Lack of Individualized Counseling Regarding Risk Factors For Induced Abortion: A Violation of Informed Consent.

Part 1

The purpose of this article is to demonstrate that the information provided by abortion facilities to women prior to first trimester suction curettage abortion purportedly describing the risks of abortion, fails to meet the necessary standards for informed consent. The only information provided is of a general nature with the same information provided to all women. However the physical, psychological, social, and reproductive risks of abortion and informational needs varies greatly among women. Thus, there is a lack of informed consent because the information is not tailored to the particular risks or informational needs of an individual woman. In addition, the potential severity of particular risks is either downplayed by use of such generalized terms such as hospitalization or unspecified surgery, or omitted entirely.

Various authorities stress the importance of individualized counseling prior to abortion

Specific informed consent requirements applicable to abortion vary from state to state. But every state has either case law or has statutes requiring informed consent for medical procedures generally. Some states have enacted statutes specifically related to informed consent prior to abortion such as the Woman’s Right to Know legislation. The necessity for informed consent prior to induced abortion is recognized by the U.S. Supreme Court. In the case of Planned Parenthood v. Danforth decided in 1976, in upholding a state statute requiring informed consent prior to abortion the Court stated, “The decision to abort is important and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences.” Later, in Planned Parenthood v. Casey (1992) the Court upheld a state statute requiring a physician to provide a woman seeking an abortion information on the risks of the abortion.

Various authorities stress the importance of individualized counseling prior to abortion. The U.S. Supreme Court has said “it remains primarily the responsibility of the physician to ensure that appropriate information is conveyed to his patient, depending on her particular circumstances.”

Correction
The name of Anne Speckhard, Ph.D. was incorrectly listed as co-author of the article Abortion Malpractice: When Patient Needs and Abortion Practice Collide, Research Bulletin, Vol. 9, No. 1, Nov/Dec 1995. The sole author was Vincent M. Rue, Ph.D. The Editor regrets the error.
Psychological Association has stated in a friend of the court brief filed in Planned Parenthood v. Casey, "Pregnant woman approach the possibility of abortion with widely varying backgrounds, attitudes, levels of knowledge and familial and social support systems. To be effective, the content of the counseling must be tailored to those individual differences and needs." (emphasis in original) The standards of the National Abortion Federation require that "patients must be supplied with materials that accurately pertain to their circumstances." (emphasis in original)

There is only one set of information provided to all women

However, a review of various informational and consent forms from various free standing ambulatory abortion facilities throughout the U.S. used during 1985-1992 reveals that there is only one set of information provided to all women. Usually the information includes a written consent form which sets forth some generalized language relative to possible risks which may be encountered from induced abortion. Again, the language of the consent form is the same for every woman. In attempting to describe the likelihood of certain risks, statistical data may be included, but usually underestimates the statistical risk. More frequently, a possible risk is stated but only by saying that it is rare or infrequent. In virtually no case is the information or consent form tailored to the specific relevant and material risks of an individual woman. Most often, the possible severity of a risk is downplayed or omitted entirely.

The following examples demonstrate why information on relevant and material risks from induced abortion must be tailored to an individual woman in order to meet the requirements of informed consent.

Post-Abortion Infections

There is a wide range of reported incidence of post abortion infections from 0.1% to as high as 43%. The difference is mainly due to (1) differences in defining the word infection; (2) time of observation; and (3) whether or not antibiotics were used.

Types of postabortion infections include pelvic inflammatory disease (PID) which is inflammation of the female genital tract, endometritis which is inflammation of the inner lining of the uterine wall, salpingitis which is inflammation of the fallopian or eustachian tube, and peritonitis, inflammation of the abdominal cavity. The term sepsis or septic abortion is also frequently used to describe any serious infection.

