

SECTION IV.

ADVANCING ABORTION INTO APC SCOPE OF PRACTICE: EVIDENCE AND METHODS

OBJECTIVES:

1. Identify the four categories of evidence necessary to establish abortion care as within APC scope of practice.
2. Discuss the historical evidence from professional organizations (e.g., position statements on abortion care) supporting APCs as abortion providers.
3. Identify specific references to abortion care within the essential documents of APC practice (e.g., practice standards, competencies, and ethical codes).
4. Identify evidence of abortion care education and training opportunities for APCs.
5. Identify the evidence of legislative, legal and regulatory environments supporting APCs as abortion providers.
6. Describe professional and regulatory models for assessing or advancing changes in scope of practice.
7. Examine case studies of NPs and PAs who have successfully incorporated abortion care into their practices.

For abortion care to be considered part of APC scope of practice, four categories of evidence must be examined: historical, professional/clinical, education/training, and legal/regulatory environment. The accumulated evidence for abortion care as within APC scope of practice must then be linked with patient safety and health care quality issues. Section IV looks at the evidence category by category as it relates to provision of abortion care by APCs:

- **Historical evidence:** APC and other professional organizations support CNMs, NPs, and PAs as appropriate providers of abortion care.
- **Professional/clinical evidence:** The evidence for abortion care as within APC scope of practice lies within the essential documents developed by CNM, NP, and PA organizations—population, specialty, and ethical practice standards as well as clinical and professional competencies. Clinical evidence demonstrating the safety of abortion was cited in Section I.
- **Education/training evidence:** There is evidence of abortion care education in entry-level APC programs, with clinical training lagging didactic education. However, education and training in abortion care knowledge and skills, including medication and aspiration abortion provision, are offered in a number of postgraduate training programs. Establishing the existence of training opportunities is important evidence but is not sufficient to provide argument that abortion care is a natural extension of APC scope of practice. There is a two-way street between education and training and the regulatory environment in the attempt to prove abortion as within APC scope of practice. On the one hand, the more common education related to abortion care becomes in APC training programs, the stronger the case that can be made for advancing APC scope of practice. On the other hand, positive regulatory and legal decisions related to scope of practice support greater student access to abortion education and training.
- **Evidence of Legislative, Legal & Regulatory Environments:** Despite the regulatory impediments resulting from vague or outdated practice acts and rules, especially in the politically charged context of abortion care, state Attorney General opinions along with

health professional regulatory advisories have been issued in a number of states to clarify APC authority to perform abortions. Licensing boards in two states have established that abortion care is within the scope of practice of appropriately prepared advanced practice nurses, offering a template for other jurisdictions to follow in reconciling their legal authority over APCs' legal scope of professional practice.

Individual APCs, APC professional organizations, APC educators, and reproductive health care advocates can use this evidence in a number of ways to advance APC practice of abortion. For example, they can:

- develop a professional portfolio that incorporates abortion care competencies and experience (see Figure V.2 in Section V.B)
- submit materials to a state licensing board documenting that abortion care falls within the essential scope of practice elements
- respond to a request from a practice advisory committee of a state regulatory board to document how scope of practice has advanced for abortion care
- support abortion care as part of APC scope of practice if an APC who is already performing abortions is investigated by a state regulatory board
- help APC educators develop abortion care education and training programs
- educate legislators and policy makers, testify before legislative committees, and draft public statements in support of abortion care as part of APC scope of practice

In this section, we describe how these evidentiary categories can be incorporated into the standards and mechanisms used by national APC organizations and state licensing boards to consider whether abortion care (or any new practice) is within professional scope of practice. Finally, we present case studies from Alaska, Arizona, Montana, New York, and Oregon outlining the experiences of advanced practice clinicians who succeeded in incorporating abortion care into their practices.

A. PROFESSIONAL-ORGANIZATION POSITION STATEMENTS ON ABORTION CARE BY APCS

APC professions and interdisciplinary organizations representing health professionals who provide reproductive health care services codify practice responsibilities through ethical codes of conduct and position statements that set out the role of PAs and advanced practice nursing roles of CNMs, NPs, in upholding patient rights and autonomy and in treating patients with respect and compassion. These documents, copies of which are available directly from the organizations, provide an ethical and legal mandate that APCs ensure patient access to comprehensive reproductive health services including, at a minimum, preconceptional care including contraception counseling, pregnancy options counseling and abortion care (American Academy of Physician Assistants, 2000; American College of Nurse-Midwives, 1997b; American Nurses' Association, 1989; Association of Reproductive Health Professionals, 2008; Association of Women's Health, Obstetric and Neonatal Nurses, 1999; National Organization of Nurse Practitioner Faculties, 2002; Nurse Practitioners in Women's Health, 1991).

All APC professional organizations can be considered pro-choice organizations.

All national APC professional organizations as well as groups including the medical specialty and public health organizations assert the obligation of their professions to assure quality reproductive health services that guarantee reproductive choice and patient autonomy.

Since 1989, the **American Nurses Association** (ANA) has defined itself as a “pro-choice organization” with the publication of its position on reproductive rights and the role of the nurse:

ANA believes that the health care client has the right to privacy and the right to make decisions about personal health care based on full information and without coercion. It is the obligation of the health care provider to share with the client all relevant information about health choices that are legal and to support that client regardless of the decision the client makes. Abortion is a reproductive alternative that is legal and that the health care provider can objectively discuss when counseling clients. If the state limits the provision of such information to the client, an unethical and clinically inappropriate restraint will be imposed on the provider and the provider-client relationship will be jeopardized. (ANA, 1989, p. 1)

The philosophy of the **American College of Nurse-Midwives** (ACNM) on abortion has changed over the years, with the current policy emphasizing women’s autonomy: “Certified nurse-midwives (CNMs) and certified midwives (CMs) believe that every individual has the right to safe, satisfying health care with respect for human dignity and cultural variations” (ACNM, 1997b, p. 1). The ACNM has adopted the following positions: that every woman has the right to make reproductive choices; that every woman has the right to access factual, unbiased information about reproductive choices, in order to make an informed decision; and that women with limited means should have access to financial resources for their reproductive choices.

The **American Academy of Physician Assistants** (AAPA) opposes attempts to restrict the availability of reproductive health care. In 1992, the AAPA House of Delegates affirmed “a patient’s right of access to any legal medical treatment or procedure made with the advice and guidance of the patient’s health care provider and performed in a licensed hospital or appropriate medical facility” (AAPA, 1992). More specifically, the AAPA opposes any intrusion into the provider/patient relationship through restrictive informed consent laws, biased patient education or information, or restrictive government requirements concerning medical facilities. This 1992 policy is reflected in current policy statements: “Patients have a right to access the full range of reproductive health care services, including fertility treatments, contraception, sterilization, and abortion” (AAPA, 2008a, p. 6). **The Association of Physician Assistants in Obstetrics and Gynecology** (APAOG) supports the 1992 policies of the AAPA regarding reproductive health (APAOG, 1992; NAF, 1997, p.22; NAF, 2009).

APC professional organizations support CNMs, NPs, and PAs as abortion providers.

Not only do many APC professional organizations support reproductive choices for patients, a number have policy statements supporting APCs as abortion providers.

Nurse Practitioners in Women’s Health (NPWH, formerly the National Association of NPs in Reproductive Health), along with the ACNM, have a tradition of reproductive rights advocacy and promotion of access to women’s health services. They are the only professional nursing organizations to formally support advanced practice nurses as abortion providers.

An NPWH policy resolution passed in 1991 states that NPs in women’s health “assure quality reproductive health services which guarantee reproductive freedom” and that “nurse practitioners, with appropriate preparation and medical collaboration, are qualified to perform abortions” (NANPRH/NPWH, 1991; NAF, 1997, p. 22; NAF, 2009).

In 1991, the **ACNM** rescinded a 1971 policy prohibiting nurse-midwives from providing abortions, essentially allowing individual CNMs the option of becoming involved in abortion

care (Summers, 1992). More recently, the **International Confederation of Midwives** (ICM) approved a new position statement recognizing the important role of midwives in providing abortion-related services in countries where abortions are legal (F. Likis, personal communication, October 2008).

In 1997, recognizing that PAs had been providing abortion care since 1973, the **AAPA** clarified its position on the role of PAs in abortion care. The AAPA “believes that PA practice should not be arbitrarily limited by political considerations, but rather should be determined by patient needs, physician delegation, and PAs’ training, experience, skills, and choice” (NAF, 1997, p. 25). The **APAOG** reaffirmed its support for AAPA policies in 1997.

Public health, physician, and specialty organizations support CNMs, NPs, and PAs as abortion providers.

The **American Public Health Association** (APHA) in three resolutions¹⁵ supports “provision of first trimester surgical and medical abortion by appropriately trained NPs, CNMs, and PAs” and urges health professionals and educators to work together to provide training and practice opportunities for CNMs, NPs, and PAs in abortion care (APHA, 1999; NAF 1997, p. 23).

NAF has long been in support of CNMs, NPs, and PAs as abortion providers. The federation has taken the lead in two national symposia that resulted in position statements and policy direction for promoting CNMs, NPs, and PAs as abortion providers (NAF, 1990; NAF, 1997).

The **American College of Obstetricians and Gynecologists** (ACOG), in a 1994 statement, “encourages programs to train physicians and other licensed health care professionals to provide abortion care in collaborative settings” to address the shortage of health care providers who perform abortions (NAF, 1997, p. 22).

In 1999, two physician groups, the **American Medical Women’s Association** (AMWA) and **Physicians for Reproductive Choice and Health** (PRCH) issued statements supporting the training of all health professionals in abortion care, including CNMs, NPs, and PAs (NAF, 2009).

B. ESSENTIAL ELEMENTS OF PROFESSIONAL PRACTICE THAT ESTABLISH APCS AS QUALIFIED PROVIDERS OF ABORTION CARE

The evidence for abortion care as APC scope of practice lies within the essential documents that have been developed by CNM, NP, and PA organizations: ethical clinical practice and professional performance standards as well as clinical and professional competencies. Four organizations have developed role, population, and specialty practice standards, clinical competencies, and educational credentialing for advanced practice nurses in women’s health. They are the Association of Women’s Health, Obstetrics and Neonatal Nurses (AWHONN), the National Organization of Nurse Practitioner Faculties (NONPF), Nurse Practitioners in Women’s Health (NPWH), and the American College of Nurse-Midwives (ACNM). In addition, the Association of PAs in Obstetrics and Gynecology (APAOG) aims to promote clinical and academic excellence for PAs practicing in women’s health. Interdisciplinary (Association of Reproductive Health Professionals [ARHP]) and specialty (NAF) organizations have developed abortion-specific standards and clinical policies that provide the foundation for abortion care, specialty professional practice, and specialty education and training.

Using the general framework of the essential elements of scope of practice delineation, we provide examples from the APC and specialty organizations demonstrating the evidence for abortion care as part of APC scope of practice, standards, competencies, and professional ethical behavior.

¹⁵ APHA Resolution No. 7626 (1976); APHA Resolution No. 9117 (1991); APHA Resolution No. 9917 (1999).

Practice Philosophies by Organization

The **ANA** Social Policy Statement (ANA, 2003), first published in 1980 and currently under revision in 2009, defines professional nursing (including advanced practice nursing) as a multifaceted social contract between nurses and the public. Several sections of the statement are applicable to this discussion. APC provision of abortion expands access to care and is in alignment with the ANA goal that “the lack of accessible, available, and acceptable healthcare services and resources are complex issues that must be addressed to improve the quality of care” (ANA, 2003, p. 3). Clarification of policy issues related to abortion care and its subsequent availability or lack thereof, is part of the professional nurse’s responsibility to address injustice in a systematic manner (ANA, 2008, p. 5). ANA policies can be interpreted to include the incorporation of advanced practices such as abortion care as part of the profession’s growth, as reflected in this statement: “Professional nursing’s scope of practice is dynamic and continually evolving. The scope of practice is characterized by a flexible boundary that is responsive to the changing needs of society and the expanding knowledge base of applicable theoretical scientific domains” (ANA, 2008, p. 9).

The **ACNM** *Philosophy of Midwifery Care* states that midwifery practice emphasizes safe, competent clinical management with an emphasis on patient self-determination. Meeting this practice standard requires individual CNMs to examine if the care they are providing is safe and if it is provided at a skilled and competent level; if not, then the care the patient needs or requires is not within the CNM’s scope of practice (ACNM, 2004). The ICM further clarified the ACNM philosophy in 2008, when it approved a new position statement recognizing the important role of midwives in providing abortion care in countries where abortions are legal (B. Lynch, RM, written communication, September 2008).

According to the **AAPA**, PA scope of practice flows from a medical model of practice that involves the PA, the physician, and the patient. The clinical role of PAs includes primary and specialty medical care in medical and surgical practice settings with direct or indirect physician supervision. In general, PA scope of practice includes any legal medical service (including abortion care) that is delegated to the PA by the supervising physician when the service is within the PA’s skills and is provided with supervision of a physician (AAPA, 2008b).

Practice and Professional Performance Standards by Organization

Clinical/ethical standards and competencies are at the core of all professional practice. For the professional organizations, regulatory boards, and educators to accept abortion as part of APC practice, these essential elements must be aligned and clearly explicated. Licensing boards want

Glossary: Standards of practice define safe practice, describe a competent level of care, address practice qualifications, document basic and advancing practice, and provide the yardstick for measuring practice.

