

October 6, 2026

Submitted Electronically

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Comment of Advanced Practice Clinician Professional Associations in Support of the Following Citizen Petitions:

FDA-2025-P-0377-0001

FDA-2025 P-0377-0250

FDA-2025-P-1576-0001

FDA-2025-P-3287-0001

FDA-2025-P-2162-0001

STATEMENT OF INTEREST

Signatories National Association of Nurse Practitioners in Women's Health ("NPWH"), American College of Nurse-Midwives ("ACNM"), and Association of Physician Associates in Obstetrics and Gynecology ("APAOG") (collectively, the "Signatories") submit this comment in support of pending citizen petitions to urge the U.S. Food and Drug Administration ("FDA") to refrain from imposing additional or increased restrictions on mifepristone. Specifically, the Signatories submit this comment to contextualize the relevant research and to explain the important role that advanced practice clinicians ("APCs") play in preserving safe and effective access to abortion care. APCs should be permitted to continue providing that care.

NPWH is the national professional association for women's health nurse practitioners and advanced practice registered nurses who provide women's and gender-related healthcare. NPWH sets a standard of excellence by translating and promoting the latest women's healthcare research and evidence-based clinical guidance, providing high-quality continuing education, and advocating for patients, providers, and the women's health nurse practitioner profession. NPWH's mission includes protecting and promoting women's and all individuals' rights to make their own choices regarding their health and well-being within the context of their lived experience and their personal, religious, cultural, and family beliefs.

ACNM is the professional association that represents certified nurse-midwives ("CNM") and certified midwives ("CM") in the United States. ACNM sets the standard for excellence in midwifery education and practice in the United States and strengthens the capacity of midwives in developing countries. Members of ACNM are primary, sexual, and reproductive care providers for people throughout their lifespans, with a special emphasis on pregnancy, childbirth, and gynecologic and reproductive health. ACNM's mission is to support midwives, advance the practice of midwifery, and achieve optimal, equitable health outcomes for the people and

communities midwives serve through inclusion, advocacy, education, leadership development, and research.

APAOG is the professional association representing physician associates/physician assistants (“PAs”) in Obstetrics and Gynecology in the United States. APAOG supports PAs practicing obstetrics, gynecology, and all of its subspecialties by advancing the role of PAs to serve patients throughout their lifespan. APAOG’s mission is to promote equitable patient care through education, research, advocacy, inclusivity, and leadership.

The Signatories care deeply about not only the APCs they represent, but also the well-being of the patients APCs serve. They are committed to continuity of care, including with respect to medication abortion administered by telehealth. The clinician members represented by the Signatories have extensive experience providing reproductive healthcare, including medication abortion, which they have been doing for many years. In this submission, the Signatories highlight the overwhelmingly positive outcomes for the hundreds of thousands of patients treated by APCs in reproductive health each year.

I. ADVANCED PRACTICE CLINICIANS MUST SATISFY RIGOROUS EDUCATION AND CERTIFICATION REQUIREMENTS TO PROVIDE THE BROAD SCOPE OF HEALTHCARE THEY ROUTINELY OFFER.

APCs, which include certified women’s health nurse practitioners, certified nurse-midwives, certified midwives, and physician associates, are vital participants in the U.S. healthcare system. They are licensed to provide a broad range of health services consistent with their heightened educational standards and rigorous certification and continuing education requirements. APCs have prescriptive authority in every state, including for controlled substances.¹ They are key providers of primary, gynecological, maternity, acute, and chronic care across the country, including for low-income patients and those living in rural and medically underserved areas.

While some APCs practice in collaboration with a physician, many practice independently as authorized by their states’ laws, and where permitted, run their own clinics.² More and more states continue to authorize APCs to practice fully independently from physicians, a trend supported by these providers’ qualifications, public health necessity and positive clinical outcomes.³ Twenty-eight jurisdictions permit nurse practitioners (“NPs”) to practice without

¹ Am. Med. Ass’n, *State Law Chart: Nurse Practitioner Prescriptive Authority* (2017), <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/specialty%20group/arc/ama-chart-np-prescriptive-authority.pdf>; Am. Acad. PAs, *PA Prescribing* (2020), <https://www.aapa.org/download/61323/?tmstv=1696531381>.

² Elena Kraus & James M. DuBois, *Knowing Your Limits: A Qualitative Study of Physician and Nurse Practitioner Perspectives on NP Independence in Primary Care*, 32 J. Gen. Internal Med. 284, 287 (2017).

³ See e.g., Miranda Laurant et al., *Nurses as Substitutes for Doctors in Primary Care*, Cochrane Database Syst. Rev. CD001271 (2018), <https://pubmed.ncbi.nlm.nih.gov/30011347/>; Michelle Butler et al., *Substitution of Nurses for Physicians in the Hospital Setting for Patient, Process of Care, and Economic Outcomes*, Cochrane Database Syst. Rev.

physician involvement,⁴ while thirty-two jurisdictions permit the same for CNMs.⁵ Eight states currently permit PAs to practice without a relationship with a specific physician, and many other jurisdictions enable various levels of independent PA practice.⁶ The states adopting these policies recognize that APCs are qualified providers of a range of health care services, and APCs are increasingly essential to meet public health needs.

In addition, APCs consistently outperform physicians on metrics of patient satisfaction, patient compliance, and health promotion.⁷ Even APCs who practice in collaboration with a physician in accordance with their states' laws regularly see patients without direct physician involvement. In such contexts, APCs frequently are, as one physician put it, the ones who "keep the lights on"⁸

NPs provide an extensive range of health services, including diagnosing and treating acute and chronic illnesses, prescribing and managing medications and other therapies, providing immunizations, performing procedures, ordering and interpreting lab tests and x-rays, coordinating patient care, and providing health education.⁹ NPs dispense these essential health services in many practice areas, including family medicine, pediatrics, geriatrics, and women's health, among others.¹⁰

NPs must satisfy rigorous educational and certification requirements. First, NPs must obtain a registered nurse license and complete graduate education at the masters, post-masters, or doctoral level.¹¹ NPs must pass a national certification exam to receive the designation of Board-

CD013616 (2026), <https://pubmed.ncbi.nlm.nih.gov/41672426/>; E. Kathleen Adams & Sara Markowitz, *Improving Efficiency in the Health Care System: Removing Anticompetitive Barriers for Advanced Practice Registered Nurses and Physician Assistants*, Brookings Inst. (Jun. 13, 2018), <https://www.brookings.edu/articles/improving-efficiency-in-the-health-care-system-removing-anticompetitive-barriers-for-advanced-practice-registered-nurses-and-physician-assistants/>. Bo Kyum Yang et al., *State Nurse Practitioner Practice Regulations and U.S. Health Care Delivery Outcomes: A Systematic Review*, 78 Med. Care Res. Rev. 183 (2021), <https://pubmed.ncbi.nlm.nih.gov/31997710/>.

