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IN THE SUPREME COURT OF THE STATE OF MONTANA
NO. DA 22-0207

HELEN WEEMS and JANE DOE,

Plaintiffs and Appellees,

v.

STATE OF MONTANA, by and through AUSTIN KNUDSEN, in his official capacity as ATTORNEY GENERAL; AND TRAVIS R. AHNER, in his official capacity as COUNTY ATTORNEY FOR FLATHEAD COUNTY,

Defendants and Appellants.

On Appeal from the First Judicial District Court,
Lewis and Clark County, Cause No. ADV-2018-73
The Hon. Mike Menahan, Presiding

OPENING BRIEF OF DEFENDANTS-APPELLANTS

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STATEMENT OF THE ISSUES

1. Did the district court err in concluding that legislatively created boards, but not the Legislature itself, may establish the relevant scope of practice rules?

2. Did the district court err in concluding that the Montana Board of Nursing ("MBN") affirmatively authorized APRNs to provide abortions in contravention of MCA § 50-20-109(1)(a)?

3. Did the district court err by finding MCA § 50-20-109(1)(a) violates Article II, Section 10 of the Montana Constitution?[1]

STATEMENT OF THE CASE

In 2005, the Montana Legislature codified this Court's holding in *Armstrong v. State*, 1999 MT 261, 296 Mont. 361, 989 P.2d 364. App.C.030. House Bill 737 ("HB 737") revised "scope-of-practice" laws related to physician assistants ("PAs") and expressly authorized them to perform abortions under the supervision of a licensed physician. *See* MCA § 50-20-109(1)(a) (2005).[2]

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[1] The district court declined to reach Weems' equal protection or right to dignity claims. App.A.002. These issues, therefore, are not part of this appeal.

[2] The Montana Legislature amended the statute in 2021, but those amendments don't affect the subsection at issue in this case. App.A.002.

Thirteen years later, in 2018, Plaintiffs Helen Weems, a certified nurse practitioner, and Jane Doe, a certified nurse midwife, (collectively, "abortionists") filed this action claiming that the law *expanding* the scope of practice for physician assistants unconstitutionally excluded advanced practice registered nurses ("APRN"s) from performing surgical and medication abortions. App.D.301.[3] At the time of filing, neither abortionist was licensed by Montana to perform abortions. *See Weems v. State*, 2019 MT 98, ¶ 30, 395 Mont. 350, 440 P.3d 4 (Rice, J., dissenting).

On April 4, 2018, the district court issued a preliminary injunction preventing the State from enforcing any laws that permit only physicians and PAs to provide abortions. App.E.329. The district court's injunction *changed* the status quo by effectively allowing abortionists—like Plaintiffs—to perform abortions for the first time in Montana. App.E.329.

In a 4-3 decision, this Court affirmed the district court's preliminary injunction. *See Weems*, ¶ 26. The dissent pointed to the scant record at that stage and the lack of any affirmative evidence supporting the entry of a preliminary injunction. *Id.* ¶¶ 29–32. (Rice, J.,

[3] Doe no longer works or lives in Montana. App.C.249.

dissenting). The dissent further noted that the State's licensing authority for the practice of medicine flows from its police power to "safeguard life and health." *Weems*, ¶ 33 (Rice, J., dissenting). The dissent concluded by warning that the majority's opinion effectively entered an advisory declaratory judgment on "minimal proceedings and record." *Weems*, ¶ 36 (Rice, J., dissenting).

The parties conducted discovery between May 2018 and June 15, 2021. The State disclosed Dr. Mulcaire-Jones, a family medicine and obstetrics physician in Butte, Montana who specializes in Cesarean-sections, surgical management of miscarriages, and care of high-risk pregnancies. App.C.125–167. Dr. Mulcaire-Jones testified to his experience in women's health, pregnancy, pregnancy-related surgery, pregnancy termination, and treatment of post-abortion complications, pre-abortion considerations, and abortion risk factors. App.C.127. The State also disclosed Dr. Kathi Aultman—an OB/GYN licensed in Florida who serves as a fellow of the American College of Obstetricians and Gynecologists—as a rebuttal witness. App.C.168–198. The abortionists disclosed two out-of-state experts: Dr. Goodman, a family medicine physician licensed in California, and Ms. Jensen, a certified nurse

midwife licensed in Oregon. App.G.360. They also disclosed Dr. Joey Banks, Planned-Parenthood of Montana's then-medical director, as an expert. App.G.360; App.F.349 n.11.

The parties both moved for summary judgment on all claims on August 30, 2021. App.F; App.G. Briefing concluded on October 18, 2021. App.H; App.I.

On February 25, 2022, the district court granted the abortionists' motion for summary judgment on their Article II, Section 10 claim only. App.A.002. The district court didn't consider either the abortionists' right to dignity or equal protection claims. App.A.002.

The State timely filed its appeal of the summary judgment order on April 25, 2022.

STATEMENT OF FACTS

This Court ruled on prior abortion cases on limited factual records. *See Armstrong*, ¶ 28 (appeal of preliminary injunction); *Weems*, ¶ 6 (same); *see also Weems*, ¶ 28 (Rice, J. dissenting) (criticizing majority in that case for effectively entering a declaratory judgment at the preliminary injunction stage). This case, by contrast, benefits from a developed factual record. The record demonstrates medically

acknowledged, *bona fide* health risks supporting Montana's law. App.C.139–161 (Dr. Mulcaire-Jones discussing risks associated with abortion); App.C.176–190 (Dr. Aultman discussing same). The abortionists and their experts acknowledge the very genuine and serious health risks at issue. App.C.213–215; App.C.238; App.C.280–283.

The record, moreover, demonstrates that the Montana Legislature acted at the behest of the medical community in enacting HB 737. App.C.029–034; App.C.045–047. The Legislature elected to codify *Armstrong*. App.C.030–031; App.C.045.[4]

I. *Armstrong* and HB 737

The Montana Legislature passed HB 737 (2005) at the request of the Montana Board of Medical Examiners ("MBME") and Montana

[4] The Montana Legislature, of course, *may* provide the parameters for legalizing abortion. As argued in other cases, that doesn't mean *Armstrong* reached the correct constitutional result. *See State's Opening Br.* at 15–23, *Planned Parenthood of Montana v. State*, DA 21-0521 (Jan. 20, 2022). This case, in fact, demonstrates the flaws inherent in *Armstrong*. On the basis of *Armstrong*, the district court declared unconstitutional a law codifying the factual case in front of this Court in *Armstrong*—that PAs may perform abortions under the supervision of licensed physicians. The district court's order realizes the warning in Justice Gray's concurrence, that *Armstrong*'s dicta will be abused to invalidate any effort by the legislature to protect patients and regulate the practice of medicine. *See Armstrong*, ¶ 79 (Gray, J., specially concurring).

