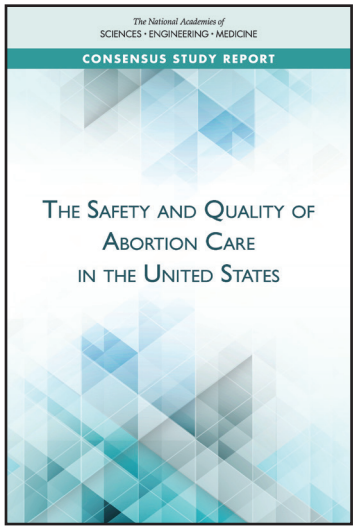
Consensus Study Report
HIGHLIGHTS
March 2018

The Safety and Quality of Abortion Care in the United States



A great deal of scientific research has been conducted on the safety and quality of abortion services in the United States in the decades since national legalization.

With support from six private foundations, the National Academies of Sciences, Engineering, and Medicine convened a committee to examine the available evidence on the safety and quality of different abortion methods, health facilities, and types of clinicians as well as the potential physical and mental health impacts on women. The resulting report, *The Safety and Quality of Abortion Care in the United States,* provides a comprehensive review of the state of the science.

ABOUT ABORTION CARE IN THE UNITED STATES

The abortion rate among U.S. women has been steadily declining, reaching a historic low of 14.6 per 1,000 or a total of 926,190 in 2014. This decline has been attributed to the increasing use of contraceptives, especially long-acting methods such as intrauterine devices and implants; historic declines in the rate of unintended pregnancy; and increasing numbers of state regulations that limit the availability of otherwise legal abortion services.

Women who have abortions are disproportionately low-income: Almost half have family incomes below the federal poverty level.

Four types of abortions are used; the vast majority of abortions are by either medication or aspiration methods. Most abortions are performed early in pregnancy—50 percent by 7 weeks' gestation and 90 percent by 12 weeks' gestation—and length of gestation is the primary factor in deciding what abortion procedure is the most appropriate. Medication abortions are used up to 10 weeks' gestation; aspiration procedures may be used up to 14 to 16 weeks' gestation. When these are no longer feasible, dilation and evacuation (D&E) and induction methods are used.

Few women are medically ineligible for abortion.

"The quality of abortion care depends on where a woman lives. In many states, regulations have created barriers to safe, effective, patient-centered, timely, efficient, and equitable abortion services."

ABORTION AND THE ATTRIBUTES OF QUALITY HEALTH CARE

Legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.

The committee agreed that women should expect abortion care to meet well-established clinical standards for objectivity, transparency, and scientific rigor. The quality of abortion care should be assessed with respect to the six dimensions of health care quality first described in the 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century:* safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

The committee concludes that the quality of abortion care depends on where a woman lives. In many states, regulations have created barriers to safe, effective, patient-centered, timely, efficient, and equitable abortion services. The regulations often prohibit qualified providers from providing services, misinform women of the risks of the procedures they are considering, overrule women's and clinician's medical decision making, or require medically unnecessary services and delays in care.

For the committee's detailed conclusions on quality, please see "Abortion Care and the Six Attributes of Quality Health Care." The report and additional resources are available at **nationalacademies.org/ReproductiveHealth.**

LONG-TERM HEALTH EFFECTS

Abortion has been investigated for its potential long-term effects on future childbearing and pregnancy outcomes, risk of breast cancer, mental health, and premature death. Based on research that meets scientific standards for rigor and lack of bias, the committee concludes that having an abortion does not increase a woman's risk of secondary infertility, pregnancy-related hypertensive disorders, abnormal placentation (after a D&E abortion), preterm birth (<37 weeks), or breast cancer. Having an abortion also does not increase a woman's risk of depression, anxiety, and/or posttraumatic stress disorder.

DELIVERY OF CARE

The committee presented many conclusions in the area of delivery of care.

Characteristics of clinical facilities

Ninety-five percent of abortions are provided in clinics and other office-based settings; most abortions can be safely provided in office-based settings.

No special equipment or emergency arrangements are required for medication abortions. For other abortion methods, the minimum facility characteristics depend on the level of sedation that is used.

Necessary clinical skills

All abortion procedures require competent providers skilled in patient preparation (education, counseling, and informed consent); clinical assessment (confirming intrauterine pregnancy, determining gestation, taking a relevant medical history, and physical examination); pain management; identification and management of expected side effects and serious complications; and contraceptive counseling and provision. Aspiration abortion requires a clinician skilled in the technical aspects of the procedure. D&E abortions require clinicians with relevant surgical expertise and a sufficient caseload to maintain the requisite skills.

Both trained physicians and advanced practice clinicians (APCs) (physician assistants [PAs], certified nurse-midwives [CNMs], and nurse practitioners [NPs]) can safely and effectively provide medication and aspiration abortions. OB/GYNs and family medicine and other physicians with appropriate training and experience can provide D&E abortions. Induction abortions can be provided by clinicians (OB/GYNs, family medicine physicians, and nurse-midwives) with training in managing labor and delivery.

If moderate sedation is used, it is essential to have a nurse or other qualified clinical staff—in addition to the person performing the abortion—available to monitor the patient. Deep sedation and general anesthesia require the expertise of an anesthesiologist or certified registered nurse anesthetist to ensure patient safety.

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Pain and pain management

NSAIDs are recommended to reduce the discomfort of pain and cramping during a medication abortion. However, women still report having pain.

The options for pain management during aspiration, D&E, and induction abortion range from local anesthesia, minimal sedation/anxiolysis, moderate sedation/analgesia, deep sedation/analgesia, to general anesthesia. Along this continuum, the physiological effects of sedation have increasing clinical implications and, depending on the depth of sedation, may require special equipment and personnel to ensure the patient's safety.

Management of medical emergencies

For all outpatient procedures, including abortion, the key safeguards are whether the facility has the appropriate equipment, personnel, and emergency transfer plan to address the complications that might occur. Different safeguards are needed for different levels of sedation.

The committee found no evidence indicating that clinicians that perform abortions require hospital privileges to ensure a safe outcome for the patient, but they should be able to provide or arrange for patient access or transfer to medical facilities equipped to provide blood transfusions, surgical intervention, and resuscitation, if necessary.

QUESTIONS MERITING FURTHER INVESTIGATION

The committee identified a number of questions regarding the safety and quality of abortion that merit further investigation, including:

- how FDA restrictions on mifepristone distribution affect quality of care;
- can the pain of medication abortion be managed prophylactically;
- optimal approach to managing pain during an aspiration abortion;
- can advanced clinical practitioners (NPs, CNMs, PAs) be trained to perform D&Es; and
- best practices for providing support services to lower-income women.

Committee on Reproductive Health Services: Assessing the Safety and Quality of Abortion Care in the United States

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