IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

PLANNED PARENTHOOD OF ALASKA, et al.,	)	
Plaintiffs.	)	
v.	)	
STATE OF ALASKA,	)	
Defendant.	)	Case No. 3AN 97-6014 Civil

PLAINTIFFS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. FINDINGS OF FACT

Plaintiffs' Witnesses

1. Dr. Nancy Adler holds a masters and Ph.D. in social psychology. (Adl. FL 470 7-8, 12-15).[1] She is a vice-chair of the Department of Psychiatry at the University of California in San Francisco, where she holds appointments in the departments of psychiatry and pediatrics. (Adl. FL 471 7-11, 17-23, 472 1-8). Dr. Adler's research for the last 25 years has focused on decision making by adults and minors in the area of reproductive health. (Adl. FL 475 15-21, 476 7-10). Dr. Adler has also conducted studies on the psychological aspects of abortion, and served on an expert panel convened by the American Psychological Association to review the research on that topic. (Adl. FL 475:25-476:2, 480:15-481:4). The Court qualified Dr. Adler as an expert on the subjects of the psychological aspects of reproductive health and adolescent decision making about abortion. (Adl. FL 477 12-17).

2. Todd Arndt is a supervisor of high school education in the Anchorage School District. As part of his responsibilities, he is familiar with the content and enforcement of attendance policies. (Arn. TR 2673:21-24, 2674:5-9).

3. Christopher Cooke is an attorney in private practice in Anchorage and Bethel. (Coo. TR 1239:18-1240:3). He was an Alaska Superior Court judge in Bethel for nearly ten years. (Coo. TR 1236:7-12, 1239:12-14, 6-7; Ex. 3). The Court qualified him as an expert in the legal system in Bethel and the surrounding area. (Coo. TR 1243:6-7).

[1] Dr Adler's Florida Testimony and Alaska deposition came in via stipulation. Cites to her testimony will be indicated by "Adl. FL" and cites to her Alaska deposition by "Adl. Dep."

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4. Stanley Henshaw, Ph.D., is the former director of research and currently a consultant for the Alan Guttmacher Institute ("AGI"), a non-profit organization that performs research, policy analysis, and public education on fertility control and reproductive health. (Hen. TR 248:1-5, 248:12-15; Exhibit 320). Dr. Henshaw has a Ph.D in sociology from Columbia University. (Hen. TR 247:14-17). His research focuses primarily on abortion services and statistics, (Hen. TR 249:11-14), and has been cited by the State of Alaska, and many of Defendant's witnesses. (Hen TR. 250:2-4, Gre. Dep. 111:11-16, Col. TR 2123:25-2124:5). The Court qualified him as an expert in sociology and demography, specializing in reproductive behavior and abortion services provision. (Hen. TR 257:2-14).

5. Dr. Susan Lemagie is a board-certified obstetrician-gynecologist who has practiced in Palmer, Alaska, for 23 years. (Lem. TR 14:9-13, 18 11-12). As part of her practice, Dr. Lemagie provides abortions through 20 weeks, and sees minors for all services. (Lem. TR 15:9-18; 15:19-16:7). Dr. Lemagie is the Medical Director for Planned Parenthood of Alaska and has been active in the Alaska section of the American College of Obstetricians and Gynecologists ("ACOG"). (Lem. TR 19:1-4, 21:14-17). Dr. Lemagie also serves on the State of Alaska's maternal/infant mortality review committee. (Lem. TR 22:20-23).

6. Judge Gerald Martin has been a state district court judge in Duluth, Minnesota for twenty-four years, (Mar. TR 952:5-14), and currently presides over judicial bypass petitions filed by minors seeking to bypass the Minnesota parental notice requirement, and has heard over 450 petitions in the past 20 years. (Mar. TR 953:3-8, 954:14-17). The Court qualified Judge Martin as an expert on the Minnesota judicial bypass system. (Mar. TR 955:23-956:1).

7. Julie Palmer is a senior epidemiologist and associate professor of epidemiology at the Slone Epidemiology Unit, at Boston University. (Pal. Dep. 8:3-7, 15-20). She received her Ph.D. in epidemiology from the Harvard in 1988. (Pal. Dep. 6:23-7:2). Dr. Palmer designs, conducts, and reviews epidemiological studies. (Pal. Dep. 8:21-9:6, 10:15-11:23). She has published approximately 25 peer-reviewed articles on breast cancer, including its association with various reproductive factors, (Pal. Dep. 12:4-13:15, Exhibit 1), and has conducted two studies examining the relationship of abortion to breast cancer. (Pal. Dep. 13:16-22, 15 7-10). Dr. Palmer was qualified by the Court as an expert in epidemiology, and specifically, epidemiological studies addressing abortion and breast cancer. (Pal. Dep. 16:10-15).

8. Elise Patkotak lived in Barrow, Alaska, for 28 years, and held various positions within the health and legal systems, in which she had direct interaction with young Native Alaskans. (Pat. TR 1170:6-9, 12-14, 1170:23-1171:22; 1181:9-24, 1182:5-7, 1183:5-16).

9. Deborah Reichard is an attorney employed as a guardian ad litem (GAL) in Bethel. (Rei. TR 917:3-5). The majority of her cases involve abused and neglected children in state custody; she also works on juvenile delinquency cases. (Rei. TR 917:19-918:2). Ms.

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Reichard has represented approximately 150 minor women between the ages of 11 and 16 as a GAL and almost 100 percent of her clients are Native. (Rei. TR 918:14-21, 3-6).

10. Dr. Sherrie Richey, is a board-certified obstetrician and gynecologist and maternal-fetal specialist who practices in Anchorage. (Ric. TR 828:1-9, 17-19, 841:12-14). As a maternal-fetal specialist, Dr. Richey treats women with high-risk pregnancies. (Ric. TR 829:20-830:1, 830:19-24). She is the medical director of the perinatal services at Providence Hospital, and the chair of the State's maternal and infant mortality review committee. ((Ric. TR 831:12-25; 832:22-24). Dr. Richey provides terminations of pregnancy for medical indications (situations where continuing the pregnancy would pose a significantly greater risk to the patient's life or health than carrying to term). (Ric. TR 830:5-831:6). Dr. Richey sees around 200-250 minors under the age of 17 per year, which is virtually all of the minors in that age group that receive maternal-fetal care in Alaska. (Ric. TR 839:5-7, 841:8-11).

11. Jamie Sabino, J.D., is co-chair of the Judicial Consent for Minors Lawyer Referral Panel, an association of attorneys who represent almost all minors seeking a judicial bypass under the Massachusetts parental consent statute. (Sab. TR 2515:3-7; 2513:8-13). In her work on the Panel since 1983, Ms. Sabino has represented minors seeking a bypass, trained other attorneys in the judicial bypass system, and interacted with judges and court personnel regarding the Massachusetts bypass. (Sab. TR 2514:23-2515:2, 2516:9-17, 2518:10-23). She has also prepared manuals for and conducted trainings in other states that have parental involvement laws, and prepared an investigative report on the effects of the judicial bypass in Massachusetts. (Sab. TR 2520:16-2521:21, 2511:9-23). The Court qualified her as an expert in judicial bypass, especially in the state of Massachusetts. (Sab. TR 2530:18-21).

12. Dr. Paul Sachdev, Ph.D., has been a professor in the Social Work School at Memorial University in Newfoundland, Canada, since 1973. He holds several graduate degrees in the areas of social work and social welfare. (Sac. Dep. 4:14-5:17, Ex. 322). Dr. Sachdev has conducted research on the decision-making process and emotional impact of abortion and adoption, the results of which have been published in various peer-reviewed books and articles. (Sac. Dep. 6:14-25, 16:9-22:3, 30:8-18, 113:22-114:6; Exhibit 322). The Court qualified Dr. Sachdev as an expert in the field of social work on the research methodology and the decision-making process and social-psychological effects of pregnant woman choosing abortion and adoption. (Sac. Dep. 23:16-22).

13. Nada Stotland, M.D., Ph.D., is a psychiatrist who holds a position in both the departments of psychiatry and obstetrics and gynecology at Rush Medical College and formerly was the chair of psychiatry at the Illinois Masonic Medical Center in Chicago. (Exhibit 321: Sto. TR 715:14-21, 714:3-7). She also has a Masters in Public Health. (Sto. TR 713:1-5). Throughout her career, Dr. Stotland has treated patients with psychiatric issues related to pregnancy, consulted with patients seeking abortions, and treated patients under the age of 17. (Sto. TR 714:24-715:13). Dr. Stotland has authored or edited seven

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books and published over fifty articles and chapters in peer reviewed journals, primarily on the topics of psychiatry and obstetrics and gynecology. (Sto. TR 715:22-716:2, 716:9-11).

14. Dr. Jan Whitefield is a board-certified obstetrician and gynecologist who has practiced in Anchorage for 18 years. (Whi. TR 1005:2-6). His private practice at Alaska Women's Health ("AWHC") and other locations includes a full range of obstetrics and gynecology, including abortions through 21 weeks and three days. (Whi. TR 1006:5-15, 1008:3-14, 1009:17-18). Abortions constitute approximately 13% of Dr. Whitefield's overall practice, and minors make up approximately five percent of his abortion practice. (Whi. TR 1007:3-11).

15. Laurie Schwab Zabin, holds a doctorate in population dynamics and is a professor of population and family health sciences at Johns Hopkins University, and a professor of obstetrics and gynecology at the Johns Hopkins Medical School. (Exhibit 160; Zab. TR 2322:3-7). Dr. Zabin extensive experience both in the United States and abroad in the field of reproductive health, and has developed numerous programs aimed at preventing adolescent pregnancy and STDs. (Zab. TR 2326: 17-25). Dr. Zabin devotes a significant amount of her research to adolescent reproductive health, the results of which have been published in numerous peer-reviewed journals and books. (Zab. TR 2327:5-13, 2329:10-23, 2330:14-21). The Court qualified Dr. Zabin as an expert in the social science aspects of adolescent reproductive and sexual health. (Zab. TR 2336:9-11).

Defendant's Witnesses

16. Dr. James Anderson was qualified as an expert in emergency room medicine and family practice. (And. TR 1795:5-21). His testimony carries very little weight in assessing the safety of abortion in Alaska. He has not treated minors for the past 9 years, and his experience is limited to Virginia. (And. TR 1840:18-1841:1, 1887:3-25). Dr. Anderson informs patients of his personal preference for them to carry to term, (And. TR 1897:7-16), and, despite his belief that parents should be involved in pregnancy-related care, contraception, and STD treatment, has actively campaigned only for a parental involvement for abortion. (And. TR 1789:11-24, 1899:21-1900:7). Dr. Anderson further believes that parents refusing consent for abortion would be a positive effect of the act. (And. TR 1901:5-8)

17. Joel Brind has a degree in biochemistry and teaches undergraduate courses at Baruch College. (Bri. Dep. 14:3-5, 15-19, 20-23). He has no formal education or training in epidemiology. (Bri. Dep. 15:3-9). His single peer-reviewed article on the topic of abortion and breast cancer, suffers from serious methodological flaws. (Bri. Dep. 8:15-19; Pal. Dep. 51 –75). Dr. Brind was not offered as an expert in epidemiology. His background and experience, are of limited value to the Court in assessing the evidence regarding an alleged link between abortion and breast cancer, which is based on epidemiological studies. (Bri. Dep. 13:21-24).

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18. Dr. Byron Calhoun was qualified by the Court as an expert in obstetrics and gynecology and as a maternal-fetal specialist. Dr. Calhoun's testimony regarding the necessity for parental involvement for abortion is undermined by the fact he has never attempted to obtain a medical history or informed consent from a minor for any purpose. (Cal. TR 1744:24-1745:1, 1749:14-23). In Dr. Calhoun's opinion, parents who support their daughter's decision to have an abortion, unless the procedure is necessary to save her life, are not acting in their daughter's best interests. (Cal. TR 1723:3-14).

19. David Elkind was qualified as an expert in the general fields of psychology, child psychology and adolescent development, but he has done no research or writing on the topic of abortion. (Elk. Dep. 15:17-21, 120:16-121:2). In his experience counseling adolescents, he has seen only "a few" pregnant teenagers. (Elk. Dep. 121 3-8).

20. Carol Everett testified about her work in abortion clinics in Texas 25 years ago. Ms. Everett's testimony has little relevance to, and sharply contrasts with the evidence regarding abortion care in Alaska, of which she has no personal knowledge. (Eve. TR 2650:19-2652:2). Her credibility on all issues is undermined by her dishonest and unscrupulous conduct, (Eve. TR 2634:7-2635:20; 2642:19-23; 2643:19-2644:5; 2645:7-14; 2656:6-13; 2665:13-2666:3), and by the fact that she is the CEO of a group who supports centers that try to discourage women from choosing abortion. (Eve. TR 2670:23-2671:15).

21. The Court qualified Dr. John Greene as an expert in pediatrics and adolescent medicine. (Gre. Dep. 20:21-25). He has never performed an abortion or seen a patient who participated in a judicial bypass proceeding. (Gre. Dep. 111:23-24, 108:22-10) Of his many publications, none have focused on abortion (Gre. Dep. 111:3-10).

22. Dr. Alan Josephson testified as an expert in adolescent psychiatry. He has done no professional writing on abortion. (Jos. TR 1420:22-1421:2, 1494:21-25). In his clinical practice he does not treat children without their parents, and always requires parental consent before treatment. (Jos. TR 1511:20-1512:2, 1512:19-25).