Academy of Physician Assistants. App.C.030; App.C.045. HB 737 updated the scope of practice for PAs. App.C.045–047. Proponents of the legislation included, among others, the Montana Medical Association, Montana Hospital Association, Billings Clinic, and the American Academy of Physician Assistants. App.C.029–034. These proponents repeatedly stressed that the scope-of-practice enlargement was justified due to the agency relationship between licensed physicians and PAs. App.C.029–034; App.C.045–047. "Physicians hold, under current law, the legal and professional responsibility and liability for the PA's care to all his or her patients." App.C.045 (testimony of Jeannie Worsech, MBME Executive Director, Senate Committee on Public Health, Welfare, and Safety hearing on HB 737, March 11, 2005). HB 737 expanded abortion access to rural parts of the state. App.C.045.

All this is unsurprising, for the bill merely codified this Court's decision in *Armstrong*. App.C.030–031. In response to direct questions, Ms. Susan Fox informed the committee that HB 737's language reflected the *Armstrong* decision. App.C.030–031. The bill's sponsor stated that the pertinent language "reads as the law is today." App.C.045. The bill's sponsor closed by reiterating that "[t]he physician will not authorize the

PA to do things they are not qualified to do." App.C.047.

Armstrong involved a PA who performed abortions under the supervision of a licensed physician, Armstrong, pursuant to a valid utilization plan and MBME rules. *Armstrong,* ¶ 64. In 1992, local interest groups demanded that Cahill and Armstrong be prosecuted. *Id.* ¶ 18. Their demands unheeded, these groups in 1995 promoted HB 442 to the Legislature. *Id.* ¶¶ 18-24, 65. HB 442 not only prohibited non-physicians from performing abortions but explicitly excluded PAs. *Id.* ¶ 25.

The *Armstrong* Court found HB 442's amendments unconstitutional. *Id.* ¶ 66. The Court relied on the physician-PA agency relationship. *Id.* ¶ 63 ("the Board of Medical Examiners, in its professional judgment, determined that, *under the supervision of a licensed physician*, she was competent to perform certain types of abortions") (emphasis added); *id.* ¶ 66 (there is "no evidence in the record of this case that laws requiring pre-viability abortions be performed only by a physician to the exclusion of a trained, experienced and medically competent physician assistant-certified, *working under the supervision of a licensed physician*, are necessary ....") (emphasis added); *see also id.* ¶

80 (Gray, J., specially concurring) ("The utilization plan requiring Board approval must set forth the scope of the physician assistant's practice, and can be approved only if the physician assistant's practice is within the scope of the training, knowledge, experience and practice of the supervisory physician and also within the scope of the training, knowledge, education and experience of the certified physician assistant.").

Properly distilled, *Armstrong* concluded that the legislative scheme authorizing utilization plans allowed PAs to perform abortions if they and their supervising physician possessed the requisite training, skill, and experience to perform abortions. *Id.* ¶ 80 (Gray, J., specially concurring).

HB 737 amended MCA § 50-20-109(1)(a) to reflect the legislative scheme *Armstrong* explicitly approved.

II. Montana's licensing regime and acknowledged risks with abortion.

"To safeguard life and health" nurses must "submit evidence that the person is qualified to practice and is licensed as provided." MCA § 37-8-101(1)–(2). Montana's nursing licensing regime doesn't confer "any authority to practice medicine, surgery, or any combination of medicine

or surgery." MCA § 37-8-103(2)(a). Nor does the licensing regime "permit any person to undertake the treatment of disease by any of the methods employed in the healing arts *unless the licensee has been qualified under the applicable law or laws licensing the practice of those professions or healing arts in the state of Montana*." MCA § 37-8-103(2)(c) (emphasis added). Applicable law in Montana allows licensed physicians and PAs to perform abortions. MCA § 50-20-109(1)(a).

An APRN becomes licensed in Montana by presenting a certification by the American Nurse Credentialing Center. MCA § 37-20-402. The certification means only that the APRN has demonstrated proficiency in core elements of nursing care. App.C.076–099; App.C.100–114; App.C.204–206. The MBN recognizes the APRN scope of practice in standards (including CNMs) published by the National Association of Nurse Practitioners in Women's Health ("NPWH) and the American College of Nurse-Midwives ("ACNM"). App.C.076–099; App.C.100–114. But the MBN itself does not specifically identify *anything* within an APRN's scope of practice. App.C.232. And neither the MBN nor the published standards by the NPWH or the ACNM state that abortion is

within an APRN's scope of practice. App.C.231–232.

Beyond recognizing other organizations' standards, the MBN does not require any additional examinations or certifications. App.C.257–258. Rather, APRNs self-teach. App.C.230–233; App.D.310–311. Even more alarming, the MBN doesn't require proof of abortion training; it merely instructs ARPNs to keep a record of their training handy in the event someone asks. App.C.217–221. The MBN simply trusts APRNs to know their scope of practice and practice accordingly. App.C.257.

None of the relevant state or national authorities specifically authorize APRNs to perform abortions. *See* Mont. Admin. R. 24.159.1406; App.C.076–099 (AANP omits any reference to abortion in its core competencies and curriculum).

The ACNM's guidance documents contain only a single reference to abortion. App.C.112. Certified midwives must apply their knowledge and skill related to "physical involution following pregnancy ending in spontaneous or induced abortion, preterm birth, or term birth." App.C.112. Uterine involution simply means the process of the pregnant uterus returning to its pre-pregnancy size. This passage does not refer to training certified midwives to perform the surgical or chemical

abortion itself.

Understandably so—both aspiration and chemical abortions fall under the prohibitions in MCA § 37-8-103(2)(a). "Aspiration abortion" is surgical abortion by another name. App.C.139; *see also* App.C.122.[5] The abortionists' expert acknowledged as much. Repeatedly. App.C.291–292; App.C.294–297; App.C.300. In a surgical—or aspiration—abortion a woman's uterus is forcibly entered, instrumented, and the human fetus is vacuumed out. App.C.141. This surgical procedure entails near universal anesthesia, a pre-surgery antibiotic regime, and use of ultrasounds during the operation. App.C.142. Of course, the surgery also requires instruments including sequential rigid dilators to open the uterine cavity and manual or electric vacuum aspirators to remove the fetus. App.C.142. For good reason, the National Abortion Federation guidelines call for specific emergency procedures to be in place to manage hemorrhage and perforation resulting from the surgery. App.C.144–145.

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[5] The American College of Surgeons' definition of surgery includes "the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transportation of live human tissue, which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles." App.C.122. The American College of Surgeons supports limiting such procedures to only licensed physicians. App.C.122.

Again, these health risks to the patient result from the instrumentation of the uterus, which is required for an aspiration abortion. App.C.148.

