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SUPERIOR COURT OF ARIZONA

IN AND FOR THE COUNTY OF MARICOPA

Greta Gill, CNM; Janna Stefanek, CNM; Erin Bottai, NP; and Denei Dolman, NP, on behalf of themselves and their patients, Plaintiffs, v. State of Arizona, a body politic, Defendant.	Case No. CV2026-005011 **FIRST AMENDED VERIFIED COMPLAINT FOR INJUNCTIVE AND DECLARATORY JUDGMENT** (Assigned to the Hon. Dewain D. Fox)

Plaintiffs Greta Gill, Janna Stefanek, Erin Bottai, and Denei Dolman bring this Complaint against the above-named Defendant, and in support thereof state the

following:

PRELIMINARY STATEMENT

1. On November 5, 2024, Arizonans voted overwhelmingly to adopt a constitutional amendment establishing and protecting "a fundamental right to abortion" in the Arizona Constitution. Ariz. Const. art. II, § 8.1 (the "Amendment").

2. By the Amendment's terms, "the state shall not enact, adopt or enforce any law, regulation, policy or practice that . . . [d]enies, restricts or interferes with" the fundamental right to abortion "before fetal viability unless justified by a compelling state interest that is achieved by the least restrictive means." *Id.* § 8.1(A)(1). And a state interest can only be "compelling" if it "[i]s enacted or adopted for the limited purpose of improving or maintaining the health of an individual seeking abortion care, consistent with accepted clinical standards of practice and evidence-based medicine," *id.* § 8.1(B)(1)(a), and it "[d]oes not infringe on that individual's autonomous decision making," *id.* § 8.1(B)(1)(b).

3. The Amendment further prohibits the State from "enact[ing], adopt[ing] or enforc[ing] any law, regulation, policy or practice that . . . [p]enalizes any individual or entity for aiding or assisting a pregnant individual in exercising the individual's right to abortion." *Id.* § 8.1(A)(3).

4. The State is violating these protections by unjustifiably restricting who can provide abortion care. In the early 2000s, throughout the state, advanced practice clinicians ("APCs") were providing abortions alongside physicians. APCs are Advanced Practice Nurses ("APNs") or Physician Assistants ("PAs"); they have post-graduate medical degrees and clinical training, and many specialize in primary care or women's health. Arizona APCs provided abortions safely for years, and in fact were critical to sustaining consistent abortion access in Northern Arizona and other rural areas.[1] Then,

[1] Ryan Heinsius, *Planned Parenthood in Flagstaff Reintroduces Medication Abortion*, Ariz. Pub. Radio (Feb. 18, 2014), https://perma.cc/2NXM-B3MJ; Sigrid G. Williams et

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in a series of statutes passed mainly between 2009 and 2011 and implemented through regulations (collectively, the "APC Ban" or the "Ban"),[2] the Legislature barred them from doing so, severely constricting abortion access in the state.

5. Some Ban provisions prohibit APCs from providing the abortion itself, while others require that physicians be involved in the medical care surrounding the abortion or that they perform certain administrative tasks.[3] APCs who violate these laws, and clinics who employ them, face a range of penalties, including disciplinary action, loss of licensure, and civil and criminal penalties.

6. The APC Ban contravenes longstanding medical consensus, as well as the Legislature's general policy of *expanding* APC scope of practice in recent decades to remove unnecessary barriers to the practice of medicine. APCs throughout the country routinely provide abortion care (as they did in Arizona), and the safety of their doing so has been well-documented over decades of research.

7. In fact, the APC Ban overrode the considered judgment of the Arizona State Board of Nursing (the "Board")—the agency charged by the state with regulating APNs and their scope of practice. In 2008, the Board had affirmed that APNs can safely provide this care. The Ban also had the effect of overriding the U.S. Food and Drug Administration's (the "FDA") conclusion, in regulating the most common medication abortion regimen, that APCs can safely provide this regimen.

8. Since the Ban was enacted, the medical evidence against it has only solidified further, with study after study confirming that APCs can provide abortion care

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al., *Effects of Legislation Regulating Abortion in Arizona*, 28 Women's Health Issues 297, 299 (2018).

[2] Plaintiffs use the phrase "APC Ban" to reflect that the state has barred all APCs (including PAs) from providing abortion care, and that none of these prohibitions (including those specific to PAs) is consistent with evidence-based medicine or accepted clinical standards. However, Plaintiffs, as APNs, seek injunctive relief specific to the APN category of licensure.

[3] A list and summary of the regulations and statutes comprising the Ban is attached as Exhibit A.

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as safely as physicians. After a recent comprehensive review of that evidence, the National Academies of Sciences, Engineering, and Medicine—the non-partisan, nongovernmental institution established to advise the nation on issues related to those disciplines—concluded: "Both trained physicians (OB/GYNs, family medicine physicians, and other physicians) and APCs . . . can provide medication and aspiration abortions safely and effectively."[4]

9. Along with other medical organizations, the leading professional organization of physicians specializing in obstetrics and gynecology, the American College of Obstetricians and Gynecologists ("ACOG")—a body that medical professionals rely on for clinical standards—has called for the repeal of "restrictions that limit abortion provision to physicians only" and called for more APCs to be trained in this care to increase patient access.[5] These medical and scientific authorities, and others, have also recognized that APC bans like Arizona's harm patients by delaying access to time-sensitive care, which in turn increases the risks and costs associated with abortion care and potentially exposes patients to the exponentially greater risks of carrying to

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[4] Nat'l Acads. of Scis., Eng'g & Med., *The Safety and Quality of Abortion Care in the United States* 2, 14 (2018), https://perma.cc/SUR3-F9PQ [hereinafter "NASEM Report"]; *see also, e.g.*, Sharmani Barnard et al., Cochrane Libr., *Doctors or Mid-Level Providers for Abortion (Review)* 2 (2015) (finding "no statistically significant difference in the risk of failure for medication abortions performed by [APCs] compared with" physicians in comparative review of medication abortion outcome studies); Julie Jenkins et al., *Midwifery and APRN Scope of Practice in Abortion Care in the Early Post-Roe Era: Everything Old Is New Again*, 68 J. Midwifery & Women's Health 734, 739 (2023) (explaining that there is "no difference in the risk of major complications for aspiration abortions even when provided by newly trained APCs compared with experienced physicians"); Keeley McNamara et al., *Privileging Midwives for Abortion Care*, 68 J. Midwifery & Women's Health 769, 772 (2023).

[5] ACOG Comm. on Health Care for Underserved Women, *Committee Opinion No. 612: Abortion Training and Education* (2014, reaff'd 2025), https://perma.cc/E2XK-ZVBK; *see also* ACOG Comm. on Practice Bulletins, *Practice Bulletin No. 225: Medication Abortion Up to 70 Days of Gestation* (2020, reaff'd 2023), https://perma.cc/XYC4-U2JR [hereinafter ACOG, Medication Abortion Up to 70 Days of Gestation] (stating that APCs "possess the clinical and counseling skills necessary to provide first-trimester medication abortion" and that trials "have consistently found that patients randomized to receive medication abortion under the care of a nurse or nurse-midwife had a statistically equivalent risk of complete abortion compared with those under the care of a physician").

term and giving birth.[6]

10. Because the APC Ban restricts and interferes with Arizonans' ability to obtain pre-viability abortion, and because it does not protect patients, is inconsistent with evidence-based medicine and clinical standards, infringes on patient autonomy, and penalizes Plaintiffs for assisting Arizonans seeking an abortion, it plainly violates the Amendment. Indeed, such a restriction has no place in a state whose citizens voted to enshrine fundamental reproductive rights in their constitution. Accordingly, Plaintiffs seek a declaratory judgment that the APC Ban is unconstitutional and permanent injunctive relief barring its enforcement.

JURISDICTION AND VENUE

11. This Court has jurisdiction under A.R.S. §§ 12-123, 12-1831, and the Arizona Constitution.

12. Venue is proper under A.R.S. § 12-401.

13. Pursuant to Arizona Rule of Civil Procedure 26.2(b)(3), this matter is properly designated a Tier 3 case given the complexity and novelty of the legal issues presented.

PARTIES

A. Plaintiffs

14. Plaintiffs are Arizona-licensed APNs, practicing in Tucson, who each have decades of experience providing pregnancy care and other gynecologic care to Arizonans throughout their reproductive lives, including both adolescents and adults.

