Exhibit 6

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 JILL L. MEADOWS, M.D.

STATE OF IOWA)
) ss.
COUNTY OF JOHNSON)

I, JILL L. MEADOWS, 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. As of July 1, 2010, I will be the Medical Director of Planned Parenthood of the Heartland, Inc. ("Planned Parenthood"). I submit this affidavit in support of Plaintiff's Motion

for a Preliminary Injunction and for a Temporary Restraining Order, preventing Legislative Bill 594 ("the Act") from taking effect.

3. I am a board-certified obstetrician and gynecologist and a Fellow of the American College of Obstetricians and Gynecologists. I have been a Clinical Associate Professor of Obstetrics and Gynecology at the University of Iowa College of Medicine for five years, and before that was an Assistant Professor of Clinical Obstetrics and Gynecology for six years, also at the University of Iowa College of Medicine; I will continue as an adjunct professor when my position at Planned Parenthood begins. As a Clinical Associate Professor, I have lectured extensively on a variety of obstetric and gynecological issues. I received my medical degree from the University of Iowa College of Medicine in 1995, and was a resident in obstetrics and gynecology at the Beth Israel Medical Center in New York from 1995 to 1999. A copy of my CV is attached as Exhibit A.

4. I have been practicing as an obstetrician and gynecologist, including as an abortion provider, since 1999. Throughout that time, in addition to my didactic and clinical teaching, I have provided a full range of obstetrical and gynecological services, including treating women with high-risk pregnancies, labor and delivery services, cesarean-sections, gynecological surgeries, a variety of in-office procedures, and abortion services. In addition to my duties as Medical Director, at Planned Parenthood I will continue to provide medical services, including some abortion services in Nebraska. I am currently licensed to practice medicine in Iowa, and my licensing application to practice medicine in Nebraska is complete and pending.

5. Both medication abortion and surgical abortion are very safe services. At the gestational ages at which Planned Parenthood provides abortions in Nebraska, they are safer than carrying a pregnancy to term.

6. As Planned Parenthood's Medical Director, I will have oversight responsibility for the medical services that Planned Parenthood provides; this includes responsibility for the quality assurance of those medical services, as well as responsibility for the medical protocols pursuant to which those services are provided.

7. As Medical Director my responsibilities will include working with Planned Parenthood's legal, operational, and clinical staff to ensure that Planned Parenthood provides medical services in a way that complies with our legal and professional obligations.

8. I have reviewed the new so-called "informed consent" requirements at issue in this lawsuit, and I do not understand what they require.

9. If the Act is read literally, it seems to me to be impossible to comply with. Among other reasons, which I understand are being developed more fully in another affidavit, it would be impossible to do an exhaustive literature search for every article, in any language, from any year, in any journal covered by the Act, that addresses any potential risk factor (as broadly defined in the Act) that has been associated with any complication (again, as broadly defined in the Act). And even if we could somehow identify and obtain every potentially responsive article, and then read and understand them – a task that would take an impossible number of hours – the task of evaluating every patient for every resulting claimed risk factor, and disclosing the associated complications (including risk factors and complications that are not applicable to our patients, have been disproven, or are otherwise bad medicine) would also take so long as to be impossible.

10. On the other hand, if reasonable limitations may be read into the Act, I do not know how to determine what they are. For example, is it permissible to read in some restrictions on the materials that must be searched, such as by eliminating articles that are too old to be reasonably likely to be relevant, or that have not been translated into English? Is it permissible to limit our searches to articles published only in journals of obstetrics and gynecology, or alternately, only in medical journals? Is it permissible to search only articles we are reasonably able to access and retrieve, such as those that can be both searched and retrieved electronically?

11. Similarly, is it permissible under the Act to exercise medical judgment, and not make disclosures that the Act on its face appears to require, if they would be medically inappropriate? For example, if a so-called risk factor or complication has been disproven, am I still obligated to disclose it to my patients even though doing so would be misleading and unethical? What if the study that finds a particular risk factor or complication is so poor in methodology that no conclusion can reasonably be drawn from it? What if the claimed risk factor or complication has been rejected by the mainstream medical community? What if the claimed risk factor or complication appears in a study done in a developing country, where medical services and context are very different from those found in Nebraska? What if a study is based on out-of-date medical practice, and its findings would not apply to contemporary abortion services as Planned Parenthood provides them? As will be discussed further below, some of the studies that would trigger obligations under the Act, if read literally, fall into each of these categories.

