



## NORTH AMERICA

# Advanced Practice Clinicians as Abortion Providers: Current Developments in the United States

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**Abstract:** *A hopeful note in the contemporary abortion environment in the United States is the expanding role of advanced practice clinicians – nurse practitioners, physician assistants and nurse-midwives – in first trimester abortion provision. A large percentage of primary health care in the US is currently provided by these non-physicians but their involvement in abortion care is promising, especially in light of the shortage of physician providers. Two national symposia in 1990 and 1996 approved the expansion of early abortion care to non-physicians. As of January 2004, trained advanced practice clinicians were providing medical, and in some cases, early surgical abortion in 14 states. This has required not only medical training but also political organising to achieve the necessary legal and regulatory changes, state by state, by groups such as Clinicians for Choice and the Abortion Access Project, described here in examples in two states and the reflections of three advanced practice clinicians. Recent surveys in three states show a substantial interest among advanced practice clinicians in abortion training, leading to cautious optimism about the possibility of increased abortion access for women. Most encouraging, advanced practice clinicians, like their physician counterparts, show a level of passionate commitment to the work that is rare elsewhere in health care in the US today. © 2004 Reproductive Health Matters. All rights reserved.*

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**I**N an otherwise quite gloomy environment, dominated by non-stop assaults by the Bush administration on various aspects of abortion care and ongoing worries over whether the Supreme Court will eventually recriminalise abortion, the emergent role of advanced practice clinicians is a promising element of the contemporary abortion scene in the United States (US). On 1 January 2003, a new California state law, the Reproductive Privacy Act, Senate Bill 1301, went into effect, which permits advanced practice clinicians – nurse practitioners, nurse-midwives and physician assistants – to provide medical abortion. Given California's historic role as a trendsetter for the rest of the country and the fact that approximately one in every five

abortions in the US occurs there,<sup>1</sup> this new law may ultimately have national ramifications. The possibility of expanded provision by advanced practice clinicians is especially promising in light of the chronic shortage of abortion providers in the United States. Some 87% of US counties are without abortion facilities, and the number of facilities declined 11% between 1996 and 2000 to less than 2,000 nationwide.<sup>1</sup> Moreover, many obstetrics and gynaecology residency programmes are failing in their responsibility to provide abortion training to young physicians.<sup>2</sup> Therefore, just as mid-level health care providers are assuming an important role in some developing countries,<sup>3-6</sup> we may soon see a similar phenomenon in the US.

Abortion provision by advanced practice clinicians in the US in fact long predates the new California legislation. This paper discusses some of the medical and legal issues involved in this phenomenon and reviews the history of involvement of advanced practice clinicians in abortion in several states. Examples of the organising and advocacy work now underway to expand the ability of advanced practice clinicians to become abortion providers are documented, including portions of interviews with several advanced practice clinicians, reflecting on their recent experiences with abortion care.

### Medical and legal issues

“Advanced practice clinician” is a shorthand term for nurse practitioners, certified nurse-midwives and physician assistants, who fill distinct professional roles in US health care. A large percentage of primary health care in the US is currently provided by these non-physicians. Nurse practitioners and certified nurse-midwives are nurses with advanced education and clinical training. Nurse practitioners may specialise in any one of a number of fields, including women’s health. Certified nurse-midwives provide a full range of ob/gyn care. Physician assistants are not nurses, but health professionals with advanced medical training. Like nurse practitioners, physician assistants may specialise in a range of fields, including women’s health or obstetrics and gynaecology. Advanced practice clinicians function independently or through collaborative agreements with physicians, who are responsible for their work; however, in many states the supervising physicians do not have to be on site when advanced practice clinicians are providing services that are within their approved scope of practice, called a practice agreement. These practice agreements are approved by state-level nursing or medical boards. The amount of supervision required by a physician for each professional group is regulated by practice acts developed in each state; there is wide variation in these practice acts from state to state.

