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

PLANNED PARENTHOOD OF THE GREAT NORTHWEST, HAWAI'I, ALASKA, INDIANA, and KENTUCKY, a Washington corporation,

Plaintiff,

v.

STATE OF ALASKA; DAVID BOSWELL, in his official capacity; LARRY DAUGHERTY, in his official capacity; CHRISTOPHER GAY, in his official capacity; SARAH BIGELOW HOOD, in her official capacity; LYDIA MIELKE, in her official capacity; STEVE PARKER, in his official capacity; RICHARD WEIN, in his official capacity; SHANNON CONNELLY, in her official capacity; CATHERINE HAMPLE, in her official capacity; LENA LAFFERTY, in her official capacity; WENDY MONRAD, in her official capacity, DANETTE SCHLOEDER, in her official capacity, and JULIE TISDALE, in her official capacity,

Defendants.

Case No. 3AN-19-11710 CI

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OPPOSITION TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

I. Introduction

Planned Parenthood has challenged a fifty-year old statute that decriminalized abortion, arguing that developments in medicine and the structure of the medical profession make the law bad policy for the twenty-first century. But despite alleging that the law unconstitutionally restricts access to abortion care, Planned Parenthood fails to take seriously its burden to show that this is actually the "real world effect" of the

law, devoting less than two pages of its motion to evidence allegedly supporting that claim. Moreover, even that discussion attempts to distract this Court by focusing on the broader, but distinct, difficulties posed by providing health care in a sparsely-populated and geographically vast state—difficulties that will not be ameliorated by enjoining the challenged law.

Planned Parenthood's constitutional claims fail because it has not offered competent evidence to show that the licensed-physician requirement actually burdens access to abortion in Alaska. To the contrary, the evidence shows that Planned Parenthood could provide abortion care on more days of the week than it chooses to while complying with the law, either by hiring more per diem doctors, or scheduling them differently. But instead, it attempts an end-run around the legislative process, asking this Court to decide that the law should be judicially updated to allow Planned Parenthood to provide abortion care at less cost to itself.

The presumption of constitutionality requires more of a plaintiff, especially when that plaintiff contends that a once constitutional law is now so outdated as to violate the constitution. Because Planned Parenthood has failed to meet its initial burden to show that the challenged law infringes on a constitutional right, this Court should deny its motion for summary judgment, and grant the State's motion.

II. Argument

A. Planned Parenthood seeks to avoid the democratic process, asking this Court rather than the legislature to update Alaska's laws regarding who may provide abortion care.

Planned Parenthood's motion for summary judgment reads like a white paper

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arguing the policy reasons for updating the State's licensed physician requirement to reflect changes in medical practice and the healthcare professions. But it is the legislature's job to update laws, not the courts'.[1] Although Planned Parenthood complains that the State "has for decades refused to repeal or cease enforcing the APC ban," [Pl.'s MSJ at 9] it fails to point to any occasion on which a repeal of the licensed physician requirement was proposed and rejected by the legislature, nor does it identify any efforts whatsoever that it has made to promote a legislative change.

Nor may "the State"—in the shape of the executive branch defendants to this lawsuit—simply decide not to enforce laws validly enacted by the legislature on the ground that there might be a better policy than that chosen by the legislature, as Planned Parenthood seems to believe. [Pl.'s MSJ at 9, 24] That is not how democracy works: the legislature enacts laws and the executive branch enforces them.[2] Thus, this Court should reject Planned Parenthood's implication of malign intent on the part of the defendants, because they are not empowered to decide not to enforce validly enacted laws simply because some interested parties think those laws are no longer good policy.

Planned Parenthood seeks to avoid the give-and-take of the legislative process, during which stakeholders with potentially different views from its own would also have an opportunity to provide input, and instead asks this Court to substitute its

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[1] *Planned Parenthood v. State (Planned Parenthood III)*, 171 P.3d at 579 (noting that courts "are not legislators, policy makers, or pundits charged with making law or assessing the wisdom of legislative enactments").

[2] Alaska Const. Art. III, § 16 ("The governor shall be responsible for the faithful execution of the laws.").

judgment for the legislature's and *amend* the statute. That is not the Court's function. To warrant judicial intervention, a plaintiff must do more than show a statute is out-of-date; it must demonstrate the statute imposes an unconstitutional burden.

B. A plaintiff must show that a law burdens a fundamental right in order to trigger strict scrutiny, but Planned Parenthood has not shown this.

Planned Parenthood notes that the "Alaska Supreme Court has repeatedly recognized that, based on the Privacy and Equal Protection Clauses, *laws that restrict access to abortion* are invalid unless they satisfy strict scrutiny." [Pl's MSJ at 17, emphasis added] But it does not take seriously the threshold requirement that it establish that *the law* actually restricts access to abortion. The cases it relies on—from *Valley Hospital* through the most recent Planned Parenthood case decided in 2019—each involved either a *new* policy or a *new* statute that imposed direct burdens on access to abortion: i.e. by prohibiting the performance of abortions in *Valley Hospital*, by limiting public funding to pay for indigent women's abortions, or by requiring minors to notify or obtain the consent of their parents before having an abortion.[3] The law challenged here is qualitatively different, because it does not *necessarily* affect access to abortion at

[3] *Valley Hospital Ass'n, Inc. v. Mat-Su Coal. for Choice*, 948 P.2d 963 (Alaska 1997) (ban on abortion in hospital); *State, Dep't of Health & Soc. Servs. v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904 (Alaska 2001) (*Planned Parenthood I*) (ban on Medicaid funding for abortion); *State v. Planned Parenthood of Alaska*, 35 P.3d 30 (Alaska 2001) (*Planned Parenthood II*) (requiring parental consent for abortion); *Planned Parenthood of Alaska*, 171 P.3d 577, 581 (Alaska 2007) (*Planned Parenthood III*) (same); *Planned Parenthood of The Great Northwest v. State*, 375 P.3d 1122 (Alaska 2016) (*Planned Parenthood IV*) (parental notification for abortion); *Planned Parenthood V*, 436 P.3d 984 (Alaska 2019) (restriction on Medicaid funding for abortion).

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all. If there are sufficient doctors available to provide abortion care to the Alaskan patients who need it, then the law does not limit access and does not infringe on women's right to reproductive choice.

Planned Parenthood appears to recognize that establishing the infringement is a necessary element of its proof, but it fails to offer actual evidence to support its claims. Instead, it simply asserts that it "has presented undisputed, common sense evidence that having full-time APCs offer abortion care would make this care more accessible than relying on occasional per diem physicians to make time outside their regular practice, particularly outside Anchorage where the physician network is more limited." [Pl.'s MSJ at 19] The flaw in this argument is that the licensed physician requirement does not require Planned Parenthood to rely on per diem physicians, so the dichotomy presented is a false one. It also ignores that Planned Parenthood's roster of per diem physicians appears to be sufficient to meet demand for abortion care in Alaska, other than in an occasional circumstance—certainly, Planned Parenthood has failed to explain why it could not provide medication abortion care daily using its current physicians.[4]

Moreover, the evidence shows that other Planned Parenthood affiliates employ full-time physicians;[5] and Planned Parenthood has not offered any evidence to show

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[4] Planned Parenthood has eight per diem physicians [Exhibit C, Pasternack Deposition at p. 143, lines 16-25] and the Anchorage clinic is open five days a week and two Saturdays a month. *See* Anchorage Clinic's website at https://www.plannedparenthood.org/health-center/alaska/anchorage/99508/anchorage-health-center-3254-91810?utm_campaign=anchorage-health-center&utm_medium=organic&utm_source=local-listing

[5] Exhibit M, Ramesh Deposition at p. 17, lines 13-15.

that this would not be financially practical for the Alaska affiliate. Its medical director, Dr. Tanya Pasternack, asserts in her affidavit in support of Planned Parenthood's motion for summary judgment, that it is too expensive to hire full-time doctors.[6] But this claim is unsupported by any additional information. Planned Parenthood could have, for example, compared the cost of employing its per diem physicians with the likely salary for a full-time physician, and demonstrated to the Court that its budget could not cover that salary. It chose not to, presumably because it isn't true. Indeed, at her deposition Dr. Pasternack denied knowledge of Planned Parenthood's finances,[7] so there also seems to be no foundation for her testimony on this issue.

Dr. Pasternack further testified that Planned Parenthood made the affirmative choice *not* to hire more per diem physicians because it was administratively easier to manage a more limited staff.[8] But Planned Parenthood cannot meet its evidentiary burden to show that the law restricts access to abortion by choosing for administrative reasons not to expand its staff or utilize its existing staff in a way that would expand access. Planned Parenthood's business model is not protected by the constitution; and if

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[6] Pasternack Aff. in support of MSJ at ¶ 20.

[7] Exhibit R, Pasternack Deposition at p. 15, lines 5-7: ("My role is not to oversee financial decisions or financial management in any way. Our affiliate has a separate operations team that does that.").

[8] Exhibit C, Pasternack Deposition at p. 145, lines 7-16 ("Every additional physician that I bring on to staff incurs a lot of investment, both time and financial, for them to be oriented to our policies and procedures, maintain electronic medical records subscription for them, make sure they're maintaining their required annual compliance modules. When more physicians are in the pool, their familiarity with those processes are all – I should say they have more frequent glitches that disrupt the flow day to day because these things aren't up to date or --").

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access to abortion is restricted by that business model, that does not make the licensed physician requirement unconstitutional. To the contrary, Planned Parenthood must show that it is *the law* that restricts access, not its own business choices.

Planned Parenthood also argues that the fact that it has "dramatically expand[ed] the days of week when medication abortion is available and far more patients than before are accessing this method" is evidence of the allegedly restrictive impact of the law. [Pl.'s MSJ at 19-20] But this demonstrates nothing more than that Planned Parenthood has chosen to increase the number of medication abortion days now that it can use its salaried APRNs rather than paying per diem rates for doctors to provide this care. No evidence in the record establishes that Planned Parenthood could not use its per diem physicians to provide abortion care on more days of the week than it was before the injunction. Indeed, the evidence shows that Planned Parenthood has eight per diem doctors,[9] that it can and does provide medication abortion care via telemedicine—meaning that so long as a physician is working at any one of its clinics, patients in other clinics can obtain a medication abortion from that doctor—and that it schedules abortion care centrally— demonstrating that it has the systems and procedures in place to schedule medication abortions via telemedicine.[10]

Given this evidence, it is hard to understand why medication abortion care was offered only once or twice a week in Anchorage and less often in Juneau and

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[9] Exhibit C, Pasternack Deposition at p. 138, line 10, p. 143, lines 20-24, p. 159, lines 5-15.

[10] Exhibit C, Pasternack Deposition, p. 108, line 7 – p. 109, line 4.

