IN THE SUPREME COURT OF THE STATE OF ALASKA

Planned Parenthood of the Great Northwest, Jan Whitefield, M.D., Susan Lemagie, M.D., *Appellants/Cross-Appellees*, *v.* State of Alaska, Loren Leman, Mia Costello, & Kim Hummer-Minnery, *Appellees/Cross-Appellants*.	**Supreme Court Nos. S-15010, S-15030, S-15039** **Superior Court No. 3AN-10-12279CI**

BRIEF OF AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS, NATIONAL ASSOCIATION OF SOCIAL WORKERS, NATIONAL ASSOCIATION OF SOCIAL WORKERS, ALASKA CHAPTER, SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE AND AMERICAN PSYCHIATRIC ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLANTS

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INTERESTS OF *AMICI CURIAE*

Sharing more than 57,000 members, the American College of Obstetricians and Gynecologists and the American Congress of Obstetricians and Gynecologists (collectively, "ACOG") are the leading professional associations of physicians who specialize in the health care of women. The American College of Obstetricians and Gynecologists is a non-profit educational and professional organization founded in 1951. The College's objectives are to foster improvements in all aspects of health care of women; to establish and maintain the highest possible standards for education; to publish evidence-based practice guidelines; to promote high ethical standards; and to encourage contributions to medical and scientific literature. The College's companion organization, the American Congress of Obstetricians and Gynecologists, is a professional organization dedicated to the advancement of women's health and the professional interests of its members. The Alaska Section of the Congress has 90 members who provide health care to women in Alaska.

Established in 1955, the National Association of Social Workers ("NASW") is the largest association of professional social workers in the world with nearly 140,000 members and 56 chapters throughout the United States and internationally. The NASW, Alaska Chapter represents 417 members. With the purpose of developing and disseminating standards of social work practice while strengthening and unifying the social work profession as a whole, NASW provides continuing education, enforces the NASW *Code of Ethics*, conducts research, publishes books and studies, promulgates

professional criteria, and develops policy statements on issues of importance to the social work profession. The NASW policy, *Adolescent Pregnancy and Parenting*, supports a range of services to help address teen pregnancy including "services and supports that are safe, legal, affordable, and confidential; comprehensive health education and services for all adolescents; a comprehensive approach to sexuality for adolescents" and "comprehensive family planning services for all adolescents." *Social Work Speaks* 8, 11 (9th ed. 2012). NASW's policy statement, *Family Planning and Reproductive Choice*, opposes "limits and restrictions on adolescents' access to confidential reproductive health services, including contraceptive and abortion services, and the imposition of parental notification and consent procedures." *Social Work Speaks* 129, 134.

The Society for Adolescent Health and Medicine ("SAHM") is a multidisciplinary organization composed of health care professionals who have dedicated their lives to the care of adolescents. SAHM is committed to improving the physical and psychosocial health and well-being of all adolescents. SAHM works to promote public and professional awareness of the health-related needs of adolescents and supports confidential access to quality health care, including reproductive health services, for all adolescents.

The American Psychiatric Association, with more than 36,000 members, is the Nation's leading organization of physicians who specialize in psychiatry. The American Psychiatric Association opposes constitutional amendments, legislation, and regulations that impede the provision of family planning and abortion services to any segment of the

population. The American Psychiatric Association has reaffirmed its long-held position that the freedom to interrupt pregnancy must be considered a mental health imperative with major social and mental health implications.

INTRODUCTION

Contrary to the assertions made by the superior court, the delay caused by compliance with Alaska's Parental Notification Law ("PNL"), AS §§ 18.16.010 *et seq.*, poses much more than a minimal risk to a minor's health. Although abortion is among the safest of medical procedures, particularly as compared to the alternative of carrying a pregnancy to term, the risks associated with abortion increase as the pregnancy progresses. Assuming mandated parental involvement does not preclude a minor from seeking help entirely, she may take days or weeks longer to effectuate the required notification or navigate the mandated judicial alternative, potentially exposing her to a less safe and more complex procedure than had she been able to obtain an abortion without delay.

The superior court also makes the unwarranted determination that minors who elect to seek abortions are on different footing from minors who carry their pregnancies to term. But the same concerns that first motivated Alaska to enact its medical emancipation law—that minors might avoid or delay obtaining needed reproductive health services if forced to confront their parents first—apply with equal force to minors seeking an abortion. Indeed, as the superior court itself acknowledged no evidence to support the conclusion that a minor is too immature to decide whether to abort, yet

mature enough to assume the risks and responsibilities of carrying a pregnancy to term and becoming a teenage parent. No justification exists for treating these two groups of minors differently.

The superior court also sought to justify Alaska's PNL on grounds that it would increase family cohesiveness. Research belies this claim. Studies have demonstrated that even in the absence of parental notice laws, a majority of minors consult with their parents or another trusted adult regarding their abortion decision. But those minors who do not consult with their parents typically have good reason for choosing not to do so, as they fear they will be subjected to physical abuse or forced to leave the family home. For these minors, parental notification laws pose real danger.

ARGUMENT

I. THE SUPERIOR COURT CORRECTLY FOUND THAT ABORTION IS SAFER FOR MINORS THAN CARRYING A PREGNANCY TO TERM AND DOES NOT DETRIMENTALLY AFFECT MENTAL HEALTH

As recognized by the superior court, abortion is one of the safest medical procedures available today, particularly as compared to the alternative of carrying a pregnancy to term.[1] Consistent with the great weight of scientific evidence, the superior

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[1] *See* Superior Court Decision & Order ("Order") 7 ("Induced abortions are very safe in the United States.") & 7-8 (observing that while "[d]elivery mortality rates are also miniscule compared to most other surgical mortality rates," complications resulting from pregnancy "are significantly more varied and health-threatening than abortion-related ones"); *see also* Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstet. & Gynecol. 729, 736 (2004) ("Legal induced abortion-related deaths occur only rarely."); Grimes & Creinin, *Induced Abortion: An*

court further found that there is no causal link between abortion and an increased risk of psychological harm.[2] The superior court nevertheless seems to rely on these findings to justify its erroneous conclusion that the risks associated with delaying an abortion to comply with Alaska's PNL are minimal. They are not. Not only do the risks associated with abortion rise quickly with delay, but requiring parental notification may deter minors from seeking needed reproductive health services at all.