15. Greta Gill is a board-certified nurse midwife ("CNM"). CNMs have specialized training and certification in nurse midwifery in addition to their education

[6] ACOG Comm. on Advancing Equity in Obstetric & Gynecologic Health Care, *Committee Opinion No. 16: Increasing Access to Abortion* (2025), https://perma.cc/WK79-S34P; NASEM Report, *supra* note 4, at 78 ("Restrictions on the types of providers and on the settings in which abortion services can be provided also delay care by reducing the availability of care[.]"); *id.* at 12 ("Delays put the patient at greater risk of an adverse event.").

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and training as a registered nurse, which qualifies them to independently provide full-spectrum reproductive health care, including but not limited to family planning, sexual health, preconception health, pregnancy care, birth, and post-partum care. Ms. Gill serves as Medical Director of Midwifery for the largest midwifery group practice in Southern Arizona, which is housed within a community health center. As part of her full-scope midwifery practice, Ms. Gill routinely performs obstetric procedures and interventions. Before the APC Ban was first enacted, she had hospital privileges to provide second trimester induction abortions to preserve maternal health and safety where miscarriage was inevitable. Ms. Gill is a Fellow of the American College of Nurse Midwives, holds admitting privileges at the Tucson Medical Center, and plays an operational role there as a member of both the Joint Operating Committee of the Obstetric Hospitalist Program and the Women's Clinical Practice Team.

16. Janna Stefanek is also a CNM practicing with the same midwifery group practice as Ms. Gill. Ms. Stefanek provides complex gynecologic care, including contraceptive care, preventative care, testing and treatment for sexually transmitted illnesses, pregnancy options counseling, follow-up care for abortion patients, miscarriage management, postpartum care (including treating postpartum mood disorders), and menopause management. Until recently, for over a decade, she also performed obstetric procedures and interventions.

17. Erin Bottai is a board-certified Nurse Practitioner ("NP") in Women's Health, which is a subspecialty that requires graduate-level education, training, and certification focused on providing care for women of all ages, from pre-adolescence through post-menopause, including during pregnancy. Ms. Bottai provides full-spectrum reproductive health care to University of Arizona students and faculty in the University's Women's Health Clinic, which includes complex gynecologic care, contraceptive care, preventative care, testing and treatment for sexually transmitted illnesses, and pregnancy options counseling. In a prior position, she provided abortion-

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related care such as counseling, monitoring vital signs, administering sedation, and providing aftercare and follow-up care.

18. Denei Dolman is also a board-certified NP in Women's Health. Ms. Dolman, as part of a group practice in Tucson, currently provides a broad range of reproductive and gynecologic care, including complex gynecologic care, prenatal care to both low-risk and high-risk patients, contraceptive care, and menopausal hormone therapy. In previous positions, she also provided obstetric and postpartum care and served as a clinical instructor for Grand Canyon University College of Nursing, teaching student nurses at Tucson Medical Center.

19. Like other APNs who specialize in gynecologic care, Plaintiffs either are already qualified to provide abortion care or could be with minimal additional training or proctoring—in the same way clinicians (including physicians) generally obtain additional education, training and/or proctoring before independently providing any new type of care. But for the APC Ban, they would take steps to provide this care, to better meet their patients' needs and improve abortion access for Arizonans. Although the practices where Plaintiffs currently work do not offer other abortion services, Plaintiffs would seek contract employment outside these practices to provide this care, including at licensed abortion clinics.

20. Additionally, but for the APC Ban, Ms. Gill would resume providing induction abortions up to 22 weeks as part of her privileges at Tucson Medical Center.

21. Plaintiffs sue on their own behalf and on behalf of their patients.

B. Defendant

22. Defendant State of Arizona is a body politic.

THE CHALLENGED LAWS

23. The APC Ban is comprised of numerous independent provisions that, separately and together, bar Arizona APCs from providing abortion care that is, or could

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readily be, within their training, experience, and scope of practice.[7] The Legislature primarily enacted these provisions through a series of statutes between 2009 and 2011, and they have been further implemented through regulations.[8] This section sets forth the prohibitions that apply to or otherwise affect Plaintiffs and other APNs.

24. Under A.R.S. § 36-2160(A), only physicians may provide medication abortion care. Under A.R.S. §§ 36-2155 and 36-2153(E), only physicians may perform "surgical" abortion procedures, which the code defines as "the use of a surgical instrument or a machine to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will cause, with reasonable likelihood, the death of the unborn child." A.R.S. § 36-2151(14); *see also* A.R.S. § 36-2155 (setting out same definition).[9] The Arizona Legislature's definition of "surgical abortion" excludes termination of an ectopic pregnancy, procedures "to remove a dead fetus," or "patient care incidental to the procedure." A.R.S. § 36-2151(14); *see also* A.R.S. § 36-2155 (setting out same definition). As a result, non-physician clinicians are permitted to perform substantially identical procedures involving uterine aspiration of fetal tissue after demise has already occurred; they are only prohibited from doing so if the procedure is done to terminate a pregnancy. In furtherance of these provisions, A.R.S. § 32-1606(B)(12) prohibits the Arizona State Board of Nursing from "decid[ing]

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[7] For a complete list of the challenged provisions, *see* Exhibit A attached hereto.

[8] The Legislature targeted PAs earlier—in 2002, excluding abortion from the definition of "minor surgery" that PAs are authorized to perform. A.R.S. § 36-2160(A); 2002 Ariz. Sess. Laws. Ch. 277 (H.B. 2542).

[9] Though the Legislature has referred to procedural abortions as "surgical," and though "surgical abortion" is sometimes used to distinguish procedural abortions from medication abortions, the term is a medical misnomer here. *See* ACOG, *Position Statement: Definition of "Procedures" Related to Obstetrics and Gynecology* (2018, reaff'd 2023), https://perma.cc/N39W-UBW7 ("A procedure is a short interventional technique that includes . . . non-incisional diagnostic or therapeutic intervention through a natural body cavity or orifice[.]"); ACOG, *ACOG Guide to Language and Abortion* 1 (2024), https://perma.cc/PV2E-5GTM ("The abortion procedure is not a surgery. Referring to it as a procedure is clinically accurate."); Am. Med. Ass'n ("AMA"), *AMA Code of Medical Ethics 4.2.7 Abortion*, https://perma.cc/F2NF-K6XU (last visited Feb. 2, 2026) (describing abortion as "a safe and common medical procedure").

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scope of practice relating to abortion."

25. Other statutory provisions and implementing regulations effectively ban APCs from providing abortion by necessitating the presence and personal involvement of a physician, rather than a qualified non-physician clinician, at various stages of the process.

26. For example, outside of certain narrowly defined emergencies, state law requires that the "physician" performing the abortion, a referring physician, or someone "working in conjunction with" a physician perform an ultrasound before an abortion. A.R.S. § 36-2156(A)(1). The law also requires that the physician providing the abortion or a referring physician deliver certain mandatory disclosures "orally and in person." A.R.S. § 36-2153(A); *see also* A.R.S. § 36-2158(A) (requiring that the providing or referring physician "orally and in person" communicate additional information related to fetal conditions). In emergency situations, A.R.S. § 36-2153(C) mandates that the providing physician explain the relevant medical circumstances to the patient. And, when minors have an abortion, A.R.S. § 36-2152(A), (B), and (H) set forth various additional procedural requirements that must be completed by "the attending physician."

27. In addition, Arizona requires outpatient health care settings providing a threshold number of abortions per year to be licensed as "abortion clinics." A.R.S. § 36-449.01(2) (defining abortion clinic as "a facility . . . in which five or more first trimester abortions in any month or any second or third trimester abortions are performed"); A.R.S. § 36-449.02. The licensing statutes and regulations, in turn, require that certain additional ancillary services be performed by a physician, including physically examining the patient prior to an abortion, estimating the gestational age of the fetus, interpreting the state-mandated ultrasound, providing state-mandated counseling, monitoring patients after a procedure, and discharging patients—all tasks that APCs are qualified to perform. *See* A.R.S. § 36-449.03(C)(3), (D)(5), (G)(4), (5), (8), (H)(2); A.A.C. R9-10-1507(B)(2), (3); A.A.C. R9-10-1509(A)(2), (B)(1), (5), (C), (D)(3)(a),

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(J); A.A.C. R9-10-1510(B)(1). These rules effectively require that a physician be physically present in all licensed clinics providing abortion care and conducting all state-mandated pre-abortion medical visits, as well as the abortion itself and other tasks.

