IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

FREDERICK W. HOPKINS, M.D., M.P.H., *et al.*	)	
	)	
Plaintiffs,	)	Case No. 4:17-cv-00404-KGB
	)	
v.	)	
	)	
LARRY JEGLEY *et al.*,	)	
	)	
Defendants.	)	

PLAINTIFFS' MOTION FOR *EX PARTE* TEMPORARY RESTRAINING ORDER

Pursuant to Federal Rule of Civil Procedure 65, Plaintiffs move for an *ex parte* temporary restraining order ("TRO") to immediately enjoin enforcement of the challenged laws,[1] preserve the status quo, and prevent irreparable harm while this Court considers Plaintiffs' motion for a second preliminary injunction. Plaintiffs' TRO motion is based on this Court's factual findings and legal conclusions from its prior preliminary injunction, *Hopkins v. Jegley*, 267 F. Supp. 3d 1024 (2017), and the attached declarations. Given the irreparable harms that will occur if the challenged laws are not enjoined, *see infra*, Plaintiffs respectfully request that this Court grant the TRO *ex parte*.

The Eighth Circuit mandate will likely issue on December 22, 2020, and this Court will then lift its prior preliminary injunction. If this Court does not immediately enter a TRO,

[1] Those four laws are: Act 45 codified at Ark. Code §§ 20-16-1801 to 1807 (H.B. 1032 or the "D&E Ban"); Act 733 codified at Ark. Code §§ 20-16-1901 to 1910 (H.B. 1434 or the "Medical Records Mandate"); Act 1018 codified at Ark. Code § 20-16-108(a)(1) (H.B. 2024 or the "Local Disclosure Mandate"); and Act 603 codified at Ark. Code §§ 20-17-801 to 802 (H.B. 1566 or the "Tissue Disposal Mandate").

Plaintiffs will be forced to begin to turn away patients starting December 22, 2020, who otherwise would be obtaining their abortions. Specifically, if this Court does not block the challenged laws, Plaintiffs will be forced to turn away at least eight patients currently scheduled for abortion care on December 22 and/or December 23 who require an aspiration or D&E abortion. Decl. of Lori Williams, M.S.N, A.P.R.N., in Supp. of Pls.' Mot. for an Ex Parte TRO ("Williams TRO Decl.") ¶ 6 (attached as Ex. 2). In addition, Plaintiffs have another eight patients scheduled for their initial visit next week who would, if these laws are not in effect, be able to obtain their aspiration or D&E abortion on December 28-30. *Id*. ¶ 6. Plaintiffs will also be forced to turn away every additional caller seeking aspiration or D&E abortion care, as well as patients between the ages of 14 and 16, and/or patients who know the sex of their embryo or fetus, unless and until this Court enters injunctive relief. *Id*. ¶ 8. All of these patients will be denied their constitutional right to obtain an abortion while these laws are in effect, and their care will be delayed or denied, pushing patients further into their pregnancies, creating medical risks. This is a quintessential example of immediate and irreparable harm. *See* Fed. R. Civ. P. 65(b)(1)(A); *see also*, *e.g.*, *Zaxby's Franchising, LLC v. MJM Foods*, *LLC*, No. 3:16-CV-00137 BSM, 2016 WL 3024074, at *1 (E.D. Ark. May 25, 2016) (granting *ex parte* TRO to prevent customer confusion before restaurant trademark dispute could be resolved); *Tempur-Pedic Int'l, Inc. v. Waste To Charity, Inc.*, No. 07 2015, 2007 WL 535041, at *5 (W.D. Ark. Feb. 16, 2007) (granting *ex parte* TRO to prevent the movement or destruction of mattresses).

Further, as discussed in Plaintiffs' accompanying brief, and confirmed in the attached declarations, the Court's findings in its 2017 opinion are as true today as they were in 2017. Nothing in the Eighth Circuit's decision cast doubt on these findings, let alone indicated that they constituted clear error. These findings are likewise undisturbed by the Supreme Court's recent

abortion cases, which solely address the legal standard this Court must apply to those facts. As explained in the accompanying brief, on the basis of the test laid out by the Eighth Circuit and the application of that test to those findings, as well as on the basis of Plaintiffs' vagueness claims, where likelihood of success is also undisturbed, this Court can and should grant Plaintiffs' motion and enter a TRO. Moreover, as more fully explained in the accompanying brief and as reflected in this Court's 2017 preliminary injunction findings, the balance of equities tips strongly in favor of Plaintiffs and their patients, and the public interest will be served by a temporary restraining order and/or an injunction. Plaintiffs further request that, given the nature of the relief sought and Plaintiffs' limited means, bond be waived should the Court grant injunctive relief.

Plaintiffs contacted counsel for Defendants on the morning of December 17, 2020 to inform them that Plaintiffs would be seeking an *ex parte* TRO to block the challenged laws as soon as the prior injunction was lifted. *See* Decl. of Ruth E. Harlow in Supp. of Pls.' Mot. for an Ex Parte TRO ("Harlow Decl.") ¶ 5 (attached as Ex. 1). Plaintiffs' counsel further informed Defendants' counsel that Plaintiffs would move for a TRO on or before December 22, 2020, and that the motion would be based this Court's prior factual findings and legal conclusions from its 2017 Order. *Id*. ¶¶ 5, 7. This is more than sufficient to satisfy Plaintiffs' obligations to give notice and, given the threat of imminent and irreparable harm, no further notice should be required. *See* Fed. R. Civ. P. 65(b)(1)(B); *see also, e.g.*, *GE Commercial Distribution Fin. Corp. v. Crabtree RV Ctr., Inc.*, 2009 WL 10707170, at *3–4 (W.D. Ark. Apr. 3, 2009) (granting *ex parte* TRO to protect interest in recreational vehicles even where "*no efforts* have been made to give notice to the Defendant," given the threat of imminent and irreparable harm) (emphasis added); *Ellis v. Jackson Nat'l Life Ins. Co.*. No. 2:11-CV-1064-WKW, 2011 WL 6300608, at *1–2 (M.D. Ala. Dec. 15, 2011) (finding single

phone call to nonmovant's counsel sufficient to grant *ex parte* TRO).

Ex parte relief is warranted for the reasons discussed in this motion, and in the accompanying brief. If, however, this Court declines to grant an *ex parte* TRO, Plaintiffs respectfully requests that this Court grant Defendants no more than 24 hours to respond to Plaintiffs' TRO request, given that (i) Defendants have had express notice of Plaintiffs' filing for more than three days, and (ii) Plaintiffs' TRO motion seeks relief that merely maintains the status quo for a short period of time while the Court rules on Plaintiffs concurrently filed preliminary injunction motion.

This Motion is based on this Court's factual and legal findings in its 2017 preliminary injunction decision; Plaintiffs' First Amended Complaint and its exhibits; the exhibits and declarations submitted in support of Plaintiffs' June 2017 motion for a preliminary injunction; the brief filed herewith; and the following documents:

1. Attached as **Exhibit 1** is a true and accurate copy of the December 21, 2020, Declaration of Ruth E. Harlow in Support of Plaintiffs' Motion for an Ex Parte Temporary Restraining Order ("Harlow Decl.").

2. Attached as **Exhibit 2** is a true and accurate copy of the Declaration of Lori Williams M.S.N., A.P.R.N., in Support of Plaintiffs' Motion for an Ex Parte Temporary Restraining Order ("Williams TRO Decl.").

3. Attached as **Exhibit 3** is a true and accurate copy of the Declaration of Mark D. Nichols, M.D., in Support of Plaintiffs' Motion for an Ex Parte Temporary Restraining Order ("Nichols TRO Decl.").

Dated: December 21, 2020

Respectfully submitted,

Ruth E. Harlow*
Elizabeth K. Watson*
Brigitte Amiri*
Alexa Kolbi-Molinas*
American Civil Liberties Union Foundation
125 Broad St, 18th Floor
New York, NY 10001
mburrows@aclu.org
rharlow@aclu.org
(212) 549-2633

Attorneys for Plaintiffs

Jenny Ma*
Arielle Humphries*
Center for Reproductive Rights
199 Water Street, 22nd Fl.
New York, NY 10038
Phone: 917-637-3705
jma@reprorights.org
ahumphries@reprorights.org

Attorney for Plaintiffs

** Motion for admission pro hac vice granted*

Bettina Brownstein (AR Bar No. 85019)
Bettina E. Brownstein Law Firm
904 West 2nd Street, Suite 2
Little Rock, AR 72201
bettinabrownstein@gmail.com
(501) 920-1764

Brooke-Augusta Ware (AR Bar No. 2004091)
Mann & Kemp, PLLC
221 West Second Street, Suite 408
Little Rock, Arkansas 72201
brooke@mannkemp.com
(501) 222-7330

Attorneys for Plaintiffs

Leah Godesky*
Christopher P. Burke*
David Cohen*
Sara N. Pahlavan*
O'Melveny & Myers LLP
Times Square Tower
7 Times Square
New York, New York 10036
lgodesky@omm.com
cburke@omm.com
(212) 326-2254
Fax: (212) 326-2061

Kendall Turner*
O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006
(202) 383-5300
kendallturner@omm.com

Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

FREDERICK W. HOPKINS, M.D., M.P.H., *et al*.	)	
	)	
Plaintiffs,	)	Case No. 4:17-cv-00404-KGB
	)	
v.	)	
	)	
LARRY JEGLEY *et al*.,	)	
	)	
Defendants.	)	

PLAINTIFFS' BRIEF IN SUPPORT OF THEIR MOTION FOR A TEMPORARY RESTRAINING ORDER

Pursuant to Federal Rule of Civil Procedure 65, Plaintiffs[1] move for a temporary restraining order ("TRO") to immediately enjoin enforcement of the challenged laws, preserve the status quo, and prevent irreparable harm while this Court considers Plaintiffs' motion for a second preliminary injunction. The Eighth Circuit mandate will likely issue tomorrow, December 22, and this Court's prior preliminary injunction will be lifted. If this Court does not immediately enter a TRO, Plaintiffs will be forced to begin to turn away patients starting December 22, 2020, who otherwise would be obtaining their abortions. Specifically, if this Court does not block the challenged laws, Plaintiffs will be forced to turn away at least eight patients currently scheduled for abortion care on December 22 and/or December 23 who require an aspiration or D&E abortion. Decl. of Lori Williams, M.S.N, A.P.R.N., in Supp. of Pls.' Mot. for an Ex Parte TRO ("Williams

[1] Plaintiff Hopkins moved to amend the complaint on December 16, 2020 (Doc. 65) to add, *inter alia*, Little Rock Family Planning Services ("LRFP"), as a Plaintiff. Accordingly, this brief refers to "Plaintiffs" throughout.

TRO Decl.") ¶ 6 (attached as Ex. 2). In addition, Plaintiffs have another eight patients scheduled for their initial visit next week who would, if these laws are not in effect, be able to obtain their aspiration or D&E abortion on December 28-30. *Id*. ¶ 6. Plaintiffs will also be forced to turn away every additional caller seeking aspiration or D&E abortion care, as well as patients between the ages of 14 and 16, and/or patients who know the sex of their embryo or fetus, unless and until this Court enters injunctive relief. *Id*. ¶ 8. All of these patients will be denied their constitutional right to obtain an abortion while these laws are in effect, and their care will be delayed or denied, pushing patients further into their pregnancies, creating medical risks.

This Court can and should enter a TRO based on the factual findings and legal conclusions it made in granting Plaintiffs' prior preliminary injunction. The Eighth Circuit remanded this case to the district court with instructions to follow Chief Justice Roberts's concurrence in *June Medical Services, LLC. v. Russo*, 140 S. Ct. 2103, 2133 (2020) (Roberts, C.J., concurring in the judgment).[2] Under that concurrence, abortion restrictions impose an unconstitutional undue burden if they impose a substantial obstacle in the path of a person seeking a pre-viability abortion or are not reasonably related to a legitimate state purpose. *Id*. at 2138. And the key question in determining whether an abortion restriction imposes an unconstitutional substantial obstacle is the "law's effect on the availability of abortion." *Id.* at 2141 n.5. This Court already factually found and legally concluded that the four challenged laws will have the effect of severely restricting, if not outright eliminating, the availability of abortion in Arkansas. *Hopkins v.*

[2] In this motion, citations to *June Medical Services* are citations to the Chief Justice's concurrence unless otherwise noted.

Jegley, 267 F. Supp. 3d 1024, 1068, 1078, 1091, 1106 (E.D. Ark. 2017). This alone is sufficient to justify a TRO. Moreover, this Court's prior factual findings and legal conclusions likewise establish that, at a minimum, three of the challenged laws are not reasonably related to a legitimate state interest. *Id*. at 1076, 1089, 1105. Additionally, because *June Medical Services* considered only an undue burden claim, the concurrence does not affect this Court's ruling that Plaintiffs are likely to succeed on their claims that two of the laws (the Medical Records and Tissue Disposal Mandates) fail to give Plaintiffs fair notice of what is prohibited, and are therefore likely unconstitutionally vague. *Id*. at 1084, 1110.

In view of the above, and as discussed further below, Plaintiffs have demonstrated that they are likely to succeed on the merits of their claims. Further, in view of the severe, ongoing, and irreparable harm Plaintiffs and their patients will face in the absence of immediate injunctive relief, this Court should grant Plaintiffs' motion for a TRO while the Court considers the motion for a second preliminary injunction. Plaintiffs contacted counsel for Defendants on the morning of December 17, 2020 to inform them that Plaintiffs would be seeking an *ex parte* TRO to block the challenged laws as soon as the prior injunction was lifted. *See* Decl. of Ruth E. Harlow in Supp. of Pls.' Mot. for an Ex Parte TRO ("Harlow Decl.") ¶ 5 (attached as Ex. 1). Plaintiffs' counsel further informed Defendants' counsel that Plaintiffs would move for a TRO on or before December 22, 2020, and that the motion would be based this Court's prior factual findings and legal conclusions from its 2017 Order. *Id*. ¶¶ 5, 7. This is more than sufficient to satisfy Plaintiffs' obligations to give notice and, given the threat of imminent and irreparable harm, no further notice should be required. *See* Fed. R. Civ. P. 65(b)(1)(B). If, however, this Court declines to grant

an *ex parte* TRO, Plaintiffs respectfully requests that this Court grant Defendants no more than 24 hours to respond to Plaintiffs' TRO request, given that (i) Defendants have had express notice of Plaintiffs' filing for more than three days, and (ii) Plaintiffs' TRO motion seeks relief that merely maintains the status quo for a short period of time while the Court rules on Plaintiffs concurrently filed preliminary injunction motion.

FACTUAL BACKGROUND

In 2017, the Arkansas Legislature passed four laws restricting abortion access: (1) a ban on the dilation and evacuation procedure (D&E Ban), which is the sole method of abortion that is provided throughout the second trimester in Arkansas; (2) a law that requires Plaintiffs to indefinitely delay providing abortion care while they unnecessarily undertake a sweeping search of patients' pregnancy-related medical records from other health care providers (Medical Records Mandate); (3) a law that requires Plaintiffs to report to local police the name of any patient between the ages of 14 and 16 who obtains an abortion, even when there is no evidence of abuse or criminality, and to provide that patient's fetal tissue, labeled with their name, to the police for indefinite retention in the state crime lab (Local Disclosure Mandate); (4) a law that imports an existing elaborate law about who controls decisions about disposition of human remains into the abortion context, which in practice includes requiring notification of the abortion to patients' sexual partners and, if they are minors, their parents and their partners' parents, to give those other individuals rights of control over disposal of tissue from an abortion (Tissue Disposal Mandate). *Hopkins*, 267 F. Supp. 3d at 1034.

Plaintiffs sought a preliminary injunction on all four laws, which this Court granted. *Id*. In so doing, this Court made detailed findings of fact based on largely undisputed evidence.

The Court's Factual Findings on the D&E Ban

This Court found that D&E accounts for 100% of second-trimester abortions currently performed in Arkansas. *Id*. at 1038, 1066. D&E is an extremely safe and common procedure. *Id*. at 1036-37, 1038. In a D&E, a physician dilates the patient's cervix then removes fetal tissue using instruments. *Id*. at 1037. Because the physician dilates the cervix only enough to allow for the safe passage of instruments, a D&E necessarily results in the separation of fetal tissue. *Id*. The D&E Ban prohibits separating fetal tissue with instruments, and thus prohibits D&E in Arkansas on pain of criminal penalties. *Id*. at 1038, 1051.

Defendants argued that Plaintiffs could circumvent this ban by performing additional, invasive medical procedures on the patient to induce fetal demise prior to removing fetal tissue, but the Court rejected this argument because there is no way for Plaintiffs to ensure fetal demise for every patient seeking a second-trimester abortion. *Id*. at 1058-64. This Court found that three procedures suggested by Defendants—injections of digoxin, injections of potassium chloride, and transection of the umbilical cord—are unreliable, risky, unstudied, and/or unavailable in Arkansas. *Id*. at 1039-41. As this Court found, digoxin is unstudied before 18 weeks in pregnancy, *id*. at 1040; it is medically inappropriate for some patients at any stage, *id*. at 1039; and it will fail five to ten percent of the time, *id*. This Court found that potassium chloride injections were unavailable in Arkansas, as providers have neither the training nor the equipment needed to safely inject

it, and a misplaced injection poses serious risks to the patient, including risk of death. *Id*. at 1040-41. This Court also found that cord transection has not been the subject of any rigorous study, *id*. at 1041; is completely unstudied before 16 weeks LMP, *id*.; and can pose risks to the patient, *id*. This Court found that Plaintiffs cannot rely on these procedures to guarantee fetal demise prior to using instruments when performing a D&E, and Plaintiffs cannot start a procedure that they do not know they will be able to complete safely and legally. *Id*. at 1059. Accordingly, this Court found "if the D&E [Ban] goes into effect, standard D&E abortions will no longer be performed in Arkansas." *Id*. at 1067.

This Court also found that requiring patients to undergo additional, invasive, and unreliable procedures prior to a D&E would impose a substantial obstacle on people seeking second-trimester abortion, including by exposing them to additional risks and pain and forcing them to make more trips to the clinic to undergo the added procedure. *Id*. at 1061, 1062-64. Many of Plaintiffs' patients have low-incomes and are already under tremendous stress and financial pressure; accordingly, this Court found it would impose a substantial obstacle to force them to try to take even more time off from work, arrange for transportation and lodging, and arrange for childcare for additional clinic visits. *Id.* at 1061.

This Court's Factual Findings on the Medical Records Mandate

This Court found that Plaintiffs provide abortion services to approximately 3,000 people per year, the majority of whom have had one or more prior pregnancies. *Id*. at 1075. Under the Medical Records Mandate, Plaintiffs would be required to request and attempt to collect from each patient's health care providers any medical records for the patient's "entire pregnancy history," over the history of any past pregnancies carried to

term, abortions, or miscarriages. *Id*. at 1069. For patients who have seen one or more health care providers for their current pregnancy, Plaintiffs would also need to request their medical records and work to gather them. This Court found that there is no medical reason for Plaintiffs to obtain medical records for the vast majority of abortion patients. *Id*. at 1042, 1073. But the law prevents Plaintiffs from providing an abortion until "reasonable time and effort" is spent to obtain these medical records, and the term "reasonable" is "undefined." *Id*. at 1069, 1080-81.

