Striking Down Physician-Only Laws: A Necessary and Constitutionally Required Answer to the United States' Critical Abortion Provider Shortage

Eva Nofri*

In 2020, women in South Dakota were deprived of an abortion provider in their state for seven months because the pandemic prevented out-of-state physicians from traveling. And as of late 2021, multiple states had only one abortion provider: if just one physician left, entire states or regions would be cut off from abortion access. The dearth of abortion care is not just caused by the pandemic or the escalating state-imposed restrictions on clinics that force them to close: it is the fact that laws in thirty-six states limiting the provision of abortion to physicians exclude an entire group of practitioners willing and able to safely administer early-term abortions. Including advanced practice clinicians (APCs)—who hold master's or doctoral degrees—in the provision of first-trimester abortion will ameliorate the United States' abortion provider shortage, especially for marginalized women.

Excluding APCs from abortion care is not just impractical: it is also unconstitutional. Since the Supreme Court made clear in Whole Woman's Health v. Hellerstedt *that medical evidence must support a state's health-motivated abortion restriction, physician-only laws cannot pass constitutional muster. It is well established that there is no difference in health outcomes between APC and physician-administered first trimester abortions. But the Supreme Court overturning* Roe. v. Wade *signals an unwillingness to appropriately follow bedrock abortion precedent, meaning that federal and state legislatures must also repeal physician-only laws in the case that the Supreme Court continues to disregard long-standing precedent.*

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* Eva Nofri, UCI Law, J.D. 2022. The author would like to extend her thanks to her parents Cathy and David Nofri for their unwavering support. One of the risks of writing about developing areas of law is the speed at which they change. The research for the present Note was concluded in February of 2022. Therefore, this Note does not consider developments in the law after February 2022. Nonetheless, the author is hopeful that this Note advances arguments that are, at the very least, theoretically relevant, and perhaps practically relevant in the event the constitutional right to abortion is once again recognized in the future.

This Note will explore how history, medicine, and the law converge to render physician-only laws obsolete: APCs are a promising new frontier for safe and accessible abortion.

INTRODUCTION

The United States is at a pivotal juncture for women's[1] reproductive rights. The Supreme Court has overturned *Roe v. Wade*.[2] Texas recently harkened back to

1. Although I use the word women throughout my Note, I acknowledge that some individuals that require access to reproductive health services may not identify as female, including intersex, nonbinary, and transgender individuals. *See* Heidi Moseson, Laura Fix, Sachiko Ragosta, Hannah Forsberg, Jen Hastings, Ari Stoeffler, Mitchell R. Lunn, Annesa Flentje, Matthew R. Capriotti, Micah E. Lubensky & Juno Obedin-Maliver, *Abortion Experiences and Preferences of Transgender, Nonbinary, and Gender-Expansive People in the United States*, 224 AM. J. OBSTETRICS & GYNECOLOGY 376.e1 (2021).

2. 410 U.S. 113 (1973), *overruled by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022); *see also* Amy Howe, Roe v. Wade *Hangs in Balance as Reshaped Court Prepares to Hear Biggest Abortion Case in Decade*, SCOTUS BLOG (Nov. 29, 2021, 8:00 AM), https://www.scotusblog.com/2021/11/roe-v-wade-hangs-in-balance-as-reshaped-court-prepares-to-hear-biggest-abortion-case-in-decades/ [https://perma.cc/3HFN-XMTC]; MISS. CODE. ANN. § 41-41-191 (West 2022).

Fugitive Slave Acts by effectively attaching a bounty to those who "aided or abetted" an abortion,[3] and the Supreme Court's unclear abortion jurisprudence[4] has called the Court's legitimacy into question.[5] The erosion of bedrock abortion protections is most devastating for low-income women and women of color,[6] many of whom bear the financial burdens of traveling across state lines to obtain the procedure.[7] The limited clinics that remain open struggle to meet the increasing demand for abortions, while others must close due to escalating state-imposed restrictions.[8] The resulting abortion provider shortage is not accidental: it is a targeted attack on women's independence, autonomy, and liberty.[9] Without prompt action by courts and legislatures, the lack of abortion providers will render any remaining abortion rights illusory, whether there is a constitutional right to abortion or not.[10]

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3. *See* Texas Heartbeat Act (S.B. 8), TEX. HEALTH & SAFETY CODE ANN. § 171.208 (West 2021) (the Texas law in question); Whole Woman's Health v. Jackson, 141 S. Ct. 2494 (2021) (failing to grant an injunction against a recently passed Texas Law, S.B. 8, that makes abortion illegal after six weeks and creates a civil fine for those aiding and abetting a woman to have an abortion after six weeks, including family members and those transporting a woman); *see also* Michele Goodwin, *The Texas Abortion Ban Is History Revisited*, MS. MAG. (Sept. 1, 2021), https://msmagazine.com/2021/09/01/texas-abortion-ban-black-women-history-fugitive-slave-acts/ [https://perma.cc/74DD-CDJF] (explaining that S.B. 8 is reminiscent of Fugitive Slave Acts after the Civil War).

4. Linda Greenhouse & Reva B. Siegel, Casey *and the Clinic Closings: When "Protecting Health" Obstructs Choice*, 125 YALE L.J. 1428 (2016) (explaining the starkly different ways that lower courts have interpreted Casey's undue burden test for health-related restrictions to abortion).

5. Ed Pilkington, *The 'Stench' of Politicization: Sonia Sotomayor's Supreme Court Warning*, GUARDIAN (Dec. 4, 2021, 2:02 AM), https://www.theguardian.com/us-news/2021/dec/04/us-supreme-courrt-sonia-sotomayor-abortion [https://perma.cc/AX3T-44X2] ("If the nation's highest court, with its newly constituted Trumpian majority, were to go along with the ploy set for it by Mississippi and throw out half a century of settled law affirming a woman's right to choose, then what would happen to the court's legitimacy as a place in American democracy that rises above the cut and thrust of grubby partisanship?").

6. *See* Ada Kozicz, Note, *Repealing Physician-Only Laws: Undoing the Burden of Gestational Age Limits*, 42 HOFSTRA L. REV. 1263, 1264 (2014); *see also Health Disparities in Rural Women*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (Feb. 2014), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/02/health-disparities-in-rural-women [https://perma.cc/D7RJ-FZCA]; Sarah London, *Reproductive Justice: Developing a Lawyering Model*, 13 BERKELEY J. AFR.-AM. L. &POL'Y 71, 77–78 (2011) (explaining that low-income women and women of color bear the heaviest burdens of abortion restrictions).

7. *See* Garnet Henderson, *There's an Abortion Provider Shortage Across the U.S. Here's How We Address It*, ELLE (Nov. 18, 2021), https://www.elle.com/culture/career-politics/a38257180/abortion-provider-shortage-how-to-fix/[https://perma.cc/KX7C-RL24] ("For seven months in 2020, South Dakota went without an abortion provider when the pandemic prevented out-of-state doctors from traveling to the state."); *see also* Janet Shamlian, *After Texas' New Abortion Law, Some Clinics in Nearby States Can Barely Keep Up with Demand*, CBS NEWS (Sept. 21, 2021, 7:23 PM), https://www.cbsnews.com/news/texas-abortion-law-pushes-women-to-clinics-in-other-states/ [https://perma.cc/B2DR-N8YU].

8. *See* Shamlian, *supra* note 7.

9. *See* Caroline Kitchener & Casey Parks, *How Mississippi Ended Up with One Abortion Clinic and Why It Matters*, WASH. POST (Nov. 30, 2021, 9:00 AM), https://www.washingtonpost.com/dc-md-va/2021/11/30/abortion-mississippi-closed-clinics/ [https://perma.cc/5H6K-JNFF].

10. *See* Henderson, *supra* note 7; *see also* Kitchener & Parks, *supra* note 9.

Expanding the ability for Advanced Practice Clinicians (APCs), such as certified nurse-midwives and physician assistants,[11] to perform abortions would greatly alleviate this shortage[12] without contraindication for women's safety.[13] Thirty-six state laws restricting the performance of abortion to licensed physicians obstruct this urgently needed solution to the provider shortage.[14] These laws flow from a deep-rooted tradition of white men monopolizing the field of reproductive healthcare,[15] the consequences of which land today as "[f]ive states have only one

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11. *See* Meera Kishen & Yvonne Stedman, *The Role of Advanced Nurse Practitioners in the Availability of Abortion Services*, 24 BEST PRAC. & RSCH. CLINICAL OBSTETRICS & GYNAECOLOGY 569, 581 (2010) https://reader.elsevier.com/reader/sd/pii/S1521693410000295?token=23E5397EF58BBD57165788DAFFD437DC3D9DCB0651264BFF3A0CD815896D4EE4CC3CAAAA2CF406B2957078CE4AA4BC61&originRegion=us-east-1&originCreation=20211209032910 [https://perma.cc/HTZ7-4JEP] ("'Advanced Practice Clinician' is a term used in the United States to encompass nurse practitioners, certified nurse-midwives and physician-assistants, who have a distinct professional role in the American health-care system . . . . In most states, APCs work under statutes that allow them to administer drugs and provide gynecological services, including surgical procedures, comparable to surgical abortion, provided they are properly trained. However, in some states, abortion-related care is interpreted as outside the scope of their practice, irrespective of their level of training and competence."); *see also* Henderson, *supra* note 7 (explaining that APCs "have masters or doctoral degrees.").

12. *See, e.g.*, Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500, 526 (S.D. Ind. 2021) (explaining that allowing APCs to perform first trimester abortions in Indiana could expand the ability of clinics to stay open five days a week instead of one or two days a week), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022), *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022); CAL. BUS. & PROF. CODE § 2725.4 (West 2014) (allowing nurse practitioners and certified nurse-midwives to perform first trimester abortions in California); *see also Improving Abortion Access in California*, BIXBY CTR. FOR GLOB. REPROD. HEALTH, https://bixbycenter.ucsf.edu/news/improving-abortion-access-california [https://perma.cc/Q3JB-TX5C] (last visited Nov. 26, 2022) ("California will now have greater access to safe and comprehensive reproductive health care, ... California Gov. Jerry Brown recently signed into law a bill (AB 154) that removes barriers to abortion access by allowing nurse practitioners, certified nurse midwives, and physician assistants to utilize their education and training to perform early abortion care . . . . [N]urse practitioners, certified nurse midwives, and physician assistants with special training provide safe aspiration abortions on par with physician providers. Their research also has found that women appreciate receiving care in their own communities from providers they know and trust, rather than having to travel to geographically distant physicians."); Women's Health Protection Act of 2021, H.R. 3755, 117th Cong. § 2 (2021).

13. *See, e.g.*, Marge Berer, *Provision of Abortion by Mid-Level Providers: International Policy, Practice and Perspectives*, 87 BULL. WORLD HEALTH ORG. 58, 58 (2009), https://apps.who.int/iris/handle/10665/270361 [https://perma.cc/2KGZ-3G2G] (explaining that "it is safe and beneficial for suitably trained mid-level health-care providers, including nurses, midwives and other non-physician clinicians, to provide first-trimester vacuum aspiration and medical abortions"); NAT'L ACADEMIES SCIS., ENG'G & MED., THE SAFETY AND QUALITY OF ABORTION CARE IN THE UNITED STATES (2018) [hereinafter NAT'L ACADS. SCIS. ENG'G & MED.], https://nap.nationalacademies.org/read/24950/chapter/1 [https://perma.cc/28RT-HU5T].

14. *See An Overview of Abortion Laws*, GUTTMACHER INST. (Nov. 23, 2022) [hereinafter GUTTMACHER INST.], https://www.guttmacher.org/state-policy/explore/overview-abortion-laws [https://perma.cc/A3V2-7YTH].

15. *See, e.g.*, LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867–1973, at 80–114 (1997); Goodwin, *supra* note 3; Jessica Ravitz, *The Surprising History of Abortion in the United States*, CNN (June 27, 2016, 10:52 AM),

clinic remaining, meaning one doctor's departure could cut off abortion access for an entire state or region."[16] This historical context is necessary to show that the promulgation of physician-only laws did not develop from legitimate concerns for women's safety. This history also shows how arguments today are equally weightless and track with a historical theme of racism and misogyny.

Striking down physician-only laws will undoubtedly protect and alleviate burdens to reproductive healthcare access for marginalized women.[17] But even if these burdens didn't exist, physician-only laws fail to pass constitutional muster and should also be stricken down to conform with more recent Supreme Court precedent.[18] However, the Supreme Court's current conservative makeup[19] and discordance on *Roe*'s[20] legality necessitates the exploration of options outside of courts for expanding APCs' capabilities.[21] State legislatures must take action locally to eliminate physician-only laws[22] and enshrine the right to abortion in their state

https://www.cnn.com/2016/06/23/health/abortion-history-in-united-states/index.html [https://perma.cc/E8BM-LEP6].

16. *See* Henderson, *supra* note 7.

17. *See id.*

18. *See* Mazurek v. Armstrong, 520 U.S. 968, 977 (1997) (outdated precedent regarding physician only laws, upholding a Montana statute that prohibits non-physicians from performing abortion despite extensive data indicating non-physician performed abortion in the first trimester is safe); *cf.* Whole Woman's Health v. Hellerstedt, 579 U.S. 582 (2016) (decided after the *Mazurek* case, which is the main precedent cited to for why physician-only laws are constitutional, and explaining that the undue burden requirement necessitates actual medical evidence for health-justified abortion restrictions, which respondents in *Mazurek* did not have), *abrogated by* Dobbs v. Jackson's Women's Health Org., 142 S. Ct. 2228 (2022); Diana Taylor, Barbara Safriet & Tracy Weitz, *When Politics Trumps Evidence: Legislative or Regulatory Exclusion of Abortion from Advanced Practice Clinician Scope of Practice*, 54 J. MIDWIFERY & WOMEN'S HEALTH 4 (2009).

19. Zachary Snowdon Smith, *Supreme Court Increasingly Seen as Conservative and Too Powerful, Poll Finds*, FORBES (Feb. 3, 2022, 10:27 AM), https://www.forbes.com/sites/zacharysmith/2022/02/02/supreme-court-increasingly-seen-as-conservative-and-too-powerful-poll-finds/?sh=92f556a81ad6 [https://perma.cc/PQ5L-4ADN].

20. Roe v. Wade, 410 U.S. 113 (1973), *overruled by Dobbs*, 142 S. Ct. 2228; *see, e.g.*, *Hellerstedt*, 579 U.S. 582; *Dobbs*, 142 S. Ct. 2228; *see also* Amy Davidson Sorkin, *The Supreme Court Looks Ready to Overturn* Roe. v. Wade, NEW YORKER (Dec. 2, 2021), https://www.newyorker.com/news/daily-comment/the-supreme-court-looks-ready-to-overturn-roe [https://perma.cc/W2KY-C994].

21. *See* CAL. BUS. & PROF. CODE § 2725.4 (West 2022); *see also* BIXBY CTR. FOR GLOB. REPROD. HEALTH, *supra* note 12; Women's Health Protection Act of 2021, H.R. 3755, 117th Cong. § 2 (2021).

