Emily Chiang, WSBA No. 50517
AMERICAN CIVIL LIBERTIES UNION
OF WASHINGTON FOUNDATION
901 Fifth Avenue, Suite 630
Seattle, WA 98164
Phone: 206-624-2184
Email: echiang@aclu-wa.org

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 SARAH PRAGER, M.D., M.A.S., IN SUPPORT OF NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION'S MOTION FOR A PRELIMINARY INJUNCTION

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Sarah Prager, M.D., M.A.S., states as follows:

1. I am a Professor of Obstetrics and Gynecology at the University of Washington, where I serve as the Director of the Family Planning Division and Family Planning Fellowship. I also serve as the Title X Director of the Feminist Women's Health Center (doing business as Cedar River Clinics) ("FWHC"). FWHC has participated in Title X since 2017. FWHC decided to become a Title X provider out of a deep commitment to reaching as many patients as possible with full, quality family planning care. I submit this declaration in support of Plaintiffs' motion for a preliminary injunction.

2. I earned a B.A. *summa cum laude* from Princeton University. I then obtained my M.D. degree from the University of Texas Southwestern Medical School in 2000, and I completed an internship and residency at the University of Vermont. Thereafter, I earned a master's degree from the University of California at San Francisco, where I also completed a fellowship in family planning. I have been board certified in Obstetrics & Gynecology since 2005. My curriculum vitae, which sets out my professional qualifications and experiences in greater detail, is attached as Exhibit A.

3. Plaintiff Dr. Deborah Oyer is my colleague and serves as Medical Director of FWHC's Cedar River Clinics. She has provided family planning and

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other reproductive health care in Washington for more than 25 years and is a graduate of Harvard Medical School.

4. In my capacity as Title X Director, and in partnership with Dr. Oyer, we oversee the provision of medical services to FWHC's Title X patients, including pregnancy counseling and contraceptive care. Dr. Oyer and I ensure that FWHC's Title X program meets the directives set forth in "Providing Quality Family Planning Services" ("QFP"), the national clinical standards of care for family planning developed by the Centers for Disease Control and Prevention ("CDC") and the HHS Office of Population Affairs ("OPA"). A central part of our mission is to give Title X patients the same, high-quality care as better-resourced patients.

5. I personally treat approximately 425 Title X patients per year at FWHC.

6. Dr. Oyer and I also provide abortions at Cedar River Clinics outside the Title X program and unsupported by Title X funds.

7. I provide the full spectrum of general obstetrics and gynecologic care, with a special clinical focus on family planning. I strive to help women navigate their needs around contraception, abortion, and miscarriage. I also conduct research on miscarriage management, contraceptive use, and pregnancy termination, including second trimester surgical abortion. I have been published in

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numerous medical journals on these topics and others. In my various professional roles, I interact with other Title X health care providers and family planning researchers around the country. I am typical of the doctors who serve as Title X medical directors across the country. Many of us are practitioners and academics who do Title X work part-time to ensure the quality of the Title X program.

8. I am familiar with the key provisions of the new Title X regulations ("New Rule"). If the New Rule were to take effect, as I explain below, I would no longer be able to serve as Title X Medical Director or to provide Title X care, and FWHC would be forced to exit the program. Having to leave Title X would significantly harm FWHC's ability to provide high quality, affordable family planning care to our low-income patients. In my expert opinion, this would create new health risks and harms for our patient population.

The New Title X Regulations

9. The New Rule would cause immediate harm to patients, physicians, and Title X providers in the form of coercive pregnancy counseling. The New Rule requires withholding information from pregnant patients by preventing referral for all available options for their pregnancy, while at the same time, forcing certain information on patients regardless of their wishes.

10. The New Rule would also cause cascading other harms, as it disrupts the provision of care, including contraceptive care, in the Title X network.

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The New Rule's Coercive Pregnancy Counseling Requirement Would Harm Patients and Providers

11. Patients that come to FWHC for pregnancy testing have a range of experiences: some hope that they are pregnant; others fear that they are; and some do not know exactly how the news would make them feel. As a result, when a pregnancy test comes back positive, a patient's emotions are often very intense.

12. If the patient has been trying to conceive, she may be elated and will want to talk through and obtain referrals for prenatal care. In that case, consistent with protocols, our pregnancy counseling focuses on appropriate next prenatal steps.

