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IN THE IOWA DISTRICT COURT FOR POLK COUNTY

PLANNED PARENTHOOD OF THE HEARTLAND, INC.; EMMA GOLDMAN CLINIC; and SARAH TRAXLER, M.D., Petitioners, v. KIM REYNOLDS, ex rel. STATE OF IOWA, and IOWA BOARD OF MEDICINE, Respondents.	Case No. _________ **AFFIDAVIT OF SARAH A. TRAXLER, M.D.**

I, Sarah A. Traxler, M.D., M.S., F.A.C.O.G., declare and state as follows:

1. I am a board-certified obstetrician and gynecologist ("OB/GYN") licensed to practice medicine in Iowa, in addition to Minnesota, South Dakota, North Dakota, Nebraska, and Maine. Since 2019, I have been the Medical Director for Planned Parenthood of the Heartland, Inc. ("PPH"). In that capacity, I oversee all medical services provided by PPH. I also provide contraception and abortion services, including both medication and in-clinic abortion, at PPH's Iowa City, Rosenfield, Council Bluffs, and Sioux City health centers in Iowa.

2. My curriculum vitae, which sets forth my experience and credentials more fully, is attached to this affidavit as Exhibit A.

3. Along with PPH, I am a petitioner in this case. I am familiar with Iowa Senate File 579 / House File 732 (the "Act"), the law challenged in this case. I submit this affidavit in support of Petitioners' motion for a temporary injunction.

4. The facts and opinions included here are based on the 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.

My Background

5. As noted above, I am a board-certified OB/GYN. I am licensed to practice medicine in Iowa, Minnesota, South Dakota, North Dakota, Nebraska, and Maine.

6. I obtained a medical degree in 2009 from Oregon Health and Science University and completed my medical residency at the University of Minnesota. I then completed a fellowship in Contraceptive Research and Family Planning at the University of Pennsylvania's Department of Obstetrics and Gynecology.

7. I hold a Master's Degree in Health Policy Research from the University of Pennsylvania's Perelman School of Medicine and a Bachelor's Degree from Newcomb College.

8. Since 2015, I have been an Adjunct Assistant Professor at the University of Minnesota's Medical School, and before that, I was an instructor in Obstetrics and Gynecology at the University of Pennsylvania School of Medicine.

9. I am a fellow and member of the American College of Obstetrics and Gynecology ("ACOG") and a member of the American Medical Association, the Society of Family Planning, and Physicians for Reproductive Health, among numerous other professional and scientific societies.

10. As Medical Director, my responsibilities include overseeing all medical services provided by PPH, including abortions performed there, and working with legal and clinical staff to ensure that those medical services are provided in a way that complies with our legal and professional obligations and in accordance with our medical standards and guidelines. As I stated above, I also provide medical services, including abortion, at PPH in Iowa. In addition to serving

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as the Medical Director for PPH, I have been the Chief Medical Officer for Planned Parenthood North Central States ("PPNCS") since 2018. In that capacity, I oversee twenty-eight health centers in four states as a strategic executive of our medical program. PPNCS is a voluntary nonprofit corporation whose purpose is to provide high quality, affordable reproductive health care to its community; it serves as the parent organization and provides management and administrative services to PPH.

The Challenged Law

11. I understand that the Act generally bans abortion as soon as a "fetal heartbeat" is detected. The Act defines "fetal heartbeat" as "cardiac activity, the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac."[1]

12. The term, therefore, covers not just a "heartbeat" in the medical sense, but also early cardiac activity present before development of any cardiovascular system. Moreover, as I understand the Act, a "fetal heartbeat" is not actually limited to a fetus. In the field of medicine, the developing organism present in the gestational sac during pregnancy is most accurately termed an "embryo" before approximately ten weeks of pregnancy, as measured from the first day of a patient's last menstrual period ("LMP"). The term "fetus" is used during pregnancy after this time. Contrary to these medical classifications, my understanding is that the Act defines "unborn child" to mean "an individual organism of the species homo sapiens from fertilization [of an egg] to live birth."[2]

13. Accordingly, as I understand the Act, it prohibits abortion any time after identification of embryonic or fetal cardiac activity. Based on my medical experience and

[1] SF 579/HF 732 § 1(2)
[2] SF 579/HF 732 § 1(7); Iowa Code § 146A.1.

expertise, that activity may be detected by abdominal or vaginal ultrasound as early as six weeks LMP (or even earlier). By that point in pregnancy, an ultrasound may reveal a ring, which represents the round sac within the uterus, and an electrical impulse that appears as a visual flicker on the edge of the sac and therefore, although this is not what one would think of as a "heartbeat," the Act's restrictions would begin to apply at this extremely early stage.[3] This activity cannot be made audible at that stage of pregnancy.[4] As described further below, many patients do not realize they are pregnant until after six weeks LMP.

14. My understanding is that the bill's exceptions are very narrow. A physician could provide an abortion after embryonic or fetal cardiac activity is detected only if the abortion is necessary to save the patient's life, to prevent extremely limited types of physical harm to the pregnant patient, and in other narrow circumstances involving rape, incest, and fatal fetal anomalies.

15. I understand that the Act does not specify what penalties providers could face for a violation. It does, however, require the Iowa Board of Medicine to adopt rules to administer the Act, which has the authority to discipline providers for violating a state law, including by imposing civil penalties of up to ten thousand dollars and revoking our medical licenses.[5]

16. As described further below, the Act will have a devastating effect on Iowans, as many patients do not realize they are pregnant until after six weeks LMP. Very few, if any, of the patients with pregnancies with detectable embryonic or fetal cardiac activity will qualify for one of the Act's limited exceptions. I anticipate that patients who can scrape together the resources

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[3] Panos Antsaklis et al., *Early Pregnancy Scanning: Step-by-Step Overview*, 13 Donald Sch. J. of Ultrasound in Obstetrics & Gynecology 236, 237 (2019).
[4] Saeed Abdulrahman Alnuaimi et al., *Challenges and Future Research Directions*, 5 Frontiers in Bioengineering & Biotechnology 3 (2017).
[5] SF 579/HF 732 § 2(5); Iowa Code §§ 148.6(1), 148.6(2)(c), 272C.3(2).

will be forced to travel out of state for medical care, and many others who cannot do so will be forced to carry a pregnancy to term against their will or seek ways to end their pregnancies without medical supervision, some of which may be unsafe. I am gravely concerned about the effect that the Act has on Iowans' emotional, physical, and financial wellbeing and the wellbeing of their families.

PPH's Services in Iowa

17. PPH is a not-for-profit corporation organized under the laws of Iowa. It operates in both Iowa and Nebraska. In Iowa, PPH operates health centers in Sioux City, Council Bluffs, Ames, Cedar Rapids, Iowa City, Des Moines (Rosenfield and Susan Knapp), and Urbandale. These health centers 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, contraception, adoption referral, miscarriage management, medication abortion, and in-clinic abortion procedures.