22. *See* CAL. BUS. & PROF. CODE § 2725.4 (West 2022).

constitutions,[23] while the federal legislature must work to expand the ability for APCs to administer abortions throughout the United States.[24]

Part I of this Note chronicles the racist and misogynistic history of male physicians' appropriation of reproductive care in the United States.[25] This includes how arguments made in the nineteenth century against midwives, which succeeded in criminalizing abortion,[26] mirror arguments made today against non-physician abortion providers.[27] Part II establishes that APC-performed abortions in the first trimester have repeatedly been shown to be as safe as those performed by physicians.[28] It also sets forth the ways in which physician-only laws render abortion rights illusory by restricting access for women living in rural areas, low-income women, and women of color.[29] Part III sets forth the legal framework for physician-only laws in the United States and examines whether, despite burdening women's safety and access to care,[30] these laws are constitutional.[31] This Note argues that they are not: physician-only laws run contrary to the Supreme Court's recent interpretation of the undue burden test because they lack medical evidence of any conferred health benefit.[32] This Part also examines other avenues for eliminating physician-only laws, including through state and federal legislatures

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23. *See* Order Granting Plaintiff's Motion for Preliminary Injunction at 1, Planned Parenthood Great Nw. v. State, No. 3AN-19-11710CI (Alaska Super. Ct. Nov. 2, 2021), https://www.plannedparenthood.org/uploads/filer_public/27/0f/270f79ef-3e9f-43c1-83fe-654a3ceac878/3an-19-11710ci.pdf [https://perma.cc/2LDL-ERFW] (finding physician-only law for medication abortion violated patients' rights to privacy under Alaska's state constitution); Wilson Ring, *State Legislatures in U.S. Poised to Act on Abortion Rights*, ASSOCIATED PRESS (Dec. 28, 2021), https://apnews.com/article/us-supreme-court-health-business-state-legislature-legislature-9d25a4a301dffe8ce788c748081176c6 [https://perma.cc/8H49-3JGC].

24. *See, e.g.*, Women's Health Protection Act of 2021, H.R. 3755, 177th Cong. § 2 (2021), https://www.congress.gov/bill/117th-congress/house-bill/3755/text [https://perma.cc/33L5-UC88] [hereinafter Women's Health Protection Act].

25. *See, e.g.*, REAGAN, *supra* note 15; Michele Goodwin, *The Racist History of Abortion and Midwifery Bans*, ACLU (July 1, 2020), https://www.aclu.org/news/racial-justice/the-racist-history-of-abortion-and-midwifery-bans [https://perma.cc/J9EU-MMED]; Annalisa Merelli, *The Reason Childbirth Is Over-Medicalized in America Has Its Roots in Racial Segregation*, QUARTZ (Nov. 27, 2017) https://qz.com/1119699/how-racial-segregation-led-childbirth-in-america-to-be-over-medicalized [https://perma.cc/V8D2-SDCP]; Ravtiz, *supra* note 15.

26. *See* REAGAN, *supra* note 15.

27. *See, e.g.*, *id.* at 80–114; Goodwin, *supra* note 25; Roslyn Y. Bazzelle, Comment, Mazurek v. Armstrong*: Should States Be Allowed to Restrict the Performance of Abortions to Licensed Physicians Only?*, 24 T. MARSHALL L. REV. 149, 169–70 (1998) (arguing that physician-only laws may protect women because they ensure the procedure is safe).

28. *See* Berer, *supra* note 13; NAT'L ACADS. SCIS. ENG'G & MED., *supra* note 13.

29. *See* Kozicz, *supra* note 6; *see also* London, *supra* note 6.

30. *See* Kozicz, *supra* note 6.

31. *See e.g.*, Whole Woman's Health v. Hellerstedt, 579 U.S. 582 (2016), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 877 (1992), *overruled by Dobbs*, 142 S. Ct. 2228.

32. *Hellerstedt*, 579 U.S. 582.

and state constitutions.[33] Part IV proposes that, by reviewing a challenge to a physician-only law, the Supreme Court could resolve a burgeoning circuit split in *Hellerstedt*'s application to health-motivated abortion restrictions, citing academic and legal scholars that have called for this review.[34] This Note explains that the changed circumstances between the last time the Court reviewed the constitutionality of a physician-only law and today's abortion landscape requires a fresh review of these laws.[35] Finally, this Part discusses challenges faced in expanding the provision of abortions to APCs.[36]

I. MEDICAL MODEL OF REPRODUCTIVE CARE: HISTORY AND COLONIAL ORIGINS

The United States administers reproductive care through the medical model, where physicians perform the vast majority of procedures, including abortion.[37] Physician-only laws that sprung from this model are problematic because they are rooted in colonialist attempts to regulate women's bodies and gain institutional power rather than in concerns for women's safety.[38] Skilled Black midwives as well as white and indigenous midwives were the persons who performed abortions before the American Civil War, and current anti-abortion efforts are similarly rooted in white supremacy.[39] The past is prologue such that the trampling of women's

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33. *See* CAL. BUS. & PROF. CODE § 2725.4 (West 2022); *see also* Planned Parenthood of the Great Nw. & the Hawaiian Islands v. Wasden, 406 F. Supp. 3d 922, 927 (D. Idaho 2019), *reconsideration denied*, No. 18-CV-00555, 2021 WL 4496942 (D. Idaho Sept. 30, 2021), *and abrogated by Dobbs*, 142 S. Ct. 2228; BIXBY CTR. FOR GLOB. REPROD. HEALTH, *supra* note 12.

34. *See* Greenhouse & Siegel, *supra* note 4; Becca Kendis, Note, Faute De Mieux*: Recognizing and Accepting* Whole Woman's Health *for Its Strengths and Weaknesses*, 69 CASE W. RES. L. REV. 1007, 1020 (2019).

35. *See* Whole Woman's Health All. v. Hill, 493 F. Supp. 3d 694, 742–44 (S.D. Ind. 2020) ("Whether a statute or regulation poses an undue burden on a woman's constitutional right to receive an abortion depends on the then-existing circumstances." (citing *Hellerstedt*, 579 U.S. at 602; Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 877 (1992), *overruled by Dobbs*, 142 S. Ct. 2228)), *order clarified sub nom.* Whole Woman's Health All. v. Rokita, No. 18-cv-01904, 2021 WL 252721 (S.D. Ind. Jan. 26, 2021); John A. Robertson, Whole Woman's Health v. Hellerstedt *and the Future of Abortion Regulation*, 7 U.C. IRVINE L. REV. 623, 645 (2017).

36. *See, e.g.*, Hill v. Whole Woman's Health All., 141 S. Ct. 189 (2020) (denying certiorari for a physician-only law challenge); Amelia Thomson-Deveaux & Laura Bronner, *The Supreme Court's Conservative Revolution Is Already Happening*, FIVETHIRTYEIGHT (Oct. 20, 2021, 6:00 AM), https://fivethirtyeight.com/features/the-roberts-court-vs-the-trump-court/ [https://perma.cc/EVF7-B23C].

37. *See Developments in the Law—Intersections in Healthcare and Legal Rights*, 134 HARV. L. REV. 2158, 2211 (2021) ("A highly medicalized approach to birth is dominant in the United States."); *see also* GUTTMACHER INST., *supra* note 14 (explaining that "36 states require an abortion to be performed by a licensed physician").

38. *See, e.g.*, Goodwin, *supra* note 25 (explaining the racist history of abortion bans); Merelli, *supra* note 25 (citing LAURA A. WILKIE, THE ARCHAEOLOGY OF MOTHERING: AN AFRICAN-AMERICAN MIDWIFE'S TALE (2003)); Ravitz, *supra* note 15; *Developments in the Law*, *supra* note 37 (explaining that a medicalized approach in the United States is not explained by superior outcomes).

39. *See* Goodwin, *supra* note 25.

reproductive autonomy, using thinly guised concerns for women's safety, resembles arguments advanced today.[40] White men have undermined reproductive health, rights, and justice dating back to the nineteenth century. Then and today, marginalized women face the resulting repercussions as they are denied meaningful access to abortion.[41]

A. Origins of the Medical Model and the Field of Obstetrics

In the years after the Civil War, obstetrics became a field within medical schools and was recognized by the American Medical Association (AMA).[42] Obstetricians began responding to threats to their field's legitimacy in the medical community by distancing themselves from traditional models of care[43] and attempting to usurp reproductive care from the midwives who had traditionally administered it.[44] Obstetricians began a campaign against midwives, creating hostility between the professions that occasionally resurfaces today.[45]

Physicians not only distanced themselves from midwives to legitimize their profession but also viewed midwives as adversaries to the profit that obstetrics would generate.[46] This acrimony was not only felt by individual physicians but also backed institutionally: "The American Medical Association . . . saw midwives as competitors for what would become the most common cause of hospitalization in America, and a reliable source of revenue."[47] In its campaign to discredit midwives, the medical community portrayed midwives as dirty, unsafe, and even associated with witches and sorcerers.[48] Dr. Joseph DeLee, a prominent obstetrician in 1915, framed birth as "pathologic" and "destructive."[49] He stated that "if the profession would realize that [childbirth] viewed with modern eyes is no longer a normal function, but has imposing pathologic dignity, the midwife would be impossible even of mention."[50] Given that their campaign conveniently displaced the women of color that many in the United States wanted to see disempowered after the Civil

40. *See e.g.*, REAGAN, *supra* note 15; Bazzelle, *supra* note 27 (arguing that physician-only laws may protect women because they ensure the procedure is safe); London, *supra* note 6.

41. *See, e.g.*, REAGAN, *supra* note 15; Henderson, *supra* note 7.

42. *See, e.g.*, REAGAN, *supra* note 15, at 80; Goodwin, *supra* note 25; Merelli, *supra* note 25.

43. Merelli, *supra* note 25 ("In 1910, a report by Abraham Flexner published in the American Foundation for the Advancement in Teaching heavily criticized medical schools in the US, noting an excess of poorly trained medical professional, and singling out childbirth practices as 'the very worst showing.'").

44. *See* REAGAN, *supra* note 15, at 80.

45. Merelli, *supra* note 25 ("The distrust between OB-GYNs and midwives runs deep in the US child-delivery business, and the feeling is mutual.").

46. *See id.*

47. *Id.* (citing WILKIE, *supra* note 38).

48. *See Developments in the Law*, *supra* note 37; *see also* Merelli, *supra* note 25 (citing BARBARA EHRENREICH & DEIRDRE ENGLISH, WITCHES, MIDWIVES & NURSES: A HISTORY OF WOMEN HEALERS (2010)); LYNETTE A. AMENT, PROFESSIONAL ISSUES IN MIDWIFERY 23 (2007).

49. *See Merelli*, *supra* note 25 (citing AMENT, *supra* note 48).

50. *See id.*

War,[51] obstetricians found no want of support.[52] Thus, the medical model of reproductive care was not conceived based on superior medical outcomes, but rather from a premeditated crusade to further disenfranchise the midwives who had been historically trusted with reproductive care.[53]

B. Midwives as Scapegoats in the AMA's Anti-Abortion Campaign

One way in which physicians disparaged midwives was by vilifying abortion and attaching midwives to the performance of the procedure.[54] The AMA's campaign to criminalize abortion was eventually successful because, similar to the anti-midwife campaign, it coincided with various interest groups who wanted to control women and people of color.[55] For example, the AMA sought to call into question women's ability to enter the medical community at a time when women were pushing for entrance into medical schools,[56] and anti-abortionists sought to ensure white women continued to reproduce when fear of immigrant takeover was high.[57] One prominent anti-abortionist queried, "'Shall' these regions . . . 'be filled by our own children or by those of aliens? This is a question our women must answer; upon their loins depends the future destiny of the nation.'"[58] The eugenics movement also was used to displace women of color by discouraging them from reproducing.[59] By attaching predominantly non-white midwives to the performance of abortion, anti-abortionists and physicians alike stigmatized the procedure and the midwife profession.

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51. *See, e.g.*, Henry Louis Gates, Jr., *How Reconstruction Still Shapes American Racism*, TIME (Apr. 2, 2019, 2:18 PM), https://time.com/5562869/reconstruction-history/ [https://perma.cc/FEE7-CTWH]; Cynthia Prather, Taleria R. Fuller, William L. Jeffries, IV, Khiya J. Marshall, A. Vyann Howell, Angela Belyue-Umole & Winifred King, *Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity*, 2 HEALTH EQUITY 249 (2018), https://www.liebertpub.com/doi/10.1089/heq.2017.0045 [https://perma.cc/W3E2-7XAQ].

52. *See, e.g.*, Goodwin, *supra* note 25; *Developments in the Law*, *supra* note 37; Merelli, *supra* note 25 (quoting a nurse-midwife that runs a prenatal care center in Florida and explaining that "'slave women delivered America,' says Joseph, but as soon as medically managed hospital births became the preferred option for anyone who could afford it, the tradition of American midwifery, which has been passed on through generations of Black women, was lost").

53. *See* REAGAN, *supra* note 15, at 80–100; Ravitz, *supra* note 15.

54. *See* REAGAN, *supra* note 15, at 81.

55. *See id.* at 11.

56. *See id.* ("Women were condemned for following 'fashion' and for avoiding the self-sacrifice expected of mothers . . . . The antiabortion campaign was a reactionary response to two important efforts of the nineteenth-century women's movements: the fight to admit women into the regular medical profession and the battle to make men conform to a single standard of sexual behavior. The antiabortion campaign coincided with the fight by male Regulars to keep women out of their medical schools, societies, and hospitals.").

57. *Id.*

58. *Id.*

59. *See* Cynthia Soohoo, *Reproductive Justice and Transformative Constitutionalism*, 42 CARDOZO L. REV. 819, 840 (2021) (explaining that the eugenics movement was also used to eliminate unwanted people of color).

Although the medical establishment succeeded in criminalizing abortion,[60] the procedure remained societally accepted in the late nineteenth century: midwives and physicians alike continued to perform abortions.[61] Since criminalization alone failed to eliminate the procedure, by the early 1900s anti-abortionists endeavored to render the procedure morally and culturally disfavored.[62] Midwives were once again the scapegoats for this second cultural anti-abortion campaign.[63] In 1907, "New York City officials and physicians agreed that midwives were primarily responsible for abortion . . . . '[S]ome go so far as to say that the two terms "midwife" and "abortionist" are synonymous.'"[64] Despite this, many physicians continued to perform abortions behind closed doors.[65]

C. Physicians' Successful Exile of Midwives from Reproductive Care

Even after the early twentieth-century cultural campaign against abortion, demand for abortion remained high and the procedure was still widely performed.[66] Although the campaign was not successful in eliminating abortion, it succeeded in effectively eliminating midwives.[67] As Adrian A. Feldhusen explained in *The History of Midwifery and Childbirth in America: A Timeline*, "Midwives were not in a position of power; they made relatively little money, were not organized and did not see themselves as professionals."[68] The eradication of midwives was detrimental to marginalized women in need of abortion services. Although physicians were performing abortions,[69] midwives cost half as much and often spoke immigrants' native languages, making them more accessible to immigrants and low-income women.[70] While "[n]ative-born, middle-class women were most likely to see physicians; immigrant and working-class women were more likely to go to immigrant midwives" and "doctors charged twice as much as midwives for abortion

60. REAGAN, *supra* note 15.

61. *Id.* at 81 ("[T[he public still accepted abortion, many physicians sympathized with women who sought abortions, and some physicians performed abortions.").

62. *Id.* at 80–81.

63. *Id.*

64. *Id.* at 90 (quoting F. Elisabeth Cromwell, *The Midwives of New York*, CHARITIES & COMMONS, Jan. 1907, at 17, *reprinted in* JUDY BARRETT LITOFF, THE AMERICAN MIDWIFE DEBATE: A SOURCEBOOK ON ITS MODERN ORIGINS 38 (1986)).

65. *Id.* at 70 ("[A] 1917 study of women who came to the Washington University Dispensary in St. Louis found that physicians and midwives had 'an equal share in the nefarious practice' of illegal abortion.").