28. Arizona statutes and regulations also require that certain reports be generated for any abortion, and explicitly or implicitly require that these be generated by a physician. *See* A.R.S. § 36-2161(A)(16)-(17), (20)-(21), (D) (requiring "the physician who performed the abortion" to create certain records); A.R.S. § 36-2162.01(A), (C) (requiring physicians to complete certain records as either the "referring physician" or the "physician who is to perform the abortion"); A.R.S. § 36-2152(M) (requiring physicians to complete reports for abortion care provided to minors); A.A.C. R9-10-1512(A)(6), (12), (D)(3)(d) (requiring medical records to include information from physicians).[10]

29. The penalties for violating these restrictions are severe. APCs who provide abortion care face disciplinary action for unprofessional conduct, including loss of licensure. A.R.S. §§ 32-1663(D), 32-1601(27); A.A.C. R4-19-403(12). If they provide abortion care to minors, they could potentially face additional criminal and civil liability. A.R.S. § 36-2152(I)-(J). APCs also face civil liability based on several statutory provisions mandating that certain information be provided to the patient by a physician prior to an abortion. A.R.S. §§ 36-2153(K), 36-2156(C), 36-2158(D).

30. Additionally, anyone operating a clinic in violation of these restrictions would be at risk of committing a misdemeanor for operating a clinic in violation of the Licensing Rules, A.R.S. § 36-431, as well as being vulnerable to civil penalties, A.R.S. §§ 36-449.03(J), 36-431.01; A.A.C. R9-10-1503(D); A.A.C. R9-10-111, and license

[10] Sections 36-2153(A), 36-2156(A), 36-2158(A), and 36-2162.01 and A.A.C. R9-10-1509(A)-(E) are being separately challenged in *Isaacson v. Arizona*, No. CV2025-017995 (Maricopa Cnty. Super. Ct.) because they also require patients to make medically unnecessary trips to their provider and receive medically unnecessary treatments and inaccurate, biased state-mandated counseling.

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revocation, A.R.S. §§ 36-427, 36-449.03(J); A.A.C. R9-10-1503(D); A.A.C. R9-10-112. Medical professionals and organizations are also subject to criminal, civil, and licensure penalties for violation of the abortion reporting requirements. A.R.S. § 36- 2163(H)-(J).

ALLEGATIONS

A. Abortion Safety & Methods

31. Abortion is one of the most common medical treatments. Approximately one in four women will have an abortion over the course of their lives,[11] for various reasons. Some decide that it is not the right time to have a child or to add to their family; some face an unexpected pregnancy complication or a health condition that makes their pregnancy risky; some are pregnant as a result of rape or incest; and some choose not to have biological children or to limit their family size.

32. Abortion is also one of the safest medical treatments in the United States and is safer the earlier it occurs in a pregnancy.[12] Complications are extremely rare, can generally be managed by APCs, and can be safely handed off to specialists when necessary.

33. In the first 12 weeks of pregnancy as measured from the last menstrual period, most patients have the option of ending their pregnancy using medications alone. Most commonly, patients take a combination of two prescription medications, mifepristone and misoprostol.[13] Mifepristone blocks the actions of progesterone, a

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[11] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States*, 2008-2014, 107 Am. J. Pub. Health 1904, 1908 (2017).

[12] NASEM Report, *supra* note 4, at 10.

[13] In roughly half of the U.S., patients can receive these medications by mail after a telemedicine appointment. Laurie Sobel et al., *The Intersection of State and Federal Policies on Access to Medication Abortion Via Telehealth After* Dobbs, KFF (July 24, 2025), https://perma.cc/P2LM-RJBZ. In other states, including Arizona, patients are legally required (for no medical purpose) to travel to a clinic to obtain the medications, but they generally then take them at home so they can undergo the abortion process in a comfortable, private and familiar setting surrounded by their chosen support people. Arizona's telemedicine abortion ban is currently being challenged in *Isaacson v. Arizona*, No. CV2025-017995 (Maricopa Cnty. Super. Ct.).

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hormone that is necessary to sustain pregnancy, and increases the efficacy of the second medication in the regimen, misoprostol. Misoprostol is generally taken within 48 hours after the mifepristone. It causes the uterus to contract and expel its contents, which generally occurs while the patient is at home or another location of their choosing. The process is essentially the same, medically, as a spontaneous miscarriage. In places where access to mifepristone is limited or non-existent, providers commonly prescribe a misoprostol-only regimen, which is also safe and effective.

34. Approximately 59% of clinician-provided abortions provided in Arizona in 2023 were medication abortions.[14] This is in line with national trends: As of 2023, medication abortion accounted for 63% of all clinician-provided abortions in the United States.[15]

35. The rate of clinically significant complications for medication abortion is extremely low.[16] If a complication arises, it occurs after the patient has left the clinic and taken the medications, usually at home. Regardless of whether the abortion provider is a physician or an APC, it is the standard of care for them to give patients the number for a 24/7 phone line—usually staffed by a nurse—to contact if they experience any concerning symptoms.

36. Most complications from medication abortion, such as excessive or prolonged bleeding, can be treated by APCs on a telemedicine or outpatient basis, which Arizona law already allows them to do; indeed, these complications are virtually identical to miscarriage complications that APCs routinely treat. In the extremely rare

[14] Guttmacher Inst., *Arizona: Monthly Abortion Provision Study*, https://www.guttmacher.org/monthly-abortion-provision-study https://perma.cc/CA4S-Q4WN (last visited Jan. 30, 2026).

[15] Rachel K. Jones & Amy Friedrich-Karnik, *Policy Analysis: Medication Abortion Accounted for 63% of All US Abortions in 2023—An Increase from 53% in 2020*, Guttmacher Inst. (Mar. 19, 2024), https://perma.cc/Z2WL-W8S8.

[16] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175 (2015).

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case where a patient needs a higher-level intervention, it is safest for that patient—regardless of whether their original provider was a physician or an APC—to go to the closest emergency medicine department.

37. The other method of abortion available in the first trimester is aspiration abortion. In this procedure, the clinician inserts a small sterile tube through the natural opening of the cervix into the uterus. A pump attached to the tube creates suction, which empties the uterine contents. The procedure takes between five and ten minutes and does not require any incision or a sterile operating field.

38. Whether an aspiration is provided by a physician or an APC, complications are rare and can often be managed by an APC.[17] Major complications are extremely rare, as they are for medication abortion, occurring in far less than one percent of patients.[18] In such cases, a patient would be transferred to a hospital setting regardless of whether their original provider was a physician or an APC.

39. Starting in the second trimester, one method clinicians use to terminate a pregnancy or complete a miscarriage is to medically induce labor and delivery. This process is the same whether or not fetal demise has occurred naturally.

40. Inducing labor and delivery is a core CNM competency, and one they routinely practice independently. Plaintiff Gill, for example, does so at a hospital, the Tucson Medical Center, both for live births and to complete miscarriages after fetal demise has occurred. However, currently, Arizona law prohibits CNMs from inducing labor for purposes of terminating a pregnancy, even in cases where patients urgently need an induction to protect their health or life.

41. Abortion is also far safer than its only alternative: continuing the

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[17] Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Pub. Health 454, 459 (2013); Marlene B. Goldman et al., *Physician Assistants as Providers of Surgically Induced Abortion Services*, 94 Am. J. Pub. Health 1352, 1355 (2004).

[18] NASEM Report, *supra* note 4, at 60 (citing Upadhyay et al., *supra* note 16).

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pregnancy. Pregnancy, labor, and delivery carry a risk of serious long-term medical and physical consequences, even for people who are healthy when they become pregnant.

42. Pregnancy stresses most major organs and involves profound and long-lasting physiological changes, including changes to a person's health and future ability to have children. Individuals are at particular risk of complications if they have a medical condition caused or exacerbated by pregnancy, such as diabetes, high blood pressure, or a psychiatric disorder.

43. In Arizona in 2023, the most recent year for which the Arizona Department of Health Services ("ADHS") published vital statistics data, 32.5% of births had complications of labor and delivery.[19] Arizona's rate of severe maternal morbidity—which includes conditions or outcomes of pregnancy, delivery, or postpartum with "significant negative effects on a women's health and wellbeing"—was 119.4 per 10,000 delivery hospitalizations from 2016-2019, the most recent period for which ADHS has published data.[20] More than 3,500 Arizona women experienced severe maternal morbidity during that period, and women of color were disproportionately affected.[21]

44. The starkest risk to a person of continuing a pregnancy is death, and that risk—though extremely low—has been rising and is exponentially higher than that associated with abortion.

