IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS **#46279**
COUNTY DEPARTMENT — CHANCERY DIVISION

THE HOPE CLINIC FOR WOMEN LTD.; ALLISON COWETT, M.D., M.P.H., Plaintiffs, v. BRENT ADAMS, Acting Secretary of the Illinois Department of Financial and Professional Regulation, in his official capacity; DANIEL BLUTHARDT, Director of the Division of Professional Regulation of the Illinois Department of Financial and Professional Regulation, in his official capacity; THE ILLINOIS STATE MEDICAL DISCIPLINARY BOARD, Defendants.	Case No. 09 C H 38661 In Chancery Preliminary Injunction/Temporary Restraining Order

VERIFIED COMPLAINT

I. PRELIMINARY STATEMENT

1. This is an action brought pursuant to the Illinois Constitution, seeking a declaratory judgment, temporary restraining order, and preliminary and permanent injunction against enforcement of the Illinois Parental Notice of Abortion Act of 1995, 750 ILCS 70/1 *et seq.* ("Act" or "Parental Notice Act"). The Act severely restricts minors' access to abortion by requiring a physician to notify a parent, grandparent, step-parent living in the household, or legal guardian of a minor's intention to terminate her pregnancy and wait at least 48 hours before performing the abortion. (For convenience, Plaintiffs will refer to these adult family members as "parents," except where necessary to differentiate among them.) Notification is not required if a minor goes to court and obtains a judicial waiver of the notification requirement or certifies in writing that she is a victim of physical abuse, neglect or sexual abuse. (A copy of the Act is attached to the Complaint as Exhibit A. A copy of Illinois Supreme Court Rule 303A, entitled

"Expedited and Confidential Proceedings Under the Parental Notice of Abortion Act," is attached as Exhibit B.) On information and belief, unless it is enjoined, the Act will be enforced starting on November 3, 2009.

2. If permitted to be enforced, the Act will work a significant change in the way safe and appropriate medical care is provided in this state. Currently, as it has for over three decades, Illinois law permits a pregnant minor to obtain any hospital, medical or surgical care without notifying a parent. She can decide to carry her pregnancy to term and parent her child, to bear her child and place it for adoption, or to terminate her pregnancy, all without involving a parent. Enforcement of the Act will fundamentally alter this scheme by requiring those minors who choose to terminate their pregnancies, but not those who choose to carry to term, to either notify a parent or obtain a judicial waiver of the notification requirement.

3. In contrast, a minor who chooses to carry her pregnancy to term may continue to consent to any hospital, medical, and surgical care, including major surgery such as a cesarean section, without involving her parent or a court. Minors who are parents are similarly entitled to make all medical decisions – including life and death decisions – for their children without notifying a parent or going to court. In addition, minors who choose to carry to term may place their children for adoption without parental or court involvement.

4. By forcing minors seeking abortions to involve a parent or obtain a court order, enforcement of the Act will immediately and irreparably harm minors in this state. The Act will prevent some young women from obtaining safe abortions and force them to carry their pregnancies to term against their will. Others will be beaten or thrown out of their homes when their parents learn of their pregnancy and planned abortion. Moreover, whether a young woman chooses to notify a parent or go to court, her abortion will be delayed, which will increase the

cost and health risks associated with the procedure and decrease its availability. Finally, the Act will lead some desperate minors in this state to resort to drastic measures such as self-induced and illegal abortions because they fear parental reaction or are overwhelmed and terrified by the prospect of going to court.

5. In placing these restrictions on minors who choose abortion, the Act violates minors' fundamental rights to privacy, substantive due process, equal protection, and gender equality under the law as guaranteed by the Illinois Constitution.

II. JURISDICTION AND VENUE

6. Jurisdiction is appropriate and venue is proper in this court pursuant to 735 ILCS 5/2-101 because Defendants have offices in Cook County, and Plaintiff Dr. Allison Cowett, conducts her medical practice in Cook County.

III. THE PARTIES

7. Plaintiff Hope Clinic for Women Ltd. ("Hope Clinic"), located in Granite City, Illinois, is a licensed private medical clinic that provides reproductive health services to patients from Illinois and elsewhere. Hope Clinic provides patients with pregnancy testing, birth control, pregnancy options counseling, and abortions up to twenty-four weeks from the date of a woman's last menstrual period or "lmp." Hope Clinic is the only clinic that provides abortion services in southern Illinois. Among Hope Clinic's patients are unemancipated women under the age of 18 who need abortions and who, for a host of reasons, cannot involve their parents. These patients include young women who are mature enough to make an informed decision about abortion. Hope Clinic sues on its own behalf and on behalf of its minor patients.

8. Plaintiff Allison Cowett, M.D., M.P.H., ("Dr. Cowett") is a physician board certified in the practice of obstetrics and gynecology and licensed to practice in Illinois. Dr.

Cowett is the Director of the University of Illinois at Chicago ("UIC") Center for Reproductive Health ("CRH") and an attending physician at UIC Hospital, as well as an Assistant Professor of Clinical Obstetrics and Gynecology and Assistant Director of the Family Planning Fellowship at the UIC School of Medicine. For more than ten years, Dr. Cowett has provided her patients – thousands of women – with a broad range of gynecologic and obstetric care, including prenatal care, labor and delivery, and induced abortions. Dr. Cowett provides abortions up to 24 weeks lmp. Among Dr. Cowett's patients are unemancipated women under the age of 18 who need abortions and who, for a host of reasons, cannot involve their parents. Dr. Cowett sues on her own behalf and on behalf of her minor patients.

9. On information and belief, defendant Brent Adams is the Acting Secretary of the Illinois Department of Financial and Professional Regulation ("IDFPR"). IDFPR is an entity of the State of Illinois with offices located at 320 West Washington St., Springfield, Illinois, 62706, and at 100 West Randolph Street, Chicago, Illinois, 60601. IDFPR oversees the licensing of regulated professions in Illinois, including physicians. Defendant Daniel Bluthardt is the Director of the Division of Professional Regulation of IDFPR. Defendants Adams and Bluthardt are sued in their official capacity.

10. On information and belief, defendant, the Illinois State Medical Disciplinary Board ("Disciplinary Board"), established by the Medical Practice Act of 1987, 225 ILCS 60/1 *et seq.*, is an entity of the State of Illinois responsible for investigating conduct allegedly in violation of the Parental Notice Act and recommending disciplinary action – including "civil penalties and any other appropriate discipline" – against physicians found to violate the Act. 750 ILCS 70/40, 225 ILCS 60/22(C). Defendants Adams, Bluthardt and the Disciplinary Board are referred to jointly as "Defendants" or "the State."

IV. FACTS

A. Statutory Framework and Litigation History

11. On information and belief, absent relief from this Court, the Act will be enforced beginning November 3, 2009.

12. Prior to adoption of the Act, Illinois law permitted an unmarried pregnant minor to consent to any hospital, medical or surgical care for herself or, if she is a parent, her child, without involving her parents. *See* 410 ILCS 210/1. The Act creates a single exception to this longstanding statutory framework by requiring only those pregnant minors who choose to terminate their pregnancies to notify a parent or obtain a court order. Minors who choose to carry a pregnancy to term may continue to provide consent for all their own medical care and to make all medical decisions for their children without notifying a parent. They can make such decision even when the decision may put the fetus at risk. Illinois law further provides that a minor may decide to place her child for adoption without notifying a parent. *See* 750 ILCS 50/11(a). Thus, the Act singles out pregnant minors who choose abortion and imposes on them alone a requirement of parental notification as a condition of receiving medical care.

13. Specifically, the Act prohibits the performance of an abortion on a minor until at least 48 hours after notice of the procedure has been provided to an adult family member, *id.* § 15, defined by the Act as the minor's parent, grandparent, step-parent living in the household, or legal guardian, *id.* § 10. Where actual notice is not possible after a reasonable effort, "the physician or his or her agent must give 48 hours constructive notice." *Id.* §15. Constructive notice is defined as "notice by certified mail to the last known address of the person entitled to notice with delivery deemed to have occurred 48 hours after the certified notice is mailed." *Id.* § 10.

14. A physician who fails to provide notice as required by the Act is subject to professional discipline and civil penalties under the Medical Practice Act of 1987. *See id.* § 40(a); 225 ILCS 60/22(A)(40), 22(C).

15. The Act does not require notification if: (1) the minor is "accompanied by a person entitled to notice;" (2) notice is waived in writing by such person; or (3) "the attending physician certifies in the patient's medical record that a medical emergency exists and there is insufficient time to provide the required notice." 750 ILCS 70/20.

16. In addition, notification is not required if the minor "declares in writing that she is a victim of sexual abuse, neglect, or physical abuse by an adult family member as defined in [the] Act." *Id.* § 20. The attending physician must certify in the minor's medical record that he or she has received this declaration. *Id.* Any legally required report of the abuse need not be made until after the minor's abortion. *Id.*

17. Finally, notice is not required if it is "waived under [the procedures for judicial waiver of notice outlined in] Section 25" of the Act. *Id.* § 20(5). In order to obtain a judicial waiver of notice, the minor bears the burden of proving by a preponderance of evidence either: "(1) that the minor . . . is sufficiently mature and well enough informed to decide intelligently whether to have an abortion; or (2) that notification under Section 15 of this Act would not be in the best interests of the minor . . . ." *Id.* § 25(d). Under the Act, unless the minor asks for an extension, the circuit court must rule on the minor's petition and "issue written findings of fact and conclusions of law within 48 hours of the time that the petition is filed," excluding weekends and holidays. *Id.* § 25(c); Ill. Sup. Ct. R. 303A(a). If a decision is not rendered immediately following a hearing, it is the minor's responsibility to contact the clerk of court for notification of the decision. Ill. Sup. Ct. R. 303A(a). The petition is deemed granted if no ruling issues within

48 hours. 750 ILCS 70/25(c); Ill. Sup. Ct. R. 303A(a). If an extension is requested, however, the Act fails to provide any deadline by which the court must rule. The Act furthermore fails to provide any mechanism by which a minor may establish to a physician that her court petition has been deemed granted.

18. The Act provides for appeal to the Court of Appeals as a matter of right where the petition is denied in the trial court. 750 ILCS 70/25(f); Ill. Sup. Ct. R. 303A(b). The Court of Appeals must issue a written ruling within three days. Ill. Sup. Ct. R. 303A(g). Should the appellate court affirm the denial of the petition, the minor may petition the Illinois Supreme Court for leave to appeal. Ill. Sup. Ct. R. 303A(h).

19. Although the Act was enacted in 1995, enforcement was enjoined because the Illinois Supreme Court had not issued rules necessary to comply with federal constitutional requirements. *Zbaraz v. Ryan*, No. 84-CV-00771, 1996 WL 33293423 (N.D. Ill. Feb. 8, 1996). On September 20, 2006, the Illinois Supreme Court adopted Illinois Supreme Court Rule 303A, entitled "Expedited and Confidential Proceeding Under the Parental Notification of Abortion Act." The United States District Court for the Northern District of Illinois declined to dissolve the permanent injunction, first because the Attorney General admitted that the Illinois courts were not prepared to apply the new procedures, and later, because the court concluded that a facial defect rendered the Act unconstitutional as written under federal law. *Zbaraz v. Madigan*, No. 84-CV-00771, 2008 WL 589028, at * 3 (N.D. Ill. Feb. 28, 2008).

20. The United States Court of Appeals for the Seventh Circuit subsequently reversed the District Court and dissolved the permanent injunction. *Zbaraz v. Madigan*, 572 F.3d 370 (7th Cir. 2009).

21. Although the Seventh Circuit's mandate issued shortly thereafter, the Illinois Department of Financial and Professional Regulation granted physicians a ninety day period to develop policies and procedures to ensure compliance with the Act and protection of the rights of patients. Ill. Dept. of Fin. & Prof'l Reg., *Medical Professionals Offered More Time for Compliance with Parental Notification Laws*, available at http://www.idfpr.com/newsrls/08052009MedProfOfferedMoreTimeComplianceParentalNotificationLaw.asp (last visited Oct. 12, 2009).

B. The Provision of Abortions in Illinois

22. Based on available data, approximately 15,000 Illinois teens – out of a population of more than 250,000 – under the age of 18 became pregnant in 2000. Approximately one-third of those teens, or 5,000, terminated their pregnancies.

23. Legal induced abortion is one of the most frequently performed surgical procedures in the United States, and is one of the safest procedures in contemporary medicine. Indeed, today the risk of death from legal induced abortion is less than that from an injection of penicillin. Both in terms of mortality (death) and morbidity (serious medical complications short of death), abortion is many times safer than continuing a pregnancy to term.

24. Pregnancy and childbirth pose serious risks for all women, even those who are generally healthy. It effects changes in every major bodily organ. It can exacerbate a preexisting medical condition. And, even the healthiest pregnancy can quickly become life threatening.

25. Although pregnancy presents significant potential health risks for any woman, it presents enhanced risks for teens. Maternal health risks are significantly higher for pregnant adolescents than for adult women. An adolescent carrying a pregnancy to term faces a mortality

rate of more than twice that of an adult woman, and teens younger than 17 years have a higher incidence of morbidity than do adult women, with risks being greatest for the youngest teens.

26. Although abortion is far safer that carrying a pregnancy to term, delay in the performance of an abortion significantly increases the health risks that women face in connection with the procedure.

27. Abortions also become more expensive the later in pregnancy they are performed, and there are fewer providers who offer abortion services later in pregnancy. This is so particularly outside the Chicago area. Because of increased cost and decreased availability, the more delay a woman faces in getting an abortion, the less likely she is to be able to obtain one.

28. The increased health risks and limited accessibility of abortion at later gestational ages is particularly significant for minors because they are more likely than older women to delay having an abortion until after the first trimester. Teens seek later abortions for a variety of reasons, including that they frequently have irregular menstrual cycles and thus take longer to recognize the signs of pregnancy, and that once they do begin to suspect pregnancy, they take a longer amount of time to overcome the logistical and financial hurdles to obtaining an abortion.

29. Women in Illinois, including minors, decide to terminate their pregnancies for a variety of maternal and fetal health, familial, economic and personal reasons. Young women in particular often feel that they are not yet ready to be parents, that they do not feel they can be the kind of parent their child would deserve, or that having a child in their teens would completely change their plan for their lives, and would thwart education and career plans.

30. Most minors involve one or both parents in the decision to obtain an abortion. The younger the minor, the more likely it is that a parent is involved. Many of those minors who do not involve a parent consult with and have the support of another adult.

31. When minors do not involve a parent in deciding whether to have an abortion, they generally have compelling reasons for not doing so. Some minors fear physical or emotional abuse by their parents if they learn of the minor's pregnancy. Other minors fear that their parents will force them out of the house. Still others fear that their parents will force them to carry their pregnancies to term against their will.

32. Some minors choose not to tell a parent because of other crises in the family, such as the death or serious illness of a family member or a parent's loss of a job and impending economic problems. These minors choose to obtain an abortion independently because they fear that news of their pregnancy will be too much for a parent already dealing with such significant problems, and the family will be unable to cope with one more crisis.

33. Other minors come from families in which they have no real parent/child relationship at all because, for example, their parents are in jail, are addicted to drugs, or have abandoned them. Minors from these families sometimes find that there are significant emotional reasons not to attempt to engage their parents and no advantage to doing so as they know that the parent will not offer help or support.

C. The Harms of the Act

34. For those minors who cannot involve a parent in their decision to terminate a pregnancy, the Act's notification requirement will result in significant and irreversible harm.

a. The Act will leave some minors little choice other than to tell a parent, contrary to their best judgment. Some of these minors will suffer: some will be beaten; some will be thrown out of their homes; and some will be forced to continue their pregnancies against their will.

b. The Act will subject some minors to other harms as well. Some minors who determine that they cannot notify a parent or go to court will take extreme action to avoid

parental involvement, including obtaining an illegal abortion or attempting to self-induce an abortion. Others will continue to carry their unwanted pregnancy to term, suffering the attendant medical risks and severe adverse education, economic, and social consequences.

c. Regardless of the route the minor chooses, telling a parent or going to court to seek a bypass, the Act will delay minors' abortions. Delay in obtaining an abortion increases the medical risks, costs and lack of availability associated with the procedure.

35. The Act's abuse and neglect exception provides little, if any, aid to minors who are endangered. Because of the psychology of abuse, many abused and neglected minors will be unwilling to reveal the abuse. In addition, the exception provides no remedy for minors who have not previously been subject to physical or sexual abuse, but who know with certainty (often because they have seen it happen to an older sister) that revealing their pregnancy will subject them to physical harm or ejection from the home.

36. In addition, for those minors who cannot involve a parent in their decision to terminate a pregnancy, the Act's provision for obtaining judicial waiver of notice (hereinafter "judicial bypass") does not provide an adequate substitute.

a. For many minors who cannot notify, the judicial bypass is not a realistic alternative. For some, the prospect of going to court and revealing to a judge the intimate details of their home, personal life, and circumstances of their pregnancies is simply too daunting. For others, the logistical hurdles, including phone calls, arranging transportation, and finding a time to be away from school and home without arousing suspicion, are too difficult to overcome.

b. Minors who do pursue a judicial bypass will be delayed in obtaining medical care as they overcome their fears and apprehensions about explaining their very private predicament to a stranger and authority figure; struggle to determine how to pursue a bypass; arrange

transportation to court; await a time when they can travel to court undetected by parents or school officials; and then actually progress through a bypass procedure. The delay will increase the risk of the abortion procedure. In addition, it will increase the cost and decrease the availability of the abortion procedure, if abortion is even still an option at her advanced stage of pregnancy.

c. Minors who do pursue a judicial bypass are at risk for their parents discovering their pregnancy and planned abortion. All of the actions required to pursue a bypass, such as arranging transportation to and from the courthouse, explaining absences from home or school, and spending time at the courthouse awaiting the hearing and decision, put minors' confidentiality at risk. Thus, the very act of pursuing a waiver of the parental notification requirement will result, in some cases, in a minor's parent learning of her pregnancy and planned abortion.

d. The delays, risks of disclosure, and humiliation suffered by being forced to reveal the intimate details of their lives to a judge that are inherent in the judicial bypass process will take a tremendous emotional toll on minors who pursue judicial bypass.

D. Lack of Justification for the Act

37. There is no justification for the Act.

38. By requiring minors to notify a parent or go to court before having an abortion, the Act will harm, not protect, minors' health and well-being, as discussed above in paragraphs 34-36.

39. The Illinois General Assembly asserted only limited justifications for the Act:

> The General Assembly finds that notification of a family member as defined in this Act is in the best interest of an unemancipated minor, and the General Assembly's purpose in enacting this

> parental notice law is to further and protect the best interests of an unemancipated minor.
>
> The medical, emotional, and psychological consequences of abortion are sometimes serious and long-lasting and immature minors often lack the ability to make fully informed choices that consider both the immediate and long-range consequences.
>
> Parental consultation is usually in the best interest of the minor and is desirable since the capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion are not necessarily related.

750 ILCS 70/5.

40. Contrary to the Act's asserted findings and purpose, the Act is not necessary to prevent "serious and long-lasting" medical, emotional and psychological consequences.

41. As already noted, abortion is one of the safest surgical procedures available, and is many times safer than continuing a pregnancy through to childbirth.

42. In addition, more than two decades of scientific research has consistently shown that for the vast majority of women, including adolescents, abortion poses no psychological hazard. Indeed, the best scientific evidence available demonstrates that adolescents who terminated their pregnancies were just as healthy – if not healthier psychologically – than those who gave birth, and there is no reliable evidence that abortion leads to long-term mental health problems.

43. Moreover, contrary to the Act's assumptions, the Act is not necessary to ensure that minors make an informed decision regarding abortion. Minors seeking abortion services independently of their parents are sufficiently mature to provide informed consent and the essential medical information to health professionals prior to obtaining treatment. They are capable of understanding their options for dealing with an unintended pregnancy, the risks and benefits of each option, and the immediate and long-range consequences of their decision.

44. The majority of minors already involve a parent in their decision to have an abortion. However, for minors who have good reasons not to involve their parents in their decision to have an abortion, the Act will not create a positive family relationship and open lines of communication where none existed previously. For these and other reasons, leading professional medical organizations, including the American Medical Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the Society for Adolescent Medicine, and the American Public Health Association, oppose laws mandating parental notification of a minor's abortion, such as the Act.

CLAIMS FOR RELIEF

COUNT I: RIGHT TO PRIVACY

45. Plaintiffs hereby reaffirm and reallege each and every allegation made in ¶¶ 1–44 above as if set forth fully herein.

46. The Act violates the Illinois Constitution's express privacy clause, Article I, Section 6, by impairing a minor woman's fundamental right to obtain an abortion. The Act does so by unlawfully intruding upon a minor woman's rights to bodily autonomy, to make medical decisions about her reproductive healthcare, and to keep medical information confidential, all without justification.

COUNT II: SUBSTANTIVE DUE PROCESS

47. Plaintiffs hereby reaffirm and reallege each and every allegation made in ¶¶ 1–44 above as if set forth fully herein.

48. The Act violates the substantive components of the Illinois Constitution's Due Process Clause, Article I, Section 2, by impairing a minor woman's fundamental right to obtain

an abortion. The Act does so by unlawfully intruding upon a young woman's rights to bodily autonomy, to make medical decisions about her reproductive healthcare, and to keep medical information confidential, all without justification.

COUNT III: RIGHT TO EQUAL PROTECTION

49. Plaintiffs hereby reaffirm and reallege each and every allegation made in ¶¶ 1–44 above as if set forth fully herein.

50. The Act violates the Illinois Constitution's guarantee of equal protection, Article I, Section 2, by discriminating against minors on the basis of their decision to exercise their fundamental right to abortion. The Act does so by subjecting minors who choose to terminate their pregnancies to a requirement of parental notification while minors who choose to carry their pregnancies to term are subject to no such restraint. The state's discriminatory scheme is without justification.

COUNT IV: GENDER EQUALITY

51. Plaintiffs hereby reaffirm and reallege each and every allegation made in ¶¶ 1–44 above as if set forth fully herein.

52. The Act violates the Illinois Constitution's guarantee of gender equality, Article 1, Section 18, by preferencing childbirth over abortion, thus improperly advancing gender based stereotypes about the role of women as mothers.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray that this Court:

53. Declare the Act to be unconstitutional and that, as a consequence, the Act is void and of no effect.

54. Enter a temporary restraining order and a preliminary and permanent injunction prohibiting Defendants from enforcing the Act.

55. Award Plaintiffs attorneys' fees, costs and expenses pursuant to 740 ILCS 23/5(c)(2).

56. Enter such relief as the Court deems just and proper.

Respectfully submitted,

By: _____
One of the Attorneys for
Plaintiffs

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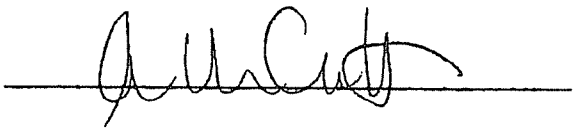
Dated: October 13, 2009

VERIFICATION

I, Allison Cowett, M.D., M.P.H., under penalties provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, hereby certify that I have read the foregoing Verified Complaint; that the factual statements set forth in paragraphs 1-4, 6, 8-18, 22-31, 34, 37-41, and 43-44 are true, except for those alleged on information and belief; and that I am informed and I believe that the facts alleged on information and belief are also true.



Allison Cowett, M.D., M.P.H.

VERIFICATION

I, Anne Baker, M.A., under penalties provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, hereby certify that I have read the foregoing Verified Complaint; that the factual statements set forth in paragraphs 1-2, 7, 11, 13-18, 26-27, and 29-40 are true, except for those alleged on information and belief; and that I am informed and I believe that the facts alleged on information and belief are also true.

Anne Baker MA

Anne Baker, M.A.

FAMILIES
(750 ILCS 70/) Parental Notice of Abortion Act of 1995.

(750 ILCS 70/1)

Sec. 1. Short title. This Act may be cited as the Parental Notice of Abortion Act of 1995.
(Source: P.A. 89-18, eff. 6-1-95.)

(750 ILCS 70/5)

Sec. 5. Legislative findings and purpose. The General Assembly finds that notification of a family member as defined in this Act is in the best interest of an unemancipated minor, and the General Assembly's purpose in enacting this parental notice law is to further and protect the best interests of an unemancipated minor.

The medical, emotional, and psychological consequences of abortion are sometimes serious and long-lasting, and immature minors often lack the ability to make fully informed choices that consider both the immediate and long-range consequences.

Parental consultation is usually in the best interest of the minor and is desirable since the capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion are not necessarily related.
(Source: P.A. 89-18, eff. 6-1-95.)

(750 ILCS 70/10)

Sec. 10. Definitions. As used in this Act:

"Abortion" means the use of any instrument, medicine, drug, or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of a child after live birth, or to remove a dead fetus.

"Actual notice" means the giving of notice directly, in person, or by telephone.

"Adult family member" means a person over 21 years of age who is the parent, grandparent, step-parent living in the household, or legal guardian.

"Constructive notice" means notice by certified mail to the last known address of the person entitled to notice with delivery deemed to have occurred 48 hours after the certified notice is mailed.

"Incompetent" means any person who has been adjudged as mentally ill or developmentally disabled and who, because of her mental illness or developmental disability, is not fully able to manage her person and for whom a guardian of the person has been appointed under Section 11a-3(a)(1) of the Probate Act of 1975.

"Medical emergency" means a condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of major bodily function.

"Minor" means any person under 18 years of age who is not or has not been married or who has not been emancipated under

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AFFIDAVIT OF RUTH KLEIMAN

I, RUTH KLEIMAN, testify under penalty of perjury that the following is true and correct:

1. I am the volunteer coordinator of the Illinois Judicial Bypass Coordination Project ("Bypass Project" or "Project"). The Project was established to provide information and assistance to minors about their rights under the Illinois Parental Notice of Abortion Act of 1995 (the "Act"), including the right to petition for a judicial waiver of notice pursuant to Section 25 of the Act. In particular, the Project is working to ensure that trained lawyers will be available to assist young women who choose to pursue a judicial bypass.

2. In order to best serve the young women who contact the Project for assistance and to best inform the volunteer lawyers, the Bypass Project has sought to collect information about the procedures for filing and pursuing a judicial bypass petition in the various state courts. As part of this effort, the Bypass Project has searched court websites and has reached out to court

personnel. We pursued this work intensively in the summer of 2009, in anticipation of the Act taking effect in early August after the federal court dissolved the injunction prohibiting its enforcement. On August 5, the Illinois Department of Financial and Professional Regulation granted physicians a ninety day grace period, until November 3, to come into compliance with the Act.

3. In anticipation of the end of the grace period, we have continued our efforts to collect information about the bypass process in place in the various state courts. As a part of this effort, on Wednesday, September 9, 2009, I placed calls to the Circuit Clerks' offices in ten counties for which we had previously collected no information: Adams County, Bureau County, Christian County, Edwards County, Gallatin County, Hancock County, Iroquois County, Rock Island County, Vermillion County, and Whiteside County. On Wednesday, October 7, 2009, I placed calls to the Circuit Clerks' offices in five additional counties for which we had no information: Clinton County, Fulton County, McLean County, Ogle County, and Will County. Of the courts I called, few were in any position to assist minors and many were in a state that would have confused, obstructed or perhaps discouraged minors attempting to file petitions.

4. By way of background, for each of the courts I called, I dialed the phone number listed on the Clerk's office website, or, if the Circuit Clerk of that county did not have a website, from the websites of either the Illinois Courts or the National Association of Counties. In each call, I explained that I was looking for information about procedures in that county for judicial waiver proceedings under the Parental Notice of Abortion Act.

5. In Christian County, I spoke to the Deputy Clerk. She said that the procedure was new to her. She reported that the office had a petition form. But she also read me a directive from the Chief Judge which stated: "Neither the Act nor Rule mandates that courts distribute

petitions; therefore it is my belief that courts should not do so. However, I leave it up to the discretion of the Clerk how you want to make these forms available, if at all." She explained that based on her understanding of the directive, the judges "don't encourage" distribution of materials because they want the minors to "go through an attorney." She also stated that once the petition is filed, the Clerk's office would give the minor a hearing date "if she asks." She estimated that the hearing would "probably" take place "in ten days to two weeks."

6. The Christian County Deputy Clerk stated further that "when a minor comes in, we want a parent or guardian present." She also informed me that the court "would not appoint an attorney" – a statement contrary to the mandates of the statute – since the bypass hearing is "a civil case." However, she also stated that the minor "can't go [into her hearing] without a lawyer."

7. In Rock Island County, the receptionist said she was not the person I should ask about the Act, she was "not familiar with the statute," and she did not believe anyone in her office was because they were "all clerks." She suggested I contact the State's Attorney's office but warned that I might get transferred around that office and that the State Attorney's office will likely say, "I don't know, contact an attorney." She then transferred me to the State's Attorney's office. The receptionist there stated that she had "absolutely no idea" what I was talking about. She then put me on hold so that she could find an attorney who might be available to talk with me. After a long period, the receptionist returned to the phone and informed me that she "spoke with one of [their] attorneys and they have no idea – if you get on-line and find the Illinois Statutory Code, or the law library at the courthouse or the court administrator or your local library or a private attorney, or the public library: look in the index under what you're asking about." She then ended the conversation.

8. In Whiteside County, I spoke with the Deputy Chief Clerk at the Clerk's office in Morrison, Illinois. She did not know about the Act and said they didn't have any forms related to the proceedings. Most troubling, when told that the Act allowed minors to file a petition to waive the notification requirements, she commented, "[b]ut if they file that petition, don't they have to give notice? So that would give notice of the abortion." Similarly, in the context of discussing the hearing, she stated that the Clerk's office could give the minor a court date when she files the petition "but she would have to provide the notice of hearing to whoever has to be notified." She also didn't know if they would appoint counsel since they "usually only do that in criminal cases" and "in juvenile cases, there are Guardian ad Litems" but she "guess[ed the decision to appoint an attorney] would be up to the judge."

9. In other courts, the clerks were not able to provide me with any information. In Iroquois County, for example, I spoke with the Clerk, who put me on hold for an extended period of time, and then came back to say she was "not sure if [the] minor would actually need to talk to a judge, or the State's Attorney." She then said she would "try and find out" more information and give me a call back. As of today – over a month later – she has not yet called back. Similarly, in Vermillion County, the receptionist transferred me to the Juvenile Division, where the staff didn't know about the measure, but suggested she "might be able to look it up." She then asked a supervisor from the Family Division, who was passing by, if she had any information. Ultimately, I was told that the supervisor from Family was "having problems" finding the information but that she would call me back. As of today – again, over a month later – no one from that court has called me.

10. In Clinton, Edwards, Gallatin, and McLean Counties, the staff people with whom I spoke were not able to provide me with any information. In Clinton County, the receptionist

who answered told me "I have no idea. We don't do anything with abortion in this office. I have no idea who you'd talk to about that," and then refused my request to take a message for the Clerk himself. In Edwards County, the receptionist stated the she did not "have the slightest idea what [I was] talking about" and told me to call back to talk to the Clerk. When I connected with the Clerk, she informed me that she "would need to talk to the judge on that" but he was "not available today." Shortly after that, she ended the conversation. In Gallatin Country, the receptionist stated that she "wouldn't know" about the Act and transferred me to the Clerk. The Clerk also said she was "not familiar" with the Act and informed me that their office did not have any forms available. The Clerk further stated that if a girl called, she would "probably tell her that I can't give legal advice and she should contact an attorney." In McLean County, the receptionist also told me she had no idea what I was talking about and also suggested I contact an attorney. She then asked what kind of case it was, whether it belonged in "Chancery or Law or Small Claims." She was unable to give me any more information.

11. Even where the clerks or their staff were familiar with the Act, they often gave some erroneous or unclear information. For example, in Adams County, the supervisor to whom I was transferred knew of the Act and knew it needed to take precedence over everything. But even that county did not yet have a petition available and, more troubling, she did not think it was possible for a minor to secure appointed counsel "on a Family matter." Similarly, in Bureau County, the Clerk to whom I was ultimately connected knew of the Act, knew of the need for expedition, and had forms for the minor – but only at the courthouse. But confusingly, when I asked what happens if a minor requests an attorney, she responded, "[t]hat's the same as a Guardian ad Litem," but then also explained there is a form for the minor to request or decline an attorney. When I called the Clerk's office in Fulton County, the Clerk also was familiar with the

Act but told me that they did not have forms available to distribute to petitioners; instead, they would tell minors to "go on the Internet to find the forms," which "maybe they'll find in one of the larger counties." She also said they would suggest to a petitioner "that she needs to get a lawyer" and would refer her to "West Central Legal Assistance in Galesburg."

12. The Ogle County Circuit Clerk was aware of the law and did not provide any incorrect information in response to my questions, but indicated that they were still working on developing written protocols and hoped to review protocols and forms developed in other courts.

13. Indeed, in only two of the fifteen counties I called on these recent days – Hancock and Will – did the staff at the clerk's office seem fully informed and somewhat prepared for petitioners. When I called Hancock County, the receptionist did not know about the Act, but the Deputy Chief Clerk called me back with information. She knew the process was to take 48 hours from the time the petition is filed and that the judge would appoint the minor a lawyer "right then." The office had neither a website nor forms available; they did have, however, "enough information to walk a person through the process." Similarly, the Customer Service Manager I spoke with in Will County seemed knowledgeable and indicated forms and internal policies were currently in development in that court. Nevertheless, she expressed some confusion about the minor's statutory right to resolution of her petition in 48 hours. She indicated uncertainty as to whether the 48-hour period ran from when the petition was filed or when the hearing takes place, and whether the "case is continued" until the court can find the minor an available GAL and attorney.

14. We are aware of additional courts that have made efforts to be prepared for young women pursuing judicial bypass proceedings. For example, the Circuit Court of Cook County has provided extensive information about its procedures. In that court, all judicial bypass

proceedings will be heard in the County Division. There are available, online and in the Clerk's office, a form petition to initiate the proceeding, instructions explaining what information is required in the petition and how the proceedings will go forward, and the room numbers in the various courthouses in the Circuit Court of Cook County where a waiver petition can be filed.

CERTIFICATION

Under penalties as provided by law pursuant to Section 1109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that she verily believes the same to be true.

10/12/09
Date

Ruth "Kelly" Kleiman
Ruth "Kelly" Kleiman

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS

COUNTY DEPARTMENT — CHANCERY DIVISION

THE HOPE CLINIC FOR WOMEN LTD.; ALLISON COWETT, M.D., M.P.H.,	)	Case No.
Plaintiffs,	)	
v.	)	AFFIDAVIT OF JUDGE GERALD C. MARTIN IN SUPPORT OF PLAINTIFFS' MOTION FOR INJUNCTIVE RELIEF
BRENT ADAMS, Acting Secretary of the Illinois Department of Financial and Professional Regulation, in his official capacity; DANIEL BLUTHARDT, Director of the Division of Professional Regulation of the Illinois Department of Financial and Professional Regulation, in his official capacity; THE ILLINOIS STATE MEDICAL DISCIPLINARY BOARD,	)	
Defendants.	)	

AFFIDAVIT OF JUDGE GERALD C. MARTIN

I, JUDGE GERALD C. MARTIN, certify under penalty of perjury that the following is true and correct:

1. I am a District Court Judge for the Sixth Judicial District of Minnesota and currently sit in Duluth, Minnesota. Since becoming a judge in 1978, I have handled cases for Southern St. Louis County. From 1978 through early-2000, when the Sixth Judicial District enacted a general rotation system for all of its judges, I served as the primary juvenile court judge in Southern St. Louis County and handled juvenile, probate, and family law cases for Southern St. Louis County. From early-2000 through the present, I have shared the responsibility of presiding over juvenile, probate, and family law cases with all of the other District Court Judges within Southern St. Louis County. Before becoming a judge I worked as a legal aid attorney for eight years. I earned my law degree from Yale Law School and my undergraduate degree from Princeton University.

2. Over the past twenty-eight years, since the enactment of a mandatory parental involvement law in Minnesota, I have decided hundreds of judicial bypass petitions. I have reviewed the Illinois Parental Notice of Abortion Act of 1995 (the "Act"). Similar to the bypass provision contained in Minnesota's parental involvement law, the Act requires that the judge grant the minor's petition if she can demonstrate that she is mature or that it is in her best interests to obtain an abortion without notifying her parents.

3. I submit this affidavit in support of Plaintiffs' motion for injunctive relief because, in my experience, mandatory parental involvement laws provide no benefit to, while substantially burdening, young women seeking to exercise their right to abortion.

4. In 1981, Minnesota enacted a parental notification law, Minnesota Statute § 144.343, which requires either notification of both parents or judicial authorization before a minor can obtain an abortion. As a district judge, I hear judicial bypass petitions filed in Southern St. Louis County. Indeed, from the enactment of the parental notification law in Minnesota in 1981 until at least 1999, I decided approximately 90% of the bypass petitions filed each year in the Southern St. Louis County Court, except for a period of three years when I shared that responsibility with another judge. From August 1981, when the law was enacted, until November 1986, when it was enjoined by the federal district court for the District of Minnesota, I decided approximately 225 petitions. Since the summer of 1990, when the injunction was lifted and judicial bypass proceedings resumed, I have decided hundreds of additional judicial bypass petitions.

5. In my experience, mandatory parental involvement laws serve no useful purpose and substantially burden young women seeking to exercise their right to abortion. The minors I see are mature; they have persuasive reasons for seeking abortions; and they have

thought through their decisions. I have no doubt that these young women are capable of making this decision in consultation with their healthcare providers. They gain nothing by having to appear before me for a waiver. Instead, they suffer harm, as the requirement that they come to court compromises their confidentiality, delays their procedures, and adds unnecessary strain to an already difficult situation.

6. In Southern St. Louis County, we have established over the years a process that is followed by every petitioner seeking a judicial bypass. This process works relatively well in large part because of the significant effort, time, and resources devoted by a local clinic, the Women's Health Center, which provides abortions. The Women's Health Center makes all the necessary arrangements and guides minors through the process. The process begins when the minor contacts the clinic. Each petitioner receives counseling from clinic personnel before appearing in court. Someone from the clinic calls my court reporter, who sets a time for a hearing. Previously, the clinic also called the Public Defender's office, which assigned an attorney to represent the minor. However, some time after 1999, the Public Defender's office eliminated this service to minors because of lack of funding. As a result, minors do not have access to a public defender prior to or during the bypass hearing and must rely in full on the small handful of counselors working at the clinic for guidance through the process.

7. Without the clinic's assistance, minors would undoubtedly face tremendous barriers to getting a bypass. If a minor, learning about the parental notice requirement and not knowing to call the clinic first, were to try to figure out on her own how to obtain a bypass, she would have a very difficult time navigating through the judicial system. Some judges in this region will not even hear bypass petitions. A minor seeking assistance thus

would likely have to make a series of unproductive calls before she received accurate information. Even then, it seems unrealistic to believe that a minor, or any person for that matter, with no experience with the court system would know how to file a petition, schedule a hearing, and take any other necessary steps. At the very least, I would expect this ordeal to provoke significant anxiety and take quite a bit of time.

8. As a practical matter, it is difficult for a minor using the judicial bypass process to maintain her confidentiality. Hearings are typically scheduled for 1:00 p.m. or 1:30 p.m. on weekdays. Although I try to be flexible in scheduling hearings, because the courthouse closes at 4:30 in the afternoon on weekdays and is not open over the weekend, minors are likely to have to miss school to attend the hearing. These absences may well arouse the suspicion of school officials, who in turn may report the absence to the minor's parents. Moreover, on the day of the hearing, minors usually receive counseling at the clinic and then come directly from the clinic to the courthouse, which is just blocks away. Minors may be confronted by picketers or others when entering or exiting the clinic. Because the clinic is widely known to be the only facility in the region to provide abortions, anyone who sees the minor proceed from the clinic to the courthouse may well ascertain her purpose.

9. The minor's confidentiality is also not necessarily secure within the courthouse walls. Because of space constraints, minors may spend a significant period of time waiting with the clinic counselor in a public corridor of the courthouse for the start of the hearing. Members of the public use the corridor for other purposes, as do peers of the minor who are appearing in juvenile court, and there have been times when a minor has been recognized and her purpose in the courthouse revealed. The minor's purpose can be determined simply by her presence with a clinic counselor, as only a small handful of clinic counselors have

attended these hearings in past the twenty-eight years. Minors were presented with a similar risk when they were previously represented by public defenders. Not only did minors generally spend a significant period of time waiting in the public corridor for a public defender, but they generally also had to go in and out of a large waiting room to reach one of three more private conference rooms when meeting with a public defender. Anyone in the waiting room, which was often full, could recognize the minor, as could any of the parties going in and out of the other conference rooms. I know of at least one instance in which, just days after a minor appeared for a judicial bypass hearing, her parents received an anonymous letter informing them of the date, time, and subject of the hearing. I understand from the former executive director of the clinic that members of an anti-abortion group saw the minor in the courthouse, identified her by searching for her face in high school yearbooks, and then notified her parents. On other occasions, young women who are related to court employees have needed to seek a bypass. I understand that in at least one of those cases, the public defender and the young woman determined that the women's restroom was the place in which it was least likely that they would encounter the young woman's family member. They therefore prepared for the hearing inside the courthouse restroom.