66. *Id.* at 110.

67. *Id.* at 111.

68. Adrian E. Feldhusen, *The History of Midwifery and Childbirth in America: A Time Line*, MIDWIFERY TODAY (2000) https://midwiferytoday.com/web-article/history-midwifery-childbirth-america-time-line/ [https://perma.cc/27GG-PCCR].

69. REAGAN, *supra* note 15, at 94 ("Dr. Elizabeth Jarrett of New York labeled midwives 'ignorant, unskillful, [and] dirty' and looked forward to their replacement by superior female physicians." (alteration in original)).

70. *Id.* at 73–76.

services, a pricing structure that matched the class of the practitioners and their patients."[71] Thus, the campaign against abortion not only disenfranchised midwives, who were most likely to be women or immigrants, but also marginalized women in need of reproductive care whose access to midwives was vital for their health.[72]

Partly as a result of their success in eliminating midwives, physicians and the AMA eventually began to approve of abortions, and some physicians exclusively performed abortions during the Great Depression to compensate for their general financial losses.[73] When abortion before viability was legalized in 1973,[74] state statutes generally limited the performance of the procedure to physicians,[75] initially as a measure to increase safety.[76] After *Roe v. Wade*, "many states enacted physician-only laws to protect women from unsafe, unlicensed abortion providers."[77] However, the American College of Nurse Midwives explained that "[m]ost recently, newer 'physician-only laws' have been used explicitly (and covertly) to limit access to abortion, sacrificing fully competent professionals' scope of practice in the name of a political agenda against legal abortion."[78] Thus,

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71. *Id.*

72. *See, e.g.*, *id.* at 80–114; Goodwin, *supra* note 25.

73. REAGAN, *supra* note 15, at 147–48 ("As the Depression damaged physicians' finances, more became interested in abortion practice. The disappearance from northern cities of immigrant midwives added to the pressure upon physicians to perform abortions." (footnote omitted)).

74. *See* Roe v. Wade, 410 U.S. 113 (1973), *overruled by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

75. *See* GUTTMACHER INST., *supra* note 14 (explaining that "36 states require an abortion to be performed by a licensed physician."); *see also* Connecticut v. Menillo, 423 U.S. 9, 11 (1975) ("Even during the first trimester of pregnancy, . . . prosecutions for abortions conducted by nonphysicians infringe upon no realm of personal privacy secured by the Constitution against state interference.").

76. *See* Taylor, Safriet & Weitz, *supra* note 18 ("However, this exclusion has de facto become a restrictive legacy, in part because of hesitation on the part of health professional organizations to address the issue of women's access to abortion services. Most recently, newer "physician-only laws" have been used explicitly (and covertly) to limit access to abortion, sacrificing fully competent professionals' scope of practice in the name of a political agenda against legal abortion. For example, in Arizona (one of six states without a physician-only abortion provision statute), legislation was passed in 2007 to prohibit PAs from performing abortions, and a new bill, introduced in the 2008 Arizona legislature that would prohibit nurses from performing abortions, was narrowly defeated. These legislative or regulatory exclusions of abortion from the scope of practice of advanced practice clinicians reflect an example of politics trumping evidence and should be of concern to all health professionals who care about their scope of practice." (footnotes omitted)); *see also* Emily M. Gindhart, Comment, *Virginia's Physician-Only Law for First Trimester Abortion: Maintaining the Unduly Burdensome Law Under* Falls Church Medical Center, LLC v. Oliver *and Its Subsequent Amendment*, 55 U. RICH. L. REV. 347, 352 (2020); Sandra G. Boodman, *Should Non-Physicians Perform Abortions? Shortage of Trained Providers of the Procedure Leads to a Controversial Proposal*, WASH. POST (Feb. 15, 1994), https://www.washingtonpost.com/archive/lifestyle/wellness/1994/02/15/should-non-physicians-perform-abortions-shortage-of-trained-providers-of-the-procedure-leads-to-a-controversial-proposal/de3b5351-aeef-4625-937f-f5155f7fa8b7/ [https://perma.cc/CJ78-E8Z3] (explaining that most physician-only statutes "were passed to protect women from the consequences of botched abortions by untrained practitioners").

77. *See* Taylor, Safriet & Weitz, *supra* note 18.

78. *Id.*

physician-only laws today are less concerned with safety and more concerned with anti-abortion political motives.[79]

But first trimester abortions by non-physicians are safe; these restrictive laws are not necessary to protect women's health.[80] Instead, in recent years, physician-only laws have been used by states as one of many strategies to erode the protections carved out by *Roe v. Wade*.[81] As a complaint in a recent federal case challenging physician-only laws stated, "physician-only statutes are typically grouped together under the broader category of Targeted Regulation of Abortion Providers (TRAP) laws. TRAP laws are being challenged for 'impos[ing] medically unnecessary requirements' that do not 'reasonably relate[]' to the preservation of women's health."[82] The historical villainization of non-physicians paved the way for states and courts today to endanger women's health and deny them access to abortion under the pretext of tradition and safety.

The history of the villainization of abortion and midwifery demonstrates that the campaign to eliminate alternative forms of reproductive care did not grow over legitimate medical or moral concerns: rather, anti-abortion efforts were rooted in anti-feminist,[83] anti-immigrant,[84] and white supremacist sentiments.[85] Today, physicians generally approve of abortion,[86] leaving pro-life groups as the central opponent to the administration of abortion by non-physicians.[87]

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79. *Id.*

80. Gindhart, *supra* note 76; *see also* Jennifer Templeton Schirmer, *Physician Assistant as Abortion Provider: Lessons from Vermont, New York, and Montana*, 49 HASTINGS L.J. 253, 258 (1997) ("The Court [in *Roe v. Wade*] explained that, because of advances in technology and safety, states' interest in maternal health had disappeared. In 1973, with medical advancement, the abortion mortality rate was as low or lower than childbirth" (footnote omitted) (citing Roe v. Wade, 410 U.S. 113, 149 (1973), *overruled by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022))).

81. *See* 410 U.S. 113.

82. Tifani M. Silveria, Whole Woman's Health*: Not the "Whole" Story*, 32 REGENT U. L. REV. 193, 200 (2020) (alteration in original) (quoting Complaint at 14, Whole Woman's Health All. V. Hill, 377 F. Supp. 3d 924 (S.D. Ind. 2019) (No. 18-cv-1904).

83. *See* Soohoo, *supra* note 59, at 841–42 (2021) ("Criminalization [of abortion and contraception] campaigns proliferated at a time when states were modifying common law rules barring married women from engaging in public life, and granting them rights to own property and wages earned outside the home. During this reform period, public campaigns attacking contraception and abortion can be understood both as an effort to reassert traditional conceptions about sex, women's roles, and marital responsibilities, and an attempt to shift the location of control over women's fertility from private actors (husbands, fathers, and slave owners) to the state and the medical profession." (footnote omitted))

84. *Id.* (explaining that fears about immigrants outnumbering middle-class White people drove the anti-abortion campaign).

85. *See* Goodwin, *supra* note 25.

86. Jenny A. Higgins, Nicholas B. Schmuhl, Cynthie K. Wautlet & Laurel W. Rice, *The Importance of Physician Concern and Expertise in Increasing Abortion Health Care Access in Local Contexts*, 111 AM. J. PUB. HEALTH 33, 33–36 (2021).

87. Schirmer, *supra* note 80, at 265.

Unfortunately, the damage caused by the anti-abortion campaigns remains: a general distrust of alternative forms of reproductive care persists.[88] Most alarming is that the campaign against abortion began a longstanding political battle that has resulted in over a thousand state laws restricting abortion since 1973, with the largest number of restrictive laws passed in 2021.[89] Expanding the ability of APCs to perform abortion is necessary to ameliorate the damage this problematic history has caused.[90]

II. SAFETY AND INCREASED ACCESS TO APC-PERFORMED ABORTION

Not only is the medical model problematic because it was borne out of the colonization of marginalized women,[91] it also fails to consistently produce better health outcomes for patients.[92] There is no evidence that early-term abortions performed by trained APCs are less safe than those performed by physicians.[93] And limiting the provision of abortions to physicians denies marginalized women access to abortion due to the continually decreasing number of physicians that practice it.[94] The decrease in abortion providers results in increased costs, travel distances, and

88. *See, e.g.*, Bazzelle, *supra* note 27, at 169–73 ("The campaign for legal abortion has historically been premised on the unquestioned assumption that only legal abortions are safe abortions because they are performed by physicians, who are licensed (and therefore presumably skilled), rather than by the notorious 'back-alley abortionists.' . . . [T]he classic justification for medical practice acts [is] the need to protect the public from 'quacks' who might take a person's money while either providing no service at all or threatening injury through incompetence." (footnote omitted) (first citing Diane Curtis, *Doctored Rights: Menstrual Extraction, Self-Help Gynecological Care, and the Law*, 20 N.Y.U. Rev. L. & Soc. Change 427, 428 (1993–1994); and then citing *id.* at 469).

89. *Developments in the Law*, *supra* note 37; Elizabeth Nash, *For the First Time Ever, U.S. States Enacted More than 100 Abortion Restrictions in a Single Year*, GUTTMACHER INST. (Oct. 4, 2021) https://www.guttmacher.org/article/2021/10/first-time-ever-us-states-enacted-more-100-abortion-restrictions-single-year [https://perma.cc/QGZ9-6NA7] (explaining that 1,336 abortion restrictions have been passed since 1973 by states).

90. *See* Henderson, *supra* note 7.

91. *See, e.g.*, REAGAN, *supra* note 15; Goodwin, *supra* note 25; *Developments in the Law*, *supra* note 37.

92. *See, e.g.*, Jennifer Templeton Dunn & Lindsay Parham, *After the Choice: Challenging California's Physician-Only Abortion Restriction Under the State Constitution*, 61 UCLA L. REV. DISC. 22, 32 (2013) ("Clinicians have safely provided early aspiration abortions for years in Vermont, New Hampshire, Oregon, Arizona, Montana, and California."); *see also* R.-M. Renner, D. Brahmi & N. Kapp, *Who Can Provide Effective and Safe Termination of Pregnancy Care? A Systematic Review*, 120 BJOG: INT'L J. OBSTETRICS & GYNECOLOGY 23, 23 (2012) ("[T]rained mid-level providers may effectively and safely provide first-trimester surgical and medical termination of pregnancy services."); Berer, *supra* note 13.

93. *See,* e.g., Berer, *supra* note 13, at 58–63; NAT'L ACADS. SCIS. ENG'G & MED., *supra* note 13; *see also* Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500, 537 (S.D. Ind. 2021) ("[T]he NASEM report . . . is the authoritative source on abortion care standards/procedures in the United States."), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022), *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022).

94. *See, e.g.*, *Rokita*, 553 F. Supp. 3d at 537; Henderson, *supra* note 7.

wait times, which is most harmful to low-income women and women of color.[95] Thus, the abortion provider shortage both endangers women's health and denies access to the marginalized women most in need of available, low-cost abortion services.

A. Safety of Early-Term Abortions Performed by APCs

The safety of first trimester abortions performed by APCs is well established. First trimester abortions are performed either by administering a pill or aspiration, depending on the timing in the pregnancy.[96] Medication abortion is performed by administering a pill for women to take at home.[97] Aspiration abortion, which occurs late in the first trimester, "[is] a simple in-office procedure that only takes about five minutes and is highly similar to other procedures APCs do, including IUD insertion."[98] The World Health Organization (WHO)[99] and the National Academies of Sciences and Engineering[100] have officially championed medication and aspiration abortion by APCs. "Looking at data from Bangladesh, Cambodia, France, Mozambique, South Africa, Sweden, the United States and Vietnam, WHO concluded that 'it is safe and beneficial for suitably trained mid-level health-care providers, including nurses, midwives and other non-physician clinicians, to provide first-trimester vacuum aspiration and medical abortions.'"[101] In addition, a multitude of studies have confirmed that there is no clinical difference in outcomes between early-term abortions performed by APCs and physicians.[102] Laws

95. *See, e.g.*, *Rokita*, 553 F. Supp. 3d at 541 ("[In Indiana,] [a]llowing APCs to provide abortion services would also reduce procedural costs for patients. As. Dr. Haskell testified, APCs are employed at a lower salaries [sic]; an abortion performed by an APC would result in a cost reduction of 10%, from $700 to $630.").

96. Henderson, *supra* note 7.

97. *Id.*

98. Henderson, *supra* note 7; *see also Rokita*, 553 F. Supp. 3d at 537 ("The 2016 amendment to the label for Mifeprex by the FDA removing language restrictions to the administration of this drug solely by physicians provides context to Plaintiffs' claim in this regard. The label as amended provides that 'any certified healthcare provider' or any 'certified prescriber' is authorized to dispense Mifeprex so long as the provider can diagnose ectopic pregnancies and provide surgical intervention in the case of incomplete abortion or severe bleeding or has 'made a plan to provide such care through others.' This amendment to the Mifeprex label, as interpreted by providers, states an implicit endorsement by the FDA of the opinion that medication abortions can be safely and competently performed by Advanced Practice Clinicians ("APCs") . . . . ." (citations omitted)).

99. *See* Berer, *supra* note 13, at 58–63.

100. NAT'L ACADS. SCIS. ENG'G & MED., *supra* note 13.

101. Berer, *supra* note 13; *see also* Sharmani Barnard, Caron Kim, Min Hae Park & Thoai D. Ngo, *Doctors or Mid-Level Providers for Abortion*, 2015 COCHRANE DATABASE SYSTEMATIC REVS., no. 7, at 1, https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD011242.pub2/epdf/full [https://perma.cc/Z4RC-75LE].

102. *See, e.g.*, Renner, Brahmi & Kapp, *supra* note 92; Tracy A. Weitz, Diana Taylor, Sheila Desai, Ushma D. Upadhyay, Jeff Waldman, Molly F. Battistelli & Eleanor A. Drey, *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 AM. J. PUB. HEALTH 454, 454–61 (2013), doi:10.2105/AJPH.2012.301159 [https://perma.cc/ZVS7-9PRN].

restricting abortion to certain providers instead create unnecessary delays to abortion access, which "increase[] [] the likelihood that a woman will face physical complications from her pregnancy or her abortion" and decrease her eligibility for medication abortions.[103] Thus, rather than protecting women's health, physician-only laws endanger it.[104]

In 2012, *BJOG: An International Journal of Obstetrics and Gynecology* performed a systematic review to evaluate the safety of abortions performed by non-physicians.[105] The researchers evaluated five controlled studies that chronicled the outcomes of physician-provided abortions versus abortions provided by a heterogenous group of non-physicians, including physician assistants, nurses, and midwives. They concluded that "[l]imited evidence indicates that trained [non-physicians] may effectively and safely provide first-trimester surgical and medical termination of pregnancy services."[106]

Another 2013 study in California evaluated APC-performed aspiration abortions.[107] It found that "[a]bortion complications were clinically equivalent between newly trained [nurse practitioners], [certified nurse midwives], and [physician assistants] and physicians, supporting the adoption of policies to allow these providers to perform early aspirations to expand access to abortion care."[108]

These findings raise the question of why laws in the United States continue to exile APCs from the reproductive care space.[109] Based on the data demonstrating the safety of APC-performed abortions, it is clear that "restrictions on reproductive choice . . . [are] not [] a neutral codification of universal best practices but [] a system based on a particular set of value judgments that cabins pregnant people's choices much more narrowly than medical evidence, standing alone, could

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103. Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500, 521–22 (S.D. Ind. 2021); Sigrid G. Williams, Sarah Roberts & Jennifer L. Kerns, *Effects of Legislation Regulating Abortion in Arizona*, 28 WOMEN'S HEALTH ISSUES 297 (2018), https://doi.org/10.1016/j.whi.2018.02.002 [https://perma.cc/957A-YC7V]; *see also* Whole Woman's Health All. v. Rokita, No. 18-cv-01904, 2021 WL 252721 (S.D. Ind. Jan. 26, 2021).