23. Dr. Elizabeth Shadigian was qualified as an expert in the field of obstetrics and gynecology. (Sha. TR 463:16-25, 464:25-465:1). Dr. Shadigian testified that her opinions were based on comprehensive reviews of the literature on the physical and psychological complications associated with abortion. Her credibility, however, is undermined by her biased presentation of the available research, as explained herein. She is not an epidemiologist and her meta-analysis of the studies on the alleged causal link between abortion and breast cancer was rejected by numerous journals and remains unpublished.

24. Dr. Peter Uhlenberg was qualified as an expert in demography and sociology of the family. (Uhl. TR 1568:3-8). Dr. Uhlenberg has published no articles or books about abortion, and his only research on the topic has been done for purposes of paid testimony in litigation defending abortion restrictions. (Uhl. TR 1623:10-1624:5). He was unaware of

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one of the most credible studies on the topic of effects of parental involvement laws, (Uhl. TR 1632:13-22, 1635:24-14, Hen. TR 274:15 – 276:8), and based many of his opinions on data from an unreliable study. (Uhl. TR 1571:24-1573:16; Hen TR 437:15-442:11; Ex. 119).
25. Dr. Tsao-Wu was qualified as an expert in adolescent pediatrics. (Tsa. TR 1298:17-25, 1299:5). Beyond pregnancy tests, Dr. Tsao-Wu has treated only 30-40 pregnant minors during his career. (Tsa. TR 1296:19-1297:1). His testimony about the difficulty of obtaining sexual histories and informed consent from pregnant minors is of little value because he generally does not minors who are pregnant or seeking contraceptives without their parents. (Tsa. TR 1345:19-1346:9, 1350:3-25, 1351:5-12, 16-20). Furthermore, his testimony as a medical expert holds little value because he consulted with his pastor before submitting his expert report to make sure he hadn't overlooked any important issues. (Tsa. TR 1367:8-12).

Minors Are Capable Of Deciding Whether Or Not To Continue A Pregnancy

26. Adolescents are as competent as adults to make informed decisions regarding abortions. (Adl. FL 515:21-516:6, 527:5-530:14, 531:6-21, 533:17-23; Sto. TR 727:4-8).

- Adolescents may be competent to make decisions in some areas, but not others. (Adl. Dep. 33:15-34:9). Based on her study of minors over the age of 14, Dr. Adler found that minors are rational decision makers about whether to have an abortion or carry a pregnancy to term, can make considered choices that weigh the costs and benefits of the decision, and do not act solely on impulse. (Adl. FL 516:17-518:19)

- In her practice, Dr. Richey sometimes counsels minors who desire to carry a pregnancy to term that termination is medically indicated and the minor must consider the risks to their own health versus the consequences for the fetus. (Ric. TR 856:5-861:9, 868:7-22; Cal. TR 1740:19-24). In Dr. Richey's experience, minors are able to make these decisions competently (Ric. TR 872:8-18, 873:5-875:23), and only 20 to 25 percent of her minor patients have a parent involved in these decisions. (Ric. TR 870:8-25)

27. Dr. Adler's opinion that minors are competent to make decisions concerning reproductive health care is particularly persuasive because it is based on her specific research and review of the literature on this issue. (Adl. FL 517:20-524:25).

- By contrast, the opinions of Defendant's experts, such as Dr. Elkind, Dr. Figley, and Dr. Josephson, are based on generalizations about the ability of adolescents to make decisions, without reference to studies looking particularly at pregnancy and abortion.

- To the extent that Defendant's experts offered general opinions that adolescents are more impulsive, less future oriented, and more emotional in their decision making,

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(Jos. TR 1421:24-1422:10), these opinions were not based on research concerning decision-making in the context of abortion.

- Brain mapping studies do not undermine research that adolescents are rational decision makers when considering abortion because they have not yet been linked to specific behavior. (Adler Dep. 40:20-42:12; Jos. TR 1497:13-17, 1504:9-22, Ex. 86)

Minors Are Capable Of Seeking and Receiving Health Care Treatment

28. Alaska physicians providing reproductive health care services to minors, including prenatal care, abortions and STD treatment, are able to obtain adequate medical histories from their minor patients, regardless of parental involvement, (Lem. TR 57:11-13; Ric. TR 875:17–23; Whi. TR 1028:6-8), and physicians obtain the same basic medical history information from all of their patients. (Lem. TR 55:16-19; Whi. TR 1025:3-7).

- In addition to the information that abortion providers obtain from the patient, additional information is obtained through physical examinations and tests. (Lem. TR 46:20-47:14; Whi. TR 1045:11-21)

- If a physician needs additional information about a patient's medical status, the physician can obtain the patient's other medical records or speak with the treating physician. (Lem. TR 56:20-25; Tsa. TR 1341:19-22)

29. Abortion providers in Alaska have not experienced complications as a result of a minor patient failing to provide a complete medical history. (Lem. TR 57:8-10; Ric. TR 877:1-4; Whi. TR 1027:24-1028:2)

30. Minors give informed consent for a variety of invasive procedures related to STD treatment and pregnancy, including LEEPs, amniocentesis, and c-sections, without parental involvement. (Lem. TR 79:16-19, 97:19-25; Sha. TR 581:24-582:13; Whi. TR 1014:1-20, 1054:18-1055:2). Although she has never treated an abortion patient younger than 14, (Ric. TR 880:6-11), Dr. Richey has treated an 11 year old who carried to term and was able to provide informed consent for a non-emergency c-section without parental involvement. (Ric. TR 882 1-8)

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31. Minors are also able to give informed consent to an abortion on their own. (Stot. TR 779:1-5-780:5; Lem. TR 97:3-18; Ric. TR 875:10-16; Whi. TR 1115:12-16)

- Dr. Adler's study comparing abortion patients aged 14 to 17 with patients 18-21 found no differences in their ability to give informed consent, except that the younger group was more likely to have talked to someone else about their decision. (Adl. FL 508:2-17); see also (Lem. TR 116:6-19, quoting Ex. 252)

- Defendant concedes that some minors under 17 who seek abortions are capable of giving informed consent for the procedure. (Ex. 63)

32. Minors are as able as adults to follow physician instructions as to when to contact the office due to complications of pregnancy, STD's or abortions. (Lem. TR 99:25-100:5; Ric. TR 877:5-16; Whi. TR 1048:20-1049:3).

- The instructions given to minors following certain STD treatments and abortions are virtually the same, and include taking vaginal precautions, returning for follow up care, watching for fevers, and contacting the physician if certain conditions arise. Similarly, pregnant minors are given instructions on when to contact their physician should certain conditions occur. (Lem. TR 34:21-35:5, 35:19-25, 38:5-13, 50:15-24, 52:8-54:8)

- While not all patients keep their follow up appointments, minors return for follow up appointments for pregnancy care, STD treatment, and abortion at the same rate as adults. (Lem. TR 98:20-99:11; Whi. TR 1049:4-8)

- That some patients do not return for their regularly scheduled appointment, however, does not mean that women experiencing complications are not being treated. Those women are likely to call their abortion provider for assistance, without waiting for the follow-up appointment. (Hen TR 405:7-14; 406:9-407:6)

- Alaska physicians have not experienced any greater problems with complications among minors whose parents were not involved in the decision and those who were. (Ric. TR 875:5-9). Thus, Dr. Shadigian's speculation that lack of parental consent may result in problems due to delay in treatment for post-abortion complications, (Sha. TR 504:24-505:2), that has not been the case in Alaska.

Abortion Is a Very Safe Procedure

33. Abortions in Alaska are performed using either medical or surgical methods. (Lem. TR 49:3–50:14, 51:4-52:8, 53:4-7; Whi. TR 1047:2-11)

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34. Abortion is a very safe procedure, and significantly safer than carrying a pregnancy to term.

- The risk of a woman dying from giving birth is at least 10 times greater than the risk of early abortion. (Lem. TR 86:2-18; Ex. 248, Hen TR 266:15-267:1)

- Major complications from abortion are very rare, occurring in approximately 0.001-0.005 percent of abortions (Hen TR 267:8-14)

- By contrast, the rate of hospitalization during pregnancy for reasons other than delivery ranges from 10 to 22%. (Lem. TR 93:2-24)

35. Defendant's experts acknowledge that all surgical procedures have a certain rate of complication that is considered normal. (And. TR 1882:6-9)

36. The risk of dying from an abortion increases with gestational age: The risk of mortality increases about 20 percent for each additional week of gestation of the fetus past eight weeks. (Hen. TR 290:24-291:5, 293:3-13); see also (Uhl. TR 1645:2-16)

- Studies from the U.S. and other countries confirm that the risks of complications from an abortion increase with gestational age. (Hen. TR 291:6-292:15). The risk of major complications increases about 20 percent for each additional week of gestation of the fetus past eight weeks. (Hen. TR 290:24-291:5)

- Although minors are more likely to obtain abortions later than adults, see Ex. 63, most abortions performed on minors are performed during the first trimester. (Hen. TR 293:22-295:10; Ex. 145, Table 16)

37. Having an abortion does not affect a woman's risk of having breast cancer. (Pal. Dep. 96:9-19).

- Well-conducted epidemiological studies show no association between abortion and breast cancer. (Pal. Dep. 17:5-18:3, 33:24-38:11).

- On this issue, the Court gives great weight to the testimony of Dr. Palmer, who herself has conducted studies on the alleged association between abortion and breast cancer, and who is uniquely qualified by her education, training and experience to assess the epidemiological studies. (Pal. Dep. 8:3-7, 8:15-20, 6:24-7:2, 13:16-22, 15:7-10)

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- The following medical groups agree that there is no association between abortion and an increased risk of breast cancer: the American Cancer Society (Ex. 191), the World Health Organization (Ex. 190), the National Breast Cancer Coalition, and the American College of Obstetricians and Gynecologists. (Bri. Dep. 88-95; Sha. TR 649:14-651:16)

38. Loss of the potential protective effect against breast cancer from termination of the pregnancy is not a "risk" associated with abortion because a woman who has an abortion is in the same position as a woman who has never been pregnant. (Pal. Dep. 96:3-8)

Abortion Does Not Cause Psychological Harm

39. Abortion is not associated with long-term psychological harm.

- The predominant emotional responses following abortion are positive feelings of relief and happiness. (Adl. FL 488:22-489:7; Zab. TR 2375:7-13; Sac. Dep. 41:16-43:22)

- Most women do not feel regret or remorse over their abortion decision, and many women feel a sense of control over their lives following an abortion. (Sac. Dep. 36:2-12, 37:14-39:9, 47:21-48:4)

- Severe emotional distress felt by women following an abortion is transient and rare. (Adl. FL 477:19-478:4, 480:19-481:2,488:17-21; Lem. TR 119:8-13, quoting Ex. 252)

- The rate of depression among women following an abortion is equal to the rate of depression in the general population of the corresponding age group. (Sac. Dep. 44:6-12, 45:22-47:9, 129:20-130:22, 139:23-141:13, Sto. TR 731:4-732:5; Ex. 2048)

- In the few cases that the psychological aftermath of an abortion is severe, symptoms generally dissipate between six months and one year. (Sac. TR 33:13-34:20, 35:17-25, 139:8-22; Sto. TR 730:6-18). Thus, there is no reason to study psychological responses following abortion beyond one year. (Sac. Dep. 37:11-38:10)

- A study that followed women for 8 years after having an abortion found no difference in their psychological response compared to women who had not had abortions. (Adl. FL 497:3-498:8).

- Because so many intervening events occur in a 5 or 10-year period, it would be very difficult to study and conclude to what extent, if any, problems women were experiencing were caused an the abortion 5 or 10 years prior. (Sac. Dep. 126:16-127:8, Sto. TR 798:18-799:10, Zab. TR 2374:5-23; 2444:18-2446:11)

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- The rate of post-traumatic stress disorder (PTSD) in women following an abortion is significantly less than the rate in the general population. (Sac. Dep. 125:13-126:9; 141:14-142:7; Sto. TR 760:21-761:16; Exhibit 2048). Being pregnant or having an abortion is not a triggering event for PTSD for women of any age. (Sto. 759:9-760:20)

- "Postabortion trauma syndrome," a term used by some people to mean that a person has PTSD from having an abortion, is not a scientific term. (Sto. TR 761:17-762:20; Adler FL 535:16-19). Dr. Stotland's comprehensive literature review, published in the Journal of the American Medical Association, concluded that there was no plausible scientific evidence for the existence of such a "syndrome." (Sto. TR 762:21-763:8)

- Women of all ages who have unwanted pregnancies experience complex emotional responses, regardless of whether they choose to terminate the pregnancy or carry to term; such a response, however, does not constitute a psychiatric illness. (Sto. TR 722:21-723:5, 726:3-20, 730:6-18). The Diagnostic and Statistical Manual of Mental Disorders (DSM), which includes both mental disorders and "passing circumstances," which do not rise to the level of mental disorders, does not include problems associated with abortion for either adults or minors. (Sto. TR 757:5-758:21)

40. To the extent that negative psychological responses follow an abortion, the abortion does not cause those responses.

- Negative sequalae following an abortion has been very clearly attributable to prior existing conditions or to a response to having to terminate a wanted pregnancy. (Zab. TR 2375:7-2376:7; Ex. 6; Adl. FL 491:10-23, 506:3-6). Other risk factors include: whether the woman has a social support network; whether she was allowed to make the decision of her own free will; whether she was a victim of abuse, neglect or violence; and whether she was poor. (Sto. TR 744:23-745:17, 730:14-731:3, 732:19-22; Adl. FL 491:10-23; Sha. TR 484:16-25, 620:20-621:3; And. TR 1854:19-1855:9)

