



Rhetoric vs. Reality

Setting the Record Straight on Medication Abortion

By Nora Ellmann and Jamila Taylor | June 10, 2019

In recent weeks, Louisiana joined Missouri, Alabama, Georgia, Ohio, Kentucky, and Mississippi in passing what are essentially total abortion bans.¹ While abortion is still legal in these states—and the courts are likely to block these laws from going into effect—these latest efforts are part of an increasingly extreme and cruel attempt to challenge *Roe v. Wade*, the 1973 U.S. Supreme Court decision that established the constitutional right to abortion,² and to criminalize abortion in the United States. In 2019 alone, more than 300 restrictions on abortion access have been introduced in state legislatures.³ As anti-choice politicians continue their assault on abortion rights, it is necessary not only to defend against these attacks, but also to find avenues to protect and expand access to abortion care.

Medication abortion can be a key tool in this fight: It has the potential to bring abortion access to those who need it most—particularly people of color, low-income people, people in rural areas, and others who cannot easily access providers—and increase the range of options for abortion care, giving individuals greater agency over their health care decisions.

Separating myth from reality

Medication abortion, or abortion with pills, is an increasingly common method of abortion care early in pregnancy both in the United States and globally.⁴ It is safe, effective, and less invasive than a surgical procedure and gives people the option to have an abortion outside of a clinic setting in the comfort and privacy of their own homes. Yet despite the proven record and benefits of the medication abortion regimen, anti-choice groups continue to spew false claims about its safety.⁵ They spread fear and misinformation, feigning concern while jeopardizing women's health and undermining reproductive autonomy.

Misinformation and attacks on medication abortion are yet another aspect of the anti-choice movement's broader campaign to outlaw abortion outright. When abortion access is under attack, all people with the capacity for pregnancy suffer.

However, the reproductive health and rights of women of color, low-income women, women with disabilities, young women, women in rural communities and other hard-to-reach areas, and immigrant women are particularly vulnerable—as are the rights of those who have abortions who do not identify as women, including transgender, nonbinary, and intersex people.⁶ Getting the facts about medication abortion and lifting onerous and politically motivated restrictions can play a key role in expanding autonomy and access to abortion care throughout the United States.

As access to quality reproductive health care is under siege, it is crucial to recognize and correct the lies around medication abortion that anti-abortion groups have propagated in order to influence federal and state policies. Here, the authors detail the truth behind four myths about medication abortion as well as steps to bring policy in line with these realities.

Myth 1: Medication abortion is unsafe

Reality: The medication abortion regimen is used in the first 10 weeks of pregnancy and consists of two medications: mifepristone and misoprostol. Mifepristone is taken first, generally in a clinic or health center, followed by misoprostol one to two days later, usually at home.⁷ Mifepristone, the first of the two pills, has extremely low rates of adverse events and is safer than many medications, including Tylenol and Viagra.⁸ A 2018 comprehensive report from the National Academies of Science, Engineering, and Medicine (NASEM) affirms the safety of medication abortions.⁹ In addition, the report concludes that state laws restricting abortion care do not contribute to patient safety and, in fact, undermine the safety of the procedure, leading to delays in care and misinformation.

In 2016, after a thorough review of medical evidence, the U.S. Food and Drug Administration (FDA) revised the initial 2000 label for Mifeprex (mifepristone), extending the eligibility period from seven weeks' to 10 weeks' gestation and reducing the approved dosage from 600 mg to 200 mg.¹⁰ The update confirmed what many providers already knew: Mifepristone is equally as safe and effective in a lower dose. In March 2018, the U.S. Government Accountability Office (GAO) issued a report affirming that the FDA acted appropriately in revising the Mifeprex label in 2016,¹¹ despite anti-choice advocates' claims to the contrary.¹²

Despite the well-established safety of the medication abortion regimen, mifepristone remains much more heavily regulated than other prescription drugs as a result of the politicization of abortion care. The FDA has required a Risk Evaluation and Mitigation Strategy (REMS) for mifepristone. REMS requirements are meant to address specific safety concerns for drugs with high risks of serious adverse events such as opioids.¹³

The mifepristone REMS limits its distribution; providers must register to be permitted to distribute mifepristone, and it can only be distributed in hospitals, clinics, or medical offices.¹⁴ This means that under the REMS, mifepristone is not available at pharmacies and can only be prescribed by a limited number of providers, which significantly and unnecessarily restricts access to medication abortion—particularly for people who live far from a clinic or do not have an approved provider in their area. The American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) support lifting the REMS, as they are not medically necessary and, as former ACOG President Dr. Mark S. DeFrancesco explained, are “inconsistent with requirements for other drugs with similar or greater risks, especially in light of the significant benefit that mifepristone provides to patients.”¹⁵ Claims that medication abortion is unsafe contradict overwhelming evidence from the medical community and are designed to scare and confuse people seeking abortion care, thus undermining their right to make informed health care decisions and restricting their access to care.

Myth 2: Medication abortion can only be safely administered in person and by a physician

Reality: In 2015, the World Health Organization issued guidelines confirming that medication abortion pills can be safely administered by nonphysician health workers and, with the proper information and guidance, can be safely self-managed.¹⁶ Access to medication abortion has been regulated far beyond what is medically necessary for safe and successful abortion care. Thirty-four states require a licensed physician to prescribe abortion medications, meaning that skilled medical care providers such as nurse practitioners, midwives, and physician assistants cannot do so—even while they have the authority to prescribe other drugs, including controlled substances.¹⁷ Such laws contradict evidence from ACOG and NASEM that proves that these non-physician clinicians can safely and effectively provide medication abortion care.¹⁸

In addition to physician requirements, 17 states require medication abortions to be administered in person, effectively banning the use of telemedicine for medication abortions.¹⁹ Telemedicine has been influential in expanding access to care for hard-to-reach populations, particularly those living in rural areas,²⁰ and has been proven to be just as safe as in-person care for medication abortions.²¹ Allowing people to access medication abortion without traveling to a clinic or meeting with a physician broadens the options for people seeking abortion care. It expands access to those who do not have a nearby clinic or who are unable to travel and allows for greater autonomy over how and where to have an abortion.

