EXHIBIT 3

IN THE IOWA DISTRICT COURT FOR JOHNSON COUNTY

PLANNED PARENTHOOD OF THE HEARTLAND, INC., and DR. JILL MEADOWS. M.D., Petitioners, v. KIM REYNOLDS ex rel. STATE OF IOWA and IOWA BOARD OF MEDICINE, Respondents.	Case No. AFFIDAVIT OF JILL MEADOWS, M.D.

1. I am an obstetrician and gynecologist ("OB/GYN") licensed to practice in the state of Iowa, and I have been practicing since 1999. I earned my medical degree from the University of Iowa in 1995, and completed my residency in obstetrics and gynecology at Beth Israel Medical Center in 1999. I have been certified by the American Board of Obstetrics and Gynecology since 2002. I have been the Medical Director of Planned Parenthood of the Heartland ("PPH") since 2010, and have worked full time at PPH since then. 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.

2. In my current role at PPH, I contribute to the leadership of abortion services, and direct the Sedation and Ultrasound programs. This includes responsibility for the quality assurance of those medical services, as well for the promulgation of and adherence to the medical protocols pursuant to which the services are provided. I also provide abortion care.

3. I served as a plaintiff and medical expert in a case challenging an unconstitutional Iowa statute imposing a mandatory 72-hour delay and additional-trip requirement on individuals seeking to have an abortion. *See Planned Parenthood of the Heartland, Inc. v. Reynolds ex rel. State*, 915 N.W.2d 206 (Iowa 2018). I also served as a plaintiff and medical expert in a case decided by this court, *Planned Parenthood of the Heartland, Inc. v. Reynolds*, No. EQCE83074, 2019 WL 312072 (Iowa Dist. Jan. 22, 2019), which found a law banning abortion early in the first trimester unconstitutional. I was qualified in that case as an expert in gynecology, including the provision of abortion care and the population of patients seeking an abortion in Iowa.

4. My curriculum vitae, which sets forth my experience and credentials more fully, is attached as Exhibit A.

5. I submit this affidavit in support of Plaintiffs' Motion for a Temporary Injunction to enjoin enforcement of section 2 of House File 594 (the "Amendment"). I understand that the Amendment requires our abortion patients to make an extra trip to us; they would have to come to us for an ultrasound (and be given certain state-mandated information), and then wait at least 24 hours after that trip before returning for their abortion.

6. In 2017, I submitted an affidavit in support of a temporary injunction of the 72-hour mandatory delay law. I also testified to the same facts at trial. My prior affidavit is attached hereto as Exhibit B. My prior trial testimony is attached hereto as Exhibit C. I have reviewed this testimony closely and reaffirm it in full.

7. The facts and opinions included here are based on my education, training, practical experience, information, and personal knowledge I have obtained as an OB/GYN and an abortion provider; my attendance at professional conferences; review of relevant medical literature; and

conversations with other medical professionals. If called and sworn as a witness, I could and would testify competently thereto.

8. Generally speaking, in the challenge to the 72-hour delay requirement, I opined that law would not benefit our patients, as we already perform an ultrasound before providing an abortion and screen our patients to ensure they are firm in their decision before we initiate treatment; would impose serious burdens on our patients, many of whom already overcome major obstacles to seek the care they need; and would delay patients, thereby exposing them to increased medical risk. My opinions in that prior case apply with equal force here. A 24-hour mandated delay is no less harmful in practical terms than a 72-hour requirement, and 24-hour delay law will not enhance patient decision making (just as a 72-hour law also would not do so).

9. Since the Amendment takes effect in about one week, and because we schedule abortion patients at least one week out, starting this week we will begin scheduling abortion patients for two appointments unless the Amendment is enjoined.

10. As I explain below, this will mean that patients will be substantially delayed in seeking an abortion, and as I testified previously, this, in turn, will expose them to health risks and other burdens, and many patients who were planning to have a medication abortion will suddenly no longer be able to do; some patients may be pushed beyond the time when abortion is available in Iowa.

I. PPH, Its Screening Protocols, and Abortion Generally and in Iowa

11. PPH is a not-for-profit corporation organized under the laws of Iowa. It operates in both Iowa and Nebraska. In Iowa, PPH operates nine health centers, all of which provide a wide range of reproductive and sexual health services to patients, including but not limited to services such as cancer screenings, birth control counseling, human papillomavirus (HPV) vaccines, annual

gynecological exams, pregnancy care, contraception, adoption referral, and miscarriage management. Additionally, six of the nine Iowa health centers (Ames, Cedar Falls, Council Bluffs, Iowa City, Des Moines, and Sioux City) provide medication abortion care through 11 weeks, 0 days of pregnancy LMP[1] and two health centers (Des Moines and Iowa City) provide in-clinic abortion procedures through 19 weeks, 6 days LMP and 20 weeks, 6 days LMP, respectively.

12. Legal abortion is one of the safest medical procedures in the United States.[2] There are two main methods of abortion: medication abortions and in-clinic abortion procedures. Both medication abortion and procedural abortion are substantially safer and require substantially fewer medical interventions than continuing a pregnancy through to childbirth. The risk of death associated with childbirth is approximately fourteen times higher than that associated with abortion,[3] and complications such as hemorrhage are far more likely to occur with childbirth than following an abortion. As many as ten percent of women who carry to term are hospitalized for complications associated with pregnancy aside from hospitalization for delivery.[4]

13. Medication abortion involves the patient ingesting a combination of two medications: mifepristone and misoprostol.[5] The patient takes the first medication in the health center and then, typically twenty-four to forty-eight hours later, takes the second medication at a location of their choosing, most often at their home, after which they expel the contents of the uterus in a manner similar to a miscarriage.

[1] A full-term pregnancy has a duration of approximately forty weeks as measured from the last menstrual period (LMP). In Iowa, abortion is almost entirely banned about halfway through pregnancy, at twenty-two weeks LMP.

[2] Nat'l Acads. of Scis. Eng'g & Med., The Safety & Quality of Abortion Care in the United States 77–78, 162–63 (2018).

[3] *Id.* at 11, 74–75.

[4] Anne Elixhauser & Lauren M. Wier, Agency for Healthcare Research & Quality, Complicating Conditions of Pregnancy and Childbirth, 2008 (Statistical Brief #113) (2011).

[5] Nat'l Acads., *supra* note 2, at 51.

14. Current medical evidence demonstrates that medication abortion is safe and effective through eleven weeks LMP. PPH provides medication abortion up to 11 weeks, 0 days LMP.

15. After 11 weeks LMP, abortions are typically performed as an in-clinic procedure. Additionally, some patients with pregnancies less than 11 weeks, 0 days LMP have an in-clinic abortion procedure due to patient preference or because of an underlying medical condition, such as an increased risk of bleeding, that makes this the safer option.[6]

16. While sometimes referred to as "surgical abortion," an in-clinic abortion procedure is not what is commonly understood to be "surgery"; it involves no incision, no need for general anesthesia, and no requirement of a sterile field. In general, up to approximately fifteen weeks LMP, physicians use the aspiration abortion technique, which involves dilating the natural opening of the cervix using medications and/or small rods, inserting a narrow tube into the uterus, and emptying the uterus through suction. This procedure typically takes five to ten minutes. To perform abortions after that gestational point in pregnancy, physicians must dilate the cervix further and use instruments to empty the uterus, which is called the dilation and evacuation ("D&E") technique. Later in the second trimester, the physician may begin cervical dilation the day before the procedure itself. PPH performs in-clinic abortion procedures in Iowa up to 20 weeks, 6 days LMP.

17. In 2019, PPH performed over 3000 abortions in Iowa. Of those, about 380 occurred beyond eleven weeks LMP.

18. Also in 2019, we provided over 2200 medication abortions and over 950 surgical abortions in Iowa.

[6] Nat'l Acads., *supra* note 2, at 51–52.

19. PPH strives to provide high-quality, patient-centered medical care: that is, "care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."[7] In the context of providing abortions, this means that we are committed to helping each patient make a voluntary, informed, and firm decision about whether to terminate her pregnancy.

20. PPH currently uses a comprehensive informed consent process for abortion, available on the day of the procedure, which provides women with all information necessary for them to fully understand the risks and benefits of abortion and of the alternatives to abortion. PPH also gives its patients multiple opportunities to ask questions and discuss concerns with their physician and other staff caring for them prior to an abortion, if that is what she chooses. This process allows a person, after thoroughly considering this information, to give consent that is informed and voluntary.

21. Staff members who take patients through this process are trained to ask open- ended questions, draw out patients about their decision-making and state of mind, and identify red flags that suggest a patient may not be confident in her decision. As part of her medical screening, each patient has an ultrasound. She is asked whether she wants to view the image, and most patients decline.

22. Most patients are already firm in their decision by the time they reach us. In my experience, they have carefully thought through their options and how those options fit, or do not

[7] Institute of Medicine, Crossing the Quality Chasm: A New Health System for the 21st Century 3 (Mar. 2001), http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm %202001%20%20report%20brief.pdf.

fit, with their values, circumstances, feelings and goals. They often have consulted others. They do not take the decision lightly.

23. If a patient has not reached a firm decision, we work with them to articulate and consider their values, goals, and circumstances relevant to the decision. And if those do not point them to a clear decision, we do not proceed with the abortion and instead advise them to take more time, and we help them identify individuals (such as family members, mentors, or professional counselors) who can support them in their deliberation.

24. As a matter of medical ethics and patient-centered care, it is important that this is an individualized process, tailored to each patient. As providers, we need to respond to each patient's individual preference as long as we can safely do so, whether a patient prefers to complete the procedure as soon as possible or to take more time with the decision.

II. The Amendment's Impact

25. I am very concerned about the Amendment and the effect it will have on our patients. I am concerned that the two-trip and mandatory delay requirements of the Amendment will make it far harder for our patients to access timely care. Many of our patients already struggle to access care for a number of reasons.

26. Although abortion is a very safe medical procedure, the health risks associated with it increase with gestational age.[8] As ACOG and other well-respected medical professional organizations have observed, abortion "is an essential component of comprehensive health care"

[8] Nat'l Acads., *supra* note 2, at 77–78, 162–63.

and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible."[9]

27. Patients generally seek abortion as soon as they are able, but many face logistical obstacles that can delay access to abortion care. Patients will need to schedule an appointment, gather the resources to pay for the abortion and related costs,[10] and arrange transportation to a clinic, time off of work (often unpaid, due to a lack of paid time off or sick leave), and possibly childcare during appointments.[11]

28. For example, the majority of our patients have low incomes that are already stretched thin. They are also juggling other commitments: e.g., demanding work-schedules that they cannot predict or control, school, and/or childcare and other family obligations. For similar reasons, it is often hard for their loved ones to arrange to come with them to support them and help them after a procedure.[12] They struggle to find the time and transportation to come for an

[9] ACOG et al., *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

[10] Iowa prohibits public insurance, including Medicaid, from covering abortion services except in the very limited circumstances where a patient's physical health or life is at risk, where the pregnancy is a result of rape or incest that has been reported to law enforcement, or where "the fetus is physically deformed, mentally deficient or afflicted with a congenital illness." Iowa Admin. Code 441-78.1(249A)(17); 441-87.8(217).

[11] Jenna Jerman, Rachel K. Jones & Tsuyoshi Onda, Guttmacher Inst., Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008, at 6, 7 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf; Sarah E. Baum et al., *Women's Experience Obtaining Abortion Care in Texas After Implementation of Restrictive Abortion Laws: A Qualitative Study*, 11 PLoS One 1, 7–8, 11 (2016); Lawrence B. Finer, Lori F. Frohwirth, Lindsay A. Dauphinee, Susheela Singh, & Ann M. Moore, *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 335 (2006).

[12] Although in normal times we welcome support companions accompanying abortion patients, we have made the difficult decision to restrict such companions (except parents accompanying minors), where guests are either not permitted to enter a health center or are confined to designated waiting areas.

appointment, particularly if they are trying to keep their decision confidential. Some people have abusive and/or controlling partners, and face additional difficulties because they must conceal their logistical efforts, and the procedure itself, from that partner. Because of the Amendment, they now will have to figure out how to make an extra trip or, if they are traveling far, they may need to make arrangements to stay overnight, perhaps multiple nights, while they wait for their procedure.

29. The COVID-19 pandemic has only exacerbated these obstacles for patients seeking abortion care.[13] It has shuttered schools and businesses, causing layoffs, and otherwise limited patients' options for childcare support and finances during a time of recommended social-distancing and economic turbulence.[14] It should be obvious that because the Amendment requires

[13] Organizations across the country that provide financial and logistical assistance to women seeking abortion care have reported enormous increases in the volume of requests they receive, due to the widespread economic hardship caused by the pandemic. Paige Alexandria, *Paying for an Abortion Was Already Hard. The COVID-19 Economic Downturn Has Made It Even Harder*, Rewire, Mar. 27, 2020, https://rewire.news/article/2020/03/27/paying-for-an-abortion-was-already-hard-the-covid-19-economic-downturn-has-made-it-even-harder/.

[14] Press Release, Office of the Governor of Iowa, Gov. Reynolds Recommends Iowa Schools Close for Four Weeks, Will Hold a Press Conference Tomorrow (Mar. 15, 2020), https://governor.iowa.gov/press-release/gov-reynolds-recommends-iowa-schools-close-for-four-weeks-will-hold-a-press-0; Iowa Proclamation of Disaster Emergency dated March 17, 2020, https://governor.iowa.gov/sites/default/files/documents/Public%20Health%20Proclamation%20-%202020.03.17.pdf (ordering closures of restaurants and bars, senior citizen centers, and any gatherings of ten or more people); Iowa Proclamation of Disaster Emergency dated March 22, 2020, https://governor.iowa.gov/sites/default/files/documents/Public%20Health%20Proclamation%20-%202020.03.22.pdf (additionally closing salons and similar service establishments); Iowa Proclamation of Disaster Emergency dated March 26, 2020 (extending pre-existing closures to 11:59 p.m. on April 16, 2020); Lee Rood, *Iowa Day Care: You Want Us to Stay Open? We Need Supplies*, Des Moines Register, Mar. 23, 2020, https://www.desmoinesregister.com/story/news/2020/03/23/coronavirus-iowa-dhs-says-its-working-help-child-care-providers-get-cleaning-supplies-covid-19/2899758001/; *see also* White House, *The President's Coronavirus Guidelines for America* (Mar. 16, 2020), https://www.whitehouse.gov/wp-content/uploads/2020/03/03.16.20_coronavirus-guidance_8.5x11_315PM.pdf; Rebecca Shabad, *Fauci Predicts Americans Will Likely Need to Stay Home for at Least Several More Weeks*, NBC News, Mar. 20, 2020, https://www.nbcnews.com/politics/donald-trump/fauci-predicts-americans-will-likely-need-stay-home-least-several-n1164701.

patients to make two trips to the health center, the Amendment needlessly increases patients and staff potential exposure to COVID-19 at a time when public-health professionals and physicians are encouraging fewer health-care interactions with patients, including by expanded use of telehealth.

30. The Amendment's mandatory delay will push many of our patients beyond the point in their pregnancy when medication abortion is an option. Over the past year, we provided medication abortion to hundreds of Iowa women who were in their ninth or tenth week of pregnancy at the time of treatment. Until now, these numbers were on the rise because we only recently extended this method to 11 weeks (in March of this year) based on safety and efficacy data in the medical literature.

31. In my prior testimony, I explain the many reasons why many patients strongly prefer medication abortion. The COVID-19 pandemic is another reason. Patients have expressed a preference for medication abortion during the COVID-19 pandemic because it can require less physical interaction with the health-care system and thus less risk of spreading and contracting the virus.

32. In my prior testimony, I also noted that some of our patients are close to the point in their pregnancy where we can no longer provide them with an abortion. We regularly see patients who are within two weeks of our gestational age cut offs. I fear that the Amendment will prevent these women from being able to have an abortion in Iowa, and may cause some women to carry an unwanted pregnancy to term or to take measures to attempt to self-abort.

33. My fears that the Amendment will cause significant delay are based not only on my knowledge of my patients' circumstances in Iowa, but also on PPH's ancillary organization's

experience in Arkansas, which enacted a 48-hour delay law in 2015. I described that experience in my prior testimony.

34. Based on that experience and the brief moment the Iowa 72-hour requirement was in effect, I believe patients will be delayed well beyond 24 hours, and that is not taking into account patients' own scheduling constraints, which also will limit their ability to closely space two medical appointments.

35. To schedule two separate patient visits at least 24 hours, we have to nearly double the number of appointments we previously provided for abortion patients. As was the case when I testified in the 72-hour challenge, PPH's health centers are already stretched thin and generally must schedule patients at least one week out. To schedule an additional visit 24 hours or longer before the abortion visit for every patient without having to schedule patients much further out, PPH would likely have to add staff, revisit scheduling templates, or extend hours, any of which impose significant financial burdens on a practice that is already financially strained. Without additional staff, in many cases, we will have to schedule patients' abortion appointment the week after their first visits (at least)—or patients will have to travel to another health center that has sooner availability.

36. Because of the shifting dynamics around COVID-19 and community health orders and proclamations, we are seeing patients who have delayed scheduling medical appointments. Since these patients waited to obtain their abortions, they are now several weeks later in their pregnancies. As a result, they may need an in-clinic procedure that will take more time than an earlier procedure or a medication abortion visit, and some will have to have their procedures completed over two days. A two-trip requirement would only compound the scheduling issues we are experiencing to accommodate patients as promptly as possible, and make it more likely that

more time than an earlier procedure or a medication abortion visit, and some will have to have their procedures completed over two days. A two-trip requirement would only compound the scheduling issues we are experiencing to accommodate patients as promptly as possible, and make it more likely that some patients will be pushed past the gestational age when they can access safe, legal abortion in Iowa.

37. Given all this, in all likelihood, the Amendment will create a backlog at least one-to-two weeks out.

38. I am also concerned that, as the COVID-19 pandemic flares up in the future, we will experience similar patient surges for many months to come.

39. Further, the Amendment would disproportionately affect people with low socioeconomic status, and thereby affect Black Iowans and Iowans of color disproportionately as well.

40. For all these reasons, and as I testified in the challenge to the 72-hour mandatory delay law, I believe that this Amendment will not improve women's decision-making but instead, will only serve to burden their access to abortion and actually threaten—rather than advance—their health.

41. I certify under penalty of perjury and pursuant to the laws of the state of Iowa that the preceding is true and correct.