A. The Physical Risks Of Abortion Are Less Than The Risks Of Carrying A Pregnancy To Term

The superior court correctly recognized that induced abortion is not only one of the *least* risky procedures in modern medicine, but, as well-accepted statistics show, abortion is far safer than its only alternative of carrying a pregnancy to term.[3] The mortality rate for all abortions is between 0.6-0.7 per 100,000 procedures, whereas the mortality rate for full-term pregnancy is 7.1 per 100,000 births.[4] The mortality rate for adolescents who give birth is even higher, at twice that of adult women.[5]

Overview for Internists, 149 Annals Internal Med. 620, 623 (2004) ("Abortion is one of the safest procedures in contemporary practice.").

2 *See* Order 9 ("[A]bortion does not detrimentally affect mental health.").

3 *See id.* at 7 ("The safest obstetrical delivery is 20 times more hazardous than a first-trimester abortion or 15 times more hazardous than a second trimester one."); *see also* Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet. & Gynecol. 215, 215, 217 (2012); Darney Trial Test., 57, Feb. 13, 2012.

4 Raymond & Grimes, 119 Obstet. & Gynecol. at 215; Bartlett et al., 103 Obstet. & Gynecol. at 734; Darney Trial Test., 51-52.

5 Klein et al., *Adolescent Pregnancy: Current Trends and Issues*, 116 Pediatrics 281, 283 (2005); *see also* Darney Trial Test., 57-58.

Indeed, every complication is more common among women carrying a pregnancy to term than among those having abortions.[6] As the superior court correctly found, complications from abortion "are relatively rare and generally resolved by an obvious, immediate medical response" before the patient even leaves the clinic.[7] Hospitalization due to an abortion is "vanishingly rare."[8] By comparison, as many as one in eight women are hospitalized for complications related to pregnancy apart from childbirth, including hemorrhage, infection, pre-eclampsia and eclampsia (conditions caused by a rapid rise in blood pressure), and worsening of preexisting medical conditions (*e.g.*, diabetes, asthma and other lung conditions, heart disease, lupus, and some cancers).[9] Notably, these pregnancy-related risks are appreciably higher in adolescents than in adult women.[10] With respect to childbirth itself, vaginal delivery presents the additional risks of hemorrhage, infection, and laceration of the cervix.[11] As observed by the superior court, "[t]he risks of vaginal delivery are considerably greater for adolescents than for women with fully developed bodies, including the risk of an obstetrical fistula."[12] And should a

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6 Raymond & Grimes, 119 Obstet. & Gynecol. at 216-217.

7 Order 7, 17.

8 *Id.* at 8.

9 Darney Trial Test., 60-61; Order 8 ("Hospitalizations during pregnancy occur 15 percent of the time, but are vanishingly rare for abortions."); Wallis et al., *Secular Trends in the Rates of Preeclampsia, Eclampsia, and Gestational Hypertension, United States, 1987-2004*, 21 Am. J. Hypertension 521, 523-524 (2008).

10 Order 8; Wallis et al., 21 Am. J. Hypertension at 523-524.

11 *See* Darney Trial Test., 68.

12 Order 8.

woman deliver via Caesarean section, a result that is more likely among adolescent women (for which Alaska law does not require any parental involvement[13]), she faces the potential of injury to her surrounding organs (*e.g.*, bladder and bowel), hemorrhage, infection, as well as those risks associated with receiving anesthesia to undergo this major invasive surgical operation.[14]

Given these facts, the State's attempts to justify Alaska's PNL on maternal health grounds are neither credible nor persuasive. First, the State's experts made much of the fact that abortion, like any medical or surgical procedure, carries some health risks.[15] However, as discussed *supra*, the lower *comparative* risk of induced abortion versus carrying a pregnancy to term reveals the fallacy of using this argument to justify a restriction only on abortion. Second, the State's experts pointed to studies indicating a purported link between abortion and the risk of pre-term birth in subsequent pregnancies, stressing the attendant risks to the woman.[16] But this argument is equally misleading, because it similarly fails to acknowledge that adolescents are far more likely to deliver pre-term than are adults, making pre-term birth a serious risk for minors *carrying a*

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13 *See* AS § 25.20.025(a)(4).

14 *See* Darney Trial Test., 69-71.

15 *See, e.g.*, Thorp Trial Test., 1619-1621, Feb. 27, 2012; Anderson Trial Test., 1682-1689, Feb. 27, 2012.

16 Thorp Trial Test., 1620-1621.

pregnancy to term.[17] It is irrational to require parental notice of abortion in the name of protecting minors from pre-term birth in subsequent pregnancies when Alaska does not require parental notice for minors to carry a pregnancy to term, which is at least as likely to result in a pre-term birth. Finally, the State's experts' erstwhile attempts to link abortion with breast cancer—a contention the State itself appears to have abandoned and did not even attempt to introduce such evidence at trial—are similarly unavailing. Exhaustive research by leading medical organizations in cancer research has determined conclusively that there is no link between abortion and breast cancer, either in minors or in adult women.[18]

B. Abortion Does Not Cause Psychological Harm To Minors

The weight of existing scientific evidence also shows that there is no causal connection between abortion and increased risk of psychological harm. Consistent with

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[17] *See* Meis et al., *Factors Associated with Preterm Birth in Cardiff, Wales*, 173 Am. J. Obstet. & Gynecol. 597 (1995).

