EXHIBIT F

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; and PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC., Plaintiffs, v. ALEX M. AZAR II, in his official capacity as Secretary, United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROGER SEVERINO, in his official capacity as Director, Office for Civil Rights, United States Department of Health and Human Services; and OFFICE FOR CIVIL RIGHTS, United States Department of Health and Human Services, Defendants.	Civil Action No. 1:19-cv-5433 (rel. 1:19-cv-4676; 1:19-cv-5435)

DECLARATION OF STEPHEN TODD CHASEN

Stephen Todd Chasen, M.D., F.A.C.O.G., declares and states as follows:

1. I am board-certified in Obstetrics and Gynecology and Maternal Fetal Medicine, and I am licensed to practice in the state of New York. I am also a Fellow of the American Congress of Obstetricians and Gynecologists. I currently hold several professional positions: I am a Professor of Clinical Obstetrics and Gynecology at Weill Cornell Medical College, Cornell University, and I am an Attending Obstetrician and Gynecologist at New York Presbyterian Hospital. A more complete account of my professional qualifications and accomplishments is set forth on my Curriculum Vitae, attached hereto as Exhibit A.

2. I submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction, preventing the enforcement of a regulation promulgated by the U.S. Department of

Health and Human Services ("HHS") entitled "Protecting Statutory Conscience Rights in Health Care."

3. In my professional opinion, implementation of the Regulation could have devastating consequences for pregnant women who need emergency medical care because it appears to allow health care providers to refuse to provide medical care, even in emergencies.

Refusing to Provide Referrals or Information About Abortion is Unethical and Contrary to Informed Consent Principles

4. The American College of Obstetricians and Gynecologists ("ACOG") advises that upon a pregnancy diagnosis, a patient should be fully informed, in a balanced manner about all options, including carrying the pregnancy to term or having an abortion. American College of Obstetricians & Gynecologists ("ACOG"), *Guidelines for Women's Health Care: A Resource Manual* 719-20 (4th ed. 2014). Furthermore, the American Medical Association ("AMA") Code of Medical Ethics advises that withholding information without the patient's knowledge or consent is ethically unacceptable. American Medical Association ("AMA") Code of Medical Ethics § 2.1.3. The challenged rules would authorize health care providers to violate medical ethics and principles of informed consent by withholding information or referrals from a patient. Withholding information about or referral to an abortion provider in an emergency could be life-threatening.

5. ACOG also recognizes that health care providers may have religious or moral objections to providing certain health care, but those objections do not extend to providing information and referrals. ACOG, *The Limits of Conscientious Refusal in Reproductive Medicine*, No. 385 (Nov. 2007, reaffirmed 2016). Indeed, even when providers have an objection to the provision of a certain aspect of reproductive health care, "they must impart accurate and unbiased information so that patients can make informed decisions about their

health care." *Id*. at 5. Similarly, "[p]hysicians and other health care professionals have a duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients requests." *Id*.

Medical Conditions That Require Emergency Abortions

6. While many women have relatively healthy and uncomplicated pregnancies, between 15 and 25% of pregnant women either spontaneously abort their pregnancies prior to 20 weeks gestation (this is sometimes called miscarriage), or develop serious medical complications that could pose a serious risk to the woman's life or health. Because of the frequency with which these situations arise, any health care provider who treats pregnant women will sometimes be faced with circumstances in which his or her patients seek prompt abortions to prevent harm to their health or life.

7. For some of these women, it would be medically inadvisable to postpone medical treatment to either end the pregnancy or to complete the abortion, if the abortion has begun spontaneously. Indeed, depending on the particular medical condition (some of which I discuss below), if there is any delay in ending a pregnancy because the hospital where she goes or is taken in an emergency refuses to provide this necessary care, the pregnant woman could suffer a variety of serious impairments, including: loss of future fertility, seizures, strokes, renal failure, and even death.