In most states, nurse-midwives, physician assistants and nurse practitioners practice under statutes that authorise them to administer medications and provide gynaecological services, including surgery that is comparable to surgical abortion, as long as they have been properly trained and are supervised. Under these profes-

sional standards, therefore, it would be logical for trained advanced practice clinicians to offer both medical and first trimester surgical abortion. However, after the US Supreme Court decision (*Roe v. Wade*) legalising abortion in 1973, when most states changed their laws to permit abortion, many added language to the new laws that stipulated that abortions could only be legally provided by a physician, with the intent of protecting women’s health from unskilled practitioners. At that time, the professions of physician assistant and nurse practitioner were just getting established; although midwives have a long history of delivering reproductive health care in the US, they were not yet licensed professionals. Moreover, the possibilities presented by medical abortion for advanced practice clinicians were still 20 years away.

In two states, Vermont and Montana, physician assistants have performed abortions since 1973 and have established impressive safety records. In Montana, a physician assistant has provided surgical abortion for over 25 years. In spite of various attempts by the state legislature to stop her, the Montana Supreme Court invalidated an existing “physician-only” law in 1999,<sup>7</sup> and has upheld the right of advanced practice clinicians to provide abortions there. Currently a small number of other physician assistants in that state have begun to offer both medical and first trimester surgical abortion.

Vermont is the state with the most extensive experience of advanced practice clinicians providing abortion care, being one of a handful of states that does not have a “physician-only” law. Physician assistants have been performing surgical abortion in Vermont since 1973 at the Planned Parenthood clinic in Burlington (formerly the Vermont Women’s Center). Indeed, the physician assistants at that clinic routinely train obstetrics and gynaecology residents from nearby medical schools in first trimester abortion techniques. A comprehensive analysis of complication rates in 2,456 first trimester abortions done between 1981 and 1982 at the Center found that the complication rates were no different than with abortions provided by physicians.<sup>8</sup> A more recent, as yet unpublished, study by researchers at Planned Parenthood Northern New England compared complication rates for 2,027 procedures by physicians and physician assistants and nurse practitioners at five sites from November 2000 through

December 2002. Complication rates for all providers were very low (2.5 per 1,000), and patients reported slightly more satisfaction with non-physician providers.<sup>9</sup>

### **Expanding advanced practice clinician involvement: some history**

A significant boost to the movement to expand advanced practice clinicians' involvement in abortion provision occurred in 1990 at a symposium in Santa Barbara CA, convened by the National Abortion Federation and the American College of Obstetricians and Gynecologists (ACOG) to address the shortage of abortion providers in the US. Although attended primarily by physicians and members of physician-relevant organisations, such as the American College of Graduate Medical Education, two of the leading proponents of advanced practice clinicians as abortion providers were also there. Rachel Atkins, the physician assistant who was then director of the Vermont Women's Health Center, and Susan Cahill, who had pioneered physician assistant provision of abortion in Montana, both spoke and persuasively made the case for first trimester abortions to be offered by non-physicians. In its final report, the symposium included in its findings that "Under physician supervision, appropriately trained mid-level clinicians...offer considerable promise for expanding the pool of qualified abortion providers" and recommended training for these groups and their integration into abortion service delivery.<sup>10</sup> To the surprise of many in the abortion rights community, the ACOG Executive Board ultimately approved this resolution.

This 1990 gathering was followed up by another symposium in 1996 in Atlanta, co-sponsored by the National Abortion Federation and the Kaiser Family Foundation: "The Role of Physician Assistants, Nurse Practitioners and Nurse-Midwives in Providing Abortions: Strategies for Expanding Abortion Access".<sup>11</sup> In attendance were representatives from the professional associations of the three main advanced practice clinicians' groups, lawyers who were expert in health law on advanced practice clinicians and members of several abortion rights activist groups. Participants re-affirmed that:

*"...one of the most effective ways to increase the number of providers is to permit appropriately trained physician assistants, nurse practi-*

*tioners, and certified nurse-midwives to provide first trimester abortions."*<sup>11</sup>

By the time of this meeting, medical abortion was beginning to be highly visible in the US. Mifepristone had undergone clinical trials under the auspices of the Population Council in 1994–95, and the Food & Drug Administration gave tentative approval in September 1996, a few months before the symposium. Moreover, starting in the early 1990s, US abortion providers had also been introduced to methotrexate (an approved cancer drug) for its "off-label" use for medical abortion.<sup>12,13</sup> At its annual meeting in 1996, the National Abortion Federation featured numerous presentations on medical abortion, and Planned Parenthood announced plans to increase use of medical abortion in its clinics.

