DEPARTMENT OF HEALTH
AND HOSPITALS

OUTPATIENT ABORTION FACILITIES

Facility Need Review License Application

☒ *Outpatient Abortion Facilities*

☒ Initial Application Or ☐ Change of Ownership

☒ *$200 FEE to PO Box 62949, New Orleans 70162-2949* *CHECK / MONEY ORDER #* _____

I. *FACILITY (DBA) NAME* *Planned Parenthood Center for Choice, Inc.*

GEOGRAPHICAL ADDRESS *4636 S. Claiborne Avenue*

CITY / STATE / ZIP *New Orleans, Louisiana 70125*

ENTITY/CORPORATE NAME *Planned Parenthood Center for Choice, Inc.*

CURRENT MAILING ADDRESS *4600 Gulf Freeway, Suite 300, Houston, Texas 77023*

ENTITY PHONE NUMBER *(713) 831-6502*

RECEIVED
OCT 20 2014
HEALTH STANDARDS

II. *APPLICANT'S DESIGNATED REPRESENTATIVE* *Melaney A. Linton*

DESIGNATED REPRESENTATIVE'S: *Telephone number (713) 831-6502*
Fax number (713) 535-2502
Email address Melaney.Linton@ppgulfcoast.org

III. *SERVICE AREA:* *DHH Region 1 and surrounding regions*

IV. *ATTESTATION:*

It is my responsibility to notify the Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct, and supportable by documentation to the best of my knowledge.

Documentation of the information above is available upon request by the Department of Health and Hospitals. I acknowledge that I have read the facility need review rule and will comply with the provisions therein.

Melaney A. Linton

AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

AUTHORIZED REPRESENTATIVE SIGNATURE *DATE* 10.15.14

This Section to be completed by Health Standards Section Program Manager

APPLICATION # A-2014-1

FACILITY NEED REVIEW APPROVAL # _____ **DATE ISSUED:** ___/___/___

HSS-FNR-05 (originated 09/2012, rev 12/2013

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Houston, TX 77023
p: 713.535.2400
f: 713.535.2418
www.ppcenterforchoice.org

Planned Parenthood Center for Choice

October 16, 2014

Planned Parenthood Center for Choice, Inc. ("PPCfC") submits this letter, along with the attached Report of Stanley Henshaw, Ph.D. and the attached Report of Lori Freedman, Ph.D., in support of its application for Facility Need Review Program ("FNR") approval for an outpatient abortion facility in New Orleans.[1] This facility ("the Center"), which would be located within the Louisiana Department of Health & Hospitals' ("DHH") Region 1 (comprised of Jefferson, Orleans, St. Bernard, and Plaquemines parishes), would fulfill an existing and unmet need for abortion facility services in both DHH Region 1 and in Southeast Louisiana more broadly. If the Center is not permitted to obtain its license to provide health services to the community, many women will be prevented from accessing abortion,[2] exposing them to health risks and depriving them of their constitutionally protected rights.

Background on Planned Parenthood Center for Choice, Inc.

PPCfC was incorporated in Texas in 2005 and has a Certificate of Authority to Transact Business in Louisiana. Prior to 2005, PPCfC operated as a department of Planned Parenthood Gulf Cost, Inc. ("PPGC"). As either a standalone corporation or a division of PPGC, PPCfC has provided abortion services since 1973. PPCfC and PPGC are both non-profit health care provider entities, and affiliates of the Planned Parenthood Federation of America. PPCfC will lease space in PPGC's new health center located at 4636 S. Claiborne Avenue, and PPCfC intends to provide abortions at that location.

PPGC submitted plans to the Louisiana State Fire Marshall and the Department of Health and Hospitals as part of the permitting process. The State Fire Marshall granted approval of the plans on

[1] By filing this application, PPCfC does not acknowledge that the Department of Health & Hospitals has the statutory authority to require outpatient abortion facilities to receive facility need review approval as a condition of licensure. *See* La. Rev. Stat. § 40:2116. PPCfC further believes that it is unconstitutional to require that there be a demonstrated need, let alone a need defined as a "probability of serious, adverse consequences to individuals' ability to access outpatient abortion facility services if the facility is not allowed to be licensed," La. Admin. Code tit. 48, pt. I, § 12524(C)(2), in order for an outpatient abortion facility to be licensed by the State. By filing this application, PPCfC does not waive and is reserving all of its legal remedies should the application be denied.

[2] Outpatient abortion facilities were previously defined by Louisiana law as outpatient facilities, other than hospitals or ambulatory surgical centers, that perform any second trimester or five or more first trimester abortions per month. La. Rev. Stat. § 40:2175.3. As of September 1, 2014, this definition changed to include facilities where five or more first trimester abortions are performed in any given calendar year. 2014 La. Sess. Law Serv. Act 620 (H.B. 388). Abortion is defined within the outpatient abortion facility licensing scheme as "any surgical procedure performed after pregnancy has been medically verified with the intent to cause the termination of the pregnancy other than for the purpose of producing a live birth, removing an ectopic pregnancy, or removing a dead fetus caused by a spontaneous abortion." La. Rev. Stat. § 40:2175.3.

This application assumes that medication abortions are performed at outpatient abortion facilities, and that access to medication abortions is therefore part of the FNR analysis. This application does not distinguish between the need for medication versus surgical abortion services. In 2011, 23% of all nonhospital abortions were medication abortions. Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2011*, 46 PERSP. ON SEXUAL & REPRODUCTIVE HEALTH 3, 8 (Mar. 2014). PPCfC intends to provide both medication and surgical abortion at the proposed Center.

September 6, 2013, and DHH issued authorization to proceed on October 17, 2013. The City of New Orleans issued a construction permit on December 16, 2013.

Unmet Need for Abortion Services in DHH Region 1

This application will first demonstrate the unmet need for abortion services within DHH Region 1. Although, as discussed below, the proposed Center would serve the needs of many women who reside outside of DHH Region 1, PPCfC notes that the regulations define the service area for FNR purposes as the DHH Region where the facility will be licensed. La. Admin. Code. § 12524. Thus, while PPCfC believes that the boundaries of DHH Region 1 are not the appropriate measure of the service area for the Center, this application will first analyze the unmet need for abortion services within DHH Region 1, and the proposed Center's ability to meet this need. The analysis of this data demonstrates that there is an unmet need for abortion services within DHH Region 1.

The Need for Abortion Services in DHH Region 1

In 2010, there were approximately 178,098 women of reproductive age (15-44) living within Region 1. Henshaw Rep. ¶ 23 & Appendix B.[3]

The rate of abortion in the United States in 2010 was 17.7 abortions per 1000 women of reproductive age. Henshaw Rep. ¶ 17. The rate of abortion in 2010 for women living in metropolitan areas, like the parishes contained in DHH Region 1, was higher: 20.2 abortions per 1000 women of reproductive age.[4] *Id.* at ¶ 19. Given the population of women of childbearing age residing in DHH Region 1 and the relevant abortion rate, we would expect that 3598 women residing in this Region would obtain an abortion each year. *Id.* at ¶ 24.[5]

This estimate of need based on the national rate of abortion is conservative, as this number represents only the expected number of women who will access services in any given year—this number does not capture the women who need to end a pregnancy, but who are unable to obtain an abortion because of financial, logistical, transportation or other hurdles. Henshaw Rep. ¶ 20. Moreover, it is appropriate to use the national rate of abortion given the high rate of unintended pregnancy for Louisiana residents and the fact that an estimated 40% of unintended pregnancies result in abortion. In 2008, the unintended pregnancy rate in Louisiana was 63 per 1000 women aged 15-44, compared to 54 per 1000 women nationally.[6] In 2008, Louisiana was the state with the third highest rate of unintended

[3] Because 2010 is the last year for which finalized data on abortion incidence in Louisiana is available, this application will analyze data from 2010.

[4] Indeed, in 2010, the rate of abortion for women residing in the metropolitan parishes of DHH Region 1 was higher than it was in the rest of Louisiana, demonstrating that it is appropriate to expect that women in metropolitan parishes and counties in this region will obtain abortions at a higher rate.

[5] Because this application seeks to calculate the actual need for abortion services in Louisiana, it would be inappropriate and tautological to calculate need in this area using the rate of abortion for Louisiana residents—this state-specific rate is necessarily tied to the lack of access to abortion services within the region. Henshaw Rep. ¶ 19 n.4.

[6] Guttmacher Institute, Unintended Pregnancy in the United States (Dec. 2013), http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html.

pregnancy in the country, suggesting that the national abortion rate may actually underestimate the need for abortion services in Louisiana. Henshaw Rep. ¶ 21.

Although this data indicates that, in 2010, 3598 women residing in DHH Region 1 would be expected to access abortion care services in that year, the data provided by DHH shows that a much smaller number of women residing in DHH Region 1 were able to access abortion services in that year. In 2010, only 2459 women residing within DHH Region 1 were able to access services, leaving an unmet need for 1139 women living within DHH Region 1. Henshaw Rep. ¶¶ 25, 27. Approximately 32% of women residing in DHH Region 1 who would be expected to need and access abortion care services in that year were unable to do so. Henshaw Rep. ¶ 42.

If the Center is not allowed to be licensed, many women residing in this DHH Region will continue to be unable to access abortion services when they need them.[7]

Unmet Need for Abortion Services in Southeast Louisiana

The Area of Louisiana Served by the Proposed Center

The actual population of Louisiana women who would be served by the proposed Center, however, goes far beyond the boundaries of DHH Region 1. Abortion providers in DHH Region 1 are the closest abortion providers for many Louisiana women living outside of this DHH Region. The next closest abortion care provider for women living in Southeast Louisiana, the Delta Clinic, is located in Baton Rouge.

Thus, in evaluating the need for a new outpatient abortion facility within DHH Region 1, it is important to recognize that providers within this region serve a population that extends beyond its borders. Measuring the need for abortion services within DHH Region 1 would not adequately capture the true need for abortion in Southeast Louisiana.

The proposed Center would also serve the needs of women residing in parishes outside of DHH Region 1 that are closer to the proposed Center than to the Delta Clinic. Women residing in Terrebonne, Lafourche, St. Charles, St. John, St. Tammany, St. Mary and Washington parishes[8] travel to DHH Region 1 to access abortion services because these are the closest providers to their respective parishes.

The broader service area for the proposed Center is borne out by the data: according to data provided by the DHH, in 2010, 3248 abortions were performed by facilities located within DHH Region

[7] While these numbers should conclude the discussion, PPCfC notes that in 2010 Region 1 contained four outpatient abortion facilities. At the present time, Region 1 contains two such facilities. Thus, presumably, the unmet need documented for 2010 has only become more severe with the decrease in the number of facilities.

[8] These driving distances were calculated using Google Maps—a parish was included in this list if the most populous city in the parish had a shorter estimated driving time to the proposed Center than to the next closest clinic. *See* Henshaw Rep. ¶ 34, Appendix A.

1.[9] Henshaw Rep.¶ 36 & Appendix C. But in that same year, only 2066 abortions were performed for women residing in DHH Region 1. *Id.* Although the state abortion data does not contain residency information for some women who obtained abortions in that year, distributing these "unknown" residences proportionally across the parishes results in an estimated 2459 residents of DHH Region 1 who obtained an abortion in 2010. Henshaw Rep. ¶ 36 & Appendix B.[10] The state data from 2010 demonstrates that between 1182 and 789 abortions were performed in Region 1 for women who resided outside of the Region: between 24% and 36% of the women who received services in DHH Region 1 did not live in that Region. Henshaw Rep. ¶ 36.

Measuring the need for abortion services just by looking at the need within the boundaries of DHH Region 1, therefore, would ignore the reality that the providers in DHH Region 1 also meet the needs of women living throughout Southeast Louisiana. That facilities within DHH Region 1 serve a broader population is no surprise: Abortion providers tend to be located in metropolitan areas where they are able to provide access to abortion services for women living in that urban environment as well as in surrounding areas. Henshaw Rep. ¶ 32.[11]

First, a populous metropolitan area, combined with the population in the surrounding less-urban regions, provides a sufficient patient base. Second, abortion providers should be located in areas that are most easily accessible to a large number of women through different transportation options. Transportation to urban areas, like New Orleans, is more accessible to a larger population because cities are transportation hubs that are accessible by highway, as well as by public transportation options.[12] Third, as set forth in the attached Report of Lori Freedman, Ph.D., because of the stigma and safety threats faced by abortion providers, particularly in the South, it is often very difficult, if not impossible, to find physicians who are willing to provide services in less populous areas where they would be the only abortion provider, and would thereby attract increased attention from abortion opponents.[13] For that reason, abortion providers generally prefer to be located in urban regions where they are not the only provider and will attract less attention from abortion opponents, and will receive fewer safety

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[9] As detailed *supra* note 7, in 2010, there were four outpatient abortion facilities located within DHH Region 1.

[10] This 2459 number may be an overestimate—it is unknown why residency information was not collected for certain women. Henshaw Rep. ¶ 36 n.9.