10. The judicial bypass hearings take place in my chambers and generally last about five minutes. While a majority of the petitions come from minors residing in Minnesota, I have seen petitioners from Wisconsin and Michigan. At each hearing, I ask the minor a series of questions about her background, the counseling and medical information she has received, whether she understands her options and has signed the requisite forms, whether she needs to speak with anyone else, the reasons underlying her decision to seek an abortion, and why she wants to proceed without notifying a parent. The minor must answer these questions before a

host of strangers, including me, my court reporter, and the clinic counselor. After I ask my questions, I sometimes determine whether the clinic counselor has further questions. I do not personally provide information or counseling to the minor in the course of the bypass proceeding. There is nothing in the law to support my taking on the role of doctor or counselor, and I do not have the proper training to perform that function. Moreover, based on the responses I receive from minors when I ask about the counseling and medical information they have already obtained before they appear at the hearing, I am confident that any further counseling or medical information provided by the court would be entirely superfluous.

11. Of the hundreds of petitions I have heard since 1981, I have granted all but one. In addition, I am not aware of any instance in which any other district court judge from Southern St. Louis County ever denied a petition. In all of the cases in which I granted the petition, I found the minor to be mature and capable of giving informed consent. When I first began holding these hearings, I thought it would be difficult to assess a minor's maturity in this context. In reality, it is surprising to me how easy the determination almost invariably is. The overwhelming majority of the petitioners I see are articulate and capable. They often explain that they feel too young to bear the overwhelming responsibility of raising a child, and that they have plans for the future, including staying in high school and possibly attending college, that they fear will be jeopardized if they have a child. They typically present compelling reasons for seeking abortions without notifying their parents. In a majority of cases, those reasons include dysfunction within the family, including chemical dependency on the part of parents; a pattern of abuse (and, as a result, fear of an abusive reaction from one or both parents); and a strained parent/child relationship. In addition, minors have cited a concern over the impact the news might have on an ill parent.

12. In the one case in which I denied a petition, more than twenty years ago, a 14-year-old came to court, accompanied by her mother, seeking waiver of the notification requirement as it applied to her long-absent father. I felt the minor was very immature. I required that a certified letter be sent to the last known address of the father because I could not conclude that notifying him was against the minor's best interests, the only basis for granting a bypass to an immature minor. This is yet a further example of the harm caused by the bypass requirement. This minor appeared before me with her mother, who supported her decision to undergo an abortion, and her father played no active role in her life. Yet, because this minor was not mature, and because I could not conclude that sending a notification to her father was against her best interests, I decided that the statute mandated that notification be sent. Thus, because of the parental involvement law, the minor's abortion was delayed for another forty-eight hours while a letter was sent to an address where, presumably, the father no longer lived.

13. I have observed hundreds of minors seeking authorization for abortions. I can see that it is an emotional ordeal for them to have to go through the judicial process. Being a witness or litigant can cause anxiety for anyone, and the stress is unusually acute for these young women, who are forced to disclose very intimate and personal matters to strangers. Their situation is rendered all the more difficult by the knowledge that a complete stranger has total control over an extremely important and potentially life-altering decision. When the hearing is over, they display great relief and exit quickly from my chambers.

14. Having presided over well in excess of 600 cases involving minors seeking court authorized abortions, I do not believe there exists any useful public purpose for a statute requiring minors who cannot involve their parents to obtain a court order. I do not believe that requiring minors to navigate the judicial process benefits them or anyone else in any

way. It simply erects a barrier to teenagers' right to abortion, and imposes needless strain on these teenagers at a very difficult time in their lives.

CERTIFICATION

Under penalties as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that he verily believes the same to be true.

9/23/09

Date

Judge Gerald C. Martin

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS

COUNTY DEPARTMENT — CHANCERY DIVISION

THE HOPE CLINIC FOR WOMEN LTD.; ALLISON COWETT, M.D., M.P.H., Plaintiffs, v. BRENT ADAMS, Acting Secretary of the Illinois Department of Financial and Professional Regulation, in his official capacity; DANIEL BLUTHARDT, Director of the Division of Professional Regulation of the Illinois Department of Financial and Professional Regulation, in his official capacity; THE ILLINOIS STATE MEDICAL DISCIPLINARY BOARD, Defendants.	Case No. AFFIDAVIT OF JAMIE SABINO IN SUPPORT OF INJUNCTIVE RELIEF

AFFIDAVIT OF JAMIE SABINO

I, JAMIE SABINO, testify under penalty of perjury that the following is true and correct:

1. I am an attorney, licensed to practice law in Massachusetts. I am the co-chair of the Judicial Consent for Minors Lawyer Referral Panel, a panel of lawyers trained to represent minors seeking judicial waivers of Massachusetts' parental consent for abortion law. In this role, I have been working with minors seeking judicial bypasses for more than twenty-five years.

2. Since 2001, I have been employed by the Trial Court of the Commonwealth of Massachusetts as the domestic violence project coordinator. In this position, I am responsible for implementing a federal grant to assess and improve how our court system handles domestic violence cases. I am also an adjunct professor at Boston University.

3. I have read Illinois' Parental Notice of Abortion Act (the "Act") and the Illinois Supreme Court Rules that govern the Act's judicial bypass provisions. I submit this affidavit in support of injunctive relief because, based on my experience with parental involvement laws and judicial bypass systems in Massachusetts and in other states, it is my opinion that the Act will cause significant and irreversible harm to young women seeking abortions in Illinois.

My Experience with Judicial Bypass Systems

4. Since 1981, Massachusetts law has required minors to obtain the consent of their parents before they may have an abortion. (Until March 1997, the law required that the minor obtain the consent of both parents. For the past twelve years, however, the law has been interpreted to require the consent of only one parent.) For minors who do not wish to involve their parents or who cannot obtain their parents' consent, the law provides a judicial bypass procedure. This bypass procedure allows a minor to consent on her own to an abortion if she can prove to a court either that she is mature and capable of providing informed consent, or that her best interests would be served by allowing her to obtain an abortion without involving her parents.

5. Before the Massachusetts law went into effect in 1981, several organizations, including the Women's Bar Association, came together to devise a system for educating clinics and minors about the bypass process and for guiding young women through that process. The participants in those meetings developed the Judicial Consent for Minors Lawyer Referral Panel (the "Panel") to recruit and train lawyers to represent young women seeking judicial bypasses. Panel lawyers, which today number about

seventy-five, have represented approximately ninety-eight percent of the adolescents who have sought a judicial bypass.

6. I have been a member of the Panel since 1981 and co-chair or chair of the Panel since 1983. As a Panel member, I have represented approximately sixty young women in judicial bypass proceedings; I have also been involved in almost all appeals that have occurred under this statute. As co-chair of the Panel, I also review the case summaries that attorneys who represent young women file with the Panel. I estimate I have reviewed approximately 7,000 such summaries. I also meet regularly with attorneys representing adolescents, with judges who hear bypass cases, and with clinic workers who assist pregnant adolescents. In addition, I conduct periodic trainings for Massachusetts attorneys on how to represent adolescents seeking a bypass. I am a co-author of the training materials given to these attorneys, and I periodically provide updates on the law and the implementation of the statute.

7. In addition to this work, I have also conducted a study on teens seeking judicial bypasses in Massachusetts. Along with two co-authors, the Research Director at the Center for Women in Politics and Public Policy and an assistant professor both at the University of Massachusetts, I examined, among other issues, the reasons teens did not discuss their decision to have an abortion with a parent, the other adults that these teens did turn to, and the teens' experiences with the judicial bypass system. This research consisted of a quantitative component in which we coded and analyzed data from all of the 490 counseling and referral interviews conducted by Planned Parenthood staff with minors seeking judicial bypasses during a one year period between 1998 and 1999. To supplement this quantitative research, we also conducted in-depth, face-to-face interviews

with twenty-six teens who sought and received judicial bypasses during that period. By reason of both my direct involvement with the Panel and my research, I am very familiar with the workings of the Massachusetts judicial bypass system and the experiences of adolescents dealing with that system.

8. In addition to my work in Massachusetts, I also have experience with bypass systems in other states. I have worked with attorneys and reproductive health care providers in at least ten other states which have or are considering implementation of parental involvement laws to help them devise systems to link minors seeking bypasses to lawyers willing to represent them and to train lawyers to provide that representation. In addition, I routinely field calls from abortion providers and lawyers across the country seeking advice about issues that arise with their judicial bypass systems.

Overview

9. In Massachusetts, the Panel has worked hard to make the bypass process function as effectively as it can, and we have had success in some areas. In fact, since the parental consent law went into effect in 1981, about 20,000 minors have gone through the bypass system. Since that time, there have been only sixteen denials, all but two of which were reversed on appeal. Approximately ninety-seven percent of the bypasses are granted based on a finding that the minor is mature enough to consent to her abortion on her own.

10. These numbers, however, do not begin to tell the full story. My experience with the bypass process has demonstrated that even though virtually all bypass petitions are granted, forcing minors to clear these legal hurdles has irreparably, and unnecessarily, harmed many young women. As an initial matter, despite all of our efforts to make the bypass process as easy as possible for young women, the process nonetheless

forces many, if not most, of them to delay their abortions. This delay increases both the medical risks and the cost of the procedure and decreases its availability.

11. Second, although the judicial bypass is supposed to provide an alternative for adolescents who cannot involve their parents in their decision, based on my experience, it is quite difficult for many teens to get through the process without their parents' learning of their pregnancy and planned abortion. Attempting to obtain a judicial bypass forces young women to take numerous steps—such as making several phone calls, arranging transportation to the courthouse, and explaining absences from school, work, and home—that are likely to, and all too often do, result in others finding out about their decision.

12. Finally, the story of our bypass is, of course, only the story of those young women who make it to court. For some adolescents, the prospect of going through the bypass is too daunting and the barriers to obtaining a waiver confidentially are too high to make it a realistic option. Some of these adolescents carry their pregnancies to term and end up becoming parents before they are ready. Others tell a parent against their better judgment and end up facing severe repercussions. Some young women have even attempted to self-induce an abortion because they feel as though they have no other choice.

13. Mandatory parental involvement laws pose all of these burdens for young women without any corresponding benefit. As my experience with the Massachusetts law has shown me, by and large minors who feel that they cannot turn to their parents in times of crisis do not change their minds simply because the law requires it. Moreover, as evidenced by the fact that a bypass has been granted in nearly all of the approximately

20,000 petitions filed, adolescents are sufficiently mature to make this decision in consultation with their health care providers. Thus, in my experience, the bypass process serves no purpose other than to impose a tremendous amount of stress on young women at an already difficult time in their lives.

Reasons Minors Do Not Involve Their Parents in Their Decision

14. As I have learned working with adolescents seeking abortions in Massachusetts, teens choose not to involve their parents in their abortion decisions for a variety of compelling reasons. Often the family is in a state of chaos, dysfunction, or stress, and the adolescent fears that news of her sexual activity, pregnancy, and desired abortion will be harmful to the family. For example, Panel members and Planned Parenthood counselors have worked with a teenager whose brother had committed suicide two weeks before; one whose mother had just been diagnosed with a brain tumor; another whose father had just lost his job; another whose father had just had a heart attack; and another whose father was brutally murdered two weeks before. These teens often feel that their parents are just barely coping with all the stress in their lives and that the added stress that disclosure of their pregnancy would cause would push their parents over the edge.

15. A significant percentage of other young women do not tell a parent because they fear a severe adverse reaction such as being ejected from the home or abuse. Some seek a bypass because they fear disclosure of their sexual activity and pregnancy will cause their parents to react violently. Some of these adolescents have already been abused by their parents. These teens know that stress often triggers an abusive episode and thus realistically fear that news of their pregnancy will lead to an attack. In a few

cases that have come before the Panel, the pregnancy was the result of incest.

16. Other minors have been threatened by their parents with a variety of severe repercussions—such as being beaten, being thrown out of the house, or having all support cut off—if they were to become pregnant. Some of these young women have witnessed a sister being thrown out of the house or otherwise ostracized from the family when her pregnancy was discovered. Others have experienced their parents' wrath first hand. For example, in our qualitative research we interviewed one young woman who lived with her father of whom she was frightened much of the time. In addition to fearing for her safety, this young woman chose not to tell her father because she believed he would react by calling her a whore and filing a child in need of supervision petition with the juvenile court—something he had done in the past.

17. All in all, in our quantitative analysis, 18.8% of minors seeking a judicial bypass in Massachusetts said that they did not involve their parent because of fear of severe adverse reactions such as these. Sadly, our qualitative research suggests that minors who give this reason are not just engaged in speculation or exaggeration. All of the young women in the qualitative sample who said that they did not tell a parent because they anticipated severe adverse consequences gave specific, concrete reasons for their fear. Indeed, all but one had been subject to physical abuse and/or serious emotional abuse or neglect. Moreover, none of the young women in the qualitative sample who had a good relationship with their parents gave concerns about a severe adverse reaction as a reason for not telling their parents.

18. We see other teenagers who know that, because their parents hold strong views against abortion, their parents would prevent them from obtaining the abortion or

even accessing the bypass if they learned of their pregnancy. These minors often have good reason to believe that their parents will act to prevent them from exercising their choice. For example, I recall one minor who sought a bypass because her parents had forced her to carry her previous pregnancy to term against her will and she was determined not to let that happen again.

19. Other adolescents simply have no real parent/child relationship at all. For example, one teenager, I'll call her Susan, explained to me that her mother provided her no support or guidance of any kind. The two of them did not discuss anything at all. In fact, Susan told me that for the past five years her mother had not even bothered to ask her what classes she was taking in school. As Susan said, "We just sort of live in the same house." When she became pregnant, she felt that there wasn't any way she could turn to her mother for support.

20. The mother of another young woman, I'll call Dion, somehow found out about her daughter's pregnancy. When her mother told her that she knew, Dion told her she wanted to have an abortion. Her mother reacted with complete indifference, except to tell Dion that she was not going to pay for it. This was the only conversation that the two of them had about the pregnancy; her mother expressed no interest in or concern for her welfare, and never even asked Dion about the abortion.

21. At the other end of the spectrum, some minors have good relationships with their parents, but nonetheless feel that they cannot tell their parents. Often they fear that their parents will be disappointed, that their parents will lose all faith and trust in them, and that their relationship with their parents will be irreparably damaged. Even if these minors are wrong and their parents actually would be supportive, the unfortunate

reality is that these minors feel that telling their parents is simply not an option and will do whatever it takes to avoid doing so.

22. What is clear, in all of these cases, is the depth of the minor's conviction that she cannot tell a parent about the abortion. Adolescents who resort to going to court are so desperate to avoid having their parents find out that they are willing to contact a lawyer, reveal some of the most private details of their lives to a stranger, arrange transportation to the courthouse, repeat their personal information, and wait while another stranger decides whether they are entitled to make a decision which will have profound consequences for their life. As I know from my experience representing young women as well as my study, the experience of going through the judicial bypass process is harrowing for many of them, producing considerable anxiety. The fact that they nonetheless continue with the court process speaks volumes about how strongly they feel that turning to their parents is not a viable option.

Effects of a Parental Involvement Law and the Bypass Process

23. Young women like these who determine that it is necessary to obtain an abortion without parental involvement encounter numerous hurdles in obtaining a timely, confidential bypass hearing. Despite the hard work of our well-trained army of volunteers and our quarter century of experience with this law, adolescents who need to use the judicial bypass process endure substantial delays—generally one to two weeks—before they are able to obtain a judicial bypass and have an abortion. In addition, although we do everything in our power to help young women get through the process and maintain their confidentiality, it is not at all unusual for an adolescent's decision to be

exposed while trying to obtain a bypass. Both delay and the loss of confidentiality can have significant consequences for adolescents' lives.

24. In Massachusetts, teens usually learn about the parental consent requirement for the first time when they call to make an appointment for an abortion. If the teen has called Planned Parenthood, her call is transferred to a counseling and referral hotline that provides options counseling and information regarding the bypass. If the teen has called another abortion provider, she is generally instructed to call Planned Parenthood's hotline. Once she reaches (or is transferred to) the hotline, the young woman speaks to a trained counselor who first explores the teen's decision to have an abortion and ensures that she has considered all of her options. If the teen is firm in her decision to have an abortion, the counselor explains the abortion procedure, as well as its medical risks. The counselor then talks with the teen about the possibility of telling her parents about her pregnancy and planned abortion. If the teen concludes that she cannot tell her parents and wishes to pursue the bypass, the counselor explains the process. If the teen can stay on the line, the volunteer also prepares her for the hearing by going over questions that she is likely to be asked by the judge. At a minimum, the volunteer tries to find out whether and when the young woman has an appointment for her abortion and when she can get to court for a hearing. The young woman is then instructed to call the hotline again in a few hours or the next morning for the name and phone number of the attorney who will handle her case. In the interim, the hotline volunteer calls attorneys from the list of those who have gone through the training until the volunteer is able to find an attorney who can take the case. The attorney then typically arranges the court date based on the information the young woman gave the hotline volunteer. The young

woman must then call both the hotline, to get the phone number of the attorney, and the attorney, to find out when the hearing will be.

25. Thus, to pursue a bypass, a young woman must, at the very least, make three or four phone calls (one to the clinic, one or two to the hotline, and one to the lawyer), as well as a trip to the courthouse. Accomplishing these tasks may sound easy, but for adolescents who must keep their abortion (and therefore their phone calls, travel, and absences) a secret and who often have tremendous difficulty accessing transportation, this is a formidable challenge.

26. One of the obstacles teens face in navigating the judicial bypass is the difficulties they encounter receiving and making confidential phone calls. Because of confidentiality concerns, many teens cannot leave a number where they can receive a return call. Teens who cannot tell their parents about their abortion often cannot receive a call from a stranger without risking detection. The home phone is almost never an option. Even if the teen has a cell phone, she often can't risk using it for these purposes. The phone numbers of all calls—incoming and outgoing—are listed either on the phone itself or the phone bill or both, and many parents check these numbers as a way of keeping tabs on their kids. Moreover, it is not unusual for a parent to confiscate or answer their child's cell phone. For all of these reasons, the vast majority of young women cannot leave a phone number for the attorney to reach her and therefore they must keep calling the lawyer until they are actually able to get the attorney on the phone. This can require the teen to make numerous calls, each of which jeopardizes her confidentiality and causes further delay. Indeed, in some cases, by the time a young woman reaches her

attorney, the date for the hearing has passed, a new one must be scheduled, and the adolescent must begin the process all over again.

27. Once an adolescent reaches the attorney and learns of the hearing date, her problems are far from over. Many adolescents experience further delay because of the difficulties they have in explaining their whereabouts as they travel to and from the courthouse and attend the hearing. Unlike the clinics, which may have hours on Saturdays, the courts hold bypass hearings only on weekdays, generally during school hours. This is often a tremendous problem for minors given that, in many schools, absences, even for one or two periods, trigger an automatic call home to the parent. And even excused absences may be recorded on a student's report card. This can be a real problem for some teens. For example, one Panel attorney received a frantic call from her client stating that, although the school was treating her absence as excused, it would nonetheless be noted on her report card. As she routinely achieved perfect attendance, she knew her parents would notice the excused absence and demand an explanation. Moreover, even if a minor devises a way to get out of school with triggering notice to her parents, sometimes the adolescent simply cannot miss school on the day the hearing is scheduled because, for example, she has a test that day.

28. Even if the hearing is scheduled for after school, adolescents often have trouble explaining their whereabouts without arousing suspicion. Often they must wait until they know their parents will be away from home for the afternoon to go to the courthouse safely. And, when their parents' plans change unexpectedly, they often must miss the hearing and start all over.

29. These problems are all the worse for those young women who have to travel to another county to obtain the bypass, and thus be away from home or school for longer periods of time. Often teens, particularly those from small towns, fear that their pregnancy and planned abortion will become public knowledge if they attempt to obtain a bypass in their home counties: They worry, for example, that a neighbor or relative who works in the courthouse will see them and they will be unable to explain their reason for being in court instead of school. In order to maintain their confidentiality, these young women often suffer added expense and delay to travel to a distant county where they will not be recognized.

30. Merely arranging transportation to the courthouse is extremely difficult for many young women and causes further delays. Hearings must be canceled and rescheduled when teens cannot get to court, for a variety of reasons, at the appointed time. Many teens do not have a driver's license or access to a car. Thus, they are forced either to rely on public transportation, which is often quite spotty, or to give up their confidentiality by revealing their plans and asking others for assistance.

31. Some adolescents resort to drastic measures to get to court. I know of some teens, desperate to maintain their confidentiality, who drove to court without a license. Others have hitchhiked to court. I recall one such young woman who lived in a town from which there was one bus each day to the courthouse. She arrived at the bus station on time, but had to run into the restroom because of her morning sickness. While she was in the bathroom, the bus pulled away. Determined not to miss her hearing which would force her to delay her abortion, she hitchhiked 40 miles to the courthouse, something she had never done before.

32. Even after minors arrange transportation, they are often late for or miss their hearing entirely because they get lost attempting to find the courthouse in a strange city or because they have difficulty with public transportation. I recall one young woman who did not have a car, had no one she could trust to take her to the courthouse, and had no access to a bus or train. Her only option was to arrange to take a taxi about 80 miles to the courthouse, which she did. Unfortunately, the taxi was more expensive than she predicted and she did not have enough money to make it to the courthouse. When she ran out of money, a good distance from the court, she had to get out of the cab at a subway station. Frightened and unfamiliar with a strange city she had never been to, this resourceful young woman eventually made it to the courthouse. Because she was forced to spend so much of her money on transportation, however, she could no longer afford the abortion without a loan.

33. For all of these reasons, the delays created by the need to seek a bypass regularly result in the postponement of the young woman's abortion. Indeed, at least two-thirds of the teens assisted by the Panel have reported that their desire to maintain confidentiality has delayed their use of the judicial bypass procedure and accordingly delayed their abortions. Panel members estimate that a delay of approximately one to two weeks separates the time a young woman first contacts Planned Parenthood for help obtaining a bypass until the bypass is granted and the abortion procedure can be performed. In some cases it has been as much as a month. As a result, some young women have been delayed to the point where they could not obtain an abortion at all—either because they could no longer afford the procedure or because the pregnancy had progressed so far that abortion was no longer an option.

34. The bypass also jeopardizes young women's confidentiality in myriad ways. As I have mentioned, each phone call an adolescent who cannot confide in her parents has to make puts her at risk. Even after the teen learns about the bypass and reaches her attorney, she faces numerous other barriers to keeping her decision private. The need to be absent during school hours has led to loss of confidentiality on numerous occasions. Even though Panel attorneys provide letters to the schools explaining that the student needs to miss classes in order to attend a court hearing, students' absences have nonetheless been reported to parents. In some cases this has been done accidentally, for example when letters submitted by attorneys to explain a student's absence have been made available to parents as part of their daughter's school records, or when an absence from school triggers an automatic call to the home. In other cases, the absences have been reported to the parent specifically to notify the parent of the student's attempt to obtain a confidential abortion. I remember one instance in which a school counselor told the student that if she left school for a court hearing her mother would be informed. Prior to the student's bypass hearing, I went to court to obtain an order to release the student from school for her hearing without informing her parents. While I was at the courthouse, the school principal removed the student from class, drove her home, and informed her mother of both her pregnancy and her desire for an abortion. I later spoke to the young woman's boyfriend who reported to me that the minor's mother had pressured her into continuing the pregnancy.

35. Moreover, once a teen gets to court she is still in danger of discovery. I know of several cases where the adolescent's pregnancy and decision to obtain an abortion was made public in the course of seeking the bypass: One young woman was

sitting in a court corridor when her sister's civic class came through; another came across a neighbor in the courthouse; another encountered her godmother, who was employed as a court officer. I even represented a young woman who ran into her father right outside of the courthouse. Once a teen is spotted by someone she knows, she is at great risk for having her pregnancy and abortion revealed. She will often be unable to explain her presence in the courthouse, especially at a time when she is supposed to be in school.

36. Based on my experience with the Massachusetts law, and my knowledge of the effect of similar laws in other states, it is my opinion that a law mandating parental involvement places teens at risk of these significant harms with no discernible benefits. As an initial matter, I am aware of no evidence that such laws actually increase parental involvement. And, I fail to see how the judicial bypass experience which forces teens to tell the intimate details of their lives to complete strangers does anything but humiliate, embarrass, frighten, and delay them. Indeed, the adolescents I work with often report being terrified of the process and having nightmares about the hearing. The stress and anxiety produced by these hearings is compounded by the fact that the young woman knows she has no control over her fate. Rather, it is entirely up to the judge to determine whether she will be allowed to have a safe, legal abortion or whether she will be forced to choose between untenable options—involving her parents, traveling to another state for an abortion, or carrying the pregnancy to tem. The fear felt by these minors is perhaps best summarized by the question of one young woman. I had reassured this particular teen many times that the judge we were going before was nice and routinely granted petitions after asking only a few questions. Nonetheless, as we were walking into the courtroom, she whispered to me "What if he doesn't like my face?" I tried to reassure

her, but the fact was that the most important decision in her life was being made by someone else, and she was scared he might just not like her.

37. Moreover, as I mentioned before, of the approximately 20,000 bypass petitions filed in Massachusetts, only two have ultimately been denied. In all but a few of the cases, the minor was determined to be mature enough to consent to the abortion on her own after a brief hearing before a judge, lasting about ten to fifteen minutes. In other words, there was no reason for these teens to endure the delay, risks to their confidentiality, and trauma of the bypass. As the decisions in literally thousands of cases demonstrate, teens are sufficiently mature to make this decision independently.

38. Although almost all bypass petitions that are filed in Massachusetts are granted, we can know little about the adolescents who never get to file a petition. Some adolescents who desire abortions are too frightened by the prospect of going to court to think of it as a viable option. I remember the truly tragic story of one young teenager I will call Amy. Amy was thirteen years old when she was raped by her mother's boyfriend. When she became pregnant, she felt that she could not turn to her mother. Upon learning from the clinic that in order to have an abortion she would have to either tell her mother or get a court order, however, Amy decided that she simply could not face a judge and explain what had happened. Left without any other option, Amy told her mother. Amy's mother was not supportive or caring or helpful. Instead, she called Amy a slut and threw her out of the house.

39. For teens who can't tell a parent and don't feel they can go to court there are few options. In Massachusetts, those who have the wherewithal to go out of state for the procedure can do so. (For teens in Illinois, this won't be a realistic option as all the

neighboring states also require parental notice or consent. Indeed, the closest states without parental involvement laws, Maryland and New Jersey, are hundreds of miles away.) Others carry their pregnancies to term against their will. Some, like Amy, involve a parent against their better judgment and suffer the consequences. Still others so desperate to end their pregnancies attempt to self-induce an abortion or otherwise harm themselves.

40. Indeed, even in states with trained attorneys dedicated to assisting young women, teens nonetheless may face insurmountable obstacles. A study published in the Journal of Law and Social Inquiry shows that many teens who might otherwise go to court to seek a waiver of the judicial bypass requirement are deterred from doing so by the courts themselves. In 1997, a research team contacted all sixty of the county courthouses in Pennsylvania, which has had a parental consent law in effect since the spring of 1994. Despite the fact that these courts are required by the law to handle minors' bypass petitions, at least forty were completely unprepared to do so. Indeed, the research team found that only ten of the sixty courts were ready to handle a judicial bypass or even to refer the caller to a clinic or one of the attorneys trained to help minors through the process. Helena Silverstein, *Road Closed: Evaluating the Judicial Bypass Provision of the Pennsylvania Abortion Control Act*, 24 Law & Social Inquiry 73, 88 (Winter 1999).

41. At best, most courts gave information that would discourage and delay an adolescent seeking a bypass. At worst, the courts were openly hostile to the young woman and her choice to have an abortion. For example, five courts gave referrals to anti-abortion pregnancy crisis centers that attempt to talk women out of having abortions.

Indeed, many of the court employees tried to dissuade the caller from terminating her pregnancy. For example, when asked for information on obtaining a bypass, one employee in the court administrator's office told the caller, "I know this is business, but I can tell you it's a very stupid thing to do and you'd have to live with it for the rest of your life." *Id.* at 82. A court administrator in another court told the caller he had never in his eleven years at the courthouse heard of the judicial bypass. He went on to say:

> I think this person should tell her parents. . . . You think that she will do this without her parents finding out? I don't see how that can happen. . . . This is not something that a person should be doing as a juvenile without consulting someone who knows [for example] adoption agencies. If it was a mistake, it was a mistake, it wouldn't help having a person make two mistakes. There are some numbers: Action Line for Life (800-848-5683), Birthright, family planning clinics, family service agency (622-2515), Concern (800-562-1457). . . . I would strongly counsel this person into finding an out before resorting to that.

Id. at 85.

42. Other courts gave advice that would lead a young woman to believe that in order get a bypass she would either have to hire a lawyer or be one herself. Although the Pennsylvania statute specifically requires the court to appoint an attorney for the minor free of charge, the best advice from twenty of the courts was for the minor to contact an attorney on her own. A woman in another courthouse explained that the adolescent would have to come to the court's law library and research the local rules regarding the elements of a bypass petition herself. The court employee informed the caller that:

> We have this [the local rules] in our law library. If you come in and look at it then you would know what the procedure is. We don't have a form to fill out, so you would need to create the petition yourself and put in the information that they have in the local rules. You may need

> to get additional information once you see what needs to be in the petition.

Id. at 85–86.

43. Other courts told the caller that the process could not be kept confidential. One judge came on the line himself and told the caller that the petition could not be handled unless the caller gave her name and phone number because "[He didn't] like doing stuff secretly. That's not the nature of our legal system. Our legal system has rights, and people [presumably meaning the minor's parents] are supposed to know when their rights are infringed." *Id.* at 87–88.

44. Indeed, even in Massachusetts, where judges have had training in handling bypass petitions and indeed the large majority act appropriately, we have judges who humiliate teens and attempt to dissuade them from having abortions. For example, one judge asked a teen why she could not keep her legs together. Another judge, who has adopted children, would hold up pictures of her kids and try to convince young women to carry to term and put their babies up for adoption. Another judge would simply harass the teens until they cried.

45. As the findings of the Pennsylvania study illustrate, and as my experiences confirm, the bypass presents formidable obstacles. Even in the best of circumstances, teens are delayed, their plans are exposed, and they suffer unnecessary stress and anxiety. Without the massive efforts of volunteer lawyers and counselors, teens would be left to fend for themselves in the court system which is, in some cases, ill-equipped to handle their petitions, and, in others, even hostile toward their rights.

46. Based on my quarter century of experience with Massachusetts' law, it is my firm opinion that the Act will harm young women seeking abortions in Illinois. Like

the teenagers in Massachusetts, adolescents in Illinois will undoubtedly be forced to delay their abortions while they try to make their way through the bypass process. In addition to increasing the risks of the abortion, this delay will prevent some minors from obtaining an abortion at all, either because they cannot afford the abortion at this later stage or because they have been pushed past the point of viability. Others, attempting to access the bypass, will have their plans exposed—as they place calls, travel to the courthouse, miss school or are away from home without a good excuse. Once their parents learn of their pregnancies, some adolescents will suffer the very consequences that led them not to tell their parents in the first place. Some will be disowned by their parents or forced to leave home, others will be prevented from having an abortion and forced to have a child they did not want, and still others will be beaten or otherwise abused.

47. Indeed, because of the differences in court organization, I am concerned that Illinois teens will face greater hurdles in their attempt to secure a judicial bypass than do Massachusetts teens. As I understand it, Illinois has one hundred and two counties in twenty-three judicial circuits, each of which is free to create its own procedures and forms for judicial bypass proceedings. By contrast, Massachusetts has only thirteen counties. Moreover, unlike Illinois, Massachusetts has one Superior Court for all thirteen counties. The Superior Court created one set of procedures and forms for use in all counties. This distinction is relevant for a number of reasons. In Massachusetts, when we need to set up processes to, for example, ensure that hearings are held at times when minors can attend or to deal with other process issues that arise, we can do that by discussing the issue with a relatively small number of individuals at the Superior Court. In Illinois, it seems that such issues must be addressed on a county-by-county basis, or, at least, on a circuit-by-

circuit basis, which will make it much more difficult to create a smooth and effectively functioning bypass system.

48. With respect to the burdens created by the Act, in my view, it makes no difference that the Illinois law requires parental notification, while Massachusetts requires parental consent. My experience with the Massachusetts law indicates that most young women seeking to avoid the parental consent requirement would not be in any better position to involve their parents if the law required notice only. (Indeed, in our quantitative research, we found that only seven percent of minors seeking a judicial bypass had told their parents about their pregnancies.) This is because the fears that lead adolescents to seek to avoid a consent law—fear of placing stress on a parent ill-equipped to deal with added pressure, fear of abuse, fear of being evicted from their homes, and fear of disappointing their parents, to name a few—would not be alleviated if the law required notice to a parent instead of consent. Moreover, once parents learn of their daughter's intention to have an abortion, they may prevent her from having one. For example, in at least two instances in which I have been involved, the fact that the parent inadvertently learned of their daughter's desire to seek an abortion led to the parent coercing the young woman not to appear in court. Notice to the parent would result in similar coercion to prevent the young woman from obtaining an abortion.

49. Nor does the fact that Illinois law allows minors to notify grandparents change my view of the law. In the course of our research, we conducted interviews with stakeholders in other states that allow minors to notify other relatives instead of a parent. We learned that those alternatives are rarely used, particularly where, as in Illinois, the alternative is restricted to particular categories of relatives. Moreover, although the large

majority of minors in our quantitative sample did turn to another trusted adult such as an adult family member, social worker, school personnel, or medical professional, very few minors (less than twenty) talked to a grandparent. I therefore believe that this alternative would be of limited utility.

Conclusion

50. In conclusion, based on more than two decades of experience with Massachusetts' parental consent law and judicial bypass system, I believe the Act is unnecessary, and will likely cause significant and irreversible harm to adolescents in Illinois.

CERTIFICATION

Under penalties as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that she verily believes the same to be true.

10.3.09
Date

Jamie Sabino

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT — CHANCERY DIVISION

THE HOPE CLINIC FOR WOMEN LTD.; ALLISON COWETT, M.D., M.P.H.,	)	
Plaintiffs,	)	
v.	)	Case No.
BRENT ADAMS, Acting Secretary of the Illinois Department of Financial and Professional Regulation, in his official capacity; DANIEL BLUTHARDT, Director of the Division of Professional Regulation of the Illinois Department of Financial and Professional Regulation, in his official capacity; THE ILLINOIS STATE MEDICAL DISCIPLINARY BOARD,	)	AFFIDAVIT OF ROBIN STEIN, L.C.S.W., IN SUPPORT OF PLAINTIFFS' MOTION FOR INJUNCTIVE RELIEF
Defendants.	)	

AFFIDAVIT OF ROBIN STEIN, L.C.S.W.

I, ROBIN STEIN, L.C.S.W., testify under penalty of perjury that the following is true and correct:

1. I am a clinical social worker, licensed in the State of Illinois. I have worked with adolescent young women and their families for 25 years. I earned my B.S. in psychology, with a minor in women's studies, in 1983 from Michigan State University and my Master's Degree in Social Work from the University of Illinois at Chicago in 1990.

2. Throughout my career, I have specialized in treating adolescents, with a particular focus on young women who have suffered from a history of trauma, most often resulting from sexual abuse and family violence. I have also had extensive professional involvement with the families of such adolescents in the form of family evaluations and intergenerational family therapy. I submit this affidavit in support of Plaintiffs' motion for injunctive relief because, based on my work with victims of abuse and their families over the past quarter century, it is my professional opinion that the Illinois Parental Notice of Abortion Act ("the Act") will cause tremendous suffering.

3. I have worked with victims of abuse since the earliest days of my career. I began my career at the Michigan Department of Family & Child Services, where I was a Case Aide. In that position, I accompanied adolescents who were in the child welfare system to supervised visits with family members. After moving to Chicago in 1984, I worked at Children's Home & Aid Society of Illinois, a group home for adolescent girls. There I supervised and counseled twelve adolescent girls at a given time, each of whom was a ward of the state with a history of abuse, neglect, and/or abandonment. Thereafter, I became a counselor at Lawrence Hall Youth Services, where I worked with pregnant and parenting young women between 17- and 19-years of age, all of whom had been abused, neglected or abandoned. The young women with whom I worked were wards of the state who could no longer be in foster care and had been placed in independent living situations.

4. In 1990, after receiving my masters degree in clinical social work, I returned to Children's Home & Aid Society, where I served as a Program Social Worker,

a Program Supervisor, and ultimately Program Coordinator. There I worked to integrate into the Illinois foster care system wards of the state who had previously been assessed as requiring "locked" residential facilities which did not exist in Illinois and who therefore had been sent to facilities out-of-state. I provided these adolescents therapy, I trained and supervised other social workers who were treating program clients, and I trained and supervised foster care parents who would be taking in these young people upon their return to Illinois. From 1996-2000, I served as the clinical director at the Harbour, an adolescent girls emergency crisis center in Park Ridge, Illinois. There, we treated wards of the state as well as homeless and runaway girls, many of whom had been in abusive and /or neglectful home settings. In the case of homeless and runaway girls, I provided family counseling in addition to individual therapy, with the goal of family reunification. For the last 9 years, I have worked at the Response Center in Skokie, Illinois, where I am the Executive Director. At the Response Center, we work with young people, aged 12-21, and their families. We do outreach and prevention, including education in schools and for community organizations; provide individual, family and group counseling; and provide adolescent girls basic reproductive health services through our teen clinic. A current copy of my resume is attached hereto as Exhibit 1.

5. Throughout the course of my career, I have treated and worked with hundreds of young people – predominantly adolescent girls – who have experienced abuse, neglect and abandonment. I have trained and supervised other professionals in their work with such young women and have conducted numerous workshops for social workers, counselors, teachers and camp staff on the topic of physical and sexual abuse,

molestation prevention and symptoms and signs of such victimization. Based on my extensive experience with child abuse and neglect and dysfunctional families, I believe the Act will have devastating consequences for some adolescents, especially those who come from homes in which there is abuse and neglect. It is my professional opinion that the Act's exception for abused or neglected minors and its judicial bypass exception fail to protect teens from such harm.

6. In my opinion, for several reasons, the Act will result in harm to minors who are subject to or at risk for abuse. Neither the abuse exception nor the judicial bypass procedure suffice to protect teens at risk. As detailed below, the abuse and neglect exception is insufficient because: 1) the abuse and neglect exception applies only to adolescents who have suffered abuse or neglect; it does nothing for the adolescents who will suffer significant harm for the first time if forced to notify a parent of their pregnancy and desired abortion; 2) it will not offer any protection for adolescents who are victims of emotional abuse – as distinct from physical or sexual abuse or neglect – or who suffer at the hand of someone other than an adult family member as defined by the Act, such as the mother's boyfriend; and 3) it only applies if the abused or neglected adolescent is willing to reveal the abuse or neglect and sign a statement attesting to it – which, based on my quarter century of experience working with victims of abuse, is something very few abused adolescents will do. Nor, based on my experience with abused and neglected young people exposed to the legal system, do I believe that the judicial bypass process will protect such young women, for they are highly unlikely to go to court based on their abuse, or, if they do, to reveal their abusive home life in a court

setting.

7. First, the Act fails the teens who have not previously suffered physical or sexual abuse or neglect but who experience very real fear that they will be thrown out of the house, coerced into carrying their pregnancy to term, or physically abused if their parents learn of their pregnancy and abortion. In my experience, such fear is often justified. I have, for example, been involved in a number of cases where an adolescent was kicked out of the home because her parents learned she was pregnant. In addition to the pregnancy, these adolescents now have to deal with several additional crises, including the effective loss of their families, finding and adjusting to a new residence, and changing schools (if they continue to go to school at all). For many of these young women, this includes a period of essential homelessness.

8. In another case, I saw a teen whose parents became quite coercive in the face of her pregnancy. At the Response Center, we were treating a teen girl of East Indian descent who had led a sheltered cultural existence until shortly before she came to us. When she came to us, she had befriended a young man of a different nationality. Her parents disapproved, but she continued to see him and became pregnant. She was very afraid of her parents' reaction to her pregnancy and wanted to have an abortion. However, her parents found out before she had done so, and sent her to India against her will to keep her from terminating her pregnancy.

