Society for Maternal-Fetal Medicine
High-risk pregnancy experts

SMFM Special Statement

smfm.org

Society for Maternal-Fetal Medicine Special Statement: A critical examination of abortion terminology as it relates to access and quality of care

Society for Maternal-Fetal Medicine (SMFM); Cara C. Heuser, MD, MS; Katelynn G. Sagaser, MS; Erika A. Christensen, BFA; Clark T. Johnson, MD, MPH; Justin R. Lappen, MD; Sarah Horvath, MD, MSHP; Reproductive Health Project Advisory Group

Legal, institutional, and payer policies regulating reproductive health care lack a shared language with medicine, resulting in great confusion and consternation. This paper critically examines the implications and ramifications of unclear language related to abortion care. Using a case-based approach, we highlight the ways in which language and terminology may affect the quality and accessibility of care. We also address repercussions for providers and patients within their team, institutional, state, and payer landscapes. In particular, we explore the stigmatization of abortion as both a word and a process, the role of caregivers as gatekeepers, the implications of viability as a limit for access, and the hierarchy of deservedness and value. Recognizing the role of language in these discussions is critical to building systems that honor the complexities of patient-centered reproductive decision-making, ensure access to comprehensive reproductive health care including abortion, and center patient autonomy. Healthcare providers are uniquely positioned to facilitate institutional, state, and national landscapes in which pregnant patients are supported in their autonomy and provided with just and equitable reproductive health care.

Key words: elective abortion, genetic counseling, induced abortion, maternal-fetal medicine, perviability, pregnancy termination

Introduction

The medical literature is unequivocal, and no dispute exists within the medical community: abortion care is an essential component of comprehensive reproductive health care, and access to such care reduces pregnancy-related morbidity and mortality.[1–4] Thus, abortion care is life-saving and life-sustaining. The 2022 Supreme Court of the United States decision in *Dobbs v. Jackson Women's Health Organization*[5] (hereafter referred to as "*Dobbs*"), which returned all regulation of abortion care to individual states, resulted in over 75 major professional medical organizations[6] releasing or joining statements in support of unrestricted access to abortion care. These organizations include, but are not limited to, the American Medical Association, Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists (ACOG), Society of Family Planning, American Academy of Family Physicians, and American Academy of Pediatrics.

Corresponding author: Society for Maternal-Fetal Medicine. RHProject@smfm.org

Although evidence regarding the safety of abortion[7] and the importance of access to it is clear,[1–4] legal and institutional policies regulating reproductive health care lack a shared language with medicine, resulting in great confusion and consternation. Critically, the lack of standardized language and terminology regarding abortion within the medical, legal, and policy arenas negatively influences abortion care provision, access, and ethics, and has provided a landscape for euphemisms and stigmatization to flourish. In addition, the lack of linguistic clarity has resulted in a national landscape in which medical practice responds to law and policy rather than an environment in which evidence-based medicine and patient-centered care are paramount. *Dobbs*[5] has added additional urgency to these discussions as state laws criminalizing abortion care become widespread and leave providers and institutions hesitant to provide care and vulnerable to litigation, which may limit access to a broad range of reproductive services. Furthermore, linguistic challenges complicate the physician-patient relationship; are a barrier to the provision of patient-centered, evidence-based reproductive health care; and hinder goals of achieving reproductive justice.

Using a case-based approach, we explore the ramifications of abortion care language by clinical care teams, patient advocates, hospital policy makers, and legislators. We highlight the ways in which language and terminology may affect the quality and accessibility of care for patients within referral networks and institutional, state, and payer landscapes. These scenarios are hypothetical examples with myriad variables, permutations of which perinatologists and other clinicians may experience many times in training and practice. By raising awareness of these challenges, we aim to encourage candid examinations of the ways in which we communicate, and universal adoption of precise abortion care terminology to build systems of care that honor the complexities of reproductive decision-making and ensure access to comprehensive reproductive health care for all patients.

