

Exhibit 3

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

AMERICAN COLLEGE OF
OBSTETRICIANS AND
GYNECOLOGISTS, *et al.*,

Plaintiffs,

vs.

UNITED STATES FOOD AND DRUG
ADMINISTRATION, *et al.*,

Defendants.

CIV. NO.

[CIVIL RIGHTS ACTION]

**DECLARATION OF HEATHER L.
PALADINE, M.D., M.ED., FAAFP, IN
SUPPORT OF PLAINTIFFS' MOTION
FOR PRELIMINARY INJUNCTION**

Heather L. Paladine, M.D., M.Ed., FAAFP, declares and states as follows:

1. I make this declaration based on my own personal knowledge. If called to testify, I could and would do so competently as follows.
2. I am a family medicine doctor licensed in New York, providing primary and maternity care at both a hospital and a low-income community health center. I am an Assistant Attending Physician at New York Presbyterian Hospital; the Residency Director of the New York Presbyterian Hospital Family Medicine Residency; and an Assistant Professor of Medicine at Columbia University Medical Center's Center for Family and Community Medicine. My practice is located at the Herman "Denny" Farrell, Jr. Community Health Center in New York, New York.
3. I am a member and serve on the Board of Directors of the New York State Academy of Family Physicians ("NYSAFP"). NYSAFP, a non-profit

advocacy organization, is the New York State chapter of the American Academy of Family Physicians. NYSAFP represents family medicine and family practice physicians throughout New York State in areas of policy, education, clinical and leadership development, and patient engagement, with the goal of improving the quality of family medicine. NYSAFP has over 3,000 practicing physician members and over 500 medical resident members, collectively serving millions of patients. Members practice in almost every county in New York State, in practice settings ranging from New York City to some of the state's most rural counties.

4. I received my undergraduate degree from Columbia College in 1992, and my medical degree from Mount Sinai School of Medicine in 1996. In 1999, I completed my residency in Family Medicine at Oregon Health and Science University. In 2000, I completed a fellowship in Maternal and Children's Health Care with the University of Southern California's Family Medicine Residency Program. In 2014, I received a Master's in Medical Education from the University of Cincinnati College of Education, Criminal Justice and Human Services and Cincinnati Children's Hospital.

5. I work at a community health center providing a range of primary care and have specific expertise in women's health. I also work in Labor and Delivery at New York Presbyterian Allen Hospital, where I supervise family medicine

residents. Allen Hospital has many COVID-19 patients and I now provide care to those patients in a rotating hospital shift.

6. I submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction. I do so only in my individual capacity and as a member of NYSAFP, not on behalf of any institution with which I am affiliated. The Mifepristone In-Person Dispensing Requirement, which requires patients to obtain mifepristone only in person at a clinic, medical office, or hospital, has forced me to deny medication abortion care to my patients, even though I can provide that care safely and effectively via telehealth, because my office has been closed due to the COVID-19 pandemic. Even as we begin to slowly see patients in person again, the In-Person Dispensing Requirement forces me to unnecessarily expose my already vulnerable patients to heightened risks of COVID-19 exposure and to delay their care.

My Practice and My Patients

7. My primary practice is located at the Herman "Denny" Farrell, Jr. Community Health Center, which is a community-based family health center owned by New York Presbyterian Hospital. The Farrell Health Center is located in the Washington Heights community of Upper Manhattan. As of March 2020, it is one of several outpatient sites in New York Presbyterian's Ambulatory Care Network that provides primary care in Upper Manhattan.

8. I provide a full range of family medicine care, such as adult chronic disease management, child well visits, and prenatal and postpartum care. I also regularly provide medication abortion care to patients at the Farrell Health Center, and I am the principal faculty member supervisor for residents during medication abortion visits.

9. The Farrell Health Center was established to meet the needs of underserved patients in Washington Heights and, in accordance with its mission, does not serve patients with private health insurance. All of Farrell Health Center's patients are low-income, and the vast majority are either uninsured or have income levels that qualify them for Medicaid.

10. The patients at the Farrell Health Center reflect the demographics of Washington Heights and the surrounding communities of Inwood, Harlem, and the Bronx. Almost all of my patients are people of color. At least 75% of my patients are Latinx, and many of my patients identify as Black or African American. The Farrell Health Center has a longstanding relationship with the significant Dominican community in Washington Heights. I also often see patients who are new immigrants from Mexico and Central and South America. About half of my patients speak only Spanish. I provide services in both English and Spanish to meet these patients' needs—indeed, the New York Presbyterian Hospital Family

Medicine Residency program offers a medical Spanish curriculum for providers serving these communities.