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Fairbanks.[11] At a minimum, it seems that Planned Parenthood could have offered medication abortion at all of its clinics on any day that a doctor was working at any of its clinics.[12] And Planned Parenthood has presented no evidence to establish that it could not have scheduled its eight physicians to maximize the number of days a week that there was a physician in at least one of its Alaska clinics. That it chose not to do so was not a result of the law; and Planned Parenthood's decision to expand the days it offers medication abortion now that it can rely on its APCs is a business choice, not evidence of the burdensome impact of the challenged law.

Planned Parenthood's other factual evidence that the law restricts abortion access is even less compelling. It first suggests that "the State has conceded" that "there is a shortage of primary care providers in Alaska, including reproductive health services providers." [Pl.'s MSJ at 8] But the deposition testimony it relies on for this claim does not support it. To make this claim, Planned Parenthood cobbles together testimony from Commissioner Crum acknowledging at one point in his deposition that Alaska doesn't have enough primary care providers; at another that reproductive care is part of primary care; and at another that primary care providers sometimes perform abortions.[13] But the

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[11] Pasternack Aff. in support of MSJat ¶ 21.

[12] Exhibit C, Pasternack Deposition at p.148, lines 1-5 (agreeing that Planned Parenthood "could increase access at virtually any of [its] clinics by having an additional per diem physician in Anchorage at least for medication abortion…?")

[13] Exhibit S, Crum Deposition at p. 54, lines 7-9 (acknowledging that reproductive health care is part of primary care); Crum Deposition at p. 75, line 2-8 (stating that Alaska doesn't have enough primary care providers); Crum Deposition at p. 146, lines 9-20 (acknowledging that some primary care providers perform abortions).

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overall shortage of primary care providers does not establish that there are not enough providers to meet the need for a subcategory of primary care, like abortion services. Moreover, when testifying directly on this issue, Crum indicated that he was not aware of a shortage of abortion providers, expressly disavowing the characterization of his comments offered here by Planned Parenthood.[14] Indeed, the shortage of primary care providers would establish a shortage of abortion providers only if primary care providers were the only providers of abortion—which is not the case[15]—*and* the primary care doctors in the state were not providing sufficient abortion care to meet the demand, something Planned Parenthood has not attempted to show.

Planned Parenthood then pivots from this unsupported claim to the shortage of health care providers in rural Alaska, as demonstrated by the State's community health aide ("CHA") program. [Pl.'s MSJ at 8-9] In effect, Planned Parenthood asks the court to conclude that because Alaska stakeholders, including tribal health organizations and the State, had the foresight and innovation to create the CHA program fifty years ago,[16] there must be a shortage of abortion care in Alaska today. This non-sequitur offers zero support for the conclusion that the physician license requirement burdens access to abortion care.

The physician license requirement did not cause the dearth of physicians or

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[14] Exhibit B, Crum Deposition at p.133, line 6 – p. 134, line 10.

[15] Dr. Pasternack is an OBGYN, not a primary care physician. Pasternack Aff. in support of MSJ at ¶ 2.

[16] *See* Exhibit B, Crum Deposition at p. 68, lines 19-25 and p. 69, lines 2-11 (describing the creation of the CHA program).

ATTORNEY GENERAL, STATE OF ALASKA
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APCs in rural Alaskan communities. The number of health care providers living and working in rural Alaska is a function of several economic factors, none of which have anything to do with the physician license requirement. Asked what some of the challenges were to recruiting health care providers to work in rural Alaskan communities, Commissioner Crum testified:

> I'd say the Number 1 challenge is actually housing, it's the cost of finding affordable housing through Alaska . . . it's an exponential difference from [population centers], when you look at rural Alaska and frontier Alaska, it's those housing needs [that are] the biggest concern.[17]

Even the significant economic incentives offered through the WWAMI medical school program are not enough to recruit physicians to work in rural Alaska.[18] Those incentives include forgiveness of 100 percent of student debt if a graduate works in a rural Alaskan community for only three years.[19] According to Commissioner Crum, recruiting health care providers to Alaska—and to rural Alaskan communities in particular—requires addressing these economic issues, including housing, and will take "a lot of time and attention from" state government over the course of "a decade . . . to implement and find solutions to really move the needle."[20]

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[17] Exhibit S, Crum Deposition at pp. 80, lines 22-25 and p. 81, lines 1-11.

[18] *Id.* at p. 79, lines 2-25 and p. 80, lines 2-4. Alaska is one of five states participating in a consortium medical school hosted by the University of Washington. Alaska subsidizes the costs of 20 Alaskan students. Students take their first two years of classes through the University of Alaska, complete their final two years at the University of Washington, and receive residency training at programs throughout the country, including in Anchorage.

[19] *Id.*

[20] *Id.* at p. 81, lines 23-25 and p. 82, lines 2-7.

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Removing the physician license requirement is *not* one of those solutions. Asked whether expanding the scope of practice for healthcare providers would "incentivize them to go work in rural areas or provide care there," Commissioner Crum said it was unlikely.[21] Planned Parenthood has offered no evidence contradicting Commissioner Crum's testimony.

Planned Parenthood notes that "[e]ighty-six percent of Alaska boroughs lack an abortion provider, and 32 percent of women live in those boroughs." [Pl.'s MSJ at 9] "Because there are only three health centers that provide abortion, patients often need to travel long distances for abortion services." [Pl.'s MSJ at 9]. This is a situation not unique to patients seeking abortion services. Providing health care services in Alaska necessarily involves travel, and the addition of more providers will not change that. In response to a question from Planned Parenthood's lawyer asking if more physicians in Alaska would reduce the costs for rural residents to travel for health care, Commissioner Crum explained that he would not expect to see a reduction because physicians practice in "populated areas" and patients "are going to have to fly to them anyway."[22] Indeed, the successful "hub and spoke" model for providing care to rural Alaskans reflects this reality.[23]

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[21] *Id.* at p. 82, lines 8-21.

[22] *Id.* at p. 78, lines 9-18 (noting that the cost of travel would not, in and of itself, impose an additional burden on Medicaid-eligible patients—i.e. patients who might be deterred from seeking or receiving care due to cost—because "the Medicaid program typically covers 100 percent of that cost").

[23] *Id.* at p. 104, lines 7-25, p. 105, lines 2-3, and p. 107, lines 4-7.

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Planned Parenthood is well aware of these constraints. Its current standard of care does not allow it to perform abortions in any communities beyond those in which Planned Parenthood presently operates.[24] Even if it were possible to provide abortions in rural Alaska communities within the standard of care, ending the licensed physician requirement for abortion will not produce sufficient patients in rural Alaska to make it economically feasible, much less attractive, for physicians or APCs to expand abortion services to facilities in rural Alaskan communities. Nor does Planned Parenthood actually contend otherwise: none of its witnesses claim that Planned Parenthood—or any other providers—will open new rural clinics if APCs can perform abortions. Indeed, the closure of the Soldotna clinic, because Planned Parenthood "couldn't financially support that clinic,"[25] shows that this is not going to happen.

The rest of the section of Planned Parenthood's motion directed to establishing that the law allegedly restricts access to abortion is actually focused on discussing the harm that delays in obtaining abortion care can cause patients in certain circumstances. [Pl.s MSJ at 11-14] While those harms might, in fact, occur if a patient is actually delayed, that misses the point. Theoretical, hypothetical, or even occasional harms are not enough, and here, Planned Parenthood failed to meet its threshold burden of demonstrating the statute caused the delays in the first place. And none of its arguments addressing harm assists it in meeting that burden.

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[24] Exhibit C, Pasternack Deposition at p. 48, line 23 – p. 49, line 4.

[25] Exhibit R, Pasternack Deposition at p. 15, line 1.

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For instance, Planned Parenthood relies on the affidavit of Dr. Ingrid Johnson, an expert in the field of intimate partner violence, to establish that a "significant percentage" of women seeking abortions have a controlling or violent partner making it particularly difficult to arrange medical appointments. [Pl.s MSJ at 11] Later, it cites her affidavit for the proposition that as a pregnancy progresses and becomes harder to conceal, the risk of partner coercion or violence increases. [Pl.s MSJ at 13] While the State has no reason to doubt either of these assertions, nothing in Dr. Johnson's affidavit or in her testimony during deposition supports the conclusion that the licensed physician requirement is the cause of delays that contribute to these harms.

Asked if she had studied whether the schedule and availability of physicians to perform abortions were sufficient to meet the needs of patients in Alaska, Dr. Johnson answered, "No." [26] Asked if she had "a sense, then, of the number of appointments that would need to be available to adequately meet the abortion care needs of intimate partner violence victim-survivors," Dr. Johnson again answered, "No."[27] Dr. Johnson also conceded that she did not know where, geographically, Planned Parenthood would need to offer abortion care to fully-meet those needs.[28] Finally, she admitted that she had not "reviewed any data or collected any data that suggests the times and locations available [for patients] to receive abortion care are insufficient to meet the need in the

[26] *See* Exhibit T, Johnson Deposition at p. 91, lines 24-25 and p. 92, lines 1-4.

[27] *Id.* at p. 96, lines 1-5.

[28] *Id.* at p. 93, lines 10-14, 18-21, & 25.

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state."[29]

Dr. Johnson's inability to answer questions related to the sufficiency of abortion care in Alaska was not because such questions are impossible to answer. She acknowledged that studies could be designed to provide those answers.[30] Planned Parenthood's expert on access, Dr. Spetz, also acknowledged that such studies could be conducted.[31] Nevertheless, Planned Parenthood did not ask either expert to investigate the impact of the licensed physician requirement on access, and its evidence remains confined to showing *harms* related to delays in care occasioned by the unique circumstances of providing healthcare in Alaska.

Finally, it is worth noting that if abortion care is delayed due to weather, distance, or expense, the impact will vary, potentially very significantly, from patient to patient depending on their circumstances, as Planned Parenthood's witnesses recognized.[32] Planned Parenthood has not shown that any of these harms actually befell any Alaska patients *as a result of the challenged law*.

In sum, Planned Parenthood has failed to meet its burden to establish that the licensed physician requirement restricts access to abortion care in Alaska or burdens

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[29] *Id.* at p. 63, lines 14-18.

[30] *Id.* at p. 53, lines 3-9.

[31] Exhibit H, Spetz Deposition at p. 47, line 3 – p. 52, line 1 (explaining the process she would follow to address whether the licensing requirement causes an access problem).

[32] Exhibit I, Bender Deposition, p. 119, lines 2 – p. 120, line 11; Exhibit C, Pasternack Deposition, p. 136, line 10 – p. 137, line 6.

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Alaska abortion patients, much less that it does so in more than "occasional" circumstances.[33]

C. Planned Parenthood's equal protection claim reads like an afterthought.

Planned Parenthood's motion for summary judgment makes generalized references to equal protection but fails to engage in an equal protection analysis of the challenged law. Applying that analysis, the law withstands constitutional scrutiny for two key reasons.