[18] ACOG Committee Opinion No. 434, *Induced Abortion and Breast Cancer Risk* (June 2009, reaffirmed 2011), *available at* http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_On_Gynecologic_Practice/Induced_Abortion_and_Breast_Cancer_Risk.aspx (citing, *inter alia*, Beral et al., *Breast Cancer and Abortion: Collaborative Reanalysis of Data from 53 Epidemiological Studies, Including 83,000 Women With Breast Cancer From 16 Countries*, 363 The Lancet 1007, 1014 (2004) ("Hence, the totality of the worldwide epidemiological evidence indicates that pregnancies ending as either spontaneous or induced abortions do not have adverse effects on women's subsequent risk of developing breast cancer."); National Cancer Institute, *Summary Report: Early Reproductive Events and Breast Cancer Workshop* (2010), *available at* http://www.cancer.gov/cancertopics/ ere-workshop-report ("Induced abortion is not associated with an increase in breast cancer risk.")).

the mainstream scientific consensus, the superior court correctly found that "abortion does not detrimentally affect mental health."[19] Rather, the best predictor for a woman's mental health following an abortion is her mental health preceding it.[20] As Dr. Nada Stotland explained at trial, the American Psychological Association ("APA") has conducted a comprehensive and critical review of the scientific literature relating to psychological responses after abortion and concluded that abortion does not pose a psychological hazard to the vast majority of women.[21] In medicine and science, there is a basic, fundamental distinction between correlation and causation: Just because there is a correlation between two variables does not mean that there is a causal association.[22] Consistent with this distinction, the report of the APA's Task Force on Mental Health and Abortion found that while "some women do experience sadness, grief, and feelings of loss following termination of a pregnancy, and some experience clinically significant disorders," the evidence does *not* show "that an observed association between abortion history and mental health was caused by the abortion per se, as opposed to other factors," such as, for example, poverty.[23] The APA Task Force further found that "[t]he best

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19 Order 9.

20 Stotland Trial Test., 463, Feb. 15, 2012; *see also* Order 9.

21 Stotland Trial Test., 467-470; *see also* Major et al., *Report of the APA Task Force on Mental Health and Abortion* 90-91(2008), *available at* http://www.apa.org/pi/women/programs/abortion/mental-health.pdf ("APA Task Force Report").

22 APA Task Force Report 19.

23 APA Task Force Report 4, 19 (emphasis added); *see also* Munk-Olsen et al., *First-Time First Trimester Induced Abortion and Risk of Readmission to a Psychiatric Hospital*

scientific evidence published indicates that among adult women who have an *unplanned pregnancy* the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy."[24]

Subsequent reviews of available evidence have reached conclusions nearly identical to the APA.[25] Indeed, in its 2011 comprehensive review of the scientific evidence, the Academy of Royal Medical Colleges concluded that the "rates of mental health problems for women with an unwanted pregnancy were the same whether they had

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in Women With a History of Treated Mental Disorders, 69 Arch. Gen. Psychiatry No. 159, 164 (Feb. 2012) (finding that "first-time first-trimester induced abortion does not influence the risk of readmission to psychiatric facilities" in study population that included "potentially vulnerable women with records of at least 1 previous psychiatric admission" and "[r]isk of rehospitalization was [instead] significantly predicted by the number of days since previous discharge").

[24] APA Task Force Report 4.

[25] *See, e.g.*, Steinberg & Finer, *Examining the Association of Abortion History and Current Mental Health: A Reanalysis of the National Comorbidity Survey Using a Common-Risk-Factors Model*, 72 Soc. Sci. & Med. 1, 9 (2010) (finding that "pre-pregnancy mental health should be taken into account because it is a risk factor for having both subsequent abortions and later mental health problems" and study "suggest[s] that focusing on abortion as the cause of mental health problems is not warranted"); Robinson et al., *Is There an "Abortion Trauma Syndrome"? Critiquing the Evidence*, 17 Harv. Rev. Psychiatry 268, 276 (2009) ("The most well controlled studies continue to demonstrate that there is no convincing evidence that induced abortion of an unwanted pregnancy is per se a significant risk factor for psychiatric illness."); Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 Contraception 436, 448-449 (2008) ("A clear trend emerges from this systematic review: the highest quality studies had findings that were mostly neutral, suggesting few, if any, differences between aborters and their respective comparison groups in terms of mental health sequelae. Conversely, studies with the most flawed methodology consistently found negative mental health sequelae of abortion.").

an abortion or gave birth."[26] Although there is less focus in scientific literature on the psychological responses of adolescents, a study that did focus on adolescents found no evidence either that women under 18 are at greater risk of suffering adverse psychological consequences from having an abortion than are women over 18, or that adolescents who had abortions are at greater risk for psychological distress than adolescents in the general population.[27]

The State's experts sought to undercut these authoritative findings by claiming that there are too many confounding factors to reach a conclusion on abortion's impact on mental health.[28] These experts, however, cited no studies to rebut the conclusions of either the APA or the Academy of Royal Medical Colleges.[29] Nor did the State's experts

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[26] Academy of Medical Royal Colleges, by National Collaborating Centre for Mental Health, *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors* 8 (Dec. 2011), *available at* http://www.nccmh.org.uk/reports/ABORTION_REPORT_WEB%20FINAL.pdf ("Report of the Academy of Medical Royal Colleges").

[27] *See* Pope et al., *Post-Abortion Psychological Adjustment: Are Minors at Increased Risk?*, 29 J. Adolescent Health 2 (2001); Warren et al., *Do Depression and Low Self-Esteem Follow Abortion Among Adolescents? Evidence from a National Study*, 42 Perspectives on Sexual & Reproductive Health 230, 233 (2010) ("The young women in this study who had an abortion were no more likely to become depressed or have low self-esteem within the year of the pregnancy or five years later than were their peers whose pregnancies did not end in abortion."); Quinton et al., *Adolescents and Adjustments to Abortion: Are Minors at Greater Risk?*, 7 Psychol., Pub. Policy & Law 491, 507 (2001) ("[M]inors are not at greater risk than adults for postabortion depression either in the short-term or long-term.").

[28] Thorp Trial Test., 1625-1627; Casey Trial Test., 1953-1958, Feb. 29, 2012.

