

THE ROLE OF PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND NURSE-MIDWIVES IN PROVIDING ABORTIONS

Strategies for Expanding Abortion Access



*Recommendations from a National Symposium
Atlanta, Georgia • December 13 - 14, 1996*



NATIONAL ABORTION FEDERATION

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In December 1996, the National Abortion Federation (NAF), convened a national symposium to explore how physician assistants, nurse practitioners, and nurse-midwives might increase their participation in abortion service delivery. The symposium's key findings and recommendations are summarized in this report.




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LETTER FROM NAF



Nearly seven years ago a national symposium was held to examine the shortage of physicians providing abortions in the U.S. The symposium participants found that the number of doctors providing abortions was dwindling, due to, among other things, anti-abortion violence and harassment, professional marginalization and the “graying” of providers. At the same time, obstetrics and gynecology residency programs were falling short of their responsibility to train new doctors in abortion services.

One of the key findings of that first symposium was that physician assistants, nurse practitioners, and nurse-midwives could be trained to perform first trimester abortions. In fact, in two states, physician assistants had already established a long history of providing such services. The symposium participants concluded that midlevel providers offered one of the most promising ways to expand abortion access.

Since the 1990 symposium, the issue of access has become even more pressing. The number of doctors providing abortion services continues to shrink. Violence against doctors and clinic workers has escalated. The involvement of midlevel clinicians is now more critical, and, recent surveys suggest that there is growing interest among these professional groups in participating in and providing first trimester abortion services.

During this time we have also seen the advent of medical abortion in this country, by which very early pregnancies can be ended with a combination of prescribed pills or injections. Management of unwanted pregnancy through the administration of medications, with appropriate follow-up, is well within the expertise and experience of physician assistants, nurse practitioners, and nurse-midwives. One of the biggest challenges ahead of us is ensuring that midlevel practitioners will be able to dispense mifepristone (RU-486) and methotrexate as they would other drugs.

In December 1996, the National Abortion Federation, with funding from the Kaiser Family Foundation convened a national symposium to explore these issues. The symposium participants agreed that there are several barriers to midlevel clinicians who want to become more involved in abortion service delivery. A common assumption shared by many clinicians and the public is that first trimester abortion can be safely provided only by physicians, a view reinforced in most states by outdated laws. But there is no reason to assume that such obstacles are insurmountable. Midlevel clinicians have a long history of responding to changes in health care, meeting the health care needs of underserved populations, and providing medical services that were once the sole domain of physicians. In most states, PAs, NPs, and CNMs routinely prescribe medications, and some perform surgery. The public has come to appreciate non-physician clinicians as trusted professionals. As attitudes have changed, so too have the regulations governing their practice.

There is no reason why laws and attitudes shouldn't change to permit midlevel providers to perform first trimester abortions. The fact is, abortion is the most common elective surgical procedure in the country. It is also one of the safest, whether performed by a doctor or a physician assistant. If women are to continue to have access to this crucial component of reproductive health care, then physician assistants, nurse practitioners, and nurse-midwives must be part of the solution. This symposium was held to develop strategies to help make this possible.



Rachel Atkins, PA; Symposium Chair

Executive Director of Vermont Women's Health Center

October 1, 1997

A NOTE ON TERMINOLOGY

Unfortunately, for our purposes, there is no single term that adequately or accurately encompasses all three of the professions that the symposium addressed: physician assistants, nurse practitioners, and nurse-midwives. The term “non-physician” is not helpful, for it only describes who they are not, rather than who they are. “Physician-extender” implies that these professionals are appendages to doctors. “Midlevel clinician” seemed, to most of the symposium participants, to be less objectionable, even with its unfortunate emphasis on hierarchy in health care.

Despite our efforts to agree on a single collective term, the symposium participants fully agreed that the three professions are distinct, and that they fill different roles in the health care mosaic. But those who attended also found that the professions share much in common, and that their common interests, in the context of abortion service delivery, outweigh their differences. Physician assistants, nurse practitioners, and nurse-midwives are united in their desire to provide the best possible patient care. They share many professional goals, and they have all contributed to a broadened definition of the health care provider, leading to expanded services for otherwise underserved populations. It is important to all three groups to ensure that their scopes of practice are not limited by arbitrary, politically motivated, non-medical considerations.

Below is a brief description of each of the professional groups the symposium addressed, and their scopes of practice:

Physician Assistant (PA)

PAs practice under the supervision of licensed physicians, providing patients with services ranging from primary medicine to very specialized surgical

care. They perform approximately 80 percent of the duties commonly done by primary care physicians and have prescriptive authority in most states. Most PAs are graduates of specially designated undergraduate physician assistant programs located at medical schools. States require PAs to pass a national certifying examination or to comply with state statutes, rules, and regulations set up to govern their practice. There are currently 29,000 practicing physician assistants in the United States.

Nurse Practitioner (NP)

An NP is a registered nurse who has advanced education (typically a masters degree) and extensive clinical training in at least one health care speciality area. NPs often serve as primary health care providers for children and adults. They diagnose and treat common health problems, order and interpret diagnostic tests, and prescribe and administer medications. Some states require NPs to pass a national certifying examination. There are more than 63,000 nurse practitioners in the United States.