- In assessing the rare occurrence of negative sequalae following an abortion, it is not possible to separate the experience of the abortion from the experience of an unwanted pregnancy. (Adl. FL 486:10-487:12, 565:3-566:1; Sto. TR 728:6-13, 729:14-730:5). Thus, studies that show a temporal association between abortion and negative psychological reactions do not establish a causal relationship because they do not distinguish between the experience of unwanted pregnancy and abortion. (Sha. TR 484:13-15)

- The testimony regarding J.R.'s abortion illustrates this point. It is impossible to separate any negative emotional responses JR may have had to her abortion from her response to discovering that she was pregnant with a boyfriend her parents

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disapproved of, wanting an abortion, and having a mother who was openly anti-choice and to whom she did not feel she could confide in about her pregnancy. (Rob. TR 2249:23-2250:6)

- Dr. Josephson's testimony regarding PTSD following abortion is unpersuasive because the article on which he relied found that minors who had had abortions suffered PTSD at lower rate than the general population. (Jos. TR 1531:17-1532:3; Ex. 2048). Moreover, the authors of one of the studies Dr. Josephson relied on to support his opinions about negative psychological responses to abortion concluded that "[w]hen history of abuse, partner characteristics and background variables were controlled, abortion was not related to poorer mental health." (Jos. TR 1151:20-1552:6; Ex. 236)

- The Court finds testimony by Defendant's experts regarding abortion and suicide unconvincing. The studies cited by Defendant's experts on this point report only a temporal association but not a causal connection. For example, the Gissler research, (Ex. 205), reports higher rates for all violent deaths and accidents following abortions. (Sha. TR 501:10-502:8, 583:3-12; Jos. TR 1483:3-21). As the author of the study notes, "The age-adjusted risk for violent death, accident, suicide, homicide, was increased for women with a recent abortion compared to other women, probably because of factors related to social class and lifestyle." (Sha. TR 610:11-22, 603:12-17; Jos. TR 1532:20-1533:7, 1536:1-12)

41. That a woman, minor or adult, may be at a higher risk for adverse psychiatric sequalae following an abortion is not a valid reason to deny her an abortion. Forcing a woman to carry a pregnancy to term against her will has negative consequences. (Sto. TR 744:3-22).

42. Age is not a risk factor for adverse psychological sequalae following abortion. (Sto. TR 739:13-22). Studies by Drs. Adler, Zabin, and others confirmed that minors experienced no significant psychological change following abortion and no difference in reaction compared to older women. (Adl. FL 487:1-24, 500:23-501:19, 506:8-20; Zab. TR 2373:24-2374:4, 2364:17-2365:9, 2441:11-13)

- Participants in some of the studies included a significant number of minors younger than 16. (Zab. TR 2441:20-2442:10)

- Following abortion, minors demonstrated an increased locus of control, and at two-year follow up review, their anxiety and stress level was significantly lower than minors who had given birth. (Zab. TR 2365:25-2368:16; Ex. 161, page 4)

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- Dr. Zabin's findings are widely generalizable because they are comparable to other studies conducted in varying locations. (Zab. TR 2372:22-2373:20, 2374:24-2375:6)

- Although the Major study reported that younger women evaluated their abortion more negatively than the older women, it did not report that young women suffered negative effects from abortions. (Sac. Dep. 121:5-122:10; Ex. 2048).

43. In addition, no data demonstrates that adolescents who obtain abortions are at a particular risk for suicide. (Adl. Dep. 56:23-57:10)

44. Studies, including Dr. Zabin's own, have shown that whether a minor was satisfied with her pregnancy decision was not related to whether she had discussed the decision with a parent or which option she chose; her satisfaction was mainly related to whether she received support and whether she felt that she made the final decision. (Zab. TR 2354:25-2356:19; Adl. Dep. 65:2-7). see also (Lem. 119:5-11, Ex. 252)

45. Defendant experts' testimony as to adverse psychological reactions to abortion is not persuasive.

- Some of Defendant's experts agree that there have not been any reliable studies that show significant adverse psychological effects on women from having an unintended pregnancy and an abortion because studies that have led authors to draw such conclusions did not include control groups (Gre. Dep. 114:5-119:1)

- The testimony of Defendant's experts regarding the alleged negative psychological consequences of abortion is undermined by their imprecise reporting of the research. Both Dr. Shadigian and Dr. Josephson, omitted critical information in offering their opinions on rates of depression following abortion by failing to note that in the study relied upon depression was higher only among married women, a group not affected by SB 24. (Sha. TR 664:19-668:9; Jos. TR 1542:3-1543:18).

- All of the studies that Defendant and its experts rely on for the proposition that women who have abortions have significant psychological reactions are unreliable for some or all of the following reasons: they are methodologically unsound because they rely on self-selected samples whose baseline psychiatric characteristics were not revealed; the researchers did not actually measure psychiatric illness; the comparison group of women who had abortions is women who wanted to have children, rather than women who did not but had them anyway; and they compare rates of hospitalization for circumstances where the likelihood for admitting patients for

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hospitalization for the same psychiatric state are not comparable. (Sto. TR 735:5-739:12, 739:23-743:12; Adl. FL 483:15-24; Sac. Dep. 50:5-16, 51:4-53:7; Exs. 213, 237, 2081, 2092)

- Dr. Shadigian's testimony in particular is undermined by the fact that although she relies on certain articles to support her opinions regarding adverse psychological consequences of abortion, she disagrees with information within those same articles that find no adverse results. (Sha. TR 685:15-690:8; Ex. 2048; Ex. 2062)

Abortion Services In Alaska

46. Abortion providers in Alaska provide quality health care to all of their patients. No evidence was presented to the Court suggesting that minors or adult women seeking abortions in Alaska are at different or increased risks than those in other parts of the country.

- All three of the Alaska doctors who testified believe that the physicians currently performing abortions in Alaska are competent to do so. (Lem. TR 151:13-19; Ric. 911:25-912:6; Whi. TR 1136: 7-10)

- The rate of patients that return for follow up visits is higher in Alaska than the national average. (Whi. TR 1134:19-1135:2, Lem. TR 98:2-22)

- Dr. Greene has no reason to believe that Alaska abortion providers don't provide quality health care to their patients. (Gre. Dep. 110:15-23)

47. Abortion providers in Alaska properly obtain informed consent for abortions from their minor patients (Tsa. TR 1358:16-23); there is no evidence to the contrary.

- As part of the informed consent process, abortion providers in Alaska discuss their patients' options, including abortion, carrying to term and raising the child, or placing the child up for adoption, with all their patients, including minors. (Lem. TR 44:14-25; Whi. TR 1038:20-1039:6). They also offer to assist the patient with additional counseling both before and after the abortion if she desires. (Lem. TR 45:3-24)

- Abortion providers in Alaska encourage parental involvement in minors' abortion decisions (Gre. Dep. 110:24-111:2; Lem. TR 102:14-25); there is no evidence to the contrary.

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- Certified nurse midwives or nurse practitioners acting under the supervision of a physician may properly obtain medical histories and informed consent from minor patients. (Whi. TR 1035:11-1036:20; And. TR 1855:10-19)

- The Court finds that Alaska abortion providers are appropriately disclosing the risks of abortion to their patients as part of the informed consent process. For example, Dr. Lemagie discloses those risks listed by ACOG in its publication on abortion. (Lem. TR 82:5-84:5; Ex. 248). It is ACOG's position that abortion does not have an adverse effect on future reproduction. (Lem. TR 95:3-24)

- Dr. Shadigian's testimony regarding additional risks that should be disclosed during the informed consent process, such as placenta previa, ectopic pregnancy, and future risk for early miscarriage, is contradicted by statements in her recently published article which found no association between those conditions and abortion. (Sha. TR 496:20-497:2; Whi. TR 1063:11-24; 1069:21-1070:3, 1065:14-16; Ex. 2218A)

- It is not necessary in order to obtain informed consent for abortion, to discuss the alleged link between abortion and breast cancer. As noted, epidemiological studies establish that no such link exists. (Pal. Dep. 96:9-19, 17:9-18:3, 33:3-38:11, 18:4-19:12). Moreover, it is ACOG's position that no link has been established. (Whi. TR 1057:12-23, 1058:13-22; Ex. 189). Alaska physicians can reasonably rely on the position of their relevant professional organization in deciding not discuss the alleged association in the informed consent process.

48. Whether a physician has had previous contact with a patient has no bearing on the safety of the abortion procedure or the quality of care provided. (Gre. Dep. 109:4-14; And. TR 1856:23-1857:16; Lem. 159:1-13; Ric. TR 883:1-10; Whi. 1014:22-25)

Many Harms May Result From Teenage Pregnancy And Childbirth, Particularly If A Minor Is Forced To Carry Her Pregnancy To Term

49. As Defendant's experts agree, the risks associated with pregnancy and childbirth are much greater than the risks associated with abortion. (Hen TR 269:2-18; Tsa. TR 1352:6-11; Ric. TR 851:5-9)

50. At least 22-25 percent of births involve major abdominal surgery (Hen TR 267:14-18)

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51. Pregnancy can be complicated, and therefore considered high-risk, by pre-existing maternal health conditions, conditions caused by the pregnancy, fetal abnormalities, or multiple fetuses. (Ric. TR 841:22-842:6; 844:24-845:2; 845:11-846:23)

- For example, diabetes, if not adequately managed, can significantly increase the risk of neural tube defects for the fetus and pose life-threatening risks to the pregnant woman. Dr. Richey has treated pregnant minors with diabetes. (Ric. TR 842:24-844:14)

- Preeclampsia is a very serious condition, which can be fatal, one aspect of which is pregnancy-induced hypertension. (Ric. TR 847:24-849:21; Jos. TR 1717:18-21). Although the hypertension can be treated with medication, the disease itself can only be cured by delivery of the pregnancy. (Ric. TR 849:22-25). The effects of preeclampsia can in some cases be mitigated in order to allow the fetus to develop to viability, but this poses a threat to the woman. (Ric. TR 850:1-17)

- It is particularly important for a pregnant woman with pre-existing maternal conditions, such as hypertension, heart disease, and asthma, to begin prenatal care as early as possible. (Ric. TR 844:24-845:7)

52. Pregnancy is more risky for a minor under 17 than for a woman of 25, and the younger the minor, the more risky it is. (Ric. TR 850:18-851:4).

53. Dr. Calhoun considers all adolescent pregnancies to be high risk, and failure to obtain prenatal as subjecting both the minor and the fetus to potentially serious health risks. (Cal. TR 1716:6-11, 1717:3-13). Dr. Calhoun has stated that: "[W]omen 19 years of age and younger have double the maternal mortality, double the risk of low-birth weight infants, and triple the neonatal death rate of the general population." (Cal. TR 1765:8-1766:2; Ex. 2055)

- Minors have an even higher risk than adults of developing certain pregnancy-related complications, including preeclampsia, preterm labor, and preterm birth. (Ric. TR 847:10-23; Cal. TR 1760:1-10)

- Full term pregnancy before the age of 18 increases a woman's risk of heart attack two-fold. (Pal. Dep. 88:16-24, 89:1-14). Following full-term pregnancy, women experience an increased risk of breast cancer for approximately fifteen years. (Pal. Dep. 91:22-93:19, 163:12-24)

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54. As Dr. Stotland testified, "The emotional consequences of unwanted pregnancy on parents and their offspring may lead to longstanding life distress and disability, and the children of unwanted pregnancies are at high risk for abuse, neglect, mental illness, and deprivation of the quality of life." (Sto. TR 754:24-756:5, 756:13-757:4, quoting Exhibit 28)

- Defendant's experts concede that denying a minor an abortion that she wants and forcing her to carry a pregnancy to term may cause that minor to experience negative psychological effects. (Gre. Dep. 87:2-11; Jos. TR 1552:8-24; Ex. 282); see also (Stot. TR 753:23-756:5; 756:13-757:4; Ex. 28) (The American Psychiatric Association recognizing that the freedom to interrupt a pregnancy is a mental health imperative)
- Dr. Josephson's testified that it is appropriate to force a pregnant minor to carry an unwanted pregnancy to term in order to further her psychological growth. (Jos. TR 1557:11-1558:18). His claim that forced pregnancy is not damaging to a minor because minors "need to learn and understand how to handle their sexual behavior and to be responsible with respect to creating human life," (Jos. TR 1458:5-11), was not only unsupported by research, but strikes the Court as punitive and reveals Dr. Josephson's bias and personal opposition to abortion.

55. Approximately 10-20 percent of women who carry pregnancies to term experience postpartum depression, a discrete psychiatric illness. (Sto. TR 728:14-22). Dr. Anderson has treated pre and post-partum women carrying to term for depression and attempted suicide. (And. TR 1873:14-23). The rate of depression and other psychiatric illnesses is approximately five times higher after childbirth than it is after abortion. (Sto. TR 732:23-733:10).