[11] *See also* Rachel Jones and Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 PERSP. ON SEXUAL & REPRODUCTIVE HEALTH 41 (Mar. 2011) (finding that in 2008, 97% of nonmetropolitan counties did not have an abortion provider); Sharon A. Dobie, Lorna Gover & Roger A. Rosenblatt, *Family Planning Service Provision in Rural Areas: A Survey in Washington State*, 30 FAM. PLANNING PERSP. 139 (May/June 1998) (noting that abortion providers are concentrated in urban areas); Stanley K. Henshaw & Lawrence B. Finer, *The Accessibility of Abortion Services in the United States, 2001*, 35 PERSP. ON SEXUAL & REPRODUCTIVE HEALTH 16 (Jan./Feb. 2003) (stating that in 2000, almost none of the nonmetropolitan areas in the country had an abortion provider).

[12] New Orleans, for example, is accessible by bus and train, as well as by highway. Within New Orleans, the New Orleans Regional Transit Authority provides public transportation by bus and streetcar.

[13] *See* Freedman Rep. ¶¶ 5, 8, 16-27; *see also* Lori Freedman, WILLING AND UNABLE: DOCTORS' CONSTRAINTS IN ABORTION CARE 35 (2010) ("[R]ural [abortion] clinics and those in conservative semi-urban areas struggle to find physicians and often rely on physicians who are willing to commute by airplane part time. Therefore, the provider shortage is predominant in rural and conservative towns."); *id.* at 93 ("For those in small-town private practices . . . the prospect of being identified with abortion . . . is profoundly threatening . . . . To perform abortions in this community means being '*evil.*'") (emphasis in original).

threats.[14] The current location of providers in Southeast Louisiana accords with this expectation: There is not a single abortion provider in DHH Regions 3 or 9.[15] Instead, women living in these DHH Regions who need to end a pregnancy must travel to the closest urban area where an abortion provider is located. Given the lack of abortion providers in the surrounding parishes, PPCfC would undoubtedly serve patients from both inside and outside of DHH Region 1's borders. *See* Freedman Rep. ¶¶ 28-29.

The relevant area of Louisiana for evaluating the need for the proposed Center, therefore, is women of reproductive age (15-44) residing in Orleans, Jefferson, St. Bernard, Plaquemines, Terrebonne, Lafourche, St. Charles, St. John, St. Tammany, St. Mary and Washington parishes (the "Catchment Area").

The Need for Abortion Services in the Catchment Area

According to census data, in 2010, a total of approximately 298,343 women of reproductive age resided within the Catchment Area. Henshaw Rep. ¶ 37. This number is a conservative estimate of the population served by the proposed Center: many women living in parishes outside of the Catchment Area live in between the proposed Center and the provider in Baton Rouge, but are not included in the 298,343 number because the most populous city in that parish is slightly closer to the other provider.[16]

As discussed above, the rate of abortion for women living in metropolitan areas in 2010 was 20.2 abortions per 1000 women of reproductive age. Henshaw Rep. ¶ 19. The rate in 2010 for women living in non-metropolitan parishes in 2010 was 10.1 abortions per 1000 women of reproductive age. *Id.* Using the metropolitan rate for women residing in metropolitan parishes, and the non-metropolitan rate for women living in other parts of the Catchment Area,[17] we would expect that approximately 5886 women residing in this area would access abortion services in any given year. Henshaw Rep. ¶ 39.

In 2010, only 3042 women residing in the Catchment Area were able to access abortion services, even though it would be expected that approximately 5886 women residing in the Catchment Area would obtain services in that year. Thus, there was an unmet need for approximately 2844 women residing in the Catchment Area in 2010. Henshaw Rep. ¶¶ 39-41 & Appendix B. An estimated 48% of women residing in the Catchment Area who would be expected to access abortion services were unable to do so. Henshaw Rep. ¶ 44.

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[14] See Freedman Rep. ¶¶ 5, 7; Freedman, WILLING AND UNABLE at 96-97, 111, 117 ("[W]hen doctors practice in small and/or conservative communities where abortion providers are in short supply, they feel too visible and vulnerable to provide abortion.")

[15] Indeed, the existing abortion providers in Louisiana are located in the three most populous urban areas: New Orleans, Baton Rouge, and Shreveport. The clinics located in Metairie and Bossier City are part of the New Orleans and Shreveport metropolitan areas, respectively.

[16] Additional parishes that are not included in the analysis, even though some women within these parishes are closer to the proposed Center than the provider in Baton Rouge, are Assumption and Tangipahoa parishes.

[17] *See supra* p. 2 & note 5 for a discussion of why these rates are appropriate.

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Adverse Health and Safety Consequences of Failure To License Clinic

The unmet need for abortion services in DHH Region 1 and the Catchment Area has dire safety and health consequences for the women who are unable to access abortion services. Some women who need to end a pregnancy, but who cannot access a provider, will attempt self-help measures, either by illegally obtaining abortion-inducing medications and self-administering these drugs, or by self-inducing a surgical abortion. Abortion restrictions that lead women to take such measures have disastrous effects on women's safety and health. *See e.g. Planned Parenthood Se., Inc. v. Strange*, 2:13CV405-MHT, _ F. Supp. 2d ___, 2014 WL 3809403, at *31 (M.D. Ala. Aug. 4, 2014) ("there are serious dangers for women who take unknown drugs which advertise themselves to be abortion-inducing, but which may not actually contain what is listed on the label. Even for those women who actually receive misoprostol, a woman who takes it without consultation with a medical professional and without the prior mifepristone pill faces increased risks of hemorrhaging and infection"); *id.* (describing some of the dangers imposed by self-induced surgical abortions as "severe infections including gangrene of the uterus and some [women] even [dying]" (internal quotation marks omitted)); *MKB Management Corp. v. Burdick*, No. 09-2011-CV-02205, slip op. at 15 (N.D. E. Cent. Jud. Dist. Ct. July 15, 2013), *available at* http://rhrealitycheck.wpengine.netdna-cdn.com/wp-content/uploads/2013/07/2013-07-15_MKBvBurdick_Perm_Injunction.pdf (noting that "it must be assumed that some women will feel compelled to resort to self-help" as a result of restrictions on the availability of abortion, and that on a global basis illegal abortions result in an estimated 47,000 deaths per year); *Margaret S. v. Edwards*, 488 F. Supp. 181, 194 (E.D. La. 1980) (noting that unavailability of second-trimester abortions would cause women to self-induce or procure abortion or an abortifacient from an unlicensed practitioner, and that "[t]he injuries suffered by women obtaining illegal abortions before *Roe* include perforated uteri, lacerated cervixes, sterility from untreated infections and death"); *see also* Daniel Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 CONTRACEPTION 73, 74 (2014) (reporting on survey results finding that, after the implementation of abortion restrictions in Texas, 7% of women reported attempting to self-induce their current pregnancy before visiting the abortion clinic (and 12% of women who visited clinics close to the Mexican border), as compared to a 2008 national survey finding that 2.6% of women have *ever* attempted to self-induce).

Those women who, because of the unmet need for abortion services in DHH Region 1 and the Catchment Area, are able to access abortion services, but who are delayed in doing so because of wait times at existing providers, are also harmed by the limited access. It is undisputed that although abortion is an incredibly safe procedure, its health risks increase with gestational age. *See e.g. Planned Parenthood Arizona, Inc. v. Humble*, 753 F.3d 905, 916 (9th Cir. 2014) (crediting Plaintiff's evidence that "delaying abortions until later in pregnancy drives up the risks of complications" (internal quotation marks omitted)); *Zbaraz v. Hartigan*, 763 F.2d 1532, 1537 (7th Cir. 1985); *Margaret S.*, 488 F. Supp. 194; *see also* Linda A. Bartlett, et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 OBSTET. GYNECOL. 729, 731 (2004) ("access to abortion even 1 week earlier reduces the risk of death disproportionately as gestational age increases"); Christine Dehlendorf & Tracy Weitz, *Access to Abortion Services: A Neglected Health Disparity*, 22 J. HEALTH CARE FOR POOR & UNDERSERVED 415, 417 (2011) ("For each week of gestation after 8 weeks, the risk of mortality

increases and most abortion-related mortalities could be eliminated if women obtained their abortions prior to 8 weeks of pregnancy.").

In addition, those women who are unable to access a provider to end their pregnancies and who carry their unwanted pregnancies to term (1) are subject to the health risks of childbirth, which are greater than the health risks associated with abortion; and (2) experience greater risks of maternal depression and childbirth complications. *See Planned Parenthood Se., Inc. v. Bentley*, 951 F. Supp. 2d 1280, 1289 (M.D. Ala. 2013) (noting Plaintiff's evidence that "women who carry unwanted pregnancies to term are at increased risk of death and childbirth complications"); Jessica D. Gipson, et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 FAM. PLAN. 18, 28 (2008) (discussing evidence suggesting "a link between unintended childbearing and a significantly increased risk of maternal depression"); Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States,* 119 OBSTET. GYNECOL. 215, 216 (2012) (concluding that the risk of death associated with childbirth is approximately 14 times higher than the risks associated with legal abortion).

Summary

The disparity between the expected need for abortion services and the number of women living in the region who were able to access services in 2010 demonstrates a need for additional services in the region. In 2010, an estimated 32% of women residing in DHH Region 1 who would be expected to access services were unable to do so. And in that same year, an estimated 48% of women residing in the Catchment Area who would be expected to need abortion services were unable to access them. Henshaw Rep. ¶ 44. There was an unmet need for an estimated 2844 women residing in the Catchment Area who were unable to access abortion services in 2010. Henshaw Rep. ¶ 43. As detailed above, those women who are unable to access abortion services, or who are delayed in doing so because of the lack of access to services in this region, will be subject to serious, adverse health consequences, including the risk of death from a self-induced abortion.

If the Center is not permitted to be licensed, there will be serious, adverse consequences to women's ability to access outpatient abortion services. The gap between the expected need for services and the actual capacity of the current providers will only continue to grow as the population of the region expands, exposing women to significant and serious risks to their safety and health. In fact, given the ongoing litigation in Louisiana over the constitutionality of the state's abortion restrictions, it is not at all clear that the existing providers in Louisiana will be able to remain open in the future, further exacerbating the unmet need for abortion services in DHH Region 1 and the surrounding areas.

REPORT OF STANLEY K. HENSHAW, Ph.D.

I. QUALIFICATIONS

1. I am an independent consultant in the field of reproductive epidemiology. For many years, and until recently, I was a Senior Fellow with the Guttmacher Institute. The Guttmacher Institute is an independent nonprofit corporation involved in research, policy analysis, and public education in the field of reproductive health care.

2. I joined the Guttmacher Institute as a Senior Research Associate in 1979 and served as its Deputy Director of Research from 1985 to 1999. Over the course of more than thirty years, I have researched and published extensively in the field of reproductive health care and reproductive epidemiology, which is the study of the patterns, causes and effects of behavior related to fertility in defined populations. I have published dozens of articles in peer-reviewed journals and numerous book chapters in the area of reproductive health care; I have given dozens of presentations at meetings and conferences of social science and medical professionals; and I have designed, executed, and analyzed numerous quantitative and qualitative studies on a variety of reproductive health care-related topics.

3. I have a doctorate in sociology from Columbia University. My education, training, responsibilities, and publications are set forth in greater detail in my *curriculum vitae*, a true and correct copy of which is attached.

II. ANALYSIS

4. I have been asked by Planned Parenthood Center for Choice, Inc. ("PPCfC") to analyze the need for a new outpatient abortion facility in New Orleans, Louisiana (the "PPCfC facility"). It is my understanding that, to obtain Facility Need Review approval for the new facility, PPCfC must demonstrate the "probability of serious, adverse consequences to

individuals' ability to access outpatient abortion facility services if the facility is not allowed to be licensed." La. Admin. Code. § 12524(C)(2).

5. As noted above and set forth in detail in my attached *curriculum vitae*, I am the author of numerous studies on abortion access in the United States. I am also familiar with the literature published by others in this area, including literature addressing how the availability of abortion services impacts the abortion rate. Based upon my review of the relevant literature and my review of the data on abortion incidence in Louisiana, it is my professional opinion that there is an unmet need for abortion services both in the New Orleans area and in the wider surrounding region. I believe that if the PPCfC facility is not permitted to open, many women residing both in the New Orleans area and in the wider region will continue to be unable to access abortion facility services.

Background Research on How Availability of Abortion Affects Abortion Rates

6. Numerous studies have analyzed the effect of restrictions on the availability of abortion in a given area on that area's abortion rate. These studies find that women who must travel farther distances to access abortion are able to obtain abortion at decreased rates—increased travel distance prevents women from having abortions they would have otherwise had.

7. For example, in *Regulating Abortion: Impact on Patients and Providers in Texas*, Silvie Colman and Ted Joyce studied the impact of a Texas law that required that all abortions after 15 weeks' gestation be performed in an ambulatory surgical center ("ASC"). Silvie Colman & Ted Joyce, *Regulating Abortion: Impact on Patients and Providers in Texas*, 30 J. Pol'y Analysis & Mgmt 775 (2011). In 2004, when the law went into effect, none of the abortion clinics in Texas qualified as an ASC, which meant that there was an immediate decrease in the availability of abortion after fifteen weeks' gestation in the state. The result of this decreased

availability of abortion providers was a significant increase in the average distance that a Texas woman had to travel to obtain an abortion after fifteen weeks' gestation: As the authors reported, the average distance from a woman's county of residence to the nearest county with a non-hospital provider of abortions after fifteen weeks' gestation increased from 33 miles in 2003 to 252 miles in 2004.

