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UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON,

Plaintiff,

v.

ALEX M. AZAR II, et al.,

Defendants.

NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, et al.,

Plaintiffs,

v.

ALEX M. AZAR II, et al.,

Defendants.

No. 1:19-cv-03040-SAB

DECLARATION OF J. ELISABETH KRUSE, M.S., C.N.M., A.R.N.P., IN SUPPORT OF NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION'S MOTION FOR A PRELIMINARY INJUNCTION

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J. Elisabeth Kruse, M.S., C.N.M., A.R.N.P., declares and states as follows:

1. I am an Advanced Registered Nurse Practitioner (ARNP) and Certified Nurse Midwife (CNM). I serve as the Lead Clinician for Sexual and Reproductive Health and Family Planning at the Public Health Department for Seattle and King County ("Public Health–Seattle & King County"). I submit this declaration in support of Plaintiffs' motion for a preliminary injunction.

2. I came to Title X family planning work because of its focus on caring for underserved and low-income patients with limited access to health care. I am deeply committed to making sure that all people, regardless of their income level, can determine their own reproductive destiny. I fear that the new Title X regulations ("New Rule") will cause serious harm to Title X patients, Title X programs (including those of local government entities like Public Health–Seattle & King County), and Title X clinicians, unless this Court grants a preliminary injunction. The New Rule will unreasonably limit the ability of non-physician clinicians to provide care to Title X patients. It will also eliminate non-directive pregnancy counseling and referrals to appropriate providers, which is contrary to medical ethics and national standards of care (including those issued by the federal government).

3. Since 2012, I have worked full-time at Public Health–Seattle & King County. I currently work exclusively in the County's Title X program. In my capacity as Lead Clinician for the Family Planning Program, I not only provide direct care to patients, but also participate in hiring, develop and run new clinician orientation and trainings for all licensed Title X staff, and conduct cross-program

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trainings for the County's Public Health Nurses. I also participate in quality management and develop and maintain clinical guidance for the Family Planning Program.

4. I have been a nurse since 1982. I hold a nursing degree from Oregon Health Sciences University and a Master's degree in Nurse-Midwifery from the Intercampus Graduate Studies Program of the University of California, San Francisco, and the University of California, San Diego. I have been on staff with the midwifery practice at Virginia Mason Hospital in Seattle, and have provided comprehensive family planning and sexual and reproductive health care in other settings in Seattle (Aradia Women's Health Center and Aurora Medical Services). I have extensive experience with preventive and screening exams; diagnosis and treatment of common gynecological disorders; sexually transmitted infections (STI) risk-reduction counseling, diagnosis and treatment; contraceptive counseling and management (including intrauterine and subcutaneous device insertion and removal); and early pregnancy diagnosis, counseling, and management. In these settings, I have also been involved in the training and supervision of medical assistants and in the development of patient education and staff training materials. I have been on the faculty of numerous professional conferences, and co-authored the chapter on quality care in the textbook *Management of Abnormal and Unintended Pregnancy* (Wiley-Blackwell, 2009).

5. At Public Health–Seattle & King County, in my capacity as a clinical ARNP, I personally conduct between 15 - 45 appointments per week with adolescent and adult Title X patients. This care includes counseling for and

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provision of all outpatient family planning methods; pregnancy testing and counseling; STI prevention, screening, diagnosis and management; and well-patient gynecological care and cancer screenings.

6. Ninety-eight percent of the patients we see in Public Health–Seattle & King County's Title X project are at or below 250% of the federal poverty line. We also provide care to a substantial number of homeless individuals. Many of our patients are refugees or immigrants; in fact, 27% of our population has limited English ability or requires an interpreter. We also serve a high number of adolescent patients, both independently and through established connections with local schools and our school-based clinics. Because of the demographics of our patient population, we are often patients' only professional health care.

7. Many of our patients return time and again—some are successive generations, or family members of other patients. Our patients come to us specifically because they trust us with highly sensitive medical concerns. We work hard to earn that trust, and to keep it, by providing a safe, nonjudgmental space for our patients on an ongoing basis.

8. Many of our patients have a history of adverse childhood experiences and other trauma, including sexual abuse, assault, and coercion. Throughout Public Health–Seattle & King County, employees at all levels are deeply committed to fostering a protective and safe environment for the patients we see who have experienced highly stressful, emotionally painful, and potentially traumatic circumstances.