Heightened attention to medical abortion inevitably strengthened proponents' arguments for advanced practice clinicians as independent providers of medical abortion. Unlike vacuum aspiration, in which the abortion is a discrete surgical procedure performed by a trained operator, medical abortion consists of a process that includes either ingestion of one medication by the woman (mifepristone) or an injection (methotrexate) followed after a delay of several days by the use of a second medication orally or vaginally (misoprostol), which together cause a miscarriage to occur. Virtually all the steps can be carried out as competently by advanced practice clinicians as by physicians. Indeed, there are those who argue that advanced practice clinicians are better at counselling than many physicians.<sup>14</sup> A study among both physicians and advanced practice clinicians experienced in methotrexate abortion revealed that a high proportion of both groups (75%) believed that the latter, with proper training, were highly suitable to offer medical abortion.<sup>15</sup>

But in spite of the arrival of medical abortion, the optimism at the Atlanta meeting was tempered with caution. The lawyers present impressed upon the group the complex legal restrictions in the majority of states that governed non-physician delivery of medical services and pointed out the significance of the political environment in each state. This encompassed both the strength of the anti-abortion movement in each state as well as the level of resistance in the medical community to expansion of the role

of advanced practice clinicians. The lawyers warned that an unsuccessful attempt to challenge physician-only laws would be a big setback, difficult to overturn in the future. Thus, one of this symposium's recommendations was to pursue legal challenges in states only after careful, state-specific background research and with secured political support.<sup>11</sup> The symposium also recommended that an abortion training curriculum be incorporated into the education of all advanced practice clinicians for them to:

*"...develop appropriate clinical skills so that they are not excluded from opportunities to participate in the delivery of medical abortions, nor to learn surgical abortion techniques."*<sup>11</sup>

Shortly after the Atlanta meeting, Clinicians for Choice,<sup>16</sup> whose purpose is to advocate for a greater involvement of advanced practice clinicians in abortion care, was founded by the National Abortion Federation. Currently, the group claims a membership of about 4,000 clinicians in 63 chapters in the US and Canada. This includes Physician Assistants for Choice, which has 27 state chapters; Nurse Practitioners for Choice with 27 state chapters, and Midwives for Choice with 16 state chapters. A number of other organisations, including the Abortion Access Project in Massachusetts<sup>17</sup> and the Access Project,<sup>18</sup> an abortion rights group started by family practice physicians in New York City, expanded their agendas to include organising advanced practice clinicians. These and similar groups are engaging in educational activities at relevant professional meetings, working with clinical education programmes to increase education and training opportunities, speaking with legislators and other advocacy efforts.

### **The Abortion Access Project's experience**

One of the lessons to emerge from the 1996 symposium was that expanding the role of advanced practice clinicians involves not only legal research and medical training but also, given the highly politicised nature of abortion in the US, political organising. The Abortion Access Project (AAP), a grassroots organising project headquartered in Cambridge MA, has pioneered efforts to apply organising techniques to this branch of medical care. The AAP's approach is to clarify the legal picture in each

state and develop legal support for advanced practice clinicians to provide abortion as a critical first step to expanding access. This legal work is followed by strategic organising. The findings of the legal research are disseminated, and pro-choice advanced practice clinicians in each state are identified, educated about the role they can play in expanding abortion access and then trained. Interested clinicians are helped to find training and support to integrate medical abortion (and where allowed by state law, early surgical abortion) into their practices. Below are two brief sketches of AAP's work in two quite different political and geographical environments.