As this Court found, there is little to ensure that the Plaintiffs will receive these records in a timely manner; indeed, "[f]ederal law allows United States providers 30 days for the initial response to records requests; the actual medical records may follow latter." *Id*. at 1073. This delay would be compounded for patients who received pregnancy-related care outside of Arkansas, or outside of the United States, in which case the medical records may be in a different language. *Id*. Even if they are obtained, "[n]othing in the Medical Records Mandate explains what a doctor is to do with these records." *Id*. at 1077. Accordingly, requiring abortion providers to undertake this search will only delay abortion care, which will push patients further into their pregnancy, increasing the risks associated with it, and will push some past the point where abortion is permitted in Arkansas. *Id*. at 1041-42. Furthermore, there is also no exception in cases where a "serious health risk to the woman is present." *Id*. at 1074.

Moreover, this Court found that a request for medical records by Plaintiff LRFP necessarily alerts the patients' prior providers that she is seeking abortion, breaching her confidentiality. *Id*. at 1042. Patients, however, frequently impress upon Plaintiffs the importance of keeping their abortion confidential from other health care providers

because they fear hostility or harassment from the other providers. *Id*. For this reason, some patients have specifically asked Plaintiffs to refrain from seeking records from other health care providers; indeed, in one of the rare instances where LRFP requested records, the provider's wife contacted the patient to try to dissuade her from having an abortion. *Id*. at 1042-43.

This Court's Factual Findings on the Local Disclosure Mandate

As this Court recognized, the Local Disclosure Mandate requires Plaintiffs to notify law enforcement in 14- to 16-year-old patients' local jurisdiction when those patients obtain an abortion, and transmit fetal tissue to the police, even where there is no evidence of abuse or criminality. The information disclosed to local law enforcement includes the patient's name, date of birth, her and her parents' address, and the name and date of birth of the "suspect." *Id*. at 1086. The law also mandates that the tissue from the patient's abortion be indefinitely stored, with the patient's personal information, in a state crime lab. *Id*. at 1087. Accordingly, this Court found that the Local Disclosure Mandate requires Plaintiffs to reveal the "most intimate and personal aspects" of teenage patients' lives to the local police. *Id*. at 1095.

To compound the problem, local law enforcement offices can be very small, and some personnel can be anti-abortion. *Id*. at 1043. "[O]nce the information is known by local community members and written on required documents, there are risks to these young women's privacy, which can engender fear on the part of these young women." *Id*. at 1088. This Court found that the Local Disclosure Mandate would humiliate patients by disclosing these private facts and would make them fearful of the reaction by the local community—potentially dissuading them from obtaining care at all. *Id*. at 1092.

Furthermore, because there is no way for Plaintiffs to preserve and transmit tissue from a medication abortion to local law enforcement, the Mandate could effectively prohibit medication abortion for these teenagers. *Id*. at 1087-88.

This Court's Factual Findings on the Tissue Disposal Mandate

This Court found that requiring abortion providers to ensure tissue from an abortion is disposed of in accordance with the Final Disposition Rights Act (FDRA) would impose significant burdens, including potentially forcing Plaintiffs to cease providing abortion care. Transporting the FDRA's elaborate scheme to the abortion context, for which the FDRA was not intended, would require notice about a patient's abortion to her "sexual partner or, if the woman and her sexual partners are minors, the parent or parents of both"—individuals a woman has a constitutionally protected right *not* to involve in her abortion. *Id*. at 1099. Furthermore, this Court found that searching for and notifying these "interested parties" would cause significant delay "that would result in harm to women seeking abortion care," in the form of the other risks of delay discussed above. *Id*. at 1102. This Court also noted that the law establishes an "unclear . . . scope of [] obligations," *id.* at 1110—including because it is unclear whether medication abortion or treatment of miscarriage falls under the law, and it is unclear what constitutes "reasonable efforts to locate an absent parent or other members of the class of grandparents," *id.*—and Plaintiffs would face criminal penalties if they fails to follow the law, *id*. at 1103.

The Pertinent Facts Underlying this Court's 2017 Factual Findings Have Not Changed

None of the core facts that were the basis of this Court's factual findings have changed since this Court entered its preliminary injunction order.

- The D&E Ban still prohibits D&E procedures, which is the sole method of abortion that is provided throughout the second trimester in Arkansas. Even if the demise methods the State proposes were feasible workarounds to the D&E Ban, which they are not, the Ban would still impose a substantial obstacle on pre-viability abortion access by forcing patients to undergo riskier procedures and/or make additional, burdensome trips to the clinic. Decl. of Lori Williams, M.S.N., A.P.R.N., in Supp. of Pls.' Mot. for an Ex Parte TRO ("Williams TRO Decl.") (attached as Ex. 2) ¶ 6; Decl. of Mark D. Nichols, M.D., in Supp. of Pls.' Mot. for an Ex Parte TRO ("Nichols TRO Decl.") (attached as Ex. 3) Ex. A ¶¶ 20– 38.
    - The State's most recent Induced Abortion Report confirms that D&E is the only second-trimester abortion method reported in Arkansas.[3]
    - D&E is also the safest method of abortion throughout the second-trimester. Nichols TRO Decl. Ex. A ¶ 19.
    - And, just as three years ago, Plaintiffs cannot circumvent the ban on D&E using the State's so-called workarounds because there is no way for Plaintiffs to guarantee fetal demise prior to using instruments. Nichols TRO Decl. Ex. A ¶ 6.
- As to the Medical Records Mandate, abortion providers still face criminal liability if they do not spend an undefined period of time and effort to obtain medical records for each patient's entire pregnancy history, and they still do not know

[3] Induced Abortion Report, Center of Health Statistics, Arkansas Dep't of Health, at 8 (June 2020), https://www.healthy.arkansas.gov/images/uploads/pdf/Induced_Abortion_final_2019.pdf.

what, if anything, they are supposed to do with the records if they obtain them. Williams TRO Decl. ¶ 7.

- As to the Local Disclosure Mandate, if the law takes effect, abortion providers will still be forced to reveal the most intimate details of a 14- to 16-year-old patient's life to local law enforcement, and the fetal tissue from the patient's abortion will be kept indefinitely in a crime lab labeled with the patient's name, even where there is no evidence of criminality or abuse. Williams TRO Decl. ¶ 8.
- As to the Tissue Disposal Mandate, it still imposes a new, unclear scheme of decision-making, under which a provider must attempt to notify patients' partners or parents about each patient's abortion, thereby breaching patient confidentiality, delaying critical care, and leaving Plaintiffs unclear on how to comply and avoid criminal penalties. Williams TRO Decl. ¶ 5.

ARGUMENT

This Court should issue a TRO "to preserve the *status quo* until the merits are determined." *Little Rock Family Planning Servs. v. Rutledge*, 398 F. Supp. 3d 330, 369 (E.D. Ark. 2019) (quotation omitted) (granting TRO and reserving ruling on request for preliminary injunction), *appeal argued*, No. 19-2690 (8th Cir. Sept. 23, 2020); *see also Tempur-Pedic Int'l, Inc. v. Waste to Charity, Inc.*, No. 07-2015, 2007 WL 535041 (W.D. Ark. Feb. 16, 2007) (same). *W. Plains, L.L.C. v. Retzlaff Grain Co.*, No. 8:13CV47, 2013 WL 541568, *5 (D. Neb. Feb. 12, 2013) (same). This Court applies the same standard for both preliminary injunction and temporary restraining order requests. *See Planned Parenthood Ark. & E. Okla. v. Jegley*, No. 4:15-cv-00784-KGB, 2018 WL 3029104, at *8 (E.D. Ark. June 18, 2018). As this Court has held, in deciding a preliminary injunction

motion, it "considers four factors: (1) the probability that the movant will succeed on the merits; (2) the threat of irreparable harm to the movant; (3) the balance of equities; and (4) the public interest." *See Hopkins*, 267 F. Supp. 3d at 1051 (citing *Dataphase Sys., Inc. v. C L Sys., Inc.*, 640 F.2d 109, 114 (8th Cir. 1981)).

I. Plaintiffs are Likely To Succeed On the Merits of Their Claims.

As discussed below, Plaintiffs are likely to succeed on the merits of their undue burden claims because, as this Court previously found, the challenged laws impose a substantial obstacle in the path of people seeking abortion, irrespective of any purported benefits. The Eighth Circuit did not disturb these findings or even suggest they are clearly erroneous; rather, with respect to the undue burden claims, the Eighth Circuit remanded to this Court solely to apply the test as articulated by Chief Justice Roberts in his *June Medical Services* concurrence.[4]

Under the Chief Justice's concurrence, abortion restrictions are unconstitutional if they are not "reasonably related" to a "legitimate purpose," or if they impose "a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *June Med. Servs.*, 140 S. Ct. at 2138 (quotations omitted). Importantly, the concurrence did not alter what constitutes a "substantial obstacle." Instead, the Chief Justice affirmed that laws impose a "substantial obstacle" when they have the effect of "likely [] prevent[ing] a significant number of women from obtaining an abortion," *id.* at 2137 (quoting *Planned Parenthood v. Casey*, 505 U.S. 833, 893 (1992)), as well as when they

[4] Plaintiffs preserve their argument, discussed in their petition for rehearing en banc, *Hopkins v. Jegley*, No. 17-2879, Entry ID 4947895 (8th Cir. Aug. 21, 2020), that Chief Justice Roberts's concurrence does not eliminate the requirement that courts must weigh the benefits of an abortion restriction with the law's burdens.

subject people seeking abortions to delay, increased travel, and/or increased medical risks, *id.* at 2140 (citing *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2313 (2016)). Applying this test, the Chief Justice joined the plurality to strike down the Louisiana law at issue in *June Medical Services* because it imposed a substantial obstacle by, *inter alia*, creating longer wait times for appointments, increasing travel distances, and increasing medical risks for patients. *Id*. at 2140. In particular, the Chief Justice recognized that these obstacles must be considered on top of the obstacles that people already faced accessing abortion in Louisiana, including affording or arranging childcare. *Id.* These are the very same burdens this Court found the challenged laws would impose here, as discussed *infra*. *See also Whole Woman's Health*, 136 S. Ct. at 2313, 2318.

Accordingly, based on this Court's previous findings that the laws impose a substantial obstacle in the path of people seeking abortion access, Plaintiffs are likely to succeed on the merits of their undue burden claims. As this Court has already found, and as discussed further below, the extensive record evidence demonstrates that each of the challenged laws imposes a substantial obstacle in the path of people seeking pre-viability abortions. *See, e.g.*, 267 F. Supp. 3d at 1068 (D&E Ban); *id.* at 1078 (Medical Records Mandate); *id.* at 1091 (Local Disclosure Mandate); *id* at 1106 (Tissue Mandate). In addition, for at least three of the four laws challenged this Court also found there was no reasonable relationship to any proffered state purpose. *See, e.g.*, *id*. at 1076 (Medical Records Mandate); *id*. at 1089 (Local Disclosure Mandate); *id*. at 1105 (Tissue Mandate). This Court's findings of fact and conclusions of law are thus more than sufficient to establish a likely substantive due process violation under Chief Justice Roberts's test.

On remand, the Eighth Circuit also instructed this Court to consider the holding in *Box v. Planned Parenthood of Indiana and Kentucky*, 139 S. Ct. 1780 (2019) (per curiam). *Hopkins v. Jegley*, 968 F.3d 912, 916 (8th Cir. 2020). The *Box* Court emphasized that because the plaintiffs there had only brought the rational basis claim, "[t]his case . . . does not implicate our cases applying the undue burden test to abortion regulations," and "expresses no view on the merits of those challenges." 139 S. Ct. at 1782; *see also id.* at 1781 (the challengers in *Box* "never argued that Indiana's law creates an undue burden on a woman's right to obtain an abortion"). Because Plaintiffs have brought undue burden claims, not rational basis claims, *Box* is inapplicable here.

Finally, since *June Medical Services* involved only substantive due process privacy claims, and *Box* involved only a rational basis claim, the Eighth Circuit's remand does not impact the other grounds upon which this Court found Plaintiffs likely to succeed, including the unconstitutional vagueness of at least two of the challenged laws (for the Medical Records Mandate and Tissue Disposal Mandate). Plaintiffs are thus likely to succeed on the merits of these constitutional claims as well.

A. D&E Ban

Plaintiffs are likely to succeed on their claim that the D&E Ban imposes a substantial obstacle in the path of people seeking abortions. *June Med. Servs.*, 140 S. Ct. at 2138. As this Court held, even considering "*only the effect of the provisions*," Plaintiffs have shown they are "likely to prevail on the merits and to establish that the challenged D&E [Ban] creates an undue burden for a large fraction of women for whom the D&E [Ban] is an actual rather than irrelevant restriction." 267 F. Supp. 2d at 1064 (emphasis

added). Specifically, this Court found that the D&E Ban would impose a "substantial obstacle" in the path of women seeking second-trimester abortions. *Id*. at 1067, 1068.

To reach this conclusion, this Court relied on extensive record evidence to find that the law prohibited D&E— which is the sole method of abortion that is currently provided throughout the second trimester in Arkansas. The Court also found that the additional medical procedures that the State proposed as so-called "workarounds" were unreliable, untested, and/or available in Arkansas.[5] *See supra* at p.5. Indeed, every district court to consider this question has reached the conclusion that fetal demise through digoxin, potassium chloride, or cord transection is not a feasible or effective workaround for a law that bans D&E abortion, and every court of appeals that has reviewed those findings has affirmed them. *See, e.g.*, *Whole Woman's Health v. Paxton,* —F.3d—, 2020 WL 6218657, at *5-8 (5th Cir. Oct. 13, 2020), *modified* Oct. 22, 2020; *EMW Women's Surgical Ctr., P.S.C. v. Friedlander*, 960 F.3d 785, 798-806 (6th Cir. 2020); *W. Ala. Women's Ctr. v. Williamson*, 900 F.3d 1310, 1322-24 (11th Cir. 2018); *Planned Parenthood of Cent. N.J. v. Farmer*, 220 F.3d 127, 145-46 (3d Cir. 2000); *Bernard v. Individual Members of Ind. Med. Licensing Bd.*, 392 F. Supp. 3d 935, 962 (S.D. Ind. 2019); *Planned Parenthood Sw. Ohio Region v. Yost,* 375 F. Supp. 3d 848, 869 (S.D. Ohio 2019); *Evans v. Kelley*, 977 F. Supp. 1283, 1318 (E.D. Mich. 1997); *Hodes &*

[5] Although the Eighth Circuit noted that Chief Justice Roberts emphasized "the wide discretion" that courts must afford to legislatures in areas of medical uncertainty, *Hopkins*, 968 F.3d at 915, 916 (8th Cir. 2020) (quoting *June Med. Servs*., 140 S. Ct. at 2136 (Roberts, C.J., concurring in judgment)), this aspect of the Chief Justice's opinion is inapplicable here. As this Court previously found, the Arkansas legislature did not make *any* findings in passing the D&E Ban. 267 F. Supp. 3d at 1057. Moreover, it is the courts' duty, after considering evidence and argument, to resolve medical uncertainty, even where, unlike here, there are explicit legislative findings. *Whole Woman's Health*, 136 S. Ct. at 2310 (citing *Gonzales v. Carhart*, 550 U.S. 124, 165-66 (2007)).

Nauser, MDs, P.A. v. Schmidt, 368 P.3d 667, 670-71, 677-78 (Kan. Ct. App. 2016), *aff'd,* 440 P.3d 461, 467-68 (Kan. 2019).

Based on this evidence, this Court correctly found "if the D&E [Ban] takes effect a large fraction of Arkansas women who select abortion throughout the second trimester would experience a substantial obstacle to abortion." *Id*. at 1068. That is because the D&E Ban would "end standard D&E practice," *id*. at 1060, and D&E is the only method of second-trimester abortion currently provided in Arkansas, *see supra* at pp.5-6. A law prohibiting the only method of second-trimester abortion indisputably imposes a substantial obstacle in the path of not just some, but all people seeking second-trimester abortions. *See, e.g.*, *EMW Women's Surgical Ctr., P.S.C.*, 960 F.3d at 1327; *W. Ala. Women's Ctr.*, 900 F.3d at 808. Indeed, as this Court found, even if patients could undergo additional medical procedures in an attempt to ensure fetal demise prior to starting the D&E procedure, requiring those procedures would impose a substantial obstacle, e.g., by requiring patients to make at least three trips to the clinic, and also by increasing medical risks. 267 F.3d at 1061; *see also EMW Women's Surgical Ctr., P.S.C.*, 960 F.3d at 798 (holding that "[a]dditional procedures, by nature, expose patients to additional risks and burdens"); *W. Ala. Women's Ctr.*, 900 F.3d at 1326 (finding no support for proposition that a state may "subject women to an increased degree of risk" by requiring demise procedures). This Court correctly found these additional trips imposed burdens—including, e.g., arranging for time off for work, childcare, and arranging and paying for transportation and lodging—that likewise constitute a substantial obstacle, particularly for the 30-40% of LRFP's patients who are low-income. *Id.* at 1061. As discussed above, this holding is entirely consistent with Chief Justice

Roberts's concurrence in *June Medical Services*, which recognized that these types of burdens amount to a substantial obstacle. *See supra* at p.13. It is also consistent with the Chief Justice's admonition to "treat like cases alike," and thus to find unconstitutional a ban on D&E, as the Supreme Court has in prior cases. *See, e.g.*, *Gonzales*, 550 U.S. at 153-54 (upholding ban on a rarely used procedure because "it does not prohibit" "the prototypical D&E procedure"); *Stenberg v. Carhart*, 530 U.S. 914, 945-46 (2000) (holding that "physicians who use D&E procedures, the most commonly used method for performing previability second trimester abortions . . . must fear prosecution, conviction, and imprisonment," "[t]he result is an undue burden upon a woman's right to make an abortion decision" and "[w]e must consequently find the statute unconstitutional"). Accordingly, Plaintiffs are likely to succeed on the merits of their undue burden claim against the D&E Ban.