First, Planned Parenthood relies on a mischaracterization of the law as an "APC ban," even though the law makes no reference to APCs. The classification created by the statute is "physicians licensed by the State Medical Board" and everyone else,[34] not physicians and APCs as Planned Parenthood contends. "[A] classification is defined *by the terms of the statute at issue*."[35] Thus, Planned Parenthood cannot manufacture a constitutional problem by proposing a narrower classification than the one created by the statute, so as to focus on a subgroup for whom the classification seems least reasonable. [36]

Second, even if Planned Parenthood's proposed classifications were legally

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33 *Planned Parenthood V*, 436 P.3d at 992.

34 AS 18.16.010(a)(1).

35 *Watson v. State*, 487 P.3d 568, 571 (Alaska 2021).

36 *Id.* ("[*T*]he *validity of a broad legislative classification is not properly judged by focusing solely on the portion of the disfavored class that is affected most harshly by its terms*.") (quoting *Schweiker v. Hogan*, 457 U.S. 569, 589 (1982)) (emphasis added).

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viable, the court must "look to the real-world effects of government action to determine the appropriate level of equal protection scrutiny."[37] And, "*[i]f the burden placed on constitutional rights by the regulation is minimal*, then the State need only show that its objectives *were legitimate* for the regulation to survive an equal protection challenge."[38] Here, as explained above, Planned Parenthood has failed to demonstrate that *the law* restricts access to abortion at all in the real-world, much less that it constitutes a "significant" deterrent to the "exercise of constitutional rights" so as to trigger strict scrutiny.[39]

There can be no serious dispute that the legislature's objectives in limiting abortion provision to physicians in 1970 were legitimate. Because the law neither targets a suspect classification nor burdens a fundamental right, nothing more is required. The law may be out of date, but that is a legislative matter. It does not render the statute unconstitutional.

D. Objection to Bender and Pasternack Testimony Regarding Patient Experiences.

Defendants object to the testimony offered in the Bender and Pasternack

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[37] *Planned Parenthood V*, 436 P.3d at 1002 (Alaska, 2019) (quoting *Planned Parenthood I*, 28 P.3d at 910).

[38] *Planned Parenthood I*, 28 P.3d at 909.

[39] *Id*. (quoting *Alaska Pacific Assurance Co. v. Brown*, 687 P.2d 264, 271 (Alaska 1984)).

affidavits regarding the experiences of their patients[40] on the basis that it is vague, inadmissible hearsay, and lacks foundation.

First, neither Bender nor Pasternack quantifies, in any meaningful way, the number of patients they are referring to, when those patients were allegedly burdened by the statute, at what clinic they sought care, or any other detail about their alleged experiences that might allow Defendants' to test their testimony. Accordingly, their testimony is too vague of be of any evidentiary value and should be excluded.

Second, neither Ms. Bender nor Dr. Pasternack identify any specific patients, and their failure to do so is not out of a concern for patient confidentiality. When asked during their depositions if they were capable of identifying the patients referred to in their testimony, both Ms. Bender and Dr. Pasternack testified that they could not.[41] Accordingly, their testimony is entirely impressionistic – i.e. they are sure they have seen the patient-experiences described in their affidavits, but they cannot say when or how many times they occurred, nor can they provide any specific examples that would allow Defendants to cross-examine their testimony.

Dr. Pasternack's testimony about patients who allegedly had to forego abortion care because of travel cost is a good example. When asked to describe a case when a

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[40] *See*, *e.g.*, Bender Affidavit, ¶¶ 22 ("…most patients I have seen who seek an abortion want to proceed with treatment as soon as possible…"), 23 ("…patients…express relief when told they do not need to come back…"), 25 ("…we have heard from patients that they have trouble accessing that care."), 30; Pasternack Affidavit, ¶¶ 8, 17, 27, 28, 29, 30.

[41] Exhibit I, Bender Deposition, p. 69, line 12 – 70, line 6; Exhibit C, Pasternack Deposition, p. 84, line 8 – p. 85, l. 4, p. 106, lines 2-19, p. 135, line 17 – p. 136, line 9.

ATTORNEY GENERAL, STATE OF ALASKA
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patient was unable to receive an abortion due to the cost of travel, Dr. Pasternack testified about a "patient who [was] physically in Fairbanks and was past the medication abortion timeframe…and couldn't afford to travel." Initially, Dr. Pasternack was confident she learned that information directly from the patient, first-hand.[42] But when cross-examined further, she backtracked:

> Uh-huh. I guess I realize I might have gotten those stories – or that story mixed up. Because if I was there, she could have had the procedure with me, so I'm trying to recollect the details of how – it must – I must have – she must have been – I remember that encounter. She must have been someone who needed to travel out of Fairbanks…

And when asked if she could identify the patient, Dr. Pasternack testified that she could not.[43] In short, Ms. Bender's and Dr. Pasternack's testimony lacks foundation, is entirely incapable of meaningful cross-examination or objective verification, and should be excluded.

Finally, Ms. Bender's and Dr. Pasternack's testimony is inadmissible hearsay. Virtually everything they recount about their patients' experiences was communicated

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[42] Exhibit C, Pasternack Deposition, p. 135, lines 6-8.

[43] *Id*. at p. 136, lines 7-9.

to them by their patients.[44] But rather than offer that evidence first-hand, through testimony from actual patients, Planned Parenthood offers it, second-hand (and sometimes even third-hand), through Ms. Bender and Dr. Pasternack. Accordingly, Ms. Bender and Dr. Pasternack's testimony is inadmissible hearsay and should be excluded.[45]

V. CONCLUSION

Because Planned Parenthood has failed to meet its burden to show that the "real world effect" of the licensed physician requirement is to restrict access to abortion in Alaska, it has not shown that the law violates the constitution, and this Court should

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[44] See, e.g., Exhibit I, Bender Deposition, p. 95, line 11 – p. 96, line 8 ("Q: So you're basically communicating here what patients have told you that they were told by other providers? A: Yes."), Exhibit I, Bender Deposition, p. 72, lines 15-20 ("Q: In paragraph 11, you state that, 'The days that medication abortion were offered differed month to month, which caused frustration'…How do you know that? A: They would verbalize that to me regularly."); Exhibit C, Pasternack Deposition, p. 113, lines 3-8, p. 119, lines 19-25, p. 137, line 23 – p. 138, line 4 ("Q. Let's look at paragraph 29, You say that, 'We know that limitations in access routinely delay patients.' How do you know that? A. Patients have told that to me both when I'm encountering them at Planned Parenthood or in my private practice, and other physician colleagues have told me that."); Exhibit R, Pasternack Deposition, p. 58, lines 2-12, p. 78, lines 3-11 ("Q. And how do you know that? How do you know that patient burdens have been greatly reduced? A. Patients have told me that."), p. 132, line 24 – p. 133, line 5.

[45] Due to Ms. Bender and Dr. Pasternack's inability to identify any patients, application of the hearsay rules is impossible. For example, an analysis of whether the declarant is unavailable cannot even be undertaken because the declarants are unidentified. Further, the fact that Planned Parenthood designated Ms. Bender and Dr. Pasternack as expert witnesses does not make their testimony. First, "[a]lthough Rule 703 is meant to expand the breadth of information on which an expert witness may rely, it is not intended merely to provide a conduit for the admission of otherwise inadmissible evidence." *Estate of Arrowwood By and Through Loeb v. State*, 894 P.2d 642, 647 (Alaska 1995). Moreover, neither Ms. Bender nor Dr. Pasternack is an expert on healthcare access.

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deny its motion for summary judgment, and let Planned Parenthood seek a legislative change.

DATED: August 29, 2022.

TREG R. TAYLOR
ATTORNEY GENERAL

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In the Matter Of:

PLANNED PARENTHOOD vs STATE OF ALASKA

TANYA PASTERNACK

June 02, 2022

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than the Anchorage clinic?
A. At this time I did not.
Q. Do you work only at the Anchorage clinic or do you travel about the state?
A. I do travel, but my primary location would be the Anchorage health center.
Q. How often do you have occasion to travel to Juneau or Fairbanks or Soldotna?
A. It's variable, but in a year where I'm not training or hiring a new physician it would be once a year. When there's an onboarding of a new physician, there might be a few extra visits for that orientation and training.
Q. So is your purpose of your visits to the clinics other than Anchorage to onboard and train new physicians?
A. Usually. On rare cases I would fill in as the provider.
Q. I understand the Soldotna clinic was recently closed; is that right?
A. Correct. Well, yeah, the end of this month -- May, end of May.
Q. So Tuesday was the last day?
A. Uh-huh.
Q. Do you have any knowledge about why that clinic closed?

A. We couldn't financially support that clinic.
Q. So that leads me to my next question.
How is Planned Parenthood of the Great Northwest funded; do you know?
A. My role is not to oversee financial decisions or financial management in any way. Our affiliate has a separate operations team that does that. But our resources are shared among the affiliate. So my understanding is that some health centers bring in a larger revenue and others are probably underbudgeted, but we try to keep those doors open for access for the patients.
Q. Did you have any role in the decision-making that led to the closure of the Soldotna clinic?
A. I did not.
Q. How are Planned Parenthood's physicians compensated?
A. They get paid per procedure performed.
Q. So as opposed to being on a salary, Planned Parenthood looks at how many procedures the physician performed during a pay period, I guess?
A. Yes.
Q. And then depending on the nature and complexity of those procedures I would assume dictates their compensation?

A. Yes. And that's for the per diem physicians. They do get a minimum amount per day for just being present. So if no patients showed up for some reason they would still be compensated for their time.
Q. Do you receive additional compensation for serving as the medical director?
A. Yes.
Q. Do you know how APRNs or APCs at Planned Parenthood are compensated?
A. My understanding is that they are salaried.
Q. With respect to a medication abortion, how long -- how long does that procedure take for you to provide?
A. Well, when -- from -- there's different aspects from -- of care the patient receives in the health center, so not all of that care is administered by me.
Q. So walk me through the process.
A. When she enters the clinic, she's checked in and updates her demographic information. She is then brought back into the health center by a -- what is referred to as a medical assistant, who will take her vital signs, review the reason for her visit that day, go over her health history, perform an ultrasound to confirm the pregnancy, if required. And review with the patient her options and decision to proceed if she was intending to have a

medication abortion that day.
The next step will be that the nurse -- currently -- prior to the injunction the nurse practitioner would spend time with the patient reviewing her medical history and her plans for post-abortion care. And the final step would be that the physician would enter the room, review the decision, review the process with the patient and administer the medications.
Q. So the medical assistant that you mentioned that takes the patient back and takes her vitals and does the ultrasound, is that an APRN or is that a different person at Planned Parenthood?
A. Different person.
Q. And I've read about an education and counseling process that occurs for medication abortion patients.
When in that kind of three-step process that you just described would that occur?
MS. POWER: Objection to form. Vague.
THE WITNESS: At our health center -- if I can proceed.
MS. POWER: Uh-huh.
THE WITNESS: The initial education and counseling is started by the medical assistant and continued with the APC and with the physician.
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Page 46

be in place for a medication abortion to be safely administered?