The "A" word: definition and stigmatization of the word "abortion"

A nullipara presents with HELLP syndrome at 21 weeks and 6 days of gestation. The patient is counseled on her options of continuing vs terminating the pregnancy by either dilation and evacuation (D&E) or induction of labor. She wishes to proceed with induction of labor. Tearfully, the patient asks if this "counts" as an abortion.

Discussion

In any attempt to discuss the nuances of language and terminology, it is prudent to begin with a definition of terms. ACOG reVITALize,[8] endorsed by many national organizations, defines induced abortion as "an intervention intended to terminate a pregnancy so that it does not result in a live birth." Although the authors will use this as a working definition, we consider it vital to note that some families choose to terminate their pregnancy through induction of labor without a feticidal agent. Such a decision may be specifically made to allow the possibility of a live birth accompanied by comfort care. The definition of abortion should include this course of care.

In this scenario, the patient's concern is driven by the stigmatization of medical terms, particularly the social and legal associations of the word "abortion," which amplify the stress, grief, helplessness, and blame that pregnant individuals in these situations may feel.[9,10] A patient is unlikely to ask if their surgery "counts" as an appendectomy, nor are they likely to contemplate family member, peer, and community perceptions regarding their care. Furthermore, clinicians are not immune to the influence of particular word choices, and given the stigma of "abortion," team members may refuse to participate in medically appropriate care.[11,12] In addition to increasing the risk of adverse outcomes and adding additional burden to the patient, this fragmentation of interdisciplinary teams may have a chronic detrimental effect on unit culture, hindering the development of highly-functioning, coordinated teams that ensure obstetrical quality and safety.[13,14]

Stigma does not stop at the individual encounter level. Terminology may make the literal difference between a patient receiving or not receiving necessary care. Many states now have statutes that prohibit abortion access except in very narrow and often ill-defined circumstances. Others restrict certain procedures or indications, set arbitrary gestational age limits, create medically unnecessary hurdles and barriers to seeking care, and require physicians to provide medically inaccurate counseling.[15] Laws often do not use medically accurate terminology. For example, Utah defines abortion as "the intentional termination or attempted termination of a human pregnancy through a medical procedure carried out by a physician or through a substance used under the direction of a physician."[16] By this statute, even induction of labor or cesarean delivery at term with the plan of live birth and neonatal survival would meet the definition of abortion. Policy makers assume that we all "know" what is meant by the term abortion, although legal definitions vary widely, do not reflect medical reality, and are inconsistently applied. The dangers of political commandeering of medical terms are gaining attention in the lay press.[17] Medical experts have an opportunity to contribute to and lead this conversation in a way that prioritizes patients and centers autonomy.

Even among medically accurate terms, definitions are not mutually exclusive. As in the case above, an intervention may be an abortion *and* an induction of labor. In a world free from legislative interference, the care team could choose to use the terms most preferred by the patient because the distinctions are irrelevant to the provision of care. In the post-*Dobbs* era, however, these false and legally contrived distinctions are elevated to critical importance.

Abortion stigma endangers maternal health[18]; undermines the medical mission of safe and comprehensive reproductive health care; and leads directly to decreased access, acceptance, and training in the care of patients experiencing pregnancy loss or needing abortion care.[19] When language is both stigmatized and stigmatizing, it leads to the production of euphemisms and alternate terminology, further reinforcing stigma, and ultimately leading to patient harm.

Recommendation

Clinicians, advocates, and policy makers should recognize that definitions of medical terms used in abortion care are not mutually exclusive and that legal and social terms do not directly correlate to specific medical care or reflect the nuances inherent therein. Clinicians should recognize, openly discuss, and work to dismantle abortion stigma with patients, team members, and institutional leadership. Caregivers have an ethical obligation to provide medically necessary and appropriate care within the scope of their training and competency. Institutional or legal restrictions that preclude provision of this care should prompt immediate referral and efforts to dismantle such restrictions.

Gatekeepers: the clinician's role in abortion access

A 26-year-old at 21 weeks and 0 days of gestation presents for confirmation of a suspected fetal central nervous system anomaly. The patient is healthy, self-pays for all care, and has chosen to terminate the pregnancy. Institutional policy permits abortion for "lethal" fetal anomalies only and requires maternal-fetal medicine (MFM) physician approval. The MFM physician reviews all images, documents a "life-limiting" condition, and orders a fetal magnetic resonance imaging (MRI) scan to confirm a "lethal" diagnosis. The MRI costs this patient an additional $1000 out-of-pocket and confirms the diagnosis. The patient undergoes D&E.