The abortionists' experts agree that aspiration abortion involves the removal and disposal of live human tissue by altering the condition of the human body through external means—instruments—which causes bleeding, cramping, and in some cases, infection. App.C.279–280. Bleeding is always present in either aspiration or medication abortion because of the removal of tissue from the uterine cavity. App.C.286–287. Weems, herself, described a first trimester abortion, where an unborn fetus—the "products of conception"—is removed from the mother through use of instrumentation or medication. App.C.209–212; App.C.235–237.

Chemical abortions carry similar risks of hemorrhage and bleeding. App.C.149. As the State entered in the record, even the American College of Obstetricians and Gynecologists—an unquestionably pro-abortion organization—recommends that "clinicians who wish to provide medical abortion services should either be trained in surgical abortion services or should be able to refer to a clinician trained to provide surgical abortions." App.C.150. In the case of either a chemical or surgical abortion, performing an abortion involves the practice of medicine or

surgery.

Both types of abortion involve the use of instruments or chemicals, tissue removal, resultant bleeding, with universally acknowledged risks of hemorrhage, infection, "punctures or injury to nearby structures," "failure to complete the abortion, [the] need for procedural intervention," and possibly death. App.C.283

The State's expert witnesses testified that even first and early second-trimester abortions carry risks of harm beyond what an APRN is capable—by education, training, and experience—of handling. Dr. Mulcaire-Jones testified that APRNs do not possess the surgical, medical, or procedural expertise to provide abortion services and manage related complications. App.C.130. Even the National Abortion Federation 2015 Clinical Guidelines specifically state that a clinician performing abortions must have personnel, equipment, policies, and procedures to manage hemorrhage complications and uterine perforation. App.C.131. The ability to treat complications in the immediate hours or days after an abortion is crucial. App.C.131. The absence of a trained, emergency backup to an APRN in the patient's area is an unacceptable risk. App.C.131. The abortionists downplay the

complications and risks associated with this surgery.

Dr. Aultman testified that permitting APRNs to operate without physician supervision exacerbates the existing health and complication risks. These risks increase with gestational age and APRNs lack the qualifications to handle resulting complications. App.C.176; App.C.187; App.C.189. Dr. Aultman also testified that an aspiration abortion constitutes a surgery that, again, presents serious risks. App.C.178. The abortionists attempt to parry this fact by arguing, without support, that aspiration abortions aren't surgical abortions. App.J.405 (describing aspiration abortion as a "gentle suction"). But even their own expert agreed that aspirations are surgical abortions. App.C.291–292; App.C.294–297; App.C.300 (describing aspiration abortion as surgery). Plaintiffs' confusion on this front should reinforce the concerns about expanding the pool of abortion providers beyond licensed physicians and PAs.

As Dr. Aultman explained, "[a]llowing less qualified practitioners to perform abortions, especially when they cannot handle the serious and life-threatening complications that can occur, creates an unacceptable risk for patients in any location. This risk expands exponentially in rural

areas without the necessary facilities and expertise to handle complications." App.C.187. Neither the abortionists nor their expert witnesses have ever addressed any of these risks.

Recognizing these acknowledged risks, MCA § 50-20-109(1)(a) authorizes PAs to perform abortions because of their professional relationship to licensed physicians. *See* MCA § 37-20-101(1)(a). This supervision is evidenced by a supervision agreement and a "duties and delegation agreement" with the supervising physician before practice, which must be on file with the MBME. MCA §§ 37-20-203, -301, -402; Mont. Admin. R. 24.156.1617.[6] None of this applies to APRNs, as the record shows.

III. The Montana Legislature elected to expand the pool of providers able to perform abortions and any remaining access issues result from issues outside the State's control.

HB 737 sought to expand the pool of qualified providers in rural parts of Montana. App.C.029. The legislation addressed PAs—not APRNs or any other providers—and updated their scope-of-practice rules to accurately convey the law's current status. App.C.045.

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[6] Summarized by the MBME at: https://boards.bsd.dli.mt.gov/medical-examiners/license-information/physician-assistant.

As of August 5, 2021, Montana had 1,033 active licensed PAs and 6,960 licensed physicians. App.C.124. The abortionists failed to marshal any evidence that the existence of 7,993 licensed providers qualified by law to perform abortions presents an impediment to Montanans seeking abortion services. *See, e.g.*, App.C.240–242 (offering only unsupported personal contentions regarding underserved rural or remote patients).

The abortionists' real frustration is that the vast majority of the almost 8,000 clinicians licensed to perform abortions in Montana make the personal and professional choice not to. But the abortionists' failure to recruit qualified professionals to perform these procedures does not mean that the State must lower its standards and permit unqualified individuals to perform abortions simply to fill a staffing gap. The record contains no evidence that Montana *law* limits qualified providers from practicing abortion. App.C.124 (Montana has approximately 8,000 qualified medical providers to perform abortions).

STANDARD OF REVIEW

This Court reviews summary judgment orders de novo. *Albert v. City of Billings,* 2012 MT 159, ¶ 15, 365 Mont. 454, 282 P.3d 704. Summary judgment is only proper where no genuine issue of material

fact exists, and the movant is entitled to judgment as a matter of law. Mont. R. Civ. P. 56(c)(3). "When there are cross-motions for summary judgment, a district court must evaluate each party's motion on its own merits." *Kilby Butte Colony, Inc. v. State Farm Mut. Auto. Ins. Co.*, 2017 MT 246, ¶ 7, 389 Mont. 48, 403 P.3d 664. Because, in this posture, the district court "is not called to resolve factual disputes," this Court reviews the district court's "conclusions of law to determine whether they are correct." *Id.*

The abortionists decidedly bear the burden of persuasion. Where a party challenges a duly enacted law, courts apply the presumption of constitutionality. *Powder River Cnty. v. State*, 2002 MT 259, ¶ 73, 312 Mont. 198, 60 P.3d 357. This presumption has teeth: "The constitutionality of a legislative enactment is prima facie presumed," and "[e]very possible presumption must be indulged in favor of the constitutionality of a legislative act." *Powder River Cnty.*, 2002 MT 259, ¶¶ 73–74. This means the abortionists must overcome the presumption of constitutionality afforded to MCA § 50-20-109(1)(a) and show, *beyond a reasonable doubt*, that Article II, § 10 of the Montana Constitution prevents the Legislature from limiting abortion providers to licensed

physicians and PAs. *Id.* ¶ 74.

