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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COUNTY OF SANTA CLARA, TRUST WOMEN SEATTLE, LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT COMMUNITY CENTER, CENTER ON HALSTED, HARTFORD GYN CENTER, MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE ASSOCIATION OF LGBTQ+ PSYCHIATRISTS, AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES and ALEX M. AZAR, II, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

DECLARATION OF LOIS BACKUS, M.P.H., IN SUPPORT OF PLAINTIFFS' MOTION FOR NATIONWIDE PRELIMINARY INJUNCTION

I, Lois Backus, M.P.H., declare as follows

1. I am the Executive Director of Plaintiff Medical Students for Choice ("MSFC"). MSFC is 501(c)(3) non-profit that advocates for full integration of reproductive healthcare, including abortion and contraception, into the curricula at medical schools and residency programs. A copy of my curriculum vitae setting forth my experience, education, and credentials in greater detail is attached as Exhibit A.

2. MSFC is comprised of student-led chapters at medical schools, and these grass-roots, student activists are supported by the national MSFC staff, who implement programming, manage resources, and provide expertise. Medical student activists make up the majority of our Board of Directors, and the MSFC student chapters provide data and information about the state of family planning training at the local-level to guide the strategic planning of the Board.

3. MSFC's central mission is to expand access to health services that allow patients to lead safe, healthy lives consistent with their own personal and cultural values, including with respect to all aspects of sexual and reproductive health. MSFC furthers this mission by supporting future generations of family planning providers in accessing training in abortion and contraception.

4. MSFC has 163 chapters in 45 U.S. states, and another 55 chapters outside of the U.S. We have thousands of current student members across the nation.

5. I submit this Declaration in support of Plaintiffs' challenge to the final rule promulgated by the Department of Health and Human Services ("HHS") relating to "Conscience Rights in Health Care" (the "Rule").

6. Despite this considerable number of students desiring family planning training and the commonality, simplicity, and safety of outpatient abortion,[1] most medical students do not receive training in abortion, and some do not even receive training in contraceptive care. Less than half of our members learned about first-trimester abortion from their schools.

[1] National Academies of Science, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States* 77 (2018) ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.").

7. When future doctors are not educated about abortion and family planning, they are unable to offer their patients the full range of reproductive healthcare.

8. Reproductive choice is only a reality for patients when there are enough family planning providers available to meet patients' needs and such providers are geographically accessible and available in an equitable distribution. Presently, the supply of such providers is not meeting the needs of American patients, in large part because facilities providing abortion are increasingly concentrated in cities, and very few primary care providers are skilled in family planning despite the continuity of care they could offer to patients, especially outside of urban areas.[2] Only a very small number of privately practicing OB/GYNs provide abortion in their practice, and one survey found that 35% of physicians who do not provide abortion do not refer for it either.[3] As threats to abortion training programs increase, this gap widens, further constraining abortion access for patients.[4]

9. Medical schools and residency programs receive substantial funding from HHS. Teaching hospitals receive a significant majority of their training budgets from HHS. In total, HHS provides over $10 billion per year directly and indirectly to teaching hospitals through Medicare, Medicaid, and other funding streams.[5] In 2018, 45 of the 50 top National Institutes of Health grant amounts were to teaching hospitals and medical education programs.[6] Residency

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[2] *See* Susan Yanow, *It Is Time to Integrate Abortion into Primary Care*, 103(1) Am. J. of Pub. Health 14 (2013).

[3] Desai S et al., *Estimating Abortion Provision and Abortion Referrals Among United States Obstetrician-Gynecologists in Private Practice*, 97(4) Contraception 297 (2018).

[4] *See* Jones RK & Jerman J, *Abortion Incidence and Service Availability In the United States, 2014*, 49(1) Persp. on Sexual & Reprod. Health 17 (2017).

[5] Elayne J. Heisler et al., *Federal Support for Graduate Medical Education: An Overview*, Congressional Research Service (Dec. 27, 2018), https://fas.org/sgp/crs/misc/R44376.pdf.

