

11-1-2020

Virginia's Physician-Only Law for First Trimester Abortion: Maintaining the Unduly Burdensome Law Under Falls Church Medical Center, LLC v. Oliver and Its Subsequent Amendment

Emily M. Gindhart
University of Richmond School of Law

Follow this and additional works at: <https://scholarship.richmond.edu/lawreview>



Part of the [Courts Commons](#), [Judges Commons](#), [State and Local Government Law Commons](#), and the [Supreme Court of the United States Commons](#)

Recommended Citation

Emily M. Gindhart, *Virginia's Physician-Only Law for First Trimester Abortion: Maintaining the Unduly Burdensome Law Under Falls Church Medical Center, LLC v. Oliver and Its Subsequent Amendment*, 55 U. Rich. L. Rev. 347 (2020).

Available at: <https://scholarship.richmond.edu/lawreview/vol55/iss1/12>

This Comment is brought to you for free and open access by the Law School Journals at UR Scholarship Repository. It has been accepted for inclusion in University of Richmond Law Review by an authorized editor of UR Scholarship Repository. For more information, please contact scholarshiprepository@richmond.edu.

VIRGINIA'S PHYSICIAN-ONLY LAW FOR FIRST TRIMESTER ABORTION: MAINTAINING THE UNDULY BURDENSOME LAW UNDER *FALLS CHURCH MEDICAL CENTER, LLC V. OLIVER* AND ITS SUBSEQUENT AMENDMENT

INTRODUCTION

Virginia's physician-only law was a narrow exemption from Virginia's general criminal ban on abortion.¹ The general criminal ban on abortion prohibits “any person” from “produc[ing] [an] abortion or miscarriage,” and violation of this prohibition is a Class 4 felony with an “authorized punishment” of “imprisonment of not less than two years nor more than 10 years, and . . . a fine of not more than \$100,000.”² The physician-only law allowed for first-trimester abortions to be provided by physicians licensed by the Virginia Board of Medicine.³ Non-physicians, regardless of medical training, were not exempted from the general criminal ban on abortion; therefore, they were prohibited from providing abortions.⁴

In May 2019, the Eastern District of Virginia considered the constitutionality of the physician-only law in *Falls Church Medical Center, LLC v. Oliver*.⁵ In *Falls Church Medical Center*, four elective abortion providers challenged the physician-only law on the basis that it “unjustifiably limits ‘the pool of abortion providers, even while advanced practice clinicians . . . safely and routinely provide abortion care, including medication and aspiration abortion, in other states throughout the country.’”⁶ While the court ini-

1. VA. CODE ANN. §§ 18.2-71 to -72 (Repl. Vol. 2014).

2. *Id.* §§ 18.2-71, -10(d) (Repl. Vol. 2014 & Cum. Supp. 2020).

3. *Id.* § 18.2-72 (Repl. Vol. 2014).

4. *See id.*

5. *Falls Church Med. Ctr., LLC v. Oliver*, No. 3:18cv428-HEH, 2019 U.S. Dist. LEXIS 76602, at *7 (E.D. Va. May 6, 2019), *vacated in part* by 2019 U.S. Dist. LEXIS 84244 (E.D. Va. May 14, 2019).

6. *Id.* at *3 n.1, *7–8 (quoting Amended Complaint ¶ 73, *Falls Church Med. Ctr.*, 2019

tially granted the Plaintiffs' Motion for Partial Summary Judgment, finding that "there is no genuine issue of material fact as to whether the Physician-Only Law poses a substantial burden on a woman's access to first trimester abortion care,"⁷ just over a week later, the court vacated this decision to "facilitate the development of a full factual record that will enable the Court to better address this question."⁸ Ultimately, while the court found that the evidence is "compelling" that advanced practice clinicians ("APCs") can safely provide abortions, the court determined, based off tangentially related precedent, that the physician-only law was only a mere "inconvenien[ce] for some individuals," not an undue burden.⁹

This physician-only law was purported to serve the state interest of protecting maternal health; however, a substantial body of peer-reviewed research shows there is no medical benefit to a physician providing the abortion service instead of a trained APC, such as a nurse practitioner, physician assistant, or certified nurse-midwife.¹⁰ While the limitation provided no medical benefit, it created a substantial burden to access to first-trimester abortions.¹¹ The requirement arbitrarily and artificially reduced the field of abortion providers, which reduced access by increasing the logistical and actual cost of abortions and increasing wait time.¹² Therefore, the physician-only law was an undue burden on abortion access.¹³

Following the decision, the Virginia General Assembly amended the physician-only law to extend the exemption to "any person jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner."¹⁴ The amended law expands the field of abortion providers; however, it still artificially and arbitrarily limits providers to only physicians and nurse practitioners.¹⁵ Thus, while the law as amended is less burdensome, it is still more burdensome than

U.S. Dist. LEXIS 76602 (E.D. Va. May 6, 2019) (No. 3:18cv428-HEH), ECF No. 41).

7. *Id.* at *26–27 (emphasis in original).

8. Falls Church Med. Ctr., LLC v. Oliver, No. 3:18cv428-HEH, 2019 U.S. Dist. LEXIS 84244, at *4 (E.D. Va. May 14, 2019), *vacating in part* 2019 U.S. Dist. LEXIS 76602 (E.D. Va. May 6, 2019).

9. Falls Church Med. Ctr., LLC v. Oliver, 412 F. Supp. 3d 668, 705–06 (E.D. Va. 2019).

10. *See infra* section I.D.

11. *See infra* section III.B.

12. *See infra* section I.B.

13. *See infra* Part III.

14. Acts of Apr. 9, 2020, chs. 898 & 899, 2020 Va. Acts __, __ & __, __ (codified as amended at VA. CODE ANN. § 18.2-72 (Cum. Supp. 2020)).

15. *See infra* Part IV.

necessary to protect the health of persons seeking first-trimester abortions.¹⁶

Alternatively, in order to ensure only medical professionals with adequate training and experience are providing abortion services, the Virginia General Assembly should appeal the general criminal ban on abortion and instead rely on the existing scope of practice laws, which prohibit APCs from providing medical care outside their training.¹⁷

This Comment seeks to critique the *Falls Church Medical Center's* holding that Virginia's first-trimester physician-only law is not an undue burden on the right to abortion. Part I is an overview of the physician-only law, discussing the historical roots of the law, the impacts of the law on access to first-trimester abortion, related laws in other jurisdictions, and a survey of research conducted on the overall safety and effectiveness of APCs as abortion providers.¹⁸ Part II is an overview of the *Falls Church Medical Center's* three decisions.¹⁹ Part III is an undue burden analysis of the physician-only law, which shows, in light of the lack of health benefits of the physician-only law and the substantial burden to access it creates, the law should be found unconstitutional.²⁰ Part IV analyzes the physician-only law as amended to include licensed nurse practitioners.²¹ Part V looks to Virginia's scope of practice laws for APCs as an assurance that only medically trained persons with education, knowledge, and experience to provide first-trimester abortions will provide these abortions.²²

I. OVERVIEW OF THE PHYSICIAN-ONLY LAW

A. *Historical Roots of the Physician-Only Law*

Throughout human history, abortion has been part of the human experience. In ancient Greece and Rome, midwives provided oral

16. See *infra* Parts IV–V.

17. See *infra* Part V.

18. See *infra* Part I.

19. See *infra* Part II.

20. See *infra* Part III.

21. See *infra* Part IV.

22. See *infra* Part V.

contraceptives and medicated abortions.²³ In common law England, there was no limitation on who performed abortion procedures or provided abortifacients.²⁴ The only limitation on abortion was that providers perform it before “quickening” or within the first four months of pregnancy.²⁵ In colonial America, there was no limitation on who performed or provided abortions as well, with knowledgeable laypersons, midwives, and physicians performing abortions and providing abortifacients.²⁶ Following the criminalization of abortion in the mid-nineteenth century, abortion providers of varied backgrounds and professions persisted in performing the procedure and providing abortifacients despite legal restrictions.²⁷ The physician-only requirement is a relatively recent development, only becoming prevalent following the Supreme Court’s landmark decision of *Roe v. Wade* in 1973.²⁸

1. Pre-Criminalization

In colonial America and early United States, there was no limitation on who could provide abortions. Knowledgeable laywomen, midwives, pharmacists, and physicians commonly advertised and provided abortion procedures and abortifacients.²⁹ However, the prevalence of folk remedies and lack of general medical knowledge contributed to the premature death of many post-abortion.³⁰ Physicians actively debated the safety and effectiveness of various medicinal and procedural practices.³¹ These debates resulted in the

23. John M. Riddle & J. Worth Estes, *Oral Contraceptives in Ancient and Medieval Times*, 80 AM. SCI. 226, 226 (1992).

24. Olga Khazan, *Bringing Down the Flowers: The Controversial History of Abortion*, ATLANTIC (Mar. 2, 2016), <https://www.theatlantic.com/health/archive/2016/03/bringing-down-the-flowers-the-controversial-history-of-abortion/471762/> [https://perma.cc/QK99-W9WN].

25. *Id.*

26. *See infra* section I.A.1.

27. *See infra* section I.A.2.

28. *See infra* section I.A.3.

29. Karen Abbot, *Madame Restell: The Abortionist of Fifth Avenue*, SMITHSONIAN MAG. (Nov. 27, 2012), <https://www.smithsonianmag.com/history/madame-restell-the-abortionist-of-fifth-avenue-145109198/> [https://perma.cc/S2EH-8Z4G] (stating Madame Restell would send “Preventative Powder” and “Female Monthly Pills” through the mail); *Practices Affecting Population*, 26 MED. & SURGICAL REP. 175, 176 (Feb. 24, 1872) (reviewing Ely Van de Warker, *Detection of Criminal Abortion*, J. GYNAECOLOGICAL SOC’Y BOS. (1872)).

30. LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867–1973, at 9–10 (1998).

31. *See, e.g.*, William Henry Weatherly, *Oleum Gossypii—(Cotton-Seed Oil)*, AM. J.

passage of federal and state laws, which restricted the use and sale of abortifacients and the provision of abortion procedures,³² and ultimately general criminal bans on abortions.³³

2. Criminalization

In the mid-to-late nineteenth century, every state criminalized the provision of abortion procedure or abortifacient.³⁴ This push towards criminalization was driven by safety and moral concerns about abortions provided by non-medical providers³⁵ and competition concerns for the American Medical Association.³⁶ The American Medical Association contributed to the push towards criminalization, due to concerns for competition with homeopaths and midwives, who generally provided these procedures.³⁷

In 1848, the Virginia General Assembly enacted its first felony abortion statute, which stated:

Any free person who shall administer to any pregnant woman, any medicine, drug or substance whatever, or use or employ any instrument or other means with intent thereby to destroy the child with which such woman may be pregnant, or to produce abortion or miscarriage, and shall thereby destroy such child, or produce such abortion or miscarriage, unless the same shall have been done to preserve the life of such woman, shall be punished, if the death of a quick child be thereby produced, by confinement in the penitentiary, for not less than one nor more than five years, or if the death of a child, not quick, be thereby produced, by confinement in the jail for not less than one nor more than twelve months.³⁸

PHARMACY, May 1861, at 208–09 (finding no support for the use of oleum gossypii for abortions in southern plantations); *Action of Opium on the Genito-Urinary Organs*, 7 MED. & SURGICAL REP. 442, 442–43 (Feb. 1, 1862) (doubting the effect of opium as an abortifacient).

