



When Politics Trumps Evidence: Legislative or Regulatory Exclusion of Abortion From Advanced Practice Clinician Scope of Practice

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The topic of abortion elicits strong opinions among the general public as well as individual clinicians. The professionally relevant question addressed in this commentary, however, is not whether abortion should be legal or not but whether appropriately trained certified nurse-midwives (CNMs), nurse practitioners (NPs), and physician assistants (PAs), who are collectively referred to as advanced practice clinicians in this commentary, are professionally capable of performing abortion procedures. As health professionals, we should expect that professional scope of practice determinations are based upon whether the “profession can provide this proposed service in a safe and effective manner.”¹

CNMs and NPs have a long history of providing reproductive health services. Abortion laws, many of which were enacted prior to both the expansion of advanced practice nursing roles and the development of newer and simpler abortion technologies, have created a confusing situation for those clinicians who want to offer abortion care. In the years directly following the *Roe v Wade* Supreme Court decision legalizing abortion, many states enacted physician-only laws to protect women from unsafe, unlicensed abortion providers. These laws were not meant to prohibit the future evolving scope of practice by advanced practice clinicians. However, this exclusion has de facto become a restrictive legacy, in part because of hesitation on the part of health professional organizations to address the issue of women’s access to abortion services.

Most recently, newer “physician-only laws” have been used explicitly (and covertly) to limit access to abortion, sacrificing fully competent professionals’ scope of practice in the name of a political agenda against legal abortion. For example, in Arizona (one of six states without a physician-only abortion provision statute), legislation was passed in 2007 to prohibit PAs from performing abortions, and a new bill, introduced in the 2008 Arizona legislature that would prohibit nurses from performing

abortions, was narrowly defeated.^{2,3} These legislative or regulatory exclusions of abortion from the scope of practice of advanced practice clinicians reflect an example of politics trumping evidence and should be of concern to all health professionals who care about their scope of practice.

SCOPE OF PRACTICE

Scope of practice can be defined as the activities that an individual health care practitioner is permitted to perform within a specific profession and is uniquely defined by the congruence between law and appropriate practice.⁴ More specifically, the boundaries of scope of practice are defined by clinical competence and skill, knowledge and training, professional and institutional standards, and legal-regulatory requirements. Scope of practice evolves and changes over time due to community needs and technology advancements, as well as health professional practice and education standards, institutional policies, and state laws or regulations.⁵

From this scope of practice perspective, a compelling argument can be made that early abortion care is within the scope of CNM, NP, and PA practice. First, advancing scope of practice requires evidence that a new skill or technique will facilitate access to safe and effective health care services and that professional and educational standards and competencies are consistent with a new area of practice.⁶ An examination of the evidence confirms that abortion is very safe and that advanced practice clinicians are safe and competent primary care providers, whose current scope includes a number of clinical skills that are much more complicated than uterine aspiration for induced abortion. It also reflects an understanding that CNMs, NPs, and PAs positively affect access to earlier and safer reproductive health care for women.

ABORTION IS SAFE

Abortion is one of the safest and most commonly provided medical procedures in the United States, and less than 1% of all abortion patients experience a major complication.⁷ Large-scale studies continue to find that legal abortion by

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uterine aspiration is an extremely safe procedure.^{7–10} Women are far more likely to die from pregnancy-related complications, from automobile accidents or from a fall, than they are from having undergone either a medication or aspiration (anachronistically labeled “surgical”) abortion⁸ (Table 1). Abortion is less risky than other medical or surgical procedures performed outside the hospital (Table 2). According to four review articles of first-trimester abortion studies,^{7–9} the death rate varies from 0 to 0.7 per 100,000 abortions and is smaller when the procedure is done under local anesthesia rather than general anesthesia.⁹ In a community-based study of 1132 surgical (e.g., aspiration) abortions, about 88% of the women were less than 13-weeks pregnant. Of these women, 97% reported no complications, 2.5% had minor complications (e.g., infection, bleeding, incomplete abortion) that were handled at a medical office or abortion facility, less than 0.5% had more serious complications that required some additional surgical procedure and/or hospitalization, and no deaths were reported.¹⁰

ADVANCED PRACTICE CLINICIANS ARE COMPETENT PROVIDERS OF REPRODUCTIVE HEALTH SERVICES

In their roles as providers of primary and specialty care, CNMs, NPs, and PAs perform a number of tasks and procedures that are relevant, and in some cases equally or more complex than abortion. Among an ever-expanding set of examples, advanced practice clinicians prescribe and provide extensive education about the use of a wide range of medications; perform ultrasounds, endometrial biopsies, insertion of intrauterine contraception, colposcopies, colonoscopies, and circumcisions; suture wounds; and order and interpret electrocardiograms and x-rays. With appropriate training, NPs and PAs are able to insert chest tubes, arterial lines, and perform spinal taps, all advanced practice skills that are deemed to be within their scope of practice. Both domestic and international studies have found that CNMs, NPs, and PAs achieve health outcomes equal to, and often better than, those of physicians.^{12,13}

Furthermore, there is a growing body of evidence that advanced practice clinicians are safe, efficacious providers of abortion, via both medication and aspiration methods.

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Table 1. What's In a Name?

“Medication abortion” most accurately represents use of safe and effective drug-based methods that can terminate an unwanted pregnancy through agents administered orally or by injection.

“Aspiration or suction abortion” is a recommended descriptor for nonmedication abortions. First-trimester abortion interventions are most often completed through uterine evacuation using either electric or manual vacuum or suction aspiration methods.