Certified Nurse-Midwife (CNM)

A CNM is a registered nurse with advanced education and clinical training in obstetrics and gynecology, who has also passed a national certification examination. The CNM practices in collaboration with other health care providers as indicated by the health status of the client. CNMs attend women during labor and delivery and are trained and experienced in prenatal, postpartum and newborn care, and in routine family planning and gynecological care. Nurse-midwives have prescriptive authority in most states. There are approximately 4,000 practicing CNMs in the United States. (In addition to certified nurse-midwives, there are also lay midwives. These midwives are not usually registered nurses, and they have not necessarily taken a national certifying exam. This group practices legally in 30 states, but was not represented at the symposium.)

Advanced Practice Nurses (APN)

This term refers to nurses with advanced education and/or clinical training. In the context of this report, this includes nurse practitioners and certified nurse-midwives. It does not include physician assistants.

SUMMARY

In December 1996, the National Abortion Federation (NAF), with funding from the Kaiser Family Foundation, convened a national symposium to explore how physician assistants, nurse practitioners, and certified nurse-midwives could be encouraged to participate more fully in abortion service delivery nationwide. We invited a group of 30 participants, each with specialized expertise in issues related to abortion care, who met together to discuss and formulate strategies to advance this goal. The symposium's key findings and recommendations, which are summarized in this report, represent the consensus of opinion expressed by the participants during the course of this two-day meeting.

In light of the shortage of physicians currently performing abortions, and based on the findings of the 1990 symposium on the shortage of abortion providers, those attending the symposium agree that one of the most effective ways to increase the number of providers is to permit appropriately trained physician assistants, nurse practitioners, and certified nurse-midwives to provide first trimester abortions.

FINDING I

The symposium participants find that one of the greatest impediments to expanding the pool of abortion providers is the notion that first trimester abortion is a dangerous procedure that only physicians can perform safely. Appropriately trained midlevel clinicians possess the skills and expertise to perform this safe and routine elective procedure.

RECOMMENDATIONS

1. Better educate the medical community about the skills and abilities of PAs, NPs, and CNMs and their potential as abortion providers.
2. Better educate health care consumers about the safety of first trimester abortion and the expertise of midlevel practitioners in performing them.


3. Encourage PAs, NPs, and CNMs to pursue abortion training through better education about the positive public health impact of safe abortion.
4. Recognize and emphasize that PAs', NPs', and CNMs' contributions to abortion access complement, rather than compete with physicians. Collaborative relationships between providers promote good patient care.

FINDING II

Those attending the symposium find that a very carefully planned state-by-state effort will be needed to overcome the current legal restrictions limiting midlevel clinicians' participation in abortion service delivery. The complex manner in which the statutes and regulations are constructed, as well as the political context in which they exist, require state-specific strategies for change.

RECOMMENDATIONS

1. Recognizing that neither medical technologies nor laws are static, ensure that PAs, NPs, and CNMs have the appropriate skills so that they are not excluded from opportunities to participate in the delivery of medical abortions, nor to learn surgical abortion techniques.

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2. Pursue legal efforts to ease “physician-only” restrictions only after careful, state-specific background research and with secured political support, since unfavorable rulings can be very difficult to overcome.
 3. Provide multifaceted professional support for PAs, NPs, and CNMs who elect to participate in abortion service delivery, including legal advice, mentoring programs, and support networks.

FINDING III

Education and understanding of all aspects of abortion care, including counseling, pre- and post-abortion care, and abortion techniques must be expanded. The symposium participants find that it is crucial to integrate principles of abortion care into midlevel clinicians' curricula.

RECOMMENDATIONS

1. Even in states with “physician-only” laws, or where it is unclear whether other practitioners can legally perform abortions, incorporate didactic training in abortion into the PAs', NPs', and CNMs' education. Also include clinical experience in options counseling and abortion aftercare.
2. Establish abortion training curricula that include all aspects of abortion care, and develop creative strategies to ensure that abortion training can be integrated into the larger curriculum.
3. Develop appropriate mechanisms to support midlevel providers who want to expand their practices to include first trimester abortion.
4. Provide support for abortion training sites to help ensure sufficient training opportunities.

INTRODUCTION

THE ROLE OF PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CERTIFIED NURSE-MIDWIVES IN EXPANDING THE POOL OF ABORTION PROVIDERS

In the 1970s, when the Supreme Court struck down state laws prohibiting abortion, there was an immediate and dramatic reduction in the morbidity and mortality that had been associated with illegal abortion. First trimester abortion was soon established as one of medicine's safest procedures. However, since the 1980's, a steady decline in the number of doctors providing abortion services has been documented.

