MedicalXpress

New report examines scientific evidence on safety and quality of abortion care in US

March 16 2018

While legal abortions in the U.S. are safe, the likelihood that women will receive the type of abortion services that best meet their needs varies considerably depending on where they live, says a new report from the National Academies of Sciences, Engineering, and Medicine. In addition, the report notes, the vast majority of abortions can be provided safely in office-based settings.

The committee that wrote the report examined the scientific evidence on the safety and quality of the four abortion methods used in the U.S.—medication, aspiration, dilation and evacuation (D&E), and induction. It assessed quality of care based on whether it is safe, effective, patient-centered, timely, efficient, and equitable according to well-established standards. Most abortions in the U.S. are performed early in pregnancy; in 2014, 90 percent occurred by 12 weeks of gestation. Medication and aspiration abortions are the most common methods and, together, account for about 90 percent of all abortions. Serious complications from abortion are rare regardless of the method, and safety and quality are enhanced when the abortion is performed as early in pregnancy as possible.

Abortion-specific regulations in many states create barriers to safe and effective care. These regulations may prohibit qualified providers from performing abortions, misinform women of the risks of the procedures they are considering, or require medically unnecessary services and delay care, the report says. Examples of these policies include mandatory waiting periods, pre-abortion ultrasound, and a separate in-person

counseling visit. Some states require abortion providers to provide women with written or verbal information suggesting that abortion increases a woman's risk of breast cancer or mental illness, despite the lack of valid scientific evidence of increased risk.

In 2014, there were 17 percent fewer abortion clinics than in 2011, and 39 percent of women of reproductive age resided in a county without an abortion provider. In 2017, 25 states had five or fewer abortion clinics, and five states had only one abortion clinic. In addition, approximately 17 percent of women travel more than 50 miles to obtain an abortion.

The vast majority of abortions can be provided safely in office-based settings, the report says. In 2014, 95 percent of abortions were provided in clinics and other office-based settings. For any outpatient procedure, including abortion, the important safeguards are whether the facility has the appropriate equipment, personnel, and an emergency transfer plan to address complications that might occur. The committee found no evidence indicating that clinicians who perform abortions require hospital privileges to ensure a safe outcome for the patient.

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 used, the report says. If moderate sedation is used, the facility should have equipment to monitor oxygen saturation, heart rate, and blood pressure as well as have emergency resuscitation equipment and an emergency transfer plan. Deeper sedation requires equipment to monitor ventilation.

The committee also reviewed the evidence on what clinical skills are necessary for health care providers to safely perform the various components of abortion care, including pregnancy determination, counseling, gestational age assessment, medication dispensing, procedure performance, patient monitoring, and follow-up assessment and care. It

concluded that trained physicians - such as OB-GYNs and family medicine physicians—as well as advanced practice clinicians - such as certified nurse-midwives, nurse practitioners, and physician assistants - can safely and effectively provide medication and aspiration abortions. Physicians with appropriate training and sufficient experience to maintain requisite surgical skills can provide D&E abortions. Clinicians with training in managing labor and delivery can safely and effectively provide induction abortions.

In its review of abortion's potential long-term health effects, the committee examined the evidence on future childbearing and pregnancy, risk of breast cancer, and mental health effects. It found that having an abortion does not increase a woman's risk of secondary infertility, pregnancy-related hypertensive disorders, preterm birth, breast cancer, or mental health disorders such as depression, anxiety, or post-traumatic stress disorder. The risk of a very preterm first birth appears to be associated with the number of prior abortions. For example, an increased risk of a first birth earlier than 28 weeks of gestation was found to be associated with having two or more aspiration abortions, compared with the first birth of women with no history of prior abortion.

Nineteen states require a physician to be physically present to provide mifepristone—the only medication specifically approved by the FDA for use in medication abortions - and 17 states require medication abortions to be performed in a facility with attributes of an ambulatory surgery center or hospital. There is no evidence that these practices improve safety or quality of care, the report says. How the limited distribution of mifepristone affects quality of abortion care merits further investigation.

Access to clinical education and training in abortion care in the U.S. is highly variable at both the undergraduate and graduate levels, the report says. Medical residents and other advanced clinical trainees often have to

find abortion training and experience in settings outside of their educational program. In addition, training opportunities are particularly limited in the Southern and Midwestern states, as well as in rural areas throughout the country.

The committee also looked at trends in abortion care. Between 1980 and 2014, the abortion rate in the U.S. decreased by more than half, from an estimated 29 to 15 per 1,000 women of reproductive age. The reason for this decline is not fully understood, but it has been attributed to the increasing use of contraceptives, especially long-acting methods such as intrauterine devices, historic declines in the rate of unintended pregnancy and increasing numbers of state regulations that limit the availability of otherwise legal abortion services.

Provided by National Academies of Sciences, Engineering, and Medicine