Glossary: Standards of professional performance describe a competent level of behavior in the professional role—including activities related to quality of practice, education, ethics, professional practice evaluation, collaboration, resource utilization, and leadership.

to hear that the individual NP, CNM, or PA, along with their representing professional organizations, can articulate the relationship between the core standards (both practice and performance), competencies, and ethical principles and abortion care.

NAF’s evidence-based *Clinical Policy Guidelines (CPGs)* include standards of practice and education for abortion care “performed by licensed physicians or licensed/certified/registered midlevel clinicians¹⁶ trained in the provision of abortion care, in accordance with state law” (2007, p. 1). The NAF CPGs were developed by consensus, based on rigorous review of the relevant

¹⁶ As noted in the *APC Toolkit* introduction, *midlevel clinician* is an earlier designator for APC.

clinical and scientific literature and known patient outcomes. The NAF CPGs are intended to provide a basis for ongoing quality assurance, to be applied rigidly, and to be followed in virtually all cases. The abortion care standards apply to all providers; APCs are evaluated in the same capacity as physicians performing the same procedures.

Since 2003, the **ACNM** has required that CNMs meet eight minimum practice standards, including the requirement to establish practice guidelines for each specialty area of practice, such as abortion care (Standard V). ACNM Standard VIII outlines policies and procedures for expanding midwifery practice beyond the ACNM core competencies to incorporate new procedures that improve care for women (ACNM, 2003).

AWHONN and **NPWH**, building upon general standards of practice of the **AANP**, provide standards and competencies related to the population focus (women's health) as well as the specialty practice of NPs in primary care and reproductive health. AWHONN addresses practice, research, and education standards in women's health, obstetric, and neonatal nursing specialty practice. AWHONN and NPWH jointly prepared *The Women's Health Nurse Practitioner: Guidelines for Practice and Education* (2002) containing the standards for the women's health NP role. Practice standards for women's health NPs (WHNPs) apply to assessment; diagnosis; health promotion; disease prevention; provision of clinical management for women having uncomplicated gynecologic problems; and provision of family planning and uncomplicated pregnancy care across the preconception, prenatal, and postpartum periods. Provision of abortion care by WHNPs would need to meet these general standards as well as NAF's standards for quality abortion care.

The PA profession does not formally specify practice standards beyond medical care standards. For example, ACOG-established practice standards for physicians specializing in obstetrics and gynecology would apply to PAs providing women's health care. A PA providing abortion care would be required to adhere to the abortion care standards in the NAF CPGs (AAPA, 2008e).

Practice Competencies by Organization

Glossary: Competence requires the ethical adaptation and integration of knowledge and skills into the behaviors needed in a particular context.

The APC professions and other standard-setting bodies establish standards that articulate expectations for the behaviors that comprise competence. The knowledge, skills, and behaviors necessary for APC practice are

specific to current professional standards and the context in which APCs practice.

Professional standards and competencies set acceptable limits for minimum, as well as advanced, scope of practice boundaries. Core competencies for basic APC practice delineate the fundamental knowledge, skills, and behaviors expected of a new practitioner and constitute the requisites for graduates of accredited APC education programs. The following paragraphs highlight competencies related to abortion care for each APC professional organization.

According to **ACNM** basic midwifery core competencies, the midwife "independently manages primary health screening and health promotion of women from the perimenarcheal through the postmenopausal periods" (ACNM, 2008, p. 4). This includes "clinical interventions and/or referral for unplanned or undesired pregnancies..." (p. 4). Basic midwifery practice also includes procedural competency in techniques for administration of local anesthesia, spontaneous vaginal delivery, third stage management, and performance and repair of episiotomy, repair of lacerations, and management of spontaneous or incomplete abortion (ACNM, 2008). The **ICM's** *Essential Competencies for Basic Midwifery Practice* includes knowledge of factors involved in decisions about unplanned or unwanted pregnancies and care and counseling needs during and after abortion (ICM, 2002). Expansion of these essential competencies to include abortion care by CNMs is planned for 2009 (A. Levi, CNM, personal communication, March 2009). The scope of CNM practice may also be advanced beyond the core competencies to incorporate abortion

care skills and procedures that improve care for women and their families by following the guidelines outlined in Standard VIII of the *Standards for the Practice of Midwifery* (ACNM, 2003).

The foundation for all NP practice, including NPs in women's health practice, is the *Nurse Practitioner Primary Care Competencies in Specialty Areas: Adult, Family, Gerontological, Pediatric, and Women's Health* (National Organization of Nurse Practitioner Faculties [NONPF] & American Association of Colleges of Nursing, 2002). These guidelines are now published by the U.S. Bureau of Health Professions and Division of Nursing and are available online through NONPF. Both **NPWH** and **AWHONN** collaborated with **NONPF** to develop these core competencies for NPs providing women's health care. According to these NP competency guidelines, upon graduation or entry into practice, the NP should demonstrate competence in all of the core competency domains and in the specific competencies relevant to women's health practice. These competencies do not preclude abortion care provision. For example, under Competency I-C, Plan of Care and Implementation of Treatment, an NP in women's health is expected to "perform primary care procedures, including but not limited to, pap smears, microscopy, post-coital tests, intrauterine device (IUD) insertion, and endometrial biopsies" (p. 37) and to facilitate "access to reproductive health care services and provide referrals that are provided in an unbiased, timely, and sensitive manner (Competency I-C.15)" (p. 37). A competency under the NP-Patient Relationship domain states that the NP "supports a woman's right to make her own decisions regarding her health and reproductive choices within the context of her belief system" (p. 37). A Professional-Role competency requires the NP to "recognize the ethical, legal and professional issues inherent in providing care to women throughout the life cycle" (p. 38).

As developed by the **AAPA**, PA practice competencies provide the basis for professional accountability and credentialing. Professional competencies for PAs include the effective and appropriate application of medical knowledge, interpersonal and communication skills, patient care, professionalism, practice-based learning and improvement, systems-based practice, as well as a commitment to continual learning, professional growth, and the physician-PA team, for the benefit of patients and the larger community being served. These competencies are demonstrated within the scope of practice, whether medical or surgical, for each individual PA as that scope is defined by the supervising physician and appropriate to the practice setting (AAPA, 2005).

More and more, the focus of clinical competencies is on patient needs and conditions rather than the specific health professional. Based on **ACOG**, **ARHP**, and **NAF** abortion care standards and education, a provider-neutral competency assessment was developed to evaluate safe and effective abortion care practice by primary care clinicians. Developed for competency assessment of family medicine residents completing an abortion training elective and subsequently used in training APCs to abortion care competency, the evaluation assesses trainees in six areas of peri-abortion care knowledge and skill (Goodman, Wolfe, & TEACH, 2007; Taylor et al., 2007). Competency is assessed in the following categories: knowledge and skill of medication and aspiration abortion care and provision (e.g., peri-procedural care); patient communication skills; professionalism; interpersonal communication; health care delivery; and practice-based learning and improvement.

Codes of Ethics by Organization

Regardless of personal beliefs, all health professionals, including APCs, are obligated to apply their profession's national (and in some cases international) ethical codes, standards, and competencies when caring for women experiencing unintended pregnancies and choosing abortion. In general, all APC professions have established ethical codes that mandate professional integrity and the responsibility to respect patient autonomy. Applying these ethical codes to abortion care, a basic competency required of all APCs providing care to women at risk for unintended pregnancy is pregnancy options counseling that is free from bias, nonjudgmental, and nondirective (Simmonds & Likis, 2005; Singer, 2004). In addition, APCs who identify irreconcilable conflicts between their personal beliefs and their professional responsibilities must refer women

for comprehensive options counseling in a seamless manner, so that women do not feel judged or are delayed in receiving appropriate services (Likis, 2009).

The **ANA's Code of Ethics for Nurses**, first published in 1940 and updated with interpretive statements in 2001, establishes the professional rights, responsibilities, and integrity of basic and advanced practice nursing. This *Code* is the standard by which ethical conduct is guided and evaluated, and it is not open to negotiation in employment settings, nor is it permissible for individuals, groups of nurses, or interested parties to adapt or change its language (ANA, 2001). It applies to all nursing activities and supersedes specific policies of institutions or employers. For example, in providing abortion care, “the nurse should avoid imposition of the nurse’s own cultural values upon others” (p. 24), and the nurse “establishes relationships and delivers nursing services with respect for human needs and values, and without prejudice” (p. 7). These responsibilities do not suggest that the nurse necessarily agrees with or condones a patient’s choice to terminate a pregnancy but that the nurse respects the patient as a person who has the right of self-determination. The ANA *Code* provides guidelines for a nurse’s refusal to participate in a particular case on ethical grounds. However, if a nurse becomes involved in such a case, “the nurse is obliged to provide for the client’s safety, to avoid abandonment, and to withdraw only when assured that alternative sources of nursing care are available to the client” (ANA, 1989, pp. 1–2). Although women may make decisions that are different from what nurses wish or believe best, upholding patient autonomy and safety are paramount (Capiello, 2008; Simmonds & Likis, 2005).

The **ACNM's** code of ethics for midwives is the guiding principle underlying midwifery practice and articulates the professional moral obligations of practicing midwives (ACNM, 2005). “Midwives have three ethical mandates in achieving the mission of midwifery to promote the health and well-being of women and newborns within their families and communities. The first mandate is directed toward the individual women and their families for whom the midwives provide care, the second mandate is to a broader audience for the ‘public good’ for the benefit of all women and their families, and the third mandate is to the profession of midwifery to assure its integrity and in turn its ability to fulfill the mission of midwifery” (p. 1). “Midwives strive for equality and justice in all aspects of their clinical and professional activity and must respect the rights of all people and their health care choices. They have the responsibility to act without discrimination by avoiding differential and negative treatment of individuals on the basis of their age, gender, race, ethnicity, religion, lifestyle, sexual orientation, socioeconomic status, disability, group membership, or the nature of their health problem” (p. 8).

The **AAPA** holds as a central tenet patient autonomy in decision making. “Physician assistants are professionally and ethically committed to providing nondiscriminatory care to all patients” (AAPA, 2008a, p. 4). In the area of reproductive decision making, “[p]atients have a right to access the full range of reproductive health care services, including fertility treatments, contraception, sterilization, and abortion” (p. 6). PAs have an ethical obligation to provide balanced and unbiased clinical information about reproductive health care. “While PAs are not expected to ignore their own personal values, scientific or ethical standards, or the law, they should not allow their personal beliefs to restrict patient access to care. A PA has an ethical duty to offer each patient the full range of information on relevant options for their health care. If personal moral, religious, or ethical beliefs prevent a PA from offering the full range of treatments available or care the patient desires, the PA has an ethical duty to refer a patient to another qualified provider” (p. 4).

In addition to the ANA ethical standards, **AWHONN** supports the protection of the individual nurse’s right to choose to participate in abortion or sterilization procedures (AWHONN, 1999). AWHONN practice documents state that any reproductive health care decision is best made by informed women in consultation with their health care providers and supports and promotes women’s right to accurate and complete information and access to reproductive health care services (AWHONN, 1999)

These essential ethical standards uphold an ethical mandate for CNMs, NPs and PAs to ensure patient access to comprehensive reproductive health services, including, at a minimum, access to accurate, timely, and caring pregnancy options counseling.

C. EVIDENCE OF EDUCATION AND TRAINING IN ABORTION CARE

To establish abortion care as within the scope of practice of CNMs, NPs, or PAs, there must be evidence of training programs at the entry level and/or advanced-practice-level education for obtaining abortion care knowledge and skills. Academic and postgraduate training programs must be based on established practice standards and competencies.

APCs in virtually all areas of specialization encounter patients with needs and concerns about contraception, sexually transmitted infections, unintended pregnancy, infertility, and intimate partner violence. Content and clinical guidelines related to these important reproductive health issues are therefore essential in APC education and training programs. Indeed, incorporating reproductive health into health service professional training has gained increased attention in recent years (Beatty, 2000; Lazarus, Brown, & Doyle, 2007). Professional associations and accreditation bodies have repeatedly identified the need to include reproductive health in the standard curricula. The American Association of Colleges of Nursing (AACN), the National Organization of Nurse Practitioner Faculties (NONPF), the AAPA, and the ACNM have all developed guidelines that recognize the need for their graduates to possess competence in providing care related to sexual and reproductive health (AACN, 1998; AAPA, 2008c; ACNM, 1997a, 2008; NONPF, 2002). Although these guidelines differ by program type, they generally require training dedicated to counseling, health promotion, risk assessment, clinical interventions, and/or referrals. Consistent with findings from graduate and undergraduate medical education (Espey, Ogburn, & Dorman, 2004; Helton, Skinner, & Denniston, 2003; Prine, Lesnewski, & Bregman, 2003), several studies have demonstrated that routine incorporation of reproductive health issues into health professional education improves exposure to abortion care and influences attitudes toward intention to provide comprehensive services (Breitbart, 2000; Hwang, Koyama, Taylor, Henderson, & Miller, 2005; Simmonds, Zurek, Polis, & Foster, in press).