Physicians who practiced before the 1970s and witnessed firsthand the public health disasters associated with black market abortions are retiring; younger physicians are leaving the field after enduring anti-abortion violence and harassment; and others complain of inadequate financial and professional rewards. At the same time, alarmingly few medical residents are being trained in the procedure. In 1991, only 12 percent of ob/gyn training programs routinely provided first trimester abortion training to their residents. (*MacKay & MacKay, 1995*)

The cumulative effect of these developments has been that 84 percent of U.S. counties had no identifiable abortion provider by 1988. (*Henshaw & Van Vort, 1994*) So difficult is it to find an abortion provider in some areas of the country that the American Medical Association stated that the shortage of providers has the "potential to threaten the safety of induced abortion." (*AMA, 1992*)

To increase the number of clinicians willing to perform abortions, and to appropriately place abortion services within the context of other gynecological services women need, the pool of providers must be expanded. Physician assistants, nurse practitioners, and nurse-midwives, with appropriate training, represent one potential solution to this public health problem.

THE ROLE OF PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND NURSE-MIDWIVES

The dramatic change in the way health care is administered means PAs, NPs, and CNMs have a greater role in patient care than ever before. With the emergence of managed care, there is an exploding demand for the cost-effective services of these professionals, whose training qualifies them to provide many of the same services as physicians. Accordingly, regulatory and statutory requirements have been adjusted to accommodate the new health care environment. Depending upon the state, PAs, NPs, and CNMs can diagnose and treat a variety of medical conditions, prescribe and administer medications, perform diagnostic tests, do biopsies, suture wounds, and deliver babies.

With the increased visibility of physician assistants, nurse practitioners, and nurse-midwives, health care consumers are learning to accept these professionals in their expanded roles. At the Vermont Women's Health Center, for example, PAs are integrated into all aspects of gynecological care, with both PAs and physicians providing services. Patients there are free to request care from a specific provider. However, according to one survey, fewer than five percent of the clinic's

patients expressed a preference. (Freedman, et al., 1986)

More and more physicians and health care provider groups are recognizing the value of PAs, NPs, and CNMs in their own practices. Again, at the Vermont Women's Health Center, PAs provide outpatient procedures including abortion care and the management of gynecological disorders. As a result, physicians at the Center are free to manage more complicated outpatient problems and to provide inpatient medical and surgical care.

SUPPORT AMONG NURSING PROFESSIONALS FOR EXPANSION INTO ABORTION SERVICES

While physician assistants have been the first of the professions with a documented record in providing first trimester abortion services, they are not alone in recognizing that their profession has a role to play. Nurse practitioners and nurse-midwives have traditionally provided patient care appropriate to their skill and training, and they have stepped forward to provide health care in underserved areas.

Just as they have done in other areas, midlevel professionals recognize the need to include abortion services in their scope of practice in order to fill the void in abortion services. In 1991, the National Association of Nurse Practitioners in Reproductive Health (NANPRH) adopted a resolution that states that nurse practitioners, with appropriate training, are qualified to perform first trimester abortions. That same year, the American College of Nurse-Midwives (ACNM)

voted to rescind its 1971 statement that had prohibited CNMs from performing abortions, thus clearing the way for individual CNMs who chose to include first trimester abortion service in their practices to do so.

A survey of ACNM members conducted in 1991 found strong support within the profession for expanding practice to include providing abortion care. (McKee & Adams, 1994) Seventy-nine percent of the 1,208 respondents considered themselves "pro-choice." Fifty-two percent said that certified nurse-midwives should be permitted to perform abortions, and 19 percent said they might be willing to provide surgical abortions themselves. A full 57 percent said they would want prescriptive authority for the abortion-inducing drug, mifepristone (RU-486).

“The experience of advanced practice nursing suggests that a pattern of access exists for the creation of new nursing roles. Advanced practice nurses tend to expand into areas of health care in which a vacancy in services exists...”

— McKee and Adams
in the *Journal of Nurse-Midwifery*, 1994

One State's Experience: PAs Providing Abortions in Vermont

Physician assistants at the Vermont Women's Health Center have been performing abortions since 1973. Currently, PAs provide nearly all of the approximately 500 first trimester abortions at the Center each year, which is about one-fourth of all abortions performed in the state. Moreover, since the 1980s, the University of Vermont has relied upon PAs at Vermont Women's Health Center to provide training for their residents in out-patient gynecological services, including abortion. Physician assistants and nurse practitioners also provide first trimester abortions at the Planned Parenthood of Northern New England affiliate in Vermont.

A comprehensive analysis of complication rates in 2,458 first trimester abortions done at the Vermont Women's Health Center between 1981 and 1982 established that the abortion care provided by PAs was safe. Publishing in the *American Journal of Public Health*, the researchers found that "...there were no differences in complication rates between those women who had abortions performed by a physician assistant and those who had the procedure performed by a physician." Freedman, et al., 1986.

A new study by researchers at the Harvard School of Public Health, to examine 1996-97 complication rates, is currently underway.

FINDING I

OVERCOMING "PHYSICIAN-ONLY" THINKING

The symposium participants find that one of the greatest impediments to expanding the pool of abortion providers is the notion that first trimester abortion is a dangerous procedure that only physicians can perform safely. Appropriately trained midlevel clinicians possess the skills and expertise to perform this safe and routine elective procedure.

