IN THE SUPREME COURT OF FLORIDA

NO. SC01-843

NORTH FLORIDA WOMEN'S HEALTH AND COUNSELING SERVICES, INC. ET AL.,

Plaintiffs/Petitioners,

v.

STATE OF FLORIDA; FLORIDA DEPARTMENT OF HEALTH; ET AL.,

Defendants/Respondents.

On Appeal from The First District Court of Appeal,
First District, State of Florida
(Case Numbers 1D00-1983, 1D00-2106)

BRIEF OF AMICI CURIAE PHYSICIANS FOR REPRODUCTIVE CHOICE AND HEALTH AND SOCIETY FOR ADOLESCENT MEDICINE IN SUPPORT OF PETITIONERS

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Pursuant to Florida Rule of Appellate Procedure 9.370, Physicians for Reproductive Choice and Health and the Society for Adolescent Medicine respectfully submit this brief as *amici curiae* in support of Plaintiffs/Petitioners North Florida Women's Health And Counseling Services, Inc., *et al.*

STATEMENT OF INTEREST

Physicians for Reproductive Choice and Health® (PRCH) is a national physician-led non-profit organization founded in 1992. PRCH represents close to 5,000 members, more than 2,600 of whom are physicians of various disciplines, including adolescent medicine, family practice, internal medicine, obstetrics/gynecology, pediatrics, and psychiatry, among others. The mission of PRCH is to enable concerned physicians to take a more active and visible role in support of universal health. PRCH is committed to ensuring that all people have the knowledge, access to quality services, and freedom of choice to make their own reproductive health decisions.

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

Amici have a particular interest in confidentiality between medical professionals and patients and in adolescents' access to reproductive health care. Thus, *amici* submit this brief to address the District Court of Appeal's assumptions about abortion, pregnancy, and other issues of health care for adolescents to help ensure that important medical facts are before this Court.

Counsel for all parties have consented to the filing of this brief. Copies of the consent letters are attached in the Appendix to this brief.

SUMMARY OF ARGUMENT

The Parental Notice of Abortion Act ("the Act") would prevent a pregnant adolescent from having access to abortion services without parental notification or a judicial bypass. *See* §_390.01115, Fla. Stat. (1999). The District Court of Appeal upheld the Act because it found the state's asserted interest in facilitating parents' involvement in protecting their minor daughters' health to be compelling. But this Court has already rejected the state's *own* interest in protecting the health of minor women, as well as the state's interest in preserving family unity, as permissible bases for restricting a minor's right to obtain an abortion. *See In re T.W.*, 551 So. 2d 1186, 1194 (Fla. 1989)); *see also J.A.S. v. State*, 705 So. 2d 1381, 1383-84 (Fla. 1998). The District Court of Appeal essentially combined those interests into a single interest. But because neither interest is sufficiently compelling to override the right to privacy under the Florida Constitution, the District Court of Appeal's analysis is unpersuasive and inconsistent with this Court's controlling precedents.

That the asserted state interest is not compelling is further shown by the Legislature's differential treatment of abortion as compared to other

medical treatments and procedures that Florida minors may obtain without parental involvement. The District Court of Appeal's explanations for that inconsistent treatment lack any foundation in medical fact and cannot provide any support for the court's conclusions. Moreover, the Act would in fact endanger minors' health by vitiating confidentiality, thus deterring teens from seeking health care. Finally, the Act would not affect the majority of teens who voluntarily confide in a parent, but would force parental involvement in precisely those family circumstances most likely to put adolescents at risk of abuse or other harm. Therefore, Defendants cannot and have not demonstrated that the Act furthers the asserted state interest.

ARGUMENT

I. THE LEGISLATURE'S APPARENT ASSUMPTION THAT ABORTION IS MORE DANGEROUS OR MORE COMPLICATED THAN OTHER HEALTH ISSUES RELATED TO SEXUALITY IS FACTUALLY WRONG.

The District Court of Appeal justified differential statutory treatment of abortion care from other sexual health issues, including pregnancy and sexually transmitted diseases, based on distinctions that do not withstand scrutiny. The court primarily emphasized that abortion entails surgery. (*See State v. North Fla. Women's Health & Counseling Servs.*, 26 Fla. L. Weekly D419, D422 (Fla. 1st DCA Feb. 9, 2001).) As empirical evidence shows, however, the court overstated both the medical risks associated with abortion and the complexity of post-abortion care — while *under*stating the risks of carrying a pregnancy to term and the complexity of proper prenatal care. The court also failed to appreciate the relative complexity of treatment for certain sexually transmitted diseases. In sum, the court's justifications for the singular and disfavored treatment of abortion care are built on facile assumptions that collapse in the face of medical facts.

a. **Abortion Is Less Likely to Result in Medical Complications or Death Than Carrying a Pregnancy to Term.**

Most abortions are performed in the first trimester, and the most common procedure in that period, though termed "surgery," in fact "takes approximately two to five minutes. ._._. [and] involves no incision and a minimum of bleeding."[1] Indeed, the trial court in this case found that "abortion is one of the safer surgical procedures" and that "[t]he risk of mortality or complications from abortion are very low." (*North Fla. Women's Health & Counseling Servs., Inc. v. State*, No. 99-3202, slip op. 5 (Fla. Cir. Ct. May 12, 2000) (*found at* R. vol. XIV at 2188-2205).) Indeed, the District Court of Appeal's undue emphasis on the surgical aspect of abortion collapses altogether in light of the court's failure to consider the Act's applicability to medical (non-surgical) abortion methods, such as mifepristone (also known as RU-486). *See North Fla. Women's Health &*

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1 *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 178 (4th Cir. 2000), *cert. denied*, 531 U.S. 1191 (2001); *see also id.* n.5 ("By way of comparison, according to one of the plaintiffs' experts whose testimony was credited by the district court, having a first trimester suction curettage abortion is safer than having a shot of penicillin in a physician's office.").