12. Further, what if a patient who has one or more supposed risk factors would be equally, or even more, likely to experience an adverse reaction if she carried the pregnancy to

term? As will be discussed further below, this also is true of some of the risk factors that would trigger obligations under the Act, if read literally.

13. And similarly, what if the risk factor and/or complication is negligible, and in my medical judgment it would be contrary to the patient's best interests and ultimately harmful to her ability to make an informed decision to disclose it to her, for example, because it would only distract her from more material information?

Taken Literally, the Act Would Require Disclosure of False and Misleading Information

14. Both as a physician and as the incoming Medical Director responsible for overseeing the provision of medical services at Planned Parenthood, I am very concerned that the Act would require me and other Planned Parenthood physicians to provide information to our patients that is false and/or misleading.

15. Nothing on the face of the Act appears to allow physicians to exercise medical judgment to avoid disclosing information to patients if it is not true, or is misleading; rather, on its face the Act appears to trigger disclosures based solely on the presence of a risk factor associated with a complication anywhere in the published literature covered by the Act. This ignores the fact that there is no doubt that the published literature contains many supposed risk factors and complications that have subsequently been disproven, are out of date, are found in studies that are too methodologically flawed to be reliable, or for other reasons are inapplicable to Planned Parenthood's patients.

(a) breast cancer

16. For example, the literature covered by the Act includes articles that find an association between abortion and breast cancer, for patients with certain risk factors. *See, e.g.*, M.C. Pike et al., *Oral Contraceptive Use and Early Abortion as Risk Factors For Breast Cancer*

in Young Women, 43 Brit. J. Cancer 72 (1981). The Pike article finds that for women without a prior full-term pregnancy having an abortion in the first trimester of pregnancy, the risk of breast cancer goes up nearly two-and-a-half times. It reached these conclusions with a p-value of .004. *Id.* at 75.

17. I am concerned that under the Act, this means every patient in her first trimester of pregnancy (which is the gestational age at which the vast majority of our abortion services are provided) without a prior full-term pregnancy would have to be told that, according to this article, having an abortion would increase her risk of breast cancer by nearly two-and-a-half times.

18. This would be extremely misleading information for Planned Parenthood providers to be forced to give patients, because as the medicine in this field has developed, a consensus has been reached among the national professional organizations with specialized expertise in cancer and reproductive health, and throughout the mainstream medical community, that having an abortion does *not* increase patients' risk of breast cancer. The National Cancer Institute ("NCI"), the American Cancer Society ("ACS"), and the American College of Obstetricians and Gynecologists ("ACOG") have all reached this conclusion. *See* NCI, Summary Report: Early Reproductive Events and Breast Cancer Workshop, http://www.cancer.gov/cancertopics/ere-workshop-report (last visited Jun. 23, 2010) ("Induced abortion is not associated with an increase in breast cancer risk."); ACS, Is Abortion Linked to Breast Cancer?, http://www.cancer.org/docroot/CRI/CRI_2_5x.asp?dt=5 (follow "Is Abortion Linked to Breast Cancer?" hyperlink) (last visited Jun. 23, 2010) ("At this time, the scientific evidence does not support the notion that abortion of any kind raises the risk of breast cancer."); ACOG Committee on Gynecologic Practice, *ACOG Committee Opinion No. 434: Induced*

Abortion and Breast Cancer Risk, 113 Obstetrics & Gynecology 1417 (2009) ("Early studies of the relationship between prior induced abortion and breast cancer risk were methodologically flawed. More rigorous recent studies demonstrate no causal relationship between induced abortion and a subsequent increase in breast cancer risk.").

19. As these leading professional groups have recognized, the methodology used in the Pike article and other early studies of abortion and breast cancer is flawed and unreliable. These early studies used a methodology known as case-control, in which women diagnosed with breast cancer are asked about their abortion history, and then compared to a control group of women who have not been diagnosed with breast cancer and are asked about their abortion history. This methodology is flawed because it is established that "healthy women are less likely to report that they have had induced abortions. In contrast, women with breast cancer are more likely to accurately report their reproductive histories. This may be because they are looking for anything that may be linked to the cancer." ACS, *supra*; *see also* ACOG Committee on Gynecologic Practice, *supra*, at 1417. This is a form of recall bias, and (as the national professional groups have recognized) makes the conclusions in such studies unreliable.