[29] Notably, the most significant study which claimed to find flaws in the APA's Task Force Report (Coleman, *Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995-2009*, 199 Brit. J. Psychiatry 180, 180, 185 (2011)),

present any other evidence to undermine the superior court's amply supported factual finding that "abortion does not detrimentally affect mental health."[30]

C. Delaying Abortions Increases Risk To The Minor

Despite its factual findings regarding the relative safety of abortion as compared to carrying a pregnancy to term, the superior court concluded that while "[t]he process of parental notice may delay a minor's abortion," the risks associated with such delay "do[] not increase precipitously" as "material risk factors increase by weeks rather than by days."[31] The superior court's reasoning is fundamentally flawed in multiple respects.

First, the superior court's seeming assumption that compliance with Alaska's PNL would result in only minor delays not longer than a few days fails to acknowledge that mandated parental involvement may cause some minors to avoid seeking medical help

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has itself been widely criticized "for violating several established guidelines for conducting meta-analyses, failing to evaluate the quality of included studies, not adhering to [the author's] own exclusion and inclusion criteria, and including studies that did not adjust for prepregnancy mental health." *See* Dreweke, Guttmacher Institute, *Study Purporting to Show Link Between Abortion and Mental Health Outcomes Decisively Debunked* (Mar. 5, 2012), *available at* http://www.guttmacher.org/media/nr/2012/03/05/index.html; *see also* Report of the Academy of Medical Royal Colleges 14 (observing with respect to the Coleman meta-analysis that "[d]etails of the search strategy and the number of papers retrieved in the search were not provided, nor was it clear why certain papers and outcomes were excluded"; studies relied on were "not required to control for mental health problems prior to the abortion"; and "[p]revalence rates of mental health problems and factors associated with poorer outcomes were not included in the review and meta-analysis").

30 Order 9.

31 *Id.* 9 (citing expert testimony from John Thorp).

entirely.[32] Moreover, as multiple expert witnesses made clear at trial, those minors who ultimately decide to seek an abortion could be delayed for several weeks as they are confronted with the difficult choice of informing their parents of their pregnancies or navigating an unfamiliar legal system for purposes of having a judge determine whether they are mature enough to make the decision absent a parent's involvement.[33] In other words, while the superior court focused solely on the forty-eight-hour delay imposed by the PNL's notification protocol and the expeditiousness of the bypass procedures themselves, the uncontradicted evidence makes clear that these delays are only part of the equation. The very existence of a mandatory parental involvement law will cause many pregnant minors to delay *for weeks* before seeking out abortion care in the first place due to fear of mandated parental notice or of going to court to seek a judicial bypass.[34] The superior court acknowledged that delays of this magnitude "meaningfully increase[]

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32 Pinto Trial Test., 323-324, Feb. 14, 2012 (observing based on her personal experience that mandated parental notification laws cause some minors to "run away"; "take[] matters into their own hands" by seeking "illegal abortions" or fashioning "their own remedies … to try to induce an abortion"; or "attempt[ing] suicide as [a] means of dealing with that" in order to avoid having to confront their parents).

33 *See* Santelli Trial Test., 210-211, Feb. 14, 2012 (judicial bypass may be "daunting" and may delay the decision until where abortion is no longer available); Darney Trial Test., 80-81 (delay is likely to be one or two weeks, beyond what is required for the judicial bypass); Pinto Trial Test., 321-322 (average delays can be up to six weeks).

34 Darney Trial Test., 79-81; Pinto Trial Test., 321-324.

risk,"[35] but appears to assume that the PNL would not lead to such delays. As this evidence shows, that assumption is unwarranted.

In any event, the risks associated with any delay may be significant. In particular, a first-trimester abortion is twenty times safer than carrying the pregnancy to term, while a second-trimester abortion—although still a very low-risk medical procedure—is only fifteen times safer than carrying a pregnancy to term.[36] As explained at trial, later abortions are necessarily more complex as they require "more prolonged cervical dila[]tion, instrumentation of the uterus, [and] increased risk of perforation."[37] Delay may also foreclose the option of a medical abortion, which is available only through the first 63 days of pregnancy; at trial, experts testified that medical abortions are often preferable to surgical abortions because "people ... prefer the privacy of taking these drugs at home and having what's more like a menstrual period or an early spontaneous abortion."[38] Thus, "in the later first and early second trimester, *delay makes a difference*" and "limits the options of the patient."[39] Accordingly, while abortion is far safer than the only available alternative of carrying a pregnancy to term, scientific evidence counsels

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35 Order 9.

36 Darney Trial Test., 57-58; *see id.* 77-78 (addressing increase in complexity of second-trimester abortions as compared to first-trimester abortions).

37 Darney Trial Test., 78.

38 *Id.* 50-51, 78; *see also* Henderson et al., *Safety of Mifepristone Abortions in Clinical Use*, 72 Contraception 175, 178 (2005) ("Early abortions are safest, with mortality risk increasing by 38% per additional week of gestation.").

39 Darney Trial Test., 78 (emphasis added).

against unnecessary delay—especially the potentially significant delays that the PNL will impose on minors in Alaska.

II. THE PRINCIPLES UNDERLYING ALASKA'S MEDICAL EMANCIPATION LAW APPLY WITH EQUAL FORCE TO ALL MINORS FOR ALL PREGNANCY-RELATED MEDICAL PROCEDURES, INCLUDING ABORTION

In deciding to uphold Alaska's PNL, the superior court reasoned that "once a minor elects an imminent abortion, the core rationale underpinning [Alaska's] medical emancipation [law] no longer applies to her."[40] This reasoning is flawed on two levels. First, it ignores that the same concerns that motivated Alaska's legislature to enact its medical emancipation law—that minors might avoid or delay obtaining needed reproductive health services if forced to confront their parents first—applies with equal force to minors seeking an abortion.[41] Second, it is inconsistent with the evidence, and with the superior court's own factual findings, showing that minors seeking abortion care and minors seeking other pregnancy-related health care are similarly situated. No rational justification exists for treating these two groups of minors differently.

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40 Order 59.

41 *See* AS § 25.20.025(a)(4) (except as prohibited by Alaska's PNL, "a minor may give consent for diagnosis, prevention or treatment of pregnancy, and for diagnosis and treatment of venereal disease") (previously codified at AS § 09.65.100 (1968)); *see also* Coleman & Rosoff, *The Legal Authority of Mature Minors to Consent to General Medical Treatment*, 131 Pediatrics 786, 789 (2013) (noting that "14 states permit mature minors to consent to general medical treatment either in all or a range of restricted circumstances, and 3 states [including Alaska] allow minors regardless of their age or maturity to consent to treatment in either all or limited circumstances").