32. *E.g.*, Comstock Act, ch. 258, 17 Stat. 598 (1873); Tariff Act of 1922, Pub. L. No. 67-318, § 305(a), 42 Stat. 858, 936–37.

33. *E.g.*, Act of Mar. 14, 1848, ch. 120, 1847–1848 Va. Acts 93, 96.

34. REAGAN, *supra* note 30, at 5.

35. *See supra* section I.A.1.

36. Douglas M. Haynes, *Policing the Social Boundaries of the American Medical Association, 1847–70*, 60 J. HIST. MED. & ALLIED SCI. 170, 174–84 (2005).

37. *See id.*

38. Act of Mar. 14, 1848, ch. 120, 1847–1848 Va. Acts 93, 96.

The distinction between a “child” pre- and post-quickening was abandoned in later statutes, and the punishments gradually increased.³⁹ For example, later versions of the Virginia criminalization statute made abortion punishable as a Class 4 felony.⁴⁰ Under Virginia law, the “authorized punishment” for a Class 4 felony was “a term of imprisonment of not less than two years nor more than 10 years, and . . . a fine of not more than \$100,000.”⁴¹

This general prohibition was upheld by the Supreme Court of Virginia, in the 1949 case *Miller v. Bennett*, as the state had an interest in the protection of the “unborn child.”⁴² Furthermore, as the purpose was not for the protection of maternal health, the statute effectively regulated morality, with “[u]nnecessary interruption of pregnancy . . . universally regarded as highly offensive to public morals and contrary to public interest.”⁴³

Despite the general criminalization of abortions, people⁴⁴ continued to seek and have abortions. For example, in the 1950s and 1960s, there were an estimated 200,000 to 1.2 million illegal abortions each year.⁴⁵ People seeking abortions could receive services from “floating abortion rings” or “abortion mills,” where medical professionals would perform the procedure.⁴⁶ For example, in Paris, Virginia, Dr. George Thomas Strother established an abortion mill, which secretly provided expensive abortion procedures with a full medical staff.⁴⁷ Alternatively, many people unable to

39. H.J. Res. 587, Va. Gen. Assembly (Reg. Sess. 2017).

40. VA. CODE ANN. § 18.2-71 (Repl. Vol. 2014).

41. *Id.* § 18.2-10(d) (Cum. Supp. 2020).

42. *Miller v. Bennett*, 190 Va. 162, 169, 56 S.E.2d 217, 221 (1949) (citations omitted).

43. *Id.* (citations omitted).

44. This Comment uses non-gender terms when discussing persons seeking abortions except when limited by the language and reasoning of judicial opinions and research studies. This is in recognition that not all persons seeking abortion procedures identify as cisgender women despite most of the literature and advocacy on abortion access focusing exclusively on cisgender women.

45. Rachel Benson Gold, *Lessons from Before Roe: Will Past be Prologue?*, GUTTMACHER REP. PUB. POL'Y (Mar. 2003) https://www.guttmacher.org/sites/default/files/article_files/gr060108.pdf [<https://perma.cc/6CAJ-JBV6>].

46. Elisabeth Stevens, *When Abortion Was Illegal: A 1966 Post Series Revealed How Women Got Them Anyway*, WASH. POST (June 9, 2019, 7:00 AM), <https://www.washingtonpost.com/history/2019/06/09/when-abortion-was-illegal-post-series-revealed-how-women-got-them-anyway/> [<https://perma.cc/3GZ7-CSUC>]; Benson Gold, *supra* note 45; Jerome E. Bates, *Abortion Mill: An Institutional Study*, 45 J. CRIM. L. CRIMINOLOGY & POLICE SCI. 157, 157 (1955).

47. Stevens, *supra* note 46.

pay for expensive abortions provided by medical personnel, which, on average, cost \$250 to \$500 in 1966 (about \$1978 to \$4352 in 2020 dollars), would be driven to self-induce.⁴⁸ Self-inducements were dangerous and prevalent, with an estimated “10 percent of D.C. General’s obstetrical admissions . . . suffering from spontaneous or criminal abortions.”⁴⁹ Many people died from these criminal abortions; thus, without adequate access to affordable, safe abortion care during criminalization, these persons faced a de facto “death penalty” for abortion, rather than ceasing to have abortions.⁵⁰

3. Post-Criminalization

In 1973, the Supreme Court effectively legalized abortion by holding that women have a fundamental, though qualified, right to abortion, implicit in the Due Process Clause of the Fourteenth Amendment.⁵¹ The right was qualified because the State could regulate abortion if there was “a compelling state interest,” and such regulation was “narrowly drawn.”⁵² During the first trimester of pregnancy, however, “the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman’s attending physician,” not the state.⁵³

In 1973, when the Court decided *Roe*, while many states had already legalized abortion,⁵⁴ Virginia still criminalized non-therapeutic abortions as a Class 4 felony.⁵⁵ However, in order to be compliant with *Roe*, Virginia passed three exceptions to the criminal statute.⁵⁶ For first-trimester abortions, Virginia’s exception re-

48. *Id.*

49. *Id.*

50. *Id.*

51. *Roe v. Wade*, 410 U.S. 113, 122, 166 (1973); *see* U.S. CONST. amend. XIV, § 1.

52. *Roe*, 410 U.S. at 155–56.

53. *Id.* at 164.

54. *Id.*; Amelia Thomson-DeVeaux, *When Abortion Was Only Legal in 6 States*, FIVETHIRTYEIGHT (Aug. 28, 2014), <https://fivethirtyeight.com/features/when-abortion-was-only-legal-in-6-states/> [<https://perma.cc/X8DF-Q9MX>].

55. VA. CODE ANN. § 18.2-71 (Repl. Vol. 1970).

56. VA. CODE COMM’N, REVISION OF TITLE 18.1 OF THE CODE OF VIRGINIA: REPORT OF THE VIRGINIA CODE COMMISSION TO THE GOVERNOR AND THE GENERAL ASSEMBLY, H. Doc. No. 10, at 4 (1974); Editor’s Comments, *Twentieth Annual Survey of Developments in Virginia Law, 1974–1975*, 61 VA. L. REV. 1627, 1711 (1975).

quired abortions to (1) be performed by a state-licensed physician.⁵⁷ For second-trimester abortions, Virginia's exception required abortions to (1) be performed by a state-licensed physician and (2) be performed at a state-licensed hospital.⁵⁸ For third-trimester abortions, Virginia's exception required abortions to (1) be performed in a state-licensed hospital, (2) be certified by the attending physician and two consulting physicians that "the continuation of the pregnancy is likely to result in the death of the woman or substantially and irretrievably impair the mental or physical health of the woman," and (3) have life support available and utilized "for the product . . . if there is any clearly visible evidence of viability."⁵⁹ Thus, while the requirements on the facility and equipment vary depending on the gestational age of the fetus, each exception required abortions to be performed by a state-licensed physician.⁶⁰

B. *Physician-Only Law's Impact on Abortion Access*

Overall, abortion access in Virginia is relatively limited in comparison to states that allow non-physician APCs to provide abortion services.⁶¹ The reduced abortion access impacts a large proportion of Virginia's population, with 1,681,168 biological females of childbearing age (fifteen to forty-four years old).⁶² There are only twelve cities and counties that have facilities, for a total of nineteen facilities, and most of these facilities only offer abortion services a few times a week.⁶³ Thus, only 697,275 (about 41.48%) biological females of childbearing age lived in a locality with an abortion facility, leaving 983,893 (about 58.52%) biological females of childbearing age without an abortion facility in their locality.⁶⁴

57. VA. CODE ANN. § 18.2-72 (Repl. Vol. 2014).

58. *Id.* § 18.2-73 (Repl. Vol. 2014).

59. *Id.* § 18.2-74 (Repl. Vol. 2014).

60. *See supra* notes 57–59.

61. *See infra* section I.C.

62. VA. DEP'T OF HEALTH, VDH MATERNAL AND CHILD HEALTH (2020) [hereinafter VDH 2020 REPORT] (on file with author).

63. Office of Info. Mgmt., *Total Induced Terminations of Pregnancy Occurring Within Virginia for 2017*, VA. DEP'T HEALTH, <https://apps.vdh.virginia.gov/HealthStats/documents/pdf/2017/ITOPXFac17.pdf> [<https://perma.cc/9X9U-3WQE>].

64. VDH 2020 REPORT, *supra* note 62.

Thus, the physician-only law influences the location, timing, and costs of abortion access.

1. Physician-Only Law

Virginia has a general criminal ban on abortion that has remained relatively unchanged since the 1950s, and it states:

if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or miscarriage, he shall be guilty of a Class 4 felony.⁶⁵

Conviction of a Class 4 felony in Virginia carries an “authorized punishment” of “imprisonment of not less than two years nor more than 10 years, and . . . a fine of not more than \$100,000.”⁶⁶ Until its amendment in 2020, Virginia’s physician-only law was a narrow exception to this general criminal ban.⁶⁷ The physician-only law stated:

it shall be lawful for . . . any physician licensed by the Board of Medicine to practice medicine and surgery, . . . to terminate or attempt to terminate a human pregnancy or aid or assist in the termination of a human pregnancy by performing an abortion or causing a miscarriage on any woman during the first trimester of pregnancy.⁶⁸

The Virginia Administrative Code reinforced this physician-only law.⁶⁹ The Code provided that while APCs may serve as facility staff, abortions “shall be performed by physicians who are licensed to practice medicine in Virginia and who are qualified by training and experience”⁷⁰ Furthermore, in order to comply with the Code, abortion facilities needed to maintain policies, procedures, and documentation to guarantee that state-licensed physicians are the only facility staff that provides medicated or surgical abortions.⁷¹

65. VA. CODE ANN. § 18.2-71 (Repl. Vol. 2014).

66. VA. CODE ANN. § 18.2-10(d) (Cum. Supp. 2020); *id.* § 18.2-71 (Repl. Vol. 2014).

67. *See id.* §§ 18.2-71, -72 (Repl. Vol. 2014).

68. *Id.* § 18.2-72 (Repl. Vol. 2014).

69. *See* 12 VA. ADMIN. CODE § 5-412-190 (2019).

70. *Id.*

71. *Id.*

Thus, despite this limitation, APCs still played an integral role in providing other health services. For example, Dr. Joanne Spetz, University of California, San Francisco professor of health economics, testified that APCs “currently carry out every procedure incident to a medication abortion except physically handing the medication to the patient.”⁷² Also, under Virginia’s scope of practice laws, APCs are permitted to provide other medical services with a higher risk of complications, such as labor and delivery services.⁷³ The physician-only requirement, therefore, was an additional limitation on top of the scope of practice laws, which limits the field of abortion providers.

