



Fields of Opportunities

STATE OF IOWA

TERRY BRANSTAD, GOVERNOR  
KIM REYNOLDS, LT. GOVERNOR

IOWA BOARD OF MEDICINE  
MARK BOWDEN, EXECUTIVE DIRECTOR

**FOR IMMEDIATE RELEASE: August 20, 2014**  
**CONTACT: Mark Bowden, ( 515) 242-3268 or**  
[mark.bowden@iowa.gov](mailto:mark.bowden@iowa.gov)

## Court affirms Board's authority to adopt rule on medical abortions

DES MOINES, IA – A Polk County District Court judge has affirmed the Iowa Board of Medicine's authority to adopt an administrative rule that establishes standards of practice for physicians who prescribe and administer abortion-inducing drugs.

In a ruling filed August 18, District Court Judge Jeffrey Farrell said the Board has the power to establish standards of practice for physicians and the Board met the legal requirements for making the new rule on medical abortions.

"The crux of the Board's decision to adopt the rule is that an in-person physical examination should be done before prescribing abortion-inducing drugs. There are legitimate reasons to support the Board's decision," the judge wrote.

After the Board adopted the new rule on August 30, 2013, Planned Parenthood of the Heartland petitioned the District Court to review the rule-making process and the basis on which the rule was pursued. A hearing on the judicial review was held June 16, 2014.

The rule was scheduled to go into effect on November 6, 2013, but it was stayed on November 5, 2013, pending the judicial review. The stay will be lifted in 30 days, absent any stay granted by the District Court or the Iowa Supreme Court.

**The following is the District Court's ruling that administrative rule 653 IAC 13.10 is valid:**

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

**PLANNED PARENTHOOD OF THE  
HEARTLAND, INC. and DR. JILL  
MEADOWS, M.D.,**

**Petitioners,**

**v.**

**IOWA BOARD OF MEDICINE,**

**Respondent.**

**Case No. CVCV 046429**

**RULING ON JUDICIAL REVIEW**

Petitioners Planned Parenthood of the Heartland, Inc. and Dr. Jill Meadows (jointly referred to as PPH) filed a petition for judicial review against respondent Iowa Board of Medicine (the board). The parties filed briefs as per the scheduling order entered by the court. The matter came on for hearing on June 16, 2014. Attorneys Alice Clapman and Sharon Malheiro represented PPH. Assistant Attorney General Julie Bussanmas represented the board.

The record included the agency's certified record pages 1-551, petitioner's amended appendix pages 552-616, and the exhibits and affidavits submitted to the court during the application for stay hearing on October 30, 2013. The certified record included a disc with audio of a public hearing held by the board on August 28, 2013 (referred to as CD).<sup>1</sup>

**STATEMENT OF THE CASE**

**Introduction and background:** On January 22, 1973, the United States Supreme Court entered its landmark decision in *Roe v. Wade*, 410 U.S. 113 (1973) in which it found a woman has a constitutional right to terminate her pregnancy, with some limitations. Those limitations

---

<sup>1</sup> This ruling refers to verbal statements made to the board during the public hearing as "testimony." To be clear, the statements were not under oath; they were made as part of each individual's request to provide input to the board.

have been the subject of additional litigation, but the “essential holding” of *Roe* allowing a woman to choose to have an abortion before viability and without “undue interference from the State” has been reaffirmed by the United States Supreme Court. *See Planned Parenthood of Southeastern Penn. v. Casey*, 505 U.S. 833, 845 (1992) (applying the undue influence standard).

In the years following *Roe*, abortion has been legally performed in the State of Iowa. As an example, in 2008, 6,560 women obtained abortions in Iowa. As of 2008, there were eleven abortion providers in Iowa, with abortion services being provided in nine of Iowa’s ninety-nine counties. The availability of abortion providers in Iowa is comparable to other states – nationally, abortion providers are present in approximately thirteen percent of counties. (App. 554-55).

Historically, abortion was performed as a surgical procedure. In 2000, the United States Food and Drug Administration (FDA) approved the use of a drug known by its test name RU-486, now known as mifepristone, for the purpose of inducing abortions. The process of taking mifepristone to induce abortion is referred to throughout the record as medical abortion, as distinguished from a surgical abortion. (App. 145, 228-29, 236).

The FDA’s approval of mifepristone requires three office visits with the patient. On the first visit, the physician or person supervised by the physician administers 600 mg of mifepristone. The patient is instructed to return two days later to determine whether the abortion has occurred. If not, the physician or person supervised by the physician would take 400 ug of misoprostol. Because there may be side effects, the patient should be monitored and given a phone number of the physician who would handle any emergencies following the office visit. The third visit is a follow-up approximately fourteen days following the first visit. The FDA

considered the follow-up visit to be “very important to confirm by clinical examination or ultrasonographic scan that a complete termination of pregnancy has occurred.” (App. 146-47, 228-29, 237).

At the time the FDA approved mifepristone, it found the drug to be safe if used within forty-nine days of gestation or less. Studies conducted since that time have found the drug to be safe up to sixty-three days of gestation when used as part of a protocol combined with the required use of misoprostol. With that protocol, the patient is given 200 mg of mifepristone to take at the clinic, and 800 ug of misoprostol to take vaginally at home approximately forty-eight hours later. The studies indicate that gestational age should be confirmed by clinical evaluation or ultrasonography, as the drug is safer and more effective earlier in gestation. The FDA has not approved the alternative protocol used for pregnancies between fifty and sixty-three days of gestation. (App. 148-49, 228-29, 236-44).

There are several contraindications for abortions with mifepristone regimens, including confirmed or suspected ectopic pregnancy or undiagnosed adnexal mass, intrauterine device in place, current long-term systemic corticosteroid therapy, chronic adrenal failure, severe anemia, known coagulopathy or anticoagulant therapy, and mifepristone intolerance or allergy. Additionally, most of the clinical trial excluded women with severe liver, renal, or respiratory disease, uncontrolled hypertension, cardiovascular disease, or severe anemia. The drug should not be used in women with an uncontrolled seizure disorder. Studies also caution against medical abortion for women with “social or psychological contraindications,” such as women who do not want to take responsibility for their care, are anxious to have the abortion over quickly, cannot return for follow-up visits, or cannot understand the instruction due to language or comprehension barriers. (App. 241).

**PPH telemedicine medical abortion protocol:** PPH is an abortion provider operating in the State of Iowa. PPH performs surgical and medical abortions. In late 2008, PPH began offering medical abortions through use of “telemedicine.” In this protocol, PPH’s physician does not personally meet the patient, but rather, talks to the patient by a real-time two-way video conferencing system. Staff members, which may include nurses or certified medical assistants (CMA), conduct the physical exam, take blood for lab work, and conduct an ultrasound. Information is relayed to the physician, who, by computer, releases a drawer in front of the patient that contains the abortion medications. The patient can then access the medication. The drawer is packed and locked by a pharmacist or a PPH staff person. (Meadows affidavit; CD – Ross, Buchacker, Grossman testimony).

PPH’s protocol requires the use of mifepristone and misoprostol taken in combination. The patient takes the mifepristone at the clinic in front of the doctor (by video) and a PPH staff person in the room. The patient is instructed to take the misoprostol at home twenty-four to forty-eight hours later. A follow-up visit is scheduled for approximately two weeks later. The patient is given information how to contact PPH medical staff with questions or concerns. (App. 434-35).

While the record is not completely clear on this point, it appears that PPH’s use in Iowa of doctor participation in medical abortions by video-conferencing was the first in the nation, and there is no evidence that the same protocol is used in the same way in other states. Dr. Thomas Ross from PPH appeared before the board at a public hearing stating that Iowa may have been the first state that telemedicine abortion was used. He was not sure whether it had been used in other states, but agreed that Iowa was the first state which it was widely used. There is no evidence in the record to show that abortions were performed by telemedicine in any other state

prior to PPH beginning the procedure in Iowa in 2008. The record does not show that telemedicine abortions are performed in other states since then. The record indicates that sixteen other states have taken action to require prescribing physicians to be in the physical presence of women when performing medical abortions. (CD – Ross testimony; App. 161-62).

Dr. Daniel Grossman, a vice president of research for Ibis Reproductive Health, conducted a study of PPH's protocol from 2008 through 2010. Dr. Grossman's study was based on a review of records and was not clinical in nature. Dr. Grossman found no difference in the complication rates between patients of medical abortion who saw a doctor in person versus those who saw a doctor by video conferencing. (CD – Grossman testimony; App. 488-90).

**The board's 2010 investigation:** The board was created to license and regulate physicians practicing in the state of Iowa. *See generally* Iowa Code chapters 147, 148, 272C. The board consists of ten members: five members licensed to practice medicine and surgery, two to practice osteopathic medicine and surgery, and three public members. Iowa Code section 147.14(1). The board has the authority to adopt all rules necessary and proper to administer and interpret its governing statutes. Iowa Code section 147.76. The board may have alternate members to hear contested case hearings, but alternate members are not authorized to perform the board's rule-making function. Iowa Code section 148.2A.

