

## SECTION II.

# ADVANCED PRACTICE CLINICIANS AS ABORTION PROVIDERS

### OBJECTIVES:

1. Describe the differences and similarities among CNMs, NPs and PAs.
2. Summarize the history of APCs in providing abortion care.
3. Supply evidence of the safety of abortion care provided by APCs.
4. Examine the barriers APCs face in providing abortion care.

## A. APCS WITHIN THE HEALTH CARE SYSTEM

*Healthy People 2010* articulates a national health goal of decreasing unintended pregnancies.<sup>6</sup> Although abortion rates have decreased overall since the late 1990s, they have risen among poor and low-income women, in part due to limited access to family planning services (Jones, Darroch, & Henshaw, 2002). Limited access to quality health care services is not a new problem. Over the past several decades, one response to our population's burgeoning demand for health care services has been to educate and credential additional categories of health care professionals in the workforce. NPs, CNMs, and PAs have been recognized as qualified and effective primary care providers for the past 40 years. Figure II.1 explains the differences and similarities among three groups of health professionals.

NPs, CNMs, and PAs are especially important in our health care delivery system because they are more likely than physicians to practice in medically underserved settings (IOM Committee on Primary Care & Donaldson, 1996). Clearly, APCs are especially well positioned within the health care system to address women's need for comprehensive primary preventive health care that includes abortion care.

In 1990, the National Abortion Federation (NAF) and the American College of Obstetricians and Gynecologists (ACOG), concerned about the increasing shortage of abortion providers, convened a national symposium: *Who Will Provide Abortions? Ensuring the Availability of Qualified Practitioners*. The final report from this symposium concluded that "appropriately trained midlevel clinicians...offer considerable promise for expanding the pool of abortion providers" and recommended abortion training for CNMs, NPs, and PAs (National Abortion Federation, 1990). The following year, the American Public Health Association issued a resolution acknowledging the public health impact of unintended pregnancy and confirming the organization's support for training APCs to provide abortion care (American Public Health Association, 1992). In 1997, NAF convened a second national symposium: *The Role of Physician Assistants, Nurse Practitioners, and Nurse-Midwives in Providing Abortions: Strategies for Expanding Abortion Access*. It was determined that strategies for expanding abortion access should be centered on overcoming notions that abortion is a dangerous procedure that only physicians can perform safely; developing a carefully planned state-by-state effort to overcome current legal restrictions; and increasing and expanding education and training for CNMs, NPs, and PAs (National Abortion Federation, 1997).

<sup>6</sup> *Healthy People 2010*, a public health compendium of national health goals, objectives, and tracking methods, is a roadmap for improving the health of all Americans. It includes 10 leading health indicators that are used to measure the nation's health over one decade (Healthy People 2010, 2004). Grounded in science, the *Healthy People 2010* national health indicators were selected because they motivate action and are important public health issues and data are available to measure progress. Improving responsible sexual behavior with the goal of improving pregnancy planning, preventing unintended pregnancy, and improving the health and well-being of women, infants, and families is the cornerstone of the national reproductive health goals in *Healthy People 2010* (Office of Population Affairs & Department of Health and Human Services, 2001)

As primary care providers for women, APCs can be part of the solution to increase community access to early abortion and postabortion contraceptive care. The marginalization and separation of reproductive health services, including abortion, from other health care services interfere with continuity of care and disrupt the protective effect of primary care. The skills used in early aspiration abortion are also necessary tools for safely managing other causes of early pregnancy loss, common conditions that affect the health status of a significant proportion of women during their reproductive years.

### FIGURE II.1

#### *NPs, CNMs, and PAs: Training and Clinical Roles*

##### **Nurse Practitioner**

A nurse practitioner (NP) is an advanced practice registered nurse who has advanced education (typically a master's degree) and extensive clinical training in both the NP role (e.g., acute or primary care) and one or more population practice areas (e.g., family, women's health) and specialty practice areas (e.g., high-risk perinatal, infertility, abortion care). NPs diagnose and manage patient care for many acute and chronic illnesses, and they also provide preventive care. Most states require that an NP achieve either a master's degree or national certification (or both). NPs are independently licensed, work collaboratively with other health care professionals, and have prescriptive authority in some form in all states. There are more than 140,000 NPs in the United States (New York Center for Health Workforce Studies, 2006).

##### **Certified Nurse-Midwife**

A certified nurse-midwife (CNM) is an advanced practice registered nurse who has advanced education (masters or doctorate) and training in both midwifery and nursing and is certified by the American Midwifery Certification Board. The American College of Nurse-Midwives (ACNM), the professional organization for CNMs, defines midwifery practice as "the independent management of women's health care, focusing particularly on common primary care issues, family planning and gynecologic needs of women, pregnancy, childbirth, the postpartum period and the care of the newborn" (American College of Nurse-Midwives, 2004). CNMs have prescriptive authority in some form in all states. There are approximately 11,500 certified CNMs (29,000 dually certified NPs and CNMs) in the United States (New York Center for Health Workforce Studies, 2006; ACNM, 2009).