B. Medical Records Mandate

This Court's conclusion that the Medical Records Mandate is likely unconstitutional also remains unchanged by Chief Justice Roberts's concurrence. That is because this Court found, when considering only the burdens imposed by the law, that "the Medical Records Mandate impermissibly delays or bars most abortions for which the law is relevant." 267 F. Supp. at 1072-73. It requires a sweeping search for records of patients' pregnancy histories without any discernible parameters, and without any instructions as to what the provider is to do with any records secured. *Id.* at 1075. It also requires Plaintiffs to wait an undefined period for medical records from the patients' prior providers. *Id*. at 1073. This Court found that this delay would impose a substantial obstacle in the path of people seeking access to abortion: a patient could be pushed past

her point in pregnancy when she could receive a medication abortion; she could be pushed from a one-day abortion procedure to a two-day one later in her second trimester; or she could be pushed past the point at which she could obtain an abortion at all. *Id*. at 1073-74; *see also id*. at 1078 (the Medical Records Mandate presents substantial obstacles to abortion care by, *inter alia*, "increasing health risks to women as gestational age advances, increasing costs associated with compliance"). The Medical Records Mandate would also impose a substantial obstacle by "violat[ing] the woman's confidentiality" and forcing disclosure of the woman's abortion decision to her other medical providers, thus "interfer[ing] with a woman's right to decide to end her pregnancy." *Id*. at 1075-76, 1078. In addition to finding that the law imposed "substantial burdens," this Court found that the law "appear[s] to serve no proper state purpose." *Id*. at 1076-77. In particular, it found, *inter alia*, that there is "no link" between the law and the State's asserted interest of enforcing the sex-selection abortion ban, especially because the law does not explain what a doctor is to do with the medical records upon receipt. *Id.* Nothing has changed since 2017 that would alter this Court's holdings. Thus, under either prong of the test advanced by the Chief Justice, these prior findings show that Plaintiffs are likely to succeed in their undue burden challenge to the Medical Records Mandate.

This Court's previous holding that the Medical Records Mandate "fails to provide fair notice and could potentially result in arbitrary enforcement," *id*. at 1082, and "contain[s] no objective criteria or clear guidelines," *id*. at 1084, is also unaffected by the Chief Justice's concurrence. The statutory language still requires an unbounded search for records, lacks defined terms, and lacks direction to providers about what to do with

any records once they are obtained. *See id*. at 1082 (concluding that the phrase "reasonable time and effort" is "subjective in nature and has no specified boundaries"). Thus, Plaintiffs are still likely to succeed on the merits of their vagueness challenge to the Medical Records Mandate.

C. Local Disclosure Mandate

The Court's prior rulings that the Local Disclosure Mandate unduly burdens access to pre-viability abortion care is similarly unaltered by *June Medical Services*. Plaintiffs challenged this provision for young people aged 14, 15, and 16, whose sexual activity indicates no potential sexual abuse or criminality and is therefore not covered by the reporting requirements under the Arkansas Child Maltreatment Act. *Id*. at 1087. The Local Disclosure Mandate still requires Plaintiffs to disclose *all* teenage patients' abortions to their local law enforcement, requires local law enforcement to come to the clinic to pick up *all* such patients' tissue as "evidence," and mandates retention of *all* such tissue indefinitely in a state crime laboratory. This Court already found, consistent with Chief Justice Roberts's concurrence, that these requirements would impose an unconstitutional substantial obstacle because they could prohibit medication abortion altogether, as there is no way to retain and transmit tissue from a medication abortion. *Id*. at 1091. And this Court found that, by requiring disclosure of minors' private reproductive decisions to local law enforcement, the Mandate could force minors to delay abortion care or deter them from abortions altogether. *Id*. at 1091-92; *see also id.* at 1094 (finding that teens who are not covered by the reporting requirements under the Arkansas Child Maltreatment Act (Non-CMA Teenagers), would be unduly burdened by the substantial obstacles created by the Local Disclosure Mandate"). As such, Plaintiffs are

still likely to succeed on the merits of their undue burden challenge to the Local Disclosure Mandate as applied to Non-CMA Teenagers.

Furthermore, this Court also considered (consistent with the Chief Justice's concurrence) whether the law is reasonably related to a legitimate state interest. This Court found the State's interest of protecting young people who are sexually abused is legitimate, but that the Local Disclosure Mandate "serves no valid state purpose as applied to" 14- to 16-year-old patients for whom there is no indication of abuse. *Id*. at 1086-89. Rather, for those minors, because "[t]here is no mandatory reporting required, [] there is no role for local law enforcement." *Id*. The same is true today. Accordingly, Plaintiffs remains likely to succeed on the merits of their constitutional challenge to the Local Disclosure Mandate as applied to Non-CMA Teenagers.

E. Tissue Disposal Mandate

This Court's holding that the Tissue Disposal Mandate is likely unconstitutional remains unchanged in light of *June Medical Services*. This law requires abortion providers, under criminal penalty, to comply with the FDRA, which gives family members the right to control the disposition of the remains of a deceased person. 267 F. Supp. 3d at 1097.

As an initial matter, this Court found that Plaintiffs are likely to succeed on the merits of their vagueness claim because it is unclear whether tissue from a medication abortion or following miscarriage care may be disposed of at home, what constitutes "reasonable efforts" to locate absent family members to inform them about their disposition rights, and how providers or their patients might otherwise comply with the FDRA in the abortion context, for which it was not designed. *Id*. at 1108-09. "Given the

potential liability for violating [the Tissue Disposal Mandate], plaintiff cannot make good faith efforts to comply and hope for the best." *Id*. at 1109. This holding is entirely unaffected by *June Medical Services*.

Plaintiffs are also still likely to succeed on the merits of their undue burden claim against the Tissue Disposal Mandate. As this Court previously held, the Tissue Disposal Mandate effectively requires notification of the abortion to minor patients' parents and the parents of her sexual partner, and for adult patients, notification to their sexual partners, so that those individuals can assert rights related to the tissue. *Id*. at 1099. As this Court held, these notification requirements amount to a substantial obstacle under Supreme Court precedent because they deprive each patient of her right to private medical decision-making. *id*. at 1099, 1101 (collecting cases); *see also e.g.*, *Casey*, 505 U.S. at 894 (rejecting spousal-notification requirement as substantial obstacle); *Bellotti v. Baird*, 443 U.S. 622, 639-40 (1979) (requiring confidential judicial bypass for parental notification requirement).

This Court also found that the Tissue Disposal Mandate would operate as a substantial obstacle for the additional reason that it would force Plaintiffs to cease providing D&E abortion procedures—the only form of abortion available after 10 weeks LMP. *See id.* at 1102, 1107-08. [6] This conclusion was based on the Court's findings that Plaintiffs would be unable to ensure tissue could be disposed in compliance with the Mandate before beginning an abortion procedure. *Id*. at 1102, 1107-08. Moreover, even if the Tissue Disposal Mandate did not prevent abortion procedures outright, the search-

[6] As noted above, this Court found that it was unclear whether at-home disposal of tissue following medication abortion or treatment of miscarriage is permitted under the Mandate. *Id*. at 1103.

and-notice requirements could delay abortion care, which increases the risks associated with the procedure, and could make it impossible for some to obtain an abortion in Arkansas. *Id*. at 1108. Thus, this Court concluded that Plaintiffs are "likely to prevail on [the] claim that in a large fraction of cases in which the Tissue Disposal Mandate is relevant" because "it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Id*. at 1105.

Chief Justice Roberts's concurrence in *June Medical Services* confirms, rather than alters, this Court's undue burden holding. In fact, the Chief Justice expressly reiterated the key holdings from *Casey* that this Court relied upon in reaching its conclusion that the notification requirements likely imposed a substantial obstacle. 140 S. Ct. at 2137 ("Without a judicial bypass, parental consent laws impose a substantial obstacle to a minor's ability to obtain an abortion and therefore constitute an undue burden."); *id.* (spousal notification law unconstitutional because it would "'likely [] prevent a significant number of women from obtaining an abortion.'" (quoting *Casey*, 505 U.S. 893)). Accordingly, the Mandate's notification requirements alone render it a substantial obstacle under longstanding and recently reaffirmed precedent. The other substantial obstacles this Court found imposed by the Tissue Disposal Mandate—i.e., delaying abortion care or outright preventing Plaintiffs from performing abortion procedures—are similarly consistent with the Chief Justice's concurrence in *June Medical Services*. As discussed *supra* at p.13, these are the same types of obstacles the Chief Justice discussed when explaining why the Louisiana law at issue in *June Medical Services* should be struck down.

This Court's findings support the additional conclusion that the Mandate is likely unconstitutional under the Chief Justice's concurrence because it is not "reasonably related" to a legitimate state goal. *See* 140 S. Ct. at 2138. This Court previously held that, even if the State's interests in enacting the Mandate were legitimate, the Mandate did not "advance[]" any such interests: This Court was "not convinced that importing the FDRA's" requirements advances a health goal, nor did it think that the Mandate furthered the state's interest in potential life, given that the Mandate applies *after* an abortion or miscarriage occurs. 267 F. Supp. 3d. at 1105.

The Eighth Circuit's instruction that, on remand, this Court consider *Box* does not disturb this conclusion. First, as noted above, *see supra* at p.14, Plaintiffs here brought an undue burden claim against the Mandate, and the challengers in *Box* brought a rational basis claim. The undue burden test requires more than mere rational basis review. *See, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2309-10 (holding that it "is wrong to equate the judicial review applicable to the regulation of a constitutionally protected personal liberty with the less strict review applicable where, for example, economic legislation is at issue" and doing so "does not match the standard that this Court laid out in *Casey*"). Accordingly, the Supreme Court's decision in *Box* is inapposite here. *See supra* at p.14. Second, the Tissue Disposal Mandate is qualitatively different than the law at issue in *Box*: Whereas the law in *Box* dictated the acceptable methods of tissue disposition after abortion, the Mandate here dictates who has rights to make disposition decisions, through an elaborate scheme that strikes at the heart of a person's ability to access confidential abortion care. *See* Ark. Code Ann. §§ 20-17-802(a), 20-17-102(d)(1) (describing the rank

order of those individuals given the "right to control the disposition of the remains"). Thus, the Supreme Court's analysis of what was "rational" in *Box* has no bearing here.

Accordingly, Plaintiffs remains likely to succeed on the merits on their claims against the Tissue Disposal Mandate.

II. Irreparable Harm

This Court concluded that if these laws took effect, they would impose irreparable harm on Plaintiffs and their patients. *Hopkins*, 267 F. Supp. 3d at 1069; *id*. at 1073-74, 1084-85; *id*. at 1093, 1095-96; *id*. at 1110. This remains as true today as it was when the Court issued its preliminary injunction order. As this Court held, "[i]t is well-settled that the inability to exercise a constitutional right constitutes irreparable harm." *Id*. at 1069, 1084, 1095, 1110. Moreover, combined, enforcement of the laws would wreak havoc on abortion access by banning, delaying, or discouraging abortion for the vast majority of people who seek access in Arkansas. *Id*. at 1069 (D&E Ban would prohibit the only method of second-trimester abortion); *id*. at 1073-74, 1084-85 (Medical Records Mandate would to lead to denial of abortion care or delayed abortion access); *id*. at 1093, 1095-96 (Local Disclosure Mandate would discourage minors from obtaining an abortion and unnecessarily disclose intensely private information to local police); *id*. at 1110 (Tissue Disposal Mandate would impose a substantial obstacle in the path of people seeking abortion). Additionally, because the Medical Records Mandate and the Tissue Disposal Mandate fail to give Plaintiffs notice as to how to comply with these laws and continue providing care, these laws are unconstitutionally vague. *Id*. at 1084-85, 1110.

III. Balancing of Harms

As this Court held, the balance of harm clearly tips in Plaintiffs' favor: if the laws take effect, the vast majority of abortions would be halted, while on the other hand, "likely unconstitutional law[s]" will not go into effect; indeed, the threatened harm to Plaintiffs and their patients "clearly outweighs" any potential harm a proposed injunction may cause the State. *Id*. at 1069, 1085, 1096, 1110. This is especially true where this Court has held that the three of the four laws do not serve the State's legitimate interests. *See supra* at pp.18, 20, 23. Furthermore, the challenged laws have been enjoined for three years, and Defendants can point to no harm to the State that has occurred in this time.

IV. Public Interest

This Court held in its preliminary injunction order that it is in the public interest is to "preserve the *status quo*." *Id*. at 1069, 1085, 1096, 1110. The same is true here: absent an immediate TRO, abortion access will be severely curtailed, and it is in the public interest to maintain the status quo until this Court can adjudicate Plaintiffs' motion for a preliminary injunction.

CONCLUSION

For all of the reasons above, this Court should grant Plaintiffs' motion for a TRO.

Dated: December 21, 2020

Respectfully submitted,

Ruth E. Harlow*
Elizabeth K. Watson*
Brigitte Amiri*
Alexa Kolbi-Molinas*
American Civil Liberties Union Foundation
125 Broad St, 18th Floor
New York, NY 10001
mburrows@aclu.org
rharlow@aclu.org
(212) 549-2633

Attorneys for Plaintiffs

Bettina Brownstein (AR Bar No. 85019)
Bettina E. Brownstein Law Firm
904 West 2nd Street, Suite 2
Little Rock, AR 72201
bettinabrownstein@gmail.com
(501) 920-1764

Brooke-Augusta Ware (AR Bar No. 2004091)
Mann & Kemp, PLLC
221 West Second Street, Suite 408
Little Rock, Arkansas 72201
brooke@mannkemp.com
(501) 222-7330

Attorneys for Plaintiffs

Jenny Ma*
Arielle Humphries*
Center for Reproductive Rights
199 Water Street, 22nd Fl.
New York, NY 10038
Phone: 917-637-3705
jma@reprorights.org
ahumphries@reprorights.org

Attorney for Plaintiffs

Leah Godesky*
Christopher P. Burke*
David Cohen*
Sara N. Pahlavan*
O'Melveny & Myers LLP
Times Square Tower
7 Times Square
New York, New York 10036
lgodesky@omm.com
cburke@omm.com
(212) 326-2254
Fax: (212) 326-2061

Kendall Turner*
O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006
(202) 383-5300
kendallturner@omm.com

Attorneys for Plaintiffs

** Motion for admission pro hac vice granted*

EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

FREDERICK W. HOPKINS, M.D., M.P.H., *et al.*	)	
	)	
Plaintiffs,	)	Case No. 4:17-cv-00404-KGB
	)	
v.	)	
	)	
LARRY JEGLEY *et al.*,	)	
	)	
Defendants.	)	

DECLARATION OF RUTH E. HARLOW IN SUPPORT OF PLAINTIFFS' MOTION FOR AN *EX PARTE* TEMPORARY RESTRAINING ORDER

I, Ruth E. Harlow, declare under 28 U.S.C. § 1746 and penalty of perjury that the following is true and correct:

1. I am an attorney at the American Civil Liberties Union Foundation, counsel of record for Little Rock Family Planning Services ("LRFP") and Dr. Frederick W. Hopkins (together, "Plaintiffs") in the above-captioned matter. I am a member in good standing of the State Bar of New York, and am admitted *pro hac vice* to represent Plaintiffs in this litigation.

2. I submit this Declaration in support of Plaintiffs' Motion for an *Ex Parte* Temporary Restraining Order of the four challenged laws enacted by the Arkansas legislature in 2017 that are the subject of this case.

3. This Court entered a preliminary injunction on July 28, 2017, before each statute's effective date, that prohibited Defendants from enforcing the challenged laws against any physician or entity subject to them. Dkt. No. 35 at 139-40. Defendants appealed. A panel of

the U.S. Court of Appeals for the Eighth Circuit determined that certain claims should be reassessed under an altered legal standard. Plaintiffs then petitioned for rehearing en banc.

4. On December 15, 2020, the Eighth Circuit denied Plaintiffs' petition for rehearing en banc. Thus, I anticipate that on December 22, 2020, or soon thereafter, the Eighth Circuit's mandate will issue, directing this Court to lift its preliminary injunction and to apply an altered legal standard to Plaintiffs' undue burden claims.

5. As reflected in Exhibit A, on the morning of December 17, 2020, I notified counsel for Defendants that Plaintiffs intended to seek an *ex parte* temporary restraining order ("TRO") immediately enjoining the challenged laws as soon as the prior injunction is lifted to continue to bar Defendants from enforcing those laws. I informed counsel for Defendants that Plaintiffs were preparing TRO and preliminary injunction papers that we anticipated filing on or before Tuesday, December 22. I also alerted counsel for Defendants in the same email that Plaintiffs would be moving to file an updated, amended complaint, which we have since done.

6. Because the timing of the Eighth Circuit's mandate will, of necessity, trigger this motion practice over the holidays, I also asked Defendants' counsel whether Defendants would agree to not enforce the laws during the holiday weeks and instead would agree to submit a joint proposed briefing schedule for Plaintiffs' preliminary injunction motion to this Court. *See* Ex. A. Defendants declined. *See id.*

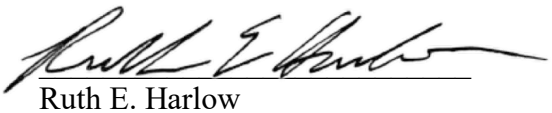
7. In the parties' correspondence, Defendants' counsel questioned the basis for Plaintiffs' seeking a TRO and why Plaintiffs "had waited so long" to file a motion. *See id.* I explained that Plaintiffs' request for an immediate TRO will be based on this Court's 2017 factual findings and legal conclusions, because those continue to apply both under the Eighth Circuit's altered legal standard for undue burden claims and with respect to Plaintiffs' vagueness

claims. *See id.* Those prior determinations show the irreparable constitutional harms that will occur if these laws are allowed to take effect even for a day or two. *See id.* I also made clear that Plaintiffs have acted as quickly as possible after the December 15, 2020, order and indeed, have acted even before the Court receives the mandate to lift the prior injunction. *See id.*

8. As discussed further in LRFP Clinic Director Lori William's declaration, attached as Exhibit 2, Plaintiffs will be forced to turn away numerous patients who are already scheduled for abortion procedures over the coming days if a TRO is not entered. *Ex parte* relief is warranted for this reason, and all the reasons detailed in Plaintiffs' concurrently filed memoranda of law in support of their requests for an *ex parte* TRO and a preliminary injunction. If the Court declines to grant *ex parte* TRO relief, Plaintiffs respectfully request that the Court grant Defendants no more than 24 hours to respond to Plaintiffs' TRO papers, given (i) that Defendants have had express notice of Plaintiffs' filing for more than three days, and (ii) Plaintiffs' TRO motion seeks relief that merely maintains the status quo for a short period of time while the Court rules on Plaintiffs' concurrently filed preliminary-injunction motion.

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

Executed this 21st day of December, 2020.



Ruth E. Harlow

EXHIBIT A

From: Ruth Harlow
To: Nicholas Bronni; "bettinabrownstein@gmail.com"
Cc: Dylan Jacobs; Elizabeth Watson; Godesky, Leah; Hillary Schneller; Michael Cantrell; Vincent Wagner
Subject: RE: Hopkins v. Jegley Next Steps
Date: Sunday, December 20, 2020 5:30:00 PM

Nick –

As you know, the district court has already made detailed findings that explain why these statutes impose irreparable harms. Plaintiffs' request for an immediate TRO will be well grounded in this Court's 2017 factual findings and legal conclusions, as those continue to apply both under the Eighth Circuit's altered legal standard for undue burden claims and with respect to Plaintiffs' vagueness claims. Those prior determinations show the constitutional harms that will occur if these laws are allowed to take effect even for a day or two. Instead, the status quo that prohibits enforcement of all four laws against any physicians or provider entities during this litigation should be preserved.