104. *See* Williams, Roberts & Kerns, *supra* note 103; *Whole Woman's Health All.*, 553 F. Supp. 3d at 522 ("[P]atients whose care is delayed past the first trimester can seek an abortion only at a hospital—which, as is detailed below, increases dramatically the expense and thus limits the accessibility of this care." (citation omitted)), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022), *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022).

105. Renner, Brahmi & Kapp, *supra* note 92.

106. *Id.*

107. Weitz et al., *supra* note 102.

108. *Id.*

109. *See, e.g.*, GUTTMACHER INST., *supra* note 14 (explaining that thirty-six states still have physician-only laws for abortion); *Developments in the Law*, *supra* note 37, at 2209–10 ("[I]n childbirth, the state controls the bodily choices of pregnant and birthing people through a patchwork of tort law standards and the regulation of healthcare providers, systematically enforcing compliance with particular, value-driven norms[] . . . these legal structures result in limits on access to care that deny pregnant persons the ability to make basic reproductive choices." (footnote omitted)).

support."[110] These "value judgments"[111] about APC-performed abortion include negative stereotypes about non-physicians and abortion that date back to the white supremacist campaign against midwives.[112] The medical evidence, on the other hand, paints a different picture: APC-performed abortions unequivocally support women's health.[113]

B. Barriers to Access for Marginalized Communities and Expanding Access to Abortion Through APCs

Abortions performed by APCs are not only safe but also will narrow the gap in access to reproductive care by expanding the number of providers available. Expanding the number of providers is especially important in rural areas with fewer physicians and higher populations of low-income women and women of color.[114]

In the past, the constitutional right to abortion established in *Roe v. Wade*[115] has been largely illusory for low-income women.[116] Abortion is an expensive medical procedure,[117] and its coverage under government-funded insurance programs is limited under the Hyde Amendment.[118] This lack of funding renders abortion an unenforceable right for some women— "[s]tudies published over the course of two decades looking at a number of states concluded that 18-35% of

110. *Developments in the Law*, *supra* note 37, at 2214 (alteration in original).

111. *Id.*

112. *See, e.g.*, REAGAN, *supra* note 15, at 90.

113. *See, e.g.*, Berer, *supra* note 13; *Developments in the Law*, *supra* note 37; Renner, Brahmi & Kapp, *supra* note 92.

114. *See, e.g.*, Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500 (S.D. Ind. 2021), Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022), *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022); Henderson, *supra* note 7; USHA RANJI, MICHELLE LONG, ALINA SALGANICOFF, SHARON SILOW-CARROLL, CARRIE ROSENZWEIG, DIANA RODIN & REBECCA KELLENBERG, HENRY J. KAISER FAM. FOUND., BEYOND THE NUMBERS: ACCESS TO REPRODUCTIVE HEALTH CARE FOR LOW-INCOME WOMEN IN FIVE COMMUNITIES (2019), https://files.kff.org/attachment/Executive-Summary-Beyond-the-Numbers-Access-to-Reproductive-Health-Care-for-Low-Income-Women-in-Five-Communities [https://perma.cc/653T-AEJ3].

115. Roe v. Wade, 410 U.S. 113 (1973), *overruled by Dobbs*, 142 S. Ct. 2228.

116. *See* London, *supra* note 6, at 78–79 ("[A]bortion remains out of reach for thousands of women each year who find that the expense, location and shortage of services create daunting barriers, ... [T]he abortion rates for women of color are increasingly higher than those of white women. The higher rate may reflect the skyrocketing costs of raising a child." (footnotes omitted)).

117. Attia @ Planned Parenthood, *How Much Does an Abortion Cost?*, PLANNED PARENTHOOD (Nov. 2022), https://www.plannedparenthood.org/learn/teens/ask-experts/how-much-does-an-abortion-cost [https://perma.cc/J94D-RE2P] (explaining that the cost of abortion can rise to $750).

118. Alina Salganicoff, Laurie Sobel & Amrutha Ramaswamy, *The Hyde Amendment and Coverage for Abortion Services*, KFF: WOMEN'S HEALTH POL'Y (Mar. 5, 2021), https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/ [https://perma.cc/D8J8-752B] ("[The Hyde Amendment] blocks federal funds from being used to pay for abortion outside of the exceptions for rape, incest, or if the pregnancy is determined to endanger the woman's life, resulting in dramatically limited coverage of abortion under Medicaid and other federal programs.").

women who would have had an abortion continued their pregnancies after Medicaid funding was cut off."[119] In addition to legislature-imposed barriers, "[c]ourts have generally upheld funding restrictions for abortions, refusing to make the leap from reproductive rights to access to the means to ensure reproductive control."[120] Funding barriers have impacted women of color more significantly than their white counterparts, compounding the access issues low-income women and women of color face.[121]

Not only are the costs of the abortion procedure prohibitive but also the other logistical barriers of obtaining abortion services, such as traveling long distances[122] and taking time off work,[123] can disproportionately affect low-income women and women of color.[124] For example, in a decision to block Indiana's physician-only law, the judge stated that "[t]he travel required to obtain services and the costs associated therewith are commonly cited as barriers for low-income women, who frequently lack reliable transportation and cannot afford the costs of gasoline necessary to make the trip to the clinic, or who live in locations without easily accessible public transit."[125] And "research shows that most women facing an unintended pregnancy find a way to pay for it, often at great sacrifice to themselves and their families. Studies indicate that many such women are forced to divert money meant for rent, utility bills, and food or clothing for themselves and their children."[126] When these barriers exist, many women cannot obtain an abortion and must follow through with an unintended pregnancy, pushing them deeper into poverty.[127]

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119. *See* London, *supra* note 6, at 78 n.44; *see also* Marlene Gerber Fried, *Abortion in the US: Barriers to Access*, 5 REPROD. HEALTH MATTERS, no. 9, 1997, at 37.

120. *See* London, *supra* note 6, at 78.

121. *Id.*

122. *See* Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500, 521 (S.D. Ind. 2021), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022), *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022).

123. *Although Many U.S. Women of Reproductive Age Live Close to an Abortion Clinic, A Substantial Minority Would Need to Travel Far to Access Services*, GUTTMACHER INST. (Oct. 3, 2017), https://www.guttmacher.org/news-release/2017/although-many-us-women-reproductive-age-live-close-abortion-clinic-substantial [https://perma.cc/LPE3-TL98] ("For many, traveling to a clinic, even if it is nearby, means having to take time off from work and arrange for transportation and childcare. In some states that have waiting periods, women have to make the trip multiple times or stay overnight. Even if a woman lives relatively close to a clinic, she may not be able to obtain care if she is unable to use her health insurance or find the money to pay for an abortion."); *see also Rokita*, 553 F. Supp. 3d at 521.

124. *See* London, *supra* note 6.

125. *Rokita*, 553 F. Supp. 3d at 521.

126. London, *supra* note 6, at 78.

127. *See* Donald P. Judges, *Taking Care Seriously: Relational Feminism, Sexual Difference, and Abortion*, 73 N.C. L. REV. 1323, 1429–31 (1995); *see also* London, *supra* note 6, at 78; Order, *supra* note 23 (explaining the near complete lack of access to abortions for some women in Alaska).

The logistical barriers to abortion are especially of concern for women living in rural areas,[128] who tend to have fewer financial resources.[129] According to the American College of Obstetricians and Gynecologists, "[r]ural residents are more likely to be poor, lack health insurance, or rely substantially on Medicaid and Medicare; they also travel longer distances to receive care or to access a range of medical, dental, and mental health specialty services."[130] These travel distances can be substantial. One study found that "[o]ne in five women across the country would need to travel at least 43 miles to reach the nearest abortion clinic," and "[i]n the three states with the longest distance to travel overall . . . at least half of women of reproductive age lived more than 90 miles from the nearest clinic providing abortion services in 2014."[131]

The dire abortion provider shortage is only worsening over time.[132] Even before 2021, during which states passed the largest number of abortion restrictions since 1973,[133] the number of abortion facilities was decreasing.[134] The most recent data available from 2017 showed that "89% of U.S. counties did not have a clinic facility that provided abortion care, and 38% of women aged 15-44 lived in these counties."[135] As of late 2021, "[f]ive states [had] only one clinic remaining, meaning one doctor's departure could cut off abortion access for an entire state or region."[136] The dire shortage today is highlighted when contrasted to the 272 abortion clinics, 517 non-specialized clinics, and 244 physician's offices that performed abortion in the United States in 2014.[137]

These provider shortages can partly be attributed to a dearth of physicians willing and able to perform the procedure. Because physicians tend to live in urban areas, rural areas suffer from shortages.[138] Additionally, only a small percentage of physicians actually perform abortions,[139] and physicians in rural areas are less likely

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128. Rachel K. Jones, Elizabeth Witwer & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2017*, GUTTMACHER INST. (Sept. 2019), https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017 [https://perma.cc/234M-DXZW] (explaining that "[o]ne in five women across the country would need to travel at least 43 miles to reach the nearest abortion clinic.").

129. *Health Disparities in Rural Women*, *supra* note 6.

130. *Id.*

131. GUTTMACHER INST., *supra* note 123.

132. *See, e.g.*, Henderson, *supra* note 7; Nash, *supra* note 89.

133. Nash, *supra* note 89.

134. Jones, Witwer & Jerman, *supra* note 128.

135. *Id.*

136. Henderson, *supra* note 7.

137. Jones, Witwer & Jerman, *supra* note 128.

138. Curtis, *supra* note 88, at 467; *see also* Henderson, *supra* note 7 (quoting Dr. Iman Alsaden, medical director of Planned Parenthood Great Plains and fellow with Physicians for Reproductive Health).

139. *See, e.g.*, Jenny Gold, *Study: Fewer Doctors are Offering Abortions*, K.H.N. (Aug. 22, 2011), https://khn.org/news/study-fewer-doctors-are-offering-abortions/ [https://perma.cc/B9FX-5H44].

to offer the procedure.[140] Physicians who express interest in abortion care early on often abandon it for a variety of reasons, including fear of repercussions in their careers and social judgment.[141] The physicians that do perform the procedure sometimes travel from abortion-friendly states to states with stricter abortion laws.[142] Unfortunately, these temporary solutions leave many clinics with limited hours and days to accommodate out-of-state physicians' schedules.[143] Expanding the provision of abortion to APCs can alleviate the burdens on overwhelmed clinics.[144]

Encouragingly, APCs express interest in abortion care, and many clinics employ APCs that are available and could easily transition to performing first trimester abortions with the appropriate training.[145] Importantly, more APCs practice in rural areas than physicians,[146] meaning that not only could allowing them to perform abortion procedures increase the number of providers, but it would also expand the location of providers to areas with the direst shortages.[147] And, as an Indiana judge recently expressed about her state, there is not a shortage of APCs: in fact, many could easily transition to providing abortions at the clinics they are already employed by to assist with other reproductive care.[148]

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140. USHA RANJI, MICHELLE LONG, ALINA SALGANICOFF, SHARON SILOW-CARROLL, CARRIE ROSENZWEIG, DIANA RODIN & REBECCA KELLENBERG, HENRY J. KAISER FAM. FOUND., BEYOND THE NUMBERS: ACCESS TO REPRODUCTIVE HEALTH CARE FOR LOW-INCOME WOMEN IN FIVE COMMUNITIES (2019), https://files.kff.org/attachment/Executive-Summary-Beyond-the-Numbers-Access-to-Reproductive-Health-Care-for-Low-Income-Women-in-Five-Communities [https://perma.cc/653T-AEJ3].

141. Lori Freedman, Uta Landy, Philip Darney & Jody Steinauer, *Obstacles to the Integration of Abortion into Obstetrics and Gynecology Practice*, 42 PERSPS. ON SEXUAL & REPROD. HEALTH 146 (2010), http://www.jstor.org/stable/20752640 [https://perma.cc/78EA-BBQZ] ("Obstetrics and gynecology residents who are trained in family planning and intend to provide abortions after residency often do not ultimately do so . . . . The stigma and ideological contention surrounding abortion manifest themselves in professional environments as barriers to the integration of abortion into medical practice.").

142. Henderson, *supra* note 7.

143. *Id.*

144. *Id.*

145. Jillian Yarnall, Yael Swica & Beverly Winikoff, *Non-Physician Clinicians Can Safely Provide First Trimester Medical Abortion*, REPROD. HEALTH MATTERS, May 2009, at 33, 61–69, http://www.jstor.org/stable/40647611 [https://perma.cc/43ZY-UF5Y] ("A substantial body of evidence exists demonstrating that mid-level providers, including nurses and midwives specialized in pregnancy-related care for women, are either already competently involved in providing medical abortions or have the requisite skills to expand their scope of practice to include medical abortion with a short course of additional training.").

146. Henderson, s*upra* note 7 (quoting Julie Jenkins of the Reproductive Health Access Project, who explained that "[w]e know that in rural places, APCs tend to be the primary care providers . . . Doctors in general are not moving to those areas and staying there").

147. Henderson, *supra* note 7; Jones, Witwer & Jerman, *supra* note 128.

148. Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500, 540–41 (S.D. Ind. 2021) ("The recruitment of APCs does not pose such obstacles, however. Indeed, we were told, there exists a supply of APCs willing and able to provide abortion care, who would do so but for the Physician-Only Law. Many APCs are already employed by licensed abortion clinics, but their duties are curtailed by this statutory restriction. Planned Parenthood, for example, employs a base of twenty APCs

It is true that "[t]o truly address the abortion provider shortage . . . would require a complete overhaul of the medical system."[149] However, "people need abortion providers in their communities *now*."[150] Allowing APCs to provide abortion care would not solve the abortion crisis, but it is an important step in alleviating the shortage of providers and disparity in access.[151]

III. LEGAL BACKGROUND OF PHYSICIAN-ONLY LAWS, CHALLENGES, AND MAJOR CASES

The Supreme Court and most lower courts have found the physician-only laws before them constitutional.[152] In the last few decades, this has been primarily due to previously controlling Supreme Court precedent in *Mazurek v. Armstrong*.[153] Importantly, that case reviewed a Montana physician-only law that had the effect of excluding *only one* licensed physician-assistant capable of performing abortions in the state; thus, the law was constitutional because it had little real effect on abortion access.[154]

But a physician-only law has not been challenged before the Supreme Court since it decided *Whole Woman's Health v Hellerstedt*,[155] which requires states to show medical evidence for health-motivated abortion restrictions.[156] Some district courts have applied the *Hellerstedt* standard,[157] finding that there are no health-related benefits to physician-only laws and that these laws' burdens surpass any benefits.[158]

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across its three Indiana abortion clinics, who routinely provide birth control, STI testing, and pap smears, among other services, and, as mentioned, would provide abortion care if the law permitted them to do so."), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022), *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022).

149. Henderson, *supra* note 7.

150. *Id.* (emphasis added).

151. *Id.*

152. *See, e.g.*, Mazurek v. Armstrong, 520 U.S. 968, 972 (1997); Falls Church Med. Ctr., LLC v. Oliver, 412 F. Supp. 3d 668, 692 (E.D. Va. 2019), *abrogated by Dobbs*, 142 S. Ct. 2228.

