2013

Section 7: Abortion

Institute of Bill of Rights Law at the William & Mary Law School

VII. Abortion

In This Section:

McCullen v. Coakley

12-1168

Ruling Below: *McCullen v. Coakley*, 708 F.3d 1 (1st Cir. 2013), *cert granted*, 2013 WL 1218466 (U.S. 2013).

Massachusetts residents who regularly engaged in pro-life counseling outside reproductive health care facilities brought action against Massachusetts' Attorney General, challenging revised Massachusetts statute, which made it a crime for speakers other than clinic employees acting within the scope of their employment to be on a public sidewalk within thirty-five feet of an entrance, exit, or driveway of a reproductive health care facility. The United States District Court for the District of Massachusetts, upheld the act. Residents appealed. The First Circuit held that law of the case doctrine precluded revisiting facial challenges; employees loitering in buffer zone did not reflect a viewpoint preference of the state; and residents had adequate alternative means of communication.

Question Presented: (1) Whether the First Circuit erred in upholding Massachusetts's selective exclusion law under the First and Fourteenth Amendments, on its face and as applied to petitioners; and (2) whether, if *Hill v. Colorado* permits enforcement of this law, *Hill* should be limited or overruled.

Eleanor McCULLEN et al., Plaintiffs, Appellants,
v.
Martha COAKLEY et al., Defendants, Appellees.

United States Court of Appeals, First Circuit

Decided on January 9, 2013

[Excerpt; some footnotes and citations omitted.]

SELYA, Circuit Judge

This case does not come to us as a stranger. At the turn of the century, the Massachusetts legislature passed a law that created fixed and floating buffer zones around abortion clinics. We rejected serial challenges to the constitutionality of that law. The Supreme Court denied certiorari.

One might have thought that the matter would end there, but it did not. In 2007, the legislature revisited the statute and amended it to create a fixed thirty-five-foot buffer zone around the entrances, exits, and driveways of abortion clinics. The revised statute drew renewed fire and, in 2009, we upheld it against a facial challenge. This decision left open the plaintiffs' as-applied

challenge, and they unsuccessfully pursued that initiative in the district court.

The plaintiffs again appeal. They advance a salmagundi of arguments, old and new, some of which are couched in a creative recalibration of First Amendment principles.

Few subjects have proven more controversial in modern times than the issue of abortion. The nation is sharply divided about the morality of the practice and its place in a caring society. But the right of the state to take reasonable steps to ensure the safe passage of persons wishing to enter healthcare facilities cannot seriously be questioned. The Massachusetts statute at issue here is a content-neutral, narrowly tailored time-place-manner regulation that protects the rights of prospective patients and clinic employees without offending the First Amendment rights of others. We therefore affirm the judgment below.

I. BACKGROUND

We briefly recount the historical background and travel of the case and then describe the particular circumstances concerning the three clinic locations that lie at the epicenter of the plaintiffs' as-applied challenge.

A. Travel of the Case.

The centerpiece of this saga is Mass. Gen. Laws ch. 266, § 120E 1/2 (2007) (the Act). The provenance and pertinent provisions of the Act are set out in some detail in *McCullen I* and we assume the reader's familiarity with that account. We rehearse here only what is necessary to place into perspective the issues on appeal.

The Act states in pertinent part that "[n]o person shall knowingly enter or remain on a public way or sidewalk adjacent to a reproductive health care facility" (RHCF) within a designated and clearly marked buffer zone. The buffer zone spans

> a radius of 35 feet of any portion of an entrance, exit or driveway of a[n RHCF] or within the area within a rectangle created by extending the outside boundaries of any entrance, exit or driveway of a[n RHCF] in straight lines to the point where such lines intersect the sideline of the street in front of such entrance, exit or driveway.

Four categories of persons identical to those enumerated in the 2000 version of the law are exempted:

(1) persons entering or leaving such facility;
(2) employees or agents of such facility acting within the scope of their employment;
(3) law enforcement, ambulance, firefighting, construction, utilities, public *4 works and other municipal agents acting within the scope of their employment; and
(4) persons using the public sidewalk or street right-of-way adjacent to such facility solely for the purpose of reaching a destination other than such facility.

On January 25, 2008, the Massachusetts Attorney General sent a letter to a wide audience, including RHCF personnel and law enforcement agencies. The text of the letter is reproduced as an appendix to our opinion in *McCullen I*. Its stated purpose is to summarize the provisions of the Act and offer "guidance to assist [ ] in applying the four exemptions."

On January 16, 2008, the plaintiffs brought this action against the Massachusetts Attorney General in the federal district court. Invoking 42 U.S.C. § 1983, they alleged a plethora of constitutional claims.

The district court bifurcated the case, separating the plaintiffs' facial challenge from their as-applied challenge. In due season, the court addressed the facial challenge and upheld the Act.

On appeal, we affirmed, holding the Act to be content-neutral, viewpoint-neutral, and a valid time-place-manner regulation. At the same time, we rebuffed the plaintiffs' overbreadth claim, citing *Hill v. Colorado*, in which the Supreme Court upheld a Colorado statute regulating communicative activities within 100 feet of healthcare facility entrances. We likewise rejected the plaintiffs' vagueness claim (which focused on the Attorney General's letter), explaining that such an attempt at interpretive guidance cannot alter the meaning of a law that is clear on its face. Finally, we ruled that the Act did not constitute an unlawful prior restraint on protected speech.

When the dust had settled, the district court took up the plaintiffs' as-applied challenge. As a threshold matter, it invoked the law of the case doctrine and resisted the plaintiffs' attempt to reargue the facial constitutionality of the Act. Next, it granted the defendants' motion for judgment on the pleadings with respect to seven as-applied counts. Turning to whether the Act, as applied, constituted a valid time-place-manner regulation, the court concluded that the only trialworthy issue concerned the adequacy of alternative channels of communication at the challenged facilities. Following a bench trial, the court upheld the Act as applied.

B. The Three Sites.

We rehearse the evidence anent the relevant clinic locations. As a prelude, we note that each of the plaintiffs engages in communicative activities outside one of these three RHCFs.

1. **Boston**. The Boston clinic is situated in a free-standing building at 1055 Commonwealth Avenue (a main thoroughfare in the Brighton section of Boston). Its front door faces Commonwealth Avenue; its rear garage entrance faces Gardner Street. All clinic patients enter through the front door and must use the twenty-five-foot-wide public sidewalk along Commonwealth Avenue. Buffer zones, marked with yellow arcs and posted signs, are appurtenant to each entrance.

Three of the plaintiffs (McCullen, Cadin, and Zarrella) regularly engage in "sidewalk counseling" at the Boston clinic. McCullen parks her car on Commonwealth Avenue and festoons it with pro-life signage; Zarrella sometimes prays aloud; and Cadin from time to time holds aloft a large pro-life sign.

A fourth plaintiff, Smith, has demonstrated outside the Boston clinic for many years. He has displayed a crucifix, sung religious hymns, and prayed aloud. His prayers are meant to be heard by passersby in hopes of persuading them to opt against abortion. He sometimes brings a loudspeaker to amplify group prayers that occur outside the clinic

on the second Saturday of every month and on Good Friday.

The plaintiffs insist that they have achieved success in their counseling efforts: they speak with prospective patients, elicit responses, and hand out literature. In some instances, they have persuaded women to decide against terminating pregnancies. McCullen estimates that, during the period between November 2007 and May 2011, her sidewalk counseling convinced approximately eighty women to refrain from seeking abortions.

Despite their accomplishments, the plaintiffs argue that the buffer zones prevent close personal contact with their intended audience and, thus, impede their ability to communicate effectively. By way of illustration, Zarrella asserts that, although women "always" respond to her offers of enlightenment and assistance, she has not been able to convince any of them to opt out of an abortion since the 2007 buffer zones were put in place.

2. Worcester. The Worcester clinic is situated in a stand-alone building at 470 Pleasant Street. Its main entrance is accessible from Pleasant Street and also from a private parking lot behind the building. The public sidewalk on Pleasant Street is nearly fifty-four feet from the main door and staggered metal fences shield the front of the building and the private pedestrian walkway that runs between these points. Neither the fencing nor the walkway is on public property. The entrance to the parking lot is on Dewey Street and all vehicular traffic must use that entrance.

There are buffer zones marked with painted white arcs and posted signs on both Pleasant Street and Dewey Street. More than eighty-five percent of all patients arrive by car, park in the clinic's lot, and walk directly to the main door (without setting foot on any public way).

Two of the plaintiffs (Bashour and Clark) engage in sidewalk counseling at the Worcester clinic. They try to divert women to Problem Pregnancy, a "pro-life pregnancy crisis center" located across the street. Bashour prays quietly outside the clinic, sometimes alone and sometimes with others. For her part, Clark often displays a large pro-life sign.

Here, too, the plaintiffs claim to have achieved some success in their counseling efforts. They speak with patients, distribute literature, and persuade women to refrain from seeking abortions. Notwithstanding these successes, the plaintiffs aver that the physical set-up renders their attempts to communicate "ineffective" by impeding their ability to view and approach individuals entering the front door, to make eye contact with patients, and to "demonstrate a caring demeanor." As they recall it, virtually no patients who park in the clinic's private lot respond to their overtures or "make the effort" to venture outside the clinic's premises. The buffer zones preclude them from speaking at "a normal conversational distance" with, or placing literature near, the vast majority of patients entering the clinic.

3. Springfield. The Springfield clinic is situated in a multi-tenant medical complex

at the corner of Main Street and Wason Avenue. The building contains at least eight separate medical offices. It is bordered on two sides by private parking lots; a third side abuts another building; and the fourth side neighbors an open expanse that contains railroad trackage. Approximately ninety percent of individuals patronizing the complex arrive by car and park in one of the lots.

There are five driveways leading to and from the complex, two of which have been painted with white arcs and posted to establish buffer zones: one on Main Street and one on Wason Avenue. The remaining three driveways have painted white arcs but no signs. They are not, therefore, buffer zones authorized by the Act. Consequently, they have no legal effect.

A plaintiff (Shea) prays aloud and engages in sidewalk counseling outside the clinic. He habitually displays a large sign that reads "They're Killing Babies Here." He laments that, from and after the creation of the buffer zones, he has not seen literature provided to anyone in a vehicle. He estimates that only five percent of those who arrive by car leave the clinic's parking lots either to accept pro-life literature or to investigate the possibility of counseling.