A. The Legislative Rationale For Alaska's Medical Emancipation Law Applies Equally To Minors Seeking An Abortion

As the American Medical Association has recognized in explaining why minors should be permitted to access abortion care without government-mandated parental involvement, "confidentiality [is] critical to ensuring that minors are not deterred from seeking medical care, particularly for sensitive problems."[42] Medical emancipation laws are based on the common sense recognition that teenagers will often delay or avoid seeking medical care if it might alert their parents to private information of a sexual nature.[43] In *Falcon v. Alaska Public Offices Commission*, this Court acknowledged that Alaska's medical emancipation law helps shield minors' "sensitive personal information" from others, including their parents.[44] Of course, parental involvement in minors'

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42 Am. Med. Ass'n, *Mandatory Parental Consent to Abortion*, 269 J. Am. Med. Ass'n 82, 82 (1993).

43 *See, e.g., American Acad. of Pediatrics v. Lungren*, 940 P.2d 797, 801 (Cal. 1997) ("[M]edical emancipation statutes identify circumstances in which a minor in need of medical care may be reluctant, for a variety of reasons, to inform his or her parents of the situation or condition that has created the minor's need for such care, and in which, because of such reluctance, there is a substantial risk that minors will fail to seek medical care[.]"); Wadlington, *Medical Decision Making For and By Children: Tensions Between Parent, State, and Child*, 1994 U. Ill. L. Rev. 311, 323-324 (noting that "[i]f minors could not personally consent to treatment, they might not obtain medical care—to the detriment of themselves, their families, and society").

44 570 P.2d 469, 479-480 & n.43 (Alaska 1977); *see also State v. Planned Parenthood of Alaska*, 35 P.3d 30, 40-41 (Alaska 2001) (observing that minors and adults "start from the same constitutional footing" with respect to privacy rights and that "[t]he 'uniquely personal' physical, psychological, and economic implications of the abortion decision ... are in no way peculiar to adult women").

decision-making will normally be the ideal,[45] but not all families are ideal families and the purposes underlying medical emancipation applies with equal force to a minor who intends to seek medical care related to pregnancy termination as it does to a minor seeking medical care related to carrying a pregnancy to term. The superior court was wrong to conclude otherwise in ruling that these two classes of minors are not similarly situated for equal protection purposes.

Since 1968, Alaska has recognized that to best protect public health, minors must be allowed to obtain medical care related to sexual conduct, including pregnancy, without potentially threatening requirements for parental involvement.[46] The legislative purpose behind medical emancipation was simple: legislators sought to protect "minor[s who] wish[] to be examined or treated ... but do[] not want [their] parents to know."[47] Consistent with these principles, Alaskan minors today need not consult with their parents on a wide range of reproductive health services, including "sexually transmitted diseases; contraception; prenatal care; obstetrical decisions including Caesarian surgery; the weighing of grave health risks of a problem pregnancy; fetal anomaly; miscarriage;

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45 *See State v. Planned Parenthood of Alaska*, 171 P.3d 577, 579 (Alaska 2007); *see also Lungren*, 940 P.2d at 833 ("[A]ll parties and all members of this court agree that, *in general*, an adolescent who learns she is pregnant and is considering an abortion will benefit substantially from consultation with a parent and should be encouraged to do so.").

46 *See* former AS § 09.65.100(b) (1968) (emancipating minors "with regard to pregnancy under the same circumstances and with the same immunity" as minors emancipated for seeking treatment for sexually transmitted infections).

47 1968 Alaska House J., at 706 (HB 575).

[or] adoption."[48] Nor are Alaskan minors required to consult with their parents before receiving other needed health services, from a simple dental procedure[49] to amputation of a limb.[50] But when an Alaskan minor chooses the comparatively safer procedure of abortion as opposed to the riskier option of carrying a pregnancy to term, Alaska's PNL requires precisely what medical emancipation was designed to avoid: compelled disclosure of "sensitive personal information" to her parents.[51]

There is no logical reason to believe that a minor seeking abortion would be any less likely to "avoid necessary and timely care" than minors seeking care in these other areas. Thus, contrary to the superior court's conclusion, the reasoning underpinning the medical emancipation law applies with equal weight to Alaska's PNL. For these reasons, the State's decision to treat abortion differently from other reproductive health services, which frequently involve risks that are just as serious (if not more so) than abortion, directly contravenes the primary purpose of medical emancipation laws in the first

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48 Order 16.

49 AS § 25.20.025(a)(1)-(3) (emancipating minors with regard to both "medical and dental services").

50 *See* Oral Argument 5:35-6:45, *State v. Planned Parenthood of Alaska*, 171 P.3d 577 (Nos. S-11365, S-11386) (question of Fabe, J.) (noting that AS § 25.20.025(a)(2) applies to "other very serious types of medical procedures, [such as] amputation [and] the most serious of surgeries"), *available at* http://www.360north.org/gavel-archives/?event_id=2147483647_2005041006.

51 *Falcon*, 570 P.2d at 480.

instance—*i.e.*, to "permit[] competent minors to give consent for other medical care" absent parental involvement.[52]

B. Minors Seeking An Abortion Are Similarly Situated To Minors Seeking To Carry A Pregnancy To Term

Legislation mandating parental involvement has long been criticized in the medical community as "incongruent with existing health care legislation" for giving preferential treatment to minors who choose the more dangerous path of carrying to term than minors electing an abortion.[53]

There is simply no evidence to support the proposition that a minor is too immature to make a decision about abortion, and yet mature enough to assume the responsibilities of carrying a pregnancy to term and becoming a teenage parent.[54] The superior court expressly acknowledged the point, observing:

> The risks of pregnancy are greater, and can lead to lifetime challenges from delivery of an unhealthy or impaired baby. Having a child affects continued education, opportunity for military service, and marital prospects; raising a child is enormously expensive and challenging. Motherhood by an unprepared adolescent can end in the abuse and neglect courts often see[n] in child-in-need-of-aid cases. While the minor may avoid these risks through adoption, the evidence at trial showed this rarely occurs. *Few life decisions could benefit more from consultation with*

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[52] Crosby & English, *Mandatory Parental Involvement/Judicial Bypass Laws: Do They Promote Adolescents' Health?*, 12 J. Adolescent Health 143, 146 (1991).