I also want to make clear that there has been no delay in Plaintiffs' filing. We have acted as quickly as possible after the December 15, 2020, order. If we are able to file tomorrow, as planned, we will have filed these motions (with multiple declarations) in less than a week—and before the Court receives the mandate to lift the prior injunction. As the State is aware, Judge Baker in an earlier case indicated that the district court does not have jurisdiction to consider and enter a new injunction before that time.

Thanks, Ruth

From: Nicholas Bronni <nicholas.bronni@arkansasag.gov>
Sent: Saturday, December 19, 2020 10:19 PM
To: 'bettinabrownstein@gmail.com' <bettinabrownstein@gmail.com>; Ruth Harlow <rharlow@aclu.org>
Cc: Dylan Jacobs <dylan.jacobs@arkansasag.gov>; Elizabeth Watson <ewatson@aclu.org>; Godesky, Leah <lgodesky@omm.com>; Hillary Schneller <hschneller@reprorights.org>; Michael Cantrell <michael.cantrell@arkansasag.gov>; Vincent Wagner <vincent.wagner@arkansasag.gov>
Subject: RE: Hopkins v. Jegley Next Steps

Ruth and Bettina-

The status quo is that duly enacted laws go into effect, and you haven't suggested any reason that wouldn't be true here. I don't see anything below that explains why plaintiff thinks Arkansas's laws protecting young girls from predators and sex traffickers, protecting unborn girls from systematic discrimination, requiring the respectful treatment of human remains, or barring a particularly barbaric manner of killing an unborn child are unconstitutional. Nor, even if plaintiff had provided *any* legal reasoning, has plaintiff explained the basis for claiming irreparable harm. So while as a professional courtesy, defendants are always willing to hear you out, it's not at all clear why plaintiff thinks he is entitled to any relief.

It's equally unclear why—whatever the basis for plaintiff's motion is—plaintiff waited so long to file

it. Plaintiff could have filed last week, and we would have easily avoided inconveniencing the district court (and, potentially, the appellate courts). But instead, plaintiff has strategically delayed bringing any motion. That alone is grounds for denying it.

Nick

From: Bettina Brownstein <bettinabrownstein@gmail.com>
Sent: Saturday, December 19, 2020 6:08 PM
To: Ruth Harlow <rharlow@aclu.org>
Cc: Dylan Jacobs <dylan.jacobs@arkansasag.gov>; Elizabeth Watson <ewatson@aclu.org>; Godesky, Leah <lgodesky@omm.com>; Hillary Schneller <hschneller@reprorights.org>; Michael Cantrell <michael.cantrell@arkansasag.gov>; Nicholas Bronni <nicholas.bronni@arkansasag.gov>; Vincent Wagner <vincent.wagner@arkansasag.gov>
Subject: Re: Hopkins v. Jegley Next Steps

Unless I hear an objection, I plan to call the lawclerk with a heads up that we're filing the TRO Mon. I will call Mon morning.

On Sat, Dec 19, 2020 at 5:31 PM Ruth Harlow <rharlow@aclu.org> wrote:

> Nick –
>
> The existing preliminary injunction protects the clinic, all of its providers, and all of its patients—not only Dr. Hopkins and his patients. Unless Defendants agree not to enforce the four challenged laws during PI briefing, we will need to move for an immediate TRO (entered as soon as the existing injunction is lifted) to preserve the status quo and prevent patients' constitutional harms. Patients are seeking care each day the clinic is open over the holidays. My questions to you have been as a matter of courtesy because of the necessary, but unfortunate timing of these motions. If the Defendants are not interested in temporarily agreeing not to enforce and working out a briefing schedule that would avoid your having to respond to these motions during the holiday week, that's up to you. Absent agreement, we will take all the steps necessary to preserve the status quo and protect patients' rights and cannot wait until January to do so.
>
> Thanks, Ruth
>
> ---
>
> **From:** Nicholas Bronni <nicholas.bronni@arkansasag.gov>
> **Sent:** Friday, December 18, 2020 11:16 PM
> **To:** Ruth Harlow <rharlow@aclu.org>
> **Cc:** Michael Cantrell <michael.cantrell@arkansasag.gov>; Godesky, Leah <lgodesky@omm.com>; Hillary Schneller <hschneller@reprorights.org>; Elizabeth Watson <ewatson@aclu.org>; Bettina Brownstein <bettinabrownstein@gmail.com>; Vincent Wagner <vincent.wagner@arkansasag.gov>; Dylan Jacobs <dylan.jacobs@arkansasag.gov>
> **Subject:** RE: Hopkins v. Jegley Next Steps
>
> Ruth,

We were trying to determine the basis for your request. I gather from your answer that Hopkins—who is the sole plaintiff in this matter—does not plan to perform abortions over the next two weeks. So there wouldn't appear to be any basis for asking Arkansas to defer enforcement. Nor would there appear to be any reason we couldn't hold any potential proceedings in January.

Nick

From: Ruth Harlow <rharlow@aclu.org>
Sent: Friday, December 18, 2020 5:18 PM
To: Nicholas Bronni <nicholas.bronni@arkansasag.gov>
Cc: Michael Cantrell <michael.cantrell@arkansasag.gov>; Godesky, Leah <lgodesky@omm.com>; Hillary Schneller <hschneller@reprorights.org>; Elizabeth Watson <ewatson@aclu.org>; Bettina Brownstein <bettinabrownstein@gmail.com>; Vincent Wagner <vincent.wagner@arkansasag.gov>; Dylan Jacobs <dylan.jacobs@arkansasag.gov>
Subject: RE: Hopkins v. Jegley Next Steps

Nick – The clinic is scheduled to provide procedures on 12/21, 12/22, 12/23 and 12/28, 12/29, 12/30 during the holiday weeks. The last time I spoke with LRFP, they had a number of initial patient visits happening late this week, which patients would then be scheduled for their procedures over the coming clinic days. If the mandate issues and the district court lifts the current injunction—which is not limited to Dr. Hopkins—procedures starting on 12/22 would have to be canceled.

If you provide more context for your question, I can better understand and can follow up for more details from our clients if appropriate. Otherwise, please advise whether Defendants will agree not to enforce the laws until after the New Year and if so, what schedule you would propose for resolution of the new PI motion.

Thanks, Ruth

From: Nicholas Bronni <nicholas.bronni@arkansasag.gov>
Sent: Friday, December 18, 2020 4:47 PM
To: Ruth Harlow <rharlow@aclu.org>
Cc: Michael Cantrell <michael.cantrell@arkansasag.gov>; Godesky, Leah <lgodesky@omm.com>; Hillary Schneller <hschneller@reprorights.org>; Elizabeth Watson <ewatson@aclu.org>; Bettina Brownstein <bettinabrownstein@gmail.com>; Vincent Wagner <vincent.wagner@arkansasag.gov>; Dylan Jacobs <dylan.jacobs@arkansasag.gov>
Subject: RE: Hopkins v. Jegley Next Steps

Ruth-

How many Arkansas abortions is Hopkins planning to perform in the next two weeks?

Nick

Nicholas J. Bronni
Solicitor General

Office of Arkansas Attorney General Leslie Rutledge

323 Center Street, Suite 200
Little Rock, Arkansas 72201
501.682.6302 ¦ 501.682.2000
Nicholas.bronni@arkansasag.gov ¦ ArkansasAG.gov

From: Ruth Harlow <rharlow@aclu.org>
Sent: Thursday, December 17, 2020 8:45 AM
To: Nicholas Bronni <nicholas.bronni@arkansasag.gov>
Cc: Michael Cantrell <michael.cantrell@arkansasag.gov>; Godesky, Leah <lgodesky@omm.com>; Hillary Schneller <hschneller@reprorights.org>; Elizabeth Watson <ewatson@aclu.org>; Bettina Brownstein <bettinabrownstein@gmail.com>
Subject: Hopkins v. Jegley Next Steps

Nick –

Given the Eighth Circuit's ruling on our motion for rehearing en banc, we anticipate that the mandate from that Court will issue next Tuesday and that shortly thereafter, the district court will lift the existing preliminary injunction. We are preparing papers to move for an ex parte TRO and/or a second preliminary injunction against all four laws, which we plan to have on file on or before Tuesday. We will ask the Court to immediately enter a new injunction, right after it lifts the initial PI, to avoid the irreparable harms of interference with patients' access to abortion care and other constitutional violations. Please let us know whether Defendants agree not to enforce any of the four challenged laws in light of those constitutional violations, or if Defendants believe that a meet and confer on any of the laws might be productive. We also plan to move to amend the complaint, and will do that this week, to bring data in that document up to date and add the clinic as an additional plaintiff.

We recognize that the timing of these motions unfortunately coincides with the holidays. This activity in the district court during the holiday period can't be avoided unless the Defendants are willing to agree not to enforce the four challenged laws during that period and, instead, agree to jointly propose a reasonable briefing schedule to the district court to allow it to decide the second PI motion before any enforcement. Please advise by COB Friday whether you will agree not to enforce the laws until after the New Year and if so, what schedule you would propose for resolution of the new PI motion.

Thank you, Ruth

Ruth E. Harlow

Pronouns: she, her

Senior Staff Attorney, Reproductive Freedom Project

American Civil Liberties Union

125 Broad St., New York, NY 10004

EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

FREDERICK W. HOPKINS, M.D., M.P.H., *et al.*	)	
	)	
Plaintifs,	)	Case No. 4:17-cv-00404-KGB
	)	
v.	)	
	)	
LARRY JEGLEY *et al.*,	)	
	)	
Defendants.	)	

DECLARATION OF LORI WILLIAMS, M.S.N., A.P.R.N., IN SUPPORT OF PLAINTIFFS' MOTION FOR AN EX PARTE TEMPORARY RESTRAINING ORDER

Lori Williams, M.S.N., A.P.R.N., declares and states as follows:

1. I am a nurse practitioner and the Clinical Director at Little Rock Family Planning Services in Little Rock, Arkansas ("LRFP" or "the clinic").

2. In June 2017, I submitted a declaration in support of Plaintiff's Motion for a Temporary Restraining Order and/or Preliminary Injunction of four laws enacted in 2017 that would burden access to abortion care in Arkansas:

- Act No. 45 (H.B. 1032, or "the D&E Ban");
- Act No. 733 (H.B. 1434 or "the Medical Records Mandate");
- Act. No. 1018 (H.B. 2024 or "the Local Disclosure Mandate"); and
- Act. No. 603 (H.B. 1566, or "the Tissue Disposal Mandate").

3. I now submit this declaration in support of the need for an immediate temporary restraining order when the 2017 preliminary injunction is lifted. I reaffirm and incorporate my statements in the June 2017 declaration about LRFP's abortion practice and how the challenged

laws would impact LRFP, our physicians, and our patients. In addition, I am also submitting a longer declaration in support of Plaintiffs' Second Motion for a Preliminary Injunction and/or Temporary Injunction with Plaintiffs' present motion filings.

4. I understand that the mandate to lift the current preliminary injunction could come to this Court as early as Tuesday, December 22.

5. LRFP will be open December 21-23 and 28-30 during the upcoming holiday weeks. As detailed below, we have a number of patients who have had their initial consent appointments and whose abortions would take place December 22 and/or 23, but would be blocked from obtaining that care if the challenged laws take effect on December 22. We have many other patients with initial consent appointments scheduled for December 21-23 who would proceed, absent the obstacle of these laws, to obtain their abortion care the week of December 28-30. And we have more calls coming in each day from additional pregnant persons seeking their initial appointment with the clinic whose care would also be stymied by these laws over the holidays.

6. More specifically, if this Court does not prevent the challenged laws from taking immediate effect, LRFP will be forced to turn away at least eight patients currently scheduled for abortion care on December 22 and/or 23 who require an aspiration or D&E abortion. Two of those eight patients require a D&E procedure.

7. In addition, LRFP has another eight patients scheduled for their initial visit next week who would, if these laws are not in effect, complete their aspiration or D&E care December 28-30. There are also 14 more patients scheduled for their initial visits next week who appear to be eligible for medication abortion, but a contraindication for medication care may become apparent during those visits and thus, require procedural care instead. If that happens,

and these laws are not enjoined, LRFP would also have to deny those patients the aspiration procedure they need.

8. LRFP will also be forced to turn away every additional caller seeking aspiration or D&E abortion care, as well as patients between the ages of 14 and 16, and/or patients who know the sex of their embryo or fetus, who attempt to seek abortion care from LRFP during this time.

9. Each of the four challenged laws, should they take effect, will be an obstacle to current patient care. As a result of the Tissue Disposal Mandate, LRFP will be forced to stop providing abortion procedures to at least all of the aspiration or D&E patients described above, because attempting to comply with the Mandate's notification requirements would violate our patients' confidentiality and risk their safety. Additionally, the clinic and our physicians would be unable to ensure compliance with all of the Tissue Disposal Mandate's vague requirements and risk criminal penalties for non-compliance.

10. As a result of the D&E Ban, LRFP will be forced to deny abortions to at least the two D&E patients described above who would otherwise complete their care on December 22 or 23, and likely other patients as the month progresses, because there is no way to guarantee fetal demise before starting a D&E procedure and therefore no way for physicians at LRFP to continue to provide D&E care without exposing themselves to penalties under the ban.

11. As a result of the Medical Records Mandate, LRFP will be forced to stop providing abortion care, at a minimum, to any patient who knows the sex of the embryo or fetus, because we would otherwise have to request and attempt to gather medical records relating to those patients' "entire pregnancy history." This would risk those patients' safety and confidentiality and subject them to uncertain and potentially significant delay. Additionally, the

clinic and our physicians would be unable to ensure compliance with all of the Medical Records Mandate's vague requirements and risk criminal penalties for non-compliance.

12. As a result of the Local Disclosure Mandate, including its unclear interaction with the Tissue Disposal Mandate, LRFP will be forced to stop providing abortion care to patients who are 14, 15, or 16 years old for whom there is no basis to report abuse or involve the police.

13. If this Court does not prevent the challenged laws from taking effect, I estimate that LRFP will be forced to turn away at least two dozen patients before the end of the year.

14. LRFP is the only provider of aspiration and D&E procedures in Arkansas. Patients turned away because of these laws are in a terrible predicament. Indeed, at the very end of last week we had to tell two other patients (in addition to those described above) who were nearing Arkansas' gestational limit for any abortion that our ability to provide care over the next two weeks was uncertain and that, if at all possible, they should try to obtain care in another state. I do not know whether they have been successful in doing so.

15. To protect patients' ongoing access to abortion care and secure patients (and their providers') constitutional rights from irreparable harm, an immediate temporary restraining order against each of the four challenged laws is necessary.

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

Executed this 20th day of December, 2020

Lori Williams, M.S.N., A.P.R.N.

EXHIBIT 3

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

FREDERICK W. HOPKINS, M.D., M.P.H. et al., Plaintiffs, v. LARRY JEGLEY, et al., Defendants.	CIVIL ACTION Case No. 4:17-CV-00404-KGB

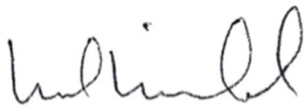
DECLARATION OF MARK D. NICHOLS, M.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR AN EX PARTE TEMPORARY RESTRAINING ORDER

I, Mark D. Nichols, M.D., pursuant to 28 U.S.C. §1746, declare under penalty of perjury that the following is true and correct:

1. I previously submitted on June 8, 2017 a Declaration in support of Plaintiffs' Motion for a Preliminary Injunction or in the Alternative a Temporary Restraining Order (Dkt. 4) (the "June 2017 Declaration"). I hereby reaffirm the statements in my June 2017 declaration, which is attached as Exhibit A.

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

Executed this 3rd day of November, 2020.



Mark D. Nichols, M.D.

EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

FREDERICK W. HOPKINS, M.D., M.P.H.,	)	
	)	
Plaintiff,	)	Case No. 4:17cv404-BRW
	)	
v.	)	
	)	
LARRY JEGLEY et al.,	)	
	)	
Defendants.	)	

DECLARATION OF MARK D. NICHOLS, M.D., IN SUPPORT OF PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION OR IN THE ALTERNATIVE A TEMPORARY RESTRAINING ORDER

Mark D. Nichols, M.D., declares and states the following:

1. I submit this declaration in support of Plaintiff's Motion for Preliminary Injunction. I am a physician licensed to practice medicine in the state of Oregon. I have been Board Certified in obstetrics and gynecology by the American Board of Obstetrics and Gynecology since 1985. I am currently the Director Emeritus of the Family Planning Fellowship and a professor at the Oregon Health and Science University in Portland, Oregon. The family planning fellowship trains obstetrician-gynecologists in complicated contraception and abortion care. In my practice, I provide a full range of gynecological and obstetric care and I have delivered approximately 3,000 babies. I also provide abortion procedures at two out-patient facilities in the Portland area.

2. Throughout my career, I have provided terminations of pregnancy, in both in-patient and out-patient settings. I provide abortions up to 24 weeks of pregnancy, as measured from the first day of the patient's last menstrual period (LMP), and have utilized both medical

and surgical methods. For many years, I have instructed and supervised residents and fellows in the provision of abortion care.

3. I have conducted research and published on a number of topics, including contraception and abortion, and have published over 20 peer-reviewed papers related to abortion. I am a long-standing member of the Association of Reproductive Health Professionals, and the Society of Family Planning, of which I am the former President. I am a member of the editorial board for the publication *Contraception* and a peer-reviewer for several publications, including the *New England Journal of Medicine* and the *American Journal of Obstetrics & Gynecology*.

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

5. The opinions in this declaration are my expert opinions, based on my education, training, practical experience as an obstetrician-gynecologist and an abortion provider, attendance at professional conferences, review of relevant medical literature, and conversations with other medical professionals. All of the opinions provided in this declaration are based on my personal knowledge.

6. I have reviewed H.B. 1032, which makes it a crime to perform a "dismemberment abortion" unless fetal demise has already occurred. The Act prohibits a procedure known in medical terms as dilation and evacuation ("D&E"), which is used in almost all abortions after the first trimester. That the ban does not apply if fetal demise has already occurred provides no protection for women's access to D&E: in the first few weeks of the second trimester, when the vast majority of D&Es occur, there is no safe, reliable way to effect fetal demise without violating H.B. 1032. After that point, there are methods physicians may

attempt, but these methods, which provide no medical benefit for the patient, are simply too risky or impossible in some patients, and they simply fail in others—and a physician cannot know ahead of time for which patients this will be true. Thus, to avoid the Act's criminal sanctions, physicians will have to stop providing D&E at any point in the second trimester.

BACKGROUND ON ABORTION

7. Abortion in the United States is a common and safe procedure: Approximately 30% of women have an abortion at some point in their lives.[1] Since abortion became legal across the country following the decision in Roe v. Wade, physicians have gained decades of experience, techniques have evolved to enhance safety, and today, the procedure is extremely safe.[2]

8. Abortion in both the first and second trimester is safer than carrying a pregnancy to term, as to both morbidity and mortality.[3] A woman's risk of death following childbirth is approximately 14 times greater than the risk of death associated with abortion.[4] In addition, complications such as blood transfusions, infection, and injury to other organs are all more likely to occur with a full-term pregnancy than following an abortion.