56. Dr. Zabin's study showed that minors who gave birth were more likely to suffer from psychological problems than those who obtained abortions. (Zab. TR 2369:18-2370:19)

- Motherhood is psychologically harmful for adolescents because it makes it difficult for them to develop an integrated sense of self, (Elk. Dep. 106:9-14). This is particularly true if their parents are not supportive of the pregnancy. (Elk. Dep. 102:24-103:14)

57. Adolescents who give birth are at serious psychological, economic, vocational and educational risk. They are twice as likely to drop out of school and less likely to finish their education than women who delay childbearing. Elk. Dep. 105:11-106:8; Cal. TR 1760:19-1761:23, 1764:1-8; Hen TR 262:10-14)

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- Dr. Zabin's studies demonstrated that minors who gave birth had lower rates of subsequent use of contraception and a higher subsequent pregnancy rate than those who obtained abortions. (Zab. TR 2368:22-2369:17; Ex. 161, page 5, Tables 5 and 6)

58. Each year in Alaska some minors relinquish babies for adoption, (Ex. 2009), and accordingly some may suffer severe psychological consequences. (Elk. Dep. 124:8-23; Sac. Dep. 33:13-34:20, 35:17-25, 53:11-58:10, 59:22-60:13); see also (Gre. Dep. 106:10-17)

- Based on Dr. Sachdev's research, which included subjects who were 16 and under at the time of relinquishment, women who relinquish a child experience pain, guilt, grief, and regret for much of the rest of their life. (Sac. Dep. 33:13-34:20, 35:17-25, 53:11-58:10; Ex. 317). These findings are consistent with the findings of other studies. (Sac. Dep. 59:22-60:13)

The Alaska Parental Consent Law Will Harm Minors

59. The Court finds that SB 24 would cause some minors to delay obtaining abortions.

- Studies from Minnesota, Mississippi, and Missouri that have examined the relationship between parental involvement laws and the gestational age at which minors have abortions have found that such laws result in some minors experiencing delay, resulting in an increase in the proportion of all abortions that took place in the second trimester. (Hen. TR 282:25-284:8, 423:10-19)

- Dr. Uhlenberg conceded that evidence from Minnesota, showed a greater proportion of minors obtained abortions after 12 weeks gestation after a parental notification law went into effect. He concluded that the data might indicate that although fewer minors were seeking abortions within the state, those that did experienced delays. (Uhl. TR 1607:25-1608:16; 1639:19-1640:18; Ex. 120

- Although Dr. Uhlenberg testified that no increase in gestational age caused by parental involvement laws had been established, one of the studies he relied on revealed that there was a statistically significant increase in the mean gestational age of the fetus at the time minors affected by the parental involvement law obtained abortions from before and after the law went into effect. (Uhl. TR 1642:23-1644:4; Ex. 121, Table 5)

60. As the American Academy of Pediatrics has noted, the delays caused by the Act will increase the risks associated with abortion (Lem. TR 107:20-113:16, 115:4-116:9, 119:24-120:11; Ex. 252); it will also extend the time of greatest distress for minors. (Adl. FL 547:7-

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16; 493:15-494:13; Hen TR 290:24-291:20) Minors generally have abortions later in their pregnancy than older women to begin with. (Hen. TR 286:16-287:7)

61. Because deciding whether to tell one's parents about an unwanted pregnancy and desire to abort takes time, parental involvement laws undoubtedly increase the tendency of minors to delay obtaining an abortion. (Hen. TR 286:16-287:22; Sto. TR 747:20-748:25; Tsa. TR 1358:24-1359:5)

- Various studies, some of which included adolescents as young as 12, have shown that a primary reason that minors delay in obtaining abortions and other reproductive health care is that they don't want to consult their parents or other people. (Hen. TR 286:16-287:22; Zab. TR 2338:19-2339:25, 2405:2-2407:18; Exs. 162, 2155)

62. Delay also can increase the cost of the abortion, which then might cause further delay to raise the additional money. (Sab. TR 2569:10-20, 2570:24-2571:4)

As a Result of the Act, Some Minors Will Be Forced To Carry An Unwanted Pregnancy To Term

63. A likely effect of parental consent for abortion laws is that some minors are forced to continue pregnancies that they would otherwise terminate by abortion. (Hen. TR 271:10-272:5)

64. Some minors will be forced to carry to term against their will by their parents. (Hen. TR 295:24-296:18; And. TR 1900:8-1901:3).

- For example, Ms. Christiansen testified that if D.M. had sought her for consent for an abortion, she would have refused unless the pregnancy threatened D.M.'s life, even though she knew that D.M. had threatened suicide or an illegal abortion. (Chr. TR 1969:4-12)

- In consulting with pregnant minors and their parents, Ms. Patkotak witnessed approximately 10-12 instances when the minor, who wanted to terminate the pregnancy, followed a mother's order to continue the pregnancy so that the mother or another relative could raise the baby. (Pak. TR 1192:16-1194:4)

- Judge Martin testified that some minors that appear before him seeking a judicial bypass testify that they do not want to tell their parents about their pregnancy and

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desire to have an abortion because an older sister got pregnant and her parents forced her to carry the pregnancy to term. (Mar. TR 967:2-13)

65. As Defendant's experts concede, some minors may carry to term because their fear of consulting their parents leads them to continue their pregnancy. (Tsa. TR 1366:22-1367:7; Whi. TR 1082:7-1083:1)

66. Other minors will be forced to carry to term because the delay caused by the parental consent requirement will prohibit them from obtaining an abortion due to unavailability, increased cost, or comfort level. (Hen. TR 295:24-296:18).

- Services for second trimester abortions are limited in Alaska. Dr. Lemagie is the only physician in Alaska who performs abortions in the second trimester for reasons other than medical indications or in cases of fetal anomalies. (Lem. TR 43:9-15, 161:6-24)

Some Minors May Take Drastic Measures To Avoid Involving A Parent Or Judge In Their Pregnancy Decisions

67. Parental consent laws may lead minors to obtain illegal, unsafe or self-induced abortions. (Hen. TR 271:10-272:5, 430:6-433:3; Sto. TR 750:20-751:4; Lem. TR 115:4-25)

- One study that asked minors who were pregnant and wanted to have an abortion what they would do if their parents had to be informed that they were having the abortion reported that 23 percent would not have the abortion, 9 percent would have a self-induced or illegal abortion, and 9 percent would continue the pregnancy and have the baby. (Hen. TR 311:7-312:18; Ex. 124, Table 7)

- Dr. Henshaw testified about one known death of a minor who had an illegal abortion in order to avoid a parental notification law. (Hen. TR 430:17-18); He further testified that for every illegal abortion that resulted in death, it is likely that more than one hundred illegal abortions occurred that did not result in death. (Hen. TR 431:13-23)

- Dr. Richey in her practice has seen young women in Alaska and elsewhere inflict life-threatening injuries from attempts to self-abort, and fears that the parental consent requirement will increase the incidents of this dangerous behavior. (Ric. TR 867:3-868:6, 912:7-913:8)

- In every country and culture where it has been studied, when abortion is not legal, obtainable and safe, women try to self-abort, which is the cause of a large number of

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complications and deaths related to pregnancy all over the world. (Sto. TR 751:12-23, 771:12-773:2).

- As Defendant's experts agree, attempts at self-induced or illegal abortions, including those caused by a minor trying to avoid the effects of a parental involvement law that did not result in death would not necessarily be reported anywhere. (Uhl. TR 1677:15-19; Sto. TR 811:3-25). Defendant's experts agree that if minors took such steps because of such a law, even if they didn't die as a result, that would be a negative effect of the law. (Uhl. TR 1677:20-1678:8)

68. Forced parental involvement laws have caused minors to travel to other states to obtain abortions in order to avoid the effects of the law. (Hen. TR 271:10-272:5; Uhl. TR 1631:5-25).

- Studies of Massachusetts, Missouri and Mississippi demonstrate a significant increase in the number of minors who traveled to other states to obtain abortions after parental involvement laws went into effect. (Hen. TR 272:13-277:15; Ex. 118; Ex. 146; Ex. 151; Sab. TR 2576:19-2577:9)

- The South Carolina study, which did not show out-of-state travel by minors, does not undermine the court's conclusion because of differences in both the law and demographics in that state. (Hen. TR 277:16-282:20)

69. To the extent that out-of-state travel may be prohibitive for Alaska minors, the Court concludes that the Act is more likely to increase forced childbearing and attempts to self-abort than in other states without the significant travel barriers that exist in Alaska.

The Act Will Expose Some Minors to Physical and Psychological Harm

70. Defendant's experts agree that some parents may abuse their minor daughter if they learned that she was pregnant. (Tsa. TR 1360:20-22; And. TR 1893:7-10; Adl. FL 548:7-14; Hen. 308:18-310:4, 358:14-358:22; Sto. TR 750:20-751:4)

- Dr. Henshaw testified that abuse and other adverse consequences would occur in Alaska, if as a result of SB 24 going into effect, minors consulted their parents against their judgment. (Hen. TR 310:22-311:06)

- Teenagers who get pregnant are more likely to have been abused or neglected than the general population. (Sto. TR 726:21-727:3). Minors generally do not report abuse in the home. (Sto. TR 751:9-11). Evidence from the Minnesota and Massachusetts

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judicial bypass systems demonstrate that minors often fear telling their parents about their desire to have an abortion because they fear either physical or emotional abuse. (Mar. TR 960:12-961:3, 967:14-968:4; Sab. TR. 2557:25-2559:8).

- Judge Martin estimates that approximately 33 percent of minors seeking a judicial bypass fear abuse or being kicked out of their house, sometimes because such the petitioners witnessed such consequences with a sister. (Mar. TR 960:12-961:3)

- "Adolescents who are strongly opposed to informing parents tend to predict family reactions accurately. . . . One third of minors who do not inform parents already have experienced family violence and fear it will recur. Research on abusive and dysfunctional families shows that violence is at its worst during a family member's pregnancy and during the adolescence of the family's children. Although parental involvement in minors' abortion decisions may be helpful in many cases, in others it may be punitive, coercive, or abusive. " (Lem. TR 112:3-114:9, quoting Ex. 252)

- Parents who learn of their daughter's abortion by some means other than being told by the minor were much more likely to have a negative reaction than those who learned about the abortion from their daughter. (Hen. TR 310:5-21, 358:14-359:15, 386:20-387:18; Ex. 123) As a result, forcing minors who, in their judgment, think it is better not to tell a parent about her desire to have an abortion will have a greater chance of suffering negative consequences as a result than those minors who voluntarily confide in their parents. (Hen. TR 309:25-311:6, 358:14-360:1)

- Although some of Defendant's experts testified that there is no evidence of abuse as a result of parental involvement laws, (Elk. Dep. 51:12-16), that testimony is unpersuasive because such abuse is unlikely to be reported, and because it was based in large part on statements in a press briefing. (Elk. Dep. 116:24-119:24; Ex. 85)

71. Minors experience a variety of other negative consequences from forced parental involvement, such as neglect, being thrown out of the home, and stress in the home.

- After Ms. Christiansen learned that her great niece had had an abortion, she told DFYS that she "want[ed] to relinquish custody of her immediately, didn't want her back," and has not seen her since. (Chr. TR 1964:2-5, 1965:10-11, 1971:10-20)

- In Henshaw and Kost's study, minors whose parents learned of their pregnancy against the minor's will reported the following consequences: their parents' stress increased, the minor became uncomfortable living at home, there were problems between the minor's mother and father or stepparent, the health of their parents suffered, there was physical violence at home, and some were forced to leave home. (Hen. TR 308:18-310:4, 358:14-359:15; Ex. 123, Table 7)

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- Some of Dr. Greene's minor patients have voluntarily told their parents that they were having an abortion and regretted doing so. (Gre. Dep. 88:9-13)

Harms To Minors From The Judicial Bypass System

72. The Court finds that the harms created by the parental consent requirement will not be mitigated by the judicial bypass option because the bypass process will delay abortions and because some minors will not be able to obtain bypasses.

73. Evidence from Minnesota and Massachusetts demonstrates that minors who go through the judicial bypass proceeding experience delay. (Sab. TR 2532:6-14; Mar. TR 963:2-15).

- In Massachusetts, where Ms. Sabino believes the process is working as well generally as a judicial bypass system can work, minors experience a 1-2 week delay between the time they contact an abortion clinic to the time they receives the abortion. (Sab. TR 2551:24-2552:2, 2615:14-17, 2565:10-2569:9)

- The problems that cause these delays include, the difficulty the minor and her attorney may have contacting each other due to schedules and confidentiality concerns, (Sab. TR 2537:4-2538:22), and delay in holding the hearing due to the inability of the minor to arrange a time when she can be away from school or family or arrange transportation. (Sab. TR 2540:3-16, 2612:14-16, 2565:14-2568:3)

- Unlike Massachusetts, in Alaska, a minor cannot have an attorney appointed until she files her petition, and thus would have to obtain the forms, complete them and file them without the assistance of an attorney. (Mil. TR1406:10-13). This will likely exacerbate the delays associated with the bypass process. (Sab. TR 2574:25-2575:14)

- Although both sides have brought to the Court's attention the existence of private organization in two states that assist minors seeking judicial bypass hearings, (Col. TR 2029:2-2030:5; Sab. TR 2511:24-2513:16), the Court cannot rely on this evidence to speculate what non-governmental third parties in Alaska may do to mitigate the burdens of the bypass should the Act go into effect.

- Defendant's argument that lack of access to abortion provides, rather than the judicial bypass, will prevent minors from rural Alaska from obtaining abortions is not persuasive. Statistics from AWHC show that a significant number of minors who live in villages without road access to providers nonetheless obtain abortions. (Ex. 2022A). The testimony of several witnesses demonstrates how minors may make arrangements to travel the location of an abortion provider. (Chr. TR 1959:24-1960:3; 1961:20-1962:11; 1970:22-1971:9; Pak. TR 1194:15-1195:12; 1234:5-15; Coo. TR 1273:10-1274:7; Mur. TR 2211:24-2212:12)

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- Defendant's suggestion that a minor may simply come to the location of an abortion provider and obtain a bypass overlooks the difficulties that would be caused by the additional time away from home and the need to find a place to stay while awaiting the abortion and is contrary to the experience in Massachusetts. (Sab. TR 2551:24-2552:2, 2552:22-2553:4) Moreover, a minor may not wish to travel to the location of the abortion provider until she knows that her petition has been approved.