Signed this 22nd day of June, 2020.

Jill Meadows, MD

EXHIBIT A

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
Principal Investigator-Mixed Methods Study of Women's Experiences with Second-Trimester Abortion Care
Principal Investigator-Open-Label Study of a Levonorgestrel-Releasing Intrauterine System for Long-Term Reversible Contraception-2015-present
Principal 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

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-2013-2019

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
Post Abortion Complications and case presentations, clinician meeting-9/19/18

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
Unity Center of Cedar Rapids Spiritual Care Team-October, 2018-present

EXHIBIT B

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

PLANNED PARENTHOOD OF THE HEARTLAND, INC., and JILL MEADOWS, M.D., Petitioners, v. TERRY E. BRANSTAD ex rel. STATE OF IOWA and IOWA BOARD OF MEDICINE, Respondents.	Case # AFFIDAVIT OF JILL MEADOWS, M.D.

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 Planned Parenthood of the Heartland, including abortion services. I am a board-certified Obstetrician/Gynecologist. 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 Plaintiffs' Motion for a Temporary Injunction to enjoin enforcement of Section 1 of Senate File 471 ("the Act"), based on my own personal knowledge. I understand that the Act requires our abortion patients to make an extra trip to us; they would have to come to us for an ultrasound (and be given certain state-mandated information), and then wait at least 72 hours after that trip before returning for the procedure. This law will not benefit our patients, as we already perform an ultrasound before providing an

abortion, and screen our patients to ensure they are firm in their decision before we initiate treatment. Moreover, the Act will impose serious burdens on our patients, many of whom already overcome major obstacles to seek the care they need. It will delay patients, thereby exposing them to increased medical risk.

3. Because the Act was given an immediate effective date, these burdens are or will be immediate for the 155 patients we have scheduled between May 1 and May 12, 2017, including 48 patients having a medication abortion via telemedicine. Absent an immediate injunction, these patients will have their abortion appointment abruptly canceled, and have to scramble to schedule an extra visit and delay her abortion. As I explain below, this will mean that patients will be substantially delayed in seeking an abortion, which in turn will expose them to health risks and other burdens, and many patients who were planning to have a medication abortion will suddenly no longer be able to do.

I. PPH and Its Screening Protocols

4. PPH provides a full range of reproductive health care services at 12 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 to safely and effectively end an early pregnancy without surgery. 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 clinics, in Des Moines and Iowa City. I understand that a separate provision just passed into Iowa law now prohibits abortions after 21.6 weeks LMP, except in the case of a medical emergency.

5. Six of our other clinics provide medication, but not surgical, abortion. In Ames, we have an in-person physician who provides this care. Since 2008, we also have used telemedicine to provide medication abortion at a number of clinics where we do not have an in-person physician but do have trained staff and the technology needed to allow the physician to remotely screen patients for contraindications. We currently offer medication abortion using telemedicine at 5 health centers, in Burlington, Cedar Falls, Council Bluffs, Bettendorf (Quad Cities), and Sioux City. We also occasionally use telemedicine to ensure continuity of services in Ames, Des Moines, and Iowa City when we are temporarily short-staffed.

6. Over the past year (April 1, 2016 to March 31, 2017), we provided over 2,100 medication abortions and over 1,200 surgical abortions in Iowa.

7. Our mission at PPH is to provide high-quality, patient-centered medical care: that is, "care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."[1] In the context of providing abortions, this means that we are committed to helping each patient make a voluntary, informed, and firm decision about whether to terminate her pregnancy.

8. PPH currently uses a comprehensive informed consent process for abortion, available on the day of the procedure, which provides women with all information necessary for

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[1] Institute of Medicine, Crossing the Quality Chasm: A New Health System for the 21st Century 3 (Mar. 2001), http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf.

them to fully understand the risks and benefits of abortion and of the alternatives to abortion. PPH also gives its patients multiple opportunities to ask questions and discuss any concerns with their physician prior to an abortion, if that is what she chooses. This process allows a person, after thoroughly considering this information, to give consent that is informed and voluntary.

9. Staff members who take patients through this process are trained to ask open-ended questions, draw out patients about their decision-making and state of mind, and identify red flags that suggest a patient may not be confident in her decision. As part of her medical screening, each patient has an ultrasound. She is asked whether she wants to view the image, and most patients decline.

10. Most patients are already firm in their decision by the time they reach us. In my experience, they have carefully thought through their options and how those options fit, or do not fit, with their values, circumstances, feelings and goals. They often have consulted others. They do not take the decision lightly.

11. Some patients have not reached a firm decision, and we work with them to articulate and consider the values, goals, and circumstances relevant to that decision. And if those do not point *them* to a clear decision, we do not proceed with the abortion and instead advise them to take more time, and we help them identify individuals (such as family members, mentors, or professional counselors) who can support them in their deliberation.

12. As a matter of medical ethics and patient-centered care, it is important that this is an individualized process, tailored to each patient. As providers, we need to respond to each patient's individual preference as long as we can safely do so, whether a patient prefers to be done with the procedure as soon as possible or to take more time with the decision.

II. The Act

13. I am very concerned about the Act, and the effect it will have on our patients.

14. As an initial matter, I am uncertain about what the Act requires. I understand that we must obtain written certification that the patient has been provided with certain information "based upon the materials developed by the department of public health," including "indicators" and "contra-indicators." The Act at 2; Iowa Code § 146A.1(1)(d)(b) (2017). "Indicators" and "contra-indicators" are not medical terms, and I am not sure what they mean. In addition, to my knowledge, the department of public health has not yet developed the materials required by the Act (which is unsurprising since the law was given an immediate effective date).

15. More importantly, I am concerned that the two-trip and mandatory delay requirements of the Act will make it far harder for our patients to access timely care. Many of our patients already struggle to access care for a number of reasons. In general, the earlier an abortion is performed in pregnancy, the safer.

16. For example, many patients have very limited incomes that are already stretched thin; in the last quarter of 2016, for example, over 50% of our abortion patients were at or below 110% of the federal poverty line (meaning, e.g., she made $13,068 or less if single or $17,622 if supporting a child[2]). They are also juggling other commitments: e.g., demanding work-schedules that they cannot predict or control, school, and/or childcare and other family obligations. For similar reasons, it is often hard for their loved ones to arrange to come with them to support them and help them after a procedure. They struggle to find the time and transportation to come for an

[2] Nat'l Conference of State Legislators, *2016 Federal Poverty Level Guidelines* (Jan. 26, 2016), http://www.ncsl.org/research/health/2014-federal-poverty-level-standards.aspx.

appointment, particularly if they are trying to keep their decision confidential. Some people have abusive and/or controlling partners, and face additional difficulties because they must conceal their logistical efforts, and the procedure itself, from that partner. Because of the Act, they now will have to figure out how to make an extra trip or, if they are traveling far, they may need to make arrangements to stay overnight for three nights while they wait for their procedure.

17. I see first-hand how even existing hurdles delay patients in seeking care, and cause them severe stress. I am very worried that the Act's onerous requirements will delay many patients still further, exposing them to unnecessary medical risks associated with later abortion. In general, the earlier in gestation an abortion is performed, the safer the abortion.

18. The Act's mandatory delay will push many of our patients beyond the point in their pregnancy when medication abortion is an option (10 weeks, as measured from the first day of a woman's last menstrual period). Women often are close to that cut-off by the time they reach us—for example, because of the time it took for them to realize they were pregnant, reach a decision to terminate that pregnancy, and/or pull together the time, money, and transportation to seek care. Over the past year, we provided medication abortion to over 600 Iowa women who were in their ninth or tenth week of pregnancy at the time of treatment. Until now, these numbers were on the *rise* because we only recently extended this method to 10 weeks (in February 2017) in response to changes in the medication label and recommendations by the American College of Obstetricians and Gynecologists. Already, in the past few months, we have provided this method to well over 100 patients in their tenth week.

19. Access to medication abortion matters for a number of reasons. First, many of our patients strongly prefer medication abortion over surgical abortion. Many patients prefer the

privacy of having an abortion at home, with loved ones. Many find it easier to fit in with their other obligations, because they can return home from the clinic sooner and control the timing of the process. For some, this method feels more natural and more under their own control. Others are averse to invasive procedures, needles, IV, or sedation. Some of our patients have a history of sexual trauma, and may for that reason be particularly averse to having instruments placed in their vaginas.

20. Some patients have a medical condition that makes medication abortion a safer option. I have had situations where I initiated a surgical procedure but switched to a medication abortion because I discovered that my patient had a condition that made surgical abortion more difficult.

21. Medication abortion is very effective, and only rarely requires surgical follow-up. However, it is most effective earliest in pregnancy, and the risk of needing surgical follow-up (though still low) increases as a patient's pregnancy approaches the 10-week point. Thus, I am concerned that, as a result of delays caused by the Act, more women will need to have surgical follow-up (the very procedure they sought to avoid); many also will need to travel farther for this care, to Des Moines or Iowa City, which will impose additional costs, both for travel and paying for a procedure that is more expensive.

22. Beyond these personal and medical reasons, as I noted above, we have been using telemedicine to offer medication abortion at a number of satellite clinics in rural or outlying areas of the state. When a woman living in one of those areas misses that narrow 10-week window because of the two-trip and mandatory delay requirements in the Act, she will have to travel much farther—in some cases, hundreds of additional miles—to have a surgical abortion in

Des Moines or Iowa City, even if (as I assume) she could have her initial visit at a satellite clinic. For example, just for the procedure itself (leaving aside the initial visit), a woman in Sioux City would have to travel approximately 400 miles round trip. Given the high number of patients we treat who are close to the 10-week cut-off, there is no question that the Act will force some women into this position.

23. I am also concerned about these inevitable delays because I know that delays cause patients severe stress. Whether it is to conceal an unwanted pregnancy from an abusive or controlling partner, or from others who would disapprove or shame her, or to terminate a debilitating pregnancy, or for some other reason, it is important for many patients to be able to end their pregnancy as soon as possible.

24. We also see patients who—because of all the circumstances I described above or because of a fetal anomaly diagnosis or a health condition that developed or worsened as their pregnancy progressed—are close to the point in their pregnancy where we can no longer provide them with an abortion. For example, in the past year, we saw 30 patients at our Des Moines clinic who were within two weeks of the 20-week cut-off there, and 17 patients at our Iowa City health center who were within two-weeks of the 22-week cut-off there. I fear that the Act will prevent these women from being able to have an abortion in Iowa, and may cause some women to carry an unwanted pregnancy to term or to take measures to attempt to self-abort.

25. My fears that the Act will cause significant delay are based not only on my knowledge of my patients' circumstances in Iowa, but also on PPH's experience in Arkansas, where PPH was providing abortions until 2016. In 2015, that state passed a two-trip, 48-hour waiting period (previously, it had required a shorter waiting period and allowed the first

interaction to be over the phone). This change was a disaster for our patients. Our staff was working late into the night (sometimes until 9 p.m.) to fit patients in for an extra visit. Even so, we had to turn away several patients a week. Other patients had to wait a week or longer to complete the process, or travel to a clinic farther away where they could be seen sooner. Additionally, we were forced to charge a higher fee for the procedure to make up costs.

26. The Act will have similar effects in Iowa. Although we will try to fit patients in quickly, just maintaining our current capacity is a big challenge due, in part, to limited clinician availability. In Iowa as elsewhere, individuals involved in abortion care are targeted for harassment or worse; for this reason, it is hard to hire new staff. This challenge is exacerbated by Iowa law, which requires that all abortions, whether surgical or medication, be performed by a physician (even though other advanced practice clinicians can safely provide early abortion, and do so in several other states). Thus, we are only able to schedule abortion patients 1-2 times a week, or even less frequently at some of our outlying clinics. And even without a mandated second visit, we already have to schedule patients out anywhere from one to three weeks or even longer.

27. As a result, patients will be delayed well beyond 72 hours, just on our end (and not taking into account patients' own scheduling constraints). To schedule separate patient visits 72 hours or longer before the abortion procedure, we literally have to double the number of appointments we previously provided for abortion patients. To manage such a drastic expansion of services, practically overnight, we would have to add staff and/or extend staff hours (including for licensed clinicians), among other clinical and operational changes. It will be extremely challenging and unlikely we can find that staff, and even if we can, we cannot sustainably absorb

the additional cost without charging patients more for an abortion. These increased costs will be in addition to increases many patients will face from having to have a later procedure; the cost of an abortion starts at $730 and increases with gestational age.

28. Without increased staffing, we may also be forced to stop providing abortion at some of our health centers. These prospects are painful because I know many of our patients already have such a hard time affording and accessing care, and that these effects, realistically, will substantially delay them or even prevent them altogether from having an abortion.

29. The Act's effects will be particularly painful for the patients we treat who are terminating a wanted pregnancy because of a lethal or severe fetal anomaly such as neural tube defects or chromosomal abnormalities. In many cases, these conditions are not discovered until later in a pregnancy. It is especially cruel to force these people, in the midst of this traumatic experience, to undergo further delay, which in some cases, could even push them past the point where abortion is available in Iowa.

30. The Act also will be especially harmful to people who need to terminate a pregnancy for health reasons that may not fit into the narrow statutory exception because they do not face a risk of death or "a serious risk of substantial and irreversible impairment of a major bodily function." Iowa Code § 146B.1(6). And it will also be particularly harmful to patients who are pregnant as a result of rape and are desperate to end that pregnancy, or who are at risk of abuse if a pregnancy is discovered.

31. Beyond these harms, I strongly object to the Act because it prevents me and other physicians from providing our abortion patients with the medical care they are seeking without imposing requirements which are not imposed on women and men seeking any other type of

medical care. Based on my 20 years of obtaining consent for and providing a wide range of medical care to thousands of patients, I believe there is no medical justification for singling out women seeking abortion care and imposing on them an extreme mandatory delay and two-trip requirement.

32. The Act also intrudes on patient decision-making, reinforces the societal message that women cannot make these decisions responsibly (which is wholly contrary to my experience), and further stigmatizes what is already a highly stigmatized (yet essential) medical option. Women are already bombarded with the message that they should not trust their own judgment and that they are doing something terrible. When they come to our clinic, they often have to walk past protesters shouting these messages at them. Some patients arrive visibly shaken, in tears, from this experience. Singling patients out to receive state-mandated information and then forcing them to wait at least 72 hours before they can return to receive the health care they desire only reinforces that message.

33. For all of these reasons, I believe that the Act will not improve women's decision-making and, instead, will only serve to burden their access to abortion and actually threaten, rather than advance, their health.

Signed this 28 day of April 2017.

Sheri Schnell

NOTARIAL SEAL IOWA
SHERI SCHNELL
COMMISSION NO. 719901
MY COMMISSION EXPIRES
12-10-17

Jill Meadows, MD

EXHIBIT A

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 Study of Women's Experiences with Second-trimester Abortion," Abstract, North American Forum on Family Planning, Contraception, October 2016.

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

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Coralville Ecumenical Food Pantry volunteer-2013-2015
First Christian Church Deacon/board member-2014-2017

EXHIBIT C

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

PLANNED PARENTHOOD OF THE HEARTLAND, INC. and JILL MEADOWS, M.D., Petitioners, vs. KIMBERLY REYNOLDS ex rel. STATE OF IOWA and IOWA BOARD OF MEDICINE, Respondents.	LAW NO. EQCE081503 TRANSCRIPT OF BENCH TRIAL Volume I of II July 17, 2017

The above-entitled matter came on for bench trial before the Honorable Jeffrey D. Farrell, commencing at 9:02 a.m. on Monday, July 17, 2017, at the Polk County Courthouse, Des Moines, Iowa.

Josie R. Johnson, CSR, RPR
Official Court Reporter
Room 304, Polk County Courthouse
Des Moines, IA 50309
josie.johnson@iowacourts.gov

A P P E A R A N C E S

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For Respondents:
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Assistant Attorney General
1305 East Walnut Street
Des Moines, IA 50319

I N D E X

E X H I B I T S

PETITIONER'S EXHIBITS		OFFERED	RECEIVED
1	Iowa Senate File 471 (the Act)	6	7
3	materials on abortion and adoption	6	7
4	affidavit of Lenore Walker	6	7
5	Dr. Walker CV	6	7
6	Dr. Meadows CV	6	7
7	Dr. Grossman CV	6	7
8	Dr. Collins CV	6	7
9	Dr. Lipinski CV	6	7
10	Dr. Meadows disclosure	6	7
11	Dr. Grossman expert report	6	7
12	Jason Reynolds disclosure	6	7
13	Dr. Collins expert report	6	7
14	Dr. Grossman rebuttal report	6	7

E X H I B I T S (continued)

PETITIONER'S EXHIBITS		OFFERED	RECEIVED
15	Dr. Collins rebuttal report	6	7
16	Dr. Lipinski rebuttal report	6	7
47	Melissa Bird disclosure	6	7
53	Iowa bus routes map	6	7
73	pamphlet	7	8

RESPONDENT'S EXHIBITS		OFFERED	RECEIVED
A	Jenny Condon disclosure	7	7
B	Ottawa Personal Decision Guide	7	7
C	Mikki Stier disclosure	7	7
D	Mikki Stier supplemental disclosure	7	7
E	Geomap	7	7
F	Medicaid provider list	7	7
G	Linda Thiesen disclosure	7	7
H	list of physicians	7	7
I	Melissa Bird disclosure	7	7
J	A report on healthcare access	7	7
K	2015 vital statistics	7	7
L	maps of Planned Parenthood clinics	7	7
M	Mark Bowden affidavit	7	7

(The bench trial commenced at 9:02 a.m. on Monday, July 17, 2017.)

THE COURT: We're on record in EQCE081503, Planned Parenthood of the Heartland, Inc., Jill Meadows, M.D., Petitioners, vs. Terry E. Branstad and Iowa Board of Medicine, Respondents. I guess one thing I will note is I saw a motion to substitute party since Governor Branstad has left his position and Governor Reynolds is now in the position.

The State is offering to have Governor Reynolds substituted as a respondent; is that correct?

MR. THOMPSON: Yes, Your Honor.

THE COURT: Is there any objection to that or resistance?

MS. CLAPMAN: No.

THE COURT: All right. That will be done, and I will issue a short order that will grant that request.

I think we talked briefly on Friday afternoon, and I indicated that in light of the prior arguments I have received in this case and the fact that we know we're going to have briefing following the case that I didn't necessarily need opening statements. But I will see if the parties have opening statements.

On behalf of Petitioners?

MS. CLAPMAN: No.

