

Should Elective Abortions be Performed by Practitioners who are Not Physicians?

There has been recent discussion about allowing non-physician healthcare providers to perform abortions. The motivation behind this recommendation is obvious. Most obstetrician/gynecologists do not want to perform abortions,^{1 2 3} because most physicians enter the medical profession to heal, and not to kill human beings⁴. The fetal human being is a genetically distinct living member of the human species. In almost all occasions, the termination of this immature human life is performed for social, not medical reasons.⁵ Since most physicians are not willing to end a fetal life for elective reasons, the abortion industry is seeking to reverse the decline in physician abortion providers by adding alternative practitioners, for example seeking to allow first and second trimester abortions by Advanced Practice Registered Nurses (APRNs) and Certified Nurse Midwives (CNMs)⁶, independent of physician participation.

Provision of surgical procedures by health care providers who are not trained in recognizing or treating the complications that inevitably follow will greatly increase the risk to women who undergo those procedures. The industry is downplaying the serious risks associated with surgical

¹ Stuhlberg. et Al. Abortion Provision among practicing obstetrician gynecologists. OBG. 2011. 118(3)609.

² Obstet Gynecol. 2019 Mar;133(3):477-483. doi: 10.1097/AOG.0000000000003110.

Induced Abortion Provision Among a National Sample of Obstetrician-Gynecologists.

Grossman D1, Grindlay K, Altshuler AL, Schulkin J.

³ Desai S. Estimating abortion provision and abortion referrals among U.S. obstetrician/gynecologists in private practice. Contraception. 97 (2018) 297-302. (I prefer this reference to #2 by Grossman because he surveyed a private research group rather than general ob/gyns.)

⁴ American Association of Pro-Life Obstetricians and Gynecologists Committee Opinion 1 Conscientious Objection to Killing Human Beings in Medical Practice. May 7, 2017.

⁵ Finer. Reasons U.S. Women have abortions. Perspectives on Sexual and Reproductive Health, 2005, 37(3):110-118.

⁶ Levi A, Goodman S, Weitz T, AbiSamra R, Nobel K, Desai S, Battistelli M, Taylor D. **Training in aspiration abortion care: An observational cohort study of achieving procedural competence.** *Int J Nurs Stud.* 2018 Dec;88:53-59. doi: 10.1016/j.ijnurstu.2018.08.003. Epub 2018 Aug 13. See Abstract: "Expansion of abortion care by these providers, consistent with their scopes of practice, could help alleviate the increasing difficulty of accessing abortion care in many states."

abortion⁷ and the fourfold increase in such risks with chemical abortion. This marketing spin will make both surgical and chemical abortion procedures much more dangerous for women.

Extensive training in diagnosis and practical skill and experience in treatment of complications is necessary to minimize the risk of any abortion, be it surgical or chemical. Physicians who are certified and licensed to perform surgeries on women’s reproductive organs complete undergraduate training, followed by an additional four-year accredited medical school or osteopathic school degree program which includes detailed instruction in normal and abnormal human anatomy and physiology. Obstetrician/gynecologists, the surgeons who predominantly operate on women’s reproductive organs, then further complete an additional four-year postgraduate residency program that specifically trains them in performing surgical procedures and the recognizing and managing treatment complications. This training includes exposure to many surgical procedures where the physician experiences a myriad of different anatomical variations. During that practical instruction, the resident is trained in the prevention and treatment of infrequent, but often urgent complications. Ob/gyns then must successfully complete a “board certification” examination and then are required to certify that they have completed continuing education in obstetrics and gynecology every year in order to maintain their certification in obstetrics and gynecology. Due to concerns for patient safety and liability, most hospitals will not allow medical personnel who are not board certified to operate on any of their patients.

The American Board of Medical Specialties has recognized the inherent complexity in performing abortions in the second and third trimesters by approving a recommendation from the American Board of Obstetrics and Gynecology recommending an additional two-year subspecialty training for abortion providers who want to do abortions past the first trimester.⁸

In contrast, the American College of Nurse Midwives (ACNM) specifies the requirements for midwifery training⁹ as follows:

“Midwifery education programs leading to the CNM and CM credentials involve graduate education. Most programs require a Bachelors Degree for entry, but some will accept Registered Nurses (RNs) without a Bachelors Degree, providing a bridge program to a Bachelor of Science in Nursing (BSN) prior to the midwifery portion of the program. Some programs leading to the CNM credential require a BSN prior to entry, but many will accept an individual who has a Bachelors Degree but is not an RN, and will provide an accelerated nursing education prior to the midwifery portion of the program. Programs leading to the CM credential require a Bachelors Degree and specific health and science courses prior to entry.”

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⁸ <https://www.abms.org/board-certification/cocert-invites-comments/>

⁹ <http://www.midwife.org/Become-a-Midwife>

CNM training is focused on normal delivery of term infants, under the supervision of a physician. Their training does not focus on performance of normal or abnormal surgeries on the female reproductive system, nor does it include training in the management of surgical complications of D&C's including perforation of the uterus or nearby organs.

An APRN may have even less training.^{10 11} An APRN may hold a Bachelor's degree in nursing, but may also enter APRN training with a 3-year Associate's degree. APRN training programs typically require between 1 and 3 years additional training, some of which may be conducted online. Their training also does not focus on the performance of normal or abnormal surgeries on the female reproductive system, nor does it include training in the management of surgical complications of D&C's including perforation of the uterus or nearby organs.

Neither a CNM nor an APRN would be eligible for surgical privileges at a hospital. That is because hospitals know the risks to patients that come from unskilled personnel providing surgery beyond their training.

During pregnancy, dramatic anatomical, physiological and biochemical changes occur in every organ of a woman's body. Pregnancy-related hormones cause changes in metabolism, stress response, immune action, electrolyte balance and even neurologic function. Growth of the uterus causes a shift in the normal position of intra-abdominal and thoracic organs, and relaxation of cartilage leads to musculoskeletal changes. Vascular modifications include altered circulation, functional changes in the heart and lungs, an increased tendency to form blood clots, and a propensity for catastrophic bleeding due to the massive amount of blood within the uterus.¹²

Causes of severe injury and death in women undergoing abortion can include vaginal and intra-abdominal hemorrhage, infection (local endometritis, cutaneous cellulitis, or systemic septicemia), thrombotic emboli (deep venous thrombosis or pulmonary embolus), intravascular amniotic or air emboli, complications of anesthesia, and cardiac or cerebrovascular events (heart attack or stroke). Incomplete tissue removal or damage to adjacent gynecologic, genitourinary, gastrointestinal or vascular organs may require additional emergency uterine surgery, hysterectomy, bowel resection, bladder repair, or other surgeries.^{13 14 15}

Complications from surgical abortions most commonly occur during one of two actions. As the cervix is dilated, the instruments may form a false channel, leading to damage to surrounding organs or vessels; or, once cervical dilation has occurred, multiple blind passes of the suction

¹⁰ <https://www.nursepractitionerschools.com/faq/np-vs-aprn/>

¹¹ <https://nursejournal.org/nurse-practitioner/what-to-know-to-become-a-nurse-practitioner/>

¹² Cunningham F. Williams Obstetrics 19th edition. Appleton & Lange. Norwalk, CT. 1993. 81-246

¹³ Niinimaki, "Immediate Complications After Medical Compared with Surgical Termination of Pregnancy" OBG. (2009) 114(4) 795-804

¹⁴ Mentula, et al, "Immediate Adverse Events After Second Trimester Medical Termination of Pregnancy: Results of a Nationwide Registry Study" Human Reproduction 26(4) (2011) 927-932

¹⁵ Ireland, et al. Medical compared with surgical abortion for effective pregnancy termination in the first trimester OBG. 126(1)22-28.

curette or grasping forceps into the soft, gravid uterus could result in uterine perforation and damage to surrounding organs.¹⁶ According to several studies, the estimated risk of hemorrhage is 5.6%; of cervical laceration 3.3%; of retained products of conception 1.6%; of infection and uterine perforation 0.2-0.5%; and of uterine rupture 0.28% if the patient had a prior C-section (0.04% without prior C-section).^{17 18} Approximately 1.8%, which is almost 1 in every 50 surgical abortions, require additional surgery to manage complications. Due to the voluntary nature of complication reporting in the U.S., the real complication rates are undoubtedly much higher.¹⁹

The frequency of complications increases for pregnancies at later gestational ages due to inherently greater technical complexity due to the anatomical and physiologic changes that occur.²⁰ The increased amount of fetal and placental tissue requires a greater degree of cervical dilation, the increased blood flow predisposes to hemorrhage, and the relaxed myometrium is more subject to mechanical perforation.²¹ Thus, it is important to emphasize that although early abortions have the least number of complications, the complication rate increases as the pregnant uterus enlarges.^{22 23 24} Although one study found an overall death rate of 0.7/100,000 legal abortions; this number rose to 6.7/100,000 for late term procedures.²⁵ Another study found that the risk of death increased by 38% for each additional week beyond 8 weeks.²⁶ Compared to early abortions, the relative risk of maternal death was 14.7 times higher at 13-15 weeks (rate 1.7/100,000 abortions), 29.5 times higher at 16-20 weeks (rate 3.4/100,000), and 76.6 times higher beyond 21 weeks (rate 8.9/100,000).²⁷

The complication rate is four times higher after a medical abortion, commonly performed by administration of two medications: RU 486 (Mifeprex or mifepristone) which blocks progesterone receptors to cut off hormonal support for the pregnancy, followed in 24 to 48 hours with Cytotec (misoprostol) which induces contractions to expel the pregnancy tissue.²⁸ The risk of hemorrhage following medical abortion is 20% , or 1 in 5, and the risk of incomplete abortion

¹⁶ Lalitkumar, et al, Mid-Trimester Induced Abortion: A Review. Human Reproduction Update, 13(1) (2007) 37-52

¹⁷ Practice Bulletin 143: Medical Management of First-Trimester Abortion: Obstetrics & Gynecology. 2014

¹⁸ Autry. A comparison of medical induction and dilation and evacuation for second trimester abortion. AJOG. 187(2)2002:393-397

¹⁹ <https://www.guttmacher.org/state-policy/explore/abortion-reporting-requirements>

²⁰ Peterson, et al, Second-Trimester Abortion by Dilation and Evacuation: An Analysis of 11,747 Cases. OBG. 62:185 (1983) 185-190

²¹ Hilgers, Abortion Related Maternal Mortality: An In-Depth Analysis. New Perspectives on Human Abortion. 1981.

²² Sykes. Complications of Termination of Pregnancy: A Retrospective Study of Admissions. New Zealand Medical Journal. 106 (1993) 83

²³ D Grossman. Complications After Second Trimester Surgical and Medical Abortion. Reproductive Health Matters, 16(31) (2008) 173-182.

²⁴ Zane, Creanga, et al. Abortion Related Mortality in the U.S.:1998-2010. OBG. 126:2 (Aug 2015)258-265

²⁵ Zane, Creanga, et al. Abortion Related Mortality in the U.S.:1998-2010. OBG. 126:2 (Aug 2015)258-265.

²⁶ Bartlett, Berg, et al, Risk Factors for Legal Induced Abortion Related Mortality in the U.S. OBG. 103:4 (April, 2004) 729-737

²⁷ Bartlett, Berg, et al, Risk Factors for Legal Induced Abortion Related Mortality in the U.S. OBG. 103:4 (April, 2004) 729-737

²⁸ Niinimaki. Immediate complications of medical compared with surgical termination of pregnancy. OBG. 114(4)2009:795-804

is around 8%, about 1 in 13, increasing as gestational age advances. Approximately 5%, or 1 in 20 medical abortions require surgical completion, a complication rate which increases as the pregnancy advances.