#### **State A: a rural, politically conservative, western state**

In April 2002, more than 20 clinicians, legal experts and women's health advocates convened in this state's capital city. AAP's organiser had spent six months working with stakeholders throughout the state to explain the potential role of advanced practice clinicians in expanding access. Current and potential providers and activists were invited to meet and develop a statewide strategy. Experts from the Northwest Women's Law Center presented the findings from their review of legal issues surrounding advanced practice clinician provision of abortion care in the state. Its constitution is exceptionally strong on privacy issues, and its nursing statutes allow for a broad scope of practice, assuming adequate training and adherence to accepted protocols. Participants were very enthusiastic about the possibilities.

Building on the momentum of the meeting, AAP's organiser spent the summer following up with individual advanced practice clinicians who were in practice settings where provision of abortion was a possibility, and developed a training session on medical abortion that covered regimens, patient management and provider resources. As a result of this work, two advanced practice clinicians are providing medical abortion in the state capital and another is offering medical abortion in a rural area 150+ miles from the capital. These three providers represent a 100% increase in the total number of abortion providers in this state; there were only three providers before they began offering medical abortion. This expansion of care is particularly remarkable given the very conservative political climate in State A, which each year faces

legislative initiatives to curtail abortion rights. The AAP organiser continues to work to identify additional advanced practice clinicians who are interested in being trained, and mobilising the resources to make further training possible.

### **State B: a densely populated, eastern state**

State B is a small state and has clinics that provide abortions in each of its three major urban areas. Although often viewed as a politically progressive state, on reproductive rights issues its laws have been influenced by official Catholic doctrine. It was among the first states to pass a parental consent law, and among the last to legalise birth control for unmarried women.

AAP began organising and educating advanced practice clinicians in State B about medical abortion in 1999, in anticipation of the release of mifepristone in the US. However, approval was delayed by anti-abortion politics, creating difficulties for training. While some advanced practice clinicians were administering medical abortion using methotrexate, many providers considered it a less desirable option than mifepristone, because of the longer time needed to complete the abortion.<sup>15</sup> Until approval of mifepristone, AAP widely disseminated information to advanced practice clinicians about mifepristone through presentations at statewide professional groups and articles in professional journals and newsletters. They convened training and built strong relationships with current providers, health department officials and others who would ultimately be key in promoting advanced practice clinician involvement in abortion care.

By the time the FDA approved mifepristone, in September 2000, AAP had well-established networks. They learned that controversies associated with abortion within the medical community and professional associations could be as daunting as legal barriers in preventing advanced practice clinicians from providing abortions. Some advanced practice clinicians' organisations were reluctant to endorse AAP's goals for fear of offending members who opposed abortion. On the other hand, some individual members felt angry that their executive committee would exclude them from receiving a brochure about abortion training in their organisation's newsletter.

Most of the clinics in State B introduced physician-administered medical abortion within a few months of FDA approval of mifepristone.

After a thorough review of the legal issues and a favourable opinion from the state Nursing Board on expanding the scope of practice, most clinics began to include advanced practice clinicians as medical abortion providers. While this did not expand geographic access, it did mean that clinics could provide abortions on more days, including the days that had been reserved for routine gynaecological care, when few protesters showed up to harass staff and patients.\* Additionally, these clinicians became important spokespersons within their professional communities for integrating abortion services into primary care and ending their marginalisation. AAP has also sponsored extensive training and support for advanced practice clinicians in neighbouring states and estimates that there are approximately 30 advanced practice clinicians providing abortions (mostly medical, but some early surgical) in that region today.<sup>17</sup>

### **Reflections of three advanced practice clinicians**

While the implications of advanced practice clinicians being abortion providers are clear for the increased access this will bring, what impact does becoming an abortion provider have on their professional identity and what are the gratifications and concerns? Drawing from a handful of interviews by the authors as part of a long-term study, it is clear that to those committed to this work, who may long have been involved in assisting at abortions, finally becoming a full-fledged provider is exhilarating. Jenna and Robin (pseudonyms), the former a nurse practitioner, the latter a physician assistant, reflect on the first medical abortions they provided:

*“As I popped the mifepristone out of its crinkly bubble packaging into ‘Jane’s’ outstretched palm, and watched her place the tablet on her tongue, a powerful feeling flowed through me. Though I had dispensed hundreds—perhaps thousands—of medications during my career as a nurse practitioner, this was the first time I had ever given a medication that actually had the ability to alter the course of a woman’s life, rather than simply*

\*Harassment of staff and patients alike at facilities that are known to offer abortion services is a common problem in the United States.<sup>19</sup>

relieve her discomfort or prevent a potential future event.”(Jenna)

“I had already been doing a lot of the pre- and post-care. But now they were ‘my’ patients. It was like I didn’t have anyone directly over my shoulder. . . The counsellor got to see them first, and then I got to have time alone with them as the provider. . . I did the whole physical exam, the pelvic exam, and the ultrasound. . . And then, actually handing the pill to the woman was incredibly powerful. I felt this amazing connection that I was – I was like a medicine woman, connected to my ancestors! It was just that instead of this herb that you take, here is this modern pill that you get to take. And I’m glad that I can help you. It was very empowering.” (Robin)

Alice, also a nurse practitioner, is more understated in her belief that medical abortion delivery is squarely within the scope of practice of her profession.

“Well, after I first heard about [mifepristone], I thought, ‘Why not?’ Because I can prescribe medicine and do counselling and that’s really all there is to it. . . No, I don’t think it’s a big leap for me. Really I am not doing anything different than I do in the rest of my practice. And the outcome of this is not the end of a migraine, it’s the end of a pregnancy.”

Yet in spite of the personal and professional gratification involved, two of the women were somewhat uneasy about the ambiguous legal and professional terrain of the states in which they worked, where lawyers have been encouraging and relevant professional associations supportive, but in which there has not yet been a legal test case. Alice provides medical abortion not at her regular workplace, a women’s health centre, but in the private practice of a physician who does surgical abortions and who agreed to act as her surgical backup, if needed. She felt herself to be in a quasi-legal situation and recounted how the abortion rights lawyer advised her:

“She didn’t say: ‘Go ahead and I am sure it will be all right.’ She said: ‘Go ahead and we’ll be behind you 100% if somebody challenges.’ And so what we were hoping was that I would do them for a couple of years, and establish a very

good safety record, and then if someone challenges me, I could point to this record. So far, the [state anti-abortion movement] hasn’t noticed. So I’m hoping to establish a foothold.”

But as a precautionary measure, Alice has the physician co-sign the charts of all the medical abortions she has performed, even though, thus far, she has managed all of them entirely on her own.

Jenna similarly recalls a “wave of fear” along with the elation that accompanied her first independent provision of medical abortion.

“I remember one of the ultrasounds being kind of questionable. . . I hadn’t had much ultrasound training and I had to depend on the other nurses to read the ultrasounds. And I remember thinking, ‘Wow, if I screw up [my organisation] is not going to be there for me.’ Of course, with any clinical error, I feel that way, but with mifepristone it was a little more potent. . .because of the legal question mark. There was an edge there that had to do with this being about abortion. I think because I realised some of my colleagues weren’t doing it, they were choosing not to, and it made me just think, ‘Am I going to be OK if push comes to shove?’”

Both Alice’s and Jenna’s concerns about legality have abated over time as both have successfully provided medical abortion without complications or legal issues arising. In Jenna’s case, a considerable number of other advanced practice clinicians have started to provide medical abortion, both in her own organisation and elsewhere in the state. In fact, the majority of all medical abortions done in her state are currently provided by advanced practice clinicians. But even as legal concerns have become minimal, both women have become acutely aware of the strains in collegial relations that abortion provision evokes, a phenomenon long known to physician providers.<sup>20</sup> In Alice’s case, she has no illusions that getting others like herself to provide medical abortions will be an easy task.

