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IN THE DISTRICT COURT OF GUAM

SHANDHINI RAIDOO, *et al.*, Plaintiffs, vs. LEEVIN TAITANO CAMACHO, *et al.*, Defendants.	CIVIL CASE NO. 21-00009 **MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION**

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INTRODUCTION

For more than four decades, Guamanians have fought to ensure and maintain access to safe and legal abortion on the island. However, because the challenged laws prevent Plaintiffs from providing pre-viability abortion care to patients in Guam, there are no known providers of legal abortion in Guam. Guamanians who seek to exercise their constitutional right to abortion are currently being forced to travel nearly 4,000 miles *each way* to Hawai'i, or even farther, to obtain a legal abortion. This imposes significant and, for many, insurmountable burdens on Guamanians and their families. Indeed, Plaintiffs have had multiple, heartbreaking conversations with individuals in Guam seeking abortions who are unable to make the journey to Hawai'i and must either carry their pregnancies to term against their will or seek care outside the medical system. Even for those who are able to make the journey, being forced to travel elsewhere in the United States in order to exercise one's constitutional rights imposes an additional, dignitary harm on Guamanians—raising questions of the meaning of citizenship, equality, national identity, and difference—that only compounds the ongoing injury caused by the lack of abortion access on the island. That Guam, like the rest of the world, is also in the midst of a global pandemic that makes travel, at best, difficult and dangerous—and, at worst, impossible—renders the situation simply intolerable.

Plaintiffs are two OB/GYNs with nearly three decades of combined experience providing comprehensive reproductive health care, including abortion, licensed to practice medicine in both Hawai'i and Guam. Since 2016, Plaintiffs, who are located in O'ahu, have been providing medication abortion care using telemedicine to eligible patients throughout Hawai'i, the majority of whom lived on islands where there are no abortion providers, and who would otherwise have to fly hundreds of miles to obtain care. But for the challenged laws, Plaintiffs would be able to

offer this service to eligible patients in Guam and thereby restore access to abortion to those on the island.

For the reasons set forth below, and under clear Supreme Court and Ninth Circuit precedent, by preventing Plaintiffs from providing medication abortion using telemedicine, the challenged laws effectively and unconstitutionally prohibit pre-viability abortion in Guam today. Even to the extent the challenged laws do not eliminate access to legal abortion outright, they create burdensome and medically unnecessary requirements that impose an unconstitutional undue burden on patients seeking pre-viability abortion—again in violation of clear Supreme Court and Ninth Circuit precedent. As such, the challenged laws are currently inflicting and will continue to inflict irreparable harm on those seeking abortions in Guam, and the balance of equities and public interest weigh heavily in favor of injunctive relief.

I. STATUTORY BACKGROUND

Guam law mandates that all abortions "be performed" by an appropriately licensed physician "in the physician's adequately equipped medical clinic or in a hospital approved or operated by the United States or [Guam]." 9 G.C.A. § 31.20(b)(2) (the "Clinic Requirement" or "Section 31.20").[1] This requirement was enacted in 1978 as part of the statute that de-criminalized abortion in Guam. Decl. of Michael Lujan Bevacqua, Ph.D., attached hereto as Ex. 1, ¶ 24. For purposes of this statute, "abortion" is defined to mean "the termination of a human pregnancy with an intention other than to produce a live birth or to remove a dead fetus." 9 G.C.A. § 31.20(a). The Clinic Requirement, which was enacted before medication abortion was available, does not differentiate between (i) procedural abortions, which are medical procedures typically performed by a health care provider in a clinical setting, and (ii) medication abortions. Medication abortions are not procedures at all, but two medications self-administered by the patient, over a period of

[1] Additional laws regulating abortion, which are not challenged in this lawsuit, including extensive reporting requirements, are set forth in ¶¶ 19–33 of the Complaint.

24–48 hours, that induce what is essentially a miscarriage while the patient is outside the clinical setting (usually at home). *See infra* pp. 7–8. Failure to comply with the Clinic Requirement is a third-degree felony, *see* 9 G.C.A. § 31.21, and could also lead to professional disciplinary action (including loss of medical license), *see, e.g.*, 10 G.C.A. § 12209(d)(3).

Guam law also requires that the abortion provider or another "qualified person" provide a patient certain mandated information *in person* at least 24 hours prior to an abortion, except in medical emergencies. 10 G.C.A. §§ 3218.1(b)(1), (b)(2) (the "State-Mandated Information Law" or "Section 3218.1"). Abortion for purposes of this statute is defined to include, *inter alia*, "the use or prescription of any instrument, medicine, drug, or other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth." *Id.* at (a)(1). This information must also be delivered to the patient "individually" and "in a private room." *Id.* at (b)(4). Failure to comply with the State-Mandated Information Law is a misdemeanor and could also result in professional disciplinary action (including loss of medical license), and other civil and administrative penalties. *Id.* at (f)–(g); *see also* 10 G.C.A. § 12209(d)(3).

Guam law permits the use of telemedicine by Guam-licensed physicians to provide medical treatment or obtain informed consent. *See generally* Guam Att'y Gen. Op. No. 17-0351 (Nov. 6, 2017). Although Guam law does not contain any *explicit* restrictions on the use of telemedicine in the context of abortion, as explained further below, the ambiguous and outdated language of the Clinic Requirement as applied to medication abortion, along with the State-Mandated Information Law's in-person requirement, effectively prohibit Plaintiffs from using telemedicine to counsel and provide medication abortion to eligible patients in Guam.

II. FACTS

A. Background on Abortion Safety and Access

Abortion is a fundamental component of comprehensive reproductive health care. In the United States, approximately 1 in 4 women will have an abortion by the age of 45. *See, e.g.*, Decl. of Mark Nichols, M.D., attached hereto as Ex. 2 ¶ 11. People have abortions for a wide variety of complex and often interrelated reasons. For example, people have abortions because, *e.g.*, they conclude that it is not the right time to become a parent or have additional children, they lack the necessary financial resources or a sufficient level of partner or familial support or stability, or because having a child or additional children would interfere with their educational and career goals. *See, e.g.*, Decl. of Sierra Washington, M.D., attached hereto as Ex. 3 ¶ 21; Decl. of Bliss Kaneshiro, M.D., attached hereto as Ex. 4 ¶ 12; Decl. of Shandhini Raidoo, M.D., attached hereto as Ex. 5 ¶ 11. Other people seek abortions because the pregnancy is the result of rape or incest, because continuing with the pregnancy could pose a risk to their health, or because of a fetal diagnosis. *Id*. The majority of abortion patients report a religious affiliation; of those patients, a majority identify as Catholic. Washington ¶ 21 n.6. A majority of women who have abortions already have at least one child. *Id.* at ¶ 20.

As a recent, robust analysis of abortion conducted by the National Academies of Sciences, Engineering, and Medicine ("NASEM") confirmed, legal abortion is one of the safest medical procedures or treatments provided in the United States today. Nichols ¶ 14; *see also* Washington ¶ 23; Kaneshiro ¶ 10; Raidoo ¶ 9.[2] Serious complications occur in less than one percent of abortions and abortion-related emergency room visits constitute just 0.01% of all emergency room visits by women of reproductive age in the United States. Nichols ¶ 14; Washington ¶ 24; Kaneshiro ¶ 26; Raidoo ¶ 25. Abortion-related mortality in the United States is lower than that

[2] The NASEM was established by Congress in 1863 to provide independent, objective expert analysis and advice to the nation to inform public policy. Nichols ¶ 14.

for colonoscopies, plastic surgery, dental procedures, and adult tonsillectomies. Kaneshiro ¶ 10; Raidoo ¶ 9.

Moreover, abortion is significantly safer than its only alternative—carrying a pregnancy to term and giving birth. Nichols ¶¶ 15–19; Washington ¶¶ 62–75; Raidoo ¶ 9; Kaneshiro ¶ 10. For example, in the United States, the risk of death (mortality) associated with childbirth is approximately 14 times greater than the risk of death associated with legal abortion. Nichols ¶ 15; Washington ¶ 63. Data suggest mortality associated with childbirth is even greater in Guam.[3]

Evidence overwhelmingly demonstrates that access to safe and legal abortion is extraordinarily important for public health. Nichols ¶¶ 18–24, 62–63, 71; Washington ¶¶ 61, 76–79. Studies show that people who are denied wanted abortions and forced to carry their pregnancies to term face not only the risks of complications from pregnancy and childbirth, which are significant, but they (and their children) also face an increased risk of physical and economic harm. Washington ¶ 76; Nichols ¶¶ 15–20; Raidoo ¶¶ 35–36; Kaneshiro ¶¶ 36–37. It is also well-documented, including in Guam, that when safe, legal abortion is unavailable or difficult to access, some people will resort to unsafe methods to terminate a pregnancy, which could result in serious complications and/or death. Compl. ¶¶ 51–53; Nichols ¶ 24; Washington ¶¶ 77–79; Kaneshiro ¶ 38; Raidoo ¶ 37. For example, in the nearby Philippines, where abortion has been criminalized for over a century, approximately 1,000 women die and approximately 100,000 women are hospitalized each year from complications of unsafe abortion. Washington ¶ 78.

Although legal abortion is very safe throughout pregnancy, the risks associated with it increase as pregnancy advances; each week that a patient is delayed can increase the risk of harm. Nichols ¶ 21; Washington ¶ 86; Raidoo ¶ 29; Kaneshiro ¶ 30. Delay can also push patients past the point in pregnancy at which a medication abortion is available, forcing patients to undergo

[3] According to the Centers for Disease Control and Prevention (CDC), the case-fatality rate for abortion for 2013–2017 was only approximately 0.44 deaths per 100,000 legal abortions. Washington ¶ 66. The average maternal mortality rate in Guam between 2008–2017 was approximately 27.0 deaths per 100,000 live births. *Id.*

more invasive, and usually more expensive, in-clinic abortion procedures. *Id.* That is why the American College of Obstetricians and Gynecologists (ACOG) and other leading medical professional organizations have affirmed that abortion is "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." Nichols ¶ 21.

While most patients seek abortion as soon as they are able, raising funds to cover health care and travel costs are the most common reasons given for delaying access to care. Washington ¶¶ 82–84; *see also* Kaneshiro ¶ 31; Raidoo ¶ 30. Here, the significant financial and logistical obstacles imposed by travel to Hawai'i or beyond to access abortion can substantially delay or prevent access to care entirely. According to the most recent data available in the United States, most people seeking abortion live at or near the federal poverty level (FPL), Nichols ¶ 13, and the poverty rate in Guam is extremely high (22.5%)—higher than anywhere else in the 50 states or District of Columbia, Washington ¶ 65. The cost of an in-clinic medication abortion or abortion procedure in Hawai'i alone ranges from $400–$7,000 and many abortion patients lack insurance coverage for abortion. *See* Kaneshiro ¶¶ 32–33; Raidoo ¶¶ 31–32.[4] On top of the costs of care itself, Guam patients also face substantial air-travel costs (approximately $1,500 for a roundtrip, economy ticket) and out-of-pocket costs (*i.e.*, ground transportation, food, lodging, and lost wages) along with the logistical hurdles (*i.e.*, arranging and paying for childcare, obtaining time off of work) that come with a potentially multi-day trip. *See* Kaneshiro ¶¶ 34–35, 72–73; Raidoo ¶¶ 33–34, 71–72. The COVID-19 pandemic and ensuing disruptions in employment, childcare, transportation, and health insurance, along with travel restrictions, have only compounded these obstacles and added additional layers of risk and complexity to travel. Washington ¶ 85. For example, this past summer, it took one of Plaintiffs' patients and her husband several weeks to

[4] Both federal Medicaid and the federal insurance program for military members and dependents exclude coverage for abortion, except in very narrow instances. Compl. ¶¶ 77, 90. Even patients with private insurance may not have a plan that covers abortion or may have significant co-pays or deductibles. Kaneshiro ¶ 33; Raidoo ¶ 32.

secure funds and make arrangements to travel from Guam to Hawai'i; by the time she arrived, she required a far more expensive procedure that cost thousands of dollars. Kaneshiro ¶ 77. Moreover, Plaintiffs had to contact local government authorities in Hawai'i not only to ensure that the patient would be permitted to leave the mandatory quarantine at her hotel in order to get her abortion but also to ensure that her husband would be able to also leave the hotel to assist with transportation. *Id.* Another patient was forced to quarantine away from her family for two weeks upon her return to Guam. Raidoo ¶ 75; *see also* Compl. ¶ 86. For these reasons, and as discussed further below, by restoring access to abortion in Guam, expanding access to early abortion and reducing travel and associated delay, the use of telemedicine to provide medication abortion greatly benefits patient health and safety.

B. Medication Abortion and Telemedicine

There are two main methods of abortion: procedural (sometimes referred to as "surgical") and medication abortion. Washington ¶ 25; Raidoo ¶ 12; Kaneshiro ¶ 13. Both methods are safe, effective means of terminating a pregnancy. Raidoo ¶ 12; Kaneshiro ¶ 13.[5] In 2000, the U.S. Food and Drug Administration ("FDA") approved a two-drug regimen—mifepristone and misoprostol—for medication abortion. Nichols ¶ 37; Washington ¶ 44. Medication abortion is typically available up to 10–11 weeks of pregnancy. Nichols ¶ 30; Kaneshiro ¶ 17; Raidoo ¶ 16. An identical regimen is also offered to patients experiencing a miscarriage. Nichols ¶ 31. To date, more than four million women have had a medication abortion in the United States, and a majority of patients 10-weeks-pregnant or less choose medication abortion over a first-trimester abortion procedure. Nichols ¶ 38; Washington ¶ 44; Kaneshiro ¶¶ 14, 27; Raidoo ¶¶ 13, 26.

[5] In the first and early second trimester, procedural abortions are generally performed by a clinician using gentle suction to empty the contents of the uterus (most commonly referred to as "aspiration abortion"). Nichols ¶ 26; Washington ¶ 28; Kaneshiro ¶ 13 n.5; Raidoo ¶ 12 n.5. This procedure is also used to treat early miscarriages. *Id.* Beginning in the early second trimester, procedural abortions are generally performed by the clinician dilating the cervix and using instruments to remove the contents of the uterus (referred to as a "dilation and evacuation" or "D&E" abortion). Washington ¶ 29; Nichols ¶ 27; Kaneshiro ¶ 13 n.5; Raidoo ¶ 12 n.5.

Both medications used in a medication abortion are approved by the FDA for self-administration by the patient without direct clinical supervision. Nichols ¶ 31; Washington ¶ 41. For this reason, abortion and miscarriage patients typically take the medications at home or in another location of their choosing. Nichols ¶¶ 29, 31. The FDA generally requires that authorized prescribers *dispense* mifepristone to patients in person at a medical office, clinic, or hospital (rather than through a pharmacy). Kaneshiro ¶ 18; Raidoo ¶ 17. However, some physicians (including Plaintiffs) have been permitted by the FDA to send mifepristone directly to patients for years, subject to compliance with certain FDA-approved protocols. *See infra* pp. 11–12. There are no such limitations on misoprostol, which can be obtained directly from a physician or from a pharmacy with a prescription, either by mail or in person. Kaneshiro ¶ 19; Raidoo ¶ 18.

In a medication abortion, the patient first takes the mifepristone and then takes the misoprostol, approximately 24- to 48-hours later. Washington ¶¶ 26, 41; Nichols ¶ 31; Kaneshiro ¶¶ 16, 20–21; Raidoo ¶¶ 15, 19–20. Approximately 2- to 24-hours after taking the misoprostol, the patient will experience cramping and bleeding and the passing of small blood clots, just like in an early miscarriage. Washington ¶¶ 26, 41; Nichols ¶ 31; Kaneshiro ¶¶ 21, 23; Raidoo ¶¶ 20, 22.[6] As noted above, the bleeding, cramping and passing of small blood clots that occur during a medication abortion are intended to occur—and virtually always do occur—while the patient is at home. Washington ¶ 42; Kaneshiro ¶¶ 16, 85, 87; Raidoo ¶¶ 15, 81, 83. Indeed, the primary difference between a medication abortion and an early miscarriage is that a miscarriage is usually unexpected and does not occur under such controlled circumstances. Kaneshiro ¶ 24; Raidoo ¶ 23.

As with all abortion, medication abortion is extremely safe. Nichols ¶¶ 37–41; Washington ¶¶ 50–58. Indeed, the FDA has acknowledged the impressive safety record of

[6] The assessment, counseling, prescription, and follow-up process for medication abortion is set forth more fully in the declaration of Plaintiffs' expert Dr. Washington, attached hereto. *See* Washington ¶¶ 31–43.

medication abortion and concluded that rates of major adverse events arising from medication abortion are exceedingly rare, generally far below 0.1%. Nichols ¶¶ 39, 41; Washington ¶ 51; Kaneshiro ¶ 26; Raidoo ¶ 25. A very small percentage of medication abortion patients may require some form of non-emergency follow-up care (*i.e.*, an additional dose of misoprostol or aspiration procedure) to complete the abortion, which is no different than the care provided to patients experiencing a miscarriage that has failed to complete naturally. Washington ¶¶ 54–57; Kaneshiro ¶ 25; Raidoo ¶ 24. Misoprostol can be obtained with a prescription from any pharmacy, and any OB/GYN can perform a uterine aspiration (the ability to do so is a requirement of board-certification). Washington ¶¶ 55–56.

Many people prefer medication abortion because it allows them to undergo the abortion in the privacy of their own home, may feel more natural than undergoing a medical procedure, and/or may provide a greater sense of control over the process. Nichols ¶¶ 33–34; Washington ¶¶ 45–46; Kaneshiro ¶¶ 27–28; Raidoo ¶¶ 26–27. For others, such as survivors of sexual assault, medication may be preferable to avoid having instruments placed in their vagina. Nichols ¶ 34; Washington ¶ 49; Kaneshiro ¶ 28; Raidoo ¶ 27. Those who may fear violence or retaliation if their abortion decision is exposed may choose medication abortion because it presents like a spontaneous miscarriage. Washington ¶ 47; Kaneshiro ¶ 28; Raidoo ¶ 27. Indeed, where it can be obtained by mail, medication abortion presents significant benefits over procedural abortion for patient privacy and confidentiality. This is particularly true for patients in Guam, as requiring an off-island trip likely requires multiple days away from home and work, and therefore makes it more difficult for Guam patients to keep their abortion decision private. *See* Kaneshiro ¶ 35; Raidoo ¶ 34; Washington ¶ 83. Finally, for patients with certain medical conditions, medication abortion has a lower risk of complications and failure than procedural abortion. Nichols ¶ 35; Washington ¶ 48.

Medication abortion is routinely provided to patients in a variety of settings, including by telemedicine. Indeed, telemedicine—the use of electronic information and telecommunications technologies to support the delivery of health care services remotely—is regularly used the world-over to counsel patients, obtain informed consent, and provide a wide range of medical care, including OB/GYN care. Nichols ¶¶ 42–52. Over the past decade, medication abortion has been provided via telemedicine throughout the United States, as well as abroad, and there is an extensive body of evidence demonstrating its safety and efficacy. Nichols ¶¶ 55–61, 73; Washington ¶ 98. Telemedicine medication abortion has also been incredibly important in expanding patient access, especially in underserved areas. Nichols ¶¶ 49, 62–65, 71; Raidoo ¶¶ 38, 44–45; Kaneshiro ¶¶ 39, 45–46. More recently, the COVID-19 pandemic has accelerated an increase in the use of telemedicine for OB/GYN care, including abortion, because it ensures patients can continue to access time-sensitive, comprehensive and also preventive care, while eliminating unnecessary in-person interactions for both patients and clinicians. Nichols ¶ 52; *see also* Washington ¶¶ 38, 91–92; Compl. ¶ 154 (describing expansion of telemedicine at Guam Regional Medical Center).

There is clear medical consensus that a clinician can evaluate a patient's eligibility for medication abortion, counsel the patient, and obtain informed consent entirely using telemedicine. *See, e.g.*, Nichols ¶¶ 53–67; Washington ¶¶ 32–38, 89–94. As the NASEM has concluded, "[t]here is no evidence that the dispensing or taking of [medication abortion pills] requires the physical presence of a clinician." Nichols ¶ 56.[7] For example, and as explained more fully in the attached declarations, a prescribing clinician does not have to conduct a physical examination of the patient to prescribe medication abortion; rather, a patient's eligibility for medication abortion can be determined through diagnostic testing (*e.g.*, ultrasounds, blood tests) obtained locally and then

[7] ACOG has likewise concluded that "medication abortion can be provided safely and effectively by telemedicine." *Id.*

transmitted to and reviewed by the prescribing clinician; or, where medically appropriate, eligibility may be determined entirely through a "question and answer" assessment, again conducted by the prescribing clinician using telemedicine. Washington ¶¶ 33–36,. 90. This sort of dialogue with patients and review of records by telemedicine is extremely common for all manner of treatments and procedures. Nichols ¶¶ 46–52; Washington ¶¶ 90–92. Likewise, patient counseling and informed consent conversations occur over telemedicine just as they do in person; a clinician provides the same information, *e.g.*, through live videoconference, that they would during an in-person visit, and patients have the same opportunity to ask questions and receive answers in real time. Nichols ¶¶ 48, 51, 64, 74.