II. THE LAW OF THE CASE

We start our appraisal of the merits with the plaintiffs' exhortation that we revisit *McCullen I*, in which we held that the Act, on its face, is a constitutionally valid time-place-manner regulation. The district court found that the law of the case doctrine barred relitigation of this issue. We agree.

The law of the case doctrine has two branches. The first, which embodies the so-called mandate rule, "prevents relitigation in the trial court of matters that were explicitly or implicitly decided by an earlier appellate decision in the same case." The second "binds a successor appellate panel in a second appeal in the same case to honor fully the original decision." Both branches of the doctrine apply here.

To be sure, the law of the case doctrine admits of certain exceptions. But the circumstances giving rise to those exceptions are narrowly circumscribed:

> A party may avoid the application of the law of the case doctrine only by showing that, in the relevant time frame, controlling legal authority has changed dramatically; or by showing that significant new evidence, not earlier obtainable in the exercise of due diligence, has come to light; or by showing that the earlier decision is blatantly erroneous and, if uncorrected, will work a miscarriage of justice.

Although the plaintiffs allude in desultory fashion to the third exception, they make no reference to the second exception and their only colorable claim concerns the first exception.

The plaintiffs base their claim on recent decisions of the Supreme Court standing for the wholly unremarkable proposition that content-based and speaker-based speech restrictions are disfavored. In their view, these neoteric decisions have so

reconfigured the First Amendment landscape as to justify a departure from the law of the case. This impressionistic argument, though ingenious, elevates hope over reason. The propositions for which the plaintiffs cite those cases are no more than conventional First Amendment principles recited by the Supreme Court in the context of factual scenarios far different than the scenario at issue here.

The decision on which the plaintiffs rely most heavily—*Citizens United*—is emblematic of this point. *Citizens United* overruled *Austin v. Michigan Chamber of Commerce*, which had held that corporate entities, as opposed to other speakers, could be prohibited from engaging in political speech. The plaintiffs contend that *Citizens United* announced, for the first time, a blanket ban on all speaker distinctions, whatever the setting. This categorical ban, they say, should serve to invalidate the Act as a speaker-specific restriction.

This is an imprecise reading of *Citizens United*. The *Citizens United* Court held that government cannot entirely prohibit corporate political speech. In support, it invoked the "central principle" laid out in *First National Bank of Boston v. Bellotti*, to the effect "that the First Amendment does not allow political speech restrictions based on a speaker's corporate identity." The Act, of course, makes no such distinction.

The plaintiffs, however, are undaunted. They seize upon an isolated statement in *Citizens United*: "Prohibited, too, are restrictions distinguishing among different speakers, allowing speech by some but not others." But they yank this statement from its context and they neglect to mention that the Court cites *Bellotti*—a case that substantially predates *McCullen I*—for this proposition. The Court's reliance on *Bellotti* is not a mere fortuity. After all, the *Citizens United* Court described its decision as a return to classic First Amendment jurisprudence rather than a departure therefrom. The Court did not retreat from its well-settled abortion clinic/buffer zone jurisprudence. Seen in this light, we cannot read *Citizens United* as undermining the First Amendment foundation on which our rejection of the plaintiffs' facial challenge rested.

So, too, *Snyder*, in which the Court held that the First Amendment precludes tort liability against persons who had peacefully protested, on public property, at the funeral of a Marine. Once again, the Court did no more than apply long-recognized First Amendment principles. And while it reiterated the special status of public streets as the "archetype of a traditional public forum," it proceeded to confirm that even public fora are subject to reasonable time-place-manner regulations. It is especially telling that, in making this point, the Court referred specifically to the abortion clinic buffer zone that it had upheld in *Madsen*.

The plaintiffs' reliance on *Sorrell* is equally mislaid. The *Sorrell* Court invalidated a Vermont law that restricted the sale, disclosure, and use of pharmacy records for marketing purposes. The law, on its face, was content-based and speaker-based, and had been enacted with the avowed purpose of "diminish[ing] the effectiveness of

marketing by manufacturers of brand-name drugs."

The case before us could not be more different. As we explained in *McCullen I*, the Act is both content-neutral and speaker-neutral. Moreover, the legislature enacted it to serve a valid, non-speech-related purpose: public safety.

In a Rumpelstiltskin-like effort to turn straw into gold, the plaintiffs dismiss these important differences and focus instead on the *Sorrell* Court's statement that "the inevitable effect of a statute on its face may render it unconstitutional." But this hoary legal precept (with which we agree) is not novel. The "inevitable effect" language derives from the Court's decision in *United States v. O'Brien*, which comfortably predates both our decision in *McCullen I* and the Supreme Court's abortion clinic/buffer zone jurisprudence.

More to the point, the *Sorrell* precept is in no way inconsistent with our holding in *McCullen I*. The "inevitable effect" of the Act is to limit the communicative activities of all demonstrators (whether pro-choice or pro-life) to exactly the same extent.

The plaintiffs have also marshaled other recent Supreme Court cases in their ambitious effort to reinvent First Amendment doctrine. It would serve no useful purpose to canvass these cases. For present purposes, it suffices that these decisions, by no stretch of even the most fertile imagination, sully either the reasoning or the doctrinal infrastructure of *McCullen I*.

The short of it is that the First Amendment principles underpinning our core holdings in *McCullen I* have not been materially altered, let alone abrogated, by any subsequent Supreme Court precedent. Accordingly, the district court did not err in declining the plaintiffs' invitation to set the law of the case doctrine to one side and revisit the plaintiffs' facial challenge to the Act.

III. JUDGMENT ON THE PLEADINGS

The plaintiffs challenge the district court's entry of judgment on the pleadings on several fronts. We review de novo an order granting or denying judgment on the pleadings. To withstand a motion for judgment on the pleadings, a "complaint must contain sufficient factual matter to state a claim to relief that is plausible on its face."

A. Viewpoint Discrimination.

The plaintiffs' principal challenge to the entry of judgment on the pleadings relates to their claim of viewpoint discrimination. They argue that Planned Parenthood employees and agents have abused the buffer zones and that this activity constitutes viewpoint discrimination under the First Amendment. The district court rejected this argument on the pleadings, holding that the plaintiffs had not alleged sufficient facts to support the claim.

In their complaint, the plaintiffs aver that "pro-choice advocates [ ] surround, cluster, yell, make noise, mumble, and/or talk loudly to clinic clients for the purpose of disrupting or drowning out pro-life speech and thwart Plaintiffs' efforts to distribute literature."

They further aver that clinic "employees and/or agents stand idly on the public sidewalks and streets inside the [buffer] zone"—sometimes smoking, speaking with each other or on mobile phones, or drinking coffee—"even when clinic clients are not present."

Because this issue was resolved at the pleading stage, we assume arguendo that the raw facts are as the plaintiffs have alleged. The question remains, however, whether the depicted conduct can fairly be characterized as viewpoint discrimination attributable to the state. The plaintiffs say that it can. The Attorney General demurs.

We begin with the basics. The Act, on its face, is viewpoint-neutral. Although it contains a "clinic employee" exemption, that exemption does not purport to allow either advocacy by an exempt person or interference by an exempt person with the advocacy of others.

The plaintiffs strive mightily to overcome this obstacle. They call our attention to the decision in *Hoye v. City of Oakland*. There, a municipal ordinance prohibited, within a 100–foot zone around entrances to RHCFs, any knowing or willful "approach within eight feet of an individual seeking entry to the clinic if one's purpose in approaching that person is to engage in conversation, protest, counseling, or various other forms of speech." The Ninth Circuit concluded that the ordinance was constitutional on its face but unconstitutional as applied. It predicated this conclusion on a determination that the city did not evenly enforce the ordinance; rather, the city's actions manifested "a firm policy of enforcing the Ordinance ... only [against] efforts to persuade women approaching [RHCFs] ... not to receive abortions or other reproductive health services, and not [against] communications seeking to encourage entry into the clinic for the purpose of undergoing treatment."

This case is at a considerable remove from *Hoye*. The *Hoye* court's finding of uneven enforcement was inevitable in light of the city's frank admission that it consciously "enforces the Ordinance in a content-discriminatory manner." In contrast, the plaintiffs here have not pleaded any facts that might suffice to ground a claim of uneven enforcement.

The conduct described, without more, has nothing to do with the First Amendment. While loitering in a buffer zone by an exempt person is not expressive in nature and arguably does not serve the purposes of the Act, such conduct, simpliciter, does not prefer one viewpoint over another.

What is more, the employees and agents about whom the plaintiffs complain are not state actors but—unlike the municipal police officers in *Hoye*—are agents of a private entity (Planned Parenthood). The Act allows these individuals to be in buffer zones under the clinic employee exemption. But to the extent that they have tried to use their exempt status either to advocate a particular point of view or to drown out the plaintiffs' message, there is no allegation that such behavior has been sanctioned by the state.

Another point is worth making. If the plaintiffs believed themselves to be

aggrieved by the employee/agent behavior that they describe, the commonsense remedy would have been to complain to police officers or other state authorities. The pleadings are barren of any allegation that such a complaint was ever made.

The bottom line is that, to be cognizable, a claim of uneven enforcement requires state action. Whatever actions the clinic employees and agents may have taken, this record reveals no basis for a plausible claim that those actions reflect a viewpoint preference of the state.

B. Overbreadth.

The plaintiffs assign error to the district court's entry of judgment on the pleadings with respect to their overbreadth claim. Although they concede that we rejected a substantially similar overbreadth claim in *McCullen I*, they suggest that the Act may be overbroad in particular applications.

Overbreadth doctrine invalidates statutes "not because [the plaintiffs'] own rights of free expression are violated, but because of a judicial prediction or assumption that the statute's very existence may cause others not before the court to refrain from constitutionally protected speech or expression." But overbreadth must be both "real" and "substantial," as assessed "in relation to the statute's plainly legitimate sweep." "Where an overbreadth attack is successful, the statute is obviously invalid in all its applications, since every person to whom it is applied can defend on the basis of the same overbreadth." Thus, the appropriate analysis "requires consideration of many more applications than those immediately before the court."