SUMMARY OF ARGUMENT

Montana may regulate the procedure of abortion without infringing on the right to a pre-viability abortion. *See Wiser v. State*, 2006 MT 20, ¶ 18, 331 Mont. 28, 129 P.3d 133 (citing *Sammon v. N.J. Bd. of Medical Exam'rs*, 66 F.3d 639, 644–45 n.9 (3rd Cir. 1995) (rejecting proposition that regulating midwifery infringed fundamental rights). Even *Roe* acknowledged that States may regulate which healthcare providers provide abortion services. *See Roe v. Wade*, 410 U.S. 113, 165 (1973) (States "may proscribe any abortion by a person who is not a physician") *overturned on other grounds by Dobbs v. Jackson Women's Health Organization*, 597 U.S. __, 142 S.Ct. 2228 (2022); *see also Mazurek v. Armstrong*, 520 U.S. 968, 974 (1997); *Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 447 (1983); *Connecticut v. Menillo*, 423 U.S. 9, 11 (1975). *Armstrong*, in fact, merely perpetuated the longstanding link between physicians and the performance of abortions. *See Armstrong*, ¶ 63. There, the PA in question could provide abortion services "under the supervision of a licensed physician." *Id.*

In 2005, the Montana Legislature enacted the version of MCA § 50-

20-109(1)(a) under challenge in this case. App.A.002. The Legislature codified this Court's decision in *Armstrong* by expanding the pool of providers to include PAs. App.C.030. Unlike HB 442 (1995)—the statute challenged in *Armstrong*—HB 737 expanded the pool of providers. App.C.030. And unlike HB 442, HB 737 responded to direct requests from the medical community. App.C.030–031, 032–033; App.C.045–048.

Weems and Doe analogize their plight to that of the PA in *Armstrong*, but they are wrong. Unlike PAs in *Armstrong*, Montana law never permitted nurses to independently perform abortions. *See Weems*, ¶ 2; MCA § 37-8-103(2); App.C.048; App.D.304–306. Unlike the law in *Armstrong*—which targeted and limited PAs' scope of practice—HB 737 expanded the pool of Montana abortion providers. App.C.030. And unlike the law in *Armstrong*, HB 737 was promoted by the MBME. App.C.030; App.C.045. Finally, HB 737 tracks—exactly—this Court's decision in *Armstrong*. App.C.030–031.

Weems and Doe seek to transform the courts into an alt-medical licensing board. And in fact, they've made some headway at the district court level. But as this Court knows, that power—the power to provide for the public's health and safety—rests with the Legislature. *See Wiser*,

¶ 19; *see also Dobbs*, 142 S.Ct. 2228, 2284 (citing *Heller v. Doe*, 509 U.S. 312, 319 (1993)); *Planned Parenthood*, 428 U.S. at 99 (White, J., dissenting) (nothing in abortion jurisprudence transforms courts into "ex officio medical board[s] with powers to approve or disapprove medical and operative practices and standards"). Many legislatures delegate some of this power to medical licensing boards. In this case, the Montana Legislature acted on the advice and request of the MBME. App.C.030; App.C.045.

The district court fundamentally erred by declaring unconstitutional under *Armstrong* a statute that codifies *Armstrong*. App.A.002. So long as *Armstrong*'s discovery of abortion rights in Article II, § 10 of the Montana Constitution remains intact, the Legislature must be permitted to regulate abortion procedures and providers—like any others in the medical context—to protect public health and safety. This Court acknowledged as much in *Wiser*. *See Wiser*, ¶¶ 15–20. So the district court's conclusion not only displaces the Legislature's role in establishing medical standards; it represents a judicial diktat that abortion is simply different—a *sui generis* medical procedure immune from all health and safety regulation. This of course vivifies the danger

Justice Gray warned about in *Armstrong*, that the sprawling decision could be read to "suggest that the Legislature has no role at all in matters relating to the health care to be provided to the people of Montana." *See Armstrong*, ¶ 82 (Gray, J., specially concurring).

This Court should heed Justice Gray's warnings and reverse the district court's order.

ARGUMENT

I. The MBN may not promulgate scope-of-practice rules that conflict with legislative enactments.

"No one has a right to practise medicine" without a license. *Dent*, 129 U.S. at 123. The State possesses a general "police power by which it can regulate for the health and safety of its citizens." *Wiser*, ¶ 19; *See also Skurdal*, 235 Mont. at 293-94, 767 P.2d at 306. To protect "the health of its citizens," the State must regulate and license health care professionals. *Wiser*, ¶ 18. The Legislature may and does regulate the scope of nurses' practice. *See Mont. Soc'y of Anesthesiologists*, 2007 MT 290, ¶ 45 ("The 'scope of practice' for [nurse]s in Montana, as established by the Legislature, is the breadth of the professional practice for which the [nurse] is licensed.").

"To safeguard life and health," nurses must "submit evidence that

the person is qualified to practice and is licensed as provided." MCA § 37-8-101(1)–(2). Montana's nursing licensure regime doesn't confer "any authority to practice medicine, surgery, or any combination of medicine or surgery." MCA § 37-8-103(2)(a). Nor does it "permit any person to undertake the treatment of disease by any of the methods employed in the healing arts *unless the licensee has been qualified under the applicable law or laws licensing the practice of those professions or healing arts in the state of Montana*." MCA § 37-8-103(2)(c) (emphasis added). By law, only licensed physicians and PAs may perform abortions. MCA § 50-20-109(1)(a).

The Montana Legislature delegated specific functions to the MBN. *See* MCA § 2-15-1734; MCA § 37-8-102(1); MCA § 37-8-202(2)(b); MCA § 37-8-409(1). Like other administrative agencies, the MBN cannot adopt rules contrary to law. *See* § 2-4-305(6)(a); *Espinoza v. Mont. Dep't of Revenue*, 2018 MT 306, ¶ 42, 393 Mont. 446, 435 P.3d 603, *rev'd and remanded* on other grounds, 140 S. Ct. 2246, 207 L. Ed. 2d 679 (2020); *Mont. Soc'y of Anesthesiologists*, ¶ 43; *Bd. of Barbers of Dep't of Professional & Occupational Licensing v. Big Sky College of Barberstyling*, 192 Mont. 159, 161, 626 P.2d 1269, 1271 (1981) (licensing

boards may only adopt rules consistent with and reasonably necessary to effectuate the purpose of a statute). Accordingly, the MBN's determinations around the scope of practice for nurses need to be (1) consistent and not in conflict with existing statute and (2) reasonably necessary to effectuate the purposes of existing statute. *See* MCA § 2-4-305(6). "[T]he Legislature has not provided the [Board of Nursing] with the authority to re-define or expand the scope of practice established by the [nurse]'s enabling legislation." *Mont. Soc'y of Anesthesiologists*, ¶ 48.

Here, two operative statutes limit the MBN's control. First, MCA § 50-20-109(1)(a) provides that only physicians and PAs may perform abortions. Second, lest any ambiguity remains, MCA § 37-8-103(2)(a) provides that nothing in the nursing licensing regime confers "any authority to practice medicine, surgery, or any combination of medicine or surgery." Under each statute, APRNs are not permitted to perform abortions in Montana.

