EXHIBIT 3

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION

COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, et al. Plaintiffs, v. PETER LYSKOWSKI, in his official capacity as Director of the Missouri Department of Health and Senior Services, et al. Defendants.	)	Case No. 2:16-cv-04313-HFS

DECLARATION OF DAVID L. EISENBERG IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

David L. Eisenberg declares the following:

1. I submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction preventing enforcement against abortion providers of Mo. Ann. Stat. §197.200, which requires facilities providing abortions to be licensed as ambulatory surgical centers (the "ASC Restriction"), and Mo. Ann. Stat. §§ 197.215, 188.080, and 188.027 and Mo. Code Regs. Ann. tit. 19, § 30-30.060(1)(C)4, which require physicians providing abortions to have various forms of hospital admitting privileges and/or a written transfer agreement with a nearby hospital (collectively, the "Hospital Relationship Restriction"). As I explain below, in my medical opinion these requirements are medically unjustified and out of step with contemporary medical practice, and detrimental to the health and well-being of women seeking abortions in Missouri.

2. I am a board-certified obstetrician-gynecologist and employed as an Associate Professor in the Department of Obstetrics and Gynecology at the Washington University School

of Medicine, and as the Director of Benign Gynecology Resident service at Barnes Jewish Hospital and Washington University in St. Louis School of Medicine. I am also a Fellow of the American College of Obstetrics and Gynecologists and a Fellow of the Society of Family Planning. I received my medical degree from the University of Alabama, and did my residency, internship, and a post-internship fellowship in family planning and contraception at the Northwestern University McGaw Center for Graduate Medical Education. I also hold a Masters degree in Public Health from Northwestern University. In addition to my duties in the Department of Obstetrics and Gynecology and as an attending physician at the Washington University School of Medicine, I also serve as an Institute for Public Health Scholar at the Washington University in St. Louis Institute for Public Health. I also am the Medical Director of Planned Parenthood of the St. Louis Region and Southwest Missouri. A complete copy of my curriculum vitae is attached hereto as Exhibit A. As indicated on my CV, I have lectured and published peer-reviewed research articles on a wide range of reproductive health issues.

3. My opinions are based on over a decade of clinical experience providing obstetric and gynecological care, including abortions, and on the knowledge I have obtained through my education; training; teaching experience; first-hand clinical research; attendance at and participation in conferences, including leading sessions on best practices relating to abortion and other reproductive and sexual health care topics; and my ongoing review of the relevant professional literature. I have been involved in the training of more than fifty ob/gyn residents in safe provision of abortion services.

4. I submit this declaration in my personal capacity, and hold the opinions in this declaration to a reasonable degree of medical certainty. My declaration represents my opinions alone. I do not speak for or serve as an authorized representative of Washington University School of Medicine or Barnes-Jewish Hospital.

Safety of Legal Abortion and Management of Complications

5. Legal abortion is one of the safest medical procedures in the United States.

6. The risk of a woman experiencing some type of complication after an abortion is extremely low. Large-scale, comprehensive studies compiled in the 1970s and 1980s showed that fewer than 1% of women obtaining first-trimester abortions experience minor complications, while the risk of a woman experiencing a complication that requires treatment in a hospital is even lower, approximately 0.3%, or 3 in 1,000 women.[1] More recent data regarding first trimester surgical abortion shows even lower complication rates: according to a 2013 study of procedures performed between 2007 and 2011 found that only 0.89% of procedures performed by physicians resulted in complications –that is 9 women out of 1,000. Further, 0.05% of the patients in the study (about 5 women in 10,000) experienced complications that required treatment in a hospital.[2] Finally, a large-scale study of medication abortions provided in 2009 and 2010 showed that approximately 1.2 women out of 10,000 were treated in an emergency room for complications following a medication abortion, and even fewer –6 women in 100,000 –had to be admitted to the hospital.[3]

7. It is important to put these very low risks into context. Women who seek abortions are pregnant, and pregnancy itself carries risk. The risk of death associated with childbirth is approximately 14 times higher than that associated with abortion, and every pregnancy-related complication is more common among women having live births than among those having

[1] Stanley K. Henshaw, *Unintended pregnancy and abortion: a public health perspective*. In: A Clinician's Guide to Medical and Surgical Abortion 11–22 (Maureen Paul, E. Steve Lichtenberg, Lynn Borgatta, David A. Grimes, & Phillip G. Stubblefield eds., New York: Churchill Livingston 1999).
[2] Tracy A. Weitz, Diana Taylor, Sheila Desai et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. of Pub. Health, no. 3. Mar. 2013, at 454, 454–61.
[3] Kelly Cleland, Mitchell Creinin, Deborah Nucatola, Montsine Nshom & James Trussell, *Significant Adverse Events and Outcomes After Medical Abortion*, 121 Obstetrics & Gynecology, no. 1, Jan. 2013, at 166, 166–71.

abortions.[4] The risk of death following an abortion is less than 0.6 deaths per 100,000 procedures, which is roughly half the risk of death following a miscarriage.[5] In contrast, the risk of death from anaphylactic shock following use of penicillin in the United States is 2.0 deaths per 100,000 uses.[6]

8. There are two types of induced abortion, medication abortion and surgical abortion. Medication abortion is a method of terminating an early pregnancy by taking medications approved by the Food and Drug Administration. In medication abortion the patient swallows a pill at the health center, and then self-administers a second medication 24-48 hours later at a location of their choosing, most often at home, which causes the expulsion of the contents of the uterus in a process similar to a miscarriage.

9. During a surgical abortion, the provider uses instruments to evacuate the uterus. Surgical abortion is not what is commonly understood to be a "surgical" procedure, as it involves no incision and no general anesthesia. In the first trimester, the procedure typically takes five to eight minutes, and does not require more than local anesthesia.

The ASC Restriction

10. Pursuant to the ASC Restriction, I understand that currently any health center providing five or more first trimester abortions a month, or any second trimester abortions, must be licensed as an ambulatory surgical center ("ASC"). I understand that for this reason, Planned Parenthood's health centers in Springfield, Joplin, Columbia, and Kansas City, Missouri are not currently able to provide abortions.

11. Both medication and surgical abortion can be provided safely and effectively in an outpatient setting similar to a doctor's office. This is true because the nature of the procedure is

[4] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*. 119 Obstetrics & Gynecology, no. 2, Feb. 2012, at 215, 215–9.
[5] David A. Grimes, *Estimation of pregnancy-related mortality risk by pregnancy outcome, United States, 1991 to1999*, 194 Am. J. Obstetrics & Gynecology, 2006, at 92, 93.
[6] Alfred Neugut, et al., *Anaphylaxis in the United States: An Investigation Into Its Epidemiology*, 161 Archives of Internal Med., Jan. 8, 2001, at 15, 18.

simple (in the case of surgical abortion; in medication abortion there is no procedure at all) and the risk of complications is exceedingly low.

Surgical Abortion

12. Surgical abortion procedures as performed at Planned Parenthood and other outpatient health centers throughout the country involve only a small number of medical personnel and a small amount of equipment, and do not involve the use of general anesthesia.

13. As noted above the risk of complications from surgical abortion is low. The types of complications that may occur following a surgical abortion include infection, bleeding, uterine perforation, and retained tissue. In the vast majority of cases these types of complications can be, and are, handled in office-style settings without the need for any hospital treatment. For example, most cases of suspected uterine perforation are asymptomatic and do not require additional interventions; non-severe bleeding may be managed in the health center or doctor's office setting with medications that increase the tone of uterine muscle and reduce bleeding. Women with mild infections are usually treated with oral and/or injected antibiotics. In the case of a missed abortion or an incomplete abortion with retained tissue, the physician can provide the necessary follow-up treatment, which may involve administration of medicine or another aspiration procedure, in the health center.