Abortion Care Education and Clinical Training in APC Education Programs

How NP, CNM, and PA faculties operationalize reproductive health and abortion care competencies and educational standards within a particular education program varies. In NP, CNM, and PA education programs, abortion care is considered specialty practice within the broader curriculum of reproductive health, women's primary care, or obstetrics-gynecology medicine. For this reason, clinical training is often assigned to elective courses. In family NP, women's health NP, and CNM training programs, curricula include didactic and clinical education in the independent provision of women's primary care and reproductive health care, such as comprehensive early pregnancy care (including miscarriage management), gynecologic care, fertility prevention and protection, prevention of unintended pregnancy, and procedural skill training (e.g., endometrial biopsy, IUD placement, procedural pain management, colposcopy, cryosurgery, artificial insemination, and ultrasound). PAs are educated in a primary care medical model where they receive basic training in women's reproductive medical assessment and treatments. About one-third of PAs practice in primary care (family and general internal medicine), where they provide care to women of reproductive age at risk for unintended pregnancy (AAPA, 2007). All PA programs are required to provide supervised clinical practice experiences in prenatal care and women's health care (Accreditation Review Commission on Education for PAs, 2007). According to APAOG (2008), PAs receive education and training in annual Pap/pelvic and breast exams, gynecologic complaints, family planning, menopause management, and prenatal care. Some PA students receive didactic knowledge of abortion care during classes they take with medical students in ob-gyn courses.

A 2001 survey of 486 accredited NP, PA, and CNM programs in the United States on the subject of didactic education and clinical training in reproductive health competencies including

abortion care found that the majority taught family planning methods and skills (IUD insertions) and therapeutic skills (endometrial biopsy, uterine aspiration for abnormal bleeding or miscarriage management) (Foster, Polis, Allee, Simmonds, Zurek, & Brown, 2006). Of the 202 programs that responded (42% response rate), family planning and contraception (including emergency contraception) received near-universal didactic coverage (96%) and significant clinical coverage (89%). The majority of respondent programs also indicated inclusion of pregnancy options counseling in both didactic (74%) and clinical (63%) education. However, only half of all responding programs offered didactic instruction and only 21% offered routine clinical training in any pregnancy termination procedure.

Accredited CNM programs (61% response rate; $n = 27$ programs) reported the highest rates of didactic instruction in abortion among all advanced practice education programs: 100% of programs included pregnancy options counseling in didactic education, and most CNM programs also included didactic instruction on surgical abortion (89%), manual vacuum aspiration (MVA) (89%), medication abortion (93%), and postabortion care (96%) (Foster et al., 2006). Fewer than 20% of the CNM programs included clinical training in surgical/aspiration (15%) and medication (19%) abortion.

Accredited NP programs (39% response rate; $n = 127$ programs) reported the lowest rates of didactic and clinical instruction in abortion among all advanced practice education programs. NP programs reported didactic teaching in surgical abortion (39%), medication abortion (37%), and MVA abortion (26%). And 13% of NP programs included clinical training in early aspiration and medication abortion (Foster et al., 2006).

Accredited PA programs (42% response rate; $n = 48$ programs) were more likely to provide clinical instruction in any abortion procedure (24%) than were CNM programs (15%) and NP programs (13%). PA programs reported didactic teaching in surgical abortion (46%), medication abortion (46%), and MVA abortion (33%).

A survey of PA educators by APAOG (2000) found that abortion care is considered a subspecialty or elective practice. According to APAOG, many PAs learn reproductive options care, without performing the actual procedures, by doing pre- and post-abortion counseling, ultrasound diagnosis, inserting laminaria and paracervical blocks, assisting with procedures, managing care after abortions (including complications), family planning, and call coverage. Generally, abortion care is covered in the OB-Gyn didactic curriculum. However, clinical training in abortion procedures and related competencies must be scheduled on an elective basis (K. Thomsen, PA educator, personal communication, December 2008).

A study of Massachusetts nursing programs provides a focused look at reasons for the low rate of representation in NP education of some reproductive health practices (Foster, Simmonds, Jackson, & Martin, 2008). In a 2007 survey of 67 program directors from all accredited Massachusetts nursing programs of their programs' didactic and clinical curricula on reproductive health, the majority of program directors (overall response rate, 60%) reported a high level of curricular adequacy for prenatal care (93%), HIV/AIDS (85%), STIs (85%), and pregnancy loss (75%). In contrast, roughly half of all respondents agreed that infertility and abortion were adequately covered (53% and 48%, respectively), with 57% and 14% of religious-based institutions reporting that reproductive health content and abortion, respectively, were adequately covered. For abortion, contraception, and infertility, additional barriers were repeatedly cited, including religious restrictions prohibiting instruction and the lack of appropriate facilities and/or qualified faculty.

Clearly, despite barriers, there is evidence of abortion care education and training in APC programs. Due to the expanding knowledge and skills required for APC practice competency, specialty practice is often assigned to elective or postgraduate courses. Examples of postgraduate training in reproductive health might include additional specialty training in abortion care, infertility treatment, or advanced procedures in family planning and obstetric-gynecologic medicine. Reproductive health procedural skill training at the postgraduate level includes ultrasound; colposcopy (including endocervical curettage, LEEP, and cryosurgery) and endometrial

biopsy; IUD and contraceptive implant insertion and removal; artificial insemination; vulvar/cervical/breast biopsy; pessary fitting; vaginal delivery; abortion; D&C; hysteroscopy; laminaria inserts; and male circumcision. Although many NP, CNM, and PA programs do not include medication and aspiration abortion skills training, APCs who want clinical training in unintended pregnancy prevention and management, including abortion provision, have options for clinical training electives, either during their initial education program or in a postgraduate program. See Section V.A for postgraduate abortion training resources.

D. EVIDENCE OF LEGISLATIVE, LEGAL & REGULATORY ENVIRONMENTS: PROVIDER RESTRICTIONS AND LEGAL STRATEGIES FOR ESTABLISHING ABORTION AS WITHIN APC SCOPE OF PRACTICE

By Jennifer Dunn, JD and Erin Schultz, JD

Notably, most state provider restrictions for abortion provision accompanied the legalization of abortion in 1973. To forestall a proliferation of potentially unsafe and untrained abortion providers, legislatures and/or regulatory bodies in most states adopted policies limiting the practice of abortion to licensed physicians. However, these abortion laws and regulations were enacted before CNM, NP, and PA roles were defined within state practice acts and before significant advances in abortion provision technology and training. Despite developments in APC scope of practice over the past 36 years, these provider restrictions, or “physician-only” laws, are still in place in many states. They have the practical effect of placing a legal roadblock in the way of well-qualified APCs who would like to incorporate abortion care into their practices.

In this section (IV.D), we consider a state to have a provider restriction if, under state law, any category of APC is explicitly prohibited from performing either medication or aspiration abortion. Currently, only five states—Kansas, New Hampshire, Oregon, Vermont, and West Virginia—have no provider restrictions for either medication or aspiration abortion*. In the majority of other states, limitations can be found in statutes, often referred to as physician-only laws, stating that abortions may be performed only by licensed physicians.

Without further interpretation, such laws prohibit APCs from providing abortions. In addition to having physician-only laws, some states explicitly prohibit nurse practitioners, nurse midwives or physician assistants from providing abortions by placing restrictions on APC scope of practice.¹⁷ Such restrictions leave little to no room for interpretations that could allow APCs to provide abortions in these states.

A number of reports, articles, and other compilations identify which states have physician-only laws (Guttmacher Institute, 2009; Jones & Heller, 2000; NAF, 2008b; NARAL Pro-Choice America, 2009). The number of states listed in the physician-only restriction category varies from one list to the next depending on how the author classifies provider restrictions. Some take into account whether APCs are permitted to provide medication abortion; others focus exclusively on aspiration abortion. Still others report no provider restrictions if *any* category of clinician other

* Please note that state laws and legal interpretations are constantly changing. This discussion and the state-specific information provided in the APC Toolkit are intended for informational purposes only and do not constitute legal advice. Clinicians who are considering incorporating abortion services into their practices should consult with regulation and legal experts as well as professional colleagues when determining whether abortion is within their scope of practice as defined by state practice acts and abortion laws.

¹⁷ See e.g. §334.7335 Rev. Stat. Missouri (Enacted 1998, excluding the performance of abortion from physician assistant scope of practice); S.D. Codified Laws § 36-4A-20.1 (Enacted 2000, prohibiting the South Dakota Board of Medical and Osteopathic Examiners from approving physician assistant practice agreements including abortion) and S.D. Codified Laws § 36-9A-17.2 (Enacted 2000, prohibiting the approval of collaborative agreements for nurse midwives or nurse practitioners that include abortion provision); Tenn. Code Ann. § 53-10-104 (c) (Enacted 1994, prohibiting nurse practitioners and physician assistants from prescribing drugs for the sole purpose of causing an abortion).

than physicians may perform abortions. For example, Arizona is often included among states without a physician-only restriction even though a provision of the Arizona PA Practice Act excludes surgical abortion from the list of minor surgeries that are within PAs' scope of practice (Az. Rev. Stat. §32-2501.11 (2007)). Other reports place a state in the "no physician-only restriction" category when laws restricting abortion provision to licensed physicians include minor exceptions but do not allow any APCs to perform either medication or aspiration abortions.¹⁸

As of April 2009, 45 states and the District of Columbia include provider restrictions in statute or regulation. However, despite the presence of provider restrictions, by 2004 APCs with additional training were providing medication or aspiration abortions in numerous states* (Joffe & Yanow, 2004). Where necessary, stakeholders have requested legal interpretations from attorneys general and other administrative bodies to demonstrate the legality of APC provision of abortions within the state (NAF, 2008b). In states where abortion restrictions are included in statutes, these nonlegislative mechanisms have been used to clarify the scope of those restrictions in order to offer legal protection to APCs who provide medication or aspiration abortions. As we discuss below, in states such as Arizona, CNMs and NPs—but not PAs—can provide abortions. In others, such as California, an updated abortion statute allows APCs to provide "non-surgical" abortion (including medication abortion) but precludes APCs from performing surgical abortion (Cal. Health & Safety Code §2253(b)(2) (2003)).

In the following sections we recount strategies that have been used to make the legal and regulatory changes necessary for APCs to provide abortion when faced with ambiguities under the laws of the state in which they practice.

State Legislative Changes

Currently, California is the only state with a statute explicitly stating that APCs can provide abortion. The result of tireless efforts by advocates and lawmakers, California's Reproductive Privacy Act replaced the state's Therapeutic Abortion Act and codified a woman's right to obtain an abortion within the state (Cal Health & Saf Code §§123460-123468; Cal. Bus. & Prof. Code §2253 (2003)). The 2003 act also provides that qualified, licensed individuals, including APCs, may provide "nonsurgical abortion" (Cal Bus & Prof Code § 2253(b)(2)), while only a licensed physician and surgeon may perform a "surgical abortion" (Cal Bus & Prof Code § 2253(b)(1)).

Under this statute, APCs are providing medication abortion, which is included under the definition of "nonsurgical abortion." Since 2007, APCs who are involved in the University of California, San Francisco's (UCSF) Health Workforce Pilot Project (HWPP) No. 171 have provided aspiration abortion under a legal waiver of the provision in the state's Reproductive Privacy Act that limits the provision of "surgical abortion" to licensed physicians (Advancing New Standards in Reproductive Health [ANSIRH], 2009; Cal Bus & Prof Code § 2253(b) (2003)). Through this demonstration project, researchers at UCSF's ANSIRH program are collecting and analyzing data on patient, clinician and health services outcomes (e.g., safety, competency, satisfaction, and access). At the end of this project, data will be distributed to state policymakers. California provides an example of how incremental legislative changes in a state's abortion statutes can create the legal environment necessary to support APC provision of abortion services.

* Please note that state laws and legal interpretations are constantly changing. Clinicians for Choice regularly updates a listing of states in which APCs are currently providing medication and/or aspiration abortion under legislative or other regulatory mechanisms; see <http://www.prochoice.org/cfc/resources/timeline.html>.

¹⁸ See, for example, Ky. Rev. Stat. Ann. § 311.760, providing that during the first trimester, abortions may be performed by a woman on herself on the advice of a licensed physician or by a licensed physician.

State Judicial Rulings

Where state constitutions provide explicit rights to privacy or courts have broadly interpreted the right to privacy within the state, provider restrictions can successfully be challenged on similar grounds (*Armstrong v. State of Montana*, 989 P.2d 364 (Mo. 1999); Schrimmer, 1997). In 1995, the Montana legislature enacted a statute restricting the practice of abortion to licensed physicians (Mont. Code Ann. §37-20-103 and §50-20-109 (1995)). At the time this law was enacted there was only one PA performing abortions in the state. A *federal* law challenge to this statute on the grounds that it placed an undue burden on a woman's right to have an abortion resulted in the U.S. Supreme Court holding that the Montana law does not violate the U.S. Constitution (*Mazurek v. Armstrong*, 520 U.S. 968 1997). However, a subsequent *state* challenge resulted in the Montana Supreme Court's enjoining enforcement of the state's provider restriction because that court found that the law violated the Montana State Constitution (*Armstrong v. State of Montana*, 989 P.2d 364 (Mo. 1999)). The Montana court held that the provisions prohibiting qualified PAs from performing abortions violated the state constitutional right to privacy, which includes a woman's right to have her abortion performed by a "health care provider of her choice." The Montana Supreme Court's determination that the state's provider restriction statutes are unconstitutional and unenforceable means that qualified APCs providing abortion care in Montana cannot be prosecuted under the state's restrictive statute.

State Administrative Regulations

As noted previously, state constitutions and legislatures typically grant administrative agencies the authority to interpret and implement laws through agency-promulgated rules and regulations. For instance, a state legislature could charge the state's health agency with protecting the health, welfare, and safety of the state's citizens. Agency rules and regulations are generally enforceable if they are within the scope of the authority granted by the legislature (2 Am Jur 2d Administrative Law § 222). In some states, APCs' authority to provide abortions has been recognized by administrative agencies within their regulations.