In the case at hand, the parties spar over whether there is such a creature as an as-applied overbreadth challenge. We need not grapple with this conundrum because, even if some overbreadth challenges may contain an as-applied component, this one does not.

In explaining the district court's supposed error, the plaintiffs repeat their complaint, rejected on their facial challenge, that all communicative activities (as opposed to, say, purely violent or aggressive activities) are banned within buffer zones. In attempting to convert this previously rejected challenge into a viable as-applied challenge, they posit that *McCullen I* cannot control because it did not specifically conclude whether the Act is substantially overbroad at the Boston, Worcester, and Springfield locations. Withal, they offer no accompanying factual allegations, other than pointing to what they identify as five buffer zones at the Springfield location. As we already have explained, only two enforceable buffer zones exist around the Springfield clinic. Thus, our Springfield-directed analysis considers only those two zones.

We need not tarry. Here, as in *Hill*, "the comprehensiveness of the statute is a virtue, not a vice, because it is evidence against there being a discriminatory governmental motive." The plaintiffs have not pleaded facts sufficient to suggest that our earlier holding in *McCullen I* does not control their present claim. Accordingly, the claim fails under the plausibility standard. It follows

that the district court did not err in granting judgment on the pleadings on the overbreadth claim.

C. Other Claims.

The plaintiffs attempt to resurrect a number of other claims that the district court laid to rest in its entry of judgment on the pleadings. There are two principal problems.

First, the plaintiffs have not pleaded an adequate factual predicate. In the absence of pleaded facts sufficient to distinguish the plaintiffs' as-applied challenge on these grounds from their failed facial challenge, the latter controls the former.

Second, the plaintiffs do not pursue this battery of claims with developed argumentation or in any other meaningful way. We routinely have held, and today reaffirm, that theories presented on appeal in a perfunctory fashion are deemed abandoned. So it is here.

IV. THE AS–APPLIED CHALLENGE

We turn next to the red meat of this appeal: the plaintiffs' as-applied challenge to the operation of the Act at the three specific RHCFs described above. The district court spurned this challenge; it concluded that because there are adequate alternative channels of communication open to the plaintiffs at each location, the Act comprises a valid time-place-manner regulation. We review this conclusion de novo.

With respect to time-place-manner regulations, the Supreme Court has explained:

> [E]ven in a public forum the government may impose reasonable restrictions on the time, place, or manner of protected speech, provided the restrictions are justified without reference to the content of the regulated speech, that they are narrowly tailored to serve a significant governmental interest, and that they leave open ample alternative channels for communication of the information.

The district court found that the issues of content neutrality and narrow tailoring were definitively resolved by *McCullen I*. The plaintiffs lament that this approach "improperly narrowed the required constitutional analysis."

We reject this lamentation. The facts proffered by the plaintiffs in support of their as-applied challenge do not raise new or different issues but, rather, repeat in relevant part the same fact patterns envisioned in our adjudication of their failed facial challenge. It is black-letter law that a plaintiff cannot rewardingly prosecute an as-applied challenge to the constitutionality of a statute based on the same legal arguments and factual predicate that underpinned an earlier (unsuccessful) facial challenge.

The congruence between the plaintiffs' facial and as-applied challenges cannot be gainsaid. The plaintiffs now attempt to raise precisely the same arguments about content neutrality and the significance of the governmental interest involved that were squarely raised (and squarely repulsed) in the course of their facial challenge. The same can be said of the narrow tailoring inquiry. In any event, to the extent that the as-applied challenge in this case implicates particularities of the three clinic locations,

those particularities are swept into—and appropriately addressed by—the inquiry into the availability of adequate alternative means of communication.

This brings us to the pivotal question of whether the Act, as applied, leaves open adequate alternative means of communication. Each of the plaintiffs engages in communicative activities outside one of the three designated RHCFs. According to the plaintiffs, these communicative activities are intended to influence individuals seeking or considering abortions as well as "those who approve or perform abortions."

The plaintiffs vouchsafe that they prefer to communicate their message through up-close, gentle conversations, accompanied by smiles and eye contact. They insist that the buffer zones authorized by the Act force them to engage in shorter, louder, and less personal exchanges. They fear that, without the ability to "make eye contact and demonstrate a caring demeanor," their communications are ineffectual. As they see it, the need to stop at the edge of the buffer zone is devastating; this restriction compels them to raise their voices, precludes them from handing literature to prospective patients in many instances, detracts from their message, and somehow makes them seem "untrustworthy."

Notwithstanding the plaintiffs' importunings, the court below concluded that adequate alternative means of communication exist at all three sites. Our inquiry focuses on this set of conclusions.

The record makes plain that communicative activities flourish at all three places. To begin, the plaintiffs and their placards are visible to their intended audience. Through their signs and demonstrations, the plaintiffs disseminate their message and elicit audience reactions. Their voices are audible. They have the option (which they sometimes have exercised) of using sound amplification equipment. When they and their cohorts deem it useful to do so, they congregate in groups outside a clinic, engage in spoken prayer, employ symbols (such as crucifixes and baby caskets), and wear evocative garments. They sometimes don costumes (dressing up as, say, the Grim Reaper).

To be sure, the Act curtails the plaintiffs' ability to carry on gentle discussions with prospective patients at a conversational distance, embellished with eye contact and smiles. But as long as a speaker has an opportunity to reach her intended audience, the Constitution does not ensure that she always will be able to employ her preferred method of communication. In the last analysis, "there is no constitutional requirement that demonstrators be granted ... particularized access" to their desired audience. As long as adequate alternative means of communication exist, the First Amendment is not infringed.

Our inquiry into the adequacy of alternative means of communication is, of course, site-specific. At the Boston clinic, all prospective patients must traverse a public sidewalk to gain entry. Given this reality, many channels of communication remain available to the plaintiffs. Those alternative channels are

adequate to offset the restrictions inherent in the buffer zones.

The analysis is somewhat different with respect to Worcester and Springfield. At these sites, it is not the buffer zones that constitute the main impediment to communicative activity; instead, it is the prospective patients' unwillingness to venture off the clinics' private property. Most prospective patients arrive by car, park in private lots, and use non-public walkways to enter the facility. The fact that these patients are not readily accessible to the plaintiffs is more a function of the physical characteristics of the sites than of the operation of the Act.

This is a critically important datum. The law does not require that a patient run a public-sidewalk gauntlet before entering an abortion clinic. That patients choose to stay on private property or not to stop their cars on approach is a matter of patient volition, not an invidious effect of the Act. First Amendment rights do not guarantee to the plaintiffs (or anyone else, for that matter) an interested, attentive, and receptive audience, available at close-range.

One additional observation seems appropriate. In the context of abortion-related demonstrations, the Supreme Court has specifically recognized the interest of clinic patients both "in avoiding unwanted communication" and "pass[ing] without obstruction." Consistent with this interest, the First Amendment does not compel prospective patients seeking to enter an abortion clinic to make any special effort to expose themselves to the cacophony of political protests. Nor does it guarantee to the plaintiffs the same quantum of communication that would exist in the total absence of regulation. A diminution in the amount of speech, in and of itself, does not translate into unconstitutionality. So long as adequate alternative means of communication exist, no more is constitutionally exigible.

We add a coda. Even if the plaintiffs' audience is diminished in some respects by the existence of the buffer zones, that diminution is not constitutionally fatal. The fact that a regulation "may reduce to some degree the potential audience for [the plaintiffs'] speech is of no consequence," as long as adequate alternative means of communication exist.

In an effort to change the trajectory of the debate, the plaintiffs tout the Supreme Court's decision in *City of Ladue v. Gilleo*. That decision is inapposite here.

Gilleo involved a municipal ordinance that broadly banned residential signs. Analyzing the ordinance as a time-place-manner regulation, the Court assumed the validity of the city's content-neutral justification and acknowledged its valid governmental interest in limiting "visual clutter." But the Court took account of the peculiar characteristics of home-lawn signs and the "special respect for individual liberty in the home" and concluded that the ordinance failed to leave open adequate alternative means of communication. Of particular pertinence for present purposes, the Court explicitly contrasted the home-lawn sign context with "the government's need to

mediate among various competing uses, including expressive ones, for public streets." The case at hand falls solidly within the latter context and, thus, outside *Gilleo*'s precedential sweep.

One further point must be made. The decision in *Gilleo* predates the Court's abortion clinic/buffer zone line of cases. The Court's majority in these cases never even mentions *Gilleo*. It would make no sense to wrest *Gilleo* from its contextual moorings and use it as a wedge to subvert the Court's later decisions addressed to the much different problem of how the First Amendment operates when the special concerns of public-sidewalk protests around abortion clinics are at stake.

We summarize succinctly. On this record, it is readily apparent that, notwithstanding the buffer zones authorized by the Act, adequate communicative channels remain available to the plaintiffs, including oral speech of varying degrees of volume and amplification, distribution of literature, displays of signage and symbols, wearing of evocative garments and costumes, and prayer alone and in groups. The Act is, therefore, a valid time-place-manner regulation as applied to the Boston, Worcester, and Springfield RHCFs.

V. LEAVE TO AMEND

In a last-ditch effort to save the day, the plaintiffs asseverate that the district court erred in denying them leave to amend their complaint to include a direct challenge to the Attorney General's letter. We review for abuse of discretion a district court's denial of a motion to amend a complaint. As a general proposition, a denial of a motion for leave to amend "will be upheld so long as the record evinces an arguably adequate basis for the court's decision," such as "futility, bad faith, undue delay, or a dilatory motive on the movant's part."

The order challenged in this case falls within the rubric of undue delay. The district court took a balanced approach. It allowed the plaintiffs to make amendments at the margins of their complaint (for example, the addition of the three district attorney defendants), but it refused to allow the plaintiffs to introduce a new theme at so late a date.

The plaintiffs' original complaint focused exclusively on the Act. The Attorney General issued the guidance letter within two weeks of the filing of the complaint, yet the plaintiffs chose to ignore it. Not until September 17, 2010 did the plaintiffs seek to enlarge their target to include the Attorney General's letter. That was more than two-and-one-half years after the docketing of their original complaint. They have offered no compelling explanation for the delay. Given the passage of this inordinate period of time, we cannot say that the district court abused its discretion in drawing the line and refusing to allow the plaintiffs to refocus their attack. The plaintiffs had ample time to get their ducks in a row, and the district court was under no obligation to give them more.