Counseling Servs., 26 Fla. L. Weekly at D425 n.3.

Medical professionals and courts have long recognized that surgical abortion is no more dangerous than carrying a pregnancy to term and, in fact, may be substantially safer, especially when performed in the first trimester. It is also generally safer for adolescent patients, who tend to be stronger and to heal more quickly.[2] Nearly 30 years ago, the United States Supreme Court recognized that "[m]ortality rates for women undergoing early abortions, where the procedure is legal, appear to be as low as or lower than the rates for normal childbirth." *Roe v. Wade*, 410 U.S. 113, 149 & n.44 (1973) (citing medical studies). Medical advancements since *Roe* have tipped the balance even further. *See City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 430 n. 11 (1983) ("There is substantial evidence that developments in the past decade,

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See National Research Council, Vol. I, *Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing* 125 (Hayes, ed. 1986) ("Complications following induced abortion are generally lower among adolescents than among older women, regardless of the gestation at which the abortion is performed or the method used.").

particularly the development of a much safer method for performing second-trimester abortions, have extended the period in which abortions are safer than childbirth." (citation omitted)).[3] In fact, the mortality rate for the most common abortion procedure used in the first trimester — when approximately 90 percent of abortions occur — is now one in 100,000, meaning that a woman is **more than 20 times less likely** to die from that procedure than to die carrying a pregnancy to term.[4]

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[3] *See also* Lisa M. Koonin *et al.*, *Abortion Surveillance — United States, 1996*, *in CDC Surveillance Summaries*, 48 Morbidity & Mortality Wkly. Rep. (No. SS-04), 8 (Centers for Disease Control, July 1999) ("From 1972 through 1992, the annual number of deaths associated with legal induced abortion has decreased by 58%.").

[4] *See Greenville Women's Clinic*, 222 F.3d at 178 ("[T]he mortality rate [from suction curettage abortion] is one in 100,000, which is about twenty-five times less risky than carrying a pregnancy to term."); Koonin *et al.*, *Abortion Surveillance*, *supra* note 3, at 6; Rachel Benson Gold, *Abortion and Woman's Health: A Turning Point for America?* 28-29 (Alan Guttmacher Inst. 1990) (providing statistics regarding mortality rates for abortion at eight weeks, nine weeks, and 11-12 weeks); Herschel W. Lawson *et al.*, *Abortion Surveillance — United States, 1984-85*, *in CDC Surveillance Summaries*, 38 Morbidity & Mortality Wkly. Rep. (No. SS-2), 11, 30-32 (providing statistics regarding number of abortions at the same intervals).

Considering abortions at all stages of pregnancy, a woman is still approximately 10 times less likely to die from abortion than from carrying a pregnancy to term.[5]

The risk of serious medical complications short of death is also low for abortion compared to pregnancy. Fewer than 8 per 1000 patients require hospitalization due to complications from surgical abortion,[6] compared to almost one hospitalization of a pregnant woman unrelated to delivery for every five deliveries of newborns.[7]

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[5] *See* Gold, *supra* note 4, at 29. Moreover, the mortality rate for pregnancy is even higher for teens. *See* Howard W. Ory, *Mortality Associated with Fertility and Fertility Control: 1983*, 15 Family Planning Perspectives 57, 59 (1983) ("Teenagers who carry a pregnancy to term have a mortality rate of 12.9 per 100,000."). In addition, researchers maintain that maternal mortality estimates related to pregnancy are underestimated by at least one-third. *See id.* at 57; Council on Scientific Affairs, American Medical Association, *Induced Termination of Pregnancy Before and After* Roe v. Wade*: Trends in the Mortality and Morbidity of Women*, 268 J. Am. Med. Assn. 3231, 3235 (1992).

[6] National Abortion Federation, *Summary of Annual Abortion Statistics* (1995).

[7] Trude A. Bennett *et al.*, *Pregnancy Associated Hospitalizations in the*

Defendants contend that the statutory distinction between an abortion (for which a minor's parent must be notified) and carrying a pregnancy to term (for which no such notification is required) is justified because, in almost all cases, a parent will be aware of a minor's pregnancy by the time she gives birth.[8] But pregnancy poses serious

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United States in 1991 and 1992: A Comprehensive View of Maternal Morbidity, 178 Am. J. Obstetrics & Gynecology 346, 348 (1998). Pregnant teens have the highest ratio of hospitalizations. *See id.* at 349.