For example, in Rhode Island the Department of Health issued a set of rules and regulations pertaining to abortion, for the express purpose of safeguarding the health, safety, and welfare of women having abortion procedures. Under these regulations only a physician or "other licensed health care practitioner practicing within the scope of his or her practice" may perform abortions. Only a physician may perform a surgical abortion (14-000-009 R.I. Code R. § 5.1 (Effective 1973; Last Amended 2002)). In Rhode Island, APCs may offer medication abortion under these regulations.

State Attorney General Decisions

To address the historical reality that many provider restrictions were written before the development of medication abortion or before advances in APC scope of practice, advocates in some states have requested that the state attorney general (AG) issue an opinion interpreting the state's laws on the issue of APC provision of abortion. Although AG opinions are not binding statements of law, they are generally given "great weight" by courts (7 Am Jur 2d Attorney General § 10). Of course, although it seldom occurs, a court charged with interpreting a statute may determine that the AG opinion should not be followed in a particular case. If charges were brought against an APC practicing in a state where the political climate is not supportive of abortion or of establishing a broad scope of practice for APCs, a judge could decide to disregard the AG's opinion and interpret the state's law differently. However, in most cases where there is an absence of controlling authority, courts are persuaded by AG opinions (7 Am Jur 2d Attorney General § 10).

Washington, Connecticut and Illinois provide three examples of states in which AG opinions have been used to determine whether medication abortion services are within APC scope of practice. Washington has a statute providing that "a physician may terminate and a health

care provider may assist a physician in terminating a pregnancy” (Wash. Rev. Code § 9.02.110 (1991)). Another section of the code provides that unauthorized persons performing abortions can be convicted of a felony (Wash. Rev. Code § 9.02.120 (1991)). Washington’s abortion restrictions are unique for two reasons. First, they include language making it clear that the intent of the voters, who enacted these laws through the ballot measure process, was to protect a woman’s right to have an abortion. The law includes a statement that regulation of abortion should “impose the least possible restrictions on the woman’s right to have an abortion” (Wash. Rev. Code § 9.02.140 (1991)). In addition, the provider restriction was enacted before advanced registered nurse practitioners (ARNP, the state term that includes NPs and CNMs) were recognized and licensed as health care professionals (which took place in 1994) with authority to prescribe certain drugs.

Recognizing that the intent of the state’s laws was not to prevent qualified health care professionals from prescribing medication abortion, the AG issued an opinion stating that it is not unlawful for an ARNP acting within the terms of his or her professional license to “perform acts or procedures which will have the effect of terminating a woman’s pregnancy” (Op. Att’y Gen. Wash. No. 1(Jan. 5, 2004)). This opinion provides some legal protection for APCs who offer medication abortion in Washington.¹⁹

Under similar reasoning, a Connecticut AG opinion issued in 2001 after the U.S. Food and Drug Administration (FDA) had approved medication abortion concludes that “advanced practice registered nurses” and PAs who are practicing in accordance with state statutory requirements and conditions may offer medication abortion (Att’y Gen. Conn. Lexis 3 (Feb. 7, 2001)). As in the Washington AG’s opinion, the Connecticut AG made this determination based on the broad scope of practice and prescriptive authority granted to APCs under state law. The Washington AG’s opinion also carefully considered FDA requirements for the use of the approved medication abortion regimen, noting that the FDA specifically states that requirements for the use of medication abortion do not preclude qualified health care providers acting within their scope of practice from dispensing medication abortion to patients so long as this provision does not conflict with state law.²⁰

The Illinois Attorney General issued the most recent opinion on the issue of APCs and abortion provision on March 5, 2009 (Att’y Gen. Ill. No. 09-002 (2009)). The Illinois Attorney General used similar reasoning to assert that the state’s abortion law stating that abortions shall only be performed by physicians (720 Ill. Comp. Stat. Ann. 510/3.1 (2009)) does not preclude APCs working under the supervision of a physician from providing medication abortion. The section of the abortion law containing this restriction was last amended before the legislature enacted the Medical Practice Act, Physician Assistant Practice Act and the Nurse Practice Act. (720 Ill. Comp. Stat. Ann. 510/3.1, originally enacted in 1975, section 3.1 added in 1979, last amended in 1984) Therefore, the AG reasoned the law must be interpreted to allow APCs to assist physicians by dispensing medicine, including mifepristone, according to the general practice within the state.

¹⁹ While the AG’s opinion focused on ARNPs, it relied on the assumption that PAs in Washington may also provide medication abortion as long as it is within their scope of practice. For more information on the Washington AG’s opinion, see the *APC Toolkit* Guest Feature by Deborah VanDerhei titled “Proactive Regulatory Strategy: Washington State Attorney General Issues Opinion Affirming Authority of ARNPs to Prescribe Medication Abortion,” which appears in Figure IV.1 of this publication.

²⁰ The FDA requires that the drug mifepristone (Mifeprex) be sold and distributed only to qualified, licensed physicians (U.S. FDA, 2000, 2007). APCs with prescriptive authority and legal recognition that provision of medication abortion is within their scope of practice work under collaborative arrangements with physicians to obtain mifepristone.

FIGURE IV.1***Proactive Regulatory Strategy: Washington State Attorney General Issues Opinion Affirming Authority of ARNPs to Prescribe Medication Abortion****Guest Feature by Deborah VanDerhei, Washington State Field Consultant, Abortion Access Project*

Filled with optimism from a recently completed legal analysis, the Abortion Access Project (AAP) launched its Washington State project in 2002, hiring a field consultant with extensive networks throughout the state. The legal summary, conducted by the Northwest Women's Law Center, suggested there were good arguments in favor of interpreting the physician-only provision of Washington's 1999 Reproductive Privacy Act, RCW 9.02, to permit the independent provision of medication abortions by APCs acting within their scope of practice. In October and November 2002, the summary was offered to a group of stakeholders representing a cross-section of the pro-choice community. Through thoughtful negotiations, the decision was made to seek an opinion from Washington's Attorney General as to whether the act permits the provision of medication abortion by APCs.

The Northwest Women's Law Center and Planned Parenthood of Western Washington worked collaboratively to identify prosecutors, one positioned in eastern Washington (rural and generally more conservative) and one in western Washington (urban and considerably more progressive), who in turn agreed to petition the AG.

In response to requests from these prosecutors, the Washington State AG issued an opinion affirming that advanced registered nurse practitioners (ARNP, the state's legal term for CNMs and NPs), acting within their scope of practice, may provide the drugs that cause medication abortion to their patients, whether or not they are acting in collaboration with a physician.

PAs may provide this service as well, as long as it is within their scope of practice. The AG's opinion did not explicitly address PAs because the opinion responded to a question that assumed that all PAs and any ARNPs acting under the supervision of a physician may lawfully provide medication abortion. The question asked for clarification only for ARNPs acting *independently*. The AG's opinion made the same assumption.

The opinion was a strong affirmation of RCW 9.02's statement that "a physician may terminate and a health care provider may assist a physician in terminating a pregnancy." The AG's opinion indicates that RCW 9.02 was intended to protect women's health and safety and to ensure a woman's fundamental right to reproductive choice in the state of Washington. As the AG states, it is highly unlikely that courts would interpret this statute to make an ARNP's action in providing medication abortion a crime in light of the fact that allowing an ARNP to perform the full range of health care services...authorized under RCW 18.79.050 "imposes the least restrictions on the woman's right to have an abortion as called for in RCW 9.02.140, and given that the availability of such procedures to women would further the evident primary purpose of Initiative 120...."

July 2004 marked the first medication abortion offered by an ARNP in Washington State. Since then, dozens of ARNPs have been trained. Estimates suggest that as this *APC Toolkit* goes to press, more than 50 ARNPs are offering medication abortion using mifepristone and misoprostol throughout the state of Washington.

State Administrative Body Opinions and Decisions**Administrative Agency Rulings**

Like AG opinions, administrative rulings and opinion letters are often persuasive authorities but do not provide APCs with the same protection as statutes or judicial rulings. New York was among the first states to look to an administrative body to clarify whether new classifications of providers could offer abortion under the state's physician-only law. Despite the presence of a statute limiting the provision of abortions to licensed physicians, the New York Department of Health (NYDH) issued a Declaratory Ruling on December 20, 1994, stating that abortions

may be assigned to and performed by PAs. (Office of the New York State Dep't of Health, Declaratory Ruling: Performance of an Abortion by Physician Assistant (Dec. 20, 1994)).

The NYDH determined in its ruling that NY Penal Law §125.05 which states that abortions are not criminal when performed by licensed physicians, was intended to assure that abortions are safe and only performed by competent medical personnel. Because this law was enacted prior to statutes authorizing PAs to provide medical services, the NYDH determined that the newer PA provisions superseded the penal provisions. However, the NYDH did also provide a warning that “[p]ersons acting in reliance on this opinion are advised that the Department of Health has no responsibility for the enforcement of NY Penal Law §125.05. Decisions about enforcement of the Penal Law will be made by the various District Attorneys in the State, and not the Department of Health” (NYDH Dec. Ruling (Dec. 20, 1994)). While APCs providing abortions in New York can cite this opinion as evidence of the safety and legality of their practice if an issue arises, this caution serves as a reminder of the limitations of administrative rulings in interpreting state laws.

State Health Professional Board Decisions

Although they often represent reactive rather than proactive strategies, decisions by state administrative bodies, such as nursing boards, can provide useful evidence of state policies on provision of aspiration or medication abortion by NPs and CNMs. In Arizona and Oregon, scope of practice investigation proceedings were initiated against NPs providing aspiration abortion services to patients that resulted in nursing board decisions in both states concluding that aspiration abortion is within the scope of practice for qualified advanced practice nurses.

When an anonymous complaint was made to the Oregon State Board of Registered Nursing (OSBN) in 2006 that an NP was providing aspiration abortions, the board made the determination that this procedure was in fact within an NP scope of practice pursuant to educational preparation and clinical competency in the procedure. The following decision was mailed to the NP²¹:

The Board determined that the performance of manual suction/aspiration abortions was not outside the scope of practice of a Family Nurse Practitioner given that certain parameters have been met; specifically, that the Family Nurse Practitioner is both educationally prepared and clinically competent.

With this decision, the OSBN became the first health professional administrative body to explicitly state an opinion that early aspiration abortion is within the scope of practice for qualified NPs. This case is further described in section IV.G.

A year later (2007) in Arizona, an anonymous complaint made to the Arizona Board of Nursing (AZBN) by a nonpatient triggered a similar mandatory investigation of the NP whose scope of practice had been questioned. As part of the required preliminary investigation, the AZBN charged its Advanced Practice Advisory Committee (made up of AZBN members and Arizona advanced practice nurses) with making a recommendation to it on questions related to abortion procedures (specifically, surgical abortion) and nursing scope of practice. The AZBN voted, with only one dissent, to accept the unanimous recommendation of its Advanced Practice Advisory Committee that “[i]t is within the scope of practice of a nurse practitioner to perform a first-trimester aspiration abortion provided the procedure is within the nurse practitioner specialty certification population; the nurse practitioner has met the education requirements of A.A.C. §R4-19-508(c)²²; there is documented evidence of competency in the procedure” (Arizona State Board of Nursing, 2008, p. 24). See section IV-G for a complete description of this case.

²¹ Copy of letter to FNP on file with Diana Taylor, RNP, PhD.

²² A.A.C. §R4-19-508(C) states: “An RNP shall only provide health care services within the nurse practitioner’s scope of practice for which the RNP is educationally prepared and for which competency has been established and maintained. Educational preparation means academic coursework or continuing education activities that include both theory and supervised clinical practice.”

In 2000, the Rhode Island Department of Health (RIDOH) included provider-neutral language in the revised regulations on medication abortion. The night before the regulations would have gone into effect; anti-abortion legislators threatened to pass a “physician-only” law but withdrew their objection when the RIDOH changed the regulatory language to allow properly trained CNMs, NPs and PAs to perform only medication abortions. To make this regulatory change, the RIDOH had to declare a public health emergency, which is the only way to change regulations overnight without hearings.

Janet Singer, CNM, Brown University School of Medicine, Providence, Rhode Island

The AZBN was the second state regulatory body to recognize aspiration abortion procedures as clearly within the scope of practice of advanced practice nurses. However, the process used by the AZBN was different than that used by the Oregon Board of Nursing. By engaging their Advanced Practice Advisory Committee in the evaluation of the question—*is surgical abortion within the scope of practice of a NP?*—the AZBN was able to hear from a representative community of advanced practice nursing (practitioners, educators and professional organizations). Furthermore, unlike the OSBN process, the AZBN meetings (e.g., advisory committee and full board meeting) relating to the investigation and scope of practice decision were public. Notably, there was no testimony presented by anti-abortion groups at any of the AZBN meetings specifically against the individual NP or generally against the premise that abortion is within the scope of practice of a competent advanced practice nurse.

This decision by the AZBN represented a significant victory for nursing and pro-choice advocates alike. However, as this *APC Toolkit* goes to press, legislators who disagree with the board's decision that advanced practice nurses should be allowed to provide aspiration abortions are challenging the board's authority. They have introduced legislation that would prohibit any nurses, including NPs and CNMs, from providing “surgical abortions,” defined to include the use of surgical instruments or a machine with the intent to terminate a pregnancy ((HB 2254, 49th Leg., 1st Sess. (Az. 2009)). The ongoing battle in Arizona demonstrates an unfortunate truth in the relationship between health professional boards and state legislatures: the legislature does have the power to override a board's determination on issues of scope of practice, even if the board's decision is based on a substantial record demonstrating the ability of APCs to provide safe and effective clinical services. .