45. In Arizona, the ratio of women who died from pregnancy-related causes increased from 21.0 maternal deaths per 100,000 live births in 2016 to 33.4 per 100,000 live births in 2020, the most recent period for which ADHS has published data.[22] During

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[19] *See* ADHS, *Arizona Health Status and Vital Statistics 2023* 54, 56 (2025), https://perma.cc/K39J-MQLY [hereinafter ADHS, *Arizona Health Status 2023*].

[20] ADHS, *Maternal Mortalities and Severe Maternal Morbidity in Arizona* 52, 54 (2020), https://perma.cc/4L5B-ATCY.

[21] *See id*. at 50, 58.

[22] See ADHS, 2016-2020 *Pregnancy-Related Maternal Mortality in Arizona Report* 18 (2025), https://perma.cc/6DL8-EYX4 [hereinafter ADHS, *2016-2020 Pregnancy-*

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that five-year period, 100 women died of pregnancy-related causes in Arizona.[23] The pregnancy mortality rate is significantly higher for Native American and Black or African American women in Arizona, and for women living in rural counties.[24] Nationally, the risk of death associated with pregnancy, relative to that associated with abortion, has been rising; by current estimations, a person is more than 40 times more likely to die from pregnancy than from an abortion.[25]

46. Despite these risks, CNMs routinely, independently, and safely care for their patients through pregnancy, labor, and delivery.

B. Regulation of APCs

47. APCs, like physicians, are highly regulated as a profession.

48. The Arizona State Board of Nursing (the "Board") licenses all registered nurses in the state.[26] APNs are a subset of registered nurses who have a broader scope of practice than other nurses by virtue of their advanced education and training. Within that subset, APNs can hold various specific licenses, including a CNM license and an NP license. Under Arizona law, all APNs must complete an approved graduate education program, pass a certification exam from a national body such as the American Midwifery Certification Board, meet the continuing educational requirements for maintaining that certification (which include periodic competency assessments and tailored educational modules), and have an expanded scope of practice in a specialty

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Related Maternal Mortality].

[23] *Id.* at 19. During that same period, ADHS reported fewer than 6 deaths from "pregnanc[ies] with abortive outcome," which includes miscarriages and ectopic pregnancies along with abortions. *See* ADHS, *Arizona Health Status 2023*, *supra* note 19, at 79.

[24] *See* ADHS, *2016-2020 Pregnancy-Related Maternal Mortality*, *supra* note 22, at 25-26, 28-29.

[25] Maria W. Steenland et al., *Pregnancy- and Abortion-Related Mortality in the US, 2018-2021*, 9 JAMA Network Open 1, 1 (2026) (estimating a mortality ratio of 44.3 between pregnancy-related and abortion-related mortality, excluding COVID-19-related mortality).

[26] PAs are separately licensed and regulated by the Board of Medicine.

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area, such as women's health. A.R.S. § 32-1601.

49. Arizona law generally permits APNs to perform all acts that are recognized as being within the role and population focus of the APN's certification and that the APN is qualified to perform based on their education, training, and demonstrated competency. A.A.C. R4-19-508(B), (C). Generally, APNs have broad authority to dispense drugs, including controlled substances (provided they obtain the required Drug Enforcement Administration registration).

50. The Legislature has given the Board broad authority to discipline licensees for harmful or otherwise unprofessional conduct, A.R.S. §§ 32-1663(D), 32-1601(27), which Board regulations have defined to include "[a]ssuming patient care responsibilities that the nurse lacks the education to perform, for which the nurse has failed to maintain nursing competence, or that are outside the scope of practice of the nurse," A.A.C. R4-19-403(12). APCs are also subject to malpractice liability if they compromise patient safety. A.R.S. §§ 12-561(2), 12-562.

51. The Legislature also has authorized the Board to "[a]dopt and revise rules necessary to carry into effect" Arizona's nursing statutes and to "[p]ublish advisory opinions regarding registered and practical nursing practice and nursing education." A.R.S. § 32-1606(A)(1), (2). Accordingly, the Board has the responsibility to "[a]dopt rules establishing acts that may be performed by a registered nurse practitioner or certified nurse midwife." A.R.S. § 32-1606(B)(12). Thus, the Legislature has made the judgment that as a general matter, the Board is capable of assessing appropriate licensing requirements and scope of practice and regulating the medical services provided by Arizona's APNs (and sub-groups of APNs, including CNMs and NPs).

52. Under this authority, the Board has identified various complex treatments and procedures as being specifically within APNs' scope of practice given appropriate

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training and education, including ones as complex as, or more complex than, abortion.[27]

53. Indeed, as noted above, in 2008, the Board recognized that first-trimester abortion procedures are within APN scope of practice.[28] Following the Board's decision, in a notable and distinct statutory carve-out that rejected the judgment of the State's expert licensing board, the Legislature prohibited the Board from recognizing that medication and procedural abortion care at any stage in pregnancy—and only such care—is within NPs' and CNMs' scope of practice. A.R.S. § 32-1606(B)(12). The Arizona Nurses Association, despite its avowedly neutral position on abortion as a general issue, opposed that bill because the legislation "[w]as adopted without the usual evidence-based process utilized by the Legislature to establish scope of practice."[29]

C. APC Qualifications to Provide Abortion Care in Arizona

54. Roughly half of the states currently allow APCs to provide abortions, which amounts to more than two thirds of the states that do not ban first trimester abortion.[30] In fact, APCs often train residents in abortion care.

55. There is no evidence that APCs have endangered their patients by providing abortion care. To the contrary, APC provision of both medication and aspiration abortion has been well-studied, and the research conclusively shows that APCs provide this care just as safely as physicians. Reviewing this literature, the

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[27] *See, e.g.*, *Advisory Opinions & Position Statements*, Ariz. Bd. of Nursing, https://azbn.gov/scope-practice/advisory-opinions (last visited Feb. 2, 2026) (for example, posting opinions authorizing APNs, under specified circumstances, to administer ketamine at home and to perform ionizing radiation scans (including chest x-rays, Dual-Energy X-ray Absorptiometry [DEXA] scan, and fluoroscopy)).

[28] Arizona State Board of Nursing, Board Meeting Minutes (May 14, 2008), attached hereto as Exhibit B; *see also* Diana Taylor et al., Regents of the Univ. of Calif. on behalf of the Univ. of Calif., S.F., *Providing Abortion Care: A Professional Toolkit for Nurse-Midwives, Nurse Practitioners, and Physician Assistants* 13 (2009), https://perma.cc/6B2Q-NPHA.

[29] Ariz. Nurses Ass'n, *Public Policy SB 1169: Nurse Practitioner Scope re: Abortion*, https://perma.cc/724L-VCP7 (last visited September 4, 2025).

[30] *Interactive Map: US Abortion Policies and Access after Roe*, Guttmacher Inst., https://states.guttmacher.org/policies/?protections=health-care-professionals-besides-physicians-provide-abortions (last updated Jan. 30, 2026).

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National Academies of Sciences, Engineering, and Medicine concluded in its recent consensus report that "[b]oth trained physicians . . . and APCs (physician assistants, certified nurse-midwives, and nurse practitioners) can provide medication and aspiration abortions safely and effectively," citing an "extensive body of research documenting the safety of abortion care in the United States."[31]

56. ACOG, likewise, has stated that APC bans, like Arizona's, "are not based in science; improperly regulate medical practice; and impede patients' access to quality, evidence-based health care," and that, if these bans were lifted, "APCs could become critical, lifesaving points of care networks for patients who would otherwise be forced to travel to access abortion care—or cut off from it entirely."[32]

57. Other leading medical authorities, including the American Public Health Association, American College of Nurse Midwives, National Association of Nurse Practitioners in Women's Health, and the World Health Organization, have concluded the same.[33]

58. The FDA agrees. Since the FDA first approved the combination medication abortion regimen in 2000, it has allowed APCs to provide that regimen. Initially, the FDA required some physician oversight (which could be remote). Starting in 2016, after reviewing the extensive medical literature on the safety of APC provision

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[31] NASEM Report, *supra* note 4, at 14.

[32] ACOG, *Issue Brief: Advanced Practice Clinicians and Abortion Care Provision* (2023), https://perma.cc/94L3-8NUB; *see also* ACOG, *Medication Abortion Up to 70 Days of Gestation*, *supra* note 5 (APCs "possess the clinical and counseling skills necessary to provide first-trimester medication abortion" and trials "have consistently found that patients randomized to receive medication abortion under the care of a nurse or nurse-midwife had a statistically equivalent risk of complete abortion compared with those under the care of a physician").