Plaintiffs have extensive experience with providing medication abortion through telemedicine. Since 2016, Plaintiffs have used a direct-to-patient telemedicine model,[8] pursuant to FDA-approved protocols, to prescribe and mail medication abortion to hundreds of eligible patients in Hawai'i—the majority of whom lived on islands where there are no abortion providers. Kaneshiro ¶ 39; Raidoo ¶ 38. As explained more fully in the attached declarations, there is no meaningful difference between the protocols Plaintiffs follow to provide a medication abortion in person versus through telemedicine. Kaneshiro ¶¶ 39–69; Raidoo ¶¶ 38–67; Washington ¶¶ 88–103. Patients using this service—known as the TelAbortion Project—have been able to access medication abortion without having to fly hundreds of miles and potentially stay overnight at a hotel; and without incurring travel costs, childcare costs, lost wages and/or jeopardizing the confidentiality of their abortion decision. Kaneshiro ¶ 46; Raidoo ¶ 45. Similar programs in Colorado, Georgia, Illinois, Iowa, Maine, Maryland, Minnesota, Montana, New Mexico, New

[8] Direct-to-patient telemedicine is telemedicine care in which the patient receives care without traveling to a clinical setting. Nichols ¶ 46. Direct-to-patient telemedicine often utilizes live videoconferencing and is frequently used for services such as medication management, the diagnosis and treatment of primary or urgent care concerns, and psychiatry and psychotherapy visits. *Id.*

York, Oregon, Washington, and the District of Columbia have served eligible patients in those and other states. Nichols ¶ 62.

In Plaintiffs' experience, as is reflected in the published research, patient satisfaction with telemedicine medication abortion is extremely high; many even find it preferable to in-person care. Kaneshiro ¶ 68; Raidoo ¶ 67; Nichols ¶¶ 57–59, 63. Some of Plaintiffs' patients have told them that, if it were not for telemedicine, they would not have been able to obtain an abortion at all. Kaneshiro ¶ 68; Raidoo ¶ 67. Not only does the availability of telemedicine reduce barriers to access by eliminating long travel distances (including, as here, significant air travel), but the increased flexibility and control over the time and setting of the appointment reduces stress and makes it easier for patients to include partners, family members, or other support people in the abortion process. *Id*. Even when abortion care is accessible locally, telemedicine offers increased privacy and providers report that telemedicine enables a more patient-centered approach to care. Nichols ¶¶ 63, 65; Kaneshiro ¶¶ 47, 68; Raidoo ¶¶ 46, 67. It is also substantially less expensive than an in-person abortion in Hawai'i, *see supra* p. 6, costing only approximately $240 (plus whatever a patient may have to pay to obtain a pre-test from a local health care provider). Kaneshiro ¶ 60; Raidoo ¶ 59.

C. Abortion Access in Guam

Historical, ethnographic and linguistic evidence dating back to the 18th century indicates that, over time, women in Guam and throughout the region have utilized a variety of methods to induce miscarriage or end their pregnancies. Bevacqua ¶¶ 12–19. More recently, prior to the legalization of abortion in Guam in 1978, those who could afford it flew to Hawai'i or Japan to obtain legal abortions. *Id.* at ¶ 22. Others were forced to obtain illegal abortions on the island. *Id.* However, in 1978, Senator Concepcion Barrett successfully amended the penal code to de-

criminalize abortion. *Id.* at ¶¶ 23–25; *see also* 9 G.C.A. § 31.20.[9] Most recently, between 2008–17, approximately 200–300 people obtained abortions in Guam each year, the vast majority in the first or early second trimester. Compl. ¶¶ 56–57. During this period, nearly 60% of Guam abortion patients identified as Chamorro. *Id.* at ¶ 58.

In 2018, the last known doctor who provided abortions in Guam retired and, as has been widely reported, no physicians have taken his place. Compl. ¶¶ 61–71; *see also* Raidoo ¶¶ 8, 69–70, 78; Kaneshiro ¶¶ 9, 71, 81. As Governor Leon Guerrero herself has recognized, stigma against abortion on the island makes it difficult to find local doctors willing to provide the service. Compl. ¶¶ 66–70. For example, Guam's extensive reporting requirements make it impossible for a physician who provides abortion to protect their identity, and even the Governor's announcement that she wanted to recruit a doctor to provide abortions to the island was met with protests. *See id.* at ¶¶ 68, 70. As a result, hundreds of people who would otherwise access legal abortion on the island each year are currently unable to exercise their constitutional rights and obtain a safe and legal abortion in Guam without traveling thousands of miles by air. *Id.* at ¶ 72.

As set forth *supra* pp. 6–7, people seeking abortion in Guam face tremendous economic, logistical and social barriers to accessing care off-island. If anything, the pandemic has given rise to travel and severe quarantine restrictions that only make it more difficult for patients to afford, arrange, and explain off-island travel. Kaneshiro ¶¶ 74, 77–79; Raidoo ¶¶ 73, 75–76; Compl. ¶¶ 84–86. These substantial burdens prevent some patients from accessing abortion care altogether. Compl. ¶ 93; Kaneshiro ¶ 79; Raidoo ¶ 76. Indeed, since 2018, Plaintiffs have spoken to multiple individuals in Guam who wanted to come to Hawai'i to obtain an abortion, but for whom the financial and logistical obstacles were too difficult to overcome; there are likely many more for whom the prospect of traveling to Hawai'i is so daunting that they do not even reach out in first

[9] In his declaration, Plaintiffs' expert Dr. Michael Lujan Bevacqua more fully explains the ongoing efforts by women in Guam to maintain access to safe and legal abortion on the island, and why ensuring access to safe and legal abortion in Guam is consistent with Chamoru culture and history. *See* Ex. 1.

place. Kaneshiro ¶¶ 73–74, 76; Raidoo ¶¶ 72–74, 76; *see also* Compl. ¶ 92 (describing 2019 case of 12-year-old victim of rape forced to continue her pregnancy). Some of these individuals have asked if they could obtain a medication abortion using telemedicine, Kaneshiro ¶ 75; however, the challenged laws currently prevent Plaintiffs from offering this service to patients in Guam. Unable to access care in Guam, these patients have no option but to carry their pregnancies to term against their will or to seek abortion care outside the medical system, placing their health and wellbeing at risk. *See supra* p. 5. These burdens fall disproportionately on Chamoru women and women with children (the majority of people seeking abortions in Guam, *see* Compl. ¶¶ 58–59); on poor and low-income women; on servicemembers, disproportionately women of color, who cannot leave the island without permission from their chain-of-command; and on women experiencing intimate partner violence (IPV). Compl. ¶¶ 74, 82, 91; Washington ¶¶ 47, 82–84; Decl. of Holly Rawlings, attached hereto as Ex. 6 ¶¶ 16–17, 23–24, 27.

Even patients who are ultimately able to overcome the immense obstacle of flying thousands of miles away face delays that expose them to increased risks to their health, as well as increased costs. *See supra* pp. 5–7; Compl. ¶ 94; Kaneshiro ¶¶ 30, 35 73; Raidoo ¶¶ 29, 34, 72. Furthermore, traveling off-island makes it difficult, if not impossible, for patients to keep their abortion decisions confidential, which may be important for many given the stigma against abortion in Guam. Kaneshiro ¶ 35; Raidoo ¶ 34; Washington ¶ 83; Compl. ¶¶ 66–70. This risk of exposure (and associated harms) is particularly heightened for those experiencing IPV. Washington ¶ 47; Nichols ¶ 65; *see also* Rawlings, Ex. 6.

D. Telemedicine Abortion in Guam

Plaintiffs could easily expand their telemedicine practice to safely serve patients in Guam the same way they serve patients on Hawaiian Islands that have no abortion providers. Compl. ¶ 190; Raidoo ¶¶ 77–82; Kaneshiro ¶¶ 80–86; Washington ¶¶ 88–103; Nichols ¶¶ 68–70. This

would not only help restore abortion access to Guam, but also expand access to early abortion and reduce travel and associated delay, which would greatly benefit public health. *See supra* Facts, Sections II.A–B; *see also* Compl. ¶ 191. It would be particularly beneficial during the current pandemic because it would reduce unnecessary travel and in-person interactions. Compl. ¶ 191; Kaneshiro ¶ 83; Raidoo ¶ 79; Nichols ¶ 52, 71; Washington ¶ 88. Moreover, since previously most abortions in Guam already were provided in the first trimester, Compl. ¶ 57, offering medication abortion using telemedicine is well-suited to meet the existing need and would likely reduce the number of patients seeking abortions later in pregnancy, which would require off-island travel and imposes greater risks and costs. Compl. ¶ 192; Kaneshiro ¶ 84; Raidoo ¶ 80.

However, as discussed further below, the two challenged laws prevent Plaintiffs from providing medication abortion to patients in Guam through telemedicine, thereby effectively banning abortion care in Guam. First, the Clinic Requirement's outdated and ambiguous language provide Plaintiffs with no notice as to how to comply in the context of medication abortion and is subject to multiple and inconsistent interpretations by those who enforce it. *See* 9 G.C.A. § 31.20(b)(2) (requiring abortions "be performed" in an adequate clinical setting); *see also* Raidoo ¶¶ 83–84; Kaneshiro ¶¶ 87–88; Washington ¶ 96; Nichols ¶ 73. As such, Plaintiffs risk criminal penalties, along with disciplinary action against their license, if they use telemedicine to provide medication abortion to patients in Guam. Raidoo ¶¶ 84, 89; Kaneshiro ¶¶ 88, 93. Second, because the State-Mandated Information Law requires that certain information be provided to each abortion patient *in person*, Plaintiffs cannot use telemedicine to comply with this requirement. 10 G.C.A. §§ 3218.1(b)(1), (b)(2); *see also* Raidoo ¶¶ 85–87; Kaneshiro ¶¶ 89–92; Washington ¶¶ 93–95; Nichols ¶¶ 74–76. A patient's only option is to make a separate in-person trip to a different health care provider, simply to receive the information that could just as effectively be provided

over telemedicine. *Id.* Moreover, by requiring certain information be provided "individually" and "in a private room," the State-Mandated Information Law imposes burdensome and medically unnecessary restrictions on patients that will only exacerbate delays and undermine patient health, safety, and wellbeing. Kaneshiro ¶¶ 89–93; Raidoo ¶¶ 85–88; Nichols ¶¶ 74–77; Washington ¶¶ 93–95. Accordingly, absent relief from this Court, the challenged laws will continue to cause irreparable harm to Plaintiffs' patients' health, safety, and constitutional rights.

ARGUMENT

To obtain a preliminary injunction a plaintiff "must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Nat'l Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). The Ninth Circuit has "also articulated an alternate formulation of the *Winter* test, under which serious questions going to the merits and a balance of hardships that tips sharply towards the plaintiff can support issuance of a preliminary injunction, so long as the plaintiff also shows that there is a likelihood of irreparable injury and that the injunction is in the public interest." *Farris v. Seabrook*, 677 F.3d 858, 864 (9th Cir. 2012) (internal citations and quotations omitted). Under this "sliding scale" approach, "the elements of the preliminary injunction test are balanced, so that a stronger showing of one element may offset a weaker showing of another." *All. for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th Cir. 2011). Plaintiffs easily satisfy either formulation of the test.

I. Plaintiffs Are Likely to Succeed on Their Claim That the Clinic Requirement Is Unconstitutionally Vague as Applied to Medication Abortion.

"It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined." *Grayned v. City of Rockford*, 408 U.S. 104, 108–09 (1972).

A statutory prohibition is clearly defined if, and only if, it (1) affords a person of ordinary intelligence a "reasonable opportunity to know what is prohibited, so that the person may act accordingly," and (2) "provide[s] explicit standards for those who apply [it]," so as to protect against arbitrary and discriminatory enforcement. *Id.* There is a "heightened need for definiteness," and thus more exacting judicial review is required, where, as here, "a statute subjects violators to criminal penalties" and the uncertainty it creates "threatens to inhibit the exercise of constitutionally protected rights." *McCormack v. Herzog*, 788 F.3d 1017, 1029, 1031 (9th Cir. 2015) (internal citations and quotations omitted); *see also id.* at 1032–33; *Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 554 (9th Cir. 2004) (given criminal penalties and "the potential for harassment of abortion providers, it is particularly important that enforcement of any unconstitutionally vague provisions of the scheme be enjoined"). Indeed, the Ninth Circuit has repeatedly affirmed injunctions against the enforcement of criminal abortion restrictions on vagueness grounds. *See, e.g., Forbes v. Napolitano*, 236 F.3d 1009, 1012–13 (9th Cir. 2000), *amended*, 247 F.3d 903 (9th Cir. 2000), *and amended*, 260 F.3d 1159 (9th Cir. 2001); *McCormack*, 788 F.3d at 1030–33. Here, while the Clinic Requirement raises no vagueness concerns in the context of abortion *procedures*, its ambiguous and outdated language is unconstitutionally vague as applied to the provision of medication abortion. Thus, Plaintiffs are unable to use telemedicine to provide medication abortion to patients in Guam and the Clinic Requirement operates as a ban on pre-viability abortion in Guam.

As explained above, the Clinic Requirement requires that an "abortion [] be performed" in an "adequately equipped medical clinic or [hospital]." *See* 9 G.C.A. § 31.20(b)(2). The Clinic Requirement was enacted in 1978 as part of a statute intended to de-criminalize abortion and liberalize Guam's abortion laws consistent with the then-understanding of *Roe v. Wade*, but has not been amended or updated since that time. Bevacqua ¶ 24. At the time the Clinic Requirement

was enacted, medication abortion did not exist. Nichols ¶ 37 (mifepristone first approved by FDA in 2000); Washington ¶ 44 (same). Thus, consistent with the understanding of how abortions were provided in 1978, the Clinic Requirement, read literally, pre-supposes that a clinician will perform some sort of direct action that terminates the pregnancy and requires that act to occur in a clinical setting.

But this is not how medication abortion works. Unlike in a procedural abortion, where the uterus is evacuated and the pregnancy terminated by a clinician, *supra* note 5, a clinician providing medication abortion does not "perform" a procedure at all; rather, the clinician simply *prescribes* two medications to the patient, which the patient takes 24–48 hours apart, to induce the miscarriage-like process, *supra* pp. 7–8. And, unlike in a procedural abortion, a medication abortion patient does not pass the pregnancy in a clinical setting; rather, the pregnancy passes while the patient is at home (or in an alternative location of her choosing). *Supra* p. 8. Thus, unlike in a procedural abortion, the relative location of the patient and clinician at the moment the patient obtains the medications or even ingests the first medication is medically irrelevant. Nichols ¶ 73 n.48; *see also id.* at ¶ 56 at (NASEM concluding "there is no evidence to suggest" mifepristone must be provided in certain clinical facilities because "the abortion will occur outside the clinical setting").[10]

Accordingly, while what the Clinic Requirement requires of physicians performing abortion *procedures* may be clear—that is, that they "perform[]" such procedures and "terminate the [] pregnancy" in an adequate clinical setting—the same cannot be said of *medication abortion*. This ambiguity leaves abortion providers without any "reasonable opportunity to know what conduct is prohibited" by the Clinic Requirement when it comes to medication abortion and puts

[10] Indeed, as discussed above, one of the primary benefits of medication abortion is that it allows patients the ability to control when they initiate the process so that they can ensure they are at home (or a similar setting) when the pregnancy passes. *Supra* p. 8. The overwhelming body of evidence confirming the safety and efficacy of telemedicine medication abortion, including Plaintiffs' own experiences, merely underscores this fact. *Supra* Facts, Section II.B.

them in the position of having to "necessarily guess at [the Clinic Requirement's] meaning" in this context. *Tucson Woman's Clinic*, 379 F.3d at 554 (quoting *Planned Parenthood of Cent. & N. Ariz. v. Arizona*, 718 F.2d 938, 947 (9th Cir.1983)). For example, it would be reasonable to construe the operative act contemplated by the statute to be the act of prescribing and/or dispensing the two medications, regardless of where the patient is located at the time. This would not only accord with how medication abortion is provided but also with how abortion is defined in more recent legislation enacted in Guam. *See, e.g.*, 10 G.C.A. 3218.1(a)(1) ("Abortion means the use *or prescription* of any instrument, medicine, drug, or other substance or device to terminate [a] pregnancy") (emphasis added). It would also avoid the additional, and significant, constitutional issues raised if the law is construed to require the patient to obtain the medications in person, thereby prohibiting telemedicine. *See infra* pp. 21–27. And, as such, it would plainly be consistent with the legislative intent behind the Clinic Requirement, which was to bring Guam's abortion laws into compliance with federal constitutional standards, not restrict access to abortion.

However, there is simply no guarantee that those charged with enforcing the Clinic Requirement will not "differ as to [the Clinic Requirement's] application." *Tucson Woman's Clinic*, 379 F.3d at 554 (quoting *Planned Parenthood of Cent. & N. Ariz.*, 718 F.2d at 947). An alternative construction could interpret the operative act by the physician to be the act of handing medications to the patient. Although entirely medically unnecessary, this would require the prescribing physician and patient to be in the same physical location. Such an interpretation would effectively prohibit Plaintiffs from using telemedicine to provide medication abortion to eligible patients in Guam and operate as a ban on a pre-viability abortion in Guam. *See infra* pp. 21–27.

Without clear notice as to how to comply with the Clinic Requirement's vague language or a guarantee that the statute's enforcers will consistently (if ever) adopt a constitutionally

sufficient saving construction, Plaintiffs are left "between the Scylla of [] flouting state law and the Charybdis of forgoing . . . constitutionally protected activity in order to avoid becoming enmeshed in a criminal proceeding." *Steffel v. Thompson*, 415 U.S. 452, 462 (1974). In short, Plaintiffs cannot use telemedicine to provide medication abortion to patients in Guam without risking criminal and other significant penalties. The Ninth Circuit has repeatedly found abortion statutes void-for-vagueness under just such circumstances. *See, e.g.*, *Forbes*, 236 F.3d at 1012–13 (criminal abortion statute void-for-vagueness where doctors could conceivably construe vague terms to permit a particular course of action, but because "police, prosecutors, juries and judges [have] no standards to focus the statute's reach" the state might consider the same action to be "illegal under the statute"); *Tucson Woman's Clinic*, 379 F.3d at 555 (criminal abortion provision void-for-vagueness where understandings of what it requires are "widely variable" and it thus "subject[s] physicians to sanctions based not on their own objective behavior, but on the subjective viewpoints of others") (internal quotation marks omitted); *McCormack*, 788 F.3d at 1031–32 (criminal abortion statute void-for-vagueness where, *inter alia*, statute's requirements were "subjective and open to multiple interpretations" and the "lack of clarity may operate to inhibit [the provision of legal abortion services]") (internal quotation marks and citations omitted). Accordingly, Plaintiffs are likely to succeed on the merits of their claim that the Clinic Requirement is unconstitutionally vague as applied to medication abortion.[11]

[11] While enjoining the application of the Clinic Requirement on vagueness grounds would be consistent with Ninth Circuit precedent, should Defendants agree to a narrowing construction that would both provide Plaintiffs with adequate notice as to how to comply with the Clinic Requirement and establish clear standards to guide its enforcement in the medication abortion context, this Court could enter an order to that effect, *see United Food & Com. Workers Loc. 99 v. Bennett*, 934 F. Supp. 2d 1167, 1201 (D. Ariz. 2013) (adopting defendants' narrowing construction to cure unconstitutional vagueness consistent with First Amendment and legislative intent). However, as explained above, the only such narrowing construction that would not itself raise new constitutional issues would be one that does not require the patients to obtain the medication abortion in person.

II. Plaintiffs Are Likely to Succeed on Their Claim That the Clinic Requirement and State-Mandated Information Law Violate Plaintiffs' Patients' Rights to Substantive Due Process.

To the extent the Clinic Requirement and State-Mandated Information Law prohibit or otherwise restrict the use of telemedicine, the Restrictions cannot survive constitutional scrutiny.

Constitutional protections of the abortion right have the "same force and effect in Guam as in a state of the United States." *Guam Soc'y of Obstetricians & Gynecologists v. Ada*, 962 F.2d 1366, 1370 (9th Cir. 1992) (internal quotations omitted). For nearly five decades, the Supreme Court has not wavered from the central holding of *Roe v. Wade*, 410 U.S. 113, 163–64 (1973)—that a State may not prohibit any person from obtaining a pre-viability abortion. *See, e.g., Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 871 (1992) ("The woman's right to terminate her pregnancy before viability is the most central principle of *Roe v. Wade*. It is a rule of law and a component of liberty we cannot renounce."). The Ninth Circuit has re-affirmed this "bright-line" rule: "Under controlling Supreme Court precedent, a woman has a right to choose to terminate her pregnancy *at any point* before viability . . . and the State may not proscribe that choice." *Isaacson v. Horne*, 716 F.3d 1213, 1227 (9th Cir. 2013) (emphasis in original).

However, even a law that does not prohibit abortion outright will still be unconstitutional if it imposes an undue burden on those seeking pre-viability abortion. *See, e.g., id.* at 1225–27. "An undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before [viability]." *Casey*, 505 U.S. at 878; *see also id.* at 877 ("undue burden is a shorthand" for "a substantial obstacle in the path of a woman seeking an abortion").[12] Although, "[a]s with any medical procedure, the

[12] As other courts have recognized, the distinction between the bright-line and undue burden tests is often more theoretical than actual: Any law that prohibits pre-viability abortion necessarily constitutes an undue burden because the "obstacle [it poses] is insurmountable, not merely substantial." *Jackson Women's Health Org. v. Dobbs*, 945 F.3d 265, 276 (5th Cir. 2019); *see also Little Rock Fam. Plan. Servs. v. Rutledge*, 398 F. Supp. 3d 330, 384 (E.D. Ark. 2019) (enjoining pre-viability abortion ban and recognizing that "even if the Court [were] to apply the undue burden

State may enact regulations to further the health or safety of a woman seeking an abortion[,] [u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right." *Id.* at 878; *see also Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 913 (9th Cir. 2014) (same). As the Supreme Court has long recognized, laws restricting abortion access in the name of patient safety must be grounded in actual evidence, not merely conjecture or government say-so. *See, e.g., Doe v. Bolton*, 410 U.S. 179, 195 (1973) (striking restriction where state failed to provide "persuasive data" that law advanced patient health and safety); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2311 (2016). Moreover, while a "State may take measures to ensure that the woman's [decision to have an abortion] is informed," *Casey*, 505 U.S. at 878, the means chosen to further this interest "must be calculated to inform the woman's free choice, not to hinder it," *id.* at 877. In short, regardless of the test applied, prior to viability *no* state interest is "strong enough [*either*] to support a prohibition of abortion *or* the imposition of a substantial obstacle to the woman's effective right to elect the procedure." *Id.* at 846 (emphasis added).

