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Increasing Access to Abortion

This Committee Statement was developed by the American College of Obstetricians and Gynecologists' Committee on Advancing Equity in Obstetric and Gynecologic Health Care in collaboration with Keith M. Reisinger-Kindle DO, MPH, MS, and Maria A. Phillis, MD, JD. The Society of Family Planning endorses this document.

Legal and accessible abortion care is a necessary component of comprehensive health care. Access to abortion is threatened by local, state, and federal government restrictions; limitations on insurance coverage of abortion care; restrictions on funding for training; restrictions imposed by hospitals and health care systems; stigma; violence against health care professionals who provide abortion care; and a subsequent dearth of health care professionals who provide this care. Since the *Dobbs v. Jackson Women's Health Organization* decision, the abortion landscape is an ever-changing and shifting map of abortion restrictions and protections based on state-level interpretations and definitions of abortion care. This is confusing and chilling to both patients and health care professionals, who must learn to navigate a web of conflicting and varying state laws. Legislative restrictions fundamentally interfere with the patient–health care professional relationship and decrease access to abortion, particularly for individuals with low incomes and those living long distances from health care professionals. This Committee Statement continues the American College of Obstetricians and Gynecologists' previous calls for advocacy to oppose and overturn restrictions, to improve access, and to affirm abortion as an essential component of health care.

SUMMARY OF RECOMMENDATIONS AND CONCLUSIONS

The American College of Obstetricians and Gynecologists calls for the cease and repeal of all legislation, policy, and executive actions that ban abortion, create barriers to abortion access, or interfere with the patient–health care professional relationship and the practice of medicine, including, for example:

- **The federal Hyde Amendment and other federal and state restrictions on public and private insurance coverage of abortion care;**
- **Gestational age–specific bans on abortion care;**
- **Requirements that only physicians or obstetrician–gynecologists may provide abortion care;**
- **Telehealth bans;**
- **Mandatory evaluation requirements, including, but not limited, to ultrasonography and**

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waiting periods before obtaining abortion care;
- **Mandatory counseling on abortion risks that are not based on current understandings of published evidence;**
- **Mandatory parental involvement in the care of minors;**
- **Restrictions on interstate or international travel for abortion care;**
- **Punitive policies for self-managed abortion;**
- **Mandatory use of non–evidence-based regimens and processes; and**
- **Facility and staffing requirements, including burdensome reporting requirements that are disproportionate to the risks and safety of abortion care provision.**

Obstetrician–gynecologists and other health care professionals have an ethical obligation to understand the nuances of abortion service access in their city, state, and region. This includes the duties to not withhold the provision of care that is legal due to fear of prosecution, to provide lifesaving and health-preserving care to the best of their training, and to appropriately transfer or refer patients, or both, when legally possible to locales and health care professionals who are able and appropriately trained to provide abortion care.

The American College of Obstetricians and Gynecologists acknowledges that a comprehensive approach to addressing all forms of oppression, including systemic racism, must acknowledge the direct effect that restrictions to abortion access have on worsening ongoing health care inequities.

The American College of Obstetricians and Gynecologists recommends that funding for opt-out abortion training for medical student, resident, and advanced-practice clinician education be ensured and that governmental restrictions on training programs and funding be removed. The American College of Obstetricians and Gynecologists acknowledges the connection between a lack of abortion training and a decrease in the safe provision of obstetric and gynecologic care more broadly.

The American College of Obstetricians and Gynecologists encourages hospitals, public health organizations, and other health care institutions to support access to abortion care by working to eliminate barriers to the provision of abortion care in these settings and preserving the availability of comprehensive reproductive health services in their local communities.

The American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists take an active role in local, state, regional, and national advocacy efforts to improve abortion access, including specific efforts to proactively advance physical and cyber security for clinics that provide abortion care, as well as their patients and staff.

The American College of Obstetricians and Gynecologists recommends that public health organizations, professional organizations, individual health care professionals, and community health care organizations prioritize efforts to reduce abortion-related stigma in their local communities.