20. The preferred methodology is to use a prospective design, which is less prone to bias. In this methodology a group of women who do not have cancer are asked about their abortion history, and then are watched over a period of time to see whether a cancer occurs. In this type of study recall bias is not an issue, because all of the women are cancer-free at the time they give their abortion history. Or alternately, another preferred methodology is to study populations in which objective information is available about abortion history, such as by studying populations in countries that have strong national health databases that include both breast cancer and abortion history information. The national professional organizations'

conclusion that abortion is not associated with an increased risk of breast cancer is based on studies using these stronger methodologies. *See* ACS, *supra*; ACOG Committee on Gynecologic Practice, *supra*, at 1417; *see also* NCI, *supra*.

21. It would be highly misleading, and frightening, to have to inform some of our patients that they are at a two-and-a-half times increased risk of breast cancer if they have an abortion, based on a study with flawed methodology whose results have been rejected by the mainstream medical community and by expert medical consensus, including by the national professional organizations with specialized expertise in cancer and reproductive health. If the Act allows me to exercise medical judgment, I would never use such an article as the basis for providing informed consent information to my patients. I would consider providing such information to be a violation of my ethical obligation toward patients.

(b) studies from developing countries

22. Another example of misleading information that the Act, if read literally, would require Planned Parenthood to disclose to its patients comes from studies done on abortion in developing countries.

23. The literature covered by the Act includes an article that studied abortion services in Nigeria and concluded (among other things) that if a woman is less than twenty years old at the time of the abortion she has an increased risk of complications, including a 31.2% risk of heavy bleeding (described as "so much bleeding you thought you might die") within a day of the procedure. Tisha M. Mitsunaga et al., *Risk Factors for Complications of Induced Abortions in Nigeria*, 14 J. Women's Health 515, 522 (2005). It reached this conclusion with a p-value of .001. It also concluded that if a woman is Protestant, she has a 29.7% risk of heavy bleeding, and if Catholic, 24.7%; whereas if a woman is a member of certain other religious groups it

concluded that her risk of these complications would be far lower. It reached these conclusions with a p-value of .009. *Id.* at 523.

24. It would be extremely misleading – and frightening – to have to disclose these complication rates to patients who are less than twenty and/or Protestant or Catholic. For example, I would have to tell every 19-year-old patient that she has a 31.2% chance of hemorrhage (the more precise term for the bleeding described in the study), when in actuality her risk of hemorrhage is far, far less.

25. For many reasons it would be medically unreasonable to apply this article's findings to patients in Nebraska, and if the Act allows me to exercise my medical judgment, I would never use this article as the basis for informed consent disclosures to Planned Parenthood's patients. Among other reasons, the article indicates that abortion is largely illegal in Nigeria, and there is no indication that the abortions at issue were provided under sanitary conditions by providers with appropriate technique, training, and equipment – as are the abortion services Planned Parenthood provides. Further, the article states that the association between membership in certain religions and the increased complication rate is likely because in Nigeria membership in these religions is a proxy for some unobserved variable, such as socioeconomic status or lack of support in finding a safe abortion provider. The social context of being Protestant or Catholic is very different in Nebraska, and clearly members of these religions are not at a heightened risk for hemorrhage. And yet, nothing in the Act indicates that I am permitted to exercise medical judgment and not make these misleading and frightening disclosures to Planned Parenthood patients (or direct other Planned Parenthood healthcare providers to make them).

(c) out-of-date medical information and techniques

26. The literature covered by the Act also includes studies based on out-of-date medical information and techniques. For example, one study of abortions in the early 1970s concluded that if a woman has an abortion after the first trimester, she has an 8.3% risk of cervical laceration, hemorrhage, repeat curettage, or other complications. David T.Y. Liu et al., *Comparative Morbidity after Vaginal Termination with regard to Parity and Gestational Stage*, 28 Brit. J. Clinical Prac. 170, 170 (1974). It makes this finding with a p-value of less than .01.