When asked about the likely response were she to make a presentation on her experience at an upcoming professional conference in her state, she thought half would be interested and half would not attend or walk out, due to the influence of the religious right. Jenna’s work environment is solidly pro-choice, but she too

sees dealing with relevant professional organisations as highly challenging.

*“There are two academic nurse practitioner organisations. One of them at the last minute rejected the Clinicians for Choice booth [at the national conference] which we were going to pay for. . . Then regionally, it took a long time to get an exhibit accepted at the annual meeting. We finally got that in, then we tried to do a presentation, that took a couple of years, but last year we were able to. It seems like a long, slow process for them [professional organisations] to feel comfortable [with abortion issues] and finding a language that makes it palatable.”*

Robin also works with co-workers who are all highly supportive of abortion, even though not all clinicians provide them. But in her fairly small city, work identities cannot easily be separated from social ones, and she is unsure how many people she should tell she is an abortion provider. This issue became salient when Robin went to the east coast for training in early manual vacuum aspiration.

*“A lot of my patients. . . knew I was going to go do something. . . because I was saying, ‘OK, I’ll be back after such and such date’ . . . and they were saying, ‘What are you going for?’ And I said, ‘I’m going to learn some surgical skills.’ And I had a 16-year-old patient, and when I got back, she asked me what kind of doctor I was. I said I am a physician assistant, not a doctor, and she said, ‘Well, have you ever done abortions?’ and I said, ‘Well, yes, I have.’ Then I was concerned, and I said, ‘Are you pregnant and is that why you are asking me this?’ And she said, ‘No, but I just wondered because you were gone for a few weeks and you said you were going to learn surgery.’ And then after that I said to myself, ‘Why did I tell her? She’s a 16-year-old who’s kind of a funny person and maybe I shouldn’t have told her.’”*

There are concerns for family members too, given the history of violence against abortion providers in the US. Both Robin’s and Jenna’s husbands expressed fears for their safety:

*“My husband has been struggling with this, he is not happy I have become a provider. . . He is concerned that somebody will eventually know that I provide abortions and will be a threat to me. He is struggling with this and I’m sorry he*

*is, but we talk about it a lot and we’re trying to work it through.”*

*“When I first told him I was doing [medical abortions] he said, ‘I’m a little worried about that.’ We need to talk about it and we basically haven’t, ever. I mean he knows I’m doing it and we’ve never revisited it. I think at that point I told him, ‘I’m sorry, I feel really strongly about this’ and I reassured him that I feel safe, and it’s something I need to do.”*

### Looking to the future

As a result of the efforts of the AAP, Clinicians for Choice and other organisations, as of January 2004 trained advanced practice clinicians are providing medical, and in some cases, early surgical abortion in 14 states. California is the only state thus far to have passed legislation specifically allowing this; in other states there have been rulings allowing it from the state Department of Health, the Attorney General’s office or the state nursing board. In most of the 14 states, however, an analysis of the law has shown clear support for advanced practice clinician practice, and advanced practice clinicians are providing abortion services without additional regulatory approval. While many of the providers work in urban clinics that also have physician providers, the true promise is of the expanded availability of medical abortion in underserved areas. In several states, trained advanced practice clinicians are providing medical abortions in rural areas that previously had inadequate or no access to abortion services at all.

Expanding the role of advanced practice clinicians as abortion providers in the US will continue to be a challenging task. Beyond the political opposition from anti-abortion forces at both national and state level, there is also internal medical politics, in which historically non-physicians have not been welcomed on physicians’ turf,<sup>21,22</sup> despite the ability of advanced practice clinicians to provide medical abortion safely.<sup>15</sup> The declining number of abortions in the US over the last several years<sup>1</sup> may only exacerbate this reluctance, in spite of the very low number of physicians who are actually willing to provide abortion across the country.