2. Increased Wait Time

Due to the restriction on the field of abortion providers in the state, many people needed to wait extensive periods before receiving abortion care. Generally, people needed to wait a week for the first appointment for the scheduled ultrasound and another week or two for the abortion procedure.⁷⁴ While this timeframe in abstract may appear reasonable, in context to the timeframe of discovering pregnancy and the regulated timeframe for medicated abortion and aspiration abortion, it is long. While there is not a conclusive study to when a person usually discovers their pregnancy, the “clinical symptoms” do not begin until after six weeks.⁷⁵ Furthermore, people with irregular menstrual cycles would likely not discover their pregnancy “right away.”⁷⁶ Despite the delay, first-trimester abortions are only available for the first thirteen weeks and six days of pregnancy and medicated abortions are only available for the first ten weeks.⁷⁷

72. Falls Church Med. Ctr., LLC v. Oliver, 412 F. Supp. 3d 668, 689 (E.D. Va. 2019).

73. VA. CODE ANN. § 54.1-2957.03 (Repl. Vol. 2019); Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 216 (2012).

74. Falls Church Med. Ctr., 412 F. Supp. 3d at 690.

75. Christina Caron, *What Does It Really Mean to Be 6 Weeks Pregnant?*, N.Y. TIMES (Apr. 19, 2020), <https://www.nytimes.com/2020/04/19/parenting/abortion-six-weeks-pregnant.html> [<https://perma.cc/U86C-XWKP>].

76. *Id.*

77. Mifeprex (mifepristone) Information, FDA (Feb. 5, 2018), <https://www.fda.gov/drug/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information> [<https://perma.cc/9TSV-T8A9>]; *Surgical Abortion (First Trimester)*, UCSF HEALTH, <https://www.ucsfhealth.org/treatments/surgical-abortion-first-trimester> [<https://perma.cc/>].

This limited period in conjunction with long wait times can lead people to require second-trimester abortions. As Paulette McElwain, President and CEO of the Virginia League of Planned Parenthood, testified in *Falls Church Medical Center*, this delay can result in people who could have had an abortion in the first trimester waiting until the second trimester.⁷⁸ Beyond the burden of needing to continue a pregnancy because of the limited number of providers, the cost of second-trimester abortions is much higher due to the higher regulatory burden and is far more limited, being available in only two facilities in Virginia.⁷⁹

If the physician-only law exception were expanded to include APCs, the wait time would decrease, according to Virginia abortion providers. For example, Dr. Shanthi Ramesh, Medical Director of the Virginia League of Planned Parenthood, testified, “[i]f APCs were allowed to perform first trimester procedures it would increase ‘the availability of appointment times that work with our patient[s]’ schedules.”⁸⁰ Similarly, Ms. McElwain testified the Hampton, Richmond, and Virginia Beach Planned Parenthoods would be able to increase the number of days abortion services were offered.⁸¹ In Hampton, they would be able to offer abortions, including medicated abortions that are currently not offered, four days a week, in Richmond; they would be able to offer abortions seven days a week; and in Virginia Beach, they would be able to offer abortions six days a week.⁸²

B6X2-J8R6].

78. *Falls Church Med. Ctr., LLC v. Oliver*, No. 3:18cv428-HEH, 2019 U.S. Dist. LEXIS 76602, at *16 (E.D. Va. May 6, 2019), *vacated in part by* 2019 U.S. Dist. LEXIS 84244 (E.D. Va. May 14, 2019).

79. Ann E. Marimow, *Virginia Abortion Laws Upheld Requiring Ultrasound, Waiting Period, Doctor-Only Procedures*, WASH. POST (Oct. 1, 2019, 7:20 PM), https://www.washingtonpost.com/local/legal-issues/virginia-abortion-laws-upheld-requiring-ultrasound-waiting-period-doctor-only-procedures/2019/10/01/21f181e2-e44f-11e9-b403-f738899982d2_story.html [https://perma.cc/A3LK-S2MT]. Compare VA. CODE ANN. § 18.2-73 (Repl. Vol. 2014) (second-trimester abortion exemption to general criminal ban), with *id.* § 18.2-72 (Repl. Vol. 2014) (first-trimester abortion exemption to general criminal ban).

80. *Falls Church Med. Ctr., LLC v. Oliver*, 412 F. Supp. 3d 668, 677, 690 (E.D. Va. 2019).

81. *Id.* at 690.

82. *Id.*

3. Increased Cost

Beyond the potential for undue delay, the physician-only law makes abortion care more expensive than if APCs could provide the same quality of care. There are two primary costs associated with abortion access, overhead costs of the facility, and the logistical costs of the individual seeking a first-trimester abortion.

Regarding overhead costs, the physician-only law requires a facility to either pay for physicians to staff their facilities or limit the availability of physicians.⁸³ These physicians require a higher salary than APCs, for example, in 2018, the median salary for a physician was \$194,500,⁸⁴ significantly higher than nurse practitioners at \$107,030,⁸⁵ and physician assistants at \$108,430.⁸⁶ In Virginia, abortion providers opt to offer abortion services fewer times a week, rather than absorb the additional costs.⁸⁷

The limitation in the number of physicians contributes to a limitation in the number of facilities and available times, which increases the logistical costs for individuals. For example, due to the limited number of facilities, only nineteen in twelve localities, people seeking abortions would need to travel an average of 21.4 miles, and in underserved areas, it may be around 46.9 miles.

In comparison, in 2014, the median number of miles to an abortion facility was 10.79 miles.⁸⁸ The issue of limited abortion facilities and timing is compounded by the ultrasound and twenty-four-hour waiting period, since it usually requires two trips to the facility, with a limited exception for people who travel over one hundred miles.⁸⁹ The increase in logistical costs is not limited to the cost of transportation; it also increases the amount of time off work and

83. *See id.*

84. Jada A. Graves, *Physician Overview*, U.S. NEWS & WORLD REP., <https://money.usnews.com/careers/best-jobs/physician> [<https://perma.cc/XL7E-6GBX>].

85. Jada A. Graves, *Nurse Practitioner Overview*, U.S. NEWS & WORLD REP., <https://money.usnews.com/careers/best-jobs/physician/salary> [<https://perma.cc/8CFM-MEVS>].

86. Jada A. Graves, *Physician Salary*, U.S. NEWS & WORLD REP., <https://money.usnews.com/careers/best-jobs/physician/salary> [<https://perma.cc/GU8Q-BN5N>].

87. *See Falls Church Med. Ctr.*, 412 F. Supp. 3d at 690.

88. Jonathan M. Bearak, Kristen Lagasse Burke & Rachel K. Jones, *Disparities and Change Over Time in Distance Woman Would Need to Travel to Have an Abortion in the USA: A Spatial Analysis*, 2 LANCET PUB. HEALTH 493, 496 (Nov. 2017).

89. *See* VA. CODE ANN. § 18.2-76 (Repl. Vol. 2014).

for childcare.⁹⁰ The increase in logistical costs is especially burdensome on low-income patients, who seek 75% of abortions.⁹¹

4. Illusory Access Leads to Illegal, Unsafe Access

Due to limited access to abortion providers, many people are turning to illegal markets online and in Mexico.⁹² In areas of more restrictive abortion laws, there is a correlation with Google inquiries for the purchase of abortion medications.⁹³ While these searches and purchases may increase access to abortions, there are concerns these medications may be dangerous.⁹⁴ For example, while there may be some reputable groups to purchase abortion medications from over the internet, the Food and Drug Administration (“FDA”) in a warning to Aid Access stated that “substitution of the unapproved drugs for FDA-approved prescription drugs poses significant health risks to U.S. consumers” because the unapproved drug is “not . . . subject to the same protections as use of the FDA approved product” including warning labels about potential complications.⁹⁵

Additionally, beyond using alternative markets for self-abortions, people are finding information about alternative means for self-managed abortions. For example, in a 2018 study of persons using Google to find information about self-managed abortions, of

90. Bearak et al., *supra* note 88, at 498.

91. Heather D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, 19 GUTTMACHER POLY REV. 46, 47 (2016).

92. Becky Little, *The Science Behind the “Abortion Pill,”* SMITHSONIAN MAG. (June 23, 2017), <https://www.smithsonianmag.com/health-medicine/science-behind-abortion-pill-180963762/> [<https://perma.cc/A5CB-99V4>].

93. See Jenna Jerman, Tsuyoshi Onda & Rachel K. Jones, *What Are People Looking for When They Google “Self-Abortion?”* 97 CONTRACEPTION 510, 512 (2018) (showing that “knowledge about legality and accessibility [of abortion services is] mixed” among respondents searching about self-managed abortions).

94. See Hannah Devlin, *Revealed: 21,000 US Women Order Abortion Pills Online in Past Year*, GUARDIAN (May 22, 2019, 2:00 PM), https://www.theguardian.com/world/2019/may/22/revealed-21000-us-women-order-abortion-pills-in-six-months?CMP=Share_AndroidApp_reddit_is_fun [<https://perma.cc/UR79-VEEX>]. E.g., Sarah McCammon, *European Doctor Who Prescribes Abortion Pills to U.S. Women Online Sues FDA*, NPR (Sept. 19, 2019, 12:00 PM), <https://www.npr.org/2019/09/09/758871490/european-doctor-who-prescribes-abortion-pills-to-u-s-women-online-sues-fda> [<https://perma.cc/K9RS-KCJ9>].

95. Letter from Center for Drug Evaluation and Research to Aidaccess.org (Mar. 8, 2019), <https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/aidaccessorg-575658-03082019> [<https://perma.cc/G9EV-BDFZ>].

the respondents who have attempted a self-managed abortion before, 54.8% used herbs or vitamins and 35.5% used alcohol or drugs.⁹⁶ Beyond the likely health risks, self-managed abortions are ineffective; in another 2018 study, only 28% of respondents that reported ever having a self-managed abortions were successful.⁹⁷

Thus, the limited abortion access, due to cost and traveling distance, may be contributing to an increase in self-induced, medicated abortion with unregulated medication.

C. *Other Jurisdictional Approaches*

In the United States, there is a range of statutory requirements for abortion providers, ranging from the most restrictive OB/GYN-only law in Mississippi to the most liberal, APC and physician-only laws in eleven states and the District of Columbia.⁹⁸ Through the restriction and expansion of the field of abortion providers, legislators have been able to decrease or increase abortion access, respectively, in their states.⁹⁹

1. OB/GYN-Only Law

The most restrictive abortion provider law in the United States is found in Mississippi, which requires, “[a]ll physicians associated with an abortion facility . . . be board certified or eligible in obstetrics and gynecology”¹⁰⁰ The OB/GYN restriction is part of a concerted effort by some Mississippi politicians to reduce abortion access in the state, such as Governor Phil Bryant, who signed the bill into law, declaring he will make Mississippi “abortion-free.”¹⁰¹

96. Jerman et al., *supra* note 93, at 513.

97. D. Grossman, L. Ralph, S. Raifman, U. Upadhyay, C. Gerdtts, A. Biggs & D.G. Foster, *Lifetime Prevalence of Self-Induced Abortion Among a Nationally Representative Sample of U.S. Women*, 97 *CONTRACEPTION* 460, 460 (2018).

98. *See infra* sections I.C.1, I.C.3.

99. *See infra* sections I.C.1–3.

100. MISS. CODE ANN. § 41-75-1(f).

101. Richard Fausset, *Mississippi Appears Poised to Close State's Sole Abortion Clinic*, L.A. TIMES (Apr. 6, 2012, 12:00 AM), <https://www.latimes.com/nation/la-xpm-2012-apr-06-la-na-nn-mississippi-abortion-issue-20120406-story.html> [<https://perma.cc/Z6P8-HFJT>]. (“Please rest assured that I also have not abandoned my hope of making Mississippi abortion-free.”).