27. It would be misleading and untrue to provide this complication rate to a patient today who seeks an abortion after the first trimester, as that patient's actual risk of such complications would be far lower.

28. Again, if the Act allows me to exercise my medical judgment I would never use this article as a basis for providing patients with informed consent information, as abortion services have changed significantly since the 1970s. In particular, for abortions past 14 weeks we now know that it is important to use agents such as laminaria and misoprostol to gradually dilate the cervix in advance of the procedure, which has significantly improved the cervical injury rate. Providers also now routinely use prophylactic antibiotics, which has reduced infection rates. And sharp curettage is no longer used routinely in conjunction with suction curettage, which has reduced the risks of perforation and uterine injury.

29. Another article examined abortions in Yugoslavia in the early 1970s, and found that having carried a pregnancy to term is a risk factor for complications from abortion, resulting in a 5.5% chance of a complication requiring hospital admission. Mark Cheng et al., *Complications Following Induced Abortion by Vacuum Aspiration*, 8 Studies Fam. Plan. 125, 127 (1977). It made this finding with a p-value of less than .01. The article also found that

being at 11 or 12 weeks gestational age at the time of the abortion increased a patient's risk of complications to 13%, and that a prior miscarriage increased complication rates to 20.3%. It made these findings with p-values of less than .01 and .005, respectively. *Id.* at 127-28.

30. Again, it would be untrue and misleading to tell patients in Nebraska in 2010 that they would incur these complication rates as a result of an abortion if they have carried a pregnancy to term, are at 11 or 12 weeks gestational age, or have had a prior miscarriage; these complication rates are extremely high, and bear no resemblance to current complication rates in the United States.

(d) articles the American Psychological Association has found unreliable

31. The literature covered by the Act also includes articles finding associations between various risk factors and negative psychological experiences after abortion that have been identified by the American Psychological Association Task Force on Mental Health and Abortion ("APA Task Force") as having serious methodological problems that make it inappropriate to rely on their results.

32. More specifically, the APA Task Force, which in addition to its obvious expertise in psychological issues also has expertise in study design and methodology, concluded that studies that employ a retrospective design "have serious methodological problems that negate their ability to answer questions about psychological experiences following abortion" – the very questions these studies purport to answer. Brenda Major et al., Report of the APA Task Force on Mental Health and Abortion 74 (2008), *available at* http://www.apa.org/pi/women/programs/abortion/mental-health.pdf. The retrospective design criticized by the APA Task Force means that potential risk factors were assessed only after the abortion, at the same time that psychological experiences after the abortion were assessed – and in the case of these studies,

these assessments often took place many years after the abortion. *Id.* As the APA further commented, "[m]ost of the half dozen retrospective studies of abortion samples had serious methodological flaws and do not warrant further discussion except as examples of poor study designs." *Id.* at 87.

33. For example, one article criticized by the APA Task Force examined multiple psycho-social risk factors and concluded, among other things, that not being employed full time, more years of education, or a history of divorce were variously associated with higher rates after abortion of symptoms of post-traumatic stress disorder, disruption in cognitive schemas, and/or self-reported stress. Vincent M. Rue et al., *Induced Abortion and Traumatic Stress*, 10 Med. Sci. Monitor SR5, SR14 (2004). These findings were reported with p-values ranging from .029 to .05. The study examined only women who had abortions, an average of 10.6 years after the abortion, and asked these women to fill out questionnaires about their history at the time of the abortion and their subsequent mental health – which as the APA recognized, is not a reliable methodology. *Id.* at SR15; Major, *supra*, at 74, 83.

34. It would be untrue, and very misleading, to have to disclose to every Planned Parenthood patient who is divorced, or educated, or not employed full-time, that these factors put her at higher risk of symptoms of post-traumatic stress disorder, disruption in cognitive schemas, and/or stress if she chooses to have an abortion, based on a study that has obvious methodological flaws, and which the APA Task Force has rejected as unreliable.

35. Another article rejected as unreliable by the APA Task Force based on its use of the retrospective methodology concluded, among other things, that if a woman has consulted with her sexual partner and he supports her abortion decision, this factor is associated with less favorable long-term adjustment after the abortion. In this study, risk factors and complications

were assessed based on questionnaires the women filled out an average of nine years after the abortion—which again, as the APA Task Force recognized, is not a reliable methodology. Jeanne Parr Lemkau, *Post-Abortion Adjustment of Health Care Professionals in Training*, 61 Am. J. Orthopsychiatry 92, 95 (1991); Major, *supra*, at 74, 83, 87.