[8] Although a majority of parents will discover their daughters' pregnancy, that is not true in all cases. (*See* Hill Aff. ¶_9 (*found at* R. vol. IV at 615-20); *North Fla. Women's Health & Counseling Servs., Inc. v. State*, No. 99-3202, slip op. 13 (Fla. Cir. Ct. May 12, 2000) (*found at* R. vol. XIV at 2188-2205).) For example, several cases of teens giving birth without their parents' knowledge have attracted national media attention, including a minor woman who gave birth at her prom, and a young couple who delivered their baby in a Delaware hotel room. *See* Doug Most, *A Grim Anniversary: Wyckoff Teens Live In Shadow of Trial in Baby's Death*, The Rec. N. N.J., Nov. 12, 1997, at A1; Laurie Goodstein & Blaine Harden, *Of Birth, Death and the Prom; Three of Life's Landmarks Converge as Teen Delivers, Abandons Baby at Dance*, Wash. Post, June 10, 1997, at A3. The problem is serious enough that 19 states have laws legalizing the safe abandonment of newborns and 19 other states are considering such laws. *See* Susan K. Livio, *Some Call Newborn Haven Law a Quick Fix – Critics Seek Focus on Prevention, Aid*, Newark Star-Ledger, Apr. 30, 2001, at 9. In addition, a parent's awareness of a pregnancy does not necessarily mean involvement in or awareness of every medical decision the minor makes in the course of

health risks long before birth — indeed, before any outward signs of pregnancy that Defendants argue give parents *de facto* notice. A variety of medical conditions caused by pregnancy can pose serious health risks to a pregnant woman of any age. For example, preeclampsia (a form of pregnancy-induced hypertension) is a leading cause of maternal morbidity during pregnancy, and can lead to destruction of the liver or the kidneys or hemorrhage into the liver.[9] Patients with preeclampsia can also experience eclampsia, characterized by grand mal seizures and comas.[10] Other conditions that women, particularly minors, may

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the pregnancy. (Hill Aff. ¶ 9 (*found at* R. vol. IV at 615-20).)

9 *See* CHERRY AND MERKATZ'S COMPLICATIONS OF PREGNANCY, 207, 213-14 (5th ed. 2000).

Left untreated, preeclampsia can cause cerebral hemorrhage, liver dysfunction, kidney failure, or vision loss. *See* Eva Martin, *Preeclampsia*, <http://www.healthanswers.com/Library/MedEnc/enc/ 2084.asp> (last visited Nov. 19, 2001); *Planned Parenthood of the Rocky Mountains Servs. Corp. v. Owens*, 107 F. Supp. 2d 1271, 1277 (D. Colo. 2000).

10 Martin, *supra* note 9.

experience during pregnancy include "premature rupture of membranes and inevitable spontaneous abortion."[11] Premature rupture of the membranes can cause serious infection and in some cases permanent damage to the reproductive system.[12] Inevitable spontaneous abortion may result in infection, extensive blood loss, shock, and even death.[13] In addition, ectopic pregnancy, in which a fertilized egg implants outside the uterus (most often in the fallopian tube), occurs in approximately one in 50 pregnancies and is the leading cause of pregnancy-related death during the first trimester.[14]

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Owens, 107 F. Supp. 2d at 1277; *see also Planned Parenthood v. Casey*, 744 F. Supp. 1323, 1347 (E.D. Pa. 1990), *aff'd in part and rev'd in part*, 947 F.2d 682 (3d Cir. 1991), *aff'd in part and rev'd in part*, 505 U.S. 833 (1992).

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See Michael T. Parsons & William N. Spellacy, *Premature Rupture of Membranes*, in DANFORTH'S OBSTETRICS AND GYNECOLOGY, at 269 (8th ed. 1999).

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WILLIAMS OBSTETRICS, at 592 (20th ed. 1997); *see also Casey*, 744 F. Supp. at 1346-47.

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Carrying a pregnancy to term is particularly dangerous for adolescents. Both preeclampsia and eclampsia occur most often in young women in first-time pregnancies.[15] Teenagers are also at higher risk for iron-deficiency anemia, toxemia, complications from small pelvises, and cervical immaturity resulting in premature birth.[16] Moreover, adolescents

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Current Trends Ectopic Pregnancy — United States, 1990-92, 44 Morbidity & Mortality Wkly. Rep. 44, 46-48 (Jan. 27, 1995), *available at* <http:// www.cdc.gov/mmwr/preview/mmwrhtml/00035709.htm>; Planned Parenthood Federation of America, *Ectopic Pregnancy*, *available at* <http:// www.plannedparenthood.org/womenshealth/ectopic.html> (last visited Nov. 19, 2001).

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See, *e.g.*, J.M. Roberts & D.W. Cooper, *Pathogenesis and Genetics of Pre-Eclampsia*, 357 Lancet 53-56 (Jan. 6, 2001) (noting that preeclampsia is most common in first pregnancies); Carolyn Makinson, *The Health Consequences of Teenage Fertility*, 17 Family Planning Perspectives 132, 133 (1985) (finding incidence of eclampsia among younger teens to be twice as high as among older teens); *see also Casey*, 744 F. Supp. at 1347 (noting that preeclampsia "tends to occur more frequently in first time pregnancies and younger patients").

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National Research Council, Vol. II, *Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing* 111-16 (Hofferth & Hayes, eds. 1988); Makinson, *supra* note 15, at 133-34.

are twice as likely as older women to delay the diagnosis of pregnancy, for a variety of reasons ranging from irregular menstruation that results in later discovery of pregnancy, lack of experience with the health care system, and difficulty paying for care.[17] This propensity to delay care places most adolescents in a higher risk category for pregnancy complications than older women. They are more likely to experience such complications, and less likely to have those complications diagnosed at an early and more treatable stage.[18] And a parent or guardian who is unaware that his or her daughter or ward is pregnant "will be at a serious disadvantage in caring for her if complications develop." (*North Fla. Women's Health & Counseling Servs.*, 26 Fla. L. Weekly at D422.)