VI. CONCLUSION

We need go no further. For the reasons elucidated above, we affirm the judgment of the district court.

Affirmed.

"Abortion Clinic Buffer Zone Gets U.S. High Court Review"

Bloomberg
Greg Stohr
June 24, 2013

The U.S. Supreme Court accepted a case that promises to redefine the speech rights of abortion opponents, agreeing to rule on a Massachusetts law that creates a 35-foot buffer zone around clinic entrances.

The justices today said they will hear an appeal from abortion foes seeking to overturn the Massachusetts law as a violation of the First Amendment. The challengers say they have a right to hand out leaflets and start conversations with women entering abortion clinics.

A Boston-based federal appeals court upheld the measure, pointing to a 2000 Supreme Court decision that upheld Colorado restrictions on abortion clinic protests.

Massachusetts enacted the law in 2007, strengthening an existing measure that had required a 6-foot buffer zone at abortion clinics. The new law makes it a crime to "knowingly enter or remain" in an area within 35 feet of a clinic entrance, exit or driveway. The measure exempts clinic employees and people entering or leaving the facility.

The high court's membership has changed significantly since the 2000 decision. Most notably, two members of that 6-3 majority, Chief Justice William Rehnquist and Justice Sandra Day O'Connor, are no longer on the court. Their successors, Chief Justice John Roberts and Justice Samuel Alito, are often sympathetic to free-speech claims.

The justices will hear arguments and rule in their 2013-14 term, which starts in October.

The case is *McCullen v. Coakley*, 12-1168.

“McCullen v. Coakley: Abortion Is Heading to the Supreme Court Again”

PolicyMic
Alexandra Ma
June 18, 2013

On Monday, the Supreme Court agreed to hear out a challenge from anti-abortion activists. This time, it is not about the mothers or their wombs, but about the freedom of speech.

The challenge from seven anti-abortion petitioners is directed at the Massachusetts abortion clinic buffer law that was enacted in 2000, which bans demonstrations within 35 feet of entrances and driveways of abortion clinics. The petitioners claim that the Massachusetts law discriminately violates their First and Fourteenth Amendments; in their petition to the Supreme Court, they write that "The law restricts the speech of only those who wish to use public areas near abortion clinics to speak about abortion from a different point of view."

The petitioners are backed by anti-abortion activists, many of whom offer "sidewalk counseling" to women on their way to the clinics. They claim that the law unfairly keeps them from engaging patients in conversation at a closer distance. Similarly, Philip Moran, the petitioners' lawyers, said, "You can't stand outside 35 feet and communicate with people ... You have to have eye contact."

The Massachusetts buffer zone laws were established after a tragic attack was carried out in 1994 outside an abortion clinic in Brookline, Massachusetts, when abortion opponent John C. Salvi III shot two clinic workers to death and wounded five others.

Many legal challenges had been rejected prior to this case, but they were revived in 2007 when Governor Deval Patrick signed a bill extending the buffer zone from 18 to 35 feet.

In 2008, the First Circuit Court of Appeals upheld the law in its ruling in *McCullen v. Coakley*, stating that the law upholds both free speech and abortion patients' rights. The First Circuit acknowledged, "The nation is sharply divided about the morality of the practice and its place in a caring society ... But the right of the state to take reasonable steps to ensure the safe passage of persons wishing to enter health care facilities cannot seriously be questioned."

Speaking since the Supreme Court's grant of a writ of certiorari on Monday, Massachusetts Attorney General Martha Coakley reiterated her belief that the law "ensure[s] a women's right to safe access to health care facilities while preserving First Amendment rights... We look forward to defending this vitally important legislation before the Supreme Court."

Equally hopeful are the anti-abortion activists, who believe that the buffer zone laws are a "clear case of viewpoint discrimination." Executive director of the Life Legal Defense Foundation Dana Cody

also expressed her optimism that the Supreme Court will not only overturn the law, "but also revisit some of its own prior precedents that led lower courts to believe that, as a matter of law, pro-life speech is less deserving of protection." Moran also mentioned that he and his clients were "delighted" that SCOTUS agreed to hear their case. "We think we have a good shot," he said on Monday.

In the past, SCOTUS has rejected a number of cases, most notably from Indiana and Colorado, which would have effectively reopened the debate on abortion, so their reason for reopening *McCullen* would be interesting to explore. Given the optimism from both sides of the case, SCOTUS's decision is not going to be easily predictable.

On one hand, given SCOTUS's sympathetic stance towards abortion-seekers, this hearing may serve as a once-and-for-all ruling that upholds *McCullen*, thereby setting a precedent for lower courts to allow buffer zones protecting women who seek abortion. On the other hand, SCOTUS may strengthen the scope of the First and Fourteenth Amendments, allowing anti-abortion activists to exercise their freedom of speech anytime, anywhere.

So, watch this space. Given the fine line between protecting abortion seekers' rights and the fundamental freedoms provided by the First and Fourteenth Amendments, this is definitely another SCOTUS judgment for which we should keep our eyes peeled.

"Court Upholds Mass. Abortion Clinic Buffer Law"

Boston Globe
Martin Finucane
January 9, 2013

A federal appeals court has again upheld the buffer zone law for Massachusetts abortion clinics, saying that the regulation protects the rights of patients while, at the same time, allowing others to express their opinions.

"Few subjects have proven more controversial in modern times than the issue of abortion," the US Court of Appeals for the First Circuit said in its ruling on Wednesday. "The nation is sharply divided about the morality of the practice and its place in a caring society. But the right of the state to take reasonable steps to ensure the safe passage of persons wishing to enter health care facilities cannot seriously be questioned.

"The Massachusetts statute at issue here is a content-neutral, narrowly tailored time-place-manner regulation that protects the rights of prospective patients and clinic employees without offending the First Amendment rights of others," said the opinion, written by Judge Bruce M. Selya, who heard the case, along with two other judges.

The appeals court ruling affirmed a decision by US District Judge Joseph L. Tauro last February.

Mark L. Rienzi, a lawyer representing the plaintiffs, said they expected to appeal the decision to the US Supreme Court.

"The same rules have to apply to all speakers. The government cannot put peaceful pro-life speakers in jail, but give Planned Parenthood free rein on the same sidewalk," he said in a statement.

The law creates a 35-foot fixed buffer zone around the driveways and entrances of clinics. The lawsuit, *Eleanor McCullen et al v. Martha Coakley et al*, was brought by seven people who regularly engaged in antiabortion counseling outside the three clinics.

"We are pleased that the court has once again upheld the Commonwealth's buffer zone law which provides safe access to reproductive health care facilities while preserving freedom of expression," Attorney General Martha Coakley, whose office defended the law, said in a statement. "We have always believed, and the court agreed, that the buffer zone leaves open the opportunity for civil engagement on public areas around these facilities while ensuring that patients and health care providers can safely access these facilities."

The challenge to the law was the latest in a series. "This case does not come to us as a stranger," the appeals court said, leading off its decision.

The court twice upheld an earlier version of the law, in 2001 and 2004. After the Legislature revised the law in 2007, the

appeals court upheld it again in 2009. More challenges were launched in Tauro's court. Tauro rejected them, but the plaintiffs appealed, leading to the court's decision today.

“Abortion Opponents: 'Buffer Zones' At Abortion Clinics Violate Free Speech”

US News
Elizabeth Flock
June 25, 2013

The Supreme Court has said it will reconsider the constitutionality of protest zones

The Supreme Court announced Monday it would hear an appeal from abortion opponents on the constitutionality of a 2007 Massachusetts law that requires protesters to stand at least 35 feet from abortion clinics, according to the Associated Press.

Chief among those opponents is the Massachusetts Citizens for Life, an anti-abortion group that's been challenging the law for years as a violation of their free speech rights.

"We consider it a First Amendment issue, because it's a law that targets very certain facilities, just abortion facilities," says Anne Fox, the group's president. Protests outside corporate buildings or by animal rights activists, for example, do not have protests "buffer zones." Fox says the zones also make it nearly impossible for anti-abortion activists to speak freely to women walking into clinics to get an abortion.

"At many [clinics] people would like to counsel a woman who would like to know her options... and this law makes it extremely difficult. You don't want to yell at someone, but you really can't get near them," she says.

Massachusetts Citizens for Life also works online to persuade women away from abortions; its website's homepage reads: "Pregnant? Need Help?" and leads to a list of Christian missions in Massachusetts that provide counseling on how to avoid an abortion.

State lawmakers first approved the law for protest zones in 2000, motivated in part by fears of violence at abortion clinics. Just several years prior, an abortion opponent, John Salvi, had walked into two Boston-area Planned Parenthood reproductive health clinics and opened fire, killing two receptionists and wounding five more.

"People seeking health services should be able to do so without fear of violence, harassment or intimidation," Planned Parenthood League of Massachusetts President Martha Walz said in a released statement Monday.

But Fox says she doesn't believe buffer zones can effectively prevent violence at clinics.

"If you're going to have violence, a 35-foot buffer zone wouldn't help. The only people abiding this are the peaceful protesters," she says. "And there are probably four incidents of violence at abortion clinics a year. It's much less likely to have violence at a clinic than at a McDonalds."

According to the National Abortion Federation (NAF), which tracks anti-abortion attacks, abortion clinics have seen less than four attacks per year for the last several years.

Massachusetts Citizens for Life, which is optimistic the Supreme Court will strike down the buffer zone law, has had success at the highest court before.

In 1978, the Federal Election Commission questioned whether corporate donations had helped the group print 100,000 pamphlets calling out the pro-abortion voting records of candidates. The case went to the Supreme Court, which ruled in favor of Massachusetts Citizens for Life, saying a ban on corporate electoral spending was unconstitutional.

Cline v. Oklahoma Coalition for Reproductive Justice

12-1094

Ruling Below: *Oklahoma Coalition for Reproductive Justice v. Cline*, 292 P.3d 27 (Okla. 2012), *cert granted*, 2013 WL 867379 (U.S. 2013).

Coalition of reproductive rights organizations brought action challenging constitutionality of state statute prohibiting prescription of abortifacient medication. The District Court held statute unconstitutional and enjoined enforcement thereof. State appealed.

