recently enacted a mandatory delay statute requiring us to provide patients with an ultrasound, offer them the "option" of hearing cardiac tones, and then send them home to wait at least 72 hours before returning for the abortion procedure. As I explained in my testimony in the case I brought challenging that other law, practically speaking that delay period would delay patients an average of at least a week, and in many cases longer. Thus, if both laws took effect, it would be functionally impossible for patients to have an abortion in Iowa outside the Act's very narrow exceptions. This would be all the more so for our minor patients. Most of these patients cannot immediately obtain written parental authorization, which means that under Iowa law they cannot have an abortion until 48 hours after a parent has been notified or until they have obtained judicial authorization, Iowa Code § 135L.3 (2015), neither of which can realistically happen before six weeks.[1]

13. By making it virtually impossible to access abortion in Iowa, the Act would

[1] Even if there were some way in theory for patients to have an abortion in compliance with both the 72-hour mandatory delay and the Act's six-week cut-off, that would come at the terrible cost of forcing patients to race to a health center for an abortion, even if they were not yet fully decided.

deprive these individuals of the ability to control their own lives and to protect their own health, safety and welfare and that of their family.

14. People seek abortions for a variety of medical, familial, economic, and personal reasons. 59% of women who seek abortions are mothers who have decided that they cannot parent another child at this time,[2] and 66% plan to have children or have another child when they are older (and, for example, financially able to provide necessities for them, and/or in a supportive relationship with a partner so their children will have two parents).[3] About one in four women in this country will have an abortion in their lifetime.[4] The vast majority of these women are poor or low-income (75% as of 2014). [5]

15. I know from decades of providing abortion how important this care is to Iowans. My patients seek an abortion for many different reasons. Most are already parents, and make their decision considering their own welfare and that of their family. These patients often make the decision to terminate because they know they lack the resources to meet the needs—emotional, financial, interpersonal or otherwise—of another child in addition to their existing family. Others decide that they are not ready to become parents, and want to gain an education and/or a profession before starting a family. In some cases, such as where a person is suffering

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[2] Jenna Jerman, Rachel K. Jones, & Tsuyoshi Onda, Guttmacher Inst., Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008, at 7 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[3] Stanley Henshaw & Kathryn Kost, Abortion Patients in 1994–1995: Characteristics and Contraceptive Use, 28 Fam. Plan. Persp. 140, 144 (1996).

[4] Rachel K Jones and Jenna Jerman, Population group abortion rates and lifetime incidence of abortion: United States, 2008–2014, 107 Am. J. of Pub. Health 1904, 1908 (2017).

[5] Jenna Jerman et al., supra n.2, at 11.

domestic violence (e.g., by a parent or partner), she may decide that termination is the safest option for herself and her family. Some patients suffer complications in their pregnancy or medical conditions caused or exacerbated by pregnancy, such as hypertension, thromboembolic risk, or cardiovascular risk, and seek to terminate to protect their own health. Still others learn that a wanted pregnancy is severely compromised, and make the painful decision that termination is the most compassionate decision they can make for their potential child and for their family as a whole.

16. It is extraordinarily important for Iowans to have timely access to safe and legal abortion. People of childbearing age who do not have access to safe and legal abortion face significantly increased risks of death and poor health outcomes. For this reason, major medical organizations such as the American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), the American Academy of Family Physicians ("AAFP"), the American Osteopathic Association ("AOA"), and the American Academy of Pediatrics ("AAP") have affirmed that "[r]eproductive healthcare is essential to a woman's overall health, and access to abortion is an important component of reproductive healthcare."[6] Similarly the American Psychiatric Association has deemed access to abortion "a mental health