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17 *See* American Academy of Pediatrics, Policy Statement, *The Adolescent's Right to Confidential Care When Considering Abortion*, 97 Pediatrics 746, 749 (1996); Aida Torres & Jacqueline Darroch Forrest, *Why Do Women Have Abortions?*, 20 Family Planning Perspectives 169, 174-75 (1988); Institute of Medicine, *Prenatal Care: Reaching Mothers, Reaching Infants* 78, 101 (Brown ed. 1988).

18 *See generally* Makinson, *supra* note 15.

The District Court of Appeal, however, disregarded the unrefuted evidence of the risks of pregnancy altogether. The court simply observed repeatedly that abortion involves a surgical procedure, then noted, in contrast, that "pregnancy-related treatment includes general checkups as a matter of course, perhaps ultrasound studies or x-rays, but by no means always surgery."[19] The court's dismissive summary of pregnancy-related treatment demonstrates the court's utter failure to appreciate the risks inherent in carrying a pregnancy to term, particularly for adolescent women — and more so for those who do not obtain proper medical care.

b. **Prenatal Care Is at Least as Complicated — and as Vital — as Post-Abortion Care.**

The District Court of Appeal underestimated the care required for pregnancy relative to post-abortion care. Proper post-abortion care is, in fact, less demanding than prenatal care.

Proper post-abortion care begins in the recovery room, where the patient is monitored to ensure that blood pressure and heart rate are stable

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19 *North Fla. Women's Health & Counseling Servs.*, 26 Fla. L. Weekly at D422.

and that there is no abnormal bleeding or discomfort.[20] When the patient is released, she is given the number for a 24-hour answering service to contact if there are symptoms of complications, such as incomplete abortion, cut or torn cervix, organ injury or infection. She may be given a prescription for antibiotics.[21] She is instructed to watch for "severe pain, chills or fever with a temperature of more than 100.4, bleeding heavier than the heaviest day of her normal menstrual period…, foul smelling discharge or drainage from her vagina, or continuing symptoms of pregnancy."[22] She is also instructed not to use tampons, have intercourse, or take a tub bath

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See National Abortion Federation, *Having an Abortion? Your Good Care Guide*, *available at* <http://www.prochoice.org/Pregnant/Choose/GoodCareGuide.htm> (last visited Nov. 19, 2001).

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See id; see also Tucson Woman's Clinic, *Taking Care of Yourself After A Surgical Abortion* <http://gynpages.com/twc/ aftercare.html> (last visited Nov. 19, 2001).

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See Susan Dudley, *Safety of Abortion*, (National Abortion Federation 2000), *available at* <http://www.prochoice.org> (July 2, 2001).

for a short period.[23] The patient is also directed to return for a follow-up exam in two to four weeks to ensure the abortion was successfully completed. The patient can often return to normal activities the next day.[24] Although a minor must be vigilant in watching for the signs of potential complications, and in seeking care if she has symptoms, the time period during which she must monitor herself is relatively short.

In contrast, proper prenatal care requires a significant commitment from an adolescent. To ensure that both the fetus and the mother are healthy, the mother must commit to eating well so that she gets the proper vitamins and minerals, and so that she does not eat something that could

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23 Tucson Woman's Clinic, *supra* note 22; Feminist Women's Health Center, *After an Abortion*, < http://www.fwhc.org/aftercare.htm> (last visited Nov. 12, 2001).

24 *See* Planned Parenthood Federation of America, *Surgical Abortion – Questions and Answers*, *available at* <http://www.plannedparenthood.org/ABORTION/surgabort3.html> (last visited Nov. 19, 2001); *see also Abortion, in ADAM Med.*, *available at* <http://my.webmd.com/content/asset/adam_surgery_induced_abortion> (last visited Nov. 19, 2001).

harm the fetus.[25] The pregnant woman must exercise, get plenty of rest, abstain from alcohol, drugs, and smoking, and reduce or eliminate her intake of caffeine.[26] Each of these recommendations could require a long-term lifestyle change.

The mother also needs to ensure she is getting proper medical care, and that she attends all of her scheduled appointments so she is properly monitored.[27] As a part of her care, her doctor may suggest an amniocentesis. During this procedure, a thin needle is inserted into the uterus to obtain a sample of amniotic fluid. The procedure has a small risk of causing miscarriage or other abnormalities such as a club foot. Florida

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25 *See* Planned Parenthood Federation of America, *Having a Healthy Baby – Your Personal Guide for Good Prenatal Care* (1998), *available at* <http://www.plannedparenthood.org/PARENTS/prenatal-page1.html> (last visited Nov. 19, 2001).

26 *See id.*

27 *See id.*

minors are allowed to weigh the risks and benefits of this procedure without parental notification.

Moreover, a pregnant minor also has to monitor herself to detect signs of premature labor, ectopic pregnancy, preeclampsia, toxemia or other serious problems so that she knows when to seek medical care. These signs include heavy bleeding, severe abdominal pain or cramps, or severe vomiting. After six months, she also must monitor whether the fetus has moved in the last eight hours.[28] These actions require a significant time commitment as well as the ability to recognize the signs of a complication. Failure to follow these recommendations can have serious consequences for both the pregnant woman and the fetus. Indeed, what the District Court of Appeal failed to appreciate, as discussed above, is that pregnancy is *more* dangerous than abortion. If parental knowledge of a minor's need for health care is important, it is especially crucial for parents to know that a minor is pregnant — early in the pregnancy — because of

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[28] *See id.*

the dangers posed by the failure to obtain pregnancy-related treatment.

