Abortion Malpractice: When Patient Needs and Abortion Practice Collide

In contemporary American life, legal remedy for harm or injury resulting from substandard or negligent medical care is commonplace. Too often the only arbiter between the needs and rights of the patient and the adequacy and standards of the health care services provided is medical malpractice litigation.

Because litigation mirrors contemporary social conflict, it provides an intense arena in which to scrutinize highly volatile issues. Nowhere is this more evident than in the fierce political controversy surrounding reproductive rights and induced abortion. “The heat of the conflict tends to melt the boundaries between demonstrated fact and personal belief.”1 Resistance to the reality that some women and men are psychologically injured as a result of an elective abortion is considerable, both in the courtroom and out.

Not all women who elect abortion have a traumatic response. Nor however is abortion such a benign psychological experience that women should be misinformed about its significant emotional risks for some individuals. The fact is, insufficient scientific data is available in this country to conclusively determine how many women and men are negatively impacted by abortion and which types of individuals are at risk compared to other possible alternatives. Though existing research has identifiable methodological weaknesses, in the aggregate, these studies suggest a direction of harm and a significant percent of individuals likely to be negatively impacted from elected abortion.

Recent publications in peer-reviewed professional journals have also documented the psychological risks of induced abortion: Rue, 19862; Hittner, 19873; Zakus & Wilday, 19874; Campbell, Franco & Jurs, 19885; Ney & Wickett, 19896; Rogers, Stoms & Phifer, 19897; DeVeber, Azjenstat & Chisholm, 19918; Rogers, 19919; El-Mallakh & Tasman, 199110; Rue & Speckhard, 199111; Angelo, 199212; Speckhard & Rue, 199213; Kosentfeld, 199214; Franz & Reardon, 199215; Speckhard & Rue, 199316; Congleton & Calhoun, 199317; Bagarozzi, 199318; Bagarozzi, 199419; and Ney, 199420.

With increased recognition of the psychological harm abortion can cause some women, it is not surprising that more and more women are filing abortion malpractice suits in the U.S.21 This article will address the underlying reasons for these cases, provide a profile of a typical plaintiff from our experience, and will offer rec-
ommendations that might better protect women from harm if they are considering an abortion. Awareness of these factors might indeed be pivotal to not only prevent postabortion injury, but also to decrease the necessity for litigation afterwards.

The Nature of the Abortion Decision

The abortion decision is a unique one, complex in nature, necessitating due deliberation and the evaluation of considerable information, some of which may be emotionally trying. The U.S. Supreme Court has ruled: (1) "Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of potential life." Harris v. McRae, 448 U.S. 297, 325 (1980); (2) that the decision whether or not to abort should be made "in light of all circumstances - psychological and emotional as well as physical - that might be relevant to the well-being of the patient." Planned Parenthood v. Danforth 428 U.S. 52, 66 (1976); and (3) that the "medical, emotional and psychological consequences of an abortion are serious and can be lasting..." H.L. v. Matheson 450 U.S. 411 (1981).

Because of the medical, moral, societal and psychological controversies surrounding abortion, some states are now insisting that reasoned and deliberate abortion decision making be legally mandated. In particular, women's right to know laws have been enacted that precisely determine the content of information and the timing as to when information should be made available before an abortion may be performed.22

In the United States today, the following elements of informed consent have been mandated in a number of states: (1) the medical risks associated with pregnancy termination; (2) the probable gestational age of the unborn child; (3) the alternative risks associated with carrying to term; (4) the medical assistance benefits if childbirth were elected; (5) the father's liability for financial assistance; (6) the opportunity to review printed information descriptive of fetal development; and (7) some waiting period for deliberation, usually 24-48 hours. Additionally, a number of states now have parental consultation statutes requiring minors seeking abortions to involve their parents in their decision making. This is to protect the adolescent from making a secret and hasty abortion decision and to insure that her decision is truly informed and voluntary.

"the decision whether or not to abort should be made in light of all circumstances - psychological and emotional as well as physical..."