##### **Physician Assistant**

Physician assistants (PAs) are certified to practice medicine with physician supervision (indirect); they provide health care services that range from primary care to very specialized surgical services. PAs, regulated by state medical boards, diagnose and treat illnesses, counsel on preventive health care, assist in surgery, and write prescriptions. There are approximately 66,000 licensed PAs in the U.S. who are graduates of accredited PA programs associated with medical schools (American Academy of Physician Assistants, 2009).

## B. APCS' HISTORY OF PROVIDING COMPREHENSIVE WOMEN'S HEALTH CARE, INCLUDING ABORTION

APCs play a large and vital role in providing women with comprehensive reproductive health care services and reaching the goals set forth in the Healthy People Initiative (U.S. Department of Health and Human Services, 2000). Women in particular are more likely to receive care from APCs than from physicians. A 2004 study found that APCs saw six times as many women as did physicians for publicly funded family planning services (Frost & Frohwirth, 2005). Another study found that APCs performed 73% of initial contraceptive exams in publicly funded clinics (Finer, Darroch, & Frost, 2002).

APCs in all specialties, including primary care, are prepared in a wide range of procedures that are recognized to be within their scope of practice and require the development of specialized skills. Examples include: cardiovascular procedures such as central venous catheter

insertion and stabilization of cardiovascular penetrating injuries; circumcision; dermatologic procedures such as abscess incision and drainage, cyst excision, skin biopsy and removal, and suturing of simple lacerations; orthopedic procedures such as dislocation reduction, arthrocentesis, and lumbar puncture; foreign body removal; gastrointestinal procedures such as nasogastric (NG) tube placement, paracentesis, and sigmoidoscopy; and respiratory procedures such as chest tube insertion, suturing and removal, cricothyrotomy, and thoracentesis (Springhouse, 2001). All of these specialized procedures can be found within APC scope of practice as defined by various professional associations and state regulatory boards.

Likewise, APCs specializing in women's reproductive health have acquired numerous advanced skills that are now considered common practice. For example, these clinicians may administer paracervical anesthesia, insert intrauterine devices, perform intrauterine aspirations and vulvar biopsies, perform colposcopies and cervical biopsies, perform and interpret ultrasound exams, conduct intrauterine inseminations, perform and repair episiotomies, suture lacerations, and incise and drain abscesses. They also prescribe a wide variety of medications, including hormonal contraception and, in many states, controlled substances (Barber, 1997; Luterzo, Mahoney, Armstrong, Parker, & Alvero, 2004; Springhouse, 2001). For many years, APCs providing reproductive health care have provided assessment and appropriate referrals as well as follow-up care for patients seeking pregnancy termination. It is a natural extension of practice for these APCs to provide early abortion as a part of comprehensive care. Figure II.2 lists studies documenting the safety of APC provision of abortion care.

## FIGURE II.2

### *Studies Documenting Safety of Abortion Care by APCs*

*In 4 studies and almost 10,000 patient procedures, no significant differences were found between nurse practitioners, midwives, physician assistants and physicians in the outcomes of first trimester abortion provision. No major complications such as hospitalizations or deaths were reported for physicians or APCs. For a comprehensive review of the literature on PA, NP, and CNM provision of abortion care in the U.S. and globally, see Berer (2009).*

Warriner et al. (2006) reported findings from randomized, control trials conducted in South Africa and Vietnam (n=2,789 procedures). In both countries, the patient outcomes provided by PAs and midwives were comparable to those of physicians.

Goldman et al. (2004) compared outcomes of 1,363 aspiration abortions provided by PAs with those of physicians. They found no differences in complications related to the type of providers.

Boyman et al. (2004) examined 1,976 first trimester aspiration abortion procedures. They compared outcomes for 10 physicians with those for 5 NPs and 2 PAs and found no significant differences between physician and APC outcomes: immediate complications were rare (<1%), and delayed complication rates were low (<2%).

Freedman et al. (1986) found no differences in complication rates between experienced PAs and MDs with respect to overall, immediate, or delayed complications in 2,458 procedures.

In fact, APCs have been providing safe abortion care to women since 1973, the same year that *Roe v. Wade* made abortion legal throughout the United States (National Abortion Federation, 1997). Eight years after this major social, legal, and medical milestone, the first study was conducted in Vermont comparing PA and physician complication rates in first trimester abortion; the study found no difference in overall, immediate, or delayed complication rates between physicians and PAs providing abortion care (Freedman, Jillson, Coffin, & Novick, 1986). Several years later, a similar study confirmed these results (Goldman, Occhiuto, Peterson, Zapka, & Palmer, 2004). Other studies have documented the safety of APCs providing abortion, comparing outcomes of NPs and PAs with those of physicians, and confirmed

comparable rates of safety and efficacy (Boyman, Gibson, & Forman, 2004; Vaz, Bergstrom, Vaz Mda, Langa, & Bugalho, 1999; Warriner et al., 2006). Most studies, particularly in the United States, have focused on comparing rates of complications using aspiration procedures.