[53] Johannsen, *Adolescent Abortion and Mandated Parental Involvement*, 21 Pediatric Nursing 82, 82 (1995).

[54] *See* Order 56 (highlighting the "far weightier consequences" for minors electing to carry a pregnancy to term).

supportive parents than a minor's decision to carry to term; the decision to abort, comparatively, involves far fewer enduring consequences.[55]

Moreover, minors who choose to abort and minors who choose to carry to term are equally situated with respect to the confidentiality concerns implicated in these sensitive life decisions.[56] Adolescents may delay seeking medical care or may very well choose not to seek care at all where they know that their private sexual backgrounds will be exposed to a third party—their parents—by the very same individuals they need to rely on for medical treatment or to a stranger, should they seek judicial bypass.[57] Understanding this dilemma, the American Medical Association reviewed the issue of confidentiality for minors seeking abortions and concluded that the minors themselves "should ultimately be allowed to decide whether parental involvement is appropriate [before getting an abortion]," with physicians providing guidance as needed.[58] This position has similarly been adopted by ACOG, NASW, the American College of Physicians, the American Academy of Pediatrics, the American Public Health Association, the Society for Adolescent Health and Medicine, and the American Medical

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55 Order 56 (emphasis added).

56 Am. Med. Ass'n, 269 J. Am. Med. Ass'n at 82.

57 *Allred v. State*, 554 P.2d 411, 428 n.12 (Alaska 1976) (Rabinowitz, J., concurring) (observing that each doctor "must have his patient's confidence or he cannot help him" and "without a promise of secrecy … a patient would not be prone to reveal personal data which he fears might evoke social disapproval" (quotations and citations omitted)).

58 Am. Med. Ass'n, 269 J. Am. Med. Ass'n at 84.

Women's Association.[59] To rank abortion as requiring less confidentiality protection than carrying a pregnancy to term, as Alaska's PNL does, risks undermining a

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[59] *See* ACOG, *Guidelines for Adolescent Health Care*, at v (2d rev. ed. 2011) ("The potential health risks to adolescents if they are unable to obtain reproductive health services are so compelling that legal barriers and deference to parental involvement should not stand in the way of needed health care for patients who request confidentiality."); NASW, *Social Work Speaks* 10 (9th ed. 2012) ("The ability of adolescents to engage in confidential contraceptive, abortion, and pre-natal services without parental consent is critical to the overall health of not only the adolescent but also the pregnancy and, if she chooses to maintain the pregnancy, the baby. When appropriate and acceptable to the adolescent, involvement of a supportive adult may be helpful." (internal citations omitted)); Snyder, Am. Coll. of Physicians, *American College of Physicians Ethics Manual: Sixth Edition*, 156 Annals of Internal Med. 73, 78 (2012), *available at* http://annals.org/data/Journals/AIM/20372/0000605-201201031-00001.pdf ("If a patient who is a minor requests termination of pregnancy ... without a parent's knowledge or permission, the physician may wish to attempt to persuade the patient of the benefits of having parents involved, but ... [i]nformation should not be disclosed to others without the patient's permission." (citation omitted)); Am. Acad. of Pediatrics, *The Adolescent's Right to Confidential Care When Considering Abortion*, 97 Pediatrics 746, 750 (1996) ("Ultimately, the pregnant patient's right to decide should be respected regarding who should be involved and what the outcome of the pregnancy will be, which is the approach most consistent with ethical, legal, and health care principles. The A[merican]A[cademy of]P[ediatrics] reaffirms its position that the rights of adolescents to confidential care when considering abortion should be protected. Genuine concern for the best interests of minors argues strongly against mandatory parental consent and notification laws."); Am. Pub. Health Ass'n, *Ensuring Minors' Access to Confidential Abortion Services*, APHA.org (Nov. 1, 2011), http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1415 (organization "[u]rges ... that minors' access to abortion services not be made conditional on parental involvement"); Soc'y for Adolescent Health & Med., *Reproductive Health Care for Adolescents*, 12 J. of Adolescent Health 649, 651 (1991); Soc'y for Adolescent Health & Med., *Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine*, 35 J. Adolescent Health 160, 160 (2004) ("Participation of parents in the health care of their adolescents should usually be encouraged, but should not be mandated."); Am. Med. Women's Ass'n, *Position Paper on Principals of Abortion & Access to Comprehensive Reproductive Health Services*, AMWA-DOC.org, http://www.amwa-doc.org/cms_files/original/Abortion___Access_to_Comprehensive_Reprod_Health_Services1.pdf (last visited May 2, 2013) (opposing "all bills that ... require parental consent

cornerstone of the doctor-patient relationship in one of the very instances where confidentiality is most needed.[60]

The superior court sought to avoid the conclusion that minors seeking abortions are similarly situated to minors who choose to carry a pregnancy to term by stating that "once a minor elects an imminent abortion, the core rationale underpinning medical emancipation no longer applies to her; she no longer requires encouragement to see a doctor to protect her own health and that of the fetus."[61] But this argument, which appears to brush aside the very concerns that animate medical emancipation laws by inappropriately equating an abortion with an "imminent abortion," misses the point. Only when one assumes away the likelihood that forced parental involvement will cause minors to delay seeking medical care (if they seek medical care at all) does an abortion become an imminent abortion.[62] But such an assumption is plainly unwarranted here, where the evidence makes clear that minors—particularly abused minors—will frequently put off seeking abortion care in the first instance when they know that they

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for minors' abortions" because of how they "interfere with the decision-making process, appropriately left to the woman and her physician").