A. Our Planned Parenthood affiliate and myself do feel that there are some level of requirements, yes.

Q. And what are those?

A. The main one is the information we extrapolate from the patient when speaking with her.

Q. How about, I was thinking things more like -- more tangible things, like blood supply for a transfusion or resuscitation equipment, things like that.

Is there anything like that that needs to be in place in order for a -- in place or available in order for a medication abortion to be safely performed?

MS. POWER: Objection to form. Compound and overbroad.

THE WITNESS: I would say the standard of care across the U.S. for medication abortion is shifting to recognize that medication abortions can be performed and completed safely in remote locations, when the patient is in a remote location.

BY MR. ROBISON:

Q. So you mentioned across the U.S.

Does the standard of care change depending on where you are in the country? Would the standard of care in rural Alaska be different than in New York City, for

Page 47

example?

MS. POWER: Object to form. Foundation.

THE WITNESS: I would say the standard of care also provides to a certain procedure or medical need. So the standard of care for an appendicitis might vary in different locations, as would potentially the standard of care for an abortion.

BY MR. ROBISON:

Q. Have you performed abortions in any state other than Alaska?

A. Yes.

Q. What state was that?

A. New Mexico.

Q. What cities?

A. Albuquerque.

Q. Is the standard of care for a medication abortion in Albuquerque different than it is in rural Alaska?

A. Presently are you asking, or when I was performing them?

Q. So let's do it both ways.

When were you performing medication abortions in New Mexico?

A. 2009 to 2013.

Q. Okay. So in that time period, do you know if

Page 48

the standard of care for performing a medication abortion was different in New Mexico than it is in Alaska, or was in Alaska at the same time?

MS. POWER: Objection to form. Relevance and foundation.

THE WITNESS: I don't know because I wasn't practicing in Alaska during that time frame.

BY MR. ROBISON:

Q. Of the 86 percent of Alaskan boroughs that lack an abortion provider, in how many of those could a medication abortion be performed while meeting the standard of care?

A. This is where standard of care, the definition in your interpretation is variable. Right now Planned Parenthood's standard of care for a medication abortion is that the patient -- the Alaska patients are -- do physically present to one of our health centers. Other health organizations are pursuing a different level of standard of care for Alaska patients.

Q. And those other health organizations are who?

A. The general term would be mail order medication abortion, or abortions.

Q. So following Planned Parenthood's requirements for standard of care, medication abortions could not be administered in communities in Alaska other than those in

Page 49

which Planned Parenthood has a clinic. Am I understanding that correctly?

A. That is our current standard of care, current practice model.

Q. So if that practice model remains unchanged, even under the preliminary injunction, Planned Parenthood would not be able to provide medication abortions in the communities other than the ones in which it has clinics; true?

A. Yes.

Q. Would the answer be any different with respect to aspiration abortions?

A. It would not be different.

Q. Since my question was probably not all that precise, let me ask a more precise question. I think we'll get the same answer.

So if APCs were some day permitted to perform aspiration abortions following Planned Parenthood's current standard of care, those could still only be provided in the four communities in which Planned Parenthood has clinics in Alaska?

A. The three, yes.

Q. The three. How about Soldotna, if the clinic there reopened, would -- well, let me ask this question first.

Page 58

A. True.
Q. In paragraph 9, you state in the first sentence that, "Patients who are eligible for either medication abortion or aspiration abortion often have a strong preference for one or the other method."
How do you know that?
A. Patient report.
Q. Patient rapport or report?
A. Report.
Q. What's that?
A. Patient -- the patient expresses her preferences to myself or another staff member.
Q. So is that recorded in a written document?
A. It is potentially noted in her health record, but I don't know if it's always.
Q. So there's not a piece of paper entitled "Patient Report" that would contain this information?
A. No.
Q. So when you say patient report, you're talking about the patient communicates what you describe in that first sentence to either yourself, the APRN, or the medical assistant, and in the latter few cases, the APRN or the medical assistant would then communicate that information to you?
A. When I say patient report, I just mean anything

Page 59

that the patient is verbally desiring or expressing to any of our health center staffs. In the process, she may express that information to a scheduler or any of the other people you mentioned. It doesn't always get -- it may or may not get communicated to.
Q. If it's communicated to the medical assistant or the staff or an APRN, would it be their -- is that something that they would communicate then to you in the ordinary case of business?
A. Only if it were modifying my expectation of what her encounter was for. So if her intent or desire was for a medication abortion and she's been determined eligible based on her medical history, her ultrasound, then that being -- that being her preference would not be communicated to me. I would just proceed and presume it was her preference.
Q. Understood. Can you quantify how often patients have communicated to you that they have a strong preference for one or the other method?
A. I'm physically in the health center administering abortion services on average once a month, and I would say on most days that I am there patients have expressed strong preferences.
Q. So that happens most of the time?
A. Most days I can't say. Most patients in that

Page 60

day.
Q. So when you're referring to patients in this sentence, are you referring to only the patients you see when you're at the clinic once a month or are you referring to all Planned Parenthood's patients?
A. Only the patients I physically see.
Q. In the remainder of that paragraph, is it fair to say that you are summarizing the reasons a patient might express for choosing one procedure or the other?
A. Yes.
Q. And the way you know that is the patients communicate that to you when they tell you which type of procedure they would prefer?
A. Yes.
Q. Pre-injunction -- kind of stepping away from paragraph 9 for a second. Pre-injunction, when -- I understood from Ms. Bender, I guess, that when a patient came in and was deemed eligible for a medication abortion, there wasn't a doctor in the clinic that day, a second appointment would have to be scheduled so the patient can come back and see a doctor.
Do you know if it's Planned Parenthood's practice in those instances to check in with the other clinics in the state to see if they had a doctor available that day?

Page 61

A. Yes.
Q. It would be?
A. It would be.
Q. So the only way that second appointment would get scheduled would be -- let's just use a hypothetical -- if the patient was in Fairbanks, for example, and there's no clinic in Fairbanks, the medical assistant or the APRN would call Anchorage and Juneau and check to see if a physician is available?
A. The first step, because we are on electronic health record, they would probably be able to check in the computer if a physician was available, and one would be whether a physician is physically present, and then they'd also be able to assess whether that physician was fully booked or had openings. If the physician appeared, based on the medical record, to have availability, it would then be followed up with a phone call to truly assess that.
Q. Okay. So there's a way for the APRN or the medical assistant to determine electronically if a physician would be available that day?
A. Yeah.
Q. So in moving on to paragraph 10, you state, "There is no health benefit to the APC ban, which I understand prohibits APCs from providing medication and aspiration abortions. Nor is there any reason to require

Page 78

brought to your attention?
A. Yes.
Q. Okay. You also state in that sentence that, "Patient burdens have been greatly reduced."
My first question is, what does that mean?
A. That means that the patient burden of having multiple visits or being only eligible to receive their care on a certain day of the week has now been reduced.
Q. And how do you know that? How do you know that patient burdens have been greatly reduced?
A. Patients have told me that.
Q. Have you performed any medication abortions since the injunction went into effect?
A. Yes.
Q. Can you estimate how many?
A. Less than five.
Q. My understanding was that -- from Ms. Bender was that, post-injunction, only in rare instances have physicians at Planned Parenthood performed medication abortions; is that correct?
A. That's correct.
Q. So the less than five that you've performed, were those exceptional circumstances that required a physician to be involved?
A. No. They were logistics exceptions that I was

Page 79

available and the nurse practitioner was not available, tied up with another patient.
Q. So there have been instances even post-injunction when an APRN or APC hasn't been available to perform a medication abortion, at least five?
A. She -- I was more immediately available. She was available, but maybe for a little bit longer wait time.
Q. So you know that patient burdens have been greatly reduced. You said that you know that from patients.
If you've only performed five since the injunction went into effect, how do you -- have you talked to other patients that received medication abortions? I'm just trying to understand your -- the level of your interaction with patients beyond the five that you've treated since the PI.
A. Yeah. I would say that most of the knowledge gets firsthand communicated to the provider performing the medication abortion. The gratitude that patients express for being able to proceed immediately, and that is expressed to our advanced practitioners who are administering the medication and they share that with me.
Anchorage, Alaska, is also a small enough community, so I do hear general feedback from both

Page 80

patients and community physicians being pleased with the access.
Q. So you've interacted with the APRNs at the Anchorage clinic since the PI -- by PI, I mean, the preliminary injunction -- you've interacted with APRNs at the Anchorage clinic or also at the other clinics?
A. Also at the other clinics.
Q. Is that via phone?
A. I was in -- I physically have been in Juneau face-to-face this year since the ban. And I don't recall the last time I was physically in Fairbanks.
Q. So since the injunction, you've been in Juneau once.
How often are you at the Anchorage clinic -- or how often have you been at the Anchorage clinic post-injunction?
A. In what role?
Q. In your role -- if you have a role other than medical director.
A. Sometimes I'm there to be the physician providing services and other times I end up being there for an administrative meeting or...
Q. So let's do it both ways then.
As a provider, how often have you been at the Anchorage clinic since the injunction?

Page 81

A. On average once a month.
Q. And then when you're there handling administrative duties, how often are you there post-injunction?
A. Highly variable. On average once a week.
Q. Can you think of any patients that you've spoken to since the injunction, other than the five that you've personally treated? And let me qualify that with, can you think of any patients you've spoken to who have been at Planned Parenthood for a medication abortion that you've spoken to beyond the five that you treated?
MS. POWER: Objection to form. Vague.
MR. ROBISON: Let me see if I can do better.
BY MR. ROBISON:
Q. You've treated five patients for medication abortion, approximately five, since the injunction; true?
A. True.
Q. And you obviously spoke with them, right?
A. Yes.
Q. Have you spoken with any other patients at Planned Parenthood who have received a medication abortion since the injunction?
A. I have patients in my private practice that see me for other reasons that had, since the injunction, received a medication abortion.

