

Providing Abortion Care

A PROFESSIONAL TOOLKIT FOR NURSE-MIDWIVES,
NURSE PRACTITIONERS, AND PHYSICIAN ASSISTANTS

Authors

Diana Taylor, RNP, PhD, University of California, San Francisco,
Advancing New Standards in Reproductive Health

Barbara Safriet, JD, LLM, University of California, San
Francisco, Advancing New Standards in Reproductive Health

Grayson Dempsey, Abortion Access Project

Beth Kruse, MS, ARNP, CNM, National Abortion Federation

Courtney Jackson, PhD, Abortion Access Project

Organizational Sponsors

Abortion Access Project, Cambridge, MA

Advancing New Standards in Reproductive Health (ANSIRH)
Program, University of California, San Francisco, CA

National Abortion Federation, Washington, DC

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Sue Davidson, PhD, RN, CNS	Diane Ranieri, MA, RPAC
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Participation by these individuals should not be interpreted as an endorsement, and any limitations of the curriculum are solely the responsibility of the authors.

ABOUT THE AUTHORS

Diana Taylor, RNP, PhD, FAAN, is a nurse practitioner, educator, and researcher and is Professor Emerita at the University of California, San Francisco (UCSF) School of Nursing where she provided leadership for interdisciplinary primary care education. Dr. Taylor has more than 100 scientific articles and publications in the area of women's health. With over 35 years of experience in providing women's health care and training health professionals, Dr. Taylor has been at the forefront of developing standards and scope of practice for advanced practice nurses, serving on national committees of the American Nurses Association, the National Organization of NP Faculties as well as state and local nursing practice committees. Dr. Taylor is an active board member of the Association of Reproductive Health Professionals, the Reproductive Options Education Consortium in Nursing; a board member of Clinicians for Choice; and Board chair (as well as a practicing clinician) of the San Francisco Women's Community Clinic. Currently, she is the director of research for a statewide project to train advanced practice clinicians in first trimester abortion care using a standardized curriculum. The goal of the project is to increase the number of abortion providers and make professional and practice improvements to normalize abortion into women's primary care.

Barbara Safriet, JD, LL.M., is a consultant to the ANSIRH Program at UCSF. She has taught Health Law and Policy at Yale Law School and Lewis and Clark Law School and has lectured and published extensively on the regulation of health care providers, with a special focus on scope of practice. Professor Safriet has served as a member of The Pew Health Professions Commission, and its Taskforce on Health Care Workforce Regulation, and as a Health Law Consultant and Presenter for the Rockefeller Foundation, the W. K. Kellogg Foundation, the Commonwealth Fund, the Association of Academic Health Centers, the U.S. Agency for Health Care Policy and Research, the U.S. Public Health Service, the National Rural Health Association, the National Council of State Legislatures, and the Office of Technology

Assessment of the U.S. Congress. In 1997, she served on a national interdisciplinary symposium establishing policy recommendations for establishing NPs, CNMs and PAs as qualified abortion services providers.

Grayson Dempsey has worked as a counselor, trainer, educator, and organizer in the field of reproductive health care since 1999. She is the founder and President of Backline, an organization that hosts an international Talk Line for women and their loved ones around all aspects of pregnancy, parenting, abortion and adoption. Ms. Dempsey has served as a consultant to the Abortion Access Project since 2003, during which time she coordinated efforts in the state of Oregon that led to the first explicit regulatory opinion on early abortion care and nurse practitioner scope of practice.

Beth Kruse, MS, ARNP, CNM, is a certified nurse-midwife with many years of clinical practice and research experience in midwifery, well-woman gynecology, family planning, and abortion care. She has helped to develop training programs in medication abortion and has served as faculty in meetings of numerous professional associations both in the United States and abroad, as well as contributing to several articles in peer-reviewed journals. She was the state of Washington's first representative to Midwives for Choice and currently holds a seat on the National Advisory Committee for Clinicians for Choice. In 2005 she joined the National Abortion Federation as its Associate Director of Clinical Services and continues to practice direct patient care with the Department of Public Health Family Planning Program of Seattle/King County.

Courtney Bangert Jackson, PhD, is a sociologist with expertise in evaluation research, reproductive health, the sociology of health professions, and quantitative data analysis. A former Charlotte Ellertson Fellow in Abortion and Reproductive Health, Ms. Jackson has conducted research on abortion training in residency training programs and APC provision of abortion. She has taught courses in research methods, women's studies, and sociology at Suffolk University, Bowdoin College, and the University of Southern Maine. Dr. Jackson has more than 12 years experience conducting applied social science research in the areas of public health and community development. Currently, Dr. Jackson is the Director of Research & Evaluation at the Abortion Access Project.

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Joyce Capiello, FNP, PhD(c)
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WELCOME TO THE APC TOOLKIT!

In the early 1990s, an experienced certified family medicine physician assistant (PA-C) in Montana became the object of a political effort to prevent her from continuing to offer abortion care within her primary care practice. With the support of her supervising physician, her professional organizations, state and national advocates, attorneys, and her community, she was able to meet and overcome this challenge successfully: the state law restricting her practice was reversed in 1999. She has recently opened a new practice and continues to provide abortion care as an essential part of primary care for the women in her remote community.

In 2006, an experienced family nurse practitioner (FNP) with a longtime primary care practice in rural Oregon was notified that the Oregon State Board of Nursing was investigating her provision of abortion in relation to scope of practice. This highly qualified NP was one of the few providers of abortion care in southern Oregon. The organizing and advocacy work this provider initiated with nursing professional organizations, pro-choice advocates, and attorneys in response to the investigation significantly furthered the in-depth evaluation by the Board of Nursing that led to the landmark ruling specifically affirming aspiration abortion care as within an Oregon NP's scope of practice.

In states across the country, advanced practice clinicians (APCs),¹ physicians, reproductive rights advocates, and attorneys have joined together to revise outdated legislative and regulatory language specifying that only physicians may perform abortions. Where it exists, this language does not take into consideration the roles of nurse practitioner², certified nurse-midwife, and physician assistant, nor does it acknowledge the experienced providers whose scope of primary and specialty practice includes management of conditions and procedures significantly more complex than early abortion. In hallmark cases, stakeholders have been able to obtain formal opinions, rulings, or changes in the law acknowledging that the provision of medication and/or aspiration abortion by qualified practitioners is not prohibited on the basis of their professional discipline, thus protecting both women's access to abortion care and practitioners' rights to provide appropriate care for their patients.

Providing Abortion Care: A Professional Toolkit for Nurse-Midwives, Nurse Practitioners and Physician Assistants (hereinafter referred to as the APC Toolkit) recounts legal accomplishments and other case histories as templates for action. These examples help to demonstrate how APCs who want to advance their existing practice, as well as those who are experienced in abortion care, can effectively develop relationships within existing professional networks, counter challenges to their scope of practice, and continue to meet the needs of the women they serve. We hope that the APC Toolkit will provide practical, field-tested resources for students, clinicians, administrators, and advocates as they pursue their goal of increasing women's access to abortion care, an integral component of comprehensive reproductive health care.

In the United States, CNMs, NPs and PAs have been categorically referred to as “midlevel provider” or “non-physician provider”, which does not reflect their contribution as independent and qualified primary care professionals. Because an ideal taxonomy has yet to be identified, the term advanced practice clinician or APC is used to refer to the collected roles of CNM, NP and PA³ in this document. The authors thank our readers for their understanding.

¹ The umbrella term *advanced practice clinician* (APC) is used to refer to the collected roles of nurse practitioner (NP), certified nurse-midwife (CNM), and physician assistant (PA) in this document. In the United States, CNMs, NPs and PAs have been categorically referred to as “midlevel provider” or “nonphysician provider,” which does not adequately reflect their contribution as independent and qualified primary care professionals. However, the ideal taxonomy has yet to be identified. The authors thank our readers for their understanding.

² Advanced practice nursing (APN) roles are defined to include those of nurse practitioner, nurse-midwife, nurse anaesthetist, and clinical nurse specialist. In addition, nurse practitioner titling in each state varies. For the sake of simplicity in this text, all nurse practitioner title references (ARNP, NP, APRN, RNC, etc.) are referred to by the generic “NP.”

³ The term, advanced practice clinician or APC is not accepted by the American Academy of PAs who have a published position on appropriate titles for PAs: “The AAPA believes that, whenever possible, PAs should be referred to as “physician assistants” and not combined with other providers in inclusive non-specific terms such as “midlevel practitioner”, “advanced practice clinician”, or “advanced practice provider” (AAPA, 2008).

What is the APC Toolkit?

The *APC Toolkit* is a professional guide for APCs in the United States who are either currently providing or would like to offer abortion care within their practice. The information provided is based on specific definitions of United States professional disciplines, organizations, and legislative/regulatory systems. However, the *APC Toolkit* also offers background information, resources, and guidelines for professional advancement that could be adapted to other health care systems.

The *APC Toolkit* helps clinicians compile crucial evidence and documentation to support the integration of early abortion care as an essential part of women's health care services. It guides APCs in the development of a professional portfolio that documents their basic and their abortion specialty education, knowledge, and training and the clinical and professional standards they use in providing safe care. It includes essential information and statistics about abortion care and access, professional standards and competencies, and the roles of state and national professional organizations and state licensing boards. Case studies demonstrating the establishment of abortion care as within the APC scope of practice provide strategies for success.

Why is the APC Toolkit Needed?

A significant proportion of the population needs abortion care.

In 2001, 49% of pregnancies in the U.S. were unintended (Finer & Henshaw, 2006), and half of those pregnancies were terminated. Abortion is one of the most common “surgical” procedures in the United States, with approximately one-third of all women having an abortion at some point during their lives (Boonstra, Benson Gold, Richards, & Finer, 2006). In 2005, the most recent year for which comprehensive data on abortion incidence are available, 22% of pregnancies (excluding miscarriages) ended in abortion (Jones, Zolna, Henshaw, & Finer, 2008). The same survey reports that 8% of women needed to travel more than 100 miles and 19% traveled 50–100 miles to obtain abortion care. The authors note that although the U.S. population is concentrated in metropolitan areas, 24% of metropolitan women and 92% of their nonmetropolitan counterparts lack an abortion provider in their county.

The need to seek out specialized abortion clinics may contribute to a delay in obtaining abortion care, along with increasing cost, especially for women in nonmetropolitan areas. Although abortion is an extremely safe procedure, at more advanced gestations it becomes more complicated and costly (Boonstra et al., 2006).

Advanced practice clinicians are essential providers of primary care.

NPs, CNMs, and PAs offer a competent source of women's primary care and often practice in medically underserved settings (Institute of Medicine Committee on the Future of Primary Care & Donaldson, 1996). A 2003 study found that 49% of NPs and 69% of PAs in California serve rural and vulnerable populations, compared with 35% of obstetrician-gynecologists (Grumbach, Hart, Mertz, Coffman, & Palazzo, 2003). In 2004, APCs saw six times as many women for publicly funded family planning services as did physicians (Frost & Frohwirth, 2005). By 2006, there were approximately 76 primary care physicians, 42 NPs, and 17 PAs per 100,000 U.S. population (New York Center for Health Workforce Studies, 2006). As primary care providers APCs are an obvious entry point to the health care system for women facing unintended pregnancies. Clearly, if early aspiration and/or medication abortion care were included in a program of comprehensive reproductive health services, women would be much more likely to receive timely, low-risk intervention.

Early abortion care belongs within the realm of primary health care.

A primary goal of the *APC Toolkit* is to improve access to abortion care, an evidence-based public health strategy for serving women facing unintended pregnancy. The *APC Toolkit* will help to prepare clinicians and administrators across the country to respond to challenges and engage in proactive strategies to further establish early abortion care as part of the range of women's health care services provided by APCs.

According to California's Primary Care Initiative (Advancing New Standards in Reproductive Health, 2006), when properly trained clinicians offer early abortion care to their communities as part of comprehensive family planning and early pregnancy care, the following outcomes are seen:

- Improvement in patient safety by allowing early diagnosis and management of unintended pregnancy
- Improvement in patient and clinician satisfaction by integrating abortion care into existing women's primary care
- Improvement in women's health care delivery by integrating abortion into early pregnancy care, thereby reducing delays and unnecessary referrals

Professional education, ethics, and experience shape scope of practice.

The *APC Toolkit* presents abortion as a scope of practice issue and further explores the provision of abortion care as a natural extension of the work of APCs. It is *pro-patient* and *pro-clinician*, acknowledging the political nature of abortion while encouraging a focus on patients' and clinicians' abilities to meet those needs.

When a specific clinical procedure is singled out as off-limits to a properly trained and competent health care professional for political purposes, this undermines the profession's rights and responsibilities and reduces patient access to qualified health professionals. At a minimum, professional practice is curtailed; at worst, professional licenses may be suspended or lost, and women and communities lose access to services.

Professional practice environments vary widely from state to state and discipline to discipline. In addition, political, social, and professional attitudes toward unintended pregnancy, contraceptive services, and abortion care are complex and multilayered. Although the clinical management of abortion is relatively straightforward, these other factors constantly shift in response to a multitude of influences. Although not state-specific, the *APC Toolkit* provides a framework for understanding both barriers to and stratagems for advancing scope of practice at the state level.

Who Can Use the APC Toolkit?

1. CNMs, NPs and PAs working in group or independent clinical practice as well as in primary care or reproductive health specialty areas.
2. Administrators responsible for developing and maintaining systems for human resources as well as clinical policies and procedures.
3. Advocates working with clinicians and administrators to protect and expand access to women's reproductive health care.
4. Faculty and administrators within APC education and training programs whose mission includes preparing health care professionals to provide comprehensive reproductive health care as a facet of primary care.
5. Representatives from professional associations and regulatory boards who recognize the value of professional determination of scope of practice and seek to further their understanding of abortion care in that context.

"The high rate of unintended pregnancy in the United States necessitates that all future APCs receive comprehensive exposure to family planning and abortion. Regardless of an individual's interest in and intention to provide abortion services as part of her or his practice, all APCs need to be knowledgeable about the full range of reproductive health options, including family planning and abortion. As integral components of women's health care, abortion, pregnancy options counseling, and family planning merit incorporation into routine didactic and clinical APC education" (Foster et al., 2006, p. 414).

Scope of practice addresses the questions of 'who can do what for whom in what clinical setting and under what circumstances.' It underpins the framework of our health provider licensing system.

How is the APC Toolkit Meant to Be Used?

The *APC Toolkit* is a professional development resource. It is intended to prepare clinicians, administrators, educators, and advocates to participate in developing a multi-level plan for advancing APC clinical practice in abortion care.

Strategies for integrating abortion care into APC practice include:

- developing a sophisticated professional portfolio, including professional practice regulations and guidelines on how to advance practice into new areas of knowledge and skill;
- acquiring familiarity with the structure and function of professional organizations and state licensing boards;
- developing relationships with the officers and members of local and regional chapters of professional organizations;
- building or strengthening existing relationships with professional colleagues known to be supportive of abortion care and/or professional autonomy;
- identifying actual and potential obstacles within and among professional organizations and regulatory boards; and
- creating pathways for incrementally advancing practice while building a network of support.

BEYOND THE *APC TOOLKIT*

Abortion care is multilayered and complex, and its provision involves dedication and rich resources of psychosocial and technical skills. Clinicians working in the field may feel overwhelmed when they consider confronting the sociopolitical and regulatory challenges that loom in the face of change. For those who want to participate in expanding necessary services for women through provider-neutral care but may have felt lost in the labyrinth of legal, governmental, and professional influences, we hope this *APC Toolkit* offers clarity and inspiration. The authors also encourage you to complete the evaluation and contact the sponsors of this project with comments, suggestions, and criticisms, as well as to ask questions and share the unique circumstances of your state and your practice. Please visit our websites and email us anytime at the following addresses:

Abortion Access Project

www.abortionaccess.org
info@abortionaccess.org

Advancing New Standards in Reproductive Health (ANSIRH) Program, University of California, San Francisco

www.ansirh.org
ansirh@obgyn.ucsf.edu

National Abortion Federation

www.prochoice.org
naf@prochoice.org

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MODULE ONE: UNDERSTANDING ABORTION CARE

One of the goals of the *APC Toolkit* is to present abortion care as a normal part of primary care and to provide the evidence for abortion care as a natural extension of the work of APCs, who care for women at risk for or experiencing an unintended pregnancy.