36. Again, it would be false and misleading for Planned Parenthood providers to have to disclose this information to every patient who has consulted with her partner about her abortion decision and received his support, based on this methodologically flawed article. If anything, having a partner's support in her abortion decision is generally understood to be helpful to a woman, not harmful.

37. Finally, it is worth noting that even with regard to those studies of risk factors for negative psychological experiences after abortion that had far sounder methodologies than the studies discussed above, the APA Task Force concluded that "many of the same factors shown to be associated with more negative post-abortion psychological experiences also predict more negative reactions to other types of stressful life events, including child-birth . . . For instance, low perceived social support and low self-esteem are risk factors for postpartum depression. Most risk factors are not uniquely predictive of psychological experiences following abortion. Women characterized by one or more such risk factors might be equally (or more) likely to experience negative psychological reactions if they pursued an alternative course of action (motherhood or adoption)." Major, *supra*, at 92 (citations omitted).

38. Thus even in the absence of specific methodological problems that make a study's findings unreliable, it would be misleading to inform a patient that, because she has a particular risk factor (such as low self-esteem), if she has an abortion she will be at an increased risk of a negative psychological reaction. If this type of information is given in the context of an

informed consent conversation, patients will naturally understand that they can avoid this risk by choosing not to have an abortion. After all, this is the whole purpose of informed consent: to enable patients to make informed medical decisions. And yet, as the APA Task Force recognizes, women with this type of "risk factor" can*not* avoid this risk by choosing not to have the abortion; carrying to term is likely to expose them to the same or greater risk of a negative psychological reaction as having the abortion. For this additional reason, the Act, if taken literally, would require Planned Parenthood to disclose misleading information to its patients.

Further affiant sayeth not.

Dated this 30 day of June, 2010.

Jill L. Meadows, M.D.

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

JOANN MURDOCK
Commission Number 139583
My Commission Expires
2/6/12

Notary Public

Exhibit A

Jill Lynelle Meadows, MD
Medical Director
Planned Parenthood of the Heartland
July 1, 2010

EDUCATIONAL AND PROFESSIONAL HISTORY

Undergraduate Education:

1991	B.S., Macalester College, St. Paul, MN
1995	M.D.,The University of Iowa College of Medicine, Iowa City, IA

Postgraduate Education:

1995-99	Resident, Obstetrics and Gynecology, Beth Israel Medical Center, New York, NY

Certification:

January 2002	American Board of Obstetrics and Gynecology

Licensure:

July 1999	Iowa, Permanent

Academic Positions:

July 1999-2005	Assistant Professor of Clinical Ob/Gyn	Univ. of Iowa College of Medicine
July 2005-2010	Clinical Associate Professor Ob/Gyn	Univ. of Iowa College of Medicine

Professional Affiliations:

1991-1995	American Medical Student Association/Chapter President, 1992-1993
1995-present	American College of Obstetricians and Gynecologists, Junior Fellow/Fellow (2002)
1996-present	National Abortion Federation
2002-2003	Iowa Medical Society
2004-2008	Physicians for Social Responsibility
2005-present	American Medical Women's Association
2005-2009	American Association of Gynecologic Laparoscopists
2007-present	Association of Reproductive Health Professionals

Awards

2005	The University of Iowa Jean Y. Jew Woman's Rights Award

2005	Emma Goldman Clinic Golden Speculum Award
1998	The Elliot Blumenthal Award for best resident research project/presentation

TEACHING AT THE UNIVERSITY OF IOWA

Classroom Teaching:

1999-2001	Formal lectures to third-year medical students, “First Trimester Bleeding” (every six weeks)
2000	Lecture to residents and medical students, “Ectopic Pregnancy”, 4/25/00
2000-2002	Lecture to residents and medical students, “Evaluation and Treatment of Abnormal Bleeding in Perimenopausal Patient”, 5/16/00, 6/16/02
2000	Lecture to residents and medical students, “Chronic Pelvic Pain”, 10/31/00
2000-2009	Obstetrics and Gynecology case studies
2000-2001	Lecture to Internal Med. residents, ”Abnormal Uterine Bleeding”, 9/28/00, 10/5/00, 1/4/01, 4/5/01
2001-2006	Formal lectures to 3rd year medical students, “Normal and Abnormal Uterine Bleeding” (every six weeks)
2006-2010	Formal lecture to 3rd year medical students, “Abortion and Women’s Health” (every six weeks)
2002-2005	Clinician mentor to 2nd year medical students for Foundations of Clinical Practice, Spring 2002, 2003, 2004, 2005
2002	Lecture to residents and medical students, “Induced Abortion”, 10/15/02
2003	Lecture to residents and medical students, "Dysmenorrhea", 5/27/03
2003	Lecture to residents and medical students, "Misoprostol in Obstetrics", 11/4/04
2004	Lecture to residents and medical students, "Spontaneous Miscarriage, Evaluation and Treatment", 2/10/04
2007	Lecture to residents and medical students, “Management of Miscarriage,” 2/13/07
2008	Lecture to residents and medical students, “Abortion Overview,” 7/8/08
2008	Lecture to residents and medical students, “Dysmenorrhea,” 10/21/08
2005-2008	Medical Consultant, Female Breast and Pelvic Exam Program Teaching Video and Simulated Patient Gynecologic Exam Program
2005-2006	Faculty Facilitator, Foundations of Clinical Practice Personal and Professional Development
2009	Clinical Skills Workshop for third year medical students using papayas (every six weeks) and for residents 1/13/09, and annually during orientation
2008	Lecture to residents and medical students, “Induced Abortion,” 7/8/08
2008	Lecture to second year medical students (FCP). “Spontaneous and Induced Abortion Overview,” 11/7/08
2008	Lecture to reproductive epidemiology students, “Fibroids” and “Spontaneous and Induced Abortion Overview,” 12/4/08
2009	Lecture to residents and medical students, “Ryan Program Overview,” 1/13/09
2009	Lecture to residents and medical students, “Mifepristone/Misoprostol for Second Trimester Medical Abortion,” 2/16/09
2009	Lecture to residents and medical students, “DMPA for Contraception,” 3/10/09
2009	Lecture to residents and medical students, “First Trimester Medical Abortion,” 6/9/09
2009	Lecture to residents and medical students, “OCPs-The Basics,” 8/11/09
2009	Lecture to residents and medical students, “Primary Reproductive Health and the Law,” 10/13/09

2009	Journal Club with residents and medical students: "Rates of Serious Infection after Changes in Regimens for Medical Abortion," NEJM, 12/09

Clinical Teaching (inpatient ward, clinic and operating room):

1995-1999	Teaching of medical students and residents, Beth Israel Medical Center
1999-2010	Teaching of medical students and residents, UIHC
2000-2008	Premedical student shadowing
1999-2010	Medical student shadow/AMWA mentor
2005-2010	Medical student advisor
1999-2010	Staff resident COC clinics
1999-2010	Staff Labor and Delivery
1999-2010	Staff Colposcopy/LEEP Clinic
1999-2010	Staff ASC and main OR
1999-2010	Staff Emma Goldman Clinic
1999-2009	Staff VAMC gynecology clinic
2003-2010	Staff Fibroid Clinic
2009-2010	Staff Procedure Clinic

SCHOLARSHIP

Publications

"Medication for Medical Abortion", Currents, Vol. 4, #4, pp. 9-10, Fall 2003

Offices Held

1999-2010	Liaison to Emma Goldman Clinic
1999-2002	Clinical Consultant, Family Practice gynecology e-mail
1999-2004	Departmental IPR "super-user"
2002-2008	Medical Director, Family Planning Council of Iowa Medical Review Committee
2003-2007	Reproductive Health Advisor for the medical student free Mobile Health Clinic
2004	Member, Women's Health Curriculum Task Force
2004-2006	Member, Medical Education Committee
2005-2007	Member, Ob-Gyn Resident Education Committee
2005	Member, Physician Assistant Program Review Committee
2005	Member, First Case Start Improvement Project
2005-2010	Faculty Advisor, Medical Students for Choice, which won Carver College of Medicine Medical Student Government Outstanding Student Organization, 2007-2008
2006-2007	Member, Perinatal Illicit Drug Screening Protocol Subcommittee
2006-2008	Member, Protection of Persons Subcommittee
2006-2007	Liaison, Family Practice resident OB/GYN rotation
2006-2008	Member, Quality and Safety Advisory Council
2009	Medical Director, Ryan Residency Family Planning Training Program
2006-2010	Reviewer, Obstetrics & Gynecology journal