Question Presented: Whether H.B. No. 1970, Section 1, Chapter 216, O.S.L. 2011 prohibits: (1) the use of misoprostol to induce abortions, including the use of misoprostol in conjunction with mifepristone according to a protocol approved by the Food and Drug Administration; and (2) the use of methotrexate to treat eptopic pregnancies. Further proceedings in this case are reserved pending receipt of a response from the Supreme Court of Oklahoma.

OKLAHOMA COALITION FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members and Nova Health Systems, d/b/a Reproductive Services, on behalf of itself, its staff, and its patients, Plaintiffs/Appellees,
v.
Terry CLINE, in his official capacity as Oklahoma Commissioner of Health, Lyle Kelsey, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision, Catherine V. Taylor, in her official capacity as the President of the Oklahoma State Board of Osteopathic Examiners, Defendants/Appellants.

Supreme Court of Oklahoma

Decided on December 4, 2012

[Excerpt; some footnotes and citations omitted.]

Per curiam

This is an appeal of the trial court's summary judgment which held House Bill 1970, unconstitutional. Upon review of the record and the briefs of the parties, this Court determines this matter is controlled by the United States Supreme Court decision in *Planned Parenthood v. Casey*, which was applied in this Court's recent decision of *In re Initiative No. 395*.

Because the United States Supreme Court has previously determined the dispositive issue presented in this matter, this Court is not free to impose its own view of the law. The Supremacy Clause of the United States Constitution provides:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties

> made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

The Oklahoma Constitution reaffirms the effect of the Supremacy Clause on Oklahoma law by providing: "The State of Oklahoma is an inseparable part of the Federal Union, and the Constitution of the United States is the supreme law of the land." Thus, this Court is duty bound by the United States and the Oklahoma Constitutions to "follow the mandate of the United States Supreme Court on matters of federal constitutional law"

The challenged measure is facially unconstitutional pursuant to *Casey*. The mandate of *Casey* remains binding on this Court until and unless the United States Supreme Court holds to the contrary. The judgment of the trial court holding the enactment unconstitutional is affirmed and the measure is stricken in its entirety.

ALL JUSTICES CONCUR.

"Supreme Court tells Oklahoma to Review Abortion Pill Law"

Los Angeles Times
David G. Savage
June 27, 2013

The Supreme Court told the high court of Oklahoma on Thursday to clarify a new state law restricting the use of the RU-486 abortion pill, setting the stage for a possible future ruling on how far states can go in regulating the practice of abortion.

Legislators in several states, including Oklahoma, have passed laws to strictly regulate the practice of abortion. Among them are measures that require all women seeking abortions to undergo an ultrasound test. Oklahoma also adopted a law restricting the use of RU-486.

But the Oklahoma Supreme Court blocked these laws from taking effect, saying they conflicted with a 1992 Supreme Court decision on abortion.

The justices, in their last meeting until late September, granted in part an appeal from Oklahoma Atty. Gen. Scott Pruitt on Thursday, but then sent the case back to Oklahoma for the state court to further explain how the RU-486 law would work in practice.

The court's action will put off consideration of the issue until the state court acts.

At issue ultimately is the meaning of the high court's 1992 decision in *Planned Parenthood vs. Casey*, which upheld a woman's right to choose abortion, but said states may regulate the practice, so long as they do not put an "undue burden" on the patients or their doctors.

The justices did not closely define what regulations were permitted, and they have largely stood aside since then. Their only major abortion ruling in recent years upheld the federal law that prohibited late-term abortions.

Besides Oklahoma, Louisiana, Texas and North Carolina have adopted laws requiring women to undergo ultrasound tests for nearly all abortions, even if they and their doctor object.

The two sides in the Oklahoma case differ sharply on the law regulating mifepristone, or RU-486. The state says it wants doctors and patients to follow the federal guidelines in using the drug. State lawmakers said they were seeking to protect the health of women.

Lawyers for the Center for Reproductive Rights said the regulations, if put into effect, would prevent women from using the abortion pill. "The statute at issue here effectively bans all abortions using medication, rather than by surgery," they told the high court.

"Abortion-Drug Case on Docket for Now"

Wall Street Journal
Louise Radnofsky & Brent Kendall
June 27, 2013

The U.S. Supreme Court on Thursday expressed interest in examining an Oklahoma law restricting the use of abortion-inducing drugs, raising the prospect of a ruling on an increasingly prevalent form of abortion.

The high court hasn't previously considered what kind of rules on drug-induced abortions might pass constitutional scrutiny. In the 1973 *Roe v. Wade* ruling and subsequent decisions modifying it, the Supreme Court has said women have a right to an abortion, while upholding certain state restrictions, such as waiting-period requirements.

The justices announced in a short written order that they would review the Oklahoma case, but added an asterisk: Before the court would move forward, it wished to hear the Oklahoma Supreme Court's views on how the state's law works. That left open the possibility that the high court could delay action or drop the case altogether after the Oklahoma court responds.

The appeal before the Supreme Court centers largely on RU-486, which was approved by the Food and Drug Administration in 2000 for use in terminating pregnancies.

Abortion-rights supporters say the drug and others like it expand women's access to abortion, because they are cheaper and less invasive than surgical abortions, can be taken privately and can be made available in areas where there are few or no abortion providers.

An Oklahoma law requires doctors to use FDA protocol when they administer RU-486 and other abortion-inducing drugs. The law's challengers—an abortion-rights group and a medical clinic—said in court documents that the state law effectively bans all abortions performed using the medication because doctors have developed better methods for administering the drugs that don't follow the original FDA protocol.

After Oklahoma enacted the law in 2011, state courts struck it down as unconstitutional, prompting Oklahoma Attorney General E. Scott Pruitt to appeal to the U.S. Supreme Court in a bid to save the measure.

Mr. Pruitt said the state was trying to protect women from off-label use of abortion-inducing drugs, which Oklahoma officials say has led to eight deaths. Oklahoma says it isn't trying to ban drug-induced abortions outright.

"We look forward to the opportunity to defend Oklahoma's right to protect its citizens," Mr. Pruitt said.

Antiabortion activists praised the high court's indication it would consider the issue. "The Supreme Court has taken a first

step toward protecting women and girls from the abortion industry's callous disregard for their health and safety when using life-ending drugs," said Charmaine Yoest, president of Americans United for Life.

Abortion-rights supporters say state restrictions on the drugs may tie doctors' hands and pose an undue burden on access to abortion. "This method has clearly been under attack," said Morgan Meneses-Sheets, program manager of the Reproductive Health Technologies Project. "Our opponents have been very creative and successful at carving away access."

Some 39 states require abortion-inducing drugs to be prescribed by a licensed physician. Four states—Arizona, North Dakota, Ohio and Oklahoma—have passed laws restricting physicians to follow the FDA protocol.

Twelve states have required the prescribing physician to be present when the drug is taken, barring the use of telephones or video conferencing, although not all of those laws are currently in effect.

"The Next Abortion Case is Here"

The New York Times
Linda Greenhouse
September 4, 2013

Justice Anthony M. Kennedy, author of the 5-to-4 opinion in June that struck down the Defense of Marriage Act, may well be a hero to the gay rights community, and deservedly so. But he's also the author of the 5-to-4 opinion that upheld the federal ban on so-called partial birth abortion back in 2007, and abortion-rights advocates have viewed with something close to dread the prospect that he could play a similarly decisive role in the Supreme Court's next abortion case.

That case has arrived.

It's understandable if you haven't heard of *Cline v. Oklahoma Coalition for Reproductive Justice*, which has received relatively little attention since the court accepted it on June 27, the day after the term ended. The lack of attention is itself understandable.

The case is an appeal by the state of Oklahoma from a ruling by its Supreme Court striking down a law that limits doctors' ability to prescribe the pills used to terminate early pregnancies. The medical abortion regimen, often referred to as RU-486, was approved by the Food and Drug Administration in 2000 as a safe and effective alternative to surgical abortion early in the first trimester. It has been used since then by close to two million American women, currently about 200,000 a year out of some 1.2 million abortions performed annually. The Oklahoma law doesn't ban the medical procedure. Rather, it requires doctors to follow the dosage and other instructions on the F.D.A. label. Viewed outside its context in the battle over abortion, the law looks perfectly sensible, a routine state regulation of medical practice. (Spoiler alert: it isn't.)

Further muddying the waters, the case is procedurally messy. While accepting it, the justices deferred scheduling it for argument until they receive clarification from the state court about what medications the somewhat ambiguously worded statute applies to. A request to another court for clarification, known as a certified question, is not unheard-of at the Supreme Court, but it is unusual. It gives the court's order granting review a tentative look, as if the justices are less than fully committed to deciding the case. It's possible that after receiving the state court's answer (there is no deadline, but the state court has invited briefs from interested groups and is likely to hear argument in October), the justices will decide not to proceed.

Possible but not, I think, likely. This case simply presents too tempting a target, for the very reasons that lie behind the emergence of this seemingly technical dispute about medical practice. At issue is the Supreme Court's own unstable abortion doctrine, specifically on where five justices might be willing to draw a line between acceptable

and impermissible obstacles to access to abortion.

While not everything about the case is clear yet, one aspect is perfectly obvious: the court's grant of review was no casual matter. Some justice or group of justices (it takes four votes to accept a case) spotted this case as a potential vehicle for saying something bigger about abortion and its regulation. By the same token, it's no accident that medical abortion (or medication abortion, as it is also known) is the latest flash point in the abortion debate. That may be counterintuitive, given the prolonged hand-wringing over "partial-birth" and other "late-term" abortions; medical abortion is most effective in the first six or seven weeks of pregnancy (by which time the embryo is about the size of a pencil eraser) and doesn't work after nine weeks (still in the first trimester, which is when about 90 percent of all abortions take place).

But if you think about it, it's evident why opponents of abortion have begun to focus on the early nonsurgical procedure. Medical abortion is the ultimate in women's reproductive empowerment and personal privacy. All it takes are two pills: mifepristone, sold as Mifeprex, which blocks the hormone progesterone, without which a pregnancy can't continue, and misoprostol, taken two days later, which causes the uterus to contract and expel the early pregnancy. In many states, women can take the second pill at home.