Nevertheless, if a complication arises, a pregnant teen is allowed to receive care without parental notification. For example, if a teen has an incomplete miscarriage, her doctor may perform a dilation and curettage — the same procedure performed in most surgical abortions.[29] A pregnant minor may also need treatment for an ectopic pregnancy — treatment she can receive without parental notification. If a doctor discovers an ectopic pregnancy, surgical treatment is normally needed.[30] In addition to normal post-operative care following surgery for an ectopic pregnancy, the doctor has to monitor the woman's human chorionic gonadotropin level for up to 12 weeks to ensure that all of the ectopic tissue was removed.[31] As noted

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29 *See* Intelihealth, *Miscarriage (Spontaneous Abortion*), *available at* <http://www.intelihealth.com> (last updated Feb. 24, 2000).

30 *See* March of Dimes, *Ectopic and Molar Pregnancy* , *available at* <http://www.modimes.org/HealthLibrary2/FactSheets/Ectopic_and_Molar.htm> (last visited Nov. 4, 2001).

31 *See Ectopic Pregnancy*, *available at* <http://kidshealth.org/parent/pregnancy_newborn/pregnancy/ectopic-pt.html> (last visited Nov. 4,

above, these complications occur early in pregnancy before a minor's pregnancy becomes evident and therefore before the *de facto* notice the District Court of Appeal found made state-mandated notice unnecessary.

In addition, the pregnant minor can make decisions on her own regarding treatment for complications that can have serious consequences either for her or for the fetus without consulting or notifying a parent.[32] For example, if the teen is in premature labor, she can choose to forestall the labor with steroids.[33] The steroids can pose serious risks, like pulmonary edema, to the woman.[34] In addition, if the teen has toxemia, she has

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2001).

32 A parent may know of a pregnancy but not of the medical decisions a minor makes during the pregnancy. (Hill Aff. ¶ 9 (*found at* R. vol. IV at 615-20).)

33 *See id.* ¶_6.

34 *See id.*

another difficult decision to make: she can choose to go forward with the pregnancy to give the fetus a better chance of survival while risking her own life[35]; or she can choose to end the pregnancy by inducing labor or by undergoing a cesarean section.[36]

Florida law allows a pregnant minor to make all of these prenatal care decisions without notifying a parent. These decisions are complicated, have long-term effects, and may have life or death consequences. Although placing abortion care within the veil of surgical care makes it appear more serious, comparison with pre-natal care puts the risks in perspective. As a result, the District Court of Appeal's assumption that abortion care is more complicated and therefore that parental notification is warranted for abortion but not for pregnancy-related care is factually false.

c. **Care for Sexually Transmitted Diseases Is at Least as Complicated — and as Vital — as Post-Abortion Care.**

Abortion after-care also can be contrasted with HIV care, which a

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35 *See id.* ¶_5.

36 *See id.*

Florida teen can seek on her own. *See* § 384.30, Fla. Stat. (2000). A person diagnosed with HIV has a lot of information to learn and many decisions to make. The type of treatment a person with HIV receives depends on what stage the disease has reached. Assuming the patient is diagnosed at the very early stages of HIV, treatment often begins with the monitoring of immune health.[37] This includes symptom observation, such as watching for thrush, pneumocystis and other opportunistic infections, and lab studies and blood analysis to measure the amount of HIV antibodies, the viral load, and the number of CD4+ cells.[38] During this stage, it is also important that the patient adopt a lifestyle that promotes good health, including good nutrition, exercise, adequate rest and avoiding alcohol,

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See Project Inform, *Day One: After You've Tested Positive* (Jan. 1998), *available at* <http://www.projectinform.org/fs/dp-day1.html> (last visited Nov. 19, 2001); *see also* Panel on Clinical Practices of HIV Infection, U.S. Dept. of Health and Human Services, *Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents*, 2 (Aug. 13, 2001), *available at* <http://www.hivatis.org/guidelines/adult/Aug13_01/pdf/AAAug13S.PDF>.

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See Project Inform, *supra* note 37.

smoking and drugs.[39]

Once the disease has progressed to medically significant point, a physician may recommend anti-HIV Therapy.[40] The choice of therapy is a complicated decision for both the patient and the doctor because the therapy chosen must be one the patient can adhere to long-term given her lifestyle, and will depend on the side effects and eating requirements the patient feels she can master.[41] The choice of therapy is critical to the patient because she must adhere to it in order to delay and perhaps prevent the onset of full-blown AIDS and death. The patient must undertake this

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39 *See id.*

40 The relevant benchmarks are where the amount of CD4+ cells has dropped below 350 or the viral load exceeds 30,000 copies by bDNA or 55,00 by RT-CPR. *See* Panel on Clinical Practices of HIV Infection, *supra* note 37, at ii.

41 *See id.* at 9; *see also* Project Inform, *supra* note 37. Some health care providers offer "dry runs" for their patients using jelly beans to familiarize them with the rigors of anti-HIV therapy. *See* Panel on Clinical Practices of HIV Infection, *supra* note 37, at 11.

complicated therapy, with its serious side effects that include headaches, anemia, and suppressed white-blood counts, while at the same time treating any opportunistic infections that arise as the patient's ability to fight infection decreases. The choice of therapies is also important to public health generally because if the patient does not adhere to the regimen there is a risk that a drug resistant strain of the HIV virus will develop.[42] Thus, treatment of HIV is complicated, involves many choices, and requires a very strong and long-term commitment from a minor for her own health as well as the health of others.