THE COURT: Respondents?

MR. THOMPSON: No, Your Honor.

THE COURT: All right. We will proceed with our first witness and/or the offering of exhibits, however you want to proceed in that manner.

MS. CLAPMAN: Yes, Your Honor. At this time we would like to offer into evidence Plaintiff's -- Petitioner's Exhibits that are subject to the stipulation that we entered into with Respondents. So those would be -- should I just read off the numbers for the Court?

THE COURT: Yeah. Give me one second, and then I'm going to let you do that. All right. Go ahead.

MS. CLAPMAN: Okay. These would also -- the numbers will correspond to the numbers in the courtesy copy binder. So Exhibits --

Exhibit 1 is a copy of the Act?

MR. OGDEN: We don't have a problem with that.

MS. CLAPMAN: So Exhibits 1, 3, 4, 5, 6, 7, 8, 9, 10, all the way through 16 -- 11, 12, 13, 14, 15, 16 -- 47, 53, and that's it for Petitioners.

THE COURT: Any objection to the exhibits just listed?

MR. OGDEN: No objection, Your Honor.

THE COURT: Those exhibits will be admitted.

Next?

MR. OGDEN: Yes, Your Honor. We have some exhibits that we would like to offer pursuant to the stipulation as well. Those would be Respondent's Exhibits A through M in the black binder.

THE COURT: Any objection to A through M?

MS. CLAPMAN: No, Your Honor.

THE COURT: A through M will be admitted. Is that all with regard to Exhibits at this time?

MS. CLAPMAN: Two more things, Your Honor. We have disclosed to respondents two additional exhibits that they -- one is a learned treatise that petitioner will introduce into evidence, and one is an informational pamphlet that one of Respondents' witnesses provides to clients. And respondents have offered no objection. I'll give Your Honor an exhibit number.

MR. THOMPSON: Alice, I think we have -- I think we have no objection to the pamphlet. The learned treatise we have no objection to being added to the exhibit list but do object to it being admitted as evidence.

MS. CLAPMAN: Thank you for that clarification.

So at this time we will offer into evidence Exhibit 73.

MR. THOMPSON: No objection, Your Honor.

THE COURT: That's the pamphlet; correct?

MS. CLAPMAN: That's the pamphlet.

THE COURT: The learned treatise we'll deal with that at the appropriate time and consider how to admit that into the record.

MS. CLAPMAN: Should I hand this to Your Honor?

THE COURT: You may. Thank you.

MS. CLAPMAN: For the record, it's the Before you Decide pamphlet. That's the name of it.

THE COURT: Okay? Anything else.

MS. CLAPMAN: That's all.

THE COURT: Call your first witness, then.

MS. CLAPMAN: We would like to call Dr. Jill Meadows to the stand.

MS. SALGADO: Can I approach the witness to hand her the exhibit binder?

THE COURT: Let me swear her in, and then I will let you do that, as there's a table you can set up.

Dr. Meadows, will you raise your right hand, please.

DR. JILL MEADOWS,

called as a witness, having been first duly sworn by the Court, was examined and testified as follows:

THE COURT: You may approach with the binder. There's a table. We'll see if Mr. Thompson can set it up right.

MR. THOMPSON: You can set it to your comfort zone. There you go.

THE COURT: When you're ready.

DIRECT EXAMINATION

BY MS. CLAPMAN:

Q. Dr. Meadows, please introduce yourself to the Court.

A. I am Dr. Jill Meadows.

Q. Can you spell your name for the record, please.

A. M-e-a-d-o-w-s.

Q. Are you a petitioner in this case?

A. Yes.

Q. Are you also offering an expert opinion in this case?

A. Yes, I am.

Q. Dr. Meadows, what is your profession?

A. I'm a physician.

Q. Could you please briefly summarize for the Court your medical education and training.

A. Sure. I attended the University of Iowa College of Medicine and I graduated in 1995. I then attended OB/GYN residency in New York City at Beth Israel Medical Center and completed medical training in 1999. And then I joined the faculty at the University of Iowa as a generalist in the department of obstetrics and gynecology.

Q. I would like you to turn to Exhibit 6 in your binder. It should be under Tab 6. Is that your CV?

A. Yes, it is.

Q. Please take a moment to look at it. Did you prepare this?

A. Yes, I did.

Q. Does it appear to be accurate?

A. Yes.

Q. Okay. Are you board certified in obstetrics and gynecology?

A. Yes, I am.

Q. What is your current position?

A. I am currently the medical director of Planned Parenthood of the Heartland.

Q. How long have you held this position?

A. Just over seven years.

Q. What does the position entail?

A. I help lead a team-based approach to providing high-quality reproductive healthcare services to our patients. I'm also a medical consultant to all of our clinicians. I'm involved in creating, updating, and implementing all of our medical policies and procedures. I'm also involved in our medical quality assurance work, which includes developing and processing improvements, and best practices for our clinical services. I also participate in direct patient care services three to four days a week.

Q. What medical care does Planned Parenthood provide?

A. We provide a variety of reproductive healthcare services, including abortion care, contraceptive counseling and care, STI evaluations, screenings, treatments. We also provide preventative services, cancer screenings, such as cervical cancer screening and mammogram referrals, as well as transgender care.

Q. I just realized I'm using the term Planned Parenthood instead of Planned Parenthood of the Heartland. Can we agree that as a shorthand, I will say Planned Parenthood and I mean Planned Parenthood of the Heartland?

A. Yes.

Q. About how many Planned Parenthood patients would you estimate you have treated?

A. I have served over tens of thousands of patients at Planned Parenthood of the Heartland.

Q. Do you perform abortions?

A. Yes.

Q. Why do you perform abortions?

A. I perform abortions because I am a Christian, and I believe it's the right thing to do because abortion care is an important part of basic reproductive healthcare. It's very common, and it's a service that's really needed by people. So I consider it my God-given calling to be a compassionate presence in a person's life at this time when much of society has turned its back on her.

Q. What methods or types of abortion do you perform?

A. I perform both medical and surgical abortion services.

Q. How long have you been providing abortion care?

A. For over 20 years.

Q. And about how many abortions patients have you treated?

A. Over tens of thousands of abortion patients.

Q. Have you also taught medicine?

A. Yes.

Q. Where?

A. At the University of Iowa.

Q. What was your title there?

A. Before I departed, I was an associate professor.

Q. And I'm sorry if you said that already. How long

did you teach there?

A. Eleven years. And I'm currently an adjunct clinical professor, so I continue to teach medical students and residents.

Q. Did you teach residents? Okay.

And what did you teach residents?

A. I taught them a variety of obstetrics and gynecology care, surgical skills, colposcopy, LEEP, obstetrics and gynecology, high-risk obstetrics, abortion care, family planning, etc.

Q. Do you still teach residents?

A. Yes, I do. So, like I said, I currently train residents from the University of Iowa as well as residents from the University of Nebraska Medical Center and Kansas University Medical Center.

Q. Does your training of residents or your teaching of residents include informed consent practices?

A. Yes.

Q. Prior to your current position were you a medical director for any other medical organizations?

A. Yes. I served as the medical director of the Family Planning Council of Iowa for over five years. I also served as the medical director for the Women's Health Center at the University of Iowa for three years. And I also started the Ryan Residency Family Planning Training

Program. At the University of Iowa I was medical director up until my departure for the position at Planned Parenthood.

Q. Based on your experiences, do you consider yourself knowledgeable about the norms and standards for providing gynecologic services including abortion?

A. I do.

MS. CLAPMAN: Your Honor, Petitioner moves to qualify Dr. Meadows in gynecology, including the specificity of abortion practice in the population of women seeking an abortion in Iowa.

MR. THOMPSON: No objection, Your Honor.

THE COURT: All right.

You may proceed.

Q. Please turn to Exhibit 10 in your binder. What is this?

A. This is my expert disclosure that was submitted to the Court.

Q. Does it accurately reflect your opinions in this case?

A. Yes, it does.

Q. Now please turn to Exhibit 1 in your binder. So you can refer to it, this is a copy of the Act. Senate file 471 contains a variety of provisions. Can I use the term Act to refer to the requirements related to the

mandatory 72-hour delay imposed by Senate File 471?

A. Yes.

Q. What do you understand the Act to require?

A. My understanding is that it requires our patients to provide written certification at least 72 hours in advance of having an abortion that she has had an ultrasound examination, been offered the opportunity to view the ultrasound, and her description of the ultrasound finding, and also to hear if fetal heart activity is present and also to be offered materials produced by the State of Iowa in regard to her options regarding the pregnancy. And also it requires that she be evaluated for specific risk factors related to the abortion.

Q. Based on your experience treating over 10,000 abortion patients, do you have an opinion about how the Act will affect women seeking abortion in Iowa?

A. I think that the Act would be very harmful to Iowans because it imposes a mandatory delay in their care, and this can increase their medical risks as well as their out-of-pocket costs and ability to even access the abortion care. In addition, it further stigmatizes women seeking abortion care and makes them feel ashamed and imposes somebody else's values on their own personal medical decision.

Q. I would like to turn to some background facts

about Planned Parenthood's patients. How many healthcare centers does Planned Parenthood operate in Iowa?

A. Currently we operate nine health centers in Iowa.

Q. Does Planned Parenthood provide abortions at all of these centers?

A. Currently we provide abortion care at six of these health centers.

Q. And where is that?

A. We provide surgical and medical abortion services in Iowa City and in Des Moines at our Rosenfield Center. We also provide medication abortions at our Bettendorf Center in the Quad Cities, Ames, Council Bluffs, and Cedar Falls.

Q. At the time this lawsuit was first filed in May, did Planned Parenthood provide abortions at any other health centers?

A. We did. We were also providing abortion services at our Keokuk -- our Burlington and our Sioux City centers.

Q. And those have closed between then and now?

A. Yes.

Q. Why was that?

A. The State passed legislation that excluded Planned Parenthood of the Heartland from a publicly funded family planning program, and this led to close to 15,000 of our patients being unable to receive care with us as their

preferred provider. And as a result of loss of reimbursement for these services, unfortunately we were forced to close some of our centers. We tried to avoid doing this. We racked our brains. We looked at every option available to us, but, unfortunately, we could not sustain keeping these centers open.

THE COURT: Before you go on, I just want to make sure I have all the centers right. Des Moines, Iowa City, Quad Cities, Ames. There were two others?

THE WITNESS: Council Bluffs. Cedar Falls.

THE COURT: Then the two you closed, it was Sioux City. Was it Burlington and Keokuk?

THE WITNESS: Yes. We closed those centers. We only provided abortion care in Burlington and Sioux City.

THE COURT: Thank you.

Q. Do you anticipate that Planned Parenthood will be able to continue providing abortion at all of these centers?

A. No. The Quad City's location will be closed by the end of the year as well.

Q. For the same reasons that you closed the other centers?

A. Correct.

Q. Over the past year, roughly how many abortions has Planned Parenthood provided in Iowa?

A. In the past year we've provided over 3,000 abortion procedures to Iowans.

Q. Okay. Roughly how many surgical?

A. Of those, about one-third were surgical abortions, or over 1,000 patients.

Q. About how many medication abortions?

A. About two-thirds were medication abortions, so just over 2,000 patients.

Q. When a patient comes to Planned Parenthood for an abortion, is she screened medically?

A. Yes, she is.

Q. And is that on the same day she receives the abortion?

A. Yes, it is.

Q. What does the screening entail?

A. She undergoes an ultrasound to date the pregnancy. She also has lab testing for her Rh type and her hemoglobin levels, and then she undergoes a series of medical screening questions that covers her past medical, surgical, and obstetrical history as well as her decision-making process. And she also goes through an informed consent counseling session.

Q. What are some of the more common conditions that you're screening for?

A. We screen for -- we also screen vital signs.

We screen for common conditions such as high blood pressure or hypertension, anemia or low blood count, and other medical conditions.

Q. Can any of these conditions require that the patient delay her abortion?

A. Yes. So in the case of uncontrolled hypertension, it's not necessarily safe to proceed with a procedure that can increase her blood pressure even further when she's having discomfort or under stress. That could put her at risk of having a stroke. So if the blood pressure is too elevated to safely proceed, we may need to refer her to her primary care doctor or another healthcare provider to get the blood pressure under control before she proceeds with the abortion.

Similarly, in a case of anemia, we need the hemoglobin to be at an acceptable level to perform the procedure safely, especially considering that she's expected to have bleeding with the procedure. So we may need to place her on iron therapy and wait one to two weeks or even further until she can return to have the abortion.

Q. Do patients at Planned Parenthood give informed consent before having an abortion?

A. Yes.

Q. What is informed consent?

A. So informed consent makes sure that the patient

understands the risks, benefits, and alternatives to the abortion procedure. It ensures that all of her questions have been answered and that she is making the decision of her own accord and signs a document attesting to that.

Q. What information do patients receive before giving informed consent for an abortion?

A. We discuss the abortion process, the efficacy, the most common risks associated with either a medical or surgical abortion, the alternatives, such as parenting or adoption, and we make sure that, as I said, all of her questions are answered before proceeding, that she's comfortable moving forward.

Q. Are there other staff involved in this process?

A. Yes. Our clinic staff are trained to conduct the informed consent process with the patients.

Q. Okay. And do these staff receive specific training for this process?

A. Yes, they do. New staff are trained by experienced staff, and they must complete a competency before they're allowed to consent patients on their own.

Q. How is that training provided?

A. It's provided also through the didactic materials, a training course online, as well, as I said, the kind of hands-on observation and mentoring of the new staff.

Q. And what does this training cover?

A. It covers the risks and alternatives to abortion, the basics of procedure, the medical questions the patient might have, screening for her decision-making assessment, and also going through the informed consent document .

Q. Are staff trained in assessing any decisional uncertainty?

A. They are. So when I mentioned that decision-making assessment, that involves a series of questions to see how firm the patient is in her decision, who she's discussed the abortion with, and whether she has support of friends, family, mentors, etc.

Q. What is your role in the informed consent process?

A. As the physician, it's my job to ensure that the patient has completed the informed consent process and that she has had all of her questions answered to her satisfaction, that she desires to proceed with the abortion, and if there's any sort of red flags in the process, I might be called in to further assess myself if the patient is firm in her decision and to make sure there's no sort of coercion, that she's not doing -- not there in the clinic because somebody is forcing her to be there or pressuring her to undergo the abortion against her wishes.

Q. As part of this role do you sometimes discuss with patients the reason for wanting to have an abortion?

A. Yes, I do. So oftentimes, when I meet with patients, even though they've already had a discussion with our staff, they want to tell me in person their reasons for having the abortion. And then sometimes , as I said, I need to investigate to make sure that it fits -- having the abortion fits with her desires and her wishes.

Q. Based on your experience treating over 10,000 abortion patients, do you have an opinion about why women decide to terminate a pregnancy?

A. Yes. So the majority of women undergo abortion because they want to be the best mothers they can be to their current and/or future children, and that's been supported by studies into this. The most common reason women give for having an abortion is their feeling of responsibility to others, and that usually means their families. Also they may not be in a position -- usually they tell me they're just -- they probably do want kids or to have another child in the future, but at that point in their life, they don't feel they're in a position to parent in a way they want to parent. For financial, physical, psychological, or situational reasons they're just not in a place where they can be the parent that they want to be .

Q. Are patients advised about the alternatives to abortion?

A. Yes. We make sure patients understand that they have the option of continuing the pregnancy and parenting or placing the child for adoption.

Q. If a patient is expresses interest in continuing her pregnancy, does Planned Parenthood provide her with resources?

A. We do. If the patient doesn't already have a primary care provider or obstetrician, we -- each center has a list of local resources for the patient in terms of people who provide prenatal care, and we also encourage the patient to start prenatal vitamins and make an appointment as soon as they can for prenatal care.

Q. If a patient expresses interest in adoption, does Planned Parenthood provide her with resources?

A. We do. In fact, we work with an adoption agency in Iowa that is willing to travel to meet our patients where they are -- so all over the state at any of the health centers -- if they're interested in us facilitating that, or we can just give them other local resources and information on where they can find out about the adoption process if they're interested in pursuing that.

Q. If a patient expresses interest in parenting, does Planned Parenthood provide her with resources ?

A. We do. So, again, we have lists of local resources where patients can get more information and support.

Q. Do the patient educators go over those lists with patients?

A. Yes, they do. If the patient wants to pursue that, then the educators will make sure she has the information she needs to take the next step.

Q. Do you advise patients about the risks associated with abortion?

A. Yes, we do. It's part of our basic informed consent process.

Q. Do all patients have an ultrasound before an abortion?

A. Yes.

Q. Who provides the ultrasound?

A. Our staff who are trained specifically in ultrasonography perform the ultrasounds on our patients.

Q. What is the purpose of the ultrasound?

A. To date the pregnancy, to confirm that it's an intrauterine pregnancy not an ectopic pregnancy, and also to make sure there are no other anatomical issues that will possibly affect the abortion in some cases.

Q. Are patients offered the opportunity to see the ultrasound?

A. Yes, they are.

Q. Are they offered the opportunity to hear embryonic or fetal heart activity?

A. Yes. So prior to the Act, that was offered if patients expressed an interest in it. After the Act was passed, we now make sure that all patients are asked specifically if they want to hear if the fetal heart activity is present and the description of the sonographic finding there.

Q. How do patients respond to this offer?

A. The majority of patients decline that option -- those options.

Q. When a patient comes to Planned Parenthood scheduled for an abortion, has she typically deliberated about the decision beforehand?

A. Yes. So the vast majority of patients are very firm in their decision by the time they arrive at the health centers.

Q. Has she typically consulted others?

A. Yes. The majority of our patients do involve family members in making this decision.

Q. I think you referred to this in the previous answer, but what percentage of your patients arrive at the clinic sure that they want to end their pregnancy?

A. I would say at least 95 percent of patients are very firm in their decision.

Q. Once they go through the patient education process and informed consent process, what percentage are certain that they want to have an abortion?

A. I would say, again, at least 95 percent of our patients.

Q. What do you do when a patient is not certain about her decision?

A. If a patient is not certain, we kind of look at her concerns and her situation and try to see what would be best for her in her opinion. So if she is at the end of that conversation not interested in having an abortion or not firm in her decision, we recommend that she take more time to think about it. And we actually will not move forward in the abortion.

Also, if there's any signs of coercion that this decision is not being made by her but by somebody else, we absolutely do not move forward in the abortion. We give her the other information and options and resources and don't proceed.