8. Colman and Joyce concluded that this increase in travel distance had a substantial negative impact on the ability of Texas women to obtain abortions after fifteen weeks' gestation. Examining vital records from Texas and from the health departments of neighboring and nearby states, the authors found that in 2004, the law was associated with a 69% decrease in the number of Texas women who obtained abortions after fifteen weeks, notwithstanding a fourfold increase in the number of Texas women who went out of state for such abortions. In other words, because of the law, many more Texas women traveled out of state to obtain abortions in 2004 than had previously been the case, but despite that fact, there still was a 69% decline in the number of Texas women having abortions after fifteen weeks in the year the ASC law went into effect. As the study explains, although the Texas law may have encouraged some Texas women to have abortions earlier in pregnancy, this did not offset the reduction in the abortion rate that the increase in travel distance imposed: The study estimated that as a result of the law, over the course of three years, 4,176 abortions did not take place that would otherwise have occurred. In other words, even accounting for women who were able to obtain abortions out of state and women who were able to have earlier abortions, the travel burden imposed by the ASC law prevented thousands of women from obtaining abortions.

9. A national study of state-level data examining the impact of increased travel distance on abortion access similarly concluded that increased travel distance was associated

with a statistically significant decrease in abortion rates. Stephen Matthews, David Ribar, &Mark Willhelm, *The Effects of Economic Conditions and Access to Reproductive Health Services on State Abortion Rates and Birthrates*, 29 Fam. Plan. Persp. 52 (1997). The authors of this study performed a time series analysis of abortion rates by state from 1978 to 1988, evaluating increases and decreases in the availability of abortion providers during the study period and controlling for all permanent characteristics of each state and for policy, demographic, and economic characteristics that changed over time. Just like the Colman/Joyce study, the Matthews study concluded that when women are forced to travel longer distances to access the nearest abortion clinic, the abortion rate decreases. In particular, the analysis showed that an increase of 100 miles in the distance women must travel each way in order to reach the nearest abortion clinic was associated with a measurable reduction in the abortion rate. A reduction in the percentage of women who live in a county with a large abortion provider—another geographical indicator of the availability of abortion services—was also associated with a large drop in the abortion rate.

10. Similarly, in their study on Georgia abortion rates, Shelton et al. concluded that "the farther a woman has to travel to obtain an abortion, the less likely she is to obtain one." James D. Shelton, Edward A. Brann, & Kenneth F. Schulz, *Abortion Utilization: Does Travel Distance Matter?*, 8 Fam. Plan. Persp. 260 (1976). The Shelton study examined abortion rates in Georgia counties at various distances from Atlanta (where all of the major abortion providers in Georgia were located in 1974), and found that for every ten miles of distance from Atlanta, there was a decline of 6.7 abortions per 1,000 live births.

11. In addition, the Shelton study evaluated the impact that reducing the distance women had to travel to obtain abortion care had on abortion rates, and found once again that

distance had a substantial impact on abortion rates. Specifically, between 1974 and 1975, two new abortion clinics opened in Georgia—one in Muscogee County and one in Richmond County, each of which is more than 100 miles from Atlanta. In parts of the state not near the new abortion clinics, abortion ratios rose by 18% from 1974 to 1975. During that same time, however, Muscogee County saw a 35% increase in the number of abortions per 1,000 live births, and, significantly, the counties within fifty miles of Muscogee saw a nearly 43% increase. Similarly, from 1974 to 1975, Richmond County had a nearly 49% increase in the number of abortions per live 1,000 live births, and the counties within fifty miles of Richmond saw a 40% increase. The decreased distance independently increased abortion rates on the order of 17% to 31%. The findings from the Shelton study show that travel distance has a substantial effect on abortion access.

12. Other studies of the impact of travel distance on abortion rates have reached comparable conclusions—longer travel distances to access an abortion provider correlate with lower abortion rates. *See* Robert W. Brown, R. Todd Jewell, & Jeffrey J. Rous, *Provider Availability, Race, and Abortion Demand*, 67 S. Econ. J. 656 (2001); Sharon A. Dobie, L. Gary Hart, Ann Glusker, David Madigan, Eric H. Larson & Roger A. Rosenblatt, *Abortion Services in Rural Washington State, 1983-1984 to 1993-1994: Availability and Outcomes*, 31 Fam. Plan. Persp. 241 (1999). The Brown study of Texas counties found that a doubling of the distance to a county with an abortion provider was associated with a 23% decline in the abortion ratio for white women, 27% for African-American women, and 50% for Hispanic women. The Dobie study found that due to a decline in the number of providers, abortion services became less available in rural but not urban areas between 1983-1984 and 1993-1994. On average, the distance traveled by rural women for an abortion increased by 12 miles. The abortion rate among

rural women declined by 27% and among urban women 17%. Thus, the 12-mile increase in distance caused a 10% fall in abortions among rural women as compared with urban women. Since only 25% of rural women were affected by the loss of providers (as only 25% of rural women had abortions in rural areas in the early time point), among those women the distance resulted in a 40% drop in abortion procedures relative to urban women.

13. This research demonstrates that an increase in the distance women must travel to obtain abortions leads to a decrease in the abortion rate. In other words, lack of access to abortion in a particular area means that some women who would otherwise have terminated their pregnancies are prevented from doing so.

14. Given this research on how lack of access decreases the abortion rate, I analyzed whether the incidence of abortion, first, in the Louisiana Department of Health and Hospitals ("DHH") Region 1 (Orleans, St. Bernard, Jefferson, and Plaquemines parishes) demonstrates that some women residing in DHH Region 1 are unable to access abortion services. Then, I did the same analysis for access to abortion services in the wider surrounding area in Louisiana that would be served by the proposed PPCfC facility ("the Catchment Area"). In both analyses, I compared the expected number of abortions in the relevant area given the population of women of childbearing age with the actual number of abortions obtained by residents of that area in 2010 to determine whether there was an unmet need for abortion services.[1]

[1] I requested data on induced terminations of pregnancy in Louisiana from the State Center for Health Statistics, Office of Public Health within the Louisiana Department of Health and Hospitals. 2010 was the last year for which final data was available from the State.

Estimated Unmet Need for Abortion Services Within DHH Region 1

15. The proposed PPCfC facility will be located in New Orleans, within Orleans parish. It would be located within DHH Region 1, comprised of Orleans, Jefferson, St. Bernard, and Plaquemines parishes.

16. There are currently two abortion providers located within DHH Region 1: one in Orleans parish, and one in Jefferson parish.

17. To estimate the unmet need within DHH Region 1, I first determined the relevant abortion rate to use in my calculations. The national abortion rate in 2010 was 17.7 abortions per 1000 women of reproductive age (aged 15 to 44). *See* Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2011*, 46 Persp. on Sexual & Reproductive Health (Mar. 2014), Table 1.[2]

18. The metropolitan abortion rate, however, is higher than the national rate. In 2000, the national abortion rate was 21.0 abortions per 1000 women of reproductive age, but the metropolitan rate was 24.0. The non-metropolitan rate in 2000 was 12.0. Rachel K. Jones et al., *Patterns in the Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001*, 34 Persp. on Sexual & Reproductive Health, No. 5, 2002: 226-235, Table 1.[3]

19. I used the data on (1) the metropolitan and non-metropolitan abortion rates in 2000, and (2) the overall abortion rate in 2010, to estimate the metropolitan and non-

[2] For this rate, and all other calculations in my affidavit, I have not distinguished between medication abortions and surgical abortions.

[3] These rates were calculated by analyzing the rate of abortion within areas designated as metropolitan or non-metropolitan according to the U.S. Census Bureau.

metropolitan rates in 2010. I calculated the metropolitan abortion rate in 2010 as 20.2 (24/21*17.7), and the non-metropolitan abortion rate in 2010 as 10.1 (12/21*17.7).[4]

20. The national metropolitan and non-metropolitan rates are a conservative estimate of the need for abortion services: these rates do not capture the women who need abortion services, but who are unable to access these services because of financial, logistical, transportation, or other hurdles.

21. Moreover, it is appropriate to use the national rate given the high rate of unintended pregnancy for Louisiana residents and the fact that an estimated 40% of unintended pregnancies result in abortion. In 2008, the unintended pregnancy rate in Louisiana was 63 per 1000 women aged 15-44, compared to 54 per 1000 nationally. Louisiana was the state with the third highest rate of unintended pregnancy in the country. Guttmacher Institute, Unintended Pregnancy in the United States (Dec. 2013), http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html. It is therefore appropriate to use the national metropolitan and non-metropolitan rates to estimate the need for services within the region.

22. All of the parishes within DHH Region 1 are considered metropolitan parishes according to the U.S. Census Bureau, so it is appropriate to use the metropolitan abortion rate in 2010.

23. In 2010, approximately 178,098 women of childbearing age (15-44) resided in DHH Region 1.

[4] Because this application seeks to calculate the actual need for abortion services in Louisiana, it would be inappropriate and tautological to calculate need in this area using the rate of abortion for Louisiana residents—this state-specific rate is necessarily tied to the lack of access to abortion services within the region.

24. Using the population data and the abortion rate, I calculate that an estimated 3598 women residing within DHH Region 1 can be expected to access an abortion each year. *See* Appendix B.

25. Using data provided by the State Department of Health Services on abortion incidence in 2010 by women's place of residency, attached as Appendix C, I calculate that an estimated 2459 women residing within DHH Region 1 were able to access abortion services in 2010. Although the state data only shows that 2066 women residing in the Catchment Area were able to access an abortion in 2010, I distributed the women who resided in "unknown" parishes proportionally across all of the parishes. *See* Appendix B.[5]

26. In 2010, there were four abortion providers in DHH Region 1. Since 2010, two of these providers have closed.

27. The disparity between the expected incidence of abortion for women residing in DHH Region 1 and the number of these women who are actually able to obtain an abortion demonstrates that there is an unmet need for abortion services in the New Orleans area. This unmet need is measured as the estimated 1139 women residing in DHH Region 1 who were unable to access services.[6]

28. The need for an additional provider in DHH Region 1 has only increased with the closure of two providers since 2010.

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[5] When distributing the women of "unknown" residency across the parishes, I subtracted the 697 women who, according to CDC data, resided somewhere in Louisiana and obtained an abortion in Texas in 2010. Because Texas is to the west of Louisiana, I expect that very few, if any, women who resided in Region 1 (or other parts of Southeast Louisiana) would have travelled to Texas to obtain an abortion.

[6] Because I am unable to discern why the residency information was not collected for certain women, my proportional distribution of the women of "unknown" residency may result in an underestimate of the unmet need. Comparing the expected number of abortions with the actual number obtained by women who are known to reside in DHH Region 1 results in a greater unmet need: 1532 women who were unable to access services.

The Catchment Area

29. Although I understand that the relevant regulations define DHH Region 1 as the "service area" for this proposed facility, because of the lack of outpatient abortion facilities in Southeast Louisiana, the actual area that would be served by the proposed facility is much larger.

30. The next closest abortion provider outside of DHH Region 1 is located in Baton Rouge, in East Baton Rouge parish. DHH Regions 3 and 9 do not have a single abortion provider.

31. That abortion providers tend to be located in metropolitan areas that serve the surrounding regions within abortion providers is well documented in the literature. A study that I authored along with Lawrence B. Finer found that almost none of the nonmetropolitan areas of the United States had an abortion provider in 2000, while 190 of the countries' 276 metropolitan areas had a provider. Stanley K. Henshaw & Lawrence B. Finer, *The Accessibility of Abortion Services in the United States, 2001*, 35 Persp. on Sexual & Reproductive Health 16 (Jan./Feb. 2003). The concentration of abortion access in more urban areas has been confirmed by more recently authored studies. Rachel Jones and Kathryn Kooistra found that, in 2008, abortion providers were concentrated in metropolitan areas and 97% of nonmetropolitan counties did not have an abortion provider. Rachel Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 Persp. on Sexual & Reproductive Health 41 (2011). *See also* Sharon A. Dobie, Lorna Gover & Roger A. Rosenblatt, *Family Planning Service Provision in Rural Areas: A Survey in Washington State*, 30 Fam. Planning Persp. 139 (May/June 1998) (noting that abortion providers are concentrated in urban areas).

32. My review of this literature and years of experience studying this field leads me to expect that a facility located in New Orleans will serve women who live in the surrounding

metropolitan and nonmetropolitan parishes that are closer to New Orleans than they are to the next closest abortion provider.

33. Women residing in parishes outside of DHH Region 1 who live closer to the proposed PPCfC facility than the Baton Rouge facility are expected to be within the service area of the proposed PPCfC facility.

34. Using Google Maps to calculate the distance and estimated driving time[7] from the most populous city (or census-designated place) in a parish to (1) the address of the proposed PPCfC facility and (2) the address of the Baton Rouge facility, I determined that women residing in Terrebonne, Lafourche, St. Charles, St. John, St. Tammany, and Washington parishes are closer to the proposed PGPC facility than they are to the Baton Rouge facility. I further determined that women residing in St. Mary's parish are roughly in between the proposed PPCfC facility and the Baton Rouge facility: the drive from the largest city in St. Mary's parish to the proposed PPCfC facility is estimated to be 4 minutes shorter, but 9.7 miles longer, than the drive to the Baton Rouge facility. To account for the fact that women within St. Mary's parish are roughly equidistant from the two providers, I assumed that 50 percent of this parish's need would be met in Baton Rouge. A chart listing the parishes that are within the service area of the proposed PPCfC facility is attached as Appendix A.[8]

35. The service area in Louisiana ("Catchment Area") for the proposed PPCfC facility is, therefore, expected to be women of reproductive age (15-44) residing in Orleans,

[7] For consistency, I compared the estimated driving times without traffic.