74. In Massachusetts, some minors have been delayed from obtaining the abortion in the first trimester to the second, and some have been prevented from obtaining an abortion in Massachusetts. (Sab. TR 2571:5-15)

75. The Court finds that many minors in Alaska are unlikely to participate in the judicial bypass process.

- Judge Cooke believes that the judicial bypass option of SB 24 is not something that minors in the Bethel area would understand or use because it involves terms, concepts and procedures that are alien to the minors, and even if the minors attempted to use it, they would be put off by the hurdles they would need to overcome to accomplish it. (Coo. TR 1249:24-1251:22, 1252:17-1253:3)

- Based on her experience with minors' reluctance to discuss personal and private matters such as unwanted pregnancy in a confidential health care setting, Ms. Patkotak believes minors in the North Slope would have difficulty overcoming their fears to appear in front of a judge. (Pak. TR 1213:21-1214:11)

- Many Alaskans do not have easy access to the courts. Alaska has 13 superior courts and 7 district courts, and approximately 30 magistrates positions in locations without superior or district courts. In many villages, the magistrate works only part-time, and when the he or she is out of town, the office is closed. (Mil. TR 1402:25-1403:20). Over 200 communities do not have road access to the court system. (Ex. 179)

- A 1997 report by the Alaska Supreme Court identified problems within the court system including "cultural misunderstandings, inadequate services, [and] lack of accessibility." (Ex. 180: p. vii). The report finds that "[o]ne-fourth of Alaskans do not live within reasonable reach of many court system services," and that "[m]any state residents see the court system as a remote, intimidating, and unfathomable institution." (Ex. 180: ix, 1-7, 14-17, 19-22, 25, 33, 48-50, 94-104, 108-118). A subsequent report from August 2000 reports that additional work needs to be done on the court system's communications system because "many rural courts have outdated

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phone systems that transmit poorly and make it difficult for rural residents to participate effectively." (Ex. 178: p.11)

76. The court does not accept Defendant's assertion that the judicial bypass option is a viable alternative to parental consent for abused minors.

- In addition to the burdens faced by any minor seeking a bypass, abused minors face the additional problems of frequently being closely controlled by the abuser and the added fear that they will be harmed if the abuser finds out that she is seeking a bypass. (Elk. TR 100:8-101:24; Sab. TR 2557:25-2559:3)

- The uncontested testimony from several witnesses establishes that abused minors are unlikely to disclose their abuse in the bypass process. (Rei. TR 933:18-934:16, 935:17-25); 934:17-935:9; 944:13-945:10; Pak. TR 1184:10-1185:4; 1186:2-8; 1190:18-1191:3; Elk. Dep. 98:10-100:1)

77. The Court finds that a pregnant minor in Alaska who is able to initially access the judicial bypass option will have great difficulty proceeding.

- A vast majority of minors in villages would have trouble filling out the judicial bypass forms. (Rei. TR 929:16-930:21, 943:19-944:1; Pak. TR 1201:16-1202:6; Ex. 2005)

- In order to have a petition notarized by a court clerk, the minor must produce some form of picture identification, unless the clerk knows her. (Mil. TR 1406:14-1407:5). Many minors, particularly those who are younger, may not have a driver's licenses or other acceptable identification. (Pak. TR 1208:15-1209:9)

- Although the forms prepared by the court system provide an alternative to notarization, that option does not alleviate the burdens of the requirement. The petition form permits the minor to certify that a notary was not available, in lieu of having the petition notarized. (Ex. 2006) For a minor who does not feel that she can maintain her confidentiality if she approaches a local notary, and who wishes to fax the petition or have it filed by someone else, the alternative certification is not available.

- Language barriers often make it difficult for people in Bethel to access the court system. (Rei. TR 927:17-928:3). Although a "cultural navigator" position was created in Bethel to help pro se people navigate the court system, the cultural navigator is only available in the Bethel area. (Rei. TR 927:1-12)

78. Some minors seeking bypasses will have difficulty communicating with their attorney and the court before and during the bypass hearing.

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- It would be difficult for a minor in the Bethel area to talk to an OPA attorney or court about the issues she would need to in order to obtain a bypass, particularly because the OPA attorney will likely be in another location, and because a Yupik girl would be uncomfortable talking to strangers about these issues. (Coo. TR 1254:5-1255:9; Rei. TR 921:6-21; Pak. TR 1211:23-25, 1212:13-1213:3)

- Minors in the Bethel are often very nervous, quiet, unsure of themselves, brief, and unwilling to volunteer information when appearing in court. (Rei. TR 925:1-7; Coo. TR 1255:10-21) They likely would be even less communicative in a bypass hearing because of the nature of the issues that would be discussed, and possibly the necessity of the minor understanding that what has happened to her constitutes abuse. (Coo. TR 1255:22-1257:21). Judge Cooke testified that many cases get dismissed because it's difficult to get minor victims of abuse to testify. (Coo. TR 1256:12-1257:3)

- Conducting bypass hearings over the telephone would compound the communication problems; some of the Native Alaskan cultures are very nonverbal; minors often speak with their heads down and express their thoughts through facial expressions such as squinting their eyes and raising their eyebrows; in the past, judges have stopped and rescheduled an in-person hearing because he couldn't really understand the minor. (Pat. TR 1213:21-1215:22; Coo. TR 1255:10-21, 1257:22-1259:5)

79. The judicial bypass process cannot guarantee confidentiality to minors and instead creates a number of opportunities that further increase the possibility that minors' confidentiality will be breached. (Mar. TR 973:19-974:11; Sab. TR 2532:6-14, 2554:13-25)

- Minors in Bethel and the North Slope would have difficulty finding a phone or fax that they could use confidentiality to communicate with the court or their attorney. (Pak. TR 1198:24-1199:24, 1211:23-1213:20; Rei. TR 925:2-7,925:16-926:5, 928:8-929:8, 947:22-948:17)

- The notarization requirement will force minors to inform another adult (the notary) of her intention to obtain an abortion, (Sab. TR 2574:14-24), and there are few notaries in the villages, which may make it difficult to approach those persons to obtain a confidential notary. (Rei. TR 931:18-932:12; Pak. TR 1209:10-1210:3)

- In addition to the court personnel who learn of the minor's request for a bypass, some minors have run into people they know, including parents, relatives, neighbors and classmates, in or in front of the courthouse (Sab. TR 2572:1-7; Mar. TR 973:19-974:11)

80. The Court finds that some parents will find out about a daughter seeking a bypass through contact with the school. (Sab. TR 2572:7-2573:2)

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- Defendant admits that if SB 24 were in effect, the parents of a student who missed classed to attend a judicial bypass hearing would be notified of the student's absence from class and the absence would also be noted on the student's report card. (Arn. TR 2685:14-18; 2674:10-2675:10; Ex. 62, Section II-3, 2676:23-2677:1; Ex. 63)

- The minor might need to tell persons to arrange to be excused from school or to obtain transportation to the hearing that she did not want to tell; additionally, those persons may tell her parents. (Sab. TR 2571:16-2572:1)

81. The experience of experts who have participated in the bypass process is that it can cause significant emotional distress to minors. (Sab. TR 2532:6-22) (Mar. TR 961:23-962:7).

- Based on his experience in the Alaska courts, Judge Cooke believes that a judicial bypass hearing could be very intimidating and traumatic. (Coo. TR 1276:2-11)

- Ms. Reichard testified that the children for whom she acts as a GAL are frightened when appearing in court, even though she or an attorney has explained to them several times what the hearing will be like. (Rei. TR 924:16-925:2; 926:14-25)

- Defendants concede that some minors under 17 might be fearful of participating as a witness or complainant in a judicial proceeding. (Exhibit 63)

The Act Will Hinder Minors from Receiving Medical Emergency Care

82. The narrow definition of medical emergency will cause physicians to delay care that they would give immediately to an adult woman. (Whi. TR 1075:18-24)

- When continuation of the pregnancy would pose a significantly greater risk to the pregnant minor's life or health than the risks of a normal pregnancy, an abortion is medically indicated. (Ric. 852:23-853:7). The affirmative defense for "medical emergencies" in the Act is more narrow than this because it requires an emergent situation. (Ric. TR 854:15-856:4)

- Even according to Defendant's experts, the definition of a medical emergency in the parental consent law employs concepts that are "inconsistent," "not terms of art that [physicians] are used to in the medical field," and do not cover the full range of what physicians perceive as medical emergencies. (And. TR 1845:18-1852:2)

83. Doctors will be hesitant to put themselves in jeopardy of prosecution and possible conviction of a felony in applying the medical emergency language because it contains vague terms such as "immediate." (Ric. TR 907:7-25, 908:5-25)

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- For example, Dr. Richey would not perform a first trimester abortion on a minor who faced a 50% risk of mortality in the third trimester without parental consent or judicial approval if the law were in effect. (Ric. TR 908:5-25). "Immediate threat" is a term that cannot be quantified. Neither "immediate threat," "serious risk," or "major bodily function" have common definitions within the medical community. (Whi. TR 1077:3-1078:13)

- For example, a patient with a partial molar pregnancy faces serious health risks that can only be alleviated by termination of the pregnancy. The patient may appear stable, but is at risk for having a seizure. In that situation, it is not clear whether the patient's condition would constitute a medical emergency under the Act. (Whi. TR 1078:14-1080:5)

- The State will prosecute physicians or others who knowingly violate the criminal provisions of SB 24 if the law comes in effect. (Exhibit 63, Def.'s Resp. to Pls.' Disc. Reqs. dated December 26, 1997)

SB 24 Will Harm Minors By Preventing Them From Accessing Health Care

84. SB 24 will have a chilling effect on not only on adolescents seeking abortion-related health care, but other reproductive health care, such as contraception, counseling and medical advice; some will delay seeking such health care and some won't seek it at all. (Zab. TR 2337:3-2338:10; 2340:1-5; 2349:8-19)

85. As recognized by many medical associations as a basis for opposing forced parental involvement laws, confidentiality is crucial to the willing of adolescents to seek reproductive health care. (Lem. TR 27:17-28:6, 28:7-30:5, 137:21-139:1; Exs. 246, 249, 253; Zab. TR 2336:15-2337:2)

- In a recent study that asked teenagers what they would do if mandatory consent were required for contraception, 47% said they would stop using all sexual health care services altogether. (Zab. TR 2347:7-2349:7; Ex. 169)

- Dr. Zabin's studies revealed that a major reason that adolescents seeking various types of reproductive health care, such as contraception and pregnancy tests, chose the facility that they did was because they didn't need to inform their parents that they were seeking such care. (Zab. TR 2338:19-2339:25; Ex. 162)

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- Yet, a large case-controlled study of Dr. Zabin's demonstrated that once they are assured confidentiality by talking with a counselor at a reproductive health care facility, adolescents will often choose to involve their parents. (Zab. TR 2340:1-2341:8)

86. Defendant's experts who do not support parental consent laws for minors seeking treatment for sexually transmitted diseases or prenatal care acknowledge that such laws will keep minors away from seeking healthcare; they oppose such requirements because they do not want to discourage minors from seeking treatment. (Tsa. TR 1319:19-1321:19; 1352:13-1353:12)

- In Dr. Tsao-Wu's opinion, the importance of confidentiality of a minor seeking contraception, pregnancy-related treatment or STD treatment trumps the benefits that a parental consent of notification law for such treatment might result in. (Tsa. TR 1347:19-1348:9, 1349:7-1350:2, 1352:13-1353:12)

- Dr. Anderson admits that a mandatory parental involvement law for STD's may delay the minors from getting treatment for STD's because they don't want to involve their parents. (And. TR 1889:20-1890:1)

87. In light of Dr. Zabin's uncontested testimony, the Court finds that SB 24 would likely deter minors seeking all reproductive health care, including care that Defendant's experts agree should be available without parental consent.

SB 24 Will Not Further the State's Asserted Interests

88. The Court finds that the following proven facts demonstrate that SB 24 will not protect the health of minors obtaining abortions, but rather will undermine the health and well-being of minors seeking reproductive health care:

- Abortion is a very safe procedure with a low rate of serious complications.

- Abortion does not pose a mental health risk to women in general or to minors in particular.

- In terms of post-abortion psychological response, studies indicate that parental involvement does not make a difference. (Adl. FL 510:24-511:10, 581:6-12)

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- The delays created by SB 24 will, however, increase the risks of abortion by forcing minors to obtain the procedure at a later gestational age.

- Moreover, by placing the parent in a position to veto the minor's decision to have an abortion or force her to go through the judicial bypass process, the Act jeopardizes the psychological health of minors.

- SB 24 will harm minors by forcing some minors to carry unwanted pregnancies to term and causing others to attempt to self-abort their pregnancies, or obtain illegal abortions.

- SB 24 will further harm the health and well-being of minors by forcing minors in abusive or dysfunctional homes to suffer adverse consequences as a result of seeking consent, and deterring minors from seeking all types of reproductive health care.

89. The Court finds that the following proven facts demonstrate that SB 24 will not further the asserted interests in ensuring that minors give informed consent and provide accurate medical histories for abortion:

- Alaska physicians are already obtaining appropriate informed consent.

- No Alaska provider has encountered a minor who was not capable of giving informed consent.