---

[1] R.K. Jones & M. Kavanaugh, Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion, 117 Obstetrics & Gynecology 1358, 1358 (2011).

[2] *See* K. Pazol et al., Ctr. for Disease Control and Prevention, Abortion Surveillance – United States, 2012, Morbidity and Mortality Weekly Report (Nov. 27, 2015) (reporting 2 deaths related to abortion out of 730,332 procedures in 2011); T.A. Weitz et al., Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver, 103(3) Am. J. of Pub. Health 454-61 (2013) (first-trimester abortion is one of the safest medical procedures and carries minimal risk—less than 0.05%—of major complications).

[3] E.G. Raymond & D.A. Grimes, The Comparative Safety of Legal Induced Abortion and Childbirth in the United States, 119 Obstetrics & Gynecology 215-19 (2012).

[4] *Id.* at 217.

9. Only extremely rarely is there any medical benefit in reviewing an abortion patient's prior medical records. One example would be a very significant prior bleeding complication with uterine instrumentation. But even then, the benefit of having the records would not justify more than minimal delay.

10. While legal abortion in the U.S. is very safe, the risks increase as pregnancy progresses. Numerous studies demonstrate increased risks of complications, such as bleeding and uterine perforation, associated with abortions performed later in pregnancy. Delay thus increases the risks a woman faces, particularly if that delay pushes her from the first to the second trimester, which, as I describe below, requires a more complicated procedure.

ABORTION CARE IN THE FIRST TRIMESTER

11. In both the first and second trimesters, there are two basic methods of abortion: using medications to cause uterine contractions, and using instruments to empty the uterus. Prior to any procedure, the clinician evaluates the patient and performs an ultrasound to determine how many weeks the pregnancy has advanced.

12. In the first trimester of pregnancy, early medication abortion is available through 70 days LMP. In a typical medication abortion, a woman takes first one drug, mifepristone, and then a second drug, misoprostol, approximately 24 hours later. She times taking these medications so that she can pass the products of conception at home over a period of hours or days, and collect and dispose of them in the same manner as she would during menstruation or a spontaneous abortion (miscarriage). First approved in this country in 2000, this regimen represents an advance in medicine. It has given women the option of a procedure that is less invasive because it does not involve the insertion of instruments into the uterus. This can be particularly advantageous for those women for whom instrumentation can be challenging:

women who are obese, women with large fibroids, and women who would find insertion of instruments into the vagina emotionally difficult, such as some women who have survived sexual assault and some minors who have not had a pelvic exam.

13. The instrumental method of abortion available in the first trimester is suction aspiration, also known as a dilation and curettage or D&C, in which clinicians use a plastic tube, called a cannula, attached to a syringe or electrical pump, to empty the uterus. Prior to starting the procedure, the physician dilates the cervix as needed to allow the cannula to enter the uterus. The size of the cannula used increases as pregnancy progresses. Beginning at approximately 9 weeks LMP, the embryo becomes a fetus and is not typically removed intact, but is broken apart by the force of the suction prior to removal. As the pregnancy progresses to the beginning of the second trimester, it is generally no longer possible to empty the uterus using suction alone; as described below, a physician must use other instruments.

ABORTION CARE IN THE SECOND TRIMESTER

14. As in the first trimester, it is possible to induce abortion in the second trimester using only medications, which is called induction, or with instrumentation, called D&E. However, second-trimester induction abortion is less common in this country. Unlike D&E, which is a quick procedure that can in most cases be scheduled as an out-patient procedure, inductions must occur in a hospital or similar facility; can take anywhere from 8 to 36 hours, sometimes longer; and entail the process of labor, which can involve pain requiring significant medication or anesthesia, and which may be psychologically challenging for some women, especially those ending a pregnancy after learning of a devastating fetal diagnosis, as inductions are often done in the labor and delivery area. In addition, there is an enormous cost difference

between an in-patient procedure requiring up to three days of hospitalization and an out-patient procedure.

15. Further, after 5-10% of inductions, the woman must undergo an additional surgical procedure to remove a retained placenta.[5] In some cases, inductions fail, and a physician must perform a D&E urgently if infection or heavy bleeding occurs. Induction abortion can cause uterine rupture, which is rare but can be life threatening. This is a particular concern for patients who have had multiple previous cesarean deliveries, a common obstetrical history.

16. For these reasons, while a few women, given the option, choose induction, almost all second-trimester patients choose D&E, which accounts for 95% of second-trimester abortions in this country.[6]

17. Physicians start using the D&E method at the beginning of the second trimester, at approximately 14 weeks LMP. At this point, when suction alone is generally no longer sufficient, physicians use additional instruments, most commonly forceps, to perform the abortion safely. As the term D&E indicates, the physician first dilates the cervix to accommodate the instruments, and then evacuates, or empties, the uterus. The cervical preparation or dilation phase entails using medications such as misoprostol, placing osmotic dilators in the woman's cervix to gradually absorb moisture and swell, or a combination of these techniques. In the early part of the second trimester, through approximately 18 weeks, the physician almost always performs the cervical preparation and the evacuation on the same day. Later in the second trimester, depending on the method of cervical preparation, the physician

[5] A.M. Autry et. al, A Comparison of Medical Induction and Dilation and Evacuation for Second Trimester Abortion, 187 Am. J. Obsetetrics & Gynecology 393 (2002).
[6] Am. Coll. of Obstetricians & Gynecologists, Practice Bulletin Number 135: Second Trimester Abortion, 121(6) Obstetrics & Gynecology 1394, 1394, 1406 (2013).

may start the dilation process on the same day as the evacuation, or earlier, such as one day before.

18. In performing the evacuation phase, the physician typically allows the amniotic fluid to flow out, or suctions it out, and then removes the fetal tissue and placenta using surgical instruments, generally forceps. This almost always entails removing the fetus in pieces because the fetus is larger than the cervical opening. The reason that the cervix is not dilated more is that the physician—to maximize safety—aims to dilate the cervix only enough to safely remove the fetus in the manner he or she thinks is best for the patient. The physician then uses suction again to ensure that the uterus is completely empty. The procedure typically takes under 10 minutes.

19. The D&E procedure has a long-established safety record in this country,[7] with major complications occurring in less than 1% of D&Es.[8] This reflects an evolution of techniques in cervical preparation, improved use of antibiotics, use of simultaneous ultrasound guidance to decrease risk of perforation of the bowel or uterus, and better pain management options. All of these mean better outcomes for our patients. The D&E method was also a major innovation in abortion care because it is well-suited to the out-patient, ambulatory setting, which significantly reduces the expense of a second-trimester abortion.

---

[7] *Id.* at 1395.

[8] U.D. Upadhyay et al., Incidence of Emergency Department Visits and Complications After Abortion, 125(1) Obstetrics & Gynecology, 175, 175, 183 (2015) (Fewer than 0.3% of U.S. abortion patients experience a complication that requires hospitalization.).

THE BAN ON D&E

20. H.B. 1032 bans D&Es. The fact that it does not apply if fetal demise has already occurred does not change its impact because physicians simply cannot safely guarantee fetal demise in any given case.

Digoxin

21. Starting in the later part of the second trimester, a minority of physicians attempt to induce fetal demise by injecting a drug called digoxin either transabdominally or transvaginally. They then wait 24 hours for the digoxin to work; for that reason, they generally attempt the injection at the same time that they start an overnight dilation process.

22. As the American Congress of Obstetricians and Gynecologists ("ACOG") concluded: "No evidence currently supports the use of induced fetal demise to increase the safety of second-trimester medical or surgical abortion."[9] This statement is fully consistent with the medical literature, which confirms that it is not safe to mandate that physicians attempt to cause fetal demise prior to evacuating the uterus for every D&E patient.[10]

23. For the most part, physicians who use such injections do so to ensure compliance with the federal "partial-birth abortion" law.[11] Attempting to cause fetal demise, even if it fails, helps ensure compliance with that law because of that law's intent requirements; my understanding is that H.B. 1032 lacks similar intent requirements.

24. The transabdominal injection can be painful and, in my experience, emotionally difficult for a patient. The injections pose risks, including infection, which can threaten the

[9] Am. Coll. of Obstetricians & Gynecologists, *supra* note 6, at 1396, 1406.
[10] *See* J. Diedrich & E. Drey, Induction of Fetal Demise Before Abortion: SFP Guideline 20101, 81 Contraception 462 (2010).
[11] *See id.* at 462, 464-65.

patient's health and future fertility, and accidental absorption of the drug into the patient's circulation, which can result in toxicity and changes in the patient's EKG.

25. Physicians who do these injections generally use an 18- to 22-gauge spinal needle passed, under ultrasound guidance, through the patient's abdomen, vaginal wall or vagina and cervix, into the uterus, and then either into the amniotic fluid or the fetus. Intraamniotic injections are easier but less effective; intrafetal injections are far more difficult but generally more effective.

26. I am not aware of any physician attempting these injections earlier than 18 weeks LMP. Earlier in pregnancy, when the fetus is smaller, injections are more difficult to administer and less likely to be intrafetal, and thus they are less likely to be effective. As far as I know, there are no studies on using digoxin in the first weeks of the second trimester, when most second-trimester abortions occur. Moreover, because a woman has to wait 24 hours after an injection before the evacuation, requiring this injection early in the second trimester—when physicians do not start cervical preparation the day before the evacuation—would necessarily prolong the procedure, adding an additional day and an additional, burdensome trip to the clinic for the patient, with no medical benefit. This is simply unacceptable from a medical standpoint.

27. Second, even later in the second trimester, digoxin can be difficult or simply impossible to administer for certain patients. For example, an injection may be difficult or impossible if the patient is very obese. Similarly, anatomical variations of uterine and vaginal anatomy, such as fibroids, a long cervix, and fetal positioning, can make transvaginal injection very difficult. The digoxin injection could also be very dangerous for patients with certain cardiac conditions, such as arrhythmias.

28. For other patients, physicians can use an injection, but they know that in 5-10% of cases the injection will not cause fetal demise. Although an experienced provider who is able to perform an intrafetal injection may have a low failure rate, the failure rate is higher for intraamniotic injections. Intraamniotic injections are easier to perform, but they take longer to cause demise and are associated with higher complication rates than intrafetal injection.[12] Intrafetal injections are technically more difficult and sometimes impossible to perform even for the most skilled physicians, due to fetal position, uterine anatomy, and other factors, especially when the fetus is smaller in size. It is impossible to know prior to attempting demise whether intrafetal injection will be possible.

29. When digoxin does fail to induce fetal demise in the expected period of time after the first injection, a second injection would be necessary for the physician to try to avoid the criminal penalties of Arkansas's new ban. Performing a second injection and waiting even longer for demise is not acceptable medical practice. Such a practice would add yet another day to the procedure and require the patient to make yet another trip to the clinic. Delaying the abortion further would increase the risk of uterine infection, extramural delivery, or digoxin toxicity. To my knowledge, there is no published information to demonstrate the safety of multiple, sequential doses of digoxin to induce fetal demise.

30. For a short period following enforcement of the federal ban on "partial-birth abortions," Oregon Health & Science University, where I teach and provide care, required digoxin injections prior to D&E procedures beginning at 18 weeks LMP. We did so to comply with the law, but we stopped after a short time—and instead used surgical steps within our D&E procedures to comply with the federal ban—because the injections provided no medical benefit

[12] *See id.* at 466, 468.

to our patients. In my experience, digoxin failed to cause demise between 5 and 10% of the time, which is consistent with the medical literature.

KCl

31. Far less common than injections of digoxin, injections of potassium chloride, or KCl, are an option for only a small number of physicians in hospital settings. Such an injection must be directly into the fetal heart, both to be effective in causing demise and to be safe for the woman. It will cause immediate fetal demise, but it requires an extremely high skill level, typically limited to Maternal-Fetal Medicine sub-specialists after a specialized fellowship with extensive and lengthy advanced training. Inadvertent injection of KCl into the woman's blood stream can put her into cardiac arrest.[13] Like digoxin, it carries risks of infection. Additionally, the magnification required to inject KCl safely requires an advanced ultrasound machine that is typically available only in a hospital setting and would be too expensive for most clinics to afford. For all these reasons, KCl is not an option for the vast majority of abortion providers in a clinic setting. Finally, as with digoxin, there are patients for whom it is not medically appropriate; physicians make case-by-case recommendations by weighing the respective benefits and risks for each individual patient.

Cord Transection

32. Another potential method of attempting to induce demise is umbilical cord transection, in which the physician ruptures the membranes; inserts a suction tube or other instrument, such as forceps, into the uterus; and, if he or she can grasp the cord, divides it with gentle traction, which will cause demise over the course of up to 10 minutes. This significantly

[13] G.A. Coke et al., Maternal Cardiac Arrest Associated with Attempted Fetal Injection of Potassium Chloride, 13 Int'l J. of Obstetrics Anesthesia 287-88 (2004).

lengthens the evacuation procedure. This procedure is not widely practiced or researched, and it cannot be performed on every patient.

33. In some cases, after the physician breaks the amniotic sac, the umbilical cord is near the cervix and can be easily grasped. In other cases, the fetus blocks access to the cord and it would be very difficult and thus risky to attempt to reach it.

34. Attempting to grasp the cord by maneuvering the instruments around the fetus with multiple passes of instruments into the uterus and then, even if successful, waiting for demise to occur, increases the duration and the risk of the procedure. Increasing the duration of the procedure prolongs the patient's bleeding, which can be heavy, and her exposure to anesthesia. Grasping for the cord repeatedly when it is not accessible increases the risk of uterine perforation and cervical injury.

35. Further, physicians will know, every time they try to locate and grasp the cord, that they may very well grasp fetal tissue instead of or in addition to cord, particularly since it is difficult if not impossible to distinguish between the fetal tissue and the very small cord once the amniotic fluid has drained out. Thus, in reaching for the cord in any given patient, the physician knows he or she may be unable to avoid the banned "dismemberment" conduct. Hence, while attempting to cut the cord may help ensure compliance with the federal ban, it would not allow a physician to continue to provide D&Es under Arkansas's ban.

Banning D&E Will Harm Women's Health

36. Making fetal demise a precondition of D&Es results in banning D&E. The most prevalent method of attempting to cause fetal demise is virtually unstudied for patients before 18 weeks LMP, and physicians cannot rely on it to cause fetal demise even at later points in

pregnancy. Thus, a physician cannot know ahead of time that it will be possible to cause fetal demise before any given D&E.

37. Physicians must, and are ethically obligated to, respond to each clinical situation they face based on what is in the best interests of the patient, given that patient's individual circumstances. Making fetal demise a precondition of D&Es bars a physician from fulfilling that obligation to provide care based on each patient's needs.

38. It is my opinion that H.B. 1032 will harm patients by banning D&Es, thus forcing a woman either to remain pregnant against her will, or to undergo an induction abortion. Induction abortions, as described above, are not widely available, take far longer to complete than D&E, are far more expensive, and, when they fail, must be completed with D&E procedures.

THE EFFECT OF BANNING EARLY MEDICATION ABORTION

39. I understand that two of the other challenged laws seem to act as effective bans on early medication abortions because they require tissue collection.

40. Banning this method of early abortion would be a real burden for patients. This method gives a woman the option of ending her pregnancy without the insertion of instruments into her body, and to pass the products of conception at home, in a process largely indistinguishable from an early miscarriage. The method is fundamentally different from suction abortion, and it should be available when a woman decides to end an early pregnancy.

41. In addition, for some patients, medication abortion, rather than suction abortion, is medically indicated by certain uterine anomalies such as a bicornuate uterus or uterine fibroids, or by high body mass. For these patients, taking away the option of early medication abortion would cause clear medical harm.

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

Executed on this 8th day of June, 2017.

Mark D. Nichols, M.D.

EXHIBIT A

1

CURRICULUM VITAE
OREGON HEALTH & SCIENCE UNIVERSITY

NAME	Mark D. Nichols, MD	DATE	June 19, 2017
Academic Rank:	Professor		
Department/Division:	Obstetrics and Gynecology		
Professional Address:	3181 SW Sam Jackson Park Road - UHN 50		

I. EDUCATION

Undergraduate and Graduate (Include Year, Degree, and Institution):

1975 Bachelor of Science in Biological Sciences, University of California, Davis

Postgraduate (Include Year, Degree, and Institution):

1979 Doctor of Medicine, University of California, Davis
1979-1983 Internship and Residency
Department of Obstetrics and Gynecology
Oregon Health Sciences University
1990 Research Fellow
Margaret Pyke Center, Middlesex Hospital
University College, London, England
(January - July)
July, 1996 Advanced Cardiac Life Support Provider Course
American Heart Association
Portland OR (Recertified in biannually, last in April, 2016)

Certification (Include Board, Number, Date, and Recertification):

American Board of Obstetrics and Gynecology, December 1985
Elected Fellow American College of Obstetrics and Gynecology, September 1986

Licenses (Include State, Date, Status, Number, and Renewal Date):

April 11, 1981 State of Oregon, License No. 12638, biannually renewed,
Sept. 2010 Zambia, Temporary Medical License

II. PROFESSIONAL EXPERIENCE

Academic (Include Year, Position, and Institution):

1983 - 1993 Assistant Professor, Oregon Health Sciences University
1993 - 2003 Associate Professor, Oregon Health & Science University
2003 – present Professor, Oregon Health & Science University

Administrative (Include Year, Position, and Institution):

1983 - 1995 Assistant Director, Residency Training Program, Oregon Health Sciences University, Department of Obstetrics and Gynecology
1988 - 2013 Chief, Division of General Gynecology and Obstetrics, Department of Obstetrics and Gynecology, Oregon Health & Science University, Portland OR
2001 - 2010 Director, Family Planning Fellowship, Oregon Health & Science University, Portland OR
2010 - 2013 Co- Director, Family Planning Fellowship, Oregon Health & Science University, Portland OR
2013 – present Director Emeritus, Family Planning Fellowship, Oregon Health & Science University, Portland OR

Other (Include Year, Position, and Institution):

1994	Interim Medical Director, Planned Parenthood Columbia Willamette Affiliate
1994 - 2011	Medical Director, Planned Parenthood Columbia Willamette Affiliate
2011 - 2013	Co-Medical Director, Planned Parenthood Columbia Willamette Affiliate
1997 - 2001	Family Planning Consultant, Oregon Health Division

International Work

2010	Consultant, Population Services International, Zambia
2010	Member, Surgical Team mission to Gimbie Hospital, Ethiopia
2012	Consultant, Population Services International, Nigeria
2014	Consultant, Population Services International, Tanzania
2014	Visiting Professor, Mekelle University, Ethiopia
2015	Obstetrician, Medecins Sans Frontieres, South Sudan
2015	Consultant, Laos Nutrition Institute, Vientiane, Laos
2016	Visiting Professor, Mekelle University, Ethiopia

III. SCHOLARSHIP

Area(s) of Research/Scholarly Interest:

Family planning with particular interest in surgical and medical abortion, emergency contraception, hormonal contraception, and training fellows, residents and medical students in family planning.

