UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF MAINE

JULIE A. JENKINS, *et al.*,

Plaintiff,

v.

R. CHRISTOPHER ALMY, District Attorney of Penobscot and Piscataquis Counties, *et al.*,

Defendants.

CIVIL NO.: 2:17-cv-00366-NT

DEFENDANTS' MOTION FOR SUMMARY JUDGMENT
WITH INCORPORATED MEMORANDUM OF LAW

Like 33 other states, Maine has a law limiting the performance of abortions to physicians. 22 M.R.S. § 1598. This law, which will be referred to in this brief as the "Physician-Only Law" or "Law," has been in place since 1979. The plaintiffs allege that the Law is unconstitutional because it prohibits Advanced Practice Registered Nurses ("APRNs") from performing abortions. They argue that the Law imposes an undue burden on a woman's access to abortion, in violation of her substantive due process and privacy rights. They also argue that the Law violates the plaintiffs' equal protection rights and those of their patients because it "singles out" abortions as the one health care service that APRNs are statutorily prohibited from providing. The plaintiffs' arguments are without merit and, under the undisputed facts, the defendants are entitled to summary judgment.

The United States Supreme Court has repeatedly held that it is permissible for States to limit the performance of abortions to physicians, even when others could safely perform them. Indeed, the Court has held that States may even require that it be physicians – and not counselors

or other trained professionals – who provide certain information to women in advance of performing abortions. Given these analogous holdings, the Physician-Only Law is constitutional as a matter of law. Even if the Court applies the "substantial obstacle" test that is used when evaluating other kinds of abortion regulations, the Physician-Only Law would pass muster. Quite simply, there is no evidence that the Law imposes an obstacle to abortion access, much less a substantial one.

Because the Supreme Court has held that States may limit the performance of abortions to physicians, the law does not run afoul of the equal protection rights of APRNs or their patients. Moreover, the Supreme Court has recognized that an abortion is a unique medical procedure. Thus, a State does not violate equal protection principles by treating abortion differently than other medical services. In further support, defendants rely upon the following Memorandum of Law:

MEMORANDUM OF LAW

History of Maine's Physician Only Law

Prior to the United States Supreme Court's decision in *Roe v. Wade*, 410 U.S. 113 (1973), it was illegal to perform an abortion in Maine unless "necessary for the preservation of the mother's life." 17 M.R.S. § 51, as enacted by Me. Rev. Stat. 1954, c. 134, § 9.[1] On January 22, 1973, the Supreme Court held in *Roe* that a Texas statute that criminalized abortions except when necessary to save the mother's life violated the Fourteenth Amendment's Due Process Clause. 410 U.S. at 164. The Court noted that "[s]imilar statutes are in existence in a majority of the States," including Maine. *Id*., at 118 & n.2. Thus, the Court's decision in *Roe* effectively abrogated the Maine statute banning abortions.

[1] Prior to 1954, predecessor statutes made it illegal to perform an abortion unless necessary to preserve the life of the mother. *See, e.g.*, Me. Rev. Stat. 1841, c. 160, § 13.

For the next few years, Maine's legislature neither repealed the statute banning abortions nor enacted other statutes directly regulating the performance of abortions. The Legislature did, however, enact a law: 1) protecting health care providers who refuse to perform or assist in the performance of abortions; 2) prohibiting the sale or use of fetuses; and, 3) imposing sanctions on persons who fail "to take all reasonable steps" to preserve the life of a "live born person" resulting from an abortion procedure. P. L. 1973, ch. 518 ("An Act to Provide Protection of Fetal Life and the Rights of Physicians, Nurses, Hospitals and Others Relating to Abortions"). This law, effective October 3, 1973, was codified at 22 M.R.S. §§ 1572-1576, and later recodified to 22 M.RS. §§ 1591-1595. P. L. 1978, ch. 696, §§ 183, 186. In 1977, the Legislature enacted a law requiring physicians to report to the Maine Department of Human Services (now known as the Maine Department of Health and Human Services) certain data regarding abortions they performed. P. L. 1977, ch. 389 ("An Act Relating to Reporting of Data of Abortions Performed by an Attending Physician"). This was codified at 22 M.R.S. § 1577, and later recodified to 22 M.RS. § 1596. P. L. 1978, ch. 696, §§ 184, 186.

It was not until 1979 that the Legislature formally repealed the statute banning abortions (17 M.R.S. § 51) and adopted new measures governing the provision of abortions in Maine. P. L. 1979, ch. 405 ("An Act Relating to Abortions"), codified at 22 M.R.S. § 1598. This Act declared: "It is the public policy of the State that an abortion after viability is to be performed only when it is necessary to preserve the life or health of the mother. It is also the public policy that all abortions may only be performed by a physician." *Id.*, § 2.[2] It declared that only a person licensed to practice medicine as a medical or osteopathic physician may perform an

[2] In 1993, this provision was amended to its current form, which now reads: "It is the public policy of the State that the State not restrict a woman's exercise of her private decision to terminate a pregnancy before viability except as provided in section 1597-A. After viability an abortion may be performed only when it is necessary to preserve the life or health of the mother. It is also the public policy of the State that all abortions may be performed only by a physician." P. L. 1993, ch. 61 § 2.

abortion and made it a crime for a physician to perform an abortion after viability if he or she "knowingly disregarded the viability of the fetus" and "knew that the abortion was not necessary for the preservation of the life or health of the mother." *Id.* As of August 1, 2018, 41 other states had laws restricting the performance of abortions to physicians, although eight of these states allow APRNs to provide medication abortions. Stipulated Facts, ¶ 31 (ECF Doc. 37, PageID # 139).[3]

The Legislature also enacted a statute requiring that a parent generally be notified before an abortion is performed on a person less than seventeen years of age. P.L. 1979, ch. 413 ("An Act to Require Parental Notification of a Minor's Abortion"), codified at 22 M.R.S. § 1597. Finally, it enacted a statute requiring that at least 48 hours before a physician performs an abortion, he or she must provide certain information to the woman and certify in writing before performing the abortion that the woman gave "informed written consent." P.L. 1979, ch. 360 ("An Act to Insure that Informed Consent is Obtained before an Elective Abortion is Performed"), originally codified at 22 M.R.S. § 1598.

Before the parental notification and informed consent statutes went into effect, two physicians and a health clinic filed a lawsuit in the District of Maine arguing that the statutes impermissibly interfered with the constitutional right of women to obtain abortions, as recognized by the Supreme Court in *Roe*. *Women's Cmty. Health Ctr., Inc. v. Cohen*, 477 F. Supp. 542, 544 (D. Me. 1979). In ruling on plaintiffs' motion for a preliminary injunction, the Court held that the plaintiffs were likely to succeed on the merits of their claim that the parental notification statute (Section 1597) was unconstitutional. *Id.*, at 546-48. The Court held that the plaintiffs were not likely to succeed on the merits of their claim that the informed consent statute

[3] The different types of abortions will be discussed below. Essentially, though, a medication abortion involves the use of drugs to cause an abortion. Stipulated Facts, ¶ 2 (ECF Doc. 37, PageID # 132-33).

(Section 1598) was unconstitutional to the extent that it required physicians to provide certain information to women. *Id*., at 548-50. But, the Court held that the plaintiffs were likely to establish that the informed consent statute was unconstitutional to the extent it imposed a 48-hour waiting period. *Id*., at 550-51. The Court thus preliminarily enjoined enforcement of the parental notification statute and the 48-hour waiting period portion of the informed consent statute. *Id*., at 552. It appears that there was no appeal or further proceedings. The parental notification provision was repealed in 1993. P. L. 1993, ch. 61, § 1.[4] The informed consent provision was also repealed in 1993 and replaced with a new informed consent provision not containing a waiting period. P.L. 1993, ch. 61 §§ 3-4, codified at 22 M.R.S. § 1599-A.

Advanced Practice Registered Nurses

APRNs are a category of registered professional nurses with advanced education and training. Complaint, ¶ 2 (ECF Doc. 1, PageID # 2). In Maine, APRNs are authorized to provide "expanded professional health care" so long as it is: 1) "Within the advanced practice registered nurse's scope of practice as specified by the [State Board of Nursing] by rulemaking, taking into consideration any national standards that exist;" and, 2) "In accordance with the standards of practice for advanced practice registered nurses as specified by the board by rulemaking, taking into consideration any national standards that may exist." 32 M.R.S. § 2102(2-A). The requirements for becoming licensed in Maine as an APRN are set forth in rules promulgated by the State Board of Nursing. 02-380 C.M.R. ch. 8 ("Regulations Relating to Advanced Practice Registered Nursing").

[4] In 1989, the Legislature enacted a new statute regarding the obligations of physicians regarding obtaining informed consent of minors. P.L. 1989 ch. 573, codified at 22 M.R.S. § 1597-A. Although the Act is entitled "An Act to Require Parental Consent to a Minor's Abortion," parental consent is not required, and consent by the minor alone may be sufficient.

Maine Family Planning and Planned Parenthood of Northern New England

Maine Family Planning ("MFP") and Planned Parenthood of Northern New England ("PPNNE") provide various health care services, including abortions. Complaint, ¶¶ 16, 19 (ECF Doc. 1, PageID # 6-7). MFP has clinics in eighteen locations – Augusta, Bangor, Belfast, Calais, Damariscotta, Dexter, Ellsworth, Farmington, Fort Kent, Houlton, Lewiston, Machias, Norway, Presque Isle, Rockland, Rumford, Skowhegan, and Waterville. *Id*., ¶ 15 (ECF Doc. 1, PageID # 6), Stipulated Facts, ¶ 4 (ECF Doc. 37, PageID # 133) and Exhibit A thereto (map showing locations of MFP's eighteen locations) (ECF Doc. 37-1, PageID # 145). MFP staffs its Augusta clinic with both physicians and APRNs. Complaint, ¶ 14 (ECF Doc. 1, PageID # 6). MFP staffs all of its other clinics almost exclusively with APRNs, and never with physicians. *Id*., ¶ 15 (ECF Doc. 1, PageID # 6).[5] PPNNE has clinics in four locations – Portland, Topsham, Sanford and Biddeford. *Id*., ¶ 18 (ECF Doc. 1, PageID # 6). PPNNE provides abortions only at its Portland location. *Id*., ¶ 21 (ECF Doc. 1, PageID # 7).[6]

MFP and PPNNE perform two types of abortions during the first trimester of pregnancies – medication abortions and aspiration abortions. Stipulated Facts, ¶ 1 (ECF Doc. 37, PageID # 132). They provide medication abortions during the first ten weeks of pregnancy, as dated from the first day of a woman's last menstrual period ("LMP"), and aspiration abortions through the end of the first trimester, which is 13.6 weeks LMP. *Id*. A medication abortion is typically performed using a regimen of two prescription drugs, mifepristone and misoprostol. *Id*., ¶ 2

[5] As will be discussed in more detail below, the fact that MFP staffs only its Augusta location with physicians does not mean that patients must travel to Augusta to obtain an abortion. Rather, a patient can obtain one type of abortion – a medication abortion – without having to travel to Augusta. Essentially, the patient, after having certain lab work done, connects with a physician over the Internet via a videoconferencing system from either one of MFP's eighteen locations or the patient's own home. The patient then obtains the abortion-inducing medication at the MFP location or at home via mail.

[6] In addition to MFP and PPNNE, women may obtain abortions at the Mabel Wadsworth Center in Bangor, Maine Medical Center in Portland, and Central Maine Medical Center in Lewiston. Defendants' Statement of Undisputed Material Facts ("DSUMF"), ¶ 34.

(ECF Doc. 37, PageID # 132). Mifepristone, also known as RU-486 or by its commercial name Mifeprex, works first by temporarily blocking the hormone progesterone, which is necessary to maintain pregnancy, and by increasing the efficacy of the second medication in the regimen, misoprostol. *Id.* Misoprostol, which the woman generally takes 6-48 hours after the mifepristone, causes the uterus to contract and expel its contents. *Id.* The woman typically passes the pregnancy at home, in a process similar to a miscarriage. *Id.*

In an aspiration abortion (also known as "suction curettage"), the clinician uses a gentle suction to evacuate the contents of the uterus. *Id.*, ¶ 3 (ECF Doc. 37, PageID # 133). To do so, the clinician inserts a small sterile tube through the cervix into the uterus. *Id.* An electric or manual pump attached to the tube creates suction, which empties the uterine contents. *Id.* The procedure takes between five and ten minutes to complete. *Id.*

Five physicians perform abortions at MFP's Augusta clinic on a regular basis. DSUMF, ¶ 17. At its Augusta clinic, MFP provides abortions primarily on Thursdays. *Id.*, ¶ 14. However, in 2017, 48 of the 507 abortions performed at MFP's Augusta clinic were performed on a day other than Thursday. *Id.*, ¶ 15. At MFP, it is rare that a woman has to wait more than two weeks to be scheduled for an aspiration abortion. *Id.*, ¶ 23. MFP provides approximately 500 abortions each year, with 517 in fiscal year 2016, 509 in fiscal year 2017, and 246 in the first half of fiscal year 2018. Stipulated Facts, ¶ 12 (ECF Doc. 37, PageID # 135). MFP pays physicians $90 for each medication and aspiration abortion performed. DSUMF, ¶ 19.

Three physicians perform abortions at PPNNE's Portland facility. *Id.*, ¶ 28. PPNNE provides abortions primarily on Fridays at its Portland clinic. *Id.*, ¶ 29.[7] On a single Friday, a

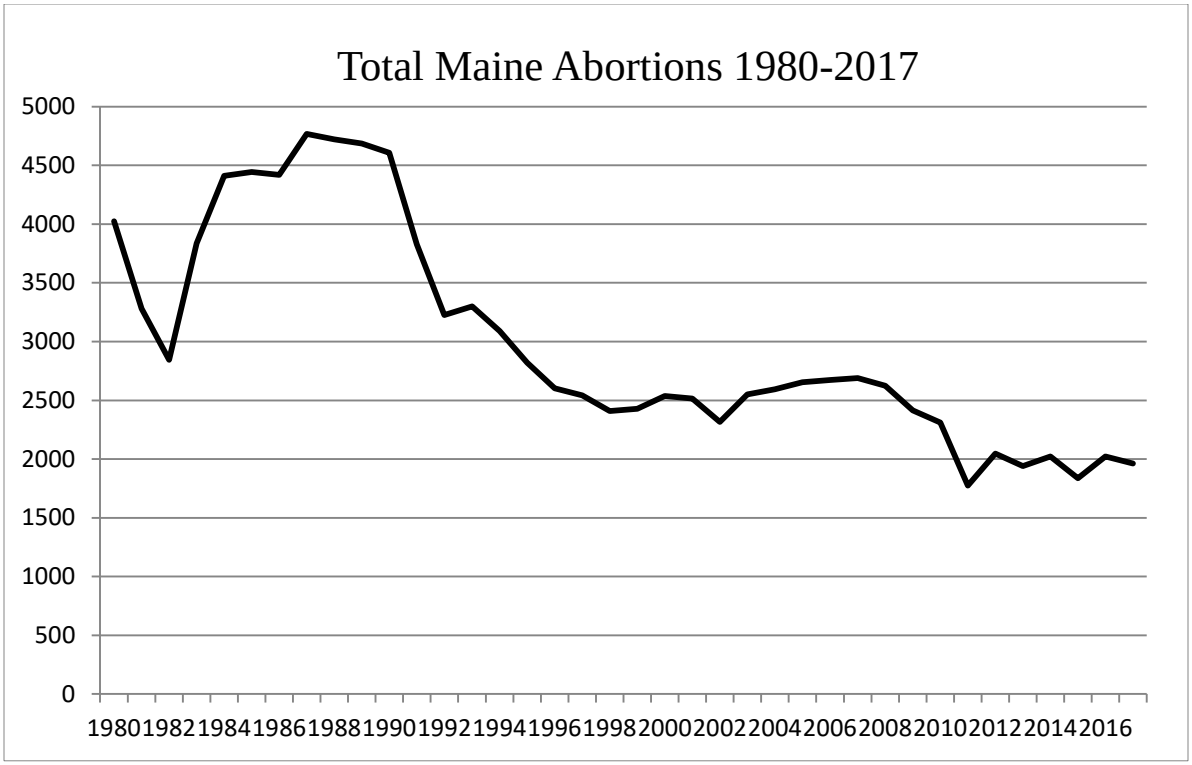
[7] PPNNE may argue that it would be able to offer abortions on other days if APRNs were allowed to perform them. In New Hampshire, though, APRNs are allowed to perform aspiration abortions. DSUMF, ¶ 32. Nevertheless, the PPNNE clinic in Manchester, N.H. provides aspiration abortions only one day a week. *Id.*, ¶ 33.

physician can perform up to 32 abortions, with appointments scheduled from 8:00 a.m. until 1:30 or 2:00 p.m. *Id.*, ¶ 31. PPNNE provides approximately 1,000 abortions each year, with 988 in 2015, 1,057 in 2016, and 995 in 2017. Stipulated Facts, ¶ 23 (ECF Doc. 37, PageID # 137).

Data Regarding Abortions in Maine

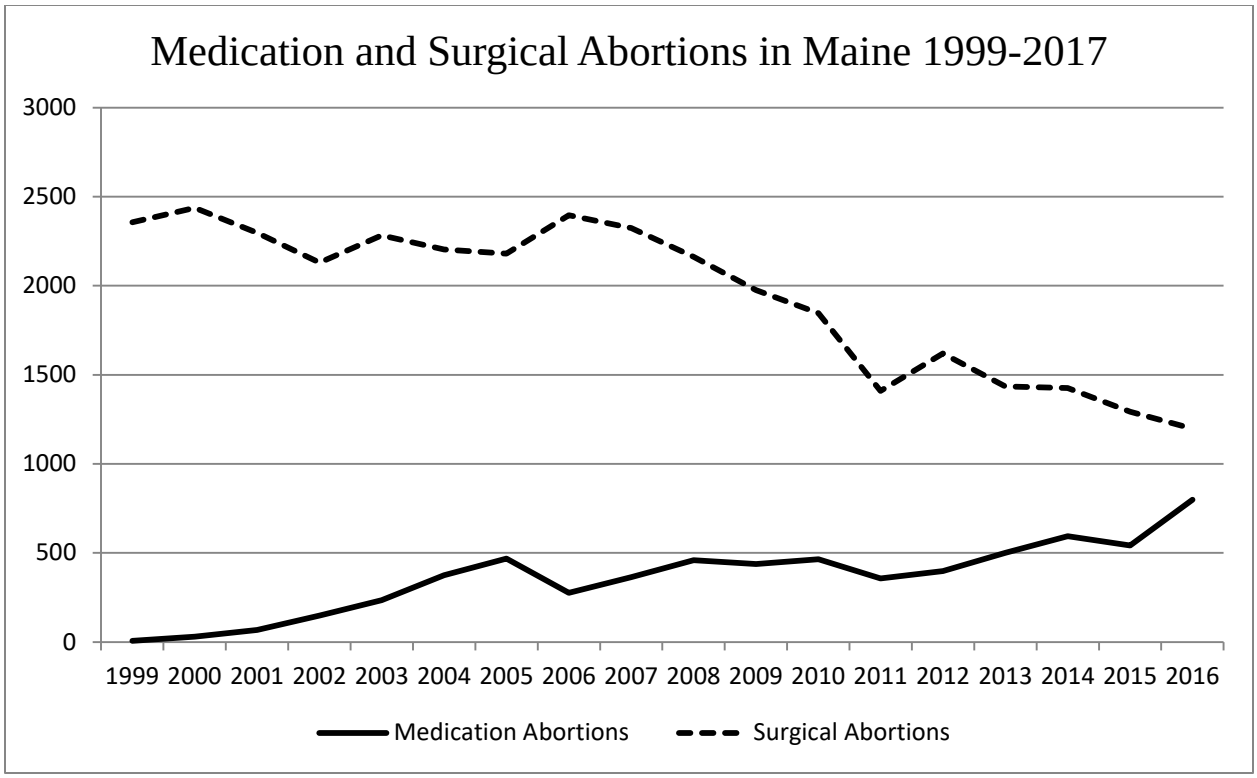
Over the years, there has been a steady decline in the number of abortions performed in Maine. For example, from 1980 to 1990, there were at least 4,000 abortions each year, with the exceptions of 1981, 1982, and 1983. Stipulated Facts, ¶ 34 (ECF Doc. 37, PageID # 140-41). In 1987 and 1988, there were more than 4,700 abortions each year. *Id.* Since 2011, the number of abortions has hovered around 2,000 per year. *Id.* In 2017, there were 1,962 abortions. *Id.* There has also been a decline in the number of live births. In every year from 1980 to 1992, there were at least 16,000 births. *Id.* Since 2011, the number of births has hovered around 12,500. *Id.* There were 12,293 live births in 2017. *Id.*[8] The following chart depicts the decline in abortions in Maine from 1980 through 2017:

[8] There is no evidence in the record regarding the reason for the decline in abortions in Maine. But one plaintiff testified that, in her opinion, the reason for the decreasing number of abortions nationwide is because "the scope of preventative care has expanded to include things like long-active contraceptives" and "that access and opportunity for patients to choose and utilize those methods has significantly reduced the amount of unintended pregnancy." DSUMF, ¶ 41. Presumably, this is also the reason for the decline in abortions in Maine, and this is supported by the fact that the birth rate in Maine has decreased over the years.



Stipulated Facts, ¶ 34 (ECF Doc. 37, PageID # 140-41).

There has also been a trend in the type of abortions performed in Maine – medication abortions have increased while surgical abortions (which are mostly aspiration abortions) have decreased. In 1999, only six medication abortions were performed in Maine. Stipulated Facts, ¶ 35 (ECF Doc. 37, PageID # 141-42). Ten years later, in 2009, 437 medication abortions were performed in Maine. *Id*. And in 2016, 799 medication abortions were performed in Maine. *Id*. During the same time, surgical abortions went from 2,357 in 1999, to 1,976 in 2009, to 1,198 in 2016. *Id*. The following chart depicts the shift away from surgical abortions and toward medication abortions from 1999 through 2017:



Stipulated Facts, ¶ 35 (ECF Doc. 37, PageID # 141-42)

In sum, there has been an overall decline in the total number of abortions performed in Maine in the last 35 years, and in the last fifteen years there has been a shift from surgical abortions to medication abortions.

Restrictions on Abortion Access in Other States

It is important to put Maine's Physician-Only Law in the broader context of the vast array of restrictions other states impose on access to abortion. According to the Guttmacher Institute,[9] 1) nineteen states require that abortions be performed in a hospital after a specified point in the pregnancy; 2) nineteen states require participation by a second physician after a specified point; 3) eighteen states require that before obtaining abortions, women must be given specific

[9] The Guttmacher Institute was founded in 1968 and was originally affiliated with the Planned Parenthood Federation of America. DSUMF, ¶ 4. It bills itself as a "leading research and policy organization committed to advancing sexual and reproductive health and rights in the United States and globally." *Id.*, ¶ 5.

information on things like the purported link between abortion and breast cancer, the ability of a fetus to feel pain, and the long-term mental health consequences for women who have abortions; and, 4) 27 states require women to wait a specified period of time (usually 24 hours) between receiving counseling and performance of the procedure. DSUMF, ¶¶ 6-9. In 37 states, a minor may not obtain an abortion unless a parent has been notified and, in many states, consented. *Id*., ¶ 9. Many states require facilities where abortions are performed to meet licensing standards comparable to those applicable to ambulatory surgical centers. *Id*., ¶ 10. Some states require physicians who perform abortions to have admitting privileges at a local hospital. *Id*., ¶ 11. Maine imposes none of these restrictions on abortion access. Rather, Maine simply requires that abortions be performed by physicians and, as will be discussed below, there is no evidence suggesting that this requirement restricts access to abortion services.

Applicable Legal Standards

In *Roe*, 410 U.S. at 153-54, the Supreme Court held that the right of personal privacy implicit in the United States Constitution includes the right to terminate a pregnancy via an abortion, but that this right "is not unqualified and must be considered against important state interests in regulation." In subsequent decisions, the Court has set forth the analysis to be used when determining whether a particular state regulation impermissibly interferes with the right to choose an abortion. For present purposes, the three most important decisions are *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833 (1992), *Gonzales v. Carhart*, 550 U.S. 124 (2007), and *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

In *Casey*, a plurality of the Court recognized the tension between a woman's right to terminate her pregnancy and a State's interest in protection of a potential life. 505 U.S. at 869-871. To reconcile these competing interests, the Court announced an "undue burden standard."

Id., at 876.[10] Under this standard, "a statute which, while furthering the interest in potential life or some other 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." *Id*., at 877; *see also id*., at 878 ("An undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability."). The relevant inquiry is whether "in a large fraction of cases in which [the law] is relevant, it will operate as a substantial obstacle to woman's choice to undergo an abortion." *Id*., at 895 (emphasis added). "[U]nder the undue burden standard a State is permitted to enact persuasive measures which favor childbirth over abortion, even if those measures do not further a health interest." *Id*., at 886.[11] So long as a law has a valid purpose, the fact that it has "the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Id*., at 874. Again, only when a regulation imposes an "undue burden" on a woman's ability to obtain an abortion is the law invalid. *Id*.

In *Gonzales v. Carhart*, 550 U.S. 124 (2007), the Court reaffirmed the balance struck in *Casey* – before viability, a State may not impose an "undue burden" on a woman's right to an abortion, which "exists if a regulation's 'purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion.'" *Id*., at 146 (quoting *Casey*, 505 U.S. at 878); *see also id*., at 156. A State, may, though, "'create a structural mechanism . . . to express profound respect for the life of the unborn'" so long as it does not impose a "substantial obstacle" on a woman's exercise of her right to an abortion. *Id*. (quoting *Casey*, 505 U.S. at 878). The Court

[10] The undue burden standard applies only to restrictions imposed on pre-viability abortions. After viability, a state may "'regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.'" *Casey*, 505 U.S. at 879 (quoting *Roe*, 410 U.S. at 164-65).

[11] When it comes to regulations intended to protect the health of women seeking abortions, they impose an undue burden – and are thus invalid – if they are "unnecessary" and have the "purpose or effect of presenting a substantial obstacle to a woman seeking an abortion." *Id*., at 878.

recognized that a State "may use its voice and regulatory authority to show its profound respect for the life within the woman." *Id.*, at 157. Further, where a State "has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power to bar certain [abortion] procedures and substitute others, all in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn." *Id.*, at 158; *see also id.*, at 157 (stating that one purpose of the statute at issue was to "express[] respect for the dignity of human life").[12]

Most recently, the Court reaffirmed the *Casey* test in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016). An abortion restriction is unconstitutional if it imposes an "undue burden" on a woman's right to have an abortion. *Id.*, at 2309. The Court noted that at least when it comes to regulations intended to provide a medical benefit, courts must compare "the burdens a law imposes on abortion access together with the benefits those laws confer." *Id.*, at 2309-10. So, for example, if a regulation "provides few, if any, health benefits" and "poses a substantial obstacle to women seeking abortions," it imposes an "undue burden" and is not valid. *Id.*, at 2318. Again, the measure for the undue burden test is whether a substantial number of women are unable to access abortion services due to the regulation. *Casey*, 505 U.S. at 895.

Cases Upholding Physician-Only Laws

Both before and after establishing the standards discussed above, the Supreme Court has upheld statutes regulating who may perform abortions, such as the Physician-Only Law, and has even upheld a statute requiring that it must be a physician who provides certain information to women before performing abortions. In *Roe v. Wade* itself – the case that first recognized the right of women to choose abortions before fetal viability – the Court stated that a State "may define the term 'physician' . . . to mean only a physician currently licensed by the State, and may

[12] At issue in *Gonzales* was a challenge to a federal statute prohibiting so-called "partial-birth abortions."

proscribe any abortion by a person who is not a physician as so defined." *Roe*, 410 U.S. at 165. Two years later, in *Connecticut v. Menillo*, 423 U.S. 9 (1975) (per curiam), the Court held that a State could prohibit a person with no medical training from performing an abortion, stating that "prosecutions for abortions conducted by nonphysicians infringe upon no realm of personal privacy secured by the Constitution against state interference." *Id.*, at 11.[13]

In *Casey*, the state law at issue required, among other things, that at least 24 hours before performing an abortion, a physician (and not any other person) provide information to the woman regarding the nature of the procedure, the health risks of abortion and childbirth, and the probable gestational age of the fetus. 505 U.S. at 881. The district court made several relevant factual findings, including that: 1) trained counselors are "fully capable" of providing the necessary information; 2) requiring physicians to provide the information would make abortions more costly; and, 3) the "state's interest in ensuring that a woman's consent to an abortion procedure is informed and unpressured is in no way furthered by mandating the identity of the person that must obtain the informed consent." *Planned Parenthood of Se. Pennsylvania v. Casey*, 744 F. Supp. 1323, 1352–53 (E.D. Pa. 1990). Nevertheless, the Supreme Court held that the "physician-only disclosure requirement" was constitutional.

Significantly, the Court recognized that its "cases reflect the fact that the 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." *Id.*, at 885. It stated that because there was "no evidence on this record that requiring a doctor to give the information as provided by the statute would amount in practical terms to a substantial obstacle to a woman seeking an abortion, we conclude that it is

[13] Admittedly, the Court in *Menillo* was drawing a distinction between physicians and lay persons, but it nonetheless supports the proposition that States may regulate who may perform abortions.

not an undue burden." *Id*., at 884-85. The Court thus upheld the constitutionality of the provision requiring that it must be a physician who provides the requisite information to women seeking abortions. *Id*., at 885. [14]

Finally, in *Mazurek v. Armstrong*, 520 U.S. 968 (1997) (per curiam), Montana enacted a statute in 1995 restricting the performance of abortions to licensed physicians. The law was challenged by physicians and a physician-assistant. *Id*., at 970. The district court denied the plaintiffs' preliminary injunction on the ground that the plaintiffs had not established "any likelihood of prevailing on their claim that the law imposed an 'undue burden' within the meaning of *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992)." *Id*. The Ninth Circuit reversed. Although it did not dispute that there was insufficient evidence to demonstrate that the physician-only requirement actually imposed a substantial obstacle to access to abortions, the court held that it might nevertheless be invalid if its purpose had been to create such an obstacle. *Id*., at 972.

The Supreme Court reversed, holding that the Ninth Circuit's conclusion that the plaintiffs had a "fair chance" of prevailing "is inconsistent with our treatment of the physician-only requirement at issue in *Casey*." *Id*., at 971. The Court noted that the requirement in *Casey* "involved only the provision of information to patients, and not the actual performance of abortions, yet we nonetheless held . . . that the limitation to physicians was valid." *Id*. (emphasis in original). The Court noted that the district court had found "insufficient evidence" in the record to support the conclusion that the requiring physicians to perform abortions constituted an undue burden. *Id*.

[14] In holding as it did, the Court expressly overruled its earlier decision in *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416 (1983), in which it had struck down a city ordinance requiring that certain information be provided to a woman in advance of an abortion and that the physician who is to perform the abortion must be the person who provides the information. *Id*., at 446-47.

The Court also concluded that even if a legislative purpose to impose a substantial obstacle on obtaining abortions is sufficient, by itself, to invalidate the measure, there was no basis for finding such a purpose with respect to the Montana statute. *Id*., at 972. The plaintiffs argued that Montana's legislature must have had an invalid purpose in enacting the law because the available evidence showed that physician-assistants could perform first trimester abortions as safely as physicians. *Id*., at 973. The Court rejected this argument, holding that it was "squarely foreclosed by *Casey* itself," where the Court had held that States have "broad latitude" to require that particular functions be performed by certain individuals even if the tasks could be performed safely by others. *Id*. Finally, the Court recognized that the Court of Appeals decision was "contradicted by [the Court's] repeated statements in past cases . . . that the performance of abortions may be restricted to physicians." *Id*., at 974 (citing *Roe*, 410 U.S. at 165; *Menillo*, 423 U.S. at 11; *City of Akron*, 462 U.S. at 447); *see also Planned Parenthood of Greater Texas Surgical Health Servs. v. Abbott*, 734 F.3d 406, 412 (5th Cir. 2013) (referring to the "longstanding recognition by the Supreme Court that a State may constitutionally require that only a physician may perform an abortion").

Under the Applicable Standards and Binding Precedent, Maine's Physician-Only Law Does Not Violate a Woman's Right to Have an Abortion.

Given the Supreme Court's pronouncements that States are entitled to restrict the performance of abortions to physicians, *Mazurek*, 520 U.S.at 973; *Roe*, 410 U.S. at 165, there is no need for the Court to assess the extent to which the Physician-Only Law imposes obstacles on access to abortions. *See A Woman's Choice-East Side Women's Clinic v. Newman*, 305 F.3d 684, 688 (7th Cir. 2002) (in *Mazurek*, the Supreme Court "held it constitutional to prevent non-physicians from performing abortions . . . without factual inquiries into whether other medical professionals could do the job as safely, and how much prices may be elevated by a physician-

only rule."). The Law is constitutional and no further inquiry is necessary. But even if the undue burden analysis were to be applied, the Law would survive. The record evidence establishes that the Physician-Only Law does not impose substantial obstacles to the right of women to obtain abortions.

As an initial matter, it is important to note that most, if not all, challenges to abortion restrictions arise when a state imposes a new restriction on the provision of abortions, and the challengers attempt to demonstrate the impact the restriction will have (or has had) on access to abortions. For example, in *Hellerstedt*, Texas passed a statute requiring that physicians have admitting privileges at hospitals within 30 miles from the "abortion facility" and that such a facility meet the standards for a "ambulatory surgical center" under state law. 136 S. Ct. at 2300. The record evidence demonstrated that if these two restrictions went into effect, the number of abortion facilities in Texas would plummet from more than 40 to seven or eight, and that seven or eight facilities would not be capable of providing the 60,000 to 72,000 abortions sought by Texas women each year. *Id*., at 2301-02, 2316-17. In *Planned Parenthood Arizona, Inc. v. Humble*, 753 F.3d 905 (9th Cir. 2014), Arizona imposed restrictions on the manner in which medications are used to perform medication abortions, and the record evidence demonstrated that as a result of these restrictions, medication abortions would not be available to women after the first seven weeks of pregnancy, would cost at least $200 more than they did before, and would require an additional clinic visit. *Id*., at 915-916.[15]

Here, on the other hand, the plaintiffs are challenging a statute regulating abortion that has been in effect for nearly 40 years – essentially since the time that abortions first became legal in Maine. There is, therefore, no "before and after" comparison that can be made here. Quite

[15] There was also evidence that medication abortions at one clinic dropped by 65% as a result of the new restrictions, one clinic was forced to stop providing abortions entirely, and one clinic faced possible closure. *Id*., at 916.

simply, and as in the majority of states, it has always been the case in Maine that abortions must be performed by physicians. This requirement has never before been challenged as imposing a substantial obstacle on access to abortions.

Moreover, the historical data regarding the number of abortions in Maine demonstrates that the Physician-Only Law does not impose substantial obstacle. Demand for abortions has decreased dramatically over the years. For example, between 1984 and 1990, over 4,000 abortions were performed in Maine each year, with a high of 4,767 abortions in 1987. Stipulated Facts, ¶ 34 (ECF Doc. 37, PageID # 140-41). The demand for abortions is much lower now, with only 2,021 abortions performed in 2016 and 1,962 performed in 2017. *Id*. The Physician-Only Law was in effect this entire time. If as many as nearly 4,800 abortions could be performed in one year despite the Law, it is hard to see how the Law imposes a significant obstacle now that demand for abortions is less than half that number.

Plaintiffs claim that the Physician-Only Law imposes a substantial obstacle on access to abortions because it increases distances women must travel to obtain abortions, given that doctors who perform abortions are located only in Portland, Lewiston, Augusta, and Bangor. MFP has clinics staffed by APRNs in a wide geographic area, and they claim that if APRNs could provide abortions, the distances women must travel would be reduced significantly. There are several flaws with this argument.

First, the Supreme Court has recognized that laws that increase the distances women must travel to obtain abortions do not necessarily impose substantial obstacles. In *Casey*, in addition to the "physician-only disclosure requirement" discussed above, another restriction at issue was imposition of a 24-hour waiting period between the physician's provision of information and the

performance of the abortion. *Casey*, 505 U.S. at 885.[16] The district court made several findings regarding the impact of the waiting period: 1) it would force every woman to make at least two trips to an abortion provider; 2) 42% of women seeking abortions travel at least an hour, and sometimes more than three hours, to obtain an abortion from the nearest provider; 3) the waiting period would "force women to double their travel time or stay overnight at a location near the abortion facility," resulting in increased costs for transportation, lodging, food, and child care, and many women might lose additional wages "if forced to miss work on two separate occasions;" 4) for the majority of women, the waiting period would result in delays in the provision of abortions ranging from 48 hours to two weeks; and, 5) in some cases, delays caused by the waiting period would "push patients into the second trimester of pregnancy substantially increasing the cost of the procedure itself and making the procedure more dangerous medically." *Casey*, 744 F. Supp. at 1351-52. While the Supreme Court referred to these findings as "troubling in some respects," it held "they do not demonstrate that the waiting period constitutes an undue burden." *Casey*, 505 U.S. at 886; *see also Planned Parenthood of Greater Texas Surgical Health Servs. v. Abbott*, 748 F.3d 583, 598 (5th Cir. 2014) ("We therefore conclude that *Casey* counsels against striking down a statute solely because women may have to travel long distances to obtain abortions.").

Second, the notion that a woman must always physically travel to the physician's location is not accurate. Maine allows medication abortions to be performed via telemedicine, and it is one of the few states to allow this. DSUMF, ¶ 24. MFP operates a telemedicine program. Stipulated Facts, ¶ 6 (ECF Doc. 37, PageID # 133). A patient goes to one of MFP's clinics

[16] In response to the district court's conclusion that the waiting period did not further the state's interest in the health of the woman, the Court stated that "under the undue burden standard a State is permitted to enact persuasive measures which favor childbirth over abortion, even if those measures do not further a health interest." *Id.*, at 886.

where an APRN evaluates her, including by performing an ultrasound. *Id*. If the APRN determines that the woman is a suitable candidate for a medication abortion, the patient consults by video with a physician, who is usually, but not necessarily, located at MFP's clinic in Augusta. *Id*. After confirming that a medication abortion is medically appropriate for the patient, that the patient has given informed consent to the abortion, and that the APRN has worked with the patient to establish a contraception plan, the physician instructs the patient to take the first pill (mifepristone). *Id*., ¶ 7 (ECF Doc. 37, PageID # 133-34). The patient uses the additional pills (misoprostol) as instructed at home 6–48 hours later, just as she would have if she obtained the first pill from the physician in-person at the Augusta clinic. *Id*. [17]

MFP also provides abortions via a "Meds by Mail" program. Stipulated Facts, ¶ 9 (ECF Doc. 37, PageID # 134). *Id*. Under this program, a woman can go to any health care facility (whether operated by MFP or not) to have an ultrasound and certain lab work done. *Id*. She then makes the reports available to MFP and interacts with MFP providers via a teleconferencing application that can be run on any laptop or smart phone that has a working camera and is connected to the Internet. *Id*. After the teleconference is over, a physician orders that mifepristone and misoprostol be mailed to the patient. *Id*., ¶ 10 (ECF Doc. 37, PageID # 134). The patient takes the pills at home or any other location of her choosing. *Id*.

As a result of the telemedicine and "Meds by Mail" programs, women in Maine can obtain medication abortions with little to no travel. A woman can go to any of MFP's eighteen clinics scattered throughout Maine, including places like Fort Kent, Houlton, Machias, Dexter,

[17] It is worth noting that in 2016, a survey was conducted of 31 women who had obtained telehealth abortions through MFP. DSUMF, ¶ 38. When asked what they would have done had telehealth abortions not been available, not one woman said that she would have forgone having an abortion. *Id*., ¶¶ 39-40. Rather, all of the women said that they would have traveled to Augusta or obtained an abortion from a different provider. *Id*., ¶ 40. In other words, at least for the survey participants, neither distance nor any other factor would have prevented them from obtaining abortions.

and Norway. *See* Stipulated Facts, ¶ 4, Exh. A (map of MFP locations). Under the "Meds by Mail" program, a woman does not even need to go to an MFP clinic. Rather, she can go to any health facility capable of performing ultrasounds and the necessary lab work. So, for example, assuming that a health clinic on Vinalhaven is capable of performing ultrasounds, a resident could obtain an abortion without ever leaving the island. DSUMF, ¶ 27.

Third, neither MFP nor PPNNE can identify a single woman who desired an abortion but was unable to obtain one as a result of any burdens imposed by the Physician-Only Law. DSUMF, ¶ 36.[18] In fact, they cannot identify a single woman in Maine who desired an abortion but, for any reason whatsoever, was unable to obtain one. *Id*., ¶ 37. There is simply no evidence that women in Maine face substantial obstacles in accessing abortion services. While MFP and PPNNE claim that it is impossible for them to determine whether there are women in Maine who wanted abortions but were unable to obtain them, this is simply not true. MFP and PPNNE note that one in five women do not show up for scheduled abortion appointments, and they apparently speculate that at least some of these women were prevented from following through with the abortions by various barriers to access. *See, e.g*., DSUMF, ¶ 35 (one of the barriers to abortion access is cost). But there was nothing preventing MFP and PPNNE from following up with these women to inquire as to the reasons they did not show up for their appointments. And if they had followed up, and some women had said, for example, that they did not come to their appointments because of the travel distances involved, this would at least have been some evidence of the extent to which distance is an obstacle to obtaining an abortion in Maine.[19] But

[18] No individual women are plaintiffs in this matter.

[19] In *Humble*, 753 F.3d at 916, a provider reported that during a period when it could not provide abortions, "many patients said they could not travel to [the next closest] clinic and would have to forego abortions entirely." There is no such evidence here.

without any follow-up, there is simply no way of making any conclusions about the significance, if any, of women not showing up for appointments.[20]

Finally, even if the fact that surgical abortions are provided only in Portland, Lewiston, Augusta, and Bangor does impose significant obstacles on access to abortion, that is a function not of the Physician-Only Law, but of the business decisions of MFP and PPNNE to staff their clinics with APRNs and not physicians. There is no legal impediment to MFP staffing its clinics outside of Augusta with physicians, or at least arranging for a physician to periodically provide abortion services at these clinics. It is not clear whether there is even any practical impediment. MFP has never asked any of the physicians with whom it contracts whether he or she would be willing to work on occasion at a clinic in Fort Kent, Belfast, or any other location outside of Augusta. DSUMF, ¶¶ 20-22. PPNNE and MFP apparently make little effort to recruit physicians. MFP advertises for APRNs through job postings on its own website as well as on external websites, such as JobsinMe, Indeed, LinkedIn, and Monster. Stipulated Facts, ¶ 20 (ECF Doc. 37, PageID # 137). When it comes to contract physicians to provide abortion services, though, MFP does not advertise on its website, other websites, help wanted listings in newspapers, or social media. *Id.*, ¶ 18 (ECF Doc. 37, PageID # 136). Similarly, PPNNE advertises for APRNs through job postings on its own website and on Indeed and JobsinMe, as well as on external websites, but does not formally advertise for contract physician positions. *Id.*, ¶¶ 28, 30. In the absence of any evidence that MFP and PPNNE face obstacles in arranging for physicians to provide abortions at clinics outside of Augusta and Portland, there is no basis for concluding that the Physician-Only Law imposes substantial obstacles on access to abortion.

[20] Presumably, there are all manner of reasons that women might not show up for appointments, including reconsidering the decision to have an abortion, experiencing a miscarriage, or obtaining an abortion from a different provider.

The Physician-Only Law Does Not Violate the Equal Protection Clause

The Equal Protection Clause of the Fourteenth Amendment declares that "No state shall . . . deny to any person within its jurisdiction the equal protection of the laws." Amend. IX, sec. 1. Essentially, this means that States must "treat alike all persons similarly situated." *Toledo v. Sanchez*, 454 F.3d 24, 33 (1st Cir. 2006) (citing *Plyler v. Doe*, 457 U.S. 202, 216 (1982)). If a statute does not burden a suspect class or infringe upon a fundamental right, it is valid so long as is rationally related to a legitimate governmental purpose. *Heller v. Doe* , 509 U.S. 312, 319 (1993). This standard, which the Supreme Court has called a "paradigm of judicial restraint," requires courts to uphold a statutory classification as long as "there is any reasonably conceivable state of facts that could provide a rational basis for the classification." *F.C.C. v. Beach Communications, Inc*., 508 U.S. 307, 313-14 (1993).

A state "has no obligation to produce evidence to sustain the rationality of a statutory classification." *Heller*, 509 U.S. at 320. Rather, the classification "comes to [court] bearing a strong presumption of validity" and the party attacking the statute has "the burden to 'negative every conceivable basis which might support it.'" *Beach Communications*, 508 U.S. at 314-15 (citations omitted). Second, the legislature's actual motivation for enacting a statute is largely irrelevant and the statute will be upheld "so long as <u>any</u> set of facts could suffice to establish a rational relationship between the law and the government's legitimate objectives." *Montalvo-Huertas v. Rivera-Cruz*, 885 F.2d 971, 978 (1989) (emphasis in original). According to the Supreme Court, "because we never require a legislature to articulate its reasons for enacting a statute, it is entirely irrelevant for constitutional purposes whether the conceived reason for the challenged distinction actually motivated the legislature." *Beach Communications,* 508 U.S. at 315; *see also United States Railroad Retirement Bd v. Fritz.*, 449 U.S. 166, 179 (1980) (where

there is a plausible reason for statute, it is "'constitutionally irrelevant whether this reasoning in fact underlay the legislative decision'"); *McGowan v. State of Maryland*, 366 U.S. 420, 426 (1961) ("A statutory discrimination will not be set aside if any state of facts reasonably may be conceived to justify it.").