The American College of Obstetricians and Gynecologists recommends the removal of the term "*elective abortion*" from institutional policies and regulations and advocates that all abortions be considered medically indicated.

BACKGROUND

Legal and accessible abortion care is a necessary component of comprehensive health care. The American College of Obstetricians and Gynecologists (ACOG) supports the availability of high-quality reproductive health services for all patients and is committed to improving access to abortion care and abortion training. Access to abortion is threatened by local, state, and federal government restrictions; limitations on insurance coverage of abortion care; restrictions on funding for training; restrictions imposed by hospitals and health care systems; stigma; violence against health care professionals who provide abortion care; and a subsequent dearth of health care professionals who provide this care. Legislative restrictions fundamentally interfere with the patient–health care professional relationship and decrease access to abortion, particularly for individuals with low incomes and those living long distances from health care professionals. This Committee Statement continues ACOG's previous calls for advocacy to oppose and overturn restrictions, to improve access, and to affirm abortion as an essential component of health care. It also continues ACOG's ongoing support for the rights of all people to decide whether and when to have children; to determine the number and spacing of their children;

and to have the information, education, and access to health services needed to make these choices for themselves and without government interference (1).

Abortion has a long history in the United States, with methods of inducing abortion documented even in the early colonial period (2). Limitations on the ability to access abortion initially were most notable in the setting of slavery—the reproductive choices of Black people were scrutinized and controlled because the perpetuation of slavery relied on control of the reproductive capabilities of Black bodies. Broad criminalization efforts began in the mid-19th century, with laws designed to prohibit abortion at various stages of pregnancy implemented state-by-state; this was a movement largely led by physicians (2). The U.S. Supreme Court decision in *Roe v. Wade* decriminalized abortion care nationwide in 1973, based on a viability framework attempting to balance a presumed state interest in the protection of fetal life with the rights of the pregnant person (3). Abortion was not allowed to be regulated in the first trimester by the state; instead, decisions about abortion were left entirely to the patient and physician. In the second trimester until viability, the state was allowed to implement some regulations to protect the health and life of the pregnant person. After viability, the state could regulate to protect fetal life as long as there were exceptions in place to protect the life and health of the pregnant patient.

Subsequently, 1992's *Planned Parenthood of Southeastern Pennsylvania v. Casey* decision reduced the legal protections of *Roe* and replaced the trimester framework with one based entirely on "viability" and that allowed state restrictions and regulation of abortion both before and after viability (4, 5). Restrictions before viability were permissible as long as they did not cause an "undue burden" in accessing abortion. Restrictions after viability were permissible as long as they included exceptions to protect the life and health of the pregnant person (6). After the *Casey* decision, states engaged in hundreds of regulatory attempts to limit care through gestational age bans, bans for particular methods of procedures, and Targeted Regulation of Abortion Providers (or TRAP) laws that imposed onerous restrictions out of proportion to what was essential for safe medical care, designed to make it too difficult to provide abortion care. In 2022 the *Dobbs v. Jackson Women's Health Organization* decision entirely reversed the *Roe* precedent, now allowing states to ban abortion without any limitations and without specific protections for the life or health of the pregnant person (7).

Since *Dobbs*, the abortion landscape is an ever-changing and shifting map of abortion restrictions and protections based on state-level interpretations and definitions of abortion care. This is confusing and chilling to both patients and health care professionals, who must learn to navigate a web of conflicting and varying state laws. Abortion-related laws are changing so rapidly that no state-specific information will remain up to date even across publication intervals. Thus, further state-specific, real-time details can be obtained through online resources (Box 1).

Although self-managed abortion using misoprostol with or without mifepristone has been shown to be both safe and effective, individuals may turn to less-safe abortion methods when access to safe abortion is limited (8). Although there are methods to safely self-manage abortion without medical supervision, globally up to 13% of maternal deaths are attributable to unsafe abortion methods (9). Restrictions on safe abortion access directly contribute to rates of unsafe abortion, and such restrictions disproportionately affect adolescents; Black, Indigenous, and other people of color; individuals living in rural areas; individuals with lower socioeconomic status; people who are incarcerated; people living with disabilities; and LGBTQ+ (lesbian, gay, bisexual, transgender, and queer) people.