[8] Women living in parishes and counties where the most populous city or census-designated place is slightly closer to a provider outside of DHH Region 1 are not included in the Catchment Area. For that reason I believe it is appropriate to assume that all of the women living within the counties listed above would obtain abortions in DHH Region 1, and that the Catchment Area is actually a conservative estimate of the service area of the proposed PPCfC facility.

Jefferson, St. Bernard, Plaquemines, Terrebonne, Lafourche, St. Charles, St. John, St. Tammany, St. Mary and Washington parishes.

36. The broader Catchment Areas for the proposed facility is borne out by the data: according to data provided to me by the Louisiana Department of Health & Hospitals, in 2010, 3248 abortions were performed by facilities located within DHH Region 1. *See* Appendix C. But in that same year, only 2066 abortions were performed on women residing in DHH Region 1. *Id.* Even after distributing the abortions obtained by women with "unknown" residency proportionally across all the parishes, an estimated 2459 abortions were obtained by residents of DHH Region 1 in 2010.[9] Appendix B. This data demonstrates that between 1182 and 789 abortions were performed in DHH Region 1 in 2010 on women who resided outside of the Region: between 24% and 36% of the women who received services in DHH Region 1 did not live in that Region.

Estimated Unmet Need for Abortion Services Within the Catchment Area

37. Using census data, I determined the number of women of reproductive age residing in the Catchment Area. The total number residing within the Catchment Area was 298,343. *See* Appendix B.

38. As discussed above, I calculated the metropolitan abortion rate in 2010 as 20.2 (24/21*17.7), and the non-metropolitan abortion rate in 2010 as 10.1 (12/21*17.7). All of the parishes within the Catchment Area are metropolitan parishes other than St. Mary and Washington parishes.

[9] See *supra* n.5 for a discussion of how the women of "unknown" residence were distributed across the parishes.

39. Using the population data and the relevant abortion rates, I calculate that an estimated 5886 women residing in the Catchment Area can be expected to access an abortion each year.

40. Using data provided by the State Department of Health Services on abortion incidence in 2010 by women's place of residency, attached as Appendix C, I calculate that an estimated 3042 women residing within the Catchment Area were able to access abortion services in 2010. Although the state data only shows that 2558 women residing in the Catchment Area were able to access an abortion in 2010, I distributed the women who resided in "unknown" parishes proportionally across all of the parishes. *See* Appendix B.[10]

41. The disparity between the expected incidence of abortion for women residing in the Catchment Area and the number of these women who are actually able to obtain an abortion demonstrates that there is an unmet need for abortion services in Southeast Louisiana. This unmet need is measured as the estimated 2844 women residing in the Catchment Area who were unable to access services.[11]

[10] See discussion *supra* n.5 regarding the method for distributing women residing in "unknown" parishes.
[11] As discussed *supra* n.6, my distribution of abortions obtained by women of "unknown" residency may result in an overestimation of the number of abortions obtained by residents of this region. Comparing the expected number of abortions with the actual number obtained by women who are known to reside in the Catchment Area results in a greater unmet need: 3328 women who were unable to access services.

Summary

42. My analysis suggests that there is an unmet need for abortion services in the New Orleans Area. Just within DHH Region 1 there was an unmet need for 1139 abortions in 2010. An estimated 32% of the women residing in Region 1 who would be expected to access an abortion were unable to do so.

43. Moreover, within the Catchment Area that will be served by the proposed PPCfC facility, there was an unmet need for an estimated 2844 abortions in 2010. Although we would expect, based on the relevant population numbers and abortion rates, that approximately 5886 women residing in the Catchment Area would access an abortion in 2010, the estimated number of women residing in these areas who were able to access an abortion in 2010 was 3042.

44. The disparity between these two numbers means that an estimated 48% of women residing in the Catchment Area who would be expected to access an abortion were unable to do so.

45. While I cannot say definitely that a lack of access to services was the cause for this disparity, I believe based on my experience that one of the reasons for this disparity is the need for an additional abortion facility in the New Orleans area.

46. The need for an additional abortion facility in the New Orleans area has only increased since 2010: my understanding is that while there were four facilities in DHH Region 1 in 2010, that number has now dropped down to just two facilities.

47. In my experience analyzing abortion data for 30 years, I have found that the addition of a clinic to a metropolitan area allows more women to obtain abortions even when one or two clinics already exist in the area.

48. My opinion is that women residing in DHH Region 1 and the Catchment Area will continue to be deprived of the ability to access abortion facility services if the proposed PPCfC facility does not open, and that there is a need for an additional facility in this region.

Dated: September 9, 2014

Stanley K. Henshaw

Curriculum Vitae

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STANLEY K. HENSHAW
24 Yancey
1082 Fearrington Post
Pittsboro, NC 27312
(919) 542-0878

Education

Ph.D. Columbia University, Department of Sociology, 1971.

A.B. Harvard College, 1960. Field of concentration, physics.

Professional Experience

2000 - present: Consultant for various nonprofit organizations on research concerning fertility control services and behavior.

2000 - 2013: Senior Fellow, Guttmacher Institute, New York, New York (part-time consultant). Report writing and advising on research regarding abortion and family planning services.

1979 - 1985: Senior Research Associate, and 1985 - 1999: Deputy Director of Research, The Alan Guttmacher Institute. General duties include proposal writing, design, supervision of data collection, analysis and report writing for research projects on fertility-related issues. Responsible for overseeing a periodic survey of all abortion providers in the United States.

1978 - 1979: Senior Analyst, Zanes & Assoc. Inc., a marketing research firm in Fort Lee, New Jersey. Responsibilities included supervising two project directors, overseeing all phases of survey research projects (sampling, questionnaire construction, data collection and validation, data processing, analysis, and report writing), and report writing for focus group interviews.

1977 - 1978: Senior Analyst, Roger Seasonwein Associates, New Rochelle, New York. Responsibilities were concentrated in the following areas of public opinion research: questionnaire construction, survey data analysis using multivariate and other statistical methods, report writing, and statistical programming.

1976 - 1978: Coadjutant, Rutgers University, teaching statistics in the nursing master's degree program, and consulting on various survey research projects.

1971 - 1976: Research Associate, Cornell University Medical College, Department of Public Health. Evaluated the PRIMEX Family Nurse Practitioner Project using survey research and experimental techniques. Also conducted an evaluation of a continuing education program for physicians and nurses.

1971 - 1975: Survey research consultant on various projects, including a study of alcoholism programs conducted by the National Study Service, a study of hospital administrators by the Alumni Association of the Columbia University School of Public Health, and others.

1969 - 1971: Research Associate, Columbia University School of Public Health. Conducted a study of consumer reactions to automated multiphasic health screening. The research involved personal interviews with 1,300 users and potential users of a free health testing program to identify factors related to acceptance and utilization of the program.

1967 - 1968: Consultant on the evaluation of an experimental rehabilitation program for skid-row alcoholics administered by the Community Council of Greater New York.

1965 - 1967: Senior Research Assistant, Bureau of Applied Social Research, Columbia University, on the "Homelessness Project," a study of skid-row alcoholics.

Professional Activities

Reviewer for the *American Journal of Epidemiology, American Journal of Obstetrics and Gynecology, American Journal of Preventive Medicine, American Journal of Public Health, American Psychologist, Demography, Health Reports* (published by Statistics Canada), *The Journal of Rural Health, Journal of Policy Analysis and Management, Journal of the American Medical Association, Journal of the American Medical Women's Association, Obstetrics & Gynecology, Paediatric and Perinatal Epidemiology, Perspectives on Sexual and Reproductive Health, Public Health Reports, Social Science & Medicine, Social Science Quarterly,* and *Studies in Family Planning.*

Member, Board of Directors, Abortion Access Project (Cambridge, MA), 2005 to 2011.

Member, Board of Directors, National Abortion Federation, 1989 to 1995.

Associate Editor, *Health and Society: The Milbank Memorial Fund Quarterly*, December, 1973 to June, 1976.

Memberships:

American Public Health Association
European Society of Contraception and Reproductive Health
International Union for the Scientific Study of Population
Population Association of America
Society of Family Planning

Honors:

Alan Guttmacher Lectureship, Association of Reproductive Health Professionals, 2008.

Carl S. Shultz Award in Recognition of Outstanding Contributions to the Field of Family Planning and Reproductive Health, American Public Health Association, Population, Family Planning and Reproductive Health Section, 2006.
Champion of Reproductive Health, Ipas (Chapel Hill, NC), 2004
Christopher Tietze Humanitarian Award, National Abortion Federation (Washington, DC), 2000
Outstanding Scientific Contribution, National Family Planning and Reproductive Health Association (Washington, DC), 2000
Best Clinical Paper, National Abortion Federation (Washington, DC), 1986

Expert witness in numerous federal and state legal proceedings concerning abortion and adolescent sexual behavior.

Publications

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"Abortion Rates by Religion, Income and Hispanic Origin: New National Data," with Jane Silverman, presented at the American Public Health Association 115th Annual Meeting, New Orleans, October, 1987.

"Prior Contraceptive Use among Abortion Patients: Preliminary Results from a National Study," with Jane Silverman, presented at the American Public Health Association 115th Annual Meeting, New Orleans, October, 1987.

"Recent Trends and Future Projections for Clinic Abortion Services," presented at the annual meeting of the National Abortion Federation, Salt Lake City, May, 1987.

"Sorting Out the Confusions in Adolescent Pregnancy Statistics," presented at the conference of the Association of Population Libraries and Information Centers, Chicago, April, 1987.

"Overview of World Situation Regarding Abortion," Population Seminar sponsored by the United Nations Population Division, New York, February, 1987.

"U.S. Abortion Laws and Policies in International Perspective," presented at the annual meeting of the American Public Health Association, Las Vegas, October, 1986.

"U.S. Abortion Rates and Trends in International Perspective," presented at the annual meeting of the American Public Health Association, Washington, D.C., November, 1985.

"Reasons for Variation in Teenage Childbearing among the States," with Susheela Singh, presented at the annual meeting of the American Public Health Association, Washington, D.C., November, 1985.

"The Number and Characteristics of Office-Based Physicians Who Performed Abortions in the U.S. in 1982," with Margaret Terry Orr, presented at the annual meeting of the American Public Health Association, Anaheim, California, November, 1984.

"Abortion Services Provided in Physicians' Offices," presented at the annual meeting of the National Abortion Federation, Los Angeles, May, 1984.

"The Availability of Abortion Services Since 1973," presented at the annual meeting of the American Public Health Association, Dallas, November, 1983.

"Future Trends in Demand for Abortion Services," presented at the annual meeting of the National Abortion Federation, New Orleans, April, 1983.

"Number of Women at Risk of Unintended Pregnancy: Estimates for 1980 in Comparison with 1979 Estimates," with Jacqueline Darroch Forrest, paper presented at the annual meeting of the National Family Planning and Reproductive Health Association, Washington, D.C., March, 1983.

"A Study of the Experience of Medicaid Recipients in Paying for Abortions in States where Medicaid-Financed Abortions are Restricted," presented at the annual meeting of the American Public Health Association, Montreal, Canada, November, 1982.

"The Public's View of the Morality of Abortion," presented at the National Abortion Federation annual meeting, Minneapolis, May, 1982.

"An Investigation into the Reasons for Increases in the U.S. Abortion Rate," poster session, annual meeting of the American Public Health Association, Los Angeles, November, 1981.

Appendix A

Parish	Most Populous City/Census Designated Place	Nearest Facility Outside of DHH Region 1	Driving Time/Distance to Nearest Facility Outside of DHH Region 1	Driving Time/ Distance to Proposed New Orleans Facility[i]
Terrebonne, LA	Houma, LA	Delta Clinic[ii]	1 hour 36 minutes 82.0 miles	1 hour 3 minutes 57.4 miles
Lafourche, LA	Thibodaux, LA	Delta Clinic	1 hour 10 minutes 66.0 miles	1 hour 7 minutes 59.7 miles
St. Charles, LA	Luling, LA	Delta Clinic	1 hour 6 minutes 71.9 miles	28 minutes 23.9 miles
St. John the Baptist, LA	LaPlace, LA	Delta Clinic	52 minutes 53.1 miles	33 minutes 28.9 miles
St. Tammany, LA	Slidell, LA	Delta Clinic	1 hour 18 minutes 86.0 miles	35 minutes 34.5 miles
Washington, LA	Bogalusa, LA	Delta Clinic	1 hour 33 minutes 91.6 miles	1 hour 16 minutes 75.3 miles
St. Mary, LA	Morgan City, LA	Delta Clinic	1 hour 24 minutes 69.4 miles	1 hour 21 minutes 85.2 miles

[i] 4636 S. Claiborne Ave, New Orleans, LA 70125
[ii] 756 Colonial Dr., Baton Rouge, LA 70806

Appendix B

Need for Abortion Services in DHH Region 1 and Catchment Area				
Louisiana	**Metropolitan parishes***	**Non-metropolitan parishes****	**Catchment area total**	**Region 1 (all metro)**
Population, women 15-44, 2010	284,517	13,726	298,343	178,098
Abortion rate per 1000 women 15-44, United States, 2010	20.2	10.1		20.2
Expected number of abortions based on national rates	5,747	139	5,886	3,598
Actual reported abortions to residents, 2010***	3,003	39	3,042	2,459
*Metropolitan parishes closer to New Orleans than to other abortion providers: Jefferson, Lafourche, Orleans, Plaquemines, St. Bernard, St. Charles, St. John The Baptist, St. Tammany, and Terrebonne and Washington.				
**St. Mary and Washington.				
***Includes "parish unknown" (other than 697 who had abortions in Texas and probably did not reside in the New Orleans area) distributed proportionately.				