Grants Received

2005-2007	University of Iowa New Clinical Initiative Grant for Fibroid Clinic
2009	Ryan Residency Family Planning Training Grant ($394,702)

Invited lectures

5/7/01	"Evaluation and Treatment of Abnormal Bleeding in The Perimenopausal Patient", Visiting Professor lecture, Broadlawns, Des Moines, IA.
4/6/01	"RU-486 Update", Conference presentation, U of I Family Practice refresher course
9/22/01	"RU-486 Update", OBG Postgraduate Conference, Iowa City, IA
5/22/02	"Elective Induction of Labor", OBG Grand Rounds
10/13/04	"Ectopic Pregnancies", Visiting Professor lecture, Mason City, IA
10/13/04	"Misoprostol in Obstetrics", Visiting Professor lecture, Mason City, IA
4/7/05	"Abnormal Bleeding in the Perimenopausal Patient", Spring Nurse Conference, U of I College of Nursing
5/25/05	"Complications of Abortion, Current Controversies", OBG Grand Rounds
10/12/05	"Symptomatic Fibroid Treatment," Women's Health Conference, UIHC Dept. of Nursing Services and Patient Care
4/25/06	"This is God's Work," Panel participant, NAF Annual Conference, San Francisco, CA
4/29/06	"First Trimester Bleeding," Visiting Professor lecture, Davenport, IA
4/29/06	"Management of Spontaneous Abortion," Visiting Professor lecture, Davenport, IA
2000-2009	Periodic presentations to local AMWA and MSFC chapters
10/19/07	"Abnormal Uterine Bleeding," Iowa Nurse Practitioner Society Annual Conference
9/12/08	"Management of Early Pregnancy Loss;" "Medication Abortion," Workshop: Options for Early Pregnancy Loss or Therapeutic Abortion: Aspiration and Medication Management, Iowa City Public Library; sponsored by the Abortion Access Project and Association of Reproductive Health Professionals
9/16/08	"Dysmenorrhea Treatment," Iowa Pharmacists CME
12/4/08	"Carhart vs. Gonzalez: A Plaintiff's Perspective," Des Moines University MSFC Chapter
4/14/09	"Essure Hysteroscopic Tubal Occlusion: Sterilization and Beyond," OBG Grand Rounds
4/21/09	Implanon Training Session, Cedar Rapids, IA

SERVICE

Clinical assignments since last promotion

1999-2010	Private gynecology and obstetric clinics
1999-2009	Gynecology weekly Pre-operative Educational Conference Coordinator
2000-2009	VA gynecology clinic and OR coverage (through 2005)
2000-2008	Interview prospective medical students at the College of Medicine
2003-2009	Fibroid Clinic Coordinator (multidisciplinary clinic with Interventional Radiology)
2003-2006	Volunteer staff for Reproductive Health student free mobile health clinic at Broadway Neighborhood Center
2005-2007	Medical Director, OB-Gyn Clinic
2005	IMEI Student Mentor
2005	Medical Consultant, Female Breast and Pelvic Program Teaching Video,

University of Iowa Carver College of Medicine

2007-2009	Medical Student Service Distinction Track Mentor
2009	Procedure Clinic Coordinator
2009	Medical Director, Ryan Residency Family Planning Training Program

Community Service

2010	President, Iowa Abortion Access Fund
2008-2010	Board Member, Iowa Medical Aid Fund; Member, Development Committee (2008); Vice President, Policies & Procedures Committee Chair (2009)
2002-2005	President, Iowa City Area NOW Chapter
2008	Chair, Faith United Church of Christ Worship Committee
2006	Chair, Iowans Marching for Women's Lives Coalition
2000-2008	Staff, Emma Goldman Clinic GBLT annual free clinic
2004-2005	Host, Riverside Theatre Actor Housing