13. If a patient's pregnancy is unplanned, she is often surprised and overwhelmed. Sometimes she is very distressed. Such patients often do not know what they will do, and they look to us to discuss their options.

14. As Title X Director, I ensure that FWHC non-physician clinicians—who are highly trained and best positioned to provide pregnancy counseling—create an open dialogue with patients. It is critical that clinicians form a relationship with patients based on sensitivity, candor, and, above all, trust.

15. FWHC aims to give patients facing unplanned pregnancies space to discuss their options and to weigh their concerns. This is one of the most sensitive areas of medical practice, so providers must be especially attentive to the feelings and needs of their individual patients.

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16. Nondirective pregnancy counseling is consistent with the relevant standards of care and medical ethics.

17. The American College of Obstetricians and Gynecologists ("ACOG") provides that, following a pregnancy diagnosis, "[t]he patient should be fully informed in a balanced manner about all options, including raising the child herself, placing the child for adoption and abortion."[i]

18. The American Medical Association ("AMA") Code of Medical Ethics similarly advises providers that "withholding information without the patient's knowledge or consent is ethically unacceptable."[ii]

19. And the American Academy of Pediatrics ("AAP") directs that "[w]hen consulted by a pregnant adolescent, pediatricians should be able to make a timely diagnosis and to help the adolescent understand her options and act on her decision to continue or terminate her pregnancy."[iii]

20. The QFP standards also state that pregnancy testing should be "followed by a discussion of options," consistent with the recommendations of professional medical associations, such as ACOG and the AAP.[iv] The QFP is clear that providers must be "respectful of, and responsive to, individual client preferences, needs, and values," ensuring that "client values guide all clinical decisions."[v]

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21. However, in contrast to the previously longstanding Title X regulations, the New Rule does not require clinicians to discuss all options with women seeking such counseling. The New Rule also requires a Title X provider to have a graduate level degree to be able to conduct nondirective pregnancy counseling. These are unnecessary and harmful limitations.

The New Rule Curtails Necessary Referrals & Misleads Patients

22. When patients seek services beyond the scope of clinicians' practice, ACOG directs that clinicians "fulfill their obligations to patients through referral to other professionals who have the appropriate skills and expertise to address the situation."[vi]

23. The AMA similarly instructs that in cases where the patient seeks treatment beyond their practice, physicians should "consult or refer the patient to … health care professionals who have appropriate knowledge and skills and are licensed to provide the services needed."[vii]

24. The QFP directs that Title X providers supply "appropriate referrals" in the course of nondirective, patient-driven pregnancy counseling.[viii]

25. Under the New Rule, however, even when a patient requests referral for abortion care, providers are prohibited from providing clear information about how to get that care. Title X clinicians are permitted only to furnish a list of "licensed, qualified, comprehensive primary health care providers (including

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providers of prenatal care), some, but not the majority, of which also provide abortion as part of their comprehensive health care services," but the provider may not "identify which providers on the list perform abortion." 84 Fed. Reg. 7714, 7789.

26. This bar on referral for abortion—even when a patient requests such information—would confuse patients. Patients may reasonably but incorrectly assume that the list includes only abortion providers—that is, after all, the information they sought. In direct violation of the standards of care and medical ethics, patients would be left to discover on their own where and how abortion care is available.

27. As both an academic and a doctor, I am committed to making available the full array of ob/gyn care to patients regardless of income and ensuring that they have access to the most complete information about treatment and options. It would be completely incongruous not to provide referral information about abortion to the patients within Title X that seek that care. Complying with the new regulations would force me to shame patients about abortion and steer them to certain types of care, which I simply cannot do.

28. In many areas there may well be *no* abortion providers who satisfy the rules' criteria to appear on the list of follow-up providers. This is because the New Rule permits listing only "comprehensive primary health care providers … which

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also provide abortion as part of their comprehensive health care services." In reality, in many parts of the country, including where I practice, abortion care is not generally available in such settings and is limited to more specialized health centers and clinics. This means that the New Rule would require especially misleading and unethical care, because Title X providers would, in some cases, be forced not only to supply referrals to prenatal care, but also could offer only a written list that excludes any option, even a hidden one, for abortion services or abortion information in response to patients' explicit requests for help in finding abortion care. This would misdirect and shame patients, pushing them toward prenatal care they do not want.