60 *See Falcon*, 570 P.2d at 480 (stressing the importance for confidentiality where "the particular type of treatment is one which patients would normally seek to keep private"); *cf. N.G. v. Superior Ct.*, 291 P.3d 328, 340-341 (Alaska Ct. App. 2012) (Bolger, J., concurring) (noting how "a healthy construction of [doctor-patient confidentiality] is necessary to avoid infringing privacy interests protected by the constitution").

61 Order 59.

62 Pinto Trial Test., 321-324 (explaining that parental notification laws may cause some minors to delay "up to six weeks" in seeking an abortion, while others may "take[] matters into their own hands" by seeking an illegal abortion or attempting to self-abort).

will face the prospect of involving their parents or going to court.[63] In other words, the superior court's conclusion that minors seeking abortion care and minors seeking other pregnancy-related medical care are not similarly situated rests entirely upon a counterintuitive assumption that the evidence plainly refutes. Due to their fears of informing a parent of their sexual activity or pregnancy, minors may well wait late in their pregnancies to seek an abortion, resulting in a riskier and more complicated procedure (if, indeed, they are still able to have an abortion at all). This is the precise outcome that Alaska's medical emancipation law seeks to avoid.

III. ALASKA'S PNL WILL NOT FOSTER INCREASED FAMILY COHESIVENESS

The superior court also erred in concluding that Alaska's PNL "sufficiently fosters a potential for worthwhile family involvement" and presents only a "small … downside" to minors.[64] In particular, the superior court's finding *overstates* the benefits of parental notification laws insofar as research reflects that most parents will learn of a minor's abortion decision independent of the law itself. The superior court's finding also *understates* the potential risks of compelling parental notification as minors who elect not to share their pregnancy with a parent often do so because they fear the grave consequences that might result or believe that sharing the information would negatively affect their relationship with their parent, effectively undercutting the intended benefit—*i.e.*, enhanced family cohesiveness—envisioned by the superior court.

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63 Darney Trial Test., 79-81; Pinto Trial Test., 321-324.

64 Order 33.

A. Most Minors Voluntarily Elect To Inform Parents Or a Trusted Adult Of Their Abortion Decisions

Studies demonstrate that the majority of minors voluntarily choose to consult with a parent or other trusted adult before deciding to have an abortion.[65] Indeed, as recognized by the superior court, the younger the minor is, the more likely she is to involve her parents.[66] Adolescents who consider themselves less mature are similarly more likely to involve their parents in their abortion decisions.[67]

These findings are notable insofar as scientific evidence supports the conclusion that minors are capable of making an informed decision about whether to have an abortion.[68] Following an extensive review of scientific literature regarding adolescents' ability to make informed abortion decisions, the APA's Interdivisional Committee on

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65 Henshaw & Kost, *Parental Involvement In Minors' Abortion Decisions*, 24 Family Planning Perspectives 194, 199-200 & Table 3 (1992); Zabin et al., *To Whom Do Inner-City Minors Talk About Their Pregnancies? Adolescents' Communication With Parents and Parent Surrogates*, 24 Fam. Plan. Persp. 148, 151 (1992).

66 Order 19; *see also* Henshaw & Kost, 24 Family Planning Perspectives at 200 & Table 3; Zabin et al., 24 Fam. Plan. Persp. at 152.

67 Griffin-Carlson & Mackin, *Parental Consent: Factors Influencing Adolescent Disclosure Regarding Abortion*, 28 Adolescence 1, 8 (1993).

68 Order 21 ("From a cognitive perspective, minors aged 13 through 17 process information similarly to adults."). Notably, and by contrast, the superior court found that a minor's decision to carry to term "is *less demonstrably* a mature one." *Id.* at 21-22 (noting expert testimony from State witness that minors "may exaggerate their own competence and harbor unrealistic expectations regarding their abilities to cope with the rigors of motherhood"; "choose to carry to term without realizing all the factors working against their baby's prospects for a decent childhood"; or "harbor unrealistic appraisals of their ability to finish school or to acquire a suitable marriage partner").

Adolescent Abortion found support for the proposition that "adolescents do not differ from adults in their ability to understand and reason about treatment alternatives."[69]

B. The Superior Court's Decision Understates The Potential Adverse Effects Mandated Parental Notification Will Have On Minors And Overstates Its Benefits

Although the superior court recognized both that a majority of minors choose to consult with a parent or other trusted adult before deciding to have an abortion and that minors are sufficiently mature to make the decision on their own, it nonetheless concluded that mandated notification could have an "unknowable" and "small but significant" upside of encouraging "worthwhile family involvement" based on its extrapolation from testimony provided by Appellants' expert that 22% of pregnant minors opt not to disclose their pregnancy to their parents, despite having a "decent" relationship with them. No basis exists for this logical leap: science does not support the unfounded conclusion that "worthwhile involvement" would necessarily result if minors were forced to notify their parents of their decision to abort.

First, the superior court cited no studies—nor are *amici* aware of any—suggesting that mandated communication in the small subset of families in which minors otherwise would not inform their parents of their decision to have an abortion improves family

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69 Melton & Pliner, *Adolescent Abortion: A Psycholegal Analysis*, Adolescent Abortion: Psychological and Legal Issues 1, 18 (1986).

relationships, cohesiveness, or communication.[70] Research instead suggests that minors who talk to their parents about abortion likely already have good, open relationships with them, including relationships where sexual issues are discussed.[71] Those minors "who do not involve their parents perceive their family communication to be less open, feel less free to talk about feelings in general, and are less comfortable talking to their parents about sex than are young women who tell their parents about their pregnancy."[72]

Second, even assuming the superior court is correct that forcing minors to notify their parents of abortion would lead to "worthwhile family involvement" and family cohesiveness for some small and unknowable percentage of families, this finding ignores the larger point that Alaska's PNL applies to all minors, including those who rightly fear abuse or being forced from the family home. Studies have found that many minors elect not to involve their parents because they fear that their parents will have severe and

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70 Webster et al., *Parental involvement laws and parent-daughter communication: policy without proof*, 82 Contraception 310, 312 (2010) (finding no evidence based upon a literature review concerning parent-daughter communication that "higher rates of parent-daughter communication about abortion improve family relationships or adolescent decision making about abortion"); *see also* Am. Acad. of Pediatrics, 97 Pediatrics at 750 ("Although the stated intent of mandatory parental consent laws is to enhance family communication and parental responsibility, there is no supporting evidence that the laws have these effects.... There is evidence that such legislation may have an adverse impact on some families and that it increases the risk of medical and psychological harm to the adolescent. Judicial bypass provisions do not ameliorate the risk.").