As abortion clinics are forced to close because of onerous state regulations (54 clinics in 27 states have closed in the last three years, and many women live hundreds of miles from the nearest provider) and as women entering clinics often have to run a gauntlet of protesters seeking to "counsel" them (in its new term, the Supreme Court will hear a First Amendment challenge to a Massachusetts "bubble zone" law that keeps speakers 35 feet away from the entrance to a "reproductive health care facility"), medical abortion offers an end-run around the obstacles that for years have been a core part of opposition strategy.

That's why, for example, 17 states have recently passed laws or issued regulations barring doctors from using video conferencing — "telemedicine" — to prescribe the abortion pills. Although video conferencing is increasingly popular in other medical settings, abortion is the only context in which states have sought to ban it. For a medical abortion, a nurse examines the woman by ultrasound as the doctor views the results over a video link. Having determined the stage of the pregnancy, the doctor then advises the woman on what to expect from the medication and dispenses the pills by sending a command that opens a drawer in the office. After taking the sequence of pills, the woman returns two weeks later for a follow-up visit.

Some 8,000 women in Iowa have used this procedure, which was pioneered in the state by Planned Parenthood and authorized in 2011 by the Iowa Board of Medicine. The board reversed itself last week. It acted on a petition from anti-abortion groups and with the support of Gov. Terry Branstad, an abortion opponent whose appointees to the board include a Catholic priest, Msgr. Frank

Bognanno. Governor Branstad's declaration that the video ban will "protect the health and well-being of Iowa women" had a familiar ring. Protecting women is always the stated rationale for new restrictions on abortion, even when the rationale is — as in Iowa, and as in the Oklahoma case before the Supreme Court — hogwash.

The law at issue in the Supreme Court case wasn't drafted in Oklahoma. It was written in Chicago by an influential anti-abortion organization, Americans United for Life, and included as the "Abortion-Inducing Drugs Safety Act" among 30 model laws made available for sponsorship by state legislators. In the name of patient safety, the statute makes it a crime for doctors to deviate from the dosage and other instructions published by the Food and Drug Administration when it approved the medication in 2000.

The problem is that after 13 years, with millions of medical abortions having been provided in Europe and Asia as well as the United States, medical opinion about the appropriate dosage and other aspects of administering the drugs has evolved, as it often does after a new medication enters widespread use. Instead of 600 milligrams of Mifeprex, doctors now use only 200. While the original F.D.A. label specified that the drugs should be used only up to 49 days of pregnancy, doctors have found the regimen safe and effective for up to 63 days — nine weeks of pregnancy. Instead of requiring a second office visit for the second drug, as specified by the F.D.A., doctors now often give the patient the second drug to be taken at home, saving her an unnecessary trip. The 200-milligram regimen is so widely accepted that the 600-milligram dose is now considered bad medicine, and many doctors would refuse the procedure entirely rather than follow the old guideline.

Post-approval modifications in the way doctors use drugs are known as off-label uses. Off-label usage is extremely common, permitted by federal law. Prescribing anti-depressants to treat nerve pain and menopausal hot flashes is one current example. What's unusual about the medical abortion situation is that doctors are simply prescribing less of an approved drug for its approved use, rather than turning a drug to a different use altogether.

In the Oklahoma case, a state trial judge, Donald L. Worthington, reviewed the evidence and found that the lower dose of Mifeprex was being used "in a great majority of cases of medication abortions in the United States" and had been "demonstrated by scientific research to be safer and more effective" than the original F.D.A.-approved dose. Requiring doctors to use the higher dose, the judge concluded in an opinion in May of last year, was "so completely at odds with the standard that governs the practice of medicine that it can serve no purpose other than to prevent women from obtaining abortions and to punish and discriminate against those women who do." The Oklahoma Supreme Court affirmed the decision last December.

Unlike the trial judge's eight-page opinion, however, the state high court's unanimous three-paragraph opinion offered no analysis.

It simply declared that "this matter is controlled by the United States Supreme Court decision in *Planned Parenthood v. Casey*," a decision that "remains binding on this court until and unless the United States Supreme Court holds to the contrary."

Planned Parenthood v. Casey was the 1992 decision that reaffirmed the basic right to abortion while also permitting states to adopt new restrictions. In its opinion, which Justice Kennedy joined, the court said it would permit restrictions that did not impose an "undue burden," defined in the opinion as "a state regulation that has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." More than two decades later, all the important words in that definition of undue burden remain contested. What kind of obstacle is "substantial"? What is a prohibited "effect"? To the present point: does the court really care about "purpose" — the real purpose behind an abortion restriction — or is it satisfied by a state's counter-factual claim that the purpose is to protect women?

In a brief he filed three weeks ago to the Oklahoma Supreme Court, E. Scott Pruitt, the state's attorney general, said the legislature's purpose "was to solve the problem of physicians using potentially dangerous unapproved protocols." Really? Requiring doctors to prescribe three times more of a drug than they think is called for is a safety improvement? When Gov. Mary Fallin signed the bill in May 2011, she was more candid, calling it "a critical part of our effort to promote the cause of life." Does candor matter to the Supreme Court?

It didn't to Justice Kennedy when he wrote the partial-birth abortion majority opinion in 2007. He accepted as fact a claim for which there was no valid basis: that the prohibited procedure placed women at special jeopardy for acute post-abortion regret, "grief more anguished and sorrow more profound," as he put it. As evidence, he cited a brief filed on behalf of "180 Women Injured by Abortion," a document filled with personal "affidavits" by women who described vividly how sorry they were for having had terminated their pregnancies (notably, few actually discussed any particular method of abortion).

Lo and behold, the new case has brought with it to the Supreme Court a "Brief of Women and Families Hurt by RU-486," filed in support of the state's appeal by the same lawyer who organized and filed the earlier brief. It, too, contains personal testimonies, although not one actually says anything on the question before the court of more Mifeprex or less.

Not knowing Oklahoma judicial politics, I can only guess at the reason for the state court's failure to analyze the case instead of invoking *Planned Parenthood v. Casey* is a purely conclusory fashion. At the least, the three-paragraph opinion was odd. Were the Oklahoma justices simply ducking for cover under the shadow of *Casey*? Or were they inviting, even prodding, the Supreme Court to reconsider *Casey*? Along with Justice Kennedy, Justice Sandra Day O'Connor was also a member of the five-justice majority in 1992. With Justice O'Connor replaced by Justice Samuel A. Alito Jr., there may no longer be a majority on the court to strike

down any burden on access to abortion, even one that is obviously and purposefully "undue." All that binds the current court to the Casey standard — whatever that standard can be said to mean today — is stare decisis, respect for precedent. As the Roberts court begins Year 9, that may not count for much.

“Oklahoma Abortion Laws Unconstitutional, State Supreme Court Rules”

Huffington Post
Tim Talley
December 4, 2012

Oklahoma laws requiring women seeking abortions to have an ultrasound image placed in front of them while they hear a description of the fetus and that ban off-label use of certain abortion-inducing drugs are unconstitutional, the state Supreme Court ruled Tuesday.

The state's highest court determined that lower court judges were right to halt the laws. In separate decisions, the Oklahoma Supreme Court said the laws, which received wide bipartisan support in the Legislature, violated a 1992 U.S. Supreme Court case.

The Oklahoma court said it has a duty to "follow the mandate of the United State Supreme Court on matters of federal constitutional law."

The Legislature passed the ultrasound law in 2010. Oklahoma is one of several states that have passed laws requiring doctors to both perform an ultrasound and provide a verbal description of the fetus before an abortion. The other law was approved in 2011.

The New York-based Center for Reproductive Rights challenged both laws, and Oklahoma County judges had halted their enforcement while the court cases made their way through the judicial system.

Michelle Movahed, a staff attorney for the abortion-rights group, said the rulings represent a "sweeping and unequivocal" rejection of the Legislature's attempt to restrict the reproductive rights of women.

Nancy Northup, the center's president and CEO, said Oklahoma has been a testing ground for a national network of organizations she said are hostile to women, doctors and the rights of both.

"But despite their best efforts to chip away at women's fundamental rights, the courts have consistently rejected these extreme assaults on reproductive freedom," Northrup said in a statement.

State Attorney General Scott Pruitt, whose office appealed lower-court decisions that invalidated the laws, said he is considering appealing to the U.S. Supreme Court.

"We disagree with the court's decision, particularly with the fact that the question on whether Oklahoma's Constitution provides a right to an abortion was left unanswered," Pruitt said in a statement.

The ultrasound law was struck down in March by District Judge Bryan Dixon, who ruled that the statute was an unconstitutional special law that could not be enforced because it addressed only patients, physicians and sonographers dealing with abortions without addressing other medical care.

Tony Lauinger, chairman of the anti-abortion group Oklahomans for Life, said he believes the state Supreme Court has misinterpreted the 1992 U.S. Supreme Court decision. He said the Oklahoma ultrasound measure provides a level of informed consent for women seeking abortions, something he said the federal decision permits.

"The ultrasound law does not prohibit abortion. It regulates abortion," Lauinger said.

The other state law was rejected in May by District Judge Donald Worthington, who ruled it violated "the fundamental rights of women to privacy and bodily integrity."

The law required doctors to follow strict guidelines authorized by the U.S. Food and Drug Administration and prohibited off-label uses of certain abortion-inducing drugs such as RU-486. Such moves include changing a recommended dosage or prescribing it for different symptoms than the drug was initially approved for.

The law also required doctors to examine women before prescribing the drugs, document certain medical conditions and schedule follow-up appointments.

Pruitt said he was disappointed with the court's decision.

"There is overwhelming evidence that the off-label use of abortion-inducing drugs leads to serious infections and death for many healthy, unsuspecting women. This is not OK," Pruitt said.

All nine justices on the court joined in the decision involving the abortion-inducing drugs, while eight justices concurred in the ultrasound ruling. Justice Noma Gurich, a former Oklahoma County judge who issued an injunction blocking enforcement of that law in July 2010, recused herself from the decision.

Earlier this year, the state Supreme Court halted an effort to grant "personhood" rights to human embryos, citing the same 1992 U.S. Supreme Court case. The U.S. Supreme Court refused to take up the case on appeal.

"Supreme Court Agrees to Review Oklahoma Abortion Pill Case"

Christian Science Monitor
Warren Richey
June 27, 2013

At issue is whether an Oklahoma law requires women and their doctors to follow a protocol that effectively limits access to chemically induced abortions. But first, the Supreme Court wants clarification on what, exactly, the state law outlaws.