8. Even if the pregnant woman's condition does not seem like an absolute emergency when she first arrives at a hospital seeking care, delaying treatment may be dangerous, as some conditions can deteriorate quickly and dangerously: an infection that seems mild may quickly become severe; moderate hemorrhage may become uncontrollable without notice; an unruptured ectopic pregnancy can hemorrhage and/or rupture at any time, with very

serious, sometimes lethal, consequences. Because the course of a serious pregnancy complication cannot be predicted, if there is *any* meaningful risk to the woman's life from continuing the pregnancy, the standard of care requires that the woman not be turned away and that an abortion be performed or completed promptly.

9. In order to understand how dangerous the Regulation is for pregnant women in this country, I will describe some of the more common situations that can arise quickly (and often without notice) in pregnancy. In considering how the Regulation will affect emergency medical treatment of pregnant women, it is important to bear in mind that most women, especially low-income women, do not have the luxury of choosing what hospital to go to and will not know in advance if their hospital has a policy that prevents the medical treatment they may ultimately need, or whether hospital staff will refuse to provide the needed care. This is especially true for women in need of emergency care who typically arrive by ambulance or simply rush to the closest emergency room. Thus, women with symptoms of ectopic pregnancy or pregnancy loss may unexpectedly end up in the emergency room of a hospital without any way of knowing if they will be unable to obtain appropriate medical treatment to prevent serious health complications or even save their life.

Threatened, Inevitable, or Incomplete Abortion

10. Among the most common complications of pregnancy are "threatened abortion," "inevitable" abortion, and "incomplete" abortion. A patient experiencing these conditions typically presents with abdominal pain and vaginal bleeding. If she is bleeding, but the cervix is not dilated, the spontaneous abortion is "threatened," but not certain. If there is bleeding and cervical dilation, the spontaneous abortion is "inevitable." If there is bleeding, cervical dilation, and gestational tissue is in the vaginal canal or has passed from her body, the spontaneous

abortion has begun, but is incomplete. Even in the presence of heavy bleeding and cervical dilation ("inevitable" abortion), the embryo may have a visible heartbeat.

11. The indicated treatment for inevitable and incomplete abortion (with significant bleeding or pain), as well as threatened abortion with significant bleeding where the woman wants to terminate the pregnancy, is to induce or complete the abortion. Because an ultrasound performed when the woman presents with any one of these conditions often confirms the presence of cardiac activity, a health care provider who is opposed to abortion may refuse to complete an inevitable or incomplete abortion.

12. However, failure to induce or complete abortion promptly in a woman with inevitable or incomplete abortion and significant bleeding, pain or signs of infection places her at risk of worsening pain, hemorrhage and/or serious infection. While some women may not end up with serious complications if they are denied care, some inevitably will: severe hemorrhage can develop or infection can set in at any point. To prevent these life- and health-threatening occurrences, if the woman presents with serious bleeding, severe pain, or evidence of infection, it is advisable to evacuate the uterus without delay.

Preterm Rupture of the Membranes with Chorioamnionitis

13. Another risky situation that arises in pregnancy is called "preterm rupture of membranes," which describes the rupture -- prior to the 37th week of gestation -- of the membranes that surround a fetus and that contain amniotic fluid. Preterm rupture of membranes most often occurs spontaneously for reasons that are not well understood. It is an important cause of maternal morbidity and mortality and can lead to serious infection.

14. When a pregnant woman experiences a preterm rupture of membranes together with chorioamnionitis – an infection of the placental lining – it is typically necessary to terminate

her pregnancy. If the fetus has not yet reached the gestational age where it is viable, the accepted medical treatment is abortion.

15. Abortion is necessary because chorioamnionitis may cause severe infection of the reproductive tract and systemic sepsis – a serious infection that spreads throughout the body – if treatment is delayed. The infection can result in scarring of reproductive organs, sometimes necessitating their removal, and may be fatal if allowed to progress untreated.