In 2010, the board received a complaint against Dr. Ross and another doctor who performed medical abortions through telemedicine. The board investigated the complaint by obtaining documents from PPH and personally interviewed Dr. Ross and the other physician. The board dismissed the complaint and took no disciplinary action against Dr. Ross or the other doctor. Dr. Ross has not changed his practice as to medical abortions following the board's

investigation. The board did not adopt any rules regarding medical abortion at that time. (Ross affidavit).

**Petition for rulemaking:** On or about June 25, 2013, the board received a “petition for rulemaking regarding the standards of practice for performing a chemical abortion.”<sup>2</sup> The petition was submitted by fourteen individuals, including five physicians. The rule sought a standard of practice for medical abortions that would require the following: 1) a physician perform an in-person physical exam of the patient to determine gestational age and intrauterine location in the pregnancy before inducing an abortion through an abortion-inducing drug, 2) physical presence of a physician at the time an abortion-inducing drug is provided, 3) the physician inducing the abortion schedule a follow-up visit with the patient at the same facility twelve to eighteen days after the use of the drug, and 4) parental notification if the patient is a minor. (App. 47-54, 525).

On June 28, 2013, the board held a public meeting regarding the petition for rulemaking. After hearing from three members of the public, a motion was made and seconded to accept the petition and commence the rulemaking process. Ann Gales, a board member, stated that the board was considering the rule too quickly. The board’s legal counsel from the Attorney General’s Office advised the board to delay accepting the petition, although she stated the board could concurrently approve a separate notice of intended action with the same language as the petition. The board’s director of legal affairs similarly stated that the board was taking action without fully considering the issues in the petition. However, Brenna Findley, the Governor’s legal counsel and state administrative rules coordinator, advised the board that it could vote to

---

<sup>2</sup> The reference to “chemical abortion” is the same as “medical abortion” as used throughout this ruling.

accept or reject the petition immediately. The chair called for a vote and the board approved the motion by an eight-to-two vote. (App. 524-527).

Following the vote, the board filed a notice of intended action to adopt the language from the petition as a formal rule. The board published notice in the Iowa Administrative Bulletin. The notice stated that the board would hold a public hearing for August 28, 2013 to hear verbal comments on the rule. The notice also informed the public that it could submit written comments by 4:30 p.m. on the same date. On July 29, 2013, the board issued a press release providing information about the public hearing. The board published a copy of the proposed rule on its website and allowed the public to review public comments. (App. 4-8, 46, 511).

The board held its public hearing on August 28, 2013 from approximately 1:00 p.m. to 4:30 p.m. The board received testimony from twenty-eight individuals and written comments from 244 individuals and organizations. On August 30, 2013, the board met to consider adoption of the rule. Each of the board members offered comments about the rule prior to the vote. The rule was adopted by an eight-to-two vote. One of the dissenting board members, Ms. Gales stated her primary concern that the board was “hasty” in adopting the rule. She preferred more dialogue with stake-holders before approval. The other dissenting voter, Dr. Michael Thompson, likewise expressed concern with the speed in which the rule was adopted (although he also shared health concerns with PPH’s telemedicine practice, citing issues with the training of clinic staff members and access to emergency care in the event of complications). (App. 12, 517-20).

On September 27, 2013, the board issued a statement regarding the adoption of the rule. The board cited five principal reasons presented in support of the rule. In summary, they were:

- 1) to adopt a standard of practice to protect the health and safety of patients who are prescribed abortion-inducing drugs;

- 2) to ensure that the practices used by physicians who are prescribing abortion-inducing drugs by telemedicine are inconsistent with protocols used by the FDA and drug manufacturers;
- 3) to ensure that Iowa Code section 707.7(3), which only allows physicians to perform abortions, is being followed;
- 4) to end physical exams of patients seeking a medical abortion by non-physicians who do not have appropriate training for the purpose of confirming or discovering contraindications, as well as performing ultrasounds to determine the age and location of the embryo; and
- 5) to ensure that physicians who prescribe and administer abortion-inducing drugs by telemedicine meet the patient in person and see the patient for a follow-up appointment.

The board also cited eight principal reasons in opposition to the rule and the board's reasons for overruling the objections. In summary, they were (reasons in opposition italicized, board's response in regular type):

- 1) *The rule would limit rural women's access to medical abortion.* The rule does not restrict where medical abortions may be provided and rural women are entitled to the same high level of health care as urban women.
- 2) *The rule is politically motivated and not sound public policy.* The board recognizes that abortion is a politicized issue, but it is only authorized to adopt rules for the licensure and practice of physician and its motivation is to protect the health and safety of Iowans.
- 3) *The rule is an attempt to ban access to a legal medical procedure.* The rule does not ban medical abortion, but only sets standards of practice for physicians who perform medical abortions.
- 4) *The board previously addressed this matter in 2010 when it investigated PPH doctors.* The membership of the board has changed and the board had never adopted a rule addressing medical abortions, so the current board felt it needed to move forward to protect the health and safety of Iowans.
- 5) *The board did not undertake a thorough study of the matter, nor did it consider the impact the rule might have on telemedicine in general.* The board considered a significant amount of data and public comments on the issue and adopted a narrowly focused rule which would allow it to consider telemedicine in a broader sense at a future date.
- 6) *An appropriate physical exam is conducted by trained staff that is provided to the off-site physician who reviews the information before prescribing abortion-inducing drugs.* The

board considers a thorough medical history and physical exam to be the cornerstone of good medical care. The board described in some detail its concerns with the lack of a physical exam and the training of staff who conduct ultrasounds to determine gestational age.

- 7) *The treatment and consultation made by the physician in a telemedicine context are the same as those in a face-to-face setting.* The board believes that prescribing physicians must be physically present to establish a proper physician-patient relationship to conduct a safe medical abortion.
- 8) *Patients are already receiving appropriate follow-up care in remote clinics where a physician is not physically present.* The board believes an in-person physical exam and consultation will strengthen the physician-patient relationship and result in improved and increased follow-up care.

**District court proceedings:** On September 30, 2013, PPH filed a petition for judicial review and motion for stay of agency action. PPH asked the board to stay implementation of the rule pending judicial review. The board refused to do so. On October 30, 2013, the district court heard evidence and argument on the motion. On November 5, 2013, the court issued its ruling. The court noted that its ruling is “extremely narrow in scope,” and that the ruling “does not, in any way, decide the merits of Petitioners’ constitutional and other claims.” (November 5, 2013 Ruling at p. 5). The court focused on a balance of the hardships incurring to each party if a stay was not granted pending a decision on the merits of the case. The court found that a weighing of the hardships favored petitioners, and therefore granted the stay. (Ruling at pp. 9-15).

Prior to the submission of the briefs on the merits, and even following submission of the last brief there have been considerable motions and debate as to what record should be considered. The board filed a certified record that included written comments provided to the board<sup>3</sup> and the audio from the public hearing on August 28, 2013. On March 24, 2014, the court issued an order granting in part and denying in part a request by petitioners to submit additional

---

<sup>3</sup> The board received a number of comments from petitions that opposed abortion generally. Those documents were redacted as duplicative. (App. 100).

documentation. Since that date, the parties have debated the ability of the court to view websites that may contain medical or abortion data. Both parties have cited to websites to support factual propositions made. For example, PPH cited to a website to show that some of the sponsors of the petition for rulemaking are members of an organization that opposes abortion generally. (PPH brief at p. 22). The board cited to several websites to support its view that a physical examination is necessary prior to a medical abortion. (Board's brief at pp. 20-21).

The court believes the best course is to limit the consideration of factual matters to the record before the agency. PPH actively participated in the public hearing by offering several witnesses, and submitted documents for the board to consider before making its decision. Supporters of the rule did the same. The board issued a written statement explaining its findings. There was ample opportunity for those in favor and in opposition to the rule of the issue to submit evidence and arguments to the board. There is more than adequate record to consider the merits of the parties contentions, based on the standard of review before the court, without delving into websites that might have changing content and unreliable information.<sup>4</sup> For these reasons, petitioners' motion to reopen the record is denied. This is intended to be responsive to petitioners' motion to clarify scope of the record.

---

<sup>4</sup> The court is mindful of the ability to consider legislative or constitutional facts in a case involving a constitutional claim. *See Varnum v. Brien*, 763 N.W.2d 862, 881 (Iowa 2009). However, this case involves multiple judicial review claims, of which it is not appropriate to consider facts outside the record. The court believes that all claims can be fairly considered based on the record made before the agency, as supplemented by PPH.

**CONCLUSIONS OF LAW**

**I. Standards of review.**

**A. General standards.**

Judicial review of agency rulemaking is governed by Iowa Code chapter 17A. *Auen v. Alcoholic Beverages Div.*, 679 N.W.2d 586, 589 (Iowa 2004). The district court acts in an appellate capacity, reviewing agency action under the standards set forth in Iowa Code section 17A.19(10). *Iowa Med. Soc. v. Iowa Bd. of Nursing*, 831 N.W.2d 826, 838 (Iowa 2013). A district court may grant relief if the agency action has prejudiced the substantial rights of the petitioner and the action meets one of the enumerated criteria contained in section 17A.19(10)(a) through (n). *Renda v. Iowa Civil Rights Comm'n*, 784 N.W.2d 8, 10 (Iowa 2010). A party challenging agency action bears the burden of demonstrating the action's invalidity and resulting prejudice. *D2 Enterprises, Inc. v. State, Dep't of Inspections & Appeals*, 752 N.W.2d 31 (Iowa App. 2008); Iowa Code section 17A.19(8)(a).