Following the law's passage, some were concerned the only abortion clinic in the state, Jackson Women's Health would be forced to close.¹⁰² While Jackson Women Health is still open,¹⁰³ no new abortion providers have opened, and the only Planned Parenthood in the state does not provide abortion services.¹⁰⁴

In the 2018 case of *Jackson Women's Health Org. v. Currier*, U.S. District Judge Daniel refused to declare the OB/GYN restriction "facially unconstitutional."¹⁰⁵ In the court's decision, the judge concluded the law was beneficial to Mississippi women, by ensuring women would be seen by known "specialists in women's reproductive healthcare" because OB/GYNs are required to "complete a four-year residency in obstetrics and gynecology."¹⁰⁶ Furthermore, the court rejected the Plaintiff's argument that by limiting the provider pool, the statute causes an undue burden to abortion access, on the basis that since its enactment, the number of abortions performed increased by 17%.¹⁰⁷ Thus, the court found in favor of the Defendants, upholding the OB/GYN restriction.¹⁰⁸

While the district court in Mississippi upheld the law, similar OB/GYN restrictions were enjoined in Arkansas and Louisiana.¹⁰⁹ In Arkansas, the OB/GYN requirement was permanently enjoined by U.S. District Judge Kristine Baker, after the state's only surgical abortion clinic was unable to find OB/GYNs to replace their staff of general practicing physicians, which would have led to its closure.¹¹⁰

102. Maya Dusenbery, *Mississippi Could Lose Its Only Abortion Clinic*, MOTHER JONES (Apr. 6, 2012), <https://www.motherjones.com/politics/2012/04/mississippi-could-lose-its-only-abortion-clinic/> [https://perma.cc/76VG-RU5Y].

103. See *Abortion Information*, JACKSON WOMEN'S HEALTH ORG., <https://jacksonwomenhealth.com/abortion-information/> [https://perma.cc/7YFW-KM9N].

104. See Zoë Beery, *What Abortion Access Looks Like in Mississippi: One Person at a Time*, N.Y. TIMES (June 13, 2019), <https://www.nytimes.com/2019/06/13/magazine/abortion-mississippi.html> [https://perma.cc/M8E6-TYDT]; *Hattiesburg Center of Hattiesburg, MS*, PLANNED PARENTHOOD, <https://www.plannedparenthood.org/health-center/mississippi/hattiesburg/39401/hattiesburg-center-4078-90330> [https://perma.cc/BF7M-KHT4].

105. *Jackson Women's Health Org. v. Currier*, 320 F. Supp. 3d 828, 832 (S.D. Miss. 2018).

106. *Id.* at 837.

107. *Id.* at 838–40.

108. *Id.* at 832, 842.

109. *An Overview of Abortion Laws*, GUTTMACHER INST. (July 1, 2020), <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws> [https://perma.cc/98PR-6JTY].

110. Jennifer Calfas, *Judge Temporarily Blocks Arkansas Laws Banning Abortion*, WALL ST. J. (Aug. 6, 2019, 9:37 PM), <https://www.wsj.com/articles/judge-temporarily-blocks-arkansas-laws-banning-abortion-11565136233> [https://perma.cc/6SQ4-ZBG4].

2. Qualified Physician-Only Law

Seven states, Hawaii, Massachusetts, New Jersey, New Mexico, New York, Rhode Island, and Washington, have qualified, physician-only laws, which only require state licensure when a person undergoes a surgical abortion, not medicated abortion.¹¹¹ For example, in New Jersey, the law states:

The termination of a pregnancy at any stage of gestation is a procedure, which may be performed only by a physician licensed to practice medicine and surgery in the State of New Jersey. "Procedure" within the meaning of this subsection does not include the issuing of a prescription and/or the dispensing of a pharmaceutical.¹¹²

Thus, while APCs can provide medicated abortions, such as with mifepristone and misoprostol, for aspiration abortions, a physician is still required.

3. Physician and APC-Only Law

Eleven states, California, Colorado, Connecticut, Illinois, Maine, Montana, New Hampshire, Oregon, Vermont, West Virginia, and, as of July 1, 2020, Virginia and the District of Columbia, permit both physicians and APCs to provide both surgical and medical abortions.¹¹³ For example, in California, the statute states:

A person shall not be subject to [statute prohibiting unauthorized practice of medicine] if he or she performs an abortion by medication or aspiration techniques in the first trimester of pregnancy, and at the time of so doing, has a valid, unrevoked, and unsuspended license or certificate obtained in accordance with the Nursing Practice Act or the Physician Assistant Practice Act, that authorizes him or her to perform the functions necessary for an abortion by medication or aspiration techniques.¹¹⁴

Thus, the statute expands access to abortion by expanding the field of providers.¹¹⁵ Furthermore, several studies conducted in

111. GUTTMACHER INST., *supra* note 109.

112. N.J. ADMIN. CODE § 13:35-4.2(b).

113. GUTTMACHER INST., *supra* note 109.

114. CAL. BUS. & PROF. CODE § 2253 (citations omitted); *see id.* § 2052.

115. Julie Balch Samora & Nan Leslie, *The Role of Advanced Practice Clinicians in the Availability of Abortion Services in the United States*, 36 J. OBSTETRIC GYNECOLOGIC & NEONATAL NURSING 471, 471–73 (2007); Lee Romney, *The Abortion Wars: New Class of Abortion Providers Helps Expand Access in California*, L.A. TIMES (Oct. 23, 2014, 6:30 AM), <https://www.latimes.com/nation/la-na-abortion-california-20141023-story.html> [https://per

these jurisdictions indicate that the risk of complications did not increase with an increase in the field of legal providers.¹¹⁶

D. APCs Can Safely Provide Abortion Services

In the 1990s, there was a significant shift in the healthcare workforce, with the provision of general health care shifting from physicians to APCs.¹¹⁷ Furthermore, since 1990, many states have enacted laws, which expanded the scope of practice of APCs, with the overall aim of cost containment.¹¹⁸ While APCs' practice scope is necessarily less than physicians for complex procedures, for relatively safe procedures and medicated processes, APCs provide a similar quality of care to physicians.¹¹⁹

Overall, legally obtained abortions are among the safest medical procedures with a 2.1% complication rate and a less than 0.25% major complication rate.¹²⁰ For first-term abortion procedures, aspiration abortion has a complication of 1.3%, and medical abortion has a complication rate of 2%.¹²¹ These rates are considerably lower than the rates and severity of risks associated with childbirth, which have a risk of death that is fourteen times greater than abortion.¹²² These relatively low-risk rates are not sacrificed when APCs provide abortion services, as evidenced by many studies conducted as early as 1986.¹²³

ma.cc/9DTD-ZYX2].

116. See *infra* section I.D.

117. Benjamin G. Druss, Steven C. Marcus, Mark Olfson, Terri Tanielian & Harold Alan Pincus, *Trends in Care by Nonphysician Clinicians in the United States*, 348 NEW ENG. J. MED. 130, 130–31 (2003).

118. *Id.* at 131.

119. John N. Mafi, Christina C. Wee, Roger B. Davis & Bruce E. Landon, *Comparing Use of Low-Value Health Care Services Among U.S. Advanced Practice Clinicians and Physicians*, 165 ANNALS INTERNAL MED. 237, 238, 244 (2016).

120. Usama D. Upadhyay, Sheila Desai, Vera Zlidar, Tracy A. Weitz, Daniel Grossman, Patricia Anderson & Diana Taylor, *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTETRICS & GYNECOLOGY 175, 181 (Jan. 2015).

121. Karima R. Sajadi-Ernazorova & Christopher L. Martinez, *Abortion Complications*, STATPEARLS, <https://www.ncbi.nlm.nih.gov/books/NBK430793/?report=classic> [https://perma.cc/44C5-PV9Q] (last updated May 24, 2020).

122. Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 216 (2012).

123. Mary Anne Freedman, David A. Jillson, Roberta R. Coffin & Lloyd F. Novick, *Comparison of Complication Rates in First Trimester Abortions Performed by Physician Assistants and Physicians*, 76 AM. J. PUB. HEALTH 550, 552 (1986).

In the 1986 study, researchers analyzed the outcomes of 2458 first-trimester abortions obtained at the Vermont Women's Health Center from January 1, 1981, through December 31, 1982.¹²⁴ When women visited the center for abortion services, the next available provider, either a physician or physician assistant, would determine which abortion procedure was most appropriate, depending on gestational age and other factors, and then perform the abortion.¹²⁵ Four weeks following the abortion procedure, the women would attend an additional appointment either at the center or with her personal physician.¹²⁶ During the follow-up, an abstract form would be completed, which detailed any complications experienced post-abortion, including uterine hemorrhage, uterine perforation, cervical laceration, incomplete abortion, infection, post-abortion syndrome, and vagal reaction.¹²⁷ The rate of complication for physician assistants, 2.74%, was lower than that of physicians, 3.08%, with an overall complication rate of 2.91%.¹²⁸ These results mirrored those of a 2004 study, which found a complication rate of 2.2% for physician assistants and 2.3% for physicians.¹²⁹

Similarly, in a 2013 study conducted in California, researchers compared abortion-related complications in 11,487 aspiration abortions provided at four Planned Parenthood clinics and one Kaiser Permanente clinic.¹³⁰ Before the start of the study, APCs at these clinics were "trained to competence" in aspiration abortion procedures, as defined as "a minimum of 40 procedures over 6 clinical days."¹³¹ These newly trained APCs' complication rates were compared with the complication rates of practicing physicians at the same facilities.¹³² Complication rates were determined based

124. *Id.* at 550.

125. *Id.*

126. *Id.*

127. *Id.* at 550–51.

128. *Id.* at 551.

129. Marlene B. Goldman, Jane S. Occhiuto, Laura E. Peterson, Jane G. Zapka & R. Heather Palmer, *Physician Assistants as Providers of Surgically Induced Abortion Services*, 94 AM. J. PUB. HEALTH 1352, 1356 (2004).

130. Tracy A. Weitz, Diana Taylor, Sheila Desai, Ushma D. Upadhyay, Jeff Waldman, Molly F. Battistelli & Eleanor A. Drey, *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 AM. J. PUB. HEALTH 454, 454–55 (2013).

131. *Id.* at 455.

132. *Id.*

on surveys completed by the women two and four weeks post-abortion and subsequent incident reports generated in the case of any reported complication.¹³³ The overall rate of complication was 1.3%, with a complication rate of 1.8% for APCs and 0.9% for physicians.¹³⁴ The researchers concluded that the care provided by the newly trained APCs was not inferior to the care provided by experienced physicians.¹³⁵ Thus, evidence shows that APCs are capable of providing safe abortion care, even with only a few weeks of training.¹³⁶

II. OVERVIEW OF *FALLS CHURCH MEDICAL CENTER, LLC v. OLIVER*

In *Falls Church Medical Center, LLC v. Oliver*, four elective abortion providers—Falls Church Medical Center, LLC, Virginia League for Planned Parenthood, Whole Woman’s Health Alliance, and Dr. Jane Doe (“Plaintiffs”)—sued several regulatory agencies and several Virginia Commonwealth’s Attorneys (“Defendants”) in the Eastern District of Virginia.¹³⁷ Plaintiffs challenged the constitutionality of several Virginia statutes and regulations, including: (1) the requirement for abortion facilities to be licensed as hospitals, (2) the requirement for an ultrasound and twenty-four-hour waiting period before informed consent, (3) the requirement to allow unannounced inspections of abortion facilities and patient medical files, and (4) the requirement for physicians to provide abortion care.¹³⁸ Plaintiffs argued that these requirements individually and collectively “pose a substantial obstacle to the availability of abortion services for Virginia women, in violation of the Fourteenth Amendment to the United States Constitution.”¹³⁹

133. *Id.* at 455–56.