9. Other young women I've treated were not abused (and thus wouldn't be eligible for the Act's exception) until they revealed their pregnancy. In one case, a 16-year-old girl had not previously been physically or sexually abused by a family member;

however, when her brother and father discovered that she was pregnant, they beat her severely.

10. I also have had clients again, who have not been abused, but are fearful because of what they have seen. In one case, one girl in the family was beaten and kicked out of the home when her parents learned she was pregnant. Later, her sister came to us, pregnant and fearful of suffering the same if her parents discovered the pregnancy.

11. In other cases, young women suffer sexual abuse for the first time when their abuser first sees them as a sexual being. Revelation of pregnancy puts such young women at significant risk. Some men (those with poor boundaries, poor impulse control, and other mental health issues) who have had sexual thoughts and/or fantasies about their daughters start to act on those thoughts once they learn that the adolescent that they are having fantasies about is having sex with someone else. All of these teens are outside the scope of the Act's exception and, based on my experience, at grave risk of harm if their parents are notified of the pregnancy. This is, however, not the only group excluded from the exception.

12. As I note above, the Act's exception also provides no coverage for young people who are the victims of emotional abuse. Emotional abuse can be crippling with devastating long-term effects, in significant part because it is so insidious. Simply put, when young people are repeatedly told by the people who are supposed to love them most in the world that they are stupid; that they aren't good enough; that they are a whore or a slut; that they will never amount to anything; they believe it. If your own parents think this of you, how can it not be true? Some of my adolescent patients have told me

that they would rather be physically beaten than subject to some of the emotional abuse they had experienced. The long-term wounds caused by this form of abuse can be harder to heal than broken bones. And, because it comes with no physical signs, emotional abuse is the form of abuse that is hardest to prove and the least likely to be reported by others. Any requirement that these teens notify a parent of a pregnancy (which is likely to be seen as yet another occasion where the young person failed) puts them at substantial risk of additional emotional abuse. In my mind, this is criminal.

13. In addition, the exception applies only if the abuser is an adult family member as defined by the Act. It will thus not apply to minors who are, for example, sexually abused by their mother's boyfriend. These teens cannot safely notify a parent, however. When a mother learns of abuse by her boyfriend, for example, it is not uncommon for her to refuse to believe her daughter; to call the daughter a slut; to accuse her daughter of seducing the boyfriend; and ultimately to choose the boyfriend over the daughter. In some instances, upon learning of the abuse, the mother will see the daughter as a threat to her relationship with the man and kick the daughter out of the house to prevent her from having contact with the mother's boyfriend. Far from helping the situation, notifying a parent in these instances compounds the problem. The adolescent now has to deal not only with the abuse and the pregnancy, but with possible homelessness and the psychological scars that come from knowing that her own mother cares more about keeping this man than she does about protecting her daughter. Other times, the boyfriend – upon learning that the teen has revealed the abuse or that she is pregnant – will become violent.

14. Some minors will not reveal their abuse because they do not recognize or acknowledge it. Sexual abuse can include subtle – and thus confusing – behavior. For example, I've seen a case where a father purchased sexy lingerie for a young girl and took her picture in provocative poses. Such young women can feel conflicted and unable to see the inappropriate actions of their father as abuse.

15. The exception offers little comfort even for those minors who experience and acknowledge physical or sexual abuse by a parent or other adult family member as defined by the Act. Indeed, based on my quarter century of experience working with victims of abuse, I can tell you that very few abused adolescents will sign the written declaration that is required. There are a number of reasons for this. First, most minors who are abused will not disclose it, largely because of the psychological impact of abuse. Most young people who are the victims of abuse truly believe that the abuse is their fault. It is common for an abused teen to say: "but, I deserved it." These young people believe that the reason they get beaten or raped or degraded is because they are bad people who constantly make mistakes. This belief can persist long into adulthood. The idea that you are such a bad person that you deserve this type of treatment from your parent is an extraordinarily difficult and terribly shameful thing to have to admit to another person. When it is revealed, it is generally done only in the context of an established trusting relationship.

16. Even when a young person does reveal abuse to me, she frequently pleads with me not to report it. Many attempt to recant; they say the abuse was their fault; they claim it wasn't really that bad. Many of these young people would surely refuse to sign a

statement. This is particularly so in light of the fact that they will likely fear that their use of the abuse exception will lead to a report of such abuse to the Department of Children and Family Services, and an investigation will be initiated that could lead to the revelation of their pregnancy and to other much feared consequences.

17. For these same reasons, an abused or neglected adolescent is unlikely to testify to their abuse before the court in a judicial bypass hearing. I have worked with numerous teens who have been involved in legal proceedings because of their abusive parents. The vast majority recant before they ever get to court. The process, and in particular, the prospect of talking about the abuse before a judge is simply terrifying to them. They are afraid of losing their families; they fear retaliatory action by the abuser; and they do not think anyone will believe them.

18. Abused adolescents understand that if they reveal the abuse, their family is likely to be torn apart. This is difficult because, as terrible as the abuse may be, abused children love their parents and the thought of losing their family feels worse than continuing to live with the abuse. To them, it is often better than losing everything they have – their parents, their siblings, their home, and their possessions – which is what many believe will happen if they tell. In addition, they are old enough to realize that they may well end up in foster care, which is frightening to many adolescents.

19. Even if an adolescent was prepared to accept this disruption for herself, she is also often concerned about the rest of the family. For example, many young people don't want abuse reported because they are concerned that if their father went to jail, their mother would be unable to handle it or there would be no one to support the rest of the

family. These young people can't bear the thought of being, in their minds, responsible for breaking up the family.

20. Victims of abuse also keep the abuse secret as a means of protecting themselves and other members of their family from severe physical abuse. It is common for someone who is physically or sexually abusive to threaten his or her victim that if the abuse is revealed, dire consequences will result. Abusers are often sophisticated in that they don't threaten the victim him or herself. They warn the victim that if the abuse is revealed, the abuser will hurt or even kill someone the victim loves – her mother or a younger brother or sister. Given the abuse they often have suffered and witnessed the abuser perpetrate on other family members, together with the control the abusers exert over their lives, these young people have little reason to doubt that the abuser will follow through on the threats.

21. Left with no alternative by the Act, I have no doubt that some young women will take dangerous actions to avoid revealing their pregnancies to their parents. Some young women will try to self-induce abortion. One young woman I treated tried to overdose on over-the-counter medication when faced with an unintended pregnancy and the fear of her parents finding out. My fear is that adolescents faced with the Act's requirements and inadequate exceptions will try to find alternative, highly risky methods of terminating pregnancy that could result in serious injury or death.

Conclusion

22. In sum, this Act will have devastating effects for some young women who cannot safely involve their parents or other adult family member identified in the Act in their abortion decision. The Act's exceptions will do little, if anything, to ameliorate the harm the Act will cause.

Certification

Under the penalties as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that she verily believes the same to be true.

9/22/2009
Date

Robin L. Stein, LCSW
Robin Stein, LCSW

Robin L. Stein, LCSW

3020 N. Odell Ave.
Chicago, IL 60707
Cell: 708-289-8971 Work: 224-625-2900

EMPLOYMENT HISTORY:

July 2001-present	Executive Director	Response Center, Skokie, IL
March 2001-July 2001	Acting Executive Director	Response Center, Skokie, IL
April 2000-March 2001	Assistant Director	Response Center, Skokie, IL
May 1996-April 2000	Clinical Director	The Harbour, Park Ridge, IL
October 1990-May 1996	Program Coordinator	Children's Home & Aid Society of Illinois
1988-1990	Counselor	Lawrence Hall Youth Services, Chicago
1985-1988	Child Care Worker	Children's Home & Aid Society of Illinois
1983-1984	Case Aide	Michigan Dept. of Family & Child Services
1982-1983	Case Assistant	Ingham Community Mental Health, Michigan

EDUCATION:

Master of Social Work, 1990, University of Illinois at Chicago
Bachelor of Science, 1983, psychology; minor in women's studies, Michigan State University
Licensed Clinical Social Worker, Illinois

HIGHLIGHTS OF QUALIFICATIONS

- 18 years management and supervisory experience
- 27 years working with adolescents and families
- Expertise in treatment of trauma
- Training in, and utilization of, community crisis debriefing techniques, including NOVA model (National Organization of Victim Assistance) and IRTE (Israeli based treatment model - Immediate Restructuring of Traumatic Experiences)
- Excellent skills in program development, including grant and budgetary expertise
- Highly effective in providing staff development opportunities and creating collaborative work environments

PROFESSIONAL EXPERIENCE

- Recruitment, Training and Supervision of professional and para-professional staff
- Creation of numerous Staff Development/Training programs
- Submission and monitoring of program and agency budgets
- Experience in successful management and supervision of a variety of programming for diverse adolescent populations, including: residential treatment facilities, group homes, foster care, transitional and independent living arrangements, emergency crisis shelter, outreach and prevention services, immigrant teen programming, adolescent sexuality unit and counseling services
- Skilled in facilitation and provision of leadership to program board and subcommittees
- Integration of statistical evaluation of programs and outcome measurement tools to evaluate effectiveness of service provision
- Engaged in numerous community presentations, advocacy on adolescent issues and development of successful community relations
- Provision of Clinical Leadership for JCERT (Jewish Community Emergency Resiliency Team) for Jewish Federation of Metropolitan Chicago

Program Development and Management

- Developed, implemented and managed "hybrid" adolescent treatment program combining concepts from residential treatment and foster care
- Designed and implemented independent living program for homeless and runaway adolescent females under a grant from the Department of Human Services
- Worked collaboratively with numerous child welfare systems, including: Illinois Department of Children and Family Services, Department of Mental Health, Governor's Youth Service Initiative, Department of Juvenile Justice, Juvenile Court, Comprehensive Community Based Youth Service Providers, Non-profit social service agencies within the state of Illinois
- Developed policy and procedure manuals and provided oversight of quality assurance process and utilization review to ensure quality service provision
- Provision of clinical supervision for social work and counseling staff, child care workers, foster parents, program coordinators and managers

Counseling and Training Experience

- Experience providing individual, group, family and couples therapy with widely diverse populations including extensive case management services
- Directed intake and placement services, provided psycho-social assessments, coordinated psychiatric hospitalizations and transition planning, developed comprehensive treatment plans, created and sustained therapeutic milieu's within foster homes, group homes, residential and emergency shelter services
- Provided specialized treatment services for pregnant and parenting adolescent females and their children
- Coordination of clinical and case management services with county and state social service agencies
- Licensed trainer for Effective Supervision Courses I and II; Albert Trieschman Center (Boston, MA)
- In-house trainer for Children's Home and Aid Society, Child Care Methods Courses I through V (1991-1996)
- Member and Trainer, Illinois Council on Training (ICOT) from 1994-2000
- Trained in and utilized numerous crisis debriefing models and techniques, including: The Mitchell Model; NOVA (National Organization for Victim Assistance) and IRTE (Immediate Restructuring of Traumatic Events- an Israeli trauma model)
- Presentations:

  - Ner Littner Memorial Conference (November 1985)- foster care issues
  - Child Care Association Conference (1986) – adaptation of independent living skills program for adolescents
  - ICOT spring conference (1988) - residential house meetings and group dynamics from a psychoanalytic perspective
  - Jewish Women International's 1st International Conference on Domestic Abuse in the Jewish Community, 2003, Baltimore, MD – Educational Empowerment model for adolescent girls regarding development of healthy relationships (panel presentation)
  - March 2006 – "A Jewish Perspective on Gender Power and Relationships," Recognizing and Responding to Adolescent Dating Violence
  - 2000-current – numerous presentations in Chicagoland community regarding: adolescents; adolescent development issues; impact of immigration experience on adolescent development; child sexual abuse issues; teen dating violence; development and integration of professional boundaries; use of genograms in clinical practice; sexual assault prevention; prevention of child sexual abuse in the Orthodox Jewish community; use of crisis debriefing techniques in a variety of community settings;

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS

COUNTY DEPARTMENT — CHANCERY DIVISION

THE HOPE CLINIC FOR WOMEN LTD.; ALLISON COWETT, M.D., M.P.H.,	)	Case No.
Plaintiffs,	)	
v.	)	AFFIDAVIT OF LAURIE SCHWAB ZABIN, Ph.D., IN SUPPORT OF INJUNCTIVE RELIEF
BRENT ADAMS, Acting Secretary of the Illinois Department of Financial and Professional Regulation, in his official capacity; DANIEL BLUTHARDT, Director of the Division of Professional Regulation of the Illinois Department of Financial and Professional Regulation, in his official capacity; THE ILLINOIS STATE MEDICAL DISCIPLINARY BOARD,	)	
Defendants.	)	

AFFIDAVIT OF LAURIE SCHWAB ZABIN, Ph.D.

I, LAURIE SCHWAB ZABIN, Ph.D., testify under penalty of perjury that the following is true and correct:

1. I am currently a professor at Johns Hopkins University in the Department of Population, Family and Reproductive Health at the Bloomberg School of Public Health with a joint appointment in the Department of Gynecology and Obstetrics at the School of Medicine. Additionally, I was the Founding Director of the Bill and Melinda Gates Institute for Population and Reproductive Health. My curriculum vitae is attached hereto as Exhibit 1.

Background

2. I obtained my Ph.D. from the Johns Hopkins University School of Hygiene and Public Health in 1979, based on my studies in formal and social demography, family planning, reproductive biology and biostatistics, and my dissertation, which focused on adolescents' risk of

pregnancy during the two years following onset of sexual activity. I attended graduate school after working for over 20 years in family planning services, and establishing one of the first federally funded, community-based family planning centers in one of the poorest neighborhoods in Baltimore, Maryland in the 1960's. In fact, it was this work that prompted me to pursue academically my interest in family planning and reproductive health. I have remained in this field throughout my academic career.

3. Since obtaining my Ph.D., I have taught at Johns Hopkins as a full professor since 1993 and as an assistant and then associate professor from 1979 to 1992. Specifically, I have taught numerous courses on adolescent pregnancy and reproductive health, mainly to physicians and other health professionals who are candidates for masters' or doctorate degrees in the School of Public Health. I also supervise the dissertation and post-doctoral work of several students each year who work in the field of adolescent pregnancy and reproductive health.

4. While Director of the Institute for Population and Reproductive Health, which was established based on a $20 million grant - followed by a $40 million supplement - from Bill and Melinda Gates, my colleagues and I created and conducted training and technical assistance programs for leaders and health care professionals from around the world to address population and family planning issues. I continue in that work with the Institute as well as directing international research programs – generally in the field of adolescent reproductive health.

5. I am or have been a member of numerous societies, including the American Public Health Association (APHA), the Society for Adolescent Medicine, the Guttmacher Institute (GI), and Planned Parenthood Federation of America (PPFA), and I have served on the governing bodies of the APHA and PPFA, and as chair of the GI Board – of which I have been made an Emeritus lifetime member. I also have served on a variety of panels, such as the White House Initiative on Adolescent Pregnancy Prevention; the Johnson & Johnson Project on

Adolescent Pregnancy Prevention of the National Organization on Adolescent Pregnancy, Parenting and Prevention; the Adolescent Motivation Project of Child Trends; and the Warren H. Pearse/Wyeth Ayerst Women's Health Policy Research Award Selection Committee of the American College of Obstetricians and Gynecologists. I am currently on the Board of the Healthy Teen Network and serve on the Selection Committee for the Post-doctoral Fellowship of Ibis Reproductive Health.

6. In the past, I have served as an advisor to the Centers for Disease Control and Prevention (Division of Adolescent and School Health, Advisory Panel on Evaluation, 1992); the Surgeon General's Select Consultant Group (Adolescent Pregnancy, 1994-95); the American Pediatric Association (1991); and the International Center for Research on Women (Technical Advisory Group, Women and AIDS Program, 1991-1993). I have also been involved in numerous international advisory programs to countries such as India, Morocco, Chile, and Argentina and am currently on an advisory panel for an adolescent study being carried out by the WHO in Geneva. Additionally, I have developed and advised numerous programs aimed at preventing adolescent pregnancy and sexually transmitted diseases, including the Johns Hopkins Teen Pregnancy Primary Prevention Program, the CDC Teen Pregnancy Prevention Center at the University of Minnesota, and the Adolescent Project Development of the American Academy of Arts and Sciences.

7. A substantial portion of my time is devoted to research. The focus of my research has been on the intersection of social science and medicine in the field of reproductive health, and much of my work has focused on adolescents. I have published several books and numerous articles in peer-reviewed journals on adolescent pregnancy, childbearing, and sexual behavior. I am also a peer reviewer for many relevant academic journals in the field, including the Journals of Adolescent Health, Adolescent and Pediatric Gynecology, the American Medical Association,

and Research on Adolescence.

8. Because of my own research, my supervision of research conducted by international colleagues and Johns Hopkins graduate students and post-doctoral fellows, and my peer review of articles for more than twenty journals, I am intimately familiar with research and findings regarding adolescent sexual behavior, pregnancy, childbirth, abortion, and adolescents' access to reproductive health care. Furthermore, my experience in establishing a family planning clinic in Baltimore and intervention programs directed at adolescents throughout the country and the world provide me with extensive practical experience with adolescents and in how, when, and under what circumstances teens access reproductive health care.

9. I have reviewed the Illinois Parental Notice of Abortion Act of 1995 (the "Act"), which I understand requires that a parent, grandparent, legal guardian, or step-parent living in the same household as a minor seeking an abortion be notified prior to the procedure, or, alternatively, that the minor go through a judicial bypass procedure in order to obtain court authorization for an abortion. I submit this affidavit in support of injunctive relief against enforcement of the Act. Based upon the entirety of my professional experience, it is my firm opinion that the Act will cause irreparable harm to the health interests of minors, as well as to the relationships among minors, their families, and their health professionals. Abortion, particularly as compared to adolescent childbearing, has no long-term negative medical, emotional, or psychological effects, making the mandates of the Act illogical. Moreover, the Act is premised on misguided and ill-founded notions of adolescent decision making and maturity. Ultimately, effective, positive communication between parents and children is best encouraged through supportive counseling, not imposed, mandatory requirements.

Adolescents' Access to Health Care: Confidentiality and Delay

10. The Act's requirement of parental notification will irreparably harm adolescents

by causing them to avoid entirely, or delay indefinitely, access to essential and time-sensitive health care.

11. As I know from my 20 years of involvement in providing reproductive health care to adolescents through family planning clinics, and as my research confirms, confidentiality of services is one of the most important factors considered by adolescents in their decision to access health care. In one study of 1,243 teenage patients in 31 family planning clinics in eight cities, the most important reason given for choosing the particular clinic they attended was that the clinic "doesn't tell their parents." Across the board, adolescents answered several different questions regarding why and when they chose to visit a clinic by referencing the importance of confidential services. Laurie Schwab Zabin & Samuel D. Clark, Jr., Institutional Factors Affecting Teenagers' Choice and Reasons for Delay in Attending a Family Planning Clinic, 15 Fam. Plan. Persp. 25, 26 (1983); Laurie Schwab Zabin & Samuel D. Clark, Jr., Why They Delay: A Study of Teenage Family Planning in Clinic Patients, 13 Fam. Plan. Persp. 205, 213-214 (1981). The importance of confidential care to adolescents was confirmed in the school context, as well – thus including those who had never attended a clinic at all. Laurie S. Zabin, Heather A. Stark & Mark R. Emerson, Reasons for Delay in Contraceptive Clinic Utilization: Adolescent Clinic and Non-Clinic Populations Compared, 12 J. Adol. Health Care 225, 229 (1991). While these findings do not imply that teenagers who value confidentiality won't voluntarily communicate with their parents about these issues at some future time - often as a result of the urging of the counselors they see when they do attend - it does mean that confidentiality is absolutely essential in prompting adolescents initially to access health care.

12. It is clear that without the guarantee of confidentiality, adolescents delay or avoid accessing reproductive health care and contraception, even while they begin or continue to engage in sexual behavior which exposes them to health risks. For example, my research also

found that the mean interval from first intercourse to first contraceptive visit for all sexually active, teenage clinic patients was over 16 months. Why They Delay at 207. Furthermore, those young women who put off their first clinic visit until the point that they actually suspected they were pregnant were almost twice as likely to be among the ones that said they feared parental discovery. Id. at 215 (Table 12); Reasons for Delay in Contraceptive Clinic Utilization at 229 (Table 1). In short, while fear of parental discovery remains a dominant reason for teenagers to delay access to health care, it apparently does not cause minors to delay or cease engaging in sexual activity.

13. A fundamental tenet of adolescent health care is thus to ensure absolute confidentiality. The Act, however, does exactly the opposite, mandating the disclosure of a teenager's intent to terminate a pregnancy to her parents or to a court before she may have the procedure. The Act thus increases the likelihood that a pregnant adolescent will delay or avoid seeking proper care. It may force her to pursue other avenues as well, such as traveling to another state -- causing the delay that attends a lengthy journey that must be kept confidential -- or attempting to self-induce an abortion, or even carrying to term.

14. More broadly, it is my opinion that a law requiring parental notification for abortion will invariably cast health care providers in an adversarial position to the very minors they should be seeking out to inform and serve. While the law requires parental notification only for abortions, teenagers will inevitably determine that since they cannot trust the health care system for confidential services in this context, there is no reason to believe that they would receive confidential care in other areas, such as contraceptive care or treatment of sexually transmitted diseases, mental health, or drug use or abuse. In short, the Act will function to place additional barriers to young people's access to health care, placing their health at risk.

15. Furthermore, even if minors do eventually decide to access appropriate health

care, mandating parental involvement will undoubtedly delay their abortions. Young women who would not otherwise tell their parents will put off their abortions while deciding whether they should confide in their parents and while working up the courage to do so. In a study in three states with parental involvement laws, approximately one out of three girls under 18 reported delays of over two weeks after a confirmed pregnancy to communicate – not a negligible delay in view of the importance of timing in abortion safety. Mary S. Griffin-Carlson & Paula J. Schwanenflugel, Adolescent Abortion and Parental Notification: Evidence for the Importance of Family Functioning on the Perceived Quality of Parental Involvement in U.S. Families, 39(4) J. of Child Psychol. Psychiatry 543, 546 (1998). Those minors who decide to use the judicial bypass will also be delayed as they attempt to figure out the system and arrange to get to court without arousing suspicion. Minors can ill afford this delay. Adolescents already tend to seek abortions later in pregnancy than older women. For example teens are more likely to delay having an abortion until after 15 weeks gestation as compared to older women. Guttmacher Institute, Facts on Induced Abortion In the United States, (2008). Such delay is caused by a number of factors, including the delay minors experience in recognizing pregnancy -- both because of irregular menstrual cycles and the denial that some minors go through even after a positive pregnancy test; the difficulties they face in negotiating a health care system with which they are unfamiliar; the problems they face in arranging for an abortion without arousing suspicion of family or friends; and the difficulty they have raising the funds for an abortion. See Aida Torres & Jacqueline Darroch Forrest, Why Do Women Have Abortions?, 20 Fam. Plan. Persp. 169, 174-75 (1988).

16. Accordingly, because pregnant adolescents are particularly prone to delaying access to health care, requiring an adolescent to obtain a court order, or alternatively, to wait while working up the courage to tell her parents about her decision, will irreparably harm such

minors by delaying their access to abortions -- potentially pushing them into their second trimester, when the risks associated with abortion increase.

Parental Involvement and Effective Communication

17. While confidentiality of health services is essential to a minor's decision to access such services, that is not to say that all adolescents avoid parental involvement. In fact, studies confirm that the majority of minors voluntarily involve a parent in their decision to terminate their pregnancy. Stanley K. Henshaw & Kathryn Kost, Parental Involvement in Minors' Abortion Decisions, 24 Fam. Plan. Persp. 194 (1992). My own research found that regardless of the final decision regarding a pregnancy outcome, the overwhelming majority of minor respondents consulted a parent or parent surrogate before deciding what to do about their pregnancy. Specifically, in a study of 334 African-American, urban teenagers who sought pregnancy tests in two Baltimore clinics, 91% of those whose test results were positive reported that they had consulted a parent or parent surrogate before deciding what to do about the pregnancy, and an additional 4% confided in another adult.[1] Laurie Schwab Zabin et al., To Whom Do Inner-City Minors Talk About Their Pregnancies? Adolescents' Communication With Parents and Parent Surrogates, 24 Fam. Plan. Persp. 148, 151 (1992). And that choice of another adult is generally a logical choice – including, for example, the person the teen perceives as head of the household – often when the mother is not even in residence.

18. Age in that study was an important factor in whether the minor consulted with a parent. Specifically, the few adolescents who did not consult with their mothers before deciding

[1] While other studies have found lower percentages of voluntary involvement (e.g., 61%), the higher percentages evidenced by our study may be partly explained by differences in attitudes regarding sexuality and communication about sexuality in African-American families.

what to do about their pregnancies were significantly older than those who did. Id. at 152. This corresponds with other studies' findings that the younger the minor, the more likely she is to consult with a parent about her decision to terminate her pregnancy. See, e.g. Michael D. Resnick et al., Patterns of Consultation Among Adolescent Minors Obtaining an Abortion. 64(2) Am. J. Orthopsychiatry 310 (1994); Parental Involvement in Minors' Abortion Decisions at 200 & Table 3.

19. Furthermore, the vast majority of our sample -- 88% -- reported satisfaction with the pregnancy outcome they chose; there was little difference between those who chose to terminate the pregnancy and those who chose to carry the pregnancy to term. Significantly, a young woman's satisfaction with her decision was not related to whether she consulted with her mother. Thus, the few young women who did not consult with their mothers were no less satisfied with the outcome than those who did. To Whom Do Inner-City Minors Talk About Their Pregnancies at 153.

20. Instead, an important factor in satisfaction with the decision was the minor's autonomy in making that decision: young women who made the decision themselves were significantly more satisfied than those who felt the decision was made for them. Id. Indeed, the minors who ultimately chose the same pregnancy outcome they had indicated as their probable preference at baseline (prior to learning of the pregnancy test results) were significantly more satisfied with the outcome than those whose projected and actual outcomes were different. Id.

21. My research findings are consistent with my observations at clinics and school-based health care programs. Not only do most minors voluntarily involve their parents in the decision of what to do about their pregnancy, but many find it extremely important to do so at their own pace. While counselors frequently are the best advocates of parental involvement – and should be seen as allies of caring adults, not in opposition to them - effective counseling to

encourage parental involvement is most successful when adolescents are allowed the autonomy to decide for themselves when and whether they should talk to a parent about a pregnancy.

22. If its purpose is to increase family communication, the Act is misguided. While effective, positive communication is usually in the interest of the young person, such communication cannot be created suddenly or through coercion; it generally exists as a long term pattern of family behavior. Thus the results of my research confirm that prior parent-child relationships and patterns of communication are among the most important variables in determining whether and when a pregnant minor communicates with a parent. Specifically, adolescents who found it easy to talk about sex with the woman who had raised them, and those who had received most of their knowledge about having a baby from their parents, were significantly more likely to have confided in their parents before the pregnancy test than those who did not have such open communication with their parents. To Whom Do Inner-City Minors Talk About Their Pregnancies at 152. Others have also found the importance of long-standing family relationships in young persons' openness to communication, and have questioned the wisdom of enforcing communication in dysfunctional families where negative results may be serious. Griffin-Carlson & Schwanenflugel at 540-50.

23. There is no evidence, to my knowledge, that mandatory notification creates a new communication pattern between minors and their parents. If the communication exists, it will persist -- in the face or absence of a law mandating parental involvement. If the pattern of communication between parent and child has been broken or is nonexistent, it will not be mended or created through legislative mandate. In fact, a study comparing the rate of parental involvement in a state with a mandatory parental notice law with the rate of parental involvement in a state without such a requirement found that there was no meaningful difference in the percentage of minors whose parents knew of their decision. Robert W. Blum, Michael D.

Resnick, & Trisha Stark, The Impact of a Parental Notification Law on Adolescent Decision-Making, 77 Am. J. of Public Health 619, 620 (1987). Indeed, for some relationships, most often in dysfunctional families as suggested above, forced communication will be worse than no communication at all, spurring incidents of abuse or coercion, or destroying a parent-child relationship rather than strengthening it. For these reasons as well, I believe that the Act will cause irreparable harm to certain family relationships.

Comparative Effects of Teenage Abortion and Childbearing

24. I understand that, while the Act requires parental notification for minors seeking to terminate their pregnancies, a minor who chooses to carry to term may provide her consent - without parental involvement - for any hospital, medical or surgical care during her pregnancy or, later, for her child. In addition, I understand that Illinois allows a minor to give her child up for adoption without notifying her parents. In an apparent attempt to justify this distinction, the Act claims that "the medical, emotional, and psychological consequences of abortion are sometimes serious and long-lasting." 750 ILCS 70/5. Numerous studies and research findings, however, prove such a legislative scheme unsound and without foundation.

25. Abortion is one of the safest surgical procedures that doctors perform -- and is, in fact, many times safer than continuing pregnancy through childbirth. David A. Grimes, Estimation of Pregnancy-Related Mortality Risk by Pregnancy Outcome, United States, 1991 to 1999, 194 Am. Jrnl. of Ob. & Gyn. 92, 93 (2006).

26. Furthermore, in terms of emotional and psychological consequences of abortion, studies have established that the overwhelming response of women after having an abortion is one of relief, and that abortion rarely has adverse psychological sequelae. See, e.g., Nancy E. Adler et al., Psychological Responses After Abortion, 248 Science 41 (1990). This is particularly true for younger women and minors. In fact, studies indicate that individual

instances of regret or unhappiness which may be associated with abortion occur most frequently among women who terminated pregnancies that they very much wanted, or among women who had long-standing psychological problems or who were pressured into having the abortion. Id. at 42. The vast majority of adolescent pregnancies -- more than 90%-- are, however, unintended and unwanted. Williams Obstetrics 570 (F. Cunningham et al., 20th ed. 1997) (citing Centers for Disease Control and Prevention 1995). For that reason, it is likely that teenagers would experience even fewer incidents of regret or negative psychological sequelae from abortion than older women might.

27. In contrast, the negative effects of a minor carrying her pregnancy to term and raising a child while she herself has not yet reached adulthood are significant and enduring. For young women who are forced to carry their pregnancy to term by parents who refuse to respect their choice to terminate their pregnancies -- adverse effects may be particularly severe.

28. Indeed, adolescent mothers and their children do worse along many dimensions than older mothers and their offspring, achieving lower social and economic attainment and enduring higher health and developmental risks. Specifically, independent adverse effects on schooling, economic status, marital stability, maternal and infant health, and future fertility have all been documented. Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing 123-39 (1987). And, while teenage mothers often come from disadvantaged backgrounds, recent studies controlling for background factors and characteristics still conclude that early childbearing results in negative effects to both adolescent mothers and their children, and that such effects are particularly long-lasting on the offspring of young mothers. Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy 13-17 (Rebecca A. Maynard ed., 1997).

29. In particular, studies show that teenage mothers complete fewer years of school

and are less likely to receive a high school diploma or to go on to college or graduate studies than women who postpone childbearing. Risking the Future at 126. Adolescent mothers also have on average more children than older childbearers, and tend to have their children over a shorter time period. Kids Having Kids at 2. As a result of these patterns, researchers have found that early childbearers face lower income levels and have lower-status occupations. Risking the Future at 130.

30. The children of younger mothers also suffer significant negative effects. Even after researchers control for other factors, the children of teen mothers tend to be in poorer health than children of women who postpone childbearing. Kids Having Kids at 184, 198. Such results are unsurprising considering that teenagers face increased health risks during their pregnancies, with a higher likelihood of receiving inadequate prenatal care and experiencing inadequate weight gain. From Data to Action: CDC's Public Health Surveillance for Women Infants, and Children at 369. Indeed, being the child of a young teen has been found to reduce chances of success as a young adult in terms of both education, because children of teens are less likely to graduate from high school than children of adults, and family formation, because daughters of adolescent mothers are more likely themselves to be teen mothers. Id. at 262, 264, 276.

31. In short, the overall negative effects of teen childbearing are significant and long ranging, while the negative effects of abortion at that age are, according to the results of considerable research, non-existent.

32. In fact, in an extensive study that I conducted with a grant from the National Institute of Child Health and Human Development - a study cited by a leading expert as "the best study of adolescent abortion," Nancy E. Adler et al., Abortion Among Adolescents, Amer. Psychol., 212 (2003) - a direct comparison of adolescents who chose to terminate their pregnancies with those who chose to carry to term revealed that two years after their abortions,

the young women who had chosen to terminate an unwanted pregnancy were doing as well as -- *and usually better than* -- those who had had a baby. Such findings were true across the board, whether we examined education, economic well-being, psychological effects, or subsequent fertility. Laurie Schwab Zabin, Marilyn B. Hirsch & Mark R. Emerson, When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy, 21 Fam. Plan. Persp. 248 (1989).

33. This study was uniquely designed to compare adolescents who chose to terminate their pregnancies with those who carried to term: In total, 360 African-American women, 17 years of age or younger, unmarried, and of similar socioeconomic background were admitted into the study at the time that they initially sought pregnancy tests from two Baltimore family planning providers. They were then enrolled and interviewed for extensive baseline data while awaiting their test results, and subsequently interviewed at six month intervals -- by phone at six and eighteen months, and in-person at one and two years. Id. at 249. The initial interview collected information on household structure, education, jobs and economic well-being, health, growth, sexual and contraceptive behavior, and conception and fertility. Respondents were also given several psychological tests, including the abbreviated Rosenberg Self-Esteem Scale, items from the Rotter Locus of Control scale, and the Spielberger State-Trait Anxiety Index. Id.

34. Ultimately, there were 334 teenagers included in the baseline reports who could be followed up for the two years -- 141 who terminated their pregnancies (the "abortion group"), 93 who carried them to term (the "childbearing group"), and 100 who had negative pregnancy-test results (the "negative-test group"). Id.

35. *Education.* Although there were only small differences between the groups at baseline with respect to the percentage who were in school and their grade-point averages, the differences at one year were dramatic, and they increased at two years. After the two-year

period, the young women who had terminated their pregnancies were far more likely to have graduated from high school or still be in school and at the appropriate grade level than were those who had decided to carry their pregnancies to term. Specifically, at the end of two years, 37.3% of the childbearing group had either left school or failed to progress the expected two years, while only 17.8% of the abortion group experienced such a negative change in education. Indeed, at the 18-month interviews, we discovered that it was the teenagers who chose to carry their pregnancy to term who experienced the greatest risk of failing to meet their own educational expectations. Id. at 250-51. The data thus confirm the effects of childbearing on education, showing that the adverse consequences of early motherhood begin immediately, and even though the pace of negative change may slow in the second year, the continuing success of the abortion group increases the differential between the childbearing and abortion groups. Id. at 254.

36. *Economic Well-Being.* Those who had obtained an abortion were also better off economically than those in the childbearing or negative-test groups at the end of two years. Whereas economic differences between the different groups were not statistically significant at baseline, they were significant both one and two years later. For example, a comparison of the ratio of working adults to all adults in the household revealed that over two years, the abortion group's status continually improved, while the childbearing group's status declined during the first year and improved only very slightly in the second year. Id. at 251. Accordingly, the differences in economic well-being between the abortion and childbearing group increased over time, with statistically significant improvements found only in the households of minors in the abortion group.

37. Furthermore, as set forth in a separate analysis of these data in Laurie Schwab Zabin et al., Dependency in Urban Black Families Following the Birth of an Adolescent's Child,

54 J. of Marriage and the Family 496 (1992), two years after baseline, among women who had turned 18, twice as many of the abortion and negative-test group were working 20 hours or more than the childbearing group. And, even among all the women who were still in school at that point, twice as many were employed if they were not yet mothers. Id. at 505. In short, even if, as some researchers have reported, adolescent mothers may overcome some of these economic disadvantages in the long-term, see. e.g., V. Joseph Hotz, Susan Williams McElroy, & Seth G. Sanders, The Impacts of Teenage Childbearing on the Mothers and the Consequences of those Impacts for Government, in Kids Having Kids 55-89 (1997); but see Saul D. Hoffman, Teenage Childbearing Is Not So Bad After All. . . Or Is It? A Review of the New Literature, 30 Fam. Plan. Persp. 236 (1998), such partial improvements should not be used to underemphasize the short-term deprivation experienced by the households of young childbearing women.

38. *Stress and Locus of Control.* Directly contradicting the Act's assertion that the "psychological consequences of abortion are sometimes serious and long lasting", our study also found that minors in the abortion group experienced no greater levels of stress or anxiety than the other teenagers at the time of the pregnancy test, and they were no more likely to have psychological problems two years later. When Urban Adolescents Choose Abortion at 251-52. Indeed, at the end of two years, the abortion group had experienced greater decreases in levels of anxiety than did the childbearing group, and were somewhat closer to the norm in that measurement than the childbearing group. Id. at 251 & Table 3; see also Laurie Schwab Zabin & Valerie Sedivy, Abortion Among Adolescents: Research Findings and the Current Debate, 62 J. of School Health 319, 323 (1992).

39. Additionally, the abortion and negative-test groups showed significant increases in their locus of control (i.e., belief that they themselves, as opposed to some external force, exercise control over events affecting them), indicating greater internalization, while the

childbearing group showed only minimal change in the same measurement. When Urban Adolescents Choose Abortion at 252 & Table 4. Finally, while the abortion group was doing well in both absolute and relative terms on each of the psychological measures we tested after the abortion, there is reason to believe that, in time, the minors who chose abortion would be in an even better psychological position relative to the other groups, because they also stayed on course with their education and placed no additional economic burden on their families. Id. at 254.

These findings are supported by a recent meta-analysis of articles addressing psychological outcomes of abortion for teens; when studies were measured by a set of objective standards of research quality (e.g. appropriate comparison groups, accredited measurement scales, etc.), the studies determined to be of highest quality suggested few if any differences between those who had aborted and comparison groups. The studies that reported negative results were all among those with most flawed research methodology. Vignetta E. Charles et al., Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence, 78 Contraception 436 (2008).

40. *Subsequent Pregnancy*. The teenagers in our study who had obtained abortions were also less likely than either those who carried to term or had negative pregnancy tests to experience a subsequent pregnancy during the following two years. Specifically, while 58% of the negative-test group and 47% of the childbearing group experienced a conception within two years, only 37% of the abortion group experienced a repeat pregnancy. Id. at 252-53. Furthermore, the abortion group was slightly more likely than the other groups to practice contraception. Id.

41. In sum, the abortion group not only did well educationally, economically, psychologically, and in terms of subsequent fertility, but the minors who chose to terminate their

pregnancies did as well as, and usually better than, those minors who carried to term in each measurement. Accordingly, in my view, a legislative scheme that singles out minors who choose to terminate their pregnancies and requires them to notify their parents, while not imposing a similar requirement on minors who choose to give birth, is entirely without basis.

Minors' Ability to Make Mature and Informed Decisions

42. Nor is there any evidence that mandatory parental involvement is necessary because "parental consultation is usually in the best interest of the minor and is desirable since the capacity to become pregnant and the capacity for mature judgment concerning the wisdom of an abortion are not necessarily related." 70 ILCS 70/5. In fact, research demonstrates that adolescents are as capable as adults of making informed, rational decisions concerning their lives and future in general, and concerning their pregnancies in particular. See, e.g., Bruce Ambuel & Julian Rappaport, Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion, 16 Law and Human Behavior 129, 144-45 (1992). Many of the studies of adolescent decision-making were reviewed by Dr. Nancy E. Adler and others, in Adler et al., Abortion Among Adolescents, and all showed evidence of the capacity of adolescents to make competent choices – which has been seen as reflected in the overwhelming credit judges have given young women whose by-pass cases have come before them.

43. Even were this not true of all adolescents, based on my own experience, it is precisely those minors who present themselves at clinics for abortions who evidence higher levels of maturity. Such a young person has already shown her capability to make informed decisions by virtue of the fact that she has recognized her condition, considered its consequences, and negotiated the health care system by locating an appropriate facility. Unfortunately, it is often those minors who carry their pregnancies to term who evidence immaturity by denying the reality of their pregnancy - sometimes even until the point of delivery

- and by failing to recognize the impact and consequences of bearing a child at such a young age. Indeed, research has confirmed that adolescents who choose to terminate their pregnancies demonstrate greater locus of control, while childbearing teens are more likely to see events as fate and have a strong tendency toward passivity. Robert W. Blum & Michael D. Resnick, Adolescent Sexual Decision-Making: Contraception, Pregnancy, Abortion, Motherhood, 11 Pediatric Annals 797, 801 (1982). Adolescents who choose abortion also have a more developed capacity to understand future consequences, lower demands for external approval, and lower dependency needs than adolescent mothers. Id.