- Even when accompanied by a parent, it is the minor, and not the parent who provides informed consent for the abortion. (Whi. TR 1019:7-14)

- Alaska providers are already required by law to obtain informed consent before providing treatment. AS 09.55.556

- Minors are able to provide appropriate medical histories prior to abortions, which information is supplemented by physical examinations, lab tests, and, if necessary, consultation with other physicians.

- The Alaska abortion providers have not experienced complications as a result of a minor giving an incomplete medical history.

- A significant percentage of parents who know that their daughter is obtaining an abortion do not accompany their daughter to the clinic to obtain the abortion, and thus are not participating in either the provision of medical history or the informed consent process: Dr. Henshaw's study found that only 60 percent of the mothers

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accompanied a 16 or 17 year old daughter and only 80 percent of the mothers accompanied a daughter under 15 years of age. (Hen. TR 305:17-306:3; Ex. 123, Table 8).

- SB 24's requirement that "the minor's parents or the minor's guardian or custodian has consented in writing," does not require the minor's parent, guardian or custodian who is providing consent to appear in-person at the facility where the abortion is to be performed for purposes of giving consent. (Ex. 66, Def.'s Resp. to Pls.' Fifth Set of Interrogs. Dated Sept. 5, 2002)

- Even when a physician consults with both a minor and her parent, the physician often does not get a full medical history of a minor patient. (Tsa. TR 1341:23-1342:1)

90. The Court finds that the following proven facts demonstrate that SB 24 will not protect minors' health in terms of monitoring minors after an abortion.

- Minors are able to understand their physician's post-abortion instructions, and to detect and seek treatment for complications.

- The Alaska abortion providers have not had minors delay seeking treatment for complications as a result of their parents not being informed of the abortion.

- Minors whose judicial bypass petitions are granted will not have a parent participating in the provision of medical history, informed consent process, or monitoring for post-abortion complications.

- Dr. Anderson's testimony that in Virginia, those minors whose parents knew about their abortion prior to the development of complications following the abortion arrived at the hospital for care sooner than those whose parents didn't know about the abortion at the time of the abortion is not credible. Dr. Anderson conceded that he does not ascertain which parents were informed of the abortion prior to the procedure, (And. TR 1875:21-1878:11), and contradicted his deposition testimony at trial, (And. TR 1880:3-13).

- Dr. Greene has little basis for his opinions that parental involvement for abortion is beneficial in providing medical history and monitoring possible complications. He has never performed an abortion and none of his articles or abstracts focused on and made conclusions or findings about abortion. (Gre. Dep. 108:22-109:2, 111:3-10, 111:23-24)

91. The Court finds that SB 24 does not foster family unity or preserve the family as a viable social unit.

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- Several studies have demonstrated that many minors want to and do consult with at least one parent before having an abortion. (Adl. FL 545:2-547:1; Zab. TR 2350:21-2351:22; Hen. TR 296:19-299:11, 300:20-301:19; Exs. 123, Table 8, 150, 157, 164)

- The vast majority of minor patients in Dr. Lemagie's practice, including abortion patients, have some level of parental involvement. (Lem. TR 101:10-14)

92. The younger the pregnant minor is, the more likely it is that she communicated with her parents about her pregnancy. (Zab. TR 2440:8-15)

- In the Henshaw and Kost study, for 68% of minors under 17 at least one parent knew of the minor's intent to have an abortion, and for minors under 15, 90% were aware. (Hen. TR 299:12-24; Ex. 123, Table 8)

- According to the American Academy of Pediatrics, "Very young adolescents almost always agree to voluntary parental involvement." (Lem. TR 112:14-16, quoting from Ex. 252)

- Dr. Anderson believes that minors under 15 are more likely to involve their parents in their pregnancy than older minors. (And. TR 1863:16-1864:18). Dr. Anderson has never seen a patient younger than 15 who did not want to involve her parents in her pregnancy. (And. TR 1865:22-1866:1)

- Based on the approximate number of abortions to minors under 13 in Alaska each year (1.2), Dr. Henshaw estimated that the number of minors under 13 who would seek an abortion without a parent knowing about the abortion would be one every 8 years. (Hen. TR 299:25-300:12)

93. As Defendant has conceded, those minors under 17 who might not choose to seek the consent of a parent or guardian to obtain an abortion might have valid reasons not to do so. (Ex. 63, Def.'s Resp. to Pls.' Disc. Reqs. Dated December 26, 1997).

94. One reason why many minors in Alaska would not voluntarily inform a parent of an abortion is that they do not live with their parents. (Chr. TR 1942:20-23; Mur. TR 2216:6-14; Zab. TR 2353:16-2354:24)

- It is very common on the North Slope and in the Bethel area for a minor to live with a relative for a few years without legal custody being transferred, for reasons such as parents attending school, working out of the community, on a fishing boat or fire-fighting in the Lower 48. (Pak. TR 1210:23-1211:16; Coo. TR 1282:10-1284:1)

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- Twelve percent of the minors Dr. Henshaw surveyed did not live with either biological parent. (Hen. TR 302:25-303:6)

95. Another reason why a pregnant minor would not voluntarily inform a parent of an abortion is because it is likely that her family is dysfunctional and parent communication and support is lacking.

- Young women who are well-parented and feel loved and secure at home are less likely to become sexually active. (Elk. Dep. 108:7-23). Teenagers who do not have good relationships with their parents are less likely to approach them for love and support if they become pregnant. (Elk. Dep. 109:8-17)

- Dr. Anderson believes that a majority of teenagers who are sexually active come from dysfunctional homes. (And. TR 1860:22-1861:2). He also believes they are looking for acceptance and intimacy in that sexual relationship because they are not getting the relational intimacy at home. (And. TR 1861:21-24)

- Dr. Josephson believes that sexual activity and pregnancy in a minor under the age of 17 signals a developmental failure for which parents are to some extent responsible. (Jos. TR 1453:22-1455:3)

- Poor parenting communication is one of the predictive factors for early teen pregnancy. (Tsa. TR 1343:3-11)

- "The adolescent most vulnerable to early pregnancy is the product of adverse sociocultural conditions involving poverty, discrimination and family disorganization . . ." (Sto. TR 754:24-756:5, 756:13-757:4; Ex. 28)

- Defendant concedes that some minors under 17 do not have supportive, caring or involved parents, and among these minors are probably some who become pregnant while they are minors. (Ex. 63)

- Judge Martin believes that 70% of the petitioners in judicial bypass proceedings in Minnesota are members of dysfunctional families. (Mar. TR 960:12-16)

- For example, Ms. Christiansen's great niece D.M., who got pregnant when she was 16, had a stepfather who molested her and her siblings, but when D.M.'s mother had to choose between her husband and D.M. and her siblings, she chose to give up her children. (Chr. TR 1966:14-1967:9)

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- For example, Crystal Lane became pregnant when she was 12 as a result of her relationship with an 18 year old, whom she described as her boyfriend. (Lan. TR 2142:2-9). In addition to the fact that Crystal was sexually active, she was also drinking alcohol and successfully lying to her mother about her whereabouts. (Lan. TR 2165:8-25, 2166:1-13). Joyce Farley's reaction to the fact that her 12 year old daughter was seeing an 18 year old, was simply to tell them both that he was no longer to come to their house. (Far. TR 2177:12-15)

- For example, Ms. Patkotak estimates that 20-25% of the children in her caseload while she was with DFYS in Barrow, most of whom were older than 11, had been sexually abused. (Pak. TR 1181:9-15, 1183:13-1184:9, 1232:8-16). In the majority of those cases, where the abuse was perpetrated by a relative or adult family friend, the mother of a child sided with the abuser. (Pak. TR 1185:5-1186:1, 1190:4-17)

- Judge Cooke and Ms. Reichard both testified that they had seen many cases of sexual abuse where the abuser was part of the household. (Coo. TR 1249:11-19; Rei. TR 934:25-935:25)

96. Some minors do not inform their parents about their desire to have an abortion because they fear adverse consequences.

- Evidence from numerous witnesses with experience in Alaska also demonstrates that a significant number of minors live in abusive homes. (Elk. Dep. 97:15-19)

- Minors in Massachusetts pursue a judicial bypass because: they fear serious adverse consequences like being thrown out of the house, physically abused, sent away to other family members, or being abandoned emotionally or financially (Sab. TR 2557:25-2558:8); they believe informing the parents of their pregnancy would greatly upset the parents (Sab. TR 2595:24-2596:4); and/or, they fear that telling their parents would damage their relationship with their parents (Sab. TR 2596:9-18)

- Minors' fears about these types of adverse consequences are usually well-founded. (Sab. TR 2558:9-20; Hen. TR 310:5-21)

97. The Court finds that minors who do not voluntarily involve a parent in their abortion decision are neither incompetent nor alone.

- Studies confirm that all minors involve someone in their decision to have an abortion.

- According to the American Academy of Pediatrics, "Research confirms that pregnant minors do not make abortion decisions in isolation. They actively involve adults to whom they feel close." (Lem. TR 111:1-5, quoting Ex. 252)

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- One –hundred percent of the minors in the Henshaw and Kost study said that there was at least one other person who knew about their abortion decision and was somehow involved in the minor's receipt of the abortion. 96 percent of the minors had someone accompany them to the clinic to obtain the abortion. (Hen. TR 303:20-23, 305:10-16; Ex. 123, Table 8)

- Dr. Zabin's study revealed that in some homes, there is an adult that an adolescent is responsible to who would not be considered an a parent or guardian under the law, whom she refers to as "parent surrogates;" she further found that not an insignificant percentage of study participants who informed an adult that they might be pregnant or were pregnant consulted parent surrogates. (Zab. TR 2351:20-2353:8; Ex. 164)

98. Both parties' experts and lay witnesses confirm that minors who do not involve their parents in their pregnancy decision involve other adults such as other relatives, teachers, school counselors, and pastors, and that those adults can provide a sufficient support network. (Lem. TR 101:15-22; Greene 83:4-84:11; Mar. TR 966:7-967:1; Chr. TR 1969:13-18; 1970:11-21)

- Defendant concedes that some minors under 17 seeking an abortion may obtain adequate emotional and physical support in deciding to have the abortion, and during the procedure and post-surgical care, from a person other than her parent, guardian or custodian. (Ex. 63)

- Dr. Greene believes that a teenager's ability to solve problems and prevent distress associate with negative life events can often be learned by role models other than her parents; a social support network, which can also significantly moderate stress, can include friends, relatives, teachers and health care providers. (Gre. Dep. 86:4-21)

- In discussing how strong social support can reduce the stress or trauma associated with a minor's unplanned pregnancy or abortion, Dr. Figley explained that social support comes from both family and friends, and that family can include people besides parents, such as grandparents or adult siblings, that the minor perceives as her family. (Fig. TR 1918: 1-1919:2)

99. Those minors who obtain abortions without involving their parents are mature.

- Pregnant minors who can navigate the health system and make a decision to abort are mature; she recognizes she might be pregnant; takes a pregnancy test, moves forward with care, negotiates a health system, receives counseling and effectuates her pregnancy decision. (Zab. TR 2360:12-2362:14)

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- The minors who are less likely to consult a parent about the decision are those who are more mature, older, employed, and/or do not live with a parent. (Adl. FL 545:17-546:23; Zab. TR 2353:9-15; Hen. TR 304:16-305:9; Mar. TR 972:25-973:15)

- Adolescents choosing abortions tend to be more future-oriented, have more of a sense of themselves and control over their decisions, and more control over their lives than those carrying to term, all of which are good psychological traits. (Adl. FL 512 11-25; Zab. TR. 2363:9-2364:16; Ex. 161; see also Mar. TR 968:17-25)

- Even Defendant's experts concede that some minors under 17 seeking abortions are mature. (And. TR 1866:18-1867:2)

100. Those minors who deny they are pregnant and do not go through the process of contemplating their pregnancy, seeking health care and making a choice regarding their pregnancy show a lower level of maturity than those minors who choose to abort. (Zab. TR 2361:18-2362:14)

Forced Communication and Parental Veto Does Not Foster or Preserve Families

101. There is no evidence that forced parental involvement for creates better communication between parents and minors. (Gre. Dep. 82:22-83:1; Zab. TR 2360:8-11)

- In fact, one study compared the rates at which pregnant minors involved their parents in their abortion decision in states with and without parental involvement laws and found the rates to be about the same (65 % v. 63%). (Hen. TR 301:3-302:5; Ex. 157)

- Dr. Zabin's own work and the work of others suggests that parent-child communication is a longstanding tradition, and that it has a positive effect on young people's behavior is when it is a longstanding part of their relationship, not when it comes only at a moment of crisis. (Zab. TR 2350:8-2351:3; Ex. 164)

- Serious family problems can be caused, however, by involuntary communication. (Zab. TR 2359:19-25; see also Stot. TR 746:16-747:19)

- SB 24 will decrease family communication about reproductive health care matters because the law will deter minors from seeking health care, and thus prevent them from consulting with counselors who encourage them to communicate with their parents. (Zab. TR 2349:8-19)

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- The American Academy of Pediatrics opposes mandatory parental involvement for minors seeking abortion, stating: "Legislation mandating parental involvement does not achieve the intended benefit of promoting family communication, but it does increase the risk of harm to the adolescent by delaying access to appropriate medical care." (Lem. TR 107-113:16, 115:4-116:9, Ex. 252)

- Dr. Josephson believes that an effect of the law will be to force some parents to confront their daughters even if they do not desire to do so. (Joe. TR 1456 11-25)

102. Requiring the consent of a parent who is not part of a functioning family unit will not improve that family or create a functioning family between the minor and the absent parent. (Zab. TR 2350:6-12)

- Minors can and frequently do live in viable family units with relatives other than their parents. (Chr. TR 1942:20-23) A minor who lives with a grandparent can constitute a viable social unit. (Tsao-Wu TR 1360:16-19)

- The concept of a parent surrogate, an adult other than a parent or legal guardian, who a minor feels responsible to and who feels responsible for the minor, is particularly applicable to the Native Alaskan population. (Zab. TR 2430:2-2431:15)

103. The Court has been presented with no evidence that demonstrates that allowing a parent to veto a daughter's abortion decision, without taking her best interests into account, improves the family in any way. The exercise of raw parental authority, which may or may not be in the child's best interest, does nothing to foster or preserve the family. (Stot. TR 749:19-750:1)

- As Dr. Elkind noted, a parent who forced a young woman to carry a pregnancy to term based solely on their religious beliefs about abortion, may not be acting in their daughter's best interests. (Elk. TR 129:23-130:3)

- Approximately 10 percent of the minors who seek a judicial bypass in Massachusetts tried to get consent from their parents, but their parents refused to provide consent. (Sab. TR 2611:6-11)

- Dr. Zabin believes that parental consent laws are particularly more dangerous to minors than parental notification laws because they permit a parent to passively avoid giving consent, thereby committing the daughter to a decision without taking any responsibility whatsoever. (Zab. TR 2457:20-2458:16)

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- Stress in the family would occur if parents denied consent for an abortion and a minor was forced to carry an unwanted pregnancy to term, or if she was forced to go through the judicial bypass process in order to get a desired abortion. (Fig. TR 1925:2-14)

104. Defendant failed to show that SB 24 will increase the detection, reporting, prosecution, and prevention of crimes against children.