[6] Alex Philippidis, *Top 50 NIH-Funded Institutions of 2018*, Genetic Engineering & Biotechnology News (June 4, 2018), https://www.genengnews.com/a-lists/top-50-nih-funded-institutions-of-2018.

programs are directly subsidized by federal programs—residents receive salaries from Medicare funding, and residency programs bill to Medicare for the services of their residents.

10. I understand that teaching hospitals and residency programs are considered "direct recipients" under the Rule. All of the institutions and programs currently training our student members must immediately comply with the Rule if it goes into effect. Moreover, to the extent that medical students and residents are considered subrecipients under the Rule, a teaching facility may also bear responsibility for the compliance of their students or residents.

11. MSFC fears that the Rule will significantly incentivize the limited number of remaining programs training students and residents in abortion and contraception to discontinue family planning training. MSFC justifiably fears further and extensive reduction in training programs because it has already become aware of extensive threats to such training even prior to the promulgation of the Rule, and the Rule will provide extremely strong incentives for the remaining providers to turn away abortion patients.

12. The national MSFC staff works to guide its student chapters on how to acquire training in family planning and avoid pitfalls imposed by certain institutions or legal requirements constraining access to such training. We monitor the state of abortion and contraception access across the country closely so we can effectively advise our chapters, and we receive data and information about access to abortion training across the 45 states in which our chapters operate.

13. Even when individual students and residents are willing to be trained in abortion care and contraception, and providers are willing to provide such education and services, their institutions may restrict the services they can learn and provide on the basis of religious or moral objection. These objections have already resulted in a severe reduction in the provision of family planning services.

14. For example, four of the ten largest healthcare systems in the United States by hospital count are now religiously-sponsored, a circumstance attributable in part to massive hospital consolidations between Catholic systems and secular institutions. Catholic hospitals now

care for approximately 1 in every 6 hospital patients in the U.S.[7] These hundreds of hospital consolidations have led many facilities to sacrifice family planning services.[8]

15. That is because religiously-affiliated institutions often have guidelines that prevent them from providing comprehensive reproductive healthcare. For example, the U.S. Conference of Catholic Bishops has issued *The Ethical and Religious Directives for Catholic Health Care* Services, which governs all Catholic health institutions and must be adopted by any hospital wishing to merge with a Catholic facility.[9] The *Directives* forbid doctors working in Catholic hospitals from all abortion and contraception procedures and counseling, except "natural family planning."[10] Aside from the direct prohibition on abortion and contraception, the *Directives* significantly restrict postpartum and direct sterilization, including tubal ligation and hysterectomy, elimination of ectopic pregnancy, medical miscarriage management or other fetal loss, screening for fetal anomalies, assisted reproductive technologies like IVF, and HIV and STI prevention counseling.[11] For example, following the merger of Swedish Medical Center ("Swedish") with Providence Health in 2012, the family medicine residency program at Swedish lost access to abortion training, and those residents have had to travel to other states to obtain it. The purchase of the Los Angeles County/University of Southern California family medicine

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[7] Lois Uttley & Christine Khaikin, *Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage Of Medicine Report*, MergerWatch 1 (2016), http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=XlfagUpjX2g9GXDKAyqHQHDUbig%3D.

[8] *See id.*

[9] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (6th ed. 2018).

[10] *Id.* at 19.

[11] *See id.* at 18-19; *see also* Uttley & Khaikin, *supra* note 7, at 1 ("Catholic hospitals operate under ethical directives that prohibit the provision of key reproductive health services (such as contraception, abortion, sterilization and infertility services). We documented instances in which, as a result of these directives, women suffering reproductive health emergencies — including miscarriages — have been denied prompt, appropriate treatment at Catholic hospitals." (citing United States Conference of Catholic Bishops, *supra* note 9)).

program by Dignity Health in 2012 (formerly known as Catholic Healthcare West) resulted in a ban on abortion training and counseling as well as a prohibition on prescribing birth control for all residents.