18. Medication abortion involves the use of medication taken to safely and effectively end an early pregnancy in a process similar to a miscarriage. Abortion by procedure involves the use of gentle suction and/or the insertion of instruments through the vagina to empty the contents of a patient's uterus. After eighteen weeks LMP, a two-day procedure is needed. Although sometimes known as "surgical abortion," abortion by procedure does not involve surgery in the conventional sense. It does not require an incision into the patient's skin or a sterile field.

19. PPH provides medication abortion at its Sioux City, Council Bluffs, Ames, Iowa City, and Rosenfield health centers through 11 weeks, 0 days LMP. Medication abortion is provided via telemedicine at the Council Bluffs, Rosenfield, Iowa City, and Sioux City health

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centers. PPH also provides in-clinic abortion procedures through 19 weeks, 6 days LMP at its Rosenfield health center and 20 weeks, 6 days LMP at its Iowa City health center.

20. In 2022, PPH provided over 3,300 abortions in Iowa, more than 88% of which were for patients who had already reached six weeks LMP. In the first half of 2023, PPH provided just under 1,200 abortions in Iowa, nearly 92% of which for patients who had already reached six weeks LMP.

Access to and Safety of Abortion in Iowa

21. To my knowledge, PPH is one of only two abortion providers that operate health centers in Iowa. I understand the other provider, the Emma Goldman Clinic, is also a petitioner in this case.

22. Legal abortion is one of the safest procedures in contemporary medical practice.[6] Nationally, the risk of death associated with childbirth is more than twelve times higher than that associated with abortion,[7] and every pregnancy-related complication is more common among people having live births than among those having abortions.[8] Less than 1% of people having abortions experience a serious complication.[9] The risk of a patient experiencing a complication that requires hospitalization is even lower, approximately 0.3%.[10] Medication abortion in particular is comparable in safety to over-the-counter medications like ibuprofen and to antibiotics. Abortion is also a common medical procedure: Nationally, approximately one in four women will

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[6] *See, e.g.,* Nat'l Acads. of Scis., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States,* at 10, 59, 79 (2018), available at http://nap.edu/24950 (hereinafter, "Nat'l Acads.").
[7] *Id.* at 75 tbls. 2–4.
[8] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012).
[9] Ushma Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 175 (2015).
[10] *Id.*

have an abortion by age forty-five, and this number does not account for the transgender men, gender nonconforming people, and nonbinary people who have abortions.[11]

23. Patients' decisions to have an abortion often involve multiple considerations that reflect the complexities of their lives.[12] More than half of PPH's Iowa patients who have an abortion are already parents. Our patients with children understand the obligations of parenting and decide to have an abortion based on what is best for them and their existing families, which may already struggle to make ends meet. Other patients decide that they are not ready to become parents because they are too young or want to finish school before starting a family. Some patients have health complications during pregnancy that lead them to conclude that abortion is the right choice for them. Some people receive diagnoses of fetal abnormalities despite the pregnancy being wanted. In some cases, patients are dealing with a substance use disorder and decide not to become parents or have additional children during that time in their lives. Still others have an abusive partner or a partner with whom they do not wish to have children for other reasons. In all of these cases, our patients decide whether abortion is the best option for themselves and their families.

24. Regardless of the reasons that bring a patient to us, PPH and I are committed to providing high-quality, compassionate abortion services that honor each patient's dignity and autonomy. PPH trusts its patients to make the best decisions for themselves, their families, and their futures.

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[11] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014,* 107 Am. J. Pub. Health 1904, 1907 (2017).

[12] *See, e.g.,* M. Antonia Biggs, Heather Gould, & Diana G. Foster, *Understanding Why Women Seek Abortions in the US,* 13 BMC Women's Health 1 (2013).

Timing of and Barriers to Abortion Services in Iowa

25. Most patients have an abortion as soon as they are able. The majority of abortions in the United States and in Iowa take place within the first trimester of pregnancy.[13]

26. However, many patients do not learn they are pregnant before six weeks LMP, with many patients facing physiological limitations in pregnancy detection. Some people have fairly regular menstrual cycles; a four-week cycle is common. For a person with a regular four-week cycle, fertilization typically occurs at two weeks LMP. Thus, a person with a highly regular, four-week cycle would already have reached four weeks LMP when a period is missed, and before that time, most over-the-counter pregnancy tests would not be sufficiently sensitive to detect a pregnancy.

27. People can also have cycles of different lengths. Some individuals can go six to eight weeks, or even more, without experiencing a menstrual period. It is also extremely common to have irregular menstrual cycles for a variety of reasons, including certain common medical conditions, contraceptive use, and age.[14] Breastfeeding can suppress menstruation for weeks or months, after which someone's menstrual cycle may return but be irregular for a period of time. Those who have had a miscarriage in the last six months may also have a higher likelihood of an irregular period contributing to delayed pregnancy detection. Cycle irregularity is more common

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[13] *CDCs Abortion Surveillance System FAQs*, Ctrs. for Disease Control & Prevention ("CDC"), https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm (last reviewed Nov. 17, 2022) ("Nearly all abortions in 2020 took place early in gestation: 93.1% of abortions were performed at ≤13 weeks' gestation . . . ."); State of Iowa Dep't of Health and Human Servs., *2021 Vital Statistics of Iowa*, at 151 (Apr. 2023), available at https://hhs.iowa.gov/sites/default/files /idphfiles/ vital_stats_2021-20230407.pdf (providing data for abortions performed 0–13 weeks).

[14] *See* Jessica A. Grieger & Robert J. Norman, *Menstrual Cycle Length and Patterns in a Global Cohort of Women Using a Mobile Phone App: Retrospective Cohort Study*, 22 J. of Med. Internet Rsch. 1 (2020) (study finding that only 25.37% of women had a cycle length variation of less than 1.5 days, and in fact over 30% had a variation period of over six days).

among young women, Hispanic women, and women with common health conditions, such as diabetes and polycystic ovary syndrome.[15]

28. Pregnancy itself is not always easy to detect. Some pregnant patients experience light bleeding that occurs when a fertilized egg is implanted in the uterus. This implantation bleeding is often mistaken for a menstrual period. Additionally, although some pregnant people experience nausea and vomiting early in pregnancy, many do not. Further, various individual characteristics during pregnancy, including younger age, lower educational attainment, and lower poverty-to-income ratios, are associated with later pregnancy awareness.[16] Use of hormonal contraceptives is also associated with delayed pregnancy awareness.[17]

29. Even after a patient learns of a pregnancy, arranging an appointment for an abortion may take some time. Due to provider availability and other operational demands, PPH's Iowa health centers are able to provide abortion from twice per month to three times per week, depending on the location. As a result, even assuming that we have sufficient appointments to meet patient demand each week, patients generally cannot obtain an appointment immediately—particularly because PPH's Iowa patients make two trips to a health center before having abortions, as discussed below. PPH's Iowa health centers are booking more than eleven days out as of June 30, 2023.