Module One presents evidence regarding the safety of abortion, the need for more abortion providers, and the role of CNMs, NPs, and PAs in providing abortion in the United States. In addition, it describes the multiple barriers that APCs face in becoming abortion providers, including lack of clinical training opportunities, professional and abortion politics, isolation of abortion care from professional credentialing or legal/regulatory mechanisms, and the wide variation in state practice and regulatory environments.

SECTION I. ABORTION IN CONTEXT

OBJECTIVES:

1. Provide background information about the need for abortion in the United States.
2. Describe the range of abortion care, and provide evidence of the safety and efficacy of early abortion procedures.
3. Explain how terminology impacts interpretations of scope of practice.
4. Provide an overview of abortion providers in the United States.

A. AN OVERVIEW OF THE ABORTION CARE SPECIALTY

As noted earlier, about half of all pregnancies in the United States are unintended (Finer & Henshaw, 2006). *Healthy People 2010*, an initiative of the U.S. Department of Health and Human Services, established a national goal to reduce unintended pregnancy (U.S. Department of Health and Human Services, 2000). Access to reproductive health care, including pregnancy options counseling and contraceptive counseling, is critical for reaching this goal.

Differences in adolescent and adult sexual and reproductive health indicators between the United States and other countries shed light on the important role of primary and secondary prevention strategies in reducing unintended pregnancies. Figure I.1 compares reproductive health outcomes in the United States with those in Sweden, France, Canada, and Great Britain.

The illustration shows that adolescents in the United States initiate sexual activity at basically the same age as their European and Canadian counterparts (Darroch, Singh, & Frost, 2001). However, U.S. adolescents are much less likely to use a form of contraception and far more likely to experience an unintended pregnancy. France has the lowest rate of adolescent pregnancy, 20.2 per 1,000 women aged 15–19, with Sweden just slightly higher at 25 per 1,000. Canada and Great Britain report 45.7 and 46.7 pregnancies per 1,000 women aged 15–19, whereas the United States reports 83.6 pregnancies per 1,000 women 15–19, a much higher rate than the other countries in the comparison.

Broadening the focus to include adult women further highlights the importance of preventing unintended pregnancies. For example, in the Netherlands, only 3% of pregnancies

are unplanned, compared with 57% in the United States (Sedgh, Henshaw, Singh, Bankole, & Drescher, 2007). With its low rate of unplanned pregnancies, the Netherlands also has a much lower abortion rate than the United States: 9 abortions per 1,000 women aged 15–44, compared with 21 per 1,000 in the United States (Delbanco, Lundy, Hoff, Parker, & Smith, 1997; Sedgh et al., 2007). Ensuring and expanding access to contraception and comprehensive reproductive health care can help the United States achieve its goal of reducing unintended pregnancies.

FIGURE I.1

Sexual and Reproductive Health: Comparison Among Sweden, France, Canada, Great Britain, and the United States

	Sweden (1996)	France (1995)	Canada (1995)	Great Britain (1995)	United States (1996)
Median age at first sex	17.1	18	17.3	17.5	17.2
Percent who used at least one method of contraception at last intercourse	93.5	89.1	86.8	95.9	80
Pregnancies per 1,000 women aged 15–19	25	20.2	45.7	46.7	83.6
Abortions per 1,000 women aged 15–19	17.2	10.2	21.2	18.4	29.2
Births per 1,000 women aged 15–19	7.8	10	24.5	28.3	54.4

Adapted from: Darroch et al., 2001

Although abortion rates among adolescent and adult women in the United States have decreased somewhat since the late 1990s, approximately 1.2 million abortions were provided in the United States in 2005, making abortion one of the most common procedures women of reproductive age experience (Jones et al., 2008). The Guttmacher Institute estimates that approximately one-third of all women will have an abortion at some point in their lives (Boonstra et al., 2006).

FIGURE I.2

Number of Abortions per 1,000 Women Aged 15–44 in 2003

	Number per 1,000
Switzerland	7
Belgium	8
Germany	8
Netherlands	9
Denmark	15
England and Wales	17
France	17
United States	21

From: Sedgh et al., 2007

Despite the great need for abortion care, most women face multiple obstacles when accessing abortion. A scarcity of clinicians trained and empowered to provide abortions is one such obstacle. Women in rural areas are particularly affected; 35% of women in the United States live in counties without an abortion provider (Jones et al., 2008). Ninety-nine percent of all facilities that perform more than 400 terminations per year are located in metropolitan areas (Jones et al., 2008). Many states also have laws mandating that only physicians may perform abortions (“physician-only” laws). These laws further impede access to abortion care by denying appropriately trained APCs the opportunity to serve their patients’ needs.⁴

FIGURE I.3

“Aspiration” versus “Surgical”: What’s in a Name?

This *APC Toolkit* uses the term *aspiration abortion* when discussing first trimester abortion care because it more accurately depicts a first trimester abortion than does *surgical abortion*. *Surgical* “implies incision, excision and suturing and is associated with the physician subpopulation of surgeons” (Weitz, Foster, Ellertson, Grossman, & Stewart, 2004, p. 78).

Most abortions performed during the first trimester use electric or manual suction to empty the uterus. These simple procedures require only local or oral analgesics and can easily be performed in a primary care setting. Using the term *surgical abortion* to describe both less invasive aspiration procedures as well as more invasive procedures blurs the boundary between these very different types of procedures (Weitz et al., 2004).

Not only does the term *aspiration abortion* clarify the important differences between types of abortions, its use can assist with efforts to challenge the thinking that only physicians should provide abortion care. Surgeons perform surgery. Aspiration abortion is not surgery. Primary care providers, including APCs, provide a wide range of procedures, including intrauterine device (IUD) insertion, endometrial biopsy, management of early pregnancy loss, and abortion. Use of the term *aspiration*, rather than *surgical*, abortion to refer to these procedures is a small but important step that all of us can take to help de-mystify early abortion techniques.

B. BASIC TYPES OF ABORTION PROCEDURES

An important first step in advocating for APCs as abortion providers involves education about the abortion procedure itself. Politicians and regulators as well as clinicians are often unaware of the basic training that is required to become a provider of medication or early aspiration abortion. This lack of understanding can lead to misinformed decisions that unduly restrict training and access.

Although there are multiple types of abortion procedures, this *APC Toolkit* focuses on the two methods most commonly used during the first trimester of pregnancy: aspiration and medication.⁵ (See Figure I.3 for a discussion of why the language used to describe these procedures is important.) The vast majority of women seeking abortion care do so in the first trimester, and this is the time when early intervention by an APC is most advantageous. Nationally, APC providers are most likely to perform abortions during this time frame.

⁴ To determine whether you are practicing in a physician-only state, contact the Abortion Access Project at <http://www.abortionaccess.org> or the National Abortion Federation at <http://www.prochoice.org>. To see an overview of state laws relating to abortion, visit the Guttmacher Institute’s website at http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf

⁵ See Janet Singer’s article—*Share with women. Early termination of pregnancy*. *J Midwifery Womens Health* 2009;54:93-4—which provides evidence-based information on early termination of pregnancy that can be used during the essential clinician–patient options counseling for a woman with an unintended pregnancy who is considering abortion or pre-abortion counseling for a woman who has chosen that option.

Medication Abortion

Medication abortion is a method of pharmacologic termination of the early first trimester of pregnancy. Depending on the agent(s), the regimen, and the provider, medication abortion may be initiated as soon as a woman finds out she is pregnant, through 7–9 weeks (49–63 days) of gestation (via menstrual dating). Together, these methods account for 13% of all abortions in the United States (Jones et al., 2008).

In the United States, three medications are available for use as abortifacients: (1) mifepristone, (2) methotrexate, and (3) misoprostol. Both mifepristone and methotrexate are only acceptably effective in terminating intrauterine pregnancy when used in combination with misoprostol (Creinin, 2000; Pymar & Creinin, 2000). Mifepristone is the only one of these agents that has been specifically labeled by the FDA for use as an abortifacient. It blocks the uptake of progesterone by receptor cells in the uterus. Without this essential hormone, the lining of the uterus begins to break down, and the cervix softens. Methotrexate, by contrast, interferes with the DNA synthesis of rapidly dividing cells—in this case, the developing embryo. Misoprostol is a prostaglandin analogue that stimulates uterine contractions and softens the cervix, facilitating uterine emptying. It is most effective when used following either mifepristone or methotrexate. Where neither methotrexate nor mifepristone is available, regimens for misoprostol alone may be used, although efficacy is lower, and the risk of side effects is higher (Carbonell et.al. 2003; Singh et.al. 2003)

FIGURE I.4

Abortion Method Terminology

Medication abortion refers to termination of pregnancy using one or more of the pharmacologic agents mifepristone, methotrexate, and/or misoprostol. Medication abortion may sometimes be referred to as RU486 (its original European name), “the abortion pill,” or as “medical” abortion.

Aspiration (or suction, or surgical) abortion refers to procedures that terminate a pregnancy by using manual or electric suction to empty the uterus. These procedures are also known as manual vacuum aspiration (MVA) or electric vacuum aspiration (EVA).

Dilation and evacuation (D&E) and dilation and extraction (D&X) describe abortion procedures performed with instrumentation of the uterus and fetus. These procedures are generally used in second trimester abortion care.

Medication Abortion Regimens

Medication abortion regimens are based on the most current clinical research evidence. The World Health Organization (WHO), the American College of Obstetricians and Gynecologists (ACOG), and several other general and specialty health organizations have described safe and effective regimens of early medication abortion (American College of Obstetricians and Gynecologists, 2005; Cheng, 2008; Chien & Thomson, 2006; Grossman 2004; Odusoga & Olatunji, 2002).

As professional organizations that together represent the majority of abortion providers in the United States, the National Abortion Federation (NAF) and the Planned Parenthood Federation of America (PPFA) offer their members continuously revised protocols for safe and effective administration of abortifacients in the first 9 weeks of pregnancy (National Abortion Federation, 2008a). Figure I.5 summarizes the most common regimens (NAF, 2008a).

Early Aspiration Abortion in the U.S.

In the first trimester, abortion can be performed as a simple office procedure using a vacuum aspirator. The designator *aspiration abortion* more accurately describes this procedure (see Figure I.3) than the traditional appellation *surgical abortion*. In aspiration abortion, the cervix usually is gradually stretched with tapered rods. After the cervix is dilated sufficiently, a plastic cannula attached to the suction apparatus is inserted into the uterus. Gentle suction (<60 mmHg) is applied to empty the contents of the uterus. Local anesthesia by means of paracervical and/or intracervical injection is almost universally used, and many clinics offer various other medications for relief of anxiety and pain management. General anesthesia is less commonly used in early abortion but may be offered in some facilities that have specialized equipment and dedicated anesthesia services.

FIGURE I.5

from NAF (2008a): Comparison of FDA-Approved and Other Evidence-Based Regimens

	FDA-Approved Regimen	Evidence-Based Alternative Regimens (vaginal misoprostol)	Evidence-Based Alternative Regimen (buccal misoprostol)	Evidence-Based Alternative Regimen (oral misoprostol beyond 49 days' EGA)
Mifepristone dose	600 mg orally (three 200 mg tablets)	200 mg orally (one 200 mg tablet)	200 mg orally (one 200 mg tablet)	200 mg orally (one 200 mg tablet)
Misoprostol dose	400 µg orally	800 µg vaginally	800 µg buccally	800 µg orally (given as 2 doses of 400 µg, 2 hours apart)
When misoprostol taken	48 hours after mifepristone	6–72 hours after mifepristone < 56 days' gestation; 6–48 hours after mifepristone < 63 days' gestation	One or two days after mifepristone < 56 days' gestation; 24–36 hours after mifepristone < 63 days' gestation	One day after mifepristone, to be repeated on day 7 (vaginally) if abortion is incomplete
Where misoprostol taken	At the medical office	At home	At home	At home
Gestational age limit	49 days' gestation	63 days' gestation	63 days' gestation	63 days' gestation
Timing of initial follow-up examination	Approximately day 14	Within approximately 4 days (e.g. day 4–14)	Within approximately 14 days (e.g. day 4–14)	One week after mifepristone and at 2 weeks (if still incomplete on day 7)
				A one-week follow-up visit is mandatory. According to one study, 10.4% of women needed to receive more misoprostol at their follow-up visit. This second dose was administered vaginally. These women returned for an additional follow-up visit 1–8 days later. Note: an initial dose of 800 µg of misoprostol orally is less effective than giving the same dose vaginally or buccally for women 53–63 days' gestation.

Efficacy and Safety of Early Abortion

Aspiration abortion is highly effective, with success rates (complete abortion) at 99% (National Abortion Federation, 2009). It is also extremely safe. Both major and minor risks are lowest when women receive abortion care in the first trimester (Boonstra, 2006). One community-based study of 1,132 aspiration abortions reported that 88% of patients had been less than 13 weeks pregnant (Paul, Mitchell, Rogers, Fox, & Lackie, 2002). 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, and less than 0.5% had more serious complications that required some additional surgical procedure and/or hospitalization. No deaths were reported.

Medication abortion is also an extremely safe procedure, with complications occurring in less than 0.5% of cases when evidence-based mifepristone/misoprostol regimens are used (Grimes, 2005). In less than 2% of medication abortions (using evidence-based regimens), the medications do not successfully terminate the pregnancy and an aspiration procedure is necessary.

Both major and minor risks are lowest when women receive abortion care in the first trimester (Boonstra, 2006). Rarely, excessive bleeding or uterine infection may occur (ACOG, 2005; Soper, 2007; Paul, Lichtenberg, Borgatta et al, 2009). Figure I.6 compares aspiration and medication abortion, describing how each works and the advantages and disadvantages of each method.

FIGURE I.6

First Trimester Abortion: A Comparison of Procedures

Procedure	How It Works	Advantages	Disadvantages
Mifepristone	Mifepristone blocks the action of progesterone, causing uterine lining to thin, the cervix to soften and dilate, and the pregnancy to detach. It also increases prostaglandin production resulting in uterine contractions. Misoprostol, a prostaglandin analogue taken orally, vaginally or buccally within a few days of mifepristone, induces uterine contractions and increases the effectiveness of mifepristone to approximately 95–98%.	<ul style="list-style-type: none"> - Usually does not require the use of surgical instruments, avoiding risk of cervical or uterine injury. - Anesthesia not required. - High success rate (95–98%) with vaginal or buccal misoprostol up to 9 weeks. - Resembles a “natural miscarriage.” - May offer women more privacy. - Can be used very early in pregnancy. - Procedure completed within 24 hours of the misoprostol administration in 90% of women. - Approved by the FDA for early abortion. 	<ul style="list-style-type: none"> - May require at least 2 visits. - Takes hours or, rarely, weeks to complete. - Postprocedure bleeding may last longer than with surgical abortion. - Women may see blood clots and pregnancy tissue.
Vacuum Aspiration	The cervix is opened gradually with tapered rods. A cannula (strawlike tube), which is attached to a suction apparatus (either an electric machine or a hand-held syringe), is inserted into the uterus. The contents of the uterus are emptied by suction.	<ul style="list-style-type: none"> - Usually requires only one visit to the provider. - Procedure is usually completed within minutes. - Allows for anesthesia and/or sedation if desired. - High success rate (approximately 99%). - Can be used early in pregnancy. 	<ul style="list-style-type: none"> - Is an invasive procedure. - May seem less private to some women than aborting at home.