BACKGROUND

"Physician-only" thinking on the part of both health care providers and patients is pervasive. Among patients, and even among some midlevel providers, first trimester abortion is mistakenly seen as a dangerous procedure. This fear can be traced to the high morbidity and mortality statistics from the years when providers of most illegal abortions had no medical training. However, since 1973, when the Supreme Court struck down state laws banning abortion, medical advances and training have made first trimester abortion one of the safest and most common surgical procedures, with complication rates far lower than those associated with carrying a pregnancy to term.

Despite the straightforward nature of first trimester abortions, few doctors have considered delegating them to other providers. Yet many midlevel providers regularly manage complications of childbirth and perform procedures such as cryosurgery and cervical or endometrial biopsies. Some of these services require skills similar to those needed in first trimester abortion procedures and carry greater morbidity risks.

Attitudes *are* beginning to change. As more and more physicians gain firsthand exposure to the skills of PAs, NPs and CNMs, many are aware of the midlevel provider's significant potential to offer expanded services.

Indeed, in 1994, the American College of Obstetricians and Gynecologists (ACOG), as part of their effort to address the shortage of first trimester abortion providers, endorsed "programs to train physicians *and other licensed health care professionals* to provide abortion services in collaborative settings." [emphasis added] Similarly, as early as 1976, the American Public Health Association (APHA) urged midwifery and physician assistant programs to include abortion procedures as part of their curricula. (*See Appendix*)

RECOMMENDATIONS

1. Better educate the medical community about the skills and abilities of PAs, NPs, and CNMs and their potential as abortion providers.

The symposium participants find that it is crucial that physicians and others in the health care community recognize that appropriately trained PAs, NPs, and CNMs have the skills to perform first trimester abortions. They should be educated about the low complication rates associated with first trimester abortions, whether performed by a physician or another practitioner.

To achieve these goals it will be important to:

- publicize the successes of the midlevel clinicians who have already established themselves as providers of first trimester abortion, along with



relevant case studies in professional journals, in newsletters, and at professional conferences;

- highlight the comprehensive range of services that midlevel practitioners already provide, and promote recognition of these skills to both physician and midlevel professional groups;
- encourage midlevel practitioners to participate in clinical training with residents and physicians so their competency is demonstrated firsthand;
- promote the skills of PAs, NPs, and CNMs to managed care (HMOs) and insurance groups; and
- create advocacy and support networks within each profession through groups like *Midwives for Choice*, *Nurse Practitioners for Choice*, and *Physician Assistants for Choice*, with the goal of ensuring that there is support for those who choose to provide first trimester abortion services.

2. Better educate health care consumers about the safety of first trimester abortion and the expertise of midlevel practitioners in performing them.

To ensure that women are comfortable with the idea that non-physicians are performing their abortion procedures, it is imperative that the public be educated about the safety of first trimester abortions and about PAs', NPs', and CNMs'

training, skill levels, and ability to perform abortions.

The Vermont (*See box, page 11*) and Montana (*See box, page 14*) models demonstrate important success stories, and the fact that PAs have been performing abortions for two decades in each case should be as widely publicized as possible. Articles in the popular press and women's magazines are one way to pursue this goal. At a more personal level, physicians in joint practices can also validate services provided by PAs, NPs, and CNMs in the course of their normal communications with patients. Large medical settings, such as HMOs, are especially well-positioned to offer this level of patient education.

“There is no doubt that midlevel clinicians can do this procedure. It’s purely and unfortunately a political problem that again affects women and children’s health care.... I do think at some point this will fly and we will be able to do this.”

— Susan Cabill, PA-C,
symposium participant

3. Encourage PAs, NPs, and CNMs to pursue abortion training through better education about the positive public health impact of safe abortion.

Because an estimated 43% of all women in the U.S. will have an abortion by the time they reach age 45, (*Alan Guttmacher Institute, 1997*) it is important for all health care professionals who treat women of reproductive age to be knowledgeable about options counseling, appropriate referrals, and pre- and post-abortion care; and to have access to opportunities to be trained to perform first trimester abortions. As an integral part of the comprehensive care that women may need, it is important that all PAs, NPs, and CNMs, even those who do not perform abortions themselves, are supportive of the efforts of clinicians within their professions who do so.

4. Recognize and emphasize that PAs', NPs', and CNMs' contributions to abortion access complement rather than compete with those of physicians. Collaborative relationships between providers promote good patient care.

Efforts to integrate midlevel professionals into first trimester abortion service delivery should not be construed as an attempt by these clinicians to compete with physicians or replace them, but rather to enhance the medical community's ability to

meet the reproductive health care needs of their patients.

In order to accept a new pool of providers in the delivery of abortion care, the medical community will need to understand and recognize that there are great benefits to having additional practitioners providing first trimester abortions, especially where unmet patient needs exist.

PAs, NPs, and CNMs cannot replace physicians. Instead, doctors in collaborative relationships with them can better ensure that *all* aspects of reproductive health care are available to their patients. The symposium participants feel strongly that collaborative relationships between doctors, PAs, and APNs need to be continually encouraged.

Family Practice: The Partnership of a Physician and a Physician Assistant in Montana

When Susan Cahill, a physician assistant who performs abortions in Montana, went through the PA program at the State University of New York at Stonybrook in the 1970's, abortion training was an integral part of her education. In fact, all medical students at SUNY learned to do abortions, unless they opted out of the training for personal reasons.