16. As a result of these mergers and other factors, it is already the case that huge regions of the country in the South and Midwest of the U.S. have deserts of abortion training where no hospitals or training programs offer abortion or contraception training.[12] This compounds the existing gaps in abortion and contraception access by preventing locally-training physicians from becoming skilled in providing family planning services.

17. In such areas, most of the limited opportunities to acquire training in family planning are offered by independent abortion clinics and Planned Parenthood affiliates. But, these facilities are themselves under tremendous strain from state restrictions in the South and Midwest.[13] And some states, including Oklahoma, require medical students to receive training at public hospitals, none of which provide family planning training.

18. There is no place in the country, however, that is not already experiencing threats to abortion training accessibility based on objections to care.[14] We expect that many hospitals that have not already bowed to the pressure from other institutions, members of their own leadership or staff, and/or political controversy to restrict or cease the provision of abortion and contraception, will quickly self-police and cease offering these services in order avoid the possibility of failing to comply with the Rule's vague and unworkable requirements. Further, we expect this self-regulation to take place not only in the South and Midwest, but in regions of the United States where access to reproductive healthcare is often assumed to be untouchable.

19. Several institutions have already bowed to this pressure, demonstrating the likelihood that the Rule will lead many other institutions to self-regulate. For example, the MSFC

[12] *See* Cartwright AF et al., *Identifying National Availability of Abortion Care and Distance From Major US Cities: Systematic Online Search*, 20(5) J. of Med. Internet Res. e186 (2018).

[13] *See id.*

[14] *See id.*

staff has spent two years working with a medical student at a major New York medical school. In 2008, this medical school simply eliminated all abortion information from the medical education curriculum because of the religious concern of a major donor who sat on the Board of the over-arching health system. Since 2017, we have been assisting with producing a proposal to reimplement reproductive healthcare education for medical students at that institution. When asked by an MSFC resident, the medical students indicated that they thought the exclusion of abortion care was normal for American medical schools.

20. Also in New York state, an MSFC alumni treated a patient who was refused service at an emergency room while she was having a pre-viability miscarriage because a fetal heartbeat could still be detected. Although prior to viability, a completion of miscarriage procedure is the standard of care in such circumstances, individuals and institutions with religious and moral objections to abortion often treat these cases as abortion cases. She travelled to another provider, and the hospital and providers who ultimately received the patient further put her in jeopardy when the only anesthesiologist available refused to participate in the completion of miscarriage procedure, even as the patient had begun to hemorrhage.

21. At another major university in the Midwest, the family medicine residency program shut down the abortion training portion of their residency program because they were unwilling to risk the loss of any funding pursuant to a funding restriction that prohibited state funding for training on abortion that was passed in that state. The OB/GYN residency program, which was under separate leadership, elected to use other streams of funding to support their abortion training. Because of that, at that institution, depending on your residency program, even in the overall area of family or reproductive health, you may or may not have access to institutional abortion training due to distinctions in leadership within an overarching structure.

22. At another major east coast university medical school, students can rotate through a clinic for the homeless. Physicians who supervise the rotation are outspoken and anti-choice. As a result, MSFC members who performed the rotation were unable to even counsel patients about

contraception because the supervising physicians informed the students that such care was "upsetting" to them (the physicians).

23. Teaching hospitals—defined as any hospital that provides any training to residents or medical students—are the vast majority of hospitals in the United States. Many training programs also place students at other hospitals in their area. For example, another large medical school sends residents to 5 hospitals. One of these is a Catholic hospital. Based arbitrarily on where they are placed, therefore, residents may not be exposed at all to reproductive healthcare.

24. Catholic hospitals are also not the only religiously-affiliated hospitals that fail to provide reproductive healthcare. Other religiously-affiliated healthcare providers, including Adventist hospitals, do not provide such services.[15]

25. A medical school in Seattle ceased its abortion training due to the adoption of the *Ethical and Religious Directives* and began sending residents to Colorado to receive that training. This imposed significant cost on the program. When Colorado ceased providing training, the program began to send residents to Hawai'i for training at an even greater cost. Few programs will be this committed to training in abortion care.