A sample statement from an abortion clinic informational form includes the following:

"Infection is caused by germs from the vagina or cervix getting into the uterus or tubes. The risk of infection associated with early abortion is less than 1 in 100 cases. Such infections usually respond to antibiotics, but in a few cases, a repeat procedure or hospitalization is necessary and occasionally surgery is required."

This statement has several errors or omissions. First, it narrowly interprets the meaning of the word infection to what is immediately observed at an abortion facility, and thus omits infections which occur a few hours, days, or weeks later. It fails to acknowledge that abortion itself can cause infection as well as spread infection. It fails to explain any of the potentially serious complications from post-abortion infections. Finally, it fails to differentiate between different populations which have varying rates of infection because of age or previous reproductive history.

Abortion facilities, to the extent that research has been done, will report only on the immediate effects of abortion, including infections from abortion. But infection following outpatient abortion is difficult to document unless severe enough to require medical attention. One study at a free standing abortion facility in the midwest and another study at a Planned Parenthood facility in New York, both reported less than 0.1% infections. This low figure
is probably because the infection has not yet had the time to manifest itself and usually women remain no more than 1 hour after their abortion. Hospital observation of women tends to increase the percentage of recorded infections. This may be due to better diagnosis, longer observation time or a generally higher at-risk population.

Infections from induced abortion will most frequently arise in the several days or weeks subsequent to the abortion. For example, in a study of 231 Swedish women with bacterial vaginosis who underwent a first-trimester abortion which resulted in post-abortion PID, the mean PID infection time was 5.5 days following their abortion with a maximum time of 16 days. Another study also found that acute salpingitis was rarely diagnosed during the first week after abortion. A postabortion infection might be discovered on a follow-up visit to the abortion facility two to three weeks later, but many women will not return to the facility, in part, because the abortion represents a negative experience. Women may also not return because the doctor performing the abortion is not her regular doctor or may not be available, or because the facility may discourage her from doing so or not offer follow-up services.

Potential Serious Risks

The statement also fails to advise about the potential serious risks from abortion. A current medical text on infections and abortion says, “the patient who desires to (or who must) interrupt her pregnancy, for whatever reason, is in a precarious position. A procedure that may appear simple is fraught with potentially serious, even life-threatening, complications. Therefore, it is imperative that any physician who performs an abortion fully understands the serious complications associated with it... Legal abortion is neither simple nor a safe procedure.”

**A procedure that may appear simple is fraught with potentially serious, even life-threatening, complications**

The same medical text lists acute complications from septic abortion as adult respiratory distress syndrome, septic shock, death, renal failure, abscess formation, and septic emboli. Chronic complications include infertility, pelvic adhesive disease, pelvic pain, and ectopic pregnancy.

The abortion procedure itself can cause an infection because of unsterile instruments or procedures.

**Pre-existing Bacteria or Viruses**

The presence of various bacteria or viruses at the time of the abortion further increases the risk of post-abortion infection. These include gonorrhea, chlamydia trachomatis, clue cells (precursors to chlamydia) or bacterial vaginosis as well as other bacteria or viruses such as Mycoplasma hominis, Group B streptococci and Trachomatis vaginalis. T. vaginalis is reportedly the most prevalent non-viral sexually transmitted disease with 180 million cases reported world-wide and 2.5-3 million infections annually in the United States.

For example, researchers at Johns Hopkins University compared women undergoing first trimester abortion and found that among those without gonorrhea at the time of the abortion only 3.3% had post-abortion endometritis and 1.1% were hospitalized compared to 14.7% incidence of endometritis and a 5.4% hospitalization rate if gonorrhea was present. John's Hopkins researchers had similar findings when chlamydia trachomatis was present at the time of the abortion. The authors stated: “it is believed that a factor in the development of endometritis is the induced abortion itself as it has been documented that dilation of the cervical canal and curettage of the uterine cavity can stimulate spread of an unrecognized infection to the uterine cavity”.

Scandinavian studies have also found that the presence of chlamydia trachomatis infection at the time of the abortion significantly increases the incidence of post-abortion pelvic
inflammatory disease from 4.4% to 23.4% in one study, and from 10% to 28% in another study.