An agency shall have only that authority or discretion delegated to or conferred upon the agency by law and shall not expand or enlarge its authority or discretion beyond the powers delegated to or conferred upon the agency. *Auen v. Alcoholic Beverages Div.*, 679 N.W.2d 586, 590 (Iowa 2004) (*quoting* Iowa Code § 17A.23). With that said, the power conferred on an agency by the legislature to adopt rules is quite broad. *Auen*, 679 N.W.2d at 590. In *Auen*, the Iowa Supreme Court cited to the agency's statutory authority to enforce and implement the laws concerning alcoholic beverages, as well as the power to adopt all rules necessary to carry out its delegated duties, in finding that the legislature had clearly vested the agency power to interpret the law relating to limitations on business interests relating to licensing. *Id.*

The legislature has clearly vested professional licensing boards with the power to make rules and interpret its governing statutes as related to the practice of its respective professions. *See Iowa Medical Society*, 831 N.W.2d at 838. In *Iowa Medical Society*, the Iowa Supreme Court held that the legislature clearly vested the Iowa Board of Nursing with rulemaking and interpretive authority for Iowa Code chapter 152 governing the practice of nursing. *Id.* (citing to Iowa Code section 147.76, which grants rulemaking authority to all of the professional licensing boards listed in the chapter). Similarly, in *Houck v. Iowa Board of Pharmacy Examiners*, 752 N.W.2d 14, 17 (Iowa 2008), the Iowa Supreme Court held that the legislature has “delegated broad authority” to the Iowa Board of Pharmacy Examiners to regulate the practice of pharmacy in Iowa through the adoption of rules. The court again cited to section 147.76, as well as the Board of Pharmacy’s governing statute, Iowa Code chapter 155A.

The board of medicine has the same statutory authority to regulate the medical profession through rulemaking as the boards of nursing and pharmacy. Section 147.76 similarly applies to the board of medicine, and gives the board statutory authority to adopt all necessary and proper rules to administer the general provisions relating to the medical profession. The board’s governing statute, Iowa Code chapter 148, provides powers similar to the statutes governing the boards of nursing and pharmacy.

PPH did not strictly challenge the board’s rule as being inconsistent with its governing statutes or otherwise outside its statutory authority. However, the court must remain mindful of these legal standards governing agency discretion to retain the proper perspective when considering the legal challenges actually made by PPH. One of the purposes for the 1998 amendments to chapter 17A was to harmonize differing court decisions regarding the level of discretion to be given agencies to interpret statutes. As stated by Professor Arthur Bonfield:

Where the General Assembly clearly delegates *discretionary* authority to an agency to interpret or elaborate a statutory term based on the agency's own special expertise, the court may not simply substitute its view as to the meaning or elaboration of the term for that of the agency but, instead, may reverse the agency interpretation or elaboration only if it is arbitrary, capricious, unreasonable, or an abuse of discretion—a deferential standard of review.

...

It would be improper for a court to simply substitute, without any deference to the agency's view of the meaning of a statutory term, the court's own view of the meaning of a statutory term that the General Assembly had clearly delegated to the discretion of any agency to elaborate, because in that situation the court would be violating the statute delegating that discretionary authority to the agency.

Arthur Bonfield, *Amendments to Iowa Administrative Procedure Act, Report on Selected Provisions to Iowa State Bar Association and Iowa State Government*, pp. 61-62 (1998) (emphasis in text) (hereafter referred to as “Bonfield”); *See also Locate.Plus.Com., Inc. v. Iowa Dep't of Transportation*, 650 N.W.2d 609, 613 (Iowa 2002) (citing to Bonfield while noting that Iowa courts have “given deference to agency interpretation of broad vague statutory terms”).

There is no question that the board has the power to establish standards of practice for the medical profession. Those standards include the authority to adopt and enforce standards regarding the minimal standards of acceptable and prevailing practice. Iowa Code section 148.6(2)(g). The legislature requires seven of the ten board members to be physicians, thus giving the board a built-in level of expertise of the medical profession. Accordingly, the board's adoption of rules relating to the practice of medicine are entitled to deference, if compliant with the other standards set forth in section 17A.19(10).

Additionally, the legislature singled out physicians as the only professionals to be able to perform an abortion. Any person who terminates a human pregnancy, with the knowledge and voluntary consent of the pregnant person, is guilty of a class C felony. Iowa Code section

707.7(3). The only exception to this provision is a person licensed to practice medicine and surgery or osteopathic medicine and surgery under Iowa Code chapter 148. The United States Supreme Court endorsed a similar statutory provision in *Roe v. Wade*, recognizing that the State may proscribe abortion by a person who is not a licensed physician. 410 U.S. at 165-66. The court indicated that the State could regulate the standard of practice for abortion as any other medical procedure, noting that judicial and intra-professional remedies may be pursued if a practitioner does not follow “proper medical judgment.” *Id.* Accordingly, while the proposed rule may be new, the concept that physicians may be subject to professional standards when performing abortions has been around since *Roe*.

**B. Standards regarding the promulgation of rules.**

PPH did not directly challenge the board’s compliance with the rulemaking process established under Iowa Code chapter 17A. This is for good reason, because there is no basis for belief that the board violated the statutory process. However, in light of the claims by PPH that the board’s process was tainted by politics and improper purpose, it is useful to review the law governing the adoption of agency rules and the board’s compliance therewith.

The rulemaking process is typically initiated by the agency and follows the process set out in Iowa Code section 17A.4. The agency must provide notice to the administrative rules coordinator and publish notice in the administrative bulletin. Any notice of intended action shall be published at least thirty-five days in advance of the action. The agency must give all interested persons at least twenty days to submit data, views or arguments in writing. If timely requested in writing by at least twenty-five persons, the agency shall give the opportunity to

make an oral presentation. The agency shall consider all written and oral submissions. The agency shall act within 180 days of the notice of the last date of oral presentation.

Any proposed or adopted rule is subject to the review of the administrative rules review committee of the Iowa legislature, the governor, and the attorney general. Iowa Code section 17A.4(6). The administrative rules review committee consists of five senators (three chosen by the majority leader and two by the minority leader) and five representatives (three chosen by the speaker and two by the minority leader). Iowa Code section 17A.8(1). The administrative rules review committee, governor, or attorney general may object to all or part of the rule. Iowa Code section 17A.4(6). If an objection is filed by one of these three bodies, the burden of proof shifts from any challenger to the agency to prove that the rule is unreasonable, arbitrary, capricious, or otherwise beyond the authority delegated to it. This process provides an additional layer of review and protection by government bodies who have special expertise and knowledge of the legislative and rulemaking process.

There is a second process to initiate the rulemaking process. Any interested person may petition an agency to adopt, amend, or repeal a rule. Iowa Code section 17A.7. Within sixty days from the submission of a petition, the agency shall deny the petition, initiate the rulemaking process established in section 17A.4, or issue some other rule if not required by section 17A.4.

In this case, the board followed the rulemaking process established in the statute. The board received a petition for rulemaking. The board was required to act within sixty days. It acted within the sixty days by initiating the rulemaking process set in section 17A.4. It gave the proper notice, allowed for written and verbal comment, considered the comments provided, and make a decision within the timeframes provided. The record does not reflect any objections by

the legislative rules review committee, the governor, or the attorney general. The board followed the legal process and any challenging party has the burden of proof to show that the rule is unreasonable, arbitrary, capricious, or otherwise beyond the authority delegated to it.

**II. Claims made by PPH.**

**A. Decision-making process – Section 17A.19(10)(j).**

PPH's first challenge is based on Iowa Code section 17A.19(10)(j), which allows the court to reverse, modify, or grant other appropriate relief from agency action if it is:

The product of a decision-making process in which the agency did not consider a relevant and important matter relating to the propriety or desirability of the action in question that a rational decision maker in similar circumstances would have considered prior to taking that action.