FIGURE IV.2

When Politics Trumps Evidence

Recently, newer physician-only laws have been used explicitly (and also covertly) to limit access to abortion, sacrificing fully competent professionals' scope of practice in the name of a political agenda against legal abortion and/or the advancement of APC scope of practice generally. For example, in Arizona (one of five states without a physician-only restriction for abortion), legislation was passed in 2007 prohibiting PAs from performing abortions. (Ariz. Stat. Ann. §32-2501.11). In 2008, an Arizona bill that would have prohibited advanced practice nurses (CNMs and NPs) from performing abortions was narrowly defeated (Ariz. Stat. Ann. §32-2501.11 (2007); Capiello, 2008). A similar bill was introduced in 2009 (HB 2254, 49th Leg., 1st Sess. (Az. 2009)).

California offers another example of the effect that interprofessional politics can play in creating barriers to APC scope of practice and abortion access. The California legislature passed the Reproductive Privacy Act (SB 1301, 2001-2002 Sess. (Ca. 2002) (enacted)), which took effect in January 2003. In addition to codifying the protections of *Roe v. Wade* into state law, the act clarified that advanced practice clinicians (e.g., CNMs, NPs, and PAs) could provide “nonsurgical” abortions by administering medications such as mifepristone. Due to political pressure from state medical groups, the law states that only a licensed physician and surgeon may perform a “surgical” abortion (Cal. Bus. & Prof. Code 2253(b)(1) (2009)). Although the state senator who authored the law charged the medical community with further clarifying what other nonsurgical abortions APCs could perform, this political compromise essentially limited access to APC-provided abortion care without consideration of relevant evidence such as ability or competency (Kuehl, 2002).

These legislative exclusions of abortion from APC scope of practice show how politics trumps evidence—and should be of concern to all health professionals (Taylor, Safriet & Weitz, 2009).

E. APPLYING THE EVIDENCE: HOW PROFESSIONAL AND LICENSING BOARDS ASSESS OR ADVANCE SCOPE OF PRACTICE

APC professional organizations have developed guidelines for advancing scope of practice. These guidelines direct individual NPs, CNMs, or PAs to follow a process and document the evidentiary basis for the proposed change. Some state regulatory boards have developed similar guidelines for assessing scope of practice changes. Evidence supporting abortion as part of APC scope of practice is detailed in Sections IV.A–D and can be used to craft requests for professional and/or state reviews of scope of practice questions.

Nursing Models for Advancing Scope of Practice

Under the nursing model of care, advances in scope of practice result from evidence of the changing health care needs of the population (e.g., need for abortion providers). When a new need is identified, one approach NPs and CNMs can take is to acquire the knowledge, skills, and expertise necessary to specialize in a particular area of care. The *Consensus Model for APRN Regulation* put forth by the 2008 APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Group provides for the expansion of scope of practice through the development of new specialties within the advanced practice nursing roles (e.g., CNM, NP). The *Consensus Model for APRN Regulation* contains the following discussion of specialty development:

New specialties emerge based on health needs of the population. APRN specialties develop to provide added value to the practice role as well as providing flexibility within the profession to meet these emerging needs of patients. Specialties also may cross several or all APRN roles. A specialty evolves out of an APRN role/population focus and indicates that an APRN has *additional* knowledge and expertise in a more discrete area of specialty practice. Competency in the specialty areas could be acquired either by educational preparation or experience and assessed in a variety of ways through professional credentialing mechanisms (e.g., portfolios, examinations, etc.). (p. 11)

This model for expanding practice is flexible enough to allow advanced practice nurses to acquire new clinical competencies, build upon their educational base, and develop new skills needed to advance their practice beyond their core competencies.²³

The ACNM created a set of *Standards for the Practice of Midwifery* (2003) to guide the practice of CNMs. Standard VIII provides a model CNMs may follow to expand their practice beyond ACNM core competencies:

The midwife:

1. Identifies the need for a new procedure taking into consideration consumer demand, standards for safe practice, and availability of other qualified personnel.
2. Ensures that there are no institutional, state, or federal statutes, regulations or bylaws that would constrain the midwife from incorporation of the procedure into practice.
3. Demonstrates knowledge and competency, including:
 - a. Knowledge of risk, benefits, and client selection criteria.
 - b. Process for acquisition of required skills.
 - c. Identification and management of complications.
 - d. Process to evaluate outcomes and maintain competency.
4. Identifies a mechanism for obtaining medical consultation, collaboration, and referral related to this procedure.
5. Reports the incorporation of this procedure to the ACNM. (p. 3)

²³ For a list of the essential documents all clinicians must have to establish that they are competent and legally authorized to practice, see Section V.B.

These national models instruct advanced practice nurses who wish to advance their scope of practice to be mindful of laws and regulations (e.g., state practice acts, abortion laws, and provider restrictions in state laws or regulations). Some state laws, practice acts, or licensing board opinions explicitly refer to national guidelines for advancing scope of practice and, therefore, allow advanced practice nurses to follow the referenced guidelines. Other state licensing boards have adapted national models or created their own guidelines for expanding scope of practice. The examples that follow demonstrate how the Boards of Nursing in Kentucky and North Dakota allow for nurses to advance their scopes of practice. The case studies in this section also show how advanced practice nurses and PAs in collaboration with professional organizations and reproductive rights advocates in Alaska, Arizona, Montana, New York and Oregon successfully protected abortion care as part of their professional scope of practice.

The Kentucky Model: Encouraging Individual Professional Judgment in Assessing Scope of Practice

Guidelines created by the Kentucky Board of Nursing (KBN) provide NPs and CNMs with a model for independently assessing whether the performance of an act or service not directly addressed under state law or an existing KBN advisory opinion (interpretation) is within the nurse's individual scope of practice. The KBN's *Scope of Practice Determination Guidelines* (2005) advise that nurses "must exercise professional judgment in determining whether the performance of the act is within the scope of practice for which the nurse is licensed" (p. 1). To assist nurses in making this independent determination, the KBN provides a decision tree for assessing whether an act or function is within their scope of practice.²⁴

The North Dakota Model: A Formalized Process for Advancing Practice

The North Dakota Board of Nursing (NDBN) provides a decision-making model for nurses to use when considering advancing scope of practice. The model recognizes evidence-based abilities and provides a mechanism for advancing nursing scope of practice (NDBN, n.d.[a]; 1999). The NDBN allows advanced practice nurses who are unsure whether an act is within their scope of practice to submit a Request for Practice Statement Related to Nursing Scope of Practice Questions (NDBN, 2006), and the board will make a determination as to whether the specific act is within the clinician's scope of practice. The NDBN recognizes the dynamic nature of nursing practice and accommodates it by issuing practice statements: "[t]he Board of Nursing recognizes that expanded technology and innovative healthcare models require ongoing adjustments in the delivery of nursing care. As such, the purpose of the practice statements is for guidance and assistance to the nurse in practice" (NDBN, n.d.[b]).

In making its determination the NDBN considers submitted responses to a series of questions. The questions elicit information including reasons nurses should or should not be performing the act; the opinions of nurses, physicians, and the agency as to whether nurses should be performing the act; potential complications; and education requirements for nurses to perform the act. Advanced practice nurses in states with similar mechanisms for determining the bounds of scope of practice should consult with their peers and professional organizations before seeking a practice statement in order to determine whether they are likely to receive a positive outcome.

PAs and the Medical Model

The process for advancing scope of practice for PAs who provide care within the medical model requires a slightly different set of considerations. The AAPA, the national membership organization representing PAs, explains that there are four parameters that determine PA scope of practice: the PA's education and experience, state law, facility policy, and delegatory decisions made by the supervising physician (AAPA, 2008b). PAs must consider all four parameters when incorporating new skills or procedures into their practice.

²⁴ See Appendices 1 and 2 of the KBN's *Scope of Practice Determination Guidelines* for decision-making models.

Physician-Delegated Approach to PA Scope of Practice

The AAPA *Guidelines for State Regulation of Physician Assistants* recommend that state laws (or practice acts) should permit PAs to “provide any legal medical service that is delegated to them by the supervising physician when the service is within the PA’s skills and is provided with supervision of the physician” (AAPA, 2006a, p. 4). Most state laws governing PA scope of practice follow this recommendation, allowing for broad delegatory authority by supervising physicians. Many states have moved away from regulating PA practice through statutes or regulations codifying a list of procedures PAs may provide. Instead they give supervising physicians wide latitude to define the scope of services PAs may provide under their supervision; this gives the physician-PA team greater flexibility. In its 1995 *Guidelines for Physician/Physician Assistant Practice*, the American Medical Association recognized that while the services delivered by PAs must be within their scope of practice defined by state law, “[t]he role of the physician assistant(s) in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician’s delegatory style” (cited in AAPA, 2006b, p.1).

In many states the supervising physician-PA team determines the scope of practice for the PA within the parameters set by state laws and regulations and facility policy. For example, in Wyoming, supervising physicians have wide latitude to determine the scope of practice of the PAs they supervise: “The physician assistant may perform those duties and responsibilities delegated to him by the supervising physician when the duties and responsibilities are provided under the supervision of a licensed physician approved by the board, within the scope of the physician’s practice and expertise and within the skills of the physician assistant” (Wyo. Stat. § 33-26-502(b)).

Checklist/Hybrid Approaches to PA Scope of Practice

Although most states have moved away from providing checklists of approved PA procedures in laws or regulations, some do require the physician-PA team to submit a delegation agreement to the medical board for approval in order to establish PA scope of practice. States and other jurisdictions that require licensing board approval for PA functions include Washington, D.C., Georgia, Kentucky, and Mississippi, among others (AAPA, 2008d; AAPA, 2009).²⁵ Other states have codified lists of duties or procedures that fall within a PA’s scope of practice, but allow supervising physicians some latitude in determining scope of practice for PAs.

While the supervising physician is always involved in determining the PA’s scope of practice based on the PA’s education and experience, state statutes and regulations may limit a PA’s practice or require board involvement in or approval of the scope of practice the PA-physician team determines. PAs and their supervising physicians who are considering expanding the PA’s scope of practice need to be mindful of specific limits the state’s licensing board or legislature may place on that scope of practice.

F. STRATEGIES FOR WORKING WITH STATE APC REGULATORY BOARDS

Many activists and health care providers are familiar with their political representatives and the processes of their state government. Surprisingly, however, few have an understanding of who serves on their state’s regulatory boards, how members are appointed, the boards’ decision-making procedures, or how these boards can influence the practice of abortion by APCs. State health professional politics can be as contentious as abortion politics which often includes the relationships between licensing boards and professional organizations. Understanding regulatory board functions as well as the roles of the board members is essential to advocating for policies and change around scope of practice, and is a critical component of making sure that

“Not too long ago I received an irate phone call from a nurse practitioner (NP) seeking collegial support for a problem she had with the Board of Nursing (BON). She was incensed that the state NP organization to which she had appealed had not been willing to use its influence with the BON to support her position. She said, “The BON doesn’t seem to be doing its job representing NPs at all.” While I am sympathetic with any NP’s problems with bureaucracy, this example illustrates that some NPs have a misguided understanding about the function of the state BON. Simply put, this board’s goal is to protect the public—not the NP!” (Edmunds, 2006, p. 357).

²⁵ A summary of all state laws and regulations by state is available from the AAPA at <http://www.aapa.org/gandp/state-law-summaries.html>.

clinicians who are providing or plan to provide abortion care have full understanding of what could happen if their practice is challenged.

Although issues tend to come and go, often the same people remain in leadership positions. Thus, learning to work with the people on the state regulatory boards makes a lot of sense. To develop good relationships, APCs should create strategies to increase the opportunities for communication, education, and cooperation. Traditionally, regulatory boards are underfunded, understaffed, and hassled by many licensure-driven tasks. Many boards have great latitude in how they draft regulatory language that practitioners may have to live with for a long time. Many complex issues are currently before them that will affect CNM, NP or PA practice in the future.

Here are some proactive approaches for clinicians and their professional organizations who want to advocate for scope of practice changes generally and/or advance abortion practice in particular. See also Figure IV.3 on “getting to know your state regulatory board” strategies.

- Volunteer to help your board, especially to serve on committees, by providing education and information about how any new regulations will affect your practice. Developing a better understanding of the issues or limitations that affect both the public and health professional groups can only help them do what they do best—focus on the patient.
- Learn about board processes; what are the mechanisms the board uses to regulate and advance scope of practice.
- Attend a Board public meeting to observe the process in action and initiate the acquaintance of board members and colleagues from around the state.
- Obtain the minutes from public meetings; in many states they are available online.
- Talk with colleagues who have been investigated for a scope of practice complaint or who have petitioned the board to advance their scope of practice.

Individual clinicians as members of their state professional organizations will have the most influence in working with their respective licensing boards. Leaders of the professional associations are likely to be the most knowledgeable about Board processes and in many cases are active members of licensing board committees or are involved in making recommendations for regulatory board appointments to the state legislature or governor. See Section III.G for how professional organizations can effectively work with state regulatory boards.