Appendix C

NUMBER OF INDUCED TERMINATIONS BY PARISH OF OCCURRENCE
REPORTED OCCURRING IN LOUISIANA, 2010

PARISH	N
All	8872
BOSSIER	867
CADDO	3087
E BATON ROUGE	1670
JEFFERSON	563
ORLEANS	2685

NUMBER OF ABORTIONS, BY PARISH OF RESIDENCE: LOUISIANA, 2010

PARISH OF RESIDENCE	
ACADIA	36
ALLEN	< 5
ASCENSION	141
ASSUMPTION	18
AVOYELLES	30
BEAUREGARD	13
BIENVILLE	25
BOSSIER	310
CADDO	1023
CALCASIEU	9
CALDWELL	< 5
CATAHOULA	7
CLAIBORNE	19
CONCORDIA	12
DESOTO	68
E BATON ROUGE	779
EAST CARROLL	21
E FELICIANA	18
EVANGELINE	11
FRANKLIN	25
GRANT	16
IBERIA	55
IBERVILLE	42
JACKSON	46
JEFFERSON	790
JEFF DAVIS	< 5
LAFAYETTE	234
LAFOURCHE	54
LASALLE	5
LINCOLN	182
LIVINGSTON	117
MADISON	16
MOREHOUSE	54
NATCHITOCHES	78
ORLEANS	1189
OUACHITA	396
PLAQUEMINES	29
POINTE COUPEE	26
RAPIDES	177
RED RIVER	22
RICHLAND	17
SABINE	25

ST BERNARD	58
ST CHARLES	50
ST HELENA	8
ST JAMES	28
ST JOHN	68
ST LANDRY	63
ST MARTIN	55
ST MARY	24
ST TAMMANY	232
TANGIPAHOA	125
TENSAS	5
TERREBONNE	53
UNION	29
VERMILION	22
VERNON	69
WASHINGTON	21
WEBSTER	87
W BATON ROUGE	38
WEST CARROLL	7
W FELICIANA	15
WINN	20
UNKNOWN	2116
OUT OF STATE	242

NUMBERS LESS THAN FIVE ARE BLOCKED TO PROTECT THE CONFIDENTIALITY OF THE RECORDS.

REPORT OF DR. LORI FREEDMAN, Ph.D.

I. QUALIFICATIONS

1. I am an assistant professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco ("UCSF"). My research is housed in Advancing New Standards in Reproductive Health ("ANSIRH"), an interdisciplinary social research program of the Bixby Center for Global Reproductive Health, which was formed in 1999 to address the health, social, and economic consequences of sex and reproduction through research and training in contraception, family planning, and sexually transmitted infections. The Bixby Center's mission is to advance women's health worldwide through research, training, policy analysis, and services.

2. I received a BA degree from the University of Oregon and a PhD in Sociology from the University of California, Davis. My work focuses on qualitative health research, clinician training and practice, medical ethics in reproductive health, and health care practices of religiously affiliated institutions. I have, in particular, concentrated on barriers to the provision of abortion care. Specifically, in 2006, as part of my Ph.D. dissertation research, I set out to examine the question of why doctors with abortion training do not integrate abortion care into their practice post-residency. I interviewed graduates from four ob-gyn residency programs around the United States chosen for their geographic diversity (Midwest, South, Northeast, and West). This research culminated in three journal articles and a book, which examine the stigma surrounding abortion practice in the United States and the effect of this stigma on physicians' willingness and ability to provide abortions.

the United States travelled an average of 30 miles to access abortion services, and women living in rural areas travelled even farther: 31% of rural women travelled more than 100 miles to access abortions services, and an additional 43% travelled between 50 and 100 miles. *See* Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?*, 22 J. OF WOMEN'S HEALTH 706 (2013).

7. I understand that the existing abortion providers in Louisiana are located in the state's three urban areas: New Orleans, Baton Rouge, and Shreveport.[1] This distribution of abortion services accords with my expectation that abortion providers prefer to be located in urban areas, particularly in politically conservative environments.

8. In my opinion, it would be difficult to recruit abortion providers who would be willing to provide services in rural parts of Louisiana. Instead, I expect that the abortion providers located in the New Orleans area serve women who reside in the surrounding rural regions and are closer to New Orleans than they are to the next closest abortion provider, in Baton Rouge.

9. Based on my experience as an expert in the sociology of reproduction, I believe it would be inaccurate to measure the need for abortion services in New Orleans by looking solely to the need for services within DHH Region 1 (comprised of Jefferson, Orleans, Plaquemines, and St. Bernard parishes). Instead, the accurate geographical scope of the area served by abortion providers in New Orleans is those regions that are closer to New Orleans than they are to the next closest abortion provider.

[1] I understand that one of the two providers in New Orleans is located in an adjacent suburb, Metarie, that is part of the same Metropolitan Statistical Area as New Orleans. I also understand that one of the providers in Louisiana is located in Bossier City, which is adjacent to Shreveport and part of the same Metropolitan Statistical Area as Shreveport.

15. Safety concerns are also particularly salient: physicians fear that if they were to become associated with abortion, both they and their family members would be subjected to threats to their personal safety.

Stigma and Other Obstacles Faced by Physicians in Rural and Conservative Areas

16. The fear of professional and social consequences of providing abortion services is exacerbated when a physician resides and works in a less-urban and more politically conservative area.

17. Because of the increased visibility an abortion provider would face in a smaller and more conservative community, many physicians feel that the consequences of providing abortion services are heightened for non-urban providers in more conservative communities. As a result, physicians practicing in these areas often do not provide abortion services out of a fear of the personal and professional consequences that would result.

18. In a study in which a colleague conducted interviews of healthcare professionals in a western state, respondents indicated that a supportive political environment and the strength of a local abortion-providing community were important to their ability to provide abortion services and deflect abortion stigma.[2]

19. The lack of this supportive community in rural and conservative areas makes it more difficult for providers in these areas to combat abortion stigma.

[2] Jerry O'Donnell, Tracy Weitz & Lori Freedman, *Resistance and Vulnerability to Stigmatization in Abortion Work*, 73 SOCIAL SCIENCE AND MEDICINE 1357, 1360-61 (2011). For further discussion, see Carol Joffe, DISPATCHES FROM THE ABORTION WARDS: THE COSTS OF FANATICISM TO DOCTORS, PATIENTS, AND THE REST OF US 22 (2009) (discussing physicians' "apprehensions about having a public identity as an abortion provider in a hostile environment, without supportive colleagues" and the need for "allies").

with abortion.[4] The strength of the stigma against abortion in these communities meant that the providers would not provide abortion services.

24. One physician I interviewed described the reasons why his private practice in a Midwestern town would not be able to provide abortion services: "If you start doing elective terminations in your practice, then the community will just kind of view you as that one thing. . . . I think if we were in LA or in Phoenix, Arizona or something like that, I don't think the partners would give a crap. Because it's such a big place that, you know, who cares if two or three thousand or a hundred thousand people believe that you're an abortion clinic when there's still 2.4 million more people out there? Here we only have a couple hundred thousand people . . . . [Private practices] guard their reputation a lot in these communities." Even though this physician did not practice in a rural area, the perception of the negative reputation his practice would develop if it were to provide abortions was enough to prevent his practice from doing so.

25. The threat of violence against abortion providers was also particularly salient for physicians working in non-urban areas of conservative regions of the country. These physicians perceived that the greater visibility of abortion providers in smaller, conservative towns would increase the likelihood of violence against the providers and their family members. This safety threat is an additional reason for the difficulty in recruiting providers in non-urban and conservative regions.[5]

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[4] Lori Freedman et al., *Obstacles to the Integration of Abortion into Obstetrics and Gynecology Practice*, 42 PERSP. ON SEXUAL AND REPRODUCTIVE HEALTH 146, 147-48 (2010).

[5] *See also* Joffe, *supra* n.2 at 23 (discussing an interview with a physician who stated she would likely no longer provide abortions if she were to no longer live in a large metropolitan area because of safety concerns for herself and her family).

University of California, San Francisco
CURRICULUM VITAE

Name: Lori R Freedman, PhD

Position: Assistant Adjunct Professor, Step 2
Obstetrics, Gynecology & Reproductive Sciences
School of Medicine

Assistant Adjunct Professor

Address: Box 1744
1330 Broadway, 1100
University of California, San Francisco
Oakland, CA 94612

Voice: 510-986-8948
Fax: 510-986-8960
email: freedmanl@obgyn.ucsf.edu
www: http://www.ansirh.org/about/staff.php#freedman

EDUCATION

1991 - 1995	University of Oregon, Eugene	BA	Majors: International Studies and Spanish Minor: Environmental Studies	
1992 - 1992	Universidad del Sol, Cuernavaca, Mexico		Spanish Intensive Study Abroad	
1999 - 2004	University of California, Davis	MA	Sociology, Master's Thesis: Abortion Work as Medical Work: The Hospital Context of Abortion Care	Qualifying Exam Chair: Vicki Smith
2004 - 2008	University of California, Davis	PhD	Sociology, Dissertation: Willing and Unable: Doctors' Constraints in Abortion Care	Dissertation Chair: Carole Joffe
2008 - 2009	University of California, San Francisco		Post-Doctoral Fellow	Advisor: Cynthia Harper

PRINCIPAL POSITIONS HELD

1997 - 1998	University of California, Los Angeles	Interviewer	Department of Social Welfare, School of Public Policy and Social Research
1998 - 1999	University of California, San Francisco	Research Assistant	Department of Obstetrics, Gynecology and Reproductive Sciences
1999 - 2004	University of California, Davis	Floyd and Mary Schwall Fellow	Department of Sociology
2000 - 2004	University of California, Davis	Graduate Teaching Assistant (six courses)	Department of Sociology
2002 - 2003	University of California, Davis	Instructor for Undergraduate Qualitative Methods (two courses)	Department of Sociology
2005 - 2008	University of California, San Francisco	Analyst	Department of Obstetrics, Gynecology and Reproductive Sciences
2008 - 2009	University of California, San Francisco	Post-Doctoral Fellow	Department of Obstetrics, Gynecology and Reproductive Sciences
2009 - 2012	University of California, San Francisco	Professional Researcher	Department of Obstetrics, Gynecology and Reproductive Sciences
2012 - present	University of California, San Francisco	Assistant Professor	Department of Obstetrics, Gynecology and Reproductive Sciences

OTHER POSITIONS HELD CONCURRENTLY

2000 - 2000	La Asociacion Para La Organizacion y Educacion Empresarial Femenina, El Salvador	Research Intern	
2003 - 2003	University of California, Davis	Reader	Sociology of Health Care, Department of Sociology

HONORS AND AWARDS

1999	Floyd and Mary Schwall Fellowship for Graduate Social Science Health Research	University of California, Davis
2004	Sociology Departmental Block Grant	University of California, Davis
2008	Bixby Center for Global Reproductive Health, Visiting Scholarship	University of California, San Francisco
2009	Blue Ribbon Award for Research Poster. Annual Meeting, Washington D.C.	American College of Obstetrics and Gynecology
2011	Outstanding Academic Titles List (Includes top 9% of books reviewed by Choice in 2011) for Willing and Unable: Doctors' Constraints in Abortion Care	Choice: Current Reviews for Academic Libraries
2012	Career Development Award for "The Bioethics of Reproductive Health Care in Catholic-affiliated Hospitals and Clinics"	Society for Family Planning
2014	Greenwall Faculty Scholar	The Greenwall Foundation

KEYWORDS/AREAS OF INTEREST

medical sociology; bioethics; sociology of health and medicine; sociology of morality; emotional labor and emotion management; professionalism; study of the professions and medical education; residency training; reproductive health care technology, science, quality, access, and disparity; women's health; abortion; contraception

PROFESSIONAL ACTIVITIES

PROFESSIONAL ORGANIZATIONS

Memberships

1998 - 2008	Graduate Student Sociological Association, University of California, Davis
2001 - 2010	Pacific Sociological Association
2005 - 2011	American Public Health Association
2002 - present	American Sociological Association
2010 - present	Society of Family Planning
2010 - present	Sociologists for Women in Society
2012 - present	American Society for Bioethics and Humanities

Service to Professional Organizations

2003 - 2004	Medical Sociology Council, American Sociological Association Student Representative

2010 - 2011	Bay Area Chapter, Sociologists for Women in Society	Vice President
2012 - 2012	Society of Family Planning, The Second Annual North American Forum on Family Planning	Judge of Poster Research Presentations