30. For patients living in poverty or without insurance, travel-related and financial barriers also help explain why the vast majority of our patients do not—and realistically could

[15] Jenna Nobles, Lindsay Cannon, & Allen J. Wilcox, *Menstrual Irregularity as a Biological Limit to Early Pregnancy Awareness*, 119 Proc. of the Nat'l Acad. of Scis. 1 (2022).
[16] Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 338 (2006).
[17] Amy M. Branum & Katherine A. Ahrens, *Trends in Timing of Pregnancy Awareness Among US Women*, 21 Maternal & Child Health J. 715 (2017).

not—have abortions before six weeks of pregnancy. Logistical delays are often more pronounced for women with two or more children, minors, Black women, and those living in poverty.[18] In 2021, 12.5% of women in Iowa lived in poverty, and that rate rose to 20.9% among Latina women and 27.8% among Black women in Iowa.[19] In 2022, 39% of PPH's patients in Iowa had incomes below the federal poverty level. These patients face particularly high barriers to obtaining abortions, including but not limited to raising money for the abortion and associated travel and childcare costs and inability to take time off work.

31. The lack of comprehensive insurance coverage also poses a barrier to Iowans confirming they are pregnant and obtaining abortion coverage when they need it. 8.1% of women in Iowa reported not receiving health care at some point in the last twelve months due to cost.[20] Even those patients who have health insurance often do not have access to abortion coverage. With very narrow exceptions, Iowa bars coverage of abortions in its Medicaid program, an important source of health insurance for vulnerable Iowans.[21]

32. Patients living in poverty and/or without insurance must often make difficult tradeoffs of other basic needs to pay for their abortions, even with assistance from PPH to those patients in need. Many patients must seek financial assistance from extended family and friends to pay for care as well, a process that takes time. Many patients must navigate other logistics, such as inflexible or unpredictable job hours, that may delay the time when they are able to have an

[18] Finer et al., *supra* note 16, at 339.
[19] *Women in Poverty, State by State 2021*, Nat'l Women's Law Ctr., https://nwlc.org/resource/women-in-poverty-state-by-state-2022/ (last visited July 10, 2023) (select "Iowa" on U.S. map).
[20] *Iowa*, Nat'l Women's Law Ctr., https://nwlc.org/state/iowa/ (last visited July 10, 2023).
[21] Iowa Dep't of Human Servs., *Certification Regarding Abortion*, https://hhs.iowa.gov/sites/default/files/470-0836.pdf?030320221614 (last revised July 2011); *State Facts About Abortion: Iowa*, Guttmacher Inst. (June 2022), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-iowa.

abortion. Over half of PPH's patients are already parents, and they must also navigate childcare needs.

33. In addition to the medical and practical impediments to having abortions—particularly before six weeks LMP—that I have just described, Iowa has also enacted numerous medically unnecessary statutory and regulatory requirements that must be met before a patient may have an abortion. For example, Iowa requires PPH to ensure that patients have an ultrasound at least twenty-four hours in advance of having an abortion.[22] PPH must also make available to patients, at least twenty-four hours in advance of an abortion, certain state-mandated information designed to discourage them from having an abortion.[23] PPH's Iowa patients therefore make two trips to a health center before they can receive an abortion. Practically speaking, this twenty-four-hour waiting period causes delays in patient care that can last far longer than one day, which may push a patient past the time limit even if they discovered they are pregnant, decided to have an abortion, and scheduled their two appointments prior to six weeks LMP.

34. The impossibility of having an abortion within the time permitted by the Act is all the more clear for our minor patients who are under the age of eighteen. Minor patients without a history of pregnancy may be less likely to recognize early symptoms of pregnancy than older patients who have been pregnant before.[24] Most of these patients cannot immediately obtain written parental authorization, which means that under Iowa law they cannot have an abortion until forty-eight hours after a parent has been notified or until they have obtained judicial authorization,[25] which cannot realistically happen before six weeks LMP.

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[22] Iowa Code § 146A.1(a)–(c).
[23] Iowa Code § 146A.1(d).
[24] Finer et al., *supra* note 16, at 338.
[25] Iowa Code § 135L.3(3).

35. Patients whose pregnancies are the result of sexual assault or who are experiencing interpersonal violence may need additional time to access abortion services due to ongoing physical or emotional trauma. According to one large study, 13.8% of women seeking abortions in Iowa reported experiencing physical or sexual abuse within the previous year; 10.8% reported physical or sexual abuse by an intimate partner within that time.[26] For these patients too, obtaining an abortion before six weeks LMP is exceedingly difficult, if not impossible. And as I discuss below, the rape and incest exceptions in the Act will not be accessible to many patients.

36. The impact of *Dobbs v. Jackson Women's Health Organization*, 142 S.Ct. 228 (2022), has made it even more difficult for patients to access care. Capacity in our health centers continues to be strained by serving patients from states that have limited access to abortion or that have banned abortion altogether. More patients are having to travel for care, and appointment wait times at PPH's Iowa health centers have gone up.

37. For all of these reasons, prior to the Act taking effect, nearly 92% of PPH's Iowa patients in the first half of 2023 did not have an abortion until they had already reached six weeks LMP.

The Act's Effects

38. As described above, the earliest a person could reasonably expect to learn that they are pregnant is at four weeks LMP. In my experience, it is common for OB/GYNs not to schedule pregnant patients for their first obstetric visits until well after six weeks LMP.[27] Accordingly, an Iowan would have roughly two weeks to detect a pregnancy, decide whether to have an abortion,

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[26] Audrey F. Saftlas et al., *Prevalence of Intimate Partner Violence Among an Abortion Clinic Population*, 100 Am. J. Pub. Health 1412, 1413 (2010).

[27] *See, e.g.*, *Our Most Frequently Asked Questions*, Central Iowa OBGYN, https://www.centraliowaobgyn.com/faq (last visited July 10, 2023) (Q: "How soon should I make my first OB appointment?" A: "We prefer that you are between 9–10 weeks pregnant.").

secure the money to pay for the abortion and associated care and travel, seek and obtain an ultrasound and abortion appointment, have their ultrasound, and endure the minimum mandatory twenty-four-hour delay. Based on my experience, the vast majority of patients, even those who suspect that they are pregnant at a very early stage, could not realistically take all of these steps before six weeks LMP. The Act's impact will be harshest for our patients with low incomes, patients of color, and patients who live in rural areas who must travel farther distances to reach our health centers.

39. As described above, many other patients do not learn that they are pregnant until after six weeks LMP. Under the Act, these patients could *never* access abortion in Iowa unless they fall into one of the Act's narrow exceptions, the flaws in which I discuss below.