- There is no nexus between Defendant's evidence regarding the prevalence of statutory rape in Alaska and other jurisdictions and the assertion that the parental consent requirement will materially increase reporting of those crimes.

- Defendant's expert Dr. Uhlenberg conceded that there is no evidence that parental involvement laws have resulted in an increase in prosecutions for statutory rape. (Uhl. TR 1674:21-25)

- Defendant's own witnesses demonstrated that even when parents know about the sexual activity of their daughters, sometimes even when they know that the daughter has gotten pregnant and had an abortion, many do not even try to stop the relationship or are unsuccessful in their attempts to stop it, and many do not report such situations to the authorities. (Rob. TR 2248:13-2249:1, 2256:23-2257:19; Fos. TR 2473:19-2474:7, 2484:8-12, 2487:15-2488:1)

- Virtually all of the evidence presented by Defendant on this issue reported on minors carrying pregnancies to term, and did not address minors seeking abortions. (Uhl. TR 1590:9-1593:21; 1600:5-1603:3; Sha. TR 553:7-554:11; 617:12-20, Ex. 283; Col. TR 2096: 20-2097:1)

- The evidence establishes that a minor impregnated by a significantly older male is much more likely to carry to term than to have an abortion. One study that looked at the age of partners of pregnant minor women who had abortions as well as those who carried to term indicates that adult sexual partners do not encourage minors to abort their pregnancy. The greater the difference between the age of the minor and the age of her sexual partner, the more likely the minor was to continue her pregnancy. (Hen. TR 312:19-314:8; Uhl. TR 1669:17-1671:9; Ex. 147, Table 2). In a study cited by Professor Collett, 62.8% of minors pregnant as a result of statutory rape gave birth, while 9.2% had abortions. (Col. TR 2097: 16-2098:2, Ex. 2169)

105. Testimony by Alaska physicians who provide abortions shows that they comply with the law's requirements, whether the minor is seeking an abortion or other reproductive health care. (Whi. TR 1051:1-15)

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- Defendant's suggestion that Dr. Whitefield and Dr. Lemagie do not comply with the State's mandatory reporting requirements is wholly unfounded. In fact, Dr. Whitefield has taken it on himself to save products of conception in situations when he suspects statutory rape, even without a formal request by law enforcement. (Whi. TR 1051:16-1052:7)

- The Court is not persuaded by the tape recordings of telephone conversations with Alaska Women's Health Services and Planned Parenthood that a problem exists with statutory rape reporting by Alaska abortion providers. The calls were made by a 24 year old actress who pretended that she was a pregnant minor with an adult boyfriend. (Zie. TR 2289:25-2290:6; 2291:7-20). Significantly, the information provided by the actress did not include sufficient identifying information to trigger the reporting requirement which does not require health care providers to investigate potential crimes. AS 47.17.010. Thus, the tapes do not establish any violations of the mandatory reporting statutes. (Exs. 2013-2020). Moreover, with one exception, none of the employees engaged in the calls were mandatory reporters. Finally, to the extent that the employees informed the actress that she could obtain an abortion and contraception without her parents being informed, that is a correct statement of current Alaska law.

106. The evidence establishes that the Act will have little, if any, impact on prosecutions for statutory rape in Alaska.

- Based on Dr. Henshaw's figures, approximately 80 minors per year will obtain abortions in Alaska. The parents of approximately 68% of those 80 minors will know their daughter is seeking an abortion.

- The evidence establishes that even when parents are informed of their daughter's pregnancy and the circumstances surrounding it, they do not necessarily report. (Rob. TR 2248:13-2249:1, 2256:23-2257:19). In some cases, another family member reports the misconduct. (Fos. TR 2473:19-2474:7, 2484:8-12, 2487:15-2488:1)

- Among the low percentage of minors under 17 whose parents would not know about their abortion before they obtain it, not all are pregnant as a result of statutory rape.

- Nothing in SB 24 requires a parent to ask about, or a minor to tell about, the age of her sexual partner.

- Should SB 24 go into effect, the fact that the minor's partner was overage may not come out in the judicial bypass hearing if the minor alleges that she is sufficiently mature to make the decision without parental consent.

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- In addition, the Court believes that Alaska abortion providers are reporting these cases when they come to their attention.

- Even when information concerning statutory rape is reported, the cases are frequently not prosecuted. Defendant's expert, Theresa Foster, the Fairbanks District Attorney, (Fos. TR 2463:19-20), testified that some of the reports are not referred for prosecution because other investigations are given higher priority. (Fos. TR 2481:1-24). Not all cases that are referred for prosecution are pursued, due to considerations such as jury appeal, which tends to be low in cases of a 19 and 15 year old engaging in consensual sex. (Fos. TR 2482:8-2484:2). In some cases, the parents of the minor do not favor prosecution because "they have grave reservations" about putting their daughters through the experience. (Fos. TR 2484:8-12, 2498:7-21)

107. A parental consent law is very unlikely to reduce the rate of sexual activity of minors. (Zab. TR 2376:8-13; Hen. TR 315:2-11). Studies of the effects of parental involvement laws in both Massachusetts and Mississippi have found no or very little effect of the law on birth rates. (Hen. TR 315:13-316:4)

- Dr. Zabin's own study demonstrated that minors' belief that their parents would have to be notified of their decision to seek reproductive health care did not delay their sexual activity (Zab. TR 2376:25-2378:7; Ex. 162)

- A recent study showed that if parental notification were required for contraception, very few minors would stop having sex as a result (Zab. TR 2376:8-24; Ex. 169)

- One of Dr. Zabin's studies showed that minors who voluntarily spoke to a parent even before having a pregnancy test had higher contraceptive use rates than those that spoke to them during the crisis period after learning they were pregnant. (Zab. TR 2378:19-2379:11; Ex. 164)

108. There is no reason to believe that being forced to ask a parent for consent for an abortion would reduce sexual activity or pregnancy rates. (Zab. TR 2378:8-18)

- In order for the Act to affect the pregnancy and abortion rates, minors would have to know about the laws and adjust their sexual activity accordingly, but studies suggest that minors are not well informed about abortion laws, and particularly parental involvement laws. (Hen. TR 316:22-317:7; 442:12-443:13; Uhl. TR 1657:21-1659:23)

- Virtually none of the minors going through judicial bypass proceedings in Massachusetts knew about the parental consent law before they got pregnant, so they

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could not have modified their sexual behavior based on the law. (Sab. TR 2624:22-2625:2-6)

109. A parental involvement law is likely to delay or completely deter adolescents from seeking contraception, which could have the effect of increasing the number of unwanted pregnancies and abortions in Alaska (or them lowering at a slower rate than they otherwise would have). (Zab. TR 2337:3-14, 2341:9-11, 2347:9-2348:23, 2376:8-24, 2448:12-25; Ex. 169)

- To the extent that some minors know about parental consents to other kinds of reproductive health care. Zab. 2413:19-2414:15). This misperception can prevent some minors from obtaining contraception and other services. (Zab. TR 2414:5-12, 2459:6-23)

- It has been demonstrated that the largest single effect on bringing down the pregnancy rate in the U.S. is increased use of contraception. (Zab. TR 2348:8-23, 2376:8-24; Ex. 169)

110. Dr. Uhlenberg's self-characterized "tentative" opinion that in the long term the Alaska parental consent law is likely to have the effect of decreasing adolescent pregnancy (Uhl. TR 1569:9-20, 1583:23-1584:5) is not credible for several reasons.

- Abortion is not Dr. Uhlenberg's area of specialty, (Uhl. TR 1623:10-1624:5). He is not even familiar with all of the studies in the small universe of studies about the effects of parental involvement laws, and therefore his conclusions are not based on complete information. (Uhl. TR 1632:13-1636:14)

- He bases his opinion on data in a study by Ellerston that, as Dr. Henshaw explained in detail, is unreliable. (Uhl. TR 1571:24-1573:16; Hen TR 437:15-442:11; Ex. 119)

- Dr. Uhlenberg recognized that the author of the one reliable published study that showed a decrease in the pregnancy rate in Minnesota for the applicable age group after enactment of a parental involvement law commented that an explanation for that decrease could be that women affected by the law went out-of-state for abortions. (Uhl. TR 1576:4-1578:1; Ex. 120)

- Finally, Dr. Uhlenberg's own analyses are methodologically flawed because he failed to compensate for minors who go out of state to get abortions to avoid their state's parental involvement laws, a phenomenon that he admits has occurred as a result of parental involvement laws. (Uhl. TR 1583:20-25, 1631:5-25, 1646:1-1652:7)

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111. Professor Collett's opinions regarding the impact of enforcement of the Texas parental notice requirement on pregnancy and abortion rates in that state are unpersuasive.

- She did not undertake a formal study of the issue, and she is neither a demographer nor a statistician. Her lack of expertise is apparent from her failure to take into account any confounding variables, including minors traveling to other states to escape the harms of parental involvement laws. (Col. TR 2005:1-3; 2112:23-2115:12, Ex. 229)

- Moreover, her opinions are undercut by the evidence showing that there was a nearly 10% drop in the number of out-of-state residents coming into Texas the year the law became effective. (Col. TR 2112:23-2115:12, Ex. 229). In addition, the only contiguous state for which information was presented showed a more than 20% increase in Texas residents traveling into that state for abortions. (Col. TR 2120:12-2121:22). The decrease in the number of abortions in Texas could be due entirely to changes in travel into and out of Texas. (Col. TR 2121:23-2122:23)

To The Extent that Parental Consent for Abortion Might Further Any of the State's Interests, There is No Basis on Which to Treat Minors Seeking an Abortion Differently Than Other Persons Similarly Situated

112. Pregnant minors have only two options in dealing with their pregnancies: carrying to term or having an abortion. One decision cannot be made in isolation from the other.

- The decision-making process of pregnant women considering an abortion is the same as the decision-making process of women considering carrying a pregnancy to term and giving the child up for adoption (Sac. Dep. 31:7-33:12); Dr. Elkind agrees that the decision to give a child up for adoption is as equally complex as the decision to have an abortion. Elkind Dep. 125: 19-23.

- Both are faced with an unwanted pregnancy and both go through several stages that involve complexities and constraints during which they try to minimize their value conflict and maximize their net gains in terms of social, psychological, financial and emotional outcome. (Sac. Dep. 31:7-33:12)

- The desirable process for all women, regardless of age, to go through in deciding whether to have an abortion is: understanding and thinking through her alternatives, values, resources, plans for the future, ability to take care of a child, and how she would feel after having a child or abortion; deciding whether and whom she wants to consult with in making her decision. (Stot. TR 745:18-746:15)

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- Defendant's suggestion that abortion is "elective," to the same extent as cosmetic surgery, ignores the reality that the minor must make a decision, even if that is only passive inaction that results in carrying the pregnancy to term. Erecting a barrier to the option that has less long-lasting effects and which is less safe, doesn't make any sense. (Zab. TR 2386:17-2388:6)

- Defendant's witnesses agree that young women will benefit from parental consultation no matter what decision they make regarding their pregnancy. (Elk. TR 28:20-29:2, 104 11-17; Sha. TR 4701:7-471:17; Joe. TR 1513:11-25, 1514:1-13; Col. TR 2134:17-22; Mur. TR 2216:15-2217:25)

- To the extent that both Plaintiffs' and Defendant's experts think that minors in general, or a particular minor who is pregnant are not psychologically capable of making a decision to abort and would benefit from parental advice, they also do not believe those minors are psychologically capable of making the decisions to carry the pregnancy to term and whether to keep or relinquish the baby. (Gre. Dep. 81:11-82:3; Stot. TR 727:9-15; Jos. TR 1498:12-19)

- Brain mapping studies have not looked at adolescent pregnancy or abortion, (Elk. TR 88:6-89:19), and do not provide a basis on which to require parental consent for abortion, but not pregnancy. To the extent that these studies identify a lack of development compared to adults, that deficit would apply to any important life decision, and not just to abortion. (Joe. TR 1453:10-21; 1497 13-17; 1498:7-17, 1504:9-22, Ex. 86)

113. To the extent that minors have unrealistic expectations when facing an unwanted pregnancy, those issues are present regardless of whether the young woman is considering carrying the pregnancy to term or having an abortion. (Elk. Dep. 44:16-45:18).