Because of these findings, some experts have concluded that “women applying for abortion should be examined and treated for gonorrhea and infection with chlamydia trachomatis either before or, at the latest, in conjunction with the abortion.”

This is the case because prompt treatment of the chlamydia infection before or in conjunction with the abortion is able to substantially reduce the likelihood of developing chlamydial PID. However, this examination for infection prior to abortion together with treatment before or at the time of the abortion, is not generally being done in U.S. abortion facilities.

Age as a Risk Factor

Age is also a risk factor for post-abortion infection. In a study done at Johns Hopkins University on post abortion endometritis (infection of the uterine wall), it was found that 7% of post-abortion women had endometritis if they were 17 years of age or less at the time of their abortion, compared to only 2.5% among women who were 20-29 years. The difference was statistically significant. Another Scandinavian study found that chlamydia positive women age 13-19 undergoing first trimester abortion were significantly more likely to develop post abortion endometritis (28%).

Long Term Effects

The presence of post-abortion PID has a very significant impact on long term reproduction. For example, in a study by Danish researcher Lars Heisterberg of 382 women without postabortal PID compared to 38 women with postabortal PID, only 5% of those without PID reported any spontaneous miscarriages 5-6 years post abortion, compared to 22% among those women with postabortal PID. Significant differences were also found with secondary infertility (2% vs. 10%), pain during sexual intercourse (5% vs. 20%), chronic pelvic pain (2% vs. 14%), and a new episode of PID within the first year after abortion (5% vs. 41%). Other studies by this same researcher on the long term effects of abortion have shown similar results. This researcher reported that the overall risk of postabortion infections requiring hospitalization among Danish women is 3-5%. Effect of Antibiotics

When and how much of an antibiotic should be used either prior to, at the time of the abortion, or following an abortion is controversial. An optimum regimen for administration of antibiotics is not yet determined because the necessary studies have not been done. Some U.S. abortion clinics who are National Abortion Federation members apparently routinely furnish a prescription to obtain antibiotics following the abortion. However, this does not assure that the antibiotics will be effective because the prescription may not be filled or may not be taken as required. Some women may delay seeking treatment believing incorrectly that the antibiotics will prevent any infection. Other abortion facilities may only provide antibiotics if there are indications of a fever, i.e. 38 degrees centigrade or above. One reason that antibiotics may not be given prior to or at the time of abortion is because a substantial amount of vomiting or nausea may result.

Among some populations, antibiotics administered prior to, or at the time of the abortion, can reduce post-abortion infections 80-90%. However, if the woman is under 20, has had no previous births, has had 2 or more sexual partners, previously had PID, gonorrhea, or untreated lower genital tract infections, antibiotics are considerably less effective or may possibly not reduce infections at all.

Also, delaying the admin-
istration of antibiotics until after the abortion may result in no reduction of infection. In one study which initiated antibiotic treatment to chlamydia-positive women two weeks after their abortion, there was no reduction in salpingitis. Another recent U.S. study found that among women with chlamydia or gonorrhea-related pelvic inflammatory disease, those who delayed care for 3 or more days were 2.6 times more likely to develop impaired fertility compared to those who sought care promptly after the onset of pain. Women with a history of prior induced abortion were likely to delay care. The importance of not delaying care is underscored in a medical text which states, "The major difficulty in preventing the septic complication associated with abortion is not having had the opportunity to examine the patient in the early stages of the infection." Another recent U.S. study found that a previous induced abortion significantly increases the risk of neonatal sepsis in a subsequent pregnancy. Neonatal sepsis has a high rate of infant mortality and is frequently complicated by meningitis. Surviving children frequently have neurological defects.

However, while antibiotics may help reduce infection, sterility may still result. One study reported that, despite antibiotic therapy, women who have had at least one episode of salpingitis, have a rate of 21% of involuntary sterility. Therefore, although antibiotics reduce infections, there is still substantial morbidity as well as potential mortality.