After Cahill completed her studies in 1976 she moved to Montana to do an apprenticeship under Dr. Jim Armstrong, who has served as a preceptor for many PAs and NPs over the years. Armstrong, a family practice doctor, eventually hired Cahill to work with him because he wanted someone skilled in providing abortions. Armstrong says that as a young doctor in a New York hospital before *Roe v. Wade*, "I used to see 20 women a day who'd had botched abortions, some of them died." He was committed to offering abortion services, believing that the procedure should be part of any family practice.

Cahill's skills have allowed Armstrong to live up to his commitment to provide abortions. As a solo practitioner today, he says his office overhead is so high that he would not be able to offer abortions — which do not generate substantial income — without someone else in his practice skilled in the procedure. "So from a practical standpoint having her here has made it possible to provide a family practice and provide abortions."

When Armstrong hired Cahill in 1977, there were no laws dictating what a PA could or could not do. Physicians were permitted to delegate patient care to their personnel, as long as they worked under a doctor's supervision, which Cahill does. Even though not a single complaint has been lodged against Cahill in nearly 20 years of practice, in 1995 the state attempted to stop her from performing abortions. Cahill's current legal status is discussed in Finding II: Overcoming Legal Obstacles.

FINDING II

OVERCOMING LEGAL OBSTACLES

Those attending the symposium find that a very carefully planned state-by-state effort will be needed to overcome the current legal restrictions limiting midlevel clinicians' participation in abortion service delivery. The complex manner in which the statutes and regulations are constructed, as well as the political context in which they exist, require state-specific strategies for change.

BACKGROUND

After the 1973 Supreme Court decision in *Roe v. Wade* (410 U.S. 113, 1973), most states amended their laws to legalize abortion. In doing so, they generally legalized abortion only when performed by a physician. These “physician-only” provisions were largely designed to ensure safe abortion services, rather than as a vehicle to exclude other licensed health care providers with the skill and training to perform abortions safely.

Today, the majority of states have “physician-only” provisions in their abortion laws. These provisions may or may not be interpreted to prohibit midlevel practitioners from performing abortions. In New York, for example, the state’s Department of Health has concluded that the “physician-only” language of the state abortion law, read in light of other statutes, does not, in fact, ban physician assistants from performing abortions. (See box, page 16). In Montana, prior to the 1995 enactment of a statute that expressly prohibited physician assistants from performing abortions, PAs were permitted to perform abortions in that state, despite a “physician-only” provision in the state abortion law. (See box, page 17).

Six states — AZ, KS, OR, VT, WV, and NH — have no “physician-only” restriction. In four of those states — AZ, VT, WV and NH — broad, unconstitutional pre-Roe abortion bans were

either struck down in court or are unenforceable. In the remaining states, the law is unclear.

LAWS GOVERNING PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS AND NURSE-MIDWIVES

The laws and regulations that control PA, NP, and CNM practice are not simple ones. Each group is separately regulated by each of the 50 states, which means that the legislative/regulatory status of the individual professional groups varies from state-to-state, and may involve restrictions and rules adopted by state legislatures, health departments, medical boards, boards of midwifery, and/or boards of nursing. This makes it nearly impossible to develop a uniform national strategy that would open opportunities to midlevel providers with respect to abortion services. However, strategies effective in one place may be helpful elsewhere. (See Pearson, 1996 for a state-by-state analysis of legislation that affects NPs and CNMs.)

The legal ambiguity that existed in New York state was clarified in 1994, when the New York State Department of Health, in a Declaratory Ruling, found that state law “permits PAs to perform abortions, provided they otherwise comply with their licensure and practice requirements.”

“Physician-only” laws, however, continue to confuse and intimidate medical communities around the country. The U.S. Supreme Court has recently confirmed states’

Resolving the Legal Ambiguities Affecting PAs in New York

In New York, a state that has a “physician-only” law, but also grants PAs the authority to perform medical procedures, the Department of Health has issued an opinion that PAs can perform first trimester abortions just as they would any other medical procedure for which they are trained.

In the early 1990’s Donna Lieberman, Esq., and Anita Lalwani, Esq., of the Reproductive Rights Project of the New York Civil Liberties Union, reasoned that despite the perceived conflict between New York’s “physician-only” and PA statutes, properly trained PAs can legally perform first trimester abortions.

“It is true that, prior to enactment of the [New York] PA statute, abortion was legal only if performed by a physician. But the qualifying clause introducing the subsequently enacted PA statute, which expressly states that *‘notwithstanding any other provision of the law [emphasis added], a physician assistant may perform medical services...when under the supervision of a physician,’* trumps the penal law.”

— *Lieberman and Lalwani, 1994*

authority to restrict abortion practice to physicians. (*See box, page 17*). However, as the New York experience demonstrates, “physician-only” laws may not necessarily exclude appropriately trained midlevel providers from providing first trimester abortions.