Q. In your opinion will the Act improve patient decision making?

A. I don't think it will improve patient decision making. I think it kind of implies that they need more time to think about it. But as I said, in my experience patients have given this a lot of thought and consideration

and the majority are very firm in their decision. And so the added time only makes it harder for them to access the care that they've decided they need. And it also adds to their out of the cost -- out-of-pocket costs in terms of transportation and childcare and missing work, etc, and just further stigmatizes them.

Q. I'm now going to ask you a few questions about the abortion procedure itself. Is abortion safe?

A. Yes. It's generally considered to be a very safe medical procedure.

Q. How does it compare to other medical procedures in terms of safety?

A. It's comparative to other office gynecological procedures such as endometrial biopsies, intrauterine device assertions, LEEPs, which are cervical cone biopsies done in the office under local anesthesia, and it's actually safer than other office medical procedures such as colonoscopies.

Q. How does abortion compare in terms of safety to childbirth?

A. Abortion is in general close to ten times safer than carrying the pregnancy to delivery.

Q. Is there more than one method of abortion?

A. Yes. In the first and second trimesters you can use a medical or a surgical method for abortion.

Q. And what is the most common protocol for a medical abortion?

A. The most common medical abortion regimen consists of administering the pill Mifepristone to the patient in the clinic, and then she takes another medicine called Misoprostol within 6 to 48 hours later, depending on the route.

Q. Is this the protocol generally referred to as medication abortion?

A. Yes, it is.

Q. How far into pregnancy is medication abortion available?

A. It's generally available through ten weeks of pregnancy.

Q. What determines what method a woman chooses?

A. It's generally a very personal decision based on the patient's own preferences. So some people see it as being more natural and less invasive where she can have the abortion in the comfort of her own home surrounded by her loved ones of her choosing. It avoids needles and having a surgical procedure where instruments are inserted into the vagina and cervix. And for some women that come in, especially a sexual assault victim, that can be very traumatic and can make them relive the assault.

So for a lot of those reasons, plus occasionally

there are medical reasons why we recommend medication abortion over surgical. Once I had patient with an extremely large fibroid uterus, and it was very difficult to reach the pregnancy with our instrument, so we recommended that she undergo a medication abortion instead, which was successful for her.

Q. To clarify the record, the reasons you were just giving for personal preferences, were those preferences for medication abortion over surgical abortion?

A. Correct, yes. So those are the reasons patients may choose medication abortion over surgical.

Q. Does the efficacy of abortion medication change as the pregnancy advances?

A. Yes, it does. So in general the earlier in pregnancy, the more efficacious the medications. So through eight weeks, the medications are 98 percent effective; eight to nine weeks, it is 96 percent effective, and nine to ten weeks, 92 percent effective.

Q. What happens if a medication abortion is not effective?

A. The patients have the option of undergoing a surgical expiration procedure, sometimes having a repeat dose of the medication.

Q. So, generally, if a medication abortion fails, can that require extra visits to the clinic?

A. Yes, it does. So even if she comes to a follow-up visit and the incomplete or failed medication abortion is diagnosed, she may need to return a second time if she desires a surgical procedure under sedation and she has not brought an escort or driver that day, she might reschedule another day to return to the clinic. Or if she comes to one of our medication abortion only sites and has a failure diagnosed, she would need to reschedule again at one of our surgical centers.

Q. Do you commonly see women who are close to the cutoff for medication abortion?

A. Yes. So in the past year there were about 600 patients who were within two weeks of the medication abortion cutoff. And more recently it's been over 50 a month close to the cutoff.

Q. Will the Act effect whether or not some of these women can have a medication abortion?

A. Yes. Because of the mandatory delay that is imposed, this would force some women who would otherwise qualify to have a medication abortion out of that gestational age range.

Q. Do the risks associated with abortion change as the pregnancy advances?

A. Could you repeat the question, please?

Q. Sure. Do the risks associated with abortion change as the pregnancy advances?

A. Yes. So, as I said, the risk of a failed or incomplete medication abortion increases with advancing gestational age. In the case of surgical abortion, the risks go up with gestation as well.

Q. Does the timing of an abortion affect the patient's costs?

A. Yes. So the earlier pregnancy, the safer and also the easier and less expensive. As the pregnancy progresses, the costs go up. If a patient is in the second trimester, this involves an additional step consisting of cervical preparation to reduce risks of injury, which increases patient time and also the procedure time and patient discomfort.

Q. Can you give a sense of how far the costs can increase from an early pregnancy -- for an early abortion to a second trimester abortion?

A. Sure. So between the first and second or third -- second trimester abortion, the costs can double or even triple in that time.

Q. Do you also see some women who are within two weeks of the cutoff for the surgical abortion in Iowa?

A. Yes. So -- okay. Yes. So we in the past year probably saw about close to 50 patients who were close to the surgical abortion cutoff in Iowa.

Q. What are some typical reasons why a woman would be seeking a termination at this point?

A. Sometimes patients present in the second trimester because they were on contraception that was masking the pregnancy -- so either still having periods on the pill, or used to not having periods on other methods of contraception that cause bleeding -- so they diagnose the pregnancy later.

Sometimes patients have life circumstances that changed drastically between the initial diagnosis of pregnancy and then her preparing for an abortion. For instance, she might have lost her job or broke up with her partner who was going to be part of her support system for the pregnancy. So relationships change. Jobs change. Financial situations change.

And also sometimes it just takes patients time to come up with the funding to pay for an abortion. And even though it gets more expensive, they may take time to get the necessary funds to have the abortion in the first place.

Q. Are there medical reasons why a woman might be seeking a termination at this point?

A. Yes. So also most fetal anomalies are not diagnosed until the second trimester when prenatal screening is done. So, in general, an anatomical

ultrasound scan is not performed until 20 weeks of pregnancy or even 20 to 22 weeks of pregnancy. So sometimes abnormalities that wouldn't show up on previous prenatal testing will only be diagnosed in the second trimester. And then sometimes there are maternal medical conditions that arise as the pregnancy progresses as well.

Q. What are some examples of maternal medical conditions that might arise?

A. So one example would be preeclampsia, a condition including elevated blood pressure and other abnormalities. So this can -- this is generally not diagnosed until 20 weeks or beyond in the pregnancy. Also hypertension can worsen as the pregnancy progresses. And then sometimes there are problems such as leaking of fluid, ruptured membranes that can occur in the second trimester as well.

Q. Other than Planned Parenthood are there other providers in Iowa that a patient might go to for a medically indicated abortion later in pregnancy?

A. Yes. So they offer these services at the University of Iowa Hospitals and Clinics and also there are some providers in Des Moines who perform abortions for these reasons.

Q. How are you aware of the services at the University of Iowa?

A. I worked at the University of Iowa for 11 years

and performed abortion procedures there myself, and I'm also in contact with the providers there currently because they're a referral source for us.

Q. When you were providing abortions at the University of Iowa, about how many of these medically indicated later in pregnancy abortions were you performing a year?

A. I would estimate at least 50 to 100 a year.

Q. Do you know roughly how many of these kinds of abortions are currently being provided at the University of Iowa?

A. Yes. Again, at least 50 a year.

Q. Is that total?

A. It's that -- I'm -- it's based on one provider's experience, but there are more than one provider there.

Q. Does Planned Parenthood offer patients an abortion -- I'm sorry. You already answered that.

Are you familiar with the concept of patient-centered care?

A. Yes, I am.

Q. Are you aware of any generally accepted definitions of this concept?

A. Yes. When preparing for this case, I relied on a definition by the Institute of Medicine, otherwise known as the National Academy of Medicine.

Q. I would like to mark Exhibit 19 in your binder. Is this the document that --

A. Yes.

Q. Is this the document you consulted?

A. Yes.

Q. Could you please read the title into the record?

A. Crossing the Quality Chasm: A New Health System for the 21st Century.

Q. Are you familiar with the Institute of Medicine?

A. Yes, I am. In general it's considered a valid resource for reliable information, and it's also expert research in regard to clinical recommendations and guidelines.

Q. Could you turn to page 3 of this document and read the definition out loud of patient-centered care.

A. "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."

Q. Is this the concept you applied -- is this the concept you apply in your clinical work?

A. Yes, it is. We strive to do this.

Q. How does this concept inform your provision of abortion services?

A. We are constantly making sure that the patient is

treated with respect and compassion and that her autonomy is preserved and that her values and needs are being honored.

Q. Is the Act consistent with this concept?

A. No, it is not, in my opinion, because it undermines her own decision making and imposes somebody else's decision on her ability to access the care that she needs and desires. As I said before, I believe it stigmatizes her and makes her feel like she's doing something wrong by having to go through all these extra unnecessary steps.

Q. Does Planned Parenthood track the income levels of its patients?

A. Yes.

Q. Are some of your abortion patients low income?

A. Yes. At least half of our patients are at or below 110 percent of the federal poverty level.

Q. Does Planned Parenthood track whether abortion patients already have children?

A. Yes, we do. And the majority have already had a child.

Q. Where do Planned Parenthood's patients come from, geographically speaking?

A. Our patients come from all over the state as well as from surrounding states.

Q. Why are patients coming to you from so far away?

A. Some patients share that that was the closest clinic available to them or the only clinic that was available on a day of the week that she was able to make the appointment in terms of work, childcare arrangements, transportation arrangements, etc.

In the case of other states, some of our patients come from states that have similar mandatory delays in place, and so it helps them avoid that two separate trips.

Q. Do patients discuss with you or your staff whether they faced any obstacles in getting to the health center for their abortion?

A. Yes. We hear on a regular basis how patients have had difficulty in arranging transportation, time off of work, work coverage, childcare coverage, etc. I mean, often they are canceling appointments for those reasons and having to reschedule or sometimes arriving very late to the appointment because of difficulties in getting there.

Q. Do these obstacles also apply to your patients' support people?

A. Yes. So if a patient wants to have the option of sedation for a surgical abortion, she must have an escort or driver to accompany her home. And so not only does the patient have to arrange all of this transportation, work issues for themselves, but also find somebody who can

accompany them to the clinic and make sure that they are freed up with their schedule as well.

Q. Are patients sometimes unable to bring a support person?

A. Yes. Sometimes it is too difficult to find somebody who is available when the patient is available and can come to the clinic, in which case they are not allowed to have the sedation option.

Q. Are some of your patients delayed by these circumstances?

A. Yes. So as I said, they may have to cancel an appointment and then reschedule the following week or even two weeks later. And then sometimes they might be diagnosed further along in the pregnancy where we would recommend sedation, and they would have to then return from another visit at the time that she can bring a driver with them.

Q. And I believe you mentioned that sometimes patients are delayed by medical issues as well. How do patients generally respond to these delays?

A. Usually they're very distraught and upset if they cannot have the abortion on the day that they have come to the clinic, because they will need to make all those arrangements again. And some people just honestly don't have -- can't afford time off of work or aren't allowed

that time off of work. And so they are pretty distressed by that, even though we need to make sure that patient safety comes first.

Q. Are some of your patients having physical discomfort related to their pregnancy?

A. Yes. So in some cases our patients are suffering from significant nausea and vomiting. They've already made several visits to the ER for treatment of Hyperemesis Gravidarum. So those cases -- those patients can't even return to normal function until they've had the pregnancy terminated. So additional delays would be even harder for them.

Q. Do patients discuss with staff their preferences about the confidentiality of their decision?

A. Yes. So often I get questions from patients saying: Will my doctor know? Do I have to tell my primary care doctor about this? Will they be able to tell that I have had an abortion? I don't want them to know. How long will the pregnancy test be positive? And things of that nature. All telling us that they want this kept secret from their healthcare providers.

Q. I want to talk you about the Act's requirement that the patient be advised of individual risk factors. In your opinion what screening is required to identify individual risk factors?

A. We would -- like I said, vital signs and screen for hypertension, the blood count, the screen for anemia, and then in terms of the medical surgical obstetrical history, look at any problems with previous abortions or deliveries, bleeding issues, just all types of medical considerations.

Q. Would this include the ultrasound as well?

A. Yes. So we look at the dating of the pregnancy.

Q. Do you think patients could avoid extra trips to Planned Parenthood by getting the screening closer to home?

A. I -- I think that would be extremely difficult for patients. I think it would be hard for them to keep the confidentiality that they desire about the abortion, and I think it would be logistically very difficult. Usually if you need a diagnostic test, you need to schedule an appointment and establish a patient-doctor relationship first. So -- and many providers are booked up several weeks, months in advance in terms of taking in new patients. Even if the patient has an established provider, may not be able to get in in a timely manner and then they would also have to have additional appointments for the diagnostic tests.

In addition to that, we would need to obtain written certification greater than 72 hours in advance that all of this had occurred. Most local or -- yeah -- local

ultrasound sonographers won't disclose information about the ultrasound to the patient until the radiologist has reviewed the image and signed off on the report, which would add an additional delay. And then there's the issue of how do we get the written certification and all of these records and reports. Sometimes it takes us a couple days, a couple weeks, sometimes we never obtain medical records that we've requested from other institutions. And the letter itself would have to be a certification, would have to be faxed. It couldn't be emailed. It could be mailed, but that would be even slower.

Q. If a patient obtained an ultrasound elsewhere, would you be able to rely on that ultrasound report?

A. It would depend on how familiar I am with that institution and the quality of their ultrasound. I've had a couple cases in the past that have made me very wary of many outside ultrasounds.

So in one instance, I had a patient that we performed an ultrasound on and did not see a pregnancy in the uterus, yet she had a positive pregnancy test, and she also had symptoms. So we referred her to her local hospital to evaluate for a possible ectopic pregnancy -- and this was a hospital in the Quad Cities -- and they sent me a report that said that there was an intrauterine pregnancy and referred the patient back to us the following

week to have an abortion.

We performed an ultrasound and still were seeing a suspicious mass in her adnexa. And we referred to her to the U of Iowa Hospital Clinics, not back to that hospital, and they diagnosed an ectopic pregnancy. So that report that I received from the local hospital was actually in error, and it was a very -- could have been a catastrophic error because she indeed did have an ectopic pregnancy as we suspected. And had it ruptured in the interim, she could have hemorrhaged to death. We're just lucky that it didn't and she made it back up to us and we were able to refer her to a more reliable healthcare provider.

Q. Based on these kinds of experiences, if you received an ultrasound report would you also want to see the images generated?

A. I would. But I'm not sure how that would really work in reality, because if you fax ultrasound images, they're too fuzzy to really utilize. I wouldn't -- I would want the actual radiographic images, which, again, could not be transmitted via email. Usually -- I mean, it's -- in the past, I've had a couple patients bring me a floppy disk with their ultrasound images, non-pregnancy related, when I was running a fibroid clinic at the University of Iowa, and even then it was hard sometimes to see those images on computers, just because of different technology

and computer systems. And I really don't know how amenable radiology seats and departments would be to producing those images.

Q. If you performed another ultrasound on a patient on the day of her procedure, would you need to charge for that ultrasound?

A. Yes. It involves time, patient-time, skills.

Q. And let's talk about the piece about risk factor and the counseling that you mentioned. If a local provider could not counsel your patient about risk factors, could you do this without the patient coming into a Planned Parenthood clinic?

A. No. We would need to establish the doctor-patient relationship and have her come in as a visit for that or do it via telemedicine, which, again, would be a visit.

Q. To do it via telemedicine, would that require her to come into a Planned Parenthood clinic?

A. Yes.

Q. Taking your more rural patients specifically, do you believe those patients could find a local OB/GYN provider for their screening?

A. Probably not, because there's a shortage of OB/GYN providers in the state, and those OB/GYN providers we do have available are often backed up in terms of their

schedules, so it could take several weeks to even months to get in for an appointment. Even if they were able to get a timely appointment, again, it would raise the issue of how do you make sure all the requirements of this Act are met.

Q. Do you think women would feel comfortable going to their local provider for preabortion screening?

A. I do not in most cases. Again, our patients are very protective of their privacy, you know. They're aware that health professionals are required to maintain confidentiality, but they would be encountering people in their local town's offices, their multiple office staff, lab staff, radiology staff, and they would just feel more comfortable not having all these people know that they're having an abortion, even if those people kept it to themselves.

Q. In your experience have patients ever been mistreated by local healthcare providers?

A. Yes. Unfortunately, we've had patients report to us that local providers when they've discovered they had pursued an abortion had insulted them, shamed them, if they had any sort of problems, saying this is what you deserve, making them feel guilty about it. And we've sometimes encountered hostility to our staff when we're trying to obtain medical records that we need to serve our patients.

Q. What are crisis pregnancy centers?

A. Crisis pregnancy centers are places where women with unintended pregnancies can receive services that are generally set up to dissuade them from having an abortion.

Q. Do some of these centers perform ultrasounds?

A. Yes. But I would not consider them to be reliable ultrasounds.

Q. Why is that?

A. Well, based on my experience with our patients, some have gone to a crisis pregnancy center prior to coming to us, and they have been shocked when we provide them the information about how far along in pregnancy they were, because they were given a very different impression by the crisis pregnancy center, either being a month earlier or two to four weeks later, to the point of, you know, barely even making it before the cutoff because they thought they had more time based on the ultrasound at the crisis pregnancy center.

Q. Based on these experiences would you feel comfortable referring a patient to a crisis pregnancy center for an ultrasound?

A. Absolutely not.

Q. Do you think women generally would -- women generally would feel comfortable going to a crisis pregnancy center for preabortion screening?

A. I don't. Again, I've had patients who tell us

about their experiences there, and they say they didn't know that it was anti-abortion but it became very obvious and it made them very uncomfortable and almost humiliated, you know, to be shamed about something that they were interested in having.

So what was the original question? Sorry.

Q. The original question was whether women would feel comfortable going to a crisis pregnancy center for a preabortion screening.

A. Again, there are privacy concerns for them as well.

Q. Can you elaborate on that?

A. Again, just having to go to another place, especially where they're feeling judged about their decision. And I have to be honest. I'm not even sure if the crisis pregnancy centers have medical oversight and how accountable they are held to the HIPAA standards.

Q. I would like to talk to you about how the Act would affect Planned Parenthood's provision of services. How many days of the week does Planned Parenthood perform abortions?

A. At some of our higher volume centers, we perform abortions two to three days a week. At other centers it's one day a week or even less.

Q. And what determines this schedule?

A. In general, you know, how many patients are making appointments and also staff availability.

Q. Can nonphysicians provide abortion services in Iowa?

A. No. Iowa law requires the abortions be performed by physicians only.

Q. If that were not a requirement, are there other licensed providers who are qualified to safely provide these services?