Page 106

BY MR. ROBISON:
Q. Can you provide any more specific quantification of how many times it's happened in the last year, other than more than once?
A. I would say more than a dozen times in the last year.
Q. Anything more specific than that?
A. No.
Q. Okay. And in terms of those more than a dozen times, can you describe to me what the patient told you about their efforts to schedule an earlier appointment?
A. That they tried to and were told that the first available was a few weeks out.
Q. Is that information that you would have recorded in the patient's medical records?
A. No.
Q. Would you be able to identify any of those patients?
A. No.
Q. So when a patient -- by the time they see you for a medication abortion, they're on their second appointment, right?
A. Most commonly.
Q. Okay. So the patients that you mention that said they tried to schedule an appointment earlier but

Page 107

this is the first -- this was the first one that was available, do you know how many of them were on their first appointment versus how many were on their second appointment?
A. I don't. As a medical director, I also get a lot of feedback from community physicians, so community physicians will reach out and say, I have a patient who has tried to get in and she was told the first available is two to three weeks later, is there anything you can do to get her in sooner?
Q. I'll object to that as nonresponsive.
When a patient tries to -- let's say it's a patient who is coming in for their first appointment. Are they able to book appointments online?
A. Yes.
Q. And if a patient is trying to book a medication appointment online and they're in Anchorage, would that patient have any way of knowing -- or would that patient be informed through Planned Parenthood's website that they can come into the Anchorage clinic and receive a medication abortion from a physician who is in Juneau or Fairbanks via telehealth?
A. I don't think that level of detail is provided on the website.
Q. If a patient calls in to book an appointment by

Page 108

phone and says, I want to make an appointment for a medication abortion and they call the Anchorage clinic -- let's use Fairbanks as an example. Patient is in Fairbanks and wants a medication abortion, calls the clinic and says, I would like to come in for a medication abortion.
When the Planned Parenthood representative that's on the phone with that patient is looking for available appointments, are they limited to days when a physician is in the Fairbanks clinic, or would it be Planned Parenthood's practice to check other clinics to see when they have a physician available that could do the procedure via telehealth?
A. We use a centralized scheduling phone center, so the patient is most commonly not communicating directly with a specific location staff. I don't know all the details of how they accommodate patients and schedule them, but my understanding is that a medication abortion time slot would never require -- the patient would always -- if there was a time slot available on a physician's schedule, be given the opportunity to do that via telehealth.
Q. The scheduler would --
A. Recognize -- two things. It's a little bit more complex scheduling. Her local health center would have to

Page 109

be open and available to accommodate her, and the physician that's in a different location would have to accommodate her. But yes, that would always be considered.
Q. In terms of the sentence that we've been talking about, "Many patients are close to gestational age" -- "by the time they're able to make an appointment." Let's just read the whole sentence so the record is clear. "Many patients are close to the gestational age limit for medication abortion by the time they're able to make an appointment."
Would it be more accurate for that sentence to say, "Many patients are close to the gestational age limit for medication abortion by the time I see them"?
A. That statement would represent my experience.
Q. In other words, they may have already made an appointment by the time you see them? They may have already had an appointment, right?
A. They likely already had an intake appointment, yes.
Q. Let's move on to the next sentence. "They may urgently need an abortion because they have a strong preference or a medical indication for avoiding an aspiration or because they live far from Anchorage and their options for an aspiration procedure are so much more

Page 130

BY MR. ROBISON:
Q. Under what circumstances?
A. If she would like it to be recorded.
Q. Is that something that you ask the patient, would you like us to record this in the medical records?
A. In this example that we're referring to where -- the case of rape, we would be specific as to knowing what she would like us to include in the medical record, knowing that that could be used in a lawsuit or a criminal process.
Q. So absent instructions from the patient, that information would not be included in the medical records?
A. Correct.
Q. What about instances where the patient is suffering emotionally because she's a victim of rape and you note that in your consultation with the patient, would you note in the patient records that, patient needs procedure urgently because patient is suffering extreme emotional distress? Would you ever note anything like that in the medical records?
A. Possibly, but not routinely.
Q. Let's move on to paragraph 28. I guess I would summarize paragraph 28 as you essentially describing the emotional and stress burden that patients face when trying to schedule abortion care. Is that a fair summary?

Page 131

A. Yes.
Q. Isn't that also true of other health procedures?
A. Sometimes.
Q. In other words, if you have a mass somewhere on your body and you need an MRI to determine if it's cancerous and you can't get one for two or three weeks, is that something that could be stressful to the patient?
A. It could be.
MS. POWER: I'm going to object to the form. Lacks foundation.
BY MR. ROBISON:
Q. Are there other conditions for which you treat patients that require follow-up testing or follow-up visits to the doctor?
A. In my care at Planned Parenthood?
Q. Let's talk about your private practice.
A. Will I see a patient for multiple visits related to the same thing?
Q. No. Let's just use my example.
Have you ever had an instance where you found a mass on one of your patients?
A. Yes.
Q. And have you ordered that it be biopsied?
A. I would perform -- in some cases I would perform a biopsy myself.

Page 132

Q. So you don't send patients out?
A. I'm trying to think. If -- it would obviously depend on the location of the mass, but if it was within the gynecological body parts.
Q. Understood. How about an MRI, have you ever found a mass or some other condition on a patient that requires an MRI?
A. Unfortunately, that's not an example that's applicable in gynecological. We don't order a lot of MRIs.
Q. For patients in rural Alaska, are there certain types of health care that is simply not available in those parts of the state?
A. Yes.
Q. And isn't it true that they can also face stress or emotional burden by virtue of having to travel to Anchorage or perhaps even out of state to get treatment for those conditions?
A. Yes.
Q. The emotional burdens that you talk about in paragraph 28, would you note those in the patient's medical records?
A. Not routinely.
Q. How do you know about the emotional burden and stress that you describe in paragraph 28?

Page 133

A. Both patients share that information with me, whether it be when I'm physically in a patient encounter at Planned Parenthood or in my private practice and they're reflecting on their experience, or other providers share that information as well.
Q. In the second-to-the-last sentence, you state that, "It is also stressful for them to face increased costs if they have to travel farther or need more complex care because they have been delayed to a later gestational age."
Can you think of any examples where a patient has had to forego abortion care because they couldn't afford the cost of travel?
A. I think foregoing abortion care often has multi factors, but yes, I have heard patients reference cost as a limiting factor.
Q. When you say limiting factor, that's -- have they told you that they did not have one because they couldn't afford it?
A. That they weren't going to be able to proceed because they couldn't afford it.
Q. If the licensing statute was lifted, would the results in those cases have been different?
A. I -- in some of those cases, yes, when I reflect back on some of those cases.

Page 146

hours, would not that help solve the problem?
A. That -- I don't foresee, myself included, many physicians wanting to take on a job that it's just a two-hour workday for them. They would not have the remainder of that day. It wouldn't be used -- they wouldn't have it as a day off completely nor as a fully productive day.
Q. Have you reached out to physicians to ask that question, if they would be interested in coming on for one day a week for a couple hours?
A. I have had casual conversations with my current staff, but not directly asked that question.
Q. With your current staff but not prospective doctors?
A. Not prospective doctors.
Q. Have you asked the medical director at Planned Parenthood of the Great Northwest if the affiliate would authorize you to perhaps increase your budget to bring on additional physicians?
A. I guess we don't tend to function exactly that way. I have -- I do reach out to her when I would like to expand the physicians, not directly. One of the factors that she considers in my request I'm sure is the budget, but...
Q. So have you reached out to her since you became medical director about expanding the number of

Page 147

physicians -- the number of per diem physicians in Alaska?
A. I would have to go back and look at each time we hired and if that actually took our number up or was replacing someone. But I do feel like some of my hires have not been direct replacements but have been expansions of our physician size.
Q. Can you recall where those physicians went?
A. We hired one of them. Is that what you mean?
Q. Which clinic?
A. Anchorage.
Q. So the size of the -- the number of per diem physicians in Anchorage was expanded at some point during your career -- during your time as medical director?
A. Yes.
Q. How about Fairbanks and Juneau, has there been any effort to expand the size of per diem physician pool at those two clinics?
A. Yes.
Q. And how did it come out?
A. I have been looking or interested in having a second abortion provider in Fairbanks from, I would say, most of my time as medical director, but I have been unable to find someone willing to be living in Fairbanks and be a provider there.
Q. Is the problem -- it seems like, with

Page 148

telehealth, you could increase access at virtually any of your clinics by having an additional per diem physician in Anchorage at least for medication abortion; would you agree with that?
A. Yes.
Q. Has Planned Parenthood given any thought or consideration to increasing its staffing -- per diem physician staffing in Anchorage in order to increase access to medication abortions in Fairbanks and Juneau?
MS. POWER: Objection to form. Assumes facts not in evidence. Go ahead.
THE WITNESS: Anchorage -- or Planned Parenthood operations is complex, but they do consider access for the patients in Fairbanks and Anchorage -- or sorry -- in Fairbanks and Juneau in their decisions of having their total number of per diem physicians.
BY MR. ROBISON:
Q. Have you noticed any -- are patients, when they receive a medication abortion -- well, let me ask this question first.
Have you administered medication abortions via telehealth?
A. Yes.
Q. To patients that are in a clinic that's different from the one in which you were sitting?

Page 149

A. Yes.
Q. And is there any reluctance or adverse reaction from your patients to having the procedure be telehealth as compared to when you're in the same room with them?
A. The patients have not expressed that they're bothered by the telehealth modality. I personally find it easier to converse with a patient in person than over videoconference.
Q. Have you ever had a patient that has refused to go forward with a medication abortion procedure because it's being done via telehealth as opposed to in person?
A. No.
(Exhibit 4 marked)
Q. So Dr. Pasternack, I've handed you what has been marked as Exhibit 4.
Can you identify this document for me?
A. Job description of a per diem physician at Planned Parenthood Great Northwest.
Q. So is this a document that you prepared?
A. No. This is a standard document that I have access to.
Q. So how would this document be used? Is this a job posting?
A. I use it as definitely something I would review with a candidate. I'm not -- I don't do the job postings.

DEPOSITION OF ADAM CRUM

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

Court File No. 3AN-19-11710CI

- -

PLANNED PARENTHOOD GREAT NORTHWEST, HAWAI'I, ALASKA, INDIANA, KENTUCKY, a Washington corporation,

Plaintiff,

v.

STATE OF ALASKA; et al.,

Defendants.

- -

- -

ZOOM DEPOSITION OF
ADAM CRUM

- -

Taken June 15, 2022 By Kelly A. Herrick

Job No. 212570

That would be taken care of by the Medicaid divisions and then work its way up.

Q. Would you say that primary care falls under your purview?

A. Primary care access, yeah.

Q. Do you understand reproductive healthcare to be part of primary care?

A. I would say yes.

Q. So would you say that access to reproductive healthcare would fall under your purview?

A. Yes, but then not as an individual basis or an individual service line, if that makes sense.

Q. I'm not sure I follow. I'm sorry. Can you tell me what you mean by -- as an individual service line.

A. You know, I don't -- you know, orthopedics, right, would be an aspect, just like saying reproductive health, but I don't get -- I don't get approval processes or waivers for items for knee surgeries or hip replacements.

That would come -- their way to my desk. I would get into overall access,

right, both on the primary care side as well as perhaps specialty side.

Q. Under whose purview would reproductive healthcare fall?

A. Reproductive health is an aspect of primary care, not healthcare, so it's an eligible service line that's provided, and so it gets monitored throughout and we do surveys.

So it's part of a larger subset. So there's not like one individual position or role that would be defined, like you're the reproductive health chief.

We do have a group on Public Health, a section called Maternal Child Family Health, but that does a large number of stuff across the board.