Out-of-State Travel and Related Burdens

40. Under the Act, I anticipate that most Iowans will be forced to seek abortions in other states (if they are able to undertake the necessary travel at all), increasing their burdens and costs. Others will be denied access to abortion care entirely. From Des Moines, for example, the nearest abortion providers outside of Iowa are in Nebraska, around 140 miles away one way, and Nebraska currently only provides abortions up to twelve weeks LMP. While clinics in Kansas provide abortions up to twenty weeks LMP and clinics in Minnesota provide abortions until fetal viability, the nearest clinics in those states are at least 200 miles away one way from Des Moines.

41. The necessary travel caused by the Act will carry with it associated costs, such as lodging, gas, food, time off work, and coverage for any caregiving responsibilities. The logistics required for out-of-state travel may also force some patients to explain the reason for their travel, thus compromising the confidentiality of their decision to have an abortion in order to obtain transportation or childcare.

42. I expect that pregnant people able to have an abortion through another provider in a different state will do so later in pregnancy than they would have had they had access to care in Iowa. Generally speaking, legal barriers to abortion can delay, and in some cases altogether prevent, people from accessing that care.[28] In addition to the logistical hurdles, the Act will cause clinics in surrounding states to have difficulty absorbing a large influx of patients. PPNCS will not be able to absorb all of our Iowa patients at our clinics in other states, and absorbing those whom we can will push appointment wait times out by days or even weeks. Although abortion is very safe, the physical risks associated with abortion—as is true with pregnancy generally—do increase with gestational age.[29] Accordingly, even for patients able to travel to another state, the delays created by the Act will still increase those patients' risk of experiencing pregnancy- and abortion-related complications and prolong the period during which they must carry a pregnancy that they have decided to end. Because the cost of abortion services also increases with gestational age,[30] delays in access to care caused by the Act may impose additional financial costs on patients related to the abortion service itself.

Forced Pregnancy and Parenthood

43. I also expect, as a result of the Act, many patients will be unable to travel out of state to have an abortion in light of the costs and coordination required and will be forced to carry pregnancies to term against their will.

44. Pregnancy affects an individual's health and social circumstances. The effects of pregnancy include a dramatic increase in blood volume, an increased heart rate, increased

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[28] Jenna Jerman et al., *Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States*, 49 Persp. on Sexual and Reprod. Health 95 (2017).
[29] Nat'l Acads., *supra* note 6, at 77–78.
[30] Rachel K. Jones et al., *Differences in Abortion Service Delivery in Hostile, Middle-ground, and Supportive States in 2014*, 28 Women's Health Issues 212, 215 (2018).

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production of clotting factors, changes in breathing, digestive complications, substantial weight gain, and a growing uterus. As a result of these and other changes, pregnant patients are at a greater risk of blood clots, nausea, hypertensive disorders, and anemia, among other complications. Some of these changes require evaluation and occasionally urgent or emergent care in order to preserve the patient's health or save their life.

45. Many people seek emergency care at least once during a pregnancy, and people with comorbidities (either preexisting or those that develop as a result of their pregnancy), such as asthma, hypertension, or diabetes, are significantly more likely to do so.

46. Pregnancy can also aggravate preexisting health conditions, including hypertension and other cardiac diseases, diabetes, kidney disease, autoimmune disorders, obesity, asthma, and other pulmonary diseases. New and serious health conditions can result, including preeclampsia, deep-vein thrombosis, hyperemesis gravidarum, and gestational diabetes. People who develop pregnancy-induced medical conditions are also at higher risk of developing the same condition in subsequent pregnancies.

47. Pregnancy may also induce or exacerbate mental health conditions. A person with a history of mental illness may experience a recurrence or worsening of their illness during pregnancy. These mental health risks can be higher for patients with unintended pregnancies. In Iowa, twenty-eight percent of pregnancies among women of reproductive age were unwanted or mistimed as of 2017.[31] For Black and Hispanic/Latina women, the rates of unintended pregnancy are likely to be even higher.[32]

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[31] Kathryn Kost et al., *Pregnancies and Pregnancy Desires at the State Level: Estimates for 2017 and Trends Since 2012*, Guttmacher Inst., at fig.2 (Sept. 2021), https://www.guttmacher.org/report/pregnancy-desires-and-pregnancies-state-level-estimates-2017.

[32] *See e.g.* Charvonne N. Holliday et al., *Racial/Ethnic Differences in Women's Experiences of Reproductive Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 26 J. of Women's Health 828, 828 (2017) (finding higher incidence of unintended pregnancy among Black and

48. Some pregnant patients also face an increased risk of intimate partner violence, and the severity of the risk can escalate during or after pregnancy. Homicides, the majority of which are committed by an intimate partner, are a leading cause of maternal mortality. Compared to women who are able to receive a wanted abortion, women denied wanted abortions are more likely to experience continued intimate partner violence from the man involved in the pregnancy.[33]

49. Labor and childbirth are significant medical events that are much riskier than legal abortion. The abortion-related mortality rate for legal abortions is only 0.7 deaths per 100,000 abortions, as compared to the national mortality rate among individuals who carry their pregnancies to term, which is 8.8 deaths per 100,000 live births.[34] Patients of color are even more at risk. In 2021, the national maternal mortality rate for Black women was 2.6 times the maternal mortality rate for white women.[35] The disparity is even higher in Iowa: Black mothers in Iowa are six times more likely to die than white mothers.[36]

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multiracial women in California in 2009); Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008–2011,* 374 New Eng. J. of Med. 843, 850 fig.3 (2016) (finding that Black and Hispanic women of reproductive age have higher unintended pregnancy rates than their white non-Hispanic peers); Guttmacher Inst., *Unintended Pregnancy in the United States*, at 1 (Jan. 2019), available at https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us.pdf ("At 79 per 1,000, the unintended pregnancy rate for non-Hispanic black women in 2011 was more than double that of non-Hispanic white women (33 per 1,000).").

[33] Sarah C.M. Roberts et al., *Risk of Violence From the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion,* 12 BMC Med. 1 (2014) (finding a statistically significant reduction in physical violence over time for women who received an abortion but no such decrease for those who were denied an abortion).

[34] Nat'l Acads., *supra* note 6, at 74, 75 tbls. 2–4.

[35] Donna L. Hoyert, CDC, Nat'l Ctr. for Health Stats., *Maternal Mortality Rates in the United States, 2021*, at 1 (Mar. 16, 2023), available at https://www.cdc.gov/nchs/data/hestat/maternal - mortality/2021/maternal-mortality-rates-2021.pdf.

[36] Charity Nebbe and Matthew Alvarez, *The growing crisis with Black maternal health*, Iowa Public Radio (Jan. 31, 2023), https://www.iowapublicradio.org/podcast/talk-of-iowa/2023-01-31/the-growing-crisis-with-black-maternal- health.