Conclusion

44. In sum, because the Act is premised on hypotheses that are without basis and that are contradicted by both academic research and my own practical experience, I believe that rather than achieving any legitimate purpose, the Act will irreparably harm the health interests of minors, and can also cause irreparable harm to relationships among minors, their families, and their health professionals.

CERTIFICATION

Under penalties as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that she verily believes the same to be true.

Sept. 18'09

Date

Laurie Schwab Zabin

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PERSONAL DATA:

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2915 Woodvalley Drive
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EDUCATION AND TRAINING:

B.A. 1946 Vassar College - English literature
M.A. 1947 Harvard Graduate School - English literature, literary criticism
Ph.D. candidate'49-51 - all but dissertation - Johns Hopkins University - English
Ph.D. 1979 Johns Hopkins University, Department of Population Dynamics, School of Hygiene and Public Health

PROFESSIONAL EXPERIENCE:

Founding Director, Bill and Melinda Gates Institute for Population and Reproductive Health, 1999-2002; member, Gates Management Committee, 2003-5, Training and Policy/Program Committees, 2005-2007

Director, Gates Leadership Program, Johns Hopkins School of Hygiene and Public Health, 1998-1999

Professor, Department of Population and Family Health Sciences, Johns Hopkins School of Public Health, 1993--. Joint Appointment, Department of Gynecology and Obstetrics, School of Medicine, 1986-- .

Associate Professor - 1987-92 - Department of Population Dynamics, JHUSHPH

Assistant Professor - 1986-87 - Department of Population Dynamics, JHUSHPH

Assistant Professor - 1979-86 - Department of Gynecology/Obstetrics, JHSM. Joint Appointment - 1983-86 - Department of Population Dynamics, School of Hygiene and Public Health

Director, Social Science Fertility Research Unit - 1982-86, Department of Gynecology and Obstetrics, Johns Hopkins School of Medicine

Acting Director - 1974 - Planned Parenthood Association of Maryland

Lecturer - 1970-75 - Family Planning Training Institute, Baltimore, MD

Founder/Director - 1966-68 - Community Action Agency Neighborhood Family Planning Center, Baltimore MD - Office of Econ Opportunity/Planned Parenthood

Assistant Editor - 1948-49 - Shakespeare Association Quarterly

PROFESSIONAL ACTIVITIES (selected only):

Society Membership and Leadership:

Healthy Teen Network – Board of Directors - 2008--
JHPIEGO - International Board of Directors- 2000-2005

American Public Health Association
Governing Council - 1987-1991; Co-Chair, AIDS Task Force - 1987-88; Chair, Population Section - 1984-85; Program Chair, Population Section 1983-84; Chair, Task Force on Adolescent Pregnancy- 1982-83
Population Association of America
Society for Adolescent Medicine
International Union for the Scientific Studyof Population
Global Health Council

Guttmacher Institute
Chair, Board of Directors - 1985-87;
member - 1974-90, 1991-1997, 1998-2004,
2006... (emeritus - lifetime member)
Chair, Executive Committee, Sr. Vice-Chair, Board of Directors - 1980-1985, member Executive Committee passim and 1998-2004
Chair, Nominating Committee, 2000-2001, 2001-2002
Science Advisory Committee, Advisory Panels & Committees on New Research, issues, organization, etc.- 1982-2004

International Planned Parenthood Federation
Western Hemisphere Council - 1972-76
Executive Committee, Western Hemisphere Region- 1975-76

Planned Parenthood Federation of America
Board of Directors - 1981-88; 1971-75; 1962-68
National Medical Committee
Research Subcommittee - IRB
Executive Committee
Scientific Advisory Panel, Program for Project Development, (and co-negotiator with I.M. Cushner of independent establishment of the Program as the Alan Guttmacher Institute)
Founding Chair, International Committee- 1973-75;
Founding Chair, Public Affairs Committee - 1972-73;
Founding Chair, Information and Education Committee- 1970-73;
Founding Chair, Expansion and Policy Committee- 1962-64;

Society Membership and Leadership (cont.):

Planned Parenthood Federation of America(cont.)
Chair, Review Committee - 1961-62
Chair, Individual Rights Committee
Chair, Bioethics Advisory Panel- 1986-87
Representative, U.N. Conference on the Human Environment, Stockholm - 1972
Task Force on Population Education- 1967;
Task Force on Sex Education- 1974;
Task Force on Expanded Medical Service- 1980;
Task Force on Adolescent Pregnancy Prevention - 1984

Planned Parenthood Association of Maryland
President, Board of Directors- 1968-70;
Board of Directors - 1968-83 and 1956-67;
Medical Committee- 1985-88;
Chair, Long Range Planning,
Chair, Budget Committee
Chair, Education Committee

Chair, Family Planning Training Institute Advisory Committee (Title X Regional Training Center) 1970-1974

Participation on Advisory Panels (selected only):
*(Participation in connection with the Gates Institute **not** included - see below)*

Ellertson Fellowship Advisory Panel– 2005---
Ibis/UCSF - Advisory Panel for Buffett Fellows Program- 2003

Advisory Panel, Coppin State College-Institute to Build Community Capacity in HIV Prevention - 2003--

Expert Witness - ACLU Reproductive Rights Division - New Jersey and Colorado Parental Consent Litigation;
Center for Reproductive Law and Policy - Florida Parental Consent Litigation, 1999-2000; State of Alaska, 2002-2003
Technical Consultant and Expert Witness - Parental notification case vs. State of California - American College of Obstetrics and Gynecology, American Pediatric Association and others- 1991

CDC/OPA/NIH Joint Advisory Panel on Contraception- 2000

Participation on Advisory Panels (selected only)- (cont.):

National Organization on Adolescent Pregnancy, Parenting and Prevention, Advisory Panel - 2000

Special Consultant, University of Minnesota, CDC Prevention Center 1999--

National Organization on Adolescent Pregnancy, Parenting and Prevention, Johnson & Johnson Adolescent Pregnancy Prevention Project- 1995-99

Warren H.Pearse/Wyeth Ayrst Women's Health Policy Research Award Selection Committee, American College of Obstetrics and Gynecology - 1993-7; Chair, 1998B1999

Adolescent Health Committee- American College of Ob/Gyn -1992-1997

Child Trends, Professional Advisory Panel, Adolescent Motivation Project - 1996B2000

NIH/Kaiser Foundation Panel on Contraceptive Continuation- 1995

National Institutes of Health Panel on Long-Acting Contraception - 1995

White House Initiative on Adolescent Pregnancy Prevention- 1995B6

Surgeon General's Select Consultant Group(Adolescent Pregnancy)- 1994-5

Centers for Disease Control, Division of Adolescent and School Health - Advisory Panel on Evaluation, 1992

Technical Advisory Group, Women and AIDS Program - International Center for Research on Women - 1991 - 1993

Committee on AIDS Research and the Behavioral and Social Sciences - National Academy of Sciences/National Research Council - 1987-88

Expert Review Panel - Evaluation of NYC Schools AIDS Initiatives - The Robert Wood Johnson Foundation- 1993 -- 1996

Advisory Committee to School-Based Clinic Program - Columbia University Center for Population and Family Heath - 1987-1990

Panel on Adolescent Initiatives- Kaiser Foundation - 1986

National Evaluation of School-Based Clinics - Center for Population Options - 1987-1990

Mayor's Advisory Committee on Adolescent Pregnancy Prevention - 1988-1991. Baltimore, MD. Chair, Subcommittee on Intervention/Evaluation

Participation on Advisory Panels (selected only)- (cont.):

Mayor's Poverty Study Group- Baltimore, MD - 1986-87
Family Planning Evaluation Team, Morocco, USAID- 1976
Chair, Ad Hoc Committee to Evaluate Family Planning International Assistance (FPIA) for Planned Parenthood Federation of America and USAID - 1972
Advisory Panel - Urban League/Planned Parenthood- 1965-69
NIH/OPA research project on Improving Condom Use for STD Prevention

Program or Project Development (selected only):

(In-country projects/consulting for international project development connected to Gates Leadership Program or Gates Institute 1998-present ***not*** *included - see below)*

University of Minnesota - CDC Teen Pregnancy Prevention Center - Special Consultant, 1997B
Consultant to Family Health Council of Central Pennsylvania, 1997B2001
Teen Incentives Program - Baltimore - Advisor and Consultant, 1997- 2001
Family Planning Council of SE PA - Office of Population Affairs-funded Condom Project - Consultant, 1997- 2001
The Futures Group - Policy Project - Project Reviewer, 1997
NIH-DC Initiative to Reduce Infant Mortality, Howard University - Consultant, 1994B1998
Association of Reproductive Health Professionals - Adolescent Health History Committee 1994B1996
Adolescent Project Development, American Academy of Arts and Sciences- 1994-1995
Centro de Medicina Reproductiva del Adolescente, Departmenta de Salud Publica, University of Chile; Consultant (and also to other Ford Foundation programs at University and elsewhere) Santiago, Chile- 1993B1996
Centro de Estudios de Estado y Sociedad; Consultant, Buenos Aires, Argentina 1993
Adolescents at Risk: Medical and Social Perspectives, 7th Annual Conference on Health Policy, Cornell Medical Cdlege - 1991
Methodological Issues in Abortion Research- Population Council - 1989
Technical Expert Reviewer *Guide to Clinical Preventive Services*- US Preventive Services Task Force - 1988-89
National Institute of Health - NICHD and Baltimore City Health Department Initiative - Baltimore, MD - 1988
National Institute of Health - NICHD - Special Review Committee, Scientific Review Program - 1987
Community Health Interventions- Group Health/Univ. of Washington- 1987
American Public Welfare Association, Adolescent Pregnancy: State Policies

and Programs - 1985

Convener, Manresa Conference on Population Education– 1969

Visiting Professorships, Lectureships (selected)*(excludes Gates related)*:

Visiting Lecturer, University of Michigan- 1995

Washington University, Dep't of Anthropology and Medical School- 2000

Visiting Scholar, Department of Adolescent Health, University of Minnesota School of Medicine - 1990, 1994 and 2000

Graduate Seminar in Nursing - University of Minnesota - 1994

Visiting Lecturer, Maternal and Child Health, University of North Carolina School of Public Health - once a year, years between 1990 and 1998

Visiting Professor, Department of Pediatrics, University of Maryland - 1986

Visiting Lecturer, Beijing Medical University- Summer term, 1989

EDITORIAL ACTIVITIES (selected only):

Peer Review Activities (selected only):

AIDS: Education and Prevention Review
American Journal of Epidemiology
American Journal of Public Health
American Sociological Review
Applied Developmental Science
Archives of Pediatrics and Adolescent Medicine
Archives of Sexual Behavior
Child Development
Contraceptive Technology
Controlled Clinical Trials
Demography
Family Planning Perspectives (Perspectives in Sexual and Reproductive Health)
Fertility and Sterility
International Family Planning Perspectives
Journal of Adolescent Health
Journal of the American Medical Association
Journal of Adolescent and Pediatric Gynecology
Journal of Consulting and Clinical Psychology
Journal of Marriage and Family
Journal of Nervous and Mental Disease
Journal of Public Health Policy
Journal of Research on Adolescence
Journal of Rural Health
Men and Masculinities
Population and Health
Population Studies
Psychological Bulletin
Social Science and Medicine

Studies in Family Planning

Reviews in 2008:

American Journal of Public Health
Demography
Journal of Adolescent Health
Men and Masculinities
Perspectives in Sexual and Reproductive Health
Studies in Family Planning

Other reviews (selected):

Office of Technology Assessment,
Centers for Disease Control,
Center for Population Options,
American College of Obstetrics and Gynecolog
Futures Group,
Academy of Finland
Ellertson Fellows
and Foundations, federal/state agencies, etc..

HONORS AND AWARDS (selected):

Distinguished Achievement Award - Vassar Co
Planned Parenthood –William G. Robertson Vol
Mayor's Citation – Baltimore, MD - 2008
Outstanding Researcher Award, Healthy Teen N
Carl Shultz Award, American Public Health Ass
Laurie Schwab Zabin Fellowship in Reproduct
Hopkins School of Public Health - 2002
ISI Highly Cited - Most Highly Cited List in the
Women who Dare, Jewish Women's Archive - 2(
American Civil Liberties Union/ACLU Foundati
Civil Liberties Award - 1996
Irvin M. Cushner Award - National Family Pl
Association - 1992
Delta Omega - Public Health Honor Society - 19
Margaret Sanger Award - Planned Parenthood A
Vassar Fellowship for Graduate Study at Harv
Sciences - 1946-7
Phi Beta Kappa Prize - 1946 - Vassar College
Phi Beta Kappa - 1945 - Vassar College

PUBLICATIONS:
Journal articles, peer reviewed:

Zabin LS, Kantner JF, Zelnik M. The risk of adolescent pregnancy in the first Months of intercourse. *Family Planning Perspectives 11*(4):215-222, 1979.

Zabin LS. The impact of early use of prescription contraceptives on reducing premarital teenage pregnancies. *Family Planning Perspectives 13*(2):72-74, 1981.

King TM and Zabin LS. Sterilization: efficacy, safety, regret, and reversal in clinical and legal implications of contraception in the '80s. *Supplement to the Female Patient* No. 1:3-9, 1981.

Zabin LS and Clark SD. Why they delay: a study of teenage family planning clinic patients. *Family Planning Perspectives 13*(5):205-217, 1981.

Zabin LS and Clark SD. Institutional factors affecting adolescents' choice of contraceptive clinics. *Family Planning Perspectives 15*(1):25-29, 1983.

Zabin LS. The effect of administration family planning policy on maternal and child health. *Journal of Public Health Policy 4*(3):268-278, 1983.

Zabin LS, Hardy JD, Streett R and King TM. A school, hospital and university-based adolescent pregnancy prevention program. *Journal of Reproduction 29*(6):421-426, 1984.

Zabin LS. The association between smoking and sexual behavior among teens in U.S. contraceptive clinics. *American Journal of Public Health 74*(3):261-263, 1984.

Clark SD, Zabin LS and Hardy JB. Sex, contraception parenthood: experience and attitudes among urban black young men. *Family Planning Perspectives 16*(2):77-82, 1984.

Zabin LS, Hirsch MB, Smith EA and Hardy JB. Adolescent sexual attitudes and behaviors: are they consistent? *Family Planning Perspectives 16*(4):181-185, 1984.

Zabin LS, Hirsch MB, Smith EA and Hardy JB. Ages of physical maturation and first intercourse in black teenage males and females. *Demography 23*(4):595-605, 1986.

Zabin LS, Hardy JB, Smith EA and Hirsch MB. Substance use and its relation to sexual activity among inner-city adolescents. *Jour of Adolescent Health Care 7*:320-331, 1986.

Zabin LS, Hirsch MB and Smith EA. Adolescent pregnancy prevention program: a model for research and evaluation. *Jour of Adolescent Health Care 7*:77-87, 1986.

Zabin LS, Smith EA, Hirsch MB, Streett R, Hardy JB. Evaluation of a pregnancy prevention program for urban teenagers. *Family Planning Perspectives 18*(3):119-126, 1986.

Zabin LS, Cushner IM and Smith EA. A study of women requesting interval sterilization who do and do not return for surgery. *Fertility and Sterility 46*(5):876-884, 1986.

Hirsch MB, Zabin LS, Streett RF and Hardy JB. Users of Reproductive Health Services in a School Pregnancy Prevention Program. *Public Health Reports*, 102(3): 307-316.

Zabin LS, Hirsch MB, Streett R et al. The Baltimore Pregnancy Prevention Program for Urban Adolescents:how did it work? *Family Planning Perspectives 20*(4):182-

187, 1988.

Journal articles, peer reviewed (cont.):

Zabin LS, Hirsch MB, Streett R, et. al. What did it cost? Expenditures on student services in a successful pregnancy prevention program. *Family Planning Perspectives 20*(4):188-192, 1988.

Zabin LS, Hirsch MB, and Emerson MR. When adolescents choose abortion: effects on education, psychological status and subsequent pregnancy. *Family Planning Perspectives 21*(6):248-255, 1989.

Zabin LS, Hirsch MB and Boscia JA. Differential characteristics of pregnancy test patients: aborters, childbearers and negative tests. *Jour of Adolescent Health Care 11*(2):107-113, March 1990.

Zabin LS. Adolescent pregnancy: the clinician's role in intervention. *Journal of General Internal Medicine 5*:S81-S88, September/October supplement, 1990.

Zabin LS, Stark H and Emerson MR. Reasons for delay in contraceptive clinic utilization: adolescent clinic and non-clinic populations compared. *Jour of Adolescent Health 12*(3):225-232, May 1991.

Zabin LS, Hirsch MB, Emerson MR and Raymond E. To whom do girls talk about their pregnancies? Urban adolescents' communication with responsible adults. *Family Planning Perspectives 24*(4):148-154, July/August 1992 .

Zabin LS, Wong R, Weinick R and Emerson MR. Dependency in urban black families following the birth of an adolescent's child. *Jour of Marriage and the Family, 54*:496-507, August, 1992.

Zabin LS and Sedivy V. Abortion among adolescents: research findings and the current debates. *Jour of School Health*, 319-324, September, 1992.

Zabin LS, Astone NM and Emerson MR. Do adolescentswant babies? The relationship between attitudes and behavior. *Jour of Research on Adolescence*, 67-86, January, 1993.

Kiragu K and Zabin LS. Correlates of Premarital Sexual Activity among High School Students in Kenya. *International Family Planning Perspectives*, 25(4), 1993.

Smith EA and Zabin LS. Marital and Birth Expectancies of Urban Adolescents. *Youth and Society*, 25(1), 1993.

Zabin LS. More Thoughts on the Adolescent Pregnancy 'Problem'.(Book review) *Family Planning Perspectives*, 26(3), 1994.

Kirby D, Short L, Collins J, Rugg D, Kolbe L, Howard M, Miller B, Sonenstein F, Zabin LS. School-Based Programs to Reduce Sexual Risk Behaviors: A Review of Effectiveness. *Public Health Reports*, 109(3):339-360, 1994.

Carter DM, Felice ME, Rosoff J, Zabin LS et al. Preventive Medicine Grand Rounds at Johns Hopkins School of Public Health: When Children have Children: The Teenage Pregnancy Predicament. *American Jour of Preventive Med*, 10(2), 1994.

Zabin LS. Addressing Adolescent Sexual Behavior and Childbearing: Self Esteem or Social Change? *Women's Health Issues*, 4(2):92-97, 1994.

Journal articles, peer reviewed (cont.):

Zabin LS, Sedivy V and Emerson MR. Subsequent Risk of Childbearing among Adolescents with a Negative Pregnancy Test. *Family Planning Perspectives,* 26(5):212-217, 1994.

Toledo V and Zabin LS. Durations of adolescent sexual relationships before and after conception. *Jour of Adolescent Health,* 17(3): 163-172, 1995.

Kiragu K and Zabin LS. Contraceptive Use Among High School Students in Kenya. *International Family Planning Perspectives,* 21(3): 108-113, 1995.

Zabin LS, Emerson MR, Ringers PA, Sedivy V. Negative Pregnancy Tests among Adolescents: Identification of an Accessible, At-risk Group. *Journal of the American Medical Association,* 275:113-117, 1996.

Finer LB and Zabin LS. Does the Timing of the First Family Planning Visit Still Matter? *Family Planning Perspectives,* 29(1): 30-33,42, 1998.

Zabin LS and Kiragu K. The Health Consequences of Adolescent Sexual and Fertility Behavior in sub-Saharan Africa. *Studies in Family Planning,* 29(2): 210-232, 1998.

Murray N and Zabin LS. Gender Differences in Factors Influencing Sexual Debut: Santiago, Chile. *International Family Planning Perspectives,*24(3): 139-144,152, 1998.

Murray N, Zabin LS, Toledo V and Luengo X. "Diferencias de Genero en Factores que Influyan en el Inicio de Relaciones Sexuales en Adolescentes Escolares Urbanos en Chile". *Perspectivas Internacionales en Planificacion Familiar,* Numero Especial de 1998.

Santelli JS, Brener ND, Lowry R, Bhatt A & Zabin LS. Multiple Sexual Partners among US Adolescents. *Family Planning Perspectives,* 30(6): 271-275, 1998

Zabin LS. Contraceptive Failure and Unintended Pregnancy *Family Planning Perspectives* 31(5):250-251, 1999.

Zabin LS, Huggins GR, Emerson MR, Cullins VE. Partner Effects on a Woman=s Intention to Conceive:>Not with This Partner.= *Family Planning Perspec* 32(1):39-45, 2000

Lutalo T, Kidugavu M, Wawer MJ, Kigozi G, Swewadda D, Sweankambo NK, Wabwire-Mangen F, Nalugoda F, Atuyambe, L, Chen MZ, Zabin LS, Gray RH. Trends and Determinants of Contraceptive Use in Rakai District, Uganda, 1995 to 1998. *Studies in Family Planning* 31(3):217-227, 2000.

Rowland DL, Zabin LS, Emerson MR. Household Risk and Child Sexual Abuse in a Low Income, Urban Sample of Women. *Adolescent and Family Health* 1(1):29-39, 2000.

Murray N, Toledo V, Luengo X, Molina R and Zabin LS. AAn Evaluation of an Integrated Adolescent Development Program for Urban Teenagers in Santiago, Chile@ *International Family Planning Perspectives,* March 15, 2000.

Zabin LS, Emerson ME and Rowland D. "Childhood Sexual Abuse and Early Menarche: The Direction of their Relationship and its Implications" *Journal of Adolescent Health* 36:393-400, 2005.

Journal articles, peer reviewed (cont.):

Weden M and Zabin LS. "Gender and Ethnic Differences in the Co-occurrence of Adolescent Risk Behaviors. *Ethnicity and Health* 10(3) 213-225, 2005

Zabin LS. Adolescent Reproductive Health: Challenges and Change. *Journal of Reproduction and Contraception,* 15(3)2005

Zhao Shuang-ling, Gao Er-sheng and Zabin LS. Unmet Needs for Reproductive Health Knowledge among Unmarried Migrant Youth,*Journal of Reproduction & Contraception* 19(4) 227-238, 2008

Zabin LS et al. Levels of Change in Adolescent Sexual Behavior in Three Asian Cities, *Studies in Family Planning* 40(1) 1-12, 2009

Submitted:

Ahmed S, Zabin LS and Emerson MR. Concurrent Analysis of Risk and Resilience: Testing a New Approach to Identify Factors Protective of Adolescents

Books:

Zabin LS and Hirsch MB. *Evaluation of Pregnancy Prevention Programs in the School Context.* Lexington, MA: Lexington Books, 1987.

Hardy JB and Zabin LS. *Adolescent Pregnancy in an Urban Environment* Baltimore, MD and Washington, DC: Urban and Schwarzenberg & the Urban Institute, 1991.

Zabin LS and Hayward S. *Adolescent Sexual Behavior and Childbearing* Developmental and Clinical Psychology and Psychiatry Series, Alan Kazdin (ed). Newbury Park, CA: Sage Pub's, 1992.

Monographs (selected):

Zabin LS, Piotrow P et al. *Lessons from Family Planning and their Application to AIDS Prevention.* World Health Organization Global Program on AIDS. 1990.

Zabin LS and Kiragu KK. *Health Consequences of Adolescent Sexuality and Childbearing in Sub-Saharan Africa.* Commissioned by the National Academy of Sciences, Population Dynamics of Sub-Saharan Africa, Working Group on Adolescent Fertility. 1991.

Book Chapters (selected):

Zabin LS, Kantner JF and Zelnik M. The risk of adolescent pregnancy in the first months of intercourse. In *Teenage Sexuality, Pregnancy and Childbearing* Furstenberg, Lincoln and Menken (eds). Philadelphia: Univ of Penna Press, 1981.

Zabin LS. Early sexual onset. In *Advances in Clinical Child Psychology,* Lahey and Kazdin (eds). New York: Plenum Press, 1990.

Zabin L.S. The two problems of adolescent pregnancy: the effects of age on unintended conception. In *Childhood and Adolescent Sexology,* Perry (ed); Vol. 7 of

Handbook of Sexology, Money and Musaph (eds). Amsterdam and New York: Elsevier, 1990.

Book Chapters (selected)(cont.):

Zabin LS, Streett R. The "crisis" of teen pregnancy and an empirically tested model for pregnancy prevention. In *Contemporary Perspectives in Crisis Intervention and Prevention*, Roberts (ed). Englewood Cliffs, N.J.: Prentice Hall, 1991.

Zabin LS. Adolescent pregnancy and early sexual onset; Problems of evaluation in the school context; and What a school-linked program can do. In *Encycl of Adol*, Brooks-Gunn, Lerner, and Petersen (eds). New York and London: Garland Publishing Co., 1991.

Zabin LS. The Johns Hopkins Program for the Primary Prevention of Adolescent Pregnancy: Evaluation Model and Results. In *Preventing Adolescent Pregnancy*, Card, Miller et al (eds). Sage Publications, 1992.

Zabin LS. Teenage pregnancy. In *Principles and Practices of Student Health* Wallace (ed). San Diego, CA, 1992.

Zabin LS. Targeting Services to Adolescents. In Family Planning Services for Special Population/Sexuality and American Social Policy series, Besharov DJ et al, editors. The Henry J. Kaiser Foundation, 1998.

Zabin LS and Cardona KM. *Adolescent Pregnancy: Handbook of Women's Sexual and Reproductive Health*, pp. 231-235, 2002.

Invited Papers for University, Professional Groups, Participation in International Conferences, etc. (selected & first author only): *(Not listed are talks, conferences, seminars, papers presented domestically/internationally with Gates Leadership Program or Gates Institute 1998-present, or related to Johns Hopkins University or its institutes and centers)*

All-Campus Address, Vassar College– February, 2008

Healthy Teen Network - Plenary Talk - November, 2007

Mid-Atlantic Public Health Training Center- Public Health Practice Grand Rounds, October, 2007

Speaker, World Population Day program, The Population Institute, UNFPA and The National Press Club, Washington DC, July, 2006

Moderator and Address, "Adolescent Reproductive Health Issues", Panel on Health Issues Facing Low Income Women and their Children, Women's Giving Circle, Baltimore, MD, March 2006

Adolescent keynote, Understanding the "Global Teenager": Challenges to Policy and Program, International Symposium on Quality Service in Family Planning/Reproductive Health, Shanghai, China, November, 2005

International Forum on Population and Development, Implementation of ICPD/ PoA and MDG, Wuhan, Hubei Province, China- September, 2004

Opening Address - International Conference on Adolescent Reproductive Health, Taichung, Taiwan - November, 2003

Opening Address and overview - Seminar on Reproductive Health Education/

Service for Adolescents, China Family Planning Association and Shanghai Institute for Planned Parenthood Research, Shanghai, PRC - October, 2003

Invited Papers for University, Professional Groups, Participation in International Conferences, etc. (selected only, first author only) (cont.)

National Institute for Child Health and Human Development- Dual method Use Workshop - January 2003

Two-day Workshop on Adolescent Sexual and Reproductive Health- Calcutta, 2002

International Institute for Population Studies, Aborton Workshop - Bombay, 2001

Keynote Address, Planned Parenthood of the St. Louis Region, September, 2001

National Organization for Adolescent Pregnancy Prevention- 2000

Planned Parenthood of Maryland- Keynote: Emergency Contraception Campaign Launching - 2000

Advocates for Children and Youth- Campaign for our Children- 1999

Population Association of America- presentation at Annual Meeting- 1999

Grand Rounds, St. Vincent's Hospital, Indianapolis, IN- 1998

University of Michigan- Institute on Women and Gender, University lecture- 1998

Grand Rounds, University ofMichigan Medical Center- 1998

Georgia Campaign for Adolescent Pregnancy Prevention- 1998

National Academy of Sciences, National Research Council, Seminar on Adolescent Fertility in the Developing World, Washington DC, 1997

Family Planning Annual Lectureship - University of Delaware - 1997

Alan Guttmacher Institute - Planned Parenthood Federation of America- Annual Address "Framing the Issues"- 1997

American Civil Liberties Union Foundation of Maryland- 1996

Grand Rounds, Department of Obstetrics and Gynecology, Washington Hospital Center - 1996

University of Chile, Medical College- Conference on Program Evaluation- 1996

Keynote Address - Pennsylvania State University and State Coalition on Adolescent Pregnancy - Conference on Teen Pregnancy - 1996

Family Planning Council of Southeast Pennsylvania- Colloquium on Unintended Pregnancy - 1996

Congressional Caucus on Women's Issues- Washington DC - 1996

American Enterprise Institute, Seminar on Family Planning Services- 1996

Robert S. Rixse Memorial Lecture, Children's National Medical Center, Washington DC - 1995

Stockholm County Council on Preventive Health, Stockholm, Sweden- 1995

Grand Rounds, Department of Pediatrics, University of Minnesota Medical School - 1994

American Psychological Association - 1994

United States Public Health Service- Annual Meeting - 1994
Jacobs Institute, American College of Obstetrics and Gynecology- 1994

Invited Papers for University, Professional Groups, Participation in International Conferences, etc. (selected only, first author only) (cont.)

Grand Rounds, Department of Obstetrics/Gynecology, Franklin Square Hospital- 1994
Committee on Welfare Reform, Prevention Subcommittee- 1994
Departments of Health and Education, Under Secretary and Surgeon General's Joint Meeting on Adolescent Initiatives- 1994
University of Chile Medical College, Conference on Adolescent Pregnancy Prevention, 1993.
Grand Rounds; Department of Pediatrics, Sinai Hospital, Baltimore- 1993
USAID - Panel on Evaluation of FamilyPlanning Intervention - 1993
USAID - Study Group on Adolescent Pregnancy- 1993
Irvin M. Cushner Award Address: National Family Planning and Reproductive Health Association, Washington, D.C. 1992.
Grand Rounds, Preventive Medicine, JHSPH - 1992
Center for the Study of Adolescence, First Conference on Adolescent Health in Sub-Saharan Africa, Nairobi, Kenya, 1992.
Society for Adolescent Medicine– 1992
Grand Rounds, Department of Pediatrics, JHU School of Medicine, 1991
American Evaluation Association- 1986
National Institute of Drug Abuse and National Institute on Alcohol Abuse and Alcoholism - 1986
National Association of Community Health Centers- 1986
Reunion Internacional Sobre Salud Sexual y Reproductiva de los Adolescentes y Jovenes (First International Meeting on the Sexual and Reproductive Health of Adolescents), Academic Mexicana de Investigacion en Demografia Medica, Oaxtepec, Mexico, 1985.
American Association for the Advancement of Science- 1984
White House Conference, National Advisory Committee Research Forum- 1981
World Health Organization, Workshop on Adolescent Sexuality and Reproductive Health, Mexico City, April/May 1980.

Gates Leadership Program (1998-1999) and **Bill and Melinda Gates Institute for Population and Reproductive Health** (since 1999) *(selected)*

International participation in Leadership programs and seminars/lectures/courses in Peru, India, Nicaragua, Indonesia, Philippines, China (Shanghai and Wuhan), Taiwan (Taipei and Taichung), Thailand, Ghana (Accra and Kumasi), Nigeria, and others

Managed programs and/or currently managing programs in India, Guatemala, Peru, China, and an international study in Taiwan, China and Vietnam

the Emancipation of Minors Act.

"Neglect" means the failure of an adult family member to supply a child with necessary food, clothing, shelter, or medical care when reasonably able to do so or the failure to protect a child from conditions or actions that imminently and seriously endanger the child's physical or mental health when reasonably able to do so.

"Physical abuse" means any physical injury intentionally inflicted by an adult family member on a child.

"Physician" means any person licensed to practice medicine in all its branches under the Illinois Medical Practice Act of 1987.

"Sexual abuse" means any sexual conduct or sexual penetration as defined in Section 12-12 of the Criminal Code of 1961 that is prohibited by the criminal laws of the State of Illinois and committed against a minor by an adult family member as defined in this Act.

(Source: P.A. 95-331, eff. 8-21-07.)

(750 ILCS 70/15)

Sec. 15. Notice to adult family member. No person shall knowingly perform an abortion upon a minor or upon an incompetent person unless the physician or his or her agent has given at least 48 hours actual notice to an adult family member of the pregnant minor or incompetent person of his or her intention to perform the abortion, unless that person or his or her agent has received a written statement by a referring physician certifying that the referring physician or his or her agent has given at least 48 hours notice to an adult family member of the pregnant minor or incompetent person. If actual notice is not possible after a reasonable effort, the physician or his or her agent must give 48 hours constructive notice.

(Source: P.A. 89-18, eff. 6-1-95.)

(750 ILCS 70/20)

Sec. 20. Exceptions. Notice shall not be required under this Act if:

(1) the minor or incompetent person is accompanied by a person entitled to notice; or

(2) notice is waived in writing by a person who is entitled to notice; or

(3) the attending physician certifies in the patient's medical record that a medical emergency exists and there is insufficient time to provide the required notice; or

(4) the minor declares in writing that she is a victim of sexual abuse, neglect, or physical abuse by an adult family member as defined in this Act. The attending physician must certify in the patient's medical record that he or she has received the written declaration of abuse or neglect. Any notification of public authorities of abuse that may be required under other laws of this State need not be made by the person performing the abortion until after the minor receives an abortion that otherwise complies with the requirements of this Act; or

(5) notice is waived under Section 25.

(Source: P.A. 89-18, eff. 6-1-95.)

(750 ILCS 70/25)

Sec. 25. Procedure for judicial waiver of notice.

(a) The requirements and procedures under this Section are available to minors and incompetent persons whether or not they are residents of this State.

(b) The minor or incompetent person may petition any circuit court for a waiver of the notice requirement and may participate in proceedings on her own behalf. The court shall appoint a guardian ad litem for her. Any guardian ad litem appointed under this Act shall act to maintain the confidentiality of the proceedings. The circuit court shall advise her that she has a right to court-appointed counsel and shall provide her with counsel upon her request.

(c) Court proceedings under this Section shall be confidential and shall ensure the anonymity of the minor or incompetent person. All court proceedings under this Section shall be sealed. The minor or incompetent person shall have the right to file her petition in the circuit court using a pseudonym or using solely her initials. All documents related to this petition shall be confidential and shall not be made available to the public.

These proceedings shall be given precedence over other pending matters to the extent necessary to ensure that the court reaches a decision promptly. The court shall rule and issue written findings of fact and conclusions of law within 48 hours of the time that the petition is filed, except that the 48-hour limitation may be extended at the request of the minor or incompetent person. If the court fails to rule within the 48-hour period and an extension is not requested, then the petition shall be deemed to have been granted, and the notice requirement shall be waived.

(d) Notice shall be waived if the court finds by a preponderance of the evidence either:

(1) that the minor or incompetent person is sufficiently mature and well enough informed to decide intelligently whether to have an abortion, or

(2) that notification under Section 15 of this Act would not be in the best interests of the minor or incompetent person.

(e) A court that conducts proceedings under this Section shall issue written and specific factual findings and legal conclusions supporting its decision and shall order that a confidential record of the evidence and the judge's findings and conditions be maintained.

(f) An expedited confidential appeal shall be available, as the Supreme Court provides by rule, to any minor or incompetent person to whom the circuit court denies a waiver of notice. An order authorizing an abortion without notice shall not be subject to appeal.

(g) The Supreme Court is respectfully requested to promulgate any rules and regulations necessary to ensure that proceedings under this Act are handled in an expeditious and confidential manner.

(h) No fees shall be required of any minor or incompetent person who avails herself of the procedures provided by this

Section.
(Source: P.A. 89-18, eff. 6-1-95.)

(750 ILCS 70/30)
Sec. 30. Minor's consent to abortion. A person may not perform an abortion on a minor without the minor's consent, except in a medical emergency.
(Source: P.A. 89-18, eff. 6-1-95.)

(750 ILCS 70/35)
Sec. 35. Reports. The Department of Public Health shall comply with the reporting requirements set forth in the consent decree in Herbst v. O'Malley, case no. 84-C-5602 in the U.S. District Court for the Northern District of Illinois, Eastern Division.
(Source: P.A. 89-18, eff. 6-1-95.)

(750 ILCS 70/40)
Sec. 40. Penalties.
(a) Any physician who willfully fails to provide notice as required under this Act before performing an abortion on a minor or an incompetent person shall be referred to the Illinois State Medical Disciplinary Board for action in accordance with Section 22 of the Medical Practice Act of 1987.
(b) Any person, not authorized under this Act, who signs any waiver of notice for a minor or incompetent person seeking an abortion, is guilty of a Class C misdemeanor.
(Source: P.A. 89-18, eff. 6-1-95.)

(750 ILCS 70/45)
Sec. 45. Immunity. Any physician who, in good faith, provides notice in accordance with Section 15 or relies on an exception under Section 20 shall not be subject to any type of civil or criminal liability or discipline for unprofessional conduct for failure to give required notice.
(Source: P.A. 89-18, eff. 6-1-95.)

(750 ILCS 70/50)
Sec. 50. Severability and inseverability. If any provision of this Act or its application to any person or circumstance is held invalid, the invalidity of that provision or application does not affect other provisions or applications of the Act that can be given effect without the invalid provision or application, except that Section 25 is inseverable to the extent that if all or any substantial and material part of Section 25 is held invalid, then the entire Act is invalid.
(Source: P.A. 89-18, eff. 6-1-95.)

(750 ILCS 70/85)
Sec. 85. (Amendatory provisions; text omitted).
(Source: P.A. 89-18, eff. 6-1-95.)

(750 ILCS 70/90)

Sec. 90. The Illinois Abortion Parental Consent Act of 1977 is repealed.

(Source: P.A. 89-18, eff. 6-1-95.)

(750 ILCS 70/95)

Sec. 95. The Parental Notice of Abortion Act of 1983 is repealed.

(Source: P.A. 89-18, eff. 6-1-95.)

(750 ILCS 70/99)

Sec. 99. Effective date. This Act takes effect upon becoming law.

(Source: P.A. 89-18, eff. 6-1-95.)

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT — CHANCERY DIVISION

THE HOPE CLINIC FOR WOMEN LTD.; ALLISON COWETT, M.D., M.P.H., Plaintiffs, v. BRENT ADAMS, Acting Secretary of the Illinois Department of Financial and Professional Regulation, in his official capacity; DANIEL BLUTHARDT, Director of the Division of Professional Regulation of the Illinois Department of Financial and Professional Regulation, in his official capacity; THE ILLINOIS STATE MEDICAL DISCIPLINARY BOARD, Defendants.	Case No. AFFIDAVIT OF ALLISON COWETT, M.D., M.P.H. IN SUPPORT OF PLAINTIFFS' MOTION FOR INJUNCTIVE RELIEF

AFFIDAVIT OF ALLISON COWETT, M.D., M.P.H.

I, ALLISON COWETT, M.D., M.P.H., testify under penalty of perjury that the following is true and correct:

1. I am a physician licensed to practice in the State of Illinois. I received my Doctor of Medicine with honors from the University of Rochester School of Medicine and Dentistry in 1998 and completed my residency in Obstetrics and Gynecology in 2002 at Northwestern University Feinberg School of Medicine. In 2004, I completed a Masters in Public Health and a Fellowship in Family Planning, also at Northwestern. I am actively engaged in the practice of obstetrics and gynecology and am board certified in this practice area. I am currently an Assistant Professor of Clinical Obstetrics and Gynecology and Assistant Director of the Family Planning Fellowship at the University of Illinois at Chicago ("UIC") School of Medicine. In addition, I am the Director of the UIC Center for Reproductive Health ("CRH") and an attending physician at UIC Hospital.

2. I am a Fellow of the American College of Obstetricians and Gynecologists and a member of the Society of Family Planning and the Association of Reproductive Health Professionals. In addition to these and other scientific and professional activities, I am a reviewer for the medical journals Obstetrics and Gynecology, International Journal of Gynecology and Obstetrics, and Ultrasound in Obstetrics and Gynecology. I have provided reproductive health care, including abortion, since I began my residency in 1998, and I currently provide my patients with a broad range of gynecologic and obstetric care, including prenatal care, labor and delivery, and induced abortions. I consider induced abortion to be an important part of the comprehensive care that I offer my patients and that I teach.

3. As the Director of CRH, I supervise and train fellows, residents and medical students in the provision of contraception, abortion care in the first and second trimesters of pregnancy, and management of ectopic pregnancies, miscarriages, and other pregnancy complications. In my capacity as an attending physician at UIC Hospital and Assistant Clinical Professor of Obstetrics and Gynecology, I train and supervise residents and medical students in the full range of obstetric and gynecologic procedures and care. This includes, for example, outpatient prenatal and general gynecologic care. It also includes inpatient labor and delivery, intra-partum and post-partum care, surgical procedures such as hysterectomy and dilation and curettage, and management of gynecologic complications such as heavy bleeding and pelvic inflammatory disease. I spend a number of days a month in the hospital operating room performing and supervising gynecologic surgery. My patients at CRH and at the hospital are predominantly low income. The majority of the patients who seek care at CRH are teens and young adults. Most are on public assistance; some have private insurance and others pay out of pocket for their medical care.