Q. Do they do reproductive healthcare?

A. We don't do -- are you talking about like direct care? We don't provide direct care at the state. It's very, very little.

Q. How would you define reproductive healthcare? I guess that's -- let's start there.

A. So are you talking about -- sorry, apology.

Are you talking about the delivery of reproductive healthcare or the payment or management of programs?

Q. I'm talking about access.

A. Access, so that would be under -- that would be actually under the payment and management of programs. That would fall under the Medicaid program, as well as a little bit under the Public Health group.

Q. And you supervise the Public Health group?

A. Yeah, that's one of the groups, yes.

Q. How long would you say you've been working on healthcare issues in Alaska for?

A. Since we -- since I took over the role on December 3, 2018.

Q. I understand that you're testifying in this case as a fact witness. That's what Counselor Pickett said before; is that correct?

A. Yes.

Q. So you're not claiming any expertise related to abortion, correct?

A. No -- or correct, sorry.

Q. And you're not claiming any expertise on

APCs?

A. No.

Q. You're not offering expert testimony on what level of abortion access is a sound Alaska policy?

A. Can I answer? So, yeah, I can answer that on what is sound Alaska policy because we do have our multiple aspects of that.

The Primary Care Assessment Report, which is mandated by HRSA, and footed for that, and we both agreed that that is actually a part of reproductive health is a part of that.

So the Primary Care Assessment Report, which is I see in this pile of stuff you guys have looked at as well, shows and identifies that the multiple groups across the board and the surveys have identified what are critical health needs, what are we lacking in access, and that would be primarily addressing health disparities for rural and tropical populations and product disease, behavioral health, substance misuse --

villages, would that also increase access to care for these rural communities?

MR. PICKETT: Objection, just for the record only to the extent -- I mean, the objection is my concern is just -- serve these communities -- I'm not sure I'm specifying what capacity or just in any capacity?

BY MS. VEGA:

Q. Do you understand my question, Commissioner Crum?

A. Could you elaborate?

Q. If APCs were available to provide services, whatever those services may be within the scope of what APRNs or PAs are able to provide, would this increase access to care for these rural communities currently served by the community health aides?

A. It's a difficult question. Maybe -- it's a yes and no. Yes in the fact that it would be nice if everybody was a nurse or a doctor so we had advanced medical care across the board, but that's not even a reality in urban Alaska.

We do not have enough primary care individuals. We don't have enough APCs or general family practitioner physicians, family practitioners or physicians, in urban areas, regardless if you live in populated settings, like Fairbanks, the Mat-Su or in Anchorage.

And the other kind of unique aspect about Alaska, in very small towns, and this is something that was really highlighted during COVID, was we were limited, as an example, in our ability to share information about COVID cases on a geographic basis because it could be a large geographic area, but if that area only had less than a thousand people, then if we were to identify COVID cases, it would be very possible that we would be then divulging private health information because individuals could easily tell who hasn't come out of their house, they must have COVID.

So it's an ongoing concern for providers for APCs and physicians in Alaska that, when they do regular rounds or visit

villages, sometimes think like a dental hygienist sometimes will do traveling work, everybody knows that the patients lose a privacy aspect.

So from the stateside, this is nothing that we enforce, but it is a cognizant thing, both on the individual patient side and the provider side, about when they rotate into villages of maintaining the individual local private privacy, which is why I say the yes and the no.

Q. What are the privacy concerns? Can you just elaborate on those for me.

A. If a certain provider that you know, if somebody is like an orthopedic surgeon, and they happen to go into any small village, the rest of the town knows, oh, they went into Bob's house, Bob must have some issue going on and, therefore, there is a loss of privacy there.

Q. Are the privacy concerns related to limited -- strike that.

Are the privacy concerns a reason

to limit access?

A. Access is not limited because even -- so like, if an individual in a small village, say a Patient X, was worried about if a provider came into town, and they went to see them, everybody would know it, they lose privacy.

Well, Patient X has the option, because service isn't provided in that community, to go to the closest hospital that provides the appropriate service within the required timeframe.

And the Medicaid program covers that, including all ancillary costs, lodging, per diem, ground transportation, and will even pay for a companion to travel with those individuals.

Q. Is that part of that hub & spoke commodity you were describing before?

A. It's part of the hub & spoke model, but it's also, because of the geographic size of Alaska, CMS mandates that the State of Alaska pays for travel.

So one extensive -- one of our big

line items in the Medicaid budget is actually covering travel costs, more so than any other state, because we have to typically fly individuals in.

If there's not regular commercial service, this would include chartered flights.

Q. Would you say that travel costs are aggravated by the physician shortage you were describing?

A. No, because if people wanted to go see a physician, the physicians are typically going to be in the populated areas, even though there's not a lot of them, and they are going to have to fly to them anyway.

And the Medicaid program typically covers 100 percent of that cost.

Q. But if there were more physicians in Alaska, could you see costs for the travel program being lower?

A. Depends upon the service being considered. I'd love to have more physicians in Alaska, so much so that it's so difficult to recruit healthcare physicians in advance practice

types in Alaska.

As an example, the WWAMI program, Washington, Wyoming, Alaska, Montana and Idaho, is the state medical school.

Because those listed schools don't have individual medical schools -- sorry, states, we use the University of Washington in order to do this. The state of Alaska pays for 20 seats each year.

In order to cover some of those costs and offset the subsidy, the State of Alaska will encourage graduates of that program to come practice in Alaska.

If they practice in an urban setting, every year they practice in an urban setting they will get 20 percent of their subsidy dismissed by the State. So five years, your debt is covered.

To get them to go to rural Alaska, which by definition is less than 5,000, which is a very loose definition of rural by Alaska standards, one-third of your subsidy debt would actually be covered, so in three years you could pay it off.

So it's a very attractive program, and we still struggle getting individuals to go out there.

Q. How would you define "rural"?

A. You know what, I grew up -- so it kind of depends. I grew up in a small town on the road system of about 1,200 people, but because it was on the road system, it was not necessarily rural by village standards, because being able to access and drive into Anchorage in half a day is much different than a lot of groups to where, if you're going to make a trip into Anchorage or Fairbanks, you're paying thousands of dollars in that, which is why the Medicaid program covering those travel costs really does kind of change the dynamic.

Q. What are some of the challenges of recruiting healthcare workers to rural areas?

A. I'd say the Number 1 challenge is actually housing, it's the cost of finding affordable housing throughout Alaska, so much so that it's -- even Fairbanks, the Department of

Law has trouble recruiting lawyers to the city of Fairbanks, which has a population of about 98,000, because the cost of housing to build there is so expensive that lawyers are having a hard time even going there.

And then you put that -- it's an exponential difference from there, when you look at rural Alaska and frontier Alaska, it's those housing needs is the biggest concern.

Q. What are some ways you can think of to address these challenges?

A. This is a statewide conversation. This is something that the legislature actually has addressed in earnest this last year about how do we actually improve both housing access for State employees in general, increase State vacancy rates, which is like 15 percent, if I believe, but also for healthcare providers and other kind of key professional groups that we need.

And so I do not have a single answer on that one, other than it has -- it's going to require a lot of time and

attention from this administration and legislature, and any future ones to really address.

It's going to be like a decade of work to implement and find solutions to really move the needle.

Q. Do you think that expanding the scope of practice for some healthcare providers might incentivize them to go work in rural areas or provide care there?

A. Probably not. I would have to say that, you know, the licensing side for the professional types doesn't fall under me, but just in the conversations I've had with providers, with a hospital clinic and different even physician groups, I'd say no, it's not so much that.

There is a lot of freedom already that Alaska provider types have over other states, so that is, in itself, an incentive.

Q. What are some of these freedoms?

A. One of them -- I apologize, Counsel Pickett, if I'm stepping outside a little bit, but one of them is the APRNs can actually

operate outside of being under a physicians's license, which is different than most other states.

Q. Do you know why they are allowed to do that?

A. I apologize. I don't know the exact specific mechanism as to why.

Q. Do you know anything about who approves that?

A. My guess would be statutory, and then the Board of Nursing or medicine.

Q. What are some strategies the department specifically is using to get rid of the physician shortages?

A. So the group we were talking about earlier, the Office of Healthcare Access, they help administer a program called the SHARP program, just S-H-A-R-P. There's three different levels: SHARP 1, 2 and 3. They all have different incentives for recruiting and paying different strategies to different healthcare license types, as well as kind of healthcare paraprofessionals, so healthcare administrators and other groups.

One of the things that we're having

a discussion on is, do where he need to ask the legislature to reinvest in programs like that, and/or do we also need to expand upon debt forgiveness programs for different areas, like registered nurses, or other groups who practice in Alaska, to help incentivize them to go to rural Alaska.

So those are conversations that we are having, and we'll actually have some meetings here -- they haven't gotten scheduled yet because we're waiting for the department split to occur on July 1, but working with our Tribal Health providers, as well as the Hospital Association, and the Alaska Primary Care Association, to meet and come up with tangible steps on healthcare work force recruitment.

Our goal is to actually devise certain things that are both new regulations that are needed, regulatory repeal that may be necessary to remove administrative burden, statutory fixes and/or appropriations in investments necessary.

So the plan is to have these series

of meetings over the interim between legislative sessions, and to come forward with something that both this kind of private group -- these private groups, as well as the executive branch, the Governor's office and my department, can agree upon or bring forward to the legislature to act upon.

This is not something that we take likely. It's a very real issue for us on every level across the board for healthcare providers.

We learned this because of the burnout that we saw throughout COVID. It was a very real issue and we want to make sure that we are doing this.

Q. So would you generally agree that having more providers is a good thing?

A. Yes.

Q. And would you generally agree that providers in Alaska should be able to practice -- should be able to exercise their full scope of practice?

A. I'd say yeah. So our goals -- the phrase

A. Those are only for behavioral health aspects, yeah, typically what's called Title 47 commitments.
Q. Could this model be replicated for other types of healthcare?
A. It depends if there's funding types available. This is a specific license type. It had to go through the certificate of need process.

They had to actually ask for -- to invest in their facility to expand this number of beds, licensed specifically as a DET or behavioral health bed facility.

So there's a lot of steps in bureaucracy throughout the process in order to do it, so that's part of the limitation.
Q. Are you able to speak at all to the department's priorities in terms of maternal or infant health?
A. You know, long-term goals, when you talk about maternal child family health, trying to do the maternal -- what is it, I had a term and I lost it -- the maternal child health aspect is the outcomes, the maternal

mortality outcomes, improve the quality of life around mothers and children.

And so those are things that we were constantly trying to look at, how do we do that?

We've gotten facilities like Alaska Regional Hospital invested over the last couple years in their nest -- I apologize for not knowing the exact acronym -- that is their unit which is specifically for babies which may be born under, like, substance abuse conditions, in order to treat those children appropriately and give them the best outcomes.