Quite obviously, MCA § 50-20-109(1)(a) precludes the MBN from authorizing APRNs to perform abortions.

Second, the abortionists in this case seek to perform both chemical and aspiration abortions. App.D.320. "Aspiration abortion" is surgical

abortion by another name. App.C.139. Weems' expert acknowledged this, repeatedly. App.C.291–292; App.C.294–297; App.C.300. In a surgical, or aspiration, abortion a woman's uterus is forcibly entered, instrumented, and the fetus vacuumed out. App.C.141. This surgical procedure entails near universal anesthesia, a pre-surgery antibiotic regime, and use of ultrasounds during the operation. App.C.142. The surgery also requires instruments including sequential rigid dilators to open the uterine cavity and vacuum aspirators to remove the fetus. App.C.142. For good reason, the National Abortion Federation guidelines call for specific emergency procedures to be in place to manage hemorrhage and perforation resulting from the surgery. App.C.144–145. Again, these health risks to the patient result from the instrumentation of the uterus, which is required for an aspiration abortion. App.C.148.

Chemical abortions contain similar risks of hemorrhage and bleeding. Even the pro-abortion American College of Obstetricians and Gynecologists recommends that "clinicians who wish to provide medical abortion services should either be trained in surgical abortion services or should be able to refer to a clinician trained to provide surgical abortions." App.C.150. In either case, providing an abortion involves the

practice of medicine or surgery.

The district court committed clear error by failing to account for the statutory limitations on the MBN's authority. App.A.007. It failed, entirely, to account for the Legislature's interest in ensuring women obtain safe abortions from qualified providers. App.A.007. The district court also incorrectly read MBN's general licensing authority in MCA § 37-8-409(1) to override the specific prohibitions in MCA § 50-20-109(1)(a) and MCA § 37-8-103(2)(a). App.A.008 (citing Admin. R. Mont. 24.159.1405(1)). Instead of looking for conflict, the district court should have harmonized the MBN's rule with its organic statutes. *See Mont. Soc'y of Anesthesiologists*, ¶¶ 43–45. If the district court had done this, then a simple rule would have emerged: the MBN rule generally allows self-certification of competency, except when that self-certification conflicts with statute. In this case, because MCA § 50-20-109(1)(a) excludes APRNs from the list of providers who may perform abortions, Admin. R. Mont. 24.159.1405(1) cannot operate to authorize such a license.

The district court engaged in an unsubtle sleight-of-hand that required the State to demonstrate the necessity of its statute in light of

the MBN's administrative rule. App.A.008. Rather than requiring the abortionists to demonstrate why the statute is unconstitutional, the district court shifted the burden and required the State to demonstrate why the administrative rule should be invalid. App.A.008; *see also* App.A.011 (the State failed "to present a compelling argument as to why the Legislature is better able to determine qualifications of potential abortion providers than the state-created medical licensing board"). In other words, the district court's conclusion required the Legislature to defer to a body the Legislature created. Fundamentally, the district court erred by elevating administrative rules above authorizing statutes. *See* MCA § 2-4-305(6); *Espinoza*, ¶ 43; *Mont. Soc'y of Anesthesiologists*, ¶ 48 (the MBN cannot re-define or expand the scope of practice for nurses contrary to statute).

Nothing in *Armstrong*, *Wiser*, or *Weems*, requires such a result. The Legislature amended MCA § 50-20-109(1)(a) to comply with *Armstrong*. App.C.030–031. Medical opinion informed the legislative process. App.C.029–034; App.C.045–047. In the context of chemical and surgical abortions, limiting the types of providers who may perform abortions to licensed physicians and PAs addresses the acknowledged health risks to

patients. App.C.142. In short, the Legislature did what *Armstrong* suggests.

The district court's conclusion relies on a flawed understanding of the MBN's power and its interaction with direct legislative power. The former—a creature of the latter—must always yield to the latter. Creatures of the law cannot be above it. And in the process, the district court ignored the evidence before it: the Legislature enacted MCA § 50-20-109(1)(a) to ensure that women who get abortions in Montana get safe abortions.

II. MBN deferred to the existing statutory regime.

The Legislature's amendment of MCA § 50-20-109(1)(a) brought the statute into alignment with the holding in *Armstrong*. The MBME requested HB 737's adoption, and the Academy of Physician Assistants, the Montana Hospital Association, hospitals, nurses, PAs, and others all testified in support. App.C.045–047. The law expanded coverage to allow PAs to perform abortions based on specific findings focused on patient safety. App.C.045–046 (education, national certification, continued training, and the requirement to practice under physician supervision). The MBME specifically drew attention to PAs' advanced education, state

licensure, physician supervision, and the fact that they do not practice medicine independently.[7]

And for the next thirteen years, Montana law permitted physicians and PAs to perform abortions. *See Weems*, ¶ 26.

Prior to this litigation, the consistent application of Montana's nursing licensure regime precluded APRNs from performing abortions. *See* MCA § 50-20-109(1)(a). The MBN administered its rules in concert with MCA § 50-20-109(1)(a). App.D.305–306. Only *after* this litigation started did MBN consider whether APRNs could be licensed to perform abortions contrary to MCA § 50-20-109(1)(a). App.C.073.

In the 2019 Montana Board of Nursing meeting, the minutes show that the board correctly deferred to the Legislature. App.C.073. Understanding rightly the hierarchy of authority—and that its powers derive entirely from the Legislature—the MBN concluded it had no authority to define a scope of practice for APRNs that conflicts with

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[7] "Physicians hold, under current law, the legal and professional responsibility and liability for the PA's care to all his or her patients." Jeannie Worsech, Executive Director, MBME (Senate Hearing, March 11, 2005; App.C.045. Under the abortionists' arguments—and the district court's preliminary injunction and summary judgment orders—APRNs can perform abortions anywhere in Montana without supervision.

statute. *See State ex rel. Dep't of Health & Env't. Scis. v. Lasorte*, 182 Mont. 267, 596 P.2d 477 (1979) (an administrative agency is not a super-legislature empowered to change statutory law under assumed delegated power). The Legislature spoke clearly in amending MCA § 50-20-109(1)(a) and the MBN properly deferred to the statute. App.C.073. This is all painfully straightforward, clear, and unambiguous.