134. *Id.* at 457.

135. *Id.* at 458.

136. *Id.*

137. *Falls Church Med. Ctr., LLC v. Oliver*, 412 F. Supp. 3d 668, 674 (E.D. Va. 2019).

138. *Id.* at 675–76. *See* VA. CODE ANN. §§ 18.2-72, -76, 32.1-127(B)(1) (Repl. Vol. 2014); 12 VA. ADMIN. CODE § 5-412-370 (2019).

139. *Falls Church Med. Ctr., LLC v. Oliver*, No. 3:18cv428-HEH, 2019 U.S. Dist. LEXIS 76602, at *3 (E.D. Va. May 6, 2019), *vacated in part* by 2019 U.S. Dist. LEXIS 84244 (E.D. Va. May 14, 2019).

With regard to the physician-only law, Plaintiffs argued that it “unjustifiably limits ‘the pool of abortion providers, even while advanced practice clinicians . . . safely and routinely provide abortion care, including medication and aspiration abortion, in other states throughout the country.’”¹⁴⁰ In response, the Defendants argued that people seeking abortions are “amply served by . . . licensed physicians”; however, Defendants did not argue that APCs cannot provide less expensive, safe first-trimester abortion care.¹⁴¹

The district court’s opinion on this issue changed drastically over the course of this case. In its first decision, the district court granted the Plaintiffs’ Motion for Partial Summary Judgment, finding that “there [was] no genuine issue of material fact as to whether the Physician-Only Law poses a *substantial* burden on a woman’s access to first-trimester abortion care.”¹⁴² Just over one week later in a second opinion, the district court vacated this judgment to “facilitate the development of a full factual record that [would] enable the Court to better address [the] question”¹⁴³ Then several months later in a third opinion, primarily relying on precedent, the district court concluded the physician-only law was not an unconstitutional burden on abortion access.¹⁴⁴

A. *Granted and Vacated Plaintiff’s Motion for Summary Judgment*

In its first decision, the district court granted the Plaintiffs’ Motion for Summary Judgment for first-trimester physician-only law.¹⁴⁵ Therefore, the court held that the first-trimester physician-

140. *Id.* at *7–8 (quoting Amended Complaint, *supra* note 6, ¶ 73).

141. *Id.* at *17, *26.

142. *Id.* at *26 (emphasis in original).

143. Falls Church Med. Ctr., LLC v. Oliver, No. 3:18cv428-HEH, 2019 U.S. Dist. LEXIS 84244, at *4 (E.D. Va. May 14, 2019), *vacating in part* 2019 U.S. Dist. LEXIS 76602 (E.D. Va. May 6, 2019).

144. Falls Church Med. Ctr., LLC v. Oliver, 412 F. Supp. 3d 668, 705–06 (E.D. Va. 2019).

145. The court also considered and ruled on whether the physician-only law was an undue burden on second-trimester abortion access. *Falls Church Med. Ctr.*, 2019 U.S. Dist. LEXIS 76602, at *27–28. While the physician-only law for first-trimester and second-trimester abortion are treated separately in the Virginia Code, the court intertwines the discussion of the two laws in its analysis, sometimes indistinguishably. Compare VA. CODE ANN. § 18.2-72 (Repl. Vol. 2014) (first-trimester abortion care), *with id.* § 18.2-73 (Repl. Vol. 2014) (second-trimester abortion care). See *Falls Church Med. Ctr.*, 2019 U.S. Dist. LEXIS 76602, at *26–29. The scope of this Comment is limited to the implications of the *Falls Church Medical Center*. decision on first-trimester abortions.

only law is an undue burden on abortion access.¹⁴⁶ In reaching this decision, the court applied a “burden versus benefits analysis.”¹⁴⁷ Plaintiffs argued, and the court agreed, the benefits of the statute are *de minimis* because the risk of complication is low and APCs have provided both aspiration and medication abortions in other states.¹⁴⁸ Furthermore, Defendants did not dispute the lack of medical justification for the first-trimester physician-only law.¹⁴⁹ In comparison, the court concluded the law was burdensome, as “[i]t is reasonable to assume that providing abortion services offered by APCs would be less expensive.”¹⁵⁰ As there was “no genuine issue of the material fact as to whether the Physician-Only law poses a *substantial* burden on a woman’s access to first trimester abortion care,” the court granted Plaintiffs’ Motion for Summary Judgment.¹⁵¹

However, on May 14, 2019, the court vacated the Plaintiffs’ Summary Judgment for the physician-only law challenge.¹⁵² The court stated that it was vacating the “improvidently awarded” judgment because there is a “material fact that is genuinely in dispute.”¹⁵³ Therefore, the court allowed the parties to better develop the “full factual record,” which in turn allowed the court to “better address this question.”¹⁵⁴

B. *Final Decision Physician-Only Law Not an Undue Burden*

In its final decision, the court held the physician-only law, while potentially an “inconvenien[ce] for some individuals,” did not produce an undue burden.¹⁵⁵ In reaching this decision, the court first balanced the State’s interests of “protecting potential life” and

146. *Falls Church Med. Ctr.*, 2019 U.S. Dist. LEXIS 76602, at *26–28.

147. *Id.* at *26.

148. *See id.* at *20.

149. *See id.* at *25.

150. *Id.* at *26.

151. *Id.* at *26–28 (emphasis in original).

152. *Falls Church Med. Ctr., LLC v. Oliver*, No. 3:18cv428-HEH, 2019 U.S. Dist. LEXIS 84244, at *4 (E.D. Va. May 14, 2019), *vacating in part* 2019 U.S. Dist. LEXIS 76602 (E.D. Va. May 6, 2019).

153. *Id.* at *3–4.

154. *Id.* at *4.

155. *Falls Church Med. Ctr., LLC v. Oliver*, 412 F. Supp. 3d 668, 706 (E.D. Va. 2019).

“protecting the health and safety of women” against the individual’s interest in “personal liberty.”¹⁵⁶ Then the court considered a “seamless line of Supreme Court authority upholding the right of states to determine what medical procedures should be performed by physicians.”¹⁵⁷

1. Law’s Benefits Are Minor: APCs Can Safely Provide First-Trimester Abortions

In this opinion, the court maintained its original conclusion from the May 6, 2019 opinion that APCs can safely provide first-trimester abortion care.¹⁵⁸ First, the court considered the procedures of first-trimester abortions, medication abortions, and aspiration abortions.¹⁵⁹ The court concluded that complications are rare, but in the case of complications, they can be “treated by a properly trained APC.”¹⁶⁰ Then the court considered APCs’ current involvement in Virginia abortion care, where APCs “carry out every procedure incident to a medication abortion except physically handing the medication to the patient.”¹⁶¹ Furthermore, Defendants conceded that APCs could have adequate training for the provision of first-trimester abortion procedures.¹⁶² In light of these considerations, the court found the evidence compelling that APCs can provide abortion procedures; thus, the physician-only law provides little benefit to maternal health.¹⁶³

2. Law Is Only a Mere Inconvenience

While experts testified that “APCs’ availability to perform first trimester procedures would increase access to abortion care,” the court concluded that the increase in access resulting from expanding the provider pool was only marginal.¹⁶⁴ The court considered

156. *Id.* at 673.

157. *Id.* at 691.

158. *Id.* at 688; Falls Church Med. Ctr., LLC v. Oliver, No. 3:18cv428-HEH, 2019 U.S. Dist. LEXIS 76602, at *25 (E.D. Va. May 6, 2019), *vacated in part* by 2019 U.S. Dist. LEXIS 84244 (E.D. Va. May 14, 2019).

159. *Falls Church Med. Ctr.*, 412 F. Supp. 3d at 688.

160. *Id.*

161. *Id.* at 689.

162. *Id.*

163. *Id.* at 705.

164. *Id.* at 689–91.

the current scheduling limitations, emphasizing while lifting the physician-only requirement would “increase the ‘availability of appointment times,’” delays in scheduling are usually a function of the individual’s unavailability, rather than a physician’s.¹⁶⁵ The court then considered traveling distances to facilities.¹⁶⁶ Plaintiffs’ witnesses testified that the long distances to abortion facilities, while not “prevent[ing] everybody . . . seeking an abortion from obtaining one’ . . . could form a barrier to some women.”¹⁶⁷ Additionally, the court considered Dr. Jane Collins’ testimony for the plaintiffs, which included an impact assessment that showed that a significant number of low-income Virginians likely have difficulty scheduling abortion care appointments because of the physician-only law.¹⁶⁸ However, the court found Dr. Collins’ assessment unpersuasive because her findings were “based on a theoretical paradigm,” rather than any interviews of any low-income individuals seeking an abortion.¹⁶⁹ The court therefore concluded that it could not find enough of a burden, especially in light of “formidable line of countervailing authority,” because the “number of women facing that situation is unquantified” and the “Plaintiffs’ evidence consisted primarily of estimates by experts.”¹⁷⁰

3. Law’s Constitutionality Is Supported by Precedent

While the court touched on the balancing of benefits and burdens of the physician-only law, the majority of the court’s analysis centered on the “seamless line of Supreme Court authority upholding the right of states to determine what medical procedures should be performed by physicians.”¹⁷¹ This analysis focused on dicta in other abortion cases, including *Roe v. Wade*, *City of Akron v. Akron Center for Reproductive Health*, and *Planned Parenthood of Southeastern Pennsylvania v. Casey*.¹⁷²

165. *Id.* at 690.

166. *Id.* at 690–91.

167. *Id.* at 691.

168. *Id.*

169. *Id.*

170. *Id.* at 691–92.

171. *Id.* at 691.

172. *Id.* at 691–92.

For example, the court quoted dicta from *Roe* stating that “the state ‘may proscribe any abortion by a person who is not a physician [as defined by state statute].’”¹⁷³ Additionally, the court quoted dicta from *City of Akron* stating that “prior case law ‘left no doubt that, to ensure the safety of the abortion procedure, the States may mandate that only physicians perform abortions.’”¹⁷⁴ Lastly, the court quoted dicta from *Casey* stating that “[o]ur 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.”¹⁷⁵

These cases, however, were deciding issues unrelated to the physician-only law at issue in this case. For example, in *Roe*, the Supreme Court was not tasked with defining the scope of privacy rights and state rights.¹⁷⁶ Instead, the Court was asked whether there is a constitutional right to privacy, as inferred from the Due Process Clause of the Fourteenth Amendment, that includes a qualified, fundamental right to abortion.¹⁷⁷

Similarly, in *City of Akron*, the Court was asked whether an informed consent statute was constitutional, not whether a physician-only law is unconstitutional.¹⁷⁸ However, as part of the informed consent analysis, the Court stated that through previous holdings, the Court has “left no doubt that, to ensure the safety of the abortion procedure, the States may mandate that only physicians perform abortions.”¹⁷⁹ The Supreme Court in *City of Akron* relied on *Connecticut v. Menillo* in this assertion.¹⁸⁰ In *Menillo*, the Supreme Court upheld the criminal conviction of Menillo, who lacked any medical training, for “attempting to procure an abortion.”¹⁸¹ This holding is a reversal from the Supreme Court of Connecticut, which overturned Menillo’s conviction on the basis that

173. *Id.* at 691 (quoting *Roe v. Wade*, 410 U.S. 113, 165 (1973)).