⁴ Am. Ass'n Nurse Pract., *2026 Nurse Practitioner State Practice Environment* (2026), <https://www.aanp.org/advocacy/state/state-practice-environment>.

⁵ Am. Coll. Nurse-Midwives, *Practice Environment for Certified Nurse-Midwives* (2026), <https://midwife.org/wp-content/uploads/2026/03/Practice-Environment-for-Certified-Nurse-Midwives-%E2%80%93-March-2026.pdf>.

⁶ Am. Acad. PAs, *PA State Practice Environment* (2026), <https://www.aapa.org/advocacy-central/state-advocacy/interactive-state-advocacy-maps/>.

⁷ *Id.* at 284.

⁸ *Id.*

⁹ Am. Ass'n Nurse Pract., *Discussion Paper: Scope of Practice for Nurse Practitioners* (2022), https://storage.aanp.org/www/documents/advocacy/position-papers/Scope-of-Practice.pdf?_gl=1*oqa1l4*_gcl_au*NDgxNzY4MzQyLjE3OTAwMjUwMjY.

¹⁰ Nat'l Governors Ass'n, *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care* 4 (2012).

¹¹ *Id.* at 8.

certified NP (NP-BC), which is required for practice in the vast majority of states.¹² Certification testing assesses the “applicant’s knowledge and skill in diagnosing, determining treatments, and prescribing for their patient population of focus.”¹³ This training and testing is highly effective. Data suggest that NPs are capable of providing approximately 90% of primary care services commonly provided by physicians, with comparable outcomes.¹⁴

The women’s health nurse practitioner (“WHNP”) is prepared at the master’s or doctoral level to provide primary care for women from puberty through adulthood, with a focus on gynecologic, sexual, reproductive, menopause-transition, and post-menopause healthcare; uncomplicated and high-risk antepartum and postpartum care; and sexual and reproductive healthcare for men. WHNP education, certification, and practice are congruent with the NP role and the women’s health population focus. The WHNP functions within the scope of practice rules and regulations established by and pursuant to the nurse practice act in the state(s) in which the WHNP is licensed and works. The WHNP provides care in outpatient, inpatient, community, and other settings, both independently and collaboratively, and provides consultation services to other healthcare providers regarding women’s unique healthcare needs. WHNPs maintain certification and recertify every three years through the National Certification Board and also are required to meet continuing education requirements.

Like NPs, certified nurse-midwives (“CNMs”) and certified midwives (“CMs”) offer a wide array of health services: they provide comprehensive assessment, diagnosis, and treatment care; prescribe medications, including controlled substances; admit, manage, and discharge patients; order and interpret laboratory and diagnostic tests; and provide wellness education and counseling.¹⁵ CNMs and CMs principally focus on the provision of patient care during pregnancy, childbirth, and the postpartum period; sexual and reproductive health; gynecologic health; menopause care; and family planning services, including preconception care.¹⁶ CNMs and CMs provide primary care for individuals from adolescence throughout the lifespan as well as care for the healthy newborn during the first twenty-eight days of life.¹⁷

¹² *Id.*; Adv. Pract. Educ. Ass’n, *How Should Nurse Practitioners List Their Credentials* (May 4, 2026), https://apea.com/blog/How-Should-Nurse-Practitioners-List-Their-Credentials-26/?srsltid=AU7gw4UUBCfZQCXQGIYnIJ7RpQp9_g19-0uLU62ZJWDP42hwWhV5rs1. In forty-seven states, NPs must receive certification from a nationally recognized certified body; in the remaining three states (California, Kansas, and New York), NPs must complete a board-approved master’s degree with similar course requirements to those accepted by one of the national certifying bodies. Am. Ass’n Nurse Pract., *supra* note 6.

¹³ Nat’l Governors Ass’n, at 8.

¹⁴ Kraus & DuBois, *supra* note 2, at 284.

¹⁵ Am. Coll. Nurse-Midwives, *Definition of Midwifery and Scope of Practice of Certified Nurse-Midwives and Certified Midwives* (2021), <https://midwife.org/wp-content/uploads/2024/10/Definition-of-Midwifery-and-Scope-of-Practice-of-Certified-Nurse-Midwives-and-Certified-Midwives.pdf>.

¹⁶ *Id.*

¹⁷ *Id.*

Education and certification requirements for CNMs and CMs are exacting. Following completion of a bachelor's degree and a graduate midwifery program, CNMs and CMs must pass a national certification exam to receive the designation of CNM (a title referring to individuals with active RN credentials when they pass the exam) or CM (a title referring to those who pass the certification exam as midwives separate from nursing licensure).¹⁸ CNMs and CMs must continuously demonstrate that they meet the Core Competencies for Basic Midwifery Practice of Signatory ACNM and are required to practice in accordance with the ACNM Standards for the Practice of Midwifery.¹⁹ The ACNM competencies and standards are consistent with or exceed the International Confederation of Midwives' global midwifery competencies and standards.²⁰ CNMs and CMs must be recertified every five years and are required to meet continuing education requirements.²¹

PAs' broad clinical practice, spanning from the beginning to the completion of care, includes taking medical histories, performing physical examinations, ordering and interpreting diagnostic tests, diagnosing illness, developing and managing treatment plans, prescribing medication (including controlled substances), and assisting at surgery, and performing certain procedures.²² PAs play an integral role in a broad array of clinical settings, including obstetrics and gynecology, in outpatient and in-hospital settings; they provide a wide range of reproductive care from the diagnosis and treatment of acute and chronic gynecological conditions to independently performing critical clinical procedures such as vaginal deliveries, amniotomies, inseminations, endometrial and vulvar biopsies, and loop excision electrocoagulation procedures, and assisting in surgeries.²³ A large body of research, including both randomized clinical trials and retrospective studies using claims and surveys, suggests that care provided by PAs and NPs produces health outcomes that are equivalent to physician-provided care.²⁴

To become licensed, PAs must first graduate from an accredited master's degree program, which spans the equivalent of three academic years and employs a rigorous curriculum modeled on the medical school program.²⁵ Students take more than 75 hours in pharmacology, 175 hours in behavioral sciences, 400 or more hours in basic sciences, and nearly 580 hours of clinical medicine, and complete over 2,000 hours of supervised clinical practice.²⁶ PAs must then become board certified by passing the PA National Certifying Examination, become state-licensed, and, in

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

²² Am. Acad. PAs, *PA Scope of Practice* (2019), https://www.aapa.org/wp-content/uploads/2017/01/Issue-brief_Scope-of-Practice_0117-1.pdf.