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9. In my capacity as Lead Clinician for our Title X project, I maintain our Clinical Practice Guidelines for Quality Family Planning Services (CPGs), updating them to ensure that they are evidence-based, consistent with nationally recognized best practices, and reflective of standards of care and medical ethics—including those promulgated by the Institute of Medicine (IOM) and the American College of Obstetricians and Gynecologists (ACOG), among others.

10. The Department of Health and Human Services published a 2014 document, setting national family planning standards, entitled "Providing Quality Family Planning Services: Recommendations of CDC and the US Office of Population Affairs" (QFP). The QFP's Recommendations serve as a foundational document governing Public-Health Seattle & King County's CPGs.

11. Complying with medical ethics and standards of care is a baseline expectation for all medical and nursing professionals. To that end, the County's CPGs provide that "clinicians are responsible for practicing in accordance with recognized national guidelines for sexual health . . . as described in [the QFP]."

12. The code of ethics for the American College of Nurse-Midwives (ACNM) states that midwives in all aspects of their practice will "develop a partnership with the woman, in which each shares relevant information that leads to informed decision-making" and will "promote just distribution of resources and equity in access to quality health services."[i]

13. Similarly, the code of ethics for the American Nursing Association (ANA) provides that "[p]atients have the moral and legal right to . . . be given accurate, complete, and understandable information in a manner that facilitates an

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informed decision."[ii] And it further states that patients "have the right to accept, refuse, or terminate treatment without deceit, undue influence, duress, coercion, or prejudice."[iii]

14. Additionally, pregnancy counseling training materials from the Family Planning National Training Center, which works in collaboration with OPA to address the needs of Title X providers, state that Title X "[s]taff providing counseling must demonstrate a consistent ability to discuss all options and resources in an unbiased, neutral and supportive manner."[iv] The materials remind the provider, "You do need to be able to clearly separate your personal values from your professional role."

15. As Lead Clinician for the Family Planning Program, I have a role in ensuring that all of our ARNPs and Certified Medical Assistants (CMAs) provide a standard of quality care consistent with the QFP and our CPGs. We have eight ARNPs on staff and an additional four ARNPs on-call to provide backup as needed. There are seven CMAs. Approximately half of our staff has been with the program for at least 10 years.

16. Both the QFP and our CPGs emphasize the importance of informed decision-making. The goal in family planning care—indeed, a principle across all health care—is to give patients the information they need to make their own decisions, to obtain the care and follow-up they need, and to facilitate that process and that care. Sharing accurate information in a useful and approachable manner is especially critical for the population Title X serves.

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17. The New Rule prohibits any referral for abortion, even where specifically requested by a patient. Not only that, but this New Rule also requires that we actively provide counseling information about prenatal care and/or adoption, even if the patient has already decided that she does not want to continue with the pregnancy and seeks only information about abortion. The *most* we can do for a patient who wants an abortion or information about where to obtain one is to provide the patient a list of "comprehensive primary health care providers," some of which, but not the majority of which, may provide abortion. *See* New Rule Section 59.14(b)(1)(ii). But we are not even allowed to identify for the patient which providers actually offer the services she seeks.

18. Even more coercive, the New Rule requires that we give all pregnant patients a referral for "medically necessary prenatal care." *See* New Rule Section 59.14(b)(1). But, of course, such care is *not* medically necessary for someone who wishes to terminate her pregnancy.

19. Selectively withholding certain information and referrals, while at the same time forcing other information and care upon our patients is deceptive and contradicts ethical standards. This approach is completely inappropriate for any patient interaction. It would also present particular challenges to Title X patients.

20. In Public Health–Seattle & King County in general, and in our Title X program in particular, we see a very diverse range of patients. Consistent with national, state, and county standards of care, we endeavor to establish a trusting, open, and nonjudgmental patient-provider relationship with everyone who comes through our doors.

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21. We encourage our patients to lead the conversation. We ask all of our patients seeking family planning care whether or not they would like to be pregnant or become a parent anytime in the next year, so that we can provide the type of counseling that will be helpful to them. Some may say "yes"; others, "no"; some indicate that they are "not sure"; and others say they are "fine either way."

22. When a patient has indicated that she would like to be pregnant, and she then receives a positive pregnancy test result, the ensuing appointment is almost always a happy one. Under these circumstances, pregnancy counseling consists of providing support, talking through next steps, offering guidance on immediate self-care, and supplying written resources and referrals for accessing medical insurance coverage, maternity support services, and high-quality prenatal care.