Adapted from: National Abortion Federation, 2009

C. WHO CAN PROVIDE ABORTION CARE?

In 2005 the majority of abortions (69%) were performed at specialized clinics that provide a large number of abortions; nonspecialty clinics provided 25% of abortions, and the remainder were performed in hospitals (5%) and private physician practices (2%) (Jones et al., 2008).

Specialist Providers of Abortion Care

Although there are no regulatory or legislative restrictions related to which categories of physician may provide abortion care, most abortions are currently provided by obstetrician-gynecologists. While the inclusion of abortion care education in obstetric/gynecology residency programs has varied over the past 20 years, the most recent study indicates that more than half of residency programs provide routine training in abortion care and another 40% provide opportunities for residents to train in their elective time (Eastwood, Kacmar, Steinauer, Weitzen, & Boardman, 2006). Only 10% of programs do not provide training opportunities in abortion care to their residents (Eastwood, Kacmar, Steinauer, Weitzen, & Boardman, 2006). Obstetrician-gynecologists may be trained in first trimester as well as second trimester procedures (often referred to as D&Es, or dilation and extraction). Recently, the American College of Obstetrics and Gynecology (ACOG) issued a formal Committee Opinion emphasizing the need for all medical school and obstetric/gynecology residency programs to integrate abortion care training into their curricula to ensure the “availability of safe, legal and accessible abortion care” (ACOG, 2009). While obstetrician-gynecologists comprise an important constituency of abortion providers, other clinicians—in particular, those providing primary care services—are well positioned within the health care system to provide abortion care.

Primary Care Providers of Abortion Care

A variety of primary care providers are showing a growing interest in including abortion care among the comprehensive range of services they offer within their practices. Primary care clinicians, a category which includes family physicians, NPs, PAs, and CNMs (IOM Committee & Donaldson, 1996), are much more likely to provide care to women at risk for unintended pregnancy who live in medically underserved areas than are specialists such as obstetrician-gynecologists (Grumbach et al., 2003).

PAs in Vermont and Montana were among the first providers of aspiration abortion after the Supreme Court decision in *Roe v. Wade* legalized abortion in the United States in 1973 (Joffe & Yanow, 2004). In Vermont, PAs and NPs have continued to provide a significant proportion of the state’s abortion care services, and their training program for physicians as well as for other APCs is one of the most respected in the nation. Although physician-only laws in other states may be daunting, there has been growing interest in defining abortion care as within the scope of practice of APCs. In a survey conducted in 1992, 52% of CNMs surveyed believed that they should be allowed to perform abortions, 19% said they might be willing to perform aspiration abortions themselves, and 57% indicated that they wanted prescriptive authority for medication abortion (McKee & Adams, 1994). More recently, approximately one quarter of APCs in a California study expressed interest in obtaining medication abortion training (Hwang, Koyama, Taylor, Henderson, & Miller, 2005). At the time of publication of this *APC Toolkit*, APCs are providing medication and/or aspiration abortion care in numerous states in a variety of clinical settings (Berer, 2009). A timeline of important historical events in APC provision of abortion care can be found on the Clinicians for Choice website at <http://www.prochoice.org/cfc/resources/timeline.html> (National Abortion Federation, 2008b).

SUMMARY

- Approximately half of all pregnancies in the United States were unintended in 2006; a U.S. national health goal to reduce the rate of unintended pregnancy to 30% by 2010 is unattainable.
- Abortion is one of the most common and safe procedures experienced by women of reproductive age; abortion care can be considered a secondary prevention strategy to reduce the rate of unintended pregnancy.
- Despite the great need for abortion care, most women face multiple obstacles when accessing abortion, including a scarcity of clinicians trained and empowered to provide the procedure.
- Most women seeking abortion do so in the first trimester, when abortion is safest and when early intervention by an APC is most advantageous.
- Both medication and aspiration abortion procedures have excellent efficacy and safety profiles, with major complications occurring in less than 1–2% of cases.
- Aspiration abortion is most commonly provided as a simple ambulatory care procedure; medication abortion is commonly completed by the woman in her home following evaluation, education, and guidance by a health care professional.
- Currently, obstetrician-gynecologists provide most abortions, although primary care clinicians (CNMs, NPs, PAs, and family physicians) are much more likely to provide care to women at risk for unintended pregnancy who live in medically underserved areas.
- Primary care clinicians in certain states have been providing safe, effective abortion care since legalization, demonstrating that early abortion combined with continuity of care reduces complications and increases access.

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SECTION II.

ADVANCED PRACTICE CLINICIANS AS ABORTION PROVIDERS

OBJECTIVES:

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

A. APCS WITHIN THE HEALTH CARE SYSTEM

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

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

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

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

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

FIGURE II.1

NPs, CNMs, and PAs: Training and Clinical Roles

Nurse Practitioner

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

Certified Nurse-Midwife

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

Physician Assistant

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

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

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

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

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

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

FIGURE II.2

Studies Documenting Safety of Abortion Care by APCs

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

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

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

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

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

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

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

C. BARRIERS TO ABORTION PROVISION BY APCS

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

FIGURE II.3

State Advocacy Efforts to Overcome Barriers

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

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

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

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

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

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

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

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

FIGURE II.4

Critical Role of Professional Organizations

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

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

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

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

SUMMARY

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

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

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MODULE TWO: ADVANCING SCOPE OF PRACTICE TO INCLUDE ABORTION CARE

Module Two explains how professional practice is regulated for CNMs, NPs, and PAs, specifically in a specialty-practice area such as abortion care. We describe the roles of state licensing boards as well as national and state professional organizations in defining, enforcing, and advancing health professional practice—and how their activities apply to abortion care.

As you read Sections III, IV, and V, consider these questions:

1. What is the relationship between state legislatures and state licensing boards?
2. What is the role of state licensing boards in defining, enforcing and advancing professional scope of practice?
3. How do state practice acts and professional standards provide for or create barriers to safe, effective care?
4. How do CNM/NP/PAs demonstrate and maintain continued clinical and professional competence?
5. How can you effectively influence the state regulatory agency that governs your practice?
6. How has your state board addressed politically charged issues regarding scope of practice in the past?
7. What is the role of, as well as your obligations to, your professional organizations? Does the organization have leaders who you see as mentors or who have experience or interest in the reproductive health field?
8. Are there provider restrictions to any or all aspects of abortion care in your state?
9. How might abortion care become normalized into CNM, NP or PA scope of practice? What barriers to this goal do you identify?
10. Were you trained in abortion care in your APC educational program or your postgraduate training? How might you obtain the training you need to integrate abortion care into your practice?

SECTION III.

APC PRACTICE REGULATION: ROLES OF LEGISLATURES, LICENSING BOARDS, AND PROFESSIONAL ORGANIZATIONS

OBJECTIVES:

1. Explain state abortion laws and their relationship to APC scope of practice regulation.
2. Identify the general credentialing framework for APCs.
3. Describe authority-based and evidence-based approaches for defining APC scope of practice.
4. Identify the authority of state legislatures and licensing boards to regulate APC practice.
5. Discuss the role of the APC professions in defining and advancing scope of practice.

Section III examines who defines APC scope of practice, explaining the roles of state and national professional organizations, state legislatures, and licensing boards, as well as key factors APCs should understand about each of these groups. First, though, we look at state abortion laws and their relationship to APC scope of practice regulation.

A. STATE ABORTION LAWS AND APCS

Abortion laws, many of which were enacted before the statutory recognition of advanced practice clinicians roles and the development of newer and simpler abortion technologies, create confusion for clinicians who want to offer abortion care. After the 1973 *Roe v. Wade* Supreme Court decision legalizing abortion, many states enacted physician-only laws presumably to protect women from unsafe, untrained, and unlicensed abortion providers. Unfortunately, these laws have become a de facto restrictive legacy to the evolution of APC scope of practice for two reasons: (1) hesitation by some health professionals and reproductive rights organizations to address the issue of women's access to abortion care from all qualified women's health care providers, and (2) uncertainty whether these laws apply to demonstrably "safe and competent" providers who are not physicians.

Even in states where APCs have a broad scope of practice including prescriptive authority, they must abide by abortion-specific limitations that prevent them from offering either aspiration or medication abortion services. For example, although in Arizona, PAs have broad physician-delegated authority to diagnose, treat, prescribe, and perform minor surgery, a statute specifically prohibits them from providing abortions (Ariz. Rev. Stat. § 32-2501.11 (2007)). Similarly, in Ohio, PAs' prescriptive authority specifically excludes abortion-inducing medications (Ohio Rev. Code § 4730.02 (2009)).

However, in a number of states, including those with physician-only laws, APCs with additional training are providing medication and, in some cases, aspiration abortions as a result of Attorney General opinions, regulatory clarifications, and other mechanisms (Joffe & Yanow, 2004; Advancing New Standards in Reproductive Health, 2007). This demonstrates that even in states where abortion is restricted by law to licensed physicians, nonlegislative strategies have provided APCs with opportunities to incorporate abortion services into their practices. (See Section IV.D and IV-E for an overview of these statutory and regulatory examples.)

These state-specific abortion laws must be considered within the context of nursing, midwifery and physician assistant practice acts which also vary from state to state. Although

the state regulation of CNM, NP and PA practice will be discussed generally in Section III-C through III-E, it is beyond the scope of the *APC Toolkit* to provide detailed description of each state's practice acts regulating advanced practice nursing roles (e.g., NPs and CNMs) and PAs. Fortunately, there are regularly updated reference documents which provide current state-by-state information on CNM, NP and PA practice regulation including state practice acts and legislative changes to scope of practice. See Figure III-1 for a description of these references.

FIGURE III.1

State laws & regulations governing NP, CNM and PA practice: **Where to find information**

Since there is no federal law governing the scope of practice, it is necessary to go to each state licensing board to access the specific practice act and rules and regulations for CNMs, NPs and PAs. Fortunately, there are now websites and published documents which summarize and update these state practice laws and regulations along with pertinent government and policy information related to proposed legislation and scope of practice changes for each state and the District of Columbia (DC).

Nurse Practitioners

Since 1988, Linda Pearson, former editor of the *Nurse Practitioner Journal*, has summarized NP legislation and related health care issues, including a recap and update of each state's nurse practice act and related rules and regulations. Now the *Pearson Report* is available in both print and electronic formats with a condensed version of each state/DC report appearing annually in the January/February issue of *The American Journal for Nurse Practitioners*. The complete version of each state/DC report is available on the NP Communications website (www.webnp.net) which includes specific details on NP scope of practice changes, statewide NP associations and schools, organized opposition to NP legislative or regulatory changes, the number of National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank filings, and the ranking of the state's NP regulation and consumer choice environment (Pearson, 2009). Dr. Pearson encourages anyone to provide her with updates by emailing her at lindapearson@comcast.net.

Nurse-Midwives

The *Pearson Report* includes some information about the regulation of CNMs. The ACNM also provides information on state laws and regulations specific to CNMs. A handbook that summarizes state laws and regulations affecting CNMs is available online to ACNM members only. Topics include the identity of the regulatory board, scope of practice, prescriptive authority, tort reform, breastfeeding and other statutory provisions governing the practice of midwifery. The ACNM website also provides public access to state/DC summaries of CNM practice regulation and key statistics (http://www.midwife.org/state_legislation.cfm). ACNM annual reports (available online) highlight state advocacy efforts related to CNM practice and regulation. The most recent published report (2007) describes activities in 17 states, including the passage of legislation in seven states advancing CNM scope of practice (http://www.midwife.org/siteFiles/about/2007_annual_Report.pdf).

Physician Assistants

The first edition of *Physician Assistants: State Laws and Regulations* was published by the AAPA in 1982 and now is available online at <http://www.aapa.org/gandp/StateLawsandRegulations.htm>. This state-by-state compendium provides summaries of more than two dozen key provisions of each state's statute and regulations complete with legal citations (<http://www.aapa.org/gandp/state-law-summaries.html>). The states are presented in alphabetical order, with each law followed by its regulations which provide the most complete picture of the requirements and conditions for PA practice. The AAPA website also lists each state PA regulatory agency with addresses, phone numbers, and Web links, available at www.aapa.org/gandp/statereg.html. Also provided is a chart that presents an overview of PA licensure or state certification requirements (<http://www.aapa.org/gandp/sumchart.html>).

If a physician-only statute in your state prohibits you from providing abortion care, you can still play an active role in providing reproductive health services to the women in your community!

Become part of a network of health professionals that advocates for improved reproductive health services including access to early abortion care.

Participate in efforts to support current abortion care providers including those physicians in primary care and specialty practice.

Become competent to provide the most comprehensive pregnancy options counseling available, and educate women about both medication and aspiration abortion.

Train to provide ultrasound, laminaria placement, postabortion exams, medication abortion counseling or provision, miscarriage management, and uterine aspiration in cases of failed or incomplete medication abortion.

B. CREDENTIALING FRAMEWORK FOR APCS

Generally, CNMs and NPs are credentialed first as registered nurses and then as advanced practice nurses (in the CNM or NP role), whereas PAs have only one credentialing mechanism. APCs may be educated and also credentialed for practice with a population (e.g., primary care, women's health) and/or a specialty (e.g., abortion care) focus.

The credentialing process is based on a set of *essential elements* that aligns government authority with regulatory and professional responsibilities. These essential elements of professional regulation and credentialing include the following:

- **Scope, standards, competencies, and ethical codes of practice and professional performance** are essential documents developed by the profession to provide a basis for education and practice regulation.
- **Education** is the professional's formal preparation in graduate degree-granting or postgraduate certificate programs.
- **Accreditation** is formal review and approval by a recognized agency of educational degree or professional certification programs.
- **Legal scope of practice** is defined in state laws and regulations.
- **Licensure** is the granting to an individual of authority to practice within a state.
- **Certification** (or *second licensure* in some states) is formal recognition of the knowledge, skills, and experience the individual demonstrates by meeting the standards the profession identifies.

While there is no uniform federal law that grants a professional license to practice, there are commonalities across states and each of the health professions. State legislatures and state licensing boards exercise legal authority in defining, enforcing, and advancing scope of practice for APCs. NP, CNM, and PA educators and professional organizations play a critical role in complementing state legislative and regulatory authority. State licensing boards rely on the professional organizations to assess and define professional practice, standards of practice (including ethical standards), and basic and advanced competencies that are the foundation for safe and effective care. State licensing boards may then codify these foundational elements for safe practice.

State licensing boards also look to state health-professional education and training programs to identify how practice standards and competencies are situated within the curriculum and clinical training. Furthermore, most state licensing boards have processes for determining how to incorporate practice advancement into existing regulations.

In all cases, the individual practitioner is accountable to the patient and the profession to practice according to legal/professional ethical standards and to adhere to professional performance criteria established and enforced by the regulatory and professional bodies.

C. GENERAL LEGAL AND REGULATORY REQUIREMENTS

Professional licensees in each state are governed by their respective practice acts and other statutes applicable to them, as well as by licensing board rules, orders, policies, advisory opinions, and procedures.⁹ In addition, generally applicable (mostly procedural) statutes such as state Administrative Procedure acts and Open Meetings laws and Government-in-the-Sunshine laws

⁹ For links to states' licensing boards and their practice statutes, rules, procedures, decisions, and opinions, see the Federation of State Medical Boards' and the National Council of State Boards of Nursing's websites at <http://www.fsmb.org> and <http://www.ncsbn.org>, respectively. Because federal laws affecting abortion services mostly concern eligibility for patient coverage or provider payment and not APCs' authority to provide such services, they are not included in this analysis. See also Figure III.1 Section III.A of this document.

also affect the ways in which licensees and boards interact.¹⁰ As is the case for any other health or medical service a licensed professional might provide, APCs providing abortion and reproductive services must understand and comply with the legal requirements, both substantive and procedural, set forth in multiple intertwined legal standards, acts, and pronouncements.