THE EMERGENCE OF MEDICAL ABORTION

The advent of pharmaceutically-induced medical abortions (non-surgical abortions) presents a unique opportunity to incorporate midlevel clinicians into direct abortion service delivery, since these providers have the authority to prescribe and administer drugs in most states. Many PAs, NPs, and CNMs already prescribe other reproductive health related medications, including oral contraceptives, emergency contraception, and treatments for STD infections. In addition, many routinely perform comprehensive health assessments and provide post-abortion care, including re-aspirations after incomplete abortions, a key element of primary abortion services.

Nevertheless, medical abortion cannot be considered independently of the “physician-only” restrictions that apply in most states. As in the case of surgical abortion, these limitations must be analyzed in the context of the broader statutory scheme regulating midlevel practice. Most states permit midlevel clinicians to prescribe and/or administer medications. In the absence of superseding legal restrictions, this prescription-writing authority should be adequate to permit midlevel clinicians to prescribe and administer abortifacients.

It must also be noted that laws on the books in roughly a dozen states specifically prohibit the use, sale, or distribution of abortion drugs, although five of these states (CO, ID, IL, IA, MI) make exceptions for *physicians*. In many cases, these laws are unconstitutional and unenforceable vestiges from the late 1800’s, when the states were trying to protect consumers from dangerous elixirs, herbs, and other folk remedies. Abortifacient restrictions of more recent vintage, however, may apply only to non-physicians and may pose a more significant obstacle to midlevel practitioners.

RECOMMENDATIONS

1. Recognizing that neither medical technologies nor laws are static, ensure that PAs, NPs, and CNMs have the appropriate skills so that they are not excluded from opportunities to participate in the delivery of medical abortion, nor to learn surgical abortion techniques.

Medical technology is rapidly changing. With the advent of non-surgical abortion, PAs, NPs, and CNMs might naturally expect to be able to administer the medications and perform the necessary health exams required by this early abortion technique, because they are already well-qualified to perform such services. PAs, NPs, and CNMs must ensure that they have the counseling and medical follow-up skills so as not to be excluded from participating in delivery of services that may increase patients’ access to safe and effective health care.

Changes are to be expected within the medical profession as well as within the midlevel providers' professions. PAs were not even legally recognized to practice until the 1970's; now they can perform surgery. The legislatures and the courts have adapted to the expanding expertise of PAs, NPs, and CNMs, and it makes sense they will continue to do so in the future.

2. Pursue legal efforts to ease “physician-only” restrictions only after careful, state-specific background research and with secured political support, since unfavorable rulings can be very difficult to overcome.

To affect change in existing law, not only a state's statutory profile, but also the political climate must be right. This means that there must be 1) a demonstrated critical shortage of abortion providers, 2) support of state regulatory boards and professional associations, and 3) support among members of the legislature and the public. The risk of political backlash or of a negative ruling needs careful assessment.

In states where abortion service shortfall can be demonstrated, and where midlevel providers are available to meet those first trimester abortion care needs, the political as well as statutory obstacles should be exhaustively studied. Before any effort to challenge the laws begins, there should be extensive research into the construction of the state's

“physician-only” restrictions, as well as investigation into how they originally came about. It is also crucial to assess other practice regulations that apply to midlevel practitioners in the state.

Obviously, overhauling these outdated “physician-only” laws will take a great deal of time and resources. But it will also require a politically sophisticated strategy. Developing and tapping grassroots support within the various segments of the health care community is crucial, because the notion of non-physicians performing first trimester abortions may be a new one to many people. Lawyers and lobbyists must be especially sensitive to this as they address legislatures, medical associations, and the public. Those states that already give wide latitude to midlevel clinicians to practice unfettered by other non-medical limitations may be more receptive to expanding their options for abortion service delivery.

3. Provide multifaceted professional support for PAs, NPs, and CNMs who elect to participate in abortion service delivery, including legal advice, mentoring programs, and support networks.

To encourage midlevel clinicians to provide abortions, there must be ample support for the pioneers. PAs, NPs, and CNMs who wish to perform abortions must receive support from their peers, as well as the medical and legal communities.

U.S. Supreme Court Ruling: A Postscript on the Montana PA Case

In Montana, Susan Cahill, PA-C, has been performing first trimester abortions under the supervision of a family practice physician since 1977. She is the only PA in Montana performing abortions. The state legislature has made numerous attempts to limit Cahill's practice, and in 1995 passed a law preventing PAs from doing abortions.

Cahill's legal counsel, Simon Heller of the Center for Reproductive Law & Policy, successfully argued to a district judge that the law restricted a woman's right to abortion. The state appealed, and the case eventually went to the U.S. Supreme Court (*Mazurek v. Armstrong*). On June 16, 1997, without hearing oral arguments, the Court decided by a 6 to 3 vote that the Montana bill did not impose an undue burden on women, and let the law stand.

Responding to the ruling, Heller said, “The Supreme Court decision makes it very unlikely that we will be able to strike down laws specifically barring physician assistants, nurse practitioners, and nurse-midwives from performing abortions. But only Montana has such a law. We can continue to argue, as was successfully done in New York, that existing laws requiring that abortions be performed by a physician do not prevent other qualified health care professionals acting under the direction of a physician (like PAs) from performing abortions.”

Heller plans to return to federal court to argue that the bill is an illegal “bill of attainder” — i.e. that it is a law affecting only one person or one group.