29. Preventing providers from clearly communicating where and how patients can access abortion care—even when patients have expressed that they want to access abortion—creates significant obstacles for patients, who are left to discover that information on their own. In contravention of standards of care and medical ethics, the New Rule places enormous burdens on patients.

30. These burdens would likely delay access to abortion care. While abortion in the U.S. is very safe, every week of delay increases the risks associated with the procedure.[ix]

31. Because many Title X patients have linguistic, educational, informational, and financial barriers to accessing healthcare, the impediments

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introduced by the New Rule may prevent such patients from accessing abortion altogether.

The New Rule Directs Providers to Coerce Patients

32. ACOG directs that "[i]t is never acceptable for [providers] to attempt to influence patients toward a clinical decision using coercion."[x] Similarly, the AMA Code of Medical Ethics provides that patients must "make an independent, voluntary decision" about care.[xi] Providing medical information to patients against their articulated interests or their will is unethical and dangerous.

33. But the New Rule forces providers to refer all pregnant patients for prenatal care or related social services, regardless of patients' wishes—and even when patients have already decided to have an abortion.

34. Having this referral forced on them may be severely upsetting to patients who are considering abortion. The prenatal referral (and refusal to provide an abortion referral) may also cause patients to mistakenly conclude that they must discount abortion as an option for medical reasons.

35. I cannot imagine directing a patient to a prenatal appointment and withholding information about care that I provide when they have expressed interest in possibly obtaining an abortion. If a patient asks me if I can provide them with abortion care, the New Rule prevents me from answering or requires me to lie.

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36. As an academic, researcher, and clinical ob/gyn who provides abortion care outside the Title X project, it would be antithetical to my medical practice, contrary to my work, and damaging to my reputation to provide care in this manner or to allow those I supervise to provide pregnancy counseling that misleadingly omits information about abortion care. I cannot—in one part of my practice, with patients who have the means to pay—provide the full scope of care and—in another part of my practice, with patients of limited means—withhold information and coerce patients to receive certain types of care. This would be seriously harmful to my practice and reputation as both a physician and an academic.

The New Rule Unreasonably Limits Provision of Care

37. Clinicians and counselors typically conduct pregnancy counseling at FWHC and other Title X sites. These providers possess relevant training and expertise.

38. But the New Rule states that only physicians and advanced practice clinicians with a graduate level degree may conduct nondirective pregnancy counseling.

39. Limiting pregnancy counseling to physicians and advanced practice clinicians would constrain FWHC's ability to treat pregnant patients.

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The New Rule Would Interrupt Patients' Access to Contraception

40. The New Rule also imposes stringent requirements that force Title X projects to completely separate from any abortion-related activity or care. Aside from their practical difficulty or impossibility, these separation requirements would introduce new barriers and health complications for women who seek contraception.

41. In overseeing counseling for patients who seek abortion care outside of the FWHC Title X project, I ensure that clinicians and counselors discuss contraceptive methods with these patients to avoid future unplanned pregnancies.

42. Discussing contraceptive care and delivering a chosen contraceptive method at the time of an unplanned pregnancy or an abortion is, consistent with clinical recommendations by the Society of Family Planning, "an optimal time to initiate use of effective contraceptives" because it removes logistical hurdles, including travel, time, and cost.[xii] It also provides a unique opportunity to talk with patients about pregnancy prevention when they may be particularly focused and motivated to "avoid a subsequent pregnancy and to leave the abortion appointment with a contraceptive method."[xiii] Especially relevant for the Title X population, the Society of Family Planning makes clear that "[f]or women who do not regularly seek or have access to gynecologic or preventive health services, the

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abortion visit may be one of their only interactions with the health care system and an important opportunity to discuss contraception."[xiv]

43. The new separation requirements would disrupt continuity of care for patients as they would have to make multiple appointments to access contraceptive counseling and care that could be accomplished on a single date, in a single location.