Post-abortion care and treatment for sexually transmitted diseases (STDs) are very similar. A minor with an STD is often treated with a course of antibiotics or an anti-viral drug.[43] She must monitor her

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42 *See id.* at 9.

43 *See generally* Planned Parenthood Federation of America, *Sexually Transmitted Infections: The Facts*, (2000) (discussing various STDs and their treatment), *at* <http://www.plannedparenthood.org/ sti/stis_index.html> (last visited July 2, 2001); *see also* CDC MMWR Recommendations and Reports, *1998 Guidelines for Treatment of Sexually Transmitted Diseases*, (Jan. 23, 1998), *available at*

symptoms to ensure that she is improving and have a follow-up visit with her doctor. Some STDs, such as herpes, require life-long care to relieve symptoms, or as in the case of human papilloma virus, require monitoring with pap tests to reveal precancerous conditions.[44] If STDs are not properly treated, the minor risks pelvic-inflammatory disease, infertility, long-term pelvic pain, arthritis, and problems with newborn children.[45]

In sum, although the fact that abortion is a "surgical procedure" may give the appearance that the possible complications of an abortion are more serious, those appearances are misleading and incorrect — the aftercare and monitoring required is similar to that required for most STDs, and much less than that required for HIV, for which parental notification is not

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<http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00050909.htm>.

44 *See* Planned Parenthood Federation of America, *Sexually Transmitted Infections*, *supra* note 43.

45 *See* Planned Parenthood Federation of America, *Fact Sheet*: *Sexually Transmitted Infections*, *available at* <http://www.plannedparenthood.org/library/STI/STI_fact.html> (Apr. 2001).

required.

The District Court of Appeal plainly failed to appreciate these medical realities, instead resting its entire analysis on the surgical aspect of abortion. The court's rationale for upholding differential statutory treatment was based solely on unsupported and incorrect assumptions about the relative risks and complexity of abortion and post-abortion care versus pregnancy and pregnancy-related care. As these medical facts show, however, the legislature's assumption that an abortion involves a greater health risk to the minor is not medically sound. Therefore, the Defendants have not met their burden of showing that the Act furthers a compelling state interest.

II. THE ACT DOES NOT FURTHER THE STATE'S PURPORTED INTEREST IN FACILITATING PARENTS' ABILITY TO PROVIDE APPROPRIATE MEDICAL CARE FOR THEIR DAUGHTERS BECAUSE IT WOULD IN FACT ENDANGER MINORS' HEALTH.

The asserted justification for the Parental Notification of Abortion Act is the state's interest in promoting adolescent health and family communication. In truth, however, the Act would *disserve* these very

interests. By requiring parental notification or judicial bypass, the Act would do nothing to foster family communications. Instead, it would ensure that a substantial number of minors would *not* receive medical care they need.

A. Depriving Minors of Confidentiality in Reproductive Health Care Would Deter Some Teens From Seeking Health Care.

Medical research demonstrates the clear need for adolescents to be able to access medical services confidentially.[46] This is particularly true when the care is for sensitive issues like substance abuse, mental health, venereal disease and pregnancy prevention and care. Studies show that in certain circumstances adolescents will forgo health care entirely if they believe their parents will find out about their use of such services.[47] Many

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46 Garry Sigman *et al.*, *Confidential Health Care for Adolescents: A Position Paper of the Society for Adolescent Medicine* (Elsevier Science Inc. 2000), *available at* <http://www.adolescenthealth.org/html/confidential.html>.

47 *See, e.g.*, Council on Ethical and Judicial Affairs, American Medical Association, *Council Report: Mandatory Parental Consent to Abortion*, 269 JAMA 82, 83 (1993) ("Organized medicine has viewed confidential care for adolescents as essential to their use of health services."); Catherine Grevers Schmidt, *Where Privacy Fails: Equal Protection and the Abortion Rights of*

states, including Florida, recognize that adolescents' choice to forgo health care raises serious public health concerns, and thus have enacted laws that permit adolescents to consent to medical care in these sensitive areas without the need for parental consent or notification. *See*, *e.g.*, §§_381.0051(5)(a), 384.30, 743.065(1), Fla. Stat. (2000).

Confidentiality is especially important to adolescents seeking reproductive health services. Lack of confidentiality has been cited by adolescent girls as a reason not to have a pelvic exam and to delay seeking contraceptive services from school-based providers.[48] Adolescent girls also cite a family planning clinic's confidentiality policy as a reason for choosing a particular clinic.[49]

Minors, 68 N.Y.U. L. Rev. 597, 636 (1993).

48 *See* Jeannie S. Thrall *et al.*, *Confidentiality and Adolescents' Use of Providers for Health Information and for Pelvic Examinations*, 154 Archives of Pediatric & Adolescent Med. 885 (2000).

49 *See* Laurie Schwab Zabin & Samuel D. Clark, Jr., *Institutional Factors Affecting Teenagers' Choice and Reasons for Delay in Attending a Family Planning Clinic*, 15 Family Planning Perspectives 25, 26-27 (1983).