Neither party cited to any case law interpreting this subsection and the court did not find any case law interpreting that subsection in its research. However, Professor Bonfield described subsections (h), (i), (j), (l), and (m) in his report to be “specific examples of agency action that any reviewing court should overturn as unreasonable, arbitrary, capricious, or an abuse of discretion.” Bonfield at 69. He stated his opinion that none of these amended provisions “really changes the law under the original IAPA section 17A.19(8)(g),” but should result in “somewhat more structured, informed, and systematic reviews by courts under the unreasonable, arbitrary, capricious, and abuse of discretion standards.” *Id.*

There are a number of decisions that define the standard for agency action that is unreasonable, arbitrary, capricious, or an abuse of discretion. Agency action is considered arbitrary or capricious when the decision was made “without regard to the law or facts.” *Doe v. Iowa Board of Medical Examiners*, 733 N.W.2d 705, 707 (Iowa 2007) (quoting *Greenwood*

*Manor v. Iowa Dep't of Public Health*, 641 N.W.2d 823, 831 (Iowa 2002)). Agency action is unreasonable if the agency acted “in the face of evidence as to which there is no room for difference of opinion among reasonable minds[.]” *Id.*; see also *Citizen's Aide/Ombudsman v. Rolfes*, 454 N.W.2d 815, 819 (Iowa 1990). The court typically defers to an agency's informed decision as long as it falls within a “zone of reasonableness.” *S. E. Iowa Co-op. Elec. Ass'n v. Iowa Utilities Bd.*, 633 N.W.2d 814, 818 (Iowa 2001) (cite omitted). When considering claims under the unreasonableness standard, the courts generally affirm the informed decision of the agency, and refrain from substituting its less-informed judgment. *Al-Khattat v. Eng'g & Land Surveying Examining Bd.*, 644 N.W.2d 18, 23 (Iowa 2002).

PPH raised several items that it contends the board did not consider when adopting the subject rule. Each is discussed under numbered headings below. As an initial matter, however, PPH argued that the process itself was irregular. During the course of the process, the board heard from several individuals and entities suggesting the process was proceeding more quickly than usual. The Iowa Medical Society (IMS) and Iowa Osteopathic Medical Association (IOMA) raised concerns that the board did not allow more time for review and to receive input from the medical community. (App. 173-74, 199). The board heard similar concerns about acting too quickly from legal counsel during consideration of the petition for rulemaking, and board members Ann Gales and Dr. Michael Thompson during the rulemaking process. None of these individuals or entities advocated against the merits of the rule itself, but regarding the process used to adopt the rule.

There is no doubt that portions of the rulemaking process invited scrutiny, even though it technically complied with the legal requirements. The board acted on the petition for rulemaking only three days after it was received, and in contravention of advice from its in-house counsel

and attorney general representative. The board's attorney represented at oral argument that the June 28, 2013 meeting was the only meeting scheduled within the sixty day period that it has to act on the petition, but the board could have scheduled another meeting within that period, even if by telephone. The governor's attorney was present at the June 28, 2013 meeting and advised the board it could proceed, which although correct legal advice, was contrary to the counsel given by the board's regularly assigned attorneys to take more time. Of course, the presence and advice given by the governor's attorney, even though she is also the State's rules review coordinator, attracts accusations that the process is more political than policy oriented. The board did little to temper such accusations by refusing to follow requests by professional trade groups such as IMS and IOMA to take additional time for before adoption to receive more input and engage in more discussion with stakeholders.

However, the board did consider these concerns and responded to them during its decision adopting the rule. One of the board members expressly stated at the time of adoption that he felt the board had sufficient time to study all materials, consider public input, and reach a decision on the rule. The board stated in its written statement following the adoption of the rule that its members studied the matter by reviewing medical research papers and a significant amount of public comments. The board stated that the rule was narrowly drafted and limited to standards of practice that physicians must use before conducting medical abortions.

PPH's point is not really a direct challenge, but more of a setup for other arguments under section 17A.19(10)(j). The focus of subsection (j) is on the failure to consider a "relevant and important matter" relating to the action in question. The argument that the board's process was irregular and taken too quickly is not a failure to consider a "relevant and important matter,"

but is offered to show that the board's haste in acting led to its failure to consider relevant and important matters relating to the proposed rule.

While the court appreciates the point made by PPH and has considered its claims in that context, it is important to remember that the time spent on the deliberative process was within the statutory requirements for the adoption of rules. The purpose of the statute is to establish standards for notice, public comment, and a deliberative process. The board received considerable information and input from the public as part as the board complied with the statutory process.<sup>5</sup> Even if the board usually takes more time when adopting rules concerning standards of practice, the board's compliance with the statute demonstrates that the process was reasonable from a notice and opportunity-to-be-heard standpoint, absent some showing to the contrary.

1. Failure to consider past "policy" concerning PPH's telemedicine abortion program. PPH first claimed that the board failed to consider "its own past policy" concerning PPH's telemedicine abortion program. PPH claims that the board adopted a policy finding the program to be safe when it investigated two PPH doctors in 2010 and did not impose disciplinary action. The board responded with two arguments: 1) it did consider the prior action in 2010 (*see* App. 94) and 2) the board adopted no policy in 2010.

The board's written statement regarding the rule shows that it did consider the 2010 investigation when deciding to adopt the rule. The board stated that it had not previously adopted a rule or initiated a rulemaking process on telemedicine medical abortion services. The board also stated that the board membership had completely changed over the prior three years,

---

<sup>5</sup> The board also provided some additional notice not required by statute – it issued a press release setting the public hearing approximately a month before the hearing and it posted public comments to the proposed rule online for the public to see.

giving the present board reason to consider the health and safety concerns with the practice. The written statement demonstrates compliance with the requirements in section 17A.19(10)(j).

The board's action in 2010 was not a "policy" as argued by PPH. The Iowa Administrative Procedures Act defines a "rule" as an "agency statement of general applicability that implements, interprets, or prescribes law or policy[.]" Iowa Code section 17A.2(11). An agency cannot rely on an agency statement of general applicability that implements policy without going through the rulemaking process. *Anderson v. Iowa Dep't of Human Services*, 368 N.W.2d 104, 108 (Iowa 1985). The board did not adopt a rule on telemedicine medical abortion in 2010, nor did it even initiate a rulemaking process. The board may have had any number of reasons for not proceeding with a disciplinary process after receiving complaints in 2010, but even if it dismissed the complaints because it considered PPH's process to be safe, that decision cannot be considered to be policy. The rule under review in this action is the first attempt by the board to set policy regarding a standard of care for medical abortion.

Even if the board had previously adopted a policy or rule, there is nothing in the statute or governing law that would prevent it from reconsidering, revising, rescinding, or amending the rule. One of the purposes of the statute allowing an interested person to petition for rulemaking is to seek the repeal of a rule. *See* Iowa Code section 17A.7(1). In fact, the legislature requires each agency to review its rules every five years to identify rules that are outdated, redundant, or inconsistent or incompatible with statute or the agency's own rules. Iowa Code section 17A.7(1). An agency clearly has the discretion and power to change any rule that it has previously enacted. There was no prior rule governing medical abortions by telemedicine, but even if there had been, the board would have had the power to review and change it, just as future boards will have the opportunity to review and consider changes or rescission of this rule.

2. Failure to consider standards for the practice of telemedicine generally. PPH claimed that the board failed to consider its own policies and other policies favoring telemedicine generally. The board's written statement shows that it did consider the impact the rule might have on telemedicine services generally. (App. 94-95). The board determined that the rule was narrowly focused and would not prevent it from considering a broader rule in the future.

This is not the first time the board has adopted rules focusing on a narrow standard of practice. For example, the board has adopted a rule establishing a standard of practice regarding pain management. *See* 653 IAC 13.2. That rule requires the physician to conduct a physical examination and comprehensive medical history prior to the initiation of treatment. 653 IAC 13.2(5)(a). This shows that the board has not singled out medical abortions as the only procedure to require a physical exam.<sup>6</sup>

Further, as pointed out by the board in its brief, a physical exam is the norm for the treatment of any type of medical illness or condition, in that a patient must typically see a doctor before getting a prescription to treat conditions as routine as ear infections. There is nothing in the record to show other contexts in which the board has either allowed or tolerated a practice of telemedicine without any physical exam by a physician. The board's rule cannot be considered unreasonable for not considering all possible uses of telemedicine.

3-5. The board failed to look at the actual facts of PPH's telemedicine program. PPH argued that the board failed to look into the actual facts of PPH's program and the role of PPH's physicians within the program. PPH also argued that its program was as safe as other abortion services. The court's review of the public hearing, the board's minutes of the meeting in which

---

<sup>6</sup> The board has adopted other specific standards of care in chapter 13 of its rules.

it approved the rule, and the board's written statement shows this is flatly not true. There was considerable debate at the public hearing among PPH and other opponents of the rule, supporters of the rule, and the board itself regarding the need for a doctor to conduct an in-person physical exam of the patient before prescribing the medication that would induce an abortion. The board specifically referenced written statements and studies offered by PPH at the public hearing. The record shows that the board understood PPH's protocol and reviewed studies submitted, but disagreed with PPH when setting the standard of practice.

The crux of the board's decision to adopt the rule is that an in-person physical examination should be done before prescribing abortion inducing drugs. There are legitimate reasons to support the board's decision. First, the board cited to various conditions that are risk factors for using mifepristone and misoprostol (such as ectopic pregnancy or undiagnosed adnexal mass) and other conditions for which there is no data as to the safety or effectiveness of the drugs (such as hypertension or severe anemia). The board cited to studies in which women died due to the failure to diagnose ectopic pregnancy. The board felt it important to the health and safety of the public that the treating physician conduct a basic in-person physical exam to exclude the list of exclusionary factors that have not been deemed safe by study.