Not so, concluded the district court. In its rendering, the MBN's silence on prohibiting ARPNs from performing abortions meant that APRN's self-certified scope of practice *must include* the performance of chemical and surgical abortions. Then, the district court made the fundamental legal error of allowing the MBN's purported silent affirmation to trump statutory law. App.A.011. As a result, according to the district court, state law must yield to an individual APRN's *self-certification* as to their scope of practice. App.A.011. The effect: APRNs aren't subject to state regulation regarding their scope of practice—*at least as it relates to abortion.*

The district court assumed that APRNs would remain subject to the scope-of-practice standards of private national nursing organizations. App.A.009. But the record shows that no national APRN organizations

specifically includes abortion within an APRN's scope of practice. App.C.076–099; App.C.100–114. The abortionists' entire argument—which the district court willingly adopted—relies on a false logical premise that the MBN's failure to explicitly exclude abortion from APRN's scope of practice (which it need not do because MCA § 50-20-109(1)(a) already produced that effect) creates an inference that it is included. App.A.009; App.C.231–232; App.D.310–311. But the fact that no national APRN organization recognizes abortion as part of their scope of practice belies this premise.

The district court's logic travels a long and winding road: since the MBN "does not identify specific procedures APRNs may or may not provide," App.D.310–311, and because the MBN publishes "a variety of guidelines" to assist APRNs in determining their own competence, App.D.311, and because national professional organizations recognized by the MBN do not specifically prohibit APRNs from providing abortion care, App.D.311, the court could—indeed, must—set aside a state law that provides a clear but contrary answer to the question. Respectfully, the MBN's statement that existing law covers the issue—necessarily including MCA § 37-8-103(2) and MCA § 50-20-109(1)(a)—eviscerates

this logic.

Even if the MBN weren't silent, state law would control. *See Mont. Soc'y of Anesthesiologists*, ¶ 45. But that conclusion is only bolstered by the MBN's silence. In any event, state law controls. MCA § 50-20-109(1)(a) clearly states who may provide abortions and nothing in the record contradicts that statement as a matter of law or fact. This Court should reverse the district court.

III. MCA § 50-20-109(1)(a) doesn't impermissibly infringe the right to privacy.

The district court misunderstood *Armstrong* to demand strict scrutiny review of any law that *affects* abortion. App.A.012. But laws may obviously touch on abortion subject matter without infringing upon the right to obtain one. *See e.g., Planned Parenthood v. Casey*, 505 U.S. 833, 873–74 (1992) (not every regulation is an infringement). That much is clear in *Armstrong* itself, which instructed strict scrutiny only when "legislation *infring[ed]* the exercise of the right ...." ¶ 34 (emphasis added). And as this Court noted when this case was previously on appeal, "not every restriction on medical care impermissibly infringes [the right to privacy]." *Weems*, ¶ 19 (citing *Wiser*, ¶ 15).

This case doesn't involve the decision *or* right *or* ability of women

to obtain abortions. Instead, MCA § 50-20-109(1)(a) regulates *who is qualified to provide* abortions—a procedure with known risks to health and life. Patients have no "right" to override the decisions of the Legislature based solely on a chosen provider's self-assessed ability to provide a service. *See Wiser*, ¶ 16. What if a woman's occupational therapist, or personal assistant, or priest determined himself self-certified to administer an abortion? Would that impinge the right this Court announced in *Armstrong*?

Of course not. Montanans do not possess an unqualified right obtain medical care, free of regulation—the State and its licensing boards determine who is qualified to provide medical services. *See* MCA § 37-3-302; *Wiser*, ¶ 17; *see also Connecticut v. Menillo*, 423 U.S. 9, 10–11, 96 S.Ct. 170, 171–72, 46 L.Ed.2d 152, 154–55 (1975) (restricting abortions by non-physicians does not implicate fundamental right to privacy); *Sammon*, 66 F.3d at 644–45, n.9 (3rd Cir. 1995) (rejecting proposition that regulation of midwifery infringed fundamental rights); *Carnohan v. United States*, 616 F.2d 1120, 1122 (9th Cir.1980) (no right to use medical drugs free of government police power).

A few short years ago, this Court articulated that the State has the

power and prerogative to regulate abortion and abortion providers. *see Weems*, ¶ 19 (citing *Wiser*, ¶ 15); *see also Gonzales v. Carhart*, 550 U.S. 124, 158 (2007) (citing *Casey*, 505 U.S. at 873–74). This regulation "furthers [the State's] legitimate interests in regulating the medical profession." *Id.* "[T]he practice of medicine is a privilege, not a right, in Montana and that it is generally subject to legislative oversight in order to protect the health, safety, and welfare of the people of Montana." *Armstrong*, ¶ 79 (Gray, J., specially concurring).

The district court erred by subjecting MCA § 50-20-109(1)(a) to strict scrutiny. *See Wiser*, ¶ 19. A health and safety regulation like this—which only remotely implicates the *Armstrong* abortion right—should be reviewed under rational basis. *Id.* But even under strict scrutiny, MCA § 50-20-109(1)(a) is narrowly tailored to advance Montana's compelling interest in protecting health and safety and regulating healthcare professions. *See supra* at 8–13 (discussing patient health and safety risks associated with both surgical and chemical abortions).

This Court should reverse the district court and uphold MCA § 50-20-109(1)(a) as a constitutional exercise of the State's ability to protect

its citizens.

A. The State has a clear and compelling interest in protecting the health of Montana women.

The Legislature passed MCA § 50-20-109(1)(a) pursuant to its authority to provide for the general health and safety of Montanans. *See Wiser*, ¶ 19. The U.S. Supreme Court recognized the states' police powers as early as 1837: "state and local governments possess an inherent power to enact reasonable legislation for the health, safety, welfare or morals of the public." *Skurdal*, 235 Mont. at 294, 767 P.2d at 306 (quoting *Proprietors of Charles River Bridge v. Proprietors of Warren Bridge*, 36 U.S. 420, 9 L. Ed. 773 (1837)). This Court has recognized the same legislative authority in Montana, even when it "implicates individual rights." *Wiser*, ¶ 19; *see also Skurdal*, 235 Mont. at 294, 767 P.2d at 306.

Because the practice of medicine in Montana is a privilege, not a right, the State's police power exertions to protect health and safety inevitably intersects with the practice of medicine. *See Armstrong*, ¶ 79 (Gray, J., specially concurring). The practice of medicine is "generally subject to legislative oversight in order to protect the health, safety, and welfare of the people of Montana." *Id*; *see* MCA § 37-3-101. The State, furthermore, "may regulate based on matters beyond 'what various

medical organizations have to say about the physical safety of a particular procedure.'" *Stenberg v. Carhart*, 530 U.S. 914, 967 (2000) (Kennedy, J., dissenting) (quoting *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 467 (1983), *overruled by Casey*, 505 U.S. at 112). "The law need not give abortion [providers] unfettered choice in the course of their medical practice." *Gonzales*, 550 U.S. at 163.