153. *Mazurek*, 520 U.S. at 972.

154. *Id.*; *see also* Cathren Cohen, *"Beyond Rational Belief": Evaluating Health-Justified Abortion Restrictions After* Whole Woman's Health, 42 N.Y.U. REV. L. & SOC. CHANGE 173, 218 (2018).

155. Whole Woman's Health v. Hellerstedt, 579 U.S. 582, 596 (2016), *abrogated by Dobbs*, 142 S. Ct. 2228.

156. *Id.*

157. *Id.*

158. *See, e.g.*, Planned Parenthood of the Great Nw. & the Hawaiian Islands v. Wasden, 406 F. Supp. 3d 922, 927 (D. Idaho 2019) (finding the physician-only laws before them an "[u]nnecessary health regulation[] that [has] the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion" (quoting *Hellerstedt*, 579 U.S. at 607), *reconsideration denied*, No. 18-cv-00555, 2021 WL 4496942 (D. Idaho Sept. 30, 2021), *and abrogated by Dobbs*, 142 S. Ct. 2228; Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500, 540–41 (S.D. Ind. 2021), *abrogated by Dobbs*, 142 S. Ct. 2228, *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022); *see also* Whole Woman's Health All. v. Hill, 388 F. Supp. 3d 1010 (S.D. Ind. 2019), *cert. denied*, 141 S. Ct. 189 (2020).

Yet, other district courts[159] and courts of appeal[160] have continued to find physician-only laws constitutional under *Mazurek*,[161] despite the much greater burdens conferred from physician-only laws today than when that case was decided. The Supreme Court needs to clarify the conflicting jurisprudence of lower courts and correctly apply *Hellerstedt*[162] to physician-only laws. This can only result in finding physician-only laws unconstitutional.[163]

There are two other important ways to eliminate physician-only laws; states can amend their constitutions to protect reproductive care[164] or state legislatures can repeal physician-only laws.[165] Since challenges to the constitutionality of physician-only laws have rarely been successful,[166] plaintiffs have sued under state constitutions to enforce reproductive choice as a right of privacy. [167] A minority of state legislatures, most notably California,[168] have recognized the benefits of APC-performed abortion and changed their laws.[169] The California law "removes barriers to abortion access by allowing nurse practitioners, certified nurse midwives, and physician assistants to utilize their education and training to perform early abortion care . . . . [W]omen appreciate receiving care in their own communities from providers they know and trust, rather than having to travel to geographically distant physicians."[170] Until legislators and the Supreme Court take direct action to eliminate physician-only laws, lower courts and state legislatures will continue to arbitrarily apply the undue burden standard to cabin women's reproductive autonomy.[171]

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159. Falls Church Med. Ctr., LLC v. Oliver, 412 F. Supp. 3d 668, 689 (E.D. Va. 2019), *abrogated by Dobbs*, 142 S. Ct. 2228.

160. Whole Woman's Health All. v. Rokita, 13 F.4th 595 (7th Cir. 2021) (per curiam), *abrogated by Dobbs*, 142 S. Ct. 2228.

161. Mazurek v. Armstrong, 520 U.S. 968, 972 (1997).

162. *Hellerstedt*, 579 U.S. at 585.

163. *Id.* (requiring a balancing of burdens and benefits when reviewing a health justified physician-only law).

164. *See, e.g.*, CAL. CONST. art. XVIII; Order, *supra* note 6, at 2–3.

165. *State Legislation Tracker: Major Developments in Sexual & Reproductive Health*, GUTTMACHER INST. (Nov. 1, 2022), https://www.guttmacher.org/state-policy [https://perma.cc/6GHL-YSDY]; *see also* CAL. BUS. & PROF. CODE § 2725.4 (West 2022) (allowing nurse practitioners and certified nurse-midwives to perform first trimester abortions in California); *Improving Abortion Access in California*, *supra* note 12.

166. *Mazurek*, 520 U.S. at 972; Falls Church Med. Ctr., LLC v. Oliver, 412 F. Supp. 3d 668, 692 (E.D. Va. 2019), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

167. *See, e.g.*, Order, *supra* note 23, at 2–3; Armstrong v. State, 989 P.2d 364, 370 (Mont. 1999) (finding that the right to privacy in Montana's state constitution incorporates a right to procreative autonomy, striking down a physician-only law that excluded physician-assistants from performing the procedure, and stating that the right to privacy in that case included "the right to seek and to obtain a specific lawful medical procedure, a pre-viability abortion, from a health care provider of her choice").

168. *Improving Abortion Access in California*, *supra* note 12.

169. *See* GUTTMACHER INST., *supra* note 14.

170. *Improving Abortion Access in California*, *supra* note 12.

171. Greenhouse & Siegel, *supra* note 4, at 1445.

A. Roe v. Wade*,* Casey*, and Early Cases Reviewing the Constitutionality of Physician-Only Laws*

The first physician-only law reviewed by the Supreme Court was a Connecticut statute reviewed in *Connecticut v. Menillo*.[172] In 1975, two years after *Roe v. Wade*[173] was decided, the Supreme Court refused to find a physician-only law unconstitutional,[174] interpreting *Roe v. Wade* narrowly as only protecting those abortions performed by physicians.[175] In *Menillo*, a non-physician with no medical training was convicted by a jury for attempting an abortion.[176] The Supreme Court distinguished the case from *Roe* by emphasizing that "Jane Roe had sought to have an abortion 'performed by a competent, licensed physician, under safe, clinical conditions,' and our opinion recognized only her right to an abortion under those circumstances."[177] But the Supreme Court failed to recognize that midwives and nurses have medical training and can provide safe abortions in a clinical setting, unlike a person without any medical training.[178] Nevertheless, it found that the Connecticut abortion statute criminalizing abortion by anyone other than a physician was constitutional.[179]

In 1992, the trimester framework established in *Roe v. Wade*[180] was replaced in *Planned Parenthood v. Casey* by a new standard[181] for evaluating the constitutionality of abortion restrictions. *Casey* established the undue burden test,[182] which was highly deferential to states' abortion decisions.[183] Regarding health-motivated

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172. Connecticut v. Menillo, 423 U.S. 9, 10 (1975).

173. Roe v. Wade, 410 U.S. 113 (1973), *overruled by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

174. *Menillo*, 423 U.S. at 10 (finding that part of a state statute that criminalized abortion by non-physicians was not unconstitutional); *see also* Schirmer, *supra* note 81.

175. *Id.*

176. *Id.* at 9.

177. *Id.* at 10.

178. *See, e.g.*, Yarnall, Swica & Winikoff, *supra* note 145.

179. *Id.*

180. Roe v. Wade, 410 U.S. 113 (1973), *overruled by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

181. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 876 (1992), *overruled by Dobbs*, 142 S. Ct. 2228; Shirmer, *supra* note 80.

182. *Id.* at 877 (explaining that "[a] finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus").

183. *See* Whole Woman's Health v. Hellerstedt, 579 U.S. 582, 588–622 (2016), *abrogated by Dobbs*, 142 S. Ct. 2228.; *see also* Whole Woman's Health All. V. Hill, 493 F. Supp. 3d 694, 731 (S.D. Ind. 2020) ("Four years after the ruling in *Hellerstedt* was handed down, the Supreme Court in *June Medical* confronted a facial challenge to a Louisiana statute it viewed as 'nearly identical' to the Texas statute at issue in *Hellerstedt*. Five justices—Justice Breyer, Justice Ginsburg, Justice Sotomayor, Justice Kagan (plurality), and Chief Justice Roberts (concurring)—concluded that Louisiana's admitting privileges requirement imposed an unconstitutional substantial burden on women in Louisiana. The plurality reiterated that the undue burden standard, as articulated in *Casey* and *Hellerstedt*, requires courts to carefully review the evidentiary record before considering a statute's burdens together with its benefits." (citation omitted)), *overruled by Dobbs*, 142 S. Ct. 2228.

abortion restrictions passed by states, the *Casey* Court explained that an "[u]nnecessary health regulation[] that [has] the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion" poses an undue burden and is unconstitutional.[184] Yet the undue burden test made it difficult for "judges to distinguish between constitutional and constitutionally suspect forms of health regulation."[185]

In *Mazurek v. Armstrong*, the Supreme Court considered the constitutionality of a physician-only law under *Casey*'s new undue burden test for the first time.[186] Finding the physician-only law did not pose an undue burden, the Court emphasized that there was only one qualified non-physician in the state who could administer abortions if the law was repealed.[187] And the Court determined that the Ninth Circuit's finding that the *purpose* of the legislature, purportedly to exclude the one physician-assistant in the state, was improper, was not enough to pose an undue burden, emphasizing that "[w]e do not assume unconstitutional legislative intent even when statutes produce harmful results."[188] Respondents' brief showed that "'all health evidence contradicts that there is any health basis for the [physician-only] law,"[189] but the Court countered by emphasizing that *Casey*[190] "gives the States broad latitude to decide that particular functions may be performed only by licensed professionals, even if an objective assessment might suggest that those same tasks could be performed by others."[191] In its decision, the Court pointed to its "several cases sanctioning physician-only requirements, the requirement's minimal effects on abortion access, and the fact that similar rules existed in forty other states."[192] The amorphous reasoning applied in *Mazurek* led courts to differ in the application of the undue burden test because it failed to offer clear guidelines for applying the test to health-motivated abortion restrictions.[193]

After *Mazurek* was decided, lower court judges diverged in their application of the undue burden test. The Fifth Circuit applied the undue burden test most leniently to health-justified abortion restrictions, which aligned with its traditionally

184. *Casey*, 505 U.S. at 878 (alteration in original).

185. Greenhouse & Siegel, *supra* note 4, at 1445.

186. Mazurek v. Armstrong, 520 U.S. 968 (1997); Greenhouse & Siegel, *supra* note 4, at 1445 (citing *Mazurek*, 520 U.S. at 972).

187. *Mazurek*, 520 U.S. at 968; Greenhouse & Siegel, *supra* note 4, at 1445 (citing *Mazurek*, 520 U.S. at 972).

188. *Mazurek*, 520 U.S. at 972.

189. *Id.* at 973 (citing Brief in Opposition at 7).

190. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 878 (1992), *overruled by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

191. *Mazurek*, 520 U.S. at 973 (emphasis added).

192. Greenhouse & Siegel, *supra* note 4, at 1445 (citing *Mazurek*, 520 U.S. at 972).

193. Greenhouse & Siegel, *supra* note 4, at 1469–80; Whole Woman's Health v. Lakey, 769 F.3d 285, 295 (5th Cir. 2014), *vacated in part*, 574 U.S. 931 (2014); Planned Parenthood Sw. Ohio Region v. DeWine, 696 F.3d 490, 504 (6th Cir. 2012).

anti-abortion jurisprudence.[194] During this time, the Fifth Circuit interpreted health-motivated restrictions by "defer[rring] to the states' rationales" even "in the face of overwhelming evidence that the health justifications for the restrictions offer[ed] a fig leaf for the expression of antiabortion sentiment."[195] Instead of weighing burdens and benefits, Fifth Circuit courts at odds with *Casey* evaluated whether a health-justified restriction had a "purpose or effect of creating a substantial obstacle to obtaining an abortion"[196] and "whether the restriction satisfied rational basis review."[197] Linda Greenhouse described this undue burden application as "mock[ing] *Casey*, if not the constitution itself."[198]

Other courts read *Casey* as requiring a balancing test of burdens and benefits.[199] One court that employed a balancing test was *Planned Parenthood of Wisconsin, Inc. v. Schimel*, which expressed that a health justified abortion restriction required

> that the medical grounds [be] valid, but also . . . that the restrictions [be] not disproportionate, in their effect on the right to an abortion, to the medical benefits that the restrictions are believed to confer . . . . If a burden significantly exceeds what is necessary to advance the state's interests, it is 'undue,' . . . which is to say unconstitutional. The feebler the medical grounds (in this case, they are nonexistent), the likelier is the burden on the right to abortion to be disproportionate to the benefits.[200]

In *Whole Woman's Health v. Hellerstedt*, the Court resolved this circuit split in interpreting how *Casey*'s undue burden test applied to health-motivated abortion restrictions.[201]

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194. *Lakey*, 769 F.3d at 295. *See generally* Mark Joseph Stern, *Federal Appeals Court Lets Texas Resume Abortion Ban*, SLATE (Mar. 31, 2020, 4:37 PM), https://slate.com/news-and-politics/2020/03/fifth-circuit-texas-coronavirus-abortion-ban.html [https://perma.cc/FPZ2-HFVQ] ("For several years, the 5th Circuit has been pioneering the jurisprudence of Trumpism, which includes a fervent desire to end abortion by any means necessary.").

195. Greenhouse & Siegel, *supra* note 4, at 1480.

196. Kendis, *supra* note 34, at 1020; *see also* Greenhouse & Siegel, *supra* note 4.

197. Greenhouse & Siegel, *supra* note 4.

198. *Id.* at 1478.

199. *See* Planned Parenthood of Wis., Inc. v. Schimel, 806 F.3d 908, 919–20 (7th Cir. 2015) (first citing Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 874, 877, 900–01 (1992) (plurality opinion), *overruled by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022); then citing Gonzales v. Carhart, 550 U.S. 124, 146, 157–58 (2007), *overruled by Dobbs*, 142 S. Ct. 2228; then citing Stenberg v. Carhart, 530 U.S. 914, 930, 938 (2000), *overruled by Dobbs*, 142 S. Ct. 2228; and then citing Planned Parenthood Ariz., Inc. v. Humble, 753 F.3d 905, 913 (9th Cir. 2014), *overruled by Dobbs*, 142 S. Ct. 2228), *overruled by Dobbs*, 142 S. Ct. 2228; Planned Parenthood of Wis., Inc. v. Van Hollen, 738 F.3d 786 (7th Cir. 2013), *abrogated by Dobbs*, 142 S. Ct. 228; *see also* Greenhouse & Siegel, *supra* note 4, at 1476.

200. *Schimel*, 806 F.3d at 919–20.

201. Whole Woman's Health v. Hellerstedt, 579 U.S. 582, 634–35 (2016) (Thomas, J., dissenting), *abrogated by Dobbs*, 142 S. Ct. 2228.

B. Courts' Analyses of Physician-Only Laws After Whole Woman's Health v. Hellerstedt

Hellerstedt[202] provided much needed clarity on how health restrictions on abortion procedures should be evaluated under the undue burden test, interpreting *Casey* as requiring a balancing test that weighs the benefits of a health restriction against its burdens.[203] The Court found two overly restrictive laws unconstitutional.[204] The first law it struck down "required abortion clinics to meet 'the minimum standards adopted under [the Texas Health and Safety Code] for ambulatory surgical centers.'"[205] The second law it found unconstitutional required doctors performing abortions to be admitted at a hospital within thirty miles of the abortion clinic on the day the procedure was performed.[206] The "admitting privileges requirement" resulted in "forced [] closure of nineteen of the state's forty-one clinics" and "the 'surgical-center requirement' . . . threatened to close fourteen to fifteen more clinics."[207] The Supreme Court held that neither law accorded health benefits sufficient to countervail its potential burdens upon abortion access.[208] In addition, the Court emphasized that in determining whether an undue burden existed, courts must heavily weigh the fact-finding presented in *judicial* proceedings, instead of affording full deference to legislative fact-finding.[209] Thus, the Court concluded that a law that restricts abortion on the premise of health benefits must "be supported by evidence showing that the law actually promotes improved health outcomes," which it did not in *Hellerstedt*.[210]

In the years since *Hellerstedt*,[211] lower courts have taken very different approaches to determining the constitutionality of physician-only laws.[212] Some courts have failed to engage in much analysis at all and instead have interpreted *Mazurek* as essentially rendering physician-only laws constitutional per se.[213] When courts do engage in analysis, the factors they have emphasized in determining

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202. *Hellerstedt*, 579 U.S. at 588–622.