14. In the exceedingly rare event that a complication occurs that cannot appropriately be managed in an office setting, I would transfer the patient to a hospital for further treatment. There is no abortion complication I would treat in a facility that meets Missouri's ASC requirements that I would not treat equally well in an office setting. Simply put, it makes no difference to the treatment of complications whether I'm doing an abortion in an office setting or an ASC. Nor is any abortion complication more or less likely to occur based on whether the abortion is performed in an ASC or an office setting.

15. Turning to the specifics of the Missouri requirements, there is no medical basis to require, for example, a procedure room that is twelve feet by twelve feet, or has nine foot ceilings. Surgical abortions are safely and routinely provided in smaller procedure rooms, and doing so is consistent with the standard of care; there is no patient benefit to the larger room size. This is true regardless of whether the procedure is done in the first or second trimester and whether it is done under local anesthesia and/or moderate sedation.

16. Nor is there any medical basis to require an abortion-providing health center to have corridors that are six feet wide, doors that are 44 inches wide, or three feet of space around a recliner in the recovery room. These requirements are presumably aimed at allowing safe evacuation of a patient in the rare case of a complication requiring a hospital transfer. But for this you would only need doors, corridors, and recovery space sufficiently wide for a gurney to pass, and gurneys routinely traverse much smaller areas. Indeed, EMS is routinely able to safely and rapidly evacuate patients from settings such as doctors' offices or airplanes. And notably, I understand that Missouri's regulations for birthing centers permit narrower doors and corridors than are permitted for ASCs providing abortion services, despite the fact that childbirth is far riskier than abortion. Mo. Ann. tit. 19 § 30-30.100(11) (permitting four foot corridors and 36 inch doors).

17. Nor is there any need for four recovery recliners per procedure room, as the lack of an incision, general anesthesia, or deep sedation mean that most patients require only minimal duration of recovery following a surgical abortion. Indeed, a patient who has had only local anesthesia and/or minimal sedation will typically require less than 15 minutes of recovery.

18. There is no medical basis to require a surgical light that is ceiling mounted. Because during a surgical abortion a woman is in the lithotomy position (i.e., with her knees up in stirrups), such a light is at the wrong angle and frequently cannot be adequately articulated to provide sufficient lighting for visualization of the vagina and cervical opening.

19. Nor is there any medical basis to require a health center providing surgical abortions to have scrub facilities outside the room where a procedure will be performed or to have those scrub facilities be knee- or foot-operated. Such requirements are appropriate for sterile procedures, that is, procedures in which an incision is made into a sterile body cavity; such procedures are done in an operating theater set up in a manner that allows the procedure's sterility to be maintained, and one typical requirement is hands-free scrub facilities located outside of the operating room. However, abortion is not a sterile procedure, because the provider accesses the patient's uterus through the vagina, which is naturally colonized by bacteria, rather than by an incision into a sterile body cavity. Such a procedure can never be sterile and while it is important that a handwashing station be available, there is no benefit to requiring a hands-free scrub facility or requiring it to be outside of the procedure room.

20. These are only examples; many of the other ASC requirements are simply inappropriate, and provide no medical benefit, in the context of surgical abortion. For example, as should be clear from the discussion above, there is nothing about the nature of abortion services that makes it appropriate to impose different fire safety or HVAC requirements than would be imposed for a doctor's office.

21. Surgical abortion is analogous to other medical procedures performed by physicians in a doctor's office setting in terms of risks, invasiveness, instrumentation, and duration. For example, there is almost no technical difference between first trimester surgical abortion and surgical completion of miscarriage, diagnostic dilation and curettage, or hysteroscopy (in which a small telescope is placed in the uterine cavity along with fluid, under pressure, in order to visualize the uterine lining). These procedures are very common; for example, as many as one in five pregnancies end in miscarriage, and many women need surgical management of their miscarriage in a manner that is nearly identical to a first-trimester surgical abortion. Each of these procedures

is frequently, and safely, provided in a doctors' office setting.

22. Other similar procedures that are routinely and safely done in office-style settings include colposcopy with cervical biopsy (in which a sample is taken from the cervix to be evaluated for cancerous cells) and loop electrosurgical excision of the cervix (in which an abnormal area of the cervix thought to be precancerous is removed).

23. While Missouri law requires any facility providing five or more first trimester abortions, or any second trimester abortions, to be licensed as an ASC, I understand that no equivalent requirement is imposed for any of these procedures; rather, facilities in which these procedures are performed would only have to be licensed as ASCs if they are operated primarily for the purpose of performing surgical procedures.

24. The same is true for non-gynecological procedures such as gastrointestinal endoscopies (including colonoscopy), many forms of plastic surgery, and dermatologic cancer surgery, each of which is comparable to or riskier than surgical abortion. Indeed some of these procedures are performed under general anesthesia or deep sedation, which by itself is much riskier than abortion. But again, Missouri law does not require facilities in which these procedures are performed to be licensed as ASCs unless the facilities are operated primarily for the purpose of performing surgical procedures.

Medication Abortion

25. The ASC requirements make even less sense in the context of medication abortion. As noted above, medication abortion is a method of terminating an early pregnancy by medications alone; there is no "procedure" and the products of conception are passed at home in a process similar to a miscarriage. More specifically, the patient takes the first medication, mifepristone (a pill) orally at the health center or doctor's office. That day, she is given the misoprostol (which are also pills) and instructed to administer them to herself 24-48 hours later at a location of her choosing, most

often at home; this second medication causes the expulsion of the contents of the uterus a short and predictable period after taking it.

26. Medication abortion is extremely safe and is associated with few complications or contraindications. It is routinely and safely provided in doctor's offices and office-style settings across the country, and doing so is consistent with the standard of care.

27. To be clear, there is nothing about the safety of mifepristone that requires it to be taken at a health center or doctor's office rather than at home; rather, this is most often what occurs in order to enable the provider to confirm that the patient has taken the mifepristone, and at what time, in order to help the woman know when to self-administer the misoprostol which will bring on the expulsion of the contents of the uterus. The risk of complications from mifepristone are exceedingly rare compared to the risk of complications from other medications for which such requirements are not imposed, and which are prescribed by physicians, dispensed by physicians or pharmacies, and consumed at locations away from a medical office.

28. Because there is no procedure to take place at the health center, there can be no medical basis to require a twelve foot by twelve foot procedure room; the woman can take her oral medication in a room of any dimensions. Similarly, there is no conceivable medical basis to require a health center providing medication abortion to have hands-free scrub facilities outside the room where a procedure will be performed, when (again) there is no procedure to be performed.

29. For the same reasons there is no need for a recovery room, as there is no procedure for the patient to recover from, and she typically will not feel any effects from the first medication while she is in the health center; patients are permitted to leave immediately after taking the mifepristone.

30. Nor are six foot corridors or 44 inch door widths relevant to patient safety in this context. The only conceivable complication of medication abortion that could arise at the health

center when the woman takes the first medication is an allergic reaction, as could occur in response to any medication (including over-the-counter medications). As with anyone having an allergic reaction, it is the standard of care to provide the patient with medications such as epinephrine if the reaction is acute enough to warrant it. No specific physical space is required to administer such medications. In my years of providing medication abortion, and of supervising its provision, none of my patients has had an allergic reaction; nor am I aware of any colleague whose patient has had such a reaction.

31. Of the small percentage of women having any complication from medication abortion, by far the most common is an incomplete abortion, which happens if some tissue is retained in the uterus, which can cause continued bleeding or spotting. This will, of course, occur away from the office where the mifepristone is taken, as any bleeding or spotting generally will not start until after the second medication is taken the next day at a location of the woman's choosing. If the abortion is not complete, which happens in 2–5% of cases, the patient has the option to take a second dose of misoprostol in the hope of completing the abortion, to have an aspiration procedure similar to a surgical abortion or miscarriage management, or, in some cases, to wait for the tissue to pass.