²³ Am. Acad. PAs, *PAs in Obstetrics and Gynecology* (2021), <https://www.aapa.org/download/19515/>.

²⁴ US Medicare Payment Advisory Committee, Report to the Congress: Medicare and the Health Care Delivery System (2019), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf.

²⁵ *Id.*; *PA Scope of Practice*, *supra* note 22.

²⁶ *PAs in Obstetrics and Gynecology*, *supra* note 23.

order to maintain national board certification, complete 100 hours of continuing medical education every two years and take a recertification exam every ten years.²⁷

Given the rigorous education and certification requirements for NPs, CNMs, and PAs, these accomplished healthcare professionals are well-qualified to provide medication abortion, as they have been doing safely for years.

II. ADVANCED PRACTICE CLINICIANS PROVIDE SAFE AND EFFECTIVE ABORTION CARE.

In 2016, the FDA approved a supplemental new drug application from mifepristone's sponsor that changed the drug's conditions for use and the FDA REMS to allow qualified, licensed healthcare providers (including APCs) to become certified prescribers of mifepristone. In assessing the appropriateness of the 2016 REMS program changes, the FDA considered "data from over 3200 women in randomized controlled trials and data on 596 women in prospective cohorts comparing medical abortion care by" APCs with that provided by physicians, all of which "clearly demonstrate[d] that efficacy is the same," if not better, with APCs compared to physicians.²⁸ And, like physicians, APCs also regularly provide safe and effective aspiration abortions, including, if necessary, as follow-up care after a medication abortion.²⁹ For many patients, especially those living in rural areas, APCs are not just the provider of choice, but also the only possible provider. Given the overwhelming body of scientific evidence before it, the FDA was exceedingly justified in removing the conditions that unnecessarily restricted APCs' ability to be certified prescribers of mifepristone.

In 2023, the FDA further revised the REMS program to formally remove the in-person dispensing requirement and add a pharmacy certification process, allowing patients to receive mifepristone through the mail or certified retail and mail-order pharmacies to dispense mifepristone. As with prior changes to the REMS program, the FDA reviewed literature on mifepristone and postmarketing safety data dating back to 2000. Such literature documents the absence of significant concerns with various delivery models and the real-world evidence supporting the conclusion that the COVID-19 enforcement suspension of the in-person dispensing requirement did not meaningfully impact safety outcomes.³⁰ In 2025, however, the FDA announced it would re-review the REMS program for mifepristone.

APCs enable people to access abortion care earlier in pregnancy, when such care is even safer and more effective. They are ideally positioned to deliver abortion care as they are often the first and primary point of contact for patients with contraception and pregnancy-related issues.

²⁷ *PA Scope of Practice*, *supra* note 22.

²⁸ FDA, Ctr. for Drug Evaluation and Rsch., *Clinical Review, NDA 020687/S-020 (Mifeprex)*, at 43 (Mar. 2016), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020MedR.pdf.

²⁹ 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, 457 (2013).

³⁰ Sophie Dilek et al., *The US Food and Drug Administration's Regulation of Mifepristone*, 335 JAMA 619-625 (2026).

APCs also remain involved in their patients' care well beyond the prescription stage, ensuring continuity of care following medication abortion. They provide follow-up care, typically through counseling and reassurance, needed after an abortion medication, and they remain trusted providers for their patients' future healthcare needs. The FDA should not restrict APCs' ability to continue to provide this essential care.

A. Advanced Practice Clinicians Achieve The Same, Or Better, Health Outcomes As Physicians When Providing Medication Abortion.

Peer-reviewed studies have long established that APCs provide medication abortions as safely and effectively as physicians, if not more so. Indeed, a 2026 study of data from 59,091 medication abortions, the largest ever conducted, found no clinical difference between APC and physician-provided medication abortion care, both in terms of efficacy and the occurrence of adverse events (less than 1% regardless of provider type).³¹ Further, after a comprehensive review of medical literature on the safety of abortion, the National Academies of Science, Engineering, and Medicine, the non-partisan, non-governmental institution established to advise the nation on issues related to those disciplines, concluded: “[b]oth trained physicians (OB/GYNs, family medicine physicians, and other physicians) and APCs (physician assistants, certified nurse-midwives, and nurse practitioners) can provide medication and aspiration abortions safely and effectively.”³² A retrospective review of patients who initiated medication abortion from 2009 to 2018 further supports the safe and effective outcomes of medication abortion provided by APCs.³³ The researchers concluded that these outcomes were well within the published benchmarks for medication abortion effectiveness and safety for medication abortion provided by physicians.³⁴

In fact, some research shows that APCs provide medication abortions with *greater* efficacy and patient acceptability than physicians. For example, one of the studies cited by the FDA in connection with the 2016 REMS review was a randomized study of 1180 women receiving medication abortions that concluded that nurse-midwives' provision of medication abortion had “superior efficacy” over that provided by physicians.³⁵ The study found that 99% of the 481 women treated by nurse-midwives did not require further intervention (i.e., follow-up aspiration to complete the abortion) following the medication abortion, as compared to 97.4% of the 699

³¹ Sarah Averbach et al., *Medication Abortion Provision by Advanced Practice Clinicians and Abortion Completeness*, 9 JAMA Network Open e2623855 (2026), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2851745>.

³² Nat. Acad. Sci., Eng'g Med., *The Safety and Quality of Abortion Care in the United States* 14 (2018), <https://www.nationalacademies.org/projects/IOM-BPH-15-11/publication/24950>; Sharmani Barnard et al., *Doctors or Mid-Level Providers for Abortion*, Cochrane Database (2015) (no statistically significant difference in risk of failure for medication abortions performed by APCs compared with physicians in comparative review of medication abortion outcome studies).

³³ L. Porsch et al., *Advanced Practice Clinicians and Medication Abortion Safety*, 101 Contraception 357 (2020).

