

## After the Choice: Challenging California's Physician-Only Abortion Restriction Under the State Constitution



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### ABSTRACT

Women in California have the right to abortion protected by statute and the state constitution. Yet for many women, the “right” to abortion is illusory. Most clinics and hospitals that provide abortions are concentrated in urban areas, leaving many counties without a single abortion provider. Practical barriers to access are compounded by California’s sheer size and geography, resulting in provider shortages and delays in care outside major urban areas.

This access problem is exacerbated by California’s physician-only abortion restriction, which prohibits qualified, licensed health professionals from providing aspiration abortion (commonly referred to as surgical abortion), the most common procedure for terminating a pregnancy in the first trimester. Numerous studies demonstrate that early aspiration abortions are as safe when performed by nurse practitioners (NPs), physician assistants (PAs), and certified nurse-midwives (CNMs) as when performed by physicians. Yet under California’s Business and Professions Code, only physicians can perform this procedure.

This Article challenges the constitutionality of California’s physician-only abortion restriction under the state constitution and argues that the state has no compelling interest in restricting trained and competent clinicians from providing aspiration abortions. Looking at a successful state constitutional challenge to a physician-only abortion restriction in Montana as a model, the Article argues that using California’s state constitution to challenge the physician-only abortion restriction could be an effective approach for improving access to abortion. Further, the strategy outlined in this Article could be used to challenge similar abortion restrictions in other states that have strong state protection for the right to privacy.

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## INTRODUCTION

Abortion has been legal in California for more than forty years. When Governor Ronald Reagan signed the Therapeutic Abortion Act in 1967,<sup>1</sup> California became one of the first states to legalize abortion in cases of rape, incest, or when continuing the pregnancy would impair a woman's physical or mental health.<sup>2</sup> Two years later, the California Supreme Court recognized for the first time the "fundamental right . . . to choose whether to bear children."<sup>3</sup> In 1972, California voters amended the state constitution to include an explicit right to privacy.<sup>4</sup> More recently, in 2002, California legislators passed the Reproductive Privacy Act<sup>5</sup> to codify the holding in *Roe v. Wade*.<sup>6</sup> The act provides that "[e]very woman has the fundamental right to choose . . . to obtain an abortion," and "[t]he state shall not deny or interfere with" this right.<sup>7</sup> Thus, California has remained at the forefront of states that recognize the right to privacy and the right to an abortion.<sup>8</sup>

To this date, California state statutes and the state constitution protect women's right to abortion. Yet, for many women in California, particularly women in rural and medically underserved communities, the "right" to an abortion is illusory. Most clinics and hospitals that provide abortions are concentrated in

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1. CAL. HEALTH & SAFETY CODE §§ 25950–25954 (West 2010), *invalidated in part by* *People v. Barksdale*, 503 P.2d 257 (Cal. 1972) (repealed 2003).
  2. Prior to 1967, the California Penal Code criminalized abortion except to save a woman's life. CAL. PENAL CODE § 275 (West 1955). In 1962, the American Law Institute (ALI) called for abortion reform and developed a Model Penal Code that authorized abortion under certain limited circumstances. Twelve states, including California, followed the ALI's Model Penal Code and relaxed their prohibition against abortion. See *BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT'S RULING 24–25* (Linda Greenhouse & Reva Siegel eds., 2010).  
 In 1970, Hawaii became the first state to legalize abortion more broadly. New York, Alaska, and Washington followed shortly thereafter. *Id.* at 122; see also Zad Leavy & Alan F. Charles, *California's New Therapeutic Abortion Act: An Analysis and Guide to Medical and Legal Procedure*, 15 UCLA L. REV. 1 (1967).
  3. See *People v. Belous*, 458 P.2d 194, 199 (Cal. 1969); see also *Barksdale*, 503 P.2d 257.
  4. CAL. CONST. art. 1, § 1. Voters in California can amend the state constitution through public initiative ballots. CAL. CONST. art. 18, § 3.
  5. CAL. HEALTH & SAFETY CODE § 123460–123468 (West 2012).
  6. 410 U.S. 113 (1973).
  7. HEALTH & SAFETY § 123462(b), (c).
  8. For example, California received an A+ from NARAL Pro-Choice America, ranking number one in the nation. See *2012 Report Card on Women's Reproductive Rights*, NARAL PRO-CHOICE AM. FOUND., <http://www.prochoiceamerica.org/assets/download-files/2012-wd-report-card.pdf> (last visited June 4, 2013).

urban areas, leaving many counties without a single abortion provider.<sup>9</sup> For women residing in such counties, California's sheer size and geography compound the practical barriers to accessing an abortion provider. Outside urban areas such as San Francisco and Los Angeles, this results in provider shortages and delays in care that are typically associated with states that do not protect abortion rights, such as South Dakota, Missouri, and Arizona—not “pro-choice” states such as California.<sup>10</sup>

California's physician-only abortion restriction exacerbates this abortion access problem. The physician-only abortion restriction prohibits qualified and licensed health professionals from providing aspiration abortion,<sup>11</sup> which is the most common procedure for terminating a pregnancy in the first trimester.<sup>12</sup> Although numerous studies demonstrate that early aspiration abortions<sup>13</sup> are as safe when performed by nurse practitioners (NPs), physician assistants (PAs), and certified nurse-midwives (CNMs) (collectively, clinicians)<sup>14</sup> as when per-

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9. *State Facts About Abortion: California*, GUTTMACHER INST., <http://www.guttmacher.org/pubs/sfaa/california.html> (last visited May 17, 2013).
  10. See Tali Woodward, *The Other Abortion Battle*, S.F. BAY GUARDIAN, Oct. 11, 2006, at 225; see also *Welcome to ACCESS*, ACCESS WOMEN'S HEALTH JUST., <http://accesswhj.org/welcome-access> (last visited June 4, 2013) (“[T]housands of women in California still find it nearly impossible to act on these [abortion] rights or obtain reproductive health care without a struggle.”).
  11. Under California's Business and Professions Code, nurse practitioners (NPs), certified nurse-midwives (CNMs), and physician assistants (PAs) are authorized to perform “nonsurgical abortion,” including the “termination of pregnancy through the use of pharmacological agents” (medication abortion). CAL. BUS. & PROF. CODE § 2253(b)(2), (c) (West 2012). Only a physician, however, may perform a “surgical abortion.” *Id.* § 2253(b)(1). Some researchers and scholars have argued that the term “nonsurgical abortion” under California's Business and Professions Code could include early aspiration abortion. See T.A. Weitz et al., “Medical” and “Surgical” Abortion: Rethinking the Modifiers, 69 CONTRACEPTION 77 (2004) (questioning the use of the term “surgical” abortion to describe aspiration procedures). Although we recognize the validity of this argument, the differing interpretations of “surgical abortion” and the resulting ambiguity in the law have served to make NPs, CNMs, and PAs uncomfortable with providing early aspiration abortion in California under the current restriction. *Abortion: Hearing on S.B. 1338 Before the S. Comm. on Bus., Professions & Econ. Dev.*, 2012 Senate (Cal. 2012) [hereinafter *Hearing on SB 1338*] (comments in support), available at <http://www.aroundthecapitol.com/billtrack/analysis.html?aid=241323>.
  12. See Karen Pazol et al., Ctrs. for Disease Control & Prevention, *Abortion Surveillance—United States, 2009*, MORBIDITY & MORTALITY WKLY. REP., Nov. 23, 2012, at 1, 3, 7, <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6108a1.htm>.
  13. Aspiration abortion is performed in the first twelve to fourteen weeks of pregnancy. JENNIFER TEMPLETON DUNN ET AL., *ABORTION IN CALIFORNIA: A MEDICAL-LEGAL HANDBOOK* 24–25 (2012). We use the specific terms aspiration abortion and early aspiration abortion interchangeably to distinguish this procedure from other methods used early in pregnancy such as a medication abortion. The terms aspiration abortion and early aspiration abortion further distinguish the procedure from later surgical procedures such as dilation and extraction and induction. *Id.*
  14. Although nurse practitioners, physician assistants, and certified nurse midwives will collectively be referred to as clinicians throughout this Article, it is important to note that the term clinicians may also include physicians in other contexts.

formed by physicians,<sup>15</sup> California's Business and Professions Code allows only physicians to perform a "surgical abortion."<sup>16</sup> Furthermore, these clinicians are more likely to be working in rural, medically underserved, and high-poverty communities than their physician counterparts.<sup>17</sup> Thus, California's physician-only restriction places a heavier burden on women in these communities, who may often be uninsured or underinsured and who are more likely to be adversely affected by the provider shortages.

This Article challenges the constitutionality of California's physician-only abortion restriction under the state constitution. By drawing on examples and studies from other states as well as the results of a major study by the University of California, San Francisco (UCSF), this Article argues that the state has no compelling interest that justifies prohibiting qualified, licensed clinicians from providing first trimester aspiration abortions. The restriction is also not narrowly tailored to this allegedly compelling interest. Therefore, if challenged, California's physician-only abortion restriction would likely be found unconstitutional under the state constitution. Further, this strategy could be used to challenge similar abortion restrictions in other states with strong state protection for the right to privacy.<sup>18</sup>

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15. One study specific to California clinicians is the Health Workforce Pilot Project sponsored by the University of California, San Francisco (UCSF). See *HWPP #171 Quarterly Data Update*, HEALTH WORKFORCE PILOT PROJECT (Sept. 2012), [http://www.ansirh.org/\\_documents/research/pci/HWPPupdate-Sep2012.pdf](http://www.ansirh.org/_documents/research/pci/HWPPupdate-Sep2012.pdf) [hereinafter *ANSIRH Data Update*]; see also Marge Berer, *Provision of Abortion by Mid-level Providers: International Policy, Practice and Perspectives*, 87 BULL. WORLD HEALTH ORG. 58 (2009); see also, e.g., Mary Anne Freedman et al., *Comparison of Complication Rates in First Trimester Abortions Performed by Physician Assistants and Physicians*, 76 AM. J. PUB. HEALTH 550 (1986); Marlene B. Goldman et al., *Physician Assistants as Providers of Surgically Induced Abortion Services*, 94 AM. J. PUB. HEALTH 1352 (2004); I.K. Warriner et al., *Rates of Complication in First-Trimester Manual Vacuum Aspiration Abortion Done by Doctors and Mid-level Providers in South Africa and Vietnam: A Randomised Controlled Equivalence Trial*, 368 LANCET 1965 (2006); Tracy A. Weitz et al., *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 (2013) (demonstrating that abortion complications were equivalent between newly trained NPs, CNMs, PAs, and physicians).
  16. BUS. & PROF. § 2253(b)(1). "Surgical abortion is the most common term for abortion procedures that use uterine aspiration or evacuation . . . . Medical or 'medication abortion' involves the administration of medications to cause cramping and bleeding and passage of the pregnancy." DUNN ET AL., *supra* note 13, at 23–24. But see Weitz et al., *supra* note 11 (questioning the use of the term surgical abortion to describe aspiration procedures).
  17. Kevin Grumbach et al., *Who Is Caring for the Underserved? A Comparison of Primary Care Physicians and Nonphysician Clinicians in California and Washington*, ANNALS FAM. MED., July/Aug. 2003, at 97, 97.
  18. For information on using state constitutions to challenge parental consent requirements and funding restrictions, see *Using State Constitutions to Protect Reproductive Rights*, CTR. FOR REPROD. RTS. (Mar. 5, 2009), <http://reproductiverights.org/en/project/using-state-constitutions-to-protect-reproductive-rights>.

## I. CALIFORNIA'S ABORTION LANDSCAPE: THE RIGHT VS. THE REALITY OF ABORTION ACCESS

State legislatures across the United States have recently attempted to reduce or frustrate women's access to abortion services. In 2011, state legislators proposed more than 1100 provisions regarding reproductive health and rights, with over two-thirds pertaining specifically to abortion.<sup>19</sup> Of the proposals regarding reproductive health, 135 were enacted, leading to greater restrictions on funding and access to care in thirty-six states.<sup>20</sup>

Amid the increasing abortion restrictions in other states, California's laws still protect a woman's right to abortion. The California Constitution grants an explicit right to privacy, which encompasses the right to choose an abortion.<sup>21</sup> The California Health and Safety Code codifies a woman's right to an abortion.<sup>22</sup> The California Supreme Court also recognizes the "fundamental right . . . to choose whether to bear children."<sup>23</sup> If *Roe v. Wade* were overturned, abortion would still be legal in California.

Yet despite these legal protections, the reality of trying to find an abortion provider and obtain an abortion is difficult for many women in California. Most clinics and abortion providers are sparsely located in rural areas.<sup>24</sup> In fact, over one-fifth of all California counties do not have an abortion provider, thereby leaving tens of thousands of reproductive-age women without access to abortion services in their community.<sup>25</sup> In the Central Valley and other rural communities, family planning clinics often rely on physicians from urban areas who must travel to these communities, thus limiting their availability.<sup>26</sup> Furthermore, the

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19. *Laws Affecting Reproductive Health and Rights: 2011 State Policy Review*, GUTTMACHER INST., <http://www.guttmacher.org/statecenter/updates/2011/statetrends42011.html> (last visited May 17, 2013).

20. *See id.* These enacted restrictions include bans on abortion after twenty weeks, partial-birth abortion bans, increased counseling and waiting periods, ultrasound provisions, prohibitions on insurance coverage of abortion, regulations placing stringent requirements on abortion clinics, and parental notification laws. *See id.*

21. CAL. CONST. art. 1, § 1; *see also* Comm. to Defend Reprod. Rights v. Myers, 625 P.2d 779 (Cal. 1981) (finding that procreative choice is a fundamental right under the California Constitution and that restrictions on Medi-Cal funding of abortions were unconstitutional).

22. Reproductive Privacy Act of 2002, CAL. HEALTH & SAFETY CODE §§ 123460–123468.

23. *See* People v. Belous, 458 P.2d 194, 199 (Cal. 1969).

24. *See* Woodward, *supra* note 10. According to a 2003 study, only approximately 6.3 percent of obstetricians and gynecologists practice in rural California. Grumbach et al., *supra* note 17, at 100 tbl.2.

25. *State Facts About Abortion: California*, *supra* note 9.

26. Jennifer Templeton Dunn & Rachel Bravo, *The Reality v. the Law: Abortion Access in California*, CAL. WOMEN LAW. NEWSL., 2007, available at <http://www.ansrh.org/library/publications.php> (Click "2007 and earlier" at the bottom of the page). The Central Valley is a large valley in the middle of the state, about 450 miles long and between forty to sixty miles wide at various points—approximately

Central Valley and other rural California communities have some of the highest rates of poverty in the state.<sup>27</sup> Many of these rural communities—as well as some urban communities—are designated as medically underserved areas, meaning that they have low ratios of primary care physicians per 1000 people and a significant percent of the population below the poverty level.<sup>28</sup> The concentration of providers in urban areas presents significant barriers for California women who live in rural and other medically underserved areas to obtain abortion care because the state's large size and mountainous geography make travel difficult.<sup>29</sup> Many of these women must travel hundreds of miles to obtain abortion care.<sup>30</sup>

Such long trips may necessitate an overnight stay, taking off several days of work for travel time and the procedure, and arranging for childcare or eldercare if the woman has a family.<sup>31</sup> Even for women with insurance, income, and a means of transportation, finding a provider in their area can be a significant obstacle.<sup>32</sup> These barriers are particularly significant for women with limited means to cover the costs associated with travel to a provider, child or family care while they are away, and possible overnight stays, let alone the cost of the procedure itself.<sup>33</sup> Furthermore, for some women, taking vacation or sick time may not be an option and could threaten their employment.<sup>34</sup>

These geographic and financial barriers cause delays in care, which may increase risks to the pregnant woman's health and safety,<sup>35</sup> add to the cost of the

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two-fifths the land mass of the entire state. The area comprises eighteen different counties spreading from Shasta County in the north (north of San Francisco) to the borders of Los Angeles County in the south. Kenneth W. Umbach, *A Statistical Tour of California's Great Central Valley*, CAL. ST. LIBR. (Aug. 1997), <http://www.library.ca.gov/crb/97/09>.

27. A 2011 census report shows considerable variation in poverty levels across California's counties, with Central Valley counties surrounding Fresno in the top quartile for poverty rates in the state. See Sarah Bohn, *Poverty in California*, PUB. POLY INST. CAL. (Dec. 2011), [http://www.ppic.org/main/publication\\_show.asp?i=261](http://www.ppic.org/main/publication_show.asp?i=261).
28. RURAL POLICY RESEARCH INST., STATE DEMOGRAPHIC & ECONOMIC PROFILES: CALIFORNIA (2007), <http://www.rupri.org/Forms/California2.pdf>.
29. For instance, the distance as the crow flies from Susanville, California (in the northeastern corner of the state), to San Francisco, California, is 205 miles. In order to drive around several national and state parks and forests, however, the driving distance is between 269 miles and 304 miles depending on the route taken. Bus travel for those without a vehicle is estimated to take thirty-two hours. Driving Directions from Susanville, CA, to San Francisco, CA, GOOGLE MAPS, <http://maps.google.com> (follow "Get Directions" hyperlink; then search "A" for "Susanville, CA" and search "B" for "San Francisco, CA" then click "Search").
30. *Hearing on S.B. 1338*, *supra* note 11 (comments in support).
31. See Woodward, *supra* note 10.
32. *Id.*
33. *Id.*
34. *Id.*
35. The risk of complications associated with abortion increases with each week of pregnancy. See Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103

procedure, or result in a woman being denied an abortion<sup>36</sup> because she is too far along in pregnancy by the time she finds a provider. These problems are so prevalent in California that some women have been able to obtain an abortion only with the help of ACCESS, a nonprofit group that is dedicated to helping women find the providers, transportation, funding, and shelter needed to obtain an abortion.<sup>37</sup> Thus, while women in California have a constitutional and legislative “right” to abortion, the scarcity of abortion providers in rural areas impedes the exercise of this right.

## II. PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CERTIFIED NURSE MIDWIVES AS EARLY ABORTION PROVIDERS

Despite the obstacles that arise from a lack of abortion providers in rural and medically underserved areas in California, state law allows only licensed physicians to perform aspiration abortion.<sup>38</sup> This physician-only abortion restriction blocks a large number of qualified, licensed NPs, CNMs, and PAs from providing aspiration abortion. This is counterintuitive because these clinicians are more likely to see patients for family planning services<sup>39</sup> and they perform the majority of initial contraceptive exams for female patients.<sup>40</sup> At some women's health

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OBSTETRICS & GYNECOLOGY 729, 729 (2004); see also Daniel Grossman et al., *Complications After Second Trimester Surgical and Medical Abortion*, 16 REPROD. HEALTH MATTERS 173 (2008); Diana Taylor et al., *When Politics Trumps Evidence: Legislative or Regulatory Exclusion of Abortion From Advanced Practice Clinician Scope of Practice*, 54 J. MIDWIFERY & WOMEN'S HEALTH 4, 5 (2009).

36. Many women are denied access to a desired abortion because they are at an advanced stage in their pregnancy that they reached because of a variety of barriers that include late detection, inappropriate or delayed referrals, difficulty finding a provider, cost barriers, and access barriers. See Diana Greene Foster et al., *Denial of Abortion Care Due to Gestational Age Limits*, 87 CONTRACEPTION 3, 4 (2013); see also *Turnaway Study*, ADVANCING NEW STANDARDS IN REPROD. HEALTH, <http://www.ansirh.org/research/turnaway.php> (last visited June 4, 2013) (describing longitudinal study examining the effects of unintended pregnancy on women's lives, including the effect of seeking an abortion and being “turned away” because they present at the hospital or clinic past the gestational age limits (internal quotation marks omitted)).
37. See Woodward, *supra* note 10. ACCESS Women's Health Justice combines “direct services, community education, and policy advocacy to promote real reproductive options and access to quality health care for California women.” *Welcome to ACCESS*, *supra* note 10.
38. See CAL. BUS. & PROF. CODE § 2253(b)(1) (West 2012).
39. In 2004, NPs, PAs and CNMs saw six times as many women for publicly funded family planning services as did physicians. See JENNIFER J. FROST & LORI FROHWIRTH, GUTTMACHER INST., FAMILY PLANNING ANNUAL REPORT: 2004 SUMMARY 35 (2005).
40. See JENNIFER J. FROST ET AL., GUTTMACHER INST., VARIATION IN SERVICE DELIVERY PRACTICES AMONG CLINICS PROVIDING PUBLICLY FUNDED FAMILY PLANNING SERVICES IN 2010, at 16 (2012) (finding that clinicians performed 65 percent of clinical exams at clinics providing family planning services); Lawrence B. Finer et al., *U.S. Agencies Providing Publicly Funded Contraceptive Services in 1999*, 34 PERSP. ON SEXUAL & REPROD. HEALTH 15, 23 (2002) (finding



clinics, clinicians provide most, if not all, reproductive health services.<sup>41</sup> Clinicians are also more likely than physicians to care for medically underserved and vulnerable populations—including low-income women, women of color, and women without health insurance.<sup>42</sup>

NPs, PAs, and CNMs are formally trained, educated, and licensed health professionals. Both NPs and CNMs are advanced practice registered nurses, meaning that they are registered nurses who hold advanced degrees in nursing science and care.<sup>43</sup> PAs attend a specialized training program associated with a medical school that includes classroom and clinical components.<sup>44</sup> PAs also practice medicine, examine patients, diagnose injuries and illnesses, and provide treatment in accordance with a written protocol signed by a supervising physician.<sup>45</sup> Such educational qualifications, training programs, and experience make clinicians safe and qualified primary care providers.<sup>46</sup>

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that clinicians performed 73 percent of initial contraceptive exams at agencies providing contraceptive services).

41. Jennifer Templeton Schirmer, Note, *Physician Assistant as Abortion Provider: Lessons From Vermont, New York, and Montana*, 49 HASTINGS L.J. 253, 254 (1997).
42. A 2003 study indicated that 49 percent of NPs and 69 percent of PAs in California serve rural and vulnerable populations, compared with 35 percent of obstetricians and gynecologists. Grumbach et al., *supra* note 17, at 100 tbl.2; *see also* Taylor et al., *supra* note 35, at 6; Diana Taylor & Amy Levi, *SB1338: Understanding the Data and the Debate*, ADVANCING NEW STANDARDS IN REPROD. HEALTH BLOG (May 15, 2012), <http://blog.ansirh.org/2012/05/sb1338-debate>.
43. BD. OF REGISTERED NURSING, GENERAL INFORMATION: NURSE-MIDWIFE PRACTICE (2011), available at <http://www.rm.ca.gov/pdfs/regulations/npr-b-31.pdf>; *Certified Nurse-Midwife*, MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/002000.htm> (last updated Sept. 12, 2011); *What's an NP?*, AM. ASS'N NURSE PRAC., <http://www.aanp.org/all-about-nps/what-is-an-np> (last visited June 4, 2013). There are two midwifery professions in California: nurse-midwives and licensed midwives. Licensed midwives have different licensing and educational requirements and are regulated by the Medical Board of California. *See Licensed Midwives*, MED. BOARD OF CAL., <http://www.mbc.ca.gov/allied/midwives.html> (last visited June 4, 2013).
44. *See What Is a PA?*, AM. ACAD. PHYSICIAN ASSISTANTS, [http://www.aapa.org/the\\_pa\\_profession/what\\_is\\_a\\_pa.aspx](http://www.aapa.org/the_pa_profession/what_is_a_pa.aspx) (last visited May 17, 2013).
45. *See id.*; *see also* CAL. ACAD. OF PHYSICIAN ASSISTANTS, THE PHYSICIAN ASSISTANT (13th ed. 2007), available at <http://www.capanet.org/Publications/The-Physician-Assistant>. Although PAs practice medicine under the supervision of a physician, only the scope of the supervising physician's practice can limit the scope of a PA's practice. *Id.* at 5.
46. In a 2011 policy statement, the American Public Health Association commented,
 

In the United States, NPs, CNMs, and PAs have been categorically referred to as “midlevel provider” or “physician extender,” which does not adequately reflect their contribution as independent, safe, and qualified primary care professionals and more than physician substitutes. The Institute of Medicine Committee on the Future of Primary Care and, more recently, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (known together as the Affordable Care Act of 2010) have defined NPs, CNMs, and PAs, along with generalist physicians, as primary care clinicians.

Furthermore, all three types of clinicians routinely perform various specialized procedures, including those that are more medically complicated than early aspiration abortions.<sup>47</sup> For example, depending on a PA's level of experience and skill, she may be the first or second assist in a major surgery.<sup>48</sup> CNMs routinely provide care for women during pregnancy and childbirth,<sup>49</sup> which has a far higher mortality rate than early abortion.<sup>50</sup> NPs specializing in family planning or women's health also perform various procedures such as intrauterine aspirations, insertion of intrauterine devices, cervical and vulvar biopsies, and ultrasound exams.<sup>51</sup> NPs, CNMs, and PAs also routinely provide medication abortion.<sup>52</sup> As part of the provision of medication abortion and other women's healthcare services, clinicians provide pregnancy options counseling, perform ultrasounds, administer and monitor medication, administer paracervical blocks, dilate the cervix, and provide post-abortion follow up care.<sup>53</sup> The skills used in these procedures are the very same skills required to perform early aspiration abortion procedures.<sup>54</sup> In fact, California's abortion restriction prohibits the evacuation or aspiration of the uterus only when performing an abortion.<sup>55</sup> Clinicians may evacuate or aspirate the contents of the uterus (using the same EVA or MVA technique as aspiration abortion) after a miscarriage or incomplete medication abortion.

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*Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants*, AM. PUB. HEALTH ASS'N (Nov. 1, 2011), <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1413> (footnote omitted) (citing PRIMARY CARE: AMERICA'S HEALTH IN A NEW ERA (Molla S. Donaldson et al. eds., 1996)).

47. See *APC's History of Providing Comprehensive Women's Health Care, Including Abortion*, APC TOOLKIT, <http://apctoolkit.org/section2b.html> (last visited June 4, 2013).
48. CAL. ACAD. OF PHYSICIAN ASSISTANTS, *supra* note 45, at 5.
49. BD. OF REGISTERED NURSING, *supra* note 43.
50. See David A. Grimes, *Risks of Mifepristone Abortion in Context*, 71 *CONTRACEPTION* 161, 161 (2005) (discussing findings that in 1997 the risk of death associated with childbirth was 12.9 deaths per 100,000 live births while risk of death associated with any induced abortion was 0.7 deaths per 100,000 procedures); Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *OBSTETRICS & GYNECOLOGY* 215, 215 (2012) ("The risk of death associated with childbirth is approximately 14 times higher than that with abortion.").
51. See *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants*, *supra* note 46; see also *APC's History of Providing Comprehensive Women's Health Care, Including Abortion*, *supra* note 47.
52. Clinicians are authorized to provide medication abortion under CAL. BUS. & PROF. CODE § 2253(c) (West 2012).
53. See *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants*, *supra* note 46.
54. *Steps for Performing Manual Vacuum Aspiration (MVA)*, IPAS WOMANCARE GLOBAL, <http://www.ipas.org/~media/Files/Ipas%20Publications/PERFMVA2E11.ashx> (last visited June 4, 2013).
55. See BUS. & PROF. CODE § 2253(b)(2). Abortion is defined as "any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing live birth." CAL. HEALTH & SAFETY CODE § 123464(a) (West 2012).

Moreover, clinicians have safely provided early aspiration abortions for years in Vermont, New Hampshire, Oregon, Arizona, Montana, and California.<sup>56</sup> At the Planned Parenthood of Northern New England,<sup>57</sup> PAs have performed abortions in clinics in Vermont and New Hampshire for over twenty-four years and have trained medical residents in this procedure.<sup>58</sup> In Oregon, trained NPs have been performing aspiration abortions since at least 2004.<sup>59</sup> NPs in Arizona performed early abortions from 2001 to 2009 until Arizona enacted a physician-only abortion restriction.<sup>60</sup> PAs have been performing abortions in Montana since the U.S. Supreme Court guaranteed a woman's right to an abortion in *Roe v. Wade*, and they have continued to perform abortions after the Montana Supreme Court overturned its physician-only abortion restriction in 1999.<sup>61</sup> Even in California, which continues to have a physician-only abortion restriction for surgical abortions, clinicians have been performing early aspiration abortions since 2007 under a legal waiver that allows a state demonstration project to collect data on patient safety, clinician competency, patient satisfaction, and abortion access.<sup>62</sup> Through this state demonstration project, over forty clinicians have been trained

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56. *Hearing on SB 1338*, *supra* note 11 (comments in support); *see also* Donna Lieberman & Anita Lalwani, *Physician-Only and Physician Assistant Statutes: A Case of Perceived but Unfounded Conflict*, 49 J. AM. MED. WOMEN'S ASS'N 146, 146–49 (1994).
57. Planned Parenthood of Northern New England was formerly Planned Parenthood of Vermont, and also known as the Vermont Women's Health Center. *Our History*, PLANNED PARENTHOOD OF N. NEW ENG., <http://www.plannedparenthood.org/ppnne/our-history.htm> (last visited June 4, 2013).
58. Schirmer, *supra* note 41, at 269; *see also* 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, at F7.
59. Jennifer Dunn & Erin Schultz, *Evidence of Legislative, Legal & Regulatory Environments: Provider Restrictions and Legal Strategies for Establishing Abortion as Within APC Scope of Practice*, APC TOOLKIT, <http://apctoolkit.org/section4d.html> (last visited June 4, 2013).
60. ARIZ. REV. STAT. § 36-2153(D) (LexisNexis Supp. 2012) (prohibiting nonphysicians from providing abortions in Arizona). *See generally* *Arizona: Targeted Regulation of Abortion Providers (TRAP)*, NARAL PRO-CHOICE AM., <http://www.prochoiceamerica.org/government-and-you/state-governments/state-profiles/arizona.html?templateName=template-161602701&issueID=8&sumID=2464> (last visited June 4, 2013). Arizona's physician-only abortion restriction is one of several antiabortion laws passed in the last several years by its pro-life legislature and governor. *See generally* *Arizona: Political Info and Laws in Brief*, NARAL PRO-CHOICE AM., <http://prochoiceamerica.org/government-and-you/state-governments/state-profiles/arizona.html> (last visited June 4, 2013).
61. *See* discussion of *Armstrong v. State* and Montana's physician-only abortion restriction *infra* Part V.
62. *See* DUNN ET AL., *supra* note 13, at 9 n.3. The Health Workforce Pilot Project (HWPP) is a "multi-site prospective study . . . collecting data from 8,000 patients whose first-trimester aspiration abortion is provided by a NP, CNM or PA ('clinicians'), and an equal number of patients seen by physicians (for a total sample size of 16,000 patients), to compare their outcomes to published standards for abortion safety and across provider groups. Approximately sixty clinicians recruited from five organizations (including Planned Parenthood centers and Kaiser Permanente) across California will be trained to competency and evaluated on safety and competency post-training." *HWPP #171 Fact Sheet*, ADVANCING NEW STANDARDS IN REPROD. HEALTH 1 (Dec. 2011), [http://www.ansirh.org/\\_documents/research/pci/HWPPfacts12.11.pdf](http://www.ansirh.org/_documents/research/pci/HWPPfacts12.11.pdf).

in early aspiration abortions and have safely performed abortions on nearly 8000 women over the last five years.<sup>63</sup> These studies and practices clearly indicate that clinicians trained in aspiration abortion procedures are safe and competent abortion providers.

### III. THE EVIDENCE SUPPORTS A CHANGE TO CALIFORNIA'S PHYSICIAN-ONLY ABORTION RESTRICTION

A first trimester abortion is one of the safest types of medical procedures.<sup>64</sup> Complications from having a first-trimester aspiration abortion are considerably less frequent and less serious than those associated with continuing the pregnancy, giving birth, or later-term abortions.<sup>65</sup> Multiple studies since 1986 have confirmed that the safety and efficacy rates of early aspiration abortion do not change by provider.<sup>66</sup> Thus, these studies have shown that an early aspiration abortion performed by a qualified, trained clinician is just as safe as one performed by a trained physician. The studies demonstrate that there are no compelling health or safety concerns sufficient to justify California's physician-only abortion restriction.

A 1986 study to compare health and safety outcomes between women who received early abortions from physicians and women who received them from trained clinicians followed the outcomes from 2458 early abortions and found comparable complication rates associated with procedures performed by PAs to those performed by physicians.<sup>67</sup> A more recent study in 2004 also found that

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63. *HWPP#171 Fact Sheet*, *supra* note 62, at 1–2.

64. Complication rates associated with first trimester abortions are extremely low: Published data from nine peer-reviewed papers comprising a combined sample size of 180,710 aspiration abortions indicate complication rates ranging from 1.3 percent to 4.4 percent. *Id.* at 1.

65. Risks associated with legally-induced abortion after the first eight weeks of pregnancy increase exponentially 38 percent each week of continued pregnancy. See Bartlett et al., *supra* note 35, at 729; see also Grossman et al., *supra* note 35. The pregnancy-associated mortality rate among women who delivered live neonates was 8.8 deaths per 100,000 live births. Raymond & Grimes, *supra* note 50, at 215. The mortality rate related to induced abortion was 0.6 deaths per 100,000 abortions. *Id.*

66. See Freedman et al., *supra* note 15; Goldman et al., *supra* note 15. A study conducted in South Africa and Vietnam confirmed that these results are consistent outside of the United States as well. See Warriner et al., *supra* note 15. For the most recent publication, see Weitz et al., *supra* note 15.

67. An overall rate of 29.1 complications per 1000 procedures was observed, with a rate of 27.4 for abortions performed by PAs and 30.8 for physicians. Freedman et al., *supra* note 15, at 550. The difference between PAs and physicians was not statistically significant. The majority of women underwent an early abortion (between nine and twelve weeks of gestation), although the types of aspiration procedure varied depending on gestational age. *Id.*

abortions performed by experienced PAs had comparable safety and efficacy rates to those performed by physicians.<sup>68</sup>

UCSF completed the most recent study. In 2007, the Office of Statewide Health Planning and Development temporarily waived California's physician-only abortion restriction in order to evaluate the safety and acceptability of advanced practice clinicians providing aspiration abortions.<sup>69</sup> By September 2012, forty-three clinicians received training in aspiration abortion care.<sup>70</sup>

Over the four years of the study, clinicians at participating sites performed 7585 first-trimester aspiration abortions and physicians performed 6195 first-trimester aspiration abortions. The complication rate for abortions performed by the clinicians was comparable to that of the physicians.<sup>71</sup> In fact, the complication rates for both groups were well below the published complication rate for the procedure.<sup>72</sup> Patient satisfaction surveys indicated a high rate of satisfaction with care provided by the clinicians and was slightly higher than the rate given to the

68. Total complication rates were 22.0 per 1000 procedures (95 percent confidence interval [CI]=11.9, 39.2) performed by physician assistants and 23.3 per 1000 procedures (95 percent CI=14.5, 36.8) performed by physicians ( $P=.88$ ). Goldman et al., *supra* note 15, at 1352.

69. *HWPP #171 Fact Sheet*, *supra* note 62. California Health and Safety Code §§ 128125–128195 established the Health Workforce Pilot Project Program. California's HWPP serves as a mechanism to temporarily waive certain practice restrictions in order to test new provider roles and health care delivery systems. See CAL. HEALTH & SAFETY CODE §§ 128125–128195 (West 2012). The California Code of Regulations, §§ 92001–92702, provide the definitions and criteria for administering the HWPP. Nonprofit educational institutions, community hospitals, clinics, and governmental agencies engaged in health or education activities may apply to conduct a pilot project under the HWPP program through the Office of Statewide Health Planning and Development. See *Healthcare Workforce Pilot Projects Program (HWPP)*, CAL. OFF. STATEWIDE HEALTH PLAN. & DEV., <http://www.oshpd.ca.gov/HWDD/HWPP.html> (last updated Apr. 12, 2013). The HWPP waiver applies only to identified health professionals working at demonstration sites participating in the HWPP Project. For an overview of workforce innovation initiatives in California, including a detailed look at the HWPP program, see CATHERINE DOWER & SHARON CHRISTIAN, CAL. HEALTHCARE FOUND., IMPROVING ACCESS TO HEALTH CARE IN CALIFORNIA: TESTING NEW ROLES FOR PROVIDERS (2009), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/I/PDF%20ImprovingAccessHealthCareCATestingNewRoles.pdf>.

70. *ANSIRH Data Update*, *supra* note 15.

71. *HWPP #171 Fact Sheet*, *supra* note 62, at 2. "Overall abortion-related complication rate: 1.5% of all procedures (197 of 14,569) have abortion-related complication diagnoses; this falls well below the expected rate of 5% for total complication diagnoses. . . . Group-specific abortion-related complication rate: 1.6% for NPs, CNMs, and PAs (128 out of 8,036) and 1.1% for physicians (66 out of 6,533); this variation in complication rates between the two groups is within an acceptable clinical margin of difference. 97% (191 out of 197) of abortion-related complications have been minor and completely resolved without adverse outcomes; 6 cases have been classified as major complications and were successfully managed and resolved with appropriate treatment." *Id.*

72. *Hearing on SB 1338*, *supra* note 11.

physicians.<sup>73</sup> The UCSF study is the largest of its kind, and bolsters the findings of the multiple, prior studies that have shown similar results.<sup>74</sup> The comparable complication rates and the high satisfaction rates in the UCSF study further demonstrate the safety and patient benefits in allowing trained clinicians to provide first-trimester aspiration abortions in California.

#### IV. EFFORTS TO REPEAL CALIFORNIA'S PHYSICIAN-ONLY ABORTION RESTRICTION

Supported by the results of the UCSF study, Democratic Senator Christine Kehoe introduced the Early Access to Care Bill (S.B. 1338)<sup>75</sup> in the California Senate in 2012. The bill would have overturned California's physician-only abortion restriction, authorizing NPs, CNMs, and PAs to perform early aspiration abortions,<sup>76</sup> but Senator Kehoe withdrew it that same year.<sup>77</sup> Although nearly all professional associations impacted by the bill supported it,<sup>78</sup> the California Nurses Association (CNA) and the California Catholic Conference opposed it.<sup>79</sup> A separate, stopgap version of the bill passed in September 2012,

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73. Patients reported an average rate of satisfaction well above 9.0 on a scale of 0–10 (0=Completely Unsatisfied, 10=Completely Satisfied), whether they were seen by a NP, CNM and PA (mean=9.4) or a physician (mean=9.3). *HWPP#171 Fact Sheet*, *supra* note 62, at 2.

74. *See* Berer, *supra* note 15; Freedman et al., *supra* note 15; Goldman et al., *supra* note 15; Warriner et al., *supra* note 15.

75. S.B. 1338, 2012 Leg., Reg. Sess. (Cal. 2012).

76. *Id.*

77. Michael Gardner, *Vargas Blocks Abortion Bill: Shows Rift Between San Diego Senators Over Issue*, UNION TRIB. SAN DIEGO, Apr. 26, 2012, <http://www.utsandiego.com/news/2012/Apr/26/vargas-blocks-abortion-bill>; Robin Marty, *California Bill to Expand Access to Safe Abortion Care Gets Stuck in Committee*, RH REALITY CHECK (Apr. 27, 2012, 7:36 AM), <http://www.rhrealitycheck.org/print/19462>.

78. The complete list of supporters included: Asian Communities for Reproductive Justice, ACT for Women & Girls, American Nurses Association of California, California Academy of Physicians Assistants, California Association of Nurse Practitioners, California Family Health Council, California Medical Association, California Nurse Midwives Association, Law Students for Reproductive Justice, League of Women Voters of California, Maternal and Child Health Access, National Asian Pacific American Women's Forum, National Center for Youth Law, National Council for Jewish Women, Nevada County Citizens For Choice, Physicians for Reproductive Choice & Health, Planned Parenthood Mar Monte, Planned Parenthood Shasta Pacific Action Fund, Santa Cruz Mujeres Women's Health Center, Service Employees International Union, Women's Community Clinic, and Women's Health Specialists of California.

79. A primary criticism leveled against the bill by the California Nurses Association (CNA) was that a peer-reviewed journal had not yet published the UCSF study. The CNA argued that S.B. 1338 was "ill-conceived and unnecessary while a study is still in progress under OSHPD's HWPP #171." *Hearing on SB 1338*, *supra* note 11, at 16. These concerns, however, ignored multiple other studies that have demonstrated the safety and efficacy of early aspiration abortions provided by clinicians. *See, e.g.*, Berer, *supra* note 15; Freedman et al., *supra* note 15; Goldman et al., *supra* note 15; Warriner

extending the duration of the UCSF study in order to allow the sponsors the opportunity to publish the data collected during the project.<sup>80</sup> Under this stopgap version of the bill, only clinician participants in the UCSF study may provide early aspiration abortions. California's physician-only abortion restriction remains intact.

In January 2013, Democratic Assemblymember Toni Atkins introduced in the state assembly a new, revised bill that would permanently remove California's physician-only abortion restriction.<sup>81</sup> If the California legislature passes the bill, it would go to the governor for his signature in the summer or in early fall. If the proposed legislation is not enacted by the end of 2013, the physician-only abortion restriction will revert to full effect on January 1, 2014.

## V. CHALLENGING THE CONSTITUTIONALITY OF CALIFORNIA'S PHYSICIAN-ONLY RESTRICTION

While legislation might ultimately lift the physician-only restriction,<sup>82</sup> an alternate course of action for California and other states with strong constitu-

et al., *supra* note 15. Moreover, the UCSF study was subsequently published. See Weitz et al., *supra* note 15.

The California Catholic Conference was the only other opponent of the bill. Since the Catholic Conference opposes abortion generally and "advocates for restrictions on its practice," its arguments that S.B. 1338 would be an "ill-advised and needless reduction in the standard of care for women" is a transparent attempt to restrict access to abortion. *Hearing on SB 1338, supra* note 11, at 16. The Montana Supreme Court rejected using patient safety as a guise for promoting political ideology. See *Armstrong v. State*, 989 P.2d 364, 384 (Mont. 1999). California courts should reject such arguments as well. See *People v. Belous*, 458 P.2d 194, 203 (Cal. 1969). ("[T]he law has always recognized that the pregnant woman's right to life takes precedence over any interest the state may have in the unborn.").

80. The bill, S.B. 623, extends the UCSF study until January 1, 2014 to allow for publication of the study. S.B. 623, 2011 Leg., Reg. Sess. (Cal. 2011). It does not permanently repeal the physician-only restriction in California. See *Hearing on SB 1338, supra* note 11. After passing the state assembly and senate, Governor Jerry Brown signed S.B. 623 on September 22, 2012. *Bill Extends Abortion Test Program for Non-doctors*, MERCURY NEWS, Aug. 30, 2012, [http://www.mercurynews.com/breaking-news/ci\\_21439237/bill-extends-abortion-test-program-non-doctors](http://www.mercurynews.com/breaking-news/ci_21439237/bill-extends-abortion-test-program-non-doctors); Patrick McGreevy & Ari Bloomekatz, *Gov. Jerry Brown Signs 25 Health-Related Bills*, L.A. TIMES, Sept. 23, 2012, <http://articles.latimes.com/2012/sep/23/local/la-me-0923-brown-bills-20120923>.

81. See A.B. 154, 2013 Leg., Reg. Sess. (Cal. 2013). Assemblymember Atkins announced the new bill at a press conference at the capitol on January 22, 2013, marking the fortieth anniversary of *Roe v. Wade*. Jeremy B. White, *Democratic Lawmakers Revive California Bill on Early-Abortion Providers*, SACRAMENTO BEE, Jan. 23, 2013, at 3A. As of June 12, 2013 A.B. 154 had passed out of the Assembly and went to the Senate Business, Professions and Economic Development Committee. Kenny Goldberg, *Bill to Expand Abortion Access Clears California Assembly*, KPBS RADIO (May 29, 2013), <http://www.kpbs.org/news/2013/may/29/bill-expand-access-abortions-clears-california-ass/>. It was in this committee that the previous bill stalled in 2012. See Gardner, *supra* note 77.

82. See, e.g., A.B. 154 2013 Leg., Reg. Sess. (Cal. 2013).

tional protection for the right to privacy and abortion is to challenge the constitutionality of these physician-only restrictions under their state constitutions.<sup>83</sup>

Although a constitutional challenge to a similar state physician-only abortion restriction was not successful at the federal level,<sup>84</sup> many states, including California, provide more robust privacy and abortion protections than the U.S. Constitution.<sup>85</sup> In *Planned Parenthood v. Casey*, the U.S. Supreme Court ceased to recognize abortion as a fundamental right and held that restrictions on abortion were subject to the undue burden test instead of the more stringent strict scrutiny standard.<sup>86</sup> In 1997, in *Mazurek v. Armstrong*, a physician and a PA challenged Montana legislation that restricted PAs from performing abortions, alleging that the physician-only abortion restriction violated the U.S. Constitution.<sup>87</sup> Applying the undue burden test, the U.S. Supreme Court held that the physician-only restriction did not present an undue burden on a woman's right to terminate her pregnancy.<sup>88</sup>

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83. See Schirmer, *supra* note 41 (arguing that Montana's physician-only abortion restriction was unconstitutional under Montana's state constitution); see also *Armstrong*, 989 P.2d at 384 (holding that Montana's physician-only abortion restriction violated the state constitution).

84. *Mazurek v. Armstrong*, 520 U.S. 968 (1997) (per curiam).

85. See, e.g., *Am. Acad. of Pediatrics v. Lungren*, 940 P.2d 797 (Cal. 1997) (finding statutory provision requiring parental notification for a minor's abortion unconstitutional under California State constitution); *Comm. to Defend Reprod. Rights v. Myers*, 625 P.2d 779 (Cal. 1981); Schirmer, *supra* note 41, at 284–85 (citing examples of state constitutions expressly recognizing a right of privacy). For a general discussion of the use of state constitutions to protect the right to abortion, see Linda J. Wharton, *Roe at Thirty-Six and Beyond: Enhancing Protection for Abortion Rights Through State Constitutions*, 15 WM. & MARY J. WOMEN & L. 469 (2009).

86. *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992).

87. *Mazurek*, 520 U.S. at 968. PA Susan Cahill had been performing early abortions for twenty years when, in 1995, Montana antiabortion groups successfully pushed for the passage of a physician-only abortion restriction to exclude PAs from performing abortions. See *Armstrong*, 989 P.2d at 371. When Montana's state legislature passed the abortion restriction, Cahill was one of eleven abortion providers in the state and the only PA in the state performing early abortions. *Id.* She had an impeccable safety record with no complaints filed against her. *Id.*; see also *Dunn & Schultz*, *supra* note 59. After a protracted four-year battle in both federal and state courts to fight the legislation, the Montana Supreme Court found the law unconstitutional in 1999. *Armstrong*, 989 P.2d at 384. PAs and other clinicians in Montana have continued to safely perform early abortions since the Montana Supreme Court decision. *Dunn & Schultz*, *supra* note 59.

88. *Mazurek*, 520 U.S. at 973 (quoting *Casey*, 505 U.S. at 885 (“[T]he Constitution 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.”) (emphasis omitted)). In *Mazurek*, the U.S. Supreme Court held that there was “insufficient evidence” to conclude that the physician-only restriction posed a “substantial obstacle to a woman seeking an abortion.” *Id.* at 972–73. The Court found Cahill's argument that the law created a “substantial obstacle” to abortion was “contradicted by the fact that only a single practitioner [was] affected.” *Id.* at 973. Furthermore, because “Cahill could only perform abortions with a licensed physician . . . present” meant that “no woman seeking an abortion would be required by the new law to travel to a different facility than was previously available.” *Id.* at 973–74. Thus, Montana's physician-only abortion restriction, which decreased the total number of abortion providers in the



Two years later, the same physician and PA challenged the law in the Montana Supreme Court under the state constitution.<sup>89</sup> Similar to California, privacy is explicitly recognized and protected as a fundamental right in the Montana Constitution. Thus, the Montana Supreme Court applied strict scrutiny in its analysis of the physician-only abortion restriction.<sup>90</sup> Under strict scrutiny, the state had to demonstrate a compelling state interest for infringing on a woman's right in "making personal health care decisions and in exercising personal autonomy."<sup>91</sup> The court found that the state's only possible compelling interest that might override the right to personal autonomy in making health decisions was that of "regulat[ing] or preserv[ing] the safety, health and welfare of . . . patients or the general public from a medically-acknowledged *bona fide* health risk."<sup>92</sup> Legislating "under the guise of protecting the patient's health," but in reality for political ideology, personal beliefs, or values, the court deemed was "not only constitutionally impermissible . . . [but] intellectually and morally indefensible."<sup>93</sup>

After reviewing the legislative history and findings, the court found no support for Montana's requirement that previability abortion be performed only by a physician "to the exclusion of a trained, experienced and medically competent physician assistant-certified."<sup>94</sup> The court also found no evidence to support the state's assertion that the physician-only abortion restriction protected the "life, health or safety of women."<sup>95</sup> As a result, the court concluded that the restriction was not grounded in a compelling state interest to protect the life and health of women, but rather was "nothing other than the divisive and vocal politics of abortion." Thus, the court held that the legislation was unconstitutional.<sup>96</sup>

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state from eleven providers to ten providers, did not pose an undue burden within the meaning of *Planned Parenthood of Southeastern Pennsylvania v. Casey*. *Id.* at 974.

89. *Armstrong*, 989 P.2d at 371.

90. *Id.* at 374.

91. *Id.* at 380.

92. *Id.*

93. *Id.*

94. *Id.* at 382. The court found persuasive that Cahill, as a PA, had provided over 3000 abortions with no record of malpractice or professional discipline and had performed them with the same rate of complications as those performed by the coplaintiff physician. *Id.* at 381. The court noted that while the legislature prohibited Cahill from performing early abortions, it did not prohibit her from performing "other more risky medical procedures such as uncomplicated deliveries of babies, inserting IUDs, and prescribing and administering most drugs," thereby further eroding the argument that the prohibition was for the sake of women's safety or health. *Id.*

95. *Id.* at 382.

96. *Id.* at 384.

Like Montana, the California Constitution provides greater protection for the right to privacy and abortion than the U.S. Constitution.<sup>97</sup> Two California Supreme Court cases in particular exemplify the state's broader constitutional protections for privacy and abortion.<sup>98</sup> In *Committee to Defend Reproductive Rights v. Myers*,<sup>99</sup> the California Supreme Court examined the state's abortion funding restrictions under the California Constitution and explicitly rejected the U.S. Supreme Court's analysis of similar funding restrictions in *Harris v. McRae* and in *Maher v. Roe*.<sup>100</sup> Applying strict scrutiny, the California Supreme Court held that federal precedent was not controlling and concluded that the state's funding restrictions were unconstitutional.<sup>101</sup>

Similarly, in *Academy of Pediatrics v. Lungren*, the California Supreme Court refused to apply *Casey*'s undue burden test to the state's parental consent statute.<sup>102</sup> Instead, the court struck down California's law requiring parental

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97. In *American Academy of Pediatrics v. Lungren*, the California Supreme Court explained the "clear and substantial difference" between the analysis under the U.S. Constitution and the California Constitution:

The California Constitution, by contrast [with the federal Constitution], contains in article I, section 1, an explicit guarantee of the right of 'privacy.' This explicit reference to the right of privacy was added to the California Constitution in November 1972, when the electorate approved an initiative measure whose purpose was to provide explicit protection of the right of privacy in the state Constitution. . . . Finally, and most significantly, not only is the state constitutional right of privacy embodied in explicit constitutional language not present in the federal Constitution, but past California cases establish that, in many contexts, the scope and application of the state constitutional right of privacy is broader and more protective of privacy than the federal constitutional right of privacy as interpreted by the federal courts.

940 P.2d 797, 808 (Cal. 1997). In addition to being an explicitly recognized and protected right under the state constitution, the right to an abortion is codified in California's Reproductive Privacy Act. CAL. HEALTH & SAFETY CODE §§ 123460–123468 (West 2012).

98. See *Lungren*, 940 P.2d 797; Comm. to Defend Reprod. Rights v. Myers, 625 P.3d 779 (Cal. 1981).

99. 625 P.3d 779.

100. In *Harris v. McRae* and *Maher v. Roe*, the U.S. Supreme Court upheld restrictions on federal and state funding for abortions. *Harris v. McRae*, 448 U.S. 297, 326 (1980); *Maher v. Roe*, 432 U.S. 464, 474 (1977). The Court reasoned that, "although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation." *McRae*, 448 U.S. at 316. The California Supreme Court explicitly rejected the federal analysis, concluding that "governing California cases . . . have long held that a discriminatory or restricted government benefit program demands special scrutiny whether or not it erects some new or additional obstacle that impedes the exercise of constitutional rights." *Myers*, 625 P.2d at 781. The California Supreme Court concluded that "once the state furnishes medical care to poor women in general, it cannot withdraw part of that care solely because a woman exercises her constitutional right to choose to have an abortion." *Id.* at 798.

101. *Myers*, 625 P.2d at 799.

102. In 1991, the U.S. Supreme Court applied the undue burden standard in *Casey*, upholding a Pennsylvania statute requiring parental consent before a minor could obtain an abortion. *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 899–900 (1992). Even before *Casey* in 1979, the Court upheld a similar Massachusetts parental consent statute in *Bellotti v. Baird*, 443 U.S. 622,

consent for abortion, stating that the “scope and application of the state constitutional right of privacy is broader and more protective of privacy than the federal constitutional right of privacy as interpreted by federal courts.”<sup>103</sup>

Thus, despite the diminishing federal constitutional protections for the right to privacy and abortion, California continues to recognize the right to abortion as a fundamental right. Under a state constitutional analysis, the state must demonstrate a “compelling interest” that is “necessary . . . to the accomplishment of a permissible state policy,” and “narrowly drawn” so as to not impinge on constitutionally protected areas.<sup>104</sup> By applying this standard to California’s physician-only abortion restriction, it becomes clear that the state has no legitimate interest, much less a compelling interest, sufficient to justify the restriction.

Because the right to privacy and abortion is a fundamental right in California, it is the state’s burden to show that the physician-only abortion restriction serves a compelling state interest.<sup>105</sup> Only restrictions necessary to protect a woman’s health or promote public safety and welfare would satisfy that burden in California.<sup>106</sup> So far, all prior studies have demonstrated that clinicians can perform abortions with comparable safety and efficacy to physician providers.<sup>107</sup> Clinicians have been providing aspiration abortion in Montana, Vermont, New Hampshire, and Oregon.<sup>108</sup> NPs also provided abortions in Arizona for several years before the state legislature enacted a physician-only abortion restriction.<sup>109</sup>

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649, 651 (1979). Despite these earlier federal precedents, in 1997, the California Supreme Court struck down the state’s parental consent statute based on the explicit guarantee of the right of privacy in the California Constitution. See *Lungren*, 940 P.2d at 831 (striking down California’s parental consent statute). Compare *Casey*, 505 U.S. 833 (upholding Pennsylvania’s parental consent statute), with *Bellotti*, 443 U.S. 622 (upholding Massachusetts’s parental consent statute).

103. *Lungren*, 940 P.2d at 808.

104. *People v. Belous*, 458 P.2d 194, 200 (Cal. 1969) (alteration in original) (citations omitted); see also *Lungren*, 940 P.2d at 823, 831 (holding state had burden to establish a “compelling” justification that “cannot be achieved by less intrusive means” and that the state failed to demonstrate adequate justification for the statute’s intrusion upon a pregnant minor’s right of privacy under the California Constitution).

105. See *Belous*, 458 P.2d at 199–200; see also *Lungren*, 940 P.2d at 818 (noting that where an abortion restriction impinged on fundamental constitutionally protected privacy interest, the statutory provision “must be evaluated under the ‘compelling interest’ standard, i.e., the defendant must demonstrate a “compelling” state interest which justifies the [intrusion] and which cannot be served by alternative means less intrusive on fundamental rights” (alteration in original) (citation omitted)).

106. See *Myers*, 625 P.2d at 795 (“The budget act seeks to limit first and second trimester abortions, not for the permissible purpose of protecting the woman’s health, but to protect the fetus. The act thus inverts the priority of interests established in *Roe* and improperly subordinates the woman’s right of choice to the lesser state interest in protecting a nonviable fetus.”). See *infra* note 114 for discussion of California cases regarding safety and scope of practice in abortion care.

107. See sources *supra* note 15.

108. See discussion *supra* Part II.

109. See discussion *supra* Part II.

Moreover, forty-three licensed and trained clinicians have been safely providing early aspiration abortion in California for over five years in clinics and hospitals throughout the state.<sup>110</sup> The results of studies from various states reveal the lack of factual basis or evidence to support the position that prohibiting licensed clinicians from performing early abortion protects women's health or safety. Without evidence that clinicians provide abortions at a lower safety or efficacy rate than do physicians, there is no compelling state interest in restricting clinicians from providing abortions. Instead, the primary reasons for this abortion restriction are likely antiabortion sentiment and the desire to restrict competition<sup>111</sup> from nonphysician health providers. A court should not recognize such a poorly disguised attempt to dress antiabortion sentiment and professional protectionism up in the cloak of health and safety as a compelling state interest.

Furthermore, the physician-only abortion restriction is not narrowly tailored. Existing laws governing clinicians already address concerns over the safety, health, and welfare of women. Such laws include the Nursing Practice Act<sup>112</sup> and the Physician Assistant Practice Act,<sup>113</sup> which set forth the scope of practice for NPs, CNMs, and PAs. Clinicians are also licensed by the state and regulated by the Board of Registered Nursing and the Physician Assistant Committee of the California Medical Board.<sup>114</sup> Moreover, hospital and clinic regulations set

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110. See *ANSIRH Data Update*, *supra* note 15.

111. The use of legislation to restrict competition from nonphysician health providers has been the subject of considerable commentary. Barbara J. Safriet, *Closing the Gap Between Can and May in Health-Care Providers' Scopes of Practice: A Primer for Policymakers*, 19 *YALE J. ON REG.* 301 (2002); Press Release, Coal. for Patients' Rights, Coalition for Patients' Rights Opposes Unnecessary Regulation of Valuable Health Care Providers (May 28, 2010), available at <http://www.patientsrightscoalition.org/Media-Resources/News-Releases/Transparency-Act.aspx>; see also Taylor et al., *supra* note 35, at 4. In fact, the first laws prohibiting abortion in the United States were attributed to a campaign by the American Medical Association to restrict competition by nonphysicians. See KRISTIN LUKER, *ABORTION AND THE POLITICS OF MOTHERHOOD* 27 (1984); LESLIE J. REAGAN, *WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867-1973*, at 81 (1997).

112. CAL. BUS. & PROF. CODE §§ 2700-2838.4 (West 2003).

113. CAL. BUS. & PROF. CODE §§ 3500-3546 (West 2011).

114. The Board of Registered Nursing regulates both NPs and PAs while the California Medical Board oversees PAs. In *Bowland v. Municipal Court*, 556 P.2d 1081 (Cal. 1976), three women were charged with the unlicensed practice of medicine for holding themselves out as midwives despite not having valid licenses. The California Supreme Court held that the statute prohibiting the unlicensed practice of the healing arts did not violate the pregnant woman's right to choose who would assist in the delivery of her child. *Id.* at 1088-89. The Court explained that the legislature "may require that those who assist in childbirth have valid licenses. Its interest in regulating the qualifications of those who hold themselves out as childbirth attenders is an equally strong one, for many women must necessarily rely on those with qualifications which they cannot personally verify." *Id.* at 1089. Unlike the unlicensed midwives in *Bowland*, NPs, PAs, and CNMs are all licensed health providers, subject to the regulations and oversight of their governing boards, as well as the training and educational requirements of their respective professions. BUS. & PROF. §§ 2700-2838.4; BUS. & PROF. §§ 3500-3546.

forth the requirements and standards for facilities that provide abortions.<sup>115</sup> These current statutes and regulations governing clinicians and facilities are sufficient to protect the health and safety of women seeking abortions. They are also more narrowly tailored to meet these ends.

Because the state cannot demonstrate a legitimate interest to justify California's physician-only abortion restriction, much less a narrowly tailored compelling interest, the abortion restriction should be found unconstitutional under the state constitution.

### CONCLUSION

California protects a woman's right to abortion and her right to privacy when making medical decisions, making it particularly striking that California has joined more politically conservative states in restricting qualified, licensed clinicians from performing abortions. Legislative proposals to remove California's physician-only abortion restriction and allow clinicians to provide early aspiration abortion would increase access to safe, high-quality abortion services for women in California and promote access to abortion earlier in pregnancy. Such legislative action would have a profound impact on women in rural and medically underserved communities where abortion services are scarce. If legislative efforts to repeal California's physician-only abortion restriction fail, challenging the abortion restriction under the state constitution is a promising alternative avenue.

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115. For an overview of the laws governing abortion in California, see DUNN ET AL., *supra* note 13. See also CAL. CONST. art. 1, § 1; CAL. BUS. & PROF. CODE §§ 2253, 2254 (West 2012); CAL. CIV. CODE § 56.11 (West 2007 & Supp. 2013); CAL. EDUC. CODE § 230 (West 2002 & Supp. 2013), CAL. EDUC. CODE § 46010.1 (West 2006); CAL. FAM. CODE §§ 6920, 6922, 6924, 6925, 6926, 6927, 6928, 6929 (West 2004 & Supp. 2013); CAL. GOV'T CODE § 27491 (West 2008 & Supp. 2013); CAL. HEALTH & SAFETY CODE §§ 1200, 1204 (West 2008 & Supp. 2013); CAL. HEALTH & SAFETY CODE § 7054.3 (West 2007); CAL. HEALTH & SAFETY CODE §§ 102100, 102400, 102775 (West 2006); CAL. HEALTH & SAFETY CODE §§ 102950, 103040.1 (West 2006 & Supp. 2013); CAL. HEALTH & SAFETY CODE §§ 123105, 123110, 123115 (West 2012); CAL. HEALTH & SAFETY CODE §§ 123418, 123420, 123425, 123435, 123440, 123445, 123460, 123462, 123464, 123466, 123468 (West 2012); CAL. PENAL CODE §§ 643 (West 2010); CAL. PENAL CODE §§ 3405, 3406; CAL. PENAL CODE §§ 4023.6, 4028 (West 2011); CAL. PROB. CODE §§ 1801, 1950–1969; CAL. PROB. CODE §§ 2354–2356 (West 2002 & Supp. 2013); CAL. PROB. CODE §§ 4651, 4652 (West 2009); CAL. WELF. & INST. CODE § 220 (West 2008); CAL. WELF. & INST. CODE § 222 (West 2008 & Supp. 2013); CAL. WELF. & INST. CODE §§ 1773, 1774 (West 1998 & Supp. 2013); CAL. WELF. & INST. CODE §§ 5358, 5358.2 (West 2010 & Supp. 2013); CAL. CODE REGS. tit. 5, § 4950, tit. 15, §§ 1122, 1416, 4736, tit. 16, § 1399.541, tit. 17, §§ 915, 916, 100085, tit. 22, §§ 51305.1, 51305.3,–51305.4, 70707.1, 70707.3, 75040, 75041–75044, 75047 (2013).