All health care professionals are legally accountable for actions they take in the course of their practice. This accountability is enforced principally through the legal mechanisms of licensure, state practice acts, and related legislative and regulatory initiatives, all of which explicitly codify the profession's obligation to act in the best interests of society. Nurse practice acts grant nurses and advanced practice nurses (such as NPs and CNMs) the authority to practice—and also grant regulatory boards the authority to sanction those who violate the norms of the profession and act in a manner that threatens public safety. PAs are similarly regulated by state PA practice acts.

D. UNDERSTANDING SCOPE OF PRACTICE

In an ideal world, statutory definitions of professional practice would be consistent with and build upon a profession's definition of its practice base, yet be general enough to encompass the dynamic nature of an evolving scope of practice. Such a consistent yet flexible definition would serve society both by enhancing the geographic mobility of providers and by promoting access by all states' residents to the full range of services nurses, NPs, CNMs, and PAs provide. Unfortunately, this consistency does not yet exist, as the wide variation in state practice authority, as well as abortion practice restrictions for CNMs, NPs, and PAs, shows. This lack of consistency in statutory definitions is one more reason it is so important for APCs to understand both their state's current scope of practice provisions and strategies for advancing their scope to encompass evolving competencies.

All APCs are familiar with the essential concept of professional scope of practice. However, a quick review¹¹ will help reinforce its relevance to sustaining and promoting the availability of safe reproductive health services, including abortion.

Scope of practice has been described as:

- “defined spheres of activity within which various types of health care providers are authorized to practice,” (Safriet, 2002, p. 303)
- “those health care services a ...health care practitioner is authorized to perform by virtue of professional license, registration, or certification,” (Federation of State Medical Boards, 2005, p. 4)
- the “[d]efinition of the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field,” (Federation of State Medical Boards, 2005, p. 19) and
- “establish[ing] which professionals may provide which health care services, in which settings, and under which guidelines or parameters.” (Dower, Christian, & O’Neil, 2007, p. 1)

In less formal terms, scope of practice addresses the questions of “who can do what for whom in what clinical setting and under what circumstances.” Answers to these questions also determine the ancillary but important issue of who can get paid for providing services.

APCs as members of their state professional organizations must continually monitor legislative proposals relevant to their practice regulations and authority. This requires attention to activities related to their particular regulatory board or practice act. It also involves monitoring bills or legislative committee actions in related areas, such as the Pharmacy Act (for prescriptive authority), the Medical Practice Act (for physician supervision or “collaboration” requirements and other constraints), and the Departments of Health or Health Services and the Insurance Commissioner (for conditions of payment for services or requirements for the range of services provided in hospitals or community health clinics).

¹⁰ Copies of these statutes are available online at the website of each state's Attorney General or Secretary of State. In addition, almost all states publish “Guides to Understanding” the Open Meetings laws or Administrative Procedures acts. These publications are invaluable aids in mastering the often-confusing procedural niceties of administrative process.

¹¹ For more comprehensive analyses of scope of practice, see Safriet (2002, 1992); Dower, Christian, & O’Neil (2007); and Christian, Dower, & O’Neil (2007).

Whether viewed in sophisticated or common-sense ways, scope of practice underpins the entire framework of our health provider licensing system. That is, state governments,¹² acting to protect and promote the public health, assess the education, training, and abilities of various provider groups and then signal to the public through licensure that these providers have been deemed competent and are authorized to provide a relatively defined range of health services in a safe and effective manner.

Defining Scope of Practice under an Authority-Based Scheme

Physicians were the first health care providers to secure licensure in all the states, and their legislatively recognized scope of practice—the “practice of medicine”—swept the entire human condition into their exclusive domain. The almost unlimited range of physicians’ authority to practice is reflected in the following typical Medical Practice Act provisions:

Definition of the practice of medicine: A person is practicing medicine if he/she does one or more of the following:

1. offers or undertakes to diagnose, cure, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality;
2. administers or prescribes drugs or medicinal preparation to be used by any other person;
3. severs or penetrates the tissue of human beings. (Washington Revised Code §18.71.011)

This all-encompassing medical scope of practice, combined with physicians’ simultaneously obtained authority to supervise, direct, and delegate to all other kinds of health care providers, preempted the practices of other health professionals and clinicians. This forced subsequent legislatively recognized health care providers, such as APCs and others, to settle for narrowly confined scopes of practice “carved out” from the universe of the practice of medicine. Even then, physician supervision or referral was usually required.

This authority-based scheme continues to affect scope of practice today, in decidedly asymmetrical ways. For example, as research and innovation expand effective treatment modalities, physicians are able to provide those treatments without having to seek revision in their legal scope of practice.¹³ In contrast, health care providers such as APCs not only must acquire the

¹² Although the federal government arguably could directly regulate individual providers, including their basic licensure, it has continued to honor the historic role of the states in carrying out these functions. Also, it should be noted that federal health care facilities (including those run by the U.S. military, the Department of Veterans Affairs, and the Indian Health Service) set the scopes of practice for health care professionals practicing in their facilities. These scopes of practice may deviate somewhat from (usually they are more expansive than) the practice laws of the state in which these professionals practice.

¹³ Interestingly, with increased medical specialization and heightened reliance on specialty “certification” as a prerequisite for institutional privileges/credentialing as well as for payment eligibility, medical organizations themselves have begun to emphasize that a physician’s “ability,” rather than professional certification or specialty status, should determine scope of practice, at least as far as physicians’ clinical privileges. For example, note the following from a listing on the American Academy of Family Physicians website of policy statements on “Family Physicians Scope of Practice”:

“It is the position of the American Academy of Family Physicians (AAFP) that clinical privileges should be based on the individual physician’s documented training and/or experience, demonstrated abilities and current competence, and not on the physician’s specialty” (AAFP, 2009).

The American Medical Association (AMA) holds a similar position. Regarding clinical privileges, the 1993 *AMA Policy Compendium* states,

“The accordance and delineation of privileges should be determined on an individual basis, commensurate with an applicant’s education, training and experience, and demonstrated current competence.”

It also states that “[i]n implementing these criteria, each facility should formulate and apply reasonable non-discriminatory standards for the evaluation of an applicant’s credentials, free of anti-competitive intent or purpose” (AMA, 1993).

AAFP strongly believes that all medical staff members should realize that there is overlap between specialties and that no one department has exclusive “rights” to privileges. (<http://www.aafp.org/online/en/home/policy/policies/c/colonoscopypositionpaper.html>)

Understanding scope of practice as the central organizing principle of our regulatory scheme lets us appreciate the history of its political and professional evolution in each state—and its continuing importance for APCs.

knowledge and ability to provide these new interventions but also must confirm that these tasks are within their scope of practice as it is currently defined. If not, these providers must engage in the time-consuming process of legislative or administrative modification of their scope.

Legislators, licensing boards, and professional organizations are well aware of the legislative and regulatory dynamics reference to this “historical” definition of physician scope of practice unleashed. Each effort to revise a particular profession’s scope of practice to more accurately reflect ever-increasing clinical abilities is met with the argument of historic authority—that is, “This is medicine, and therefore only physicians can do it.” Of course, given the undifferentiated, universal, and timeless scope of practice legally authorized in medical practice acts,¹⁴ the “This is medicine” portion of the argument isn’t inaccurate. However, the second prong of the argument (“...and therefore only physicians can do it”) is both inaccurate and irrelevant to the question of who is competent to do what.

Defining Scope of Practice under an Evidence-Based Scheme

Fortunately for health care providers, and for the public they serve, the tide is turning slowly but inevitably toward emphasizing evolving ability and competence rather than static, historic grants of exclusive authority. This laudable and necessary shift in approach to scope of practice is succinctly set forth in a 2006 monograph entitled *Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations* (hereinafter referred to as *Scope Changes*) (Association of Social Work Boards [ASWB] et al., 2006). Though not binding, the document provides information and guidance to health policy decision makers. Several aspects of *Scope Changes* are noteworthy for APCs and others interested in facilitating access to safe and effective care for their patients.

First, a unique process was used to develop *Scope Changes*. Its authors describe the publication as “a collaborative project developed by representatives of the [associations of] regulatory boards of the following health care professions: medicine, nursing, occupational therapy, pharmacy, physical therapy and social work” (p. 5). Second, the drafters rejected the static, historic-authority perspective and its resulting turf battles and opted instead to focus on patient safety. The resulting framework “rests on the premise that the only factors relevant to scope of practice decision-making are those designed to ensure that all licensed practitioners be capable of providing competent care” (p. 15).

To put to rest the most common arguments inherent in the “first-in-time, first-in-right” historic-authority approach, the document explicitly sets forth several basic assumptions informing the group’s framework for scope of practice decision making:

1. Public protection, rather than professional self-interest, should have top priority in scope of practice decisions; this promotes the public’s access to safe and competent providers.
2. Changes in scope of practice are inherent in our current health care system, as knowledge and capabilities are ever evolving.
3. Collaboration between health care providers should be the professional norm, not a selectively-imposed statutory requirement only for some.
4. Overlap among professions is necessary. No one profession actually owns a skill or activity in and of itself.
5. Practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service. (ASWB et al., 2006, pp. 8–10)

In short, demonstrated clinical ability and competence are to be the touchstones guiding legal authority for health professional scope of practice.

¹⁴ Even though physicians’ legally defined scope of practice remains exceedingly inclusive and authorizes them to perform virtually any kind of medical or health intervention, most physicians do not and would not engage in such unfettered practice. A combination of extralegal constraints, including common sense, professional judgment, professional ethics, institutional credentialing systems, voluntary accreditation standards, and malpractice insurance provisions, reinforces self-restraint to keep physicians from practicing beyond the boundaries of their abilities.

Assessing Changes in Scope of Practice

Finally, with patient safety as the goal and clinical ability as the metric, *Scope Changes* articulates four areas of inquiry relevant to assessing changes in scope of practice. These include:

1. **Historical basis:** How do the history, theory, and evolution of the profession and its practice support the requested change?
2. **Education and training:** Do entry-level training programs provide the knowledge base and skill sets necessary for providers to acquire new skills? Do postprofessional training programs and/or competence assessment tools indicate that the advanced skill can be performed safely?
3. **Evidentiary base:** What clinical evidence and research, standards of care, risk data, and other benchmarking data are available to support the inclusion of new skills or techniques in the safe practice of these providers?
4. **Regulatory environment:** Is the licensing board authorized and prepared to resolve any regulatory issues resulting from the proposed change, including identifying standards of practice and training, as well as assessment mechanisms for competence? (ASWB et al., 2006, pp. 11–13)

The authors of the monograph conclude that if the analysis of these factors demonstrates a strong basis for redefining a particular scope of practice, the request should be approved, since doing so would promote public access to quality care.

This evolution in scope of practice assessment from an authority-based perspective to one of evidence-based ability bodes well for APCs in their desire to better meet the needs of their patients by providing a model to safe and effective reproductive health care services, including abortion.

E. WHO DETERMINES SCOPE OF PRACTICE?

Many factors and processes interact to shape the legally recognized scope of practice of APCs. There is significant variation among the states (and sometimes even within the same state) in the legal authority for health care providers' professional services. Regardless of these differences, however, there is a common framework for the development and implementation of scope of practice policy. To best serve their patients and their profession, as well as to protect their own professional integrity and license, APCs must understand the actors and processes involved in the legal determination of scope of practice.

The Common Legal Framework: State Practice Acts and Licensing Boards

For each group of licensed health care providers, the basis of regulation resides the practice act. This statute, enacted by the state legislature, determines that, to protect the public, only those who meet specified requirements, usually including successful completion of educational programs and a professionally relevant and validated examination resulting in licensure, can perform certain services or functions. The practice act sets out the rights and responsibilities of licensees and, in varying degrees of specificity, states what those license holders are authorized to do in their professional roles.

In addition, the practice act establishes an administrative agency (such as the Board of Nursing or PA Practice Committee of the Board of Medicine) comprised principally of practitioners and educators from the regulated profession, as well as public members, and gives it a variety of powers: to determine who meets the qualifications for licensure; to gather, analyze, and disseminate information on the licensed profession's practice; to ensure licensees' compliance with requirements and standards; and importantly, to implement the legislature's intent by adopting and enforcing rules and regulations designed to further that intent.

The role of these boards in policy development, especially in the area of scope of practice, is extensive and, in many ways, inevitable. Almost no practice act can specify

Although the title of the board, the exact responsibilities, and the specific duties may vary, each state has a regulatory board responsible for implementing legislative statutes governing the practice of CNMs, NPs and PAs. Traditionally, these boards are staffed by a combination of clinicians and non-clinicians whose goal is to protect the safety of the public by implementing licensure regulations that describe the minimum requirements for the practice of CNMs, NPs or PAs. The board keeps a list of all the practitioners who have met these requirements for licensure and serves as the disciplinary arm to deal with practitioners who do not follow the rules. As such, the licensing boards are not necessarily the advocate for the CNM, NP or PA. They cannot set up special rules to help practitioners or defend them in actions against employers or physicians, and its members are not lobbied like members of the legislature. (Edmunds, 2006)

in advance each and every permutation of professional practice, especially given the rapid evolution of clinical knowledge and techniques and the concomitant expansion in educational curricula. As a result, licensing boards must constantly “update” their interpretations and applications of practice act provisions and policies. They do this through a variety of means, including issuing Advisory Opinions and Policy Statements and promulgating rules and regulations that establish more detailed rights and responsibilities than those typically found in the original practice act. In addition, in carrying out their enforcement functions in individual adjudications or disciplinary actions, licensing boards must grapple with the interpretation and application of policy to new and unique facts and circumstances. Their decisions affect not just the licensee involved, but also the entire profession through development of precedent. Finally, boards often are in the best position to identify the need for revisions to the practice act itself, and they can recommend proposals for statutory modifications to the legislature.

Licensing boards, especially Boards of Nursing responsible for NPs and CNMs, are constantly evaluating and assessing scope of practice issues. APCs and their professional associations must be active participants in these determinations.

Rulemaking is the most obvious method boards use to act on their authority to articulate and adopt policy. Usually, rulemaking is done in accordance with the state’s Administrative Procedures Act, which generally requires public notice of the proposed rule and an opportunity for comment, either in a public hearing or through the submission of written testimony. Once it has evaluated the comments, the board either adopts the rule in its original or a modified form or decides not to finalize the proposal. In either case, it is important for APCs, individually and collectively through professional organizations, to analyze the policy issues involved and share their informed opinions on how the proposed rule would affect the public’s access to safe and effective reproductive health care services.

Most nursing boards have other mechanisms directly focused on scope of practice development and interpretation. These include standing committees on advanced practice and scope of practice. These committees conduct ongoing assessments and evaluations of parameters for advancing educational and clinical practice. On their own initiative, on referral from the board, or by petition from an individual practitioner, these committees issue Practice Statements, Opinions, or Recommendations to the full board addressing whether a skill, procedure, or technique is within the authorized scope of practice of a licensed provider group. In taking these actions, nursing boards evaluate existing statutory and administrative policies, research and clinical studies, professionally developed standards of care, educational and training curricula, and experiences from other states, all with the goal of determining whether the new skills or techniques can be effectively and safely included in a provider’s practice. As individuals or (more commonly) through their professional organizations, advanced practice nurses can play an important role in these processes, including providing testimony and documentation on factors relevant to demonstrating clinical ability and competence.