Discussion

Physicians find themselves in an untenable position, whereby the language used in diagnostic interpretation, counseling, and documentation has outsized effects on the patient's access to care and its cost. Although the role of medical professionals as legal and institutional gatekeepers to abortion access is largely undesired and unsought, caregivers, in particular MFM subspecialists, often find themselves as the formal or informal gatekeepers to abortion care.[20,21] The terminology that physicians use in clinical practice may affect whether a patient can receive abortion care according to state laws and institutional policies and whether such care is covered by insurance.

Many states restrict the provision of abortion care to particular maternal or fetal diagnoses, with physicians who provide abortions outside those narrow exceptions facing loss of licensure and felony charges.[22–25] Similarly, insurance policies may cover, or health institutions allow, abortion only in a narrow set of circumstances, if at all. Individuals with federal insurance, including Medicaid, are subject to the Hyde Amendment,[26] which prohibits coverage for abortion except in rare circumstances that lawmakers have deemed politically expedient (currently limited to rape, incest, and maternal life endangerment). Coverage may correlate with specific billing codes and/or a letter of medical necessity. The limitations imposed by insurance,[27] institutions, and states may not align, further complicating a patient's ability to obtain care.

Some common exceptions, when any exist, are endangerment of maternal life or health and "lethal" fetal anomalies, each of which is subject to a physician's discretion and tolerability of risk. These exceptions may hinge on the physician's interpretation of ambiguous or subjective criteria, and hospital administrators and courts can challenge even good-faith determinations. Legal, institutional, and insurance policies are often written in concrete terms that demand diagnostic or prognostic certainty at odds with medicine, which is appropriately accustomed to probabilities and uncertainty. Such restrictions fail to account for the range of prognoses that accompany many fetal diagnoses and maternal medical conditions, and the complexities of mental health, psychosocial circumstances, and disparities in access to care.[28] This range of prognoses can only be fully contextualized within the unique life circumstances of the individual patient by that person themselves, in consultation with trusted family, community, and caregivers. Enshrining physicians as gatekeepers within the law infantilizes patients and reduces their autonomy. As the case illustrates, such restrictions may also cause harm by adding cost and delaying care.

The language used in clinical documentation further embeds physicians in the role of gatekeepers to abortion care while simultaneously constraining their ability to offer care to some patients. It has been noted that MFM and complex family planning-trained physicians preferentially use the terms "pregnancy termination" and "abortion care," respectively. Other confusing and inaccurate terms have been described, including elective, therapeutic, medically-indicated, nonmedically indicated, and voluntary.[29,30] Multiple terms may be medically accurate for a given encounter (eg, induction of labor and medically induced abortion), yet the language used in documentation often determines access to and coverage for care. Although semantic differences may have little or no impact on care provision itself, word choice may dictate the patient's legal, institutional, or financial ability to access it. On a policy level, using differential language to describe care reinforces abortion stigma, enabling legislation that limits patient options. Physicians, then, occupy the unenviable position of potentially limiting options for future patients when advocating for any individual patient. In essence, harm reduction efforts that prioritize the present patient may also make future care provision for others more difficult.

Legal and regulatory policies that force clinicians to gatekeep abortion care are anathema to a therapeutic physician-patient relationship and the fundamental concepts of autonomy and consent. In addition, these policies neglect the prognostic ambiguity intrinsic to science and ignore the nuances inherent to the art of medicine.

Recommendations

Providers may find themselves unwillingly positioned in gatekeeper roles by legal and institutional frameworks. Qualified healthcare providers should be free to discuss a wide range of prognoses when they exist and to support patients in making individualized decisions that reflect their own risk tolerance and circumstances. We recommend working to dismantle restrictive policies that place clinicians in the position of abortion care gatekeepers in favor of policies that center pregnant patients as decision-makers.