16. For a physician to refuse to treat a patient with preterm rupture of membranes with chorioamnionitis would violate the standard of care. If the chorioamnionitis is severe, continued pregnancy is life-threatening. Even if the chorioamnionitis is relatively mild when the woman first presents, delaying treatment exposes her to a significantly increased risk of serious and even life-threatening infection that can develop rapidly and may not be brought under control with antibiotics. The presence of a fetal heartbeat does not change the risk of severe morbidity or death to the mother, and does not alter the obligation of a physician to promptly terminate the pregnancy to preserve maternal health.

Preeclampsia

17. Another condition that occurs in pregnancy is called "preeclampsia." It tends to occur toward the end of pregnancy, but can occur in the second trimester, prior to fetal viability, as well. Preeclampsia is a form of pregnancy-induced hypertension characterized by high blood pressure and proteinuria (excessive urinary protein). Patients with preeclampsia can also experience "eclampsia," characterized by grand mal seizures.

18. A patient with inadequately treated preeclampsia is at significant risk for cerebral hemorrhage (i.e. stroke), as well as liver dysfunction or failure, kidney failure, temporary or permanent visual disturbances or vision loss, coma, and death.

19. The only cure for severe preeclampsia is termination of the pregnancy. If severe preeclampsia occurs before the fetus has reached viability, the medically accepted treatment is abortion. To minimize the risk of significant physical injury or even death, it can be critical to stabilize the patient and then begin the abortion process without delay.

Placental Abruption

20. Some pregnant women develop a serious condition called placental abruption in which the placenta separates from the inner wall of the uterus, either partially or completely. Placental abruption can cause the woman to bleed heavily. If the fetus has not reached viability and the patient presents with severe hemorrhage, ending the pregnancy immediately is required to stop the bleeding.

Ectopic Pregnancy

21. A common complication of pregnancy is called "ectopic pregnancy." An ectopic pregnancy occurs whenever a fertilized egg – called a "blastocyst" at this stage – implants anywhere other than in the endometrial lining of the uterus. The vast majority of ectopic pregnancies involve a fertilized egg implanting in one of the fallopian tubes. In some cases, the pregnancy may develop significantly and cardiac activity may be present.

22. According to the Centers for Disease Control and Prevention, ectopic pregnancy accounts for approximately 2% of all reported pregnancies. Ruptured ectopic pregnancy is a significant cause of pregnancy-related mortality and morbidity, accounting for approximately 3.0% of all pregnancy-related deaths. It is the leading cause of obstetric hemorrhage-related mortality. The prevalence of ectopic pregnancy among women presenting to an emergency department with first-trimester vaginal bleeding, or abdominal pain, or both, has been reported to be as high as 18%. [ACOG Practice Bulletin #193. "Tubal Ectopic Pregnancy". The American

College of Obstetricians and Gynecologists: Washington DC, 2018.]

23. A fertilized egg that implants in one of the fallopian tubes may subsequently extrude into the peritoneal cavity. Such a "tubal abortion" typically occurs spontaneously and can result in hemorrhage.

24. A fertilized egg implanted in a fallopian tube may also cause the tube to rupture, resulting in hemorrhage.

25. In addition to life- or health-threatening hemorrhage, a ruptured tubal pregnancy can cause scarring of the tube, which can then result in either compromised fertility, infertility, and future ectopic pregnancy. An ectopic pregnancy can also attach to various organs, including the ovaries, the liver, and the intestines. These organs can be permanently compromised by the pregnancy.

26. An ectopic pregnancy generally requires either surgical or medical intervention. If no rupture has occurred, the ectopic pregnancy may often be terminated safely and effectively using the drug methotrexate. This drug causes the rapidly dividing cells comprising the pregnancy to die and to be either reabsorbed or expelled.

27. If surgery is necessary, such as in the case of a ruptured fallopian tube or impending rupture, it involves removing the pregnancy from the fallopian tube, and in some cases removal of a portion or all of the fallopian tube is required. Rarely, the ovary may be involved, and removal of the ovary may be necessary. In some circumstances, the implantation site may be such that removal of the entire uterus becomes necessary to protect the patient's life. Surgical intervention is less complicated and carries substantially less risk for the patient when performed before the ectopic pregnancy ruptures the fallopian tube or other organs.