50. Other complications resulting from labor and childbirth occur at a rate of over 500 per 1,000 delivery hospital stays.[37] Hemorrhage is the leading cause of severe maternal morbidity. During labor, increased blood flow to the uterus places the patient at risk of hemorrhage and possibly death. Other unexpected adverse events include transfusion, ruptured uterus (the spontaneous tearing of the uterus) or liver, stroke, perineal laceration (the tearing of the tissue around the vagina and rectum), and unexpected hysterectomy (the surgical removal of the uterus). The most severe perineal tears involve tearing between the vagina through the anal sphincter and into the rectum and must be surgically repaired. These can lead to long-term urinary and fecal incontinence and sexual dysfunction. Vaginal delivery can also lead to long-term internal injuries, including injury to the bowel and the pelvic floor, causing urinary incontinence, fecal incontinence, and pelvic organ prolapse. Anesthesia or an epidural administered during labor can create additional risks, including infection, severe headaches, and nerve damage. Patients who become pregnant during their teens or after age thirty-five are more likely to experience complications, placenta previa, and preterm labor.

51. In Iowa, 29.7% of live births in 2021 were the result of a cesarean delivery.[38] Because a cesarean delivery is an open abdominal surgery, patients must be hospitalized for at least a few days afterwards and the procedure carries significant risks of hemorrhage, infection, blood clots, and injury to internal organs. Cesarean deliveries also carry long-term risks, including an increased risk of placenta previa in later pregnancies (when the placenta covers the cervix, resulting in vaginal bleeding and requiring bed rest), increased risk of placenta accreta (when the

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[37] Anne Elixhauser & Lauren M. Wier, Healthcare Cost & Utilization Proj., *Stat. Br. No. 113, Complicating Conditions of Pregnancy and Childbirth*, at 2 tbl. 1, 5 tbl. 2 (May 2011), available at https://www.hcup-us.ahrq.gov/reports/statbriefs/sb113.pdf.

[38] *Cesarean Delivery Rate by State*, CDC, https://www.cdc.gov/nchs/pressroom/sosmap/cesarean_births/cesareans.htm (last reviewed Feb. 25, 2022).

placenta grows into and possibly through the uterine wall, potentially necessitating complicated surgical interventions, massive blood transfusions, hysterectomy, and risk of maternal death), and bowel or bladder injury in future deliveries. Individuals with a history of cesarean delivery are also more likely to need cesarean delivery with subsequent births.

52. Pregnant people with a prior history of mental health conditions also face a heightened risk of postpartum illness, which may go undiagnosed for months or even years.

53. Due to structural barriers that limit access to contraceptives,[39] people with lower incomes experience disproportionately high rates of unintended pregnancies.[40] For people already facing an array of economic hardships, the cost of pregnancy can have especially long-term and severe impacts on their family's financial security. Many of the side effects of pregnancy prevent patients from working the same number of hours that they had prior to pregnancy or working altogether, and patients can lose their jobs as a result. For example, some patients with hyperemesis gravidarum must adjust work schedules because they vomit throughout the day. Patients with preeclampsia must severely limit activity for a significant amount of time.

54. Even in the absence of pregnancy-related side effects, pregnancy-related discrimination can result in lower earnings both during pregnancy and over time.[41] Iowa does not require private employers to provide paid family leave, meaning that for many pregnant Iowans,

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[39] ACOG, *Comm. Op. No. 615: Access to Contraception*, 125 Obstetrics & Gynecology 250 (2015); *see also* May Sudhinaraset et al., *Women's Reproductive Rights Policies and Adverse Birth Outcomes: A State-Level Analysis to Assess the Role of Race and Nativity Status*, 59 Am. J. Preventive Med. 787, 788 (2020).
[40] Guttmacher Inst., *supra* note 21, at 1.
[41] *See, e.g.*, Nat'l P'ship for Women & Fams., *By the Numbers: Women Continue to Face Pregnancy Discrimination in the Workplace*, at 1–2 (Oct. 2016), available at https://nationalpartnership.org/wp-content/uploads/2023/02/by-the-numbers-women-continue-to-face-pregnancy-discrimination-in-the-workplace.pdf; Jennifer Bennett Shinall, *The Pregnancy Penalty,* 103 Minn. L. Rev. 749, 787–89 (2018).

time taken to recover from pregnancy and childbirth or to care for a newborn is unpaid.[42] On average, a person in Iowa who takes four weeks of unpaid leave loses more than $3,000 in income.[43]

55. Aside from lost wages, pregnancy-related health care and childbirth are some of the costliest hospital-based health services, particularly for complicated or at-risk pregnancies. Many pregnant patients must pay for significant labor and delivery costs out of pocket, even with insurance coverage. In 2015, of the 98.2% of commercially insured women who had out-of-pocket spending for their labor and delivery, the mean spending for all modes of delivery was $4,569; the mean out-of-pocket spending for that same group of women for vaginal birth, specifically, was $4,314; and for cesarean deliveries, it was $5,161.[44] And the average proportion of delivery costs paid by patients has increased over time.[45]

56. Beyond childbirth, raising a child is expensive, both in terms of direct costs and due to lost wages. On average, women experience a large and persistent decline in earnings following the birth of a child, an economic loss that compounds the additional costs associated with raising a child.[46] In Iowa, the average cost of infant care is more than $10,000 per year, meaning it would take a minimum wage worker thirty-six weeks working full time to afford

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[42] Nat'l P'ship for Women & Fams., *Paid Leave Means a Stronger Iowa*, at 1 (Feb. 2023), available at https://nationalpartnership.org/wp-content/uploads/2023/02/paid-leave-means- a-stronger-iowa.pdf.
[43] *Id.*
[44] Michelle H. Moniz et al., *Out-of-Pocket Spending for Maternity Care Among Women With Employer-Based Insurance, 2008*, 39 Health Affrs. 18, 20 (2020).
[45] *Id.*
[46] Amanda Fins, Nat'l Women's L. Ctr, *.Effects of COVID-19 Show Us Equal Pay Is Critical for Mothers* (May 2020), available at https://nwlc.org/wp-content/uploads/2020/05/ Moms-EPD-2020-v2.pdf (analyzing the U.S. Census Bureau 2018 Current Population Survey and determining that mothers in the U.S. are paid 71 cents for every $1 fathers make, about $16,000 a year in lost wages).

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childcare for a single infant.[47] These costs can be particularly impactful for people who do not have partners or other support systems in place.

57. Most abortion patients do not consider adoption an equally acceptable substitute for abortion.[48] Placing a child for adoption can be very emotionally challenging for patients.[49] Adoption can also be expensive, involving medical, legal, and counseling costs. Patients who choose to place their infant for adoption also face physical risks and significant physiological changes associated with full-term pregnancy, labor, and delivery.