The Effect of the COVID-19 Crisis on My Practice and My Patients

11. As has been well-documented in the media, the COVID-19 emergency has been particularly grave in New York City. By some accounts, New York State's caseload exceeds that of any other country in the world, and the majority of those cases are concentrated in New York City.¹ When adjusted for age, the fatality rate of COVID-19 in New York City is about twice as high for Black and Latinx residents as for white residents.² COVID-19 presents a higher risk of severe illness and fatality for adults with preexisting conditions, such as obesity and hypertension. These conditions are common among the Farrell Health Center's patients.

12. On March 22, 2020, New York State implemented the "PAUSE" Plan, an executive order designed to minimize the transmission of COVID-19. PAUSE mandates, among other things, closure of non-essential businesses, strict social distancing, and limited use of public transportation. PAUSE also

¹ Chris Mooney & Ben Guarino, *A stunning 1 in 100 New York Residents have now tested positive for coronavirus*, WASHINGTON POST (Apr. 13, 2020), <https://www.washingtonpost.com/health/2020/04/13/stunning-1-100-new-york-residents-have-now-tested-positive-coronavirus/>.

² N.Y.C. DEP'T OF MENTAL HEALTH & HYGIENE, *COVID-19: Data Summary* (May 19, 2020), <https://www1.nyc.gov/site/doh/covid/covid-19-data.page>.

recommends that providers and patients utilize telehealth to minimize unnecessary in-person visits. The PAUSE Plan is currently in effect in New York City through at least May 28, 2020, and may be extended further.

13. In response to the COVID-19 emergency in New York City, New York Presbyterian consolidated its community-based family health centers. In March, the Farrell Health Center switched the vast majority of its scheduled in-person appointments to telehealth visits and closed for in-person visits; it only re-opened on May 21, 2020. During our office closure, I exclusively served Farrell Health Center patients through telehealth visits. Even before our office closure, we were essentially performing telehealth even *within* the office during in-person visits; to minimize the duration of face-to-face contact, our providers would often conduct certain screening and counseling via telephone from one examination room while the patient was located in a different examination room.

14. Even though our office recently reopened, our capacity is so limited that we cannot yet offer medication abortion appointments. As an initial matter, we substantially modified our practice and severely limited the number of patients we see in order to ensure proper social distancing and reduce, as much as possible, the possibility of COVID-19 transmission. We currently only allow for one patient appointment at a time. At present, our office plans to operate at around 10% of our previous in-person capacity. Given the ongoing threat of COVID-19, I estimate

that we will operate at around 25% of our previous in-person capacity through at least Spring 2021. Thus, it will be very challenging for my patients who need abortion care to get an appointment for the foreseeable future and being able to provide medication abortion through telehealth will continue to be critically important.

15. As a result of the In-Person Dispensing Requirement, I have been completely unable to provide medication abortion care to my patients, because my office has been closed and thus my patients could not come in to pick up their mifepristone prescription. If there is another major outbreak of COVID-19 in New York City and my office closes again, I will again be entirely barred from providing this urgent service—not for any medical reason, but solely because I do not have a physical office where the patient can be handed her medication.

16. If the In-Person Dispensing Requirement were suspended, I would be using telehealth to evaluate my patients' eligibility for medication abortion, provide comprehensive counseling (including reviewing the FDA's required "Patient Agreement" form), and obtain and document informed consent – like I would do for any other medication I prescribe. Then, for those patients whose eligibility for medication abortion can be determined without an in-person assessment (that is, through patient reporting of last menstrual period, symptoms, medical history, and/or results of home pregnancy tests), I could simply mail the

medication directly or call in a prescription to a mail-order pharmacy. This would permit me to provide medication abortion to a substantial percentage of my patients to whom I cannot currently provide care.

17. I have a longstanding relationship with many of my patients and see many of them regularly for ongoing prenatal, postpartum, or chronic disease management care. Many of my patients express relief that they can also turn to me when they need abortion care. But the In-Person Dispensing Requirement forces me to deny them medication abortion care.

18. For instance, I recently conducted a telehealth visit with a long-time patient for whom I have provided both prenatal and postpartum care. The patient has two young children, including an eight-month-old infant. During a postpartum care visit, the patient shared with me that she missed her period, and wanted to discuss her options for abortion care. Because my office was closed for in-person visits and because I cannot provide medication abortion services via telehealth, I could not provide her the care she needs. When I last heard from her, several weeks later, she still had not been able to get the care she needed.