In addition to the harm experienced from less-safe abortion methods when abortion is illegal, being denied a wanted abortion also can cause harm to pregnant people and their children. People who are denied a wanted abortion have been shown to have worse health outcomes than those who obtained an abortion. Individuals denied an abortion are more likely to stay in unsafe relationships and to raise children without a partner or other family support. They also have increased levels of stress and anxiety compared with those who are able to access abortion care (10, 11). Individuals denied abortion care are four times more likely to experience poverty after abortion denial, and children born after abortion denial also are more likely to experience economic insecurity than those born later from people who were able to access a wanted abortion (10).

Between 1990 and 2017, abortion incidence in the United States steadily decreased. However, since 2017, the incidence of abortion in the United States has steadily increased by approximately 8%, with 2020 data reflecting an annual incidence of approximately 930,000 in 2020 (12). The number of abortions continues to increase. From January 2024 to March 2024, a monthly average of 98,990 abortions was reported (13). Although many hypotheses have been proposed to explain the reversal of this downward trend in recent years, data remain limited to draw any definitive conclusions at this time. Nonetheless, abortion remains incredibly common, with 25% of women in the United States having an abortion before age 45 years (14).

Box 1. State Abortion Policies and Legal Resources

The Guttmacher Institute

The Guttmacher Institute's Interactive Map: US Abortion Policies and Access After Roe (https://states.guttmacher.org/policies/) and its State Legislation Tracker (https://www.guttmacher.org/state-legislation-tracker) provide updated details about which states have bans, restrictions, or protections in place. Languages: English.

AbortionFinder

AbortionFinder (http://www.abortionfinder.org) provides a directory of verified abortion service providers and assistance resources in the United States. Languages: English and Spanish.

Abortion Defense Network

The Abortion Defense Network (https://abortiondefensenetwork.org) connects people facing legal threats related to abortion care with attorneys who have volunteered to provide pro bono legal advice and representation in civil and criminal proceedings. Clinicians will be matched with attorneys who can help provide them with information and resources to understand their rights and defend themselves against legal proceedings related to providing and supporting abortion care. The initiative also includes legal defense funds to pay for attorney fees and other legal expenses. Anyone in the United States working to provide or support abortion care can seek no-cost legal assistance from the Abortion Defense Network. The Abortion Defense Network is hosted by the Lawyering Project in collaboration with national law firms. Languages: Chinese, English, and Spanish.

Reproductive Health Legal Assistance Project

Lawyers for Good Government provides legal guidance for reproductive health care professionals through the Reproductive Health Legal Assistance Project (https://www.lawyersforgoodgovernment.org/repro-health-lap). This database includes links to legal research for 56 U.S. states and territories, a reproductive health digest newsletter, and a media-collection project. The newsletter and media archives are immediately accessible and searchable by state or territory. Users must fill out a brief application to access the legal research, which is updated every business day and continues to grow with more questions. This is a free and accessible tool for all who need it. Languages: English.

If/When/How

If/When/How's Repro Legal Helpline (https://www.reprolegalhelpline.org) is a free, confidential helpline where people can receive information about abortion laws in their state, including self-managed abortion and judicial bypass for minors. It also provides assistance for people who have been arrested, questioned by the police, or charged with a crime for their abortion. Languages: Chinese, English, Spanish.

RAD (Resources for Abortion Delivery)

RAD (https://radprogram.org/for-allies-providers) offers legal defense funding and legal defense compliance advice to clinicians who provide abortion care nationwide. Languages: English.

Abortion safety has increased greatly over time due to advancements in abortion procedure technology and abortion-specific research. Although the overall risk of complications is low, gestational age remains the most important risk factor for complications (15). The risk of major complications (those requiring hospital admission, surgery, or blood transfusion) increases from 2 per 1,000 procedures at 8 weeks of gestation to 15 per 1,000 procedures at 20 weeks (16). These risks are far outpaced by comparable complication rates of childbirth for every complication type. Abortion is at least 14 times safer than childbirth (17).