Medical boards governing PA practice may also have separate PA committees. In California the Medical Board includes a Physician Assistant Committee that provides limited guidance on scope of practice questions through answers to Frequently Asked Questions and Information Bulletins. In addition to the restrictions on scope of practice provided under state statutes and regulations, scope of practice determinations for PAs are often left to individual supervisory physicians who work with PAs to develop PA duties and delegation agreements. In some states, such as Montana, the supervision agreements developed by the supervisory physician and the PA must be submitted to the state’s medical board (Mont. Code Ann. § 37-20-301(1)(c)(2007). In addition to the filing requirement of the PA supervision agreement to the Montana Board of Medical Examiners; Mont. Code Ann. § 37-20-301(2) and (3), the PA is required to have a signed “duties and delegation agreement” that must be kept by the PA and made available as requested. Individual PAs advocate for themselves by working with their supervising physicians to develop scope of practice and delegation agreements that allow them to provide the full

Continuous engagement with the relevant board (nursing, medical, PA, or midwifery) is vital to protecting and promoting professionally appropriate practice scopes. Although a proceeding on a specific practice issue may draw focused APC attention, engaging in ongoing dialogue with board members and staff to keep them updated on developing clinical abilities and the need for continual realignment of ability-based regulatory authorization is critical. This “early and often” relationship with licensing boards is an essential activity of state professional organizations.

range of services that are within the PA's competency and training and the supervising physician's area of specialization.

Please refer to Figure IV.3 in Section IV.F where we suggest effective strategies for working with licensing boards. In this section we describe how individual APCs and their professional organizations are most effective in informing regulatory boards.

One final scope of practice policy venue deserves special note: the adjudicatory or disciplinary proceeding, including investigation of outside complaints of alleged scope of practice violations. In carrying out their responsibility to ensure a licensee's compliance with legal practice requirements, boards can initiate disciplinary or adjudicatory proceedings directed at an individual provider. These proceedings are usually triggered by information gathered by board staff or by the receipt of a complaint (sometimes anonymous) from a member of the public or another health care provider. The process begins with informal information gathering by board staff or investigators. Depending on the results of this investigation, the proceeding can be concluded at this stage with a finding of no violation or a decision that a violation did occur, with the board and the practitioner agreeing to a set of penalties or corrective actions. If there is a finding of a likely violation and no mutually agreeable resolution, then the case can proceed to a formal adjudicatory hearing before the board, with a panoply of procedural rights and requirements specified by both the state Administrative Procedures Act and the board's own procedural rules.

Several issues integral to these disciplinary proceedings are noteworthy. First, the resolution of these cases often involves issues of "first impression." That is, the board is asked to interpret and apply the practice act and board policies to a unique set of circumstances that the legislature probably did not specifically anticipate when it wrote the act. The board must base its determination on the best fit between legislative intent, the authority granted to the board, and the facts and issues before it. Often, scope of practice issues are central to these cases. The board must analyze whether the individual provider's decision to perform the task(s) in question was supported by appropriate training and education and whether the provider demonstrated competence, both of which would place the task within the provider's scope of practice. Decisions like these have salience, not just for the individual involved, but also for the broad professional cohort. The board's determination of "within" or "not within" the scope of practice will have precedent-setting influence in delineating scope of practice policy.

The adjudicatory nature of these licensing board proceedings is markedly different from that of other policy-making processes. In rulemaking and the development of Practice Statements, for example, public and professional input of many kinds is permitted, and often encouraged. In adjudications, however, requirements of due process and fairness dictate that the board base its decision only on the information and evidence appropriately introduced by parties at the hearing. This generally precludes board receipt of communications outside the formal proceedings (ex parte contact). This emphasizes how important it is for individual APCs and their professional organizations to provide policy input on an issue before any disciplinary proceedings arise. It also reinforces that any assistance in demonstrating the competence basis for an inclusive interpretation of scope of practice must be filtered through the individual practitioner involved in the proceeding and her/his attorney for the board to consider it. If the clinician whose scope of practice is challenged has not been active in or in contact with state and national professional organizations, she/he may not receive the valuable assistance that peers and associations can offer.

The Role of the Professions in Defining Scope of Practice

National NP, CNM, and PA organizations have developed documents and policies related to philosophy of practice, practice boundaries, standards of practice and education, competencies

for entry into practice and excellence, ethical codes, practice guidelines, educational program accreditation, and practice policies such as institutional privileging, collaborative practice agreements, and so forth. These professional policies and documents establish criteria by which professional organizations credential clinicians. These criteria are also adopted by boards and other regulatory bodies from state to state to monitor and regulate clinical practice, deem it safe or unsafe, and discipline clinicians. Specialty practice (e.g., abortion care as a component of women's primary care or reproductive health) standards and clinical care guidelines build upon these foundational elements.

At the education level, academic programs that prepare APCs use these practice standards and competencies as the basis for curriculum development and program accreditation. Most national organizations also have state chapters and practice committees that play an important role in the implementation, review, and revision of regulatory and credentialing documents. Because professional regulation is implemented at the state level through licensing boards and legislative action, members of state practice organizations and committees must provide essential formal and informal expertise to these boards and agencies.

Advanced practice nursing organizations, nurse-midwifery organizations, and PA organizations along with professional organizations representing women's health practice have established a number of essential documents, policies, and mechanisms to assure clinical competence, safety, and quality care.

For more information on these professional organizations and their functions, see the Appendix:

- **Table A.1** describes APC professional organizations—who they are and their role in credentialing and defining scope of practice.
- **Table A.2** outlines the credentialing functions of nursing, midwifery, and PA organizations as they relate to patient and public safety: education standards, program requirements, and educational accreditation agencies; scope of practice delineation by role (e.g., CNM, NP, and PA) and by population (e.g., women's health, primary care); professional practice policies and documents (e.g., philosophy, standards, core competencies, clinical guidelines, and ethical codes); and professional certification programs.
- **Table A.3** lists websites for all these professional organizations.

F. HOW INDIVIDUAL APCS CAN PARTICIPATE IN SCOPE OF PRACTICE DETERMINATIONS

Participation in our professional organizations is a responsibility for all health professionals. If the professions fail to provide leadership in developing, maintaining, and advancing professional standards and responsibilities, then licensing boards and legislatures will take the lead.

What Professional Organizations Do for Individual NPs, CNMs, and PAs

Although the essential practice documents of each professional role are developed at the national level, each of the professional organizations representing APCs has regional or state chapters.

State nursing organizations are professional organizations which can be organized as labor unions and are often affiliated with the American Nurses Association. They provide a variety of services to their members, including lobbying at the state legislature, representing the profession before government agencies, providing continuing education for nurses, and disseminating information and updates about national and state professional issues. State nursing organizations also review and implement standards of practice and education, and in many states they provide collective bargaining services. State nursing organizations also encompass an active community of peers that can effect change and respond to challenges in politics, practice, and labor as well as advocate for nursing and quality health care. State nursing organizations affiliated with the American Nurses Association (ANA) represent advanced

Given the great number of bills proposed in state legislatures each year, state or national professional associations are better positioned than are individual APCs to gather and monitor this range of information. To be privy to this information and play a role in what is happening legislatively, APCs need to affiliate themselves with a professional organization active at the state level. Individuals and associations must remember that “early and often” contact with legislators is preferable to an “only in a crisis” approach. That is, APCs—individually and through their state professional organizations—need to continuously educate legislators about the value of their services. They must also emphasize that their patients and the public (the legislators' constituents/voters) are best served by laws that promote the fullest utilization of providers' ever-evolving clinical abilities.

practice nursing, which includes CNMs and NPs. States may also have free-standing NP organizations or NP organizations that function as subsidiaries within the state nursing organization.

Glossary: Practice essentials are documents developed by health professional organizations (such as practice philosophy, standards, core competencies, and ethical guidelines) that are essential for competent clinical and professional practice. These “practice essentials” provide the basis for education, legal regulation, professional certification, and practice credentialing.

Similarly, state and regional chapters of the American Academy of Physician Assistants (AAPA), the American College of Nurse-Midwives (ACNM), and the American Academy of Nurse Practitioners (AANP) provide support and leadership for their members in the area of **practice essentials**.

Getting Involved with Your Professional Organization

Participation in your professional organization can take many forms. A passive (but certainly important) form of participation is to pay membership dues to keep your membership in good standing and support your colleagues in bringing a professional voice to scope of practice conversations at the state and national levels. See Figure III.2

Much of what all the APC organizations accomplish is due to the volunteer efforts of their members: NPs, PAs, and CNMs across the country who contribute their expertise, energy, time, and perspective to the work of these groups. Raising the profile of APCs and their critical role in the future of health care delivery is one of the important activities of these organizations. The more members who are involved in and support their professional organization, the greater the organization’s professional voice and impact.

Most state nursing organizations and chapters of national CNM and PA organizations have professional practice committees that provide leadership in that area. How various state APC organizations structure their professional practice–related activities varies, but all provide guidance and support for developing and maintaining the scope, standards, and competencies of professional APC practice. Join your organization’s professional practice committee if you are interested, or form a subcommittee with other APCs working in reproductive health and/or abortion care. Such a subcommittee can

- provide support to its members,
- clarify professional practice issues (e.g., care refusal, restrictive legislation or regulations),
- provide expertise to a generic practice committee within the organization, and/or
- examine the limitations of your state’s NP, CNM, or PA practice acts for advancing scope of practice into abortion care and/or provision.

Working with State-Based Professional Associations: Benefits and Challenges

Most state associations are powerful forces in influencing scope of practice and political decisions affecting APCs. Because the relationship between professional associations and regulatory boards differs from state to state, understanding your state’s unique circumstances will prepare you to develop strategies and messages that will be most effective in meeting your goals.

“Do the Math!” Because CNMs, NPs and PAs represent a small fraction of the total health workforce, usually less than 10% of the licensed nurses, it is important to work with state nursing organizations. For example, in California there are almost 20,000 APCs compared with over 300,000 RNs. These state nursing organizations have experienced government relations committees and lobbyists who are knowledgeable about practice laws, regulations and they maintain formal relationships with medical and nursing regulatory boards on behalf of their profession. State PA chapters contribute to collaborative advocacy efforts by working with both state medical and nursing organizations.

Glossary: Collective bargaining is negotiation between organized workers and their employer or employers to determine wages, hours, rules, and working conditions.

Case studies throughout the United States lead us to recommend that all APCs belong to their state professional associations, but individuals may resist this recommendation for many reasons. Sue Davidson, Assistant Executive Director of Nursing Practice, Education, and Research at the Oregon Nurses Association (ONA), cites the **collective bargaining** aspect of her organization as the largest barrier to membership (S. Davidson, personal communication, September 2008). Davidson explains that although ONA (and its sister organization, Nurse Practitioners of Oregon) puts practice issues front and center, many potential members are uncomfortable with or are prohibited from participating in the bargaining aspects and therefore do not see a role for themselves in the association. Davidson believes that even when collective bargaining is not a barrier to membership, the perception of “union politics” and historical antipathy toward bargaining units create divisions within the profession and may prevent clinicians from joining their state association. In Oregon, only 29% of all licensed nurses belong to the ONA, a statistic that may undermine the association’s ability to influence scope of practice conversations and decisions as effectively as it might otherwise. This low membership reflects the national trend to decreasing membership in health professional organizations.

Davidson explains that there has traditionally been a professional expectation (as codified in professional ethics codes for nursing, midwifery and PAs) that licensed professionals would belong to their state and national professional associations. She believes that while collective bargaining is the largest barrier to membership (for nurses), the decrease in membership nationwide is also largely a result of the training received during nursing education. She notes that clinician training programs focus almost entirely on clinical care, yet the majority of challenges to advanced practice nurses such as NPs and CNMs have to do with issues of professional ethics. Clinicians are often not prepared for these types of challenges and are unaware of the support that their professional associations can offer, both in proactively educating about ethical practice and in offering assistance when members are challenged.

Many APCs practicing in the field of reproductive health feel that it is the controversial nature of the specialty that makes them vulnerable. Professionals such as Davidson, however, cite the additional responsibilities, including self-regulation, that bring additional vulnerabilities and point out that beyond issues like abortion, *anyone* practicing in today’s health care climate is operating in a politically charged environment. We’ve noted that protecting the interests of the public is the primary job of the regulatory boards; these politically appointed boards are bound by law to regulate professional practice and education and to discipline any licensed professional who violates the statutes and rules. Professional licensing boards are mandated to investigate any complaint made against an individual clinician. Clinicians who do not understand the roles and responsibilities of the licensing boards may misinterpret board action as adversarial or punitive.

Preoccupation with the daily demands of their practice or busy personal lives may keep clinicians from seeking involvement in their statewide professional community. Yet it is precisely this involvement, according to Davidson, that not only protects clinicians by bringing their collective voice to scope of practice determinations but also reinvigorates them for practice and shows them how to operate from a base of power rather than a defensive stance. Building alliances with peers and colleagues, presenting a unified voice within one’s professional association, and then representing the views of that profession to the larger community of regulatory boards and legislative bodies can have tremendous impact on the priorities and strategies of those bodies, impact that cannot be replicated by those working outside a professional association. In this regard, membership and involvement in one’s professional organizations is a key element of protecting and advancing scope of practice into politically charged areas of practice such as abortion care.

The anti-choice groups are ramping up their efforts to “chip away” at abortion access. We are seeing parental consent bills, bills requiring abortion providers to be obstetrician-gynecologist physicians, bills requiring waiting periods, and “middle of the night” bills introduced to restrict PA practice. We notify state (AAPA) chapters of these legislative measures to restrict PA practice and provide resources so they can respond effectively.

Ann Davis, AAPA Director of State Government Affairs, 2009

Clinicians are often not prepared for these types of challenges and are unaware of the support that their professional associations can offer, both in proactively educating about ethical practice and in offering assistance when members are challenged.

Membership in a state professional association can offer a chance to network with colleagues, to exchange ideas, strategies, and lessons learned; it gives APCs local professional support that the national specialty organizations cannot replicate. State professional associations can often recommend attorneys with expertise in administrative procedures that govern investigations into scope of practice issues. They may offer benefits, such as a certain amount of free legal assistance for members who need it, as part of their membership fee. Even more important, however, is that whatever the association's stance on abortion, clinicians will certainly find colleagues who are committed to protecting scope of practice, and these colleagues will support a clinician whom they believe to be acting within her/his scope regardless of their political feelings about a women's right to choose abortion. Messages like this can go a long way in gaining allies: "No matter how you feel about abortion, this is an issue about scope of practice. It is dangerous to let politically motivated complaints against nurses drive decisions about the best patient care."

FIGURE III.2

The Importance of Membership in Professional Organizations

Pulling the Load

By Susan Wysocki, RNC, NP, FAANP; President and CEO, Nurse Practitioners in Women's Health (NPWH)

The other day a nurse practitioner colleague of mine called to ask for NPWH's help in alerting our members in a state in which an NP was having her scope of practice (SoP) challenged. This NP had been providing pregnancy termination services for several years. The NP was experienced and skilled. But someone complained to the board of nursing (BoN). Even before the BoN had completed their investigation (required whenever such a complaint is made)—legislation was submitted that would create a "doctor only" law for the services that this NP was providing. The legislation passed the state senate before NPs in the state were even aware of it. Leaving aside the fact that the original issue concerned pregnancy termination services, the SoP issue would have set a precedent for "doctor-only" language for other circumstances and procedures as well.

The NP's state group rallied in support of her practice. The state chapter of the American Academy of Nurse Practitioners did the same. At NPWH, we sent out an email alert to our members in the state to send letters to state legislators asking that this bill limiting NP SoP not be passed. This particular NP needed support from all of these groups if she were to continue her practice. The problem had mushroomed beyond the BoN investigation of a scope of practice issue. The NP needed deeper and wider help and support.

The irony is that the NP under investigation was not a member of any of the groups that supported her. In fact, she was not a member of any state or national NP organization. But these organizations were there for her. Think about why they supported her. They did so because other NPs had been paying their membership dues and supporting these organizations and their goals. Member dues pay for the phone and fax lines that alerted NPs across the state. Member dues allow NPWH to send out email alerts within minutes of receiving the call.

