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Key legal barriers for provision of abortion by Advanced Practice Clinicians

In response to the legalization of abortion in 1973, states enacted various abortion restrictions. Among these were restrictions on who may legally provide abortions.

Framed both by the language used in the *Roe v. Wade* opinion (which held that states cannot proscribe abortions provided by "licensed physicians"[1]) and by the need to forestall a proliferation of potentially unsafe and untrained abortion providers,[2] legislatures and/or regulatory bodies in most states adopted policies limiting the practice of abortion to licensed physicians. However, many of these provider-specific restrictions, often referred to as "physician-only" laws, were enacted before the roles of physician assistants (PAs), certified nurse midwives (CNMs), and nurse practitioners (NPs)—collectively referred to as advanced practice clinicians or APCs—were defined within state practice acts and before significant advances in abortion provision technology and training. Despite developments in APCs' clinical abilities and scopes of practice over the past 36 years, abortion provider restrictions are still in place in most states.

This paper provides a brief overview of the current status of these provider restrictions across the United States, and reviews strategies state advocates have used to eliminate or lessen the impact of these restrictions on APCs providing abortions.

Current status of provider restrictions for abortion within the United States

Currently, only five states—Kansas, New Hampshire, Oregon, Vermont, and West Virginia—do not have laws prohibiting the provision of either medication or aspiration abortion by NPs, CNMs and/or PAs.[3] In the majority of other states, restrictive statutes exclude abortion from the legal scope of practice of APCs, and thus prohibit well-qualified clinicians from providing abortion services.

Typically, the general parameters of APC scope of practice are established under state practice acts, and through subsequently-promulgated licensing board rules and regulations, which are intended to assess and validate the ever-evolving clinical competences of licensees. But, provider-specific restrictions place abortion outside of this typical governance model by excluding abortion procedures from APCs' scope of practice. While some states place these provider restrictions within practice acts,[4] most of these laws appear within targeted abortion statutes, some of which are located within state penal codes.[5]

Despite the presence of "physician-only" provider restrictions in most states, by 2004, APCs with appropriate training were providing medication or aspiration abortions in approximately 14 states.[6] Stakeholders in many of these states have used a variety of mechanisms to secure clarification and some level of legal protection for APCs who provide medication or aspiration abortions. These mechanisms include: legislative changes and state-sanctioned demonstration/pilot projects, judicial challenges, Attorney General opinions, and administrative agency and professional licensing board rulemaking, declaratory rulings, and opinions.

State legislative changes

In California, advocates have worked for incremental statutory reform to allow for APC provision of abortion. California is currently the only state with a statute explicitly stating that APCs are authorized to provide abortion.

The Reproductive Privacy Act of 2002, which codified a woman's right to obtain an abortion within the state,[7] includes a provision stating that qualified and licensed individuals — including APCs — may provide "nonsurgical abortion," while only a licensed physician and surgeon may perform a "surgical abortion."[8] Under this statute, APCs in California are providing medication abortion, which is included under the definition of "nonsurgical abortion."

Additionally, since 2007, APCs involved in the University of California, San Francisco's (UCSF) Health Workforce Pilot Project (HWPP) No. 171 are providing aspiration abortion under a legal waiver of the surgical abortion statute.[9] Through this demonstration project, researchers at UCSF's Advancing New Standards in Reproductive Health (ANSIRH) program are collecting and analyzing data on patient, clinician and health services outcomes that will be distributed to state policymakers in an effort to inform decision-making related to the provision of early aspiration abortion by APCs.

State judicial rulings

As Montana's experience demonstrates, provider restrictions could be successfully challenged in states where constitutions provide explicit rights to privacy or courts have broadly interpreted the right to privacy.[10] In 1995, the Montana legislature enacted a statute restricting the practice of abortion to licensed physicians.[11] Although the U.S. Supreme Court held that the Montana law does not violate the U.S. Constitution,[12] a subsequent challenge in state court resulted in the Montana Supreme Court's enjoining enforcement of the Montana law.

That court found 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."[13] The Montana Supreme Court's determination means that qualified APCs providing abortion care in Montana cannot be prosecuted under the state's restrictive statute.

State Attorney General decisions

In light of the historical reality that many provider-specific restrictions were written before the development and FDA approval of medication abortion or before advances in APC scope of practice, advocates in some states have requested that their state attorney general (AG) provide an interpretation of 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.[14] Therefore, receiving a positive AG interpretation of the state's abortion laws may provide APCs with the reassurance needed to incorporate abortion care into their scopes of practice.