Shifting sand: the implications of "viability" as a standard

A 32-year-old at 24 weeks and 0 days of gestation presents with preterm premature rupture of membranes, anhydramnios, severe fetal growth restriction with an estimated

fetal weight of 300 g, and critically abnormal umbilical artery Doppler studies. After comprehensive counseling, she chooses induction of labor without fetal monitoring or neonatal resuscitation. Other unit staff members object and state that because the clinical care plan is a "post-viability abortion," they will not be able to participate in this patient's care. The physician leaves the conversation confused, having felt that a patient-centered, appropriate care plan was achieved through the shared decision-making process.

Discussion

Before the recent *Dobbs* decision, the federal framework for protecting abortion access incorporated the concept of "fetal viability" as the point before which abortion was a fundamental right.[31] Thus, this term has been important in abortion discussions and policy, despite the discordance between legal language and medical reality. The semantics surrounding this complex space of periviability, which rests at the nuanced intersection of obstetrical and neonatal care, have substantial implications.

Although some advocates fight to preserve the right to abortion before "viability," we must also note the nebulous and dynamic nature of the term. As this case illustrates, the likelihood of any fetus surviving the transition to extrauterine life is ultimately an estimate based on numerous factors, including but not limited to gestational age, fetal size, health system capabilities, and other fetal or maternal comorbidities.[32,33] Furthermore, with increased knowledge and improved technologies, prognoses will change. Individual success stories in the care and treatment of conditions long deemed life-limiting or at extremes of gestational age should embolden patients to expect comprehensive counseling on the complete spectrum of perinatal possibilities. Clinicians are accustomed to considering probabilities, outliers, and risk-benefit calculations but may struggle to communicate outcome ranges to patients. Physicians are then forced into the precarious position of arbiter between patients' variable tolerance for risk and unyielding policies restricting access to care.

Although "viability" has been the foundation of many legal and regulatory frameworks and has often been a focus of efforts to defend the right to abortion,[34,35] this imprecise concept is a troublesome cornerstone on which to base access to care. An argument in the recent *Dobbs* decision centered around the idea that if viability is a poor standard, any arbitrary gestational age will do. The authors wish to be clear that our conclusion is the exact opposite: neither "viability" nor any particular gestational age estimate can adequately demarcate the complex and unpredictable process that is human development. The decision to terminate a pregnancy does not belong within the realm of legislation or dogmatic policy. These decisions require a nuanced consideration of individual circumstances and values rather than an inflexible and uniform legislative approach.

Recommendation

We recommend that medical caregivers use appropriate medical terms that promote empathetic, patient-centered care for periviable complications. Similar to recent changes from ACOG,[1] we recommend against the use of potential viability as a threshold to place restrictions on abortion care. Advocates and caregivers should recognize that *any* dogmatic legal approach presumes a certainty that rarely exists in medicine. If potential fetal viability must be used as a standard for accessing abortion care, it should not be defined solely by gestational age, but instead considered within the comprehensive maternal and fetal medical circumstances for each pregnancy. We recommend a patient-centered approach to care that incorporates obstetrical, medical, and contextual risk factors and a patient's desire to be pregnant into a shared decision regarding the continuation or termination of pregnancy.

Equitable access: hierarchy of deservedness and value

The genetic counseling team at an academic medical center must bring the cases of patients requesting abortion care after 22 weeks of gestation to the institution's ethics committee, composed of clinicians, lawyers, and community members. Three cases are presented today, as follows:

- A 26-year-old, G2P0010, Black, married female with commercial insurance at 23 weeks and 3 days of gestation has a new suspected fetal diagnosis of thanatophoric dysplasia. Continuation of pregnancy is expected to be complicated by the accelerated growth rate of the fetal head, which may necessitate a primary cesarean delivery for an infant anticipated to die neonatally from respiratory insufficiency. The patient has expressed a desire to spare her infant from any pain.
- A 19-year-old, G1P0, White, single trans male has a newly-identified pregnancy at 23 weeks and 0 days of gestation. He is employed at 2 minimum-wage positions, attends classes at the local community college, shares the rent of a small home with 4 roommates, and does not have health insurance. He has had no prenatal care. Continuation of pregnancy risks the possibility of extreme poverty, loss of safe housing, and pregnancy-induced gender dysphoria.[36–38]
- A 46-year-old, G8P6016, Latina female with state Medicaid learned of her pregnancy during yesterday's gynecologic visit, scheduled to evaluate for menopause. Four of the patient's children live in Honduras with family members, whereas the other two, both born in the United States, have significant physical and developmental needs and require her attention as a full-time caregiver. The patient is in the process of divorce from an abusive partner against whom she is attempting to obtain a restraining order. Her dates are consistent with 23 weeks and 1 day of gestation. Continuation of

pregnancy risks the possibility of continued abuse and significant strain on already limited resources.

Discussion

Differences in terminology create a "deservedness hierarchy" that determines which patients, clinical situations, or diagnoses are found to be deserving of abortion care. The use of qualifiers such as "elective," "therapeutic," or "medically indicated" suggests that to earn institutional or societal approval for abortion care, the desire and decision for abortion must appear to be out of a person's control or reasonable best wishes. If clinicians agree that a patient's autonomy is paramount, "elective" abortion is an unnecessary term because all abortions are equally worthy, appropriate, and necessary.[39]

Within the practice of medicine, the ethical principle of justice must reflect not only fairness and equality but also access. Rhetoric promoting deservedness hierarchies in accessing abortion care protects neither the pregnant person nor the fetus. Instead, these linguistic tools, subtly disguised as empathetic language, serve as proxies for much more explicit shaming of exercising bodily autonomy. The most egregious flaw of categorizing diagnoses is the removal of a patient's agency in determining which pregnancy circumstances are acceptable for them within their individual life circumstances. Although vague language and euphemisms may be used to protect abortion access for medically complex cases, this very same language causes widespread harm by failing to center the autonomy of the pregnant individual within the unique circumstances of each case.

Recommendation

Frameworks that create deservedness hierarchies perpetuate stigma and create unjust barriers to abortion care. We recommend that clinicians work to dismantle deservedness hierarchies and systems that unjustly discriminate on the basis of indication for abortion care and center the decision-making autonomy of the pregnant individual. All abortions are either spontaneous or induced and either medication or procedural.

Conclusion

The role of language in reproductive health care will become more pronounced as the legal landscape continues to evolve following the *Dobbs* decision. Ambiguous and inconsistent language used within restrictive legal and institutional policies obfuscates the provision of evidence-based, patient-centered, comprehensive reproductive health care. It is imperative to remain thoughtful and informed about the implications of language in abortion care. Candid examinations of the ways in which we communicate, and the universal adoption of precise abortion care terminology are critical for building systems that honor the complexities of reproductive decision-making and ensure access to comprehensive reproductive health care for all patients. Through education and advocacy, we hope that health professionals can facilitate institutional, state, and national landscapes in which pregnant patients are supported in their autonomy and provided with just and equitable reproductive health care.

ACKNOWLEDGMENTS

The authors would like to thank Jessie Hill, JD and Skye Perryman, JD for legal expertise, and Helena Hernandez, MPH and Alicia Luchowski, MPH for helping to finalize and guide this project.

REFERENCES

1. American College of Obstetrics and Gynecology. Statement of abortion policy. Revised and approved May 2022. Available at: https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy. Accessed January 4, 2023.

2. Addante AN, Eisenberg DL, Valentine MC, Leonard J, Maddox KEJ, Hoofnagle MH. The association between state-level abortion restrictions and maternal mortality in the United States, 1995-2017. Contraception 2021;104:496–501.

3. Vilda D, Wallace ME, Daniel C, Evans MG, Stoecker C, Theall KP. State abortion policies and maternal death in the United States, 2015-2018. Am J Public Health 2021;111:1696–704.

4. Okonofua F. Abortion and maternal mortality in the developing world. J Obstet Gynaecol Can 2006;28:974–9.

5. Dobbs vs Jackson Women's Health Organization, vol. 19—1392. United States of America; 2022: 597. Available at: www.oyez.org/cases/2021/19-1392. Accessed January 4, 2023.