4. I lecture in the area of obstetrics and gynecology. I have conducted and supervised research studies in obstetrics and gynecology and have published the results of many of those studies in peer reviewed journals. A list of my publications may be found in my attached curriculum vitae

5. Since beginning my practice, I have personally treated and supervised the treatment of thousands of pregnant women – including both women who have chosen to carry their pregnancies to term and those who have chosen to terminate their pregnancies. Currently, I perform, teach and supervise over 500 abortions per year. I perform abortions prior to twenty-four weeks measured from a woman's last menstrual period, which is roughly consistent with the earliest point of viability in healthy pregnancies. I perform abortions only where the fetus is not viable, meaning that it cannot survive outside the woman's uterus.

6. Many of my patients are adolescents; I have observed first-hand the risks and effects of adolescent pregnancy, childbirth, and abortion. I provide and supervise abortions for minors who choose not to carry their pregnancies to term. I also provide and supervise the full range of health care for adolescents who choose to carry to term – from providing prenatal care, to treating illnesses that arise during, or are exacerbated by, pregnancy, to caring for young women during labor and the delivery of their babies. Through my experience, I have confronted a broad range of the problems and risks associated with pregnancy, childbearing, and abortion, for adult women as well as adolescents. I am also familiar with the medical research on these topics and rely on it when teaching, researching and caring for my patients.

7. I have reviewed the Illinois Parental Notice of Abortion Act (the "Act"). The Act requires that an "adult family member," defined by the Act as a parent, grandparent, step-parent living in the home or legal guardian, of a minor seeking an abortion, be notified at least 48 hours

before the procedure. The Act creates exceptions for minors who obtain a court waiver of the notification requirement or who declare in writing that they are victims of sexual abuse, neglect or physical abuse by one of the adult family members set forth in the Act. I submit this affidavit in support of Plaintiffs' motion for injunctive relief against enforcement of the Act, because it is my professional opinion that the Act is without a medical or public health basis and, in fact, will cause significant and irreversible harm to minors. In forming this opinion, I rely on my own professional experience as well as authoritative and reliable research, studies and treatises.

8. In Illinois, a pregnant minor can consent on her own, without notifying a parent or other adult family member, to all medical care – pregnancy related or otherwise – except abortion. While the Act does not alter the minor's ability to consent to her abortion, the Act singles out abortion – requiring that for abortion and abortion only, one of the adult family members listed in Act be told about the minor's plans. It is my professional opinion that there is absolutely no medical basis for this discriminatory treatment of minors seeking abortion. Indeed, requiring all minors to notify one of the identified family members or get court authorization before having an abortion will harm, rather than advance, minors' health.

Unintended Pregnancy and Abortion

9. The United States has one of the highest rates of unintended pregnancy in the industrialized world. Guttmacher Institute, In Brief - Contraception Counts: Ranking State Efforts 1 (2006). In 2000, nearly half of the 6.4 million pregnancies that occurred in the United States (including those that ended in miscarriages) were unintended, and about half of those resulted in abortion. Rachel K. Jones et al., Abortion in the United States: Incidence and Access to Services, 2005, 40(1) Persp. on Sexual and Reprod. Health 6, 6 (2008). In 2002, nearly 270,000 adolescents under the age of 18 became pregnant. Guttmacher Institute, U.S. Teenage

Pregnancy Statistics: National and State Trends by Race and Ethnicity 6 (Table 2.2), 8 (Table 2.4), (2006). This was the lowest teen pregnancy rate in this country in 30 years. Id. More than half of these adolescents – almost 150,000 – carried their pregnancies to term, 32% terminated their pregnancies, and 14% miscarried. Id. Based on available data, fewer than 15,000 Illinois teens – out of a population of more than 250,000 – under the age of 18 became pregnant in 2000. Id. at 12 (Table 3.2), 16 (Table 3.6). Approximately 5,000 of those teens terminated their pregnancies. Id. at 12 (Table 3.2).

Comparative Safety of Having an Abortion and Carrying a Pregnancy to Term

10. The Act imposes notification requirements only when a minor seeks to terminate her pregnancy. This requirement is unsupported by the reality of the relative risks of abortion and childbirth. Legal induced abortion is one of the most frequently performed surgical procedures in the United States and, according to statistics compiled by the United States government, is one of the safest procedures in contemporary medicine. Linda A. Bartlett et al., Risk Factors for Legal Induced Abortion-Related Mortality in the United States, 103(4) Obstet. & Gynec. 729, 729 (2004). In terms of both mortality (death) and morbidity (serious medical complications short of death), abortion is many times safer than continuing pregnancy through to childbirth. David A. Grimes, Estimation of Pregnancy-Related Mortality Risk by Pregnancy Outcome, United States, 1991 to 1999, 194 Am. J. Obstet. & Gynec. 92, 93 (2006). This is especially true for first trimester abortions, which account for 89% of the abortions performed in 2004. Guttmacher Institute, In Brief: Facts on Induced Abortion in the United States (2008).

11. The mortality rate for all abortions is 0.6 per 100,000 procedures, while for women who carry a pregnancy to term, the mortality rate is much higher at 7.1 per 100,000 births. Id. Indeed, today the risk of death from legal induced abortion is less than that from an

injection of penicillin. Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care 136 (Maureen Paul et al. eds., 2009).

12. The risk of morbidity is also low for women who choose abortion and, again, much lower than it is for women who carry to term. Less than one percent of all abortion patients experience a major complication, such as infection or hemorrhage, and fewer than three in 1,000 patients require hospitalization because of an abortion complication. Guttmacher Institute, In Brief: Facts on Induced Abortion in the United States (2008); Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care at 136-137. In contrast, research shows that in 2002, 12.3 women were hospitalized for overall pregnancy-related complications for every 100 live births. Letitia Williams et al., Ctr. Disease Control & Prev., PRAMS 2002 Surveillance Report. Pregnancy Risk Assessment Monitoring System 124, 126 (2006).

13. In comparison to abortion, pregnancy and childbirth pose serious risks for all women, even those who are generally healthy. Some pregnancy related conditions cause discomfort, while others can put the pregnant woman's life and health at significant risk. Almost all pregnant women experience symptoms such as fatigue, headaches, backaches, and difficulty sleeping. Many suffer from nausea, and some develop hyperemesis (frequent vomiting, which can require short or long term intravenous nourishment). They suffer gassiness, heartburn, chronic constipation and hemorrhoids; they may develop varicose veins in their legs, vulvas, or vaginas, causing discomfort and increasing the risk of hemorrhage during labor.

14. Pregnancy effects changes in every major bodily organ. It causes the heart and kidneys to work harder, and the lungs to alter in function, with some women feeling chronically short of breath. Pregnancy increases the risk of blood clots, and, in some cases, the blood loses

the ability to clot altogether, increasing the risk of hemorrhage. Because of changes in pancreatic hormones, gestational diabetes may develop, requiring women to regulate their diet carefully, some to use insulin, and some to be hospitalized.

15. Even the most normal pregnancy can quickly become life threatening. For example, a pulmonary thromboembolism – a blood clot in the lungs that decreases a person's oxygen intake – can suddenly develop and is a major cause of maternal death, as are hypertension, hemorrhage, and stroke. All women, including adolescents, are at risk of developing these conditions.

16. For adolescents as well as adults, pregnancy can exacerbate a preexisting medical condition. For example, mild asthma can become severe. I have treated an adolescent whose asthma was so severely exacerbated by pregnancy that she had to be hospitalized and delivered preterm because her asthma continued to worsen. Diabetes also may worsen as a result of pregnancy and, without careful insulin control, can cause maternal kidney failure and blindness as well as significant fetal anomalies. Like adults, pregnant adolescents with congenital heart disease have a significantly increased risk of maternal mortality. I have terminated pregnancies for such women. Renal disease is also a significant cause of health complications during pregnancy. Adolescents with renal disease risk kidney failure, leading to the need for life-long dialysis or kidney transplant. While kidney disease is less common in teens than in older people, I have treated patients with kidney disease that has presented in childhood as well as teens whose kidney function is compromised because of a disease such as lupus.

17. Pregnancy frequently accelerates the clinical course of sickle cell anemia, causing more frequent and more severe sickle cell crises, which are characterized by excruciating pain. In addition, women with sickle cell disease are at increased risk of pneumonia and urinary tract

infections, congestive heart failure and pulmonary complications, spontaneous abortion and perinatal mortality. I recently terminated a pregnancy for a 16-year-old girl who had had multiple childhood strokes as a result of sickle cell anemia and was at significant risk if she were to continue her pregnancy.

18. Pregnant women who take medication to address a preexisting medical condition often must decide whether to continue treatment that may be necessary for their health but puts their fetus at risk. Again, this is true for adolescents as well as older women. For example, I have cared for numerous pregnant adolescents who take anticonvulsant medications to control epilepsy. This medication puts their fetuses at significant risk; however, without such medication, these young women face the possibility of uncontrolled seizures, respiratory arrest, and even neurological damage. Some of these patients have chosen to carry their pregnancies to term, and I have referred them to high risk specialists. Others decide to terminate. Similarly, women who take medication for mental health conditions such as anxiety disorders, bipolar illness and schizophrenia, also must decide whether to continue to take medication that may increase the risk of fetal abnormalities or to forego treatment – at the risk of aggravating their condition.

19. Although pregnancy presents significant potential health risks for any woman, it presents enhanced risk for teens. The mortality rate associated with an adolescent carrying a pregnancy to term is more that twice that of an adult woman. Jonathan D. Klein & Comm. on Adolescence, Adolescent Pregnancy: Current Trends and Issues, 116(1) Pediatrics 281, 283 (2005). Pregnant adolescents younger than 17 years also have a higher incidence of morbidity than do adult women, with risks being greatest for the youngest teens. Id. For example, a pregnant teen is at significantly greater risk for gestational hypertension, preeclampsia, and

eclampsia than a pregnant adult. Anne B. Wallis et al., Secular Trends in the Rates of Preeclampsia, Eclampsia, and Gestational Hypertension, United States, 1987–2004, 21(5) Am. J. Hyperten., 521, 523–524 (Table 2) (2008). Each of these conditions places a young woman at serious risk, with eclampsia posing the most severe consequences, including compromised cardiac function, potentially life threatening hematologic, endocrine and metabolic changes, compromised renal and liver function, and stroke. Adolescent pregnancy has also been associated with poor maternal weight gain, Klein, supra, at 283; Williams Obstetrics 194 (F. Gary Cunningham et al. eds., 22nd ed. 2005), and the infants born to adolescent mothers, particularly younger teens, have a higher risk of negative health outcomes, such as prematurity, low birth weight, newborn anemia, respiratory distress syndrome, and assisted ventilation. Klein, supra, at 283.

20. The Act's singling out of abortion for special restriction is without any medical or public health basis. Under the Act, a parent or other adult family member identified in the Act must be notified if the adolescent decides to terminate the pregnancy, but not if she decides to continue her pregnancy, with all its attendant health risks. In that case, the minor can consent on her own to all care for herself and subsequently for her child. So, for example, a pregnant minor who chooses to undergo intrauterine surgery to repair a fetal anomaly can do so without involving a parent or other adult family member. Irrationally, that same adolescent cannot choose, based on the same fetal anomaly, to undergo a far safer abortion procedure without such involvement. In addition, a minor can consent without involving a parent or other adult family member to a caesarean section, which is far riskier than an abortion. Such procedures, though common, are major surgical procedures, requiring an incision in the abdomen and generally lengthier hospitalization than vaginal delivery. If a pregnant teen chooses to forego an abortion

and to carry her pregnancy to term without involving a parent – which the Act permits – her parent may only learn of the pregnancy later, based on physical changes in the young woman's body. At that point, it is likely to be too late for the parent to have any input into the decision of whether to terminate or continue the pregnancy, as the passage of gestational weeks will have foreclosed the abortion option. And yet, this young woman will be faced with far higher risks of morbidity and mortality as a result of the pregnancy than she would have from an abortion.

21. In yet another example of the Act's irrationality, a minor who is concerned that medication she takes for a preexisting condition may interfere with a healthy pregnancy, like an adult, has three choices: She may stop taking her medication, potentially putting her own health in jeopardy; she may keep taking her medication, potentially putting her fetus at risk; or she may choose to terminate her pregnancy and continue her medication. Under the Act, the pregnant minor can choose the first two options without parental involvement. It is only if she chooses the third – to keep taking her medication and terminate the pregnancy – that she is forced to involve a parent or other adult family member indentified in the Act.

22. In my experience, minors making the decision whether to carry a pregnancy to term or to undergo a safe and legal abortion are capable of doing so. Minors, like adult women, decide to terminate pregnancies for a variety of reasons. I see patients who choose to terminate their pregnancies because of maternal health concerns, as discussed above. Others consider termination because of fetal health issues. I recently performed an abortion for a 17 year old who was in her second trimester of pregnancy when she learned that her fetus suffered from a genetic abnormality incompatible with life. Others fear that having a child will thwart education and career plans and that they will struggle to care for dependants. Some simply do not feel ready to be a parent and do not want to be a single parent. My experience is consistent with the

leading research. See Lawrence B. Finer et al., Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives, 37(3) Persp. on Sexual & Reprod. Health 110, 112-117 (2005).

23. In addition, the vast majority of my patients are highly motivated, intelligent young women who have thought through their decision carefully. My minor patients are also capable of giving me the medical information I need to provide them the best care. In my experience, my adolescent patients are capable of giving me as accurate a medical history as are my adult patients. I have never had a minor patient suffer a complication because I treated her without parental involvement and she omitted an important piece of medical history. I also have never had a minor patient who did not involve a parent suffer a complication because she failed to care for herself properly after the procedure. Again, my experience is consistent with authoritative research which shows that adolescents who considered abortion appeared as competent as legal adults to make this decision. Bruce Ambuel & Julian Rappaport, Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion, 16(2) Law & Hum. Behav. (1992). In my practice, we will not treat any woman, minor or adult, for any health care, whether it is abortion or a more complicated procedure with greater attendant risks, who lacks the capacity to give informed consent.

24. For all of the above reasons, the Act simply makes no sense from a medical or public health perspective.

Negative Consequences of the Act

25. Not only is the Act irrational, it is my professional opinion that it will affirmatively harm teens. It will cause some minors to suffer at the hands of their parents, others

to delay their care with consequences for their health, and some to be forced – by parents or time – to continue their pregnancies against their will.

26. First, by way of background, many of my minor patients are accompanied by a parent or other supporting adult when they come to my practice for an abortion. The younger the girl, the more likely she is to have a parent with her, supporting her. My experience is consistent with the leading authoritative research. Stanley K. Henshaw & Kathryn Kost, Parental Involvement in Minor's Abortion Decisions, 24 Fam. Plan. Persp. 196, 196 (1992).

27. Some of my patients, however, do not feel they can tell a parent – or even a grandparent or step-parent about their pregnancy and abortion decision. Such young women often have very good reason for not sharing this information. I have had teen patients who are terrified that if their parents learn of their pregnancy and abortion, they will kick them out of the house. My experience is consistent with research reporting that teens who do not involve a parent do so most often to preserve their relationship with the parent or to protect the parent from stress and conflict. Thirty percent of minors not involving parents have experienced violence in their home, feared violence, or feared being forced to leave home. Id. at 196. I recently cared for a teen who did not share news of her pregnancy or her decision to have an abortion with her parents. She grew up in a violent home in which her emotionally disturbed brother had attacked her and eventually been sent to live in a group home. She feared that the news of her pregnancy would be stressful and burdensome to her mother who was already struggling with coordinating her brother's care. She feared she too would be removed from the home if she told her mother about the pregnancy. Another teen patient of mine presented for her abortion with her adult sister who was in her late 20s or early 30s. My patient did not believe she could tell her parents without permanently damaging her relationship with them, and her adult sister agreed. This

young woman felt strongly that abortion was the right option for her. She wanted to finish high school and go to college – something no one else in her family had ever done.

28. I have had patients who feared that if their parents knew of their pregnancy, their parents would force them into a decision they did not want. This fear of coercion is very real. In fact, I have seen parents go to great lengths to impose their wishes on their adolescent daughters. A few years ago, I saw a young woman who was pregnant. She had come with her mother, aunt and boyfriend to my office. Her mother did not want her to have the baby because the boyfriend was of another race; the mother threatened to kick the young woman out of the house and to try to have her boyfriend arrested if she did not terminate the pregnancy. My patient was adamant that she wanted to continue her pregnancy – which led her mother to leave the teen in my office in Chicago and return without her to their home in Joliet.

29. I had a teen patient a number of years ago who did not present until she was 26 weeks pregnant. Although she wanted to terminate her pregnancy, abortion was no longer an option given the stage of her pregnancy. As a result, she decided she wanted to place her baby for adoption. She was afraid, however, that if her parents learned of her pregnancy, they would force her to keep and raise the child. This patient hid her pregnancy from her parents for its duration. She went so far as to refuse to be hospitalized for preeclampsia at 32 weeks against medical advice because she feared her parents would become suspicious when she did not come home. She was desperate to continue to hide her pregnancy, believing it was the only way she could preserve her relationship with her parents.

30. My experience is consistent with research that shows that young women who choose not to involve a parent in their abortion decision do so for many good reasons. For example, a leading study on this issue found that of the minors whose parents learned of their

pregnancy without the minor voluntarily telling them, a majority (58%) reported adverse consequences. A minimum of six percent reported being kicked out of their house, being physically assaulted or causing a negative affect on their parent's health. Ten percent reported that learning of the minor's pregnancy caused problems between their parents. Such adverse reactions were two to four times more likely to occur when the parent's discovery of the minor's pregnancy was not the young woman's choice. Id. at 204 (Table 7). Moreover, this study only looked at minors whose parents actually discovered their pregnancies and abortions and not those who were successful in keeping such information from their parents. It thus suggests that the percentages of adverse consequences would likely be even higher if the law had mandated parental involvement.

31. If the Act is enforced, I fear for my minor patients who may be forced to involve their parents, against their better judgment. Unfortunately, the alternative of notifying a grandparent or step-parent is not an option for many of my patients. In my experience, many do not have a grandparent or step-parent to whom they can turn. Others do not feel they can tell these family members because they fear the same kind of negative reaction they might get from their parents. Still others do not feel they can share their most intimate and confidential personal information with people with whom they may not even have a close relationship. This need for confidentiality is very real. In fact, the American Medical Association has reported that the desire to maintain secrecy about abortion has been one of the leading reasons for deaths from illegal abortions since *Roe v. Wade*. Council on Ethical and Judicial Affairs, Mandatory Parental Consent to Abortion, 269 JAMA 82, 83 (1993).

32. Because of the harm to adolescent health resulting from mandatory parental involvement laws and the lack of proven benefits, the American Medical Association, the

American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Public Health Association, the Society for Adolescent Medicine as well as other health professional organizations have taken the position that, while minors should be encouraged to discuss their pregnancy with their parents and other adults, they should not be compelled to do so before obtaining an abortion. Madlyn C. Morreale et al., Ctr. for Adols. Health & Law, Policy Compendium on Confidential Health Services for Adolescents: Policy Statements About Adolescents' Informed Consent and Confidential Access to Specific Health Care Services 61-68 (2nd ed. 2005); Am. Acad. of Pediat., Comm. on Adolescence, The Adolescent's Right to Confidential Care When Considering Abortion, 97(5) Pediatrics 746, 746 (1990) (reporting that the AMA, the Society for Adolescent Medicine, the American Public Health Association, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics "have reached a consensus that minors should not be compelled or required to involve their parents in their decisions to obtain abortions"). Indeed, the American Academy of Pediatrics has concluded that laws that mandate parental involvement "do[] not achieve the intended benefit of promoting family communication but do[] increase the risk of harm to the adolescent by delaying access to appropriate medical care." Id. at 746.

33. As the American Academy of Pediatrics cautions, laws like the Act harm minors by delaying access to abortion. Such delay will put their health at risk, and for some, push them out of the healthcare system entirely. Even if a minor, in the face of the Act, felt she had no choice but to tell her parents about her plan to have an abortion, the Act will likely result in medically significant delay as the young woman attempts to work up the courage to tell her parents, and then as her parents attempt to deal with the issue of their daughter's pregnancy. Those young women who know they cannot inform their parents will also suffer delay as they

attempt to figure out and then negotiate the judicial bypass process to obtain a court waiver of the notification requirement.

34. Although abortion is far safer than carrying a pregnancy to term, the risks of morbidity and mortality associated with abortion increase as gestation advances. Lawrence B. Finer et al., Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States, 74 Contraception 334, 334 (2006); Guttmacher Institute, Facts on Induced Abortion in the United States.

35. The increased risks associated with abortion at later gestational ages is particularly significant for teens, because, as experience and authoritative research shows, teens are more likely than older women to delay having an abortion. Bartlett et al., supra, at 732. As compared to older women, teens are more likely to delay having an abortion until after the first trimester and even until after 15 weeks gestation. Guttmacher Institute, Facts on Induced Abortion In the United States.

36. In my experience, teens delay their abortions for a variety of reasons: they frequently have irregular menstrual cycles and thus take longer to recognize the signs of pregnancy, and once they do begin to suspect pregnancy, they take longer to accept it as a reality. See Lawrence B. Finer et al., Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States at 343. For example, I have seen adolescents who have not suspected they were pregnant for several months, or struggle to face it. I recently treated a 16-year-old girl who had been sexually assaulted at a party. She was so afraid to tell anyone about the assault and resulting pregnancy that by the time she came to us, her pregnancy had advanced beyond 20 weeks.

37. As a result of delay, some minors will be unable to get the abortion they need. In some cases, because of delay, the pregnancy will have advanced to a point where an abortion is no longer an option. This was the case in the example I noted above where the young woman did not present until 26 weeks – beyond the time in pregnancy when she could choose to terminate. In other cases, where it is not too late, the minor will still face formidable if not insurmountable obstacles because of delay. There are very few facilities in the state – particularly outside of Chicago – that offer second trimester abortions. Moreover, after the first trimester, the price of an abortion increases steeply as pregnancy progresses. In some cases, the minor will be unable to obtain the additional resources needed to have the later abortion. I fear that some may be so afraid of others finding out that they may take extreme measures – including attempting to self-induce an abortion, seeking an illegal abortion or deciding to carry the pregnancy to term against their better judgment.

38. It is my professional opinion that forced notice, against my patient's wishes, to a parent or other adult family member, will undermine the privacy and confidentiality that otherwise characterizes the physician patient relationship, will destroy my patients' trust in me, and is inconsistent with my patients' medical interests.

39. In addition to being entirely without medical or public health basis, the Act will cause serious and irreversible harm to minors who will be forced to delay their access to medical care and in some cases will be deprived of it altogether.

Under the penalties as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that she verily believes the same to be true.

10/12/09

Date

Allison Cowett, M.D., M.P.H.

Curriculum Vitae

Personal Information

Name	Allison A. Cowett, MD MPH
Office Address	Department of Obstetrics and Gynecology University of Illinois at Chicago 820 South Wood Street, M/C 808 Chicago, Illinois 60612
Email	acowett@uic.edu

Current Titles and Affiliation

2004-present	**Assistant Clinical Professor** Department of Obstetrics and Gynecology University of Illinois at Chicago College of Medicine
2006-present	**Assistant Director, Family Planning Fellowship** Department of Obstetrics and Gynecology University of Illinois at Chicago College of Medicine
2004-present	**Attending Physician** University of Illinois Medical Center at Chicago
2005-present	**Director, Center for Reproductive Health** University of Illinois Medical Center at Chicago

Education

1989-1993	**Bachelor of Science in Biology,** ***cum laude*** Duke University Durham, North Carolina
1994-1998	**Doctor of Medicine,** ***with honors*** University of Rochester School of Medicine and Dentistry Rochester, New York
1998-2002	**Residency Training in Obstetrics and Gynecology**

Department of Obstetrics and Gynecology
Northwestern University Feinberg School of Medicine
Chicago, Illinois

2002-2004 **Fellowship in Family Planning**
Department of Obstetrics and Gynecology
Northwestern University Feinberg School of Medicine
Chicago, Illinois

2002-2004 **Master in Public Health**
Northwestern University Program in Public Health
Chicago, Illinois

Honors and Awards

2009 Best Doctors in America® database by peer selection

2006 Certificate of Recognition in honor of extraordinary contribution to women's reproductive health in the state of Illinois
Illinois House of Representatives

2006 AOA Clinical Teaching Award
Alpha Omega Alpha

2005 APGO Excellence in Teaching Award
Association of Professors of Gynecology and Obstetrics

2002 Ralph A. Reis, MD Award. First Place, Best Paper and Presentation: Ultrasound evaluation of the endometrium following medical termination of pregnancy: a retrospective review
Annual Residents' Research Seminar, Northwestern University

2002 Family Planning Award for scholarship in the field of Family Planning and Contraception
Northwestern University Feinberg School of Medicine

2000 Berlex Award for excellence in teaching as a resident
Berlex Foundation

1998 Alpha Omega Alpha Honor Society
University of Rochester School of Medicine and Dentistry

1998 Trombetta Award for outstanding medical student

performance in Obstetrics and Gynecology
University of Rochester School of Medicine and Dentistry

1998 SRO Award for medical student contribution to community health
University of Rochester School of Medicine and Dentistry

1995-1996 Commendation for Outstanding Academic Performance in the Pre-clinical Medical School Curriculum
University of Rochester School of Medicine and Dentistry

Licensure and Certification

1998- present Licensed Physician and Surgeon, State of Illinois # 036-104263
2002- present DEA Registration

Board Certification

2007 Diplomate, American Board of Obstetrics and Gynecology

Academic Appointments

2004- present **Assistant Clinical Professor**
Department of Obstetrics and Gynecology
University of Illinois at Chicago College of Medicine
Chicago, Illinois

Teaching Responsibilities

Curriculum development

2008-2009 **Resident Training in Gynecologic Ultrasound**
Developed and implemented comprehensive training in Gynecologic ultrasound for the Obstetrics and Gynecology residents including didactics, course readings and hands on clinical training

2005 **Residency Training in Family Planning**
Developed and implemented Family Planning curriculum for

Obstetrics and Gynecology residents including didactics, course readings, clinical training and weekly journal club

Courses taught

2009 **Residency Training in Gynecologic Ultrasound**
Instruction of first and third year Obstetrics and Gynecology residents in weekly didactic sessions and supervision of hands on gynecologic ultrasound

2005- present **Residency Training in Family Planning**
Instruction of first and third year residents in the didactic and clinical portions of the Family Planning curriculum

Lecturing

2004- present **Resident Lecture Series**
Semiannual lectures to the Obstetrics and Gynecology residents
- Abnormal First Trimester Pregnancy
- Contraception

2004- present **Medical Student Lecture Series**
Given each rotation to students in the Obstetrics and Gynecology Third Year Clerkship
- Case Studies in Contraception

2005- present **Family Planning Policy and Practices, School of Public Health**
Biannual lecture to MPH candidates
- Second Trimester Pregnancy Termination

2005- present **Medical Students for Choice**
Annual lecture
- Birth Control: Dispelling Common Myths

2006- present **Essentials of Clinical Medicine**
Annual lecture in Second Year College of Medicine Curriculum
- Abnormal First Trimester Pregnancy

Administrative Responsibilities/Service

Department

2008- present **Chair, Departmental IRB Committee**
Organized systematic approach for departmental review of research proposals prior to submission to the university OPRS; oversee the ongoing review of proposals by department faculty members

University

2005- present **Faculty advisor**
Medical Students for Choice
University of Illinois at Chicago College of Medicine

2002-2004 **Faculty advisor**
Medical Students for Choice
Northwestern University Feinberg School of Medicine

Community/Public Service/International Service

2003 **Assessment Advisor**
JHPIEGO, Pathfinder joint project in Vietnam.
Pre-service Training in Reproductive Health: Foundation for replication and adaptation on a national scale in Vietnam

1993-1994 **Community organizer.**
Project *Otzma*, Volunteer Service Corps, Israel
Elementary and secondary school teacher of Hebrew, English, algebra and geometry to under-privileged and immigrant youth.

Society Memberships

2007-present Fellow, American College of Obstetricians and Gynecologists

1998-2006 Junior Fellow, American College of Obstetricians and Gynecologists

2007-present	Junior Fellow, Society of Family Planning
2003- present	Member, Association of Reproductive Health Professionals
2002- present	Member, National Abortion Federation

Editorial Activities

2002- present	**Reviewer** International Journal of Gynecology and Obstetrics
2004- present	**Reviewer** Obstetrics & Gynecology
2008- present	**Reviewer** Ultrasound in Obstetrics and Gynecology

Research

2005-2006	**Faculty advisor** Non-attendance at an Urban Family Planning Clinic
2006-2007	**Faculty advisor** Knowledge and Attitudes of Male Partners Regarding Contraception
2007- present	**PI/Faculty advisor** Administration of Ibuprofen Prior to IUD insertion
2007-2008	**PI/Faculty Advisor** Intrauterine device knowledge, attitudes and experience: a survey of Obstetrics and Gynecology residents
2007-2009	**Co-investigator** Interval tubal sterilization: procedure selection, outcomes, and body weight
2008- present	**PI/Faculty advisor** Provision of post partum contraception in women with chronic medical conditions
2009- present	**PI/faculty advisor** High dose pitocin and misoprostol versus misoprostol alone for treatment of retained placenta following induction of labor in the second trimester

Publications

Peer-reviewed articles

1 **Cowett AA**, Kopriva CJ and Chin N. Integrating community experience and medical practice: SRO as a vehicle to enhance BPSM. Journal of the Rochester Medical Center 1996; 8(1): 45-7.

2 **Cowett AA**, Farrag HM and Cowett RM. Hyperglycemia in the micropremie. Prenatal and Neonatal Medicine 1997; 2(4): 360-5.

3 **Cowett AA**, Cohen L, Lichtenberg ES and Stika C. Ultrasound evaluation of the endometrium following medical termination of pregnancy. Obstet Gynecol 2004;103(5):871-5.

4 **Cowett AA**, Golub R and Grobman WA. Cost-effectiveness of dilation and evacuation versus induction of labor for second trimester pregnancy termination. Am J Obstet Gynecol 2006;194:768-73.

5 **Cowett AA.** Contraceptive options for your obese patients. Contemporary Ob/Gyn 2007;52(3):52-7.

6 Hardman JL, **Cowett AA**. Misinformation about emergency contraception. Am J Health Syst Pharm 2007; 64(11): 1136.

7 Schwartzberg JG, **Cowett AA**, VanGeest J, Wolf MS. Communication techniques for patients with low health literacy: a survey of physicians, nurses and pharmacists. Am J Health Behav 2007;31 Suppl 1:S96-104.

Book chapters

1 **Cowett AA**, Lichtenberg ES. Pregnancy Loss and Termination. In AI Sokol, ER Sokol (eds) General Gynecology: The Requisites in Obstetrics and Gynecology, Mosby Inc 2007 Chapter 10 pages 225-256.

2 **Cowett AA**, Hardman J: Injectable and Implantable Methods of Contraception. Gynecology for the Primary Care Physician, Second Edition, Springer 2008 Chapter 15 pages 115-121.

Articles in progress

1 Cabiya M, **Cowett AA**, Harwood B. Intrauterine device knowledge, attitudes and experience: a survey of Obstetrics and Gynecology residents, submitted for publication.

Abstracts

Oral presentations

1 **Cowett AA**, Cohen L, Lichtenberg ES and Stika C. Ultrasound evaluation of the endometrium following medical termination of pregnancy: a retrospective review. National Abortion Federation Annual Meeting; Seattle, Washington, April 2003

Posters

1 Hammond C, **Cowett A,** Stika C. Training Obstetrics and Gynecology residents in manual vacuum aspiration technique. Association of Professors of Gynecology and Obstetrics Annual Meeting; Anaheim, California; March 2003

2 Cabiya M, **Cowett AA**, Harwood B. Knowledge, attitudes and experience with the intrauterine device among senior Obstetrics and Gynecology residents training in the United States. Association of Reproductive Health Professionals Annual Meeting; Washington, DC; September 2008.

3 Warden M, **Cowett AA,** Harwood B. Counseling, patient selection and provision of the intrauterine device: a survey of primary care providers. Association of Reproductive Health Professionals Annual Meeting; Washington, DC; September 2008.

4 Jain P, **Cowett AA**, Harwood B. Interval tubal sterilization: procedure selection, outcomes, and body weight. ACOG Annual Meeting; Chicago, IL; May 2009.

Invited presentations

1 **Antibiotic Prophylaxis for Elective and Spontaneous Abortion**
Department of Obstetrics and Gynecology Grand Rounds
Northwestern University Feinberg School of Medicine
Chicago, Illinois, January 2002

2 **Combined Oral Contraceptives**
Seminars in Reproductive Health

Ho Chi Minh City Medical Faculty
Ho Chi Minh City, Viet Nam, November 2003

3 **Combined Oral Contraceptives**
Seminars in Reproductive Health
Hai Phong Medical Faculty
Hai Phong, Viet Nam, November 2003

4 **Abortion Law in the US: Landmark Decisions & Clinical Implications**
Department of Obstetrics and Gynecology Grand Rounds
University of Illinois at Chicago College of Medicine
Chicago, Illinois, June 2005

5 **Second Trimester Abortion: Procedures, Providers and Politics.**
Department of Obstetrics and Gynecology Grand Rounds
Mt. Sinai Hospital, Chicago, Illinois, September 2005

6 **Birth Control: Dispelling Common Myths**
University of Illinois Medical Center at Chicago
Chicago, Illinois, March 2006

7 **Contraceptive Options for the Obese Patient**
Title X/Region V Family Planning Program
Chicago, Illinois, September 2007

8 **Complications of Second Trimester Pregnancy Termination**
National Abortion Federation Risk Management Seminar
Victoria, British Columbia, October 2007

9 **Faculty, ACOG Postgraduate Course: Office Based Gynecologic Procedures**, ACOG Annual Meeting
New Orleans, Louisiana May 2008

10 **Contraceptive Update**
Chicago Department of Pubic Health
Chicago, Illinois, January 2009

11 **Promoting Psychosocial Well-Being**
Fellowship in Family Planning
Psychosocial Aspects of Abortion Care Annual Workshop
San Francisco, California, April 2009

12 **Faculty, ACOG Postgraduate Course: Office Based Gynecologic Procedures**, ACOG Annual Meeting
Chicago, Illinois, May 2009

13 **Improving Outpatient Clinical Services**
Ryan Residency Training Program Annual Meeting
Chicago, Illinois, May 2009

14 **Post Abortion Care: Diagnosis and Management of Complications**
Mercy Hospital Grand Rounds

Chicago, Illinois, July 2009

15 **Abnormal Uterine Bleeding**
Chicago Department of Public Health
Chicago, Illinois, September 2009

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS

COUNTY DEPARTMENT — CHANCERY DIVISION

THE HOPE CLINIC FOR WOMEN LTD.; ALLISON COWETT, M.D., M.P.H.,	)	Case No.
Plaintiffs,	)	
v.	)	AFFIDAVIT OF NANCY E. ADLER, Ph.D., IN SUPPORT OF INJUNCTIVE RELIEF
BRENT ADAMS, Acting Secretary of the Illinois Department of Financial and Professional Regulation, in his official capacity; DANIEL BLUTHARDT, Director of the Division of Professional Regulation of the Illinois Department of Financial and Professional Regulation, in his official capacity; THE ILLINOIS STATE MEDICAL DISCIPLINARY BOARD,	)	
Defendants.	)	

AFFIDAVIT OF NANCY E. ADLER, Ph.D.

I, NANCY E. ADLER, Ph.D., testify under penalty of perjury that the following is true and correct:

1. I am currently a Professor of Medical Psychology and the Vice-Chair of the Department of Psychiatry at the University of California at San Francisco ("UCSF"). I am also the director of UCSF's Center for Health and Community, which brings together social behavioral and policy scientists to conduct research addressing a range of health problems including violence prevention, infertility, and work and health. In addition, I serve as the Program Director for the National Institute of Mental Health Training Program in "Psychology and Medicine" at UCSF, and as a Professor of Medical Psychology, teaching courses in research methodology and on the determinants of health. In the past, I have also taught social psychology and psychology of reproductive behavior. A copy of my curriculum vitae is attached hereto as Exhibit 1.

2. I have reviewed the Illinois Parental Notice of Abortion Act ("the Act"), and I submit this affidavit in support of injunctive relief against enforcement of the Act. Based on my research and expertise, the Act is entirely unjustified from a psychological standpoint and, indeed, would harm minors' psychological health.

Background

3. I earned my Doctorate and Master's degrees from Harvard University in 1973 and 1971, respectively, with a major in social psychology and a minor in personality/clinical psychology. I earned my undergraduate degree in psychology from Wellesley College in 1968. For more than twenty-five years, beginning with my dissertation on the psychological responses of women to abortion, I have conducted extensive research on psychological aspects of reproductive health.

4. I am a member of numerous professional organizations, as noted fully in my curriculum vitae. I am a Fellow of the American Psychological Association ("APA"), which is the major professional organization for psychology, representing both the clinical and academic sides of the field. I received a "Distinguished Scientific Award for the Application of Psychology," the highest scientific award given by the APA, in 2009, and a commendation for "Outstanding Contribution to Health Psychology" from the APA in 2004. In addition, I am a member of the Academy of Behavioral Medicine Research and the Society for Experimental Psychology, to which I was elected on the basis of my research. This year I was also elected to the American Academy of Arts and Sciences, which is considered a mark of distinction across all professions (Former Secretary of State Colin Powell, Secretary of Defense Robert Gates, and Bono, the lead singer of U2, were also elected to the Academy this year). I have also been elected to the Institute of Medicine of the National Academy of Sciences, which is considered one of the highest

honors in the medical profession. I am also a fellow of the American Psychological Society. I have also served as a consultant to the Federal Government's National Institute of Child Health and Human Development and completed a term as a member of the Advisory Committee to the Director of the National Institutes of Health..

5. My research brings together theoretical and applied interests. My theoretical interest in reproductive health has been in decision-making and testing theoretical models of decision-making from a social psychological standpoint. My applied research has focused on reproductive health, including analysis of the psychological responses of women after abortion and psychosocial contributors to the occurrence of unwanted pregnancy and sexually transmitted diseases.

6. As a result of my research interests and expertise, in 1988-89, I chaired an expert panel convened by the APA to review the existing literature relating to psychological responses to abortion. The APA convened the panel to determine whether any kind of definitive conclusion could be reached as to whether abortion was psychologically harmful for women. The six members on the panel, including myself, were invited to participate by the APA because, in the organization's opinion, we had conducted the highest quality research on abortion to date and/or had expertise in the relevant scientific issues related to the psychological effects of abortion.

7. I have conducted studies on the psychological effect of abortion on women, including one study specifically designed to systematically examine whether adolescents face an increased risk of adverse psychological consequences from having an abortion when compared with adult women. I have also engaged in several studies on adolescent decision-making in the context of reproductive health care. I have published articles setting forth my findings from these studies. A current, complete list of my publications is contained in my curriculum vitae. (All the

articles published in periodicals discussed herein, including my own, are peer reviewed.)

8. In addition, I am familiar with the scientific literature concerning both psychological responses after abortion and decision-making about reproductive health care, and have published several reviews of this literature. For example, in 1998, I, along with two colleagues, published a chapter entitled "Abortion Among Adolescents," which appeared in a book published by the American Psychological Association Books, entitled The New Civil War: The Psychology, Culture and Politics of Abortion (Linda J. Beckman et al., eds., 1998). Our chapter summarizes the findings from many studies relevant to adolescents' psychological sequelae after abortion, and adolescent decision-making about abortion.

9. It is from this perspective that I have reviewed the Act. As I understand it, the Act states that it is based in part on the hypotheses that "the medical, emotional, and psychological consequences of abortion are sometimes serious and long-lasting," and that "minors often lack the ability to make fully informed choices that consider both the immediate and long-range consequences." Act § 5. Based on my own empirical research and my thorough review of other research in the field, it is my firm opinion that these hypotheses are unsupportable. In fact, just the opposite is true. The best scientific evidence shows that for the vast majority of women, including adolescents, abortion poses no risk to their mental health. The research further demonstrates that minors considering abortion are as capable as adults of making an informed decision. Indeed, minors engage in the same kind of decision-making processes as adults, including weighing the costs and benefits of an abortion procedure as opposed to other options.