A. Yes. In some other states nurse practitioners and certified nurse midwives are able to perform abortions, and this is within their scope of practice.

Q. Typically how soon can Planned Parenthood schedule a patient seeking an abortion?

A. Usually within one to two weeks.

Q. Does this depend in part on the patient's own schedule?

A. Yes. So sometimes we'll have appointments available but it doesn't mesh with her schedule and her ability to make the appointment, so it is moved back a week.

Q. Would the Act affect this scheduling?

A. It would, because it would require a medically unnecessary visit, at least one additional visit, and the mandatory delay. So it would require every abortion

patient we had to have two visits, so double the appointments, but we wouldn't be able to, you know, do as many abortions in those cases in one day. So we wouldn't be able to accommodate our patients as well. We would likely be, you know, backed up for several weeks.

Q. If the Act goes into effect, what kinds of delay would you expect between the ultrasound visit and the abortion visit?

A. Even though it's a minimum of 72 hours in terms of delay, it would in reality translate more to a one- to two-week delay, just because we don't -- we wouldn't have all the appointments, as I said. We would be trying to serve our patients having abortions and also undergoing family planning services. And we wouldn't be able to see all the patients prior to that 72-hour mark.

Q. From a medical perspective, does it matter whether the patient has the ultrasound on the day of her procedure or some time before her procedure?

A. It does. Things can change. So, for instance, miscarriages are fairly common in early pregnancy. So about one in five to eight recognized pregnancies results in miscarriage. So if a patient had an ultrasound one to two weeks before the abortion, she may in fact have an undiagnosed miscarriage by the time of the abortion and then undergo an unnecessary medical procedure.

Q. Would the changes you've been describing affect your nonabortion services as well?

A. Yes. So most of our clinic staff provide family planning services on the days that abortion care is not being delivered, and we wouldn't want to jeopardize our mission of helping to prevent unintended pregnancies.

Q. Could you hire more staff to expand services?

A. Well, we're a nonprofit, and we are already pretty spread thin in terms of our resources. We -- our clinics only have so many exam rooms, and so it wouldn't work just to double staff. We can't just double patients and treat them in these facilities. It's also very expensive and costly, and I'm not sure that, you know, wouldn't be doing more abortions. So I'm not sure it would be sustainable to hire more staff. And it can also be difficult to find staff willing to work in this area of medicine.

Q. Can you say more about that?

A. So there's a lot of stigmas, as I said, surrounding abortion care. And, you know, a lot of backlash in this society. So people who have abortions, perform abortions, work in abortion care, can be the subject of harassment and real threats of physical violence. And even if a person really feels called to that -- to that area of medicine, their family members

might be very powerful in dissuading them from doing that work because of concerns for their personal safety.

Q. Are you personally concerned for your safety as an abortion provider?

A. Excuse me. Sometimes this topic makes me emotional. Yes. So I've been the target of harassment by antiabortionists in the form of emails and letters and threats and the subject of -- just the subject of attack.

Q. Dr. Meadows, do you need a break?

A. Just maybe a minute here. Okay. I'm okay.

Q. Are you sure?

A. Mm-hmm.

Q. Do you need water or anything?

A. I could use some more water.

Q. Sure.

A. All right.

Q. You okay?

A. Yes.

Q. Okay. If you were scheduling an extra visit to comply with the Act, would this affect the cost of abortion?

A. It would because of the additional staff time that would be involved. So it would unfortunately probably involve costs that would be passed on to the patient.

Q. Has Planned Parenthood had to comply with an

extra like mandatory delay law in any other state?

A. Yes. When we were affiliated with Arkansas, Arkansas passed a law that required a mandatory waiting period.

Q. How did the law affect your patients?

A. It was pretty disastrous for both patients and staff. So to accommodate the extra time involved with the visit, the extra appointment slots needed, staff were staying late in the evening, working extra hours, and patients were -- oftentimes were forced to find abortion services elsewhere even further away from where they lived because they weren't able to meet the medication abortion cutoff following the mandatory wait period implementation.

Q. If a patient is delayed in accessing abortion, how does that affect her?

A. Most patients as soon as they've made their decision they're sure, they want to proceed as soon as possible with the abortion to get on with their lives and regroup. So they're usually pretty upset if there's unnecessary delays, as I mentioned. And, again, it can be sometimes very physically distressing to be pregnant if they're having problems, and it can be hard to hide their pregnancy symptoms or keep private their abortion decision.

Q. Do you see patients who are suffering domestic violence?

A. Yes, we do.

Q. About how often do you see that kind of situation?

A. Oh, at least once a weak, and that's just me. So probably, you know -- we see plenty of patients, unfortunately, affected by domestic violence.

Q. Do you think the Act will affect these patients?

A. Yes. So in some cases these patients are particularly vulnerable because their partners may not be in support of their abortion decision. And if their partners knew about their decision to have an abortion, it might escalate their violence and put them in a further risk of harm. So adding that second appointment and the delay makes it harder to, again, keep it private from their partners.

Q. Do you see patients who are pregnant as a result of sexual assault?

A. Yes, we do see rape victims.

Q. About how often do you see these patients?

A. I would say at least once a month, if not more.

Q. How do you think the Act will affect these patients?

A. So it's already a very distressing situation and traumatic experience. So having to make multiple visits for the same issue might mean they're -- the patients are

reliving that trauma each time and being reminded of it. And then again, they just want to terminate the pregnancy as soon as possible so that they can emotionally move on.

Q. And I believe we already discussed patients who are terminating late in pregnancy because of a maternal medical condition or fetal anomaly. Do you think the Act will affect these patients?

A. Yes. Because it might put the abortion out of reach with the delay. They're already further along and close to the cutoff, and so they might not be able to access that care that they desire and deserve.

Q. Could it have other effects for these groups?

A. What was the initial question?

Q. I'm sorry. It was a very long question. Why don't I take them individually.

A. Okay.

Q. So talking about patients who are terminating later in pregnancy because of a maternal medical condition, do you think the Act will affect these patients?

A. Yes. It can be a threat to their -- to their life and health. So if there's a delay, the medical condition can worsen to the point of being life-threatening.

Q. Okay. I would like to refer you back to Exhibit 1, the copy of the Act. And if you could please

read to yourself the exception at Iowa Code 146B.1(6). It's on the bottom of the page 3 leading into page 4. Do you see that?

A. Yes.

Q. Does the Act have a medical emergency exception?

A. It does, but it's a narrow exception.

Q. In your opinion does this exception clearly cover all the situations where you think there's a medical risk to delaying a termination?

A. No, I do not. And I can give you an example. So if a patient has second trimester ruptured membranes, previability to the point where it's extremely unlikely that there would be survival of the pregnancy, the standard of care would be to perform an abortion right away to prevent the risk of infection developing which could lead to life-threatening sepsis. But under the Act, you won't be able to say at a particular point in time it is a threat to the woman's life, necessarily. So it's kind of engrained on those.

And there was a similar case in Ireland where abortion is illegal except life-threatening emergencies, and a women actually died as a result because by the time the infection became life-threatening, it was too late.

Q. I would like to return for a moment to patients who are terminating later in pregnancy because of a fetal

anomaly, either a lethal or a viable fetal anomaly. You mentioned the Act might affect these patients by pushing them past the gestational cutoff. Could the Act affect these patients in other ways?

A. Yes. So just, you know, knowing that the pregnancy is not viable or not healthy can also be psychologically traumatic for patients, and it's helpful for them to be able to have the termination so that they can move on mentally.

Q. Dr. Meadows, what are your ethical obligations to your patients?

A. So my main ethical obligations follow the main ethical principles in medicine in general: To preserve patient autonomy as much as possible, to practice nonmaleficences or do no harm, to practice -- when necessary, we try to help our patients as much as we can and also keeping social justice principles in mind.

Q. Is the Act consistent with these obligations?

A. No, it is not, in my opinion. It especially undermines patient autonomy. Again, it implies that her decision is not the right one, you know. It places obstacles in front of her in terms of accessing safe medical care, so it also violates nonmaleficences.

Q. Do your abortion patients feel stigmatized?

A. Yes. So not just from society in general as

we've alluded to, but they are also the targets of our protestors at the clinics. So when they come for an appointment they're subjected to hostility, yelling, threats, insults, and they're often very distressed to the point of being fearful by the time they come to us. And they're also sometimes afraid to leave the clinic after the appointment for those reasons.

Q. In your opinion will the Act increase this sigma?

A. It will. I mean, prior to the Act, it's being stigmatized. It also subjects our patients to more visits, more medically unnecessary visits where, again, they are the target of protestors at each and every visit.

MS. CLAPMAN: No further questions.

THE COURT: This would be probably be a good time for our mid-morning break, so we will do that. Take 15 minutes.

One question, though, before we leave. As I understand the petition in this case, the only challenge is to Division 1 of the Act. Division 2 concerns the 20-week prohibition, but that's not an issue with regard to this particular action; is that correct?

MS. CLAPMAN: Correct.

THE COURT: The only reason I ask is because we've had some discussion of the timeframes for abortions that could not be done. But you're just asking those

questions to show, in your opinion, the 20-day delay could be imposed by Division 1 of the Act?

MS. CLAPMAN: Yes, Your Honor.

THE COURT: All right. I just wanted to make sure I was clear on that. We will take 15 minutes.

(The bench trial recessed at 10:24 a.m.)

(The bench trial resumed at 10:43 a.m.)

THE COURT: Cross?

MR. THOMPSON: Yes, Your Honor. Thank you.

CROSS-EXAMINATION

BY MR. THOMPSON:

Q. Dr. Meadows, good morning.

A. Good morning.

Q. We've not met. My name is Jeff Thompson. I'm one of the lawyers who represent the State in this case. And I've got a little cross-examination and a few questions, but I will try to be brief.

First of all, just by way of background, are you generally familiar with the statistics related to abortion in Iowa and how it relates to the national picture?

A. Yes.

Q. And so are you aware that the U.S. rate for abortion has peaked in about 1990? Does that sound right?

A. Mm-hmm.

Q. And that it's been coming down?

A. Mm-hmm.

THE COURT: You need to say yes or no.

A. Yes. Correct.

Q. And if there's any time that I interrupt you, I will apologize in advance, because sometimes I do that. But if you don't understand my question, please don't hesitate to ask me to repeat it. Okay?

A. Okay.

Q. Thank you. In Iowa abortions peaked in 2006; correct?

A. I'm not sure how the peak related to the national peak.

Q. Well, I'm not -- I know the national peak is in 1990; right? I just -- in Iowa, are you aware that the number of abortions peaked in 2006?

A. I was not.

Q. Okay. Are you aware that the rate of abortions in Iowa -- which is the number of abortions measured against per thousand, I guess, women of childbearing age, correct -- is roughly half the national rate?

A. Correct.

Q. And in Iowa the trend is that the number of abortions is decreasing?

A. Correct.

Q. And so at one point in 2014 the number was the

lowest number in number, rate, and ratio since 2004. Does that make sense to you?

A. Yes.

Q. Okay. And then 2015, which is the most recent numbers that we have, those numbers were lower yet; right?

A. Yes.

Q. And so the trend is down?

A. Yes. That's the work of Planned Parenthood of the Heartland in part.

Q. Okay. And then in the state, generally speaking, if we look at 2014 and 2015, for 2014 the total number of abortions including what you described as medical and surgical is right around 4,000 -- 4,017. Does that make sense?

A. Yes.

Q. And for 2015 it's down a bit, but it's at 3,980. Does that sound right to you?

A. Yes.

Q. And of those totals, if I understand your testimony, Planned Parenthood of the Heartland performs a little over 2,000 -- a little over half, perhaps?

A. 3,000.

Q. A little over 3,000. You're right.

A. Yes.

Q. Exactly. It's 1,200 plus 2,100. So it's 3,300?

A. 1,200 surgical, yeah, and 2,100 medical. Correct.

Q. Perfect. So about two-thirds?

A. Of the state total?

Q. Yes.

A. I would need those numbers again to be sure.

Q. Well 3,000 and 4000, so pretty close.

A. Yes.

Q. All right. And so that's the context in which we start this discussion of abortion.

You're a named plaintiff in this case; correct?

A. Yes.

Q. And your organization Planned Parenthood of the Heartland is also a named plaintiff in this case; right?

A. Correct.

Q. You're aware that the Act, as you refer to it, has never gone into effect. It was stayed by the Court before it went into effect?

MS. CLAPMAN: Objection --

A. No.

THE COURT: Please proceed.

A. Our legal counsel was unclear whether certain portions of the Act were in fact in effect.

Q. Well, to be clear, the portion of the Act that's the subject of this lawsuit division --

A. Right. The 72-hour --
Q. -- was stayed by the supreme court?
A. Yes. I'm aware that the 72-hour wait has been stayed for now.
Q. Right. And that's what we're talking about; right?
A. Mm-hmm.
Q. And so, again, for context, there is no information that you have, no evidence, no data, that shows how the law has impacted any Iowan?
A. We experienced the full effect of the Act for a couple hours in between the law being signed by the governor and the state supreme court stay. And that couple hours was pretty painful for our patients.
Q. But you're talking about some scheduling, trying to reschedule a small group of patients, I think 43, who had -- actually had appointments that Friday morning?
A. Right.
Q. Correct?
A. Correct.
Q. Okay. And so, I mean, you've told the Court this morning about 72-hour delays and travel times, and all of the different things that you predict will happen, but none of this has played out yet because the statute has not been in effect?

A. Correct. But as I testified previously, we had experience with this similar requirement in the state of Arkansas during my tenure as the medical director of the Planned Parenthood of the Heartland.
Q. Sure. But to be clear -- and I think we'll talk about that in a minute. But my question to you is: No evidence, no information, no data of its impact on any Iowan because it has not been in effect?
MS. CLAPMAN: Objection. Mischaracterizes previous testimony.
THE COURT: Overruled. You can answer.
A. Can you restate the question, please?
Q. It's not -- this really isn't a trick question. The statute has not been in effect because it was stayed by the supreme court. So there's nobody subjected yet to a 72-hour delay or the mandatory second trip that you're testifying about; correct?
A. Not in Iowa, correct.
Q. Correct. And so today what you're talking about in both -- you talked about in your declaration of your testimony before the court is really a predictor of what might happen if it goes into effect; right?
A. Yes.
Q. And so you talked about some of the general problems, delays and scheduling; correct?

A. Yes.
Q. And you've identified some specific population subsets of your patients that might be affected; right?
A. I think all of our patients would be adversely affected.
Q. Well, but you have talked specifically about some that you've described specific issues for; right? I think; right?
A. Correct.
Q. And so you've talked about people who live many miles away from any center; correct?
A. Yes.
Q. But that -- I mean, people in Des Moines, for example, that wouldn't apply to?
A. But the medically unnecessary visit would apply to everyone.
Q. That's a different issue. But I'm asking -- in your testimony you've focused on describing certain specifics that might be unique facts and circumstances as to a particular patient or a group of patients; right?
A. Yes.
Q. You talked about rural Iowans; correct?
A. Yes.
Q. You talked about domestic violence victims --
A. Yes.

Q. -- in particular?
Have you reviewed the testimony of your expert Lenore Walker, for example?
A. No, I have not.
Q. Okay. Would you be surprised to hear that the numbers of people who present with the issues that you described are a very, very small percentage of your -- of your patients?
A. No.
Q. Okay. But my whole point is that some of the things you've described apply to people under specific facts and circumstances but not to all patients or all women seeking an abortion; right?
A. Not all women have been sexually assaulted, but, again, I would -- I believe I have testified to how the Act would adversely affect all of my patients.
Q. Well, you are, and you're going to get a chance to talk about that. We'll talk about that. But my point is: You have been very specific in testifying about particular hardships for people in different specific circumstances; right?
A. Yes.
Q. And some of those really deal with a very small proportion or percentage of the overall patient population that you serve. Would you agree with that?

A. No, I wouldn't, just because each patient is unique and has a set of individual circumstances that make an added trip to accessing abortion care more burdensome.

Q. Okay. Well, let me go to an example you used with the Court. You were talking about around 50 people who were -- that you saw in the last two weeks, I mean, the eighth week of their pregnancy that were within two weeks of the 20-week deadline; right?

A. Mm-hmm.

Q. And that -- and you said that it's possible that some of those people might ultimately be unable to actually obtain an abortion; right? You told the Court that?

A. Correct.

Q. But you don't know how many that would be. You can't quantify that?

A. Correct.

Q. And you don't know for sure. There's no data to show whether any of those people will be denied access to an abortion; is that not true?

A. Correct.

Q. And even if -- even if those, I think it's 47 in your other disclosures, I think you said about 50. If you look at those 47 or 50 people in the context of the patients that you serve, even if you limit it to the people who get surgical abortions, that's only 4 percent of the

population; right?

A. Yes, but --

Q. And it's a much smaller percentage of the overall patient population that you're talking about being affected by the Act?

A. I -- I want to just draw your attention to the testimony about the majority of our patients being low income or 50 --

Q. I'm going to interrupt you. I said I wouldn't, but I'm going to interrupt you. With all due respect, your lawyer is going to get a chance to ask you more questions, so it will really go better if we just -- if you don't understand my question, ask me, please.

A. Sure.

Q. Sometimes I'm not very clear.

A. Can you repeat the question.

Q. But I will ask it again so you can answer the question. So of this 4 percent of people who are scheduled, you know, who ultimately obtain a surgical abortion, it would be a much smaller percentage, like half of the people of your whole population seeking abortion; right?

A. For that one individual circumstance.

Q. Right. And so that's kind of what I'm going to try to get to, is that example that you had of maybe some

of these people might be denied access to abortion because they would be too late, even if you assume that's true and you can't quantify it, it applies to a very small percentage of your patients; right?

A. Correct. But if you're that one patient affected, it's a major life issue.

Q. And to be clear, I'm not minimizing any of that. And you've given testimony about individual patients and your duty to individual patients. But you understand that this is a challenge, a Constitutional challenge to a statute. Do you understand? I mean, that's what the lawsuit is?

A. Yes.

Q. And you're challenging it's Constitutionality on a blanket basis; right?

A. No.

Q. You're not? You're only challenging it as to how it applies to that 4 percent?

A. I don't know what you mean by "a blanket basis," I guess.

Q. Well --

MS. CLAPMAN: I would object to any question that calls for a legal conclusion.

Q. So to be clear --

THE COURT: Hold on a second. I'm not going to

rule on the objection because there's not a question pending.