19. The ability to use telehealth is a critical tool to ensure that my patients can get appropriate access to urgent care without unnecessarily putting themselves, and our providers and staff, at risk for COVID-19 exposure by traveling for in-person care. The vast majority of my patients cannot afford private transportation

and rely on the subway and buses to get to work and medical appointments. And many of my patients work in essential jobs that are particularly high-risk during this pandemic—for example, as home health aides in private residences throughout New York City. As a result, my patients are both more vulnerable to COVID-19 exposure themselves, and at higher risk of spreading COVID-19 to others. And yet, the In Person Dispensing Requirement forces them to take an unnecessary trip on the subway and/or bus system, increasing the risk to their health and lives (and those of others), for the sole purpose of picking up a pill that I could otherwise mail to them. It seems to me unconscionable that the government would impose this risk on my patients without any justification.

20. In addition, the In-Person Dispensing Requirement exacerbates other barriers and harms that patients are facing during the COVID-19 crisis. For example, as a general rule, we are instructing patients not to bring their children with them to health care visits to minimize exposure risks. But many of my patients have children who are too young to be left unsupervised. And many of these patients are single parents or have partners who work in essential jobs with minimal leave. With schools and day care facilities closed and people sheltering-in-place, many of my patients will have no childcare assistance. These patients will either have to forego care, leave their children with others in their community who may be at high risk of infection, or have their children travel with them through the

city and to my office, increasing their risk of exposure to the virus. If it were not for the In-Person Dispensing Requirement, my patients would not face this untenable choice.

My Telehealth Use During the COVID-19 Crisis

21. Patients seeking medication abortion care are the only group of patients that I am barred from treating via telehealth even where, in my clinical judgement, telehealth would be appropriate. As a result, I cannot provide these patients care while the Farrell Health Center is operating at minimal capacity.

22. While the Farrell Health Center was closed, I otherwise provided all of my care for Farrell Health Center patients through telehealth visits, including the chronic disease management and prenatal and postpartum care that I would offer in-person if not for the COVID-19 pandemic. Because our office is operating at minimal capacity because of COVID-19, I am continuing to provide the vast majority of my care through telehealth and expect to do so for the foreseeable future. During these telehealth visits, I provide comprehensive patient counseling and secure and record the patient's informed consent when in accordance with the standard of care. Many of these telehealth visits are no different than an in-person visit. Patients share their symptoms and any relevant metrics with me and I counsel them on a course of treatment, just as I would during an office visit.

23. For example, my patients with diabetes share their glucose monitor results with me via phone or video conference, just as they would during an in-person visit, so that I may advise them on their insulin dose in real time. I have also transitioned the majority of my prenatal care visits to telehealth appointments. I issued each of my prenatal patients a prescription for an at-home blood pressure monitoring cuff, so that patients can monitor their blood pressure and share the results with me from home. Just like in-person prenatal appointments, I spend much of these visits asking patients how they have been feeling and discussing any symptoms they have been experiencing.

24. In order to best protect our patients, I and many other medical professionals are also using telehealth for acute patient needs, such as when the patient reports symptoms consistent with a urinary tract infection or a vaginal bacterial infection—even when we might otherwise use in-person testing to rule out other serious infections or conditions. Given the risk of COVID-19 exposure, in these and many other circumstances, it is safer for me to follow up with a patient to confirm that an initial round of treatment cleared up their symptoms than to require my patient to undergo a potentially unnecessary in-person test before receiving treatment.

25. In addition to mail-order pharmacies, many pharmacies in New York City offer delivery services, and my telehealth patients who need to fill

prescriptions have the option to have their medications delivered to their homes. In other words, many of my patients can participate in a medical appointment and receive prescription drug treatment without leaving their apartments. These innovations in health care delivery have been literally life-saving during this crisis.

26. The In-Person Dispensing Requirement is the only barrier to my continuing to provide care for patients seeking medication abortions. If the In-Person Dispensing Requirement is suspended, I could quickly begin to provide medication abortion care via telehealth to those patients for whom, in my professional judgment, no in-person assessment is necessary to confirm eligibility for mifepristone. As discussed above, I am already conducting telehealth visits with all of my other patients, and there is tremendous buy-in and infrastructure for telehealth across my health care system, the medical community at-large, and even the state government.

27. My inability to mail mifepristone denies my patients access to abortion care and creates unnecessary risks to the health and lives of other already vulnerable patients. Telehealth is regarded as a best practice during the COVID-19 emergency, and if not for the In-Person Dispensing Requirement, I could and would safely provide medication abortion care to eligible patients via telehealth.

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

Executed on May 22, 2020.

A handwritten signature in black ink, appearing to read "Heather L. Paladine", is written over a horizontal line.

Heather L. Paladine, M.D., M.Ed., FAAFP