26. We are familiar with numerous other instances of providers referring to our alumni because they were not allowed to provide the abortion care or contraceptive care needed by a patient at their institution. Even patients seeking to terminate wanted pregnancies due to fetal anomalies or experiencing miscarriage struggle to obtain care if they come across a provider who either refuses to assist or refuses even to provide them with a referral or any other kind of information.

27. Recently, an MSFC alumnus was called in to perform a therapeutic abortion in the second trimester for a patient whose life was endangered by her pregnancy. The hospital treating the patient did not have any trained physicians, and had to bring in an outside physician at considerable expense. These types of costs are also typically passed onto the patient.

[15] Amy Littlefield, *Meet Another Religious Health System Restricting Reproductive Care*, Rewire (Jan. 30, 2019), https://rewire.news/article/2019/01/30/meet-another-religious-health-system-restricting-reproductive-health-care.

28. To the extent that the Rule forces an institution of medical education to comply with onerous and unworkable rules at the risk losing the majority of its funding, we believe that many facilities will simply remove abortion and contraception from their curricula. There are numerous individuals involved in patient care at a major hospital—those responsible for scheduling, cleaning, testing—all before you get to the medical staff. If, under the Rule, all of these people are empowered to delay or deny care or information related to abortion or contraception based on their own beliefs, and the hospital is powerless to intervene without risking loss of all federal funding, the Rule will impose innumerable harms on both patients and healthcare facilities. Rather than risk the loss of funding or an ethical and malpractice crisis related to patients denied and delayed access to care, even in an emergency, many facilities will self-regulate and eliminate contraceptive and abortion services.

29. Aside from the loss of training opportunities for our student and resident members, such a reduction in access to abortion and contraception training will impose significant harm on MSFC as whole by placing even greater strains on our already thinly stretched resources, which even today are insufficient to train all those who need such training outside of their institutions.

30. MSFC alumni are among the shrinking pool of abortion providers across 42 states. These alumni are the primary faculty at our educational programs. We have two sets of programs that we operate for our members who cannot acquire abortion training at their home institutions.

31. First, we run educational seminars that offer intensive education on family planning over several days. We can accept fewer than 500 students a year based on our current budget. This intensive education gives students a full picture of family planning as well as the social and political barriers they may face when seeking to become abortion providers. We also provide abortion training institutes for smaller groups of students. Acceptance to these institutes is competitive. We can accept fewer than 50% of those who apply.

32. Second, we run externship programs through independent clinics and Planned Parenthood affiliates. With the help of these strong allies, we are able to give some of our members a view into the day-to-day provision of care. Our members report that their externship is

mind-opening—not because abortion is controversial—but precisely because of how simple and safe the procedure actually is. Members also have an opportunity to hear the stories of patients seeking abortion first-hand. This externship program is more difficult for residents, as compared with medical students, because they are insured through their training institution's malpractice program, and they must have approval to participate in the program. Residents also have less flexibility in their schedule, and those that are able to take advantage of the program typically do so on vacation or during off-hours.

33. Further complicating the program, the number of clinics providing abortion care is dwindling. According to the most recent data from 2014, the number of facilities in the United States that held themselves out as providers of abortion care on a regular basis has markedly decreased.[16] Almost 90% of counties in the United States do not have an abortion clinic at all,[17] and several states have only one clinic left in the entire state.[18]

34. We financially assist students and residents participating in our training. We typically expend $1,000 to $2,000 per student or resident. These monies are spent on travel, accommodations, administrative fees, and any temporary licensing fees for receiving medical training outside a participant's home state. In total, we are currently spending in excess of $100,000 annually on these expenses, a substantial amount of money for our organization. We anticipate that the Rule could at least double the amount of money we need to spend, and therefore raise, in order to meet the anticipated increase in demand for training opportunities.