Source: Weitz et al., 2004.¹¹

Studies published in 1986, 2004, and 2006 comparing abortions performed by physicians to abortions performed by NPs and PAs found comparable rates of safety and efficacy.^{14–16}

Advanced practice clinicians now routinely perform medication abortion (using the abortion pill mifepristone, formerly RU-486) in 14 states and perform aspiration abortion (commonly called “surgical abortion”) in six states that do not restrict abortion provision to physicians, including Arizona, Montana, New Hampshire, New York, Oregon, and Vermont, as well as internationally in countries such as South Africa and Vietnam. Several European countries, including Great Britain, are initiating an expansion of access to abortion provision by incorporating advanced practice clinicians as abortion providers. Recognizing the competence and potential to significantly contribute to patient care in this area of reproductive health, numerous professional organizations have made statements in support of CNMs, NPs, and PAs as providers of abortion services (American Association of Physician Assistants, 1992; American College of Nurse-Midwives, 1991; American College of Obstetricians and Gynecologists, 1994; American Medical Women's Association, 1995; American Public Health Association, 1991; International Confederation of Midwives, 1996; National Association of Nurse Practitioners in Women's Health (formerly NANPRH), 1991; Physicians for Reproductive Health, 1999).¹⁷

ADVANCED PRACTICE CLINICIANS INCREASE ACCESS TO EARLY CARE

The risk of complications associated with abortion increases with each week of pregnancy,⁷ and thus, expanded access to early abortion services promotes safer care and improvements in public health. CNMs, NPs and PAs (with appropriate training and professional credentialing) currently provide the full range of pregnancy care, except for the few clinicians currently offering abortions in unregulated states.¹⁸ When regulatory barriers, not personal consciences, prohibit advanced practice clinicians from offering abortion services, the continuity of care for a woman receiving care from a clinician who could perform the abortion may be artificially broken, thereby disrupting the protective effect of a regular source of care.

Table 2. Early Aspiration Abortion Is Not a Surgical Procedure

Aspiration abortion is often called “surgical abortion”; it does not involve surgery and the term “surgical” procedure is a holdover from a time when all abortions were performed in hospitals. Rather, a thin plastic cannula is placed into the uterus to remove the pregnancy tissue. Gentle suction, either created by a handheld pump called a manual vacuum aspirator or an electric pump, is used to empty the contents of the uterus. The entire procedure takes about 3–5 minutes to perform. There is no cutting or stitching like there is in classic surgery. Women are usually awake and given mild medications to help with the cramping that accompanies the procedure. Uterine aspiration for diagnosis and treatment of dysfunctional uterine bleeding or endometrial dysplasia is not considered “surgery,” despite employing similar techniques to stabilize the cervix with a tenaculum to enter the uterus through the cervical os, often after minor dilation. Uterine aspiration via manual or electric suction is also used in an outpatient or office setting to treat a “spontaneous or threatened abortion,” commonly called a miscarriage. This suction or aspiration procedure for uterine evacuation or pregnancy termination does not meet the criteria for surgery and is safely performed in outpatient and primary care clinics.

In the United States, there are approximately 200,000 licensed CNMs, NPs, and PAs who today perform primary health care services once provided only by licensed physicians. In the more than three decades since the 1973 *Roe v Wade* decision legalizing abortion in the United States, these clinicians have become essential health care providers for diverse communities in hospitals, clinics, and public health systems across the United States, with special representation among poor and underserved populations. The majority of CNMs, NPs, and PAs provide primary care to reproductive-aged women, see patients with unintended pregnancies, and often practice in medically underserved settings. A recent study, for example, indicates that 49% of NPs and 69% of PAs in California serve rural and vulnerable populations, compared with 35% of obstetricians/gynecologists.¹⁹ And in 2004, advanced practice clinicians saw six times as many women for publicly funded family planning services as did physicians.²⁰ Thus, the provision of early abortion by CNMs, NPs, and PAs increases access to care for those populations most underserved by the health care system.

POLITICS OVER EVIDENCE: EXCLUDING ABORTION FROM ADVANCED PRACTICE CLINICIAN SCOPE OF PRACTICE

The criteria related to who is qualified to perform functions safely without risk of harm to the public are the only justifiable conditions for defining or restricting scopes of practice.¹ Qualification criteria assume professional standards for practice, minimum competency, and education (basic and postgraduate preparation). The basic principles of safe and ethical practice remain a constant, whether an advanced practice clinician practices independently, collaboratively, or in a rural or an urban area. Self-examination and reflective practice, through examination of the scope domains, combined with adherence to educational and clinical practice standards, provide the foundation for legal and professional regulation and advancement of professional practice, as well as the improvement of access to safe and effective health care.²¹

The procedures of abortion and follow-up care fall well within the scope of practice for CNMs, NPs, and PAs who have received adequate education and training to competently and safely perform the procedures. Interpreting

these safe and relatively uncomplicated procedures to be outside the scope of practice of CNMs, NPs, and PAs, regardless of their documented competence, runs directly counter to the extensive evidence of these essential women’s primary care providers’ current, safe performance of even more complicated procedures. Whatever one’s personal opinion about the legal status of abortion, unfettered professional support for evidence-based decisions about scope of practice should not be sacrificed in the name of politics.

CONCLUSION

Supporting advanced practice clinicians as providers of early abortion will make abortion safer and more accessible for traditionally underserved populations. Furthermore, the exclusion of the safe and uncomplicated procedures of uterine aspiration for induced or spontaneous abortion and medication abortion from the scope of practice of qualified CNMs, NPs, and PAs results in a limitation of professional expertise, safety, and access as the central principles guiding the evolution of all professionals’ scope of practice. This result is harmful to the public as well as the professions and can be avoided by evidence- and competence-based interpretations and applications of the practice authority of CNMs, NPs, and PAs.

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