203. *Id.*; *see also* Cohen, *supra* note 154.

204. *Hellerstedt*, 579 U.S. at 634–35 (Thomas, J., dissenting).

205. Kendis, *supra* note 34, at 1009 (citing *Hellerstedt*, 579 U.S. at 588–622).

206. *Id.*

207. *See id.* (alterations in original).

208. *See id.*

209. *Hellerstedt*, 579 U.S. at 608 ("The statement that legislatures, and not courts, must resolve questions of medical uncertainty is also inconsistent with this Court's case law. Instead, the Court, when determining the constitutionality of laws regulating abortion procedures, has placed considerable weight upon evidence and argument presented in judicial proceedings.").

210. Cohen, *supra* note 154; *see also* Kendis, *supra* note 34, at 1009 (citing *Hellerstedt*, 579 U.S. at 588–622).

211. Kendis, *supra* note 34, at 1009.

212. *See, e.g.*, Falls Church Med. Ctr., LLC v. Oliver, 412 F. Supp. 3d 668 (E.D. Va. 2019), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022); Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500, 526 (S.D. Ind. 2021), *abrogated by Dobbs*, 142 S. Ct. 2228, *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022).

213. *See, e.g.*, *Oliver*, 412 F. Supp. 3d at 689; *Rokita*, 553 F. Supp. 3d at 557–58.

whether the specific physician-only law poses an undue burden include the availability of physicians in the state at the time the physician-only law was challenged, the amount of trained APCs in the state capable of performing abortion procedures, and whether women are able to obtain an abortion in a timely manner.[214] Some lower courts have shown promise by correctly weighing the benefits and burdens of physician-only laws and declaring them unconstitutional.[215] Unfortunately, these decisions have seldom been upheld on appeal.[216]

The analysis in *Falls Church Medical Center*[217] provides insight into the ways in which courts misinterpret *Hellerstedt*.[218] In analyzing the physician-only law before it, the District Court for the Eastern District of Virginia appropriately referenced *Hellerstedt*[219] as the starting point for analysis.[220] However, it ultimately failed to engage in any weighing of benefits and burdens that *Hellerstedt* requires.[221] Rather, the court instead pointed to the Supreme Court's decision in *Mazurek*,[222] which was decided *before* the *Hellerstedt*[223] test was articulated.[224] The court then engaged in a one-sided analysis that determined whether the physician-only law was a "substantial obstacle" to abortion access,[225] reasoning that "a statute which, while furthering [a valid state interest], has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends."[226] And despite the court's acknowledgement that *Hellerstedt* requires a balancing of burdens and benefits,[227] the court failed to examine the benefits conferred by the physician-only law under review.[228]

In concluding, the court explained that "[p]laintiffs' evidence has demonstrated convincingly that APCs are capable of safely performing first trimester abortion procedures, and that the requirement that the procedure be undertaken by a physician is inconvenient, and perhaps for those living in more

214. *See, e.g.*, *Oliver*, 412 F. Supp. 3d at 690; *Rokita*, 553 F. Supp. 3d at 562–63.

215. Planned Parenthood of the Great Nw. & the Hawaiian Islands v. Wasden, 406 F. Supp. 3d 922, 927 (D. Idaho 2019), *reconsideration denied*, No. 18-CV-00555, 2021 WL 4496942 (D. Idaho Sept. 30, 2021), *and abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

216. *See, e.g.*, Whole Woman's Health All. v. Rokita, 13 F.4th 595, 601–02 (7th Cir. 2021) (per curiam).

217. *Oliver*, 412 F. Supp. 3d 668.

218. Whole Woman's Health v. Hellerstedt, 579 U.S. 582, 608 (2016), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

219. *Id.*

220. *Oliver*, 412 F. Supp. 3d at 689–92.

221. *Hellerstedt*, 579 U.S. at 608.

222. Mazurek v. Armstrong, 520 U.S. 968, 972 (1997).

223. *Hellerstedt*, 579 U.S. at 608.

224. *Oliver*, 412 F. Supp. 3d at 689–90.

225. *Id.* at 689.

226. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 837 (1992), *overruled by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

227. *Oliver*, 412 F. Supp. 3d at 689.

228. *Id.* at 688–92 (vaguely referencing a benefit of the physician-only law as the "[s]tate's responsibility for ensuring safe abortion care").

rural areas, a burden."[229] However, the court held that the physician-only law in question did not "impose an undue burden."[230] Importantly, following the decision in *Falls Church Medical Center*,[231] the Virginia legislature chose to expand the law, allowing nurse practitioners to perform first trimester abortions.[232]

On the other hand, some district courts have interpreted physician-only laws in their state to be unconstitutional under *Hellerstedt*[233] and *Casey*'s[234] weighing test.[235] In *Planned Parenthood of Great Northwest v. Wasden*,[236] the court declined to follow *Mazurek*,[237] emphasizing the fact-specific nature of the undue burden test, especially under Ninth Circuit precedent.[238]

> [T]his Court is not bound to dismiss Plaintiffs' undue burden claims regarding Idaho's Physician-Only Law simply because the Supreme Court overruled the Ninth Circuit's finding that Montana's physician-only law was unconstitutional [in Mazurek]. Instead, the Court must look to the burdens the Idaho Physician-Only Law places on Idaho women seeking abortions in Idaho. Then, the Court must balance those burdens, if any, against the law's constitutionally-acceptable objectives of protecting the health of the mother and the life of the unborn.[239]

Distinguishing *Mazurek*,[240] the court emphasized that in that case there was only one qualified non-physician available to perform abortions.[241] APCs were more accessible in Idaho: at the time the case was decided there were multiple

229. *Id.* at 705–06.
230. *Id.*
231. *Id.* at 689–90.
232. VA. CODE ANN. § 18.2-72 (2022).
233. Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2310, *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2310 (2022).
234. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 878 (1992), *overruled by Dobbs*, 142 S. Ct. 2228.
235. Planned Parenthood of the Great Northwest & the Hawaiian Islands v. Wasden, 406 F. Supp. 3d 922, 927 (D. Idaho 2019), *reconsideration denied*, No. 18-CV-00555, 2021 WL 4496942 (D. Idaho Sept. 30, 2021), *and abrogated by Dobbs*, 142 S. Ct. 2228; *see also* Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500, 540–41 (S.D. Ind. 2021), *abrogated by Dobbs*, 142 S. Ct. 2228, *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022).
236. *Wasden*, 406 F. Supp. 3d 833.
237. Mazurek v. Armstrong, 520 U.S. 968, 973 (1997).
238. *Wasden*, 406 F. Supp. 3d at 928.
239. *Id.*
240. *Mazurek*, 520 U.S. at 973.
241. *Wasden*, 406 F. Supp. 3d at 928.

licensed APCs that could administer abortions.[242] Ultimately, under *Hellerstedt*'s[243] weighing test and due to the case's distinguishable facts, the court declined to follow *Mazurek*[244] and declared Idaho's physician-only law unconstitutional.[245]

The most recent instance of a district court blocking enforcement of a physician-only law is in *Whole Woman's Health Alliance v. Rokita*.[246] Plaintiffs claimed that global abortion provisions in Indiana's regulatory and statutory regime violated the Fourteenth and First Amendments.[247] In finding that the part of the statute that only allowed medication abortion to be performed by physicians was unconstitutional, Judge Sarah Evans Barker emphasized the dearth of abortion providers in Indiana and how APCs could alleviate that shortage.[248] The state had only six first trimester abortion clinics at the time the lawsuit was filed.[249] These clinics only offered abortions one or two days a week or, in some cases, every other week.[250] Judge Barker also reiterated that "[t]hese clinics report that physician recruitment and availability is a significant—if not the most significant—barrier to expanding abortion services to additional days."[251] The same issues did not exist for APCs: "there exists a supply of APCs willing and able to provide abortion care, who would do so but for the Physician-Only Law. Many APCs are already employed by licensed abortion clinics, but their duties are curtailed by this statutory restriction."[252]

Regarding *Mazurek*,[253] the court stated that

> We agree today, with Plaintiffs' argument that Mazurek does not automatically foreclose further judicial review of this physician-only issue. Though the Seventh Circuit has not yet

242. *Id.* at 929 ("Because Plaintiffs allege that APCs play a much larger role in patient care now than in 1997, that advances in medication and aspiration abortion make these procedures much safer than in 1997, and that expanding the abortion-provider group to include APCs would make abortions in Idaho more available, the benefits and burdens at issue here are very different than those the Supreme Court considered in *Mazurek*.").

243. Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2300–18, *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2310 (2022).

244. *Mazurek*, 520 U.S. at 973.

245. *Wasden*, 406 F. Supp. 3d at 928.

246. Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500 (S.D. Indiana 2021), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022), *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022).

247. *Id.* at 507.

248. *Id.*

249. *Id.*

250. *Id.* at 561 ("But for the effects of the Physician-Only Law, abortion clinics in Indiana would expand to provide services five days a week, which expansions would reduce wait times and allow women to access care at an earlier point in their pregnancies and with greater convenience, reduced anxieties, and ameliorated risks that result when women are delayed in receiving abortion services and their likelihood of needing aspiration abortion care increases.").

251. *Id.* at 518.

252. *Id.* at 540.

253. Mazurek v. Armstrong, 520 U.S. 968, 972 (1997).

> addressed Mazurek's precise scope and application, we read Mazurek to apply only to challenges to the legislative purpose, and, *where the challenged statute does not, in effect, create burdens for women accessing abortion services.*[254]

Frustratingly, the Seventh Circuit reversed the injunction pending appeal in a conclusory opinion, finding that Indiana was likely to "prevail on the contested issues"[255] and citing to *Mazurek* as precedent without further explanation.[256]

As recently as 2020, the Supreme Court reaffirmed that the constitutionality of a health-justified restriction hinges on the law's benefits outweighing its burdens.[257] In *June Medical Services L.L.C. v. Russo*, the Court struck down an admitting privileges requirement almost identical to the one in *Hellerstedt*, this time in Louisiana.[258] It held that such a requirement posed an undue burden upon abortion access without benefits to justify such hardship.[259] The Court has made clear in *Hellerstedt* and *June Medical* that *Casey*'s undue burden standard requires a health-justified abortion restriction to confer evidence-supported health benefits.[260] The clarification of this standard along with lower courts' incoherent application of it underscores the need for the Court to reconsider physician-only laws under its recent jurisprudence.[261]

C. Physician-Only Laws Under State Constitutions

Because the Supreme Court has so far refused to find a physician-only law unconstitutional,[262] some plaintiffs have turned to bringing cases under state constitutions.[263] Eleven states have incorporated a right to privacy in their state

254. *Rokita*, 553 F. Supp. 3d at 557–58 (emphasis added) (citing *Mazurek*, 520 U.S. at 972).

255. Whole Woman's Health All. v. Rokita, 13 F.4th 595, 598 (7th Cir. 2021); *see also* Maeve Allsup, *Indiana Can Enforce Abortion Law After Court Lifts Block (1)*, BLOOMBERG L. (Sept. 8, 2021, 4:47 PM), https://news.bloomberglaw.com/us-law-week/indiana-can-enforce-abortion-law-after-court-lifts-injunction [https://perma.cc/5JUL-7AQW].

256. *Rokita*, 13 F.4th at 598.

257. Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2300–18, *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022); June Medical Services L.L.C. v. Russo, 140 S. Ct. 2103 (2020), *abrogated by Dobbs*, 142 S. Ct. 2228; Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 837 (1992), *overruled by Dobbs*, 142 S. Ct. 2228.

258. *Russo*, 140 S. Ct. at 2112–13

259. *Id.*

260. *Id.*

261. *See, e.g.*, *Hellerstedt*, 136 S. Ct. at 2300–18; *Russo*, 140 S. Ct. at 2112–13; *Casey*, 505 U.S. at 837.

262. Mazurek v. Armstrong, 520 U.S. 968, 977 (1997).

263. *See, e.g.*, Order, *supra* note 23.

constitutions,[264] and some state courts have found that physician-only laws infringe on that right.[265]

Most recently, Planned Parenthood obtained a court victory in Alaska to expand the provision of abortion to APCs. On November 2, 2021, an Alaska state court granted an abortion provider's motion for preliminary injunction, "halting part of a state law that prohibits [APCs] from providing medication abortion."[266] The court found that the law violated patients' right to privacy under Alaska's constitution and equal protection rights.[267] Planned Parenthood Alaska faced similar problems to the clinics in Indiana: it had trouble recruiting physicians to the four clinics in the state, and the physicians who did work there worked per diem around one day a week.[268] In contrast, APCs employed at the clinics worked full time.[269] The court went on to state that allowing APCs to provide abortions could increase the days these clinics were open to three to six days a week, depending on the area.[270]

Like Alaska, other states have expressly included a right to privacy under their state constitutions, which some courts have read as incorporating reproductive rights.[271] California voters opted to amend the state constitution to include a privacy right, and courts have interpreted that right to include a greater right to reproductive freedom than the federal constitution guarantees.[272] One case that exemplifies this interpretation is *American Academy of Pediatrics v. Lungren*.[273] In that case, the California Supreme Court struck down a law requiring parental consent for abortion of minors, explaining that the "scope and application of the state constitutional right

264. *Privacy Protections in State Constitutions*, NAT'L CONF. STATE LEGISLATURES (Jan. 3, 2022), https://www.ncsl.org/research/telecommunications-and-information-technology/privacy-protections-in-state-constitutions.aspx [https://perma.cc/YS75-825L]; *see, e.g.*, CAL. CONST. art. I, §§ 1, 1.1.

265. *See, e.g.*, Order, *supra* note 23; Planned Parenthood of the Great Nw. & the Hawaiian Islands v. Wasden, 406 F. Supp. 3d 922, 927 (D. Idaho 2019), *reconsideration denied*, No. 18-CV-00555, 2021 WL 4496942 (D. Idaho Sept. 30, 2021), *and abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

266. Press Release, Planned Parenthood, Breaking: In Win that Expands Access to Medication Abortion, Alaska State Court Enters Preliminary Injunction Against Unnecessary Abortion Restrictions (Nov. 2, 2021), https://www.plannedparenthood.org/about-us/newsroom/press-releases/breaking-in-win-that-expands-access-to-medication-abortion-alaska-state-court-enters-preliminary-injunction-against-unnecessary-abortion-restrictions [https://perma.cc/9PGH-4MWF]; Order, *supra* note 23.

267. Order, *supra* note 23.

268. *See id.* at 2–3.

269. *Id.* at 4.

270. *Id.* at 2–3.

271. CAL. CONST. art. I, § 1; *id.* art. XVIII, § 3; *see also* Comm. to Defend Reprod. Rts. v. Myers, 625 P.2d 779, 784 (Cal. 1981) (finding that reproductive choice is a fundamental right under the California Constitution); Armstrong v. State, 989 P.2d 364 (Mont. 1999); Dunn & Parham, *supra* note 92.