35. Although MSFC offers a number of training programs, the existing programs already are unable to meet the need.

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[16] The number of U.S. abortion-providing facilities declined 3% between 2011 and 2014 (from 1,720 to 1,671). Jones & Jerman, *supra* note 4. The number of clinics providing abortion services declined 6% over this period (from 839 to 788). *Id.*

[17] *Id.*

[18] *Bad Medicine: How a Political Agenda is Undermining Abortion Care and Access*, National Partnership for Women & Families (Mar. 2018), http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf.

36. Starting about ten years ago, MSFC began monitoring the impact of efforts to protect individual conscience at the expense of abortion training and patients' access to abortion. MSFC is part of a coalition of groups, including Catholics for Choice and various LGBTQ organizations, that focuses on religious refusals and "conscience rights" around the country. We stay in close contact with this coalition, so we can stay abreast of removals of abortion training and other threats to abortion access at teaching facilities across the country. MSFC has started to train students and residents on the impact of religious and moral refusals in the provision of family planning as well.

37. I have been in reproductive and community healthcare in some form my whole career. I completed a Master of Public Health at Yale, and I spent many years as the Executive Director of Planned Parenthood affiliates.

38. To the extent that the Rule enables almost any hospital staff-person, including some non-medical staff, to refuse to take any action related to an abortion, contraception, or other objected-to care, even in an emergency and without informing the patient, it is the broadest expansion of "conscience rights" that I and MSFC generally have seen or could have anticipated. Were it to take effect, the Rule would be impossible for a hospital to practically implement. Hospitals that provide abortion or have provided abortion already struggle to maintain patient care with medical staff refusing to assist with patients in need of care, as described above.

39. If the Rule goes into effect, the U.S. will see an even more dramatic reduction in the already dwindling number of medical-education institutions where abortion is regularly provided and taught to students and residents. Family planning training in the U.S. is already suffering; and the Rule will immeasurably exacerbate the problem.

40. MSFC would have to try to bridge the gap for highly motivated students. This would mean educating thousands of students a year. There will be many students who we cannot accommodate, and likely many more who will simply give up.

41. We already exist in a national medical system in which most licensed family medicine doctors and OB/GYNs are completely ignorant of both abortion, one of the most

common and extremely safe reproductive procedures for women, and many forms of contraceptive counseling.

42. At MSFC, we believe that licensed physicians have an obligation to serve the needs of their patients. This means that physicians who object to providing care must ensure that their objection does not inhibit the patient from ultimately getting the care that they need in a timely manner. When a provider's personal beliefs conflict with a patient's need for care, medical ethics as well as state and federal law require the needs of the patient to take precedence. Within the medical community, this bedrock principle is clear and well-accepted *outside of the provision of abortion care*, but compromised with respect to family planning, despite the opinions of major medical organizations that this ethical principle is particularly essential in reproductive healthcare.[19]

43. If this Rule goes into effect, abortion may simply fall out of mainstream medical education, and once a medical practice is removed, it may take years to reintroduce it into a complex hospital system.

44. Anti-abortion laws and campaigns have heavily stigmatized abortion and contraception,[20] and the professionals who providers these services.[21] Already, our students face incredible stigma when they relate their interest in becoming abortion providers. In many cases,

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[19] *See, e.g.*, American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion No. 385: The Limits of Conscientious Refusal in Reproductive Medicine*, 110 Obstetrics & Gynecology 1203 (2007) ("Physicians and other health care providers have the 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 patients request."); American Medical Association, *Code of Medical Ethics Opinion 1.1.7: Physician Exercise of Conscience*, Ethics, https://www.ama-assn.org/delivering-care/physician-exercise-conscience (last visited June 6, 2019) ("In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer.").

[20] *See* Norris A et al., *Abortion stigma: a reconceptualization of constituents, causes, and consequences*, 21(3 Suppl) Women's Health Issues S49 (2011); Smith W et al., *Social Norms and Stigma Regarding Unintended Pregnancy and Pregnancy Decisions: A Qualitative Study of Young Women in Alabama*, 48(2) Persp. on Sexual & Reprod. Health 73 (2016).