Use of Language

The American College of Obstetricians and Gynecologists recognizes and supports the gender diversity of all patients who seek obstetric and gynecologic care. In original portions of this document, authors seek to use gender-inclusive language or gender-neutral language. When describing research findings, this document uses

gender terminology reported by investigators. To review ACOG's policy on inclusive language, see https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language.

RECOMMENDATIONS AND CONCLUSIONS

The American College of Obstetricians and Gynecologists calls for the cease and repeal of all legislation, policy, and executive actions that ban abortion, create barriers to abortion access, or interfere with the patient–health care professional relationship and the practice of medicine, including, for example:

- **The federal Hyde Amendment and other federal and state restrictions on public and private insurance coverage of abortion care;**
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- **Requirements that only physicians or obstetrician–gynecologists may provide abortion care;**
- **Telehealth bans;**
- **Mandatory evaluation requirements, including, but not limited, to ultrasonography and waiting periods before obtaining abortion care;**
- **Mandatory counseling on abortion risks that are not based on current understandings of published evidence;**
- **Mandatory parental involvement in the care of minors;**
- **Restrictions on interstate or international travel for abortion care;**
- **Punitive policies for self-managed abortion;**
- **Mandatory use of non–evidence-based regimens and processes; and**
- **Facility and staffing requirements, including burdensome reporting requirements that are disproportionate to the risks and safety of abortion care provision.**

Even when abortion was legal nationally, abortion care remained out of reach for many people because of the numerous restrictions imposed by state governments targeting both patients seeking abortion and health care professionals. With the 2022 *Dobbs* decision and subsequent loss of protection for abortion care nationally, state-based efforts to criminalize people seeking abortion care, clinicians who provide abortion care, and those funding and logistically supporting abortion care have only increased.

Many states have passed laws completely banning or severely limiting the availability of abortion care. Although some states offer vaguely worded exceptions to their abortion bans for vaguely defined medical emergencies, these medical emergency clauses do not offer adequate protection for the myriad pregnancy complications people experience, resulting in substantial harm to patients. One study conducted at two Texas hospitals after the enactment of a near-total abortion ban found that, despite a medical emergency clause in the state law, maternal morbidity in the periviable period doubled compared with the time period before the enactment of the law (18). In a different Texas-based study, physicians across the state described that medical emergency exceptions for the abortion law varied from hospital to hospital, creating confusion and fear among physicians (19). In this same study, some physicians even reported fear about providing a referral for emergent intervention, and others described being forced to tell patients who ordinarily would receive immediate medical intervention to return when they had sepsis or when their cardiovascular status had collapsed so that the physicians could intervene with less fear of legal prosecution. Given the complexity and holistic range of factors that affect the health of pregnant people, it would be impossible to write any piece of legislation that adequately encompasses the wide range of possible factors that could contribute to health and safety exceptions for pregnant people.

Although a comprehensive overview of abortion restrictions is beyond the scope of this Committee Statement, some examples, with their effects, are highlighted below:

- *Insurance coverage restrictions*—Barriers to abortion care coverage constitute a substantial barrier to abortion access and increase reproductive health inequities. The passage of the federal Hyde Amendment in 1977, which denies federal Medicaid coverage of abortions except when a patient's life is endangered or in cases of rape or incest, and its annual renewal has severely limited Medicaid coverage of abortion (20, 21). States can choose to use their own Medicaid funding for abortion, but the majority of states also restrict state Medicaid coverage of abortion (22). Restrictions on abortion coverage also exist for military personnel, retirees, and their dependents through the TRICARE military health care system; for veterans accessing care through the U.S. Department of Veterans Affairs (23); for federal employees and their dependents insured through the Federal Employees Health Benefits Program; for individuals incarcerated in federal facilities; and for those receiving care through the Indian Health Service (24, 25). These coverage restrictions impede access to safe abortion care, and, in some cases,

function as a de facto abortion ban (26, 27). Legislative bans on private insurance coverage of abortion further marginalize abortion and represent a departure from the insurance industry's usual practice of covering abortion services equitably with other procedures. In addition, restrictions attached to appropriations and other public monies received by hospitals can jeopardize patient care as well as medical education and training programs for all health care professionals. Abortion care should be considered part of essential health care services, regardless of insurance type or status, and not singled out for exclusion or additional administrative or financial burdens.