³⁴ *Id.*

³⁵ H. Kopp Kallner et al., *The Efficacy, Safety and Acceptability of Medical Termination of Pregnancy Provided by Standard Care by Doctors or by Nurse-Midwives*, 122 BJOG: Int'l J. Obstetrics & Gynecology 510, 515 (2015).

women treated by physicians).³⁶ Women randomized to meet with nurse-midwives were more likely to prefer their allocated provider than women randomized to meet with physicians, and were significantly more likely to express a preference for nurse-midwives if they ever required another medication abortion in the future.³⁷

Similarly, another FDA-cited randomized study of 1295 women who received medication abortions found that abortions provided by nurses and auxiliary nurse midwives who received government-certified training did not pose any higher risk of failure or incomplete abortions compared to abortions provided by physicians.³⁸ In fact, 97.3% of the medication abortions provided by certified nurses or auxiliary nurse midwives were completed without further intervention, as compared to 96.1% of those provided by physicians.³⁹ A later review of data collected in that same study found that of the women receiving care from certified nurses and auxiliary nurse midwives, 38% reported being highly satisfied with their care and 62% reported being satisfied, reflecting a 100% satisfaction rate, compared to 35%, 64%, and 99% for physicians, respectively.⁴⁰

Further, APCs working in collaboration with physicians often take on leadership roles, educating the physicians about medication abortion or being asked to take the lead with patients who are under a physician's care. A study of NPs who provided medication abortion in Canada found that NPs commonly "educat[ed] physician colleagues about mifepristone."⁴¹ One NP who participated in the study explained that she provided a number of physician-attended information sessions and held one-on-ones to answer physician questions, and that she understood "that [her] role was to try to teach [the physicians]" about medication abortion.⁴² Similarly, Lindsey Piper, a WHNP who has been providing abortion care for over 20 years, "is often called upon by physicians to provide assistance and guidance in difficult abortion procedures" and is often shadowed by medical residents as part of their training. Piper reports that she "is not the only one. Many of [her] colleagues regularly work with physicians and physicians-in-training in order to teach them best practices [with respect to abortion medication]."⁴³ WHNP Julie Jenkins, who has been involved in

³⁶ *Id.* at 513-14. *None* of the 1180 women participating in the study experienced any serious complications, across provider groups.

³⁷ *Id.*

³⁸ IK Warriner et al., *Can Midlevel Health-Care Providers Administer Early Medical Abortion as Safely and Effectively as Doctors? A Randomised Controlled Equivalence Trial in Nepal*, 377 *Lancet* 1155, 1155-61 (2011).

³⁹ *Id.*

⁴⁰ Anand Tamang et al., *Comparative Satisfaction of Receiving Medical Abortion Service from Nurses and Auxiliary Nurse-Midwives or Doctors in Nepal: Results of a Randomized Trial*, 14 *Reproductive Health* 1 (2017).

⁴¹ Andrea Carson et al., *Nurse Practitioners on 'the Leading Edge' of Medication Abortion Care: A Feminist Qualitative Approach*, 79 *J. Adv. Nursing* 686, 690 (2023).

⁴² *Id.* at 690-91.

⁴³ Interview with Lindsey Piper, MSN, WHNP-BC (Sep. 25, 2026). Piper is a Board-Certified WHNP with a Master of Science in Nursing. She has served on the faculty of an abortion training program at a health center in Maine, as a guest lecturer at the University of Maine and Northeastern University, and has been involved in programs providing abortion training of family medicine residents, medical students, NP students, and others.

abortion care for over 30 years, also trains physicians, NPs, and PAs in medication abortion. After Jenkins trained 18 practitioners of a health care center in 2023 on medication abortion, the physician-medical director of the center told her, “I’ve been providing abortions since the 1980s and medication abortions since 2000. I learned so much from you today.”⁴⁴

B. The Ability Of Advanced Practice Clinicians To Prescribe Mifepristone Improves Already Exceedingly Safe Abortion Care.

Although abortion is safe at any stage of pregnancy, safety increases the earlier care is provided.⁴⁵ It is no surprise that participation in abortion care by trained APCs improves patient safety *and* overall outcomes, as it allows early diagnosis and management of unintended pregnancies and integrated abortion care, thereby reducing delays and unnecessary referrals.⁴⁶ Restricting APCs’ ability to prescribe mifepristone would compromise safe abortion care and miscarriage management, as both types of care require the same treatment.⁴⁷

APCs are, and will continue to be, easier to access than physicians for healthcare. Demand for healthcare is projected to continue to outpace supply. The number of physicians is expected to increase annually by only 1.1% from 2016 to 2030, leading to a projected nationwide shortage of up to 86,000 physicians by 2036.⁴⁸ By contrast, the number of APCs is expected to increase more rapidly, with a predicted 11% increase in NPs annually during that same period and a predicted 35% increase of clinically active PAs from 2020 to 2035.⁴⁹

She is also a member of Signatories NPWH and ACNM. All interviews cited herein were conducted by counsel for the Signatories and the interviewed APCs reviewed and approved information attributed to them.

⁴⁴ Interview with Julie Jenkins, DNP, APRN, WHNP-BC (Sept. 25, 2026). Jenkins, who has a Doctor of Nursing Practice degree, has taught in nursing programs at the University of California San Francisco, University of Maine, and Massachusetts General Hospital Institute of Health Professions, and is a Clinical Associate Professor at the University of Washington and the Program Strategist for Clinicians in Abortion Care at the National Abortion Federation. Jenkins is also a member of Signatory NPWH.

⁴⁵ Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998–2010*, 126 *Obstetrics & Gynecology* 258, 262 (2015).

⁴⁶ D. Taylor et al., *Advanced Practice Clinicians as Abortion Providers: Preliminary Findings from the California Primary Care Initiative*, 80 *Contraception* 199 (2009).

⁴⁷ Interview with Alexi Child, MMS, PA-C (Oct. 1, 2026). Child is an Illinois PA and member of Signatory APAOG. Child explained that “being able to prescribe both mifepristone and misoprostol for medication abortion and for miscarriage management of early pregnancy loss enables me to give my patients the best evidence-based medical care they need given their individual circumstances.”

⁴⁸ Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2021 to 2036*, Ass’n Am. Med. Colls. (2024), <https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage>.

