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Commentary

Society of Family Planning Committee Statement: Abortion nomenclature☆

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1. Introduction

Models of abortion care are continually evolving and expanding. Historically, advocates, lawyers, journalists, clinicians, and researchers have used a variety of terms to refer to different types of abortion. In 2004, Weitz and colleagues published an editorial laying out the need to develop consensus on standard terms because, "the terminology used to describe abortion procedures influences political, legislative, and medical institutions" [1]. Standardization of abortion nomenclature and terms used to refer to different types of abortion will increase uniformity and accuracy in communication about abortion care. The Society of Family Planning's recommendation is to use the terms *medication abortion* and *procedural abortion* for common use in clinical guidance, journal articles, print materials, websites, media, advocacy, policy briefs, and other communication about abortion care. These recommendations align with recommendations from several other organizations including the American College of Obstetricians and Gynecologists [2], the Society for Maternal-Fetal Medicine [3], and the COMS Project [4]. We recognize the importance of language and its role in providing access to care that is both equitable and that centers the patient experience. We also recognize that language is complex and nuanced. We encourage medical societies and others in sexual and reproductive health, rights, and justice fields, to use these terms, while also inviting discussion and continued research on the optimal approach to abortion nomenclature.

2. Recommendations

a. Abortion primarily with medications, including mifepristone, misoprostol, and misoprostol alone, should be referred to as *medication abortion* regardless of the setting, context, gestational duration, or legal status.

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Historically, a variety of terms have been used to refer to medication abortion: medical abortion, RU486, the abortion pill(s), abortion with pills, pharmaceutical abortion, medicinal abortion, no test abortion, no touch abortion, medically induced, and induction termination.

The term medication abortion is now widely used in the United States which suggests ease of comprehension and adoption by the media, advocates, and policy-makers. It is also the accepted term in clinical practice and scientific publications. However, widespread public knowledge that one can end a pregnancy with medications remains limited. In a 2021–2022 nationally representative survey of participants assigned female at birth, 64% were aware of medication abortion [5]. In another study done in 2022, less than a third (27%) of U.S. adults reported having heard of mifepristone [6]. Furthermore, people who report being aware of medication abortion often erroneously confuse it with emergency contraception [7,8].

The term medication abortion is preferable because the mechanism—that medications are involved—is intuitively understood (unlike medical abortion). "Medical" may imply that the abortion is being done for medical reasons, is a medical necessity, or requires a complication of pregnancy to be completed. "Medical" also implies the medical infrastructure or health care system is required or involved. However, medication abortion can also safely occur outside of the formal health care system, as with self-managed medication abortion [9–11]. Greater use of the term medication abortion may facilitate and expand public knowledge that an abortion with pills exists as an option.

b. Abortion primarily with instrumentation, including uterine aspiration (manual or electric), dilation and curettage, dilation and evacuation, or dilation and extraction should be referred to as *procedural abortion* or *abortion procedure* regardless of the setting, context, pregnancy duration, or legal status.

The following terms have been used to refer to procedural abortion: surgical, aspiration, in-clinic procedure, instrumentation, surgery, put to sleep, anesthesia abortion, manual/electric vacuum aspiration, suction abortion, and uterine scraping. The term procedural abortion conveys that it involves a mechanical intervention that is facilitated by a skilled clinician [4]. This avoids creating artificial distinctions based on the stage of the pregnancy (e.g., by trimester), specific tools, or resources available to the clinician or setting. The term procedural abortion may be new for patients, but greater use of this term may facilitate a more accurate understanding of what it involves.

The term procedural abortion groups multiple clinical abortion techniques using a common term. For specific documents or contexts, such as medical charts, research, or patient counseling, specifying the technique used to perform the abortion procedure may be necessary [12].