44. Barriers to access for low-income patients—such as requiring patients to make multiple appointments and trips, to take additional time off work, and perhaps to find childcare on multiple occasions—have been shown to decrease contraceptive use, and increase instances of unplanned pregnancy, abortion rates, and harmful outcomes.[xv]

45. Moreover, if patients choose an intrauterine device ("IUD")—one of the most effective forms of contraception—a particularly safe and easy time to insert the device is immediately after a surgical abortion because the cervix is already dilated.[xvi] However, under the new separation requirements, the patient would have to travel to a separate site and see a different team of clinicians for IUD insertion. Therefore, the New Rule's complete separation requirement creates a new barrier to patients electing an IUD.

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The New Rule Would Force Title X Providers like Me out of the Program

46. The New Rule would harm not only high-need Title X patients, who would receive substandard and misleading care under its dictates, but also their physicians: The New Rule forces providers to adopt a highly unprofessional and unethical approach to patient care.

47. Each clinician and physician who currently serves Title X patients would be forced to choose between, on the one hand, continuing to serve Title X patients but with mandated substandard and unethical care; or, on the other, ceasing to offer family planning care to high-risk, high-need patients.

48. For me, because of the New Rule, I would be forced to leave the program. As I stated above, I cannot provide the full spectrum of care to a subset of my patients (i.e., those who can afford comprehensive family planning care without public support), while offering substandard care to the most vulnerable patients by shaming them about abortion and coercing them into receiving prenatal care. It is inconceivable to me to provide differing standards of care depending on a patient's means, especially in a manner that is so flagrantly inconsistent with my approach to medical practice and my academic research. As a result, I could no longer be a Title X provider or serve as FWHC's Title X Medical Director.

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

Sarah Prager, M.D., M.A.S.

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[i] American College of Obstetricians & Gynecologists ("ACOG"), *Guidelines for Women's Health Care: A Resource Manual* 719-20 (4th ed. 2014).

[ii] American Medical Association ("AMA") Code of Medical Ethics § 2.1.3.

[iii] American Academy of Pediatrics ("AAP"), Policy Statement: Counseling the Adolescent About Pregnancy Options, *Pediatrics* (Vol. 101, Issue 5, May 1998) at 938; reaffirmed Jan. 2006.

[iv] *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs* ("QFP"), 63 Recommendations & Reports 1, 14 (2014), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.

[v] *Id.* at 4.

[vi] ACOG, *Guidelines for Women's Health Care: A Resource Manual* at 100-01.

[vii] AMA Code of Medical Ethics § 1.2.3.

[viii] QFP at 14.

[ix] U.D. Upadhyay, et al. *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175-83 (2015).

[x] ACOG, *Committee Opinion No. 664: Refusal of Medically Recommended Treatment During Pregnancy*, 127 Obstetrics & Gynecology 175-82 (2016).

[xi] AMA Code of Medical Ethics, § 2.1.1(a).

[xii] Andrea Hsu Roe & Deborah Bartz, *Society of Family Planning Clinical Recommendations: Contraception after Surgical Abortion*, 99 Contraception 2, 2 (2019) (citations omitted); *cf.* QFP at 14 (explaining that a "negative pregnancy test" where the pregnancy was unplanned "also provides an opportunity to discuss the value of making a reproductive life plan" and providing that "[i]deally, these services will be offered in the same visit as the pregnancy test because clients might not return at a later time for contraceptive services").

[xiii] Roe & Bartz, *Society of Family Planning Clinical* at 2.

[xiv] *Id.*

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[xv] *See, e.g.*, Gina M. Secura et al, The Contraceptive CHOICE Project, 203 Am. J. of Obstetrics & Gynecology e1 (2010) (reducing access and information barriers increases long-acting reversible contraception usage and decreases unintended pregnancies); M. Antonia Biggs et al, *Did Increasing Use of Highly Effective Contraception Contributing to Declining Abortions in Iowa?* 91 Contraception 167 (2015) (abortion rate decline); Paul D. Blumenthal et al, *Strategies to Prevent Unintended Pregnancy*, 17 Human Reproduction Update 121 (2011) (unintended pregnancy increases risks of, *inter alia*, low birthweight babies, adverse behaviors, and physical violence by partners).

[xvi] *See* Elizabeth Micks & Sarah Prager, *Plan A: Postabortion Contraception*, 57 Clinical Obstetrics & Gynecology 751 (2014).

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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*
Emily Chiang, WSBA No. 50517

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