Importantly, "[n]either the Supreme Court nor [the Ninth Circuit] has ever held that a burden must be absolute to be undue." *Humble*, 753 F.3d at 917. Rather, it is well-settled that burdens that fall short of preventing abortion access outright may nevertheless constitute an undue burden. *See June Medical Servs., LLC v. Russo*, 140 S. Ct. 2103, 2129–30 (2020) (finding substantial obstacle where "[w]omen not altogether prevented from obtaining an abortion would face other burdens" including "delays . . . [that] increase the risk . . . [of] complications from the procedure and may make it impossible . . . to [obtain] a medication abortion"); *id.* at 2140 (Roberts, C.J., concurring) (finding substantial obstacle from "increase[d] travel distance" to abortion providers, "exacerbat[ing]" some patients' "difficulty affording or arranging for

analysis [to the ban], the Court likewise finds [it] not only places a 'substantial,' but an insurmountable, obstacle in the path of women . . . seeking pre-viability abortions.").

transportation and childcare on the days of their clinic visits"); *Hellerstedt*, 136 S. Ct. at 2313, 2318 (finding substantial obstacle where patients are forced to "travel long distances to get abortions").

To determine whether a burden is substantial, courts evaluate "the burdens a law imposes on abortion access together with the benefits th[e] law[] confer[s]." *Hellerstedt*, 136 S. Ct. at 2309 (citation omitted).[13] "The feebler the medical grounds, the likelier the burden, even if slight, is to be undue." *Humble*, 753 F.3d at 914. Courts must also consider "the ways in which [an] abortion regulation interacts with women's lived experience, socioeconomic factors, and other abortion regulations." *Humble*, 753 F.3d at 915; *see also June Medical*, 140 S. Ct. at 2140 (Roberts, C.J., concurring).

Applying these principles in *Humble*, the Ninth Circuit considered a law that forced abortion providers to follow an outdated protocol for medication abortion; specifically, it required prescribers to limit medication abortion to seven weeks of pregnancy and use a more expensive and less effective regimen, and required patients to make additional visits to the clinic to obtain care. The Ninth Circuit concluded that the law "substantially burden[ed] women's access to abortion services" and could not withstand constitutional scrutiny. *Humble*, 753 F.3d at 916. "For a significant number of women, the law [would] effectively ban medication abortions outright." *Id.* at 915. However, the court also found "the burden imposed by the Arizona law [] undue even

[13] Although Chief Justice Roberts criticized this balancing test in his concurrence in *June Medical Services, LLC v. Russo* ("*June Medical*")—arguing instead that courts should strike abortion restrictions either because they impose a substantial obstacle (without regard to the benefits) *or* are not reasonably related to a legitimate state interest—his criticism is not controlling, and the test remains good law. 140 S. Ct. 2103, 2138 (Roberts, C.J., concurring). As an initial matter, the Chief Justice was clear that *Hellerstedt* endures: "The question today . . . is not whether [*Hellerstedt*] was right or wrong but whether to adhere to it in deciding the present case." *June Medical*, 140 S. Ct. at 2133 (Roberts, C.J., concurring). Moreover, under Ninth Circuit precedent, a concurrence is only controlling under these circumstances when it "posits a narrow test to which the plurality *must necessarily agree* as a logical consequence of its own, broader position." *Cardenas v. United States*, 826 F.3d 1164, 1171 (9th Cir. 2016) (emphasis added) (quoting *United States v. Epps*, 707 F.3d 337, 348 (D.C. Cir. 2013)). Here, the *June Medical* plurality expressly applied the test the Chief Justice rejected, 140 S. Ct. at 2120, and thus it can hardly be said that the plurality "must necessarily agree" with the Chief Justice's rejection of its own test. Notwithstanding that courts outside the Ninth Circuit have reached a different conclusion, *see, e.g.*, *EMW Women's Surgical Ctr., P.S.C. v. Friedlander*, 978 F.3d 418 (6th Cir. 2020); *Hopkins v. Jegley*, 968 F.3d 912 (8th Cir. 2020), Ninth Circuit case law is clear.

if some women . . . nonetheless obtain an abortion." *Id.* at 917. For example, the law would decrease the availability of abortion providers, requiring patients to travel longer distances to obtain care. *Id.* at 916. The law also increased the costs of the medication by approximately $200, and by increasing the number of visits to the clinic—at often greater distances—the law increased "costs to the patient for transportation, gas, lodging, and the time she must take off from work" to obtain care. *Id.* at 915–16. In turn, these increased costs could cause delays in accessing care, increasing the risks from the abortion procedure. *Id.* at 916. Notably, the fact that the law did not directly impact the availability of other abortion methods in Arizona "d[id] not preclude a finding of an undue burden." *Id.* at 917.

At the same time, the Ninth Circuit found the challenged law was "wholly unnecessary as a matter of women's health." *Id.* at 915 (internal citations and alterations omitted). To the contrary, the court found there was "no supporting evidence for any asserted legislative fact," and, if anything, the evidence showed the law undermined patient health. *Id.* at 914–15. The law at issue thus substantially burdened patient access to abortion care while conferring no benefit, imposing a clear undue burden.

Following this precedent, and as set forth further below, it is plain that the challenged laws cannot withstand constitutional scrutiny. First, to the extent it prohibits Plaintiffs from using telemedicine to provide abortions in Guam, the Clinic Requirement essentially eliminates the only means of obtaining a pre-viability abortion in Guam, thereby violating the bright-line rule against abortion bans. Second, as applied to telemedicine, the State-Mandated Information Law both burdens and restricts patients' access to abortion, while failing to advance any legitimate state interest in patient health or informed consent. Accordingly, Plaintiffs are extremely likely to succeed on the merits of their claim that these laws are unconstitutional.

A. *Clinic Requirement*

As Plaintiffs are the sole known physicians willing to provide abortion care to patients in Guam, to the extent the Clinic Requirement prohibits them from providing telemedicine medication abortion to Guam-based patients, it "does not just restrict a woman's right to choose a particular *method* of terminating her pregnancy before viability; it eliminates a woman's 'right to choose abortion itself.'" *Isaacson*, 716 F.3d at 1226 (emphasis in original) (quoting *Stenberg v. Carhart*, 530 U.S. 914, 930 (2000)). The Clinic Requirement thus leaves "thousands of… women with no practical means of obtaining a safe, legal abortion." *June Medical*, 140 S. Ct. at 2130. This alone is sufficient to render the Clinic Requirement unconstitutional as applied to telemedicine medication abortion under any test. *Casey*, 505 U.S. at 846 ("Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure.").[14]

That some patients, at great personal cost and likely increased risk to their health, are ultimately be able to access abortion off-island is irrelevant. Guam cannot escape its constitutional obligations to its citizens by relying on the availability of abortion in other jurisdictions. *See, e.g.*, *Missouri ex rel. Gaines v. Canada*, 305 U.S. 337, 350 (1938) (state's refusal to admit African-American students to state law school cannot be rendered constitutional by availability of adjacent states' law schools); *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 918–19 (7th Cir. 2015) (rejecting as "untenable" argument that abortion restriction could be justified by looking outside Wisconsin's borders because "no State can be excused from performance by what another State may do or fail to do") (internal quotations and citations omitted); *Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 457–58 (5th Cir. 2014), *cert. denied*, 136 S. Ct. 2536 (2016) (holding that "*Gaines* locks the gate for Mississippi to escape to another state's protective

[14] Indeed, even if it was not considered an outright ban, by blocking patients from obtaining medication abortion pursuant to evidence-based protocols, while providing no medical benefit and only undermining patient health and safety, the Clinic Requirement is unconstitutional under *Humble*. *See* 753 F.3d at 914–917.

umbrella and thus requires us to conduct the undue burden inquiry by looking only at the ability of Mississippi women to exercise their right within Mississippi's borders"). Indeed, neither the Supreme Court nor the Ninth Circuit has ever considered the availability of out-of-state abortion to be legally relevant when assessing the constitutionality of a law prohibiting or otherwise restricting pre-viability abortion.

Moreover, the Clinic Requirement could not survive constitutional scrutiny even if the availability of out-of-state abortion was legally relevant. Because of the Clinic Requirement, people seeking abortions in Guam are nearly *four thousand* miles (one way) from a legal abortion. *Supra* p. 1. Both the Supreme Court and the Ninth Circuit have held *intra-state* travel distances of a far lesser magnitude unconstitutional, regardless of whether some patients can ultimately make the journey. *June Medical*, 140 S. Ct. at 2130 (1–5 hour driving distance) (plurality); *id.* at 2140 (Roberts, C.J., concurring) (320-mile driving distance); *Hellerstedt*, 136 S. Ct. at 2313 (150–200 mile driving distance); *Humble*, 753 F.3d at 916 (300–700 mile driving distance). Indeed, the additional costs relating to travel alone are over a thousand dollars, *supra* p. 6—far more than the hundreds of dollars previously recognized as unconstitutional. *See, e.g.*, *Humble*, 753 F.3d at 915. And that does not even include the other costs, logistical burdens, and delay and increased health risks associated with such extensive, likely multi-day travel. *Supra* pp. 5–7. As the Supreme Court and Ninth Circuit have repeatedly recognized, such burdens pose substantial, if not insurmountable obstacles, particularly for patients who have children and/or are living in poverty or have low incomes. *See, e.g.*, *June Medical*, 140 S. Ct. at 2140 (Roberts, C.J., concurring); *Humble*, 753 F.3d at 915–16 (finding substantial obstacle where "difficulties … in obtaining time off from work" and "increase[d] costs to the patient for transportation, gas, lodging" may be "prohibitive" for some women, including poor women); *id.* at 915 (restriction imposed undue burden because it "delay[ed] and deter[red] patients obtaining abortions, and that delay in abortion

increases health risks") (quoting *Eden*, 379 F.3d at 542).[15] In short, even if access to out-of-state abortion is considered, the evidence overwhelmingly establishes that the burdens on abortion access here far exceed those that binding precedent has already recognized to be unconstitutional.

For all these reasons, Plaintiffs are extremely likely to succeed on the merits of their claim that the Clinic Requirement is unconstitutional as applied to telemedicine medication abortion.

B. *State-Mandated Information Law*

To the extent it prohibits Plaintiffs from using telemedicine to provide patients with certain mandated information prior to abortion and restricts patients' ability to receive that information in a safe and supportive environment, all the while providing no benefit to patient health or informed consent, the State-Mandated Information Law is likewise unconstitutional. As explained above, even though states may enact laws mandating that patients receive certain information prior to providing informed consent to abortion, such laws "must be calculated to inform the woman's free choice, not hinder it." *Casey*, 505 U.S. at 877. As such, courts have not hesitated to enjoin those applications of state-mandated information laws that "serve[] no legitimate state interest and make[] little sense under the circumstances." *Karlin v. Foust*, 188 F.3d 446, 489 n.16 (7th Cir. 1999) (construing exception to state-mandated information requirement for patients with lethal fetal diagnoses); *see also Summit Med. Ctr. of Ala., Inc. v. Siegelman*, 227 F. Supp. 2d 1194, 1202–03 (M.D. Ala. 2002), *amended* Oct. 14, 2002 (same). Moreover, because the evidence shows these restrictions are "wholly unnecessary" in this context, the burdens imposed on patients are not justified. *See Hellerstedt*, 136 S.Ct. at 2309; *see also*

[15] While no state interest is sufficient to justify the effect of the Clinic Requirement on the availability of pre-viability abortion in Guam, *see Casey*, 505 U.S. at 846, the evidence plainly shows that any health-related justification for the Clinic Requirement is not "merely feeble, [it is] non-existent," *Humble*, 735 F.3d at 917. The safety, efficacy, and benefits of telemedicine medication abortion are well-established. *Supra* pp. 8–11. If anything, the evidence overwhelmingly shows that blocking Plaintiffs from providing medication abortion to eligible patients in Guam only undermines the short-term and long-term health and wellbeing of people in Guam. *Supra* pp. 5–7.

Humble, 753 F.3d at 914 ("The feebler the medical grounds, the likelier the burden, even if slight, is to be undue.")

First, by requiring the provision of certain information to abortion patients *in person* at least 24 hours prior to an abortion, *see* 10 G.C.A. §§ 3218.1 (b)(1), (b)(2), the State-Mandated Information Law prohibits Plaintiffs from using live, videoconference technology to comply with that statute. Plaintiffs' patients already undergo a comprehensive assessment, counseling, and informed consent process with Plaintiffs during a live, face-to-face videoconference, which already covers much of the information required under the statute. *Compare* 10 G.C.A. § 3218.1(b)(1) *and* Kaneshiro ¶¶ 50–69; Raidoo ¶¶ 49–67. Plaintiffs could just as easily deliver the rest of the statutorily-mandated information during the same appointment and answer any patient questions in real time.[16] Yet this does not satisfy the State-Mandated Information Law; instead, to satisfy the law, patients will be forced to make a separate visit to a different clinician in Guam solely to receive the mandated information *in person*—even though that clinician does not provide abortions and may not even have the medical knowledge to answer a patient's questions about the information provided. *See id.* at (a)(13), (b)(1), (b)(2) (allowing, *e.g.*, a psychologist, to provide the patient information about, *e.g.*, the "probably anatomical and physiological characteristics" of the fetus and "the need for anti-Rh immune globulin therapy").

This not only fails to advance any legitimate interest in informed consent, it is also simply irrational. The government cannot conceivably claim that it is necessary or even preferable to require patients to undertake an additional, separate trip just to get the information from a different clinician in Guam, when the physicians providing the abortion could deliver the exact same information, face-to-face, through a live, videoconference and answer any questions in real time. Indeed, there is ample evidence showing there is no meaningful difference between obtaining

[16] If permitted to provide the mandated information by telemedicine, Plaintiffs could email patients a "copy" of the required pamphlet and would not prescribe and dispense the medication abortion until at least 24-hours had elapsed from the provision of the oral and written information.

informed consent through a live, face-to-face teleconference and doing so in person. Nichols ¶¶ 48, 51, 60, 64, 74; Washington ¶¶ 37–38, 93–94; Kaneshiro ¶¶ 55–59; Raidoo ¶¶ 54–58. As the evidence shows, clinicians regularly use telemedicine to counsel patients about the risks, benefits, and alternatives to their treatment options, and otherwise ensure their decisions are voluntary and informed, not only for a range of OB/GYN care, but across all areas of medicine. Nichols ¶¶ 48, 51, 74; Washington ¶¶ 37–38, 91–94. Nor are there any limits in Guam law on using telemedicine to provide such counseling in any other context. *See, e.g.*, Compl. ¶ 154.

What is more, the burdens imposed by prohibiting the use of telemedicine in this manner are significant. For example, to obtain the requisite information "in person" a patient would have to disclose their abortion decision to another clinician in Guam. As other courts have recognized, the unnecessary "exposure of private or confidential information" relating to abortion is a substantial obstacle. *Planned Parenthood Se., Inc. v. Strange*, 9 F. Supp. 3d 1272, 1289 (M.D. Ala. 2014); *see also Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1355, 1363 (M.D. Ala. 2014) (enjoining regulation that forced abortion patients to suffer "invasion of privacy" and "forgo their medical confidentiality"); *cf. Planned Parenthood Minn., N.D., S.D. v. Daugaard*, 799 F. Supp. 2d 1048, 1061 (D.S.D. 2011) (enjoining law that "force[d] the woman against her will to disclose her decision to undergo an abortion").

Moreover, even if the patient does not have to leave the island, these unnecessary visits to additional health care providers, and the resources they require, impose financial and logistical burdens, *see Humble*, 753 F.3d at 915–16 (holding law requiring additional in-state clinic visits imposed undue burden by "increas[ing] costs to the patient for transportation, gas . . . and the time she must take off from work"), which can also make it harder to keep their abortion decision confidential, *see e.g.*, Nichols ¶ 76; Washington ¶ 47; *W. Ala. Women's Ctr. v. Williamson*, 120 F. Supp. 3d 1296, 1310 (M.D. Ala. 2015) (recognizing that being forced to disclose plans for

abortion care "may present risks to women's employment and safety"). These burdens become even more difficult to justify in the midst of the current pandemic when travel and in-person interactions, particularly in a health care facility, exposes patients and clinicians alike to increased risks. Nichols ¶¶ 52, 74; Washington ¶ 85.

Second, by imposing unreasonable requirements on telemedicine patients concerning the setting in which they receive the mandated information, the State-Mandated Information Law likewise serves no legitimate state interest and imposes unjustified burdens on patients.[17] The State-Mandated Information Law requires the information be provided to the patient "individually and in a private room" to "protect her privacy and maintain the confidentiality of her decision and to ensure that the information focuses on her individual circumstances and that she has an adequate opportunity to ask questions." 10 G.C.A. § 3218.1(b)(4). Certainly, Plaintiffs always take necessary steps to protect the privacy and confidentiality of their telemedicine patients, including by utilizing a secure Internet platform; they never provide "group" counseling to more than one abortion patient at a time, and are not seeking the ability to do so here; and they always address any and all of each individual patient's questions and concerns. Kaneshiro ¶¶ 51–59, 92; Raidoo ¶¶ 50–58, 88. But many of the privacy concerns that relate to in-person counseling at a health care facility simply do not apply in the context of telemedicine. For example, it is nonsensical to prevent a patient using telemedicine from choosing to *receive* the mandated information while seated in their living room with their partner, while a child plays in the corner, if that is the best option for them.

Nor can the government seriously argue that *removing* trusted friends and loved ones from the process actually "inform[s]" the patient. *Casey*, 505 U.S. at 877. In fact, in his signing

[17] Although the penalties under 10 G.C.A. § 3218.1 run to the physician performing the abortion (or another "qualified person"), not the patient, in the context of telemedicine this means that, to avoid liability, Plaintiffs cannot provide patients with the information mandated under the statute unless the patients comply with the "individually and in a private room" requirement.

statement to the State-Mandated Information law, then-Governor Calvo explained that one of the purposes of the law was to provide "accurate information" to "women who face the agonizing decision – most often, alone – of whether to carry their unborn child to term."[18] As such, it would be absurd to defend these restrictions on the basis that it is actually in the government's interest to force patients *against their will* to go through the process alone.[19]

Indeed, the evidence shows that among the many advantages of telemedicine is that patients have more flexibility to schedule their appointments, allowing them to include people they trust in their decision-making process, and can protect their confidentiality by avoiding the need to schedule and travel to a clinical facility for an appointment. *Supra* p. 12. There is no justification for undermining these benefits *solely* for patients who use telemedicine for abortion. By contrast, requiring patients to jump through any number of hoops to create the statutorily-mandated setting will only burden patients. For example, patients may have to take time off from work, find childcare, etc. just to find an "individual" and "private" space, which imposes unnecessary financial and logistical burdens. People seeking abortions are just as competent to decide whether and whom to include in their decision-making process and the safest and most appropriate setting to engage with a clinician over telemedicine as people seeking any other form of health care.

* * *

[18] Letter from Eddie Baza Calvo, Gov. of Guam, to Judith Won Pat, Speaker of the Guam Legislature (Nov. 6, 2012), http://www.guamlegislature.com/Public_Laws_31st/P.L.%2031-235%20-%20SBill%20No.%2052-31%20(COR).pdf.

[19] For these reasons, Plaintiffs believe it would be consistent with legislative intent and resolve the constitutional flaws discussed herein if Defendants interpreted the statute to impose limitations on the ability of the physician performing the abortion or another qualified person to, *e.g.*, provide group counseling to patients or otherwise take steps to diminish a patient's privacy, but not as a limitation on a telemedicine patient's ability to control where and with whom they receive the information.

In sum, because they fail to advance any legitimate state interest in patient health or informed consent in this context and impose unjustified burdens on patients, these restrictions impose an undue burden and cannot stand.

III. Plaintiffs and Their Patients Will Suffer Irreparable Harm Absent Injunctive Relief.

"[T]he deprivation of constitutional rights 'unquestionably constitutes irreparable injury.'" *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) (quoting *Elrod v. Burns*, 427 U.S. 347, 373 (1976)); *see also Nelson v. Nat'l Aeronautics & Space Admin.*, 530 F.3d 865, 882 (9th Cir. 2008) ("Unlike monetary injuries, constitutional violations cannot be adequately remedied through damages and therefore generally constitute irreparable harm."), *rev'd on other grounds*, 562 U.S. 134 (2011); *Ne. Fla. Chapter of Associated Gen. Contractors v. City of Jacksonville*, 896 F.2d 1283, 1285 (11th Cir. 1990) ("[A]n on-going violation [of the constitutional right to privacy] constitutes irreparable injury" because "invasions of privacy, because of their intangible nature, could not be compensated for by monetary damages; in other words, plaintiffs could not be made whole.") (internal citations omitted), *overruled on other grounds*, 508 U.S. 656 (1993). Because the challenged statutes violate the due process rights of Plaintiffs and their patients, this alone is sufficient to constitute irreparable harm. *See Valle del Sol Inc. v. Whiting*, 732 F.3d 1006, 1029 (9th Cir. 2013). However, the evidence also shows that, absent injunctive relief, Plaintiffs' patients will suffer numerous additional "harm[s] for which there is no adequate legal remedy." *Ariz. Dream Act Coal. v. Brewer*, 757 F.3d 1053, 1068 (9th Cir. 2014). For example, by blocking pre-viability abortion in Guam, the challenged laws force people seeking abortion in Guam to travel several thousands of miles for a safe and legal abortion—delaying their ability to access care and depriving some of the ability to have an abortion entirely. *Supra* pp. 6–7, 14. As such, the challenged laws inflict precisely the sort of physical and emotional injury that constitute irreparable harm. *See, e.g., Harris v. Bd. of*

Supervisors, 366 F.3d 754, 766 (9th Cir. 2004) (plaintiffs established likelihood of irreparable harm where evidence showed they would experience pain, complications, and other adverse effects due to delayed medical treatment); *Planned Parenthood Se., Inc. v. Bentley*, 951 F. Supp. 2d 1280, 1289 (M.D. Ala. 2013) (finding irreparable harm where "women who carry unwanted pregnancies to term are at increased risk of death and childbirth complications" and delay in seeking abortion "also carries a heightened risk of medical complication"). Additionally, the challenged laws inflict irreparable harm by jeopardizing the ability of people in Guam to keep their abortion decision confidential, *supra* pp. 9, 14. Certainly, "[n]o remedy at law could adequately compensate [Plaintiffs' patients] for any physical, psychological, or emotional trauma they might suffer at the hands of one obtaining this personal information." *Kallstrom v. City of Columbus*, 136 F.3d 1055, 1069 (6th Cir. 1998). As such, Plaintiffs readily satisfy the second injunctive relief factor.