Psychological Responses After Abortion

10. As discussed above, underlying parental involvement legislation, such as the Act, is the assumption that abortion is likely to cause minors to experience adverse emotional and

psychological effects. The evidence, however, shows just the opposite. I have closely followed the scientific literature on the psychological consequences of abortion for women since the mid 1970's, when I published my first study on this subject. See Nancy E. Adler, Emotional Responses of Women Following Therapeutic Abortion, 45 American Journal of Orthopsychiatry 446 (1975). Both my own research, as well as my review of research others have done, indicates that the termination of an unwanted pregnancy rarely results in serious negative psychological effects. This is true for adolescents, as well as for adults: None of the well-conducted studies show that adolescents are at heightened risk of clinically significant adverse psychological consequences after an abortion.

11. The APA has conducted two comprehensive reviews of the scientific literature relating to psychological responses after abortion—the first in the late 1980s and the most recent in 2006—both of which belie the Illinois' Act's assertions. The first review took place in 1988-89, when I, along with several colleagues, was asked to conduct a comprehensive review of the scientific literature relating to psychological responses after abortion. We conducted this review at the request of the APA, which wanted a panel of experts to determine whether any kind of definitive conclusion could be reached as to whether abortion caused women to experience negative psychological effects. As discussed above, I served on and chaired this panel.

12. The APA convened this panel after U.S. Surgeon General C. Everett Koop was charged in 1987, at the request of President Ronald Reagan, to study postabortion psychological responses. As part of the study, Dr. Koop and his staff reviewed numerous articles, heard testimony on, among other things, methodological issues in research on the psychological sequelae of abortion, and met with a variety of groups and experts, including psychologists. See Nancy E. Adler et al., Psychological Factors in Abortion: A Review, 47 American Psychologist

1194, 1194-95 (1992). After 15 months of study, Dr. Koop did not issue a report; however, Dr. Koop ultimately testified before Congress that the development of significant psychological problems related to abortion is "minuscule from a public health perspective." Id. at 1202.

13. At the time our panel conducted our review, there were over 200 studies of psychological responses to abortion, but they varied dramatically in quality. With the goal of limiting the review to only studies that were scientifically rigorous, our panel considered only those studies that met three criteria: (1) they used a United States sample -- we imposed this requirement because we wanted to be able to generalize about women in the United States and cultural beliefs might affect the response; (2) they involved nonrestrictive legal abortion -- we excluded illegal abortions for which the psychological experience is quite different, and legal abortions performed prior to Roe v. Wade under the restriction that abortion could be performed only if continuing the pregnancy posed a threat to the woman's mental or physical health; and (3) they used an identifiable sample so that it could be replicated -- that is, the researchers had to use empirical techniques that could be subjected to some kind of statistical analysis (such as a questionnaire or standardized test, that could be replicated and evaluated independently, as opposed to, for example, a study that reported that women had been interviewed and the interviewer had reached certain conclusions based on his or her impressions). Twenty-one studies, including my 1975 study, met these criteria and were reviewed by the APA panel.

14. After reviewing the literature, we found that, for the vast majority of women having an elective first-trimester procedure, abortion poses no psychological hazard. Id. at 41. Instead, the predominant emotional responses to abortion were relief and happiness. Id.; see also Emotional Responses of Women Following Therapeutic Abortion at 453. We published our conclusions in the journal Science, the premier journal for all science, not limited to the field of

psychology. Nancy E. Adler et al., Psychological Responses After Abortion, 248 Science 41 (1990).

15. Several of the studies we reviewed had pre-abortion and post-abortion measures of psychological well-being. That is important because, as we noted in our review, women who come in for abortions are often already experiencing the stress and anxiety of dealing with an unwanted pregnancy. Therefore, a study of the psychological responses following abortion also picks up responses to the entire experience of having an unwanted pregnancy, making it difficult to separate any negative reaction from the abortion from any pre-existing negative feeling toward the unwanted pregnancy. By comparing both pre- and post- abortion measures, however, the researchers in each of these studies were able to show that the negative emotions decreased and the positive emotions increased after the abortion. For instance, one study of women's responses found significant decreases in anxiety and depression. Psychological Responses After Abortion at 41 (citing Larry Cohen and Susan Roth, Coping with Abortion, 10 Journal of Human Stress 140, 142 (1984)). Moreover, in each study, the great majority of women responded that they felt positively after the abortion.

16. Although our review revealed that the vast majority of women had positive responses to abortion, the research did find that some women had negative reactions. Our review yielded interesting conclusions on that score as well. Women who experienced negative responses were more likely to be women who were terminating wanted pregnancies, often because of medical problems; women who felt unsupported in their abortion decision; and women who had more conflicting feelings or were less sure of their decision beforehand. Id. at 43.

17. Thus, based on our comprehensive review of the literature, we concluded, in a report issued by the APA, that for the vast majority of women, abortion poses no psychological

hazard. Id. at 41.

18. Literature published in the past twenty years only reinforces this conclusion. See, e.g., APA, Task Force on Mental Health and Abortion, Report of the APA Task Force on Mental Health and Abortion (2008); Vignetta E. Charles, et al., Abortion and long-term mental health outcomes: a systematic review of the evidence, 78 Contraception 436-450 (2008); see also Psychological Factors in Abortion: A Review at 1202 (supplementing initial 1990 study conducted by APA panel); Nancy Felipe Russo & Kristin L. Zierk, Abortion, Childbearing, and Women's Well-Being, 23 Professional Psychology 269, 277-79 (1992).

19. In particular, the most recent APA review is consistent with that from 1989. In 2006, the Council of Representatives of the APA established a new Task Force on Mental Health and Abortion ("TFMHA"), which included scientific experts in the areas of stigma, stress and coping, interpersonal violence, methodology, women's health, and reproductive health, to update our 1988-1989 review. As with our report, the TFMHA assessed the existing literature, relying only on those studies that met certain core criteria. Report of the APA Task Force, at 21. The final report, issued in 2008, includes an analysis of much of the literature published since the last report, noting the sample size, comparison groups (where appropriate) primary outcomes, results, and limitations specific to each study.

20. The final report concluded, based on the most methodologically sound research, the following:

- "The best scientific evidence published indicates that among adult women who have an unplanned pregnancy the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy." Id. at 4.

- "In general, . . . the prevalence of mental health problems observed among women in the United States who had a single, legal, first-trimester abortion for non-therapeutic reasons was consistent with normative rates of comparable mental health problems in the United States." Id.

- While some women do experience sadness, grief, and feelings of loss following abortion, as well as clinically significant outcomes, such as depression or anxiety, there was "no evidence sufficient to support the claim that the observed association between abortion history and mental health problem was *caused* by the abortion *per se*, as opposed to other factors" (such as pre-existing mental health problems, or the termination of a wanted pregnancy). Indeed, the TFMHA identified many methodological problems inherent in studies that purport to find damaging effects of abortion on women's psychological health. Id. at 4, 90-92.

- Finally, the report identified several factors predictive of more negative psychological responses following abortion, including "perceptions of stigma, need for secrecy, and low or anticipated social support for the abortion decision; a prior history of mental health problems; personality factors such as low self esteem and use of avoidance and denial copying strategies; and characteristics of the particular pregnancy, including the extent to which the woman wanted and felt committed to it." Id. at 4.

21. Another systematic literature review published last year, which focused on post-1988 articles examining the long-term mental health effects of abortion, also confirms these longstanding findings. See Vignetta E. Charles, et al., Abortion and long-term mental health outcomes. The authors of this review separated the articles into two major categories: articles which included a comparison group of women who did not undergo abortions (analytical studies)

and articles without such a comparison group (descriptive studies). The distinction between analytical and descriptive studies—which was part of the APA assessment too—is an important one because the existence of a comparison group provides better evidence of potential causal relationships between abortion and mental health outcomes. Id. at 437.

22. As did the two APA literature reviews, this review concluded that the highest quality research consistently found few, if any, differences between the mental health of women who have abortions and their respective comparison groups. Id. at 448. For example, one study, which compared women who had abortions with women who delivered an unwanted first pregnancy, found that the women who had abortions were no more likely to be clinically depressed than the group that delivered the unwanted pregnancy. Similarly, another study that compared women who had abortions with women who carried their pregnancies to term found there was no greater risk of anxiety after abortion, despite the fact that the comparison group included women carrying *wanted* pregnancies. Id. at 440 (Table 2), 445-46. By contrast, it was again the studies with the most flawed methodology that found negative mental health consequences from abortion. Id. at 449. Thus, this review, like those discussed above, concluded that there is no evidence that abortion leads to long-term mental health problems. Id. at 449.

23. While there is clearly a significant body of scientific literature addressing post-abortion psychological sequelae among women, there are fewer studies that specifically examine the psychological response of adolescents to abortion. Nevertheless, my own research, as well as my review of the existing literature, supports the conclusion that minors are at no greater risk than legal adults of suffering significant adverse psychological consequences from having an abortion.

24. A study I conducted along with two colleagues, a professor in UCSF's Department of Pediatrics and a medical student, found no evidence that women under 18 are at greater risk of

suffering adverse psychological consequences from having an abortion than are women over 18. See Linda M. Pope, Nancy E. Adler, & Jeanne M. Tschann, Post-abortion psychological adjustment: Are minors at increased risk?, 29 Journal of Adolescent Health 2-11 (2001). We further found that adolescents who had abortions were at no greater risk for psychological distress than adolescents in the general population.

25. Our study is based on interviews with young women ages 14 to 21 at four different clinics in the San Francisco Bay Area at the time they were seeking counseling for an unwanted pregnancy. We chose our original subjects based on the following four criteria: (1) they had a positive pregnancy test; (2) they decided to terminate their pregnancy; (3) they were six to twelve gestational weeks pregnant; and (4) they spoke English. At the initial meeting, we measured variables that might be associated with adjustment, such as sociodemographic variables, depression, emotion ratings, feelings about the pregnancy, difficulty of decision, reproductive history, relationship with partner, and perceived pressure from partner and from parents. Id. at 3-4.

26. We then followed up with the young women four weeks later. We chose a four-week follow-up period because it is sufficiently long to provide a fairly stable response to what has happened, which is not likely to change too much over a long period of time, and it is short enough that you avoid losing contact with the minors. See, e.g., Camille Wortman & R.C. Silver, The Myths of Coping with Loss, 57 Journal of Consulting and Clinical Psychology 349 (1989). At the follow-up interview, we again gathered depression and emotion ratings from our participants. We also gave them several psychological tests, including the Spielberger State Anxiety Inventory, the Rosenberg Self-Esteem Scale, the Impact of Events Scale (which measures stress), and the Positive States of Mind Scale. We interviewed 96 subjects before the abortion.

Although we tried to re-interview all of the subjects, we were unable to contact some and others did not wish to be re-interviewed. As a result, we re-interviewed 63 of the 96. There was no difference in attrition between those under age 18 and those over age 18. Pope, et al., Post-abortion psychological adjustment, at 4-5.

27. After comparing the scores of women who were under age 18 with those who were aged 18 to 21, we found that there were no differences between the two groups with respect to their scores on any of the psychological measures. Moreover, on the two measures that were taken pre- and post-abortion (depression and negative emotions), all of the women in our study who had abortions (those under 18 as well as those over 18) showed significant decreases from beforehand to afterwards. Id. at 5-9.

28. In addition, we compared the psychological well-being of those who had abortions (we combined the results of those over 18 and those under 18 because there was no difference between the two groups) to the psychological well-being of adolescents in the general population. Our research showed that with respect to several standard psychological measures (e.g., depression, self-esteem, and positive states of mind) those who had abortions scored, in general, just as well if not better than adolescents in the general population. Id.

29. Nor does it appear that involving one's parents in the abortion decision is an important factor in determining the psychological consequences of abortion for minors. Indeed, we found no significant difference in psychological adjustment between those subjects who had told a parent and those who had not. Id. at 9-10; see also Laurie Schwab Zabin et al., To Whom Do Inner-City Minors Talk About Their Pregnancies? Adolescents' Communication With Parents and Parent Surrogates, 24 Fam. Plan. Persp. 148, 151 (1992).

30. Other studies I have reviewed reach similar conclusions, and the chapter I co-

authored in The New Civil War summarizes the findings from several of these studies. For example, one study followed over 300 adolescents who came for a pregnancy test and compared those who had a negative pregnancy test, those who had a positive pregnancy test and carried to term, and those who had a positive pregnancy test and terminated their pregnancy. When those adolescents were retested two years later, the study found that those who had terminated their pregnancy were just as healthy, if not healthier psychologically, than those who had either carried to term or had a negative pregnancy test. Laurie Schwab Zabin et al., When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy, 21 Fam. Plan. Persp. 248, 251-52 (1989); see also Nancy E. Adler, Emily J. Ozer, Jeanne Tschann, Abortion Among Adolescents, 58(3) American Psychologist 211-217 (2003).

31. Thus, based on my own research as well as the research of others, it is my professional opinion that minors do not face any increased risk, compared to legal adults, of suffering adverse psychological consequences from having an abortion.

Informed Consent

32. Nor can the Act be supported on the ground that minors are not competent to make informed decisions about abortion. Again, the evidence shows just the opposite. The scientific literature on minors' capacity to make decisions, which I have followed for many years, as well as my own research, supports the conclusion that young women making decisions about pregnancy are rational in their decision-making and are as capable as adults of making adequately informed decisions about abortion.

33. For instance, in 1986, the APA's Interdivisional Committee on Adolescent Abortion conducted a comprehensive review of the scientific literature on adolescent competency to make informed decisions about abortion. Based on this review, the Committee concluded that

"[t]here is now a substantial literature showing that adolescents do not differ from adults in their ability to understand and reason about treatment alternatives." Gary B. Melton & Anita J. Pliner, Adolescent Abortion: A Psycholegal Analysis, in Adolescent Abortion: Psychological and Legal Issues 1, 18 (Gary B. Melton ed., 1986).

34. Subsequent scientific literature confirms the APA's findings. Along with another colleague, I reviewed several of these studies for our chapter in The New Civil War. In a particularly relevant study, Bruce Ambuel and Julian Rappaport specifically analyzed assessments of legal competence to consent to abortion, and found that adolescents considering abortion were as competent to consent to abortion as adults. Bruce Ambuel & Julian Rappaport, Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion, 16 Law and Human Behavior 129, 144-45 (1992).

35. Ambuel and Rappaport compared adolescents and legal adults who were coming to a clinic for pregnancy tests, and interviewed them regarding their reasoning about what they were going to do about the pregnancy. The women were divided into three age groups: 15 years or younger, 16-17 years of age, and legal adults aged 18 to 21 years. The full group was also divided into two populations, those who reported at the time of their pregnancy test that they would consider abortion, and those who reported that they would not. Id. at 129. All participants were then measured in terms of several components of competency, including volition, global quality, consequences, and richness of considerations. Id. at 138.

36. The study found that adolescents considering abortion in each age group were as competent as legal adults. Id. at 144-45. The only group less competent than adults was the group of adolescents aged 15 and younger who did not consider having an abortion -- that group scored lower on volition and global quality. Id. at 145.

37. This finding is supported by other research that has found that adolescents who choose abortion are more oriented towards the future, better able to realize the problems posed by childbearing at a young age, and more likely to have higher educational goals than those who carry to term. See The New Civil War at 291-92. Thus, there is evidence that adolescents seeking abortions may be relatively more mature and more competent to make informed decisions than the average adolescent. Id. at 292.

38. For instance, one study of adolescent decision-making analyzed four groups of minors -- those minors who consistently used contraception and had never been pregnant; those minors who had had an abortion within the previous six months; currently pregnant minors; and teen mothers (women under age 18 who had had one birth). Robert W. Blum & Michael D. Resnick, Adolescent Sexual Decision-Making: Contraception, Pregnancy, Abortion, Motherhood, 11 Pediatric Annals 797, 801 (1982). The study found that minors seeking abortion were more capable than their peers of making an informed decision regarding their pregnancy. Compared with the other groups, minors who had abortions had the most sophisticated time perspective -- that is, the capacity to understand future consequences. Id. Minors who had abortions were also found to have the lowest demand for external approval and the most internalized locus of control (the extent to which one views herself as having control over her life). The teen mothers, in contrast, repeatedly expressed the belief that they had no control over anything in their lives, and that there was nothing they could do about having a baby. Id. at 802, 804.

39. The available research also refutes the presumption that minors fail to solicit sufficient input from adults in making their abortion decision. Absent a mandatory parental involvement law, studies consistently show that the majority of adolescents consult with their parents before having an abortion. Stanley K. Henshaw & Kathryn Kost, Parental Involvement in

Minors' Abortion Decisions, 24 Fam. Plan. Persp. 194, 199-200 & Table 3 (1992); To Whom Do Inner-City Minors Talk About Their Pregnancies? at 151. Those who don't consult with a parent often confer with another trusted adult. Parental Involvement in Minors' Abortion Decisions at 205.

40. Moreover, the younger the minor is, the more likely it is that she will involve her parents. Id. at 200 & Table 3; To Whom Do Inner-City Minors Talk About Their Pregnancies? at 152. In addition, adolescents who consider themselves less mature are more likely to confide in their parents. Mary S. Griffin-Carlson & Kathleen J. Mackin, Parental Consent: Factors Influencing Adolescent Disclosure Regarding Abortion, 28 Adolescence 1, 8 (1993). The fact that most minors seek guidance about their abortion decision from adults in their lives indicates that they have engaged in active reasoning and solicited sufficient input about their decision.

41. Other research, including my own, into minors' capacity to make specific kinds of decisions has reinforced my opinion that adolescents do not differ significantly from adults in their ability to make an informed decision about abortion and their reproductive health. In a study colleagues and I conducted in approximately 1990, we examined whether you could use one of the sociopsychological models, known as a "rational model of decision-making," to understand adolescents' contraceptive choice and behavior. The rational model of decision-making had been developed for application to adult populations, based in part on psychological theories and economic models of costs and benefits. Nancy E. Adler et al., Adolescent Contraceptive Behavior: An Assessment of Decision Processes, 116 Journal of Pediatrics 463 (1990). This research was funded by the National Institute of Health.

42. Under the "rational model of decision-making," for behavior to be "rational" means that:

(a) your intention to engage in a behavior should reflect your beliefs about the consequences of doing the behavior -- the risks and benefits of engaging in the behavior, and your perception of what important people want you to do and whether or not you want to do what they want you to do; and
(b) your intentions predict what you actually do. Id. at 464

43. We found that the "rational model of decision-making" was as applicable in understanding adolescents' behavior as it has been found to be in understanding the behavior of older persons -- both college students and adults generally. In other words, we found that adolescents did not differ from adults in their ability to make rational decisions about contraceptive choice and behavior. Id. at 464, 469-70.

44. Based on all of this research, it is my professional opinion that adolescents who are seeking abortions, as a group, are as competent as adult women in making informed decisions about terminating their pregnancies.

Conclusion

45. Thus, there is little evidence to support policies about abortion that differentiate between adolescents and adults on psychological grounds. Research does not support either the contention that adolescents who seek abortion are incapable of making reasoned decisions about abortion, or the assumption that adolescents are vulnerable to serious psychological harm as a result of abortion.

46. Indeed, I believe that the Act will have a harmful effect on minors. It will work to extend the period before resolution of an unwanted pregnancy -- the period research has shown to be the time of greatest distress; it will add to the secrecy surrounding the procedure; and it may push some minors to the second-trimester, which poses a risk of more negative psychological responses (for both minors and adults alike).

CERTIFICATION

Under penalties as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that she verily believes the same to be true.

Sept 30, 2009

Date

Nancy E Adler

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Education

B.A., Wellesley College, 1968 (Psychology, *summa cum laude*).

Ph.D., Harvard University, 1973 (Psychology); Advisor: Herbert Kelman, Ph.D.

Academic and Administrative Appointments

1998-present	Director, Center for Health and Community; University of California, San Francisco
1994-present	Vice-Chair, Department of Psychiatry; University of California, San Francisco
1991-present	Program Director, National Institute of Mental Health Training Program in "Psychology and Medicine"; University of California, San Francisco
1988-2001	Director, Health Psychology Program; University of California, San Francisco
1984-present	Professor of Medical Psychology, Departments of Psychiatry and Pediatrics; University of California, San Francisco
1994-1995	Senior Research Scientist in Psychology, Yale University
1977-1984	Associate Professor of Medical Psychology, Departments of Psychiatry and Pediatrics; University of California, San Francisco
1976-1977	Associate Professor of Psychology, University of California, Santa Cruz
1975	Visiting Assistant Research Psychologist, Institute of Personality Assessment and Research; University of California, Berkeley
1972-1976	Assistant Professor of Psychology, University of California, Santa Cruz

Professional Honors & Awards

1968	Wellesley College: *Summa Cum Laude*, Sigma Xi and Phi Beta Kappa
1968	Woodrow Wilson Fellow
1968-72	National Science Foundation Fellow
1974	University of California Regents Summer Fellowship
1977	Elected member, Society for Experimental Social Psychology

1979	Elected fellow, American Psychological Association, Division of Population and Environmental Psychology
1984	Society for Adolescent Medicine award for best research paper (with Millstein and Irwin)
1986	Elected fellow, American Psychological Association, Division of Health Psychology
1988	Elected member, Academy of Behavioral Medicine Research
1984-94	Core Group Scientist, Health Behavior Network, John D. and Catherine T. MacArthur Foundation
1991	Centennial Lecturer, Wellesley College, Wellesley, Mass.
1991	Superior Service Award, Division of Population and Environmental Psychology, American Psychological Association
1992	Elected fellow, Society for the Psychological Study of Social Issues, American Psychological Association
1994	Elected fellow, Society of Personality and Social Psychology, American Psychological Association
1994	Elected member, Institute of Medicine of the National Academy of Science
1994-96	Chair, SES and Health Planning Initiative, John D. and Catherine T. MacArthur Foundation
1995	Chancellor's Award for the Advancement of Women, University of California, San Francisco
1997	Robert Miller Memorial Lecturer, University of Pittsburgh
1997	Invited fellow, Center for Advanced Study in the Behavioral Sciences
1997	Elected fellow, American Psychological Society
1997-2006	Director, SES and Health Research Network, John D. and Catherine T. MacArthur Foundation
2002	George Sarlo Prize for Excellence in Teaching; Department of Psychiatry, University of California, San Francisco.
2002	National Associate of the National Academies, National Academies of Science
2004	Outstanding Contribution to Health Psychology, Division of Health Psychology, American Psychological Association.
2009	Distinguished Scientific Award for the Application of Psychology, American Psychological Association.
2009	Lifetime Achievement in Mentoring Award, University of California, San Francisco
2009	Elected to American Academy of Arts & Sciences

Grants

1981	"UC Health Psychology Conference," University of California Intercampus Opportunity Fund Grant
1983-85	"The Role of Psychosocial Factors in Preterm Labor," March of Dimes, Principal Investigator
1983-86	"Adolescent Decision-Making Regarding Contraceptive Use," National Institute of Child Health and Human Development, Principal Investigator
1983-88	"Determinants and Consequences of Health-Promoting and Disease-Preventing Behavior," John D. and Catherine T. MacArthur Foundation, Principal Investigator, UCSF "Node"
1988-91	"Predictors of Sexual Behavior in Adolescents," National Institute of Child Health and Human Development, Co-Investigator (Mary-Ann Shafer, Principal Investigator)
1988-92	"Conscious and Preconscious Motivation for Pregnancy Among Adolescent Females," National Institute of Child Health and Human Development, Principal Investigator (1992 supplement to study issues of self-report bias in adolescents)
1990-91	"Validity of Self-Reported Health Behaviors," John D. and Catherine T. MacArthur Foundation, Principal Investigator
1990-92	"Socioeconomic Status and Health," John D. and Catherine T. MacArthur Foundation, Principal Investigator

1990-93 "Pregnant Smokers: Prediction of Cessation and Relapse," Tobacco-Related Disease Research Program, Principal Investigator

1991-93 "Ethical Issues in Biotechnology Research in the Health Sciences," UC Systemwide Biotechnology and Research and Education Program, Co-Principal Investigator (Bernard Lo, Principal Investigator)

1991-96 "Psychology and Medicine: An Integrative Research Approach," National Institute of Mental Health, Principal Investigator

1992-93 "Health Behavior Change in Pregnancy and Postpartum," John D. and Catherine T. MacArthur Foundation, Principal Investigator

1992-97 "Marital Conflict and Adolescent Health Risk Behaviors," Bureau of Maternal and Child Health, Co-Investigator (Jeanne Tschann, Principal Investigator)

1992-03 "Interdisciplinary Adolescent Health Training Project," Maternal & Child Health, Core Faculty (Charles Irwin, Principal Investigator)

1994-96 "Planning Initiative on Socioeconomic Status and Health," John D. and Catherine T. MacArthur Foundation, Principal Investigator

1994-95 "Beliefs and Behavior: An Analysis of Adolescent Contraceptive Use," Kaiser Family Foundation, Principal Investigator

1994-96 "Sex and AIDS Methodology Survey: Minority Expansion," National Institutes of Health, Co-Principal Investigator (Joseph Catania, Principal Investigator)

1995-97 "Development of an Older Peer Health Education Program for Middle School Students," UCSF Pediatric Advisory Council, Co-Principal Investigator (Charles Irwin, Principal Investigator)

1995-99 "Perceived Risk for Sexually Transmitted Diseases," National Institutes of Health, Principal Investigator

1995-99 "Barrier Methods to Prevent Disease," National Institutes of Health, Key Investigator (Nancy Padian, Principal Investigator)

1995-00 "Behavioral Intervention Training," STD/HIV Prevention Training Centers, Centers for Disease Control, Principal Investigator

1996-99 "Risk Perception Biases in Adolescents and Adults," National Institute for Child Health and Human Development, Co-Investigator (Susan Millstein, Principal Investigator)

1996-00 "Adolescent Neighborhood Crowds: A Longitudinal Study," National Institute of Mental Health, Co-Investigator (Margaret Dolcini, Principal Investigator)

1996-00 "Psychology and Medicine: An Integrative Research Approach," National Institute of Mental Health, Principal Investigator

1997-01 "Research Network on Socioeconomic Status and Health," John D. and Catherine T. MacArthur Foundation, Principal Investigator

1998 "Socioeconomic Status, Work and Health," The California Endowment, Principal Investigator

1999-00 "Income Inequality, Work and Health of Californians," California Wellness Foundation, Co-Principal Investigator (Carol Somkin, Principal Investigator)

1999-04 "STD Risk Associated with Adolescents' Sexual Network," National Institute of Allergy and Infectious Diseases, Co-Principal Investigator, (Jonathan Ellen, Principal Investigator)

1999-05 Individual, Family and Societal Outcomes of Infertility," Program Project Grant, National Institute of Child Health and Human Development, Principal Investigator. Also Project PI, Psychological Consequences of Failure of Assisted Reproductive Technology

2000-04 "Development of a Curriculum on Culture and Behavior," The California Endowment, Principal Investigator

2000-05 "Promoting Effective Communication and Decision-Making for Diverse Populations," Agency for HealthCare Research and Quality, (A. Eugene Washington, Principal Investigator)

2001-05 "Center to Address Disparities in Children's Oral Health," NICDR (NIH), Co-Investigator, (Jane Weintraub, Principal Investigator)

2001-02 "Health & Society Scholars Program Planning Grant," Robert Wood Johnson Foundation, Principal Investigator

2001-06 "Psychology and Medicine: An Integrative Research Approach," National Institute of Mental Health, Principal Investigator

2002-09 Research Network on Socioeconomic Status & Health: Phase 2," John D. & Catherine T. MacArthur Foundation, Principal Investigator

2002-06 "Social Ordering and Mental/Physical Health in Children," NIH/NICHD, Co-Principal Investigator (Thomas Boyce, Principal Investigator)

2002-11 "Robert Wood Johnson Health and Society Scholars Program," Robert Wood Johnson Foundation, Principal Investigator

2003-07 "Educational Disparities in Diabetes Complications," Kaiser Foundation Research Institute, Co-Principal Investigator (Andrew Karter, Principal Investigator)

2005-10 "Integrating Social and Behavioral Sciences into Undergraduate Medical Education," National Institute of Health, Co-Principal Investigator (Jason Satterfield, Principal Investigator)

2006-11 "Psychology and Medicine: Translational Research on Stress, Behavior and Disease," National Institute of Mental Health, Principal Investigator

Publications

A. *Articles and Book Chapters*

Adler, N.E. (1973). Impact of prior sets given experimenters and subjects on the experimenter expectancy effect. *Sociometry, 36*(1), 113-126.

Adler, N.E., & Goleman, D. (1975). Goal-setting, T-group participation and self-rated change: An experimental study. *Journal of Applied Behavioral Science, 11*, 197-208.

Adler, N.E. (1975). Emotional responses of women following therapeutic abortion. *American Journal of Orthopsychiatry, 43*, 446-454.

Adler, N.E. (1976). Women students. In J. Katz & R. Hartnett (Eds.), *Scholars in the making.* Cambridge, Massachusetts: Ballinger.

Adler, N.E. (1976). Sample attrition in studies of psychosocial sequelae of abortion: How great a problem? *Journal of Applied Social Psychology, 6*, 240-259.

Adler, N.E. (1978). Women in graduate education: Some speculations on the future. *Signs: Journal of Women in Culture and Society, 3*, 912-915.

Adler, N.E. (1979). Abortion: A social psychological perspective. *Journal of Social Issues, 35*, 110-119.

Adler, N.E., & Milstein, A. S. (1979). Psychological perspectives on health system planning. In G. C. Stone, F. Cohen, N. E. Adler, & Associates, *Health psychology--a handbook* (pp. 395-418). San Francisco: Jossey-Bass.

Adler, N.E., & Stone, G. C. (1979). Social science perspectives on the health system. In G. C. Stone, F. Cohen, N. E. Adler, & Associates, *Health psychology--a handbook* (pp. 19-46). San Francisco: Jossey-Bass.

Adler, N.E., Cohen, F., & Stone, G. C. (1979). Themes and professional prospects in health psychology. In G. C. Stone, F. Cohen, N. E. Adler, & Associates, *Health psychology--a handbook* (pp. 573-590). San Francisco: Jossey-Bass.

Adler, N.E. (1979). Decision models in population research. *Journal of Population, 2*, 187-202.

Smetana, J., & **Adler, N.E.** (1979). Decision-making regarding abortion: A value X expectancy analysis. *Journal of Population, 2*, 348-357.

Adler, N.E. (1980). Psychosocial issues of therapeutic abortion. In D. D. Youngs & A. A. Ehrhardt (Eds.), *Psychosomatic obstetrics and gynecology.* New York: Appleton-Century & Crofts.

Smetana, J., & **Adler, N.E.** (1980). Fishbein's value X expectancy model: An examination of some assumptions. *Personality and Social Psychology Bulletin, 6*, 89-96.

Adler, N.E. (1981). Unwanted pregnancy in adolescent and adult women. *Professional Psychology, 12*, 56-66.

Millstein, S., **Adler, N.E.**, & Irwin, C. (1981). Adolescent conceptions of illness. *Journal of Pediatrics, 68*, 834-839.

Adler, N.E. (1982). The abortion experience: Social and psychological influences and after-effects. In H. Friedman & R. DiMatteo (Eds.), *Interpersonal issues in health care*. New York: Academic Press.

Adler, N.E., & Stone, G. C. (1983). Health psychology. In J. Ruffini (Ed.), *Advances in medical social science*, Volume I. New York: Gordon & Breach.

Adler, N.E., & Milstein, A. (1983). Evaluating the impact of physician peer review. *American Journal of Public Health, 73*, 1182-1185.

National Working Conference of Education and Training in Health Psychology. *Health Psychology*, 1983, 2 (whole volume - Supplement). Task Force Reports on Applied Research, Ethical Concerns, Relationship of Health Psychology to Other Areas of Psychology, and Predoctoral Education/Doctoral Training.

Shafer, M. A., Irwin, C. E., **Adler, N.E.**, & Crittenden, M. R. (1984). Self-concept in the DES daughter. *Obstetrics and Gynecology, 63*, 815-819.

Millstein, S., **Adler, N.E.**, & Irwin, C. (1984). Sources of anxiety about pelvic examinations among adolescent females. *Journal of Adolescent Health Care, 5*, 105-111.

Adler, N.E. (1984). Contraception and unwanted pregnancy. *Behavioral Medicine Update, 5*, 28-34.

Beck, A. L., **Adler, N.E.**, & Irwin, C. E. (1985). A comparison of nurses' attitudes toward hospitalized adolescents and adults. *Journal of Adolescent Health Care, 6*, 211-215.

Cohen, M., **Adler, N.E.**, Beck, A., & Irwin, C. (1986). Exploration of parental reactions to the onset of adolescence. *Journal of Adolescent Health Care, 7*, 101-106.

Adler, N.E., & Dolcini, P. (1986). Psychological issues in abortion in adolescents. In G. Melton (Ed.), *Adolescent abortion: Psychological and legal issues*, (pp. 74-95). University of Nebraska Press, Lincoln NE.

Adler, N.E., Taylor, S., & Wortman, C. (1987). Basic field research health psychology. In G. C. Stone, S. M. Weiss, J. D. Matarazzo, N. E. Miller, J. Rodin, C. D. Belar, M. J. Follick, & J. E. Singer (Eds.), *Health psychology: A discipline and a profession*. University of Chicago Press.

Interdivisional Committee on Adolescent Abortion. (1987). Adolescent abortion. *American Psychologist, 42*(1), 73-76.

Cohn, L. D., **Adler, N.E.**, Irwin, C. E., Millstein, S., Kegeles, S. M., & Stone, G. S. (1988). Body figure preferences in adolescent males and females. *Journal of Abnormal Psychology, 96*, 276-279.

Cohn, L. D., Millstein, S., Irwin, C. E., **Adler, N.E.**, Kegeles, S. M., Dolcini, P., & Stone, G. C. (1988). A comparison of two measures of egocentrism. *Journal of Personality Assessment, 52*, 212-222.

Kegeles, S. M., **Adler, N.E.**, & Irwin, C. E. (1988). Sexually active adolescents and condoms: Changes over one year in knowledge, attitudes and use. *American Journal of Public Health, 78*, 460-461.

Horowitz, M., **Adler, N.E.**, & Kegeles, S. (1988). A scale for measuring the occurrence of positive states of mind: A preliminary report. *Psychosomatic Medicine, 50*, 477-483.

Dolcini, P., Cohn, L., Adler, N., Millstein, S., Irwin, C., Kegeles, S. M., & Stone, G. (1989). Adolescent egocentrism and feelings of invulnerability: Are they related? *Journal of Early Adolescence, 9*, 409-418.

Kegeles, S. M., **Adler, N.E.**, & Irwin, C. E. (1989). Adolescents and condoms: Associations of beliefs with intentions to use. *American Journal of Diseases of Children, 143*, 911-915.

Adler, N.E., Keyes, S., & Robertson, P. (1990). Stresses of obstetrical procedures. In M. Johnson & L. Wallace (Eds.), *Stress and medical procedures*. Oxford, England: Oxford University Press.

Adler, N.E., Kegeles, S. M., Irwin, C. E., & Wibbelsman, C. (1990). Adolescent contraceptive behavior: An assessment of decision processes. *Journal of Pediatrics, 116*(3), 463-471.

Adler, N.E., David, H. P., Major, B. N., Roth, S.H., Russo, N.F., & Wyatt, G.E.. (1990). Psychological responses after abortion. *Science, 248*, 41-44. Reprinted in *Le Journal International de Médecine*, May 2, 1990, *158*, 23-27.

Adler, N.E. (1990). Health and self-care. In J. A. Graham & R. L. Wallace (Eds.), *Bodycare*. New York: Simon and Schuster.

Adler, N.E., Kegeles, S. M., & Irwin, C. E. (1990). The utility of multiple strategies for understanding complex behaviors. *American Journal of Public Health, 80*, 1180-1182.

Adler, N.E., Keyes, S., & Robertson, P. (1991). Psychological issues in new reproductive technologies: Pregnancy-inducing technology and diagnostic screening. In J. Rodin & A. Collins (Eds.), *Reproductive technologies: Multidisciplinary perspectives*. New York: Erlbaum.

Adler, N.E., Kegeles, S. M., & Genevro, J. L. (1992). Risk-taking and health. In F. Yates (Ed.), *Risk taking behavior*. West Sussex, England: John Wiley and Sons.

Cohn, L. & **Adler, N.E.** (1992). Female and male perceptions of ideal body shapes: Distorted views among Caucasian college students. *Psychology of Women Quarterly, 16*, 69-79.

Millstein, S. G., Irwin, C. E., **Adler, N.E.**, Cohn, L. D., Kegeles, S. M., & Dolcini, M. M. (1992). Health-risk behaviors and health concerns among young adolescents. *Pediatrics, 3*, 422-428.

Adler, N.E. (1992). Abortion: A case of crisis and loss? An examination of empirical evidence. In L. Montada, S. H. Filipp & M. J. Lerner (Eds.), *Life crises and experiences of loss in adulthood.* New York: Erlbaum.

Adler, N.E. (1992). Unwanted pregnancy and abortion: Definitional and research issues. *Journal of Social Issues, 48*(3), 19-35.

Ammerman, S. D., Perelli, R., **Adler, N.E.** & Irwin, C. E. (1992). Do adolescents understand what physicians are saying about sexuality and health? *Clinical Pediatrics, 31*(10), 590-595.

Adler, N.E., David, H. P., Major, B. N., Roth, S. H., Russo, N. F. & Wyatt, G.E. (1992). Psychological factors in abortion: A review. *American Psychologist, 47*(10), 1194-1204.
Reprinted in Davidson, J. K., & Moore, N. B. (Eds.) (2001). *Speaking of sexuality: Interdisciplinary readings*. Los Angeles: Roxbury Publishing Co.

Adler, N.E. & Tschann, J. M. (1993). The abortion debate: Psychological issues in adult women and adolescents. In S. Matteo (Ed.), *American women in the 90's: Today's critical issues* (pp.193-212). Boston: Northeastern University Press.

Adler, N.E. & Tschann, J. M. (1993). Conscious and preconscious motivation for pregnancy among female adolescents. In A. Lawson & D. Rhode (Eds.), *The politics of pregnancy: Adolescent sexuality and public policy* (pp. 144-158). New Haven: Yale University.

Adler, N.E., Boyce, W.T., Chesney, M., Folkman, S. & Syme, L. (1993). Socioeconomic inequalities in health: No easy solution. *JAMA, 269*(24), 3140-3145.

Adler, N.E. & Ozer, E. J. (1993). Mentoring strategies for meeting the challenges of academic medicine. *Journal for Minority Medical Students, 6*(1), BB11-26.

Adler, N.E. & Matthews, K. (1994). Health Psychology: Why do some people get sick and some stay well? *Annual Review of Psychology, 45*, 229-59.

Adler, N.E., Boyce, W. T., Chesney, M., Cohen, S., Folkman, S., Kahn, R., & Syme, S.L. (1994). Socioeconomic status and health: The challenge of the gradient. *American Psychologist, 49*. 15-24.
Reprinted in Mann, J. M., Gruskin, S., Grodin, M. A., & Annas, G. J. (1999). *Health and human rights: A reader*. New York: Routledge.

Tschann, J. M., **Adler, N.E.**, Irwin, Jr., C. E., Millstein, S. G., Turner, R. A., & Kegeles, S. M. (1994). Initiation of substance use in early adolescence: The roles of pubertal timing and emotional distress. *Health Psychology, 13*(4), 326-333.

Lieu, T. A., Black, S. B., Ray, P., Chellino, M., Shinefield, H. R., & **Adler, N.E.** (1994). Risk factors for delayed immunization among children in a health maintenance organization. *American Journal of Public Health, 84*(10), 1621-1625.

Dolcini, M. M. & **Adler, N.E.** (1994). Perceived competencies, peer group affiliation, and risk behavior among early adolescents. *Health Psychology, 13*(6), 496-506.

Adler, N.E. (1995). Socioeconomic status and health: Do we know what explains the association? *Advances: The Journal of Mind-Body Health, 11*(3), 6-9.

Moore, P. J., **Adler, N.E.**, & Kegeles, S. M. (1996). Adolescents and the contraceptive pill: The impact of beliefs on intentions and use. *Obstetrics and Gynecology, 88*(3), 48-56.

Coriell, M. & **Adler, N.E.** (1996). Socioeconomic status and women's health: How do we measure SES among women? *Women's Health, 2*(3), 141-156.

Moore, P. J., Turner, R. A., Park, C. L., & **Adler, N.E.** (1996). The impact of behavior and addiction on psychological models of cigarette and alcohol use during pregnancy. *Addictive Behaviors, 21*(5), 645-658.