272. Am. Acad. of Pediatrics v. Lungren, 940 P.2d 797 (Cal. 1997).

273. *Id.*

of privacy is broader and more protective of privacy than the federal constitutional right of privacy as interpreted by the federal courts."[274]

Similarly, Montana's Constitution has incorporated a right to privacy, which the Montana Supreme Court reads as including a right of "procreative autonomy."[275] Notably, the Montana Supreme Court struck down the same physician-only law the Supreme Court had upheld in *Mazurek v. Armstrong*, reading procreative autonomy to include "the right [for a woman] to seek and to obtain . . . a pre-viability abortion, from a health care provider of her choice."[276] It found that the State had not shown a compelling interest to require that physicians, rather than physician-assistants, perform the procedure.[277] This decision shows that the very same law that may pass federal constitutional muster may be struck down under a state constitution if a state opts to include a right to privacy in its constitution.[278]

Thus, bringing cases under state constitutions that afford enhanced privacy rights may be a promising way to expand APCs' rights to perform abortions in states. However, this legal avenue contains significant drawbacks, especially for marginalized women.[279] Bringing cases under state constitutions fails to protect women in states that aim to undermine women's reproductive rights.[280] For example, in Iowa, state supreme court justices that affirmed the right to privacy in the state's constitution—including a right to abortion—four years ago have been replaced with newer, conservative justices.[281] The Iowa Supreme Court is now considering whether to reaffirm that reading of the Iowa Constitution or reinterpret it.[282] Women in states passing the most anti-abortion laws likely need protections from state constitutions the most.[283] And states with robust anti-abortion efforts may be less likely to protect women in their constitutions.[284] Still, conservative states such as Montana and Alaska incorporate the right to privacy in their Constitutions and this right, which has been judicially interpreted to protect reproductive choice, has been a vital safeguard in those states against further erosion of reproductive

274. *Id.* at 808.
275. *See, e.g.*, *Armstrong*, 989 P.2d at 370.
276. *Id.*
277. *Id.*
278. *Id.*; Dunn & Parham, *supra* note 92.
279. Dunn & Parham, *supra* note 92.
280. Nick Ehli, *Privacy Rights in State Constitutions May Protect Their Abortion Access*, WOMEN'S HEALTHCARE (Feb. 17, 2022), https://www.npwomenshealthcare.com/privacy-rights-in-state-constitutions-may-protect-their-abortion-access/?utm_source=rss&utm_medium=rss&utm_campaign=privacy-rights-in-state-constitutions-may-protect-their-abortion-access [https://perma.cc/LF8R-BG5T]; *see also* David Pitt, *Iowa Justices Reconsider State Constitution's Abortion Right*, ABC NEWS (Feb. 23, 2022, 11:24 AM), https://abcnews.go.com/US/wireStory/iowa-justices-reconsider-state-constitutions-abortion-83067773 [http://web.archive.org/web/20220318232727/https://abcnews.go.com/US/wireStory/iowa-justices-reconsider-state-constitutions-abortion-83067773].
281. Pitt, *supra* note 280.
282. *Id.*
283. Ehli, *supra* note 280.
284. Pitt, *supra* note 280.

freedom.[285] However, state constitutions are subject to amendment by vote or a constitutional convention, so they fail to afford the type of robust protection the federal government can provide.[286] Unfortunately, the federal government has been stagnant in offering reproductive freedom protections, making it unlikely that it will actually enact necessary protections.[287]

D. Legislative Responses to Physician-Only Laws

Because states like Montana and Vermont never passed laws restricting the provision of abortion to physicians after *Roe v. Wade* was passed, APCs have performed early term abortions in those states since 1973.[288] Other states, such as California,[289] have recently repealed physician-only laws.[290] In fact, "[a]s of January 2004, trained APCs were routinely performing medical abortions in 14 American states and surgical abortions in six."[291] Some states have repealed physician-only laws more recently in the wake of record numbers of abortion restrictions being passed.[292] For example, in April of 2021, Hawaii's Governor "approved a measure (H 576) that permits advanced practice nurses to provide both medication and procedural abortion in the first trimester."[293] Additionally, in October of 2021, the New Jersey Board of Medical Examiners approved a regulation allowing APCs to administer abortions.[294]

Unfortunately, other states, such as Texas and Mississippi, are moving in the opposite direction. These states are passing increasingly restrictive laws that widen the disparity in abortion access.[295] As is the case for state constitutional protections, women in states where abortion is hardest to obtain are most affected by physician-only laws.[296] However, anti-abortion states may be least likely to successfully repeal these laws, compounding the inequality in access for

285. *See, e.g.*, Armstrong v. State, 989 P.2d 364, 370 (Mont. 1999); Order, *supra* note 23.

286. Ehli, *supra* note 280; Pitt, *supra* note 280.

287. *See, e.g.*, Women's Health Protection Act of 2021, H.R. 3755, 117th Cong. § 2 (failing in the Senate).

288. *See* Kishen & Stedman, *supra* note 11, at 571.

289. CAL. BUS. & PROF. CODE § 2725.4 (West 2022).

290. GUTTMACHER INST., *supra* note 14.

291. *See* Kishen & Stedman, *supra* note 11, at 571.

292. Nash, *supra* note 89.

293. GUTTMACHER INST., *supra* note 14; *see* HAW. REV. STAT. § 457-8.7 (2022).

294. GUTTMACHER INST., *supra* note 14; *see* 53 N.J. Reg. 12(a) (Jan. 4, 2021).

295. *See* TEX. HEALTH & SAFETY CODE ANN. § 171.208 (West 2021); MISS. CODE ANN. § 41-41-191 (2022).

296. *See, e.g.*, Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500, 528 (S.D. Indiana 2021) (explaining that allowing APCs to perform first trimester abortions in Indiana could expand the ability of clinics to stay open five days a week instead of one or two days a week), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022), *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022).

marginalized women.[297] Thus, federal protections are necessary to ensure that women in states that refuse to protect women's reproductive autonomy are still granted procreative choice.[298]

Encouragingly, federal legislation has been proposed to legalize APC-performed abortion. For example, "[a] bill called the Women's Health Protection Act, first introduced in 2013 and reintroduced this year, would invalidate physician-only requirements and ensure all qualified health care providers can perform abortions. This bill would also remove medically unnecessary requirements including mandatory ultrasounds, waiting periods, and biased state-mandated counseling."[299] As of late 2021, "[t]he bill passed in the House of Representatives . . . and [was] supported by President Biden, but face[d] an uphill battle in the Senate."[300] Unfortunately, the bill failed in the Senate in February of 2022 and was largely opposed by Republican lawmakers.[301] Nevertheless, the bill showed federal legislative support for abortion rights and "got lawmakers—including vulnerable Republicans—on the record about where they stand."[302] If Americans choose to vote differently for their federal representatives as the Supreme Court and many states threaten abortion rights,[303] it is possible a bill repealing physician-only laws could eventually pass.[304] In addition, many Americans have advocated for ending the filibuster, which requires sixty votes in Congress to close debate as opposed to fifty.[305] If filibuster reform were passed, it is possible a federal bill protecting abortion rights could more easily pass in the Senate.[306]

The cases and legislation surrounding physician-only laws make clear that there are multiple avenues for eliminating physician-only laws.[307] These strategies

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297. *See* Whole Woman's Health All. v. Rokita, 13 F.4th 595, 601–02 (7th Cir. 2021) (upholding a physician-only law in Indiana, where it is not uncommon for women to be referred out of state to obtain an abortion due to shortage of providers in state).

298. *See, e.g.*, Women's Health Protection Act of 2021, H.R. 3755, 117th Cong. § 2.

299. Henderson, *supra* note 7; *see also* Women's Health Protection Act of 2021, H.R. 3755, 117th Cong. §2 (2021).

300. Henderson, *supra* note 7.

301. Li Zhou, *Why the Senate Took a Doomed Vote on Abortion Rights*, VOX (Mar. 1, 2022, 10:52 AM), https://www.vox.com/2022/2/28/22946299/womens-health-protection-act-senate-vote-abortion-rights [https://perma.cc/UU85-XK34].

302. *Id.*

303. *See, e.g.*, Amy Howe, Roe v. Wade *Hangs in Balance as Reshaped Court Prepares to Hear Biggest Abortion Case in Decades*, SCOTUSBLOG (Nov. 29, 2021, 8:00 AM), https://www.scotusblog.com/2021/11/roe-v-wade-hangs-in-balance-as-reshaped-court-prepares-to-hear-biggest-abortion-case-in-decades/ [https://perma.cc/M4SW-4MN7]; Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2021); MISS. CODE. ANN. § 41-41-191 (2022).

304. *See* sources cited *supra* note 303.

305. *See, e.g.*, Ronald Brownstein, *The Democrats' Last Best Shot to Kill the Filibuster*, ATLANTIC (Sept. 30, 2021), https://www.theatlantic.com/politics/archive/2021/09/filibuster-senate-democrats/620243/ [https://perma.cc/53DM-FJNB].

306. *Id.*; Women's Health Protection Act of 2021, H.R. 3755, 117th Cong. § 2.

307. *See, e.g.*, Dunn & Parham, *supra* note 92; Women's Health Protection Act of 2021, H.R. 3755, 117th Cong. § 2 Cohen, *supra* note 154, at 218 ("An argument can be made that Whole

include challenging the constitutionality of physician-only laws under both the Federal Constitution[308] and state constitutions,[309] generating political will in states to expand protections for reproductive rights in their constitutions[310] and garnering support for federal legislation that will discard physician-only laws.[311] Because women's reproductive freedom in states that restrict abortion will be most marginalized,[312] it is vital that Congress and the Supreme Court take action to grant access to APC-performed abortion for *all* women.[313]

IV. POTENTIAL SOLUTIONS FOR REPEALING PHYSICIAN-ONLY LAWS: THE SUPREME COURT AND LEGISLATION

APCs provide a feasible solution to the severe abortion provider shortage in the United States today, especially given that many states have the infrastructure to quickly transition APCs to providing first trimester abortions.[314] Despite the public policy reasons to eliminate physician-only laws, the Supreme Court needs to overturn *Mazurek*[315] and proclaim physician-only laws unconstitutional. Doing so would comport with its own recent precedent[316] and resolve a burgeoning circuit split in lower courts on how to interpret health-justified abortion restrictions after *Hellerstedt*.[317] In addition, the changed circumstances that exist today, in comparison to the landscape when *Mazurek* was decided, necessitates a different outcome.[318]

Woman's Health's clarification of the standard has opened the door to a different result today [regarding physician-only laws].").

308. Order, *supra* note 23 (finding that a physician-only law violated equal protection rights).

309. *Id.* (finding physician-only law violated state constitution).

310. Ehli, *supra* note 281.

311. Zhou, *supra* note 301.

312. *See, e.g.*, Sarah McCammon, *'Trigger laws' Are Abortion Bans Ready to Go If 'Roe v. Wade' Is Overturned*, NPR (Dec. 6, 2021, 5:06 PM), https://www.npr.org/2021/12/06/1061896291/trigger-laws-are-abortion-bans-ready-to-go-if-roe-v-wade-is-overturned [https://perma.cc/2KUP-MQ5Q] (explaining that many states have laws in place that will ban abortion if *Roe v. Wade* is overturned).

313. *See, e.g.*, Women's Health Protection Act of 2021, H.R. 3755, 117th Cong. § 2.

314. Henderson, *supra* note 7; Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500, 537 (S.D. Ind. 2021), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022), *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022); *see* Erin Vogt, *N.J. Midwives, Physician Assistants Could Legally Perform Abortions Under Proposal*, N.J. 101.5 (Jan. 6, 2021), https://nj1015.com/nj-expanding-abortion-access/?utm_source=tsmclip&utm_medium=referral [https://perma.cc/J96A-DTMT].

315. Mazurek v. Armstrong, 520 U.S. 968, 977 (1997).

316. *See* Whole Woman's Health v. Hellerstedt, 579 U.S. 582, 588–622 (2016), *abrogated by Dobbs*, 142 S. Ct. 2228; Mary Ziegler, *After Life: Governmental Interests and the New Antiabortion Incrementalism*, 73 U. MIAMI L. REV. 78, 138 (2018).

317. *See, e.g.*, Rokita, 553 F.Supp.3d at 500; *cf.* Falls Church Med. Ctr., LLC v. Oliver, 412 F. Supp. 3d 668, 668 (E.D. Va. 2019), *abrogated by Dobbs*, 142 S. Ct. 2228; *Hellerstedt*, 579 U.S. at 634–35; *see also* Kendis, *supra* note 34, at 1047–48.

318. *See* Whole Woman's Health All. v. Hill, 493 F. Supp. 3d 694, 738 (S.D. Ind. 2020) ("Whether a statute or regulation poses an undue burden on a woman's constitutional right to receive an abortion depends on the then-existing circumstances."(citing *Hellerstedt*, 579 U.S. at 602; Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 877 (1992), *overruled by Dobbs*, 142 S. Ct. 2228), *order*

A. Lower Courts' Varied Application of Hellerstedt *and Burgeoning Circuit Split*

The Supreme Court needs to resolve the confusion growing in lower courts regarding how to interpret *Hellerstedt*[319] when applied to health restrictions on abortion.[320] One way to do this that would also result in meaningful increases in access for women is to accept a case challenging a physician-only law and overturn *Mazurek*.[321]

For instance, one example of a difference in interpretation of health restrictions between lower courts is the way the Seventh Circuit and Fifth Circuit have applied *Hellerstedt*.[322]

The Seventh Circuit applied a true balancing test before *Whole Woman's Health* was decided and has stayed true to this interpretation in more recent decisions. Under this interpretation, even minor burdens can justify the invalidation of certain abortion restrictions: "[t]he more feeble the state's asserted interest, 'the likelier the burden, even if slight, to be "undue" in the sense of disproportionate or gratuitous.'" In direct contrast, the Fifth Circuit opined in Gee that the standard articulated in *Whole Woman's Health* is not "a 'pure' balancing test under which any burden, no matter how slight, invalidates the law."[323]

The Fifth Circuit has interpreted *Hellerstedt*[324] not to require any balancing test so long as the burdens posed by a restriction are not substantial.[325]

This articulation is conspicuously reminiscent of the Fifth Circuit's prior articulation of the undue burden test, which the Supreme Court summarily rejected in [*Hellerstedt*]. The dissenting judge on the Fifth Circuit panel criticized the majority for not heeding the Court's recent admonitions, "failing to meaningfully balance the burdens and benefits . . . and leav[ing] the undue burden test devoid of meaning."[326]

Until the Supreme Court provides guidance on how *Hellerstedt* should be applied, the Fifth Circuit will continue to misapply *Hellerstedt*."[327]

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clarified sub nom. Whole Women's Health All. v. Rokita, No. 18-cv-01904, 2021 WL 252721 (S.D. Ind. Jan. 26, 2021); Robertson, *supra* note 35.

319. Whole Woman's Health v. Hellerstedt, 579 U.S. 582,634–35 (2016), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022); *see also* Kendis, *supra* note 34, at 1047–48.

320. Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500, 507 (S.D. Ind. 2021) *abrogated by Dobbs*, 142 S. Ct. 2228, *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022).

321. *See* Henderson, *supra* note 7.

322. *Hellerstedt*, 579 U.S. at 634–35; *see also* Kendis, *supra* note 34, at 1047–48.

323. Kendis, *supra* note 34, at 1047 (citing June Med. Servs. L.L.C. v. Gee, 905 F.3d 787 (5th Cir. 2018), *rev'd sub nom.* June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103 (2020)).

324. *Hellerstedt*, 579 U.S. at 588–622.

325. Kendis, *supra* note 34, at 1048.

326. *Id.* at 1047 (citing June Med. Servs., 905 F.3d at 831 (Higginbotham, J., dissenting)).