IV. The Balance of Equities Strongly Favors Plaintiffs and the Public Interest Is Served by An Injunction.

Finally, "by establishing a likelihood that Defendants' [laws] violate[] the U.S. Constitution, Plaintiffs have also established that both the public interest and the balance of the equities favor a preliminary injunction." *Ariz. Dream Act Coal.*, 757 F.3d at 1069. As explained above, absent an injunction, the challenged laws prevent people in Guam from exercising their constitutional rights and accessing safe and legal abortion on the island and, in so doing, subject them to many significant and irreparable physical, mental, and emotional harms. Defendants, by contrast, "cannot suffer harm from an injunction that merely ends an unlawful practice." *Rodriguez v. Robbins*, 715 F.3d 1127, 1145 (9th Cir. 2013). Moreover, as the Ninth Circuit has repeatedly held, "it is always in the public interest to prevent the violation of a party's

constitutional rights." *Melendres*, 695 F.3d at 1002 (citation omitted). Accordingly, Plaintiffs satisfy the remaining criteria for injunctive relief.

CONCLUSION

For the reasons discussed above, Plaintiffs respectfully request that the Court enjoin the Clinic Requirement and the State-Mandated Information Law as applied to the provision of medication abortion and use of telemedicine to provide medication abortion to patients in Guam.

Respectfully submitted this 5th day of February, 2021.

LAW OFFICE OF VANESSA L. WILLIAMS, P.C.
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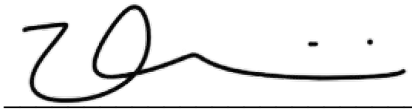

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EXHIBIT 4

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**ADMISSION PRO HAC VICE PENDING*

Attorneys for Plaintiffs

IN THE DISTRICT COURT OF GUAM

SHANDHINI RAIDOO, *et al.*, Plaintiffs, vs. LEEVIN TAITANO CAMACHO, *et al.*, Defendants.	CIVIL CASE NO. 21-00009 **DECLARATION OF BLISS KANESHIRO, M.D., M.P.H., IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION**

I, Bliss Kaneshiro, M.D., M.P.H., declare and state the following:

1. I am a board-certified obstetrician-gynecologist ("OB/GYN") with nearly two decades of experience providing comprehensive reproductive health care, including abortion. After my OB/GYN residency, I completed a two-year Fellowship in Complex Family Planning Fellowship, where I received subspecialist training in research, teaching, and clinical practice in complex abortion and contraception. I am licensed to practice medicine in Hawai'i and Guam.

2. Currently, I am an Endowed Professor with Tenure in the Department of Obstetrics, Gynecology, and Women's Health at the University of Hawai'i in Honolulu. Since

2012, I have also served as the Chief of the Division of Family Planning and as the Co-Program Director of the Family Planning Fellowship, also within the Department of Obstetrics, Gynecology, and Women's Health at the University of Hawai'i. Additionally, between 2008–19, I held the position of Medical Director of Family Planning at the Hawai'i State Department of Health.

3. For nearly twenty years, I have provided comprehensive obstetric and gynecological care – i.e., prenatal care, labor and delivery, surgery, preventative care (e.g., pap smears, STD testing), contraception, and medication and procedural abortion – to hundreds of patients each year. For nearly fifteen years, I have also provided abortion services at Planned Parenthood health centers in Honolulu and Maui. Throughout my career, I have also taught, trained, and supervised hundreds of medical students, residents, and/or fellows.

4. Since 2006, I have provided numerous workshops and clinical trainings to health care providers on a range of reproductive health care issues throughout Micronesia, including in the Republic of the Marshall Islands, Federated States of Micronesia, Commonwealth of the Northern Marianas, and Guam. In Guam, specifically, I have provided several lectures and trainings on the provision of contraceptive services, cervical and breast cancer screening, and screening for sexually transmitted diseases.

5. I also conduct research and have published nearly one hundred articles in peer-reviewed journals on a number of topics relating to reproductive health care, including abortion and contraception. I have also written curricular content and numerous chapters of medical textbooks on a range of gynecological care issues, including abortion. I estimate that, throughout my career, I have managed millions of dollars in research funding, including as part of a multi-year grant to build research infrastructure at the University of Hawai'i, with a specific focus on perinatal health, growth, and development.

6. A copy of my CV, which more fully sets forth my experience and credentials, is attached as Exhibit A.

7. The statements and opinions in this declaration are my own, and not made on behalf of the medical or academic facilities in which I provide care. The statements and opinions expressed herein are based on my personal knowledge, experience, education, training, and review of the relevant medical literature.

8. I submit this declaration in support of Plaintiffs' motion for a preliminary injunction. I have reviewed 9 G.C.A. § 31.20 and 10 G.C.A. § 3218.1, which currently prevent and otherwise restrict my ability to use telemedicine to counsel and prescribe medication abortion to eligible patients in Guam.

9. Prior to 2018, approximately 200–300 abortions per year were provided in Guam. However, to the best of my knowledge, since the last known abortion provider in Guam retired in 2018, no physicians in Guam have taken his place. Based on my training, experience, and firsthand knowledge of the obstacles abortion patients in Guam must overcome to obtain abortion care, it is my opinion that the lack of access to abortion services in Guam is detrimental to public health. I am a plaintiff in this lawsuit because I believe that restoring abortion access through the use of telemedicine is a critical step to removing burdens to safe, legal abortion and improving the health and wellbeing of all people seeking abortions in Guam.

Background on Abortion Safety and Medication Abortion

10. Legal abortion is one of the safest medical procedures or treatments in the United States and is substantially safer than continuing a pregnancy through to childbirth.[1] Abortion-related mortality in the United States is lower than that for colonoscopies, plastic surgery, dental

[1] As explained *infra* ¶¶ 13–21, abortions can be accomplished through a procedure performed by a clinician or through medications self-administered by the patient themselves.

procedures, and adult tonsillectomies.[2]

11. Approximately one in four women in this country will have an abortion by age forty-five.[3]

12. In my experience, individuals seek abortion for a variety of personal and often interrelated reasons. A majority of women having abortions in the United States already have at least one child.[4] People have abortions because, e.g., they conclude that it is not the right time to become a parent or have additional children, they lack the necessary financial resources or a sufficient level of partner or familial support or stability, or because having a child or additional children would interfere with their educational and career goals. Other people seek abortions because the pregnancy is the result of rape or incest, because continuing with the pregnancy could pose a risk to their health, or because of a fetal diagnosis.

13. There are two main methods of abortion: procedural (sometimes referred to as "surgical") and medication abortion. Both methods are safe, effective means of terminating a pregnancy.[5]

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[2] *See* "The Safety & Quality of Abortion Care in the United States." *National Academies of Sciences, Engineering, and Medicine*, 2018, pp. 74–76, doi:10.17226/24950 (hereinafter "NASEM Report"); *see also* Raymond, Elizabeth G. & Grimes, David A. "The Comparative Safety of Legal Induced Abortion and Childbirth in the United States." *Obstetrics & Gynecology*, vol. 119, no. 2, 2012, pp. 217–218, doi:10.1097/aog.0b013e31823fe923.

[3] *See* "Induced Abortion in the United States." *Guttmacher Institute*, 2019, p. 1, https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf.

[4] *Id.*

[5] In the first and early second trimester, procedural abortions are generally performed using gentle suction to empty the contents of the uterus (most commonly referred to as "aspiration abortion"). This is also how early miscarriages are treated. Beginning in the early second trimester, procedural abortions are generally performed by dilating the cervix and using instruments to remove the contents of the uterus (referred to as a "dilation and evacuation" or "D&E" abortion). Even though the term "surgical" is sometimes used to refer to these procedures, that is a misnomer; neither entails what is commonly considered to be "surgery,"

14. The majority (60%) of abortions performed up to 10 weeks of pregnancy, as measured from the last menstrual period ("LMP") – and nearly half (39%) of all abortions – are medication abortions.[6]

15. Medication abortion is neither a "surgery" nor a "procedure." In fact, medication abortion may be safer than procedural abortion for certain patients, i.e., patients with certain uterine anomalies.

16. In the United States, the medication abortion regimen typically involves a combination of two pills – mifepristone and misoprostol – that can be taken at a location of the patient's choosing, usually at home.[7] The same regimen is also offered to patients experiencing an early miscarriage.

17. The current FDA label approves the mifepristone/misoprostol regimen for use up to 70 days or 10.0 weeks LMP, although more recent evidence shows that it is safe up to 77 days or 11.0 weeks LMP.[8]

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e.g., an incision into bodily membranes.

[6] Jones, Rachel K., et al. "Abortion Incidence and Service Availability in the United States, 2017." *Guttmacher Institute*, 2019, p. 8, https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017.

[7] While medications can be used in a hospital or hospital-like setting to cause abortions in the second trimester by inducing labor, when I refer to "medication abortion" in this declaration I am talking about the use of the mifepristone-misoprostol regimen by patients at home, in the first trimester, to initiate a miscarriage-like process. *See* ¶¶ 13–20. Although misoprostol alone can be used to cause an abortion, particularly in settings where mifepristone is not available, it is far less effective, and research shows higher side effects and risks of complications when misoprostol alone is used for abortion.

[8] *See, e.g.*, Dzuba, Ilana G., et al. "A Non-Inferiority Study of Outpatient Mifepristone-Misoprostol Medical Abortion at 64–70 Days and 71–77 Days of Gestation." *Contraception*, vol. 101, no. 5, 2020, p. 305, doi:10.1016/j.contraception.2020.01.009; Kapp, Nathalie, et al. "Medical Abortion in the Late First Trimester: A Systematic Review." *Contraception*, vol. 99, no. 2, 2019, pp. 82–84, doi:10.1016/j.contraception.2018.11.002.

18. The FDA generally requires patients to obtain the first medication in the regimen – mifepristone – in person from an authorized physician who pre-stocks the medication; typically, it cannot be obtained from a pharmacy, or by mail.

19. However, as discussed below, some clinicians (including myself) are permitted to send mifepristone directly to patients, subject to compliance with certain FDA-approved protocols. There are no comparable restrictions on the second medication, misoprostol.

20. The first step in the mifepristone/misoprostol regimen is for the patient to take the mifepristone, which blocks the body's receptors for the hormone progesterone, which is necessary to maintain the pregnancy.

21. Next, typically 24–48 hours later, the patient takes the misoprostol, which causes the uterus to contract and pass the pregnancy in a manner similar to an early miscarriage.

22. Contraindications for medication abortion are few, and mostly uncommon. Contraindications include chronic adrenal failure; concurrent long-term corticosteroid therapy; history of allergy to mifepristone, misoprostol, or medications with a similar chemical make-up; hemorrhagic disorders or concurrent anticoagulant therapy; and inherited porphyrias, a rare blood disorder. In addition, patients with an intrauterine device ("IUD") in place, a form of long-acting reversible contraception, should not undergo a medication abortion unless the IUD is first removed.[9]

23. It is expected that patients undergoing a medication abortion will experience cramping, bleeding, and the passing of small blood clots or tissue after taking the misoprostol, just like in an early miscarriage. Patients may also experience temporary nausea, diarrhea, fatigue, headaches, dizziness, soreness and/or a low-grade temperature.

[9] Medication abortion also cannot be used to treat an ectopic pregnancy—a non-viable pregnancy that implants outside the uterus. A person with an ectopic pregnancy that does not resolve naturally will need to use different medications or undergo a surgical procedure to remove it.

24. The primary difference between a medication abortion and an early miscarriage is that a miscarriage is usually unexpected and does not occur under controlled circumstances. A patient undergoing a medication abortion knows what to expect in advance, chooses when to initiate the process and can ensure that she does so in a safe and appropriate setting, and is more likely to be prepared to handle the outcome.

25. A small percentage of medication abortion patients may seek follow-up treatment, e.g., because the uterus has retained some tissue (approx. 1–5%)[10] or because the medications failed to terminate the pregnancy (approx. 0.8–2.9%)[11] but neither is considered a serious adverse event. The treatment required in such situations is no different than the treatment provided to patients experiencing a miscarriage that has failed to complete naturally, i.e., an additional dose of medications and/or a uterine aspiration.

26. Serious complications from medication abortion are extremely rare. According to the FDA's clinical review of the current mifepristone/misoprostol regimen, rates of serious adverse events, such as death or serious infection, "are exceedingly rare, generally far below 0.1%."[12] Any emergency room physician is equipped to handle these extremely rare complications.

27. Some patients have a strong preference for medication abortion, even when other methods are available. Indeed, medication abortions increased from 5% of all abortions in 2001

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[10] Chen, Melissa J. & Creinin, Mitchell D. "Mifepristone with Buccal Misoprostol for Medical Abortion: A Systematic Review." *Obstetrics & Gynecology*, vol. 126, no. 1, 2015, p. 17, doi:10.1097/AOG.0000000000000897; Winikoff, Beverly, et al. "Extending Outpatient Medical Abortion Services Through 70 Days of Gestational Age." *Obstetrics & Gynecology*, vol. 120, no. 5, pp. 1072–1073, doi:10.1097/aog.0b013e31826c315f.

[11] Chen & Creinin, *supra* note 10, at 13.

[12] "Medical Review: Mifeprex," *U.S. Food and Drug Administration*, 2016, p. 47, https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020MedR.pdf.

to 39% of all abortions in 2017, even while the overall number of abortions declined.[13]

28. In my experience, many patients who choose medication abortion do so because they feel more autonomy and agency over the abortion process. Some patients have a strong preference to experience something more akin to a miscarriage than to undergo a procedure. Some patients, including those who have experienced rape or sexual abuse, choose medication abortion to avoid the trauma of having instruments placed in the vagina. And for people experiencing intimate partner violence (IPV) or who otherwise must keep their abortion decision secret, a medication abortion, which looks identical to a miscarriage, can be essential to protecting themselves from violence or retaliation for their decision.

29. During the COVID-19 pandemic, the number of patients seeking medication abortion – particularly through telemedicine – has increased dramatically because it decreases the risk of contracting the COVID-19 virus through unnecessary travel and/or in-person clinical visits.

Risks From Delayed and Denied Abortions

30. Although abortion is always a very safe medical procedure, the health risks associated with it do increase as the pregnancy advances.[14] Evidence shows that each week that a patient is delayed in obtaining the abortion can increase the risk of harm.[15] Delay can also push patients past the point in pregnancy at which a medication abortion is available, forcing patients to undergo more invasive, and usually more expensive, in-clinic abortion procedures.

31. While most patients seek abortions as soon as they are able, many face logistical

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[13] *See* "Induced Abortion in the United States," *supra* note 3, at 2.

[14] NASEM Report, *supra* note 2, at pp. 77–78, 163.

[15] *See, e.g.*, Bartlett, Linda A., et al. "Risk Factors for Legal Induced Abortion-Related Mortality in the United States." *Obstetrics & Gynecology*, vol. 103, no. 4, 2004, p. 731, doi:10.1097/01.aog.0000116260.81570.60.

and financial obstacles that can delay access to care.

32. In Hawai'i, out-of-pocket costs for procedural abortion and *in-clinic* medication abortion services range from approximately $400–700 in the first trimester to as much as $3,000–7000 in the second trimester. As discussed below, our telemedicine medication abortion services cost a little under $250, in addition to whatever the patient may pay if they are required to obtain any pre-tests from a local provider.

33. While Hawai'i's state Medicaid program covers abortion for eligible Hawai'i residents, not all patients are eligible for Medicaid. Even those patients with private insurance may not have a plan that covers abortion or may have significant co-pays or deductibles. These patients are often stuck in a vicious cycle: by the time they have saved up enough money, it may be too late for a first trimester procedure; they must then delay even longer to raise more money for a more expensive second trimester procedure.

34. These obstacles are particularly burdensome for patients who must also travel long distances to get to an abortion provider. Due to stigma and a lack of training, abortion is not widely available in all areas or communities. While some clinicians in under-resourced areas may quietly offer abortion services to their pre-existing patients, this does not help the vast majority of patients in these areas facing an unintended pregnancy who will have to identify and travel to a clinician who openly provides abortion services. Clinicians who do not regularly offer abortion services may not have access to mifepristone either, and therefore might not even be able to offer their patients the safest and most effective medication abortion regimen.

35. Travel leads to greater out-of-pocket costs (i.e., for transportation, food, and lodging; childcare; and lost wages) and, in turn, greater delay. Moreover, the farther a patient has to travel to obtain care – and the longer they are away from work and/or home – the more difficult it is to keep their decision to have an abortion private.

36. Denial of a wanted abortion has both short-term and long-term negative effects on a person's health and wellbeing, along with that of their family. A person who has been denied access to abortion has no choice but to continue their pregnancy to term, which leads to substantially increased risks: the risk of death associated with pregnancy is approximately 14 times higher than the risk of death associated with abortion, and studies show that all complications associated with pregnancy, including hemorrhage and infection, are far more common among women carrying to term and giving birth than among those having abortions.[16]

37. Evidence also shows that people who are denied a wanted abortion are at increased risk of negative physical and economic consequences, including greater likelihood of living in poverty and staying in abusive relationships, as compared to people who are able to obtain wanted abortions.[17]

38. Moreover, when people are unable to access legal abortion, they are more likely to take matters into their own hands and attempt to end their pregnancies themselves, using unsafe methods.[18]

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[16] Raymond & Grimes, *supra* note 2, at pp. 216–217; NASEM Report, *supra* note 2, at pp. 74–75.

[17] *See, e.g.*, Ralph, Lauren J., et al. "Self-Reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study" *Annals of Internal Medicine*, vol. 171, no. 4, 2019, p. 244–245, doi:10.7326/M18-1666; Foster, Diana Greene, et al. "Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States." *American Journal of Public Health*, vol. 108, no. 3, 2018, pp. 409–411, doi:10.2105/AJPH.2017.304247; Roberts, Sarah C.M., et al. "Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion." *BMC Medicine*, vol. 12, no. 144, 2014, p. 5, doi:10.1186/s12916-014-0144-z.

[18] *See, e.g.*, Grossman, Daniel, et al. "Self-Induction of Abortion Among Women in the United States." *Reproductive Health Matters*, vol. 18, no. 36, 2010, p. 136, doi:10.1016/s0968-8080(10)36534-7.

Our Telemedicine Abortion Practice

39. Since 2016, my colleagues and I have used telemedicine to provide medication abortion to hundreds of patients in Hawai'i, the majority of whom lived on islands without abortion providers.

40. Since 2016, subject to compliance with certain FDA-approved protocols, we have been permitted by the FDA to send both medications used for a medication abortion directly to eligible patients, instead of requiring the patient to pick up the first medication – mifepristone – in person. This means we can use telemedicine to consult with the patient and obtain informed consent, and then send the medication abortion directly to eligible patients, without requiring them to come to our office for an in-person visit.

41. Similar telemedicine programs are currently in effect in Colorado, Georgia, Illinois, Iowa, Maine, Maryland, Minnesota, Montana, New Mexico, New York, Oregon, Washington, and the District of Columbia, serving eligible patients in those and other states, where permitted by law.

42. These programs are part of the TelAbortion Project; the TelAbortion Project provides ongoing updates to the FDA, including on safety and efficacy, which has allowed the program to continue.

43. Each one of our patients who utilizes this service (TelAbortion) is informed that the medications are the same as what they would get if they came to the office for a medication abortion, but that the process differs in 3 main ways:

a. The initial and follow-up consultations with the abortion provider will be conducted via telemedicine instead of in person;

b. Any necessary exams, ultrasounds, and lab tests will be performed at medical facilities near the patient rather than at the abortion provider's office; and

c. The medications will be delivered by mail rather than handed to the patient in person.

44. Each patient provides specific consent to these protocols, as well as to the sharing of certain health information with the FDA.

45. As of December 2020, approximately 80% of our TelAbortion patients have lived on those Hawaiian Islands where local abortion services are either limited or non-existent.

46. This service has enabled these patients to access the care they need without unnecessary delay; without having to fly hundreds of miles and potentially staying overnight at a hotel; and without incurring travel costs, childcare costs, lost wages and/or jeopardizing their ability to keep their abortion decision confidential.

47. As of December 2020, the other approximately 20% of our TelAbortion patients have lived on O'ahu, where there is regular access to in-clinic medication and procedural abortions. These patients nevertheless opted to use the service because of the privacy and flexibility it provides.

48. For patients who live locally or do not want to receive the medications by mail, there is also the option to use telemedicine for their appointment and then pick up the medications from our office, without the need for an appointment.

49. Indeed, since the onset of the pandemic, we have seen a dramatic increase in the number of patients seeking to obtain a medication abortion by telemedicine, including on O'ahu; between March and December 2020, we saw an approximately 70% increase in the average number of TelAbortion patients per month alone. Other patients are completing the counseling and consent portions of the process by telemedicine and picking up the medicines from the front desk of our office (thereby minimizing contact with staff and other patients).

50. All patients who are interested in obtaining a medication abortion through

telemedicine undergo an initial screening by telephone. During this screening a trained staff member obtains basic information (i.e., the patient's last menstrual period for initial pregnancy dating purposes; the patient's Rhesus ("Rh") type, if known; and any pre-existing major medical conditions) to preliminarily assess eligibility and explains the process, including any lab work, ultrasound, or other testing that may be necessary.