6. American College of Obstetricians and Gynecologists news release July 7, 2022. More than 75 health care organizations release joint statement in opposition to legislative interference. Available at: https://www.acog.org/news/news-releases/2022/07/more-than-75-health-care-organizations-release-joint-statement-in-opposition-to-legislative-interference. Accessed January 4, 2023.

7. Raymond EG, Grimes DA. The comparative safety of legal induced abortion and childbirth in the United States. Obstet Gynecol 2012;119:215–9.

8. The American College of Obstetricians and Gynecologists. ReVITALize: gynecology data definitions. Available at: https://www.acog.org/en/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions. Accessed April 5, 2022.

9. Kumar A, Hessini L, Mitchell EMH. Conceptualising abortion stigma. Cult Health Sex 2009;11:625–39.

10. Seewald M, Martin LA, Echeverri L, Njunguru J, Hassinger JA, Harris LH. Stigma and abortion complications: stories from three continents. Sex Reprod Health Matters 2019;27:1688917.

11. Guttmacher Institute. Refusing to provide health services. Available at: https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services. Accessed April 5, 2022.

12. Fleming V, Frith L, Luyben A, Ramsayer B. Conscientious objection to participation in abortion by midwives and nurses: a systematic review of reasons. BMC Med Ethics 2018;19:31.

13. Harris LH, Martin L, Debbink M, Hassinger J. Physicians, abortion provision and the legitimacy paradox. Contraception 2013;87:11–6.

14. The American College of Obstetricians and Gynecologists. Collaboration in practice: implementing team-based care. Available at: https://www.acog.org/en/clinical/clinical-guidance/task-force-report/articles/2016/collaboration-in-practice-implementing-team-based-care. Accessed April 5, 2022.

15. Guttmacher Institute. State legislation tracker. Available at: https://www.guttmacher.org/state-policy. Accessed October 7, 2022.

16. Utah SB 174. Abortion prohibition amendments. SB0174. Available at https://le.utah.gov/2020/bills/static/sb0174.html. Accessed January 4, 2023..