In doing this kind of research, preparation and relationship-building, individual clinicians (as members of their professional organizations) and their allies are not only able to move forward with confidence in providing abortion care, but they also show members of the regulatory board that they are committed to abortion care as a *scope of practice issue* and not just a political hot potato or headline-grabber. Too often, regulatory boards have been ignored by activist groups who favor the legislative process, and it takes a shift in perspective for advocates to begin working hand in hand with healthcare providers toward goals that are truly *pro-professional* and *pro-patient*. Building relationships, educating members of the regulatory board about the barriers to access and the safety of abortion, offering oneself up as a resource when questions arise, and showing interest in the goals of the regulatory board and colleagues in various fields can go a long way toward building goodwill and open lines of communication prior to meeting over a challenge, when emotions may run high.

FIGURE IV.3***Getting to Know Your State's Professional Regulatory Boards***

It is never too early (or too late!) to do some research on the members of the state licensing boards that have authority for regulating medical, nursing or midwifery practice in one's state. Some questions to ask when doing research on these members:

- Who lives in rural communities and who lives in urban communities? Both of these groups may understand access issues in different ways and may be eager to learn how APCs are providing care to patients in their area.
- Are there members of the Board with whom you have mutual interests, mutual acquaintances, or mutual experiences that can be used as entrée to getting to know each other and discussing issues of reproductive health access generally, or specifically access to abortion care in your state?
- Who appointed the members? What have the members' stances been on other decisions regarding reproductive health care or issues deemed "controversial" (such as end-of-life care)?

G. CASE STUDIES: MONTANA, NEW YORK, OREGON, ARIZONA, AND ALASKA

The case studies that follow were, in many ways, the inspiration for this *APC Toolkit*. These examples highlight the statutory, professional, regulatory, and political issues that arise when APCs attempt to advance their scope of practice into abortion care, especially abortion provision. Examining the cases of PAs and NPs in five different states, as well as the stories of APCs who have faced similar struggles in advancing their scope of practice into abortion care, lets us identify common themes:

- Many APCs are only now learning the requirements and procedures for pursuing changes in scope of practice through professional or regulatory mechanisms.
- The complexity of abortion politics combined with health-professional politics can overwhelm APCs attempting to add abortion care to their existing practice.

On the other hand, these cases also illustrate how APCs, with the help of their professions, have formulated the evidence to situate abortion within APC scope of practice and reveal the mechanisms state regulatory boards follow in deciding whether abortion is within an APC's scope of practice. Two of the cases also show how legislative and political power can overwhelm rational processes for assessing and advancing scope of practice. All five case studies make it clear that "it takes a village" to protect scope of practice when APCs attempt to advance their practice into politically charged areas such as abortion care.

Montana Constitutional Right to Privacy Trumps the State Legislature's PA Abortion Restriction: Then & Now

Guest feature by Mindy Opper PA-C and Erin Cassard Schultz, JD

After receiving training in abortion as part of her PA program at the State University of New York and completing an apprenticeship in Montana with family practice physician Dr. Jim Armstrong, Susan Cahill began working with Armstrong offering first trimester abortion services. A Montana law dating back to 1974 provided that abortions could only be performed by a physician (Mont. Code Ann §50-20-109(1)(a)(Enacted 1974)). However, the law had been interpreted to allow PAs like Cahill who were working under the supervision of a physician pursuant to a Board of Medical Examiners approved utilization plan to perform abortions.

Cahill provided abortions for nearly 20 years with an impeccable safety record and not a single complaint against her before the Montana legislature challenged her legal status as an abortion provider. In 1995 the Montana legislature passed a law restricting the practice of

abortions to licensed physicians (Mont. Code Ann. §37-20-103 and §50-20-109 (1995)). The intent of this legislation seemed clear: to stop Cahill – the one PA in the state known to be providing abortions – from continuing to offer abortion services to her patients.

Cahill and a group of physicians practicing in Montana, represented by the Center for Reproductive Rights, challenged the constitutionality of this legislation under the federal constitution. They argued that the law imposed an “undue burden” on a woman’s right to have an abortion. In addition, they argued that the purpose for passing the legislation was impermissible, as the legislature could not pass a law with the intent to prevent one individual from providing abortions. After the lower courts issued an injunction to prevent the law from going into effect, the US Supreme Court held in *Mazurek v. Armstrong* (520 U.S. 968 (1997)) that there was insufficient evidence to support either argument.

Cahill and her co-plaintiffs continued their fight to ensure PAs could continue to provide abortions in Montana by challenging the law under Montana’s state constitution. The Montana State Constitution provides: “The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest” (Mont. Const. Art. II Sect. 10). After a hard-fought four year legal battle in the federal and then state courts, the Montana Supreme Court determined that the PA restriction for abortion was unconstitutional under the broader right to privacy provided by the Montana constitution. In their opinion striking down the 1995 statutes, the court states: “Quite simply, the statutory amendments at issue prevent a woman from obtaining a lawful medical procedure – a previability abortion – from a health care provider of her choosing. In so doing, these amendments unconstitutionally infringe a woman’s right to individual privacy under Montana’s Constitution.” *Armstrong v. State of Montana*, 989 P.2d 364 (Mo. 1999).

The major lessons learned from the “Cahill bill” was that the Montana state constitution has strong protections for an individual’s right to privacy and right to choose his or own health care provider. The court was able to de-politicize the issue of abortion and focus on access to care. There has not been a successful challenge to this ruling since, nor do we feel there will be as the court made it clear they do not want to address this issue again. Similarly, the Montana PA association looked past politics on this issue. The state AAPA chapter testified on behalf of a PA’s ability to provide abortions, even though many members are “flat out anti-choice”. They were able to see the impending threat to all primary care provider scope of practice.

Following the Montana Supreme Court’s decision, Susan Cahill continued as the sole abortion provider until 2001 when I became the second PA in Montana to offer medication abortion through my care at Blue Mountain Clinic. After submitting the required supervisory agreement²⁶ to the Montana Board of Medical Examiners in 2001 to provide medication abortion I was asked to appear before the board, a highly unusual request. I was thoroughly evaluated by the board and asked to answer questions about my training, my qualifications to provide abortion services and how I would handle abortion-related problems with my supervising physician. Several members on the board were surprised that I could competently perform gestational dating using ultrasound without having completed formal radiology courses. I provided documentation of post-graduate abortion training through NAF workshops on comprehensive abortion care (e.g., pregnancy diagnosis, gestation estimation, MVA, medication abortion, and complication management) along with documentation of supervised ultrasound training and work site supervision of abortion procedures. During the meeting, when the provision of medication abortion was put into context of primary women’s health care that I regularly provide, including more invasive procedures such as chest tubes, NG tubes etc., they understood that providing medication abortion and MVA was much lower risk than imagined. My request was approved.

²⁶ In order to practice as a PA in Montana the PA must have on file with Board in accordance to Mont. Code Ann. § 37-20-301(a)(2), a supervision agreement. A new supervision agreement is required for licensure, a new supervising physician and PA practice relationship or a change in supervising physician.

Today I continue to provide medication abortion and follow up care for medication and aspiration abortion as does my colleague at Blue Mountain Clinic. Susan Cahill also continues to provide both medication and aspiration abortion care for her patients. Having started as an abortion counselor back in 1980, I have come full circle as I am now able to provide women with a full range of reproductive health services. Unfortunately, we can identify only five advanced practice clinicians (3 PAs and 2 NPs) who are currently providing medication and/or aspiration abortion in Montana. Through the efforts of the Montana Abortion Access Project and national medication abortion and MVA training workshops our hope is that additional APCs in Montana and throughout the United States will continue to receive training in all aspects of abortion care and incorporate these safe procedures into their primary care practices.

Resolving the legal ambiguities affecting APCs in New York

Guest feature by Karla Silverman, CNM, MS and Jini Tanenhaus, PA-C, MA

In the early 1990s, Donna Lieberman, Esq., and Anita Lalwani, Esq., of the Reproductive Rights Project of the New York Civil Liberties Union (NYCLU), reasoned that despite the perceived barriers created by New York's "physician-only" statutes, properly trained PAs could legally perform first trimester abortions under the authority of their supervising physicians. Lieberman and Lalwani wrote a carefully worded memo to the New York State Department of Health (NYSDOH) asking for clarification as to whether the authority that allows properly trained PAs to perform medical procedures with physician supervision should apply to abortion procedures. Despite the presence of a statute limiting the provision of abortions to licensed physicians, the NYSDOH issued a Declaratory Ruling on December 20, 1994 stating that abortions may be assigned to and performed by PAs.

The NYSDOH determined that NY Penal Law §125.05, which states that abortions are not criminal when performed by licensed physicians, was intended to assure that abortions are safe and only performed by competent medical personnel. Because this law was enacted prior to statutes authorizing PAs to provide medical services, the NYSDOH determined that the penal code section was superseded by the newer PA provisions. The NYSDOH stated that the law permits "PAs to perform abortions, provided they otherwise comply with their licensure and practice requirements." However, the Department also provided a warning that "[p]ersons acting in reliance on this opinion are advised that the Department of Health has no responsibility for the enforcement of NY Penal Law §125.05. Decisions about enforcement of the Penal Law will be made by the various District Attorneys in the State, and not the Department of Health."

As a result of the NYCLU's advocacy in 2001, then State Attorney General Eliot Spitzer issued an opinion that New York State law does not prevent advanced practice clinicians from providing medication abortion. A number of advanced practice clinicians across the state were trained and are currently providing medication abortion. Surveys conducted by PPNYC indicate strong interest across the state by APCs in providing aspiration abortion as well. Despite these promising developments, the "physician-only" stipulation in New York State's abortion law remains an impediment to the full provision of abortion services by PAs, NPs and CNMs, as in some jurisdictions clinicians and administrators still fear prosecution.

Currently, advocates in New York are working to pass the Reproductive Health Act, which was first introduced by the Senate Committee on Rules at the request of former Governor Elliot Spitzer in 2007 (Governor's Program Bill No. 16, S.5829 Rules, Sponsor, 2007). This act would amend and update the state's abortion laws. Two features of this important bill are particularly relevant to APCs. First, the bill would authorize the performance of an abortion by "qualified, licensed health care practitioners," resolving any remaining ambiguities about the legal status of APCs as providers of abortion in New York. The Act would also remove abortion from the Penal Law [NY CLS Penal § 125.05 and §125.15], appropriately placing the amended abortion laws within the Public Health Law.

As the time of publication, there are approximately 75 APCs providing medication abortion across the state. Only physicians are performing aspiration abortions including reaspirations for medication abortion failures. However, despite the NYDOH ruling about PAs being able to provide abortions as long as their supervising physician provides them combined with the State Attorney General's determination that advanced practice nurses can provide medication abortion, there are still significant practice barriers. The existence of the physician language in the penal law can make obtaining medical malpractice coverage an issue, as some carriers view this as an uncovered risk. However, the proposed *Reproductive Health Act* legislation will be introduced in the 2009 NY State Legislature. We are hopeful that the alignment of APC professional organizations, reproductive rights advocates and political allies will predominate in the protection of APC scope of practice and the advancement of access to early abortion care for the women of New York State.

For New York updates or specific information about the efforts to advance the practice of APCs as abortion providers in New York, contact Clinicians for Choice at www.prochoice.org/cfc or Karla Silverman, CNM, MS, Project Manager for The APC Initiative of New York State, Planned Parenthood of New York City.

Oregon State Board of Nursing Investigation Results in Abortion Scope of practice Opinion

By Grayson Dempsey with Shannon Rio, FNP, MA

In Oregon, a progressive Nurse Practice Act²⁷ and the lack of a physician-only abortion provision law suggested that both medication abortion and aspiration abortion could be considered within NP scope of practice. In 2002, the Abortion Access Project hired the Northwest Women's Law Center to explore this issue more extensively. The study determined that although aspiration abortion was not specifically defined as within advanced practice nursing scope of practice, "the broad language of the scope of practice regulations [within the Oregon Nurse Practice Act] encompasses abortion services" (M. Zurek, personal communication, June 2002). Following a statewide stakeholders meeting hosted by the Abortion Access Project, NPs working for the state's largest Planned Parenthood affiliate, as well as one family NP (FNP) in private practice in a medically underserved county in southern Oregon, began providing medication abortion. The FNP in southern Oregon traveled to the Planned Parenthood affiliate to receive training before beginning medication abortion services, and she returned to her clinic able to perform uterine aspirations for incomplete medication abortions, with her physician partner providing medical backup (he had been providing aspiration procedures up to 13 weeks for more than 20 years).

In late 2004, this FNP evaluated abortion access in her county and determined that a shortage of providers was imminent. Many of the physicians in her county, including her partner, were on the verge of retirement. She examined her options thoroughly and, although she did not seek out a Board of Nursing opinion, she sought an updated legal analysis from the Northwest Women's Law Center, which concluded, as it had in 2002, that early abortion care was within her scope of practice as defined by the Oregon Nurse Practice Act. The FNP traveled to the University of Rochester for two weeks to receive didactic and high-volume clinical training from experts in the field and at the beginning of 2005 began to provide medication and aspiration abortion services up to 10 weeks LMP. Coincidentally, another NP practicing at Planned Parenthood in northern Oregon began providing early aspiration abortion services at the same time.

In January 2006, the FNP received a notice from the Oregon State Board of Registered Nursing (OSBN, www.osbn.state.or.us) stating that it was investigating an anonymous (non-

²⁷ Oregon Nurse Practice Act, OR Revised Statutes, Chapter 678 (2007) available at <http://www.osbn.state.or.us/OSBN/pdfs/npa/ORS.pdf> and <http://www.osbn.state.or.us/OSBN/pdfs/npa/Div50.pdf> (for NP/CNM scope of practice)

patient initiated) complaint regarding the provision of aspiration abortion as within NP scope of practice. The FNP contacted the state nursing association (she had not been a member of the association for several years) and was advised to rejoin the association as well as seek immediate legal counsel. She also sought support from her national reproductive health colleagues who not only supported her and her vital work for the women of her community but also recognized the broader implications of a regulatory board ruling on aspiration abortion and scope of practice.