32. Contained within that 2–5% of patients who have an incomplete abortion is a smaller number–only one out of every 200 (or 0.5%) of women who have medication abortion–who will have not only retained tissue but a continuing pregnancy. For this reason, it is the standard of care for medication abortion patients to have either an ultrasound or a pregnancy test one to two weeks after taking the misoprostol, to confirm that the abortion was successful. If a patient has a continuing pregnancy, she has the option to take a second dose of misoprostol in the hope of completing the abortion or to have an aspiration procedure.

33. In the rare event that a woman elects to or needs to have an aspiration procedure to

complete the abortion, it does not need to be performed immediately and does not need to be performed at the same health center where she took the mifepristone. She can be scheduled for the procedure, generally within the next few days, at another health center or doctor's office.

34. All other possible complications following medication abortion are even rarer and would never occur at the health center, but rather long after the woman has left. For example, in the extremely rare case that a medication abortion patient has experienced sufficient blood loss that she might need emergency treatment (such as a transfusion or fluid support), it will typically occur one to three weeks after the procedure. And the protocol in such a situation is the same as in any outpatient setting; when the patient phones the outpatient facility to report the heavy bleeding, advise her to go to the nearest emergency room (or, if she came in person to the health center rather than telephoning, transfer her to the hospital). She would not be treated at the health center even if it offered surgical abortion and even if it met Missouri's ASC requirements.

The Hospital Relationship Restriction

35. Pursuant to the Hospital Relationship Restriction, I understand that currently any physicians providing abortion in Missouri must meet several overlapping requirements for hospital admitting privileges and/or a written transfer agreement with a nearby hospital. More specifically, I understand that a physician providing either medication or surgical abortion must–on pain of criminal penalty–have clinical privileges at a hospital offering obstetrical or gynecological care within 30 miles of the location where the abortion is performed, Mo. Ann. Stat. § 188.080; a physician performing surgical abortion in an ASC must have either privileges to perform surgical procedures in a hospital in the community where the ASC is located or a working agreement with such a hospital guaranteeing the transfer and admittance of patients, Mo. Ann. Stat. § 197.215(2); and a physician providing either medication or surgical abortions in an ASC must have admitting privileges at a hospital within 15 minutes travel time from the ASC or must show proof of a

working arrangement with such a hospital, Mo. Code Regs. Ann. tit 19, § 30-30.060(1)(C)4. Each of these requirements is medically unnecessary and inappropriate to the nature of abortion care.

36. As discussed above, first trimester surgical abortion is essentially identical in terms of risks, invasiveness, instrumentation, and duration to surgical completion of miscarriage, diagnostic dilation and curettage, and hysteroscopy, and similar in these terms to colposcopy with cervical biopsy and loop electrosurgical excision of the cervix. Yet while Missouri law requires a physician providing even a single abortion to have hospital admitting privileges, and separately requires a physician providing abortions at a facility that provides five or more first-trimester abortions a year, or any second-trimester abortions, to have either admitting privileges or written transfer agreement, I understand that no equivalent requirement is imposed for any of the other procedures I described. Rather, these requirements apply only if the physician is providing services at a facility operated primarily for the purpose of performing surgical procedures.

37. Similarly, I understand that physicians providing procedures of comparable or greater risk than abortion such as gastrointestinal endoscopies (including colonoscopy), many forms of plastic surgery, and dermatologic cancer surgery, are not required to have admitting privileges or a written transfer agreement unless they provide the procedures at facilities operated primarily for the purpose of performing surgical procedures

38. As discussed above the risk of complications from abortion is very low, and the overwhelming majority can be, and are, managed in the health center providing the abortion or (in the case of complications that arise after the patient has gone home) another similar health center, without any need for hospital treatment. For this reason, and because of how continuity of care is addressed in the rare case of a complication requiring hospital treatment, there is no need for requiring the physician providing abortions to have any form of admitting privileges at a local hospital, or written transfer agreement with such a hospital.

Treatment of Complications

39. In the extremely unlikely event that an abortion patient experiences a serious complication at the health center that requires emergency hospital treatment, an important factor in ensuring a good outcome for the patient—as it is for any patient who is transferred to a hospital under any circumstances—is continuity of care. Continuity of care should involve direct communication between the abortion provider and the emergency room physician; this is standard medical practice and will ensure that the emergency room physician is aware of the extent of the complication, prior treatment, and medication received. Thus, Planned Parenthood's Medical Standards & Guidelines, as well as Reproductive Health Services of Planned Parenthood of the St. Louis Region's ("RHS") own policies, require the abortion provider to communicate directly with the staff that will treat the patient at the hospital, as well as sending medical information with the patient in the ambulance. Continuity of care, however, does not require that the abortion provider administer the emergency treatment, have admitting privileges at the hospital where treatment is given, or have a transfer agreement with that hospital; such requirements are not medically necessary.

40. If an emergency room physician decides that it is necessary to involve an ob-gyn in the patient's care, he or she will contact the ob-gyn on call at that hospital, and that ob-gyn can admit the patient if necessary. Because the potential complications from induced abortion are essentially identical to those that may occur from other common procedures, including surgical completion of miscarriage, diagnostic dilation and curettage, and hysteroscopy, all ob-gyns, regardless of whether they perform abortions, are qualified to manage the care of a patient experiencing a complication from an abortion, and to refer the patient, when necessary, to the appropriate subspecialist. If the on-call ob-gyn needs any additional medical history from the abortion provider, this is readily available and commonly obtained by telephone contact,

providing further continuity of care. Again, whether the physician providing abortions has hospital admitting privileges, and/or the facility has a written transfer agreement with a hospital, makes no difference to this process.

41. Even if the abortion provider had privileges at a local hospital, or a transfer agreement was in place, the provider often has little ability to control where the Emergency Medical Technicians (EMTs) take the patient. The EMTs will take the patient to the hospital that they determine the emergency warrants. And if the emergency room where the provider seeks to send a patient is full and not accepting additional transfers, which can happen, the patient will be taken to a different hospital. The patient or her family also may request transport to a specific hospital where the provider does not have privileges or where no transfer agreement is in place. Such requests are very common when, for example, a patient has private insurance that requires them to be taken to an in-network hospital.

42. It is my opinion that admitting privileges are also irrelevant to providing optimal care in the event of a complication because regardless of whether he or she has such privileges, the physician who provides the abortion may not be the appropriate physician to manage the patient's care in the hospital. Because abortions have such a low complication rate, abortion providers may, depending on their practice, only rarely perform the types of surgeries that might be necessary to treat a complication requiring surgery. In other circumstances, even an ob-gyn who performs a wide range of gynecological surgical procedures might not have the relevant expertise to treat the patient. For example, in the very rare case of uterine perforation with a vascular or bowel injury, it is critical that the appropriate subspecialist treat the patient. And of course, having a transfer agreement in place makes no difference to which physician will treat the patient.

43. Similarly, if I perform a hysterectomy in a hospital on a patient with asthma and the

patient experiences a pulmonary complication from anesthesia, it might become necessary to involve a pulmonologist. When I used to deliver babies, if a patient had a blood clot event following delivery (a relatively common and serious complication), it might become necessary to involve a hematologist, vascular surgeon, and/or cardiologist. Given how specialized the practice of medicine has become, particularly in a hospital setting, such handoffs to the appropriate specialists are common and necessary across medicine.

44. The admitting privileges and transfer agreement restrictions are also unnecessary to providing optimal care because if, after discharge from the abortion clinic, a woman who lives far from the facility where she obtained her abortion experiences a rare complication that requires hospital treatment, she should and will be treated at a hospital that is close to her. She should not travel to a hospital near the abortion clinic—indeed, it might be unsafe for her to do so—just because her abortion provider has admitting privileges there, or because a transfer agreement was in place there. While abortion complications requiring hospital treatment are exceedingly rare, they are more likely to occur after a patient has gone home than during or immediately after a procedure.

45. Further, the treatment of complications from abortion that occur after a patient has left the health center is straightforward and does not require any specialized knowledge of abortion practice. Indeed, the treatment for these complications from abortion is identical to treatment for complications of a spontaneous miscarriage, and, as noted above, spontaneous miscarriages are very common.

46. As is required by Planned Parenthood's Medical Standards & Guidelines, as well as by RHS's policies, all Planned Parenthood abortion patients receive detailed instructions on what to expect, including what level of bleeding or other symptoms constitute cause for concern, as well as a twenty-four hour after-hours line to call with any questions or concerns. This number is staffed

by a nurse or physician at all times, and a physician is always available for consultation. Most commonly, once the patient explains her symptoms it becomes clear that they can be addressed by phone, with reassurance that the bleeding or cramping they are experiencing is not cause for concern. If further evaluation is needed, most patients will be directed to come to the closest Planned Parenthood health center for a follow-up appointment, and most symptoms can be appropriately treated at the health center. In the very rare case that the nurse or physician determines the patient should be evaluated immediately and our health center is inappropriate, he or she will direct her to the closest emergency room. Health center staff subsequently telephones the patient to ascertain whether she went to the emergency room and what care (if any) she received and determine whether any further follow-up is appropriate. All of this is the typical of the way that follow-up care is commonly – and safely – provided for a wide range of outpatient procedures.

47. Every hospital has an obligation under a federal law called the Emergency Medical Treatment and Labor Act (EMTALA) to provide emergency treatment to any patient who arrives at the hospital. Thus, if a patient experiencing a complication is brought to a hospital or subsequently seeks care at a hospital, that patient would receive the necessary care there regardless of whether the abortion-providing physician has admitting privileges at the hospital, and/or whether a written transfer agreement is in place.

48. Whether I have admitting privileges at and/or a transfer agreement with a hospital makes no difference to the care my patient would receive there. Even if my patient were admitted to a hospital at which I have admitting privileges (either as a transfer from the health center, or after coming in from home), I would not leave my other patients or other obligations to go provide care to that patient; I would trust the physicians at that hospital to provide competent care.

49. The practice guidelines of the leading professional organization of ob/gyns, the

American Congress of Obstetricians and Gynecologists ("ACOG"), PPFA, and the leading professional organization of abortion providers, the National Abortion Federation ("NAF"), recognize that clinics that perform abortions should have arrangements in place for transferring patients who require emergency treatment. They do not, however, suggest or require that abortion-providing physicians have admitting privileges at a nearby hospital or that a written transfer agreement be in place. For example, ACOG states that "Clinicians who perform abortions in their offices, clinics, or freestanding ambulatory care facilities should have a plan to provide prompt emergency services if a complication occurs and should establish a mechanism for transferring patients who require emergency treatment," and that "ACOG opposes laws or other regulations that require abortion providers to have hospital privileges."[7] NAF states that "Protocols for the management of medical emergencies must be in place. These protocols must include indications for emergency transport and written, readily available directions for contacting external emergency assistance (e.g., an ambulance)"[8], and that, "Hospital admitting privileges are not needed to provide safe abortion care."[9]

Contemporary Medical Practice and Admitting Privileges

50. In my opinion, the admitting privileges restriction is completely at odds with the reality of contemporary medical practice, including the trend of dividing ambulatory and hospital care. The "Marcus Welby" model of the community physician who provides all of his or her patient's care–whether inpatient or outpatient–is out of date and no longer the norm. In fact, hospitals today typically have their own dedicated admitting physicians (hospitalists) and, in more and more cases, only those physicians who have truly hospital-based practices actually

[7] ACOG, Guidelines for Women's Health Care: A Resource Manual, 720 (2014); *See also* ACOG, Statement on State Legislation Requiring Admitting Privileges for Physicians Providing Abortion Services, Apr. 25, 2013, http://www.acog.org/About-ACOG/News-Room/News-Releases/2013/Hospital-Admitting-Privileges-for-Physicians-Providing-Abortion-Services.
[8] NAF, 2016 Policy Guidelines, 51 (2016).
[9] *Id*. at 1.

have and maintain admitting privileges.

51. It is extremely common for physicians to cover for each other and refer patients to other physicians as necessary to treat the patient. It is also well understood in medicine that, while a physician must be properly trained and qualified to perform the procedures he or she performs, he or she need not be properly trained and qualified to handle all of the potential consequences and complications of those procedures. All physicians, at some point, must (and should) refer their patients to another specialist, or a subspecialist, to ensure quality of care. In fact, I believe that knowing when to refer patients in this manner is a mark of a good physician or surgeon.

52. The admitting privileges restriction is also completely out of step with the realities of hospital credentialing. For example, many hospitals require that physicians with privileges admit a certain number of patients each year. This requirement, among other things, allows hospitals to ensure that physicians providing care at the hospital frequently provide hospital-based care and can demonstrate their ability to provide that care well. As a result, this requirement further increases the divide between outpatient and hospital-based care. When a patient requires inpatient care, more and more highly qualified and proficient outpatient providers hand off care of their patients to doctors who provide inpatient care. This is not patient abandonment, but the way that good, safe medicine is practiced today.

53. Another reality of the process by which hospitals grant admitting privileges is that it involves multiple levels of approval by various committees, whose members can vote against approval for any reason whatsoever, including based on opposition to abortion. Any physicians applying for privileges must list current and previous employers on his application, as well as every type of procedure he performs. That a physician performs abortions could,

in and of itself, prompt committee members to vote against a grant of admitting privileges. Committee proceedings are closed and confidential, and the only information ever disclosed is whether an applicant was approved.

Inability to Obtain Hospital Privileges In Joplin and Springfield

54. There are two hospitals located within from the distance allowed by the Hospital Relationship Restriction for the Joplin health center: Mercy Hospital Joplin and Freeman Health Systems. There are also two hospitals located within the allowed distance for the Springfield health center: Mercy Hospital Springfield and Cox Health. I have reached out to each of these hospitals to inquire about their requirements for privileges and have determined that I am unable to meet the requirements at any of these hospitals.

Joplin

55. I reached out to a Physician Recruiter at Freeman Health System in Joplin, Missouri in September 2016 to request information about the hospital's requirements for privileges, and the bylaws and a privileges application were provided to me in late October. I have reviewed those documents and determined that I cannot meet the hospital's requirements for privileges. First, the hospital requires that all privileged physicians reside and maintain an office within the geographical service area of the hospital, defined on the privileges application as within 15 minutes of the hospital. Since I reside in St. Louis, I cannot meet this requirement. In addition, the hospital requires that privileged physicians take emergency calls, care for unassigned patients, and mentor new members of the hospital staff, none of which I would be able to fulfill given that I reside in St. Louis.

56. I also exchanged emails with the Medical Staff Coordinator at Mercy Hospital Joplin in September and October 2016 regarding the hospital's requirements for privileges and was provided with the staff bylaws in mid-October. I have reviewed the bylaws and determined that I

cannot meet the hospital's requirements for privileges. The bylaws indicate that physicians who hold privileges at the hospital must utilize the hospital consistent with the Ethical and Religious Directives for Catholic Health Facilities. Those Directives state that abortion is never permitted. This is contrary to my deeply held, personal beliefs and conscience that being a women's health specialist and board-certified obstetrician-gynecologist obligates me to provide abortion care. Given that my sole practice in Joplin would be providing abortion services at Planned Parenthood, and my use of the hospital would be limited to treating my Planned Parenthood patients (if any such treatment was needed), I cannot meet this requirement. In addition, the hospital requires privileged physicians to participate in emergency department calls, peer review and monitoring of new appointees to the medical staff, none of which I would be able to do given that I reside in St. Louis.

Springfield

57. I emailed a Physician Recruiter at Mercy Springfield in September 2016 to request information about the hospital's requirement for privileges, but did not receive any response. However, I am aware that, as with Mercy Joplin, Mercy Springfield adheres to the Ethical and Religious Directives for Catholic Health Facilities, which prohibit abortion. As in Joplin, my sole practice in Springfield would be providing abortion services at Planned Parenthood, and my use of the hospital would be limited to treating my Planned Parenthood patients. Therefore, I am unable to adhere to the Directives and cannot obtain privileges at Mercy Springfield.

58. I also exchanged several emails with physician recruitment staff at Cox Health during September 2016. Initially, my request for information about hospital privileges was greeted positively, with Cox staff stating they were impressed with my resume and informing me about open positions in their practice groups. However, when I explained that I was not seeking full time employment with the hospital but was instead seeking to provide outpatient care at the Planned Parenthood health center, I received no further response from the hospital. The hospital

did provide me with the staff bylaws during this exchange, and it is clear from my review of that document that I cannot meet the hospital's requirements for privileges. The hospital requires physicians to complete a period of provisional status, during which the physician's work in the hospital is proctored by other physicians already on staff. Because abortion is extremely safe, I would not have enough, and probably would not have any, patients who need care in the hospital, so I would be unable to fulfill the requirements of this provisional period. In addition, the hospital requires physicians to identify another physician on staff who would provide coverage for patients. Because of the hostility in the community to abortion, physicians are unwilling to be publicly associated with Planned Parenthood for fear of harassment or negative consequences to their own practices. Therefore, I am unable to meet this coverage requirement as well.

Impact of ASC and Hospital Relationship Restrictions on Missouri Women's Health

59. I understand that because of the ASC and Hospital Restrictions, Planned Parenthood's health centers in Springfield, Joplin, Kansas City, and Columbia are currently unable to provide abortions, and women seeking abortions in Missouri, regardless of where in the state they live, are limited our single health center in St. Louis. In my opinion, this is detrimental to women's health and well-being.

60. Although abortion is legal throughout the United States, meaningful access continues to be a very significant problem for many women. Indeed, 87% of counties in the country do not have an abortion provider, with the shortage particularly acute in rural counties. This is of particular concern because abortion is a medical service sought by many women of reproductive age. Current data show that approximately 30% of women will have an abortion by the age of 45.[10]

61. The lack of providers often delays access to abortion significantly, which is detrimental to women's health because gestational age is an important determinant of medical risk.

[10] Rachel K. Jones & Megan L. Kavanaugh, *Changes in Abortion Rates between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 Obstetrics & Gynecology, no. 6, 2011, at 1358, 1358.

While abortion is a safe procedure and the risk of complications from an abortion is very low, the risk of abortion increases as the pregnancy advances.[11]

62. Medication abortion is available only early in pregnancy, and specifically, until seventy days after the first day of the woman's last menstrual period. This means that delay may result in medication abortion no longer being an option for a woman, even though it may be the woman's strong preference to have a medication abortion rather than a surgical one.

63. I know from my conversations with thousands of patients, as well as with other medical professionals, that once women are counseled about both medication and surgical abortion, most have a strong and clear preference between the two options. One of the most common reasons that women choose medication abortion is that it allows them to more control over the process, and to avoid having a clinician insert instruments into their bodies. Many women also like that it feels more "natural," like an early miscarriage. Further, in a medication abortion the woman takes the mifepristone at the health care center, but will expel the contents of the uterus later, usually four to five hours after taking the misoprostol. This means the patients can experience this process largely at a time and location of their choice, most often in their own homes, with the support of the family and friends they want around them, and without the presence of health center staff who, while kind, are nonetheless unfamiliar. These options are not available with a surgical abortion.

64. For these reasons, the ASC and Hospital Relationship restrictions–which impose medically irrelevant and hard-to-satisfy restrictions on the provision of abortions, and have the practical effect of limiting the entire state to a single abortion provider–are harmful to the health and well-being of women in Missouri.

[11] Linda A. Bartlett, Cynthia J. Berg, et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology, no. 4, 2004, at 729, 731–32 (risk of death increases at a rate of 38% for each additional week of gestation and gestational age is the risk factor most strongly associated with mortality).

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

Executed on December 12, 2016

/s/ David L. Eisenberg
David L. Eisenberg, MD, MPH

EXHIBIT A

CURRICULUM VITAE
David L. Eisenberg, MD, MPH

Date: November 9, 2016

Address and Telephone Numbers:

(Office) Department of Obstetrics and Gynecology
Washington University School of Medicine
660 S. Euclid Ave, Box 8064
St .Louis, MO 63110-1501
Phone: (314) 362-3751
Fax: (314) 747-6722

Present Position(s): Associate Professor, Department of Obstetrics and Gynecology
Washington University School of Medicine
Saint Louis, Missouri

Medical Director
Planned Parenthood of the St. Louis Region & Southwest Missouri

Education:

Fellowship:	2007-2009	Northwestern University Feinberg School of Medicine, Northwestern Memorial Hospital Fellowship in Family Planning & Contraception
Graduate:	2007-2009	Northwestern University Master of Public Health
Residency:	2004-2007	Northwestern McGaw Center for Graduate Medical Education
Postgraduate:	2003-2007	Northwestern University, Chicago, IL
Internship:	2003-2004	Northwestern McGaw Center for Graduate Medical Education Department of Obstetrics and Gynecology Resident Physician
Medical School:	1999-2003	University of Alabama School of Medicine Doctor of Medicine
Undergraduate:	1995-1999	University of Pittsburgh, *Magna cum Laude* B.S. Neuroscience, Minor in Chemistry

Academic Positions/Employment:

2016-Present	Associate Professor, Obstetrics and Gynecology Washington University in St. Louis School of Medicine
2011-Present	Director Benign Gynecology Resident service at Barnes Jewish Hospital and Washington University in St. Louis School of Medicine

2011-2013	Co-Director Ryan Residency Training Program, Washington University in St. Louis School of Medicine
2009-2015	Assistant Professor, Obstetrics and Gynecology Washington University in St. Louis School of Medicine Saint Louis, Missouri
2009-Present	Medical Director, Planned Parenthood of the St. Louis Region and Southwest Missouri
2009-Present	Institute Scholar, Washington University in St. Louis Institute for Public Health
2007-2009	Northwestern University, Northwestern Memorial Hospital Fellow, Family Planning & Contraception

University/Hospital/Departmental Appointments and Committees:

2011-Present	Gynecology Quality Improvement Committee, Washington University in St. Louis School of Medicine
2011-Present	Director Benign Gynecology Resident service at Barnes Jewish Hospital and Washington University in St. Louis School of Medicine
2010-Present	Washington University in St. Louis, School of Medicine, Meaningful use of EMR committee
2009-Present	Washington University in St. Louis, School of Medicine, ITC Board
2009-2013	Barnes-Jewish Hospital Perinatal Bereavement Council
2005-2007	Northwestern Memorial Hospital, Information Technology improvement and implementation committee
2004-2007	Evanston Northwestern Healthcare, Labor & Delivery Physician & Nurses quality committee, Housestaff representative

Medical Licensure and Board Certification:

Licensure**:**	036-114385	MD license, State of Illinois (expires 7/31/2017)
	2009004523	MD license, State of Missouri (expires 1/31/2017)
Board Certification:	2011	Board Certified, Obstetrics & Gynecology Diplomate # 931605