17. New York times. What does 'abortion' mean? Even the word itself is up for debate. Available at: https://www.nytimes.com/2022/10/18/us/abortion-roe-debate.html. Accessed December 2, 2022.
18. Harris LH. Stigma and abortion complications in the United States. Obstet Gynecol 2012;120:1472–4.
19. Weigel G, Sobel L, Salganicoff A. Criminalizing pregnancy loss and jeopardizing care: the unintended consequences of abortion restrictions and fetal harm legislation. Womens Health Issues 2020;30:143–6.
20. Zeldovich VB, Rocca CH, Langton C, Landy U, Ly ES, Freedman LR. Abortion policies in U.S. teaching hospitals: formal and informal parameters beyond the law. Obstet Gynecol 2020;135:1296–305.
21. Kavanaugh ML, Jerman J, Frohwirth L. "It's not something you talk about really": information barriers encountered by women who travel long distances for abortion care. Contraception 2019;100:79–84.
22. Texas SB | 2021-2022 | 87th Legislature. LegiScan. 2022. Available at: https://legiscan.com/TX/text/SB8/id/2395961. Accessed April 5, 2022.
23. NPR. With little discussion, Oklahoma passes a bill to make most abortions illegal. Available at: https://www.npr.org/2022/04/05/1091119507/oklahoma-legislature-abortion-illegal. Accessed April 5, 2022.
24. Office of the Arizona governor. Governor Ducey signs common sense legislation to maintain fairness in school athletics, protect children and affirm life. Available at: https://azgovernor.gov/governor/news/2022/03/governor-ducey-signs-common-sense-legislation-maintain-fairness-school. Accessed April 5, 2022.
25. Elliott D, Wamsley L. Alabama governor signs abortion ban into law. NPR. 2019. Available at: https://www.npr.org/2019/05/14/723312937/alabama-lawmakers-passes-abortion-ban. Accessed April 5, 2022.
26. KFF. The Hyde amendment and coverage for abortion services. Available at: https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/. Accessed April 5, 2022.
27. Guttmacher Institute. Regulating insurance coverage of abortion. Available at: https://www.guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion. Accessed April 5, 2022.
28. Society for Maternal-Fetal Medicine. Access to abortion services: an official position statement of the Society for Maternal-Fetal Medicine. Available at: https://s3.amazonaws.com/cdn.smfm.org/media/2418/Access_to_Abortion_Services_(2020).pdf. Accessed April 5, 2022.
29. Smith BEY, Bartz D, Goldberg AB, Janiak E. "Without any indication": stigma and a hidden curriculum within medical students' discussion of elective abortion. Soc Sci Med 2018;214:26–34.
30. Janiak E, Kawachi I, Goldberg A, Gottlieb B. Abortion barriers and perceptions of gestational age among women seeking abortion care in the latter half of the second trimester. Contraception 2014;89:322–7.
31. Planned Parenthood of Southeastern Pennsylvania v. Casey; Oyez. 1992. Available at: https://www.oyez.org/cases/1991/91-744. Accessed April 5, 2022.
32. Periviable birth. Available at: https://www.acog.org/en/clinical/clinical-guidance/obstetric-care-consensus/articles/2017/10/periviable-birth. Accessed April 5, 2022.
33. National Institutes of Health. Extremely preterm birth outcomes tool. 2022. Available at: https://www.nichd.nih.gov/research/supported/EPBO. Accessed April 5, 2022.
34. H.R.3755 - Women's health protection act of 2021. Available at: https://www.congress.gov/bill/117th-congress/house-bill/. Accessed April 5, 2022.
35. Millhiser I. Democrats have a high-risk, high-reward plan to save Roe v. Wade. Vox. 2021. Available at: https://www.vox.com/20930358/codify-roe-wade-womens-health-protection-act-supreme-court-nancy-pelosi-democrats. Accessed April 5, 2022.
36. Ennis D. The poorest among us. Available at: https://www.forbes.com/sites/dawnstaceyennis/2020/12/30/the-poorest-among-us-1-in-4-lgbt-southerners-live-in-poverty/. Accessed April 5, 2022.
37. NorthWestern Now. Texas abortion ban will likely 'disproportionately impact trans and marginalized people.'. Available at: https://news.northwestern.edu/stories/2021/september/texas-abortion-trans-marginalized-people/. Accessed April 5, 2022.
38. The Disproportionate Harm of Abortion Bans: spotlight on Dobbs v. Jackson Women's Health. Center for Reproductive Rights. 2021. Available at: https://reproductiverights.org/supreme-court-case-mississippi-abortion-ban-disproportionate-harm/. Accessed April 5, 2022.
39. The American College of Obstetricians and Gynecologists. ACOG guide to language and abortion. Available at: https://www.acog.org/contact/media-center/abortion-language-guide. Accessed October 22, 2022.

All authors and Committee members have filed a disclosure of interests delineating personal, professional, business, or other relevant financial or nonfinancial interests in relation to this publication. Any substantial conflicts of interest have been addressed through a process approved by the Society for Maternal-Fetal Medicine (SMFM) Board of Directors. SMFM has neither solicited nor accepted any commercial involvement in the specific content development of this publication.

This document has undergone an internal peer review through a multilevel committee process within SMFM. This review involves critique and feedback from the SMFM Reproductive Health Project Advisory Group and Document Review Committee and final approval by the SMFM Executive Committee. SMFM accepts sole responsibility for the document content. SMFM publications do not undergo editorial and peer review by the *American Journal of Obstetrics & Gynecology*. The SMFM Reproductive Health Project Advisory Group reviews publications every 36 to 48 months and issues updates as needed. Further details regarding SMFM publications can be found at www.smfm.org/publications.

The SMFM recognizes that obstetrical patients have diverse gender identities and is striving to use gender-inclusive language in all of its publications. SMFM will be using terms such as "pregnant person" and "pregnant individual" instead of "pregnant woman" and will use the singular pronoun "they." When describing study populations used in research, SMFM will use the gender terminology reported by the study investigators.

Reprints will not be available.