SERVICE TO PROFESSIONAL PUBLICATIONS

2008 - 2008	Medical Care, Article Reviewer
2011 - 2011	Vanderbilt University Press, Book Reviewer
2012 - 2012	Sociological Forum Journal, Article Reviewer
2012 - 2012	New York University Press, Book Reviewer
2012 - 2012	Health Care Management Review, Article Reviewer
2013 - 2013	American Journal of Bioethics Primary Research, Article Reviewer
2014 - 2014	Contraception, Article Reviewer
2014 - 2014	Gender & Society, Article Reviewer
2014 - 2014	Michigan Sociological Review, Article Reviewer

INVITED PRESENTATIONS

NATIONAL

2007	National Advisory Board on Religious Restrictions in Health Care (NAB)	Report
2009	National Abortion Federation, "Barriers to Abortion Practice", Annual Meeting	Panel Organizer
2009	National Advisory Board on Religious Restrictions in Health Care (NAB)	Report
2011	Medical Students for Choice, University of Chicago: Book Discussion of Willing and Unable: Doctors' Constraints in Abortion Care	Speaker
2011	National Abortion Federation, Annual Meeting: "Critics meet authors to discuss Willing and Unable: Doctor's Constraints in Abortion Care and Dispatches from the Abortion Wars" with Carole Joffe	Discussant
2011	Brookings Institution, Liberty of Conscience Roundtable	Participant
2011	American Sociological Association, Sociologists for Women in Society Roundtable	Discussant
2011	Society of Family Planning, North American Forum on Family Planning, Annual Meeting, "The Institutionalization of Abortion Stigma"	Invited Presentation
2013	Physicians for Reproductive Health, Leadership Training Academy, "Negotiating the Integration of Family Planning into Practice"	Invited Presentation

REGIONAL AND OTHER INVITED PRESENTATIONS

2006	UCSF, San Francisco General Hospital, Dept. of Ob, Gyn and Reproductive Sciences Research Seminar, "Preliminary Findings: Barriers to Abortion Provision", December 12	Invited Presentation
2007	UC Davis, Department of Sociology, Sociology of Gender, "Abortion and Gendered Social Change." November 29	Invited Lecturer
2008	UCSF, Grand Rounds, Department of OB, Gyn, and Reproductive Sciences, "When there's a heartbeat: Catholic-owned hospitals, miscarriage management, and standards of care." March 11	Invited Presentation
2010	University of San Francisco (USF), Global Women's Rights Forum, "Catholic doctrine in the health care setting: Implications for women of reproductive age." March 10	Invited Presentation
2010	UCSF, Health Workforce Pilot Project Clinician Training Day, Book Discussion of Willing and Unable: Doctors' Constraints in Abortion Care	Invited Presentation
2010	UC Berkeley/UCSF, Joint Medical Program Experientia: Book Discussion of Willing and Unable: Doctors' Constraints in Abortion Care	Invited Presentation
2010	Training in Early Abortion for Comprehensive Healthcare: Book Discussion of Willing and Unable: Doctors' Constraints in Abortion Care	Invited Presentation
2010	Family Planning Fellowship, Extern, and Student Conference, San Francisco General Hospital, UCSF, "Interviewing Skills." October 8	Invited Presentation
2011	Medical Students for Choice Regional Meeting, UCSF, " Religious Hospitals and Reproductive Health Care: Negotiating Patient, Practitioner, and Institutional Autonomy." March 6	Invited Presentation
2011	UCSF, Health Workforce Pilot Project Clinician Training Day, Preliminary Findings of HWPP Qualitative Study, Nov 14	Invited Presentation
2012	UCSF, San Francisco General Hospital, Abortion Research Seminar, "Nursing and 'Prohibited' Care", January 18	Invited Presentation
2012	UCSF, San Francisco General Hospital Family Planning Friday Conference, "Qualitative Methods," March 23	Invited presentation
2012	UC/UCSF Hastings Consortium on Law, Science & Health Policy, "Conflicts over Patient Care for Ob-Gyns in Catholic Hospitals." October 9	Invited Presentation
2012	UC Berkeley De Cal Course: Reproduction in Modern Society, "Religion and Medicine: How Catholic Hospitals	Guest Speaker

	Affect Women's Reproductive Health in the U.S." October 23	
2012	UC Berkeley School of Public Health Course (Prof. Ndola Prata): Family Planning, Population Change, and Health, "When There's a Heartbeat: Abortion and Miscarriage in Catholic Hospitals." October 23	Guest Speaker
2013	UCSF, Nursing and Medical Students for Choice, UCSF. "Conflicts in Ob-gyn Care in Catholic Hospitals." February 5	Invited Presentation
2013	UC Berkeley De Cal Course: Reproduction in Modern Society, "Catholic Health Care in the United States." November 19	Invited Presentation
2013	TEACH Program: Continuing Reproductive Education for Advanced Training Efficacy, "Who are the Willing and Able: Predictors of Continued Abortion Provision." April 17	Invited Presentation
2014	Freedman L.R. Nursing and Medical Students for Choice, UCSF. "Conflicts in Ob-gyn Care in Catholic Hospitals." San Francisco, CA. February 12, 2014.	Invited Presentation
2014	Joint Medical Program, University of California, Berkeley/San Francisco. Mentorship Panel. July 17	Invited Panelist

UNIVERSITY AND PUBLIC SERVICE

UNIVERSITY SERVICE

DEPARTMENTAL SERVICE

2000 - 2000	Colloquium Committee, Department of Sociology, UC Davis	Student Representative
2001 - 2002	Graduate Program Committee, Department of Sociology, UC Davis	Student Representative
2013 - 2013	Bixby Peer-Review Process Committee, Department of Obstetrics, Gynecology and Reproductive Sciences	Committee Member
2013 - 2013	Mission Vision Working Group, Advancing New Standards in Reproductive Health (ANSIRH)	Committee Member
2014 - 2014	Executive Director Hiring Committee for Advancing New Standards in Reproductive Health (ANSIRH)	Committee Member

PUBLIC SERVICE

2013 - present	American Civil Liberties Union	Testified as an Expert Witness to contest Alabama's new abortion law requiring hospital privileges

		of all abortion providers.
2008 - present	Parent Teacher Association at Malcolm X Elementary School, Berkeley, CA	Active member. Walkathon organizer, raffle helper, assisted in various money raising endeavors.
2010 - present	Malcolm X Elementary School, Berkeley, CA	Volunteered in classroom, hosted beekeeping fieldtrips for 2nd graders in our backyard. Lead reading groups with students. Numerous small projects.

SUMMARY OF SERVICE ACTIVITIES

My departmental service activities has involved committee work to improved Bixby peer-review processes, to revise and publish a new mission and vision for ANSIRH, and, most recently, to sit on hire ANSIRH's new executive director. I also regularly contribute to the department through journal clubs, qualitative methods support. and voluntary teaching. I have volunteered considerable time over the past year for the American Civil Liberties Union case against the State of Alabama's new abortion restriction that requires all abortion clinics to have doctors with hospital privileges (designed to shut down 3 out of 5 of the states remaining clinics). I testified to my own research and as an expert in the related literature and how they relate to Alabama's abortion care landscape. I am also an active parent in my children's public schools in Berkeley, helping with fundraisers as well as direct teacher support in the classroom.

TEACHING AND MENTORING

TEACHING

FORMAL SCHEDULED CLASSES FOR UCSF STUDENTS

Qtr	Academic Yr	Course Number and Title	Teaching Contribution	Units	Class Size
F	2000 - 2001	Sociology 2, Self & Society (Social Psychology) UC Davis	Discussion Section Leader and Grader; 2 one hour sessions per week	4	20
W	2000 - 2001	Sociology 2, Self & Society (Social Psychology) UC Davis	Discussion Section Leader and Grader; 2 one hour sessions per week	4	20
S	2000 - 2001	Sociology 46A, Introduction to Social Research, UC Davis	Discussion Section Leader and Grader; 2 one hour sessions per week	4	20
F	2001 - 2002	Sociology 46A, Introduction to Social	Discussion	4	20

Qtr	Academic Yr	Course Number and Title	Teaching Contribution	Units	Class Size
		Research, UC Davis	Section Leader and Grader; 2 one hour sessions per week		
W	2001 - 2002	Sociology 185, Social Welfare, UC Davis	Assisted Professor and Graded	4	80
F	2002 - 2003	Internship and Research Practicum (Undergraduate Field Methods), UC Davis	Instructor; 2 two hour classes per week	4	20
F	2003 - 2004	Internship and Research Practicum (Undergraduate Field Methods), UC Davis	Instructor; 2 two hour classes per week	4	20
W	2003 - 2004	Sociology 185, Social Welfare, UC Davis	Assisted Professor and Graded	4	80
S	2003 - 2004	Sociology 154, Sociology of Health Care, UC Davis	Graded Exams and Papers	4	80

POSTGRADUATE AND OTHER COURSES

2012 - 2012	Dr. Ndola Prata's course: Family Planning, Population Change, and Health, UC Berkeley School of Public Health	Guest Lecturer
2013 - present	LifeCycle Course, Medical dilemmas in Pregnancy and Delivery, UCSF	Co-organized and revised syllabus, trained discussants, led small group discussion of UCSF medical students
2014 - present	Dr. Jodi Halpern's course: Public Health Ethics, UC Berkeley School of Public Health	Guest Lecturer
2014 - present	Coursera, Massive Online Open Course (MOOC) with Jody Steinauer, MD. "Abortion: Quality Care and Public Health Implications." UCSF	Gave two recorded lectures and filmed three interviews

INFORMAL TEACHING

2008 - 2009 Stigma Literature Journal Club at ANSIRH for Bixby Center Researchers, UCSF [Organized journal club and facilitated five meetings at ANSIRH with interdisciplinary group of sexuality and reproductive health researchers]

2008 - 2009 Qualitative Research Methods Seminar at ANSIRH for Bixby Center Researchers, UCSF [Co-taught monthly meetings, half theory lecture, half methodological workshop focused on participants' questions from their ongoing research and writing]

2009 - 2010 Qualitative Research Methods, Small Groups of Bixby Center Researchers [Teaching interviewing techniques and analytical coding methods to public health

and physician researchers new to qualitative methods]

2011 - 2011 Women's Health Issues Journal Club. Organized and facilitated meeting of Bixby and ANSIRH researchers in the discussion of a special edition of Women's Health Issues focused on abortion and contraception research

2014 - 2014 Qualitative Methods Summer Workshop for ANSIRH and Bixby staff and faculty. Conducted a five-part series to help resolve technical and theoretical problems for researchers new to qualitative methods.

TEACHING NARRATIVE

In my capacity as a researcher at UCSF, I have primarily taught medical students, residents, and physician fellows one-on-one and in small groups about how to design interviews, code qualitative data, and approach the analysis of their qualitative studies. Before finishing my doctoral work, the undergraduate teaching I enjoyed most was a qualitative methods research seminar. I was the instructor for two classes of 20 students who discussed readings about ethnographic field methods and simultaneously conducted their own mini-ethnography of the workplace. My preferred mode of teaching is to focus deeply on fewer readings, rather than to stay at the surface of many. I also strive to make theory come alive through cases and empirical examples. While working with ANSIRH at UCSF I have designed and instructed informal courses reviewing literature in social science theory and methodology. The first, the Stigma Journal Club, was organized in 2008 to help researchers become familiar with new literature in a special issue of the journal Social Science & Medicine dealing with prejudice and stigma as they relate to health disparities. These are subjects of importance to researchers of reproductive and sexual health. We worked to understand the findings in the journal about smoking, mental health, and a variety of other topics and relate them to our own research. The second course, a Qualitative Research Methods Seminar, was organized to help physician researchers, demographers, public health researchers, and others who have embarked on qualitative research projects to learn more about how to collect and analyze that data. Participants come from Laurel Heights (Bixby Center), the Center for Aids Prevention Studies, and ANSIRH. For the past two years, I have been co-teaching and organizing the Life Cycle course for UCSF medical students entitled, "Medical Dilemmas in Pregnancy and Delivery." I facilitated a small group discussion to tease out the ethical conflicts and solutions to complex problems in obstetrics. I have resumed teaching qualitative methodology to groups this summer at ANSIRH and have joined a team of faculty to create an innovative MOOC.