[33] *See* Brief of Amici Curiae the Nat'l Ass'n of Nurse Pracs. in Women's Health, Am. Coll. of Nurse-Midwives, Ass'n of Physician Assocs. in Obstetrics & Gynecology, & Am. Acad. of Physician Assocs. in Support of Appellee at 1, 27-29, *State v. Planned Parenthood Great Nw., Haw., Alaska, Ind., Ky.*, No. S-19277 (Alaska June 4, 2025); World Health Organization, *Health worker roles in providing safe abortion care and post-abortion contraception* (2015), https://perma.cc/6HN8-UH6R.

of medication abortion, the FDA removed this supervision requirement altogether, authorizing APCs to provide medication abortion with full independence.[34]

59. As discussed *supra*, after reviewing the safety evidence and medical consensus on APC provision of aspiration abortion, the Board took a similar approach. When asked, the Board voted in 2008 "that it is within the scope of practice of a nurse practitioner to perform a first-trimester aspiration abortion provided the procedure is within the nurse practitioner specialty certification population; the nurse practitioner has met the education requirements of A.A.C. R4-19-508(C); and there is documented evidence of competency in the procedure."[35]

60. Although the Arizona Legislature has barred APCs from providing abortions, APCs such as Plaintiffs routinely provide similarly or more complex care to their patients, including care that is closely analogous to abortion care.

61. Medication abortion is essentially an induced miscarriage and, like other APCs specializing in gynecology, Plaintiffs regularly treat patients for miscarriage. As part of that treatment, they already prescribe misoprostol, which is one of the medications commonly used in a medication abortion. In fact, misoprostol's mechanism of action, contraindications, risk factors, and potential complications in the context of miscarriage management are virtually identical when used to induce an abortion, either alone or in combination with the other commonly-used medication, mifepristone.[36]

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[34] Ctr. for Drug Evaluation & Rsch., *Application Number: 020687Orig1s020, Cross Discipline Team Leader Review* 17-18, 27 (2016), https://perma.cc/VJE8-QASB.

[35] Arizona State Board of Nursing, *supra* note 28, at 24. Under A.A.C. R4-19-508(C), NPs and CNMs "shall only provide health care services including prescribing and dispensing within…[their] population focus and role and for which…[they are] educationally prepared and for which competency has been established and maintained. Educational preparation means academic coursework or continuing education activities that include both theory and supervised clinical practice."

[36] Plaintiff Gill is also a certified mifepristone prescriber, and in the coming weeks will begin prescribing mifepristone for miscarriage in combination with misoprostol. The regimen she will provide is identical to the one most commonly used in a medication abortion.

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Moreover, these medications carry fewer risks than some of the controlled substances that Plaintiffs are licensed to prescribe, such as oral or intravenous opioids.[37] Plaintiffs are also highly trained in counseling patients and obtaining informed consent, which are the main components of medication abortion care.

62. Plaintiffs, like other APCs who specialize in women's health, also have years of experience performing complex and invasive gynecologic procedures that carry risks and that require manual dexterity similar to aspiration. This experience gives them all the baseline skills needed to train in aspiration abortion (skills comparable to those of many physicians who seek this training).[38] Plaintiffs regularly perform procedures that require them to access the cervix or uterus with instruments, such as endometrial biopsy (a diagnostic procedure, very similar to aspiration, that requires inserting a pipette though the cervix and into the uterus and using suction to extract a tissue sample from the uterine lining); cervical biopsy; and inserting and removing intrauterine devices (which requires them, before they insert the device, to insert another instrument into the uterus to estimate its length, and which also, in more challenging cases, can require inserting various instruments into the cervix or uterus to remove the device).[39]

63. Indeed, like other CNMs, Plaintiffs Greta Gill and Janna Stefanek routinely perform or have performed obstetric procedures and interventions that pose risks and can be significantly more complex than medication and aspiration abortion. For example, they have induced labor to deliver babies or manage pregnancy loss;

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[37] Additionally, CNMs prescribe misoprostol, along with oxytocin, in contexts where they pose higher risks than in the context of medication abortion, i.e., for pregnancies that are more advanced and/or complicated by a condition such as diabetes or high blood pressure.

[38] In fact, Plaintiff Gill is currently training in aspiration.

[39] On information and belief, APCs in Arizona, like elsewhere, also perform Loop Electrosurgical Excision Procedure, a procedure to screen for and treat precancer in which the clinician inserts a thin wire loop carrying a low-voltage electrical current and uses the instrument to surgically excise a layer of cervical tissue and then cauterize the exposed remaining tissue.

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manually dilated a patient's cervix using a balloon catheter; inserted intrauterine pressure catheters; manually removed the placenta and/or retained products of conception from a patient's uterus (which requires the clinician to insert their whole hand into the patient's uterus); managed postpartum infection; administered medications and used bimanual compression to treat obstetric hemorrhage; and surgically repaired tears in the vagina, vulva, and perineum.

64. In fact, before the APC Ban was first enacted, Ms. Gill provided second trimester induction abortion. Her hospital privileges authorized her to induce labor in a compromised pregnancy where the patient would inevitably miscarry but fetal demise had not yet occurred, up until 22 weeks as measured from the last menstrual period. This medical intervention—which is critical to reduce the patient's distress and their risk of infection or hemorrhage, among other complications—is considered an abortion under Arizona law. As such, when the APC Ban took effect, Ms. Gill lost these particular privileges, even though she had decades of experience providing this intervention and still holds privileges to induce labor in clinically identical circumstances after fetal demise has occurred.

65. Now, when Ms. Gill is on call at Tucson Medical Center and a patient is having an inevitable miscarriage (without fetal demise), she has to transfer the patient to a physician who can induce labor, even though that transfer is medically unnecessary and often distressing for the patient. Ms. Gill has found this limitation on her practice and the impact on her patients so frustrating that she has considered moving to another state where, as an APN, she could provide this critical and urgent care to her patients and, more generally, practice to the full scope of her qualifications.

66. As noted above, Arizona law allows APCs to prescribe the same medications for miscarriage care that they are barred from prescribing for abortion care, and APCs commonly prescribe those. Arizona law also expressly carves out miscarriage management from its ban on APCs' performing aspirations, even though the procedure

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is clinically identical in these two settings. *See*, *e.g.*, A.R.S. § 36-2155(B)(2) (excluding procedure "to remove a dead fetus" from the definition of "surgical abortion" in provision banning APCs from providing abortions). In fact, the only meaningful clinical difference between these scenarios is that a patient experiencing bleeding from a *miscarriage* may face *greater* risk of complications, necessitating more medical intervention, than a patient receiving a planned abortion. And Arizona law recognizes that CNMs can independently (without physician supervision) deliver babies and manage pregnancy complications, which involves care that is significantly more complex than a planned abortion. Thus, the purpose of the APC Ban can only be to limit abortion access.

D. The APC Ban's Impact

67. The APC Ban bars a broad and numerous category of clinicians, including Plaintiffs, from providing or obtaining the necessary training to provide abortion care that is appropriately within their scope of practice and that they consider to be integral to their profession and their specialty in women's health.

68. In doing so, the APC Ban denies, restricts, and interferes with Arizonans' fundamental right to abortion by deliberately and artificially limiting the pool of providers who can offer this care, including in rural areas where APCs may be the only health care providers available for miles.

69. Many Arizonans choose APCs for their primary and/or sexual and reproductive health care. That may be based on a general preference for APCs, or a past positive experience with an APC or a recommendation from a friend or family member.[40] Or it may simply be that the clinician who practices closest to them and/or can see them soonest happens to be an APC. As a result, many Arizonans learn of an

[40] *See* Thomas Kippenbrock et al., *A national survey of nurse practitioners' patient satisfaction outcomes*, 67 Nursing Outlook 707, 708-12 (2019) (in large-scale study, finding significantly higher ratings for NPs as compared to physicians, both in overall satisfaction and in satisfaction with the provider's communication).

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unwanted pregnancy, or experience a complication in a wanted pregnancy, while under the care of an APC.

70. Plaintiffs' experience reflects this dynamic. Their patients have sought abortion care from them because they have established, trusting provider-patient relationships. They may, for example, have provided those patients with prenatal care in the past or other reproductive health care. Ms. Gill's midwifery practice has had established patients suffer medical emergencies in which, because of the APC Ban, they had to transfer the patient to a physician even though they were perfectly qualified to treat that patient.