Second, the board expressed concern with the quality of the ultrasound performed to determine the gestational age of the embryo. Under either of the primary protocols for use of medical abortion, it is critical to determine the gestational age because the drugs are only safe if used early in the pregnancy – within forty-nine days of gestation under the FDA-approved protocol and within sixty-three days of gestation under the protocol used by PPH. Also, the board found that a basic physical exam is needed in all cases to exclude risk factors, and a pelvic

exam may be needed in some cases to corroborate ultrasound findings and properly determine gestational age.

Additionally, the board found that an in-person examination may strengthen the patient-physician relationship. The board found that a personal meeting between physician and patient may reinforce the need to return for a follow-up examination, and thus increase the likelihood of the follow-up exam. A follow-up exam is required under any of the primary protocols for medical abortion, including the protocol used by PPH.

The board's adoption of the rule is one that is precisely within the expertise of the board of medicine and not one to be decided by the court. The board includes seven physicians who are educated, trained, and experienced in the practice of medicine. Iowa Code section 147.14(1)(b) *see also* Iowa Code section 146.16(1) (requiring each physician to have been in practice for five years). The board's decision is supported by the opinions of other physicians and health care professionals who testified at the public hearing and submitted documents as part of the public record. The petition for rule-making itself was signed by five physicians. The board's decision is supported by its reasoning that a physician needs to conduct a physical exam, which the board generally considers to be "the cornerstone of good medical care." (App. 95). The FDA standards also require a physical examination. The record shows that sixteen states have taken action to require a physician to be physically present before prescribing an abortion inducing drug. The record does not show any state that has formally approved the medical abortion by telemedicine protocol used by PPH.

PPH's position that its protocol is safe and serves the welfare of the public also has support in the record, most significantly from the testimony and study performed by Dr. Daniel

Grossman. However, it is not for the court to review medical studies and determine which is the most persuasive. If it did so, it would be substituting its judgment for that of the board of medicine. The only question for the court is whether the board considered the information submitted by PPH and other opponents of the rule. The board clearly considered the information provided by PPH, but disagreed with PPH's opinions and ultimately determined that the proposed rule better met the board's goal of protecting the safety and welfare of Iowans.

6-8. The rule will create a hardship for rural Iowa women. PPH's points six through eight are similar will be discussed as a group. PPH has been able to provide medical abortions at more clinics through telemedicine, making medical abortions more accessible to rural Iowa women. Without the availability of telemedicine medical abortions, PPH argued that women will need to travel further, which will lead to delays, which, in turn, will increase risks. PPH argued that these obstacles may lead more women to illegal abortions.

This argument is, once again, not a matter of the board failing to consider PPH's position, but disagreeing with it. The board specifically considered the argument that the rule would limit rural Iowa women's access to medical abortions. (App. 94). The board did not dispute that the rule would result in medical abortions being conducted in fewer locations. Rather, it responded by finding that all women in Iowa should be entitled to the same high level of health care, whether they live in rural or urban Iowa. The board found that the rule best protects all patients' health and safety. The board's reasoning is not unreasonable and must be granted deference by the court.

9. The board ignored basic facts about the FDA approval process. Next, PPH argued that the board did not consider facts regarding the FDA approval process. There is no

evidence to suggest that the board ignored evidence submitted regarding the FDA approval process. In fact, the proposed rule would not prohibit some aspects of PPH's protocol, such as the sixty-three day timeframe to use mifepristone and misoprostol in combination. The FDA has only approved a protocol up to forty-nine days of gestation, but the board's rule does not limit medical abortions to forty-nine days. The rule would allow women to receive a medical abortion within sixty-three days of gestation if they meet the physical exam requirement and other requirements of the rule.

10-11. Use of office staff to perform exams. PPH's final point is that some aspects of a physical exam, such as vital signs and ultrasounds, are routine tasks frequently performed by nurses and medical assistants. PPH claimed that it provided information to show staff members were qualified to perform ultrasounds. The board did express some of those concerns, but its concerns went deeper than whether CMAs could perform ultrasounds.<sup>7</sup> Again, the board's central concern was that a doctor be present to conduct a physical exam before the abortion. The board considered the information provided by PPH, but came to a different conclusion as to the required standard of practice.

**B. Not required by law and negative impact – Section 17A.19(10)(k)**

PPH's second claim is under Iowa Code section 17A.19(10)(k), which allows reversal if the agency's action is:

[n]ot required by law and its negative impact on the private rights affected is so grossly disproportionate to the benefits accruing to the public interest from that action that it must necessarily be deemed to lack any foundation in rational agency policy.

---

<sup>7</sup> Susan Thayer, the former long-time PPH employee who testified at the board's public hearing, stated that she was told that she would be expected to perform ultrasounds, even though she was a center manager and had no medical training at all.

Subsection (k) is one of the subsections which Professor Bonfield described as a more structured version of the unreasonable, arbitrary, capricious, and abuse of discretion standard that was previously part of chapter 17A. Accordingly, PPH's claim under this section will be reviewed with that standard in mind. *See Zieckler v. Ampride*, 743 N.W.2d 530, 532-33 (Iowa 2007) (applying the unreasonable, arbitrary, capricious, or abuse of discretion standard to a claim made under subsection (k)).

This argument amounts to a reiteration of points made above. PPH argued that the rule serves no public health benefit and would deprive accessible, safe, and early abortion services to hundreds of Iowa patients per year. However, both points are a matter of debate. The board determined that a physical exam was important to protect Iowa patients, and in doing so, disagreed with PPH's argument that its protocol was just as safe. The board did not dispute that the rule might result in the PPH closing clinics, and thus make access to medical abortions less convenient to Iowans in those areas. Instead, the board found that the benefits of providing a higher standard of practice outweighed the convenience factor. While abortion may not be convenient and may cost more money due to driving distance, the rule would not deprive Iowa patients of medical abortions. At the very least, the court cannot find that the negative impact of the board's rule is so grossly disproportionate to the benefits accruing to the public interest that it must necessarily be deemed to lack any foundation in rational agency policy.

**C. Improper purpose – Section 17A.19(10)(e).**

PPH next argued that the board's decision to adopt the rule should be reversed under Iowa Code section 17A.19(10)(e), which allows court action if the agency action is:

[t]he product of decision making undertaken by persons who were improperly constituted as a decision-making body, were motivated by an improper purpose, or were subject to disqualification.

Professor Bonfield offered no real explanation for new subsection (e), other than (d) and (e) were “beneficial, clarifying elaborations” of original sections 17A.19(8)(d) and (e). Those original subsections simply permitted reversal when (d) made upon unlawful procedure, or (e) affected by other error of law. *Iowa Farm Bureau Federation v. Environmental Protection Comm’n*, 2014 WL 3377072, \_\_\_ N.W.2d \_\_\_, n. 8 (Iowa July 11, 2014).

In *Iowa Farm Bureau*, the Iowa Supreme Court considered a challenge to rulemaking under subsection (e). The plaintiff objected to a rule adopted by the Iowa Environmental Protection Commission (EPC), in part, because one of the commission members appointed by Governor Culver was employed by a nonprofit environmental organization and had taken an advocacy position on the subject matter of the proposed rules. *Id.* at 2. In fact, as part of her full-time job, the commission member had developed proposed rules that were presented to the agency as part of a petition for rulemaking, and she was active in pushing the agency to initiate the rulemaking process. The commission member was recognized as a lead person among environmental groups advocating for the rule proposed in the petition.

The court held that subsection (e) was generally intended to “incorporate general conflict-of-interests standards and enable judicial development of these standards.” *Id.* at \*8. Important to this case, the court found that the standard for judging conflicts of interest in a rulemaking context are much more lenient than judging conflicts in the judicial setting of a contested case. *Id.* at \*10-11.

The court started by generally recognizing the ability of the governor to develop policy within the executive branch through the appointment of board and commission members with compatible views:

[A] governor, as the top-elected representative of the people, has always had the ability to shape the overall perspective and direction of commissions through the power of appointment. Thus, the “political considerations” excluded from the appointment process by statute do not normally extend to the ability of a governor to appoint Commission members who have particular views about subjects expected to come before the Commission that may be consistent with the views of the Governor or the political party of the Governor. Instead, this concept reflects the basic nature of governing through public elections and is deeply embedded within the executive and legislative branches of government.

*Id.* at \*5-6. Agency decision-makers must “consider in good faith, and to objective evaluate, arguments presented to them; agency officials, however, need not be subjectively impartial.” *Id.* at \*15 (cites omitted). Favoring a specific rule over another is not a basis for disqualification absent evidence that the member’s view “could not be changed by the rulemaking proceedings that were to follow.” *Id.* The court established the following standard in considering challenges to rulemaking based on an improper purpose claim:

we think a district court may vacate a rulemaking on the ground of bias upon no less than a showing by clear and convincing evidence that the administrator has undertaken the agency action with an “unalterably closed mind,” thereby making their action “motivated by an improper purpose.