In this particular NP's case, NPWH did help because the issue could potentially affect every NP in that state, including members of NPWH. Legislation to decrease any NP's scope of practice could become a new strategy for limiting procedures that NPs are qualified to perform.

Membership is your insurance if your scope of practice is ever threatened. Membership is your insurance that when you call, someone will answer the phone (because their salary and the phone bill have been paid). Membership is your insurance if someone other than you is challenged or you are simply in the line of fire.

Source: Previously published in Women's Health Care for NPs, 7(2), 6, 33; 2008 by NP Communications.

Specialty Organizations— Important Allies with Professional-Role Organizations

Specialty organizations such as the National Abortion Federation (NAF) and Association of Reproductive Health Professionals (ARHP) are critically important in the development and maintenance of practice standards, competencies, and evidence-based clinical guidelines for reproductive health care and abortion care. However, membership in these organizations does not substitute for membership in a national (with state/regional chapters) NP, CNM, or PA organization.

Despite the strong case for membership in one's professional association, additional barriers should be noted. For some, finances are the issue. APCs who provide abortion care may feel forced to choose between belonging to their professional association or to associations that specifically serve abortion providers (and they may also have to decide between attendance at professional conferences and clinical training opportunities). For those working in small clinics, this financial barrier, albeit an important professional investment, can feel insurmountable. Still others express reluctance to join their professional association because they feel ostracized for their pro-choice stance or their commitment to providing abortion care. All of these are valid concerns that clinicians should address with their professional associations and colleagues.

Building relationships with members of your state professional association before there is a scope of practice challenge (rather than waiting to act until a crisis presents itself) can increase communication and goodwill. We have been surprised to learn that, in some cases, while the pro-choice groups feel that the professional associations are inaccessible, the professional associations believe they cannot take a pro-choice stance because their membership would not support it. Clinicians working in family planning settings and abortion clinics may be ideal catalysts for bringing these parties together in conversation.

G. GETTING TO KNOW YOUR PROFESSIONAL COMMUNITY

Here are some proactive approaches for clinicians who want to become familiar with their professional community and take advantage of the learning opportunities that exist there:

- Read your professional practice act. Know how your scope of practice is defined in statute and regulations, including the rules (if any) for how your scope of practice can be advanced.
- Get to know the members of your licensing board: check out their profiles on the board's website and/or attend a board meeting. Identify board members who understand scope of practice regulation, and reach out to them *before* a crisis occurs. See section IV-E for additional strategies for working with state regulatory boards.
- Participate in practice development or maintenance where you work—for example, in institutional professional practice committees.
- Attend a meeting of your state professional association, and offer yourself as a resource to those who have questions about reproductive health.
- Form a practice group to apply your professional code of ethics or conduct to ethical issues in reproductive health and abortion care that are relevant to your practice.
- Seek membership on practice-related advisory councils associated with primary care or women's health. These councils may be at the level of a professional practice organization, the state department of health, the state/county public health system, or a state licensing board.
- Request a private meeting with the association's leadership to talk about your practice and the issues that are most important to you.
- Attend statewide conferences, and submit proposals for workshops focused on the evidence for maintaining access to abortion. Use evidence in *Toolkit* Section I-II as a template.
- Seek appointment to advisory committees and task forces that provide input to your state licensing board or to national councils representing state licensing boards.
- Offer testimony at state and national hearings on the subjects of proposed regulatory changes, prescriptive authority, or reimbursement schemes.
- Respond to invitations to review, edit, or provide feedback on circulated drafts of professional and regulatory policies that directly affect APC education and practice.
- Use your professional role in the service of your communities: on the PTA, in neighborhood associations, and in other volunteer roles that interest you.

Advocacy Activities with Professional Organizations: Pro-choice & Pro-professional Positions

Engage professional organizations in the adoption of position papers or resolutions on the role of nurses and PAs in preventing unintended pregnancies and protecting reproductive rights. For example, reproductive rights activists working with nurses in New York drafted a resolution titled "The role of nurses in patient education on birth control and reproductive health" that was subsequently passed at the New York State Nurses Association Annual Convention in October of 2004. The resolution read as follows: "...resolved, that the New York Nurses Association collaborate with other interested organizations to develop and disseminate educational materials on the provision of comprehensive pregnancy prevention methods and abortion procedures, and on the history of the role of nurses in providing this essential care to women." (New York State Nurses Association, 2004).

SUMMARY

- APCs must become familiar with the essential government actors—state legislatures and state licensing boards—who are responsible for developing and enforcing regulations governing their practice, including scope of practice determinations.
- Involvement of and input from both APC professional organizations and individual APCs at various stages in the regulatory process is critical.
- State licensing boards rely on the professional organizations to assess and define professional practice, standards of practice, and basic and advanced competencies that are the foundation for safe and effective care. These boards also look to state health-professional education and training programs to identify how practice standards and competencies are situated within the curriculum and clinical training.
- One of the important responsibilities of APC professional organizations is to align the essential elements necessary for APC legal scope of practice and credentialing (licensure and certification of competency) with evolving practice.
- Scope of practice is a central issue for APCs and their national and state professional organizations. Working with other reproductive rights advocacy and policy groups, individual APCs and their organizations must continue to situate early pregnancy termination procedures within the scope of health care services APCs can capably provide for their patients.
- Disciplinary proceedings and scope of practice investigations target individual clinicians. To protect against such inquiries, APCs and their professional organizations must provide regulators with policy input demonstrating APC ability/competence and supporting an inclusive interpretation of scope of practice before these challenges occur.
- APCs who have not been active in, or in contact with, their state and national organizations may not receive the professional assistance those organizations can offer should their scope be challenged. This is detrimental to both the individual and the profession as a whole.
- Working with your professional organization provides political support when facing challenges from anti-abortion groups but also challenges from organized medicine to limit APC scope of practice.

A Tip for Administrators and Advocates:

Actions you can take:

- Become familiar with how scope of practice is regulated for CNMs, NPs and PAs in your state.
- Support APCs in your organization to become involved in their professional organizations.
- Work with APC organizations to craft common messages in response to anti-abortion attacks on APC scope of practice.
- Offer to help APCs in your organization research the use of state-specific mechanisms for changing health professional statutes and regulations such as state administrative law procedures.

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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); *Schrimer*, 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 Oppen 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 mislead 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.

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SECTION V.

BECOMING CLINICALLY COMPETENT AND DOCUMENTING COMPETENCY IN ABORTION CARE

OBJECTIVES:

1. Identify abortion education and training opportunities for APCs.
2. Identify resources to help APCs become clinically competent in the provision of abortion care.
3. Provide guidelines for professional portfolio development.
4. Offer a template for documenting professional credentials, clinical competency, education, and experience.

A. SPECIALTY EDUCATION AND TRAINING IN ABORTION CARE: OPPORTUNITIES AND RESOURCES

A 2003 survey of 14,000 licensed APCs conducted in California determined that 25% desired training in abortion (Hwang, Koyama, Taylor, Henderson, & Miller, 2005). The reason APCs cited most frequently for not providing or assisting with abortion procedures was lack of training opportunities (Hwang et al., 2005). Conducted shortly after the passage of new reproductive privacy legislation establishing the role of APCs in the provision of nonsurgical (assumed to mean only medication) abortion, the survey found that approximately one third of APC respondents believed that aspiration abortion was a surgical procedure outside the practice of APCs. These results suggest that, regardless of their intention to provide or not provide abortions, many actively practicing NPs, CNMs, and PAs want training in abortion care or need education related to new knowledge and technologies for preventing and/or terminating unintended pregnancies.

A few examples show how some programs are helping to advance education and training in reproductive health including abortion care:

The **Reproductive Options Education (ROE) Consortium** of the **Abortion Access Project** promotes the integration of abortion-related content into undergraduate and graduate nursing education by offering training, teaching materials, and support to nursing faculty. ROE launched a two-year pilot program in 2002 to increase the number of nursing students prepared to provide abortion-related care. During the pilot project, 13 nursing education classrooms used ROE curriculum tools to increase the ability of more than 500 students to counsel women with unintended pregnancies and to provide support during an abortion and with postabortion care. In 2005–2006, 135 nursing faculty, students, and practicing clinicians attended ROE Consortium trainings. ROE has developed educational resources including the free, downloadable *Caring for the Woman with an Unintended Pregnancy: Teaching Nurses What They Need to Know* (AAP, 2001), two guides titled *Teaching Reproductive Choice Options: A Resource Guide for Nurse Educators, Practicing Nurses and Nursing Students* (Simmonds & Abortion Access Project, 1997) and values clarification tools, case studies, and fact sheets. About 300 nurses, nursing students, and faculty access these tools annually at www.abortionaccess.org.

At the **University of California, San Francisco School of Nursing's Family and Women's Primary Care Program** (NP and CNM students), required coursework includes didactic

information on primary prevention of unintended pregnancy (contraception, emergency contraception) and secondary prevention of unintended pregnancy (pregnancy options counseling and first trimester abortion methods). Clinical training includes procedural skill training in IUD insertion, ultrasound, and MVA for miscarriage management and abnormal bleeding, along with pain management (such as paracervical blocks) for these procedures. For those students who want more experience, supervised clinical training is arranged.

At the **Stonybrook University Physician Assistant Education Program**, the reproductive health curriculum includes both required didactic coursework and elective clinical training in abortion and assisted reproductive technology. In addition, as part of the general ethics course taken by all PA students, one class focuses on the history of abortion and infertility treatments in the US as well as the ethical considerations facing women's health professionals who provide these reproductive health services (Ranieri, 2009).

Some APC faculty has been successful in promoting reproductive rights and health in curriculum and educational policy. For example, the faculty of the **Nurse-Midwifery and Women's Health Nurse Practitioner Program at the University of Illinois at Chicago** support the international definition of reproductive health that "All people have the right to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so; and the right to make decisions concerning reproduction free of discrimination, coercion and violence" (United Nations, 1995). This definition provides the foundation for educational requirements for students in the program, as their policy on this subject states: "[w]hile individuals may have beliefs that differ, students are required to learn the full range of reproductive options available to women throughout the world and be able to counsel and refer women appropriately" (University of Illinois-Chicago Nurse Midwifery and Women's Health Nurse Practitioner Program, 2003).

Postgraduate Education and Training for APCs in Abortion Care and Provision

NPs, CNMs, or PAs who did not receive specialty didactic and clinical training in reproductive health and abortion care in their basic education program must look to postgraduate or continuing education programs for that training. National professional organizations and a few academic or residency training groups have developed standards, curricula, and training guidelines for prelicensure health professional students, medical residents, and women's health professionals who want didactic and clinical training in abortion care or procedures or who wish to advance their practice into abortion care.

It is worth noting, however, that training in abortion care can be very difficult for APCs to access. Many abortion care facilities with established training programs have already committed their training slots to medical residents, students, or their own staff, and APCs may face prejudice from trainers who are not supportive of abortion as part of APC scope of practice or who see APCs as possible competitors. Depending on the APC's prior experience, training in skills such as ultrasound, pregnancy options counseling, paracervical anesthesia, conscious sedation, medication abortion provision, and endometrial biopsy using MVA may also be necessary, and the training slots for these procedures may be equally competitive.

The following resources offer suggestions for self-study as well as guidelines for training to competency in abortion care. APCs who wish to learn more about acquiring abortion training should contact the Abortion Access Project at info@abortionaccess.org or the National Abortion Federation at naf@prochoice.org to talk about the opportunities and possible challenges.

The **Association of Reproductive Health Professionals** (ARHP), an interdisciplinary organization that includes advanced practice nurses and PAs has developed educational standards and curricula for health professionals training in reproductive health. ARHP and its organizational partners have developed an innovative web-based curriculum resource called CORE (Curricula Organizer for Reproductive Health Education). CORE is a collection of peer-reviewed, evidence-

based teaching materials that allows clinicians and educators to (1) access up-to-date teaching materials on reproductive health topics including abortion care; (2) build their own curricula and other educational presentations; and (3) download activities, case studies, and other handouts for learners. The ARHP website, www.arhp.org, lists a number of publications on abortion care from multiple organizations as well as practice guidelines, clinical reports, interactive tools, and other resources designed for health care providers. In the area of abortion, the ARHP website provides:

- Abortion research from peer-reviewed journals.
Available at <http://www.arhp.org/topics/abortion/featured-research>
- Abortion-related clinical and educational publications and resources, such as training modules in the provision of abortion care from abortion counseling through postabortion care, as well as medication and aspiration abortion procedural training.
Available at <http://www.arhp.org/topics/abortion/clinical-publications-and-resources>
- Online continuing education programs in abortion-related topics, such as webinars on MVA for early pregnancy loss, slide and lecture downloads on abortion from the Guttmacher Institute, and web-based CE offerings from NAF.
Available at <http://www.arhp.org/topics/abortion/continuing-education>

The **National Abortion Federation** (NAF) is the professional association of abortion providers in the United States and Canada. NAF sets the standard for quality abortion care in North America through its evidence-based *Clinical Policy Guidelines* (CPGs), to which NAF members are required to adhere as a condition of membership (NAF, 2008). These are the only such abortion-related guidelines published in the Agency for Healthcare Research and Quality's (AHRQ) National Guidelines Clearinghouse (AHRQ, 2008). In these guidelines, NAF fully supports APCs as qualified abortion providers.

NAF's Training and Education Program offers accredited continuing medical education for health care professionals through a variety of educational resources, including semiannual conferences, workshops, seminars, and online and electronic self-study modules. NAF's CME program incorporates a wide range of topics related to the provision of abortion care, including emerging technologies, first and second trimester abortion methods, quality assurance, and pain management. NAF's CME programming is appropriate not only for physicians, but also for others who are important to the successful provision of abortion care, including APCs, nurses, counselors, clinic administrators, and medical assistants.

NAF was the first organization to train U.S. providers (including many APCs) in early medication abortion and currently sponsors basic and advanced training in medication and aspiration abortion care procedures. NAF has also published a number of educational and practice resources for clinicians interested in becoming abortion providers. Some of these resources include: *Clinical Training Curriculum in Abortion Practice* (2005a); *Principals of Abortion Care: A Curriculum for Physician Assistants and Advanced Practice Nurses* (Policar, Pollack, Nicholas, & Dudley, 1999), and the textbook *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care* (Paul, Lichtenberg, Borgatta, Grimes, Stubblefield, & Creinin, 2009).

NAF curriculum modules are available for download at <http://www.prochoice.org/>. They include the following titles:

- *Early Medical Abortion with Mifepristone and Other Agents: Overview and Protocol Recommendations* (NAF, 2002)
- *Early Options Educational Slide Program on CD-ROM* (NAF, 2005c)
- *Early Options: A Provider's Guide to Medical Abortion* (NAF, 2005b)
- *Early Options Medical Abortion Education Modules*
 - The Historical and Social Context of Medical Abortion
 - Medical Abortion Regimens
 - Expected Side Effects and Management of Complications in Medical Abortion
 - Early Surgical Abortion: An Alternative to and Backup for Medical Abortion

- *Clinical Training Curriculum in Abortion Practice* (NAF, 2005a) (available for download in slide format)
 - Ten modules including didactic and clinical skills for medication and aspiration abortion care
 - Didactic content: pregnancy verification; estimation of gestational age; counseling and informed consent; selection of appropriate procedure; medical screening for aspiration abortion; pain management and postabortion care and follow-up
 - Clinical skills training: medication and aspiration abortion procedure skills and techniques; management of medication and aspiration abortion complications

Planned Parenthood Federation of America's Consortium of Abortion Providers (CAPS) has provided onsite didactic and practicum training since 2001 for provision of medication abortion. This training relies on material that has been reviewed by expert physician and clinician reviewers and is presented by an APC with extensive experience in provision of medication abortion. Topics include client selection, client assessment, the medication regimens, the pharmacologic action of the medicines, timing of medicines, expected course of medication abortion, side effects and their management, assessment of after-hours emergencies, and assessment at the follow-up visit.