The State "may regulate abortion for legitimate reasons, and when such regulations are challenged under the Constitution, courts cannot 'substitute their social and economic beliefs for the judgement of legislative bodies.'" *Dobbs*, 142 S. Ct. at 2283–84 (quoting *Ferguson v. Skrupa*, 372 U.S. 726, 729–30 (1963)). Legitimate state interests include "*the protection of maternal health and safety*; the elimination of particularly gruesome or barbaric medical procedures; the mitigation of fetal pain; and the prevention of discrimination on the basis of race, sex, or disability." *Dobbs*, 142 S.Ct. at 2284 (emphasis added); *see also Gonzales*, 550 U.S. at 158 (the State possesses "legitimate interests in regulating the medical profession in order to promote respect for life"). Montana considers these interests legitimate and compelling.

"[L]aw[s] regulating abortion, like other health and welfare laws,

[are] entitled to a 'strong presumption of validity.'" *Dobbs*, 142 S. Ct. at 2284 (quoting *Heller v. Doe*, 509 U.S. 312, 319, 113 S.Ct. 2637, 125 L.Ed.2d 257 (1993)). MCA § 50-20-109(1)(a), a law passed pursuant to the Legislature's police power, aimed at protecting the health and safety of Montanans by regulating abortion providers, merits the same strong presumption of validity in Montana courts.

The State and the MBN not only have an interest in determining who can perform certain medical procedures, they have a duty to protect the health and safety of *all* involved. App.C.130 (Montana's healthcare licensing boards "have a duty to protect the health and safety of Montana citizens."). The district court's skepticism and distrust of the State's power and obligations were fully display below, and directly contributed to its erroneous conclusions. App.A.013 ("*[E]ven if* the Court finds the State has an interest in the health and welfare of Montana citizens seeking an abortion") (emphasis added).

Abortion—both chemical and surgical—carries inherent risks such as infection, hemorrhage, and uterine perforation; and sometimes the procedures are complicated. *See* App.C.130; *see also* App.C.149 (describing how potential bleeding is not limited to only surgical

abortions); App.C.150 (American College of Obstetrics and Gynecology recommendation that clinicians should be trained in surgical abortions or able to refer to such clinicians because of risks); App.C.174 ("risks of abortion are understated, and the risk increases significantly as gestational age increases"). Needless to say, risks to women become "greater than acceptable when an abortion is performed by a healthcare provider that is not trained, proficient, and experienced in managing abortion complications that arise both immediately or hours or days after the patient has been dismissed from the clinic where the abortion was performed." App.C.130–131. No party disputes the reality of these risks. App.C.279–283; App.C.286–287.

MCA § 50-20-109(1)(a) ensures only those providers equipped to address the complications and risks associated with abortion may perform abortions. App.C.130 (the State's expert testified that abortions carry risks of harm beyond what an APRN is capable—by education, training, and experience—of handling); *see also* App.C.131–132. Limiting surgical procedures to licensed physicians and PAs falls in line with the medical community's recommendations. App.C.122. "Allowing less qualified practitioners to perform abortions, especially when they

cannot handle the serious and life-threatening complications that can occur, creates an unacceptable risk for patients in any location. This risk expands exponentially in rural areas without the necessary facilities and expertise to handle complications." App.C.131–132.

The district court manifestly erred by failing to properly frame the State's health and safety interests and instead shifting the burden to the State to defend its law. App.A.014. Without any citation to authority, the district court noted "the State has the burden to defend the statute." App.A.014. Not so. That's simply not how constitutional law works. MCA § 50-20-109(1)(a) is presumptively valid; the plaintiffs must prove otherwise. *See Powell*, ¶ 13 ("The party challenging a statute bears the burden of proving that it is unconstitutional beyond a reasonable doubt and, if any doubt exists, it must be resolved in favor of the statute."). This unsupported misstatement of law alone justifies reversal.

Contrary to the record, the district court also concluded the "medical community clearly considers APRNs competent" to self-certify their abortion practice. App.A.013; *but see* App.C.076–099; App.C.100–144; App.C.122; App.C.130–133; App.C.174–175. First, aspiration abortion unquestionably constitutes a surgical procedure, which the

American College of Surgeons says must be limited to licensed physicians. App.C.122; App.C.139–150. Second, nothing in the record affirmatively authorizes APRNs to self-certify that their scope of practice includes abortion. App.C.076–099; App.C.100–114 (national certification organizations don't specifically authorize such practices); *see also* Mont. Admin. R. 24.159.1406. The record demonstrates a clear showing that the medical community acknowledges risks inherent in abortion and that only medical personnel qualified to deal with the surgical and medical risks associated with abortions should be licensed to perform them. App.C.122; App.C.139–150; App.C.174–175.

The district court, moreover, completely ignored the evidence demonstrating that the Legislature enacted the MCA § 50-20-109(1)(a) amendments at the behest of the medical community. App.C.029–034; App.C.045–047.

This Court in *Wiser* considered the implications of an order like the district court's. *See Wiser*, ¶¶ 18–20. There, this Court expressly stated that the licensure and regulation of healthcare professional must be subject to rational basis, not strict scrutiny. *Id.*, ¶ 18. If, by contrast, courts subjected healthcare licensure to strict scrutiny, the State must

then "demonstrate a compelling state interest in order to license and regulate health care professionals." *Id.* "The State would, in effect, 'shoulder the burden of demonstrating that no less restrictive set of qualifications for a license could serve the state's interest in protecting the health of its citizens.'" *Id.* (quoting *Sammon*, 66 F.3d at 645, n.9.). The State isn't, however, required to make that showing because such a rule would make it "very difficult, if not impossible" for the State to impose any regulations on the healthcare profession. *Id.* *Armstrong* doesn't extend "that broadly" and the State instead need only demonstrate a rational basis for its licensing and regulatory regime. *Id.*

¶ 20.[8] That it has done.

B. The right to privacy isn't implicated in this case

The right to privacy, MONT. CONST. art. II, § 10, is not implicated here. The decision to seek and obtain an abortion is not at issue. Rather, the statute merely regulates who can provide a surgical procedure with known risks to human health and wellbeing. While patients have a fundamental right to seek healthcare, they must do so in all lawful ways. *See Mont. Cannabis Indus. Ass'n v. State*, 2012 MT 201, ¶ 22, 366 Mont. 224, 286 P.3d 1161. That requires seeking care from qualified providers.

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[8] The district court declined to consider "the fact-dependent issue" of MCA § 50-20-109(1)(a)'s impact on provider availability. App.A.002. Plaintiffs failed to demonstrate the law had any impact on provider availability. App.C.124. Any lingering impediment to abortion access results from the individual choices of qualified medical providers to not provide abortions. *Cf.* App.C.249 (Doe—an unqualified medical provider—voluntarily left and no longer practices in Montana). The abortionists' plea to dilute medical standards to increase the pool of providers finds no support in the record. App.C.187–189. Across Montana, in both rural and urban areas, licensed physicians and PAs practice. App.C.124. That was the point of HB 737—to *expand* healthcare access. App.C.030–031. A law cannot be rendered unconstitutional by virtue of the individual choices of physicians and PAs not to perform specific surgeries that the law authorizes them to perform. All this to say, the record supports that MCA § 50-20-109(1)(a) expands abortion access. This Court should make that point emphatically clear, so that after reversal and remand, the district court will not be able to exchange its faulty legal analysis for equally faulty factual analysis.