While there is greater variation in preferred nomenclature for this type of abortion, there is broad consensus that the terms "surgical" and "dilation & curettage" should be avoided. The term procedural avoids a false suggestion that the procedure involves incisions. "Surgical abortion" is a misnomer [13] obfuscating the training requirements for provision. Physician assistants, nurse practitioners, midwives, and other clinicians who are not clearly labeled as surgeons can provide high-quality and safe procedural abortion care [14]. The use of the term surgical has fueled a perception that abortion carries substantial risks [15], when it is in fact an essential and extremely safe intervention [16,17]. Labeling abortion procedures as surgery may evoke for the patient scary imagery of a sterile surgical suite with scalpels and monitors that is inconsistent with office-based care, contributes to wider misunderstanding [1,18], and provides an erroneous rationale that abortion care must be done in an ambulatory surgical center. Most procedural abortions are safely completed in an outpatient clinical care setting, similar to an intrauterine device (IUD) insertion, and do not require surgery [19]. The complexity of support services required is usually related to the type of pain relief (anesthesia or analgesia) offered to the patient rather than the abortion procedure performed. The term "dilation and curettage" is also a misnomer as guidelines recommend against the practice of using a sharp curette to scrape the uterus and it is no longer the recommended primary method used in a procedural abortion [20].

3. Continued discussion

During the development of this document we identified multiple areas where further discussion, research, and consensus are needed specific to abortion nomenclature and terminology:

- Qualifiers such as induced, spontaneous, missed, medically indicated, and elective, are often used to describe abortion or in efforts to distinguish abortion from pregnancy loss or to differentiate why a patient is seeking abortion [21,22]. Although outside the original scope of the document, it is important to uplift this conversation as it directly impacts the broader abortion nomenclature paradigm. On a policy level, using disparate language to describe care reinforces abortion stigma, enabling legislation that limits patients' options [2]. There seems to be consensus that qualifiers such as medically indicated and elective are not needed when describing abortion or pregnancy loss in clinical guidance, research publications, print materials, websites, media, advocacy, legislation, and other communication with the public. However, more work is needed to explore how to best use the terms recommended in this guidance and still recognize the patient-preferred language in individual counseling [23].
- Current international classification of disease (ICD) and current procedural terminology (CPT) codes for pregnancy loss and abortion include descriptors such as "missed" and "induced," which may contribute to confusion, stigma, and bias.
- Consideration should be given to using *medication* and *procedural* to describe the management of pregnancy loss (i.e., medication management of pregnancy loss and procedural management of pregnancy loss).
- The terms *medication abortion* and *procedural abortion* may not translate into other languages or be used commonly in practice outside of the United States. More work is needed in order to explore and uplift ideal terminology in languages other than English and to build international consensus.
- The terms gestational duration and pregnancy duration may be preferable to the term gestational age which personifies the fetus.

4. Conclusion

As abortion care models expand, we need to review our terminology and refine our language as needed. These recommended terms may continue to evolve, and we invite continued discussion and research on the topic among all stakeholders. Additionally, for specific documents or contexts, such as medical charts and research, further clarification, detail, and definitions may be needed to describe the specific type of intervention and model of care. When counseling people seeking to end a pregnancy, there may be a need to use terminology that is aligned with each individual's understanding and values. However, for common use in clinical guidance, research publications, print materials, websites, media, advocacy, legislation, and other communication with the public, we encourage those in the sexual and reproductive health, rights, and justice fields to use the terms *medication abortion* and *procedural abortion*. Using uniform language will support greater shared public knowledge of the different abortion types, minimize myths and misperceptions, and ensure public discussions reflect the latest

preferred terminology. Given that abortion is increasingly in public discourse, and the terminology used to describe abortion influences political, legislative, and medical institutions, the use of standard terminology is as important as ever.

Intended audience

This Committee Statement is intended for Society of Family Planning members; family planning clinicians; reproductive health service clinicians; family planning, abortion, reproductive health researchers; and policymakers.

Authorship

This Committee Statement was prepared by Ushma D. Upadhyay, PhD, MPH; Leah Coplon, CNM, MPH; and Jessica Atrio, MD, MSc, with the assistance of Margaret Villalonga. It was reviewed and approved by the Clinical Affairs Committee on behalf of the Board of Directors of the Society of Family Planning. The American College of Obstetricians and Gynecologists, the National Abortion Federation, Planned Parenthood Federation of America, and the Society for Maternal-Fetal Medicine endorse this document.

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