Myth 3: Medication abortion is traumatic

Reality: Everyone experiences abortion differently, and those who have abortions are entitled to the full range of emotions about their experience. However, research and powerful personal storytelling indicate overwhelmingly that people do not regret their abortions. A 2015 study showed that more than 95 percent of women believed their abortion was the right decision—even if it was not an easy decision—both in the short term and years later.²² So-called post-abortion syndrome,²³ which anti-choice groups often point to as evidence of the traumatic effects of abortion, is not recognized by the American Psychological Association.²⁴ Moreover, decades of research have disproven the claim that abortion compromises mental health.²⁵

As for the physical experience of a medication abortion, most people report bleeding, nausea, cramping, and fatigue.²⁶ For many, these symptoms resemble those of a heavy period, and over-the-counter medications such as Ibuprofen are recommended for pain management.²⁷ Most people are able to resume normal activity within a day or two after a medication abortion.²⁸ Claims that medication abortion is a traumatic experience are nothing more than falsehoods designed to scare and intimidate people in need of abortion care;²⁹ they are myths perpetuated by anti-choice politicians and activists who demonstrate a contempt and derision for those seeking reproductive health care.

If there is any trauma involved in abortion care, it is the struggle of having to navigate unjust restrictions on abortion access and attacks from anti-choice protesters and politicians. The landmark Turnaway Study from Advancing New Standards in Reproductive Health (ANSIRH) provides evidence of this experience. The study found that while having an abortion was not associated with mental health issues, being denied a wanted abortion was associated with anxiety and low self-esteem in the short-term.³⁰ Abortion stigma is powerful, and for some, clinic settings can be challenging, particularly due to the barrage of harassment that patients may face from anti-choice protesters when entering a clinic. Furthermore, making arrangements around clinic appointments can be nearly impossible for those who have limited access to transportation or child care—a challenge that is further compounded by restrictions on access to abortion services. These restrictions include mandatory waiting periods, bans on insurance coverage, and medically unnecessary requirements that force clinics to close—which limit options for care.³¹ The option to end a pregnancy at home provides patients with greater access to care and prioritizes autonomy and comfort in the abortion experience.

Myth 4: Medication abortion is ineffective and reversible

Reality: Medication abortion is more than 95 percent effective³² and has been used safely in the United States for nearly two decades.³³ Although the two-drug protocol is recommended, misoprostol—the second medication—is about 75 percent to 90 percent effective in terminating an unplanned pregnancy when taken alone.³⁴ On the rare occasion that an unplanned pregnancy continues after both medications have been taken, physicians, in consultation with the pregnant person, will determine how best to proceed.³⁵ Sometimes, another dose of medication is needed. In other cases, the abortion will be completed in a health clinic or facility. Claims that the procedure is ineffective are meant to disrupt the doctor-patient relationship and manipulate reproductive health choices.

In April 2019, Oklahoma’s governor signed into law a bill that requires medical providers to provide medically dubious information about so-called “abortion reversal” to people having medication abortions or face felony charges.³⁶ In doing so, Oklahoma joined Arkansas, Idaho, Kentucky, Nebraska, South Dakota, and Utah, which have all adopted similar laws in recent years.³⁷ The medical community overwhelmingly agrees that claims of “abortion reversal” are unsupported by medical and scientific evidence.³⁸ Promoters of this myth claim that abortion may be reversed after mifepristone is taken as long as the second drug, misoprostol, is not taken and the hormone progesterone is administered throughout the first trimester.³⁹ However, this simply is not true. Furthermore, the notion that abortion can be reversed implies that those who choose to have abortions second-guess themselves and later regret the decision. In reality, people who have abortions take their reproductive health decisions seriously and, as previously discussed, almost universally do not regret the decision. These false claims represent a deep distrust of women and are insulting and dangerous.

Policy steps to improve access to medication abortion

On both the state and federal level, policymakers can take key steps to increase access to medication abortion and remove medically unnecessary restrictions. On the state level, legislators should lift restrictions on and affirm the availability of telemedicine for abortion care in order to bring access to rural and other communities that cannot easily access a provider. In addition, states should remove laws that only allow physicians to administer the medication abortion regimen, as these requirements restrict the supply of providers and contradict evidence that skilled nonphysician practitioners can safely provide medication abortion care. These state-level steps are important, yet without accompanying federal action, they would not be fully effective. On the federal level, the FDA should lift the unwarranted and politically driven REMS on mifepristone. These policy interventions would expand the availability of medication abortion, especially for communities that have historically experienced barriers to health care access and whose access to abortion is most restricted.

Conclusion

In the face of an anti-choice majority on the U.S. Supreme Court and a president who has said that women who have abortions should be punished,⁴⁰ it is more important than ever that state and federal policymakers take action to protect and expand access to abortion. Medication abortion is a proven safe and effective method that can significantly improve the availability and experience of abortion care. It is a powerful enabler of reproductive autonomy, allowing people to choose the abortion setting that is safest and most comfortable for them. To ensure access to this crucial health care option, we must put an end to the lies that undermine the health care decisions of all people seeking abortion care.

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