- In fact, a young woman deciding whether or not to have an abortion is likely to have unrealistically positive expectations of what her experience will be raising the baby should she carry to term. (Elk. 33:15-34:7; Joe. TR 1504:23-1505:7)

- Young women deciding to carry to term will also likely have unrealistic expectations that they will marry the father of the baby, finish school and avoid having to go on welfare. (Elk. TR 43:19-44:15, 54:9-55:3, 104:20-105:9; Joe. TR 1505:8-12)

114. To the extent that parental involvement would be helpful or necessary for the provision of abortion services, it would be equally, if not more, helpful or necessary for pregnant minors carrying to term.

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- Defendant's experts believe that it is important to have parents involved in providing the medical history of a minor seeking prenatal care and other pregnancy-related treatment. (Cal. TR 1701:1-4; 1705:3-25, 1706:1-5; Tsa. TR 1351:21-1352:1)

- Defendant's experts believe that parental involvement is important for a minor to give informed consent for all treatment. (Tsa. TR 1310:23-1311:17; 1312:7-12)

- When asked whether minors are capable of making complex medical decisions, Dr. Calhoun stated he did not think they were capable "without significant input from either physicians and/or their parents or support groups." (Cal. TR 1690:2-7)

- Virtually every condition that would potentially increase the risk of abortion would also pose an increased risk to a minor carrying a pregnancy to term. (Lem. TR 95:25-97:2; Whi. TR 1033:4-11)

- Pregnant adolescents may undergo invasive procedures such as amniocentesis, which pose risks to both the woman and the fetus, including a one in 200 risk that the fetus will die. (Lem. TR 41:11-42:12; Sha. TR 594:7-22; Whi. TR 1014:5-17.

- The medical history obtained from patients who are seeking prenatal care is more detailed as to genetic history than that obtained from abortion patients. (Lem. TR 59:24-60:4); for example, information about a family history of bleeding disorders would be important to a physician performing an amniocentesis or a c section. (Whi. TR 1026:23-1027:4, 1030:6-1031:17)

- The medical history obtained from patients seeking prenatal care is more detailed as to genetic history than that obtained from abortion patients. (Lem. TR 59:24-60:4)

- Pregnant minors may also undergo delivery by cesarean section, which is major surgery that requires hospitalization. (Lem. TR 42:13-43:8. The risks associated with cesarean section include death, bleeding, infection, damage to internal organs, injury to the fetus, stroke and heart attack. (Sha. TR 595:6-23) Defendant's expert agreed that a cesarean section may not always be in a minor's best interests, and requires balancing the mother's needs against those of the fetus. (Sha. TR 581:16-23)

- Some of the causes of the high mortality rate for teenagers, such as toxemia, preeclampsia, and eclampsia, are closely associated with insufficient prenatal care. (Gre. Dep. 96:14-24)

- There are minors that deny they are pregnant up until the time they deliver a baby; those minors do not receive any prenatal care. (Tsa. TR 1353:13-1354:10)

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- Pregnant patients who seek prenatal care, including adolescents, are instructed on lifestyle changes and advised to return for regular visits throughout pregnancy. Not all women, including minors, obtain the recommended prenatal care, (Whi. TR 1021:14-1022:3), nor do they follow medical instructions, (Cal. TR 1709:22-1710:10)

- Dr. Calhoun believes that is extremely helpful to have parents actively involved in a minor's prenatal care. (Cal. TR 1691:15-1701:10). For high risk pregnancies, compliance with medical recommendations is important and requires sophistication and assistance. (Cal. TR 1740:19-1741:5). Parents can help a minor detect and monitor complications associated with pregnancy. (Cal. TR 1741:11-14)

- All of the Alaska obstetricians and other doctors who testified in this case had personal experience with minors presenting for delivery without their parents being aware of the pregnancy. (Lem. TR 41:1-10; 158: 20-159;13; Ric. TR 883:1-10; Whi. TR 1020:10-18; Gre. Dep. 74:1-13; Tsa. TR 1353:13-17); see also (Gre. Dep. 89:8-90:1; Tsa. TR 1314:15-1315:7)

- Parents would be helpful in following medical instructions and monitoring complications after all medical procedures, not just abortion. (Gre. Dep. 32:15-33:17, 42:2-10; Tsa. TR 1306:15-1307:10, 1354:11-24, 1355:5-8); patients who delay in seeking care for complications following all medical procedures, not just abortion, could result in hospitalization or and/or could be life-threatening. (Gre. Dep. 41:9-22; And. TR 1885:8-24)

- In Dr. Anderson's opinion, all young people who have had surgery, not just those who have had abortions, deny post-surgery complications because they don't want to go back to the physician. (And. TR 1875:7-11)

- Physicians sometimes provide treatment to adolescents on her first visit, including invasive procedures such as amniocentesis, treatment for sexually transmitted diseases, c sections and abortions, and can establish an adequate physician-patient relationship to do so. (Lem. TR 32:14-33:1; Whi. TR 1013:7-1014:21; Ric. TR 891:12-892:5)

115. Abortion carries less medical risks and less risk of psychological and social consequences than pregnancy. (FF 55-58)

- To the extent that abortion may be a traumatic event for some minors, so would labor or a c-section. (Fig. TR 1923:14-24)

- There is no valid reason, from a psychosocial perspective, for placing restrictions on an abortion decision and not on an adoption decision. (Sac. Dep. 60:19-25).

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- The distinction that Dr. Calhoun sees between minors making a decision to carry a pregnancy to term or to have an abortion is that abortion "is unique and involves the death of the child." (Cal. TR 1690:8-14; 1707:19-20; 1750:16-19). Although the Court respects this deeply held personal belief, it does provide an appropriate factual basis for the Court to make such a distinction.

116. Excluding parents from the discourse about the pregnancy, whether the outcome is birth or abortion, has a negative effect on the family. (Fig. TR 1921:14-20)

- Dr. Figley believes that a minor denying a pregnancy or hiding her pregnancy from the family will have a negative effect on the family. (Fig. TR 1921:10-13, 1921:21-25, 1922:1-61)

- Dr. Figley testified that for a minor and her family, an unplanned pregnancy is a traumatic event. (Fig. TR 1910:9-13). One of the consequences to the family of a minor withholding information is the loss of trust between the parent and child. This would be true whether the minor hides a pregnancy, an abortion, or a sexually transmitted disease. (Fig. TR 1924:5-20)

117. All of the concerns expressed by Dr. Figley about the premature emancipation that could occur if a minor is able to make an autonomous decision about abortion also apply to the decision to carry the pregnancy to term. (Fig. TR 1926:7-1927:11)

118. Defendant suggests a distinction between minors carrying to term and minors seeking abortion in terms of statutory rape reporting and parental intervention to prevent future high-risk sexual behavior. The Court finds that the evidence on this issue does not support Defendant's contention for the following reasons:

- The evidence presented to the Court regarding pregnancies resulting from statutory rape establish that these pregnancies are far more likely to be carried to term than to be terminated by abortion. This evidence supports that mandatory parental involvement for minors seeking pregnancy care would have more of an impact than parental consent for abortion.

- According to Dr. Calhoun, as many as 25% of adolescents' births are to teens that have previously been pregnant or given birth. (Cal. TR 1763 18-25). Thus, in situations where it is likely that a parent has been made aware of the adolescent sexual activity through the birth of a baby, it does not appear that that knowledge has led to a significant decrease in the minor's high risk behavior.

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- Dr. Shadigian's concerns about physicians underreporting violence apply to health care providers in general and not just abortion providers. (Sha. TR 668:11-19. Her opinion that abortion providers as a group are reluctant to report statutory rape is not supported by the article she relies on, (Ex. 337) which refers generally to reproductive health care providers.

There is no basis on which to distinguish minors seeking abortions from those seeking other reproductive health care

119. Failure to treat sexually transmitted diseases could have severe medical implications for patients, including death. (Tsa. TR 1348:20-1349:2)

- Chlamydia, a common STD among Alaskan minors, can cause impaired fertility and sterility, and increased risk for ectopic pregnancies, (Lem. TR 33:9-25, 36:1-2). Chlamydia is generally treated on an out-patient basis with antibiotics, although severe cases may require hospitalization. (Lem. TR 34 1-10). When treating a patient for chlamydia, patient compliance and follow up is critical. Patients are instructed to take all of their antibiotics, to return for follow up in 72 hours and some weeks later, and to follow pelvic precautions, such as abstaining from sex or putting anything in the vagina. (Lem. TR 34:21-35:5, 35:19-25)

- Another common STD among minors is genital warts, or human papilloma virus (HPV). (Lem. TR 39:11-13). Some forms of HPV predispose an infected woman to the formation of cervical cancer. (Lem. TR 36:1-20). HPV can be treated using invasive procedures, such as LEEP or cone biopsy. (Lem. TR 36:21-25). Patients who have had these procedures are instructed to follow pelvic precautions and to return for follow up examinations. (Lem. TR 37:21-38:4). In addition, patients are instructed to watch for bleeding and signs of infection, such as a fever or foul smelling discharge. (Lem. TR 38:5-13)

120. Many of Defendant's experts believe that requiring parental involvement in reproductive health care other than abortion, including pregnancy, contraception and STD's, would be beneficial for purposes of obtaining medical history, treating STD's, and ensuring treatment, compliance and follow up care. (Cal. TR 1732:12-1733:6; Tsa. TR 1301:18-1302:5, 1303:11-1304:5, 1340:20-23, 1344:23-1345:2, 1349:7-15; Gre. Dep. 98:14-17; And. TR 1890:16-1891:3)

- Minors have failed to disclose pertinent medical conditions when seeking contraception from doctors. (Gre. Dep. 29:14-30:3; 38:20-39:12)

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- A woman who fails to disclose high blood pressure and is prescribed birth control pills could have an increased risk of heart attack or stroke. (Sha. TR 591:1-12)

- A study showed that minors who had parents involved in contraceptive care were more likely to return to doctor for follow up visits. (Gre. Dep. 49:11-24)

- Dr. Anderson believes that 50 percent of minor women who are treated for pelvic infection from an STD aren't compliant with their antibiotic regiment. (And. TR 1890:16-1891:3)

- Defendant's experts believe that having a mandatory parental involvement law for treatment of STD's, contraception or pregnancy might help to alter some of the minor's high risk behavior because it makes the parent aware that the child is sexually active. (And. TR 1889:8-1891:20)

121. Giving minors autonomous decision making to obtain STD testing and treatment without parental involvement undermines the family integrity. (Fig. TR 1922:11-13)

II. CONCLUSIONS OF LAW

1. SB 24 infringes on the fundamental privacy rights of minors to choose an abortion, guaranteed by Article I, section 22 of the Alaska Constitution.

2. Implementation of SB 24 will harm minors.

3. The interests that the State has argued SB 24 furthers are not compelling.

4. SB does not further any of the State's interests.

5. SB 24 fails to employ the least restrictive means to further any of the interests the State argues underlie it.

6. SB 24 violates the equal protection rights of minors seeking abortion, guaranteed by Article I, section 1 of the Alaska Constitution, by establishing a classification based on the exercise of a fundamental right.

7. Pregnant minors under 17 who seek an abortion are similarly situated to pregnant minors under 17 who seek to carry their pregnancy to term.

8. Pregnant minors under 17 who seek an abortion are similarly situated to all other persons under 17 seeking reproductive health care.

9. SB 24 is not properly tailored to further its objectives; the State has not justified its classifications distinguishing between pregnant minors seeking an abortion and

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pregnant minors carrying their pregnancy to term in its infringement on the right to privacy, guaranteed by Article I, section 22 of the Alaska Constitution.

10. SB 24 is not properly tailored to further its objectives; the State has not justified its classifications distinguishing between minors seeking an abortion and minors seeking all other reproductive health care in its infringement on the right to privacy, guaranteed by Article I, section 22 of the Alaska Constitution.

11. SB 24 violates the Alaska Constitution's prohibition against sex discrimination, guaranteed by Article I, sections 1 and 3 of the Alaska Constitution, by creating a gender-based classification that burdens only young women.

12. Female minors under 17 seeking reproductive health care are similarly situated to male minors under 17 seeking reproductive health care.

13. SB 24 is not properly tailored to further its objectives; the State has not justified distinguishing between the class of female minors under 17 seeking reproductive health care and the class of male minors seeking reproductive health care in its infringement on the right to privacy, guaranteed by Article I, section 22 of the Alaska Constitution.

14. The lack of a medical emergency exception in SB 24 violates the right to privacy of minor women under 17, guaranteed by Article I, section 22 of the Alaska Constitution.

15. SB 24 violates the due process rights of physicians, guaranteed by Article I, section 7 of the Alaska Constitution, by requiring them to prove an element of the underlying offense.

16. SB 24 cannot be constitutionally construed, rewritten or modified to contain a medical emergency exception.

17. SB 24 cannot constitutionality be severed such that its parental consent requirements remain in effect.

18. The affirmative defense for medical emergencies in SB 24 is unconstitutionally vague in violation of Article I, section 7 of the Alaska Constitution.

19. The punitive damages provision in SB 24 violates the rights to due process and trial by jury, guaranteed by Article I, sections 7 and 16 of the Alaska Constitution.

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Respectfully submitted this _____, 2003,

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