*Id.* To emphasize the difficulty in meeting this standard, the court cited to a federal decision finding that no court had ever, under any standard, disqualified an agency administrator from participating in an informal rulemaking process based on bias. *Id.* at 16 citing *Lead Industries Association, Inc. v. Environmental Protection Agency*, 647 F.2d 1130 (D.C. 1980). Applying

these standards, the court found that the EPC member was not disqualified from approving the rule notwithstanding her prior research and advocacy on the same issues. *Id.* at 17.

PPH's primary argument focused on the role of board member Monsignor Frank Bognanno. On August 20, 2010, prior to his appointment to the board, Monsignor Bognanno sent a letter to the board asking it to take action to end telemedicine abortions. (App. 560). His letter centered on the protection of a "pre-born child," and not the standard of care to conduct medical abortions. Following the petition for rulemaking in 2013, now as a board member appointed by Governor Branstad, Monsignor Bognanno sent emails to board members with attachments that supported adoption of the rule. (App. 561-612). The attachments include information from PPH sources, other articles, and some personal stories regarding medical abortion. Each of the attachments concerned medical abortions, and not just abortion generally. Monsignor Bognanno voted to accept the petition for rulemaking and to adopt the proposed rule. In his public comments during the adoption of the rule, Monsignor Bognanno focused on the standard of medical care and not his beliefs on abortion generally. (App. 519).

There is very little difference between Monsignor Bognanno's actions and that of the EPC member in the *Iowa Farm Bureau* case. Both cases involve individuals who took a position on an issue prior to joining the agency, pushed and advocated for the rule consistent with their prior position, and voted for adoption. In some ways, the commissioner member in *Iowa Farm Bureau* was more involved prior to joining the commission because she had drafted a petition for rulemaking that ultimately led to adoption of a rule that was closely aligned with that view.

The one concern here, in comparison to *Iowa Farm Bureau*, is that the statute governing the EPC not only requires five of its members to be actively engaged in delineated practice areas, but all members to have knowledge of the subjects embraced by the agency's governing laws.

*Id.* at 5 *citing to* Iowa Code section 455A.6(1). The statute governing the board's membership requires seven physician members, but sets no requirements for the three public members. Monsignor Bognanno is one of the public members. So, while EPC members could be expected to arrive with some preconceived ideas on policy issues relative to the mission of the agency based on their knowledge of the subject area, the same would not necessarily hold true of public members on the board of medicine. Further, Monsignor Bognanno's opposition to abortion went beyond issues of standards of medical care that are the province of the board.

After considering the entire record, the court cannot find Monsignor Bognanno engaged in an improper purpose based on the high standard set by the Iowa Supreme Court in *Iowa Farm Bureau*. Monsignor Bognanno may oppose all abortion, but the record demonstrates that he focused his attention on medical abortion and the applicable standard of care. The materials he sent to other board members focused on medical abortion, and his public comments were limited to the standard of care for medical abortion. Even though he might personally choose more limits or even a total ban on abortion, the rule he supported does not ban abortion in general, nor does it ban medical abortion specifically. His vote in favor of the rule was supported by seven other board members including six of the seven physician members. There is not clear and convincing evidence to show that Monsignor Bognanno's participation in the adoption of the rule was improper as defined by the Iowa Supreme Court.

PPH also argued that the petition for rulemaking was improper because it was supported by individuals who seek a total ban on abortion. The improper purpose provision is directed at the decision-maker, and not the intent of the individuals who request agency action. Whatever the intent of the individuals who seek the rulemaking, the court must focus on the action taken by the agency, and not that of the parties seeking rulemaking.

**D. PPH's constitutional claims.**

**Federal constitution claims:** PPH's final claim is that the board's rule violates the due process and equal protection clauses of the Iowa and United States Constitutions. The standard for evaluating the federal constitutional claims is set forth in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 878-79 (1992). In *Casey*, the court reaffirmed the central holding of *Roe v. Wade* that the State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability. *Id.* To protect the central right recognized by *Roe* while at the same time accommodating the State's profound interest in protecting potential life, the court adopted an "undue burden analysis." *Id.*

An undue burden exists, and therefore a provision of law regulating abortion is unconstitutional, "if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability." *Id.* The court recognized that, "[a]s with any medical procedure, the State may enact regulations to further the health or safety of a woman seeking an abortion." *Id.* However, "[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion" may amount to an undue burden. *Id.*

The *Casey* court considered five provisions of Pennsylvania law under the undue burden standards. One of the provisions required that, except in a medical emergency, a physician must, at least twenty-four hours before performing an abortion, inform the patient of the nature of the procedure, the health risks of abortion and childbirth, and probable gestational age of the unborn child. *Id.* at 881. The plaintiff claimed that the twenty-four hour waiting period imposed an undue burden on women seeking an abortion because some women must travel a long distance to

an abortion provider, and the necessity of making two trips to a physician would result in delays and cause them to incur additional financial and emotional costs. *Id.* at 886. The court accepted the argument that the waiting period would have the effect of increasing the cost and risk of delay of abortions, but did not find that the waiting period amounted to a substantial obstacle to abortion. The court specifically rejected the claim that a woman has a right to abortion on demand. *Id.* at 887. The court found that the twenty-four hour waiting period did not violate due process.

In *Gonzalez v. Carhart*, 550 U.S. 124, 158 (2007), the court added to the undue burden analysis that restrictions on abortions must also pass rational basis review. *See Planned Parenthood of Greater Texas v. Abbott*, 748 F.3d 583, 590 (5<sup>th</sup> Cir. 2014). The *Abbott* court rejected Planned Parenthood's argument that a strict scrutiny test should be used. *Id.* The rational basis test only requires the court to consider whether there is a reasonable fit between the government interest and means utilized to advance that interest. *King v. State*, 818 N.W.2d 1, 32 (Iowa 2012).

In *Abbott*, Planned Parenthood challenged two provisions passed by the Texas legislature. The first required physicians who perform or induce abortions to have admitting privileges at a hospital no more than thirty miles from the location the abortion is performed. *Abbott*, 748 F.3d at 587. This was expected to reduce the number of locations at which abortions could be provided. The second provision required medical abortions to be performed in compliance with the FDA protocol. *Id.*

In upholding the Texas law, the *Abbott* court found no undue burden to the admitting privileges requirement even though the change in law may require patients to increase travel by

up to 150 miles to obtain an abortion. The court cited the district court's decision in *Casey*, which found that women in sixty-two of Pennsylvania's sixty-seven counties were required to travel at least one hour and sometimes longer than three hours to obtain an abortion from the nearest provider. *Id.* at 598 citing to *Casey*, 744 F.Supp. 1323, 1352 (E.D.Pa. 1990). The Supreme Court found no undue burden in *Casey*, even though the twenty-four hour waiting period required most women to make two trips. To put the matter in perspective, the court noted that, because only thirteen of Texas' 254 counties had abortion facilities before the change in law, any obstacles created did not substantially alter the access to abortion services compared with access prior to enactment. *Id.* at 597.

The court likewise found no undue burden to the medical abortion provision. Planned Parenthood argued that the law imposed an undue burden on women seeking an abortion of fetuses with an age between fifty and sixty-three days because medical abortion would be prohibited. The court rejected that claim, noting that the Texas law did not ban an entire abortion method, but rather, shortened the window during which a woman might choose a medication abortion. *Id.* at 604. The court reiterated the holdings from *Casey* and *Gonzalez* that discouraged facial constitutional attacks on statutes (or in this case, an administrative rule) because there is often too little evidence to show that a particular condition has occurred or is likely to occur. *Id.* at 604.

There is no dispute that implementation of the board's rule will reduce the locations at which abortions are provided. PPH currently has facilities in four cities that offer surgical and medical abortions: Bettendorf, Des Moines, Iowa City, and Sioux City. (Meadows affidavit; App. 591). It offers telemedicine medical abortions in ten locations, although two (Urbandale and a second Des Moines location) are in Polk County. Dr. Meadows of PPH stated in her

affidavit that PPH would close the ten telemedicine locations if the rule goes into effect, thus leaving only four PPH locations to provide abortion services. As an example, a woman from Creston or Red Oak, who can presently obtain a telemedicine abortion in her home town, would have to drive to Council Bluffs or Des Moines to obtain an abortion from a PPH provider.

While implementation of the rule will result in longer travel times and additional costs for some women who seek abortions, there is no undue hardship under the Supreme Court's test. The courts have already found that travel distances of 150 miles or travel time of three hours are not undue burdens. There is no indication that any woman in Iowa would have a longer travel time than that approved in *Casey*. Also, PPH's argument does not consider that other abortion providers have been available in Iowa. Prior to PPH beginning its telemedicine protocol in late 2008, there were eleven providers in Iowa offering abortion services in nine counties. (App. 554-55). The location of the other providers was not listed in the record, but the other providers necessarily operated in some counties not serviced by PPH. Therefore, the cost and distance argument is not as dire as portrayed by PPH. And while nine of ninety-nine counties may seem small, the proportion of counties offering providers was greater in Iowa than Texas, in which only thirteen of 254 counties had providers, and Pennsylvania, in which only five of sixty-seven counties had providers.