These informed consent requirements are additive in nature, insuring the woman has more rather than less information. These requirements do not appear to restrict the patient's decision making capacity - they enhance it. If information regarding abortion alternatives is conspicuously absent in the "counseling process", it is not possible for a woman to weigh the benefits and risks of electing an abortion. Indeed, if informed consent is not obtained prior to an abortion, then grounds for medical malpractice litigation are warranted. Because the doctrine of informed consent is well established, courts and legislatures have consistently required physicians to provide a minimum of information to the patient prior to making a decision regarding treatment. This information is generally composed of a determined diagnosis, reasonable prognosis, the risks and benefits of proposed treatment and non treatment, all of which should be provided in terms that the patient can comprehend. In abortion malpractice cases, serious breaches in these standards of care have been identified and litigated.

The "Typical" Plaintiff

In numerous cases in which we have either evaluated the patient, testified as expert witnesses, or consulted generally on a case, it is apparent to us that most plaintiffs have a number of factors in common.

First, most were between 22 and 35 years of age, unmarried and experienced both physical and emotional injuries postabortion.

Second, most did not receive preabortion counseling, or if they did, it was so deficient as to be meaningless to the plaintiff at the time of the abortion.

Third, most of these women remembered signing informed consent forms but did not read them or understand them.

Fourth, most were not given options counseling nor the opportunity to ask questions pri-
vately.

Fifth, most had four to eight predisposing risk factors to postabortion trauma that were unacknowledged or unexplored at the abortion clinic or minimized by either the abortion counselor or the physician.

Sixth, most experienced the staff and abortion provider as insensitive to their special circumstances or emotional state.

Seventh, most felt ill-prepared for the emotional traumatization postabortion and deceived by the abortion counselor regarding the developmental characteristics and humanity of the fetus.

Eighth, most plaintiffs have suffered serious and significant emotional injury that has negatively impacted their primary relationships, subsequent parent-child interactions, and resulted in lowered self-esteem, the use of dysfunctional coping mechanisms (drinking, drugs, food, avoidance behaviors, emotional numbing) and experienced posttraumatic decline in overall functioning.

Ninth, most of these women had first trimester abortions.

Tenth, most of these women had some preexisting psychosocial stressors, most were competent and functioning individuals in society prior to their abortion traumatization.

The following cases are presented here by way of example of the degree and variance of postabortion emotional injury.

Case One

D. had a first trimester abortion to hide the fact that she was having sex with someone other than her mate. She felt she had no other choice. She did not receive any preabortion counseling. After the procedure she found herself thinking about the abortion hundreds of times during the day. When she had her menstrual period, she would save whatever blood clots that passed into the toilet and place them in glass bottles every month. She hoped for another pregnancy both as an attempt to “undo” the abortion and to “replace” her lost child. In addition, she had nightmares and suffered from depression and unrelenting guilt.

“I looked down and it had two eyes, the formation of a nose and a mouth.”

Case Two

M. had a first trimester abortion. She recounted she had approximately 5 minutes of preabortion counseling. After the abortion she returned to the abortion clinic for her follow-up visit. She reported that she was continuing to bleed and that the pain was severe. In her own words: “They wouldn’t listen to me. They told me there was nothing wrong except rectum strain. I told them that I couldn’t sleep and they gave me Halcion. I think they just wanted me to die in my sleep.” For the next three months this woman suffered significant physical and psychological trauma since her incomplete abortion. She had unrelenting pain, diarrhea, and kept smelling something rotten coming from her vagina. She continued bleeding. She felt she was going crazy because the smell was intermittent and the pain was overwhelming. Her mate discounted her feelings and called her names. The experience finally culminated in an emergency D&E abortion at which time a fetal corpse was identified in her cervix and was removed.