Proceed with your next question.

MR. THOMPSON: I'm going to restate, Your Honor.

Q. I'm not minimizing the impact on any single plaintiff or any single patient.

A. I guess for me, blanket means without consideration or specifics or using intellectual analysis. So that's why I said I didn't think it was blanket because there's a lot of intellectual analysis that goes into our challenge.

Q. Right. I get that. But how about there's no specific patient here as a plaintiff in the case; right?

A. No.

Q. So none of these -- of those 4 percent have said under these circumstances, under my circumstances, this statute is un-Constitutional?

A. Correct.

Q. But your testimony -- let's get back to what you testified to earlier. I mean, you have said that it's possible that some of these people might be unable to obtain an abortion, but you don't know whether or not they -- that will be true?

A. Correct. But I know from past experience some patients have not been able to obtain an abortion.

Q. But even before the 20?
A. Mm-hmm.
Q. And so you can't give the Court --
A. If they meet the cutoff.
Q. But you can't testify to the Court that you're certain that any of these people will be denied an abortion?
A. Based on my experience, I am certain that it would move people out of the range of having the abortion in Iowa or the method of their choice.
Q. Well, that's different. Now, the method of your choice is one thing, but to be moved out of the range for any access to abortion is something different; right?
A. Yes.
Q. And so how many?
A. I don't know.
Q. Because you have no basis for which to say how many?
A. I have the basis of my experience to date, but I can't predict how many.
Q. All right. And so just to, I guess, close that loop, you were talking about the people who present towards the end of their pregnancy, that you talked about the 50. You've also testified about people who prefer a medication abortion; correct?

A. Correct.
Q. And that some of those people, I think your words might be pushed back into later in the calendar so that they would not be able to obtain a medication abortion; right?
A. Correct.
Q. And that that would -- I think you testified that many of your patients prefer medication abortion?
A. Yes.
Q. But as you sit here today for Judge Farrell, you can't say with any level of confidence how many people will be denied access to medication abortion; right?
A. I can make an educated guess based on our numbers, but I can't give you an exact figure today.
Q. Okay. One of the things that you testified to the judge about was the requirements of the statute. And I think that you talked about the need for an ultrasound, the information, and then you talked about the delay. You told the judge that you do an ultrasound already; right? That's something --
A. Yes.
Q. -- that you do as part of the process?
A. We do, yes.
Q. You provide information and options to your patients?

A. Correct.
Q. And you also, I think, testified that if you have a patient who expresses uncertainty about the decision, I think in your words, were not firm about the decision, that it's your advice to take some time and think about it; right?
A. Correct.
Q. And why do you do that?
A. To make sure that the patient is undergoing the procedure with full consent.
Q. Okay. And you talked with the Court about something called informed consent; right?
A. Yes.
Q. And that's -- in the medical word, that's a term of art. There's kind of a legal concept of informed consent; is that correct?
A. Yes.
Q. And it's -- there are certain standards that deals with the doctor's obligations to the patient, and it is to ensure that the patient is consenting to the procedure?
A. Correct.
Q. Fully informed?
A. Yes.
Q. The statute doesn't try to substitute that. You

understand that. In other words, it's not just an informed consent statute, because it's actually designed -- I mean, it is the purpose of the statute and the law is to, in addition to considering the risks of the procedure, to encourage a potential patient to consider whether or not they want to choose the procedure at all. Do you understand that?
A. Could you rephrase the question, please.
Q. It's -- the statute is more of an informed choice preference than informed consent statute. There's a separate statute that deals with informed consent, correct, as a doctor?
A. Yes. It doesn't substitute informed consent.
Q. Right. And it doesn't -- it doesn't purport to substitute for your informed -- or substitute for your informed consent obligations with your patient. You understand that?
A. Correct.
Q. It does -- it does create another step that's designed to encourage an informed choice and informed decision about whether or not to pursue the procedure; right?
A. I wouldn't call it that, but you can call it that.
Q. Okay. One of the things that's unique about kind

of where we are today, you're here again, as we've talked about, there's -- the law hasn't gone into effect, and you're giving opinions and making predictions about what's going to happen; right?

A. Based on our experience with our patients, yes.

Q. It is. And a lot of what you're testifying about, I mean, you have under your own control; right?

A. Can you be more specific?

Q. Scheduling. Staffing. Access to compliance. I mean, there are a lot of things that -- decisions that Planned Parenthood of the Heartland makes unrelated to the statute that affect some of the things that you talked about today; right?

A. Yes. Those aren't necessarily my control though.

Q. I'm not blaming you. I'm just -- I think one of the things we need to get clear here is we're here to talk about the statute, but you've testified about scheduling issues, closing of clinics; right?

A. Mm-hmm. Yes.

Q. Staffing problems?

A. Yes.

Q. Other care providers who, at least based on your testimony, don't appear to be taking their ethical obligation very seriously with their patients; right?

A. Yes.

Q. Societal issues?

A. Yes.

Q. Right? Protesters. All those things.

A. Yes.

Q. I don't minimize the reality of those, but none of these are created by the Act; right?

A. No.

Q. And even -- you've got an expert, and I think --

A. I would amend that. The scheduling difficulty would be directly impacted by the Act, but the protesters aren't caused by the Act. Correct.

Q. Well, we'll talk about scheduling in a minute, because, I mean, in part, you do have a role in the scheduling. I mean, you've testified that you schedule abortions one or two days a week; right?

A. It depends on the center.

Q. Right. And your staffing decisions -- I'm not -- I'm not minimizing that, but I'm trying to focus the decision about what things are being caused by the Act itself. Do you understand that?

A. Sure.

Q. And so, I mean, you, for example, were a plaintiff a few years ago in another case against Iowa. Do you remember that? We call it the telemed case; right?

A. Yes.

Q. Planned Parenthood vs. State. And you provided testimony back in 2013, I think -- yeah. October 2013 -- about it. And at the time you testified that you had 15 clinics in Iowa. Does that ring a bell?

A. That sounds right.

Q. And you told, I think Judge Farrell -- certainly you told the Supreme Court -- that if the rule went into effect you would have to close some of those clinics and it would make access more difficult for your patients and there would be caused delays and many of the things you told Judge Farrell today; right?

A. Yes.

Q. And you won that case, and the rule did not go into effect; right?

A. Correct.

Q. But you closed clinics anyway; right?

A. Yes.

Q. And you made that decision for reasons other than Iowa law or certainly this Act, because it occurred before this Act and reduced services to rural Iowans for your own institutional reasons?

A. It did increase access, though. Studies have shown that women were able to get abortions earlier in pregnancy with the telemedicine abortion care that we provide as opposed to later, which is, as I have testified,

much safer for patients.

Q. And I'm not here to fuss with you about that. My whole point is you closed before this Act went into effect. In June of this year or July of this year, you closed a significant number of your clinics; right?

A. Yes.

Q. And these are the clinics that when we talk about how many miles away patients would be from the closest clinic to be able to get this 72-hour screening, they're closed now?

A. Yes. We had to make tough financial decisions to best serve as many patients as we could with our limited resources.

Q. I'm not -- again, I'm not -- I'm not fussing at you about it. It's just the reality. It's the facts. And that wasn't caused by this Act. It was a decision made by your organization; right?

A. Yes.

Q. And that as you've already testified, before this Act -- the Act we're here to talk about, Senate File 471 became the law, you made a decision to close three more; right?

A. Three more and one more to go.

Q. Right. And so to the extent that you're predicting that there's going to be a lot of scheduling

issues and delays because of lack of access, in part, there are factors involved that weren't created by the Act that we're here to talk about; right?

A. You lost me again.

Q. The Act couldn't have created -- didn't force you to close the clinics that were closed before the Act was even passed.

A. You're talking about the current Act not the telemedicine case?

Q. Correct.

A. Yeah. We have not closed clinics due to this Act as of this time.

Q. Right. And so the world, the framework, in which we analyze this statute is what existed prior to the Act, and that was the framework that existed after you had made a decision to go ahead and close some clinics; right?

A. Can you rephrase the question?

Q. You had already decided to close the clinics before the Act was passed?

A. Due to separate legislation that was passed.

Q. So you're saying all the -- all the clinics that you have closed since 2012 you closed because of legislation?

A. No. I'm talking about the most recent four clinics.

Q. Okay. Other legislation but not this Act.

A. Correct.

Q. Okay. And then other decisions that are, I guess to, some degree within your power, you talked with the judge about the fact that you don't believe that you can rely on ultrasound done by somebody else other than Planned Parenthood; right?

A. It would depend on the source.

Q. Right. Well, I mean, you've pretty broadly said that in your opinion that potential patients don't really have access to other ultrasound. Isn't that what you told the judge?

A. They have access, but I couldn't necessarily rely on the quality of the ultrasound examination. I could at the University of Iowa Hospitals and Clinics.

Q. Okay. And I think in that testimony you used an example of a single plaintiff, single patient, that had a particular problem that you caught after the fact that could have been bad. You didn't name the clinic or the hospital, but it was one hospital or clinic; right?

A. Yes. I have had other patients as well.

Q. But so a clinic that has, you know, a licensed physician and a licensed radiologist, perhaps a board certified radiologist, you know, reading the ultrasound and providing reports. It's your testimony that you don't

think that you can rely upon those?

A. In some cases I've had -- in that situation those were -- conditions were in place, but the ultrasound report was obviously erroneous. And I've had other situations involving other local hospitals as well.

Q. But those have caused you to have a general rule that you won't rely upon other ultrasound?

A. Correct.

Q. But you've decided --

A. Depending on the source. I need to be familiar with the source.

Q. You keep saying that. You keep saying "depending on the source."

A. There's a lot of hospitals in Iowa, but there is some that I know are reliable.

Q. But, again, you're choosing. You're kind of making a judgment about what you can and can't rely upon?

A. Based on my experience, yes.

Q. And you've also told the judge that you won't refer for that reason. That rather than trying to schedule yourself when somebody calls, you won't refer them to a local clinic or hospital for this because you're concerned that the local treaters won't do a good job?

A. Yes.

Q. And you testified that even now you're scheduling

appointments one to two weeks ahead of time; right?

A. Some of the time, yes.

Q. And, in fact, in your disclosure, you said one to three weeks. So is that -- are things getting better?

A. It depends on our schedules versus the patient's schedule.

Q. Right. But just hypothetically -- and I understand what you told the Court. But if you adjusted your process from the way you used to do business to the way this Act might require you to do business, and, I mean, you could literally refer somebody for an ultrasound to a provider closer to home or another provider in time to have it done before the first appointment date for the procedure; right?

A. No. Because usually the patients aren't scheduling sooner because they have their own barriers to getting off of work or arranging childcare or transportation. And that would hold true for making any medical appointment.

Q. So the two- to three-week or the one- to three-week number you told the judge is because of the patient's problems or your scheduling problems?

A. It's, as I said, a combination.

Q. Okay. All right. So in some cases -- so I guess now I'm confused, because I really interpreted the

testimony you gave both in your disclosure and in that you're so busy that the staffing is thin and that if somebody called today to try to arrange even the first visit, that they would have to wait one to two weeks in order to get the first visit. Is that not what you said?

A. No. It can take up to one to three weeks. And it can occasionally happen within one to two days.

Q. All right. So you have some flexibility, right, in terms of making decisions about how to use those available slots. Some are available that quickly; right?

A. Can you rephrase the question?

Q. I think I was under the impression that the delay was something that created a timeline that then if you add 72 hours to, it gets longer and longer. What you're saying --

A. It does.

Q. -- it's fact specific, and somebody literally could call and get an appointment in two days?

A. Sometimes. It depends. You know, there's variation in terms of the demand, and sometimes we're busier than others. Sometimes our providers are on vacation or at conferences. And so that influences it. There's more factors.

Q. Sure. But I just -- you know, we've -- a little while ago, you and I talked about the approximately 50

people who are within a couple of weeks of 20 weeks, and so it's not that they can't call you up and, perhaps, if it's an exigent situation, get an appointment in a couple of days; right?

A. If their life schedule, finances, allows it, yeah.

Q. All right. So this is back to something you and I were just talking about. It's not just the scheduling issues; that a lot of the factors that you're talking about about the cause of these delays are specific to specific patients?

A. Yes. If the Act were to go into place, though, we're not talking about one opening here or there that's available within a short time period. We're talking about doubling all of the patients. So instead of, you know, these 3,000 abortion patient visits, that would be 6,000 visits for 3,000 abortions. So that it's --

Q. But they're different visits. Let's be honest here; right? I mean, it's not the same visit.

A. I know. But currently we don't have the capacity to handle that.

Q. Okay. So it's a capacity issue?

A. In terms of our staff and our finances, etc. so...

Q. And you talked about --

A. We would have to pass those costs on to the patient.

Q. Okay. And so one of the things I was going to ask you is: How often do you set up an appointment just to do an ultrasound for somebody to confirm and date the pregnancy?

A. We don't do that as part of our policy.

Q. At all? You don't offer that at all?

A. No.

Q. Why not?

A. Why not?

Q. Yeah.

A. It's our policy to perform and evaluate for patients who are coming in for abortion care.

Q. So you don't even offer the option of providing an ultrasound to date and confirm pregnancy unless somebody has called to schedule an abortion; right?

A. Correct.

Q. And so you testified, for example, about crisis pregnancy centers. And kind of generally, I think, your testimony suggests that in your opinion they're all the same, that they discourage pregnancy, that in your personal experience they're judgmental and various things. Is that really based upon personal experience with all the different centers throughout Iowa?

A. It's based on my experience with my patients. I can't tell you exactly which centers they went to. They don't necessarily name the name or the place, but --

Q. So you don't know, really. If I give you a name, you wouldn't know. So you know that InnerVisions, for example, provided testimony in this case. Do you know anything about their operation?

A. No, I do not.

Q. You don't know whether a radiologist reads their ultrasounds, whether their operating procedures require them to be nonjudgmental and to facilitate the patient's decision making. You don't know that at all?

A. Correct.

Q. And since a woman can't call you and just say, hey, I would just like to get an ultrasound to confirm my pregnancy and date it so I can figure out whether I'm pregnant or maybe who the father is, you turn them away; right?

A. No, we don't necessarily turn them away.

Q. Well, you don't do that. You just told me. You don't do that. You don't do the procedure that way?

A. Right. They need to schedule an abortion and appointment for an abortion.

Q. And so --

A. But this -- we diagnose a miscarriage, we provide

miscarriage management options. If they don't want to pursue the abortion, they have that information available to them, and then we are happy to forward their records to anyone they choose.

Q. Sure. But -- and I'm just trying to sort this out in my head, is that when you say 95 percent of the people that you see have kind of a firm -- they've made a firm decision that they want to have an abortion, it's because you don't schedule them unless they're scheduling an abortion; right?

A. Correct. It just that -- the standard of care in obstetrics and gynecology is not to do ultrasounds under 20 weeks. So at the University of Iowa Hospitals and Clinics when I worked there, people would not just schedule appointments on their own for ultrasound dating. They establish that they're obtaining prenatal care, and then it would be performed at certain junctions in the pregnancy where it would give the most valuable information.

Q. All right. I have sat up there for you what's been marked as Petitioner's Exhibit 35 and ask you if you can pick it up. And you've already told the judge -- the judge knows you are the plaintiff in the case, but as part of your role as plaintiff in the case have you reviewed the disclosures that you filed and the expert reports that were filed?

A. Yes. That I filed, yes.

Q. And so you're familiar with Dr. Grossman; right?

A. Mm-hmm. Yes.

Q. He's going to come testify this afternoon. And so this is one of the articles that Dr. Grossman cites, and it really kind of deals with two general issues that you've talked to the judge about. One is I think what you called decisional certainty. Is that what -- let me get the right term. Yeah. Decisional uncertainty. But basically the decision-making dynamic; right?

A. Yes.

Q. And it also deals with delay, which is something you talked to the Court about; right?

A. Yes.

Q. And to be clear, you're making some predictions based on your experience. I think you also referenced to the Court Arkansas -- that Planned Parenthood had some experience in Arkansas; right?

A. Yes.

Q. But are you -- I mean, this article, which is Exhibit 35, it is titled "Utah's 72-hour Waiting Period for Abortion: Experiences Among a Clinic Based Sample of Women." It is in *The Journal of Perspectives on Sexual and Reproductive Health*, and it was published in 2016. This is a published study that deals with a 72-hour waiting period;

right?

A. It looks like that, yes.

Q. 72-hour waiting period with two visits; right?

A. Yes.

Q. And so this is a scientific study that looked at 309 women who presented to a clinic, not unlike your framework. In other words, these are folks that presented to an abortion provider and then they did a study about it. Okay? Are you familiar with this at all? The finding of this study?

A. I've seen the article before --

Q. Okay.

A. -- but I'm not very familiar with it right at this moment.

Q. Well, let me -- let me ask you to look at page 182. And I have kind of conveniently -- if you take that clip off to kind of help you, if you just flip the page, I have put tabs to help you find what I'm going to point to. So if you flip it over and look up in the right-hand corner of page 182. And I've got a tab up there by the paragraph that starts with the words: That baseline. Do you see that?

A. Yes.

Q. And the reason I tabbed this, is because it's the number of -- the same number that you told the Court about

about the level of people who were, I think, firm in their decision when they came to your clinic, right, 95 percent?

A. Yes.

Q. And so can you read that paragraph that starts with: At baseline?

A. "At baseline, 95 percent of women indicated they would prefer to have an abortion, 4 percent preferred to have the baby and raise it, and fewer than 1 percent preferred to have the baby and place it for adoption."

Q. Okay. Go ahead.

A. "The mean decisional conflict score was 15 (range 0 to 69), indicating low conflict. 71 percent of women had scores indicating low conflict, and 8 percent had scored indicating high conflict (not shown.)"

Q. That's good. Stop.

So this idea of high conflict/low conflict, you understand that they actually study in the medical profession the measures of how conflicted somebody is about a decision. Are you familiar with that concept?

A. No.

Q. That's what they did here?

A. Right.

Q. And so if you've got -- as we go through what you just read -- 95 percent of the people, of the sample, said that they were -- they preferred an abortion, that's the

starting point, the baseline, if you will. And of those 95 percent, 71 percent of the women had scores indicating low conflict. So kind of along this end of the scale, which is actually 0 to 25, and in the study, it talks about it being a level of confidence that essentially means they're implementing a decision. They've made up their mind. Does that make sense?