327. *Id.* at 1047–48; *see also Hellerstedt*, 579 U.S. at 634–35.

B. Academic and Legal Sources: Calls for Supreme Court to Reconsider Mazurek

Both academics and courts have called for the clarification of what *Mazurek* means in light of the Supreme Court's decision in *Hellerstedt*.[328] Indeed, a Supreme Court Justice himself admitted in his dissent in *Hellerstedt* that *Mazurek*[329] would be on unstable ground because of the Court's decision.[330] Justice Clarence Thomas emphasized that in *Mazurek*[331] the Court upheld the Montana physician-only law "even though no legislative findings supported the law and the challengers claimed that 'all health evidence contradict[ed] the claim that there is any health basis for the law.'"[332] He felt the decision in *Hellerstedt* was wrongly decided because it would bring into question prior Supreme Court jurisprudence, lending credence to the fact that *Hellerstedt* renders *Mazurek* unworkable.[333]

In *"Beyond Rational Belief": Evaluating Health-Justified Abortion Restrictions After Whole Woman's Health*, Cathren Cohen chronicled the way that health restrictions on abortions have been interpreted since *Hellerstedt*[334] and called for clarification.[335] She specifically claimed that "an argument can be made that *Whole Woman's Health*'s clarification of the standard has opened the door to a different result today."[336] Further, John A. Robertson wrote that

> Challenges to licensing laws that require only physicians to perform abortions can also be close under *Hellerstedt*'s emphasis on real medical benefit. For example, *Mazurek v. Armstrong* upheld a Montana ban on a physician assistant performing first trimester abortions even though she was qualified, in part because there the petitioners *did not argue that the law burdened access* . . . . [A]fter *Hellerstedt* such bans may be challenged if physicians are not available to meet abortion needs and physician assistants or nurse practitioners are adequately trained and supervised.[337]

In addition, the dissenting judge[338] in *Whole Woman's Health All. v. Rokita*, who disagreed with upholding a physician-only law in Indiana, questioned

328. Ziegler, *supra* note 316, at 138 ("*Whole Women's Health* does not fully explain how courts should evaluate the purpose of abortion regulations. To clarify how judges should measure the claimed benefit of a law, the Court should demand more precision when it comes to the problem and solution that lawmakers have identified."); *see also Hellerstedt*, 579 U.S. at 608.

329. Mazurek v. Armstrong, 520 U.S. 968, 977 (1997).

330. *Hellerstedt*, 579 U.S. at 628–29 (Thomas, J., dissenting).

331. *Mazurek*, 520 U.S. at 977.

332. Cohen, *supra* note 154 (citing *Hellerstedt*, 579 U.S. at 634–35 (Thomas, J., dissenting)).

333. *Hellerstedt*, 579 U.S. at 628–29 (Thomas, J., dissenting).

334. *Id.*

335. Cohen, *supra* note 154, at 218.

336. *Id.*

337. Robertson, *supra* note 35 (emphasis added) (first citing *Hellerstedt*, 579 U.S. at 588–622; and then citing Mazurek v. Armstrong, 520 U.S. 968, 972 (1997)).

338. Whole Woman's Health All. v. Rokita, 13 F.4th 595, 598 (7th Cir. 2021) (Wood, J., dissenting).

Mazurek's[339] application to that case.[340] She stated that "[t]he [*Mazurek*] Court's opinion leaned heavily on the district court's finding that there was insufficient evidence in the record that a law that disabled only one abortion provider (the physician assistant) from providing these services could amount to a prohibited 'substantial obstacle' to abortions."[341] She contrasted *Mazurek*[342] with the case before the Seventh Circuit. In doing so, she emphasized that that case only applied to aspiration abortions as the abortion pill did not exist at the time it was decided, that case was primarily examining legislative *purpose*, and only one physician assistant in the entire state was licensed to perform abortions.[343]

Finally, the medical community has also called for the approval of APCs to perform abortions.[344] In *When Politics Trumps Evidence: Legislative or Regulatory Exclusion of Abortion from Advanced Practice Clinician Scope of Practice*, the American College of Nurse-Midwives chided courts for politicizing APC-performed abortion and failing to actually take women's safety into account in upholding these restrictions.[345] In referencing recent laws passed that have banned APCs from performing abortion, the article notes "legislative or regulatory exclusions of abortion from the scope of practice of advanced practice clinicians reflect an example of politics trumping evidence and should be of concern to all health professionals who care about their scope of practice."[346]

C. Physician-Only Laws Pose More Burdens Today Than When Mazurek *Was Decided*

Not only have scholars called for clarification of the constitutionality of physician-only laws[347] but also the reality of the abortion landscape has changed since *Mazurek*[348] was decided.[349] Physician-only laws burden women more today than they did twenty-six years ago for two reasons: first, access to abortion is more curtailed than ever in the current U.S. climate,[350] and second, there exist more APCs ready and willing to perform abortions today than when *Mazurek*[351] was decided.[352]

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339. *Mazurek*, 520 U.S. at 972.
340. *Rokita*, 13 F.4th at 595.
341. *Id.* at 601–02 (Wood, J., dissenting) (quoting *Mazurek*, 520 U.S. at 973).
342. *Mazurek*, 520 U.S. at 972.
343. *Rokita*, 13 F.4th at 601–02 (Wood, J., dissenting) (quoting *Mazurek*, 520 U.S. at 973).
344. Taylor, Safriet & Weitz,, *supra* note 18; *see also* Berer, *supra* note 13.
345. Taylor, Safriet & Weitz, *supra* note 18.
346. *Id.* at 1.
347. *See, e.g.*, Kendis, *supra* note 34.
348. Mazurek v. Armstrong, 520 U.S. 968, 972 (1997).
349. *See, e.g.*, Henderson, supra note 7; *see also* Kendis, *supra* note 34.
350. Kendis, *supra* note 34.
351. *Mazurek*, 520 U.S. at 972.
352. *See, e.g.*, *New Jersey Expands Access to Reproductive Health Care, Adopts New Rules from Unanimous Vote by State Board of Medical Examiners*, OFF. SITE ST. N.J.: Governor Phil Murphy (Dec. 6, 2021), https://nj.gov/governor/news/news/562021/approved/20211206a.shtml [https://perma.cc/62DX-QCWN]; *see also* 53 N.J. Reg. 12(a) (Jan. 4, 2021).

This means stopping them from performing abortions is directly restricting access that would exist but for restrictive physician-only laws.[353]

The Supreme Court has stated that changed circumstances can impact the way a statute is reviewed.[354] And recently, the court in *Whole Woman's Health v. Hill* emphasized that

> [O]ne judicial determination that a specific abortion law poses no undue burdens to one group of women at a prior time and place does not foreclose a subsequent finding that a similar abortion law does impose such an undue burden on a group of women in another time and place. The burdens of an abortion law can change over time as medical technology and research evolve, as the population demographics of a state change, or as other abortion regulations are adopted or amended.[355]

As an Indiana district court recently noted, "the nature of abortion care has evolved substantially in the years since Mazurek was decided . . . . For example, medication abortions available today did not even exist at the time that Mazurek was decided."[356]

In *Mazurek*, the Court emphasized the fact that there was only *one* licensed physician assistant in the whole state that could even perform abortions, and it had to be under the supervision of a physician.[357] This meant that access to abortion was not realistically burdened because even if a physician-only law was repealed, there were no ready and willing APCs that would perform abortions.[358] However, many states do have ready and willing APCs to perform abortions.[359] For example, in New Jersey, where the board of medical examiners recently approved a regulation that would allow APCs to perform first trimester abortion.[360] "[T]he rule changes significantly expand access to reproductive care . . . . Currently, there are approximately 11,956 Advanced Practice Nurses, 4,495 Physician Assistants,

353. Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500, 500 (S.D. Ind. 2021) (per curiam), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022), *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022).

354. *See* Whole Woman's Health All. v. Hill, 493 F. Supp. 3d 694, 738 (S.D. Ind. 2020) ("Whether a statute or regulation poses an undue burden on a woman's constitutional right to receive an abortion depends on the then-existing circumstances."(citing Whole Women's Health v. Hellerstedt, 579 U.S. 582, 602 (2016), *abrogated by Dobbs*, 142 S. Ct. 2228; Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 877 (1992), *overruled by Dobbs*, 142 S. Ct. 2228)), *order clarified sub nom.* Whole Woman's Health All. V. Rokita, No. 18-cv-01904, 2021 WL 252721 (S.D. Ind. Jan. 26, 2021).

355. *Hill*, 493 F. Supp. 3d at 737.

356. *Rokita*, 553 F. Supp. 3d at 558 (citing *Mazurek*, 520 U.S. at 970).

357. *Mazurek*, 520 U.S. at 970.

358. *Id.* at 971.

359. *Rokita*, 553 F. Supp. 3d at 500.

360. OFF. SITE ST. N.J., *supra* note 352; *see also* 53 N.J. Reg. 12(a) (Jan. 4, 2021).

393 Certified Nurse Midwives, and 18 Certified Midwives in the State who could become authorized to perform the procedure."[361]

John A. Robertson expressed in *Whole Woman's Health v. Hellerstedt and the Future of Abortion Regulation* that

> *Mazurek v. Armstrong* upheld a Montana ban on a physician assistant performing first trimester abortions even though she was qualified, in part because there the petitioners did not argue that the law burdened access. The Court simply relied on the language in *Roe* and *Casey* that stated states may require only licensed doctors to perform abortions. But after *Hellerstedt* such bans may be challenged if physicians are not available to meet abortion needs and physician assistants or nurse practitioners are adequately trained and supervised.[362]

Given that no studies show a medical benefit to physician-performed abortions in the first trimester in comparison to APC-performed abortion,[363] there is no argument that these physician-only laws confer a benefit. [364] As the court in *Whole Woman's Health v. Rokita* stated, "[t]he Court in Mazurek did not address whether a challenge to the constitutionality of a physician-only requirement would be cognizable if it posed substantial obstacles to those seeking abortions"[365] Today, "there exists a supply of APCs willing and able to provide abortion care, who would do so *but for* the Physician-Only Law. Many APCs are already employed by licensed abortion clinics, but their duties are curtailed by this statutory restriction."[366] It is obvious that the landscape today and in states outside Montana is distinguishable from the landscape in *Mazurek*, where APC-performed abortion would not greatly increase abortion access.[367] Today, access would realistically be expanded, and quickly, with the passage of laws that permit APCs to perform first trimester abortions.[368]

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361. *Id.*

362. Robertson, *supra* note 35, at 645.

363. NAT'L ACADS. SCIS. ENG'G & MED., *supra* note 13; *Medication Abortion*, GUTTMACHER INST. (Nov. 23, 2022), https://www.guttmacher.org/state-policy/explore/medication-abortion [https://perma.cc/4KSM-BK5L].

364. *See* sources cited *supra* note 363.

365. Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500, 558 (S.D. Ind. 2021) (citing Mazurek v. Armstrong, 520 U.S. 968, 977 (1997), *abrogated by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022), *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022).

366. *Rokita*, 553 F. Supp. 3d at 540 (emphasis added).

367. *Mazurek*, 520 U.S. at 977.

368. Henderson, *supra* note 7.

D. Potential Challenges to Repealing Physician-Only Laws

Although there is a strong case for physician-only laws being repealed by the Supreme Court and *Mazurek* getting overturned,[369] there will certainly be challenges to this strategy.[370] Given the makeup of the current Supreme Court, it is less likely now than it would have been five years ago that the Court will expand rather than restrict abortion access.[371] But with challenges to the Supreme Court's legitimacy mounting,[372] it is more important than ever that the Court follow the law and its own jurisprudence over contemporary political influences.[373]

The Court has denied certiorari for a recent physician-only law challenge.[374] And it may desire to pause reviewing abortion restrictions until it decides whether to follow *Roe v. Wade*'s[375] precedent in *Dobbs*.[376] And worse, if the court were to overturn *Roe v. Wade*,[377] physician-only laws would likely get stricter.[378] This is why it is also imperative that federal legislators take action and pass the Women's Health Protection Act, which would allow APCs to perform abortion by federal law.[379]

CONCLUSION

The profound shortage of abortion providers available in the United States today[380] coupled with jurisprudence and legislation that dramatically restricts abortion[381] makes *now* the time for the Supreme Court and federal[382] and state legislatures[383] to strike down physician-only laws. Midwives and nurses have not only performed abortion as the main providers of reproductive care since before the American Civil War[384] but also have become more trained and available to

369. Kendis, *supra* note 34; *Mazurek*, 520 U.S. at 977.

370. *See, e.g.*, Thomson-Deveaux & Bronner, *supra* note 36; Hill v. Whole Woman's Health All., 141 S. Ct. 189 (2020) (mem.) (denying certiorari for a physician-only law challenge).

371. Thomson-Deveaux & Bronner, *supra* note 36.

372. *See* Pilkington, *supra* note 5.

373. Taylor, Safriet & Weitz, *supra* note 18; Henderson, *supra* note 7.

374. *See Hill*, 141 S. Ct. 189 .

375. Roe v. Wade, 410 U.S. 113 (1973), *overruled by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

376. *Dobbs*, 141 S. Ct. 2619.

377. *Roe*, 410 U.S. 113.

378. McCammon, *supra* note 312.

379. Women's Health Protection Act of 2021, H.R. 3755, 117th Cong. § 2.

380. Henderson, *supra* note 7.

381. *See* Whole Woman's Health v. Jackson, 141 S. Ct. 2494 (2021) (failing to grant an injunction against a recently passed Texas Law, S.B. 8, that makes abortion illegal after six weeks and creates a civil fine for those aiding and abetting a woman to have an abortion after six weeks, including family members and those transporting a woman.); *see also* TEX. HEALTH & SAFETY CODE ANN. § 171.208 (West 2021).

382. Women's Health Protection Act of 2021, H.R. 3755, 117th Cong. § 2.

383. GUTTMACHER INST., *supra* note 14.

384. REAGAN, *supra* note 15; Goodwin, *supra* note 25; Merelli, *supra* note 25.

provide abortions today.[385] APC-performed abortion is safe[386] and removes many of the logistical barriers that marginalized women face in accessing abortion.[387] The racist and misogynistic history of physician-only laws[388] is not only a relic of the past: these laws continue to oppress marginalized women at a time when they most need fundamental protections for their reproductive autonomy.[389] Thus, law, history, and science converge to support the provision of abortion by APCs.[390]

385. *See,* e.g., Whole Woman's Health All. v. Rokita, 553 F. Supp. 3d 500, 537 (S.D. Ind. 2021), *abrogated by Dobbs*, 142 S. Ct. 2228, *and vacated*, Nos. 21-2480 & 21-2573, 2022 WL 2663208 (7th Cir. July 11, 2022).

386. *See, e.g.*, Berer, *supra* note 13; NAT'L ACADS. SCIS. ENG'G & MED., *supra* note 13.

387. Henderson, *supra* note 7.

388. REAGAN, *supra* note 15; Goodwin *supra* note 25; Merelli, *supra* note 25.

389. *See* Kozicz, *supra* note 6, at 1264; Henderson, *supra* note 7.

390. *See, e.g.*, Berer, *supra* note 13; NAT'L ACADS. SCIS. ENG'G & MED., *supra* note 13; Whole Woman's Health v. Hellerstedt, 579 U.S. 582, 588–622 (2016), *abrogated by Dobbs*, 142 S. Ct. 2228; Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 877 (1992), *overruled by Dobbs*, 142 S. Ct. 2228; REAGAN, *supra* note 15, at 80–114.