In summary, it is most likely that the overall infection rate from first trimester abortion in the U.S. substantially exceeds 1%. In Denmark, the overall infection rate is estimated to be 3-5%, and because of a number of factors, is likely to be substantially higher in the U.S. However, necessary studies and published data are lacking. As previously outlined, there are many variables which influence the risk of post-abortion infection.

Perforation of the Uterus

The following typical statement relative to uterine perforations is found in abortion clinic informational or consent forms. "Rarely, an instrument may go through the wall of the uterus. The frequency of this event is about 2 per 1000 cases." Another British study found an overall incidence of 0.4% for uterine perforations 21 days post abortion. The rate of perforations or lacerations was 3 times higher in a public hospital compared to a private clinic, 1.8 times higher if sterilization was also performed at the time of the abortion, and 1.37 times higher if gestational age was over 12 weeks compared to under 9 weeks. It was unclear in these studies whether laparoscopic visualization was used to determine the incidence of uterine perforations.

The incidence of uterine perforations has been reported to be much higher if direct laparoscope visualization is used to obtain accurate assessment. For example, one study without direct laparoscopic visualization found only 8 cases of uterine perforation in 6408 women undergoing first trimester abortion (1.3 per 1000), but the same study found 19.8 perforations per 1000 women if direct laparoscopic visualization was used.

The seriousness of uterine perforations range from relatively mild and self-healing to those that result in death.

Another study using laparoscopy to detect perforations, found 30.4 uterine perforations per 1000 women. Thus, it cannot be said that uterine perforations are rare and they appear to be substantially higher than 2 per 1000 abortions.
why a perforated uterus may result from an abortion. Many of these reasons are related to the skill or lack thereof of the person performing the abortion. Thus the incidence of uterine perforations at one facility may not apply to another facility. Various studies have demonstrated that the incidence of uterine perforations is significantly higher if the doctor is inexperienced; lacks ultrasound; underestimates the length of gestation; uses forcible or rigid dilation by using metal dilators as opposed to laminaria tents, Dilipan, or Lamicel; uses general anesthesia instead of local anesthesia; fails to protect against abrupt relaxation of the cervix; or fails to make the correct judgement of the uterine position and size immediately prior to the abortion.

Characteristics of women which make it significantly more likely that the uterus may be perforated at the time of abortion include, obesity, woman has had one or more children or a recent childbirth, has an ante- or retroflexed uterus or has a uterine anomaly. Clearly, an overall average figure would not apply to these particular women because they have an increased risk.

The statement does not discuss the potential seriousness of uterine perforations which range from those that may be relatively mild and self-healing to those that result in death from laceration of the uterine artery. A uterine perforation is a predisposing factor for post abortion infection. If a uterine perforation occurs and goes unrecognized at the time of the abortion, with damage to the bowel or perforation to the bowel, and several hours elapse without treatment, peritonitis and fever can result. This would require immediate hospitalization and treatment and a possible hysterectomy.

Missed Abortion

Missed abortion can have serious consequences for the women because of the potential risk of rupture in the case of ectopic or tubal pregnancy or serious infection and even death of the woman. Typically, abortion facilities state in their informational or consent forms that missed abortion is “rare”. A specific form stated, “abortion fails to end the pregnancy in less than one case per thousand.”