Case Three

G. had a first trimester abortion. During preabortion counseling she stated that she asked if this was a baby and her counselor assured her it is just a clump of tissue. Shortly thereafter she went home and took a shower. Afterwards she felt something strange and looked down at the bathroom floor: “I looked down and it had two eyes, the formation of a nose and a mouth: the rib cage was sticking out. It was all broken up. You could even see an arm. You could just see what it was.” In her shock and panic, she quickly picked it all up and took it into the kitchen and put in the cupboard. Then she just started to shake and cry.

Known Deficiencies of Abortion Counseling

The two most common causes of action in abortion malpractice are: (1) negligence in evaluating/screening a patient preabortion; and (2) lack of informed consent which constitutes battery. Because abortion is a medical procedure, legally it is the physician’s duty to evaluate, counsel and assess the patient beforehand.

Current abortion clinic practices severely limit physician-patient contact and instead preabortion counseling is most typically delegated to the physician’s agent, i.e., the abortion counselor. Nevertheless, it is the physician who actually performs the abortion, and it is always his/her ultimate responsibility to (a) protect the patient’s health; (b) to see to it that the patient’s decision is firm, freely made, and duly thoughtful; and (c) that her consent is truly informed.
The Abortion Counselor

Abortion counseling in most countries suffers from obvious and serious conflicts of interest and procedural inadequacies. Abortion counseling between physician and patient is largely nonexistent. Instead, the patient is “counseled” by someone other than a physician, i.e., his agent, who most typically is not professionally trained and who receives “on the job training.” In the U.S., abortion counselors as a “profession” are unlicensed and are unregulated in 95% of the states. “Professional background is considered less important than such personal attributes as warmth, caring, empathy and a commitment to the pro-choice cause.”24

Counselor bias can clearly be a negative force in the counseling process, particularly if the situation is compounded by a conflict of interest, i.e. pecuniary benefit in the outcome, namely, abortion.

All too often the abortion counselor has only a high school diploma, has herself had one or two abortions and feels compelled to assist others by affirming the abortion decision. She thereby affirms her own decision, unknown to her and her client. Because she may be in denial about the emotional after effects of her own abortion, she is either unaware of postabortion emotional trauma, or is simply uninformed.

During the course of one abortion malpractice trial, it became known that one of the clinic’s abortion counselors worked two days at the clinic and the remainder of her work week as a bartender at a “biker’s bar”. Another abortion counselor responded at her deposition when asked when human life began: “it begins at birth”. Sadly, this kind of counselor and counseling may be more normative than the exception.

Abortion counselors as a “profession” are unlicensed and are unregulated in 95% of the states.

Duration of Preabortion Counseling

Contemporary abortion counseling is so time limited and volume oriented as to be impossibly tailored to the unique needs and circumstances of the individual patient. Indeed, thorough, thoughtful, and deliberative pregnancy outcome decision making is handicapped by existing abortion counseling procedures.

Several empirical studies in the U.S. have indicated the deficiencies of current abortion counseling practices with the majority of respondents reporting insufficient information provided by the abortion counselor, insensitive, unhelpful abortion clinic personnel with respect to providing assistance in decision making, and the provision of misinformation thereby contributing to increased anxiety, confusion and levels of post abortion depression and hostility.25

Clearly, effective counseling that is empathic, durational and substantive in content benefits women considering abortion as a solution to an undesired pregnancy. On the other hand, biased “counseling” which is of 5-15 minutes duration, one outcome orient-
The current nature of preabortion counseling virtually insures the impossibility of achieving its objectives.

The provision of information on fetal development further insures that, in deciding whether or not to have an abortion, a woman has an opportunity to use her own personal values, including her view of the time at which human life begins. If she is informed about fetal development and concludes that the unborn child is indeed a human life, then given her legal options, she can act accordingly in light of her own values. If she concludes that either the product of conception or the aborted material is not human, and decides to abort it, then she will have minimized the risk of future potential psychological harm arising from post-operative reflection prompted by obtaining fetal information not “made available to her before it took place.

