IN THE IOWA DISTRICT COURT FOR POLK COUNTY

PLANNED PARENTHOOD OF THE HEARTLAND, INC., EMMA GOLDMAN CLINIC, and SARAH TRAXLER, M.D., Petitioners, v. KIM REYNOLDS ex rel. STATE OF IOWA, IOWA BOARD OF MEDICINE, Respondents.	Equity Case No. _____ **PETITION FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF**

COME NOW Petitioners Planned Parenthood of the Heartland, Inc. ("PPH"), Sarah Traxler, M.D., and Emma Goldman Clinic ("EGC") (collectively, "Petitioners"), by and through their attorneys, Rita Bettis Austen and Sharon Wegner of the American Civil Liberties Union of Iowa Foundation; Peter Im, Anjali Salvador, and Dylan Cowit of Planned Parenthood Federation of America; and Caitlin Slessor and Samuel E. Jones of Shuttleworth & Ingersoll, PLLC, pray for emergency temporary injunctive relief, as well as permanent injunctive relief, restraining Respondents Governor Kim Reynolds ex rel. State of Iowa and the Iowa Board of Medicine (collectively, "the State") from enforcing House File 732 ("HF 732" or "the Act"), as well as a declaratory judgment that the Act violates the Iowa Constitution, and in support thereof state the following:

STATEMENT OF THE CASE

1. Petitioners bring this action to challenge the constitutionality of HF 732, to be codified at Iowa Code chapter 146E, which will go into immediate effect when Governor Reynolds signs into law on July 14, 2023. The Act bans abortions upon the detection of embryonic or fetal cardiac activity, which can occur as early as six weeks of gestational age, as measured from the first day of a pregnant person's last menstrual period ("LMP")—before many people even know that they are pregnant. *See* HF 732 § 2(2)(a) ("Exhibit A"); Affidavit of Sarah A. Traxler ("Traxler Aff.") ¶ 13. If it is not enjoined, the Act will decimate access to abortion in Iowa.

2. In 2019, this Court permanently enjoined a virtually identical 2018 law that also banned abortions upon the detection of embryonic or fetal cardiac activity ("the 2018 Six-Week Ban"). *See* Ruling on Mot. for Summ. J., *Planned Parenthood of the Heartland, Inc. v. Reynolds*, No. EQCE83074 (Polk Cnty. Dist. Ct. Jan. 22, 2019). Last December, this Court denied the State's motion to dissolve that injunction, holding that "[t]he ban on nearly all abortions" would violate the Iowa Constitution under the undue burden standard. Ruling on Mot. to Dissolve Perm. Injunction Issued Jan. 22, 2019 at 15, *Planned Parenthood of the Heartland*, No. EQCE83074 (Dec. 12, 2022). Less than one month ago, the Iowa Supreme Court affirmed this Court's ruling by operation of law. *See Planned Parenthood of the Heartland, Inc. v. Reynolds*, No. 22-2036 (Iowa June 16, 2023).

3. On July 5, 2023, less than three weeks after the Supreme Court issued its order, Governor Reynolds called the Iowa General Assembly into a one-day special session on July 11 "for the sole and single purpose" of enacting an abortion ban to replace the one permanently enjoined by this Court. *See* Proclamation of Special Session (July 5, 2023) ("Exhibit B").

4. During this one-day special session, the General Assembly introduced, debated, and passed the Act. Debate in each chamber lasted less than seven hours, and the entire session

lasted less than a day—less than the twenty-four hours that Iowa law requires patients to wait before having an abortion. *See* Iowa Code § 146A.1. The General Assembly passed the Act before midnight on July 11.

5. Shortly afterward, Governor Reynolds issued a statement in response to the passage of the Act, stating that she will sign it into law on Friday, July 14, 2023. *See* Press Release, Office of Governor Kim Reynolds, Gov. Reynolds Statement on Special Session to Protect Life (July 11, 2023), https://governor.iowa.gov/press-release/2023-07-11/gov-reynolds-statement-special-session-protect-life ("Exhibit C").

6. The Act will take effect immediately upon Governor Reynolds's signature. *See* HF 732 § 3.

7. Because the Act takes effect so early in pregnancy, it will ban the vast majority of abortions in Iowa. The Act bans abortions at a stage at which many people do not yet know they are pregnant, and even those who do know may not have had time to make a decision about whether to have an abortion, research their options, and schedule appointments at a health center, not to mention overcoming the logistical and financial obstacles required to travel to a health center for an abortion.

8. By banning the vast majority of abortions in Iowa, the Act unlawfully violates the rights of Petitioners, their medical providers and other staff, and their patients under the Iowa Constitution and would severely jeopardize their health, safety, and welfare.

9. To safeguard themselves, their medical providers and other staff, and their patients from this unconstitutional law, Petitioners seek a temporary injunction to take effect upon the Act's enactment by the Governor, followed by declaratory and permanent injunctive relief, to prevent the State from enforcing the Act.

PARTIES

10. Petitioner PPH is a nonprofit corporation headquartered in Des Moines, Iowa. At its eight Iowa health centers, PPH provides a wide range of health care, including annual gynecological exams, cancer screenings, sexually transmitted infection testing and treatment, a range of birth control options including long-acting reversible contraception, gender affirming care, and medication and procedural abortions.

11. PPH provides procedural abortions at two Iowa health centers, in Des Moines and Iowa City, and medication abortions at five Iowa health centers, in Ames, Council Bluffs, Des Moines, Iowa City, and Sioux City. PPH provided over 3500 abortions in Iowa in 2021 and over 3300 abortions in Iowa in 2022. In the first half of 2023, PPH provided just under 1200 abortions in Iowa. PPH provides pre-viability abortions up to 20 weeks and 6 days LMP.

12. PPH sues on its own behalf, on behalf of its medical providers and other staff, and on behalf of its patients who will be adversely affected by the State's actions.

13. Petitioner Dr. Sarah Traxler is the Medical Director for PPH. Dr. Traxler is a board-certified obstetrician and gynecologist licensed to practice medicine in Iowa, in addition to Minnesota, South Dakota, North Dakota, and Maine. Dr. Traxler provides reproductive health care to PPH patients in Iowa, including medication and procedural abortions. Dr. Traxler sues on her own behalf and on behalf of her patients who will be adversely affected by the State's actions.

14. Petitioner EGC is a not-for-profit independent organization with one clinic location in Iowa City. EGC provides reproductive health care through all stages of life. Its services include annual gynecological exams; cancer screenings; sexually transmitted infection testing and treatment; a range of birth control options, including long-acting reversible contraception such as intrauterine devices; physical exams for men, transgender, and gender non-conforming people; and abortion services.

15. EGC provides medication and procedural abortions at its clinic in Iowa City. From October 2020 through September 2021, EGC provided 686 abortions; from October 2021 through September 2022, EGC provided 703 abortions. EGC provides pre-viability abortions up to 19 weeks and 6 days LMP.

16. EGC sues on its own behalf, on behalf of its medical providers and other staff, and on behalf of its patients who will be adversely affected by the State's actions.

17. Respondent Kim Reynolds is the Governor of Iowa, and as such is the chief executive for the State, responsible for ensuring the enforcement of the State's statutes. *See* Iowa Const. art. IV, §§ 1, 9. The Governor is sued in her official capacity.

18. Respondent Iowa Board of Medicine is a state agency as defined in the Iowa Administrative Procedures Act, Iowa Code § l7A.2(1). It is charged with administering the Act, *see* HF 732 § 2(5), as well as with disciplining individuals licensed to practice medicine and surgery or osteopathic medicine and surgery pursuant to Iowa Code § 148.1–14, including licensees who violate a state statute that "relates to the practice of medicine." Iowa Code § 148.6(2)(b).

JURISDICTION AND VENUE

19. This action seeks a declaratory judgment and injunctive relief pursuant to Iowa Rules of Civil Procedure 1.1101–1.1109, 1.1501–1.1511, and the common law. This Court has jurisdiction over this matter pursuant to Iowa Code § 602.6101.

20. Venue is proper in this district pursuant to Iowa Code § 616.3(2) because part of the cause arose in Polk County and Respondent Iowa Board of Medicine's primary office is located in Polk County, as is the office of Respondent Governor Reynolds.

OPERATIVE FACTS

Prior Iowa Abortion Law

21. On May 4, 2018, Governor Reynolds signed Senate File 359 into law, which would have banned abortion as soon as embryonic or fetal cardiac activity could be detected by ultrasound, which can occur as early as six weeks LMP. *See* 2018 Senate File 359. The 2018 Six-Week Ban was set to take effect on July 1, 2018. *See* Iowa Code § 3.7(1). At that time, abortion was still legal in Iowa through approximately twenty-two weeks LMP. *See* Iowa Code § 146B.2(2)(a).

22. Before the 2018 Six-Week Ban could take effect, this Court entered a temporary injunction preventing the State from enforcing the ban, thereby allowing abortion to remain legal in Iowa through approximately twenty-two weeks LMP. *See* Ord. Entering Temp. Injunction, *Planned Parenthood of the Heartland*, No. EQCE83074 (June 4, 2018). This Court subsequently entered a permanent injunction against the 2018 Six-Week Ban. *See* Ruling on Mot. for Summ. J., *Planned Parenthood of the Heartland*, No. EQCE83074 (Jan. 22, 2019).

23. More than three years later, soon after the United States Supreme Court ruled in *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), that the federal Constitution does not protect the right to an abortion, the State moved this Court for an order dissolving this Court's permanent injunction against the 2018 Six-Week Ban. *See* Mot. to Dissolve Perm. Injunction Issued January 22, 2019, *Planned Parenthood of the Heartland*, No. EQCE83074 (Aug. 11, 2022).

24. Following a hearing, this Court denied the State's motion to dissolve the permanent injunction against the 2018 Six-Week Ban, recognizing that the law was "a ban on nearly all abortions" and would violate the Iowa Constitution under the undue burden standard. *See* Ruling on Mot. to Dissolve Perm. Injunction Issued January 22, 2019, *Planned Parenthood of the*

Heartland, No. EQCE83074 (Dec. 12, 2022). The State then appealed this Court's ruling to the Iowa Supreme Court.

25. On June 16, 2023, an evenly divided Supreme Court affirmed this Court's ruling by operation of law, allowing the permanent injunction against the 2018 Six-Week Ban to remain in effect. *See Planned Parenthood of the Heartland, Inc.*, No. 22-2036 (June 16, 2023). Abortion has thus remained legal in Iowa through approximately twenty-two weeks LMP.

The Act

26. On July 5, 2023, less than three weeks after an evenly divided Iowa Supreme Court allowed this Court's permanent injunction against the 2018 Six-Week Ban to remain in effect, Governor Reynolds issued a proclamation calling the Iowa General Assembly into a one-day special session on July 11 "for the sole and single purpose" of enacting a new ban on abortion. *See* Ex. B.

27. The Governor's proclamation noted that the Supreme Court's order had prevented the State from enforcing the 2018 Six-Week Ban, and asserted that "Iowans deserve to have their legislative body address the issue of abortion expeditiously and all unborn children deserve to have their lives protected by their government as the fetal heartbeat law did." *Id.*

28. The General Assembly met in a one-day special session on July 11, 2023. In the span of a single day, the General Assembly introduced, debated, and passed the Act. Each chamber debated the Act for less than seven hours, and before debate on the Senate floor was complete, proponents of the bill forced a vote at around 11:00 p.m., in the dead of night.

29. Shortly before midnight on July 11, Governor Reynolds announced that she plans to sign the Act into law on Friday, July 14. *See* Ex. C.

30. The Act will take effect immediately upon Governor Reynolds's signature. *See* HF 732 § 3.

31. Just like the 2018 Six-Week Ban, the Act bans abortions when there is a "detectable fetal heartbeat." HF 732 § 2(2)(a). The Act defines a "fetal heartbeat" as "cardiac activity, the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac." *Id.* § 1(2). Because embryonic or fetal cardiac activity can be detected as early as six weeks LMP, the Act bans abortions starting at approximately six weeks LMP. *See* Traxler Aff. ¶ 13.

32. When a pregnant person seeks an abortion, the Act requires the abortion provider to perform an abdominal ultrasound to detect whether there is cardiac activity and to inform the patient in writing both (1) whether cardiac activity was detected; and (2) that if cardiac activity was detected, the patient cannot have an abortion. *See* HF 732 § 2(1)(a)–(b). The Act then requires the patient to sign a form acknowledging that they received this information. *See id.* § 2(1)(c). The Act also requires abortion providers to retain in the patient's medical record documentation of the ultrasound, documentation of whether cardiac activity was detected, and the patient's signed form. *See id.* § 2(3)(a)–(b).

33. The Act allows for only a few narrow exceptions under which either a provider need not test for cardiac activity, or a patient can have an abortion despite the detection of cardiac activity. First, an exception applies if the provider determines in their "reasonable medical judgment" that there is a "medical emergency," which existing Iowa law defines as occurring either when (1) the patient's "life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy, but not including psychological conditions, emotional conditions, familial conditions, or the woman's age"; or (2) "when continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function defined elsewhere." *Id.* §§ 1(4), 2(2)(a); Iowa Code § 146A.1(6)(a).

34. Second, an exception applies if the pregnancy resulted from rape or incest *and* the

patient reports the rape or incest to law enforcement or to a "public or private health agency which may include a family physician." HF 732 §§ 1(3)(a)–(b), 2(2)(a). To qualify for the exception, the rape must have been reported within 45 days; incest must have been reported within 140 days. *See id.* §§ 1(3)(a)–(b). This exception is no longer available once the pregnancy reaches a "postfertilization age" of "twenty or more weeks"—approximately twenty-two weeks LMP or later. *Id.* § 2(2)(b).

35. The Act uses the word "rape" without defining the term, even though "rape" is not a crime defined elsewhere in the Iowa Code, which instead uses the terms "sexual abuse" and "sexual assault." Iowa Code §§ 709.1 *et seq.*, 915.40; *see also* Traxler Aff. ¶ 62; Affidavit of KellyMarie Z. Meek ("Meek Aff.") ¶ 22. The Act also does not define the term "incest," which is defined in the criminal code as a sex act with "an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece, or nephew." Iowa Code § 726.2. It is unclear whether this definition of "incest" includes, for example, a sex act with a stepsibling or stepparent. *See* Meek Aff. ¶ 21. Nor does the Act define the term "private health agency," which is not defined elsewhere in the Iowa Code; the Act thus fails to provide sufficient clarity about the types of institutions or medical providers to which a patient needs to have reported rape or incest. *See* Traxler Aff. ¶ 63.

36. Third, an exception applies if the provider certifies that there is a "fetal abnormality" that is "incompatible with life" in their "reasonable medical judgment." HF 732 §§ 1(3)(d), 2(2)(a). As with the exception for reported rape and incest, this fetal abnormality exception is no longer available once the pregnancy reaches approximately twenty-two weeks LMP. *Id.* § 2(2)(b).

37. The Act also lists as an exception "[a]ny spontaneous abortion, commonly known as a miscarriage, if not all of the products of conception are expelled." *See id.* §§ 1(3)(c), 2(2)(a).

38. The Act provides that, after a pregnancy has reached twenty weeks post-

fertilization—approximately twenty-two weeks LMP—an abortion may be performed despite the detection of cardiac activity if "the abortion is necessary to preserve the life of an unborn child." *See id.* § 2(2)(b).

39. The Act does not specify what penalties providers could face for a violation. It does, however, require the Iowa Board of Medicine to adopt rules to administer the Act. *See id.* § 2(5). The Board of Medicine has the authority to discipline providers for violating a state law, including by imposing civil penalties of up to ten thousand dollars and revoking their medical licenses. *See* Iowa Code §§ 148.6(1), (2)(c); Iowa Code §§ 272C.3(2).

Abortion in Iowa

Abortion Is Safe, Common, and Critical to Pregnant People's Health & Welfare

40. Access to safe and legal abortions is critical to pregnant people's health and welfare. Legal abortions are one of the safest procedures in modern medicine, and are far safer than childbirth at any stage in pregnancy. Abortions are also very common: approximately one in four women in this country will have an abortion by age forty-five, and this number does not account for the trans men, gender nonconforming people, and nonbinary people who also have abortions. *See* Traxler Aff. ¶ 22.

41. People decide to have abortions for a variety of reasons, including familial, medical, financial, and personal ones. Most people who seek abortions are already parents, and they may struggle with basic unmet needs for their families. Some people end a pregnancy because they conclude that it is not the right time in their lives to have a child or to add to their families. Others have an abusive partner or a partner with whom they do not wish to have children for other reasons. Some people have health complications during pregnancy that lead them to conclude that an abortion is the right choice for them; indeed, for some, abortion is medically indicated to protect their lives or health, including their reproductive health. Some do so because they receive

diagnoses of fetal abnormalities despite the pregnancy being wanted. In some cases, people are dealing with a substance use disorder and decide not to become parents or have additional children during that time in their lives. Some make that decision because they have become pregnant as a result of rape. Others do so because they choose not to have biological children. *See id.* ¶ 23; Meek Aff. ¶¶ 10–16.

42. Childbirth poses far greater health risks than abortion. Every pregnancy-related complication is more common among people having live births than among those having abortions. *See* Traxler Aff. ¶ 22.

43. The National Academies of Sciences, Engineering, and Medicine—a private nonprofit organization established by the United States Congress to provide objective advice to the nation on matters of science and technology—conducted a review of the existing high-quality research and concluded that abortion is safer than childbirth. *See id.* ¶ 49. The National Academies found that the national abortion-related mortality rate was only 0.7 deaths per 100,000 legal abortions, a rate more than twelve times lower than that for those who carried their pregnancies to term, which is 8.8 deaths per 100,000 live births. *See id.*

44. Those forced to carry an unwanted pregnancy to term are at increased risk of preterm birth and failure to bond with a newborn, and are less likely to escape poverty, less likely to be employed, less likely to escape domestic violence, and less likely to formulate and achieve educational, professional, and other life goals. Additionally, when pregnant people lack access to safe, legal abortion, some will attempt to self-induce an abortion, including in ways that can further jeopardize their health or life. *See id.* ¶ 58.

Most People Who Seek Abortions Do Not Know They Are Pregnant by Six Weeks LMP

45. In a typical pregnancy, embryonic or fetal cardiac activity can be detected by an ultrasound as early as six weeks LMP. The vast majority of patients who have an abortion in Iowa

have reached at least six weeks LMP by the time of the abortion.

46. As an increasing number of states have banned or severely restricted abortion in the aftermath of the U.S. Supreme Court's ruling in *Dobbs*, patients have faced substantial obstacles in seeking care and have been forced to delay their abortions later into their pregnancies. *See id.* ¶ 36.

47. In 2022, more than eighty-eight percent of the abortions that PPH provided were for patients who had already reached six weeks LMP; and approximately ninety-two percent of the abortions that PPH provided during the first half of 2023 were for patients who had already reached six weeks LMP. *See id.* ¶ 20.

48. From October 2021 through September 2022, approximately ninety-four percent of the abortions that EGC provided were for patients who had already reached six weeks LMP. *See* Affidavit of Abbey Hardy-Fairbanks, M.D. ("Hardy-Fairbanks Aff.") ¶ 16. During the following year, from October 2022 through May 2023, approximately ninety-nine percent of the abortions that EGC provided were for patients who had already reached six weeks LMP. *See id.*

49. There are many reasons why most pregnant people do not have an abortion until six weeks LMP or later. Many do not even know that they are pregnant by six weeks LMP, and even those who do often face substantial financial and logistical obstacles to having an abortion. *See* Traxler Aff. ¶ 16.

50. For a person with regular monthly periods who becomes pregnant, fertilization typically occurs two weeks after their last menstrual period (two weeks LMP). Another two weeks would pass before a person would miss their period, generally the first clear indication of a possible pregnancy—at this point, the pregnancy would have reached four weeks LMP. At-home pregnancy tests are not generally effective until at least four weeks LMP. *See id.* ¶ 26.

51. As a result, even a person with highly regular menstrual cycles of approximately

twenty-eight days who learns that they are pregnant at the earliest possible instance would have roughly two weeks to (1) decide whether to have an abortion; (2) secure an appointment at one of the few available health centers in Iowa that provide abortions, which do not provide abortions every day of the week; (3) take time off from work and arrange transportation, childcare, and care for other family members; (4) obtain state-mandated counseling materials; (5) wait twenty-four hours; and (5) go to a health center to have an abortion. *See id.* ¶ 29.

52. Moreover, although patients who have abortions demonstrate a strong level of certainty with respect to their decisions, the Act will force even those patients who successfully navigate the above hurdles to race to a health center to avoid missing the extremely narrow window when an abortion is available. Thus, under the Act some Iowans may be forced to rush into their decision out of fear that they will lose the opportunity altogether to have an abortion.

53. The above obstacles apply to pregnant people who learn very early that they are pregnant. But many patients do not know they are pregnant until six weeks LMP or later, especially patients who have irregular menstrual cycles, cycles longer than approximately twenty-eight days, or who experience bleeding during early pregnancy, a common occurrence that is frequently and easily mistaken for a period. Other patients may not develop or recognize symptoms of early pregnancy. Other factors, including younger age and use of hormonal contraceptives, can also result in delayed recognition of symptoms of early pregnancy. *See id.* ¶ 27–28.

54. Particularly for patients living in poverty or without insurance, travel-related and financial barriers also pose a barrier to having an abortion before six weeks LMP. With very narrow exceptions, Iowa bars coverage of abortion in its Medicaid program, *see id.* ¶ 31, forcing patients living in poverty or without private insurance to make difficult tradeoffs among other basic needs like food or rent to pay for their abortions. Many must seek financial assistance from extended family and friends or from local abortion funds to pay for care, a process that takes time.

Moreover, many patients must navigate other logistics, such as inflexible or unpredictable job hours and childcare needs, that may delay the time when they are able to have an abortion. *See id.* ¶ 32.

55. In addition to the medical and practical impediments to accessing an abortion, Iowa has also enacted numerous medically unnecessary statutory and regulatory requirements that must be met before a patient may have an abortion. For example, Iowa law requires PPH to ensure that patients have an ultrasound at least twenty-four hours before having an abortion. *See* Iowa Code § 146A.1(a)–(c). Patients must also have available, at least twenty-four hours before an abortion, certain state-mandated information designed to discourage them from having an abortion. *See id.* § 146A.1(d). As a result, a patient makes two trips to a health center before they can receive an abortion. Practically speaking, the effect of this twenty-four-hour delay law can last far longer than one day, which may push a patient past the time limit even if they discovered they are pregnant, decided to have an abortion, and scheduled an appointment prior to six weeks LMP. *See* Traxler Aff. ¶ 33.

56. Accessing abortions is even more difficult for minors. Minor patients without a history of pregnancy may be less likely to recognize early symptoms of pregnancy than older patients who have been pregnant before. Most of these patients cannot immediately obtain written parental authorization, which means that under Iowa law they cannot have an abortion until forty-eight hours after a parent has been notified or until they have obtained judicial authorization, neither of which can realistically happen before six weeks LMP. *See id.* ¶ 34.

Impact of the Act on Petitioners and Their Patients

The Act Has Decimated Access to Abortion in Iowa

57. By banning abortions at the earliest stages of pregnancy, the Act will decimate access to abortion in Iowa and thereby impose an undue burden on Petitioners' patients. The Act

is particularly devastating for lower-income Iowans, people of color, and rural Iowans, who already face inequities in access to health care.

58. The Act bans abortions starting at approximately six weeks LMP. At six weeks LMP, many people do not know that they are pregnant, and even those who do may not yet have decided to have an abortion and been able to make the necessary financial and logistical arrangements to have an abortion that early in pregnancy. The Act thus prohibits the vast majority of abortions in Iowa.

59. The vast majority of people in Iowa who have an abortion do so once their pregnancies have already reached six weeks LMP. As described above, approximately ninety-two percent of the abortions that PPH has provided in Iowa in 2023 were for patients who had already reached six weeks LMP, *see id.* ¶ 20, and approximately ninety-nine percent of the abortions that EGC provided between October 2022 and May 2023 were for patients who had already reached six weeks LMP, *see* Hardy-Fairbanks Aff. ¶ 16.

60. The Act's few limited exceptions will do little to help patients seeking an abortion in Iowa. The Act's rape and incest exceptions require patients to have reported the rape or incest to law enforcement or a health agency within limited time windows, a step that very few people who seek an abortion for a pregnancy resulting from rape or incest will have taken. Victims of rape and incest often do not report the incidents, whether due to their young age, fear of violence or retaliation by their assailant, or severe trauma and shame. *See* Meek Aff. ¶¶ 25–28. According to the U.S. Department of Justice, approximately seventy-eight percent of rapes and sexual assaults were not reported to the police in 2021. *See* Traxler Aff. ¶ 64; Meek Aff. ¶ 26. Moreover, the exception is no longer available once the pregnancy reaches approximately twenty-two weeks LMP. *See* HF 732 § 2(2)(b). The vast majority of Iowans who seek an abortion for a pregnancy resulting from rape or incest thus will not be able to rely on these exceptions. *See* Meek Aff. ¶¶

20–29.

61. Similarly, the Act's "medical emergency" exception will do little to help patients seeking an abortion in Iowa under dire health circumstances. The Act relies on a definition of "medical emergency" that excludes all psychological conditions, even conditions so severe that the patient is at an immediate risk of self-harm or suicide, even though mental health conditions are the leading underlying cause of twenty-three percent of pregnancy-related deaths. *See* HF 732 §§ 1(4), 2(2)(a); Iowa Code § 146A.1(6)(a); Traxler Aff. ¶ 66. And even for physical conditions, the Act uses vague definitions, placing providers in the untenable position of having to decide whether an exception applies while knowing that they could lose their license if the Board of Medicine disagrees with their conclusion. *See* HF 732 § 2(5); Iowa Code §§ 148.6(1), (2)(c); Iowa Code § 272C.3(2). Patients with rapidly worsening medical conditions may be forced to wait for care until a provider determines that their conditions become deadly or threaten substantial and irreversible impairment so as to meet the exception.

The Act Forces Pregnant Iowans to Leave the State or Carry Their Pregnancies to Term

62. If the Act goes into effect, the vast majority of Iowans who decide to have an abortion will either have to travel out of state or, if they do not have the resources to do so, carry an unwanted pregnancy to term.

63. Those who are forced to travel out of state to seek an abortion will face significant logistical and financial obstacles in doing so, causing substantial delays in their access to a critical form of health care. Research shows that legal barriers to abortion can delay, and in some cases altogether prevent, people from accessing that care. *See* Traxler Aff. ¶ 42.