51. If the patient is preliminarily eligible and interested in proceeding, the staff member will schedule the patient for a video appointment – using a secure Internet-based platform – with a physician (myself or one of my colleagues) and provide the patient with information and forms to review prior to the appointment.

52. Based on physician availability, the video appointment can usually be scheduled within one or two days, if that works for the patient. Because of the flexibility afforded by this model, we are able to schedule patient appointments outside of regular clinic hours (8 a.m. – 4:30 p.m.) to accommodate those patients who may, e.g., have difficulty getting time off from work during the day.

53. As noted above, patients may be instructed to obtain certain pre-abortion tests from a local provider, i.e., an ultrasound or serum hCG test (blood test for pregnancy hormones), to confirm the existence and duration of pregnancy and/or rule out an ectopic pregnancy, or other blood tests (e.g., to check for anemia). However, these tests are not medically necessary for all patients.[19]

54. Because many patients have already seen their health care provider to confirm their

[19] The most up-to-date medical guidelines concerning the provision of medication abortion state that "[f]or patients with regular menstrual cycles, a certain last menstrual period within the prior 56 days, and no signs, symptoms, or risk factors for ectopic pregnancy, a clinical examination or ultrasound examination is not necessary before medication abortion." *See* Committee on Practice Bulletins—Gynecology, the Society of Family Planning. "Medication Abortion Up to 70 Days of Gestation." *Contraception*, vol. 102, no. 4, 2020, p. 226, doi:10.1016/j.contraception.2020.08.004.

pregnancy, many patients already have these test results. For those who do not, these services are available at OB/GYN, family medicine, or other general medical offices, as well as radiology offices and laboratories. Because these are routine services relating to the confirmation of pregnancy, patients do not need to disclose they intend to have an abortion to obtain these tests. They can ask that the results be sent directly to us or can send the results to us themselves electronically or by fax.

55. During the video appointment, we assess eligibility for medication abortion the same way we would if the patient was at the clinic. For example, we obtain information from the patient, i.e., the patient's menstrual and pregnancy history; any other relevant medical history, including known contraindications to medication abortion (*see supra* ¶ 22); and Rh type, if known. Where relevant, we explain the rationale for Rh-testing and the risks and benefits of receiving an RhD immunoglobulin injection if the patient is Rh-negative.[20]

56. For those patients for whom some sort of pre-abortion testing is required, if the results are available at the time of the video appointment, we will review them with the patient at that time. Approximately half of these patients already have the results they need by the time of the video appointment. For those who do not and are having difficulty obtaining them, we can assist in finding local providers who offer these services. We will not prescribe, dispense, or mail the medication abortion unless and until we have been able to review any necessary test results. If we review them after the video appointment, we will call the patient to let them know whether they are eligible to proceed with the abortion.

[20] During pregnancy, starting around 8 weeks LMP, blood cells from the fetus can enter the pregnant person's bloodstream. While most people are "Rh-positive," which means their red blood cells carry the Rh factor protein, some are "Rh-negative," which means they lack the protein. If the fetus is Rh-positive and the pregnant person is Rh-negative, the pregnant person can develop antibodies against the Rh-positive blood, which can impact subsequent pregnancies. As such, it is recommended that an Rh-negative patient obtaining a medication abortion after 8 weeks LMP, and who may want to have children in the future, obtain an RhD immunoglobulin injection to block the development of antibodies.

57. During the appointment, we also explain the medication abortion process, again providing all the same information we would provide to a patient who came to the clinic for a medication abortion—e.g., how to take the medications, what to expect when they take the medications, potential side effects and complications. In particular, we explain what symptoms and side effects are normal, and when to seek additional or emergency medical attention. Patients are informed that they may be prescribed additional medications to treat minor but common side effects, i.e., cramping, nausea, vomiting, or mild fever. We further explain that there is a very small risk that the medications fail to terminate the pregnancy, in which case we advise that the patient seek additional treatment to end the pregnancy.[21]

58. Finally, just as with patients obtaining a medication abortion in person, we go over the required consent forms, answer any questions, and take any other necessary steps to ensure that the patient's consent is informed and voluntary. If an eligible patient wishes to proceed with the abortion, we instruct them how to use a program to sign the required consent forms electronically.

59. In my experience, the vast majority of patients are certain of their abortion decision by the time of their video appointment. For those who are uncertain, we answer their questions and provide nondirective counseling to enable them to make the decision that is best for them and their circumstances, including deciding not to have an abortion. This is the same process we follow for in-clinic patients expressing ambivalence about their decision.

60. Once the patient's eligibility is confirmed and consent forms are e-signed, we either mail them the medications or they can come to the office to pick them up. All patients are provided the medications (one 200 mg tablet of mifepristone and eight 200 mg tablets of

[21] While a patient could decide to continue the pregnancy to term under these circumstances, we explain that there is some risk (the precise risk is unknown) of an anomaly or abnormality as a result of the fetus's or embryo's exposure to misoprostol.

misoprostol), instructions, and two urine pregnancy tests. The total cost to telemedicine patients, for the video appointment and follow-up appointments and the medications, is $240.40.

61. TelAbortion patients do not pay for shipping costs.

62. We provide all patients – whether they obtain care by telemedicine or in person – with the following instructions: Patients taking the medications under 64 days LMP are instructed to take the mifepristone and then four tablets of misoprostol, 24–48 hours later; if, 24 hours after taking the misoprostol, the patient has not started bleeding, they are instructed to take the additional four tablets of misoprostol at that time. Patients taking the medications who are 64 days LMP or greater are instructed to take the additional four tablets of misoprostol 4 hours after the first dose.

63. We provide all patients – whether they obtain care by telemedicine or in person – with the phone number to our office, as well as a phone number staffed 24-hours a day/7-days a week (for any issues that arise after regular office hours).

64. We ask all patients – whether they obtain care by telemedicine or in -person –when they intend to start the medication abortion and a follow-up call with a member of our staff is scheduled for 7 days later. The purpose of this call is to do an initial assessment of whether the abortion was successful, e.g., to discuss the amount of bleeding, and whether the patient is experiencing any symptoms of ongoing pregnancy, incomplete abortion, or other complications. If that assessment triggers any concerns, the patient will be referred to myself or another physician for additional follow-up at that time.

65. If there are no issues, the patient will be told to take a urine pregnancy test 4 weeks after they started the medication abortion and scheduled for a follow-up call with a physician at that time. Patients are advised that they may also obtain an ultrasound or serum hCG test to confirm the abortion was successful, if they prefer.

66. At the four-week follow-up, we review the results of the urine pregnancy test or any other tests the patient might have obtained to confirm the abortion was successful. At this time, we also discuss whether there were any previously unreported complications or unscheduled medical visits after the medication abortion, and also their satisfaction with the overall process.

67. In my experience, when patients fail to attend a scheduled follow-up appointment it is because there were no unforeseen side effects or complications, the abortion was successful, and there are no ongoing issues. This is not unique to telemedicine patients or patients who live outside O'ahu. In fact, when we required in-person follow-up after an abortion our no-show rate was over 50%; whereas our most recent data show that 83.9% of patients make their follow-up appointment when it is offered to them through telemedicine. Nevertheless, we make a concerted effort to follow-up with the small number of telemedicine abortion patients who miss their scheduled follow-up appointment, including making multiple attempts by different modes of contact.

68. In my experience, patient satisfaction with medication abortion using telemedicine is extremely high both because of the privacy and flexibility it affords. Some of our patients have told us that, if it were not for telemedicine, they would not have been able to obtain an abortion at all. Moreover, our telemedicine patients often seem more comfortable and at ease than patients who obtain medication abortion through an in-person visit. Not only do telemedicine patients have more flexibility and control over the time and setting of their video appointment, which reduces stress, but it is also much easier to include partners, family members, or other support people in the process, if that is their preference.

69. The benefits also run both ways. I often feel a deeper connection to the patients I care for when we meet via telemedicine. I can see their homes or places of work. In many instances, children are playing in the background. Telemedicine gives me a similar window into

my patients' lives, which is something you do not necessarily have when you meet with a patient in a clinical setting. This is a unique, and valuable, benefit to providing care through telemedicine, and I have found it deeply rewarding to be a telemedicine provider.

Abortion Access in Guam

70. Prior to 2018, it was extremely rare for my colleagues or I to see abortion patients from Guam. I estimate that we saw such patients once a year or less. These patients usually came to Hawai'i in order to consult with specialists at our hospital after receiving a diagnosis of a fetal anomaly. If, after consulting with a specialist, they decided to terminate the pregnancy we could provide that care to them.

71. In 2018, I learned from news articles that the last known abortion provider in Guam retired. Based on Dr. Raidoo's outreach, it became clear that no other physician in Guam was going to take his place. *See* Decl. of Shandhini Raidoo, M.D., ¶ 73.

72. I have seen first-hand the impact of the lack of abortion access in Guam. Since mid-2018, I estimate that my colleagues and I have seen approximately 5–10 abortion patients from Guam. While still a small number, this is obviously a tremendous increase as compared to the numbers we used to see.

73. I have spoken to some of these patients about the huge logistical and financial obstacles they faced, including taking time off of work and paying approximately $1500 for the flight and even more money for overnight stays at a hotel. This is in addition to the out-of-pocket costs for the procedure itself, as most of them do not have any insurance that covers abortion. I remember a particularly moving phone call with one such patient and her family: the patient was incredibly upset because the costs were overwhelming, and her extended family was trying to reassure her, offering to contribute what little they could to help raise the funds. Not all patients are so lucky, however.

74. For example, we have spoken to patients in the military stationed in Guam who are under a travel ban as a result of the pandemic and prohibited from leaving the island. These conversations have been particularly heartbreaking to me. For some non-military patients who contact our office too, the financial and other logistics end up being too difficult to overcome and they never make it.

75. Not surprisingly, I am aware of multiple requests from people in Guam who heard about the TelAbortion Project, asking whether they could obtain abortions through this service without leaving the island. As discussed further *infra*, but for the statutes we are challenging in this lawsuit, we would be able to offer this service to them.

76. Given that there were approximately 200–300 abortions per year on Guam before Dr. Freeman retired, I believe there are many other people for whom the prospect of coming to Hawai'i for abortion care is so daunting that they do not even reach out in the first place.[22] These patients have no option but to continue their pregnancies to term against their will or to take matters into their own hands.

77. Indeed, because of the pandemic, it has become even more difficult for patients from Guam to come to Hawai'i. For example, a few months ago, we had a patient who traveled from Guam to receive abortion services in Hawai'i. It took several weeks for her and her husband to secure funds and make travel arrangements to come to Hawai'i. By the time she arrived, she required a far more expensive procedure that cost thousands of dollars. We had to contact local government authorities in Hawai'i not only to ensure that she would be permitted to leave the mandatory quarantine at her hotel in order to get her abortion but also to ensure that her husband would be able to also leave the hotel to assist with transportation.

78. Indeed, with the recent surge in COVID-19 cases, a pattern that is likely to

[22] "2018 Guam Statistical Yearbook." *Office of the Governor, Bureau of Statistics and Plans*, 2019, pp. 205–208, http://www.spc.int/DigitalLibrary/Get/o5r7x.

continue at least until there is widespread inoculation, the situation remains quite challenging for patients trying to come to Hawai'i from Guam. For example, at the time of filing, anyone traveling to Hawai'i must submit proof of a negative COVID-19 test result (from an FDA-authorized "trusted testing" partner) within 72 hours before departure and complete and submit a travel questionnaire 24 hours before departure; anyone arriving without proof of a negative test result will be subject to a mandatory 10-day quarantine.[23] And this does not even account for any restrictions or quarantine they may be subject to upon returning to Guam.

79. At a minimum, I fear these sorts of restrictions will make it even more difficult, if not impossible, for patients to keep the fact that they have obtained an abortion confidential in the first place. For many, I fear the prospect of a prolonged quarantine and the inability to work or fulfil caregiving responsibilities etc., will prevent them from leaving Guam altogether.

Expanding TelAbortion to Guam

80. My colleagues and I already have professional relationships with OB/GYNS in Guam and are committed to expanding the services we can offer to patients on the island. Those of us with Guam medical licenses have also already made ourselves available for referrals for telemedicine consults for OB/GYN patients who are considering traveling to Hawai'i for abortion or other gynecological care.

81. We have discussed flying out to Guam periodically to provide abortion and other gynecological services, but so far, we have been unable to locate a clinical site in which we could provide care. We are aware of multiple supportive physicians in Guam who are willing to provide pre- and post-abortion testing and care to abortion patients. However, at this point in time they are unwilling to let us provide abortion services in their practices because of fear of retaliation,

[23] *See generally Travel Requirements*, The Hawaiian Islands, https://www.gohawaii.com/travel-requirements (last visited Jan. 25, 2021); *Safe Travels: Mandatory State of Hawaii Travel and Health Form*, State of Hawaii, https://travel.hawaii.gov/#/ (last visited Jan. 25, 2021).

protests, and disapproval from colleagues, family, friends, and other patients. In any event, the pandemic makes that sort of inter-island travel unfeasible right now.

82. I have personal experience with what it means for a community when abortion access is reduced or eliminated altogether. During the latter part of my OB/GYN residency, a longstanding abortion provider in Hawai'i retired. Though many doctors provided some abortion services for some of their established patients, no one provider was able to accommodate the large number of patients who were in need of abortion services. As resident physicians, we were unable to care for all of these patients. Some of them were turned away and were forced to continue an unwanted pregnancy. Through that experience I learned what happens when an entire community is dependent on a single doctor, and how the loss of that doctor can disrupt systems of care. This is what inspired me to pursue my Complex Family Planning Fellowship and establish a family planning residency training program at the University of Hawai'i, and later to establish one of the first TelAbortion Project sites in the United States. Today, it is part of what inspires me to expand the TelAbortion Project from Hawai'i to serve patients in Guam.

83. I believe that if we could expand telemedicine abortion services to Guam, we would be able to meet a real need for patients seeking abortion services right now. There is ample evidence showing that a lack of abortion is detrimental to public health, both because of the long-term physical and psychological risks of forced pregnancy and denied abortion care and because of the risks that patients end their pregnancies by unsafe means. Providing medication abortion using telemedicine to patients in Guam would directly address and mitigate this harm. It would also be especially beneficial during the current pandemic, because it enables people to obtain the health care they need while reducing unnecessary travel and in-person interactions, thereby reducing the risk of exposure and transmission of the COVID-19 virus.

84. Moreover, since most abortions are already sought in the first trimester when

medication abortion is available, offering medication abortion using telemedicine is well-suited to meet the existing need. Indeed, if we were able to extend these services to Guam it would likely reduce the number of patients seeking abortions later in pregnancy because patients would no longer need to take the time to save for over $1000 in travel costs to get to Hawai'i, along with hundreds or even thousands for the abortion itself.

85. As I have already discussed, using telemedicine for medication abortion is extremely safe, effective, and has high patient-satisfaction. Because a medication abortion occurs at home, there simply is no need for the patient to obtain the medications from us in person. We are already successfully using this model to provide medication abortion to patients on islands located hundreds of miles from an abortion provider. And we know from experience that these patients are able to obtain, if necessary, pre- and post-abortion care close to home because it is the same care provided to patients confirming pregnancy or experiencing a miscarriage. Based on my conversations with physicians on Guam, I am confident that patients in Guam would similarly be able to access such care without leaving the island.

86. I would be able to start using telemedicine to provide medication abortion to patients in Guam if it were not for the two laws we are challenging in this lawsuit.

87. First, there is a law that makes abortions a crime if they are not "performed" in a hospital or "adequately equipped medical clinic." 9 G.C.A. § 31.20 ("Clinic Requirement"). This language does not make sense in the context of medication abortion because medication abortions are not procedures that are "performed" at all, let alone in a clinical setting. Rather, as explained above, in a medication abortion we prescribe the patient two different medications, which the patient self-administers 24–48 hours apart, in the location of their choosing (usually at home), and which cause the patient to pass their pregnancy outside the clinical setting. As also explained above, for years the FDA has permitted us to mail both medications directly to our patients

without requiring us to personally perform a clinical examination of the patient or requiring the patient to obtain the medications in person.

88. Given the above, I am unsure what it means to "perform" a medication abortion in a clinical setting. If "perform" is understood to encompass the act of prescribing and/or dispensing the medications (including by mail), regardless of where the patient is located, then I could provide medication abortion using telemedicine to patients in Guam in compliance with this law. However, I am concerned that the law may be interpreted to require me to be in the same physical location as the patient, even though there is no medical justification for such a requirement, which would make it unlawful for me to provide medication abortion to patients in Guam using telemedicine. Moreover, I understand that there are multiple different entities that have the power to enforce this law, so I cannot risk criminal and/or licensure penalties by assuming *all* of them will interpret the law in the same way. That is why, without clarification from this Court, I will not risk my liberty and livelihood by providing telemedicine medication abortion to patients in Guam.

89. Second, even if the Clinic Requirement was not standing in our way, I understand that there is a Guam law that requires certain state-mandated information be provided to every abortion patient "in person," both orally and in writing, at least 24-hours prior to prescribing the medications necessary for a medication abortion, which means we cannot use telemedicine to comply with the requirements of this law. 10 G.C.A. § 3218.1. This law also requires the information be provided to the patient "individually" and in a "private room." *Id.*

90. To start, there is no reason to require us to provide this information to patients when they are physically in our presence, as opposed to through a live, face-to-face video appointment. Using telemedicine to counsel patients and obtain informed consent is routine throughout all areas of medicine; we could easily email the patients the requisite written

information and convey the oral information during the video appointment. There is simply no justification for preventing us from using telemedicine in this context, particularly since the result is to impede the access to essential, time-sensitive care.

91. Even if we delegated the responsibility of conveying the state-mandated information in person to a qualified provider in Guam, which I understand the statute allows, our patients would still be burdened. It is completely irrational and serves no medical purpose to force patients to go to a different health care provider to obtain the same information we are perfectly capable of providing to them during a live, face-to-face video appointment. Moreover, for those patients for whom it is not medically necessary to obtain any in-person testing prior to the abortion, this "in person" requirement forces them to take the time to schedule and make a completely unnecessary trip to a health care provider—in the midst of a pandemic, no less. This will only create delay, which will only increase risks to the patient.

92. Additionally, one of the benefits of telemedicine is that it enables patients to do the video appointment at the time and place that is best for them, which may involve including one or more support persons. As we do with patients we see in person, my colleagues and I take all appropriate steps to protect the privacy and confidentiality of our telemedicine patients, including by utilizing a secure Internet platform, and we never provide "group" counseling to more than one abortion patient at a time—whether in person or over telemedicine. However, our patients are competent decision-makers and there is no justification for any government to force a patient to conduct the video appointment "individually" and/or in a "private room" if a patient has made the personal decision to do so in a different setting and to include others in the process.

93. While I believe these laws serve no medical purpose and will only undermine patient health and safety, because violations of these laws carry criminal and licensure penalties, not to mention the risk of civil lawsuits, I cannot risk violating them. As a result, without an order

from this Court, I cannot provide telemedicine medication abortion services to eligible patients in Guam.

* * *

94. I believe that all too often people who live in Hawai'i and the mainland United States forget that Guam is part of the United States, and that people in Guam have the same constitutional right to abortion as the rest of us. People in Guam deserve access to safe, legal abortion in their community, and I believe expanding telemedicine medication abortion to Guam is essential to restoring that access.

95. For all these reasons, and the reasons stated above, I urge this Court to grant the preliminary injunction.

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

Executed this 27 of January, 2021.