28. Delaying treatment in cases of un-ruptured ectopic pregnancies exposes patients

to the risk of substantial physical harm and possibly of death. This is because at any moment, the patient may suddenly experience a rupture, requiring emergency surgery and resulting in permanent injury to one of more of her organs, or death from uncontrollable hemorrhage. Even if the woman does not die of hemorrhage, she may need blood transfusions, which carry their own risks.

29. To prevent the grave harms posed by an ectopic pregnancy, the standard of care for treating a suspected ectopic pregnancy does not permit delay in intervention. Indeed, any delay might well make the difference between a situation that may be treated with medication or relatively minor and uncomplicated surgery and an emergency procedure that carries greater risk of permanent injury or death.

Women Seeking Abortions Sometimes Need Emergency Care

30. Abortion is a very safe procedure. The overall abortion-related mortality rate in the United States is approximately 0.6 per 100,000 procedures (compared to a mortality rate for childbirth of approximately 8 per 100,000 women). Complications short of death are also very low. There are, however, occasions when women having abortions will need emergency care.

31. The most common serious complications occurring during surgical abortion procedures are uterine injury and/or hemorrhage. These conditions usually require immediate transfer from the health care facility where the abortion is being performed to a hospital. Delay in treatment once the woman arrives at the hospital could be catastrophic, leading to infertility or worse.

32. Often second-trimester surgical abortions are performed as a two-step, two-day procedure in which dilators are inserted into the woman's cervix on day one and the uterine evacuation is performed on day two. Patients return home between the two procedures. In a

very small percentage of cases, however, women go into labor at home as a result of the cervical dilators. These women often go to a hospital emergency room where they present in a similar condition to women who are in the midst of a miscarriage. If they are experiencing significant bleeding or have evidence of infection, they face all the same risks I describe above for women experiencing threatened, inevitable, or incomplete abortions, and require the same care.

33. Women having first-trimester medication abortions may also need hospital care. While this procedure is also extremely safe, a small percentage of patients undergoing medication abortion will experience significant blood loss. If these women call their health care provider, they may be told to go to the emergency room; other women will simply go to an emergency room on their own. Some medication abortion patients who are bleeding heavily do not require transfusions, but are best treated by completing the abortion surgically to stop the bleeding. Any delay in evacuating the uterus increases the risk that transfusion will become necessary.

34. Finally, some women who have already had a first- or second-trimester surgical abortion will develop serious complications a few days after the procedure is completed. The most common post-abortion serious complication is infection, the signs and symptoms of which usually arise within 48-96 hours post-abortion. In some cases, infection may be due to retained gestational tissue. If the woman first becomes aware of the symptoms (pain and fever) during normal business hours, and she lives near the health facility where the abortion was performed, she will often go there for treatment. However, if the symptoms develop over the weekend, or at night, or if the woman lives far from the abortion provider, she will generally go to the emergency room. Because untreated infection can result in chronic pelvic pain, infertility, or systemic sepsis and death, a high index of suspicion and expedient treatment are warranted.

35. Women in these circumstances may need immediate care, and this could include surgically evacuating any retained gestational tissue as well as administration of antibiotics. I am afraid that because the care they need could be seen as completing their abortions, or cooperating in the provision of abortion services, health care providers and hospital staff could refuse to provide or assist with that care, thereby threatening the lives and health of these women.

Conclusion

36. Based on ACOG's *The Limits of Conscientious Refusal in Reproductive Medicine*, No. 385 (Nov. 2007, reaffirmed 2016), "[a]ny conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the patient can be fulfilled." In an emergency, in which referral is not possible, "providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections."

37. If the Regulation is enforced, and if health care providers are permitted to refuse to provide necessary medical care to pregnant women even in an emergency, some women in this country will be subjected to sub-standard medical care, and will result in meaningfully increased maternal injury and mortality.

EXECUTED: June 13, 2019

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

Stephen Todd Chasen, M.D., F.A.C.O.G.