Washington, Connecticut and Illinois, provide three examples of states in which AG opinions have determined that medication abortion services are within the scope of practice of APCs in their states, based on their interpretations of physician-only statutes that predated FDA approval of medication abortion and/or enactment of APC practice acts.[15]

In Washington, a statute provides that "a physician may terminate and a health care provider may assist a physician in terminating a pregnancy."[16] The intent of this voter-enacted law[17] was not to prevent qualified health care professionals from prescribing medication abortion. Indeed the voters' intent to protect women's health is clear from the language of the statute stating that regulation of abortion should "impose the least possible restriction on the woman's right to have an abortion."[18] Based on this language, the Washington AG issued an opinion stating that it is not unlawful for an advanced practice nurse acting within the terms of her professional license to "perform acts or procedures which will have the effect of terminating a woman's pregnancy."[19]

Under similar reasoning, the Connecticut AG issued an opinion in 2001 that allows advanced practice nurses and PAs who are practicing in accordance with state statutory requirements and conditions to offer medication abortion.[20] This opinion considered the broad scope of practice and prescriptive authority granted to APCs and the FDA's approved medication abortion regimen.[21]

Most recently, the Illinois AG issued an opinion finding that Illinois abortion law does not preclude APCs working under the supervision of a physician from providing medication abortion. The Illinois AG reasoned the section of the abortion law containing the physician-only restriction[22] was last amended before the legislature enacted the practice acts that allow APCs to assist physicians by dispensing medicine, including mifepristone, according to the general practice within the state.[23]

These three AG opinions helped clear the path for APCs practicing in these states to provide medication abortion and demonstrate a possible strategy for advocates in other states with outdated provider restrictions.

State administrative agency actions—regulations, declaratory rulings, and decisions

State administrative regulations

State constitutions and legislatures typically grant administrative agencies the authority to interpret and implement laws through agency-promulgated rules and regulations, which are generally enforceable if they are within the scope of the authority granted by the legislature.[24] A recent action in Rhode Island provides an example of how APCs' authority to provide abortions was recognized by rulemaking by the state's Department of Health (DOH). Acting pursuant to the express authority to safeguard the health, safety, and welfare of women who are terminating pregnancies, the DOH issued a set of rules and regulations specifying that a physician or "other licensed health care practitioner practicing within the scope of his or her practice" may perform pregnancy termination procedures, while only a physician may perform "surgical terminations."[25] Thus, APCs practicing in Rhode Island may offer medication abortion under these administrative regulations.

Administrative agency declaratory rulings

Like AG opinions, administrative declaratory rulings and opinion letters are often persuasive authorities but do not provide APCs with the same protection as statutes or judicial rulings.

In New York, stakeholders sought clarification from the New York Department of Health on whether new classifications of providers, such as PAs, could offer abortion under the state's physician-only law. Despite the presence of a criminal statute limiting the provision of abortions to licensed physicians, the Department issued a Declaratory Ruling in December 1994, stating that abortions may be assigned to and performed by PAs.[26]

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."[27] While APCs providing abortions in New York can cite this opinion in support of their practice if an issue arises, this caution serves as a reminder of the limitations of administrative rulings interpreting state laws.

State health professional licensing board decisions

In carrying out their legislatively delegated responsibility to investigate and decide allegations concerning a licensee's scope of practice, some state health profession licensing agencies (such as nursing boards) have by necessity had to grapple with the issue of whether APCs are authorized to provide aspiration or medication abortions. For example, in 2006, after receiving a complaint against an NP who provides

aspiration abortion, the Oregon State Board of Registered Nursing (OSBN) determined "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." [28]

A year later, after receiving and investigating a similar complaint, the Arizona Board of Nursing (AZBN) stated: "[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); there is documented evidence of competency in the procedure."[29] In both cases, decisions were made after careful review of the credentials, experience and skills required for advanced practice nurses to provide aspiration abortion.

These decisions represent significant victories for nursing and pro-choice advocates alike. However, subsequent events in Arizona illustrate the political fragility of such rulings. Legislators who objected to the AZBN's decision that aspiration abortion was within the scope of practice of appropriately prepared NPs, introduced legislative proposals to explicitly 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.[30] The replacement of a pro-choice by an anti-choice governor in Arizona, in combination with an anti-choice legislature, facilitated the passage of this legislation at the close of the most recent legislative session.