⁴⁹ David I. Auerbach et al., *Growing Ranks of Advanced Practice Clinicians – Implications for the Physician Workforce*, 378 *N. Engl. J. Med.* 2358, 2359 (2018); Roderick S. Hooker et al., *Forecasting the Physician Assistant/Associate Workforce: 2020-2035*, 9 *Future*

In reproductive healthcare, from 2000 to 2009 alone, the percentage of women who reported receiving maternity care from a midwife, NP, or PA increased 4% annually, indicating a cumulative increase of 48% over the decade.⁵⁰ APCs also are “important contraception providers” in the reproductive healthcare landscape.⁵¹ The increased role of APCs in reproductive healthcare is especially pronounced in rural areas, where lower physician availability means that patients rely on NPs and PAs at higher rates for their reproductive healthcare needs.⁵²

Approximately 25% of women decide to terminate a pregnancy in their lifetime.⁵³ They are often young, unmarried, low-income women seeking abortion care within the first six weeks of gestation.⁵⁴ For many women, especially those living in remote locations hours away from any physician providing abortion care, APCs are the only providers reasonably available.⁵⁵ These

Healthcare J. 57, 57 (2022);

<https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.01747>.

⁵⁰ Katy Backes Kozhimannil et al., *Recent Trends in Clinicians Providing Care to Pregnant Women in the United States*, 57 J. Midwifery Womens Health 433, 433 (2012).

⁵¹ Candice Chen et al., *Who is Providing Contraception Care in the United States? An Observational Study of the Contraceptive Workforce*, 226 Am. J. Obstetrics & Gynecology E1, E5 (2021).

⁵² Hyungjung Lee et al., *Determinants of Rural-Urban Differences in Health Care Provider Visits Among Women of Reproductive Age in the United States*, 15 PLoS ONE, e0240700 (2020); Chen et al., *supra* note 51, at E5 (“advanced practice nurses,” i.e., NPs and CNMs, are “especially” important for provision of contraceptive care in rural areas); Asvini K. Subasinghe et al., *Primary Care Providers’ Knowledge, Attitudes and Practices of Medical Abortion: A Systematic Review*, 47 BMJ Sex & Reproductive Health 9 (2021), <https://pubmed.ncbi.nlm.nih.gov/31888950/>.

⁵³ Guttmacher Inst., *One in Four US Women Expected to Have an Abortion in Their Lifetime*. (Apr. 2024) <https://www.guttmacher.org/news-release/2024/one-four-us-women-expected-have-abortion-their-lifetime>.

⁵⁴ Margot Sanger-Katz et al., *Who Gets Abortions in America?*, N.Y. Times (Dec. 14, 2021), <https://www.nytimes.com/interactive/2021/12/14/upshot/who-gets-abortions-in-america.html>.

⁵⁵ Declaration of Helen Weems in Support of Plaintiff’s Motion for a Preliminary Injunction 1, *Whole Woman’s Health All. v. U.S. Food & Drug Admin.*, No. 3:23-cv-00019 (W.D. Va. Aug. 21, 2023) (“I am also the only clinician providing abortion care in Northwest Montana. The next closest abortion provider is almost a 3-hour drive away, each way. Before [the clinic] opened in 2018, the Northwest region had been without an abortion provider since 2014. And, prior to 2014, another [APC] was the only abortion provider in the region for many years.”); Interview with Britannia McDonald, BS, MS, MPAS, PA-C (Sep. 30, 2026). McDonald is Chief of Medicine at Speare Memorial Hospital in Plymouth, New Hampshire and a member of Signatories APAA and APAOG. Interview with Alexi Child, *supra* note 47; Interview with Debbie Barish, DNP, RN, WHNP-BC (Sep. 24, 2026). Barish is a WHNP with 30 years of experience who has provided thousands of medication abortions and has been performing aspiration abortions for over 17 years.

women depend on and develop trusting relationships with APCs, who are often their reproductive healthcare providers well before they seek abortion care.⁵⁶

In 2020, clinics, including abortion clinics, made up only 50% of abortion providers in the U.S. but administered 96% of all abortions.⁵⁷ One study showed that of 9,087 women who sought a first-trimester aspiration abortion from 22 California clinics, 81% of women who were offered APC care accepted such care, and the majority received an abortion provided by an APC.⁵⁸

As a result of the COVID-19 pandemic, the practice of medicine drastically shifted in favor of telehealth when appropriate.⁵⁹ Telehealth accounted for 29% of all abortions in the United States in 2025.⁶⁰ Medication abortion is one area that has been shown to be particularly appropriate for telehealth for eligible patients,⁶¹ and many women have expressed gratitude that telehealth enables APCs to provide high-quality, flexible abortion care. As one APC stated, allowing women to obtain abortion care without being required to leave their communities and drive many hours to see a physician – none of which is warranted for medication abortion – has been a “silver lining of the pandemic.”⁶²

The relative availability of APCs compared to physicians, coupled with APCs’ authority to independently prescribe mifepristone, means that patients seeking an abortion can access healthcare earlier, facilitating the provision of safe critical care. Reverting to a physician-only certified prescriber requirement or constraining telehealth prescribing would leave many women without such care.⁶³ As one WHNP states, “it simply is not a good use of physicians’ time to be involved in medication abortion, especially when APCs are available.”⁶⁴

⁵⁶ Interview with Julie Jenkins, *supra* note 44; Interview with Lindsey Piper, *supra* note 43.

⁵⁷ Jeff Diamat et al., *What the Data Says About Abortion in the U.S.*, Pew Rsch. Ctr. (June 17, 2026), <https://www.pewresearch.org/short-reads/2023/01/11/what-the-data-says-about-abortion-in-the-u-s-2/>.

⁵⁸ Diana Taylor et al., *Multiple Determinants of the Abortion Care Experience: From the Patient’s Perspective*, 28 Am. J. Med. Quality 510, 511-14 (2013).

⁵⁹ Julia Shaver, *The State of Telehealth Before and After the COVID-19 Pandemic*, 49 Primary Care: Clinics in Office Practice 517 (2022).

⁶⁰ Guttmacher Inst., *How Innovative Uses of Telehealth Can Support Abortion Access* (June 12, 2026), <https://www.guttmacher.org/fact-sheet/how-innovative-uses-telehealth-can-support-abortion-access>.

⁶¹ Ushma D. Upahyay et al., *Effectiveness and safety of telehealth medication abortion in the USA*, 30 Nat. Med. 1191-1198 (2024) (99.8% of telehealth medication abortions (in a sample of 6,034) were not followed by serious adverse events).

⁶² Interview with Julie Jenkins, *supra* note 44.

⁶³ Reprod. Health Initiative for Telehealth Equity & Sols., *Telehealth for Abortion Care & Advanced Practice Clinicians (APCs): Key Aspects of Expanding Access to Care* (Nov. 2025), https://cdn.prod.website-files.com/6733817ea3257b118351a50f/69a5bc7e245f48626daf7360_APCs%20info%20pager.pdf

⁶⁴ Interview with Julie Jenkins, *supra* note 44.