[21] *See* Norris, *supra* note 20; Freedman L et al., *Obstacles to the integration of abortion into obstetrics and gynecology practice*, 41(3) Persp. on Sexual & Reprod. Health 146 (2010).

once a physician has "outed" themselves as an abortion provider, they become isolated from the mainstream.

45. This Rule institutionalizes this isolation and will make it impossible even for many highly motivated MSFC members to acquire training. The result, should the Rule go into effect, will be compromised access to reproductive healthcare and staggering health consequences for patients across the nation.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: June 6, 2019

Respectfully submitted,

/s/ Lois Backus
Lois Backus, M.P.H., Executive Director
Medical Students for Choice

EXHIBIT A

Lois V. Backus, M.P.H.

Medical Students for Choice
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Lois V. Backus, MPH has been a non-profit chief executive in the reproductive health field for 30 years, with more than 17 years as the leader of Medical Students for Choice, an organization supporting the education and training of medical students in abortion.

Executive Experience -- 1989 through Today

2001 to present **Medical Students for Choice** Philadelphia, PA

Executive Director, responsible for leading an international, grassroots organization of more than 10,000 medical student activists worldwide who are working to make family planning a standard part of medical education and training. Primary programs include supporting 163 medical school chapters in the US and 60 chapters in 24 other countries with educational materials, funding, and training conferences in the US.

- Developed training conferences focusing on filling gaps in medical curricula pertaining to abortion, including the annual Conference on Family Planning and the Abortion Training Institutes. These training programs serve more than 500 US medical students each year.
- Expanded the Reproductive Health Externship Funding Program which places medical students in abortion-providing facilities for an intensive 2 to 4 week educational experience. This program serves between 180 and 200 medical students per year.
- Sustained and expanded MSFC's chapters from 96 to over 200 chapters.

1996-2001 **Planned Parenthood of the Columbia/Willamette** Portland, OR

Executive Director, responsible for all aspects of a 115 employee non-profit women's health and advocacy organization, with headquarters and six satellite facilities across Oregon and southwest Washington.

- Expanded the services provided in the flagship clinic to include reproductive surgeries for both men and women.
- Worked closely in collaboration with other social justice organizations to successfully fight ballot measures that would have hindered vital access to health services.
- Developed local community groups to support the expansion of government subsidized family planning services for the underserved in rural communities across Oregon.
- Opened three new facilities providing abortions, including establishing the first independent, comprehensive women's health clinic in central Oregon**.**

1989-1996 **Planned Parenthood of Central Pennsylvania** York, PA

Executive Director, responsible for leading a non-profit women's health organization serving York County, Pennsylvania. During these seven years, nine new services were added, including abortion services.

Education

M.P.H., Yale University School of Medicine, Department of Public Health, New Haven, CT.
A.B., Political Science and Religion, Mount Holyoke College, South Hadley, MA.

Other Relevant Experience

1988-1989 **Toltzis Communications** Glenside, PA
Project Manager Developed healthcare communications solutions for a marketing firm serving the pharmaceutical industry.

1987-1988 **Abington Memorial Hospital** Abington, PA
Coordinator, Community Health Education Provided medical screening and health education to a community of 100,000 people, including planning and implementing large community events.

1985-1987 **People's Medical Society** Emmaus, PA
Director of Policy Affairs Managed a nationwide grassroots organizing project focused on health care access for seniors.

1983-1984 **Community Treatment Complex** Worcester, MA
Program Coordinator Managed a residential treatment program for emotionally disturbed adolescents.

1980-1982 **Centers for Disease Control** Nashville, TN
Public Health Advisor Coordinated a federal sexually transmitted disease tracking program.

1978-1979 **Peace Corps** Kabul, Afghanistan
Volunteer Teacher Taught English and Business Mathematics to vocational college students.