The plaintiffs make two claims in support of their argument that the Physician-Only Law violates the Equal Protection Clause. First, the Law treats APRNs who wish to provide abortion services differently than APRNs who wish to provide "comparable health services." Complaint, ¶ 154 (ECF Doc. 1, PageID # 34). Second, it treats patients who seek abortion services differently than patients who seek "comparable health care services." *Id.*, ¶ 155. As an initial matter, it is impossible to see how the Physician-Only Law even implicates the Equal Protection Clause. The Physician-Only Law simply bans a specific act – abortions performed by a person other than a physician. That there are some people who wish to perform this act does not mean, for purposes of an equal protection analysis, that they are being treated differently than people who do not want to perform it. If a state bans fireworks, people who wish to set off fireworks do not have an equal protection claim that they are being treated differently than people who do not want to set off fireworks. The same is true with respect to the equal protection claim the plaintiffs make on behalf of their patients. If a state bans the sale of lottery tickets, people who wish to buy lottery tickets do not have an equal protection claim that that they are being treated differently than people who do not wish to buy tickets.[21]

[21] The only conceivable way in which the Physician-Only Law might implicate the Equal Protection Clause is that it treats physicians differently than APRNs. It allows the former to perform abortions, but does not allow the latter to do so. The plaintiffs, though, do not base their equal protection argument on this theory. And, if they did, the argument would fail inasmuch as 1) physicians and APRNs are not similarly situated, and 2) the Supreme Court has expressly held that states may limit the performance of abortions to physicians.

Even if the Equal Protection Clause were implicated here, the plaintiffs' claim would fail. The premise of their argument is that abortion is comparable to any other health care service and so a state cannot apply different rules to it than it applies to other services. The premise is flawed. As the Supreme Court stated, ""[a]bortion is a unique act." *Casey*, 505 U.S. at 852. "Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life." *Harris v. McRae*, 448 U.S. 297, 325 (1980); *see also* DSUMF, ¶ 1 (plaintiff agrees that abortion is the termination of a potential human life). "The long stream of cases that followed *Roe* has only heightened an awareness that for purposes of regulation, abortion services are rationally distinct from other routine medical services, if for no other reason than the particular gravitas of the moral, psychological, and familial aspects of the abortion decision." *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 173 (4th Cir. 2000).

The plaintiffs themselves acknowledge that abortion is a controversial and volatile issue. DSUMF, ¶¶ 2-3. When asked, one plaintiff could not think of any other medical procedure in the United States that is as volatile and politicized as abortion. *Id*., ¶ 12. Some physicians who perform abortions for MFP will not perform abortions as part of their private practice because they do not want to be known as providers of that procedure and because their staff would not support providing abortions. *Id*., ¶ 13. Quite simply, abortion is different than other medical procedures.

Because of the unique nature of abortion, APRNs who wish to provide abortion services are not similarly situated with APRNs who wish to provide other medical services. And, patients who wish to obtain abortions are not similarly situated with patients who wish to obtain other medical services. Thus, the plaintiffs' equal protection claim fails for the basic reason that the

Physician-Only Law does not result in similarly-situated persons being treated differently.

Even if plaintiffs could establish differential treatment among similarly-situated persons, their equal protection claim still would fail. The Supreme Court has expressly recognized that States may limit the performance of abortions to physicians even when the objective evidence demonstrates that others can safely perform the procedure. *Mazurek v*, 520 U.S. at 973. The Court has never suggested that this is true only so long as States limit other medical procedures to physicians. Again, abortion is unique, and States do not run afoul of the Equal Protection Clause by singling it out for special treatment. *See Greenville Women's Clinic*, 222 F.3d at 173 ("The rationality of distinguishing between abortion services and other medical services when regulating physicians or women's healthcare has long been acknowledged by Supreme Court precedent.").

Finally, even if an equal protection analysis were to be applied, the Physician-Only Law would survive. Presumably, plaintiffs are not claiming that the Law burdens a suspect class. They may argue, however, that it infringes upon a fundamental right – the right of women to obtain abortions, as recognized in *Roe*. Assuming, though, that the Court agrees that the Physician-Only Law does not infringe upon this right, as argued above, this necessarily disposes of any argument that it infringes upon a fundamental right. *See Harris*, 448 U.S. at 322 (because the Hyde Amendment did not impinge on the right recognized in *Roe*, it did not implicate a fundamental right for purposes of equal protection analysis); *see also Greenville Women's Clinic*, 222 F.3d at 173 ("having concluded that a law restricting federal funding for abortion violated no constitutionally protected right, the Court [in *Harris*] held it was unnecessary to analyze whether the law infringed a fundamental right for equal protection purposes"). Because no suspect class or fundamental right is implicated, the "rational basis" standard of review

applies. *See Harris*, 448 U.S. at 326 ("Where, as here, the Congress has neither invaded a substantive constitutional right or freedom, nor enacted legislation that purposefully operates to the detriment of a suspect class, the only requirement of equal protection is that congressional action be rationally related to a legitimate governmental interest.").

The Physician-Only Law passes this standard. In light of the Supreme Court's holdings that States may limit the performance of abortions to physicians, it would seem that no other State interest need be asserted. In enacting the Law, Maine was simply doing what the Supreme Court said States may do. As the Supreme Court noted, abortion is the only medical procedure involving "the purposeful termination of a potential life." *Harris*, 448 U.S. at 325. To the extent any further interest need be identified, the Legislature could rationally have concluded that allowing only physicians to perform abortions provides a "structural mechanism" to "express profound respect for the life of the unborn" and the "dignity of human life," *Carhart*, 550 U.S. at 146, 157, and to signal the "unique" nature of the abortion procedure. *Casey*, 505 U.S. at 852. Requiring that it be physicians who perform abortions is a legislative expression of the uniqueness and import of the procedure.

To be clear, properly trained APRNs likely can perform abortions as capably as physicians. Indeed, the Attorney General has proposed legislation repealing the Physician-Only Law and supports expanding the provision of abortion services to APRNs.[22] That said, it cannot reasonably be disputed that physicians occupy a unique position in the medical profession by virtue of their education, training, and experience. The Legislature thus rationally could have concluded that limiting the performance of abortions to physicians is an appropriate way for the State to afford the proper dignity and respect to the procedure. Plaintiffs present a strong case that, from a public policy standpoint, it makes good sense to allow APRNs to perform abortions,

[22] The bill did not get out of committee during the last legislative session.

and they should make their case to Maine's Legislature. Their arguments premised on the Constitution, however, fail.

Conclusion

For the reasons set forth above, the Court should grant defendants' Motion for Summary Judgment and hold that Maine's Physician-Only Law is constitutional.

DATED: September 21, 2018

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this, the 21st day of September 2018, I electronically filed the above document with the Clerk of Court using the CM/ECF system which will send notification of such filing to the following:

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