As a continuing education provider approved by the California Board of Registered Nursing, CAPS provides continuing education credits (CEU) for its abortion training programs. CAPS also provides onsite didactic and hands-on training for administration of conscious sedation and introductory ultrasound training.

For sites starting to offer aspiration abortion as well as medication abortion, CAPS provides training (with CEUs) in this service, with a focus on client selection; contraindications; informed consent; techniques of aspiration abortion; emergency triage; emergency drills; common complications; and client questions, follow-up, and contraception, among other topics. CAPS also provides didactic and hands-on training for performance of moderate-complexity Rh testing of the fetus.

CAPS has also used physician consultants to provide didactic and hands-on training for evaluation of fresh tissue specimens following aspiration abortion and other technical procedures related to aspiration abortion.

In collaboration with Affiliate Risk Management Services (the insurance corporation of Planned Parenthood) and with support from NAF, CAPS created an ACCME-accredited interactive CD, *Ultrasound in Abortion Care*. The CD provides a series of interactive learning exercises to teach the proper techniques and skills for accurately dating a pregnancy, evaluating the intrauterine position of a pregnancy, screening for ectopic pregnancy, screening for first trimester variants, and assessing the uterine cavity following medication abortion. Many clinical training sites and direct-service facilities as well as residency programs and schools of nurse-midwifery use this CD.

Additional Training and Curricular Resources

A number of educational resources are available as textbooks, CD-ROMs, and web-based materials. Although some academic texts may be available only from the publishers, the following curricula and training programs are available online or directly from the training programs:

- *Abortion Training: A Guide to Establishing an Effective Program at Your Facility* (Abortion Access Project & University of Massachusetts Medical Center, 1998); available at http://www.abortionaccess.org/component/option,com_docman/task,doc_details/gid,111/
- *Abortion Training in Residency Programs: An Interactive Guide for Medical Students* (Medical Students for Choice, (2008); available at <http://medicalstudentsforchoice.org/index.php?page=residency-guide>

- *Guide for Students Considering Residency in Ob/Gyn or Family Practice* (Medical Students for Choice, 2008); available at <http://medicalstudentsforchoice.org/index.php?page=ob-gyn-or-family-practice>
- *Early Abortion Training Workbook* (UCSF Advancing New Standards in Reproductive Health, 2007); available at <http://www.ansirh.org/training/trainingworkbook.php>
- *Surgical Abortion Training Curriculum* (Gold & Planned Parenthood of New York City, 1996); to order, call PPNYC Clinician Training Initiative at 212-274-7255.
- *Ipas Start-up Kit for Integrating Manual Vacuum Aspiration (MVA) and Medication Technologies into Women's Reproductive Health-Care Services* (Ipas, 2008); available at http://www.ipas.org/Publications/asset_upload_file449_3514.pdf
- *Vermont Women's Health Center: Training Program for Abortion and Related Services* (Nicholas, 1991)
- *Obtaining Abortion Training: A Guide for Informed Decision Making* (NAF, 2009); available from the National Abortion Federation at http://www.prochoice.org/education/resources/postgrad_training.html
- *Medication Abortion: A Training Module for Health Professionals* (Ibis Reproductive Health, 2003); available at http://www.ibisreproductivehealth.org/pub/downloads/Medication_Abortion_Training_Module.ppt

The APC Health Workforce Pilot Project: A New Development in Abortion Care Education and Training

As part of a demonstration and evaluation project to prepare APCs to provide early abortion care, the Health Workforce Pilot Project (HWPP) 171³⁰ is testing a standardized competency-based, provider-neutral early abortion care curriculum and training plan. Following training, APCs will integrate first trimester pregnancy diagnostic and termination procedures into existing health services, along with medication and uterine aspiration for treatment of early pregnancy failure, incomplete abortion, and miscarriage management. The HWPP training plan consists of didactic education and “hands-on” clinical experience, along with knowledge testing (online examination) and periodic clinical skills (competency) assessment with the goal of training NPs, CNMs, and PAs to competence in all aspects of early abortion care. The APC curriculum is based on the ANSIRH *Workbook in Early Abortion Care* (UCSF ANSIRH, 2007). The HWPP training plan is based on the ARHP-accredited TEACH Project (Training in Early Abortion for Comprehensive Health Care), which is used to train residents and primary care physicians nationwide. After evaluation of trainee and patient outcomes, the standardized curriculum and competency-based training will be submitted for postgraduate specialty continuing education accreditation (e.g., CEU, CME credits).

³⁰ The APC-HWPP Project 171 is being undertaken by the University of California, San Francisco's Advancing New Standards in Reproductive Health (ANSIRH) Program in collaboration with eight participating health care organizations across California and under the auspices of the California Office of Statewide Health Planning and Development's (OSHPD) Health Workforce Pilot Program. The California OSHPD HWPP provides a protective mechanism whereby, for the duration of the project, regulations that may restrict CNMs, NPs, and PAs from providing aspiration abortion are temporarily suspended. Data are being collected on APC competency achievement using a standardized curriculum, as well as on patient outcomes for APC and MD comparator abortion procedures. UCSF/ANSIRH's APC-HWPP staff and faculty are providing oversight and evaluation of the research plan and the project. The project has been approved by the UCSF IRB as well as secondary review boards for each of the partner organizations.

FIGURE V.1***A Question for NP, CNM, and PA Educators: What Is Your Role in Advancing Abortion Care for APCs?***

Of the four categories of evidence for situating abortion care within APC scope of practice, education and training is the essential one. Regulatory boards look to NP, CNM, and PA educators for the reproductive health standards and clinical competencies when assessing whether a procedure such as abortion care is within the scope of practice of an APC. Certainly there is an established need for women's primary care providers such as CNMs, NPs, and PAs to have the knowledge base and skills to prevent and manage unintended pregnancies. For example, 70% of patients seen by NPs and PAs and 90% of CNM patients are at risk for unintended pregnancy (Hwang et al., 2005). Furthermore, although the *Healthy People 2010* initiative set as a national health goal (focused on primary care providers) reducing unintended pregnancy to 30% (U.S. DHHS, 2000), the rate has remained steady at 49% since 2000 (Finer & Henshaw, 2006).

APC educators have been in the lead in developing reproductive health curriculum and core competencies for women's health practice. We urge them to continue their dedication to high-quality education by aligning educational curriculum and core competencies in women's and reproductive health with those for unintended pregnancy prevention, including abortion care. For example:

1. Situate the abortion care curriculum within a broader public health model of unintended pregnancy prevention and management. Currently, all programs teach primary prevention of unintended pregnancy (such as preconception counseling, family planning, and contraception skills including emergency contraception). Secondary prevention of unintended pregnancy focuses on knowledge and skills of pregnancy diagnosis, pregnancy options counseling, and early abortion care such as knowledge and skills for medication and aspiration abortion provision. It is this secondary unintended pregnancy prevention component that needs to be developed and incorporated into APC education and training (Levi, Simmonds, & Taylor, 2009).
2. Specify core competencies for unintended pregnancy prevention and management across primary, secondary, and tertiary prevention competencies. For NP faculty, this can mean specification of the women's health core competencies (NONPF & AACN, 2002). For PA faculty, the APAOG could work with PAEA to develop curriculum in secondary prevention of unintended pregnancy.
3. Integrate core competencies into curriculum. Establish clinical opportunities for CNM, NP, and PA students to learn medication and/or aspiration abortion skills.

Founded by nursing students with a desire to build support for reproductive health education and training at their schools, Nursing Students for Choice (NSFC) is a collaborative, nationwide organization that works to promote women's health and reproductive rights through advocacy, activism, and provider education and training. NSFC welcomes any undergraduate, graduate, or doctoral level nursing student who is interested in ensuring that nurses are fully trained to meet the reproductive health care needs of women and their families. To find out more about NSFC's work, contact the Abortion Access Project (www.abortionaccess.org). PA students will typically attend Medical Students for Choice meetings; sometimes the groups will become Students for Choice to be more inclusive but that varies from campus to campus.

B. THE PROFESSIONAL PORTFOLIO: PROACTIVE DOCUMENTATION OF PROFESSIONAL CREDENTIALS

A professional portfolio is a representative sample of documents identifying who you are as a professional and showcasing the breadth and depth of your professional credentials. A portfolio differs from a resume or curriculum vitae (CV) by being more inclusive. In addition to containing a list of all your previous positions and your educational background, the professional portfolio contains all your:

- credentials,
- competency achievements,
- essential scope-of-expertise documents across the role, population, and specialty, and
- examples of your work across clinical, professional, scholarship, research, and service accomplishments.

Professional portfolios describe a professional's skills and profile the professional's major accomplishments. All health professionals—whether APCs or physicians—are responsible for compiling essential documents and credentials that establish them as competent and legally, as well as professionally, authorized to practice. Developing your professional portfolio should be

Glossary: Peri-abortion care encompasses pregnancy options counseling through the abortion procedure (medication, aspiration) to postabortion follow-up and care.

the first step you take as a new graduate beginning your practice—or in advancing your practice as an experienced APC.

Figure V.2 provides a template for constructing a professional portfolio with a focus on specialty preparation and experience in **peri-abortion care**.

FIGURE V.2

Professional Portfolio Template—Focus: Peri-Abortion Care

1. Education and Training: **Role Preparation** (RN, APN, CNM, NP, PA)
 - a. Institutions, program of study, dates
 - b. Type of degree, diplomas, certificates, transcripts
 - c. Course information: titles, descriptions, units, outlines
 - d. Clinical residencies, units/hours, site, preceptors
 - e. Procedural skills and special courses (e.g., ACLS, suturing, adolescent health)
2. Education and Training: **Population Preparation** (primary care, women's health)
 - a. Institution, program of study, dates, degree and/or certificate
 - b. Continuing education contact hour certificates
 - c. Course information: titles, descriptions, units, outlines
 - d. Clinical residencies, units/hours, site, preceptors
 - e. Procedural skills and special courses (e.g., endometrial biopsy, MVA, infertility care, IUD placement, menopause management)
3. Education and Training: **Specialty Preparation** (peri-abortion care)
 - a. Training program, course of study, dates
 - b. Clinical training hours, site, preceptor
 - c. Specialty competencies of peri-abortion care: pregnancy options counseling, diagnostics (e.g., ultrasound), abortion counseling, interventions (e.g., MVA, EVA, local anesthesia, cervical dilation, pain management), postabortion care, complication management
 - d. Clinical guidelines and standards of care for abortion care (National Abortion Federation, Planned Parenthood Federation Committee of Abortion Providers)
 - e. Position abortion care within overall philosophy of care—national health goals, your profession's philosophy of care, women's health core competencies
4. Legal Credential—License
 - a. Documentation of state license(s) for basic (RN) or advanced practice (CNM, NP, PA)
 - b. Record of application documentation
 - c. Copy of license with COPY written over it but not in color
5. Professional Credential—Certification
 - a. Professional certification program
 - i. Role certification (CNM, NP, PA)
 - ii. Population certification (women's health, family, adult, pediatrics, etc.)
 - iii. Specialty certification (e.g., colposcopy, first assist for C-sections, medication abortion)
 - b. Record certification as voluntary or mandatory (second license for advanced practice)
 - c. Documentation of original certification and recertification
6. Scope-of-Expertise Documents and History
 - a. Philosophy of practice documents
 - b. Scope and standards of practice (role, population, specialty)
 - c. Core competencies (role, population, specialty)
 - d. Code of ethics
 - e. Employment/practice history
 - i. Institution, dates, role, advancement
 - f. Clinical guidelines and standards of care (role, population, specialty)
 - g. Other professional credentials
 - i. Payer and provider authorization (e.g., federal/private insurances)

- ii. Prescriptive and DEA authority
- h. Institution-specific documents
 - i. Delegation agreements
 - ii. Admitting privileges
- i. Special recognition—honors, awards, news clippings
- 7. Clinical Accomplishments by Role, Population, and Specialty
 - a. Performance appraisals—employment or preceptor (competency-based)
 - i. Role performance as CNM, NP, PA
 - ii. Population competencies: women's health (e.g., contraception, fertility protection, obstetrics/maternity care, gynecologic expertise or competency)
 - iii. Specialty competencies: abortion care, including provision of abortion procedure
 - b. List of clinical skills and procedures by role, population, and specialty (differentiate these skills from those learned in a formal entry-level or postgraduate training program; list skills learned in the practice setting)
 - c. Clinical logs; patient summary data by role, population, and specialty
 - d. Sample of clinical documentation
 - e. Patient education materials by role, population, and specialty
 - f. Evidence of clinical teaching and presentations
 - i. Lesson plans, evaluations, teaching materials (e.g., handouts)
 - ii. Learner type: students, residents, peers, colleagues
- 8. Scholarship/Research
 - a. Publications, posters, exhibits (by organization or institution)
 - b. Project/research summary reports
- 9. Professional/Community Service
 - a. Professional organization membership—list elected office, committee participation
 - b. Community activities—volunteer or elected positions

C. CASE STUDY: DEVELOPING A PORTFOLIO IN RESPONSE TO A CHALLENGE

In 2006, when the Oregon FNP was investigated by the Board of Nursing for a potential violation of her scope of practice, the NP created a portfolio that became the foundation of the template in Figure V.2.

Creating this portfolio involved the collation of evidence demonstrating her competence and training, as well as broader support for her work as an abortion provider. Having evidence of all essential documents—licenses, certifications, nursing/NP education, training in abortion care, practice standards, and clinical practice documents—in one easily accessible format made the investigation go much more smoothly. The portfolio demonstrated the interconnectedness of all her education, training and expertise—not just her work in reproductive health, but preparation and competency associated with primary care, mental health, and other aspects of her practice that showed abortion care to be a natural extension of her work with women and families.

In addition to these primary documents, the NP included in her portfolio detailed course outlines and clinical training materials relating to abortion care specialty training. These materials proved critical in her investigation because the investigator was largely unaware of how the abortion procedure was performed as well as of the elements of standard abortion training. The thorough review of abortion care standards, including actual procedural steps, provided in the portfolio was essential to receiving a favorable ruling. A regulatory board cannot accurately assess how abortion is situated within an APC's scope of practice without complete and accurate information.

Finally, the NP included the following supporting evidence in her portfolio:

- national professional standards and competencies for advanced practice nursing, NP practice, and abortion care;
- statements of support from professional and practice organizations;
- empirical research demonstrating the safety of abortion care and the competency of APCs as abortion providers; and
- documentation of women's lack of access to abortion services nationally and in her state and the NP's role in meeting patient needs.

The NP also collected personal letters of support from respected clinician colleagues who spoke to the need for primary care providers to integrate abortion into their rural or community-based clinics. These support letters also attested to the high-quality primary care the NP was providing to women in her medically underserved part of the state. The portfolio format allowed her to refer easily to these documents during her investigation. The professional portfolio also demonstrated to the Board of Nursing this NP's thoughtfulness and careful consideration in pursuing abortion care as a natural part of her scope of practice. In June 2006, the Board ruled that early aspiration abortion was within her scope of practice as a family NP. (To read the entire case study, see Section IV.G)

SUMMARY

- Practicing APCs cite lack of training opportunities as an important reason for not providing abortion procedures in jurisdictions where they can do so. One quarter want more training in these procedures, and one third lack accurate knowledge about technologies for secondary prevention of unintended pregnancies (e.g., early abortion care).
- Among sources of post-graduate abortion care training for APCs are the National Abortion Federation clinical conferences, the Abortion Access Project's Reproductive Options Education Consortium, and Planned Parenthood Federation of America's Consortium of Abortion Providers. The Association of Reproductive Health Professionals and the National Abortion Federation offer self-study materials and resources for educators. Hands-on training programs are limited, and admission is competitive.
- UCSF ANSIRH's Health Workforce Pilot Project No. 171 is testing a standardized competency-based, provider-neutral early abortion care curriculum and training plan for APCs, with the intent of submitting it for specialty continuing education accreditation after outcomes are evaluated.
- APC educators have a good track record in developing reproductive health curriculum and core competencies for women's health practice. Their challenge is to situate the abortion care curriculum and competencies within the broader public health model of unintended pregnancy prevention and management—aligning the two areas. A focus on secondary prevention of unintended pregnancies is vital.
- APCs must compile a professional portfolio—to document their credentials, competency, scope of expertise, and examples of their work accomplishments. More inclusive than a resume or CV, the portfolio is a valuable tool for spotlighting specialty preparation and experience. It also serves as documentation should one's scope of practice be challenged.