64. Pregnant Iowans will be forced to take time off from work, arrange care for their children and other family members, and figure out how to travel to the nearest state where they can legally access an abortion, which may be hundreds of miles from their homes. Many will also

have to do so in secret to hide their decision from an abusive partner. They will also be forced to gather extra funds—in addition to the cost of the abortion itself—to pay for the lodging, gas, and food required to make these trips, cover the cost of care for their children and other family members, and account for the time off from work, forcing lower-income Iowans to make difficult choices between an abortion and rent, food, and other basic necessities. And because some nearby states such as Kansas and Nebraska require patients to make multiple trips to a health center to have an abortion, many Iowans will have to either make multiple trips to or have an extended stay in another state, further increasing the logistical and financial obstacles and causing additional delays to accessing care.

65. All of these logistical and financial obstacles will force pregnant Iowans to delay their abortions further into pregnancy, which can increase the risk of complications and prevent them from being able to access the abortion method that they feel most comfortable with. For instance, a patient might prefer to have a medication abortion instead of a procedural abortion because they feel more comfortable and safe undergoing the process in the privacy of their own homes, but if the patient is delayed in accessing care because they are forced to travel to another state, they may reach a point in gestation at which only procedural abortions are available. Similarly, a patient who might otherwise have been eligible for a procedural abortion by aspiration may instead have to undergo a dilation and evacuation procedural abortion if they are delayed in seeking care. And although abortion is very safe and is safer than childbirth at any stage in pregnancy, the risk of complications associated with an abortion increases as the pregnancy progresses, causing pregnant Iowans to face an increased risk of complications the longer their abortion is delayed.

66. For some pregnant Iowans, these obstacles will prove impossible to overcome. Some may choose to self-manage their abortions outside of the healthcare system, potentially

increasing the risks to their health. Others will be forced to carry their pregnancies to term against their will.

Iowans Forced to Carry Pregnancies to Term Will Face Risks of Death, Major Complications, and Social and Financial Hardships

67. Those who are forced to carry an unwanted pregnancy to term will be exposed to an increased risk of death and major complications. Even under ideal circumstances, pregnancy causes significant physiological changes that can affect a person's health and social circumstances both during the pregnancy and for years afterwards. Many people seek emergency care at least once during a pregnancy, and people with comorbidities (either preexisting or those that develop as a result of their pregnancy) are significantly more likely to need emergency care. *See id.* ¶ 45.

68. During pregnancy, even people without preexisting health conditions will experience significant physiological changes, including a dramatic increase in blood volume, faster heart rate, increased production of clotting factors, breathing changes, digestive complications, and a growing uterus, putting them at greater risk of blood clots, nausea, hypertensive disorders, anemia, and other complications. *See id.* ¶ 44.

69. Pregnancy can present even greater health risks to those with preexisting health conditions, such as hypertension and other cardiac diseases, diabetes, kidney disease, autoimmune disorders, obesity, asthma, and other pulmonary diseases. *See id.* ¶ 46.

70. Pregnancy can also lead to the development of new serious health conditions, such as hyperemesis gravidarum, preeclampsia, deep-vein thrombosis, and gestational diabetes. People who develop new conditions during pregnancy are at an even higher risk of developing the same conditions in subsequent pregnancies. *See id.*

71. Pregnancy may also induce or exacerbate mental health conditions. Those with a history of mental illness may experience a recurrence during pregnancy. Moreover, pregnant

people taking medication for a mental health condition may need to discontinue or modify their medication regimen to avoid risking harm to the fetus, increasing the likelihood that mental illness recurs both during and after pregnancy. These risks can be higher for patients with unintended pregnancies, who may face physical and emotional changes and risks that they did not choose to take on. Pregnant people with a history of mental health conditions also face a heightened risk of postpartum illness, which may go undiagnosed for months or even years. *See id.* ¶¶ 47, 52.

72. Some pregnant people also face an increased risk of intimate partner violence, with the severity sometimes escalating during or after pregnancy. Homicide is a leading cause of maternal mortality; the majority of these homicides are committed by an intimate partner. Moreover, if forced to carry to term, a person facing intimate partner violence may also find it more difficult to leave an abusive partner because of new financial, emotional, and legal ties with that partner. *See id.* ¶ 48.

73. Labor and childbirth are also significant medical events with risks of health complications and death, far greater than those for abortions. In some cases, labor must be induced, and labor can last hours or sometimes days and be tremendously painful. Even a pregnancy with no comorbidities or previous complications can suddenly become life-threatening during labor and delivery. For example, during labor, increased blood flow to the uterus places the patient at risk of hemorrhage and, in turn, death. Hemorrhage is the leading cause of severe maternal morbidity. Other unexpected adverse events include transfusion, a ruptured uterus, perineal laceration, and unexpected hysterectomy. The most severe perineal tears involve tearing between the vagina through the anal sphincter and into the rectum and must be surgically repaired, which can result in long-term urinary and fecal incontinence and sexual dysfunction. Moreover, vaginal delivery often leads to long-term internal injuries, such as bowel injury or injury to the pelvic floor, which can also lead to urinary incontinence, fecal incontinence, and pelvic organ prolapse. *See id.* ¶ 50.

74. Some people who are forced to carry an unwanted pregnancy to term may also need to undergo a cesarean delivery, an open abdominal surgery that requires hospitalization and entails a significant risk of complications such as hemorrhage, infection, venous thromboembolism (blood clots), and injury to internal organs. Cesarean deliveries can also create long-term risks, including an increased risk of placenta previa in later pregnancies (when the placenta covers the cervix, resulting in vaginal bleeding) and bowel or bladder injury in future deliveries. *See id.* ¶ 51.

75. Particularly for people with low incomes or who are facing economic hardship, pregnancy can have severe impacts on their and their families' financial security. Some side effects of pregnancy render patients unable to work, or unable to work the same number of hours that they otherwise would, sometimes resulting in job loss. And pregnancy-related health care and childbirth are some of the costliest hospital-based health services, particularly for complicated or at-risk pregnancies. Beyond childbirth, raising a child is expensive, due to both direct costs and lost wages. These costs can be particularly impactful for people who do not have partners or other support systems in place, such as single parents. *See id.* ¶ 55.

76. Even after childbirth, those who are forced to carry their pregnancies to term and their newborns will be at risk of negative health consequences, including reduced use of prenatal care, lower breastfeeding rates, and poor maternal and neonatal outcomes. When compared to those who are able to access abortions, women who seek but are denied an abortion are more likely to moderate their future goals and less likely to be able to exit abusive relationships. Their existing children are also more likely to suffer measurable reductions in achievement of child developmental milestones and an increased chance of living in poverty. Finally, as compared to women who received an abortion, women who are denied abortions are less likely to be employed full-time, more likely to be raising children alone, more likely to receive public assistance, and more likely to not have enough money to meet basic living needs. *See id.* ¶ 58.

CLAIMS FOR RELIEF

COUNT I – RIGHT TO DUE PROCESS

77. Petitioners hereby reaffirm and reallege each and every allegation made above as if set forth fully herein.

78. The Act violates the due process rights of patients seeking and obtaining abortions in the state of Iowa, as guaranteed by article I, section 9 of the Iowa Constitution, by banning the vast majority of abortions in Iowa.

COUNT II – INALIENABLE RIGHTS OF PERSONS

79. Petitioners hereby reaffirm and reallege each and every allegation made above as if set forth fully herein.

80. The Act violates the inalienable rights of persons, as guaranteed by article I, section 1 of the Iowa Constitution, by banning the vast majority of abortions in Iowa.

COUNT III – RIGHT TO EQUAL PROTECTION

81. Petitioners hereby reaffirm and reallege each and every allegation made above as if set forth fully herein.

82. The Act violates Petitioners' and their patients' rights to equal protection of the laws in the state of Iowa, as guaranteed by article I, sections 1 and 6 of the Iowa Constitution, by:

(a) singling out abortion from all other medical procedures; and

(b) discriminating against women on the basis of their sex and on the basis of gender stereotypes.

PRAYER FOR RELIEF:

DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF

83. Petitioner hereby incorporates the allegations of all previous paragraphs as though those allegations were fully set forth herein.

84. This matter is appropriate for declaratory relief pursuant to Iowa Rules of Civil Procedure 1.1101–1.1109, and granting such relief, in conjunction with the supplemental injunctive relief Petitioners pray for, would terminate the legal dispute that gave rise to this Petition.

85. This matter is also appropriate for temporary injunctive relief pursuant to Iowa Rules of Civil Procedure 1.1501–1.1511, to take effect upon Governor Reynolds's signing HF 732 on July 14, 2023. Absent temporary injunctive relief, Petitioners and their patients will continue to suffer irreparable injury for which there is no adequate remedy at law.

86. This matter is also appropriate for permanent injunctive relief pursuant to Iowa Rule of Civil Procedure 1.1106. Absent permanent injunctive relief, Petitioners and their patients will continue to suffer irreparable injury for which there is no adequate remedy at law.

WHEREFORE, Petitioners respectfully urge this Court to enter judgment as follows.

(1) Declaring that:

HF 732 violates the Iowa Constitution;

(2) Enjoining Respondents, upon Governor Reynolds's signing HF 732 on July 14, 2023, from:

Enforcing HF 732;

(3) For Petitioners' costs incurred herein; and,

(4) For such other and further relief as the Court deems just and proper.

Respectfully submitted,

/s/ Rita Bettis Austen
RITA BETTIS AUSTEN (AT0011558)
American Civil Liberties Union of Iowa Foundation
505 Fifth Ave., Ste. 808
Des Moines, IA 50309–2317
Phone: (515) 243-3988
Fax: (515) 243-8506
rita.bettis@aclu-ia.org

/s/ Sharon Wegner
SHARON WEGNER (AT0012415)
American Civil Liberties Union of Iowa Foundation
505 Fifth Ave., Ste. 808
Des Moines, IA 50309–2317
Phone: (515) 243-3988
Fax: (515) 243-8506
sharon.wegner@aclu-ia.org

/s/ Peter Im
PETER IM*
Planned Parenthood Federation of America
1110 Vermont Ave., N.W., Ste. 300
Washington, D.C. 20005
Phone: (202) 803-4096
Fax: (202) 296-3480
peter.im@ppfa.org

/s/ Anjali Salvador
ANJALI SALVADOR*
Planned Parenthood Federation of America
123 William Street, 9th Floor
New York, NY 10038
Phone: (212) 541-7800
Fax: (212) 245-1845
anjali.salvador@ppfa.org

/s/ Dylan Cowit
DYLAN COWIT*
Planned Parenthood Federation of America
123 William Street, 9th Floor
New York, NY 10038
Phone: (212) 541-7800
Fax: (212) 245-1845
dylan.cowit@ppfa.org

Attorneys for Petitioners Planned Parenthood of the Heartland, Inc., and Sarah Traxler, M.D.

/s/ Caitlin Slessor
CAITLIN SLESSOR (AT0007242)
SHUTTLEWORTH & INGERSOLL, PLC
115 3RD St. SE Ste. 500 PO Box 2107
Cedar Rapids, Iowa 52406-2107
Phone: (319) 365-9461
Fax: (319) 365-8443
Email: CLS@shuttleworthlaw.com

/s/ Samuel E. Jones
SAMUEL E. JONES (AT0009821)
SHUTTLEWORTH & INGERSOLL, PLC
115 3RD St. SE Ste. 500; PO Box 2107
Cedar Rapids, Iowa 52406-2107
Phone: (319) 365-9461
Fax: (319) 365-8443
Email: SEJ@shuttleworthlaw.com

Attorneys for Petitioner Emma Goldman Clinic

*Application for admission *pro hac vice* forthcoming

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

PLANNED PARENTHOOD OF THE HEARTLAND, INC.; EMMA GOLDMAN CLINIC; and SARAH TRAXLER, M.D., Petitioners, v. KIM REYNOLDS, ex rel. STATE OF IOWA, and IOWA BOARD OF MEDICINE, Respondents.	Case No. _____ **PETITIONERS' EMERGENCY MOTION FOR TEMPORARY INJUNCTIVE RELIEF**

COME NOW Petitioners, Planned Parenthood of the Heartland, Inc. ("PPH"), Sarah Traxler, M.D., and the Emma Goldman Clinic ("EGC"), respectfully move this court for a grant of temporary injunctive relief pursuant to Iowa R. Civ. P. 1.1502, on an immediate and emergency basis, to take effect upon Governor Kim Reynolds's signing House File 732 (the "Act"),[1] and state:

1. On July 11, 2023, Governor Reynolds convened a special session of the General Assembly, during which the General Assembly passed the Act.
2. On July 11, 2023, Governor Reynolds announced that she will sign the Act on July 14,

[1] In 2017, the General Assembly passed Senate File 471, a bill imposing a mandatory 72-hour delay requirement and an additional trip requirement on people seeking abortions, which also included an immediate effective date. *See* 2017 Senate File 471. Governor Terry Branstad announced he would sign the bill into law on May 5, 2017; because of its immediate effective date, PPH filed a motion for a temporary injunction to enjoin the law two days earlier, on May 3, 2017. *See* Pet. for Decl. J. and Injunctive Relief, ¶ 1, *Planned Parenthood of the Heartland, Inc. v. Reynolds*, No. EQCE81503 (Polk Cnty. Dist. Ct. May 3, 2017) (filed as *Planned Parenthood of the Heartland v. Branstad*). This Court set a hearing on the motion for the following day, May 4, before the law went into effect. *See* Order Setting Hearing on Mot., *id.* After the hearing, this Court issued a ruling that would "become effective immediately upon the governor signing the bill." Ruling on Pls.' Pet. For Temp. Inj. at 4, *id.* Similarly, Petitioners in this case request that the Court issue a temporary injunction, to take effect upon Governor Reynolds's signing the Act on July 14, 2023.

2023. *See* Press Release, Office of Gov. Kim Reynolds, Gov. Reynolds Statement on Special Session to Protect Life (July 11, 2023), https://governor.iowa.gov/press-release/2023-07-11/gov-reynolds-statement-special-session-protect-life.

3. The Act has an immediate effective date. Absent expedited temporary relief, when the Act goes into effect, it will prohibit the vast majority of Iowans from accessing abortion. The Ban will irreparably harm Petitioners and their patients, and there is no adequate legal remedy.

4. The Act bans abortion if embryonic or fetal cardiac activity can be detected, which can occur starting at approximately six weeks of pregnancy, as measured from the first day of a patient's last menstrual period ("LMP"), before many people know they are pregnant. Affidavit of Sarah Traxler, M.D. ("Traxler Aff.") ¶ 13. The vast majority of abortions in Iowa occur after six weeks LMP: nearly 92% of the abortions PPH provided in Iowa in the first half of 2023 and 99% of the ones EGC provided between October 2022 and May 2023 were for patients whose pregnancies had already reached six weeks LMP. Traxler Aff. ¶ 20; Affidavit of Abbey Hardy-Fairbanks, M.D. ("Hardy-Fairbanks Aff.") ¶ 16.

5. Therefore, in practical effect, the Act would prohibit the vast majority of abortions in Iowa.

6. The Act does not specify the penalties providers could face for a violation, but the Iowa Board of Medicine has the authority to discipline providers for violating a state law, including by imposing civil penalties of up to ten thousand dollars and revoking their medical licenses. *See* House File 732 § 2(5); Iowa Code §§ 148.6(1), (2)(c); Iowa Code § 272C.3(2).

7. The Ban violates Petitioners' patients' right to access abortion under the Due Process Clause and Inalienable Rights Clause of the Iowa Constitution. Iowa Const. art. I, §§ 1, 9.
8. The number of people harmed by this law is overwhelming: in 2022, PPH provided over 3300 abortions in Iowa, and from October 2021 to September 2022, EGC provided 703 abortions. Traxler Aff. ¶ 20; Hardy-Fairbanks Aff. ¶ 4.
9. The Iowa Supreme Court has recognized that abortion restrictions must satisfy the undue burden test to pass constitutional muster. *Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med.*, 865 N.W.2d 252, 263, 269 (Iowa 2015) ("*PPH I*"); *Planned Parenthood of the Heartland, Inc. v. Reynolds*, 975 N.W.2d 710, 716 (Iowa 2022) ("*PPH IV*") (holding that undue burden "remains the governing standard"); *Planned Parenthood of the Heartland, Inc. v. Reynolds*, No. 22-2036, slip op. at 6 (Iowa June 16, 2023) ("*PPH V*") ("[T]he undue burden test remains the governing standard.") (Waterman, J., non-precedential op.).
10. The Act does not satisfy the undue burden standard. At oral argument before the Iowa Supreme Court in April, the State conceded that the six-week ban the General Assembly passed in 2018, which was virtually identical to the Act, did not satisfy the undue burden test. Oral Argument at 2:56, *PPHV V*, https://www.youtube.com/watch?v=_NvW74QAl2s; *see also PPH V*, slip op. at 13 (noting it is "clear and indeed conceded by the State at oral argument" that the 2018 ban does not satisfy the undue burden standard) (Waterman, J., non-precedential op.).
11. Temporary injunctive relief under Iowa R. Civ. P. 1.1502 is appropriate when necessary "to maintain the status quo of the parties prior to final judgment and to protect

the subject of the litigation." *Kleman v. Charles City Police Dep't,* 373 N.W.2d 90, 95 (Iowa 1985). Such relief is appropriate if the movant demonstrates: (1) a likelihood of success on the merits; (2) a threat of irreparable injury; and (3) that the balance of harms favors relief. *See generally Opat v. Ludeking*, 666 N.W.2d 597, 603–04 (Iowa 2003); *Max 100 L.C. v. Iowa Realty Co., Inc.*, 621 N.W.2d 178, 181 (Iowa 2001).

12. As explained more fully in Petitioners' Brief in Support, filed herewith, Petitioners are likely to succeed on the merits of their claims that the Act violates their patients' rights under the Due Process Clause and Inalienable Rights Clause of the Iowa Constitution.
13. The constitutional violations themselves constitute irreparable harm. *See LS Power Midcontinent, LLC v. State*, 988 N.W.2d 316, 338 (Iowa 2023). Further, the Act will harm Petitioners' patients, who will be forced to remain pregnant against their will or to overcome substantial obstacles to seek abortions outside the state. The Act will also irreparably harm Petitioners and their medical providers and other staff members, who will no longer be able to provide medical care consistent with their medical judgment and in support of patient well-being.
14. While the Ban will cause severe harm to Petitioners and their patients, Respondents will not suffer any harm if Petitioners' patients continue to have access to abortion, as they have for over fifty years.
15. Finally, there is no adequate legal remedy. *See Ney v. Ney*, 891 N.W.2d 446, 452 (Iowa 2017). The Ban will cause grievous injury to each person denied an abortion under it, and such injuries cannot later be compensated by damages.
16. For the reasons set forth above, and incorporating all the arguments set forth in their concurrently filed Brief in Support of Motion for Temporary Injunctive Relief,

Petitioners are entitled to the preliminary relief they seek as necessary to protect the legal rights of their patients, as well as their patients' immediate health and safety while this case proceeds toward final resolution.

WHEREFORE, Petitioners pray that this Court issue an order to take effect upon Governor Kim Reynolds's signing House File 732, ENJOINING Respondents and their agents, employees, appointees, and successors from enforcing House File 732 during the pendency of this case. Petitioners request a hearing on this motion at the earliest possible date.

Respectfully submitted,

/s/ Rita Bettis Austen
RITA BETTIS AUSTEN (AT0011558)
American Civil Liberties Union of Iowa Foundation
505 Fifth Ave., Ste. 808
Des Moines, IA 50309–2317
Phone: (515) 243-3988
Fax: (515) 243-8506
rita.bettis@aclu-ia.org

/s/ Sharon Wegner
SHARON WEGNER (AT0012415)
American Civil Liberties Union of Iowa Foundation
505 Fifth Ave., Ste. 808
Des Moines, IA 50309–2317
Phone: (515) 243-3988
Fax: (515) 243-8506
sharon.wegner@aclu-ia.org

/s/ Peter Im
PETER IM*
Planned Parenthood Federation of America
1110 Vermont Ave., N.W., Ste. 300
Washington, D.C. 20005
Phone: (202) 803-4096
Fax: (202) 296-3480
peter.im@ppfa.org

/s/ Anjali Salvador
ANJALI SALVADOR*
Planned Parenthood Federation of America
123 William Street, 9th Floor
New York, NY 10038
Phone: (212) 541-7800
Fax: (212) 245-1845
anjali.salvador@ppfa.org

/s/ Dylan Cowit
DYLAN COWIT*
Planned Parenthood Federation of America
123 William Street, 9th Floor
New York, NY 10038
Phone: (212) 541-7800
Fax: (212) 245-1845
dylan.cowit@ppfa.org

Attorneys for Petitioners Planned Parenthood of the Heartland, Inc., and Sarah Traxler, M.D.

/s/ Caitlin Slessor
CAITLIN SLESSOR (AT0007242)
SHUTTLEWORTH & INGERSOLL, PLC
115 3RD St. SE Ste. 500 PO Box 2107
Cedar Rapids, Iowa 52406-2107
Phone: (319) 365-9461
Fax: (319) 365-8443
Email: CLS@shuttleworthlaw.com

/s/ Samuel E. Jones
SAMUEL E. JONES (AT0009821)
SHUTTLEWORTH & INGERSOLL, PLC
115 3RD St. SE Ste. 500; PO Box 2107
Cedar Rapids, Iowa 52406-2107
Phone: (319) 365-9461
Fax: (319) 365-8443
Email: SEJ@shuttleworthlaw.com

Attorneys for Petitioner Emma Goldman Clinic

*Application for admission *pro hac vice* forthcoming

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

PLANNED PARENTHOOD OF THE HEARTLAND, INC.; EMMA GOLDMAN CLINIC; and SARAH TRAXLER, M.D., Petitioners, v. KIM REYNOLDS, ex rel. STATE OF IOWA, IOWA BOARD OF MEDICINE, Respondents.	Case No. _____ **BRIEF IN SUPPORT OF PETITIONERS' EMERGENCY MOTION FOR TEMPORARY INJUNCTIVE RELIEF**

TABLE OF CONTENTS

INTRODUCTION

In 2019, this Court permanently enjoined a ban on abortions upon the detection of embryonic or fetal cardiac activity (the "2018 Six-Week Ban"), which can occur starting at approximately six weeks of pregnancy, as measured from the first day of a patient's last menstrual period ("LMP"). *See* Ruling on Mot. for Summ. J., *Planned Parenthood of the Heartland, Inc. v. Reynolds*, No. EQCE83074 (Polk Cnty. Dist. Ct. Jan. 22, 2019); Affidavit of Sarah A. Traxler, M.D. ("Traxler Aff.") ¶ 13. In December 2022, this Court reaffirmed that the 2018 Six-Week Ban violated the Iowa Constitution, recognizing that it was "a ban on nearly all abortions," and denied the State's motion to dissolve the permanent injunction. *See* Ruling on Mot. to Dissolve Perm. Injunction Issued Jan. 22, 2019, *Planned Parenthood of the Heartland, Inc. v. Reynolds*, No. EQCE83074 (Polk Cnty. Dist. Ct. Dec. 12, 2022). Just last month, the Iowa Supreme Court affirmed by operation of law, allowing this Court's ruling to remain in effect. *See Planned Parenthood of the Heartland, Inc. v. Reynolds*, No. 22-2036 (Iowa June 16, 2023) ("*PPH V*").

The ink on the Iowa Supreme Court's order was barely dry before Governor Reynolds called a special session of the Iowa General Assembly to enact a new abortion ban. *See* Proclamation of Special Session (July 5, 2023). During this one-day special session on July 11, 2023, the General Assembly passed House File 732 ("HF 732" or "the Act"), a law virtually identical to the 2018 Six-Week Ban that again bans abortions upon the detection of embryonic or fetal cardiac activity. The General Assembly rushed to introduce, debate, and pass the Act as quickly as it could. Each chamber debated the Act for less than seven hours, and the entire special session, from convening to passage of the Act by both chambers, took less than a day—less than the twenty-four hours that Iowa law requires patients to wait before having an abortion, *see* Iowa Code § 146A.1.

Shortly thereafter, Governor Reynolds issued a statement in response to the passage of the Act, stating that she will sign it into law on Friday, July 14, 2023. *See* Press Release, Office of Gov. Kim Reynolds, Gov. Reynolds Statement on Special Session to Protect Life (July 11, 2023), https://governor.iowa.gov/press-release/2023-07-11/gov-reynolds-statement-special-session-protect-life. The Act will take effect immediately upon Governor Reynolds's signature. *See* HF 732 § 3.

The Act bans the vast majority of abortions in Iowa: nearly 92% of the abortions that Petitioner Planned Parenthood of the Heartland, Inc. ("PPH") provided in Iowa in the first half of 2023 and 99% of the ones that Petitioner Emma Goldman Clinic ("EGC") provided between October 2022 and May 2023 took place once the patients' pregnancies had already reached six weeks LMP. Traxler Aff. ¶ 20; Affidavit of Abbey Hardy-Fairbanks, M.D. ("Hardy-Fairbanks Aff.") ¶ 4.[1]

The Act blatantly violates the Iowa Constitution. This case is squarely controlled by precedent from the Iowa Supreme Court holding that abortion restrictions must be evaluated under the undue burden standard. *See Planned Parenthood of the Heartland, Inc. v. Reynolds*, 975 N.W.2d 710, 716 (Iowa 2022) ("*PPH IV*"); *Planned Parenthood of the Heartland, Inc. v. Reynolds*, 865 N.W.2d 252 (Iowa 2015) ("*PPH I*"). The Act cannot survive the undue burden test. It bans the vast majority of abortions in Iowa, forcing people seeking an abortion to carry a pregnancy to term against their will, travel out of state to access care at great cost to themselves and their families, or attempt to self-manage their abortions outside the medical system. The Act is an affront to the dignity and health of Iowans. In particular, it is an attack on families with low incomes,

[1] The affidavits accompanying this motion cite to both Senate File 579 and House File 732 or to "SF 579/HF 732." During the special session, these identical bills were debated simultaneously. Ultimately, the House passed HF 732 and transmitted it to the Senate, which substituted HF 732 for SF 579 and passed it.

Iowans of color, and rural Iowans, who already face inequities in access to health care and who will bear the brunt of the law's cruelties.

Petitioners PPH, EGC, and Sarah Traxler, M.D. (collectively, "Petitioners") seek a temporary injunction to prevent the widespread and irreparable harm that the Act will inflict each day it is in effect on Petitioners' patients and on their medical providers and other staff members. Petitioners have 200 patients scheduled for abortion services in the weeks of July 10 and 17. If the Act goes into effect, they will not be able to provide abortions to most of those patients.

FACTUAL BACKGROUND

PPH and EGC are the only abortion providers that operate health centers in Iowa. Traxler Aff. ¶ 21. PPH operates eight health centers throughout Iowa, and in 2022, it provided over 3300 abortions in the state. *Id.* ¶ 20. EGC is a clinic in Iowa City that, between October 2021 and September 2022, provided 703 abortions. Hardy-Fairbanks Aff. ¶ 4.

Legal abortion is one of the safest procedures in contemporary medical practice, and it is much safer than carrying a pregnancy to term. *See* Traxler Aff. ¶ 22. It is also very common: nearly one in four women will have an abortion by age 45, and this number does not account for the transgender men, gender nonconforming people, and nonbinary people who have abortions. *See id.* Patients' decisions to have an abortion often involve multiple considerations that reflect the complexities of their lives. *See id.* ¶ 23. Many are already parents, and they decide to have an abortion based on what is best for them and their existing families. *See id.* Others decide that they are not ready to become parents because they are too young or want to finish school before starting a family. *See id.* Some patients conclude that abortion is the right choice for them because of health complications during pregnancy or a life-limiting fetal diagnoses, or because they have an abusive partner or a partner with whom they do not wish to have children. *See id.* Access to legal abortion

is critical for the welfare of pregnant people.

On July 5, 2023, less than three weeks after an evenly divided Iowa Supreme Court allowed this Court's permanent injunction against the 2018 Six-Week Ban to remain in effect, Governor Reynolds issued a proclamation calling the Iowa General Assembly into a special session on July 11 "for the sole and single purpose" of enacting a new ban on abortion. *See* Proclamation of Special Session. The Governor's proclamation noted that the Supreme Court's ruling had prevented the State from enforcing the 2018 Six-Week Ban, and asserted that "Iowans deserve to have their legislative body address the issue of abortion expeditiously and all unborn children deserve to have their lives protected by their government as the fetal heartbeat law did." *Id.* at 2.

The General Assembly met in a special session on July 11, 2023. Debate in each chamber lasted less than seven hours, and before debate on the floor of the Senate was complete, proponents of the bill forced a vote at around 11:00 p.m., in the dead of night. The entire session—from convening of the special session to passage of the Act by both chambers of the General Assembly—took less than a day. Governor Reynolds announced she will sign the Act into law on Friday, July 14, 2023. *See* Press Release, Gov. Reynolds Statement on Special Session to Protect Life, *supra* at 2.

Just like the 2018 Six-Week Ban, the Act bans abortions when there is a "detectable fetal heartbeat." HF 732 § 2(2)(a). When a pregnant person seeks an abortion, the Act requires the abortion provider to perform an abdominal ultrasound to detect whether there is cardiac activity and to inform the patient in writing both (1) whether cardiac activity was detected; and (2) that if cardiac activity was detected, the patient cannot have an abortion. *Id.* § 2(1)(a)–(b). The Act then requires the patient to sign a form acknowledging that they received this information. *Id.* § 2(1)(c).

The Act's references to a "fetal heartbeat" are inaccurate and misleading. The Act defines

"fetal heartbeat" as "cardiac activity, the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac" and bans abortions if a "fetal heartbeat" is detected via ultrasound. *Id.* § 1(2). Cardiac activity may be detected via abdominal ultrasound as early as six weeks LMP. *See* Traxler Aff. ¶ 13. At this very early stage of pregnancy, cardiac activity is merely an electrical pulse; nothing that could be considered a "heart" has yet formed. *See id.* Further, despite the Act's use of the term "fetal heartbeat," a pregnancy is still an embryo when cardiac activity may first be detected, not a fetus; the developing pregnancy is an embryo until at least ten weeks LMP, only after which the term "fetus" is used. *See id.* ¶ 12.

Because embryonic or fetal cardiac activity can be detected as early as six weeks LMP, the Act bans abortions starting at approximately six weeks LMP. *See id.* ¶ 13. By banning abortions so early in pregnancy, the Act will prevent the vast majority of people from having an abortion in Iowa. *See id.* ¶ 16. Although most abortion patients get an abortion as soon as they are able, nearly 92% of the abortions PPH provided in Iowa during the first half of 2023—and 99% of the ones EGC provided between October 2022 and May 2023—took place after six weeks LMP. *See id.* ¶ 20; Hardy-Fairbanks Aff. ¶ 16. Even for patients with regular four-week menstrual cycles, six weeks LMP is only two weeks past the first missed period. *See* Traxler Aff. ¶ 26. Further, many people do not know that they are pregnant by six weeks LMP for a wide variety of reasons, including because of irregular menstrual cycles as a result of common medical conditions, contraceptive use, age, and breastfeeding; because implantation of a fertilized egg can cause light bleeding, which is often mistaken for a period; and because pregnancy is not always easy to detect. *See id.* ¶¶ 27–28. And even those who do know they are pregnant by six weeks LMP will face substantial logistical and financial obstacles in arranging to have an abortion in Iowa before their time runs out, including raising money for the abortion and arranging time off work, transportation,

childcare, and care for other family members. *See id.* ¶¶ 29–32.

The Act allows for only a few narrow exceptions under which either a provider need not test for cardiac activity or a patient can have an abortion despite the detection of cardiac activity. First, an exception applies if the provider determines in their "reasonable medical judgment" that there is a "medical emergency." HF 732 §§ 1(4), 2(2)(a); Iowa Code § 146A.1(6)(a). Second, an exception applies if the pregnancy resulted from rape or incest *and* the patient reports the rape or incest to law enforcement or to a "public or private health agency which may include a family physician" within a limited time window (45 days for rape, and 140 days for incest). HF 732 §§ 1(3)(a)–(b), 2(2)(a). This exception is no longer available once the pregnancy reaches a "postfertilization age" of "twenty or more weeks"—approximately twenty-two weeks LMP or later. *Id.* § 2(2)(b). Third, an exception applies if the provider certifies that the fetus has a "fetal abnormality" that is "incompatible with life" in the provider's "reasonable medical judgment." *Id.* §§ 1(3)(d), 2(2)(a). As with the exception for reported rape and incest, this fetal abnormality exception is no longer available once the pregnancy reaches approximately twenty-two weeks LMP. *Id.* § 2(2)(b).

Further, the Act includes several unclear provisions that will cause needless confusion for Petitioners and their patients. The General Assembly rushed to pass the Act in less than one day, without making changes to the enjoined 2018 law necessary to avoid uncertainty.[2] Notably, the

[2] For example, the Act requires the Board of Medicine to promulgate regulations to administer the ban, *id.* § 2(5), but the Board of Medicine has not yet done so. This provision was copied verbatim from the 2018 Six-Week Ban, Iowa Code § 146C.2(5), but that bill did not have an immediate effective date. *See* 2018 Senate File 359. By including an immediate effective date, the General Assembly eliminated the time built into the 2018 Six-Week Ban for the Board of Medicine to promulgate rules. Moreover, the Board of Medicine's ability to make rules has been hamstrung by Governor Reynolds's executive order issuing a "moratorium on rulemaking." Exec. Order No. 10, § IV, https://governor.iowa.gov/media/182/download?inline.

And for abortions "necessary to preserve the life of an unborn child"—which appears to refer to abortions necessary to preserve the life of a twin fetus—the Act nonsensically includes

rape and incest exceptions in the Act do not provide sufficient clarity about when they apply. The Act fails to define its use of the word "rape," even though "rape" is not a crime defined elsewhere in the Iowa Code, which instead uses the term "sexual abuse," Iowa Code §§ 709.1 *et seq*. The Act also does not define "incest," which is defined in the criminal code as a sex act with "an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece, or nephew," Iowa Code § 726.2, leaving it unclear whether the term includes, for example, a stepsibling or stepparent. Further, the rape and incest exceptions require that the incident be reported "to a law enforcement agency or to a public or private health agency which may include a family physician." HF 732 §§ 1(3)(a)–(b). The Act does not define "private health agency" or "family physician," leaving unclear whom a survivor needs to report to in order to qualify for an abortion. Reporting rape or incest, even to a medical provider, can be retraumatizing for survivors. Meek Aff. ¶ 24. The Act fails to give survivors the clarity they need to access abortion care, and it fails to give abortion providers the clarity they need to determine whether they can provide the requisite care to this vulnerable population.

The rape and incest exceptions language was copied verbatim from the 2018 Six-Week Ban, Iowa Code §§ 146C.1(4)(a)–(b). As Justice Waterman explains in his non-precedential *PPH V* opinion, "when the statute was enacted in 2018, it had no chance of taking effect. To put it politely, the legislature was enacting a hypothetical law." *PPH V*, slip. op. at 10 (Waterman, J., non-precedential op.). As such, the 2018 General Assembly did not draft the 2018 Six-Week Ban with the care needed to ensure clarity were it to take effect. And Petitioners raised these issues in the litigation about the 2018 ban. Petition, ¶ 28, *Planned Parenthood of the Heartland, Inc. v. Reynolds*, No. EQCE83074 (Polk Cnty. Dist. Ct. filed May 15, 2018); Appellees' Final Brief at 23

---

these among the abortions allowed after twenty weeks post-fertilization, *id*. § 2(2)(b), but not those allowed from six weeks LMP up to twenty weeks post-fertilization, *id*. § 2(2)(a).

n.1, *PPH V*. Nonetheless, the General Assembly again refused to fix these flaws when it passed the Act.

The Act also fails to specify what penalties providers could face for a violation. It does, however, require the Iowa Board of Medicine to adopt rules to administer the Act. HF 732 § 2(5). The Board of Medicine has the authority to discipline providers for violating a state law, including by imposing civil penalties of up to ten thousand dollars and revoking their medical licenses. *See* Iowa Code §§ 148.6(1), (2)(c); Iowa Code § 272C.3(2).

LEGAL STANDARD

Under Rule 1.1502 of the Iowa Rules of Civil Procedure, temporary injunctive relief is appropriate when necessary "to maintain the status quo of the parties prior to final judgment and to protect the subject of the litigation." *Kleman v. Charles City Police Dep't,* 373 N.W.2d 90, 95 (Iowa 1985). Such relief is appropriate if the movant demonstrates: (1) a likelihood of success on the merits; (2) a threat of irreparable injury; and (3) that the balance of harms favors relief. *See generally Opat v. Ludeking*, 666 N.W.2d 597, 603–04 (Iowa 2003); *Max 100 L.C. v. Iowa Realty Co., Inc.*, 621 N.W.2d 178, 181 (Iowa 2001).

ARGUMENT

I. PETITIONERS ARE LIKELY TO SUCCEED ON THE MERITS OF THEIR CLAIMS.

A. The Act violates the Iowa Constitution's Due Process Clause because it imposes an undue burden on the right to abortion.

The Iowa Supreme Court has addressed the status of abortion restrictions under the Iowa Constitution several times since 2015, but the applicable level of scrutiny is clear: as Justice Waterman unequivocally stated in *PPH V* last month, "the undue burden test remains the governing standard." *PPH V*, slip op. at 6 (Waterman, J., non-precedential op.). The Act

unquestionably imposes an undue burden on the right to abortion and therefore violates Petitioners' patients' substantive due process rights under the Iowa Constitution.

In 2015, the Iowa Supreme Court applied the undue burden standard[3] to hold that a ban on telemedicine medication abortions violated the Iowa Constitution. *See PPH I*, 865 N.W.2d at 262–69. The Court later held that abortion restrictions should be reviewed under strict scrutiny. *See Planned Parenthood of the Heartland, Inc. v. Reynolds*, 915 N.W.2d 206 (Iowa 2018) ("*PPH II*"). The Court subsequently overturned *PPH II*'s holding that strict scrutiny applies, but it explicitly held that the undue burden standard articulated in *PPH I* remains the "governing standard." *PPH IV*, 975 N.W.2d at 716. It explained, "[A]ll we hold today is that the Iowa Constitution is not the source of a fundamental right to an abortion *necessitating a strict scrutiny standard of review* for regulations affecting that right." *Id.* (emphasis added). In *PPH IV*, the Court expressly declined to hold that the rational basis standard applied, even though an amicus curiae requested that it do so. *Id.* at 745. In fact, two justices specifically *dissented* on this point, stating that they would direct the trial court on remand to apply rational basis. *Id.* at 746 (McDermott, J., concurring in part and dissenting in part).

Unlike rational basis, the undue burden standard accounts for the competing interests at stake in the abortion context. *See PPH V*, slip op. at 21 ("The undue burden test balances the state's interest in protecting unborn life and maternal health with a woman's limited liberty interest in

[3] The undue burden standard from *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), governed abortion restrictions under the United States Constitution before the United States Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. ___, 142 S. Ct. 2228 (2022). The standard has parallels in other constitutional contexts in which the Iowa Supreme Court has rejected strict scrutiny but adopted a standard of review higher than rational basis scrutiny. *See, e.g.*, *Democratic Senatorial Campaign Comm. v. Pate*, 950 N.W.2d 1, 7 (Iowa 2020) (election law); *State v. Musser*, 721 N.W.2d 734, 743 (Iowa 2006) (commercial speech and content-neutral regulations of speech). And Iowa's adoption of the undue burden standard allows Iowa courts to draw on the ample federal precedent applying the standard between *Casey* and *Dobbs*.

deciding whether to terminate an unwanted pregnancy.") (Waterman, J., non-precedential op.); *PPH II*, 915 N.W. 2d at 249–50 (Mansfield, J., dissenting) ("The fact that there are *two* profound concerns—a woman's autonomy over her body and human life—has to drive any fair-minded constitutional analysis of the problem. . . . *Casey*'s undue burden standard was not an unprincipled decision by Justices O'Connor, Kennedy, and Souter 'to deviate downward' in constitutional jurisprudence. It was an effort to recognize the unique status of this particular constitutional conflict between a woman's autonomy and respect for human life.").

Notably, the Iowa Supreme Court chose not to wait for the United States Supreme Court's decision in *Dobbs* before issuing its decision reiterating the undue burden standard, even though Mississippi had asked the United States Supreme Court to overrule *Casey* many months before—not to mention that Justice Alito's draft opinion in *Dobbs* already had become public. The United States Supreme Court ultimately decided *Dobbs*—a *federal* constitutional case—one week after *PPH IV*, but *Dobbs* did not change *PPH IV*'s holding that the undue burden test remains the standard under the *Iowa* Constitution. In *PPH IV*, the Court noted that the opinions of the U.S. Supreme Court could inform how it should rule, but also made clear that it "zealously guard[s] [its] ability to interpret the Iowa Constitution independently of the Supreme Court's interpretations of the Federal Constitution." *PPH IV*, 975 N.W.2d at 716, 745–46. After *Dobbs*, the State petitioned the Iowa Supreme Court for rehearing in an effort to convince the Court to establish rational basis as the new standard of review in abortion rights cases. Appellants' Pet. for Reh'g, *PPH IV* (No. 21-0856). The Court summarily rejected this invitation to set a new and lower standard of review than the federal undue burden standard applied in *PPH I*. Pet. for Reh'g Denied, *PPH IV* (No. 21-0856); *see also PPH V*, slip op. at 18 (describing the petition for rehearing as an "attempt at a shortcut to adopting *Dobbs*") (Waterman, J., non-precedential op.). Indeed, as Justice

Waterman noted in his non-precedential *PPH V* opinion, "To date, not a single state supreme court that previously recognized protection for abortion under its state's constitution has overruled its precedent in light of *Dobbs* to adopt rational basis review." *PPH V*, slip op. at 19 (Waterman, J., non-precedential op.).

Because the opinions of the evenly divided Iowa Supreme Court in *PPH V* are non-precedential, the undue burden standard that the Iowa Supreme Court left in place in *PPH IV* remains the governing standard. *See id.* at 6 ("[T]he undue burden test remains the governing standard . . . .") (Waterman, J., non-precedential op.). As this Court explained last December when it denied the State's motion to dissolve the injunction against the 2018 Six-Week Ban, *PPH IV* "was clear in its holding that 'for now, this means that the *Casey* undue burden test [the court] applied in *PPH I* remains the governing standard.'" Ruling on Mot. to Dissolve Perm. Injunction at 14 (alteration in original). This Court therefore concluded that the 2018 Six-Week Ban "would be an undue burden and, therefore, the statute would still be unconstitutional and void." *Id.* at 15.

The same is true of the Act in this case. It puts in place not just a substantial—but a complete—obstacle in the path of Iowans seeking pre-viability abortions after all but the earliest stages of pregnancy. The Act provides an extremely narrow window for Iowans to confirm a pregnancy; decide whether to have an abortion; secure an appointment at one of the few available health centers in Iowa that provide abortions, which do not provide abortions every day of the week; take time off from work and arrange transportation, childcare, and care for other family members; obtain an ultrasound and state-mandated counseling materials; wait twenty-four hours; and have an abortion. The Act will prevent the vast majority of Iowans from having access to

abortion. There can be no doubt, therefore, that it imposes an undue burden. Indeed, at oral argument before the Iowa Supreme Court in April, the State *conceded* as much.[4]

Moreover, every single court that has considered a pre-viability abortion ban under an undue burden standard has concluded that the ban is unconstitutional. *See, e.g.*, *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 773 (8th Cir. 2015) (six-week ban); *Edwards v. Beck*, 786 F.3d 1113, 1117 (8th Cir. 2015) (twelve-week ban); *Isaacson v. Horne*, 716 F.3d 1213, 1227 (9th Cir. 2013) (twenty-week ban); *Jane L. v. Bangerter*, 102 F.3d 1112, 1117–18 (10th Cir. 1996) (twenty-week ban); *Sojourner T. v. Edwards*, 974 F.2d 27, 31 (5th Cir. 1992) (total ban); *Guam Soc'y of Obstetricians & Gynecologists v. Ada*, 962 F.2d 1366, 1368–69, 1371–72 (9th Cir. 1992) (total ban); *Planned Parenthood S. Atl. v. Wilson*, 527 F. Supp. 3d 801, 810 (D.S.C. 2021) (6-week ban); *Memphis Ctr. for Reprod. Health v. Slatery*, No. 3:20-CV-00501, 2020 WL 4274198, at *15 (M.D. Tenn. July 24, 2020) (6-week ban); *SisterSong Women of Color Reprod. Justice Collective v. Kemp*, 472 F. Supp. 3d 1297, 1312 (N.D. Ga. 2020) (6-week ban); *Robinson v. Marshall*, No. 2:19-cv-365, 2019 WL 5556198, at *3 (M.D. Ala. Oct. 29, 2019) (total ban); *Preterm-Cleveland v. Yost*, 394 F. Supp. 3d 796, 800–04 (S.D. Ohio 2019) (6-week ban); *Bryant v. Woodall*, 363 F. Supp. 3d 611, 630–32 (M.D.N.C. 2019) (20-week ban).[5]

The burdens that the Act imposes on patients' access to abortions are not alleviated by the limited scope of its exceptions and the muddled, confusing language it uses to frame these exceptions, which impact some of the most vulnerable patients. For example, the Act's failure to define "rape" and "incest," its arbitrary requirements that rape be reported within 45 days and

[4] Oral Argument at 2:56, *PPH V*, available at https://www.youtube.com/watch?v=NvW74QAl2s; *see also PPH V*, slip op. at 13 (noting it is "clear and indeed conceded by the State at oral argument" that the 2018 Six-Week Ban does not satisfy the undue burden standard) (Waterman, J., non-precedential op.).

[5] Because these cases were decided under the federal undue burden standard, they were abrogated by *Dobbs*.

incest within 140 days, and its unclear requirement that the reporting be done to a "public or private health agency which may include a family physician," HF 732 § 1(3)(a)–(b), all put substantial obstacles in the way of survivors of rape and incest. The Act would thus cause confusion among survivors about whether they qualify for an abortion. The Act's incorporation of the definition of "medical emergency" from Iowa Code § 146A.1(6)(a), HF 732 § 1(4), which expressly excludes abortions provided because of the pregnant person's "psychological conditions, emotional conditions, familial conditions, or . . . age," would also prevent access to abortions for particularly vulnerable patients. Thus, the Act unduly burdens the right to abortion even for patients who may fall within the scope of the exceptions, and Petitioners are likely to succeed on the merits of their challenge under the Due Process Clause.

B. Petitioners are likely to succeed on their claims under the Iowa Constitution's Inalienable Rights Clause.

PPH I and *PPH IV* were decided under the Due Process Clause of article I, section 9. Substantive due process offers ample protection for abortion rights under the Iowa Constitution. *Cf. PPH IV*, 975 N.W.2d at 737 ("[S]tates relying on the due process clauses of their state constitutions typically have applied the undue burden test.") (alteration in original) (quoting *PPH II*, 915 N.W. 2d at 254 (Mansfield, J., dissenting). But this clause does not stand alone in protecting the right to abortion under the Iowa Constitution. *Accord Women of State of Minn. by Doe v. Gomez*, 542 N.W.2d 17, 26 (Minn. 1995) (recognizing fundamental right to abortion under combination of several clauses of Minnesota Constitution). The right to abortion is also protected under article I, section, 1 of the Iowa Constitution, the Inalienable Rights Clause.

Article I, section 1 provides, "All men and women are, by nature, free and equal, and have certain inalienable rights—among which are those of enjoying and defending life and liberty,

acquiring, possessing and protecting property, and pursuing and obtaining safety and happiness." Iowa Const. art. I, § 1. No "mere appendage," the section was "purposefully placed at the beginning of the Bill of Rights" and "makes the point of emphasizing 'inalienable rights,' which . . . include[] rights that cannot be abrogated by the legislature, or this court." *Baldwin v. City of Estherville*, 915 N.W.2d 259, 285 (Iowa 2018) (Appel, J., dissenting).[6] The clause's use of the word "among" shows that the list of inalienable rights is not exhaustive. *See Hodes & Nauser, MDs, P.A. v. Schmidt*, 440 P.3d 461, 473 (Kan. 2019) (interpreting the use of the word "among" in a similar clause of the Kansas Constitution to mean the list of rights "was not intended to be exhaustive"); Bruce Kempkes, *The Natural Rights Clause of the Iowa Constitution: When the Law Sits Too Tight*, 42 Drake L. Rev. 593, 636 (1993) ("[The] drafters [of the Inalienable Rights Clause] chose to use language more detailed and more encompassing than the grand endowment of rights set forth earlier in the Declaration of Independence and later in the Fourteenth Amendment.").

The sweeping language in article I, section 1, encompasses a broad right to bodily autonomy. Accordingly to a scholarly article on the provision, the clause "protects those preferred personal freedoms that include expression, associate, assembly, spirituality, and privacy," in other words "the right to personal autonomy, . . . the right of an individual to seek his or her own answers, or the right to self-ownership," and these freedoms "implicate, among other things, the right of a person to decide . . . whether to bear a child." *Id.* at 640–42 (internal quotation marks and citations

[6] Although Iowa courts typically use the rational basis test when applying article I, section 1, *see Garrison v. New Fashion Pork LLP*, 977 N.W.2d 67, 83 (Iowa 2022) (collecting cases); *PPH IV*, 975 N.W.2d at 743 n.23, the Iowa Supreme Court has cited its protections to buttress guarantees found in other parts of the Iowa Constitution. *See, e.g.*, *McQuistion v. City of Clinton*, 872 N.W.2d 817, 830 n.6 (Iowa 2015) ("[E]qual protection law arises out of the confluence of article I, section 1 and article I, section 6. Article I, section 1 protects individuals' rights, while article I, section 6 prevents the government granting any citizen or class of citizens privileges or immunities not granted to all citizens on the same terms."); *Varnum v. Brien*, 763 N.W.2d 862, 878 (Iowa 2009) (citing art. I, § 1, as textual basis for equal protection under Iowa Constitution).

omitted). Courts in other states have recognized abortion protections under similar clauses of their constitutions. *See, e.g.*, *Hodes & Nauser*, 440 P.3d at 471 (per curiam) ("[S]ection 1 of the Kansas Constitution Bill of Rights acknowledges rights that are distinct from and broader than the United States Constitution and that our framers intended these rights to be judicially protected against governmental action that does not meet constitutional standards. Among the rights is the right of personal autonomy. This right allows a woman to make her own decisions regarding her body, health, family formation, and family life—decisions that can include whether to continue a pregnancy."); *Planned Parenthood of Cent. N.J. v. Farmer*, 762 A.2d 620, 631 (N.J. 2000) ("Article I, paragraph 1, of the New Jersey Constitution . . . incorporates within its terms the right of privacy and its concomitant rights, including a woman's right to make certain fundamental choices.").

Further, in 1998, an overwhelming majority of the Iowa electorate voted to amend article I, section 1 to expressly include women. Iowa Const. amend. XLV.[7] As amended, the clause guarantees the inalienable rights of "[a]ll men *and women*," Iowa Const. art. I, § 1 (emphasis added). In interpreting the state constitution, Iowa courts' purpose "is to ascertain the intent of the framers," meaning they "look first at the words employed, giving them meaning in their natural sense and as commonly understood," then also "examine constitutional history." *Rants v. Vilsack*, 684 N.W.2d 193, 199 (Iowa 2004) (internal citations and quotation marks omitted); *see also Edge v. Brice*, 113 N.W.2d 755, 759 (Iowa 1962) ("It is proper in our determination to consider the intention of the framers of the provision as the language used, the object to be attained, or evil to be remedied, and *the circumstances at the time of adoption* indicate." (emphasis added)). The

[7] 83.6% of the electorate voted in favor of the amendment. *Iowa Equal Rights, Amendment 1 (1998)*, Ballotpedia, https://ballotpedia.org/Iowa_Equal_Rights,_Amendment_1_(1998) (last visited July 11, 2023); *see also 1998 Gen. Election Stat. Reps. by Cnty.*, Iowa Sec'y of State, https://sos.iowa.gov/elections/pdf/1998GEResultsByPCT.pdf.

express inclusion of "women" in article I, section 1 incorporates the conception of equality of the sexes and of women's rights in 1998, when abortion was unquestionably protected and the *Casey* undue burden standard was the law of the land. *Cf. PPH II*, 915 N.W.2d at 254 (Mansfield, J., dissenting) (finding significant the timing of adoption of constitutional guarantees, noting that among states with "explicit guarantees of privacy in their constitutions" that have adopted strict scrutiny, "for the most part, those privacy guarantees have been adopted only recently"). Notably, unlike the Iowa Constitution, neither the Kansas Constitution nor the New Jersey Constitution expressly includes women in their guarantees of inalienable rights, and yet both state supreme courts nevertheless recognized that a fundamental right to abortion exists under their constitutions. *See Hodes & Nauser*, 440 P.3d at 471 (interpreting Kan. Const. art. I, § 1 (guaranteeing inalienable rights to "[a]ll men")); *Planned Parenthood of Cent. N.J.*, 762 A.2d at 631 (interpreting N.J. Const. art. I, § 1 (guaranteeing "certain natural and unalienable rights" to "[a]ll persons")).[8]

In *PPH IV*, the Court took into account the historical context to determine the meaning of the Iowa Constitution, ultimately concluding that abortion was not a fundamental right subject to strict scrutiny because around the time of the Iowa Constitution's ratification in 1857, abortion was prohibited in many circumstances from 1843 to 1851 and from 1858 until *Roe v. Wade* was decided in 1973. 975 N.W.2d at 740–41. By that same reasoning, the historical context at the time of the 1998 amendment leads to the conclusion that the amendment encompasses the right to abortion and the undue burden standard. Further, in *Bechtel v. City of Des Moines*, 225 N.W.2d 326 (Iowa 1975), the Iowa Supreme Court ascertained the meaning of the home-rule amendment

[8] Much of the language of article 1, paragraph 1 of the New Jersey Constitution, is substantially identical to article 1, section 1 of the Iowa Constitution. *Compare* N.J. Const. art. I, § 1 ("All persons are by nature free and independent, and have certain natural and unalienable rights, among which are those of enjoying and defending life and liberty, of acquiring, possessing, and protecting property, and of pursuing and obtaining safety and happiness.") *with* Iowa Const. art. I, § 1.

by turning to "[t]he individuals who were in the forefront of the struggle to obtain" the amendment, who were "in the best position to know the intent of the framers." *Id.* at 333. The individuals at the forefront of the fight to add "women" to article I, section 1 included elected officials publicly associated with the fight for abortion rights. For example, Representative Minnette Doderer, who according to contemporaneous reports, was a "driving force behind the effort," Associated Press, *Flap Erupts Over Rights Language*, Des Moines Register, June 10, 1998, at 1M, also publicly supported abortion rights. *See* Jonathan Roos, *Abortion Bill Survives Test in Legislature*, Des Moines Register, Feb. 19, 1998, at 4A (noting Rep. Doderer's opposition to an abortion restriction); Quote of the Day, Des Moines Register, Feb. 19, 1998, at 3A (quoting Rep. Doderer as urging lawmakers to vote against abortion restriction, saying, "You're not going to go to hell either way you vote"); Rekha Basu, *Doderer Wears Label Proudly*, Des Moines Register, Feb. 21, 1997, at 1T (reporting that Rep. Doderer wore the label of "feminist" proudly and that "the abortion issue . . . pushed her into 'conscious feminism.'"). Similarly, Senator Elise Szymoniak, who less than a month before the election was reported as having "been with the movement since the beginning," Pat Denato, *Women Would Belong Everywhere, Even in the Constitution*, Des Moines Register, Oct. 11, 1998, at 3E, also publicly supported abortion. *See* Thomas A. Fogarty, *Abortion Bill OK'd by State Senate*, Des Moines Register, Feb. 6, 1998, at 4A (front page story quoting Sen. Szymoniak as saying, "If you stop legal abortion, you won't stop abortion; you'll only make it more difficult"); *Quote of the Day*, Des Moines Register, Feb. 6, 1998, at 4M (quoting her as saying "[t]here will be women who die" as a result of an abortion ban). The public involvement of Rep. Doderer and Sen. Szymoniak in the campaign lends further support to the connection between the amendment and abortion rights.

In the words of a supporter of the amendment before the election, "[W]ith two words—'and women'—women will take their rightful place in the Iowa Constitution. And we, as Iowans will say that we believe people should be free to pursue their life goals—whatever their gender." Stephanie R. Pratt, *Fixing a 131-Year-Old Constitutional Omission*, Des Moines Register, Oct. 18, 1998, at 5AA. Article I, section 1's broad guarantees of inalienable rights, including a specific guarantee of these rights to women, protects Iowans' right to bodily autonomy, including the right to decide whether to terminate a pregnancy. Because the challenged Act would strip the rights of women to control their bodies and their lives, *see PPH IV*, 975 N.W.2d at 746 ("[A]utonomy and dominion over one's body go to the very heart of what it means to be free.") (quoting *PPH II*, 915 N.W.2d at 237), Petitioners are likely to succeed on the merits of their article I, section 1 claim.[9]

[9] Petitioners focus here on their claims under the Due Process and Inalienable Rights Clauses, but the Act also violates the Iowa Constitution's equal protection guarantee. For classifications based on pregnancy, Iowa courts apply intermediate scrutiny, not strict scrutiny. *See Quaker Oats Co. v. Cedar Rapids Human Rights Comm'n*, 268 N.W.2d 862, 866–67 (Iowa 1978) ("[A]ny classification which relies on pregnancy as the determinative criterion is a distinction based on sex." (citation and internal quotation marks omitted)), *superseded on other grounds by* Iowa Code § 216.19 (2009); *accord N.M. Right to Choose/NARAL v. Johnson*, 975 P.2d 841, 854 (N.M. 1998). The undue burden standard is an intermediate level of scrutiny that balances the unique interests at stake in the abortion context. *See PPH II*, 915 N.W.2d at 249 (noting balance of concerns that "underlies the 'undue burden' standard set forth in *Casey*) (Mansfield, J., dissenting); *see also* Richard H. Fallon, Jr., *Strict Judicial Scrutiny*, 54 UCLA L. Rev. 1267, 1299 (2007) (referring to the undue burden test as "a form of intermediate scrutiny").

Further, the undue burden test effectuates the understanding of equal protection in *PPH IV*. In *PPH IV*, the Court recognized that "being a parent is a life-altering obligation that falls unevenly on women in our society." 975 N.W.2d at 746 (quoting *PPH II*, 915 N.W.2d at 249 (Mansfield, J., dissenting)). Because abortion restrictions threaten the bodily autonomy of women, applying rational basis would be inappropriate. *See PPH V*, slip op. at 21 (declining to apply rational basis because "[i]t would be ironic and troubling for our court to become the first state supreme court in the nation to hold that trash set out in a garbage can for collection is entitled to more constitutional protection than a woman's interest in autonomy and dominion over her own body.") (Waterman, J., non-precedential op.).

II. THE ACT WILL IRREPARABLY HARM PETITIONERS AND THEIR PATIENTS

"Iowa Rule of Civil Procedure 1.1502(1) permits a temporary injunction to prevent irreparable harm to the movant." *LS Power Midcontinent, LLC v. State*, 988 N.W.2d 316, 338 (Iowa 2023). In a determination of whether injunctive relief is warranted, "each case must rest on its own peculiar facts." *Johnson v. Pattison*, 185 N.W.2d 790, 798 (Iowa 1971). Here, the irreparable harm requirement is met because Petitioners have shown, *see supra*, that they are "likely to succeed in showing a constitutional violation," which itself constitutes irreparable harm. *LS Power Midcontinent*, 988 N.W.2d at 338. Additionally, their harms cannot be remedied by monetary damages. *IES Utilities Inc. v. Iowa Dep't of Revenue and Finance*, 545 N.W.2d 536, 541 (Iowa 1996) (stating that monetary loss is "insufficient under most circumstances to be considered irreparable injury").

If the Act goes into effect, it will be catastrophic for Iowans. It will force many people seeking abortions to carry their pregnancies to term against their will, with all of the physical, emotional, and financial costs that entails. *See* Traxler Aff. ¶¶ 43–58. Some will inevitably turn to self-managed abortions, which may in some cases be unsafe. *See id.* ¶ 60. And even Iowans who are ultimately able to get an abortion—either because they have been able to scrape together resources to travel out of state or if they are one of the very few who can satisfy one of the law's narrow exceptions—will suffer irreparable harm. *See id.* ¶ 43–70. Finally, Petitioners and their staff will also suffer harms that cannot possibly be compensated after judgment.

A. Petitioners and their patients will suffer irreparable harm from forced pregnancy.

The Act threatens severe, actual, and irreparable harm to Iowans' lives and livelihood—harms that are more than sufficient to justify a temporary injunction. If the Act takes effect, Petitioners will be forced to turn away the vast majority of patients seeking abortions. *See id.* ¶ 20;

Hardy-Fairbanks Aff. ¶ 16. Petitioners have 200 patients scheduled for abortion services for the weeks of July 10 and 17, and few, if any, will fall within the Act's narrow exceptions. *See* Traxler Aff. ¶ 20; Hardy-Fairbanks Aff. ¶ 13–15. Iowans will be forced to carry their pregnancies to term and give birth. *See* Traxler Aff. ¶ 43. For these patients, who will suffer a range of physical, mental, and economic consequences, there is no effective monetary remedy after judgment for the impact of forced pregnancy and loss of bodily autonomy. *See Curtis 1000, Inc. v. Youngblade*, 878 F. Supp. 1224, 1248 n.24 (N.D. Iowa 1995) (irreparable harm may be found in situations that "involve imminent health or safety risks").

Even an uncomplicated pregnancy challenges a person's entire physiology. *See* Traxler Aff. ¶ 44; Hardy-Fairbanks Aff. ¶ 10. And many pregnant people experience complications. *See* Traxler Aff. ¶ 49–52. Pregnancy can cause new and serious health conditions or aggravate pre-existing health conditions. *See id.* ¶ 46. It can also induce or exacerbate mental health conditions, which are explicitly excluded from the Act's "medical emergency" exception. *See id.* ¶¶ 47, 66; HF 732 § 1(4); Iowa Code § 146A.1(6)(a). Some pregnant patients also face an increased risk of intimate partner violence—including possible homicide, with the severity sometimes escalating during or after pregnancy. *See* Traxler Aff. ¶ 48. Indeed, homicide, most frequently caused by an intimate partner, is a leading cause of maternal mortality. *See id.*

Separate from pregnancy, labor and childbirth are themselves significant medical events with many risks. *See id.* ¶ 49; Hardy-Fairbanks Aff. ¶ 10. Maternal mortality has been rising in the United States, and the risk of mortality associated with childbirth is more than twelve times higher than that associated with abortion. *See* Hardy-Fairbanks ¶ 10; Traxler Aff. ¶ 22. The health risks of childbirth also go beyond mortality. Complications from labor and childbirth occur at a rate of over 500 per 1,000 delivery hospital stays. *See* Traxler Aff. ¶ 50. Even a normal pregnancy with

no comorbidities or complications can suddenly become life-threatening during labor and delivery. *See id.* Patients of color are even more at risk for negative pregnancy and childbirth-related health outcomes. In 2021, the maternal mortality rate for Black women was 2.6 times the maternal mortality rate for white women. *See id.* ¶ 49; Hardy-Fairbanks Aff. ¶ 10. The disparity is even higher in Iowa, with Black mothers six times more likely to die than white mothers. *See* Traxler Aff. ¶ 49. The Act will make it more difficult for all pregnant patients to receive quality health care. Iowa already has the fewest number of OB/GYN specialists per capita of any state in the country, and abortion bans cause OB/GYNs to move elsewhere and make it harder to recruit quality medical students. *See* Hardy-Fairbanks Aff. ¶ 11.

If the Act takes effect, it will also lead to long-term negative impacts for people forced to give birth and for their existing children. More than half of Petitioners' abortion patients already have one or more children. *See* Traxler Aff. ¶ 23; Hardy-Fairbanks Aff. ¶ 5. Women who seek but are denied an abortion are, when compared to those who are able to access abortion, more likely to moderate their future goals, and less likely to be able to exit abusive relationships. *See* Traxler Aff. ¶ 58; Hardy-Fairbanks Aff. ¶ 12 Their existing children are also more likely to suffer measurable reductions in achievement of child developmental milestones and an increased chance of living in poverty. *See* Traxler Aff. ¶ 58. As compared to women who received an abortion, women denied an abortion are also less likely to be employed full-time, more likely to be raising children alone, more likely to receive public assistance, and more likely to not have enough money to meet basic living needs. *See id*.

The economic impact of forced pregnancy, childbirth, and parenting will also have potentially exponential, negative effects on Iowa families' financial stability. Some side effects of pregnancy render people entirely unable to work, or unable to work the same number of hours as

they otherwise would. *See id*. ¶ 53. Pregnancy-related discrimination can also result in lower earnings for women during pregnancy, and the impacts of discrimination during pregnancy continue over time. *See id.* ¶ 54 Further, Iowa does not require private employers to provide paid family leave, meaning that for many pregnant Iowans, time taken to recover from pregnancy and childbirth or to care for a newborn is unpaid. *See id.* On average, a person in Iowa who takes four weeks of unpaid leave could lose more than $3,000 in income. *See id*.

Pregnancy-related health care and childbirth are also some of the costliest hospital-based health services, particularly for complicated or at-risk pregnancies. *See id.* ¶ 55. While insurance may cover most of these expenses, many pregnant patients with insurance must still pay for significant labor and delivery costs out of pocket, impacting a patient's existing children and other dependents. *See id*. Beyond childbirth, raising a child is expensive in terms of direct costs and due to lost wages. *See id.* ¶ 56. In sum, pregnancy and parenting are hugely consequential in Iowans' lives, and being denied an abortion has long-term, negative effects on individuals' physical and mental health, economic stability, and the well-being of their families, including existing children.

In addition to these physical, mental, and economic injuries, the Act also imposes irreparable harm on Plaintiffs' patients by impinging on one of the most consequential decisions a person will make in a lifetime: whether to become or remain pregnant. *See PPH IV*, 975 N.W.2d at 746 ("[A]utonomy and dominion over one's body go to the very heart of what it means to be free.") (quoting *PPH II*, 915 N.W.2d at 237). In this way, the Act will have an impact on a person's existing family that cannot be compensated by future monetary damages. Many people decide that adding a child to their family is well worth the risks and consequences of pregnancy and childbirth. Conversely, together with their partners and with the support of other loved ones and trusted

individuals, thousands of Iowans each year determine that abortion is the right decision for them. Traxler Aff. ¶ 20.

B. The Act will irreparably harm patients forced to try to get abortions outside of Iowa.

Although some Iowans forced to remain pregnant may eventually be able to get abortions out of state, they will also suffer irreparable injury if the Act takes effect.

First, people will be forced to remain pregnant against their will, with all the attendant risks and medical consequences, until they can get out-of-state abortion care, likely later in pregnancy and at greater expense than if they had had abortion access in Iowa. *Id.* ¶ 42. Although abortion is extremely safe and is much safer than labor and childbirth, the medical risks associated with abortion increase with gestational age. *Id.*. Forcing people to remain pregnant while they save money or arrange logistics to travel out of state exposes them to entirely unnecessary medical risk. *Id.* It could also mean that a patient who would have been eligible for a medication abortion may have to undergo a procedural abortion by aspiration, or a patient who would have been eligible for aspiration abortion may have to have a more involved, longer dilation and evacuation procedure.

Second, these Iowans will suffer the additional burdens and costs associated with substantial travel. From Des Moines, for example, the nearest abortion providers outside of Iowa are in Omaha, Nebraska, around 140 miles away.[10] *Id.* ¶ 40. The closest clinics in Kansas and Minnesota are over 200 miles away from Des Moines. *Id.* The burdens associated with travel will have the greatest impact on Iowans who do not own a car, Iowans with disabilities for whom long-distance travel is especially onerous, and low-income Iowans for whom the cost of gas—and other expenses, such as for childcare—could be prohibitive.

[10] Nebraska has enacted a ban on abortion after twelve weeks LMP, meaning that patients past that point in pregnancy will have to travel even further. Neb. Rev. Stat. LB 574 § 4(2)(b).

Third, some patients may also be forced to compromise the confidentiality of their decision to have an abortion in order to arrange transportation or childcare for their travel to an appointment out of state. *Id.* ¶ 41 This could jeopardize the safety of patients whose families and social networks may strongly disapprove of their decision to get an abortion.

Each of these impacts constitutes irreparable harm. *See, e.g.*, *Planned Parenthood of Kan. v. Andersen*, 882 F.3d 1205, 1236 (10th Cir. 2018) ("A disruption or denial of . . . patients' health care cannot be undone after a trial on the merits." (internal quotations omitted)); *Harris v. Bd. of Supervisors, L.A. Cnty.*, 366 F.3d 754, 766 (9th Cir. 2004) (irreparable harm where individuals would experience complications and other adverse effects due to delayed medical treatment); *Banks v. Booth*, 468 F. Supp.3d 101, 123 (D.D.C. 2020) (same).

C. The Act's exceptions do not cure these irreparable harms.

Even patients who might meet the Act's limited exceptions will suffer irreparable harm in accessing abortions. Physicians caring for pregnant patients with rapidly worsening medical conditions—who, prior to the Act, could have gotten an abortion without explanation—may be forced to wait for care until their conditions become deadly or threaten substantial impairment of a major bodily function so as to meet the medical emergency exception. Traxler Aff. ¶ 65. Significantly, the medical emergency exception explicitly excludes psychological conditions including suicidal ideation, despite the fact that mental health conditions are the leading underlying cause of 23% of pregnancy-related deaths. HF 732 § 1(4); Iowa Code § 146A.1(6)(a); Traxler Aff. ¶ 66. This exclusion arguably makes the exception narrower than even Iowa's pre-*Roe v. Wade* ban, which had no such exclusion. *State v. Snyder*, 59 N.W.2d 223, 225 (Iowa 1953) (quoting Iowa Code § 701.1 (1950)[11] (banning abortion "unless such [abortion] shall be necessary to save her

[11] This pre-*Roe v. Wade* ban was repealed by 1976 Iowa Acts 774, § 526.

life")).

Patients facing devastating fetal diagnoses will only be able to have abortions if the diagnoses are "incompatible with life." HF 732 § 1(3)(d). For cases in which a fetal diagnosis guarantees that the fetus's life will be tragically short and painful, physicians may fear having their judgment second-guessed as to whether a fetus falls within the scope of the statutory exception. *See* Traxler Aff. ¶ 67; Hardy-Fairbanks Aff. ¶ 15.

The vast majority of survivors of rape and sexual assault choose not to report their abusers. *See* Traxler Aff. ¶ ¶ 64; Meek Aff. ¶ 23. These survivors will be faced with choosing between accessing abortion services and maintaining their privacy. HF 732 § 1(3)(a)–(b). Even the act of reporting an incident of rape or incest could be retraumatizing. *See* Meek Aff. ¶ 24. Moreover, rape survivors will only be able to access the exception if they make a report within 45 days of the incident, and incest survivors within 140 days. HF 732 § 1(3)(a)–(b). And as explained above, *supra* Part I.A, the lack of clarity in the rape and incest exceptions will cause confusion for survivors, who may be unsure whether they fall within the scope of the exceptions.

D. The Act will irreparably harm Petitioners and their staff.

Petitioners and their physicians and staff will also be irreparably injured by the Act, which eliminates their ability to offer abortion to many Iowans who need it. The Act interferes with Petitioners' ability to provide medical care consistent with their medical judgment and in support of patient well-being. *See Koelling v. Board of Trustees of Mary Frances Skiff Memorial Hospital*, 146 N.W.2d 284, 291 (Iowa 1966) (recognizing the "right to practice medicine").

Petitioners and staff will also face reputational harm and harm from the threat of severe civil penalties, including license revocation, posed by the Act. These harms too are irreparable. *Medicine Shoppe Intern., Inc. v. S.B.S. Pill Dr., Inc.*, 336 F.3d 801, 805 (8th Cir. 2003) (loss of

reputation can constitute irreparable injury). The threat to Petitioners is particularly grave because of the risk that the Board of Medicine might disagree with decisions they make to provide care under the Act's exceptions. *See* Traxler Aff. ¶ 63; Hardy-Fairbanks Aff. ¶ 14.

III. The balancing of harms weighs in favor of a temporary injunction.

In determining whether to issue a temporary injunction, "courts consider the 'circumstances confronting the parties and balance the harm that a temporary injunction may prevent against the harm that may result from its issuance.'" *Max 100 L.C. v. Iowa Realty Co., Inc.*, 621 N.W.2d 178, 181 (Iowa 2001) (quoting *Kleman v. Charles City Police Dept.*, 373 N.W.2d 90, 96 (Iowa 1985)). Courts "carefully weigh the relative hardship which would be suffered by the enjoined party upon awarding public relief." *Matlock v. Weets*, 531 N.W.2d 118, 122 (Iowa 1995). This weighing may also be framed as a "balance of convenience." *Myers v. Caple*, 258 N.W.2d 301, 305 (Iowa 1977).

There is no question that the harms to Petitioners and their patients that will be prevented if this Court grants this motion are far greater than any harm to Respondents that could possibly result. All but a few Iowans who might seek abortions will be impacted by the Act, as evidenced by the fact that the vast majority of Petitioners' patients get an abortion after six weeks LMP. *See* Traxler Aff. ¶ 20; Hardy-Fairbanks Aff. ¶ 16. Due to the extreme limitations of the Act's exceptions, *see supra* Part II.C, few people will be able to qualify for them. Even those patients who are able to leave Iowa to receive care will be irreparably harmed. *Supra* Part II.B.

On the other side, Respondents will face little, if any, injury from issuance of a temporary injunction. A temporary injunction would merely preserve the status quo, under which pre-viability abortion has been legal in Iowa for over half a century. As discussed above, *see supra*, the Act blatantly violates the Iowa Constitution. Any interest the state has in being allowed to

enforce a duly enacted law "does not apply if the law in question is unconstitutional." *LS Power Midcontinent*, 988 N.W.2d at 339; *see also Free the Nipple-Fort Collins v. City of Fort Collins, Colorado*, 916 F.3d 792, 807 (10th Cir. 2019) (It is "always in the public interest to prevent the violation of a party's constitutional rights.") (citation omitted). Additionally, granting a temporary injunction will impose no affirmative obligation, administrative burden, or cost upon Respondents. There is no question here that any "inconvenience the injunction imposes on [Respondents] does not outweigh the harm to [Petitioners] it seeks to prevent." *Matlock v. Weets*, 531 N.W.2d 118, 123 (Iowa 1995).

CONCLUSION

WHEREFORE, Petitioners pray that this Court GRANT their Emergency Motion for Temporary Injunctive Relief and issue an order enjoining Respondents and their agents, employees, appointees, and successors from enforcing House File 732 during the pendency of this case, to take effect upon Governor Kim Reynolds's signing House File 732.[12] Petitioners also request a hearing on their motion at the earliest possible date.

[12] In 2017, the General Assembly passed Senate File 471, a bill imposing a mandatory 72-hour delay requirement and an additional trip requirement on people seeking abortions, which also included an immediate effective date. *See* 2017 Senate File 471. Governor Terry Branstad announced he would sign the bill into law on May 5, 2017; because of its immediate effective date, PPH filed a motion for a temporary injunction to enjoin the law two days earlier, on May 3, 2017. *See* Pet. for Decl. J. and Injunctive Relief, ¶ 1, *Planned Parenthood of the Heartland, Inc. v. Reynolds*, No. EQCE81503 (Polk Cnty. Dist. Ct. May 3, 2017) (filed as *Planned Parenthood of the Heartland v. Branstad*). This Court set a hearing on the motion for the following day, May 4, before the law went into effect. *See* Order Setting Hearing on Mot., *id.* After the hearing, this Court issued a ruling that would "become effective immediately upon the governor signing the bill." Ruling on Pls.' Pet. For Temp. Inj. at 4, *id.* Similarly, Petitioners in this case request that the Court issue a temporary injunction, to take effect upon Governor Reynolds's signing the Act on July 14, 2023.

Respectfully submitted,

/s/ Rita Bettis Austen
RITA BETTIS AUSTEN (AT0011558)
American Civil Liberties Union of Iowa Foundation
505 Fifth Ave., Ste. 808
Des Moines, IA 50309–2317
Phone: (515) 243-3988
Fax: (515) 243-8506
rita.bettis@aclu-ia.org

/s/ Sharon Wegner
SHARON WEGNER (AT0012415)
American Civil Liberties Union of Iowa Foundation
505 Fifth Ave., Ste. 808
Des Moines, IA 50309–2317
Phone: (515) 243-3988
Fax: (515) 243-8506
sharon.wegner@aclu-ia.org

/s/ Peter Im
PETER IM*
Planned Parenthood Federation of America
1110 Vermont Ave., N.W., Ste. 300
Washington, D.C. 20005
Phone: (202) 803-4096
Fax: (202) 296-3480
peter.im@ppfa.org

/s/ Anjali Salvador
ANJALI SALVADOR*
Planned Parenthood Federation of America
123 William Street, 9th Floor
New York, NY 10038
Phone: (212) 541-7800
Fax: (212) 245-1845
anjali.salvador@ppfa.org

/s/ Dylan Cowit
DYLAN COWIT*
Planned Parenthood Federation of America
123 William Street, 9th Floor
New York, NY 10038
Phone: (212) 541-7800
Fax: (212) 245-1845
dylan.cowit@ppfa.org

Attorneys for Petitioners Planned Parenthood of the Heartland, Inc., and Sarah Traxler, M.D.

/s/ Caitlin Slessor
CAITLIN SLESSOR (AT0007242)
SHUTTLEWORTH & INGERSOLL, PLC
115 3RD St. SE Ste. 500 PO Box 2107
Cedar Rapids, Iowa 52406-2107
Phone: (319) 365-9461
Fax: (319) 365-8443
Email: CLS@shuttleworthlaw.com

/s/ Samuel E. Jones
SAMUEL E. JONES (AT0009821)
SHUTTLEWORTH & INGERSOLL, PLC
115 3RD St. SE Ste. 500; PO Box 2107
Cedar Rapids, Iowa 52406-2107
Phone: (319) 365-9461
Fax: (319) 365-8443
Email: SEJ@shuttleworthlaw.com

Attorneys for Petitioner Emma Goldman Clinic

*Application for admission *pro hac vice* forthcoming

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

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

I, Abbey Hardy-Fairbanks, M.D., F.A.C.O.G., declare and state as follows:

1. I am the Medical Director of the Emma Goldman Clinic ("EGC") and am board-certified in obstetrics and gynecology ("OB/GYN") and complex family planning. I provide reproductive health care, including abortion services, to patients of EGC. I am also responsible for training medical students and residents. In addition, I have given academic presentations on medication and in-clinic procedural abortions to family medicine and gynecology physicians. I attach my CV hereto as Exhibit A.

2. I submit this affidavit based on my own personal knowledge in support of Petitioners' Emergency Motion for Temporary Injunctive Relief to enjoin enforcement of Senate File 579 / House File 732 (the "Act"). I understand that the Act generally bans abortion as soon as a "fetal heartbeat" can be detected, which can be as early as six weeks, as measured from the first day of a patient's last menstrual period ("LMP"), with only extremely narrow exceptions.

3. EGC is an independent reproductive health care clinic located in Iowa City. It provides a full range of reproductive health care services, including routine gynecological exams; cancer screenings; STI testing and treatment; a range of birth control options including long-acting

reversible contraception such as intrauterine devices; physical exams for men, transgender, and gender non-conforming people; and abortion services.

4. EGC provides medication abortion through 11 weeks, 0 days LMP. We provide in-clinic abortion procedures through 19 weeks, 6 days LMP. From October 1, 2021, through September 30, 2022, EGC provided 703 abortions. From October 1, 2022, through May 31, 2023, EGC provided 375 abortions; of those, only 1% were provided before six weeks LMP.

5. My patients choose to have abortions for a variety of reasons. Sometimes their concerns are financial or related to their educational or professional aspirations. Other times they are victims of domestic or sexual abuse. Sometimes they know that carrying a pregnancy to term will harm their own health. In 2022, almost two-thirds of EGC's patients were already parents; they understood what is involved in carrying a pregnancy to term and caring for a child and thought about what is best for their particular situation. In some cases, a wanted pregnancy has complications that makes termination the choice a patient believes is best for their potential child.

6. Even without the Act, abortion is already difficult for many of my patients to access. My patients already face significant financial, legal, and logistical barriers to seeking abortion care. In 2023 to date, 74% of EGC's patients have used our subsidy program, eligibility for which is determined based on household income and access to insurance. In order to access abortions, patients often have to seek financial assistance, find coverage for child care or elder care duties, and arrange transportation and time off work. Iowa already has medically unnecessary restrictions that make it harder for my patients to access abortions,[1] and these affect my most

[1] *See* Iowa Code. § 146A.1(a–c) (requiring patients to have an ultrasound at least 24 hours in advance of having an abortion), *id.* § 135L.3(1) (requiring a minor's parent to be notified at least 48 hours before a minor can receive an abortion).

vulnerable patients the most acutely. These restrictions disrupt provider-patient relationships and are an obstacle to safe and timely medical care.

7. It has become even harder for my patients to access abortions since the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, 142 S.Ct. 2228 (2022). My patients are angry, upset, and confused. Many patients already travel to see us from many hours away or even from out of state, and I worry constantly that for every one of them who makes it to our clinic, there are many who do not. They are calling multiple clinics trying to find the first available appointment, resulting in increased numbers of no-shows and cancellations as appointment availability changes. The increased demand has caused all of our patients to now have to wait two to three weeks to get an abortion, as opposed to one week or less, particularly because EGC only provides abortions one day each week.

8. I am concerned that the Act effectively bans abortion for a vast majority of my patients at EGC who desire to end their pregnancies. Given that many of my patients do not even learn that they are pregnant until after six weeks LMP and that EGC does not regularly see pregnant patients until after embryonic or fetal cardiac activity can be detected, they will not have the chance to choose abortion, even if they otherwise need or want it. My patients will lose their ability to decide their futures and determine what is best for their welfare and that of their families.

9. The Act puts the burden of leaving Iowa to seek reproductive health care—which will impact most those who are most vulnerable. While some patients may be able to leave Iowa and access abortions, I know that many of them will not be able to do so because of the financial, logistical, legal, and other barriers that already make abortions difficult to access. Unwanted pregnancies are especially hard on low-income people, people of color, and people in abusive

relationships. My patients will be forced to continue their pregnancies, and some of them will face health and safety consequences as a result.

10. Even uncomplicated pregnancies carry health risks, and many pregnancies have complications. Maternal mortality in the United States, unlike in other developed nations, is increasing.[2] The maternal mortality rate is higher for Black Iowans, who are six times more likely to die than white Iowans.[3] The risk of death from childbirth is more than twelve times higher than the risk associated with abortion, which is incredibly safe.[4]

11. The Act will make it harder for pregnant patients, both those who are carrying wanted pregnancies and those who are forced by the Act to remain pregnant against their will, to get high-quality medical care. Abortion bans cause OB/GYNs to move elsewhere and make it harder to recruit quality medical students; I have spoken to medical students who are concerned about being able to get quality training in states with abortion bans.[5] Additionally, the recruitment of high quality attending physician OB/GYNs will be negatively impacted by this bill, which will

---

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

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

[4] Nat'l Acads. of Scis., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States,* at 75 tbls. 2–4 (2018), available at http://nap.edu/24950.

[5] *See* Janet Shamlian, *OB-GYN shortage expected to get worse as medical students fear prosecution in states with abortion restrictions*, CBS News (June 19, 2023), available at https://www.cbsnews.com/amp/ news/ob-gyn- shortage -roe-v-wade-abortion-bans/; Sarah Varney and Maea Lenel Buhre, *Idaho's strict abortion laws create uncertainty for OB-GYNs in the state*, PBS NewsHour (May 1, 2023), available at https://www.pbs.org/newshour/ amp/show/idahos-strict-abortion-laws-create-uncertainty-for-ob-gyns-in-the-state.

be particularly harmful in Iowa, which has the fewest number of OB/GYN specialists per capita of any state in the country.[6]

12. Even without health complications, pregnancy and parenting have huge financial and emotional tolls on patients and their families. Being denied wanted abortions results in a lower likelihood of full-time employment and a greater likelihood of not having enough money to meet basic living needs.[7] People who seek abortions but are denied are also less likely to leave abusive relationships.[8] I anticipate that instead of carrying an unwanted pregnancy, some patients may seek ways to end their pregnancies without medical supervision, some of which may be unsafe or dangerous.

13. While I understand that the Act contains a narrow exception for patients with a physical condition that threatens their life or poses a "serious risk of substantial and irreversible impairment of a major bodily function,"[9] this exception is extremely limited. For example, depending on the circumstances, I might hesitate to provide an abortion to a patient based on a physical health risk such as a previous severe pregnancy-related complication.

14. When I am determining whether a patient qualifies for the exception, I will have to balance my desire to protect my patients from harm with my concern that the Board of Medicine might disagree with a decision I make and cause me to lose my license. Working under these circumstances is horrible for patient care and for providers.

---

[6] Emily Nyberg, *Iowa has the fewest OB-GYN specialists per capita nationwide, regent report reveals*, The Daily Iowan (Nov. 9, 2022), available at https://dailyiowan.com/2022/11/09 /iowa-has-the-fewest-ob-gyn-specialists-per-capita- nationwide-regent-report-reveals/.

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

[8] *Id.*

[9] SF 579/HF 732 § 1(4); Iowa Code § 146A.1(6)(a).

15. I have the same concern about how to determine that an embryo or fetus has a condition that is "incompatible with life," or whether a pregnancy is the result of a reported rape.[10] These exceptions are not well-defined and reasonable professionals can have different opinions. I also know that many survivors of rape choose not to disclose it, not only to law enforcement but also to health care providers and even people close to them, because of reasons such as trauma or fear or retaliation.[11] The exception will not help those rape or incest survivors.

16. The Act will make it more difficult for EGC to care for even those patients who clearly fit within the exceptions. From October 1, 2021, through September 30, 2022, 94% of the abortions EGC provided were after six weeks LMP, and 99% of the abortions that EGC provided from October 1, 2022, through May 31, 2023 were after six weeks LMP. If the Act went into effect and prevented us from being able to provide abortions in the vast majority of cases, it is highly unlikely that we could maintain the staffing, medical equipment, and supplies necessary to provide abortions.

17. For all of these reasons, I believe that the Act will severely harm EGC and its patients' health and safety. The Court's intervention here is urgently needed: EGC has 55 patients scheduled for the weeks of July 10 and 17, and if the Act goes into effect, a vast majority of them will be forced to cancel their appointments. These patients are already having to deal with terrible uncertainty, and they will not receive abortions if the Act goes into effect. Even a temporary period where the Act is in effect would hurt them; as I discussed, many patients have to deal with financial and logistical difficulties in advance of having an abortion. It is important that EGC be able to reassure our patients that their abortions will go forward.

---

[10] SF 579/HF 732 § 1(3)(a), (d).

[11] *See* Alexandra Thompson & Susannah N. Tapp, U.S. Dep't of Just., *Criminal Victimization, 2021*, at 5 (Sept. 2022), available at https://bjs.ojp.gov/content/pub/pdf/cv21.pdf.

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

Signed this 11th day of July, 2023

Abbey Hardy-Fairbanks, M.D., F.A.C.O.G.

NOTARY PUBLIC

State of Texas

County of Harris

The foregoing instrument was acknowledged before me this July 11th, 2023 (date) by Dr. Abbey Hardy-Fairbanks.

This notarial act was an online notarization via two-way webcam and audiovisual technology.

Linda F. Peeples ,Online Notary Public

Signature of Online Notary Public

Produced USA Passport as identification along with multi-factor KBA authentication.

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

Exhibit A

Abbey Hardy-Fairbanks, MD, FACOG

Associate Clinical Professor
University of Iowa Hospitals and Clinics
Medical Director, Obstetrics and Gynecology Clinic, Main
Medical Director, Emma Goldman Clinic
Medical Director, Iowa Department of Public Health Title X
Co-Director, Ryan Resident Education Program
200 Hawkins Drive, Iowa City, IA 52242
abbey-hardy-fairbanks@uiowa.edu

I. EDUCATIONAL AND PROFESSIONAL HISTORY

Undergraduate Education

1999-June 2002 The Colorado College; Colorado Springs, Colorado
Bachelor of Arts, Biology, cum laude, with distinction

Graduate Education

2002- 2006 Creighton University School of Medicine; Omaha, Nebraska
Doctor of Medicine

Postgraduate Education

2006- 2010 Dartmouth-Hitchcock Medical Center; Lebanon, NH
Internship and Residency in Obstetrics and Gynecology

Licensure

Iowa	4/26/2010 Renewal 7/1/2011-present
Kansas	9/10/2019-present
DEA	3/23/2018-present Buprenorphine waiver for treatment of opioid use disorder

Board Certification

12/7/2012	Diplomate of the American Board of Obstetricians and Gynecologists Maintenance of certification 2013, 2014, 2015, 2016, 2017, 2018, 2019
4/2012	Fellow of the American Congress of Obstetricians and Gynecologist
7/2022	ABOG sub-specialty, Complex Family Planning Boards, pending results

Specialty Professional Memberships

2006-2012	Junior Fellow, American College of Obstetricians and Gynecologists
2008-present	Member American Institute of Ultrasound Medicine
2011-present	Member American Reproductive Health Professionals
2012-2017	Junior Fellow, Society for Family Planning
2013-present	Fellow, American College of Obstetricians and Gynecologists
2017-present	Full Fellow, Society for Family Planning
2018-present	Fellow of Physicians for Reproductive Health (PRH)
2021-present	Member, American Society of Addiction Medicine (ASAM)

Professional and Academic Positions

07/2010- 6/2015	University of Iowa Hospitals and Clinics, Iowa City, IA *Clinical Assistant Professor of Obstetrics and Gynecology*
07/2010-11/2010	University of Iowa Hospitals and Clinics Department of OB/GYN *Ryan Program Assistant Director*
11/2010-present	University of Iowa Hospitals and Clinics Department of OB/GYN *Ryan Program Co-Director*
06/2010-2016	University of Iowa Hospitals and Clinics *Emma Goldman Reproductive Health Clinic/UIHC Liaison*
5/2011-present	University of Iowa Hospitals and Clinics *Procedure Clinic Director*
6/2016-present	University of Iowa Hospitals and Clinics *Academic promotion: Associate Clinical Professor in Obstetrics and Gynecology*
7/2016-present	Emma Goldman Reproductive Health Clinic *Medical Director*
7/2017-present	University of Iowa Hospitals and Clinics Women's Health Center, University of Iowa *Medical and Clinical Director*
7/2017-Present	Obstetrics and Gynecology WHC, ND and Quad Cities Family Medicine University of Iowa Clinic Point of Care *Lab Director*
9/2019-present	Trust Women Clinic—Wichita, KS *Physician, abortion provider*
10/2019-present	ACOG Abortion Access and Training Expert Work Group American College of Obstetricians and Gynecologists *Group member*
10/2019-present	Iowa Department of Public Health Family Planning and Title X *Medical Director*
5/2022-present	Ryan National Residency Training Program—Advisor Advisor due to pollical climate changes surroundings training

Grants Received

6/2010-2020	University of Iowa Hospitals and Clinics LARC grant director and coordinator. Grant to provide low-cost long acting reversible contraceptive devices to those without coverage or excessive co-pay with the goal to also increase learner exposure to long acting contraceptive devices.
8/2012-05/2013	Investigator initiates trial grant recipient Kinetic Concepts, Inc. Grant provided single use negative pressure devices and device support for study period. 110 devices awarded in the grant
5/2013-8/2013	Grant recipient: Iowa Medical Student Research Program. Summer research fellowship Grant Supervision of Ivy Lin, BS
5/2015-8/2015	Grant recipient: Iowa Medical Student Research Program. Summer research fellowship Grant Supervision of Allison Rapp, BS
5/2016-8/2016	Grant recipient: Iowa Medical Student Research Program. Summer research fellowship Grant Supervision of Kelsey Sheets, BA and Petra Hahn, BA
5/2017-8/2017	Grant recipient: Iowa Medical Student Research Program Summer research fellowship grant Supervision of Sara Bakir, BA
5/2018-8/2018	Grant recipient: Iowa Medical Student Research Program Summer research fellowship grant Supervision of Sara Bakir, BA
5/2019-8/2019	Grant recipient: Iowa Medical Student Research Program Summer research fellowship grant Supervision of Hannah Botkin, BA
11/2019-present	SOR-SBIRT IDPH Grant Co-Primary Investigator State Opioid Response--Screening, Brief Intervention and Referral to Treatment Grant via the Iowa Department of Public Health, Division of Behavioral Health and funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment Allowed for creation of MSUD Clinic and ancillary services for this population https://medicineiowa.org/fall-2021/maternal-substance-use-disorder-clinic-provides-trauma-informed-pregnancy-care
7/2019-1/2021	EpiCenters Grant via University of Illinois--Chicago

SUpPress SSI – Single Use Negative Pressure Wound Therapy (NPWT) to Reduce Surgical Site Infections
PI: Loreen Herwaldt, MD; Abbey Hardy-Fairbanks, MD

5/2021-8/2021 Grant recipient: Iowa Medical Student Research Program
Summer research fellowship grant
Supervision of Elijah Reische, BA

5/2022-8/2022 Grant recipient: Iowa Medical Student Research Program
Summer research fellowship grant
Supervision of Mallory Kallish, BAL

Honors, Awards and Recognitions

05/2008 ACOG Resident Reporter American College of Obstetrics & Gynecologists; District I

05/2010 Dartmouth-Hitchcock Medical Center- Excellence in Resident Research Award

06/2010 Dartmouth-Hitchcock Medical Center- Jackson Beecham Humanism Award

01/2012 Exxcelence in Family Planning Research course. Previously known as the "Berlex Course". Tucson, AZ

2/29/2014 2nd place for outstanding poster: *The Impact of Clinical Clerkships on Medical Students" Attitudes towards Contraception and abortion.* APGO/CREOG 2014. The Council on Resident Education in Obstetrics and Gynecology/Association of Professors of Gynecology and Obstetrics Annual Meeting. Atlanta, GA.

10/11/2014 Winner "Top 15" Research Poster Award. *Mid-Trimester pregnancy interruption: provider perspectives, practice and knowledge.* SFP 2014. Society of Family Planning Annual Clinic Meeting. Miami, FL

6/2014 University of Iowa, Carver College of Medicine
M3 Junior Faculty Teacher of the Year

6/2014 American College of Obstetricians and Gynecologists CREOG National *Faculty Award for Teacher of the Year.*
University of Iowa OB/GYN Residency program.

4/2015 University of Iowa, Carver College of Medicine
Nominated M3 Junior Faculty Teacher of the Year

6/2015 *University of Iowa Hospitals and Clinics Excellence in Clinical Coaching award*
Department of Graduate Medical Education

10/2015	*University of Iowa Hospitals and Clinics Clinician of the Year* University of Iowa Physicians
5/2016	University of Iowa, Carver College of Medicine *M3 Junior Faculty Teacher of the Year*
7/2018-5/2019	Physicians for Reproductive Health Leadership Training Academy Physicians for Reproductive Health, New York, NY
09/14/2018	*Excellence in Clinical Research in Obstetrics & Gynecology* Oral Presentation: Accuracy of Vaginal pH Testing Before and After Addition of Sterile Saline Carver College of Medicine, Medical Student Research Conference
12/6/2019	Society of Family Planning Top 10 Most Talked About Abortion Articles published in 2019. Based on the most attention in 2019 from academics, traditional and social media, and other sources based on the Altmetric Attention Score SFP_2019_TopTen_r3.pdf (societyfp.org)
4/5/2022	*Culturally Responsive Health Care Award* University of Iowa Hospitals and Clinics Maternal Substance Use Disorder (MSUD) Clinic Team Abbey Hardy-Fairbanks, MD; Sarah Hambright,BA; Alison Lynch, MD\
6/25/2022	SASGOG Academic Teacher of the Year Award University of Iowa Hospitals and Clinics OBGYN Residency Program

II. TEACHING

Teaching Assignments

07/2010-present Full-time clinical faculty in the General Obstetrics and Gynecology Division of the Department of OB/GYN, University of Iowa College of Medicine.
20-40 hours/week clinical teaching
- Resident Continuity of Care Clinic
- Ambulatory surgery
- Colposcopy/laser/cryotherapy/LEEP clinic
- Labor and Delivery
- Benign Gynecology Inpatient Service
- In-house "staff" call- involves remaining in hospital night/weekends and holidays for purposes of resident and medical student education and training.
- OB "group" call- back-up call from home nights/weekends/holidays
- Maternal Substance use disorder clinic
- Generalist HROB clinic

01/2010-present Gynecologic ultrasound analysis staff
American Institute of Ultrasound in Medicine certified

08/2010-present Resident research mentor and co-investigator

07/2010-present M3 lecture series, presented during six week core clerkship
12/2010-present "Induced Abortion" Given every 6 weeks.
1/2010 "Intrapartum Management"
-Faculty mentor for M3 students on OB/GYN core clerkship

07/2010-2015 M2 lecture series, Foundations of Clinical Practice III, Medicine and Society
11/1/2010 "Spontaneous and Induced abortion"
10/31/2011 "Abnormal Uterine Bleeding"
11/4/2010 "Spontaneous and Induced abortion"
11/4/2011 "Contraception"
11/5/2011 "Spontaneous and Induced abortion"
12/13/2012 "Spontaneous and Induced abortion"
12/13/2012 "Contraception"
11/7/2013 "Spontaneous and Induced abortion"

7/2015-present Medicine and Society (MAS) III course lecturer, Carver College of Medicine
3/28/2016 "Women's Health and Public Health"
4/28/2017 "Women's Health and Public Health"
4/30/2017 "Women's Health and Public Health"
4/30/2018 "Women's Health and Reproductive Justice"
4/5/2019 "Women's Health and Reproductive Justice"
5/5/2021 "Public Health and Reproductive Health"
4/6/2021 "Public Health and Reproductive Health"
4/7/2022 "Public Health and Reproductive Health"

12/2010-present University of Iowa Ryan Program Lecture Series

12/14/2010	"History Lesson: Contraception and Abortion legislation"
1/18/2011	"Medical Abortion"
3/1/2011	"Surgical abortion in the first trimester"
6/19/2011	"Care of women before Roe v. Wade" Hosted a panel discussion with several providers who trained prior to Roe Versus Wade.
10/25/2011	"US CDC MEC for Contraception"
6/19/2012	"Emergency Contraception"
7/24/2012	"Care of women before Roe v. Wade" Hosted a panel discussion with several providers who trained prior to Roe Versus Wade.
11/14/2012	"Oral contraceptive pills in depth"
1/9/2013	"Oral contraceptive pills in depth cont"
4/14/2014	"Complicated abortion procedures"
5/4/2014	"Pre-operative assessment for second trimester pregnancy interruption"
5/27/2015	"Miscarriage management
7/28/2015	"Second trimester abortion
12/15/2015	"First and second trimester pregnancy loss"
7/26/2016	"Roe versus Wade and other historical contexts"
3/28/2017	"Second trimester abortion"
7/3/2017	"Ryan Program Introduction and Papaya work-shop"
4/10/2018	"Tubal sterilization and Ethical implications"
5/15/2018	"History of Contraception"
6/5/2018	"Problem patients and professionalism"
1/14/2019	"First Trimester Abortion"
1/29/2019	"Second trimester Abortion"

Continuing on a rotating basis annually

03/28/2010-present M2 Problem Based Learning OB/GYN Small Group Session, FCP IV

Fall 2015	Medicine and Society Small group (M1), weekly
Spring 2016	Problem based learning small group (M2), weekly
Fall 2016	Problem based learning small group (M1), weekly
Spring 2017	Clinical based learning small group (M1), weekly
Spring 2018	Clinical based learning small group (M1), weekly
Spring 2019	Clinical based learning small group (M1), weekly

01/2010-6/2013 Mentor- resident class of 2013

3/23/2011 Discuss OB/GYN career choices with University of Iowa Premedical Club

3/29/2011 Lecture to M1 and M2 students concerning OB/GYN specialty, Carver College of Medicine, University of Iowa

6/2011-present Faculty mentor Medical Students for Choice, University of Iowa Carver

	College of Medicine group
3/2011-present	Mentor for pre-medical students interested in OB/GYN. Allow shadowing of myself in private clinic or while on L&D to expose them to life as a physician in OB/GYN
8/2011-12/2011	Foundations of Clinical Practice Small group for M2 physical exam and history taking faculty facilitator.
2/2013-present	M3 OB/GYN Ethics discussion co-facilitator. Required lecture/discussion group for each student on OB/GYN rotation. Review ethical papers for medical students and facilitate lecture on ethics of OB/GYN care.
3/2013-7/30/2014	Thesis committee member for Kasey Diebold. "Development of model for prediction of post-operative infections following cesarean delivery"
4/17/2013, 9/4/2015, 9/14/2017, 9/16/2021	University of Iowa Health Sciences Research day judge
7/2014-present	Medical student research distinction tract mentor
12/2014-present	American Medical Women's Association national mentor program for medical students
5/2016-8/2016 5/2017-8/2017	C.A.R.E Program. Shadowing program for pre-medical student athletes University of Iowa
7/29/2016	Women in Medicine: a panel for athletes seeking careers in health care Gerdin Learning Center, Student Athletic services
9/21/2017	Medical Students for Choice Lecture: Induced abortion in the US University of Iowa Carver College of Medicine
6/2018-present	Family Planning Elective Clerkship Director
7/3/2018, 7/17/2019 7/21/2021	Insertion of modern intrauterine devices. University of Iowa Family Medicine Residency
10/23/2017, 11/20/2018, 5/3/2019, 6/10/2021.	Leopold Society and Medical Students for Choice event Manual uterine aspiration and IUD insertion simulation
9/24/2018	*Abortion access and restrictions* University of Iowa Medical Students for Choice invited lecture

9/30/2020	*Community Health Outreach: Being a Physician Advocate and Activist* University of Iowa Carver College of Medicine
10/6/2020	*Introduction to Reproductive Health Advocacy* American Medical Women's Association, University of Iowa Chapter University of Iowa Carver College of Medicine
11/30/2020	*Trauma Informed Gynecologic Care* University of Iowa: Carver College of Medicine: Women's Health Seminar
9/1/2020	*Management of Early and Late Spontaneous Abortion* Family Medicine Department Grand Rounds University of Iowa Hospitals and Clinics
10/30/2020	*Mifepristone: The People's Drug* Grand Rounds Mount Sinai Medical Center Department of OBGYN Miami Beach, FL (virtual conference) Ryan Program National Grand Rounds Speaker
1/18/2022	*Maternal Substance Use Disorder.* Abbey Hardy- Fairbanks, Sarah Hambirght, Meagan Thompson Family Medicine Residency Program, Invited lecture University of Iowa Hospitals and Clinics.
3/5/2022	*Dilation and Evacuation in Ambulatory Setting* 2022 Perianesthesia Nursing Conference, Annual Clinical Meeting Virtual Conference, University of Iowa Hospitals and Clinics

Formal Presentations

10/2010	"*Asthma in Pregnancy"* Post-Graduate Conference University of Iowa Hospitals and Clinics, Iowa City, IA
10/12/2011	*"Epidemiology of Abortion in the United States"* Graduate Course, Epidemiology of Reproduction School of Public Health, University of Iowa, Iowa City, IA
10/17/2011	*"Family Planning for MFM Specialists"* MFM Fellow Lecture Series University of Iowa Hospitals and Clinics, Iowa City, IA
3/23/2015	*Interactions of reproductive health and abortion with society and public health.* Guest lecture to the Leopold Society. Student interest group in OB/GYN Carver College of Medicine; University of Iowa
7/17/2015	*Medicine and athletics*

Formal presentation to student athletes interested in health professions careers

9/14/2015 *Abortion in the law*
MFM Fellow Lecture Series
University of Iowa Hospitals and Clinics, Iowa City, IA

10/26/2015 *Psychological implications of abortion: what is the evidence?*
Women's Wellness Clinic Lecture Series
University of Iowa Department of Psychiatry

1/22/2018 *Long Acting Reversible Contraception*
University of Iowa College of Pharmacy; Iowa City, IA

9/24/2018 *Induced abortion in the United States.*
University of Iowa Carver College of Medicine, Medical Students for Choice

9/25/2018 *Women's health and implications for correctional systems*
Educational series for new staff for women's facility including residential, probation officers, guards, social workers and unit managers.
6th District Department of Corrections Service, Cedar Rapids, IA

7/2019 Ryan National Program Journal Club: *Cesarean Scar Pregnancies*
Online Journal club discussion for all Ryan Programs

3/30/2020 *Cesarean Scar Pregnancies: Diagnosis and Management*
MFM Fellow Lecture Series
University of Iowa Hospitals and Clinics, Iowa City, IA

6/3/2021 *Family Planning Updates*
University of Iowa Hospitals and Clinics: REI Fellowship Seminar Series

8/17/2021 *Complex Contraception Update*
Title X MAB: Fall Clinical Site Meeting
Virtual meeting

4/28/2022 *Maternal Substance Use Disorder Collaborative Care*
Women's Wellness Clinic, Weekly lecture series
Abbey Hardy-Fairbanks, Sarah Hambright, Meagan Thompson

Teaching and Hospital committees

6/2008-6/2010 Department Research Committee, Resident representative
Dartmouth-Hitchcock Medical Center, Department of OB/GYN

10/2008 Pathology Residency Internal Review Committee,
Graduate Medical Education, Dartmouth-Hitchcock Medical Center

05/2009	Hospice Fellowship Internal Review Committee, Graduate Medical Education, Dartmouth-Hitchcock Medical Center
10/2015-present	Resident Education Committee University of Iowa Department of Obstetrics and Gynecology

CME Conferences Organization and Planning

2011 *Miscarriage Management*

Course organizer and presenter in conjunction with the Abortion Access Fund and Planned Parenthood. Conference for rural family practice and general practitioners.

III. SCHOLARSHIP/PROFESSIONAL PRODUCTIVITY

Publications or creative works

a. Peer-Reviewed

Hardy-Fairbanks AJ, Baker ER. Asthma in Pregnancy: Pathophysiology, diagnosis and management. *Obstetrics and Gynecology Clinics of North America*. 2010 Jun; 37(2):159-72. PMID: 20685546
This work was done prior to working at University of Iowa. I was responsible for all writing and research for this review.

Hardy-Fairbanks, AJ, Strobehn, K, and Aronson, MP. Urinary Tract Injuries in Pelvic Surgery: Prevention and Recognition. *Contemporary OB/GYN*. October 1, 2010.
10% of this work was done while at University of Iowa. I was responsible for all writing and research for this review.

Cowman WL, Hansen JM, **Hardy-Fairbanks AJ**, Stockdale CK. Vaginal misoprostol aids in difficult intrauterine contraceptive removal: a report of three cases. *Contraception*. 2012 Sep; 86(3):281-4. PMID: 22364817
100% of this work was done at Iowa. I aided in patient identification, writing and editing of the work.

Hardy-Fairbanks AJ, Lauria MR, Mackenzie T, McCarthy M. Intensity and Unpleasantness of Pain Following Vaginal and Cesarean Delivery: A Prospective Evaluation. *BIRTH*. 2013; 40(2): 125-133. PMID: 24635467
Patient recruitment was done at another facility. Analysis and writing were done at Iowa. Writing, analysis and publication were done while at Iowa. I was responsible for study design, patient recruitment, data collection, initial data analysis, writing, editing and publication.

Hardy-Fairbanks AJ, Pan SJ, Decker MD, Johnson DR, Greenberg DP, Kirkland KB, Talbot EA, Bernstein HH. Immune Responses in Infants Whose Mothers Received Tdap Vaccine during Pregnancy. Pediat Infect Dis J. 2013; 32(11) 1257-60. PMID: 20685546
Patient recruitment and data collection occurred while at Dartmouth Medical Center. Analysis, writing and publication were done while at Iowa. I was responsible for all control subject recruitment, all intervention group chart review, writing of the paper and presentation of findings via oral presentation at international infectious disease conference.

Cowman W, **Hardy-Fairbanks AJ**, Endres J, Stockdale CK. A select issue in the postpartum period: contraception. *Proc Obstet Gynecol*. 2013; 3(2) Article 1 [15 p.].
100% of this work occurred at Iowa. I aided in writing, article review and editing of the final review.

Tikkanen S, Button A, Zamba G, **Hardy-Fairbanks AJ**. Effect of chlorhexidine skin prep and subcuticular skin closure on postoperative infectious morbidity and wound complications following cesarean section. *Proc Obset Gynecol*. 2013; 3 (2): Article 2 [10 p.]
100% of this work was done at Iowa. I was responsible for grant application, supervision as well as study design. I served as a primary mentor and leader on this project. Chart review and initial writing was done by Swift.

Wahle EM, Hansen JM, Cowman WL, **Hardy-Fairbanks AJ**, Stockdale CK. Tbe effect of vaginal misoprostol on difficult intrauterine contraceptive removal. Med J Obsetet Gynecol 2014; 2(1): 1020.
100% of this work was done at Iowa. I was a secondary mentor on this project. I was responsible for data analysis, supervision of writing and publication.

Murray ME, **Hardy-Fairbanks AJ**, Racek A, Stockdale CK. Pain control options for first trimester surgical abortions: a review. Proc Obstet Gynecol. 2014;4(2):Article 2 [6p.].
100% of this work was done at Iowa. I was a secondary mentor on this project. I helped in review of articles, writing, editing and final review.

Hansen, Santillan MK, Stegmann BJ, Foster T, **Hardy-Fairbanks AJ**. Maternal demographic and clinical variables do not predict intrauterine contraception placement: Evidence for postplacental intrauterine contraception placement. Proc Obstet Gynecol. 2014;4(2):Article 4 [7p.].
50% of this work was done while at Iowa. I collected patient data while at Dartmouth Hitchcock Medical center. I was responsible for study design and data collection. I aided in a data analysis and supervised writing and publication.

O'Shea AS, Steines JC, **Hardy-Fairbanks AJ**. Retroperitoneal hematoma following hysteroscopic removal of levonorgestrel intrauterine system: a case report. Proc Obset Gynecol. 2014;4(2):Article 7 [3p].
100% of this was done at Iowa. I was a primary mentor on this project. Writing primarily done by Steines. I was responsible for review, editing and publication.

Roberts KE, **Hardy-Fairbanks AJ**, Stockdale CK. The effects of obesity with pregnancy termination: a literature review. Proc Obstet Gynecol. 2014;4(2): Article 3 [5p.].
100% of this was done at Iowa. I was responsible for patient identification. I supervised writing, editing and publication of this work.

Dickerhoff LA, Mahal AS, Stockdale CK, **Hardy-Fairbanks AJ**. Management of cesarean section scar pregnancy with dehiscence in the second trimester: a case series and review of the literature. J Reprod Med. 2015;60(3-4):165-8. PMID 25898481
100% of this was done at Iowa. I was responsible for patient identification. I supervised the writing, editing and publication of this work.

Swift SH, Zimmerman BM, **Hardy-Fairbanks AJ**. Effect of single-use negative pressure wound therapy on post-cesarean infectious wound complications for high-risk patients. J Reprod Med. 2015; 60(5-6):211-8. PMID: 26126306
100% of this work was done at Iowa. I was responsible for grant application, supervision of data collection/analysis and study design. I served as a primary mentor on this project. Chart review and initial writing was done by Swift.

Lin I, **Hardy-Fairbanks AJ**. Impact of obesity on rates of successful vaginal delivery after term induction of labor. Proc Obset Gynecol. 2015 August; Article 1 [5 p.]. Available from: http://ir.uiowa.edu/pog_in_press/. Free full text article.
100% of this work was done at Iowa. This work was done as part of a summer research

fellowship grant and I served as primary mentor. I was responsible for study design, analysis and editing of final publication. Data collection done by Lin with my supervision.

Brock EN, Stockdale CK, House HR, **Hardy-Fairbanks AJ**. The impact of clinical clerkships on medical students attitudes toward contraception and abortion: a pilot study. Proceedings in Obstetrics and Gynecology, 2015;5(2). Available from: Available from: http://ir.uiowa.edu/pog_in_press/. Free full text article.
100% of this work was done at Iowa. I was responsible for study design, implementation and statistical analysis. This work was the recipient of 2nd place research award at APGO/CREOG meeting. I was also responsible for editing the final work for publication.

Mancuso A, Lee K, Zhang R, Hoover E, Stockdale C, **Hardy-Fairbanks AJ**. Deep sedation without intubation during second trimester surgical termination in an inpatient hospital setting. *Contraception*. 2016; pii: S0010-7824(15)30214-6. PMID: 27713005
100% of this work was done at Iowa. I was responsible for study design, database building, statistical analysis and editing/publication. Initial writing and chart review done by Mancuso.

Hardy-Fairbanks AJ, Mackenzie T, McCarthy M, Goldman MB, Lauria MR. A randomized controlled trial comparing two types of retractors at caesarean delivery. J Obstet Gynaecol. 2017. 37(8):1009-1014. PMID: 28635352
25% of this work was done while at Iowa. Data collection and study design took place at Dartmouth Hitchcock Medical Center. I was responsible for study design, implementation, and data collection. Writing, editing and publication occurred while at Iowa.

Smid MC, Dotters-Katz SK, Grace M, Wright ST, Villers MS, **Hardy-Fairbanks AJ**, Stamilio DM. Prophylactic Negative Pressure Wound Therapy for Obese women after cesarean delivery: A systematic review and meta-analysis. Obstetrics and Gynecology, 2017. PMID: 29016508
100% of this work occurred while at Iowa. I was responsible for re-analysis of data from previous work on negative pressure wound therapy as well as editing, writing and assistance in publication.

Goad LM, Williams HR, Treolar MS, Stockdale CK, **Hardy-Fairbanks AJ**. A pilot study of patient motivation for postpartum contraception planning during prenatal care. Int J Women's Health and Wellness. 2017;3(1):048. https://clinmedjournals.org/articles/ijwhw/international-journal-of-womens-health-and-wellness-ijwhw-3-048.pdf
100% of this work was done at Iowa. I was responsible for study design, grant applications (SRF), implementation, database building and data analysis. I served as primary mentor on this project. Initial data collection and writing done by Williams. I was responsible for final editing and publication.

Brock EN, Stockdale CK, House HR, **Hardy-Fairbanks AJ**. Effect of Clinical Clerkships on Medical Student Attitudes toward Abortion and Contraception. Madridge J of Women's Health Eman. 2017; 1(1):4-6. https://madridge.org/journal-of-womens-health-and-emancipation/MJWH-1000102.pdf
100% of this work was done at Iowa. I was responsible for study design, implementation and data analysis. Initial data collection and writing done by Brock. I completed final review and publication.

Hoover E, **Hardy-Fairbanks AJ**, Stockdale CK. Use of Vaginal misoprostol prior to placement of an intrauterine device: a review. J of Gynecol Res Obstet. 2017; 7(3): 029-033. https://www.peertechz.com/articles/use-of-vaginal-misoprostol-prior-to-placement-of-an-intrauterine-device-a-review.pdf
100% of this work was done at Iowa. I was a secondary mentor on this project and was responsible for final editing and assisted in publication of the final review.

Williams HR, **Hardy-Fairbanks AJ**, Stockdale CK, Radke S. Management of vaginal wall perforation during a second trimester dilation and evacuation. Proceed in Obstet Gynecol. 2017 Oct; 7(3): [1-7 p]. https://doi.org/10.17077/2154-4751.1375
100% of this work was done at Iowa. I was a secondary mentor on this project and was responsible for final editing and publication. Initial writing done by Williams.

Mancuso A, **Hardy-Fairbanks AJ** and Mejia R. Laparoscopic guided dilation and evacuation following a uterine perforation. J Reprod Med. 2017;62:681-683.
100% of this work was done at Iowa. I was a secondary mentor on this project and was responsible for final editing and publication. Initial writing done by Mancuso.

Michaels LL, Stockdale CK, Zimmerman MB, **Hardy-Fairbanks AJ**. Factors affecting the contraceptive choices of women seeking abortion in non-urban area. J Reprod Med, 2018 August: 63 (3).
100% of this work was done at Iowa. I was responsible for study design, implementation and data collection systems. I served as primary mentor on this project. I completed final editing and publication. Initial writing by Michaels.

Steelman AM, Shaw C, Shine L, **Hardy-Fairbanks AJ**. Retained surgical sponges: a descriptive study of 319 occurrences and contributing factors from 2012 to 2017. Patient Safety in Surgery. 2018, 12:20. PMID 29988638
100% was done at Iowa. I was responsible for writing a portion of manuscript, review of gynecologic related portions of the research/manuscript, manuscript editing and assisted in publication.

Steelman VM, Shaw C, Shine L, and **Hardy-Fairbanks AJ**. Unintentionally Retained Foreign Objects: A Descriptive Study of 308 Sentinel Events and Contributing Factors. Jt Comm J Qual Saf. 2018. S1553-7250 PMID: 30341013
100% was done at Iowa. I was responsible for writing a portion of manuscript, review of gynecologic related portions of the research/manuscript and assisted in publication.

Mattson JN and **Hardy-Fairbanks AJ**. Clostridium sordelli Toxic Shock after Endometrial Ablation: Review of Gynecologic Cases. Journal of Gynecologic Surgery. 2018;34(6):311-314. https://www.liebertpub.com/doi/10.1089/gyn.2018.0037
100% of this work was done at Iowa. I was responsible for patient identification, manuscript editing, review and publication. Initial writing by Mattson.

Kerestes CA; Sheets K; Stockdale CK and **Hardy-Fairbanks AJ.** Prevalence, attitudes and knowledge of misoprostol for self-induction of abortion in women presenting for abortion at Midwestern reproductive health clinics. Reproductive Health Matters. 2019; 27(1):1-8.

https://tandfonline.com/doi/full/10.1080/09688080.2019.1571311
100% of this work was done at Iowa. I served as primary mentor for this project and responsible for study design, implementation, database building, grant writing, and supervision of student researchers. Initial data collection by Sheets and writing by Kerested/Sheets. I completed final manuscript review/editing and was publication.

Kerestes CA; Stockdale CK; Zimmerman MB and **Hardy-Fairbanks AJ**. Abortion Providers' experiences and views on self-managed medication abortion an exploratory study. Contraception. 2019;100(2):160-164. PMID: 31002777
100% of this work was done at Iowa. I served as primary mentor for this project and responsible for study design, implementation and database building. I completed final manuscript review/editing and was publication.

Meurice ME, Goad LM, Barlow PB, Kerestes CK, Stockdale CK, **Hardy-Fairbanks AJ**. Efficacy-based contraceptive counseling for women experiencing homelessness in Iowa City, IA. Journal of Community Health Nursing. 2019;35(4): 199-207. PMID: 31621431
100% of this work was done at Iowa. I served as primary mentor for the project. I was responsible for study design and guidance on data collection. Initial writing done by Meurice and Goad. Data analysis by Barlow. I was responsible for final editing and publication.

Whitis AM; **Hardy-Fairbanks AJ**; Stockdale CK. New directions in medical student clerkship evaluations. Proceedings in Obstetrics and Gynecology. 2019;9(2):9.
https://ir.uiowa.edu/cgi/viewcontent.cgi?article=1471&context=pog
100% of this work was done at Iowa. I was a secondary mentor on this project and was responsible for data analysis as well as final editing of publication.

Williams HR, Goad L, Treolar M, Ryken K, Mejia R, Zimmerman MB, Stockdale CK, **Hardy-Fairbanks AJ**. Confidence and readiness to discuss, plan and implement postpartum contraception plan during prenatal care versus after delivery. Journal of Obstetrics and Gynaecology. 2019;39:7, 941-947, DOI: 10.1080/01443615.2019.1586853
100% of this work was done at Iowa. I served at primary mentor on this project and was responsible for project design, implementation and grant writing. I assisted on data analysis. I was responsible for final manuscript editing and publication. Initial writing was by Williams.

Meurice ME, Todd C, Barlow PB, Gaglioti AH, Goad L, **Hardy-Fairbanks A**, Stockdale CK. Unique Health needs and characteristics of homeless women in Iowa City, Iowa. Proceedings in Obstetrics and Gynecology. 2020;9(3):11-13.
https://ir.uiowa.edu/cgi/viewcontent.cgi?article=1455&context=pog
100% of this work was done at Iowa. I served as a primary mentor on this project. I was responsible for final editing and assisted in publication.

Bakir S, Hoff T, Hahn P, Stockdale CK, **Hardy-Fairbanks A**. Planned use of long acting reversible postpartum contraception in low-risk women in CenteringPregnancy® group versus individual physician prenatal care. Proceedings in Obstetrics and Gynecology. 2020;10(1):Article 7 [11 p.].
https://ir.uiowa.edu/cgi/viewcontent.cgi?article=1476&context=pog
100% of this work was done at Iowa. I served as a primary mentor for this project. I was responsible for study design, grant writing, database building and supervision of data collection. Initial writing by Bakir and Hoff. I was responsible for final manuscript editing

and publication.

Mattson J, Thayer M, Mott Sarah, Lyons Y, **Hardy-Fairbanks AJ,** Hill E. Multimodal Perioperative Pain Protocol for Gynecologic Oncology Laparotomy is Associated with Reduced Hospital Length of Stay. The Journal of Obstetrics and Gynaecology Research. 47: 2021. https://obgyn.onlinelibrary.wiley.com/doi/10.1111/jog.14640
100% of this work was done at Iowa. I served as a secondary mentor on this project. I was involved in study design and database building. I assisted in manuscript editing and publication.

Bachur CD, Stockdale CK, Murray M, **Hardy-Fairbanks AJ.** Resident Abortion Training during COVID-19 Pandemic. Journal of Graduate Medical Education, under second review/revision.
100% of this work was done at Iowa. I served as a primary mentor for this project. I was responsible for study design, grant writing, database building and supervision of data collection. Initial writing by Bachur. I was responsible for final manuscript editing and publication.

Frahm A, **Hardy-Fairbanks AJ**, Stockdale CK. Look before you LEEP: Patient reported pain with IV sedation versus local analgesia. Proceedings of Obstetrics and Gynecology, 2022;11(1): Article 8 [6p.]. DOI: https://doi.org/10.17077/2154-4751.31432
100% of this work was done at Iowa. I served as a secondary mentor for this project. I was responsible for study design, grant writing, database building and data analysis. Initial writing by Frahm. I was responsible for final manuscript editing and publication.

Kerestes CA, Koch, S, Freese M, Stockdale CK, Zimmerman MB, **Hardy-Fairbanks AJ.** Searching for abortion pills: a systematic analysis of the accuracy, quality and credibility of online information about medical abortion. Proceedings of Obstetrics and Gynecology, under review.
100% of this work was done at Iowa. I served as a primary mentor for this project. I was responsible for study design, database building and supervision of data collection. Initial writing by Kerestes. I was responsible for final manuscript editing and publication.

b. <u>Reviews</u>

Hardy-Fairbanks AJ. Asthma in Pregnancy. *The Iowa Perinatology Letter*. December 2010.

Hardy-Fairbanks AJ, Elson M, Lara-Torre E. Contraception for Women with Migraines. Pearls of Exxcelence. The Foundation for Exxcelence in Women's Health. March 2017. https://exxcellence.org/pearls-of-exxcellence/list-of-pearls/contraception-for-women-with-migraines/

<u>c. Books and Chapters</u>

Hardy-Fairbanks AJ and Swanson J. Office-based Gynecology, Chapter 20: Long Acting Reversible Contraception. Wiley and Sons. Editor Amy Garcia, MD.

Hardy-Fairbanks AJ, Reviewer. DeGowin's Diagnostic Examination, 11th Edition. Chapter 11: The Female Genitalia and Reproductive System. McGraw Hill, 2020.

d. Abstracts

Hardy-Fairbanks AJ, Pan SJ, Johnson DR, Bernstein HH. *Immune Responses in Infants Following Receipt of Pertussis Immunization by their Mothers during Pregnancy*. Accepted to the late breaker session of the Infectious Disease Society of America Annual Clinical Meeting, Vancouver, British Columbia, September 2010. Abstract and oral presentation

Hansen JM, Santillan MK, Stegmann BJ, Foster, TC, **Hardy-Fairbanks AJ**. *Maternal demographic and clinical variables do not predict IUC placement: evidence for postplacental IUC placement*. Contraception. 2012 March:85(3):322

Swift SH, Zimmerman BM, **Hardy-Fairbanks AJ**. *Effect of single-use negative pressure wound therapy on post-cesarean infectious wound complications for high-risk patients*. Oral presentation at: COGI 2013. 18th World Congress on Controversies in Obstetrics, Gynecology and Infertility; 2013 October 24-27; Vienna, Austria.

Brock EN, Stockdale CK, **Hardy-Fairbanks AJ**. *The Effect of Clinical Clerkships on Medical Students" Attitudes Toward Abortion and Contraception.* Obstet Gynecol. May 4, 2015. http://journals.lww.com/greenjournal/Abstract/2015/05001/The_Effect_of_Clinical_Clerkships_on_Medical.202.aspx

Kerestes CA, Sheets K, Stockdale C, **Hardy-Fairbanks AJ**. *Prevalence, attitudes and knowledge of misoprostol for self-induction of abortion in women presenting for abortion at reproductive health clinics*. Oral presentation at 41st National Abortion Federation Annual Meeting. Hotel Bonaventure, Montréal, Québec, Canada. April 24th, 2017.

Kerestes CA, Stockdale CK, **Hardy-Fairbanks AJ**. *Provider Perspectives on Self-Sourced Abortion*. Oral presentation at 42nd National Abortion Federation Annual Meeting. The Westin Seattle. Seattle, WA. April 23rd, 2018.

Mattson JN, Thayer M, Mott SL, Lyons YA, Reyes HD, McDonald ME, **Hardy-Fairbanks AJ**, Hill EK. *Multimodal Perioperative Pain Protocol for Gynecologic Oncology Laparotomy Reduces Length of Hospital Stay*. Oral presentation at Western Association of Gynecologic Oncologists Annual Meeting. Westgate Park City Resort. Park City, UT. June 15th, 2018.

Bakir S; Stockdale CK; Elas D, **Hardy-Fairbanks, AJ**. Accuracy of Vaginal pH Testing Before and After Addition of Sterile Saline. Oral presentation and abstract. Annual Scientific Meeting of American Society for Colposcopy and Cervical Pathology. Virtual meeting secondary to COVID, 3/31-4/3/2020.

e. Posters

Hardy-Fairbanks, AJ, Lauria, MR, Mackenzie, T, McCarthy, M. *A Randomized Controlled Trial*

Comparing Two Types of Retractors at Cesarean Delivery. American College of Obstetrics and Gynecology Annual Clinical Meeting, Washington, DC. 5/3/2011

Hansen JM, Santillan MK, Stegmann BJ, Foster TC, **Hardy-Fairbanks AJ**. *Maternal Demographic and Clinical Variables do not predict IUC placement: Evidence for postplacental IUC placement.* American Reproductive Health Professional Annual Clinical Meeting, Las Vegas, NV. 9/15/2011

Whale EM, Hansen JM, Cowman WL, **Hardy-Fairbanks AJ,** Stockdale CK. *The effect of vaginal misoprostol on difficult intrauterine contraceptive removal: A retrospective chart review*. ACOG 2012. American Congress of Obstetrics and Gynecology District IV Annual Clinical Meeting. Phoenix, AZ. 9/21-9/23/2012.

Michaels LL, Stockdale CK, Zimmerman MB, **Hardy-Fairbanks AJ**. *Factors affecting the contraceptive choices of women seeking abortion in Iowa.* ACOG District VI Annual Clinical Meeting 2013. Maui, Hawaii. 9/26-9/28/2013.

Lin I, Bolger H, Wen C, **Hardy-Fairbanks AJ**. Impact of obesity on induction of labor at term. ACOG District VI 2014. ACOG Tridistrict Annual Meeting. Napa, CA. 9/4-9/7/2014.

Brock EN, Stockdale CK, House HR, Che W, **Hardy-Fairbanks AJ**. *The Impact of Clinical Clerkships on Medical Students" Attitudes towards Contraception and abortion.* APGO/CREOG 2014. The Council on Resident Education in Obstetrics and Gynecology/Association of Professors of Gynecology and Obstetrics Annual Meeting. Atlanta, GA. 2/28-3/1/2014. Winner 2nd place for Excellent Research Poster

Krohn M, Hansen J, Che W, Stockdale CK, **Hardy-Fairbanks AJ**. *Mid-Trimester pregnancy interruption: provider perspectives, practice and knowledge.* SFP 2014. Society of Family Planning Annual Clinic Meeting. Miami, FL. 10/11-10/13/2014. Winner Top 15 Research Poster.

McDonald M, Che W, Stockdale CK, **Hardy-Fairbanks AJ**. *Vaginal misoprostol versus concentrated oxytocin for midtrimester labor induction: a retrospective chart review.* SFP 2014. Society of Family Planning Annual Clinic Meeting. Miami, FL. 10/11-10/13/2014.

Brock EN, Stockdale CK, **Hardy-Fairbanks AJ**. *The Effect of Clinical Clerkships on Medical Students" Attitudes Toward Abortion and Contraception.* ACOG 2015. American Congress of Obstetricians and Gynecologists Annual Clinical Meeting. San Francisco, CA. 5/2-5/6/2015.

Rapp A, Racek A, Stockdale CK, **Hardy-Fairbanks AJ**. *Patient satisfaction with immediate post-delivery long acting reversible contraception placement.* Research day 2015. Carver College of Medicine Research Day.

Goad L, Williams H, Treolar M, Stockdale CK, **Hardy-Fairbanks AJ**. *A pilot study of patient motivation for postpartum contraception planning during prenatal care.* ACOG joint-District 2015. ACOG joint district-V, VI, VII, VIII and IX annual meeting. Denver, CO. 9/18-9/20/2015

Treolar M, Williams H, Goad L, Stockdale CK, **Hardy-Fairbanks AJ.** *A pilot study of patient motivation for postpartum contraception planning during hospitalization* following delivery. ACOG joint-District 2015. ACOG joint district-V, VI, VII, VIII and IX annual meeting. Denver, CO. 9/18-9/20/2015

Mancuso AC, Lee K, Zhang R, Stockdale CK and **Hardy-Fairbanks AJ**. Deep sedation without intubation during second trimester surgical terminations in an inpatient. SFP 2015. North American Forum on Family Planning Chicago, IL. 11/14-11/15/2015

Rapp A, Racek A, Stockdale CK, **Hardy-Fairbanks AJ**. *Patient satisfaction with immediate post-delivery long acting reversible contraception placement.* ACOG 2016. American Congress of Obstetricians and Gynecologists Annual Clinical Meeting. Washington DC, 5/20/16-5/23/2016.

Williams HR, Treolar M, Goad L, Stockdale CK, **Hardy-Fairbanks AJ**. *Postpartum contraception acceptance and readiness (PCAR).* SFP 2016. North American Forum on Family Planning. Denver, CO. 11/5-7/2016

Hahn P, Hoff T, Stockdale CK, **Hardy-Fairbanks AJ**. Comparison of outcomes in low-risk women in Centering Pregnancy® versus individual certified nursing midwife prenatal care. ACOG ACM 2017. American Congress of Obstetricians and Gynecologists Annual Clinical Meeting. San Diego, CA. 5/6/17-5/9/2017

Williams HR, Goad LM, Treolar MS, Mejia RB, Stockdale CK, **Hardy-Fairbanks AJ.** Postpartum contraception acceptance and readiness for long acting reversible contraception. ACOG ACM 2017. American Congress of Obstetricians and Gynecologists Annual Clinical Meeting. San Diego, CA. 5/6/17-5/9/2017

Hoff T, Hahn P, Sharma D, Huntley J, **Hardy-Fairbanks AJ**, Stockdale CK. Postpartum LARC use in low-risk women in group vs individual CNM prenatal care. ACOG ACM 2017. American Congress of Obstetricians and Gynecologists Annual Clinical Meeting. San Diego, CA. 5/6/17-5/9/2017

Songer K, Richards H, Stockdale CK, **Hardy-Fairbanks AJ.** Inappropriate use of vancomycin for GBS prophylaxis in women who report a penicillin allergy. American Congress of Obstetrics and Gynecology tri district (VI, VII, XI) annual clinical meeting. Hyatt Regency Hill County, San Antonio, TX 9/15-17/2017.

Goad L, Meurice ME, Barlow R, Kerestes C, Stockdale CK, **Hardy-Fairbanks AJ.** Efficacy-based contraceptive counseling for women experiencing homelessness in Midwest. Oral presentation: American Congress of Obstetrics and Gynecology tri district (VI, VII, XI) annual clinical meeting. Hyatt Regency Hill County, San Antonio, TX 9/15-17/2017.

Sheets KA; Hansen HE; Gnade C; **Hardy-Fairbanks AJ**; Stockdale C. Morbid Obesity: Effects on Cervical Cancer Screening and Presentation. Poster Presentation. Annual Scientific Meeting on Anogenital & HPV-related Diseases. Atlanta, GA.4/4-7/2019.

Hansen HE; Sheets KA; Gnade C; Hill EK; **Hardy-Fairbanks AJ**; Stockdale C. Cervical cancer: Relationships between symptomatic presentation and patient demographics. Annual Scientific Meeting on Anogenital & HPV-related Diseases. Atlanta, GA.4/4-7/2019.

Gnade C; Hill EK; Botkin H; Hefel A; Hansen H; Mott S; **Hardy-Fairbanks AJ**; Stockdale CK. Effect of Obesity on Cervical Cancer Screening and Outcomes. Annual Meeting of Society of Gynecologic Oncology. Toronto, Canada, 3/28-31/2020.

Gnade C; Hill EK; Botkin H; Hefel A; Hansen H; Mott S; **Hardy-Fairbanks AJ**; Stockdale CK Is the age of cervical cancer diagnosis changing over time? Annual Meeting of Society of Gynecologic Oncology. Toronto, Canada, 3/28-31/2020.

Botkin H; Gnade C; Hefel A; Hansen H; Hill, E; **Hardy-Fairbanks, AJ;** Stockdale CK. Immunosuppression in Cervical Carcinoma. Poster presentation. Annual Meeting of ASCCP; Virtual meeting due to COVID 4/7-4/9/2020.

Bakir S, Stockdale CK, Elas D, **Hardy-Fairbanks, AJ**. Accuracy of Vaginal pH Testing Before and After Addition of Sterile Water. Oral Presentation. Annual Meeting of ASCCP, Virtual meeting due to COVID 4/7-4/9/2020.

Bachur CD, Stockdale CK, Murray M, Hardy-Fairbanks AJ. Resident Abortion Training during COVID-19 Pandemic. Poster presentation. National Abortion Federation Annual Clinical Meeting, May 11-12, 2021. Virtual meeting.

Reische E, Sharp A, Jain S, Herwaldt L, Stockdale CK, **Hardy-Fairbanks AJ**. The effect of the PICO® negative-pressure dressing on cesarean section infection rates in obese women. Carver College of Medicine Research Day. 9/16/2021

Sharp A, Reische E, Jain S, Herwaldt L, **Hardy-Fairbanks AJ**, Stockdale CK. Comparison of infection rates post cesarean section of Prevena® negative pressure and standard sterile dressings in obese women. Carver College of Medicine Research Day. 9/16/2021

f. <u>Other publications</u>

Abstract/Video/Oral Presentation: **Hardy-Fairbanks AJ**, Whiteside JL. *Pelvic Surgery After Kidney Transplant: Technique and Comment*. American Urogynecology Society Annual Clinical Meeting, 09/2010.

Hardy-Fairbanks, Abbey. *A Mother and Abortion Provider—I can be both.* Newsweek. May 11th, 2019. https://www.newsweek.com/abortion-provider-mother-opinion-1409871

Hardy-Fairbanks AJ; Bourne C. *"Abortion is not elective": Midwest Reproductive Health Care During a Pandemic.* Ms. Magazine. April 17, 2020. https://msmagazine.com/2020/04/17/abortion-is-not-elective-midwest-reproductive-health-care-during-a-pandemic/

Clancy, G. Rounding@Iowa: Maternal Substance Use Disorder. Podcast December 14, 2021.

https://uiowace.libsyn.com/32-maternal-substance-use-disorders. Guests: **Hardy-Fairbanks AJ**, Hambright S, Thompson M.

University of Iowa Public Information and **Hardy-Fairbanks, AJ**. *Vaxx Facts* – Pregnancy and COVID-19 Vaccine. December 30th, 2021. https://www.youtube.com/watch?v=75FTBSe0MWk

The Short Coat, University of Iowa Carver College of Medicine Podcast. Dave Etler, Producer & Host. Lessons from the Wards: What Future Residents Need to Know, **Abbey Hardy-Fairbanks, MD.** https://podcast.uiowa.edu/com/osa/408-abbey-hardy-fairbanks.mp3

g. Areas of Research Interest and Current Projects

2016-2020	Internet site information quality on self-sourced medical abortion Principal investigators: Hardy-Fairbanks AJ, Stockdale C, Kerestes CA
2015-present	Touching Hearts mementoes for families undergoing dilation and evacuation, qualitative study Principal investigators: Hardy-Fairbanks AJ, Stockdale CK, Murray M
2017-2020	Antibiotic use for GBS prophylaxis Principal investigators: Hardy-Fairbanks AJ, Hope R, Songer K
2020-2021	Impact of COVID-19 on procedural abortion training Principal investigators: Hardy-Fairbanks AJ, Stockdale CK, Murray M
2019-present	Negative pressure wound therapy (NPWT) for prevention of infectious and wound complications after cesarean delivery Principle investigators: Hardy-Fairbanks AJ, Herwaldt L, Stockdale CK, Jain S and Akella S
2019- 2020	TelAbortion Study: National Multi-Center study of Telemedicine and Mail delivery of Medication Abortion https://telabortion.org/ Site Principle Investigator: Hardy-Fairbanks AJ
2021-present	Mifepristone and misoprostol for early pregnancy loss, actual clinical use outcomes. Principle investigators: Hardy-Fairbanks, AJ, Hardy-Fairbanks AJ, Stockdale CK, Murray M
2021-present	MOAT: Implementing SBIRT in OBGYN Outpatient Clinics Principle investigators: Hambright S, Thompson M, Lynch A, Hardy-Fairbanks, AJ

h. Invited lectures

12/2010	*How to Avoid the Scrooge: Women and Holiday Stress.* University of Iowa Hospitals and Clinics, Iowa City, IA, Community Health Seminar Series.
4/12/2011	National Abortion Federation Annual Meeting, Chicago, IL. Panel discussion: *Fostering relationships between University Ryan programs with independent abortion clinics.*
5/4/2011	American College of Obstetrics and Gynecology Annual Clinical Meeting, Washington, D.C. Ryan Program Panel discussion for medical students concerning residency choices for those interested in family planning careers.
03/7/2011 & 4/22/2015	*Motherhood and Medicine.* Panel discussion by AMWA. University of Iowa Carver College of Medicine. University of Iowa, Iowa City, IA
05/2011	*Birth Options in Iowa.* National Public Radio, Iowa Public Radio. *Talk of Iowa.*
10/5/2011	*Post-Cesarean Infectious Complications* 2011 University of Iowa Obstetrical Nursing Conference Hampton Inn; Coralville, Iowa
08/2/2012	*Deciding to provide abortion: provider perspectives*. Panel discussion by Medical Students for Choice. University of Iowa Carver College of Medicine.
2/2/2013	*Conscious birthing in Iowa*: *Doulas and Hospital Practitioners.* Panel discussion at 6th Annual Conscious Birth Summit. Iowa City Public Library. Iowa City, IA
6/12/2013	*Abnormal Uterine Bleeding* Visiting Professor for Siouxland Family Medicine Residency Program St. Luke's Hospital, Unity Point Health. Sioux City, IA
11/5/2013	*Early Pregnancy Failure* University of Iowa Hospitals and Clinics Department of OB/GYN grand rounds presentation.
4/21/2014	*Complex Contraception* Visiting Professor for Siouxland Family Medicine Residency Program St. Luke's Hospital, Unity Point Health. Sioux City, IA
9/18/2014	*Evaluation and Treatment of Abnormal Uterine bleeding* Visiting Professor for Broadlawns Family Medicine Residency and Grand Rounds Program. Broadlawns Medical Center, Des Moines, IA
9/18/2014	*Evaluation and Treatment of Abnormal Uterine bleeding*

Visiting Professor Iowa Lutheran Family Medicine Residency and Grand Rounds Program
Iowa Lutheran Hospital, Unity Point Health, Des Moines, IA

10/7/2014 *Miscarriage Diagnosis and Management*
Children's and Women's Health Conference: Women's Health.
2014 Annual University of Iowa Obstetrical Nursing Conference
Holiday Inn; Coralville, Iowa

3/7/2015 *Reproductive Health Clinic Collaborations: The latest Hybrid Motor in Medical Education. Panel discussion*
2015 CREOG & APGO Annual Meeting
JW Marriott San Antonio Hill Country Resort; San Antonio, TX

4/1/2015 *Reproductive Health and Societal implications*
Community Health Outreach Seminar Course guest lecturer
Carver College of Medicine
University of Iowa, Iowa City, Iowa

4/22/2015 *American Medical Women's Association: Being a mom in medicine*
Carver College of Medicine
University of Iowa, Iowa City, Iowa

5/4/2015 *Junior Fellow Round Table: Family Planning*
2015 American Congress of Obstetricians and Gynecologists Annual Clinical Meeting
San Francisco, CA

6/30/2015 *Non-Tubal Ectopic Pregnancies*
University of Iowa Hospitals and Clinics Department of OB/GYN grand rounds presentation.

1/12/2015 *Abortion in the United States*
Visiting Professor Cedar Rapids Family Medicine Residency
Unity Point Health, Cedar Rapids, IA

1/16/2015 *Doctors and Midwives, a necessary collaboration.* Panel discussion at 10th Annual Conscious Birth Summit. Iowa City Public Library. Iowa City, IA

4/6/2016 *Immediate Postpartum Long Acting Reversible Contraception.*
42nd Annual Iowa Conference on Perinatal Medicine.
Iowa Statewide Perinatal Care Program and the University of Iowa Carver College of Medicine
West Des Moines Marriott, West Des Moines, IA

4/18/2016 *Prevention of abortion complications through collaborations between Ryan programs and independent abortion clinics.*
National Abortion Federation Annual Clinical Meeting

JW Marriott, Austin, TX

5/20/2016 *Cesarean scar ectopic pregnancy: diagnosis and management*
Dartmouth-Hitchcock Medical Center
Department of Obstetrics and Gynecology Grand Rounds
Lebanon, NH

2/3&4/2017 Building a Ryan Program: multi-day workshop for new Ryan program directors and coordinators
Building enthusiasm for teaching residents and medical students, Lead facilitator
Examples of Ryan Programs
New Service Development, Office and hospital based procedures: expanding services
And now you know how to build a Ryan Program? Workshop Wrap up
Laurel Center, University of California, San Francisco. Ryan Program National Office

3/7/2017 *Complex Contraception decision making: CDC MEC use*
Visiting Professor for Broadlawns Family Medicine Residency and Grand Rounds Program.
Broadlawns Medical Center, Des Moines, IA

3/10/2017 *Through the Looking Glass: enchanting your medical students with flipped classrooms, team-based learning and clinical opportunities focused on family planning*
Presenter, large group session at APGO/CREOG Annual National meeting, 2017
Hyatt Regency Hotel, Orlando Florida.

9/21/2017 *Abortion today in the Midwest: a policy update*
Medical Students for Choice.
University of Iowa Hospitals and Clinics, Carver College of Medicine

10/2/2017 *Immediate postpartum long acting reversible contraception: cutting edge contraception*
Children's and Women's Services Fall Nursing Conference
University of Iowa Hospitals and Clinics, Stead Family Children's Hospital
Radisson Hotel and Conference Center, Coralville, IA

10/14/2017 Career Paths in Family Planning: Workshop for Career planning in reproductive health
How did I get here?
How to be successful as an academic generalist in family planning
Small group discussion
North American Forum on Family Planning
Hyatt Regency Hotel and Conference Center, Atlanta, GA

1/17&18/2018 Building a Ryan Program: multi-day workshop for new Ryan program Directors and coordinators
Relationships with Independent Clinics, Lead facilitator
Examples of Ryan Programs

Laurel Center, University of California, San Francisco. Ryan Program National Office

3/1/2018 *All Hands on Deck! Hands-on and digital simulation for teaching family planning procedures.*
CREOG & APGO Annual Meeting. Gaylord National Resort and Convention Center in National Harbor, MD.

3/3/2018 *Winds of Change: Bold Innovations in Undergraduate Medical Education in Family Planning.*
CREOG & APGO Annual Meeting. Breakout Session. Gaylord National Resort and Convention Center in National Harbor, MD.

4/6/2018 *Contraception Update*
University of Iowa Family Medicine Annual Refresher Course. Coralville Marriott Hotel and Conference Center. Coralville, IA

10/19/2018 *Starting a sustainable Post-Placenta LARC Program*
Society of Family Planning: North American Forum on Family Planning
Hyatt Regency Hotel and Conference Center. New Orleans, LA

2/5-7/2019 Building a Ryan Program: multi-day workshop for new Ryan program directors and coordinators
Examples of Ryan Programs
Collaborating with an Independent Abortion Clinic
Building Enthusiasm for Training and Mentoring
Developing Institutional Leadership
And now you know how to build a Ryan Program? Workshop Wrap up
Laurel Center, University of California, San Francisco. Ryan Program National Office

1/17/2019 Topic in Complex Contraception and Reproductive Justice
Visiting Professor for Broadlawns Family Medicine Residency
Broadlawns Medical Center, Des Moines, IA

2/13/2019 *Topics in Complex Contraception and Reproductive Justice*
Visiting Professor for Quad Cities Genesis Family Medicine Residency
Genesis Family Medicine Center, Davenport, IA

4/10/2019 *Evaluation and Treatment of Abnormal Uterine Bleeding*
Visiting Professor for Northeast Iowa Medical Education Foundation
Northeast Iowa Family Medicine Residency Program, Medical Arts Building, Waterloo, IA

5/7/2019 *Engaging, Inspiring and Influencing Future Abortion Providers*
National Abortion Federation Annual Meeting
Sheraton Grand Hotel. Chicago, IL 5/4-7

10/19/2019	*Mentoring physicians who provide abortion care: navigating personal relationships, professional conflicts and career transitions* Annual Forum on Family Planning, Society of Family Planning JW Marriot, Los Angeles, CA. 10/18-21
1/14/2020	*Abortion care in the Midwest: "Our Bodies Our Doctors"* Panel Discussion, Augustana College, Rock Island, IL
2/12/2020	*Reproductive Health Care* Iowa Society of Medical Assistants, Iowa City/Cedar Rapids Chapter. Iowa River Landing Conference Center, Coralville, IA
5/5/2020	*Evaluation and Treatment of Abnormal Uterine Bleeding* Visiting Professor for Broadlawns Family Medicine Residency Broadlawns Medical Center, Des Moines, IA
5/11/2021	*Providing Abortion Care to Persons Who Use Drugs* National Abortion Federation Annual Clinical Meeting, 5/10-12/2021. Virtual annual meeting
5/12/2021	*Complex Contraception Concepts* Iowa Society of Medical Assistants, Iowa City/Cedar Rapids Chapter. Virtual presentation
10/27/2021	COVID-19 Pandemic and impact on Reproductive Health Carver College of Medicine Health Seminar University of Iowa Hospitals and Clinics, Iowa City, IA
11/29/2021	*Complex Contraception updates and Reproductive Justice* Visiting Professor for Broadlawns Family Medicine Residency Broadlawns Medical Center, Des Moines, IA
2/3-4/2022	*Building a Ryan Program*: multi-day workshop for new Ryan program directors and coordinators. *University of Iowa Program Overview: Building and Sustaining a Ryan Program in a Restrictive State* *Collaborating, Building/Sustaining Relationships with an Independent Abortion Clinic* *Break-out sessions for questions and mentorship of new programs*
2/25/2022	*Cesarean Scar Pregnancy: Diagnosis and Management* University of Texas Health, Rio Grande Valley; Department of Obstetrics and Gynecology. Lecture given as part of Ryan National Grand Rounds Speaker
4/13/2022	*Emergency Contraception* Iowa Society of Medical Assistants, Iowa City/Cedar Rapids Chapter. Virtual presentation

4/13/2022	*Long Acting Reversible and other Contraception Updates* 49th Annual Family Medicine Refresher Course, April 12-14, 2022. University of Iowa Hospitals and Clinics, Department of Family Medicine, Virtual Conference

IV. SERVICE

Professional Affiliations

2002-2006	Member and past officer, Medical Students for Choice
2002-current	Member, American Medical Women's Association
2007-current	Member, Physicians for Reproductive Choice and Health
2011-current	Member, American Institute of Ultrasound Medicine
2008-current	Member, Society for Women's Health Research
2011-2016	Junior Fellow, Society for Family Planning
2013-present	Member, Society for Academic Specialists in General Obstetrics and Gynecology
2017-present	Full Fellow, Society of Family Planning
2021-present	Member, American Society of Addiction Medicine

Offices held in professional organizations

2003-2004	American Medical Women's Association President of Creighton School of Medicine Section
2006-2010	American College of Obstetricians and Gynecologists Section Vice chair

Department, collegiate and university national committees

4/2014-2016	Labor and Delivery infection prevention committee University of Iowa Hospitals and Clinics
5/2016-1/2018	Labor and Delivery Safety Standards committee University of Iowa Hospitals and Clinic
3/2015-present	Supervisor of Natasha Clark, ARNP (2017); Abbey Costello, ARNP; Brandy Mitchell, ARNP University of Iowa Hospitals and Clinics Women's Health Center

10/2018-present	Gynecology Standards and Safety Committee University of Iowa Hospitals and Clinic
10/2018-present	Pharmacy and Therapeutics Committee University of Iowa Hospitals and Clinic
10/2018-present	Procedural Sedation Committee University of Iowa Hospitals and Clinics, OB/GYN representative
11/2018-present	Women's Services Leadership Committee University of Iowa Hospitals and Clinics
10/2020-present	Department of OBGYN COVID Response Committee University of Iowa Hospitals and Clinics, Department of OBGYN

Relevant community involvement

12/2010-11/2015	Board Member, Iowa Abortion Access Fund, Iowa City, Iowa
9/2011-present	Emma Goldman Clinic—Women Migrant Worker Clinic Volunteer, African American Clinic Volunteer, LGBT Clinic Volunteer
10/19/2013	Keynote speaker: Iowa Abortion Access Fund Annual Auction.
9/2014	Consultant for contraception for Brides Magazine.
10/18/2014	Keynote speaker: Iowa Abortion Access Fund Annual Auction.
7/14/2016, 7/16/2017	Speaker at Day or Remembrance, ceremony to honor those how have lost pregnancies and children
1/19/2018	Keynote Speaker Emma Goldman CHOICE Fundraising Event. Brown St. Inn, Iowa City, IA
2/24/2018	Keynote Speaker: Vaginal Monologues by Medical Students for Choice. Proceeds to benefit Emma Goldman Clinic
10/13/2018	Keynote Speaker: No Foot Too Small Gala event. Graduate Hotel Event Center, Iowa City, IA
11/27/2018	Opinion Editorial: *Patient's should be able to make decisions without politicians interfering.* https://www.press-citizen.com/story/opinion/letters-to-the-editor/2018/11/27/patients-should-able-make-decisions-without-interference/2123447002/ Iowa City Press-Citizen, USA Today Network

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

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

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

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

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

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

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

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

My Background

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

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

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

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

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

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

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

The Challenged Law

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

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

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

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

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

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

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

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

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

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

PPH's Services in Iowa

17. PPH is a not-for-profit corporation organized under the laws of Iowa. It operates in both Iowa and Nebraska. In Iowa, PPH operates health centers in Sioux City, Council Bluffs, Ames, Cedar Rapids, Iowa City, Des Moines (Rosenfield and Susan Knapp), and Urbandale. These health centers provide a wide range of reproductive and sexual health services to patients, including but not limited to services such as cancer screenings, birth control counseling, human papillomavirus ("HPV") vaccines, annual gynecological exams, contraception, adoption referral, miscarriage management, medication abortion, and in-clinic abortion procedures.

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

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

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

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

Access to and Safety of Abortion in Iowa

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

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

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

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

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

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

---

[11] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014,* 107 Am. J. Pub. Health 1904, 1907 (2017).
[12] *See, e.g.,* M. Antonia Biggs, Heather Gould, & Diana G. Foster, *Understanding Why Women Seek Abortions in the US,* 13 BMC Women's Health 1 (2013).

Timing of and Barriers to Abortion Services in Iowa

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Act's Effects

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

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

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

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

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

Out-of-State Travel and Related Burdens

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

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

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

Forced Pregnancy and Parenthood

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

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

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

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

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

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

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

---

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

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

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

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

---

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

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

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

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

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

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

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

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

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

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

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

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

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

---

[39] ACOG, *Comm. Op. No. 615: Access to Contraception*, 125 Obstetrics & Gynecology 250 (2015); *see also* May Sudhinaraset et al., *Women's Reproductive Rights Policies and Adverse Birth Outcomes: A State-Level Analysis to Assess the Role of Race and Nativity Status*, 59 Am. J. Preventive Med. 787, 788 (2020).

[40] Guttmacher Inst., *supra* note 21, at 1.

[41] *See, e.g.*, Nat'l P'ship for Women & Fams., *By the Numbers: Women Continue to Face Pregnancy Discrimination in the Workplace*, at 1–2 (Oct. 2016), available at https://nationalpartnership.org/wp-content/uploads/2023/02/by-the-numbers-women-continue-to-face-pregnancy-discrimination-in-the-workplace.pdf; Jennifer Bennett Shinall, *The Pregnancy Penalty,* 103 Minn. L. Rev. 749, 787–89 (2018).

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

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

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

---

[42] Nat'l P'ship for Women & Fams., *Paid Leave Means a Stronger Iowa*, at 1 (Feb. 2023), available at https://nationalpartnership.org/wp-content/uploads/2023/02/paid-leave-means- a-stronger-iowa.pdf.

[43] *Id.*

[44] Michelle H. Moniz et al., *Out-of-Pocket Spending for Maternity Care Among Women With Employer-Based Insurance, 2008*, 39 Health Affrs. 18, 20 (2020).

[45] *Id.*

[46] Amanda Fins, Nat'l Women's L. Ctr, .*Effects of COVID-19 Show Us Equal Pay Is Critical for Mothers* (May 2020), available at https://nwlc.org/wp-content/uploads/2020/05/ Moms-EPD-2020-v2.pdf (analyzing the U.S. Census Bureau 2018 Current Population Survey and determining that mothers in the U.S. are paid 71 cents for every $1 fathers make, about $16,000 a year in lost wages).

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

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

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

---

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

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

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

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

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

Other Harmful Impacts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***

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

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

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

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

Signed this 11th day of July, 2023

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

NOTARY PUBLIC

State of Texas

County of Harris

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

Linda F. Peeples, Online Notary Public
Signature of Online Notary Public

NOTARY PUBLIC STATE OF TEXAS
LINDA F PEEPLES
Notary ID #132579084
My Commission Expires
July 21, 2024

Exhibit A

PLANNED PARENTHOOD NORTH CENTRAL STATES
Curriculum Vitae

Date: 05/2023

Sarah Ann Traxler, MD, MS, FACOG

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

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

Education:

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

Postgraduate Training and Fellowship Appointments:

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

Institutional Appointments:

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

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

Hospital and/or Administrative Appointments:

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

Specialty Certification:

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

Licensure:

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

Awards, Honors and Membership in Honorary Societies:

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

Memberships in Professional and Scientific Societies and Other Professional Activities:

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

Academic and Institutional Committees:

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

Lectures by Invitation:

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

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

Bibliography:

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

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

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

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

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

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

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

Research Publications, peer-reviewed reviews:

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

Abstracts and posters:

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

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

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

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

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

I, KellyMarie Z. Meek, declare and state as follows:

1. I am the Prevention and Public Health Initiatives Coordinator at the Iowa Coalition Against Sexual Assault ("IowaCASA"), a statewide organization comprised of twenty-two agencies that provided assistance to 10,928 survivors of sexual violence in Iowa during fiscal year 2022. IowaCASA exists to improve services available for survivors of sexual violence and to support communities to prevent violence before it occurs.
2. I submit this affidavit in support of Petitioner's Emergency Motion for Temporary Injunctive Relief, based on my twenty-six years of personal and professional experience working directly with thousands of survivors of sexual and domestic violence, supporting hundreds of professionals engaged in this work, and based on my education, training, and familiarity with research in this area.
3. I understand that Senate File 579 / House File 732 (the "Act") generally bans abortions as soon as a "fetal heartbeat" can be detected. I also understand that the Act excepts from this ban terminations of pregnancies that are the result of a rape or incest that has been reported "to a law enforcement agency or to a public or private health agency which may

include a family physician," within forty-five days of the incident in the case of rape or within 140 days in the case of incest. SF 579/HF 732, § 1(3)(a).

4. My *curriculum vitae* is attached as Exhibit A.

5. I began working at IowaCASA in 2008, and I have served the agency in a variety of roles, including training and supporting professionals who work directly with survivors, expanding survivors' access to Sexual Assault Nurse Examiners, and coordinating state and community sexual violence prevention efforts.

6. Prior to this position, I spent ten years, initially as a volunteer and later as a staff member, working at a local domestic violence and sexual assault program in eastern Iowa. I provided emergency and long-term advocacy, training on hospital and police response, sheltering services, hotline response, and legal advocacy for survivors of sexual assault, rape, incest, child abuse, and stalking. During my time with that program, I supported survivors who were pregnant as a result of the sexual and domestic violence that they experienced. Many of those survivors chose to parent, many chose adoption, and many chose abortion. As an advocate, I supported them in all of those decisions.

7. Based on my extensive experience, it is my opinion that the Act will be devastating to survivors who become pregnant as a result of abuse, despite its exceptions.

Access to Abortion Is Essential to Survivors of Assault Who May Become Pregnant

8. Each year, thousands of Iowans are victims of violence that may result in pregnancy.[1] Survivors desperately need accessible health care, including abortion.