Grants and Contracts:

1. R W Johnson Pharmaceutical, "A Double Blind Placebo Controlled Safety and Efficacy Study of Antocin™ for the Prolongation of Gestation," November 1994 - July 1997, $138,654. PI: Jeff Jensen, MD, Sub PI: Mark Nichols, MD

2. The Population Council, Inc., RU-486, "Evaluation of the Efficacy, Safety and Acceptability of Mifepristone and Misoprostol in Inducing Abortion in Pregnant Women with Amenorrhea of up to 63 Days," November 1994 - December 1995 - $209,800. PI: Mark Nichols, MD

3. Wyeth-Ayerst Laboratories and University Hospital Consortium, "Norplant Observational Cohort," June 1995 - June 2003, $275,000. PI: Mark Nichols, MD

4. Wyeth-Ayerst Laboratories, "A Multi center, Open-Label, Randomized, Comparative Study to Evaluate the Effects of Alesse™ and Loestrin FE 1/20® on Clinical and Biomedical Measures of Androgenicity," November 1996 - June 1997, $16,920. PI: Mark Nichols, MD

5. Parke-Davis, "A Randomized, Double Blind, Active-Controlled, Parallel Group, Multi-center Study Assessing Menstrual Cycle Control and Ovulation Suppression Associated with Vaginal Administration of Five Dose Combinations of Norethindrone Acetate and Ethinyl Estradiol," December 1996 - March 1997, $86,689. PI: Leon Speroff, MD, Sub PI: Mark Nichols, MD

6. Pharmacia & Upjohn, "Cyclo Provera™ Contraceptive Injection: A Comparative Study of Safety, Patient Acceptability and Efficacy to Ortho-Novum® 7/7/7, 28 Tablets," June 1997 - June 1999, $92,556. PI: Mark Nichols

7. Organon, "An Open Label, Multi center, Randomized, Comparative Safety, Efficacy, Cycle Control, and Quality of Life Study of CTR 25, Alesse™, and Ortho Tri-Cyclen®," April 1998 - July 1999, $76,310. PI: Kenneth Burry, MD, Sub PI: Mark Nichols, MD

8. John Hopkins University, "Comparing Acceptability of Manual vs Electrical Vacuum Aspiration for First Trimester Induced Abortion," $37,310. June 2000 – July 2001. PI: Mark Nichols, MD

9. Pharmacia Co. "Phase III Study of DMPA Injection (DMPA-SC) in Women with Endometriosis in the US and Canada" $42,480. January 2000 - January 2001. PI: Mark Nichols

10. Galen Holdings "A Multi-center, Randomized Controlled Double-Blind Study to Determine Efficacy in the Relief of Hot Flushes in Women Receiving Oral Estradiol" $23,527. Sept. 2001 – Aug. 2002. PI: Leon Speroff, MD, Sub-PI: Mark Nichols, MD

11. Organon-Thebes "A Multinational, Multi-center, Randomized Controlled Trial, to Assess the Endometrial Histological Profile Following Treatment with Tibolone (ORG 0D14) Versus Conjugated Estrogen (CE) Plus Medroxyprogesterone Acetate (MPA) in Postmenopausal Women" $138,000. PI: Jeffrey Jensen, MD, Sub PI: Mark Nichols, MD

12. Pfizer Care "A Randomized, Double Blind, Multi-Center, 24 Week Study to Assess Cumulative Amenorrhea in Postmenopausal Women Taking Femhrt® and Prempro®". $37,275. PI: Leon Speroff, MD, Sub-PI: Mark Nichols, MD

13. Buffett Foundation Grant. "Intrauterine Lidocaine Infusion for Pain Management in First Trimester Abortions" $48,000. June 2002 – June 2003 PI: Alison Edelman, MD Sub PI: Mark Nichols, MD

14. Buffett Foundation Grant. "Continuous Oral Contraceptive Pills: Are Bleeding Patterns Dependent on the Hormone Chosen?" $51,000. PI: Alison Edelman, MD Sub PI: Mark Nichols, MD

Publications/Creative Work:

Peer-reviewed

1. Nichols, M. Diagnosing Breast Disease, *West. J. Med.*, 148:324, 1988.

2. Novy MJ, Haymond J, Nichols M. Shirodkar Cerclage in a Multifactorial Approach to the Patient with Advanced Cervical Changes, *AJOG*, 162:1412-20, 1990.

3. Nichols MD. Review of Vulvar Ulcers, *Postgraduate Obstet. Gynecol.*, 11(No. 7):1991.

4. Nichols M, Robinson GER, Bounds W, Johnson J, Upward E, Newman B, Guillebaud J. Effect of Four Combined Oral Contraceptives on Blood Pressure in the Pill-Free Interval, *Contraception*, 47:367-76, 1993.

5. Thurmond A, Weinstein A, Jones M, Jensen J, Nichols M. Localization of Contraceptive Implant Capsules for Removal, *Radiology*, 193:580-581, 1994.

6. Carp H, Jayaram A, Vadhera R, Nichols M, Morton M. Epidural Anesthesia for Cesarean Delivery and Vaginal Birth After Maternal Fontan Repair: Report of Two Cases, *Anesth Analg*, 78:1190-2, 1994.

7. Nichols M. Curriculum Change in an OB/GYN Residency Program and It's Impact on Pregnancy in Residency, *AJOG*, 170:1658-65, 1994.

8. Winikoff B, Ellertson C, Elul B, Sivin I; for the Mifepristone Clinical Trials Group. Acceptability and Feasibility of Early Pregnancy Termination by Mifepristone-Misoprostol. Results of Large Multi center Trial in the United States, *Arch Fam Med*, 7:360-6, 1998. (Member of the Mifepristone Clinical Trials Group)

9. Spitz IM, Bardin CW, Benton L, Robbins A. Early Pregnancy Termination with Mifepristone and Misoprostol in the United States, *New Eng J Med*, 338:1241-7, 1998. (Cited as Principal Investigator)

10. Jensen JT, Astley SJ, Morgan E, Nichols MD. Outcomes of Suction Curettage and Mifepristone Abortion in the United States, *Contraception*, 59(3):153-9, 1999.

11. Kaunitz AM, Garceau RJ, Cormie MA, Lunelle Study Group (Member). Comparative Safety, Efficacy and Cycle Control of LUNELLE Monthly Contraceptive Injection (Medroxyprogesterone Acetate and Estradiol Cypionate Injectable Suspension) and Ortho-Novum 7/7/7 Oral Contraceptive (Norethindrone/Ethinyl Estradiol Triphasic), *Contraception*, 60:179-187, 1999.

12. Thorneycroft IH, Stanczyk FZ, Bradshaw KD, Ballagh SA, Nichols m, Weber ME. Effect of Low-dose Oral Contraceptives on Androgenic Markers and Acne, *Contraception*, 60:255-62, 1999.

13. Paul M, Schaff E, Nichols M. The Roles of Clinical Assessment, Human Chorionic Gonadotropin Assays, and Ultrasonography in Medical Abortion Practice, *Am J Obstet Gynecol,* 183(2):S34-S43, 2000.

14. Borgatta L, Burnhill M, Haskell S, Nichols M, Leonhardt K. Instituting Medical Abortion Services: Changes in Outcome and Acceptability Related to Provider Experience, *JAMWA*, 55:173-6, 2000.

15. Westhoff C, Dasmahapatra R, Winikoff B, Clarke S, and the Mifepristone Clinical Trials Group. Predictors of analgesia use during supervised medical abortion. *Contraception* 2000;61:225-229 (Member of the Mifepristone Clinical Trials Group)

16. Bird ST, Harvery SM, Nichols M. Comparing the Acceptability of Manual Vacuum Aspiration and Electric Vacuum Aspiration as Methods of Early Abortion. *JAMWA* 56: 124-126;2001

17. Edelman AT, Nichols MD, Jensen J. Comparison of pain and time of procedures with two first-trimester abortion techniques performed by residents and faculty *Am J Obstet Gynecol* 184:1564-7;2001

18. Nichols M, Edelman A. RU 486 for Primary Care Providers. *Primary Care Reports* , 7:89-95;2001

19. Phair N, Jensen J, Nichols M. Paracervical block and elective abortion: The effect of waiting between injection and procedure pain. *Am J. Obstet. Gynecol.* 186:1304-7;2002

20. Nichols M, Morgan E, Jensen J. Comparing bimanual pelvic examination to ultrasound measurements for the assessment of gestational age in the first trimester of pregnancy. *Journal Repro Med* 50:825-8;2002

21. Kwiecien M, Edelman A, Nichols MD, Jensen JT. Bleeding patterns and patient acceptability of standard or continuous dosing regimens of a low dose oral contraceptive: a randomized trial. *Contraception* 67:9-13;2003

22. Edelman A, Jensen J, Nelson E, and Nichols M. Cannula fracture in first trimester abortion: a case report and survey of National Abortion Federation providers. *Contraception* 67:49-51;2003

23. Bird ST, Harvey SM, Beckman LJ, Nichols MD, Rogers K, and Blumenthal PD. Similarities in Women's Perceptions and Acceptability of Manual Vacuum Aspiration and Electric Vacuum Aspiration for First Trimester

Abortion. *Contraception* 67:207-212;2003.

24. Picardo CM, Nichols MD, Edelman AE, Jensen JT. Attitudes and information sources of the risks and benefits of oral contraception. *JAMWA* 58:112-116;2003

25. Edelman A.B., Jensen J.T., Lee D.M., Nichols M.D. Successful medical abortion of a pregnancy within a non-communicating rudimentary uterine horn. *AJOG* 189:886-7;2003

26. Emmons S, Adams KE, Cain JM, Nichols M. The impact of perceived gender bias on obstetric and gynecology skills acquisition by third year medical students. *Academic Medicine*, 79:1-7;2004

27. Edelman A, Nichols M, Leclair C, Astley S, Shy K, and Jensen JT. Intrauterine Lidocaine Infusion for Pain Management in First-Trimester Abortions *Obstet. Gynecol.* 103:1267-127;2004

28. Smits AK, Clark EC, Nichols MD, Saultz JW. Factors Influencing Cessation of Maternity Care in Oregon. *Family Medicine* 36:87-92;2004

29. Rodriguez M, Nichols M Adventitious Bursitis: An Unusual Cause of a Vulvar Mass. Accepted for publication in *Journal of Reproductive Medicine*

30. Cwiak CA, Edelman AB, Hatcher RA, Zieman M, Nichols MD, Jensen JT, Emmons SL, and Khan IM. Teaching contraception: An interactive presentation using *Managing Contraception. AJOG* 191:1788-92;2004

31. Harvey S M, Nichols MD. Development and Evaluation of the Abortion Attributes Questionnaire. *Journal of Social Issues*. 61:95-107;2005

32. Edelman A.B., Jensen J.T., Lee D.M., Nichols M.D., Buckmaster J, Goetsch, M. Cervical preparation using laminaria with adjunctive buccal misoprostol prior to second trimester dilation and evacuation procedures: a randomized clinical trial, *AJOG* 194:425-30;2006

33. Emmons SL. Adams KE. Nichols M. Cain J. The impact of perceived gender bias on obstetrics and gynecology skills acquisition by third-year medical students. *Academic Medicine* 79:326-32;2004

34. Emmons SL. Nichols M. Schulkin J. James KE. Cain JM. The influence of physician gender on practice satisfaction among obstetrician gynecologists. *American Journal of Obstetrics & Gynecology.* 194:1728-38; 2006

35. Edelman AB. Gallo MF. Jensen JT. Nichols MD. Schulz KF. Grimes DA. Continuous or extended cycle vs. cyclic use of combined oral contraceptives for contraception. *Cochrane Database of Systematic Reviews. (3):CD004695, 2005.*

36. Edelman A.B., Jensen J.T., Nichols M.D. Continuous Oral Contraceptives: Are Bleeding Patterns Dependent on the Hormones Given? *Obsterics & Gynecology* 107:657-65, 2006

37. Edelman, Alison MD, MPH; Nichols, Mark D. MD; Leclair, Catherine MD; Jensen, Jeffrey T. MD, MPH. Four Percent Intrauterine Lidocaine Infusion for Pain Management in First-Trimester Abortions. *Obstetrics & Gynecology* 107:269-275;2006.

38. Edelman A, M.F. Gallo MF, Nichols MD, Jensen JT, Schulz K, and Grimes DA. Continuous versus cyclic use of combined oral contraceptives for contraception: systematic Cochrane review of randomized controlled trials. *Hum. Reprod.* 2006 21: 573-578.

39. Nichols M, Carter J, and Fylstra D. A comparative study of hysteroscopic sterilization performed in-office versus a hospital operating room. *Journal of Minimally Invasive Gynecology* 13:447-50, 2006.

40. Edelman A, Lew R, Cwiak C, Nichols M, Jensen J. Acceptability of contraceptive-induced amenorrhea in an racially diverse group of U.S. women. Contraception 2007;75:450-453.

41. Kaskowitz A., Carlson N., Nichols M., Edelman A., Jensen J. Online Availability of Hormonal Contraceptives Without a Health Care Examination: Effect of Knowledge and Health Care Screening. *Contraception.* 76:273-7;2007

42. Munks EB, Edelman AB, Jensen JT, Nichols MD, Burry K and Patton P. IVF Patients' Attitudes Toward Multifetal Pregnancy Reduction. *Journal of Repro Med* 52:635;2007

43. Bednarek PH, Nichols MD, Carlson N, Edelman AB, Creinin MD, Truitt S, Jensen JT. Effect of "Observed Start" versus traditional "Sunday Start" on hormonal contraceptive continuation rates after medical abortion. *Contraception* 78:26-30,2008

44. Kaneshiro B, Jensen JT, Carlson N, Nichols M, 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* 77(4):234-8, 2008 Apr

45. Singh RH, Ghanem KG, Burke AE, Nichols MD, Rogers K, Blumenthal PD. Predictors and perception of pain in women undergoing first trimester surgical abortion. *Contraception* 78(2):155-161;2008

46. Michelle M. Isley, Alison Edelman, Bliss Kaneshiro, Dawn Peters, Mark D. Nichols, and Jeffrey T. Jensen. Sex education and contraceptive use at coital debut in the U.S.: Results from cycle 6 of the National Survey of Family Growth. Accepted in *JAMA*

47. Kaneshiro B. Jensen JT. Carlson NE. Harvey SM. Nichols MD. Edelman AB. Body mass index and sexual behavior.*Obstetrics & Gynecology.* 112(3):586-92, 2008 Sep.

48. Stanek AM, Bednarek PH, Nichols MD, Jensen JT, Edelman AB. Barriers associated with the failure to return for intrauterine device insertion following first-trimester abortion. *Contraception.* 79:216-20, 2009

49. Kraemer DF, Yend, P, Nichols, M. An economic comparison of female sterilization of hysteroscopic tubal occlusion with laparoscopic bilateral tubal ligation. *Contraception* 80: 254–260, 2009

50. Renner RM. Jensen JT. Nichols MD. Edelman A. Pain control in first trimester surgical abortion.*Cochrane Database of Systematic Reviews.* (2):CD006712, 2009.

51. Kaneshiro B, Jensen JT, Carlson N, Nichols M, Edelman A. Treatment of Unscheduled Bleeding in Continuous Oral Contraceptive Users With Doxycycline: A Randomized Controlled Trial. *Obstet Gynecol.* 115(6):1141-9, 2010 Jun

52. Renner RM. Jensen JT. Nichols MD. Edelman AB Pain control in first-trimester surgical abortion: a systematic review of randomized controlled trials. *Contraception.* 81(5):372-88, 2010 May.

53. Isley M, Edelman A,. Kaneshiro B,. Peters,D. Nichols, M, Jensen, JT. Sex education and contraceptive use at coital debut in the United States: results from Cycle 6 of the National Survey of Family Growth. *Contraception.* 82(3):236-42, 2010 Sep

54. Kaneshiro B, **Bednarek P,** Isley M, **Jensen J, Nichols M, Edelman A**. Blood loss at the time of first-trimester surgical abortion in anticoagulated women. Contraception 2011; 83:431-435.

55. Renner RM, **Nichols M, Jensen JT,** Hong L**, Edelman AB**. Paracervical block for pain control in first-trimester surgical abortion: a randomized controlled trial. Obstet Gynecol 2012; 119: 1030-1037.

56. Kaneshiro B**, Edelman AB,** Carlson N**, Nichols M, Jensen JT**. A randomized controlled trial of subantimicrobial doxycycline to prevent unscheduled bleeding with continuous oral contraceptive pill use. Contraception.2012; 85: 351-358.

57. Isley MM, **Jensen JT, Nichols MD,** Lehman A**, Bednarek P, Edelman A**. Intrauterine lidocaine infusion for pain management during outpatient transcervical tubal sterilization: a randomized controlled trial. Contraception 2012; 85: 275-281.

58. Kaneshiro B, **Edelman A,** Carlson N**, Nichols M, Jensen J**. Unscheduled bleeding with continuous oral contraceptive pills: a comparison of progestin dose. *Contraception accepted 2011, available epub*

59. Bayer LL; Jensen JT; Li H; **Nichols MD**; Bednarek PH.Adolescent experience with intrauterine device insertion and use: a retrospective cohort study. *Contraception. 86(5):443-51, 2012 Nov.*

60. Micks EA; Edelman AB; Renner RM; Fu R; Lambert WE; Bednarek PH; **Nichols MD**; Beckley EH; Jensen JT. *Obstetrics & Gynecology. 120(5):1060-9, 2012 Nov.*

61. Goldthwaite LM; Baldwin MK; Page J; Micks EA; **Nichols MD**; Edelman AB; Bednarek PH.Comparison of interventions for pain control with tenaculum placement: a randomized clinical trial. *Contraception. 89(3):229-33, 2014 Mar.*

62. Krashin JW; Edelman AB; **Nichols MD**; Allen AJ; Caughey AB; Rodriguez MI. *American Journal of Obstetrics & Gynecology. 211(1):76.e1-76.e10, 2014 Jul.*

63. Bayer LL; Edelman AB; Fu R; Lambert WE; **Nichols MD**; Bednarek PH; Miller K; Jensen JT. An Evaluation of Oral Midazolam for Anxiety and Pain in First-Trimester Surgical Abortion: A Randomized Controlled Trial.*Obstetrics & Gynecology. 126(1):37-46, 2015 Jul.*

64. Patil, Eva; Darney, Blair; Orme-Evans, Kaebah; Beckley, Ethan H; Bergander, Linn; **Nichols, Mark**; Bednarek, Paula H. Aspiration Abortion With Immediate Intrauterine Device Insertion: Comparing Outcomes of Advanced Practice Clinicians and Physicians. *J Midwifery Womens Health. 61(3):325-30, 2016 May.*

65. Baldwin MK; Edelman AB; Lim JY; **Nichols MD**; Bednarek PH; Jensen JT. Intrauterine device placement at 3 versus 6 weeks postpartum: a randomized trial. *Contraception. 93(4):356-63, 2016 Apr.*

Non-peer-reviewed

1. Nichols MD. Formal Discussant. An Obstetric and Gynecologic Clerkship's Influence on a Medical Community, *Am J Obstet Gynecol*, 176:1363-8, 1997.