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APPENDIX

TABLE A.1

APC Professional Organizations—Who They Are and Their Roles in Credentialing and Defining Scope of Practice

The history of professional organizations for advanced practice nursing (NPs and CNMs)³¹ began with the founding of the **American Nurses Association** (ANA) and the **National League for Nursing Education** in 1911 and 1912, respectively. These organizations established the first scope and standards for nursing practice and education.

Although the first NP scope of practice and standards documents were established within the ANA in the early 1980s, multiple organizations have emerged to represent and credential NPs, all with varying philosophies and requirements. In addition, specialty organizations such as the Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN) and the National Association of NPs in Women's Health (NPWH) were formed to establish standards and credentialing for nurses and NPs in women's health practice. (More on these organizations below.)

Historically, nurse-midwives have been well-organized since the 1920s. The **American College of Nurse-Midwives** (ACNM), incorporated in 1955, represents both certified nurse-midwives (CNMs) and certified midwives (CMs) nationally and through state chapters (ACNM, 2009b). The ACNM provides the singular voice for professional credentialing of nurse-midwives and has developed a number of foundational documents that address the scope, standards, and competencies of CNM practice. All nurse-midwifery education programs are accredited by the independent **Accreditation Commission for Midwifery Education** (ACME), and all CNMs are required to be certified to practice as midwives (ACNM, 2006a, 2006b). The independent **American Midwifery Certification Board** (AMCB) is charged with ensuring that individual nurse-midwives are competent to enter practice as CNMs through the national certification examination.

Unlike for CNMs and PAs, no single professional organization provides sole leadership in professional credentialing and regulation of NPs. Currently, both the **ANA** and the **American Academy of Nurse Practitioners** (AANP) represent the national and state interests of practicing NPs in the professional regulation and credentialing arenas. The ANA's unified definition, scope, and standards of nursing practice and ethics (including advanced practice nursing) linked with a broad social policy and core values provide the foundation of NP credentialing. The AANP's contribution to professional credentialing includes an NP-focused role definition along with both scope and standards of NP practice (AANP, 2002, 2007a, 2007b). The **Association of Women's Health, Obstetric and Neonatal Nurses** (AWHONN) and **Nurse Practitioners in Women's Health** (NPWH) provide standards and competencies related to the NP role, the population focus (women's health), as well as the specialty practice of NPs in primary care and reproductive health (AWHONN, 1998; AWHONN & NPWH, 2002). AWHONN addresses practice, research, and education issues in women's health, obstetric, and neonatal nursing specialty practice. The **National Organization of NP Faculties** (NONPF) represents NP educators and is responsible for establishing entry-into-practice competencies and program reviews (NONPF & AACN, 2002).

All NP programs are required to be accredited. The **National League for Nursing Accreditation Commission** (NLNAC) and the **Commission on Collegiate Nursing Education** (CCNE) accredit the majority of NP education programs at the graduate level (CCNE, 2008).

³¹ Since the 1980s, state nursing practice acts have increasingly adopted the term *advanced practice nurse* (APN) or *advanced practice registered nurse* (APRN) to delineate the unique roles of certified registered nurse anesthetists (CRNAs), certified nurse-midwives (CNMs), clinical nurse specialists (CNSs), and nurse practitioners (NPs). The contemporary term *advanced practice* reflects a vertical or hierarchical movement encompassing graduate education within nursing, rather than a simple expansion of expertise through the development of knowledge and skills.

The American Nurses

Association (ANA) is the only full-service professional organization representing the nation's 2.9 million registered nurses (RNs) through its 54 constituent member associations (ANA, 2009). The ANA advances the nursing profession by fostering the development of high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and lobbying Congress and the regulatory agencies on health care issues affecting nurses and the public.

The American College of Nurse-Midwives

(ACNM) is the professional association that represents CNMs and CMs in the United States. ACNM provides research, administers and promotes continuing education programs, establishes clinical practice standards, and creates liaisons with state and federal agencies and members of Congress (ACNM, 2009b). The ACNM has six regions incorporating multiple state chapters that represent nurse-midwives at the state level within professional, community, and government arenas to promote legislation/regulations supportive of maternal child health and nurse-midwifery practice (ACNM, 2009a).

The U.S. Department of Education also recognizes the **NPWH Council on Accreditation** as a national accrediting agency for women's health NP education programs. The foundation for the NP certification programs of the **American Nurses Credentialing Center (ANCC)**, the **AANP**, and the **National Certification Corporation (NCC)** for NPs in Women's Health is the *Nurse Practitioner Primary Care Competencies in Specialty Areas: Adult, Family, Gerontological, Pediatric, and Women's Health* (NONPF & AACN, 2002).

The **American Academy of Physician Assistants (AAPA)**, founded in 1968, is the only national organization representing PAs in all medical specialties. The Academy assures the competency of PAs through active involvement in the accreditation of PA programs, provides continuing education, and explicates scope and standards of PA practice. In all states PA licensure requires that individuals graduate from a PA program accredited by the independent **Accreditation Review Commission for Education of the PA (ARC-PA)** and successfully complete a certification process through the **National Commission on the Certification of Physician Assistants**, which certifies that individual PAs meet knowledge and skill standards (AAPA, 2008a, 2008b). In addition, the **Physician Assistant Education Association (PAEA)**, the membership association for PA educators and program directors, develops education standards and competency criteria.

The mission of the American Academy of Physician Assistants (AAPA) is to promote quality, cost-effective, accessible health care and to promote the professional and personal development of PAs (AAPA, 2009). The AAPA has a federated structure of 57 chartered chapters representing PAs in all 50 states, the District of Columbia, Guam, and the federal services. These chapters, through committees such as government relations, political action, and professional practice, advocate for their PA members by engaging in legislative and regulatory activities that promote the profession as well as ensure patient safety.

The **American Academy of Nurse Practitioners (AANP)** represents the interests of the more than 125,000 practicing NPs in the United States (AANP, 2009). Formed in 1985, it is the largest and only full-service U.S. professional membership organization for NPs of all specialties. The AANP has 36 state affiliate member organizations; the mission of the state/regional chapters is to advance and protect NPs and the profession and to provide quality services including representation, advocacy, communication, and educational opportunities to members.

The mission of the **American Academy of Physician Assistants (AAPA)** is to promote quality, cost-effective, accessible health care and to promote the professional and personal development of PAs (AAPA, 2009). The AAPA has a federated structure of 57 chartered chapters representing PAs in all 50 states, the District of Columbia, Guam, and the federal services. These chapters, through committees such as government relations, political action, and professional practice, advocate for their PA members by engaging in legislative and regulatory activities that promote the profession as well as ensure patient safety.

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TABLE A.2*Credentialing Mechanisms and Professional Organizations*

Credentialing Mechanisms	Advanced Practice Nursing		PA
	CNM	NP	
Education requirements	Graduate degree offered by all CNM programs by 2010	Graduate program required (master's, doctorate)	Graduate degree not required; 75% of PA programs offer master's degree
Education program standards	Commission on Collegiate Nursing Education (CCNE) or National League for Nursing Advisory Committee (NLNAC) for nursing programs; ACNM Committee on Education	CCNE or NLNAC; National Organization of NP Faculties (NONPF) AWHONN/NPWH Guidelines for some WHNP Education Programs	PA Education Association (PAEA)
Education program accreditation	Accreditation Commission for Midwifery Education	AACN/CCNE and NONPF	Accreditation Review Commission (ARC) on Education for the PA
Philosophy of care	ANA Social Policy Statement ACNM Philosophy of Midwifery Care	ANA Social Policy Statement	AAPA Role of the PA; Medical Practice Model
Scope of practice: Role (CNM, NP, PA) Population (women's health, primary care)	ANA Scope of Advanced Practice Nursing ACNM definition of CNM and midwifery practice	ANA Scope of Advanced Practice Nursing AANP Scope of NP Practice	AAPA PA Scope of Practice
Standards of practice and professional performance	ANA Standards of Nursing Practice ACNM Standards of Midwifery Practice	ANA Standards of Nursing Practice AANP Standards of NP Practice	PA practice standards use medical practice standards
Standards of practice—women's health care	ACNM Standards of Midwifery Practice	AWHONN/NPWH Guidelines for WHNP Practice	APAOG guidelines—ObGyn PA practice; defer to medical specialty standards (ACOG)
Core competencies	ACNM Core Competencies for basic midwifery practice	U.S. DHHS/Division of Nursing NP Primary Care Competencies: Adult, Family, Gerontologic, Pediatrics, Women's Health	AAPA Competencies for the PA Profession
Code of ethics	ANA Code of Ethics ACNM Code of Ethics for Midwives	ANA Code of Ethics	AAPA Guidelines for Ethical Conduct for PA Profession
Certification programs	American Midwifery Certification Board	American Nurses Credentialing Center (ANCC); AANP Certification Program; NCC-WHNP	National Commission on Certification of PAs
Specialty standards, guidelines: Reproductive health, abortion care	ARHP Reproductive Health Education and Core Curriculum; AAP Reproductive Options in Nursing Education Consortium; National Abortion Federation Abortion Care Standards and Guidelines		

TABLE A.3***National APC Professional and Specialty Organization Websites***

American Nurses Association (ANA): <i>APN philosophy, standards, and scope of practice</i>	www.nursingworld.org
American College of Nurse-Midwives (ACNM) <i>Midwifery philosophy, scope, standards, and core practice competencies</i>	www.midwife.org
American Academy of Nurse Practitioners (AANP): <i>NP scope and standards of practice</i>	www.aanp.org
American Academy of Physician Assistants (AAPA) <i>PA scope and standards of practice</i>	www.aapa.org
National Organization of NP Faculties (NONPF): <i>NP core competencies (role, population)</i>	www.nonpf.org
National Association of Nurse Practitioners in Women's Health (NPWH): <i>Population standards and scope of practice</i>	www.npwh.org
Physician Assistant Education Association (PAEA) <i>PA education standards</i>	www.paeaonline.org
Association of Women's Health, Obstetric & Neonatal Nurses (AWHONN): <i>Population standards, scope, and clinical guidelines</i>	www.awhonn.org
Association of Reproductive Health Professionals (ARHP): <i>Educational and professional resources in reproductive health and abortion</i>	www.arhp.org
Clinicians for Choice/National Abortion Federation (NAF): <i>Abortion care clinical guidelines, standards</i>	www.prochoice.org
Association of PAs in Obstetrics-Gynecology (APAOG): <i>Standards and training opportunities</i>	www.apaog.org

TABLE A.4*Organizational Acronyms Used in the APC Toolkit*

Acronym	Organization
AACN	American Association of Colleges of Nursing
AAFP	American Academy of Family Physicians
AANP	American Academy of Nurse Practitioners
AAP	Abortion Access Project
AAPA	American Academy of Physician Assistants
ACME	Accreditation Commission for Midwifery Education
ACNM	American College of Nurse-Midwives
ACOG	American College of Obstetricians and Gynecologists
AMA	American Medical Association
AMCB	American Midwifery Certification Board
AMWA	American Medical Women's Association
ANA	American Nurses Association
ANCC	American Nurses Credentialing Center
APA	American Psychological Association
APAOG	Association of Physician Assistants in Obstetrics and Gynecology
APHA	American Public Health Association
ARHP	Association of Reproductive Health Professionals
AWHONN	Association of Women's Health, Obstetric and Neonatal Nurses
AZBN	Arizona Board of Nursing
BON	Board of Nursing
CAPS	Planned Parenthood Consortium of Abortion Providers
CCNE	Commission of Collegiate Nursing Education
FSMB	Federation of State Medical Boards
ICM	International Council of Midwives
KBN	Kentucky Board of Nursing
NAF	National Abortion Federation
NANPRH	National Association of Nurse Practitioners in Reproductive Health (now NPWH)
NCC	National Certification Corporation
NCSBN	National Council of State Boards of Nursing
NDBN	North Dakota Board of Nursing
NLNAC	National League for Nursing Accreditation Commission
NONPF	National Organization of Nurse Practitioner Faculties
NPWH	Nurse Practitioners in Women's Health (formerly NANPRH)
NPWH	National Association of Nurse Practitioners in Women's Health
NSFC	Nursing Students for Choice
ONA	Oregon Nurses Association
OSBN	Oregon State Board of Nursing
PAEA	Physician Assistant Education Association
PPFA	Planned Parenthood Federation of America
PRCH	Physicians for Reproductive Choice and Health
ROE	Reproductive Options Education Consortium
WHO	World Health Organization

APPENDIX A.5

Glossary

Advanced Practice Clinicians: The umbrella term *advanced practice clinician* (APC) is used to refer to the collected roles of nurse practitioner (NP), certified nurse-midwife (CNM), and physician assistant (PA) in this document. In the United States, CNMs, NPs and PAs have been categorically referred to as “midlevel provider” or “nonphysician provider,” which does not adequately reflect their contribution as independent and qualified primary care professionals. However, the ideal taxonomy has yet to be identified. The term, advanced practice clinician or APC is not accepted by the American Academy of PAs who have a published position on appropriate titles for PAs: “*The AAPA believes that, whenever possible, PAs should be referred to as “physician assistants” and not combined with other providers in inclusive non-specific terms such as “midlevel practitioner”, “advanced practice clinician”, or “advanced practice provider” (AAPA, 2008).*”

Collective Bargaining: Collective bargaining is negotiation between organized workers and their employer or employers to determine wages, hours, rules, and working conditions. (p.41)

Competence: Competence requires the ethical adaptation and integration of knowledge and skills into the behaviors needed in a particular context. (p. 52)

Credentials: Titles or degrees held by an individual, indicating the level of education, certification, or licensure. (p. 31)

Credentialing: Refers to regulatory mechanisms that are applied to individual professionals, educational programs, or organizations. Forms of credentialing include state licensure, national certification of practice expertise, and accreditation of generic and advanced practice education programs. (p. 31)

Peri-abortion Care: Peri-abortion care encompasses pregnancy options counseling through the abortion procedure (medication, aspiration) to postabortion follow-up and care. (p. 87)

Practice Essentials: Practice essentials are documents developed by health professional organizations (such as practice philosophy, standards, core competencies, and ethical guidelines) that are essential for competent clinical and professional practice. These “practice essentials” provide the basis for education, legal regulation, professional certification, and practice credentialing. (p.40)

Scope of Practice: Scope of practice statements define what health professionals can do for/with patients, what they can delegate, and when collaboration with others is required. APC scope of practice is defined by professional organizations and codified and monitored by state regulatory agencies. Although CNMs and NPs have markedly different scopes of practice, both have their roots in nursing. And physician assistant (PA) practice which grew out of a medical model of care, shares an overlapping scope of practice with advanced practice nurses who are providing women’s primary care. (p. 33)

Standards of Practice: 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. They reflect the values and priorities of the profession. (p.52)

Standards of Professional Performance: 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. (p.52)

APPENDIX: A.6

Supplemental References

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