Confidentiality is so important because adolescent sexuality and accompanying pregnancy issues are delicate subjects that some teens cannot discuss with their parents. In particular, some teens choose not to inform their parents of their pregnancy due to fear of experiencing physical abuse, hurting or disappointing their parents, triggering punishment, or causing their parents additional stress (if for example, the parent is ill).[50] In addition, nearly one-third of all minors who decide not to tell a parent about their abortion decision say they chose not to do so because of a fear of violence based on an earlier episode of parental violence in the home.[51] Moreover, teens who delayed their first clinic visit until the point where they suspected they might be pregnant were almost twice as likely to be

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50 *See* Stanley K. Henshaw & Kathryn Kost, *Parental Involvement in Minors' Abortion Decisions*, 24 Family Planning Perspectives 196, 202 tbl.5 (1992).

51 *See id.* at 196.

among those who said they feared parental discovery.[52]

Unfortunately, as discussed further in Part B, *infra*, the teens' fears are not unfounded. Adolescents who strongly oppose informing their parent of their pregnancy tend accurately to predict the family reaction to it.[53] Studies of confidentiality policies and practices demonstrate it is not always in the adolescent's best interest to notify a parent.

Lack of confidentiality for reproductive health care results in a serious public health problem — teens who forgo or delay health care rather than risk having their parents discover they were seeking such services. One study found that of adolescents who have abortions, nearly

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See Laurie Schwab Zabin & Samuel D. Clark, Jr., *Why They Delay: A Study of Teenage Family Planning Clinic Patients*, 13 Family Planning Perspectives 205, 215 tbl.12 (1981); Laurie S. Zabin et al., *Reasons for Delay in Contraceptive Clinic Utilization: Adolescent Clinic and Nonclinic Populations Compared*, 12 J. Adolescent Health 225, 230 tbl.2 (1991).

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See American Academy of Pediatrics, Policy Statement, *supra* note 17, at 748.

25 percent stated they had not informed their parents of their decision.[54] In addition, if their parents had found out, between 6 and 11 percent said they would not have come to a clinic but rather would have had a self-induced abortion or an illegal abortion.[55]

This study shows the need for confidential abortion care for minors is critical. Without confidentiality some teens will not seek the care they need or may delay obtaining care, thereby putting their health at risk. Additionally, adolescents who make their own decisions regarding abortion without being unduly influenced by someone else, including a parent, are most likely to be satisfied with their decisions in the long run.[56]

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See Aida Torres et. al., *Telling Parents: Clinics Policies and Adolescents' Use of Family Planning and Abortion Services*, 12 Family Planning Perspectives 284, 289 tbl.7 (1980).

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See id.

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See American Academy of Pediatrics, *supra* note 17, at 748; Laurie Schwab Zabin *et al.*, *When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy*, 21 Family Planning Perspectives 248 (1989).

For these reasons, confidentiality is important to both a minor's physical health and her mental health. Rather than protect the health of minor women, the Act would deter them from seeking care and would actually endanger their health.

B. Forced Parental Notification Would Not Facilitate Parental Involvement, But Could Harm Some Minors.

The Act fails to further the state's asserted interest in facilitating parents' provision of medical care for their daughters. Indeed, as discussed above, the Act's principal effect would be just the opposite — preventing adolescents from obtaining medical care. Moreover, the statute does not merely fail to protect minors' health, but actually subordinates minors' fundamental health and privacy interests to their parents' interest in being informed — which in abusive or dysfunctional families could have devastating consequences. As a result, although the Act would be largely superfluous as to most pregnant minors seeking abortions, it would be ineffective for its stated purpose, and potentially dangerous, as to the rest.

The legislature's folly is the belief that healthy family interactions can

be imposed by legislative fiat.[57] That proposition is not only implausible on its face but also empirically false. In reality, the effect of the statute will be determined by preexisting family relationships.[58] The majority of adolescent women, having sufficiently positive relationships with one or more parents that they would, in any event, involve a parent in the decision whether to obtain an abortion, would be largely unaffected by the Act (except to the extent that it imposes burdensome administrative requirements that could delay medical care).[59] The substantial minority of

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[57] "[T]he Legislature's purpose in enacting parental notice legislation is to further the important and compelling state interests of ._._. fostering family unity and preserving the family as a viable social unit ._._._." 1999 Fla. Laws ch. 99-322, at 3419.

[58] *See* Zabin TT 63:7-15 ("I know of no evidence in any study . . . that suggests that . . . the kind of positive communication which results in better outcomes can be legislated or forced on a family. It appears from everything I have ever seen that these are patterns that are established very, very early and that communication either exists in this family situation or does not exist.")

[59] Though not inconsiderable, the burdensomeness of such requirements (such as additional delay, multiple visits to a clinic, etc.) is not the focus of this brief.

adolescent women who are not so fortunate, however, could be deterred from seeking medical care, as discussed above, or could be harmed if they did seek care. They would, at best, be penalized for their circumstances, and, at worst, be placed in jeopardy due to violence, other abusive behavior, or expulsion from their homes.[60]

Research has shown that most minors who seek abortions do so with their parents' knowledge even absent laws requiring notice. In a leading study that surveyed minors seeking abortions in states where parental involvement was not mandatory, approximately 61 percent of minors seeking abortions had at least one parent who knew of their intent to obtain an abortion; of those, the minors had told 75 percent of the parents themselves.[61] Moreover, researchers found that 91 percent of the minors in

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60 Abused minors may be the least likely to be willing to use the judicial bypass. Kro Tr. at 798:17-799:11, 801:22-802:10, 803:12-16, 804:4-17.