The following should be made available:

- state-specific legal advice;
- support from appropriate professional associations;
- mentoring programs and networking opportunities so no one is forced to practice in isolation from supportive colleagues; and
- resources for evaluation of and advice about security issues.

“We couldn’t have made the arguments we made in New York and done what we did in New York...in terms of opening up the practice without knowing New York history backward and forward and knowing New York politics backward and forward. And we didn’t do it until we were extremely confident that we were going to win. Now maybe we were over-cautious, but we got the right result.”

— Donna Lieberman, Esq.,
symposium participant

FINDING III

OVERCOMING TRAINING OBSTACLES

Education and understanding of all aspects of abortion care, including counseling, pre- and post-abortion care, and abortion techniques must be expanded. The symposium participants find that it is crucial to integrate principles of abortion care into midlevel clinicians' curricula.

BACKGROUND

While there are limited opportunities for medical residents to get clinical training in abortion, there are virtually none for PAs, NPs, and CNMs. One of the few facilities currently offering first trimester abortion training to midlevel clinicians is the Vermont Women's Health Center. As of 1996, the center had trained 14 PAs.

The symposium participants noted that midlevel clinicians have often had to practice beyond their mandate in order to rise above antiquated laws. To gain professional legitimacy, PAs, NPs, and CNMs have sometimes taken on certain new services, demonstrated their ability to perform them safely, gained acceptance as legitimate providers of these services, and *then* sought recognition by certifying, regulatory, or licensing boards. The history of their professions is full of many examples where midlevel clinicians established themselves legally by first working illegally.

Those who attended the symposium do not suggest that PAs, NPs, or CNMs provide abortions where it is not legal to do so. Rather, they stress that only when relevant abortion education is built into the curricula, will governing bodies, physicians, and health care consumers be convinced that this is a reasonable area in which PAs, NPs, and CNMs may practice.

Above all, abortion education for midlevel clinicians must

emphasize that abortion is a fundamental part of women's comprehensive health care, regardless of the legal restrictions.

RECOMMENDATIONS

1. Even in states with “physician-only” laws, or where it is unclear whether other practitioners can legally perform abortions, incorporate didactic training in abortion into the PAs', NPs', and CNMs' education. Also include clinical experience in options counseling and abortion aftercare.

If abortion care is not part of the basic competency for PAs, NPs, and CNMs, and is not recognized as part of their scope of practice, then legislators and regulatory boards will be hesitant to grant midlevel clinicians new practice options. Therefore, it should be a priority of the midlevel clinicians' professional organizations to require their members to have at least some exposure to the basics of abortion care in their curricula.

2. Establish training curricula that include all aspects of abortion care, and develop creative strategies to ensure that abortion training can be integrated into the larger curriculum.

All PA, NP, and CNM students should have “curricular exposure” to abortion, though not necessarily clinical expo-

sure. Didactic training is not only legal but can help to emphasize to students that abortion is part of comprehensive gynecological care. To achieve this, the symposium attendees recommend development of profession-appropriate training objectives which include options counseling, abortion techniques, and follow-up care. These curriculum guidelines should be made available not only to PA, NP, and CNM programs, but to nursing and medical schools as well.

All students should be exposed to:

- pregnancy options counseling techniques that emphasize unbiased and non-judgmental assistance, including values clarification and referral information;
- the management of unwanted pregnancy, the abortion procedure, and recommended follow-up care; and
- the historical and public health aspects of abortion delivery services.

In order to convince faculty to include abortion education in their curriculum, it is imperative to:

- reach out to faculty who believe abortion should be part of their school's curriculum;
- lobby professional associations to require abortion education as part of training; and
- ask agencies that administer national/state tests to include abortion questions on exams.

Those who attended the symposium understand that there are educational problems unique to abortion. Due to the highly charged political environment, there is a potential for abortion education to be marginalized. In addition, because so few midlevel clinicians have been trained to perform abortions, it may be difficult initially to find enough people even to teach the procedure.

To deal most effectively with potential educational problems it is important to:

- develop a “train-the-trainers” program to make up for the shortfall of medical personnel who can teach abortion;
- integrate abortion education into the total curriculum, rather than isolating it in a separate course; and
- provide legal support and advice for PA, NP, and CNM students who want to begin clinical training.

3. Develop appropriate mechanisms to support midlevel providers who want to expand their practices to include first trimester abortion.

Every effort should be made to make it as simple as possible for PAs, NPs, and CNMs to pursue clinical abortion training. **Such efforts should include:**

- publicizing abortion training opportunities in PA, NP, and CNM newsletters;
- assisting students by offering scholarships and grants for clinical training in abortion;

- offering guidance with licensing or certification processes;
- evaluating security concerns and needs, and offering security consultations; and
- establishing “Students for Choice” groups on campuses to provide mentors and networking options for students.

The symposium participants expressed concern that mid-career professionals not be ignored. PAs, NPs and CNMs who have already received their training/certifications should have the opportunity to learn first trimester abortion techniques, whether through formal continuing education programs or special sessions at professional conferences.