2. Nichols, MD. Formal Discussant. Real-time Ultrasonographically Guided Removal of Nonpalpable and Intramuscular Norplant Capsules, *Am J Obstet Gynecol*, 178:1185-93, 1998.

3. Nichols, MD. Formal Discussant. Cytologic evaluation of non-bloody breast cyst fluid. *Am J Obstet Gynecol, Am J Obstet Gynecol*, 182:1300-5, 2000

4. Nichols, MD. Letter to the Editor, "Fewer Abortions would be needed". *Oregonian*, June 15, 2001

5. Nichols, MD. Methotrexate for management of a pregnancy in a non-communicating uterine horn. Letter to the editor. *Journal Repro Med* 50:878-9;2002

6. Nichols, MD. Clinical Trials Report, *Current Women's Health Reports*, 2:407-408;2002

7. Reeves MF; Blumenthal PD; Jones RK; **Nichols MD**; Saporta VA. New research at the 2014 National Abortion Federation Annual Meeting: continuously improving abortion care. *Contraception. 89(5):339-40, 2014 May.*

8. Reeves MF; Blumenthal PD; Jones RK; **Nichols MD**; Saporta VA. New research at the 2015 National Abortion Federation Annual Meeting: putting research into practice.*Contraception. 91(5):359, 2015 May.*

Publications (submitted)

Chapters

1. Nichols M. "Faculty Ownership". In: *Teaching and Evaluating Clinical Skills*, 1995, APGO.

2. Nichols M, Halvorson-Boyd G, Goldstein R, Gevirtz D and Healow D. "Pain Management" in *Management of Unintended and Abnormal Pregnancy.* Wiley –Blackwell, 2009

Abstracts

1. Thulin PC, Carter JH, Nichols MD, Kurth M, Nutt JG. Menstrual-cycle Related Changes in Parkinson's Disease, *Neurology*, 46:A376, 1996.

2. Fossum GT, Thomas M, Wise R, Nichols M, Sinofsky F, Pasquale S. Preliminary Evaluation of a New Instrument Design for the Removal of Norplant Capsules.

3. Bird ST, Harvey SM, Nichols MD. Women's Acceptability of Manual Vacuum Aspiration (MVA: An Exploratory Study of Abortion Patients in Portland, Oregon.

4. Romm J, Nichols M. The Men's Group: Discussion Group for Male OB/GYN Residents, International Society of Psychosomatic Obstetrics and Gynecology, June 1998, Washington DC.

5. Stanczyk FZ, Bradshaw KD, Ballagh BA, Nichols MD, Thorneycroft, LH. Effect of Oral Contraceptive Progestins on Production of Ovarian, Adrenal and Peripheral Androgens, European Society of Contraception, June 1998, Prague.

6. Sheryl Thornbird PhD, Marie Harvey DrPH, Linda Beckman,PhD, Mark Nichols, MD, Paul Blumenthal. MD. Men's involvement in abortion: Perceptions of women having abortions in three U.S. cities Population, Family Planning, and Reproductive Health section of the 130th Annual APHA Meeting, Philadelphia, PA November, 2002.

7. Singh RH, Nichols MD, Rogers K, Ghanem KG, & Blumenthal Pd. Subjective predictors of pain in women

undergoing electrical vacuum aspiration (eva) versus manual vacuum aspiration (mva) for first trimester abortion. Assoc. of Reproductive Health Professionals Annual meeting, Tampa FL, Sept. 2005

8. Edelman A, Nichols M, Leclair C, & Jensen JT. 4% intrauterine lidocaine infusion for pain management in first trimester abortions. Assoc. of Reproductive Health Professionals Annual meeting, Tampa FL, Sept. 2005.

9. Drath E, Nichols M, & Edelman A. Ultrasound, Twin Gestation, and Abortion Decision Making: Patients and Providers. NASPOG Annual Scientific Meeting, February, 2006, Hawaii

10. Bednarek P, Nichols M, Edelman A, Jensen JT, Truitt S, Creinin MD. Effect of observed start compared with Sunday start on contraceptive continuation after medical abortion. *Obstet Gynecol* 2007, supp 57S.

Audio Presentations

1. "RU-486," Audio-Digest Obstetrics and Gynecology, Vol. 41, No. 8, April 19, 1994

2. "Family Planning/STD Case Consultation," Center for Health Training, June 7, 1999

3. "Legal and Medical Implications of the Federal Abortion Ban" Podcast from Lewis & Clark Law School, Portland, OR Jan. 2006

Posters

1. Nichols MD, Kirk EP. Resident Retreat: A Stress Reducer and Morale Booster, CREOG and APGO Meeting, March 1991, Orlando, FL

2. Thomas L, Nichols MD. Ultrasound Evaluation of the Post Mifepristone Abortion Patient, Pacific Coast Obstetrical and Gynecological Society, Sunriver OR, 1996

3. Edelman A, Nichols MD. Comparison of Resident and Faculty Performed Abortions using Two Different Abortion Techniques, District VIII Meeting, American College of Obstetricians and Gynecologists, Anchorage AK, August 2000

4. Edelman A, Nichols MD. Comparison of Resident and Faculty Performed Abortions using Two Different Abortion Techniques, District VIII Meeting, American College of Obstetricians and Gynecologists, Anchorage AK, August 2000.

5. Phair N, Jensen J, Nichols M. Paracervical block and elective abortion: The effect of waiting between injection and procedure pain, PCOGS Annual meeting, Ashland OR, October, 2001. Received award as best poster of the meeting.

6. Lew R, Edelman A, Cwiak C, Jensen J, Nichols M. Acceptability of Contraceptive-Induced Amenorrhea in American Women, ACOG Annual Clinical Meeting, San Francisco, May 2005.

7. Koontz, Edelman A, Jensen J, Nichols M. Continuous Oral Contraceptives: Are Bleeding Patterns Dependent on the Hormones Given? ACOG Annual Clinical Meeting, San Francisco, May 2005.

8. Paula Bednarek, MD, Mark Nichols, MD, Alison Edelman, MD, MPH, Jeffrey T. Jensen, MD, MPH, Sarah Truitt, MD, Mitchell D. Creinin, MD. Effect of "Observed Start" versus "Sunday Start" on hormonal contraception continuation after medical abortion. ACOG Annual Clinical Meeting, SanDiego, May 2007

Invited Lectures, Conference Presentations or Professorships (since promotion to Associate Professor):

Local (Selected)

1. "IUD Review," Grand Rounds, Kaiser Sunnyside Hospital, Department of Obstetrics and Gynecology, January 1993.
2. "Breast Disease for the Gynecologist," Langley Memorial Lectures, Portland OR, February 1993.
3. "Second Trimester Abortion Technique," Grand Rounds, Bess Kaiser Hospital, Obstetrics and Gynecology Department, April 1993.
4. "RU-486," City Club of Portland, July 1994.
5. "Circumcision Review," Grand Rounds, OHSU, Department of Obstetrics and Gynecology, June 1995.
6. "Abortion" and "Breast Disease," OHSU, Nursing School Advanced Gynecology Course, October 1995.
7. "Emergency Management of Vaginal Bleeding," St. Vincent Hospital, January 1996.
8. "Trauma in Pregnancy," OHSU, Emergency Medicine Residents, September 1996.
9. "Contraception Review," OHSU, Internal Medicine Residents, January 1997.
10. "Management of Miscarriages," OHSU, Student Health Service, January 1997.
11. "Contraception and World Population," Portland State University Population Control Class, January 1997.
12. "Emergency contraception: Coca-Cola to Mifepristone," Grand Rounds, OHSU, Department of Obstetrics and Gynecology, April 1997.
13. "First Trimester Bleeding," OHSU, Emergency Medicine Residents, June 1997.
14. "Approach to Dysfunctional Uterine Bleeding," Grand Rounds, OHSU, Internal Medicine Department, March 1998.
15. "Medical Abortion Review," Kaiser Grand Rounds, Clackamas OR, December 1998.
16. "Update on Emergency Contraception and Medical Abortion," Grand Rounds, OHSU, Department of Obstetrics and Gynecology, January 1999.
17. "Emergency Contraception," OHSU, School of Nursing, Graduate Program, January 1999.
18. "Emergency Contraception," Planned Parenthood, Columbia/Willamette Affiliate, Portland OR, March 1999.
19. "Emergency Contraception," Mt. Hood Medical Center, OB/GYN and Pediatrics Department Meeting, June 1999.
20. "Abnormal Uterine Bleeding," Grand Rounds, OHSU, Department of Obstetrics and Gynecology, July 1999.
21. "Medical Abortion Review," St. Vincent Medical Center Ob/Gyn Dept., Portland OR, October 1999.

22. Norplant/IUD Training, Clinicians from Lane, Linn, Josephine, Tillamook, Marion, Coos, Polk, Lincoln, Malheur, Douglas, Washington, Multnomah and Klamath Counties and Planned Parenthood, Portland OR, November 1999.

23. "Review of Emergency Contraception," Tuality Hospital, Hillsboro OR, March 2000.

24. "Wedge Issues of Choice," NARAL Leadership Training, Unitarian Church, Portland OR, April 2000.

25. "Emergency Contraception" Emanuel Hospital, Ob/Gyn Department, June 2000

26. "Emergency Contraception" Center for Women's Health, OHSU, September 2000

27. "Mifepristone: FDA Approval and Review," OHSU, Grand Rounds, Department of Obstetrics and Gynecology, October 2000.

28. "RU486," OB/GYN Department Educational Conference, Providence St. Vincent Medical Center, Portland OR, March 2001.

29. "Review of Emergency Contraception". Pediatric Department, Emanuel Hospital, Portland, OR, February, 2002

30. "Contraceptive Update: What's New?" OHSU, Grand Rounds, Department of Obstetrics and Gynecology, March 2002.

31. "Women seeking abortion care. Are they discriminated against?" Reed College VOX course, Portland, OR, March, 2002.

32. "Update in Contraception" Lorenzen Women's Physician Forum, Portland, OR, November 2002

33. "Update in Contraception" Grand Rounds, Good Samaritan Hospital, Portland, OR, February 2003

34. "Becoming an abortion provider" Reed Vox seminar, Reed College, Portland, OR, April, 2003

35. "Planned Parenthood Update" SW Washington Medical Center, Ob/Gyn Department Grand Rounds, Vancouver, WA, June, 2003

36. "Update on Contraception", Student Health Center, OHSU, November 2003

37. "IUD Review", Legacy Hospital CNM Department, Portland, OR February 2004

38. "Oral Contraceptive Update", St. Vincent Medical Center, Resident teaching conference, Portland, OR, March 2004

39. "Essure device for female sterilization", SW Washington Med. Center, Ob/Gyn dept. Grand Rounds, Vancouver, WA, Jan. 2005

40. "Transcervical Female Sterilization", East Portland Rotary Club, Portland, OR Jan. 2005

41. "Legal and Medical Implications of the Federal Abortion Ban" Lewis & Clark Law School, Portland, OR Jan. 2006

42. "Pain Management of Gyncologic Procedures" Grand Rounds, OHSU Ob/Gyn department, Portland, OR Oct.

12

2008

43. "Management of Breech Presentation" Grand Rounds, OHSU Ob/Gyn department, Portland, OR Sept 2009

44. "Alternatives to Hysterectomy" Brown Bag Lecture, OHSU, Portland, OR October 2009

45. "Pain management for gynecologic procedures", Grand Rounds Dept of Anesthesiology, OHSU, September 2010.

Regional

1. "Norplant Review and Insertion Training," Washington Academy of Family Practice Review Course, Spokane WA, April 1993.

2. "Gynecology for the Primary Care Provider: Preventive Health Care," Primary Care Conference, Sunriver OR, June 1993.

3. "Contraception for Patients with Chronic Health Problems," Nurse Practitioners of Oregon, September 1995.

4. "RU-486 Review," Ashbury Memorial Lectureship, Guest Speaker, Corvallis OR, November 1995.

5. "Common Gynecologic Problems and the Internist," 3rd Annual Internal Medicine Review Course, April 1996.

6. "Contraceptive Update," Family Planning Conference, Eugene OR, September 1996.

7. "Gynecological Procedures," 28th Annual Family Practice Review, Portland OR, February 1997.

8. "Contraception," 28th Annual Family Practice Review, Portland OR, February 1997.

9. "Family Planning," Reproductive Health Conference 1997, Portland OR, March 1997.

10. "Elective Abortions: RU-486 and Methotrexate," Reproductive Health Conference, Portland OR, March 1997.

11. "Medical Abortion," 5th Annual Oregon Section ACOG Update in Obstetrics, Gynecology, and Primary Care, Bend OR, April 1997.

12. "Hormonal Contraception for Females: Recommendations and Guidelines," Endocrine Conference, Ashland OR, August 1997.

13. "Emergency Contraception: From Coca-Cola to Mifepristone," 21st Annual Pacific NW Review of OB-GYN, Portland OR, October 1997.

14. "Office Gynecology," 29th Annual Family Practice Review, Portland OR, February 1998.

15. "IUD Insertion Technique," Roseburg OR, March 1998.

16. "Office Gynecology," 5th Annual Internal Medicine Review, Portland, April 1998.

17. "Contraceptive Overview," Planned Parenthood, Eugene OR, November 1998.

18. "Emergency Contraception," 30th Annual Family Practice Review, Portland OR, February 1999.

19. "Gynecologic Procedures," 30th Annual Family Practice Review, Portland OR, February 1999.

20. "Emergency Contraception," Oregon Section, ACOG 6th Annual Meeting, Sunriver OR, April 1999.

21. "Emergency Contraception: New Innovations," Center for Health Training, 28th Annual Clinical Update, Portland OR, April 1999.

22. "Emergency Contraception," Sacred Heart Medical Center, 1st Annual Primary Care Conference, Eugene OR, May 1999.

23. "Update in Contraception," Sacred Heart Medical Center, 1st Annual Primary Care Conference, Eugene OR, May 1999.

24. " Laparoscopic Tubal Ligation Techniques," 23rd Annual Pacific NW Review of OB-GYN, Portland OR, October 1999.

25. "Impact of Religious Hospital Mergers on Training Residents in Abortion Care." Toward Rational Living Conference, Portland OR, November 1999.

26. "Gynecology: Office Procedures," 31st Annual Family Practice Review, Portland, February 2000.

27. "RU486 in OB/GYN," Women's Health Care Symposium, Eugene OR, September 2000.

28. "Savvy About Sex," Martha Browning Bryant Memorial Lecture, Oregon Chapter of The American College of Nurse-Midwives, October 2000.

29. "Emergency Contraception," Institute of Women's Health and Integrative Medicine, October 2000.

30. "Update on Pap Smears" Family Practice OB Ski and Women's Health Conference, Bend OR, January 2001.

31. "Gynecological Skills Workshop", Family Practice OB Ski and Women's Health Conference, Bend OR, January 2001.

32. "Gynecology: Office Procedures," 32nd Annual Family Practice Review, OHSU, February 2001.

33. "Dysfunctional Uterine Bleeding," 8th Annual Internal Medicine Review, April 2001.

34. "Sonohysterography or SIS (Saline Infusion Sonography)," 8th Annual Oregon ACOG Update in Obstetrics and Gynecology, Bend OR, April 2001.

35. "Where are we with RU-486" Oregon Nurses Association/Nurse Practitioners of Oregon, 24th Annual Meeting, Eugene, OR Sept. 2001

36. "Pharmacology of Oral Contraceptives", OHSU with 4 remote sites, Nurse Practitioner curriculum, Oct. 2001

37. "Laparoscopic Supracervical Hysterectomy: Making the Recovery Even Faster". 25th Annual Pacific Northwest Review Conference, Portland OR, November 2001

38. "Review of Emergency Contraception", Oregon Pharmacology Association, Nov. 2001

39. "Intrauterine contraception" Nurse Practitioner Training Course, Portland, OR, Jan. 2002

40. "What's new in contraception?" Montana section ACOG Annual Meeting, Big Sky, MT, Feb. 2002

41. "RU-486 in Ob/Gyn", Montana section ACOG Annual Meeting, Big Sky, MT, Feb. 2002

42. "Review of Emergency Contraception", Montana section ACOG Annual Meeting, Big Sky, MT, Feb. 2002

43. "What's New in Contraception", 33rd Annual Family Practice Review, Portland, February, 2002

44. "Gynecologic Procedures" 33rd Annual Family Practice Review, Portland, February, 2002

45. "Update on Contraception" Good Samaritan Hospital, Corvallis, OR, March 2002

46. "RU-486 in Ob/Gyn" Good Samaritan Hospital, Corvallis, OR, May, 2002

47. "Labor Inductions" OAFP Women's Health Conference, Bend, OR, Jan. 2003

48. "The new IUD"OAFP Women's Health Conference, Bend, OR, Jan. 2003

49. "Update in Contraception" Reproductive Health Conference, Portland, OR, March 2003

50. "IUD training" Reproductive Health Conference, Portland, OR, March 2003

51. "Essure Device for Tubal Sterilization" 10th Annual Oregon ACOG Update in Obstetrics and Gynecology, Bend OR, April 2003.

52. "Update on Contraception for the New Millenium" Women's Health Care Symposium, Eugene, OR, May 2003

53. "Trans-Cervical Sterilization: A review of the Essure device" 27th Annual Pacific NW Review of OB-GYN, Portland OR, October 2003.

54. "Medical Abortion Review" National Abortion Federation Course, Portland, OR, October, 2003

55. "What's New in Contraception", 35th Annual Family Practice Review, Portland, February, 2004

56. "Gynecologic Procedures" 35th Annual Family Practice Review, Portland, February, 2004

57. "IUD Training" Center for Health Training, Portland, OR October, 2004

58. "Why Women Wait". Western Regional meeting of Medical Students for Choice, Portland, October, 2004

59. "MVA Training Sessions" Western Regional meeting of Medical Students for Choice, Portland, October, 2004

60. "Ultrasound in Medical Abortion" Sponsored by NAF , Portland, OR, November, 2004

61. "Gynecologic Procedures" 36th Annual Family Practice Review, Portland, February, 2005

62. "Contraceptive Update" 36th Annual Family Practice Review, Portland, February, 2005

63. "Alternatives to Hysterectomy" 36th Annual Family Practice Review, Portland, February, 2005

64. "Looking in the Future: New Contraceptive Methods" Reproductive Health Conference, Portland, OR, March 2005

65. "Shortage of Abortion Providers in the U.S." Students for Choice conference, Willamette University, Jan. 2006

66. "Gynecology Procedures" 37th Annual Family Practice Review, Portland, February, 2006

67. "Review of Medical Abortion" Pacific Northwest Review Course, Portland, OR October, 2006

68. "Implanon training" Sponsored by Implanon, Portland, OR March, 2007

69. "Review of Contraceptive Implants" Reproductive Health 2007, Portland, OR March 2007

70. "Management of Early Pregnancy Failure", Nurse Practioners of Oregon annual meeting, Hood River, OR Oct. 2008

71. "Medical Abortion", Nurse Practioners of Oregon annual meeting, Hood River, OR Oct. 2008

72. " Addressing the abortion provider shortage" Western regional meeting, Medical Students for Choice, Portland, OR, April 2009

National

1. "IUD Review," Grand Rounds, University of Maryland, Obstetrics and Gynecology Department, February 1993.