If information causes discomfort or dissonance, this does not mean it is antithetical to the doctrine of informed consent. According to former U.S. Supreme Court Chief Justice Rehnquist and Justice White: “It is in the very nature of informed consent provisions that they may produce some anxiety in the patient and influence her in her choice. This is in fact their reason for existence, and - provided that the information required is accurate and nonmisleading - it is an entirely salutary reason.”

Predisposing Risk Factors for Postabortion Trauma

Research evidence is clear that certain women are predisposed to significant negative post abortion adjustment. Existing biased abortion counseling places maternal health of these women at risk. These women are in need of more counseling, more information, more exploration and deliberative time, and more assistance than others.

Abortion traumatization may in many cases be prevented or remediated if women who give evidence of documented risk factors receive adequate counsel to make a decision that fits their unique psychological and social needs.

Empirical evidence suggests emotional harm from abortion is probable when the following risk factors are present:

1. prior history of mental illness
2. immature interpersonal relationships
3. unstable, conflicted relationship with one's partner
4. history of a negative relationship with one's mother
5. ambivalence regarding abortion
6. religious or cultural background hostile to abortion
7. single status, especially if one has not borne children
8. age, particularly adolescents versus adult women
9. second-trimester versus first trimester abortions

(e) the non-exploration of alternatives; (f) the absence of information on fetal development; (g) the conflict of interest for the abortion counselor; and (h) the counselor biases.
10. abortion for genetic reasons, i.e., fetal anomaly
11. pressure or coercion to abort
12. prior abortion
13. prior children
14. maternal orientation
15. biased preabortion counseling

Research evidence is clear that certain women are predisposed to significant negative postabortion adjustment.

An example of inadequate abortion counseling is illustrated by Donna M., who came to the Institute for emotional and behavioral evaluation pending a medical malpractice suit against her abortion provider. Because information about gestation and fetal characteristics was not made available, her traumatization was worsened postabortion. She recalls: "... I guess I was a little bit naive. You know, three months, you look at yourself and say, 'I don't look any bigger,' and I hadn't gained any weight, and I felt, you know, what could be really inside of you?"

Prior to her abortion she failed to keep two appointments at the clinic. She expressed considerable ambivalence and moral conflict with the decision, was under pressure to abort by her social worker, and possessed ten of fifteen risk factors for postabortion traumatization, none of which were considered in her preabortion counseling. Clinical evaluation of this patient's functioning supported the finding of Postabortion Syndrome (PAS), a type of Posttraumatic Stress Disorder.29

Women who are emotionally traumatized by their abortions, and perhaps physically traumatized as well, are frequently overwhelmed by the depths of emotions that the abortion experience evokes. The factors of being surprised and overwhelmed by the intensity of the emotional and physical response to the abortion experience frequently act upon the postabortive woman to cause her to resort to the defenses of repression and denial.

Women who repress or deny their emotional responses to the abortion trauma are more likely to re-experience that trauma in memory at a later time.30 When denial breaks and painful symptoms cause significant suffering, it is far more likely at this point that a woman will consider bringing a lawsuit against her abortion provider.

"Every time my period comes around and I see blood, I just start shaking. There it all is again in front of me."

In the case of PAS, re-experience of the abortion event can occur in nightmares or any events during the day associated with childbirth or with abortion. One woman reported a recurring nightmare in which she dreams that her aborted baby is pointing a gun at her and she wakes up in a sweat just before the trigger is pulled.

Re-experience also occurs in PAS women in the form of preoccupation in their waking and sleeping moments with thoughts about pregnancy in general, and the aborted child specifically. Such preoccupation frequently becomes most intense on subsequent anniversary dates of the abortion or on anniversaries of the projected due date of the aborted child.

PAS re-experience also occurs in the form of flashbacks to the abortion experience. As one woman described her flashbacks, "Everytime my period comes around and I see blood, I just start shaking. There it all is again in front of me."

It has been the authors' experience in counseling hundreds of women that many encounter guilt, anxiety, loss, and depression now associated with Postabortion Syndrome. This condition was worsened because they received inadequate and misleading information prior to their abortion. All too often we have heard: "If I knew then what I know now, I would never have allowed myself to get into this mess."