- *"Personhood" measures*—Legislation that establishes fertilized eggs as separate legal individuals subject to the laws of the state can have a wide range of effects, including the criminalization of abortion, embryonic stem cell research, some infertility treatments, some cancer treatments, and some methods of contraception (28–30). These measures not only create barriers to reproductive and early pregnancy care, but also may lead to the criminalization of pregnant people (for alleged behavior during pregnancy) and health care professionals (for poor obstetric outcomes).
- *Physician and facility requirements*—Requirements that only physicians, sometimes only those with admitting privileges at a nearby hospital, or only obstetrician–gynecologists specifically, can provide abortion services are regulatory barriers to abortion care. Additional barriers include non–evidence-based requirements for the facility where the procedure is performed, which may vary by gestational age. Advanced practice clinicians can provide abortion care at safety rates equal to those of their physician peers, and admitting privileges have not been shown to be helpful in making care safer (31, 32). Legislation also exists that mandates burdensome staffing and reporting requirements on facilities that perform abortions, requirements that often are notably more burdensome than those imposed on facilities performing procedures and surgeries with much higher complication rates.
- *Gestational age bans*—These bans legislate arbitrary gestational age (or alternatively termed menstrual age, gestational duration, clinical age, or clinical date) cutoffs beyond which an abortion cannot be performed. These bans sometimes, but not always, include vaguely and arbitrarily defined exceptions that contribute to the confusing legal landscape for patients and health care professionals. There is no gestational age ban that increases the safety of abortion procedures. In fact, gestational age bans create unnecessary barriers that make it more likely that patients may need to seek abortion care at later gestational ages (33, 34). The American College of Obstetricians and Gynecologists also opposes proxies for gestational age bans, such as laws based on cardiac activity or viability.
- *Procedure-specific abortion bans*—The federal Partial-Birth Abortion Ban Act of 2003, upheld by the U.S. Supreme Court in 2007, makes it a federal crime to perform procedures that fall within the definition of a "partial-birth abortion" contained in the statute, with no exception for procedures necessary to preserve the health of the patient (35). Although "partial-birth abortion" is not a medical term and is vaguely defined in the law, health care professionals and lawyers have interpreted the banned procedures as including intact dilation and evacuation unless fetal demise occurs before the procedure. Several states also have passed bans on so-called "partial-birth abortions," which impose additional restrictions and penalties on clinicians who provide abortions in those states. These bans interfere with the patient–physician relationship by prohibiting options for patients who may have cultural, religious, medical, or other reasons that intact procedures may be preferred, including lower rates of complications for some patients (36).
- *Pre-abortion evaluation*—Some states require mandated scripts written by the state, visits to anti-abortion crisis pregnancy centers, and the provision of ultrasonography before receiving abortion services. Mandated scripts often include inaccurate data and misinformation about pregnancy, fetal development, and abortion (37). These scripts may include inaccurate information about the association of abortion with breast cancer, depression, and infertility. Some states have mandated that health care professionals provide information to patients about so-called abortion "reversal," an unproven regimen of progesterone treatment aimed at increasing the likelihood of pregnancy continuation in the rare case that a patient decides to try to continue the pregnancy after taking mifepristone for medication abortion (38). This is particularly concerning because not only are abortion "reversal" options not based on evidence, but they may be associated with an increased risk of complications, including hemorrhage (38, 39). Mandating pre-abortion ultrasonography often accompanies unethical and traumatic requirements, including forcing patients to view the images of their ultrasonogram or listen to Doppler cardiac tones (40).
- *State-level mandatory delay requirements*—These laws require individuals to make at least two trips for

a 1-day procedure, typically with a 24- to 72-hour mandated delay between counseling and the abortion procedure (37). These laws create additional burdens, especially for people in rural areas, who often must travel for many hours to reach a health care professional.