An APRN is not certified in abortion, emergency, or surgical care. App.C.076–099; App.C.100–114.[9] Patients do not have a fundamental right to obtain medical care from professionals who have not been determined by the regulating authority to be qualified to provide the specific service. *Wiser*, ¶ 17.

Since *Roe*, courts have distinguished between abortion access regulations and those regulations that determine the types of providers qualified and competent to perform abortions. *See Roe*, 410 U.S. at 165 *overturned on other grounds by Dobbs*, 142 S.Ct. 2228; *Akron*, 462 U.S. at 447; *Preterm-Cleveland*, 994 F.3d at 520. Montana jurisprudence, too, recognizes this distinction. *See Wiser*, ¶ 18.

Whether a Montana woman delivers her child or elects to have an abortion, Montana retains an exceedingly strong interest in protecting her health and wellbeing. *See Casey*, 505 U.S. at 846. The regulation at issue here doesn't implicate a woman's decision to obtain an abortion; it dictates what medical providers may perform an abortion. No evidence

[9] For example, the PA program at the University of Washington includes second year (clinical) rotations in surgery, emergency medicine, inpatient and "elective" medicine in a field chosen by the student, which could include abortion. App.C.061–070. Weems admits that she has no emergency medicine training. App.C.203.

in this case demonstrates that MCA § 50-20-109(1)(a) presents an "obstacle to a woman's choice to undergo an abortion." *See Casey*, 505 U.S. at 895. None. By contrast, the record shows that HB 737's regulation of abortion providers was extensively supported by state medical organizations and individual doctors. App.C.029–034; App.C.045–047; *see also* App.C.122; App.C.126–167.

This Court should scrutinize MCA § 50-20-109(1)(a) under rational basis review. *See Wiser*, ¶ 19 ("the State need only demonstrate a rational basis" for the regulation and licensure of health care professionals); *see also Dobbs,* 142 S.Ct. at 2284 (a law regulating abortion "must be sustained if there is a rational basis on which the legislature could have thought that it would serve legitimate state interests"). The district court erred by concluding otherwise. App.A.012.

The statute here doesn't implicate the right to abortion that this Court identified in Article II, § 10 of the Montana Constitution. For that reason, it must be assessed under rational basis, which it clearly satisfies.

C. MCA § 50-20-109(1)(a) survives even strict scrutiny

The State's legitimate interests in safeguarding maternal health

are also compelling. *See Regents of Univ. of Cal. v. Bakke,* 438 U.S. 265, 310, 98 S. Ct. 2733, 57 L. Ed. 2d 750 (1978) (recognizing a State's interest in "facilitating the health care of its citizens is sufficiently compelling"); *see also Real Alternatives, Inc. v. Burwell,* 150 F.Supp.3d 419, 453 (M.D. Pa. 2015) (recognizing Pennsylvania's "compelling interest in promoting public health"); *Legacy Church, Inc. v. Kunkel,* 472 F.Supp.3d 926 (D. N.M. 2020) (stating that the state's interest in public health is compelling); *Planned Parenthood of Middle Tenn.*, 38 S.W.3d at 17. *Armstrong* itself recognized the State's compelling interests in ensuring pre-viability abortions are only performed by qualified medical professionals. *Armstrong*, ¶¶ 63–66.

The record demonstrates that MCA § 50-20-109(1)(a) advances a compelling interest and is narrowly tailored to that interest. First, as previously stated, in line with *Armstrong* the Legislature enacted HB 737 at the request of the medical community. App.C.029–034; App.C.045–047. Second, HB 737 expanded the pool of medical providers licensed to perform abortions in Montana. App.C.029; App.C.045; App.C.124. Third, HB 737 codifies *Armstrong*'s factual circumstances. App.C.030–031; App.C.048; *see also Armstrong*, ¶ 79 (Gray, J. specially concurring).

Fourth, the law's limitations comport with the medical community's views of risks associated with abortions and the training and qualifications necessary to address those risks. App.C.122; App.C.130–133; App.C.174–175. Since its inception, HB 737 considered and implemented medical standards. The Legislature may of course do this on its own; but here, its decision to act in concert with the medical community provides additional evidence that the State's selected means were narrowly tailored to achieve compelling government interests.

* * *

The cold irony of the district court's order is that it makes abortion less safe for Montana women. Rather than upholding the law that ensures women obtain safe abortions and complications management from qualified providers, the district court's decision—in the name of abortion access—re-exposes Montana women to back-alley medical standards. If this Court wishes to create a *sui generis* rule that abortion is completely off-limits for reasonable regulation, it must clearly say so. But such a rule would ultimately corrupt the law and disserve Montana women.

Everyone agrees that prior to this case Montana never licensed

APRNs to perform abortions. Montana has determined *who* may provide abortions, and that decision in rooted in sound medical and scientific judgments. The law here is a textbook exercise of the State's power to safeguard health and safety and regulate the practice of medicine.

CONCLUSION

The district court was wrong. This Court should reverse. Given the constitutional issues of great importance raised in this litigation, the Court should give the parties their day in court and grant oral argument.

DATED this 5th day of August, 2022.

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 11 of the Montana Rules of Appellate Procedure, I certify that this principal brief is printed with a proportionately spaced Century Schoolbook text typeface of 14 points; is double-spaced except for footnotes and for quoted and indented material; and the word count calculated by Microsoft Word for Windows is 8,593 words, excluding cover page, table of contents, table of authorities, certificate of service, certificate of compliance, signature, and any appendices.

/s/ David M.S. Dewhirst
David M.S. Dewhirst

IN THE SUPREME COURT OF THE STATE OF MONTANA
NO. 22-0207

HELEN WEEMS AND JANE DOE,

Plaintiffs and Appellees,

V.

STATE OF MONTANA, BY AND THROUGH AUSTIN KNUDSEN, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL; AND TRAVIS R. AHNER, IN HIS OFFICIAL CAPACITY AS COUNTY ATTORNEY FOR FLATHEAD COUNTY,

Defendants and Appellants.

On Appeal from the First Judicial District Court,
Lewis and Clark County, Cause No. ADV-2018-73
The Hon. Mike Menahan, Presiding

APPENDICES

Order Granting Motion for Summary Judgment (D.C. Doc. 121) .... Appendix A

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