BLISS KANESHIRO, M.D., M.P.H

EXHIBIT A

NAME	Bliss Kaneshiro, M.D., M.P.H.	DATE	August 21, 2020

PRESENT POSITION AND ADDRESS

Academic Rank:	Professor with Tenure
Division **Department** **Institution:**	Family Planning, Generalist Division Department of Obstetrics and Gynecology University of Hawaii
Professional Address:	1319 Punahou Street #824 Honolulu, HI 96826
E-Mail Address:	blissk@hawaii.edu

I. EDUCATION

Undergraduate and Graduate:

1997 – 2001	Doctor of Medicine John A. Burns School of Medicine University of Hawaii Honolulu, Hawaii
1994 – 1997	Bachelor of Arts, Major in History Pomona College Claremont, California

Postgraduate:

2005 - 2007	Family Planning Fellowship Department of Obstetrics and Gynecology Oregon Health & Science University
2005 – 2008	Master of Public Health, Epidemiology & Biostatistics Oregon Health & Science University Portland, Oregon
2001 – 2005	Internship and Residency

Department of Obstetrics, Gynecology & Women's Health
University of Hawaii John A. Burns School of Medicine
Honolulu, Hawaii

II. PROFESSIONAL EXPERIENCE

Academic:

2020 – Present Colin C. McCorriston Endowed Professor

2007 – Present Professor with Tenure
Department of Obstetrics, Gynecology & Women's Health
University of Hawaii

2014 – 2015 Interim Associate Chair of Education
Department of Obstetrics, Gynecology &Women's Health
University of Hawaii

2012 – Present Co-Program Director, Family Planning Fellowship
Department of Obstetrics, Gynecology &Women's Health
University of Hawaii

2012 – Present Chief of the Division of Family Planning
Department of Obstetrics, Gynecology, & Women's Health
University of Hawaii

2008 – 2012 Director of the Kenneth J. Ryan Residency Training Program
Department of Obstetrics, Gynecology & Women's Health
University of Hawaii

Other:

2014 – Present Associate Cooperating Graduate Faculty
Biomedical Science – Clinical Research
John A. Burns School of Medicine

2008 - Present Medical Director of Family Planning
Hawaii State Department of Health

2007 – Present Physician
Planned Parenthood of the Great Northwest and Hawaiian Islands
Honolulu, Hawaii

2005 – 2007 Obstetric Hospitalist (Locums Tenens Position)
Salem Hospital

	Salem, Oregon
2005 – 2007	Physician Planned Parenthood of the Columbia Willamette Portland, Oregon
Certification:	Diplomate, American Board of Obstetrics and Gynecology since November 2006
License:	State of Hawaii, Active Status, Expiration 1-31-20

III. SCHOLARSHIP

Peer-Reviewed Publications *In Press*

1. Delafield R, Elia J, Chang A, **Kaneshiro B**, Sentell T, Pirkle CM. A cross-sectional study examining differences in indication for cesarean delivery by race/ethnicity. Healthcare. Accepted January 25, 2021.
2. Harris S, **Kaneshiro B**, Ahn HJ, Saito-Tom L, Timing of Insertion Affects Expulsion in Patients using the Levonorgestrel 52 mg Intrauterine System for Non-Contraceptive Indications. Contraception. Accepted November 25, 2020

Peer Reviewed Publications

1. Chin J, **Kaneshiro B**, Elia J, Raidoo S, Savala M, Soon R. Buffered Lidocaine for Paracervical Blocks in First Trimester Abortions: A Randomized Controlled Trial. Contraception X 2020. 2:100044.
2. Davis C, **Kaneshiro B**, Tschann M. Insurance coverage for long-acting reversible contraception placed in office: a buy and bill demonstration project in Hawaii. HMJPH 2020. 79: 312-316.
3. Delafield R, Elia J, Chang A, **Kaneshiro B**, Sentell T, Pirkle C. Perspectives and experiences of obstetricians who provide labor and delivery care for Micronesian women in Hawaii: What is driving cesarean delivery rates?. Qualitative Health Research. Qual Health Res 2020. 30: 2291-2302.
4. **Kaneshiro B**, Kon Z, Tschann M, Williams A, Kajiwara K, Soon R. Meeting Women's Requests for Intrauterine Device and Contraceptive Implant Discontinuation. HJMPH 2020. 79: 296-301.
5. Edelman A, **Kaneshiro B**, Simmons KB, Hauschildt JL, Bond K, Boniface ER, Jensen JT. Treatment of Unfavorable Bleeding Patterns in Contraceptive Implant Users: A Randomized Controlled Trial. Obstet Gynecol 2020. 136:323-332.
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Analysis of Patient Contraceptive Choice Method at Time of Abortion May 2010 to December 2016. HJMPH 2020. 79: 272-278.

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8. Raidoo S, Tschann M, Elia J, **Kaneshiro B**, Soon R. Dual Method Contraception Among Adolescents and Young People: Are LARC Users Different? A Qualitative Study. J Pediatr Adolesc Gynecol 2020; 33: 45-52.
9. Stevens K, Elia J, **Kaneshiro B**, Salcedo J, Soon R, Tschann M. Updating Fetal Foot Length to Gestational Age References: a chart review of abortion cases from 2012 to 2014. Contraception 2020; 101: 10-13.
10. Raidoo S, Tschann M, **Kaneshiro B**, Sentell T. Impact of Insurance Coverage for Abortion in Hawai'i on Gestational Age at Presentation and Type of Abortion, 2010-2013. HJMPH 2020; 79: 17-22.
11. Yin C, Harvey S, Elia J, **Kaneshiro B**, Hayes D, Soon R. Highly-Effective Contraception Use More Likely Among Native Hawaiian Women than Non-Native Hawaiian Women at Title X Clinics in Hawai'i. HJMPH 2020; 79:16-22.
12. Tschann M, Wright T, Lusk H, Giorgio W, Colon A, **Kaneshiro B**. Understanding the Family Planning Needs of Female Participants in a Syringe-Exchange Program: A Needs Assessment and Pilot Project. Journal of Addiction Medicine 2019;13:366-371.
13. Raymond E, Chong E, Winikoff B, Platais I, Lotarevich T, Castillo P, **Kaneshiro B**, Tschann M, Fontanilla T, Baldwin M, Schnyer A, Coplon L, Mathieu N, Bednarek P, Keady M, Priegue E. Evaluation of a Direct to Patient Telemedicine Abortion Service in the United States. Contraception 2019; 100: 173-177.
14. Whitehouse K, Tschann M, Soon R, Davis J, Micks E, Salcedo J, Savala M, **Kaneshiro B**. Effects of prophylactic oxytocin on bleeding outcomes in women undergoing dilation and evacuation: a randomized, double-blinded, placebo-controlled trial. Obstetrics and Gynecology 2019; 133: 484-491. ***Awarded the 2019 Roy M. Pitkin Award***
15. Wong J, **Kaneshiro B**, Oyama I, Primary Care Physician Perceptions of Female Pelvic Floor Disorders. Hawaii J Med Public Health 2019; 78:132-136.
16. Porter T, Tsai PJS, Chang A, **Kaneshiro B**. Health Locus of Control: Beliefs in Health Care Providers in the Pacific Basin. Hawaii J Med Public Health 2018; 77:325-329

17. Friedlander EB, Soon R, Salcedo J, Davis J, Tschann M, **Kaneshiro B**. Prophylactic Pregabalin to Decrease Pain During Medication Abortion: A Randomized Controlled Trial. Obstetrics and Gynecology 2018; 132:612-618.

18. Tschann M, Salcedo J, Soon R, **Kaneshiro B**. Patient choice of adjunctive non-pharmacologic pain management during first-trimester abortion: a randomized controlled trial. Contraception 2018; 98:205-209.

19. Whitehouse K, Fontanilla T, Kim L, Tschann M, Soon R, Salcedo J, **Kaneshiro B**. Use of medications to decrease bleeding during surgical abortion: a survey of abortion providers' practices in the United States. Contraception 2018; 97:500-503.

20. Kuwahara M, Yamasato K, Tschann M, **Kaneshiro B**. Interpregnancy Interval and Subsequent Pregnancy Outcomes After Dilation and Evacuation. Journal of Obstetrics and Gynaecology 2018; 38:516-520.

21. Soon R, McGuire K, Salcedo J, **Kaneshiro B**. Immediate versus delayed insertion of the levonorgestrel intrauterine device in postpartum adolescents: A randomized pilot study. Hawaii J Med Public Health 2018; 77:60-65

22. Williams A, Kajiwara K, Soon R, Salcedo J, Tschann M, Elia J, Pauker K, **Kaneshiro B**. Recommendations for Contraception: Examining the Role of Patients' Age and Race. Hawaii J Med Public Health 2018; 77:7-13.

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81. Chang A, Soon R, **Kaneshiro B**. The Prevalence of Gestational Diabetes among Micronesians in Honolulu. HMJ, Native and Pacific Health Disparities Research – He Huliau 2010;69:5 Supplement 2.

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85. Harris M, **Kaneshiro B**. Controversies in Reproductive Health: An Evidence Based Approach Hormonal Contraception and Headaches. Contraception 2009;80:417-421.

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Refereed Oral Abstract Presentations

1. Fox K, Raidoo S, Soon R, Fontanilla T, Kameoka A, **Kaneshiro B**. Patient barriers to discontinuing long acting reversible contraception. Dynamic Collaborations in Reproductive Medicine ASRM 2020. Virtual Congress. October 2020.

2. Collins-Doijode H, **Kaneshiro B**. Expanded Access to Contraception: The Availability of Pharmacist Prescribed Contraception in Hawaii. 2020 SURE Symposium. July 31, 2020. Honolulu, HI.

3. Oehlers J, **Kaneshiro B**. Expanded Access to Contraception. 2020 SURE Symposium. July 31, 2020. Honolulu, HI

4. Long J, Schreiber C, Creinin MD, **Kaneshiro B**, Dart C, Nanda K, Blithe D. Menstrual Cup Use and Intrauterine Device Expulsion in a Copper Intrauterine Device Contraceptive Efficacy Trial. 2020 Annual Clinical and Scientific Meeting. April 24-27, 2020. Seattle, WA. *Awarded 2nd Place for Oral Abstracts*

5. Moayedi G, Stevens S, Tschann M, Salcedo J, Soon R, **Kaneshiro B**. Intranasal Fentanyl for Pain Control During First-Trimester Uterine Aspiration: A Randomized Controlled Trial. Society of Family Planning Annual Meeting. October 19-20, 2019. Los Angeles, CA.

6. Chong E, Raymond E, **Kaneshiro B**, Baldwin M, Coplon L, Bednarek P, Priegue E, Winikoff B. Mife by Mail: Findings from a telemedicine abortion service in the U.S. International Federation of Professional Abortion and Contraception Associates. September 14-15, 2018. Nantes, France.

7. Whitehouse K, Tschann M, Soon R, Davis J, Micks E, Salcedo J, Savala M, **Kaneshiro B**. The effect of prophylactic oxytocin on bleeding outcomes in women undergoing dilation and evacuation: a randomized, double-blind, placebo-controlled trial. North American Forum in Family Planning. October 20-22, 2018. New Orleans, LA. *Selected as one of the top four oral abstract presentation to be presented in a special session.*

8. Friedlander E, Davis J, Soon R, Salcedo J, **Kaneshiro B**. Prophylactic pregabalin to decrease pain during medical abortion: a randomized controlled trial. North American Forum on Family Planning. October 13-16, 2017. Atlanta, GA.

9. Bullock H, Tschann M, **Kaneshiro B**, Salcedo J. "Best if taken as soon as possible": pharmacy instructed timing of emergency contraceptive pill administration. American Society for Reproductive Medicine Emerging Research Session. October 15 to 19, 2016.
10. Soon R, Tschann M, Salcedo J, **Kaneshiro B**. Paracervical block to decrease pain with second trimester laminaria insertion: a randomized controlled trial. North American Forum on Family Planning. November 5 to 7, 2016. Denver, CO.
11. Tschann M, Salcedo J, Soon R, **Kaneshiro B.** Characteristics and contraceptive practices of patients seen for repeat abortion at the University of Hawaii Women's Options Center. Department of Obstetrics, Gynecology, and Women's Health Research Day 2016. April 28, 2016. Honolulu, HI.
12. Hiraoka M, Kamikawa G, **Kaneshiro B**. Obstetrics and Gynecology Faculty and Resident Utilization of Social Networking Sites and Awareness of the Risks. 2013 Council on Resident Education in Obstetrics and Gynecology (CREOG) and the Association of Professors of Gynecology and Obstetrics (APGO) Annual Meeting. February 27 to March 2, 2013. Phoenix, AZ.
13. Melo J, **Kaneshiro B**, Hiraoka M. The impact of a longitudinal curriculum on medical student Obstetrics and Gynecology clinical training. 2011 Council on Resident Education in Obstetrics and Gynecology (CREOG) and the Association of Professors of Gynecology and Obstetrics (APGO) Annual Meeting. March 9 to 12, 2012. San Antonio, TX.
14. **Kaneshiro B**, Edelman A, Carlson N, Nichols, M, Jensen J. Prophylactic Administration of Subantimicrobial dose doxycycline to prevent unscheduled bleeding in continuous oral contraceptive pill users. Fertility and Sterility 2010;94: S3. American Society for Reproductive Medicine Annual Meeting, October 23 to 27, 2010. Denver, CO.
15. **Kaneshiro B**, Edelman A, Morgan K, Nichols, M, Jensen J. Treatment with doxycycline does not decrease unscheduled bleeding in continuous oral contraceptive users. Fertility and Sterility 2009; 92:S40. American Society for Reproductive Medicine Annual Meeting, October 16 to 20, 2009, Atlanta, GA.
16. Isley M, Edelman A, **Kaneshiro B**, Nichols M, Jensen J. Sex education and contraceptive use at coital debut in the United States: results from cycle 6 of the national survey of family growth. Contraception 2008;78:171. Association of Reproductive Health Professionals Annual Meeting. September 17 to 20, 2008, Minneapolis, MN.
17. Chang A, Soon R, **Kaneshiro B**. Prevalence of Diabetes in Micronesians in Hawaii. 13th Pacific Basin Medical Association Conference. August 18 to 20, 2008. Yap, The Federated States of Micronesia.

18. **Kaneshiro B**, Jensen JT, Carlson NE, Harvey SM, Nichols MD, Edelman AB. The relationship between BMI and sexual behavior. Obstet Gynecol 2008;111:4S. The American College of Obstetricians and Gynecologist Annual Clinical Meeting. May 3 to 7, 2008, New Orleans, LA. *Awarded first place for scientific presentations*

19. **Kaneshiro B**. Effect of delivery route on the natural history of cervical dysplasia. American College of Obstetricians and Gynecologists District VI, VIII, XI Annual District Meeting. September 17 to 19, 2004, Salt Lake City, UT.

Refereed Poster Presentations

1. Au L, Horiuchi W, Tyson J, Tschann M, **Kaneshiro B**. Establishing Pain Scales for Gynecologic Procedures Using a Novel VAS App. Dynamic Collaborations in Reproductive Medicine ASRM 2020. Virtual Congress. October 2020.

2. Chin J, **Kaneshiro B**, Elia J, Raidoo S, Savala M, Soon R. Buffered lidocaine for paracervical blocks in first trimester outpatient surgical abortions. Society of Family Planning Annual Meeting. October 19-20, 2019. Los Angeles, CA.

3. Delafield R, Elia J, Chang A, **Kaneshiro B**, Sentell T, Pirkle CM. A qualitative study examining obstetricians' perspectives on labor and delivery care for women from Micronesia. American Public Health Association Annual Meeting and Expo. November 2-6, 2019. Philadelphia, PA.

1. Friedlander E, Davis J, Soon R, Salcedo J, **Kaneshiro B**. Text message link to online survey: a new highly effective method of longitudinal data collection. John A. Burns School of Medicine Biomedical Sciences and Health Disparities Symposium. April 19, 2018. Honolulu, HI.

2. Friedlander E, Davis J, Soon R, Salcedo J, **Kaneshiro B**. The longitudinal experience of pain during medical abortion. John A. Burns School of Medicine Biomedical Sciences and Health Disparities Symposium. April 19, 2018. Honolulu, HI.

3. Chong E, Raymond E, **Kaneshiro B**, Baldwin M, Priegue E, Winikoff B. The TelAbortion Project: Delivering the abortion pill to your doorstep by telemedicine and mail. ACOG Annual Clinical and Scientific Meeting April 27-30, 2018; Austin, TX.

4. Stevens K, Elia J, **Kaneshiro B**, Salcedo J, Soon R, Tschann M. Updating fetal foot length to gestational age reference ranges: a chart review of abortion cases from 2012 to 2014. ACOG Annual Clinical and Scientific Meeting April 27-30, 2018; Austin, TX.

5. Torre B, Nokovic J, Shelton J, **Kaneshiro B**, Tsai PJS. Impact of Long-Acting Reversible Contnraceptive Counseling on Postpartum Contraceptive Choice in High-Risk Women. ACOG Annual Clinical and Scientific Meeting April 27-30, 2018;

Austin, TX.

6. Friedlander E, Davis J, Soon R, Salcedo J, **Kaneshiro B**. Text message link to online survey: a new highly effective method of longitudinal data collection. North American Forum on Family Planning. October 13-16, 2017. Atlanta, GA.

7. Friedlander E, Davis J, Soon R, Salcedo J, **Kaneshiro B**. The longitudinal experience of pain during medical abortion. North American Forum on Family Planning. October 13-16, 2017. Atlanta, GA.

8. Tschann M, Elia J, Salcedo J, Soon R, **Kaneshiro B**. A comprehensive reproductive health needs assessment for syringe exchange program participants. North American Forum on Family Planning. October 13-16, 2017. Atlanta, GA.

9. Tschann M, Salcedo J, Soon R, **Kaneshiro B**. Assessing the effectiveness of patient-centered non-pharmacologic pain management techniques on pain during first trimester aspiration abortion: a randomized controlled trial. North American Forum on Family Planning. October 13-16, 2017. Atlanta, GA.

10. Saito-Tom, Ahn H, **Kaneshiro, B**. Levonorgestrel Intrauterine Device Complications among Obese women in a Multiracial Population. American College of Obstetricians and Gynecologists 2017 Annual Clinical and Scientific Meeting. May 6 to 9, 2017. San Diego, CA.

11. Harris S, Saito-Tom L, Ahn H, **Kaneshiro B**. Levonorgestrel intrauterine device expulsion in patients with abnormal uterine bleeding. North American Forum on Family Planning. November 5 to 7, 2016. Denver, CO.

12. Kuwahara M, Yamasato K, Tschann M, **Kaneshiro B**. Interpregnancy interval and subsequent pregnancy outcome after dilation and evacuation. The 71st meeting of the American Society of Reproductive Medicine October 17 to 21, 2015. Baltimore, MD.

13. Bullock H, Tschann M, Elia J, **Kaneshiro B**, Salcedo J. From Oahu to Lanai: Access to Emergency Contraceptive Pills throughout the Hawaiian Islands. Districts V, VI, VII, VIII & IX Annual Meeting American College of Obstetricians and Gynecologists. September 18 to 20, 2015. Denver, CO.

14. Soon R, Elia J, Beckwith N, **Kaneshiro B**, Dye T. Contraceptive decision-making among Native Hawaiian women. North American Forum on Family Planning. November 8 to 10, 2015. Chicago, IL.

15. Tschann M, Salcedo J, Soon R**, Kaneshiro B**. Characteristics and contraceptive practices of patients seen for repeat abortion at the University of Hawaii Women's Options Center. North American Forum on Family Planning. November 8 to 10, 2015. Chicago, IL.

16. Elia J, Soon R, Beckwith N, Uemoto M, **Kaneshiro B**, Dye T. Understanding pregnancy intention and contraceptive decision-making among Native Hawaiians: focus groups with women and men. North American Forum on Family Planning. November 8 to 10, 2015. Chicago, IL.

17. Bullock H, Steele S, Kurata N, Tschann M, Elia J, **Kaneshiro B**, Salcedo J. Access to ulipristal acetate in Hawaii: is a prescription enough?. North American Forum on Family Planning. November 8 to 10, 2015. Chicago, IL.

18. Bullock H, Steele S, Kurata N, Tschann M, Elia J, **Kaneshiro B**, Salcedo J. "I need to look that up. I've never filled it before": information from pharmacy staff regarding ulipristal acetate. North American Forum on Family Planning. November 8 to 10, 2015. Chicago, IL.

19. Whitehouse K, Tschann M, Davis J, Soon R, Salcedo J, **Kaneshiro B**. Association between oxytocin use during dilation & evacuation and estimated blood loss. North American Forum on Family Planning. November 8 to 10, 2015. Chicago, IL.

20. Soon R, Elia J, Beckwith N, **Kaneshiro B**, Dye T. Cultural factors affecting attitudes toward pregnancy and pregnancy planning among Native Hawaiians. North American Forum on Family Planning. October 10 to 12, 2014. Miami, FL.

21. Tschann M, Edelman A, Jensen J, Bednarek P, **Kaneshiro B**. A registry case series of surgical abortion with dilation and evacuation in anticoagulated women. North American Forum on Family Planning. October 10 to 12, 2014. Miami, FL.

22. Soon R, Elia J, Hayes D, Harvey S, Salcedo J, **Kaneshiro B**. Highly effective contraception more likely among Native Hawaiian women than non-Hawaiian women at Title X clinics in Hawai'i. North American Forum on Family Planning. October 10 to 12, 2014. Miami, FL.

23. Elia J, Soon R, Hayes D, **Kaneshiro B**. Age as a determinant of contraceptive non-use: An examination of Hawai'i Title X data. North American Forum on Family Planning. October 10 to 12, 2014. Miami, FL.

24. **Kaneshiro B**, Tschann M, Jensen J, Bednarek P, Texeira R, Edelman A. Blood loss at the time of surgical abortion up to 14 weeks in anticoagulated women: a registry case series. North American Forum on Family Planning. October 10 to 12, 2014. Miami, FL.

25. Soon R, Elia J, Beckwith N, **Kaneshiro B**, Dye T. Understanding pregnancy intention and contraceptive decision-making among Native Hawaiians: Key Informant Interviews. He Huliau 2014. September 18 to 20, 2014. Kapolei, HI.

26. Chang A, Hurwitz E, Miyamura J, **Kaneshiro B**, Sentell T. Perinatal outcomes

among Pacific Islanders in Hawaii. American Public Health Association 141st Annual Meeting and Exposition. November 2 to 6, 2013. Boston, MA.

27. **Kaneshiro B**, Jensen JT, Edelman A, Pandhare J, Dash, CV. Effect of oral contraceptives and doxycycline on endometrial levels of MMP-2 and MMP-9. Fertility and Sterility 2013;100:3S. Conjoint Meeting of the International Federation of Fertility Societies and the American Society for Reproductive Medicine. October 12 to 17, 2013. Boston, MA.

28. Saito-Tom L, Harris S, Soon R, Salcedo J, **Kaneshiro B**. Intrauterine device use in overweight and obese women. 2013 North American Forum on Family Planning. October 6 to 7, 2013. Seattle, WA.

29. Dye TD, Wojtowyz M, Dozier A, **Kaneshiro B**, Bacchi D, Glantz C, Towner D. Should unwanted pregnancy be considered a high-risk perinatal condition? 33rd Annual Meeting Society for Maternal Fetal Medicine, February 11 to 16, 2013. San Francisco, CA.

30. Hiraoka M, Kamikawa G, **Kaneshiro B**. A Structured Orientation Curriculum Improves the Confidence of Incoming Obstetrics and Gynecology First Year Residents. 2013 Council on Resident Education in Obstetrics and Gynecology (CREOG) and the Association of Professors of Gynecology and Obstetrics (APGO) Annual Meeting**.** February 27 to March 2, 2013. Phoenix AZ.

31. Yamasato K, Duffy C, **Kaneshiro B**, Hiraoka M. The Impact of Robotic Surgery on Gynecologic Surgical Trends in Hawaii. 2013 Council on Resident Education in Obstetrics and Gynecology (CREOG) and the Association of Professors of Gynecology and Obstetrics (APGO) Annual Meeting. February 27 to March 2, 2013. Phoenix, AZ.