174. *Id.* (quoting *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 447 (1983)).

175. *Id.* (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 885 (1992)).

176. *See Roe*, 410 U.S. at 129.

177. *Id.*

178. 462 U.S. at 416.

179. *Id.* at 447, 452 (citing *Connecticut v. Menillo*, 423 U.S. 9, 11 (1975); *Roe*, 410 U.S. at 165).

180. *Id.* at 447; *see Menillo*, 423 U.S. at 11.

181. 423 U.S. at 9, 11.

the criminal statute, which prohibited all providers from providing abortion, was unconstitutional under *Roe v. Wade*.¹⁸² The Supreme Court, however, found error in this reasoning because, while “*Roe* teaches that a state cannot restrict a decision by a woman, with the advice of her *physician*, to terminate her pregnancy during the first trimester,” the State lacks a sufficient interest in maternal health or the potential life of the fetus at this point,¹⁸³ this holding is “predicated upon the first trimester abortion’s being as safe for the woman as normal childbirth at term, and that predicate holds true only if the abortion is performed by *medically competent personnel* under conditions insuring maximum safety for the woman.”¹⁸⁴ Furthermore, the Court held that “[e]ven during the first trimester of pregnancy prosecutions for abortions conducted by nonphysicians infringe upon no realm of personal privacy secured by the Constitution against state interference;” thus, upholding a physician-only restriction.¹⁸⁵

Additionally, in *Casey*, the Court was examining challenges to five provisions of the Pennsylvania Abortion Control Act of 1982, which required (1) women’s informed consent after receiving specific information at least twenty-four hours before the procedure, (2) parental informed consent or judicial bypass, (3) a signed statement that the husband had been notified, and (4) abortion facilities to report each abortion and excused compliance from these requirements for “medical emergencies.”¹⁸⁶ While none of these challenges dealt explicitly with the physician-only requirement, the Supreme Court still considered the role of physicians in obtaining a woman’s informed consent.¹⁸⁷

This “seamless” line of authority and rudimentary balancing led the district court in *Falls Church Medical Center* to conclude that

182. *Id.*

183. *Id.* at 10–11 (emphasis added).

184. *Id.* at 11 (emphasis added).

185. *Id.*

186. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 844 (1992).

187. *Id.*

the physician-only law was not an undue burden on abortion access.¹⁸⁸ This holding is a stark contrast from its initial grant of the Plaintiffs' Motion for Summary Judgment earlier that year.¹⁸⁹

III. CRITIQUE OF *FALLS CHURCH MEDICAL CENTER, LLC v. OLIVER*

While the district court ultimately held in *Falls Church Medical Center, LLC v. Oliver* that the physician-only law was not an undue burden on abortion access, the path to this decision was unconventional.¹⁹⁰ First, there was a peculiar procedural history, as the court initially granted the Plaintiffs' Motion for Summary Judgment and held that the law was unconstitutional, vacated this judgment only eight days later, and ultimately decided the law was constitutional and not an undue burden on abortion access.¹⁹¹ Second, the reasoning of the decision was odd in comparison to other opinions on abortion access by focusing on tangentially related precedent and conducting a limited undue burden analysis.¹⁹²

A. *Role of Precedent*

In *Falls Church Medical Center*, the majority of the district court's analysis for the physician-only law was based on tangentially related precedent. While following precedent is necessary to promote a stable and predictable legal system,¹⁹³ the rule of *stare decisis* is not an "inexorable command," requiring a "mechanical formula."¹⁹⁴ Furthermore, the duty to follow precedent relates to the sameness of the cases; thus, where the fact or legal patterns differ significantly, the precedent is inapplicable.¹⁹⁵ In *Falls Church Medical Center*, the court relied on the tangentially related

188. *Falls Church Med. Ctr., LLC v. Oliver*, 412 F. Supp. 3d 668, 688, 691–92 (E.D. Va. 2019).

189. *See supra* section II.A.

190. *See supra* Part II.

191. *See id.*

192. *See infra* sections III.A–B.

193. *See* Randy J. Kozel, *Stare Decisis as Judicial Doctrine*, 67 WASH. & LEE L. REV. 411, 412–13 (2010).

194. *Payne v. Tennessee*, 501 U.S. 808, 828 (1991) (citing *Helvering v. Hallock*, 309 U.S. 106, 119 (1940)).

195. *See* Nina Varsava, *How to Realize the Value of Stare Decisis: Options for Following Precedent*, 30 YALE J.L. & HUMAN. 62, 72 (2018).

dicta of several cases, as if these cases were deciding similar issues as the Virginia first-trimester physician-only law.¹⁹⁶

For example, while the Supreme Court stated in *Roe v. Wade* that “[t]he State may define the term ‘physician,’ as it has been employed in . . . this opinion, to mean only a physician currently licensed by the State, and may proscribe any abortion by a person who is not a physician . . . ,”¹⁹⁷ the Court was not considering the issue of who can provide abortions, but whether there is a fundamental right to abortions.¹⁹⁸ Additionally, the Court was likely responding to the provision of abortion care by non-medically trained individuals, which was prevalent during criminalization and led to severe injury or death for many women.¹⁹⁹ Furthermore, the shift in the healthcare workforce to embracing APCs did not occur until the 1990s, about twenty years following the *Roe* decision, making it improbable the Court had adequate information even to consider their role in abortion care.²⁰⁰

Similarly, in *City of Akron v. Akron Center for Reproductive Health*, while the Court stated there is “no doubt that, to ensure the safety of the abortion procedure, the States may mandate that only physicians perform abortions,”²⁰¹ a physician-only law was not being challenged.²⁰² Furthermore, *City of Akron* relied on the case *Connecticut v. Menillo*, which challenged the conviction of a person without medical training under a general felony abortion provision.²⁰³ In *Connecticut v. Menillo*, the Court reasoned the fundamental right to abortion was “predicated upon the first trimester abortion’s being as safe for the woman as normal childbirth at term, and that predicate holds true only if the abortion is performed by *medically competent personnel* under conditions insuring maximum safety for the woman.”²⁰⁴ At the time the case was

196. See *Falls Church Med. Ctr., LLC v. Oliver*, 412 F. Supp. 3d 688, 691 (E.D. Va. 2019).

197. 410 U.S. 113, 165 (1973).

198. *Id.* at 116.

199. See *supra* section I.A.

200. See Benjamin G. Druss, Steven C. Marcus, Mark Olfson, Terri Tanelian & Harold Alan Pincus, *Trends in Care by Nonphysician Clinicians in the United States*, 348 NEW ENG. J. MED. 130, 130 (2003).

201. *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 447 (1983) (citing *Connecticut v. Menillo*, 423 U.S. 9, 11 (1975)).

202. *Id.* at 452.

203. *Id.* at 447 (citing *Menillo*, 423 U.S. at 9).

204. *Id.* at 11 (emphasis added).

determined in 1975, it may have been intuitive to assume physicians were the only “medically competent personnel” prior to the major shift in the health market in the 1990s.²⁰⁵ However, there is now compelling evidence that APCs are medically competent to provide first-trimester abortion care.²⁰⁶

Also, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court stated in dicta that “the Constitution gives the States broad latitude to decide that particular functions may be performed only by licensed professionals;” however the Court, yet again, was not responding to a challenge to a physician-only law.²⁰⁷ Furthermore, the Court was applying *Williamson v. Lee Optical of Oklahoma, Inc.*, a 1955 case that determined the state could mandate only licensed physicians could provide a prescription for eyeglasses, even if the requirement was not necessary in most cases; however, this case rested upon the less stringent rational basis review where this case, dealing with access to abortion, is subject to the more stringent undue burden review.²⁰⁸

The district court’s reliance on these cases in *Falls Church Medical Center* was unfounded considering none of the dicta has binding authority over this factually dissimilar case. This case is factually dissimilar because none of the precedent cases challenged a physician-only law as it pertains to APCs, which research shows are as competent as physicians when it comes to the provision of abortion services.²⁰⁹ As none of the cases are on point, it was inappropriate to rely on them as a “seamless line of Supreme Court authority upholding the right of states to determine what medical procedures should be performed by physicians.”²¹⁰

B. Role of the Undue Burden Analysis

Initially, after *Roe v. Wade*, state regulation of the constitutional right to abortion was analyzed through strict scrutiny.²¹¹ However,

205. See Druss et al., *supra* note 200, at 130.

206. See *Falls Church Med. Ctr., LLC v. Oliver*, 412 F. Supp. 3d 668, 688–89 (E.D. Va. 2019); *supra* section I.D.

207. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884–85 (1992).

208. See *Williamson v. Lee Optical, Inc.*, 348 U.S. 483, 487 (1955).

209. See *supra* section I.D.

210. *Falls Church Med. Ctr.*, 412 F. Supp. 3d at 691.

211. See *Casey*, 505 U.S. at 833.

in 1992, the Supreme Court adopted the undue burden standard, which requires a court to determine if a state law or regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking abortion of a non-viable fetus.²¹² Thus, the court weighs the proposed compelling state interest against the burden on the exercise of the constitutional right to abortion.²¹³ In this case, *Falls Church Medical Center*, the district court does a rudimentary balancing of the purported benefits and burdens of the physician-only standard; however, it falls short by prematurely discounting the theoretical analyses of the Plaintiffs' experts.²¹⁴

1. Undue Burden Standard

The undue burden standard weighs the benefits of a law against the burdens it causes for abortion access.²¹⁵ The standard was first defined in *Planned Parenthood of Southeastern Pennsylvania, v. Casey* as a “finding . . . that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”²¹⁶ In its analysis, the Court further clarified the standard, explaining “the means chosen by the State to further the interest in potential life must be calculated to inform the woman’s free choice, not hinder it” and if the state is for “furthering the interest in potential life or some other valid state interest, [a law cannot have] the effect of placing a substantial obstacle in the path of a woman’s choice [and] be considered a permissible means of serving its legitimate ends.”²¹⁷ In 2016, the Court restated the standard in *Whole Woman’s Health v. Hellerstedt*, which held:

[T]here “exists” an “undue burden” on a woman’s right to decide to have an abortion, and consequently a provision of law is constitutionally invalid, if the “purpose or effect” of the provision “is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.” The plurality added that “[u]nnecessary

212. *See id.*

213. *See id.*

214. *See supra* section II.B.

215. *Casey*, 505 U.S. at 877.

216. *Id.*

217. *Id.*

health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right.”²¹⁸

Thus, in general, the undue burden standard requires a court to determine, based on the relative burdens and benefits, whether the “purpose or effect” of the challenged law is to place a “substantial obstacle” in the way of abortion access.²¹⁹

For example, in *Whole Woman’s Health v. Hellerstedt*, the Supreme Court held the Texas statutes that (1) required abortion providers to have “active admitting privileges at a hospital”²²⁰ and (2) required abortion facilities to have equivalent “minimum standards” as “ambulatory surgical centers,”²²¹ each constituted an undue burden on the right to abortion.²²²

For the admitting privileges requirement, Texas argued that the state’s interest was to “help ensure that women have easy access to a hospital should complications arise during an abortion procedure.”²²³ However, the Supreme Court determined that there was “no significant health-related problem that the new law helped to cure,”²²⁴ and the requirement “brought about no such health-related benefit” as indicated by peer-review studies and expert testimony, which stated abortion-related complications are rare, and a woman’s health outcome would not be negatively impacted.²²⁵ Furthermore, the Supreme Court determined the requirement “places a ‘substantial obstacle in the path of a woman’s choice,’” as indi-

218. *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2300 (2016) (emphasis in original) (quoting *Casey*, 505 U.S. at 878).

219. *See id.* *But see* *June Med. Servs. v. Russo*, 140 S. Ct. 2103, 2136 (2020) (Roberts, C.J., concurring) (“There is no plausible sense in which anyone, let alone this Court, could objectively assign weight to such imponderable values and no meaningful way to compare them if there were.”).

220. *Whole Woman’s Health*, 136 S. Ct. at 2300 (quoting TEX. HEALTH & SAFETY CODE ANN. § 171.0031(a) (West Cum. Supp. 2015)).

221. *Id.*

222. *Id.*

223. *Id.* at 2311.

224. *Id.*

225. *Id.*

cated by about half of abortion facilities closing due to the regulation because of the inability to obtain admitting privileges.²²⁶ This in turn, reduced access to abortion facilities.²²⁷

For the surgical-center requirement, Texas argued that the state interest was “preserving women’s health.”²²⁸ However, the Supreme Court determined the “risks are not appreciably lowered for patients who undergo abortions at ambulatory surgical centers as compared to nonsurgical-center facilities,”²²⁹ considering that “[m]any of the building standards mandated by the act and its implementing rules have such a tangential relationship to patient safety.”²³⁰ Therefore, the Supreme Court concluded it was “inappropriate” to apply surgical center requirements to abortion facilities.²³¹ Furthermore, the requirement “places a substantial obstacle in the path of women seeking a previability abortion” because it would reduce the number of abortion facilities to only seven.²³²

2. The Undue Burden Analysis in This Case

While the district court acknowledged the balancing requirements of the undue burden standard from *Planned Parenthood of Southeastern Pennsylvania v. Casey* and *Whole Woman’s Health v. Hellerstedt*, the court failed to fully develop the analysis, relying on non-precedential dicta to fill the gaps.²³³ The court was unable to articulate a benefit to the physician-only law, and the court acknowledged there were some barriers to access, including increased costs and the potential for delay.²³⁴ Rather than balancing the non-existent benefits with the burdens on abortion, the court merely dismisses the analysis.²³⁵

226. *Id.* at 2312–13 (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992)).

227. *Id.*

228. *Id.* at 2315.

229. *Id.*

230. *Id.* at 2316 (quoting *Whole Woman’s Health v. Lakey*, 46 F. Supp. 3d 673, 684 (W.D. Tex. 2014)).

231. *Id.* at 2315.

232. *Id.* at 2300–01.

233. *See Falls Church Med. Ctr., LLC v. Oliver*, 412 F. Supp. 3d 668, 668–91 (E.D. Va. 2019).

234. *See supra* sections II.B.1–2.

235. *See Falls Church Med. Ctr.*, 412 F. Supp. 3d at 688–92.

In regard to the benefits from the physician-only law, while the court gave credence to the state's interests in "protecting the health and safety of women,"²³⁶ the court was unable to articulate a benefit for maternal health or safety. In fact, the court determined that the evidence showed that adequately trained APCs can safely provide first-trimester abortions, and the Defendants concurred on this point.²³⁷ This conclusion is supported by a full breadth of peer-reviewed research and anecdotal evidence from states that permit APCs to provide abortions.²³⁸

In regard to the burdens imposed by the physician-only law, the court held the barriers to access were only a mere "inconveni[ce] for some individuals," rather than an undue burden.²³⁹ The court considered the current scheduling limitations, emphasizing lifting the physician-only requirement would "increase the 'availability of appointment times;'" however, the court seems to consider any delay a function of coordination with the individual's availability, rather than physician availability.²⁴⁰ The court fails to acknowledge that an increase in physician availability will allow individuals to find an appointment that fits their schedules more efficiently. For example, most abortion facilities in Virginia only offer abortion services on select days of the week, but if there was a broadening of the provider pool to include APCs, then the abortion facilities would be able to offer abortion care more days of the week.²⁴¹ Furthermore, the scheduling delay has contributed to individuals waiting until the second trimester for an abortion, which are more expensive and have a higher rate of complication.²⁴² Additionally, the physician-only law generally increases the expense of abortion

236. *Id.* at 673.

237. *Id.* at 689, 692.

238. *See supra* section I.D.

239. *Falls Church Med. Ctr.*, 412 F. Supp. 3d at 706.

240. *Id.* at 690–91.

241. *Id.*

242. *See Falls Church Med. Ctr., LLC v. Oliver*, No. 3:18cv428-HEH, 2019 U.S. Dist. LEXIS 76602, at *15–16 (E.D. Va. May 6, 2019), *vacated in part* by 2019 U.S. Dist. LEXIS 84244 (E.D. Va. May 14, 2019); Ann E. Marimow, *Virginia Abortion Laws Upheld Requiring Ultrasound, Waiting Period, Doctor-Only Procedures*, WASH. POST (Oct. 1, 2019), https://www.washingtonpost.com/local/legal-issues/virginia-abortion-laws-upheld-requiring-ultrasound-waiting-period-doctor-only-procedures/2019/10/01/21f181e2-e44f-11e9b403-f738899982d2_story.html [<https://perma.cc/A3LK-S2MT>]. Compare VA. CODE ANN. § 18.2-73 (Repl. Vol. 2014) (second-trimester abortion exemption to general criminal ban), *with id.* § 18.2-72 (Repl. Vol. 2014) (first-trimester abortion exemption to general criminal ban).

care by requiring higher salaried abortion providers than necessary to ensure safety.²⁴³ The court also considered the decrease in cost associated with APCs providing abortion services, concluding it is a reasonable assumption that costs would be contained.²⁴⁴

While these burdens may be substantial to some individuals seeking an abortion, the court was unwilling to consider them entirely because the “number of women facing that situation is unquantified” and the “Plaintiffs’ evidence consisted primarily of estimates by experts.”²⁴⁵ However, the court failed to discuss how the testifying experts’ estimations of burden are not sufficient to show any burden, as courts frequently need to rely on expert analysis, even estimations, in order to come to well-informed conclusions.²⁴⁶ Ultimately, the court failed to consider the relative benefits against the burdens of the law, which considering there is no purported benefit to maternal health, it is clear that any burden to access, including increased wait time and cost, would be undue.²⁴⁷

IV. VIRGINIA’S AMENDED PHYSICIAN-ONLY LAW

Following the November 5, 2019, elections, where all one-hundred forty of the seats in the Virginia General Assembly were up for re-election, the Democratic Party controlled the majority of both the House of Delegates and the Senate and controlled the governor’s mansion for the first time since 1994.²⁴⁸ Over the course of sixty days, the General Assembly passed and the Governor signed into law 1290 bills.²⁴⁹ Many of these bills were re-introduced as they failed to pass in Republican-controlled government.²⁵⁰ One of

243. See *supra* section I.B.3.

244. *Falls Church Med. Ctr.*, 2019 U.S. Dist. LEXIS 76602, at *25, *vacated in part by* 2019 U.S. Dist. LEXIS 84244 (E.D. Va. May 14, 2019).

245. *Falls Church Med. Ctr.*, 412 F. Supp. 3d at 691.

246. See FED. R. EVID. 702 advisory committee’s note. See, e.g., *Daubert v. Merrell Dow Pharm., Inc.*, 43 F.3d 1311, 1316 (9th Cir. 1995).

247. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992).

248. Scott Calvert & Jon Kamp, *Election Results 2019: Democrats Take Control of Virginia Legislature*, WALL ST. J. (Nov. 6, 2019, 11:07 AM), <https://www.wsj.com/articles/election-results-2019-democrats-take-control-of-virginia-senate-11573008587> [<https://perma.cc/K5VU-3TCH>].

249. Virginia House Clerk’s Office, *Virginia Legislative Information System 2020 Session Cumulative Index* (2020), <https://index.lis.virginia.gov/?ses=27> [<https://perma.cc/T853-DP TJ>].

250. Gregory S. Schneider & Laura Vozzella, *Va. General Assembly Takes Flurry of Historic Legislation Down to Wire*, WASH. POST (Mar. 8, 2020, 12:05 AM), <https://www.washi>

these re-introduced bills, the Reproductive Health Act, amended several Virginia Code sections relating to the provision of abortion care, including, the transvaginal ultrasound requirement, the informed consent requirement, the physician-only law, and the facility requirements.²⁵¹

A. *Virginia Amended the Physician-Only Law*

Under the Reproductive Health Act, the physician-only law was amended to allow for licensed nurse practitioners to provide first-trimester abortions.²⁵² The law now reads, in relevant part:

[I]t shall be lawful for (i) any physician licensed by the Board of Medicine to practice medicine and surgery, or (ii) any person jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner and acting within such person's scope of practice to terminate or attempt to terminate a human pregnancy or aid or assist in the termination of a human pregnancy by performing an abortion or causing a miscarriage on any woman during the first trimester of pregnancy.²⁵³

While a majority of Virginia voters, 60%, “support allowing trained nurse practitioners, advanced practice nurses, and physician assistants to provide early abortion care to increase access to areas without providers,” the amendment only expands the exemption to nurse practitioners.²⁵⁴ Earlier versions of the bill in both the

ngtonpost.com/local/virginia-politics/va-general-assembly-final-day/2020/03/07/75a46d06-5ff9-11ea-9055-5fa12981bbbf_story.html [https://perma.cc/6D92-6RJ4] (discussing the “cyclone of pent-up legislative change” after “[the Democrats] first consolidated hold on power in a generation”). See, e.g., Gregory S. Schneider, Laura Vozzella & Patricia Sullivan, *A Long Time to Wait: Virginia Passes Equal Rights Amendment in Historic Vote*, WASH. POST (Jan. 15, 2020, 5:34 PM), https://www.washingtonpost.com/local/virginia-politics/2020/01/15/0475d51a-36f1-11ea-9541-9107303481a4_story.html [https://perma.cc/GH5C-DV2L] (discussing the ratification of the Equal Rights Amendment after Republican lawmakers “bottled up the ERA in subcommittee during their 26 years in control of the House of Delegates”).

251. Acts of Apr. 9, 2020, chs. 898 & 899, 2020 Va. Acts __, __ & __, __ (codified as amended at VA. CODE ANN. § 18.2-72 (Cum. Supp. 2020)); Anna North, *How Abortion in Virginia Went from a Trump Talking Point to a Winning Issue for Democrats*, VOX (Jan. 30, 2020, 8:10 AM), <https://www.vox.com/identities/2020/1/30/21113492/virginia-abortion-laws-trump-general-assembly-vote> [https://perma.cc/6U3V-V3Q4].