Nevertheless, there is reason for cautious optimism. A recent survey of 17,000 advanced practice

clinicians in California, done shortly after the new legislation permitting this group to offer medical abortion, suggests that about one quarter of them want medical abortion training.<sup>23</sup> Surveys conducted in February and April 2004 by the Abortion Access Project in New Mexico and Massachusetts showed a similar level of interest. While it is too soon to know if this will indeed translate into training, let alone eventual abortion provision, in such numbers, it is nonetheless suggestive of a possible substantial infusion of new abortion providers. State-by-state efforts will doubtless continue to expand involvement of advanced practice clinicians in medical (and in a few states, early surgical) abortion. Most encouraging, however, advanced practice clinicians who are drawn to abortion provision, like their physician counterparts, show a level of passionate commitment to the work that is rare elsewhere in health care in the US right now. As Robin recounted when asked by a

colleague why she was embarking on abortion provision in such a terrible political climate:

*“Because it is such a terrible political climate. The radical in me wants to make sure that should this right be taken away, I can help women and go underground with this. Because this is one of the few issues in my life that I would go to jail for.”*

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## Résumé

L'expansion du rôle des cliniciens spécialisés – infirmières spécialisées, assistants médicaux et infirmières accoucheuses – dans les avortements du premier trimestre est source d'espoir dans l'environnement contemporain de l'interruption de grossesse aux États-Unis. Ces personnels paramédicaux assurent un fort pourcentage des soins de santé primaires aux USA, mais leur participation aux interruptions de grossesse est prometteuse, compte tenu surtout de la pénurie de médecins dans ce secteur. Deux symposiums nationaux en 1990 et 1996 ont approuvé la pratique d'avortements précoces par les personnels paramédicaux. En janvier 2004, les cliniciens spécialisés assuraient des avortements médicamenteux et, parfois, chirurgicaux précoces dans 14 États. Cela a exigé une formation médicale, mais aussi une organisation politique pour introduire les changements juridiques et réglementaires nécessaires, État par État, de la part de groupes tels que *Clinicians for Choice* et *Abortion Access Project*; ce processus est décrit dans deux États et à travers les réflexions de trois cliniciens spécialisés. De récentes enquêtes dans trois États montrent que les cliniciens spécialisés s'intéressent à la formation à l'avortement, autorisant un optimisme prudent sur la possibilité d'élargir l'accès à l'avortement. Plus encourageant encore, les cliniciens spécialisés, comme leurs homologues médecins, s'investissent passionnément dans ce travail, chose rare dans le domaine de la santé aux USA aujourd'hui.

## Resumen

Una nota esperanzadora en el ambiente contemporáneo de aborto en Estados Unidos es el aumento del personal clínico de práctica avanzada – enfermeras practicantes, auxiliares médicos y enfermeras-obstétricas – en la prestación de servicios de aborto en el primer trimestre. Actualmente, este personal no médico presta un alto porcentaje de la atención de primer nivel en EE.UU., pero su participación en el aborto es prometedora, particularmente en vista de la escasez de prestadores médicos. En dos simposios nacionales en 1990 y 1996 se aprobó la ampliación de las funciones del personal no médico. A partir de enero de 2004, el personal clínico de práctica avanzada capacitado practicó abortos con medicamentos y, en algunos casos, abortos quirúrgicos en etapa temprana, en 14 estados. Para ello fue necesaria no sólo una capacitación médica, sino también una organización política para lograr los cambios jurídicos y reguladores requeridos, estado por estado, promovidas por grupos como *Clinicians for Choice* y *Abortion Access Project*, descritos aquí en ejemplos en dos estados, y las reflexiones de tres colaboradores de práctica avanzada. Las últimas encuestas de tres estados muestran un marcado interés entre el personal clínico de práctica avanzada en la capacitación en aborto, lo cual fomenta un optimismo cauteloso sobre la posibilidad de un mayor acceso al aborto. Aun más alentador, dicho personal clínico, al igual que su contraparte médica, muestra un nivel de compromiso vehemente al trabajo, raro en otros ámbitos actuales de atención en salud en EE.UU.