32. **Kaneshiro B**, Jensen JT, Edelman A, Hildreth JEK, Fujimoto C, Lum J, Chang A, Dash CV. Effect of oral contraceptives and doxycycline on endometrial MMPs. 13th Research Centers in Minority Institutions (RCMI) International Symposium on Health Disparities. December 10 to 13, 2012**.** San Juan, PR.

33. Melo JR, Kuwahara MK, **Kaneshiro B**. Women's Willingness and Ability to Palpate their IUD Strings. American College of Obstetricians and Gynecologists Annual Clinical Meeting 2012. May 5 to 9, 2012. San Diego, CA.

34. **Kaneshiro B**, Edelman A, Carlson N, Jensen J. Unscheduled bleeding in continuous oral contraceptive pills, a comparison of progestin dose. American Society for Reproductive Medicine Annual Meeting, October 15 to 19, 2011. Orlando, FL.

35. Minaglia S, **Kaneshiro B**, Soules K, Harvey S, Grzankowski K, Millet L, Oyama I. Assessment of internet-based information regarding urinary incontinence. The

American Urogynecologic Society (AUGS) Annual Scientific Meeting. September 15 to 17, 2011. Providence, RI.

36. Minaglia S, **Kaneshiro B**, Soules K, Harvey S, Gryznkowski K, Millet L, Oyama I. Assessment of internet-based information regarding urinary incontinence. The 41st Annual Meeting of the International Continence Society. August 29 to September 2, 2011. Glasgow, Scotland.

37. Yu J, Lowery L, **Kaneshiro B**, Bidwell B. Knowledge and Attitudes of Pediatric Residents About the Use of the IUD in Adolescents. The 2011 Pediatric Academic Society and Asian Society for Pediatric Research Joint Meeting. April 30 to May 3, 2011. Denver, CO.

38. **Kaneshiro B**, Barrett M, Takekawa S, Soon R. Knowledge of intrauterine devices in a diverse adolescent population. 12th Research Centers in Minority Institutions (RCMI) International Symposium on Health Disparities. December 6 to 9, 2010. Nashville, TN.

39. Tsai S, Hiraoka M, Oyama I, **Kaneshiro B**. Racial differences in perineal body length in labor. 12th Research Centers in Minority Institutions (RCMI) International Symposium on Health Disparities. December 6 to 9, 2010. Nashville, TN.

40. Chu, V, Kim, I, Adrian, C, **Kaneshiro, B**. Assessment of the accuracy of information regarding emergency contraception on the internet. American College of Obstetricians and Gynecologists District VII, VIII, IX, & XI Combined 2010 Annual District Meeting. October 14 to 16, 2010. Maui, HI.

41. Woo, G, Thomas, J, Soon, R, **Kaneshiro, B**. Factors affecting reproductive health education in the school system. American College of Obstetricians and Gynecologists Annual Clinical Meeting. May 15 to 19, 2010. San Francisco, CA.

42. Sueblinvong, T, Carney, ME, Sing, C, **Kaneshiro, B**, Killeen, J. Prediction of metastatic disease of endometrial carcinoma using preoperative endometrial biopsy or curettage. Society of Gynecologic Oncologists 40th Annual Meeting on Women's Cancer. February 5 to 8, 2009. San Antonio, TX.

43. **Kaneshiro B**, Jensen JT, Harvey SM, Edelman A. The Association of Body Mass Index and Unintended Pregnancy in the US: Results from Cycle 6 of the National Survey of Family Growth. Contraception 2007;76:177. Association of Reproductive Health Professionals Annual Meeting. September 26 to 29, 2007, Minneapolis, MN.

44. **Kaneshiro B**, Aeby T, Kamikawa G. The relationship between problem-based learning and academic performance in residency. 2006 Council on Resident Education in Obstetrics and Gynecology (CREOG) and the Association of Professors of Gynecology and Obstetrics (APGO) Annual Meeting, March 2 to 5, 2006. Orlando, FL.

Electronic Publications

1. **Kaneshiro, B**, Edelman, A. Contraceptive counseling for obese women. In: UpToDate, Zieman, M (Ed), UpToDate, Waltham, MA 2008.
   Viewed 10,408 times in 2016

2. **Kaneshiro, B**, Edelman, A. Management of unscheduled bleeding in women using contraception. In: UpToDate, Zieman, M (Ed), UpToDate, Waltham, MA 2008.
   Viewed 62,791 times in 2016

Non-Peer-Reviewed Publications

1. IPAS Core Clinical Content (CCC): Ultrasound findings after medical abortion. March 31, 2010.

2. IPAS Core Clinical Content (CCC): Medical abortion without the routine use of ultrasound. December 31, 2009.

3. IPAS Core Clinical Content (CCC): Follow up after second trimester surgical abortion. July 1, 2009.

4. **Kaneshiro B**, Kessel B. Obesity and Sexuality: Is There a Connection. The Female Patient 2009;34:38-40.

5. **Kaneshiro B**, Edelman AB. Bone loss is reversible in women of all ages after discontinuation of depot medroxyprogesterone acetate injectable contraception. OB/GYN Clinical Alerts. October 2008.

6. **Kaneshiro B**, Edelman AB. First Trimester Medication Abortion without ultrasound. IPAS Best Practices. 2008.

7. **Kaneshiro B**, Edelman AB. The use of medication abortion without ultrasound technology, IPAS training curriculum. 2008.

8. Statement to the Senate Health Committee of the Hawaii State on Senate Bill 1111, February 2007

Book Chapters

1. Wass, J and Wiebke A (Eds). Oxford Textbook of Endocrinology and Diabetes. Chapter on Hormonal Contraception (2020).

2. Gilliam, M and Whitaker, A (Eds). (2014). Contraception for Adolescent and Young Adult Women. Chapter on Contraception for women and girls who are obese. Springer Science + Business Media. New York, NY.

3. Wass, J and Stewart P (Eds). Oxford Textbook of Endocrinology and Diabetes. Chapter on Hormonal Contraception.

4. Hillard, P. (Ed). (2008). *The 5-Minute Obstetrics and Gynecology Consult*. Chapter on Paratubal/Paraovarian Cysts in Section II Gynecologic Diseases. Lippincott, Williams, and Wilkins. Philadelphia, PA.

5. Hillard, P. (Ed). (2008). *The 5-Minute Obstetrics and Gynecology Consult*. Chapter on Reversible Contraception – Hormonal Combined Oral Contraceptive Pills in Section III Women's Health and Primary Care. Lippincott, Williams, and Wilkins. Philadelphia, PA.

Grants:

Current

The LARC Ombudsman Program – Improving Contraceptive Access in the State of Hawaii
May 15, 2020 to May 15, 2021 $39,945.36
The Hawaii State Department of Health
Primary Investigator: Bliss Kaneshiro

Expanding Access to Contraception
April 1, 2020 to December 31, 2020 $50,000.00
The Hawaii State Department of Health
Primary Investigator: Bliss Kaneshiro

SBIRT – Screening Brief Intervention and Referral to Treatment
April 1, 2020 to December 31, 2020 $50,000.00
The Hawaii State Department of Health
Primary Investigator: Reni Soon
Role: Co-Investigator

A Qualitative Study of Abortion Patients as Research Participants
January 1, 2018 to June 30, 2020 $14,979.00
The Society of Family Planning Research Fund
Primary Investigator: Paris Stowers
Role: Mentor

The Experience of Medical Abortion by Mail: A Qualitative Study of Telabortion Participants

January 1, 20120 to May 1, 2021 $14,970.00
The Society of Family Planning Research Fund
Primary Investigator: Courtney Kerestes
Role: Mentor

A multicenter, randomized study of the efficacy of ulipristal acetate (UPA) 30 mg, levonorgestrel (LNG) 1.5 mg, and LNG 3.0 for emergency contraception (EC) in women with weight > 80 kg (CCN013C)
September 26, 2017 to December 31, 2019 $212,152.00
National Institutes of Health NICHD Contraceptive Clinical Trials Network
Role: Subsite Principal Investigator

Addressing Systems and Administrative Barriers to LARC in Hawaii
January 18, 2018 to December 31, 2019 $86,774.04
National Institutes of Reproductive Health (NIRH)
Role: Principal Investigator

A multi-center, single-blind, randomized clinical trial to compare two copper IUDs: Mona Lisa NT Cu380 Mini and ParaGard (CCN016)
March 1, 2017 to June 30, 2020 $107,246.00
National Institutes of Health NICHD Contraceptive Clinical Trials Network
Role: Subsite Principal Investigator

Treatment of unfavorable bleeding patterns in contraceptive implant users
February 2, 2017 to June 30, 2020 $115,959.00
Merck Sharp & Dohme
Role: Principal Investigator for the University of Hawaii Site

Evaluation of the Effectiveness, Safety and Tolerability of LevoCept (Levonorgestrel-Releasing Intrauterine System) for Long-Acting Reversible Contraception
August 1, 2016 to April 15, 2020 $236,735.00
Contramed LLC.
Role: Principal Investigator for the University of Hawaii Site

Feasibility of medical abortion by direct-to-consumer telemedicine
January 1, 2016 to December 31, 2019 $60,165.00
Gynuity Health Projects
Role: Principal Investigator for the University of Hawaii Site

UH Fellowship in Family Planning
I have secured renewable yearly funding to develop and expand the Fellowship in Family Planning at the University of Hawaii. Funds are used for the development of research infrastructure and education to support Fellows in the University of Hawaii's Family Planning Fellowship program.

Total Amount	$2,949,715.00
July 1, 2019 to June 30, 2020	$489,674.00
July 1, 2018 to June 30, 2019	$313,643.00
July 1, 2017 to June 30, 2018	$277,932.00
July 1, 2016 to June 30, 2017	$459,971.00
July 1, 2015 to June 30, 2016	$446,768.00
July 1, 2014 to June 30, 2015	$420,024.00
July 1, 2013 to June 30, 2014	$330,601.00
July 1, 2012 to June 30, 2013	$211,103.00

The Society of Family Planning
Role: Principal Investigator

RMATRIX (U54MD007584) RCMI Multidisciplinary And Translational Research Infrastructure eXpansion
Total grant of 12.6 million dollars was awarded to the University of Hawaii from the National Institute on Minority Health and Health Disparities of the National Institutes of Health build research infrastructure at the University of Hawaii. My role is to direct one of three clinical research sites whose focus is perinatal health and growth and development. My role began on 4/1/14 and includes ongoing yearly support of 0.1FTE equivalent to $16,353.00 per year.
November 1, 2010 to April 30, 2020
Principal Investigator: Jerris Hedges MD, MS, MMM
Role: Kapiolani Participant & Clinical Resources Site Director

Subsite of the Contraceptive Clinical Trials Network (CCTN)
The Network is funded through the NICHD Contraception and Reproductive Health (CRH) Branch. Sites are located at university research centers and medical centers across the country and are capable of recruiting for and conducting phase I, II, and III clinical trials. The University of Hawaii is a subsite under Oregon Health & Science University.
July 1, 2013 to June 30, 2019
National Institutes of Health (NICHD-CRHB-2012-03)
7/1/13-6/30/2019
Site Principal Investigator: Jeffrey Jensen MD, MPH
Role: University of Hawaii Subsite Principal Investigator

<u>Previous</u>
Exploratory Study of Cesarean Delivery Among Micronesians in Hawaii
May 1, 2017 to April 31, 2019 $100,000.00
National Institutes of Health (U54MD007584)
Principal Investigator: Rebecca Delafield
Role: Mentor

Streamlining TelAbortion through an educational video intervention
May 15, 2017 to Dec 31, 2018 $14,746.00

Gynuity Health Projects
Principal Investigator: Ghazaleh Moayedi
Role: Primary Mentor

The Society of Family Planning Midcareer Mentor Award
July 15, 2016 to June 14, 2018 $80,000.00
Society of Family Planning
Primary Investigator: Bliss Kaneshiro

A Multicenter, Open-label, Single-Arm Study to Evaluate the Contraceptive Efficacy and Safety of a Combined Oral Contraceptive Containing 15 mg Estetrol and 3 mg Drospirenone
December 1, 2016 to October 1, 2018 $295,037.00
Mithra Pharmaceuticals
Role: Principal Investigator for the University of Hawaii Site

Sources of Sexual and Reproductive Health Information for Adolescents and Young People
September 1, 2016 to October 31, 2017 $6,200.00
The Sharma Endowment
Principal Investigator: Shandhini Raidoo
Role: Primary Mentor

A randomized controlled trial comparing dilation and evacuation outcomes with and without oxytocin use
March 30, 2013 to December 31, 2017 $70,000.00
The Society of Family Planning
Principal Investigator: Kate Whitehouse DO
Role: Primary Mentor

Long Acting Reversible Contraceptives Demonstration Project
October 16, 2016 to October 16, 2017 $15,000.00
Hawaii State Department of Health Office of Planning, Policy and Program Development
Role: Principal Investigator

Intranasal Fentanyl for Pain Control During First-Trimester Uterine Aspiration: A Randomized Controlled Trial
February 14, 2017 to June 30, 2018 $92,859.00
Society of Family Planning Research Fund
Principal Investigator: Ghazaleh Moayedi
Role: Primary Mentor

LARC and Dual Use in Adolescents and Young Women $99,050.00
July 13, 2015 to June 30, 2017
Society of Family Planning Research Fund

Principal Investigator: Shandhini Raidoo
Role: Mentor

Reproductive health needs assessment
August 30, 2016 to June 30, 2017 $67,500.00
Hawaii State Department of Health Office of Policy and Program Development
Role: Co-Principal Investigator

A Phase III, Single Arm, Clinical Trial To Study The Contraceptive Efficacy And Safety Of The MK-8342B Vaginal Ring
October 1, 2015 to October 1, 2016 $312,894.00
MERCK Pharmaceuticals
Role: Principal Investigator of the University of Hawaii Site

Prophylactic pregabalin to decrease pain during medical abortion: a randomized controlled trial
April 3, 2015 to June 30, 2016 $99,984.00
The Society of Family Planning
Principal Investigator: Emmakate Friedlander MD
Role: Primary Mentor

Pacific Regional Program to Increase Cervical Cancer Screening
A project funded by the Centers for Disease Control and Prevention National Comprehensive Cancer Control Program to assist the Republic of the Marshall Islands in training clinicians to provide cancer screening. I provided clinician training for Visual Inspection with Acetic Acid (VIA) for cervical cancer screening.
July 1, 2013 to July 1, 2014 $84,901.00
Principal Investigator: Neal Palafox MD, MPH and Lee Buenconsejo Lum MD
Role: Sub-Contractor

Understanding pregnancy intention and contraceptive decision-making among Native Hawaiians
August 1, 2013 to June 30, 2014 $67,442.00
Principal Investigator: Reni Soon MD, MPH
Role: Mentor

Oral Contraceptives and Subantimicrobial Doxycycline: Effect on Endometrial MMPs
July 1, 2011 to July 1, 2012 $50,000.00
National Institutes of Health (NCRR)
Role: Principal Investigator

Kenneth J Ryan Residency Training Program in Abortion and Family Planning
July 1, 2009 to June 30, 2010 $103,708.00
The Society of Family Planning

Role: Principal Investigator

Blood loss at the time of first trimester surgical abortion in anticoagulated women.
October 1, 2007 to April 30, 2010 $14,737.00
Society of Family Planning
Role: Principal Investigator

A study of continuous oral contraceptives and doxycycline to decrease breakthrough bleeding: a randomized, double-blind placebo controlled trial.
March 1, 2007 to March 31, 2010 $341,491.00
Wyeth Pharmaceuticals (unrestricted research award)
Role: Principal Investigator

A study of continuous oral contraceptives and doxycycline to decrease breakthrough bleeding: a randomized, double-blind placebo controlled trial.
March 1, 2007 to March 31, 2010 $70,000.00
The Society of Family Planning
Role: Principal Investigator

IV. EDUCATION

Invited Lectures

International

1. Measuring Pain with In-Office Surgical Procedures. Vancouver, Canada. February 2018.

2. VIA and Cryotherapy: Implementing your Cervical Cancer Screening Program. Planned and conducted a workshop and clinical training. Yap, Federated States of Micronesia. July 2016.

3. Contraceptive Update. Yap, Federated States of Micronesia, July 2016.

4. Long Acting Reversible Contraception. Okinawa Chubu Hospital, Okinawa, Japan. January 2016.

5. Contraception for Medically Complicated Patients. Okinawa Chubu Hospital, Okinawa, Japan. January 2016.

6. Contraception: The Game. Okinawa Chubu Hospital, Okinawa, Japan. January 2016

7. Medical and Surgical Abortion. Okinawa Chubu Hospital, Okinawa, Japan. January 2016.

8. Prenatal Diagnosis. Okinawa Chubu Hospital, Okinawa Japan. January 2016.

9. VIA and Cryotherapy: Implementing your Cervical Cancer Screening Program. Planned and conducted a workshop and clinical training. Majuro, Republic of the Marshall Islands. September 2015.

10. VIA and Cryotherapy: Implementing your Cervical Cancer Screening Program. Planned and conducted a workshop and clinical training. Ebeye, Republic of the Marshall Islands. September 2015.

11. VIA and Cryotherapy: Decreasing the Burden of Cervical Cancer. Planned and conducted a 5-Day workshop. Majuro, Republic of the Marshall Islands. March 2014.

12. Plenary: Contraceptive Management Update. The 26th Annual Pacific Basin Family Planning Conference. Saipan, Commonwealth of the Northern Marianas. April 2012.

13. Clinical Management of Women with Chronic Medical Conditions. The 26th Annual Pacific Basin Family Planning Conference. Saipan, Commonwealth of the Northern Marianas. April 2012.

14. Adolescent Reproductive Health Care Plenary. The 26th Annual Pacific Basin Family Planning Conference. Saipan, Commonwealth of the Northern Marianas. April 2012.

15. Chlamydia and Gonorrhea Medical Management. The 26th Annual Pacific Basin Family Planning Conference. Saipan, Commonwealth of the Northern Marianas. April 2012.

16. The Periodic Well-Woman Examination. The 26th Annual Pacific Basin Family Planning Conference. Saipan, Commonwealth of the Northern Marianas. April 2012.

17. Contraceptive Update and the US Medical Eligibility Criteria. The 25th Annual Pacific Basin Family Planning Conference. Hagatna, Guam. April 2011.

18. Management of Gynecologic and Contraceptive Problems in Women with Abnormal Bleeding. The 25th Annual Pacific Basin Family Planning Conference. Hagatna, Guam. April 2011.

19. Pelvic Exam Practicum. The 25th Annual Pacific Basin Family Planning Conference. Hagatna, Guam. April 2011.

20. Birth Control and Obesity. The 25th Annual Pacific Basin Family Planning Conference. Hagatna, Guam. April 2011.

21. Cervical Cancer Screening. The 25th Annual Pacific Basin Family Planning Conference. Hagatna, Guam. April 2011.

22. Adolescent Women's Health. The 25th Annual Pacific Basin Family Planning Conference. Hagatna, Guam. April 2011.

23. Breast Exam Practicum – USPSTF Recommendations. The 25th Annual Pacific Basin Family Planning Conference. Hagatna, Guam. April 2011.

24. STD Screening Guidelines and Partner Management. The 25th Annual Pacific Basin Family Planning Conference. Hagatna, Guam. April 2011.

25. Ask the Consultants. The 25th Annual Pacific Basin Family Planning Conference. Hagatna, Guam. April 2011.

26. Clinical Teaching in the US and Hawaii. Hiroshima Faculty Development Workshop "Clinical Teaching Hawaii-Style" Hiroshima, Japan. November 2009.

27. Teaching Psychomotor Skills in the Operating Room. Hiroshima Faculty Development Workshop "Clinical Teaching Hawaii-Style" Hiroshima, Japan. November 2009.

28. Creating Simulations for Clinical Teaching. Hiroshima Faculty Development Workshop "Clinical Teaching Hawaii-Style" Hiroshima, Japan. November 2009.

29. Teaching the Physical Exam and Bedside Teaching. Hiroshima Faculty Development Workshop "Clinical Teaching Hawaii-Style" Hiroshima, Japan. November 2009.

30. Women in Medicine, Panelist for Muscat Program. Okayama, Japan. November 2009.

31. Grand Rounds for the Waab Community Health Center, Yap, Micronesia. "A Contraceptive Update". December 2006.

National

1. Informing State Policy in Hawaii, Engaging the Physician Voice. Society of Family Planning Annual Meeting. Los Angeles, CA. October 2019.

2. Panelist - Navigating Research, Clinical Practice and Advocacy as a Leader of Color. Society of Family Planning Annual Meeting. Los Angeles, CA. October 2019.

3. Providing Contraception Using a Social Justice Framework. John A. Burns School

of Medicine Conference Alumni Conference. Las Vegas, NV. October 2019.

4. cVAS- A Novel Pain Scale. Pacific NW Family Planning Fellowship Annual Symposium. Portland, OR. March 2017.

5. Abortion Care for Anticoagulated Patients. North American Form on Family Planning. Chicago, IL. November 2015.

6. Research and Media Attention: Case Study. Fellowship in Family Planning Annual Meeting. San Francisco, CA. May 2015.

7. Weight, Obesity, and Contraception. Planned Parenthood Medical Directors Council Annual Update on Reproductive Health and Medical Leadership. Orlando, FL. February 2015.

8. Postgraduate Course: Epidemiology and Experimental Design: Using Evidence-Based Medicine to Understand Contraceptive Controversies. American Society for Reproductive Medicine 69th Annual Meeting. Honolulu, HI. October 2014. Postgraduate Course Chair: Bliss Kaneshiro

9. Contraception Special Interest Group and Health Disparities Special Interest Group Interactive Session – Contraceptive Strategies for Disadvantaged Women. American Society for Reproductive Medicine 69th Annual Meeting. Honolulu, HI. October 2014.