58. Women who are denied an abortion are, when compared to those who are able to access abortion, more likely to moderate their future goals and less likely to be able to exit abusive relationships. Their existing children are also more likely to suffer measurable reductions in achievement of child developmental milestones and an increasing chance of living in poverty. Finally, as compared to women who received an abortion, women who are denied abortions are less likely to be employed full-time, more likely to be raising children alone, more likely to receive public assistance, and more likely to not have enough money to meet basic living needs.[50] Research shows that 95% of women who have abortions continue to believe that it was the right decision

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[47] *Child Care Costs in the United States, The cost of child care in Iowa*, Econ. Pol'y Inst., https://www.epi.org/child-care-costs-in-the-united-states/#/IA (last updated Oct. 2020).

[48] Liza Fuentes et al., *"Adoption is just not for me": How abortion patients in Michigan and New Mexico factor adoption into their pregnancy outcome decisions*, 5 Contraception: X, 1 (2023).

[49] Gretchen Sisson, *"Choosing Life": Birth Mothers on Abortion and Reproductive Choice*, 25 Women's Health Issues 349, 351–52 (2015) (majority of 40 study participants describing adoption experiences as "predominantly negative," including those who "felt they had no options available to them other than adoption," and finding "lack of employment" as an "enduring variable[] that led participants to consider adoption despite their desire to parent"); *see also* Gretchen Sisson, *Who Are the Women Who Relinquish Infants for Adoption? Domestic Adoption and Contemporary Birth Motherhood in the United States*, 54 Persps. on Reprod. Health 46, 50 (2022) (majority of birth mothers who chose adoption reported annual income under $5,000).

[50] Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407, 409, 412–13 (2018).

for them three years later.[51] Those forced to carry an unwanted pregnancy to term are at increased risk of preterm birth and failure to bond with a newborn, and are less likely to escape poverty, less likely to be employed, less likely to escape domestic violence, and less likely to formulate and achieve educational, professional, and other life goals. Additionally, when pregnant people lack access to safe, legal abortion, some will attempt to self-induce an abortion, including in ways that can further jeopardize their health or life.

Other Harmful Impacts

59. Even where it is possible for patients to have an abortion in compliance with the Act and in light of all the other legal and logistical barriers, the Act will also force patients to race to a health center for an abortion to avoid missing the extremely narrow window when abortion is legally available to them. Although patients who have abortions demonstrate a strong level of certainty with respect to their decision, some patients take longer to make a decision than others. Thus, under the Act, some Iowans would be forced to rush into their decision out of fear that they will lose the opportunity altogether to have an abortion.

60. The Act will force some Iowans who cannot travel out of state for care to seek abortions outside the medical system using pills or other methods that may in some instances be unsafe.

61. The Act also will particularly harm patients who want to end a pregnancy because it is the result of rape or incest, as well as adult or adolescent patients who are at risk of abuse if a pregnancy is discovered. While the Act ostensibly exempts patients who are pregnant as a result of rape or incest, I understand that it does so only if they reported that abuse within an arbitrary period (forty-five days for rape, 140 days for incest), which survivors often do not do because of

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[51] Corinne H. Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study,* 10 PLOS ONE 1, 10 (2015).

a range of reasons, including out of shame and/or fear of repercussions for themselves or their partners or families.[52] I also understand that the rape and incest exceptions do not apply if the postfertilization age of the fetus is twenty or more weeks, which corresponds to approximately twenty-two weeks LMP or later.[53]

62. While the Act refers to situations involving a reported "rape," it does not define that term. My understanding is that Iowa law generally defines "sexual abuse" and "sexual assault" but not "rape."[54] Moreover, my and my patients' understanding of what constitutes rape, sexual abuse, and sexual assault might differ from that of law enforcement officials and others, especially in situations involving abuses of authority or in relationships that involve intimate partner violence. Because the Act fails to define the term "rape" or rely on a definition of that term elsewhere in Iowa law, the Act does not provide sufficient clarity about when the exception might apply.

63. I am concerned that the Board of Medicine might disagree with a determination I make that a victim has reported rape or incest. I also do not understand what the Act means when it requires victims to report rape or incest to a "private health agency which may include a family physician,"[55] and specifically which physicians would be included in that definition. Finally, I cannot tell from the language of the Act whether I can take a patient at their word when reporting an incident, or whether I am supposed to verify the incident somehow (and if the latter, how I would do that). Again, the Act will jeopardize patient health and safety and provider livelihood by placing providers in danger of losing their license and paying a fee of up to $10,000 if their interpretation of the exemptions is more lenient than the Board of Medicine's.

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[52] SF 579/HF 732 § 1(3)(a)–(b).
[53] *Id.* § 2(2)(b).
[54] Iowa Code § 709.1; Iowa Code § 915.40(10).
[55] SF 579/HF 732 § 1(3)(b)–(c).

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64. In addition, by conditioning the availability of abortion on reporting of rape or incest, the Act will deny needed care to survivors who do not wish to involve law enforcement or who do not wish to discuss the circumstances of their pregnancy as a mandatory condition of obtaining an abortion. In the United States, statistics show that approximately seventy-eight percent of rape and sexual assault cases were not reported to the police in 2021, due to factors including trauma and fear of violent retaliation from the abuser.[56]

65. The Act's harms will be especially grave for people who need to terminate a pregnancy for health or safety reasons. The Act exempts only those patients with a physical condition that threatens their life or poses a "serious risk of substantial and irreversible impairment of a major bodily function."[57] Pregnancy can pose a wide range of severe health problems that are not necessarily encapsulated by this exception. For example, pregnancy may exacerbate diabetes, hypertension, or multiple sclerosis, or cause an autoimmune disorder, such as Crohn's disease, to flare. Diabetic patients with depression or another underlying mental health condition can find their diabetes extremely challenging to manage during pregnancy. Further, pregnant patients with rapidly worsening medical conditions—who, prior to the Act, could have had an abortion without explanation—may be forced to wait for care until a physician determines that their conditions become deadly or threaten substantial and irreversible impairment so as to meet the exception.

66. I also expect that the Act's exclusion of psychological and emotional conditions, including suicidal ideation, from the medical emergency exception will harm our patients.[58] Mental health conditions are the leading underlying cause of twenty-three percent of pregnancy-

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[56] Alexandra Thompson & Susannah N. Tapp, U.S. Dep't of Just., *Criminal Victimization, 2021*, at 5 (Sept. 2022), available at https://bjs.ojp.gov/content/pub/pdf/cv21.pdf.
[57] SF 579/HF 732 § 1(4); Iowa Code § 146A.1(6)(a).
[58] SF 579/HF 732 § 1(4); Iowa Code § 146A.1(6)(a).

related deaths.[59] Psychiatric disorders may emerge for the first time during pregnancy, especially among people who have had negative reactions to hormonal contraception in the past or due to psychosocial risk factors, such as youth, poverty, substance use, or a lack of family support. These psychiatric issues can range from worsening anxiety and mood disorders to active suicidal ideation with intentions to self-harm or psychotic symptoms, such as hallucinations or intrusive thoughts. Someone with a documented history of mental illness whose condition is stable before pregnancy may experience a worsening of mental illness as a result of the hormonal and neurochemical changes to their body and stress and anxiety relating to pregnancy. Moreover, patients regulating a mental health condition with medication that carries risk to the fetus may need to discontinue or modify their medication in order to avoid risking harm to the fetus, but this will significantly increase the likelihood that mental illness recurs. In these situations, the pregnant person faces an increased risk of mental illness both during and after pregnancy because it is more difficult to return to equilibrium after relapse than it is to maintain a stable condition. My understanding is that these patients would not qualify for abortion services under the Act's exception for certain medical conditions.