As you know, the first couple hours and days of life mean a lot going forward. So those are things like that that we continue to look at.

When we look at the Alaska Medicaid program when it comes to pregnant mothers, it's a very inclusive program. It's up to 200 percent of the federal poverty level.

We also have the retro activity, meaning that any services within three full

months of somebody being determined to be Medicaid eligible, if it's an eligible service, it will be retroactively paid for.
Q. How are you improving these outcomes in rural communities?
A. Working with our Tribal Health providers to what are their areas of concern to do this.

And this is the unique thing about Alaska, 15 percent of our population is Alaska native, and we have an exceptionally sophisticated Tribal Health system, more so than a lot of others because we don't necessarily have reservations like other states do.

We have these groups that really took it upon themselves under the Indian Self-Determination Act, which I apologize, it was in the '70s, they really took it and ran with it when they created Alaska Native Tribal Health Consortium.

And they have created -- it was the Tribal Health groups themselves that created this hub & spoke model, and they're so sophisticated that actually most

subspecialties in Alaska are only at the Alaskan Native Medical Center.

As an example would be a pediatric endocrinologist, to the best of my knowledge, unless one was recently hired, they only worked for Alaska Native Medical Center.
Q. Is that in a rural community?
A. No, that's in Anchorage.
Q. But it's part of a hub & spoke model for rural communities?
A. Yes.
Q. What are some of the problems with the hub & spoke model?
A. I don't know. I think, you know, just -- we have what we refer to as the tyranny of distance in Alaska, and depends on where you're at, you're going to have weather-based issues, but you can plan in advance.

But this is true kind of regardless and/or population size. UnAlaska is an example, right, the charter, if you're familiar with that, has -- at any one time

will have an extra 10,000 people working there in the fishing industry and seafood processors.

UnAlaska is one of the most difficult places to fly into in the world, the way they have their runways situated. It's a very short runway and a sheer cliff, but the wind hits at weird angles, and so flights are delayed in and out.

And so it's almost on a monthly basis we'll have calls that a trauma-based patient is unable to have a life flight leave UnAlaska, or a life flight can't go get them because of the weather.

Some of the first COVID vaccines that we lost as a state were actually because we were trying to deliver them to UnAlaska and then out there to the Aleutian Islands.

Alaska, just being so big, is part of the issue, but then there's also the economy of scale, how do you have a provider type in a certain area of a small town if there's nothing to pay for it, or for the

individual to see. So it's kind of just the reality of living and being in Alaska.

Q. In terms of accessing emergency care, do you think the hub & spoke model is fairly efficient, would you say?

A. I would say it's as efficient as it can be. We actually have a Trauma Review Committee, which a couple members of the state sit on, but it's comprised of trauma or emergency physicians from around the state.

And they look at what is the best needs for Alaska overall. And there's varying levels of trauma centers, and we only have one at the highest level, and that's kind of a concerted effort to not have other groups apply for it, because there's a certain number of patients that you have to see.

While Alaska is very big, we have a relatively limited population, so in order to maintain certain statuses of peer groups, you have to see a certain number of patients, if that makes sense.

Some of the examples -- a much more

direct example, having gone to school on the East Coast, in Baltimore -- I think it was Baltimore Memorial -- has what's called a shock trauma unit.

The shock trauma unit actually was a primary training ground for US Army physicians because they were most likely to see gunshot victims.

And it was the number of victims who came through there gave them that special designation, and for funding and accreditation purposes.

So that's why you can't have an emergency room in every community because there's different levels of trauma level of care that's necessary and required, the equipment required, and/or then the billing. It may not necessarily be the most appropriate needs.

Q. Would you say that Alaskans generally have good access to emergency care, though, through this model?

A. I'd say yes. I'd say it's better than could be expected in a state our size with a

population as small as we have.

Q. Has access to emergency care improved during your tenure?

A. I don't think so, nor do I think it's changed much. There has been a change in the -- so emergency care is a very broad term, but EMS, the Emergency Medical Services side, we did -- there was a bill last year that moved paramedic licensing from the Department of Commerce to Division of Public Health within the Department of Public Health & Social Services to keep it aligned with our EMS services we already do, such as the emergency medical technicians.

So that helps, because a lot -- throughout Alaska, when you talk about emergency care, you pretty much rely on these emergency medical technicians or paramedics, or an individual who perhaps was a Veteran, Alaska being the highest per capita Veteran population, who may have been either a naval corpsman or in -- done some medical training in the military.

Q. You would say that access to emergency care

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here.

MR. PICKETT: Actually, no, that covered it. I think that's all I have. Thank you.

FURTHER EXAMINATION

BY MS. VEGA:

Q. If I could just ask a quick followup.

Commissioner Crum you testified that Alaska doesn't have enough primary care providers, but you clarified that your testimony wasn't specific to abortion providers.

Do you have knowledge of the type of physicians who provide abortion care in Alaska?

A. Not specifically. Anecdotally, I've heard it's varied across all physician types.

Q. Would it include primary care providers?

A. To the best of my knowledge, yes.

Q. You also testified that the delay was an inherent part of seeking medical care in rural communities.

What's DHSS doing to help minimize delay for time-sensitive services?

DEPOSITION OF ADAM CRUM

A. We try to expedite as much as possible, so this would be things that we talked about, rural Alaska, the Tribal Health providers that actually take control of the tribal coordination piece we're trying to short-circuit in order to move items along and get preauthorizations.

And so we don't intently throw up roadblocks. If an item comes forward, and then it does meet timely guidelines, we try to process that through and/or even work on retroactively sometimes.

So there's no barriers there that we try to do, and really it's just about the time that a patient comes forward with an item or an issue, when the referral comes through and where they sit in the necessary area.

Q. Do you agree that delay in getting care to impact a patient with an emergent health issue?

A. Yes.

MS. VEGA: No further questions.

MR. PICKETT: Nothing further.

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THE WITNESS: Please. If I may take advantage, Ms. Vega, you mentioned earlier a clarification aspect.

I did a Google in between, and I looked up the difference between mediation and deposition, and the two items outside of this role that I mentioned were actually mediation and not depositions.

MS. VEGA: Got it.

THE WITNESS: I just wanted to clarify that for the record. I was thinking about it more, like, wait, the other party was, in fact, there at the table, and I was like -- so I just wanted to make sure that was a clarification.

MS. VEGA: You were like, wait, it didn't quite feel like this, yeah.

THE WITNESS: Yeah.

MS. VEGA: Thank you for clarifying, Commissioner Crum. I really appreciate it.

THE REPORTER: Would you like to order a copy of the transcript?

MR. PICKETT: The State would, yes,

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please.

MS. POWER: And Plaintiff will as well, thanks.

MR. PICKETT: If we could please read and review, we'd appreciate that as well. If we could.

MS. VEGA: And, Jeff, I think Commissioner Crum just mentioned a new document that he looked at in preparation, if we could get access to what he looked at.

MR. PICKETT: Yes, well, with the proviso that we need to ensure that none of it is privileged or otherwise not subject to turning over, but yes, as a general matter, yes, of course.

MS. VEGA: Thank you.

(At 7:38 p.m. the deposition was recessed.)

In the Matter Of:

PLANNED PARENTHOOD vs STATE OF ALASKA

INGRID JOHNSON

June 29, 2022

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Page 50

globally, or within the United States, all of the research demonstrates when you limit options, it creates a barrier.

Q. Have you looked at -- in noting that all the research shows that limiting options creates a barrier to care, have you looked at the sort of need for care, the numbers of people seeking care?

A. For abortions?

Q. For abortions in particular.

A. I have not. I don't -- you know, I don't know even that that data exists in the state of Alaska, but I don't -- yeah, so I have not.

Q. Would it be possible to acquire that data?

MS. POWER: Objection to form.

THE WITNESS: Like hypothetically could you create --

BY MR. PICKETT:

Q. Yeah. Could a researcher acquire that data?

A. Yes, hypothetically. It would be very difficult. If you wanted to know about people who had a need for abortion care but didn't necessarily seek those services or get those services, you would need to do a similar type survey to the Alaska Victimization Survey or some kind of population-based randomly contacting people, asking them behaviorally specific questions, yeah, and that is extremely expensive and time-consuming kind of

Page 51

research to do.

Q. With respect to Planned Parenthood's provision of abortion services, would you expect data to exist within the organization that captures the need for abortions and whether just generally in the population -- in the Alaska population and whether those people seeking them are able to receive the care?

MS. POWER: Objection to form. Compound, calls for speculation, assumes facts not in evidence.

BY MR. PICKETT:

Q. I guess my question then is whether you would expect Planned Parenthood to have any data that would inform --

MS. POWER: Same objection. I'm sorry. You didn't finish your question.

MR. PICKETT: That's fine.

BY MR. PICKETT:

Q. That would inform a researcher's -- that would inform the answer to the question of whether people seeking abortion care in the state are impeded by this statute?

MS. POWER: Again, same objection. But to the extent that you know, you can answer.

THE WITNESS: To the extent that I know, I would say, if we want to look at how many people don't get the

Page 52

care they need, which is the concern here, the people providing that care are only going to -- I mean, not only, but they're primarily going to have data on people who sought and got the care that they needed.

So if somebody is prevented from getting the abortion care they need because they have a controlling partner who monitors their movements and monitors their money and controls who they see and where they go, Planned Parenthood is never going to know about that person because they're not going to come in contact with them.

So Planned Parenthood's data might have -- this is me speculating, because I don't know what it looks like. I'm just thinking of other health care data systems and what kind of data they collect. You know, they would maybe have people who presented past the gestational limit, so they would know people that needed an abortion but got here late. They would have that data potentially, or could have that data.

They might document experiences with intimate partner violence. My experience just as a user of the health care system, but also with my knowledge of health care records, the questions about intimate partner violence are very limited and don't usually have questions to capture things like coercive control and entrapment, so they might not even have very good data on experiences

Page 53

with violence. So I just don't know.

BY MR. PICKETT:

Q. Fair enough. So if I understand correctly, based on an earlier answer you gave, one way to better understand whether there's sufficient abortion care services in the state would be to design a survey along the lines of the Alaska Victimization Survey and conduct it?

A. Yeah. Which is -- I think I have the price tag in the report -- a very expensive survey.

Q. Okay.

A. And takes several years to do.

Q. Okay.

MS. POWER: If we're at an okay point or when we are, can we just take five minutes?

MR. PICKETT: Sure. That's fine.

(Recess taken)

BY MR. PICKETT:

Q. Dr. Johnson, if I may turn your attention to page 5 of your expert report. And I'm looking at the first sentence on page 5, and I'll just read it out loud. "It is my professional opinion that limitations on the availability of abortions are likely to disproportionately harm victims of intimate partner violence in Alaska particularly those living in rural areas."

altogether."

Just for clarity, when you write "such restrictions creates more opportunity," what restrictions are you referring to?

