Exhibit 4

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

PLANNED PARENTHOOD OF THE HEARTLAND, Plaintiff, v. DAVE HEINEMAN, Governor of Nebraska, in his official capacity; JON BRUNING, Attorney General of Nebraska; in his official capacity; KERRY WINTERER, Chief Executive Officer, and DR. JOANN SCHAEFER, Director of the Division of Public Health, Nebraska Department of Health and Human Services, in their official capacities; and CRYSTAL HIGGINS, President, Nebraska Board of Nursing, and BRENDA BERGMAN-EVANS, President, Nebraska Board of Advanced Practice Registered Nurses, in their official capacities; Defendants.	)	Case No. 4:10-cv-3122

AFFIDAVIT OF DARLA EISENHAUER, M.D.

STATE OF NEBRASKA)
) ss.
COUNTY OF LANCASTER)

I, DARLA EISENHAUER, M.D., being first duly sworn upon oath, depose and state as follows:

1. I am over 18 years of age and competent to provide this affidavit.

2. I am a board-certified obstetrician and gynecologist in private practice in Lincoln, Nebraska. I am a fellow of the American College of Obstetricians and Gynecologists ("ACOG")

and a member of the Nebraska Medical Association and the Lancaster County Medical Society. I attended medical school at the University of Nebraska Medical Center, and did my residency in obstetrics and gynecology at the University of Missouri in Kansas City.

3. In my practice I provide general gynecological care; prenatal services, including both low risk and high risk pregnancy management; and labor and delivery services. Procedures I perform include hysterectomies, caesarian sections, diagnostic laparoscopies, miscarriage management, endometrial ablation, vaginal repairs, suburethral sling procedures, and others.

4. I have been made aware of Legislative Bill 594, the proposed new law that would govern informed consent for abortion in Nebraska ("the Act"). I submit this affidavit in support of Plaintiff's Motion for a Preliminary Injunction and for a Temporary Restraining Order preventing the Act from taking effect.

5. As I understand it, the Act would require Nebraska healthcare providers, as part of the process of informed consent for abortion, to screen the patient for the presence of any "risk factor associated with abortion" (as defined in the Act) that has been published in any peer-reviewed journal indexed in PubMed or MedLine or listed on the Thomson Reuters Master Journal list as being associated with any "complication associated with abortion" (again, as defined in the Act). If the patient has a particular "risk factor," the healthcare provider would have to inform her of each "complication" associated with it.

6. I cannot imagine how any Nebraska healthcare provider could fully comply with these requirements (if taken literally), either for abortion or for any other medical service; certainly, I could not. Further, these requirements bear little or no resemblance to the way that I provide informed consent in my practice, and I am aware of no doctor, in Nebraska or elsewhere,

who undertakes anything remotely resembling this process in providing informed consent for their patients.

7. First, it simply would not be possible to do a full literature survey for a given medical service, including every risk factor (very broadly defined) and associated complication (also very broadly defined) relating to that service that has ever been published, in any peer-reviewed journal encompassed by the Act, in any language, in any year. I have never, in my years of training and practice, attempted to do a literature survey this exhaustive, and if I did, it is clear to me that I would never be able to accomplish it, in the sense that any survey I attempted would necessarily exclude some articles that would be responsive under the Act (if taken literally).

8. Even if I somehow were able to perform this comprehensive search and obtain all of the hundreds or thousands or tens of thousands of responsive articles, that would only be the first step – I would then have to read and understand all of the articles, which would be an impossibly monumental task in and of itself.

9. Turning to what this would mean in terms of my interactions with patients, I would then have to evaluate every patient for a huge number of potential risk factors, and inform the patient of the associated complications, even in instances where (for any of a variety of reasons, as discussed below) it would be bad medicine for me to discuss the particular potential risk factor or complication with my patients. This would be an extremely time-consuming process for both me and my patients, and confusing and potentially frightening for my patients.

10. While I look to the literature to stay informed about medical developments and to research any questions that come up in my practice, I would never attempt to read every article ever published on a procedure or treatment that I provide. Rather, I routinely review the key

journals in my area of practice, such as the *American Journal of Obstetrics and Gynecology* and ACOG's publication *Obstetrics & Gynecology*; I rely on practice bulletins and committee opinions from professional organizations such as ACOG, which include summaries and analysis of key publications; and I attend continuing medical education and other professional meetings, at which experts present condensed information and analysis that allows me and other practitioners to stay up to date on the most relevant developments in the literature. I also review the *Journal of the American Medical Association*, though fewer of these articles are relevant to my practice. And finally, I discuss developments with my colleagues and partners in Nebraska. These methods allow me to stay up to date while focusing my time and energy on treating patients. They also allow me to rely appropriately on the judgment of experts (including experts on study methodology and statistical analysis, which are not areas in which I or many other practitioners have particular expertise) as to what developments are worthy of note, and what studies and findings are reliable and likely to be applicable to my patients.

11. These methods of staying up to date on developments in medical knowledge are standard practice; they are what I do, what my partners and colleagues in Nebraska do, and what doctors are taught to do in medical school and residency.

12. Nor do the Act's requirements about evaluating patients for risk factors and disclosing associated complications bear any resemblance to how I or my colleagues in Nebraska provide informed consent. I do not screen patients for every conceivable risk factor of which I am aware (much less that was ever published in a peer-reviewed journal encompassed by the Act), or disclose every associated complication. Rather, I disclose complications to patients if the information is likely to be material to their medical decision-making, based largely on whether the complication is reasonably common and on how severe it is. Similarly, I screen

patients for risk factors if the presence of the risk factor would change the informed consent information I would want to give that patient, or would cause me to change my treatment of that patient.

13. The decision of what complications to disclose to patients requires medical judgment and discretion. It is important to be somewhat selective in deciding what information to provide, as otherwise the patient will be overwhelmed with information. In practice, there is only a certain amount of information that a given patient will process and understand, and healthcare providers must prioritize the information that is most important. Further, it can be counter-productive to give patients information about risks that are extremely unlikely, as patients tend to latch onto this information and become overly concerned about these unlikely risks, and to overestimate the chances that they will experience them. Once this happens, it is very difficult or impossible to change. And finally, I think it is human nature for patients to gauge the dangerousness of a procedure or treatment by the length of the informed consent conversation, or of the printed materials they are looking at; accordingly, it would be misleading and frightening to patients to spend too much time going through a list of risks that are extremely unlikely or only marginally relevant.

14. The medical literature contains many articles that don't reflect the current state of medical knowledge, have been disproven, draw inappropriate conclusions based on studies with poor methodologies, or don't apply to my patients for any of a variety of reasons. I would never give disclosures to my patients based on information I think is out of date, wrong, or inapplicable; this would be a violation of my ethical duty to my patients. And yet this is what the Act appears to require.

15. Ultimately, the goal of the informed consent process is to allow patients to make meaningfully-informed decisions about their care. Requiring doctors to give patients information on every potential complication or risk factor, based on a single publication in the medical literature, would only get in the way of informed decision-making. This is true because it exposes patients to information that is out-of-date, untrue, or misleading; forces them to try to digest medical details that are unlikely to be relevant to the decisions they are making; and distracts them from any information that is actually material to their decision-making.

Further affiant sayeth not.

Dated this 30 day of June, 2010.

Darla Eisenhauer MD

Darla Eisenhauer, M.D.

Subscribed and sworn to before me this 30th day of June, 2010.

GENERAL NOTARY - State of Nebraska
PATRICIA L. KNOLL
My Comm. Exp. Feb. 2, 2013

Patricia L. Knoll

Notary Public