71. By requiring these patients to seek out another provider for their abortion care, even though their established provider may be able and willing to provide that care, the APC Ban interferes with the provider-patient relationship at a time when patients may feel particularly vulnerable, disrupts continuity of care, and delays that care.

72. Nor are the APC Ban's harms limited to Arizonans who are already under an APC's care. More broadly, the ban restricts access to care by severely limiting the pool of potential providers. This effect is clear from the history of abortion access in Arizona. Before the APC Ban took effect, abortion was available in 5 of Arizona's 15 counties (Coconino, Maricopa, Pima, Yavapai, and Yuma), partly sustained by APC provision.[41] Since the Ban, it has only consistently been available in Maricopa and Pima counties, with interrupted and limited services offered at a single clinic in Coconino County (in Flagstaff).[42] As a result of fewer provider locations, some patients have had

[41] Williams et al., *supra* note 1, at 299.

[42] *Id.*; Heinsius, *supra* note 1; Larry Hendricks, *Abortion services resume at new Planned Parenthood clinic in Flagstaff*, Arizona Daily Sun (Feb. 18, 2014), https://azdailysun.com/news/local/abortion-services-resume-at-new-planned-parenthood-clinic-in-flagstaff/article_9da0f2d8-9864-11e3-ae56-0019bb2963f4.html; Howard Fischer, *Abortions discontinued at 7 locations in Arizona*, tucson.com (Aug. 19, 2011), https://perma.cc/RE7E-MJ4E.

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to travel over a hundred more miles to access care.[43]

73. Researchers studying the combined effects of Arizona's APC Ban and its extra trip requirement law found that, after these laws took effect and more rural clinics ceased providing abortion, the proportion of patients able to access care in their first trimester decreased.[44] That finding is consistent with more general research that patients seeking an abortion often face various barriers to long-distance travel, such as: limited financial resources, transportation limitations, childcare obligations, inflexible work schedules, and controlling partners who limit their access to abortion care.[45] Courts have reached similar conclusions in examining the effects of APC bans in Minnesota, Montana, Ohio, Alaska, and Michigan.[46]

74. That Arizona's APC Ban, like others, delays access to care is not surprising given that Arizona has physician shortages statewide,[47] particularly in rural

[43] Williams et al., *supra* note 1, at 299. This study looked at the effects of the APC Ban combined with the requirement that patients receive certain state-mandated information and testing and then wait 24-hours before having an abortion.

[44] *Id*.

[45] *See* Jenna Jerman et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* 7, 11 (2016), https://perma.cc/ZR3L-RBCN; Sameera S. Nayak et al., *Intimate partner violence and time to making an abortion appointment in the United States*, 380 Social Science & Medicine 1, 1-5 (2025); Nancy F. Berglas et al., *Changes in Abortion Access, Travel, and Costs Since the Implementation of State Abortion Bans, 2022-2024*, 115 Am. J. Pub. Health 1713, 1713 (2025).

[46] *See Doe v. State*, No. 62-CV-19-3868, 2022 WL 2662998, at *25 (Minn. Dist. Ct. July 11, 2022) (Minnesota's APC ban made abortion more costly and less accessible); *Weems v. State*, 529 P.3d 798, 804-805, 812 (Mont. 2023) (Montana's ban imposed increased costs and travel on patients); *Planned Parenthood Sw. Ohio Region v. Ohio Dep't of Health*, No. A 2101148, 2024 WL 4183293, at *6 (Ohio Ct. Com. Pl. Aug. 29, 2024) (Ohio's ban fell particularly hard on "low-income patients, patients with children, and patients in unstable living situations"); *Planned Parenthood Great Nw., Haw., Alaska, Ind., Ky. v. State*, No. 3AN-19-11710CI, at ¶¶ 58-59 (Alaska Super. Ct. Sept. 4, 2024) (as a result of Alaska's APC ban, patients had to travel farther for care and were sometimes delayed or even prevented from accessing that care); *Northland Fam. Plan. Ctr. v. Nessel*, No. 24-000011-MM, 2025 WL 2098474, at *29 (Mich. Ct. Cl. May 13, 2025) (ban limited the provider pool, and increased logistical barriers, travel distances, and wait times).

[47] *See* Bryna Koch et al., University of Arizona Center for Rural Health, *Qualifying Arizona's Primary Care Shortage Using Health Professional Shortage Data* 1-2 (2024), https://perma.cc/G6MR-6MST (finding that Arizona has primary care physician shortages—including internal and family medicine physicians, pediatricians, and

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and tribal areas.[48] A 2024 ADHS report on medically underserved areas found that two-thirds of primary care shortages were in rural or semi-rural areas.[49] Rural and tribal communities also have disproportionately high rates of low birthweight, infant mortality, and late or no prenatal care, and four rural counties had limited or no access to maternity care.[50]

75. Particularly in these rural areas, APCs are critical health care providers. Specific to women's health, for example, a 2020 report from the University of Arizona Center for Rural Health found that 8% of Arizonans lived in rural areas, but only 4.7% of OBGYNs worked in rural areas, compared to 7.9% of CNMs.[51] ADHS has repeatedly identified building the non-physician health workforce as a key strategy for addressing health disparities and improving maternal health in rural and other underserved areas in Arizona.[52] Authoritative national governmental and nongovernmental bodies[53] and high-

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OBGYNs—in all 15 of its counties); ADHS Bureau of Women's and Children's Health, *Arizona Medically Underserved Areas: Biennial Report* 3-4, 21-22 (2024), https://perma.cc/Y8G6-P85P [hereinafter *Arizona Medically Underserved Areas*] (designating 83 of Arizona's 126 primary care areas as Medically Underserved Areas, including both rural and urban areas).

[48] *See Arizona Medically Underserved Areas*, *supra* note 47, at 21-22; *Arizona Health Workforce Profile Report: Health Professionals by RUCA*, University of Arizona Center for Rural Health, https://crh.arizona.edu/resources/interactive-data-visualizations/arizona-health-workforce-profile-report (last updated May 2025) (data from 2023 show that more than 95% of physicians in Arizona were located in metropolitan areas, while less than 1% were in rural areas).

[49] *Arizona Medically Underserved Areas*, *supra* note 47, at 22.

[50] *Id.* at 24.

[51] Bryna Koch et al., University of Arizona Center for Rural Health, *Rural Availability of the Obstetrician-Gynecologist Physician and Certified Nurse Midwife Workforce* 1 (2020), https://perma.cc/G72Z-BEK8.

[52] ADHS, *Arizona Health Improvement Plan: Rural & Urban Underserved Health, 2024-2025 Update* 12-13, 21-22 (2024), https://perma.cc/4NWV-ZSVN; *see also* Press Release, Office of the Governor, Governor Katie Hobbs Submits State Application for Federal Rural Health Transformation Program Grant (Nov. 5, 2025), https://perma.cc/3XTQ-TGQL (proposing program for expanding the rural health workforce by prioritizing non-physician providers including nurses, physician assistants, and community health workers); Office of the Governor, *The State of Arizona's Rural Health Transformation Program: Project Narrative* 16 (2025), https://perma.cc/4K7M-3Y2V (same).

[53] *See, e.g.*, Daniel J. Gilman & Tara Isa Koslov, Fed. Trade Comm'n, *Policy*

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quality studies[54] have reached the same conclusion, consistently finding that APCs expand access to care, especially for underserved communities.

76. Indeed, except with respect to abortion, the Arizona Legislature has repeatedly acted to expand general APC scope of practice and facilitate APC provision of health care, including legislation enacted over the last decade that, *inter alia*, expanded the prescribing and dispensing authority of APNs,[55] clarified that APNs are not required to work under physician supervision,[56] allowed APCs to provide mental health evaluations for use in court,[57] expanded PA scope of practice,[58] and allowed APCs to enter collaborative agreements with pharmacists.[59]

77. The APC Ban does not just affect access in rural areas. Even in the more urban areas where abortion clinics currently are located, patients can struggle to get

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Perspectives: Competition and the Regulation of Advanced Practice Nurses 25 (2014), https://perma.cc/KX8C-87V9 ("As primary care provider shortages have worsened, [Advanced Practice Registered Nurses] have played an even greater role in alleviating the effects of shortages and mitigating access problems. For example, APRNs make up a greater share of the primary care workforce in less densely populated areas, less urban areas, and lower income areas, as well as in [health professional shortage areas]."); Inst. of Med. of the Nat'l Acads. of Scis., Eng'g & Med., *The Future of Nursing: Leading Change, Advancing Health* 98 (2011), https://perma.cc/D9YP-USYV (noting that increased APC participation "has helped ease access bottlenecks, reduce waiting times, increase patient satisfaction, and free physicians to handle more complex cases").