The board's rule is likewise supported by a rational basis. As discussed above, the board is authorized to adopt a standard of practice, and it did so in this instance on rational grounds. The rule does not prevent PPH or any other abortion provider from offering medical abortions, but simply requires an in-person physician examination as the center of its standard of practice. The rule likewise does not prevent PPH from using its protocol up to sixty-three days of gestation, even though not compliant with the protocol approved by the FDA. The rule

constitutes a reasonable fit between the board's interest in protecting the safety and welfare of patients, and the means utilized to advance that interest.

PPH also made an equal protection claim. Typically, when the rational basis test is involved, the court evaluates that basis similarly for equal protection and due process purposes. *King v. State*, 818 N.W.2d 1, 32 (Iowa 2012). However, as pointed out by the board in its brief, the claim is difficult to evaluate because PPH has not precisely defined the groups it claims has been treated differently, a must for an equal protection evaluation. To any extent PPH claims that the board's rule has violated equal protection because telemedicine abortion is treated differently than other telemedicine, such a facial challenge must be rejected for reasons discussed in *Gonzalez*. There is no evidence indicating to what extent the board allows telemedicine in other contexts, so there is no means to evaluate a broad equal protection claim.

**State constitution claims:** PPH finally argued that the rule violates Iowa constitutional provisions relating to due process and equal protection. The Iowa and federal constitutions have generally, throughout the history of this State, been construed similarly. *See e.g. Bowers v. Polk County Board of Supervisors*, 638 N.W.2d 682, 689 (Iowa 2002) (“[w]e usually deem the federal and state equal protection clauses to be identical in scope, import, and purpose.”). PPH argued that the court should consider the Iowa constitutional claims by applying a higher standard, citing to the Iowa courts ability to employ a different analytical framework to “independently apply the federally formulated principles.” (PPH brief at 25).

PPH's argument has some support in the case law. The concept that the Iowa courts can interpret the Iowa constitution differently than the United States Supreme Court has interpreted the federal constitution was recently advanced by the Iowa Supreme Court's decision in *Racing*

*Association of Central Iowa v. Fitzgerald*, 675 N.W.2d 1 (2004) (hereinafter, *RACI*). In *RACI*, the Iowa Supreme Court found a tax statute unconstitutional under the federal and state equal protection clauses. The State successfully sought certiorari to the United States Supreme Court, which reversed in a unanimous decision. The case came back to the Iowa Supreme Court to decide the Iowa constitutional claim. The court used the same constitutional test to decide the Iowa claim, but again found the statute unconstitutional, even though the United States Supreme Court had found the same statute constitutional using the same test in the same case.

The approach used by the majority in *RACI* has been criticized. Justice Cady, in dissent, while recognizing that state courts have a role in protecting individual rights not recognized by the federal courts, stated that the doctrine of independent interpretation cannot be used to justify a decision that conflicts with the United States Supreme Court in every instance. *Id.* at 17-18. Justice Waterman, who was appointed to the court following *RACI*, has stated that *RACI* should be overruled as “plainly erroneous.” *Qwest Corp. v. Iowa State Board of Tax Review*, 829 N.W.2d 550, 566 (Iowa 2013) (Waterman, J., concurring). In *King*, a majority of the court ruled that *RACI* has “not been the death knell for traditional rational basis review,” thus seemingly limiting the application of the *RACI* decision in future cases involving a rational basis review. 818 N.W.2d at 30.

Notwithstanding these critiques of *RACI*, the Iowa Supreme Court has continued to employ the concept of interpreting the Iowa Constitution differently than decisions interpreting the United States Constitution in cases involving more highly protected civil rights. In *Varnum v. Brien*, 763 N.W.2d 682 (Iowa 2009), the court found an Iowa marriage statute unconstitutional under the equal protection clause of the Iowa Constitution because it denied marriage between individuals of the same sex. The court reviewed the history of Iowa courts being on the forefront

of recognizing and protecting various civil rights, often before the federal courts or the courts of other states. *Id.* at 877-78. The *Varnum* decision has served as a lead decision as other states and federal courts considered similar challenges to same-sex marriage.

As recently as July 18, 2014, the court, in a four-to-three decision, reversed a criminal conviction under the warrants clause of the Iowa Constitution, notwithstanding a unanimous 2001 United States Supreme Court decision to the contrary. *State v. Short*, 2014 WL 3537029, \_\_\_ N.W.2d \_\_\_ (Iowa 2014). Following a lengthy review of the Iowa and federal lines of cases, the court stated its disagreement with the trend of United States Supreme Court decisions, and declined to overrule an Iowa case that was inconsistent with the more recent United States Supreme Court decisions. Now-Chief Justice Cady specially concurred to “emphasize the importance of independently interpreting our Iowa Constitution.” *Id.* at 31.

This approach does create challenges at the district court level when faced with a claim under the Iowa Constitution and one party presents a seemingly controlling United States Supreme Court decision. However, this does not appear to be an instance that calls for a different evaluation under the Iowa Constitution. The undue burden standard has been in place at the federal court level for twenty-two years since *Casey* was announced in 1992. There is no comparable line of cases at the State level. The court could only find one reference to *Casey* in an Iowa appellant court decision, and that was merely a footnote in *War Eagle Village Apartments v. Plummer*, 775 N.W.2d 714, n.3 (Iowa 2009). As pointed out by PPH, there is a reference in *Sanchez v. State*, 692 N.W.2d 812, 820 (Iowa 2005) to abortion being a fundamental right, but the reference was in passing and not central to the holding to the case, which involved a challenge to the denial of a driver’s license to illegal aliens.

The lack of any parallel state case law experience to the federal line of cases is important when considering whether the due process clause of the Iowa Constitution should be utilized to develop a different standard from *Casey*. *Casey* itself was announced nineteen years after *Roe*, so the federal courts now have more than forty years of experience in applying the challenging balancing test discussed in that line of cases. In contrast, cases such as *RACI* and *Short* involved issues that were commonly decided in Iowa courts, so Iowa courts at least had some context to consider the possibility of alternative tests. *Varnum* too involved familiar principles of equal protection, but *Varnum* is different because Iowa was on the forefront of jurisdictions considering challenges to statutes prohibiting same-sex marriage. Moreover, the reasoning in *Varnum* is hardly troubling from a constitutional standpoint, as there is little question in hindsight that the result would have been any different if the court had decided the case under the federal equal protection clause.

Iowa courts are certainly familiar with substantive due process claims in other contexts, but this court is not inclined to deviate from the complex constitutional balancing tests set forth in *Casey* and *Gonzalez*.<sup>8</sup> Unlike *Varnum* and other cases cited in *Varnum* where Iowa courts played a leading role on important constitutional issues, the parameters governing legalized abortion in this country were led by the United States Supreme Court through its decision in *Roe v. Wade*, and refined by the decisions that followed. There is no reason to deviate from the standards set by the federal courts. Therefore, PPH's claims under the Iowa Constitution must be denied for the same reasons which the federal constitutional claims are denied.

---

<sup>8</sup> Recent Iowa decisions considering substantive due process claims follow the federal standards. *King*, 818 N.W.2d at 31-32; *Horsfield Materials, Inc. v. City of Dyersville*, 834 N.W.2d 444, 458-59 (Iowa 2013).

**RULING**

The claims made in the petition for judicial review are hereby denied. The board's rule set forth at 653 IAC 13.10 is upheld as valid. The stay previously put in place by the court on November 5, 2013 is lifted, effective 30 days from the date of this ruling, absent any stay granted by this court or the Iowa Supreme Court. All costs are assessed to petitioners.



State of Iowa Courts

**Type:** OTHER ORDER

**Case Number** CVCV046429  
**Case Title** PLANNED PARENTHOOD V. IOWA BOARD OF MEDICINE

So Ordered

A handwritten signature in cursive script, appearing to read 'Jeffrey Farrell', written over a horizontal line.

Jeffrey Farrell, District Court Judge,  
Fifth Judicial District of Iowa

September 27, 2013

## IOWA BOARD OF MEDICINE'S STATEMENT ON ADOPTED AND FILED RULE ARC 1034C

On August 30, 2013, the Iowa Board of Medicine voted to adopt and file ARC 1034C (previously ARC 0891C) to establish standards of practice for physicians who prescribe or administer abortion-inducing drugs to terminate a pregnancy – medical abortion. The goal of the new rule is to protect the health and safety of Iowans. The Board believes that all patients, including those in rural Iowa, deserve the highest level of care. The Board believes that a physician must establish an appropriate physician-patient relationship prior to the provision of a medical abortion. The physician's in-person medical interview and physical examination of the patient are essential to establishing that relationship.

Pursuant to Iowa Administrative Code 653 – Chapter 1.8(2)“c”(6), the Board presents this statement of the principal reasons for and against the rule, incorporating therein the reasons either for accepting or overruling considerations urged against the rule. ARC 1034C will be published in the Iowa Administrative Bulletin on October 2, 2013, and will become effective on November 6, 2013.