[1] Jingzhen Yang et al., *Costs of Sexual Violence in Iowa (2009): Final Report to the Department of Public Health*, at 1 (2012), available at https://iprc.public-health.uiowa.edu/wp-content/uploads/2016/03/Cost-Sexual-Violence-Iowa-FINAL-1.pdf ("In 2009, an estimated 23,709 adults in Iowa were raped.").

9. Survivors of abuse are at heightened risk of unwanted pregnancy, either because their abusers do not care about helping to prevent pregnancy or because they are actively trying to cause pregnancy to keep their victims connected to them so they can continue to harm.[2] Survivors' access to contraception is often blocked by fear and violence or threat of violence, as well as by factors such as age, disability, cost, and stigma.[3]
10. Because of the association between abuse and unintended pregnancy, a significant portion of individuals seeking an abortion are currently being abused or are at risk for abuse. In one large-scale study of patients seeking abortion services in Iowa, 13.8% reported having experienced physical or sexual abuse in the previous year, and 10.8% reported intimate partner violence (meaning abuse specifically perpetrated by a romantic partner) in the previous year.[4] Notably, this study did not measure patients experiencing emotional abuse, though coercion and threats can and do lead to unwanted sexual contact and pregnancy. It also did not measure patients who were at increased risk of experiencing physical or sexual abuse, the experiences of adult survivors of child sexual abuse, or patients who had experienced violence longer than one year ago—all of which impact survivors' experiences of reproductive health care and pregnancy.
11. IowaCASA commonly sees situations in which an abusive partner uses pregnancy as a means of controlling a victim. For example, survivors of intimate partner violence or

---

[2] *See* Leah S. Sharman, et al., *Associations Between Unintended Pregnancy, Domestic Violence, and Sexual Assault in a Population of Queensland Women*, 26 Psychiat., Psychol. and Law 541 (Oct. 2018); Anthony Idowu Ajayi & Henrietta Chinelo Ezegbe, *Association Between Sexual Violence and Unintended Pregnancy Among Adolescent Girls and Young Women in South Africa*, 20 BMC Public Health 1370 (2020).
[3] Lauren Maxwell et al., *Estimating the Effect of Intimate Partner Violence on Women's Use of Contraception: A Systematic Review and Meta-Analysis*, 10 PLoS 1 (2015).
[4] Audrey F. Saftlas et al., *Prevalence of Intimate Partner Violence Among an Abortion Clinic Population*, 100 Am. J. Pub. Health 1412, 1413 (2010).

sexual abuse often report that their partner denies them access to birth control (e.g., by denying them the money or insurance information they would need to obtain contraception) or sabotages their birth control (e.g., by throwing away pills or forcibly removing intrauterine devices (IUDs)). Some abusers do so because they know that pregnancy, childbearing, and parenting will be physically taxing and will create financial, emotional, and practical dependencies—as well as legal ties—that will make it harder or impossible for the victim to leave them. Research indicates that between 8% and 31% of women have experienced reproductive coercion.[5]

12. On the other hand, we see victims and survivors who are desperate to terminate their pregnancy so that they, and any children they already have, can escape and gain independence from their abuser. Indeed, research indicates that victims who manage to terminate their pregnancy are more likely to escape (and less likely to suffer continuing physical violence) than victims who seek to terminate their pregnancy but are unable to do so.[6] I have seen this in my work as well. I have seen victims and survivors who were forced to stay with their abusers because they were raising small children and could not do so without the abuser's financial assistance, and I have seen survivors for whom ending their pregnancy allowed them (and their children) to escape and become independent from their abuser.

13. We also see victims who are desperate to terminate a pregnancy because of the traumatic circumstances, such as rape, in which that pregnancy is occurring or because they are still

[5] Laura Tarzia & Kelsey Hegarty, *A Conceptual Re-evaluation of Reproductive Coercion: Centring Intent, Fear and Control*, 18 Reprod. Health 87 (2021).
[6] Sarah C.M. Roberts, et al., *Risk of Violence From the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med 1 (2014).

healing from past experiences of violence. The physical aspects of pregnancy, including the sense of losing control of one's body, can be particularly traumatic to survivors who are otherwise not in control of their bodies or lives. I have seen situations where such pregnancies trigger flashbacks, dissociative episodes, and other symptoms of re-traumatization, and survivors have described being forced to continue with a pregnancy as an additional assault. I have talked to survivors as recently as last week who are not currently pregnant but who are experiencing sexual assault trauma triggers from discussions about limiting access to abortion services, as it feels like yet another violation on their bodily autonomy and right to make their own decisions.

14. Many victims of abuse or sexual assault have health reasons for seeking an abortion. There is a strong association between intimate partner violence, incest, and mental health challenges such as complex PTSD, and survivors may feel they are not healthy enough to survive pregnancy or parent a child.[7] I have seen victims seek an abortion because they were taking psychiatric medications that would be dangerous to a pregnancy. The Act will place these victims at particular risk because it could force them to discontinue medications that are critical to their health, safety, and wellbeing.

15. It is already hard for victims of sexual assault or incest to access abortion care. In particular, it can be difficult if not impossible for victims to escape their abuser's physical, emotional, and financial control long enough to access an abortion—often secretly. In cases where they have been physically isolated from the community, they

[7] *See* Arielle A.J. Scoglio et al., *Intimate Partner Violence, Mental Health Symptoms, and Modifiable Health Factors in Women During the COVID-19 Pandemic in the US*, 6 JAMA Netw. Open 1 (2023); *Preventing Intimate Partner Violence Improves Mental Health*, World Health Org. (Oct. 6, 2022), https://www.who.int/news/item/06-10-2022-preventing-intimate-partner-violence-improves-mental-health.

may not be able to leave their homes to seek routine medical care in the hours or days directly following the assault, let alone have access to transportation and the financial means to access other follow-up services, including abortion. Survivors of abuse may also have to hide their situations from family or household members in order to preserve their own safety.

16. Even when survivors are able to access reproductive care, there are many reasons that care can be substantially delayed. For example, one of the survivors I worked with who was raped by her partner was unable to access emergency contraception during the time period when it would have been most effective because he worked only intermittently, and she had to wait for him to leave the house before she could travel to a hospital or pharmacy without his knowledge.
17. These are some of the reasons why access to abortion is critical for the many Iowans each year who face an unwanted pregnancy while also struggling with past abuse or assault or ongoing intimate partner violence.

The Act's Exceptions Will Not Protect Victims

18. As I noted at the outset, the Act excepts certain victims of rape or incest from its general prohibition on abortion. However, many of the survivors we work with would not fall under this narrow and burdensome exception.
19. The definition of "incest" in the Iowa Code only includes sex between blood relatives.[8] Thus, it is unclear whether the Act's incest exceptions would protect adolescents who became pregnant from incest perpetrated by a stepparent or stepsibling, which is by far the most common form of incest seen in my work across the state.

[8] Iowa Code § 726.2.

20. Similarly, the Act excepts situations involving a reported "rape," but does not define that term. "Rape" is not a term defined under Iowa law. Although a survivor could report instances of various types and degrees of "sexual abuse" to law enforcement,[9] they could not report an incident that would be classified as "rape" under criminal law because no such classification exists.

21. Moreover, individuals disagree about what constitutes rape or sexual abuse. For example, in situations involving intimate partner violence, an abusive partner might set expectations of sex after resolution of a violent episode or create a general level of fear in which the victim might be subjected to sex that they did not want but were not in a position to resist. Or a student who was intoxicated and cannot remember what happened to them the night before might not even realize that they were assaulted—or if they did, they may blame themselves for drinking instead of holding the person who committed the assault responsible. My colleagues and I would certainly consider such acts to be rape, but in my experience law enforcement officials and others could well disagree. I would anticipate similar disagreement over incidents in which an authority figure, such as a counselor, exploits that position to obtain sex from someone in a vulnerable state and/or position. Thus, the Act does not provide guidance to abortion providers as to when they can provide an abortion under the rape exception, nor does it clearly cover all situations where someone may face an unwanted pregnancy that is the result of unwanted or coerced sex.

22. Most victims of incest do not report the abuse for many different reasons: because they fear their abuser may harm them physically, because they feel guilty or ashamed about

[9] Iowa Code § 709.1.

the abuse, because they fear they will not be believed, or because they are afraid to break up their family.[10]

23. Rape is also underreported for similar reasons, particularly in situations where the perpetrator is a spouse or partner.[11] In my experience, a victim may fear retaliation, may fear loss of that partner's love or support, or may fear repercussions for their family. They may feel partly responsible for the rape; that is a common dynamic in an abusive relationship. Or the victim may be so far under their partner's psychological control that they have not yet processed that a traumatic and/or violent event was rape.

24. For victims of rape or incest, another barrier to reporting is that reporting, and describing, abuse can itself be re-traumatizing because it takes them back mentally to the time of the abuse. Victims of abuse often actively avoid situations, such as reporting, that will have this effect because they know and fear how painful that experience will be. I have seen this again and again in my work. Many victims delay reporting or avoid it altogether to avoid re-traumatization. Under the Act, they will find themselves unable to access an abortion, however traumatic or disastrous it will be for them to continue their pregnancy. This is especially so given the very short and arbitrary restriction on the time—forty-five days—within which a rape must be reported to qualify for an exception under the Act.

25. Moreover, a victim often may not know whether a pregnancy is the result of rape or incest or a consensual relationship, as it is not uncommon for a survivor to have ongoing

[10] Maria Sauzier, *Disclosure of Child Sexual Abuse: For Better or For Worse*, 12 Psychiatr. Clinics of N. Am. 455, 460-61 (1989); Tina B. Goodman-Brown et al., *Why Children Tell: A Model of Children's Disclosure of Sexual Abuse*, 27 Child Abuse & Neglect 525, 535–37 (2003).
[11] Alexandra Thompson & Susannah N. Tapp, U.S. Dep't of Just., *Criminal Victimization, 2021*, at 5 (Sept. 2022), available at https://bjs.ojp.gov/content/pub/pdf/cv21.pdf (finding that approximately 78% of rape and sexual assault cases were not reported to the police in 2021).

consensual sexual activity with a partner and be raped in the same time period. This means that they are unsure whether a pregnancy is the result of consensual sex or rape until genetic testing could be done, at which point it would be too late to obtain an abortion. If the patient does not know, it appears to me that the physician cannot apply the Act's exception.

26. I also anticipate that the Act's exceptions will be particularly hard for undocumented immigrants and their families to access. These individuals reasonably fear that if they contact any law enforcement officials, they or their families might be placed in detention and removal proceedings. Many of them are unaware of programs such as the U visa, which provide protection to some survivors in some cases. Even if they are aware, the years-long processing time[12] for U visas may deter or overwhelm survivors. I know from my work that fear of detention or removal proceedings is widespread in Iowa, and it is a huge barrier to victims' reporting abuse.

27. For all of these reasons, I believe that the Act will cause great harm to Iowans.

[12] U.S. Dep't of Homeland Sec., U.S. Citizenship & Immigr. Servs., *Humanitarian Petitions: U Visa Processing Times* (2021), available at https://www.uscis.gov/sites/default/files/document/reports/USCIS-Humanitarian-Petitions.pdf.

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

Signed this 11th day of July, 2023

Signer(s): KellyMarie Zea, produced: Iowa Driver License, as identification along with multi-factor KBA authentication, and audio/video recording to be notarized online in the County of Rockwall, State of Texas, USA.

KellyMarie Z. Meek

NOTARY PUBLIC

State of Texas

County of Rockwall

The foregoing instrument was acknowledged before me this 07/11/2023 (date) by

Jurat for Oath:
State of Texas, County of Rockwall: This is a remote online notarization.
Sworn to or affirmed and subscribed before me on this 11th day of July, 2023.
By Signer: KellyMarie Zea.

Sonia Platz, Notary Public, State of Texas _____. Seal:

NOTARY PUBLIC STATE OF TEXAS
SONIA PLATZ
Notary ID #11048993
My Commission Expires
May 12, 2024

Exhibit A

KellyMarie Z. Meek

PROFESSIONAL EXPERIENCE

Iowa Coalition Against Sexual Assault November 2015 to Present
Prevention and Public Health Initiatives Coordinator

- Provide training, technical assistance, and monitoring of all state and federally funded sexual violence prevention programs, including but not limited to: subcontracted staff training and support; RFP development; evaluation; data collection; and grant reporting
- Educate member program staff and allied professionals about sexual violence prevention, supporting survivors, and other public health topics at certification trainings, continued education opportunities, conference workshops and tabling events
- Create or assist with communications related to supporting survivors and preventing harm, including social media, press releases, interviews with various media outlets, and managing the Safe Youth Collaborative site
- Build and maintain collaborative relationships with state and local agencies and organizations working on sexual violence shared risk and protective factors and supporting survivors
- Lead grant writing and reporting for three grant funds through the Iowa Department of Public Health/Iowa HHS, and provide support as needed for other grant writing and reporting tasks

Iowa Coalition Against Sexual Assault October 2008 to November 2015
Education/Prevention Specialist

- Developed curriculum for basic and advanced sexual assault certification (2009) and revamped curriculum (2013) to meet changing needs and funding of victim service programs
- Provided training, technical assistance, and monitoring of all state and federally funded sexual violence prevention programs, including but not limited to: subcontracted staff training and support; RFP development; evaluation; data collection; and grant reporting
- Organized and facilitate a minimum of 3 certification trainings, 2 statewide prevention trainings, and 6 continued education trainings each year
- Provided support, training and technical assistance for allied professionals around issues such as: responding to disclosures, neurobiology of trauma, public health approaches to primary prevention, and consent and healthy sexuality across the lifespan

Iowa Coalition Against Domestic Violence December 2006 to December 2008
Housing and Economic Justice Coordinator

- Provided training and technical assistance to domestic violence advocates across Iowa on housing and economic issues facing domestic violence survivors
- Conducted focus groups with survivors and advocates to determine effectiveness of services
- Monitored pertinent legislation and disseminate action alerts to members
- Partnered with Legal Aid, financial institutions, and other area businesses to work on grants and other projects to help improve the quality of services to survivors

Family Resources, Inc. October 2000 to December 2006
Illinois Domestic Violence Legal Advocate May 2005 to December 2006
and June 2001 to May 2003

- Guided clients through legal system for obtaining orders of protection, including paperwork and court
- Counseled, supported, and empowered clients during court proceedings and after, as appropriate

- Partnered with the State's Attorney's Office to provide support and advocacy for domestic violence survivors involved in the criminal process
- Educated judges, police officers, lawyers, other court personnel, volunteers, staff, and community members about DV laws and statutes, including orders of protection
- Acted as on-call advocate to survivors of domestic violence and sexual assault in hospital settings as scheduled, approximately three times per month

Assistant Supervisor, Domestic Violence Shelter May 2003 to May 2005

- Managed day-to day operations of the shelter, including scheduling, shift coverage, staffing crisis line for domestic violence and sexual assault survivors, and serving as a resource for staff and clients
- Ensured compliance with various grants and funding sources, including appropriate documentation and grant reporting
- Assisted with staff and volunteer training and community presentations
- Maintained a rotating 24 hour availability as a supervisory support system for shelter staff
- Partnered with various community, state, and national agencies to develop a cohesive strategy for combating family violence

EDUCATION

Augustana College 1995-2000
Rock Island, Illinois
Bachelor of Arts, English

RELEVANT VOLUNTEER EXPERIENCE

American Model United Nations International September 1996 to November 2019
Chicago, Illinois
Secretariat member of international collegiate conference to debate world politics and simulate the work of the United Nations for educational purposes.

- Write and deliver training curriculum for various departments (Committee Chairs, Rapporteurs, and Home Government) to prepare staff departments of 8-25 to provide support for a conference that draws over 1500 college students each year
- Act as a resource to trainers, helping troubleshoot in-person trainings, develop on-line trainings, energizers, and activities to keep volunteers engaged

CERTIFICATIONS

Certified Sexual Assault Advocate
Licensed Foster Parent
Certified Foster Parent trainer – PSMAPP and NTDC (contracted through Four Oaks)
Certified Trainer for the following programs/curricula:

- Care for Kids/Nurturing Healthy Sexual Development
- Understanding and Responding to the Sexual Behaviors of Children and Adolescents
- Mentors in Violence Prevention
- Addressing Intimate Partner Violence, Reproductive and Sexual Coercion in Health Care Settings

Exhibit A

House File 732 - Introduced

HOUSE FILE 732
BY COMMITTEE ON HEALTH AND HUMAN SERVICES

(SUCCESSOR TO HSB 255)

A BILL FOR

An Act prohibiting and requiring certain actions relating to abortion involving the detection of a fetal heartbeat, and including effective date provisions.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. NEW SECTION. **146E.1 Definitions.**

As used in this chapter, unless the context otherwise requires:

1. *"Abortion"* means the termination of a human pregnancy with the intent other than to produce a live birth or to remove a dead fetus.

2. *"Fetal heartbeat"* means cardiac activity, the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac.

3. *"Fetal heartbeat exception"* means any of the following:

a. The pregnancy is the result of a rape which is reported within forty-five days of the incident to a law enforcement agency or to a public or private health agency which may include a family physician.

b. The pregnancy is the result of incest which is reported within one hundred forty days of the incident to a law enforcement agency or to a public or private health agency which may include a family physician.

c. Any spontaneous abortion, commonly known as a miscarriage, if not all of the products of conception are expelled.

d. The attending physician certifies that the fetus has a fetal abnormality that in the physician's reasonable medical judgment is incompatible with life.

4. *"Medical emergency"* means the same as defined in section 146A.1.

5. *"Physician"* means a person licensed under chapter 148.

6. *"Reasonable medical judgment"* means a medical judgment made by a reasonably prudent physician who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.

7. *"Unborn child"* means the same as defined in section 146A.1.

Sec. 2. NEW SECTION. **146E.2 Abortion prohibited —— detectable fetal heartbeat.**

1. Except in the case of a medical emergency or fetal heartbeat exception, a physician shall not perform an abortion unless the physician has first complied with the prerequisites of chapter 146A and has tested the pregnant woman as specified in this subsection, to determine if a fetal heartbeat is detectable.

a. In testing for a detectable fetal heartbeat, the physician shall perform an abdominal ultrasound, necessary to detect a fetal heartbeat according to standard medical practice and including the use of medical devices, as determined by standard medical practice and specified by rule of the board of medicine.

b. Following the testing of the pregnant woman for a detectable fetal heartbeat, the physician shall inform the pregnant woman, in writing, of all of the following:

(1) Whether a fetal heartbeat was detected.

(2) That if a fetal heartbeat was detected, an abortion is prohibited.

c. Upon receipt of the written information, the pregnant woman shall sign a form acknowledging that the pregnant woman has received the information as required under this subsection.

2. *a.* A physician shall not perform an abortion upon a pregnant woman when it has been determined that the unborn child has a detectable fetal heartbeat, unless, in the physician's reasonable medical judgment, a medical emergency or fetal heartbeat exception exists.

b. Notwithstanding paragraph "*a*", if a physician determines that the probable postfertilization age, as defined in section 146B.1, of the unborn child is twenty or more weeks, the physician shall not perform an abortion upon a pregnant woman when it has been determined that the unborn child has a detectable fetal heartbeat, unless in the physician's reasonable medical judgment the pregnant woman has a condition which the physician deems a medical emergency, as defined in section 146B.1, or the abortion is necessary to preserve the

life of an unborn child.

3. A physician shall retain in the woman's medical record all of the following:

a. Documentation of the testing for a fetal heartbeat as specified in subsection 1 and the results of the fetal heartbeat test.

b. The pregnant woman's signed form acknowledging that the pregnant woman received the information as required under subsection 1.

4. This section shall not be construed to impose civil or criminal liability on a woman upon whom an abortion is performed in violation of this section.

5. The board of medicine shall adopt rules pursuant to chapter 17A to administer this section.

Sec. 3. EFFECTIVE DATE. This Act, being deemed of immediate importance, takes effect upon enactment.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill creates Code chapter 146E relating to a prohibition on abortions based upon the detection of a fetal heartbeat. The bill provides definitions of terms used in the Code chapter, including those for "fetal heartbeat exception", "medical emergency", "reasonable medical judgment", and "unborn child". For the purposes of Code chapter 146E, unless otherwise provided, "medical emergency" means a situation in which an abortion is performed to preserve the life of the pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy, but not including psychological conditions, emotional conditions, familial conditions, or the woman's age; or when continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman.

The bill provides that, except in the case of a medical emergency or fetal heartbeat exception, a physician shall not perform an abortion unless the physician has first complied with the prerequisites of Code chapter 146A (prerequisites for abortion ── licensee discipline) and has tested the pregnant woman to determine if a fetal heartbeat is detectable. The bill prescribes the standards for testing for a fetal heartbeat, and provides that, following the test, a physician shall inform the pregnant woman, in writing, whether a fetal heartbeat was detected and that if a fetal heartbeat was detected, an abortion is prohibited. Upon receipt of the written information, the pregnant woman is required to sign a form acknowledging that the pregnant woman has received the required information. A physician shall retain documentation of the testing for a fetal heartbeat, the results of the test, and the pregnant woman's signed form acknowledging that the pregnant woman received the required information.

A physician is prohibited from performing an abortion upon a pregnant woman when it has been determined that a fetal heartbeat was detected, unless a medical emergency or fetal heartbeat exception exists. However, notwithstanding the prohibition relating to the detection of a fetal heartbeat and the medical emergency and fetal heartbeat exceptions under Code chapter 146E, if the physician determines that the probable postfertilization age, as defined in Code chapter 146B, of the unborn child is 20 or more weeks, the physician shall not perform an abortion on the pregnant woman when it has been determined that the unborn child has a detectable fetal heartbeat unless, in the physician's reasonable medical judgment, the pregnant woman has a condition which the physician deems a medical emergency as defined in Code section 146B.1 ("medical emergency" means a situation in which an abortion is performed to preserve the life of the pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering

physical condition caused by or arising from the pregnancy, or when continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman) or the abortion is necessary to preserve the life of an unborn child.

The bill is not to be construed to impose civil or criminal liability on a woman upon whom an abortion is performed in violation of the division. The board of medicine is directed to adopt administrative rules to administer the bill.

The bill takes effect upon enactment.

Exhibit B

State of Iowa

Executive Department

IN THE NAME AND BY THE AUTHORITY OF THE STATE OF IOWA

PROCLAMATION OF SPECIAL SESSION

WHEREAS, the Iowa General Assembly adjourned its 2023 regular session *sine die* on May 4, 2023, the 116th day of said regular session.

WHEREAS, based upon the extraordinary occasion in question, and in accordance with Article IV, Section 11, and Article III, Section 2, of the Constitution of the State of Iowa, work remains to be done protecting unborn children.

WHEREAS, the legislative authority of Iowa shall be vested in a general assembly pursuant to Article III, Section 1, of the Constitution of the State of Iowa.

WHEREAS, no bill shall be passed by the general assembly unless approved by a majority of all members elected to each branch of the general assembly pursuant to Article III, Section 17, of the Constitution of the State of Iowa.

WHEREAS, in 2018 the Iowa General Assembly passed legislation that prohibits abortions "when it has been determined that the unborn child has a detectable fetal heartbeat, unless, in the physician's reasonable medical judgment," one of several exceptions applies ("fetal heartbeat bill").

WHEREAS, before a bill can become "law" after passing the general assembly, it must be presented to the governor for approval pursuant to Article III, Section 16, of the Constitution of the State of Iowa.

WHEREAS, the fetal heartbeat bill was approved by the Governor of Iowa in 2018 as reflected in Iowa Acts, Ch. 1132, § 4 (codified at Iowa Code § 146C).

WHEREAS, with the fetal heartbeat bill becoming the "fetal heartbeat *law*", it was enjoined by a single district court judge from being enforced based on prior legal precedent that was unsound at the time and subsequently overruled.

WHEREAS, on June 16, 2023, the Iowa Supreme Court, by a 3-3 tie, failed to exercise its discretionary authority to dissolve the lower court's injunction of the Iowa fetal heartbeat law.

WHEREAS, in the opinion of three justices, the Iowa Supreme Court "fail[ed] the parties, the public, and the rule of law in our refusal today to apply the law and decide this case." Those same justices would have dissolved the injunction and further recognized that "[u]nder the rational basis standard, it is inequitable to continue to enjoin the State from enforcing a law that is now presumptively constitutional."

WHEREAS, the other three justices, who voted to affirm the district court and did not feel that an exercise of their discretionary authority to act was warranted, "politely" declared that when the General Assembly passed, and the Governor signed, the fetal heartbeat law, that law was no law at all but only a "hypothetical law."

WHEREAS, those same three justices stated their belief that "uncertainty exists about whether a fetal heartbeat bill would be passed today," given turnover in membership of the General Assembly through three intervening election cycles.

WHEREAS, Iowans deserve to have their legislative body address the issue of abortion expeditiously and all unborn children deserve to have their lives protected by their government as the fetal heartbeat law did.

WHEREAS, the Speaker of the House, the House Majority Leader, the House Minority Leader, the Senate President, the Senate Majority Leader, the Senate Minority Leader, and other members of the Iowa General Assembly, should work together with the Governor to seek a solution to address the aforementioned issues in a timely and expeditious manner.

NOW, THEREFORE, I, Kim Reynolds, Governor of the State of Iowa, by virtue of the authority vested in me by Article IV, Section 11, and Article III, Section 2, of the Constitution of the State of Iowa, do hereby convene the General Assembly of the State of Iowa in Special Session in the Capitol at Des Moines on July 11, 2023, at 8:30 a.m. for the sole and single purpose of enacting legislation as described above.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name and caused the Great Seal of Iowa to be affixed. Done on the 5th day of July, in the year of our Lord two thousand twenty-three.

KIM REYNOLDS
GOVERNOR OF IOWA

ATTEST:

Exhibit C

Gov. Reynolds Statement on Special Session to Protect Life

Tuesday, July 11, 2023 Press Release

Gov. Kim Reynolds released the following statement in response to the Iowa Legislature passing the heartbeat bill:

“Today, the Iowa legislature once again voted to protect life and end abortion at a heartbeat, with exceptions for rape, incest, and life of the mother.”

“The Iowa Supreme Court questioned whether this legislature would pass the same law they did in 2018, and today they have a clear answer. The voices of Iowans and their democratically elected representatives cannot be ignored any longer, and justice for the unborn should not be delayed.”

“As a pro-life Governor, I am also committed to continuing policies to support women in planning for motherhood, promote the importance of fatherhood, and encourage strong families. Our state and country will be stronger because of it.”

Gov. Reynolds plans to sign the bill on Friday, July 14, 2023.