23. For a patient who has indicated that she either does not want to be pregnant at all, or at least not at the time, a positive pregnancy test result will mean something very different. Patients in such circumstances often express disbelief and distress—sometimes extreme distress—at the test result. They may say, "This can't be true, this can't be happening," or, "I can't do this right now, I just can't." Patients often cry. They sometimes describe feeling trapped or desperate by the news that they are pregnant when the circumstances of their lives are such that they cannot imagine continuing a pregnancy. In these circumstances, pregnancy counseling *also* consists of providing support, talking through next steps, offering guidance on immediate self-care, and supplying written resources and referrals for accessing medical insurance coverage and other support services.

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24. When a patient is upset about being pregnant, pregnancy counseling is very delicate. Accordingly, the QFP, our CPGs, and opinions and guidance by ACOG, ACNM and other professional organizations provide for neutral, non-directive counseling.

25. As described in our CPGs, our staff will "share both the [pregnancy] test results and accurate information about the available options for pregnancy; specifically, either abortion or continuation/childbirth; with further options for either relinquishing for foster care/adoption, or parenting." The QFP similarly instructs that Title X providers give "appropriate referrals" to patients in the course of "[c]lient-centered" pregnancy counseling.[v]

26. Above all, it is most important to let patients guide the conversation with reactions and questions. Patients frequently need to process the news and talk through their options with a trained medical professional who has complete information about all options. It is essential that counseling remain nondirective and nonjudgmental, and center on communicating to uncertain or distressed patients that they are not trapped. They have choices.

27. That's why, consistent with my training and experience as an ARNP, I always encourage patients to express their thoughts and feelings—positive, negative, or ambivalent. I offer support by affirming the validity of patients' feelings, and when they indicate they are ready, I offer to give further information about any and all options in which they express interest.

28. If a patient with a positive pregnancy test says she does not want to be pregnant, I first explain that she does not have to remain pregnant. Abortion is a

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safe, locally accessible, and legal option. I assure her that she will have support and resources available no matter what she decides. I ask her about people in her life who will support her emotionally, regardless of what she decides. I then ask her which options she'd like to hear more about. If she's interested in more information about abortion (regarding the types of abortion available, or other anticipatory guidance), we'll go into more depth about pros and cons, risks and benefits of different methods, and any other information. If she affirms that she wants to be referred for abortion care, I provide that. If she wants to talk about options for continuing the pregnancy, we'll discuss the pros and cons of that option (also safe, locally accessible, and legal), along with available resources and support (medical coverage, maternity support services, housing and food programs, and any other relevant information). If the patient is interested, we can discuss the options of temporary foster placement or adoption and arrange for a referral for prenatal care or other appropriate services.

29. The New Rule bans that basic level of care by forbidding providers from providing referrals for abortion or clearly indicating where a patient can obtain abortion care. What's more, it requires providers to force information about, discussion of, and referral for prenatal care on patients *regardless* of those patients' wishes. I would have to provide that information even if the patient asked me to stop or said she didn't want to hear anymore because it was upsetting her. I would have to continue even through her tears. And I would need to help facilitate an appointment for prenatal care that is a direct affront to what she has expressed

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she wants and needs. As I see it, this would constitute verbal and emotional abuse; it would be the antithesis of trauma-informed care.

30. Providing an inappropriate and unwanted referral is unprofessional, unethical, and harmful. It risks misleading patients about the kind of care they will receive from the follow-up provider, and misleading the referral providers as to the type of service that a patient needs or wants. For example, staff (and other patients) at prenatal care clinics may quite logically assume that any new patient is there because she wishes to continue her pregnancy. When she is forced to correct their assumptions, she becomes vulnerable to the potential disapproval of strangers who cannot know her situation.

31. If my patients were to be subjected to the experience of forced counseling, they would very likely interpret the barrage of information about continuing the pregnancy, as well as the referral for prenatal care, as judgment: clearly, they would assume that their provider thinks they should or must continue the pregnancy. This will never happen in my exam room. If my words and actions were to cause a patient to think I was judging her, or that she was somehow wrong, or bad, or immoral, I would be contravening my own professional ethics and standards of care.