252. Chs. 898 & 899, 2020 Va. Acts __, __ (codified as amended at VA. CODE ANN. §§ 16.1-77, 18.2-72, -76, 32.1-127 (Cum. Supp. 2020)).

253. VA. CODE ANN. § 18.2-72 (Cum. Supp. 2020).

254. *Id.*; Katherine Patterson, *Majority of Virginians Believe Abortion Should Be Legal; Oppose Unnecessary Restrictions Targeting Abortion Providers*, PUB. POL'Y POLLING (Jan. 24, 2020), <https://virginia.prochoiceamericaaffiliates.org/wp-content/uploads/sites/12/2020/01/Majority-of-Virginians-Believe-Abortion-Should-Be-Legal-Oppose-Unnecessary-Restrictions-Targeting-Abortion-Providers.pdf> [https://perma.cc/9Q7P-Q5GR].

House of Delegates and the Senate included physician assistants in the exemption; however, following committee hearings, the bill was amended in both the Senate and House of Delegates to exclude physician assistants.²⁵⁵ A floor amendment that removed physician assistants was adopted in the Senate²⁵⁶ after several members of the Committee of Education and Health expressed concerns for expanding the exemption to non-physicians during a hearing the week before.²⁵⁷ Subsequently, the companion bill from the House of Delegates was substituted to become identical to the Senate bill.²⁵⁸

In early March 2020, both of the companion bills passed in both chambers.²⁵⁹ On April 10, 2020, Governor Ralph Northam signed the bills into law.²⁶⁰ After signing the law, Governor Ralph Northam declared that “[n]o more will legislators in Richmond—most of whom are men—be telling women what they should and should not be doing with their bodies . . . The Reproductive Health Protection Act will make women and families safer, and I’m proud to sign it into law.”²⁶¹

255. *Hearing Before Va. S. Comm. on Health and Education*, VA. GEN. ASSEMBLY (Feb. 20, 2020, 8:00 AM) (statement of Delegate Charniele L. Herring), http://virginia-senate.granicus.com/MediaPlayer.php?view_id=3&clip_id=3116 [<https://perma.cc/2V86-ZPW4>].

256. *Regular Session*, VA. GEN. ASSEMBLY (Jan. 28, 2020, 12:00 PM), http://virginia-senate.granicus.com/MediaPlayer.php?view_id=3&clip_id=2945 [<https://perma.cc/Y5LJ-MLKF>].

257. *Hearing Before Va. S. Comm. on Education and Health*, VA. GEN. ASSEMBLY (Jan. 23, 2020, 8:00 AM), http://virginia-senate.granicus.com/MediaPlayer.php?view_id=3&clip_id=2918 [<https://perma.cc/R77B-TN6W>]. During this hearing, Senators Stephen D. Newman, Siobhan S. Dunnavant, and John A. Cosgrove emphasized the central role physicians play in patient care due to their expertise. *Id.*

258. *Hearing Before Va. S. Comm. on Health and Education*, VA. GEN. ASSEMBLY (Feb. 20, 2020, 8:00 AM) (statement of Delegate Charniele L. Herring), http://virginia-senate.granicus.com/MediaPlayer.php?view_id=3&clip_id=3116 [<https://perma.cc/2V86-ZPW4>].

259. *SB 733 Abortion; Expands Who Can Perform in First Trimester; Informed Consent Required*, VA.’S LEGIS. INFO. SYS. (2020), <https://lis.virginia.gov/cgi-bin/legp604.exe?201+sum+SB733> [<https://perma.cc/W42N-X3TV>]; *HB 980 Abortion; Expands Who Can Perform in First Trimester; Informed Consent*, VA.’S LEGIS. INFO. SYS. (2020), <https://lis.virginia.gov/cgi-bin/legp604.exe?201+sum+HB980> [<https://perma.cc/Z2HF-HPJ6>].

260. Justin Mattingly, *Northam Signs Bills to Roll Back Abortion Restrictions*, RICH. TIMES-DISPATCH (Apr. 10, 2020), https://richmond.com/news/virginia/northam-signs-bills-to-roll-back-abortion-restrictions/article_26cba5d2-6c10-59dd-9de8-b977df3dee9f.html [<https://perma.cc/BPD8-737V>].

261. *Id.*

B. *Critique of the Amended Law*

While the expansion of the exemption of the physician-only law to include nurse practitioners will likely be less burdensome and increase abortion access in Virginia, the law is still more limited than necessary to preserve the health and safety of persons seeking abortion services.

The overall benefits of the physician-only law as amended to include only nurse practitioners are minimal. For example, as determined in *Falls Church Medical Center* and as supported by a full-breadth of peer-reviewed research conducted and anecdotal evidence that permit physician assistants to provide abortions, physician assistants can safely and effectively perform abortion procedures with adequate training and supervision.²⁶² Thus, as with the physician-only law prior to amendment, the amended section now continues to perpetuate an unnecessary limitation on abortion providers.

However, the overall costs of the physician-only law as amended to include only nurse practitioners is significantly less than the physician-only law prior amendment. For example, with the increase number of potential providers, the wait times at facilities that offer abortions will likely decrease, in part due to the lower costs of maintaining a staff of nurse practitioners.²⁶³ Additionally, because nurse practitioners with “the equivalent of at least five years of full-time clinical experience” can practice without a practice agreement,²⁶⁴ the expansion of the exemption to nurse practitioners may encourage more facilities, especially rural facilities, to offer abortion services.²⁶⁵

Therefore, in balance, a court is unlikely to find that the law has the “purpose or effect . . . to place a substantial obstacle in the path

262. See *Falls Church Med. Ctr., LLC v. Oliver*, 412 F. Supp. 3d 668, 668–91 (E.D. Va. 2019); *supra* section I.D.

263. See *Falls Church Med. Ctr.*, 412 F. Supp. 3d at 677, 690; *supra* sections I.B.2–3.

264. VA. CODE ANN. § 54.1-2957(E) (Repl. Vol. 2019).

265. See Edward J. Timmons, *Healthcare License Turf Wars: The Effects of Expanded Nurse Practitioner and Physician Assistant Scope of Practice on Medicaid Patient Access* 18 (Mercatus Ctr. Working Paper, 2016) (finding that “broader scope of practice for NPs and PAs has little effect on the quality of care delivered, increases access to health care, and also potentially reduces the cost of providing health care to patients”).

of a woman seeking an abortion before the fetus attains viability.”²⁶⁶ However, by excluding physician assistants, without any clear reason why, the exemptions from the general criminal ban on abortion are still insufficient to promote safe and equitable access to abortion services.

V. A LESS BURDENSOME ALTERNATIVE: SCOPE OF PRACTICE LAWS

The enduring nature of the physician-only law is partially due to a concern that unqualified individuals will carelessly induce abortions at significant risk to maternal health.²⁶⁷ For example, prior to *Roe v. Wade*, abortions that were not induced by medical professionals for therapeutic purposes were viewed as a de facto “death penalty” due to their substantial risk to maternal health.²⁶⁸ However, there is a less burdensome and restrictive means to mitigate the risk to maternal health: scope of practice laws. By shifting the focus to already existing laws on physician and APC scope of practice, there are protections to ensure provider competency, without singling out abortion with unduly burdensome physician-only laws.²⁶⁹

Under the Virginia Drug Control Act, physicians and APCs can “prescribe, dispense, or administer controlled substances,” such as mifepristone and misoprostol for medicated abortions, with due care.²⁷⁰ Therefore, in order for the prescription, dispensation, or administration of mifepristone and misoprostol to be legal, the physician or APC must do so “in good faith for medicinal or therapeutic purposes within the course of his professional practice.”²⁷¹ Beyond medicated abortions, physician assistants may only provide “medical care services that are within the scope of the practice and proficiency of the supervising physician as prescribed in the

266. *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2300 (2016) (internal quotation marks omitted) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878 (1992)).

267. *See supra* sections I.A.3, I.B.4.

268. *See Stevens, supra* note 46.

269. *See, e.g.*, VA. CODE ANN. §§ 54.1-2957(C) (nurse practitioner), -2952.1 (physician assistant), -3408(A) (prescription authority) (Repl. Vol. 2019).

270. *Id.* § 54.1-3408(A) (Repl. Vol. 2019).

271. *See id.* § 54.1-3408(A) (Repl. Vol. 2019).

physician assistant's practice agreement."²⁷² Similarly, nurse practitioners, while able to practice independently after receiving five years of clinical experience, "may practice in the practice category in which he is certified and licensed . . ." ²⁷³ Under these existing laws, qualified APCs could provide abortions services while unqualified APCs would be liable for the unlawful practice of medicine.²⁷⁴

Thus, while there is always the potential for the careless provision of medical care that can result in serious harm to the patient, these concerns are effectively resolved through the general scope of practice laws, prohibitions on the unlawful practice of medicine, and medical malpractice cause of actions. These laws require APCs and physicians to only provide procedures they are qualified to provide through adequate training and experience.²⁷⁵

CONCLUSION

While Virginia's physician-only law has been on the books since the legalization of abortion post-*Roe*, the requirement posed an undue burden on abortion access.²⁷⁶ A proper application of the undue burden analysis from *Casey* and *Hellerstedt* shows that the physician-only law provided little, if any, benefit to maternal health or safety while creating significant burdens on abortion access by artificially and arbitrarily limiting the provider pool, thereby increasing the costs and decreasing the availability of abortion care.²⁷⁷ This conclusion is contrary to the 2019 holding from the Eastern District of Virginia in *Falls Church Medical Center*, where the court held that Virginia's physician-only law was not an undue burden on first-trimester abortion access.²⁷⁸ However, the court was erroneous in this opinion, failing to adequately weigh the benefits against the burdens in the undue burden analysis and relying heavily on tangentially related dicta.²⁷⁹ Furthermore, while the

272. 18 VA. ADMIN. CODE § 85-50-115 (2019).

273. VA. CODE ANN. § 54.1-2957(C) (Repl. Vol. 2019).

274. *Id.* § 54.1-2902 (Repl. Vol. 2019).

275. *Id.*

276. *See supra* sections I.A.3, III.B.

277. *See supra* sections I.B., III.B.

278. *See supra* section II.B.

279. *See supra* section III.A.

physician-only law, as amended and effective on July 1, 2020, expanded the exception to licensed nurse practitioners, there are still less restrictive and more effective means of protecting maternal health.²⁸⁰ A potential means is repealing the general criminal ban on abortion and relying on Virginia scope of practice laws.²⁸¹ These scope of practice laws, which govern every other procedure and prescription provided by a physician or APC, ensure that only qualified, experienced medical professionals provide medical services in order to protect the health and safety of Virginians generally.²⁸²

Emily M. Gindhart *

280. *See supra* Part IV.

281. *See supra* Part V.

282. *Id.*

* J.D. Candidate, 2021, University of Richmond School of Law; B.A., 2018, University of Virginia. I owe a great debt and gratitude to Professor Rachel J. Suddarth for her invaluable feedback and encouragement during the writing process and law school. I am also thankful to Professor Margaret E. Ivey and Ms. Lynne Damaty, whose insightful conversations taught me that to understand the law, we must look beyond the letter of the law. Additionally, this piece's quality is credited to the exceptional staff and editors of the *University of Richmond Law Review*, including Glenice B. Coombs, Diana C. Dominguez, and Jamie H. Wood, whose hard work and careful editing made this Comment possible.