ProLife OB|GYNS
AAPLOG American Association of Pro-life Obstetricians & Gynecologists

April 30, 2019

AAPLOG POLICY STATMENT

Abortion Provision by Non-Physicians

There has been recent discussion about allowing non-physician providers to perform abortions. The motivation behind this recommendation is obvious. Most obstetrician/gynecologists do not want to perform abortions[1] because most physicians enter the medical profession to become healers, not killers. The fetal human 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.[2] Because most physicians are not willing to end a fetal life for elective reasons, the abortion industry cannot find enough providers to perform the number of abortions they feel women "need." Thus, they are compelled to recruit non-physician providers to fill this gap.

The American Association of Pro-Life Obstetricians and Gynecologists is opposed to allowing non-physicians to perform the termination of a pregnancy. The motivation for the legalization of elective abortion in the U.S. in 1973 was to improve the safety of the procedure. Now, the movement to allow lesser trained medical providers to perform this procedure will undermine its safety.

After completing a four-year bachelor's degree, physicians complete a four-year accredited medical school or osteopathic school program which includes detailed instruction in normal and abnormal human physiology. Obstetrician/gynecologists then complete an additional four-year postgraduate residency program that allows supervised clinical care specific to the field of women's reproductive health. This training includes a large amount of surgical procedures where the physician is exposed to a myriad of anatomical variations and possible complications. The American Board of Medical Specialties has recognized the inherent complexity in the performance of abortions after the first trimester by recommending an additional two-year subspecialty training for these abortion providers.[3]

Nurse practitioners, on the other hand, complete only a four-year undergraduate nursing degree, followed by a two-year master's program. Similarly, a physician's assistant training program can also be completed in six years after high school, not twelve as is required of ob/gyns. While it may be possible to teach these providers the technical skills to perform the most basic, uncomplicated, early abortions, it should be noted that each human body is unique, and complications can occur in any procedure. When these complications occur, it is unlikely that these minimally trained technicians will have the skills and experience to manage the complications. This will lead to more adverse outcomes in women who have entrusted their health to the abortionist's care.

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 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.[4]

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 uterine surgery, hysterectomy, bowel resection, bladder repair, or other surgeries.[5,6,7]

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 passages of the surgeon's suction curette or grasping forceps into the soft, gravid uterus could result in uterine perforation and damage to surrounding organs.[8] The estimated risk of hemorrhage is 5.6%, cervical laceration 3.3%, retained products of conception 1.6%, infection and uterine perforation 0.2-0.5%, and uterine rupture 0.28% if the patient had a prior C-section, 0.04% without.[9,10] 1.8% of 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.[11]
The frequency of complications increases in later gestational ages due to inherently greater technical complexity related to the anatomical and physiologic changes that occur as the pregnancy advances.[12] 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."[13] Thus, it is important to emphasize that although early abortions do appear to be generally safe, they become less so as the pregnant uterus enlarges.[14,15,16] 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.[17] Another study found that the risk of death increased by 38% for each additional week beyond 8 weeks. Compared to early abortions, the relative risk of 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).[18]

The complication rate is four times higher after a medical abortion, commonly performed by provision of two medications: RU 486 (Mifeprex or mifepristone) which blocks progesterone receptors to cut off hormonal support for the pregnancy, followed in 24 hours with Cytotec (misoprostol) which induces contractions to expel the pregnancy tissue.[19] The risk of hemorrhage following medical abortion is 20% and incomplete abortion is around 8%, increasing as gestational age advances. 5.9% of medical abortions

require surgical completion. The FDA has released very strict guidelines requiring medical abortions to be performed by a physician who has received special training in the use of mifepristone. These providers need to be able to accurately determine the gestational age and location of the pregnancy because ruptured ectopic (extra-uterine) pregnancies are a common cause of maternal deaths, and the failure rate of the abortion is far higher at more advanced gestational ages. The prescriber must have the ability to intervene surgically if the abortion was unsuccessful or if complications resulted; or he needs to have an agreement with another doctor and facility to provide this care.

The frequency of complications of both medical and surgical abortions as described above underscores the necessity of ensuring that an abortion provider is well trained and prepared to handle complications as they arise. Many physicians providing abortions have been unable or unwilling to obtain hospital admitting privileges which guarantee oversight by his peers to assure he is practicing with an acceptable standard of care and that he will be available to handle complications that occur. Abortion providers have been content to dump the care for their complications on non-abortion providing obstetrician/gynecologists who are providing emergency coverage for local emergency rooms (rarely in the context of a contractual agreement as required by the FDA). Now, by recommending that non-physician providers also be allowed to perform abortions, the abortion industry is lowering the standard once again. These non-physician providers cannot and will not care for the abortion complications they create. This can only lead to pain and heartache for women who choose abortion, and for this reason non-physicians should not be allowed to become abortion providers.

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