A. The restrictions on availability of. So that the restrictions on availability created by the physician-only law limits when and where abortions can be provided, which is restrictive.

Q. What's your understanding of the restrictions caused by the physician license requirement?

A. What is my understanding?

Q. How would you describe those restrictions specifically caused by the physician license requirement?

A. Well, it limits the days of the week, the days of the month, and where and what locations these procedures can be offered.

Q. And do you have any -- have you reviewed any data or collected any data that suggests that the limitations on days of week or months -- basically days that abortion care is availability and the location of availability has hampered a woman's ability to receive abortion care?

A. I don't know that I saw any research on that specific to abortion care, but, as I mentioned earlier, all of the research on help-seeking of any variety is very

clear that distance traveled, time of -- how often the hours are available, all of those kinds of restrictions are barriers, and they decrease people's access to care. So I don't think it's -- I don't think we would expect for some reason needing abortion care to be any different from any of the other forms of help-seeking.

And I think, you know, these -- these are forms of help-seeking that carry similar levels of stigma. So substance abuse treatment seeking, help-seeking for domestic violence, sexual assault, those all carry a similar stigma to seeking abortion care. So they're actually quite comparable as far as, when we make it harder to get that care, it's harder to get.

Q. Have you reviewed any data or collected any data that suggests the times and locations available to receive abortion care are insufficient to meet the need in the state?

A. No.

Q. In concluding that the lack of flexibility in scheduling and delays caused by such limitations creates more opportunity for abusers to discover their partner's pregnancies and/or abortion-seeking efforts, did you talk to any patients to reach that conclusion?

A. No. I based that off of other studies that had been done.

Q. And were those studies specific to abortion?

A. Yes.

Q. Do you cite those studies in your paper or your report?

A. Yes.

Q. And can you just point me to those studies?

A. Yes. So got to flip forward quite a bit. So I think we're starting on page 14. So we have, under that subheading 2, "Pregnancy increases risk for ongoing or increased intimate partner violence." So we have the cite 37 where it says, "One study found that among women seeking abortions, those who were able to obtain an abortion experienced a decrease in intimate partner violence over time, whereas those who wished to have an abortion but were unable to access care experienced an increase in physical violence."

There we have "Pregnancy also increases women's risk of being a victim of homicide. Intimate partners commit over half of all homicides of women." Citations are included for those. "And an even greater percentage of homicides of pregnant and postpartum women."

So it just then continues on to talk about how women view remaining pregnant as a barrier to escaping violence and how children complicate that decision.

And then let's see if there's any more. We

have, on page 16, "Research has demonstrated that men who perpetrate physical IPV are 2.6 times as likely as those who do not to try to prevent their partners from seeking abortions." We have some qualitative research documenting male abusers threatening to kill their partners if they obtain abortions.

We have some evidence from other qualitative research that some abusive partners will forcibly impregnate their partners to keep them from leaving the relationship. And then we have some cites on hiding -- hiding pregnancy and abortion-seeking amongst women who are in violent relationships.

So I'm not sure if that answers your question succinctly, but...

Q. I appreciate that answer. I guess my question was more directed at delays caused by -- and I'm going to quote your term in the report -- such limitations.

A. Restrictions.

Q. I'm sorry. Restrictions.

And just to clarify, such restrictions refers to the physician license requirement; is that accurate?

A. Yes.

Q. So in the studies that you just referred to, do any of them look at the impact of the physician license requirement --

Page 90

violence and what we know about abortion. Stringing all of those together, what is the reasonable conclusion? So you could call it an assumption. It has negative connotations, but --

BY MR. PICKETT:

Q. Well, and I certainly don't mean to imply negative connotations. I'm curious if you have any actual knowledge -- knowledge of an actual person who --

A. No.

Q. -- is engaged in this? Okay.

On page 20, so the first full sentence on that page, I'd like to read that. It reads, "These limitations combined with the extremely limited availability of appointments for abortion care could prevent victim-survivors from accessing care within the gestational limit on abortion care."

My question is whether you are aware of any specific patient who has been prevented from accessing care within the gestational limit on abortion care?

A. I am not.

Q. In drafting this report, did you attempt to identify any specific person who that might have been true for?

A. No.

Q. When you use the term "extremely limited

Page 91

availability of appointments for abortion care," or the phrase, what do you mean by "extremely limited"?

A. Well, I believe I -- I mean, I know this is in the complaint, and I believe it's in the last bit of the report on the days of the week and where they're available. But with the closure of the Soldotna Planned Parenthood, we're now looking at Anchorage, Fairbanks, and Juneau. So just geographically those are very limited locations, even for people on the road system.

And then as far as days of the week that they're available, that is -- let's see, here we are. It's on page 21. So we're looking at -- let's see. There's aspiration. Aspiration abortions are limited to one to two days per month in Fairbanks and Juneau, one day per week in Anchorage. Medical abortions, approximately one to two days per week in Anchorage and one day per week in the other Planned Parenthood locations.

So one day a week to me is extremely limited availability when, again, thinking about people's job schedules, their child care needs, their travel needs, trying to accommodate all of those needs while dealing with a partner who might be threatening to kill them, in addition to everything else they're dealing with.

Q. And with respect to the schedule and availability of providers that you just referenced, have

Page 92

you studied whether that's -- that availability is sufficient to meet the needs for abortion care in the state?

A. No.

Q. Is it possible that schedule you just referenced in the various locations in the state, is it possible that those are sufficient to meet the needs for abortion care in Alaska?

MS. POWER: Objection to form. Lacks foundation, calls for speculation.

THE WITNESS: The term "possible" not "probable" comes to mind, of course. Could be possible. Given the evidence, I would say that's unlikely that it is meeting the level -- the level of care needed.

BY MR. PICKETT:

Q. And what is that evidence?

MS. POWER: Same objection. Lacks foundation, calls for speculation.

THE WITNESS: Again, just the evidence that, from all of the different help-seeking literature, that when we limit availability, we see people not getting the help they need, whether that's, again, substance abuse treatment, domestic violence services, police, sexual assault services.

So we know that we have the worst rates of

Page 93

intimate partner violence in the country. We know that from the Alaska Victimization Survey and comparing that to the National Intimate Partner Violence and Sexual Violence Survey, and so we know that we have the most difficult travel circumstances in the United States. So looking at those different facts, I think it's very safe, like, to say that we are not meeting the needs of intimate partner violence victims.

BY MR. PICKETT:

Q. What number of providers would be required to meet the needs of intimate partner violence victim-survivors?

A. I don't know. And obviously we're never going to meet them a hundred percent, but...

Q. Okay. Can I ask the same question -- or I'd like to ask the same question then about which locations in the state are -- would be necessary -- strike that.

What other locations would be necessary for Planned Parenthood to provide abortion care if the full needs of intimate partner violence victims survivors for abortion care were to be met?

MS. POWER: Objection to form. Calls for speculation and outside the scope. If you know, you can answer.

THE WITNESS: Yeah, I don't know. I think you

Page 94

would have to do some kind of assessment of, you know, maybe -- yeah, where patients were coming from. Yeah, I don't even know how you would make that assessment, but...
BY MR. PICKETT:
Q. Okay. My apologies if I've asked you this already, and if I have, you can just tell me you've already answered it.
Are you personally aware of any IPV victim-survivors who have been prevented from accessing abortions within the gestational limit for abortion care?
A. No.
Q. I have a few more questions. We could take a break or we can just continue on depending on --
A. I'm good.
MS. POWER: Keep going.
THE WITNESS: We have company.
MR. PICKETT: For the record, the company is outside the building washing the windows.
BY MR. PICKETT:
Q. So if I could, Dr. Johnson, please direct your attention to page 21 of your report. And if I could, I will read the first sentence of that page under the heading "Impact of Alaska's APC Ban," and it reads, "Having read the plaintiff's complaint about Alaska's APC ban, it is my understanding that both aspiration and

Page 95

medical abortions are available at limited locations and times in Alaska."
And this again may feel somewhat repetitive, but because it's a statement in your report, I'd like to just ask the questions.
What do you mean by "limited" when you use it here on this page?
A. So limited meaning there are only three locations and limited in that they're only available once a week, twice a week, you know, depending on the location.
Q. What would not limited or unlimited -- not limited times look like?
A. Well, I mean, again, if we're thinking about we have to accommodate people who work and have children, etcetera, etcetera, etcetera, in a perfect, ideal world you would have services seven days a week, you would have them open, you know, into evenings, because that's when people are not at work. But obviously that is very difficult to achieve for any kind of health care provider.
So I'm not sure that there's like a -- it's sort of like a progression rather than a line, right? Like it's not just limited versus not limited. It's sort of -- it's a spectrum from limited to unlimited and so there's just sort of, on the spectrum, in between.
Q. Okay. It's on a spectrum.

Page 96

Do you have a sense, then, of the number of appointments that would need to be available to adequately meet the abortion care needs of intimate partner violence victim-survivors?
A. No.
Q. Have you -- when you -- okay. I think I have asked these questions, so I won't need to go through it again.
Staying on page 21, you state -- this is the second full paragraph, first sentence, "It is my professional opinion that limitations on the availability of abortions are likely to disproportionately harm victim-survivors of IPV in Alaska, particularly those living in rural areas, by reducing their ability to obtain an abortion without their abuse partner's knowledge, thus increasing the risk of further abuse, control, and even death, and increasing the likelihood that they will not be able to obtain the abortion altogether."
A. Typo.
Q. Where is the typo?
A. It should be "abusive" partners.
Q. Abusive partners. Okay.
With respect to this professional opinion, have you seen any data or collected any data or conducted any studies that suggest the physician license requirement

Page 97

limits the availability of abortions in such a way that causes the problems you identify in this sentence?
MS. POWER: Objection. Asked and answered.
THE WITNESS: Yeah, to restate, no singular study that is -- included a policy-level analysis, but it's, again, just a stringing together of we know that availability is limited, and what does that mean in light of all of the other research.
BY MR. PICKETT:
Q. And in forming this opinion that I just read, did you talk to any patients who were seeking abortion care?
A. No.
Q. Did you talk to any intimate partner violence victim-survivors in forming this opinion?
A. No.
Q. Did you talk to any health care providers in forming this opinion?
A. No.
Q. Did you talk to any health care policy-makers in forming this opinion?
A. No.
Q. Did you talk to anyone at the Alaska Department of Health and Social Services when you formed this opinion?

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

PLANNED PARENTHOOD OF THE GREAT NORTHWEST, HAWAI'I, ALASKA, INDIANA, and KENTUCKY, a Washington corporation, Plaintiff, v. STATE OF ALASKA, et al., Defendant.	Case No. 3AN-19-11710 CI

CERTIFICATE OF SERVICE

I certify that on August 29, 2022, true and correct copies of the **Opposition to Plaintiff's Motion for Summary Judgment, Exhibits R-T a**nd this **Certificate of Service** were served on the following via email:

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