[54] *See, e.g.*, Monica O'Reilly-Jacob et al., *Socioeconomic Characteristics of Communities With Primary Care Practices With Nurse Practitioners*, 8 JAMA Network Open e2462360 (2025), https://perma.cc/U3GV-8D8F ("Practices with NPs predominated in areas with the highest need for but the lowest supply of primary care practices."); Matthew A. Davis et al., *Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status*, 33 J. Gen. Internal Med. 412, 412 (2018), https://perma.cc/26CW-PXZH (finding that NPs "are more likely to be located in areas of lower socioeconomic and health status than are physicians").

[55] *See, e.g.*, 2016 Ariz. Sess. Laws. Ch. 212 (H.B. 2355); 2017 Ariz. Sess. Laws. Ch. 182 (S.B. 1336); 2018 Ariz. Sess. Laws. Ch. 78 (H.B. 2085); 2019 Ariz. Sess. Laws. Ch. 87 (H.B. 2068); 2021 Ariz. Sess. Laws. Ch. 265 (H.B. 2633); 2023 Ariz. Sess. Laws. Ch. 42 (H.B. 2564).

[56] *See* 2017 Ariz. Sess. Laws. Ch. 80 (S.B. 1133).

[57] *See* 2022 Ariz. Sess. Laws. Ch. 122 (H.B. 2098); 2023 Ariz. Sess. Laws. Ch. 201 (S.B. 1710).

[58] *See* 2023 Ariz. Sess. Laws. Ch. 54 (H.B. 2043).

[59] *See* 2024 Ariz. Sess. Laws. Ch. 123 (H.B. 2582).

timely appointments with one of the limited physician providers. In 2023 alone, there were nearly 13,000 abortions in the state of Arizona, the vast majority of which were provided by just seven licensed abortion clinics.[60] Plaintiffs' patients sometimes tell them the clinic nearest to them could not see them for several weeks. They have heard from patients forced to drive hours to another city to get timely care, and even seen patients forced to carry to term because of difficulties obtaining an appointment. In present and past positions as safety net providers treating patients with limited resources, Plaintiffs have also encountered patients who had to travel to Tucson from elsewhere in Southern Arizona just to access health care; when one of those patients discovers they are pregnant and wants to end that pregnancy, they have to figure out how to either stay in Tucson and wait until a physician can see them or leave and travel back.

78. By delaying access to care, the APC Ban increases patients' medical risk. Although abortion is one of the safest medical interventions in the United States, and is safer than continuing the pregnancy to term, there is an incremental but continuous increase in the risk level and complexity of abortion care as pregnancy progresses.[61]

79. Delays can also push patients past the gestational point at which medication abortion is available, requiring them to instead undergo a more invasive procedure.[62]

80. There are many reasons a person may have an indication or strong preference for a medication abortion over a procedural abortion.[63] For patients with certain medical conditions that make it harder to access the uterus with instruments, medication abortion is safer. Other people strongly prefer medication abortion because it can offer privacy and control. As described *supra*, a medication abortion in effect

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[60] *See* ADHS, *Abortions in Arizona: 2023 Abortion Report* 4, 19, 21 (2024), https://perma.cc/VK6H-MWQT.

[61] NASEM Report, *supra* note 4, at 10, 77-78.

[62] *Id*. at 77-78.

[63] See ACOG, Medication Abortion Up to 70 Days of Gestation, supra note 5.

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induces a process indistinguishable from a spontaneous miscarriage, often making it far easier to keep the abortion private, including from an abusive partner.

81. People who are survivors of sexual abuse or other forms of intimate-partner violence may also strongly prefer medication abortion because it does not require the insertion of instruments into their body.

82. As described *supra*, remaining pregnant longer than necessary can increase health risks for patients with underlying health problems. Pregnancy can exacerbate the symptoms of diabetes, hypertension, autoimmune disorders, cardiac disease, and mental health conditions. It can also trigger the onset of new conditions, including, *inter alia*, hyperemesis gravidarum (severe nausea and vomiting), severe depression, and gestational diabetes.

83. In sum, when someone has made the decision to have an abortion, barriers that delay their access to care can limit their health care options and/or cause a substantial toll on their physical, emotional, and psychological health. It can also harm the stability and well-being of their family, including their existing children.

84. These burdens do not fall evenly. Approximately two-thirds of abortion patients in Arizona are Native American and/or people of color, though these populations account for approximately half of Arizona's total population.[64] In addition to their disproportionate impact on people living in rural areas, abortion restrictions also disproportionately impact adolescents and young adults, who often have fewer resources to navigate state-imposed obstacles.[65]

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[64] ADHS, *Abortions in Arizona: 2022 Abortion Report* 8 (2023), https://perma.cc/N8NJ-FUBH; *QuickFacts: Arizona*, U.S. Census Bureau, https://perma.cc/W3VX-T3ZE (last accessed Jan. 30, 2026). These disparate rates are partly the result of disparities in access to contraception and other sexual health services related to pregnancy planning. Latoya Hill et al., *What are the Implications of the Dobbs Ruling for Racial Disparities?*, Kaiser Fam. Found. (Apr. 24, 2024), https://perma.cc/43PG-CW5T.

[65] See Doris W. Chiu et al., *Characteristics and Circumstances of Adolescents Obtaining Abortions in the United States*, 21 Int. J. Environ. Res. Public Health 477 (2024).

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E. The APC Ban Violates the Amendment

85. Under article II, section 8.1(A)(1) of the Arizona Constitution, "the state shall not enact, adopt or enforce any law, regulation, policy or practice that . . . [d]enies, restricts or interferes with" the fundamental right to abortion "before fetal viability unless justified by a compelling state interest that is achieved by the least restrictive means."

86. Under article II, section 8.1(A)(3), the state also shall not "[p]enalize[] any individual or entity for aiding or assisting a pregnant individual in exercising the individual's right to abortion as provided in this section."

87. The APC Ban violates both of these prohibitions.

1. The APC Ban Denies, Restricts, and Interferes with Access to Abortion (Section 8.1(A)(1))

88. The APC Ban explicitly prohibits APC provision of abortion care outright. As set forth *supra*, it forces Plaintiffs to turn away patients seeking this care and decreases access to abortion by restricting the pool and geographic distribution of available providers in the state. In so doing, the APC Ban delays and impedes access to abortion care: it forces patients to change providers and/or travel farther for care, pushes patients past the gestational age limit for a medication abortion, and forces patients to remain pregnant longer than necessary, all of which increases their medical risks and financial costs. In these ways, the APC Ban denies, restricts, and interferes with the right to abortion.

89. As such, the APC Ban violates the Amendment unless Defendant proves that it is the least restrictive means of serving a compelling state interest. Defendant cannot do so.

2. The APC Ban Is Not the Least Restrictive Means of Advancing a Compelling State Interest (Section 8.1(B)(1))

90. To justify the APC Ban under the Amendment, Defendant must establish that it is the least restrictive means of achieving a compelling state interest that meets

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two independent requirements: (1) the interest itself must be limited to "improving or maintaining the health of an individual seeking abortion care, consistent with accepted clinical standards of practice and evidence-based medicine," *and* (2) it must "not infringe on that individual's autonomous decision making." Ariz. Const. art. II, § 8.1(B)(1)(a)-(b). A law cannot survive constitutional scrutiny under the Amendment if it fails *either* part of this test.

91. The APC Ban fails both of these independent requirements.

a) The APC Ban Does Not Improve or Maintain the Health of the Person Seeking Abortion Care

92. As set forth *supra*, the APC Ban does not at all "improv[e] or maintain[] the health of an individual seeking abortion care, consistent with accepted clinical standards of practice and evidence-based medicine," still less is it the least restrictive means of doing so. Ariz. Const. art. II, § 8.1(B)(1)(a). To the contrary, accepted clinical standards and evidence-based medicine affirm that patient health is best served by: 1) allowing licensed medical professionals to practice to the full scope of their education, training, and clinical skills; 2) in particular, allowing qualified APCs to provide abortion care, which is well within their scope of practice; and 3) removing medically unnecessary state-imposed barriers to abortion, to allow patients to obtain that care earlier in pregnancy, when it is safest.