C. Advanced Practice Clinicians Providing Medication Abortion Give Follow-Up Care And Support As Indicated.

APCs begin providing care well before they write a prescription for mifepristone and continue to provide care well after. APCs, or the healthcare clinics in which they practice, often have pre-existing relationships with medication abortion patients, providing annual exams, cancer screenings, contraception counseling, STI screenings, and other care. Whether or not they have those relationships, prior to prescribing mifepristone, APCs assess patients' medical histories and presenting signs and symptoms to determine their eligibility to receive, and the appropriateness of providing, medication abortion.⁶⁵

Before any medication is prescribed or administered, APCs provide their patients with counseling and extensive information, including information from the manufacturer of mifepristone, regarding exactly what to expect after taking the medication and giving guidance as to when follow-up care may be indicated.⁶⁶

After a medication abortion, APCs remain available to provide care as appropriate. Like physicians, many APCs provide telephone numbers with 24-hour on-call support; some provide patients with their direct phone numbers and make sure patients know they are available “for medical and emotional support before, during, and after” they take the medication.⁶⁷ In the vast majority of instances where patients seek additional care or advice following a medication abortion, their concerns can be resolved completely with additional education and counseling, which APCs can provide virtually or in-person. Many patients, for example, simply need to be reassured that “bleeding is actually the necessary, intended mechanism of action.”⁶⁸ Whether the medication was provided after a telehealth visit or an in-person visit, APCs frequently check in on their patients a week or so later to ensure that results are progressing as expected, to answer questions patients may have, and, often most importantly, to provide reassurance that bleeding is not an adverse effect, but rather the desired outcome.⁶⁹

In the exceedingly rare case that a medication abortion presents issues that do not resolve on their own, APCs can provide the vast majority of necessary follow-up care, including prescribing antibiotics, performing or referring for an aspiration to “empty the uterus” of excess tissue, prescribing additional doses of medication, and treating anemia.⁷⁰

⁶⁵ *Id.*; Interview with Alexi Child, *supra* note 47; Interview with Debbie Barish, *supra* note 55; PA Scope of Practice, (describing how PAs' broad, generalist medical education prepares them to take medical histories).

⁶⁶ Interview with Debbie Barish, *supra* note 55; Interview with Lindsey Piper, *supra* note 43; *Medication Guide*, Danco Lab., https://www.earlyoptionpill.com/wp-content/uploads/2016/01/DAN_MedGuideEng_FINAL.pdf.

⁶⁷ Interview with Julie Jenkins, *supra* note 44.

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*; Kopp Kallner, *supra* note 35; Weitz, *supra* note 29; Interview with Debbie Barish, *supra* note 55.

Where permitted by state law, APCs also safely and effectively provide aspiration abortions, which involve the dilation of the cervix and gentle suction to remove uterine contents; the *identical* procedure is used in the event of an incomplete miscarriage.⁷¹ In one study, researchers compared 5,812 aspiration procedures performed by physicians with 5,675 aspiration procedures performed by APCs over four years.⁷² The study concluded that abortion “care provided by newly trained NPs, CNMs, and PAs was not inferior to that provided by experienced physicians.”⁷³ The study found no significant difference in terms of risk of major complications between provider groups.⁷⁴ The results “confirm[ed] existing evidence from smaller studies that the provision of abortion[s] by [APCs] is safe and from larger international and national reviews that have found these clinicians to be safe and qualified health care providers.”⁷⁵ Further buttressing these studies, PAs have a long history of successfully providing aspiration abortions, and have performed procedural abortions in some states since as early as 1973.⁷⁶ An early study analyzing the outcomes of first-trimester procedural abortions performed in a Vermont clinic found that of 2,458 first trimester abortions, PA-performed abortions presented an even lower rate of complications than the already low rate for physician-performed abortions.⁷⁷

Because they are capable of providing most follow-up care themselves, APCs prefer and are trained to maintain continuity of care rather than needing to have their patients seek care elsewhere. Even APCs who provide only telehealth services often arrange for intervention as needed by collaborating with local providers who are knowledgeable about medication abortion.

The medication abortion process frequently results in close, trusting relationships between APCs and their patients. Even APCs without preexisting relationships with their patients often

⁷¹ Kate Coleman-Minahan et al., *Interest in Medication and Aspiration Abortion Training Among Colorado Nurse Practitioners, Nurse Midwives, and Physician Assistants*, *Women’s Health Issues* 167, 169 (2020); Amy J. Levi & Tara Cardinal, *Early Pregnancy Loss Management for Nurse Practitioners and Midwives*, *Women’s Healthcare: A Clinical Journey for NPs* 43, 44 (2016).

⁷² Weitz et al., *supra* note 29, at 457.

⁷³ *Id.* at 458.

⁷⁴ *Id.* at 459.

⁷⁵ *Id.*; Eva Patil et al., *Aspiration Abortion with Immediate Intrauterine Device Insertion: Comparing Outcomes of Advanced Practice Clinicians and Physicians*, 61 *J. Midwifery & Women’s Health* 325, 329 (2016) (finding no clinically significant differences between aspiration abortions followed by IUD insertions performed by physicians versus APCs); Amy Levi et al., *Training in Aspiration Abortion Care*, 88 *Int’l J. Nursing Studies* 55, 57 (2018) (no significant difference in complication rates in aspiration abortions performed by APC trainees versus physician residents).

⁷⁶ Carole Joffe & Susan Yanow, *Advanced Practice Clinicians as Abortion Providers: Current Developments in the United States*, 12 *Reproductive Health Matters Supp.* 198, 199 (2004).

⁷⁷ Mary Anne Freedman et al., *Comparison of Complication Rates in First Trimester Abortions Performed by Physician Assistants and Physicians*, 76 *Am. J. Public Health* 550, 550 (1986).

develop meaningful relationships, and their patients return to them or their clinics for annual gynecologic exams, STI screening, contraception, and other reproductive care.⁷⁸

In short, APCs provide medication abortion patients with an expectation of continuity of safe and effective care, within the context of their medication abortion and beyond.

III. ADVANCED PRACTICE CLINICIANS REGULARLY PROVIDE HEALTHCARE, INCLUDING CHILDBIRTH CARE, THAT IS EQUALLY OR MORE COMPLEX THAN MEDICATION ABORTION.