Conclusion

Although antiquated provider restrictions present barriers for APCs who would like to provide abortions, these state strategies demonstrate some of the approaches stakeholders can adopt to remove or limit the impact of these barriers. Whether seeking legislative reform, a state constitutional interpretation, regulatory decision or administrative ruling, the political and legal climates within the state influence the strategy chosen and may affect the permanence of the outcome.

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Endnotes

1 *Roe v. Wade*, 410 U.S. 113, 149 (1973). *See also* Schirmer, Jennifer Templeton (1997). *Physician Assistant as Abortion Provider: Lessons Learned from Vermont, New York, and Montana, 49 Hastings L.J. 252, 283.*

2 Kruse, B., Gordon & Tanenhaus, J. (2001). *The role of midlevel providers in abortion care in the United States.* Country profiles on abortion services: USA. Paper presented at the Expanding Access: Advancing the Role of Midlevel Providers in menstrual Regulation and Elective Abortion Care conference (December 2-6, 2001), Pilanesberg National Park, South Africa. Abstract available at: www.tinyurl.com/yjhprm9.

3 *See* Guttmacher Institute. (2009). *State policies in brief: An overview of abortion laws*. New York; 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; NARAL Pro-Choice America. (2009). *Who decides? The status of women's reproductive rights in the United States.* Retrieved March 5, 2009, from www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/state-profiles/.

4 *See e.g.* Mo. Rev. Stat. §334.735 (Enacted 1998, applies to PAs); S.D. Codified Laws § 36-4A-20.1 (Enacted 2000, applies to PAs) and S.D. Codified Laws § 36-9A-17.2 (Enacted 2000, applies to NPs and CNMs); Tenn. Code Ann. § 53-10-104 (c) (Enacted 1994, applies to medication abortion for NPs and PAs).

5 *See e.g.* N.Y. Penal Law §125.05(3) (Enacted 1965; Amended 1970).

6 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. *See also* National Abortion Federation. Timeline, State by State: Expanding CNM, NP, and PA Provision of Abortion Care. Retrieved September 18, 2009 from www.prochoice.org/cfc/resources/timeline.html.

7 Cal Health & Saf Code §§123460-123468; Cal. Bus. & Prof. Code §2253.

8 Cal Bus & Prof Code § 2253(b).

[9] Advancing New Standards in Reproductive Health [ANSIRH] (2009). Health Workforce Pilot Project No. 171. Information available at: www.ansirh.org/research/hwpp.php. *See* Cal Bus & Prof Code § 2253(b) (2003) for California's surgical abortion law.

[10] *Armstrong v. State of Montana*, 989 P.2d 364 (Mt. 1999); Schrimer, *supra.* The Montana statute at issue was widely acknowledged to be specifically directed to the one PA practicing in Montana who had been safely providing abortions for years.

[11] Mont. Code Ann. §37-20-103 and §50-20-109 (1995).

[12] *Mazurek v. Armstrong,* 520 U.S. 968 (1997).

[13] *Armstrong* 989 P.2d 364 (Mt. 1999).

[14] 7 Am Jur 2d Attorney General § 10.

[15] 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.

[16] Wash. Rev. Code § 9.02.110 (Enacted 1991).

[17] Wash. Rev. Code § 9.02.110 and Wash. Rev. Code § 9.02.120.

[18] Wash. Rev. Code § 9.02.140.

[19] Op. Att'y Gen. Wash. No. 1(Jan. 5, 2004). While the AG's opinion focused on Advance Registered Nurse Practitioners, it relied on the assumption made by the party requesting the opinion that PAs in Washington may provide medication abortion when this is properly delegated by supervising physicians.

[20] Att'y Gen. Conn. Lexis 3 (Feb. 7, 2001).

[21] *Id.*

[22] 720 Ill. Comp. Stat. Ann. 510/3.1 (2009).

[23] Att'y General Ill. No. 09-002 (2009).

[24] 2 Am Jur 2d Administrative Law § 222.

[25] 14-000-009 R.I. Code R.§ 5.1 (Effective 1973; Last Amended 2002).

[26] Office of the New York State Dep't of Health, Declaratory Ruling: Performance of an Abortion by Physician Assistant (Dec. 20, 1994).

[27] *Id.*

[28] Copy of letter to FNP on file with Diana Taylor, RNP, PhD.

[29] Arizona State Board of Nursing. (May 14, 2008) Board Meeting Minutes, 24. Retrieved September 19, 2009 from www.tinyurl.com/yegx9jp. 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."

[30] HB 2254 and SB 1175, 49th Leg., 1st Sess. (Az. 2009), both signed on July 13, 2009.