In the six months that followed, the FNP prepared for her investigative hearing by developing a professional practice portfolio that became the template for the one in this *APC Toolkit* (see Figure V.2 in Section V.B). In addition to “getting her ducks in a row,” she worked with her allies to educate her state professional association and members of the OSBN about the safety of early abortion care and NP scope of practice (e.g., professional care standards, competencies, and ethical practice standards) pointing out the important role she played as a provider in an underserved community. Surprised at the lack of dialogue between the reproductive health community and the larger nursing community, this FNP sought to bring the two groups together to foster mutual understanding of the issues most important to women and patients throughout the state. This was her first experience with the complexity of the regulatory and investigative process, which prompted conversation about how scope of practice is determined and how individual nurses should become more involved in a proactive, rather than strictly reactive, manner.

At its June, 2006 meeting, the OSBN dismissed the complaint after investigation, and notified the NP involved of its disposition via letter, indicating that the Board had determined that aspiration abortion was not outside the scope of practice of a Family Nurse Practitioner whose qualifications included both educational preparation and clinical competency in this procedure. See section IV-E, page 69, for text of the OSBN determination.

With this decision, Oregon’s became the first state nursing board to explicitly state a regulatory opinion on early abortion care and NP scope of practice. The FNP who was challenged continues to work as the primary abortion care provider for almost 700 women a year in her county.

Scope of Practice: Politics Meddling in Professional Norms in Arizona

Guest Feature by Joyce Capiello, FNP, MS (2008)

Scope of practice issues for advanced practice nurses raise their ugly head from time to time. For NPs providing abortion care, scope of practice issues are unique and complex. Many states still have physician-only laws that date back to the 1960s and 1970s, when they were passed to protect women from unsafe abortion providers. Some states have used these antiquated laws to preclude advanced practice nurses from providing abortion care, particularly aspiration procedures, which may have been anachronistically defined as surgical abortion. Other states do not have such laws in place, and it is usually assumed that the Nurse Practice Act encompasses the provision of abortion care, among many other women’s health care procedures. However, given the contentious nature of the abortion debate in the United States, a variety of strategies have been used by the anti-abortion movement to attempt to limit the provision of abortion in any way possible.

In 2007, an anonymous complaint was filed with the Arizona state board of nursing against an NP who was providing aspiration abortion procedures for a Planned Parenthood clinic. The complainant, who could have been anyone—a patient, a member of the general public or the health care community—expressed concern that the NP was acting outside her scope of nursing practice by performing abortions. Once the complaint was made, the board was obligated by statute to investigate the situation; although anonymous, it was determined that the complainant was not a patient. This NP had begun providing abortion care in 2001 to meet the needs of women in her area. The NP had an excellent safety record and had previously trained in

abortion care at an academic health center as well as completing an extensive preceptorship with an experienced physician abortion provider. The NP also had been providing abortion skills training to residents from a nearby medical school.

After investigation and research, the Advanced Practice Committee of the Arizona Board of Nursing voted unanimously to recommend to the full board that NPs with special training be permitted to perform abortions in the first trimester. The full board reviewed the recommendation of the Advanced Practice Committee and voted, with one dissent, that NPs in Arizona can perform aspiration abortion in the first trimester of pregnancy. Although the NP had been safely performing abortions up to 17 weeks gestation, the board did not penalize her for performing second trimester procedures because it had not previously had the “first trimester” rule in place.

While this issue was before the Arizona Board of Nursing, HB 2269, a bill to prohibit nurses from performing surgical abortions, was introduced in the Arizona legislature. It quickly and quietly passed the Arizona House in the spring of 2008, before state nursing organizations were notified of the proposed legislation. The bill moved more slowly through the state Senate, allowing nurses to mobilize their opposition and to use their significant political influence to refocus legislators on scope of practice protection rather than abortion politics. The bill was defeated in the state Senate on June 26, 2008. In large part, because of the state and regional nursing organization political support, it was the only anti-abortion legislation to be defeated in the Arizona legislature in 2008.

If the proposed legislation had become law, it would have changed the way nursing practice, not solely abortion care, is regulated. The Arizona legislature, under the passage of HB 2269, could have paved the way for other state legislatures to introduce similar bills, making nursing regulatory boards subject to control by legislative mandates for any number of health care services provided by nurses, NPs, and CNMs.

Thanks are due the Arizona Nurses Association, the Arizona chapter of the AANP, and the many NPs and nurses in Arizona who opposed this legislation. The defeat of this bill was important to scope-of-professional-practice protection for all nurses.

Unfortunately, a law enacted in 2006 prohibits PAs from performing abortions in Arizona. The fact that that this legislation passed speaks to the need for coordinated efforts by all health care professional organizations, educators, reproductive health service providers, and reproductive rights advocates.

Alaska Board of Nursing Affirms One NP’s Scope of Practice to Include Uterine Aspiration

Guest Feature by Diana Taylor with Jo Fortier, FNP, MS

Although the Oregon and Arizona cases describe challenges to NP scope of practice for clinicians who had been providing medication and/or aspiration abortion, the following case study highlights the contentious debate that can surround abortion when an APC proactively attempts to advance her scope of practice into abortion provision.

In September 2005, an NP appeared before the Alaska Board of Nursing (BON) to affirm that uterine aspiration was within NP scope of practice. Because Alaska has a physician-only law pertaining to abortion care, the NP was performing uterine aspirations only for nonviable pregnancies, which included incomplete spontaneous abortion and complications arising from suction and medication abortions²⁸. The primary goal in seeking affirmation from the BON was to proactively address the issue before any complaints could be filed. The secondary goal was to strengthen future legislative attempts to include abortion care as part of NP practice.

²⁸ APCs in Alaska provide all aspects of abortion care (pregnancy diagnosis; pregnancy options counseling; pre-abortion examinations, including ultrasonography; pain management; and post-abortion care, recovery, and follow-up, including contraception) *except* the administration of the abortion medication or the aspiration abortion procedure.

The Arizona Board of Nursing (AzBON) concluded, quite rightly, that appropriately prepared NPs are qualified to safely perform aspiration abortions. And, we were gratified that the AzBON further determined that an anonymously-submitted disciplinary complaint should be dismissed against a qualified NP, who has been providing these services for 7 years with an excellent safety record. This decision-making process should reassure the public that patient-safety and provider-ability, NOT political pressure, are guiding the answers to these public health issues. Partisan and special-interest politics no doubt have an ongoing place in our lives, but for some things, like the public’s access to safe and effective health services, objective evidence must trump politics.

Regulation 12 ACC 44.430 Scope of Practice (as contained in the Alaska Nurse Practice Act (AS 08.68) states: “The board recognizes advanced and specialized acts of nursing practice as those described in the scope of practice statements for nurse practitioners certified by national certification bodies recognized by the board” (Alaska Dept of Commerce, 2008).²⁹ The NP was certified through the American Academy of Nurse Practitioners, which is recognized by the Alaska BON. The Scope of Practice for Nurse Practitioners (AANP, 2007) is written intentionally without reference to specific procedures to allow for advancement of clinical skills beyond the basic competencies of formal education. The publication emphasizes education, autonomy, accountability, and responsibility with regard to advancing NP scope of practice.

This NP had extensive reproductive health care experience and documentation of training and competency with regard to uterine aspiration. She was practicing in a licensed clinic with physician collaboration and accepted quality improvement practices. The case review should have been routine (according to the Alaska BON and AANP’s own written descriptions of scope of practice), but what ensued was a fierce battle over abortion (despite continued assurances on the NP’s part that the procedure was being used for nonviable pregnancies only) spanning nine months and requiring four meetings to conclude.

The first meeting ended with the BON stating that it needed time to review documents presented at the meeting. Over the next four months, however, the BON’s requirements escalated. The NP was informed that the case had been referred to the Assistant Attorney General for review and opinion and that a letter of support was needed from the AANP stating that uterine aspiration was within NP scope of practice. When she inquired about getting a letter of support from AANP, the NP was informed that scope of practice is the jurisdiction of each state’s BON and not a function of the certifying bodies. While the BON waited for the opinion from the Assistant Attorney General, the NP’s next appearance before the board was postponed for three months.

In preparation for the second meeting, the NP went to the Alaska Nurse Practitioner Association requesting a letter of support to take to the BON. The organization’s leadership decided that the whole membership needed to be informed and a vote taken before a supportive letter could be issued. Again, this request was treated differently from issues that had come before the group in the past; in response to similar earlier requests, the officers and members present at a meeting had granted written support without a membership vote. After much discussion among the membership, there was a vote of unanimous support for the NP. Regardless of how individual members felt about abortion, the Alaska NP Association clearly supported abortion care as within the scope of NP scope of practice.

At the third BON meeting, the NP presented her letter of support from the state professional association as well as expert testimony. Despite broad support for abortion as part of NP scope of practice, the BON remained focused on the politics surrounding abortion and postponed making a decision until the fourth meeting, three months away.

Following the third meeting, the medical director at the NP’s clinic was informed by the Alaska Department of Health and Social Services (the state agency charged with overseeing health clinics) that a state senator had received a complaint that an NP was performing illegal abortions. After an agency representative met with the clinic medical director, the agency did not pursue an investigation of the complaint. This outcome was reassuring to the NP and her supporters, but the threat of harassment was also disquieting.

At the final meeting of the BON, testimony was submitted (without names or credentials) suggesting that the NP had misled the BON to believe that uterine aspiration was similar to other procedures such as endometrial biopsy and IUD placement. Another concern was raised about the margin of error of ultrasound allowing for the unintentional performance of an abortion. The NP was not allowed to speak or rebut the testimony.

²⁹ See also *Alaska Board of Nursing Position Statement: Registered Nurse and Advanced Nurse Practitioner Scopes of Practice*, Appendix C of the Alaska Nurse Practice Act (AS 08.68), pp. 57–58. Adopted May 1983; readopted September 2005.

Despite the efforts to negatively influence the BON's decision, there was a unanimous vote in favor of the NP. There were, however, two restrictions placed on the decision:

1. The NP requesting the scope of practice determination was the only NP granted permission to do uterine aspiration, and she was restricted to performing the procedure only in her current place of practice;
2. If another NP also wanted to do uterine aspirations, the individual would have to request BON approval.

While this outcome paves the way for other APCs wanting to provide abortion care in Alaska, the tortuous process involved underscores the political nature of confirming a competent health care provider's freedom to perform what should be considered a standard part of women's primary health care.

SUMMARY

- To establish abortion care as within APC scope of practice, interested parties should examine four types of evidence: historical, professional/clinical, education/training, and evidence of legislative, legal and regulatory environments. This evidence can be used to prepare a professional portfolio, educate state licensing boards about advancing scope of practice, support fellow APCs whose scope is challenged, and work with APC educators to develop abortion care training programs.
- There is substantial historical evidence of support from APC professional organizations for abortion care as within APC scope of practice. In addition, the essential documents of the professional organizations (practice standards, clinical and professional competencies, and ethical codes of conduct) contain language supporting abortion care as within APC scope. There is also clear clinical evidence that early abortion is safe.
- APC education curricula show the existence of didactic and, to a lesser degree, clinical abortion care training in entry-level APC programs, with greater emphasis on and availability of both at the post-graduate level.
- Since abortion was legalized in 1973, a number of state attorneys general have issued legal opinions and professional regulatory entities have issued advisories clarifying APC authority to perform abortions, especially in states with outdated practice acts or provider-restriction statutes. Two state licensing boards have placed abortion care within the scope of practice of competent and trained advanced practice nurses.
- Among the bases for stakeholder challenges to outdated abortion care laws are right-to-privacy provisions in state constitutions; state agencies' charge to protect citizens' health, welfare, and safety; requests (often based on proactive legal analysis) of state attorneys general to interpret anachronistic provisions in state laws; and the population's changing health care needs.
- APCs must proactively protect and advance their scope of practice, while acting within state laws and regulations that govern their practice and in concert with their own knowledge and skills. Waiting until your own or a colleague's scope is challenged to educate legislators and professional regulatory boards can spell disaster.