71 Webster et al., 82 Contraception at 312; Henshaw & Kost, 24 Family Planning Perspectives at 205-206.

72 Adler et al., *Abortion Among Adolescents*, 58 Am. Psychol. 211, 214 (Mar. 2003).

negative reactions that could compromise the minor's relationship with the parent or expose the minor to harm.[73] Those fears are not unfounded: minors have been shown to be perceptive and accurate with respect to predicting their parents' reactions to such information.[74] Health care providers and investigators have similarly voiced concern "about possible physical or emotional harm to adolescents who are forced to involve their parents in their abortion decision."[75] To statutorily require minors to inform their parents about their decisions to abort thus may, in fact, undermine the desired goal of family cohesiveness and strain family communication further.

The superior court's finding that "no expert disagreed that parental involvement in the termination decision is beneficial to the minor absent abuse of coercion" ignores the expert testimony that was developed at trial.[76] Appellants' expert Dr. Darney expressly testified that Alaska's PNL would not lead to enhanced family communication.[77] He

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[73] J. Shoshanna Ehrlich, *Grounded in the Reality of Their Lives: Listening to Teens Who Make the Abortion Decision without Involving Their Parents*, 18 Berkeley Women's L. J. 61, 131-135 (2003); Henshaw & Kost, 24 Family Planning Perspectives at 207. In Alaska, the risk to minors is arguably greater as the state has an above-average rate of physical and substance abuse compared with other states in the U.S. Downs Trial Test., 556, Feb. 15, 2012. Notably, experts at trial testified that, these statistics notwithstanding, there is significant underreporting of abuse in Alaska. *See, e.g., id.* 573-574 (observing that "a lot of times ... people have a hard time believing that a child has been abused").

[74] Henshaw & Kost, 24 Family Planning Perspectives at 207.

[75] Adler et al., 58 Am. Psychol. at 214.

[76] Order 30.

[77] Darney Trial Test., 43 ("I believe that such laws do not facilitate communication between minors and their parents.").

explained that where a minor does not choose to involve a parent in her abortion decision, it is important to consider the family dynamics, and declined to agree with the State that merely because a minor is in a non-abusive or "decent" family relationship telling her parents could lead to worthwhile results.[78] Dr. Darney's testimony thus also refutes the superior court's conclusion that merely because a minor has a "decent" relationship with her parents, a law forcing her to inform her parents about a decision to abort necessarily improves family cohesiveness.[79]

At the same time, the superior court also understated the harm to minors in unstable or delicate families. The lower court's conclusion that forced parental notification carries with it only a "small" downside and "dire outcomes are relatively rare" appears to be based largely on a misreading of a study published by Stanley Henshaw and Kathryn Kost that surveyed more than 1,500 unmarried minors having an abortion in order to better understand both how those minors initially reacted to their pregnancy and how they ultimately decided to abort. Contrary to the superior court's suggestion that the Henshaw and Kost study reported only 6% of minors would suffer serious consequences as a result of parental notification,[80] the study actually found that of

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78 *Id.* 116-117.

79 *See* Webster et al., 82 Contraception at 312.

80 Order 23 (observing that the Henshaw and Kost survey found that "[a]pproximately six percent of disclosing or discovered minors actually encountered serious problems with their parents: violence in the home, beatings, or banishment from the home.") & 33 ("[O]nly six per cent of aware parents cause serious problems for their daughters.").

the parents who learned of their child's pregnancy through a third-party rather than their child (whom the study's authors noted were "probably more typical of parents who would be informed of a pregnancy as a result of legislative requirements"), "*a minimum of* 6% of … minors appear to have suffered relatively harmful consequences" of their parents knowing such as "physical violence in the home, being beaten, being forced to leave home or having the health of their parents affected."[81] Henshaw and Kost go on to note that *this number could be higher* because, in the study, the group of parents who learned about their child's pregnancy included parents whose minors likely wanted them to learn about it and did not take active steps to avoid discovery—that is, the study included minors who did not fear their parents' reaction to news of their pregnancy.[82] Henshaw and Kost further found that among minors whose parents found out about the pregnancy from a third-party, *58% of minors reported one or more adverse results* (*e.g.*, news of the pregnancy caused the minor to feel uncomfortable living at home or the minor was punished) and these parents "were much more likely to be upset than supportive and were more likely to be angry than were parents whose daughters told them about the pregnancy."[83] Finally, Henshaw and Kost observe that while "[t]here is no way to determine exactly which minors would be harmed by obligatory parental notification," based on what the minors themselves had reported, as many as "30% of

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81 Henshaw & Kost, 24 Family Planning Perspectives at 207 (emphasis added).

82 *Id.*

83 *Id.*

those who did not tell their parents would be at risk: These minors feared physical violence between themselves and their parents (in many cases because it had already occurred), or they were afraid of being forced to leave home."[84] Taken together, these facts—particularly when viewed against testimony at trial reflecting that Alaska suffers from above-average rates of child abuse, domestic violence, and substance abuse compared with other states, (note 73, *supra*)—suggest that the "downside" minors are likely to experience as a result of Alaska's PNL is far from "small," notwithstanding the superior court's suggestion to the contrary.

CONCLUSION

For the reasons set forth above, *amici* join Plaintiffs-Appellants in urging this Court to reverse the decision of the superior court.

Respectfully submitted,

/s/

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84 *Id.*

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May 10, 2013

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CERTIFICATE OF COMPLIANCE

Pursuant to Alaska Rule of Appellate Procedure 513.5(c)(B), the undersigned hereby certifies that this motion has been prepared in proportionally spaced typeface in 13-point Times New Roman font.

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May 10, 2013