A. Yes.

Q. On the other end, it says that 8 percent has scored indicating high conflict, which is they're conflicted. They don't know what they want to do for sure. They are unsure. And that's over on this other end of the spectrum, and those are higher numbers. And so you've got 71 over here that are certain. You've got 8 that are, like, really not certain, and then squeezed in the middle is another 21 percent that aren't -- that are less than no -- or greater than no conflict. So you've got 29 percent of the people, of the 95 percent, who are not absolutely sure. Okay? Does that make sense?

A. (The witness nodded her head.)

Q. Then if you will flip to page 185 -- and now this is going to be on the left-hand side, the tab that I've got for you -- and see the paragraph that begins: Other advocates?

A. Yes.

Q. And then the sentence starts with: 8 percent. Can you read that sentence?

A. "8 percent of women reported changing their minds."

Q. Okay. And it goes on to note that changing the mind kind of depends on how you categorize changing the mind. And if you follow down further in that paragraph, you'll see that they -- it's 8 percent of kind of the broader group, but it's only 2 percent of the people who were, you know, all in the 71 percent that were absolutely certain. Do you see that?

A. Just a second. I would like to read this whole paragraph, if I may.

Q. You got it?

A. Not quite.

Q. Okay. I'm sorry.

A. Okay.

Q. All right.

A. Go ahead.

Q. Okay. And so -- and if you flip to the front page, the very front page, even in the results --

A. Did you have a question about this? I don't feel like I --

Q. No, not yet. We'll go back.

A. Okay -- answered it.

Q. So even on the results of the abstract, it says 8 percent were no longer seeking an abortion. Do you see that on the abstract, on the results?

A. Yes.

Q. Okay. And so if we take -- and it seems like a little number, but if we take 8 percent of these people that were firm --

A. But that 8 percent includes people who had miscarried and were not pregnant.

Q. It actually doesn't. But if you will just wait for a question it would help. It would be best. And, again, your lawyer can ask you questions about this --

A. Sure.

Q. -- if she wants.

I just want to get to the point that 8 percent changed their minds, you know, in a clinical setting where people, 95 percent, said they preferred an abortion when they walked in. If you take 8 percent times, you know, the 4,000 abortions performed in Iowa, for example, I mean, that's -- that's -- excuse me -- it's 320 people; right?

A. I'm disagreeing with the numbers based on my interpretation of this article.

Q. It is. But with all due respect, you need to answer my questions, and your lawyer can talk to about that.

A. Okay. What is the question?

Q. Is that would you would agree that 8 percent of 4,000 is 320?

A. As the mathematical calculation, yes, but I don't believe in that number being how many changed their minds.

Q. Okay. And of the about 3,000 abortions that you performed of people that scheduled the abortion and come in and that you've testified are firm, I mean, that would be 240 people if you just take the 8 percent; right?

A. What's the question?

Q. Math --

A. Sorry. Just a math figure? Okay.

Q. That would make it 240 people out of the population that -- your patient population, if assuming you take that number and it translated. I'm not saying it does, but I'm just using it as an example.

A. I don't think you have to -- sometimes our patients change their mind. They need more time, and we recommend more time to think about it. And so those patients would fall under the changed their mind category, but then they end up having an abortion because they do come back to us one week, two weeks later, sometimes a month later and still have a abortion.

Q. Right. But you understand in this study of a 72-hour waiting period, these are the people who didn't

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come back and that not --
A. For what time course? Because I haven't had time to review the whole study.
Q. Not just didn't come back, but then were interviewed and said, I'm no longer seeking an abortion.
A. From what time course?
Q. What do you mean "what time course"?
A. How long did they go out? I'm just curious.
Q. You want to know when they followed up with them or --
A. How many weeks later.
So, as I said, sometimes our patients come back a month later, or two months later and still have an abortion. So I would just qualify that it doesn't capture all the patients who end up coming back for an abortion.
Q. And that's fair. And I'm -- again, you can interpret it. Your lawyer can talk to you about it. But the proposition that people when they walk in just aren't going to change their mind is just not true based on that data set; right?
A. Can you rephrase the question, please?
Q. That data set shows that people that walk in and say, hey, I'm firm, I prefer an abortion, some people -- some of those people actually change their minds?
A. I would like to read this other sentence that

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directly followed what you had me read.
Q. Sure. Go ahead.
A. "Our estimate of 2 percent changing their minds from unconflicted at the information visit to continuing the pregnancy is in the range of the proportions found changing their minds (1 to 3 percent) in settings with no or minimal waiting periods."
Q. Right. So that's the unconflicted part?
A. That's a very small number --
Q. That's 2 percent.
A. -- among those that I've seen in my experience.
Q. Sure. But 2 percent, those are the absolute people, 2 percent of 4,000 is what? That's a lot of people?
A. I don't understand the question.
Q. I mean, it's still not an insignificant number of people who change their minds; right?
A. I don't understand the question, because as I said, we have about that number who do change their minds, and we accommodate that and support patients with that decision not to have an abortion.
Q. All right. Okay. So just --
A. The Act doesn't change that, in other words.
Q. Kind of back to this study, which is -- this is a published study about a 72-hour waiting period. You

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understand that?
A. Yes.
Q. So this is data that's been peer-reviewed and published?
A. I haven't had time to revisit this as often as you have.
Q. I understand.
And then the other issue is the delay, the question of delay. And there's been testimony today that under some circumstances some people might not be able to obtain either the abortion they prefer or any abortion at all; right?
A. Yes.
Q. And you told me that that's a prediction, and you can't specify how many because you just don't know?
A. I can provide an educated guess in terms of numbers, but not right here on the spot.
Q. Right. And this study studied a 72-hour period with two visit requirements. And if you go to page 84 -- 184, down in the right bottom corner, where it starts with: Discussion. Go ahead and read the first sentence.
A. "Overall, Utah's 72-hour waiting period and two-visit requirement did not prevent a woman who presented for information visits at the study facilities from having abortions, but it did burden women with financial costs,

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logistical hassles, and extended periods of dwelling on decisions they had already made. They also led some women to worry they may not be able to have the type of abortion -- excuse me -- they preferred and pushed at least one woman beyond her facility's gestational limit for abortion."
Q. Okay. And you kind of went on, so go ahead and read, if you would -- just go ahead and read the next two sentences of that next paragraph.
A. "Our findings raise questions about some aspects of advocacy arguments and are consistent with others. For example, although some advocates argue that logistical difficulties presented by two-visit requirements and waiting periods make women unable to have abortions, this was not the case in our study cohort."
Q. All right.
A. "However, we did find that having to make two visits created logistical and financial difficulties, including increasing the cost of having an abortion by about 10 percent. We also confirmed findings from other states" --
THE COURT: Hold on a second.
I think the response was done.
MR. THOMPSON: I haven't asked a question.
A. Oh, I thought you wanted me to keep reading.

Sorry about that.

Q. No. I think we are done with that.

Let me, then, focus for a minute and just see whether we can wrap up. You're familiar with the Act. You have testified about the requirements of the Act; right?

A. Yes.

Q. And you would agree with me that the Act does not take away a woman's right to make the ultimate decision about whether or not to have an abortion?

A. It may take away her ability to have an abortion, but not the decision to have an abortion.

Q. Okay. So let me go to the other point. You agree that it doesn't take away her ability to make the ultimate decision?

A. Correct.

Q. And you have said that you think that it may affect or impede her ability to obtain an abortion; right?

A. Yes. And especially the method of her choice.

Q. But you would agree with me that the Act, if you look at the statute and its requirements, doesn't directly interfere or prevent with the ability -- a woman's ability to obtain an abortion?

A. It does interfere with her ability to obtain an abortion.

Q. Well, does it indirectly? So does it directly

affect the ability to obtain an abortion?

A. I believe it does.

Q. Okay. In what way?

A. By making it more difficult logistically and financially and privately to have an abortion.

Q. Okay. So those effects that you're talking about -- scheduling, cost, stigma, you mentioned a lot of them -- and none of them are actually in the Act; right? I mean, those are collateral consequences of the two visits; right? Would you agree with me on that?

A. Yes. It doesn't say you must increase the cost of an abortion this much, right. You're right about that.

Q. I mean, those are indirect effects of the law?

A. Correct.

Q. Not direct effects of the law?

A. Well, a direct effect is having to make two visits. I guess it -- to me, it's direct, indirect, it's a semantic issue. But for me it's almost direct, but --

Q. And you would agree with me that when we talk about these effects, whether we call them direct or indirect, it's difficult to separate what's caused by the Act from all the other things you and I have talked about, the, you know, the healthcare system, the lack of general access to the healthcare system for rural Iowans. That's something not created by the Act. It's the context; right?

A. Yes. But in the context, I don't see the separation that you do.

Q. Right. And the societal attitudes that you talked about isn't caused by the Act?

A. No, but increased. I mean, it's expanded, but yeah, the exposure.

Q. And Planned Parenthood's own decisions before the Act was even enacted to close rural clinics is something that is a factor here as well; right?

A. I don't understand the question.

Q. Planned Parenthood's own decisions to close clinics before the enactment of this law is in part, part of what we're dealing with here in terms of access and scheduling and driving time, and all the things you've talked about today?

A. Our decisions to close the clinics -- what was the question? Sorry. I just don't understand the question.

Q. Can you separate the logistical issues, the staffing issues, the scheduling issues that you have had in your operations that preexisted the enactment of this statute? The fact that you went from 15 clinics to 8 from 2013 to before this statute became, can you separate that from the problems that you're describing of access?

A. I can. Those are separate causes than what the

Act would cause.

Q. How?

A. The Act itself would impose -- would cause -- create more logistical burdens for our patients on top of those that already do exist.

Q. There you go. So there are already logistical problems that exist?

A. Yes. But that would make those -- increase them exponentially.

Q. All right.

MR. THOMPSON: I don't have any further questions. Thank you.

THE COURT: Thank you.

Redirect?

MS. CLAPMAN: Yes, Your Honor. Brief redirect.

REDIRECT EXAMINATION

BY MS. CLAPMAN:

Q. You discussed with counsel for the State some categories of women who maybe don't make up the majority of your patients. The number of women who are anxious to proceed with the abortion, is that a small percentage of your patients?

A. No. That's -- the majority or our patients would fit into that category.

Q. The number of patients who have difficulty

scheduling an abortion, is that a small percentage of your patients?

A. No. That's, again, the majority of our patients.

Q. The number of patients who have difficulty scheduling around their work obligations, is that a small percentage?

A. No. That's a large percentage if you also add school courses, classwork.

Q. And the number of women who have difficulty arranging for childcare so that they can come for their appointment, is that a small percentage of your patients?

A. No, that's a significant percentage as well.

Q. The number of patients -- the abortion patients which have transportation limitations reaching the clinic, is that a small percentage of your abortion patients?

A. It's more of a minority. It's not the majority, but it's a substantial number.

Q. You discussed with counsel for the State that the number of abortions has been decreasing in Iowa. Why is that?

A. We believe that it's due to better access to contraception, including or own efforts to decrease unintended pregnancy rates.

Q. And you discussed with counsel as well a study which is Exhibit 35. For the record, it was the Roberts

Study on the Utah mandatory delay period; correct?

A. Yes.

Q. Do you recall the last time you read this study before today?

A. I do not.

Q. Okay. So you haven't recently reviewed it?

A. No, I have not.

Q. Would you need to reread the study in full before opining about its findings?

A. Yes, I would.

Q. You testified that based on your experience women will not be able to obtain abortions. Does the fact that you don't know the names of the specific women who won't be able to make you any less certain that for some women this will be the result?

A. No.

MS. CLAPMAN: No further questions.

THE COURT: Anything else, Mr. Thompson?

MR. THOMPSON: No, Your Honor.

THE COURT: Thank you for your testimony. You can step down.

Should we get started with your next witness?

MS. RATAKONDA: Yes, Your Honor. And he's outside, if we can bring him in.

THE COURT: Who is it?

MS. RATAKONDA: I'm sorry. It's Mr. Reynolds. Jason Burkhiser Reynolds.

THE COURT: Jason?

MS. RATAKONDA: Burkhiser Reynolds.

THE COURT: Will you raise your right hand, please.

JASON BURKHISER REYNOLDS,

called as a witness, having been first duly sworn by the Court, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. RATAKONDA:

Q. Mr. Reynolds, can you please introduce yourself to the Court?

A. Yes. My name is Jason Burkhiser Reynolds. I am the center manager of the Rosenfield Health Center for Planned Parenthood of the Heartland on the south side of Des Moines, Iowa.

Q. How long have you been the manager of the Rosenfield Health Center?

A. I've been the manager of this health center since October of 2015.

Q. What medical services are offered at the Rosenfield Health Center?

A. There are a number of services offered at this health center, including SDI screenings, family planning

services, including birth control, long-acting reversible contraceptives, cancer screenings, well-women exams, pap smears, as well as surgical and medication abortions.

Q. How many days per week are abortions currently performed at Rosenfield?

A. Currently three days per week.

Q. Are surgical abortions performed on all three days?

A. They can be, yes.

Q. Do you work at the health center on the days that abortions are performed?

A. Yes.

Q. Currently what are your duties as the health center manager?

A. As the health center manager, my main duty is to supervise employees. I tend to fill in to a role that they call the flow facilitator. It is to kind of jump in at different places in the clinic to help out. So I do have patient contact at that point as well.

Q. Do you interact with abortion patients as well?

A. Yes.

Q. And in what way do you have contact with them?

A. Yeah. So depending on the day, I might check in patients. I will room them to different areas. I will also perform what we call the patient education sessions.

Q. And you mentioned supervising staff. Do you train staff as well?
A. I do.
Q. Have your duties been the same since you started at Rosenfield in October 2015?
A. They have changed a little bit. In -- since about March, we made a couple changes in the clinic.
Q. What are those changes? What were your duties before?
A. Yes. So previously I was still supervising employees in the overall clinic, but my main duty at that point was really those patient education sessions.
Q. So can you briefly describe what a patient education session is?
A. Yes, of course. So, really, the main part of this is going -- ensuring that the patient is firm in their decision for an abortion.
Q. Before the recent change in your role, how many abortion patients did you speak to per week through the patient education process?
A. Through any of my normal weeks, it would be between 10 and 20 patients.
Q. And how many abortion patients total have you spoken to as part of the patient education process in your time at Rosenfield?

A. I would say well over 500 patients.
Q. How long does a patient education session usually take?
A. It's hard to place a number on that, but -- because we spend as much time with the patient, as long as they really need. It can really vary around between 30 to 45 minutes.
Q. Are you familiar with the financial circumstances of an abortion patient who has come to Rosenfield?
A. Yes.
Q. How are you familiar with this?
A. As in how does that come about --
Q. Yes.
A. -- or how do I interact with patients?
Q. How does that come about that you are familiar ?
A. So during these patient information sessions , the patient education, one of the things that we really try and do is ask open-ended questions, those tend to be where people really open up to us about their decision to be here, why they're there, those burdens that it took to get to those appointments as well, which a lot of times those are financial issues related with the abortion.
Q. How much do these discussions come up in your conversations with abortion patients?
A. I would say most patients we probably discuss

something to do with financial.
Q. And taking a step back, if a patient wants to have an abortion at Rosenfield, what is the first thing that the patient has to do?
A. The first thing the patient has to do is either come to the clinic or call our call center to schedule an appointment.
Q. And do you sometimes interact with patients at this stage?
A. Definitely. When those patients come into the clinic, I will -- I will schedule those appointment sometimes.
Q. What about when a patient calls the call center? Do you interact with patients sometimes at that stage?
A. Yes. There are times when patients call. There may be a financial issue related to payment for an abortion, and these phone calls do come into the clinic at that point. And I myself will talk with that patient.
Q. In your current role, do you still interact with abortion patients?
A. I do.
Q. In what capacity?
A. I kind of mentioned this earlier. So I spend a lot of time either checking them in, rooming them between the areas. I also do spend time walking them out of the

clinic after a procedure has been completed. I also interact with patients during their medication abortion follow-ups at times as well.
Q. And do you still do patient education sessions?
A. I do, yes.
Q. Are you involved in any other way in the patient education process?
A. I also do the training for many employees at Planned Parenthood of the Heartland for that patient education process.
Q. And as -- do you also periodically evaluate patient educators?
A. Yes. So we have an annual set-up to evaluate all of those employees who complete those patient education sessions.
Q. How long have you been training patient educators?
A. A little over a year now.
Q. And at which health centers do you -- have you trained patient educators?
A. I have trained at health centers at multiple locations here in Iowa, including the Iowa City clinic as well.
Q. And as the health center manager, who do you supervise at Rosenfield?

A. I supervise our entire clinical staff on site for that day. That includes nurses, so registered nurses, licensed practical nurse, LPNs, CMAs, those that serve as our medical assistants, clinic assistants. We also have an assistant manager on site as well.

Q. Do you supervise the patient educators at Rosenfield?

A. Yes.

Q. What does that supervision entail?

A. So the supervision entails doing random chart audits, so ensuring that their documentation is correct. It also entails shadowing those employees through patient education sessions at some points throughout the year and on this annual sign-off as well to ensure that they are completing these correctly.

Q. How many abortions does the Rosenfield Health Center provide as compared to other Planned Parenthood Iowa Health Centers?

A. It completes more medication abortions and surgical abortions than any of the other health centers.

Q. Other than your position as the health center manager at Rosenfield, have you held any other positions at Planned Parenthood?

A. I was also the center manager for the Urbandale Health Center. It's Urbandale, Iowa, here in Des Moines.

Q. What were your primary responsibilities in that role?

A. So still supervising employees at the clinic. I also tended to be the person who did a lot of the pregnancy tests and options counseling for patients at the clinic.

Q. And how long were you at that Urbandale Health Center?

A. Almost an entire year.

Q. Were there patients at Urbandale who wanted to have an abortion?

A. Yes.

Q. Did you interact with those patients?

A. Yes, we did. I did, specifically.

Q. In what capacity did you interact with them?

A. So I mentioned options counseling. So when a patient comes in, we do a pregnancy test. If it does come back positive, we will go through all of the options counseling. So that includes talking about creating an adoption plan, prenatal care, and talking about the different types of termination as well. Those can include referral to a different agency, including OB/GYNs or adoption agencies as well.

Q. And did you discuss obstacles that these abortions -- or a patient who wanted to have an abortion may face in accessing healthcare?

A. Yes.

Q. What did you do prior to working at the Urbandale Health Center?

A. Prior to that, I was a healthcare manager for a federally qualified health center that worked with migrant and seasonal farm workers throughout the state of Iowa. It was for primary care, but it did incorporate some family planning services into them.