However, there are several reasons why missed abortion may occur with a much higher incidence than one case in a thousand depending upon the circumstances of a particular woman. The leading abortion practice text lists the following possible reasons for missed abortion. These include: failure to interrupt an early pregnancy, ectopic pregnancy, perforation of the uterus, or failure to detect a uterine anomaly. The incidence of missed early abortion (less than 7 weeks gestation) was 6% in one study. A large multicenter prospective study of 33,090 women under the auspices of the Centers for Disease Control (CDC) found that the overall unrecognized rate of missed abortions where the woman left the abortion facility thinking she had an abortion but did not, was 2.3 failures per 1000 abortion procedures at no more than 12 weeks gestation. The rate of unrecognized failure to abort was twice as high among multigravidas as among women with no previous pregnancies. Unrecognized failure rates associated with abortions performed at 6 weeks gestation or less were nearly three times higher than those performed at 7-12 weeks gestation, particularly when smaller cannulas were used. Unrecognized failure rates were more than 90 times as likely to occur in women with uterine anomalies, such as a bicornate uterus, as among women without such anomalies.

Even the unrecognized overall missed abortion rate (2.3) was substantially higher than the rate quoted in the abortion form. Further, the unrecognized missed abortion rate would not include all of the abortions which were missed, because some should be recognized prior to leaving the facility. Little study has been done on women with uterine anomalies, but one study at a military hospital found that as high as 0.48% of women patients had uterine anomalies. Based
up on demographic data on U.S. women published by CDC for 1992, 13.8% of women had abortions at 6 weeks gestation or less and 28% had two or more live births when they underwent abortion. Therefore, substantial numbers of women entering a facility would have an increased risk for a unrecognized missed abortion compared to an overall average risk.

Substantial numbers of women have an increased risk for unrecognized missed abortion

A missed ectopic pregnancy is also a missed abortion. These may rupture at any time and may result in loss of a fallopian tube, ovary, possible hysterectomy, infertility and even death. The CDC has reported that between 1970-85 the estimated rate of ectopic pregnancy concurrent with induced abortion in the U.S. was 1.35 per 1000 abortions. It appears that these ectopic pregnancies are frequently missed. One study published in 1977, found that among 41,753 women seeking abortions only 2 of 11 unruptured ectopic pregnancies were actually diagnosed at a Planned Parenthood abortion facility. It was also reported that many patients were lost to follow-up and that the actual number of ectopic pregnancies not actually diagnosed was probably much greater.

A more recent study of women obtaining abortions at a New York city abortion facility using state of the art diagnostic methods found that 8.7 per 1000 of the women seeking abortion had concurrent ectopic (5.8) or tubal pregnancies (2.9). This is a rate several times higher than the earlier figure of 1.35 concurrent ectopic pregnancies per 1000 abortions reported by CDC from 1970 to 1985. This higher rate may be due to a population with a greater incidence of sexually transmitted diseases or repeat abortions. This same New York City study found that among the women presenting for first trimester abortion, 7.5% were found to be at 13 weeks or greater gestation thus requiring a different method of abortion. These women would also be at risk for missed or incomplete abortion if the usual suction method for first trimester abortion was used. Proper diagnosis thus determines who is at the greatest risk. An overall figure supposedly applicable to all means little and is false and misleading.

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Footnotes


Proper diagnosis frequently determines who is at the greatest risk

16. Induced Abortion: Microbiological Screening and Medical Complications, B Stray-Pederson et al., Infection 19, No. 5305, 1991
18. Untreated Endocervical Gonorrhea and Endometritis Following Elective Abortion, RT
32. Delayed Care of Pelvic Inflammatory Disease as a Risk Factor for Impaired Fertility, SD Hillis et al., Am. J. Obstet. Gynecol. 165:1503-1509, 1993
36. Induced Abortion Operations and Their Early Sequelae, PI Frank et al., J. of the Royal College of General Practitioners, 35:175-180, 1981
49. Infectious Diseases, SL Gorbach, JG Bartlett, MR Blacklow (1992) p.87
51. Morbidity Risk Among Young Adolescents Undergoing Elective Abortion, RT Burkman et al., Contraception 30(2):99, Aug, 1984
55. Uterine perforation During First Trimester Abortion, Lars Heisterberg, Danish Medical Bulletin 35(1), Feb, 1988
58. Infections and Abortion, S Faro and M Pearlman (1992) pp.73-74, 83