61 Henshaw & Kost, *supra* note 50.

a study of urban teenagers reported consulting a parent or a "parent surrogate" (such as a grandparent, other relative, family friend, teacher, or clergy) with respect to the decision whether to abort.[62]

Younger minors are even more likely to involve their parents in the decision to obtain an abortion than are older teens. Henshaw and Kost determined that approximately **90 percent** of minors aged 14 or younger told a parent.[63] Those minors who did not tell a parent were disproportionately older (16 or 17) and employed.[64] And of those minors, 52 percent consulted another trusted adult and 22 percent consulted a

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See Laurie Schwab Zabin *et al.*, *To Whom Do Inner-City Minors Talk About Their Pregnancies? Adolescents' Communication With Parents and Parent Surrogates*, 24 Family Planning Perspectives 148 (1992); Zabin *et al.*, *When Urban Adolescents Choose Abortion*, *supra* note 56.

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See Henshaw & Kost, *supra* note 50, at 200 tbl.3. *See also* Zabin TT 56:1-3 (confirming that Dr. Zabin's research showed "a very strong relationship" between age and consultation with a parent, such that younger adolescents "were much more likely to have talked to parents").

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See Henshaw & Kost, *supra* note 50.

professional.[65]

Abortion providers believe that parental involvement in minors' decision making about abortion is desirable in most circumstances. Indeed, abortion counselors routinely encourage adolescent patients to consult their parents.[66] While they share the legislature's ideal, however, they recognize that not all family relationships are conducive to such communication, that healthy relationships cannot be imposed by law, and that in some families parental involvement would actually endanger the pregnant minor.

Studies confirm this sad fact. Of the minors surveyed by Henshaw and Kost whose parents did not know they were pregnant, 30 percent had a history of violence in their families, feared violence, or were afraid of

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65 *See id.*

66 *See*, *e.g.*, Zabin TT 32:2-5. *See also id.* at 34:19-35:1 ("This doesn't mean that most teens don't want to communicate with parents. They desperately do on some level and, in fact, those who do so voluntarily and early are certainly the best off . . . .").

being thrown out of their homes if their parents found out.[67] And the evidence shows such fears to be well-founded. In opposing parental consent or notification laws like the one at issue here, the Council on Ethical and Judicial Affairs of the American Medical Association noted that in dysfunctional families, disclosure of a minor's pregnancy often exacerbates the dysfunction:

> Research on abusive and dysfunctional families has shown that family violence is at its worst during a family member's pregnancy, immediately following childbirth, and during the adolescence of the family's children._._._. Parental notification [of a minor's pregnancy] *often precipitates a family crisis*, characterized by severe parental anger and rejection of the minor."[68]

Setting aside the facial implausibility that a legislative act of

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67 *See* Henshaw & Kost, *supra* note 50.

68 Council on Ethical and Judicial Affairs, American Medical Association, *Council Report: Mandatory Parental Consent to Abortion*, 269 JAMA 82, 83 (1993) (emphasis added); *see also* Henshaw & Kost, *supra* note 50, at 207 ("Our data suggest that informing parents of a daughter's pregnancy would produce negative reactions in some families.").

compulsion could magically create healthy, functional family relationships where they do not currently exist, there is simply no evidence to support a finding that the Act would further its stated purposes (and to counter the plentiful empirical evidence that it would have undesirable effects). The American Academy of Pediatrics has concluded that "[n]o studies show that forced disclosure results in improved parent-child relationships, improved communication, or improved satisfaction with the decision about pregnancy outcome."[69]

Amici fully support the laudable purpose of encouraging minors to communicate openly with their parents about important life choices, especially the decision whether to obtain an abortion. We aspire to a world in which no minor would walk into an abortion clinic without a parent holding her hand. The sad truth, however, is that not every family works that way, and — unfortunately for everyone — no act of the Florida legislature can make it so. In the meantime, while we all work to

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[69] American Academy of Pediatrics, Policy Statement, *supra* note 17, at 748.

improve the health of the nation's families, it is important that the health of minor women in the state of Florida not be sacrificed by legislation that will cause affirmative harm to the physical and emotional well-being of a significant number of these unfortunate young women. To the extent the legislature intended to facilitate parents' ability to help pregnant minors obtain medical care that is in their own best interests and promotes their medical and psychological well-being, it is clear that compulsory parental involvement wholly fails that purpose. By deterring minors from seeking needed medical care and exposing them to abusive and dysfunctional family situations, the Act harms minors.[70]

CONCLUSION

For the foregoing reasons, the judgment of the District Court of Appeal should be reversed.

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[70] Judicial bypass does not cure this harm but rather creates obstacles, thereby harming minors in a different manner.

Respectfully submitted,

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November 20, 2001

CERTIFICATE OF SERVICE

I certify that a true and correct copy of the BRIEF OF AMICI CURIAE PHYSICIANS FOR REPRODUCTIVE CHOICE AND HEALTH AND SOCIETY FOR ADOLESCENT MEDICINE IN SUPPORT OF PETITIONERS was served by first-class mail, postage pre-paid on November 20, 2001, on counsel for the parties, as follows:

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CERTIFICATE OF COMPLIANCE

As required by Florida Rule of Appellate Procedure 9.210(a)(2), I certify that this brief is submitted in Times New Roman 14-point font.

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