Q. And did you provide options counseling for patients at that health center?

A. Yeah. We definitely talked about abortions if that's what a patient was interested in at that point.

Q. And did you also discuss obstacles with these -- that these patients may face in accessing healthcare?

A. Yes. Definitely.

Q. How long were you at this health center?

A. For around two years.

Q. Now turning back to your current employer Planned Parenthood, are there health center managers at other Planned Parenthood centers?

A. There are.

Q. Is this true for all health centers?

A. Are there health center managers at all? Yes. At every single health center.

Q. In the course of your work at Rosenfield, do you

interact with health center managers at other Planned Parenthood health centers?

A. I do. We hold weekly -- not weekly, excuse me -- monthly management meetings, really to go over different policies and guidelines. I also work with those managers for creating training plans for their employees who need to get trained with this patient education portion. Those employees do tend to come to Rosenfield to get trained, so there's a big portion of working with those managers through that.

Q. And do you discuss patients with these other health center managers?

A. Yeah, we can. Oftentimes if a patient needs follow-up at a different location, we're able to refer them to one of those other clinics as well.

MS. RATAKONDA: Your Honor, petitioners move to qualify Mr. Reynolds as an expert in Planned Parenthood's patient education process and abortion patient population.

THE COURT: Any objection?

MR. OGDEN: No objection, Your Honor.

Q. Mr. Reynolds, you will see a binder in front of you. Can you turn to Tab 12 of that binder, which is Plaintiff's Exhibit 12?

THE COURT: Tell you what. I'm going to stop you, just because I think we're at a good point to stop for

the morning now that we're going to get to some exhibits, rather than do that for three minutes. So why don't we wait until after lunch.

So we'll take a break at this point in time and be back and ready to proceed at 1:30. Thank you.

(The bench trial recessed at 11:57 a.m.)

(The bench trial resumed at 1:31 p.m.)

THE COURT: Mr. Reynolds, you can come back to the stand.

MS. RATAKONDA: Thanks, Tom.

THE COURT: When you're ready.

Q. Mr. Reynolds, do you see a binder in front of you? Can you turn to Tab 12. This is a document marked as Plaintiff's Exhibit 12.

A. Okay.

Q. Do you recognize this document?

A. I do.

Q. What is it?

A. My expert disclosure.

Q. Does this document accurately reflect your view and opinions in this case?

A. It does.

Q. Thank you. You can close the binder.

Mr. Reynolds, are you offering an expert opinion in this case?

A. I am.

Q. And can you tell us briefly what is that opinion?

A. My opinion is that this Act will greatly reduce access to abortions and in some cases prevent patients from receiving an abortion.

Q. Before we get into your opinions more specifically, I would like to ask you some background questions. Before an abortion patient goes through the patient education process which you mentioned earlier, what happens?

A. So a patient will check in at the front of the clinic, and before -- after they check in, they will go through ultrasound.

Q. And is a patient offered the option to view the ultrasound?

A. Yes. All patients.

Q. Can you now describe the patient education process in more detail?

A. Yes. To start off, in these information education sessions, the most important thing we do is confirm that the patient is confident in their decision. So we do this by asking open-ended questions. The first thing we really ask a patient is tell me a little bit about your decision to be here today. That right there really starts by patients opening up to us, telling us why they're

there, and we can dig into the reasons behind that. It also opens up other burdens if those are around. After that, we will then talk about the procedure. So if they are doing a medication abortion, we would talk about those medications. We would talk about the procedure itself. And we would also then talk about the informed consent process, so the risks, benefits, and alternatives to that.

Q. And who does the patient education process with patients?

A. Trained staff, trained employees.

Q. And what kind of training do patient educators go through?

A. The training is quite vigorous in this case. To start, they generally shadow another assigned-off person or myself at this point for multiple different patient education sessions, just so that they can learn a feel for what we do during this time. We also require seven interactive modules that those employees have to watch before they can even begin communicating with these patients. And then from there they would start themselves doing the talking during these sessions, all while having me as a designated trainer in those sessions. And then from there, once they are assigned off by themselves, I would still continue periodically to listen in on their sessions and continue checking their charts as well.

Q. How long does a patient education training typically take?

A. Multiple weeks.

Q. Do all patient educators go through this training?

A. Yes.

Q. Do patients typically ask questions in the patient education process?

A. Definitely. I feel that a lot of patients ask questions. The majority of these questions usually are around what's going to happen during the procedure, how to take the medications, what they will feel like afterwards, when to call us, that type of thing.

Q. Do patients typically have some information on the abortion procedure before they come to the health center?

A. In my experience, if not -- I mean, most patients do come having researched this a lot. It's something that they really look into before stepping into the clinic.

Q. And during the patient education process are patients asked if they have considered alternatives to abortion?

A. During the patient education session?

Q. Yes.

A. Yes. That is one of -- it is one of the main

things that we go over, offering adoption counseling, whether that's creating an adoption plan, offering prenatal care, not necessarily through us, but with a referral, and still talking about these terminations as well.

Q. And do patients in your experience typically arrive at the health center having already considered alternative options?

A. In my experience, yes.

Q. And how many patients typically would you say have already considered their options before they come into the health center?

A. I would say close to all patients have.

Q. During the patient education process are patients assessed for whether they're certain in their decision to have an abortion?

A. Yes. So I mentioned, you know, that question that we ask right away is tell me a little bit about your decision to be here today. Again, that gets patients to open up. We can tell if they are affirmative patients, use those words, I am confident in this decision. It is right for me and my family today, those types of affirmations.

Q. And how else do patient educators determine if patients are certain in their decision?

A. So another important thing that we really go over is something called intimate partner violence screening.

This is to ensure that patients are safe at home. That's one thing we talk a lot about. It's very -- it's kind of a longer series of questions, about 15 questions, in fact, that really ask: Are you making this decision today; is anyone threatening you in regards to the pregnancy; do you feel safe at home; have you been hit, slapped, kicked, or otherwise physically hurt since you've been pregnant or within the last year, really delving into those questions about relationships.

Q. And are patient educators trained to assess -- trained to assess decisional certainty?

A. Yes. It's something that we really take a look at during those training sessions with the employees. Something I do during these trainings is after an information session I will pull that employee aside and sit down with them and talk about what we saw during that education session, whether there are certain emotional cues or if it -- how they showed their confidence for their decision.

Q. And you previously mentioned some training modules. Are those used to train on decisional certainty?

A. Yes. There are specific ones that go into that.

Q. Are patients typically -- in your experience are patients typically firm in their decision to have an abortion when they first arrive at the health center for their abortion appointment?

A. In my experience almost all patients are firm in that decision.

Q. And after going through the patient education session are patients typically certain that they want to have an abortion?

A. Yes, in my experience.

Q. What happens if a patient educator determines that a patient is not certain?

A. We don't complete the abortion, but we still do go over the options counseling with all of these patients, again, talking about creating a adoption plan, talking about parental care referrals, and we also talk about the terminations. If they still would decide to do that, we talk about that time frame that they still have.

Q. How often is a patient uncertain after the patient education process?

A. In my experience, very rarely.

Q. And after the patient education session is finished, what is the next step for a patient who wants to proceed with an abortion?

A. At that point if it is a medication abortion, they would meet with the -- with the physician. If it is a surgical abortion, they would be moved to the procedure room and, again, at that point meet with the physician.

Q. And does the physician interact with the patients in any way?

A. Yes. So the physician, they again confirm their decision for the procedure for that medication abortion. They will also again talk about those risks, benefits, and alternatives at that point.

Q. Do you interact with patients after the abortion procedure?

A. After the procedure? Yes. I tend to be the person who would walk a patient from the recovery room back out to the front waiting room.

Q. And what about for medication abortion patients? Do you intact with them as well?

A. Yes. So for medication abortion patients, we do schedule follow-up appointments for them, so I tend to work with some of those patients for their follow-ups.

Q. How do patients typically feel after their abortion procedure?

A. In my experience, most patients do feel relief. They can feel emotional at times, but most in my experience do feel relieved.

Q. Has a patient ever expressed regret to you that she had had an abortion procedure?

A. Not at all.

Q. And after the abortion procedure, has a patient

ever expressed to you that she wished she had more time to think about her decision?

A. In my experience, no.

Q. After an abortion procedure, has a patient ever expressed to you that she wished she had continued her pregnancy?

A. No.

Q. Has a patient ever expressed to you that she felt rushed through a patient education session?

A. No. We do spend a lot of time with patients , and I think it's important to say that we spend enough time that the patient needs. We make that feel comfortable for them.

Q. From your experience speaking to hundreds of abortion patients in Iowa, what are some of the reasons patients have for seeking an abortion?

A. There are a number of reasons out there, whether they're not ready to be a parent, whether that is financial reasons to continuing or to parent a child. I do see patients for fetal anomalies as well. Health of the mother has come up a few times. And we also feel, sometimes, for safety of the patient too.

Q. And you mentioned financial reasons. So do patients discuss with you their financial circumstances?

A. Yes. In those patient education sessions,

sometimes before.

Q. And do patients mention to you any other obstacles that they face in seeking an abortion?

A. Yeah. I think one thing that I can say often is confidentiality kind of with their family. So whether that is a younger person living with their parents, for example. The ability to come to multiple appointments can be difficult. Whether that is someone in an abusive relationship, their safety is key. In that point it can be difficult to come to those appointments. As far as financial burdens go, ability to pay for the appointment, ability to pay for gas to arrive when you are driving multiple hours to the clinic. Yeah.

Q. And do patients ever -- or do patients ever express a preference for medication abortion over surgical abortion?

A. Yes, they definitely do.

Q. What are some of the reasons for that?

A. Some of the reasons that I've seen in my experience are a lot of times the medication abortion feels more natural for women. They can do it in their own home around loved ones and feel safe in that point. On the same side of this, for medication abortions we do -- in my experience I have talked with rape victims who don't feel comfortable getting an abortion in a surgical manner due to

their emotional ties to their attacker.

Q. Mr. Reynolds, now I want to direct you to the day the Act took effect. On Friday May 5th were you working at the Rosenfield Health Center?

A. Yes.

Q. What happened on the morning of that Friday?

A. So on the morning of the Friday the Act was put into place?

Q. For approximately how long was it in effect?

A. A couple, few hours.

Q. And taking a step back, did you do anything in preparation for the Act potentially taking effect?

A. Yes. We knew that it was going to be signed the day before, so we did call all patients to let them know they might not be able to have their abortion on that following Friday.

Q. And did you -- were you able to reach all of the patients?

A. We did reach most patients.

Q. How did patients react during these phone calls ?

A. There were a number of reactions. A lot of patients were very angered at that, on why somebody could decide this type of thing for them. Other patients were very upset because they had already made this decision. Other patients were confused on exactly what that meant for

their healthcare.

Q. On Friday May 5th did you interact with abortion patients at the Rosenfield Health Center?

A. I did.

Q. How many abortion patients did you interact with that day?

A. Close to all.

Q. While the law was in effect that Friday morning did abortion patients who came to Rosenfield know that they wouldn't be able to have an abortion that day?

A. Most of them when they arrived at the health center, they were still a little unclear as to what exactly it meant. But, like I mentioned, we did talk to most of those patients the day before.

Q. And for the patients who did arrive at the health center, how did they react to not being able to have their abortion that day?

A. It was that same type of anger that I had mentioned. Patients were crying because they could not receive the abortion that day. They were all still really confused on why someone could make that decision for them.

Q. Did patients explain to you or your staff why they were so upset?

A. Why did the patients?

Q. Why were patients upset? Can you give some

examples?

A. Yes. So, you know, I talked with multiple patients about this. One that comes to my mind are someone who had a fetal anomaly. She had multiple doctor's visits, already had made the decision with their family and had chosen to have an abortion on this day. Other patients, there was a rape victim who only felt confident enough to be able to tell her mother that she was raped, wanted to have a medication abortion, and due to this, that was going to push her out past that time frame of getting a medication abortion. Yeah, it was difficult.

Q. And do you have any other examples of patients that you interacted with that day?

A. Off the top of my head right now, no.

Q. Did any of the abortion patients you spoke to that day indicate they may not be able to return for another visit?

A. Can you repeat the question? I'm sorry.

Q. Sure. Did any of the abortion patients you spoke to that day indicate that day that they may not be able to return for another visit?

A. Yeah. There was one patient who we had seen at our health center who was trying to get back home. She was studying abroad here and had already had to delay her care multiple visits because of a health-related issue. And by

delaying this even more, it was going to impact her further.

Q. And were any patients uncertain about their ability to come back to the health center?

A. Yeah. Multiple patients were uncertain. A lot of it did kind of go back to that financial burden, you know. How were they going to pay for childcare again on another appointment, would their partner or spouse be able to be with them at the appointment a second time. And, again, it really goes back to how Rosenfield Clinic really sees a lower-income population. And those people in my experience tend to get paid hourly. When you're looking at multiple appointments, they don't have the ability to take paid time off from work. In those cases you're creating and even bigger financial burden on them.

Q. And would you be able to estimate approximately how many of your patients are low income?

A. I would say most patients.

Q. Did you discuss with colleagues at other health centers what their experiences were on that day?

A. I did.

Q. And what were their experiences?

A. I had spoke with the health center manager in the Ames location, and she saw those exact same things.

Q. Mr. Reynolds, in your time speaking to hundreds

of patients at Rosenfield, have you spoken to patients who are victims of domestic abuse?

A. I have.

Q. Do you have an opinion on how the Act would affect these patients?

A. In certain cases, you know, this would delay them receiving the care that they choose, especially in that case where it was a medication abortion. It could push them past that when that's the type of abortion they would choose to do.

Q. And for domestic abuse victims, are there any confidentiality issues that may come up?

A. Yes. I think it's more about patient safety at that point. So for domestic abuse patients, they sometimes do have trouble making it to appointments, have to find someone to take them to the appointments. And this would create a burden at that point.

Q. And in your experience have you spoken to patients who are victims of sexual assault?

A. I have.

Q. Do you have an opinion of how the Act would affect these patients?

A. Okay. I think this is kind of what I meant to answer on that last one. I may have misspoke a little bit about that, about in regards to that medication abortion.

When somebody does want to complete a medication abortion, this could delay them and allow them not to have that type of abortion.

Q. And have you spoken to patients who are terminating because of a fetal anomaly?

A. I have.

Q. Do you have an opinion of how the Act may affect these patients?

A. Yes. This could greatly restrict access to care. And in my experience, these patients sometimes are a little further along in pregnancy, and it could restrict them from receiving care at all.

Q. And why would they be further along in pregnancy?

A. Due to the fact that those ultrasound scans and we don't find out that they have fetal anomalies until a little further in pregnancy.

Q. And have you spoken to minors who want to have an abortion?

A. I have.

Q. Do you have an opinion as to how the Act would affect these patients?

A. Again, this goes back to safety as well as financial burden. When a minor has to have their parent at that appointment with them, meaning two people could have to be off work at that point, as well as safety if that

patient is not able to tell the provider about this and completes it in a different way, then it would be harder for them to get access to that care.

Q. And you already spoke about low-income patients. How would the Act, in your opinion, impact these patients?

A. It would create a bigger burden for those patients financially.

Q. Can you elaborate on that?

A. Yeah. Since most of our patients are lower income at our health center, having to come to multiple appointments, take off multiple days of work, find childcare, find -- if their partners are going to come with them as well -- so two people would be losing income at that point. It would create a bigger burden for patients.

Q. And one last question, Mr. Reynolds. If this law were to take effect, how would this impact Planned Parenthood's patients on a whole?

A. I have said this already, but I do believe that this would reduce access for patients to receive the type of care that they wanted with abortions and in some cases prevent patients from receiving an abortion.

MS. RATAKONDA: No further questions.

THE COURT: Cross?

MR. OGDEN: Yes. Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. OGDEN:

Q. Good afternoon, Mr. Reynolds.

A. Good afternoon.

Q. My name is Tom Ogden. I'm here on behalf of the Governor and the Board of Medicine. I will be very brief, I promise.

You would agree with me that the decision whether to have an abortion or to carry a pregnancy to term is an important one?

A. I would.

Q. That's in part why you do counseling of patients prior to them making a decision?

A. Correct.

Q. You've opined that this, the challenged Act, is likely to prevent women from accessing an abortion. Are you aware that a study was done in Utah with the 72-hour, two-visit waiting period, that they found in the study that it did not prevent women from having abortions? Are you aware of that?

A. I'm not familiar with that study.

Q. Are you aware that -- well, I guess you wouldn't be aware, but just to make sure. Since you're not familiar with the study, you're also not aware that they found that on average the cost of the procedure was increased by only

1 percent?

A. Again, I'm not familiar with that study.

MR. OGDEN: No further questions.

MS. RATAKONDA: No further questions.

THE COURT: Thank you for your testimony. Next witness?

MS. CLAPMAN: Your Honor, I apologize. Our next witness is on his way, but I underestimated the prior testimony. But he should be here any minute. Would it be okay to take a five-minute break?

THE COURT: Why don't we do that.

(The bench trial recessed at 1:56 p.m.)

(The bench trial resumed at 2:10 p.m.)

THE COURT: Will you raise your right hand, please.

DANIEL GROSSMAN,

called as a witness, having been first duly sworn by the Court, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. CLAPMAN:

Q. Dr. Grossman, please state and spell your full name for the record.

A. Daniel Grossman. D-a-n-i-e-l. G-r-o-s-s-m-a-n.

Q. I would like you to turn to what should be Tab 7 in your binder, which is marked Exhibit 7, which appears to

be a copy of your CV. Do you see it?

A. Yes, I do.

Q. Did you prepare this document?

A. I did.

Q. Is the information on this document accurate?

A. Yes.

Q. Where did you do your medical training?

A. I went to medical school at Stanford University, and I did my residency in obstetrics and gynecology at the University of California, San Francisco.

Q. Are you a board certified OB/GYN?

A. Yes, I am.

Q. Where do you currently practice medicine?

A. I'm a professor in the Department of Obstetrics and Gynecology and Reproductive Sciences at the University of California, San Francisco, and my practice is focused at Zuckerberg San Francisco General Hospital.

Q. Please describe your medical practice.

A. So the clinical part of my work is currently focused on outpatient obstetrics and gynecology, primarily outpatient gynecology, including family planning and abortion care.

Q. And do you perform abortions?

A. Yes, I do.

Q. What procedures do you perform?