The US Supreme Court on Thursday agreed to wade into a dispute over an Oklahoma regulation of the abortion-inducing drug RU-486.

In a brief order, the justices agreed to take up the case, and then asked the Oklahoma Supreme Court to determine whether the disputed state law bars the application of certain drugs used in chemically induced abortions.

The court said that further proceedings in the case would be reserved pending receipt of a response from the Supreme Court of Oklahoma.

The action came in an appeal filed on behalf of the Oklahoma attorney general asking the justices to reinstate an Oklahoma law regulating RU-486 abortions that was struck down by the state high court in December.

The law sought to limit chemically induced abortions to a protocol of procedures that critics said were outdated and would effectively ban the procedure.

In his brief to the court, Oklahoma Solicitor General Patrick Wyrick asked the justices to examine whether the Oklahoma Supreme Court ruled correctly when it invalidated the 2011 state law that had mandated that all drug-induced abortions in the state follow a specific protocol.

Under the law, abortion providers were required to follow instructions approved by the Food and Drug Administration back in 2000 when chemically induced abortions were first approved.

The Oklahoma Coalition for Reproductive Justice challenged the law, arguing that the 2000 protocol had since become obsolete and had been replaced by newer time-tested procedures and doses that were safer, more effective, and less expensive.

The new procedures allow a woman to self-administer a second drug at home rather than in a clinic. They also extended the effective use of the chemically induced abortion process from 49 days into the pregnancy to 63 days.

Mr. Wyrick said the state legislature was justified in favoring the older protocol because eight otherwise healthy young women have died from bacterial infections following chemically induced abortions using one of the newer protocols. In contrast, he said, no women have died following use of the older protocol.

The state solicitor general said the Oklahoma law merely regulates the manner

in which abortion-inducing drugs were administered and does not ban the use of those drugs.

A state court judge struck the statute down, because it was deemed to impose a substantial obstacle to a woman obtaining an abortion.

The judge concluded in part that the state law "is so completely at odds with the standard that governs the practice of medicine that it can serve no purpose other than to prevent women from obtaining abortions, and to punish and discriminate against those who do."

On appeal, the Oklahoma Supreme Court ruled that the state law was unconstitutional under the US Supreme Court's abortion precedent, *Planned Parenthood of Pennsylvania v. Casey*.

Wyrick said the state high court was wrong. "House Bill 1970 does not prohibit any type of abortion," he said in his brief to the court. "It merely requires that abortion inducing drugs be administered in the manner approved by the FDA."

Michelle Movahed, a lawyer with the Center for Reproductive Rights, which is representing the Oklahoma Coalition, said in her brief that the Oklahoma law goes too far in restricting access to abortions.

She said the Oklahoma legislature had enacted several laws in recent years seeking to restrict abortions in the state. The state Supreme Court has upheld some, but overturned others as too restrictive.

"The statute at issue here effectively bans all abortions performed using medication (rather than by surgery), no matter how early in the pregnancy," Ms. Movahed wrote in her brief.

"The statute's only practical consequence is to force a woman who wishes to terminate a pregnancy to undergo a surgical procedure even though a safe, effective, non-invasive, and widely used alternative is available," she said.

Movahed said the newer protocols were legal and common. She said nationwide protocols other than FDA approved protocol from 2000 are being used in at least 96 percent of chemically induced abortions.

The case is *Terry Cline v. Oklahoma Coalition for Reproductive Justice* (12-1094).

“State Laws Limiting Abortion May Face Challenges on 20-Week Limit”

NPR
Julie Rovner
July 22, 2013

Banning abortions after a specific point in pregnancy has been a popular trend in the states this year. Last week, GOP Gov. Rick Perry made Texas the 12th state to ban most abortions after 20 weeks.

But how states define the starting point for that 20 weeks may cause headaches for women and their doctors — and ultimately affect whether these laws pass constitutional muster.

Like all but one of the abortion bans passed so far in the states, the Texas law starts its 20-week calendar at fertilization. But that's not the same as saying 20 weeks of pregnancy, because that's not how doctors measure pregnancy.

"When we refer to the weeks of pregnancy, weeks of gestation, we measure pregnancy from the date of the last normal menstrual period," says Dr. Daniel Grossman. He's an assistant professor of obstetrics, gynecology and reproductive sciences at the University of California, San Francisco and a vice president of IBIS Reproductive Health, a reproductive rights advocacy group.

"For a woman who has a normal menstrual period, ovulation or fertilization would generally occur two weeks later, after that start of that normal menstrual period," Grossman says. "The age of the embryo or the fetus is essentially two weeks less than the number of weeks measured from the last menstrual period."

Last menstrual period, or LMP, is generally how doctors refer to the weeks of pregnancy. Forty weeks LMP is considered full term for a normal pregnancy, even though at that point fertilization occurred only 38 weeks before. So why do doctors use a measurement that's so imprecise?

That standard developed in the old days before ultrasound was widely used, Grossman says. "The last menstrual period was something that was knowable and was measurable, whereas it wasn't always known when fertilization took place."

With few exceptions, however, that's not how the state laws — and a bill that passed the U.S. House last month — are being written.

"What we're seeing with these laws is that they are pegging the beginning of pregnancy to fertilization," says Elizabeth Nash, who tracks state issues for the Guttmacher Institute, an abortion rights think tank.

"So when we talk about a law that bans abortion at 20 weeks post-fertilization, we're really talking about a law that bans abortion at 22 weeks of pregnancy," she says.

Why is it, then that people keep referring to these as 20 week laws?

Nash says it's not that hard to figure out. "That's the term that is used in the bill, and oftentimes when you see a term used in the bill it becomes the headline," she says.

But whether the laws seek to ban abortion at 20 weeks or 22 weeks, one thing is clear, says Daniel Grossman. The ban they would impose is earlier than what's currently considered viability, or when a fetus can survive outside the womb.

"I think there's definitely consensus that viability doesn't happen before 24 menstrual weeks," he says. "So when we're talking about banning abortion at 20 or 22 weeks even, that's clearly at least two weeks before the earliest point in pregnancy where viability would be a concern."

That's important, because current Supreme Court precedent says states can't ban abortion before viability. But those pushing these laws clearly hope that by the time one of these laws makes its way to the justices, they might change their minds.

Similar doubts were raised about about the constitutionality of an earlier ban few thought would survive court scrutiny, according to Douglas Johnson of the National Right to Life Committee.

"The Partial Birth Abortion Ban Act was struck down by every lower fed court that considered it," Johnson said last week at a press conference on the federal version of the 20-week ban. "Three U.S. District Courts; three U.S. Courts of Appeals all ruled it was in clear violation of U.S. Supreme Court precedent. But when it reached the U.S. Supreme Court they said otherwise. And they upheld it."

So whether you count to 20 or 22, the ultimate number that will matter most is five — the number of Supreme Court justices needed for a majority.

"Abortion Restrictions Become Law in Texas, but Opponents Will Press Fight"

The New York Times
Manny Fernandez
July 18, 2013

Six months after declaring his goal to make abortion at any stage "a thing of the past," Gov. Rick Perry signed a bill into law Thursday giving Texas some of the toughest restrictions on abortion in the country, even as women's rights advocates vowed to challenge the law's legality in court.

Surrounded by Republican legislators and abortion opponents in an auditorium at the Texas Capitol in Austin, Mr. Perry said they were celebrating and cementing "the foundation on which the culture of life in Texas is built upon." As he spoke, the chants and shouts of "Shame! Shame!" by the bill's opponents, gathered outside the auditorium, could be heard.

The measure, House Bill 2, bans abortions after 20 weeks of pregnancy, requires abortion clinics to meet the same standards as hospital-style surgical centers and mandates that a doctor have admitting privileges at a hospital within 30 miles of the facility where he or she performs abortions.

Abortion rights advocates and Democrats said the law could force a majority of the state's 42 abortion clinics to close. The new provision that clinics be licensed as ambulatory surgery centers would require costly renovations or relocations to meet the architectural and equipment standards.

Only five abortion clinics — in Austin, San Antonio, Dallas and Houston — meet those standards. The requirement that doctors performing abortions have admitting privileges at nearby hospitals could force the closing of some clinics that use visiting doctors or that are located where local hospitals refuse to provide such privileges.

Mr. Perry and other Republicans said the law would improve patient safety and hold abortion clinics to safer standards. Opponents said that it amounted to an unconstitutional attack on legal abortion in Texas and that many of the restrictions were found to be medically unnecessary by physicians groups.

"The fight over this law will move to the courts, while the bigger fight for women's access to health care in Texas gains steam," said Cecile Richards, the president of the Planned Parenthood Federation of America and the Planned Parenthood Action Fund, and a daughter of Ann Richards, the former Texas governor. "People are enraged by this law, and it has created a whole new generation of activists who are in it for the long run to elect leaders who will protect women's health."

The law does not take effect immediately. The admitting privileges restriction and the ban on abortions after 20 weeks take effect 90 days after a special legislative session

ends later this month. Abortion clinics have until September 2014 to comply with the surgical-center standards. Opponents of the law said they were evaluating their litigation options, and it appeared likely that lawsuits would be filed before any of the restrictions take effect.

Similar restrictions that have been enacted in other states have been tied up in legal challenges. Bans on abortions after 20 weeks have been adopted by 11 other states, but in three of those states — Arizona, Georgia and Idaho — courts have blocked the laws from taking effect. The requirement that doctors have admitting privileges at a nearby hospital has been blocked by courts in Mississippi, Alabama and North Dakota.

The United States Supreme Court has ruled that states can regulate abortions so long as the rules do not pose an "undue burden" on a woman's right to an abortion. Opponents of the law are likely to argue that the surgical-center standards and their effect on women seeking abortions across the state pose an undue burden and are thus unconstitutional.

"The A.C.L.U. is involved in litigation in 5 of the 10 states where similar abortion restrictions have been enacted, and we are evaluating our options in Texas," said Terri Burke, the executive director of the American Civil Liberties Union of Texas. "What makes Texas different is our size: House Bill 2 leaves 35 percent of the population without access to abortion care and those are rural and, often, poor women."