MENTORING

PREDOCTORAL STUDENTS SUPERVISED OR MENTORED

Dates	Name	Program or School	Role	Current Position
2008 - 2009	Felisa Preskill	UC Berkeley Public Policy	Qualitative Research Advisor	Graduate Student
2008 - 2009	Sarah Dixon-Cipriano	UCSF Medical School	Qualitative Research Advisor	Medical Student
2008 - 2009	Signy Judd	UCSF Sociology	Research Design Consultation	Doctoral Student
2007 - 2009	Jennifer Schradie	UC Berkeley Sociology	Career Advisor	Graduate Student
2008 - 2009	Mitchel	UCSF Department of	Qualitative	Analyst

Dates	Name	Program or School	Role	Current Position
	Hawkins	Ob, Gyn, and R.S.	Research Advisor	
2009 - 2010	Rachna Vanjani	UCSF Department of Ob, Gyn, and R.S.	Qualitative Research Advisor	Research Analyst and Medical Student at George Washington University
2009 - 2010	Jenny O'Donnell	Harvard School of Public Health	Qualitative Research and Writing Advisor	Public Health Student
2010 - 2010	Margot Brown	UCB/UCSF Joint Medical Program	Qualitative Research Advisor	Medical Student
2010 - 2010	Michaela Ferrari	Fulbright Fellow	Qualitative Study Design Advisor	Placement in country: Georgia
2010 - 2010	Rebekah Lewis	McGill Sociology Department	Research Design and Mentorship	Doctoral Student
2010 - 2010	Roxana Bahar	UC Davis Sociology Dept.	Research Design and Mentorship	Doctoral Student
2011 - 2011	Stephanie Bussmann	UCSF School of Nursing	Qualitative Research Advisor	Nursing Masters Student
2011 - present	Erica Li	UC Davis School of Medicine	Research Design and Mentorship	Medical Student
2011 - present	Kendra Ford	Institute of Transpersonal Psychology	Dissertation Advisor	Psychology Doctoral Candidate
2012 - present	Sirina Keesara	UCSF School of Medicine	Qualitative Research Advisor	Medical Student and Research Intern Kenya
2013 - present	Tara Gonzalez	UCB/UCSF Joint Medical Program	Qualitative Research Advisor (interviewing)	Medical Student
2014 - present	Cassandra Blazer	UCB School of Public Health	Qualitative Research Advisor	Doctoral Candidate

POSTDOCTORAL FELLOWS AND RESIDENTS DIRECTLY SUPERVISED OR MENTORED

Dates	Name	Fellow	Faculty Role	Current Position
2008 - 2009	Sarah Newman, MD	Family Planning Fellow	Qualitative Research Advisor	Assistant Clinical Professor, Department of Ob, Gyn, & R.S. UCSF
2008 - 2009	Davida Becker, PhD	Post-Doctoral Fellow	Qualitative Research Advisor	Bixby Center for Global Reproductive Health, UCSF
2009 - 2009	Jennifer Kerns, MD	Family Planning Fellow	Qualitative Research Advisor	Family Planning Fellow, Department of Ob, Gyn, & R.S. UCSF
2010 - 2010	Sarah Kennedy, MD	Family Planning Fellow	Qualitative Research Advisor	Family Planning Fellow, Department of Ob, Gyn, & R.S. UCSF
2010 - 2010	Jessica Morse, MD	Family Planning Fellow	Qualitative Research Advisor	Family Planning Fellow, Department of Ob, Gyn, & R.S. UCSF
2010 - 2010	Rasha Koury,	Ob-Gyn Resident	Qualitative	3rd Year Resident,

Dates	Name	Fellow	Faculty Role	Current Position
	MD		Research Advisor	Department of Ob, Gyn, & R.S. UCSF
2010 - 2011	Jema Turk, PhD	Research Manager	Qualitative Design and Analysis Advisor	Research Manager in Dept of Ob, Gyn, & R.S., UCSF
2012 - 2013	Colleen Denny, MD	Resident	Bioethics Advisor	PGY-1 (first year resident) Dept of Ob, Gyn, & R.S., UCSF
2013 - present	Meredith Warden, MD, MPH	Family Planning Fellow	Qualitative Research Advisor	Family Planning Fellow, Dept of Ob, Gyn, & R.S., UCSF
2013 - present	Anna Altshuler, MD	Family Planning Fellow	Qualitative Research Advisor	Stanford University

FACULTY MENTORING

Dates	Name	Position While Mentored	Mentoring Role	Current Position
2011 - present	Monica McLemore, PhD	Nurse and Researcher	Qualitative Research Advisor	Assistant Clinical Professor, Family Health Care Nursing Department, UCSF
2013 - present	Michelle Oberman, JD	Professor of Law	Qualitative Research Advisor	Professor of Law, Santa Clara University School of Law

MENTORING NARRATIVE

In my role as a qualitatively trained sociologist working in a medical school, I often mentor fellows, residents, and medical students who are embarking on qualitative research projects for the first time. I have given talks in my research group (ANSIRH) about qualitative methods. However, I primarily meet with mentees one-on-one to discuss qualitative methods readings, research design and feasibility, interviewing skills, analysis and writing. I have trained several mentees to use qualitative data management software as well. I work to help mentees have realistic goals about the feasibility of the project and to translate what I learned through years of doctoral training into the most critical elements necessary for limited scope medical research. In the past two yearsI have begun to advise more junior researchers about career strategy as well.

SUMMARY OF TEACHING AND MENTORING HOURS

2000 - 2004

1680 total hours of teaching (including preparation)

Formal class or course teaching hours: 480 hours

Informal class or course teaching hours: hours

Mentoring hours: hours

2008 - 2009	164 total hours of teaching (including preparation) Formal class or course teaching hours: hours Informal class or course teaching hours: 40 hours Mentoring hours: 44 hours
2009 - 2013	270 total hours of teaching (including preparation) Formal class or course teaching hours: hours Informal class or course teaching hours: 50 hours Mentoring hours: 140 hours
2013 - 2014	160 total hours of teaching (including preparation) Formal class or course teaching hours: 20 hours Informal class or course teaching hours: 80 hours Mentoring hours: 60 hours
2014 - 2015	Total anticipated hours of teaching: 160 hours

RESEARCH AND CREATIVE ACTIVITIES

RESEARCH AWARDS

CURRENT

A124002 (Primary Investigator)	07/01/2014 - 06/30/2017
Greenwall Foundation	$87,001 direct/yr1
Informed Consent for Catholic Hospital Patients Regarding Effects of Doctrine on Care	$277,384 total
A123719 (Primary Investigator)	10/01/2014 - 09/30/2015
Society of Family Planning	$117,674 direct/yr1
Understanding Patient Experiences with Obstetric Care in Catholic Health Care Facilities	$117,674 total
A122692 (Primary Investigator)	01/01/2014 - 12/31/2015
Anonymous Foundation	$242,190 direct/yr1
Qualitative Assessment of Clinician Practice Patterns Post-HWPP/AB 154	$490,389 total
P0048983 (Co-Investigator)	07/01/2012 - 06/30/2014
Packard Foundation	$179,913 direct/yr1

Changing the Conversation	$347,826 total

Gift (Principal Investigator)	01/01/2012 - 01/31/2014
Wohlford Foundation	$60,000 direct/yr1
Institutional Influences on Physician Practices in Sexual and Reproductive Health	$60,000 total

A123146 (Co-Investigator)	07/01/2014 - 06/30/2016
Hewlett Foundation	$220,000 direct/yr1
Increasing access to long‐acting reversible contraceptive methods among adolescent and young adults through provider training	$400,000 total

PAST

CA-0039685 (Co-Investigator)	06/01/2012 - 05/31/2014
National Institutes of Health	$231,168 direct/yr1
Race, Contraception, and Untended Pregnancy (PI Sonya Borrero, University of Pittsburgh)	$426, 756 total total

A120001 (Principal Investigator)	08/01/2012 - 07/31/2013
Society for Family Planning	$114,494 direct/yr1
The Bioethics of Reproductive Health Care in Catholic-affiliated Hospitals and Clinics	$114,494 total

REAC 34185-523145 (Principal Investigator)	01/01/2011 - 01/01/2011
REAC Grant-Anonymous Heart	$29,700 direct/yr1
"Institutional Influences on Physician Practices in Sexual and Reproductive Health"	$29,700 total

A115829 (Co-Investigator)	07/01/2010 - 06/30/2011
Greenwall Foundation (subcontract)	$22,584 direct/yr1
"Institutional Influences on Physician Practices in Sexual and Reproductive Health"	$22,584 total

A107706 (Co-Investigator)	07/01/2007 - 06/30/2010
William and Flora Hewlett Foundation	$681,818 direct/yr1
Reducing unintended pregnancy and the need for abortion in the US through promotion of long-acting reversible contraception (the LARC program)	$1,681,818 total

A113465 (Co-Investigator)	10/01/2007 - 09/30/2011
Anonymous Foundation	$2,264,377 direct/yr1
"Kenneth J. Ryan Residency Training Program in Abortion and Family Planning"	$21,507,058 total

A109955 (Co-Investigator)	07/01/2008 - 06/30/2010
The David and Lucille Packard Foundation	$326,087 direct/yr1

PEER REVIEWED PUBLICATIONS

1. Jackson, RA, Schwarz, EB, **Freedman, L**, Darney, P. Knowledge and willingness to use emergency contraception among low-income post-partum women. Contraception 2000; 61: 351-357.

2. Jackson, RA, Schwarz, EB, **Freedman, L**, Darney, P. Advance supply of emergency contraception: effect on use and usual contraception- a randomized trial, Obstetrics & Gynecology 2003; 102: 8-16.

3. **Freedman, LR**, Landy, U, and Steinauer, J. When there's a heartbeat: miscarriage management in Catholic-owned hospitals, Am J Pub Health 2008; 98(10): 1774-8.

4. **Freedman, LR**, Landy, U, and Steinauer, J. Ob-gyn experiences with abortion training: physician insights from a qualitative study, Contraception. 2010 Jun;81(6):525-30. Epub 2010 Feb 10.

5. **Freedman, LR**; Landy, U; Darney, P; and Steinauer, J. Obstacles to the integration of abortion into ob-gyn practice. Perspectives on Sexual and Reproductive Health. 2010 Sep; 42(3).

6. Upadhyay UD, Cockrill K, **Freedman LR**. Informing abortion counseling: An examination of evidence-based practices used in emotional care for other stigmatized and sensitive health issues. Patient Educ Couns. 2010;81(3):415-421.

7. Wallace RR, Goodman S, **Freedman LR**, Dalton VK, Harris LH. Counseling women with early pregnancy failure: Utilizing evidence, preserving preference. Patient Educ Couns. 2010;81(3):454-461.

8. O'Donnell J, Weitz T, **Freedman LR**. Resistance and Vulnerability to Stigmatization in Abortion Work. Social Science and Medicine 73 (2011) 1357e1364

9. Kerns J, Vanjani R, **Freedman L,** Meckstroth K, Drey EA, Steinauer J. Women's decision making regarding choice of second trimester termination method for pregnancy complications. International Journal of Obstetrics and Gynecology, Volume 116, Issue 3, March 2012

10. **Freedman LR** and Weitz TA. The Politics of Motherhood Meets the Politics of Poverty. Contemporary Sociology: A Journal of Reviews January 2012 vol. 41 no. 1 36-42.

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14. **Freedman LR** and Levi, A. How Clinicians Develop Confidence in Their Competence in Performing Aspiration Abortion. Qualitative Health Research. January 2014 24: 78-89

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16. Stulberg, D. B., Hoffman, Y., Dahlquist, I. H., & **Freedman, L. R.** 2014. Tubal Ligation in Catholic Hospitals: A Qualitative Study of Ob-Gyns' Experiences. Contraception 90:422-428.

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1. **Freedman LR** and Weitz TA. The Politics of Motherhood Meets the Politics of Poverty. Contemporary Sociology: A Journal of Reviews January 2012 vol. 41 no. 1 36-42.

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1. **Freedman, LR**. Willing and unable: doctors' constraints in abortion care. Vanderbilt University Press. Nashville, Tennessee. July 2010.

2. **Freedman, L. R.** 2014. Practice Constraints and the Institutionalized Buck-Passing of Abortion Care. In Reproduction and Society: Interdisciplinary Readings. edited by Joffe, C. & Reich, J. London: Routledge.

3. **Freedman, L. R.** 2014. Abortion in American Medicine: A Recent History. In Deeply Private, Incredibly Public, Readings on the Sociology of Human Reproduction edited by Marrone, C. San Diego: Cognella.

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1. Marcotte, A, "*Doctors Who Want To Provide Abortion But Can't*" Interview for Podcast, RH Reality Check. June 13, 2010.

2. Freedman, LR, "*Letters: The New Abortion Providers*" New York Times. July 29, 2010.

3. Freedman LR. "*Bishop Olmstead's innovative solution to the Catholic health care problem*" ANSIRH Blog, January 7, 2011.

4. Freedman LR and O'Donnell J. "*Abortion Providers Aren't Passive Victims of Stigma*" ANSIRH Blog, October 8, 2011.

5. Freedman LR. *"It Could Happen Here."* The Huffington Post, November 19, 2012

6. Freedman LR. 2013. "*When a Pregnancy Goes Wrong in Catholic Hospitals*" ANSIRH Blog, February 4.

7. Freedman L.R. 2014. Forgiveness in the Abortion Clinic. Atrium: The Report of the Northwestern Humanities and Bioethics Program. 12:6-8. And reprinted in Pacific Standard.

8. Freedman, L.R. 2014. Washington State Case Study: A Difficult Miscarriage Made Worse by Hospital's Religious Restrictions on Care. Huffington Post.

9. Freedman, L.R. 2014. Yes, the Church Should Be Liable When Doctrines Interfere with Safe Medical Care for Women: New research into medical decisions at church-run facilities. The New Republic.