- *Parental involvement*—Thes barriers require one or both parents to be notified or give consent before a minor may undergo abortion care, despite any potential danger to the minor. Minors already face barriers accessing the health care system, and parental involvement laws create additional barriers to accessing abortion care. Minors have the ability to go through a judicial bypass process, but it is onerous and delays needed care (41, 42).

Several organizations track abortion restrictions to help patients and health care professionals navigate the ever-changing landscape. For example, see the Guttmacher Institute's state-by-state overview of legislation restricting abortion access (43).

Obstetrician–gynecologists and other health care professionals have an ethical obligation to understand the nuances of abortion service access in their city, state, and region. This includes the duties to not withhold the provision of care that is legal due to fear of prosecution, to provide lifesaving and health-preserving care to the best of their training, and to appropriately transfer or refer patients, or both, when legally possible to locales and health care professionals who are able and appropriately trained to provide abortion care.

As abortion care becomes increasingly criminalized, health care professionals are placed in a conflict between their ethical obligations to care for patients and state or local laws and restrictions on abortion. In one study in a state with substantial legislative restrictions to abortion access, of those physicians across multiple specialties who reported being willing to refer patients for abortion services, more than 50% reported not knowing how to do so (44). Although most obstetrician–gynecologists report having helped patients seek abortion care even when their own personal beliefs conflict with abortion provision (45), there remains a substantial proportion of obstetrician–gynecologists who report either never referring patients or, when they do refer, they make only a general referral to the patient and not to a specific practice or health care professional (46).

Although many patients report receiving information on accessing abortion services online, there is an alarming amount of misinformation (47). Health care professionals play a critical role in providing accurate information to patients who need access to abortion care; this role is even more critical in hostile states where patients may need additional resources to travel to receive care (48). Health care professionals should familiarize themselves with factual online resources they can share with patients about where they can receive abortion care and sources for financial or logistical support to receive abortion care.

The American College of Obstetricians and Gynecologists acknowledges that a comprehensive approach to addressing all forms of oppression, including systemic racism, must acknowledge the direct effect that restrictions to abortion access have on worsening ongoing health care inequities.

A diverse range of published literature suggests that, not only do abortion bans increase rates of maternal mortality, but these effects disproportionately affect Black communities (49–53). Some estimates suggest that a complete abortion ban could result in a 21% increase in overall maternal mortality in the general population, with a 33% increase in Black pregnant people (54). This is likely due to the underlying effects of social and structural determinants of health (55) and some of the unique additional barriers experienced by patients seeking abortion care.

Underlying social determinants of health that affect an individual's ability to access health care in general certainly also affect a patient's ability to access abortion care. Unfortunately, the resources and support individuals may use to access other forms of health care may be unavailable when seeking abortion care. In communities where people can no longer access contraception and abortion care, access to prenatal care services also is declining, with the most pronounced decrease in access seen in Black, Latinx, and Indigenous communities (56). These same communities have the highest maternal mortality rates and experience the most severe effects of restrictions to abortion access (57). For example, although a pregnant person may use transportation services provided by their insurance company to assist with transportation to and from appointments, when private and public insurers do not cover abortion-related services, this resource may no longer be available. This decrease in resource availability disproportionately affects access for individuals from systematically oppressed or marginalized communities, or both, including but not limited to the following: individuals with disabilities, individuals with lower socioeconomic status, individuals in rural communities, and individuals who are incarcerated. This disparity in access is further compounded by the fact that, as more abortion clinics close, transportation becomes even more challenging to navigate as travel time to abortion access increases. Unfortunately, with increased barriers to care, delays in access to abortion-related care become inevitable, and delays in

access are associated with worse outcomes. Although pregnancy termination at all gestational ages is safe, as gestational age increases, the risk of complications increases and the number of available trained health care professionals decreases, further fueling access concerns for patients with transportation barriers.

The American College of Obstetricians and Gynecologists recommends that funding for opt-out abortion training for medical student, resident, and advanced-practice clinician education be ensured and that governmental restrictions on training programs and funding be removed. The American College of Obstetricians and Gynecologists acknowledges the connection between a lack of abortion training and a decrease in the safe provision of obstetric and gynecologic care more broadly.