93. Given the overwhelming evidence and consensus that APCs can provide abortion care as safely as physicians, and that restricting access itself increases risks for patients, the state cannot justify the APC Ban as the least restrictive means of protecting patient health.

b) The APC Ban Infringes on Arizonans' Autonomous Decision Making

94. The APC Ban also fails constitutional scrutiny on the independent ground that it violates Arizonans' autonomy to consent to and obtain care from a qualified provider they trust. *See* Ariz. Const. art. II, § 8.1(B)(1)(b). People choose their health

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care provider, whether a physician or an APC, for various reasons, some deeply personal. Particularly when it comes to abortion care, they may have a strong preference for a trusted provider they have seen for other primary or reproductive health care. They may know people who have had a positive experience with a particular provider, whether a physician or an APC. They may generally prefer APCs to physicians. Or, they may simply prefer a particular APC provider who can see them sooner or is closer to their home. By overriding people's choice of provider, for no medical reason, the APC Ban violates their autonomy.

3. The APC Ban Violates the Prohibition on Penalizing Providers for Helping Others Access Abortion

95. The APC Ban targets an entire class of qualified clinicians who had been providing safe abortion care in Arizona for nearly a decade—barring APCs from continuing to provide this care, and barring others from employing them to do so, on pain of loss of licensure and other penalties. Thus, in addition to violating the rights of Plaintiffs' patients, the APC Ban plainly violates the Amendment by "[p]enaliz[ing] any individual or entity for aiding or assisting a pregnant individual in exercising the individual's right to abortion." Ariz. Const. art. II, § 8.1(A)(3).

CLAIMS FOR RELIEF

COUNT I

(Declaratory Judgment – Fundamental Right to Abortion)

96. Plaintiffs incorporate the above paragraphs as if set forth herein.

97. For the reasons set forth therein, the APC Ban violates Ariz. Const. art. II, § 8.1(A)(1); it denies, restricts, and/or interferes with Arizonans' fundamental right to abortion, and it is not the least restrictive means of furthering a "compelling state interest" as that term is defined in the Amendment.

98. There is no adequate remedy at law to address these harms.

99. For all these reasons, Plaintiffs' patients' rights, status, and other legal

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relations are directly affected by the APC Ban, and Plaintiffs' patients are thus entitled to a "declaration of rights, status or other legal relations thereunder." *See* A.R.S. § 12-1832.

COUNT II

(Declaratory Judgment—Prohibition on Penalizing an Individual for Assisting a Pregnant Individual in Exercising Their Right to Abortion)

100. Plaintiffs incorporate the above paragraphs as if set forth herein.

101. For the reasons set forth therein, the APC Ban violates Ariz. Const. art. II, § 8.1(A)(3); it "[p]enalizes" Plaintiffs and other APCs "for aiding or assisting a pregnant individual in exercising the individual's right to abortion." Ariz. Const. art. II, § 8.1(A)(3).

102. Plaintiffs have no adequate remedy at law to address these harms.

103. For all these reasons, Plaintiffs' rights, status, and other legal relations are directly affected by the APC Ban, and Plaintiffs are thus entitled to a "declaration of rights, status or other legal relations thereunder." *See* A.R.S. § 12-1832.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs ask this Court:

A. That the Court issue a declaratory judgment that A.R.S. § 32-1606(B)(12) (prohibiting the Arizona State Nursing Board from "decid[ing] scope of practice relating to abortion") violates article II, section 8.1 of the Arizona Constitution;

B. That the Court issue a declaratory judgment that the following statutory provisions violate article II, section 8.1 of the Arizona Constitution as applied to prevent APNs from independently providing pre-viability medication, aspiration, and induction abortion care: A.R.S. §§ 36-2160(A) (prohibiting APCs from providing medication abortion); 36-2155 (prohibiting APCs from performing surgical abortions); and 36-2153(E) (same);

C. That the Court issue a declaratory judgment that, insofar as the following

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statutory and regulatory provisions are applied to require that medical and administrative tasks be performed by a physician to the exclusion of APNs, such a requirement violates article II, section 8.1 of the Arizona Constitution: A.R.S. §§ 36-449.03(C)(3) (requiring a physician to be "available" at a clinic at which medication or procedural abortions are performed), (D)(5) (requiring "the physician" to estimate the gestational age of the fetus), (G)(4) (requiring a physician to be physically present at, or in the vicinity of, a clinic where medication or procedural abortions are performed, and requiring physician to sign discharge orders), (G)(5) (requiring a physician to provide certain counseling), (G)(8) (requiring "[t]he physician" performing the abortion to ensure specific follow-up), (H)(2) (requiring a physician to be consulted if a continuing pregnancy is suspected at follow up); 36-2152(A), (B), (H), (M) (permitting only physicians to provide minors with abortion services); 36-2153(A) (requiring physicians to provide state-mandated information "orally and in person"), (C) (requiring physicians to provide information when an abortion is performed because of a medical emergency); 36-2156(A) (requiring "the physician who is to perform the abortion" or "the referring physician" to facilitate provision of an ultrasound); 36-2158(A) (requiring physicians to provide state-mandated information related to fetal conditions "orally and in person"); 36-2161(A)(16)-(17), (20)-(21), (D) (requiring "the physician performing the abortion" to create certain records); 36-2162.01(A), (C) (requiring physicians to complete, sign, and transmit to ADHS certain records as either the "referring- physician" or the "physician who is to perform the abortion"); A.A.C. R9-10-1507(B)(2), (3) (requiring a physician to be on the premises of an abortion clinic until patients are stable and ready to leave following medication and procedural abortions); A.A.C. R9-10-1509(A)(2) (requiring a physician to perform a physical examination), (B)(1), (5) (requiring a physician to provide certain information to the patient and make certain records), (C) (requiring a physician to estimate and record gestational age of the fetus), (D)(3)(a) (requiring a physician to interpret ultrasound), (J) (requiring a physician to be consulted if a continuing pregnancy

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is suspected at follow up); A.A.C. R9-10-1510(B)(1) (requiring a physician to sign the patient's discharge order); and A.A.C. R9-10-1512(A)(6), (12), and (D)(3)(d) (requiring medical records to include information from physicians);

D. For a permanent injunction enjoining Defendant from enforcing the challenged provisions to bar APNs from independently providing pre-viability medication, aspiration, and induction abortions;

E. For an order awarding Plaintiffs their attorneys' fees under the private attorney general doctrine or any applicable statute or common law doctrine;

F. For an order awarding Plaintiffs their taxable costs under A.R.S. §§ 12-341 and 12-1840; and

G. For any other relief as may be appropriate.

DATED this 10th day of March, 2026.

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/s/Lindsey Huang
Lindsey Huang
Jon Weiss

AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF ARIZONA

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**Pro Hac Vice* Applications Forthcoming

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Electronically filed this 10th day of March, 2026, and a copy emailed to:

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VERIFICATION

I, Greta Gill, declare the following to be true under penalty of perjury: I have read the foregoing First Amended Verified Complaint for Injunctive and Declaratory Relief, am familiar with its content, and believe the facts alleged therein to be true and accurate to the best of my knowledge, information, and belief.

DATED this 9 day of March, 2026.

Greta Gill (Mar 9, 2026 18:44:47 MDT)

Greta Gill

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VERIFICATION

I, Janna Stefanek, declare the following to be true under penalty of perjury: I have read the foregoing First Amended Verified Complaint for Injunctive and Declaratory Relief, am familiar with its content, and believe the facts alleged therein to be true and accurate to the best of my knowledge, information, and belief.

DATED this 9 day of March, 2026.

Janna Stefanek
Janna Stefanek (Mar 9, 2026 19:45:46 PDT)

Janna Stefanek

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VERIFICATION

I, Erin Bottai, declare the following to be true under penalty of perjury: I have read the foregoing First Amended Verified Complaint for Injunctive and Declaratory Relief, am familiar with its content, and believe the facts alleged therein to be true and accurate to the best of my knowledge, information, and belief.

DATED this 10th day of March, 2026.

Erin Bottai
Erin Bottai (Mar 10, 2026 09:10:24 PDT)

Erin Bottai

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VERIFICATION

I, Denei Dolman, declare the following to be true under penalty of perjury: I have read the foregoing First Amended Verified Complaint for Injunctive and Declaratory Relief, am familiar with its content, and believe the facts alleged therein to be true and accurate to the best of my knowledge, information, and belief.

DATED this 3/9/2 day of March, 2026.

Denei Dolman (Mar 9, 2026 16:49:41 PDT)

Denei Dolman

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