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

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[59] *Four in 5 pregnancy-related deaths in the U.S. are preventable*, CDC (Sept. 19, 2022), https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html.

lose my license. It is terrible for patient safety to place providers in that dilemma at a time when they should be focused on providing the best care possible for their patient.

68. For patients who receive a severe fetal anomaly diagnosis, the Act bars physicians from terminating these pregnancies unless they certify that the fetus has a condition that is "incompatible with life."[60] I understand that even this exception does not apply after twenty weeks postfertilization, or approximately twenty-two weeks LMP.[61] There is no prenatal testing for fetal anomalies available at six weeks LMP or earlier. Indeed, many anomalies cannot be identified until eighteen to twenty weeks LMP, or even later in pregnancy.

69. The term "incompatible with life" is not a medical term. I do not use it in my practice, either in conversations with patients or in their medical records. In order to determine whether pregnancies fall within the scope of that term, I may need to consult with an attorney. To me, it is unconscionable that patients and their families may lose the ability to decide that termination is the most compassionate decision for a fetus that, if it survived to birth, would live a short, incapacitated, painful life.

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

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[60] SF 579/HF 732 § 1(3)(d).
[61] *Id.* § 2(2)(b).

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71. For all of these reasons, I believe that the Act will harm PPH and deprive PPH's patients of access to critical health care and will threaten their health, safety, and lives.

72. This Court's intervention to bar enforcement of the Act and prevent these grave harms is urgently needed: as of July 12, 2023, PPH already has abortions scheduled for 145 patients in Iowa for the weeks of July 10 and July 17, and *all* of these patients are over six weeks LMP. Therefore, these patients are already grappling with the uncertainty of whether they will be able to receive care, and all of them will be prohibited from having abortions if the Act remains in effect.

73. Leaving the Act in place, even for a matter of days, would also impose additional and substantial logistical, emotional, and financial burdens on patients. As discussed above, particularly because PPH's Iowa patients make two trips to a health center before having abortions, many of our patients must make advance preparations to have abortions, including by finding childcare, asking for time off work and missing out on earnings for that time, and potentially traveling long distances to reach our health centers. It is critically important that PPH be able to assure patients relying on their upcoming appointments that abortion services in Iowa will remain available as planned.

I declare under penalty of perjury that the foregoing is true and correct.

Signed this 11th day of July, 2023

Sarah A. Traxler, M.D., M.S., F.A.C.O.G

NOTARY PUBLIC

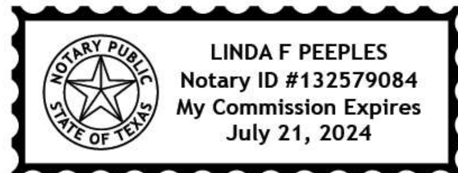
State of Texas

County of Harris

The foregoing instrument was acknowledged before me this July 11th, 2023(date) by Dr. Sarah A. Traxler. This notarial act was an online notarization via two-way webcam and audiovisual technology. Produced Minnesota Driver License as identification along with multi-factor KBA authentication.

,Online Notary Public

Signature of Online Notary Public



LINDA F PEEPLES
Notary ID #132579084
My Commission Expires
July 21, 2024

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Exhibit A

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PLANNED PARENTHOOD NORTH CENTRAL STATES
Curriculum Vitae

Date: 05/2023

Sarah Ann Traxler, MD, MS, FACOG

Address: Planned Parenthood North Central States
671 Vandalia Street
Saint Paul, Minnesota 55114 United States

If you are not a U.S. citizen or holder of a permanent visa, please indicate the type of visa you have:
none (U.S. citizen)

Education:

2015	M.S.H.P.	University of Pennsylvania, Perelman School of Medicine Philadelphia, Pennsylvania (Health Policy Research)
2009	M.D.	Oregon Health and Science University, Portland, Oregon
1997	B.A.	Newcomb College, Tulane University, New Orleans, Louisiana (Spanish and Latin American Studies – *cum laude*)
1995		Universidad de Madrid, Madrid, Spain (Spanish)

Postgraduate Training and Fellowship Appointments:

2013-2015	Fellow, Contraceptive Research and Family Planning University of Pennsylvania, Department of Obstetrics and Gynecology, Philadelphia, Pennsylvania
2009-2013	Resident, Obstetrics and Gynecology, University of Minnesota, Minneapolis, Minnesota

Institutional Appointments:

2019-present	Medical Director Planned Parenthood of the Heartland (PPH) Des Moines, IA
7/2018-present	Chief Medical Officer Planned Parenthood North Central States Saint Paul, MN
5/2017-present	Medical Director Planned Parenthood Minnesota, North Dakota, South Dakota, Saint Paul, MN

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2017-present	Laboratory Director, Planned Parenthood Minnesota, North Dakota, South Dakota (PPMNS) South Dakota Health Center
2019-present	Laboratory Director, Planned Parenthood of the Heartland (PPH)
8/2015-5/2017	Associate Medical Director Director of Family Planning Services Planned Parenthood Minnesota, North Dakota, South Dakota, Saint Paul, MN
2015-present	Adjunct Assistant Professor University of Minnesota Medical School
2014-2015	Instructor in Obstetrics and Gynecology, University of Pennsylvania School of Medicine, Philadelphia, PA, University of Pennsylvania

Hospital and/or Administrative Appointments:

2018-present	Medical Staff Department of Obstetrics and Gynecology Regions Hospital
2016-present	Medical Staff Obstetrics, Gynecology, and Women's Health University of Minnesota Medical Center, Minneapolis, MN
2014-2015	Attending in Obstetrics and Gynecology, Hospital of the University of Pennsylvania, Department of Obstetrics and Gynecology, Philadelphia, PA

Specialty Certification:

2015, current	Diplomate, American Board of Obstetrics and Gynecology
Current	Board Eligible, Senior Candidate, Complex Family Planning Subspecialty Certification (exam July 2023)

Licensure:

Current	Minnesota Medical Licensure
Current	South Dakota Medical Licensure
Current	North Dakota Medical Licensure
Current	Iowa Medical Licensure
Current	Nebraska Medical Licensure
Current	Maine Medical Licensure

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Awards, Honors and Membership in Honorary Societies:

2008	The Robert H. Kaplan Resident Award for outstanding diagnostic and technical skills in obstetrics and gynecology
2009	The Laura Edwards Resident Award for excellence in obstetrics and gynecology
2016-present	Disparities Leadership Program
2021	Minneapolis/St. Paul Business Journal Health Care Hero Award
2023	Advocates for Better Health First a Physician Award

Memberships in Professional and Scientific Societies and Other Professional Activities:

2004-2009	Medical Students for Choice (Student Leader)
2004-present	American Medical Association
2006-present	American Congress of Obstetricians and Gynecologists (Physician Member, Junior Fellow (2006-2015), Fellow (2015-present)
2014-present	Society of Family Planning
2014-present	Physicians for Reproductive Health
2014-2019	Association of Reproductive Health Professionals
2014-present	National Abortion Federation
2014-present	Leonard David Institute of Health Economics (fellow)
2015-2021	Minnesota Medical Association
2015-present	Twin Cities Medical Society
2018-2020	Minnesota Medical Association, Medical Legal/Ethics Committee
2018-present	Twin Cities Medical Society, Board of Directors (President 2020-2021)
2018-present	Medical Director Council, Inc. Board of Trustees, Treasurer
2017-present	MN Chapter, American Congress of Obstetricians and Gynecologists Legislative Committee

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Academic and Institutional Committees:

2015-present	Clinical Research Committee
2018-present	Afaxys Clinical Advisory Board
2017-present	Planned Parenthood Minnesota, North Dakota, South Dakota Executive Team
2017-present	Clinical Quality and Risk Management Committee, PPMNS
2018-2021	Society of Family Planning, Clinical Affairs Subcommittee

Lectures by Invitation:

Feb, 2014	Penn Nursing Students for Choice, Speaker, “Abortion 101: Procedural Basics”
Feb, 2014	Hospital of The University of Pennsylvania Department of Obstetrics and Gynecology Grand Rounds: “Is Depo-Provera a safe contraceptive for adolescents: a debate regarding bone health”
Mar, 2014	Penn Nursing Students for Choice, Speaker, Trainer: “Manual Vacuum Aspiration and IUD Placement”
Apr, 2014	Speaker, Medicine-Pediatrics Residency Didactic, Philadelphia, PA: “Issues in Reproductive Healthcare: Women with Intellectual and Developmental Disabilities”
May, 2014	Speaker, Mid-Atlantic Cystic Fibrosis Research Consortium, Villanova, PA: “Contraceptive Hormones and Women with Cystic Fibrosis”
June, 2014	Family Planning Council Annual Meeting Breakout Session, Philadelphia, PA: “Providing Long-Acting Reversible Contraception to Young Women”
Oct, 2014	Grand Rounds Speaker, University of Nebraska, Omaha, NE: “Contraception in the Adult Cystic Fibrosis Population”
Dec, 2014	Division of Pulmonology, Children’s Hospital of Pennsylvania: “Contraception, Abortion and Early Pregnancy Failure”
Mar, 2015	Temple University Law Students for Reproductive Justice, panel speaker: “Provider Perspectives”
Mar, 2015	Penn Nursing Students for Choice, Speaker, Trainer: “Manual Vacuum Aspiration and IUD Placement”
Apr, 2015	Medical Students for Choice Annual Meeting Philadelphia, PA: “Products of Conception and Post Procedure Care”

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Apr, 2015	Hospital of The University of Pennsylvania Department of Obstetrics and Gynecology Resident Didactic: "Abortion Complications"
Apr, 2015	Hospital of the University of Pennsylvania Department of Obstetrics and Gynecology Resident Didactic: "Cancer and Contraceptive Hormones"
May, 2015	Fellowship in Family Planning, National Meeting: "Family Planning in the Adult Cystic Fibrosis Population: Utilization, Preferences and Impact on Contraception Use"
Apr, 2016	Women's Health OB/GYN Update, HealthPartners: "The Right Contraception: How to choose and how to start"
May, 2016	Teen Pregnancy Prevention Month, Planned Parenthood: "Teen Pregnancy in the US: What it looks like and how to prevent it"
Sept, 2017	Minnesota Reproductive and Sexual Health Update: "What's New in Contraception" & "Focusing on Contraception in Medically Complicated Women"

Bibliography:

Research Publications, peer reviewed (print or other media):

1. O'Rourke RW, Kay T, Lyle EA, Traxler SA, Deveney CW, Jobe BA, Roberts CT Jr, Marks D, Rosenbaum JT. "Alterations in peripheral blood lymphocyte cytokine expression in obesity." *Clinical and Experimental Immunology*. 2006 Oct;146(1): 39-46.

2. Stanczyk M, Deveney CW, Traxler SA, McConnell DB, Jobe BA, and O'Rourke R. "Gastro-gastric Fistula in the Era of Divided Roux-en-Y Gastric Bypass: Strategies for Prevention, Diagnosis, and Management." *Obesity Surgery*. 2006 Mar;16(3): 359-364.

3. Roe AH, Traxler SA, Hadjiliadis D, Sammel MD, Schreiber CA. "Contraceptive choices in a cohort of women with cystic fibrosis." *Respiratory Medicine.* 2016 Dec;121:1-3.

4. Traxler, SA et al. "Fertility considerations and attitudes about family planning among women with cystic fibrosis." *Contraception.* 2019 Sep;100(3):228-233.

5. Horvath S, Goyal V, Traxler S, Prager S. "Society of Family Planning committee consensus on Rh testing in early pregnancy," *Contraception.* 2022 Oct;114:1-5.

6. Borchert K, Thibodeau C, Varin P, Wipf H, Traxler S, Boraas C. "Medication abortion and uterine aspiration for undesired pregnancy of unknown location: A retrospective cohort study," *Contraception.* 2023 Jun;122.

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Research Publications, peer-reviewed reviews:

1. Roe A, Traxler S, Schreiber CA. "Contraception in Women with Cystic Fibrosis: A Systematic Review of the Literature," *Contraception.* 2016 Jan;93(1):3-10.

Abstracts and posters:

1. Traxler S, Hadjiliadis D, Schreiber CA, Mollen C. "Understanding how women with cystic fibrosis make decisions about family planning." Poster presentation, American Society for Reproductive Medicine Annual Meeting. Baltimore, MD. October 2015.
2. Roe A, Traxler S Hadjiliadis D, Schreiber CA. "Contraceptive Needs and Preferences in a Cohort of Women with Cystic Fibrosis" Poster presentation, American College of Obstetrics and Gynecology Annual Meeting. San Francisco, CA. May 2015.

Editorials, Reviews, Chapters, including participation in committee reports (print or other media):

1. Schreiber, CA; Traxler SA: The State of Family Planning. *Clinical Obstetrics & Gynecology.* Rebekah Gee (eds.). Lippincott Williams & Wilkins, 2015.