The shortage of trained health care professionals capable of safely performing abortion procedures is an additional preventable barrier to abortion access (58). Although more than 81% of medical schools report that they provide at least some education on abortion-related topics (59), several survey-based studies have demonstrated that large numbers of medical students remain dissatisfied with the level of information they receive during their medical school training (60, 61). There are currently no standardized requirements for medical student education to include abortion-specific training through the AAMC.

In 2022, the Accreditation Council for Graduate Medical Education revised its abortion training requirements for obstetrics and gynecology residents, mandating that all residents at accredited training programs receive abortion training unless they opt out. This model requires that abortion training routinely be integrated into residency training programs while allowing provisions for those with moral or religious objections to opt out of such training. Even residents who only partially participate in abortion training programs report benefits (62). No other medical specialty currently has required abortion training.

Advanced practice clinicians are legally permitted to perform pregnancy termination procedures in some states. There are robust data affirming advanced practice clinicians' ability to safely provide these services (32), with complication rates in the first trimester comparable with those of their physician colleagues (63–65). Abortion training for advanced practice clinicians should be available.

The American College of Obstetricians and Gynecologists encourages hospitals, public health organizations, and other health care institutions to support access to abortion care by working to eliminate barriers to the provision of abortion care in these settings and preserving the availability of comprehensive reproductive health services in their local communities.

As abortion care rapidly becomes unavailable regionally, existing facilities that still can perform procedures likely will be inundated with additional requests for care. Therefore, all hospitals and other health care institutions should work to ensure access to abortion care by allowing the provision of all legally available abortion care in their clinics and surgical centers (66). Institutions should ensure the availability of comprehensive reproductive health care in their local communities to assist with this projected surge of patient needs. This may involve the following: eliminating prior restrictive policies; hiring appropriately trained staff; training current staff in these procedures; and supplying admission privileges, trained staff, transfer agreements, or other assistance that may be required to continue to support community provision of these procedures. Values-clarification exercises may be helpful as new services are integrated (67–69). These discussions also should cover that opt-out policies cannot ultimately limit a patient's ability to access health care.

The American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists take an active role in local, state, regional, and national advocacy efforts to improve abortion access, including specific efforts to proactively advance physical and cyber security for clinics that provide abortion care, as well as their patients and staff.

Abortion clinics, clinicians who provide abortion care, staff, and patients experience physical, emotional, verbal, and cyber abuse. The National Abortion Federation reports an increase in all forms of violence and intimidation since 1977, with the most dramatic increase in reported violence seen over the past 10 years. Since that time, there have been more than 11 murders, 42 facility bombings, 200 facility arsons, and thousands of documented incidents of other criminal activity, including assault, bomb threats, clinic invasions, delivery of suspicious or threatening packages, stalking, and harassment (70). Violence against abortion clinics should be condemned, and actions should be taken both within institutions and through state and federal policy to protect health care professionals, staff, and patients from future harm.

Obstetrician–gynecologists have an important role to play in local, state, regional, and national advocacy efforts to ensure the availability of abortion access. They have expertise that they can leverage to explain abortion and its status as essential health care to policymakers, the public, and other stakeholders. Additionally, obstetrician–gynecologists can publicly share the effects and experience of acts of violence and intimidation on

clinicians who provide abortion care, patients, and staff. Obstetrician–gynecologists have knowledge of patient experiences receiving abortion care and of health care professionals and staff navigating the sometimes dangerous environment of providing this care. By sharing these experiences, obstetrician–gynecologists can assist communities in understanding the realities of seeking and providing abortion care and advocate for legislative advancements in these spaces. They have a duty to ensure that patients can access care that is free of legal and safety barriers, and, by engaging in this space, obstetrician–gynecologists can ensure that patients' and colleagues' stories are being told and that their care is prioritized.

The American College of Obstetricians and Gynecologists recommends that public health organizations, professional organizations, individual health care professionals, and community health care organizations prioritize efforts to reduce abortion-related stigma in their local communities.