10. Postgraduate Course: Contraception Controversies and Conundrums. American College of Obstetricians and Gynecologists Annual Clinical Meeting, Chicago, Ill, April 2014.

11. Benefits and Risks of Sterilization. American College of Obstetricians and Gynecologists Combined District V, VI, VIII, IX Annual District Meeting, Wailea, Maui, HI, September 2013.

12. Controversies in Family Planning. American College of Obstetricians and Gynecologists Combined District V, VI, VIII, IX Annual District Meeting, Wailea, Maui, HI, September 2013.

13. Developing, Sustaining and Growing Services. Ryan Residency Training Program Meeting. Denver, CO, October 2012.

14. Obesity and Contraception. Presented with Alison Edelman MD, MPH and Anne Burke MD, MPH. American Society for Reproductive Medicine 67th Annual Meeting. Orlando, FL, October 2011.

15. Contraceptive Considerations in Obese Women. North American Forum on Family Planning 1st Annual Meeting. Washington DC, October 2011.

16. Contraceptive Use and Outcome in Obese Women. Obesity and Oral Contraception: What do we know and need to know? National Institute of Child Health and Human Development (NICHD). Rockville, MD. November 2010.

17. ASRM Roundtable: Contraceptive Controversies. American Society for Reproductive Medicine Annual Meeting. Denver, CO. October 2010.

18. Contraception, Integrating Science into Clinical Practice. American College of Obstetricians and Gynecologists Combined District VII, VIII, IX, XI Annual District Meeting. Wailea, Maui, HI. October 2010.

19. ACOG Roundtable: Innovations in Contraception. American College of Obstetricians and Gynecologists Annual Clinical Meeting. San Francisco, CA. May 2010.

20. ACOG Roundtable: Innovations in Contraception. American College of Obstetricians and Gynecologists Annual Clinical Meeting. Chicago, IL. May 2009.

21. ACOG Roundtable: Innovations and Controversies in Contraception. American College of Obstetricians and Gynecologists Annual Clinical Meeting. New Orleans, LA. May 2008.

22. Abortion Training in Residency. Grand rounds for the Department of Obstetrics & Gynecology at Harbor-UCLA Medical Center, Torrance, CA. September 2006.

23. A Contraceptive Update. Grand Rounds for Kapiolani Medical Center, Honolulu, HI. June 2006.

Local

1. TelAbortion. Hawaii Affiliate of the American College of Nurse Midwives. January 2019.

2. Providing Long Acting Reversible Contraception. Hawaii Academy of Family Physicians Annual Meeting. March 2018

3. Family Planning Updates. Queens Medical Center Grand Rounds. November 2017.

4. One Key Question. Preparing for Zika: Prevention, Diagnosis, Counseling, and Providing Family Planning Care For Non-Pregnant Women and Men of Reproductive Age in the Context of Zika. February 2017

5. Case Studies of Zika in Hawaii. Preparing for Zika: Prevention, Diagnosis, Counseling, and Providing Family Planning Care For Non-Pregnant Women and Men of Reproductive Age in the Context of Zika. February 2017.

6. Contraception for Women with Medical Comorbidities. Family Planning and Your Patients: National Perspectives, Local Applications. December 2016.

7. A New IUD? Updates in Contraception. Kapiolani Medical Center Grand Rounds. December 2016.

8. Long Acting Reversible Contraception. Hawaii Maternal and Infant Health Collaborative Conference. January 2015.

9. Contraception Controversies and Conundrums Part 2. Queens Medical Center. December 2015.

10. LARC. Family Planning Provider Title X Training. October 2015.

11. Contraception Controversies and Conundrums Part 1. Queens Medical Center. July 2015.

12. Contraception Controversies and Conundrums Part 1. Kapiolani Medical Center Grand Rounds. July 2014.

13. Contraception Controversies and Conundrums Part 2. Kapiolani Medical Center Grand Rounds. July 2014.

14. 10 Things You Should Know About Family Planning in 2013. Kapiolani Medical Center Grand Rounds. November 2013.

15. Family Planning: A Global Perspective. Queens Medical Center Grand Rounds. Honolulu, HI. January 2013.

16. Contraceptive Options for Obese Women. The 6th Annual Queen's Medical Center Obesity Symposium. Honolulu, HI. June 2012.

17. The New Well Woman Exam. The 31st Annual Family Planning and Reproductive Health Conference Presented by the Family Planning Program for the Hawaii State Department of Health and the Center for Health Training. Honolulu, HI. May 2012.

18. Sexual Abuse in Children. Presented with Robert Bidwell MD, and Roshni Koli MD. Kapiolani Medical Center Grand Rounds. Honolulu, HI. February 2012.

19. Contraception in the Obese Woman. Presented by Chief Resident: Teresita Santiago MD, Mentor: Bliss Kaneshiro MD. MPH. Kapiolani Medical Center Grand Rounds. Honolulu, HI. January 2012

20. US. Medical Eligibility Criteria: Integrating Science into Clinical Practice. The 30th Annual Family Planning and Reproductive Health Conference, Presented by the Family Planning Program for the Hawaii State Department of Health and the Center for Health Training. Honolulu, HI. May 2011.

21. US Medical Eligibility Criteria. Queens Medical Center Grand Rounds. Honolulu, HI. May 2011.

22. Gynecologic Procedures in the Office. Hawaii Academy of Family Physicians Hawaii Update 2011: Family Medicine for Everyone….Everywhere. Honolulu, HI. February 2011.

23. Contraception. Hawaii State Department of Health. Perinatal Support Services Providers Meeting. Honolulu, HI. February 2011.

24. Adolescent Gynecologic Care. The 29th Annual Family Planning and Reproductive Health Conference Presented by the Family Planning Program for the Hawaii State Department of Health and the Center for Health Training. Hyatt Regency, Honolulu, HI. May 2010.

25. IUC Practicum: Basics and Beyond. Presented with Anita Nelson MD from Harbor-UCLA. The 29th Annual Family Planning and Reproductive Health Conference Presented by the Family Planning Program for the Hawaii State Department of Health and the Center for Health Training. Hyatt Regency, Honolulu, HI. May 2010.

26. Now's Your Chance! Case Study Question and Answers. Presented with Anita Nelson MD from Harbor-UCLA. The 29th Annual Family Planning and Reproductive Health Conference Presented by the Family Planning Program for the Hawaii State Department of Health and the Center for Health Training. Hyatt Regency, Honolulu, HI. May 2010.

27. What's up with Drosperinone?. Queens Medical Center Grand Rounds. Honolulu, HI. December 2009.

28. Contraception Top 10. Kapiolani Medical Center Grand Rounds. Honolulu, HI April 2009

29. Post Partum Sterilization – Why Wait the 30 days?. Presented by Chief Resident Chrystie Fujimoto, Mentor: Bliss Kaneshiro. Kapiolani Medical Center Grand Rounds. Honolulu, HI. 2008.

30. Revisiting Post Partum Contraception. American College of Obstetricians and Gynecologists Hawaii Section Meeting. Lanai, HI. November 2008.

31. Adolescent Health" Pediatrics Island Style: The Adolescent Visit. American Academy of Pediatrics, Hawaii Chapter, Honolulu, HI. October 2008.

32. Intrauterine Devices: Part II. Queens Medical Center Grand Rounds. Honolulu, HI. July 2008.

33. Intrauterine Devices: Part I. Kapiolani Medical Center Grand Rounds. Honolulu, HI. May 2008.

34. A Contraceptive Update. Hawaii Academy of Family Physicians Hawaii Update 2008: Caring for our Communities with Excellence, Honolulu, HI. March 2008.

35. Contraception, What's Old, What's New, What's Coming. 38th Annual Family Medicine Review, Portland, OR. February 2007.

36. Intrauterine Devices. Grand Rounds for Kapiolani Medical Center, Honolulu, HI. 2004.

37. Abnormal Pap Smears in Pregnancy. Grand Rounds for Kapiolani Medical Center, Honolulu, HI. 2004.

38. Obstetric Emergencies. Lifeguard Training Program at Kapiolani Community College, Honolulu, HI. 2003.

39. Sexually Transmitted Diseases. Salvation Army Drug Rehabilitation Program, Honolulu, HI. 2003.

40. Emergency Contraception. Grand Rounds for Kapiolani Medical Center, Hawaii, Honolulu, HI. 2003.

41. Overview of Obstetrics and Gynecology. Mobile Intensive Care Technician Training Program at Kapiolani Community College. Honolulu, HI, 2002.

42. Analysis of HIV positive blood samples from Vietnam with long distance PCR. Pacific Biomedical Research Center, Retrovirology Research Laboratory, Honolulu, HI.1996.

Thesis, Dissertation Committees

2016 – present	Rebecca Delafield, DrPH Candidate, "An Investigation of Medical and Non-Medical Factors Influencing Cesarean Delivery Among Micronesian Women in Hawaii, Office of Public Health Studies, University of Hawaii, Honolulu, Hawaii

2015 – 2017	Shandhini Raidoo, MPH Candidate, “Implications of State-Specific Insurance Coverage for Abortion and Characteristics of Private, Public and Self-Pay Abortion Patients in Hawaii,” Office of Public Health Studies, University of Hawaii, Honolulu, Hawaii
2014 – 2017	Mary Tschann, PhD Candidate, “Nonpharmaceutical Pain Control Adjuncts During First Trimester Surgical Abortion,” Clinical Research Program, University of Hawaii, Honolulu, Hawaii
2014 – 2017	Emmakate Friedlander, PhD Candidate, “Prophylactic Pregabalin to decrease pain during medical abortion: a randomized controlled trial,” Clinical Research Program, University of Hawaii, Honolulu, Hawaii
2013 – 2015	Kate Whitehouse, MSCR Candidate, “Association Between Prophylactic Oxytocin Use During Dilation & Evacuation and Estimated Blood Loss,” Clinical Research Program, University of Hawaii, Honolulu, Hawaii

Other Teaching

1. A Career in Obstetrics and Gynecology. Hawaii Pacific Health SSRI Program. August 2018, August 2019

2. Combined Adolescent Health Day for Family Medicine and Pediatric Residents. Lecturer on Adolescent Gynecology. March 2018.

3. Family Planning Curriculum for University of Hawaii Family Planning Fellows. 2012 to Present.

4. Obstetrics and Gynecology Preceptor for 6L program at Waimanalo Health Center, 2014 to present

5. Clinical Skills Preceptor for Second Year Medical Students, MD7 “The Life Cycle”, 2009 to Present.

6. Contraception, An Interactive Lecture (presented to all third year medical students at the University of Hawaii during their obstetrics and gynecology rotation), December 2007 to Present.

7. Office Based Gynecologic Surgical Procedures Simulation Workshop in Obstetrics (presented to all third year medical students at the University of Hawaii during their obstetrics and gynecology rotation), February 2008 to Present.

8. Family Planning Curriculum for University of Hawaii Obstetrics and Gynecology

Residents. October 2008 to October 2012

9. Problem Based Learning Case for second year medical students during The Life Cycle Unit. Developed in 2010.

10. Contraception Lecture for the University of Hawaii Internal Medicine Residency Program, Women's Health Lecture Series. June 2009.

11. Ryan Program Panelist, Family Planning Fellowship Annual Meeting. Chicago, IL. May 2009.

12. Psychosocial Workshop in Abortion Training, Facilitator. San Francisco, CA. February 2008.

13. Birth Control and Sexual Education High School Series, Mid-Pacific High School, Castle High School, lecture series, December 2007 to 2008.

14. Family Planning Women's Health Panel (first and second year medical students). Panel Member, Oregon Health and Science University. April 2007.

15. Abnormal Menstrual Cycles (second year medical students), Oregon Health and Science University. April 2006.

16. Perinatal Loss Discussant, Medical Student Conference (first year medical students), Oregon Health and Science University. April 2006

Courses Taught
OBGYN 531 – OBGYN Clerkship
OBGYN 532 – OBGYN Longitudinal Clerkship
OBGYN 545-B – Subinternship in Labor and Delivery
OBGYN 545-C – Outpatient Clinic at Queen Emma Clinic
OBGYN 545-D – Family Planning
OBGYN 545-H – Topics with Individual Preceptors
HON 496 – Senior Honors Project

V. SERVICE

Membership in Professional Societies

American Society for Reproductive Medicine	2009 to present
Society of Family Planning	2005 to present
Association of Reproductive Health Professionals	2005 to present
Physicians' for Reproductive Choice and Health	2004 to present
American College of Obstetricians and Gynecologists	1999 to present

Committees

National

ACOG District VIII Secretary, 2020
The Working Group, Society of Family Planning Abortion Clinical Research Network, 2019
Changemakers Ambassador (working to promote the full participation of people of color in science), Society of Family Planning, 2019
Society of Family Planning Awards Committee, 2019
District VIII & IX Combined 2018 Annual District Meeting, Conference Co-Chairperson, 2017 to 2018
Scientific Reviewer, Scientific Program for American Society for Reproductive Medicine (ASRM) Annual Meeting, 2013, 2014, 2015, 2017
North American Forum on Family Planning Scientific Abstract Committee, 2016, 2017
American College of Obstetricians and Gynecologists Practice Bulletin Committee, 2017 to present
American College of Obstetricians and Gynecologists Continuing Medical Education Representative for District VIII, 2016 to 2017
American College of Obstetricians and Gynecologists 2016 Annual District Meeting Co-Chair, 2015 to 2016
American Academy of Pediatrics Adolescent Health Consortium National Advisory Committee, 2014 to 2018
American College of Obstetricians and Gynecologists Committee on Adolescent Health Care, 2014 to 2017
Vice Chair, American Society for Reproductive Medicine (ASRM) Contraception Special Interest Group, 2011 to 2012
Chair, American Society for Reproductive Medicine (ASRM) Contraception Special Interest Group, 2012 to 2014
Immediate Past Chair, American Society for Reproductive Medicine (ASRM) Contraception Special Interest Group, 2014 to 2015
Editorial Board, Clinical Updates in Women's Health Care, American College of Obstetricians and Gynecologists, 2011 to 2015
Leader, Women's Health and Reproductive Biology Cluster, Research Center in Minority Institutions Translational Research Network (RTRN), National Institute on Minority Health and Health Disparities of the National Institute of Health (NIH), November 2012 to 2014
Special Reviewer, Committee on Scientific Program for the 61st Annual Clinical Meeting of the American College of Obstetricians and Gynecologists, 2013
ASRM Contraception Special Interest Group, Annual Meeting Contraception Day Planning Committee 2010, 2011, 2012, 2013, 2014
Scientific Reviewer, Committee on Scientific Program for the 59th Annual Clinical Meeting of the American College of Obstetricians and Gynecologists, 2011
District VII, VIII, IX, & XI Combined 2010 Annual District Meeting, Planning Committee and Scientific Abstract Review Committee, 2010
Reproductive Health 2009 Planning Committee, Association of Reproductive Health Professionals 2008 to 2009

Physicians' for Reproductive Choice and Health Advocacy Committee, 2006 to 2008
Physicians' for Reproductive Choice and Health, Leadership Training Academy, 2006 to 2007

Local
Hawaii Maternal Infant and Health Collaborative, member since 2014, Chair since 2018
Perviability Task Force Member, 2018
Family Planning and Your Patients: National Perspectives, Local Applications, Conference Chairperson, 2016
Queens Medical Center Summer Research Intern Selection Committee, 2016, 2017
Scientific Reviewer, Hawaii Pacific Health 2007 to present
Planning Committee Family Planning Provider Title X Training. 2015
American College of Obstetricians and Gynecologists Hawaii Section Advisory Committee, 2015 to present
American College of Obstetricians and Gynecologists Hawaii Section Legislative Committee, 2015 to present
American College of Obstetricians and Gynecologists Hawaii Section Junior Fellow Chair, 2004 to 2005
American College of Obstetricians and Gynecologists Hawaii Section Junior Fellow Vice-Chair, 2003 to 2004
Emergency Contraception Implementation Committee, Healthy Mothers Healthy Babies 2003 to 2005
Selection Committee, Hawaii Medical Association, 1997 to 1999

Departmental, Medical School, Hospital
JABSOM Clinical Research Task Force, 2019
University of Hawaii Department of Obstetrics, Gynecology and Women's Health Coming Back to the Future, A Reunion Conference, Conference Chairperson 2017
Department of Obstetrics, Gynecology and Women's Health Departmental and Promotions Committee (DPC), 2015 to present
Associate Chair of Education (interim), Department of Obstetrics and Gynecology, 2014 to 2015
John A. Burns School of Medicine RMATRIX Regulatory Knowledge & Support Advisory Committee, 2014 to present
Department of Obstetrics and Gynecology Executive Committee, 2012 to present (provides monthly guidance to the Chair in the department's activities)
Director of Resident Research, 2012 to 2014
John A. Burns School of Medicine 5-0 Planning Committee (medical school committee to increase community engagement in the medical school), 2011 to present
University of Hawaii Department of Obstetrics, Gynecology & Women's Health Clinical Competency Committee (CCC) Member, 2011 to present
University of Hawaii Department of Obstetrics, Gynecology & Women's Health Resident Education Committee (REC) 2011 to present
Kapiolani Medical Center Obstetrics and Gynecology Administrative Committee, 2011 to present
Hawaii Pacific Health Scientific Review Committee, 2010 to present

Department of Obstetrics, Gynecology and Women's Health Resident Applicant Interviewer, 2008 to present
University of Hawaii Department of Obstetrics, Gynecology & Women's Health Medical Student Curriculum Committee, 2008 to present
University of Hawaii Department of Obstetrics, Gynecology & Women's Health Family Planning Elective Director, 2008 to 2012
Vice President, John A. Burns School of Medicine Class of 2001

Community Service
Hawaii Maternal and Infant Health Collaborative Core Team, 2015 to present
Consultant for Na Pu'uwai Native Hawaiian Heath Care Center and Ke Ola Hou O Lana'i, volunteer for health screenings, 2005 to Present
Hiroshima/Nagasaki Atomic Bomb Survivors Medical Team in Hawaii, 2011 to 2012
Alumni Interviewer, Pomona College, 1997 to 2005
McGuire Fund Administrator, 1997 to 2001

International Service
Cervical Cancer Screening Program Consultant, Yap - Federated States of Micronesia, 2016
Visiting Professorship, Okinawa Chubu Hospital, Okinawa Prefecture, 2016
Family Planning Consultant, Republic of the Marshall Islands, 2014, 2015
Family Planning Title X Program Assessment, Pohnpei, Micronesia, 2011
Women's Health Project, Yap, Micronesia 2007
Family Planning Needs Assessment, Yap, Micronesia, 2006
IPAS Consultant – I created tools to help train clinicians (Core Clinical Content) internationally. IPAS is a global non-governmental organization dedicated to ending preventable deaths from unsafe abortion. 2007 to 2010

Other
Graduate, The American College of Obstetricians and Gynecologists Robert C. Cefalo National Leadership Institute, 2019
Editor of Contraception Issue, Obstetrics and Gynecology Clinics of North America, 2015.
Moderator, Scientific Program for Contraception Day at the American Society for Reproductive Medicine (ASRM) Annual Meeting, Honolulu, HI, 2014.
Moderator, Scientific Program for Contraception Day at the American Society for Reproductive Medicine (ASRM) Annual Meeting, San Diego, CA, 2012.
Reviewer: Journal of Women's Health, International Journal of Obstetrics and Gynecology, American Journal of Obstetrics and Gynecology, Contraception, Journal of Pediatric and Adolescent Gynecology, British Journal of Obstetrics and Gynecology, Maternal and Child Health Journal, BMC Pregnancy and Childbirth
Society of Family Planning, Full Fellowship since 2013 (The Society of Family Planning is an academic society of researchers, clinicians and educators dedicated to improving sexual and reproductive health)

VI. HONORS and AWARDS

University of Hawaii Chancellor's Citation for Meritorious Teaching, 2019

Robert A. Hatcher Family Planning Mentor Award 2018. Created in recognition of the extraordinary role in educating and mentoring family planning health providers played by the award's namesake and first recipient, this award is given to individuals who have demonstrated dedication to supporting and furthering the careers of a new generation of professionals in the field of family planning.

American College of Obstetricians and Gynecologists 2018 Mentor of the Year Award District VIII

Hawaii Reproductive Rights Doctors Patsy T. Mink Political Action Committee 2015 Giraffe Award presented by the Hawaii State Legislature

Congressional Recognition from U.S. Senator Mazie K. Hirono presented to Hawaii Reproductive Rights Doctors October 14, 2015

Association of Professors of Gynecology and Obstetrics (APGO) Excellence in Teaching Award (awarded to the faculty member with the highest medical student evaluation scores), June 2014

University of Hawaii Department of Obstetrics, Gynecology & Women's Health "Golden Speculum Award" (teaching award given by Chief Residents to one faculty member each year), June 2011

University of Hawaii Department of Obstetrics, Gynecology & Women's Health Medical Student Teaching Award (awarded to one faculty member each year), June 2011

University of Hawaii Faculty Teaching Award, June 2010, June 2009

National Faculty Award, The American College of Obstetricians and Gynecologists and The Council on Resident Education in Obstetrics and Gynecology, June 2009

Finalist for the Robert Wood Johnson Foundation Physician Scholars Program (25 nationwide finalists), August 2009

First place for Scientific Presentations at the American College of Obstetricians and Gynecologists Annual Clinical Meeting, May 2008

Association of Reproductive Health Professionals Scholar, September 2005

Excellence in Medical Student Teaching Award, Department of Obstetrics, Gynecology & Women's Health John A. Burns School of Medicine, University of Hawaii, June 2005, June 2004, June 2003 (one resident awarded per year)

Alpha Omega Alpha, Honorary Medical Society, May 2005

Donald F Richardson Memorial Prize Paper Nominee, November 2004

Association of Professors of Gynecology and Obstetrics Resident Scholar Award, March 2004

Hans and Clara Zimmerman Foundation Scholarship, 1998, 1999, 2000

John A. Burns School of Medicine Office of Medical Education Scholarship, 1998