Adler, N.E. & Rosengard, C. (1996). Adolescent contraceptive behavior: Raging hormones or rational decision-making? In S. Oskamp (Ed.), *Safer sex today: Understanding and preventing HIV risk behavior* (pp. 31-56). Thousand Oaks, CA: Sage.

Dolcini, M. M., **Adler, N.E.** & Ginsberg, D. (1996). Factors influencing agreement between self-reports and biological measures of smoking among adolescents. *Journal of Research on Adolescence, 6* (4), 515-542.

Speier, P. L., Mélèse-d'Hospital, I. A., Tschann, J. M., Moore, P. J., & **Adler, N.E.** (1997). Predicting contraceptive vigilance in adolescent females: A projective method for assessing ego development. *Journal of Adolescent Health, 20*, 14-19.

Adler, N.E. & Coriell, M. (1997). Socioeconomic status and women's health. In S. J. Gallant, G. P. Keita, & R. Royak-Schaler (Eds.), *Health care for women: Psychological, social, and behavioral influences*, (pp. 11-23). Washington, DC: American Psychological Association Press.

Weiss, A. H., Fortinsky, R. H., Laughlin, J., Lo, B., **Adler, N.E.**, Mudge, C. & Dimand, R. J. (1997). Parental consent for pediatric cadaveric organ donation. *Transplantation Proceedings, 29*,1896-1901.

Adler, N.E., Moore, P., & Tschann, J. M. (1997). Planning skills in adolescence: The case of contraceptive use and non-use. In S.L. Friedman & E. K. Scholnick (Eds.), *The developmental psychology of planning. Why, how, and when do we plan?* (pp. 321-336). Mahwah, NJ: Erlbaum.

Tschann, J. M., & **Adler, N.E.** (1997). Sexual self-acceptance, communication with partner, and contraceptive use among adolescent females: A longitudinal study. *Journal of Research on Adolescence, 7*, 413-430.

Park, C. L., Moore, P. J., Turner, R. A., & **Adler, N.E.** (1997). The roles of constructive thinking and optimism in psychological and behavioral adjustment during pregnancy. *Journal of Personality and Social Psychology, 73*, 584-592.

Adler, N.E. & Smith, L. B. (1998). Psychosocial issues of abortion. In E. Blechman & K. Brownell (Eds.), *Behavioral medicine for women: A comprehensive handbook* (pp.510-514). New York: Guilford.

Lieu, T. A., Black, S. B., Takahashi, H., Ray, P., Capra, A. M., Shinefield, H.R., & **Adler, N.E.** (1998). Varicella serology among school age children with a negative or uncertain history of chickenpox. *The Pediatric Infectious Disease Journal, 17*, 120-125.

Brown, H. D. & **Adler, N.E.** (1998). Socioeconomic status. *Encyclopedia of Mental Health* (pp. 555-561). San Diego: Academic Press.

Adler, N.E., Horowitz, M., Garcia, A., & Moyer, A. (1998). Additional validation of a scale to assess positive states of mind. *Psychosomatic Medicine, 60*, 26-32.

Seeman, T. E. & **Adler, N.E.** (1998). Older Americans: Who will they be? *National Forum, 78* (2), 22-25.

Fares, S. L. & Adler. N. E. (1998). Top-of-the-head descriptions of baby and self: Links to reported health behaviors and social context in early pregnancy. *Journal of Social and Personal Relationships, 15*(4), 555-564.

Adler, N.E., Smith, L. B., & Tschann, J. M. (1998). Abortion among adolescents. In L.J. Beckman & S.M. Harvey (Eds.), *The new civil war: The psychology, culture, and politics of abortion* (pp. 285-298). Washington, D.C.: American Psychological Association Books.

Ostrove, J. M., & **Adler, N.E.** (1998). Socioeconomic status and health. *Current Opinion in Psychiatry, 11*, 649-653.

Ostrove, J. M. & **Adler, N.E.** (1998). The relationship of socioeconomic status, labor force participation and health among men and women. *Journal of Health Psychology, 3*(5), 451-463.

Smith, L. B., **Adler, N.E.**, & Tschann, J. M. (1999). Underreporting sensitive behaviors: The case of young women's willingness to report abortion. *Health Psychology, 18*(1), 37-43.

Rosenberg, M.D., Gurvey, J.E., **Adler, N.E.**, Dunlop, M.B.V., & Ellen, J.M. (1999). Concurrent sex partners and risk for sexually transmitted diseases among adolescents. *Sexually Transmitted Diseases, 26*(4), 208-212.

Ostrove, J. M., Feldman, P., & **Adler, N.E.** (1999). Relations among socioeconomic status indicators and health for African Americans and whites. *Journal of Health Psychology, 4*(4), 451-63.

Canin, L., Dolcini, M.M., & **Adler, N.E.** (1999). Barriers and facilitators to HIV/STD behavior change: Intrapersonal and relationship-based factors. *Review of General Psychology, 3*(4), 338-371.

Adler, N.E. & Ostrove, J.M. (1999). SES and health: What we know and what we don't. *Annals of the New York Academy of Sciences, 896*, 3-15.

Adler, N.E., Epel, E. Castellazzo, G., & Ickovics, J. (2000). Relationship of subjective and objective social status with psychological and physiological functioning: Preliminary data in healthy white women. *Health Psychology, 19*(6), 586-592.

Ostrove, J.M., **Adler, N.E.**, Kuppermann, M., & Washington, A. E. (2000). Objective and subjective assessments of socioeconomic status and their relationship to self-rated health in an ethnically diverse sample of pregnant women. *Health Psychology, 19*(6), 613-618.

Moore, P.J., **Adler, N.E.**, & Robertson, P.A. (2000). Medical malpractice: The effects of doctor-patient relations on medical patient perceptions and malpractice intentions. *Western Journal of Medicine, 173*, 244-250.

Adler, N.E. (2001). A consideration of multiple pathways from socioeconomic status to health. In J. A. Auerbach & B.K. Krimgold (Eds.), *Income, socioeconomic status, and health: Exploring the relationships* (pp. 56-66). Washington, D.C.: National Policy Association, Academy for Health Services Research and Health Policy.

Coriell, M. & **Adler, N.E.** (2001) Social ordering and health. In B.S. McEwen (Ed.). *Handbook of physiology Vol. IV: Coping with the environment: Neural and endocrine mechanisms* (pp. 533-546). New York: Oxford University Press.

Halpern-Felsher, B.L., Millstein, S.G., Ellen, J.M., **Adler, N.E.**, Tschann, J.M., & Biehl, M.C. (2001). The role of behavioral experience in judging risks. *Health Psychology, 20*(2), 120-126.

Pope, L.M., **Adler, N.E.**, & Tschann, J.M. (2001). Post-abortion psychological adjustment: Are minors at increased risk? *Journal of Adolescent Health, 29*, 2-11.

Goodman, E., **Adler, N.E.**, Kawachi, I., Frazier, A.L., Huang, B., & Colditz, G.A. (2001). Adolescents' perceptions of social standing: Development and evaluation of a new indicator. *Pediatrics, 108*(2) Retrieved August 30, 2001, from http://www.pediatrics.org/cgi/content/full/108/2/e31.

Rosengard, C., Ellen, J.M., **Adler, N.E.**, Gurvey, J.E., Dunlop, M.B.V., Tschann, J.M., & Millstein, S.G. (2001). Protective role of health values in adolescents' future intentions to use condoms. *Journal of Adolescent Health, 29*(3), 200-207.

Ott, M.A., **Adler, N.E.**, Millstein, S.G., Tschann, J.M., & Ellen, J.M. (2002). The trade-off between hormonal contraceptives and condoms among adolescents. *Perspectives on Sexual and Reproductive Health, 34*(1), 6-14.

Adler, N.E. & Newman, K. (2002). Socioeconomic disparities in health: Pathways and policies. *Health Affairs, 21*(2), 60-76.

Moore, P.J., **Adler, N.E.**, Williams, D.R., & Jackson, J.S. (2002). Socioeconomic status and health: The role of sleep. *Psychosomatic Medicine, 64*, 337-344.

Ellen, J.M., **Adler, N.E.**, Gurvey, J.E., Dunlop, M.B.V., Millstein, S.G., & Tschann, J.M. (2002). Improving predictions of condom behavioral intentions with partner-specific measures of risk perception. *Journal of Applied Social Psychology, 32*, 648-663.

Tschann, J.M., **Adler, N.E.**, Millstein, S.G., Gurvey, J.E., & Ellen, J.M. (2002). Relative power between sexual partners and condom use among adolescents. *Journal of Adolescent Health, 31*, 17-25.

Ellen, J.M., **Adler, N.E.**, Gurvey, J.E., Millstein, S.G., & Tschann, J. (2002). Adolescent condom use and perceptions of risk for sexually transmitted diseases: A prospective study. *Sexually Transmitted Diseases, 29*(12), 756-762.

Singh-Manoux, A., **Adler, N.E.**, & Marmot, M.G. (2003). Subjective social status: Its determinants and its association with measures of ill-health in the Whitehall II study. *Social Science and Medicine, 56*, 1321-1333.

Milstein, A., & **Adler, N.E.** (2003). Out of sight, out of mind: Why doesn't widespread clinical quality failure command our urgent attention? *Health Affairs, 22*(2), 119-127.

Adler, N.E. (2003). Community preventive services: Do we know what we need to know to improve health and reduce disparities? *American Journal of Preventive Medicine, 24*(3S), 10-11.

Adler, N.E., Ozer, E., & Tschann, J. (2003). Abortion among adolescents. *American Psychologist, 58*(3), 211-217.

Adler, N.E. (2003). Looking beyond the borders of the health sector: The socioeconomic determinants of health. In E.R. Rubin & S.L. Schappert (Eds.), *Meeting health needs in the 21st century* (pp. 14-27). Washington, DC: Association of Academic Health Centers.

Goodman, E., **Adler, N.E.**, Daniels, S.R., Morrison, J.A., Slap, G.B., & Dolan, L.M. (2003). Impact of objective and subjective social status on obesity in a biracial cohort of adolescents. *Obesity Research, 11*, 1018-1026.

Adler, N.E., & Snibbe, A.C. (2003) The role of psychosocial processes in explaining the gradient between socioeconomic status and health. *Current Directions in Psychological Science, 12*, 119-123.

Dolcini, M.M., **Adler, N.E.**, Lee, P., & Bauman, K.E. (2003). An assessment of the validity of adolescent self-reporting smoking using three biological indicators. *Nicotine and Tobacco Research, 5*(4), 473-483.

Park, C.L. & **Adler, N.E.** (2003). Coping style as a predictor of health and well-being across the first year of medical school. *Health Psychology, 22*(6), 627-631.

Satterfield, J.M., Mitteness, L.S., Tervalon, M., & **Adler, N.E.** (2004). Integrating the social and behavioral sciences in an undergraduate medical curriculum: The UCSF Essential Core. *Academic Medicine, 79*(1), 6-15.

Adler, N.E. (2004). Rigor *and* vigor: Spanning basic and applied research. In A.H. Eagly, R.M. Baron, & V.L. Hamilton (Eds.), *The social psychology of group identity and conflict: Theory, application, and practice* (pp. 83-96). Washington, DC: APA Books.

Adler, N.E. (2004). Socioeconomic status and health. In N.B. Anderson (Ed.). *Encyclopedia of Health and Behavior* (pp. 768-770). Thousand Oaks, CA: Sage Publications.

Rosengard, C., **Adler, N.E.**, Millstein, S.G., Gurvey, J.E., & Ellen, J.M. (2004). Perceived STD risk, relationship, and health values in adolescents' delaying sexual intercourse with new partners. *Sexually Transmitted Infections, 80*, 130-137.

Operario, D., **Adler, N.E.**, & Williams, D.R. (2004). Subjective social status: Reliability and predictive utility for global health. *Psychology and Health, 19*(2), 237-246.

Moore, P.J., Sickel, A.E., Malat, J., Williams, D., Jackson, J.S., & **Adler, N.E.** (2004). Psychosocial factors in medical and psychological treatment avoidance: The role of the doctor-patient relationship. *Journal of Health Psychology, 9*(3), 421-433.

Milstein, A. & **Adler, N.E.** (2004). Grounding consumer-driven health care in social science research. In R.E. Herzlinger (Ed.). *Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers* (pp. 454-457). San Francisco, CA: Jossey-Bass.

Altschuler, A., Somkin, C.P., & **Adler, N.E.** (2004). Local services and amenities, neighborhood social capital, and health. *Social Science and Medicine, 59*(6), 1219-1229.

Adler, N.E. (2004). Socioeconomic status and health. In A.J Christensen, R. Martin , & J.M. Smyth (Eds.), *Encyclopedia of Health Psychology*. Norwell, MA: Kluwer Academic Publishers.

Epel, E.S., Blackburn, E.H., Lin, J., Dhabhar, F.S., **Adler, N.E.**, Morrow, J.D., & Cawthon, R.M. (2004). Accelerated telomere shortening in response to life stress. *Proceedings of the National Academy of Sciences, 101* (49), 17312-17315.

Rosengard, C., Phipps, M.G., **Adler, N.E.**, & Ellen, J.M. (2004). Adolescent pregnancy intentions and pregnancy outcomes: A longitudinal examination. *Journal of Adolescent Health, 35*, 453-461.

Kopp, M., Skrabski, Á., Réthelyi, J., Kawachi, I., & **Adler, N.E.** (2004). Self-rated health, subjective social status and middle-aged mortality in a changing society. *Behavioral Medicine, 30*, 65-70.

Bettinger, J.A., Celentano, D.D., Curriero, F.C., **Adler, N.E.**, Millstein, S.G., & Ellen, J.M. (2004). Does parental involvement predict incident sexually transmitted diseases in female adolescents? *Archives of Pediatrics and Adolescent Medicine, 158*, 666-670.

Jennings, J., Glass, B., Parham, P., **Adler, N.E.**, & Ellen, J.M. (2004). Sex partner concurrency geographic context and adolescent sexually transmitted infections. *Sexually Transmitted Diseases, 31*, 733-739.

Bettinger, J.A., **Adler, N.E.**, Curriero, F.C., & Ellen, J.M. (2004). Risk perceptions, condom use and sexually transmitted diseases among females according to social network position. *Sexually Transmitted Diseases 31*(9), 575-579.

Goodman, E., McEwen, B. S., Huang, B., Dolan, L. M., & **Adler, N.E.** (2005). Social inequalities in biomarkers of cardiovascular risk in adolescence. *Psychosomatic Medicine, 67*, 9-15.

Brindis, C.D., Loo, V.S., **Adler, N.E.**, Bolan, G.A., & Wasserheit, J.N. (2005). Service integration and teen friendliness in practice: A program assessment of sexual and reproductive health services for adolescents. *Journal of Adolescent Health, 37(2)*, 155-162.

Hu, P., **Adler, N.E.**, Goldman, N., Weinstein, M., & Seeman, T.E. (2005). Relationship between subjective social status and measures of health in older Taiwanese. *The Journal of the American Geriatrics Society, 53*, 483-488.

Burke, H.M., Fernald, L.C., Gertler, P.J., & **Adler, N.E.** (2005). Depressive symptoms are associated with blunted cortisol stress responses in very low-income women. *Psychosomatic Medicine, 67*(2), 211-216.

Kopp, M., Skrabski, A., Kawachi, I., & **Adler, N.E.** (2005). Low socioeconomic status of the opposite sex is a risk factor for middle aged mortality. *Journal of Epidemiology and Community Health, 59*, 675-678.

Sieverding, J.A., **Adler, N.E.**, & Ellen, J.M. (2005). The influence of parental monitoring on adolescent sexual initiation. *Archives of Pediatrics and Adolescent Medicine, 159*, 724-729.

Rosengard, C., **Adler, N.E.**, Gurvey, J.E., & Ellen, J.M. (2005). Adolescent partner-type experience: Psychosocial and behavioral differences. *Perspectives on Sexual and Reproductive Health, 37*(3), 141-147.

Singh-Manoux, A., Marmot, M.G., & **Adler, N.E.** (2005). Does subjective social status predict health and change in health status better than objective status? *Psychosomatic Medicine, 67*, 855-861.

Goodman, E., McEwen, B.S., Dolan, L.M., Schafer-Kalkhoff, T., & **Adler, N.E.** (2005). Social disadvantage and adolescent stress. *Journal of Adolescent Health, 37*, 484-492.

Rosengard, C., Phipps, M.G., **Adler, N.E.**, & Ellen, J. M. (2005). Psychosocial correlates of adolescent males' pregnancy intention. *Pediatrics, 116*(3), 414-419.

Gurvey, J.E., **Adler, N.E.**, & Ellen, J.M. (2005). Factors associated with self-risk perception for sexually transmitted diseases among adolescents. *Sexually Transmitted Diseases, 32*(12), 742-744.

Adler, N.E. (2006). Overview of health disparities. In G.E. Thompson, F. Mitchell & M. Williams (Eds.), *Examining the health disparities research plan of the National Institutes of Health: Unfinished business* (pp 129-188). Washington: National Academic Press.

Epel, E.S., Lin, J., Wilhelm, F.H., Wolkowitz, O.M., Cawthon, R., **Adler, N.E.**, Dolbier, C., Mendes, W.B., & Blackburn, E.H. (2006). Cell aging in relation to stress arousal and cardiovascular disease risk factors. *Psychoneuroendocrinology, 31*, 277-287.

Adler, N.E. (2006). When one's main effect is another's error: Material vs. psychosocial explanations of health disparities. *Social Science and Medicine, 63*, 846-850.

Schillinger, D., Barton, L.R., Karter, A.J., Wang, F., & **Adler, N.E.** (2006). Does literacy mediate the relationship between education and health outcomes? A study of low-income population with diabetes. *Public Health Reports, 121*, 245-254.

Lenoir, C.D., **Adler, N.E.**, Borzekowski, D.L.G., Tschann, J.M., & Ellen, J.M. (2006). What you don't know can hurt you: Perceptions of sex-partner concurrency and partner-reported behavior. *Journal of Adolescent Health, 38*, 179-185.

Friedman, H.S. & **Adler, N.E.** (2007). The history and background of Health Psychology. In H.S. Friedman & R.C. Silver (Eds.), *Foundations of Health Psychology* (pp 3-18). New York: Oxford University Press.

Grumbach, K., Braveman, P., **Adler, N.E.**, & Bindman, A.B. (2007). Vulnerable populations and health disparities: An overview. In T. King, M. Wheeler, A. Bindman, A. Fernandez, K. Grumbach, D. Schillinger, & T. Villela (Eds.), *Medical management of vulnerable and underserved patients: Principles, practice and populations* (pp 3-11). New York: McGraw-Hill.

Janicki-Deverts, D., Cohen, S., **Adler, N.E.**, Schwartz, J.E., Matthews, K.A., & Seeman, T. (2007). Socioeconomic status is related to urinary catecholamines in the Coronary Artery Risk Development in Young Adults (CARDIA) study. *Psychosomatic Medicine, 69*, 514-520.

Goodman, E., Huang, B., Schafer-Kalkhoff, T., & **Adler, N.E.** (2007). Perceived socioeconomic status: A new type of identity which influences adolescents' self rated health. *Journal of Adolescent Health*, 41, 479-487.

Goodman, E. & **Adler, N.E.** (2007). *The biology of social justice: Linking social inequalities and health in adolescence*. In C. Wainryb, J.G. Smetana, & E. Turiel (Eds.), *Social development, social inequalities, and social justice* (pp 109-130). New York: Lawrence Erlbaum Associates.

Adler, N.E. & Rehkopf, D.H. (2008). U.S. Disparities in health: Descriptions, causes, and mechanisms. *Annual Review of Public Health, 29*, 235-252.

Adler, N.E., Singh-Manoux, A., Schwartz, J., Stewart, J., Matthews, K., & Marmot, M.G. (2008). Social status and health: A comparison of British civil servants in Whitehall II with European- and African-Americans in CARDIA. *Social Science & Medicine, 66*, 1034-1045.

Cohen, S., Alper, C.M., Doyle, W.J., **Adler, N.E.**, Treanor, J.J., & Turner, R.B. (2008). Objective and subjective socioeconomic status and susceptibility to the common cold. *Health Psychology, 27*, 268-274.

Brown, R.A., **Adler, N.E.**, Worthman, C.M., Copeland, W.E., Costello, E.J., & Angold, A. (2008). Cultural and community determinants of subjective social status among Cherokee and White youth. *Ethnicity and Health, 13*(4), 289-303.

Moffet, H.H., **Adler, N.E.**, Schillinger, D., Ahmed, A.T., Laraia, B., Selby, J.V., Neugebauer, R., Liu, J.Y., Parker, M.M., Warton, M., & Karter, A.J. (2008). Cohort Profile: The Diabetes Study of Northern California (DISTANCE)—objectives and design of a survey follow-up study of social health disparities in a managed care population. *International Journal of Epidemiology,* Advance Access published March 7, 2008, doi:10.1093/ije/dyn040.

Leu, J., Yen, I.H., Gansky, S.A., Walton, E., **Adler, N.E.**, & Takeuchi, D.T. (2008). The association between subjective social status and mental health among Asian immigrants: Investigating the influence of age at immigration. *Social Science & Medicine, 66*(5), 1152-1164.

Fernald, L.C.H. & **Adler, N.E.** (2008). Blood pressure and socio-economic status in low-income women in Mexico: a reverse gradient? *Journal of Epidemiology & Community Health, 62,*(5).

Obradović, J., Bush, N.R., Stamperdahl, J., **Adler, N.E.,** Boyce, W.T. (in press). Biological sensitivity to context: The interactive effects of stress reactivity and family adversity on socio-emotional behavior and school readiness. *Child Development.*

Epel E.S., Merkin S.S., Cawthon R., Blackburn E.H., **Adler N.E.**, Pletcher M.J., Seeman T.E. (2009). The rate of leukocyte telomere shortening predicts mortality from cardiovascular disease in elderly men. *Aging, 1*(1), 81-88.

Adler, N.E., Stewart, J. (2009). Reducing obesity: Motivating action while not blaming the victim. *The Milbank Quarterly, 87*(1), 49-70.

Ritterman, M. L., Fernald, L. C., Ozer, E. J., **Adler, N. E.,** Gutierrez, J. P., Syme, S. L. (2009). Objective and subjective social class gradients for substance use among Mexican adolescents. *Social Science & Medicine, 68,* 1843-1851.

B. *Books*

Stone, G.C., Cohen, F., **Adler, N.E.**, & Associates. (1979). *Health psychology--a handbook: Theories, applications, and challenges of a psychological approach to the health care system*. San Francisco: Jossey-Bass.

Katz, M., Gill, P., Turiel, J., **Adler, N.E.**, et al. (1988). *Preventing preterm birth: A parent's guide*. San Francisco: Health Publishing Company.

Adler, N.E., Marmot, M., McEwen, B. & Stewart, J. (1999). *Socioeconomic status & health in industrialized nations.* New York: Annals of the New York Academy of Sciences.

Adler, N.E., Stewart, J., et al. (2007). *Reaching for a healthier life: Facts on socioeconomic status and health in the U.S.* The John D. and Catherine T. Macarthur Foundation Research Network on Socioeconomic Status and Health.

Adler, N.E. & Page, A.E.K. (Eds.). (2008). *Cancer care for the whole patient: Meeting psychosocial health needs*. Washington, D.C.: National Academies Press.

C. *Reviews, Reports, Essays and Editorials*

Adler, N.E., & Everett, W. (1978). Abortion: Public policy, public opinion, and behavioral research. *Newsletter of the Division of Population and Environmental Psychology, 5* (1), 24-28.

Adler, N.E. (1979). Review of *Abortion in America*, by James Mohr; and *In necessity and sorrow*, by Magda Denes. *Sex roles: A journal of research, 5*, 841-844.

Adler, N.E. (1979). Review of *Abortion in psychosocial perspective*: *Trends in transnational research*, edited by David, Friedman, van der Tak, & Sevilla. *Newsletter of the Division of Population and Environmental Psychology of the American Psychological Association, 6* (1), 13-14.

Adler, N.E. (1979). *Psychological issues of abortion.* Report prepared for the American Psychological Association Committee on Women.

Adler, N.E. (1982). Review of *The fertility fallacy*, by Lynn Baker. *Sex roles: A journal of research.*

Adler, N.E. (1983). Survey of recent graduates in health psychology. In *Sourcebook for participants in national conference on training in health psychology.*

Adler, N.E. (1984). Social psychology and medicine: Two views of the intersection. *Contemporary Psychology, 29*, 227-228.

Adler, N.E. (1988). An ounce of prevention: Psychology and health. *Contemporary Psychology, 33*, 516.

Adler, N.E. (1991). Review of *Health psychology and public health: An integrative approach*, by R.A. Winett, A. King, & D. Altman. *Journal of Nervous and Mental Diseases, 179*(3), 180.

Adler, N.E. (1991). Cogent thoughts on a difficult subject. *Contemporary Psychology, 36*, 235-236.

Adler, N.E. (1991). Women mentors needed in academic medicine. *Western Journal of Medicine, 154*, 468-469.

Adler, N.E. (1991). Foreword to *Infertility: Perspectives for stress and coping research.* A.L. Stanton & C. Dunkel-Schetter (Eds.), New York: Plenum.

Adler, N.E. (1991). Adolescents and abortion: Are they at risk? *TEC (Too-Early-Childbearing) NETWORKS Newsletter*, #31, December, 1991.

Adler, N.E. (1997). Talk early, talk often: Talking to teens about sex. *ParenTEEN*, 1997, 3 (#4), 1-4.

Adler, N.E. (1998). Commentary: Sexually transmitted disease information center (invited editorial), *JAMA Women's Health*, JAMA Web Site.

Adler, N.E., & Ostrove, J.M. (1999). *SES, work and health.* Report prepared for the California Endowment.

Adler, N.E. (2000). Abortion and the null hypothesis: Commentary on "Psychological response of women following first trimester abortion" (invited editorial), *Archives of General Psychiatry, 57*, 785-786.

Ellen, J, & **Adler, N.E.** (2001). Sexual initiation: Predictors and developmental trends (invited editorial). *Sexually Transmitted Diseases*.

Haas, J.S. & **Adler, N.E.** (2001) *The causes of vulnerability: Disentangling the effects of ethnicity, socioeconomic status and insurance coverage on health.* Report prepared for the IOM Subcommittee on Health Outcomes for the Uninsured.

Adler, N.E. (2003). Looking upstream and downstream from the middle of the river: A commentary on Prilleltensky and Prilleltensky. *Journal of Health Psychology, 8* (2), 211-213.

Adler, N.E. (2007). Health disparities: What's optimism got to do with it? (invited editorial). *Journal of Adolescent Health, 40*, 106-107.

Weitz, T.A., Moore, K.., Gordon, R. & **Adler, N.E.** (2008). You say "regret" and I say "relief": A need to break the polemic about abortion (editorial). *Contraception, 78*, 87-89.

D. *Selected Papers, Invited Talks and Abstracts* (past 5 years)

Adler, N.E. (March 2002). *Health disparities: Social and economic determinants and their biological mechanisms*. Health Disparities Opening remarks to Institute of Medicine Conference, Washington, D.C.

Yip, D. N., **Adler, N.E.**, & Cooper, B. A. (March, 2002). *The effect of ethnicity, income, and education on the relationship between self-rated health and subjective socioeconomic status.* Poster session presented at the annual meeting of the American Psychosomatic Society, Barcelona, Spain.

Adler, N.E. (April 2002). *How does socioeconomic status get under the skin to affect health?* The RAND Psychology Speaker Series, Santa Monica, CA.

Sidney, S. Matthews, K.A. & **Adler, N.E.** (April 2002). *Self-reported hours of sleep and cardiovascular risk factors: The CARDIA study.* American Heart Association 42nd Annual Conference on Cardiovascular Epidemiology and Prevention, Honolulu, Hawaii.

Satterfield, J.M., Epel, E, Pasch, L. & Adler, N. (April 2002). *Behavioral science in the essential core curriculum*. Presented at UCSF Medical Education Day, San Francisco, CA.

Satterfield, J.M., **Adler, N.E.** & Tervalon, M. (May 2002). *The integration of culture and behavior in an undergraduate medical curriculum: The new UCSF Essentials Core*. Society of General Internal Medicine, Atlanta, GA.

Adler, N.E. (June 2002). *Social determinants of health*. Joint board meeting: The California Endowment and The Rockefeller Foundation, Half Moon Bay, CA.

Adler, N.E. (July 2002). *Do we know what we need to know to eliminate disparities in health outcomes?* National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health, Department of Health and Human Services, Washington DC.

Adler, N.E. (August 2002). *SES and health: The role of psychology in unraveling the mystery*. Keynote address for Thematic Program on Biocultural Determinants of Health. American Psychological Association Annual Convention, Chicago, IL.

Adler, N.E. (September 2002). *SES and health: The role of psychology in unraveling the mystery*. Grand Rounds, Department of Psychiatry, University of California, San Francisco, CA.

Adler, N.E. (September 2002). *Social determinants of health: The role of SES in determining health*. Health Economics and Policy Rounds, Department of Medicine, University of California, San Francisco, CA.

Satterfield, J. & **Adler, N.E.** (October 2002). *The integration of culture and behavior in an undergraduate medical curriculum: Potential impacts on health disparities*. Association for the Behavioral Sciences and Medical Education, Lake Tahoe, CA.

Adler, N.E. (October 2002). *Looking beyond the borders of the health sector: Socioeconomic determinants of health*. Association of Academic Health Centers Annual Meeting: Meeting Health Needs in the 21st Century, Pasadena, CA.

Adler, N.E. (October 2002). *Psychological pathways from SES to health*. Health Psychology Program, California Pacific Medical Center, San Francisco, CA.

Adler, N.E. (October 2002). *Pathways from education to health. Education and health: Building a research agenda*. NIH Center for Health and Well Being, Princeton University, Chevy Chase, MD.

Adler, N.E. (October 2002).). *Social determinants of health: The powerful, pervasive and perplexing effects of socioeconomic status*. Distinguished Public Lecture, University of Colorado, Boulder, CO.

Adler, N.E. (October 2002). *Determining the determinants of health*. Population and Health Seminar Series, University of Colorado, Boulder, CO.

Adler, N.E. (October 2002). *Health care is not synonymous with health: Looking upstream for determinants of health*. Iowa Health Systems, Des Moines, IA.

Adler, N.E. (October 2002). *How social and community factors get into the body to influence cardiovascular risk and disease*. Focus on Cardiology Annual Conference, Des Moines, IA.

Adler, N.E. (November 2002). *Subjective social status and health*. Integrating Mind, Body & Society, Harvard Center for Society and Health, Boston, MA.

Adler, N.E. (November 2002). *Center for Health and Community: Why it is. What it is. Where it's going*. Center for Health and Community, University of California, San Francisco, CA.

Adler, N.E. (November 2002). *SES and health: Unraveling the mystery of the gradient*. Dean's Lecture, University of California, Berkeley School of Public Health, Berkeley, CA.

Goodman, E., **Adler, N.E.**, Daniels, S.R., Slap, G.B., Morrison, & Dolan, L.M. (November 2002). *Impact of objective and subjective social status on obesity in a biracial high school cohort*. The 130th Annual Meeting of APHA, Philadelphia, PA.

Adler, N.E. (April 2003). *Socioeconomic status and health*. President's Roundtable, John D. & Catherine T. MacArthur Foundation, Chicago, IL.

Adler, N.E. (April 2003). *Unraveling the mystery of the SES-health gradient*. Harvard University Interfaculty Program for Health Systems Improvement, Harvard University, Boston, MA.

Adler, N.E. (April 2003). *Health disparities: Understanding the social gradient*. Health Policy Seminar, Institute for Health Policy Studies, University of California, San Francisco, CA.

Adler, N.E. (May 2003). *Income, income inequality and other SES effects on health*. Symposium on Equality, Hierarchy and Social Class: Across Species, in the Classroom, and in Health, The Center for the Development of Peace & Well-being, University of California, Berkeley, CA.

Adler, N.E. (July 2003). *Socioeconomic status and health: Unraveling the mystery of the gradient*. Grand Rounds. Division of General Internal Medicine, Department of Medicine. University of California, San Francisco, CA.

Adler, N.E. (September 2003). *Socioeconomic status and health: Unraveling the mystery of the gradient*. Primary Care Grand Rounds. San Francisco General Hospital, San Francisco, CA.

Adler, N.E. (October 2003). *The effect of economic development on health: Lessons learned from research in psychosocial pathways from SES to health*. Harvard School of Public Health, Cambridge, MA.

Adler, N.E. (October 2003). *Determinants of health: The role of socioeconomic status*. Robert Wood Johnson Scholars Program, University of California, Berkeley, CA.

Adler, N.E. (December 2003). *Socioeconomic status and health: Unraveling the mystery of the gradient.* Adolescent Research Seminar, Adolescent Medicine, University of California, San Francisco, CA.

Adler, N.E. (December 2003). *Toward a behavioral understanding of disparities in health.* Board on Neuroscience and Behavioral Health. Institute of Medicine: Beckman Center, Irvine, CA.

Adler, N.E. (December 2003). *Socioeconomic status and health.* Board of Directors, John D. & Catherine T. MacArthur Foundation, Chicago, IL.

Snibbe, A.C., Stewart, J., & **Adler, N.E.** (January 2004). *Where we stand: Determinants of Black and White women and men's subjective social status.* Poster presentation at Annual meeting of the Society for Personality and Social Psychology, Austin, TX.

Adler, N.E. (March 2004). *Determinants of health: The role of socioeconomic status.* Medical Effectiveness Research Center for Diverse Populations (MERC), University of California, San Francisco, CA.

Adler, N.E. (March 2004). *The mystery of the gradient: Identifying pathways from socioeconomic status to health.* Social Determinants of Health and Disease, University of California, Davis and Northern California Epidemiology Group, Napa, CA.

Fernald, L.C., Gertler, P.J., & **Adler N.E.** (2004). Salivary cortisol and heart rate in low-income Mexican children and their mothers (Abstract). *Psychosomatic Medicine*, 65(1): A65.

Adler, N.E. (2004). *Health and economic status.* [Interviewed by Layna Berman]. On *Your Own Health and Fitness*, KPFA, http://www.YourOwnHealthandFitness.com.

Adler, N.E. (2004). *Socioeconomic status and health: Unraveling the mystery of the gradient.* Faculty Seminar on Health Disparities Research, San Francisco State University, San Francisco, CA.

Adler, N.E. (2004). *Socioeconomic influences on health.* Lokey Lecturer, Human Biology, Stanford University, Stanford, CA.

Adler, N.E. (2004). *Social determinants of Health.* Kaiser Permanente Blue Sky Research Conference, San Francisco, CA.

Adler, N.E. (2004). *Socioeconomic influences on health.* Public Policy Institute of California, San Francisco, CA.

Ostrove, J.M. & **Adler, N.E.** (August 2004). *Subjective social status, social comparisons, and health.* Poster presentation at APA Annual Meeting, Honolulu, Hawaii.

Adler, N.E. (September 2004). *The role of socioeconomic status in health* . Interdisciplinary Forum on Ecology and Population Health, University of California, Berkeley, CA.

Adler, N.E. (September 2004). *Socioeconomic status: What explains the gradient?* Center on Social Disparities in Health, University of California, San Francisco, CA.

Goodman, E., McEwen, B.S., Huang, B., Dolan, L.M., Daniels, S.R., & **Adler, N.E.** (November 2004) *Parental Education's Influence on Adolescents' Cardiovascular Risk is Independent of BMI*, Poster presentation at NAASO 2004 Annual Scientific Meeting, Las Vegas, NV.

Adler, N.E. (March 2005). *Health Disparities: What are they and how to they occur?* Kaiser Division of Research, Oakland, CA

Burke, H. M., Fernald, L. C., Gertler, P. J., & **Adler, N.E.** (2005). *Depressive symptoms are associated with blunted cortisol stress responses in very low-income women.* Paper presented at the annual American Psychosomatic Society meeting, Vancouver, B.C., Canada.

Rosengard, R., **Adler, N.E.**, Gurvey, J.E., & Ellen, J.M. (March 2005). *Adolescent partner type experience: Psychosocial and behavioral differences.* Abstract presentation at Society for Adolescent Medicine, Los Angeles, CA.

Garovoy, N., Hannigan, L., Turner, R., **Adler, N.E.**, Epel, E., Gracie, C., Adams, J., Wexman, M., Reus, V., & Wolkowitz, O. (April 2005). *Psychosocial factors and neuroendocrine activity following a cardiac event.* Poster presentation at Society of Behavioral Medicine annual meeting, Boston, MA.

Adler, N.E. (2005). *Socioeconomic influences on health.* Lokey Lecturer, Human Biology, Stanford University, Stanford, CA.

Adler, N.E. (August 2005). *From Mac to Map: The importance of interdisciplinary work.* American Psychological Association Annual Meeting, Washington, D.C.

Yip, W. & **Adler, N.E.** (July 2005). *Does social standing affect health and happiness in rural China?*, Abstract presentation at 2005 International Health Economics Association World Congress, Barcelona, Spain.

Jamison, J., Fernald, L., Burke, H., & **Adler, N.E.** (July 2005). *Relationship of objective and subjective socioeconomic status and health among poor Mexican women.* Abstract presentation at 2005 International Health Economics Association World Congress, Barcelona, Spain.

Adler, N.E. (July 2005). *The many paths to academic leadership.* Mid-career Women Faculty Professional Development Seminar. Association of American Medical Colleges. Lansdowne, VA.

Epel, E., Burke, H., Adler, N., Wolkowitz, O., Sidney, S. & Seeman, T. (September 2005). *Socioeconomic status and the anabolic/catabolic neuroendocrine balance.* International Society of Psychoneuro-endocrinology, Montreal, Canada.

Boyce, W.T., Stamper, J., Alkon, A., & **Adler, N.E.** (September 2005). *Is there a biology of misfortune? Neuroendocrine correlates of subordination in societies of kindergartners.* International Society for Psychoneuroendocrinology, Montreal, Canada.

Somkin, C.P., Altschuler, A., & **Adler, N.E.** (September 2005). *Community and Health: The Impact of Social Capital and Local Communities on Health.* DOR Health Disparities Symposium, Kaiser Division of Research. Oakland, CA.

Adler, NE. (September 2005). *Socioeconomic status and biological mediators.* International Society of Psychoneuroimmunology, Montreal, Canada.

Nuru-Jeter, A, **Adler, N.E.**, & Singer, B. (October 2005). *Socioeconomic Status and Mortality: For whom does the gradient apply?* 4th International Conference on Urban Health, Toronto, Canada.

Adler, N.E. (February 2006). *How important is the subjective dimension of social position?* Experience-based Brain and Biological Development Program Meeting, Canadian Institutes of Advanced Research, San Francisco, CA.

Adler, N.E. (February 2006). *Subjective socioeconomic status and health.* Dental Public Health Seminar, UCSF, San Francisco, CA.

Goodman, E., Huang, B., Schafer-Kalkhoff, T., & **Adler, N.E.** (March 2006). *Developmental trajectories in perceived social status.* Annual Meeting of the Society for Adolescent Medicine, Boston, Massachusetts.

Adler, N.E. (March 2006). *Socioeconomic status and physical health: The case of the metabolic syndrome.* Society for Behavioral Medicine, San Francisco, CA.

Adler, N.E. (March 2006). *Social determinants of health: Socioeconomic pathways.* Social and Behavioral Science Seminar, Comprehensive Cancer Center, UCSF, San Francisco, CA.

Satterfield, J., Adler, S., Chen, H.C., Hall, H., Adler, J., & **Adler, N.E.** (April 2006). *Integrating the social and behavioral sciences in undergraduate medical education.* Society of General Internal Medicine 2006 Annual Meeting: Activism to Promote the Health of Patients and the Public, Los Angeles, CA.

Satterfield, J., Adler, S., Chen, H.C., Adler, J., & **Adler, N.E.** (April 2006). *Integrating the social and behavioral sciences in undergraduate medical education.* Western Group on Educational Affairs, Asilomar, CA.

Adler, N.E. (October 2006). *From bench to bedside to biosphere and back: Diabetes as a case study.* Clinical and Translational Sciences Workshop: Building a Multidisciplinary and Translational Research Program (CTST), UCSF, San Francisco, CA.

Adler, N.E. (October 2006). *The socioeconomic gradient in health: What do we know?* The Center on Social Disparities in Health, UCSF, San Francisco, CA.

Adler, N.E. (October 2006). *Health disparities: Pathways and policies.* Keynote address: NIH Conference on Understanding and Reducing Health Disparities: Behavioral and Social Science Contributions, Bethesda, MD.

Adler, N.E. (April 2007). *Social Status and Health.* Keynote address: Risk, Resilience and Recovery: The Interface of Poverty, Early Parenting and Social Policy, Yale University, New Haven, CT.