Stigma has been described as, "…an attribute that is deeply discrediting," one that reduces the possessor, "…from a whole and usual person to a tainted, discounted one" (71). The consequences of abortion stigma on the well-being of clinicians who provide abortion care have not been well studied, but hypothesized effects include stress, professional difficulties with anti-abortion colleagues, fears about disclosing one's work in social settings, and burnout (71). Data show that the majority of people who access abortion care report experiencing stigma that is associated with later psychological distress (72). This stigma also has been shown to result in lower-quality care (73). A 2022 analysis of the literature on abortion stigma identified four themes: 1) abortion as a sin and other religious views; 2) regulation of abortion; 3) judgment, labeling, and marking; and 4) shame, denial, and secrecy (73). The study further characterized the emerging ways in which abortion stigma operates to inhibit quality in abortion care into seven manifestations of the relationship between abortion stigma and quality in abortion care: 1) poor treatment and the repercussions, 2) gatekeeping and obstruction of access, 3) avoiding disclosure, 4) arduous and unnecessary requirements, 5) poor infrastructure and lack of resources, 6) punishment and threats, and 7) lack of a designated place for abortion services.

The American College of Obstetricians and Gynecologists recommends the removal of the term "*elective abortion*" from institutional policies and regulations and advocates that all abortions be considered medically indicated.

Differentiating abortions as "elective" as opposed to "therapeutic" or "medically indicated" is a problematic practice, both because it serves no medical purpose and because there is a widespread variance in how politicians and institutions define what is considered "medically indicated" (74). An elective procedure is one in which delay would not substantially affect a person's life or well-being. That term simply does not apply to abortion services, where delays in care are directly associated with significant reductions in patient access and safety.

Some states, for example, have legislation in place that specifically does not include worsening of mental health disorders as a "medical indication" for an abortion. This false dichotomy places the health care professional in an unnecessary position of needing to parse out the exact reason(s) that the patient is seeking an abortion, often against their own rational medical judgment. Furthermore, there are substantial problematic assumptions underlying such a binary attempt to classify reasons that patients seek abortion care. Specifically, this approach downplays the critical role that social determinants of health (eg, financial resources, interpersonal reasons, choosing to focus on current children and family, wanting to advance one's own career or education) play in the health of patients. Health care professionals should not be put in a position to make this distinction. In fact, doing so in a manner that is accurate and nonjudgmental is not possible. The reasons patients choose to terminate pregnancies are diverse and complex (75). Every abortion is performed for a therapeutic reason.

CONCLUSION

When restrictions are placed on abortion access, patients, health care professionals, and communities suffer. Abortion access increasingly is limited, and research shows that restrictions affect both whether care can be obtained safely and the quality of that care. Restrictions disrupt the patient–health care professional relationship, create substantial obstacles to the provision of safe medical care, and disproportionately affect adolescents; Black, Indigenous, and people of color; people living in rural areas; individuals with lower socioeconomic status; people who are incarcerated; people living with disabilities; and LGBTQ+ people. Additionally, clinicians who provide abortion care may face stigma in the workplace and communities, as well as from their colleagues. Clinicians who provide abortion care face violence and threats to themselves, their staff, and their families. Finally, patients are prevented from or experience delays in obtaining abortion care because of inadequate health coverage, insurance coverage

restrictions imposed by the state, or waiting periods and are subject to stigma and shame. Individuals who are unable to obtain a wanted abortion report worse physical health and more economic insecurity compared with those obtaining the abortion. These obstacles marginalize abortion services from routine clinical care and are harmful to people's health and well-being.

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All ACOG committee members and authors have submitted a conflict of interest disclosure statement related to this published product. Any potential conflicts have been considered and managed in accordance with ACOG’s Conflict of Interest Disclosure Policy. The ACOG policies can be found on acog.org. For products jointly developed with other organizations, conflict of interest disclosures by representatives of the other organizations are addressed by those organizations. The American College of Obstetricians and Gynecologists has neither solicited nor accepted any commercial involvement in the development of the content of this published product.

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