10. Freedman, L.R. 2014. Dispelling Six Myths About Catholic Hospital Care in the United States. RH Reality Check.

11. Freedman, L.R. 2014. Tubal Ligations in Catholic Hospitals. ANSIRH Blog, September 8.

ABSTRACTS

1. **Freedman, L.** *Abortion Practice and the Pro-Choice Movement: Investigating Frame Adequacy for Abortion Workers.* Pacific Sociological Association Annual Meeting. San Francisco, March 2001

2. **Freedman, L.** *Abortion Work as Medical Work: The Hospital Context of Abortion Care.* Pacific Sociological Association Annual Meeting. San Francisco, April 2004

3. **Freedman, L.** *The Marginalization of Abortion in Medicine: Stigma, Conflict, and Barriers to Integrative Practices.* Pacific Sociological Association Annual Meeting. Oakland, California. March 2007

4. **Freedman LR**, Landy U, Preskill F, Steinauer J. *Barriers to Abortion Care in the U.S.* Poster presentation at the annual meeting of the American Public Health Association in Washington, D.C., November 2007

5. **Freedman, LR**. *Professional Obligation and Abortion Provision: A Typology of Physician Perspective and Practices.* American Sociological Association Annual Meeting. Boston, MA. August 2008

6. **Freedman, LR**. *Barriers to the Integration of Abortion Care among Ob-Gyns.* National Abortion Federation Annual Meeting. Portland, OR. April 2009

7. Hawkins M, Steinauer J, **Freedman LR**. *What is the Culture of Abortion Care in Your Practice? Ob-Gyns' Experiences of Professional Barriers.* Preconference Blue Ribbon Winner. American College of Obstetricians and Gynecologists 57th Annual Clinical Meeting (ACM) in Chicago, Illinois, May 2 - 6, 2009

8. Cipriano S, Gonzalez M, **Freedman LR**, Perucci A, Newmann S, Steinauer J. *Values Clarification as a Tool to Increase Medical Student Self-awareness of Discomfort with Patient Behaviors.* Academy of Medical Educators Medical Education Day, UCSF. April 27, 2009

9. **Freedman LR,** Harper CC, Thompson KMJ, Waxman NJ, Morse JE, Speidel JJ. *Cost is a major barrier to post-abortion LARC provision: qualitative findings.* National Abortion Federation Annual Meeting. Philadelphia, PA. 2010

10. O'Donnell J, Weitz TW, **Freedman LR**. *Occupational abortion stigma.* National Abortion Federation Annual Meeting. Philadelphia, PA. 2010

11. **Freedman, LR.** *Values clarification workshops in medical school: Teaching professionalism through a 'mindfulness' lens.* Pacific Sociological Association Annual Meeting. Oakland, CA. April 2010

12. **Freedman LR** and Weitz TA. *"Kristin Luker's enduring contributions and the evolution of the meaning of abortion for U.S. women.* A Quarter Century Retrospective: Abortion and the Politics of Motherhood, Invited Panelists, Pacific Sociological Association Annual Meeting. Oakland, CA. April 2010

13. O'Donnell J, **Freedman LR,** Weitz TA. *"Abortion Provision, Occupational Stigma, and Abortion Access."* American Public Health Association Annual Meeting. Denver, CO. November 2010

14. **Freedman LR** and Stulberg D. "*Standards in conflict: How Catholic health care doctrine interacts with ob-gyn physician practice.*" American Public Health Association Annual Meeting. Washington DC, Nov 1, 2011

15. **Freedman LR**. "*California's new abortion provider: how nurse practitioners, physician assistants, and nurse midwives learning to perform abortions understand their work and professional identity.*" California Sociological Association Meeting, November 4, 2011

16. **Freedman LR**. *"Abortion and 'Conscience' Clauses: Conflicts Between Catholic-owned Hospitals and Physicians in Patient Care."* The Eastern Sociological Society Annual meeting, February 24, 2012

17. **Freedman LR**. "*Negotiation New Identities After Abortion Training: Experiences of HWPP Clinicians.*" National Abortion Federation Annual Meeting. New York, New York, April 28, 2013

18. **Freedman LR** and Stulberg D. "*Achieving Compromise when Religious Doctrine and Medical Practices Conflict.*" Annual Meeting of the Program on Religion and Medicine, The University of Chicago. Chicago, Illinois, May 28, 2013

19. **Freedman LR** and Weitz TA. *"Stratified Legitimacy in Abortion Care."* Annual Meeting of the American Sociological Association. New York, New York. August 10, 2013

20. **Freedman L.R.,** Harris, L and Watson, K. "Moral Agency: Institutions, Physicians, and Patients." Annual Meeting of the American Society for Bioethics and Humanities. Atlanta, GA, October, 2013.

21. **Freedman L.R.** "How Catholic Hospitals Affect Women's Reproductive Health in the U.S." UC Berkeley De Cal Course: Reproduction in Modern Society, March 17 2014.

22. **Freedman L.R.** Nursing and Medical Students for Choice, UCSF. "Conflicts in Ob-gyn Care in Catholic Hospitals." San Francisco, CA. February 12, 2014.

23. **Freedman L.R.,** Harris, L and Watson, K. "The Moral Agency of the Institution." In panel: Moral Agency: Institutions, Physicians, and Patients. Annual Meeting of the National Abortion Federation. San Francisco, CA, April 7, 2014.

24. **Freedman, L.R.** "Health and Reproductive Access" vs. "Religious Freedom": How Changes in the Landscape of Hospital Administration and Insurance Coverage Affect Our Access to Care. Panel member. Sociologists for Women in Society, San Francisco, August 18, 2014.

25. **Freedman, L.R.** "Taking Research into the Courtroom" Annual Meeting of the American Sociological Association. San Francisco, CA, August 17, 2014.

RESEARCH PROGRAM

My research is conducted through Advancing New Standards in Reproductive Health (ANSIRH). ANSIRH is a program of the Bixby Center for Global Reproductive Health in the UCSF Department of Obstetrics, Gynecology and Reproductive Sciences, San Francisco General Hospital Division. Through my research projects, I seek to understand the ways in which reproductive health care policies and practices are shaped by our social structure and enacted in health settings.

How Doctrine-based Policies in Religiously-affiliated Hospitals affect Care

Unexpected findings from my previous research about abortion practice stimulated interest in a new project about the effects of religiously affiliated health care expansion in the U.S. on women's reproductive health. Catholic-owned hospitals, in particular, merged with or overtook numerous hospitals in the 1990s. Currently, one in nine acute care patients are treated in a Catholic facility, which prohibit a variety of reproductive health services. Much is written about the ethics of such health care refusals, but little is known about how they affect the care women receive. My recent research includes a study with researchers at the University of Chicago involving in-depth interviews with a national sample of 31 ob-gyns about how their employer influences the sexual and reproductive health care they deliver. I am currently launching two new studies to understand patient experiences with religiously restricted care as well.

Workforce Transition: A Qualitative Study of Abortion Trained Midwives, Nurse Practitioners, and Physician Assistants

An interview based evaluation of an innovative study training nurse practitioners, physician assistants, and midwives in aspiration abortion care. By permission of a state waiver, these clinicians are broadening their procedural repertoire into a particularly sensitive and contested arena of abortion care. The study asks, how have the practitioners responded to the training professionally, socially, and emotionally? How has this expansion of their scope of work affected their understanding of themselves and their professional role? How has it affected their relationships inside and outside of work? How has the training served their professional growth and where has the training fallen short? What does this transition mean to providers and their identity overall? Interviews began summer 2010. 30 clinician interviews were completed and analyzed. Writing and dissemination is in process. In addition, the next stage of the research is underway: an evaluation of clinician abortion practice since 2013 when the law was changed (AB-154) to officially allow nurse practitioners, physicians assistants and midwives to provide abortion in California. This post-law change study relies on in-depth interviews with clinicians, administrators, and medical directors, as well as regular surveys to track practice.

Qualitative Methods in Medical Research

Increased acceptance of qualitative methodology for health research in recent years has been followed by increased funding from the NIH and increased interest from health researchers with quantitative training. I am interested in both teaching and researching how to best make the two worlds meet. Because qualitative data is not managed and analyzed in the same way as quantitative data, evaluation of the quality of the work can be especially elusive in an interdisciplinary health context. With a team of qualitative and quantitative researchers, I plan to

undertake a review of qualitative methods and analysis in health journals in order to propose evaluative criteria amenable to interdisciplinary translation and acceptance.

SIGNIFICANT PUBLICATIONS

Freedman, LR. Willing and unable: doctors' constraints in abortion care. Vanderbilt University Press, Nashville, Tennessee. July 2010.

Summary of Book: *Willing and Unable*explores the social world where abortion politics and medicine collide. The author interviewed physicians of obstetrics and gynecology around the United States to find out why physicians rarely integrate abortion into their medical practice. While abortion stigma, violence, and political contention provide some explanation, her findings demonstrate that willing physicians are further encumbered by a variety of barriers within their practice environments. Structural barriers to the mainstream practice of abortion effectively institutionalize the buck-passing of abortion patients to abortion clinics. Drawing from forty in-depth interviews, the book presents a challenge to a commonly held assumption that physicians decide whether or not to provide abortion based on personal ideology. Physician narratives demonstrate how their choices around learning, doing, and even having abortions themselves disrupt the pro-choice/pro-life moral and political
binary.

Designed the research, conducted all interviews, analyzed qualitative data, wrote dissertation (Completed Spring 2008) and revised into book form.

Freedman, LR; Landy, U; Darney, P; and Steinauer, J. *Obstacles to the integration of abortion into ob-gyn practice.* Perspectives on Sexual and Reproductive Health. 2010 Sep; 42(3). Epub May 24, 2010.

Summary of the Article: A streamlined version of above book findings from Chapter 5, focusing exclusively on obstacles to the integration of abortion. The majority of physicians were unable to provide abortions within their practice because of formal and informal policies imposed by their private practice groups, employers, and hospitals, as well as a prohibitive degree of strain on collegiality with superiors and coworkers. The stigma and ideological contention surrounding abortion manifest in professional environments as barriers to the integration of abortion into medical practice. New physicians often lack the professional support and autonomy necessary to continue to offer abortion services to their patients. Article was reviewed in several on-line venues including Salon.com, Ms. Magazine's blog, and RHrealitycheck.org.

Designed the research, conducted all interviews, analyzed qualitative data, and lead the writing.

3. O'Donnell J, Weitz T, **Freedman LR**. Resistance and Vulnerability to Stigmatization in Abortion Work. Social Science and Medicine 73 (2011) 1357e1364

The stigma surrounding abortion in the United States commonly permeates the experience of both those seeking this health service as well as those engaged in its provision. Annually there are approximately 1.2 million abortions performed in the United States; despite that existing research shows that abortion services are highly utilized, women rarely disclose their use of these services. In 2005 only 1787 facilities that offer abortion services remained, a drop of almost 40 percent since 1982 (Jones, Zolna, Henshaw, & Finer, 2008). While it has been acknowledged that all professionals working in abortion are labeled to some degree as different, no published research has explored stigmatization as a process experienced by the range of individuals that comprise the abortion-providing workforce in the USA. Using qualitative data from a group of healthcare professionals doing abortion work in aWestern state, this study begins to fill that gap, providing evidence of how the experience of stigma can vary and is managed within interactions in the workplace, in professional circles, among family and friends, and among strangers. The analysis shows that the experience of stigma for those providing abortion care is not a static or fixed loss of status. It is a dynamic situation in which those vulnerable to stigmatization can avoid, resist, or transform the stigma that would attach to them by varying degrees within selective contexts.

Made substantial contributions to the analysis and writing. Mentored first author through the process.

4. **Freedman LR** and Weitz TA. "The Politics of Motherhood Meets the Politics of Poverty." Contemporary Sociology: A Journal of Reviews January 2012 vol. 41 no. 1 36-42 /
A retrospective examination of a seminal sociological analysis of abortion in the U.S., Kristin Luker's Abortion and the Politics of Motherhood. The article argues that while Luker's analysis endures as critical to understanding the unfolding of the American debate around abortion, certain demographic shifts have brought about new questions. New studies should address the increasing proportion of poor women having abortions, and relatedly, how the meaning of abortion for both the women having them and the activists fighting about them may have changed in the last three decades.

Took the lead role in this collaborative analysis and writing project. Both authors have studied abortion for the past decade and wrote as observers of this area of inquiry.

Freedman, LR, Stulberg, D. Conflicts in Care for Obstetric Complications in Catholic Hospitals. American Journal of Bioethics Primary Research. October 2013.
Summary of Article: recent national survey revealed that over half of obstetrician-gynecologists working in Catholic hospitals have conflicts with religious policies, but the survey did not elucidate the nature of the conflicts. Our qualitative study examines the nature of physician conflicts with religious policies governing ob-gyn care. Results related to restrictions on the management of obstetric complications are reported here. Methods: In-depth interviews lasting about one hour were conducted with obstetrician-gynecologists throughout the United States. Questions focused on physicians' general satisfaction with their hospital work settings and specific experiences with religious doctrine-based ob-gyn policies in the various hospitals where they have worked. Results: Conflicts reported here include cases in which Catholic hospital religious policy (Ethical and Religious Directives for Catholic Health Care Services) impacted physicians' abilities to offer treatment to women experiencing certain obstetric emergencies, such as pregnancy-related health problems, molar pregnancy, miscarriage, or previable premature rupture of membranes (PPROM), because hospital authorities perceived treatment as equivalent to a prohibited abortion. Physicians were contractually obligated to follow doctrine-based policies while practicing in these Catholic hospitals. Conclusions: For some physicians, their hospital's prohibition on abortion initially seemed congruent with their own principles, but when applied to cases in which patients were already losing a desired pregnancy and/or the patient's health was at risk, some physicians found the institutional restrictions on care to be unacceptable.
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ADDITIONAL RELEVANT INFORMATION: