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**MONTANA FIRST JUDICIAL DISTRICT COURT,
COUNTY OF LEWIS AND CLARK**

PLANNED PARENTHOOD OF MONTANA; ALL FAMILIES HEALTHCARE; BLUE MOUNTAIN CLINIC; SAMUEL DICKMAN, M.D.; and HELEN WEEMS, APRN-FNP, on behalf of themselves and their patients Plaintiffs, vs. STATE OF MONTANA; MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES; and CHARLIE BRERETON, in his official capacity as Director of the Department of Public Health and Human Services Defendants.	Cause No.: CDV-23-299 Judge: Seeley **AFFIDAVIT OF SAMUEL DICKMAN, MD, IN SUPPORT OF PLAINTIFFS' APPLICATION FOR A TEMPORARY RESTRAINING ORDER, PRELIMINARY INJUNCTION, AND WRIT OF PROHIBITION**

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**Applications for admission pro hac vice forthcoming

STATE OF MONTANA)
)ss.
County of_______________)

I, Samuel L. Dickman, being first duly sworn upon his oath, state as follows:

Background and Qualifications

1. I am a board-certified internal medicine physician and the Chief Medical Officer of Planned Parenthood of Montana ("PPMT"), a role I have served in since 2022. In my role, I provide clinical care, including primary care and family planning care, as well as medication and procedural abortion. I provide medication abortions up to 11 weeks of pregnancy as counted from the first day of a patient's last menstrual period ("LMP") and procedural abortions up to 21 weeks and 6 days LMP. My role also includes clinical leadership, supervision, and oversight of PPMT providers; medical oversight and compliance duties; administrative duties; research duties; and public relations and advocacy duties.

2. Prior to my role at PPMT, I was the Medical Director for Primary Care at Planned Parenthood South Texas.

3. I received my medical degree from Harvard Medical School in 2016 and completed a residency in internal medicine at the University of California, San Francisco in 2019.

4. I am also a health policy researcher. My research focuses on access to health care, specifically to reproductive health care, access to care for survivors of sexual violence, and medical debt.

5. I am familiar with the rule proposed by the Montana Department of Public Health and Human Services ("DPHHS") that would restrict access to abortion under the Montana Medicaid Program. I understand that the Rule will be adopted as proposed on April 28, 2023 and will take effect on May 1. I understand that the Rule would restrict the generally applicable definition of "medically necessary service" in Montana for abortions and no other services, and would allow Medicaid coverage for an abortion only if a physician certifies that a physical health condition places a patient in danger of death, a patient's physical health condition would be significantly aggravated by the pregnancy, or a patient's psychological condition would be significantly aggravated by the pregnancy.

6. I further understand that the Rule would require Medicaid patients to seek prior authorization for abortions from DPHHS officials, which requires the submission of extensive supplemental documentation and highly personal information of patients, including, among others, an extensive medical history, the results of a physical exam, ultrasound images, and "documentation that the diagnosis of the physical or psychological condition leading to the medical necessity determination has been made by a medical professional qualified by education,

training, and/or experience to make such diagnosis and that the woman is receiving care for such condition." Rule at 2355. The regulation does not prescribe a period of time during which the agency must decide whether to approve or deny the procedure and seemingly leaves this decision to the pure discretion of unknown individuals at DPHHS. I understand that these new requirements will only apply to pregnant patients who choose to have an abortion and that pregnant patients seeking other medical care, such as prenatal care or miscarriage management, will not be required to submit for prior authorization.

7. I also understand that the Rule prohibits advanced practice clinicians ("APCs") from being reimbursed by Montana Medicaid for abortions, and that because the required documentation for prior authorization must include the results of a physical examination and/or ultrasound images, it would prevent the provision of medication abortion by telehealth to Medicaid patients.

8. In my opinion, there is no medical basis for the Rule's restrictive and extremely onerous requirements that target pregnant patients with low incomes who are seeking an abortion. The Rule restricts patients' ability to obtain medically necessary care by narrowly defining when an abortion may be considered medically necessary and fails to account for the wide range of factors and medical conditions that may make an abortion necessary for a particular patient. Additionally, the Rule's requirement that prior authorization be obtained for an abortion will delay critical medical care for those patients whom DPHHS deems to fall within the Rule's definition without any medical justification. Moreover, I am very concerned that the prior authorization process requires extensive sensitive, private medical information about my patients to be turned over to unknown staff at DPHHS for no medical reason. Furthermore, the Rule's prohibitions on both APCs providing abortions and telehealth for medication abortion will

restrict access to care for a population of patients who are by definition poor or low-income and will have difficulty traveling to access care in-person at a facility that employs a physician to provide abortions. Individually and together, these various restrictions will end access to abortion care for the most of Montana Medicaid patients and cause medically unnecessary, dangerous delays for those few patients who are still able to access care.

9. I submit this declaration in support of Plaintiffs' Motion for Temporary Restraining Order, Preliminary Injunction, and Application for a Writ of Prohibition.

10. My curriculum vitae, which sets forth my experience and credentials in greater detail and contains a full list of my publications and lectures, is attached as Exhibit A to this declaration. All of my opinions in this declaration are stated to a reasonable degree of professional and medical certainty.

Abortion Reasons, Methods, and Safety

11. It is medically necessary that all pregnant people receive medical care. If a patient is continuing their pregnancy, they need care during the prenatal period, care during delivery, and postpartum care. If the pregnancy ends in a fetal demise or miscarriage, a patient may need medical care to help complete the miscarriage in a timely and safe fashion. Similarly, if a patient decides to end the pregnancy, they need medical care to complete an abortion. The ability to control one's reproduction—including the ability to terminate a pregnancy rather than continue to term—is essential to a patient's overall health, their ability to contribute to society, and the health of their families. Pregnancy and childbirth have a profound effect on every patient's body, mind, and well-being for the nine months they are pregnant and beyond. Pregnancy is risky. Pregnancy alone can make a healthy patient sick. This truth can be magnified for patients who have chronic medical issues or are in less-than-optimal health at baseline. However, given the

impact that even an uncomplicated pregnancy can have on the healthiest patient, a patient who decides to have an abortion is making a decision that protects their health and well-being.

12. Patients choose abortion for a variety of interrelated personal, medical, familial, and financial reasons. Some patients have prior health conditions that are complicated by pregnancy or have been diagnosed with health conditions that cannot be safely treated during pregnancy. Other patients choose abortion because their pregnancy has been diagnosed with a fetal anomaly. Some patients are struggling with addiction and do not wish to carry a pregnancy under those circumstances. Some patients lack the necessary financial resources, partner or familial support, or stability to become a parent. Others are in abusive relationships or are pregnant as a result of rape or sexual assault and are concerned that carrying to term will tether them to their abuser. Each decision is valid in its own right.

13. There are two main methods of abortion: medication abortion and procedural abortion. Typically, a medication abortion is provided via a two-drug regimen: a patient takes the first medication, mifepristone, then a second one, misoprostol, up to 72 hours later, after which they pass the pregnancy in a process similar to a miscarriage; medication abortion can also be provided via misoprostol alone. Medication abortion is generally available in Montana up to 11 weeks LMP.[1] Procedural abortions early in pregnancy involve removing the contents of the uterus using suction aspiration, a procedure that typically takes less than 10 minutes. For procedural abortions beginning at approximately 15 weeks LMP, clinicians often perform a dilation and evacuation procedure ("D&E"), which involves dilation of the cervix, followed by removal of the pregnancy using a combination of aspiration and instruments, and typically takes

[1] Consistent with the FDA-approved label for mifepristone, Montana Medicaid reimburses up to 10 weeks LMP for medication abortions using mifepristone. Providing medication abortions via mifepristone and misoprostol between 10 and 11 weeks LMP is an off-label use that is in line with scientific research and best practices.

less than 30 minutes. Despite sometimes being referred to as "surgical abortions," these procedures are not surgery as that term is typically understood: they do not involve any incision into the patient's skin and in many cases can be performed with only local anesthesia. Procedural abortion is available at PPMT up to 21 weeks and 6 days LMP.

14. Regardless of the method used, abortion is extremely safe and far safer than carrying a pregnancy to term and giving birth. The National Academies of Sciences, Engineering, and Medicine—a body of esteemed experts that was established by Congress to provide independent, objective expert analysis and advice to the nation to inform public policy and "focus[] on finding reliable, scientific information"—has conducted an analysis of the full range of abortion care in the United States and concluded that abortion continues to be one of safest, most common medical procedures performed in the nation.[2]

15. Both medication and procedural abortion carry a low risk of complications and a very low risk that a complication would need to be treated in a hospital. As the National Academies explain, "[s]erious complications are rare; in the vast majority of studies, they occur in fewer than 1 percent of abortions."[3] Studies estimate that the risk of death associated with childbirth nationwide is approximately 13 times higher than that associated with abortion,[4] and serious complications occur far less frequently with abortion than childbirth.[5]

16. Abortion is time-sensitive health care. Patients whose access to abortion is delayed face ongoing risks associated with continuing a pregnancy and increased risks from the

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[2] Nat'l Acads. of Scis., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States* 37, 77–78 (2018), https://nap.nationalacademies.org/read/24950/ [hereinafter "Nat'l Acads."]; *see also id.* at 162–63.

[3] *Id.* at 77–78.

[4] Nat'l Acads. at 74.

[5] *Id.* at 11.

abortion itself; while abortion is very safe throughout pregnancy, the risk of complications associated with the procedure increases incrementally as pregnancy progresses.

APCs and Abortion Care

17. APCs are licensed health care providers with advanced education and training. APCs include advanced practice registered nurses ("APRNs") and physician assistants ("PAs"). APCs have provided safe and effective abortion care in Montana, including for Montana Medicaid members, for years, and PAs in particular have provided safe and effective abortion care in Montana for decades.

18. APCs perform a variety of reproductive health procedures that are similar in skill to or more complex than aspiration abortion and that carry comparable or greater risk. For example, like an aspiration procedure, inserting and removing an IUD (an intrauterine device that is a long-acting, reversible method of birth control) involves placing an instrument through the cervix, and difficult IUD removals may also require dilation.

19. As another example, managing miscarriage requires nearly identical skill and carries the same risk as early abortion. APRNs are routinely involved in miscarriage management. Like abortion, miscarriage can be managed with medications, and specifically, misoprostol with or without mifepristone, the medications typically used in a medication abortion. APRNs also manage miscarriage with clinical intervention, typically a uterine aspiration—in which the cervix is dilated, and a curette is used to remove the uterine contents through suction—essentially the same procedure as an early abortion.

20. Unsurprisingly, given the above, the safety, efficacy, and acceptability of medication and aspiration abortion are the same as between physicians, physician assistants, nurse practitioners and certified nurse midwives. Indeed, the American Public Health

Association ("APHA") recognizes that "[e]mpirical evidence . . . demonstrates the competency of NPs, CNMs [certified nurse midwives], and PAs in providing all aspects of medication abortion" and "research findings indicate the ability of primary care clinicians—including NPs, CNMs, and PAs—to provide first trimester aspiration abortions with complication rates comparable to those of physician abortion providers."[6]

21. As such, a broad array of leading medical and public health organizations support the provision of early abortion by APRNs, including the American College of Obstetricians and Gynecologists ("ACOG")[7], the Association of Reproductive Health Professionals ("ARHP"),[8] the Society of Family Planning,[9] and the World Health Organization ("WHO").[10] Nursing professional organizations likewise support the provision of medication and aspiration abortion by APRNs, including the American College of Nurse Midwives[11] and the National Association of Nurse Practitioners in Women's Health ("NPWH").[12]

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[6] *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants, Policy No. 20112*, APHA (Nov. 1, 2011), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistant.

[7] ACOG, Practice Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation*, 136 Obstetrics & Gynecology 1, 5 (2020); ACOG, Committee Opinion No. 612, *Abortion Training and Education, 124 Obstetrics & Gynecology 1055 (2014).*

[8] *Improving Patient Care through Collaborative Practice, ARHP* (Aug. 29, 2022), http://www.arhp.org/about-us/position-statements; *see also Reproductive Rights, ARHP* (Aug. 29, 2022), http://www.arhp.org/about-us/position-statements.

[9] Society of Family Planning, *Clinical Guidelines: Medical Management of First Trimester Abortion, 89 Contraception* 157 (2014); Society of Family Planning, *Clinical Guidelines: Surgical Abortion Prior to 7 Weeks of Gestation*, 88 Contraception 7 (2013).

[10] WHO, *Safe Abortion: Technical and Policy Guidelines for Health Systems* 65–67 (2d ed. 2012).

[11] *Position Statement: Access to Sexual and Reproductive Health Care*, Am. Coll. of Nurse Midwives (revised Oct. 2016), http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000087/Access-to-Comprehensive-Sexual-and-Reproductive-Health-Care-Services-FINAL-04-12-17.pdf.

[12] NPWH, *Resolution on Nurse Practitioners as Abortion Providers* (Oct. 1991) (included in Nat'l Abortion Fed'n & Clinicians for Choice, *Role of CNMs, NPs, and PAs in Abortion Care* 3, https://prochoice.org/wp-content/uploads/CNM_NP_PA_org_statements.pdf).

22. At PPMT, APCs provide about 85% of our abortion care, and in my role supervising clinical care and abortions at PPMT, I have seen no difference in the quality of care provided by our APCs and our physicians.

23. There is no health justification for preventing APCs from providing medication and aspiration abortions to patients who have Medicaid insurance, and indeed prohibiting APCs from providing abortion instead reduces access to critical care and harms patient health. It is particularly unjust that only our patients who are low-income and are Medicaid-eligible are restricted to receiving abortion care from physicians when there are many other qualified providers who can provide them timely and equally safe care.

24. APCs tend to staff health centers in rural or underserved areas, and so their ability to provide abortion care is critical for ensuring access to care for these communities. This is true for PPMT as well. Our health centers in Billings and Great Falls are staffed exclusively by APCs.

25. Moreover, APCs fill an important gap, as there are not enough physicians who provide abortion in Montana to meet patient demand. I provide abortions twice per month for one day at a time, adding a second day to accommodate any procedures that require overnight dilation. We have one other contract physician who provides abortions at PPMT once per month, but our APCs are able to offer medication abortion appointments nearly every day, and procedural abortions an additional day each month on top of physician procedural abortion days. In addition to the fact that physician appointments are already few and far between, if physicians had to provide all abortions to Medicaid patients in the state, there would be a waiting list for appointments given the number of patients that would need to be served. The Rule's prohibition

on APCs providing care to Medicaid patients will drastically reduce access to care for this already vulnerable community.

Abortion via Telehealth

26. Telehealth is the delivery of health care services at a distance through information and communication technology. It has been used to expand the reach of health care providers in many different areas of medicine and has been found to be safe and effective. Telehealth has become much more common in medicine in general since early 2020 because of the Covid-19 pandemic, but it was recognized to be safe and effective well before the pandemic as well.

27. Telehealth is safe and effective for the provision of medication abortion and has been used around the world beginning approximately 18 years ago.[13] Telehealth for medication abortion has been available in Montana since 2016.

28. There are different possible models by which telehealth can be provided. In a direct-to-patient model, a patient with internet access can connect with a health care provider from their own home or a location of their choosing, and following the telehealth appointment the medication abortion pills are mailed to her. Alternatively, a patient may utilize in-office telehealth services, in which a patient located in one health center can talk by video to a health care provider in a different location; this is often referred to as a site-to-site model. Both models have been studied by researchers and found to be safe and effective.

[13] *See, e.g.*, Elizabeth G. Raymond et al., *Commentary: No-Test Medication Abortion: A Sample Protocol for Increasing Access During a Pandemic and Beyond*, 101 J. Contraception 361, 361 (2020); Erica Chong et al., *Expansion of a Direct-to-Patient Telemedicine Abortion Service in the United States and Experience During the COVID-19 Pandemic*, 104 Contraception 43, 46 (2021); Daniel Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 Obstetrics & Gynecology 296, 300 (2011).

29. At PPMT, we offer both models and patients can choose which works best for them. Patients who live closer to a health center tend to choose the site-to-site model. Patients who choose the direct-to-patient model tend to be those patients who live far away, in rural areas, or who have barriers to getting to a health center, including because of disabilities, lack of access to a car, or an unsupportive partner or family member to whom the abortion would have to be disclosed in order for the patient to visit a clinic. Whichever model they choose, I can see my patients during their telehealth appointments, and my and my staff's interactions with patients during a telehealth appointment are essentially the same as an in-person visit.

30. In 2020, ACOG, the premier professional membership organization for U.S. obstetrician-gynecologists, updated its practice bulletin focused on medication abortion to recognize that medication abortion provided using telehealth is as safe and effective as in-person services, well-liked by patients, and also may help reduce delays to care.[14] The National Academies of Sciences, Engineering, and Medicine has also examined the research regarding telehealth for medication abortion and concluded that the rates of adverse events for telehealth and in-person abortion are similarly low.[15]

31. Telehealth furthers public health because it improves access to medication abortion for underserved communities and in underserved areas, including people living on low incomes and those living in rural and other underserved areas who are not readily able to travel.[16]

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[14] ACOG, Practice Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation,* 136 Obstetrics & Gynecology 1, 5 (2020).

[15] Nat'l Acads. at 57-58.

[16] ACOG, Practice Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation,* 136 Obstetrics & Gynecology 1, 5 (2020)

32. The number of abortion providers has declined over time in the United States, resulting in greater distances and higher costs for some patients to obtain treatment: in 2017, 93% of Montana counties had no clinics that provided abortions, and 56% of Montana women lived in those counties.[17]

33. Patients in rural areas are disproportionately impacted by a ban on telehealth. ACOG has expressed ongoing concern over the lack of medical services available to women in rural communities, and has asked ob-gyns to "[f]oster and participate in efforts to utilize effective telehealth technologies...to expand and improve services for rural women."[18] According to the 2010 census, 44.1% of Montana's population is rural.[19]

34. I have personally seen these impacts play out. PPMT's use of telehealth allows us to see patients sooner than we otherwise could, reduce patients' need to travel, and open up access for rural, impoverished communities in the state. This is especially relevant for Native American communities in the state.

35. The Rule's elimination of telehealth as an option for patients on Montana Medicaid will greatly decrease access for a population of people who by definition are living on low incomes and will have greater difficulty traveling to access care than the general population.

Prior Authorizations

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[17] Guttmacher Inst., *State Facts About Abortion: Montana* (June 2022), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-ohio (citing Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2017,* Guttmacher Inst. 1, 17 table 4 (Sept. 2019), https://www.guttmacher.org/report/abortion-incidence-service -availability-us-2017).

[18] ACOG, Committee Opinion No. 586, *Health Disparities in Rural Women,* 123 Obstetrics & Gynecology 384 (2014, *reaff'd* 2016), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2014/02/health-disparities-in-rural-women.pdf.

[19] U.S. Census Bur., *Montana: 2010 – Population and Housing Unit Counts* at 2 tbl. 2 (2012), https://www2.census.gov/library/publications/decennial/2010/cph-2/cph-2-28.pdf.

36. The Rule's requirement that providers obtain prior authorization from DPHHS before providing an abortion will prevent Medicaid patients from obtaining an abortion on their initial visit to a health center and so will act as a de facto waiting period requirement for Medicaid patients seeking abortion. Because the Rule provides no limitation on the amount of time that DPHHS may take to decide whether Medicaid will approve or deny coverage for an abortion, a patient could be forced to wait for extended periods, increasing risks to their health, if DPHHS even approves the abortion at all. I understand that DPHHS has stated that it requires its contractor to complete the prior authorization process in three business days, which could mean five or more calendar days if it includes a weekend or a long weekend. Because of the time-sensitive nature of abortion, this would be a significant delay for patients.

37. In addition, in my experience as a physician, prior authorizations may be denied not for medical reasons but because of clerical errors or because the reviewer wants more information or supporting documentation—which may require providers to get additional information from a patient's other medical providers or have the patient return to the clinic for additional tests. This sort of back and forth would only increase the delay created by the prior authorization process. And if the prior authorization is ultimately denied, an administrative appeal would only exacerbate the delay.

38. The prior authorization process interferes with the clinician-patient relationship and second-guesses the medical determinations of the providers actually treating abortion patients. Requiring that an unknown employee of DPHHS review my medical determination that an abortion is necessary for my patients inserts arbitrariness into the process and is bad for my patients' health.

39. Moreover, the Rule requires that extensive private medical information about my patients be turned over to DPHHS staff, including their medical history and even ultrasound images. I am very disturbed by this invasion of my patients' privacy, especially because there is no medical need for DPHHS to have access to this sensitive information regarding my patients' reproductive health and decision-making.

40. The interaction between the prior authorization requirement and the Rule's prohibition on APCs providing abortion will create extensive waits at PPMT. Physician availability at PPMT is limited—I provide abortions twice per month for two days at a time, and a contract physician provides abortions one day per month. Variations in scheduling mean that the time between physician appointments varies between 1–3 weeks. Even if DPHHS is able to turn prior authorization requests around in three business days, a second appointment with a physician will not be available for anywhere from 1–3 weeks, and if we do not get authorization from DPHHS for an abortion by the next available physician appointment, a patient would have to wait yet another 1–3 weeks. These are unacceptable delays that would increase risks to patients.

41. Further, the physical exam requirement is medically unnecessary for the vast majority of patients. For the few cases for which it would be necessary, the exam could be done on the day of the procedure.

<u>Physiological Effects of Pregnancy</u>

42. Even for the healthiest patients, pregnancy is a time of profound physiological changes. These changes can have a lasting effect on a patient's health and well-being, including their ability to have, and to parent, children in the future.

43. Pregnancy poses challenges to a patient's entire physiology. Almost all pregnant patients experience conditions such as fatigue, headaches, backaches, difficulty sleeping, and difficulty with mobility. Their bladders must be emptied frequently. The hormonal changes in pregnancy induce changes in their bowels, causing bloating, heartburn, chronic constipation, and hemorrhoids, and varicose veins may develop on their legs, vulvas, and vaginas. Even these "minor" conditions can cause discomfort, pain, and stress for the patient, and can make work, child care, and other daily tasks extremely difficult. Some patients are unable to perform their usual tasks during pregnancy. If pregnancy renders a patient unable to work, or work as often as they did prior to becoming pregnant, they may not be able to support their family financially.

44. Pregnancy stresses most major organs. For example, during pregnancy the heart rate increases in order to pump 30-50 percent more blood. By the second trimester, the heart is already doing 50 percent more work than usual, and that heightened rate continues throughout the rest of the pregnancy. This increased blood flow results in enlarged kidneys and increased production of clotting factors by the liver to prevent the patient from bleeding to death. The increase in clotting factors poses health risks to pregnant patients in that it increases the risks of blood clots or thrombosis.

45. Pregnancy also weakens the immune system and as a result makes pregnant patients more vulnerable to infections, such as urinary tract infections. These infections can be more severe among pregnant patients than among non-pregnant patients and lead to life-threatening complications such as sepsis much more frequently among pregnant patients.

46. During pregnancy, a patient's lungs must also work harder to clear both the carbon dioxide produced by their own body and the carbon dioxide produced by the fetus. Yet their very ability to breathe in the first place is hampered by the fetus growing in the patient's

abdomen, leaving many pregnant patients feeling chronically short of breath. Every organ in the abdomen—e.g., intestines, liver, spleen—is increasingly compressed throughout pregnancy by the expanding uterus.

47. Sometimes the nausea and vomiting commonly associated with "morning sickness" develops into a syndrome known as hyperemesis gravidarum ("HG"). HG is accompanied by vomiting so severe that it may result in dangerous weight loss, dehydration, acidosis from starvation, or hypokalemia, a potentially dangerous condition caused by a lack of potassium that can trigger psychosis, delirium, hallucinations, and abnormal heart rhythms, among other things. Patients with this condition may require multiple hospital admissions throughout pregnancy.

48. Moreover, there is a 15 to 20 percent risk of miscarriage associated with every pregnancy. Complications from miscarriage can lead to infection, hemorrhage, surgery, and even death.

49. Even a normal pregnancy can suddenly become life-threatening during labor and delivery, when 20 percent of the patient's blood flow is diverted to the uterus. This increased blood flow places a patient at risk of hemorrhage and, in turn, death; indeed, hemorrhage is the leading cause of maternal mortality worldwide. To try to protect against hemorrhage, the body again produces more clotting factors, which increases the risk of blood clots or thromboembolism. This heightened risk extends past delivery into the postpartum period and is another dominant cause of maternal mortality.

50. Pregnant patients can develop preeclampsia, a disease unique to pregnancy characterized by high blood pressure and a high level of protein in the urine, which can develop suddenly and with little warning and can cause significant damage to a patient's vision, kidneys,

and liver and cause a stroke. Preeclampsia can progress to eclampsia, where a patient has seizures or goes into a coma. Preeclampsia/eclampsia and their complications are associated with an increase in maternal mortality in the United States and are one of the leading causes of maternal mortality worldwide; they are responsible for approximately twenty percent of perinatal (fetal and newborn) deaths.

51. Furthermore, one-third of pregnancies result in a cesarean delivery. Unlike procedural abortions, which are not surgeries and do not require an incision, a cesarean delivery involves a significant abdominal surgery that carries risks of hemorrhage, infection, and injury to internal organs. Vaginal delivery can also cause physical injury, such as injury to the pelvic floor. This can have long-term consequences, including fecal or urinary incontinence (inability to control the bowels or the bladder).

52. Pregnancy can be especially dangerous for patients with baseline medical conditions or multiple coexisting conditions or diseases (known as comorbidities). Because pregnancy may exacerbate these conditions, it is important that a patient has the option to terminate a pregnancy before their health worsens, as disease progression is often irreversible. These pre-existing conditions include cardiovascular disease, systemic lupus erythematosus, cancer, diabetes, obesity, hypertension, kidney disease, liver disease, epilepsy, sickle cell disease, and numerous other conditions.

53. Diabetes, to take just one example, is more prevalent among people of lower socioeconomic status and poses particular challenges for poor and low-income people who lack easy or regular access to health care. Pregnancy compounds the challenges of managing diabetes. The risks associated with diabetes during pregnancy include, at one end of the spectrum, the patient becoming *hypoglycemic* (caused by low blood sugar), which can lead to hypoglycemic

shock, and, at the other end, the patient becoming *hyperglycemic* (caused by excessive blood sugar). If left untreated, a hyperglycemic patient may develop diabetic ketoacidosis, a life-threatening complication of diabetes that can lead to coma, brain swelling (*cerebral edema*), and death. For people with diabetes experiencing multiple comorbidities—for example a patient with comorbid systemic lupus erythematosus or asthma—managing their diabetes is already difficult, and it becomes even more so during pregnancy.

54. In fact, healthy patients can actually *acquire* diabetes during pregnancy, called gestational diabetes, because pregnancy is accompanied by insulin resistance. Gestational diabetes mellitus develops during pregnancy in people whose pancreatic function is insufficient to overcome the insulin resistance associated with the pregnant state. Patients with gestational diabetes are at increased risk of preeclampsia and eclampsia, stillbirth, and excessively large fetuses (macrosomia) which can result in delivery complications and need for cesarean delivery. Risks associated with gestational diabetes extend beyond the pregnancy and neonatal period.

55. In addition to these physical health conditions, pregnancy and the postpartum period are times of increased vulnerability to mental health issues. Pregnant patients may experience a relapse of a mental health condition or may experience a mental health condition for the first time. There is a spectrum of illness during the perinatal period. On one end of the spectrum, a pregnant person may experience worsening anxiety and mood disorders during pregnancy, but will not have suicidal ideation or psychosis. On the other end, a pregnant person could experience active suicidal ideation with plan and/or intent to self-harm, or they could also experience psychotic symptoms.

56. Moreover, patients who learn that their fetus has been diagnosed with a severe or lethal anomaly, such as anencephaly (a severe neural tube defect associated with lack of brain

development), may experience significant stress, anguish, and anxiety from carrying the pregnancy to term. For some patients, continuing a pregnancy only to give birth to a fetus that will suffer and die is too much to bear. Pregnant people and couples who learn that their pregnancy is abnormal may decide that termination of the pregnancy is the most humane option in a terrible situation.

Impacts of the Rule

57. The Rule's restriction of the definition of medically necessary means that patients who have a health condition that does not rise to the level of severity required by the Rule will be ineligible for Medicaid coverage for an abortion, even if I, in my professional judgment, believe that an abortion is medically necessary, and even if a patient's pregnancy has been diagnosed with a fetal anomaly. A patient could also be denied coverage because of their inability to comply with the paperwork requirements of the Rule, or because a bureaucrat second-guesses their health care provider's medical judgment.

58. If Medicaid will not cover some medically necessary abortions, the cost of care would then become the overriding consideration for patients. Without Medicaid funding, it will be extremely difficult, if not impossible, for many Medicaid-eligible patients to gather the funds needed for the expense of obtaining an abortion. Many patients who are Medicaid-eligible are unlikely to have friends or relatives in a position to lend them the money necessary to secure an abortion because they come from communities where nearly everyone is poor or low-income. To pay even for part of an abortion, patients will have to forgo paying for other life essentials, such as rent or food, causing suffering for their families.

59. I have previously conducted research on the impact of a lack of insurance coverage for abortion, particularly on low-income people, in Texas, where Medicaid does not

cover abortions except in cases of rape, incest, or life-endangerment. My colleagues and I found that more than half of uninsured (57%) and publicly insured (55%) patients reported financial hardship related to the cost of their abortion.[20] Three-fifths (61%) of low-income respondents experienced financial hardship, compared with 38% of respondents with incomes above 200% of the federal poverty level. Overall, 19% of respondents sold something of value to pay for abortion care, and this was most common among low-income (24%) and uninsured (27%) respondents.[21] One in 5 (20%) uninsured respondents and 17% of low-income respondents reported that they delayed buying food to pay for their abortion.[22] The most common financial hardships related to out-of-pocket abortion costs were delayed bills (28%) and delayed nonmedical expenses (18%).[23]

60. Research further shows that being denied an abortion has serious consequences on patients' overall well-being. People denied an abortion who are forced to carry a pregnancy to term have four times greater odds of living below the federal poverty level. In addition, people denied abortion are: (1) more likely to stay tethered to abusive partners; (2) more likely to suffer anxiety and loss of self-esteem in the short term after being denied abortion; and (3) less likely to have aspirational life plans for the coming year.[24]

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[20] Samuel L. Dickman et al., *Financial Hardships Caused by Out-of-Pocket Abortion Costs in Texas, 2018*, 112 Am. J. Pub. Health 758, 759 (2022).

[21] *Id.*

[22] *Id.*

[23] *Id.*

[24] Diana Greene Foster, et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions*, 108 Am. J. Pub. Health 407 (2018).

61. The research also shows that being denied an abortion has serious implications for the existing children in the pregnant person's family. Denying an abortion may have negative developmental and socioeconomic consequences for their existing children.[25]

62. At a minimum, even patients whose health conditions make them eligible for Medicaid coverage will be delayed in obtaining care because of the combined effects of the prohibitions on APCs providing abortion and on telehealth for abortion, and because the Rule requires prior authorizations before an abortion can be performed. Even if DPHHS is able to turn prior authorization requests around within three business days, all Medicaid patients will likely have to have two appointments, with at least one of those appointments being in person. PPMT physician appointments are severely restricted and are scheduled anywhere from 1–3 weeks apart. If we do not get authorization from DPHHS for an abortion by the next available physician appointment, a patient would have to wait yet another 1–3 weeks for another in-person physician appointment.

63. In addition to these delays, some patients may be delayed because when they initially seek an abortion, DPHHS determines that their condition does not rise to the level of the definition in the Rule, meaning they may be forced to wait until their condition deteriorates to a point where DPHHS will approve an abortion. When a patient needs an abortion to protect their physical or mental health, I would not delay until their condition "would be significantly aggravated by the pregnancy." If the patient decided to terminate the pregnancy, I would perform the termination at the earliest opportunity. Because medical conditions may worsen during pregnancy, it is important that patients have the option to terminate a pregnancy before

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[25] Diana Greene Foster, et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J. Pediatrics 183 (2018).

progressing to a more severe health state, as disease progression may become irreversible as it worsens.

64. When an abortion is needed, delays in performing it would expose the patient to unnecessary health risks in two respects: First, the patient would face longer exposure to the underlying health risks presented by the pregnancy itself and any comorbidities the patient may have, which may increase in magnitude over time. Second, the patient would face an increased risk of abortion-related complications.

65. Moreover, delays in obtaining an abortion can push patients past the point in pregnancy when they would be eligible for a medication abortion. Most people who choose medication abortion have a strong preference for this method because they can complete the process in the privacy of their home at a time of their choosing, and it allows them to avoid a procedure and having instruments placed in their vagina. Other patients will be pushed to a point in pregnancy where they would need a two-day D&E procedure involving overnight dilation. Delays can push a patient past the gestational age limit for obtaining an abortion in Montana altogether, which would force them to have to travel to distant providers in Colorado, Washington, or Oregon, an option that will be impossible for the low-income population that relies upon Montana Medicaid.

66. In my opinion, there is absolutely no medical justification for the arbitrary restrictions imposed on Medicaid coverage by the Rule. In short, a policy that forces even healthy patients to carry a pregnancy to term, or to delay an abortion forcing a patient to remain pregnant longer, puts patients' physical and mental health and life at risk above and beyond the relatively minimal risk that having an abortion presents and is antagonistic to the promotion of health and well-being.

67. Because it will force some patients to carry a pregnancy that will be detrimental to their physical and/or mental health and delay others in obtaining the care they need, exposing them to unnecessary, increased health risks, the Rule should be enjoined.

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

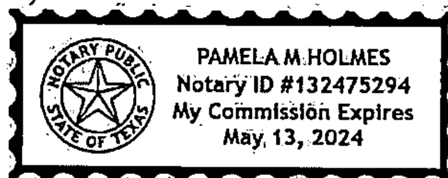
Dated: 04/27/2023

S Dickman, MD

Samuel L. Dickman

State of Texas
County of Fort Bend
Subscribed and sworn to before me this 27th day of April, 2023.

(NOTARIAL SEAL)



Pamela M. Holmes

Printed Name: Pamela M. Holmes

Disclosure - This notarial act was completed as an online notarization via two-way webcam and audiovisual technology.
The signer(s), Samuel Dickman produced a USA Passport as identification and were approved with multi-factor KBA authentication.

Exhibit A

Samuel L. Dickman, MD

1116 Grand Ave. Suite 201
Billings, MT 59102
sam.dickman@ppmontana.org

Employment

Chief Medical Officer, Planned Parenthood of Montana, 2022 - present

Research Associate, Texas Policy Evaluation Project, University of Texas at Austin, 2020 - present

Physician Accreditor, Planned Parenthood Federation of America, 2021 - present

Medical Director for Primary Care, Planned Parenthood South Texas, 2020 - 2022

Staff Physician, Planned Parenthood South Texas, 2019 - 2020

Postdoctoral training

Internship and residency in internal medicine, University of California, San Francisco, 2016-2019
Primary care track at San Francisco General Hospital

Education

MD, Harvard Medical School, 2016
Cum Laude

BA, Mathematics, Brown University, 2010
Magna Cum Laude

Mathematics, University of Utah, 2006-2007
Honors at Entrance

Board certification

Internal Medicine, American Board of Internal Medicine, 2019 - present

Advising and consulting (*pro bono*)

Neighborhood Defender Service, New York, NY. Consultant for immigration and asylum cases, 2021 - 2022.

Proyecto Dilley Pro Bono Project, Dilley, TX. Consultant for immigration and asylum cases, 2020 - 2022.

Refugee and Immigrant Center for Education and Legal Services, San Antonio, TX. Consultant for immigration and asylum cases, 2019 - 2022.

Centro Legal de la Raza, Oakland, CA. Expert witness for immigration and asylum cases, 2020 - present.

Northwest Immigrant Rights Project, Seattle, WA. Consultant for immigration and asylum cases, 2020 - 2021.

New Jersey Office of the Public Defender, Trenton, NJ. Consultant for appellate defense and compassionate release, 2020 - 2021.

Journal articles

1. White K, Sierra G, Lerma K, Beasley A, Hofler L, Tocce K, Goyal V, Ogburn T, Potter JE, **Dickman SL.** Association of Texas' 2021 Ban on Abortion in Early Pregnancy With the Number of Facility-Based Abortions in Texas and Surrounding States. JAMA. 2022 Nov 1.

2. Gaffney A, Himmelstein DU, **Dickman S,** McCormick D, Woolhandler S. Uptake and Equity in Influenza Vaccination Among Veterans with VA Coverage, Veterans Without VA Coverage, and Non-Veterans in the USA, 2019-2020. J Gen Intern Med. 2022 Sep 26:1–8.

3. Himmelstein DU, **Dickman SL,** McCormick D, Bor DH, Gaffney A, Woolhandler S. Prevalence and Risk Factors for Medical Debt and Subsequent Changes in Social Determinants of Health in the US. JAMA Netw Open. 2022 Sep 1;5(9):e2231898.

4. **Dickman SL,** Himmelstein G, Himmelstein DU, Strandberg K, McGregor A, McCormick D, Woolhandler S. Uncovered Medical Bills after Sexual Assault. N Engl J Med. 2022 Sep 15;387(11):1043-1044.

5. **Dickman SL,** Gaffney A, McGregor A, Himmelstein DU, McCormick D, Bor DH, Woolhandler S. Trends in Health Care Use Among Black and White Persons in the US, 1963-2019. JAMA Netw Open. 2022 Jun 1;5(6):e2217383.

6. Gaffney A, Himmelstein DU, **Dickman S,** McCormick D, Cai C, Woolhandler S. Trends and Disparities in the Distribution of Outpatient Physicians' Annual Face Time with Patients, 1979-2018. J Gen Intern Med. 2022 Jun 6.

7. Himmelstein J, Cai C, Himmelstein DU, Woolhandler S, Bor DH, **Dickman SL,** McCormick D. Specialty Care Utilization Among Adults with Limited English Proficiency. J Gen Intern Med. 2022 Mar 29.

8. **Dickman SL,** White K, Sierra G, Grossman D. Financial Hardships Caused by Out-of-Pocket Abortion Costs in Texas, 2018. Am J Public Health. 2022;112(5):758-761.

9. Cai C, Woolhandler S, McCormick D, Himmelstein DU, Himmelstein J, Schrier E, **Dickman SL.** Racial and Ethnic Inequities in Diabetes Pharmacotherapy: Black and Hispanic Patients Are Less Likely to Receive SGLT2is and GLP1as. *J Gen Intern Med.* 2022;10.

10. Himmelstein J, Himmelstein DU, Woolhandler S, **Dickman S,** Cai C, McCormick D. COVID-19-related care for Hispanic elderly adults with limited English proficiency. *Ann Intern Med.* 2021;10.7326/M21-2900.

11. Gaffney A, **Dickman S,** Cai C, McCormick D, Himmelstein DU, Woolhandler S. Uninsurance and underinsurance among US children: Findings from the National Survey of Children's Health, 2016-19. *JAMA Pediatrics* 23:e212822, 2021.

12. Cai C, Gaffney A, McGregor A, Woolhandler S, Himmelstein DU, McCormick D, **Dickman S.** Racial and Ethnic Disparities in Outpatient Visit Rates Across 29 Specialties. *JAMA Internal Medicine.* 2021;e213771.

13. **Dickman S,** White K, Grossman D. Affordability and Access to Abortion Care in the United States. *JAMA Internal Medicine.* 181(9):1157-1158, 2021.

14. Himmelstein J, Himmelstein DU, Woolhandler S, Bor DH, Gaffney A, Zallman L, **Dickman S,** McCormick D. Health Care Spending And Use Among Hispanic Adults With And Without Limited English Proficiency, 1999–2018. *Health Aff (Millwood)* 2021 Jul;40(7):1126-1134.

15. Woolhandler S, Himmelstein DU, Ahmed S, Bailey Z, Bassett MT, Bird M, Bor J, Bor D, Carrasquillo O, Chowkwanyun M, **Dickman S**, Fisher S, Gaffney A, Galea S, Gottfried RN, Grumbach K, Guyatt G, Hansen H, Landrigan PJ, Lighty M, McKee M, McCormick D, McGregor A, Mirza R, Morris JE, Mukherjee JS, Nestle M, Prine L, Saadi A, Schiff D, Shapiro M, Tesema L, Venkataramani A. (2021). Public policy and health in the Trump era. *Lancet,* 397(10275), 705–753.

16. **Dickman S,** Mirza R, Kandi M, et al. Mortality at For-Profit Versus Not-For-Profit Hemodialysis Centers: A Systematic Review and Meta-analysis. *Int J Health Serv.* 2021;51(3):371-378.

17. **Dickman S,** Himmelstein DU, Woolhandler S. Inequality and the health-care system in the USA. *Lancet,* 389(10077):1431-41, 2017.

18. **Dickman S,** Woolhandler S, Bor J, McCormick D, Bor D, Himmelstein D. Health spending for low, middle, and high-income Americans, 1963-2012. *Health Affairs, 35*(7):1189-96, 2016.

19. **Dickman S,** Himmelstein D, McCormick D, Woolhandler S. Health and financial harms of 24 states' decision to opt out of Medicaid expansion. *International Journal of Health Services,*43(1):135-42, 2015.

20. Matusow H, **Dickman S**, Rich J, Fong C, Dumont D, Hardin C, Marlowe D, Rosenblum A. Medication assisted treatment in US drug courts: results from a nationwide survey of availability, barriers, and attitudes. *Journal of Substance Abuse Treatment* 44(5):473-80, 2013.

21. Nunn A, **Dickman S,** Nattrass N, Cornwall A, Gruskin S. The impacts of AIDS movements on the policy responses to HIV/AIDS in Brazil and South Africa: a comparative analysis. *Global Public Health,* 7(10):1031-44, 2012.

22. Nunn A, Eng W, Cornwall A, Beckwith C, **Dickman S**, Flanigan T, Kwakwa H. African American patient experiences with a rapid HIV testing program in an urban public clinic. *Journal of the National MedicalAssociation,* 104(1-2):5-13, 2012.

23. Nunn A, **Dickman S**, Mayer K, Flanigan T, Kwakwa H. Causes and patterns of concurrent sexual partnerships among heterosexual African American women in urban Philadelphia: a qualitative study. *Sexual Health,* 9(3):288-96, 2012.

24. Trigg B, **Dickman S.** Medication-assisted therapy for opioid-dependent incarcerated populations in New Mexico: statewide efforts to increase access. *Substance Abuse,* 33(1):76-84, 2012.

25. Harris A, Selling D, Luther C, Hershberger J, Brittain J, **Dickman S**, Glick A, Lee J. Rate of community methadone treatment reporting at jail reentry following a methadone increased dose quality improvement effort. *Substance Abuse*, 33(1):70-5, 2012.

26. McKenzie M, Zaller N, **Dickman S**, Green TC, Parikh A, Friedmann PD, Rich JD. A randomized trial of methadone initiation prior to release from incarceration. *Substance Abuse*, 33(1):19-29, 2012.

27. Dumont D, Brockmann B, **Dickman S**, Alexander N, Rich J. Public health consequences of mass incarceration. *Annual Review of Public Health* 33:325-39, 2012.

28. Rich JD, Wakeman SE, **Dickman S**. Medicine and the epidemic of incarceration in the United States. *New England Journal of Medicine* 364:2081-2083, 2011.

29. **Dickman S**, Rich JD. The health of prisoners *(letter)*. *Lancet*, 377:9782, 2011-2012.

30. Rich J, McKenzie M, **Dickman S**, Bratberg J, Lee J, Schwartz R. An adverse reaction to buprenorphine/naloxone induction in prison: a case report. *Addictive Disorders & Their Treatment*, 10(4):199-200, 2011.

31. Nunn A, **Dickman S**, Cornwall A, Rosengard C, Kwakwa H, Kim D, James G, Mayer K. Social, structural, and behavioral drivers of concurrent partnerships among African American men in Philadelphia. *AIDS Care*, 23(11):1392-9, 2011.

32. Nunn A, Zaller N, Cornwall A, Mayer K, Moore E, **Dickman S**, Beckwith C, Kwakwa H. Low perceived risk and high HIV prevalence among a predominantly African American population participating in Philadelphia's rapid HIV testing program. *AIDS Patient Care and STDs*, 229-235, 2011.

33. Nunn A, Zaller N, **Dickman S**, Nijhawan A, Rich J. Improving access to opiate addiction treatment for prisoners. *Addiction*, 105(7), 2010.