## C. BARRIERS TO ABORTION PROVISION BY APCS

As the rhetorical claims of the anti-abortion movement intersect with challenges to APC scope of practice from within and outside the professions, APCs face a multiplicity of barriers to abortion provision. These include the confusion occasioned by the interstate variation of APCs' regulatory environments, each governed by complex set of laws, regulations, and education standards. In addition, the long-standing efforts of organized medicine to use the political process to control scope of practice generally must be reckoned with. For example, the American Medical Association (2006, 2007) and other physician organizations (coordinated through the AMA Scope of Practice Partnership Project) consistently and explicitly oppose any expansion of scopes of practice by providers "other than medical doctors".<sup>7</sup>

### FIGURE II.3

#### *State Advocacy Efforts to Overcome Barriers*

Since 2000, the Abortion Access Project (AAP) ([www.abortionaccess.org](http://www.abortionaccess.org)) and coalition partners have been conducting legal research in individual states to assess opportunities for APCs to provide abortion care. Where conditions are favorable, AAP convenes stakeholders to develop suitable strategies and to address existing barriers. In some states, an effective strategy may focus on seeking an Attorney General Opinion or advocating for a change in legislation to incorporate provider-neutral language.

In other states, opinions from regulatory boards may be sought by institutions employing APCs, by professional associations advocating for APCs, or by individual clinicians. In some cases, decisions regarding APCs and abortion care have been triggered by challenges to individual clinicians' scope of practice. Although these decisions have largely been favorable, the process is stressful, time-consuming, and costly for the clinician involved and requires coordinated effort on the part of advocates.

In states where conditions may not be favorable, stakeholders don't proceed, or APCs are advised not to proceed to advance scope of practice to include abortion provision, there are incremental activities that clinicians can be involved in to promote access to early abortion care. Refer to the side-bar information on page 25 and/or contact the Abortion Access Project for more detailed information. In the next sections of the *APC Toolkit*, both proactive and reactive strategies are proposed to help clinicians before they are faced with a scope of practice challenge.

Increasing support and enthusiasm for APCs as abortion providers in recent years has been undermined by unclear laws and other regulatory and professional barriers that either explicitly discourage APCs from providing abortion care or create enough confusion that APCs and their advocates are hesitant to move forward with training and service provision for fear of reprimand or professional consequence.

As noted previously, many states have laws that specify that only physicians can perform abortion procedures. It is worth noting that in several physician-only states, subsequent interpretations of the law have authorized APCs to provide various types of abortion care. In addition, PAs are licensed to practice medicine under the supervision of a physician, which

<sup>7</sup> AMA Scope of Practice Partnership: "Our AMA will take a lead role in coordinating medicine's response to proposed scope expansions that are not warranted by non-physicians' education, training or experience. The Scope of Practice Partnership (SOPP) provides a foundation for these activities." (<http://www.ama-assn.org/ama1/pub/upload/mm/475/902.pdf>)

means that the supervising physician can delegate procedures or care to the PA (as long as the procedures have been recognized as within the PA's skill set).

Lack of training opportunities is another barrier to abortion provision by APCs. A national survey conducted in 2005 found that only 53% of APC educational programs included didactic training in at least one abortion procedure (MVA, EVA, or medication abortion) and only 20% provided clinical training in at least one type of abortion procedure (Foster et al., 2006).<sup>8</sup> Including the principles of abortion care in basic and post-graduate APC programs is an important way to disseminate the recognition that abortion is within the APC's scope of practice.

#### FIGURE II.4

### *Critical Role of Professional Organizations*

Professional organizations must continue to engage as allies in the effort to promote APCs as abortion care providers. In 1991 and 1992, four professional organizations adopted policy resolutions acknowledging the practice of abortion as within the scope of APCs. They are:

- the American Public Health Association (APHA, 1992),
- the National Association of Nurse Practitioners in Reproductive Health (NANPRH), now Nurse Practitioners in Women's Health (NPWH, 1991),
- the American College of Nurse-Midwives (ACNM, 1991), and
- the American Association of Physician Assistants (AAPA, 1992).

Three physicians' organizations have also adopted position statements to address the shortage of abortion providers:

- In 1994 ACOG "encouraged programs to train physicians and other licensed health care professionals to provide abortion care in collaborative settings" (National Abortion Federation, 1997, p. 17), and
- In 1999 both the American Medical Women's Association (AMWA) and Physicians for Reproductive Choice and Health (PRCH) endorsed the training of APCs to provide abortion care. (National Abortion Federation & Clinicians for Choice, 2009)

## SUMMARY

- The services provided by NPs, CNMs, and PAs are of vital importance to the population and to the nation's health care system.
- As key primary care providers for women, APCs are in an especially good position to decrease the risks and consequences of unintended pregnancy, a major national health goal.
- Reintegrating abortion care into primary care, family practice, and comprehensive women's health care services will increase women's access to safe, early abortion.
- Numerous studies document that APCs are safe, competent providers of abortion care.
- APCs already routinely perform many procedures that are at least as complex as early aspiration abortion.
- APCs face many barriers in their efforts to integrate abortion care into their practices. However, important advances include expanding training opportunities, legal and regulatory victories, and increasing support within professional associations.

<sup>8</sup> See Specialty Education and Training in Abortion Care (Section V.A) for a thorough review of these studies and Section IV-C for educational and training resources.

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