Honors and Awards:

2016	APGO Excellence in medical student Teaching Award
2016	CREOG Teacher of the Year for Ob/Gyn residency

2016	Clinical Teacher of the Year for academic year 2015-2016
2015	Medical Students for Choice Alumni Award
2015	APGO Excellence in medical student Teaching Award
2015	Kenneth J. Ryan, MD Memorial Scholarship Award from Physicians for Reproductive Health
2015	Arnold P. Gold Humanism Honor Society Faculty selection
2015	Clinical Teacher of the Year for academic year 2013-2014
2014	Clinical Teacher of the Year for academic year 2012-2013
2013-Present	*St. Louis Magazine's* "Best Doctor's in St. Louis"
2013-Present	*The Best Doctors in America*®
2013-Present	Fellow of American College of Obstetrics & Gynecology (FACOG)
2010-11	ACOG/Bayer HealthCare Pharmaceuticals Research Award in Long Term Contraception
2008-9	Physicians for Reproductive Choice & Health, Leadership Training Initiative
2007	Excellence in medical student teaching award, Northwestern University Medical School
2007	Special Excellence in Endoscopic Procedures, American Association of Gynecologic Laparoscopists
2006-7	CARE Award, Evanston Northwestern Healthcare
2006	ACOG Resident Reporter Program at Annual Clinical Meeting, Washington, DC
2005	Excellence in medical student teaching award, Northwestern University Medical School
2003-9	Medical Students for Choice, Northwestern University, Advisor

National Committees

2013-2016	ACOG Gynecologic Practice Committee Vice-chair of committee 2015-2016
2014-Present	Association of Zoos and Aquariums Wildlife Contraception Center Advisory group
2011-Present	Planned Parenthood Federation of America Medical Directors' Council Trustee
2011-Present	Planned Parenthood Federation of America National Medical Committee
2011	CDC Experts' consultation on the use of combined hormonal contraception in immediate postpartum period

2010-2011	CDC Experts' meeting on US adaptation of WHO Selected Practice Recommendations for Contraception
2008	National Abortion Federation, Risk Management Seminar Planning Committee

Editorial Responsibilities:

2013-2014	Reviewer, *Expert Reviews of Obstetrics & Gynecology*
2011-2012	Reviewer, *Journal of General Internal Medicine*
2010-Present	Reviewer, *American Journal of Obstetrics & Gynecology*
2010-Present	Reviewer, *Obstetrics & Gynecology*
2007-2012	Reviewer, *International Journal of Gynecology & Obstetrics*
2007-2010	Reviewer, *Ultrasound in Obstetrics & Gynecology*
2007-2012	Reviewer, *Journal of Family Planning and Reproductive Health Care*
2009-2010	Reviewer, *Anesthesia & Analgesia*
2009-Present	Reviewer, *Contraception*
2009-Present	Consultant Editor of *The Global Library of Women's Medicine* for the section on sterilization

Professional Societies and Organizations:

2009-Present	American Public Health Association, Member
2009-Present	St. Louis Gynecologic Society, Member
2008-Present	Association of Professors of Gynecology and Obstetrics, Member
2008-2010	American Medical Association, member
2007-Present	Society of Family Planning, Fellow
2007-2009	American Association of Gynecologic Laparoscopists, Member
2006-Present	Physicians for Reproductive Choice & Health, Member
2005-Present	National Abortion Federation, Member
2005-Present	Association of Reproductive Health Professionals, Physician Member
2002-Present	American College of Obstetricians and Gynecologists, Fellow
1999-Present	Medical Students for Choice
1999-2003	American Medical Association, Student Member

Major Invited Professorships and Lectureships:

National & International:

February 2016	"Set It and Forget It: Long-Acting Reversible Contraception" presented at Obstetrical Society of Philadelphia

September 2014	ACOG LARC National Webinar: "Best Practices in Long-Acting Reversible Contraception: Recommendations from ACOG and the CDC"
June 2014	"Long-Acting Reversible Contraception: The First-Line Option for All Women, Including Teems," Texas Department State Health Services, Community Health Services Section, Annual Conference, Austin, TX
August 2013	"Early Pregnancy Failure: outpatient management," Grand Rounds, Department of Ob/Gyn, University of Alabama School of Medicine, Birmingham, AL
May 2013	"Updates on Contraception & Evidence-based Abortion Care" Mekelle University of Health Sciences, Mekelle, Tigray Province, Ethiopia
April 2013	"Management of Complications from Elective Abortion," Grand Rounds, Department of Ob/Gyn, University of Oklahoma-Tulsa, Tulsa, OK
October 2012	"The Importance of Long Acting Reversible Contraception (LARC)," Grand Rounds, Department of Ob/Gyn, University of Alabama School of Medicine, Birmingham, AL
May 2012	"Controversies in Family Planning: Postabortion ovulation and IUD insertion," Family Planning Fellowship National Conference, San Diego 2012
February 2009	"Contraception: Perspectives from the US & Rwanda," Grand Rounds, King Faisal Hospital and Central University Hospital of Kigali, Rwanda
Jan-Feb, 2009	Visiting professor of gynecology and family planning, National University of Rwanda
November 2008	"Role of Men in Family Planning & Women's Health," Medical Students for Choice National Conference, St. Louis, MO
November 2008	"Issues in 2nd Trimester Abortion," Medical Students for Choice National Conference, St. Louis, MO
October 2008	"Peri-abortal Hemorrhage: Training to Manage Risk," NAF Risk Management Seminar, Halifax, Nova Scotia
April 2008	"Emergency Transports," Panel discussion. NAF National Conference
April 2006	"Filling the Gap: Abortion Education Throughout Medical Training," Panel discussion. AMSA National Convention, Chicago, IL

Regional & Local:

September 2015	"Long-acting reversible contraception: The first-line contraceptive option for women can be challenging for clinicians," Grand Rounds, Memorial Hospital, Carbondale, IL

February 2015	"Pregnancy of Unknown Location & Ectopic Pregnancy" Grand Rounds, Department of Ob/Gyn, Washington University in St. Louis School of Medicine
May 2014	"Second Trimester Abortion," Medical Students for Choice Abortion Training Institute, St. Louis, MO
March 2014	"Best Practices in Sexual Health," Mini-Med School, Washington University in St. Louis School of Medicine
October 2012	"Pregnancy of Undetermined Location & Ectopic Pregnancy," 38th Annual Symposium in Obstetrics & Gynecology, Washington University in St. Louis School of Medicine
October 2011	"Contraception Update: US MEC and Contraceptive CHOICE Project," 37th Annual Symposium in Obstetrics & Gynecology, Washington University in St. Louis School of Medicine
March 2011 & 2012	"Reproductive Options," Kansas City University of Medicine & Biosciences, Kansas City, MO
March 2010	"Intrauterine Contraception: Past, Present & Future," Grand Rounds, Department of Ob/Gyn, Washington University in St. Louis School of Medicine
November 2009	"Perspectives of an Abortion Provider," Lecture, Eden Theological Seminary, St. Louis, MO
April-May 2009	Medical Decision Making, Small Group Facilitator, Northwestern University Feinberg School of Medicine, Chicago, IL
December 2008	"Pregnancy Options Counseling," Lecture, University of Michigan School of Medicine, Ann Arbor, MI
June 2008	"Short-term Reversible Contraception," Lecture, Loyola University Medical School, Chicago, IL April 2007 "Unintended Pregnancy: An Overview." Lake Forest College, Dept. of Psychology, Lake Forrest, IL

Research Support:

Government: *(Federal & Private Foundations)*

The Contraceptive CHOICE Project (PI: Peipert, JF)
A longitudinal cohort study of 10,000 women in the St. Louis region to encourage the use of long-term, reversible contraception (i.e. implants and intrauterine devices). Population-based outcomes include reducing the rate of teen pregnancy and unintended pregnancy.
Role: Co-Investigator
Source: Susan Thompson Buffett Foundation
08/01/2007 – 07/31/2014

Randomized, open-label, controlled trial of immediate postpartum versus interval insertion of Mirena® to increase the usage at 6 months after delivery (Mirena Intrauterine System Timing of Insertion Controlled (MISTIC) trial)
Role: Principal Investigator
Source: Society of Family Planning (SFP 4-13)
7/1/2010-5/31/2012

Survey of primary care physicians' perceptions of barriers to providing contraception to women on potentially teratogenic medications at an urban academic institution
Role: Principal Investigator
Source: Family Planning Fellowship
10/1/08-6/30/09

Nongovernment: *(Pharmaceutical and other)*
A Phase 3, single arm, clinical trial to study the contraceptive efficacy and safety of the MK-8342B (etonogestrel + 17β-estradiol) vaginal ring in healthy women 18 years of age and older, at risk for pregnancy.
Role: Principle Investigator
Source: Merck
4/1/15-4/1/2017

Prospective Bilateral Cornual Placement and Radiopaque Contrast Media Delivery Trial for the FemBloc™ Delivery System (Delivery System Trial)
Role: Principle Investigator
Source: Femasys
7/1/2015-12/31/2015

Clinical Evaluation of the Xpert® TV Assay Protocol 168
Role: Principal Investigator
Source: Cepheid
4/16/2014-12/31/2014

A Phase 1, Multi-Center Study to Assess the Performance of a LNG20 Intrauterine System Inserter
Role: Principle Investigator
Source: Medicines360, non-profit pharmaceutical company
1/1/2014-4/1/2014

Evaluation of the cobas® HSV 1 and 2 Test using Clinician-Collected External Anogenital Lesion Swab Specimens
Role: Principal Investigator
Source: Roche Molecular Systems, Inc.
6/1/2013-5/31/2014

Evaluation of the Performance of the cobas® CT/NG Test for Detection of Chlamydia trachomatis (CT) and Neisseria gonorrhoeae (NG) in Urogenital Swabs and Urine, and in Cervical Samples Collected in PreservCyt® Solution to support 510k Clearance, Protocol No. COB-CTNG-282
Role: Principal Investigator
Source: Roche Molecular Systems, Inc.
08/1/2012 – 7/31/2013

A Phase 1, Multi-Center Study to Assess the Safety and Performance of a Novel LNG20 Intrauterine Inserter
Role: Principal Investigator
Source: Medicines360, non-profit pharmaceutical company
09/01/2011-03/30/2012

A Phase 3, Randomized, Multi-Center, Open-Label Study of a Levonorgestrel-Releasing Intrauterine System (20 mcg/day) and Mirena® for Long-Term, Reversible Contraception up to Five Years.
Role: Principal Investigator
Source: Medicines360, non-profit pharmaceutical company
03/1/2010 – 03/1/2017

Immediate Postpartum insertion of Etonogestrel Subdermal Implant Contraceptive Device: Impact on Bleeding Profile
Role: Principal Investigator
Source: ACOG/Bayer HealthCare Pharmaceuticals Research Award in Long Term Contraception
07/1/2010 – 6/30/2011

Clinical Titles and Responsibilities:

Title: Associate Professor & Attending Physician, Washington University School of Medicine
Responsibilities:

- Benign inpatient and ambulatory gynecology including minor and major surgical procedures
  - Provide supervision for gynecology housestaff
- Cover all clinical aspects of the Family Planning service and oversee fellows and residents in the provision of care
  - Preoperative consultations, postoperative follow-ups
  - Outpatient & inpatient, major & minor surgical procedures
  - Medication abortion
  - Surgical abortion
  - Complex contraceptive patients
  - Routine gynecologic care
- Provide surgical services at Reproductive Health Services of Planned Parenthood of the St. Louis Region

Title: Director Benign Gynecology Resident service at Barnes Jewish Hospital and Washington University in St. Louis School of Medicine
Responsibilities:

- Serve as the champion and academic leader of the "Green team" (benign gynecology service) and the liaison of this service with other departments
  - Attend Gyn QI meetings

- Organize and coordinate Green team response to Emergency Department
  - Develop & ensure compliance with guidelines for appropriate Gyn consults and when Attending must see ED patient
- Ensure consistent high quality care for inpatient benign gynecology
- Support educational goals & objectives for resident education in benign gynecology
  - Work with residency program director & assistant director to develop reading/didactic priorities

Title: Medical Director, Planned Parenthood of the St. Louis Region (PPSLR)
Responsibilities:

- Director and physician provider of medication and surgical abortion services for Reproductive Health Services of PPSLR
- Director of Colposcopy and Cryotherapy services
- Supervise basic gynecology and family planning care provided by Nurse Practitioners at all PPSLR sites
- Director of Laboratory services for all PPSLR sites

Teaching Title and Responsibilities:

Title: Associate Professor & Attending Physician
Responsibilities:

- Didactics for medical students, residents
- Daily teaching in the clinical setting including patient care, ultrasound and surgery for patients on the benign gynecology service at Barnes-Jewish Hospital and Reproductive Health Services of PPSLR
- Participate in Family Planning Fellowship and Ob/Gyn resident journal club

Title: Institute for Public Health Scholar
Responsibilities:

- Participate in lectures and workgroups focused on achieving vision and mission of the Institute for Public Health
- Serve as a mentor to students in the Institute for Public Health

Bibliography:

Peer Reviewed Publications

1) Eisenberg, DL, Leslie, VC, "Threats to reproductive health care: time for obstetrician-gynecologists to get involved," *American Journal of Obstetrics & Gynecology*, in press, accepted on 10/26/16, e-published 11/4/2016
2) Eisenberg, DL, Tyson, N, Espey E, "Committee Opinion No 672: Clinical Challenges of Long-Acting Reversible Contraceptive Methods." *Obstet Gynecol* 128(3): e69-77 2016
3) Turok, DK, Eisenberg, DL, Teal, SB, Keder, LM, Creinin, MD, "A prospective assessment of pelvic infection risk following same-day sexually transmitted infection testing and levonorgestrel intrauterine system placement" *American Journal of Obstetrics & Gynecology*, 2016;215:599.e1-6