[6] Br. of Amici Curiae ACOG, AMA, AAFP, AOA, & AAP in Supp. of Pets. at 4, Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016) (No. 15-274), 2016 WL 74948 at *4; see also AAP Comm. on Adolescence, The Adolescent's Right to Confidential Care When Considering Abortion, 139 Pediatrics 1 (2017) (stating that access to abortion in important for adolescent health and well-being "because of the significant medical, personal, and social consequences of adolescent childbearing"); see also ACOG, Comm. on Health Care for Underserved Women, Op. 613: Increasing Access to Abortion 1 (2014, reaffirmed 2017) ("Safe, legal abortion is a necessary component of women's health care.").

imperative with major social and mental health implications,"[7] and the American Psychological Association has affirmed that "freedom of choice and a woman's control over her critical life decisions promotes psychological health."[8]

17. Individuals forced to carry an unwanted pregnancy to term face a range of serious adverse outcomes. They are exposed to increased risks of death and major complications from childbirth.[9] As many as 10% of women who carry to term are hospitalized for complications associated with pregnancy aside from hospitalization for delivery.[10] The main risks associated with carrying a pregnancy to term are hemorrhage, infection, and worsening medical conditions. Other potential complications are preeclampsia and eclampsia, embolism, and trauma to the genital tract. Women who carry to term are many times more likely to experience anemia, hypertensive disorder, pelvic and perineal trauma, obstetric infection, and hemorrhage than women who obtain an abortion.[11]

18. Additionally, delivery itself, whether vaginal or cesarean, poses significant risks,

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[7] Am. Psychiatric Ass'n, APA Official Actions: Abortions and Women's Reproductive Health Care Rights, https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.2010.167.6.726 (last visited May 8, 2018).

[8] Am. Psychol. Ass'n, Abortion Resolutions, http://www.apa.org/about/policy/abortion.aspx (last visited May 7, 2018).

[9] Elizabeth G. Raymond & David A. Grimes, The Comparative Safety of Legal Induced Abortion and Childbirth in the United States, 119 Obstetrics & Gynecology 215, 216 (2012); see also Ctrs. for Disease Control and Prevention, Reproductive Health: Severe Maternal Morbidity in the United States, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited May 11, 2018) (reporting that severe maternal morbidity "has been steadily increasing in recent years and affected more than 50,000 women in the United States in 2014").

[10] Anne Elixhauser & Lauren M. Wier, Agency for Healthcare Research & Quality, Complicating Conditions of Pregnancy and Childbirth, 2008 (Statistical Brief #113) (2011), http://www.hcup-us.ahrq.gov/reports/statbriefs/sb113.pdf.

[11] F. Carol Bruce et al., Maternal Morbidity Rates in a Managed Care Population, 111 Obstetrics & Gynecology 1089, 1092 (2008); Raymond & Grimes, supra n.9, at 216.

many times greater than those associated with abortion.[12] Risks associated with vaginal delivery include hemorrhage, infection, and lacerations of the cervix. Cesarean delivery, which is common in childbirth, is a major invasive surgical operation and associated risks include injury to surrounding organs (particularly bladder and bowel), hemorrhage, and infection, in addition to the risks associated with anesthesia.

19. Individuals forced to carry an unwanted pregnancy to term, and their newborns, also are at risk of other negative health consequences such as reduced use of prenatal care, lower breastfeeding rates, and poor maternal and neonatal outcomes.[13] Some of these risks may be higher for individuals living in rural areas, where there are fewer medical providers.[14] The medical risks and adverse outcomes for patients carrying to term and their children are worse for patients struggling with poverty, as most of our patients are, as compared to the general population.[15]

20. Individuals forced to carry an unwanted pregnancy to term are significantly less

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[12] Compare William M. Callaghan et al., Severe Maternal Morbidity Among Delivery and Post-Partum Hospitalizations in the U.S., 120 Obstetrics & Gynecology 1029, 1031 (2012), and Bruce et al., supra n.11, at 1092, and David A. Asch, et. al, Evaluating Obstetrical Residency Programs Using Patient Outcomes, 302 JAMA 1277 (2009), with Ushma D. Upadhyay et al., Incidence of Emergency Department Visits and Complications After Abortion, 125 Obstetrics & Gynecology 175, 180–181 (2015).

[13] A.P. Mohllajee et al., Pregnancy Intention and Its Relationship to Birth and Maternal Outcomes, 109 Obstetrics & Gynecology 678 (2007); Jessica D. Gipson, Michael A. Koenig, & Michelle J. Hindin, The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature, 39 Stud. Fam. Plan. 18 (2008).

[14] ACOG, Comm. on Health Care for Underserved Women, Op. No. 586: Health Disparities in Rural Women 1–2 (2014, reaffirmed 2016).

[15] Charles P. Larson, Poverty during pregnancy: Its effects on child health outcomes, 12 Paediatr Child Health 673 (2007); Janet L. Peacock, J. Martin Bland, & H. Ross Anderson, Preterm delivery: effects of socioeconomic factors, psychological stress, smoking, alcohol, and caffeine, 311 BMJ 531 (1995); Lindsay M. Silva et al., Low socioeconomic status is a risk factor for preeclampsia: the Generation R Study, 26 J. of Hypertension 1200 (2008).

likely to be able to bring themselves and their family out of poverty.[16] And individuals who are victims of partner violence will, in many cases, face increased difficulty escaping that relationship (because of new financial, emotional, and legal ties with that partner).[17]

21. The Act's harms will be especially grave for people who need to terminate a pregnancy for health reasons or safety reasons. The Act exempts only those patients with a physical condition that threatens their life or poses "a serious risk of substantial and irreversible impairment of a major bodily function." S.F. 359, § 2 (2018) (to be codified at Iowa Code §146A.1(6)(a)). Thus it prevents me from providing an abortion in other circumstances where I would deem this care necessary to a patient's health or safety, such as a dangerous domestic violence situation, a severe depression or other psychiatric condition exacerbated by an unwanted pregnancy, or physical health risks such as hypertension or thromboembolic risk that, even if they may not be sufficiently extreme to meet the Act's definition, are nonetheless real and could be alleviated by an abortion. I have treated patients in all of these circumstances.

22. I also am very concerned that I, or another provider, might perform an abortion based on a judgement that this exception applies, only to have that judgment second-guessed by the Board of Medicine. Specifically, the Board might question my medical judgments as to the seriousness of the risk, whether that risk is to a "major" bodily function, or whether the potential damage to that function is "substantial and irreversible." Those are all determinations as to which individual professionals might disagree. In making that determination, I would face a conflict

[16] Ushma D. Upadhyay, M. Antonia Biggs & Diana Greene Foster, The Effect of Abortion on Having and Achieving Aspirational One-Year Plans, 15 BMC Women's Health 102 (2015); Diana Greene Foster et al., Socioeconomic Outcome of Women Who Receive and Women Who are Denied Wanted Abortions in the United States, 108 Am. J. Pub. Health 407 (2018).

[17] Sarah C.M. Roberts et al., Risk of Violence From the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion, 12 BMC Med. 144 (2014).

between the imperative of protecting my patient (which is both a personal imperative and the professional ethical obligation commonly termed "beneficence"), and the fear that I could lose my license. It is terrible for patient safety to place providers in that dilemma at a time when they should be focused on providing the best care possible for their patient.

23. The Act also will particularly harm patients who are desperate to end a pregnancy because they believe it may be a result of rape or incest, as well as adult or adolescent patients who are at risk of abuse if a pregnancy is discovered. While the Act ostensibly exempts patients who are pregnant as a result of rape or incest, it does so only if they reported that abuse within an arbitrary period (45 days for rape, 145 days for incest), which victims often do not do because of a range of reasons, including out of shame and/or fear of repercussions for themselves or their partners or families. I am also concerned that the Board of Medicine might disagree with a determination I make that a victim has reported "rape," for example in a situation where she reported a incident in which she was not physically forced to have sex but I believed she did not give consent under the circumstances.

24. I also do not understand what the Act means when it requires victims to report abuse to a "private health agency which may include a family physician," and specifically which physicians would be included in that definition. S.F. 359, § 3 (2018) (to be codified at Iowa Code §146C.1). Finally, I cannot tell from the language of the Act whether I can take a patient at her word when she says she reported the incident, or whether I am supposed to verify that fact somehow (and if the latter, how I would do that). Again, the Act will jeopardize patient health and safety by placing providers in danger of losing their license if their interpretation of the exemptions is more lenient than the Board of Medicine's.

25. For individuals who receive a severe fetal anomaly diagnosis, which would

invariably occur after six weeks lmp, the Act bars physicians from terminating these pregnancy unless they certify that the fetus has a condition that is "incompatible with life." Id. I do not know exactly what that means. For example, if a maternal fetal medicine specialist tells a patient that her fetus is *unlikely* to survive to term, or long past birth, does that probability mean that the abnormality is "incompatible with life"? Additionally, this definition prevents physicians from providing an abortion to a patient who receives a diagnosis that her fetus, if it survives to birth, will live a short, incapacitated, painful life. To me, it is unconscionable that patients and their families would lose the ability to decide that termination is the most compassionate decision for that potential child.

26. Even for individuals who have a health condition or fetal diagnosis sufficiently severe to clearly fit within the Act's exceptions or who meet the Act's overly narrow rape or incest exceptions, the Act would make it far more difficult, or perhaps impossible, for them to access an abortion—particularly on a timely basis. If the Act went into effect and prevented us from providing abortions in most cases, it is highly unlikely that we could continue to maintain the staffing, medical equipment, supplies and medical skills necessary to provide abortion at all the health centers where we currently provide it. As a result, many individuals in these dire circumstances would only have access to care if they were able to travel long distances, potentially out of state.

27. I would also be extremely concerned that some of these individuals would be so desperate to terminate their pregnancy that, deprived of legal medical supervision, they would attempt to self-induce. Already, some individuals in Iowa, faced with current barriers to care,

consider or even attempt self-induction.[18] If the Act takes effect, it is likely that many more people would attempt self-induction, including in ways that will seriously jeopardize their health and even their lives. We know this from experience in the United States and elsewhere: whenever abortion is banned or severely restricted, people die from unsafe abortion.[19]

28. For all of these reasons, I believe that the Act will deprive my patients of access to critical health care and will threaten their health, safety, and lives. I strongly object to the Act's preventing me and other physicians from providing our patients with the medical care they are seeking.

Signed this 11th day of May 2018.

Jill Meadows, MD

SHERI SCHNELL
NOTARIAL SEAL
IOWA
COMMISSION NO. 719901
MY COMMISSION EXPIRES
12-10-20

[18] C. Kerestes et al., Prevalence, attitudes and knowledge of misoprostol for self-induction of abortion in women presenting for abortion at reproductive health clinics, 95 Contraception 515 (2017).

[19] Lisa B. Haddad & Nawal M. Nour, Unsafe Abortion: Unnecessary Maternal Mortality, 2 Rev. in Obstetrics & Gynecology 122 (2009); see also ACOG, Op. 613: Increasing Access to Abortion, supra n.5, at 2 ("[H]istorical and contemporary data show that where abortion is illegal or highly restricted, women resort to unsafe means to end an unwanted pregnancy, including self-inflicted abdominal and bodily trauma, ingestion of dangerous chemicals, self-medication with a variety of drugs, and reliance on unqualified abortion providers.")

JILL LYNELLE MEADOWS, MD
Medical Director
Planned Parenthood of the Heartland
850 Orchard Street
Iowa City, IA 52246

EDUCATION

B.S., Macalester College, St. Paul, MN-1991
M.D., University of Iowa College of Medicine, Iowa City, IA-1995
Resident, Obstetrics and Gynecology, Beth Israel Medical Center, New York, NY-1995-1999

PLANNED PARENTHOOD OF THE HEARTLAND

Medical Director-July, 2010 to present
Abortion Services Director-2010 to present
Early Pregnancy Complications Director-2010 to present
Sedation Program Director-2010 to present
Ultrasound Director-2011 to present
Preceptor for medical students and residents-2010 to present
Laboratory Director-2013 to present
LEEP Program Director-2012 to 2014
Colposcopy Program Director-2013 to 2014
Principle Investigator-Mixed Methods Study of Women's Experiences with Second-Trimester Abortion Care
Principle Investigator-Open-Label Study of a Levonorgestrel-Releasing Intrauterine System for Long-Term Reversible Contraception-2015-present
Principle Investigator-Non-Surgical Alternatives to Treatment of Failed Medical Abortion-2016-present

PROFESSIONAL HISTORY

Academic Positions

Clinical Assistant Professor, University of Iowa Carver College of Medicine, Dept. of OB/Gyn-1999-2005
Clinical Associate Professor, University of Iowa Carver College of Medicine, Dept. of OB/Gyn-2005-2010
Clinical Adjunct Faculty, University of Iowa Carver College of Medicine, Dept. of OB/Gyn-2010 to present

Certification

American Board of Obstetrics and Gynecology-2002

Current Licensure

Iowa-1999
Nebraska-2010
Oklahoma-2016

Professional Affiliations

American Medical Student Association-1991-1995; Chapter President, 1992-1993
American Congress of Obstetricians and Gynecologists, Junior Fellow/Fellow (2002)-1995 to present
Association of Reproductive Health Professionals-2007 to present

Offices

University of Iowa gynecology clinical consultant, Family Practice E-mail Consult Service-1999-2002
University of Iowa departmental Inform Patient Record "super-user"-1999-2004
University of Iowa Gynecology Pre-operative Educational Conference Coordinator-1999-2009

University of Iowa Dept. of OB/Gyn liaison to the Emma Goldman Clinic-1999-2010
Medical Director, Family Planning Council of Iowa Medical Review Committee-2002-2008
Reproductive Health Advisor for the medical student free Mobile Health Clinic-2003-2007
University of Iowa Fibroid Clinic Coordinator (multidisciplinary clinic with Interventional Radiology)-2003-2009
University of Iowa Women's Health Curriculum Task Force-2004
University of Iowa Medical Education Committee-2004-2006
Medical Consultant, Female Breast and Pelvic Exam Program Teaching Video and Simulated Patient Gynecologic Exam Program-2005-2008
University of Iowa Physician Assistant Program Review Committee-2005
University of Iowa First Case Start Improvement Project Committee-2005
Medical Director, University of Iowa Women's Health Clinic-2005-2007
University of Iowa OB/Gyn Resident Education Committee-2005-2007
Faculty Advisor, Medical Students for Choice-2005-2010; awarded Carver College of Medicine Medical Student Government Outstanding Student Organization, 2007-2008
University of Iowa liaison for the Family Practice resident OB/Gyn rotation-2006-2007
University of Iowa Perinatal Illicit Drug Screening Protocol Subcommittee-2006-2007
University of Iowa Protection of Persons Subcommittee-2006-2008
University of Iowa Hospitals and Clinics Quality and Safety Advisory Council-2006-2008
Reviewer, Obstetrics & Gynecology journal-2006-2010
Coordinator, University of Iowa Women's Health Center Procedure Clinic-2009
Medical Director, University of Iowa Ryan Residency Family Planning Training Program-2009
Board of Medical Directors, Physicians for Reproductive Health-2013-present

University of Iowa Service Activities
Private gynecology and obstetric clinics-1999-2010
Teaching of medical students and residents-1999-2010
Staff resident continuity of care clinics-1999-2010
Staff Labor and Delivery-1999-2010
Staff Colposcopy/LEEP Clinic-1999-2010
Staff Ambulatory Surgery Center and Main OR-1999-2010
Staff Emma Goldman Clinic-1999-2010
Staff VAMC gynecology clinic/OR-1999-2009
Medical student shadow/AMWA mentor-1999-2010
Interview prospective medical students-2000-2008
Premedical student shadowing-2000-2008
Staff Fibroid Clinic-2003-2010
Medical student advisor-2005-2010
Medical Student Service Distinction Track Mentor-2007-2009
Staff Procedure Clinic-2009-2010

Publications
"Medication for Medical Abortion", Currents, Vol. 4, #4, pp. 9-10, Fall 2003
"Mixed-methods Study of Women's Experiences with Second-trimester Abortion," Poster, NAF annual meeting, April 2016.
"Mixed-methods investigation of women's experiences with second-trimester abortion care in the Midwest and Northeast United States," KellyBlanchard, Jill L.Meadows, Hialy R.Gutierrez, Curtiss PSHannum, Ella F.Douglas-Durham, Amanda J.Dennis. Contraception, 96: 401-410. December 2017.

Grants
University of Iowa New Clinical Initiative Grant for Fibroid Clinic-2005-2007

Ryan Residency Family Planning Training Grant-2009

Awards
The Elliot Blumenthal Award for best resident research project/presentation-1998
The University of Iowa Vagina Warrior Award-2004
Emma Goldman Clinic Golden Speculum Award-2005
The University of Iowa Jean Y. Jew Woman's Rights Award-2005
National Abortion Federation C. Lalor Burdick Award-2013

LECTURES

University of Iowa
Lectures to third-year medical students, “First Trimester Bleeding” (every six weeks)-1999-2001
Lecture to residents and medical students, “Ectopic Pregnancy”-4/25/00
Lecture to residents and medical students, “Evaluation and Treatment of Abnormal Bleeding in Perimenopausal Patient”-5/16/00, 6/16/0
Lecture to residents and medical students, “Chronic Pelvic Pain”-10/31/00
Obstetrics and Gynecology case studies-2000-2009
Lecture to Internal Medicine residents, ”Abnormal Uterine Bleeding”-9/28/00, 10/5/00, 1/4/01, 4/5/01
Lectures to 3rd year medical students, “Normal and Abnormal Uterine Bleeding” (every six weeks)-2001-2006
Clinician mentor to 2nd year medical students for Foundations of Clinical Practice-2002-2005
Lecture to residents and medical students, “Induced Abortion”-10/15/02
Lecture to residents and medical students, "Dysmenorrhea"-5/27/03
Lecture to residents and medical students, "Misoprostol in Obstetrics"-11/4/04
Lecture to residents and medical students, "Spontaneous Miscarriage, Evaluation and Treatment"-2/10/04
Faculty Facilitator, Foundations of Clinical Practice Personal and Professional Development-2005-2006
Lecture to 3rd year medical students, “Abortion and Women’s Health” (every six weeks)-2006-2010
Lecture to residents and medical students, “Management of Miscarriage”-2/13/07
Lecture to residents and medical students, “Abortion Overview”-7/8/08
Lecture to residents and medical students, “Dysmenorrhea”-10/21/08
Clinical Skills Workshop for third year medical students using papayas (every six weeks)-2009; for residents 1/13/09 and 6/09
Lecture to residents and medical students, “Induced Abortion”-7/8/08
Lecture to second year medical students (FCP). “Spontaneous and Induced Abortion Overview”-11/7/08
Lecture to reproductive epidemiology students, “Fibroids” and “Spontaneous and Induced Abortion Overview”-12/4/08
Lecture to residents and medical students, “Ryan Program Overview”-1/13/09
Lecture to residents and medical students, “Mifepristone/Misoprostol for Second Trimester Medical Abortion”-2/16/09
Lecture to residents and medical students, “DMPA for Contraception”-3/10/09
Lecture to residents and medical students, “First Trimester Medical Abortion”-6/9/09
Lecture to residents and medical students, “OCPs-The Basics”-8/11/09
Lecture to residents and medical students, “Primary Reproductive Health and the Law”-10/13/09
Journal Club with residents and medical students: “Rates of Serious Infection after Changes in Regimens for Medical Abortion,” NEJM-12/09

Planned Parenthood of the Heartland
Reversal Agents for Moderate Sedation-11/1/10
Sedation Basics Review-5/4/12
BHCG Review webinar-10/15/12
Miscarriage Management webinar-1/14/13

Delayed Post Abortion Complications webinar-3/11/13
Delayed Post Abortion Complications presentation, clinician meeting-9/9/14
2015 Medical Standards & Guidelines Abortion Update/Sedation webinar-2/15
Presentation on Abortion Services to PPHeartland Board-1/16
Delayed Post Abortion Complications presentation, clinician meeting-9/20/16

Invited Lectures

"Evaluation and Treatment of Abnormal Bleeding in The Perimenopausal Patient," Visiting Professor lecture, Broadlawns, Des Moines, IA-5/7/01
"RU-486 Update," Conference presentation, University of Iowa Family Practice refresher course, Iowa City, IA-4/6/01
"RU-486 Update," OB/Gyn Postgraduate Conference, Iowa City, IA-9/22/01
"Elective Induction of Labor," University of Iowa OB/Gyn Grand Rounds-5/22/02
"Ectopic Pregnancies," Visiting Professor lecture, Mason City, IA-10/13/04
"Misoprostol in Obstetrics," Visiting Professor lecture, Mason City, IA-10/13/04
"Abnormal Bleeding in the Perimenopausal Patient," Spring Nurse Conference, University of Iowa College of Nursing, Iowa City, IA-4/7/05
"Complications of Abortion, Current Controversies," University of Iowa OB/Gyn Grand Rounds-5/25/05
"Symptomatic Fibroid Treatment," Women's Health Conference, University of Iowa Dept. of Nursing Services and Patient Care-10/12/05
"This is God's Work," Panel participant, NAF Annual Conference, San Francisco, CA-4/25/06
"First Trimester Bleeding," Visiting Professor lecture, Davenport, IA-4/29/06
"Management of Spontaneous Abortion," Visiting Professor lecture, Davenport, IA-4/29/06
Periodic presentations to local AMWA and MSFC chapters-2000-2009
"Abnormal Uterine Bleeding," Iowa Nurse Practitioner Society Annual Conference, Des Moines, IA-10/19/07
"Management of Early Pregnancy Loss;" "Medication Abortion," Options for Early Pregnancy Loss or Therapeutic Abortion Workshop, Iowa City, IA-9/12/08
"Dysmenorrhea Treatment," Iowa Pharmacists CME, Iowa City, IA-9/16/08
"Carhart vs. Gonzalez: A Plaintiff's Perspective," Des Moines University-12/4/08
"Essure Hysteroscopic Tubal Occlusion: Sterilization and Beyond," University of Iowa OB/Gyn Grand Rounds-4/14/09
Implanon Training Session, Cedar Rapids, IA-4/21/09
"Induced Abortion," Reproductive Health Elective, Des Moines University-2/15/11
"Medical Students for Choice-Finding Your Voice," MSFC Regional Conference, Minneapolis, MN-3/24/12
Nebraska roundtable discussion on family planning education, sponsored by the Urban Institute-University of Nebraska Medical Center, 9/13

COMMUNITY SERVICE

Emma Goldman Clinic GBLT annual free clinic volunteer staff-2000-2008
Iowa City Area NOW Chapter President-2002-2005
Reproductive Health free mobile medical clinic volunteer staff, Broadway Neighborhood Center-2003-2006
Riverside Theatre actor housing host-2004-2005
Iowans Marching for Women's Lives Coalition Chair-2006
Church worship committee chair-2008
Iowa Abortion Access Fund board member-2008-2010; Development Committee-2008; Vice President and Policies & Procedures Committee Chair-2009; President-2010
Children's Moment church leader-2010-2016
First Christian Church Mission and Witness committee member-2012-2016; Chair-2014-2016
Coralville Ecumenical Food Pantry volunteer-2013-2015
First Christian Church Deacon/board member-2014-2017