Adler, N.E. (April 2007). *Disparities in health: How does wealth buy better health?* Distinctive Voices Series, National Academies: Beckman Center, Irvine, CA.

Kroenke, C.H., Thurston, R., Kubzansky, L.D., Wright, R., Rich-Edwards, J., **Adler, N.E.**, Holmes, M.D., & Kawachi. I. (June 2007). *Socioeconomic status and time to natural menopause.* Poster presentation at Society for Epidemiologic Research, Harvard, Boston, MA.

Adler, N.E. (September 2007). *Transforming a medical care system into a health care system: Integrating population health.* Transforming the Organization and Financing of the US Health System, Los Angeles, CA.

Bleil, M.E., Pasch, L.A., Gregorich, S.E., Katz, P.P., Millstein, S.G., & **Adler, N.E.** (October 2007). *Dispositional optimism and psychological adjustment to fertility treatment.* American Society for Reproductive Medicine, 63rd Annual Meeting, Washington Convention Center, Washington, DC.

Adler, N.E. (October 2007). *Addressing behavioral determinants of obesity without blaming the victim.* Research Summit: Revisiting the Call to Action on Obesity, University of Utah.

Adler, N.E. (November 2007). *Cancer care for the whole patient: Meeting psychosocial health needs.* Comprehensive Cancer Center, UCSF, San Francisco, CA.

Adler, N.E. (March 2008). *Healthy, wealthy and wise?* National Health Policy Forum, Washington, DC.

Sarkar, U., Karter, A.J., **Adler, N.E.**, Liu, J.Y., Moffet, H.H., & Schillinger, D. (April 2008).*Limited health literacy and hypoglycemia among Type 2 Diabetes patients: The DISTANCE Study.* Translating research into practice: Enhancing education, patient care, and community health, Society of General Internal Medicine 31st Annual Meeting, Pittsburgh, PA.

Adler, N.E. (March 2008). *Unnatural causes: Is inequality making us sick?*

Panel presentation, Commonwealth Club, San Francisco (3/25/08)

KQED radio, *Forum* (3/26/08)

Adler, N.E. (May 2008). *Health Disparities: A psychological perspective.* Stanford University Psychology Department Colloquium, Stanford, CA.

Adler, N.E. (June 2008). *Reaching for a healthier life.* Sonoma County Department of Health, Santa Rosa, CA.

Adler, N.E. (July 2008). *Health disparities across the lifespan.* Inaugural lecture, Health Disparities Lecture Series, NIH, Bethesda, MD.

Adler, N.E. (February 2009). *Social determinants of health: the role of socioeconomic status.* Summit on Integrative Medicine and Health of the Public Institute of Medicine, Washington, DC.

Adler, N.E., Fernald L. (May 2009). *Socioeconomic status and health: Can more be less?* American Psychological Society, San Francisco.

Adler, N.E. (August 2009). *Health disparities: What's psychology got to do with it?* American Psychological Association, Toronto, Canada.

Professional Activities

Service to Professional Organizations

National Academy of Sciences

Report review Committee, Member, 2006-2009
Review Coordinator and/or Monitor:
"Understanding Preterm Birth and Assuring Health Outcomes," 2005
"Ending the Tobacco Control Problem," 2007
Adolescent Health Services: Missing Opportunities, 2008

Review of the National Children's Study Research Plan, 2008

Institute of Medicine

Study Committee Member on Prevention and Control of STDs, 1995-96
Study Committee Liaison. Health Literacy, 2002-2003
Board on Neuroscience and Behavioral Health (NBH)
Member, NBH Board, 2000-2005
Strategic Planning Subgroup, 2004-2005
Vice-Chair, Section 11, 2005-present
Member, Membership Committee, 2005-present
Chair, IOM Committee on Psychosocial Services to Cancer Patients/Families in a Community Setting, June 2006-Dec. 2007
Reviewer:
"Future Directions for Behavioral and Social Sciences Research at the National Institutes of Health," April 2000
"Promoting Health Intervention Strategies from Social Behavior Research," May 2000
"Improving Medical Education: Enhancing Behavioral and Social Science Content in Medical School Curricula," January 2004

American Psychological Association

Fellow: Divisions 8, 9, 34 and 38
Secretary-Treasurer, Division 34 (Population and Environmental Psychology), 1975-1978
President, Division 34, 1979-1980
Planning Committee for National Conference on Training in Health Psychology, 1982-1983
Chairperson, Fellows Committee, Division 34, Chairperson: 1982-1986, Member: 1986-present
Participant, Arden House Conference on Education and Training in Health Psychology, 1983
Chairperson, Nominations Committee, and Member of Executive Committee, Division 38 (Health Psychology), 1986-1987
Member, Expert Panel on Psychological Effects of Abortion, 1989-1990
Member, Task Force on Promotion of Population Psychology, 1992-1995
Member, Task Force on Socioeconomic Status and Health, 2005-2007

Other

Member: Association for Psychological Science; Society of Experimental Social Psychology; International Association of Applied Psychology; Society for Advancement of Social Psychology; Society of Personality and Social Psychology; Association of Medical School Professors of Psychology; Society for Research on Adolescence; American Association of Applied and Preventive Psychology; Society for Behavioral Medicine; Academy of Behavioral Medicine Research; New York Academy of Sciences; Women's International Science Collaboration (WISC) Program; American Association for the Advancement of Science (AAAS)

Service to Government – Grant Review

Ad Hoc Grant Reviews: National Institutes of Mental Health, National Heart, Lung and Blood Institute, National Institute of Child Health and Human Development, National Science Foundation, Social Sciences and Humanities Research Council of Canada, Society of Behavioral Medicine, March of Dimes Foundation, Centers for Disease Control, Economic and Social Research Council (England), Medical Research Council (England), Schweizerischer Nationalfonds zur Förderung (Switzerland)

Service to Government – Other

Advisory Committee for 5-year Plan, Demographic and Social Sciences Branch, Center for Population Research, NICHD, 1986-87
Advisory Committee, Demographic & Social Science Branch, Center on Population Research, NICHD, 1991
National Institute of Mental Health: Intramural Research Review Committee, 1996-97
Member, Advisory Committee; Center for Population Research, NICHD Strategic Plan 2000 ("From Cells to Selves"), 2000
Participant and group leader for agenda-setting meeting: "Towards Higher levels of Analyses: Progress and Promise in Research in Social and Cultural Dimensions of Health." NIH, June, 2000
Participant, Trans-HHS Cancer Disparities Roundtable, 2003
Review Committee NIH Pioneer Awards, 2004
Member, Advisory Committee to the Director, NIH, 2004-08
Consultant, Developing NIH health disparities research agenda, 2006
Member, Review Committee: NIH Institute Director 5-year leadership review, 2006-07
Member, Search Committee. Director of NCCAM, NIH, 2007
Member, Secretary's Advisory Committee on Environmental Determinants, National Health Prevention and Disease Prevention Objectives for 2020
Advisor/Reviewer PROMIS item bank, NIH, 2009
Member, Blue Ribbon Review of Intramural Research, NCCAM, NIH, 2008-09

Service to Journals & Editorial Boards

Associate Editor: *Health Psychology*, 1984-90
Women's Health: Research in Gender, Behavior and Policy, 1994-99

Editorial Board: *Journal of Population and Environment*, 1982-88
Health Psychology, 1990-present
Journal of Applied Social Psychology, 1991-present
Journal of Health Psychology, 1994-present
UCSF Magazine, 1998-present
Annals of Behavioral Medicine, 2000-present
Action Editor, *Health Psychology, 2005-06*

Editorial Committee: *Epidemiologic Reviews*, 2008

Manuscript reviewer:

Journal of Personality and Social Psychology; *Journal of Nervous and Mental Disease*; *Personality and Social Psychology Bulletin*; *Journal of Health and Social Behavior*; *Journal of Applied Social Psychology*; *Basic and Applied Social Psychology*; *Gastroenterology*; *Psychology of Women Quarterly*; *The Western Journal of Medicine*; *Sexually Transmitted Diseases*; *Journal of Social and Personal Relationships*; *Psychological Bulletin*; *Journal of Adolescent Health Care*; *Family Planning Perspectives*; *American Journal of Public Health*; *Journal of Consulting and Clinical Psychology*; *American Psychologist*; *Women & Health*; *Psychosomatic Medicine*; *Journal of Social & Clinical Psychology*; *JAMA*; *The Milbank Quarterly*; *Journal of Research on Adolescence*; *Journal of Environmental Psychology*; *JAMA*; *Women's Health Web Site Review*; *Archives of General Psychiatry*; *Preventive Medicine*; *Physiology and Behavior*; *Journal of Psychosomatic Research*; *Social Science & Medicine*; *Psychology, Public Policy & Law*; *Archives of Pediatrics & Adolescent Medicine*; *American Journal of Psychology*; *Journal of Behavioral Medicine*; *Human Reproduction*; *American Journal of Medicine*; *Journal of Marriage & Family*; *Journal of Health Care for the Poor and Underserved*; *Psychological Science*; *Psychoneuroendocrinology*; *BMC Family Practice*; *International Journal of Epidemiology*; *Journal of Urban Health, BMC Endocrine Disorders*; *Social Cognitive & Affective Neuroscience*; *Psychological Reports, Perceptual and Motor Skills; New England Journal of Medicine; Lancet.*

Advisory Board, *Encyclopedia of Mental Health*, Academic Press, 1995-98
International Advisory Editorial Board, *Handbook of Social Studies in Health and Medicine*, 1996-99
Advisory Panel, *Health Psychology*, Oxford University Press, 2007-

Service to Foundations, Universities & Non-profit Organizations

Center for the Advancement of Health, Washington, D.C., Scientific Advisory Board 1995-96
Consultant, Segment on "Health Psychology." PBS Television Show, "Psychology," 1987.
Testified on behalf of the American Psychological Association on psychological responses of women following abortion before the Human Resources and Intergovernmental Relations Subcommittee on Government Operations of the U.S. House of Representatives. Washington, D.C., March 16, 1989

Expert Witness. American Academy of Pediatrics, California District IX, et al., vs. John K. Van de Kamp, Attorney General for the State of California, et al., 1991
Member, Search Committee, Vice-President for Research, Kansas Research Institute, Topeka, Kansas, 1997
Member, MacArthur Foundation Network on Poverty and Inequality in Broader Perspectives, 1997-99
Member, National Advisory Committee for the Robert Wood Johnson Tobacco Etiology Research Network, 1997-
Member, Search Committee, Dean of the School of Public Health; University of California, Berkeley, 1997-98
WETV (Washington D.C. Public Television). Program on The Brain, 1999.
California Endowment "Blue Sky to Blueprint," 2003-
Moore Foundation, review of grant, 2005
California Endowment, Addressing Health Disparities, 2005
Macy Foundation: Convergence of neuroscience, behavioral science, neurology and psychiatry, 2005
Rockefeller Foundations: social science and global HIV/AIDS portfolio, 2005
Public Policy Institute of California, review of health disparities report, 2005
California Newsreel, Advisor on documentary series on social class and health, 2005-06
International Advisory Board, International Congress on Stress, Cell Stress Society, 2006
Member, Search Committee, Faculty position in Social Epidemiology, School of Public Health, University of California, Berkeley, 2006-07
Michael Smith Foundation; Canada. Grant review; 2007

Visiting & Advisory Committees

Member, Visiting Committee to review Department of Health and Social Behavior, Harvard School of Public Health, 1999
Member, Visiting Committee to review Department of Social Medicine, Harvard Medical School, 2000
Member, Advising Committee: Experience-based Brain & Biological Development Program of the Canadian Institute of Advanced Research, 2003 –
External Advising Board: Bloomberg School of Public Health, Johns Hopkins University, Health and Behavior, 2003-04
Scientific advisor: ABC News Medical Coverage Division, 2002 - present
Advisor: California Health Interview Survey, 2005-present, Project on Social Determinants of Health
Faculty Member: AAMC Mid-career Women Faculty Professional Development Seminar, 2005
External Advisory Committee: Pittsburgh Mind-Body Center, 2005-present
Scientific Member: Center for Studies on Human Stress, McGill University; Montreal, Canada, 2006- present
Member, Review Committee: Center for Health Research, University of California, Berkeley, 2006-07
Member, Scientific Advisory Committee; California Breast Cancer Research Program; 2007-2008

University Committees and Administrative Responsibilities

Director, Graduate Program in Health Psychology, 1984-1987, 1988-96
Chairperson, Graduate Group in Psychology, 1984-1987, 1988-02
Adolescent Health Training Program Core Faculty Committee, 1978-present
School of Nursing: Research Advisory Committee, 1978-86
Department of Psychiatry Space Committee, 1979-87
Department of Psychiatry Faculty Diversity Committee, 1991-94
Graduate Council, 1982-85
School of Medicine Admissions Committee, 1985-87
Dean's Advisory Committee, AIDS Clinical Research Center, 1987-88

Search Committees (e.g., Chair of Department of Psychiatry, 1984-85; Director of Child and Adolescent Psychiatry, 1987-88; Chair of Department of Mental Health, Community, and Administrative Nursing, School of Nursing, 1988-90; Division of General Internal Medicine, Department of Medicine, 1990-91, 1993-94; Director of Health and Behavior Clinic, 1990-91; Director of Medical Anthropology Program, 1992; Chair of Department of Epidemiology and Biostatistics, 1993-94; Director, Institute for Health Policy Studies, 1994-95; Vice-Dean of Education, School of Medicine (Chair), 1996-97; Dean, School of Public Health, UC Berkeley, 1997-98; Chief, Division of General Internal Medicine, 1998-99; Deputy Director, Institute for Global Health, 1999; Director, Academy of Medical Educators (Chair), 2000; Director, Osher Center for Integrative Medicine, 2000; Professor of Medical Psychology (Chair), 2000; Director of Population Health Division, UCSF Cancer Center, 2001-present
Faculty Teaching Plan Committee, Department of Psychiatry, 1989-90
UC Systemwide Committee on Role of Social and Behavioral Sciences in the Health Professions, 1988-91
Chancellor's Advisory Committee on the Status of Women, 1987-1994.
Co-chair, Sub-Committee on Students and Trainees, 1990-92
Member, Sub-Committee on Leadership, 1994-present.
Compensation Plan Committee, Department of Psychiatry, 1987-1991; Chair, 1989-90
Appointments and Promotions Committee, Department of Psychiatry, 1992-present
Advisory Committee, Institute for Health and Aging, 1989-present
Advisory Committee, Robert Wood Johnson Clinical Scholars Program, 1991-96
Privilege and Tenure Committee, Academic Senate, 1992-93
Chair, Chancellor's Committee on the Social and Behavioral Sciences, 1993-98
Committee on Academic Planning and Budget, Academic Senate, 1993-96
Executive Advisory Committee, Department of Psychiatry, 1993-present
Committee on Women Faculty, School of Medicine, 1994-96
Committee on Indirect Cost Recovery, 1994-96
Vice-chair, Department of Psychiatry, 1994-present
Chancellor's Task Force on Health Care Reform; 1994-96
Strategic Planning Board, 1994-96
School of Medicine Leadership Retreat Planning Committee, 1995-96
School of Medicine Fundraising Advisory Committee, 1995-present
School of Medicine Subject Area Committee (Doctor/Patient in Society), 1995-98
UC Systemwide Committee for Selection of University Professor, 1996.
Member, Committee on Second Campus Development, 1996-97
Member, Advisory Committee for Laurel Heights Child Care Center, 1996-97
Director, Center for Health and Community, 1998-present.
Member, Advisory Committee, Foundations of Patient Care, 1997-present.
Chair, Selection Committee, Kaiser Awards for Excellence in Teaching, 1997, 1998
Member, Executive Committee, Osher Center for Integrative Medicine, 1997-2001
Member, Psychosocial Oncology Committee, UCSF Cancer Center, 1997-98
Committee on Curriculum and Educational Policy, School of Medicine:
Member, 1993-present.
Vice-chair, 1996-97
Chair, 1997-present
Resource Allocation Committee; 1997-present
Member, Committee to Review the Department of the History of Health Sciences, 1997-98
Member, Faculty Council, School of Medicine, 1997-present
Joint Faculty Committee of the UCSF/UCB Joint Medical Program, 1997- present
Member, Clinical Research Training Committee, Department of Psychiatry, 1998- present

Member, Task Force to Review Strategic Planning Board, 1998
Member, Advisory Board, School of Nursing ANP-ICH Program, 1998-present
Chair, Department of Psychiatry, Task Force on Diversity, 1999-2000
Member, Chancellor's Award for Advancement of Women Selection Committee, 2000-02
Chair, 2002-03
Member, Advisory Committee, Center for Tobacco Control Research & Education, 2000-03
Member, Chancellor's Advisory Committee on Long Range Development Plan, 2001-03
Member, Committee on Academic Planning for the Long Range Development Plan, 2001-03
Member, School of Medicine Space Committee, 2001-04
Member, Advisory Board, Osher Center for Integrative Medicine, 2001-present
Member, LCME Self-study Task Force and subcommittees on: (1) Governance & Administration and (2) Objectives & Education Program Leading to the M.D. Degree, 2001-02
Member, Committee on Arts, Honors and Recognition, 2002-04
Member, Search Committee, Distinguished Professorship in Health and Health Care, Department of Medicine, 2003-04
Member, Search Committee, Director, Center for AIDS Prevention Studies, 2003-04
Member, Sarlo Prize Selection Committee, 2003-2008 (Chair, 2008)
Member, UCSF Community Partnerships Task Force, 2004-05
Member, Task Force on Recruitment and Retention of Underrepresented Minorities, School of Medicine, 2004-05
Member, Faculty Mentor and Selection Committee, Roadmap K12, 2005-
Member, Executive Committee, Global Health Sciences, 2005-
Co-Chair, Organizational Structure Working Group, Global Health Sciences, 2006-
Member, Strategic Planning Board, 2006-
Co-Chair, Strategic Planning, Subcommittee on Governance and Leadership, 2006-07
Chair, Search Committee, Director. Philip R. Lee Institute of Health Policy Studies; 2007-
Member, Search Committee; Dean of School of Medicine, 2008-

Board and Special Committee Membership

Board of Directors, E.T.R. Associates (Education, Training, and Research), Santa Cruz, California, 1981-84
Board of Trustees, Center for the Advancement of Health, Washington, D.C., 1996-99
Board of Trustees, San Francisco Day School, 1995-2001
Chair, Education Committee
Member, Agenda Committee
Member, Faculty Compensation Committee
Member, Values & Mission Committee
Special Gifts Committee, Wellesley College Class of 1968; 1997-98; 2002-03
Advisory Council, Hybrid Vigor Institute, 2001-
Board of Directors, The Greenbelt Alliance, 2003-
Strategic Planning Committee, Congregation Sherith Israel

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS

COUNTY DEPARTMENT — CHANCERY DIVISION

THE HOPE CLINIC FOR WOMEN LTD.; ALLISON COWETT, M.D., M.P.H., Plaintiffs, v. BRENT ADAMS, Acting Secretary of the Illinois Department of Financial and Professional Regulation, in his official capacity; DANIEL BLUTHARDT, Director of the Division of Professional Regulation of the Illinois Department of Financial and Professional Regulation, in his official capacity; THE ILLINOIS STATE MEDICAL DISCIPLINARY BOARD, Defendants.	Case No. AFFIDAVIT OF ANNE BAKER, M.A., IN SUPPORT OF PLAINTIFFS' MOTION FOR INJUNCTIVE RELIEF

AFFIDAVIT OF ANNE BAKER

I, ANNE BAKER, testify under penalty of perjury that the following is true and correct.

1. I am the Director of Counseling at The Hope Clinic for Women Ltd. ("Hope Clinic") in Granite City, Illinois. I have been involved in providing reproductive health care services to women, including teenagers, for thirty-three years.

2. I have read the Illinois Parental Notice of Abortion Act of 1995 (the "Act"). I understand that the Act requires young women under the age of eighteen to notify a parent, grandparent, step-parent living in the house, or legal guardian, or seek a judicial waiver of this requirement, before they may have an abortion. (For simplicity, I will refer to the law as requiring parental notice.) In so doing, the Act works a substantial change in the way abortions have been provided in this state for over three decades. I submit this affidavit in support of Plaintiffs' motion for injunctive relief because, based on my experience working with minors

seeking abortions, I am convinced that the Act will cause significant and irreversible harm to minors in this state. Moreover, in my view, the Act is based on presumptions about minors and their families that are wholly unfounded.

Background

3. I have a Master's Degree in Counseling Psychology from Lindenwood University in St. Charles, Missouri, and have been the Director of Counseling at Hope Clinic for thirty-three years. I estimate that I have counseled roughly 25,000 patients seeking abortions, approximately 20% of whom were under 18.

4. In addition to my work at Hope Clinic, I write and speak about abortion counseling. My book, *Abortion and Options Counseling: A Comprehensive Reference*, is used as a resource by counselors and medical professionals all over the United States, Canada, and Australia. In addition, I am the main author of a chapter entitled *Informed Consent, Patient Education, and Counseling* in the leading medical textbook on abortion called *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*. I also provide training sessions on pregnancy options and abortion counseling for counselors in the United States and Canada.

Obtaining an Abortion at Hope Clinic

5. Hope Clinic is a private clinic licensed by the State of Illinois as an ambulatory surgical treatment center. We provide patients with pregnancy testing, birth control, pregnancy options counseling, and abortion services up to twenty-four weeks of pregnancy. (Pregnancy is generally measured by the number of weeks that have passed starting from the first day of the woman's last menstrual period or lmp.) Located in Granite City, Hope Clinic is the only

provider of abortion services in southern Illinois. We offer services on weekdays as well as Saturdays and after school hours to assist patients who cannot come to the clinic during traditional business hours.

6. Before any woman (adult or minor) may have an abortion at Hope Clinic, a trained counselor, such as myself, meets with her to ensure that she understands all of her options; that she understands the abortion procedure and its risks and potential complications; that she has an opportunity to discuss how she feels about the abortion and to talk through those feelings; that all of her questions are answered; and that she is confident in her decision to have an abortion. In order to best tailor our counseling session to address the patient's needs, we first ask her to fill out an emotional needs assessment form that asks her questions about how she is feeling about the abortion, how sure she is of her decision, who she has told about her plan to have an abortion and whether they are supportive, and how she expects to feel after the abortion. The length and depth of each counseling session depends on the needs of the individual patient. Sometimes I spend an hour with a patient; other times the session is shorter. An average session lasts about half an hour. For each patient, we spend as much time as is needed to ensure that she understands the procedure and all of its risks, benefits, and alternatives, has had all of her questions answered, and is sure of her decision.

7. Although most women, regardless of their age, come to Hope Clinic with a support person, we always start the counseling session with the woman by herself. We do this for two reasons: First, we need to ensure that the decision to have the abortion is the patient's and that she is not being pressured to have an abortion by her parents or her partner. We will not provide an abortion to any woman, adult or teen, who is being coerced. The decision to have an abortion must be hers.

8. Second, we want to allow the woman the chance to explore her feelings about abortion and we must ensure that she is confident in her decision. Although most women come into the counseling session sure of their decision, in about 1% of cases, a patient either decides that she does not want the abortion (in which case she, of course, returns home) or the counselor is concerned that she has unresolved feelings about abortion or is not sure of her decision. If anything in the counseling session or the emotional needs assessment form leads us to believe that a patient has such feelings or doubts, a counselor will provide further counseling to assure that the patient understands the full range of options available to her and to help her explore her feelings about each option. We will not provide an abortion to any patient – adult or teen – if she expresses unresolved ambivalence or feels that she will regret her abortion. When we have such concerns, we talk to the patient about who in her life she can turn to for support and guidance, and we send her home to think with further information, an extensive pregnancy options workbook to help her work through her decision, and appropriate referrals which could include information about public aid, adoption, and pastoral or secular pregnancy options counseling, depending on the patient.

9. As part of the counseling process we also discuss the patient's support system. We encourage all women, regardless of their age, to reach out to their support network and to be open about their decision to have an abortion with the people they can turn to for support. With minor patients, we determine whether a parent is aware that she is pregnant and seeking an abortion. If the minor has not told a parent, we discuss her reasons. If she describes her parents as generally loving and supportive, we explore the possibility of talking to her parents. We acknowledge that a parent might be angry at first, but we encourage these teens to talk about how their parents might react after the initial anger has subsided. As part of this discussion, we often

ask them to think and talk about other times when they or their siblings did something that angered or disappointed their parents and what happened after the initial anger wore off. Sometimes, we role play conversations where the minor pretends to be the parent and we pretend to be her so that we can model constructive ways for her to approach telling a parent. If, however, a minor is convinced that telling a parent will have harmful consequences, we talk with her about the other people, including other family members or adults in her life, she can turn to for emotional support.

10. In addition to discussing the emotional aspects of the abortion decision, the counseling session also covers the medical aspects of abortion. All patients must fill out a medical information form. The type of questions contained on the form are questions that teens routinely know the answer to like, do you have asthma, diabetes, or a heart condition and how many times have you been pregnant. We have never had a complication that resulted from a lack of information on the medical history form. During the counseling session, the abortion procedure itself is discussed and the patient is thoroughly informed about the risks and possible complications associated with the procedure. We make sure that the patient understands all of this information and is given as much time as she needs to get answers to any questions she may have...

11. After this process and after the patient gives her informed consent to the procedure, she undergoes the abortion. After the abortion, patients spend time in the recovery room. There we discuss aftercare with her and give her a copy of aftercare instructions to take home. A counselor remains on duty at the clinic until the final patient has been deemed to be without physical or emotional difficulties by the recovery room nurse.

12. The actual abortion procedure for a woman at less than sixteen weeks lmp generally takes between five and ten minutes. In total, between paperwork, counseling, lab and prep work, the abortion procedure, and time spent in recovery, a typical patient who is less than sixteen weeks pregnant spends between three and four hours at Hope Clinic.

13. As a woman's pregnancy progresses, however, the time it takes to have an abortion also increases. At Hope Clinic, after fifteen weeks lmp, the abortion procedure is performed over a two-day period. On the first day, a substance called laminaria is inserted into a woman's cervix to gradually dilate the cervix which facilitates the abortion. The abortion is then performed on the following day. If a patient lives more than forty-five minutes away from the clinic, we require her to obtain a hotel room nearby for the night between the two procedure days. After twenty-one weeks lmp, the cervix needs to dilate more, and therefore at Hope Clinic, we usually insert additional laminaria on the second day, and perform the abortion on the third day.

14. As a woman's pregnancy progresses, the cost of the abortion also increases sharply. For example, at Hope Clinic, the cost of an abortion before twelve weeks lmp ranges from $390-$440. At twelve weeks, an abortion costs $565; at fourteen weeks, $600; at sixteen weeks, $695; at eighteen weeks, $810; at twenty weeks, $950; at twenty-two weeks, between $1500 and $1800, and after twenty-two weeks an abortion costs $2000 or more. In addition, if a woman has Rh negative blood (which we screen all patients for), she must pay for a Rhogham shot to protect future pregnancies which costs between $60 and $120, depending on her stage of pregnancy.

15. After their abortions, patients can either return to Hope Clinic in two or three weeks for their post-abortion check-up or can seek such care from another healthcare provider.

In addition to performing an ultrasound at the follow-up visit, we take the opportunity to talk with the patient about her experience with the abortion. The vast majority of women, including most minors, report feeling relief following their abortion and are generally doing better than before their abortion. Some women do experience mixed emotions, including some feelings of guilt, shame, or sadness, but regardless of their emotions, almost all of them report that the abortion was the right decision for them. In addition, my thirty plus years of experience has taught me that women's post-abortion psychological health generally depends on a number of factors largely unrelated to the abortion, including the patient's self-esteem and prior mental health, if the male partner abandoned or abused them, whether there is an abusive or loveless home situation, any strongly held spiritual fear of punishment from God, and whether those who she chooses to tell about her pregnancy and abortion decision are supportive.

Reasons Minors Elect Not to Notify Their Parents

16. Most of our minor patients are accompanied by a parent. The younger she is, the more likely it is that a parent knows about the abortion and is with her. Those who come without a parent are often accompanied by another trusted adult such as an adult sister, aunt, or grandparent.

17. Although the majority of our minor patients come in with a parent, it is my belief that we see more teens without a parent than many other clinics. This is because teens from elsewhere in the midwest and south who were too afraid to involve a parent or to go to court to seek a waiver, have been able to come to Illinois for care.

18. I know from my over thirty years counseling these and other teens, that minors who do not involve a parent in their abortion decision have very strong reasons for that decision.

Indeed, the strength of their conviction that involving a parent or going to court was impossible is evidenced by the distance some of our patients travel: Not only do we routinely see minors from Missouri and Kentucky, but we also have patients from states that are much further away such as Minnesota, Texas, and Florida. (Traveling to another state won't be a realistic option for most Illinois teens who cannot tell a parent. The closest places with no parental involvement requirement are New Jersey and the District of Columbia.)

19. Some of the minors I see do not tell a parent because of what they have seen in their homes. They fear for their safety, physically and emotionally. The following stories provide just a small sampling of some of the very real reasons teens cannot safely involve a parent. One seventeen year old came to us from Missouri, anxious to avoid suffering as her sister had. When the patient was just thirteen, her sixteen year old sister told their parents that she was pregnant and planning to obtain an abortion. Their father proceeded to beat the sister and throw her and all of her clothes out of the house. He then ordered the patient (again, then thirteen) and her ten year old brother to box their sister's belongings and take them to a dumpster. Everyone in the family was forbidden from having contact with the older sister. Four years later, the patient and her family still knew nothing of the sister's whereabouts. Her mother was submissive and took the father's side. The teen was terrified her father would react similarly if she told him of her pregnancy and decision to have an abortion.

20. Another minor patient spoke of her sister who had become pregnant when the patient was younger. The sister had told her parents, and they forced her to give birth and put the child up for adoption. The sister subsequently tried to commit suicide and, at the time the patient came to us, was institutionalized for depression. This patient did not want to involve her parents for fear that she, like her sister, would be forced to continue the pregnancy.

21. Another minor patient told me about her older sister who was thrown out of the house by her parents when she became pregnant as "punishment for her sin." When the patient came to us, her parents still acted as if they had only one daughter. This patient did not want to lose her family and home, or the sense that she ever even existed for her family.

22. Yet another minor patient, the youngest of four girls, told me how her sisters had all became pregnant as minors, and how her parents threw each sister out of the house. The patient was an excellent student, had a college scholarship, and, in general, felt that she had her life ahead of her. Understandably, given what she had seen, she feared that, if her parents found out about her pregnancy, they would throw her out of the house too. She also could not bear the thought that her parents would think that they had failed in raising all of their children.

23. Another minor who came to Hope Clinic with her DCFS case worker told me that DCFS removed her from her home after she was beaten by her mother. The minor had confided in her favorite teacher about being pregnant, and the teacher must have told the principal, who called the minor's mother. When the minor came home from school, her mother was furious. That night when the minor was asleep, her mother came into her room, turned on the light, threw off her covers, tore her clothes off, and beat her with a cord. The minor told her best friend about the beating, and it was the best friend's mother who called DCFS to report the mother's actions.

24. Although these stories may seem unbelievable because they are so harsh, I have witnessed first hand some of the truly awful behavior some parents are capable of when faced with their daughters' pregnancy. Indeed, some parents try to force their daughters to have abortions against their will. We screen all minors for this possibility (just like we screen all women for partner and other types of coercion) and if we are concerned that the minor is being

pressured we will not provide the abortion. Although we meet with the parents to explain why we cannot provide the abortion and to attempt to calm the parents down, sometimes parents have reacted severely. In some cases, a parent's rage has been so out of control, I have been afraid to be in the room alone with the parent for fear that I would be attacked. In other instances, the parent has abandoned their daughter right there at the clinic. They have said things to us like "I'm finished with her" or "You can have her," and then proceeded to storm out of the clinic and drive away. Sometimes we have managed to reach them on a cell phone and explain to them that it is against the law to leave their daughter at the clinic far away from home with no way to get back. Sometimes they relent and come back, but sometimes they don't. Indeed, we have had situations where we eventually had to call the police and DCFS because the parent literally would not come back for their child.

25. I have also counseled minors who are estranged from their parents because, for example, their parents are in jail, are drug abusers, or abandoned the patient when she was young. These minors see no benefit and much emotional downside to initiating contact with these "parents" who are absent from their lives and who provide them with no support or guidance for the sole purpose of telling them they are pregnant and want an abortion. Some of these minors live with an adult sibling or an aunt who supports their decision to have an abortion, but who does not qualify as a recipient of notice under the Act.

26. Other minors come from loving homes but still feel they cannot involve a parent because of deep concern for their parents' mental and/or physical health. For example, one minor patient chose not to tell her parents about her pregnancy and abortion because her brother was in prison, her maternal grandmother had just died, and her mother had just been diagnosed with breast cancer and put on antidepressants. This minor, who had no relationship with her

father, came to our clinic with her eighteen year old sister. Both she and her sister believed that news of the pregnancy would devastate their mother and possibly compromise her health.

27. Finally, some minors we counsel are the "good girls" in their families: they are the type of teen who is a straight-A student, star athlete, or singer in the church choir and who helps around the house, goes to church every Sunday, and is destined for college. These teens are deeply ashamed of the fact that they became pregnant, and the prospect of disappointing their parents by telling them is simply unimaginable. As difficult as it may be for some people to understand, these teens are concerned that it would completely alter their parents' perception of them and they are terrified of emotional abandonment and loss of their parents' love.

28. I know that some people think that the parental notice law will push these teens to talk to their parents and that nothing terrible will come of it. And, in fact, as I discussed before, we do talk to the teens we counsel about this possibility. But even if forcing a minor to talk to her parent would be o.k. for some teens, I can say with certainty that it won't be for all minors. I have seen teens who are so desperate not to disappoint their parents that they will go to extremes to avoid disclosing an abortion. For example, one such minor who came to Hope Clinic from Minnesota (which has a parental involvement law) came from a family who strongly opposed pre-marital sex and abortion on religious grounds. She was a straight-A student and was college bound. She felt so ashamed of herself and afraid of disappointing her parents that she drove the hundreds of miles to Hope Clinic so that she could have the abortion without letting her parents down. Another teen, Becky Bell from Indiana, went so far as to get an illegal abortion rather than tell and disappoint her parents. She died from the complications of the illegal abortion. Her story has been the subject of significant press, and her parents now travel the country to speak in opposition to parental involvement statutes.

Effect of the Act

29. The Act harms minors who have a compelling reason for not telling their parents about their pregnancies. As noted above, minors choose not to tell their parents about their decision to have an abortion for many reasons, including fear of abuse, fear of being disowned and being thrown out of the house, and fear of being forced to carry the pregnancy to term. The Act's alternatives – the abuse exception and the judicial bypass – are not sufficient for the teens I counsel.

30. The Act's abuse exception will not protect teens who fear abuse but have not previously been abused either physically or sexually. Consider the teens I described above who had seen their sisters abused or disowned but had not personally experienced the abuse. I do not even see how they could avail themselves of the Act's abuse exception, which requires the minor to declare that "*she* is a victim of sexual abuse, neglect, or physical abuse." (Emphasis added.)

31. Nor does it protect those who are at risk of emotional abuse. Unfortunately, this is a very real prospect for some of our patients. As just one example, I remember getting a call from the much older adult sister of a teenage patient. I don't know the full details of this patient's home situation, but suffice it to say that it was bad enough for this adult woman to recount to me how guilty she felt about having moved out of the house years before leaving her younger sister alone with her parents, but, as she said to me, she had to "get the hell out of there." This woman told me that since they learned of her sister's pregnancy, her parents had engaged in a prolonged period of degrading her sister (by, for example, repeatedly calling her a whore and telling her that she was no good) and isolating her from all outside sources of support, which for an adolescent who is having serious trouble at home, can cause significant depression. In fact, this patient was so depressed that her sister was seriously afraid that the patient would try

to kill herself. This adult woman thought that the situation was so dire that, after talking with us, she called DCFS about her own family.

32. Nor do I believe that the judicial bypass procedure set out in the Act provides an adequate safeguard for minors who cannot involve their parents. Every year, minors with very compelling reasons for not telling their parents drive long distances – sometimes hundreds of miles – to Hope Clinic rather than seek a judicial bypass in their home state. Many of these teens are so ashamed to find themselves pregnant and so fearful of having to reveal the intimate details of their lives to a complete stranger whose decision will alter the course of their lives that it simply is not a realistic option for them. Indeed, I have counseled minors who have resorted to drastic measures in attempts to self-induce an abortion to avoid notifying a parent or going to court. One patient intentionally picked a fight with her brother so that she could provoke him into punching her in the stomach because she thought that this would cause her to miscarry. Another minor threw herself down the stairs in an attempt to induce a miscarriage. Still another minor, who was a gymnast, told me that she devised a gymnastics practice regimen that she hoped would cause her to miscarry.

33. Moreover, regardless of the route they choose, the Act will delay some minors' abortions. Some minors faced with what they see as two untenable options will, as is human nature, delay while they decide what to do. For those who ultimately choose to go to court, that process will take additional time. Some older minors will delay their abortions until they are 18 in order to avoid the Act's requirements. Delaying an abortion has serious ramifications. Although abortion remains very safe, the medical risks do increase as pregnancy progresses. Moreover, as I explained before, the cost of an abortion increases sharply as a pregnancy progresses, putting an abortion out of reach for some teens.

Lack of Justification for the Act

34. Since we opened in 1974, teens who are unable to turn to a parent have been able to access safe, compassionate abortion care at Hope Clinic. The Act works a change in that longstanding practice based on inaccurate assumptions about teenagers and their families. As I explained above, I have no doubt that the Act is not in the "best interests" of minors, but rather will cause significant and irreversible harm. This is particularly upsetting to me because, based on my thirty-three years of experience, I see no justification for this Act. As an initial matter, while talking to a parent is, for many minors, a positive thing to do, we don't need a law to make this happen. Young people who feel that they can safely involve a parent do so on their own, or with a little help from us. As I explained above, those who don't, have strong reasons. Minors know their parents, their family history and family dynamics, and are in the best position to know if talking to a parent is or is not in their best interest.

35. My experience also shows me that the General Assembly's assumption that minors "often lack the ability to make fully informed choices that consider both the immediate and long-range consequences" is without basis. Our patient education and counseling sessions are extensive. I know from my years of professional counseling experience that minors are just as capable as adult women of understanding the short- and long-term risks and benefits of having an abortion. Some minors tell me that they wish to have an abortion because they have seen the impact of teenage pregnancies on the lives of their classmates and older sisters. Other minors want to finish high school, graduate with honors, get a scholarship, and go to college. These minors recognize that having a baby and being a mother would require them to divert their time and resources from their long-range goals for their lives. Minors tell me that they believe having a baby at their age would force them and their boyfriend to quit school, to find a job, and they

fear that they would never have enough time or money to continue with their education. They aptly reason that if they forego school, they will not be able to find a decent-paying job, which would deprive them and their child in the long-run.

36. Some minors fear that, at their age, they simply could not provide what they believe a child deserves. Many minors choosing an abortion explain that they feel unprepared to take on the responsibility of raising and providing for a child, and do not want their parent to raise both them and their child. Some minors tell me that they were raised by mothers who gave birth to them as teens, and they want better for their children. Regarding adoption, like many adult women, minors have told me that they could not face the prospect of parting with a baby once they carried it for nine months and gave birth. Based on my experience, these are thoughtful decisions made by minors who can ably assess the pros and cons of ending a pregnancy, becoming a parent at their age, or carrying to term and placing the child for adoption.

37. I talk to adult women about the long-term consequences of their previous decision to have an abortion when they were in their teens, and what these women tell me is directly contrary to the findings of the General Assembly. When I see patients who are seeking an abortion later in their lives for whatever reason and I learn that they had an abortion when they were minors, I always ask them how that first abortion impacted their lives. These women generally tell me that they were young, and that, though they recall the time as an emotional period in their lives, the abortion was undoubtedly the right choice for them in the long-run. These women echo the reasons that I hear from my minor patients – they confirm that, as minors, they were not financially capable of supporting a baby; they could not have provided a stable home life to a new baby; and they watched as their friends who had children when they were minors could not finish high school, go to college, and most ended up in dead-end jobs. In

contrast, women who tell me they were forced by their parents to have a baby when they wanted to abort have recounted long-term hardships for themselves and their children.

Conclusion

In sum, based on my thirty-three years of experience, I see no need for this law. It is based on false assumptions about minors and their families and will undoubtedly cause significant and irreversible harm.

Under penalties as provided by law pursuant to Section 1–109 of the Illinois Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that she verily believes the same to be true.

10/10/09 Anne Baker

Date Anne Baker