SECTION IV REFERENCES

- Accreditation Review Commission on Education for Physician Assistants (2007). Accreditation Standards for Physician Assistant Education (3rd edition). Johns Creek, GA: ARC-PA. Available at <http://www.arc-pa.org/Standards/standards.html>
- Advancing New Standards in Reproductive Health. (2009). Health Workforce Pilot Project-171. Retrieved March 5, 2009, from <http://ansirh.org/research/hwpp.php>
- Alaska Department of Commerce, Community, and Economic Development, Division of Corporations, Business and Professional Licensing. (2008). *Nursing statutes (AS 08.68) and regulations (12 AAC 44)*. AS 08.68.100, 12 AAC 44.430: Scope of practice (p. 23). Accessed February 20, 2009, from: <http://www.commerce.state.ak.us/occ/pub/NursingStatutes.pdf>
- American Academy of Nurse Practitioners. (2007). Scope of practice for nurse practitioners. Retrieved on September 21, 2008 at http://www.aanp.org/AANPCMS2/Publications/PositionStatementsPapers/Scope_of_Practice.pdf
- American Academy of Physician Assistants. (Adopted in 1988, amended 1993, 1998, 2002, 2005, and 2006). *Guidelines for state regulation of physician assistants*. Alexandria, VA: Author.
- American Academy of Physician Assistants. (Adopted in 1992, reaffirmed 1997, 2002, and 2007). Reproductive Health Policies HX-4600.6.o. *2008-2009 AAPA Policy Manual*, pp 75-76. Alexandria, VA: Author. Retrieved January 10, 2009, from <http://www.aapa.org/manual/external.pdf>
- American Academy of Physician Assistants. (2000). Guidelines for ethical conduct for the physician assistant profession. Retrieved February 24, 2009, from <http://www.aapa.org/manual/22-EthicalConduct.pdf>
- American Academy of Physician Assistants. (2005). *Competencies for the physician assistant profession*. Alexandria, Virginia: Author.
- American Academy of Physician Assistants. (2006a). *Guidelines for state regulation of physician assistants*. Retrieved January 15, 2009 at <http://www.aapa.org/manual/06-GuideforStateRegs.pdf>.
- American Academy of Physician Assistants. (2006b). *American Medical Association suggested guidelines for physician- physician assistant practice* (Adopted by AMA House of Delegates, June 1995; Updated October 4, 2006). Retrieved March 21, 2009 at <http://www.aapa.org/gandb/ama-guidelines.htm>.
- American Academy of Physician Assistants. (2007). *2007 AAPA physician assistant census report for Ob/Gyn* [Report]. Alexandria, Virginia: Author.
- American Academy of Physician Assistants. (2008a). *Guidelines for ethical conduct for the physician assistant profession*. Alexandria, VA: Author.
- American Academy of Physician Assistants. (2008b). *Issue brief: Physician assistant scope of practice*. Alexandria, VA: Author.
- American Academy of Physician Assistants. (2008c). *Physician assistants in obstetrics and gynecology*. [Issue briefs]. Retrieved February 24, 2009, from <http://www.aapa.org/gandp/issuebrief/womenh.pdf>
- American Academy of Physician Assistants. (2008d). *Summary of state laws for physician assistants* (abridged version). Alexandria, VA: Author.
- American Academy of Physician Assistants. (2008e). *2008-2009 AAPA policy manual* (Report No. PA Definition, HP-3100.2.o). Alexandria, VA: Author.
- American Academy of Physician Assistants. (2009). *Compendium of physician assistant state laws and regulations*. Retrieved March 5, 2009, from <http://www.aapa.org/gandp/StateLawsandRegulations.htm>
- American Association of Colleges of Nursing. (1998). *The essentials of baccalaureate education for professional nursing practice*. Washington, DC.
- American College of Nurse-Midwives. (1997a). *Expansion of midwifery practice and skills beyond basic core competencies*. Silver Spring, MD: Author.
- American College of Nurse-Midwives. (1997b). *Reproductive choices* [Position statement]. Silver Spring, MD: Author.
- American College of Nurse-Midwives. (2003). *Standards for the practice of midwifery*. Silver Spring, MD.
- American College of Nurse-Midwives. (2004, 2005). Philosophy of the American College of Nurse-Midwives. Retrieved March 2, 2009, from <http://www.acnm.org/display.cfm?id=480&print=2>
- American College of Nurse-Midwives. (2005). *Code of ethics with explanatory statements*. Silver Spring, MD: Author.

- American College of Nurse-Midwives. (2008). *Core competencies for basic midwifery practice*. Silver Spring, MD: Author.
- American Medical Women's Association. (1999). Abortion and access to comprehensive reproductive health services. Retrieved from <http://www.amwa-doc.org/index.cfm?objectId=0A5FBB23-D567-0B25-530D43B3A7BA6627>
- American Nurses Association. (1989). *Position statement: Reproductive health*. Washington, DC: Author. Available at <http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/ANAPositionStatements/social/screpr14512.aspx>
- American Nurses Association. (2001). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: Nursesbooks.org.
- American Nurses Association. (2003). *Nursing's social policy statement, 2nd edition*. Silver Spring, MD: Nursesbooks.org.
- American Public Health Association. (1999). APHA Policy Statement 9917: Advocating for nurse practitioners, nurse-midwives, and physician assistants as abortion providers. In: APHA Public Policy Statements 1948-present, cumulative. Washington, DC: Author.
- APRN Consensus Work Group, & National Council of State Boards of Nursing APRN Advisory Group. (2008). *Consensus model for APRN regulation: Licensure, accreditation, certification and education*. Chicago: National Council of State Boards of Nursing.
- Arizona State Board of Nursing. (2008). Board meeting minutes, May 14, 2008 (pp. 1–56). Phoenix: Author.
- Association of Physician Assistants in Obstetrics and Gynecology (APAOG). (1992). Reproductive health policy statement. Kimberly, WI: APAOG, www.paobgyn.org.
- Association of Physician Assistants in Obstetrics and Gynecology (APAOG). (2000). Survey results—PA educators. Retrieved June 20, 2008 from <http://www.paobgyn.org/pro-practice.htm>
- Association of Physician Assistants in Obstetrics and Gynecology (APAOG). (2008). FAQs. Retrieved March 5, 2009, from <http://www.paobgyn.org/faq.html#duties>
- Association of Reproductive Health Professionals. (2008). Position statement on abortion. Retrieved February 24, 2009, from <http://www.arhp.org/about-us/position-statements#1>
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). (1998). *Standards and guidelines for professional nursing practice in the care of women and newborns* (5th ed.). Washington, DC: Author.
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). (1999). *Health care decision making for reproductive care*. (Policy Position Statement. Washington, DC: Author.
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). (1999). Nurses' rights and responsibilities related to abortion and sterilization. Retrieved from http://www.awhonn.org/awhonn/binary.content.do;jsessionid=C3C9604156388ACAC5EADDCBD988F3F4?name=Resources/Documents/pdf/5H2e_PS_NurseRightsResponsAbortion.pdf
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), & Nurse Practitioners in Women's Health (NPWH). (2002). *The women's health nurse practitioner: Guidelines for practice and education* (5th ed.). Washington, DC: Authors.
- Beatty, R. M. (2000). Health professionals' knowledge of women's health care. *Journal of Continuing Education in Nursing*, 31(6), 275–279.
- Breitbart, V. (2000). Counseling for medical abortion. *American Journal of Obstetrics and Gynecology*, 183(2 Suppl), S26–S33.
- California Health Workforce Pilot Program. (2007). APC-health workforce pilot project #171. Retrieved on March 21, 2009 at <http://www.oshpd.ca.gov/HWDD/HWPP.html>.
- Capiello, J. (2008). Scope of practice: Politics meddling in professional norms. Retrieved from <http://www.abortionaccess.org/content/view/full/176/119/>
- Clinicians for Choice (2009). Timeline, state by state: Expanding CNM, NP, and PA provision of abortion care. Retrieved June 15, 2009 from <http://www.prochoice.org/cfc/resources/timeline.html>.
- Edmunds, MW (2006). Learning to work with the board of nursing. *J for Nurse Practitioners*, 2: 357.
- Espey, E., Ogburn, T., & Dorman, F. (2004). Student attitudes about a clinical experience in abortion care during the obstetrics and gynecology clerkship. *Academic Medicine*, 79(1), 96–100.
- Foster, A., Simmonds, K., Jackson, C., & Martin, S. (2008.). *What are nursing programs teaching students about reproductive health? A survey of program directors in Massachusetts*. Poster presentation at the National Abortion Federation Annual Meeting, Minneapolis, MN April 2008

- Foster, A. M., Polis, C., Allee, M. K., Simmonds, K., Zurek, M., & Brown, A. (2006). Abortion education in nurse practitioner, physician assistant and certified nurse-midwifery programs: A national survey. *Contraception*, 73(4), 408–414.
- Goodman, S., Wolfe, M., & TEACH Trainers Collaborative Working Group. (2007). *Early abortion training workbook* (3rd ed.). San Francisco: University of California, San Francisco Bixby Center for Reproductive Health Research and Policy.
- Guttmacher Institute. (2009). *State policies in brief: An overview of abortion laws*. New York: Author.
- Helton, M., Skinner, B., & Denniston, C. (2003). A maternal and child health curriculum for family practice residents: Results of an intervention at the University of North Carolina. *Family Medicine*, 35(3), 174–180.
- Hwang, A. C., Koyama, A., Taylor, D., Henderson, J. T., & Miller, S. (2005). Advanced practice clinicians' interest in providing medical abortion: Results of a California survey. *Perspectives on Sexual and Reproductive Health*, 37(2), 92–97.
- International Confederation of Midwives. (2002). Essential competencies for basic midwifery practice 2002. Retrieved from http://www.internationalmidwives.org/Portals/5/Documentation/Essential%20Compsenglish_2002-JF_2007%20FINAL.pdf
- Joffe, C., & Yanow, S. (2004). Advanced practice clinicians as abortion providers: Current developments in the United States. *Reproductive Health Matters*, 12(24 Suppl), 198–206.
- Jones, B. S., & Heller, S. (2000). Providing medical abortion: Legal issues of relevance to providers. *Journal of the American Medical Women's Association*, 55(3 Suppl), 145–150.
- Kentucky Board of Nursing. (2005). *Scope of practice determination guidelines*. Louisville: Author.
- Lazarus, C. J., Brown, S., & Doyle, L. L. (2007). Securing the future: A case for improving clinical education in reproductive health. *Contraception*, 75(2), 81–83.
- Likis, FE (2009). With woman: Midwifery care of women with unintended pregnancies, *Journal of Midwifery and Women's Health*, 54: 1-3.
- NARAL Pro-Choice America. (2009). *Who decides? The status of women's reproductive rights in the United States*. Retrieved March 5, 2009, from http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/state-profiles/
- National Abortion Federation, American College of Obstetricians & Gynecologists. (1990). Who will provide abortions? Recommendations from a national symposium (October 25-26, 1990). Washington, DC: NAF/ACOG.
- National Abortion Federation. (1997). *The role of physician assistants, nurse practitioners, and nurse-midwives in providing abortions: Strategies for expanding abortion access*. Washington, DC: Author.
- National Abortion Federation. (2007). *Clinical policy guidelines*. Washington, DC: Author.
- National Abortion Federation. (2008a). *Clinical policy guidelines*. Washington, DC: Author.
- National Abortion Federation. (2008b). Timeline of work to enhance the role of certified nurse-midwives (CNMs), nurse practitioners (NPs), and physician assistants (PAs) in abortion care. Available at www.prochoice.org/cfc/resources/timeline.html
- National Abortion Federation. (2009). *Professional organizations speak*. Retrieved February 8, 2009, from http://www.prochoice.org/cfc/resources/professional_organizations.html
- National Association of Nurse Practitioners in Women's Health (now NPWH). (1991). Resolution on nurse practitioners as abortion providers, October 1991. Washington, DC: NPWH, www.npwh.org.
- National Organization of Nurse Practitioner Faculties, & American Association of Colleges of Nursing. (2002). *Nurse practitioner primary care competencies in specialty areas: Adult, family, gerontological, pediatric, and women's health*. Prepared for Department of Health and Human Services, Health Resources and Services Administration, No. HRSA 00-0532(P)). Rockville, MD.
- North Dakota Board of Nursing. (n.d.[a]). Decision-making model for scope of practice. Retrieved March 5, 2009, from http://www.ndbon.org/practice/decision_making_model.shtml. (See also, Decision-making model summary: http://www.ndbon.org/practice/decision_making_model_summary.shtml).
- North Dakota Board of Nursing. (n.d.[b]). Practice statements. Retrieved March 5, 2009, from <http://www.ndbon.org/opinions/opinions.shtml>
- North Dakota Board of Nursing. (2006). *Request for practice statement related to nursing scope of practice questions*. SFN 52120 (9-06). Available at <http://www.ndbon.org/documents/1127593637.pdf>
- Prine, L., Lesnewski, R., & Bregman, R. (2003). Integrating medical abortion into a residency practice. *Family Medicine*, 35(7), 469–471.

- Simmonds, K., Zurek, M., Polis, C., & Foster, A. (2009). The Reproductive Options Education Consortium for Nursing: A unique approach to stimulating curricula reform in nursing education. *Journal of Nursing Education*. Under review. In press.
- Simmonds, K. E., & Likis, F. E. (2005). Providing options counseling for women with unintended pregnancies. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 34(3), 373-379.
- Singer, J. (2004). Options counseling: Techniques for caring for women with unintended pregnancies. *Journal of Midwifery and Women's Health*, 49(3), 235-242.
- Summers, L. (1992). The genesis of the ACNM 1971 Statement on Abortion. *Journal of Nurse-Midwifery*, 37(3), 168-174.
- Taylor, D., Levi, A., Battistelli, M. Nobel, K. & Weitz, T.A (2007). APC Curriculum & Syllabus in Early Abortion Care. Oakland, CA: University of California, Advancing New Standards in Reproductive Health, www.ansirh.org.
- Taylor, D., Safriet, B.J. & Weitz, T.A. (2009). When politics trumps evidence: Legislative or regulatory exclusion of abortion from advanced practice clinician scope of practice. *Journal of Midwifery and Women's Health*, 54: 4-7.
- U.S. Food and Drug Administration. (2000). FDA approves mifepristone for the termination of early pregnancy. Retrieved March 5, 2009, from <http://www.fda.gov/bbs/topics/NEWS/NEW00737.html>
- U.S. Food and Drug Administration. (2007). Mifeprex (mifepristone) information. Retrieved March 5, 2009, from <http://www.fda.gov/cder/drug/infopage/mifepristone/>