2. "IUD Review," Grand Rounds, Pennsylvania Hospital, Obstetrics and Gynecology Department, May 1993.

3. "IUD Review," Grand Rounds, Maricopa County, Obstetrics and Gynecology Department, June 1993.

4. "OB/GYN Review Course," Loma Linda University, Guest Faculty, Yosemite CA, April 1995.

5. "Incorporating Abortion Training Into the Ob/Gyn Residency Curriculum," National Abortion Federation Conference, Baltimore MD, November 1998

6. "Second Trimester Abortion Technique" and "Abortion Providers Panel: Incorporating Abortion Care Into Your Practice," Medical Students for Choice, 6th Annual Meeting, Atlanta, GA, April 1999.

7. "Fine Needle Aspiration for the Evaluation of Breast Masses," National Medical Committee Planned Parenthood Federation of America, Dallas TX, Sept. 1999.

8. "Parenteral Estrogen and Progestin Contraceptive: a Review," Risk Management Seminar, National Abortion Federation, Denver CO, Sept. 1999.

9. "Faculty Models" National Abortion Federation Resident Training Workshop, New Orleans LA, February 2000.

10. "Building Support in Your Department & Negotiating the Contract: From a Residency Program Perspective," National Abortion Federation Resident Training Workshop, New Orleans LA, February 2000.

11. "Background/Historical Context," "Medications: Mifepristone, Misoprostol and Methotrexate," "Protocol,"

"Patient Management," National Abortion Federation & Planned Parenthood Federation of America "Mifepristone 2000," Pleasant Hill CA, March 2000.

12. "Required Training in Abortion" Training in Abortion: The Next Level, Washington DC, October 2000

13. "Family Planning Fellowships and Planned Parenthood", PPFA National Medical Committee, Washington DC, December, 2001

14. "Evidence Based Regimen for mifepristone abortions" National Abortion Federation Annual Meeting, San Jose, CA, April 2002

15. "Faculty Models" National Abortion Federation Residency Training Workshop, Phoenix, AZ, December 2002

16. "The Who-What-When-How of Training" National Abortion Federation Residency Training Workshop, Phoenix, AZ, December 2002

17. "Gender Discrimination in Obstetrics and Gynecology: the Impact on recruiting men and retaining women" APGO Faculty Development Seminar, Kapalua, Maui, January 2003

18. "Clinical Issues in First Trimester Abortion", Medical Students for Choice, Annual Meeting, Seattle, WA, April 2003

19. "Clinical Issues in Second Trimester Abortion", Medical Students for Choice, Annual Meeting, Seattle, WA, April 2003

20. "Medical Student and Resident Education in Abortion" National Abortion Federation, Annual Meeting, Seattle, WA, April 2003

21. "The Who-What-When-How of Training", National Abortion Federation Residency Training Workshop, Chicago, March, 2004

22. "Alternatives to Hysterectomy" Medica Symposia Conference, Maui, Hawaii, December, 2004

23. "Contraceptive Options for Women over 40" Medica Symposia Conference, Maui, Hawaii, December, 2004

24. "Gynecologic Procedures" Medica Symposia Conference, Maui, Hawaii, December, 2004

25. "Workup and Management of Postmenopausal Bleeding" Medica Symposia Conference, Maui, Hawaii, December, 2004

26. "Transcervical Female Sterilization", PPFA Medical Directors Conference, Steamboat Springs, CO, March, 2005

27. "Multi-site Studies", Family Planning Fellowship Directors Meeting, San Francisco, CA, May, 2005

28. "Infections in Medical Abortion" Annual Meeting of the National Abortion Federation, San Francisco, CA April, 2006

29. "Technique of IUD insertion to minimize perforation risk" PPFA teleconference, November 2006

30. "Requiring abortion training in Ob/Gyn residency: Does it effect recruitment?" 34th Annual national meeting of the North American Society for Psychosocial Obstetrics and Gynecology, Portland, OR February 2007

31. "First Trimester Abortion Technique", Medical Students For Choice National Meeting, Tampa, FL, March 2007

32. "Review of Essure Procedures", ASRM, Washington DC, October 2007

33. "Abortion training in Ob/Gyn Residencies" Medical Students for Choice National Meeting, Minneapolis, MN, April 2008

34. "OHSU Feticide Policy" Family Planning Fellowship Annual meeting, New Orleans, LA, May 2008

35. "Balancing Life and Work Panel" ARHP annual meeting, Washington DC, Sept 2008

36. "Update on pain management in surgical abortion". National Abortion Federation annual meeting, Portland, OR, April, 2009.

37. "Management of the non-lethal anomaly". National Abortion Federation annual meeting, Portland, OR, April, 2009.

38. "Pain Management of Gynecologic Procedures" Grand Rounds, Northwestern University, Ob/Gyn department, Chicago, IL May 2009

39. "Essure Review", American Society of Reproductive Medicine annual meeting, Atlanta GA, October 2009

40. "Issues in second trimester abortion", MSFC annual meeting, Salt Lake City, UT, November 2009

41. "Practitioners Perspective Panel", MSFC annual meeting, Salt Lake City, UT, November 2009

42. "Abortion Panel", MEDC meeting, Salt Lake City, UT, March 2010

43. "IUD Review", Grand Rounds, University of Utah Department Ob/Gyn, Salt Lake City, UT, March 2010

44. "Hysteroscopic Sterilization Review" MEDC annual meeting, Las Vegas, NV, March 2011

45. "Patient Safety in Abortion Care", MEDC annual meeting, Las Vegas, NV, March 2011

46. "Pain management in gyn procedures" Grand Rounds, Dept Ob/Gyn, Wayne State University, Detroit MI, March 2011

47. "Values clarification workshop" Residents, Dept Ob/Gyn, Wayne State University, Detroit MI, March 2011

International

1. "Background/Historical Context," "Medications: Mifepristone, Misoprostol and Methotrexate," "Protocol," "Patient Management," National Abortion Federation & Planned Parenthood Federation of America "Mifepristone 2000," Vancouver BC. September 2000

2. "IUD Review", Grand Rounds, Ob/Gyn Department, University of Zambia, Lusaka, Zambia, September 2010

3. "Contraception Review" Hospital Staff Meeting, Gimbie Adventist Hospital, Gimbie Ethiopia, November 2010

4. "Post abortion IUCDs to reduce subsequent pregnancies" International Family Planning Conference, November 2011, Dakar, Senegal

5. "Update on USA contraception research" Shanghai Institute of Planned Parenthood Researach, October 2013

IV. SERVICE

Membership in Professional Societies:

Oregon Medical Association, 1983 - present

American College of Obstetrics and Gynecology, Oregon Section, 1983-present

Multnomah County Medical Society, 1983 - present

Association of Reproductive Health Professionals, 1983 - present

Association of Professors in Gynecology and Obstetrics, 1983 - 1993

American Fertility Society, Elected 1984

National Abortion Federation 1996 - present

National Abortion Rights Action League, 1987 - present

Pacific Northwest Obstetrical and Gynecological Society, 1989 - present

Pacific Coast Obstetrical and Gynecological Society, 1993 – present

Society of Family Planning, 2005 - present

Appointed or Elected Positions in Professional Societies:

American College of Obstetrics and Gynecology, Oregon Section
- Advisory Committee Member, 1984-1987
- Program Coordinator, 1984-1987
- Vice Chair, 1997-2000
- Chair, 2000-2003
- Program Chair, Annual Meeting, April 1998
- Program Chair, Annual Meeting, April 1999
- Program Chair, Annual Meeting, April 2000
- Program Chair, Annual Meeting, April 2001
- Program Chair, Annual Meeting, April 2002
- Program Chair, Annual Meeting, April 2003

American College of Obstetrics and Gynecology, District VIII
- Advisory Council member, 1997-2003
- Junior Fellow Advisor, 2000-2003

Association of Reproductive Health Professionals
Program Planning Committee, 1998
Co-Chair, Planning Committee, 2009

National Abortion Federation
Co-Chair, Risk Management Seminar, 1999
Co-Chair of Scientific Session at NAF National Meeting
Atlanta GA, April 1998
Vancouver BC, April 1999
Pittsburgh PA, April 2000
St. Louis MO, April 2001
San Jose, CA, April 2002
Seattle, WA, April 2003
New Orleans, LA, April 2004
Montreal, Canada, April 2005
San Francisico, CA, April 2006
Boston, MA, April 2007
Minneapolis, MN, April 2008
Portland, OR, April 2009
Philadelphia, PA, April 2010
Chicago, IL, April 2011
Vancouver BC, April 2012

Pacific Coast Obstetrical and Gynecological Society
Program Chair, 1998 meeting
Member program committee, 1997-2003
Program Chair, 2001 meeting

Society for Family Planning
President Elect, 2007-2009
Chair Scientific Committee, 2007-2009
President, 2009-2011
Immediate Past President, 2011-2013

Editorial and Ad Hoc Review Activities:

Member, Editorial Board

Contraception

Journal Reviewer

American Journal of Obstetrics and Gynecology
Obstetrics and Gynecology
Journal of American Women's Association (JAMWA)
British Journal of Obstetrics and Gynecology
New England Journal of Medicine
International Journal of Obstetrics and Gynecology
Contraception

Section Editor

Current Women's Health Reports, General Gynecologic Issues Section, 2001, 2002, and 2003

Committees:
International/National

Norplant Training in the Community, Panel Member, Dallas, Texas, April 1996

Planned Parenthood Federation of America
National Medical Committee, April 1996 - 2002
Primary Care Subcommittee, April 1996 - 2002
Nominating Committee, 1997, 1999
Chair, Nominating Committee, 2001

National Abortion Federation
Planning Committee, Risk Management Seminar, Denver CO, September 1999

American College of Obstetrics and Gynecology,
Oregon Section
Advisory Committee Member, 1984-1987

District VIII
Advisory Committee 2000-2003
Junior Fellow Advisor 2000-2003

Association of Reproductive Health Professionals
Program Planning Committee, 1998, 2008

Regional

Pacific Coast Obstetrical and Gynecological Society, 1993 - present
Member program committee, 1997-2003

Institutional

OHSU School of Medicine
Grievance Committee, September 1985 - June 1989
Joint Conference Committee on Graduate Medical Education, January 1987 - 1994
Student Health Advisory Committee, January 1988 - June 1994
Curriculum Review Task Force, Transition to Residency Course, February 1991 - 1993
Faculty Council, August 1991 - June 1997
Faculty Senate, June 1994- June 1996
Search Committee for Director for Maternal Fetal Medicine Division, 1998
Promotion and Tenure, October 1996 - 2002
Women's Health Student Interest Group, Faculty Advisor, 1998 - present
Medical Students for Choice, OHSU Chapter, Faculty Advisor, 1998 - present
School of Medicine Awards Committee, 2002-2007
Faculty Practice Plan Board of Directors, elected member, 2009-2012

Departmental

Executive Committee 1988-present
Promotion and Tenure Committee 1995-present
Clinical Care Committee 1999-present
Education Committee 1999-present
Combined Education Committee 1983-1995

Hospital

Medical Records Committee, September 1983 - 1987
Ambulatory Care Committee, July 1987 - July 1990
Operating Room Committee, 1988 - 1992
University Medical Group
- Finance Committee, April 1993 - April 1997
- Clinical Practice Committee, May 1994 - April 1997
- Board of Directors, Specialty Care Representative, March 1998 - 2001
- Compensation Committee, 1998
- Board of Directors, 1998 - 2001

IPCO Advisory Board, 1995 - 1998
University Hospital North, Ambulatory Surgery Move Task Force, March 1997 - June 1998
Surgical Services Committee, 1998 - present
Ambulatory Surgery Management Group, 2000 - 2003.

Local, State, National Recognition for Clinical Excellence:

Selected as one of the "Top-Rated Physicians in America", in Guide to Top Doctors, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012
Named as one of the "Best Doctors for Women-coast to coast", *Ladies Home Journal*, April, 2002
Selected as one of "Our Best Doctors" by Portland physicians, *Portland Monthly*: 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2013
"Pioneer and Leader Award", for introduction of Essure in PPFA, September 2004

Clinical Care Awards:

Rose Awards: numerous

Community Service:

Birth Home, Board of Directors, Portland OR, 1982 - 1987
Planned Parenthood Columbia Willamette
- Medical Committee, April 1984 - present
- Chairman Medical Committee, June 1991 - 1994
- Board of Directors, July 1991 – 1994 and June 2016 to present

Portland Feminist Women's Health Center, Medical Advisor, 1983 - 1987
Oregon State Health Division
- Out of Hospital Birth Task Force, September 1985 - November 1987
- Direct Entry Midwifery, Board of Directors, 1993 - 1999
- Family Planning Consultant, April 1997 - present

Teen Pregnancy Prevention Task Group Member, December 1996 - present
Region X Chlamydia Project Member, February 1997 - present
Population Services International
- Advisory Committee on Emergency Contraception Promotion Project 2000-2001

V. TEACHING (OHSU Educator's Portfolio):

Overview of your Role as an Educator:

Almost all of my clinical activities occur with a learner present. I see patients at the Center for Women's Health with third year medical students, provide care at Planned Parenthood with Ob/Gyn residents and Family Planning fellows, perform surgery and deliver babies with medical students and residents. My philosophy of teaching is to allow learners to perform to their abilities and to encourage assumption of increasing responsibility as skills and knowledge grow. I believe that learning occurs best when individuals are given autonomy (commensurate with their training) to provide medical care. I attempt to foster this type of learning by providing feedback during and after the learners care for patients. In surgery, that occurs while directing every action of the learners. In the clinic setting, the learners have more independence to develop their skills without step by step direction.

Scholarship of Teaching:

Curriculum Development

I developed the program objectives for the Family Planning Fellowship. This document was submitted to the Buffett Foundation, and we received approval as a training site.

Educational Conference Presentations

See "Invited Lectures, Conference Presentations or Professorships:" (above)

Classroom Teaching (Since 1995, and not cited in Local Presentations above)

Principles of Clinical Medicine,
"Obstetric Physical Examination", 1995, 1996, 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005
Pelvic/GU Examination Instructor, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010

Gross Anatomy Class – MS I Course:
Instructor 2001, 2003, 2004

Physician Assistant Curriculum
"Breast Disease" 1999, 2001
"Contraception" 1999, 2001
"Ectopic Pregnancy" 2003, 2004, 2005, 2006, 2007

Human Growth and Development - MS II Course
"Contraception, Abortion, and Sterilization" 1995-2012
"Female Infertility" 1995-2001
"Abnormal Menstrual Cycles" 1995-2004
"Panel: Population Growth", 1995-1998

Pediatric Resident Noon Conference Series
"Contraception for Adolescents," 1996, 1998, 2000, 2003
"Evaluation and Management of Abnormal Bleeding in Adolescents," 2000, 2002

Internal Medicine Resident Noon Conference Series

"Contraception Review", 2004

Students for Reproductive Choice Elective
"Surgical Abortion Technique" 1997-2007

Women's Health Care Nurse Practitioner Curriculum
"Abortion Review" 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003
"Benign Breast Disease" 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003
"Oral Contraceptives and Emergency Contraception" 2002, 2003

Nurse-Midwifery Curriculum
"Shoulder Dystocia" 1995-2016
"Breech Presentation" 2006, 2008, 2010, 2012, 2014, 2016

Family Practice Resident Noon conference
"Contraception Update" 2003
"Medical Abortion" 2003

Endocrinology Fellows Noon Conference
"Contraceptive Review" 2005

Women's Health Interest Group
"Management of Breech Presentation" 2010

Education Grants and Contracts:

Fellowship in Family Planning, funded by the Buffett Foundation. This pays for the salary of two fellows (R5 & R6) and 10% of the faculty of the fellowship director, (split evenly with the assistant fellowship director)

Effectiveness of Educational Activity:

Evaluations from teaching activities are available.

Mentorship:

Served on the MPH thesis committee for Kim Goldsmith, 2003-2004.
Served as mentor of numerous residents for their research projects including Lisa Thomas, Alison Edelman, Neva Phair, Carla Picardo, Marni Kwiecen, Liz Morgan, Gary Burgoine, Stephanie Koontz, Gina Allison, Emily Drath

Service and Membership of Educational Committees:

Steering Committee for the Human Growth and Development Course, SOM, OHSU, 1995-2002
Course Development Committee, Transition to Internship, SOM, OHSU, 1998
Member, Thesis Advisor for Kim Goldsmith, candidate for MPH, 2003

Honors and Awards for Education:

Outstanding Teaching Award, presented by graduating chief residents, OB/GYN Department at OHSU, June 1992.

APGO/CREOG National Faculty Award, presented for excellence in teaching to one faculty member in the

Ob/Gyn Dept. at OHSU each year, June 1993.

Excellence in Basic Sciences Teaching MSII Curriculum, OHSU, School of Medicine, 1994-1995.

Teaching Excellence Award, OHSU, School of Medicine, 1999-2000

J. David Bristow Award, OHSU, School of Medicine, Senior Class recognition to "one faculty member who exemplifies the ideals of the true physician as he/she conducts clinical practice with patients and colleagues", June 2001.

APGO/CREOG National Faculty Award, presented for excellence in teaching to one faculty member each year, June 2001

Planned Parenthood Federation of America, Affiliate Excellence Award given to one affiliate in the country for outstanding clinical teaching and research, 2003

Chosen as Faculty Marshal, OHSU School of Medicine Commencement Ceremony, June, 2004

Teaching Excellence Award, OHSU, School of Medicine, 2003-2004

Medical Students for Choice Faculty Mentor Award, presented at MSFC National meeting, Philadelphia, March, 2005

J. David Bristow Award, OHSU, School of Medicine, Senior Class recognition to "one faculty member who exemplifies the ideals of the true physician as he/she conducts clinical practice with patients and colleagues", June 2007.

The Leonard Tow Humanism in Medicine Award, June 2007

Chosen as Faculty Marshal, OHSU School of Medicine Commencement Ceremony, June, 2008

Outstanding Teacher Award, presented by graduating chief residents, OB/GYN Department at OHSU, June 2009.

Medical Students for Choice Faculty Mentor Award, presented at MSFC National meeting, Salt Lake City, UT, October 2009.

Robert Hatcher Family Planning Mentor Award, Society of Family Planning, 2015