The provision banning abortions at 20 weeks after fertilization and later is based on a medically disputed theory that a fetus can feel pain at that stage. The Supreme Court has ruled that women have a right to an abortion until the point at which the fetus is viable outside the womb — usually around 24 weeks after a woman's last menstrual period, or 22 weeks after fertilization.

Mr. Perry addressed the issue of fetal pain at the bill-signing ceremony on Thursday. "At five months, many studies indicate that these children feel pain," he said, adding that it was Texans' responsibility "to give voice to the unborn individuals whose survival is at stake."

The ceremony was a procedural coda to the heated battle over abortion that has played out at the Capitol. Thousands of men and women — on the both sides of the debate, though opponents of the bill largely outnumbered supporters — have testified, rallied and protested there since June, when Mr. Perry added the bill to the Legislature's agenda.

The bill failed to pass during the regular session, which ended May 27, so Mr. Perry added it on June 11 to a special session in an effort to get it passed. But at the end of the special session on June 25, an 11-hour filibuster by State Senator Wendy Davis, Democrat of Fort Worth, helped kill the bill, turning her into a national political celebrity.

Mr. Perry responded by calling a second special session, and the Republican-dominated Legislature quickly passed the restrictions last week. Though their efforts

to block the bill had ultimately failed, Democrats have been emboldened by the filibuster and the battle over abortion. In June, Ms. Davis received nearly $1 million in campaign contributions in two weeks. She received more than 15,000 individual contributions, many from people who gave her $50 or less.

"California Abortion Bill Shows Gulf with Other States"

Bloomberg
Michael B. Marois & Esme E. Deprez
August 28, 2013

To see the growing gulf over abortion between California and other states, look no further than the Colorado River that marks the state's border with Arizona.

On the California side, a bill heading soon to Democratic Governor Jerry Brown would make it easier for rural women to terminate pregnancies by allowing nurse practitioners and midwives to perform abortions in the first 12 weeks, now provided only by doctors.

Across the river in Arizona, Republican Governor Jan Brewer effectively banned nurse practitioners from doing the procedures in 2011. Five Planned Parenthood clinics stopped offering abortions when doctors couldn't be found, according to Cynde Cerf, a spokeswoman.

California "completely bucks the trend that we've been seeing in other states in the past three years, which is to adopt abortion restrictions en masse," said Elizabeth Nash, state issues manager for the New York-based Guttmacher Institute, which researches and compiles reproductive health data. "This is moving in a completely different direction than what we are seeing in other states."

The California measure, approved this week by the Democrat-controlled state Senate, contrasts with at least 178 laws restricting abortion that other states have passed since 2010, according to the institute. The laws have made it more difficult for women to get abortions, despite the U.S. Supreme Court's 1973 decision in *Roe v. Wade* that legalized a woman's right to terminate her pregnancy.

Five States

If signed into law by Brown, California would be the fifth state to permit non-physician abortions, joining Montana, New Hampshire, Oregon and Vermont, according to a study by the University of California, San Francisco. Thirty-nine states require a licensed physician.

The author of the California bill, Assembly Majority Leader Toni Atkins, a San Diego Democrat, said the legislation was needed to help women in the half of the state's counties without a doctor to perform abortions. The Senate version of the bill will go back to the Assembly to reconcile amendments before it's sent to Brown.

Arizona's law signed by Brewer two years ago prohibited the state nursing board from determining whether abortion care was within the scope of practice for nurse practitioners.

The effect was immediate. There are seven abortion clinics in the state today, down from 19 in 2010 because of the measure and other restrictive laws, according to NARAL Pro-Choice Arizona, which opposes the limits.

Local Facilities

Eighty-seven percent of U.S. counties have no local facilities for abortion, according to the University of California study. Those areas are home to more than a third of women aged 15 to 44, the study showed.

A similar California bill failed last year after some Democrats said they were concerned that abortions performed by non-physicians wouldn't be as safe. That measure was amended to allow nurse practitioners and other clinicians to dispense abortion-inducing drugs, and was signed Brown.

Many of the anti-abortion laws passed in recent years have been argued on the basis that they improve health and safety. They have also proven effective at shuttering providers: In addition to Arizona, restrictions have been blamed for closing at least a dozen clinics in states including Michigan, Ohio and Pennsylvania.

A University of California study published in January in the American Journal of Public Health found that complications from abortions by nurse practitioners, nurse midwives or physician's assistants were "clinically equivalent" to those performed by doctors.

"I can't think of a single national trend that California isn't bucking," said Brian Johnston, the Western Regional Director at the National Right to Life Committee. "The reality is that a human life must end for this to be an abortion and so this is an issue of huge significance, and other states recognize that."

“Anti-Abortion Laws Take Dramatic Toll On Clinics Nationwide”

Huffington Post
Laura Bassett
August 26, 2013

More than 50 abortion clinics across the country have closed or stopped offering the procedure since a heavy wave of legislative attacks on providers began in 2010, according to The Huffington Post's nationwide survey of state health departments, abortion clinics and local abortion-focused advocacy groups.

At least 54 abortion providers across 27 states have shut down or ended their abortion services in the past three years, and several more clinics are only still open because judges have temporarily blocked legislation that would make it difficult for them to continue to operate. Nebraska and Massachusetts have each added one clinic since 2010, and the other 21 states and the District of Columbia, most of which have not passed new anti-abortion laws since 2010, were unable to accurately count their clinics because their health departments do not license abortion providers separately from other kinds of medical providers. The Huffington Post's tally did not include hospitals that provide abortions.

"This kind of change is incredibly dramatic," said Elizabeth Nash, state issues manager at the Guttmacher Institute, a reproductive health research organization. "What we've been seeing since 1982 was a slow decline, but this kind of change ... [is] so different from what's happened in the past."

A comprehensive survey by The Daily Beast found that as of January 2013, 724 abortion clinics remained operational across the U.S.

While some of the 54 closures were due to unrelated factors, the states that have lost the most clinics over the past three years are the same ones that have seen draconian new abortion restrictions and the biggest cuts to family planning funding. In Texas, which has lost nine clinics, lawmakers have slashed family planning funding in the state budget, required abortion clinics to become ambulatory surgical centers and required abortion doctors to have admitting privileges at a local hospital. Arizona lawmakers passed similar legislation and pushed out a total of 12 providers; the state had 18 abortion clinics in 2010 and now has only six, according to NARAL Pro-Choice Arizona.

"This has turned into a nightmare," said Kat Sabine, executive director of NARAL's Arizona affiliate. "The kind of efforts the women have to take to get family planning or abortion services are just incredible, and you can only get care if you can get out of the community to do it. If you're on a reservation or rural part of the state, unless you have reliable transportation, you're not going to get care."

In Lake Havusu, Ariz., there are several anti-abortion Crisis Pregnancy Centers and a

Catholic charity hospital that does not offer abortion care, but women have to travel over 150 miles to either Phoenix or Las Vegas to find the nearest abortion or family planning clinic, Sabine said. The situation mirrors problems rural women face in other states. Mississippi, North Dakota and South Dakota have only one abortion clinic each, and the first two are hanging onto their only clinics pending court decisions. Other larger states, like Alaska and Texas, do not have nearly enough providers to respond to the needs of women in rural areas, because the clinics are concentrated in a few major cities.

Compounding the problem, 26 states require women to wait at least 24 hours between their consultation sessions and abortion procedures, making it twice as difficult for rural and low-income women to access abortion care.

"These restrictions have an uneven impact," Nash said. "Women who have resources, have a car, have some money in the bank, can access childcare and take time off work can obtain an abortion, and women who are less well-off and don't have those kinds of resources are not able to access abortion services."

While states have been passing abortion restrictions since long before 2010, the recent legislative trend has been to directly target abortion providers and make it harder for them to operate. In addition to passing mandatory waiting periods and mandatory ultrasounds, states are passing so-called "TRAP" laws -- the Targeted Regulation of Abortion Providers. These laws often require abortion clinics to undergo extensive and costly renovations in order to become ambulatory surgical centers, which are essentially mini-hospitals.

Anti-abortion advocates, meanwhile, argue that TRAP laws are designed to protect women's health by forcing clinics to widen their hallways, install specific ventilation systems and build locker rooms for physicians. Kristi Hamrick, a spokesperson for Americans United for Life, told HuffPost that the new restrictions are not the reason clinics are shutting down. "It was the choice of the abortion industry to locate their profitable abortion businesses in older buildings that would never pass muster for other outpatient surgical centers," she said. "It was their choice to ignore the laws of any given state on building requirements for outpatient medical facilities -- set by that state in line with a national standards board, not AUL -- and choose locations that were not as safe."

Hamrick added that the fact that most of the available information on abortion clinic closures comes from the clinics themselves is evidence of the fact that states do not regulate the clinics enough. While some state health departments have specific licenses for abortion providers, states vary widely in how they count providers. Some only license ambulatory surgical centers that provide abortions, and others have no separate category for abortion providers, making it difficult to get an accurate count of how many providers there are without thumbing through the phone book.

"While the abortion industry has claimed that their businesses have suffered, we have only their word on that," she said.

The murder trial of Kermit Gosnell, the abortion provider in Pennsylvania who performed illegal, late-term abortions and allegedly "snipped" the spines of fetuses born alive, has fueled the drive to regulate abortion clinics even further. A group of House Republicans wrote letters to the health departments and attorneys general of all 50 states in May, citing the Gosnell trial and asking what exactly states are doing to "protect the civil rights of newborns and their mothers."

RH Reality Check obtained 38 states' responses to that inquiry and published them. The publication's analysis of the documents concluded that abortion clinics in most states are aggressively regulated and extremely safe.

"Most states said that they conduct regular inspections of abortion clinics, or of hospitals, ambulatory surgical centers, or other types of facilities where abortions can be carried out," RH Reality Check reported. "And most states said they were aware of very few — if any — incidents of patients being harmed as a result of an abortion."

Still, Republicans at the state and federal level are proposing new ways to restrict abortion every time a legislative session begins, giving women in their states fewer and fewer options when faced with an unplanned or unhealthy pregnancy.

"These restrictions do nothing to reduce the need for abortion or to reduce unintended pregnancy," Nash said. "I would say that those that are promoting these very burdensome clinic regulations have as an end goal the elimination of legal abortion. They don't have women's health in mind."