34. Nunn A, Zaller N, **Dickman S**, Trimbur C, Nijhawan A, Rich JD. Methadone and buprenorphine prescribing and referral practices in US prison systems: results from a nationwide survey. *Drug and Alcohol Dependence*, 105(1-2), 2009.

35. Ko J, **Dickman S**, and Li V. A mathematical model to predict performance of advanced therapies in wound healing. *Proceedings of Modeling in Medicine and Biology VIII*, 234-246, Wessex Institute of Technology, United Kingdom, May 2009.

36. Wilkey J, Hansen C, **Dickman S**, Sundberg S, Crews N, Thompson J, Harvey IR. Teaching engineering teamwork and communication: How creating community systems improves an engineer's education. *Proceedings of the Conference of the American Society for Engineering Education* Provo, UT, April 2007.

Invited talks

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1. Abortion access in Texas after Dobbs. University of Texas Health Sciences Center at San Antonio Women's Health Elective. October 4, 2022.

2. Abortion access after Roe. The Lancet Health Justice Seminar Series. June 17, 2022.

3. Abortion access in the Roe and post-Roe eras. Cambridge Health Alliance Social Medicine Grand Rounds. June 13, 2022.

4. Understanding the state of abortion law in the United States. University College London Bioethics & Medical Law Society. November 23, 2021.

5. Office-based dilation and evacuation for miscarriage and abortion care. Brooke Army Medical Center Department of Obstetrics & Gynecology Grand Rounds. San Antonio, Texas, November 18, 2021.

6. Texas abortion ban: What it means and what happens next. Sexual and Reproductive Health Matters. October 20, 2021.

7. Understanding & Upending SB8: Arguments in the Court. NYU Law School. September 27, 2021.

Abstracts

1. **Dickman S,** Himmelstein D, Woolhandler S. Diverging medical prices and increasing inequality in US health care spending. *Society of General Internal MedicineNational Meeting,* 2018. (Oral presentation.)

2. **Dickman S,** Goldman A, Himmelstein H, Bor D, Woolhandler S. Medicare Case Mix Trends: For-profit and non-teaching hospitals appear to be winning the coding race. *Society of General Internal Medicine NationalMeeting,* 2017. (Poster.)

3. **Dickman S,** Woolhandler S, Bor J, McCormick D, Bor D, Himmelstein D. Health spending by low, middle, and high-income Americans. *Society of General InternalMedicine National Meeting,* 2015. (Oral presentation.)

4. **Dickman S,** Himmelstein D, McCormick D, Woolhandler S. Health and financial harms of 25 states' decision to opt out of Medicaid expansion. *Society of GeneralInternal Medicine National Meeting,* 2014. (Poster; oral presentation at SGIM New England Regional Meeting.)

5. **Dickman S,** Podolsky S. Pain Contracts and the Evolution of Opioid Treatment for Chronic Pain. *Harvard Medical School Soma Weiss Research Symposium,* 2013. (Poster.)

6. **Dickman S**, Kwakwa H, Mayer K, Eng W, Flanigan T, Nunn A. Social, Structural and Behavioral Factors Driving Concurrent Sexual Partnerships among Heterosexual African Americans in Urban Philadelphia: A Qualitative Study. *XVIII International AIDS Conference*, 2010, Vienna. (Poster.)

7. **Dickman S**, Pinkston M, Kwakwa H, Cornwall A, Rich J, Nunn A. Gender Differences in the Impact of Crack Cocaine Use on Concurrent Sexual Partnerships among African Americans in Philadelphia. *XVIII International AIDS Conference*, 2010, Vienna. (Poster.)

8. Green T, Zaller N, Parikh A, Friedmann P, McKenzie M, **Dickman S**, Rich J. Initiation of Buprenorphine During Incarceration and Linkage to Treatment Upon Release. *XVIII International AIDS Conference*, 2010, Vienna. (Poster.)

9. Zaller N, McKenzie M, Green T, Parikh A, Friedmann P, **Dickman S**, Rich J. Initiation of methadone during incarceration and linkage to treatment upon release: results of a randomized control trial. *XVIII International AIDS Conference*, 2010, Vienna. (Oral presentation.)

10. Nunn A, **Dickman S**, Rosengard C, Mayer K, Flanigan T, Eburuoh R, Kwakwa H. Causes and Patterns of Concurrent Sexual Partnerships among Heterosexual African American Men in Urban Philadelphia: A Qualitative Study. *Center for AIDS Research Social and Behavioral Sciences Research Network Conference*, Boston, Oct 1-2, 2009. (Poster.)

11. Eddings E, Lighty J, Silcox G, Whitty K, Deo M, Ghandi K, Call D, Wagner DA, Wagner DR, Okerlund R, **Dickman S**, Jankovich P. Retort process characterization. *Utah Energy Discovery Conference*, 2008, Provo, UT, March 13, 2008. (Poster.)

12. **Dickman S**, Whitty K. Design and implementation of a biomass fuel pressurized grid heater. *Utah Undergraduate Research Symposium*, Salt Lake City, UT, April 4, 2007. (Poster.)

13. **Dickman S**, Addepalli B, Pardyjak E. Pollution dispersion in an urban street canyon. *Utah Conference on Undergraduate Research*, Salt Lake City, UT, December 2006. (Poster.)

Other writing

1. **Dickman S**, White K. How some Texans are getting abortions despite a devastating law. *The New York Times*. March 24, 2022.

2. **Dickman S.** I'm an abortion doctor in Texas. My patients are desperate. *The Guardian*. October 6, 2021.

3. **Dickman S.** Abortion attacks hurt the poor. *The New York Times*. February 16, 2021.

4. **Dickman S**, Woolhandler S. If we really want fair and less expensive health care, it's single payer. *The Salt Lake Tribune*. July 24, 2016.

5. **Dickman S**, Himmelstein D, McCormick D, Woolhandler S. Opting out of Medicaid expansion: The health and financial impacts. *Health Affairs Blog*, January 2014. (*Health Affairs Blog*'s most-read article in 2014).

Awards

Harvard Medical School

- Class of 1967 Scholarship
- HMS Center for Primary Care research scholarship

Brown University

- Phi Beta Kappa
- Frank Stead Manton Scholarship
- Brown University Center for the Economic Analysis of Race and Inequality research award

University of Utah

- Honors at Entrance scholarship
- Engineering Scholars Program scholarship
- National Science and Mathematics Access to Retain Talent scholarship

- John Zink Scholarship
- Undergraduate Research Opportunities Program award
- Tony Cummings Award for Undergraduate Research

Research areas

Reproductive health; Sexual assault; Health policy; Substance use; Incarceration