### I. PRINCIPAL REASONS PRESENTED IN SUPPORT OF THE RULE

- 1. To protect the health and safety of patients, standards of practice are needed for physicians who prescribe and administer abortion-inducing drugs to terminate a pregnancy.**
- 2. The practices used by physicians who prescribe and administer abortion-inducing drugs using telemedicine are inconsistent with the protocols approved by the U.S. Food and Drug Administration (FDA) and the manufacturer of the drugs.**
- 3. Iowa Code Section 707.7(3) only allows physicians to perform abortions in Iowa.**
- 4. A physical examination of the patient in telemedicine settings is not being performed by the physician who prescribes and administers the abortion-inducing drugs, but is delegated to non-physician persons who do not have appropriate training to confirm or discover**

contraindications or to perform an ultrasound to determine the age and location of the embryo.

**5. Physicians who prescribe and administer abortion-inducing drugs using telemedicine may never meet with the patient in person and may never see the patient again for a follow-up appointment.**

## **II. PRINCIPAL REASONS PRESENTED IN OPPOSITION TO THE RULE AND THE BOARD'S REASONS FOR OVERRULING THESE CONSIDERATIONS**

**1. The rule would limit rural Iowa women's access to medical abortions.** *The new rule does not restrict where medical abortion services may be provided. The emphasis of the rule is on the patient's health and safety and the responsibility of physicians who perform medical abortions. The Board believes that all Iowans are entitled to the same high level of health care, regardless of whether they live in rural or urban areas. The Board believes that the physician's decision that the patient should have a medical or surgical abortion should depend on multiple factors including patient preference, medical and psychological status of the patient, and the patient's access to emergency medical services.*

**2. The rule is politically motivated and is not sound public policy.** *While issues such as abortion have been politicized, the Board does not have authority to react politically to any issue. The Board is only authorized to adopt all necessary and proper rules for the licensure and standards of practice for health care providers licensed pursuant to Iowa Code Chapters 148 (physicians) and 148E (acupuncturists). The Board is motivated to adopt this administrative rule by its mandate to protect the health and safety of Iowans.*

**3. The rule is an attempt to ban access to a procedure that is legal. It deprives Iowa women of their constitutionally protected right to obtain a pre-viability abortion.** *Abortion is legal in Iowa and the goal of the new rule is to protect the health and safety of patients who seek medical abortions. Federal court decisions have set the guidelines for the availability of abortion. Nothing in the rule bans medical abortion. Rather, the rule sets forth the standards of practice that must be followed by physicians who perform medical abortions.*

**4. The Board previously addressed this matter in 2010 when it reviewed Planned Parenthood of the Heartland's medical abortion services using telemedicine and concluded they were safe.** *The membership of the Board has changed completely over the past three years. The Board has not previously promulgated any rules addressing medical abortion services using telemedicine. This is the first rulemaking proceeding which has given licensed physicians and the public an opportunity to comment on the use of telemedicine in this context. Because there was no rule in place addressing this particular procedure, the Board determined a rule was necessary to protect the health and safety of Iowans.*

**5. The Board promulgated rulemaking without a thorough study or analysis of the matter under regulatory consideration and the Board did not take into consideration the impact the rule may potentially have on expectations and requirements for telemedicine delivery of**

**other medical services.** *After accepting a petition on June 28, 2013, to promulgate rulemaking on the standards of practice for physicians who perform medical abortions, Board members studied the matter and reviewed medical research papers and a significant amount of public comments received on a broad spectrum of issues regarding medical abortions. The Board determined that the new rule is narrowly focused on the standards of practice for physicians who perform medical abortions. The Board may determine in the future to more broadly address the standards of practice for other medical services using telemedicine.*

**6. An appropriate physical examination, including an ultrasound to determine age and location of the embryo, is performed by appropriately trained staff in the telemedicine setting and this information is provided to an off-site physician who remotely prescribes and administers the abortion-inducing drugs.** *The Board considers a thorough medical history and physical examination to be the cornerstone of good medical care. On this foundation an accurate diagnosis can be made and the most appropriate treatment plan offered to the patient. The Board is concerned about the quality and sufficiency of the physical examination being performed prior to a medical abortion. The first area of concern is the lack of opportunity for a physician to perform a basic physical examination of the patient to screen for conditions that would be contraindications to medical abortion. The drugs used in a medical abortion are mifepristone and misoprostol. As listed in the FDA literature the contraindications to these medications include “confirmed or suspected ectopic pregnancy or undiagnosed adnexal mass; an intrauterine device (IUD) in place; chronic adrenal failure; concurrent long-term corticosteroid therapy; history of allergy to mifepristone, misoprostol, or other prostaglandins; hemorrhagic disorders or concurrent anticoagulant therapy; and inherited porphyrias.” As stated in the FDA literature on abortion-inducing drugs, “There are no data on the safety and efficacy of mifepristone in women with chronic medical conditions such as cardiovascular, hypertensive, hepatic, respiratory, or renal disease; insulin-dependent diabetes mellitus; severe anemia or heavy smoking. Women who are more than 35 years of age and who also smoke 10 or more cigarettes per day should be treated with caution because such patients were generally excluded from clinical trials of mifepristone.” The Board believes that a basic physical examination of a patient is necessary to exclude this narrower list of contraindications and essential to exclude the list of exclusionary conditions that were not part of the clinical studies. The second area of concern is the quality of the ultrasound that is being performed prior to a medical abortion. Without the option of a clinical pelvic examination of the patient to confirm dating of the embryo, these remote clinics are relying primarily on ultrasound to date the embryo and rule out ectopic pregnancy, which occurs when an embryo implants somewhere other than the uterus. The Board is concerned about the uncertainty of whether clinic staff members providing the ultrasounds are actually qualified to produce useful images to sufficiently rely upon for diagnostic purposes. If an ectopic pregnancy was missed the medications may not expel the embryo and may lead to delayed diagnosis and treatment of this dangerous condition. In the FDA reports of deaths from mifepristone and misoprostol two of the 14 deaths were related to ruptured ectopic pregnancies, and 58 other women suffered morbidity from failed diagnosis of ectopic pregnancy. The Board believes that a basic physical examination for every patient will help to exclude the conditions that are contraindications to the medications. The*

*Board believes that a pelvic examination may be necessary in some cases to correlate with ultrasound findings and should be available to all women presenting for a medical abortion. The Board believes that adequate ultrasound services and interpretation are necessary if a clinical pelvic examination is not being used to date the embryo. For all these reasons the Board believes that a physician should be present to conduct this physical examination before proceeding with a medical abortion.*

**7. The treatment and consultation recommendations made by the physician in the telemedicine setting are the same standards of appropriate practice as those in face-to-face settings. The physician does not have to be present to perform a medical abortion.** *Iowa Code section 707.7(3) requires that abortions in Iowa be performed by physicians. The Board believes that the prescribing physician must be physically present with the patient to administer the abortion-inducing drug. This physician-patient relationship is fundamental to the provision of a safe medical abortion. It is the expectation of the Board that physicians recognize the obligations, responsibilities and patient rights associated with establishing and maintaining an appropriate physician-patient relationship in the specific context of prescribing and administering abortion-inducing drugs.*

**8. Patients are already receiving appropriate follow-up care to their medical abortions in remote clinics where a physician is not physically present.** *The Board believes that follow-up care of the patient is critical after providing a medical abortion. The new rule requires the physician who prescribes and performs a medical abortion to make all reasonable efforts to ensure that the patient is aware of the importance of follow-up care and that she returns for an appointment with the prescribing physician. The Board believes that the physician's in-person interview to collect the patient's medical history and an in-person physical examination will strengthen the physician-patient relationship and result in improved and increased follow-up care of the patient.*

### **III. ADOPTED AND FILED RULE ARC 1034C**

**653—13.10(147,148,272C) Standards of practice—physicians who prescribe or administer abortion-inducing drugs.**

**13.10(1) Definition.** As used in this rule:

*“Abortion-inducing drug”* means a drug, medicine, mixture, or preparation, when it is prescribed or administered with the intent to terminate the pregnancy of a woman known to be pregnant.

**13.10(2) Physical examination required.** A physician shall not induce an abortion by providing an abortion-inducing drug unless the physician has first performed a physical examination of the woman to determine, and document in the woman's medical record, the gestational age and intrauterine location of the pregnancy.

**13.10(3) Physician's physical presence required.** When inducing an abortion by providing an abortion-inducing drug, a physician must be physically present with the woman at the time the abortion-inducing drug is provided.

**13.10(4)** *Follow-up appointment required.* If an abortion is induced by an abortion-inducing drug, the physician inducing the abortion must schedule a follow-up appointment with the woman at the same facility where the abortion-inducing drug was provided, 12 to 18 days after the woman's use of an abortion-inducing drug to confirm the termination of the pregnancy and evaluate the woman's medical condition. The physician shall use all reasonable efforts to ensure that the woman is aware of the follow-up appointment and that she returns for the appointment.

**13.10(5)** *Parental notification regarding pregnant minors.* A physician shall not induce an abortion by providing an abortion-inducing drug to a pregnant minor prior to compliance with the requirements of Iowa Code chapter 135L and rules 641—89.12(135L) and 641—89.21(135L) adopted by the public health department.

#