4. Provide support for abortion training sites to help ensure sufficient training opportunities.

As new students develop interest in abortion, additional training opportunities will have to be developed. **It will be necessary to:**

- ensure that training centers have security support;
- find ways to provide appropriate financial compensation at sites where training activities are offered;
- increase training opportunities so that PAs, NPs, and CNMs do not have to compete with residents for training; and
- identify facilities that are centers of excellence.

CONCLUSION

Women may have won the right to safe, legal abortion, but it is a right that means little unless access to these services is preserved. The solution those attending the symposium offer — training physician assistants, nurse practitioners, and nurse-midwives in abortion — should be viewed as a promising opportunity for these midlevel clinicians and their patients. The potential of these new groups of health care professionals to provide high quality abortion care is significant, and worthy of serious efforts toward implementation. The symposium participants believe that these recommendations will result in better patterns of patient care.

“This expansion of the provider pool makes sense because abortion will be an empty right if there is no one to provide it. But it also makes sense because it is sensible. Why not allow professionals to provide a medical service for which they are qualified?”

— Anna Quindlen, *New York Times*, April 21, 1993



APPENDIX: ORGANIZATIONAL STATEMENTS ON MIDLLEVEL PROVIDERS AND ABORTION

AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

“The AAPA affirms a patient’s right of access to any legal medical treatment or procedure made with the advice and guidance of their health care provider and performed in a licensed hospital or appropriate medical facility.

“The AAPA supports the free exchange of information between the patient and provider and opposes any intrusion into the provider/patient relationship through restrictive informed consent laws, biased patient education or information, or restrictive government requirements of medical facilities.

“The AAPA opposes attempts to restrict the availability of reproductive health care.”

— *Policy Adopted by the AAPA House of Delegates, May 1992*

“The AAPA is committed to the principle that a physician assistant should be allowed to perform any medical task, including abortion, delegated by a physician under whose supervision the task will be performed.”

— *Deposition statement in defense of a challenge to Montana’s “physician-only” abortion law, (Doe v. Esch), 1993*

ASSOCIATION OF PHYSICIAN ASSISTANTS IN OBSTETRICS AND GYNECOLOGY

“In 1992, the Board of Directors of the Association of Physician Assistants in Obstetrics and Gynecology (APAOG) voted to support the policies of the American Academy of Physician Assistants (AAPA) regarding reproductive health.”

— *Statement of the Association of Physician Assistants in Obstetrics and Gynecology, September 9, 1997*

NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN REPRODUCTIVE HEALTH

“Whereas, the purpose of the National Association of Nurse Practitioners in Reproductive Health (NANPRH) is to ‘assure quality reproductive health services which guarantee reproductive freedom and to protect and promote the delivery of these services by nurse practitioners’;

“Let it be resolved that NANPRH believes that nurse practitioners, with appropriate preparation and medical collaboration, are qualified to perform abortions.”

— *Resolution on Nurse Practitioners as Abortion Providers, October 1991*



AMERICAN COLLEGE OF NURSE-MIDWIVES

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 to 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.

— *Approved by the Board of Directors, February 3, 1991*

In 1991, the ACNM asked its membership whether it wanted to rescind a 1971 statement prohibiting members from performing abortions. Members voted to remove the prohibition. The ACNM leadership wrote in the association's newsletter *Quickening* that the vote did not mean the ACNM has gone on record for or against abortion. The vote meant that individual CNMs now have the option to become involved in abortion service provision.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

“That to address the shortage of health care providers who perform abortions, the College encourages programs to train physicians and other licensed health care professionals to provide abortion services in collaborative settings.”

— *Statement of ACOG's Executive Board, January 1994*

AMERICAN PUBLIC HEALTH ASSOCIATION

“Urges medical, nursing and public health schools, residency training programs, and midwifery and physician assistant programs to develop and incorporate materials on the medical need, procedures, and technology, as well as the history and public health aspects of abortion into current curricula.”

— *APHA Resolution No. 7626, 1976*



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ENDORSEMENTS



National Association of Nurse Practitioners in Reproductive Health (NANPRH)

The mission of the National Association of Nurse Practitioners in Reproductive Health (NANPRH) is “to assure quality reproductive health services which guarantee reproductive freedom, and to promote and protect the delivery of these services by nurse practitioners.” In keeping with its mission, NANPRH supports the delivery of abortion services by nurse practitioners who are qualified by advanced preparation and who have appropriate medical collaboration. We strongly endorse the recommendations contained in this report.

American Academy of Physician Assistants (AAPA)

As indicated in this report, abortion services have been provided by some physician assistants for a number of years. The American Academy of Physician Assistants (AAPA) believes that PA practice should not be arbitrarily limited by political considerations, but rather should be determined by patient needs, physician delegation, and the PA’s training, experience, skills, and choice. To the extent that abortion services meet these criteria, the AAPA concurs with the basic statements in this report.

American College of Nurse Midwives (ACNM)

The American College of Nurse-Midwives (ACNM) recognizes the importance of the recommendations contained in this report in terms of ensuring access to safe, humane, and individualized services. ACNM further recognizes that where state licensure permits, some of our members may seek training in this service as an advanced practice procedure which goes beyond the core competencies, and appropriate guidelines should be utilized therefore.



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