4) Eisenberg, DL, Schreiber, CA, Turok, DK, Teal, SB, Westhoff, CL, Creinin, MD, "Three-year efficacy and safety of a new 52-mg levonorgestrel-releasing intrauterine system." *Contraception*. Volume 92, Issue 1, July 2015: 10–16
5) Madden, T, McNicholas, C, Zhao, Q, Secura, GM, Eisenberg, DL, Peipert, JF, Association of Age and Parity with Intrauterine Device Expulsion, *Obstet Gynecol*, 2014 Oct;124(4):718-26
6) Xu H, Eisenberg DL, Madden T, Secura GM, Peipert JF, Medical Contraindications in Women Seeking Combined Hormonal Contraception, *Am J Obstet Gynecol* 210(3): 210 e211-215. 2014
7) Eisenberg DL, McNicholas C, Peipert JF. Cost as a barrier to long-acting reversible contraceptive (LARC) use in adolescents. *J of Adolescent Health,* April 2013, 52 (4) supplement: S59-63
8) Madden, T, Eisenberg DL, Zhao Q, Buckel C, Secura G, Peipert J, Continuation of the etonogestrel implant in women undergoing immediate postabortion placement, *Obstet Gynecol* 2012;120:1053–59
9) Eisenberg DL, Secura GM, Madden TE, Allsworth JE, Zhao Q, Peipert JF. Knowledge of contraceptive effectiveness. *Am J Obstet Gynecol* 2012 Apr 6.
10) Eisenberg DL, Allsworth JE, Zhao Q, Peipert JF. Correlates of dual-method contraceptive use: an analysis of the national survey of family growth (2006-2008). *Infect Dis Obstet Gynecol* 2012;2012:717163.
11) Barber EL, Eisenberg DL, Grobman WA, "Type of attending obstetrician call schedule and changes in labor management and outcome," *Obstetrics & Gynecology*, 118(6):1371-1376, December 2011.
12) Stoddard A, Eisenberg DL, "Controversies in family planning: timing of ovulation after abortion and the conundrum of postabortion intrauterine device insertion," *Contraception*, August 2011, 84 (2) : 119-121
13) Peipert JF, Zhao Q, Allsworth JE, Petrosky E, Madden T, Eisenberg DL, Secura G, "Continuation and satisfaction of reversible contraception," *Obstetrics & Gynecology*, 2011, May, 117 (5): 1105-13
14) Eisenberg DL, Allsworth JE, Vickery Z, Schaecher CP, Ogutha JO. "Discussion: 'Recommendations for intrauterine contraception' by Dehlendorf et al." *Am J Obstet Gynecol.* Oct 2010;203(4):e1-4
15) Eisenberg DL, Stika C, Desai A, Baker D, Yost KJ., "Providing contraception for women taking potentially teratogenic medications: A survey of internal medicine physicians' knowledge, attitudes and barriers," *Journal of General Internal Medicine*, 2010 Apr;25(4):291-297

Invited Publications & Book Chapters:

1) Schmidt, EO, Diedrich JT, Eisenberg, DL, Surgical Procedures for Tubal Sterilization, chapter for online textbook *Global Library of Women's Medicine, www.glowm.com* (ISSN: 1756-2228) 2014; DOI 10.3843/GLOWM.10400
2) Diedrich JT, Schmidt, EO, Eisenberg, DL, Postpartum Sterilization Procedures, chapter for online textbook *Global Library of Women's Medicine, www.glowm.com* in press

3) Schmidt, EO, Diedrich JT, Eisenberg, DL, Laparoscopic Sterilization: Prevention of Failures, chapter for online textbook *Global Library of Women's Medicine, www.glowm.com* in press
4) Eisenberg DL, Peipert JF, Sexually Transmitted Diseases, *Guidelines for Women's Health Care: A Resource Manual, 4th Edition*, ACOG, 2014
5) Eisenberg DL, Shulman LP, Use of a low-dose 24-day formulation of drospirenone 3mg and ethinylestradiol 20µg in contraception, *Gynaecology Forum*, Vol. 14, No. 1, 2009
6) Eisenberg DL, Postpartum Sterilization Procedures, chapter for online textbook *Global Library of Women's Medicine*, November, 2008, www.glowm.com *(ISSN: 1756-2228)* 2008; DOI 10.3843/GLOWM.10145
7) Eisenberg DL, Sciarra JJ, Surgical Procedures for Tubal Sterilization, chapter for online textbook *Global Library of Women's Medicine*, November, 2008, www.glowm.com *(ISSN: 1756-2228)* 2008; DOI 10.3843/GLOWM.10400
8) Eisenberg DL, Shulman LP, Simon MA, Examining the use of misoprostol in obstetrics and gynecology, *The Forum*, Nov. 2007, Vol. 5 (3), 14-17
9) Eisenberg DL, "Beyond MSFC: A Man's Place in Women's Health" MSFC Update National Newsletter, November 2003

Published Abstracts:

1) Harris LH, Cwiak CA, Gilliam ML, Eisenberg DL, Thomas MA, Creinin MD, Amenorrhea and discontinuation rates for bleeding events in women using Liletta® for up to 3 years 19th annual conference National Association of Nurse Practitioners in Women's Health, September, 2016 in New Orleans, Louisiana
2) CA Gaydos, J Coleman, T Davis, J Schwebke, J Marrazzo, D Furgerson, S Taylor, R Lillis, B Smith, L Bachman, R Ackerman, T Spurrell, D Ferris, H Reno, J Lebed, DL Eisenberg, P Kerndt, S Philip, J Jordan; Performance of the Cepheid Xpert® TV Test for the Detection of Trichomonas vaginalis in Women, presented at 2016 American Society of Microbiology
3) Turok, DK, Eisenberg, DL, Westhoff, CL, Keder, LM, Creinin, MD, Evaluation of pelvic infection in women using Liletta, a new 52mg levonorgestrel-releasing intrauterine system, for up to 2 years, oral abstract presented at FIGO 2015, Vancouver, BC
4) Eisenberg, DL, Lange, J, Zhao, Q, Madden, T, Peipert, J, Factors Associated with Unintended Pregnancy Outcome Among CHOICE Participants, accepted as poster abstract at ACOG Annual Clinical Meeting, May 2015, San Francisco, CA
5) Eisenberg, DL, Benzoni, N, Zhoa, Q, Madden T, Secura GM, Immediate postpartum insertion of etonogestrel implant: impact on continuation and satisfaction, accepted as Poster abstract for October 2014 Forum on Family Planning, Miami, FL
6) Xu H, Eisenberg DL, Madden T, Secura GM, Peipert J. Medical Contraindications in Women seeking Combined Hormonal Contraceptives, poster accepted for presentation at 2012 American Academy of Family Physicians Scientific Assembly, October 2012, Philadelphia, PA
7) Madden T, Eisenberg DL, Zhao Q, Buckel, C, Secura GM, Peipert JF Continuation of the Etonogestrel Implant in Women Undergoing Immediate Postabortion Placement,

poster accepted for presentation at 2012 North American Forum on Family Planning, October 2012, Denver, CO

8) Xu H, Eisenberg DL, Madden T, Secura GM, Peipert J. Medical Contraindications in Women seeking Combined Hormonal Contraceptives, poster accepted for presentation at 2012 North American Forum on Family Planning, October 2012, Denver, CO
9) Peipert JF, Madden T, Allsworth JE, Zhao Q, Eisenberg DL, Secura GM. Continuation and satisfaction of reversible contraception: A preliminary analysis from the Contraceptive Choice Project. Contraception 2010; 82(2):193-194
10) Eisenberg DL, Secura GM, Madden T, Allsworth JE, Zhao Q, Peipert JF. Knowledge of contraceptive effectiveness among a cohort of St. Louis women choosing reversible contraception. Contraception 2010; 82(2):193
11) Eisenberg DL, Lally E, Grobman WA, Do Obstetricians on night-float call schedule do things differently? Poster presentation at SMFM Annual Mtg, February 2010, Chicago, IL
12) Guiahi M, Heraty S, Lukens, Trester M, Eisenberg DL, Summers S, Kenton K, Teaching Everything About Contraceptive Health (TEACH), Poster presented at APGO-CREOG Annual Meeting, March 2009, San Diego, CA
13) Guiahi M, Heraty S, Lukens M, Trester M, Eisenberg DL, Summers S, Kenton K, Obstetrics & Gynecology Residents' Self-perception of Family Planning Training: Results of a regional survey, Oral Abstract at APGO-CREOG Annual Meeting, March 2009, San Diego, CA
14) Kiley J, Yee L, Eisenberg DL, Feinglass J, Simon M, Delays in Request for Abortion: Comparison of Patients in the First and Second Trimesters, *Contraception*, Volume 78, Issue 2, p.188, August 2008

Master's Thesis:

1) Providing contraception for women on potentially teratogenic medications: Survey of internal medicine physicians. Accepted by the faculty of the Department of Preventative Medicine, Northwestern University Feinberg School of Medicine, in candidacy for the degree of *Masters of Public Health,* May 2009.