Victims No Longer

While some find their lives filled with daily emotional torture from their abortions, others may be living marginally and unconnected to their abortion feelings. For these women, it may be too difficult or threatening to face the unacknowledged pain of their abortion experience. These women believe feelings buried by design are best left buried.

For this reason, denial is common among women who have elected abortion. In particular,
some women may minimize or deny: (a) that they have experienced an emotional injury, especially when they “chose” to have the procedure; (b) that they feel grief and/or were traumatized; (c) the extent of their emotional suffering from the abortion, particularly when this is minimized by society, friends, and family; (d) that they have had multiple abortions because of the shame and guilt attached to these experiences and because of unmastered unconscious repetition compulsions; (e) the extent of psychological disruption the abortion caused in their psyches and lives because they “deserved” it as warranted punishment; and (f) the need for treatment because the media and many professionals minimize the painful reality of postabortion trauma.

Consequently, the story of the aftereffects of abortion is largely untold and unknown. While appearing “invisible” at the societal level, the story is very visible at the personal level where rhetoric collides with reality and where women live out the consequences of their decisions.

It is recommended that the following necessary changes be instituted to enable enhanced informed consent and remediate deficient standards of abortion counseling:

- Counseling for women considering abortion should only be undertaken by professionals who are trained and who possess a minimum of a master’s degree in the mental health field.
- Counseling for women considering abortion should include complete, full and factual information regarding fetal development, all possible pregnancy outcome alternatives and appropriate referral sources, risks and benefits of each alternative, and risks of non-treatment.

- All women seeking abortion should be required to attend a minimum of three individual counseling sessions of one hour duration before being able to provide their informed consent for the procedure.
- There should be a minimum waiting period of at least one week before being able to provide their assent to abortion.
- All psychological risks of abortion should be explained and carefully evaluated according to each person’s individual background and emotional status. Adolescents should be required to obtain the consent of their parents in order to obtain an abortion, or in the event of severe family dysfunction and/or abuse, an alternative method of evaluation may be substituted, e.g., a juvenile court may appoint an independent social worker to provide a psychosocial assessment of the individual and her circumstances.
- All women seeking an abortion should be fully appraised of their legal rights to carry to term and their right to obtain financial assistance from the child’s father.
- All women seeking an abortion have the right to unbiased professional counseling and a full opportunity to discuss any and all information concerning their crisis pregnancy and possible outcome, as well as be afforded the opportunity to freely and privately ask questions.
- All women considering an abortion should be provided with the opportunity to view a video presentation that is scientifically accurate that depicts human fetal development. In addition, all women should be afforded the opportunity to view a video presentation that depicts both sides of the scientific controversy over Postabortion Syndrome.
- Abortion counseling should not be undertaken by any provider who has any financial interest in the outcome of the pregnancy decision making process.
- Each state should be required by law to compile health statistics on abortion, including morbidity and mortality, and these statistics should be annually forwarded, according to federal regulations, to the Centers for Disease Control.

- Vincent M. Rue, Ph.D. & Anne Speckhard, Ph.D.

VINCENT M. RUE, Ph.D. is Co-Director with his wife, Dr. Susan Stanford-Rue of the Institute for Pregnancy Loss. He has lectured widely both in this country and internationally. He is a traumatologist, researcher, psychotherapist and forensic expert.

ANNE SPECKHARD, Ph.D. has a private clinical, research & consulting practice in Alexandria, VA. She has been a U.S. Public Health Service Fellow and is a frequent trauma & dissociation lecturer regarding pregnancy loss. She is also a forensic expert.
Bibliography

22. In the U.S., the States of Ohio, Pennsylvania, North Dakota, South Dakota, Utah, Montana, Mississippi and Indiana have enacted statutes that expressly proscribe the nature and content of informed consent in pre-abortion counseling and decision making.