As part of their everyday practice, APCs provide healthcare services that are essentially the same as, comparable to, or more complex than medication abortion. These services include reproductive health-related care and non-reproductive health-related procedures. APCs also regularly prescribe controlled substances and assist in complicated surgeries and medical procedures. Finally, studies have demonstrated that APC-provided obstetrical care results in better outcomes than that provided by physicians despite the inherent, serious risks associated with such care, underscoring APCs' excellent provision of complex care to patients.⁷⁹

A. Medication Abortion Is Essentially Equivalent To Care For Early Pregnancy Loss.

APCs routinely provide reproductive health-related care that is akin to medication abortion. APCs provide miscarriage care, for example, which frequently calls for the same course of medication used in medication abortion.⁸⁰

Medical management of miscarriage today commonly involves the use of a combination of mifepristone and misoprostol, the same as in medication abortion. Brittanica McDonald, who has been a certified PA for 20 years, provides miscarriage care but does not provide medication abortion.⁸¹ She used to give patients undergoing early pregnancy loss misoprostol, but she now provides both mifepristone and misoprostol, because research has shown the combined regimen to be more effective.⁸² McDonald says she hates to think about healthcare regressing to the point that

⁷⁸ Interview with Debbie Barish *supra* note 55; Interview with Lindsey Piper, *supra* note 43 (noting she has “even had patients who received abortions refer their family and friends to see [her]. It is all about building a trusting relationship.”).

⁷⁹ Kopp Kallner, *supra* note 35; Weitz, *supra* note 29.

⁸⁰ Am. Coll. Obstetricians & Gynecologists, *Early Pregnancy Loss Practice Bulletin* (2018), <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss>; Interview with Lindsey Piper, *supra* note 43; Interview with Alexi Child, *supra* note 47. Child regularly serves as a preceptor and educates PA and NP students on proper abortion and miscarriage management. As she informs her students, “the course of medication is the same for both medication abortion and miscarriage medication treatment.” *Id.*

⁸¹ Interview with Brittanica McDonald, *supra* note 55.

⁸² *Id.*; Honor MacNaughton et al., *Mifepristone and Misoprostol for Early Pregnancy Loss and Medication Abortion*, 103 Am. Fam. Physician 473, 477 (2021) (“For early pregnancy loss, the rate of unplanned aspiration attributed to persistent pain or bleeding is 8.8%

APCs would be unable to provide care for early pregnancy loss that, in their clinical judgment, is the best approach for their patients.⁸³

B. Medication Abortion Is More Straightforward Than Much Of The Healthcare Provided By APCs.

As a part of their everyday practice, APCs provide reproductive and non-reproductive healthcare that is far more complex than medication abortion. APCs insert and remove intrauterine contraceptive devices (“IUDs”) and other contraceptive implants and perform endometrial biopsies.⁸⁴ Inserting and removing an IUD involves placing an instrument through the cervix, and complicated removals may necessitate cervical dilation.⁸⁵ These procedures exceed the complexity involved in medication abortion.

Other non-reproductive healthcare provided by APCs that is more complex than medication abortion includes neuraxial anesthesia, central line insertions, arterial line insertions, intubations, chest tube insertions, surgical first assistance, colonoscopies, and endoscopies. All PAs, and other APCs with Drug Enforcement Administration registrations, can prescribe controlled substances, which are potentially dangerous and addictive and carry far greater risk than the medications used in medical abortions.⁸⁶ APCs also provide vital assistance in complex specialist procedures, including orthopedic, cardiac, and plastic surgery.⁸⁷

There is no principled basis for disallowing APCs from continuing to independently prescribe mifepristone, where permitted by state law, as they have successfully done since 2016.⁸⁸

when using combined regimens of mifepristone and misoprostol and 23.5% when using misoprostol alone.”).

⁸³ *Id.*

⁸⁴ Courtney B. Jackson, *Expanding the Pool of Abortion Providers: Nurse-Midwives, Nurse Practitioners, and Physician Assistants*, Women’s Health Issues S42, S42 (2011); Am. Pub. Health Ass’n, *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (2011), <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants>.

⁸⁵ Aimee C. Holland et al., *Preparing for Intrauterine Device Consults and Procedures*, Women’s Healthcare 37, 39 (2020).

⁸⁶ U.S. Dep’t of Justice, *Mid-Level Practitioners Authorized by State*, <https://www.deadiversion.usdoj.gov/drugreg/practioners/practioners.html>; PA Prescribing.

⁸⁷ Grant R. Martsolf et al., *Employment of Advance Practice Clinicians in Physician Practice*, 178 JAMA Intern. Med. 988, 988-90 (2018), <https://pubmed.ncbi.nlm.nih.gov/29710094/>.

⁸⁸ 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 (2023).

C. Advanced Practice Clinicians Provide Prenatal And Labor Care That Is As Safe and Effective, If Not More So, As The Care Provided By Physicians.

Childbirth is far more dangerous to women than abortion, and many APCs routinely manage deliveries.⁸⁹ Significantly, studies comparing the outcomes of prenatal and labor care provided by APCs and physicians demonstrate that APC care is often more effective than physician care.⁹⁰

One study comparing the outcomes of midwife- and obstetrician-provided care in low-risk pregnancies found that midwife care resulted in “less intervention in labor, higher rates of physiologic birth, and similar hospital length of stay” as compared to physician-provided care.⁹¹ Another study found that women receiving care from a midwife were at lower risk of cesarean and preterm birth and did not have increased risk of neonatal intensive care admissions, neonatal deaths, or severe maternal morbidity.⁹²

With respect to NPs, one study of women at high risk of delivering low-birth-weight infants found notably better outcomes and satisfaction rates for those receiving prenatal care from NPs at home than from physicians at hospital clinics.⁹³ As with abortion care, physicians themselves recognize the significant benefits of APCs providing women’s healthcare. Physicians in the study “approached the APNs [advanced practice nurses] with a patient they believed needed the [APN-led care] program and the APN expertise; the APNs had to remind them that this was a randomized controlled trial.”⁹⁴

IV. MAINSTREAM MEDICAL AND PUBLIC HEALTH GROUPS OVERWHELMINGLY SUPPORT THE PROVISION OF MEDICATION ABORTION CARE BY APCS.

Leading medical and public health groups support provision of medication abortions by APCs as a means of providing patients greater access to qualified healthcare providers.

⁸⁹ Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics & Gynecology* 215, 215 (2012); Y. Tony Yang et al., *State Scope of Practice Laws, Nurse-Midwifery Workforce, and Childbirth Procedures and Outcomes*, 26 *Women’s Health Issues* 262, 262 (2016).