The 2003 consensus statement from 32 medical and surgical academies, societies, associations and commissions, entitled “Core Principles of Patient Safety for Office-Based Surgery” focused on requirements for patient safety during surgical procedures.²⁹ All of these ten core principles assume that the person performing the surgery or procedure is of the minimal level of training of a physician. Six of ten core principles are specifically violated by allowing APRNs or CNM’s to perform office-based surgery: The core safety principles violated are:

***Core Principle #3** – Physicians who perform office-based surgery should have their facilities accredited by the JCAHO, AAAHC, AAAASF, AOA, or by a state-recognized entity such as the Institute for Medical Quality, or be state licensed and/or Medicare-certified.*

***Core Principle #4** – Physicians performing office-based surgery must have admitting privileges at a nearby hospital, a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital.*

***Core Principle #7** – Physicians performing office-based surgery must obtain and maintain board certification from one of the boards recognized by the American Board of Medical Specialties, AOA, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care.*

***Core Principle #8** – Physicians performing office-based surgery may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center, for the procedures they perform in the office setting. Alternatively, the*

²⁹ American College of Surgeons. Statement on Patient Safety Principles for Office-Based Surgery Utilizing Moderate Sedation/Analgesia, Deep Sedation/Analgesia or General Anesthesia. 2004 available at: <https://www.facs.org/about-acs/statements/46-office-based-surgery>. See intro:

“The following principles were based on a document that was unanimously agreed to by the following groups during a March 17, 2003, ACS/AMA coordinated consensus meeting on office-based surgery: Accreditation Association for Ambulatory Health Care, American Academy of Cosmetic Surgery, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Ophthalmology, American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology-Head and Neck Surgery, American Academy of Pediatrics, American Association for Accreditation of Ambulatory Surgery Facilities, American College of Obstetricians and Gynecologists, American College of Surgeons, American Medical Association, American Osteopathic Association, American Society for Dermatologic Surgery, American Society for Reproductive Medicine, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Society of General Surgeons, American Society of Plastic Surgeons, American Urological Association, Federation of State Medical Boards, Indiana State Medical Society, Institute for Medical Quality-California Medical Association, Joint Commission on Accreditation of Healthcare Organizations, Kansas Medical Society, Massachusetts Medical Society, Medical Association of the State of Alabama, Medical Society of the State of New York, Missouri State Medical Association, National Committee for Quality Assurance, Pennsylvania Medical Society, and Society of Interventional Radiology.”

governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards.

Core Principle #9 – *At least one physician, who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (Advanced Trauma Life Support[®], Advanced Cardiac Life Support, or Pediatric Advanced Life Support), must be present or immediately available with age- and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in basic life support.*

Core Principle #10 – *Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training.*

Starting a surgical or medical procedure without having the skill set and ability to handle the known complications of that procedure is unethical. However, currently, many abortion providers do not maintain hospital privileges, and their patients with complications are commonly sent to the local emergency room, to be cared for by other physicians who often do not have the medical record of the patient, and in rural areas, may not have on call the specialist physicians who can handle uterine perforations or other complications from surgical abortion. This problem can only get worse with performance of elective abortion by non-physicians, untrained in the recognition or management of the complications they may induce.

One argument frequently made for allowing non-physician providers to perform abortions is to increase access for women who desire elective abortions, but who live a long distance from an abortion provider. A patient who lives in a rural area is far safer if she travels to an urban area where she is more likely to find well-trained physician abortion providers, and where any potential complications can be managed immediately. To have an elective abortion performed by a non-physician provider without adequate backup and without knowledge, training or equipment to manage life-threatening complications should be unthinkable. Hemorrhage can occur rapidly due to anomalous anatomy or poor techniques, and a woman remote from assistance can easily die from massive blood loss.

The abortion industry argues that some CNM's and APRN's do certain procedures like colposcopies, endometrial biopsies, and LEEPs, and then compare these minor procedures to abortion. Those procedures are done on non-pregnant patients and therefore the risk of bleeding is much lower. Those procedures also do not require the level of anesthesia or sedation needed for an abortion. The possible complications from those procedures are minimal compared to the life-threatening complications which can occur with a medical or surgical abortion, either from the administration of anesthesia or from the abortion procedure itself.

It is clear that profit, rather than patient safety, is driving the abortion industry's drive to incorporate APRN's and CNM's into the abortion business. It is the position of the American Association of Pro-Life Obstetricians and Gynecologists that this poses an unnecessary and unacceptable risk to patients. If a woman is determined to abort, it is far safer for her to travel to an

area where there are adequately trained personnel and emergency services. Abortion is not an emergency medical procedure, especially because abortion does not treat any disease. Pregnancy is not a disease; it is a normal physiological process which is voluntarily interrupted by abortion.

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