32. The New Rule's ban on referrals for abortion care is especially dangerous in the context of Title X because nearly all of our patients are low-income, and many also have low literacy and/or low health literacy. Many patients, especially (but not only) those from immigrant or refugee communities, may not know that abortion is legal in the United States. They may have no idea

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that affordable, high-quality abortion care is locally accessible. Our homeless patients, as well as patients with mental or behavioral health challenges, may lack any means to access care without assistance. Adolescent patients may also find it especially challenging to figure out where and how to access abortion, particularly if they are concerned about confidentiality. This will also be true for victims of abuse, assault, incest or reproductive coercion, of any age.

33. Health care providers are expected routinely to provide referrals where patient needs and conditions are outside of their particular scope of practice. Our patients receive referrals not only for prenatal or abortion care, but also for a wide range of other services, such as diagnostic imaging for a breast mass (identified during a wellness visit), cervical biopsy (following an abnormal Pap smear), or diagnosis and management of common chronic health conditions such as hypertension, diabetes or heart disease; the list is long.

34. As noted above, the New Rule narrowly permits certain providers to provide a list of "comprehensive primary health care providers," some, "but not the majority of which," may also provide abortion. *See* New Rule Section 59.14(c)(2). But it is well known that the overwhelming majority of abortion services throughout the United States (including in King County) are available at health centers that specialize in gynecology, and do not offer obstetrical care or "comprehensive primary health care." (There are instances when an obstetrician, midwife, or family practice clinician may offer abortion care in addition to prenatal care, but this is normally in the context of caring for a current patient in their practice.) Practically speaking, Public Health–Seattle & King County would be

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unable to offer patients any sort of choice of providers who offer both prenatal and abortion services (in keeping with the New Rule's mandate).

35. Without referrals or other information about follow-up care, the patient populations we serve will meet numerous, sometimes insurmountable, barriers in accessing safe, affordable abortion services.

36. As discussed above, our patients often have no other health care professionals to whom they can turn. Challenges include significant literacy and language barriers, as well as financial difficulties. These obstacles mean that patients are unlikely to independently obtain information about health care providers, including referrals. The fact that the New Rule's discussion suggests that information about abortion is readily available "on the internet" betrays a complete lack of understanding of the realities of our Title X patient population, or the relative sophistication needed to navigate the web safely. From many years of experience in this work, I know that the information or referral I provide is often a patient's only viable way to access additional health care—because of language, literacy (including health literacy and electronic literacy), or economic barriers.

37. As a result, I am very concerned that if we cannot provide our patients with complete information about their options—including where they can obtain care if they so choose—it will forestall or foreclose access to those services.

38. I believe in the core message of the American College of Midwives with all my heart: "Listen to Women." The New Rule's coercive requirements would force me to disrespect, contradict, and patronize my patient, and violate her trust, compounding her feelings of isolation and vulnerability.

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39. The New Rule's ban on referral for and information about obtaining abortion care is not only unethical, but also cruel and dangerous. It will delay or prevent patients from obtaining the care they want and need. It will make patients distrust me, my colleagues, our clinic, and health care providers in general. Forcing any unwanted and directive information on patients is unethical and inconsistent with national standards of care for, including, but certainly not limited to, the QFP. It will destroy the delicate trust at the heart of the patient-provider relationship. It goes against the basic medical and ethical obligations of CNMs, ARNPs, and of all health care providers.

40. I am a highly competent professional with more than 36 years of experience in the field of sexual and reproductive health; and the prospect of being required to withhold referrals and information that is responsive to my patients' needs, and to disrespect, mislead and confuse my patients, is untenable. As a result, I will be forced to choose to leave the Title X program if the rules take effect.

I declare under penalty of perjury that the foregoing is true and correct and that this declaration was executed on 20 March 2019 in Seattle, Washington.

J. Elisabeth Kruse, M.S.,
C.N.M., A.R.N.P.

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[i] *See* Code of Ethics, American College of Nurse Midwives, http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000048/Code-of-Ethics.pdf.

[ii] ANA, Code of Ethics, at 2 (2015), https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/ (Provision 1.4).

[iii] *Id.*

[iv] *See* "Exploring All Options: Pregnancy Counseling Without Bias" Discussion Guide, https://www.fpntc.org/sites/default/files/resources/2017-10/fpntc_expl_all_options2016.pdf.

[v] Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs ("QFP"), 63 Recommendations & Reports 4, 14 (2014), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.

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DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED, this 22nd of March, 2019, at Seattle, Washington.

/s/ *Emily Chiang*
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