⁹⁰ Yang et al., *supra* note 89, at 262 (women in states with autonomous practice laws for nurse-midwives have lower rates of cesarean delivery, preterm births, and low birth weight compared to women in states without such laws).

⁹¹ Vivienne Souter et al., *Comparison of Midwifery and Obstetric Care in Low-Risk Hospital Births*, 134 *Obstetrics & Gynecology* 1056, 1057 (2019).

⁹² Yiska Lowenberg Weisband et al., *Birth Outcomes of Women Using a Midwife Versus Women Using a Physician for Prenatal Care*, 63 *J. Midwifery & Women’s Health* 399 (2018).

⁹³ Dorothy Brooten et al., *A Randomized Trial of Nurse Specialist Home Care for Women with High-Risk Pregnancies: Outcomes and Costs*, 7 *Am. J. Managed Care* 793, 798-99 (2008).

⁹⁴ *Id.* at 802.

The American Public Health Association (“APHA”) is the largest organization of professionals dedicated to addressing public health issues and policies backed by science. APHA has advocated for the provision of abortion care by APCs since 1999, and has long recommended that medication abortion fall within this scope.⁹⁵ APHA also cites evidence to conclude that APCs “are well positioned within the healthcare system to address women’s needs . . . includ[ing] abortion care.”⁹⁶

The American College of Obstetricians and Gynecologists (“ACOG”) is the leading professional organization of physicians specializing in obstetrics and gynecology. ACOG recommends “support[ing] . . . clinical training for residents and advanced practice clinicians in abortion care in order to increase the availability of trained abortion providers,” alongside calling for increased hiring of APCs trained in abortion care.⁹⁷ ACOG also has called for the cease and repeal of “requirements that only physicians or obstetrician-gynecologists may provide abortion care. . . .”⁹⁸

The American Medical Women’s Association (“AMWA”) is dedicated to the advancement of women in medicine and the improvement of women’s health. AMWA has pledged to “work to increase the number of abortion providers by supporting initiatives to improve and increase training for medical students, residents and physicians in the full range of abortion procedures, and to add adequately trained [APCs] to the pool of potential abortion providers.”⁹⁹

The positions of these medical and public health organizations reflect and support the recommendations that organizations representing APCs have long asserted regarding APCs’ ability to provide abortion care. Since 1991, Signatory NPWH has maintained that abortion care is within WHNPs’ scope of practice.¹⁰⁰ This policy has been reaffirmed, with NPWH stating in its guidelines that “a WHNP program curriculum . . . prepares the [NP] with distinct competencies to provide advanced assessment, diagnosis, and management,” including the ability to “[p]rovide medication abortion.”¹⁰¹ NPWH’s recent 2026 position statement affirms that abortion is within

⁹⁵ Am. Pub. Health Ass’n, *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (2011), <https://www.apha.org/policy-and-advocacy/public-health-policy-briefs/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants>.

⁹⁶ *Id.*

⁹⁷ Am. Coll. Obstetricians & Gynecologists, *Abortion Training and Education*, Committee Opinion No. 612 (2014), <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/11/abortion-training-and-education>; Am. Coll. Obstetricians & Gynecologists, *Issue Brief: Advanced Practice Clinicians and Abortion Care Provision* (2023), <https://www.acog.org/advocacy/abortion-is-essential/trending-issues/issue-brief-advanced-practice-clinicians-and-abortion-care-provision>.

⁹⁸ *Id.*

⁹⁹ Am. Med. Women’s Ass’n, *Position Paper on Principals of Abortion & Access to Comprehensive Reproductive Health Services*, <http://amwa-doc.org/wp-content/uploads/2025/06/Principals-of-Abortion.pdf>.

¹⁰⁰ Nat’l Abortion Fed., *Strategies for Expanding Abortion Access: The Role of Physician Assistants, Nurse Practitioners, and Nurse-Midwives in Providing Abortions* 22 (1997).

¹⁰¹ NPWH, *Guidelines for Practice and Education* 13-14 (2022).

WHNPs' professional scope, calls for expanded telehealth access, and opposes all legislative restrictions on APC-provided abortion.¹⁰² In 2019, Signatory ACNM asserted, and re-affirmed in 2025, that "medication abortion may be safely provided by trained advance practice clinicians (APCs), including midwives."¹⁰³

The views of these professional organizations are shared more globally. Since 2012, the World Health Organization ("WHO") has emphasized the importance of APC-provided abortion care. In a policy guidance paper, the WHO noted: "[s]ince the advent of vacuum aspiration and medical abortion, [] abortion can be safely provided by a wide range of health workers in diverse settings" and recommended that APCs be permitted to deliver medication abortion using mifepristone plus misoprostol, or misoprostol alone, at up to 12 weeks gestational age.¹⁰⁴

The message of these organizations is clear: the provision of medication abortion involving mifepristone falls well within APCs' scope of practice. Promoting women's health, which the Signatories aim to do, is best achieved by allowing APCs to broadly and independently provide medication abortion as they have been doing for many years. These professional organizations made their assessment based not only on scope of practice norms, but also on the well-established safety record of mifepristone. Decades of safety and efficacy research support the use of mifepristone by APCs and this data has become more, not less, persuasive and extensive since the FDA correctly reached this same conclusion in 2016. There is no reason to disturb that conclusion now. Doing so would be "devastating to abortion and miscarriage care."¹⁰⁵

V. CONCLUSION

The Signatories urge the FDA to refrain from imposing additional or increased restrictions on mifepristone, consistent with citizen petitions FDA-2025-P-0377-0001, FDA-2025 P-0377-0250, FDA-2025-P-1576-0001, FDA-2025-P-3287-0001, and FDA-2025-P-2162-0001.

Sincerely,

National Association of Nurse Practitioners in Women's Health

American College of Nurse-Midwives

Association of Physician Associates in Obstetrics and Gynecology

¹⁰² NPWH, *Access to Abortion Care: WHNP Role as Abortion Provider and Advocate* (2026), https://npwh.org/resource/resmgr/positionstatement/2026/NPWH_PositionStatement_Abort.pdf.

¹⁰³ Am. Coll. Nurse-Midwives, *Midwives as Abortion Providers* (2025), https://midwife.org/wp-content/uploads/2025/04/2025-ps_midwives-as-abortion-providers_amended.pdf.

¹⁰⁴ World Health Org., *Abortion Care Guideline*, 2nd ed. 68 (2025), <https://iris.who.int/bitstream/handle/10665/349316/9789240039483-eng.pdf?sequence=1>.

¹⁰⁵ Interview with Julie Jenkins, *supra* note 44.